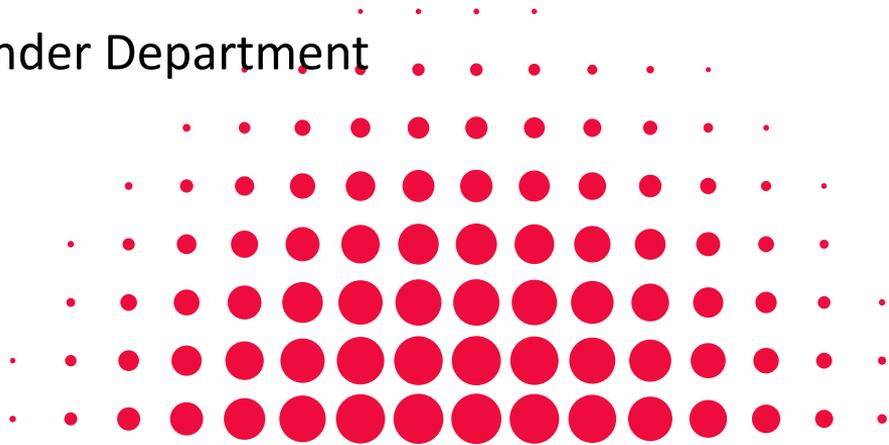
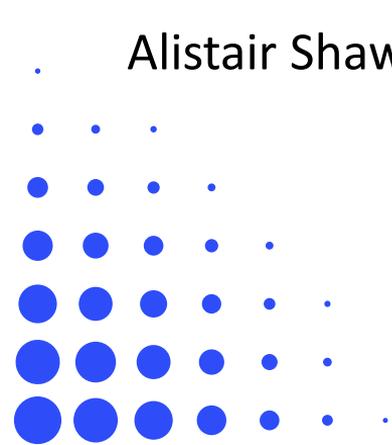
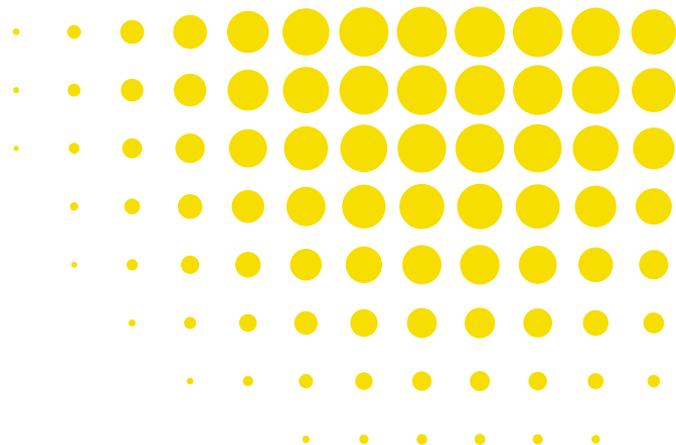




Community, Human Rights, Gender and Malaria

Sub-Regional National
RBM CRSPC Meeting, JULY 5-8 2022

Alistair Shaw, Community, Rights and Gender Department



Agenda

1. Overview / Setting the Scene

Alistair Shaw

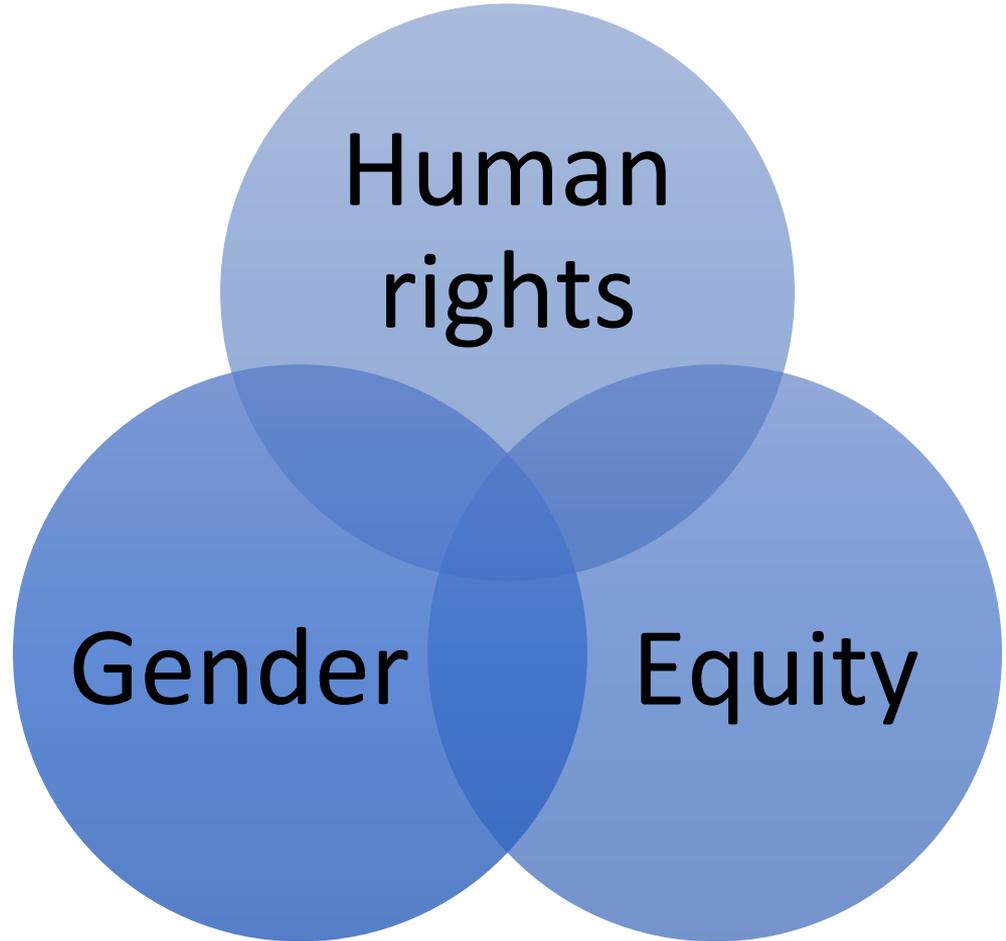
2. Training on Community, Human Rights and Gender in malaria programming

Dr. Denise Njama-Meya

3. Good Practices from Malaria Matchbox Assessments and Implementation of Findings

Olivia Ngou

**Defining key
concepts**



The image features a central text question, "What are human rights?", set against a background of a checkerboard pattern. The text is rendered in a bold, blue, sans-serif font. Surrounding the text is a dense border of numerous hands and arms, each in a different color (including shades of blue, green, orange, purple, and teal). Some hands are open, while others are in various gestures, such as pointing or thumbs up. The overall composition is vibrant and inclusive, symbolizing global unity and human diversity.

What are human rights?

Human rights in the context of malaria

Human rights-based approach in malaria programming

- The right to malaria prevention and treatment services.
- There still remain populations who are underserved and unable to receive these services.
- All health programs, including malaria programs are obligated to conform to human rights standards and deliver services to all without discrimination.

Promoting human rights can:

- Help overcome barriers to malaria service access.
- Create optimal conditions for the uptake of essential malaria services.
- Empower individuals and communities.

Core components of the right to health in the context of malaria

Availability

Accessibility

Acceptability

Quality

Reference: [WHO Human rights and health](#)

Equity v/s Equality

Photo A

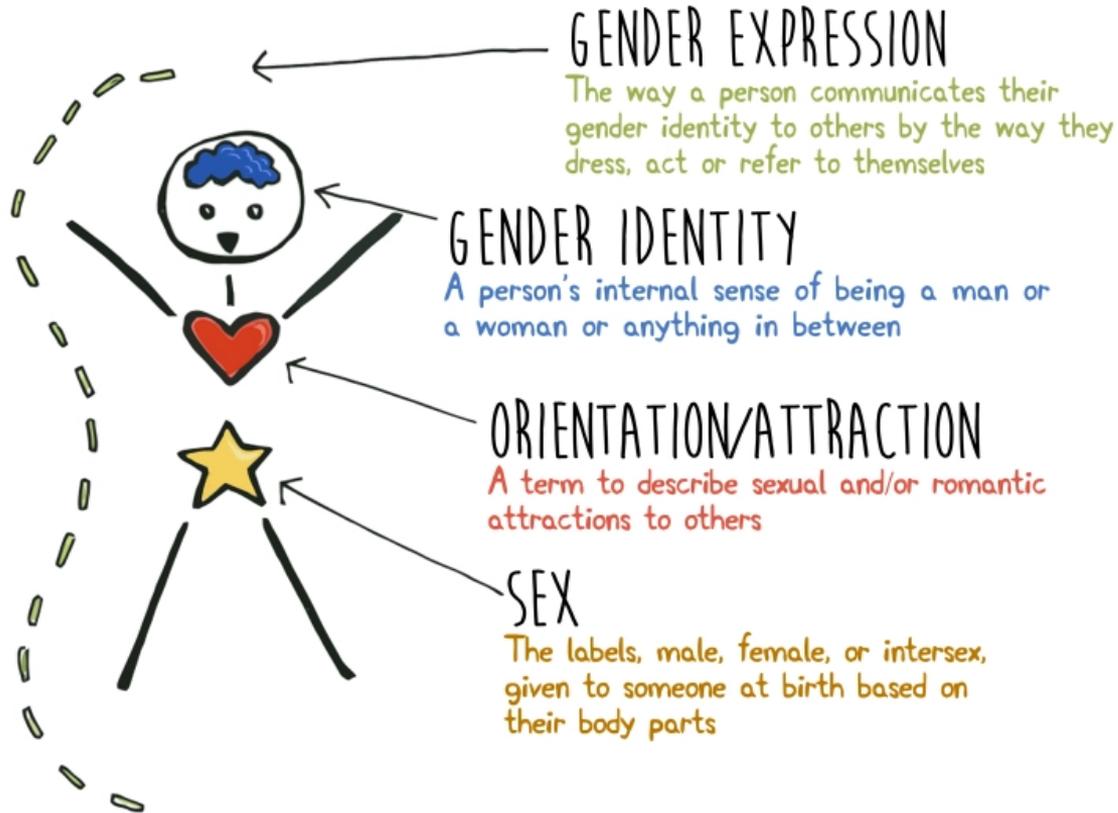
Photo B



5369 6197

<https://www.menti.com/5t6dfrp8vu>

Understanding Gender



Why does gender matter?

Gender inequity

Gender influences people's experience of and access to healthcare.

Gender inequity and discrimination faced by women and girls puts their health and well-being at risk.

Harmful gender norms can also affect boys and men's health and wellbeing negatively.

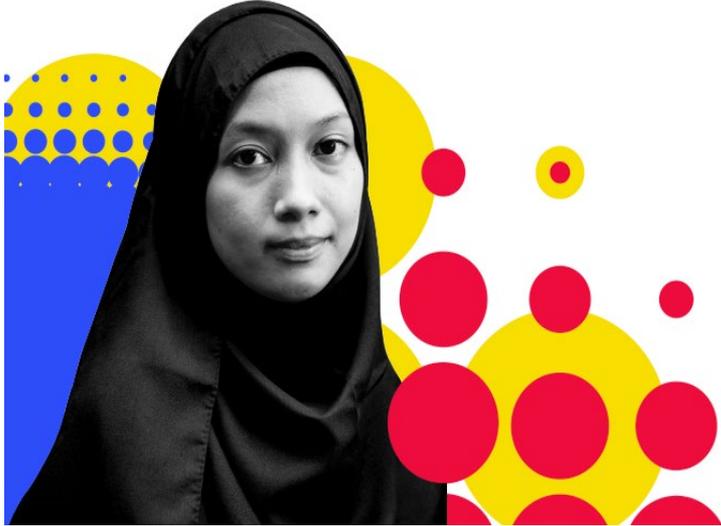
Barriers

- Restrictions on mobility.
- Lack of decision-making power.
- Lower literacy rates.
- Lack of financial freedom.
- Discriminatory attitudes of communities and healthcare providers.
- Lack of health systems that cater for specific health needs and challenges based on gender.
- Lack of training and awareness amongst healthcare providers.

Gender and malaria



Gender Responsive and Gender Transformative programming



© The Global Fund to Fight AIDS, Tuberculosis and Malaria

Gender responsive programming:

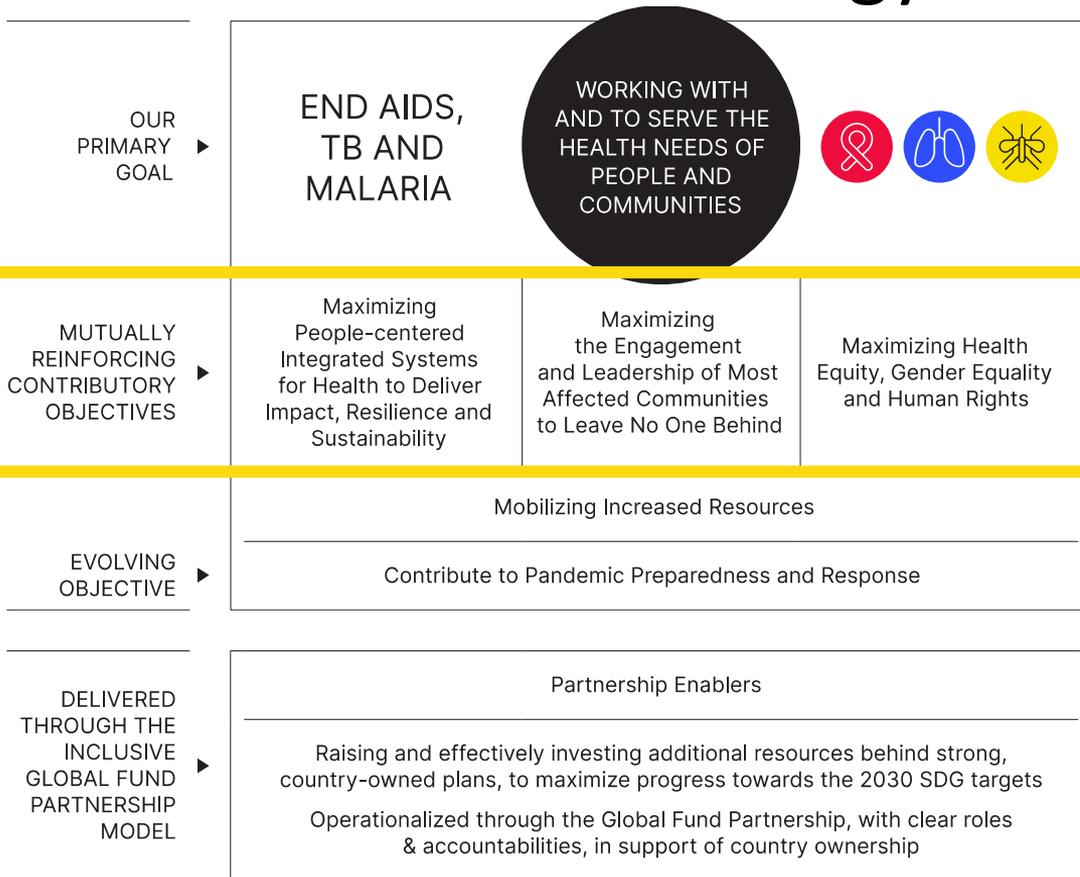
- Programs where gender inequities, norms, roles and inequalities have been considered, and measures have been taken to actively address them.
- Tailored to ensure that everyone is reached with quality and appropriate prevention, treatment and care services.

Gender-transformative programs:

Programs, approaches or activities that actively seek to build equitable social norms and structures in addition to individual gender-equitable behaviour.

Seek to transform gender roles and create more gender-equitable relations.

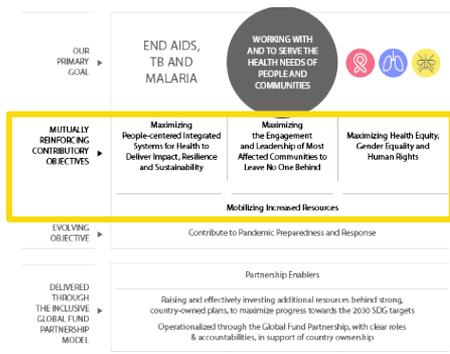
The Global Fund Strategy Framework



- **Strategy's primary goal** is to end AIDS, TB, and Malaria.
- **People and communities are at the heart** of our Strategy.
- Achievement of the primary goal is **supported by 4 mutually reinforcing contributory objectives** and an **evolving objective**.
- Partnership Enablers outline **roles and accountabilities** of all stakeholders.

The Global Fund Strategy Framework

Mutually Reinforcing Contributory Objectives



Achievement of our primary goal will be underpinned by **4 mutually reinforcing contributory objectives** that must be concurrently and synergistically pursued to achieve our aims.

Maximizing People-centered Integrated Systems for Health to Deliver Impact, Resilience and Sustainability

To catalyze sustainable HTM and broader health outcomes and in support of UHC, the Global Fund will strengthen RSSH by supporting countries and communities to:

- Deliver integrated, people-centered quality services
- Strengthen and reinforce community systems and community-led programming, integrated within national health and social systems
- Strengthen generation and use of quality, timely, transparent, and disaggregated digital and secure data at all levels, aligned with human rights principles
- Strengthen the ecosystem of quality supply chains to improve the end-to-end management of national health products and laboratory services
- NextGen market shaping focus on equitable access to quality health products through innovation, partnership, and promoting sustainable sourcing and supply chains at global, national and community levels
- As part of Global Fund efforts to strengthen country oversight of the overall health system, better engage and harness the private sector to improve the scale, quality and affordability of services wherever patients seek it
- Deepen partnerships between governments & non-public sector actors to enhance sustainability, transition-readiness and reach of services, including through social contracting

Maximizing the Engagement and Leadership of Most Affected Communities to Leave No One Behind

To deliver greater impact and ensure the HTM response is responsive to and led by those living with and most affected by the 3 diseases, the Global Fund will reinforce community leadership by:

- Accelerating the evolution of CCMs and community-led platforms to strengthen inclusive decision-making, oversight and evaluation throughout Global Fund-related processes
- Evolving Global Fund business processes, guidelines, tools and practices to support community-led organizations to deliver services and oversight, and to be engaged as providers of technical expertise
- Supporting community- and civil society-led advocacy to reinforce the prioritization of health investments and drive toward UHC
- Expanding partnerships with communities living with and affected by emerging and related health areas to support more inclusive, responsive and effective systems for health

Maximizing Health Equity, Gender Equality and Human Rights

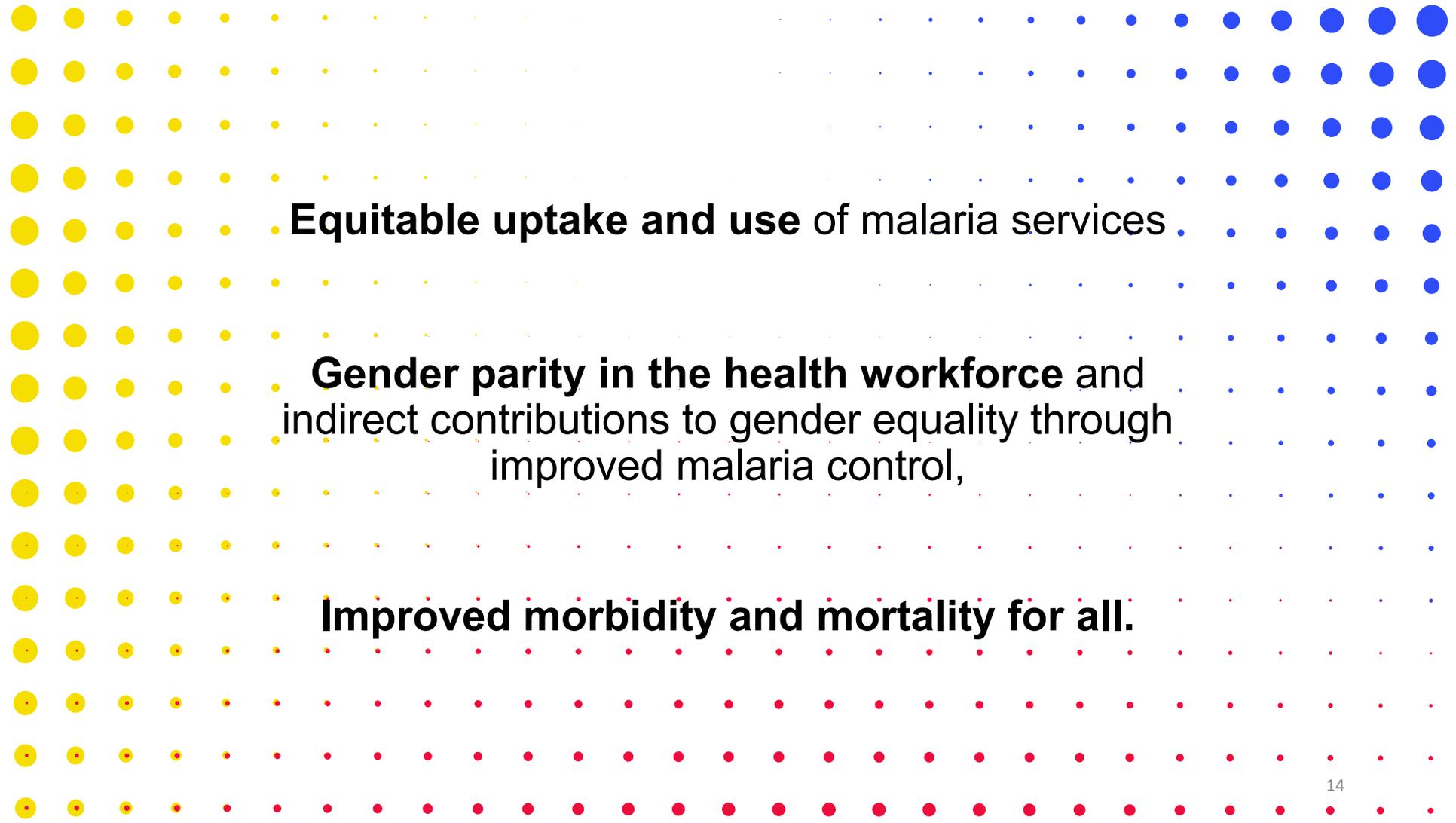
To improve HTM outcomes and drive more equitable access to health services, the Global Fund will support countries and communities by:

- Scaling up comprehensive programs and approaches to remove human rights and gender-related barriers across the portfolio
- Supporting comprehensive SRHR programs and their strengthened integration with HIV services for women in all their diversity and their partners
- Advancing youth-responsive programming, including for AGYW and young KVP and their partners
- Deploying quantitative and qualitative data to identify drivers of HTM inequity and inform targeted responses, including by gender, age, geography, income and for KVP
- Leveraging the Global Fund's diplomatic voice to challenge laws, policies and practices that limit impact on HTM

Mobilizing Increased Resources

To strengthen the scale, sustainability, efficiency and effectiveness of health financing for national and community responses the Global Fund will work across the partnership to:

- Increase international financial and programmatic resources for health from current and new public and private sources
- Catalyze domestic resource mobilization for health to meet the urgent health needs for SDG 3
- Strengthen focus on VfM to enhance economy, efficiency, effectiveness, equity & sustainability of Global Fund-supported country programs & systems for health
- Leverage blended finance and debt swaps to translate unprecedented levels of debt and borrowing into tangible health outcomes
- Support country health financing systems to improve sustainability, including reducing financial barriers to access and strengthening purchasing efficiency



Equitable uptake and use of malaria services

Gender parity in the health workforce and indirect contributions to gender equality through improved malaria control,

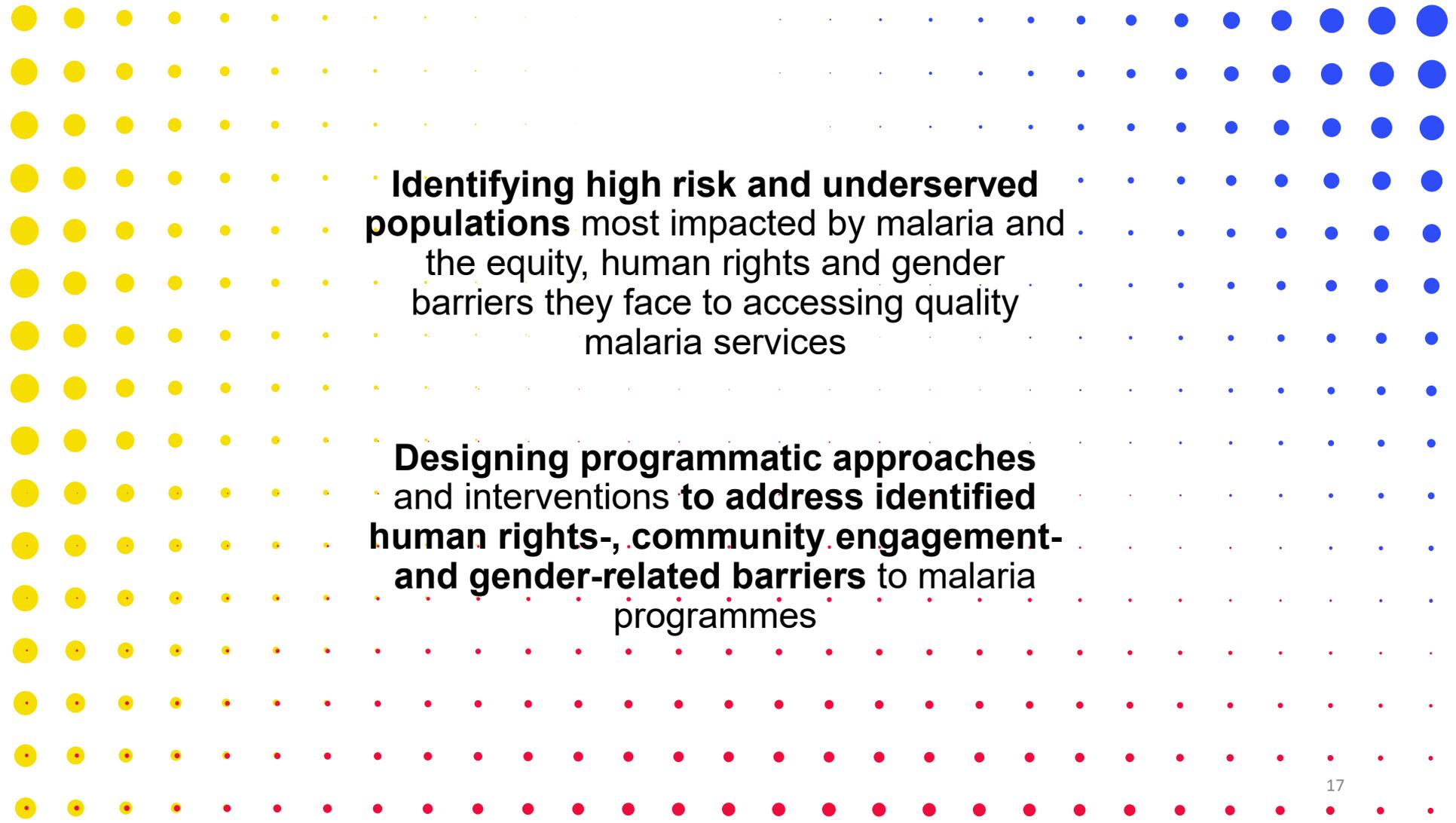
Improved morbidity and mortality for all.

How do we get there using solutions based on community Engagement, human rights and gender equality?

- Strengthen health outcomes through improved service quality and health services that **maximize the engagement of most affected communities, and maximize equity, human rights and gender equality.**
- **Strengthen data systems and effective use of data**, including from community-led monitoring, for decision making at all levels.
- Ensure **meaningful engagement of communities** and other relevant **experts in the design, delivery and monitoring of services**, and working with all partners to integrate services and related data to deliver people-centered quality care.
- **Promote collaboration** across sectors to **revise laws, policies and practices** to tackle structural determinants of HTM outcomes, including human rights barriers, gender-related barriers and inequities.
- **Increase financial / non-financial contributions** to community-based and community-led services.

Available Guidance, Support and Training

- **Technical Brief on Malaria, Gender and Human Rights**
 - Current version: November 2019
 - Revised version: Available mid-2022
- **Technical Assistance**
 - CRG Technical Assistance Program (available to communities and civil society and CCMs in unique situations)
 - Human Rights and Gender Technical Assistance (through RBM), available to NMCPs, CCM, PRs and other implementers from countries that have received CRG-related TRP comments during NFM3
- **Training**
 - Developed through the GF-RBM CRSPC relationship, eLearning and face-to-face training now addresses community, gender and human rights-related barriers in malaria programming and the strategies to mitigate these barriers with the goal of establishing more equitable malaria programs.
 - Training targeting NMCPs and CCMs, PRs and other implementers
 - Training targeting TA Providers
- **Malaria Matchbox**



Identifying high risk and underserved populations most impacted by malaria and the equity, human rights and gender barriers they face to accessing quality malaria services

Designing programmatic approaches and interventions to address identified human rights-, community engagement- and gender-related barriers to malaria programmes

Training on Community, Human Rights and Gender in malaria programming

Sub-Regional National Malaria Program and Partners Annual Meeting
RBM CRSPC Meeting, JULY 5-8 2022
Harare, Zimbabwe

Dr. Denise Njama-Meya, CRSPC Consultant MBCHB, DTMH, MSc.

Training outline

Session 1: Introduction on malaria epidemiology

Session 2: The Malaria Matchbox tool

Session 3: Conducting the CRG assessment, best practices and lessons learned

Session 4: Designing of programmatic approaches and interventions



Build capacity

- Identify the vulnerable and underserved populations.
- Identify inequities and barriers.
- Identify actions.

SESSION 1: INTRODUCTION

Malaria epidemiology and programming

- Understanding malaria epidemiology in a country is critical.
- Malaria epidemiology varies widely over relatively small geographic areas.
- Severity of malaria infection depends on the species of malaria parasite and also on the level of malaria-specific acquired immunity.
- Understanding the complex heterogeneity of risk factors that can contribute to an increased risk of malaria at the individual/household level will enable more effective use of control measures.



Identify malaria risk factors including biological, socio-economic and cultural factors.

Identify the resulting high risk and underserved populations respectively.



Biological Risk factors

Not all people in malaria endemic areas are at the same risk of becoming sick or dying from malaria.

Acquired immunity is an important factor.

After repeated attacks of malaria, a significant degree of immunity is acquired.

This partial immunity reduces the risk that malaria infection will cause severe disease.

Malaria non-immunes are those who have had minimal or no previous exposure to malaria infection.

The risk of severe disease and potentially death is high among non-immunes or those with low immunity to malaria parasites.



File Photo: The Independent Uganda

High Risk populations



© World Vision, Uganda

Children under 5 years of age in high-transmission areas



© The Global Fund to Fight AIDS, Tuberculosis and Malaria

Pregnant women



© PMI, U.S. President's Malaria Initiative

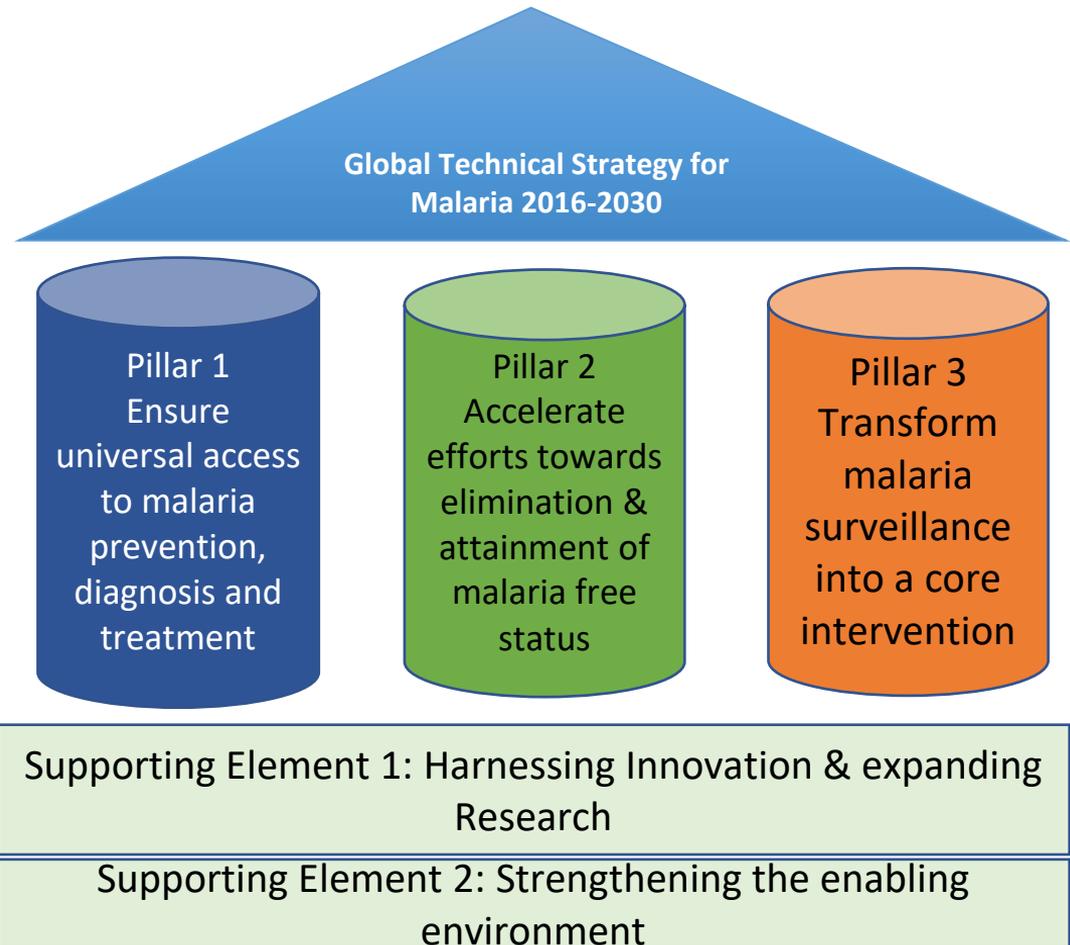
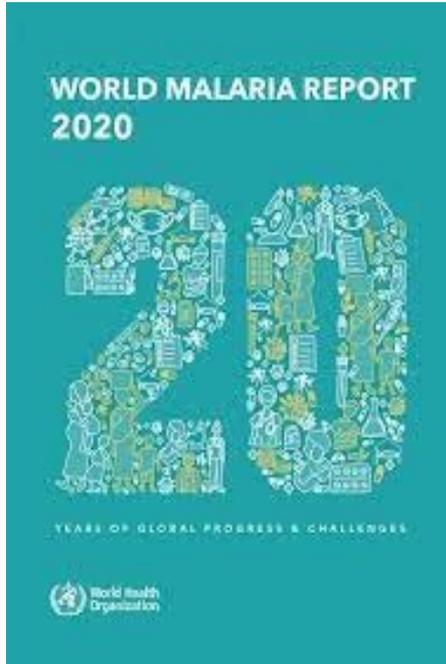
Non-immune migrants, mobile populations and travellers

Socio economic and cultural risk factors

Risk factors		
Poverty	Accessibility barriers	Social exclusion
Literacy barriers	Human rights barriers	Economic opportunities
Financial barriers	Cultural norms	Complex emergencies
Physical barriers	Psycho-social barriers	



Underserved populations



Most countries are not on track to achieving the Global Technical Strategy for malaria milestones. 28

Summary

- Need to strengthen the focus on socio economic and cultural factors.
- Insufficient levels of access to and uptake of malaria services in high risk and underserved populations.
- Identifying the high risk and underserved populations and barriers they face.
- Inform the design and implementation of malaria interventions.
- Engage high risk and underserved populations.
- Success of malaria strategies/interventions, should be evaluated by their impact.

Successful malaria strategies

Successful malaria strategies should include interventions that are:

1. Integrated



2. Equitable



3. People-centred



Successful malaria strategies

4. Community Systems Strengthening:

- Involvement of communities is essential to ensure the services provided meet the demands of the populations served and consider potential barriers.
- Community led advocacy can guide development of tailored advocacy activities.



- Community based monitoring can enable maximizing the reach and impact of health interventions.
- Community systems can also be strengthened through mobilization, coordination of communities and building community linkages.



**SESSION 2: CRG -THE MALARIA MATCHBOX
TOOL**

What is the Malaria Matchbox Tool?

Participants to use the following mentimeter link to select the correct answer/s.

<https://www.menti.com/4yznbwd17g>

**Polling/Voting code: 5995
5881**

Or Scan the QR code:



Overview of the Malaria Matchbox Tool



- It is an equity assessment toolkit.
- Used to help identify:
 1. **Who** are the populations, groups or individuals most affected by malaria (high-risk and underserved).
 2. **What** are the key social rights and gender related barriers disproportionately affecting malaria outcomes in those populations.
 3. **How** their malaria programmes can address those barriers.

Other useful documents [Health Equity Assessment Toolkit](#) (HEAT) and the [Equitable Impact Sensitive Tool](#) (EQUIST)

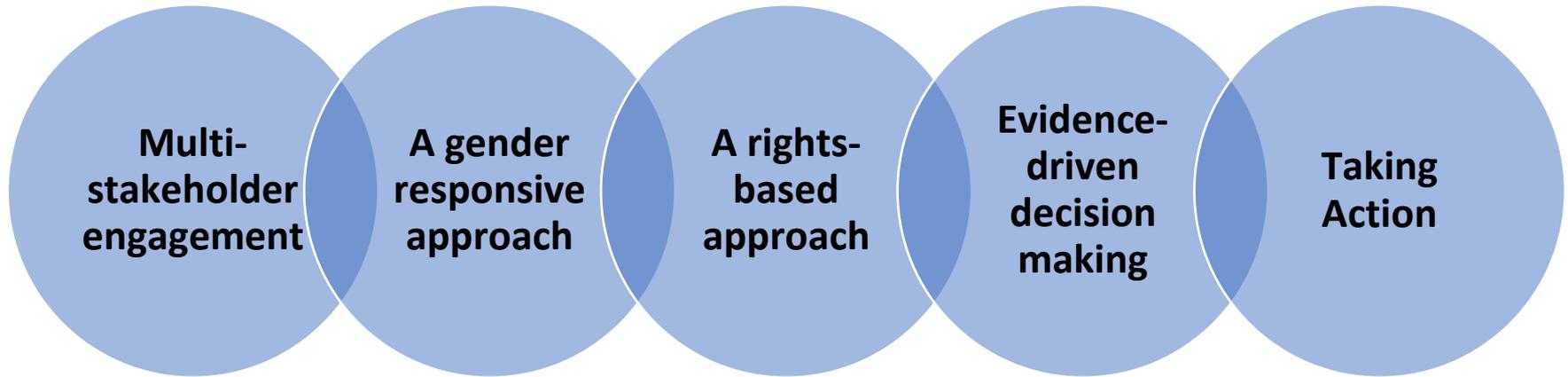


When to use the Malaria Matchbox Tool

- As a part of national program processes, such as MPRs
- To guide strategic and implementation plans.
- In response to Technical Review Panel comments of Global Fund country applications.
- To provide evidence and guidance in the development of specific initiatives e.g. HBHI approach



Overall principles



Adapted to the required scope and country context



Structure of the Malaria Matchbox Tool

Pre-
assessment
Phase

Assessment
phase

Pre-assessment/preparation steps

Country Context

- Understand what the country's specific needs are.
- Identify if/how the tool can be placed in the national malaria strategic planning process

Engage stakeholders

- Led by the national malaria program.
- Multisectoral participation.
- Map key stakeholders.
- Secure commitment at all levels.

Form the assessment team

- Select a team with diverse skills.
- Ensure clear terms of reference.
- 5-7 core members with dedicated time.

Planning and budgeting

- Assess what data is available and what data needs to be collected and how.
- Develop a concept note.
- Develop a budget and identify source of funding.

Development of the research proposal

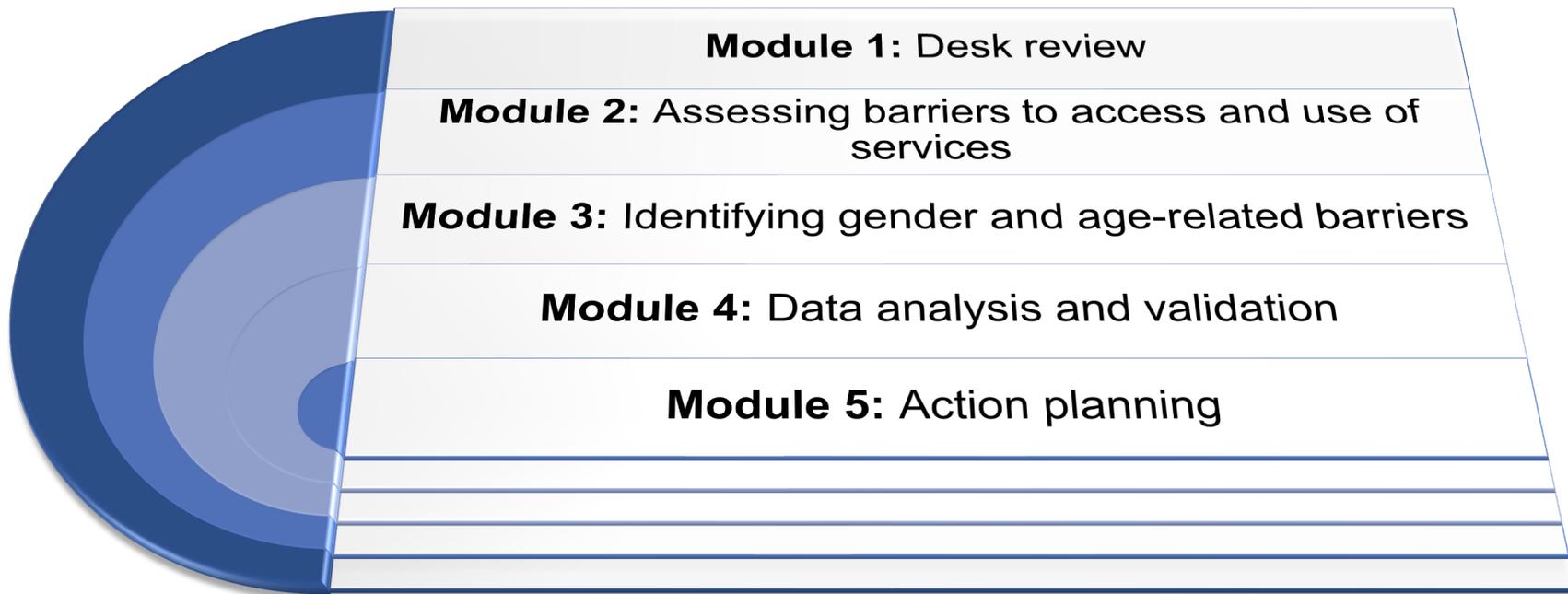
- Develop the full proposal.
- Develop data collection tools.
- Obtain ethical approval.
- Obtain informed consent.

Lessons learned- Planning phase

- Country engagement is key.
- Ensure the project is driven by NMCP whose leadership and time commitment is key to lead the process and engage stakeholders.
- Set up the steering committee of the project with members from diverse sectors to ensure a multisectoral approach.
- Leverage an existing Steering Committees.
- Recruit a local consultant in addition to the international consultant, with experience in similar data collection projects.
- Conduct regular virtual or in person meetings with the Steering Committee members.



Assessment Phase



Use one or two words to describe these photos



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The young code 0100 011



SESSION 3: CONDUCTING THE ASSESSMENT,
BEST PRACTICES AND LESSONS LEARNED

Module 1: Identifying the populations most impacted by malaria

Aim: To identify and spatially locate the populations most impacted by malaria.

Specific Objectives:

1. Understand the overall country malaria burden.
2. Understand the country policy and programme context in terms of equity in health and malaria.
3. Identify inequities in malaria service coverage and malaria health outcomes.
4. Identify potential geographic areas and/or populations with sub-optimal access and use of malaria and primary health care services.
5. Identify the information gaps.

Lessons learned - Desk Review

- **The consultants conduct the Desk Review** to set the country context and initial understanding about the determinants of health, particularly malaria services and mapping/identification of the most vulnerable groups.
- **In several countries inception reports included:** overall malaria burden, country policy and program context in terms of equity in malaria & identification of inequities in malaria service coverage.
- **The selection of data sources is key:** Engagement of NMCP & health partners to provide country reports and relevant documents that facilitate this phase. Documents can include: NSPs, NMCP annual reports, NFM malaria concept notes and reports, TRP reports, DHS, MIS/MICS, Census population and housing, WHO health equity database, community data bases.
- **The inception report provides preliminary recommendations and indicates which data is missing from the desk review** and guides what should be collected to respond to the the assessment question.

Module 2: Examine how risk factors, barriers to accessing services, and bottlenecks for service delivery affect health equity in the context of malaria

Objectives

1. Assess potential prohibitive factors and barriers to access and use of malaria services.
2. Engage key stakeholders to better understand the context.

Focus areas

1. Behaviour and sociocultural barriers to services.
2. Information accessibility and health literacy.
3. Financial accessibility.
4. Geographical accessibility.

Module 3: Identifying intra-household inequity

Specific Objective

- Collection of intra-household qualitative data to inform key areas where gender- and/or age- responsive approaches are needed.

Includes assessment of:

- i. Intra-household decision power affecting malaria prevention.*
- ii. Intra-household decision power affecting treatment*
- iii. Division of labour*

Best practices | Data collection

Preparation is key

- **Data collection tools should not be lengthy or wordy** but the questions should be very straight to the point. Shortening time allocation of the interviewees should be considered for quality of the data.
- **Quality of data is key:** the selection of data collectors and their training should be well prepared
- Some countries enrolled data collectors already working with NMCPs and who are used to collect data at community level, district level and national level in malaria or health related projects.
- **NMCPs to introduce data collectors early to all targeted groups** who will take part in the data collection to ensure availability of people/partners/ govt officials and health staffs.
- **Engagement of CSOs leaders and Community leaders** in the setting up of communities focus group is key to ensure full participation and adherence.
- **The use of local languages** during focus groups allow better engagement of communities. Translators might be needed in some cases.

Module 4: Data analysis and validation

- When implemented as part of a HBHI strategy or MPR/MTR, data analysis will be conducted in line with the recommended processes.
- Analyse, synthesize and triangulate data to identify barriers.
- Document identified barriers and where applicable merge into the HBHI or MPR/PTR preliminary report to be shared with technical experts.
- Conduct a 2–3-day stakeholder meeting to review and validate findings.
- Produce and disseminate a draft assessment report of the validated findings.

Best Practices | Data Analysis

This is a **QUALITATIVE Assessment**

- It is important to follow the best methods for analysis of this type of assessment, the Malaria Matchbox tool proposes methodologies.
- The data should be synthesized, triangulated and barriers identified and documented. A format is available in the Malaria Matchbox.
- The analysis can be done by the consultants (many countries used this method).
- The analysis can be done by consultants with the involvement of data collectors/designated partners in groups work (*Zimbabwe*).
- The data analysis report should be reviewed by the Steering Committee led by the NMCP for feedback before finalization.
- The data analysis should present facts, key findings and provide key recommendations on how to address barriers identified.

Some examples of data analysis findings resulting from the Malaria Matchbox assessment



Challenges and Gaps to Current Programmes

- **Insufficient engagement of IDPs and refugees (themselves) in the design and delivery of malaria interventions:** Few if any IDP or refugee participants discussed being involved in developing or delivering malaria interventions.
- **Limited to no engagement of traditional healers in malaria prevention and control:** The assessment findings were quite clear on the preferences of IDPs and refugees for traditional remedies and traditional healers as first points of call in the event of illness (for all illnesses, not just malaria).
- **Limited efforts to address linguistic and cultural barriers to malaria information and awareness activities:** Among refugees, a number of participants mentioned linguistic barriers as a main factor in low levels of knowledge and awareness about malaria risks.
- **Inadequate integration and coordination across health and humanitarian sectors:** As the assessment noted, there are a large number and an equally large variety of governmental and non-governmental actors involved. Coordination and collaboration remain uneven, including between national and state entities.

Challenges and Gaps to Current Programmes

- **Limited range of malaria prevention and control modalities:** As the findings of the assessment illustrate, provision of LLINs remains the primary strategy for malaria prevention despite the challenges this raises for mobile or unstable populations living where there is inadequate shelter.
- **Limited resources in relation to population needs:** Many participants noted the challenge of lack of sufficient resources to adequately respond to the needs of IDPs and refugees. This included coverage of core interventions such as LLINs, but also for adapted responses that are more specific to IDP or refugees: ex nets SBCC programs in their local languages.
- **Insufficient attention to the influence of gender and gender norms:** While many participants, particular key informants from organisations or who were service providers, could describe the influence of gender and gender norms on malaria prevention and control interventions, few if any spoke of ways to address these effects.

Analysis regarding Equity Barriers

- Challenges related to general malaria knowledge, attitudes and practices.
- Specific negative attitudes and beliefs about malaria interventions.
- Trends in health seeking behaviour linked to traditional beliefs.
- Physical and financial accessibility by IDPs and refugees.
- Negative experiences with health facilities.
- The influence of gender norms on women's and children's access to services.
- Other environmental factors

Module 5: Action planning

Specific objectives:

1. Review the assessment findings and identified barriers.
2. Develop actions to address barriers and improve equity in the malaria programme.
3. Review and prioritize proposed actions.
4. Outline next steps to mainstream proposed actions.

Methodology

- Conduct a consultative review of the findings and in-depth assessment of the identified barriers led by the malaria country programme.
- Multisectoral participation as well as community engagement is essential.
- Develop actions to address barriers and improve equity in malaria programme.
- Review and prioritize each of the barriers identified.
- Conduct the core analysis identifying the possible mechanisms of action to address inequities in the specific programme area.

Engaging stakeholders in a National Workshop

•This phase enables a multisectoral approach to define targeted responses to the challenges and barriers found in the data analysis report.

- NMCP, with the support of the consultants, organizes a 3 to 5 days workshop with key participants from the national, regional, district and community levels.
- It is key to include community representatives in the workshops, especially from the most vulnerable groups identified or who took part in the assessments.
- Include diverse partners from diverse sectors and related Ministries (example: Ministry of Women and Families, Environment, Agriculture, Labor, etc.)
- Organizations or agencies/NGOs/CSOs working with vulnerable groups
- Malaria technical and financial partners
- Malaria PR, SRs, SSRs
- Human rights and gender experts

The action plan

- Outlines challenges and barriers identified by vulnerable groups
- Proposes key interventions/actions to reduce those barriers
- The period of implementation of these actions
- The cost of each intervention
- The parties who can support these interventions or include in their current work or source of funding

Table of barriers and proposed actions/strategies

Barriers	Associated program area	Proposed actions/strategies	Target group /Community	Indicators	Strategic partners	Responsible Sectors/Entity	Implementation budget

Break out session – 50 minutes



1. Country group discussions (20 minutes)

- Review case studies and document actions that can be taken to address identified barriers.

2. Plenary presentations (30 minutes)

- Group presentations and discussions.



Group 1	Zambia	Botswana	Malawi	South Africa
Group 2	Angola	Comoros	Zanzibar - URT	Zimbabwe
Group 3	Madagascar	Eswatini	Mozambique	Namibia



SESSION 4

DESIGNING OF PROGRAMMATIC APPROACHES AND INTERVENTIONS TO ADDRESS IDENTIFIED BARRIERS IN COMMUNITY, GENDER, AND HUMAN RIGHTS DETERMINANTS OF THE MALARIA PROGRAMME

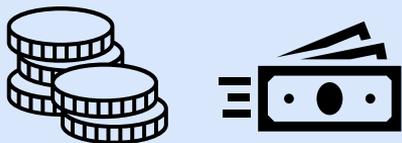
Program Area 1: Monitoring and reforming laws, policies and guidelines

- Ensure that laws, policies and guidelines are non-discriminatory and advocate for improving access to malaria services.
- Prioritize ensuring a policy environment that guarantees inclusivity of all, including undocumented migrants, refugees, asylum-seekers and prisoners.
- Ensure the implementation of existing relevant policies, laws and guidelines.
- Identify laws, policies and guidelines that may prevent or delay access to malaria services.

Barriers related to laws, policies and guidelines and possible actions

Barriers

User fees



Laws and policies



Actions

- Provision of vouchers.
- National health insurance programs for informal sector.
- National subsidies.
- Removal of user fees.
- Transformative gender policies.
- Inclusion and empowerment of high risk and vulnerable populations.
- Advocacy for amendment or removal of the barrier laws, policies or strategies.
- Multisectoral involvement.

Program Area 2: Addressing barriers to ITN use

- ITN coverage needs to reach population groups at risk.
- There is both inadequate coverage and inadequate usage.
- Understanding barriers to receiving and using a net will help programs modify their distribution and SBC strategies appropriately.
- Consider strategies to target high risk, vulnerable populations.
- Malaria programmes should identify, deploy and evaluate innovative methods to address barriers
- Ensure access and utilization of ITNs is achieved without leaving anyone behind.

Example of barriers to ITN use and possible actions

Barrier: Limited ITN access in hard-to-reach populations



Action

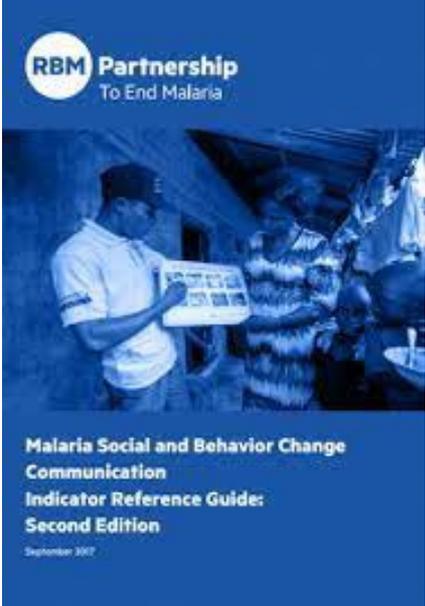
- i. Altered distribution strategies.
- ii. Alternative transport measures where roads are bad.
- iii. In flooded areas, consider use of boats.
- iv. War torn zones require multi-sectoral engagement and strong coordination with all stakeholders.
- v. In emergency situations integrate ITN distribution with distribution of other essential items e.g. food.
- vi. Plan targeted ITN distribution to specific vulnerable or high-risk populations.

Examples of barriers to ITN use and possible actions (2)

Barriers	Action
Gender or age - related barriers	<ol style="list-style-type: none">1. Develop gender- and age-specific SBCC strategies.2. Ensure adequate number of nets are provided to each household.3. Recruiting and training more females to support the ITN mass campaign distribution.
Socially or legally excluded populations	<ol style="list-style-type: none">1. Targeted ITN distribution.2. Community dialogue and engagement.3. Establish innovative registration techniques.4. Multisectoral engagement.
Low literacy/language diversity barriers	<ol style="list-style-type: none">1. Messages are translated to the local language.2.3. Pictorial messaging in the case of limited literacy.4. Messaging adapted to take into consideration specific cultural beliefs

Program Area 3: Addressing barriers to IRS

Inadequate information and education



Religious beliefs and cultural practices.



Gender barriers



Operational barriers in hard to reach areas

Program Area 4: Addressing barriers in IPTp

Barriers

Negative healthcare-worker attitudes and cultural/social.

Delayed or lack of attendance of ANC

Language and literacy barriers

Economic barriers such as transport costs, time off work etc.

Cultural and gender norms, and intrahousehold dynamics

Actions:

- Sensitization/training of health care workers.
- A women/adolescent-centred approaches.
- Explore existing evidence-based strategies.
- Identify, pilot and evaluate innovative actions.

Program Area 5: Addressing barriers to Seasonal Malaria Chemoprevention (SMC)

- Acceptability of SMC is influenced by social and cultural factors.

Barriers	Actions
Hard to reach areas due to poor infrastructure, insecurity, political unrest, floods etc.	<ul style="list-style-type: none">• Provide safe and alternative transportation for CHWs and of SMC commodities.• Provide alternative innovative distribution strategies.
Language and literacy barriers	<ul style="list-style-type: none">• Enhance SBC for parents of targeted children.• Ensure messages are translated to the local language or use pictorial messaging in the case of limited literacy.• Community Mobilization and sensitization.• Consider integrating SMC with other already established and accepted health programs such as EPI.

Program Area 6: Addressing barriers to timely and appropriate malaria case management

Barriers	Potential Actions
Gender and cultural barriers	<ul style="list-style-type: none">• Training of healthcare workers in provision of cultural and socially acceptable services.• Community involvement and empowerment.• Community sensitization.• Deployment of female health workers where required.
Delayed access to malaria services in hard-to-reach populations	<ul style="list-style-type: none">• Use of community/village health workers.• Provision of innovative safe transport e.g. bicycle ambulances.• Introduction of Mobile malaria clinics.
Language Barriers	<ul style="list-style-type: none">• Targeted training and employment of health facility workers and community health workers who speak the language of the underserved or hard to reach community.

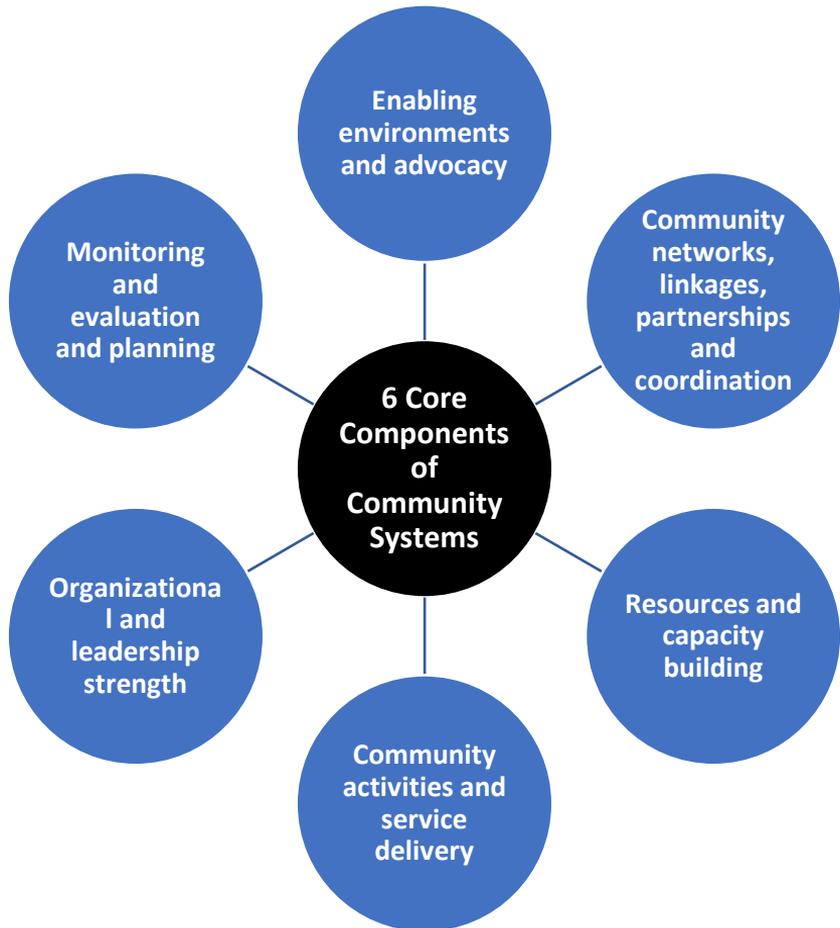
Program Area 7: Addressing barriers to SBC messaging

- Malaria communication strategies tailored for the specific barriers identified/prioritized should be developed.
- Reference to the RBM Strategic Framework for Malaria Social and Behaviour Change Communication 2018-2030 can provide guidance to the country in addressing the identified barriers.
- The communication strategies developed should be evidence based and theory-informed.
- The SBC strategies should be identified at the different programmatic levels to maximize impact.
- A multisectoral consultation in development of communication strategies is fundamental.

Community Systems Strengthening in malaria programming to improve access and uptake of malaria services

- Community participation is an essential element.
- Community action is fundamental.
- Community Systems strengthening is aimed at engaging and establishment of roles for the community.
- Communities should be involved at all steps of programmatic implementation.

Core Components of Community Systems



Source: The Global Fund Community Systems Strengthening Framework. Revised edition, February 2014

Module 5: Conclusion

- Actions recommended should be specific and realistic.
- Conduct wide consultation and collaboration including affected groups.
- It is essential that the recommended actions are mainstreamed into the country's malaria programming, policies and guidelines.
- For some barriers, no concrete actions may be identified immediately but a plan should be developed, and clear steps outlined towards the exploration and identification of suitable actions.
- Use of tools such as EQUIST can help identify strategies to address health system level barriers and bottlenecks.

Resource documents

- Malaria Matchbox Tool
[https://endmalaria.org/sites/default/files/Malaria Matchbox Tool en web.pdf](https://endmalaria.org/sites/default/files/Malaria%20Matchbox%20Tool%20en%20web.pdf)
- UNDP Gender Malaria discussion paper
[https://www.undp.org/content/dam/undp/library/HIV-AIDS/Gender HIV and Health/Discussion Paper Gender Malaria.pdf](https://www.undp.org/content/dam/undp/library/HIV-AIDS/Gender%20HIV%20and%20Health/Discussion%20Paper%20Gender%20Malaria.pdf)
- Global Fund: Technical Brief Malaria, Gender and Human Rights
[https://www.theglobalfund.org/media/5536/core malariagenderhumanrights technicalbrief en.pdf](https://www.theglobalfund.org/media/5536/core_malariagenderhumanrights_technicalbrief_en.pdf)
- [WHO Innov8technical handbook](#)

THANK YOU

Where, after all, do universal human rights begin? In small places, close to home—so close and so small that they cannot be seen on any maps of the world. . . . Such are the places where every man, woman, and child seeks equal justice, equal opportunity, and equal dignity, without discrimination.

—Eleanor Roosevelt, U.S.A., 1958
Chair of the Commission of the
United Nations

COUNTRY EXPERIENCES IN CONDUCTING THE MALARIA MATCHBOX ASSESSMENT

Panel discussion– E8, Zimbabwe

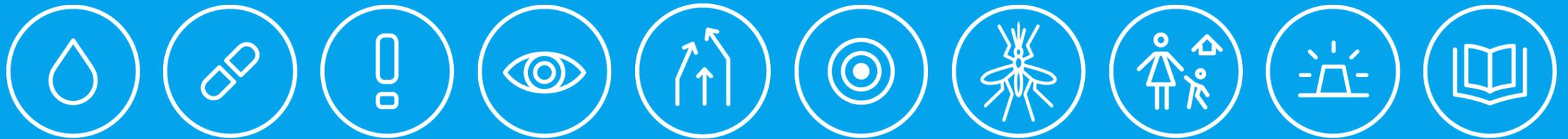
Moderator- Olivia Ngou

**The use of data for decision making and programs,
following the implementation of the matchbox in Zimbabwe
and E8 regional desk review experience**



Development of a strategy to respond to antimalarial drug resistance in Africa

RBM Southern Africa National Malaria Programmes and Partners Annual Meeting



Harare, July 6th, 2022

Global **Malaria** Programme



World Health
Organization

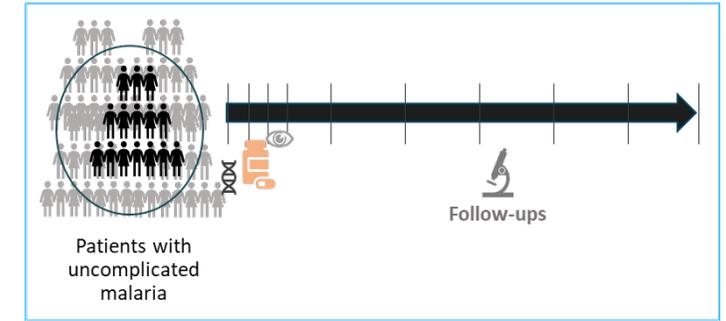
Outline of presentation

- **Technical background**
- **Resistance situation in Africa**
- **Process of development of a strategy**
- **Proposed interventions**
- **Proposed country assessments**

Sources of information on drug efficacy and resistance

Therapeutic Efficacy Studies (TES)

- Gold standard for **monitoring drug efficacy** to inform treatment policy
- Follow-up and procedures in accordance with standard protocol
- WHO recommends that TES are done in sentinel sites at least once every 2 years



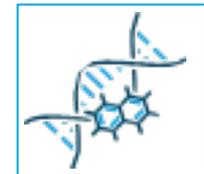
Integrated Drug Efficacy Studies (iDES)

- In very low endemic areas implementing elimination activities
- Methods and data collected in iDES vary between countries depending on the systems in place and the resources available



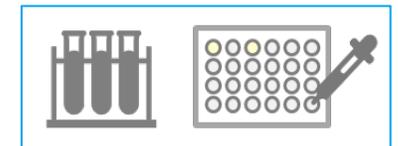
Molecular markers

- For drugs resistance where molecular markers has been identified, **resistance can be confirmed, and trends monitored** with molecular techniques.
- Samples collected in surveys or TES



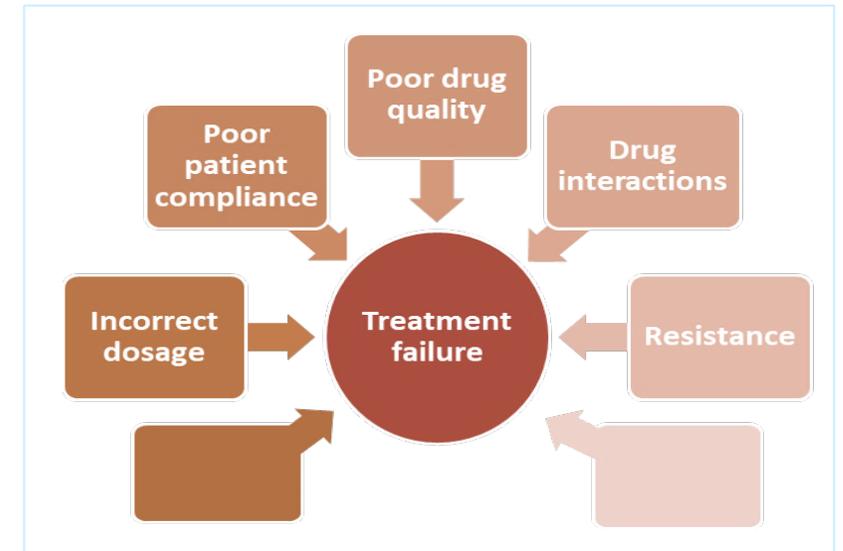
In-vitro and ex-vivo studies

- Testing the **sensitivity of parasites** to precise concentration of antimalarial drugs



Resistance definitions

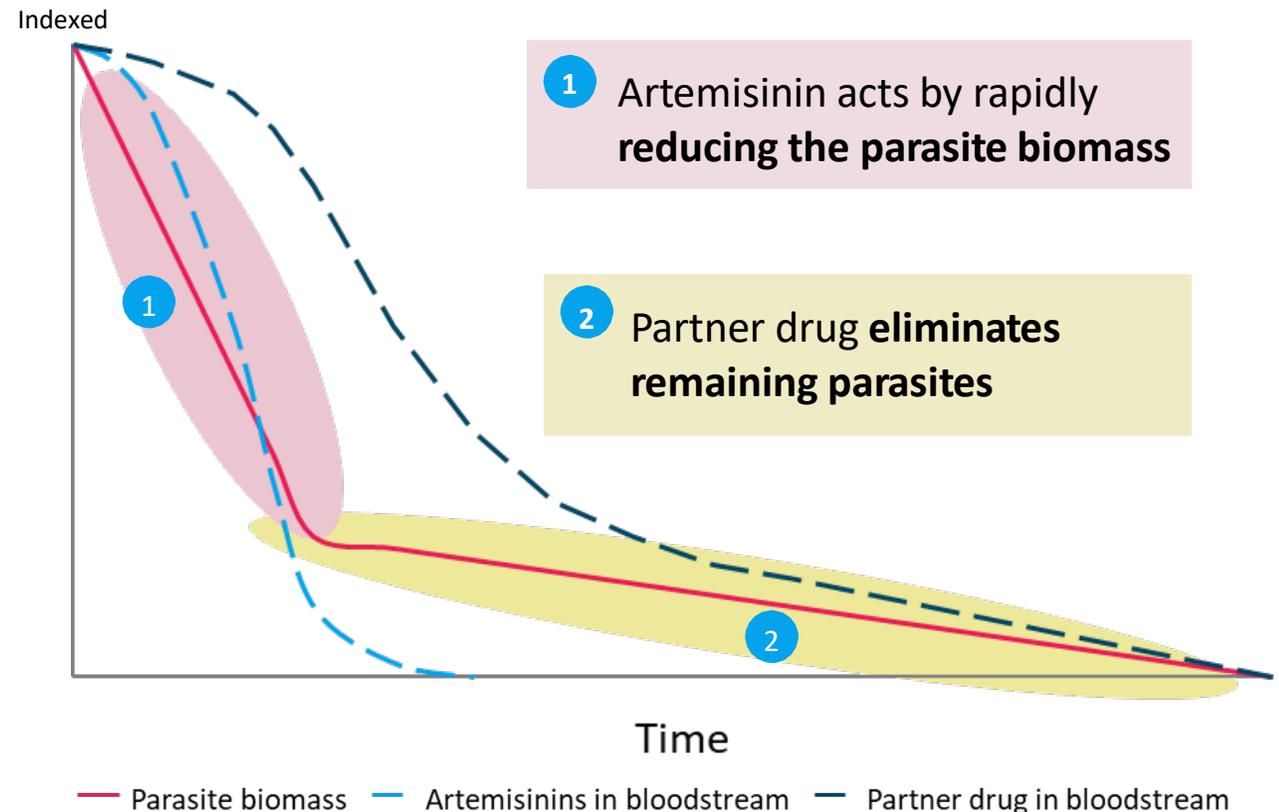
- **Antimalarial resistance** is defined as the ability of a parasite strain to survive and/or multiply despite the administration and absorption of a drug given in doses equal to or higher than those usually recommended but within tolerance of the subject.
- **Treatment failure (\neq resistance)** is the inability to clear parasites from a patient's blood or to prevent their recrudescence after the administration of an antimalarial. Many factors can contribute to treatment failure, including incorrect dosage, poor patient adherence, poor drug quality, and drug interactions and resistance. Most of these factors are addressed in therapeutic efficacy studies.



