



Republic of Rwanda
Ministry of Health



Rwanda Malaria and Neglected Tropical Diseases Annual Report

2025/26



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Foreword

The Ministry of Health and Rwanda Biomedical Centre (RBC) would like to take this opportunity to express our deep gratitude and sincere thanks to everyone (Partners and Stakeholders) who contributed to the compilation of this FY 2025-2026 Annual Report of the Malaria and Other Parasitic Diseases Division (MOPDD) in Rwanda.

This report has been developed based on Health Management Information System (HMIS) and Program Data and program activity reports from July 2025 to June 2026. It presents a comprehensive picture of the prevention, control, and management of malaria and Neglected Tropical Diseases (NTDs) in Rwanda and is structured based on the National Malaria and NTDs Strategic Plans.

Actions needed to control the malaria and NTDs burden in Rwanda require partnership and close collaboration between stakeholders in environmental control programs and strengthening the surveillance systems across all sectors at national and decentralized levels. These programs must be conducted using an innovative and evidence-based package of interventions for prevention, treatment, and support for patients, community health workers, and the communities where these strategies are implemented.

I would like to acknowledge the efforts of the dedicated staff in various government institutions in Rwanda who worked tirelessly to complete this report. We remain entirely grateful for the inputs and support provided by our partners in malaria and NTDs Response.

Special thanks to the members of the Civil Society Organizations, Local and International Non-Governmental, Bilateral Organizations as well as the Rwandan Government institutions who fully supported the implementation of malaria and NTDs control activities during this reporting period.

I would also like to thank all members of the malaria and NTDs Technical Working Groups who reviewed and validated the content of this report. We thank you all for your support in the fight against Malaria and NTDs in Rwanda.



Digitally Signed By Claude Mambo MUVUNYI
Director General

List of Abbreviations

ACT	Artemisinin-based Combination Therapy
AL	Artemether Lumefantrine
ANC	Ante-Natal Care
CDC	Centers for Disease Control
CHW	Community Health Worker
CPDS	Coordinated Procurement and Distribution System
DQA	Data Quality Audit
EPI	Expanded Program on Immunization
EQA	External Quality Assurance
FY	Fiscal Year
GF	Global Fund
GoR	Government of Rwanda
HBM	Home Based Management
HBMA	Home Based Management in Adults
HMIS	Health Management Information System
HSSP IV	Third Health Sector Strategic Plan IV
iCCM	Integrated Community Case Management of Malaria
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
IVM	Integrated Vector Management
LLINs	Long-Lasting Insecticide Nets
MDA	Mass Drug Administration
MoH	Ministry of Health
MOPDD	Malaria and Other Parasitic Diseases Division
MSP	Malaria Strategic Plan

MTEF	Mid-Term Expenditure Framework
NRL	National Reference Laboratory
NSP	National Strategic Plan
NTD	Neglected Tropical Diseases
PCR	Polymerase Chain Reaction
PMI	President's Malaria Initiative
PSM	Procurement and Supply chain Management
QC	Quality Control
QMIA	Quality Management Improvement Approach
RDT	Rapid Diagnostic Test
SBC	Social Behavior Change
SCH	Schistosomiasis
SOP	Sprayer Operators
STH	Soil-Transmitted Helminthiasis
TWG	Technical Working Group
UC	Universal Coverage
WHO	World Health Organization

Executive Summary

The Malaria, Neglected Tropical Diseases and Other Parasitic Diseases Division (MOPDD) is a technical division in charge of coordinating all national efforts in malaria, Neglected Tropical Diseases (NTDs) and Other Parasitic Diseases (OPDs) prevention, diagnosis and treatment countrywide.

Following the sharp resurgence of the previous year, malaria control showed early signs of stabilization in FY 2025-2026: the malaria Annual Parasite Incidence (API) eased from 76 cases per 1,000 persons in FY 2024-2025 to 72 in FY 2025-2026 (a 5% decline, the first reduction since the resurgence), while the slide positivity rate (SPR) fell from 21% to 17%. Incidence nonetheless remains high at 72/1,000, above the FY 2023-2024 level of 45 per 1,000.

The preceding rise had been driven by a complex interplay of factors, including climatic changes such as increased temperatures, humidity and rainfall, together with the growing resistance of mosquitoes to insecticides and partial parasites resistance to antimalarial drugs, which continue to undermine existing control measures. The FY 2025-2026 improvement followed intensified and better-targeted interventions, notably focal and reactive indoor residual spraying and a move to sector-level, incidence-based stratification although these underlying threats persist.

Furthermore, 23 of 30 districts maintained an annual parasite incidence (API) below 100 cases per 1,000 in FY 2025-2026, and 339 of 416 sectors (81%) recorded an API below 100. Uncomplicated malaria cases decreased from 1,075,821 in FY 2024-2025 to 1,023,072 in FY 2025-2026 (a 5% reduction), with 46% of these cases managed at the community level. Compared to FY 2024-2025, severe malaria cases stabilized, rising only slightly from 4,429 to 4,504 in FY 2025-2026 (a 2% increase), after the sharp rise of the previous year.

The number of deaths due to malaria, however, increased from 87 in FY 2024-2025 to 109 in FY 2025-2026 (a 25% increase), driven almost entirely by a concerning rebound in deaths among children under five (from 16 to 36).

During FY 2025-2026, a total of 5,649,770 rectangular ITNs were procured through the combined support of the Government of Rwanda with the Global Fund via RMS Ltd, and United States Government-PMI through TRMS/GHSC-PSM. ITNs were distributed to pregnant women attending their first antenatal care visit and to children under one year receiving MR1 (achieving 93% coverage). Beyond routine and mass distribution channels, ITNs were also provided to special groups such as hospitals, prisons and boarding schools 46,754 ITNs distributed nationwide during the reporting year).

In response to the malaria upsurge in some districts, malaria Reactive Case Detection and index-case household investigation were carried out in Kigali City (Gasabo, Kicukiro, and Nyarugenge Districts), Gisagara and Nyagatare, covering 23 sectors between July and October 2025. Investigation around 46,110 index cases identified 191,382 household members, of whom 113,806 (59%) were tested and 17,359 (15%) were found malaria-positive confirming that transmission clusters around index cases validating the targeted, household-based response. Malaria case investigation was also carried out in Nyagatare, Nyanza, Bugesera, Kicukiro and Gasabo Districts

Indoor Residual Spraying (IRS) was sustained and expanded in FY 2025-2026, covering 98 sectors in total; 28 sectors were sprayed ahead of the peak in October 2025 and 70 in March 2026 combining focal spraying in high-burden districts and hotspots sectors. The intervention showed strong impact: in the 28 sectors sprayed in October 2025, half-year incidence fell by 90% (from 509 to 52 cases per 1,000), compared with a 39% seasonal decline in unsprayed sectors, while dual IRS rounds drove Gisagara from about 930 to 89 per 1,000 and Bugesera from 228 to 30.

To strengthen surveillance and data-driven targeting, the MOH Digital Division rolled out the Community Electronic Medical Record (cEMR), with devices distributed to 99.7% of community health workers and 97.7% of targeted CHWs trained across 17 districts, alongside the adoption of sector-level stratification to tailor interventions to local transmission.

1. Introduction

Malaria and NTDs represent major public health problems in Rwanda and are considered among the leading causes of morbidity and mortality. Rwanda has made significant strides in controlling these diseases through the implementation of various control interventions, including (1) mass and routine distribution of Long-Lasting Insecticidal Nets (LLINs); (2) Indoor Residual Spraying (IRS) in high-endemic districts and hotspot sectors; (3) mandatory laboratory confirmation of malaria before treatment and the use of artemisinin-based combination therapies (ACTs) for uncomplicated malaria, the national scale-up of community-based case management, and the strengthening of routine surveillance, monitoring and evaluation platforms; and (4) Mass Drug Administration (MDA) targeting Soil-Transmitted Helminthiasis (STH) and Schistosomiasis (SCH). Despite these combined efforts, malaria and NTDs remain a public health concern in Rwanda, with millions of people affected every year.

The Rwanda Malaria and NTDs Strategic Plans build on national policies and strategies such as the Health Sector Strategic Plan IV (HSSP IV), which recognizes malaria and NTDs as major diseases contributing to the health and economic burden. The vision of the Malaria and NTDs Strategic Plans is for Rwanda to become free from malaria and NTDs and thereby contribute to socio-economic development. Reducing malaria and NTDs burden will be achieved by strengthening and implementing appropriate control interventions and delivering quality health services. Achieving this vision will require a concerted and collaborative effort between the Government of Rwanda (GoR) and other partners.

Malaria and NTDs control efforts are implemented at all levels through evidence-based interventions to reduce the burden of both diseases in the population. This consists of the effective implementation of high-impact interventions, including countrywide MDA for NTD chemoprophylaxis, mass and routine LLIN distribution, IRS using an effective insecticide in targeted high-endemic malaria sectors, early diagnosis and treatment at health-facility and community level, environmental management, surveillance, monitoring and evaluation, and Social and Behaviour Change Communication (SBCC).

To ensure these interventions are directed where they are needed most, Rwanda has adopted a sector-level, incidence-based stratification of malaria that tailors the mix of interventions to each area's transmission intensity. In FY 2025-2026, the country's 416 sectors were classified into four strata according to their Annual Parasite Incidence (API): high (≥ 100 cases per 1,000 population), moderate (50–99), low (30–49) and very low (< 30). This exercise confirmed that the burden is highly concentrated 77 high-incidence sectors and the 69 moderate-incidence sectors together hold about 39% of the population but 84% of malaria cases, whereas the 211 very-low-incidence sectors (about 47% of the population) account for only 8% of cases. Each stratum is matched to a tailored package of interventions: focal and reactive IRS in high-incidence sectors; reactive IRS combined with mass LLIN distribution in moderate-incidence sectors; mass LLIN distribution in low-incidence sectors; and Reactive Case Detection (RACD) with intensified surveillance in very-low-incidence sectors — underpinned across all strata by routine LLIN distribution to pregnant women, infants and special groups, SBCC, and community-led integrated vector management. This sub-national tailoring concentrates resources on the highest-burden communities while sustaining gains and advancing toward elimination in low-transmission areas.

The following report presents the malaria and neglected tropical diseases (NTDs) control activities carried out between July 2025 and June 2026. These activities were coordinated by the Malaria and Other Parasitic Diseases Division (MOPDD) of the Rwanda Biomedical Centre (RBC), with support from other GoR institutions, health facilities and Community Health Workers (CHWs), and implementing partners, under the leadership of RBC, the Ministry of Health (MoH) and partners.

Malaria Program Results per Strategic Plan Framework

Goal: By 2027, reduce malaria morbidity and mortality by at least 50% of the 2019 levels

Objective 1: By 2027, at least 90% of population at risk will be effectively protected with preventive interventions.

Objective 2: All suspected malaria cases are promptly tested and treated in line with the national guidelines.

Objective 3: By 2027, strengthen surveillance and reporting in order to provide complete, timely and accurate information for appropriate decision making at all levels.

Objective 4: Strengthen coordination, collaboration, procurement & supply management and effective program management at all levels.

Objective 5: By 2027, 85% of the population will have correct and consistent practices and behaviors towards effective malaria control.

The MOPDD and stakeholders have developed a new Malaria Strategic Plan 2026-2030 which came into effect at the beginning of FY 2026-2027. This new strategic plan brings in strategic shifts that would enable the country to move forward with concerted efforts for malaria elimination by 2030. The Malaria Strategic Plan 2026-2030 goal and objectives are as described below.

Goal: By 2030, reduce malaria morbidity and mortality rates by at least 70% of the 2025 levels.

1. By 2030, at least 90% of population at risk will be effectively protected with preventive interventions.

2. By 2030, all suspected malaria cases are promptly tested and treated in line with the national guidelines.

3. By 2030, strengthen surveillance and reporting to provide complete, timely and accurate information for appropriate decision making at all levels.

4. By 2030, strengthen coordination, collaboration, procurement & supply management and effective program management at all levels.

5. By 2030, at least 85% of the population at risk will have correct and consistent practices and behaviors towards malaria control interventions.

PART I: MALARIA PREVENTION

Key Achievements

During the fiscal year 2025/2026, the funding and execution of Indoor Residual Spraying (IRS) enabled the spraying of over 887,256 structures/houses (coverage rate of 99.76%) across 22 districts as as targeted IRS in hotspot sectors.

This effort provided protection to a total population of 3,311,093 in high malaria-endemic areas, including 403,880 children under the age of five and 70,908 pregnant women.

Key Challenges

1. Reduced funding for malaria vector surveillance and control

- The reduction in available funding, further exacerbated by the suspension of United States Government (USG) support in early 2025, necessitated a shift from blanket district-wide IRS to focal IRS targeting sectors with the highest malaria burden. Consequently, the scale of IRS implementation declined from 1,611,699 structures sprayed and 6,121,104 people protected in FY 2024/2025 to 887,256 structures sprayed and 3,311,093 people protected in FY 2025/2026.
- Funding constraints also affected critical entomological activities. Laboratory analyses, including PCR-based mosquito species identification and ELISA testing for Plasmodium infection, could not be conducted, while routine entomological monitoring activities previously supported by the USG in IRS districts were suspended.

2. Temporary interruption of the national entomological surveillance system

- Funding constraints further led to the suspension of routine entomological surveillance activities at the entomology sentinel sites at the beginning of FY 2026/2027, pending the availability of sustainable financial support.
- Rwanda has developed an Integrated Entomological Surveillance Framework based on 30 strategically selected surveillance sites. Once operational, the new framework will strengthen the monitoring of vector bionomics, insecticide resistance, and malaria transmission, while providing a sustainable platform for evidence-based vector control decision-making.

Objective 1: By 2027, at least 90% of population at risk will be effectively protected with preventive interventions

Strategy 1. Sustain and Expand IRS in High Malaria Incidence Districts

1. Introduction

Vector control interventions are crucial for the effective control of malaria and other vector-borne diseases. The World Health Organization (WHO) identifies two core vector-control interventions that have been implemented in Rwanda: Indoor Residual Spraying (IRS) and Long-Lasting Insecticidal Nets (LLINs). IRS involves applying residual insecticide to the interior surfaces of houses, targeting mosquitoes that rest indoors¹. To ensure maximum efficacy, IRS is implemented with high coverage of targeted structures, ideally before the peak malaria transmission seasons. First introduced in the three districts of Kigali City in 2007, IRS was subsequently expanded to rural districts with a high malaria burden by 2011.

Since 2008, these core interventions have been progressively supplemented with additional innovative measures. These include larval source management using bio-larvicides, environmental management, the use of mosquito repellents, and the introduction of larvivorous fish in water dams. These measures aim to address the aquatic stages of mosquito life cycles, reducing the vector population before it reaches maturity. To ensure the sustainability and success of these efforts, Integrated Vector Management (IVM) was introduced in Rwanda. IVM is based on five key pillars: (i) advocacy and social mobilization to engage communities, (ii) collaboration among various sectors and partners, (iii) capacity building to enhance local expertise, (iv) an integrated approach that combines different interventions, and (v) evidence-based decision-making to guide strategies and interventions.

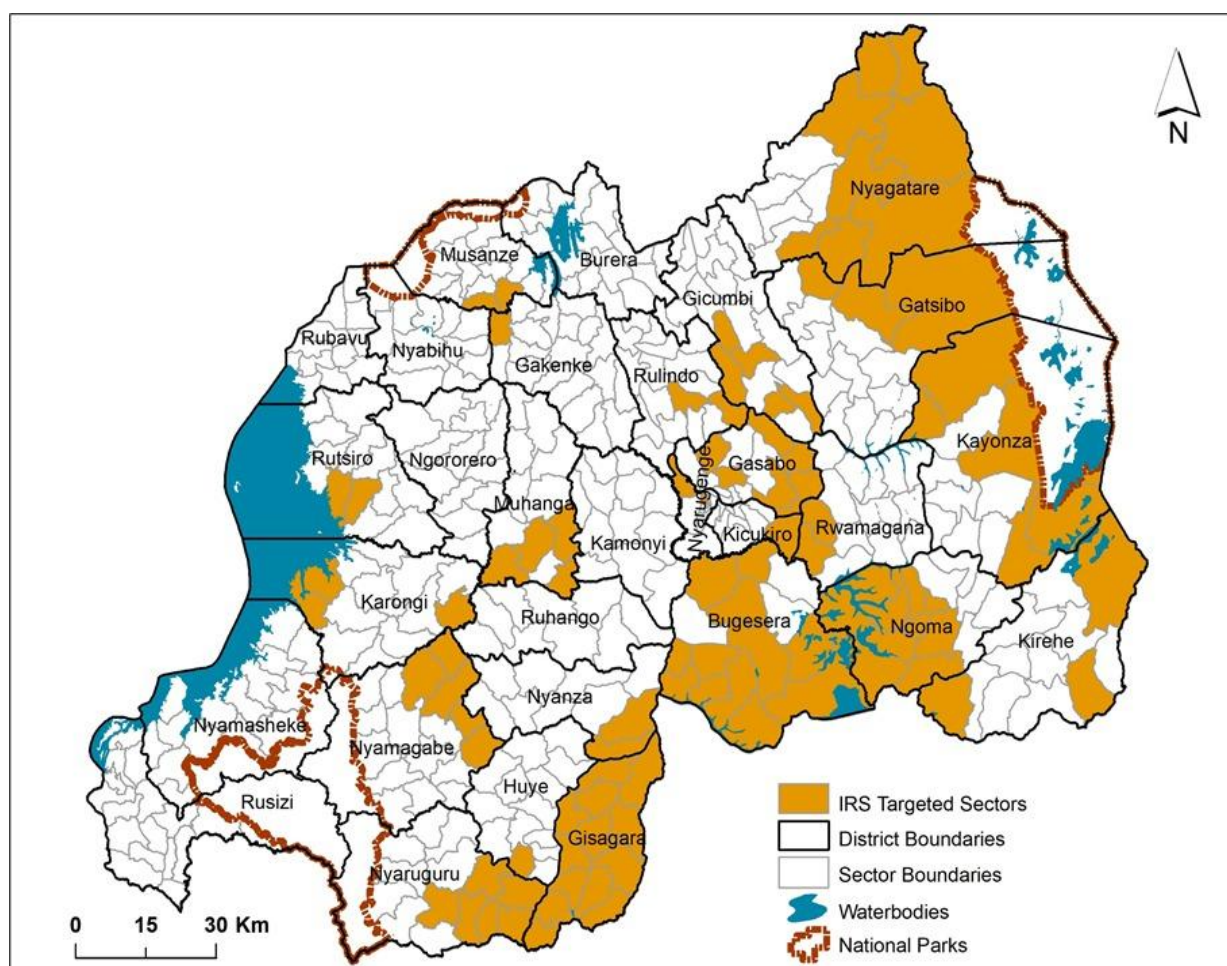
To support this approach, entomological surveillance is conducted annually to gather local evidence on vector bionomics, ecology, and transmission patterns. This surveillance includes monitoring mosquito species composition and density, assessing biting and resting behavior, evaluating vector susceptibility to insecticides, and determining the infection rate of mosquitoes with the Plasmodium parasite. Additionally, the entomological inoculation rate is estimated each fiscal year. The coverage, usage, quality, and durability of vector-control products and interventions are also regularly monitored in collaboration with key partners to ensure continued effectiveness in controlling malaria.

¹ WHO 2018, Malaria terminology, Global Malaria Programme, **Geneva-Switzerland. 38 pp**

2. Indoor Residual Spraying

During FY 2025/2026, Rwanda adopted a revised IRS implementation strategy, shifting from blanket district-wide spraying to a focal, sector-based approach targeting areas with the highest malaria burden. Sector selection was guided by malaria epidemiological data, prioritizing sectors with an Annual Parasite Incidence (API) exceeding 100 cases per 1,000 population. This targeted strategy was designed to maximize the impact and cost-effectiveness of IRS while maintaining high operational quality and coverage.

Figure 1: Map showing the 98 targeted sectors of the new focal IRS strategy

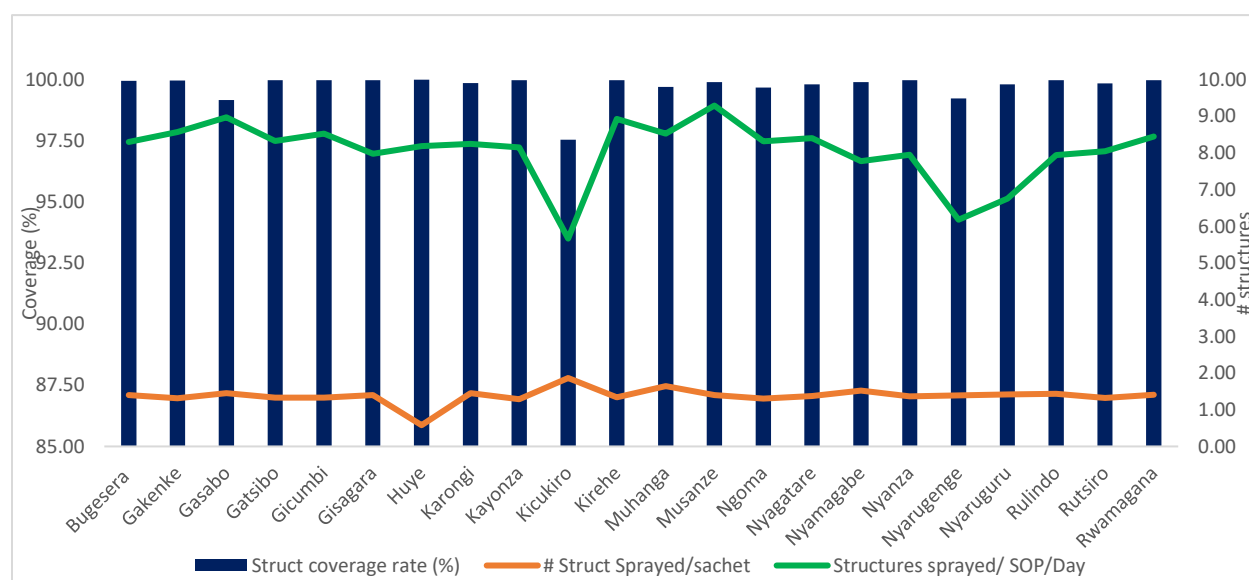


Implementation was conducted in two phases. The first phase took place from October to November 2025, while the second phase was implemented from March to April 2026. IRS operations were delivered through five Civil Society Organizations (CSOs), Society for Family Health (SFH), Rwanda Interfaith Council on Health (RICH), Pro-femmes Twese Hamwe (PFTH), Society for Rwanda (SFR), and CARITAS Rwanda under the coordination of the Rwanda Biomedical Centre (RBC) and with financial support from the Global Fund and the Government of Rwanda.

Overall, 98 high malaria-risk sectors across 22 districts were targeted for IRS. The intervention protected populations residing in the highest malaria transmission foci while optimizing available resources compared with the previous blanket district-wide approach. A total of 894,602 structures were targeted during the campaign, of which 889,382 were found and 887,256 were successfully sprayed, resulting in an overall structure coverage of 99.76%. The intervention protected 3,311,093 people, including 70,908 pregnant women and 403,880 children under five years of age. In total, 3,062,622 rooms were sprayed using 647,259 sachets of insecticide. Vectron™ T500 was the primary insecticide used across the targeted sectors, while Fludora® Fusion was deployed in the Ndera sector (Gasabo District) and Masaka sector (Kicukiro District).

Operational performance remained high throughout the campaign despite the transition to focal IRS. The campaign achieved high-quality implementation across all targeted sectors while improving efficiency by concentrating interventions in the areas contributing most to malaria transmission.

Figure 2: Performance of IRS (Coverage, Structures per SOP per Day and per Sachet)



Regarding the funding of IRS operations, a total of RWF 2,349,201,166 was disbursed by the Global Fund and transferred to the implementing Civil Society Organizations (CSOs) to support IRS operational activities. For insecticide procurement, the Global Fund contributed RWF 15,443,158,834 (85.04%), while the Government of Rwanda contributed RWF 2,717,037,611 (14.96%).

Table 1:IRS implementation by district, and targeted sectors, FY 2025/2026

S/N	District	Sector	Month	Year	# Struct Targeted	# Struct Found	# Struct Sprayed	Coverage (%)	# SOPs	# Struct sprayed / SOP/Day
1	Gisagara	Gikonko	10	2025	9 135	9 011	9 011	100.00	57	7.90
2	Gisagara	Gishubi	10	2025	8 915	9 343	9 343	100.00	56	8.34
3	Gisagara	Kansi	10	2025	6 687	6 714	6 710	99.94	42	7.99
4	Gisagara	Mamba	10	2025	12 920	12 958	12 955	99.98	81	8.00
5	Gisagara	Muganza	10	2025	10 834	10 473	10 470	99.97	68	7.70
6	Gisagara	Mugombwa	10	2025	10 303	9 952	9 945	99.93	64	7.77
7	Gisagara	Mukindo	10	2025	9 059	9 113	9 113	100.00	57	7.99
8	Gisagara	Musha	10	2025	8 390	8 437	8 437	100.00	52	8.11
9	Gisagara	Ndora	10	2025	8 471	8 517	8 517	100.00	53	8.03
10	Gisagara	Nyanza	10	2025	6 052	5 552	5 550	99.96	38	7.30
11	Nyanza	Kibirizi	10	2025	11 234	10 889	10 889	100.00	70	7.78
12	Nyanza	Ntyazo	10	2025	10 198	10 241	10 236	99.95	63	8.12
13	Bugesera	Gashora	10	2025	7 327	7 951	7 945	99.92	46	8.64
14	Bugesera	Kamabuye	10	2025	6 529	6 647	6 635	99.82	41	8.09
15	Bugesera	Mareba	10	2025	7 174	7 306	7 305	99.99	45	8.12
16	Bugesera	Mayange	10	2025	12 058	12 362	12 359	99.98	72	8.58
17	Bugesera	Ngeruka	10	2025	11 404	11 857	11 855	99.98	71	8.35
18	Bugesera	Nyamata	10	2025	10 423	10 380	10 364	99.85	65	7.97
19	Bugesera	Nyarugenge	10	2025	6 837	6 999	6 999	100.00	43	8.14
20	Bugesera	Ruhuha	10	2025	7 889	7 962	7 962	100.00	45	8.85
21	Bugesera	Rweru	10	2025	9 149	9 361	9 361	100.00	57	8.21
22	Rwamagana	Muyumbu	10	2025	11 734	12 197	12 191	99.95	73	8.35
23	Kirehe	Gahara	10	2025	10 945	12 062	12 059	99.98	68	8.87
24	Kirehe	Mpanga	10	2025	9 889	11 121	11 117	99.96	62	8.97
25	Kirehe	Nyamugari	10	2025	10 570	11 811	11 811	100.00	66	8.95
26	Nyagatare	Karangazi	10	2025	19 582	20 576	20 326	98.78	122	8.33

S/N	District	Sector	Month	Year	# Struct Targeted	# Struct Found	# Struct Sprayed	Coverage (%)	# SOPs	# Struct sprayed / SOP/Day
27	Nyagatare	Matimba	10	2025	6 354	6 407	6 407	100.00	40	8.01
28	Nyagatare	Musheri	10	2025	7 998	8 316	8 306	99.88	50	8.31
Total October 2025 IRS round					268 060	274 515	274 178	99.88	1 667	8.22
29	Karongi	Gishyita	3	2026	5 898	6 227	6 226	99.98	37	8.41
30	Karongi	Mubuga	3	2026	5 840	6 011	5 999	99.80	36	8.33
31	Karongi	Murambi	3	2026	5 571	5 610	5 598	99.79	35	8.00
32	Rutsiro	Gihango	3	2026	6 842	6 949	6 947	99.97	43	8.08
33	Rutsiro	Musasa	3	2026	6 403	6 430	6 413	99.74	40	8.02
34	Gakenke	Rusasa	3	2026	4 791	5 146	5 144	99.96	30	8.57
35	Gicumbi	Giti	3	2026	4 622	4 992	4 991	99.98	29	8.61
36	Gicumbi	Kageyo	3	2026	5 201	5 129	5 128	99.98	33	7.77
37	Gicumbi	Mutete	3	2026	7 806	7 799	7 795	99.95	49	7.95
38	Gicumbi	Nyamiyaga	3	2026	5 213	6 521	6 520	99.98	28	11.64
39	Gicumbi	Rwamiko	3	2026	4 471	4 404	4 404	100.00	33	6.67
40	Rulindo	Cyinzuzi	3	2026	3 926	4 032	4 030	99.95	25	8.06
41	Rulindo	Ntarabana	3	2026	6 162	6 112	6 112	100.00	39	7.84
42	Musanze	Nkotsi	3	2026	4 319	4 817	4 817	100.00	27	8.92
43	Musanze	Rwaza	3	2026	5 756	6 975	6 961	99.80	36	9.67
44	Gasabo	Gikomero	3	2026	5 345	5 242	5 227	99.71	195	1.34
45	Gasabo	Jabana	3	2026	15 900	14 193	13 828	97.43	33	20.95
46	Gasabo	Kinyinya	3	2026	31 222	26 367	26 282	99.68	96	13.69
47	Gasabo	Ndera	3	2026	23 694	16 594	16 379	98.70	148	5.53
48	Gasabo	Rusororo	3	2026	15 384	9 365	9 316	99.48	99	4.71
49	Gasabo	Rutungu	3	2026	6 515	6 245	6 244	99.98	41	7.61
50	Kicukiro	Masaka	3	2026	19 616	14 292	13 941	97.54	123	5.67
51	Nyarugenge	Kanyinya	3	2026	7 725	5 922	5 909	99.78	48	6.16
52	Nyarugenge	Mageragere	3	2026	14 876	11 685	11 532	98.69	93	6.20

S/N	District	Sector	Month	Year	# Struct Targeted	# Struct Found	# Struct Sprayed	Coverage (%)	# SOPs	# Struct sprayed / SOP/Day
53	Gisagara	Kibirizi	3	2026	10 323	10 415	10 415	100.00	65	8.01
54	Gisagara	Kigembe	3	2026	6 855	7 364	7 363	99.99	43	8.56
55	Gisagara	Save	3	2026	9 992	9 957	9 957	100.00	62	8.03
56	Huye	Gishamvu	3	2026	4 383	4 421	4 421	100.00	27	8.19
57	Muhanga	Cyeza	3	2026	8 600	9 424	9 420	99.96	54	8.76
58	Muhanga	Muhanga	3	2026	7 146	8 071	7 986	98.95	45	8.94
59	Muhanga	Nyarusange	3	2026	7 048	8 122	8 121	99.99	44	9.22
60	Muhanga	Shyogwe	3	2026	12 689	11 399	11 393	99.95	79	7.18
61	Nyamagabe	Cyanika	3	2026	7 782	7 955	7 955	100.00	49	8.12
62	Nyamagabe	Kaduha	3	2026	5 701	5 786	5 766	99.65	36	8.01
63	Nyamagabe	Mbazi	3	2026	3 808	3 750	3 749	99.97	24	7.81
64	Nyamagabe	Mugano	3	2026	4 914	4 126	4 122	99.90	31	6.65
65	Nyamagabe	Musange	3	2026	5 226	5 490	5 487	99.95	33	8.31
66	Nyaruguru	Cyahinda	3	2026	6 207	6 174	6 154	99.68	38	8.10
67	Nyaruguru	Munini	3	2026	4 920	5 060	5 019	99.19	47	5.34
68	Nyaruguru	Ngera	3	2026	6 526	6 546	6 545	99.98	50	6.55
69	Nyaruguru	Ngoma	3	2026	6 711	7 026	7 026	100.00	50	7.03
70	Nyaruguru	Nyagisozi	3	2026	5 095	4 821	4 821	100.00	37	6.51
71	Nyaruguru	Rusenge	3	2026	6 700	6 900	6 900	100.00	49	7.04
72	Bugesera	Mwogo	3	2026	7 635	7 635	7 635	100.00	48	7.95
73	Bugesera	Ntarama	3	2026	6 081	6 458	6 458	100.00	38	8.50
74	Bugesera	Shyara	3	2026	4 810	4 925	4 923	99.96	30	8.21
75	Gatsibo	Kabarore	3	2026	20 508	20 758	20 752	99.97	128	8.11
76	Gatsibo	Ngarama	3	2026	12 293	12 607	12 607	100.00	77	8.19
77	Gatsibo	Rwimbogo	3	2026	14 096	15 304	15 300	99.97	88	8.69
78	Kayonza	Kabare	3	2026	12 392	12 444	12 442	99.98	77	8.08
79	Kayonza	Murundi	3	2026	15 140	15 284	15 280	99.97	95	8.04

S/N	District	Sector	Month	Year	# Struct Targeted	# Struct Found	# Struct Sprayed	Coverage (%)	# SOPs	# Struct sprayed / SOP/Day
80	Kayonza	Mwiri	3	2026	10 990	11 663	11 656	99.94	69	8.45
81	Kayonza	Ndego	3	2026	7 297	7 527	7 527	100.00	46	8.18
82	Kayonza	Rukara	3	2026	10 884	10 929	10 926	99.97	68	8.03
83	Ngoma	Gashanda	3	2026	5 138	5 260	5 229	99.41	32	8.17
84	Ngoma	Jarama	3	2026	8 397	9 181	9 176	99.95	52	8.82
85	Ngoma	Karemba	3	2026	4 840	4 954	4 948	99.88	30	8.25
86	Ngoma	Kazo	3	2026	8 833	9 076	9 061	99.83	55	8.24
87	Ngoma	Mugesera	3	2026	8 350	8 474	8 466	99.91	52	8.14
88	Ngoma	Mutenderi	3	2026	6 603	6 952	6 950	99.97	41	8.48
89	Ngoma	Rukumberi	3	2026	8 975	9 075	9 020	99.39	56	8.05
90	Ngoma	Sake	3	2026	7 253	7 481	7 438	99.43	45	8.26
91	Ngoma	Zaza	3	2026	7 391	7 836	7 787	99.37	46	8.46
92	Nyagatare	Katabagemu	3	2026	12 049	13 129	13 101	99.79	75	8.73
93	Nyagatare	Mimuri	3	2026	8 896	9 398	9 384	99.85	56	8.38
94	Nyagatare	Nyagatare	3	2026	18 143	19 714	19 714	100.00	113	8.72
95	Nyagatare	Rukomo	3	2026	12 029	12 563	12 562	99.99	75	8.37
96	Nyagatare	Rwempasha	3	2026	6 665	6 724	6 723	99.99	42	8.00
97	Nyagatare	Rwimiyaga	3	2026	17 584	19 390	19 390	100.00	110	8.81
98	Rwamagana	Nyakaliro	3	2026	9 546	10 260	10 260	100.00	60	8.55
Total March 2026 IRS round					626 542	614 867	613 078	99.71	3 963	7.74
Grand Total					894 602	889 382	887 256	99.76	5 630	7.88

Table 2: Population protected, rooms sprayed, and insecticide use by sector

Sector	Population Targeted	Total Pop Protected	Pregnant Women	Children U5 YO Protected	Rooms Sprayed	Rooms Coverage (%)	Average Room per Struct	Qty Insecticides Used	# Struct Sprayed/ Sachet
Gikonko	30 473	30 473	337	3 378	29 615	99.71	3.30	6 813	1.32
Gishubi	33 034	33 034	481	4 150	32 892	99.01	3.56	6 932	1.35
Kansi	26 762	26 746	369	3 198	28 404	99.30	4.26	4 876	1.38
Mamba	45 565	45 554	615	5 632	43 358	98.48	3.40	9 188	1.41
Muganza	38 336	38 325	570	5 303	37 714	99.32	3.63	7 308	1.43
Mugombwa	39 627	39 599	489	5 099	39 185	98.65	3.99	7 533	1.32
Mukindo	34 034	34 034	477	4 487	39 871	99.86	4.38	6 737	1.35
Musha	28 937	28 937	335	3 275	29 636	99.58	3.53	6 012	1.40
Ndora	32 636	32 636	428	3 977	30 157	99.06	3.57	6 623	1.29
Nyanza	20 075	20 068	268	2 333	22 581	99.28	4.10	4 148	1.34
Kibirizi	37 265	37 265	467	4 654	35 248	97.87	3.31	7 717	1.41
Ntyazo	34 854	34 837	412	4 368	32 063	99.67	3.14	7 712	1.33
Gashora	31 883	31 859	398	3 576	25 613	98.32	3.28	5 571	1.43
Kamabuye	26 654	26 606	332	2 986	22 808	98.70	3.48	4 622	1.44
Mareba	29 298	29 294	366	3 288	23 432	97.66	3.28	4 937	1.48
Mayange	49 573	49 561	619	5 563	49 956	99.21	4.07	9 053	1.37
Ngeruka	47 547	47 539	594	5 336	38 721	98.79	3.31	8 547	1.39
Nyamata	41 625	41 561	519	4 665	35 058	97.66	3.46	7 148	1.45
Nyarugenge	28 066	28 066	350	3 150	21 635	99.17	3.12	5 049	1.39
Ruhuha	31 928	31 928	399	3 583	24 705	98.27	3.16	5 451	1.46
Rweru	37 538	37 538	469	4 213	33 449	98.37	3.63	6 400	1.46
Muyumbu	40 128	40 108	488	4 998	44 806	98.08	3.75	8 483	1.44
Gahara	44 275	43 774	603	5 427	45 908	99.48	3.83	9 342	1.29
Mpanga	43 785	40 355	556	5 003	38 499	99.54	3.48	8 236	1.35
Nyamugari	40 369	42 874	591	5 315	21 645	99.65	1.84	8 511	1.39

Sector	Population Targeted	Total Pop Protected	Pregnant Women	Children U5 YO Protected	Rooms Sprayed	Rooms Coverage (%)	Average Room per Struct	Qty Insecticides Used	# Struct Sprayed/ Sachet
Karangazi	81 686	80 694	1 016	9 553	70 861	97.55	3.53	14 809	1.37
Matimba	25 436	25 436	320	3 011	20 143	97.96	3.21	4 467	1.43
Musheri	33 015	32 975	415	3 904	26 894	98.22	3.29	5 850	1.42
Total October 2025	1 034 404	1 031 676	13 283	123 425	944 857	98.76	3.48	198 075	1.38
Gishyita	25 088	25 087	264	2 405	23 261	97.24	3.84	4 033	1.54
Mubuga	22 611	22 582	294	2 596	19 792	98.40	3.35	4 397	1.36
Murambi	37 981	37 958	208	2 160	21 599	98.77	3.90	3 888	1.44
Gihango	28 496	28 492	441	3 033	29 237	98.59	4.27	4 729	1.47
Musasa	25 256	25 202	254	2 554	26 874	96.42	4.33	5 481	1.17
Rusasa	18 515	18 514	195	2 055	18 480	98.69	3.64	3 917	1.31
Giti	17 632	17 632	187	1 941	17 706	96.78	3.66	3 669	1.36
Kageyo	19 325	19 325	192	2 150	18 950	98.31	3.76	4 313	1.19
Mutete	26 562	26 558	290	2 878	28 023	99.39	3.62	6 169	1.26
Nyamiyaga	22 581	22 581	252	2 413	22 428	99.31	3.46	4 442	1.47
Rwamiko	14 579	14 579	146	1 457	16 029	99.26	3.67	3 228	1.36
Cyinzuzi	14 695	14 695	153	1 514	14 721	99.66	3.66	2 738	1.47
Ntarabana	22 903	22 903	254	2 567	21 648	98.33	3.60	4 371	1.40
Nkotsi	17 879	17 879	239	1 783	17 425	99.57	3.63	3 500	1.38
Rwaza	24 996	24 970	416	2 372	20 827	99.71	2.99	4 860	1.43
Gikomero	18 323	18 271	188	1 810	18 898	98.71	3.65	4 016	1.30
Jabana	54 608	53 382	700	6 157	50 538	94.76	3.76	9 163	1.51
Kinyinya	97 507	97 161	2 089	11 550	67 601	96.33	2.66	16 087	1.63
Ndera	60 315	59 503	879	7 394	46 489	95.88	2.92	9 235	1.77
Rusororo	35 359	35 256	437	4 059	30 025	90.26	3.55	8 050	1.16
Rutunga	22 454	22 451	207	2 215	24 833	94.77	4.20	4 688	1.33
Masaka	52 662	51 715	701	6 023	43 509	98.33	3.10	7 474	1.87

Sector	Population Targeted	Total Pop Protected	Pregnant Women	Children U5 YO Protected	Rooms Sprayed	Rooms Coverage (%)	Average Room per Struct	Qty Insecticides Used	# Struct Sprayed/ Sachet
Kanyinya	22 163	22 118	278	2 890	16 652	95.26	2.95	3 967	1.49
Mageragere	43 927	43 352	593	5 281	36 284	94.89	3.27	8 917	1.29
Kibirizi	38 452	38 452	500	4 457	42 799	99.04	4.15	7 800	1.34
Kigembe	25 943	25 943	414	3 133	29 272	99.63	3.99	5 226	1.41
Save	32 340	32 340	375	3 243	35 345	99.19	3.58	5 226	1.91
Gishamvu	15 205	15 205	202	1 847	16 425	99.07	3.75	7 637	0.58
Cyeza	31 962	31 956	313	3 072	28 533	99.34	3.05	8 810	1.07
Muhanga	26 573	26 290	324	2 821	24 642	92.87	3.29	3 034	2.63
Nyarusange	28 443	28 443	294	2 884	25 964	98.64	3.24	7 039	1.15
Shyogwe	51 551	51 536	357	4 305	38 211	96.50	3.47	6 666	1.71
Cyanika	29 324	29 324	293	3 003	29 041	97.51	3.74	3 872	2.05
Kaduha	21 892	21 877	274	2 390	15 592	94.83	2.84	3 398	1.70
Mbazi	12 429	12 429	111	1 351	13 716	98.63	3.71	4 030	0.93
Mugano	14 551	14 544	152	1 621	12 214	97.76	3.03	3 088	1.33
Musange	17 996	17 996	161	1 806	17 267	98.87	3.18	3 477	1.58
Cyahinda	29 829	29 752	352	3 343	22 818	96.64	3.82	4 105	1.50
Munini	21 425	21 317	303	2 724	19 118	95.75	3.95	4 460	1.13
Ngera	25 718	25 713	291	3 024	25 684	96.92	4.05	3 269	2.00
Ngoma	27 272	27 272	367	3 129	28 883	99.69	4.12	4 081	1.72
Nyagisozi	19 656	19 656	256	2 311	21 524	99.73	4.48	5 810	0.83
Rusenge	29 797	29 797	377	3 658	29 133	98.22	4.30	5 197	1.33
Mwogo	26 823	29 258	26 798	26 798	26 821	100.00	3.51	4 646	1.39
Ntarama	24 877	24 877	680	3 338	22 001	97.40	3.50	3 907	1.26
Shyara	15 405	15 400	139	1 613	13 644	97.88	2.83	15 841	1.31
Kabarore	79 027	78 999	1 222	8 809	72 458	98.33	3.55	9 479	1.33
Ngarama	40 693	40 693	562	4 499	41 034	99.13	3.28	11 953	1.28

Sector	Population Targeted	Total Pop Protected	Pregnant Women	Children U5 YO Protected	Rooms Sprayed	Rooms Coverage (%)	Average Room per Struct	Qty Insecticides Used	# Struct Sprayed/ Sachet
Rwimbogo	51 743	51 743	612	6 128	51 645	98.94	3.41	8 951	1.39
Kabare	44 345	44 343	655	5 174	40 201	98.76	3.27	11 489	1.33
Murundi	54 471	54 458	805	6 355	50 694	99.10	3.35	9 400	1.24
Mwiri	41 573	41 542	614	4 848	41 305	97.66	3.63	6 022	1.25
Ndego	26 827	26 827	396	3 130	24 543	99.86	3.27	8 603	1.27
Rukara	38 949	38 940	575	4 544	38 574	98.98	3.57	3 902	1.34
Gashanda	19 852	19 755	252	2 366	21 618	98.92	4.15	7 400	1.24
Jarama	31 141	31 133	567	3 975	31 160	98.75	3.44	3 836	1.29
Karembo	18 608	18 578	203	2 174	20 884	97.39	4.33	6 663	1.36
Kazo	34 094	34 039	401	3 851	34 755	97.87	3.91	6 468	1.31
Mugesera	29 260	29 224	342	3 303	33 158	99.15	3.95	5 490	1.27
Mutenderi	25 876	25 873	286	2 845	26 411	98.07	3.87	6 833	1.32
Rukumberi	35 708	35 508	489	4 336	32 572	97.89	3.67	5 766	1.29
Sake	28 285	28 124	328	3 472	29 107	98.42	3.95	5 899	1.32
Zaza	31 010	30 866	431	3 489	34 321	97.28	4.50	9 633	1.36
Katabagemu	43 416	43 307	487	4 856	43 018	98.95	3.31	6 800	1.38
Mimuri	29 361	29 310	326	3 146	29 922	97.45	3.27	15 049	1.31
Nyagatare	81 414	81 414	1 663	9 922	66 314	97.29	3.46	9 375	1.34
Rukomo	43 056	43 049	476	5 059	41 391	98.50	3.34	5 093	1.32
Rwempasha	28 733	28 733	439	3 583	23 739	98.20	3.60	14 568	1.33
Rwimiyaga	78 695	78 695	1 908	9 741	64 622	96.02	3.47	7 126	1.44
Nyakaliro	32 721	32 721	396	3 722	33 843	98.36	3.35	7 435	1.38
Total March 2026	2 282 738	2 279 417	57 625	280 455	2 117 765	97.76	3.52	449 184	1.36
Grand Total	3 317 142	3 311 093	70 908	403 880	3 062 622	97.76	3.52	647 259	1.36

Key achievements

- Successfully transitioned from blanket district-wide IRS to evidence-based focal IRS targeting high-risk sectors.
- IRS was implemented in 98 priority sectors across 20 districts.
- Achieved 99.76% structure coverage, exceeding the national target of 98%.
- 887,256 structures were sprayed, protecting over 3.31 million people, including 70,908 pregnant women and 403,880 children under five years.
- Implementation through five CSOs strengthened decentralized delivery while maintaining high operational quality.
- Successfully introduced and deployed Vectron™ T500, ensuring continued protection against insecticide-resistant malaria vectors.

Key Challenges

- The transition from blanket to focal IRS required substantial microplanning, community sensitization, and coordination with district authorities to clearly communicate the rationale for sector prioritization.
- Delays in the disbursement of operational funds affected the smooth implementation of IRS activities by the CSOs, making it difficult to meet essential operational needs such as communication, timely payment of suppliers, and other field implementation requirements.
- Recruitment and retention of seasonal spray personnel remained challenging. In particular, some IRS managers were unavailable or not ready for deployment to remote sectors, especially in the Western and Northern provinces. In addition, the age eligibility criteria for Community Health Workers (CHWs) limited the pool of eligible candidates, making it difficult to recruit the required number of personnel in some areas.

3. Insecticide Resistance Monitoring

3.1. Biological Resistance

During FY 2025/2026 (July 2025 _ June 2026), insecticide susceptibility monitoring was conducted in 30 sentinel sites established for routine surveillance of malaria vector resistance. Biological susceptibility tests followed the WHO tube test protocol for conventional insecticides, including representatives of four insecticide classes: carbamates (Bendiocarb 0.1%), organophosphates (Fenitrothion 1% and Pirimiphos-methyl 0.25%), organochlorines (DDT 4%), and pyrethroids (Deltamethrin 0.05%, Permethrin 0.75%, and Alpha-cypermethrin 0.05%). In addition, CDC bottle bioassays were conducted to evaluate susceptibility to the neonicotinoid Clothianidin (4 µg/bottle).

Larvae of *Anopheles gambiae* s.l. were collected from natural breeding habitats using the WHO standard dipping method and reared to adults in field insectaries established at each sentinel site under standard environmental conditions (26–28°C and 70–80% relative humidity). Susceptibility tests were performed using 3–5-day-old, non-blood-fed female mosquitoes, with a minimum of 100 mosquitoes per insecticide (four replicates of 25 mosquitoes) for WHO tube bioassays and 100 mosquitoes (five replicates of 20 mosquitoes) for CDC bottle bioassays. Each assay included two untreated control replicates comprising 50 mosquitoes.

For WHO tube bioassays, mosquitoes were exposed to insecticide-treated papers for one hour and mortality was recorded after 24 hours. For Clothianidin CDC bottle bioassays, delayed mortality was assessed at 24, 48 and 72 hours, in accordance with WHO recommendations for slow-acting insecticides. Mortality was calculated as the proportion of dead mosquitoes among those exposed. According to WHO criteria, mortality of 98–100% indicates susceptibility, 90–97% indicates suspected resistance requiring confirmation, and <90% indicates confirmed resistance.

The results demonstrated that pyrethroid resistance remains widespread among *Anopheles gambiae* s.l. populations across the surveillance sites. Among sites where susceptibility tests were successfully conducted, confirmed resistance was highest for Alpha-cypermethrin 0.05% (85.7%), followed by Permethrin 0.75% (75.0%) and Deltamethrin 0.05% (65.0%) (Table 3). In contrast, susceptibility remained relatively high to DDT 4%, Bendiocarb 0.1%, and Pirimiphos-methyl 0.25%, with very few sites exhibiting confirmed resistance. These findings continue to support the use of non-pyrethroid insecticides for malaria vector control in Rwanda.

It should be noted that not every insecticide was tested at all 30 sentinel sites. In several locations, susceptibility testing could not be performed because insufficient numbers of *Anopheles* larvae were collected and successfully reared to produce the minimum number

of adult mosquitoes required for standardized bioassays. Consequently, the number of sentinel sites included in the analysis varies by insecticide, and all percentages presented in this report are calculated only from sites where susceptibility testing was successfully completed.

Table 3: Biological susceptibility status by insecticide, FY 2025/2026

Insecticide	Class	Sites tested (N)	Confirmed resistance N (%)	Suspected resistance n (%)	Susceptible N (%)
Alpha-cypermethrin 0.05%	Pyrethroid	21	18 (85.7)	2 (9.5)	1 (4.8)
Deltamethrin 0.05%	Pyrethroid	20	13 (65.0)	6 (30.0)	1 (5.0)
Permethrin 0.75%	Pyrethroid	20	15 (75.0)	4 (20.0)	1 (5.0)
DDT 4%	Organochlorine	20	1 (5.0)	5 (25.0)	14 (70.0)
Bendiocarb 0.1%	Carbamate	20	0 (0.0)	9 (45.0)	11 (55.0)
Pirimiphos-methyl 0.25%	Organophosphate	21	1 (4.8)	14 (66.7)	6 (28.6)

Note: Percentages are based only on sentinel sites where susceptibility tests were successfully performed. Missing observations indicate that susceptibility testing could not be conducted because insufficient *Anopheles* larvae were collected and successfully reared to adults.

Figure 3: Distribution of pyrethroids and organophosphates resistance across surveyed sites.

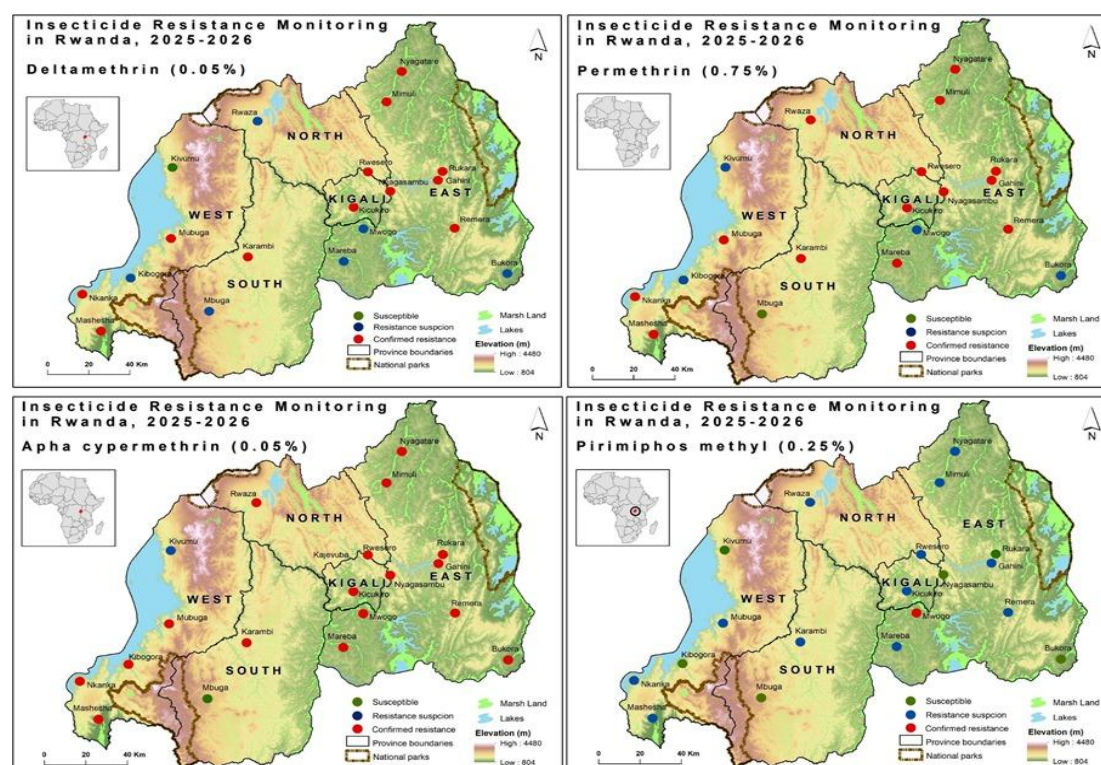
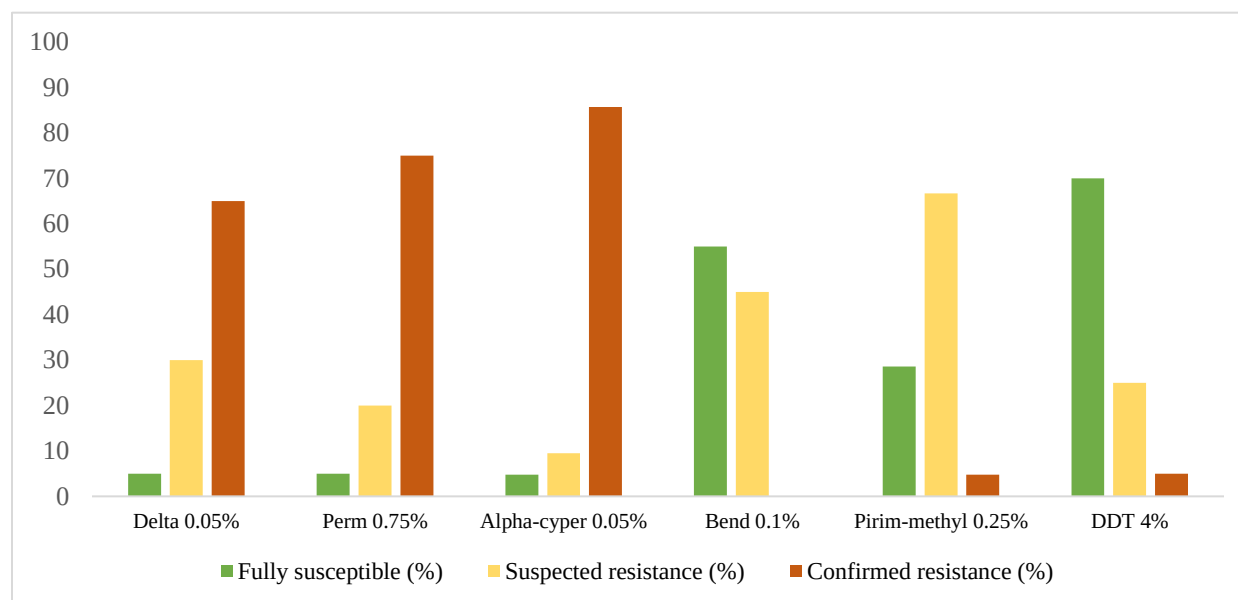


Figure 4: Susceptibility status by insecticide tested, FY 2025/2026



3.2. Resistance Mechanisms

To investigate the contribution of metabolic resistance mechanisms, Piperonyl Butoxide (PBO) synergist bioassays were conducted only in sentinel sites where resistance to the corresponding pyrethroid insecticide had previously been confirmed. Consequently, the number of sites included differed among pyrethroid insecticides.

The addition of PBO substantially restored susceptibility to all three pyrethroids tested. Susceptibility was restored in 66.7% of sites tested with Deltamethrin 0.05% + PBO, 63.0% of sites tested with Permethrin 0.75% + PBO, and 75.0% of sites tested with Alpha-cypermethrin 0.05% + PBO (Table 4). Nevertheless, confirmed resistance persisted in 9.5%, 18.5%, and 7.1% of sites for Deltamethrin, Permethrin and Alpha-cypermethrin, respectively, despite PBO pre-exposure.

The substantial restoration of susceptibility following PBO exposure indicates that cytochrome P450-mediated metabolic detoxification is a major mechanism contributing to pyrethroid resistance among *Anopheles gambiae* s.l. populations in Rwanda. However, because susceptibility was not completely restored at all sites, the results also suggest the involvement of additional resistance mechanisms, including target-site mutations (e.g., knockdown resistance, *kdr*) and other metabolic pathways, which warrant further investigation.

Table 4: Results of PBO synergist bioassays, FY 2025/2026

Susceptibility status	Deltamethrin 0.05% + PBO (n = 21)	%	Permethrin 0.75% + PBO (n = 27)	%	Alpha-cypermethrin 0.05% + PBO (n = 28)	%
Confirmed resistance	2	9.52	5	18.52	2	7.14
Suspected resistance	5	23.81	5	18.52	5	17.86
Susceptibility restored	14	66.67	17	62.96	21	75.00

Note: PBO synergist bioassays were conducted only at sentinel sites where resistance to the corresponding pyrethroid insecticide had previously been confirmed. Consequently, the number of sites differs among insecticides.

3.3. Resistance Intensity Using WHO Susceptibility Test Kits

Resistance intensity assays were performed in sentinel sites where confirmed resistance to pyrethroid insecticides had previously been demonstrated at the diagnostic concentration. The assays employed 5× and 10× WHO discriminating concentrations to determine the intensity of resistance.

The results revealed varying levels of pyrethroid resistance intensity across the surveyed sites (Table 5). At the 5× discriminating concentration, the majority of sites continued to record <98% mortality, indicating moderate-intensity resistance. Specifically, mortality below 98% was observed in 95.2% of sites tested with Deltamethrin 0.25%, 85.2% of sites tested with Permethrin 3.75%, and 89.3% of sites tested with Alpha-cypermethrin 0.25%.

At the 10× discriminating concentration, mortality improved but remained below 98% in a substantial proportion of sites, indicating the persistence of high-intensity resistance. High-intensity resistance was observed in 66.7% of sites tested with Deltamethrin 0.5%, 66.7% of sites tested with Permethrin 7.5%, and 32.1% of sites tested with Alpha-cypermethrin 0.5%. Conversely, mortality of at least 98%, consistent with moderate-intensity resistance, was achieved in 33.3%, 33.3%, and 67.9% of sites for Deltamethrin, Permethrin and Alpha-cypermethrin, respectively.

As with the diagnostic susceptibility assays, resistance intensity testing could not be conducted at every sentinel site because sufficient numbers of adult mosquitoes were not always available following larval collection and rearing. Therefore, the number of sites included in each intensity analysis varies according to insecticide, and percentages were

calculated only among sites where the corresponding intensity bioassays were successfully completed.

The persistence of moderate and high-intensity resistance, particularly to pyrethroid insecticides, highlights the continued selection pressure on malaria vector populations and reinforces the importance of implementing insecticide resistance management strategies, including the deployment of non-pyrethroid insecticides and rotational use of insecticides with different modes of action.

Table 5:Resistance intensity assays, FY 2025/2026

Insecticide	Concentration	Sites tested	Mortality <98%	Mortality ≥98%	Interpretation
Deltamethrin	0.25% (5×)	21	20 (95.2%)	1 (4.8%)	Moderate intensity
Deltamethrin	0.5% (10×)	21	14 (66.7%)	7 (33.3%)	High intensity
Permethrin	3.75% (5×)	27	23 (85.2%)	4 (14.8%)	Moderate intensity
Permethrin	7.5% (10×)	27	18 (66.7%)	9 (33.3%)	High intensity
Alpha-cypermethrin	0.25% (5×)	28	25 (89.3%)	3 (10.7%)	Moderate intensity
Alpha-cypermethrin	0.5% (10×)	28	9 (32.1%)	19 (67.9%)	Moderate intensity

Remark: According to WHO guidance, mortality of ≥98% at the 5× discriminating concentration indicates low-intensity resistance, while mortality <98% indicates moderate-intensity resistance. At the 10× discriminating concentration, mortality ≥98% indicates moderate-intensity resistance, whereas mortality <98% indicates high-intensity resistance.

Conclusion

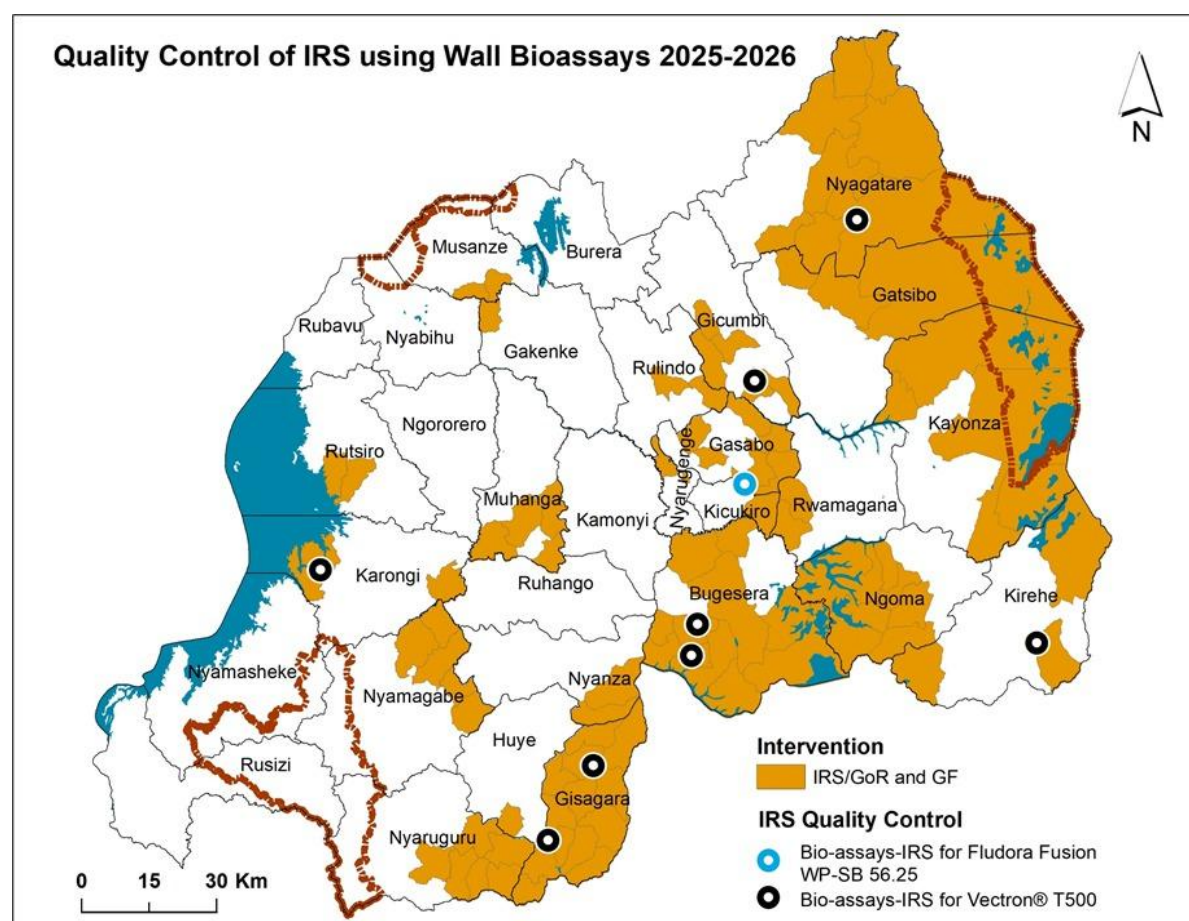
The FY 2025/2026 surveillance demonstrated widespread resistance to pyrethroid insecticides among *Anopheles gambiae* s.l. populations across the sentinel sites where susceptibility testing was conducted. Confirmed resistance was highest for Alpha-cypermethrin 0.05% (85.7%), followed by Permethrin 0.75% (75.0%) and Deltamethrin 0.05% (65.0%). In contrast, susceptibility remained relatively high to DDT 4%, Bendiocarb 0.1%, and Pirimiphos-methyl 0.25%, with very few sites exhibiting confirmed resistance. PBO synergist assays restored susceptibility in approximately two-thirds to three-quarters of resistant sites, suggesting that cytochrome P450-mediated metabolic resistance remains a major mechanism of pyrethroid resistance. Resistance intensity assays further showed that moderate to high intensity pyrethroid resistance persists in

many sentinel sites, supporting the continued use of non-pyrethroid insecticides and insecticide resistance management strategies within Rwanda's malaria vector control programme.

4.4 Quality Control of IRS using Wall Bioassays

IRS quality control was conducted using wall bioassays one week after each Indoor Residual Spraying (IRS) campaign and subsequently on a monthly basis to assess the residual efficacy of the insecticide on sprayed wall surfaces. Wall bioassays were conducted in the districts of Bugesera, Gisagara, Kirehe, Gicumbi, Nyagatare, Karongi, and Gasabo. Vectron® T500 was used for IRS in Bugesera, Gisagara, Kirehe, Gicumbi, Nyagatare, and Karongi districts, whereas Fludora® Fusion WP-SB 56.25 was used in Gasabo District (Kigali City). The wall bioassays were performed to evaluate the persistence and effectiveness of the insecticides on sprayed wall surfaces over time.

Figure 5: Quality Control of IRS using Wall Bioassays 2025-2026



Indoor Residual Spraying (IRS) quality control was conducted in nine sectors across seven districts selected from the 98 sectors that received IRS under the targeted IRS

strategy. During the 2025/2026 IRS campaign, implementation shifted from blanket coverage to a targeted and reactive approach because of substantial reductions in funding from major donors, including the Global Fund and the United States Government. Consequently, IRS was prioritized in high-malaria-incidence and outbreak prone sectors.

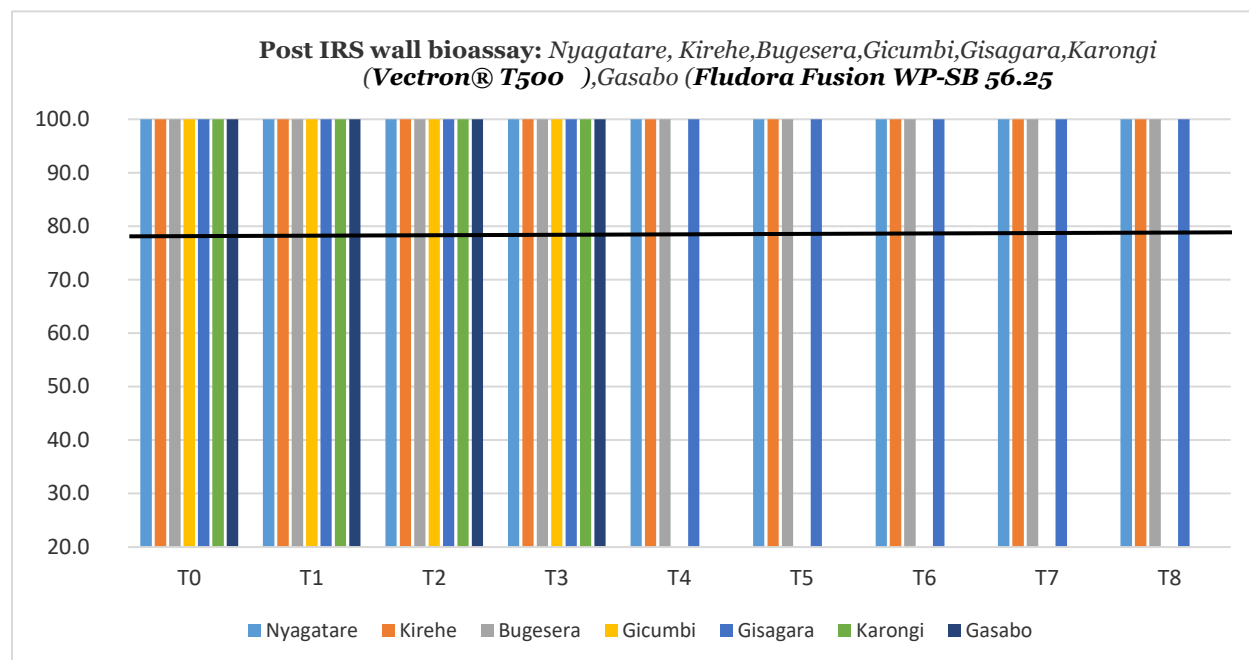
Within each selected sector, six sprayed houses representing the major wall surface types were enrolled for wall bioassays: two plastered and painted houses, two plastered but unpainted houses, and two mud walled houses. Wall bioassays were performed one week after spraying and subsequently at monthly intervals to assess the residual efficacy of the insecticides on sprayed surfaces.

The insecticides evaluated were Vectron® T500, used in Bugesera, Gisagara, Nyagatare, Kirehe, Karongi, and Gicumbi districts, and Fludora® Fusion WP-SB 56.25, used in Gasabo District (Kigali City).

Bioassays were conducted using the insecticide-susceptible Kisumu strain of *Anopheles gambiae* s.s., reared at the Rwanda Biomedical Centre (RBC) Malaria and Other Parasitic Diseases Division (MOPDD) insectary located at the National Entomology Laboratory. Prior to the wall bioassays, the susceptibility of the Kisumu strain was verified using standard WHO susceptibility tests, with mortality exceeding 98%, confirming that the colony was fully susceptible and suitable for quality control testing.

Female mosquitoes aged 2 to 5 days were exposed to treated wall surfaces using WHO cone bioassays. In each house, cones were placed at three positions on the sprayed walls (top, middle, and bottom), with two replicates conducted for each wall surface type. Following exposure, mosquitoes were transferred to holding cups and mortality was recorded at 24-hour intervals for up to 96 hours to capture the delayed mortality effect of the insecticides, particularly Vectron® T500. Mortality was calculated for both exposed and control groups, and results were interpreted in accordance with WHO guidelines for IRS quality control.

Figure 6: Post IRS Wall Bioassays Performed in FY 2025-2026



The results of the IRS quality control assessment are presented in Figure 6. A total of nine sectors from seven districts were assessed following the 2025/2026 IRS campaign. The residual efficacy of Vectron® T500, a broflaniide based insecticide (500g/kg), was evaluated using WHO cone wall bioassays, with mosquito mortality assessed 48 hours after exposure to account for its delayed mode of action. Residual efficacy monitoring was conducted up to eight months (T8) post spraying in Bugesera, Kirehe, Nyagatare, and Gisagara, while Gicumbi, Karongi, and Gasabo were monitored up to three months (T3) post spraying.

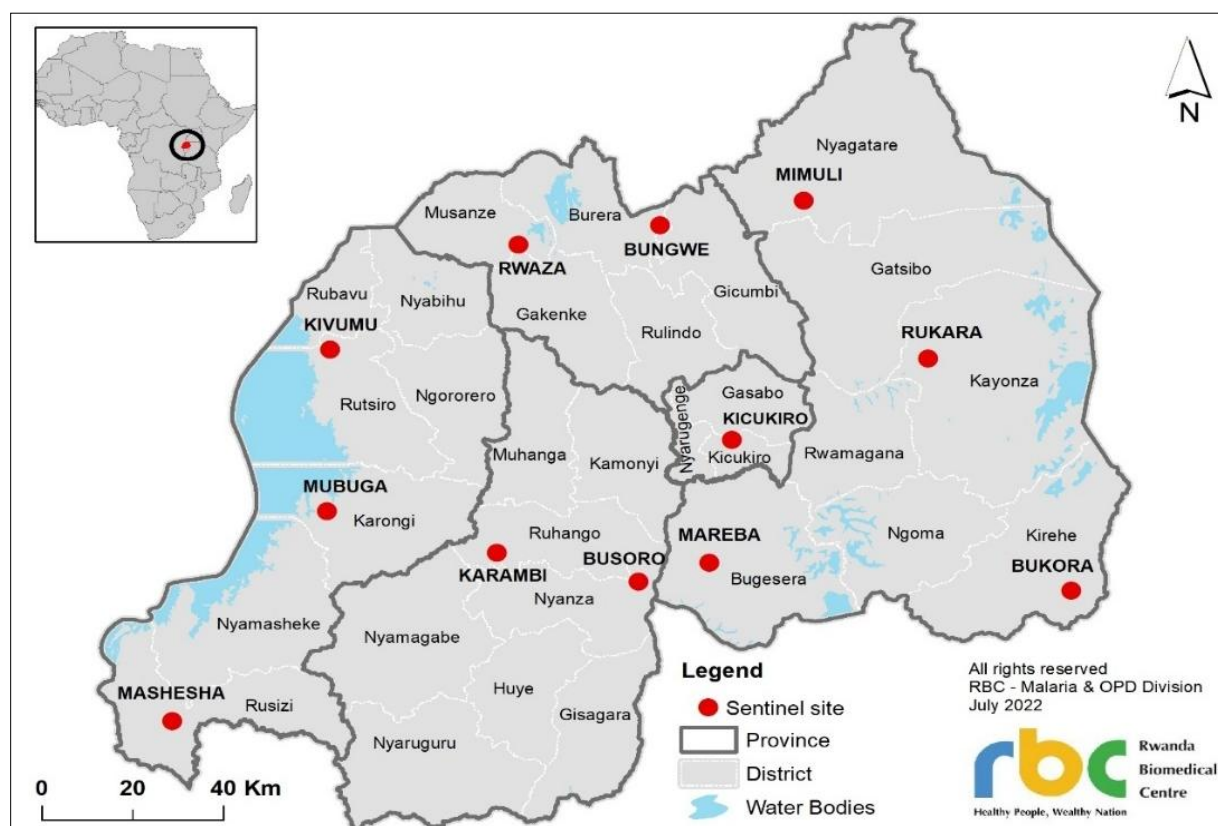
The findings showed that Vectron® T500 maintained mosquito mortality above the WHO efficacy threshold of 80% at 48 hours post exposure throughout the monitoring period, demonstrating sustained residual efficacy on sprayed wall surfaces. Overall, the quality of IRS implementation was satisfactory across all assessed districts and consistent with national and WHO operational standards. Continued monitoring up to 11 to 12 months post spraying is recommended to confirm the full residual efficacy of Vectron® T500 under operational conditions and to guide future IRS insecticide selection and resistance management strategies.

5. Entomology Surveillance in 12 Sentinel Sites

Routine entomological surveillance was conducted at 12 sentinel sites located across Rwanda's different malaria eco-epidemiological strata: Bungwe and Rwaza in the

Northern Province; Rukara, Bukora, Mareba, and Mimuli in the Eastern Province; Busoro and Karambi in the Southern Province; Mashasha, Kivumu, and Mubuga in the Western Province; and Kicukiro in the City of Kigali (Figure 6). Between July 2025 and June 2026, adult mosquitoes were collected monthly using the human landing catch (HLC) method at both indoor and outdoor collection points to monitor malaria vector abundance, species composition, biting behaviour, and other key entomological indicators.

Figure 7: The sentinel sites for entomology surveillance



As shown in Table 6, during the entomological surveillance activities conducted in FY 2025/2026, a total of 83,856 mosquitoes (Culicidae) were collected. Of these, 5.02% were *Anopheles gambiae* s.l., 0.16% were *Anopheles funestus* group, 6.06% were total *Anopheles*, and 93.94% were culicines. Out of the 5,082 *Anopheles* mosquitoes collected, 82.84% were *Anopheles gambiae* s.l., 2.70% were *Anopheles funestus* group, and 14.46% were other *Anopheles* species. Similar to the previous year, *Anopheles gambiae* s.l. remained the primary malaria vector during FY 2025/2026 (Figure 8).

Overall, 67.79% of *Anopheles gambiae* s.l. were collected outdoors, ranging from 0.00% in Bungwe to 95.74% in Bukora. A total of 137 *Anopheles funestus* mosquitoes were collected from five sentinel sites: Bungwe (44.53%, $n = 61$), Kivumu (29.20%, $n = 40$), Mubuga (16.06%, $n = 22$), Karambi (9.49%, $n = 13$), and Mareba (0.73%, $n = 1$). No

Anopheles funestus were recorded in Bukora, Busoro, Rukara, Mashsha, Kicukiro, or Rwaza during the reporting period. Continued targeted vector control interventions, including IRS, should focus on areas where indoor malaria vectors remain established, particularly sites with persistent *Anopheles funestus* populations.

Regarding the human biting rate (HBR), *Anopheles gambiae* s.l. ranged from 0.00 bites per person per night (b/p/n) in Bungwe to 4.88 b/p/n in Mashsha, with an overall average of 0.81 b/p/n. The HBR for *Anopheles funestus* averaged 0.03 b/p/n, ranging from 0.00 to 0.14 b/p/n. The overall Culicidae HBR was 16.18 b/p/n, ranging from 3.00 b/p/n in Busoro to 69.85 b/p/n in Mashsha.

Compared with FY 2024/2025, mosquito collections declined substantially. Total Culicidae collections decreased by 24.82% (from 111,534 to 83,856 mosquitoes), while total *Anopheles* collections declined by 72.76% (from 18,660 to 5,082 mosquitoes). Likewise, *Anopheles gambiae* s.l. collections decreased by 74.23% (from 16,340 to 4,210 mosquitoes), and *Anopheles funestus* collections declined by 70.28% (from 461 to 137 mosquitoes). The overall endophagic rate of *Anopheles gambiae* s.l. was 32.21%, indicating that approximately one-third of *Anopheles gambiae* s.l. mosquitoes were collected indoors, while 67.79% were collected outdoors (Figure 9).

Figure 8: Comparison of *An. gambiae* s.l. and total *Anopheles* collected vs to total *Anopheles* spp and Culicidae FYs 2025/2026

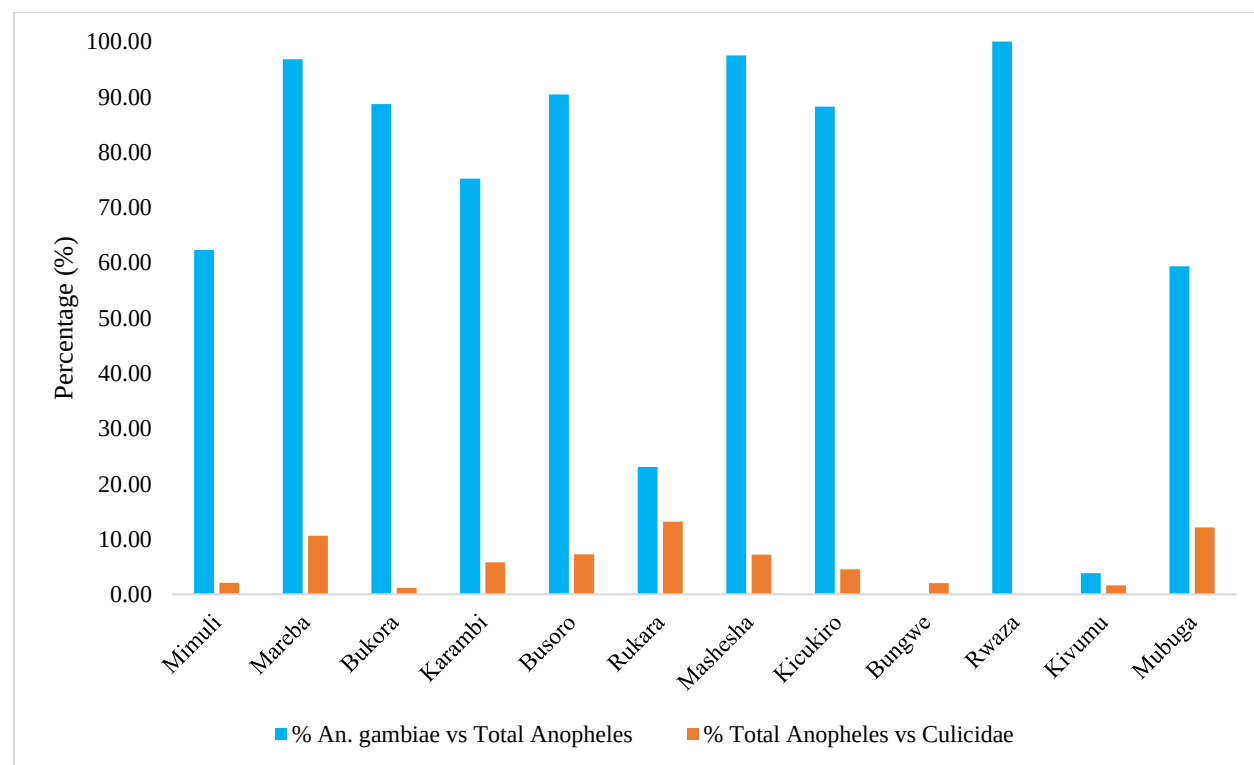


Figure 9: Indoor (Endophagic) and Outdoor (Exophagic) Biting Proportions of *Anopheles gambiae* s.l. by Sentinel Site, July 2025–June 2026

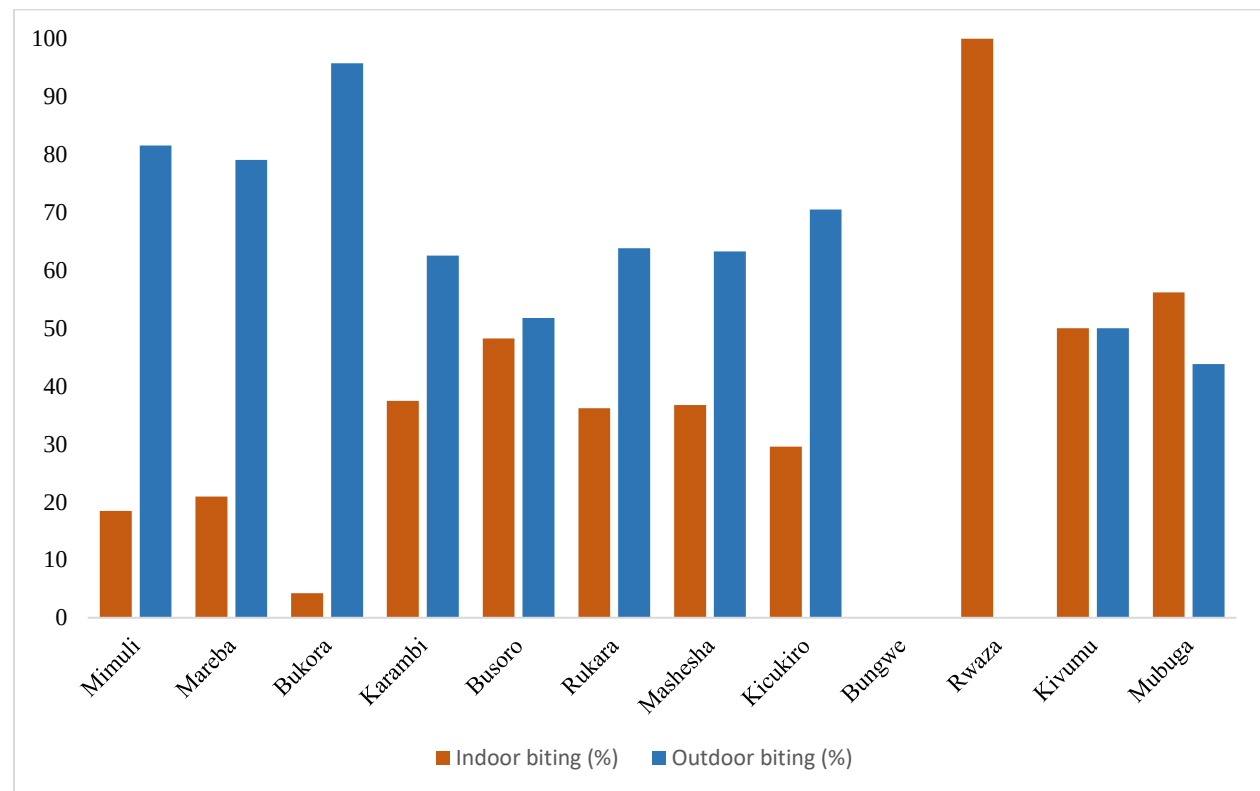


Table 6: Distribution of Malaria Vectors in 12 Sentinel Sites in Number

No	Site	<i>Anopheles gambiae</i> s.l.			<i>Anopheles funestus</i>			Total <i>Anopheles</i>	Total <i>Culicinae</i>	Total <i>Culicidae</i>
		Inside	Outside	Total	Inside	Outside	Total			
1	Mimuli	7	31	38	-	-	-	61	2 842	2 903
2	Mareba	285	1 078	1 363	-	1	1	1 408	11 915	13 323
3	Bukora	2	45	47	-	-	-	53	4 476	4 529
4	Karambi	67	112	179	4	9	13	238	3 864	4 102
5	Busoro	41	44	85	-	-	-	94	1 204	1 298
6	Rukara	21	37	58	-	-	-	252	1 665	1 917
7	Mashesha	775	1 334	2 109	-	-	-	2 164	28 011	30 175
8	Kicukiro	31	74	105	-	-	-	119	2 518	2 637
9	Bungwe	-	-	-	6	55	61	167	8 077	8 244
10	Rwaza	1	-	1	-	-	-	1	1 971	1 972
11	Kivumu	3	3	6	20	20	40	156	9 551	9 707
12	Mubuga	123	96	219	13	9	22	369	2 680	3 049
Total		1 356	2 854	4 210	43	94	137	5 082	78 774	83 856

Table 7: Distribution of Malaria Vectors in 12 Sentinel Sites

No	Site	% An. gambiae vs Total An.	% An. funestus vs Total An.	% Total An. vs Culicidae	% Culicines vs Culicidae	Biting behavior, %				Human biting rate (bi/p/n)		
						Ag. Endo	Ag. Exo	Af. Endo	Af. Exo	Ag	Af	Culicidae
1	Mimuli	62.30	0.00	2.10	97.90	18.42	81.58	0.00	0.00	0.09	0.00	6.72
2	Mareba	96.80	0.07	10.57	89.43	20.91	79.09	0.00	100.00	3.16	0.00	30.84
3	Bukora	88.68	0.00	1.17	98.83	4.26	95.74	0.00	0.00	0.11	0.00	10.48
4	Karambi	75.21	5.46	5.80	94.20	37.43	62.57	0.00	0.00	0.41	0.03	9.50
5	Busoro	90.43	0.00	7.24	92.76	48.24	51.76	0.00	0.00	0.20	0.00	3.00
6	Rukara	23.02	0.00	13.15	86.85	36.21	63.79	0.00	0.00	0.13	0.00	4.44
7	Mashesha	97.46	0.00	7.17	92.83	36.75	63.25	0.00	0.00	4.88	0.00	69.85
8	Kicukiro	88.24	0.00	4.51	95.49	29.52	70.48	0.00	0.00	0.24	0.00	6.10
9	Bungwe	0.00	36.53	2.03	97.97	0.00	0.00	9.84	90.16	0.00	0.14	19.08
10	Rwaza	100.00	0.00	0.05	99.95	100.00	0.00	0.00	0.00	0.00	0.00	4.56
11	Kivumu	3.85	25.64	1.61	98.39	50.00	50.00	50.00	50.00	0.01	0.09	22.47
12	Mubuga	59.35	5.96	12.10	87.90	56.16	43.84	59.09	40.91	0.51	0.05	7.06
Total		82.84	2.70	6.06	93.94	32.21	67.79	31.39	68.61	0.81	0.03	16.18

Abbreviations: In: Inside; Out: Outside; An.: *Anophelines*; An.g: *Anopheles gambiae* s.l.; An.fun: *Anopheles* group

6. Climate Surveillance

The spatial variation in three key climatic variables (temperature, rainfall and relative humidity) plays a significant role in shaping the distribution of malaria vectors. From July 2025 to June 2026, Mashesha (Rusizi District) recorded the highest mean temperature

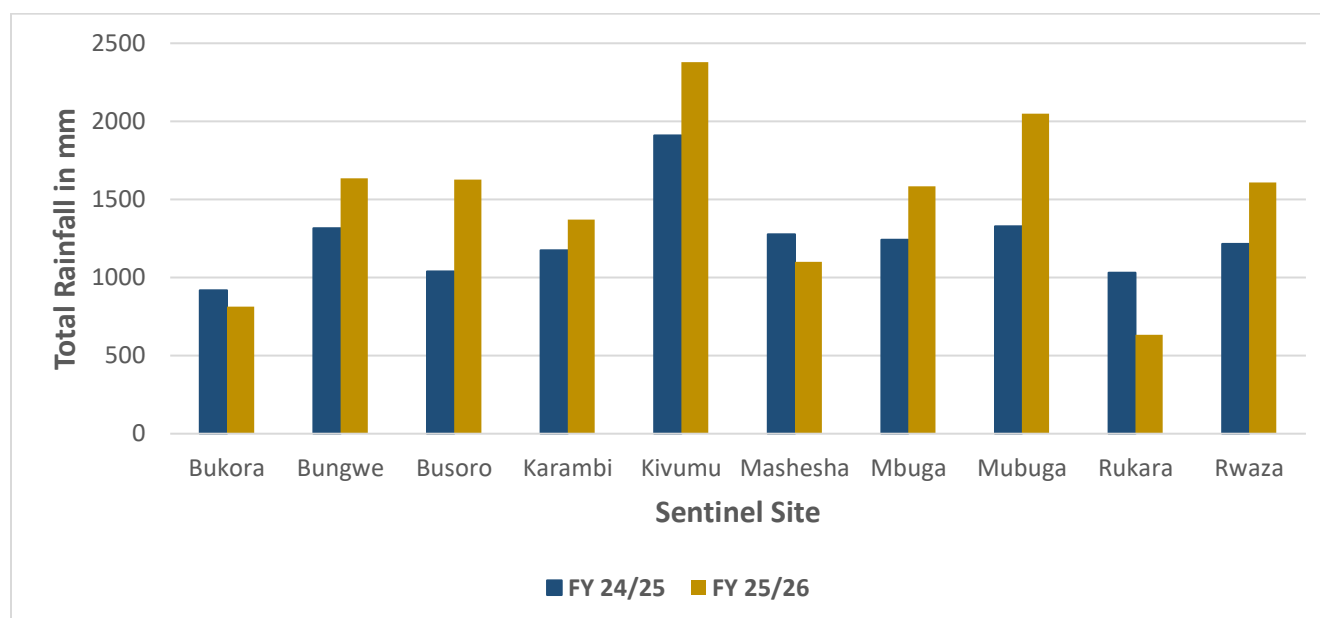
(24.57°C), Kivumu (Rutsiro District) received the highest annual rainfall (2,379.40 mm), and Mbuga (Nyamagabe District) exhibited the highest mean relative humidity (76.54%). Over the same period, seven of the ten sentinel sites recorded annual rainfall totals exceeding 1,200 mm, indicating unusually high precipitation levels. These sites were Karambi (Ruhango District: 1,371.20 mm), Mbuga (Nyamagabe District: 1,584.00 mm), Rwaza (Musanze District: 1,608.40 mm), Busoro (Nyanza District: 1,627.47 mm), Bungwe (Burera District: 1,635.93 mm), Mubuga (Karongi District: 2,049.20 mm), and Kivumu (Rutsiro District: 2,379.40 mm).

Table 8: Annual Rainfall, Temperature, and Relative Humidity for Ten Entomology Sentinel Sites in 2025/2026

District	Station	An. Max Temp	An. Min Temp	An. Mean Temp	An. Rainfall	R. Humidity (%)
Kirehe	Bukora	30.90	15.36	23.12	814.30	65.65
Burera	Bungwe	20.07	12.57	16.32	1635.93	70.16
Nyanza	Busoro	26.97	12.28	19.40	1627.47	61.48
Ruhango	Karambi	27.08	12.47	19.78	1371.20	56.64
Rutsiro	Kivumu	24.62	13.48	19.05	2379.40	70.27
Rusizi	Mashesha	32.26	16.88	24.57	1100.07	65.79
Nyamagabe	Mbuga	23.78	13.52	18.65	1584.00	76.54
Karongi	Mubuga	24.51	14.49	19.50	2049.20	66.43
Kayonza	Rukara	25.55	16.97	21.54	633.47	63.84
Musanze	Rwaza	25.34	13.63	19.48	1608.40	60.41

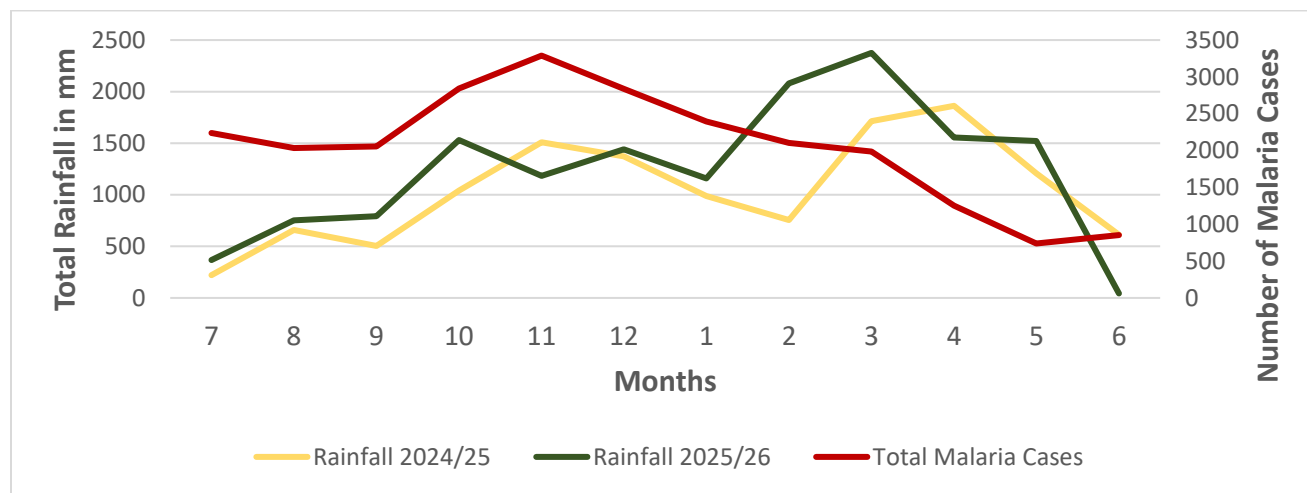
Compared with the previous year, the total annual rainfall increased by 9% during the FY 2025/2026. The average annual rainfall across all sites rose from 1,357 mm in 2024/2025 to 1,480 mm in 2025/2026.

Figure 10: Comparison of Rainfall for year 2024/2025 and 2025/2026



In 2024/2025, rainfall exhibited a bimodal pattern, with peak precipitation occurring in November 2024 and April 2025. During the FY 2025/2026, the rainfall peaks shifted earlier, occurring in October 2025 and March 2026. In both fiscal years, the lowest rainfall amounts were consistently recorded in July and June, corresponding to the main dry seasons (Figure 11).

Figure 11: Annual Rainfall Patterns Reported from 10 Sites, 2024/25 vs 2025/26 and Trends of Malaria Cases



The combined effects of temperature, rainfall, and relative humidity suggest that Mashsha is particularly conducive to malaria vector proliferation compared with the other nine sentinel sites, despite the implementation of vector control interventions. Consistent with these favorable climatic conditions, Mashsha accounted for 42.5% (n=2,164) of all *Anopheles* mosquitoes collected across the 12 sentinel sites, ranking second only to Mareba (Bugesera District), which contributed 27.7% (n=1,408) of the total collections.

Overall, the climatic conditions recorded across the ten monitored sentinel sites indicate that most of these areas remain environmentally suitable for malaria transmission within their respective catchment areas. Evidence indicates that malaria transmission is most likely to occur in areas where the mean monthly temperature ranges from 18°C to 35°C, monthly rainfall exceeds 80 mm, and relative humidity is greater than 60%², particularly in settings where malaria prevention and vector control measures are insufficient or inadequately implemented.

² Ceccato P., Connor S. J., Jeanne I., Thomson M.C. Application of Geographical Information Systems and Remote Sensing technologies for assessing and monitoring malaria risk. *Parassitologia* .47.1 (2005), 81-96

7. Supplemental Vector Control Activities

7.1 IVM training and support to other vector borne diseases surveillance

In the framework of integrated vector management (IVM) approach, building capacity and strengthening inter-sectorial collaboration, and community based environmental management and entomology surveillance, the following activities were achieved:

- The RBC/MOPDD in collaboration with Jhpiego and SFH conducted the IVM capacity building in 3 districts, covering 5 sectors. The training targeted different stakeholders at sector level. In total 453 participants have been trained as IVM trainers to support and cascade awareness and training on IVM approach to the identified targeted groups at the lay communities. The training used mixed training methods involving in class theories and in field practices for mosquito larval collection and their physical identification “learning by doing or seeing” in anophelines and culicines levels. The participants were identified in collaboration with respective districts, Jhpiego and SFH. The trainees were mainly made by in charge of agriculture and livestock (Agronome), president of rice farmers cooperatives (where applicable), president of fish farmers cooperatives (where applicable), president of mining cooperatives (where applicable), in charge of social affaires, in charge of schools, in charge of community health workers, head of health center, malaria focal person and CHW representative at sector level.
- The RBC/MOPDD in collaboration with Rwanda Environmental Management Authority, Rwanda Entomology Team have conducted Entomological Field assessment in Kigali eco-tourism Marshlands for the public health risks identification and report were the potential creation of conducive environment for mosquito breeding sites in case the mitigation measures are not implemented. The primary public diseases highlighted were malaria transmitted by mosquitoes and schistosomiasis transmitted by aquatic snails. In addition, different infrastructures enabling gathering of eco-tourists and neighboring communities will be developed in each rehabilitated marshland.

Therefore, despite these above findings, any vector control measures and surveillance have not been mentioned during the management of the project. The only mitigation measure was proposed during the construction phase and regarding the intensification of awareness on malaria and its prevention. Any vector control measures and surveillance were proposed on malaria and schistosomiasis diseases. It is also important to mention that the lack of appropriate management solid and liquid waste, such as latrines, solid waste, etc., may contribute to the creation of suitable habitats of other insects such as flies, cockroaches that are transmitting mechanically some protozoas, helminths, bacterias to humans.

In total, 17 facilities under construction in the five marshlands have been visited and mapped. The potential key public health observed were the creation of stagnant water, the potential poor drainage allowing flowing of water, the mosquito breeding sites, and potential snail habitats that are hosts of schistosomiasis parasites. These were observed across sites and may

increase the risks of malaria and other vector-borne diseases in case their mitigation measures are not included/considered in management phase of the project.

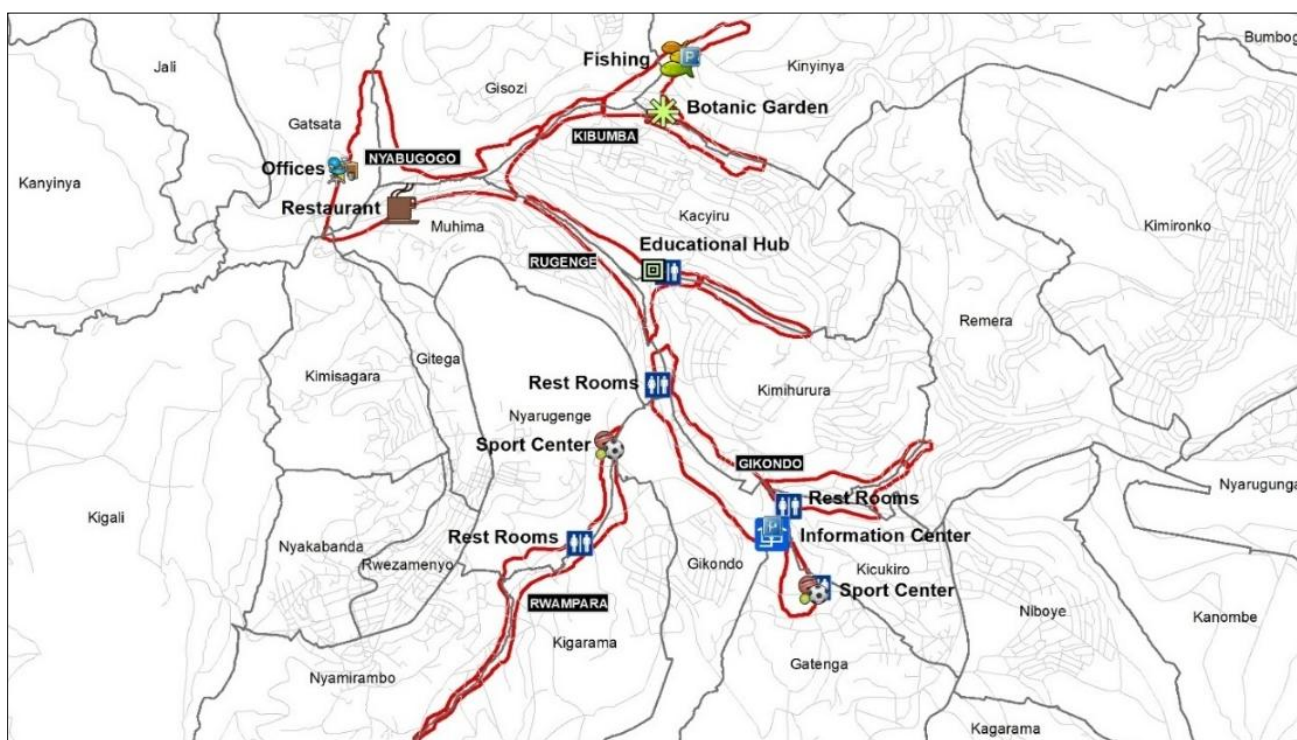


Table 9: Mosquito Larvae Survey

Infrastructure Location	Week1		Week II		Week III		Density	
	#Larvae	#Pupae	#Larvae	#Pupae	#Larvae	#Pupae	Larvae	Pupae
Marsh1	0	0	0	0	0	0	0	0
Marsh2	0	0	0	0	0	0	0	0
Marsh 3	0	0	0	0	0	0	0	0
Marsh 4	0	0	0	0	0	0	0	0
Marsh5	36	45	210	42	556	40	9.27	2.12
Total	36	45	210	42	556	40	9.27	2.12

Table 10:Adult Mosquito Survey

Infrastructure Location	Week1		Week II		Week III		Total	
	An. collected	Culex Counted	An. Counted	Culex Counted	An. Counted	Culex Counted	Total An. Counted	Total Culex Counted Culex
Marsh1	0	22	0	62	0	18	0	81
Marsh2	0	21	0	19	0	21	0	61
Marsh 3	0	14	0	13	0	23	0	50
Marsh 4	0	21	0	31	0	28	0	80
Marsh5		31	0	113	0	35	0	238
Total	0	109	0	238	0	125	0	510

Table 11:Malacology Surveys

Infrastructure Location	Week1		Week II		Density	
	Total Collected	Total Infected	Total Collected	Total Infected	Total Collected	Density
Marsh1	91	2	115	6	156	5.25
Marsh2	0	0	21	2	146	2.62
Marsh 3	42	3	52	10	136	2
Marsh 4	37	0	64	3	176	4.27
Marsh5	NA	NA	100	5	100	5.55
Total	70	5	352	26	714	19.69

- The RBC/MOPDD and Emergency Preparedness and Response Division (PHS&EPR division) in collaboration with Rwanda Agriculture Board (RAB) have started Entomological surveillance in Districts where confirmed the outbreaks of Rift Valley Fever Vectors which is a zoonotic mosquito-borne viral disease of domestic and wild ruminants that can cause severe disease in a small proportion of infected humans and it is also threatens primarily animal health but also with a capacity to infect humans.
- Building at the village and community levels, where most vector control activities are implemented, should remain a central component of Integrated Vector Management (IVM). Adequate resources should be allocated to sustain and expand training, strengthen community participation, and promote community-based environmental management. This should include regular door-to-door mosquito breeding-site assessments to identify, eliminate, and manage potential larval habitats, particularly in peridomestic settings. Communities should be encouraged and empowered to take ownership of routine larval source management through actions such as removing stagnant water, clearing blocked drainage, properly managing water storage containers, improving environmental sanitation, and eliminating other potential mosquito breeding sites.