Artemisinin-based combination therapies

- Artemisinin-based combination therapies (ACTs) combine an artemisinin and partner drug
- The efficacy of ACTs is dependent of efficacy of both components
- All 6 partner drugs highly efficacious as monotherapies in absence of resistance
- Artemisinins rapidly lower the parasite biomass while partner drug completes elimination of the parasites

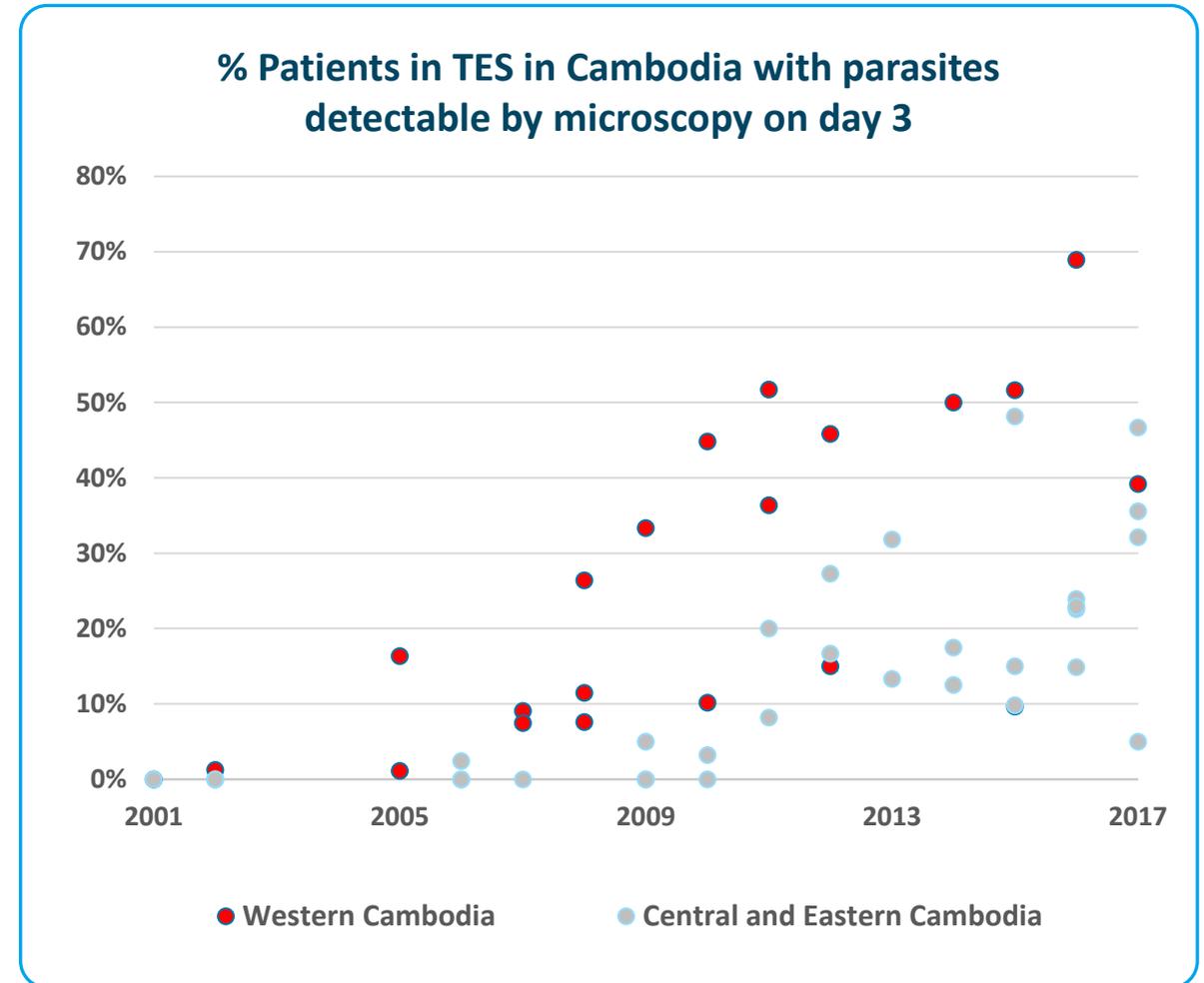
Evolution of parasite biomass in the body following ACTs administration



Illustrative

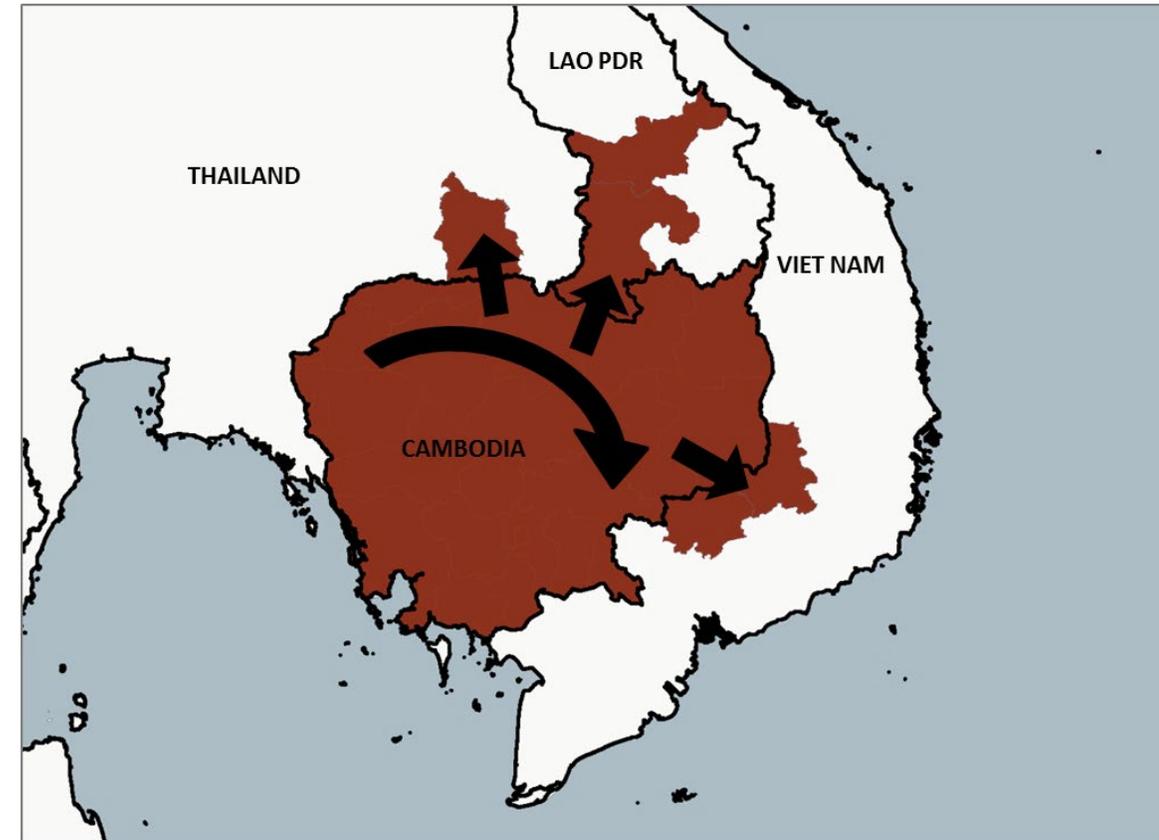
Artemisinin partial resistance

- Delayed clearance after treatment with an artemisinin was first detected on the border of Cambodia and Thailand
- 7-day artesunate treatment showed > 90% efficacy even in areas of high prevalence of delayed clearance
- **Artemisinin partial resistance** is seen as delayed parasite clearance following treatment with artemisinin-based monotherapy or with an ACT
- Delayed clearance alone does not lead to ACT treatment failure
- However, in combination with partner drug resistance, very high failure rates have been seen



Spread of partner drug resistance

- In Southeast Asia, artemisinin partial resistance has not been seen to cause the emergence of partner drug resistance but may have helped spread piperazine resistance through a strain with artemisinin partial resistance and piperazine resistance
- The spread of the resistant parasites across the region linked to massive drug pressure
- However, change in first-line treatment in Cambodia does appear to select against this strain



Imwong et al. 2017 Lancet Inf Dis.



Delayed parasite clearance after treatment with artemisinins found to be associated with *PfKelch13* (K13) mutations

PfK13 markers of artemisinin partial resistance

Validated markers

- F446I
- N458Y
- C469Y
- M476I
- Y493H
- R539T
- I543T
- P553L
- R561H
- P574L
- C580Y
- R622I
- A675V

Candidate markers

- P441L
- G449A
- C469F
- A481V
- R515K
- P527H
- N537I/D
- G538V
- V568G

Resistance situation in Africa

Key messages from Technical workstream on drug resistance | Situation still under control, but measures should be implemented to avoid ACT treatment failure



- Artemisinin partial resistance confirmed in Rwanda, Uganda, Horn of Africa
- Lack of geographical coverage of data



- Fitness cost and parasite genetic background expected to play a key role in resistance's ability to spread
- Spread potential likely to differ from the Greater Mekong Subregion



- For partner drugs, scattered reports of treatment failure but no resistance confirmed (*in vitro*, molecular markers or blood levels)



- Potential risk of issue underestimation by local stakeholders (≠ GMS)
- Communication and advocacy will play a key role

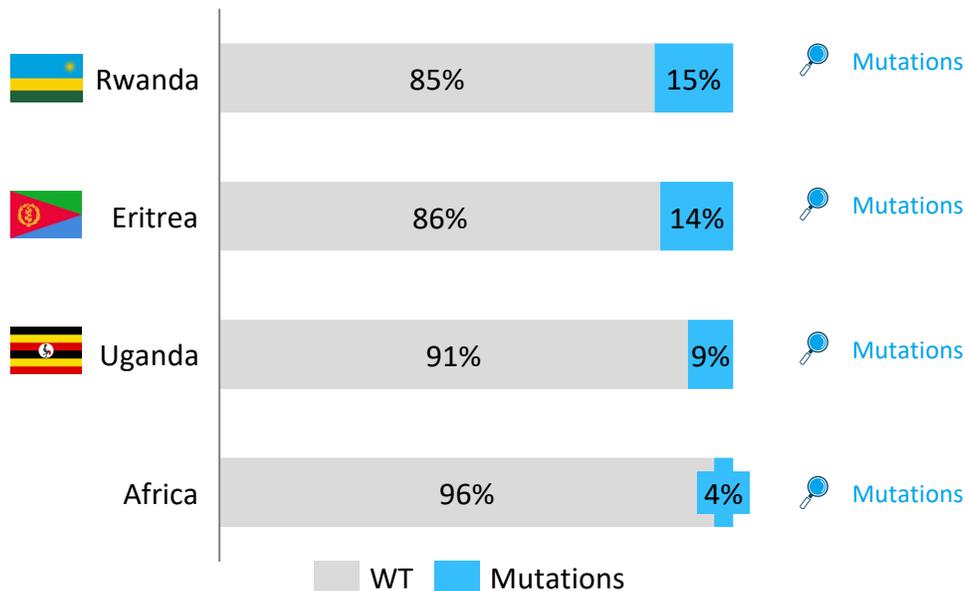


K13 Wild Type still dominant in Africa, but presence >5% of mutants already identified in 3 countries

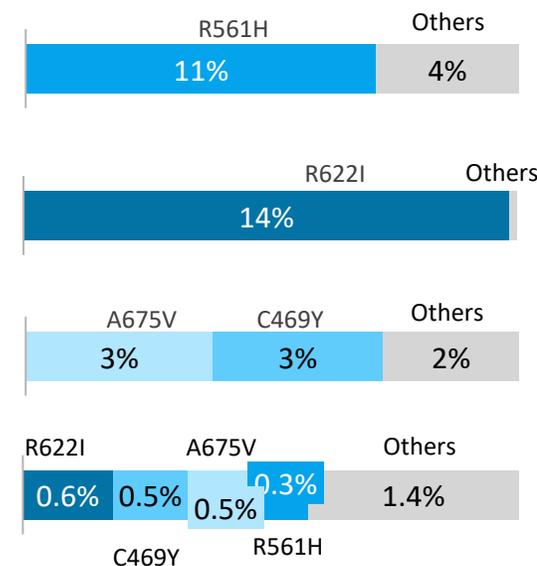
3 countries with more than 5% K13 mutations (2015-2020)



Wild Type still significantly dominant



Various K13 mutants identified in different countries



- Mutations not spread from Asia
- Mutations have been found to be associated with increased proportion of patients with detectable parasites on day 3 but tested ACTs still efficacious



So far, no confirmed partner drug resistance in Africa¹

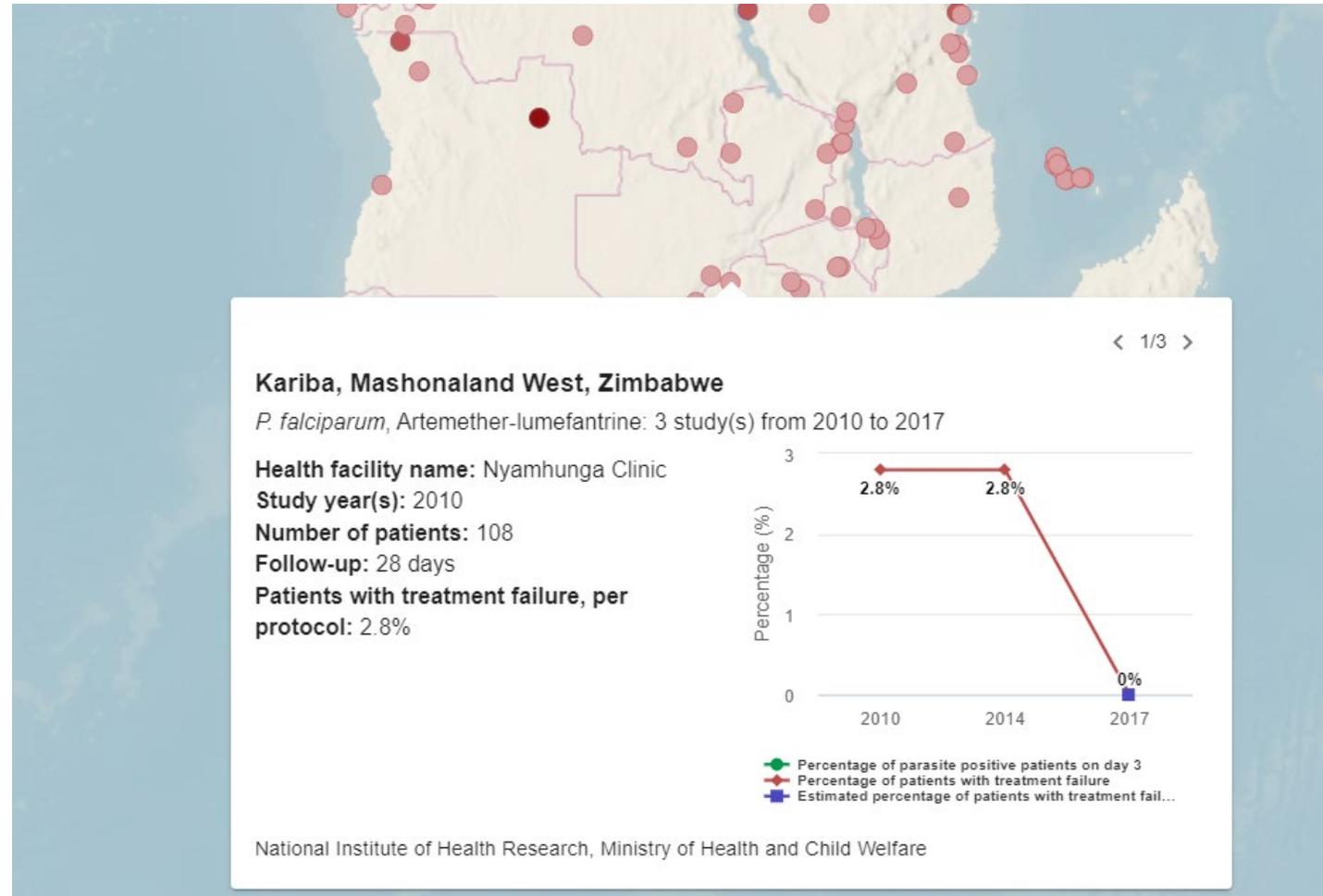
Partner drug	Current evidence	Molecular markers of resistance	Comments
Amodiaquine	<ul style="list-style-type: none"> Treatment failure rates > 10% identified in two TES in Liberia in 2017-2018 	To be validated in Africa	<ul style="list-style-type: none"> IC₅₀ affected in vitro by <i>Pfcr</i>t and <i>Pfmdr</i>1 mutations but shift of IC₅₀s less significant than for chloroquine, and <i>Pfcr</i>t and <i>Pfmdr</i>1 mutations cannot be considered amodiaquine resistance markers at present
Lumefantrine	<ul style="list-style-type: none"> Treatment failure rates > 10% reported in 4 countries (Angola, Burkina Faso, Democratic Republic of Congo and Uganda) between 2009 and 2019 Increased IC₅₀ in Uganda 	To be validated	<ul style="list-style-type: none"> Studies show that lumefantrine selects for <i>Pfmdr</i>1 mutations (N86) Short half-life → potential misclassification of reinfections as recrudescences Studies have used PCR-correction method based on microsatellites and a Bayesian algorithm Concerns on quality of microscopy In Burkina Faso, Uganda and DR Congo, AL treatment failures in sites where DP treatment failures were also found
Piperaquine	<ul style="list-style-type: none"> Treatment failure rates > 10% reported in 3 countries (Burkina Faso, Uganda and Democratic Republic of Congo) 	To be validated in Africa (Pfpm2–3 increased copy number and <i>Pfcr</i> t mutations validated in GMS and South America)	<ul style="list-style-type: none"> Studies have used PCR-correction method based on microsatellites and a Bayesian algorithm Concerns on quality of microscopy In Burkina Faso, Uganda and DR Congo, AL treatment failures in sites where DP treatment failures were also found

¹ Excluding sulfadoxine-pyrimethamine

Additional information and data

Malaria threat maps

<http://apps.who.int/malaria/maps/threats/>



Strategy development

Why a strategy for antimalarial drug resistance in Africa is needed



Context

- **Artemisinin-based combination therapies (ACTs)** as main medicine to fight malaria.
- There is **heavy reliance on artemether-lumefantrine** (85% of courses procured by GF).
- ACT treatment failures due to artemisinin partial resistance and partner drug resistance appeared in **GMS**.
- High number of cases (>90% of global malaria cases) and reliance on few treatments put Africa particularly at risk **if resistance emerges and spreads**.



Problem statement

- **Artemisinin partial resistance** confirmed in Uganda, Rwanda and Horn of Africa.
- Artemisinin partial resistance **puts pressure on partner drug** and might trigger de novo emergence of resistance or selection of existing partner drug resistance.
- There are huge gaps in information and data that urgently needs to be addressed



Way forward

- Need to **define a strategy to respond to antimalarial drug resistance in Africa**, and
 1. Prevent the emergence of resistance
 2. Tackle resistance once it has emerged
- Strategy will rely on a **better use of existing tools & development of new tools & strategies**, with actions at global, regional and local level

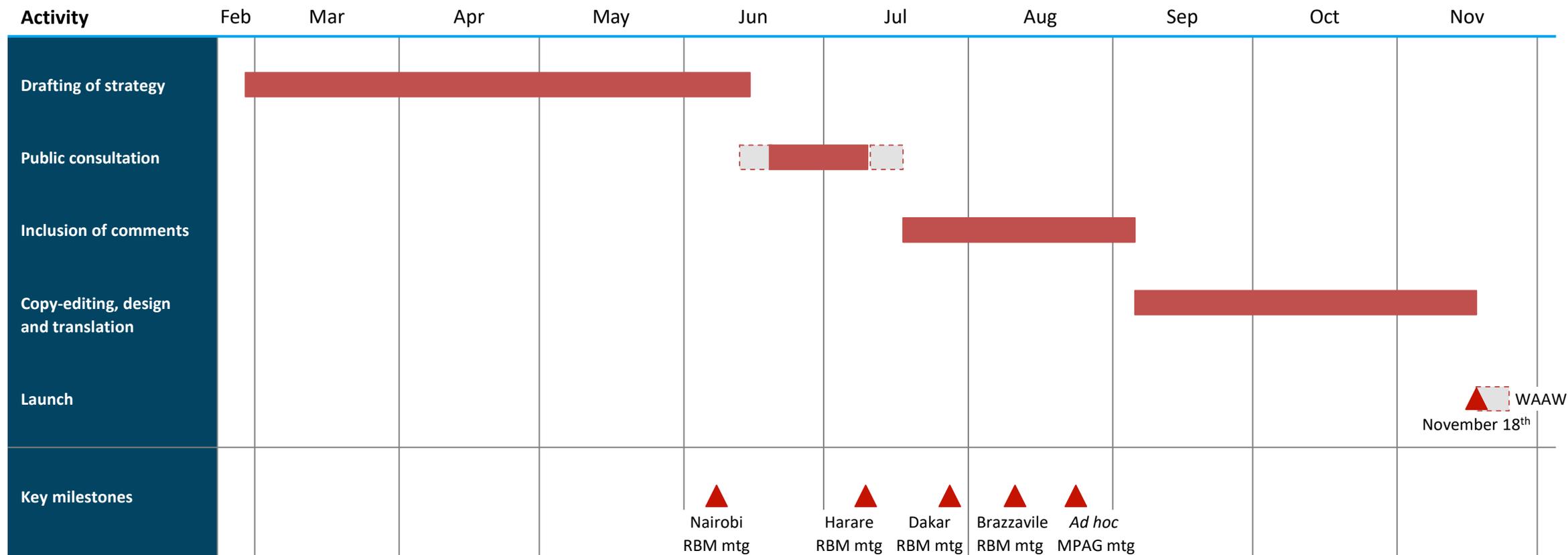
Large consultation & literature review in progress, convergence on building blocks of strategy



Key outputs

- Align on high-level list of **drivers of resistance**
- Align on high-level list of **interventions that could be deployed** to detect and respond to resistance (*see next pages*)
- Collect **relevant data and evidence**
- **Test framework of interventions** and identify key success factors for the strategy (e.g., stakeholders to involve, regional coordination, etc.)

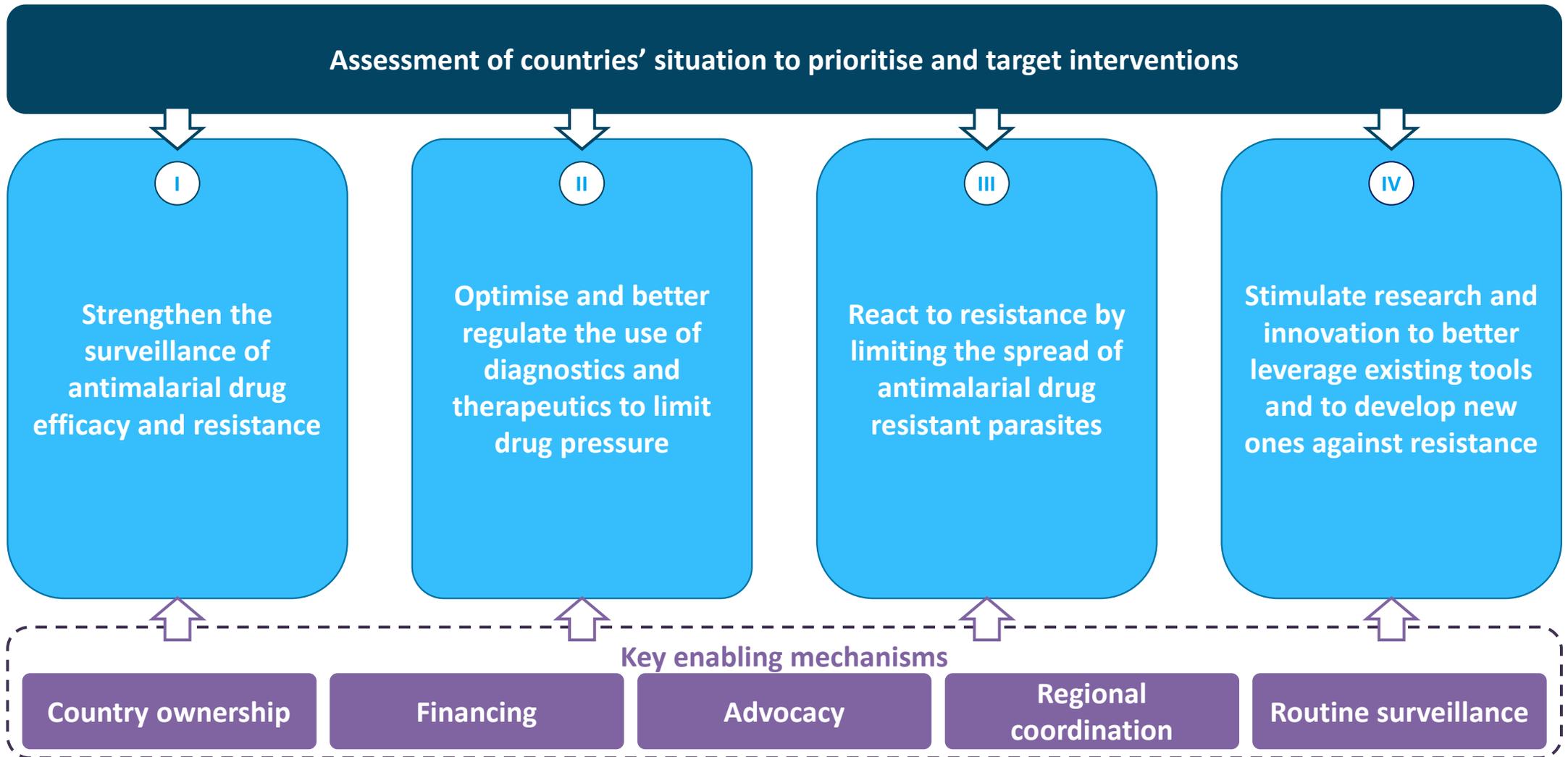
Public consultation will begin in end June, Strategy to be launched in November during Worldwide Antimicrobial Awareness Week



Note: one-week buffer for public consultation
 Global **Malaria** Programme

Proposed interventions

Four proposed areas of interventions to be prioritised and targeted through country assessment



Pillar I | Strengthen the surveillance of antimalarial drug efficacy and resistance

Challenges

Data not collected in line with standard protocols causing issues of comparability and quality

Insufficient lab capacity for genotyping and pharmacokinetics

Quality of samples and analysis inconsistent

Insufficient geographical and longitudinal coverage of surveillance

Detailed data needed to characterize resistance and track parasite changes

Delays in communication and dissemination of data hinders timely, coordinated response



Proposed interventions

1.1 Enhance capacity and capabilities to ensure better quality and standardised data on efficacy and resistance

1.2 Increase coverage of surveillance on efficacy and resistance

1.3 Increase detailed data collection on resistance from selected sites

1.4 Improve data dissemination systems to facilitate reactive and coordinated response to resistance data

Pillar II | Optimise and better regulate the use of diagnostics and therapeutics to limit drug pressure

Challenges

National policies not always in line with WHO recommendations (e.g., second-line treatment)

Reliance on a few ACTs and risk of delays in procurement if change is needed

Substandard and/or falsified drugs in circulation

Access to quality care uneven

Overuse / misuse of monotherapies

Instances of misdirected demand / utilization

Proposed interventions

2.1 Develop national treatment policies that promote deliberate use of existing treatments to prevent the emergence and the spread of resistance

2.2 Promote the availability of a diversified drug portfolio in countries

2.3 Prevent exposure to subtherapeutic drug levels driven by substandard/falsified ACTs by promoting drug quality

2.4 Remove non recommended monotherapies and ensure that other monotherapies are used in accordance with guidelines

2.5 Promote equitable access to quality drugs

2.6 Promote equitable distribution of and access to high quality diagnostics to reduce drug pressure

2.7 Empower patients, health care workers and other stakeholders to make informed decisions and provide appropriate treatment



Pillar III | React to resistance by limiting the spread of antimalarial drug resistant parasites

Challenges

Room to improve coverage and implementation of preventive measures

Recrudescence cases pose risk for transmitting resistant parasites

Artemisinin-resistant parasites may have increased gametocyte carriage

Nationally-centred only approach could limit effectiveness of response to resistance



Proposed interventions

3.1 Ensure optimal malaria vector control interventions coverage in priority areas

3.2 Leverage preventive measures to reduce transmission of antimalarial drug resistant parasites

3.3 Limit the risk of increased transmission of resistant parasites

3.4 Strengthen cross-border collaboration on malaria activities to ensure coordinated action

Pillar IV | Stimulate research and innovation to better leverage existing tools and to develop new ones against resistance

Challenges

Uncertainty regarding feasibility, acceptability and impact of innovative approaches using current tools

Uncertainty on settings / populations where resistance is more likely to develop

Need for combinations not reliant on artemisinin and with drugs with better matched half-lives

Limited knowledge of mechanisms of resistance and markers are missing for key drugs

Proposed interventions

4.1 Identify innovative approaches using currently available drugs to delay the development and spread of resistance

4.2 Identify areas and populations where drug resistance is deemed more likely to develop and spread

4.3 Develop new treatments with the objective of delaying the emergence and the spread of resistance

4.4 Identify and develop innovative tools to limit malaria infection and transmission

4.5 Conduct research and modelling to better understand and track resistance



Assessment of country's baseline | Need to assess different country specific challenges and opportunities to determine how to prioritise and target interventions



Current drug efficacy, resistance situation and data availability

- Efficacy data
- Known molecular markers in country and region
- Coverage of available and up-to-date data
- Capacity and quality of surveillance
- Processes of data sharing



Potential important drivers of resistance in the country

- Access to, availability and use of diagnostics, drugs, and vector control interventions
 - Treatment seeking patterns
 - Drug availability
 - Drug use
 - Regulation of private sector
 - Quality of drug and management of supply chain
 - Diagnosis availability, use and quality
 - Vector control availability and use
- Current behavioural drivers behind care providers and patient choices
 - Knowledge and understanding
 - Practices
 - Communication
 - Felt needs and preference
 - Barriers and incentives that could affect effectiveness of interventions



Areas and populations with higher risk of resistance developing and spreading

- Burden and transmission
- Data gaps
- Demographic and social patterns of access to services and vector control
- Demographic and social patterns of over- and misuse of treatment
- Population groups with limited or no access to regular health services and groups with increased risk of malaria



Capacity, opportunities and bottlenecks affecting successful implementation

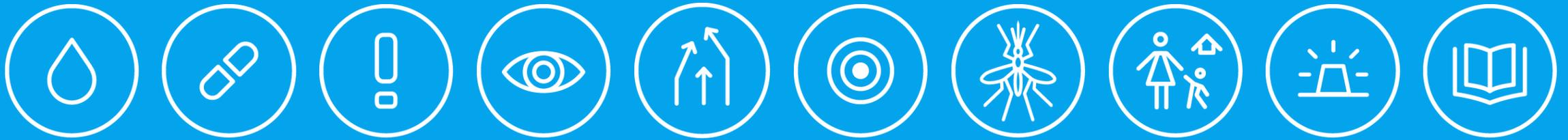
- Structures, resources and initiatives that may affect the capacity to implement

Public consultation open for the draft of the Strategy to respond to antimalarial drug resistance in Africa

- The consultation aims at further expanding contributions
- Strategy available for public consultation from June 23rd to July 22nd
- **Document can be accessed at: <https://www.who.int/news-room/articles-detail/draft-strategy-to-respond-to-antimalarial-drug-resistance-in-africa>**



Thank You



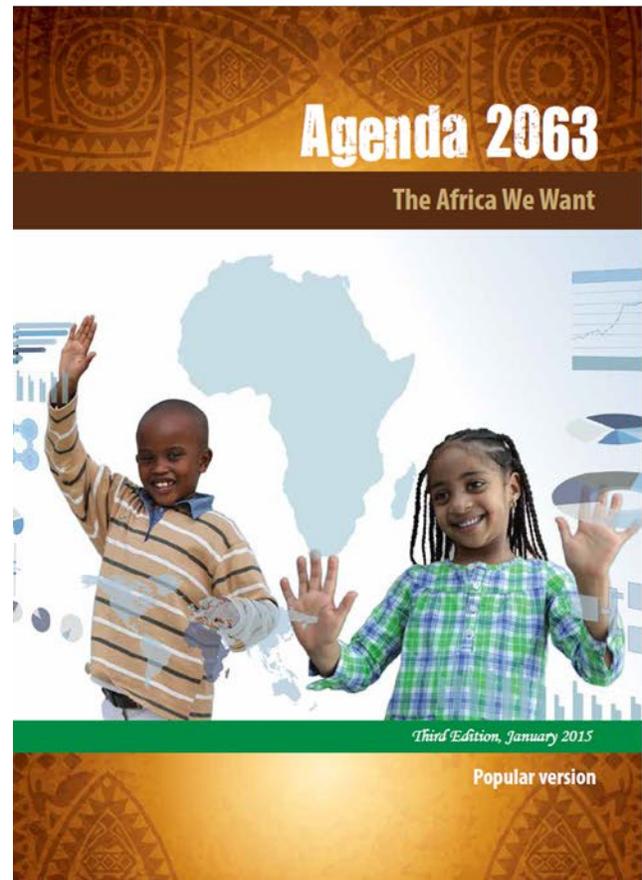
Global **Malaria** Programme



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Organization



Malaria Control and Elimination in the Africa Union



AFRICAN UNION

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Website: www.africa-union.org

SPECIAL SUMMIT OF AFRICAN UNION
ON HIV AND AIDS, TUBERCULOSIS
AND MALARIA (ATM)
ABUJA, NIGERIA
12-16 July 2013

DECLARATION OF THE
SPECIAL SUMMIT OF AFRICAN UNION ON HIV/AIDS,
TUBERCULOSIS AND MALARIA

"ABUJA ACTIONS TOWARD THE ELIMINATION OF HIV AND AIDS,
TUBERCULOSIS AND MALARIA IN AFRICA BY 2030"

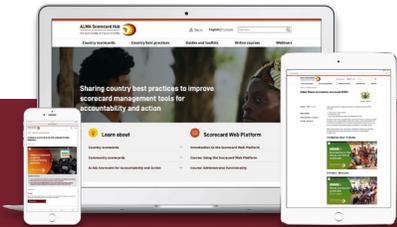
Abuja, Nigeria, 16 July 2013

Catalytic Framework to End AIDS, TB and Eliminate
Malaria in Africa By 2030

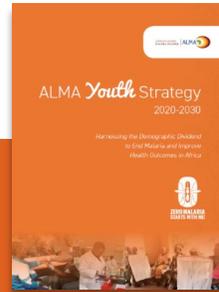
Stride towards sustainable health in Africa

An integrated, prosperous and peaceful Africa, driven by its own citizens, representing a dynamic force in the international arena

H.E. President Uhuru Kenyatta outlined key priorities to accelerate progress against malaria



Increased digitalisation and use of evidence-based tools (including national malaria scorecards and workplans)



Creation of national Malaria Youth Armies to recruit and engage youth leaders to champion the fight against malaria

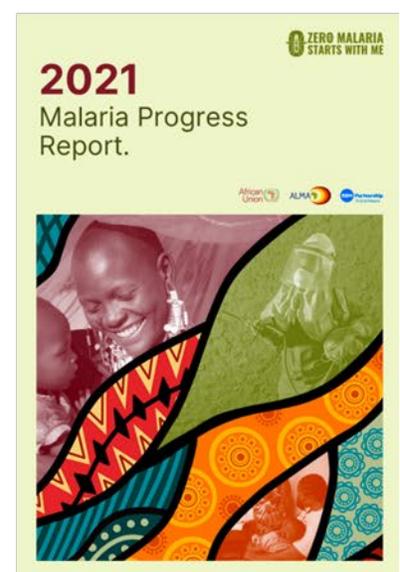
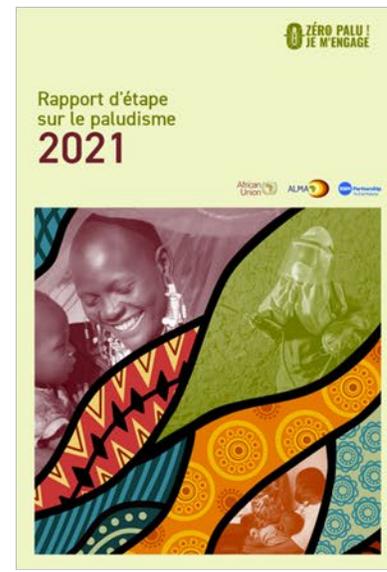
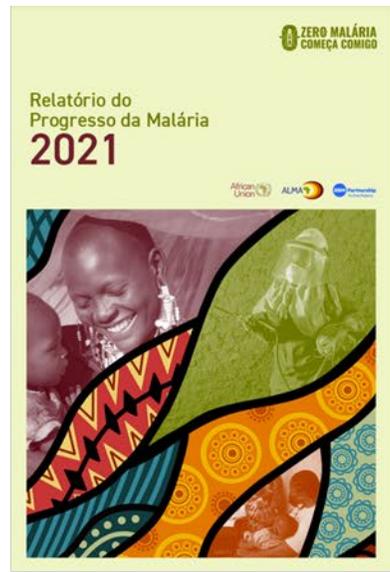
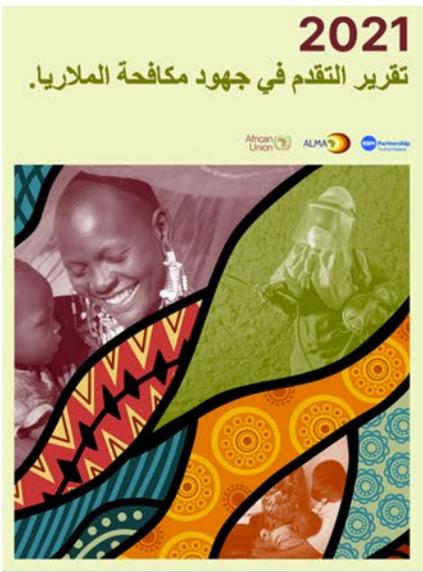


Establishment of End Malaria Councils & Funds to support a multisectoral response to malaria

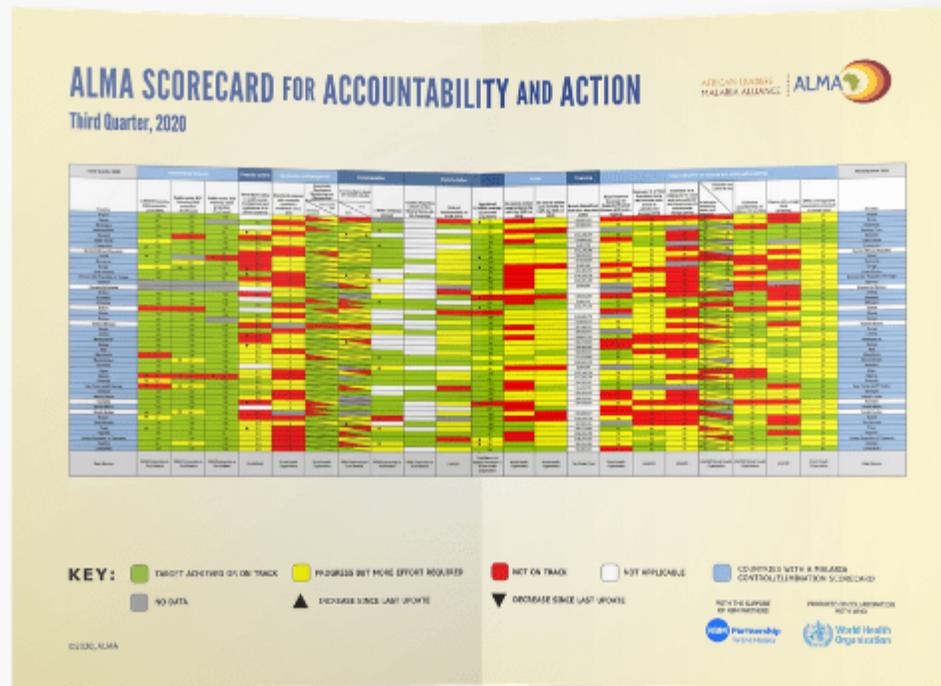


Enhanced regional coordination on malaria through Regional Economic Communities

Renewed commitment to local manufacturing of commodities

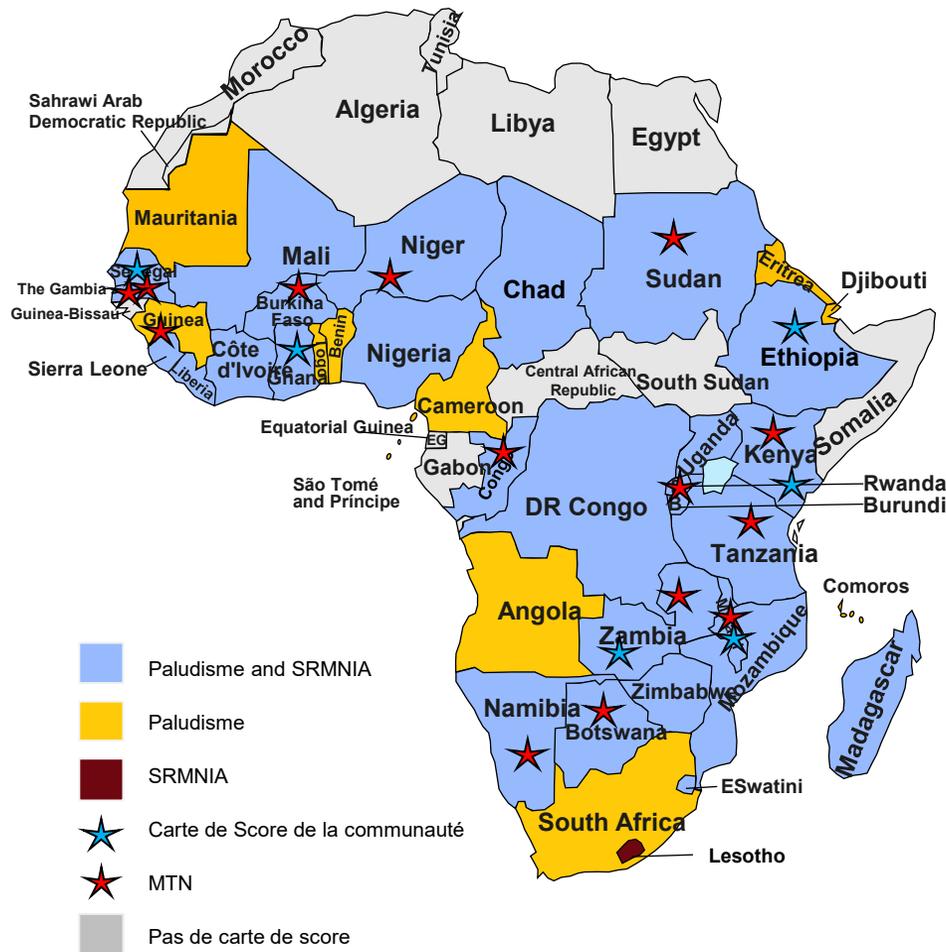


The ALMA Scorecard for Accountability and Action highlights performance on key indicators for Heads of State & Government



- The ALMA scorecard is produced quarterly and is shared with Heads of State and Government, Ministers of Health and Finance and ambassadors
- Includes a mixture of malaria indicators, as well as indicators on Neglected Tropical Diseases, RMNCAH, and COVID-19
- The accompanying quarterly reports include progress updates, recommended actions and response

ALMA has supported countries in the implementation of 40 malaria, 29 RMNCAH, 13 NTD, 3 nutrition, and 6 community scorecards for accountability and action



Country scorecard management tools are country-owned tools used to:

- track national and sub-national real time health data against priority indicators aligned to national plans
- identify bottlenecks or gaps
- increase accountability
- enhance decision-making to drive action

They are integrated into existing accountability and management processes

Drive action including addressing upsurges, stock-outs, task-shifting, filling resource gaps etc

Used at National, Sub-national and even community levels (quality of care) and at both technical and political levels



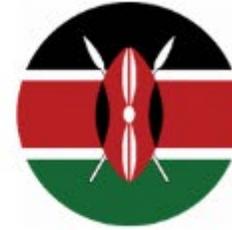
Tanzania trained 90 additional members of parliament in the use of the malaria scorecard



Nigeria linked their scorecard to the new Malaria Data Repository (DHIS2) and is planning to decentralise to State level in 2022



Zambia piloted their community scorecard (CSC) and made training videos, linked the scorecard to DHIS2 and scorecard used during EMC meetings



Kenya linked their malaria scorecard to DHIS2, and decentralized malaria scorecard to 10 malaria epidemic prone counties



Ghana's mobilized \$3.2m for strengthening scorecard use at community level, and linking it to AMMREN (media). Trained parliamentarians on scorecard



DRC strengthened the capacity of a central level team in preparation for decentralisation



Angola decentralised the malaria scorecard to all Provinces and linked the scorecard to DHIS2



Guinea decentralised the malaria scorecard to all Regions and Districts and linked the scorecard to DHIS2



Burkina Faso decentralised malaria scorecard to three regions with CHAI support



Mozambique linked the scorecard to DHIS2 and now includes health facility level data



Togo linked to DHIS2 and decentralised their malaria scorecard to all regions and districts of country,



Burundi linked scorecard to DHIS2 and decentralised to all regions

COMMUNITY SCORECARDS

- Social accountability tool mobilising communities to be more active participants in health systems strengthening
- On a quarterly basis, community votes and scores indicators related to quality of care to produce scorecard
- Community and health facility staff develop joint action plans to address gaps identified in scorecard
- Scores and action plans are uploaded into HMIS and online web platform to produce colour-coded scorecards with aggregate data that can be used by all stakeholders to identify and address bottlenecks
- ALMA has supported community scorecards in Ethiopia, Ghana, Malawi, Senegal, Zambia, and Kenya.
- Common indicators: Respectful care, Waiting times, availability of medicines, Quality of infrastructure, Cleanliness and safety of facility, management, CHW services, insurance, emergency vehicle

Scoring session



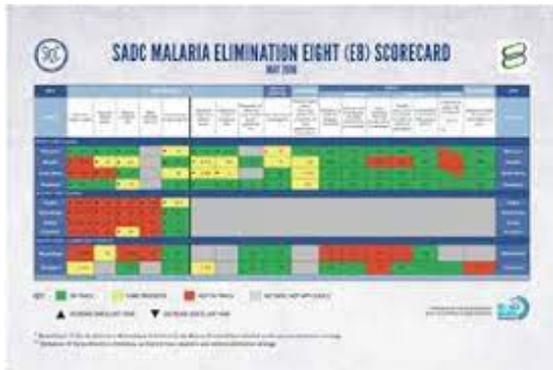
Community feedback captured in scorecards

Region	Community scorecard					
	Caring, respectful and compassionate care	Waiting time for provision of health care services	Availability of medicines, diagnostic services and medical supplies	Availability, accessibility of health care service and infrastructure	Leadership and management of facilities	Cleanliness and safety of facility
Sub-district	100	100	43	43	100	100
CHPS Zone A	33	100	33	33	33	67
CHPS Zone B	100	100	67	67	100	100
CHPS Zone C	67	100	33	33	100	67

Action plans



Work is ongoing with Regional Economic Communities to engage Heads of State and Government to address challenges and provide solutions to end malaria



Regional scorecards for review by Heads of State & Government and Ministers of Health & Finance



Sharing lessons learned and best practices



Awards for Excellence at the regional level

Regional economic community	Sign memorandum of understanding	Develop work plan	Engage Head of State and Minister forums	Develop sub-regional scorecard
 SADC	✓	✓	✓	✓ <i>E8 Scorecard</i>
 ECOWAS	✓	✓	✓ <i>Parliamentarian engagement</i>	✓
 ECCAS	✓	✓	✓	 <i>Preliminary discussions underway</i>
 EAC	✓	✓ <i>Great Lakes Malaria Initiative</i>		✓
 IGAD	✓	✓	 <i>Malaria TWG reactivated as part of IGAD structure</i>	

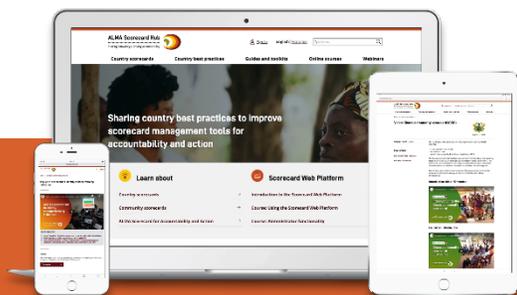
- Ongoing support to the E8 Scorecard, SADC Annual Malaria report and Strategic Plan
- Malaria advocacy mainstreamed into the virtual Minister’s meetings

- Supported development of the SaME scorecard and SaME RM Plan
- Launch of the REPEL network

- Held a joint ALMA RBM brief for ECCAS Commissions
- supported strategic plan

- Supported resource mobilisation for EAC Secretariat on malaria coordination
- Strengthening of GLMI Scorecard

- Supporting the implementation of a regional work plan
- Conducting a rapid assessment of the malaria situation



ALMA Scorecard Hub

A public directory of scorecard tools shared by African countries (filterable by country, scorecard type and year)

Country best practices and video case studies highlighting how countries have used scorecard tools for impact

Guides and toolkits to provide step by step guidance on creating, analyzing and improving scorecard tools

Online courses for ministry of health national and sub-national staff to build their capacity on the scorecard management tools

Events and webinars to encourage users to share experiences of using scorecards and to develop a community of practice

Technical support for ministries of health to request help and guidance with scorecard management tools

All materials available in English and French

Additional funding support from:



ALMA Scorecard Hub

Since February 2021



34,000 visitors

have visited the Scorecard Hub since February 2021
Monthly avg: 2,430 visitors



940 people

have attended ALMA webinars
Webinar avg: 134 attendees



1,845 certificates

have been issued (including 700 young people)
Monthly avg: 132 certificates

Scorecard sharing



14 countries

have shared scorecards on the hub

10 countries share malaria scorecards



8 countries share RMNCAH scorecards



4 countries share NTD scorecards



Country best practices

The total numbers do not match because some best practices cover multiple health groups and some countries have multiple best practices.



44 best practices

available on the hub, covering case studies from 14 countries

16 malaria scorecard best practices



15 RMNCAH scorecard best practices

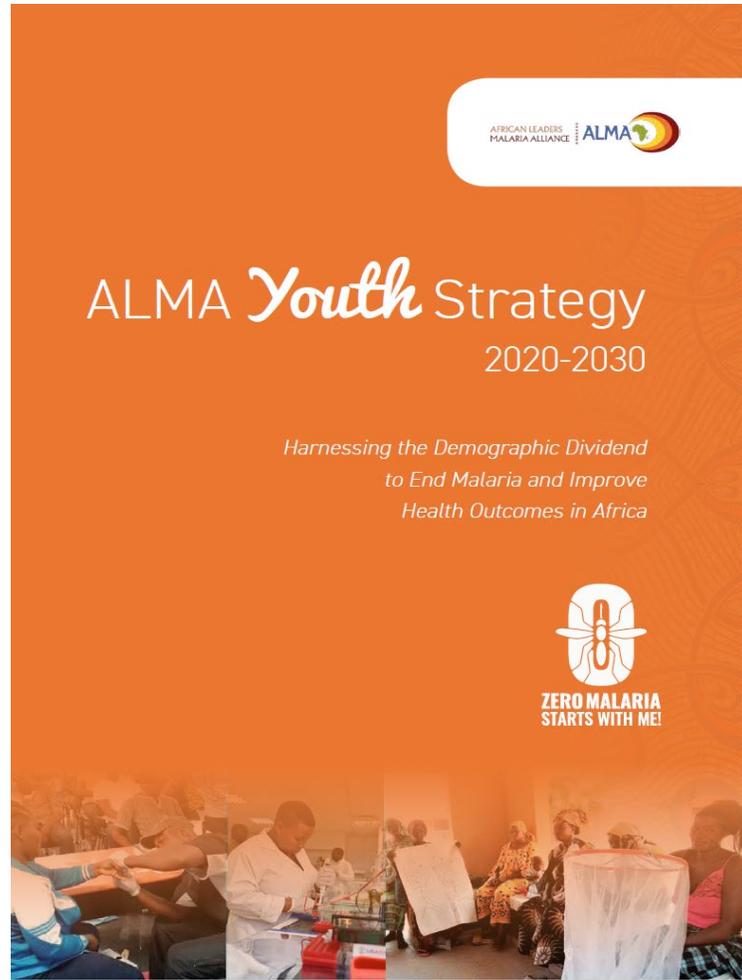


8 community scorecard best practices



7 neglected tropical disease scorecard best practices





Vision and Mission

Vision

Youth across Africa advocating and driving action towards malaria elimination and contributing towards Universal Health Coverage.

Mission

To promote mainstreaming of malaria into existing youth structures at continental, regional and country levels and have young people actively engaged in/at the centre of malaria elimination efforts in the context of Zero Malaria Starts with Me and Universal Health Coverage through advocacy, communication, and evidence-informed action.

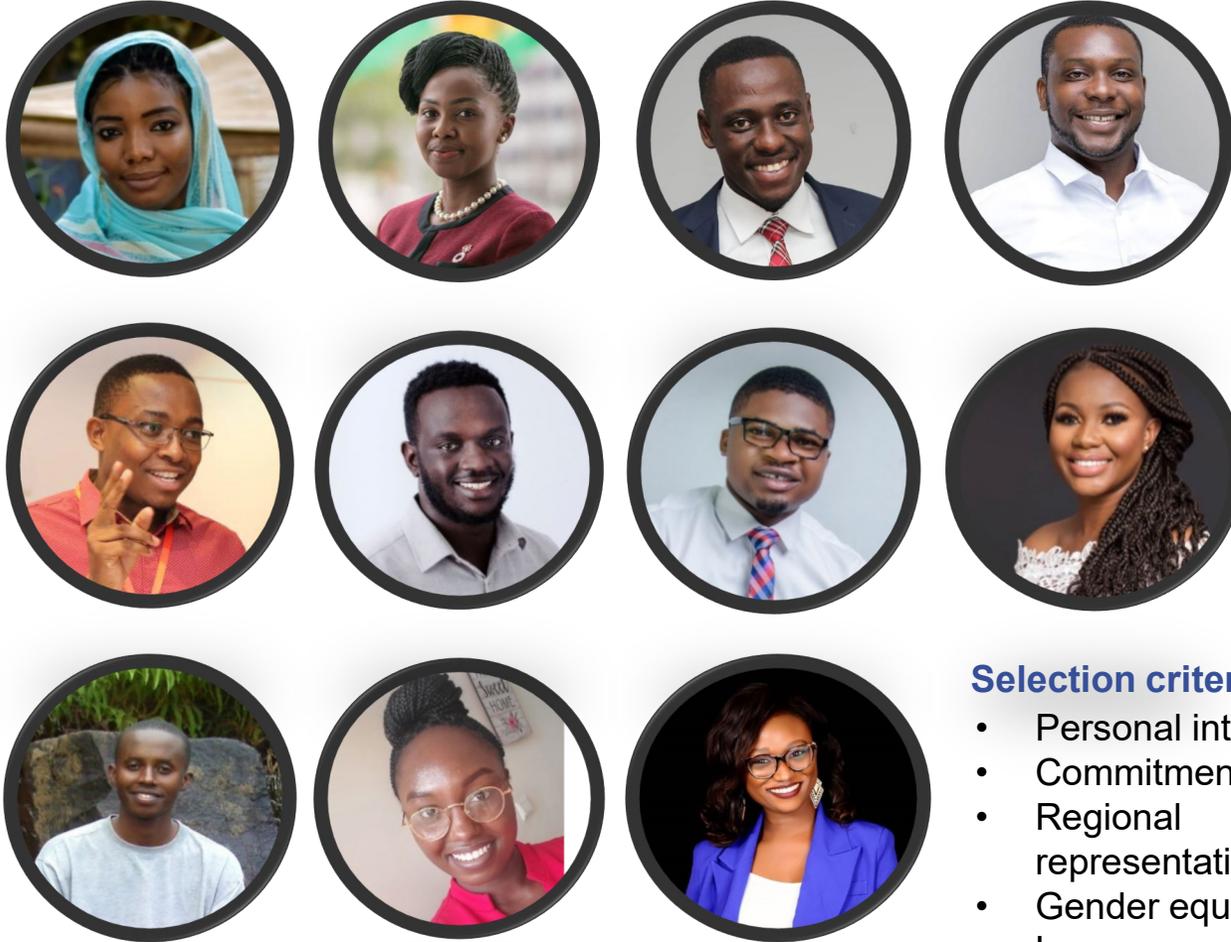
Objectives

Objective 1: At continental and regional levels, and through the engagement of young Africans in the diaspora, youth in existing structures are mobilized to form an ‘ALMA youth army’ to contribute to ending malaria and expanding Universal Health Coverage.

Objective 2: At country level, a cadre of youth (‘youth armies’) in existing leadership positions across sectors are advocating for malaria elimination and the expansion of Universal Health Coverage and are mobilizing collective youth-driven solutions, towards ending malaria.

Objective 3: Young people access advocacy tools, digital toolkits and best practice documents on the ALMA Scorecard Knowledge Hub to facilitate informed action against malaria.

ALMA Youth Advisory Council



11 members, young leaders from Africa and diaspora with a recognized background in malaria advocacy

Selection criteria:

- Personal interest
- Commitment
- Regional representation
- Gender equality
- Language

Key roles and responsibilities:

Advise ALMA on how to ensure youth participation in advocacy for malaria at continental, regional and country levels.

Serve as malaria and UHC ambassadors including through participation in key meetings, events and launches.

Support Country Youth Armies' activities in promoting existing youth initiatives and in mainstreaming malaria and UHC in their existing agenda as well as engaging in existing malaria forums including national dialogues and forums

Provide guidance on implementation plans for country youth armies

Participate in continental, regional and national youth coordination forums, meetings on malaria and UHC particularly those organized in collaboration with ALMA

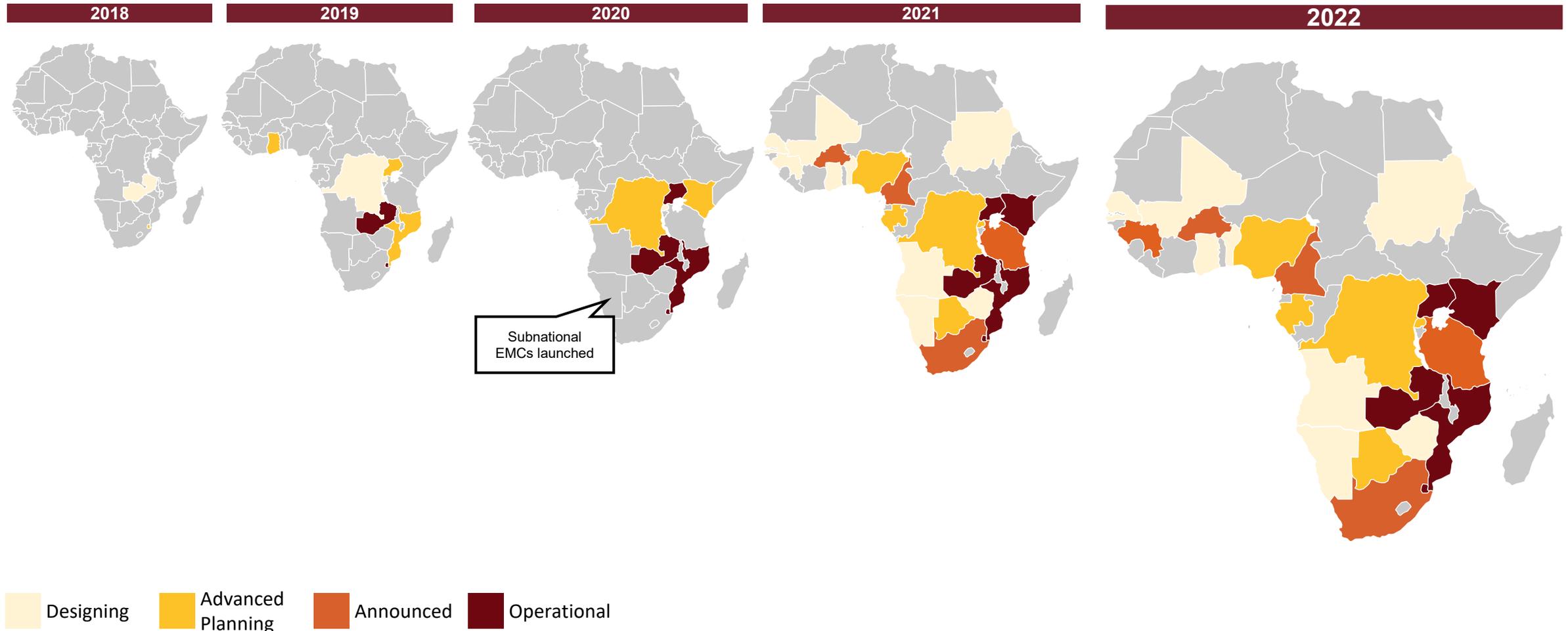
WMD celebration: A voice A Day Campaign; Video Collage; Engage a Youth Webinar; Feature article on the ALMA Website

Produce a biennial (every two years) assessment report on effectiveness of the ALMA youth strategy implementation and recommend improvements.

National Malaria Youth Armies are launching across the continent to mobilise a new generation of advocates and leaders



End Malaria Councils and Funds are rapidly increasing across the African continent



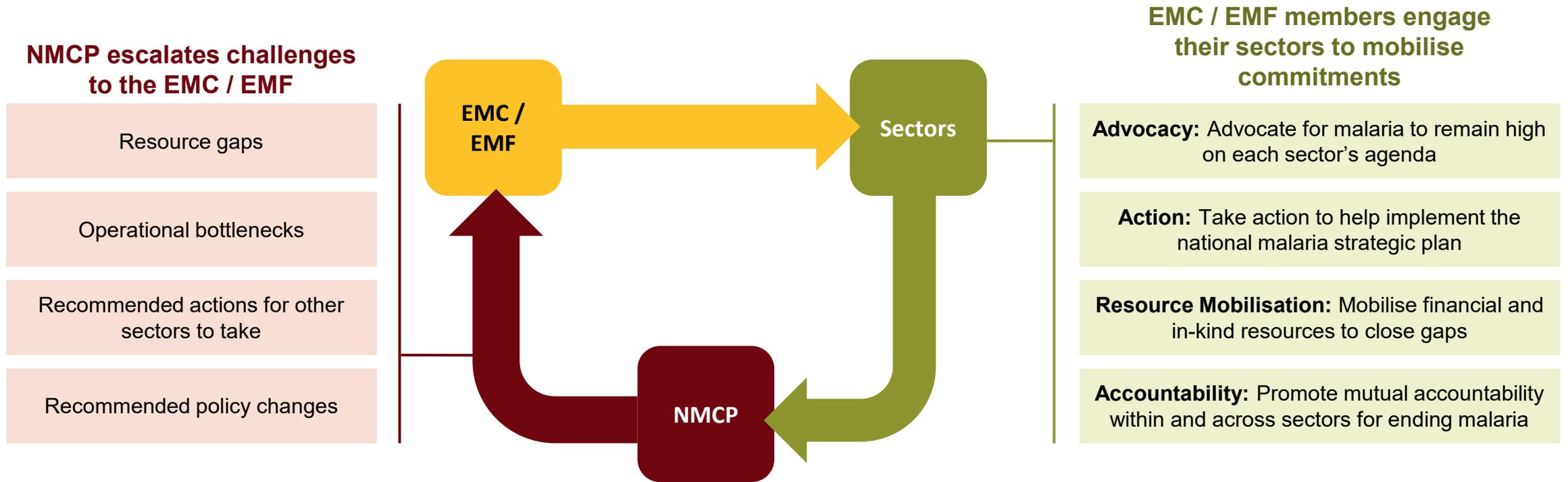
End Malaria Councils & Funds are country-owned and country-led, multisectoral mechanisms that support the national malaria strategic plan



EMCs are a forum of senior leaders that meet quarterly to review the status of malaria control and elimination (including via the national scorecard).

The members then engage their respective sectors to mobilise commitments for advocacy, action and resources to address gaps to support the fight against malaria.

End Malaria Councils & Funds mobilise commitments for advocacy, action, resource mobilisation, and accountability to address gaps and bottlenecks faced by the NMCP



The NMCP remains primarily responsible for implementing the national strategic plan with the support of commitments mobilised by the EMC / EMF

National malaria scorecards can help prioritise gaps and drive advocacy, action and resources through EMCs



The national malaria scorecard is used in EMC meetings to prioritise areas of focus and promote mutual accountability for achieving national targets

Region	Vector Control		Case management			Surveillance			
	% US children receiving LLIN through EPI	% of Pregnant women receiving LLIN through ANC	% of Pregnant women that receive ≥3 doses of IPTp through ANC	Proportion suspected malaria cases that receive a parasitological test by public facilities	Case Fatality Rate (CFR)	Malaria incidence rate	Proportion of malaria cases confirmed	% of facilities with complete reporting	Timeliness of reporting
Zambia									
Central					2%	114			100%
Copperbelt					1%	114			100%
Eastern									100%
Lusitula			12%		1%	121	52%		
Lusaka								100%	100%
Muchinga					2%			100%	100%
Northern					2%	107			100%
North Western					1%				100%
Southern					13%	120			100%
Western					2%	120			100%

Source : NMEP Scorecard

National malaria scorecard being presented to the End Malaria Council during the June 2019 EMC meeting

Context

- In 2019, the scorecard showed very low levels of IPTp coverage

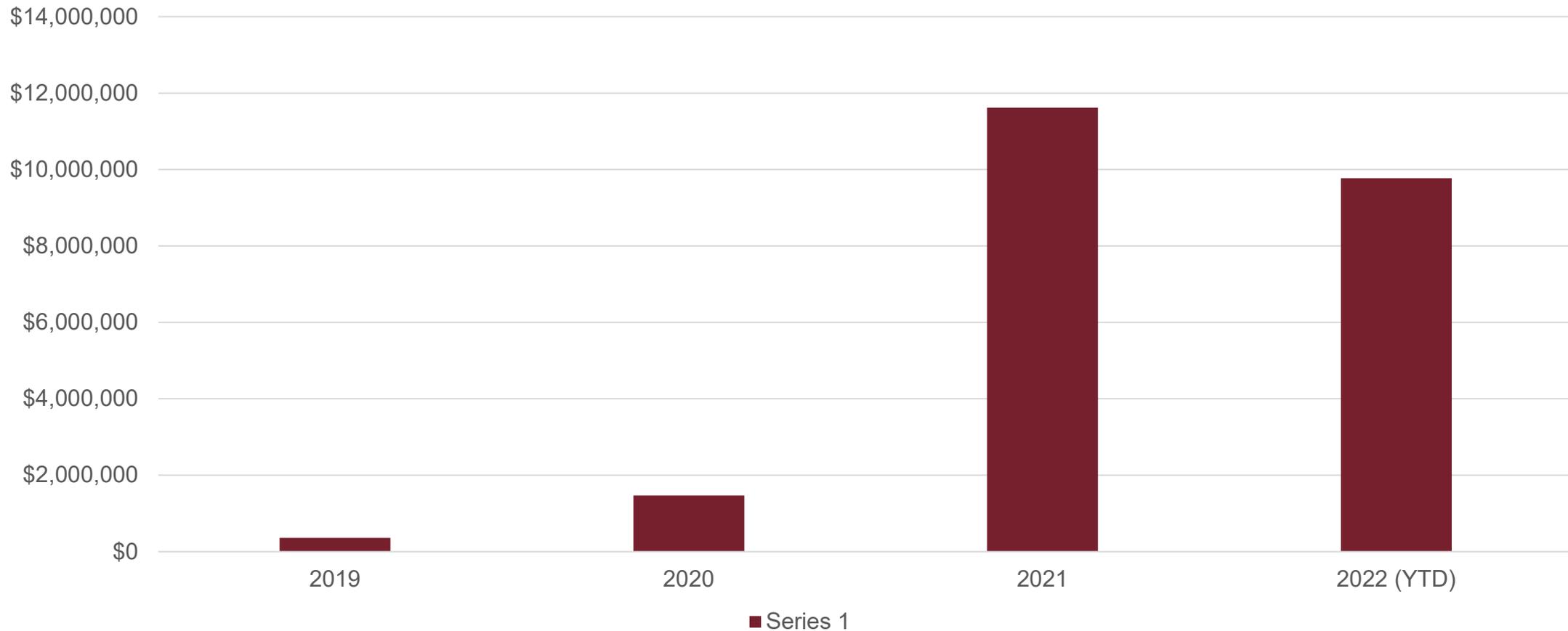
EMC engagement

- Private sector and community leaders engaged the Ministry of Health about the root causes of lower performance
- It was revealed that there was a nationwide stock-out of SP and no funding to procure additional supply

Actions taken

- A task force was established to mobilise resources for SP
- Partners provided emergency funding to procure replacement stock
- The private sector pledged to support sustainable sourcing of commodities

More than \$23 million USD in financial and in-kind commitments have been mobilised by End Malaria Councils & Funds





- Malaria Free Uganda is a non-profit foundation established in 2020 to mobilise advocacy, action and resources
- Managed by a multisectoral Board of Directors

FOSUN PHARMA

Provided \$200,000 USD in in-kind training of health workers and pharmacists on malaria diagnosis and treatment

Ecobank
The Pan African Bank

Pledged \$120,000 USD in matching funds to support private sector resource mobilisation under ZMBLI



Pledged to provide in-kind transportation of malaria commodities



- Coalition of multisectoral leaders launched in February 2021 to mobilise advocacy, action and resources for the Kenya Malaria Strategy



- Met with executives from SC Johnson during the launch of the Great Lakes Malaria Initiative
- Signed multi-year Memorandum of Understanding to support SBCC, vector control, local manufacturing, and other priorities.

ALMA has partnered with AUDA/NEPAD, MMV and others to support local manufacture



Lead advocacy for the implementation of the Pharmaceutical Manufacturing Plan for Africa by NEPAD

Highlight bottlenecks in local manufacturing and registration with African Heads of State and Government.

Support streamlining of pharmaceutical regulation through dissemination of our assessment of regulatory frameworks.

Promote harmonization of registration of vector control products through Regional Economic Communities (RECs).

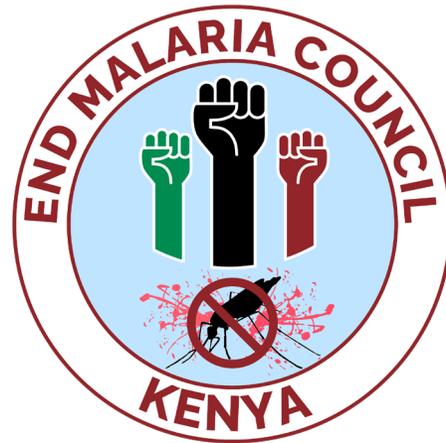
Identify opportunities to address gaps and increase investments in local manufacture and facilitate technology transfer (e.g., Tanzania)

Assess national manufacturer capabilities and provide focused support to generic manufacturers to achieve WHO prequalification (e.g. MMV technical assistance to countries)

Details to follow

End Malaria Councils & Funds can help drive multisectoral advocacy and action to stimulate local manufacturing

End Malaria Councils are a potential mechanism for helping create an enabling environment for local manufacturing



- Supported a landscaping analysis of local manufacturing firms in Kenya that could produce malaria and other health commodities
- Established partnership with SC Johnson to drive advocacy to remove barriers to local manufacturing
- Directly engaged the Cabinet Secretary for Health on issues of tariffs for raw manufacturing materials
- Includes representation from several industrial and manufacturing firms

A number of barriers continue to limit the local manufacturing of malaria and other health commodities



High labor costs,
scarcity of available
expertise



Taxes on imported
raw materials
(imported finished
products are
exempted from
taxes)



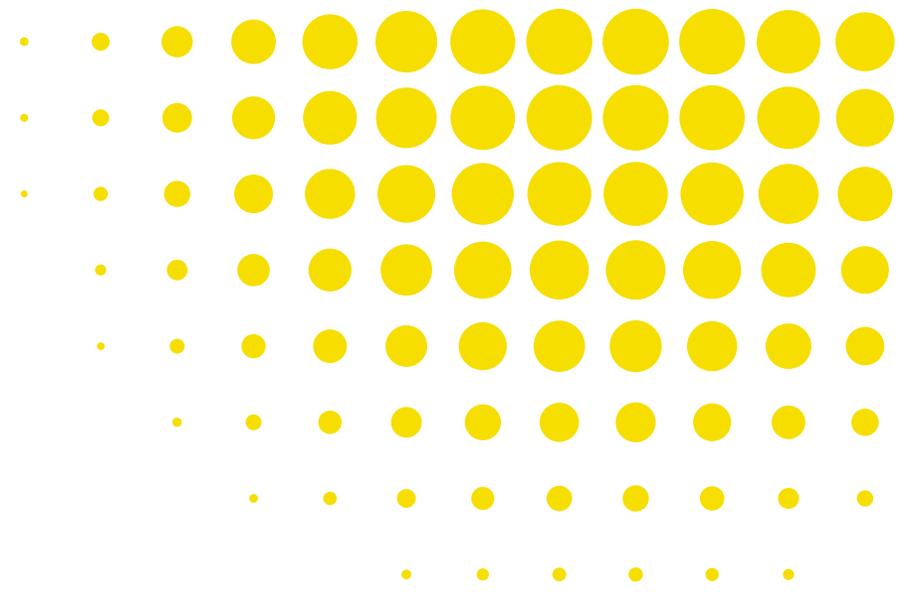
Unfavorable foreign
currency policies



Lack of assurance
of regional and
international
markets

Conclusions & recommendations

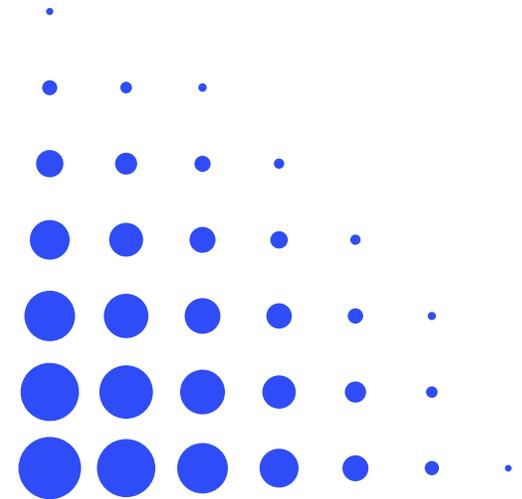
- 1 We greatly appreciate the efforts made to sustain malaria high on the development agenda
- 2 We encourage countries to further institutionalise national and subnational malaria scorecards and to publish them on the ALMA Scorecard Hub and in other forums to drive multisectoral accountability and action
- 3 We are excited about the Youth response across the continent and look forward to working with countries on Malaria Youth Armies
- 4 End Malaria Councils & Funds continue to gain momentum and we look forward to the upcoming launches
- 5 We look forward to increased cross-border coordination and collaboration, including through the Regional Economic Communities
- 6 Supply chain bottlenecks continue to be a challenge for global health commodities and we encourage the region to prioritise local manufacturing of malaria commodities to improve resilience



CRG and Malaria

Alistair Shaw, Community, Rights and Gender Department

07.07.2022



Agenda

1. Setting the Scene

Alistair Shaw

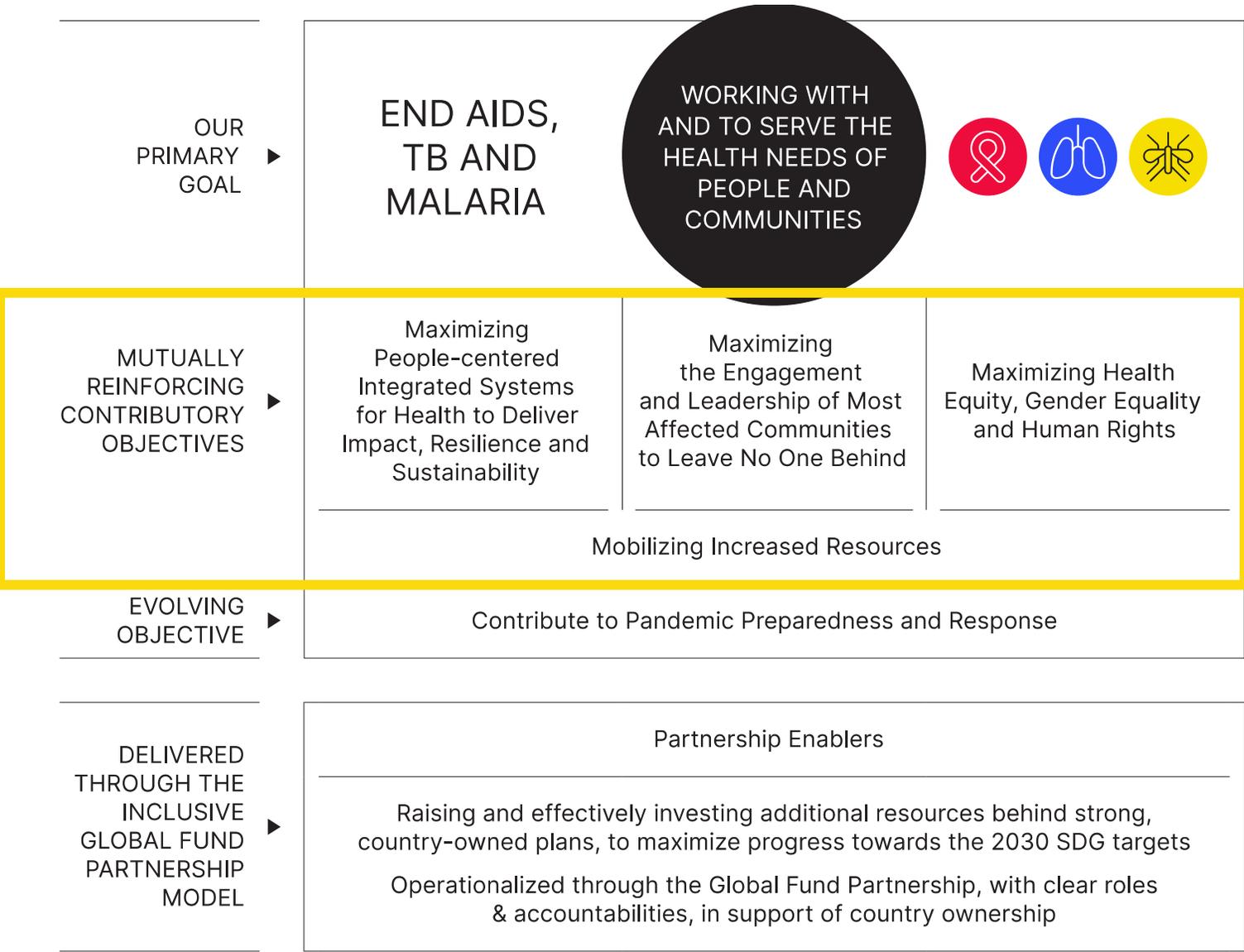
2. Training on Community, Rights and Gender in the Context of Malaria

Dr Denise Njama-Meya

3. Good Practices from Malaria Matchbox Assessments and Implementation of Findings

Olivia Ngou

The Global Fund Strategy Framework



- **Strategy’s primary goal** is to end AIDS, TB, and Malaria.
- **People and communities are at the heart** of our Strategy.
- Achievement of the primary goal is **supported by 4 mutually reinforcing contributory objectives** and an **evolving objective**.
- Partnership Enablers outline **roles and accountabilities** of all stakeholders.



Intensified action to address **inequities, human rights-** and **gender-related barriers**

A stronger **role** and **voice for communities** affected by malaria

Greater emphasis on **integrated, people-centered services**

Equitable health services through community engagement and a rights-based design and delivery approach

- Strengthen health outcomes through improved service quality and health services that **maximize the engagement of most affected communities, and maximize equity, human rights and gender equality.**
- **Strengthen data systems and effective use of data**, including from community-led monitoring, for decision making at all levels.
- Ensure **meaningful engagement of communities** and other relevant **experts in the design, delivery and monitoring of services**, and working with all partners to integrate services and related data to deliver people-centered quality care.
- **Promote collaboration** across sectors to **revise policies and practices** to tackle structural determinants of HTM outcomes, including human rights barriers, gender-related barriers and inequities.
- **Increase financial / non-financial contributions** to community-based and community-led services.

Available Guidance, Support and Training

- **Malaria Information Note 2022 and Modular Framework**
- **RSSH Information Note 2022**
- **Technical Brief on Malaria, Gender and Human Rights**
 - Current version: November 2019
 - Revised version: Available mid-2022
- **Technical Assistance**
 - CRG Strategic Initiative Technical Assistance Program aimed at meaningful engagement of communities (available to communities and civil society and CCMs in some situations)
 - Human Rights and Gender Technical Assistance (through RBM), available to NMCPs, CCM, PRs and other implementers from countries that have received CRG-related TRP comments during NFM3
- **Training**
 - Developed through the GF-RBM CRSPC relationship, eLearning and face-to-face training now addresses community, gender and human rights-related barriers in malaria programming and strategies to mitigate these barriers with the goal of establishing more equitable malaria programs.
- **Malaria Matchbox Tool**

Malaria Matchbox Tool

An equity assessment tool to improve the effectiveness of malaria programs

Identifying high risk and underserved populations most impacted by malaria and the equity, human rights and gender barriers they face to accessing quality malaria services

Designing programmatic approaches and interventions to address identified human rights-, community engagement- and gender-related barriers to malaria programmes



Country & Regional Support Partner Committee Update

National Malaria Programmes and Partners Annual Meeting, 2022

CRSPC Purpose

The CRSPC provides a platform to engage the RBM Partnership community in coordinating support to countries and regions as they execute their malaria control and elimination programmes.

Support is based on country demand and is tailored to suit the requirements, existing capacity and partner support

The CRSPC operates a triage mechanism to ensure that support does not compete with or duplicate existing mechanisms that are working effectively

Consultants are sourced from within the region where they are working (south south collaboration)

CRSPC Roles and Responsibilities

1

Technical Strategies and Implementation Plans

Role of the CRSPC

Co-ordinate support for the development and validation of technically sound, implementable, country-led malaria control and elimination strategies, and sustained financial plans

Example support provided

- Malaria Programme Reviews
- Updating National malaria strategic plans
- Regional strategies and plans

2

Resolve Implementation Bottlenecks

Co-ordinate an early warning system that **identifies bottlenecks** both proactively and reactively and implement a rapid response mechanism to support countries to overcome these implementation bottlenecks

- COVID-19 mitigation
- Planning and implementing campaigns (LLINs, SMC, IRS)
- High Burden High Impact
- Emergencies and upsurges
- Zero Malaria Starts with Me!
- Data sharing for joint problem solving

3

Resource Mobilisation

Co-ordinate and provide technical assistance and implementation support for comprehensive financial gap analyses, development of funding proposals and investment requests, fostering country coalitions, and coordinating engagement with donors at all levels to address bottlenecks and gaps

- Financial gap analyses
- Global Fund funding requests
- Identifying flexibility within existing sources of funding
- Innovating financing including End Malaria Funds

1 Support countries in the design of quality, prioritized programmes at country and regional levels

Support the design of quality, prioritized programmes at the country level

Support provided

- CRSPC in collaboration with WHO, has provided support to 3 countries and 4 regions in developing malaria strategic plans and in conducting MPRs with 3 more countries and 2 regions in process
- CRSPC is supporting 3 countries in the Malaria Matchbox implementation to identify and address barriers in CRG
- Support has switched from virtual to in-person support at the request of countries

Impact

- Align malaria planning with the broader health and development agenda, and support to resource mobilization.
- Opportunity to incorporate a mix of new tools and best practices, including strategy to ensure access to everyone.
- Enable countries to design policies, set new targets and improve their coordination systems, including incorporation of CRG programming

Building regional capacity in Africa and Southeast Asia

- Regional bodies: EAC (GLMI), SADC and E8, SaME, and SEA were supported in the development of the Malaria Strategic plans, coordination activities, and others
- Recruited focal points in EAC, SADC and WAHO to enhance regional capacity

- Align malaria planning with the broader health and development agenda, and support to resource mobilization.
- Mainstream malaria in the agenda of the regional economic communities including at Head of State, minister and technical level

2 Facilitate timely access to implementation support to address bottlenecks and gaps

Implementation support to address bottlenecks and gaps

- 23 implementation supports provided /ongoing to countries and regions through international and local consultants in 2022
- These include planning ITN, IRS campaigns in the context of the COVID-19 pandemic and working to support continuity of care by addressing resource gaps and commodity stock outs etc
- Other support included development of communication and behaviour change strategies, launch and implementation of Zero Malaria Starts with Me campaigns, Retrospective assessment of the malaria programme, surveillance etc



- Support has helped to mitigate against the impact of COVID-19

Support provided

Impact

COVID-19 continues to disrupt malaria control programmes



Commodity delivery times continue to be at least 2 months longer than before COVID-19 and countries have faced stock outs for case management as well as delays to campaigns. This has reduced during Q1 2022 compared to Q4 2021



Countries are reporting that domestic resources originally committed to malaria have been diverted to the fight against COVID-19



The cost of delivering commodities to end users and commodity prices have increased in 2022 – especially for LLINs

CRSPC Support

Essential Commodity Tracking: Tracking supply availability in countries (ACTs, RDTs, artesunate, LLINs, IRS, SMC commodities) and working to troubleshoot filling of gaps as they arise including resource mobilization, airlifting of commodities and splitting deliveries where required in close collaboration with PMI and the Global Fund and encouraging early procurement

Addressing Bottlenecks: Regular multi-partner check-ins with countries to track and problem solve as real time malaria programming bottlenecks arose including addressing upsurges, supporting countries in reprogramming and resource mobilization to address gaps, and working together across the partnership

Advocacy: Linking to political level as required to advocate against delays in campaigns and to sustain malaria programming

2 Support countries to Implement HBHI

Countries continued to implement the major activities in the four response elements

- Political Will
- Strategic Information to drive impact
- Better guidance, policies and strategies
- Coordinated national malaria response

In 2021, RBM and WHO organised quarterly partner coordination calls with HBHI countries to review the status of implementation of these activities

In 2022 we are undertaking a joint evaluation of the HBHI approach

All HBHI countries in Africa have been using their malaria scorecard management tools

Mozambique and **Uganda** have launched their End Malaria Councils and Funds and **Tanzania, Nigeria, Cameroun, Burkina Faso** and **DRC** are at an advanced stage of launching to keep malaria high on the national financing and development agenda

Enhanced parliamentary engagement in malaria e.g. Tanzania and Ghana

Sub-national Stratification has been mainstreamed into NSPs, MPRs and GF funding applications for ALL HBHI countries

Zero Malaria Starts with Me launched in 9 HBHI countries

Enhanced resources have allowed switch to PBO nets and expansion of SMC and CHWs

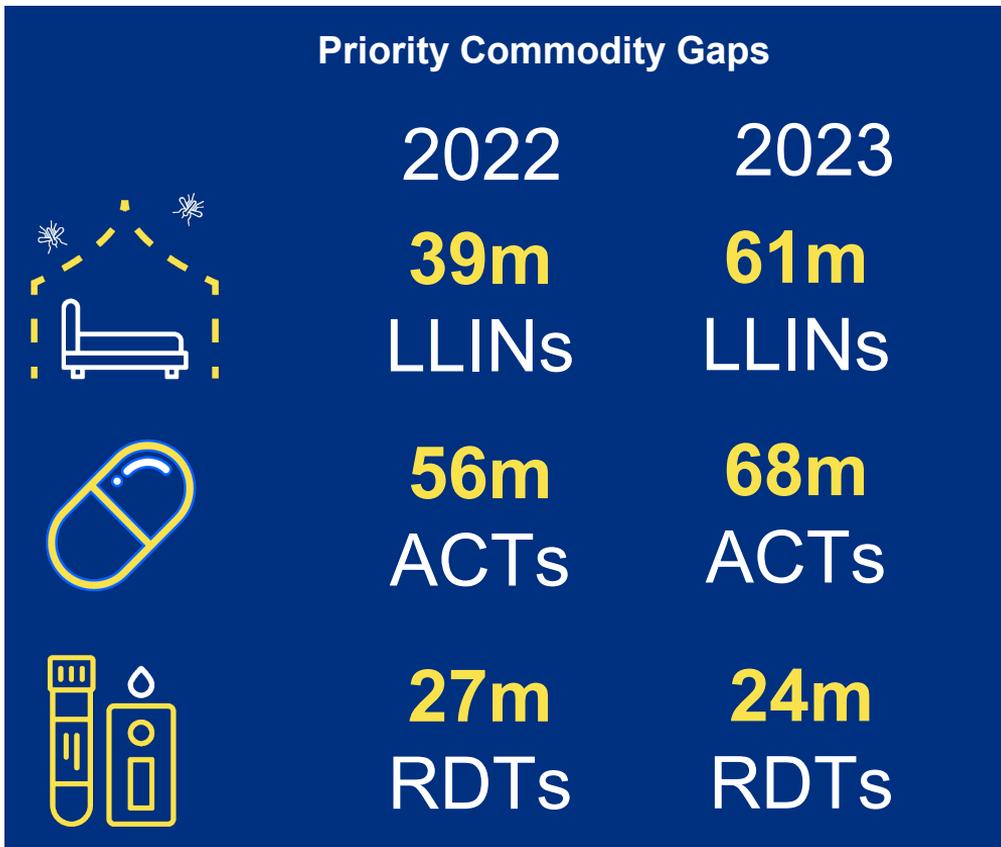
3 Support countries with mobilizing and prioritizing domestic and other resources

Support provided

- In 2022 CRSPC has supported MOSASWA in their GF application
- Supported Tanzania for domestic resource mobilisation and multi-sectoral engagement
- The country gap analysis for 2021-2023 period was compiled by CRCPC is available on RBM website

Impact

- Updated gap analysis revealed that 95% of highly and moderately endemic countries mobilised sufficient resources to cover their LLIN, IRS, SMC and case management gaps in 2022 but we still need to understand how the increased commodity prices and delivery costs will impact this



GF Funding Request Support

- To ensure timely submission of high quality funding proposals and to avoid gaps in implementation, the CRSPC will provide a comprehensive package of support to countries, based on a tried and tested country-led approach
 - GF Funding Application Orientation meeting to inform countries on the differentiated application approach and prepare detailed TA plans. (December 2022)
 - International consultants provide TA to support the development of the funding applications
 - Gap analysis (we recommend work begins now!)
 - Address outstanding TRP comments including issues around CRG/malaria matchbox implementation
 - Update MPRs/NSPs (support in collaboration with WHO)
 - Funding request development
- Funds to countries to support in-country consultations, country dialogue and recruitment of local consultants.
- Mock TRP meetings will be held to facilitate country peer review of draft applications.
- Remote expert review of final draft funding applications will be provided by CRSPC members
- Support is planned to assist countries to achieve timely grant signature (Grant making).

Priority Activities for 2022

Ensure countries have sufficient funding, capacity and political commitment to implement their National plans

1

Technical Strategies and Implementation Plans

- Support to MPRs and NSPs
- Support to the Malaria Matchbox implementation
- Support to Regional Economic Communities in strengthening the implementation of regional Initiatives and coordination
- Document best practices including in malaria matchbox implementation

2

Implementation Support

- Continue to support countries to mitigate the impact of the COVID-19 pandemic including support to address malaria upsurges, implement campaigns and address stock-outs
- Support to address bottlenecks
- Data sharing to facilitate joint problem solving
- Support implementation of HBHI approach and Zero Malaria Starts with Me campaigns

3

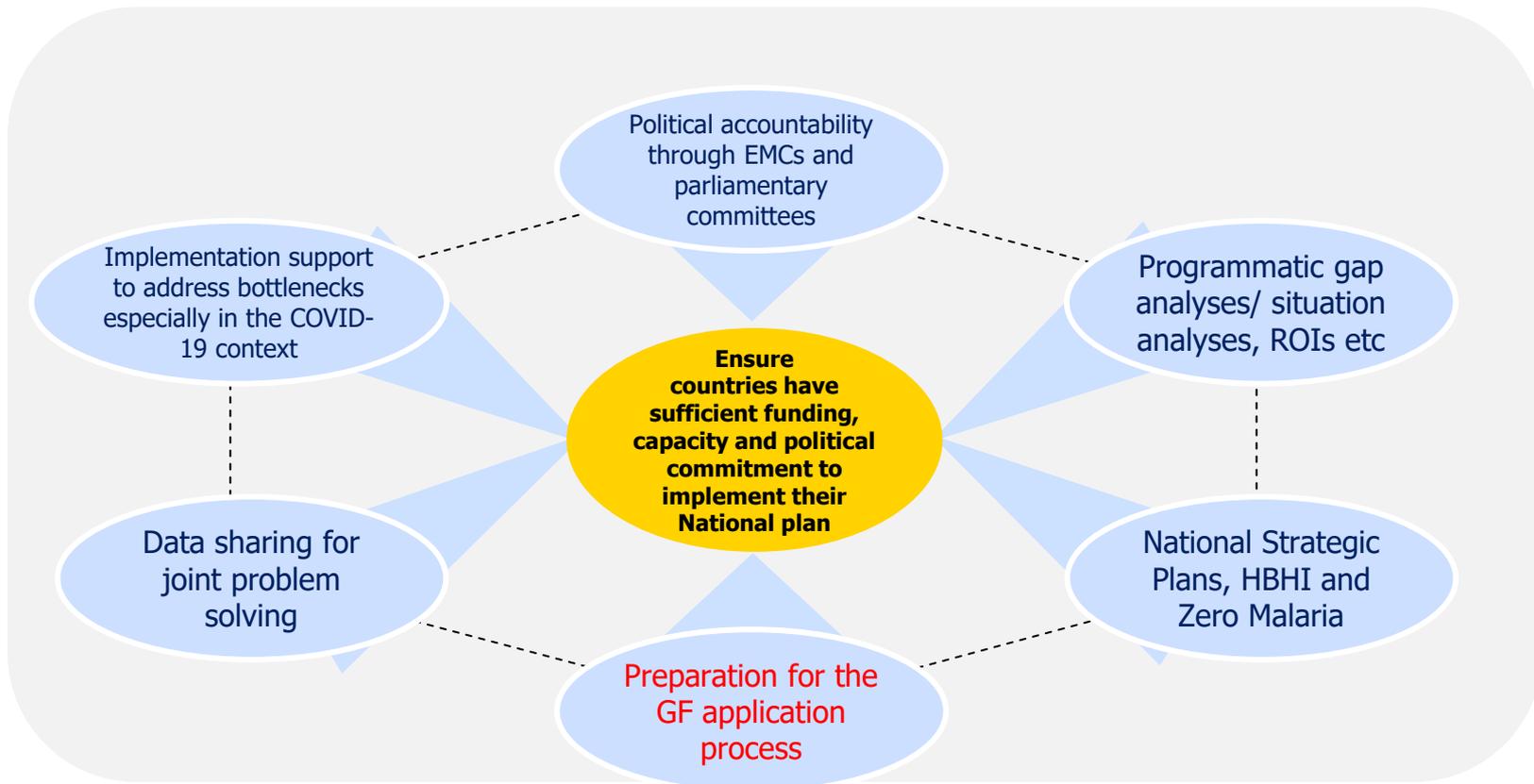
Resource Mobilisation

- Support Countries to initiate the process of NFM4 - GF funding applications including malaria and RSSH (CHWs/data for decision making) and positioning malaria at the forefront of PPR.
- Political accountability through EMCs and parliamentary committees
- Domestic Resource mobilization including through EMFs

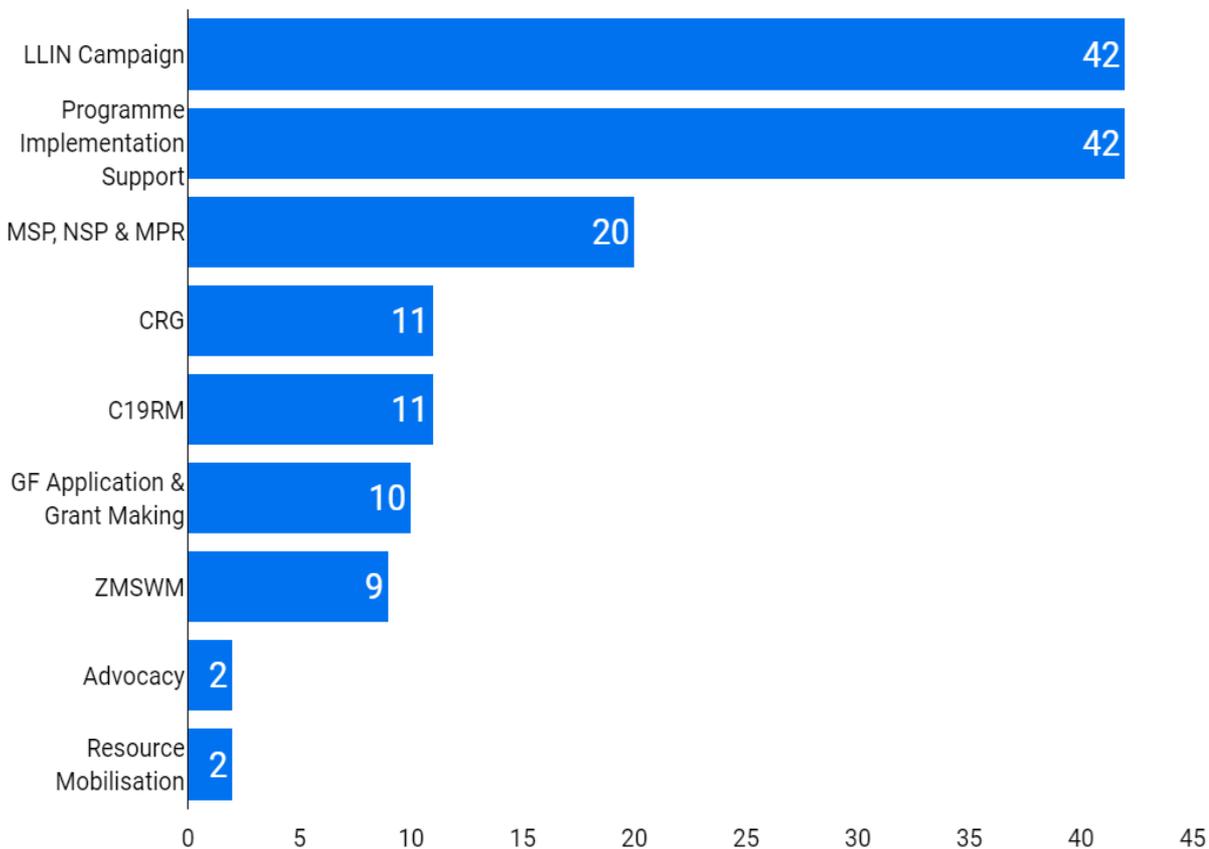
CRSPC sub-regional malaria programmes and partners meetings

- The meetings will give an opportunity for the countries to share best practices, challenges in mitigating the impact of COVID-19 on malaria intervention
- The meeting will also be an opportunity to inform countries on the current malaria prevention control tools, perspectives to better plan and implement – updates from WHO and other partners
- Facilitates the process of planning TA needs
- An opportunity to updates on GF implementation, GF application process, gap analysis updates, updates on Global, regional and continental initiatives.

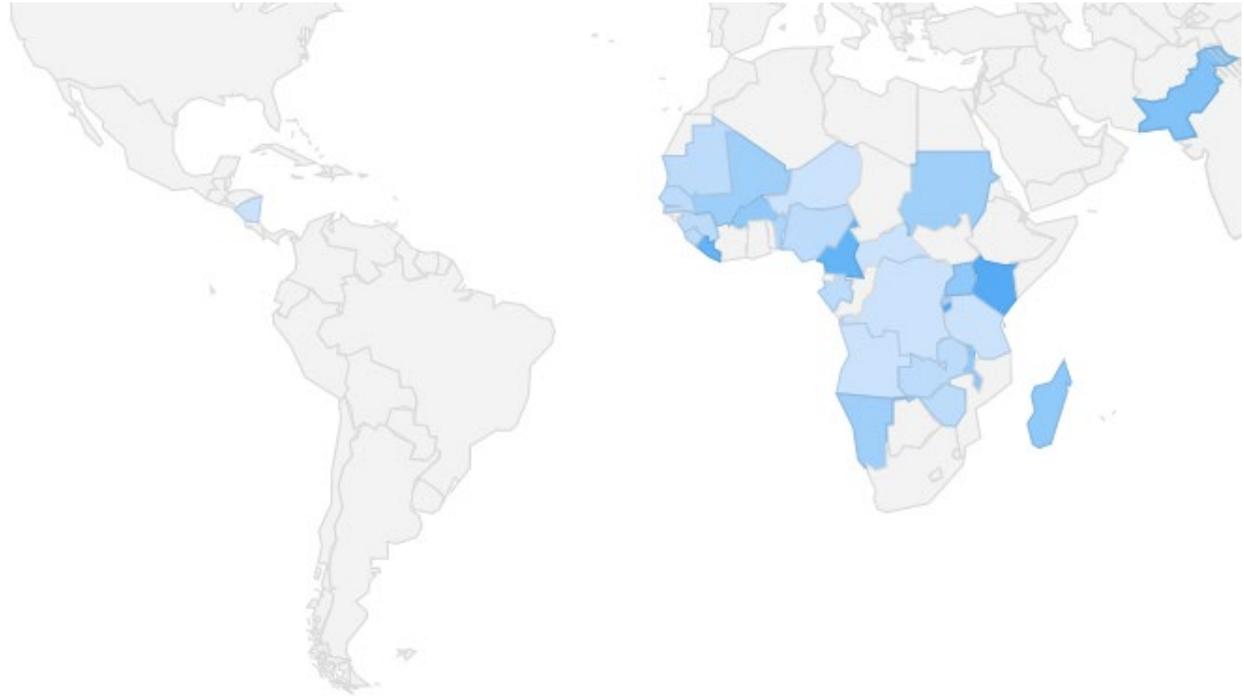
Priority Areas for CRSPC in 2022



Distribution of 2021 - 2022 TA Support by Countries and focus Area



Distribution of TA Support Across Malaria Endemic Countries, 2021 - 2022



Technical Assistance Process

- First exhaust the potential of different capacities at country or at the regional levels.
- TA on annual the TA plan, New TA can be requested
 - ✓ TA request form, and TORs
- Submit TA needs (email, letter) to our sub-regional team. TA can also be submitted online through RBM Global Malaria Dashboard
 - ✓ Timing is important esp when it involves travel
 - ✓ Send TA needs such as MPR, NSP to WHO
- TA implementation status update, feedback and concluding

Technical Assistance Timelines

- **International consultants** (from the Rosters) - request for the TA at least a month before the actual TA start date....
- **Local consultants** - CRSPC will transfer funds to the country to MOH or to UN organizations. In both cases, Countries are required to develop Concept note, and sign an agreement with UNOPS. This process will take at least 1-2 months.
- Link local malaria programme person or local consultant with the international consultant as a process of local capacity building effort.
- If the area of the support requires different areas of expertise, CRSPC can recruit consultants through quick **desk review process** - this can take up to 3 weeks.

Roster of Consultants

SN	Area of Speciality
1	Broader Malaria Senior Specialist
2	ITN mass campaign planning and implementation consultants
3	SBCC Consultants
4	Resource mobilisation Consultant
5	Advocacy Consultants
6	Community, Rights and Gender Consultants
7	Digital Health specialist
8	RSSH Consultants

CRSPC Workstream

- Country resource mobilization
 - GF funding proposals and grant signature
 - Country resource mobilization and advocacy
- Implementation support
 - Alliance for Malaria Prevention (AMP)
 - Support for implementation bottleneck resolution
 - SMC
- Programme review and National Strategic Plans
- Regional representation of programme managers
 - East Africa
 - West Africa
 - Central Africa
 - Southern Africa
 - Americas: – we are liaising with PAHO
 - South-East Asia: – we are liaising with SEARO
 - Eastern Mediterranean: – we are liaising with EMRO
 - Western Pacific: – we are liaising with WPRO

RBM Working Groups

- Case Management Working Group
- Malaria in Pregnancy Working Group
- Surveillance, Monitoring and Evaluation Working Group
- Multi-Sectoral Engagement Working Group
- Social and Behaviour Change Communication Working Group
- Vector Control Working Group

Thank you

amp

The Alliance for
Malaria Prevention

Global ITN presentation

CRSPC SRN meetings
2022





To national malaria programmes, implementation, financial and technical partners for the efforts to successfully implement ITN campaigns in 2020 and 2021 despite all the challenges encountered

How did we do in 2020/21 despite the COVID-19 pandemic?

- **Most 2020 campaigns took place within the year, but with different levels of delay**
- **~74% of planned ITNs were distributed in 2020 (01/15/21)**
 - ~219M ITNs planned for distribution
 - ~162M ITNs distributed
- **64.5% of planned campaigns were completed or partially completed**
 - 31 countries planned ITN campaigns
 - 20 countries completed planned ITN campaigns
 - Majority of countries that didn't complete made significant progress
- **Most remaining ITNs from 2020 were distributed in 2021**
- **~62% of planned ITNs were distributed in 2021**
 - ~192M ITNs planned for distribution
 - ~119M ITNs distributed
- **~62% of planned campaigns were completed or partially completed**
 - 21 countries planned ITN campaigns
 - 13 countries completed or partially completed planned ITN campaigns
 - Delayed campaigns for various reasons

Caveats and challenges

- Numbers are not complete for all countries, progress unknown for some (particularly for countries outside Africa)
 - India has huge volumes of nets for campaigns but no direct contact with country for updates
 - “ITNs distributed” is based on “ITNs available” since distribution data not often available (to be adjusted for 2022 numbers)
- For 2020 campaigns, most ITNs were already in-country pre-pandemic
 - More delays in 2021 campaigns due to supply chain disruptions, including for late ordering or delivery of PPE

Campaign tracker + CD tracker

- ITN campaign tracker
 - Linked to RBM dashboards
 - Information from national programmes (no contact/info, no tracker update)
 - Lots of errors – please help to fix them!
- **CD tracker**
 - Thanks to Uganda for the only completed tracker 😊
 - Objective to highlight needs (and massive gaps) to “sustain ITN access” in advance of GF applications
 - Highlights importance of unified system for reporting on ITNs, all channels

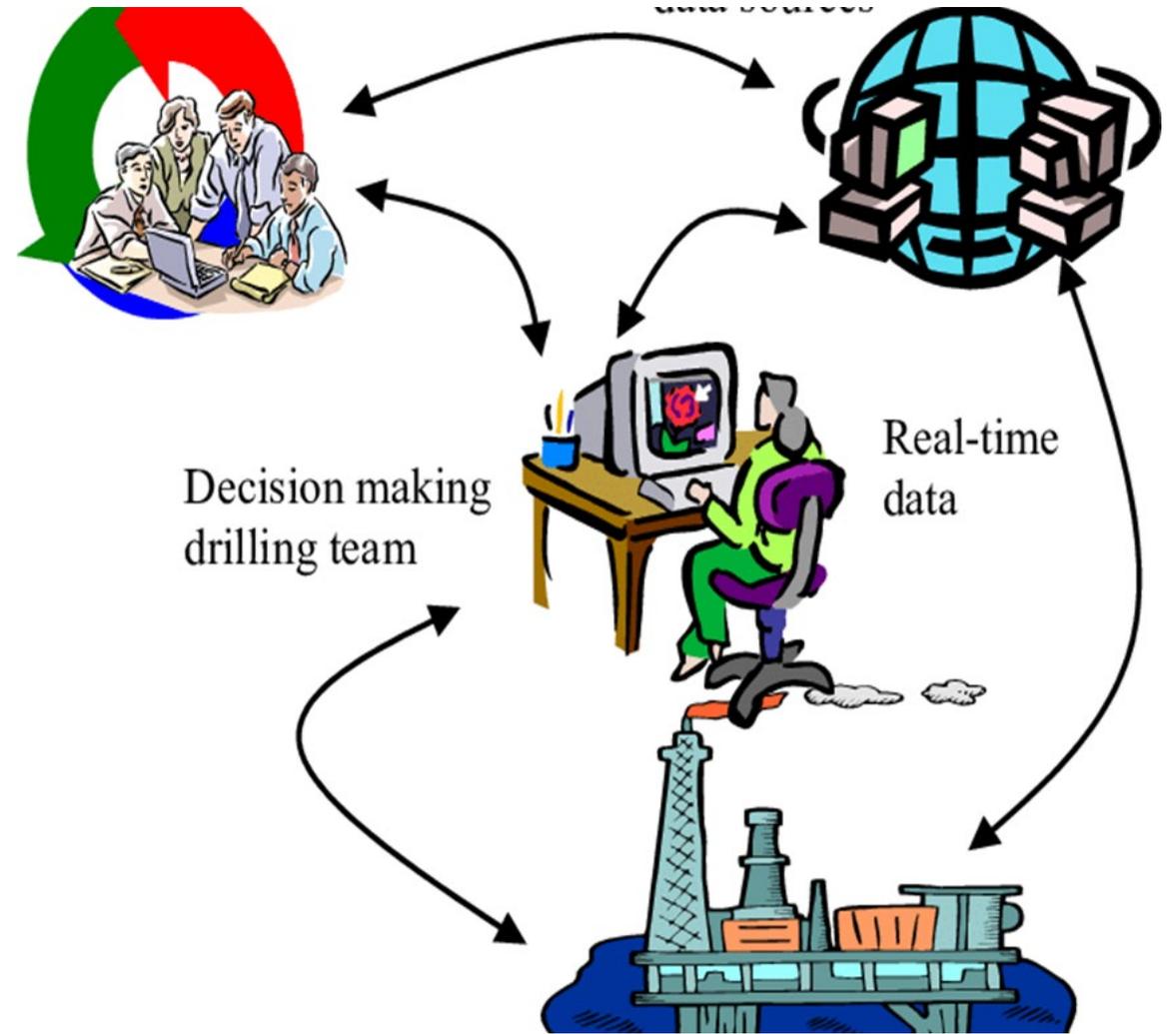
ITN campaigns and digital tools

Background

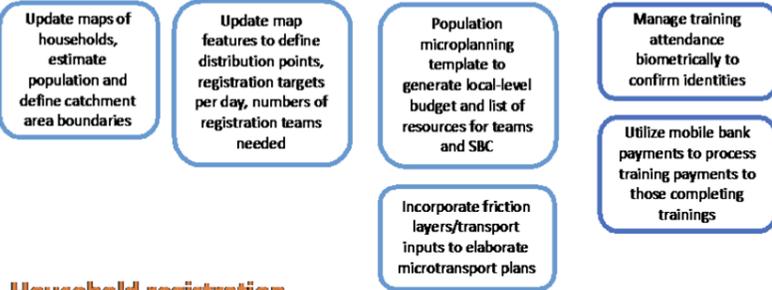
- Funded through BMGF ITN Campaign Efficiency Project
- Retrospective interviews with 14 countries that have transitioned to digital tools
- Prospective tracking of 11 countries planning for digital tools in 2022/23 ITN campaigns

Objective to identify facilitators, barriers and risk mitigation for switching from paper-based to digital tools, including for non-cash-based payments

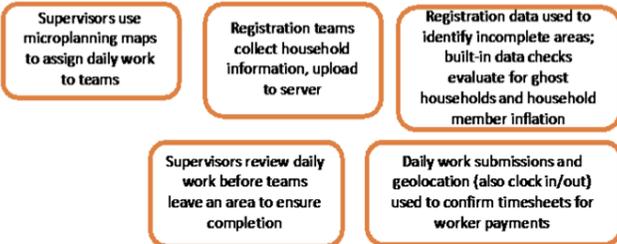
Digitalization will improve availability of real-time data for decision-making, data quality, ITN accountability and will reduce time and costs in the long term



Planning and training



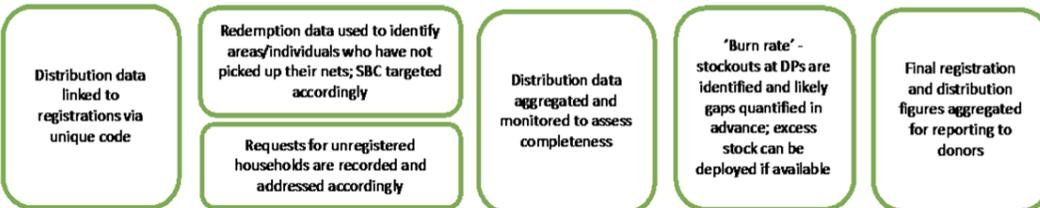
Household registration



Supply chain



ITN distribution



Expanding our digitalization to "The Wish List" will improve our campaign efficiency

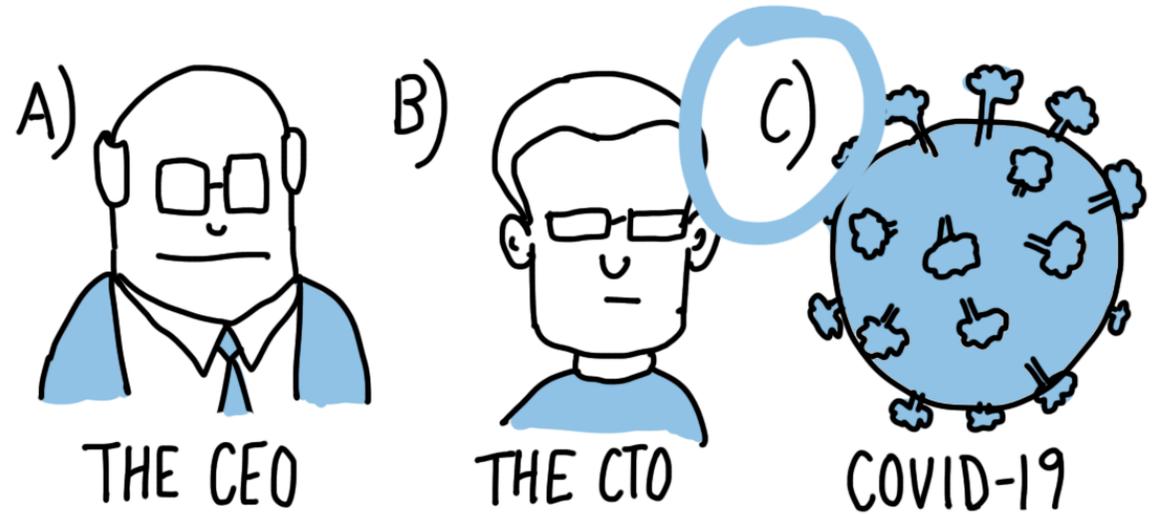
https://allianceformalariaprevention.com/wp-content/uploads/2021/06/AMP_Improving_Efficiency_Digital_Tools_21052021.pdf

**Strong leadership buy-in
and commitment is key to
successful transition from
paper based to digital
tools**

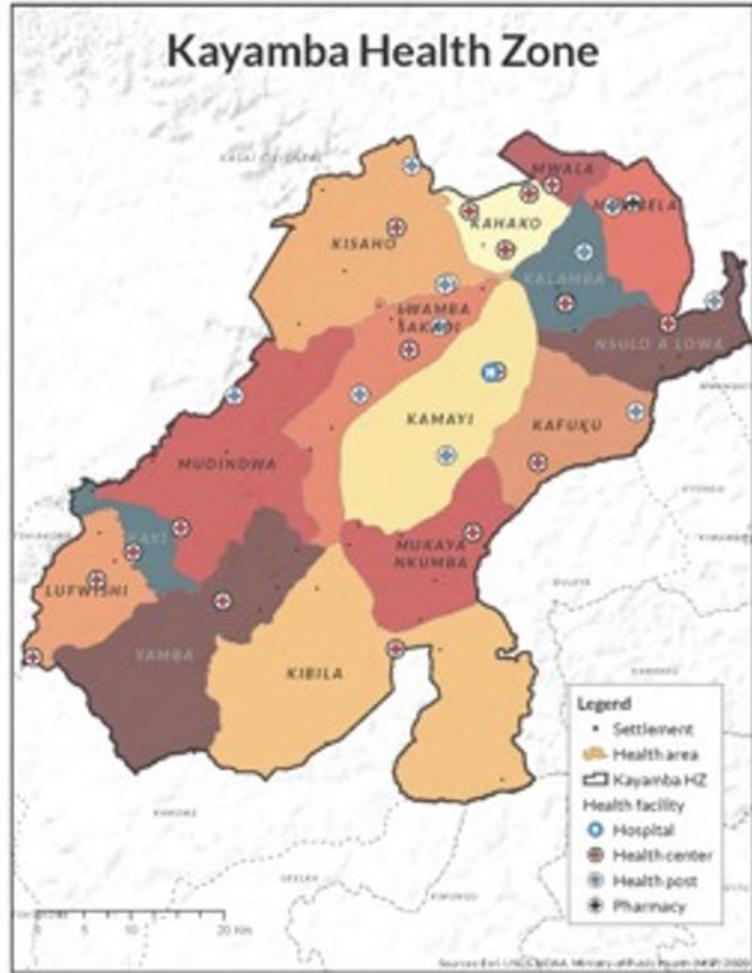
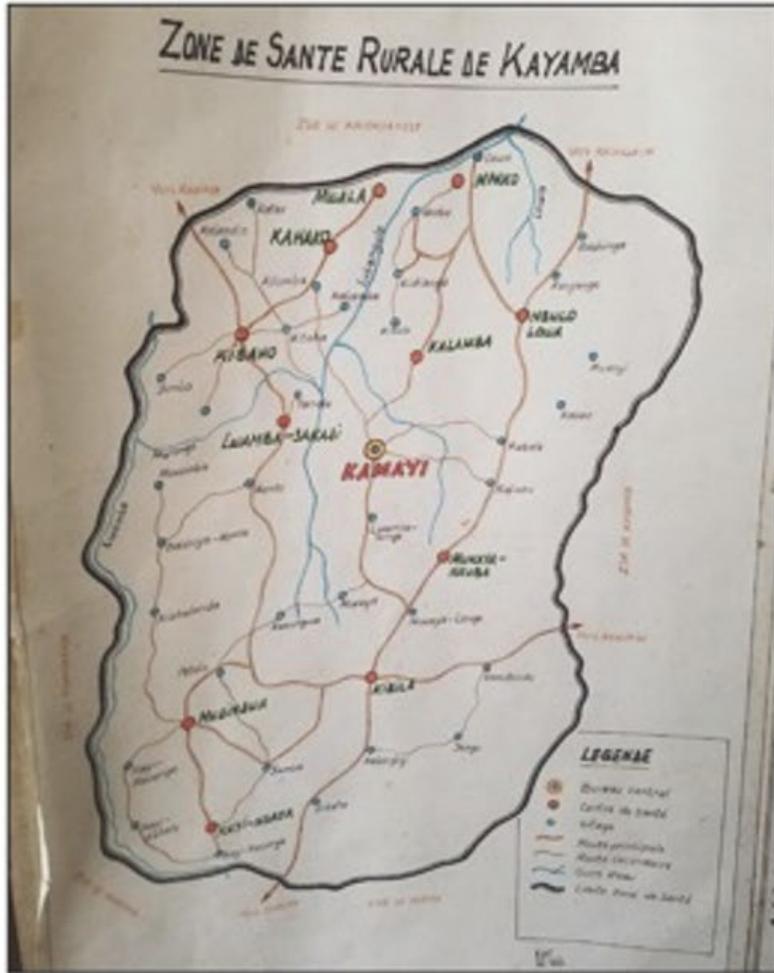


Early planning and budgeting, including identification of technical support needs (internal/external), will improve the digital tools transition and minimize delays

WHO LED THE DIGITAL TRANSFORMATION OF YOUR COMPANY ?