- These interventions are particularly important as part of Rift Valley Fever (RVF) outbreak response, while also contributing to the prevention and control of malaria and other vector-borne diseases whose vectors breed in or around households. Routine malaria vector control should therefore be integrated with RVF preparedness and response activities to promote coordinated, timely, and sustainable vector control. Adequate resources, community engagement, and continuous capacity building will be essential to achieve broad coverage and sustained implementation of effective vector control interventions at household and community levels.

Table 12: Summary Adult Mosquito Collection

HHs surveyed	Trap Used		# of Mosquito Collected			Density		
	TRAP Nights/BG	Trap nights/ CDC-LT	BG	CDC-LT	Total Collection	BG	CDC-LT	Average Density
3	9	9	112	648	760	12.44	72.0	42.22
3	9	9	8	745	1154	0.89	82.8	64.11
3	9	9	29	72	101	3.22	8.0	5.61
3	9	9	114	662	776	12.67	73.6	43.11
3	9	9	17	1149	1166	1.89	127.7	64.78
3	9	9	81	1999	2080	9.00	222.1	115.56
3	9	9	9	57	66	1.00	6.3	3.67
3	9	9	6	54	60	0.67	6.0	3.33
3	9	9	23	156	179	2.56	17.3	9.94
27	81	81	399	5,542	6,037	40.11	586.10	335.39

7.2 Support to collaborators and dissemination of best practices

1. Support to collaborators or partners

The support was provided by the vector control unit through the joint projects or on requests from partners. The following are the supports that we provided during this financial Year 2025/26.

a- Tech for Health Equity Foundation (TFHE-Foundation)

Through the collaboration with Tech for Health Equity Foundation (TFHE-Foundation) and CHARIS UAS. RBC/MOPDD and, an Innovative Research Protocol entitled “Tech Enabled Larval Source Management (LSM) in Malaria Control, Sub Urban of Kigali, in Rwanda” was jointly prepared and received funding from Bill and Melinda Gates Foundation for three years (September 2025-August 2028). The above research project was presented to the Rwanda Research Ethic Committee (RNEC) and received the ethic clearance IRB00001497, RNEC 1000/2025. The above research project has the following main objective that aiming to develop and validate a scalable malaria control model by implementing LSM powered with drones and AI technologies and assess its impact on efficiencies, agricultural crop yields and community perceptions and acceptance in Sub Urban of Kigali, Rwanda.

This main objective will be achieved following these specific objectives:

- To develop and validate AI and deep learning models for detecting and prioritizing high-risk mosquito breeding sites for targeted LSM.
- To assess and generate data-driven evidence on the sustained entomological and epidemiological impact of technology-enabled LSM on malaria transmission.
- To analyze the correlation between improved mosquito control (Bti application) and increased crop yield and productivity.
- To assess the socioeconomic impact of technology-driven LSM through community, gender, and cost-effectiveness analyses.

The above objectives will be accomplished through the following work packages of activities and each one led by a co-investigator with related expertise: **1-** Remote Sensing and AI-Driven Habitat Detection, **2-**Entomological and Epidemiological Impact – Assessing Vector Population Declines, **3-**Agricultural Impact – Evaluating Crop Productivity, **4-**Operational and Programmatic Efficiency and Cost effectiveness of Targeted LSM, Enhanced Targeted LSM vs No LSM, **5-**Community Engagement, Perceptions, and Socio-Economic Impact. The institutions collaborating for implementation of this project are respectively:

National Collaborators: 1- Rwanda Biomedical Centre (Division of Malaria and Other Parasitic Diseases Control, Division of Research, Innovations and Data Sciences), 2- TECH for Health Equity-Foundation, 3- Charis Unmanned Aerial Survey (UAS), University of Rwanda, Kigali, Rwanda, 4- University of Rwanda. Two **external collaborators** are: 1- London School for Hygiene and Tropical Medicine (LSHTM), London, UK, Department of Medical Entomology, Michigan State University, Michigan, USA.

b- Charis UAS and GIZ

Another small project entitled “Initiative of Drones Against Malaria” is supported by GIZ and implemented by Charis UAS in collaboration with the district of Bugesera. The project started from January 2026 and will be extended to 12 months of period. This drone based larviciding project targets the largest marshland covering 93 ha and located between the two sectors of Mareba and Ruhuha with high malaria transmission. It will enable us to significantly reduce malaria burden through the abatement of mosquitoes in irrigated rice fields with two farming seasons, and thus to control the residual malaria cases from outdoor interventions. The collaborative partners in implementation of this project are respectively: 1- Rwanda Biomedical Centre/MOPDC Division, 2- Rwanda Agricultural Board (RAB), 3- Rwanda Ministry of Local Government, 4- Rwanda Civil Aviation Authority, 5- Rwanda Information Society Authority (RISA), 6-Charis Unmanned Aerial Survey Company (Charis UAS)

c- Other supports to partner institutions

Following the requests of partners of RBC/MOPDD regarding the abnormal nuisance of mosquitoes in their catchment settlements, two investigations of mosquito breeding habitats have been conducted respectively in Kigali Golf Club-Nyarutarama from 17 to 21 November 2025 and the second investigation was conducted at King Faisal Hospital between 29-30 January 2026.

2. Dissemination of vector control best Practices

In FY 2025/26. The vector control unit contributed to the preparation, submission of four abstracts that were accepted for presentation at the American Society for Tropical Medicine and Hygiene (ASTMH) 9-13 November 2025 at Metro Toronto Convention Centre, Toronto Ontario, Canada. The following abstracts have been accepted and published:

- a. Identification of potential vectors and detection of rift valley fever virus in mosquitoes collected before and during the 2022 outbreak in Rwanda (Abstract #6105)
- b. Elias et al., 2025: Improving vector surveillance through Digital innovation: impact and lessons from the introduction of vector borne diseases platform (VBDS360) in Rwanda (Abstract #6704)
- c. Beatus et al., 2025: The physical integrity and survival patterns of Interceptor® G2, PermaNet® 3.0, Yahe® and Olyset® brand insecticide-treated nets in Rwanda from 2020 to 2023. (Abstract # 6976)
- d. Dunia et al., 2025. Identifying key breeding habitats of malaria vectors to inform larval source management in Peri-urban Gasabo district, Kigali, Rwanda. (Abstract #7366)

The following abstract has been accepted at ASTMH annual meeting 2025 for presentation during the symposium sessions “Bytes Against Bites: Building A Unified Digital Framework for Vector Surveillance and Control”

8. Overall key challenges

1. Reduced funding for malaria vector surveillance and control

- The reduction in available funding, further exacerbated by the suspension of United States Government (USG) support in early 2025, necessitated a shift from blanket district-wide IRS to focal IRS targeting sectors with the highest malaria burden. Consequently, the scale of IRS implementation declined from 1,611,699 structures sprayed and 6,121,104 people protected in FY 2024/2025 to 887,256 structures sprayed and 3,311,093 people protected in FY 2025/2026.
- Funding constraints also affected critical entomological activities. Laboratory analyses, including PCR-based mosquito species identification and ELISA testing for Plasmodium infection, could not be conducted, while routine entomological monitoring activities previously supported by the USG in IRS districts were suspended.

2. Temporary interruption of the national entomological surveillance system

- Funding constraints further led to the suspension of routine entomological surveillance activities at the entomology sentinel sites at the beginning of FY 2026/2027, pending the availability of sustainable financial support.
- Rwanda has developed an Integrated Entomological Surveillance Framework based on 30 strategically selected surveillance sites. Once operational, the new framework will strengthen the monitoring of vector bionomics, insecticide resistance, and malaria transmission, while providing a sustainable platform for evidence-based vector control decision-making.

Strategy 2. Sustain Universal Access to Long Lasting Insecticide Treated Nets (LLINs)

Key Achievements

Nets secured: 5,649,770 dual-active-ingredient LLINs mobilized for the period through the Government of Rwanda, the Global Fund (RMS Ltd), and the USG (PSM and TRMS/GHSC-PSM).

Strong household mass-campaign coverage: 1,720,486 nets distributed (94% of planned), reaching 705,033 households (95% coverage) across 88 targeted sectors in 19 districts.

Smarter, incidence-based targeting: Shifted from district-wide to sector-level targeting (30–99 cases/1,000 population), guided by surveillance data, covering 114 health-centre catchment areas and focusing resources on the highest-risk populations.

Solid routine distribution: national coverage of 91.7% (ANC) and 92.8% (EPI); 18 districts reached ≥95% for ANC and 22 for EPI, with 10 districts achieving ≥95% on both supported by effective micro-planning, CHW mobilization, close supervision, and net reconciliation.

Key Challenges

Funding shortfalls reduced the planned quantity of nets, which is expected to weaken the overall effectiveness of the strategy.

Low-performing pockets in the campaign, notably Kicukiro (75% of nets, 62% of households), largely due to population movements.

Persistent routine under-coverage in Gasabo, Kicukiro, and Nyarugenge, which recorded low coverage (<85%) under both ANC and EPI.

Data-quality gaps — discrepancies between planned targets and actual household populations, and missed opportunities during ANC visits, pointing to the need for continued validation.

Way forward

Prioritize the weakest districts while sustaining performance in those already above the 95% target and conduct post-distribution verification in low-coverage areas.

Eliminate LLIN stock-outs and ensure uninterrupted net availability at health facilities. Strengthen registration, micro-planning, and integrated ANC/EPI delivery to reduce missed opportunities during maternal and child health services. Improve HMIS data quality, completeness, and timeliness, and secure adequate financing to close the net gap and protect strategy effectiveness.

Long-Lasting Insecticidal Nets (LLINs)

The extended National Malaria Strategic Plan (MSP) 2020–2027 and the World Health Organization (WHO) both recommend prioritizing universal coverage of the population at risk with Long-Lasting Insecticidal Nets (LLINs). Protecting at least 90% of the population through universal coverage combining Indoor Residual Spraying (IRS) with LLIN distribution is one of the principal objectives of the extended MSP. LLINs are distributed countrywide through mass campaigns targeting households in areas of low and moderate malaria incidence, as well as through routine distribution channels focused on the most vulnerable groups, primarily children under five years of age and pregnant women. Implementation of this strategy was, however, constrained by funding shortfalls, which reduced the planned quantity of nets and are expected to weaken the overall effectiveness of the strategy. During the reporting period, the programme implemented the following activities:

1. LLIN Procurement

During the 2025–2026 period, a total of 5,649,770 rectangular LLINs were procured for mass and routine distribution

Table 13: LLINs procured, in process of procurement, and distributed, by funding source (FY 2025/2026)

Funding Source	Type of LLIN	Number	Status	Channels						Targeted Sectors
				Campaign		Routine		RACD		
				Distributed	Planned	Distributed	Planned	Distributed	Planned	
RMS/GF	Dual	2,936,000	Received	1,838,234	413,600	0	421,600	0	0	107 (86 covered, 20 planned)
USG/PSM	Dual	1,877,920	In process	0	750,550	0	1,127,370	0	490,000	25
USG/TRMS	Dual	835,850	In process	0	0	0	0	0	835,850	39
Total	Dual	5,649,770	—	1,838,234	1,164,150	0	1,548,970	0	1,325,850	171

Table 12 shows the LLINs procured and distributed in FY 2025/26 by funding source. Of 5,649,770 nets mobilized (RMS/Global Fund, USG/PSM, and USG/TRMS), 1,838,234 were distributed through the mass campaign by 30 June 2026, with more planned across 171 targeted sectors

Long-Lasting Insecticidal Nets (LLINs) Household Distribution

During the fiscal year, the MOPDD implemented a revised LLIN household distribution strategy to improve the efficiency and impact of malaria prevention. Departing from the previous approach which targeted all districts classified as non-IRS Districts having low and moderate malaria incidence, the revised strategy focuses specifically on sectors with a malaria incidence of 30 to 99 cases per 1,000 population, regardless of their district's classification. The procured LLINs were distributed through household mass campaigns, primarily in areas of moderate malaria incidence, and distribution was guided by malaria surveillance data to

ensure that interventions remained data-driven and focused on high-risk populations and geographic hotspots.

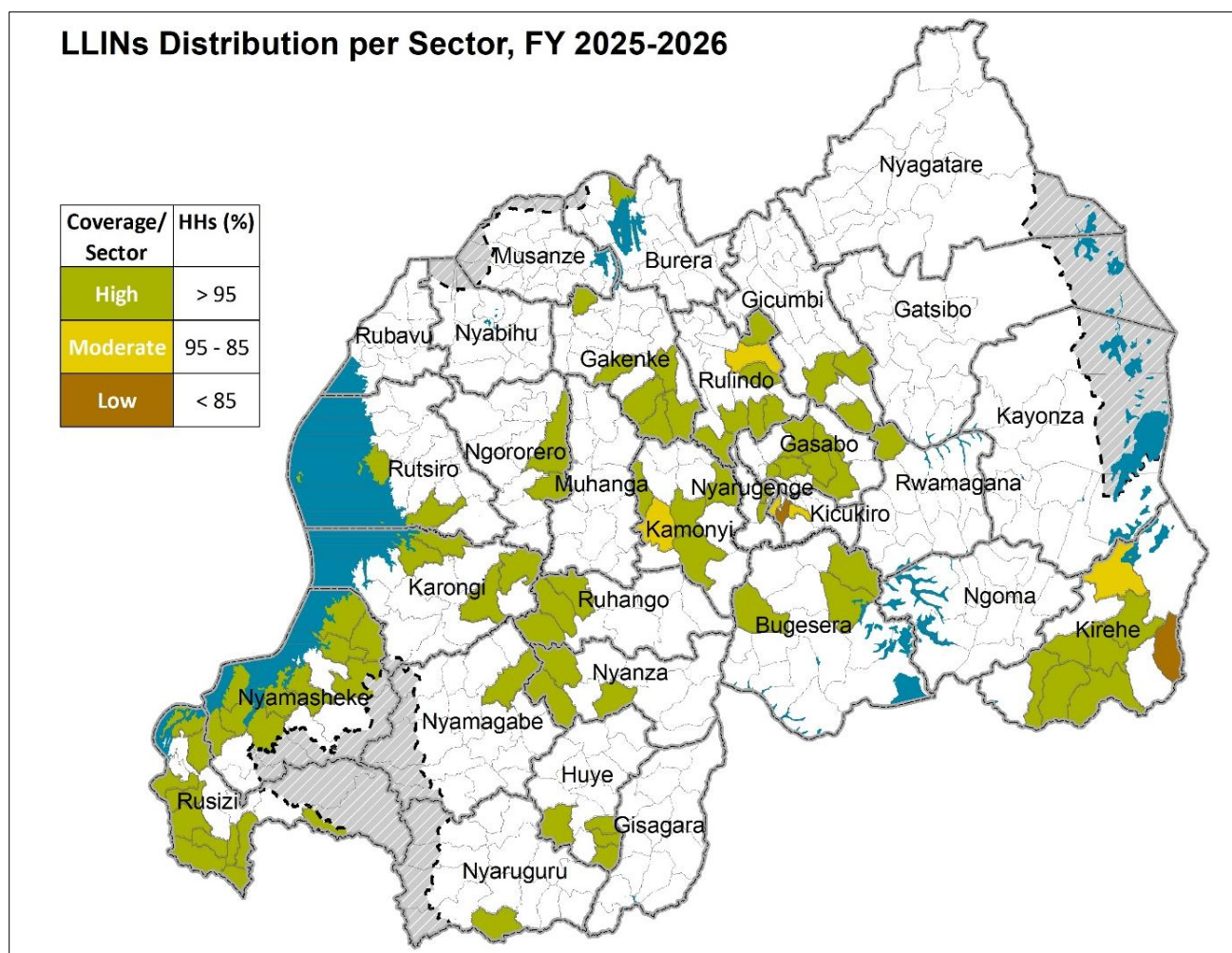


Table 14: LLIN mass distribution to households in 88 targeted sectors with malaria incidence between 30 and 99 cases per 1,000 population (FY 2025/26)

District	LLINs planned	LLINs distributed	LLIN coverage	Households targeted	Households reached	Household coverage	Sectors
Bugesera	68,061	68,147	100%	28,701	28,691	100%	2
Burera	14,900	14,067	94%	5,767	5,767	100%	1
Gakenke	76,858	68,638	89%	29,723	29,630	100%	6
Gasabo	166,891	148,844	89%	68,811	68,805	100%	5
Gicumbi	41,055	39,265	96%	17,306	16,958	98%	3
Huye	71,915	69,205	96%	26,955	27,039	100%	4
Karongi	229,444	215,272	94%	92,759	90,135	97%	9
Kicukiro	99,650	75,071	75%	62,960	38,916	62%	2
Kirehe	180,215	168,860	94%	73,567	67,963	92%	9
Ngororero	72,550	71,408	98%	30,200	29,870	99%	4

District	LLINs planned	LLINs distributed	LLIN coverage	Households targeted	Households reached	Household coverage	Sectors
Nyamasheke	183,359	182,311	99%	66,517	66,351	100%	10
Nyanza	67,850	64,530	95%	25,859	25,859	100%	3
Nyarugenge	104,235	95,769	92%	44,590	44,529	100%	4
Nyaruguru	19,550	19,492	100%	7,277	7,277	100%	1
Ruhango	53,227	53,227	100%	22,243	22,073	99%	3
Rulindo	118,530	111,874	94%	46,211	45,023	97%	7
Rusizi	197,288	195,774	99%	68,697	68,349	99%	12
Rutsiro	37,082	37,082	100%	13,284	13,197	99%	2
Rwamagana	21,650	21,650	100%	8,601	8,601	100%	1
Total	1,824,310	1,720,486	94%	740,028	705,033	95%	88

Notes: LLIN coverage = nets distributed ÷ nets planned; Household coverage = households that received nets ÷ households targeted. LLIN = long-lasting insecticidal net. Source: RBC/MOPDD distribution records, FY 2025/26.

Overall, campaign implementation was successful. Most health centres achieved very high coverage, indicating that most eligible households received LLINs. Household coverage averaged 95%, reflecting effective beneficiary mobilization and sound distribution planning, while LLIN coverage the share of households' net needs met reached 94%, likewise demonstrating strong implementation by health centres. Only a few health centres recorded comparatively lower performance, owing to operational challenges.

Operational strengths

- Effective micro-planning and household registration.
- Timely delivery of LLINs to health facilities ahead of campaign implementation.
- Strong community mobilization through Community Health Workers (CHWs).
- Close supervision and monitoring during household distribution.
- Regular reconciliation of distributed nets against household registration forms.

Challenges observed

- A small number of health facilities recorded LLIN coverage below target, largely owing to population movements.
- Minor discrepancies between planned targets and actual household populations, pointing to the need for continued data validation.

Recommendations

- Conduct post-distribution verification in areas with lower-than-target coverage.
- Strengthen household registration and micro-planning ahead of future campaigns.

- Apply lessons learned from this targeted approach to guide future LLIN replacement campaigns.

The shift from district-wide to sector-level targeting, guided by malaria incidence (30–99 cases per 1,000 population), has enabled a more focused and efficient household distribution campaign. The high coverage achieved across the targeted sectors indicates that the strategy can effectively reach the populations at greatest risk of malaria while optimizing the use of available resources. Continued strengthening of micro-planning, surveillance, and data quality will further enhance the effectiveness of future LLIN distribution campaigns.

LLIN Distribution to Pregnant Women and Children under One Year (Routine Distribution)

Pregnant women and children under one year of age are among the groups most vulnerable to malaria. To strengthen their protection, LLINs were provided routinely through the Antenatal Care (ANC) package and the Expanded Programme on Immunization (EPI) services at all health centres. This distribution is reported monthly through the National Health Management Information System (HMIS).

During the fiscal year, 328,215 LLINs were distributed to pregnant women out of 357,966 who attended their first ANC visit (91.7%), while 285,709 LLINs were distributed to children under one year out of 307,846 who received their first measles-rubella immunization dose at MR1 (92.8%).

As shown in Table 15, ten districts achieved the optimal target of at least 95% coverage for both pregnant women (ANC) and children under one year (EPI), reflecting strong integration of LLIN distribution into routine maternal and child health services.

Table 15: Districts achieving $\geq 95\%$ LLIN coverage for both pregnant women (ANC) and children under one year (EPI), FY 2025/2026

District	Children <1 year (EPI)	Pregnant women (ANC)
Burera	99.4%	99.3%
Gakenke	99.0%	97.6%
Gatsibo	98.7%	97.3%
Huye	96.1%	95.0%
Karongi	97.3%	96.6%
Kayonza	96.8%	95.9%
Kirehe	97.5%	96.7%
Muhanga	97.1%	95.3%
Nyabihu	97.3%	97.1%
Nyagatare	99.7%	99.5%

Several districts, however, remained below the desired target in ANC and/or EPI coverage, pointing to the need to strengthen routine LLIN distribution. Improving stock management, ensuring uninterrupted net availability at health facilities, reinforcing follow-up, and enhancing data quality and reporting will be essential to raising coverage in lower-performing districts.

To provide a fuller picture, district-level routine coverage was grouped into three performance categories. Table 16 presents ANC coverage by district and category.

Table 16: ANC-LLIN routine distribution coverage by district and performance category, FY 2025/2026

Coverage Category	Coverage Range	#Districts	District Name
High coverage	>95%	18	Burera, Gakenke, Gatsibo, Karongi, Kayonza, Kirehe, Muhanga, Nyabihu, Nyagatare, Nyamagabe, Nyamasheke, Nyaruguru, Rubavu, Ruhango, Rulindo, Rusizi, Rutsiro, Huye
Medium coverage	85–94%	9	Bugesera, Gisagara, Gicumbi, Kamonyi, Musanze, Ngoma, Ngororero, Nyanza, Rwamagana
Low coverage	<85%	3	Gasabo, Kicukiro, Nyarugenge

ANC coverage – interpretation

- 18 districts (60%) achieved the national target of over 95% ANC coverage, demonstrating strong integration of LLIN distribution into antenatal care services.
- Nine districts (30%) recorded moderate coverage (85–94%), indicating room for improvement through better stock management, closer follow-up, and fewer missed opportunities during ANC visits.
- Three districts (10%) recorded low coverage (below 85%), requiring targeted interventions to improve commodity availability, service delivery, and reporting quality.

Table 17:EPI-LLIN routine distribution coverage by district and performance category, FY 2025/2026

Coverage Category	Coverage Range	#Districts	District Name
High coverage	>95%	22	Burera, Gakenke, Gatsibo, Gisagara, Huye, Karongi, Kayonza, Kirehe, Muhanga, Ngoma, Nyabihu, Nyagatare, Nyamagabe, Nyamasheke, Nyaruguru, Rubavu, Ruhango, Rulindo, Rusizi, Rutsiro, Bugesera, Gicumbi
Medium coverage	85–94%	5	Kamonyi, Musanze, Ngororero, Nyanza, Rwamagana
Low coverage	<85%	3	Gasabo, Kicukiro, Nyarugenge

EPI coverage interpretation.

- 22 districts (73.3%) achieved over 95% EPI coverage, indicating that routine LLIN distribution through child immunization services is performing well in most districts.
- Five districts (16.7%) recorded moderate coverage (85–94%) and require targeted support to reach the national target.
- Three districts (10%) remained below 85%, highlighting challenges in ensuring that all eligible children receive LLINs during immunization visits.

Table 18 summarizes the distribution of districts across coverage categories for both services.

Table 18:EPI-LLIN routine distribution coverage by district and performance category, FY 2025/2026

Coverage Category	ANC	EPI
High (>95%)	18 districts (60%)	22 districts (73.3%)
Medium (85–94%)	9 districts (30%)	5 districts (16.7%)
Low (<85%)	3 districts (10%)	3 districts (10%)

Routine LLIN distribution through EPI services outperformed ANC, with 22 districts meeting the national target compared with 18 for ANC, suggesting that immunization services provide a strong platform for routine net distribution. Nevertheless, Gasabo, Kicukiro, and Nyarugenge consistently recorded low coverage under both ANC and EPI, underscoring the need for intensified follow-up, improved stock management, stronger data quality, and reduced missed opportunities during maternal and child health service delivery.

Way forward for routine LLIN distribution

To achieve universal routine LLIN coverage, priority should be given to medium- and low-performing districts while sustaining the strong performance of districts that have consistently exceeded the 95% national target. Key actions include:

- Maintaining LLIN coverage above 95% among pregnant women attending ANC and children under one year receiving immunization services.
- Eliminating LLIN stock-outs at health facilities.
- Strengthening routine malaria prevention through integrated ANC and EPI services.
- Improving data quality, completeness, and timeliness to support evidence-based malaria control planning and monitoring.

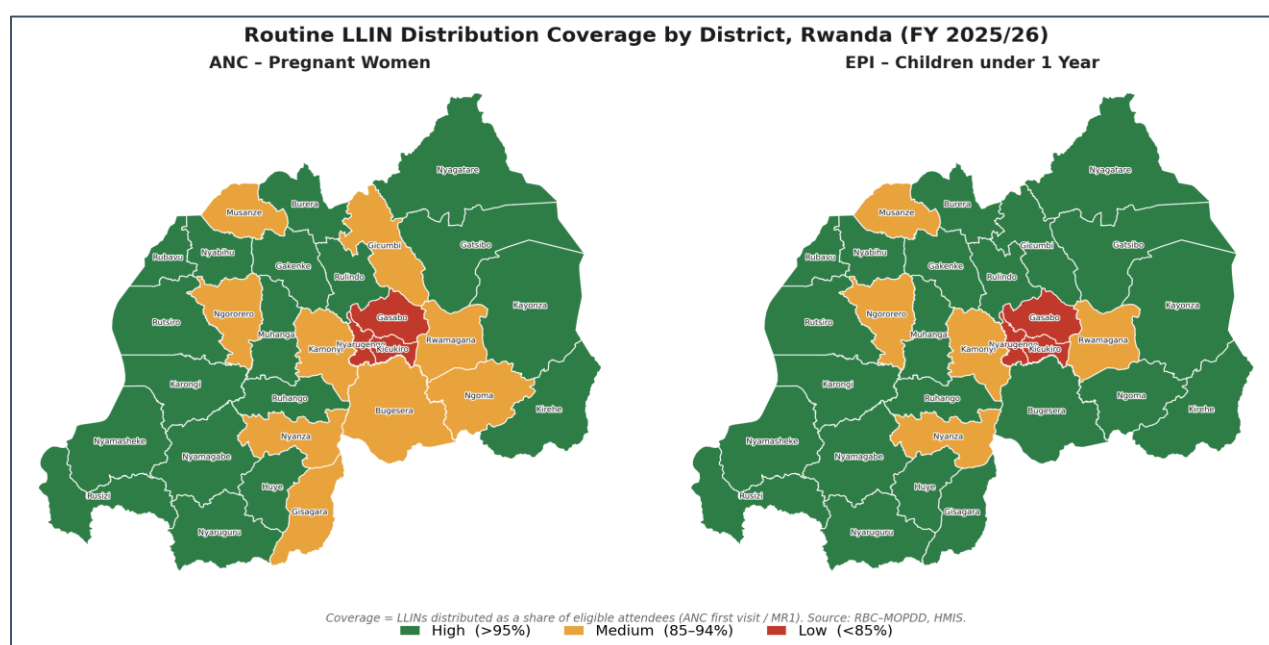


Figure 12: LLIN Distribution to Special High-Risk Groups

Beyond routine service delivery and household mass campaigns, LLINs are also distributed to defined special high-risk groups, including health facilities (hospitals and health centres), prisons, boarding schools, security personnel, and other populations at elevated risk of malaria. During the fiscal year 2025/26, a total of 46,754 LLINs were distributed to these special high-risk groups countrywide.

Key Achievements

During the fiscal year 2025-2026, Community Health Workers (CHWs) and Health Posts (HPs) significantly contributed to the management of uncomplicated malaria cases, maintaining a contribution rate exceeding 50%. Consequently, over 95% of patients presenting with fever were tested and treated within 24 hours of symptom onset. The quality of malaria diagnosis remains high. Furthermore, the new Malaria treatment strategy (MFT) aiming to address the ongoing emergence of antimalarial drug resistance was implemented.

Key Challenges

The emergence of artemisinin resistance and delays in seeking care among certain patients in Kigali Districts, along with the lack of visibility of stock at the Central Medical Store and RMS branches, continue to undermine the progress achieved in malaria case management. This situation has largely contributed to the increase in severe malaria cases and related fatalities.

Way Forward

Continue the rotation of malaria drugs as per MFT implementation plan, monitor the efficacy of newly introduced drugs as well as the feasibility and acceptability of the MFT strategy. Reinforce the SBC for early consultation.

Strengthen the proper management of severe Malaria cases. Close collaboration with RMS to ensure continued monitoring of Malaria Drugs Stock Status.

Objective 2: Maintain 100% Prompt Testing & Treatment of All Suspected Malaria Cases in Line with National Treatment Guidelines by 2025

Malaria testing, diagnosis, and treatment remain core components of malaria control and elimination efforts. This year, the Malaria and Other Parasitic Diseases Division (MOPDD) has implemented a range of strategic interventions aimed at improving access to timely diagnosis and appropriate case management across all levels of the health system. These interventions are intended to ensure that all suspected malaria cases are promptly tested and confirmed malaria cases are treated according to national treatment guidelines, thereby contributing to reductions in malaria-related morbidity and mortality.

During FY 2025–2026, the MOPDD, in collaboration with implementing partners, continued to strengthen the capacity of healthcare providers in malaria diagnosis and case management to ensure that all suspected malaria cases are accurately diagnosed and appropriately managed. In accordance with the national malaria treatment guidelines, all suspected malaria cases underwent parasitological confirmation using either a malaria rapid diagnostic test (mRDT) or microscopy (blood smear). Confirmed malaria cases were subsequently classified as uncomplicated malaria, uncomplicated malaria with minor digestive symptoms, or severe malaria, and treated with the appropriate antimalarial regimen based on clinical classification.

The nationwide implementation of Home-Based Management of Malaria (HBM) for all age groups has enabled Community Health Workers (CHWs) to provide timely diagnosis and treatment of uncomplicated malaria cases at the community level. This intervention has contributed to reducing progression to severe malaria, improving access to prompt treatment, and limiting onward malaria transmission. In August 2025, the MOPDD introduced Multiple First-Line Treatment (MFT) as a new strategy for the management of uncomplicated malaria in response to the emergence of partial resistance to artemisinin-based combination therapies (ACTs). The MFT strategy aims to diversify first-line antimalarial treatment options while preserving the efficacy of existing ACTs. Through the combined implementation of community and facility-based case management, and by ensuring early diagnosis and appropriate treatment across all levels of the health system, suspected malaria cases continue to be tested and managed in accordance with the National Malaria Treatment Guidelines.

Strategy 1: Strengthen the quality of malaria diagnosis of all levels including the private sector

1. Quality Control/Quality Assurance of Malaria Diagnosis

To uphold the quality of malaria diagnosis within the national laboratory network, External Quality Assurance (EQA) for malaria is implemented by RBC/MOPDD in partnership with the National Reference Laboratory (NRL), Parasitology Section. The EQA includes blind slide rereading and proficiency testing. Quarterly evaluation of the quality of thick and thin smear practices, Giemsa staining, and microscopy results are enforced in health facilities. Health center practices are supervised by the District Hospital, and District Hospitals are supervised by the NRL.

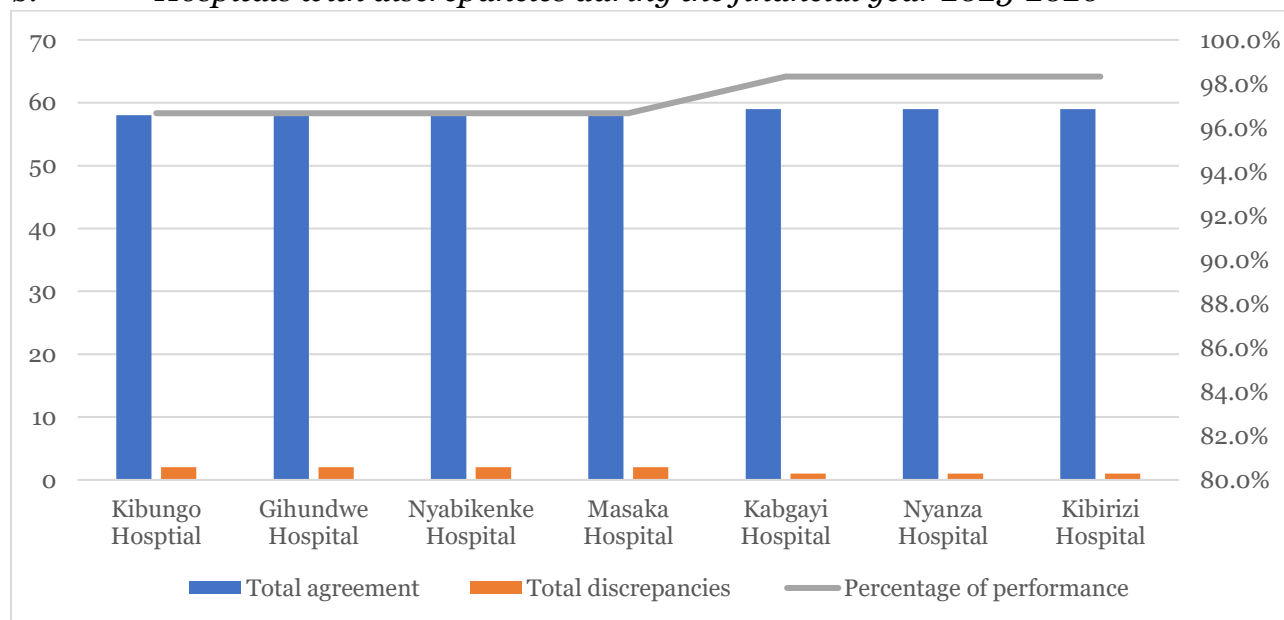
Table 19: External Quality Control Results at Hospital level FY 2025-2026

Results from hospitals with discrepancies (percentages represent the proportion of discordant results compared to the number of slides retested in the hospital)

a. *Percentage of discrepancy per quarter*

Period of Assessment	# Sites	#Blood Smear	#Discrepancy	% Discrepancy
July–September 2025	50	750	3	0.40%
October–December 2025	49	735	1	0.14%
January–March 2026	50	750	4	0.53%
April–June 2026	50	750	3	0.40%
Total	199	2,985	11	0.37%

b. *Hospitals with discrepancies during the financial year 2025-2026*



During the 2025–2026 fiscal year, EQA/Quality Control of blood smears was conducted in 50 public and private hospitals/clinics. The overall discrepancy was 0.37% during the reporting period. Discordant slide readings between two observers were identified in 7 hospitals. Overall, the 2025–2026 blood slide Quality Control results indicated that discrepancies remained within the acceptable threshold of 5% (Figure 19. a). Corrective Measures were immediately taken, including performing validation of new Giemsa solution, performing the quality control of HCs blood films regularly and reporting parasites density for positive blood films. The malaria program will continue to work closely with NRL to correct reported discrepancies in district hospitals through formative and refresher training during FY 2026-2027

Strategy 2: Strengthen Prompt Access to Treatment of Malaria

2.1. Dissemination of the MFT Strategy, Implementation plan, and SBC toolkits

During FY 2025/26, the Rwanda Biomedical Centre (RBC), through the Malaria and Other Parasitic Diseases Division (MOPDD), in collaboration with the STOP-AMDR project and other implementing partners, developed and operationalized the national Multiple First-Line Treatment (MFT) Strategy, MFT Implementation Plan, and Social and Behaviour Change (SBC) toolkit to support the introduction of MFT for the management of uncomplicated malaria. The MFT strategy was adopted in response to the emergence of partial resistance to artemisinin-based combination therapies (ACTs) and aims to preserve the effectiveness of antimalarial medicines through the use of multiple first-line treatment options. A nationwide dissemination campaign was conducted across all provinces and the City of Kigali through provincial workshops that officially launched the MFT strategy and implementation toolkit.

The dissemination process strengthened the capacity of healthcare providers and Community Health Workers (CHWs) across hospitals, health centres, health posts, private clinics, and pharmacies, while also reinforcing the role of District Health Management Teams in coordinating implementation at district level. The workshops promoted integration of MFT into existing health coordination mechanisms, including DHMT meetings, hospital and health Centre performance reviews, and community engagement platforms.

The MFT Strategy and implementation tools were disseminated to the Hospitals and cascaded to the lower level of health systems, detailing the official policy framework endorsed by MOH/RBC, outlining the vision, objectives, principles, and governance of MFT in Rwanda. In addition, a comprehensive MFT Implementation Plan and operational roadmap were developed to guide the rollout, covering key areas including block assignment, supply chain management, training, monitoring and evaluation. The Social and Behaviour Change (SBC) toolkit was also developed to support effective communication and engagement among key target audiences, including high-level decision-makers, malaria patients and caregivers, the general public, community members, CHWs, NGOs, community leaders, and healthcare providers.

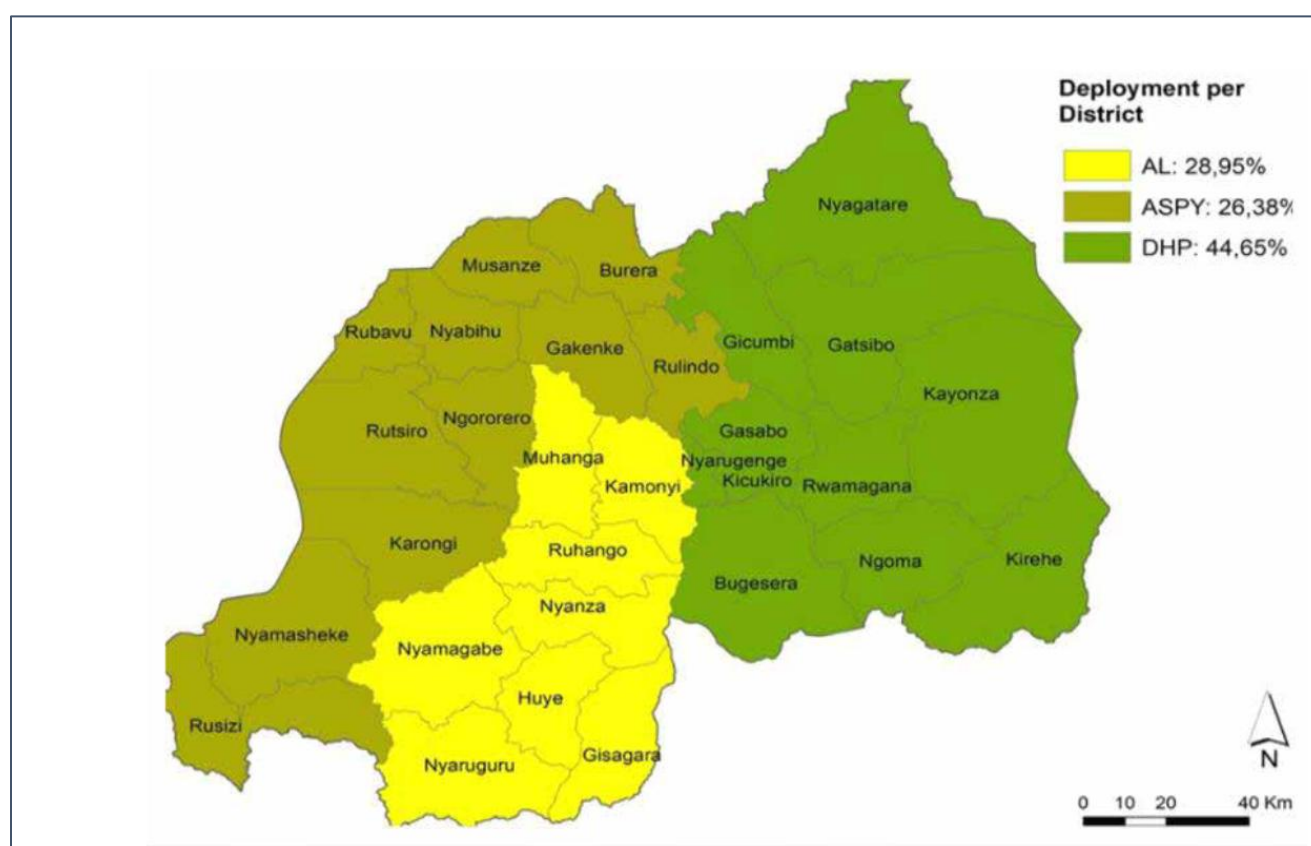
1. MFT implementation

Following the provincial dissemination meetings, 378 participants, including Hospital Director Generals, Hospital Clinical Directors, Directors of Nursing, Directors of Hospital Pharmacies, District Directors of Health, and representatives from Rwanda Medical Supply (RMS) branches, committed to supporting the implementation of the Multiple First-line Therapy (MFT) strategy. Specifically, they pledged to strengthen the capacity of Community Health Workers (CHWs) and healthcare providers (HCPs) at hospitals, health centers, health posts, private clinics, and private pharmacies; coordinate the implementation of the MFT strategy at both facility and community levels; promote the integration of MFT discussions into existing health coordination platforms such as District Health Management Team (DHMT) meetings, hospital and health center review meetings, and community forums; facilitate hospital-led training for health centers, health posts, private clinics, and private

pharmacies; enhance community awareness and engagement through Social and Behavior Change (SBC) platforms in collaboration with civil society organizations (CSOs); ensure the timely and coordinated supply of malaria commodities by Rwanda Medical Supply (RMS) in line with the MFT implementation plan; and coordinate the reverse logistics of malaria commodities in accordance with the MFT strategy.

Following the Rwanda Multiple First-Line Therapies (MFT) Strategy and implementation tools dissemination to the Hospitals and cascading to the lower level of health systems, the program initiated the distribution of new malaria drugs including Dihydro artemisinin-Piperaquine in Block A and Artesunate Pyronaridine in Block C. The remaining quantities of Artemether -Lumefantrine in those MFT Blocks were relocated in Block B where it was initially planned.

Figure 13:MFT Implementation in Year One (Y1)



Starting in September 2025, all levels of healthcare began using the newly assigned antimalarial medicines according to their respective MFT blocks. To minimize prescribing errors and support correct use of the new medicines, job aids for Dihydro-artemisinin and Artesunate–Pyronaridine were distributed to all CHWs in Blocks A and C, providing guidance on the appropriate prescribing and administration of these medicines.

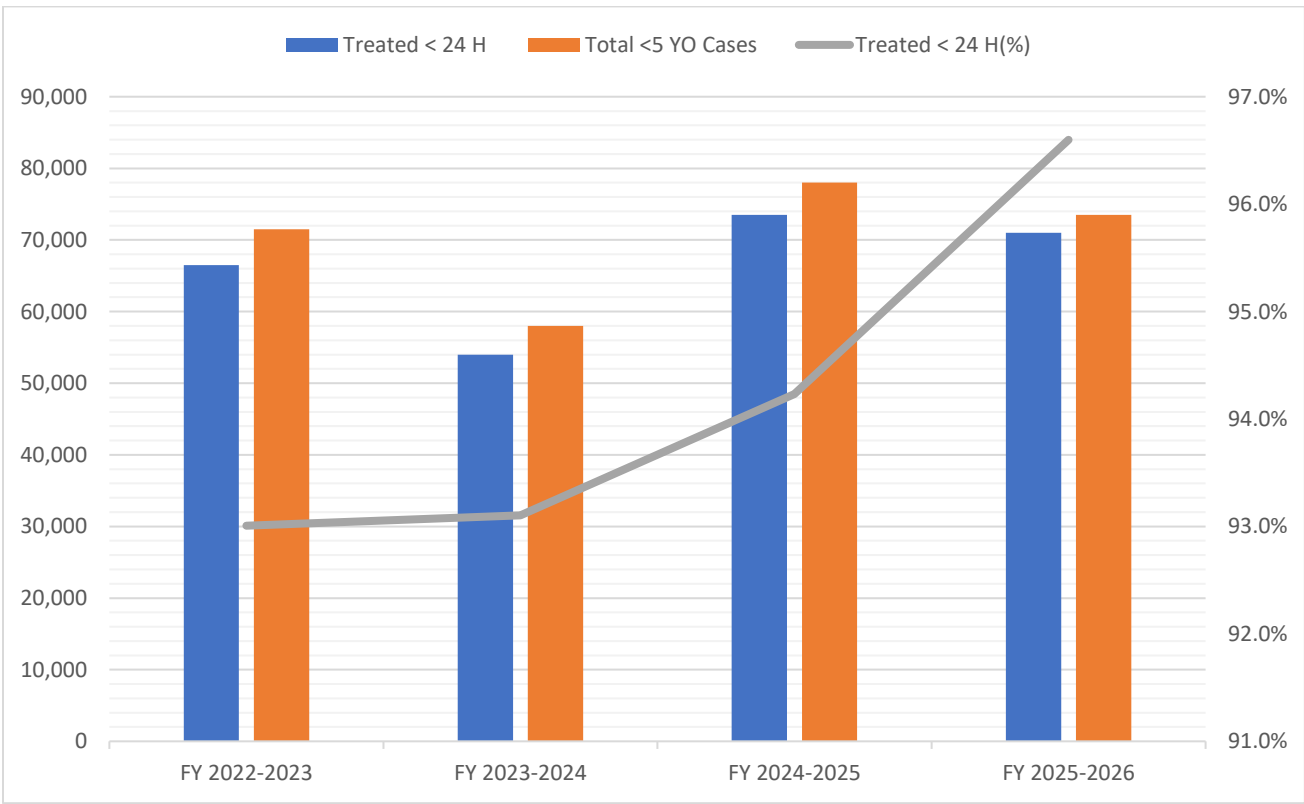
For health facilities, a mobile application named “MalariaRx” was developed and shared with healthcare providers for installation on their smartphones. The application serves as a prescribing aid and reminder to support healthcare providers in the correct prescribing and use of the newly introduced antimalarial medicines under the MFT strategy. In addition, the

malaria program initiated systematic monitoring of MFT implementation to assess progress, identify challenges, and inform corrective actions. In December 2025, a Malaria Technical Working Group (TWG) workshop was convened to review the implementation status and agree on the way forward. The workshop confirmed the successful nationwide rollout of the MFT strategy, with no significant resistance or concerns reported by either healthcare providers or patients. This positive reception was supported by the implementation of targeted Social and Behaviour Change (SBC) interventions, which engaged key stakeholders, including high-level decision-makers, malaria patients and caregivers, the general public, community members, CHWs, NGOs, community leaders, and healthcare providers.

2. 2. Case Management at the Community Level

In 2016, the community case management of malaria was extended to children above five years of age and adults countrywide following the success of the iCCM program. Since the extension of HBM of Malaria intervention to children above five years and adults, there has been a steady increase of the proportion of malaria patients seeking care in the community contributing to the prompt treatment of malaria cases.