BUSINESSILLUSTRATOR.COM



Improving our microplanning will improve our ability to reach everyone and avoid duplication and waste of limited resources

**Working in partnership
and leveraging existing
data, information and
tools can move us
forward more quickly**





Re-imagine integration for more effective use of data, information and resources within and across health programmes

Piloting under different contexts and for different activities (SMC, IRS) to learn lessons for scale up will improve the success of ITN campaign digitalization



Consider existing infrastructure and local context: network access, security of devices and local regulations in planning for campaign digitalization



Remember to train
“beyond the device” to
improve campaign
outcomes

correct_rec	correct_no	nb_hhs	p_correct	class
72	8	80	90	Pass
72	8	80	90	Pass
68	12	80	85	Pass
62	18	80	78	Intermediate
59	21	80	74	Intermediate
55	25	80	69	Intermediate
55	25	80	69	Intermediate
54	26	80	68	Intermediate
54	26	80	68	Intermediate
53	27	80	66	Intermediate
49	31	80	61	Intermediate
43	37	80	54	Fail
43	37	80	54	Fail
42	38	80	53	Fail
40	40	80	50	Fail

$$\frac{3}{4} + \frac{2}{3} = \frac{9}{12} + \frac{8}{12}$$

different
denominators

common
denominator

Working together,
hopefully we can “fix
the denominator” and
ensure our resources
are used as well as
possible

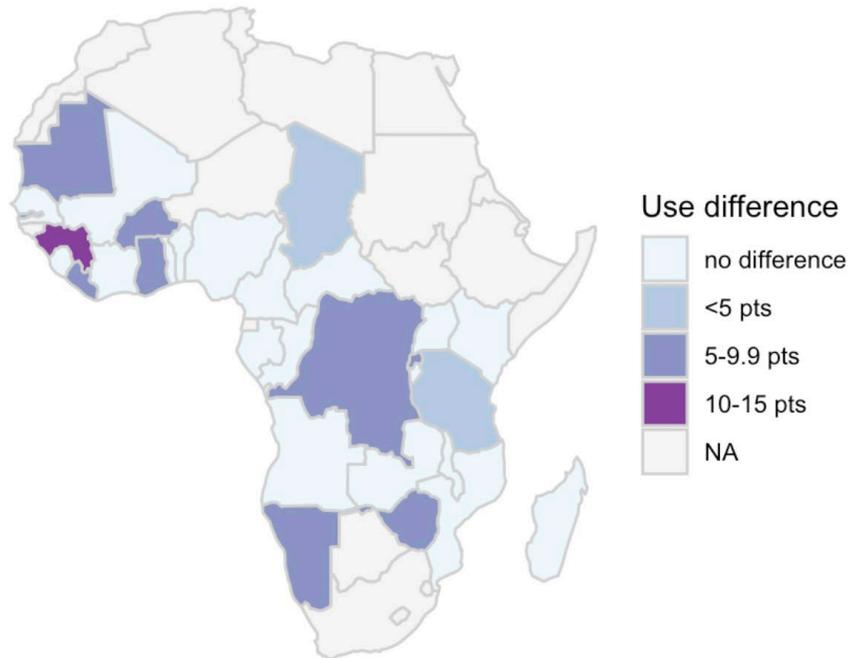
Digitalization tools: Available end July

- Digitalization decision-making matrix
- Digitalization planning and budget checklist
- Digitalization plan of action template

Considerations for ITN campaign and continuous distribution

ITN textile and ITN use

Figure 1: Crude difference in % of nets used between textiles



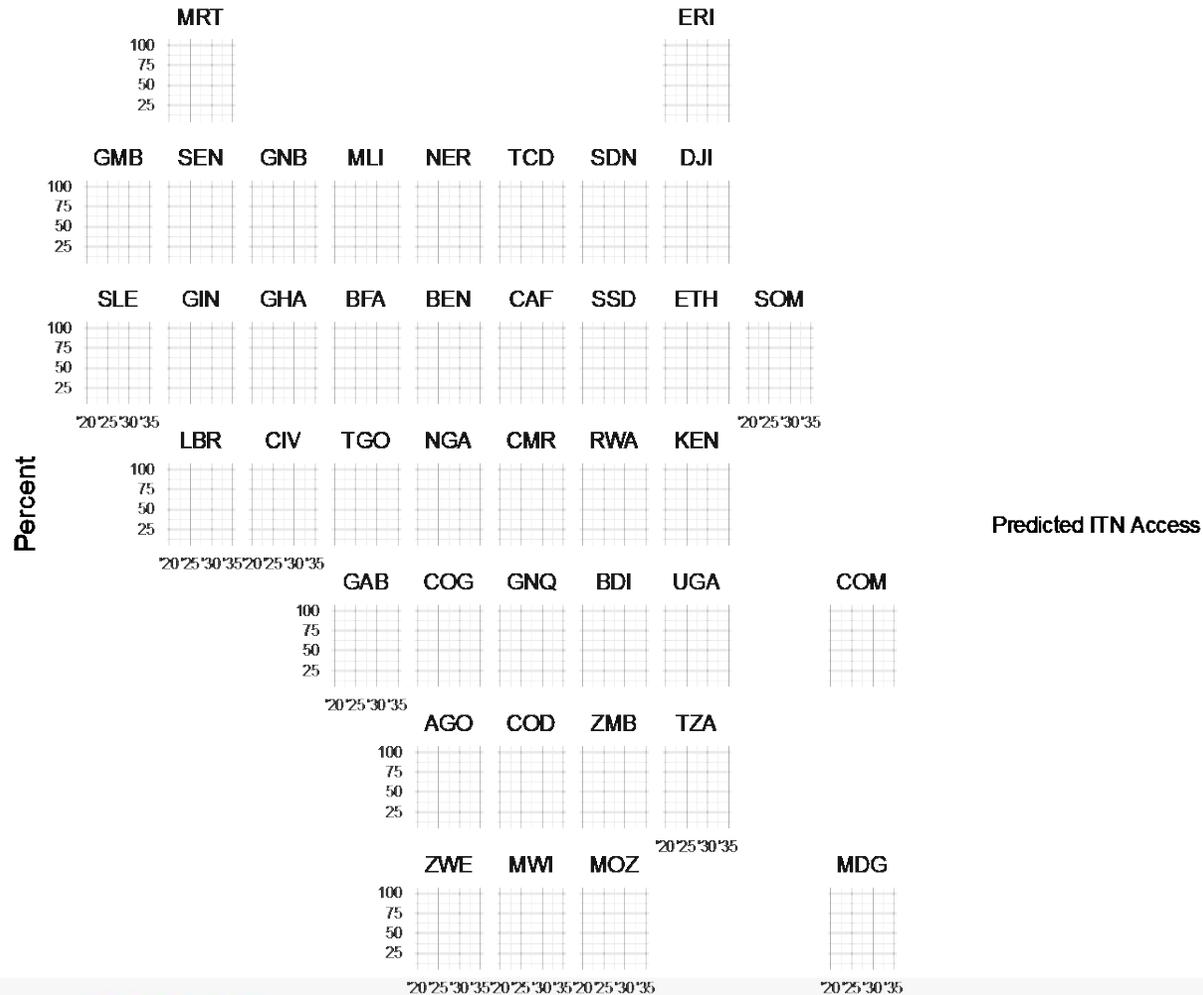
Programmes may wish to procure ITNs of a particular textile

Reports use large HH survey data to evaluate whether there are differences in use between polyester and polyethylene nets in a particular country, and whether net textile is associated with these differences after controlling for other determinants of net use

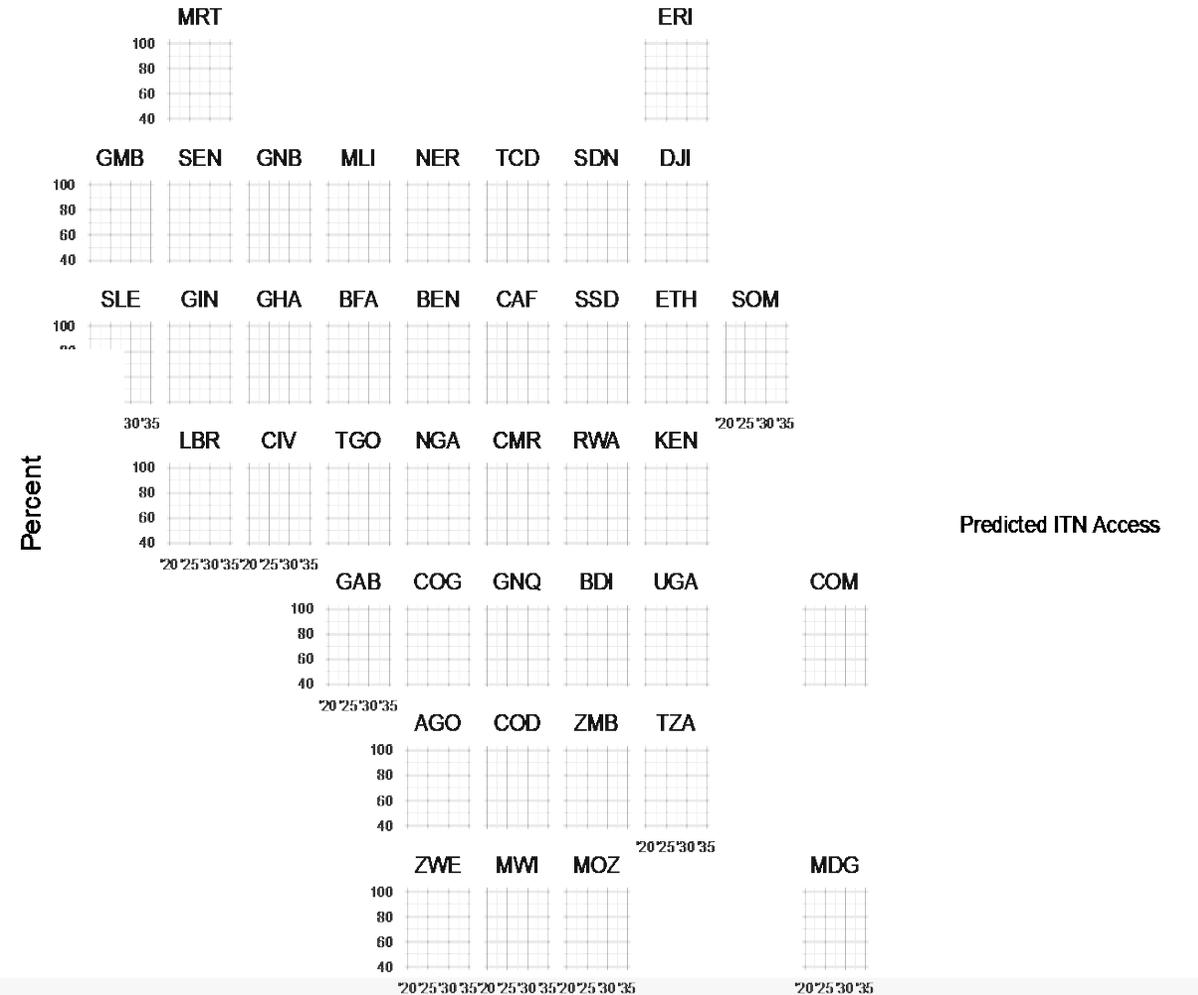
<https://net-textile-use-reports.netlify.app>

Country's different retention times affect how ITN strategies may perform

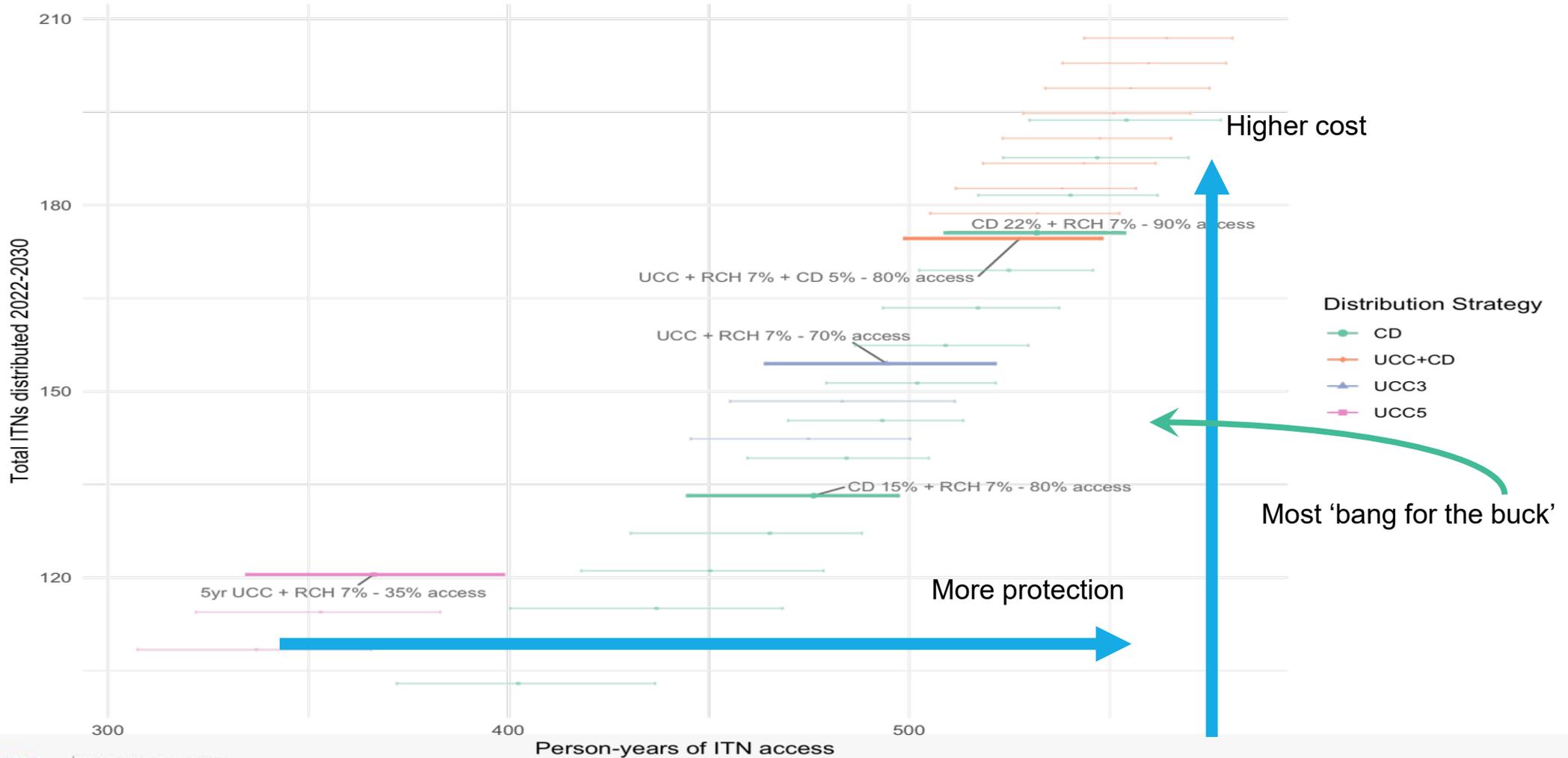
3-year mass campaigns with ANC/EPI, at population / 1.8 % of the population



ANC/EPI at 6% and annual school/community distribution at 17 % of the population



CD could provide comparable protection with 14% fewer nets than 3-year mass campaigns



Getting the right (most effective) nets to people at the right time (when they are needed) will involve expanding ITN distribution channels and trade offs



Sustaining access to effective ITNs is critical: we need more functional CD channels to ensure that people have access to ITNs when they need them

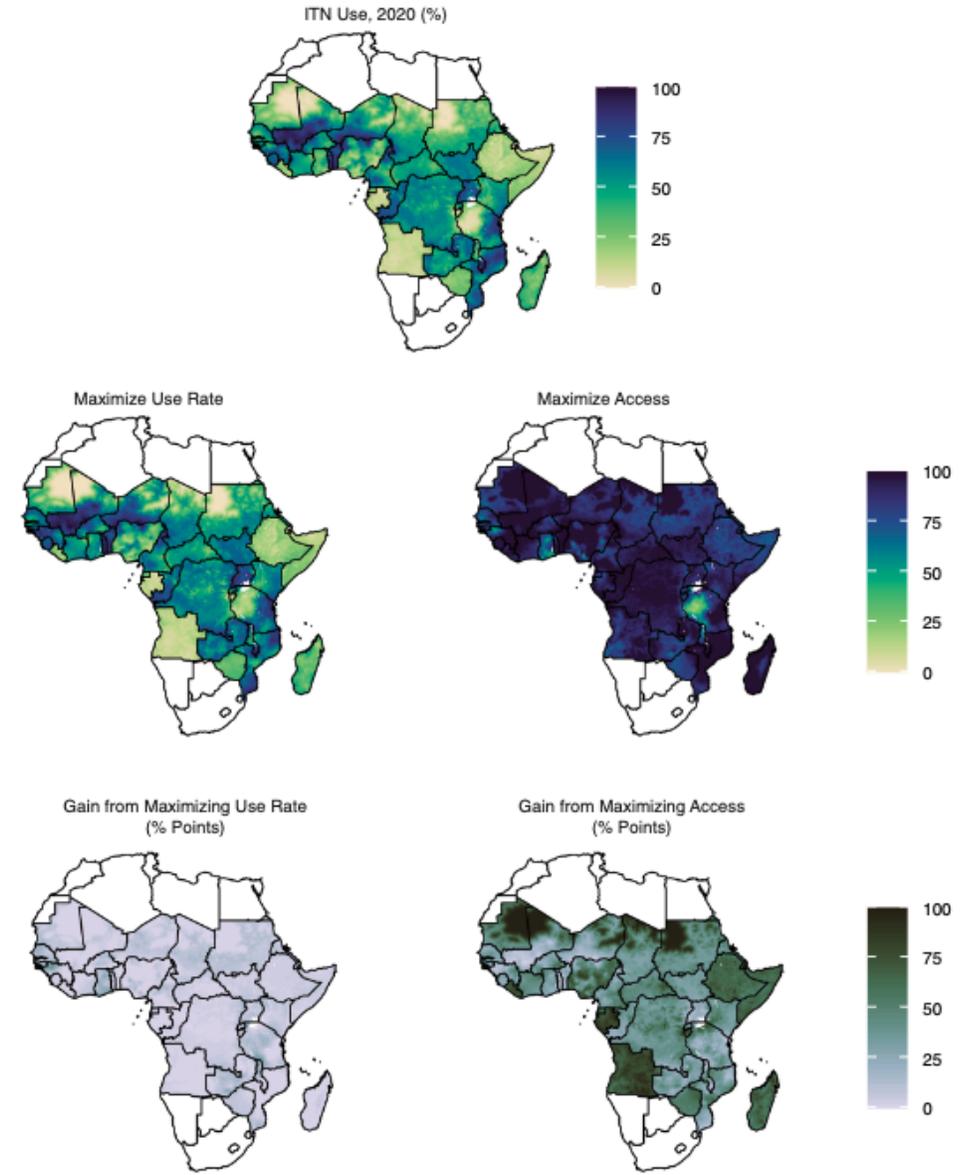


Fig. 6 Magnitude of change in insecticide-treated net (ITN) use possible from increasing use rate versus increasing access. The top row shows estimated ITN use in 2020. The second row shows what use could be if access remained unchanged and the use rate were set to 100% (left), compared to if the use rate remained unchanged and access was set to 100% (right). The final row shows the magnitude gain in use from each of these two scenarios. With few exceptions, increasing access has a larger impact than increasing the use rate.



Optimize routine ANC and EPI ITN distribution

- Uninterrupted routine distribution of ITNs has been an important part of an overall ITN strategy since the early 2000's
- Currently 32 countries deliver nets through ANC clinics and 28 through EPI
- ITN issuing rates are variable across countries, regions and season (a multi-country review is now taking place)
- Critical to ensure these channels are reaching their full potential in all countries in order to be certain of reaching the most biologically vulnerable

Advocate for CD beyond pilots where appropriate: more frequent campaign cycles don't solve our access problem and create additional challenges for national malaria programmes



Consider scaling up or introducing new channels

School-based distribution:

- Large scale distribution in Tanzania and Ghana
- Pilots in several countries including DRC, Guinea, Mozambique and Zambia
- See PMI VectorLink School-based distribution exemplar-available in French, English and Portuguese
[\(MS Word Chapter Setup Template allianceformalariaprevention.com\)](#)

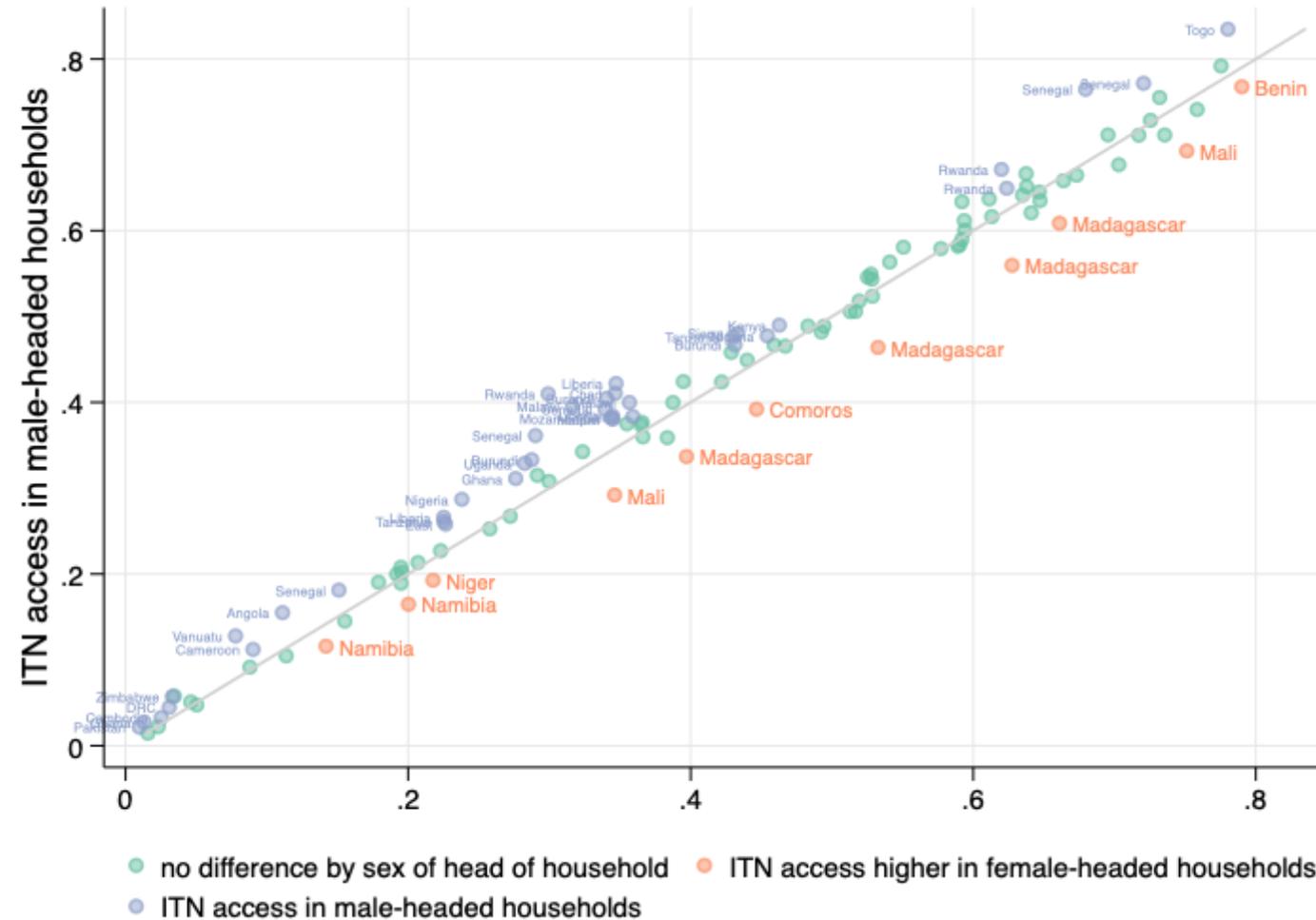
Community-based distribution:

- Large scale distributions in Madagascar and Zanzibar
- Allianceformalariaprevention.org and continuousdistribution.org for details, tools and more!

Reaching IDPs, refugees and hard-to-reach populations requires sustained investment, appropriate technology and channels that ensure continuous ITN access
→ we need to do better



“Brilliant, Ed! A slogan we can finally live up to!”



Use data and consider gender – it may be an important factor for ITN access

Use data to inform SBC planning and plan and budget to collect data where insufficient information exists

<https://malariabehaviorsurvey.org>

<https://breakthroughactionandresearch.org/resource/itn-use-and-access-report/>



Consider rumour management as we move to sub-national tailoring

- Ensuring that rumour management plans are:
 - Validated as part of ITN distribution planning
 - Understood by all campaign actors at the different levels
 - Budgeted for in case of need for rapid deployment



Improve planning and budgeting for waste management and consider the environmental effect including end of life ITNs





Use data and consider what is effective and efficient for urban areas to rationalize resources available

Guidance updates

- See website – both COVID and non-COVID guidance has been updated
- If you don't see what you are looking for, please let us know!

ITN quality convening: Key outcomes and next steps

RESEARCH

Open Access



Correlation of textile 'resistance to damage' scores with actual physical survival of long-lasting insecticidal nets in the field

Albert Kilian^{1*}, Emmanuel Obi², Paul Mansiangi³, Ana Paula Abílio⁴, Khamis Ameir Haji⁵, Estelle Guillemois⁶, Vera Chetty⁶, Amy Wheldrake⁶, Sean Blaufuss⁷, Bolanje Olapeju⁷, Stella Babalola⁷, Stephen J. Russell⁶ and Hannah Koenker⁷

Abstract

Background: Attempts have been made to link procurement of long-lasting insecticidal nets (LLIN) not only to the price but also the expected performance of the product. However, to date it has not been possible to identify a specific textile characteristic that predicts physical durability in the field. The recently developed resistance to damage (RD) score could provide such a metric. This study uses pooled data from durability monitoring to explore the usefulness of the RD methodology.

Methods: Data from standardized, 3-year, prospective LLIN durability monitoring for six LLIN brands in 10 locations and four countries involving 4672 campaign LLIN were linked to the RD scores of the respective LLIN brands. The RD score is a single quantitative metric based on a suite of standardized textile tests which in turn build on the mechanisms of damage to a mosquito net. Potential RD values range from 0 to 100 where 100 represents optimal resistance to expected day-to-day stress during reasonable net use. Survival analysis was set so that risk of failure only started when nets were first hung. Cox regression was applied to explore RD effects on physical survival adjusting for known net use environment variables.

Results: In a bivariate analysis RD scores showed a linear relationship with physical integrity suggesting that the proportion of LLIN with moderate damage decreased by 3%-points for each 10-point increase of the RD score ($p = 0.02$, $R^2 = 0.65$). Full adjustment for net care and handling behaviours as well as other relevant determinants and the country of study showed that increasing RD score by 10 points resulted in a 36% reduction of risk of failure to survive in serviceable condition ($p < 0.0001$). LLINs with RD scores above 50 had an additional useful life of 7 months.

Conclusions: This study provides proof of principle that the RD metric can predict physical durability of LLIN products in the field and could be used to assess new products and guide manufacturers in creating improved products. However, additional validation from other field data, particularly for next generation LLIN, will be required before the RD score can be included in procurement decisions for LLINs.

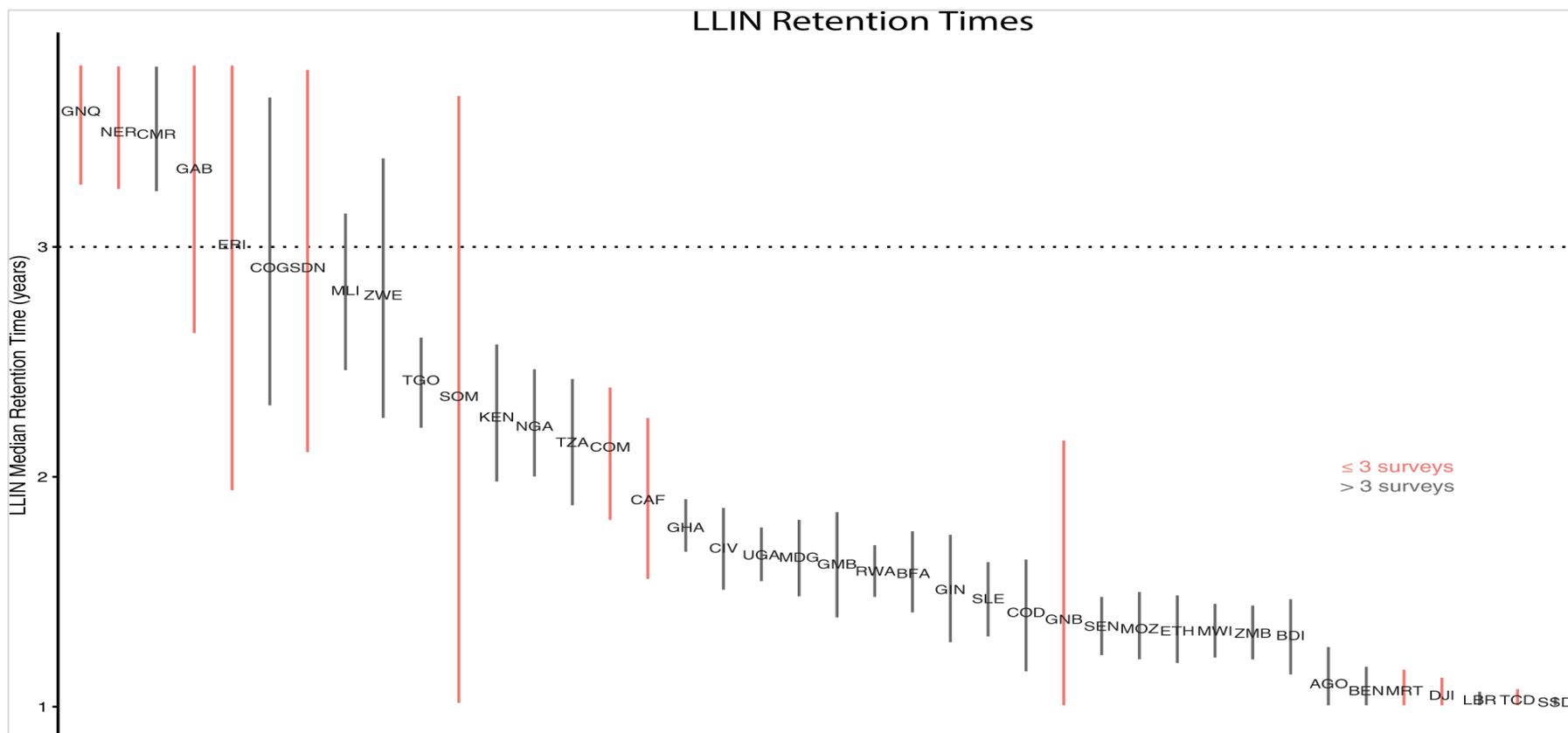
Keywords: LLIN physical durability, Textile resistance to damage

ITN quality is a factor and needs to be addressed to avoid a lack of trust in ITN efficacy

Despite ubiquitous 3-year distribution cycle, median net retention is 1.64 years

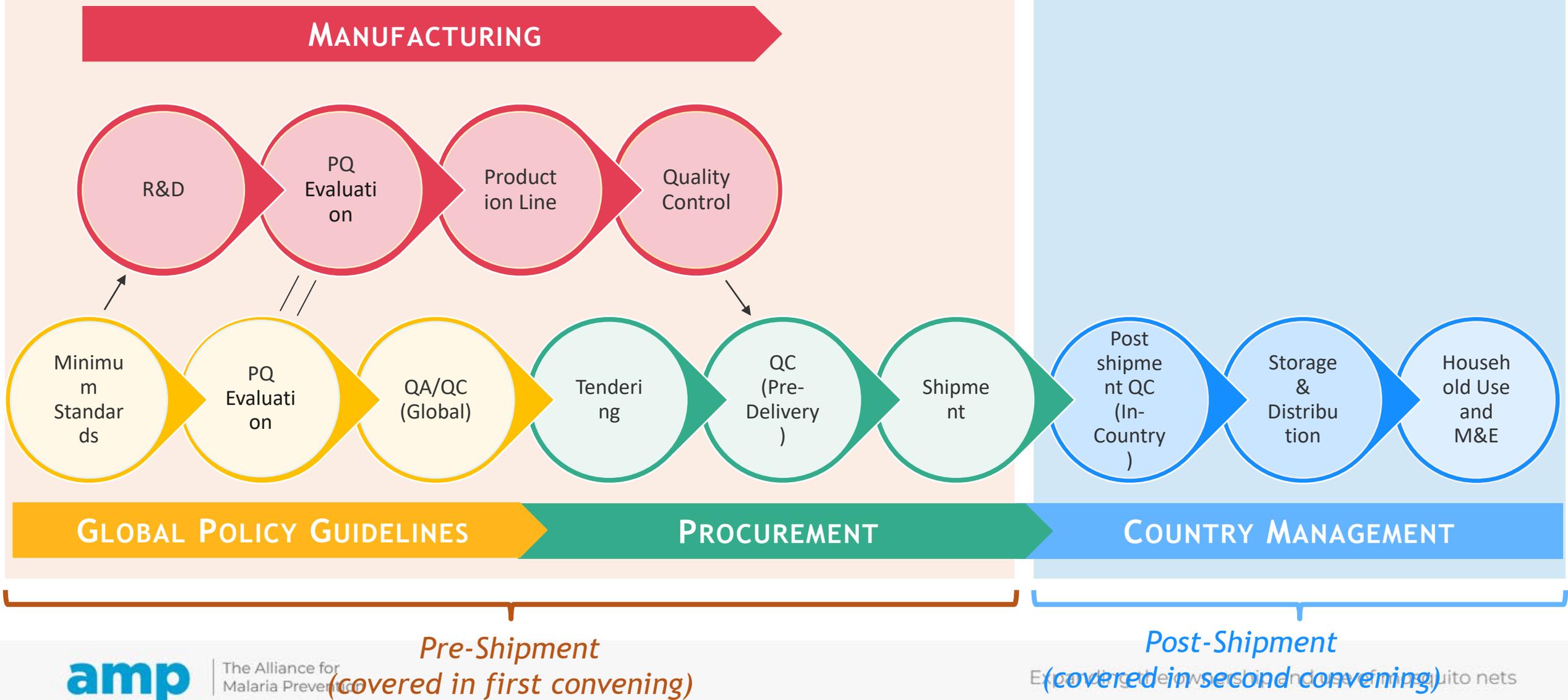
“the bulk of existing evidence supports the notion that median net retention is commonly lower than 3 years.”

“The primary motivation for discarding a net in these studies was the perception that it was too torn, with even a modest amount of net damage often regarded as unseemly or untidy.”

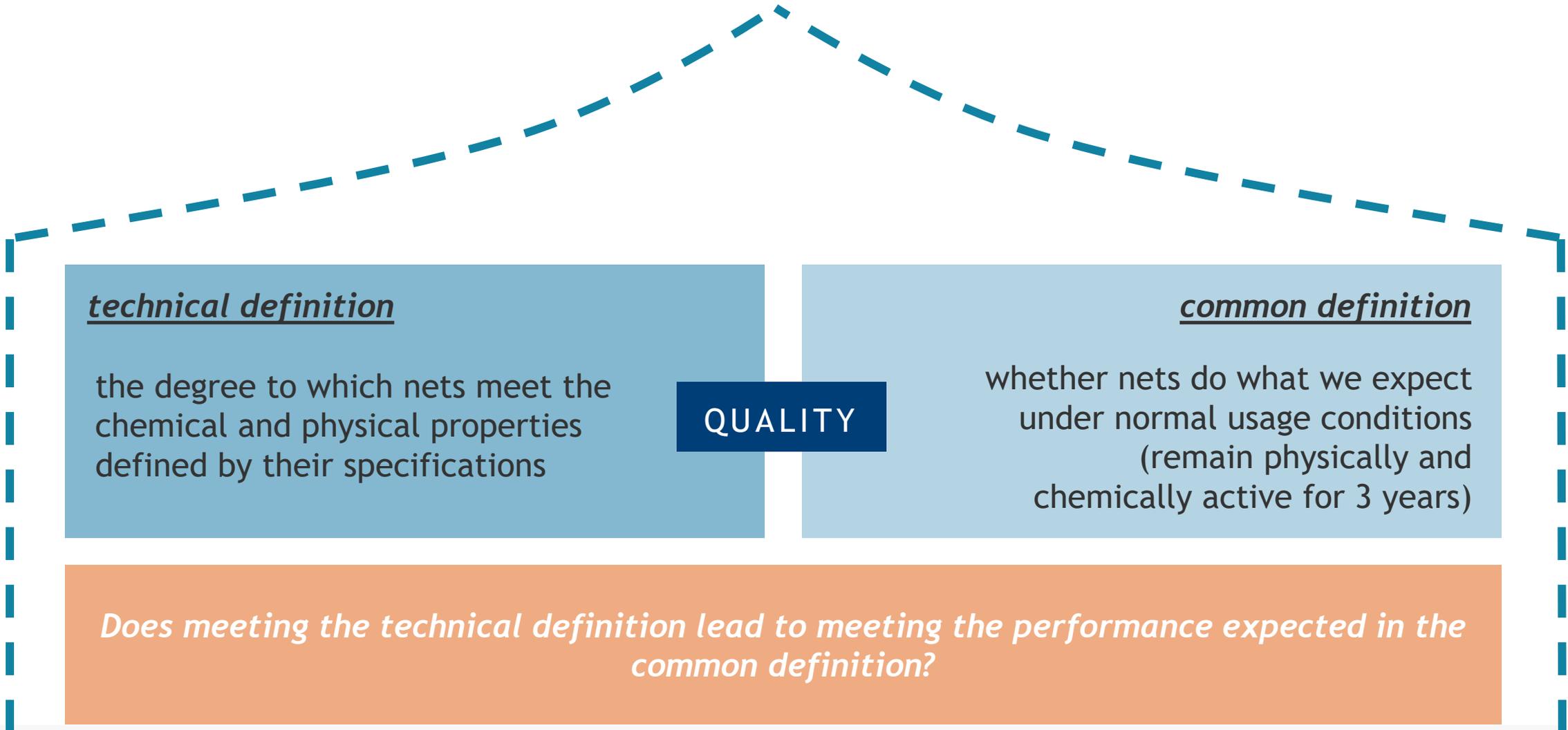


Bertozzi-Villa, A., Bever, C.A., Koenker, H. *et al.* Maps and metrics of insecticide-treated net access, use, and nets-per-capita in Africa from 2000-2020. *Nat Commun* 12, 3589 (2021).

The ITN Quality Lifecycle is an effort to map out the different factors that can affect net quality



A fundamental challenge with this topic is that key stakeholders define “quality” differently



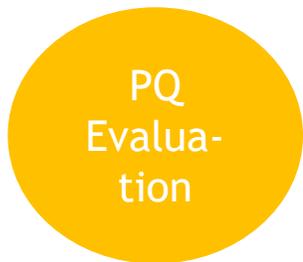
Key themes: Global Policy

GLOBAL POLICY



Minimum Standards

- Need to develop **specifications** that link net quality to performance



PQ Evaluation

- **Update testing guidance** to reflect new products



QA/QC

- **Insufficient QA/QC testing infrastructure** - testing methodologies and different laboratories not perceived to deliver consistent results

TOP CHALLENGES

PRIORITIZED SOLUTIONS

- Build the “foundation” for ITN attributes. Inclusion of **textile integrity** to specifications

- Update and disseminate testing guidelines

- Review capacity of GLP facilities for testing ITNs
- Review QA of pre/post - shipment lab testing infrastructure

Key themes: Manufacturing

TOP CHALLENGES

PRIORITIZED SOLUTIONS

R &D

- Metrics to differentiate ITN performance needed. Current market tends towards quantity over performance making it high risk to innovate

- Delineation of standards and specifications that allow procurers to justify price premiums and demonstrate how improved quality can be a better value for money

PQ
Evaluati
on

- Identify how product specifications can be linked to attributes that improve field performance

- Build clear, reproducible characteristics to deliver desired performance and separate primary and secondary ITN attributes based on linkage to durability and bioefficacy

QA/QC

- Inspection burden and lack of harmonized quality processes

- Procurers align on quality processes and agree on key attributes to be tested

MANUFACTURING

Key themes: Procurement

TOP CHALLENGES

PRIORITIZED SOLUTIONS

Tendering

- Too much focus on price over quality

- Document and measure characteristics that lead to better performance. Set standards to deliver higher quality outcomes and be willing to pay more

QC
(Pre-Delivery)

- Clarify criteria for acceptance of ITNs that deviate from specs
- ISO 9001 is the industry standard, but does it give enough information on ITN specific issues?

- LQAG working on harmonized pre-shipment testing guidelines. Global Fund developing pre-shipment sampling guidance
- Agreement between manufacturers, procurers and implementers on standards, methods and margins of error

Shipment

- Assigning accountability for OOS results is difficult due to lack of clear data along the chain of custody

- Clarify the chain of custody for ITNs and look at ways to provide better data regarding a net's life cycle (QC data, testing, transportation/storage conditions)

Key themes: Country Management

COUNTRY MANAGEMENT

Post shipment inspection

TOP CHALLENGES

- **Non-standardized post-shipment testing** may cause rejection of good products or acceptance of poor products

Port delays & storage

- No guidelines exist for warehousing
- **Delays and storage at port** including customs clearance and distribution related delays

Distribution strategy

- Lack of clear distribution strategy/microplans and delays in distribution at different levels perhaps leading to inappropriate storage

PRIORITIZED SOLUTIONS

- Develop **harmonized guidance on pre- and post delivery inspection** criteria and SOPs

- Definition of and guidance on optimal storage conditions (net specific where necessary)
- Advocacy to facilitate **rapid customs clearance**

- Develop clear/proactive distribution strategy/microplanning
- Digital real-time data collection systems/proper data capture and use/Digital tracing of nets

Key themes: Cross-cutting

CROSS-CUTTING

TOP CHALLENGES

PRIORITIZED SOLUTIONS

Common
Glossary
of terms

- Varying **definitions** of key terms (quality, performance, efficacy, durability, QA, QC, etc.) makes it difficult to discuss these issues

- **Develop a clear glossary** of terms and communicate to key stakeholder groups

Trust
b/w
stakehol-
-ders

- **Trust** amongst different stakeholder groups around ITN quality needs reinforcing

- **Develop communication strategy** to help drive clarity and build trust
- Build transparency through data sharing

Data

- Lack of data on performance/ bio efficacy, durability monitoring/risk factors in country that influence life of a net

- Post market surveillance on retention, bioefficacy, AI concentration, physical integrity and use
- Publication of data to make appropriate data available to all

New Nets Project: Operational issues and key findings

New Nets Project consortium



- Lead and coordinator
- Liaison with industry partners
- Link to vector control product development pipeline



- Compilation of cross-country lessons learned from pilot studies, funding for process evaluations

The Alliance for Malaria Prevention

- Technical assistance

Imperial College London

- Modelling of trials design and implementation impact



- Cost-effectiveness determination from pilot implementations



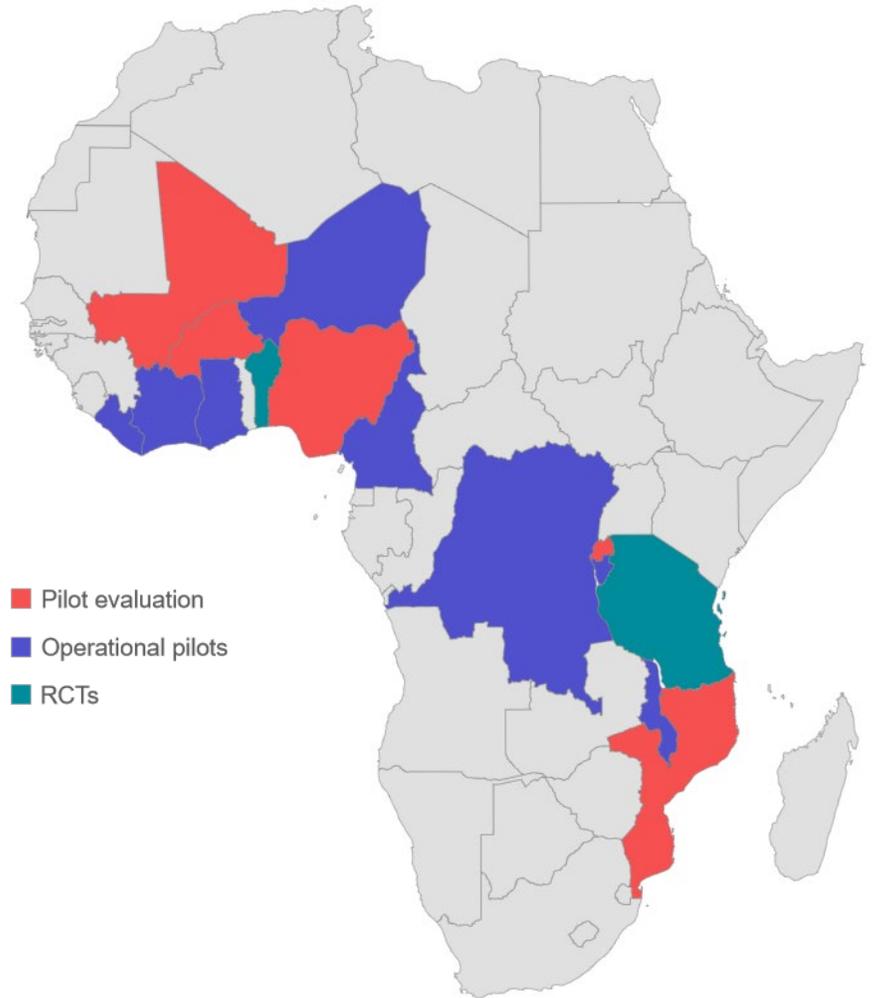
- Entomological correlates of epidemiological impact



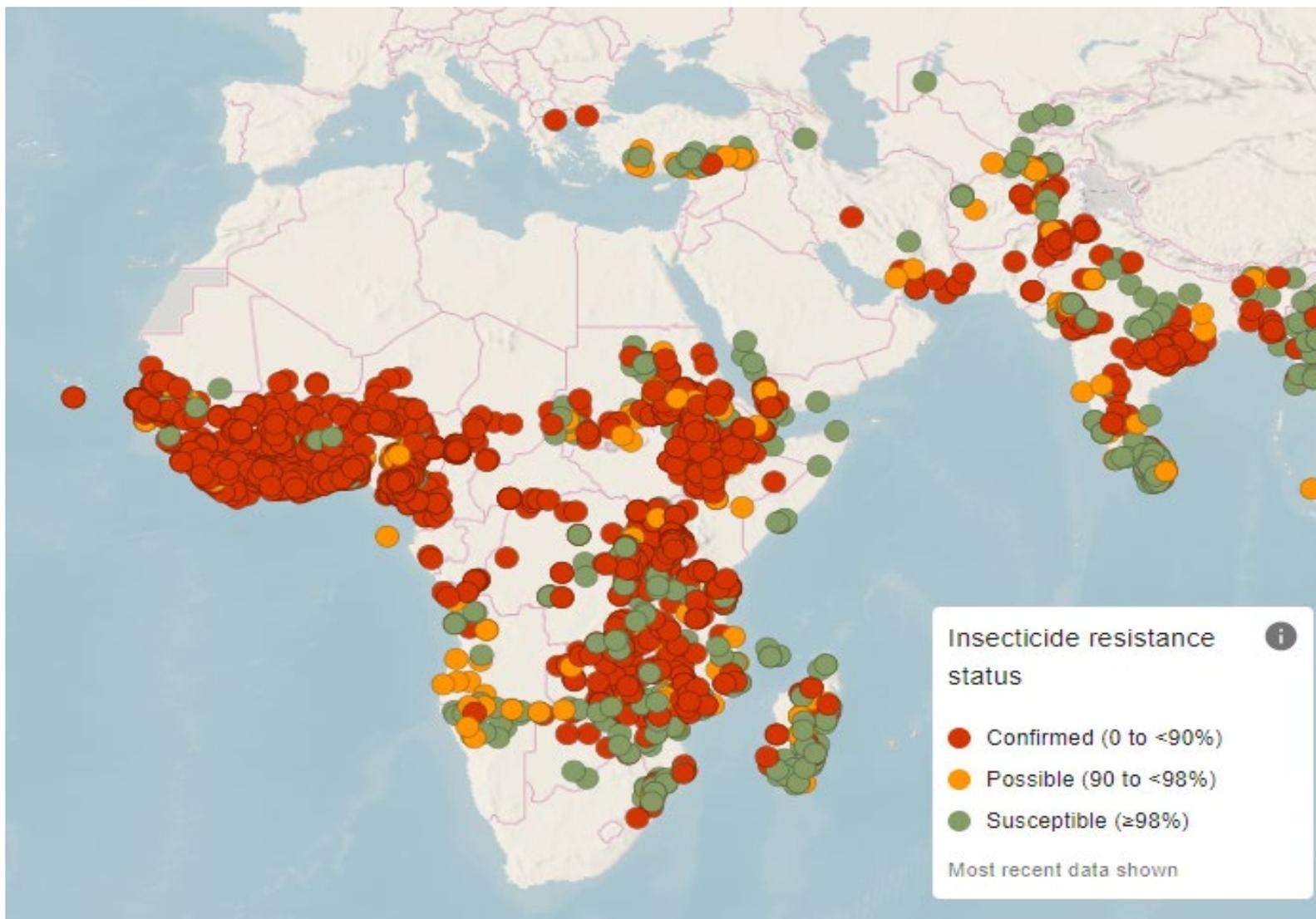
- Cost effectiveness study design and data collection



- Cluster-randomized trials of dual active-ingredient ITNs and entomological correlates in trials



The challenge: Insecticide resistance



The effect of malaria control on *Plasmodium falciparum* in Africa between 2000 and 2015, S. Bhatt et al, Sep 2015

<https://apps.who.int/malaria/maps/threats>

Project overview



The New Nets Project (NNP: funded by Unitaid and the Global Fund and primed by IVCC) helps to pilot the next generation of nets, **dual-active ingredient ITNs**

Pyrethroid-only

Standard ITNs

**Pyrethroid +
Synergist**

PBO ITNs

**Pyrethroid +
Chlorfenapyr**

Interceptor® G2 ITN

**Pyrethroid +
Pyriproxyfen**

Royal Guard® ITN

- These new nets
 - Are more expensive
 - Still need a WHO policy recommendation
- NNP will help
 - Remove market barriers and **improve access** to dual-active ingredient ITNs
 - **Build the evidence** needed for WHO policy recommendation: Epidemiology, Entomology, Anthropology, Cost-effectiveness, Durability monitoring

Operational issues

CS456197



"Oh, great. NOW you discover fire!"

Desynchronized delivery of different ITN types is a challenge that needs to be resolved



Feasible waste management (or environmentally friendly) solutions are needed urgently

Key findings: Mozambique interim results



Malaria burden to date *Northern Mozambique*

	Gurue (standard ITNs)		Cuamba (IG2 ITNs)		Mandimba (RG ITNs)	
	2020	2021	2020	2021	2020	2021
Population that slept under a net last night (95% CI)	23.0% (21.3%–24.7%)	87.4% (82.8%–90.8%)	19.4% (17.9%–21.0%)	67.9% (57.0%–77.1%)	17.0% (15.5%–18.6%)	81.6% (74.7%–87.0%)
Population ITN access (95% CI)	23.1% (21.8%–24.4%)	85.7% (82.5%–88.8%)	21.0% (19.7%–22.3%)	64.8% (54.8%–74.8%)	16.4% (15.3%–17.6%)	75.5% (69.0%–82.3%)
Use given access*	0.99	1.02	0.92	1.05	1.03	1.08

- ITN access and usage went up significantly after the campaign

	Gurue (Standard ITNs)		Cuamba (IG2 ITNs)		Mandimba (RG ITNs)	
	2020	2021	2020	2021	2020	2021
Malaria prevalence for children under 5 years old (RDT+) (95% CI)	64.9% (54.8%–75.0%)	52.5% (42.9%–61.9%)	47.5% (38.1%–57.0%)	29.4% (20.9%–39.5%)	66.0% (57.5%–74.4%)	46.2% (38.2%–54.4%)

- **Malaria burden decreased significantly as well**
 - **~19% in Gurue (Std)**
 - **~38% in Cuamba (IG2)**
 - **~30% in Mandimba (RG)**

Malaria burden to date *Northern Mozambique*

Difference-in-difference (DiD) comparison of malaria incidence with next-generation ITNs and standard pyrethroid ITNs

	2021 year 1 (Jan–June) change from baseline	DiD relative to standard ITNs
Gurue (Standard ITNs)	8% (–3% to 24%)	
Cuamba (IG2 ITNs)	–48% (–52% to –40%)	56%
Mandimba (RG ITNs)	–28% (–31% to –23%)	36%

Passive malaria case incidence rates from 2020 to 2021 indicated:

- Similar number of cases in Gurue (standard)
- ~28% fewer cases in Mandimba (RG)
- ~48% fewer cases in Cuamba (IG2)

Malaria burden to date *Western Mozambique*

	Chemba (Standard ITNs)		Guro (IG2 ITNs)		Changara (PBO ITNs)	
	2020	2021	2020	2021	2020	2021
Population that slept under a net last night (95% CI)	33.3% (32.1%–34.7%)	90.1% (87.1%–92.4%)	18.5% (17.2%–19.8%)	92.8% (90.4%–94.7%)	23.0% (21.8%–24.2%)	84.6% (80.5%–88.0%)
Population ITN access (95% CI)	30.4% (29.3%–31.6%)	86% (82.0%–90.1%)	18.8% (17.5%–20.1%)	88.9% (86.8%–91.1%)	26.3% (24.9%–27.6%)	84.2% (81.1%–87.3%)
Use given access*	1.10	1.05	0.98	1.04	0.88	1.00

- ITN access and usage went up significantly after the campaign

	Chemba (Standard ITNs)		Guro (IG2 ITNs)		Changara (PBO ITNs)	
	2020	2021	2020	2021	2020	2021
Malaria prevalence for children under 5 years old (RDT+) (95% CI)	44.3% (36.5%–52.1%)	39.0% (31.3%–47.2%)	17.1% (11.6%–22.7%)	3.8% (2.2%–6.7%)	5.7% (2.3%–9.1%)	2.1% (0.8%–5.4%)

- **Malaria burden decreased significantly as well**
 - ~12% in Chemba (Std)
 - ~77% in Guro (IG2)
 - ~63% in Changara (PBO)

Key findings: Burkina Faso interim results



Malaria burden to date

	Gaoua (Standard ITNs)			Banfora (IG2 ITNs)			Orodara (PBO ITNs)		
	2019	2020	2021	2019	2020	2021	2019†	2020	2021
Population that slept under a net last night (95% CI)	20.8% (18.6%–23.1%)	44.2% (40.9%–47.5%)	37.0% (30.5%–42.5%)	67.7% (64.9%–70.3%)	90.4% (88.5%–92.1%)	82.8% (79.0%–86.6%)	78.8% (76.1%–81.2%)	84.8% (82.3%–87.0%)	83.5% (79.9%–87.1%)
Population ITN access (95% CI)	44.4% (42.4%–46.2%)	53.8% (51.4%–56.2%)	40.5% (37.9%–43.1%)	58.9% (57.1%–60.7%)	84.2% (83.1%–85.3%)	74.9% (73.5%–76.2%)	94.0% (93.1%–94.9%)	87.4% (86.3%–88.5%)	82.0% (80.7%–83.3%)
Use given access*	0.47	0.82	0.91	1.15	1.07	1.11	0.84	0.97	1.02

- Increases in ITN access and use after the campaign were variable (remained low in Gaoua)

		Gaoua (Standard ITNs)			Banfora (IG2 ITNs)			Orodara (PBO ITNs)		
		2019	2020	2021	2019	2020	2021	2019†	2020	2021
Malaria prevalence in children from CSS (RDT+) (95% CI)	<5	81.0% (74.9%–86.0%)	48.9% (41.9%–56.1%)	21.1% (15.5%–27.5%)	39.6% (33.0%–46.6%)	18.4% (13.5%–24.6%)	11.6% (7.4%–17.0%)	28.4% (22.4%–35.3%)	3.7% (1.8%–7.5%)	2.1% (0.6%–5.3%)
	5 - 10			54.5% (47.1%–61.7%)			36.1% (29.3%–43.4%)			19.9% (14.5%–26.3%)

- Timing of campaign associated with decreases in malaria prevalence through 2 years

- ~74%% in Gaoua (Std)
- ~71% in Banfora (IG2)
- ~93% in Orodara (PBO)

†The ITN distribution campaign was complete at the time of the cross-sectional survey.

*Use given access is calculated by dividing use (population that slept under a net last night) by access. Values over 1 are possible given that the calculation is a ratio.

Malaria burden

Difference-in-difference (DiD) comparison of malaria incidence with next-generation ITNs and standard ITNs.

	Year 1 (November–May) change from baseline	Year 1 DiD relative to standard ITNs	Year 2 (June–May) change from baseline	Year 2 DiD relative to standard ITNs
Gaoua and Nouna (Standard ITNs)	-18.4% (-24.8% to -14.8%)		-20.6% (-24.9% to -17.5%)	
Banfora and Tougan (IG2 ITNs)	-0.76% (-6.1% to 1.8%)	-18%	-35.3% (-36.7% to -34.6%)	14.7%
Orodara (PBO ITNs)	-22.9% (-28.8% to -2.7%)	4.5%	-26.4% (-29.2% to -24.8%)	5.8%

Passive malaria case incidence rates indicate that in the two years after the ITN campaign indicated fewer malaria cases reported in each district:

- ~ 21% fewer in Standard ITN districts
- ~ 35% fewer in IG2 districts
- ~ 26% fewer in the PBO district

Key issues

- Variability and diversity in malaria transmission dynamics across and within countries
- Variability and changes in other key malaria interventions (e.g. SMC expansion in Burkina Faso)
- Human and vector behavior could be an important factor in determining ITN effectiveness
- Next steps are ongoing, more complete and nuanced analyses will consider ITN access, durability of ITNs after more than one year, sleeping and ITN use patterns, climate factors, etc.

Key takeaways – Interim results

- Mass ITN distributions (universal coverage campaigns) are strongly associated with increased ITN use and decreases in malaria transmission regardless of ITN type
- In areas of moderate to high transmission with pyrethroid resistant vectors:
 - Distribution of any of the new net types (IG2, PBO, and RG ITNs) seems more effective at controlling malaria than campaigns distributing standard, pyrethroid-only ITNs
 - May be less pronounced in West African settings with complex resistance profiles
- Final results pending – please stay tuned!

Let's ensure that every pregnant women, every child and every person at-risk is sleeping under an ITN



Credit: PMI VectorWork

Contacts

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 - marcy.erskine@ifrc.org
- ITN tracker and digital tools
 - robert.opoku@ifrc.org
- New Nets Project
 - giovanni.dusabe@ifrc.org
- Continuous Distribution Working Group (CDWG)
 - Jmiller@psi.org
 - ballakandeh@yahoo.co.uk

amp

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The Alliance for
Malaria Prevention



The Alliance for
Malaria Prevention

Présentation mondiale sur les MII

Réunions SRN du
comité CRSPC de
2022







Merci aux programmes nationaux de lutte contre le paludisme et aux partenaires de mise en œuvre, financiers et techniques des efforts déployés pour garantir la mise en œuvre des campagnes de distribution de MII en 2020 et 2021, en dépit de tous les défis rencontrés.

Notre action en 2020/2021 malgré la pandémie de Covid-19

- **La plupart des campagnes prévues en 2020 ont eu lieu dans l'année, mais avec plus ou moins de retard**
- **74% environ des MII prévues ont été distribuées en 2020 (15/01/2021)**
 - 219 millions environ de MII prévues pour la distribution
 - 162 millions environ de MII distribuées
- **64,5% des campagnes prévues ont été menées à bien, partiellement ou en totalité**
 - 31 pays ont planifié des campagnes de distribution de MII
 - 20 pays ont mené à bien des campagnes de distribution de MII prévues
- **La majorité des pays où les campagnes ont été menées partiellement ont fait d'importants progrès**
- **La plupart des MII restant de 2020 ont été distribuées en 2021**
- **62% environ des MII prévues ont été distribuées en 2021**
 - 192 millions environ de MII prévues pour la distribution
 - 119 millions environ de MII distribuées
- **62% des campagnes prévues ont été menées à bien, partiellement ou en totalité**
 - 21 pays ont planifié des campagnes de distribution de MII
 - 13 pays ont mené à bien des campagnes de distribution de MII prévues
 - Campagnes retardées pour diverses raisons

Mises en garde et défis

- Chiffres incomplets pour certains pays, manque d'informations sur les progrès réalisés par d'autres (en particulier pour les pays en dehors de l'Afrique)
 - Importants volumes de moustiquaires pour les campagnes organisées en Inde, mais pas de contact direct avec le pays pour des mises à jour
 - Le nombre de « MII distribuées » s'appuie sur le nombre de « MII disponibles », car les données concernant la distribution sont souvent indisponibles (à ajuster avec les chiffres de 2022)
- Pour les campagnes de 2020, la plupart des MII étaient déjà sur place avant la pandémie
 - Retards plus importants pour les campagnes de 2021, en raison des perturbations des chaînes d'approvisionnement, notamment pour les commandes ou livraisons tardives d'équipements de protection individuelle

Outil de suivi des campagnes et de la distribution continue

- Outil de suivi des campagnes de distribution de MII
 - Lié aux tableaux de bord du partenariat FRP
 - Informations issues de programmes nationaux (en l'absence de coordonnées/d'informations, pas de mise à jour de l'outil de suivi)
 - Beaucoup d'erreurs – merci d'aider à les corriger
- Outil de suivi de la distribution continue
 - Merci à l'Ouganda d'avoir soumis le seul outil de suivi complet 😊
 - Objectif : mettre en lumière les besoins (et les immenses lacunes) pour l'« accès soutenu aux MII » en amont des candidatures pour le Fonds mondial
 - Met en lumière l'importance d'un système unifié de soumission de rapports sur les MII, tous canaux confondus

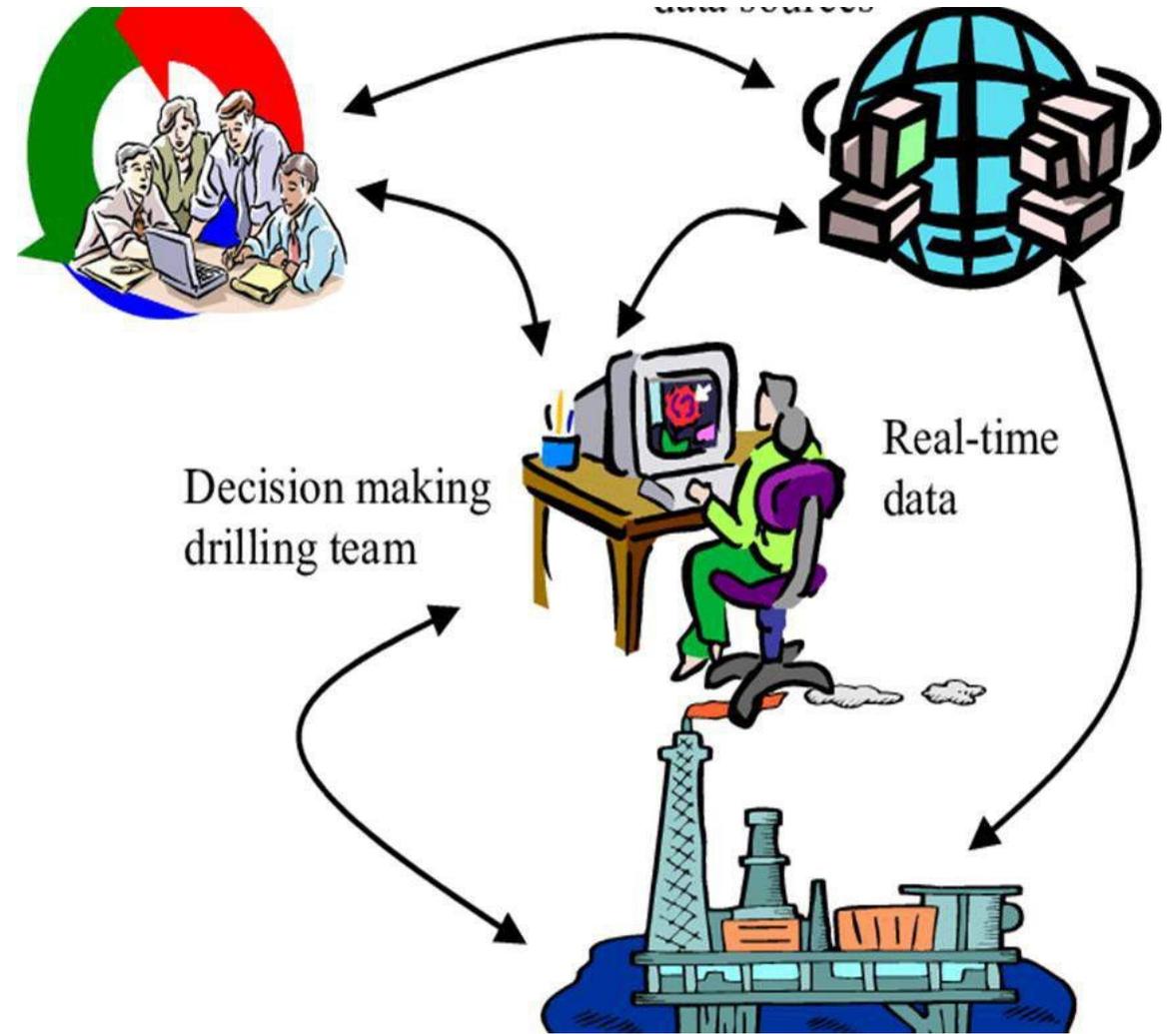
Campagnes de distribution de MII et outils numériques

Contexte

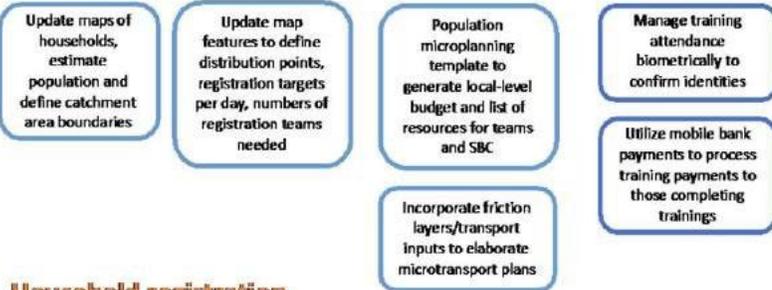
- Financement via le Projet d'accroissement de l'efficacité des campagnes de distribution de MII de la Fondation Bill et Melinda Gates
- Entretiens rétrospectifs avec 14 pays qui sont passés aux outils numériques
- Suivi prospectif de X pays planifiant leur passage aux outils numériques à l'occasion des campagnes de distribution de MII de 2022/2023

Objectif : dégager des facilitateurs, des obstacles et des mesures de limitation des risques pour le passage d'outils papier à des outils numériques, y compris pour les paiements autres qu'en espèces

La numérisation améliorera la disponibilité de données en temps réel au service de la prise de décisions, de la qualité des données et de la redevabilité concernant les MII, et réduira les délais et les coûts à long terme



Planning and training



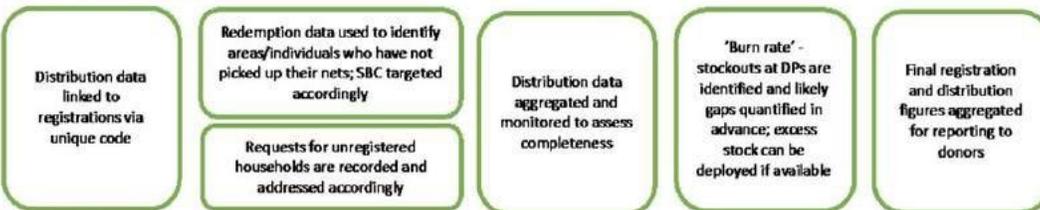
Household registration



Supply chain



ITN distribution



Étendre notre numérisation à la « liste de souhaits » améliorera l'efficacité de nos campagnes

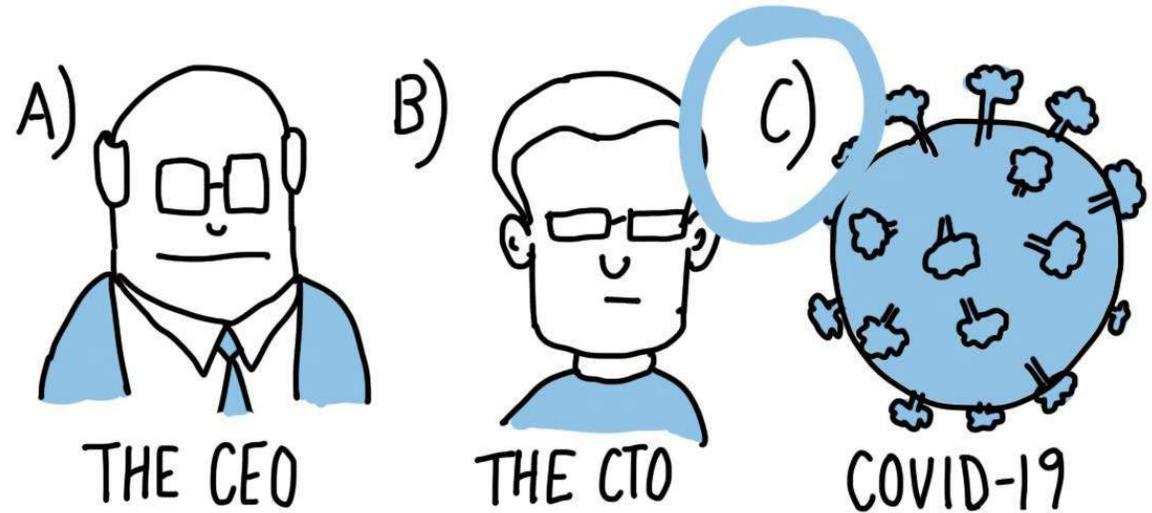
https://allianceformalariaprevention.com/wp-content/uploads/2021/06/AMP_Improving_Efficiency_Digital_Tools_21052021.pdf

L'adhésion et l'engagement sans réserve des dirigeants sont essentiels pour réussir la transition des outils papier aux outils numériques



La planification et la budgétisation anticipées, notamment l'identification des besoins en soutien technique (interne/externe), améliorera le passage aux outils numériques et limitera les retards.

WHO LED THE DIGITAL TRANSFORMATION OF YOUR COMPANY ?



BUSINESSILLUSTRATOR.COM

Le fait de travailler en partenariat et de tirer parti des données, des informations et des outils existants peut nous faire avancer plus rapidement.



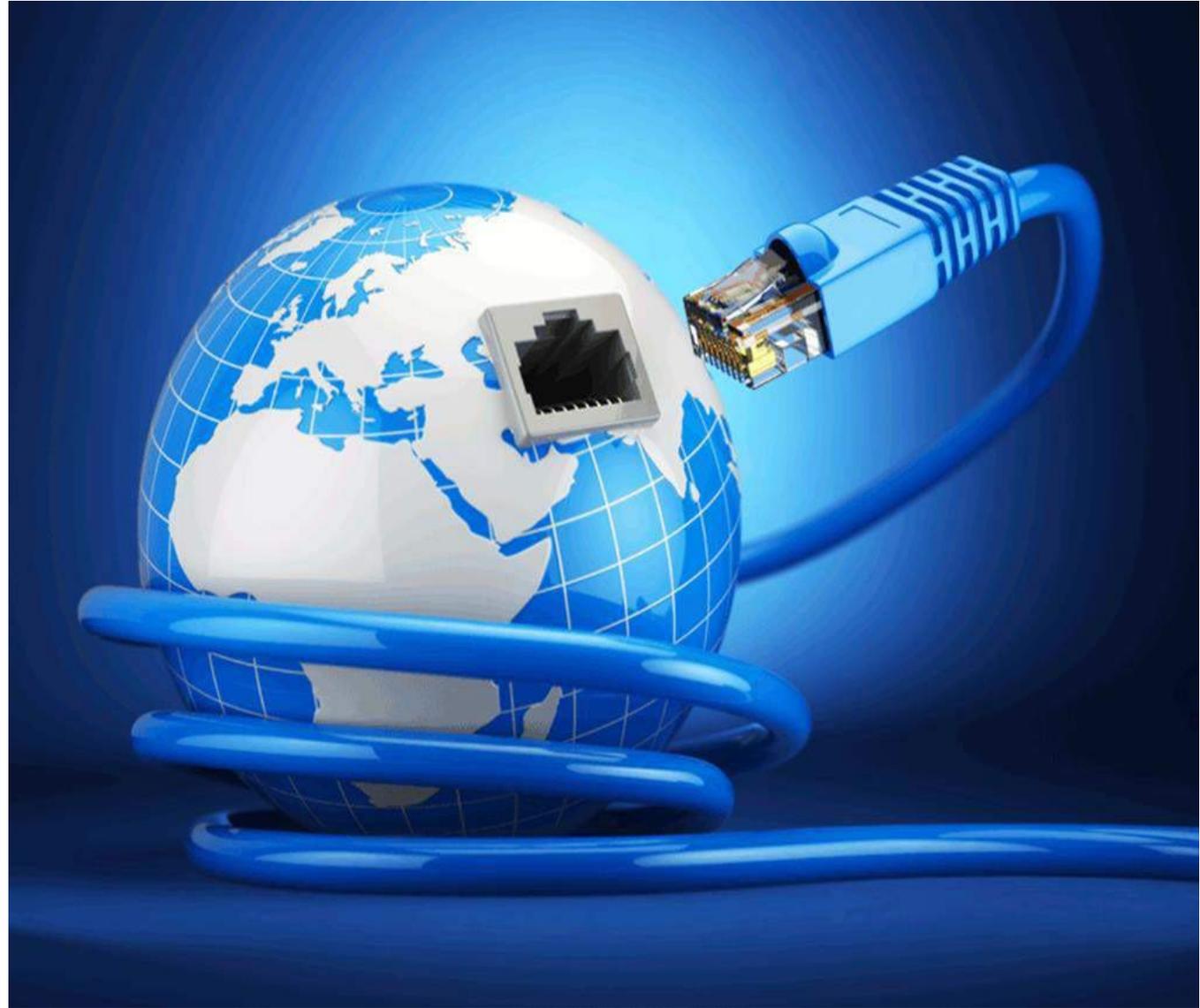


**Repenser l'intégration
pour une utilisation plus
efficace des données, des
informations et des
ressources au sein des
programmes de santé et
entre eux**

Le pilotage de projets dans différents contextes et pour différentes activités (CPS, pulvérisation intradomiciliaire) pour tirer des enseignements en vue d'intensifier notre action améliorera la numérisation des campagnes de distribution de MII



Étudier l'infrastructure existante et le contexte local : accès au réseau, sécurité des dispositifs et réglementations locales concernant la planification pour la numérisation des campagnes de distribution



Ne pas oublier pas de former « au-delà du dispositif » pour améliorer les résultats des campagnes

correct_rec	correct_no	nb_hhs	p_correct	class
72	8	80	90	Pass
72	8	80	90	Pass
68	12	80	85	Pass
62	18	80	78	Intermediate
59	21	80	74	Intermediate
55	25	80	69	Intermediate
55	25	80	69	Intermediate
54	26	80	68	Intermediate
54	26	80	68	Intermediate
53	27	80	66	Intermediate
49	31	80	61	Intermediate
43	37	80	54	Fail
43	37	80	54	Fail
42	38	80	53	Fail
40	40	80	50	Fail

$$\frac{3}{4} + \frac{2}{3} = \frac{9}{12} + \frac{8}{12}$$

different
denominators

common
denominator

En travaillant ensemble, nous pouvons éventuellement « ajuster le dénominateur » et faire en sorte que nos ressources soient utilisées le mieux possible

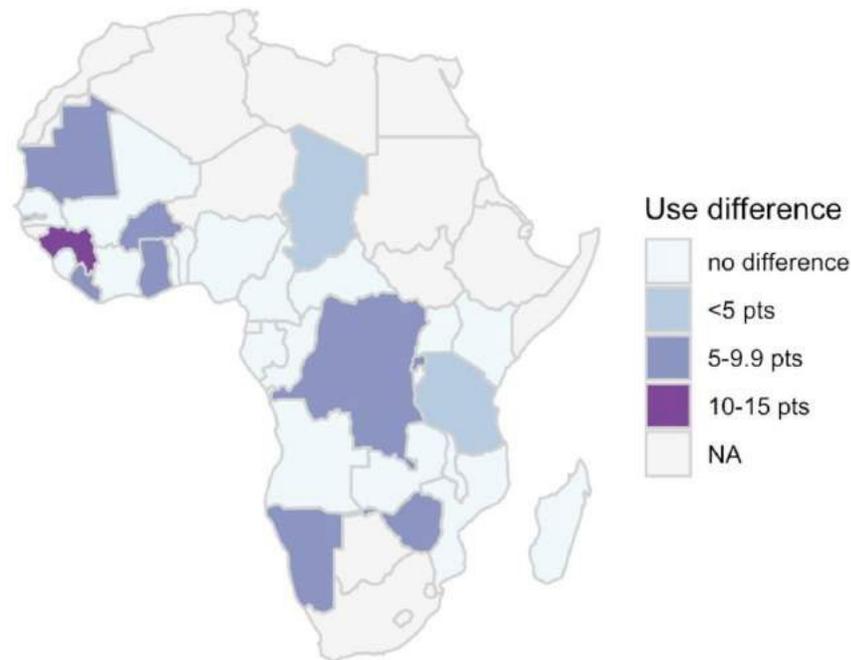
Outils pour la numérisation : disponibles fin juillet

- Matrice pour la prise de décision concernant la numérisation
- Liste de vérification de la planification et du budget concernant la numérisation
- Modèle de plan d'action pour la numérisation

Réflexions concernant les campagnes de distribution et la distribution continue de MII

Textile utilisé pour les MII et utilisation des MII

Figure 1: Crude difference in % of nets used between textiles



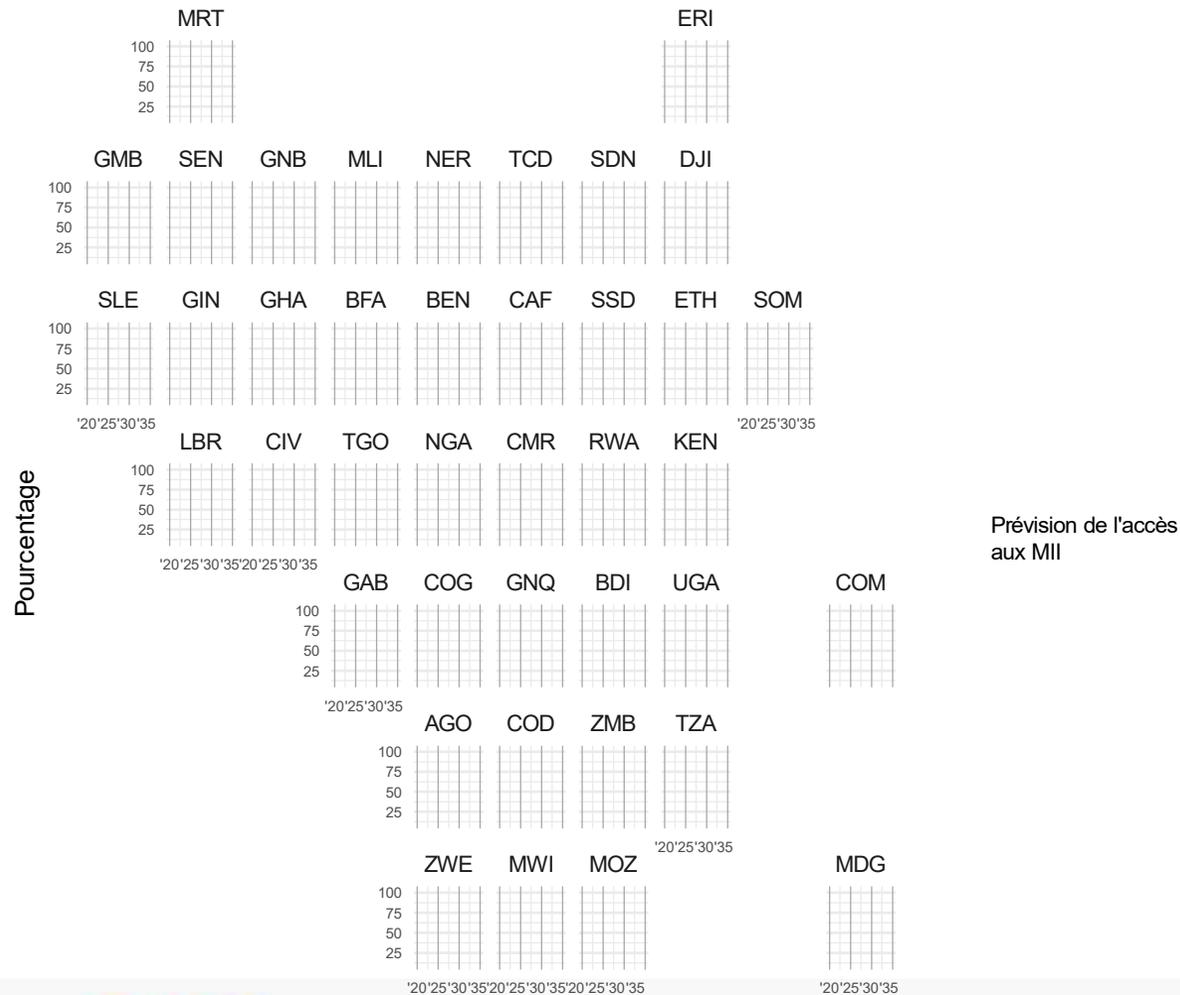
Les programmes souhaitent parfois se procurer des MII d'un textile particulier.

Les rapports se basent sur des données tirées d'enquêtes auprès des ménages pour évaluer s'il existe des différences d'utilisation entre les moustiquaires en polyester et celles en polyéthylène dans un pays donné, et si la matière des moustiquaires est corrélée à ces différences après avoir contrôlé d'autres déterminants de l'utilisation des moustiquaires.

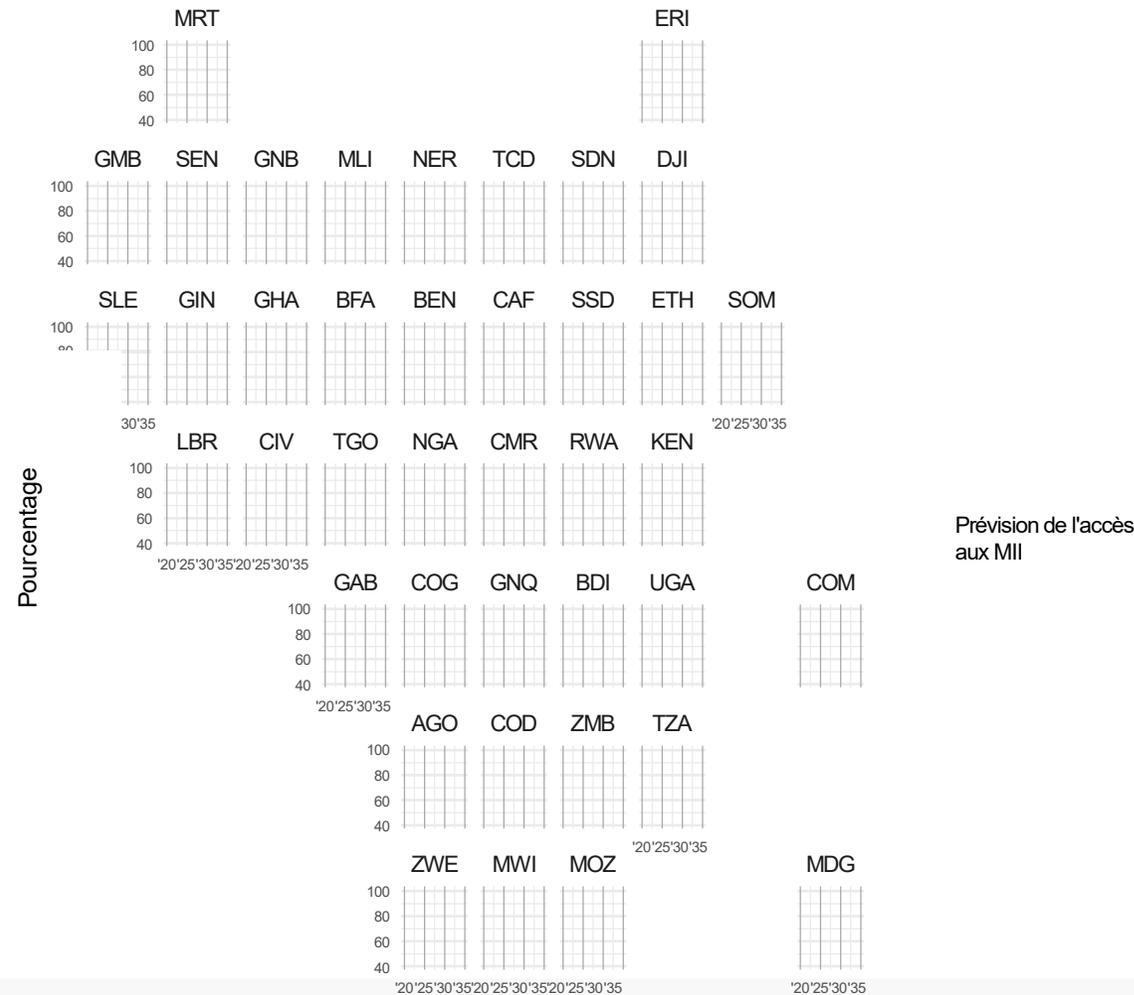
<https://net-textile-use-reports.netlify.app>

Les différences de temps de rétention d'un pays à l'autre affectent la réussite des stratégies en matière de MII

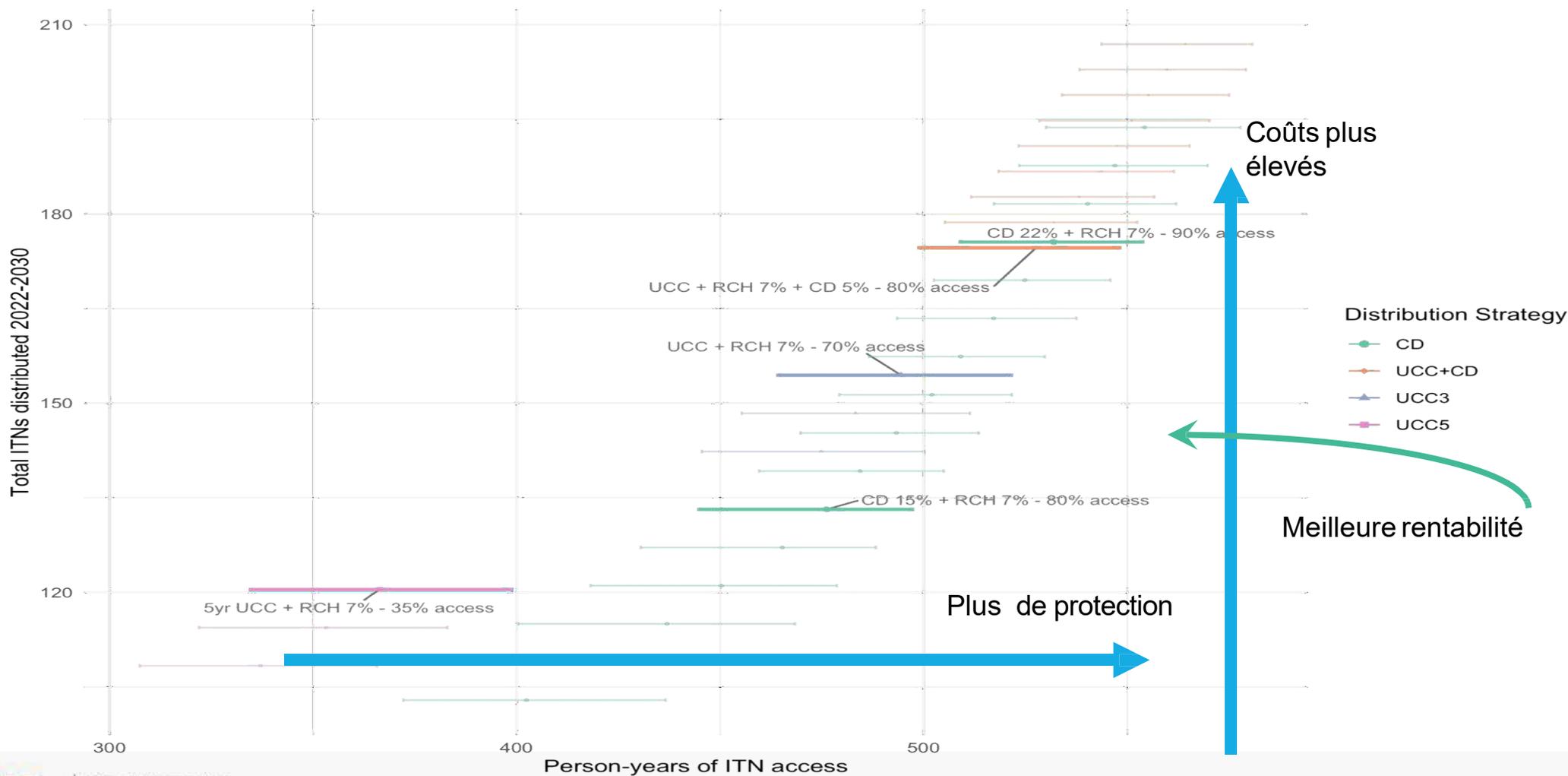
Campagnes de distribution massive sur trois ans avec soins prénataux/programmes élargis d'immunisation, à 1,8% de la population



Soins prénataux/programmes élargis d'immunisation à 6% et distribution annuelle scolaire/communautaire à 17 % de la population



La distribution continue pourrait offrir une protection comparable avec 14% de moustiquaires de moins en comparaison des campagnes de distribution massive sur trois ans



La distribution des moustiquaires les plus efficaces, au bon moment (lorsqu'elles sont nécessaires) nécessitera d'étendre les canaux de distribution et les échanges de MII



Il est essentiel de maintenir l'accès à des MII efficaces : nous avons besoin de plus de canaux de distribution continue fonctionnels pour garantir l'accès aux MII lorsque nécessaire

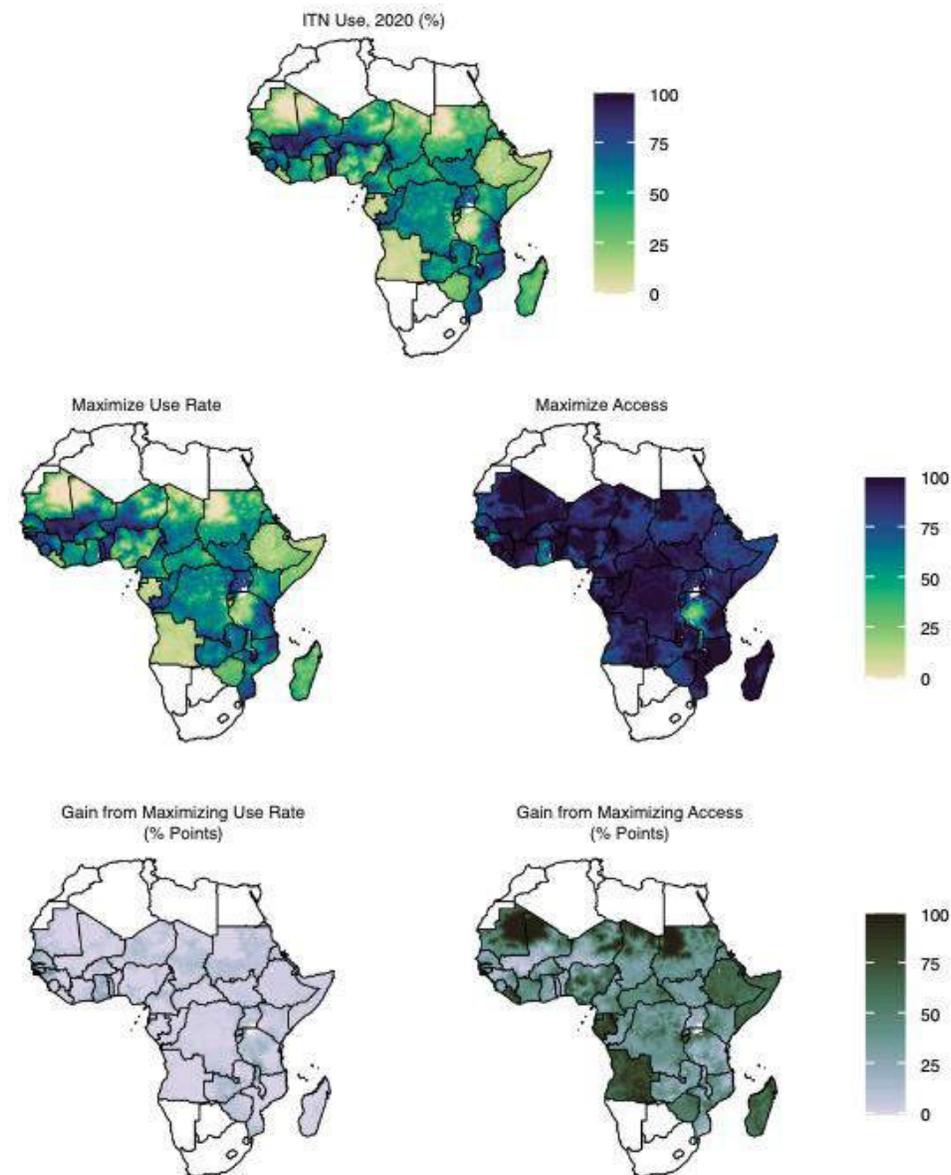
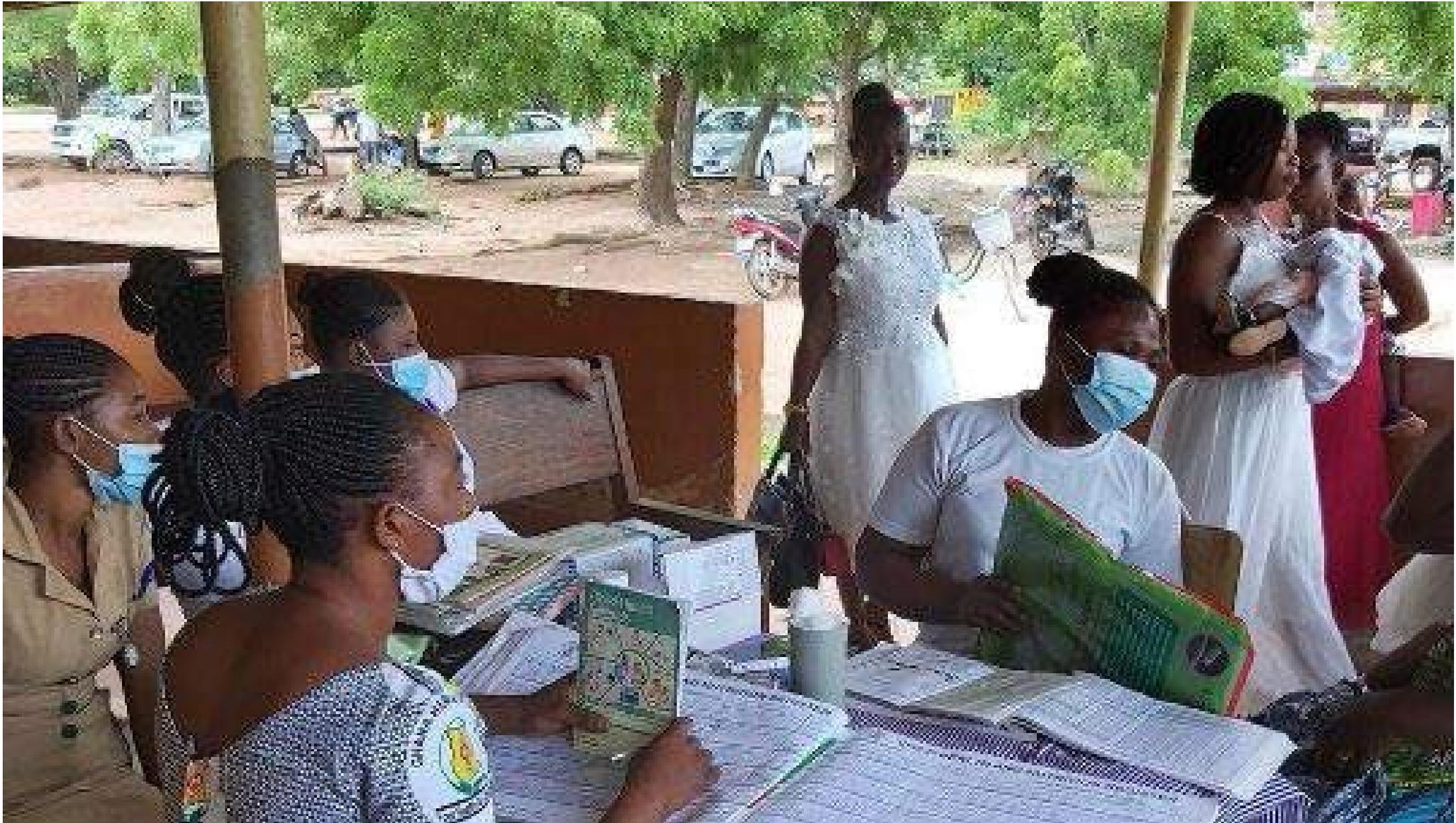


Fig. 6 Magnitude of change in insecticide-treated net (ITN) use possible from increasing use rate versus increasing access. The top row shows estimated ITN use in 2020. The second row shows what use could be if access remained unchanged and the use rate were set to 100% (left), compared to if the use rate remained unchanged and access was set to 100% (right). The final row shows the magnitude gain in use from each of these two scenarios. With few exceptions, increasing access has a larger impact than increasing the use rate.

Expanding the ownership and use of mosquito nets



Optimiser la distribution de MII dans les cliniques de soins prénatals et les programmes élargis d'immunisation

- La distribution de routine en continu de MII constitue un élément important d'une stratégie globale de distribution de MII depuis le début des années 2000
- À l'heure actuelle, 32 pays distribuent des moustiquaires par le biais de cliniques de soins prénatals et 28 par le biais de programmes élargis d'immunisation
- Les taux de délivrance de MII diffèrent d'un pays, d'une région et d'une saison à l'autre (un examen multi-pays est en cours)
- Il est essentiel de veiller à ce que ces canaux soient pleinement exploités dans tous les pays, afin de s'assurer d'atteindre les personnes les plus vulnérables du point de vue biologique

Défendre la distribution continue au-delà des projets pilotes lorsque nécessaire : des cycles de campagnes plus fréquents ne résolvent pas notre problème d'accès et engendrent des difficultés supplémentaires pour les programmes nationaux de lutte contre le paludisme



Envisager l'intensification ou l'ajout de nouveaux canaux

Distribution en milieu scolaire :

- Distribution à grande échelle en Tanzanie et au Ghana
- Projets pilotes dans plusieurs pays, y compris en RDC, en Guinée, au Mozambique et en Zambie
- Voir le document relatif au projet de distribution en milieu scolaire de PMI VectorLink disponible en français, anglais et portugais

[\(MS Word Chapter Setup Template
allianceformalariaprevention.com\)](#)

Distribution communautaire :

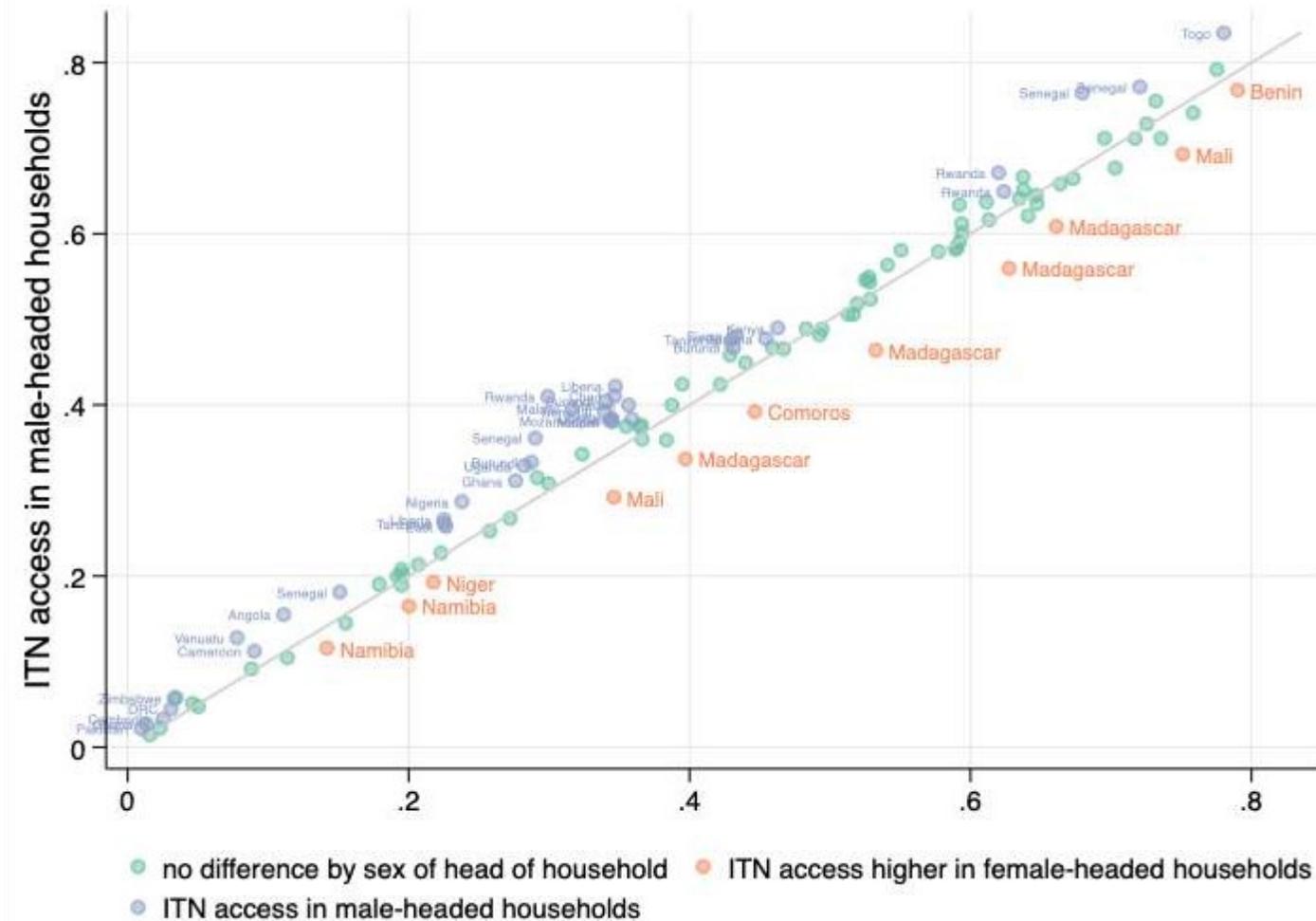
- Distribution à grande échelle à Madagascar et Zanzibar
- Consultez les sites allianceformalariaprevention.org et continuousdistribution.org pour en savoir plus et trouver des outils

Afin de toucher les personnes déplacées, réfugiées et difficiles d'accès, des investissements soutenus sont nécessaires, ainsi que les technologies et des canaux appropriés garantissant un accès continu aux MII.

Nous devons faire mieux !



"Brilliant, Ed! A slogan we can finally live up to!"



Utiliser les données et tenir compte de la question du genre – il peut s'agir d'un facteur important pour l'accès aux MII

Utiliser les données pour éclairer la planification du changement social et de comportement, ainsi que les plans et budgets, pour recueillir des données en cas de renseignements insuffisants

<https://malariabehaviorsurvey.org>

<https://breakthroughactionandresearch.org/resources/itn-use-and-access-report/>



Tenir compte de la gestion des rumeurs lors de l'adaptation des programmes au niveau sous-national

- Veiller à ce que les plans de gestion des rumeurs soient :
 - validés dans le cadre de la planification de la distribution de MII ;
 - compris par tous les acteurs des campagnes aux différents niveaux ;
 - prévus au budget, si un déploiement rapide est nécessaire.



**Améliorer la planification
et la budgétisation de la
gestion des déchets et
réfléchir aux effets
environnementaux, y
compris pour les MII en
fin de vie**





Utiliser les données et réfléchir à ce qui est efficace et efficient dans les zones urbaines pour rationaliser les ressources disponibles

Voir le site web – les orientations, relatives ou non au Covid-19, ont été mises à jour
Si vous ne trouvez pas ce que vous cherchez, faites-le nous savoir

Mises à jour des orientations

Organiser la qualité des MII : résultats clés et prochaines étapes

RESEARCH

Open Access



Correlation of textile 'resistance to damage' scores with actual physical survival of long-lasting insecticidal nets in the field

Albert Kilian^{1*}, Emmanuel Obi², Paul Mansiangi³, Ana Paula Abilio⁴, Khamis Arneir Haji⁵, Estelle Guillemois⁶, Vera Chetty⁶, Amy Wheldrake⁶, Sean Blaufuss⁷, Bolanje Olapeju⁷, Stella Babalola⁷, Stephen J. Russell⁶ and Hannah Koenker⁷

Abstract

Background: Attempts have been made to link procurement of long-lasting insecticidal nets (LLIN) not only to the price but also the expected performance of the product. However, to date it has not been possible to identify a specific textile characteristic that predicts physical durability in the field. The recently developed resistance to damage (RD) score could provide such a metric. This study uses pooled data from durability monitoring to explore the usefulness of the RD methodology.

Methods: Data from standardized, 3-year, prospective LLIN durability monitoring for six LLIN brands in 10 locations and four countries involving 4672 campaign LLIN were linked to the RD scores of the respective LLIN brands. The RD score is a single quantitative metric based on a suite of standardized textile tests which in turn build on the mechanisms of damage to a mosquito net. Potential RD values range from 0 to 100 where 100 represents optimal resistance to expected day-to-day stress during reasonable net use. Survival analysis was set so that risk of failure only started when nets were first hung. Cox regression was applied to explore RD effects on physical survival adjusting for known net use environment variables.

Results: In a bivariate analysis RD scores showed a linear relationship with physical integrity suggesting that the proportion of LLIN with moderate damage decreased by 3%-points for each 10-point increase of the RD score ($p = 0.02$, $R^2 = 0.65$). Full adjustment for net care and handling behaviours as well as other relevant determinants and the country of study showed that increasing RD score by 10 points resulted in a 36% reduction of risk of failure to survive in serviceable condition ($p < 0.0001$). LLINs with RD scores above 50 had an additional useful life of 7 months.

Conclusions: This study provides proof of principle that the RD metric can predict physical durability of LLIN products in the field and could be used to assess new products and guide manufacturers in creating improved products. However, additional validation from other field data, particularly for next generation LLIN, will be required before the RD score can be included in procurement decisions for LLINs.

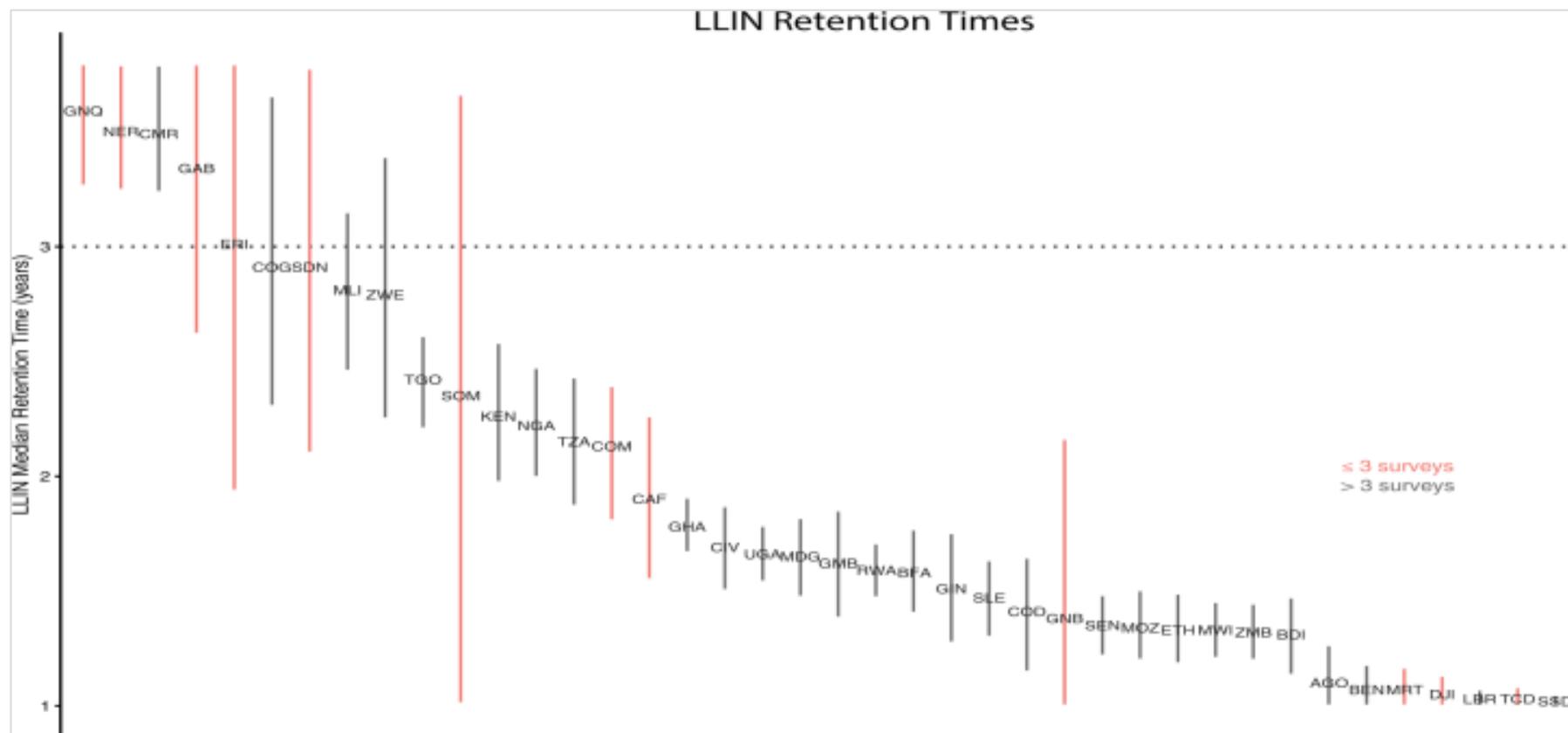
Keywords: LLIN physical durability, Textile resistance to damage

La qualité des MII est un facteur qui doit être abordé pour éviter un manque de confiance en leur efficacité

Malgré des cycles de distribution universelle sur trois ans, le temps moyen de rétention des moustiquaires est d'1,64 an

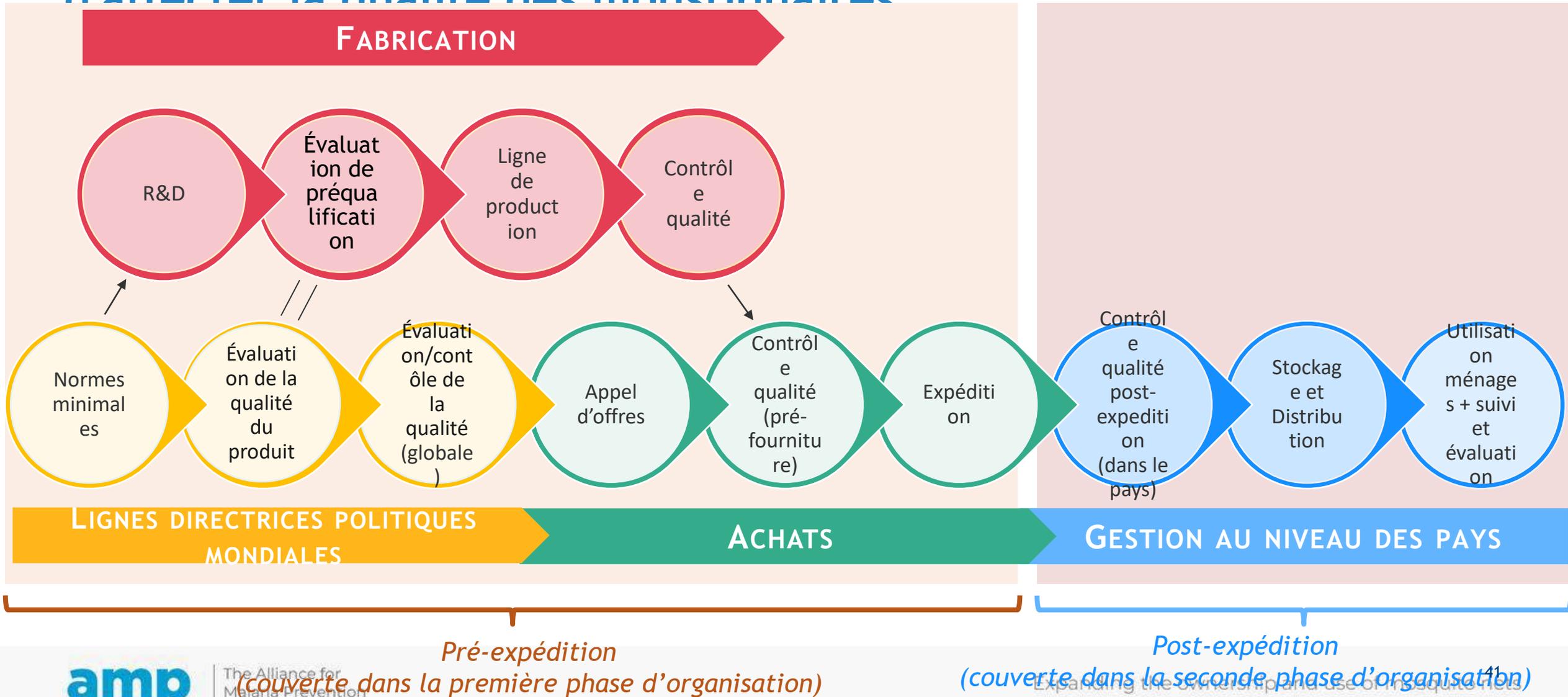
« [...] la majorité des preuves existantes indique que la rétention moyenne des moustiquaires est généralement inférieure à 3 ans. »

« Selon ces études, la motivation première pour jeter une moustiquaire est l'impression qu'elle est trop déchirée, même si les dommages sont peu importants, ce qui est souvent considéré comme inconvenant ou négligé. »



Bertozi-Villa, A., Bever, C.A., Koenker, H. *et al.* Cartes et indicateurs de l'accès aux moustiquaires imprégnées d'insecticide et de leur utilisation, et taux de moustiquaires par habitant en Afrique entre 2000 et 2020. *Nat Commun* 12, 3589 (2021).

L'initiative ITN Quality Lifecycle (« cycle de vie de la qualité des MII ») vise à cartographier les différents facteurs susceptibles d'affecter la qualité des moustiquaires



Une difficulté importante sur ce sujet : les définitions différentes de la « qualité » selon les parties prenantes

Définition technique

Degré de coïncidence des moustiquaires avec les propriétés chimiques et physiques définies dans leurs caractéristiques

QUALITÉ

Définition courante

Comportement des moustiquaires conforme à ce qu'on en attend dans des conditions normales d'utilisation (restent actives physiquement et chimiquement pendant trois ans)

La correspondance avec la définition technique signifie-t-elle que la performance attendue au vu de la définition courante est atteinte ?

Thèmes essentiels : politique g

PRINCIPAUX DÉFIS

SOLUTIONS PRIVILÉGIÉES

Normes
minimales

- Nécessité de mettre en place des **spécifications** qui associent la qualité des moustiquaires à leur performance

- Élaborer la « base » des attributs des MI
Intégration de **l'intégrité textile** aux spécifications

Évaluati
on de
préquali
fication

- **Mise à jour des orientations relatives aux tests** pour tenir compte des nouveaux produits

- Mise à jour et diffusion des lignes directrices de test

Assuranc
e/Contr
ôle
qualité

- **Infrastructure de test d'assurance/de contrôle qualité insuffisante** – méthodologies de test et différents laboratoires non perçus comme fournissant des résultats cohérents

- Revoir les capacités en matière de BPL pour les tests des MI
- Réviser l'assurance qualité de l'infrastructure de test en laboratoire pré- et post-expédition

Thèmes essentiels : fabrication

R & D

PRINCIPAUX DÉFIS

- Indicateurs pour différencier la performance nécessaire en matière de MII. **Tendances actuelles du marché vers la priorité accordée à la qualité par rapport à la performance, rendant l'innovation risquée**

Évaluation de préqualification

- Identifier comment les spécifications des produits peuvent être associées aux attributs qui améliorent la performance sur le terrain

Assurance/Contrôle qualité

- Charge d'inspection et manque de processus de qualité harmonisés

SOLUTIONS PRIVILÉGIÉES

- Délimitation des normes et des spécifications qui permettent aux acheteurs de justifier de prix plus importants et qui prouvent comment la qualité peut être plus rentable**

- Définir des caractéristiques claires et reproductibles pour fournir les performances souhaitées et distinguer les attributs primaires et secondaires des MII en s'appuyant sur la durabilité et la bioefficacité**

- Les acheteurs s'alignent sur les processus de qualité et s'accordent sur les attributs clés à tester

Thèmes essentiels : achats

PRINCIPAUX DÉFIS

SOLUTIONS PRIVILÉGIÉES

Appels d'offres

Trop d'importance accordée au prix par rapport à la qualité

- **Caractéristiques des documents et des mesures entraînant une meilleure performance.** Établir des normes pour fournir des résultats de meilleure qualité et être disposé à payer un prix plus élevé

ACHATS

Contrôle qualité (pré-livraison)

- Clarifier les critères d'acceptation des MII qui divergent par rapport aux spécificités
- **La norme ISO 9001 est la norme industrielle applicable, mais donne-t-elle assez d'informations sur les questions spécifiques liées aux MII ?**

- **Groupe chargé de l'évaluation de la qualité :** travaille sur des lignes directrices harmonisées concernant les tests pré-expédition. Le Fonds mondial élabore des orientations concernant les échantillons avant expédition
- Accord entre les fabricants, les acheteurs et les exécutants sur les normes, les méthodes et les marges d'erreur

Expédition

- Il est difficile d'attribuer la responsabilité des résultats OOS en raison du **manque de données claires le long de la chaîne de responsabilité**

- **Clarifier la chaîne de responsabilité pour les MII et chercher des moyens de fournir de meilleures données concernant le cycle de vie d'une moustiquaire (données de contrôle qualité, test, conditions de transport/stockage)**

Thèmes essentiels : gestion au

Inspection post-expédition

- Les tests non normalisés post-expédition peuvent entraîner le rejet de produits valides ou l'acceptation de produits de mauvaise qualité

Retards de livraison et stockage

- Absence de lignes directrices concernant le stockage
- **Retards et stockage au port**, y compris formalités douanières et retards liés à la distribution

Stratégie de distribution

- L'absence d'une stratégie claire/de microplans en matière de distribution et de retards à différents niveaux peuvent entraîner un stockage inapproprié

PRINCIPAUX DÉFIS

SOLUTIONS PRIVILÉGIÉES

- Mise en place d'orientations harmonisées concernant les critères d'inspection pré- et post-fourniture et les procédures opérationnelles normalisées
- Définition des conditions de stockage optimales et orientations à cet égard (propres aux moustiquaires lorsque nécessaire)
- Sensibilisation pour faciliter des formalités douanières rapides
- Mise en place d'une stratégie/de microplans clairs/proactifs en matière de distribution
- Systèmes numériques de collecte des données en temps réel/collecte et utilisation appropriées des données/traçage numérique des moustiquaires

Termes essentiels : éléments t

Glossaire commun de termes

- L'existence de diverses définitions de termes essentiels (qualité, performance, efficacité, durabilité, évaluation de la qualité, contrôle de la qualité, etc.) rend difficiles les discussions sur ces sujets

Confiance des parties prenantes

- **La confiance** parmi les différents groupes de parties prenantes concernant la qualité des MII doit être renforcée

Données

- Manque de données sur la performance/la bioefficacité, le suivi de la durabilité/les facteurs de risque dans le pays qui influencent la vie d'une moustiquaire

SOLUTIONS PRIVILÉGIÉES

- **Élaboration d'un glossaire clair de termes**, à transmettre aux groupes de parties prenantes essentiels
- **Mettre en place une stratégie de communication** pour favoriser la clarté et renforcer la confiance
- Renforcer la transparence par le biais du partage de données
- Surveillance post-commercialisation concernant la rétention, la bioefficacité, la concentration en principe actif, l'intégrité physique et l'utilisation
- Publication des données pour rendre les données appropriées disponibles à tous



Projet Nouvelles moustiquaires : problèmes opérationnels et résultats clés

Consortium du Projet Nouvelles moustiquaires



- Direction et coordination
- Relations avec les partenaires du secteur
- Lien avec la filière du développement de produits destinés à la lutte antivectorielle



- Compilation des enseignements tirés dans les différents pays à partir des études pilotes, financement destiné aux évaluations du processus

The Alliance for
Malaria Prevention

- Assistance technique

**Imperial College
London**

- Modélisation de la conception des essais et de l'impact de la mise en œuvre

PATH



- Point sur l'efficacité financière à partir de la mise en œuvre du projet pilote



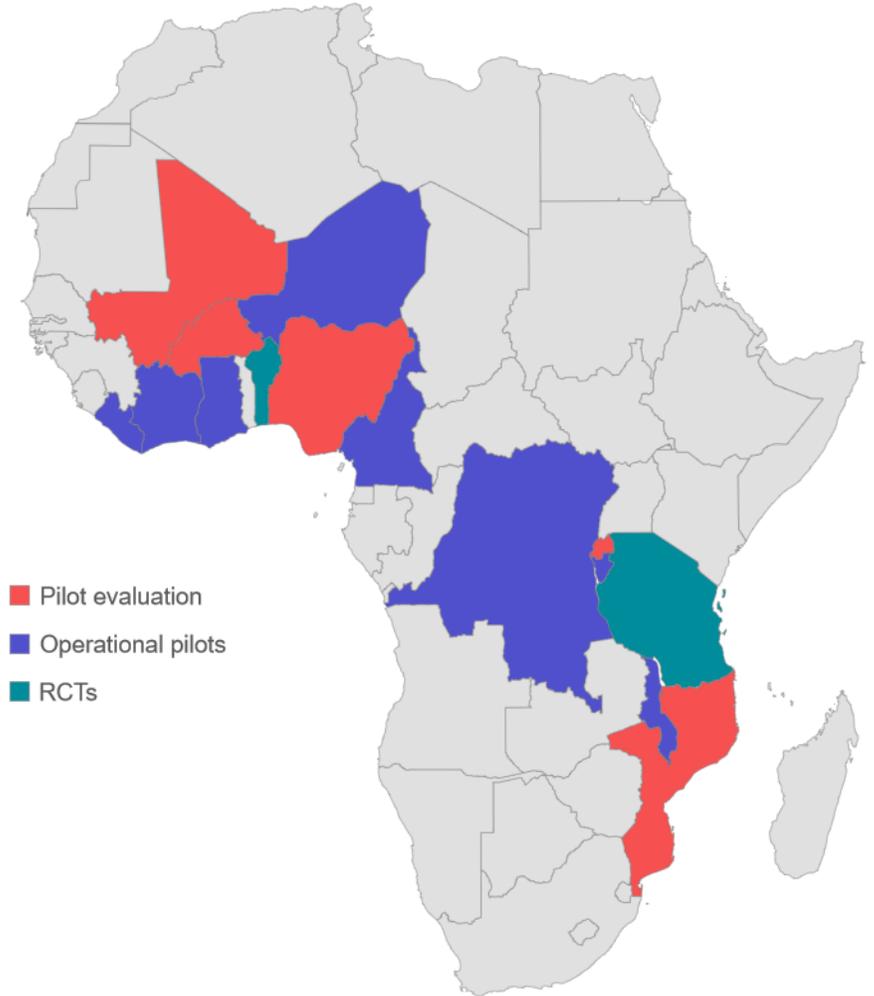
- Corrélats entomologiques de l'impact épidémiologique



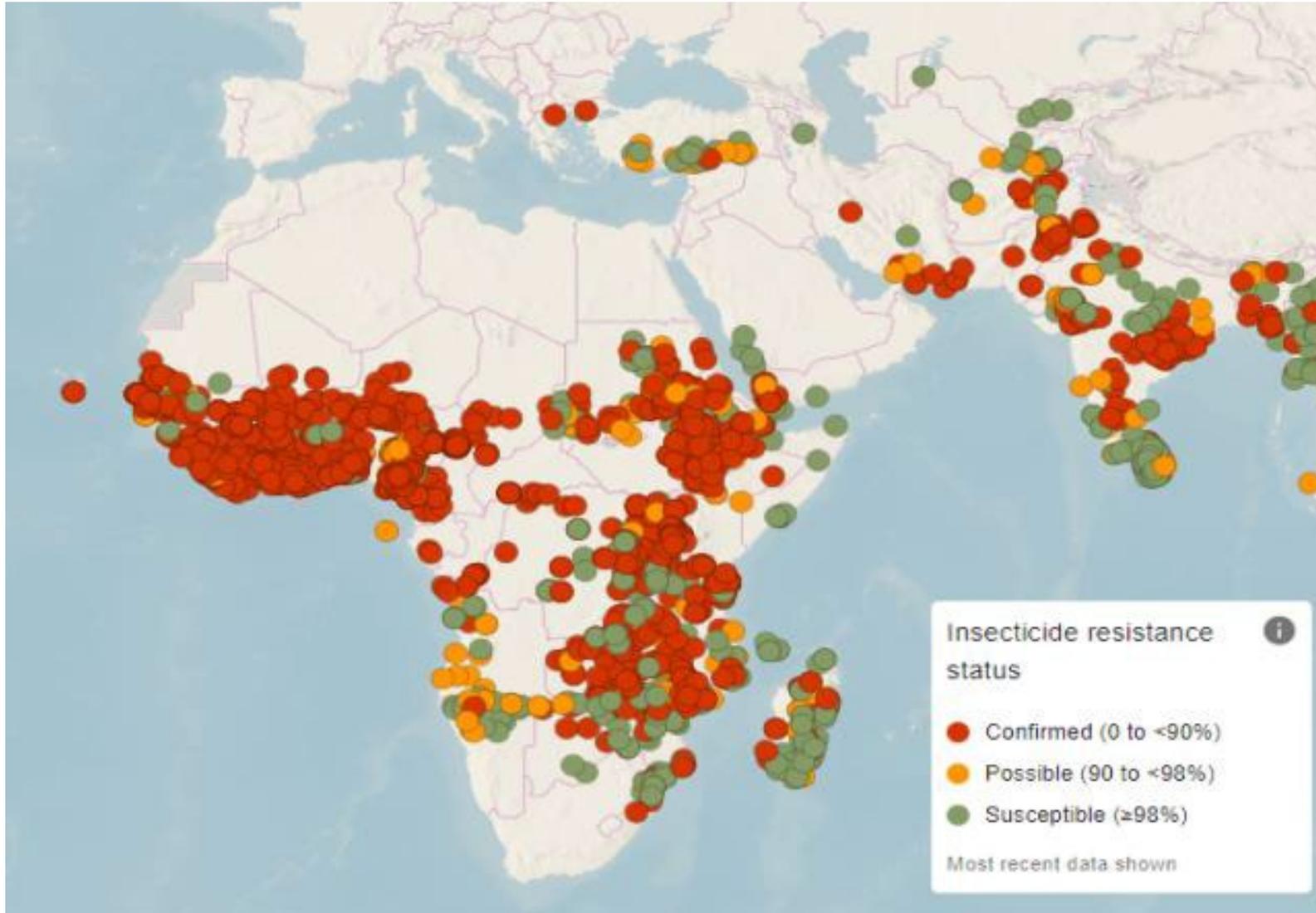
- Conception de l'étude sur la rentabilité et collecte des données



- Essais randomisés par grappes sur les MII imprégnées de deux ingrédients actifs et corrélats entomologiques dans les essais



Défi : la résistance aux insecticides



The effect of malaria control on *Plasmodium falciparum* in Africa between 2000 and 2015 (Effet de la lutte antipaludique sur *Plasmodium falciparum* en Afrique entre 2000 et 2015), S. Bhatt et al, Sep 2015

<https://apps.who.int/malaria/maps/threats>

Aperçu du projet



Le Projet Nouvelles moustiquaires (financé par Unitaid et par le Fonds mondial, et amorcé par l'IVCC) aide à piloter la nouvelle génération de moustiquaires, les **MII à double principe actif**.

Pyréthroïde seul

MII classiques

**Pyréthroïde +
synergiste**

MII imprégnées de
PBO

**Pyréthroïde +
Chlorfénapyr**

MII G2 Interceptor®

**Pyréthroïde +
Pyriproxifène**

MII Royal Guard®

- Ces nouvelles moustiquaires :
 - sont plus onéreuses ;
 - nécessitent encore une orientation stratégique de l'OMS.
- Le projet Nouvelles moustiquaires aidera :
 - à supprimer les barrières commerciales et **améliorer l'accès** aux MII à double principe actif ;
 - **à réunir les preuves nécessaires** pour l'orientation stratégique de l'OMS : épidémiologie, entomologie, anthropologie, rentabilité, suivi de la durabilité.

Problèmes opérationnels

CS456197



"Oh, great. NOW you discover fire!"

La fourniture désynchronisée de différents types de MII constitue un défi qui doit être résolu



Des solutions réalistes (et respectueuses de l'environnement) de gestion des déchets sont nécessaires d'urgence

Résultats clés : résultats provisoires pour le Mozambique



Poids du paludisme à ce jour *dans le nord du Mozambique*

Proportion de la population ayant dormi sous une moustiquaire la nuit précédente (CI 95%)

Accès de la population aux MII (IC 95%)

Utilisation en fonction de l'accès*

Gurue (MII classiques)		Cuamba (MII IG2)		Mandimba (MII RG)	
2020	2021	2020	2021	2020	2021
23,0% (21,3%–24,7%)	87,4% (82,8%–90,8%)	19,4% (17,9%–21,0%)	67,9% (57,0%–77,1%)	17,0% (15,5%–18,6%)	81,6% (74,7%–87,0%)
23,1% (21,8%–24,4%)	85,7% (82,5%–88,8%)	21,0% (19,7%–22,3%)	64,8% (54,8%–74,8%)	16,4% (15,3%–17,6%)	75,5% (69,0%–82,3%)
0,99	1,02	0,92	1,05	1,03	1,08

- L'accès aux moustiquaires et leur utilisation ont augmenté de façon significative après la campagne

Prévalence du paludisme pour les enfants de moins de 5 ans (TDR+) (IC 95 %)

Gurue (MII classiques)		Cuamba (MII IG2)		Mandimba (MII RG)	
2020	2021	2020	2021	2020	2021
64,9% (54,8%–75,0%)	52,5% (42,9%–61,9%)	47,5% (38,1%–57,0%)	29,4% (20,9%–39,5%)	66,0% (57,5%–74,4%)	46,2% (38,2%–54,4%)

- **Le poids du paludisme a également baissé de façon significative**

- **~19 % à Gurue (MII classiques)**
- **~38 % à Cuamba (MII IG2)**
- **~30 % à Mandimba (MII RG)**

Comparaison de l'incidence du paludisme avec MII de nouvelle génération et MII imprégnées de pyréthroïde classiques selon la méthode des doubles différences

Poids du paludisme à ce jour *dans le nord du Mozambique*

	2021 année 1 (janvier - juin) modification par rapport au point de départ	Méthode des doubles différences concernant les MII classiques
Gurue (MII classiques)	8% (- 3% à - 24%)	
Cuamba (MII IG2)	-48% (-52% à -40%)	56%
Mandimba (MII RG)	-28% (-31% à -23%)	36%

Les taux passifs d'incidence des cas de paludisme entre 2020 et 2021 ont indiqué :

- un nombre de cas similaires à Gurue (MII classiques)
- ~28 % de moins à Mandimba (MII RG)
- ~48 % de moins à Cuamba (MII IG2)

Poids du paludisme à ce jour *dans l'ouest du Mozambique*

Proportion de la population ayant dormi sous une moustiquaire la nuit précédente (CI 95%)
Accès de la population aux MII (IC 95%)
Utilisation en fonction de l'accès*

Chemba (MII classiques)		Guro (MII IG2)		Changara (MII imprégnées de PBO)	
2020	2021	2020	2021	2020	2021
33,3% (32,1%–34,7%)	90,1% (87,1%–92,4%)	18,5% (17,2%–19,8%)	92,8% (90,4%–94,7%)	23,0% (21,8%–24,2%)	84,6% (80,5%–88,0%)
30,4% (29,3%–31,6%)	86% (82,0%–90,1%)	18,8% (17,5%–20,1%)	88,9% (86,8%–91,1%)	26,3% (24,9%–27,6%)	84,2% (81,1%–87,3%)
1,10	1,05	0,98	1,04	0,88	1,00

- L'accès aux moustiquaires et leur utilisation ont augmenté de façon significative après la campagne

Prévalence du paludisme pour les enfants de moins de 5 ans (TDR+) (IC 95 %)

Chemba (MII classiques)		Guro (MII IG2)		Changara (MII imprégnées de PBO)	
2020	2021	2020	2021	2020	2021
44,3% (36,5%–52,1%)	39,0% (31,3%–47,2%)	17,1% (11,6%–22,7%)	3,8% (2,2%–6,7%)	5,7% (2,3%–9,1%)	2,1% (0,8%–5,4%)

- **Le poids du paludisme a également baissé de façon significative**
 - **~12 % à Chemba (MII classiques)**
 - **~77 % à Guro (MII IG2)**
 - **~63 % à Changara (MII imprégnées de PBO)**

Résultats clés : résultats provisoires pour le Burkina Faso



Poids du paludisme à ce jour

	Gaoua (MII classiques)			Banfora (MII IG2)			Orodara (MII imprégnées de PBO)		
	2019	2020	2021	2019	2020	2021	2019 [†]	2020	2021
Proportion de la population ayant dormi sous une moustiquaire la nuit précédente (CI 95%)	20,8% (18,6%–23,1%)	44,2% (40,9%–47,5%)	37,0% (30,5%–42,5%)	67,7% (64,9%–70,3%)	90,4% (88,5%–92,1%)	82,8% (79,0%–86,6%)	78,8% (76,1%–81,2%)	84,8% (82,3%–87,0%)	83,5% (79,9%–87,1%)
Accès de la population aux MII (IC 95%)	44,4% (42,4%–46,2%)	53,8% (51,4%–56,2%)	40,5% (37,9%–43,1%)	58,9% (57,1%–60,7%)	84,2% (83,1%–85,3%)	74,9% (73,5%–76,2%)	94,0% (93,1%–94,9%)	87,4% (86,3%–88,5%)	82,0% (80,7%–83,3%)
Utilisation en fonction de l'accès*	0,47	0,82	0,91	1,15	1,07	1,11	0,84	0,97	1,02

- Les augmentations en matière d'accès aux MII et de leur utilisation après la campagne ont été variables (et sont restées faibles à Gaoua)

	Gaoua (MII classiques)			Banfora (MII IG2)			Orodara (MII imprégnées de PBO)			
	2019	2020	2021	2019	2020	2021	2019 [†]	2020	2021	
Prévalence du paludisme pour les enfants CSS (TDR+) (IC 95 %)	<5	81,0% (74,9%–86,0%)	48,9% (41,9%–56,1%)	21,1% (15,5%–27,5%)	39,6% (33,0%–46,6%)	18,4% (13,5%–24,6%)	11,6% (7,4%–17,0%)	28,4% (22,4%–35,3%)	3,7% (1,8%–7,5%)	2,1% (0,6%–5,3%)
				54,5% (47,1%–61,7%)			36,1% (29,3%–43,4%)			19,9% (14,5%–26,3%)
	5 — 10									

- Calendrier des campagnes associé à la baisse de la prévalence du paludisme sur deux ans
 - ~74 % à Gaoua (MII classiques)
 - ~71 % à Banfora (MII IG2)
 - ~93 % à Orodara (MII imprégnées de PBO)

[†] La campagne de distribution de MII était terminée au moment de l'enquête transversale

*Pour obtenir l'indicateur d'utilisation en fonction de l'accès, il faut diviser l'utilisation (population ayant dormi sous une moustiquaire la nuit précédente) par l'accès. Des valeurs supérieures à 1 sont possibles, ce calcul étant une proportion.

Comparaison de l'incidence du paludisme avec MII de nouvelle génération et MII classiques selon la méthode des doubles différences

Poids du paludisme

	Année 1 (novembre- mai) modification par rapport au point de départ	Année 1 Méthode des doubles différences concernant les MII classiques	Année 2 (juin- mai) modification par rapport au point de départ	Année 2 Méthode des doubles différences concernant les MII classiques
Gaoua et Nouna (MII classiques)	-18,4% (-24,8% à -14,8%)		-20,6% (-24,9% à -17,5%)	
Banfara et Tougan (MII IG2)	-0,76% (-6,1% à 1,8%)	-18%	-35,3% (-36,7% à -34,6%)	14,7%
Orodara (MII imprégnées de PBO)	-22,9% (-28,8% à -2,7%)	4,5%	-26,4% (-29,2% à -24,8%)	5,8%

Les taux passifs d'incidence des cas de paludisme indiquent que, dans les deux ans qui ont suivi la campagne de distribution de MII, un nombre inférieur de cas de paludisme a été signalé dans chaque district.

- 21 % de moins dans les districts de distribution de MII classiques
- 35 % de moins dans les districts de distribution de MII IG2
- 26 % de moins dans les districts de distribution de MII imprégnées de PBO

Problèmes essentiels

- Variabilité et diversité des dynamiques de transmission du paludisme à travers les pays et au sein des pays
- Variabilité et modifications concernant d'autres interventions clés face au paludisme (par ex. élargissement de la CPS au Burkina Faso)
- Les comportements humains et des vecteurs pourraient être un facteur important pour déterminer l'efficacité des MII
- Les étapes suivantes sont en cours, des analyses plus complètes et nuancées tiendront compte de l'accès aux MII, de leur durabilité après plus d'un an, des schémas de sommeil et d'utilisation des MII, des facteurs climatiques, etc.

Points à retenir — résultats provisoires

- Les distributions massives de MII (campagnes de couverture universelle) sont fortement associées à une utilisation accrue des MII et à une baisse de la transmission du paludisme, peu importe le type de MII
- Dans des zones de transmission modérée à élevée avec des vecteurs résistants aux pyréthroïdes :
 - la distribution d'un des types de nouvelles moustiquaires (IG2, PBO et RG) semble plus efficace pour maîtriser la transmission du paludisme que les campagnes de distribution de MII classiques, imprégnées de pyréthroïde seulement ;
 - résultats peut-être moins clairs en Afrique de l'Ouest, où l'on trouve des profils de résistance complexes.
- Résultats finaux en attente — restez connectés !

Faisons en sorte que chaque femme enceinte, chaque enfant et chaque personne à risque dorme sous une MI



Crédits PMI VectorWorks

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amp



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Malaria Prevention

amp

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Malaria Prevention

Apresentação global de MTI

Reuniões de CRSPC e
SRN 2022





aos programas nacionais de malária, aos parceiros de execução, de financiamento e técnicos pelos esforços em prol do êxito da implantação das campanhas de MTI em 2020 e 2021, não obstante todos os problemas enfrentados

Como correu 2020/21, apesar da pandemia de COVID-19?