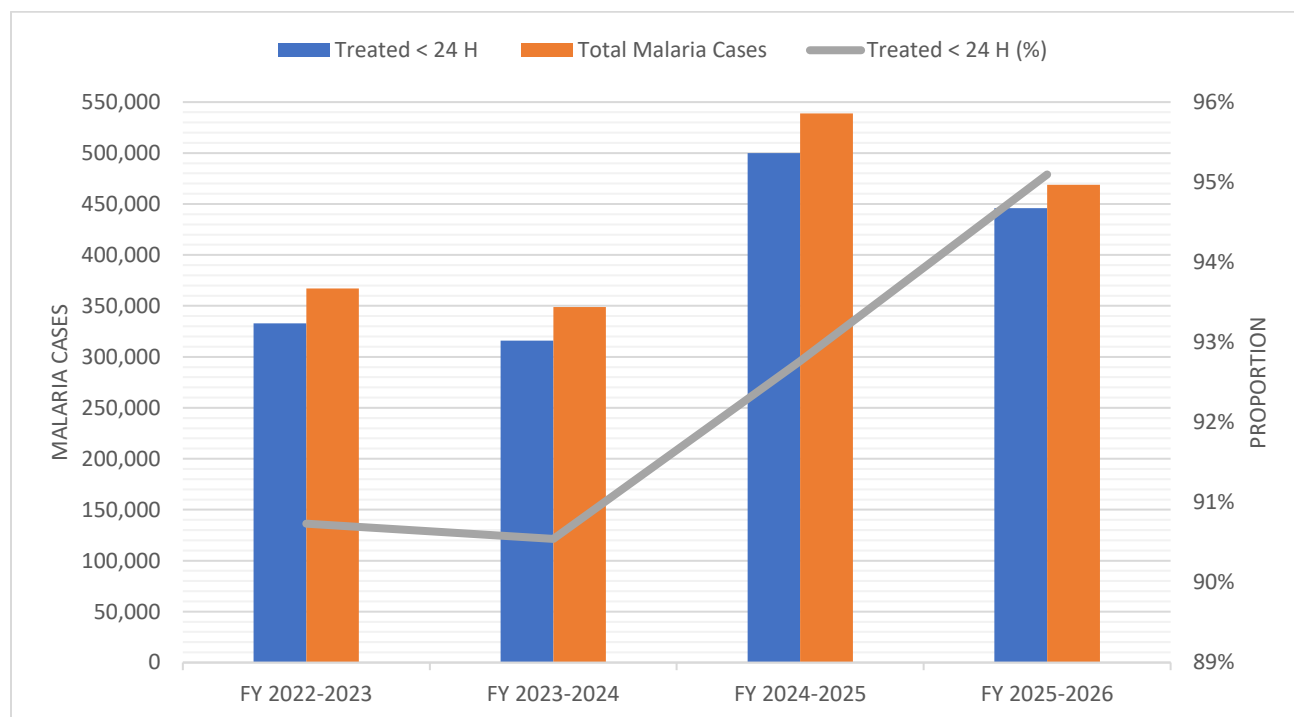
Figure 14:Proportion of Under 5 YO Treated within 24 Hours at the Community Level (2022-2026)



During FY 2025–2026, 95% of children under five years and 92% of individuals aged five years and above sought malaria treatment within 24 hours of symptom onset at the community level. Among children under five, the proportion of malaria cases treated within 24 hours showed a steady improvement over the four fiscal years, increasing from approximately 92.9% in FY 2022–2023 to

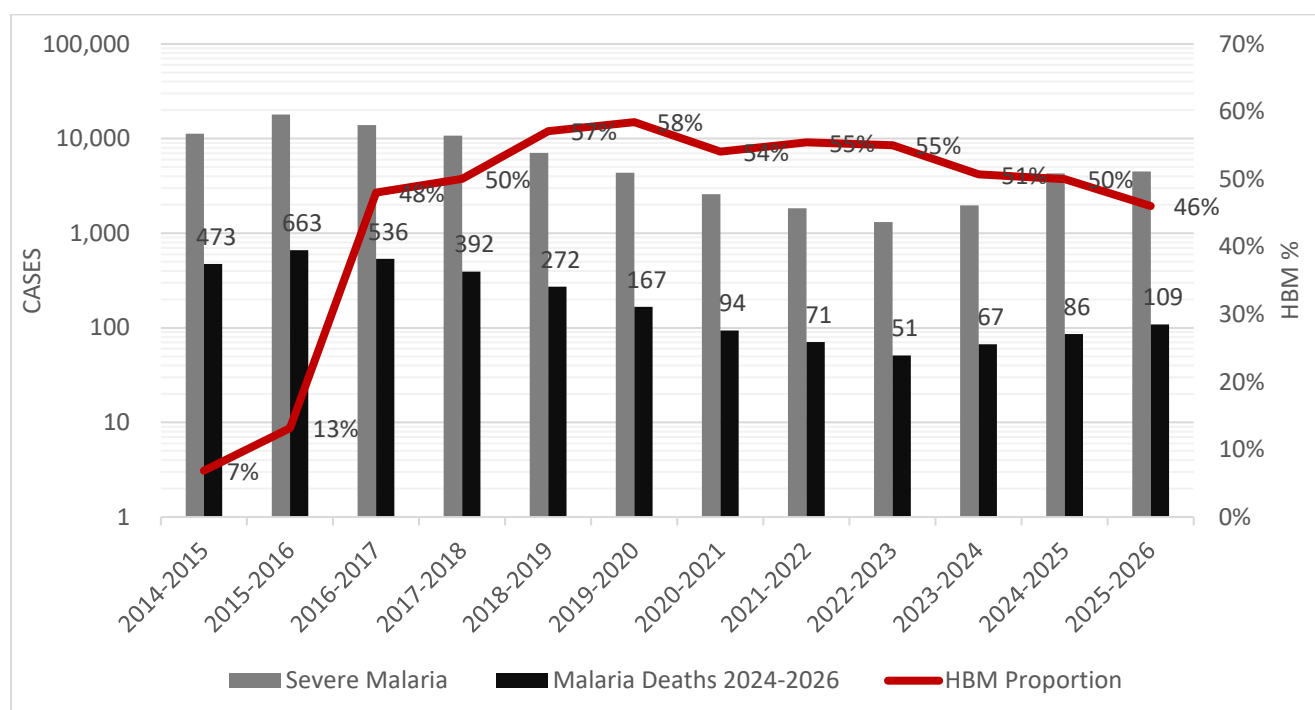
96.6% in FY 2025–2026 (Figure 14). Despite fluctuations in the overall number of malaria cases during the period, the continued increase in the proportion treated promptly indicates improved early care-seeking and timely community-based malaria case management. Patients seeking care at the community level were tested using rapid diagnostic tests (RDTs), and antimalarial treatment was provided only to those with a positive RDT result.

Figure 15: Proportion of Total Malaria Cases Treated Within 24 Hours at the Community Level (All ages)



The proportion of malaria cases treated within 24 hours at community level increased steadily from approximately 90.5% in FY 2022–2023 to 95.0% in FY 2025–2026. The number of total malaria cases treated within 24 hours also increased substantially, reaching about 446,000 cases in FY 2025–2026. This improvement indicates strengthened early care-seeking and timely malaria case management, with the highest performance recorded in FY 2025–2026

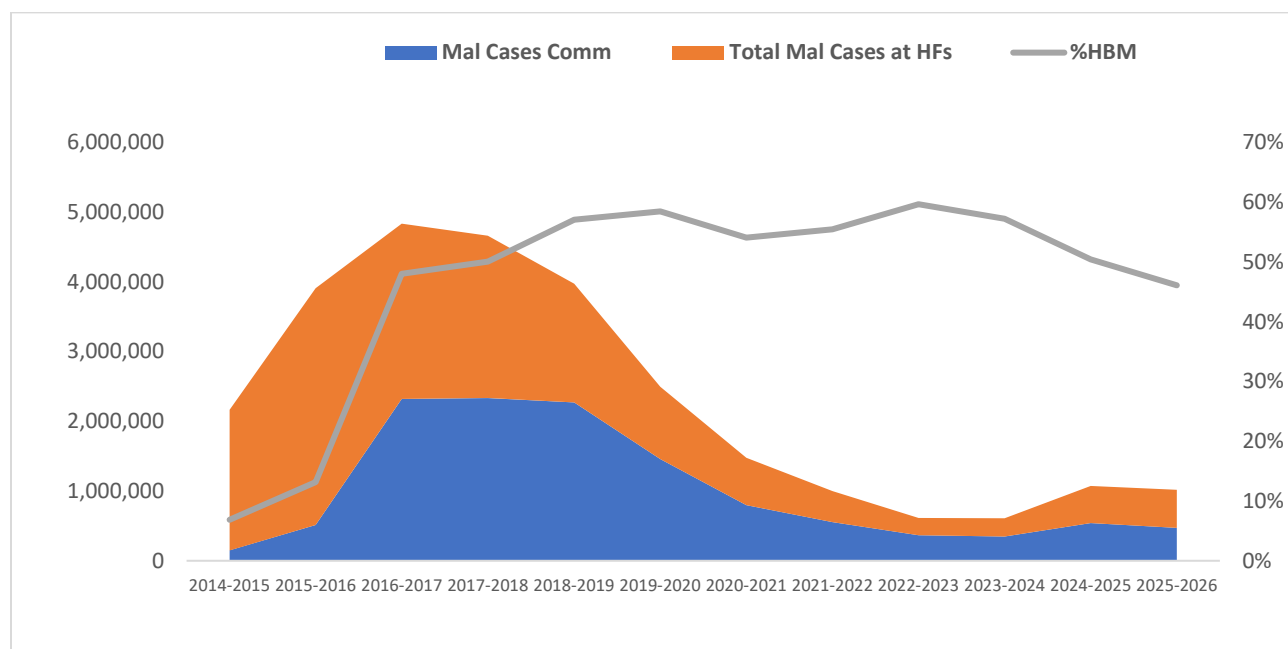
Figure 16: Home Based Management, Severe Malaria Cases and Malaria deaths, 2014 to June 2026



During the scale-up period, a decline in severe malaria cases and malaria-related deaths was observed up to FY2022–2023. However, from FY2022–2023 to FY2025–2026, severe malaria cases showed a steady increase, reaching 117% higher in FY2024–2025 compared to the previous year (2023–2024). During the reporting period, severe malaria remained stable with only 5% increase compared to the previous year. In contrast, malaria-related deaths increased by only 25% over the same period, reflecting the significant efforts invested in strengthening case management, particularly through the capacity building of healthcare providers at health facility level (Figure 16). In response to the rising number of severe malaria cases and to reduce malaria-related mortality, the program launched an active follow-up system for patients with severe malaria.

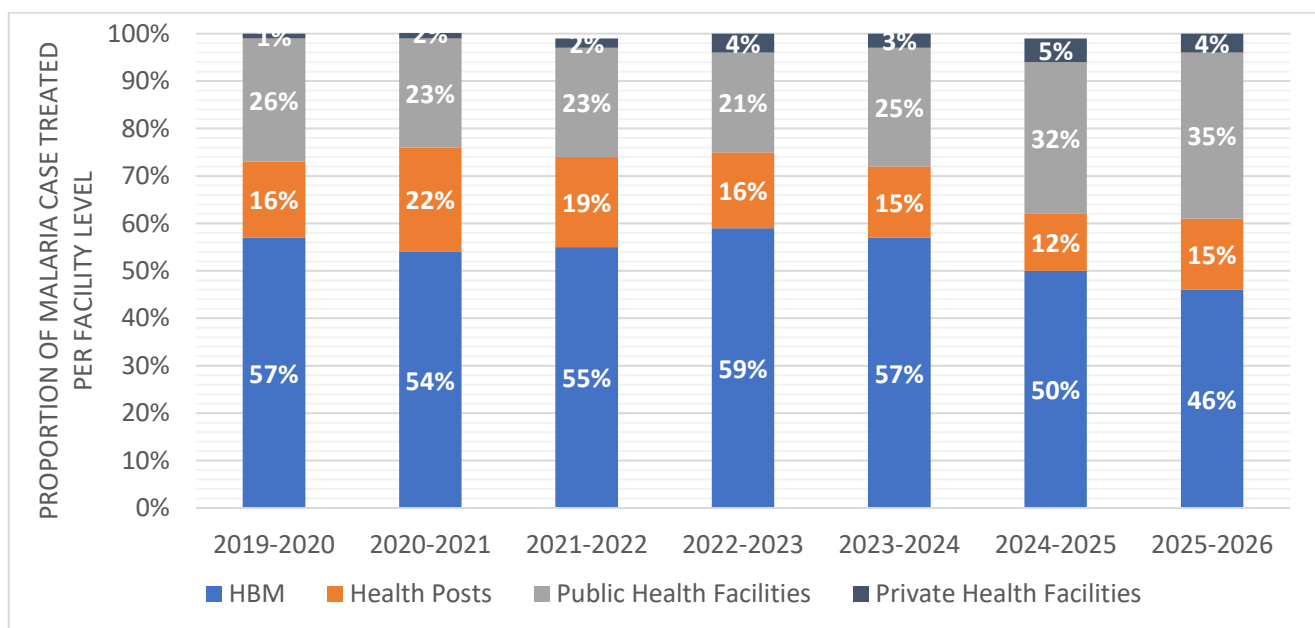
As an initial step, an assessment was conducted on severe malaria cases reported between March and April 2026 to identify the risk factors contributing to disease progression and the development of complications. The analysis identified 80 severe malaria hotspots (cells reporting more than 10 severe cases), with nearly half located in the Eastern Province. Key risk factors included farming activities that increase exposure to mosquitoes; delayed care-seeking, particularly the failure to consult Community Health Workers (CHWs); limited availability of malaria commodities at the community level; underlying comorbidities and other vulnerability conditions; poor housing that allows mosquito entry; and the presence of mosquito breeding sites around households.

Figure 17: Proportion of Community Malaria Cases against Total Cases, 2014- June 2026



The proportion of malaria cases treated in the community decreased to 46 % since the scale-up of the home-based management of simple malaria to adults. The introduction of HPs posts in the health system, a new strategy adopted by the GoR to scale up health services closer to the community and alleviate workload for the CHWs, contributed to 15% of simple malaria cases (Figure 18). Coupled with the shortage of malaria rapid diagnostic tools used in the community due to funding gaps may have contributed to the decrease in malaria cases treated by CHW's (Figure 17)

Figure 18: Proportion of Malaria Cases by Level of Service Delivery, July 2019 to June 2026



Note: A Shift from Community Malaria Services (HBM & HPs) to Public and Private Health Facilities, which may justify the increased number in severe cases and deaths due to malaria

Strategy 3: Strengthen Prompt and Correct Treatment of Simple Malaria at All Levels Through Training and Supportive Supervision

1. Capacity Building of Healthcare Providers through supportive supervision

During the fiscal year 2025-2026, the MOPDD, in collaboration with its partners, significantly advanced the provision of high-quality malaria services through rigorous supportive supervision. From July 2025 to June 2026, 13 hospitals, 101 health centers, and 12 health posts benefitted from integrated supervisory efforts spearheaded by MOPDD in close collaboration with partners.

At the hospital level, 114 hospital-based trainers received refresher training and subsequently cascaded the training to 809 providers, covering staff working in emergencies, OPD, internal medicine, pediatrics, and maternity services. At the HC level, 627 health center staff including nurses, midwives, laboratory technicians, and health center managers were reached and benefited on-job training sessions to improve case management. The training combined theoretical knowledge and hands-on practice with real cases and focused on fever screening and triage, malaria testing, case classification, recognition of danger signs, ACT dosing, and preparation and administration of artesunate for severe malaria. Knowledge improved substantially, with test scores increasing from 66% (pre-test) to 86% (post-test).

Additionally, MOPDD in close collaboration with partners conducted quarterly clinical mentorship to strengthen the quality of malaria case management at health center and community levels in malaria hotspot areas. Using a standardized mentorship checklist, the activity enrolled 167 healthcare providers from 40 high-burden health centers located in 11 districts in a continuous mentorship program focused on fever screening and triage, malaria testing, management of uncomplicated malaria, recognition and pre-referral management of severe malaria, and referral documentation

2. Stakeholder's capacity building and coordination for MFT rollout

The Multiple First-Line Therapy (MFT) strategy serves as a cornerstone of Rwanda's national response to drug resistance and is fully aligned with the World Health Organization's (WHO) 2022 Strategy to Address Antimalarial Drug Resistance in Africa. By promoting the use of multiple, equally effective first-line therapies, the strategy aims to reduce drug pressure and delay the spread of resistance. For successful implementation of this new strategy, different MFT documents and SBC tools were developed to guide the implementation process.

In FY2025–2026, the Rwanda Biomedical Center (RBC), in collaboration with partners, conducted dissemination meetings across all provinces. These dissemination meetings were cascaded at all levels of healthcare provision in both public and private facilities. The dissemination meetings aimed to refresh the knowledge of healthcare providers (HCPs) at hospitals, health centers, health posts, community health worker (CHW) networks, and

private clinics on Rwanda MFT implementation model, the rationale of introducing MFT, the MFT implementation plan including new ACT deployment, supply chain in MFT context, Monitoring and Evaluation in context of MFT and social mobilization strategies.

a. Cascade refresher training of Health Care providers on Multiple First-Line Therapies (MFT) Strategy.

Prior to the implementation of the MFT strategy, a cascade training of health care providers at hospitals, health centers, private clinics, and health posts was conducted online by hospital teams' Leads through RBC supervision team. During these trainings, the MFT implementation strategy and implementation document as well as the SBC tools were disseminated to participants.

The stakeholder engagement meetings and capacity-building activities were conducted to ensure readiness across the health system. The trainings of health care providers were conducted during the coordination meetings where district officials and heads of health facilities were introduced to the MFT implementation arrangements and clarify the key roles and responsibilities of district leadership and health facility managers in MFT implementation as well as the STOP-AMDR initiative. In addition, leveraging on the usual CHW's planning meeting at Health center level, the CHW Supervisors at Health Centers organized training sessions of CHWs on MFT strategy, specifically on prescription of new drugs.

Table 20: Summary of refresher training of Health Care providers on Multiple First-Line Therapies (MFT) Strategy

Level of capacity building	Target Group	Achievements
Hospital level	Training of representatives from 467 Health Centers, 792 Health Post and 70 private clinics/Hospitals	Participants received training on the MFT strategy, and a set of implementation tools including the implementation plan, social and behavior change (SBC) materials, and training slides used during the Training of Trainers. In addition, a roadmap for the rollout of MFT implementation in specific Health centers was established.
Capacity building of Health facility staff by the teams trained at hospital level	Training of staff working in 467 Health Centers, and 70 private clinics/Hospitals	Participants received training on the MFT strategy, and a set of implementation tools including the implementation plan, social and behavior change (SBC) materials.

b. The CHWs Cascade training of Community Health workers on the MFT implementation

To support implementation at the community level, refresher trainings were conducted countrywide for all Community Health Workers (CHWs) on the proper use of the newly introduced ACTs-Artunate-Pyronaridine (ASPY) and Dihydro-artemisinin-Piperaquine (DHP). During the training, clinical ACT algorithms were distributed to facilitate standardized malaria case management and treatment decision-making.

3. Training of Health Care Providers on National Malaria Case Management Guideline

During the reporting period, the Malaria Program strengthened the capacity of healthcare providers to ensure that malaria case management was aligned with the National Malaria Control Guidelines. In collaboration with its partners, the program trained healthcare providers at all levels on best practices for the diagnosis and management of both uncomplicated and severe malaria cases.

The table below summarizes the capacity-building activities conducted to support the implementation of the National Malaria Control Guidelines.

Table 21:Summary of Health Care Providers trained on National Malaria Case Management Guideline

SN	Training	Target Group	Achievement
1	Training of Trainers on Integrated Malaria Control Guidelines at Hospital level.	A team of Hospital-based Trainers including Nurses (1 per Hospital) Doctors (1 per Hospital) CHWs Supervisors (1 per Hospital), Pharmacist (1 per hospital), Malaria supervisor (1 per hospital)	15 Medical Doctors, 42 Nurses and 20 CHW supervisors from 20 District, 12 Pharmacists and 20 Malaria supervisors from level II Teaching Hospitals, Provincial and District Hospitals were trained and were able to cascade the training sessions and health centers. 809 hospital providers were trained
2	Training of Health Center level Clinicians on Integrated Malaria Control Guidelines	Health Center Nurses and Midwives, Health lab technicians, Head of Health Centers	627 health centers providers were trained.
3	Clinical mentorship to strengthen the quality of malaria case management at health centers and Community level	Health care providers working in IMCI, ANC and OPD	167 healthcare providers from 40 high-burden health centers
4	Conduct ECMR cascade training in Gisagara and Nyagatare districts	All CHWs in both districts	4595 CHWs were capacitated on cEMR

4. Implementation of the Therapeutic Efficacy Study (TES)

Monitoring the efficacy of antimalarial medicines is a critical component of malaria control. In line with WHO recommendations, national malaria control programs should continue using current first-line treatments when the Adequate Clinical and Parasitological Response (ACPR) is 95% or higher, with TES conducted at least every 24 months at designated sentinel sites. Preserving the efficacy of artemisinin-based combination therapies (ACTs) for the treatment of *Plasmodium falciparum* malaria remains a top national and global public health priority. In recent years, the MOPDD, in collaboration with partners, developed a TES protocol aligned with WHO standards. The study assessed the efficacy of AL and DHAP for the treatment of uncomplicated malaria at three sites across Rwanda. This study was conducted from 2021 to 2023 owing to a low number of patients due to a significant decline in malaria incidence between 2017-2018 to 2023-2024. Enrollment, uncorrected and adjusted PCR analysis were completed and the findings of PCR correction for AL are as indicated in Table 22 below.

Table 22: TES Sites, enrolled participants, and treatment outcome by site

Treatment outcomes by day 28 with AL by study site				
Variables	Study sites			Total
	Ngoma	Masaka	Bugarama	(n=264)
Number of enrolled cases (n)	88	88	88	264
PCR corrected				
Early treatment failure	0	0	1 (1.13)	1 (0.4)
Late clinical failure	0	2 (2.2)	1 (1.13)	3 (1.13)
Late parasitological failure	0	9 (10.2)	0	9 (3.41)
Adequate clinical and parasitological response (%)	88 (100)	77 (87.5)	86 (97.7)	251 (95.08)
Treatment outcomes by day 42 with DP by study site				
Variables	Study Sites			Total
	Ngoma	Masaka	Bugarama	(n=264)
Number of enrolled cases (n)	88	88	88	264
PCR unadjusted				
Early treatment failure	0	0	0	0
Late clinical failure	0	0	1 (1.13)	1 (0.3)
Late parasitological failure	0	1 (1.13)	0	1 (0.3)
Adequate clinical and parasitological response (%)	100	87 (98.9)	87 (98.9)	262 (99.24)
Day 3 Parasitemia				
AL Day 3 parasitemia	3 (3.4)	11(12.5)	3 (1.13)	
DP Day 3 Parasitemia	4 (4.5)	13 (14.5)	1 (1.2)	

AL: Artemether Lumefantrine; DP: Dihydro-artemisinin Piperaquine; ETF: Early Treatment Failure; LTF: Late Treatment Failure.

In the AL arm, PCR-corrected results showed that one case of early treatment failure was recorded in Bugarama. Three patients were noted as Late Clinical Failure (LCF), two of whom were from Masaka Health Center. All the 9 patients who were recorded as Late Parasitological Failure (LPF), were from Masaka. In the Dihydro-artemisinin piperazine arm, unadjusted results show that there were no cases of early treatment failure, with only one case of LCF in Bugarama and one case of LPF in Masaka site.

To strengthen national capacity for advanced molecular analyses, including PCR correction to distinguish new infections from recrudescence, and DNA sequencing to identify resistance markers, 10 National Reference Laboratory (NRL) technicians were trained by Swiss TPH in collaboration with RBC. After the training, the technicians performed MSP1 and MSP2 genotyping, as well as microsatellite analysis, for PCR correction of TES samples. The next step, which is currently ongoing, is assessing the status of K13 and other molecular markers of artemisinin resistance for the 2021-2023 TES results and an expansion of malaria molecular surveillance sites across the country.

Strategy 4: Ensure Accurate Quantification and Distribution of Quality Assured

Malaria Commodities

Quantification and Procurement of Malaria Commodities

Accurate quantification and timely procurement are essential to maintain adequate stock of malaria commodities across all levels of the supply chain. MOPDD, in collaboration with CPDS partners, conducted the annual quantification, and regular supply plan reviews to align procurement with current malaria transmission trends. Following a rise in malaria cases in the first semester of the fiscal year (July- December 2025) and the reduction in US funding, targets were revised to increase the quantities of malaria drugs and RDTs, prompting emergency procurement to prevent stockouts. The surge in emergency procurement created a funding gap under the Global Fund. These actions ensured continuity of malaria case management and strengthened the national response to both seasonal and resistance-driven challenges.

Table 23: Malaria Commodities Procured in FY 2025/2026

#	Product	Global Fund/	RMS (PMI)	GHSC- PSM (PMI)	Total Procured Qty
1	RDT	3,001,800	-	-	3,001,800
2	DHAP 20/160 Mg Dispersible 3 Tab/Blister	-	48,750	-	48,750
3	DHAP 30/240mg Dispersible	-	147,025	-	147,025
4	DHAP 40/320mg 3 Tab	59,958	1,513,900	-	1,573,858
5	DHAP 80/640mg 9 Tab	58,500	244,550	-	303,050
6	Pyro/Artes 60/20mg Granule/Susp 3 Sachets	77,870	-	-	77,870
7	Pyro/Artes 180/60mg Film-Coat 9tab/Blister	241,500	233,610	-	475,110
8	Artesunate inj.	-	206,954	-	206,954

From July 2025 to June 2026, the MOPDD managed to procure antimalarial drugs commodities using USG funds through RMS and GHSC-PSM implementing partners.

Malaria commodities were routinely distributed to health facilities via RMS branches and subsequently from health centers to the community, with redistribution conducted as needed. In response to emerging antimalarial resistance, “rescue” malaria products were distributed across all RMS branches, supplying new ACTs (DHAP and ASPY) to hospitals and trained health centers.

2. Validation of RMS Branch Reports and Distribution of Malaria Commodities

The objectives of the validation of malaria commodities were to:

- Ensure that the RMS Branches and lower service levels receive the right amount of malaria commodities at the right time.
- Ensure that RMS Branches are given the quantities they need to be stocked according to plan (stock to be between the minimum and the maximum levels) and that they receive feedback on the validation report.
- To ensure e-LMIS data accuracy as the validation exercise is currently based on the information found in e-LMIS.
- Rationalize the quantities available at the RMS store in case of understock. This was done through the redistribution of commodities within districts not only to prevent stock out at RMS but also to avoid expiration of malaria commodities.

3. Distribution of malaria commodities 2025 -2026

During FY 2025-2026, the validation exercise allowed to align the distribution of malaria commodities with the trend of malaria cases in different districts.

Table 24: Distribution of malaria commodities 2025 -2026

Product description	Quantity (in smallest unit)
Albendazole 400 Mg Tablet	12,895,802
Artemether/Lumefantrine 20/120Mg Tab (6X1)(Disp.)	121,045
Artemether/Lumefantrine 20/120Mg Tab (6X2) (Disp.)	145,274
Artemether/Lumefantrine 20/120Mg Tab (6X3)	77,331
Artemether/Lumefantrine 20/120Mg Tab (6X4)	260,729
Artesunate 60 Mg Powder Inj. with Solvent	107,714
DHAP 20/160 Mg Dispersible 3 Tab/Blister	287,865
DHAP 20/160 Mg Tab 3 Blister/Coated Tab	158,531
DHAP 30/240Mg (Disp.) 3 Tabs/Blister	371,128
DHAP, Fdc,40/320 Mg Tablet, 3 Tab/Blist.	6,346
DHAP, Fdc,40/320 Mg Tablet, 6 Tab/Blist	217,201
DHAP, Fdc,40/320 Mg Tablet, 9 Tab/Blist	29,501
DHAP, FDC, 80/640 Mg, 6Tablets/Blister	144,300
Ivermectin 3Mg Tab	1,570,700
Malaria Rapid Diagnostic Ag P.F/Pan Test	2,937,270
Mebendazole 500Mg Tablet	5,422,400
Praziquantel 600 Mg Tablet	6,054,000
Pyro/Artes 180/60Mg Film-Coat 9Tab/Blister	186,140
Pyro/Artes 60/20Mg Granule/Susp 3 Sachets	143,049

4. Stock Status of Malaria Commodities, end June 2026

By the end of FY 2025/2026, the stock status of malaria commodities remained within acceptable levels, as presented in Table 24. However, overstocking was observed for AL 6×1, AL 6×2, and DHAP 40/320 mg, while AL 6×3 was the only commodity identified as understocked. To mitigate the risk of expiry and optimize the use of available stocks, the following measures were recommended: AL 6×1 and AL 6×2 were prioritized for patients requiring AL 6×3 where clinically appropriate, while DHAP 40/320 mg was prioritized for patients requiring DHAP 80/640 mg, in accordance with the applicable treatment guidelines and dosing requirements. These measures are intended to rebalance stocks, minimize wastage due to expiry, and ensure continued availability of antimalarial commodities.

Table 25: Stock Status of Malaria Commodities

Product	RMS HQ	RMS Branches	Stock SDPs	Stock all levels	AMC all Levels	MoS all Levels	Qty in pipeline
Artemether/Lumefantrine 20/120mg Tab (6x1) (Disp)	69,180	38,075	42,873	150,128	5,935	25.3	-
Artemether/Lumefantrine 20/120mg Tab (6x2) (DISP)	109,680	62,095	68,052	239,827	7,483	32.0	-
Artemether/Lumefantrine 20/120mg Tab (6x3)	-	6,445	55,007	61,452	9,074	6.8	87,480
Artemether/Lumefantrine 20/120mg Tab (6x4)	98,730	64,286	100,417	263,433	11,068	24.0	-
Malaria RDT	241,260	1,025,210	673,704	1,940,174	218,310	8.9	3,060,000
Artesunate injectable	38,186	32,549	21,895	92,630	6,304	14.7	12,271
Dihydroartemisinin/Piperaquine 20/160 mg Dispersible 3 Tab/Blister	21,875	23,050	57,336	102,261	5,362	28.0	43,575
Dihydroartemisinin/Piperaquine 30/240 mg Dispersible	62,400	27,484	66,578	156,462	9,797	16.0	64,825
Dihydroartemisinin/Piperaquine 40/320 mg 3 Tab	1,332,140	111,070	161,660	1,604,870	22,741	70.6	-
Dihydroartemisinin/Piperaquine 80/640 mg Dispersible Tablet	192,700	34,110	61,713	288,523	31,792	9.1	194,600
Pyronaridine/Artesunate 60/20 mg Granul/Susp 3 Sachets	99,132	32,059	86,726	217,917	16,369	13.3	315,000
Pyronaridine/Artesunate 180/60 mg Film-Coat 9tab/Blister	91,770	63,703	275,126	430,599	13,976	30.8	262,500

5. Monitoring of Stock Status

Quarterly and monthly monitoring of malaria commodities provided a clear picture of stock levels and helped maintain supplies within the nationally required thresholds (minimum 9 months, maximum 12 months). During FY2025–2026, this monitoring supported the balancing of newly introduced products under MFT implementation, ensuring optimal use of molecules and reducing the risk of expiration. When redistribution was needed, it was coordinated through weekly and monthly stock status reviews in close collaboration with RMS headquarters, branches, and PSM stakeholders.

Key activities supported by the GHSC-PSM:

a. National Malaria Commodity Quantification Review

The MoH through the CPDS coordination RBC RMS, and partners conducted the forecast of health commodities including malaria commodity needs and developed the FY2026/27–FY2029/30 supply plan. The aim of this activity was to:

- Review epidemiological trends, consumption history, logistics, procurement pipeline, funding, supplier lead times, and inventory.
- Quantify health commodities including ACTs (AL, DHAP, ASPY), injectable artesunate, RDTs, LLINs, and IRS commodities.
- Incorporate MFT strategy by estimating ACT demand per treatment block.

The result of the exercise was the forecast of national requirements for 4 years, revised ACT needs, and adjusted treatment mix assumptions based on early MFT experience.

b. Malaria Supply Plan Reviews

The Supply plan reviews were conducted in **October 2025 and April 2026**. The purpose of the Supply plan reviews sessions was to evaluate the malaria supply chain performance and updated procurement plans; review the stock status, the procurement progress, shipments, consumption trends, pipeline, and funding for ACTs, RDTs, Artesunate, LLINs, and vector control commodities. The team assessed consumption of the abovementioned commodities against forecasts to validate assumptions.

Key findings: Stable national availability; delayed DHAP/ASPY procurement; ACTs redistribution prevented wastage of near-expiry stocks. At the end of the activities, the revised supply plans were aligned procurement with program needs and ensured uninterrupted MFT implementation.

c. Data quality and MFT assessment

During the reporting period, in collaboration with partners, the program conducted a Malaria Commodities Data Quality Assessment as part of the MFT implementation monitoring. From March to April 2026, a team composed of MoH and RBC staff with the support of the GHSC-PSM conducted the data quality and MFT assessment across 302 facilities, combining logistics data cleaning with the monitoring of MFT implementation status. During the assessment, the verification of physical stocks vs stock recorded, and malaria commodity reporting, prescriber knowledge, and digital system use (e-Buzima, e-LMIS) was performed. The assessment found a strong prescriber knowledge and confirmed MFT rollout across treatment blocks. However, the team noticed missing dissemination tools, inconsistent reporting of new ACTs, uneven DHAP/ASPY availability, limited pharmacy staff training, incomplete digital system use. The team recommended to have a standardized reporting of malaria drug, strengthen distribution planning, expand refresher training, accelerate digital system rollout, and improve stakeholder coordination.

6.Challenges

During the reporting period, the Program successfully implemented the procurement of malaria commodities. However, the main challenge was the lack of secured funds to settle supply invoices upon receipt of commodities, particularly for RDTs and LLINs, following the surge in malaria cases that increased demand. This funding gap poses a risk, as suppliers may suspend upcoming shipments, potentially leading to stock-outs of essential commodities.

PART III : MALARIA SURVEILLANCE AND EPIDEMIOLOGY

Key Achievements

- Malaria incidence declined and the caseload fell for the first time since the resurgence. National incidence eased from 76 to 72 cases per 1,000 (–5%), and total cases dropped about 5% (to roughly 1.02 million) a turning point after the sharp rise of the previous year.
- A steep sustained second-half decline. From the November 2025 peak, the monthly caseload fell by 83% through June 2026, and the January–June 2026 total was less than half that of the same period a year earlier, bringing May and June 2026 to the two lowest monthly figures in three years.
- Targeted IRS worked in the 28 October-sprayed sectors, half-year incidence fell 90% (versus 39% in unsprayed); Gisagara fell 930 to 89 and Bugesera 228 to 30 after dual rounds (98 sectors sprayed in total).
 - Broad low-burden base, 23 of 30 districts and 339 of 416 sectors (81%) below 100 per 1,000; high-incidence sectors eased from 82 to 77.
- More testing, lower positivity, stronger data systems testing up 15% and ABER up 37% to 42% while positivity fell 21% to 17%; sector-level stratification adopted and cEMR rolled out (devices to 99.7% of CHWs).

Key Challenges

- A resurgence in mortality with malaria deaths rose 25% (from 87 to 109), driven almost entirely by a concerning rebound in under-five deaths (16 to 36); severe malaria cases also edged up about 2%.
- Burden increasingly concentrated in hotspots. Gisagara intensified further (511 per 1,000, holding seven of the country's highest-burden sectors) and Ngoma emerged as a major new hotspot in the East — a geographic redistribution of the burden rather than uniform improvement.
- Persisting data-quality gaps. Fever cases were over-reported (73% concordance, over-reported in 15 of 20 assessed districts) and confirmed-treated counts showed large local errors in both directions (for example Gicumbi and Gakenke); alongside the lack of more granular data (cell, village and individual level) to inform targeted interventions and inadequate use of data at the decentralized level for timely response.
 - Insufficient funds to enable supervision from the central to the peripheral level.
- Community-level treatment fell from 50% to 46% of cases, and under Multiple First-Line Therapy drug pressure remained concentrated on DHAP (57%), with ASPY under-used (about 10%).

Way Forward

Complete the nationwide cEMR rollout (targeted for end September 2026) to improve data use, granularity, and timely, targeted response.

- Build district teams' capacity in data use for decision-making, and strengthen quarterly data quality assessments and district data review meetings

Objective 3: BY 2027, Strengthen Surveillance and Reporting Complete and Timely Accurate Information for Appropriate Decision Making at All Levels

Strategy 1: Strengthen Malaria Routine Surveillance and Epidemic Preparedness and Response (EPR) at All Levels

Between FY 2018-2019 and FY 2023-2024, Rwanda achieved a remarkable reduction in malaria incidence, from 317 to 45 cases per 1,000 population a decline of about 86%. Since then, incidence has risen modestly and stabilized at around 76 cases per 1,000 in FY 2024-2025 and 72 in FY 2025-2026, still roughly 77% below the 2018-2019 level and more than 80% below the 2016-2017 peak of 409 per 1,000. This progress underscores the country's sustained commitment to public health and disease prevention, while the recent plateau signals that continued vigilance is needed to protect and extend these gains. This success is attributed to a combination of strategic interventions, including the widespread distribution of insecticide-treated nets, expanded and targeted indoor residual spraying in hotspot sectors, community-based healthcare delivery, and targeted education campaigns.

Nevertheless, malaria remains a major public health challenge, with the entire population at risk. The modest resurgence over the past two years accompanied by a rise in malaria deaths, from 87 in FY 2024-2025 to 109 in FY 2025-2026, including a concerning rebound among children under five — highlights the importance of maintaining strong surveillance and a rapid, targeted response. In Rwanda, the malaria surveillance system is integrated into the Health Management Information System (HMIS), through which the malaria program collects data on malaria epidemiology to inform the planning, implementation, monitoring and evaluation of malaria control interventions.

The establishment of a robust malaria surveillance and reporting system through strengthening routine IDSR, HMIS and SISCOP reporting, improving the monitoring and evaluation of programme implementation, and promoting the generation and use of evidence to inform malaria programming — is essential to the success of this strategic plan. In addition, population-based surveys and operational research such as surveillance of antimalarial drug efficacy and drug resistance, entomological surveillance and vector-control monitoring, Malaria Indicator Surveys (MIS), the Demographic and Health Survey (DHS), and other studies are conducted on a regular basis to support evidence-based decision-making in the fight against malaria.

2. Key Malaria Program Indicators.

Health facilities report malaria data on a weekly and monthly basis through IDSR and HMIS while community data are reported monthly through SISCOP system. Key malaria data includes malaria cases, malaria related deaths, malaria inpatients cases (severe malaria),

number of testing and treatment. The program produces trends on key malaria indicators on a monthly basis both at national and district level in order to detect any changes and respond to outbreaks in a timely manner. Table 26 summarizes the key malaria indicators for **FY 2025-2026** compared to previous reporting period:

Table 26:Key Malaria Program Indicators

Indicators	2022/2023	2023/2024	2024/2025	2025/2026
Malaria Incidence per 1,000 Persons per Year	47	45	76	72
Slide Positivity Rate (%)	14	14	21	17
Uncomplicated Malaria Cases	621,465	613,415	1,068,522	1,017,596
Inpatient Malaria cases	3,307	4,055	10,216	10,129
Total Malaria Cases	624,772	617,470	1,078,738	1,027,725
Severe Malaria Cases	1,316	1,969	4,338	4,504
Malaria Deaths	41	67	87	109
Case Fatality Rate (per 100,000 Malaria cases)	6.4	10.9	7	10.68
Proportion of Malaria Cases Treated at the Community	59%	57%	50%	46%

Key Malaria Program Indicators

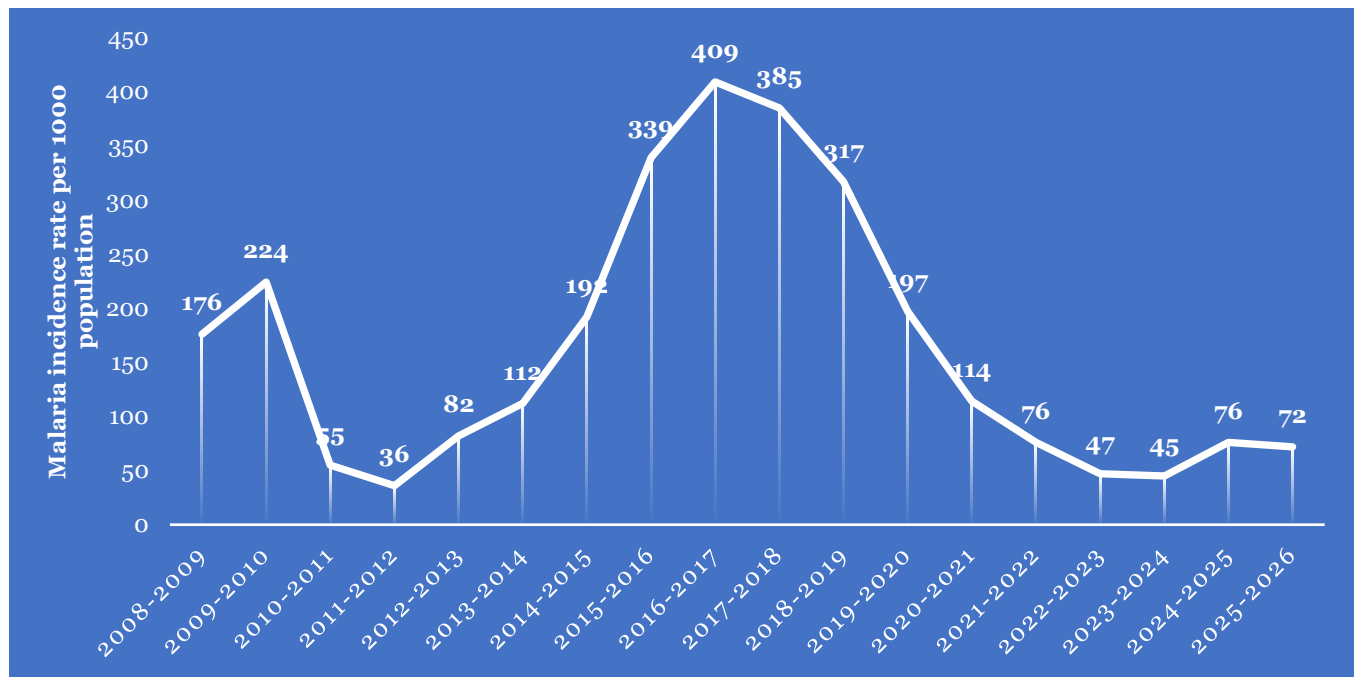
- 5,3 % Decline in Malaria Incidence from 2024/2025 (76 per 1,000) to 2025/2026 (72 per 1,000)
- 5% Decline in Uncomplicated Malaria Cases from 1,068,522 in 2024/2025 to 1,017,596 in 2025/2026 (a drop of ~50,926 cases).
- 4% Increase in Severe Malaria Cases from 4,338 in 2024/2025 to 4,504 in 2025/2026.
- 25% Increase in Malaria Deaths from 87 in 2024/2025 to 109 in 2025/2026.
- Stable Inpatient Malaria Cases with a slight decline of 1% from 10,216 in 2024/2025 to 10,129 in 2025/2026.
- Community-Level Treatment Decline: Today, 46% of malaria cases are treated at the community level by CHWs compared to 50% in FY 2024/2025.

1.1 Malaria Incidence

Malaria incidence, calculated using the average medium-projected population for 2025 and 2026, eased slightly from 76 cases per 1,000 persons per year in FY 2024–2025 to 72 in FY 2025–2026, a

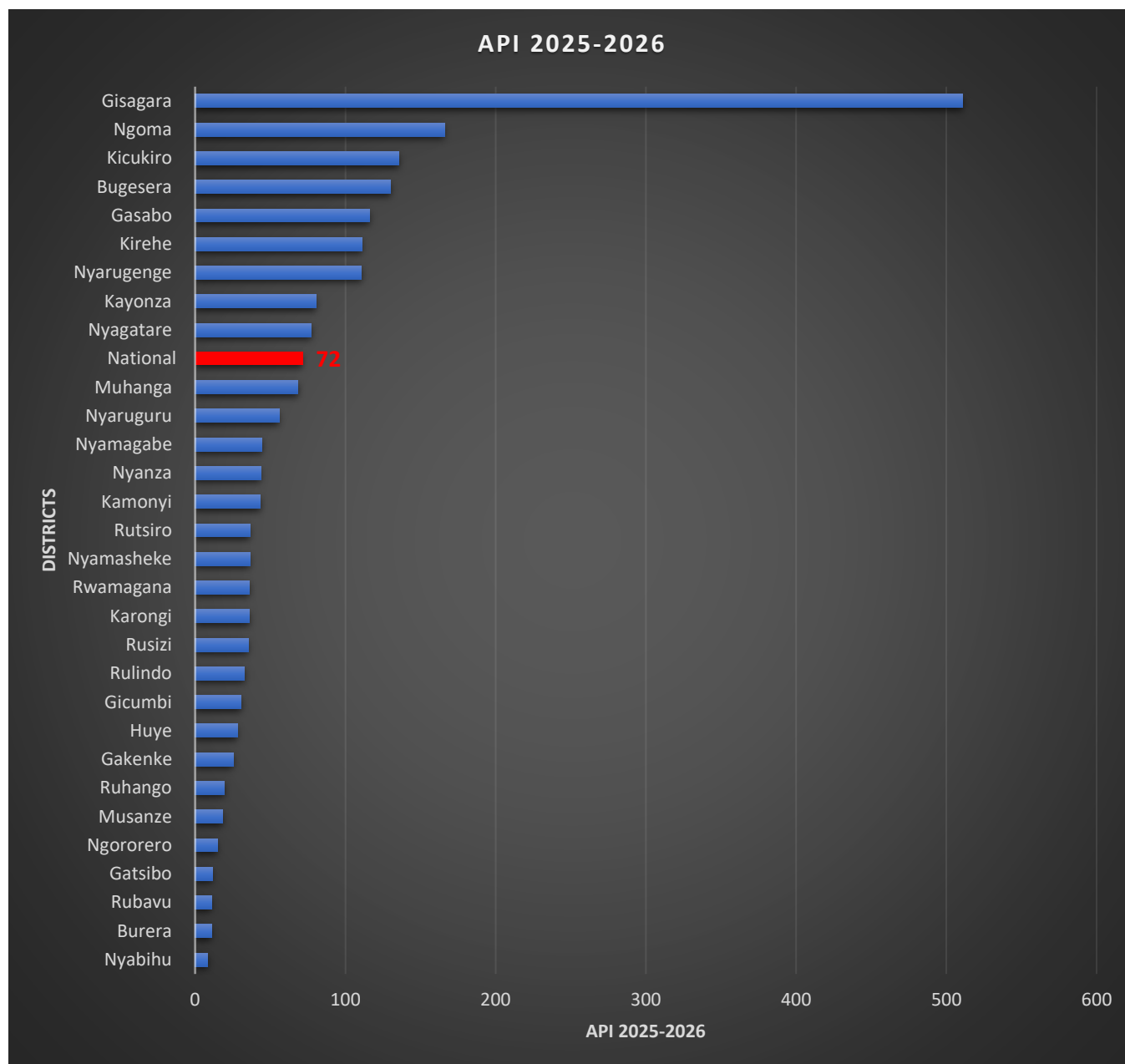
decrease of 5.3%. This improvement follows the sharp surge of the preceding year, when incidence had climbed from 45 to 76 per 1,000 between FY 2023–2024 and FY 2024–2025 (a 69% increase). While the recent decline is encouraging, the burden remains well above the levels recorded in FY 2022–2023 and FY 2023–2024, underscoring that malaria transmission continues to pose a significant public health challenge despite this modest improvement.

Figure 19: Trends in Malaria Incidence per 1000 Persons Year, 2008-2026



Malaria incidence in 2025–2026 is dramatically lower than the 2016–2017 epidemic peak and remains historically low by the standards of the past eighteen years, but it has stalled at a level notably above the recent trough: broadly flat against the previous year (72 versus 76) yet about 60 percent above the 2023–2024 low. The slight dip from 76 to 72 is too small, on its own, to indicate whether control is regaining momentum or simply holding steady; the next one to two years will show whether incidence resumes its decline toward the earlier lows or settles at this modestly elevated plateau. This pattern is consistent with the district- and sector-level resurgence documented for 2024–2025 and 2025–2026, in which the burden did not disappear but became concentrated in specific high-transmission areas.

Figure 20: Malaria Incidence (per 1000) by District, FY2025-2026



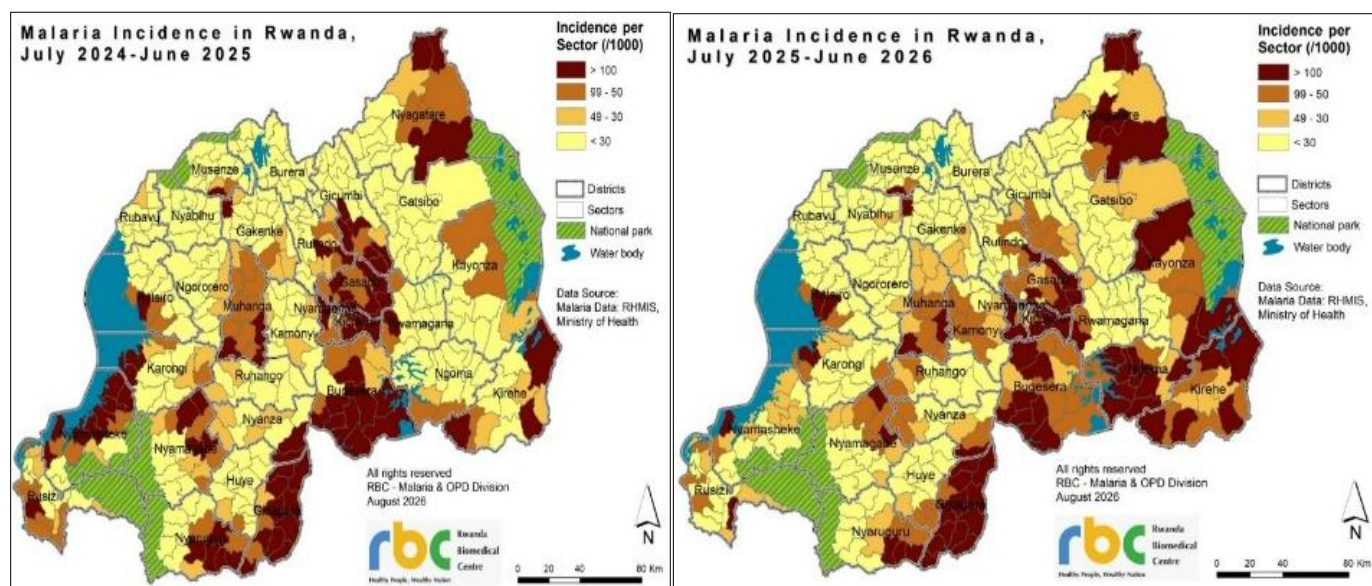
In FY 2024–2025, nine districts recorded malaria incidence above the national average of 76 per 1,000 persons. Out of 30 districts, 7 registered API above 100 per 1,000: Gisagara (364‰), Kicukiro (221‰), Gasabo (188‰), Bugesera (153‰), Nyarugenge (130‰), Nyamasheke (107‰), and Nyaruguru (101‰).

By FY 2025–2026, the national average declined slightly to 72 per 1,000 persons. Nine districts again recorded API above this national average, and 7 of them exceeded 100 per 1,000:

Gisagara (511‰), Ngoma (166‰), Kicukiro (136‰), Bugesera (130‰), Gasabo (116‰), Nyarugenge (111‰), and Kirehe (111‰).

This year-to-year analysis shows that while the number of districts above the 100-threshold remained constant (7 districts), the composition shifted: Nyamasheke and Nyaruguru fell below 100 in 2025–2026, while Ngoma and Kirehe rose above it. Most notably, Gisagara's incidence surged dramatically from 364‰ to 511‰ a roughly 40% increase reinforcing its position as the highest-burden district nationwide.

Figure 21: Malaria Incidence (per 1000) by District



During this reporting period, malaria incidence at the national level rose sharply from 45 cases per 1,000 persons in FY 2023–2024 to 76 per 1,000 in FY 2024–2025, before showing a slight decline to 72 per 1,000 in FY 2025–2026.

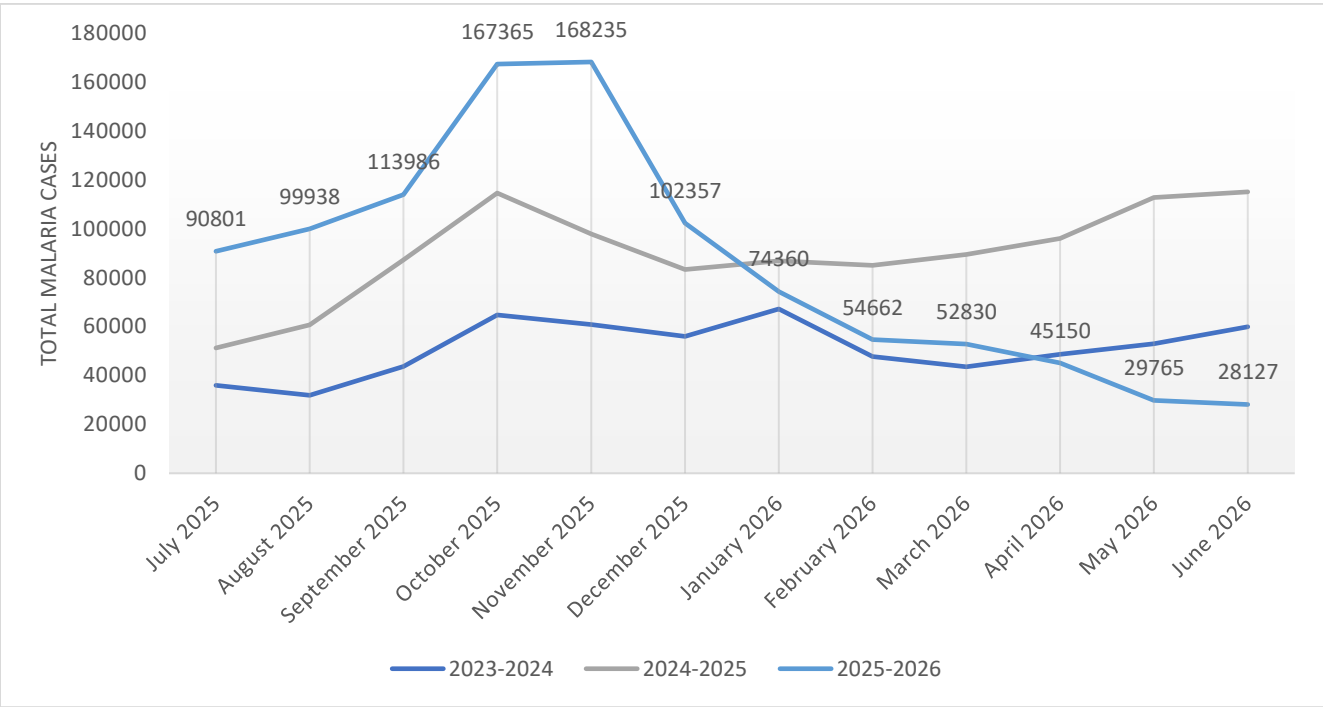
At district level the picture was highly mixed and based on the values of malaria incidence, the majority of districts (16 of 30) actually recorded declines, while 14 recorded increases.

Increases (14 districts): One district recorded only a modest rise, Huye (+8%). Four recorded moderate increases of 20–100%: Gicumbi (+41%), Nyanza (+47%), Ngoma (+73%), and Nyaruguru (+75%). The remaining nine more than doubled: Musanze (+138%), Rusizi (+150%), Gakenke (+213%), Muhanga (+224%), Nyamagabe (+275%), Kicukiro (+353%), Kirehe (+455%), Nyarugenge (+754%), and Gisagara (+813%). Gisagara stands out as the most severely affected district, surging from 56 to 511 cases per 1,000 persons by far the highest burden nationwide.

Declines (16 districts): Two districts showed marginal declines of under 10%: Rwamagana (–3%) and Kayonza (–4%). Four declined moderately by 10–30%: Bugesera (–15%),

Nyamasheke (–23%), Nyagatare (–24%), and Gatsibo (–29%). Six recorded substantial declines of 30–70%: Rutsiro (–33%), Karongi (–50%), Gasabo (–68%), Ngororero (–68%), Ruhango (–68%), and Rulindo (–69%). Four registered steep declines of more than 70%: Kamonyi (–80%), Rubavu (–83%), Nyabihu (–94%), and Burera (–94%).

Figure 22: Malaria Cases Trends, 2023-2024 to 2025-2026



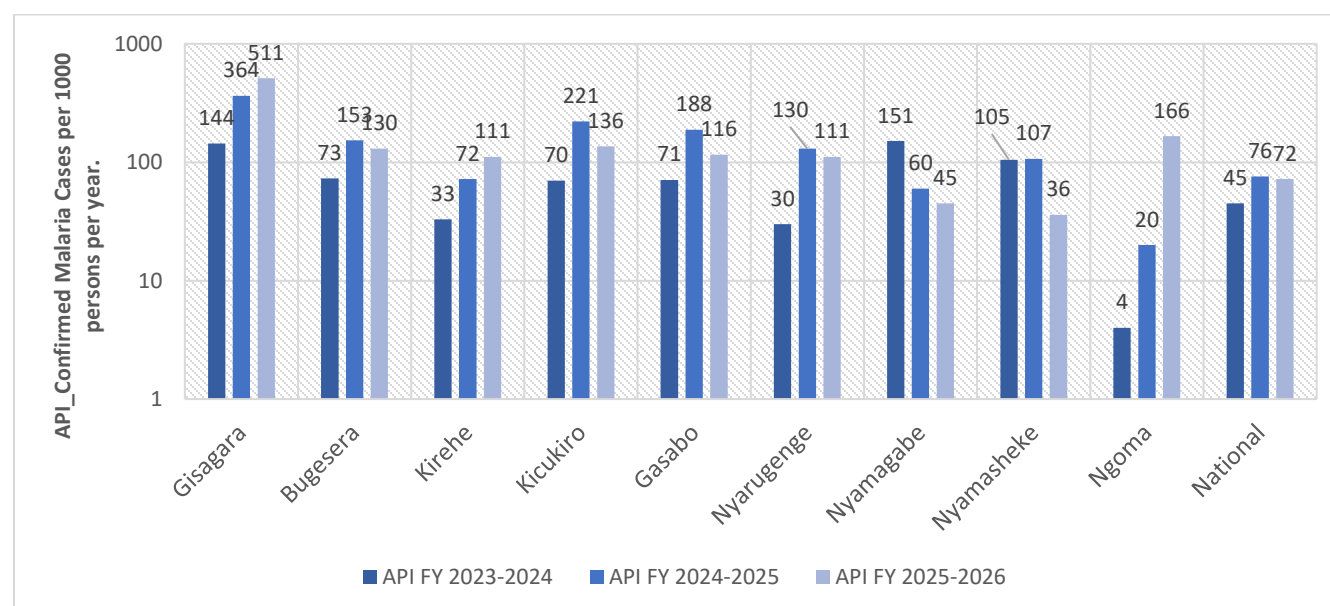
During the 2025-2026 reporting period, a total of 1,027,576 malaria cases were recorded nationwide, representing a decrease of approximately 5% compared with the 1,080,250 cases reported in 2024-2025. This marks a turning point following the sharp resurgence observed the previous year, when the annual caseload had risen by more than 76% from the 613,113 cases recorded in 2023-2024. Although the total for 2025-2026 remained above the 2023-2024 level, the year-on-year reduction signals a return to a downward trajectory in the malaria burden.

The distribution of cases throughout the year differs considerably from previous years and constitutes the main characteristic of the 2025-2026 season. Transmission was heavily concentrated during the first half of the year: the period from July to December 2025 recorded more cases than the corresponding the same period of the 2023-2024 and 2024-2025 seasons. The number of cases increased steadily from the beginning of the year, reaching a peak of 168,235 cases in November 2025, the highest monthly figure recorded in the three years observed. In total, the period from July to December 2025 accounted for 742,682 cases, the highest number of cases observed in the first half of these three years.

From January 2026 onward, the trend reversed sharply. Monthly case counts declined month after month and, throughout the entire second half of the year, remained below the levels recorded in both previous years. By the close of the reporting period, cases had fallen to 29,765 in May and 28,127 in June 2026, the two lowest monthly figures in the three-year series. The second half of 2025-2026 recorded 284,894 cases, less than half the 585,304 cases reported over the same months a year earlier. From its November peak to June 2026, the monthly caseload fell by 83%, a steep and sustained decline that ultimately brought the annual total below that of the preceding year.

This pattern an intense early-season surge followed by a pronounced and sustained decline coincided with the scale-up of malaria control interventions implemented through the Rwanda Biomedical Centre in its Malaria and Others Parasitic Disease Division, including the IRS carried out in October 2025 in 20 sectors of the country which had an incidence of 100 and more per 1000 population, followed by another session of IRS in March 2026, in 70 sectors but also ITN mass distribution in different sectors with incidence of 30 to 99 per 1000 population. The reduction recorded in the latter part of the year is an encouraging indication of impact and provides a favorable basis for the 2026-2030 strategy, which aims to consolidate these gains toward the national target of reducing malaria morbidity and mortality by at least 70% by 2030.

Figure 23: Trend in Malaria Cases in High-Incidence Districts (≥ 100 per 1,000) from 2023/2024 to 2025/2026



Over the three-year period, malaria incidence across the reporting districts above sharply divergent paths. At the national level, API rose steeply from 45 to 76 confirmed cases per 1,000 persons between FY 2023/24 and FY 2024/25 (+69%), before easing to 72 per 1,000 in FY

2025/26 (–5%), a net three-year increase of roughly 60%. Beneath this national average, however, districts diverged into three distinct trajectories.

Sustained increases across all three years with three districts rose every single year. Gisagara climbed relentlessly from 144 to 364 to 511 per 1,000 (+153% then +40%), a 3.5-fold rise over three years, and remains the highest-burden district by a wide margin about seven times the national average. Kirehe more than doubled and then rose again (33 to 72 to 111, +236% overall). Most striking is Ngoma, which surged from a very low base of 4 per 1,000 in FY 2023/24 to 20 and then to 166 a more than forty-fold increase that moved it from the least-affected district to among the most-affected in just two years.

Surge followed by partial reversal, with four districts mirroring the national curve a large FY 2024/25 spike followed by a FY 2025/26 pullback. Kicukiro (70 to 221 to 136), Gasabo (71 to 188 to 116), Nyarugenge (30 to 130 to 111), and Bugesera (73 to 153 to 130) all peaked in FY 2024/25 and then declined by 15–38% in FY 2025/26. Despite this recent improvement, all four remain well above their FY 2023/24 starting points, so the pullback has not yet returned them to baseline.

Sustained declines with only two districts show clear, continued improvement. Nyamagabe fell each year (151 to 60 to 45, –70% over three years), and Nyamasheke held roughly flat before dropping sharply (105 to 107 to 36, –66%). Both now sit below the national average and represent the strongest gains in the group.

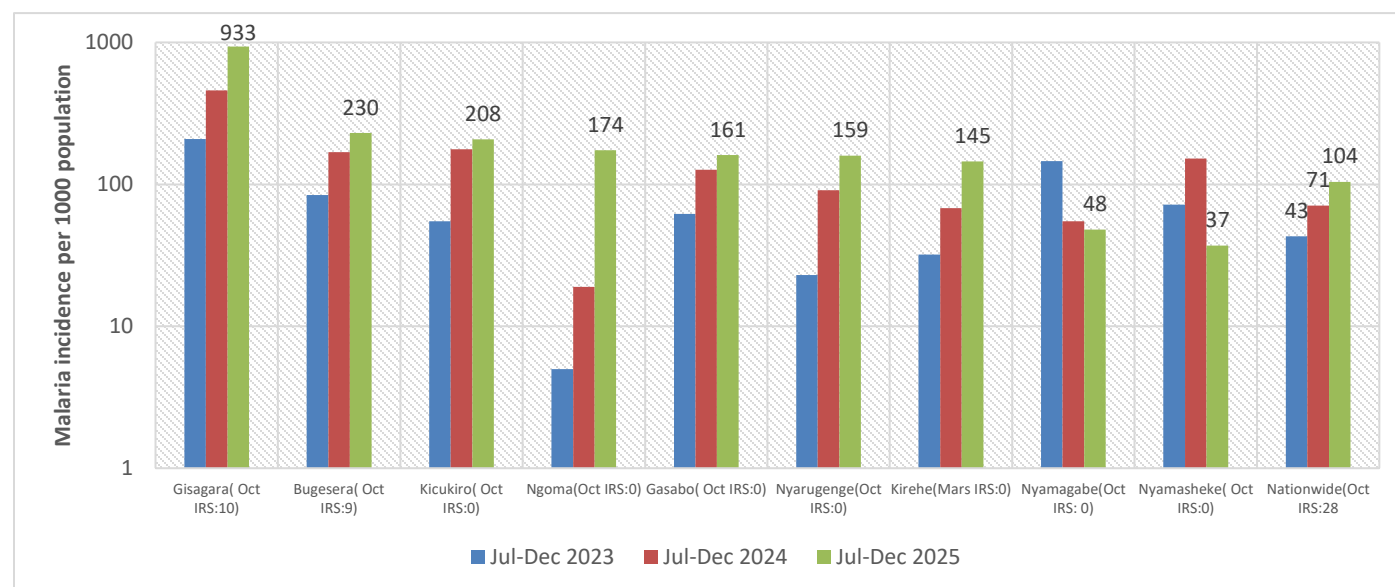
Malaria Cases by Season, 2024–2026: July–December vs January–June

Malaria transmission in Rwanda follows a seasonal rhythm, and the way the disease burden is distributed across the year as well as how that distribution shifts over time has direct implications for how prevention, case management, and surveillance are planned and resourced. This section compares malaria incidence between the two halves of the malaria year, July–December and January–June, across recent reporting periods, in order to understand not only how the overall burden has evolved but also when during the year transmission is concentrated.

Two complementary comparisons are made. First, each season is compared across consecutive years the July–December periods of 2023, 2024 and 2025 side by side, and the January–June periods of 2024, 2025 and 2026 side by side which isolates the year-on-year trend within each season while holding the time of year constant. Second, the two seasons are compared within the same year, which reveals whether the burden is becoming more concentrated in one part of the year. This seasonal lens is particularly relevant for the timing of interventions such as indoor residual spraying and net distribution, for the forecasting of diagnostic and treatment commodities, and for the readiness of the surveillance and epidemic-response system.

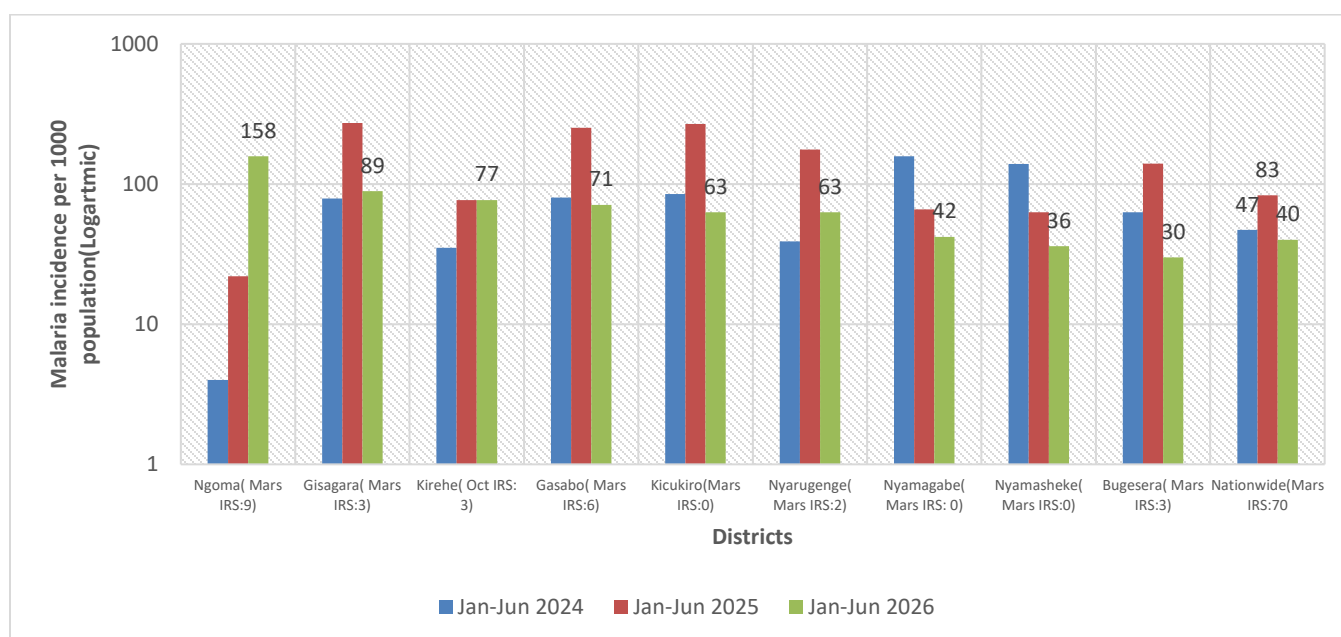
The analysis draws on routine case data reported through the Health Management Information System (HMIS), expressed as annualized incidence per 1,000 population for each six-month period, and covers the reporting districts with high incidence together with the nationwide figure. It is intended as a descriptive assessment of seasonal patterns; where associations with interventions are noted.

Figure 24: Malaria Cases by Season, 2024–2026: July–December



Malaria incidence in the July–December season rose clearly year on year, and the trend was overwhelmingly upward. Seven of the nine districts increased every year and reached their highest burden in 2025, making the most recent season the heaviest. Some increases were dramatic, Gisagara roughly doubled each year to 933 per 1,000 (over three times its 2023 level), and Ngoma climbed about thirty-five-fold from 5 to 174. Nyarugenge, Kirehe, and Kicukiro all more than tripled, while Bugesera and Gasabo rose more moderately. The rise was sharpest in the final year, meaning the upward trend accelerated into 2025. Only two districts improved: Nyamagabe declined every year (146 to 48), and Nyamasheke fell to 37 after a 2024 peak both ending below the national figure as the lowest-burden districts. Nationally, the July–December figure also rose to its highest point in 2025, though it sits below these predominantly high-burden districts.

Figure 25: Malaria Cases by Season, 2024–2026: January–June.



In the January–June season, malaria incidence changed markedly year on year, but in the opposite shape to the July–December pattern: instead of a steady climb, it rose to a peak in 2025 and then fell sharply in 2026. The 2024–2025 step was a broad, steep increase, the national resurgence with Nyarugenge more than quadrupling (39 to 176), Kicukiro and Gasabo roughly tripling (to 269 and 252), and Gisagara climbing to 272. The 2025–2026 step reversed this almost everywhere: Bugesera fell about four-fifths (140 to 30), Kicukiro three-quarters (269 to 63), Gasabo around 70% (252 to 71), and Gisagara two-thirds (272 to 89), with most districts ending at or below their 2024 starting point. Two districts broke the pattern: Ngoma rose every year and surged to 158 in 2026, becoming the highest-burden district, while Kirehe held flat at 77. Only Nyamagabe (158 to 42) and Nyamasheke (139 to 36) improved steadily throughout. Nationally, the figure followed the same rise-then-fall shape, peaking in 2025 before dropping below its 2024 level (though the 2025 national value should be confirmed against the source system).

In general, the Annual Parasite Incidence (API) rose from 45 in 2023/24 to 76 in 2024/25, before slightly declining to 72 in 2025/26. The seasonal split shows a peak of 104 between July and December 2025, followed by a sharp decline to 40 in January–June 2026. This national reduction coincided with IRS campaigns, which covered 28 sectors in October 2025 and expanded to 70 sectors in March 2026.

At the district level, Gisagara and Bugesera illustrate the strongest impact of IRS. Gisagara's incidence surged to 930 in late 2025, but after IRS in 10 sectors in October and 3 in March, it fell to 89 in early 2026. Bugesera followed a similar trajectory, dropping from 228 to 30 after

IRS in 9 sectors in October and 3 in March. These results highlight the effectiveness of dual IRS rounds in high-burden districts.

Districts sprayed only in March also benefited. Gasabo (6 sectors), Nyarugenge (2 sectors), Kicukiro (1 sector), and Nyamagabe (5 sectors) all recorded significant declines between late 2025 and early 2026. Kirehe, sprayed in 3 sectors in October only, saw a moderate reduction, suggesting that single-round spraying may be less impactful. Ngoma, however, remained a stubborn hotspot. Despite IRS in 9 sectors in March 2026, incidence stayed very high, dropping only slightly from 173 to 157. Importantly, because IRS was implemented in March 2026 and the reporting period ended in June 2026, only three months later, the full impact of spraying could not yet be thoroughly observed. This short observation window means the apparent limited effect may not reflect the true long-term benefits of IRS in Ngoma.

Interestingly, Nyamasheke, which had no IRS in either round, also recorded a decline from 107 to 36, pointing to other contributing factors such as ecological changes, community-level interventions, or improved case management.

2.2 Malaria Incidence per Sector

Over the three years, malaria incidence across sectors has shifted noticeably toward higher-risk categories.

Year	Very Low (<30)	Low (30–49)	Moderate (50–99)	High >100)	Total
2023/24	276	37	51	52	416
2024/25	224	48	62	82	416
2025/26	211	59	69	77	416

In 2023/24, the majority of sectors remained in the lower-incidence groups. Of the 416 sectors, 313 reported fewer than 50 cases per 1,000, 276 in the very low category (below 30) and 37 in the low category (30–49). The remaining 103 sectors fell into the higher-burden groups, split almost evenly between the moderate category (51 sectors, 50–99) and the high category (52 sectors, above 100). Within that high category, just 4 sectors recorded an incidence above 450 per 1,000.

By 2024/25, the situation deteriorated. The number of very low-incidence sectors dropped sharply from 276 to 224, while low-incidence areas rose from 37 to 48, so the number of sectors reporting fewer than 50 cases per 1,000 fell from 313 to 272. More concerning was the growth in the higher-burden categories: moderate-incidence sectors rose from 51 to 62 and high-incidence sectors from 52 to 82, bringing the combined moderate and high total to 144 an increase of about 40 percent over the previous year. The number of sectors above 450 per 1,000 also rose slightly, from 4 to 5.

During 2025/26, the picture was mixed. The number of very low-incidence sectors continued to fall, from 224 to 211, while low-incidence sectors rose again, from 48 to 59, leaving the number of sectors reporting fewer than 50 cases per 1,000 broadly unchanged at 270 (compared with 272 the previous year). Within the higher-burden categories the trend diverged: high-incidence sectors (above 100) eased slightly from 82 to 77 a modest improvement at the very top of the scale — but moderate-incidence sectors (50–99) continued to climb, from 62 to 69. As a result, the combined moderate-and-high total edged up slightly to 146 rather than falling, leaving the overall higher-burden picture marginally worse than in 2024/25 and still well above the 103 recorded in 2023/24. Most strikingly, the number of sectors exceeding 450 cases per 1,000 rose again, from 5 to 7 and all seven (Kansi, Kibirizi, Muganza, Mugombwa, Mukindo, Musha and Gishubi, the last reaching 1,094 per 1,000) are in Gisagara District.

Table 27: Change in Malaria Incidence in High-Incidence Sectors (incidence above 100 per 1,000 population)

District	Sector	API 2024-25	API 2025-26	Increase / Decrease
Bugesera	Kamabuye	623	268	-57%
Bugesera	Mareba	117	154	+32%
Bugesera	Ngeruka	242	360	+49%
Bugesera	Ntarama	79	140	+77%
Bugesera	Nyamata	202	144	-29%
Bugesera	Nyarugenge	148	159	+7%
Bugesera	Ruhuha	252	253	0%
Gakenke	Rusasa	164	156	-5%
Gasabo	Gikomero	303	320	+6%
Gasabo	Kacyiru	426	177	-58%
Gasabo	Kinyinya	333	221	-34%
Gasabo	Ndera	250	145	-42%
Gasabo	Remera	420	215	-49%
Gasabo	Rusororo	263	178	-32%
Gasabo	Rutunga	164	137	-16%
Gisagara	Gikonko	101	148	+47%
Gisagara	Gishubi	829	1094	+32%
Gisagara	Kansi	146	623	+327%
Gisagara	Kibirizi	99	499	+404%
Gisagara	Kigembe	70	130	+86%
Gisagara	Mamba	594	388	-35%
Gisagara	Muganza	959	752	-22%
Gisagara	Mugombwa	307	751	+145%
Gisagara	Mukindo	432	802	+86%
Gisagara	Musha	324	528	+63%

District	Sector	API 2024-25	API 2025-26	Increase / Decrease
Gisagara	Ndora	145	347	+139%
Gisagara	Nyanza	291	248	-15%
Karongi	Mubuga	245	132	-46%
Kayonza	Kabare	6	112	+1767% *
Kayonza	Murundi	87	211	+143%
Kayonza	Ndego	31	189	+510%
Kayonza	Rukara	16	108	+575%
Kicukiro	Gahanga	279	202	-28%
Kicukiro	Gikondo	315	158	-50%
Kicukiro	Kanombe	341	177	-48%
Kicukiro	Kicukiro	329	172	-48%
Kicukiro	Masaka	317	202	-36%
Kicukiro	Niboye	373	229	-39%
Kicukiro	Nyarugunga	204	102	-50%
Kirehe	Gahara	125	103	-18%
Kirehe	Mpanga	211	245	+16%
Kirehe	Musaza	41	103	+151%
Kirehe	Nasho	25	141	+464%
Kirehe	Nyamugari	168	240	+43%
Muhanga	Cyeza	154	124	-19%
Muhanga	Nyarusange	114	110	-4%
Musanze	Nkotsi	388	158	-59%
Ngoma	Gashanda	7	254	+3529% *
Ngoma	Jarama	95	393	+314%
Ngoma	Karembo	2	257	+12750% *
Ngoma	Kazo	6	134	+2133% *
Ngoma	Mugesera	6	155	+2483% *
Ngoma	Mutenderi	51	169	+231%
Ngoma	Rukira	5	114	+2180% *
Ngoma	Sake	29	378	+1203%
Ngoma	Zaza	10	336	+3260% *
Nyagatare	Karangazi	367	189	-49%
Nyagatare	Matimba	211	166	-21%
Nyagatare	Musheri	138	158	+14%
Nyagatare	Nyagatare	68	112	+65%
Nyamagabe	Mbazi	125	125	0%
Nyamagabe	Musange	284	206	-27%
Nyamasheke	Nyabitekera	124	118	-5%
Nyanza	Ntyazo	117	132	+13%
Nyarugenge	Kanyinya	162	149	-8%
Nyarugenge	Kigali	125	119	-5%
Nyarugenge	Mageragere	93	139	+49%

District	Sector	API 2024-25	API 2025-26	Increase / Decrease
Nyarugenge	Muhima	463	284	-39%
Nyarugenge	Nyarugenge	658	398	-40%
Nyaruguru	Cyahinda	295	111	-62%
Nyaruguru	Ngoma	191	120	-37%
Nyaruguru	Nyagisozi	295	201	-32%
Rulindo	Ntarabana	273	112	-59%
Rusizi	Gikundamvura	80	109	+36%
Rutsiro	Gihango	79	109	+38%
Rutsiro	Musasa	140	126	-10%
Rwamagana	Nyakaliro	90	177	+97%
National		76	72	-5%

Across the sectors that carried a high malaria burden (API above 100 per 1,000), the change from 2024-2025 to 2025-2026 was almost evenly split of the 77 sectors, 38 rose, 37 fell, and 2 were unchanged and the national all-sector figure edged down only slightly, from 76 to 72 per 1,000 (-5%). But this near-balance is misleading: beneath it lies a pronounced geographic redistribution of the burden, with sharp declines in one part of the country offsetting sharp increases in another.

The clearest decline was in Kigali City. Almost every high-incidence sector in the three urban districts fell, and most fell steeply.

In Gasabo, Kacyiru dropped from 426 to 177 (-58%), Remera from 420 to 215 (-49%), Ndera from 250 to 145 (-42%), and Kinyinya from 333 to 221 (-34%). In Kicukiro, all seven sectors declined, Gikondo (315 to 158), Nyarugunga (204 to 102), Kicukiro (329 to 172) and Kanombe (341 to 177) each roughly halving.

In Nyarugenge, the two heaviest sectors eased substantially: Nyarugenge from 658 to 398 (-40%) and Muhima from 463 to 284 (-39%). Elsewhere, several previously very high sectors also came down markedly, Bugesera's Kamabuye (623 to 268), Musanze's Nkotsi (388 to 158), Rulindo's Ntarabana (273 to 112), Karongi's Mubuga (245 to 132), and Nyaruguru's Cyahinda (295 to 111). It is important to note, however, that “decline” here generally means a retreat from extreme 2024-2025 peaks; most of these sectors remain above 100 per 1,000 and are still high burden, not controlled.

The increases were concentrated in the Eastern Province and in Gisagara. The most striking cluster is Ngoma, where every high-incidence sector rose many from a near-negligible base, turning the district into a major new hotspot. Sake climbed from 29 to 378, Jarama from 95 to 393, Zaza from 10 to 336, Karemba from 2 to 257, Gashanda from 7 to 254, and Mugesera, Kazo, and Rukira all rose from single-digit levels into the 100–160 range. Kayonza followed the same pattern on a smaller scale, with Kabare (6 to 112), Murundi (87 to 211), Ndego (31 to 189), and Rukara (16 to 108) all emerging as high-burden.

In Kirehe, Nasho (25 to 141), Musaza (41 to 103), Nyamugari (168 to 240), and Mpanga (211 to 245) rose, and scattered increases appeared elsewhere in the East, Bugesera's Ngeruka (242 to 360) and Ntarama (79 to 140), and Rwamagana's Nyakaliro (90 to 177). Gisagara stands out as the epicentre of the burden.

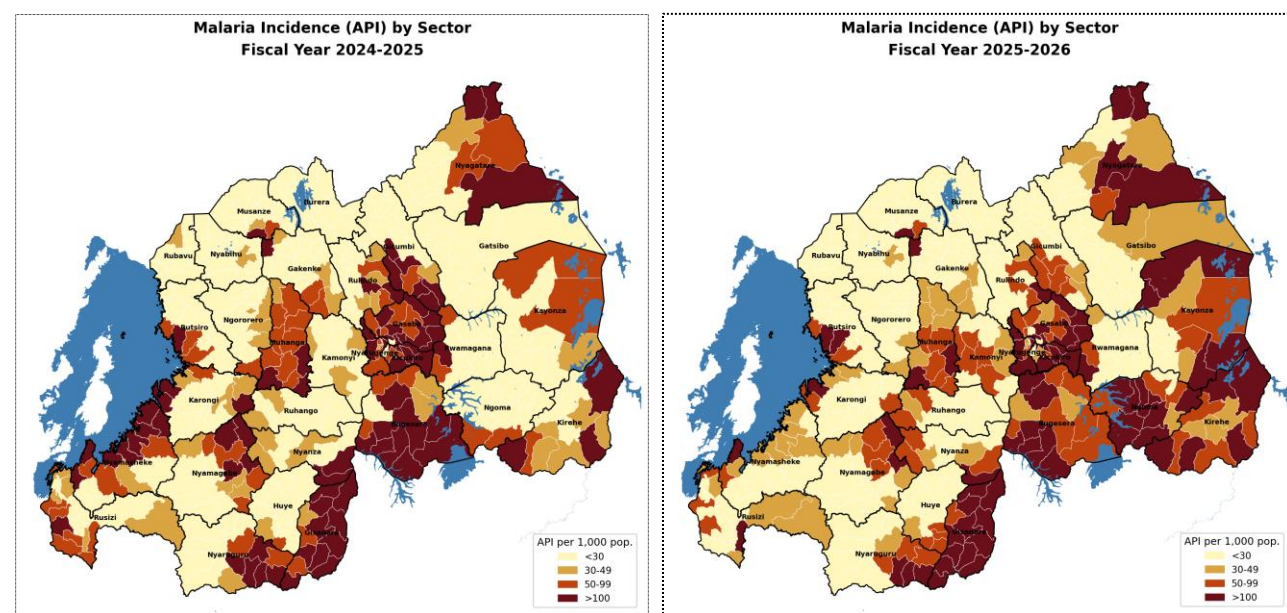
It combines the highest absolute levels in the country with several of the steepest increases. Kansi surged from 146 to 623, Kibirizi from 99 to 499, Ndora from 145 to 347, Mugombwa from 307 to 751, and Mukindo from 432 to 802, while Gishubi rose further to 1,096, the single highest sector value recorded.

A few of Gisagara's most extreme sectors eased slightly (Muganza 959 to 752, Mamba 594 to 388, Nyanza 291 to 248), but even after those declines, they remain at extraordinary levels. Taken together, Gisagara holds seven of the highest-burden sectors nationally, and its overall direction is strongly upward.

Table 28: Distribution of Sectors per API Category per Type of Intervention

Mal incidence category (per 1000)/Year	FY2024-2025		FY2025-2026	
	IRS	No IRS	IRS	No IRS
>=100	39	43	61	16
49-99	21	39	28	40
30-49	22	27	6	51
<30	95	130	3	211

Figure 26: Malaria Incidence (per 1000) by Sector 2025-2026



2.3. Malaria Cases distribution in IRS and no IRS Sectors 2025-2026.

Indoor residual spraying (IRS) remains one of the most effective vector control strategies for reducing malaria transmission. It involves coating the interior walls of houses with insecticides that kill mosquitoes resting indoors, thereby interrupting the transmission cycle.

During the year 2025–2026, IRS was implemented in 98 sectors across different districts of the country. These interventions specifically targeted areas where malaria incidence had reached 100 or more cases per 1,000 population, both as part persistent transmission and in response to sudden surges of malaria cases. IRS was conducted in two sessions. The first took place in October 2025, covering 28 sectors, while the second was carried out in March 2026, extending coverage to 70 sectors. This phased approach allowed health authorities to respond quickly to emerging hotspots in the earlier session and then broaden the intervention to additional high-risk areas in the second session.

IRS was prioritized in districts where malaria incidence was rising sharply, complementing other interventions such as the distribution of insecticide-treated nets, improved case management, and community awareness campaigns. By focusing on high-risk and outbreak-prone areas, IRS aimed to rapidly reduce transmission, protect vulnerable populations.

Table 29: Pooled malaria incidence by IRS and no IRS group, 2024-2025 to 2025-2026 (API = annual; EPI = annualized half-year, per 1,000 population)

Group	Sectors	Population	API 2024-25	API 2025-26	Annual change	EPI Jul– Dec 2025	EPI Jan– Jun 2026	Half- year change
IRS Sectors October 2025	28	1,176,543	273	281	+3%	509	52	–90%
IRS Sectors March 2026	70	2,629,421	125	130	+4%	169	91	–46%
No IRS	318	10,538,702	43	34	–22%	42	26	–39%
National (all)	416	14,344,667	77	72	–7%	104	40	–62%

Before spraying, the October 2025 group had a pooled API of 273 per 1,000 more than six times the No-IRS group (43) and the March 2026 group 125. With annual change (2024-2025 to 2025-2026), on the annual measure, the two IRS groups were essentially unchanged (October +3%, March +4%), while the No-IRS group declined by 22%. However, the annual 2025-2026 figure is dominated by the July–December 2025 half, during which the October sectors targeted for IRS were still surging and had only just been sprayed. In these sectors sprayed in October 2025, transmission was very high before the spraying took full effect, with about 299,700 cases between July and December 2025, but it dropped sharply afterwards to about 30,400 cases from

January to June 2026. The half-year incidence (EPI) fell dramatically from 509 to 52 per 1,000, a decline of 90 percent, showing the strong impact of IRS once protection was in place. Over the full year the annual incidence (API) was essentially stable (273 to 281 per 1,000), because the annual figure is dominated by the high, pre-protection first half.

In the sectors sprayed in March 2026, the spraying took place at the very end of the period and therefore could not yet protect whole January–June 2026; its effect will only appear in 2026–2027. Within the observed period these sectors behaved much like unsprayed sectors: cases fell from about 222,800 in July–December 2025 to about 120,100 in January–June 2026, and half-year incidence declined from 169 to 91 per 1,000 (–46 percent) close to the ordinary seasonal decline rather than an IRS effect. Annual incidence was broadly stable (125 to 130 per 1,000), on a 2025–2026 total of about 342,900 cases.

In the sectors without IRS, transmission followed the normal seasonal pattern, with about 220,200 cases in July–December 2025 and about 134,400 cases in January–June 2026 (a total of about 354,600 cases in 2025–2026). The half-year incidence fell from 42 to 26 per 1,000 (–39 percent), and annual incidence fell from 43 to 34 per 1,000. This modest seasonal reduction, well short of the 90 percent drop in the protected October sectors is the key point of comparison: the steep fall in the October group stands out clearly against this background.

2.4. Malaria Cases Stratification by Sectors and by Intervention 2025-2026.

Considering major changes in malaria burden per district and sector, Rwanda has transitioned from broad district-level malaria zones to a sector-level incidence-based stratification, that provide granular spatial heterogeneity of transmission, enabling a tailored and targeted deployment of interventions and efficient use of resources. The malaria stratification is conducted annually using data from HMIS. The malaria situation in the country as of 2025–2026 is summarized below (Table 30). Distribution of at-risk population based on the sector level incidence and proposed interventions are summarized below:

High-incidence sectors (API >100/1,000: 3.06M people, 77 sectors across 18 districts): These are the most vulnerable areas, often in low-altitude, warmer regions with irrigation-linked breeding sites. Indoor Residual Spraying (IRS) is applied in new hotspots, while Reactive IRS is used in sectors that previously had blanket IRS but still record high incidence.

Moderate-incidence sectors (API 50–99/1,000: 2.49M people, 69 sectors across 23 districts): Interventions combine Reactive IRS to suppress outbreaks with mass distribution of ITNs in non-IRS sectors, balancing vector control with community protection.

Low-incidence sectors (API 30–49/1,000: 2.07M people, 59 sectors across 24 districts): Transmission is lower but still significant. Mass ITN distribution remains the main intervention, ensuring households are protected while IRS is scaled back.

Very low-incidence sectors (API <30/1,000; 6.73M people, 211 sectors across 24 districts): These near-elimination zones rely on Reactive Case Detection (RACD) to rapidly identify and treat cases, with surveillance as the cornerstone strategy.

Universal interventions (all districts: 14.34M people, 416 sectors across 30 districts): Across the country, routine ITNs are distributed to vulnerable groups (pregnant women, infants, and special populations identified in the malaria matchbox analysis — Figure 7). Social and Behaviour Change (SBC) campaigns and community-led Integrated Vector Management (IVM) sustain engagement and target hotspot villages.

Table 30: Malaria Stratification of Sectors and Planned Interventions by Incidence Level, 2025–2026

In 2025–2026, all 416 sectors were classified into four strata by their annual parasite incidence (API). The table below shows the population, sectors, cases, and measured incidence in each stratum, together with the intervention package applied.

Stratum	API band	Population	Sectors	Malaria cases (2025-26)	Measured API (2025-26)	Key interventions
High	>=100	3,061,483	77	689,931	225	Focal IRS in new Sectors with the Annual Malaria Incidence > 100 cases per 1,000 population. 2. Focal IRS or Reactive IRS in sectors initially with Blanket IRS and recording Malaria Incidence >50 cases per 1,000 population.
Moderate	50–99	2,487,116	69	177,118	71	Focal IRS or Reactive IRS in sectors initially with blanket IRS and recording Annual Malaria Incidence >50 cases per 1,000 population. 2. Mass Distribution of ITNs in all Non-IRS Sectors with the Annual Malaria Incidence 30–100 per 1,000 population
Low	30–49	2,066,408	59	79,419	38	Mass distribution of ITNs in all non-IRS sectors with the Annual Malaria Incidence 30–50 per 1,000 population
Very low	<30	6,729,660	211	80,868	12	Reactive Case Detection (RACD) across all sectors with the Annual Malaria Incidence <30 cases per 1,000 population
Total	—	14,344,667	416	1,027,336	—	Routine ITNs (pregnant women, infants, special groups); SBC; community-led IVM

Districts by stratum: High (API >100) — 18 districts: Bugesera, Gakenke, Gasabo, Gisagara, Kayonza, Kicukiro, Kirehe, Muhanga, Musanze, Ngoma, Nyagatare, Nyanza, Nyarugenge, Nyaruguru, Rulindo, Rusizi, Rutsiro, Rwamaga.

Moderate (API 50–99), 23 districts: Bugesera, Gasabo, Gicumbi, Gisagara, Huye, Kamonyi, Kayonza, Kicukiro, Kirehe, Muhanga, Musanze, Ngoma, Nyagatare, Nyamagabe, Nyamasheke, Nyanza, Nyarugenge, Nyaruguru, Ruhango, Rulindo, Rusizi, Rutsiro, Rwamagana.

Low (API 30–49), 24 districts: Bugesera, Gakenke, Gasabo, Gatsibo, Gicumbi, Huye, Kamonyi, Karongi, Kayonza, Kicukiro, Kirehe, Muhanga, Ngoma, Ngororero, Nyabihu, Nyagatare, Nyamagabe, Nyanza, Nyarugenge, Nyaruguru, Ruhango, Rulindo, Rusizi, Rwamagana.

Very low (API <30), 24 districts: Burera, Gakenke, Gatsibo, Gatsibo, Gicumbi, Huye, Kamonyi, Karongi, Ngororero, Ngoma, Kayonza, Kicukiro, Musanze, Nyabihu, Nyabihu, Nyagatare, Nyamagabe, Nyamasheke, Nyanza, Nyarugenge, Rubavu, Ruhango, Rulindo, Rusizi, Rutsiro, Rwamagana, Kayonza, Kicukiro, Musanze, Nyabihu, Nyabihu, Nyagatare, Nyamagabe, Nyamasheke, Nyanza, Nyarugenge, Rubavu, Ruhango, Rulindo, Rusizi.

The burden is strikingly uneven across the strata: the two upper strata (high and moderate), with about 39% of the population, generate about 84% of all cases, while the two lower strata (low and very low), with about 61% of the population, generate only about 16%. The malaria situation therefore, ranges from an intense, concentrated epidemic in a small number of sectors — led by Gisagara — to near-elimination across nearly half the country, which is precisely why the intervention package is tiered rather than uniform.

2.5. Distribution of Malaria Cases and ACT Use Across the MFT Treatment Blocks, 2025–2026.

Proportion of the national caseload treated with each first-line ACT under Multiple First-Line Therapy.

Under the Rwanda Multiple First-Line Therapy (MFT) strategy, three first-line artemisinin-based combination therapies (ACTs) were deployed across three treatment blocks: DHAP in Block A, AL in Block B, and ASPY in Block C. Because each block uses a designated ACT, the share of malaria cases arising in each block indicated how much of each ACT was used and therefore, how drug pressure was distributed across the three medicines, a key measure of whether MFT was diversifying drug pressure as intended. By simultaneously deploying three structurally distinct ACTs (e.g DHA-PPQ, AL, and AS-PY) across a population, the MFT strategy seeks to break the monopoly of using AL to treat all cases which places uniform selection pressure on parasites to evolve resistance. Ideally, each individual drug was intended to be used for about one-third of the total treatment volume for effective implementation of MFT.

MFT implementation began in October 2025; the tables below therefore present the proportions both for the full year (July 2025 to June 2026, which includes three pre-MFT months) and for the October 2025 to June 2026 period that corresponds to MFT implementation.

Proportion of ACT use, July 2025 – June 2026 (full year)

Malaria cases and share of the national caseload by treatment block, July 2025 to June 2026 (full year). MFT implementation began in October 2025, so July–September 2025 precedes the MFT period.

Table 31: Proportion of ACT use, July 2025 – June 2026 (full year)

Block	ACT	Districts	Malaria cases	Caseload Share
Block A	DHAP	12	586,042	57.0%
Block B	AL	8	341,302	33.2%
Block C	ASPY	10	99,992	9.7%
Total	—	30	1,027,336	100%

Proportion of ACT use, October 2025 – June 2026 (MFT implementation period).

Malaria cases and share of the national caseload by treatment block, October 2025 to June 2026 (9 months) - the period since MFT implementation began in October 2025.

Table 32: Proportion of ACT use, October 2025 – June 2026 (MFT implementation period)

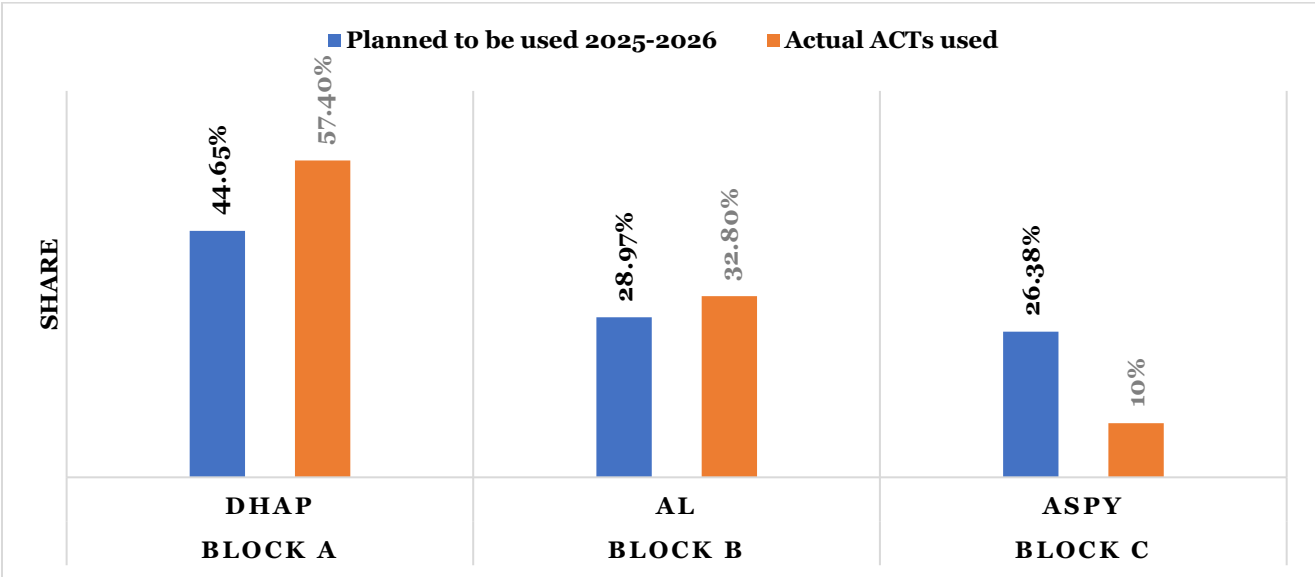
Block	ACT	Districts	Malaria cases	Caseload Share
Block A	DHAP	12	414,718	57.4%
Block B	AL	8	237,039	32.8%
Block C	ASPY	10	70,854	9.8%
Total	—	30	722,611	100%

MFT implementation began in October 2025, so the October 2025 – June 2026 period represents the malaria caseload during actual MFT implementation and is the more meaningful measure of how drug pressure was distributed across the three ACTs; the full-year figures additionally include July, August, and September 2025 before MFT implementation began. During the MFT period, drug pressure was heavily weighted toward DHAP: Block A (DHAP) accounted for 57.4 percent of the national caseload, Block B (AL) for 32.8 percent, and Block C (ASPY) for 9.8 percent. The full-year split is almost identical (57.0, 33.2 and 9.7 percent), presumably because the two peak months of October and November which dominate the annual caseload fell within the MFT period.

The practical implication for MFT is that, although three ACTs were deployed, their use was far from evenly balanced: more than half of all treatment volume was DHAP and less than a

tenth was ASPY. Since MFT's resistance-slowing benefit is greatest when use is reasonably diversified, this uneven distribution is the key point to monitor and, where feasible, to rebalance. These case-based shares are a proxy for ACT courses dispensed and are appropriately paired with drug-consumption data, therapeutic-efficacy studies, and molecular surveillance in each block.

Figure 27:Planned versus Actual Share of Each ACT by Treatment Block under MFT, 2025–2026



DHAP was used more than planned (up about 13 percentage points, or 29 percent), and AL modestly more (up about 4 points). ASPY, by contrast, was used far less than planned about 10 percent of treatment against a 26 percent target, a shortfall of roughly 62 percent, so barely a third of the ASPY use that had been intended. As a result, actual use was considerably more concentrated than planned: the planned mix was a relatively even 45 / 29 / 26 split (a spread of about 18 percentage points), whereas actual use was 57 / 33 / 10 (a spread of about 47 points), with the leading ACT rising from 45 to 57 percent and the smallest falling from 26 to 10 percent.

Actual ACT use closely followed the actual caseload in each block given that each block treated cases with the block's assigned drug; the actual 57 / 33 / 10 percent distribution essentially mirrors where the malaria burden fell: heavily in the DHAP and AL blocks. The MFT plan had assumed a balanced burden across the three blocks. The divergence, therefore, indicates that the burden concentrated more in the DHAP and AL blocks driven by high-burden districts such as Gisagara in the AL block and Bugesera, Gasabo and Ngoma in the DHAP block while the

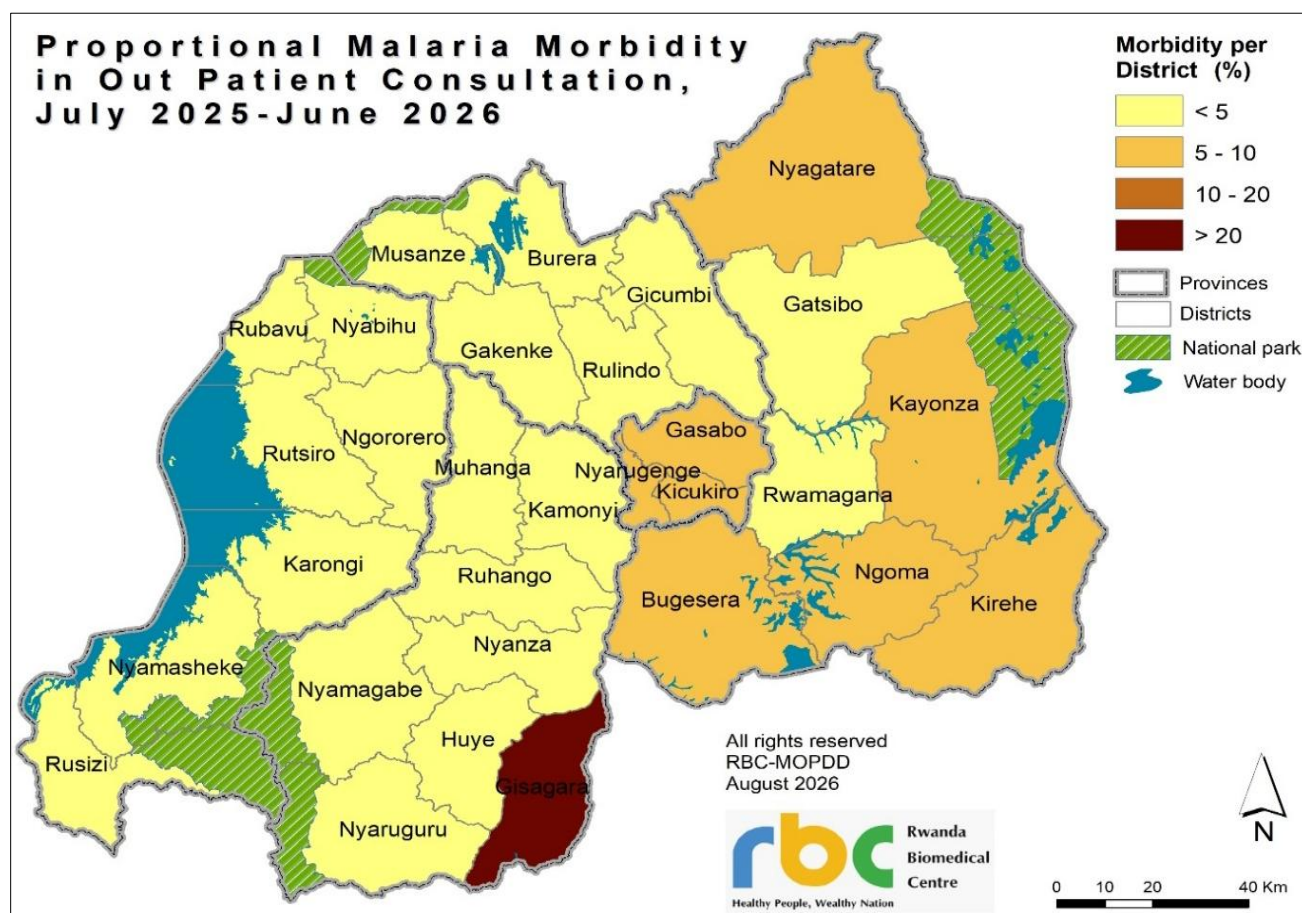
ASPY block composed largely of low-incidence districts, generated far fewer cases than the plan assumed. This is primarily an allocation and epidemiological mismatch: ASPY was assigned to low-burden areas and was therefore likely to fall short of a 26 percent target. The planned treatment volumes balanced across the three ACTs were only partly realized, leaving DHAP carrying most of the drug pressure. Achieving the intended diversification would require aligning the three geographical blocks based on current caseload to ensure that each block one-third of the treatment volumes.