- **A maioria das campanhas de 2020 decorreu durante o ano, mas com diferentes atrasos**
- **~ 74 % dos MTI previstos para 2020 foram distribuídos (15/01/21)**
 - ~ 219 milhões de MTI previstos para distribuição
 - ~ 162 milhões de MTI distribuídos
- **64,5 % das campanhas planeadas foram concluídas no todo ou em parte**
 - 31 países planearam campanhas de MTI
 - 20 países concluíram as campanhas planeadas
 - A maioria dos países que não completaram as campanhas fez progressos significativos
- **A maioria dos MTI sobrantes de 2020 foi distribuída em 2021**
- **~ 62 % dos MTI previstos para 2021 foi distribuída**
 - ~ 192 milhões de MTI previstos para distribuição
 - ~ 119 milhões de MTI distribuídos
- **~ 62% das campanhas planeadas foram concluídas no todo ou em parte**
 - 21 países planearam campanhas de MTI
 - 13 países concluíram as campanhas de MTI planeadas no todo ou em parte
 - Campanhas atrasadas por diversos motivos

Alertas e problemas

- Os números não estão completos para todos os países, o progresso de alguns é desconhecido (sobretudo fora de África)
 - A Índia tem grandes volumes de mosquiteiros para campanhas, mas não há contacto direto com o país para atualizações
 - Os «MTI distribuídos» baseiam-se nos «MTI disponíveis», pois é frequente os dados de distribuição não estarem disponíveis (a ser ajustado para os números de 2022)
- Para as campanhas de 2020, a maioria dos MTI já se encontrava nos países antes da pandemia
 - Mais atrasos nas campanhas de 2021 devido a ruturas na cadeia de abastecimento, incluindo para encomendas ou entregas tardias de EPI

Rastreador de campanhas + rastreador de DC

- Rastreador de campanhas de MTI
 - Ligado aos *dashboards* da Parceria RBM
 - Informações de programas nacionais (sem info. de contacto, sem atualização do rastreador)
 - Muitos erros — por favor, ajude a corrigi-los!
- Rastreador de DC
 - Obrigado ao Uganda pelo único rastreador completo 😊
 - Objetivo de salientar as necessidades (e lacunas graves) para «manter o acesso aos MTI» antes das candidaturas ao FG
 - Realça a importância de um sistema unificado para elaborar relatórios sobre MTI, todos os canais

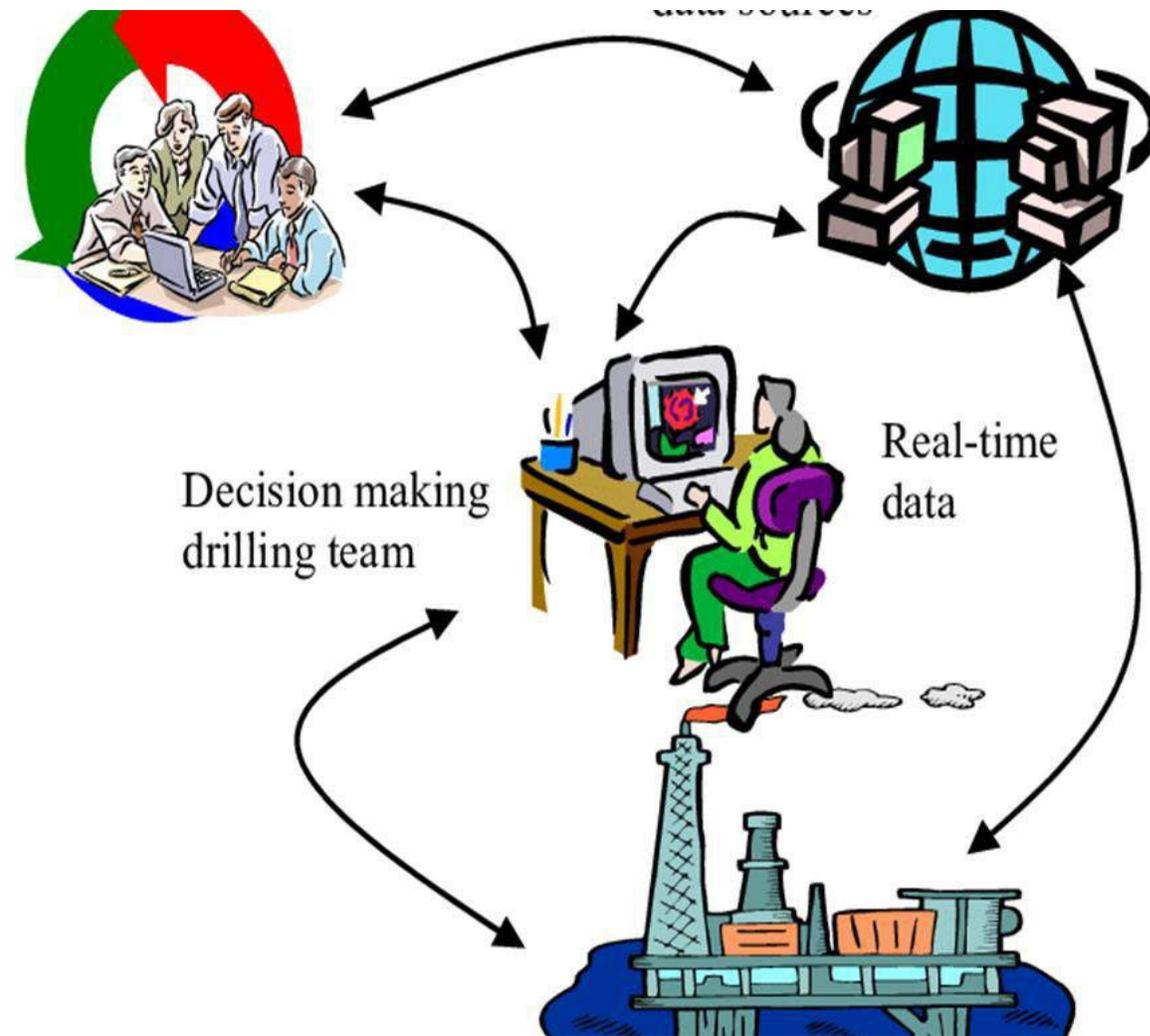
Campanhas de MTI e ferramentas digitais

Enquadramento

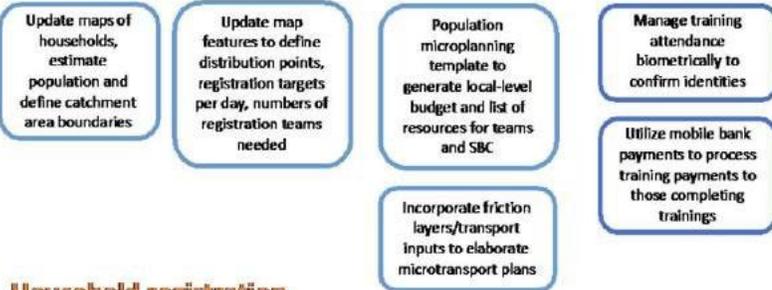
- Financiadas pelo Projeto para a Eficiência das Campanhas de MTI da FBMG
- Entrevistas retrospectivas a 14 países que fizeram a transição para ferramentas digitais
- Rastreamento prospectivo de 11 países que planeiam usar ferramentas digitais em campanhas de MTI em 2022/23

Objetivo de identificar facilitadores, obstáculos e formas de mitigar os riscos de transitar das ferramentas em papel para as ferramentas digitais, incluindo para pagamentos que não em dinheiro

A digitalização irá melhorar a disponibilidade de dados em tempo real para a tomada de decisões, a qualidade dos dados e a contabilização dos MTI e reduzirá tempo e custos a longo prazo



Planning and training



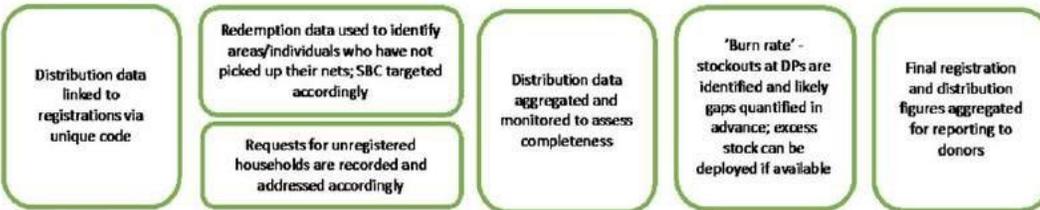
Household registration



Supply chain



ITN distribution



Expandir a nossa digitalização para «A Lista de Desejos» irá melhorar a eficiência da nossa campanha

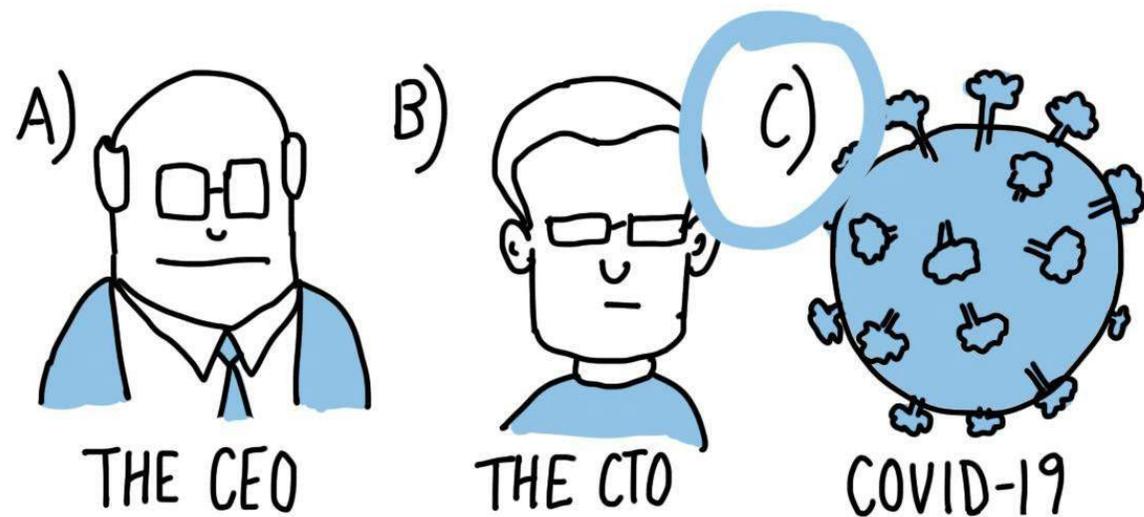
https://allianceformalariaprevention.com/wp-content/uploads/2021/06/AMP_Improving_Efficiency_Digital_Tools_21_052021.pdf

Uma forte adesão e empenho dos coordenadores é a chave para uma transição bem-sucedida de ferramentas em papel para ferramentas digitais

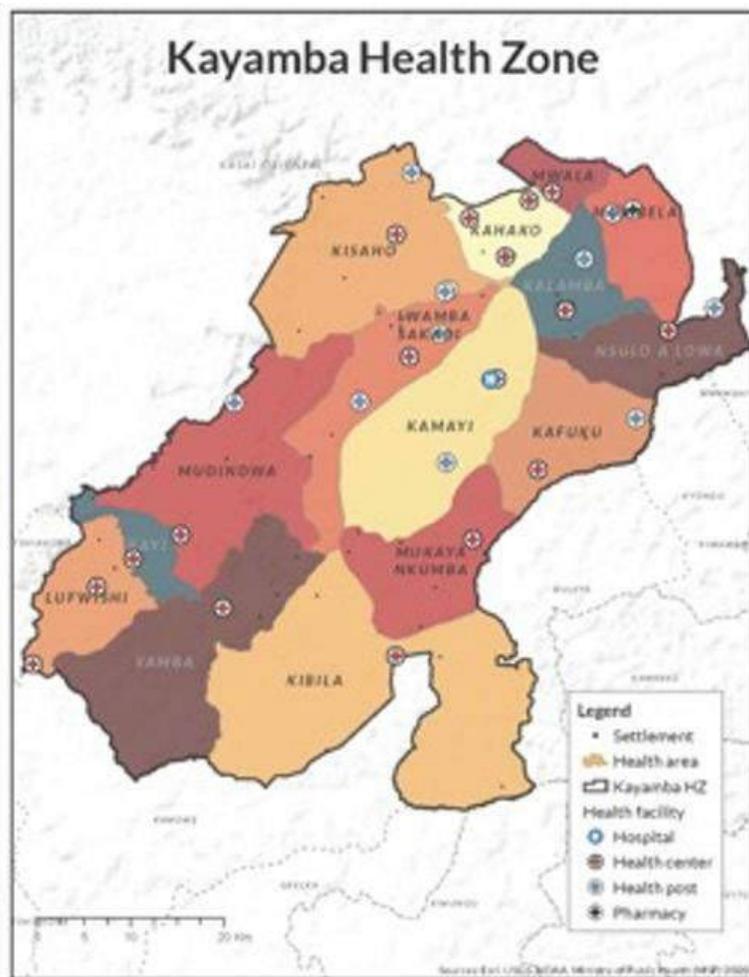
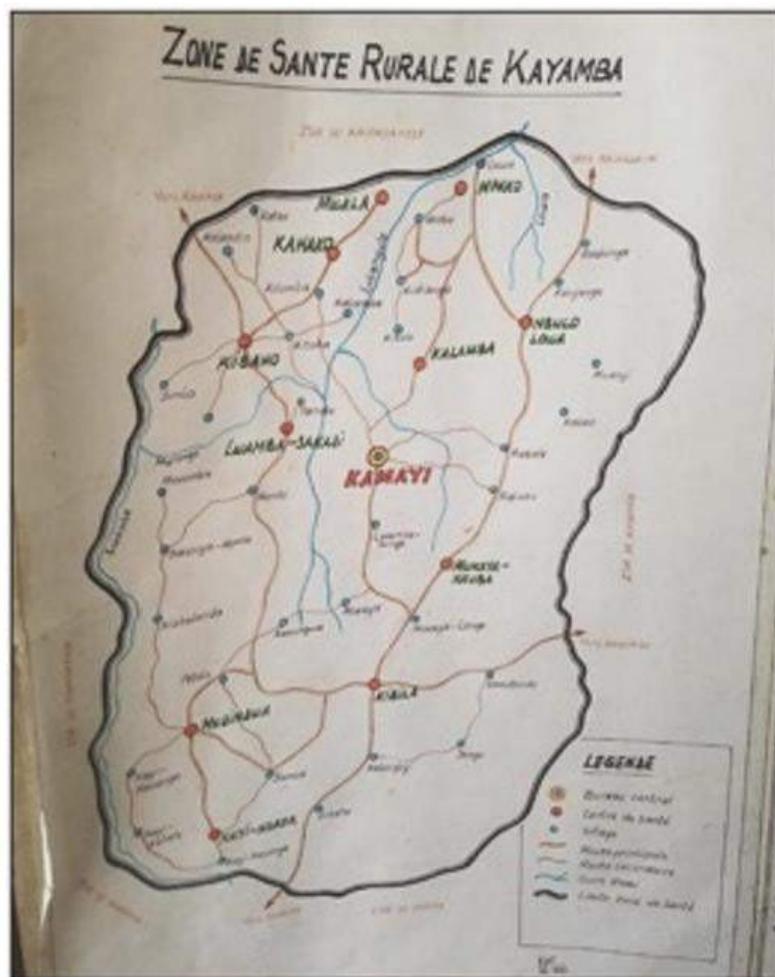


O planeamento e a orçamentação precoces, incluindo a identificação das necessidades de apoio técnico (interno/externo), irão melhorar a transição para as ferramentas digitais e reduzir atrasos

WHO LED THE DIGITAL TRANSFORMATION OF YOUR COMPANY ?



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Melhorar o nosso microplaneamento aumentará a nossa capacidade de chegar a todos e evitar a duplicação e o desperdício de recursos limitados

Trabalhando em parceria e aproveitando os dados, as informações e as ferramentas existentes podemos avançar mais rápido



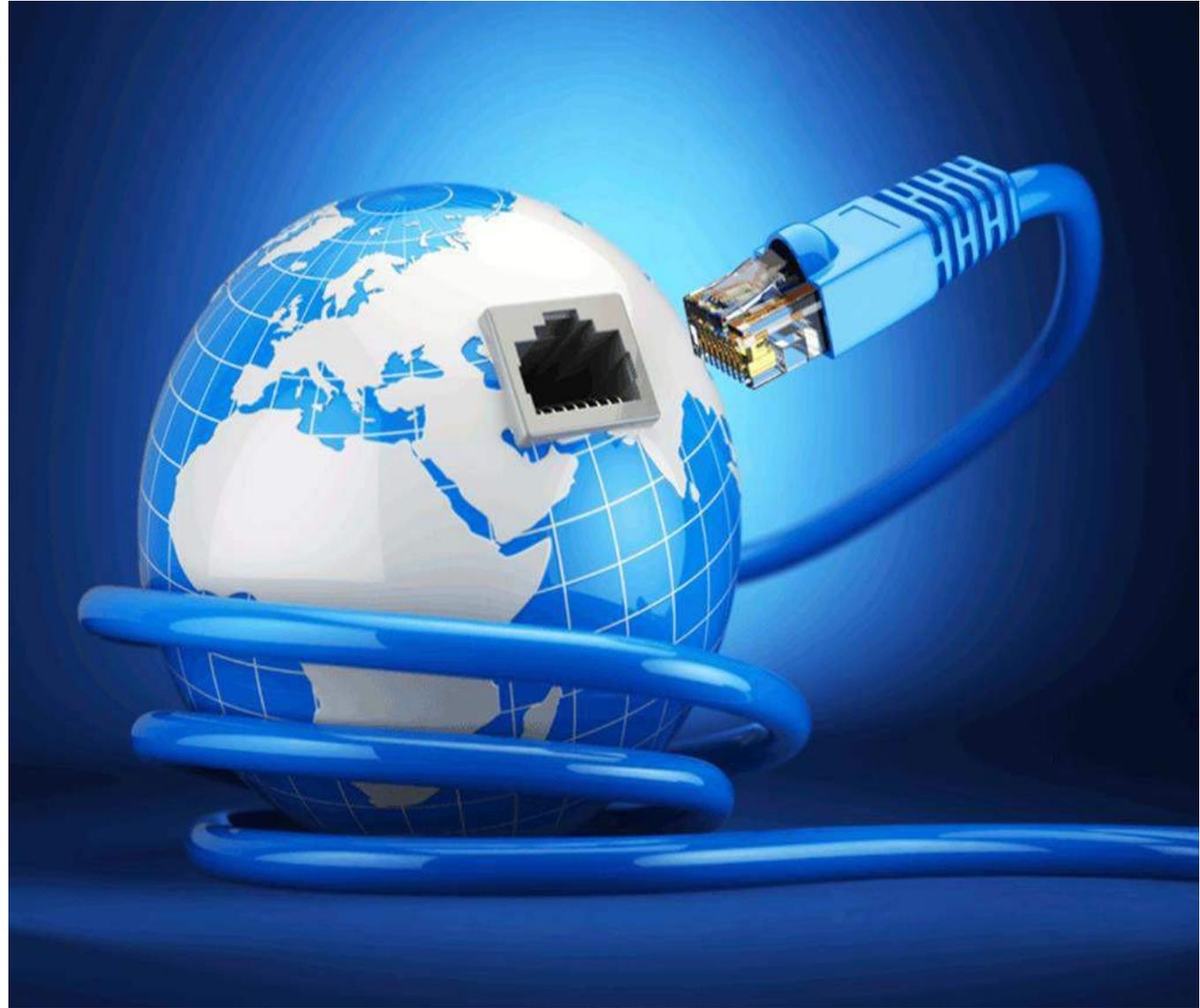


Repensar a integração para um uso mais eficaz dos dados, da informação e dos recursos dentro e entre programas de saúde

Projetos-piloto em vários contextos e para diferentes atividades (SMC, PRI), em prol do crescimento pela aprendizagem, irão aumentar o êxito da digitalização das campanhas de MTI



Considerar as infraestruturas existentes e o contexto local – acesso à rede, segurança dos dispositivos e regulamentos locais – ao planear a digitalização das campanhas



Não esquecer que a formação deve ir «além do dispositivo», para melhorar os resultados das campanhas

correct_rec	correct_no	nb_hhs	p_correct	class
72	8	80	90	Pass
72	8	80	90	Pass
68	12	80	85	Pass
62	18	80	78	Intermediate
59	21	80	74	Intermediate
55	25	80	69	Intermediate
55	25	80	69	Intermediate
54	26	80	68	Intermediate
54	26	80	68	Intermediate
53	27	80	66	Intermediate
49	31	80	61	Intermediate
43	37	80	54	Fail
43	37	80	54	Fail
42	38	80	53	Fail
40	40	80	50	Fail

$$\frac{3}{4} + \frac{2}{3} = \frac{9}{12} + \frac{8}{12}$$

different
denominators

common
denominator

Trabalhando em conjunto, esperamos «igualar o denominador» e assegurar que os nossos recursos são usados da melhor forma

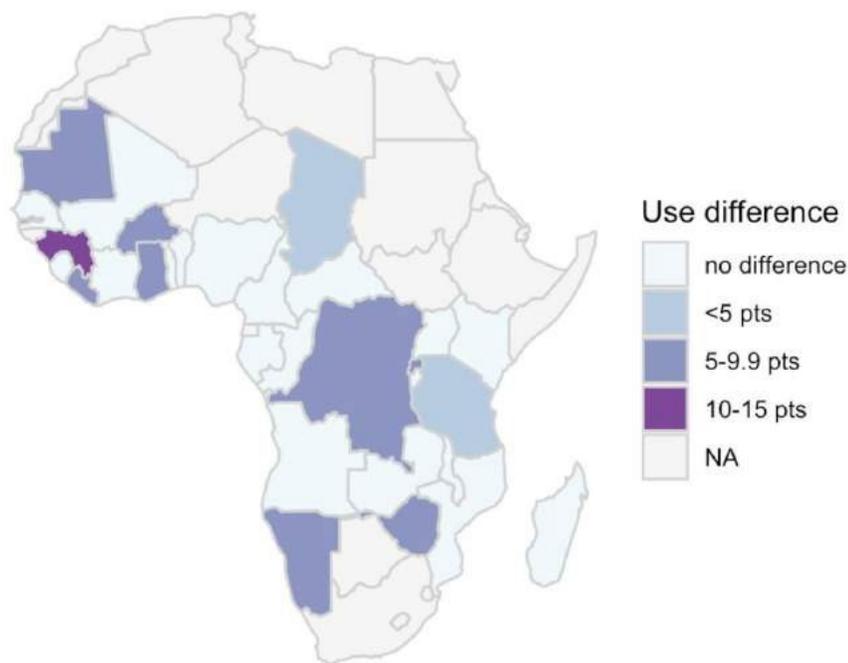
Ferramentas de digitalização: disponíveis no final de julho

- Matriz de tomada de decisão sobre a digitalização
- Lista de verificação do planeamento da digitalização e dos orçamentos
- Modelo do plano de ação de digitalização

Considerações sobre a campanha de MTI e a distribuição contínua

Tecido dos MTI e uso dos MTI

Figure 1: Crude difference in % of nets used between textiles



Os programas podem desejar adquirir MTI de um tecido específico

Os relatórios usam grandes volumes de dados de inquérito às famílias para apurar se há diferenças no uso de mosquiteiros de poliéster e de polietileno num determinado país, e se o tecido dos MTI está associado a essas diferenças, depois de verificados outros fatores determinantes no seu uso

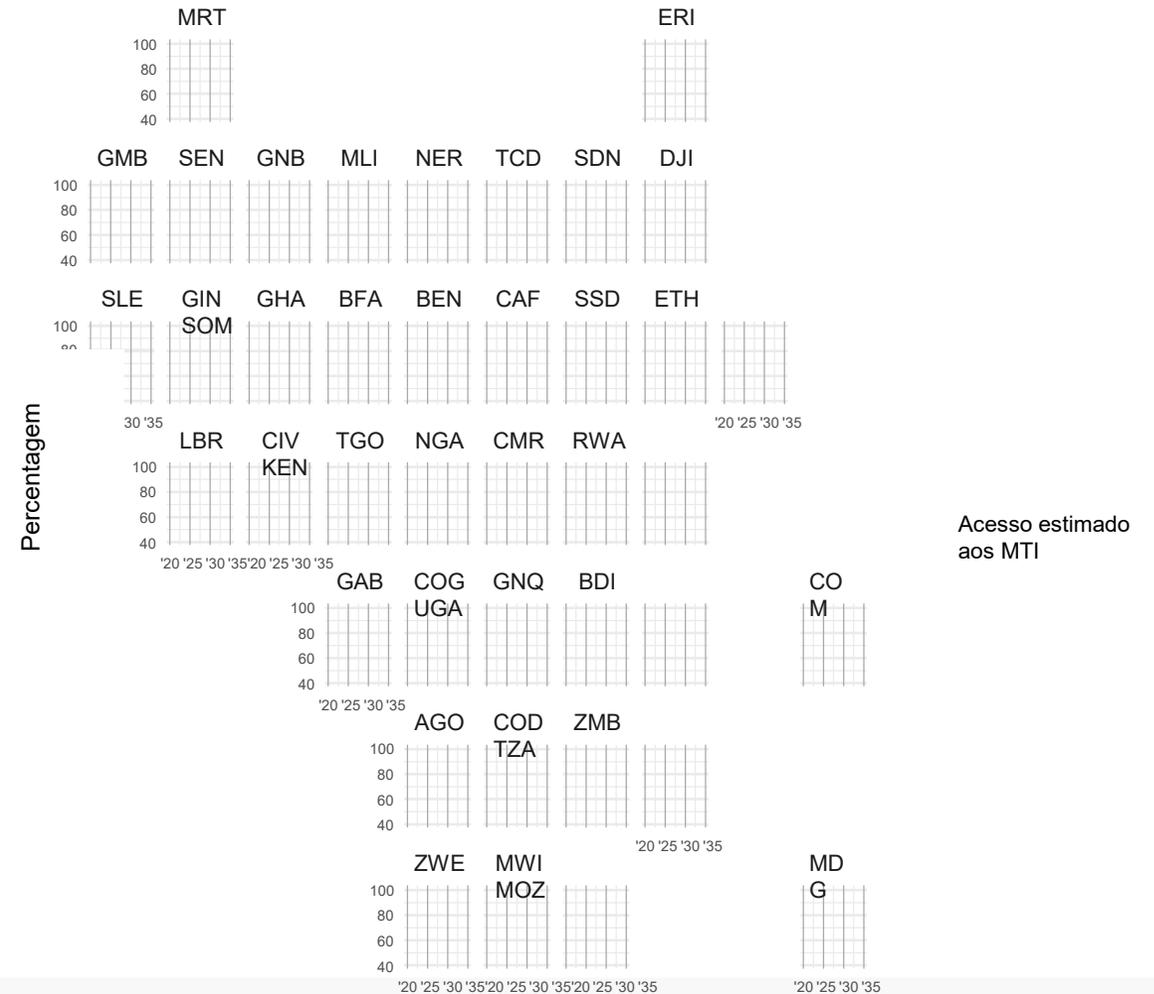
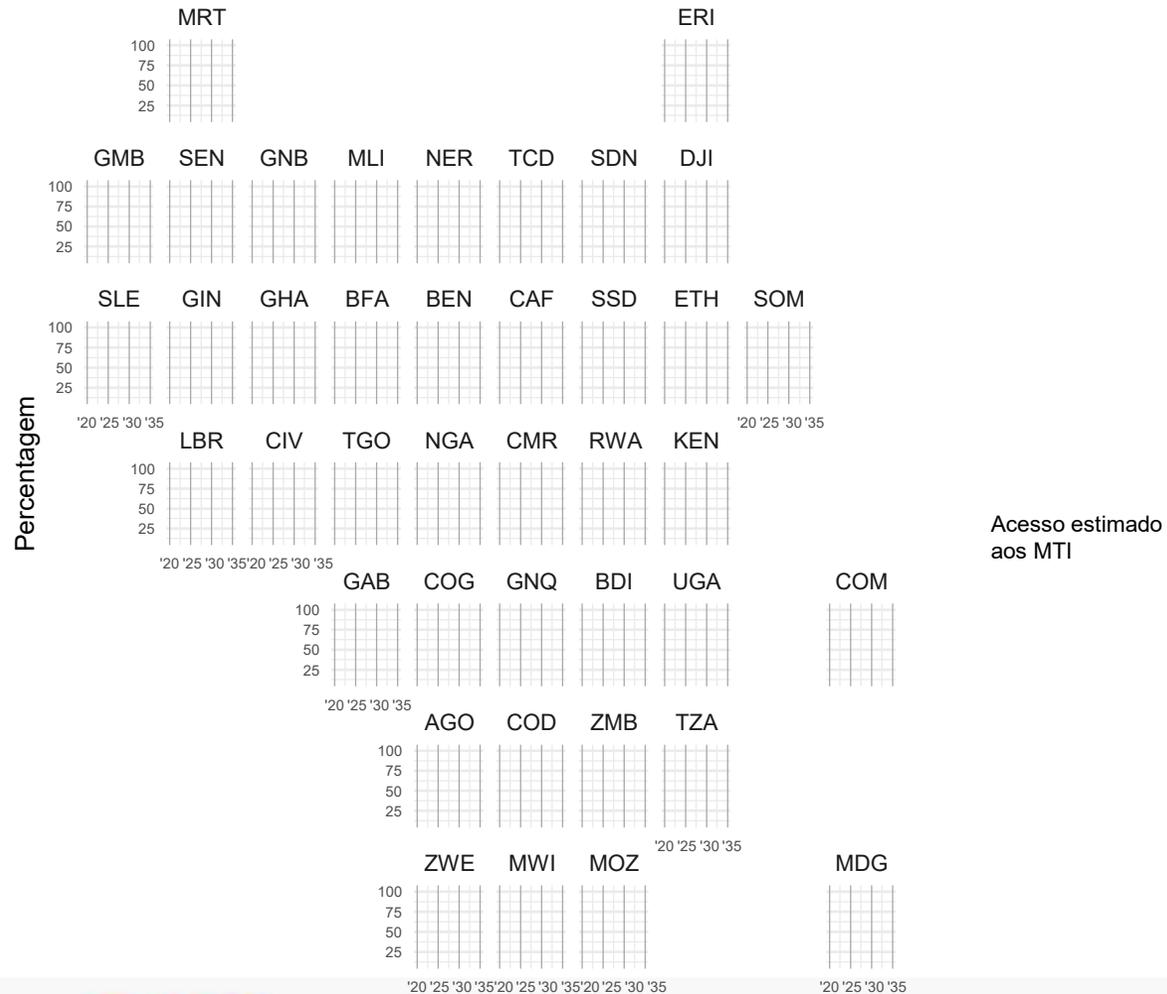
<https://net-textile-use-reports.netlify.app>

Expanding the ownership and use of mosquito nets

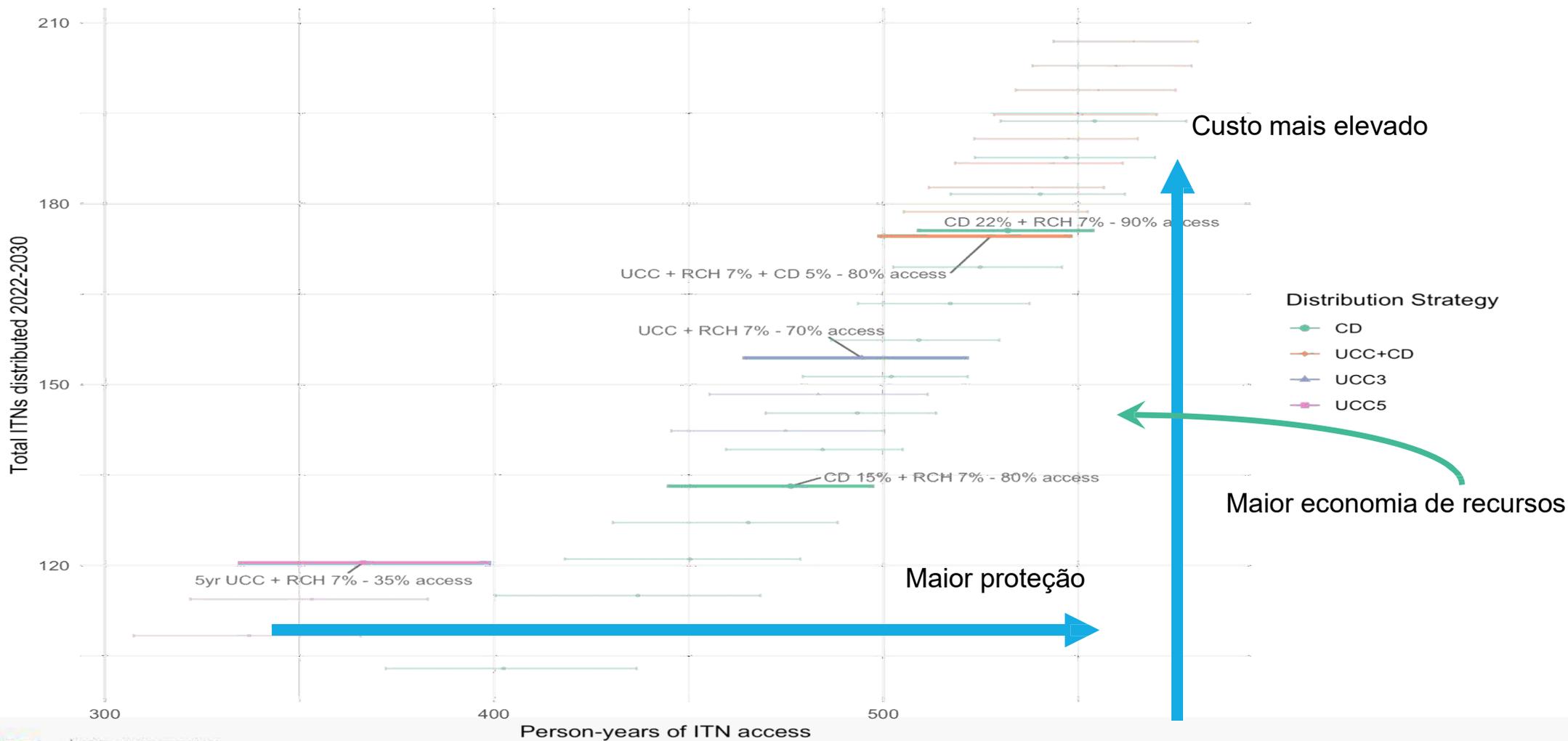
Os diferentes tempos de retenção dos países podem afetar o funcionamento das estratégias de MTI

Campanhas em massas de 3 anos com CPN/PAV, na população / 1,8 % da população

CPN/PAV a 6 % e distribuição anual nas escolas/na comunidade a 17 % da população



A DC poderia conferir uma proteção análoga com 14 % menos mosquiteiros que as campanhas em massa de 3 anos



Levar os mosquiteiros certos (mais eficazes) às pessoas no momento certo (quando são necessários) implicará a expansão dos canais de distribuição de MTI e soluções de compromisso



É crucial manter o acesso a MTI eficazes: precisamos de mais canais de DC operacionais para garantir o acesso das pessoas aos MTI quando deles necessitam

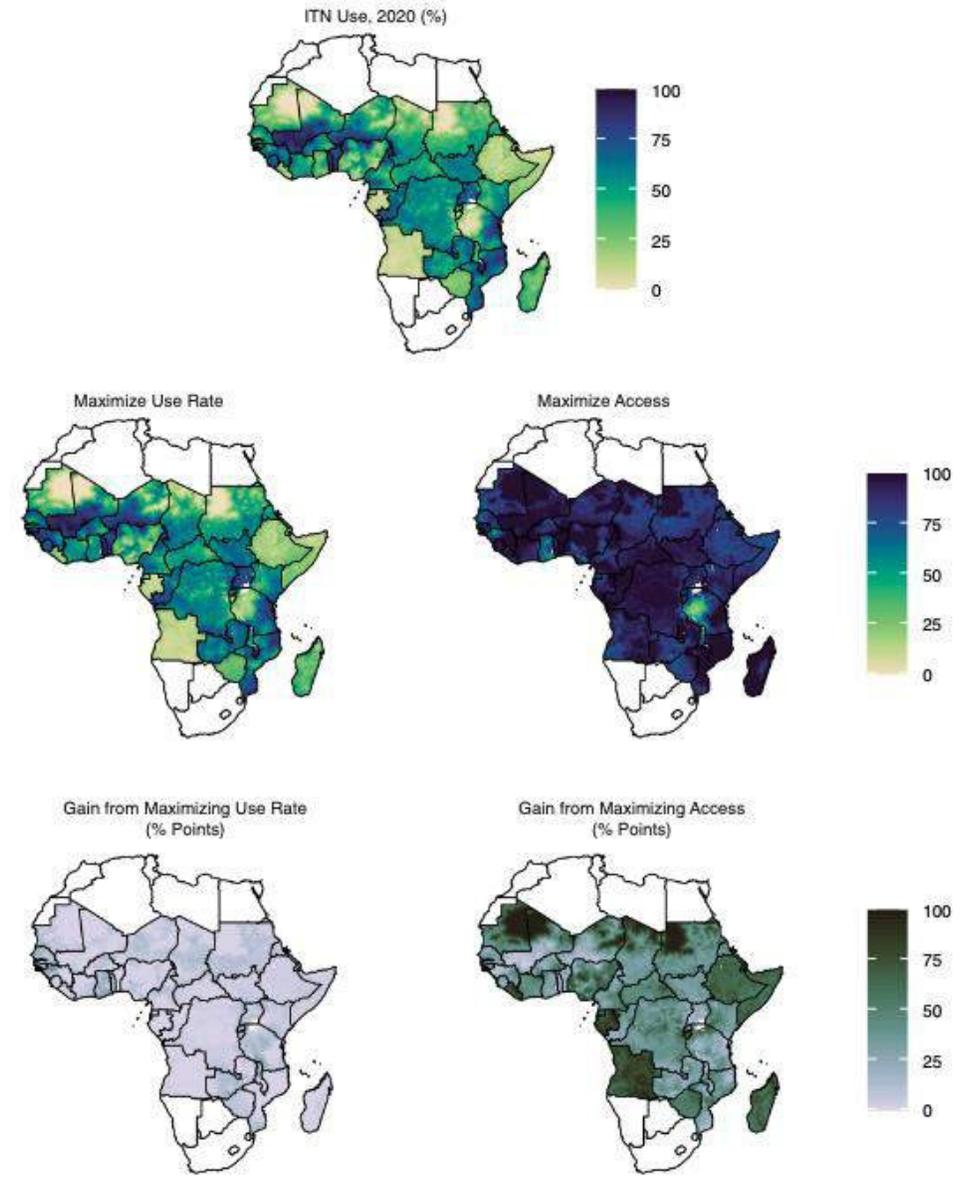
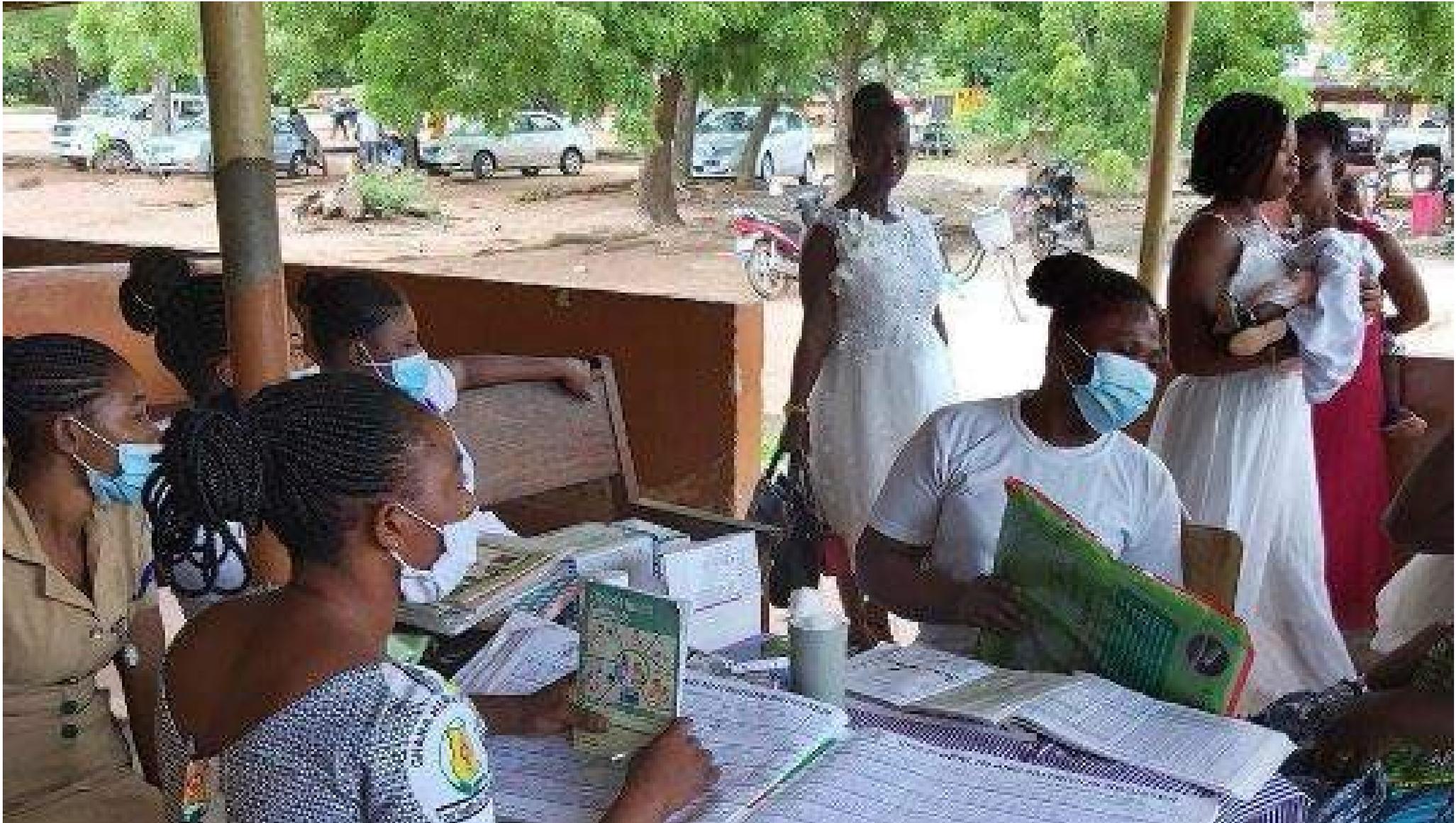


Fig. 6 Magnitude of change in insecticide-treated net (ITN) use possible from increasing use rate versus increasing access. The top row shows estimated ITN use in 2020. The second row shows what use could be if access remained unchanged and the use rate were set to 100% (left), compared to if the use rate remained unchanged and access was set to 100% (right). The final row shows the magnitude gain in use from each of these two scenarios. With few exceptions, increasing access has a larger impact than increasing the use rate.

Expanding the ownership and use of mosquito nets



Otimizar a distribuição de rotina de MTI no âmbito dos CPN e do PAV

- A distribuição de rotina ininterrupta de MTI tem sido uma parte importante de uma estratégia global de MTI desde o início da década de 2000
- Atualmente, 32 países entregam mosquiteiros em clínicas de CPN, e 28, através do PAV
- As taxas de entrega de MTI variam entre países, regiões e estações do ano (está agora em curso uma análise multi-país)
- É fundamental que estes canais atinjam o seu pleno potencial em todos os países, para garantir que se chega aos que são biologicamente mais vulneráveis

Sensibilizar para a DC além dos projetos-piloto, onde for necessário: ciclos de campanhas mais frequentes não resolvem o nosso problema de acesso e colocam mais problemas aos programas nacionais de malária



Ponderar alargar a escala de distribuição ou introduzir novos canais

Distribuição nas escolas:

- Distribuição em grande escala na Tanzânia e no Gana
- Projetos-piloto em vários países incluindo a RDC, a Guiné, Moçambique e a Zâmbia
- Consultar o modelo de distribuição nas escolas do PMI VectorLink — disponível em francês, inglês e português

[\(Estrutura-modelo de capítulo MS Word\)](#)
allianceformalariaprevention.com

Distribuição nas comunidades:

- Distribuições em grande escala em Madagáscar e Zanzibar
- Informações detalhadas, ferramentas e muito mais em Allianceformalariaprevention.org e continusdistribution.org!

Chegar às PDI, aos refugiados e às populações de difícil acesso requer um investimento sustentado, tecnologia e canais adequados, que assegurem o acesso contínuo aos MTI

7 precisamos de fazer mais



“Brilliant, Ed! A slogan we can finally live up to!”

Usar dados para orientar o planejamento e o plano da MSC e orçamentar a recolha de dados quando há falta de informação

<https://malariabehaviorsurvey.org>

<https://breakthroughactionandresearch.org/resource/itn-use-and-access-report/>



Levar em conta a gestão de rumores à medida que avançamos para as adaptações subnacionais

- Assegurar que os planos de gestão de rumores são:
 - validados como parte do planeamento da distribuição de MTI
 - compreendidos por todos os atores de campanha nos diferentes níveis
 - orçamentados para o caso de ser necessária uma mobilização rápida



Melhorar o planejamento e a orçamentação da gestão de resíduos e considerar o efeito ambiental, incluindo dos MTI em fim de vida





Usar dados e ponderar o que é eficaz e eficiente para racionalizar os recursos disponíveis nas zonas urbanas

Consultar o sítio da internet: as orientações COVID e não COVID foram ambas atualizadas

Orientações atualizadas
Se não encontrar o que procura, por favor informe-nos!

Reunião sobre a qualidade dos MTI: Principais resultados e próximos passos

RESEARCH

Open Access



Correlation of textile 'resistance to damage' scores with actual physical survival of long-lasting insecticidal nets in the field

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Abstract

Background: Attempts have been made to link procurement of long-lasting insecticidal nets (LLIN) not only to the price but also the expected performance of the product. However, to date it has not been possible to identify a specific textile characteristic that predicts physical durability in the field. The recently developed resistance to damage (RD) score could provide such a metric. This study uses pooled data from durability monitoring to explore the usefulness of the RD methodology.

Methods: Data from standardized, 3-year, prospective LLIN durability monitoring for six LLIN brands in 10 locations and four countries involving 4672 campaign LLIN were linked to the RD scores of the respective LLIN brands. The RD score is a single quantitative metric based on a suite of standardized textile tests which in turn build on the mechanisms of damage to a mosquito net. Potential RD values range from 0 to 100 where 100 represents optimal resistance to expected day-to-day stress during reasonable net use. Survival analysis was set so that risk of failure only started when nets were first hung. Cox regression was applied to explore RD effects on physical survival adjusting for known net use environment variables.

Results: In a bivariate analysis RD scores showed a linear relationship with physical integrity suggesting that the proportion of LLIN with moderate damage decreased by 3%-points for each 10-point increase of the RD score ($p = 0.02$, $R^2 = 0.65$). Full adjustment for net care and handling behaviours as well as other relevant determinants and the country of study showed that increasing RD score by 10 points resulted in a 36% reduction of risk of failure to survive in serviceable condition ($p < 0.0001$). LLINs with RD scores above 50 had an additional useful life of 7 months.

Conclusions: This study provides proof of principle that the RD metric can predict physical durability of LLIN products in the field and could be used to assess new products and guide manufacturers in creating improved products. However, additional validation from other field data, particularly for next generation LLIN, will be required before the RD score can be included in procurement decisions for LLINs.

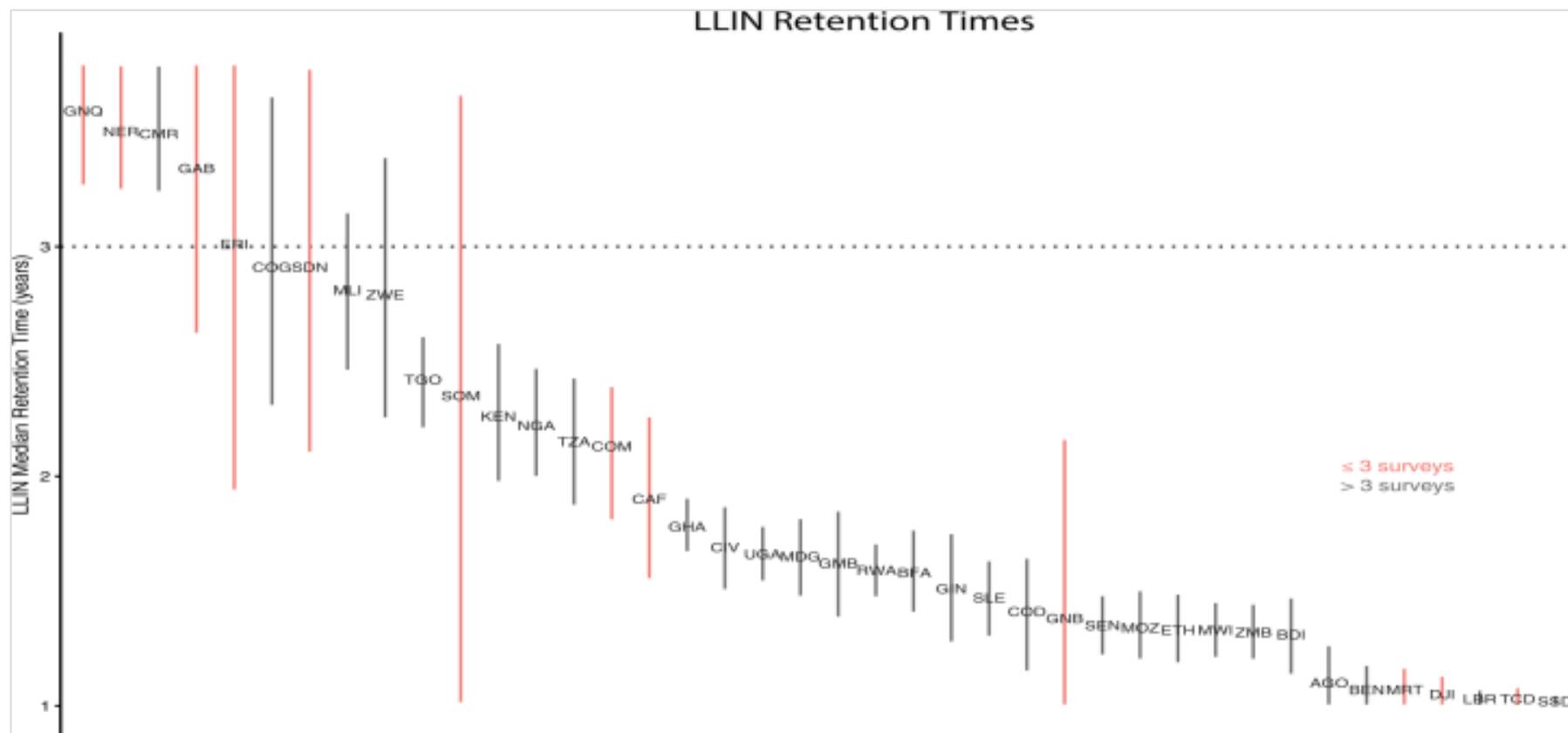
Keywords: LLIN physical durability, Textile resistance to damage

A qualidade dos MTI é um fator que tem de ser abordado para evitar a falta de confiança na eficácia dos mosquiteiros

Apesar do ciclo de distribuição ubíquo de 3 anos, a mediana da retenção de mosquiteiros é de 1,64 anos

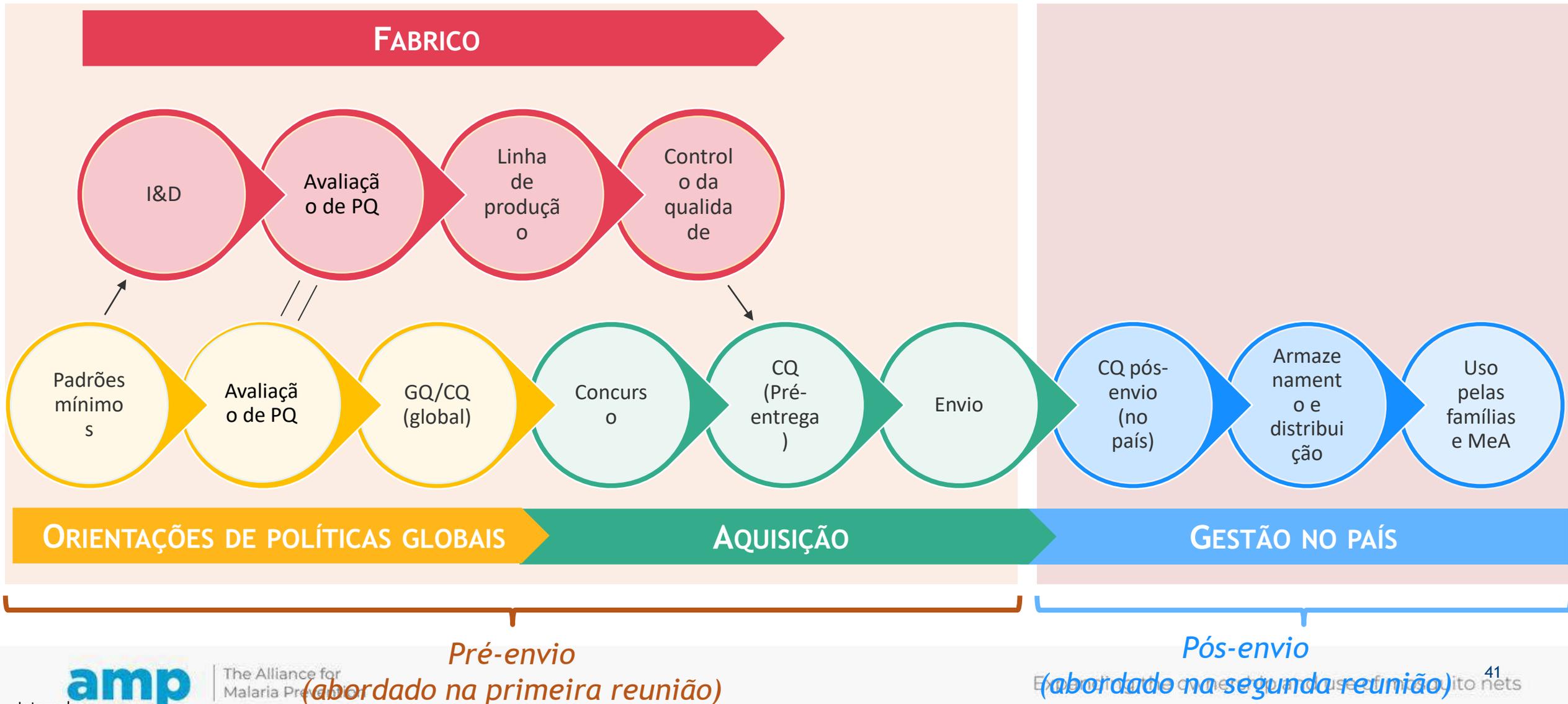
«... a maioria das evidências existentes apoia a noção de que a mediana da retenção de mosquiteiros é geralmente inferior a 3 anos.»

«Segundo estes estudos, a principal motivação para descartar um mosquiteiro foi a percepção de este estar demasiado rasgado, mesmo tendo poucos danos, muitas vezes considerados feios ou desalinhados.»



Bertozzi-Villa, A., Bever, C.A., Koenker, H. *et al.* Maps and metrics of insecticide-treated net access, use, and nets-per-capita in Africa from 2000-2020. *Nat Commun* 12, 3589 (2021).

O ciclo de vida da qualidade dos MTI é um esforço para mapear os vários fatores que podem afetar a sua qualidade



Um problema de base nesta matéria é as principais partes interessadas definirem «qualidade» de forma diferente

definição técnica

em que medida as propriedades químicas e físicas dos mosquiteiros correspondem às suas especificações

QUALIDADE

definição comum

os mosquiteiros fazem ou não o que esperamos em condições normais de uso (manter-se física e quimicamente ativos durante 3 anos)

Obedecer à definição técnica leva a que se alcance o desempenho esperado na definição comum?

Temas-chave: Política global

PRINCIPAIS PROBLEMAS

SOLUÇÕES PRIORITÁRIAS

Padrões mínimos

- É necessário desenvolver **especificações** que associem a qualidade do mosquiteiro ao desempenho

- Definir as «bases» dos atributos dos MTI. Incluir a **integridade do tecido** nas especificações

Avaliação de PQ

- **Atualização das orientações de ensaio** para refletir novos produtos

- Atualizar e divulgar diretrizes de ensaio

GQ/CQ

- **Insuficiente infraestrutura de ensaios de GQ/CQ:** as metodologias de ensaio e os diferentes laboratórios não fornecem resultados consistentes

- Analisar a capacidade das instalações de BPL para testar MTI
- Analisar a GQ da infraestrutura de ensaios laboratoriais pré/pós envio

Trans-chave: Fabrico

PRINCIPAIS PROBLEMAS

SOLUÇÕES PRIORITÁRIAS

I&D

- São necessárias métricas para diferenciar o desempenho dos MTI. O mercado atual favorece a quantidade em detrimento do desempenho, fazendo da inovação um grande risco

- **Delinear normas e especificações que permitam aos adquirentes justificar os preços** e mostrar como a melhoria da qualidade pode significar uma melhor relação custo-benefício

Avaliação de PQ

- Definição da forma de associar as especificações do produto a atributos que melhorem o desempenho no terreno

- Desenvolver **características claras e reprodutíveis para obter o desempenho desejado** e distinguir os atributos dos MTI **primários e secundários** através da associação à durabilidade e à bioeficácia

GQ/CQ

- Sobrecarga de inspeções e falta de processos de qualidade harmonizados

- Levar os a adquirentes harmonizar os processos de qualidade e acordar os atributos-chave a serem testados

PRINCIPAIS PROBLEMAS

SOLUÇÕES PRIORITÁRIAS

As-chave: Aquisição

Concurso

Enfoque excessivo no preço em detrimento da qualidade

- Documentar e avaliar características que levem a um melhor desempenho. Definir padrões para obter resultados de maior qualidade e estar disposto a pagar mais

AQUISIÇÃO

CQ
(Pré-
entrega)

- Clarificação dos critérios de aceitação dos MTI que se desviam das especificações
- Embora a **ISO 9001** seja a norma para este setor, ela dá informações suficientes sobre os aspetos específicos dos MTI?

- O grupo de garantia da qualidade de MTILD está a trabalhar em diretrizes harmonizadas de ensaio pré-envio. O Fundo Global está a elaborar orientações de amostragem pré-envio
- Acordar normas, métodos e margens de erro entre fabricantes, adquirentes e executantes

Envio

- É difícil atribuir responsabilidades pelos resultados OOS por falta de dados precisos ao longo da cadeia de custódia

- Explicitar a cadeia de custódia dos MTI e procurar formas de fornecer melhores dados sobre o ciclo de vida de um mosquiteiro (dados de CQ, ensaios, condições de transporte/armazenamento)

Temas-chave: Gestão no país

Inspeção pós-envio

- PRINCIPAIS PROBLEMAS**
- Ensaaios pós-envio não padronizados podem causar a rejeição de bons produtos ou a aceitação de maus produtos

SOLUÇÕES PRIORITÁRIAS

- Elaborar orientações harmonizadas sobre critérios de inspeção pré e pós-entrega e POP

Atrasos portuários e armazenamento

- Não existem diretrizes para o armazenamento
- **Atrasos e armazenamento no porto**, incluindo atrasos relacionados com o desalfandegamento e a distribuição

- Definir e dar orientações sobre as condições ideais de armazenamento (específicas para mosquiteiros, se necessário)
- Sensibilizar para a **agilização do desalfandegamento**

Estratégia de distribuição

- Falta de estratégia clara de distribuição/microplanos e atrasos na distribuição a diferentes níveis, que talvez levem a um armazenamento inadequado

- Elaborar uma estratégia de distribuição/microplaneamento clara/proativa
- Sistemas digitais de recolha de dados em tempo real/recolha e uso adequado dos dados/rastreio digital de mosquiteiros

Termos-chave: Aspectos transversais

PRINCIPAIS PROBLEMAS

SOLUÇÕES PRIORITÁRIAS

Glossário de termos comum

- A variabilidade das definições dos termos-chave (qualidade, desempenho, eficácia, durabilidade, GQ, CQ, etc.) dificulta a discussão destas questões

- **Elaborar um glossário de termos claro e divulgá-lo** aos principais grupos de partes interessadas

Confiança entre partes interessadas

- A **confiança** na qualidade dos MTI tem de ser reforçada entre os diferentes grupos de partes interessadas

- **Desenvolver uma estratégia de comunicação** que promova a clareza e aumente a confiança
- Partilhar dados para uma maior transparência

Dados

- Falta de dados sobre o desempenho/ bioeficácia, monitorização da durabilidade/fatores de risco no país que influenciam a vida de um mosquito

- Fazer vigilância pós-comercialização da retenção, da bioeficácia, da concentração de IA, da integridade física e do uso
- **Publicar os dados para tornar os dados certos disponíveis a todos**



New Nets Project: Problemas operacionais e principais resultados

Consórcio do New Nets Project



- Líder e coordenador
- Ligação a parceiros na indústria
- Vínculo ao pipeline de desenvolvimento de produtos de controlo vetorial



Healthy lives. Measurable results.

- Compilação das lições aprendidas em estudos-piloto entre países, financiamento para avaliações de processos

The Alliance for
Malaria Prevention

- Assistência técnica

**Imperial College
London**

- Modelação da conceção dos ensaios e impacto da sua realização

PATH



- Determinação da rentabilidade dos projetos-piloto concretizados



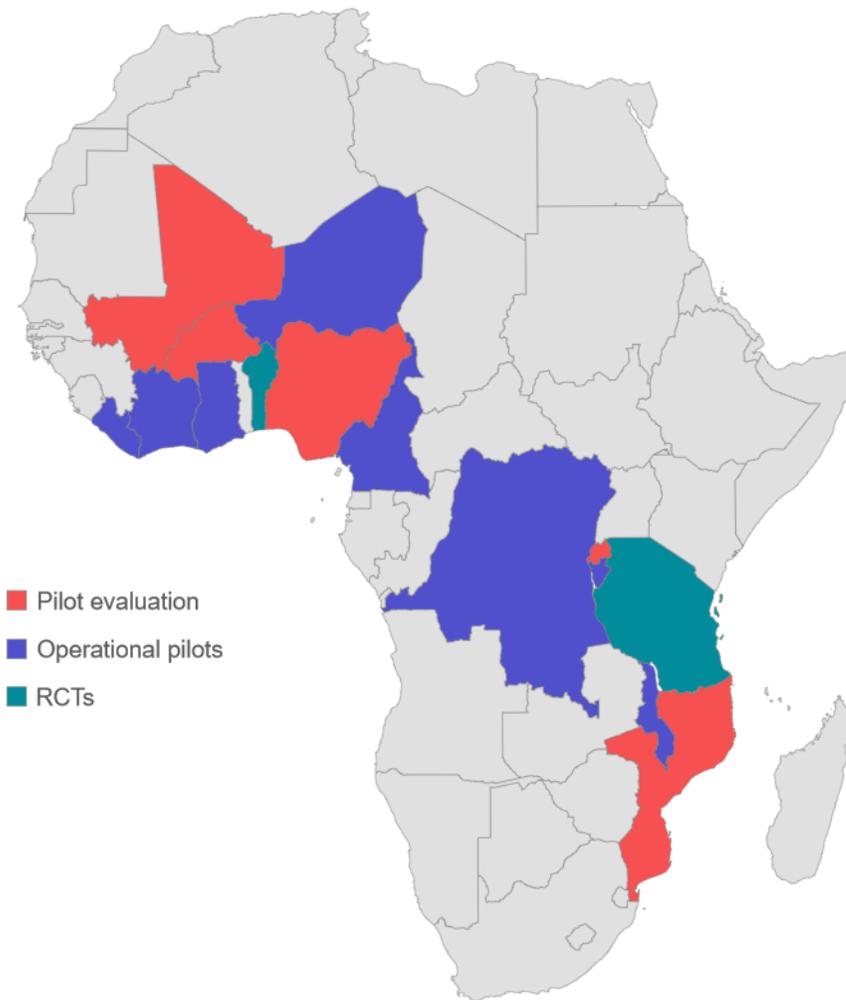
- Correlatos entomológicos de impacto epidemiológico



- Conceção do estudo de rentabilidade e recolha de dados

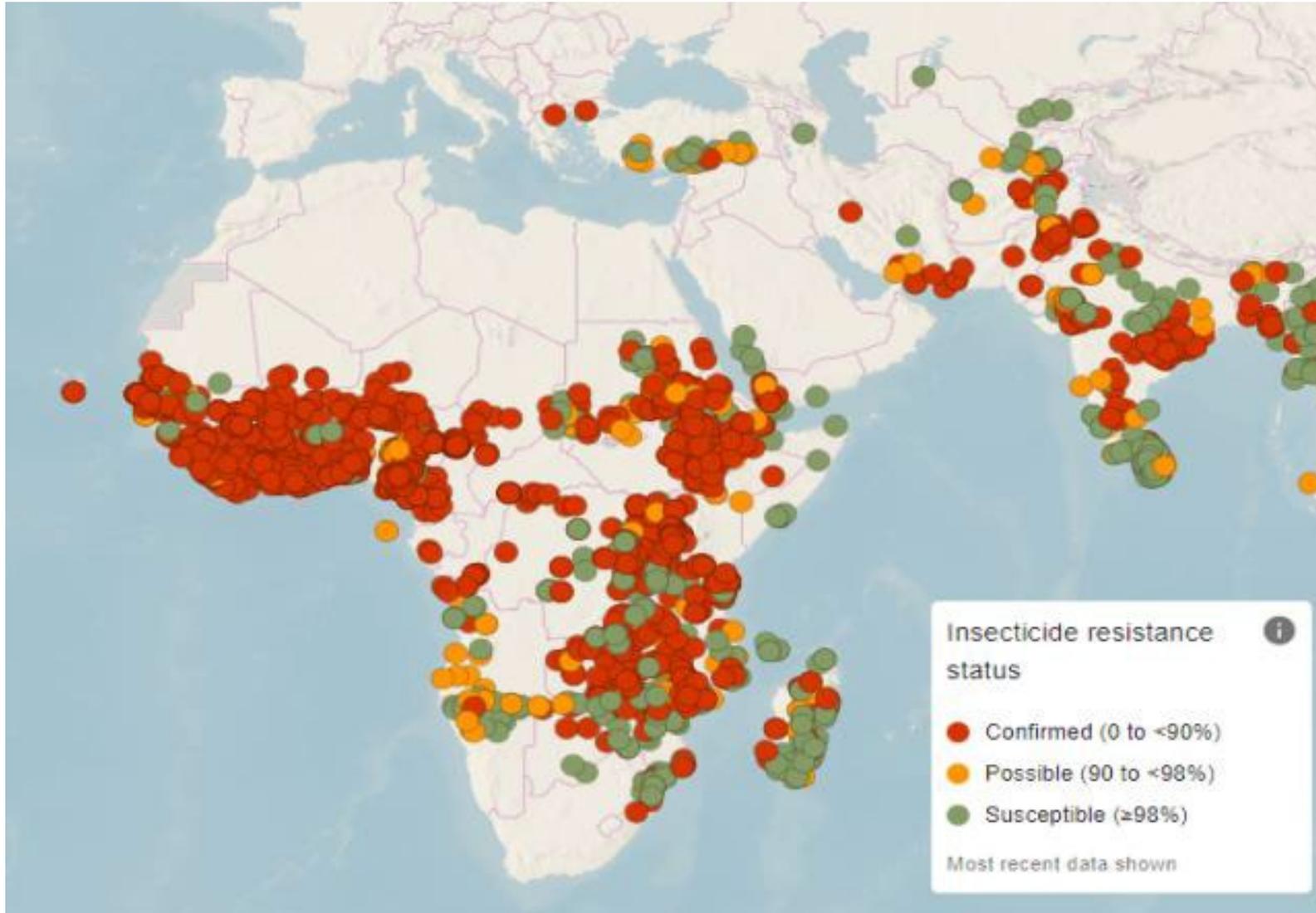


- Ensaios aleatorizados por cluster de MTI com dois ingredientes ativos e correlatos entomológicos em ensaios



Expanding the ownership and use of mosquito nets

O problema: resistência aos inseticidas



The effect of malaria control on *Plasmodium falciparum* in Africa between 2000 to 2015, S. Bhatt et al, Sep 2015

<https://apps.who.int/malaria/maps/threats>

Descrição geral do projeto



O New Nets Project (NNP, financiado pela Unitaaid e pelo Fundo Global e preparado pelo IVCC) ajuda a testar a próxima geração de mosquiteiros, os **MTI de ingrediente ativo duplo**

Só piretróide

MTI padrão

Piretróide +
sinérgico

MTI com PBO

Piretróide +
clorfenapir

MTI Interceptor® G2

Piretróide +
piriproxifena

MTI Royal Guard®

- Estes novos mosquiteiros
 - são mais caros
 - ainda necessitam de uma recomendação de política da OMS
- O NNP irá ajudar a
 - eliminar os entraves do mercado e **melhorar o acesso** a MTI de ingrediente ativo duplo
 - **reunir as evidências** necessárias para a recomendação de política da OMS: epidemiologia, entomologia, antropologia, rentabilidade, monitorização da durabilidade

Problemas operacionais

CS456197



"Oh, great. NOW you discover fire!"

A entrega dessincronizada de diferentes tipos de MTI é um problema que precisa de ser resolvido



É urgente adotar soluções viáveis de gestão de resíduos (ou amigas do ambiente)

Principais resultados: Resultados provisórios de Moçambique



Incidência da malária até à data *Norte de Moçambique*

	Gurue (MTI padrão)		Cuamba (MTI IG2)		Mandimba (MTI RG)	
	2020	2021	2020	2021	2020	2021
População que dormiu sob um MTI na noite passada (IC 95%)	23,0% (21,3% - 24,7%)	87,4% (82,8% - 90,8%)	19,4% (17,9% - 21,0%)	67,9% (57,0% - 77,1%)	17,0% (15,5% - 18,6%)	81,6% (74,7% - 87,0%)
Acesso da população a MTI (IC 95%)	23,1% (21,8% - 24,4%)	85,7% (82,5% - 88,8%)	21,0% (19,7% - 22,3%)	64,8% (54,8% - 74,8%)	16,4% (15,3% - 17,6%)	75,5% (69,0% - 82,3%)
Uso tendo acesso*	0,99	1,02	0,92	1,05	1,03	1,08

- O acesso e o uso de MTI aumentou significativamente após a campanha

	Gurue (MTI padrão)		Cuamba (MTI IG2)		Mandimba (MTI RG)	
	2020	2021	2020	2021	2020	2021
Prevalência da malária em crianças com menos de 5 anos (TDR+) (IC 95%)	64,9% (54,8% - 75,0%)	52,5% (42,9% - 61,9%)	47,5% (38,1% - 57,0%)	29,4% (20,9% - 39,5%)	66,0% (57,5% - 74,4%)	46,2% (38,2% - 54,4%)

- **A incidência da malária também diminuiu consideravelmente**
 - ~ 19% em Gurue (padrão)
 - ~ 38% em Cuamba (IG2)
 - ~ 30% em Mandimba (RG)

Comparação da incidência da malária com MTI da próxima geração e MTI de piretróide padrão pelo método da diferença na diferença (DD)

Incidência da malária até à data *Norte de Moçambique*

2021 1.º ano (junho - julho) Mudança em relação à referência DD em relação aos MTI padrão

Gurue (MTI padrão)	8% (-3% para 24%)	
Cuamba (MTI IG2)	-48% (-52% para -40%)	56%
Mandimba (MTI RG)	-28% (-31% para -23%)	36%

As taxas de incidência passiva de casos de malária de 2020 a 2021 indicaram:

- número análogo de casos em Gurue (padrão)
- ~ 28% menos casos em Mandimba (RG)
- ~ 48% menos casos em Cuamba (IG2)

Incidência da malária até à data *Oeste de Moçambique*

	Chemba (MTI padrão)		Guro (MTI IG2)		Changara (MTI com PBO)	
	2020	2021	2020	2021	2020	2021
População que dormiu sob um MTI na noite passada (IC 95%)	33,3% (32,1% - 34,7%)	90,1% (87,1% - 92,4%)	18,5% (17,2% - 19,8%)	92,8% (90,4% - 94,7%)	23,0% (21,8% - 24,2%)	84,6% (80,5% - 88,0%)
Acesso da população a MTI (IC 95%)	30,4% (29,3% - 31,6%)	86% (82,0% - 90,1%)	18,8% (17,5% - 20,1%)	88,9% (86,8% - 91,1%)	26,3% (24,9% - 27,6%)	84,2% (81,1% - 87,3%)
Uso tendo acesso*	1,10	1,05	0,98	1,04	0,88	1,00

- O acesso e o uso de MTI aumentou significativamente após a campanha

	Chemba (MTI padrão)		Guro (MTI IG2)		Changara (MTI com PBO)	
	2020	2021	2020	2021	2020	2021
Prevalência da malária em crianças com menos de 5 anos (TDR+) (IC 95%)	44,3% (36,5% - 52,1%)	39,0% (31,3% - 47,2%)	17,1% (11,6% - 22,7%)	3,8% (2,2% - 6,7%)	5,7% (2,3% - 9,1%)	2,1% (0,8% - 5,4%)

- **A incidência da malária também diminuiu consideravelmente**
 - ~ 12% em Chemba (padrão)
 - ~ 77% em Guro (IG2)
 - ~ 63% in Changara (PBO)

Principais resultados: Resultados provisórios do Burkina Faso



Incidência da malária até à data

	Gaoua (MTI padrão)			Banfora (MTI IG2)			Orodara (MTI com PBO)		
	2019	2020	2021	2019	2020	2021	2019 [†]	2020	2021
População que dormiu sob um MTI na noite passada (IC 95%)	20,8% (18,6% - 23,1%)	44,2% (40,9% - 47,5%)	37,0% (30,5% - 42,5%)	67,7% (64,9% - 70,3%)	90,4% (88,5% - 92,1%)	82,8% (79,0% - 86,6%)	78,8% (76,1% - 81,2%)	84,8% (82,3% - 87,0%)	83,5% (79,9% - 87,1%)
Acesso da população a MTI (IC 95%)	44,4% (42,4% - 46,2%)	53,8% (51,4% - 56,2%)	40,5% (37,9% - 43,1%)	58,9% (57,1% - 60,7%)	84,2% (83,1% - 85,3%)	74,9% (73,5% - 76,2%)	94,0% (93,1% - 94,9%)	87,4% (86,3% - 88,5%)	82,0% (80,7% - 83,3%)
Uso tendo acesso*	0,47	0,82	0,91	1,15	1,07	1,11	0,84	0,97	1,02

- O acesso e o uso dos MTI registaram aumentos variáveis após a campanha (permaneceram baixos em Gaoua)

	Gaoua (MTI padrão)			Banfora (MTI IG2)			Orodara (MTI com PBO)			
	2019	2020	2021	2019	2020	2021	2019 [†]	2020	2021	
Prevalência da malária em crianças, estudo transversal (TDR+) (IC 95%)	<5	81,0% (74,9% - 86,0%)	48,9% (41,9% - 56,1%)	21,1% (15,5% - 27,5%)	39,6% (33,0% - 46,6%)	18,4% (13,5% - 24,6%)	11,6% (7,4% - 17,0%)	28,4% (22,4% - 35,3%)	3,7% (1,8% - 7,5%)	2,1% (0,6% - 5,3%)
				54,5% (47,1% - 61,7%)			36,1% (29,3% - 43,4%)			19,9% (14,5% - 26,3%)
	5 - 10									

- Calendário da campanha associado à diminuição da prevalência da malária ao longo de 2 anos

- ~ 74% em Gaoua (padrão)
- ~ 71% em Banfora (IG2)
- ~ 93% em Orodara (PBO)

[†]A campanha de distribuição de MTI estava concluída na altura do inquérito transversal.

*O uso tendo acesso é calculado dividindo a utilização (população que dormiu sob um mosquito na noite passada) pelo acesso. São possíveis valores superiores a 1, dado que o cálculo é um rácio.

Comparação da incidência da malária com MTI da próxima geração e MTI padrão pelo método da diferença na diferença (DD).

Incidência da malária

	1.º ano (novembro - maio) Mudança em relação à referência	1.º ano DD em relação aos MTI padrão	2.º ano (junho - maio) Mudança em relação à referência	2.º ano DD em relação aos MTI padrão
Gaoua e Nouna (MTI padrão)	-18,4% (-24,8% para -14,8%)		-20,6% (-24,9% para -17,5%)	
Banfara e Tougan (MTI IG2)	-0,76% (-6,1% para 1,8%)	-18%	-35,3% (-36,7% para -34,6%)	14,7%
Orodara (MTI com PBO)	-22,9% (-28,8% para -2,7%)	4,5%	-26,4% (-29,2% para -24,8%)	5,8%

As taxas de incidência passiva de casos de malária indicam que, nos dois anos após a campanha de MTI, houve menos casos de malária registados em cada distrito:

- ~ 21% menos casos nos distritos com MTI padrão
- ~ 35% menos casos nos distritos com MTI IG2
- ~ 26% menos casos nos distritos com MTI PBO

Questões-chave

- Variabilidade e diversidade na dinâmica da transmissão da malária entre países e dentro de cada país
- Variabilidade e mudanças noutras intervenções-chave contra a malária (por exemplo, expansão da MSC no Burkina Faso)
- O comportamento humano e vetorial pode ser um fator importante na determinação da eficácia dos MTI
- Os próximos passos estão em curso, análises mais completas e específicas irão debruçar-se sobre o acesso aos MTI, a sua durabilidade depois de mais de um ano, padrões de sono e de uso dos MTI, fatores climáticos, etc.

Pontos-chave: Resultados provisórios

- As distribuições de MTI em massa (campanhas de cobertura universal) estão fortemente associadas ao aumento do uso de MTI e ao decréscimo da transmissão da malária independentemente do tipo de MTI
- Em áreas de transmissão moderada a elevada com vetores resistentes aos piretróides:
 - a distribuição de qualquer um dos novos tipos de mosquiteiro (MTI IG2, PBO e RG) parece mais eficaz no controlo da malária do que as campanhas de distribuição de MTI padrão, apenas de piretróides
 - pode ser menos pronunciada em locais da África Ocidental com perfis de resistência complexos
- Resultados finais pendentes — por favor, fique atento!

Vamos assegurar que todas as mulheres grávidas, todas as crianças e todas as pessoas em risco dormem sob um MTI



Crédito: Projeto PMI Vect

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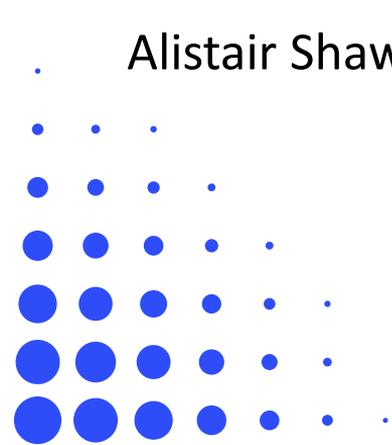
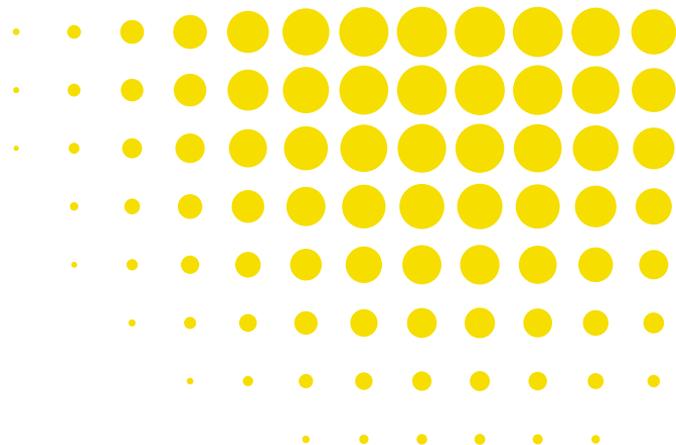
The Alliance for
Malaria Prevention



Community, Human Rights, Gender and Malaria

Sub-Regional National
RBM CRSPC Meeting, JULY 5-8 2022

Alistair Shaw, Community, Rights and Gender Department



Agenda

1. Overview / Setting the Scene

[Alistair Shaw](#)

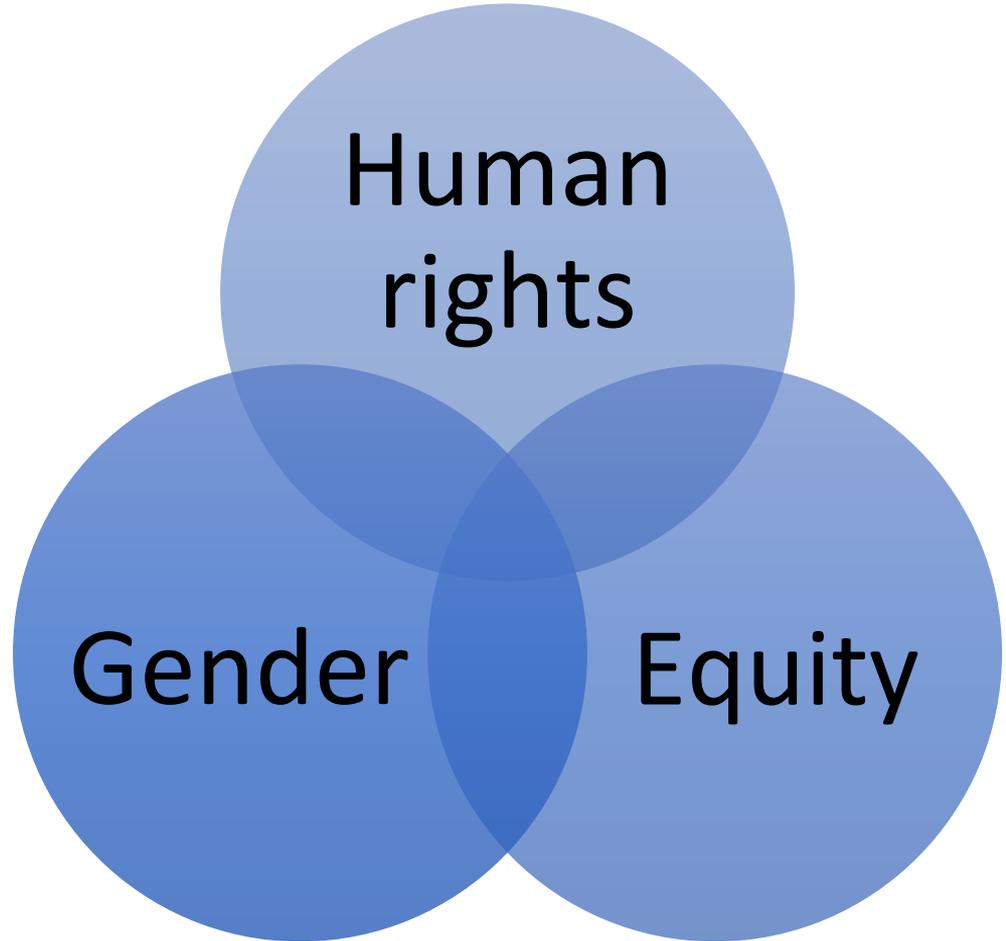
2. Training on Community, Human Rights and Gender in malaria programming

[Dr. Denise Njama-Meya](#)

3. Good Practices from Malaria Matchbox Assessments and Implementation of Findings

[Olivia Ngou](#)

**Defining key
concepts**





What are human rights?

Human rights in the context of malaria

Human rights-based approach in malaria programming

- The right to malaria prevention and treatment services.
- There still remain populations who are underserved and unable to receive these services.
- All health programs, including malaria programs are obligated to conform to human rights standards and deliver services to all without discrimination.

Promoting human rights can:

- Help overcome barriers to malaria service access.
- Create optimal conditions for the uptake of essential malaria services.
- Empower individuals and communities.

Core components of the right to health in the context of malaria

Availability

Accessibility

Acceptability

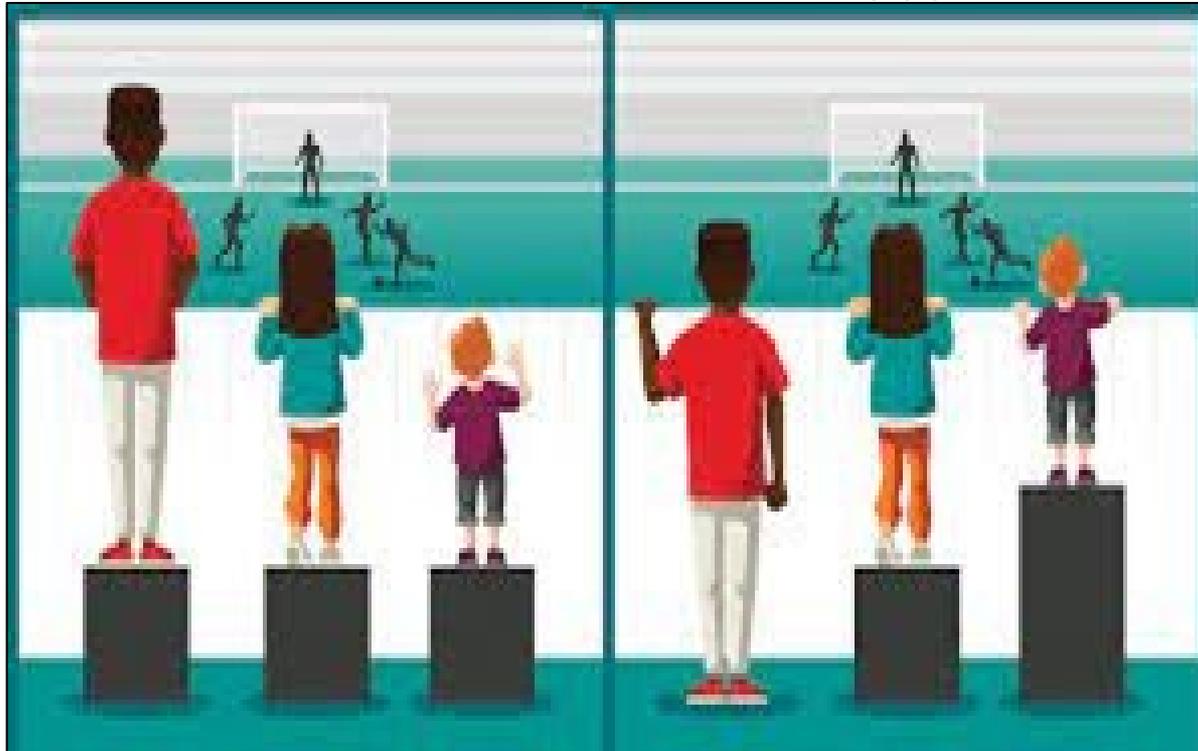
Quality

Reference: [WHO Human rights and health](#)

Equity v/s Equality

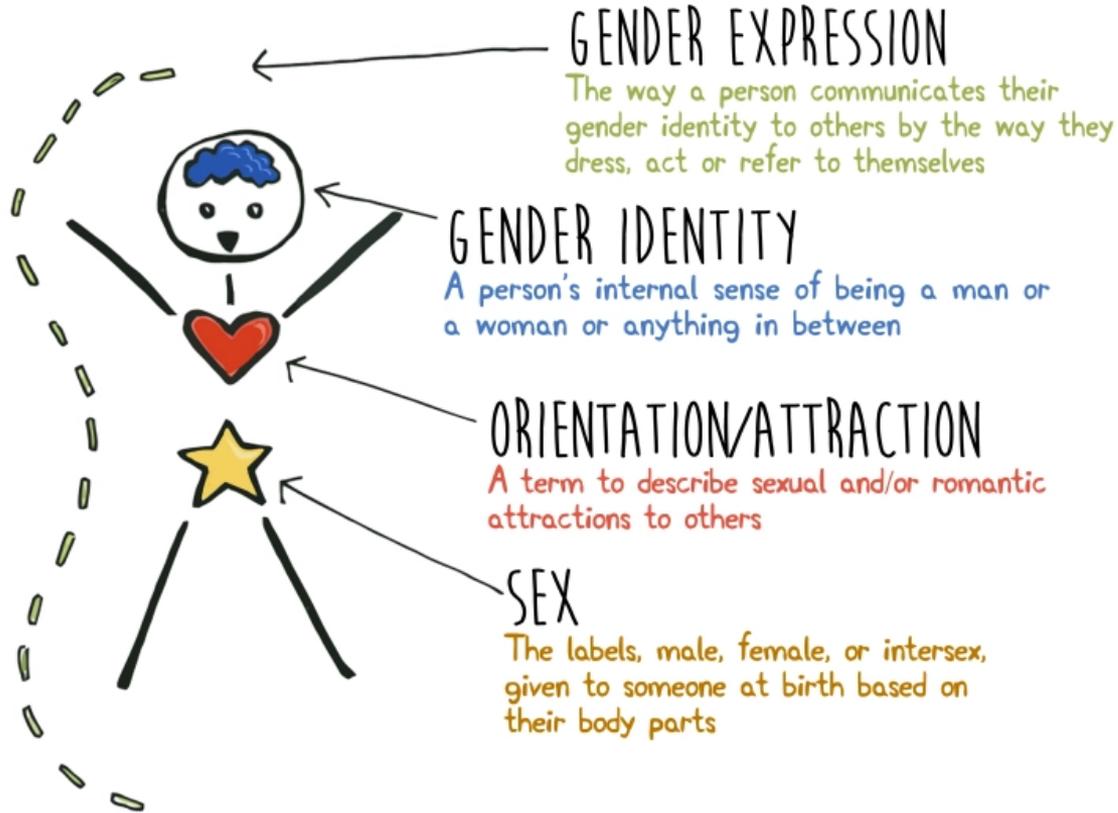
Photo A

Photo B



Which photo represents Equity and which one equality? - Use Mentimeter code/link to respond.

Understanding Gender



Why does gender matter?

Gender inequity

Gender influences people's experience of and access to healthcare.

Gender inequity and discrimination faced by women and girls puts their health and well-being at risk.

Harmful gender norms can also affect boys and men's health and wellbeing negatively.

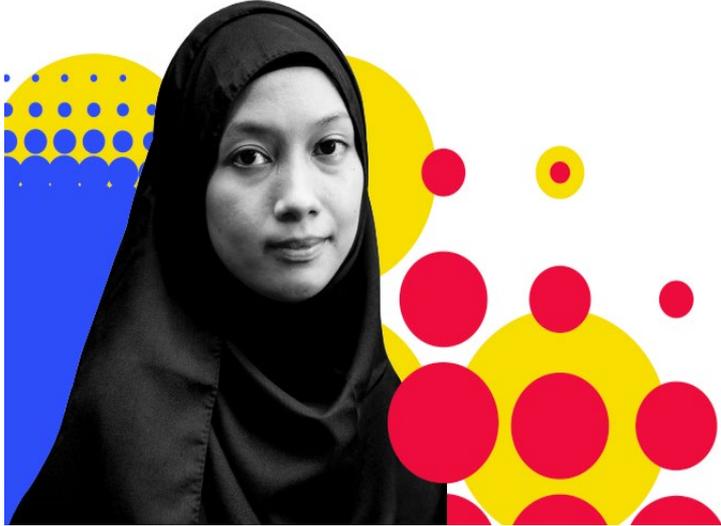
Barriers

- Restrictions on mobility.
- Lack of decision-making power.
- Lower literacy rates.
- Lack of financial freedom.
- Discriminatory attitudes of communities and healthcare providers.
- Lack of health systems that cater for specific health needs and challenges based on gender.
- Lack of training and awareness amongst healthcare providers.

Gender and malaria



Gender Responsive and Gender Transformative programming



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Gender responsive programming:

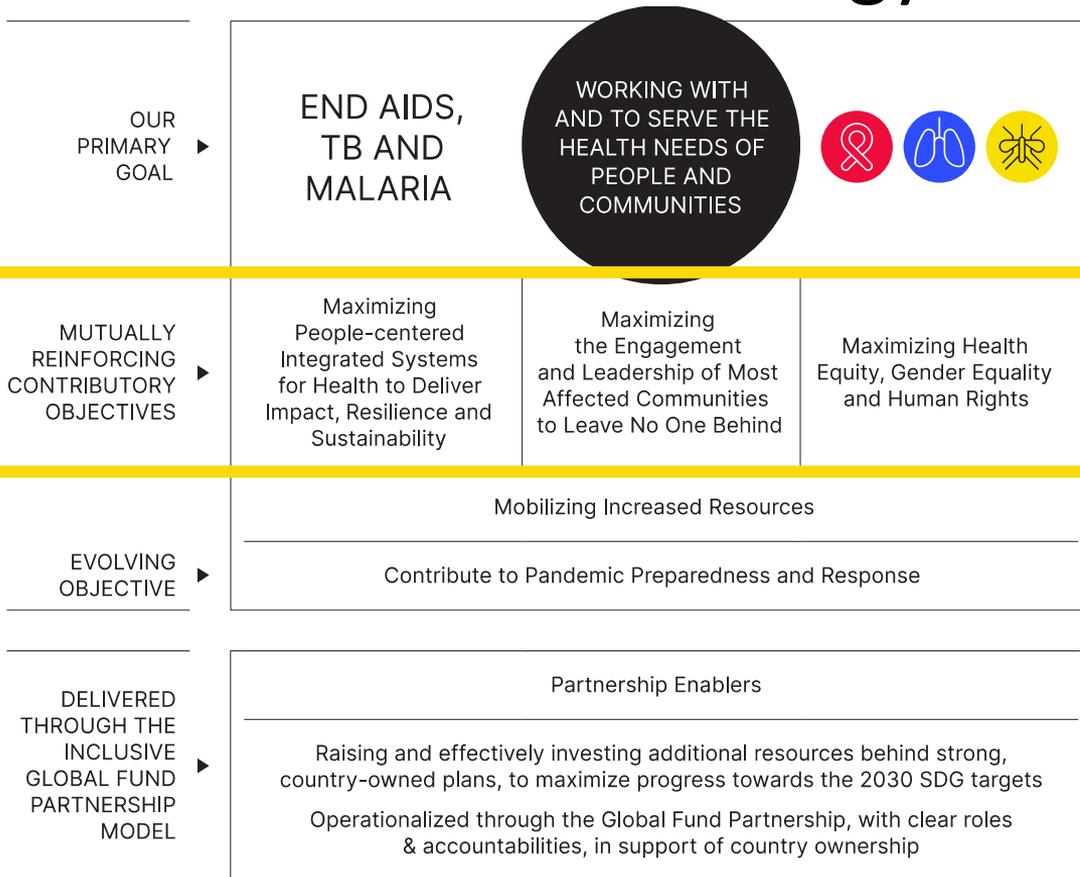
- Programs where gender inequities, norms, roles and inequalities have been considered, and measures have been taken to actively address them.
- Tailored to ensure that everyone is reached with quality and appropriate prevention, treatment and care services.

Gender-transformative programs:

Programs, approaches or activities that actively seek to build equitable social norms and structures in addition to individual gender-equitable behaviour.

Seek to transform gender roles and create more gender-equitable relations.

The Global Fund Strategy Framework



- **Strategy's primary goal** is to end AIDS, TB, and Malaria.
- **People and communities are at the heart** of our Strategy.
- Achievement of the primary goal is **supported by 4 mutually reinforcing contributory objectives** and an **evolving objective**.
- Partnership Enablers outline **roles and accountabilities** of all stakeholders.

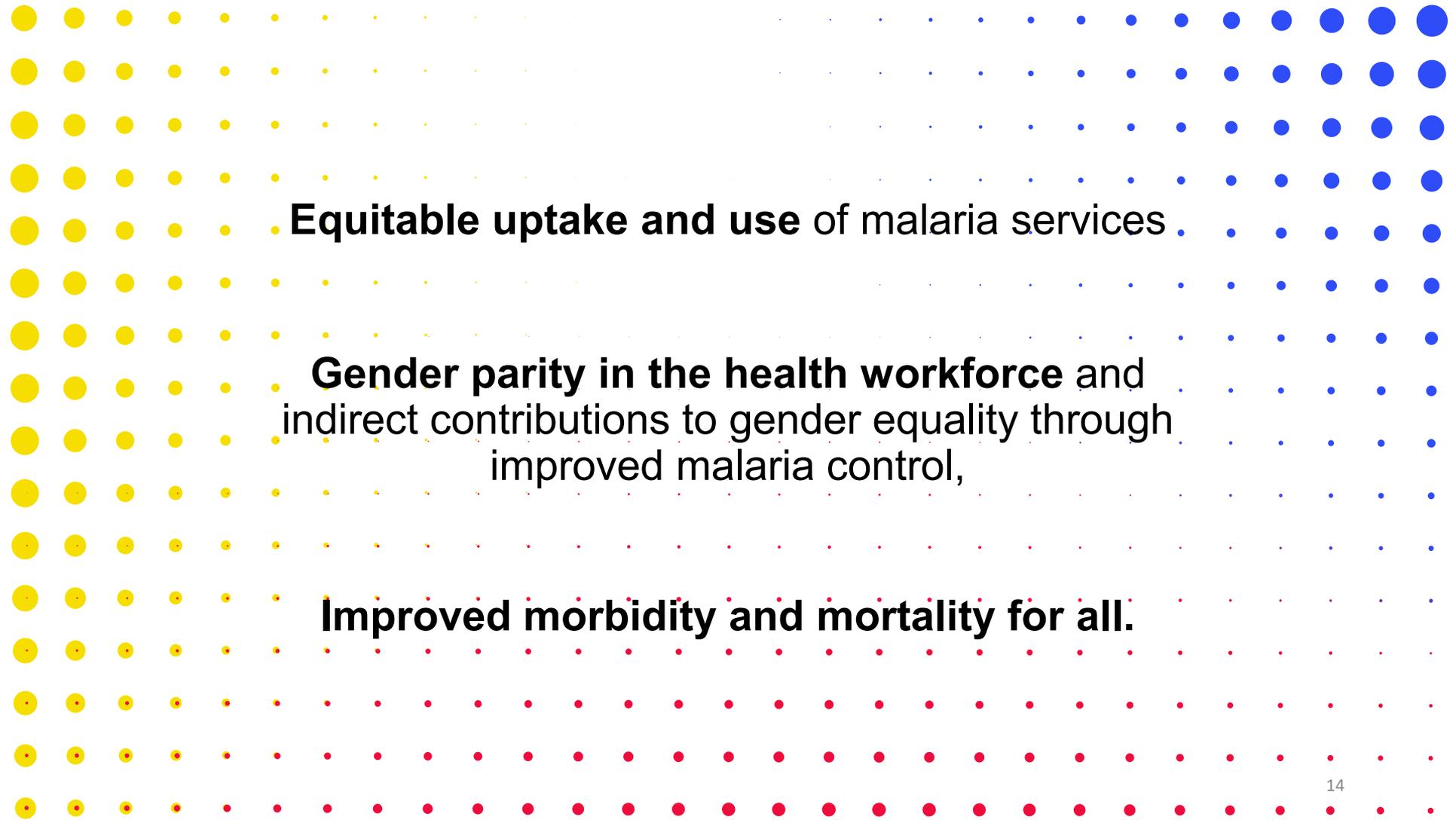
The Global Fund Strategy Framework

Mutually Reinforcing Contributory Objectives



Achievement of our primary goal will be underpinned by **4 mutually reinforcing contributory objectives** that must be concurrently and synergistically pursued to achieve our aims.

Maximizing People-centered Integrated Systems for Health to Deliver Impact, Resilience and Sustainability	Maximizing the Engagement and Leadership of Most Affected Communities to Leave No One Behind	Maximizing Health Equity, Gender Equality and Human Rights
<p>To catalyze sustainable HTM and broader health outcomes and in support of UHC, the Global Fund will strengthen RSSH by supporting countries and communities to:</p> <ul style="list-style-type: none"> • Deliver integrated, people-centered quality services • Strengthen and reinforce community systems and community-led programming, integrated within national health and social systems • Strengthen generation and use of quality, timely, transparent, and disaggregated digital and secure data at all levels, aligned with human rights principles • Strengthen the ecosystem of quality supply chains to improve the end-to-end management of national health products and laboratory services • NextGen market shaping focus on equitable access to quality health products through innovation, partnership, and promoting sustainable sourcing and supply chains at global, national and community levels • As part of Global Fund efforts to strengthen country oversight of the overall health system, better engage and harness the private sector to improve the scale, quality and affordability of services wherever patients seek it • Deepen partnerships between governments & non-public sector actors to enhance sustainability, transition-readiness and reach of services, including through social contracting 	<p>To deliver greater impact and ensure the HTM response is responsive to and led by those living with and most affected by the 3 diseases, the Global Fund will reinforce community leadership by:</p> <ul style="list-style-type: none"> • Accelerating the evolution of CCMs and community-led platforms to strengthen inclusive decision-making, oversight and evaluation throughout Global Fund-related processes • Evolving Global Fund business processes, guidelines, tools and practices to support community-led organizations to deliver services and oversight, and to be engaged as providers of technical expertise • Supporting community- and civil society-led advocacy to reinforce the prioritization of health investments and drive toward UHC • Expanding partnerships with communities living with and affected by emerging and related health areas to support more inclusive, responsive and effective systems for health 	<p>To improve HTM outcomes and drive more equitable access to health services, the Global Fund will support countries and communities by:</p> <ul style="list-style-type: none"> • Scaling up comprehensive programs and approaches to remove human rights and gender-related barriers across the portfolio • Supporting comprehensive SRHR programs and their strengthened integration with HIV services for women in all their diversity and their partners • Advancing youth-responsive programming, including for AGYW and young KVP and their partners • Deploying quantitative and qualitative data to identify drivers of HTM inequity and inform targeted responses, including by gender, age, geography, income and for KVP • Leveraging the Global Fund's diplomatic voice to challenge laws, policies and practices that limit impact on HTM
Mobilizing Increased Resources		
<p>To strengthen the scale, sustainability, efficiency and effectiveness of health financing for national and community responses the Global Fund will work across the partnership to:</p> <ul style="list-style-type: none"> • Increase international financial and programmatic resources for health from current and new public and private sources • Catalyze domestic resource mobilization for health to meet the urgent health needs for SDG 3 • Strengthen focus on VfM to enhance economy, efficiency, effectiveness, equity & sustainability of Global Fund-supported country programs & systems for health • Leverage blended finance and debt swaps to translate unprecedented levels of debt and borrowing into tangible health outcomes • Support country health financing systems to improve sustainability, including reducing financial barriers to access and strengthening purchasing efficiency 		



Equitable uptake and use of malaria services

Gender parity in the health workforce and indirect contributions to gender equality through improved malaria control,

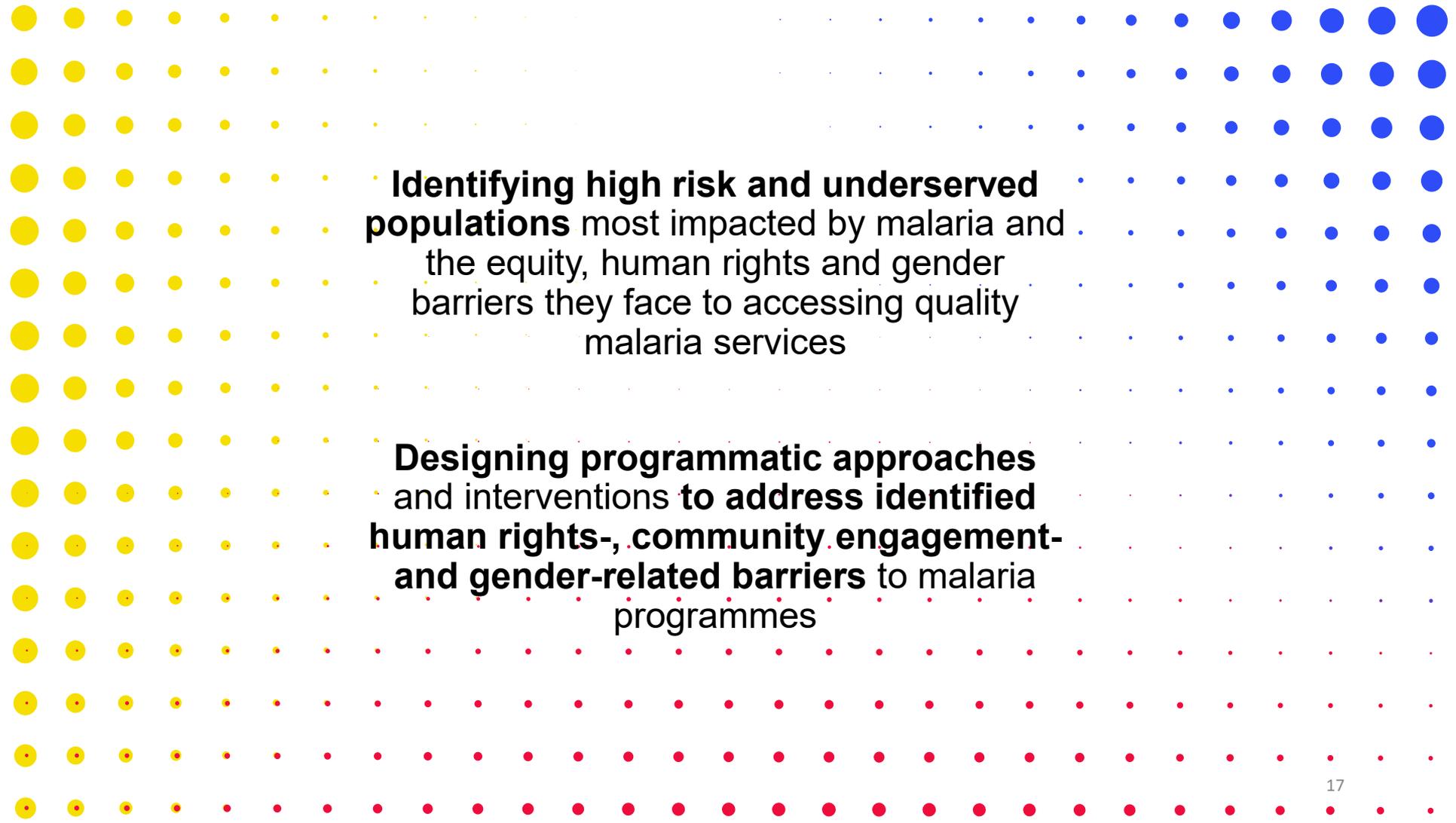
Improved morbidity and mortality for all.

How do we get there using solutions based on community Engagement, human rights and gender equality?

- Strengthen health outcomes through improved service quality and health services that **maximize the engagement of most affected communities, and maximize equity, human rights and gender equality.**
- **Strengthen data systems and effective use of data**, including from community-led monitoring, for decision making at all levels.
- Ensure **meaningful engagement of communities** and other relevant **experts in the design, delivery and monitoring of services**, and working with all partners to integrate services and related data to deliver people-centered quality care.
- **Promote collaboration** across sectors to **revise laws, policies and practices** to tackle structural determinants of HTM outcomes, including human rights barriers, gender-related barriers and inequities.
- **Increase financial / non-financial contributions** to community-based and community-led services.

Available Guidance, Support and Training

- **Technical Brief on Malaria, Gender and Human Rights**
 - Current version: November 2019
 - Revised version: Available mid-2022
- **Technical Assistance**
 - CRG Technical Assistance Program (available to communities and civil society and CCMs in unique situations)
 - Human Rights and Gender Technical Assistance (through RBM), available to NMCPs, CCM, PRs and other implementers from countries that have received CRG-related TRP comments during NFM3
- **Training**
 - Developed through the GF-RBM CRSPC relationship, eLearning and face-to-face training now addresses community, gender and human rights-related barriers in malaria programming and the strategies to mitigate these barriers with the goal of establishing more equitable malaria programs.
 - Training targeting NMCPs and CCMs, PRs and other implementers
 - Training targeting TA Providers
- **Malaria Matchbox**



Identifying high risk and underserved populations most impacted by malaria and the equity, human rights and gender barriers they face to accessing quality malaria services

Designing programmatic approaches and interventions to address identified human rights-, community engagement- and gender-related barriers to malaria programmes

Training on Community, Human Rights and Gender in malaria programming

Sub-Regional National Malaria Program and Partners Annual Meeting
RBM CRSPC Meeting, JULY 5-8 2022
Harare, Zimbabwe

Dr. Denise Njama-Meya, CRSPC Consultant MBCHB, DTMH, MSc.

Training outline

Session 1: Introduction on malaria epidemiology

Session 2: The Malaria Matchbox tool

Session 3: Conducting the CRG assessment, best practices and lessons learned

Session 4: Designing of programmatic approaches and interventions



Build capacity

- Identify the vulnerable and underserved populations.
- Identify inequities and barriers.
- Identify actions.

SESSION 1: INTRODUCTION

Malaria epidemiology and programming

- Understanding malaria epidemiology in a country is critical.
- Malaria epidemiology varies widely over relatively small geographic areas.
- Severity of malaria infection depends on the species of malaria parasite and also on the level of malaria-specific acquired immunity.
- Understanding the complex heterogeneity of risk factors that can contribute to an increased risk of malaria at the individual/household level will enable more effective use of control measures.



Identify malaria risk factors including biological, socio-economic and cultural factors.

Identify the resulting high risk and underserved populations respectively.



Biological Risk factors

Not all people in malaria endemic areas are at the same risk of becoming sick or dying from malaria.

Acquired immunity is an important factor.

After repeated attacks of malaria, a significant degree of immunity is acquired.

This partial immunity reduces the risk that malaria infection will cause severe disease.

Malaria non-immunes are those who have had minimal or no previous exposure to malaria infection.

The risk of severe disease and potentially death is high among non-immunes or those with low immunity to malaria parasites.



File Photo: The Independent Uganda

High Risk populations



© World Vision, Uganda

Children under 5 years of age in high-transmission areas



© The Global Fund to Fight AIDS, Tuberculosis and Malaria

Pregnant women



© PMI, U.S. President's Malaria Initiative

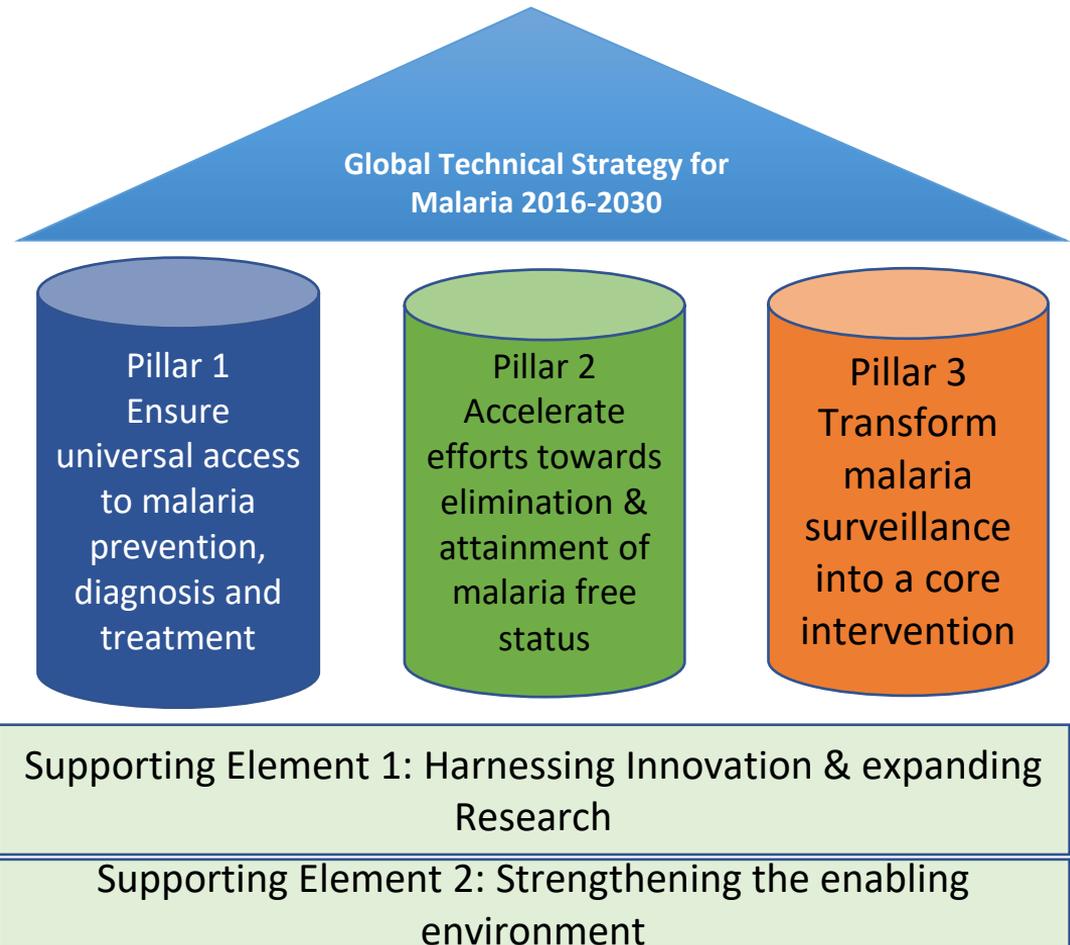
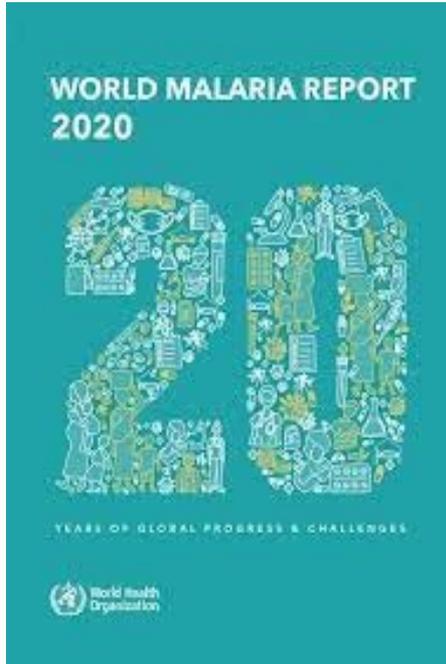
Non-immune migrants, mobile populations and travellers

Socio economic and cultural risk factors

Risk factors		
Poverty	Accessibility barriers	Social exclusion
Literacy barriers	Human rights barriers	Economic opportunities
Financial barriers	Cultural norms	Complex emergencies
Physical barriers	Psycho-social barriers	



Underserved populations



Most countries are not on track to achieving the Global Technical Strategy for malaria milestones. 28

Summary

- Need to strengthen the focus on socio economic and cultural factors.
- Insufficient levels of access to and uptake of malaria services in high risk and underserved populations.
- Identifying the high risk and underserved populations and barriers they face.
- Inform the design and implementation of malaria interventions.
- Engage high risk and underserved populations.
- Success of malaria strategies/interventions, should be evaluated by their impact.

Successful malaria strategies

Successful malaria strategies should include interventions that are:

1. Integrated



2. Equitable



3. People-centred



Successful malaria strategies

4. Community Systems Strengthening:

- Involvement of communities is essential to ensure the services provided meet the demands of the populations served and consider potential barriers.
- Community led advocacy can guide development of tailored advocacy activities.



- Community based monitoring can enable maximizing the reach and impact of health interventions.
- Community systems can also be strengthened through mobilization, coordination of communities and building community linkages.



**SESSION 2: CRG -THE MALARIA MATCHBOX
TOOL**

What is the Malaria Matchbox Tool?

Participants to use the following mentimeter link to select the correct answer/s.

<https://www.menti.com/4yznbwd17g>

**Polling/Voting code: 7902
5047**

Or Scan the
QR code:



Overview of the Malaria Matchbox Tool



- It is an equity assessment toolkit.
- Used to help identify:
 1. **Who** are the populations, groups or individuals most affected by malaria (high-risk and underserved).
 2. **What** are the key social rights and gender related barriers disproportionately affecting malaria outcomes in those populations.
 3. **How** their malaria programmes can address those barriers.

Other useful documents [Health Equity Assessment Toolkit](#) (HEAT) and the [Equitable Impact Sensitive Tool](#) (EQUIST)

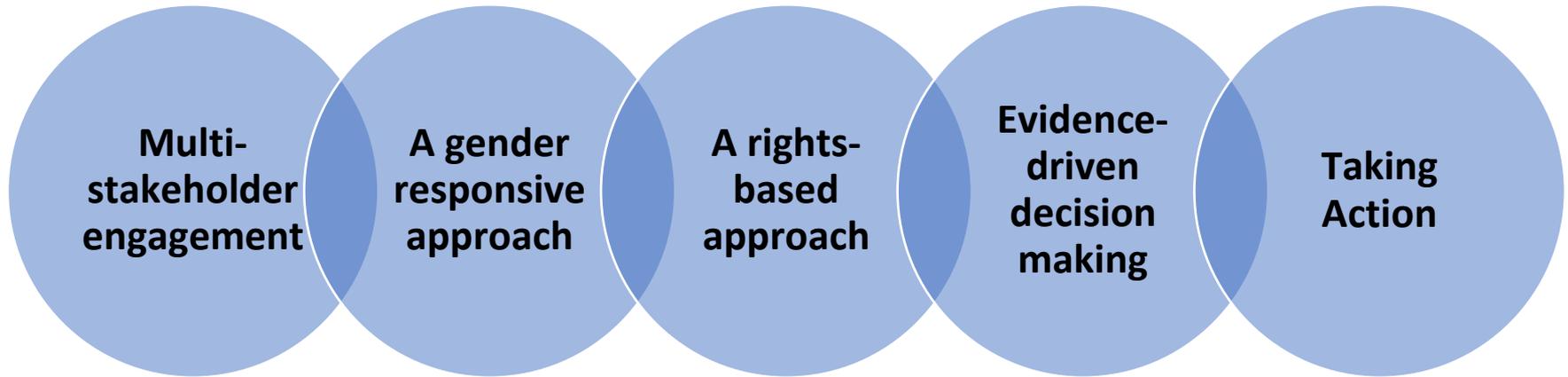


When to use the Malaria Matchbox Tool

- As a part of national program processes, such as MPRs
- To guide strategic and implementation plans.
- In response to Technical Review Panel comments of Global Fund country applications.
- To provide evidence and guidance in the development of specific initiatives e.g. HBHI approach



Overall principles



Adapted to the required scope and country context



Structure of the Malaria Matchbox Tool

Pre-
assessment
Phase

Assessment
phase

Pre-assessment/preparation steps

Country Context

- Understand what the country's specific needs are.
- Identify if/how the tool can be placed in the national malaria strategic planning process

Engage stakeholders

- Led by the national malaria program.
- Multisectoral participation.
- Map key stakeholders.
- Secure commitment at all levels.

Form the assessment team

- Select a team with diverse skills.
- Ensure clear terms of reference.
- 5-7 core members with dedicated time.

Planning and budgeting

- Assess what data is available and what data needs to be collected and how.
- Develop a concept note.
- Develop a budget and identify source of funding.

Development of the research proposal

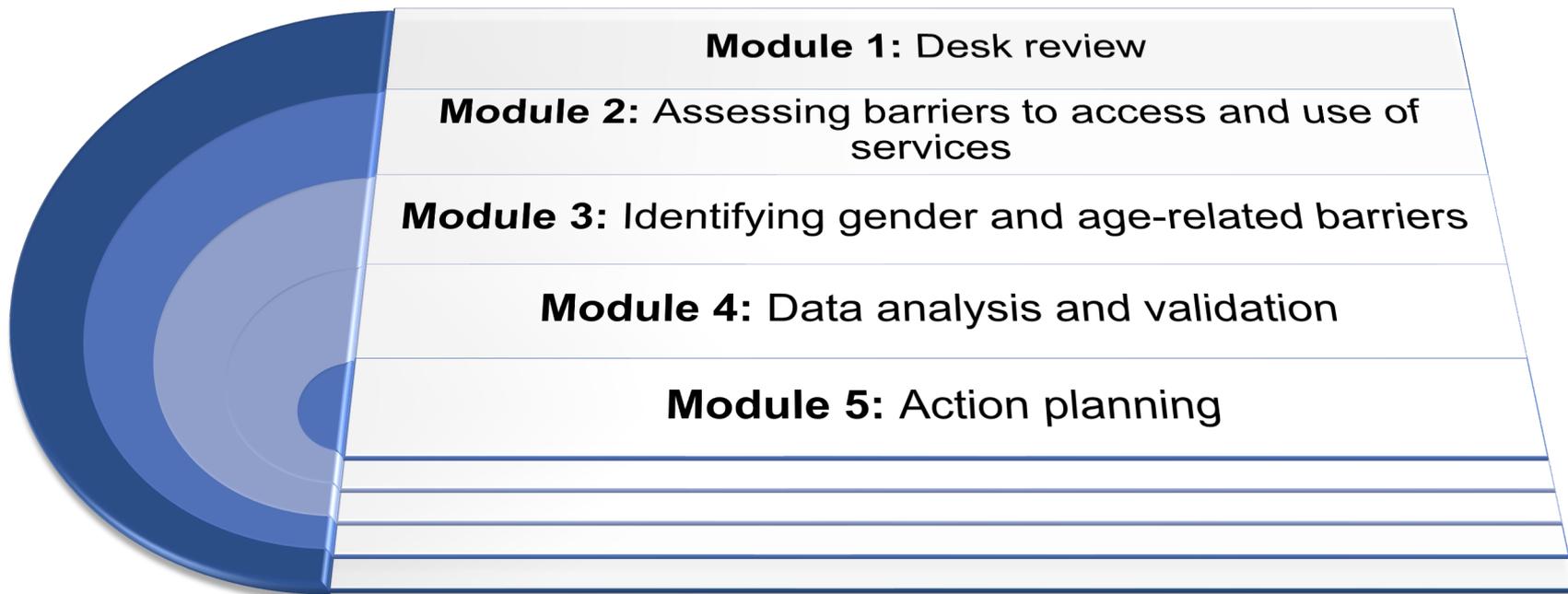
- Develop the full proposal.
- Develop data collection tools.
- Obtain ethical approval.
- Obtain informed consent.

Lessons learned- Planning phase

- Country engagement is key.
- Ensure the project is driven by NMCP whose leadership and time commitment is key to lead the process and engage stakeholders.
- Set up the steering committee of the project with members from diverse sectors to ensure a multisectoral approach.
- Leverage an existing Steering Committees.
- Recruit a local consultant in addition to the international consultant, with experience in similar data collection projects.
- Conduct regular virtual or in person meetings with the Steering Committee members.



Assessment Phase



Use one or two words to describe these photos



<https://www.menti.com/ibo2s4e9q4>

The voting code **3931 7756**



SESSION 3: CONDUCTING THE ASSESSMENT,
BEST PRACTICES AND LESSONS LEARNED

Module 1: Identifying the populations most impacted by malaria

Aim: To identify and spatially locate the populations most impacted by malaria.

Specific Objectives:

1. Understand the overall country malaria burden.
2. Understand the country policy and programme context in terms of equity in health and malaria.
3. Identify inequities in malaria service coverage and malaria health outcomes.
4. Identify potential geographic areas and/or populations with sub-optimal access and use of malaria and primary health care services.
5. Identify the information gaps.

Lessons learned - Desk Review

- **The consultants conduct the Desk Review** to set the country context and initial understanding about the determinants of health, particularly malaria services and mapping/identification of the most vulnerable groups.
- **In several countries inception reports included:** overall malaria burden, country policy and program context in terms of equity in malaria & identification of inequities in malaria service coverage.
- **The selection of data sources is key:** Engagement of NMCP & health partners to provide country reports and relevant documents that facilitate this phase. Documents can include: NSPs, NMCP annual reports, NFM malaria concept notes and reports, TRP reports, DHS, MIS/MICS, Census population and housing, WHO health equity database, community data bases.
- **The inception report provides preliminary recommendations and indicates which data is missing from the desk review** and guides what should be collected to respond to the the assessment question.

Module 2: Examine how risk factors, barriers to accessing services, and bottlenecks for service delivery affect health equity in the context of malaria

Objectives

1. Assess potential prohibitive factors and barriers to access and use of malaria services.
2. Engage key stakeholders to better understand the context.

Focus areas

1. Behaviour and sociocultural barriers to services.
2. Information accessibility and health literacy.
3. Financial accessibility.
4. Geographical accessibility.

Module 3: Identifying intra-household inequity

Specific Objective

- Collection of intra-household qualitative data to inform key areas where gender- and/or age- responsive approaches are needed.

Includes assessment of:

- i. Intra-household decision power affecting malaria prevention.*
- ii. Intra-household decision power affecting treatment*
- iii. Division of labour*

Best practices | Data collection

Preparation is key

- **Data collection tools should not be lengthy or wordy** but the questions should be very straight to the point. Shortening time allocation of the interviewees should be considered for quality of the data.
- **Quality of data is key:** the selection of data collectors and their training should be well prepared
- Some countries enrolled data collectors already working with NMCPs and who are used to collect data at community level, district level and national level in malaria or health related projects.
- **NMCPs to introduce data collectors early to all targeted groups** who will take part in the data collection to ensure availability of people/partners/ govt officials and health staffs.
- **Engagement of CSOs leaders and Community leaders** in the setting up of communities focus group is key to ensure full participation and adherence.
- **The use of local languages** during focus groups allow better engagement of communities. Translators might be needed in some cases.

Module 4: Data analysis and validation

- When implemented as part of a HBHI strategy or MPR/MTR, data analysis will be conducted in line with the recommended processes.
- Analyse, synthesize and triangulate data to identify barriers.
- Document identified barriers and where applicable merge into the HBHI or MPR/PTR preliminary report to be shared with technical experts.
- Conduct a 2–3-day stakeholder meeting to review and validate findings.
- Produce and disseminate a draft assessment report of the validated findings.

Best Practices | Data Analysis

This is a **QUALITATIVE Assessment**

- It is important to follow the best methods for analysis of this type of assessment, the Malaria Matchbox tool proposes methodologies.
- The data should be synthesized, triangulated and barriers identified and documented. A format is available in the Malaria Matchbox.
- The analysis can be done by the consultants (many countries used this method).
- The analysis can be done by consultants with the involvement of data collectors/designated partners in groups work (*Zimbabwe*).
- The data analysis report should be reviewed by the Steering Committee led by the NMCP for feedback before finalization.
- The data analysis should present facts, key findings and provide key recommendations on how to address barriers identified.

Some examples of data analysis findings resulting from the Malaria Matchbox assessment



Challenges and Gaps to Current Programmes

- **Insufficient engagement of IDPs and refugees (themselves) in the design and delivery of malaria interventions:** Few if any IDP or refugee participants discussed being involved in developing or delivering malaria interventions.
- **Limited to no engagement of traditional healers in malaria prevention and control:** The assessment findings were quite clear on the preferences of IDPs and refugees for traditional remedies and traditional healers as first points of call in the event of illness (for all illnesses, not just malaria).
- **Limited efforts to address linguistic and cultural barriers to malaria information and awareness activities:** Among refugees, a number of participants mentioned linguistic barriers as a main factor in low levels of knowledge and awareness about malaria risks.
- **Inadequate integration and coordination across health and humanitarian sectors:** As the assessment noted, there are a large number and an equally large variety of governmental and non-governmental actors involved. Coordination and collaboration remain uneven, including between national and state entities.

Challenges and Gaps to Current Programmes

- **Limited range of malaria prevention and control modalities:** As the findings of the assessment illustrate, provision of LLINs remains the primary strategy for malaria prevention despite the challenges this raises for mobile or unstable populations living where there is inadequate shelter.
- **Limited resources in relation to population needs:** Many participants noted the challenge of lack of sufficient resources to adequately respond to the needs of IDPs and refugees. This included coverage of core interventions such as LLINs, but also for adapted responses that are more specific to IDP or refugees: ex nets SBCC programs in their local languages.
- **Insufficient attention to the influence of gender and gender norms:** While many participants, particular key informants from organisations or who were service providers, could describe the influence of gender and gender norms on malaria prevention and control interventions, few if any spoke of ways to address these effects.

Analysis regarding Equity Barriers

- Challenges related to general malaria knowledge, attitudes and practices.
- Specific negative attitudes and beliefs about malaria interventions.
- Trends in health seeking behaviour linked to traditional beliefs.
- Physical and financial accessibility by IDPs and refugees.
- Negative experiences with health facilities.
- The influence of gender norms on women's and children's access to services.
- Other environmental factors

Module 5: Action planning

Specific objectives:

1. Review the assessment findings and identified barriers.
2. Develop actions to address barriers and improve equity in the malaria programme.
3. Review and prioritize proposed actions.
4. Outline next steps to mainstream proposed actions.

Methodology

- Conduct a consultative review of the findings and in-depth assessment of the identified barriers led by the malaria country programme.
- Multisectoral participation as well as community engagement is essential.
- Develop actions to address barriers and improve equity in malaria programme.
- Review and prioritize each of the barriers identified.
- Conduct the core analysis identifying the possible mechanisms of action to address inequities in the specific programme area.

Engaging stakeholders in a National Workshop

•This phase enables a multisectoral approach to define targeted responses to the challenges and barriers found in the data analysis report.

- NMCP, with the support of the consultants, organizes a 3 to 5 days workshop with key participants from the national, regional, district and community levels.
- It is key to include community representatives in the workshops, especially from the most vulnerable groups identified or who took part in the assessments.
- Include diverse partners from diverse sectors and related Ministries (example: Ministry of Women and Families, Environment, Agriculture, Labor, etc.)
- Organizations or agencies/NGOs/CSOs working with vulnerable groups
- Malaria technical and financial partners
- Malaria PR, SRs, SSRs
- Human rights and gender experts

The action plan

- Outlines challenges and barriers identified by vulnerable groups
- Proposes key interventions/actions to reduce those barriers
- The period of implementation of these actions
- The cost of each intervention
- The parties who can support these interventions or include in their current work or source of funding

Table of barriers and proposed actions/strategies

Barriers	Associated program area	Proposed actions/strategies	Target group /Community	Indicators	Strategic partners	Responsible Sectors/Entity	Implementation budget

Break out session – 50 minutes



1. Country group discussions (20 minutes)

- Review case studies and document actions that can be taken to address identified barriers.

2. Plenary presentations (30 minutes)

- Group presentations and discussions.



Group 1	Zambia	Botswana	Malawi	South Africa
Group 2	Angola	Comoros	Zanzibar - URT	Zimbabwe
Group 3	Madagascar	Eswatini	Mozambique	Namibia



SESSION 4

DESIGNING OF PROGRAMMATIC APPROACHES AND INTERVENTIONS TO ADDRESS IDENTIFIED BARRIERS IN COMMUNITY, GENDER, AND HUMAN RIGHTS DETERMINANTS OF THE MALARIA PROGRAMME

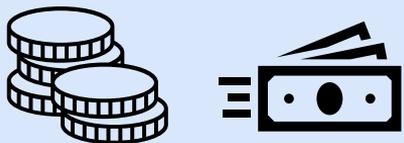
Program Area 1: Monitoring and reforming laws, policies and guidelines

- Ensure that laws, policies and guidelines are non-discriminatory and advocate for improving access to malaria services.
- Prioritize ensuring a policy environment that guarantees inclusivity of all, including undocumented migrants, refugees, asylum-seekers and prisoners.
- Ensure the implementation of existing relevant policies, laws and guidelines.
- Identify laws, policies and guidelines that may prevent or delay access to malaria services.

Barriers related to laws, policies and guidelines and possible actions

Barriers

User fees



Laws and policies



Actions

- Provision of vouchers.
- National health insurance programs for informal sector.
- National subsidies.
- Removal of user fees.
- Transformative gender policies.
- Inclusion and empowerment of high risk and vulnerable populations.
- Advocacy for amendment or removal of the barrier laws, policies or strategies.
- Multisectoral involvement.

Program Area 2: Addressing barriers to ITN use

- ITN coverage needs to reach population groups at risk.
- There is both inadequate coverage and inadequate usage.
- Understanding barriers to receiving and using a net will help programs modify their distribution and SBC strategies appropriately.
- Consider strategies to target high risk, vulnerable populations.
- Malaria programmes should identify, deploy and evaluate innovative methods to address barriers
- Ensure access and utilization of ITNs is achieved without leaving anyone behind.

Example of barriers to ITN use and possible actions

Barrier: Limited ITN access in hard-to-reach populations



Action

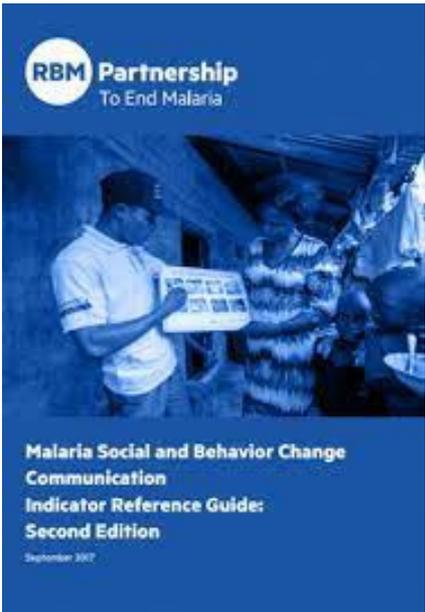
- i. Altered distribution strategies.
- ii. Alternative transport measures where roads are bad.
- iii. In flooded areas, consider use of boats.
- iv. War torn zones require multi-sectoral engagement and strong coordination with all stakeholders.
- v. In emergency situations integrate ITN distribution with distribution of other essential items e.g. food.
- vi. Plan targeted ITN distribution to specific vulnerable or high-risk populations.