3. Malaria Morbidity

In the fiscal year 2025–2026, malaria morbidity at the national level was estimated at 5%, but the burden varied widely across districts. Twelve districts recorded very low morbidity (1–2%): Burera, Gakenke, Gatsibo, Musanze, Nyabihu, and Rubavu (all 1%), together with Gicumbi, Huye, Karongi, Ngororero, Ruhango, and Rulindo (all 2%). These areas reflect relatively limited malaria transmission compared with the national average. Ten districts reported moderate morbidity (3–5%): Nyamasheke, Rusizi, Rutsiro, Rwamagana, Nyanza, and Nyaruguru (3%), Nyamagabe and Kamonyi (4%), and Muhanga and Nyagatare (5%). These show a more noticeable burden but remain at or below the national level. Seven districts experienced higher morbidity (6–10%): Nyarugenge (6%), Kayonza, Kicukiro, and Kirehe (7%), Gasabo (8%), Bugesera (9%), and Ngoma (10%). These figures highlight areas where malaria remains a significant public health challenge

The most striking finding was in Gisagara District, which reported 22% morbidity more than double the next-highest district (Ngoma at 10%) and over four times the national average marking it as by far the most severely affected area nationwide. This distribution underscores the need for targeted malaria control strategies, with intensified interventions in the highest-burden districts above all Gisagara, followed by Ngoma, Bugesera, and Gasabo while sustaining the gains in low-morbidity districts.

Figure 28: Malaria Proportional Morbidity by District



4. Malaria Test Positivity Rate

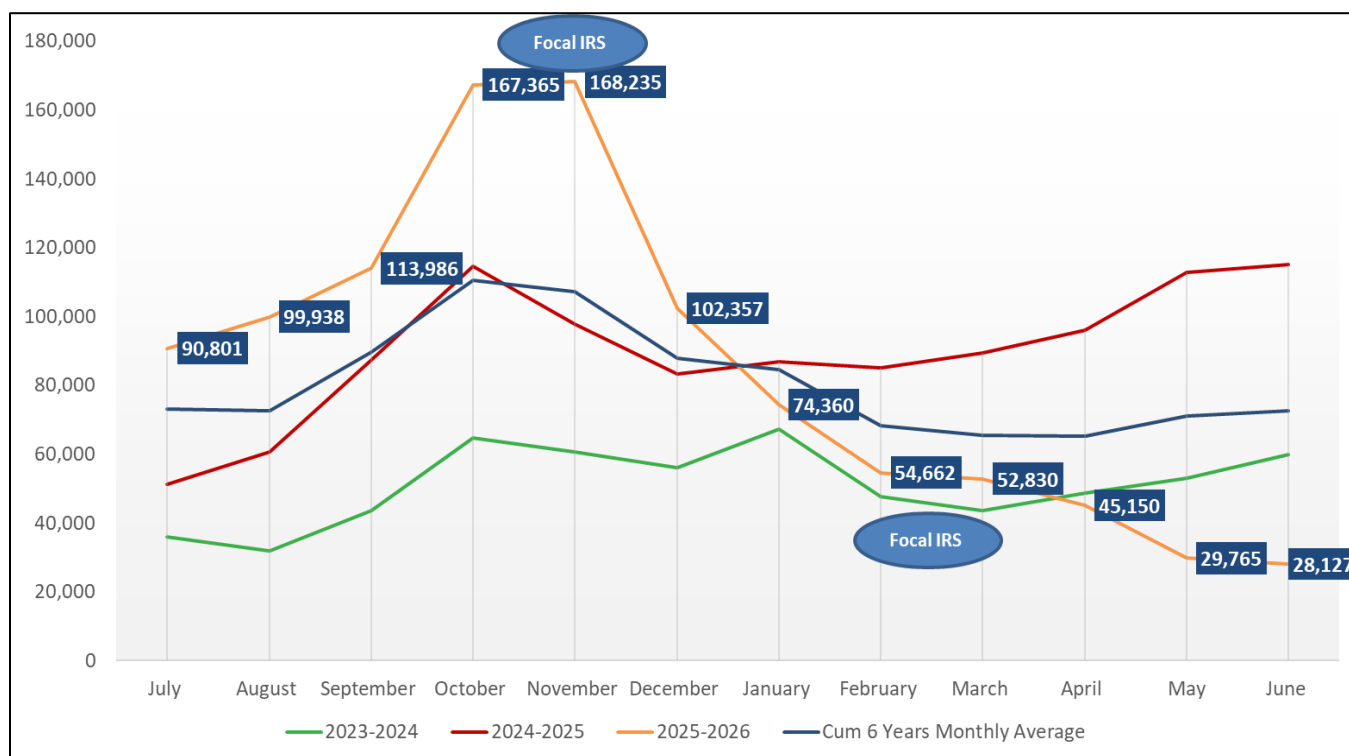
During the reporting period FY 2025-2026, a total of 5,967,545 laboratory tests were performed, an increase of about 15% from 5,196,126 in FY 2024-2025. This includes 4,239,334 blood smears and 1,730,098 RDTs. The number of RDTs done by community health workers was 1,174,172, representing 68% of all malaria RDT tests performed. The overall test positivity rate was 17% for FY 2025-2026, down from 21% the previous year. The positivity rate was 10% for blood smears and 34% for RDTs. At community level, the test positivity rate was 40%, compared with 43% in FY 2024-2025. The Annual Blood Examination Rate (ABER) was 42%, compared to 37% during FY 2024-2025.

5. Trends in Uncomplicated Malaria Cases

From July 2025 to June 2026, a total of 1,023,072 uncomplicated malaria cases were reported, compared to 1,075,821 during FY 2024-2025, representing a decrease of about 5%. Malaria cases treated at the community level accounted for 470,101 (46% of all cases), down from 540,603 (50%) the previous year. Private health facilities accounted for 145,893 cases (14%), up from 128,415 (12%) in FY 2024-2025. Children under five years accounted for 147,779

malaria cases (14%), a slight increase from 138,387 (13%) the previous year. The estimated malaria incidence among pregnant women attending antenatal care was 5% in FY 2024-2025; to 0 for FY 2025-2026.

Figure 29: Trends in Malaria Cases, FY 2024-2025, 2025-2026 and Previous 6 Years Cumulative Monthly Average cases for the last 6 years using the C-sum method



Note: The 6-year average was calculated using the C-Sum method.

The 6-year average describes Rwanda's typical malaria year: a rise to a peak of about 110,000 cases in October–November, a decline to a low of about 65,000 around March–April, and a slight uptick again in May–June. This is the expected curve against which the two years are judged.

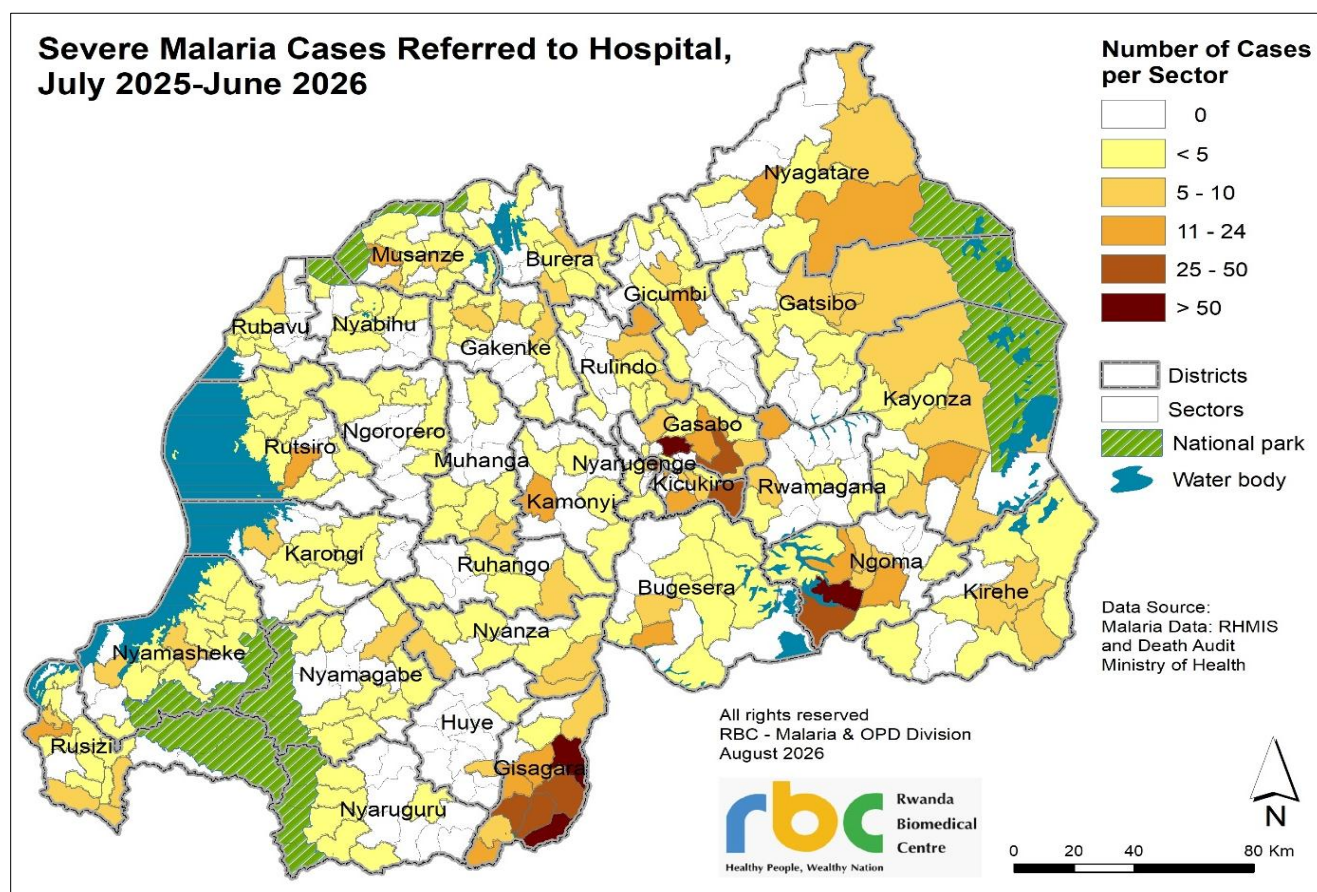
By the C-Sum method, 2025–2026 was a front-loaded epidemic year, a strong above-baseline surge peaking ~55% over the historical norm in October–November 2025, whereas 2024–2025 was back-loaded, staying near or below baseline early and breaching above it late. The excess simply moved from the second half of the year to the first, and the season's alert window sits squarely at October–November.

Strategy 4. Strengthen Severe Malaria Notification and Malaria Death Audits

1. Severe Malaria Cases

Over the reporting period FY 2025-2026, 4,504 cases of severe malaria were reported at hospital level, compared to 4,429 in FY 2024-2025 — a slight increase of about 2%. The number of malaria inpatient cases remained broadly stable, at 10,130 in FY 2025-2026 compared to 10,216 the previous year (a decrease of about 1%). The cases of severe malaria referred to higher-level facilities by health centers fell markedly, from 2,659 in FY 2024-2025 to 1,466 in FY 2025-2026, a decrease of about 45%. These figures are shown in the table below: There is a variation of severe malaria cases by sectors within a district as per the map (Figure 30)

Figure 30: Distribution of Severe Malaria Cases Referred to Hospitals per Sectors



Number of Severe Malaria Cases Referred to Hospitals per District.

During FY 2025-2026, a total of 1,466 severe malaria cases were referred from the outpatient department (OPD) to hospital, reported across 244 sectors in all 30 districts.

The referrals were heavily concentrated in a small number of districts and sectors, as shown in the table below.

Table 33: Severe Malaria Referrals by District, FY 2025–2026

Rank	District	Referrals	% National
1	Gisagara	328	22.4%
2	Ngoma	147	10.0%
3	Gasabo	145	9.9%
4	Kicukiro	81	5.5%
5	Nyarugenge	65	4.4%
6	Rusizi	59	4.0%
7	Kayanza	47	3.2%
8	Gicumbi	46	3.1%
9	Musanze	44	3.0%
10	Bugesera	36	2.5%
11	Rulindo	36	2.5%
12	Kirehe	35	2.4%
13	Rutsiro	35	2.4%
14	Nyanza	34	2.3%
15	Nyagatare	33	2.3%
16	Nyamasheke	30	2.0%
17	Rwamagana	30	2.0%
18	Burera	26	1.8%
19	Gakenke	25	1.7%
20	Gatsibo	25	1.7%
21	Kamonyi	22	1.5%
22	Muhanga	22	1.5%
23	Nyamagabe	22	1.5%
24	Rubavu	17	1.2%
25	Ngororero	15	1.0%
26	Ruhango	15	1.0%
27	Karongi	14	1.0%
28	Huye	11	0.8%
29	Nyabihu	11	0.8%
30	Nyaruguru	10	0.7%
	Total	1,466	100%

Source: OPD severe malaria referral records, Rwanda, FY 2025–2026. Districts are ranked by number of referrals; the three highest-burden districts are highlighted.

Concentration and Leading Sectors:

The burden of severe malaria referrals was strongly concentrated geographically. Gisagara District alone accounted for 328 referrals (22.4% of the national total), more than double the next district spread across 11 sectors. It was followed by Ngoma (147, 10.0%) and Gasabo (145, 9.9%). Together, these three districts accounted for about 42% of all severe malaria referrals, and the top five districts (adding Kicukiro and Nyarugenge) accounted for about 52%. At the other end, the lowest-reporting districts Nyaruguru, Huye, Nyabihu, Karongi and Ruhango each recorded 10 to 15 referrals over the year.

Table 34: Distribution of Severe Malaria Cases Across the Top 15 Sectors, FY 2025–2026

At sector level the concentration was even sharper. The fifteen highest-referral sectors are listed below; together they accounted for about 41% of all severe malaria referrals nationwide, and six of them are in Gisagara District.

Rank	Sector	District	Referrals	% National
1	Gishubi	Gisagara	98	6.7%
2	Kinyinya	Gasabo	72	4.9%
3	Mukindo	Gisagara	67	4.6%
4	Sake	Ngoma	61	4.2%
5	Masaka	Kicukiro	40	2.7%
6	Mugombwa	Gisagara	38	2.6%
7	Ndera	Gasabo	31	2.1%
8	Kansi	Gisagara	30	2.0%
9	Jarama	Ngoma	29	2.0%
10	Muganza	Gisagara	28	1.9%
11	Nyarugenge	Nyarugenge	28	1.9%
12	Muhima	Nyarugenge	25	1.7%
13	Rukomo	Gicumbi	22	1.5%
14	Zaza	Ngoma	19	1.3%
15	Kibirizi	Gisagara	18	1.2%

Source: OPD severe malaria referral records, Rwanda, FY 2025–2026. Sectors located in Gisagara District are highlighted.

Understanding Severe Malaria Burden, Drivers, and the Path Forward

After years of steady decline, Rwanda has experienced a marked resurgence of malaria. Between FY 2023/24 and FY 2024/25, the annual parasite incidence rose from 45 to 76 cases per 1,000 population, severe malaria cases more than doubled from 1,969 to 4,261 and malaria-

related deaths increased from 67 to 77; during the current reporting period, 2025/26, this upward trend has persisted. To understand what is driving the severe burden and to guide a sharper, evidence-based response, RBC/MOPDD conducted an implementation assessment across all 30 districts to map hotspots, document individual-level risk factors, and propose a real-time case-notification model.

Analysis of 3,455 severe malaria cases recorded between July 2025 and April 2026 confirmed a strongly uneven geography of risk. The Eastern Province carried the heaviest burden (1,331 cases), followed by the Southern Province (770), while the Northern Province recorded the fewest (221). Eighty cells were identified as hotspots concentrated in the Eastern Province, the City of Kigali (notably Gasabo), and Gisagara District and children under five accounted for nearly 40% of cases.

A complementary home-based assessment of individual risk factors among 404 patients pointed to modifiable behavioral and environmental drivers. Almost half sought care only two to three days after the onset of symptoms; most had not first consulted a community health worker, and where they did, diagnostics and medicines were sometimes unavailable.

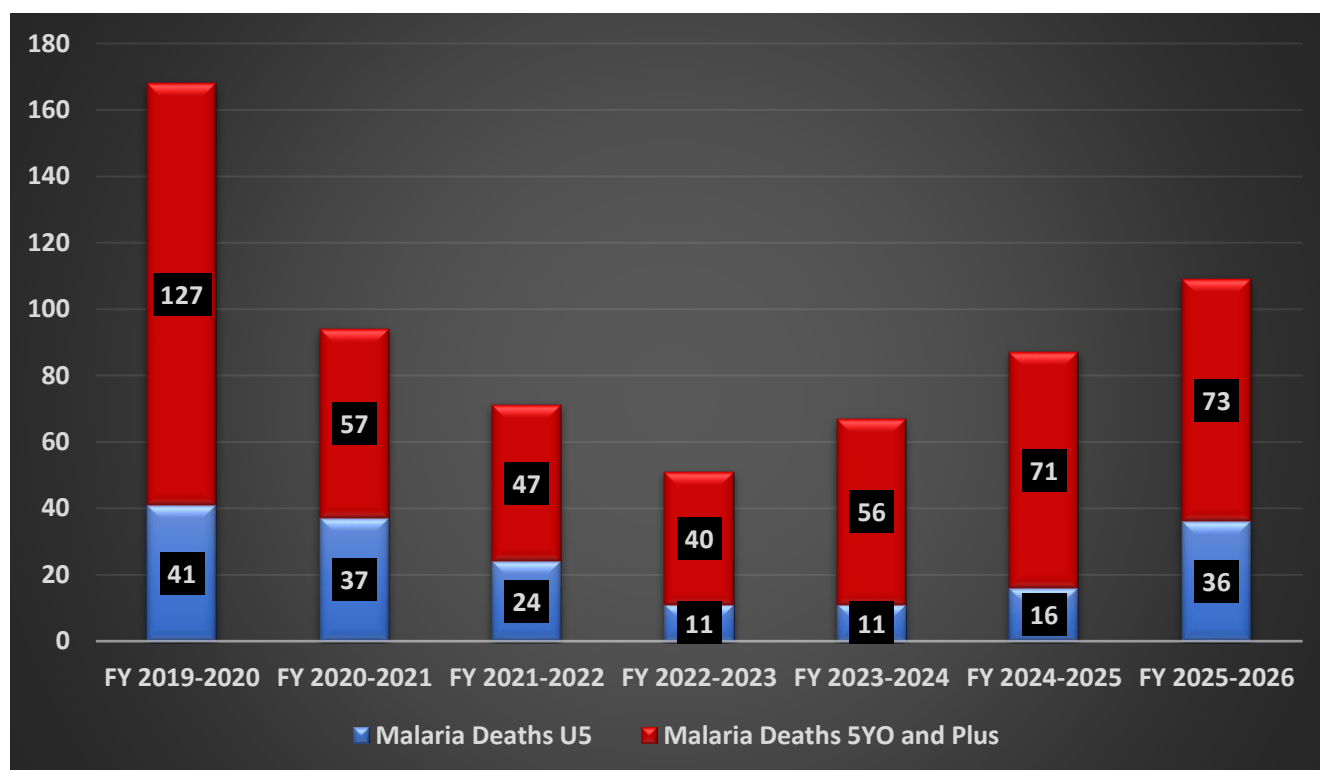
Many lived in housing that admitted mosquitoes or was situated near breeding sites, and a substantial share of nets were ageing or torn.

Taken together, the evidence affirms a clear message: the means to prevent severe malaria largely exist, and the task now is to reach every household in time. The proposed real-time notification model will be shared with stakeholders and its integration into the community electronic medical record (cEMR) explored, so as to strengthen the current severe-malaria notification system. Sustained investment in early detection, uninterrupted commodities, timely net replacement, and real-time surveillance will be decisive in reversing this rise and keeping Rwanda on course for malaria elimination by 2030.

2. Malaria Mortality and Deaths Audit

During FY 2025-2026, 109 malaria deaths were recorded, compared with 87 in FY 2024-2025 an increase of about 25%. Almost all of this rise was among children under five, whose deaths rose from 16 to 36, while deaths in those aged five and above increased only slightly (71 to 73).

Figure 31: Malaria Related Deaths per Aged Group from 2019-2026



From a peak of 168 deaths in FY 2019-2020, malaria-related deaths declined for three consecutive years to a low of 51 deaths in FY 2022-2023, a reduction of about 70%. Since then, deaths have risen for three consecutive years, reaching 109 in FY 2025-2026; this remains about 35% below the 2019-2020 peak but is more than double the 2022-2023 low. Deaths among those aged five years and above consistently made up the majority, falling from 127 (FY 2019-2020) to 40 (FY 2022-2023) before rising to 73 (FY 2025-2026). Over the same recent period the HBM indicator declined from 0.59 (FY 2022-2023) to 0.46 (FY 2025-2026), its lowest level in the series, so the rise in deaths coincided with a fall in HBM.

a. Malaria Death Data Quality Audit.

The malaria death audits formerly designed to determine the circumstances of each malaria patient's death, identify the underlying bottlenecks, and propose corrective and preventive measures to avert similar malaria deaths were not conducted by central-level supervisors; this task rested with the attending physicians at the hospital. Central-level work instead focused on verifying, for each patient who died of malaria, the consistency between the source documents and the data management systems. Data recorded in the eUBUZIMA system, or in the paper registers where these were still in use, were verified against the CRVS system, and finally, the HMIS system, in which confirmed malaria deaths are reported.

Malaria Deaths by Health Facility and District (2025-2026)

During FY 2025-2026, the 109 malaria deaths were recorded at 28 health facilities across 24 of the 30 districts, of which 36 (33%) were children under five. Almost all deaths occurred at referral and district hospitals (Level 2 Teaching Hospitals, district hospitals, and one provincial hospital), consistent with facility-based in-patient deaths reported and verified through the HMIS and CRVS systems. The burden was heavily concentrated in a small number of facilities, as shown in the table below.

Table 35: Malaria Deaths by Health Facility, FY 2025–2026

Rank	District	Health facility	Deaths	Under-5	% National.
1	Bugesera	Nyamata L2TH	15	12	13.8%
2	Nyagatare	Nyagatare DH	12	3	11.0%
3	Ngoma	Kibungo L2TH	11	3	10.1%
4	Gisagara	Kibilizi DH	9	6	8.3%
5	Gicumbi	Byumba L2TH	7	0	6.4%
6	Gasabo	Kibagabaga L2TH	5	0	4.6%
7	Musanze	Ruhengeri L2TH	5	0	4.6%
8	Huye	Butare CHU	4	3	3.7%
9	Kicukiro	Masaka DH	4	0	3.7%
10	Kirehe	Kirehe DH	4	2	3.7%
11	Nyamagabe	Kaduha DH	3	0	2.8%
12	Nyamasheke	Bushenge PH	3	1	2.8%
13	Nyarugenge	CHUK	3	0	2.8%
14	Rusizi	Mibilizi DH	3	3	2.8%
15	Gatsibo	Kiziguro DH	2	1	1.8%
16	Karongi	Mugonero DH	2	0	1.8%
17	Kayonza	Gahini DH	2	0	1.8%
18	Muhanga	Nyabikenke DH	2	1	1.8%
19	Rubavu	Gisenyi DH	2	1	1.8%
20	Rulindo	Rutongo DH	2	0	1.8%
21	Rusizi	Gihundwe DH	2	0	1.8%
22	Kayonza	Rwinkwavu DH	1	0	0.9%
23	Ngororero	Kabaya DH	1	0	0.9%
24	Ngororero	Muhororo DH	1	0	0.9%
25	Nyamasheke	Kibogora L2TH	1	0	0.9%
26	Nyaruguru	Munini DH	1	0	0.9%
27	Rutsiro	Murunda DH	1	0	0.9%
28	Rwamagana	Rwamagana L2TH	1	0	0.9%
	Total		109	36	100%

The distribution of malaria deaths was strongly concentrated. Nyamata L2TH (Bugesera) recorded the most deaths 15, or 13.8% of the national total followed by Nyagatare DH (12), Kibungo L2TH in Ngoma (11) and Kibilizi DH in Gisagara (9). The top three districts (Bugesera, Nyagatare, Ngoma) accounted for about 35% of all malaria deaths, and the top five for about 50%.

The concentration was even sharper among children under five. Nyamata L2TH alone accounted for 12 of the 36 under-five deaths, one third of all under-five malaria deaths in the country — and together with Kibilizi DH in Gisagara (6) made up half of them. Under-fives formed the majority of deaths in Bugesera (12 of 15, 80%), Huye (3 of 4, 75%), Gisagara (6 of 9, 67%) and Rusizi (3 of 5, 60%), pointing to a particular vulnerability of young children in these areas.

STRATEGY 5. IMPROVE REPORTING FROM THE PRIVATE SECTOR AND SUSTAIN PUBLIC SECTOR REPORTING

5.1. Data Quality Assurance

High-quality health data are fundamental to effective planning, monitoring, evaluation, and continuous improvement of healthcare services. Data quality assurance (DQA) is a core component of the National Health Management Information System (HMIS), ensuring that routine health data are accurate, complete, timely, consistent, and reliable for evidence-based decision-making at all levels of the health system. Within malaria prevention and control programs, high-quality routine data are essential for monitoring disease trends, tracking intervention coverage, assessing program performance, identifying data discrepancies, and guiding targeted interventions in high-burden areas. The national malaria strategic direction emphasizes the use of quality data for surveillance and timely response.

Achieving these objectives depends on the capacity of health facility staff and data managers to implement national data quality standards and routinely apply data quality assurance processes, including data verification, validation, consistency checks, and supportive supervision. Despite ongoing efforts, several challenges continue to affect data quality, including discrepancies between the data reported in HMIS and data recounted in data source documents or systems, incomplete or inaccurate data reporting, inadequate data validation, limited capacity for data verification or checking. These challenges reduce the reliability of routine data and can negatively affect the health system.

To address these gaps, the SOP guidelines recommend conducting internal and external quarterly data quality assessment (DQA), data validation meetings at health facility level. These interventions are intended to strengthen data quality, improve data management practices, promote data use for action, and foster a sustainable culture of evidence-based decision-making across all levels of the health system.

5.2. Data Quality Assessment/Audit at Health Center level

During the 2025–2026 fiscal year, the Rwanda Biomedical Centre (RBC), through the Malaria and Other Parasitic Diseases Division (MOPDD), in collaboration with partners including the RISE Malaria Project, civil society organizations (CSOs), and faith-based organizations (FBOs), conducted malaria Data Quality Assessments (DQAs) in 60 health centers reporting a high malaria case across 20 districts, with an average of three health centers assessed per district.

The malaria data quality assessment focused on verifying the quality of key malaria indicators, including total fever cases, total malaria diagnostic tests performed, total malaria test positives and total confirmed cases treated.

Malaria Data Quality Assessment (Reported vs Recounted), by District

Concordance between reported figures and source-document recount, 20 districts

This assessment compares, for each district, the figures reported in the system against the figures recounted from source documents, across four indicators along the malaria testing-and-treatment chain. The percentage discrepancy is calculated as (reported – recounted) ÷ reported, so a positive value indicates over-reporting (the reported figure exceeded the recount) and a negative value indicates under-reporting. Concordance within $\pm 10\%$ is generally considered acceptable.

Table 36: Overall Concordance by Indicator

Indicator	Reported	Recounted	Concordance	Accurate ($\leq 5\%$)	Significant ($> 10\%$)
Fever cases	89,523	65,774	73%	4 / 20	15 / 20
Diagnostic tests	81,506	74,898	92%	14 / 20	5 / 20
Positive tests	12,970	12,758	98%	15 / 20	2 / 20
Confirmed treated	10,344	10,214	99%	12 / 20	8 / 20

Reported and recounted totals across the 20 districts; concordance is the recount as a percentage of the reported figure.

Data quality **improves along the diagnostic chain**: fever counts are the least reliable, while diagnostic tests and positive tests are recorded well. The near-perfect overall total for confirmed cases treated (99%) is, however, misleading, because large district-level errors in opposite directions cancel out.

District-Level Discrepancies (% discrepancy by indicator)

Table 37: District-Level Discrepancies (% discrepancy by indicator)

District	Fever cases	Diagnostic tests	Positive tests	Confirmed treated
Bugesera	+50%	0%	+50%	+53%
Gakenke	+51%	+22%	+2%	+94%
Gicumbi	+51%	+3%	+1%	-145%
Gisagara	0%	0%	0%	0%
Huye	+18%	+1%	-3%	0%
Karongi	+53%	+14%	0%	+1%
Kayonza	+19%	-2%	-5%	+1%
Kirehe	+28%	+2%	-4%	+10%
Muhanga	+6%	+55%	0%	+13%
Musanze	+28%	+13%	+5%	+1%
Ngoma	0%	0%	0%	+3%
Nyagatare	+42%	+9%	+1%	+1%
Nyamagabe	+43%	+4%	0%	+29%
Nyamasheke	+30%	+1%	0%	+34%
Nyanza	+68%	+4%	+1%	+4%
Rubavu	-3%	0%	-5%	0%
Rulindo	+13%	+35%	+49%	+1%
Rusizi	+68%	+1%	+9%	0%
Rutsiro	+18%	+1%	0%	+21%
Rwamagana	0%	0%	0%	0%
≤5% accurate		5–10% minor	10–50% significant	>50% severe

Positive = over-reporting; negative = under-reporting. Cells are shaded by the size of the discrepancy.

Fever cases, the weakest indicator: The recount captured only 73% of reported fever cases (about 27% over-reporting overall), and in the same direction everywhere, all 15 districts with a significant discrepancy over-reported, none under-reported. The largest gaps were in Nyanza and Rusizi (both +68%), Karongi (+53%), Gakenke and Gicumbi (+51%), Bugesera (+50%), Nyamagabe (+43%) and Nyagatare (+42%). This systematic over-counting points to a recording or aggregation problem specific to the fever indicator rather than random error.

Diagnostic tests and positive tests, generally reliable: Fourteen of twenty districts recorded diagnostic tests within 5%, and fifteen recorded positive tests within 5%; overall concordance was 92% and 98% respectively. The main exceptions were Muhanga (+55%) and Rulindo (+35%) for tests, and Bugesera (+50%) and Rulindo (+49%) for positives.

Confirmed cases treated, accurate overall but with serious local errors: Although the national totals matched almost exactly, eight districts were off by more than 10%, in both directions, which is why they offset. The two extremes are the most concerning: Gicumbi reported 531 treated cases but the recount found 1,302 (−145%, gross under-reporting), while Gakenke reported 239 but the recount found only 14 (+94%, gross over-reporting). Other notable gaps were Bugesera (+53%), Nyamasheke (+34%), Nyamagabe (+29%) and Rutsiro (+21%).

Strongest data quality: Gisagara and Rwamagana were essentially perfect across all four indicators, and Ngoma and Rubavu were within about 1–2%. **Weakest data quality:** Gakenke, Bugesera and Rulindo each had three of four indicators off by more than 10%, and Gicumbi recorded the single largest error (−145% on treated cases); Nyamagabe, Muhanga, Karongi and Nyamasheke each had two indicators with significant discrepancies.

Key gaps identified included limited proficiency and utilization of eBUZIMA (Electronic Medical Record System) and inconsistent interpretation of malaria indicators. To address these gaps, RBC/MOPDD provided hands-on coaching on eBUZIMA and reinforced the correct interpretation and use of malaria indicators during feedback meetings. In addition, to ensure high-quality, timely and accurate malaria data for improved program performance monitoring and decision-making.

5.3. Conduct quarterly malaria data review meetings.

This fiscal year, RBC/MOPDD strengthened evidence-based malaria surveillance and data use through district data review meetings across 17 districts, engaging 729 stakeholders including 596 Data Managers and Nurses from health centers; 95 M&E Team members and Director Generals from hospitals; 21 Directors of Health Unit from districts; 14 staff from RBC/MOPDD; and 10 staff from partners. The meetings reviewed malaria trends, status of malaria commodities, malaria data quality and use, and prevention; enabling stakeholders to identify gaps and make timely, data-driven decisions tailored to their district context.

5.4. Integrated Surveillance of Malaria and Neglected Tropical Diseases (NTDs).

During this fiscal year, the Rwanda Biomedical Centre (RBC), through the Malaria and Other Parasitic Diseases Division (MOPDD), established an integrated surveillance system for Malaria and Neglected Tropical Diseases (NTDs). The surveillance system is laboratory-based and operates at the central as National laboratory, 4 regionals, and 30 sentinel sites across the countrywide. The surveillance system design, including the diagnostic package, equipment requirements, and staffing structure, was determined, and the implementation plan was developed and finalized.

5.5. Malaria Reactive Case Detection.

During Fiscal Year 2025-2026, RBC/MOPDD conducted Malaria Reactive Case Detection (RACD) in 23 sectors across five districts: Gasabo, Nyarugenge, Kicukiro, Gisagara, and Nyagatare. This activity was implemented following the identification of index malaria cases within the community. A total of 46,110 index cases were reached, and 191,382 household members were screened. Of these, 113,806 household members were tested for malaria with testing rate of 59% and the malaria positivity rate among those tested was 15%.

**Table 38: Index-Case Household Investigation (Reactive Case Detection)
July-October 2025, three districts (23 sectors)**

Indicator	Kigali City (15 sectors)	Gisagara (6 sectors)	Nyagatare (2 sectors)	Total
Index cases	15,933	27,662	2,515	46,110
Household members identified	57,504	123,140	10,738	191,382
Household members tested	32,131	75,082	6,593	113,806
Household members positive	6,678	9,477	1,204	17,359
Testing rate	56%	61%	61%	59%
Positivity rate	21%	13%	18%	15%
Yield (positives per index case)	0.42	0.34	0.48	0.38

Testing rate = household members tested ÷ identified; positivity rate = positive ÷ tested; yield = positives ÷ index cases.

Between July and October 2025, index-case household investigation was carried out around 46,110 confirmed (index) malaria cases in 23 sectors across three districts. This identified 191,382 household members, of whom 113,806 (59%) were tested, and 17,359 (15% of those tested) were found malaria-positive additional infections detected in the community around index cases. The approach yielded a substantial number of additional cases while overall, investigation found about 0.38 additional positive cases for every index case investigated. Because positivity among household contacts (15%) is high relative to routine community testing, the results confirm that malaria clusters around index cases, which validates the reactive, household-based targeting strategy.

Testing coverage was incomplete; however, with a testing rate of 59%, about 41% of identified household members (roughly 77,600 people) were not tested a coverage gap that means the 17,359 positives understate the true number of infections around index cases. Coverage was lowest in Kigali City (56%) and higher in Gisagara and Nyagatare (both 61%).

The three areas differed markedly. Gisagara dominated the volume, contributing 60% of all index cases and 55% of all positives, with by far the most index cases per sector (about 4,610, versus roughly 1,060 in Kigali and 1,260 in Nyagatare) consistent with its position as the

country's principal malaria hotspot. Yet it had the lowest positivity (13%) and the lowest yield per index case (0.34), suggesting that in a high-transmission setting infection is so widespread that household contacts are not much more likely to be positive than the general population. Kigali City had the highest positivity (21%), pointing to sharply focal, clustered transmission in the urban setting even though its testing coverage was the lowest. Nyagatare was small in scale (5% of index cases) but had the highest yield per index case (0.48) and high positivity (18%).

5.6 Malaria Community-Led Surveillance and Response (CRACDT)

5.6.1 Reactive Case Detection (RACD) Feasibility Pilot

Reactive case detection (RACD) is a case-based surveillance approach central to Rwanda's malaria-elimination agenda: each malaria case confirmed in the community the index case prompts a community health worker (CHW) to test household members to treat or refer to those found positive. During April 2025–May 2026, RACD was introduced in low burden sectors on a pilot basis to test the feasibility of delivering the approach through the community health system in four districts Rwamagana, Kirehe, Musanze, and Burera using the community electronic medical record (cEMR) and eCHIS platforms.

5.6.2 Participants Trained

To deliver community reactive case detection and treatment (cRACDT), a full cascade of health workers was trained across the four pilot districts of Kirehe, Musanze, Rwamagana, and Burera. In total, 2,220 community health workers (CHWs) were trained to conduct reactive case detection at household level — 1,044 in Kirehe, 540 in Burera, 340 in Musanze, and 298 in Rwamagana. Their work was supported by 100 health-facility staff (community and environmental health officers, store managers, health-centre managers, and data managers) across the 25 participating health centres, 4 hospital-based CHW supervisors, and a 5-member coordination team, bringing the total number of participants trained to 2,331. A total of 2,222 were equipped with smartphones to support the implementation of the activities.

Table 39: Trained participants on cRACDT

Institution	Role	# Staff
Project coordination		
Project coordinator	Research Coordinator	1
District coordinator	Overall project coordination and district study supervision	4
Subtotal		5
CHW supervision		
Kirehe District Hospital	CHW supervision	1
Ruhengeri Referral Hospital	CHW supervision	1
Butaro Level 2 Teaching Hospital	CHW supervision	1
Rwamagana Level 2 Teaching Hospital	CHW supervision	1
Subtotal		4
Health-centre staff (25 health centres)		
Health centres, Kirehe (7)	CEHO, Store Manager, HC Manager, Data Manager	28
Health centres, Musanze (4)	CEHO, Store Manager, HC Manager, Data Manager	16
Health centres, Rwamagana (6)	CEHO, Store Manager, HC Manager, Data Manager	24
Health centres, Burera (8)	CEHO, Store Manager, HC Manager, Data Manager	32
Subtotal		100
Community health workers (CHWs)		
Kirehe (Kirehe Level 2 TH)	CHWs	1,044
Musanze (Ruhengeri Referral Hospital)	CHWs	340
Burera (Butaro Level 2 TH)	CHWs	540
Rwamagana (Rwamagana Level 2 TH)	CHWs	298
Subtotal – CHWs trained		2,222
Total participants trained		2,331

2. RACD Implementation.

Across the four pilot districts, 1,709 confirmed index malaria cases were investigated in 1,570 households, spanning 25 sectors, 86 cells, and 25 health-centre catchment areas (Table 40). These investigations generated 2,121 expected HH members and 1,027 were traced, of whom 32 were tested positive, giving a positivity rate of 3%. HH member tracing reached 48.4% of index cases, identifying complete contact investigation as the main area to strengthen.

Detection concentrated in the two Eastern-Province districts Kirehe (50%) and Rwamagana (43.5%) with Burera and Musanze, in the Northern Province, contributing the remainder; within Kirehe and Rwamagana, cases clustered in a few hotspot cells, notably Ruhanga and Rugarama in Kigina sector. Cases were highly seasonal, peaking in November 2025, and fell mainly on the young (children under 15 years, 43.2%; median age 17 years; males 53.9%).

The pilot demonstrated strong feasibility: RACD was applied in 99% of investigations, 98.9% of RDTs were valid, and 89.1% of index cases were treated in the community all on the same day as testing – with a further 9.8% referred to a health centre. These results support refining and scaling RACD prioritising complete contact tracing and the highest-burden cells as part of the elimination agenda.

Table 40: Index cases, Household members, and Test positivity by pilot district.

Indicator	Value
Reporting period	2025-04-22 – 2026-05-31
Pilot districts	Rwamagana, Kirehe, Musanze, Burera
Sectors / cells / health centres	25 / 86 / 25
Fever Cases Tested	5,470
Index cases (RDT-positive) / households	1,709 / 1,570
House member expected / tested / positive	2,121 / 1,027 / 32
Tested positivity	3%
Coverage (index with ≥ 1 contact)	45.2%
RACD implemented / RDT validity	99% / 98.9%
Community treatment (same-day) / referred	89.1% (100%) / 9.8%

Table 41:Key indicators of the cRACDT feasibility pilot, 2025/2026

District	Index cases	% Total	HH members traced	HH member positivity
Kirehe	853	50.0%	319	17 (5.4%)
Rwamagana	745	43.5%	606	13 (2%)
Burera	65	3.8%	68	2 (2.9%)
Musanze	46	2.7%	34	0%
Total	1,709	100%	1,027	32 (3%)

Risk Factor Distribution Among Positive Index Cases

Risk factor data were collected from all 1,709 confirmed positive index cases. A total of 961 risk factor instances were documented, capturing occupational and behavioural outdoor night-time exposure and travel history to high malaria burden areas.

Travel to high malaria burden areas (25.6%) was the single dominant risk factor across all districts, confirming the critical role of cross-border and inter-district population movement in sustaining transmission in near-elimination settings;

- Rice farming at night (12.5%) was concentrated almost entirely in Kirehe (105 of 120 instances, 87.5%), pointing to a high-priority occupational group requiring targeted interventions;
- Other outdoor night-time activities (11.7%) represent a heterogeneous category requiring further sub-classification in the analytical phase;
- Private sector workers, boarding school students, seasonal agricultural workers, and cross-border traders each contributed 4–8% of risk factor instances;
- Musanze showed a notably different profile, with travel dominating (26 of 38 instances, 68%), consistent with its tourism-adjacent geography.
- The findings from cRACDT illustrated the the gaps in malaria preventive intervention not covering the whole population at risk requiring additional innovative interventions such as repellent to protect those spending most of the time outside during the night.

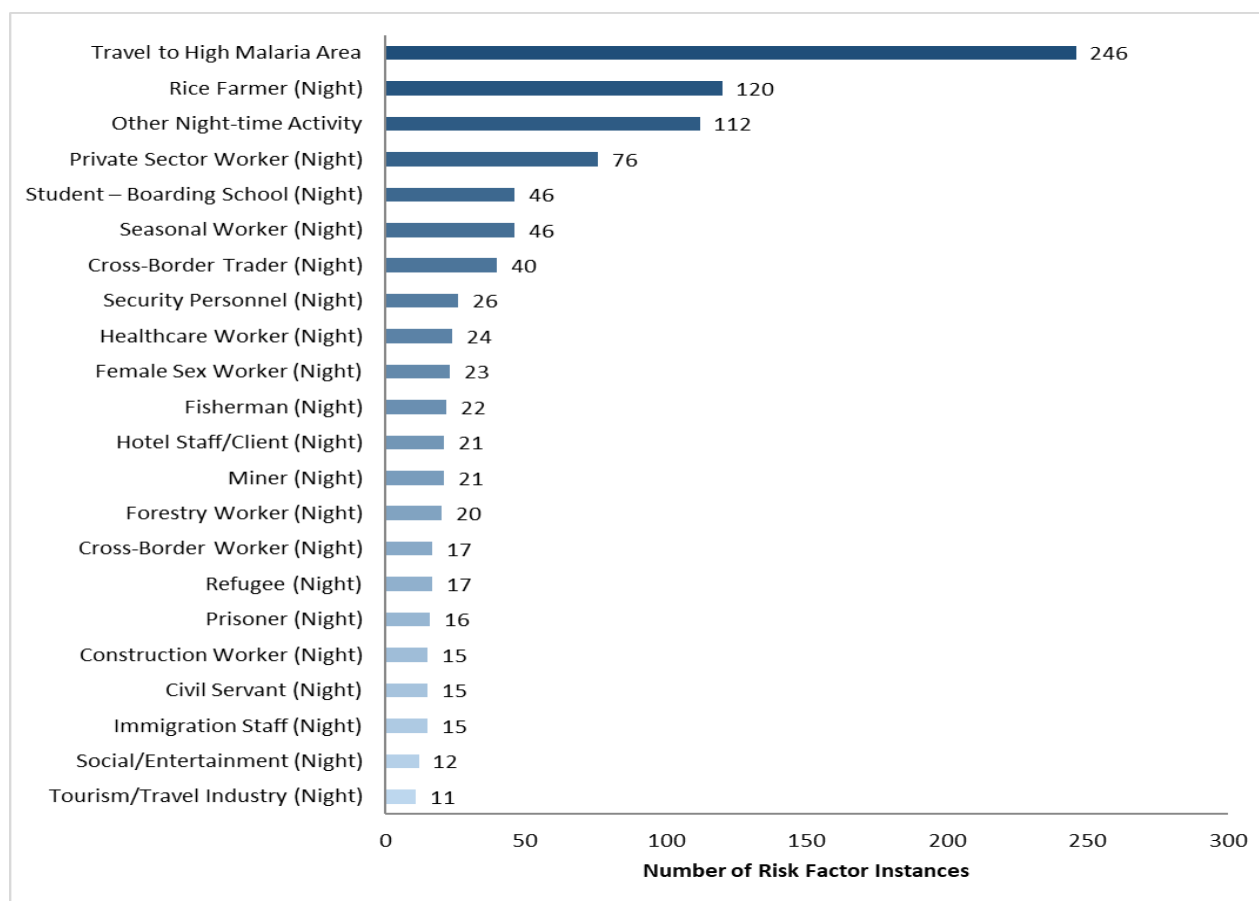


Figure 32: Risk Factor Distribution Among Positive Index Cases (n = 961 instances from 1,709 positive cases)

Support for the digitization of tools for community health workers

To strengthen Community Health Workers' (CHWs) capacity to deliver timely, high-quality healthcare services, the Ministry of Health, through the Rwanda Biomedical Centre (RBC), in collaboration with its partners, developed the Community Electronic Medical Record (cEMR) system. This user-friendly digital platform replaces paper-based tools, enabling CHWs to efficiently collect, manage, and report health data during routine service delivery. The system also provides supervisors and program managers with real-time data, supporting evidence-based decision-making, improved monitoring, and continuous program improvement. Accurate, timely, and complete community-level health data are critical for effective malaria surveillance, case management, and response.

To support this objective, the Ministry of Health, through the Rwanda Biomedical Centre (RBC), in collaboration with its development partners, has provided both technical and financial support to implement the nationwide rollout of the Community Electronic Medical Record (cEMR) system. As part of this effort, all Community Health focal people at district hospitals and health centers across the country have been trained to support implementation.



and provide ongoing supervision. In addition, training of all 58,354 Community Health Workers (CHWs) on the use of the cEMR system is underway.

Up to date, devices to be used have been distributed countrywide where 57,915 out of 58,354 of CHWs (99.7%) received Devices to be used. A total of 30,001 out of 30,697 targeted CHWs in 17 Districts were reached, resulting in an overall coverage of 97.7%. Training in the remaining districts is being conducted in phases and is expected to be completed by the end of September 2026, achieving nationwide coverage.

PART IV: PROGRAM COORDINATION AND MANAGEMENT

Objective 4: By 2027, Strengthen Coordination, Collaboration, PSM, and Effective Program Management

Strategy 1: Mobilization of Adequate Financial Resources

- **Mobilisation of funds through G2G mechanism between US government & Government of Rwanda**

During the FY 2025-2026, the National Malaria Control Program (NMCP) strengthened resource mobilization efforts to support the implementation of national malaria priorities. The programme submitted requests for financial support through the Government-to-Government (G2G) mechanism between the Government of Rwanda and the Government of the United States of America. The G2G Implementation Plan has been developed and funds to support malaria control interventions from 2026 expected.

- **Development of National Strategic plan 2026-2030**

The development of the National Malaria Strategic Plan (NSP) July 2026– June 2030 also represents an important step toward strengthening resource mobilization and ensuring that malaria priorities, targets, and resource requirements are clearly defined. The NSP has been developed and is currently in the final stages of review, pending approval by the relevant authorities. Once approved, it will provide a five-year framework for guiding malaria control and elimination efforts, including prioritization of investments and resource allocation.

- **Evidence-Based Resource Allocation through Subnational Tailoring (SNT)**

The program with technical support from AHADI, conducted an in-depth analysis of malaria program data to inform Subnational Tailoring (SNT) of malaria interventions. This evidence-generation process supported more efficient and targeted allocation of available resources by aligning investments with the specific epidemiological and operational needs of different geographic areas.

- **Planning and Resources Mobilization for the FY 2026/2027**

In FY 2025-2026, the MOPDD participated in the Action Plan (AP) development process coordinated by the Ministry of Finance (MINECOFIN) and the Ministry of Health (MOH) and successfully mobilized a total budget of 15,265,695,102 FRW from the Ordinary Budget, END Fund and Global Fund to support malaria and NTDs programs.

Strategy 2: Strengthen Intra- and Inter-Sector Collaboration and Coordination

○ Strengthened Stakeholder Coordination through Technical Working Groups meetings

This year, the programme strengthened coordination and collaboration among malaria stakeholders through the Technical Working Group (TWG) meetings. quarterly TWG meetings brought together key stakeholders and partners to review program performance, discuss emerging challenges, share evidence, and coordinate the national malaria response. These meetings contributed to evidence-based decision-making, strengthened multi-sectoral collaboration, facilitated monitoring of progress against strategic plan targets, and enabled timely adaptation of interventions in response to changing epidemiological trends.

○ Building Consensus for Subnational Tailoring of Malaria Interventions

The programme also conducted two workshop sessions, with technical support from AHADI, to review malaria program data and build consensus around the approach for Subnational Tailoring (SNT). These sessions strengthened collaboration among technical stakeholders and laid the foundation for a coordinated, geographically targeted, and evidence-based approach to malaria intervention planning and implementation.

○ Aligning National Strategies and Strengthening Cross-Program Collaboration

Furthermore, the development of the National Malaria Strategic Plan 2026–2030 involved coordination among relevant stakeholders and provides a common strategic framework for aligning partners and sectors around national malaria priorities. In parallel, the development of the National Strategic Plan for Neglected Tropical Diseases (NTDs) during the 2025–2026 reporting period reflects broader efforts to promote integrated approaches to disease control and elimination and strengthen collaboration across related health programs.

Strategy 3: Synchronization and Alignment of Malaria Commodities Procurement and Supply Management

○ Aligning Malaria Commodity Management with the Multiple First-Line Therapies Strategy

The programme finalized the Multiple First-Line Therapies (MFT) Strategic Plan and accompanying Implementation Plan. The MFT strategy involves the simultaneous deployment of more than one first-line antimalarial treatment, typically different Artemisinin-based Combination Therapies (ACTs), rather than relying on a single treatment nationwide. The development of the strategic and implementation plans provided a structured framework for aligning the selection, quantification, procurement, deployment, and management of malaria commodities with the country's evolving treatment strategy.

- **Aligning Commodity Requirements with National Malaria Priorities**

The ongoing development of the National Malaria Strategic Plan 2025/26–2029/30 further provides an opportunity to align malaria commodity requirements with national strategic priorities, intervention targets, and resource availability. Once approved, the NSP will guide the planning of commodity needs and support better synchronization between program implementation, financing, procurement, and supply management.

- **Strengthening Evidence-Based Commodity Forecasting through Subnational Tailoring**

The Subnational Tailoring (SNT) data analysis undertaken by the programme, with technical support from AHADI, will also contribute to more evidence-based planning of malaria commodity requirements. By tailoring interventions according to the epidemiological and operational context of different geographic areas, the approach can support more accurate forecasting and allocation of malaria commodities and reduce the risk of mismatches between commodity availability and program needs.

PART V: SOCIAL BEHAVIOR CHANGE

Key Achievements

During FY 2025–2026, MOPDD and partners strengthened coordination through district-level and task force meetings, engaging over 1,680 participants to reinforce leadership and community involvement in malaria prevention. Technical support enabled malaria case investigation and data stratification in hotspot districts, while community outreach activities by reaching 309,173 people. In addition, CSO-supported reactive case detection and severe malaria risk factors investigation. Furthermore, malaria SBC interventions focused on increasing community awareness and uptake of malaria prevention and control where Door-to-door community mobilization during IRS campaign Was periodized and reached over 884,802 household. Complementary the programme aired 2,713 radio spots and DJ mentions and 25 radio talk shows, and produced and distributed information, education, and communication (IEC) materials, including banners, teardrops, stickers, T-shirts, and flyers.

Additionally, the National World Malaria Day 2026 was successfully hosted, engaging over 5000 participants and highlighting progress, community involvement, and the need for continued investment and innovation toward malaria elimination. Through trainings on Integrated Vector Management, a total of 885 participants were reached, strengthening local capacity for sustained malaria control.

Key Challenges

Lower involvement and participation for community and local leader for decision making
Non availability of outdoor control tools including Repellents and etc.

Funding Gap, Delays of fund availability and transfers led to delays activity Implementation

Way Forward

Scale up community-level decision-making meetings and address low involvement and participation.
Intensify behavior change interventions in persistent hotspot districts with tailored strategies.
Investigate the drivers of malaria in hotspots and transmission foci to generate local evidence
Strengthen IVM implementation at districts and lay community at village levels
Advocacy for establishment of sustainable and innovative financial resource mobilization mechanisms to enable Timely implementation of the SBC interventions at full scale

Objective 5: By 2027, at least 85% of the population at risk will have correct and consistent practices and behaviors towards malaria control interventions.

1. Introduction

The Government of Rwanda advanced its malaria prevention and control efforts through evidence-based interventions delivered under the National Malaria Strategic Plan (MSP) 2020–2027. During FY 2025–2026, Social and Behavior Change (SBC) interventions were carried out in accordance with the National SBC Strategy for Malaria Prevention and Control, which is designed to close gaps in communication strategy, behavior change interventions, messaging, communication channels, and community engagement. The strategy further draws on the findings of the Matchbox Toolkit Assessment to address the human rights and gender-related barriers that heighten vulnerability to malaria.

Implementation was additionally guided by the National Health Promotion Policy and its emphasis on community mobilization, health education, advocacy, partnerships, and expanded access to malaria services. Collectively, these approaches were intended to build wider acceptance and sustained uptake of core malaria interventions, namely Insecticide-Treated Nets (ITNs), Indoor Residual Spraying (IRS), prompt diagnosis and treatment, and integrated vector management.

SBC activities were delivered through a partnership between the Rwanda Biomedical Centre (RBC) and a range of stakeholders, including district authorities, health facilities, Community Health Workers (CHWs), JHPIEGO, and seven Civil Society Organizations (CSOs). Five of these CSOs implemented community-based malaria SBC interventions across the country's five provinces, reaching the general population, while two national CSOs — ASOFERWA and RNGOF — delivered tailored interventions for identified high-risk groups nationwide. This approach strengthened community engagement and promoted positive malaria prevention and care-seeking behaviors.

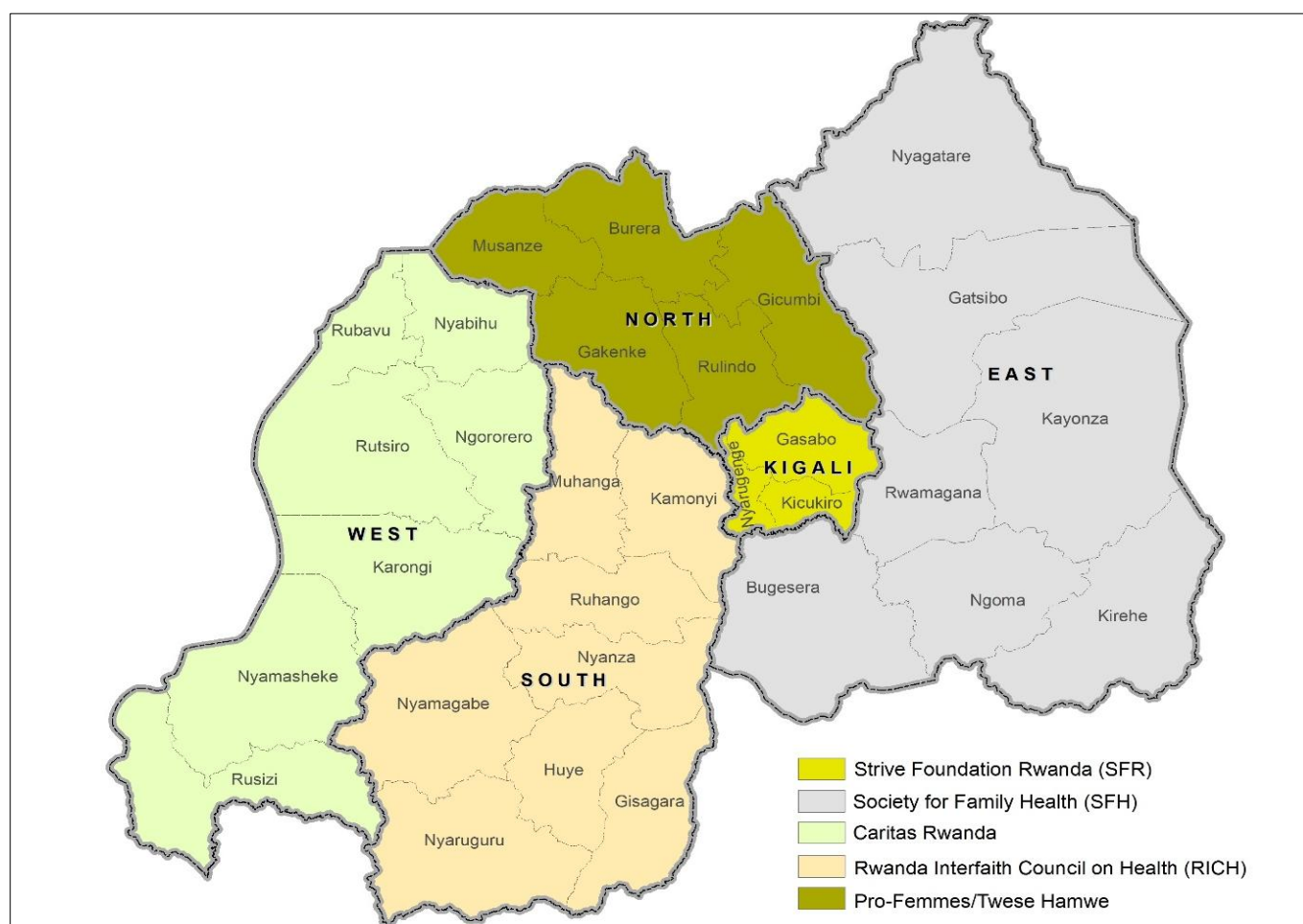


Figure 33:Deployment of Five CSOs Implementing Malaria SBC Activities per Province in the General Population

2. Strengthen the Malaria SBC Framework

During FY 2025–2026, the Malaria and Other Parasitic Diseases Division (MOPDD), in collaboration with implementing partners and stakeholders, convened district- and sector-level malaria coordination meetings, reaching 1,680 of the 1,700 planned participants. These meetings reinforced government leadership, strengthened stakeholder coordination, mobilized communities, and enhanced local ownership of malaria prevention and control interventions. Aligned with the District Malaria Task Force meetings, they further reinforced local leadership, coordination, and accountability.

This approach strengthened malaria case follow-up and data-driven decision-making in hotspot sectors. Priority sectors were identified using HMIS data, and joint field visits were conducted with district health teams and Civil Society Organizations (CSOs) to support data stratification, case follow-up, and the implementation of targeted interventions. The multi-

sectoral model improved collaboration among district authorities, health facilities, CSOs, and communities, contributing to better-coordinated implementation of malaria interventions. Sustaining active participation and ownership beyond project support nonetheless remains a challenge, and the absence of a formal coordination and accountability framework may affect the efficiency and consistency of implementation.

To ensure long-term sustainability, malaria coordination meetings and District Malaria Task Force activities have been institutionalized within existing government structures and integrated into district health plans. Clearly defined roles and responsibilities, strengthened accountability mechanisms, and increased domestic financing were identified as essential to sustaining leadership, coordination, and community engagement beyond externally funded projects.

3. Increase Awareness of Communities' Role in Malaria Prevention and Control

Social and Behavior Change (SBC) interventions focused on promoting Integrated Vector Management (IVM) including larval source management, the removal and elimination of mosquito breeding sites, early care-seeking, and adherence to malaria treatment. Delivered from the provincial to the community level, these interventions strengthened community ownership of malaria prevention and advanced the "Zero Malaria Starts with Me" (*Kurandura Malariya Bihera Kuri Njye*) campaign.

Community engagement was conducted through interpersonal communication (IPC) sessions integrated into existing community platforms, notably Umuganda and Inteko z'Abaturage, reaching 152,147 of the 160,420 planned participants. Outreach campaigns in high-burden sectors reached 309,173 of the 319,500 targeted individuals, while 224 supportive supervision visits were carried out at health facilities and health posts. Community decision-making meetings engaged local leaders, healthcare providers, and community influencers who convened to identify challenges and develop practical solutions.

SBC efforts were further reinforced through educational and edutainment activities, including special Umuganda campaigns and targeted outreach for high-risk populations, reaching 6,200 people against a target of 6,500. To broaden public awareness, the programme aired 2,713 radio spots and DJ mentions and 25 radio talk shows, and produced and distributed information, education, and communication (IEC) materials, including banners, teardrops, stickers, T-shirts, and flyers.

Despite these achievements, limited engagement by some district stakeholders affected coordination and the timeliness of responses to malaria upsurges. Strengthening district malaria coordination mechanisms, stakeholder participation, routine data review, and

communication will be essential to improving surveillance, decision-making, and rapid response.

4. Increase Advocacy for High-Level Support to Sustain Malaria Prevention and Control Interventions

Fiscal year 2025/2026 marked significant progress in advocacy for malaria prevention and control. Stakeholders at all levels reaffirmed their commitment to the Government of Rwanda's goal of reducing the malaria burden by systematically integrating malaria prevention and control into their daily activities and operational frameworks. In collaboration with Civil Society Organizations (CSOs) and local leaders, RBC/MOPDD organized the national and community-based World Malaria Day commemoration on 25 April 2026, which gathered over 5,000 participants and surpassed the target of 3,000.

Rwanda observed World Malaria Day 2026 under the global theme "Driven to End Malaria: Now We Can. Now We Must." and the national slogan "Zero Malaria Starts with Me." Held in Gahanda Sector, Kicukiro District, the event brought together community members engaged in their routine community-based activities, alongside local leaders, policymakers, and development partners, to showcase achievements, inspire collective action, and underscore the central role of communities and stakeholders in malaria prevention and control.

The commemoration therefore served as a call to prevent malaria deaths and to unite behind the "Big Push" against malaria. The 2026 World Malaria Day Commemoration provided an opportunity to review progress, address existing gaps, and reinforce collective commitment across government institutions, development partners, civil society organizations, the private sector, and communities. It further underscored the importance of aligning with global efforts and the urgent need for continued investment, innovative approaches, and sustained political will to accelerate malaria elimination.



Community members, local leaders, and policymakers at the World Malaria Day 2026 commemoration in Gahanda Sector, Kicukiro District – "Zero Malaria Starts with Me"

5. Promote Community Engagement in Malaria Prevention and Control Interventions

During FY 2025–2026, Malaria and Other Parasitic Diseases Division (RBC/MOPDD), in collaboration with implementing partners and Civil Society Organizations (CSOs), delivered a range of interventions that strengthened community participation in malaria prevention and control. These interventions promoted early diagnosis and treatment, raised community awareness, and reached both the general population and identified high-risk and vulnerable groups, including hard-to-reach communities.

Community engagement was carried out through multiple platforms religious institutions, schools, mass media, Umuganda, and other community structures to disseminate key malaria prevention messages. These emphasized the consistent use of Insecticide-Treated Nets (ITNs), the appropriate use of mosquito repellents, environmental sanitation to eliminate mosquito breeding sites, and prompt care-seeking for suspected malaria.

Through coordinated efforts by RBC/MOPDD, JHPIEGO, CSOs, and other partners, Integrated Vector Management (IVM) interventions were implemented at the community level. These included awareness campaigns on larval source management, the identification of mosquito breeding sites, and community-led environmental management through monthly Umuganda activities. In addition, IVM training was provided to sector-level stakeholders and peer educators drawn from high-risk groups, reaching 885 of the 1,293 planned participants.

Despite these achievements, sustained malaria prevention remains constrained by limited community-level access to essential malaria commodities and innovation tools, including ITNs and mosquito repellents. To enhance the effectiveness and sustainability of SBC interventions, efforts should prioritize strengthening community access to these commodities and tools, aligning behavior change interventions with available resources, reinforcing community leadership, and improving supply chain management to prevent stock-outs

Table 42: Malaria SBC Activities Implementation, FY 2025–2026 (Country-wide)

No	Activity	Target	Reached	%
1	Conduct coordination meetings at district level	1,700	1,670	98%
2	Conduct training on IVM for the general population	1,293	885	68%
3	Conduct community mobilization on malaria prevention and control in hotspots using mobile sound systems (sessions)	89	89	100%
4	Organize radio and TV talk shows	25	23	92%
5	Air radio spots and DJ mentions (ITN use, malaria early treatment, environmental management, and HBM)	2,713	2,713	100%
6	Door-to-door community mobilization during IRS campaign	885,057	884,802	100%
7	Production of IEC materials – banners	51	51	100%
8	Production of IEC materials – teardrops	71	71	100%
9	Production of IEC materials – T-shirts	6,400	6,400	100%
10	Production of IEC materials – stickers	20,850	20,850	100%
11	Production of IEC materials – booklets	18,715	18,715	100%
12	Organize and conduct outreach awareness campaigns in malaria hotspot sectors on ITN hanging and use, early care-seeking, MFT, and IRS strategies (people reached)	319,500	309,173	97%
13	Raise community awareness through existing platforms (Umuganda) for locally driven interventions in hotspot sectors (people reached)	45,540	43,646	96%
14	Raise community awareness through existing platforms (Inteko z'Abaturage) for locally driven interventions in hotspot sectors (people reached)	114,920	108,501	94%
15	Conduct supportive supervision at health centers/posts targeting high malaria incidence	224	224	100%
16	Production of educative videos on malaria prevention and control	7	7	100%

No	Activity	Target	Reached	%
17	Produce and disseminate educative radio sketches on malaria prevention and control	7	7	100%
18	Produce and air educative malaria TV series with key messages for prevention and control among hard-to-reach groups	3	3	100%
19	Organize and conduct special Umuganda with hard- and easy-to-reach groups and local leaders	6,500	6,200	95%
20	Organize follow-up meetings and mentorship for trained peer educators per district representing hard-to-reach groups	480	480	100%
21	Conduct targeted malaria IPC sessions and supervision in identified hotspots through existing community platforms	13,295	12,983	98%
22	Distribution of Guardian mosquito repellents	21,752	21,752	100%
23	Conduct severe malaria notification and household visits for case investigation, education, and risk-factor assessment	1,828	1,502	82%
24	Conduct malaria reactive case detection and treatment	188,868	169,062	90%
25	Training of CHWs on malaria reactive case detection and treatment using digital tools (cEMR and eCHIS)	2,927	2,292	78%
26	ICON 10 CS (lambda-cyhalothrin) insecticide for vector control	200	200	100%
27	ACTELLIC 300 CS (pirimiphos-methyl) insecticide for vector control	80	80	100%
28	BALLOT mosquito repellent lotion, 130 ml	1,000	1,000	100%
29	Conduct World Malaria Day 2026	7,500	6,745	90%
30	Conduct household visits to families affected by malaria cases in hotspot sectors	500	482	96%

Status key: Exceeded (>100%) · Achieved (90–100%) · Partially achieved (60–89%) · Not achieved (<60%).

PART VI: NEGLECTED TROPICAL DISEASES & OTHER PARASITIC DISEASES

Key Achievements

During this reporting period, the NTD validated the new NTD strategic plan 2026-2030 to guide the interventions for the next 5 years. Remarkable progress was made to reduce the burden of Schistosomiasis; to enhance elimination interventions we conducted the capacity building for snail control to achieve the interruption of transmission. The interventions were piloted in Bugesera and Ruhango districts. To enhance the prevention of malaria and NTDs an integrated community awareness was conducted selected high-risk population in western, southern and Northern provinces and 79,000 population was reached. The awareness was conducted at the community, schools, working area, and other public places.

Under WHO's support, the NTD developed the training manual for integrated snakebite management and trained 125 health care providers including emergency nurses, medical doctors, IDSR Focal person, and data managers to enhance proper case management. The World NTDs Day was celebrated on 30 January 2026, and it was marked by the leader's remarks focusing on the need for community engagement and empowerment in the fight against NTDs. Conducted STOP MDA survey of STH and SCH, the preliminary results showed substantial progress toward the interruption of SCH transmission while the prevalence of STH remains above 1% by Kato-Katz, and not meeting criterias for IoT.

To tackle the resistance of Trichuris Trichiura to Albendazole alone the Combination Therapy MDA (ALB+IVM) in Rubavu, Rutsiro, and Nyabihu districts, and treated 417,901 children aged 5 to 15 years in Rwanda, and 883,311 adults aged 16 years and above. Validated NTDs strategic documents including Podoconiosis Prevention and Management guideline, SCH active case detection and response, Onchocerciasis elimination plan, NTD-WASH coordination toolkits.

Challenges

The NTDs program faced challenges in this FY including understaffing of the unit that impacted the implementation of all planned activities. In addition, during this FY the program faced a reduction of government funds allocated to NTDs specifically the funds needed to procure MDA drugs for adults for STH as they are not targeted in the WHO donation, and it has an impact on the effectiveness on future MDA.

Mitigation plan

To meet the elimination target, the NTDs program plans to integrate interventions like surveillance with other programs including malaria, through one health and others. In addition the multisectoral collaboration will be enhanced to improve WASH and NTDs control interventions as well as joint planning and implementation.

6.1. INTRODUCTION

In Rwanda, Neglected Tropical Diseases (“NTDs”), include intestinal worms–Ascariasis, Trichuriasis and Hookworm, Schistosomiasis (SCH), Scabies and other ectoparasites (Tungiasis or Jigger disease), Podoconiosis, Leprosy, Rabies, Snakebite envenoming (SBE), Trachoma, Taeniasis/Cysticercosis, Mycetoma, Lymphatic filariasis, Onchocerciasis and Human African Trypanosomiasis (HAT). Other parasitic diseases (OPDs) include amoebiasis and giardiasis, trichomonas intestinalis. According to 2020, remapping of Soil Transmitted Helminthiasis (STH) commonly known as intestinal worms and schistosomiasis, STH is the most common NTDs with the overall national prevalence of 38.7%. The same remapping shows that adults (16 years and above) are the most affected age group with 46.1%, followed by School Aged Children -SAC (5-15years old) with 38.8% and Pre-SAC with 30.2%. Persisting high prevalence was observed in 10 out of 23 districts that had high prevalence (>50%) in 2008 initial nationwide mapping. The persistence of high prevalent infections is observed in districts with high infections with *Trichuris trichiura*, a species that poorly responds to a single dose of benzimidazoles in mass deworming. For Schistosomiasis, 1,013 were found endemic and eligible for mass deworming annually using Praziquantel tablets.

The planned 2026 mapping of STH and SCH will inform the elimination strategies including revision in the implementation of intervention and MDA strategy. The activities implemented during the FY 2025-2026 are grouped in thematic areas, including NTDs prevention, case management, surveillance and research, WASH and NTDs coordination and awareness.

6.2. Prevention and Control of NTDs and Other Parasitic Diseases

6.2.1 Mass drug administration

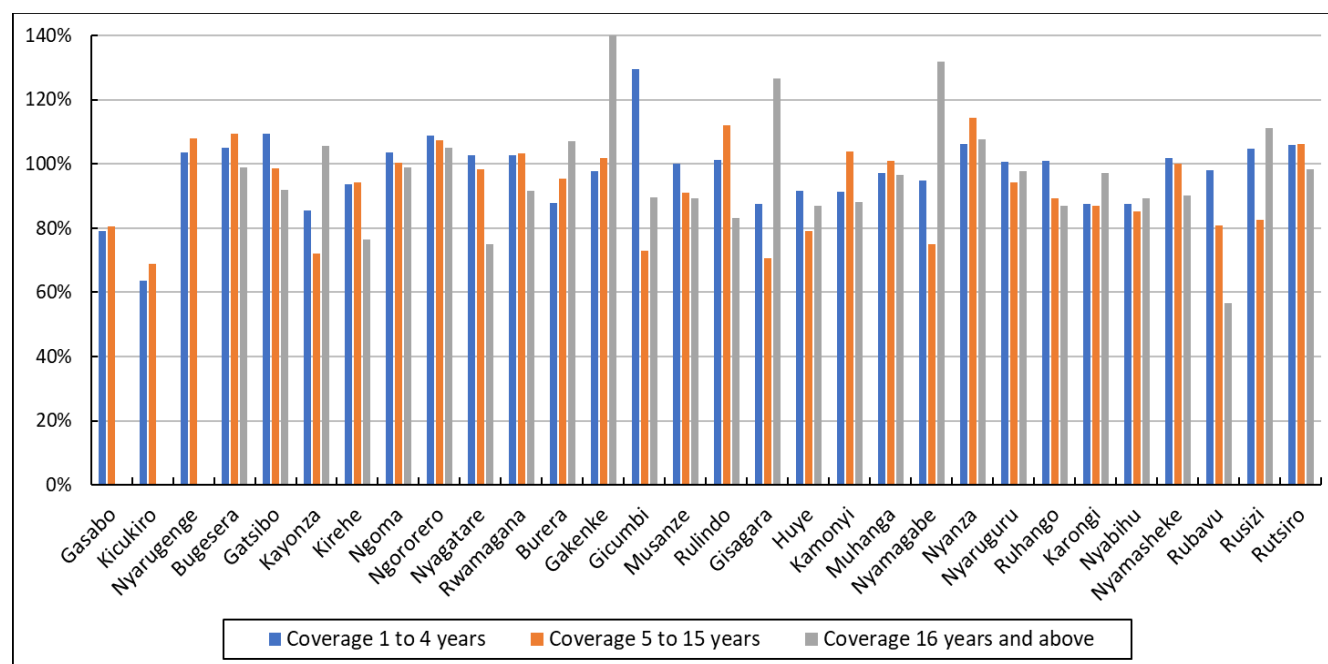


Figure 34:MDA coverage for Preschool age, School age and Adults 25th September to 15th October 2025

During FY 2025-2026, the first round of MDA for STHs using ALB/MBZ and for SCH using Praziquantel was conducted from 25th September to 15th October 2025. The MDA was conducted through “**Transition strategy to sustain key interventions of MCH week campaign in routine care**” through integration of MDA into CHWs routine services.

During the MDA conducted in the current FY the coverage was above 90% in most of the districts. A total of 9,480,014 population aged 1 year and above were treated including 1,378,169 children aged from 12 to 59 months, 2,754,699 aged from 5 to 15 years, and 5,347,146 adults aged 16 years and above. Regarding MDA for Schistosomiasis using Praziquantel tablets 2,536,388 people aged 5 years and above were treated.

6.2.2. Increasing awareness of NTDs and other Parasitic Diseases

The community mobilization was conducted using different platforms to ensure that messages reach the community for behavior change to prevent NTDs and OPDs. These included radio spots, radio talks, and TV shows. In this report, Bilharzia story telling lab, celebration of the world NTD day and media engagement to streamline the uptake of preventive measures are highlighted.

a) Bilharzia Story Telling initiative

The project was supported by Merck KGaA in collaboration with the END Fund aiming at assessing possible behavior change interventions to improve knowledge, attitude and perception of School Aged Children (aged between 5 and 15 years) about schistosomiasis. It was conducted at selected schools in Bugesera, Ruhango and Gatsibo districts. The Activities implemented included training of teachers, students’ education baseline and endline assessment. The demonstrated innovation in teaching children for behavior change for Schistosomiasis prevention.





b) Celebration of World NTD Day (WNTDD 2026)

On an annual basis, the World Health Organization (WHO) celebrates World NTDs Day to raise awareness, mobilize resources, and unite global efforts to end preventable illnesses affecting over one billion vulnerable people. The Ministry of Health, through Rwanda Biomedical Centre joins the World in this day celebration.

NTDs day celebration of 2025-2026 was celebrated on 30th January 2026 in Ruhango district, Ruhango sector, Nyamagana cell. The NTD Day celebration was honored by the presence of Dr MUKAGATARE Isabelle, HoD of Bios, Dr CHIROMBO Brian, Representative of WHO Rwanda and NUKANGENZI Alphonsine, the Vice Mayor in charge of social affairs in Ruhango district. Local population and school learners attended the event as well. The theme of this year was “Act. Unite. Eliminate”. The rationale of this theme is to push for shared global cooperation, prompt direct medical and hygiene interventions, and reach the 2030 target of freeing vulnerable communities from these preventable illnesses. The theme was translated and put in Rwandan context as *Tujyanemo, mu Isuku n’isukura; tutwanye indwara ziterwa n’umwanda*. The central message of the day emphasized the role of multisector collaboration in NTDs control due an array of factors and causes of NTDs.

A showcase on snail control in Nyamagana marshland and exhibition of WASH and health education materials were among key activities conducted that day.



Dr Isabelle Mukagatire, HoD Bios, Vice Mayor in charge of social affairs, Dr Chiromo Brian, the WHO country representative at showcasing snail collection session.

Guests attending World NTD Day celebration in Ruhango district pose for a photo



Media professionals and social media influencers participated in the NTDs Media Tour on January 26–30, 2026, visiting Ngoma, Gatsibo, Bugesera, Kigali, and Ruhango districts to document Rwanda's efforts to eliminate NTDs. Media coverage generated through the tour and

the national celebration included 31 published articles across outlets such as The New Times, KT Press, Top Africa News, and several Kinyarwanda-language platforms. Forty-eight posts on X, 21 YouTube live streams and video recordings, and community stories were shared on Facebook. The reporting brought community experiences to bigger audiences, helping raise awareness, correct misconceptions about diseases such as leprosy, and encourage participation in prevention and treatment programmes. Influencers extended the campaign's reach to younger audiences. In total, 22 media houses were represented and 2 social media influencers participated in the NTD media tour.

Journalists conducting interviews with one of rice farmers in Gatsibo district



In conclusion, the NTD media tour proved to be a resounding success, capturing the attention of both traditional and social media. The combined impact of radio, television, online articles, and extensive social media engagement showcases the tour's effectiveness in reaching diverse audiences and promoting the significance of World NTD Day.

c) Integrated community awareness campaign on Malaria, STH and schistosomiasis for high-risk communities in endemic districts

Accelerating the control and elimination of soil-transmitted helminths (STH) and schistosomiasis in Rwanda requires robust, sustained community engagement. For such initiatives to be effective, local populations must first understand the risk factors, transmission pathways, health consequences, and overall burden of these diseases. To address this gap, targeted community mobilization campaigns were conducted across ten high-priority districts: Rubavu, Burera, Rutsiro, Karongi, Nyamasheke, Rusizi, Nyamagabe, Nyabihu, Gisagara, and Musanze.

These campaigns were conducted in November and December 2025 in collaboration with MOPDD stakeholders and reached targeted schools and communities surrounding them. The campaigns resulted in an increase of understanding of STH and schistosomiasis transmission and prevention measures among community members and school population. Below is the summary table of schools and communities reached.

Table 43: Campaign results (table to be arranged in landscape mode)

Indicator	Districts										Total
	Musanze	Gisagara	Nyamagabe	Nyabihu	Nyamasheke	Rusizi	Rubavu	Burera	Karongi	Rutsiro	
Number of schools visited	2	4	6	6	5	5	15	11	4	5	63
Number of students met	680	2,568	6,756	6,140	4,383	8,229	22,310	13,920	3,614	4,979	73,579
Number of wet/marshlands visited	3	5	7	0	2	2	5	3	0	2	29
Number of farmers in wetland met	75	525	76	0	58	141	121	121	0	94	1,211
Number of tea plantations visited	0	0	2	1	2	1	3	0	0	0	9
Number of farmers in tea plantation met	0	0	220	25	51	89	82	0	0	0	467
Number of Irish potato farmers (leaders) met	8	0	0	0	0	0	0	0	0	0	8
Number of ports (ibyambu) visited	1	0	0	1	4	2	0	0	2	5	15
Number of fishermen met	34	0	0	2	51	201	0	0	90	151	529
Number of people met in Inteko zabaturage	700	217	250	160	117	120	283	190	154	334	2,525
Number of visited health centers	0	2	1	5	8	5	4	5	2	6	38

Showcasing schistosomiasis transmission in Musanze district/ Muko sector



d) Prevention and control of dog bite, rabies, and snakebite

Rabies is a preventable viral disease that is almost always fatal once clinical symptoms appear. In Rwanda, dog bites remain the leading cause of hospital and health center consultations among animal bites.

Rwanda Rabies Awareness Week

Rabies remains a prevalent Neglected Tropical Disease (NTD) of significant public health concern in Rwanda. Health facilities continuously report dog bites, confirmed rabies cases, and associated fatalities. Local health facilities regularly document dog bite incidents, rabies cases, and related human fatalities, underlining the urgent need for integrated intervention. This situation stems from a significant awareness gap in rabies control. In alignment with World Rabies Day (celebrated annually on September 28) and the Government of Rwanda's commitment to eliminating all Neglected Tropical Diseases (NTDs) by 2030, the Rwanda Biomedical Centre (RBC) hosted Rabies Awareness Week from 3rd –7th October, 2025.

Organized in partnership with the Rwanda Agriculture and Animal Resources Development Board (RAB) and supported by the World Health Organization (WHO) and Welfare for Animals Guild (WAG), the campaign featured radio talk shows, training sessions for 23 journalists and social media influencers, and targeted advocacy. Based on listener feedback, published media articles, and online engagement, the campaign successfully heightened public awareness regarding dog vaccination and responsible dog ownership. Additionally, 26 key stakeholders received specialized training on rabies prevention and control at the WHO Country Office in Rwanda

Participants posing for a group photo with the WHO Country Representative at WHO Country Office.



6.3. NTDs AND OTHER PARASITIC DISEASES CASE MANAGEMENT

6.3.1. Scaling up NTD Case Management Interventions for Chronic NTDs

6.3.1.1. Podoconiosis Management

The patients with podoconiosis get services from 14 treatment centers supported in collaboration with Heart and Sole Africa (HASA) and University of Global Health Equity (UGHE). During this FY a new treatment center was created at Butaro HC supported by UGHE. By June 2026 the clinic had enrolled 67 podoconiosis patients. The services are delivered by trained nurses in the health centers and physiotherapists from corresponding district hospitals. The program has a plan to scale-up and create 11 new treatment centers across different districts.

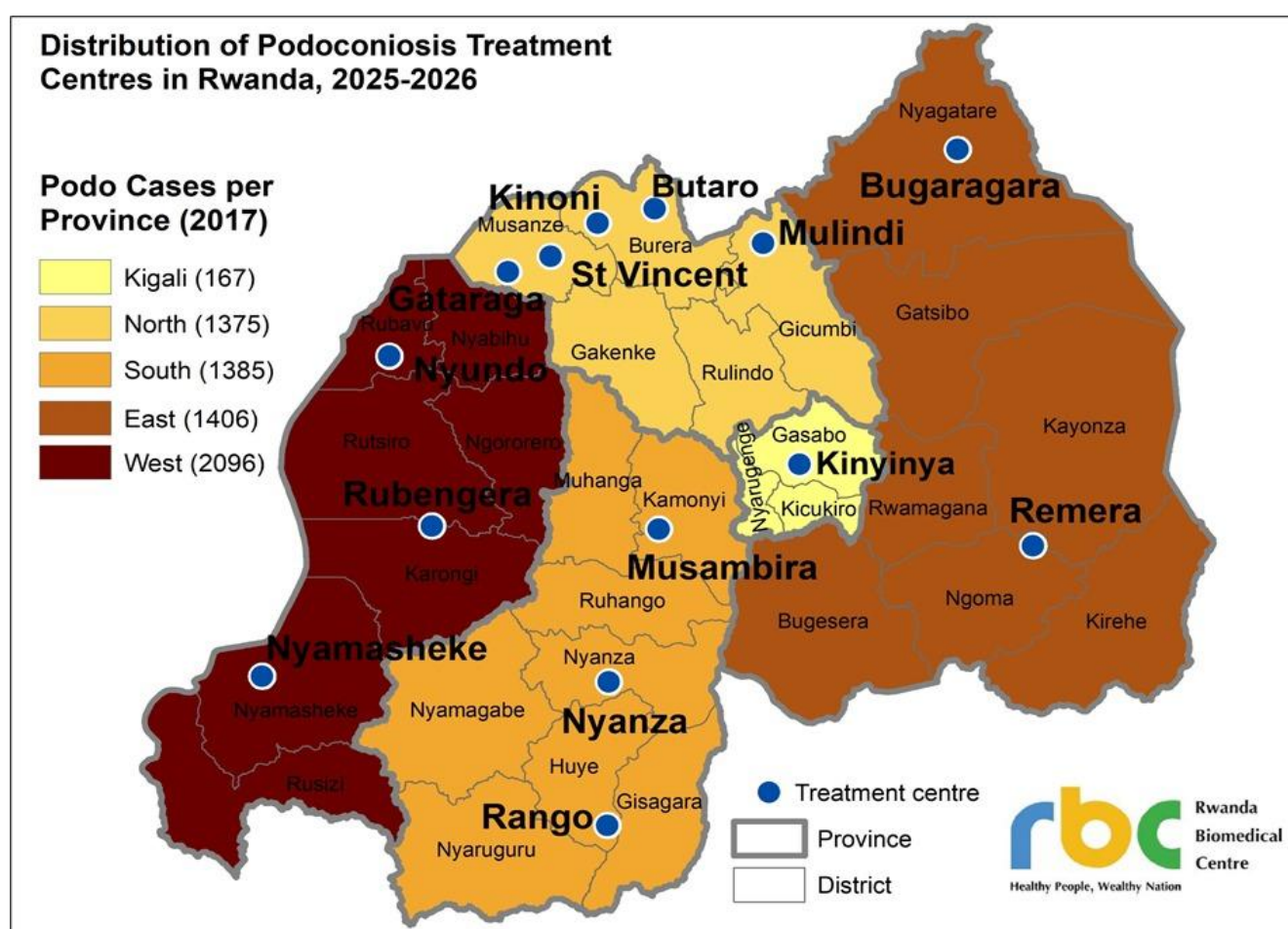
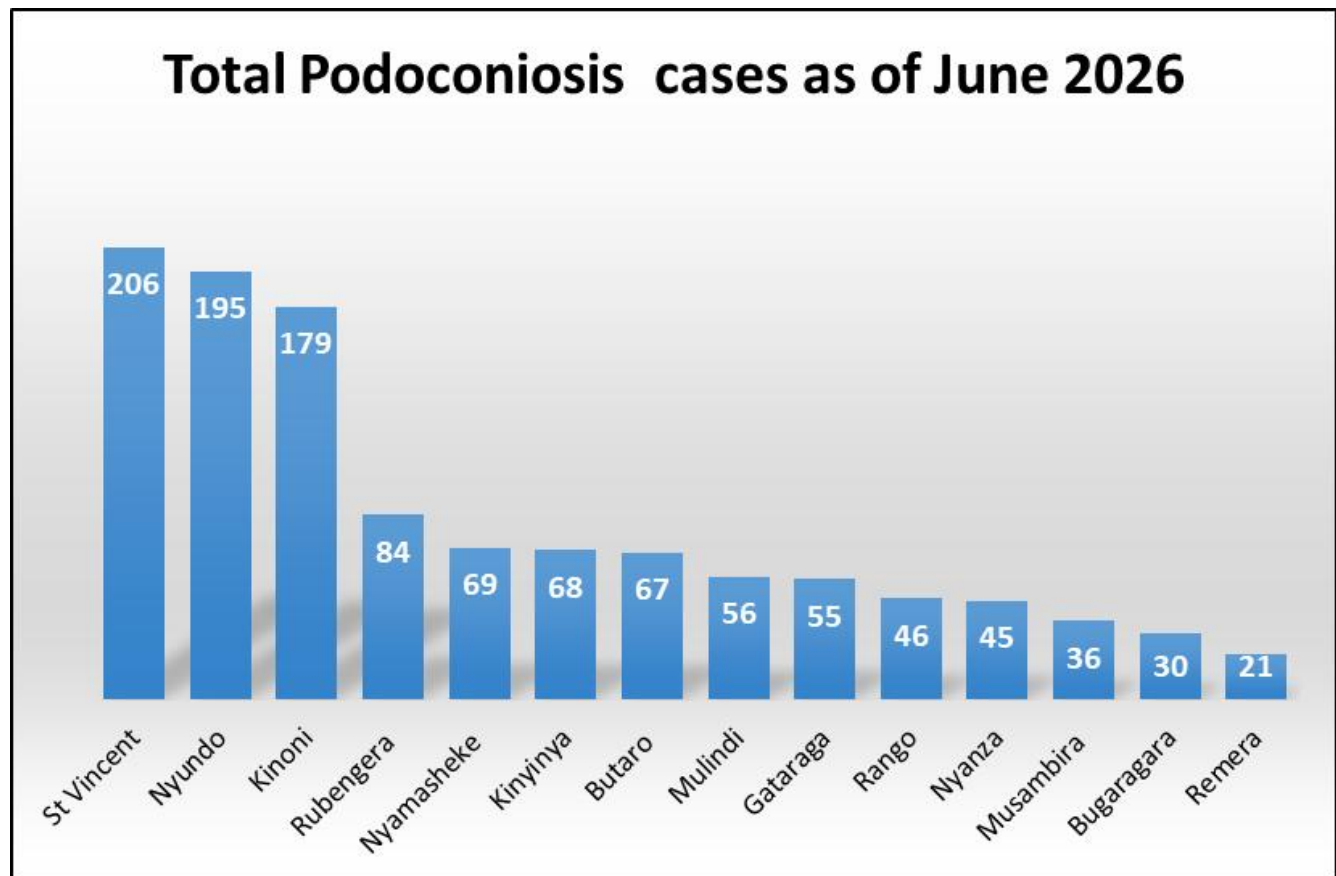


Table 44: Distribution of Podoconiosis Treatment Centers in Rwanda, 2025-2026

In collaboration with HASA we distributed needed supplies to treatment centers including custom shoes to Mulindi, Kinyinya and Nyundo Health Centers, and Gataraga HC. Other

supplies distributed included soaps, ointments, whitefields, and vinegar. In addition, screening and onsite training was conducted to the health centers with new focal persons such as Nyundo HC.

A total of 1,157 podoconiosis patients were enrolled in treatment centers by June 2026, of whom 144 (12%) were under home-based care.



6.3.1.2. Refresher training of Podoconiosis treatment staff and supportive supervision

During FY 25/26 in collaboration with the Heart and Sole Action/Africa conducted supportive supervision and mentorship in the treatment centers. Furthermore, materials including brushes, vinegar, white field anti-fungal, soap, vaseline ointment, custom shoes were distributed to support services. The refresher training was conducted in June 2026, and 34 treatment centers attended the sessions



6.3.2. Integrated skin NTDs management

Following the pilot conducted on Integrated skin NTDs in Rusizi, Gisagara, Bugesera and Ngoma districts, in collaboration with WHO developed the proposal for integrated skin NTDs screening, referral and management and secured a funding of 70,000USD. The consultants were hired by WHO to support the development of the guideline and epidemiological survey. Conducted consultative meetings engaging the Rwanda Dermatologists Society members as well and developed the concept note.

6.3.3. Soil Transmitted Helminthiasis

STH, a composite of *Ascaris lumbricoides*, Hookworms (*Ankylostoma* species) and *Trichuris Trichiura*, still present a public health problem in Rwanda with surgeries due to intestinal obstructions. Progress has been made in the last 15 years where the national prevalence was reduced from 66% in 2008 to 38.7% in 2020 with significant decline expected in the next impact assessment in October to December 2026. Looking at the positivity rate for STH cases received in health facilities, it reduced significantly from 32% in 2017 to 12% in 2026. The average annual positivity rate was 12% with *Ascaris* predominance 11.2%. *Trichirus Trichiura* and ankylostome species showed a positivity rate of less than 1%. Northern, Western and Southern Provinces are the most endemic.

The high positivity rates $\geq 20\%$ of STH were observed in Rutsiro, Nyamagabe, Nyaruguru, Rubavu, Ngororero and Nyabihu districts (Fig 45). The results illustrate the need to strengthen interventions focusing on education for behaviour change toward prevention of NTDs and WASH improvement.

Figure 35: Laboratory STH positivity rate in HF FY 2025/2026

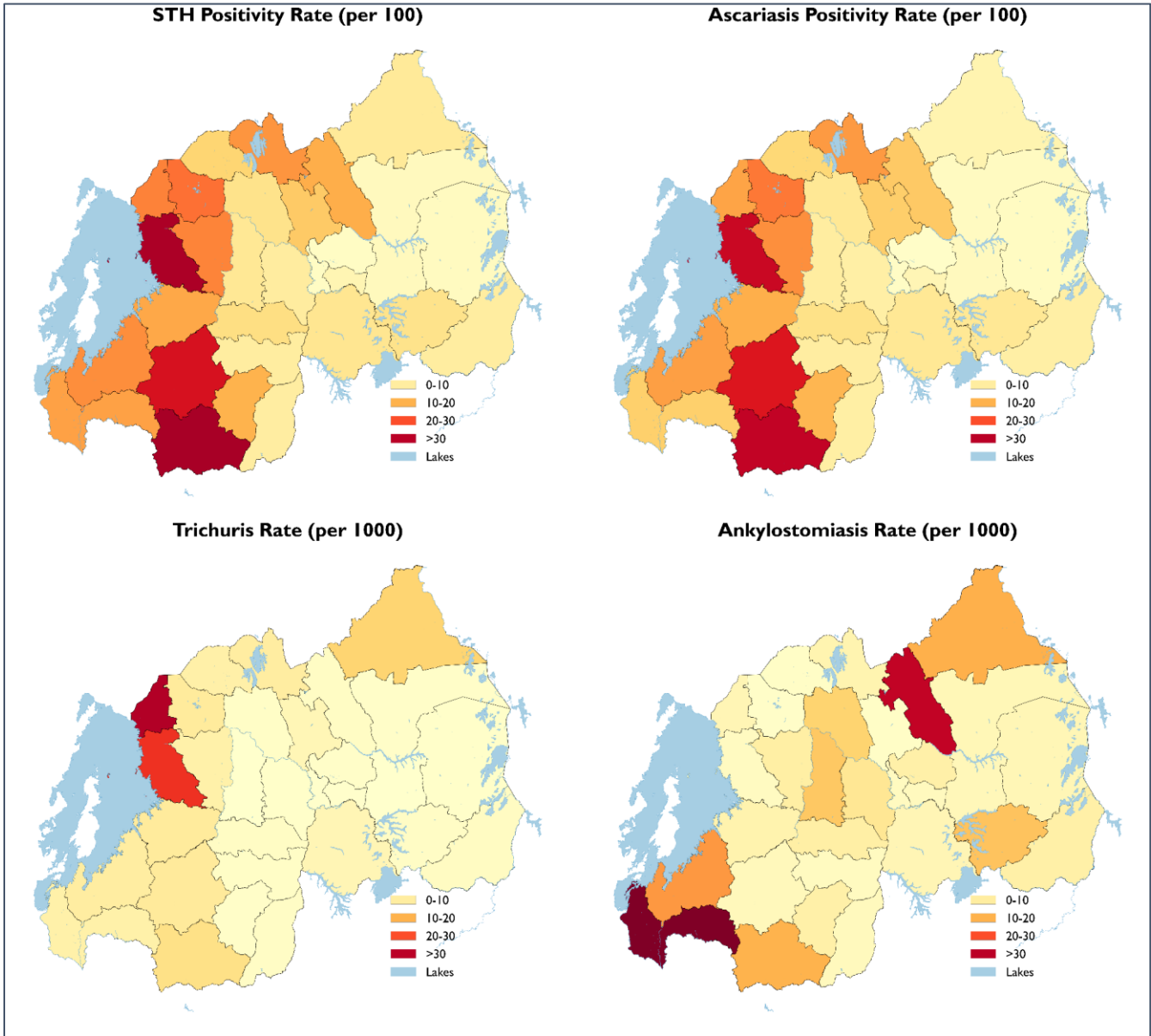
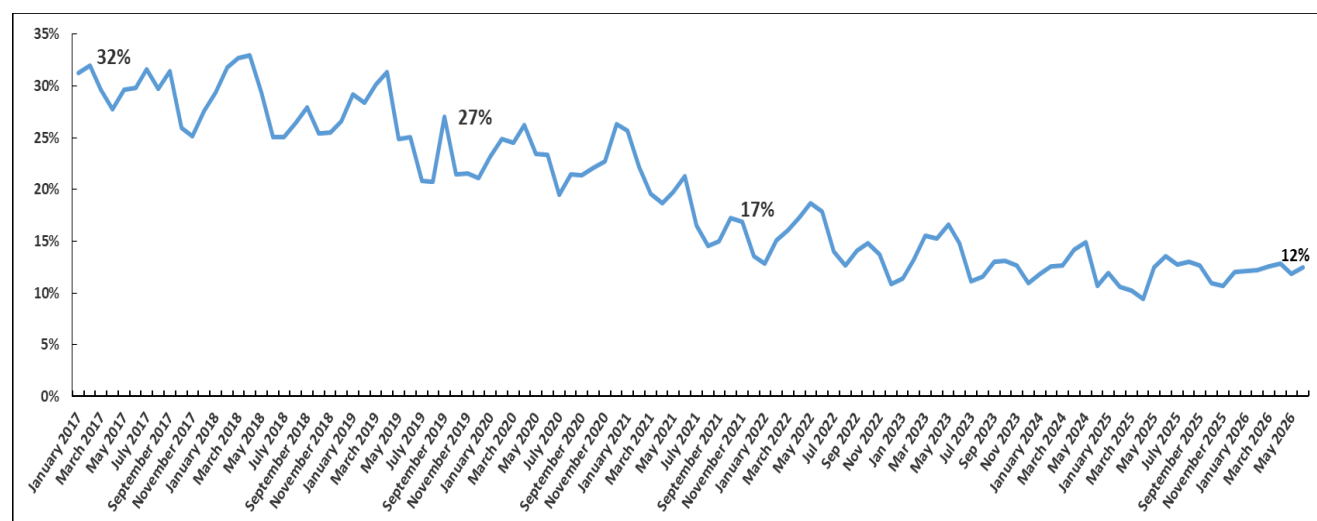


Figure 36: Proportion of STHs Positive Cases in Stool Exams Performed in Health Facility Laboratories July 2025 to June 2026



6.3.4. Integrated dog and snakebite management

i) TOT on prevention and management of snakebite, dog bite and rabies, Kigali, 09-10 September 2025

WHO country office in collaboration with WHO-HQ, AFRO, RBC, RAB, WAG Rwanda organized a training of trainers on 09 and 10 September 2025 on prevention, and management of snakebite, dog bite, and rabies. Participants were eleven doctors, and seven nurses from hospitals (King Faysal Hospital, Rwanda Military Hospital, Kibagabaga, Masaka, Nyarugenge, and Rwinkwavu), three IDSR focal persons from the University of Rwanda (UR), Rwanda Biomedical Center, three veterinary doctors from Rwanda Agriculture, and Animal Resources (RAB) and Welfare Animal Guild (WAG Rwanda), and three staff from Rwanda Biomedical Center (RBC).

The TOT was facilitated by Dr. Katie Corridan, rabies expert, and Dr David Willian, snakebite expert, both from the Global Programme for Neglected Tropical Diseases, World Health Organization, Geneva. The TOT was in alignment with national priorities and the Snakebite, Taeniasis and Rabies Elimination Committee (STREC) strategic plan. The training covered the epidemiology, prevention and management of snakebite, dog bite, and rabies. Three recommendations were formulated after the TOT which were (a) to develop the national guidelines, and training materials on prevention, management, and reporting on snakebite, dog bite and rabies, (b) to conduct capacity building of doctors, nurses, data managers, and IDSR focal persons from all fifty hospitals and to build capacity of nurses and data managers from health centers, (c) to improve snakebite, dog bite, and rabies data recording, reporting, data analysis, and data use.

ii) Development of national guidelines, protocols, algorithms, job aids, and training materials on prevention and management of snakebite, dog bite, and rabies.

In October and November 2025, two workshops were organized by RBC in collaboration with partners to develop national guidelines, protocols, algorithms, job aids, and training materials on prevention, and management of snakebite, dog bite, and rabies.

Twelve participants attended each workshop and were from WHO, UR, RBC, RAB, WAG, Heart and Sole Africa (HASA), King Faysal Hospital, Rwanda Military Hospital, Masaka, Rwinkwavu, and Kibagabaga hospitals. During the workshop we developed two guidelines, one for snake bite prevention and management and the other for dog bite and rabies prevention, and management. We also developed protocols, algorithms, job aids, and training materials for snake bite, dog bite, and rabies prevention and management.

iii) Capacity building of doctors, nurses, data managers, and IDSR focal persons from hospitals on prevention, management, and reporting of snakebite and dog bite, and rabies

WHO in collaboration with RBC, University of Rwanda, and Welfare Animals Guild (WAG) organized a capacity building workshop on snakebite, dog bite, and rabies prevention and management for health care workers from all fifty hospitals in Rwanda. 40 doctors and 45 nurses from 46 hospitals (CHUB, Gahini, Gakoma, Gitwe, Kabutare, Kabgayi, Kaduha, Kibilizi, Kibungo, Kirehe, Ngarama, Nyamata, Nyanza, Remera Rukoma, Ririma, Rwamagana, Rwinkwavu, RMRTH, KFH, Kibagabaga, Masaka, Muhima, Nyarugenge, Munini, Gatunda, Kiziguro, Shyira, Murunda, Muhororo, Mugonero, Mibilizi, Kirinda, Kibuye, Kibogora, Kabaya, Gisenyi, Bushenge, Rutongo, Ruli, Ruhengeri, Nemba, Kinihira, Gatonde, Byumba, and Butaro). Four hospitals (Kacyiru, CHUK, Nyagatare, and Nyabikenke) did not send participants (doctors and nurses) to the training. Facilitators were staff from WHO, RBC, University of Rwanda, Welfare Animals Guild (WAG), Heart and Sole Africa (HASA), Rwanda Agriculture, and Animals Resources Board (RAB), Rwanda Military Hospital, Kibagabaga and Masaka district hospitals. In addition two separate training sessions were organized for 47 data managers and 48 IDSR focal persons.

Data managers and IDSR focal persons were given opportunities to conduct data analysis for the hospitals and health centers in their respective catchment areas. Dummy tables were developed for them to facilitate presentations during the plenary session. Data managers and IDSR focal persons were happy to do data analysis and to discover for themselves how they can use data to improve programming. They discovered that there were some duplications of data between data reported by health centers and hospitals, especially for patients who first consult

health centers and then referred to hospitals. They also learned how to conduct data extraction, and data quality check. They learned that the majority of victims of snakebite or dog bites prefer to consult traditional healers and that they needed to conduct outreach activities to sensitize communities, and traditional healers on the importance of seeking health care at health facilities after dog bite or snakebite.

A gap was highlighted in terms of coordination between human and animal health about dog registration and vaccination of dog population management, ten days dog observation after a bite and in data sharing from both sectors. At the end of the training, data managers and IDSR focal persons reiterate their commitment to improving data reporting and data analysis.

Snakebite envenomation and dog bite cases reported in hospitals from July 2025 to June 2026

In 2025-2026 Rwanda recorded 3,184 dog bites and two rabies cases that were reported through HMIS. Similarly, snake bite envenomation continues to pose significant health and economic burdens, particularly in rural and vulnerable communities. Rwanda registered 835 snakebite cases in 2025-2026 at hospitals. Of the 835 cases reported on, 12% were children under five years

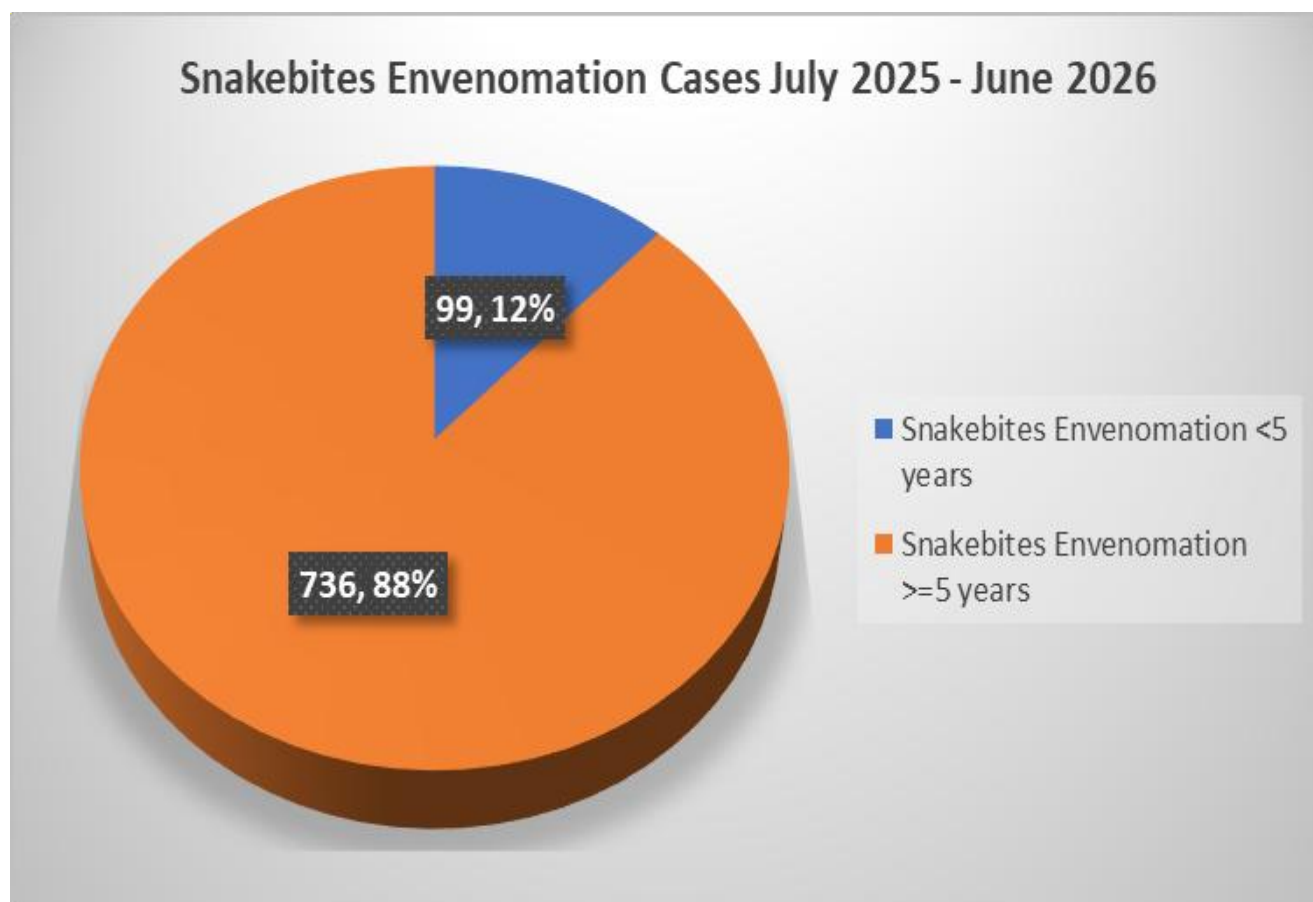
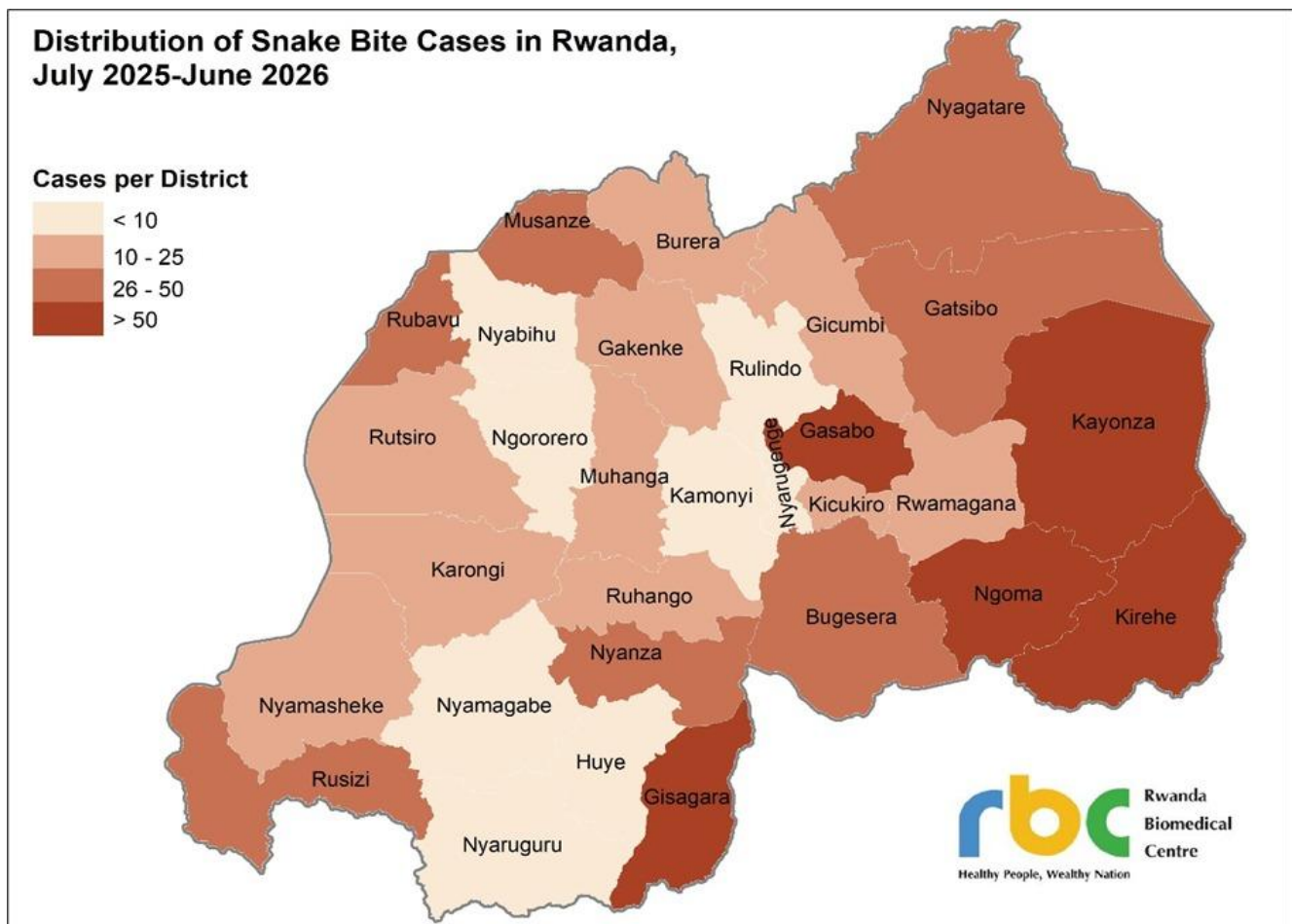
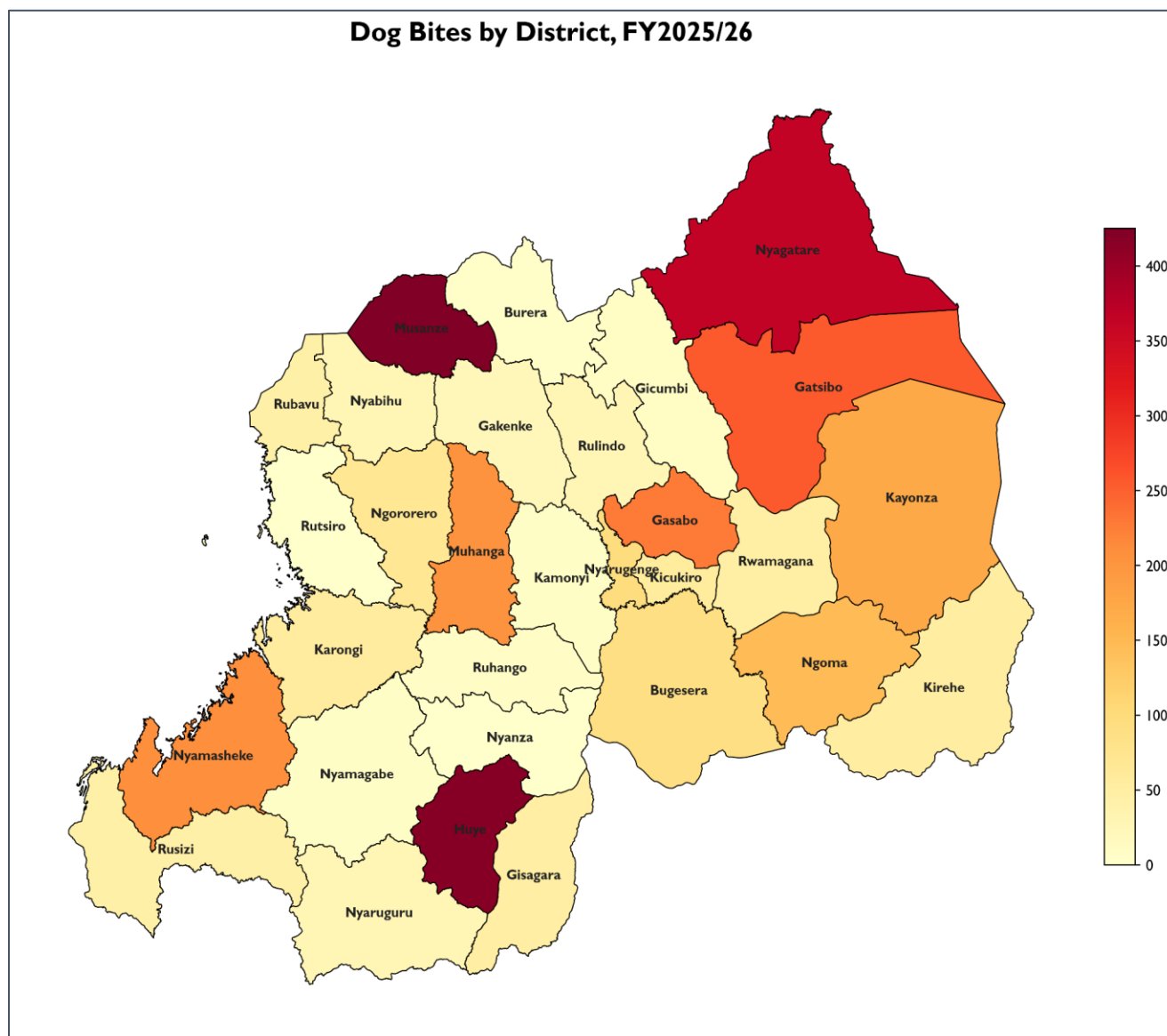


Figure 37: Snakebites Envenomation cases July 2025 -June 2026



The Eastern province in the most affected province, with a total of 835 cases were reported from hospitals between July 2025 to June 2026

Figure 38: Distribution of dog bites and human rabies.



During FY 25/26 3,184 dog bites cases were reported, the top five districts included Musanze, Nyagatare, Huye, Gasabo, and Muhanga counting 45% of all cases.

b) Other NTDs and Parasitic Diseases

From July 2025 to June 2026, amoebiasis was the most diagnosed intestinal parasitic disease in patients visiting the health facilities, as of last year, followed by *Ascaris lumbricoides*.

Table 45: Routine cases reported from health facilities June 2025 to July 2026

No	Variables (parasites/ stool examined)	Number
1	Stools total samples analyzed Negative	1,571,989
2	Entamoeba (Unspecified species)	632,401
3	Ascariasis lumbricoides	194,103
4	Hookworms (Ankylostomiasis)	14,893
5	Taenia species	11,025
6	Trichuris trichiura	8,053
7	Entamoeba histolytica (specified species)	1,139
8	Schistosoma in Stool	696
9	Giardia lamblia or intestinalis	156
10	Trichomonas intestinalis	150
11	Strongyloides stercoralis (Angillule)	26
12	Enterobius vermicularis (Oxyure)	10

In addition, during the FY recorded 16,814 cases of scabies in health facilities

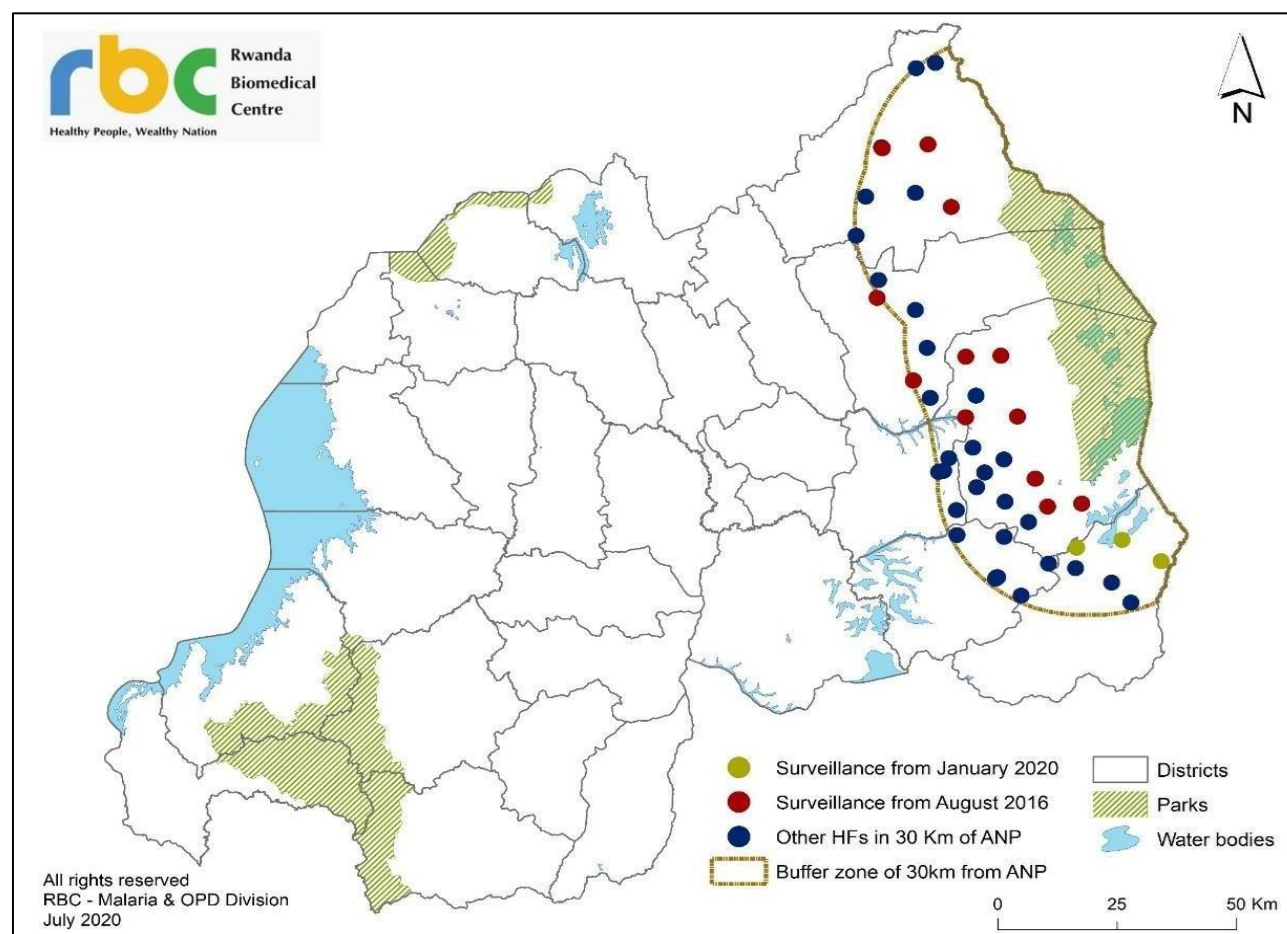
6.4. NTDs & OPDs SURVEILLANCE, EPIDEMIOLOGY, AND RESEARCH

6.4.1. Surveillance of Rhodesiense Human African Trypanosomiasis (r-HAT)

6.4.1.1. Passive surveillance through routine cases testing

During the FY 2025-2026, passive surveillance was conducted for Human African Trypanosomiasis (HAT) surveillance in 16 sentinel sites from Nyagatare, Gatsibo, Kayanza, and Kirehe district.

Figure 48: Sentinel Sites for Human African Trypanosomiasis



On 26 April 2022, WHO validated Rwanda as having eliminated rhodesiense Human African trypanosomiasis (r-HAT) as a public health problem. Efforts were made to maintain passive surveillance in 16 sites (health centers and hospitals) surrounding the Akagera National Park where tsetse flies are present. r-HAT diagnosis is similar to the diagnosis of malaria by screening a blood smear with a microscope. From July 2025 to June 2026, a total of 111,827 blood smears screened, 25,161 (22%) positive malaria cases were diagnosed, and no single case of r-HAT was identified.

Table 46 : Data of HAT and Malaria by Passive Surveillance in Sentinel Sites, July 2025 - June 2026

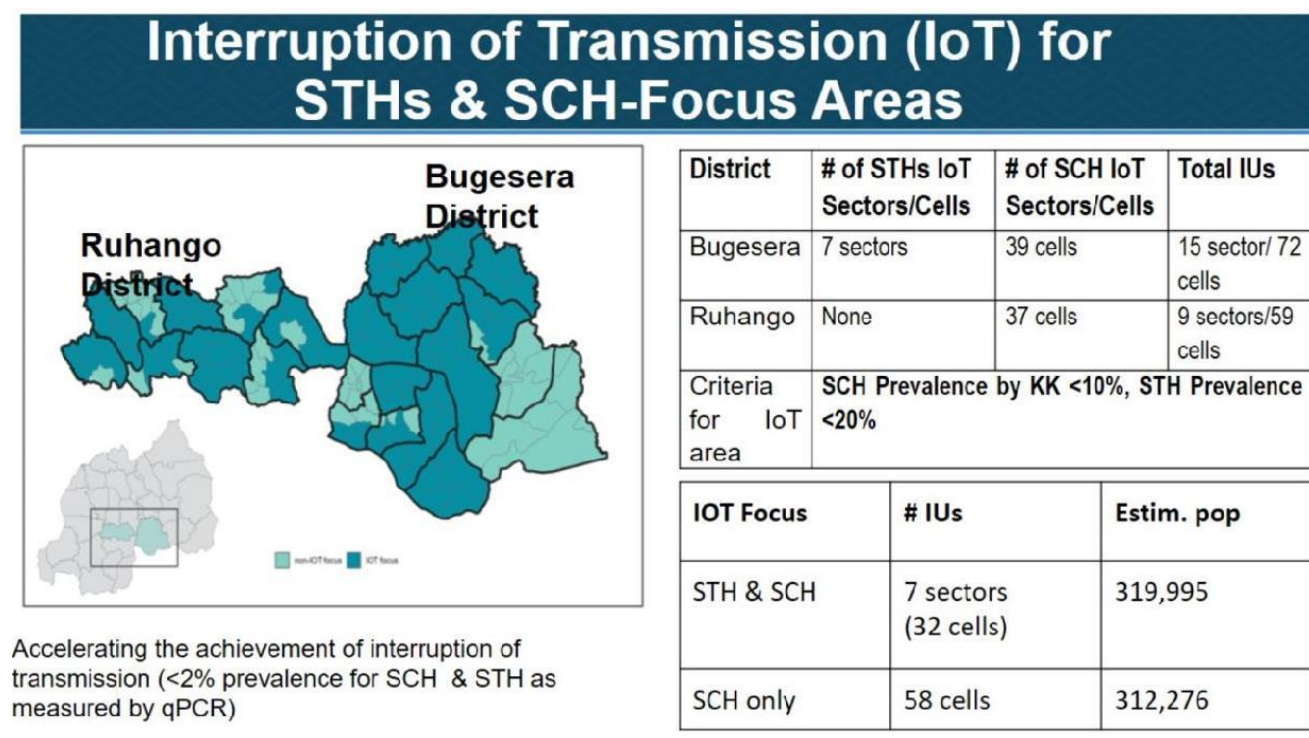
District	Surveillance Sites	Suspected	Malaria (-)	Malaria (+)	HAT
					Positive
Nyagatare	Nyagatare DH	6,681	6,009	672	0
	Bugaragara HC	8,031	6,652	1,379	0
	Ndama HC	13,868	8,127	5,741	0
Subtotal		28,580	20,788	7,792	0
Gatsibo	Kiziguro DH	4,936	4,783	153	0
	Rwimbogo HC	8,706	7,590	1,116	0
Subtotal		13,642	12,373	1,269	0
Kayonza	Gahini DH	3,614	3,329	285	0
	Nyakabungo HC	4,664	3,434	1,230	0
	Buhabwa HC	13,645	9,754	3,891	0
	Ryamanyoni HC	11,899	8,684	3,215	0
	Rwinkwavu DH	4,493	4,024	469	0
	Cyarubare HC	7,044	4,446	2,598	0
	Ndego HC	3,765	3,037	728	0
Subtotal		49,124	36,708	12,416	0
Kirehe	Kirehe DH	3,910	3,556	354	0
	Nasho HC	4,437	4,056	381	0
	Mulindi HC	5,781	4,521	1,260	0
	Kabuye HC	6,353	4,664	1,689	0
Subtotal		20,481	16,797	3,684	0
General Total		111,827	86,666	25,161	0

6.4.1.2. Supportive supervision and quality control

During the current FY with WHO support, the supervisions were conducted from January 2026 and June 2026. Although the disease is no longer existing, the surveillance was maintained along with bi-annual supportive supervision and laboratory quality control to sentinel surveillance sites.

6.4.2. Monitoring the interruption of SCH and STHs transmission in Ruhango and Bugesera districts

With the support from the END FUND, Bugesera and Ruhango districts were selected for interruption of SCH and STH transmission. The project is being implemented in collaboration with HASA and Rwanda NGOs Forum on HIV/AIDS and Health Promotion.



The goal of IoT is to reduce to < 2% prevalence of STH and SCH as measured by qPCR in targeted areas, by 2027.

The objectives of IoT are:

- To increase the correct knowledge and healthy practices of STH & SCH to at least 95% of community members in targeted areas by 2027.
- To increase access to improved WASH to 100% of all households and public places in targeted areas, by 2027.
- To increase to at least 95% of people with occupational risk in targeted areas having effective protective equipment, by 2027.
- To reach at least 95% of all people in the IoT intervention areas with drugs for both STH and SCH per each mass drug administration (MDA) round, by 2024-2027.
- To diagnose and treat 100% of suspected cases of STH&SCH according to national guidelines, in 2024-2027.
- Strengthen surveillance and reporting of STH&SCH at all levels for impact measurement and timely response.
- Strengthen coordination, and collaboration for STH&SCH Elimination at all levels

6.4.2.1. Snail control intervention to interrupt schistosomiasis transmission Conducted

Following the finding from the Environmental Impact Assessment for snail control to eliminate Schistosomiasis RBC, led by the Rwanda NGOs Forum on HIV/AIDS and Health Promotion conducted capacity building for snail control through environmental management. Trained 16 ToT staff from RBC, NTD partners, Bugesera and Ruhango districts. Later the trained ToT from the districts trained 70 peers and later trained 492 community members mainly composed of high-risk farmers and fishermen. The interventions were piloted in selected two marshlands in Bugesera and other two in Ruhango districts.

Before starting the interventions, baseline data were collected on snails' presence, density, infectivity and water parameters. The follow-up assessment will be conducted after 12 months to evaluate the impact of interventions. The NTDs program plans to scale-up interventions around Kivu and Muhazi lakes to accelerate the elimination of Schistosomiasis.



6.4.2.2 Laboratory mentorship in Ruhango and Bugesera districts

Conducted laboratory mentorship in December 2025 and in June 2026, distributed Kato-Katz materials in all hospitals and HCs in the IoT districts. The enhancement of the laboratory capacity will contribute to the improved STH and SCH case detection to prevent any resurgence after stopping MDA.





6.4.3. Research and dissemination of NTDs findings

List of Publications July 2025-June 2026

- Assessing the sustainability of Rwanda's mass drug administration program for schistosomiasis and soil-transmitted helminthiasis: A mixed-methods application of the program sustainability assessment tool. 25 June 2026, Plos NTD, <https://doi.org/10.1371/journal.pntd.0014455>
- Mass drug administration for soil-transmitted helminthiasis and schistosomiasis in selected districts of Rwanda: Coverage, implementation factors, and household water, sanitation, and hygiene conditions. 07 May 2026, Plos NTD, <https://doi.org/10.1371/journal.pntd.0014267>
- Strengthening health systems through NTD integration: Key insights from a multi-country webinar, 2026. 17 February 2026, Plos NTDs,

- <https://doi.org/10.1371/journal.pntd.0013628>
- Evaluating short-term changes in helminth burdens using sequential community-based surveys in Rwanda, 2026. 16 February, Nature Scientific Reports, <https://doi.org/10.1038/s41598-026-39367-w>
 - Evaluation of Impact of Bilharzia Storytelling on Community Awareness of schistosomiasis among primary school-aged children in Bugesera District, Rwanda, 2024. 31 December 2025, Rwanda Public Health Bulletin. <https://dx.doi.org/10.4314/rphb.v6i4.3>
 - Integration of diagnostics for Strongyloides stercoralis into the soil-transmitted helminths control programme in Rwanda. 29 September 2025, Nature Communications, <https://doi.org/10.1038/s41467-025-63715-5>
 - Remapping parasite landscapes: Nationwide prevalence, intensity and risk factors of schistosomiasis and soil-transmitted helminthiasis in Rwanda. 25 August 2025, Plos NTD, <https://doi.org/10.1371/journal.pntd.0013328>

6.4.4. School WASH Supportive Supervision

To improve quality education, the Government of Rwanda through the Ministry of education set a number of programs including school feeding program to alleviate short-term classroom hunger, directly boosting cognitive functions, memory retention, and attention spans. However, this program cannot work without other programs' support namely deworming and access to Water, Sanitation and Hygiene (WASH) at school.

During 2025-2026, RBC conducted two rounds of MDA in all schools and communities as well. We also conducted school WASH supportive supervision in 8 schools of Nyaruguru district and 8 schools of Gisagara district. School rounds were conducted and interviews with school leaders and school children were conducted in selected classrooms.

Strengths	Area of improvement
- Cleanliness in schools in the majority of school supervised, - Good management of (running/rain) water using rain water harvesting tanks - Availability and functionality of school health/hygiene clubs - Presence of safe drinking water <i>inside</i> the classrooms so that thirsty children can find water without delay - Good coverage of deworming	- Inadequate hand washing station, - Use of human faeces as fertilizer by schools and surrounding community, - Lack of WASH ownership for some school leadership and teachers - Damaged rain water harvesting tanks but not maintained - Insufficiency of latrines compared to the number of users - Doors of the latrines not closed either inside nor outside or on both sides

We developed action plans for each school that will guide implementation of recommendations on areas of improvement identified at each school.



GS Kibeho is among schools that have cleanest latrines

6.4.5. Onchocerciasis Elimination in Rwanda

6.4.5.1. Onchocerciasis serological survey

In collaboration with partners under End Fund's support, conducted a serological survey around 12 identified productive breeding sites of *Simulium Damnosum* along major rivers, including Rubyi, Mukungwa, Nyamyazi, Ntontwe, Macokori, Koko, Umuvumba and Akagera. Serological surveys reported evidence of transmission in Nyamasheke and Rusizi districts. Tested 5,393 in total including 2,917 (54.1%) female and 2,476 (45.9%). Furthermore, the participants included 3,588 (66.5%) children aged 5 to 9 years and 1,805 adults aged 20 years and above, and 59 villages were selected. The positive cases were only confirmed in Rusizi and Nyamasheke districts. Of 1,174 adults tested by Ov16 RDT 290 (24.7%) in both districts were positive. The positive cases were identified more in Rusizi (206/652; 31.5%) than in Nyamasheke districts (84/552; 15.2%). However, the high proportion could not confirm the ongoing transmission as the Ov16 RDT could not distinguish recent or past exposure.

For children out of 2,389 tested children 17 (0.7%) were positive with nearly similar cases identified in each of the two districts. The confirmed cases among children reflected the ongoing transmission in both districts requiring interventions to eliminate the disease.

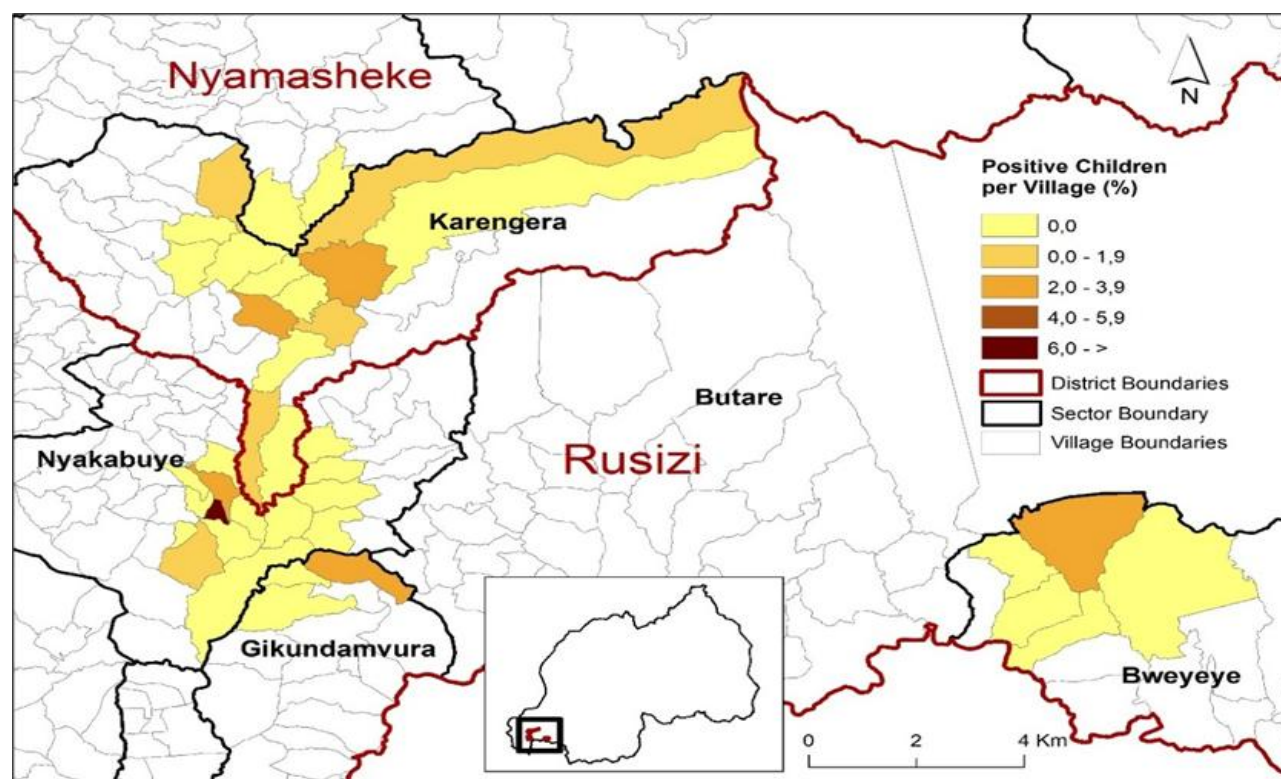


Figure 39: Prevalence of Onchocerciasis in Rwanda (Nyamasheke and Rusizi Districts) among children

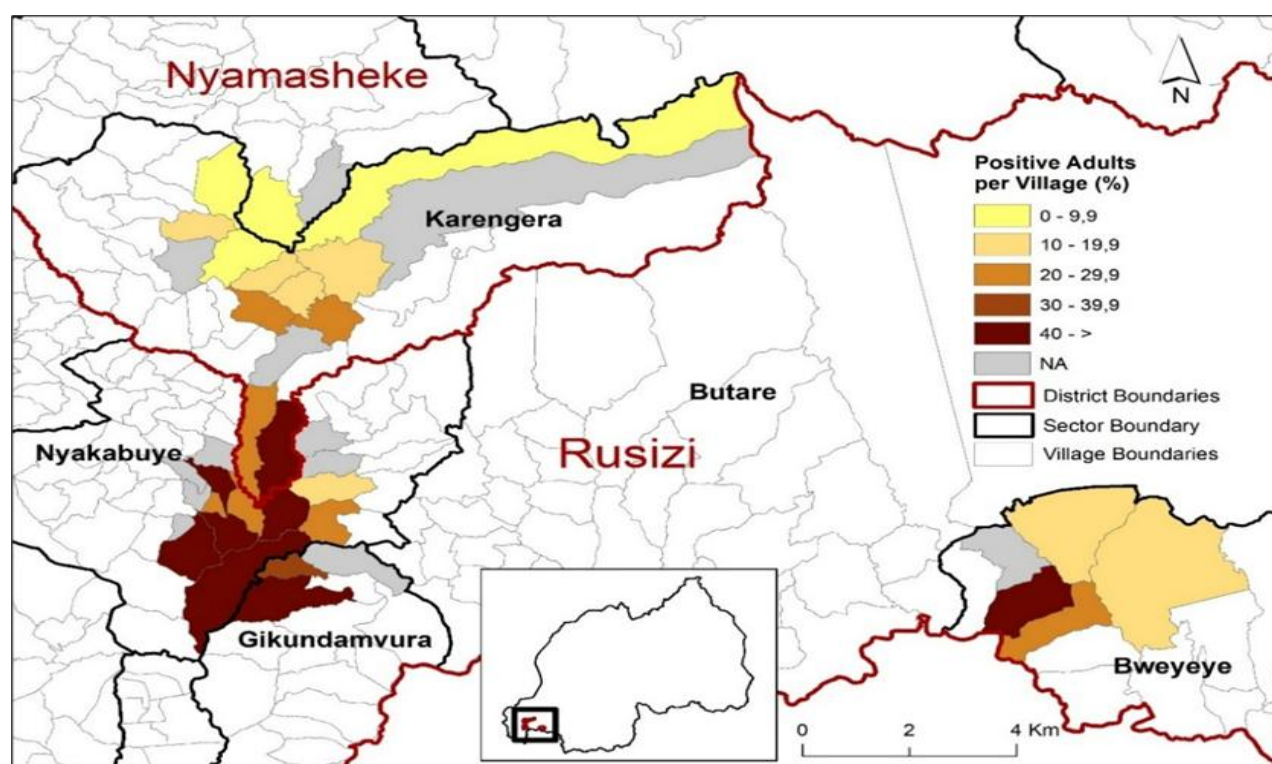


Figure 40: Prevalence of Onchocerciasis in Rwanda (Nyamasheke and Rusizi Districts) among adults

6.4.5.2. Onchocerciasis breeding site mapping and serological survey results dissemination and validation the Onchoceciasis elimination plan 2026-2039

Following the breeding sites mapping and serological survey results developed the onchocerciasis elimination plan following the WHO guideline. The plan included intervention for treatment of the exposed population in Rusizi and Nyamasheke districts and vector control interventions in the confirmed breedings site. The plan was validated by the RBC leaders, NTD partners and members of the NTD Sub-Technical working group.



Dissemination of Onchocerciasis breeding site mapping and serological survey results dissemination and validation of the elimination plan 2026-2030

6.5. Multisectoral collaboration and advocacy

6.5.1 NTD Sub-Technical Working Group meeting

Sustained control and elimination of Neglected Tropical Diseases (NTDs) depend on multisectoral collaboration across both health and non-health sectors, given the wide array of causative agents involved. To facilitate this, the Rwanda Biomedical Centre (RBC) established the NTD sub-Technical Working Group (sub-TWG)—a platform that brings together experts and professionals from complementary fields.

The NTD sub-TWG members meet regularly to review progress, highlight achievements, and establish action-oriented plans for NTD control. During this fiscal year, the group held one meeting in Kigali and one workshop in Musanze district. During both activities, the sub-committees of NTD sub-TWG presented their achievements for previous quarters and outlined plans for the upcoming period. Specifically, the meeting held on August 29th, 2025, yielded several key recommendations. Stakeholders urged relevant institutions to nominate replacements for outgoing NTD sub-TWG members and recommended accelerating online dog registration to support rabies elimination efforts. Additionally, the meeting highlighted the need to conduct a workshop with district officials to evaluate latrine availability around agricultural and recreational wetlands, advocate for a fully

functional One Health Approach, and establish a clear annual meeting plan with active progress tracking.

The NTD sub-TWG participants in the workshop of 11th - 13th May 2026, recommended integrating Neglected Tropical Diseases (NTDs) interventions into School Health Programmes to strengthen disease prevention and early detection among school-aged children, alongside embedding leprosy prevention into existing NTD awareness campaigns. To support rabies control, they called for developing and disseminating evidence-based public awareness messages on responsible dog ownership and proper dog population management. Furthermore, participants highlighted the need to conduct updated podoconiosis mapping to assess the current disease burden and urged stronger collaboration between Community Health Workers (CHWs) and agricultural extension workers to enhance information sharing and coordinate joint community awareness efforts. The workshop ended up with validation of the NTD Strategic Plan 2026–2030, podoconiosis prevention and treatment guidelines, and the guideline for active SCH case detection and response.



NTD Sub-TWG Meeting, Kigali, 29th August 2025

6.5.2 WASH Competition and refresher training of local authority and HFs' representatives

To foster sustainable behavior change and heighten community accountability, a WASH competition was organized in Ruhango and Bugesera districts in partnership with RNGOF. Implemented through the Excellent Village Initiative, the intervention recognized top-performing villages, cells, and sectors with awards including certificates, bicycles, and construction materials (iron sheets), significantly boosting public awareness and active participation across both districts.

As achievements, WASH competitions motivated communities to improve hygiene. They encouraged peer accountability and made progress visible across sectors. This approach turned hygiene from a health message into a community achievement. Finally, recognition inspires replication. Awarding the best-performing sectors and documenting their approaches gave other communities practical examples to learn from and apply. This helped spread impact in other communities.



Leaders of the winning villages in a group photo with the Mayor of Ruhango District and institutional guests during the awards ceremony.

In addition to the WASH competition, capacity-building workshops were held in Ruhango and Bugesera districts to enhance community mobilization, engagement, and accountability for long-term STH and SCH elimination. The training targeted local administrative representatives (sector, cell, and village levels) alongside health facilities

personnel. A total of 3,222 persons including 6 representatives from district and hospital staff, 24 staff from selected Sectors and HC, 168 leaders from 84 selected cells, 3,024 participants from village level participated in the training.

6.5.3. National WASH-NTDs Stakeholders Coordination and advocacy dialogue meeting

Coordinated by the Rwanda NGOs Forum hosted the first **National WASH-NTD Stakeholders Coordination and advocacy dialogue meeting** on 31st July 2025. The key outputs included sharing the progress and challenges for NTDs interventions, gaps in WASH-NTDs coordination and validation of the policy brief on linkage between WASH and NTDs and need to enhance the coordination

6.5.4. Launch of the Rwanda Malaria and NTDs Youth Corps

To drive community action, advocacy, research, and policy engagement in the fight against malaria and NTDs, RBC through RNGOF and in collaboration with African Leaders Malaria Alliance (ALMA) 2030, launched Rwanda Malaria and NTDs Youth Corps in November 2025. So, Rwanda became the 19th African Union Member State to roll out a Youth Corps under ALMA's continental model. The forum provides guidance, coordination, and mentorship, enabling young leaders to raise awareness, promote prevention, and drive community action. Putting in place such a forum seeks to nurture a generation capable of sustaining progress toward a malaria- and NTD-free future and speed up Rwanda Government's commitment on eliminating all NTDs by 2030.





The annual Deworming Innovation Fund Meeting

Under the END Fund, Rwanda hosted the annual Deworming Innovation Fund (DIF) meeting from 24th to 26th February 2026 gathering NTDs program managers and partners from Rwanda, Kenya, Ethiopia and Zimbabwe. The opening remarks were addressed by the Director General of RBC Prof. Claude Mambo Muvunyi and highlighted the need for multisectoral collaboration through One Health to address NTDs burden. Furthermore, highlighted the integration of NTDs interventions where the co-delivery of services is possible.

The participants shared experiences on the progress made for interruption of STH and SCH transmission. Key updates included the readiness to conduct the STOP MDA survey to inform control interventions in IoT districts. The participants developed the plan and proposed budget for 2026/2027.



DIF meeting, 24th to 26th February 2026, Kigali Serena Hotel

PART VII: FINANCING THE MALARIA AND NTD PROGRAMS

1. Introduction

The financing of Malaria Strategic Plan becomes a high priority for the GoR. The MSP is funded by the Government of Rwanda, the Global Fund for HIV & AIDS, TB and Malaria Results Based Financing (GF), the US President's Malaria Initiative and END FUND.

Through SMART FMIS (Integrated Financial Management Information System), data of the actual financial report were generated given that HRTT captured so far budget and expenditures of the reporting period. To facilitate the collection of financial information for this year's report, a separate data collection process was adopted using for Global Fund grant and Government contribution.

2. Public and External Funding Sources for Malaria Program

Below a summarized table illustrates the malaria budget by source of funding with: Global Fund, Government of Rwanda, US President's Malaria Initiative (PMI), END Fund for financial year 2025-2026. The current total expenditures are amounting to **USD 64,141,701** which represents **93%** of total budget of **USD 69,278,902**.

Table 47: Malaria Budget and Expenditures by Source of Funds, FY 2025-2026

Funding Sources	Initial approved budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Expenditures for FY 2025-2026 in USD	Balance on 30 June 2026 in USD	Performance rate in %
Global Fund for AIDS, TB and Malaria (GFATM)	17,202,293	20,890,539	20,890,539	0	100%
GoR	27,700,655	29,180,216	29,669,208	-488,992	102%
US President's Malaria Initiative (PMI)	19,000,000	19,000,000	13,456,188	5,543,812	71%
END Fund	668,920	208,147	125,766	82,381	60%
TOTAL	64,571,868	69,278,902	64,141,701	5,137,201	93%

3. Government Expenditures by MTEF Chapter for Financial year 2025-2026

The total revised budget of GoR contribution to malaria expenditures is USD 29,180,216 from this budget the total expenditures are USD 29,669,208 represents 102 % of total budget.

As presented in Table below, of the total expenditure was allocated to: (i) Compensation of employees, (ii) Use of goods and services, (iii) Subsidies (iv) Grants (v) Social assistance; (vi) Other expenditures; (vii) Inventory, (viii) Building and structures and (ix) Machinery and equipment MTEF Chapter.

3.1 Government Expenditures by MTEF Chapter for Financial Year 2025-2026

Table 48: Government Expenditures by MTEF Chapter for Financial Year 2025-2026

MTEF Chap	Approved budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Actual expenditures for FY 2025-2026 in USD	Balance in USD	Performance in %
Compensation of employees	16,724,273	17,014,711	16,686,914	327,797	98%
Use of goods and services	4,145,957	4,835,729	6,214,789	-1,379,060	129%
Subsidies	442,891	646,613	715,227	-68,614	111%
Grants	1,102,128	1,396,653	1,355,254	41,399	97%
Social assistance	1,341,088	1,335,858	1,234,952	100,906	92%
Other expenditures	276,391	220,200	191,417	28,783	87%
Inventory	77,037	104,763	104,763	0	100%
Building and Structures	750,078	1,044,651	341,190	703,460	33%
Machinery and Equipment	2,840,813	2,581,039	2,824,702	-243,663	109%
Total	27,700,655	29,180,216	29,669,208	-488,992	102%

3.2 Government Expenditures by Budget Agencies for Fiscal Year 2025-2026

As reflected in the table below, the GoR budget per budget agencies is USD 29,180,216 whereas the expenditure is USD 29,669,208. The type of budget agencies with the highest budget ceiling is Districts hospitals with USD 12,323,460; RBC with USD 6,811,785 and Ministry of Health with USD 5,094,798. The expenditures were respectively USD 11,813,015 for Districts, USD 7,162,765 for RBC and USD 5,613,765 for Ministry of Health.

Table 49: Government Expenditures by Budget Agencies for Fiscal Year 2025-2026

Budget Agency	Budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Actual expenditures in USD	Balance in USD	Performance rate in %
CHUB	953,374	1,026,619	1,026,619	0	100%
CHUK	1,342,275	1,648,313	1,648,313	0	100%
Districts	12,895,574	12,323,460	11,813,015	510,445	96%
HNN	303,726	491,534	598,547	-107,013	122%
MINISANTE	4,597,335	5,094,798	5,613,115	-518,317	110%
RBC	5,936,400	6,811,785	7,162,765	-350,980	105%
RMH	1,032,452	1,190,930	1,190,930	0	100%
RFDA	639,520	592,777	615,904	-23,127	104%
Total	27,700,655	29,180,216	29,669,208	-488,992	102%

4. Global Fund contribution to Malaria Program

As reflected the table below, the Global Fund contribution, the revised budget for the year 2025-2026 was USD 20,890,539 which was totally executed at 100%.

Table 50: Global Fund Expenditures by MTEF Chapter for 1 July 2025 to 30 June 2026

EF Chapter	Approved budget FY 2025-2026 in USD	Revised budget FY 2025-2026 in USD	Actual expenditures FY 2025-2026 in USD	Variance as of 30 June 2026 in USD	Performance rate in %
Use of goods and services	13,279,908	15,625,512	15,625,512	0	100%
Grants	435,430	2,834,523	2,834,523	0	100%
Other expenditures	3,486,955	2,430,504	2,430,504	0	100%
Total	17,202,293	20,890,539	20,890,539	0	100%

5. US President's Malaria Initiative (PMI) contribution to Malaria Program

From 1st July 2025 to 30th June 2026, the US President's Malaria Initiative (PMI) contribution was **USD 19,000,000**; to MALARIA Program in Rwanda and this budget was spent with **USD 13,456,188** represents **71%**.

Through the previous U.S President’s Malaria Initiative (PMI), the USG contribution for malaria expenditures went specifically to malaria preventive intervention and to malaria case management interventions. For the fiscal year 2025-2026, USG committed USD 18,000,000 through the PMI Malaria Operational Plan of FY 2024. However, USG halted all PMI implementation in Rwanda in January 2025 leading to suspension of PMI-supported malaria interventions during the first half of GOR FY 2025-2026. Limited activities’ implementation resumed slowly in December 2025 and have been implemented for the remaining 6 months of the reporting period. The budget for preventive interventions was spent mainly on the procurement of LLINs and IRS. The total budget of USD 18,000,000 was obligated in totality at 100% at end June 2026. However, as of June 2026, at total of USD 15,106,188 was fully utilized, either through procurement of commodities or implementation of activities. A balance of USD 2,893,812, though fully obligated, is still being used for continued implementation of activities until the end of the case management project lifespan

As part of the RBC/MOPDD continued resource mobilization, the GOR through RBC and MINECOFIN, engaged the USG to shift the mode of funding operations in Rwanda to a fully-fledged Government-to-Government (G2G). Through the G2G model, the MOPDD has managed to secure about USD 40,910,000 for implementation of case management, indoor residual spraying, and strengthening surveillance systems for the next three fiscal years.

6. END Fund budget execution for Financial Year 2025-2026

As reflected the table below, the END Fund contribution, out of the revised budget for the year 2025-2026 of **USD 208,147**, the total expenditures were **USD 125,766** represents 60%.

Table 51: END FUND Budget Execution for 1 July 2025 to 30 June 2026

Funding Sources	Initial approved budget FY 2025-2026 in USD	Disbursed 2025-2026 in USD	Expenditures for FY 2025-2026 in USD	Balance on 30 June 2026 in USD	Performance rate in %	Comment
END Fund	668,919.68	208,147.21	125,765.90	82,381.31	60%	USD 115,677.31 Balance from the year 2024-2025 USD92,469.90 were disbursed for the FY 2025-2026

7. Conclusion

The overall Malaria Program Budget execution for Financial Year 2025-2026 is at **93%**

PART VIII: MALARIA PERFORMANCE FRAMEWORK

Table 52: Impact Indicators

ITEMS	INDICATORS	Baseline	Year of Baseline	2025-2026 Targets	2025-2026 Results	%
Goal	Impact Indicators					
By 2027, reduce malaria morbidity and mortality by at least 90% of the 2019 levels	Annual Parasite Incidence per 1,000 persons	321	2018-19	35	72	49%
	Inpatient malaria deaths per 100,000 persons per year	2.1	2018-19	0.3	0.76	39.5%
	Number of confirmed malaria deaths	264	2018-19	30	109	27.5%

Table 53: Coverage and Outcome Indicators

ITEMS	INDICATORS	Baseline	Year of Baseline	2025-2026 Targets	2025-2026 Results	%
Objective 1:	Coverage Indicators					
By 2027, at least 85% of population at risk will be effectively protected with preventive interventions	Proportion of structures in targeted areas that received indoor residual spraying (IRS) during the reporting period	98%	2018-19	98%	99.76%	100%
	Proportion of population protected by indoor residual spraying within the last 12 months in targeted districts	98.8%	2018-19	98%	99.8	100%
Objective 2:	Outcome Indicators					
All suspected cases are promptly tested and treated in line with national guidelines	Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	NA	2018-19	99	100%	100%
	Proportion of suspected malaria cases that receive a parasitological test at the community level	NA	2018-19	99	99.8%	100%
	Proportion of confirmed malaria cases that received first-line antimalarial treatment according to national guidelines at public sector health facilities	100%	2018-19	99	100%	100%
	Proportion of confirmed malaria cases that received first-line antimalarial treatment according to national guidelines at the community	100%	2018-19	100	100%	100%

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