Examples of barriers to ITN use and possible actions (2)

Barriers	Action
Gender or age - related barriers	<ol style="list-style-type: none"><li data-bbox="523 172 1437 211">1. Develop gender- and age-specific SBCC strategies.<li data-bbox="523 277 1707 316">2. Ensure adequate number of nets are provided to each household.<li data-bbox="523 382 1812 465">3. Recruiting and training more females to support the ITN mass campaign distribution.
Socially or legally excluded populations	<ol style="list-style-type: none"><li data-bbox="523 500 1006 539">1. Targeted ITN distribution.<li data-bbox="523 604 1232 644">2. Community dialogue and engagement.<li data-bbox="523 709 1329 749">3. Establish innovative registration techniques.<li data-bbox="523 814 1025 853">4. Multisectoral engagement.
Low literacy/language diversity barriers	<ol style="list-style-type: none"><li data-bbox="523 860 1367 899">1. Messages are translated to the local language.<li data-bbox="523 910 556 950">2.<li data-bbox="523 960 1412 1000">3. Pictorial messaging in the case of limited literacy.<li data-bbox="523 1065 1760 1092">4. Messaging adapted to take into consideration specific cultural beliefs

Program Area 3: Addressing barriers to IRS

Inadequate information and education



Religious beliefs and cultural practices.



Gender barriers



Operational barriers in hard to reach areas

Program Area 4: Addressing barriers in IPTp

Barriers

Negative healthcare-worker attitudes and cultural/social.

Delayed or lack of attendance of ANC

Language and literacy barriers

Economic barriers such as transport costs, time off work etc.

Cultural and gender norms, and intrahousehold dynamics

Actions:

- Sensitization/training of health care workers.
- A women/adolescent-centred approaches.
- Explore existing evidence-based strategies.
- Identify, pilot and evaluate innovative actions.

Program Area 5: Addressing barriers to Seasonal Malaria Chemoprevention (SMC)

- Acceptability of SMC is influenced by social and cultural factors.

Barriers	Actions
Hard to reach areas due to poor infrastructure, insecurity, political unrest, floods etc.	<ul style="list-style-type: none">• Provide safe and alternative transportation for CHWs and of SMC commodities.• Provide alternative innovative distribution strategies.
Language and literacy barriers	<ul style="list-style-type: none">• Enhance SBC for parents of targeted children.• Ensure messages are translated to the local language or use pictorial messaging in the case of limited literacy.• Community Mobilization and sensitization.• Consider integrating SMC with other already established and accepted health programs such as EPI.

Program Area 6: Addressing barriers to timely and appropriate malaria case management

Barriers	Potential Actions
Gender and cultural barriers	<ul style="list-style-type: none">• Training of healthcare workers in provision of cultural and socially acceptable services.• Community involvement and empowerment.• Community sensitization.• Deployment of female health workers where required.
Delayed access to malaria services in hard-to-reach populations	<ul style="list-style-type: none">• Use of community/village health workers.• Provision of innovative safe transport e.g. bicycle ambulances.• Introduction of Mobile malaria clinics.
Language Barriers	<ul style="list-style-type: none">• Targeted training and employment of health facility workers and community health workers who speak the language of the underserved or hard to reach community.

Program Area 7: Addressing barriers to SBC messaging

- Malaria communication strategies tailored for the specific barriers identified/prioritized should be developed.
- Reference to the RBM Strategic Framework for Malaria Social and Behaviour Change Communication 2018-2030 can provide guidance to the country in addressing the identified barriers.
- The communication strategies developed should be evidence based and theory-informed.
- The SBC strategies should be identified at the different programmatic levels to maximize impact.
- A multisectoral consultation in development of communication strategies is fundamental.

Community Systems Strengthening in malaria programming to improve access and uptake of malaria services

- Community participation is an essential element.
- Community action is fundamental.
- Community Systems strengthening is aimed at engaging and establishment of roles for the community.
- Communities should be involved at all steps of programmatic implementation.

Core Components of Community Systems



Source: The Global Fund Community Systems Strengthening Framework. Revised edition, February 2014

Module 5: Conclusion

- Actions recommended should be specific and realistic.
- Conduct wide consultation and collaboration including affected groups.
- It is essential that the recommended actions are mainstreamed into the country's malaria programming, policies and guidelines.
- For some barriers, no concrete actions may be identified immediately but a plan should be developed, and clear steps outlined towards the exploration and identification of suitable actions.
- Use of tools such as EQUIST can help identify strategies to address health system level barriers and bottlenecks.

Resource documents

- Malaria Matchbox Tool
[https://endmalaria.org/sites/default/files/Malaria Matchbox Tool en web.pdf](https://endmalaria.org/sites/default/files/Malaria%20Matchbox%20Tool%20en%20web.pdf)
- UNDP Gender Malaria discussion paper
[https://www.undp.org/content/dam/undp/library/HIV-AIDS/Gender HIV and Health/Discussion Paper Gender Malaria.pdf](https://www.undp.org/content/dam/undp/library/HIV-AIDS/Gender%20HIV%20and%20Health/Discussion%20Paper%20Gender%20Malaria.pdf)
- Global Fund: Technical Brief Malaria, Gender and Human Rights
[https://www.theglobalfund.org/media/5536/core malariagenderhumanrights technicalbrief en.pdf](https://www.theglobalfund.org/media/5536/core_malariagenderhumanrights_technicalbrief_en.pdf)
- [WHO Innov8technical handbook](#)

THANK YOU

Where, after all, do universal human rights begin? In small places, close to home—so close and so small that they cannot be seen on any maps of the world. . . . Such are the places where every man, woman, and child seeks equal justice, equal opportunity, and equal dignity, without discrimination.

—Eleanor Roosevelt, U.S.A., 1958
Chair of the Commission of the
United Nations

COUNTRY EXPERIENCES IN CONDUCTING THE MALARIA MATCHBOX ASSESSMENT

Panel discussion– E8, Zimbabwe

Moderator- Olivia Ngou

**The use of data for decision making and programs,
following the implementation of the matchbox in Zimbabwe
and E8 regional desk review experience**



High Burden High Impact (HBHI) : a targeted malaria response

EVALUATION OF THE GLOBAL APPROACH

Presentation to CRSPC | June 2022



World Health
Organization



Plan of the presentation

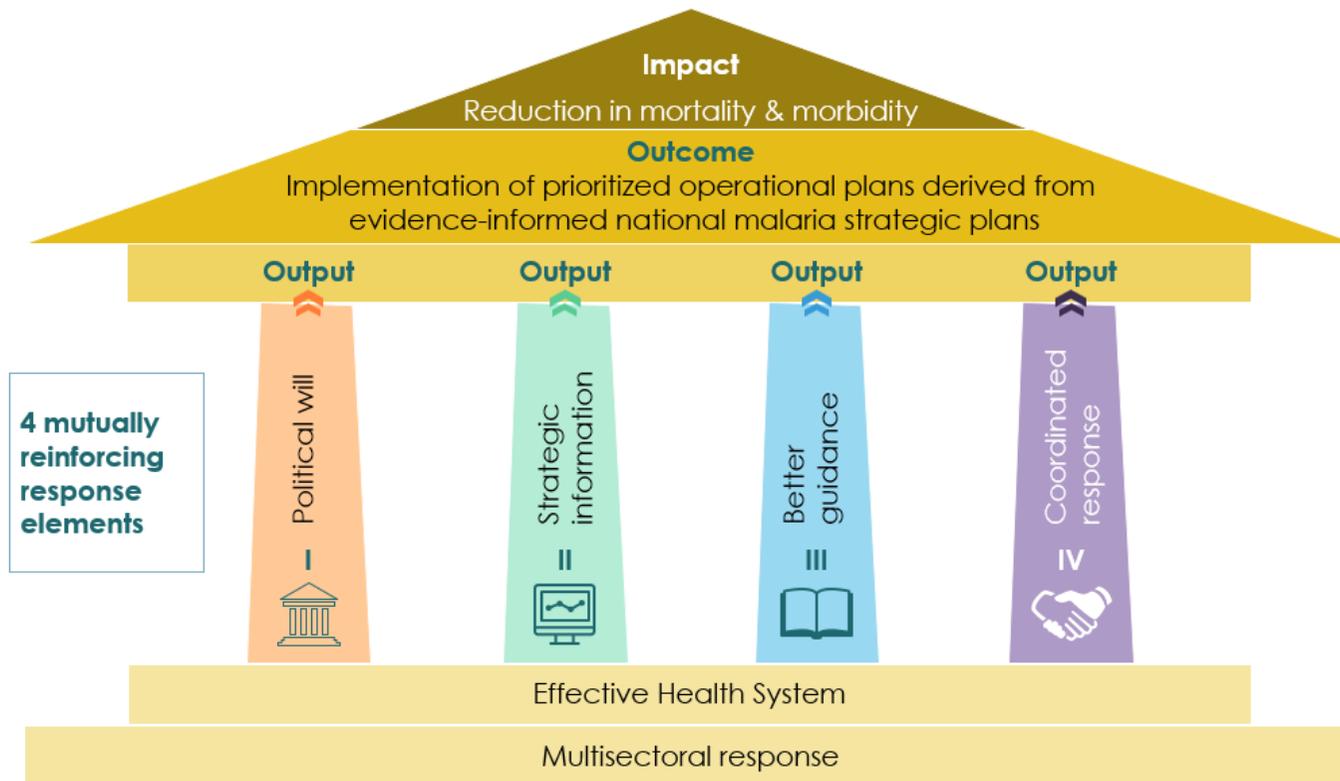
- HBHI Background
- HBHI evaluation rationale
- HBHI objectives & approach
- Evaluation objectives & questions
- Evaluation methods & process
- Evaluation Findings
- Recommendations
- Next steps
- Acknowledgment

HBHI : Background

- HBHI approach **to accelerating progress against malaria** was first launched in 2018 by the World Health Organization (WHO) and the RBM Partnership to End Malaria
- Focus : improving the public health response in the 11 highest burden malaria endemic countries : **Burkina Faso, Cameroon, Democratic Republic of Congo (DRC), Ghana, Mali, Mozambique, Niger, Nigeria, Uganda, United Republic of Tanzania & India.**

HBHI : Background

- HBHI approach categorizes the public health response in term of **4 elements**



Why evaluate the global HBHI approach now?

- HBHI focus countries have achieved successes and suffered setbacks since the launch of the approach. The evaluation addressed **how global implementation can improve** by better understanding these case studies.
- There are **opportunities to expand the HBHI approach** and this evaluation will inform that process to learn from the experience to date.
- **NOTE:** The evaluation has **not** been an evaluation of country performance, per se. Rather the evaluation focuses on the **process and value of the HBHI approach**.

High Burden High Impact : Objectives of the Approach

The approach aims to reaffirm commitment and refocus to accelerate progress towards GTS goals through 4 response elements



Political will to reduce malaria deaths



Strategic information to drive impact



Better guidance, policies and strategies



A **coordinated** national malaria **response**

1 Burkina Faso, Cameroon, DRC, Ghana, India, Mali, Mozambique, Niger, Nigeria, Tanzania, Uganda

High Burden High Impact : Objectives of this Evaluation

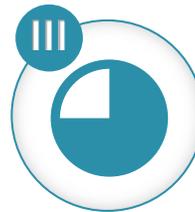
This evaluation of HBHI includes 4 research objectives



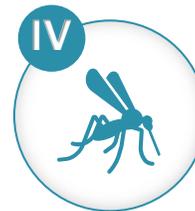
Evaluating the process of **global implementation**



Evaluating **country impact**, barriers to success and best practices



Scaling up all **4 HBHI elements** in countries



Scaling up to **additional malaria endemic countries**

1 Burkina Faso, Cameroon, DRC, Ghana, India, Mali, Mozambique, Niger, Nigeria, Tanzania, Uganda

4 Evaluation Questions (EQ) to address the Objectives

- EQ1** **Global Implementation Processes:** To what extent has the process of global HBHI implementation facilitated improved malaria programme engagement with partners?
- EQ2** **Impact on Country Level Performance:** To what extent has HBHI implementation led to improved performance at the country level?
- EQ3** **Scaling up all 4 Elements:** How can examples of good practices and lessons learned from HBHI implementation inform the scale up of all four elements?
- EQ4** **Scaling up HBHI to additional countries:** How can examples of good practices and lessons learned from HBHI implementation inform the scale up to additional countries?

Research Methods and Processes for the Evaluation

Study design

Qualitative research methods

- Desk review of HBHI documents
- HBHI Country consultations
- Questionnaire design for different interview formats
- Completed in early March

Interviews

Interview modalities

- Key Informant Interviews (KII), global and country level
- Electronic survey (English, French, and Portuguese) for partners
- In-depth interviews with malaria programme managers
- Final interviews completed in June

Recommendations

Areas to Improve

- Global coordination
- Resources for technical assistance
- Political support
- Applying best practices in new contexts

Evaluation Findings: Overall Impact on Country Performance

While the concepts in the HBHI approach were not new, they provided a form and organization that was useful for:

- Political engagement with national leadership
- Encompassing and elevating the profile of existing malaria initiatives
- Framing the development of new NSPs and MPRs
- Providing justifications for interventions in Global Fund grant applications

While subnational stratification and tailoring has helped to prioritize interventions, some respondents highlighted the difficulty of prioritization when resources are insufficient.

“There has not been an adequate methodology for removing recommended and needed interventions when funding is scarce.” – Global stakeholder

Evaluation Findings: Political Will

“Political Will” is widely accepted as a necessity for countries to build and maintain progress against malaria. However, stakeholders recognized that the term needs to be “unpacked” and defined operationally by country programmes. Some positive examples have included:

- Increased financing for malaria at national and subnational levels
- Greater availability of human, capital, and financial resources for malaria activities from all sectors
- Commitments from political leaders for policies and actions to fight malaria
- Accountability and results for malaria commitments
- Engagement and participation of new champions in the fight against malaria
- Elevation in status and visibility of malaria programmes and financing efforts

Evaluation Findings: Examples of Political Will

The elevation of the Malaria Programme to a Division and the promotion of the Manager to an Assistant Commissioner provided the ability “to be more visible, exert influence, and be heard at the senior management meetings.” – Uganda stakeholder

“In 2018, the LLINs campaign was conducted in a state without support from the state government. By 2021, the same state government not only provided N18 million (USD \$43,000) in cash but also availed warehouses for nets and SMC commodities.” – Nigeria stakeholder

The HBHI plan that countries produced helped to mainstream other efforts already being done and gave them broader political recognition, such as the formation of End Malaria Councils and Funds, use of malaria scorecards, a more thoughtful multisectoral strategy, and Zero Malaria Starts with Me campaigns.” – global stakeholder

Evaluation Findings: Strategic Information

The HBHI approach, tools, and technical assistance to drive impact through Strategic Information have been well received by stakeholders. Areas of effective implementation have included:

- Development of National Malaria Data Warehouses
- Digitalization of malaria campaign tools
- Stratification analysis of malaria at more granular levels
- Development of different intervention mixes for different geographical strata
- Regular review of DHIS2 data and malaria scorecards

“The [HBHI] process and tool enables the country to sit around the table and make a critical and honest diagnosis of the malaria situation and reach a consensus on prioritizing and moving forward.” – Nigeria stakeholder

Evaluation Findings: Better Guidance, Policies, and Strategies

Continuous improvement and updating of guidance, policies, and strategies is recognized by all stakeholders as important to maintaining progress. Countries noted improvements in areas such as:

- Development and updating of new policies, SOPs, job aids, and tools for data collection and analysis
- Building capacity at lower levels for service delivery and reporting
- Formulating new NSPs in line with the HBHI approach

The HBHI approach has had a “significant impact” on the country’s objectives for better policies and strategies. – Burkina Faso stakeholder

Evaluation Findings: Programme Coordination

Malaria programmes have effectively coordinated external partners in a number of countries, while challenges remain in others. Engagement and coordination of other government ministries, departments and agencies outside of the health sector requires different political and organizational assets than coordination with external partners, though both are widely acknowledged to be necessary.

- Some stakeholders claimed that programme coordination was already working very well and so little new work needed to be done.

However, others noted some challenges with the HBHI approach in supporting programme coordination including:

- Incomplete understanding among country partners about the meaning and purpose of HBHI
- Insufficient information sharing and engagement among global and country partners
- Inadequate private sector involvement in programme coordination
- A lack of coordination efforts at the sub-national levels

There is a lack of a unifying structure that brings together stakeholders and their partners at the community level. – DRC stakeholder

Evaluation Findings: Multisectoral Action for Malaria

National End Malaria Councils and Funds have been identified as effective mechanisms for engaging sectors outside of health, and mainstreaming malaria needs into the budgets and work plans of ministries, departments, and agencies across sectors. However, the HBHI approach not been seen as providing a roadmap for improvement in this area. Barriers to this work include:

- Incentives to joint collaboration for other sectors
- Non-existent platforms for multisectoral dialogue on malaria
- Funding for multisectoral plans, and M&E

Some non-health sector interventions in the malaria NSP include annual teacher training on malaria; training on insecticide use, disuse, and resistance; and development of a multisector entomological surveillance and national resistance management plan. – Burkina Faso stakeholder

Evaluation Findings: Health System Integration

Although stakeholders widely recognize that success against malaria requires effective integration with other health services, most malaria programmes are structured and financial incentivized to perform as vertical programmes. Even efforts such as the integration of malaria and RSSH Global Fund grants do not seem to have realized the desired effect of integration in strategic planning and implementation. Some proposals for improving on the status quo include:

- Joint development of funding proposals in malaria and health systems from the outset
- Including the concept of integrated programming in the curriculum of medical training institutions
- Changing the organizational structure of disease programmes away from their current silos

“We have perfected the art of vertical programming, [but others should understand that] specialization does not deny your ability to take advantage and leverage on others.” - Nigeria stakeholder

Evaluation Findings: Satisfaction with the HBHI Approach

Country stakeholders were largely satisfied with the conceptual framing of the HBHI approach and claimed that it encompasses the necessary components of a successful malaria program. In fact, many argued that the approach was equally valuable for countries with low malaria burdens as well.

Stakeholders were also satisfied that the HBHI approach effectively encompassed activities and initiatives that were already in progress. HBHI provided a framing and a justification after the fact that could be useful for communication with national leaders as well as with international funders.

It was especially noteworthy that all HBHI countries got comparative increases in their Global Fund malaria allocations, and that the HBHI approach informed the funding requests and proposed intervention mixes.

“The HBHI approach is a fantastic idea. WHO and the RBM Partnership empower countries to critically look at how their programs are running and then look for home-grown solutions.” – Nigeria stakeholder

Evaluation Findings: Areas of Concern with the HBHI Approach

Many country stakeholders initially struggled with the purpose and function of HBHI, and it was taken as a project or a specific set of interventions, rather than as a holistic approach for malaria programmes. This led to misunderstandings and dissatisfaction with the HBHI process at the outset. However, this misunderstanding was corrected during subsequent HBHI rollouts.

Many country stakeholders also anticipated that the launch of the HBHI approach would be accompanied by a separate stream of dedicated financial resources, in line with the presumption that this was a type of malaria project.

Some stakeholders also found that the HBHI approach did not have enough involvement from all global partners, and seemed to be only supported by WHO, ALMA, and RBM.

While the framing of HBHI was seen as appropriately broad and holistic, technical and financial support were concentrated primarily in certain areas (such as in strategic information) with less support for others (such as coordination or health system integration).

Countries asked for additional resources to implement new approaches, but funds were often not available. – Global stakeholder

Evaluation Findings: Recommendations for the Global Community

- Effective coordination needs to be extended to involve all global partners, including in the preparatory meetings.
- Involve country stakeholders in HBHI from the community level, as well as the national programme and political leadership
- Effectively communicate the rationale behind each HBHI pillar and supporting structure
- Appropriate and deploy existing malaria programme structures and initiatives with the HBHI approach. It does not require changing processes for NSP development or starting new “HBHI projects”.

“Countries should not see [HBHI] as a side thing, but the main thing.” – Nigeria stakeholder

Next Steps in the Evaluation

1. Results from the Mozambique will be added to the data collected from Burkina Faso, DRC, Nigeria, Uganda, and global stakeholders and summarized in a report.
2. WHO consultants will collect data from the remaining HBHI countries and learn from the first phase of the evaluation.
3. Recommendations from all countries will inform the improvement and scale up of the HBHI approach

Acknowledgements

Special thanks to all evaluation stakeholder participants in Burkina Faso, DRC, Mozambique, Nigeria, and Uganda – as well as global level stakeholders.

Guidance and support also provided by the RBM and WHO Steering Committee

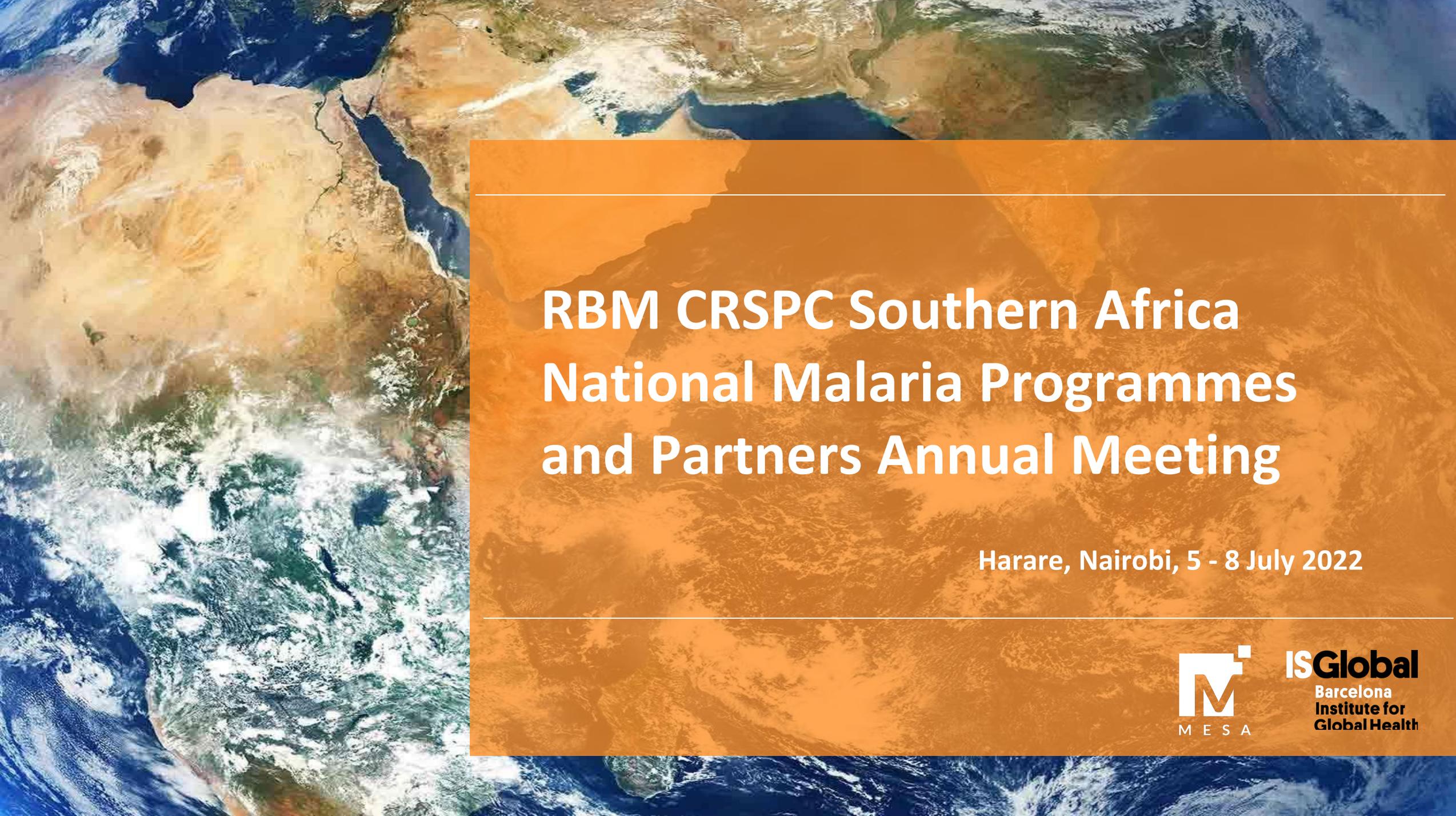
This evaluation was supported by RBM consultants at the global and national level with additional support from ALMA.

Thank you for your attention



World Health
Organization





RBM CRSPC Southern Africa National Malaria Programmes and Partners Annual Meeting

Harare, Nairobi, 5 - 8 July 2022

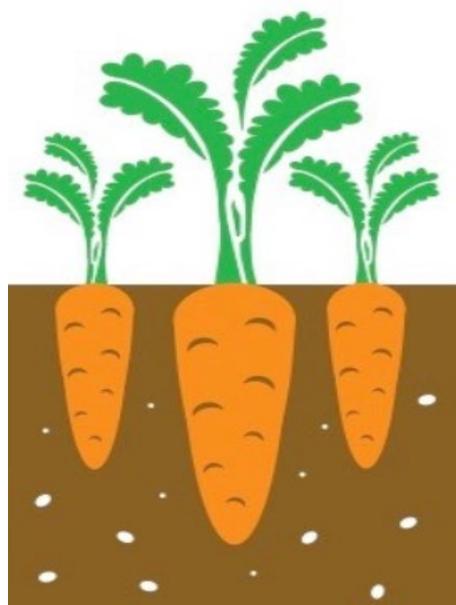


ISGlobal
Barcelona
Institute for
Global Health

Sharing knowledge & catalysing research towards a malaria free world

- Mapping the landscape of active malaria research projects including Operational Research (OR) 
- Creating **effective avenues** for malaria researchers and professionals **to use emerging data for advocacy, decision making, policy and strategies**
- Creating **effective fora** for:
 1. Scientific discourse and learning
 2. Highlighting a problem or a solution

MESA Track: ongoing and completed malaria research



Completed research
& published results

Relevant
Accessible
Visible
Shareable
“Referenceable”

Ongoing research

Relevant
Accessible?
Visible?
Shareable?
“Referenceable”?



A living database which captures research projects and institutions' portfolios in malaria elimination and eradication.

Collaborating with NMCPs to:

1. Learn how NMCPs systematically collect information on OR
2. Learn what's being learned in country and priorities being set for malaria control
3. Increase the **coverage** of project landscaping across different countries via the MESA Track tool
4. Gather the portfolio of research in country
5. Bring to discussion or awareness of solutions or problems for discussion and problem solving
6. Perform evidence review exercises (Deep Dives) on specific themes

We need to systematically document and review learning from the practice across different countries and technical areas

Overview of all projects in MESA Track from the Southern Africa Region



- Mozambique**, 87 Total projects, \$560M Total Funding
- Malawi**, 84 Total projects, \$231M Total Funding
- Zambia**, 61 Total projects, \$268M Total Funding
- Namibia**, 27 Total projects, \$216M Total Funding
- South Africa**, 25 Total projects, \$168M Total Funding
- Zimbabwe**, 24 Total projects, \$331M Total Funding
- Angola**, 15 Total projects, \$297M Total Funding
- Madagascar**, 15 Total projects, \$398M Total Funding
- Botswana**, 12 Total projects, \$73.5M Total Funding
- Comoros**, 1 Total projects, Not known Total Funding

Summary of projects in MESA Track from the Southern Africa Region

TOTAL PROJECTS

258

31 active

TOTAL FUNDING

\$1.14B

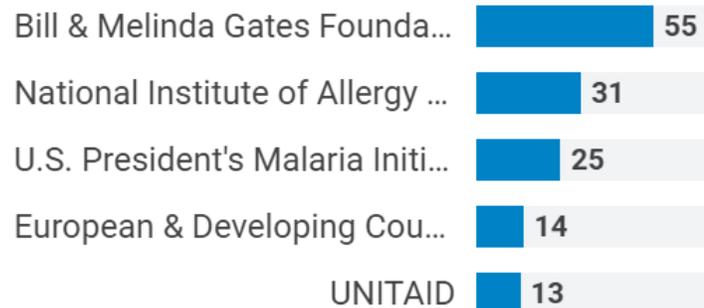
\$217M active

PROJECT SITES

110

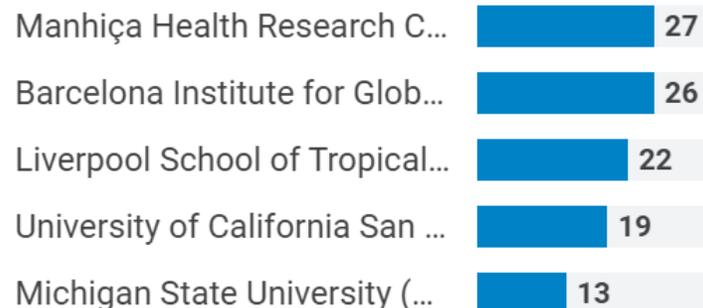
45 active

Funding Sources



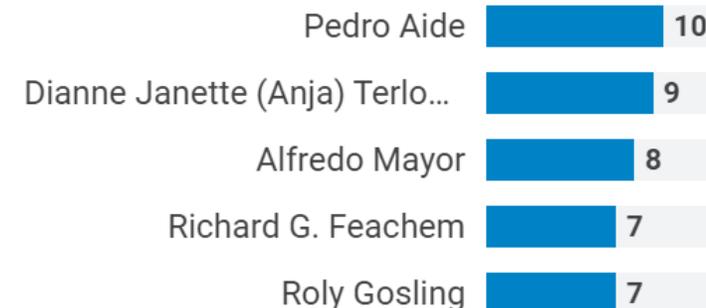
Show All + Download ↓

Principal Institutions



Show All + Download ↓

Principal Investigators



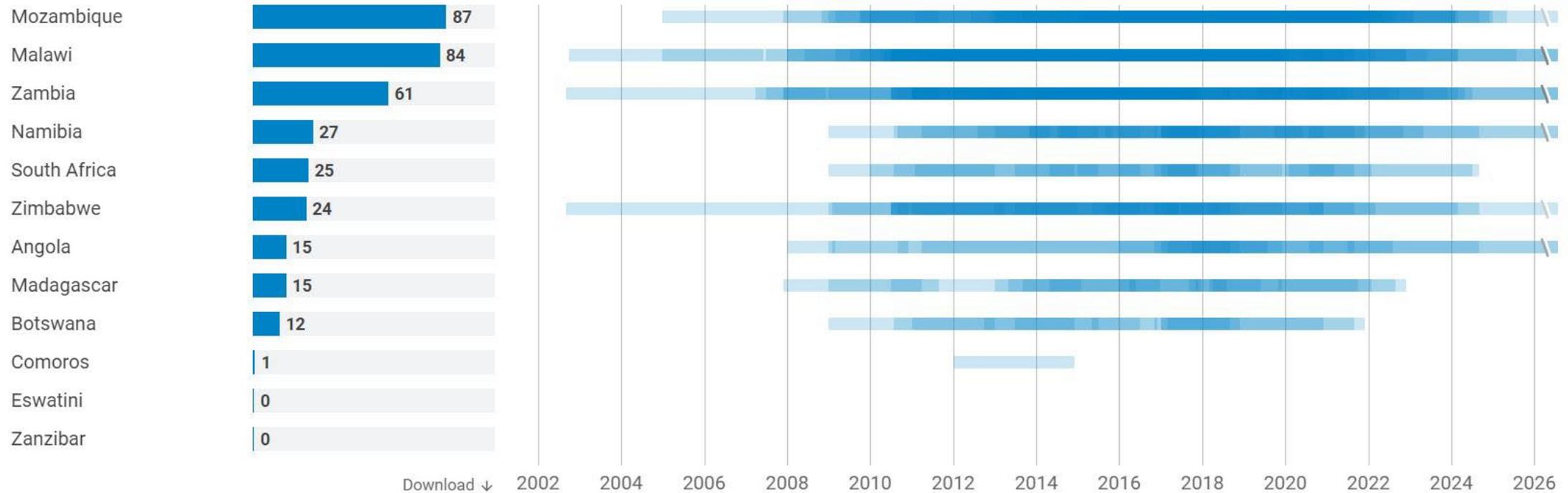
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Summary of projects in MESA Track from the Southern Africa Region

Research Area

Total Projects

Project Timeline



Evidence review exercises “Deep Dives”

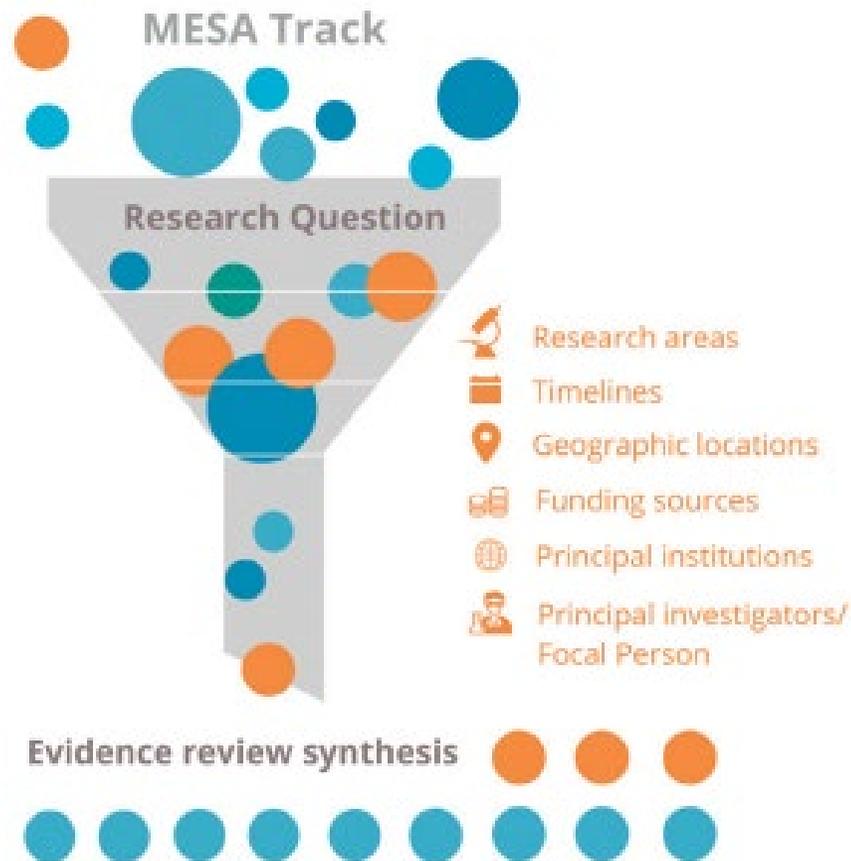
MESA Track enables the community of malaria researchers, programs and policy makers to know what research (including OR) is ongoing.

Through the “Deep Dives”, policy makers can identify what new questions are being asked by the malaria community, foresee emerging evidence and plan the timing for future revision of guidance. Examples include:

- Larval Source Management
- Ivermectin for Malaria
- SMC
- MDA
- IPTi, IPTp
- Urban Malaria
- Border Malaria
- Baits & Traps for Vector Control
- and many more!!

Deep Dives

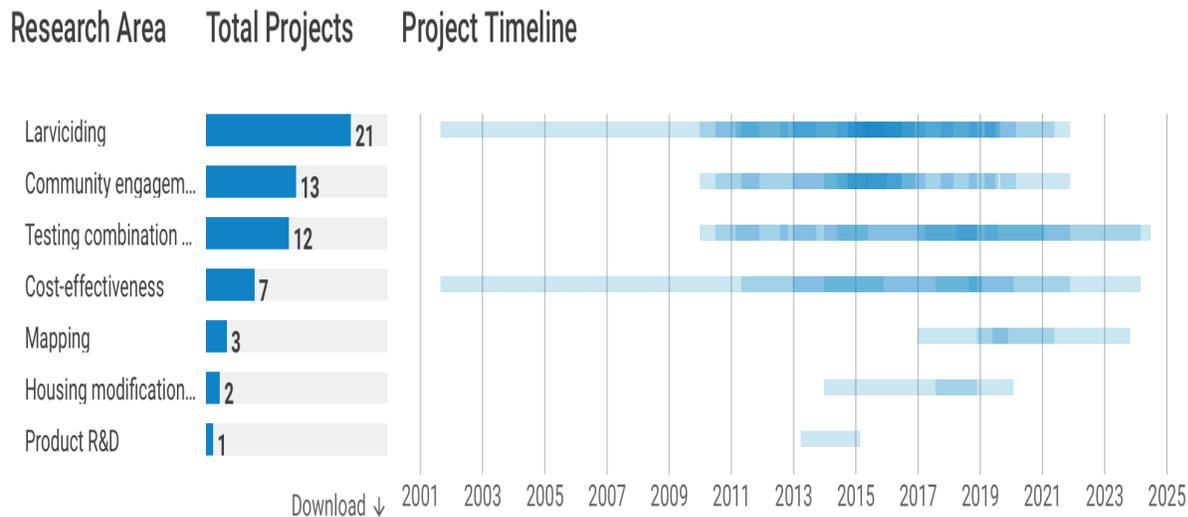
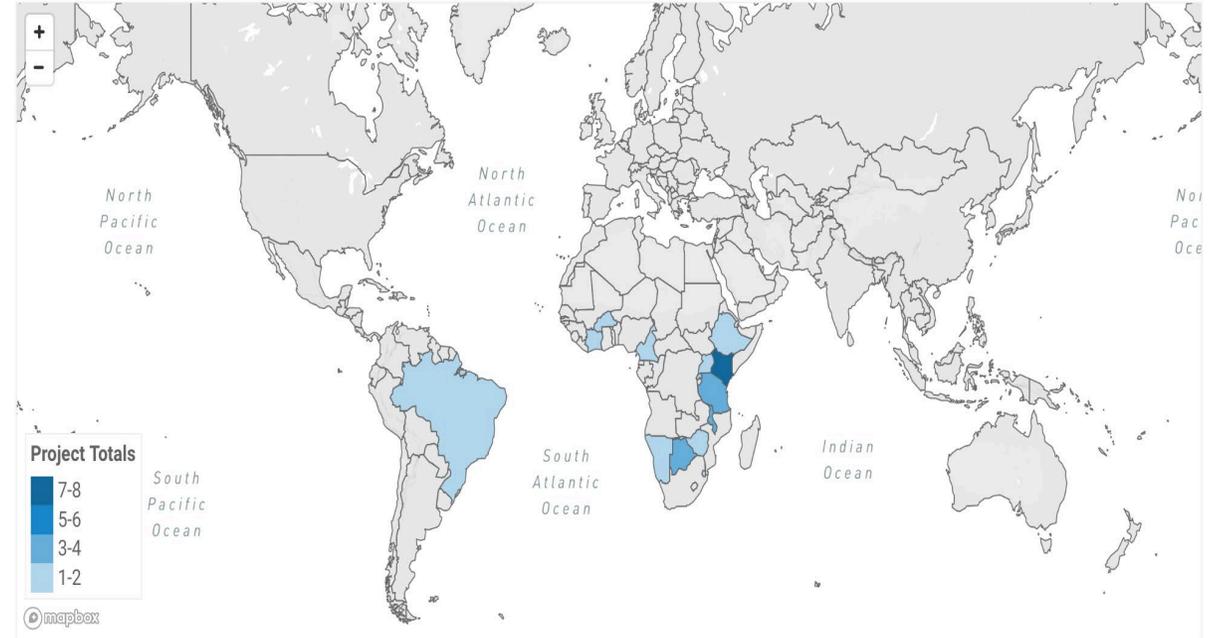
A one-stop shop to glance at the research being done on some of the most pertinent malaria topics.



Larval Source Management Deep Dive

TOTAL PROJECTS 31 3 active	TOTAL FUNDING \$33.0M \$7.79M active	PROJECT SITES 16 3 active	VIEW ALL
--	--	---	--------------------------

Total projects | Total funding ⓘ [FILTER +](#)



Funding Sources



Principal Institutions



Principal Investigators



Objectives

1. Describe the geographic scale and scope of ongoing *An. stephensi* research and other projects.
2. Overview of the distribution of active *An. stephensi* surveillance or monitoring programmes.
3. Describe the funding sources for projects.
4. Document the list of questions under evaluation.
5. Identify or draw on any overlaps between the urban malaria Deep Dive and the *An. stephensi* Deep Dive.

Thank you

We request your review of the MESA platform for your country and update your active Operational Research projects: [***https://mesamalaria.org/mesa-track***](https://mesamalaria.org/mesa-track)

MESA focal point:
Nana Aba Williams
nana.williams@isglobal.org

A woman with a colorful headwrap and a patterned dress is smiling and holding a baby. The background is a blurred outdoor setting with greenery and a building. The image is overlaid with a large yellow circle on the right side containing text.

MMV update

Southern Africa National Malaria
Programmes and Partners Annual Meeting
Harare, Zimbabwe, 5-8 July 2022

Hans Rietveld
Director, Access & Product Management
7 July 2022

Product development partnership

Swiss Foundation/US Charity



MMV

reducing the burden of malaria
in disease-endemic countries, by
DISCOVERING, DEVELOPING
and **DELIVERING**
new, effective and affordable
antimalarial drugs

Agenda

- MMV's impact
- R&D Pipeline
- Severe Malaria products
- ACT resistance mitigation strategies
- Seasonal malaria chemoprevention extension
- African manufacturing

MMV-supported products have saved an estimated 3 million lives since 2009



450 million treatment courses¹ delivered by Novartis to more than 50 countries

Saving an estimated >969,000 children's lives



255 million vials of Injectable Artesunate delivered since 2011²

Saving an estimated 1.36 million additional lives³



Reducing uncomplicated and severe malaria episodes by 75%⁴

**Protecting over 44 million children in 2021 –
reducing uncomplicated and severe malaria by 75%⁵**



7.6 million capsules delivered since 2017

Halving disability and death⁶

1 Source – Novartis 2021

2 Source – Fosun 2021 and Ipca 2021

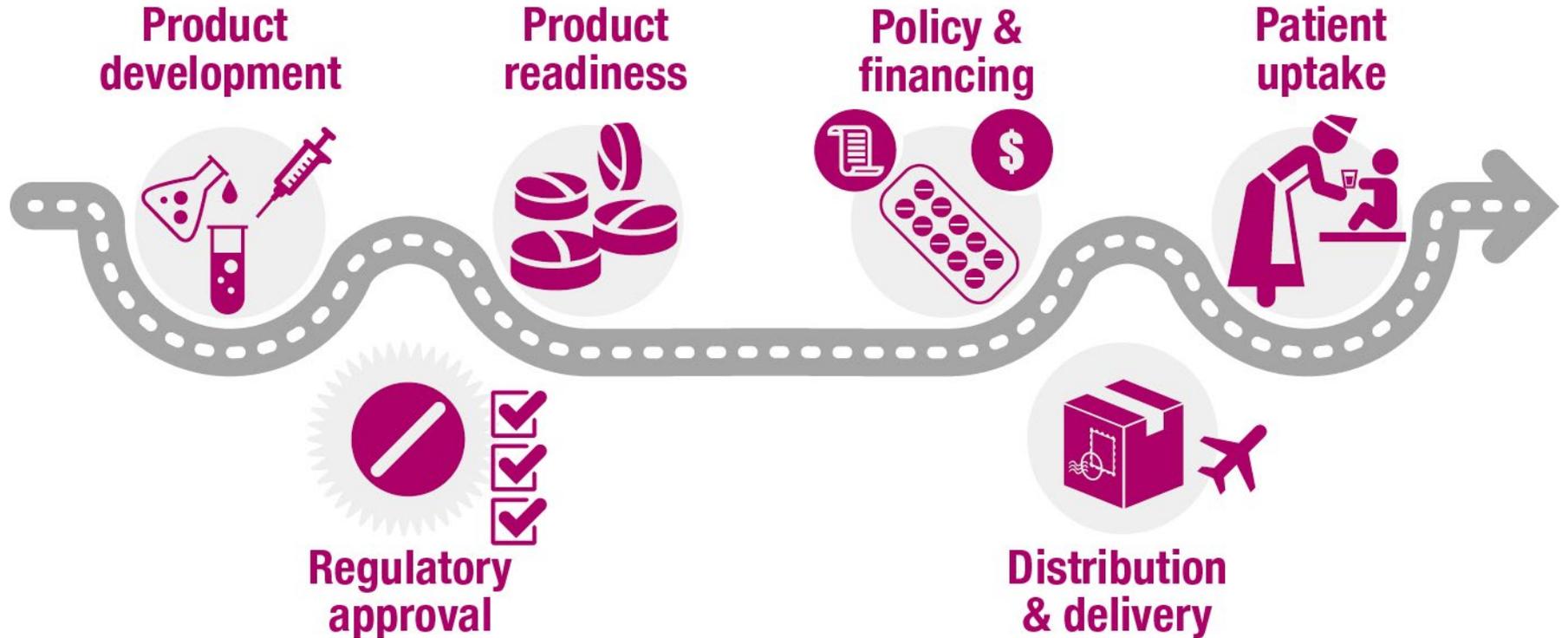
3 Additional children's lives saved by providing injected artesunate versus injected quinine to children with severe malaria – AQUAMAT and SEAQUAMAT studies

4 WHO

5 Fosun distribution data (2018)

6 WHO TDR Study 13

Access > The road to health impact



Public-private partnership: a way to finance new medicines

Private Foundations

Bill & Melinda Gates Foundation (BMGF)

43.8%

Governments

UK Foreign, Commonwealth & Development Office (FCDO, ex-DFID)

27.2%

European and Developing Countries Clinical Trials Partnership (EDCTP)

11.2%

Ministry of Foreign Affairs of the Netherlands (DGIS)

3.8%

German Federal Ministry of Education and Research (BMBF)

3.2%

Australian Government Department of Foreign Affairs and Trade (DFAT)

3.1%

Swiss Agency for Development and Cooperation (SDC)

2.6%

Ireland Department of Foreign Affairs (Irish Aid)

1.3%

United States Agency for International Development (USAID)
and National Institutes of Health (NIH)

1%

Principality of Monaco Direction de la Coopération Internationale (DCI)

0.1%

Others (Other donors, partnerships, individual donations)

Global Health Innovative Technology Fund (GHIT)

1.5%

Bristol Myers Squibb Foundation

0.6%

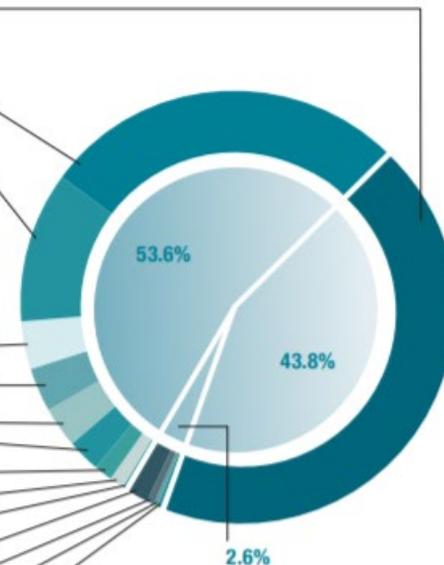
Program for Appropriate Technology in Health (PATH)

0.3%

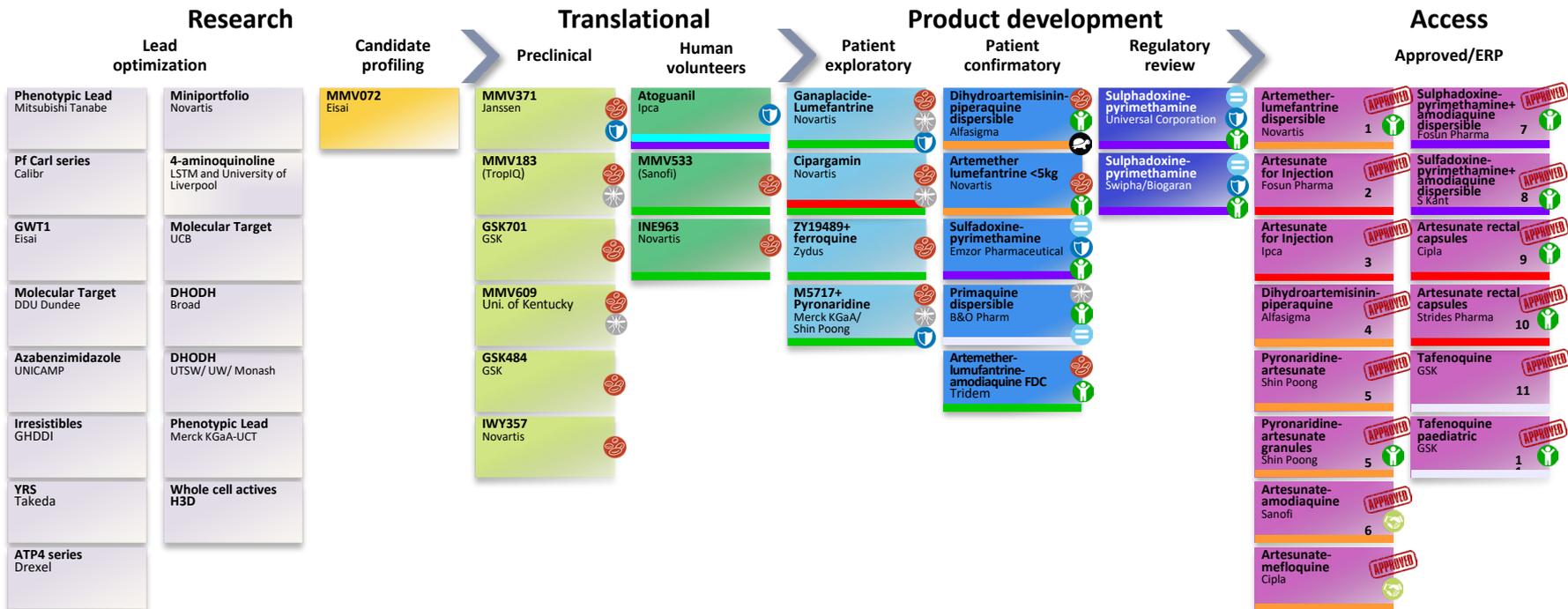
Newcrest Mining Limited

0.2%

100%



MMV-supported projects



MMV support to projects may include financial, in-kind, and advisory activities.

Footnotes: Included in MMV portfolio after product approval and/or development. DNDi and partners completed development and registration of ASMQ and ASAQ. | Global Fund Expert Review Panel (ERP) reviewed product – permitted for time-limited procurement, while regulatory/WHO prequalification review is ongoing. | WHO Prequalified OR approved/positive opinion by regulatory bodies who are ICH members/observers. | paediatric formulation. | via a bioequivalence study. Past partners are in brackets (-).

Brand names 1: Coartem® *Dispersible*; 2: Artesun®; 3: Larinate® 60mg; 4: Eurartesim®; 5: Pyramax® tablets or granules; 6: ASAQ Winthrop®; 7: SPAQ-CO™; 8: Suprya® 9: 100mg Artesunate Rectocaps; 10: Articap™; 11: *Kozenis or Krintafel* (Trademarks owned or licensed by GSK)

Key products for severe malaria



Cipla
Strides Shasun



FOSUNPHARMA
Innovation for Global Health
ipca



MacLeods obtained
WHO
prequalification on
April 13, 2021

Artemether 80mg injectable (Sanofi) WHO prequalified on August 29, 2019

www.severemalaria.org

Suppository vs. Softgel Capsule

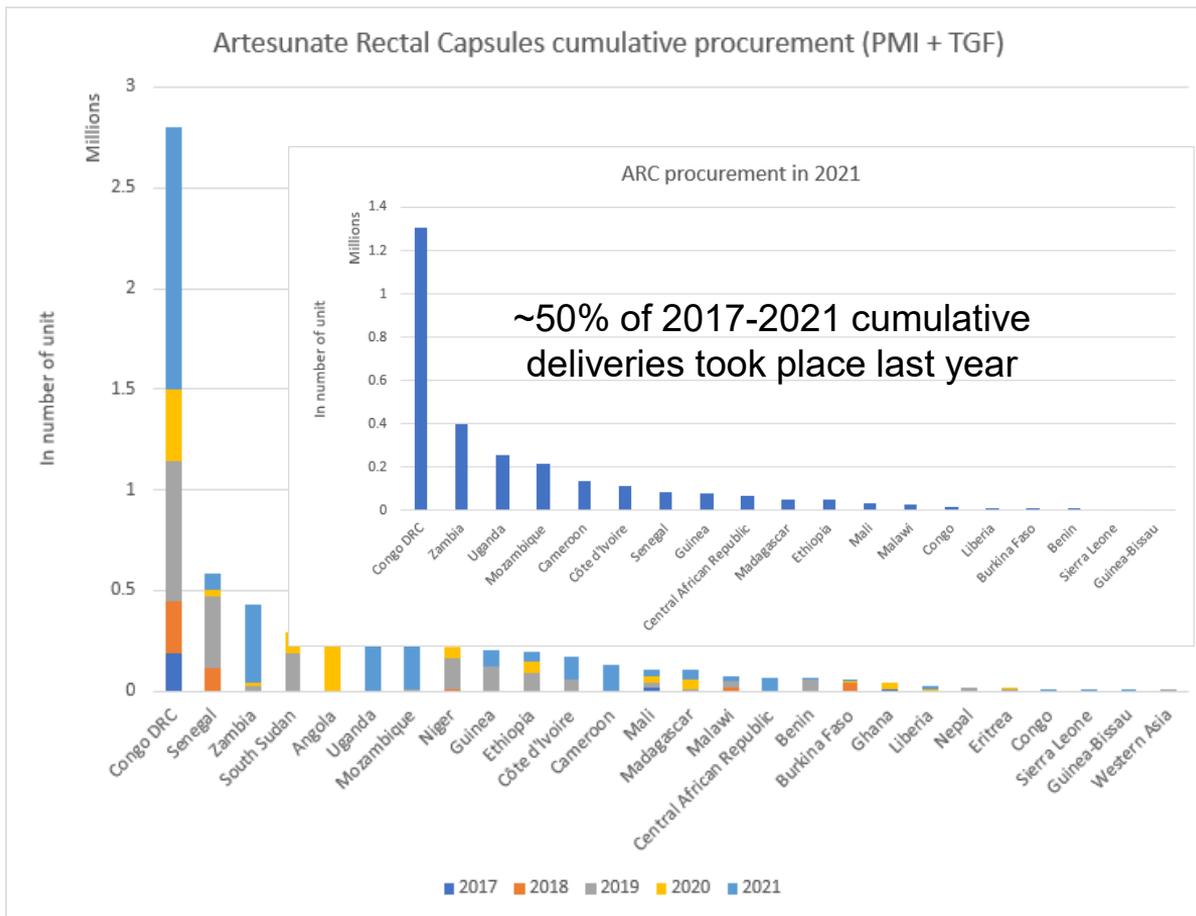


- Softgel rectal capsule
 - Consistent thermostable shape
 - The resistance of the gelatin shell allows, with care, insertion when soft



- “Classic” fat or wax-based suppository
 - Melts in the hand and deforms easily
 - Difficult to insert when soft and unusable when molten

Rectal artesunate was procured by 19 countries in 2021



Selected findings from RASIEC study

- Ongoing clinical support/supervision & patient care standards for severe malaria are needed at all levels of care
- Referral slips can enhance the continuum of care & indicating the care received on the slip and returning the referral slips via the patient to the VHC – will close the feedback loop adding further value to the process.
- Only 6.9% of Village Health Clinics underwent on-site supervision during 12 months
- Additional continuing education was minimal for HSAs

Full report available on www.severemalaria.org

Post – Rectal Artesunate

Referral Slip - RASIEC Study

College of Medicine/WellSense/MMV

This form is to be used when referring a child 5 years and under after administering pre-referral RAS.

S500

Date: _____ Time: _____

From: _____ (Name of VHC) District: _____

To: _____ (Health Facility)

Please receive _____

a male /female child aged _____ months (circle correct)

administered Rectal Artesunate _____ milligrams.

_____ (number of suppositories).

This child presented with the following DANGER SIGNS:

(tick the signs that the child presented with)

Fever or Recent history of fever	<input type="checkbox"/>
Unconsciousness	<input type="checkbox"/>
Recent history of convulsions	<input type="checkbox"/>
Convulsions observed	<input type="checkbox"/>
Repeated vomiting/vomiting everything	<input type="checkbox"/>
Unable to eat/suckle	<input type="checkbox"/>
Lethargy	<input type="checkbox"/>
Severe anaemia	<input type="checkbox"/>

Please provide the required follow up care for suspected severe malaria.

With thanks _____ Signature (Referring NSA)

Receiving Health Worker:

Please add this referral slip to the RASIEC referral filing box for collection by the research team - with thanks - RASIEC study team

For further information please contact: Salima DHMT: Mr Precious Mzungu | 088 836 0380

- The date and time of referral
- The child's demographics
- Danger signs presented
- Treatments given at VHC



Key findings from severe malaria case management assessments

- **Angola**
- **Liberia**
- **Mali**
- **Uganda**
- **DRC**

Full reports available on www.severemalaria.org

Context of Severe Malaria Global Stakeholder Meeting 8-9 February 2022

**Rising malaria
mortality¹**

**Reports of
artemisinin
resistance in
Africa²**

Severe Malaria Stakeholder
Meeting 2022



**CARAMAL project:
challenges and
deficiencies along
the cascade of care³**



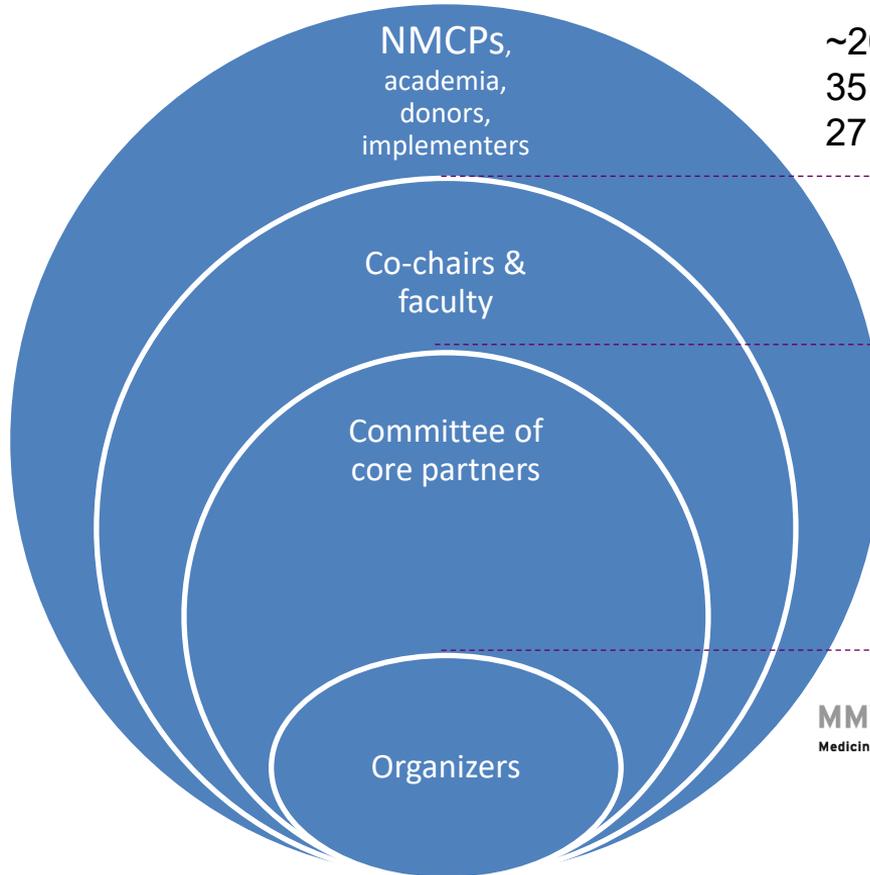
The use of rectal artesunate as
a pre-referral treatment for severe
P. falciparum malaria

JANUARY 2022

INFORMATION NOTE

1. World Malaria Report 2021
2. Evidence of artemisinin-resistant malaria in Africa. *N Engl J Med* 2021; 385:1163-1171
3. Not yet published
4. The use of rectal artesunate as a pre-referral treatment for severe *P. falciparum* malaria. WHO Information Note, January 2022 <https://apps.who.int/iris/handle/10665/351187>

Meeting development, organization and attendance



~200 attendees:
35 malaria endemic countries;
27 global organizations

Prof. Olugbenga Mokuolu, NMCP Nigeria
Dr. Elizabeth Chizema, End Malaria Council, Zambia
7 Country presentations

PMI | U.S. PRESIDENT'S MALARIA INITIATIVE

THE GLOBAL FUND



Key message from Severe Malaria Global Stakeholder Meeting

- RAS as a life saving intervention should be made available to all children in accordance with the WHO guidelines
- Strengthening of referral and post referral services should be prioritised and supported on a continuing basis
- RAS must not be withheld from any child where no alternative is available
- Complete treatment with at least 24 hours of injectable artesunate and a three-day ACT

Severe Malaria Global Stakeholder Meeting

8-9 February 2022



Defeating Malaria Together

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Annex 3	32

ACT resistance in Africa: an emerging threat?



- In August 2020 *Nature Medicine* reported the *de novo* emergence of *Pf* mutations in Rwanda, presumably leading to reduction of parasite clearance speeds.
- Similar mutations have also been reported in both Uganda, Eritrea and Burkina Faso
- ACTs are still fully active in these regions, but the concern is that there will be increased pressure on the partner drugs. Data on the impact on severe malaria are not available
- This has reinforced the urgent need for the development and deployment of both mitigation strategies and non-artemisinin drug treatments

A number of mitigation strategies



- Multiple First-Line Treatment (MFLT): the use of more than one first-line drug simultaneously – either in parallel or in rotation – to reduce the drug pressure on any single medicine and help avoid or slow the emergence of resistance
- Triple ACT combinations (TACTs): adding in a 3rd drug to existing combinations to maintain efficacy and protect the individual components. This strategy could be considered either alongside or as an alternative to MFLT
- Adding a single dose of low-dose primaquine (LDPQ) to an ACT to block transmission
- Developing and introducing novel non-artemisinin anti-malarials

Rationale for Multiple Firstline Treatments strategy

- **MFTs strategy: A drug policy with more than one effective treatment for managing uncomplicated malaria cases**
- **MFTs a promising strategy to extend the useful therapeutic life of the current ACTs (theoretical models) by:**
 - reducing drug pressure
 - slowing the spread of resistance
- **Scenarios for implementing MFTs:**
 - Use of one ACT for community case-management and a different ACT in the clinic
 - Partition of the ACTs market by segment of the same population: paediatric patients, pregnant women, adult patients....
 - Partition of the ACTs market by private/public sectors
 - Mosaic distribution of ACTs: alternative distribution of different ACTs in the same population over a given period of time....

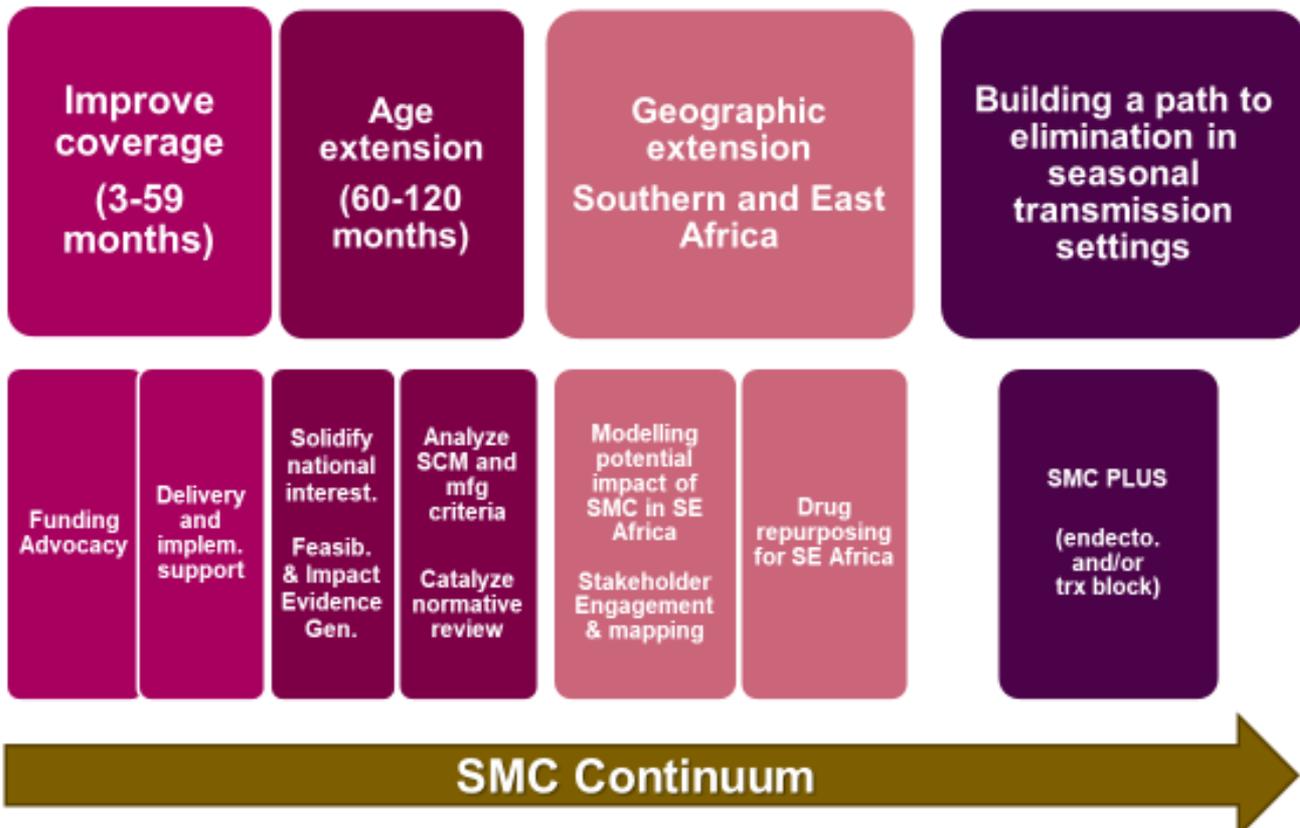
MMV has supported 2 Multiple First Line Treatment pilots in order to inform future policy and implementation.

Designing studies to demonstrate the efficacy of MFLT in mitigating the emergence of resistance in practice is virtually impossible – therefore both pilots are operational research studies to better understand the costs, trade-offs and practicalities of implementing MFLT in real life.

- Pilot 1: Kaya region, Burkina Faso
 - Approach: parallel use of different ACTs for different patient groups
- Pilot 2: Homabay and Migori counties, Kenya
 - Approach: rotational use of AL (control), ASAQ, pyronaridine-artesunate and DHA-PQP every 8 months

SEAMACE

(SEASonal MALARIA Chemoprevention Extension)

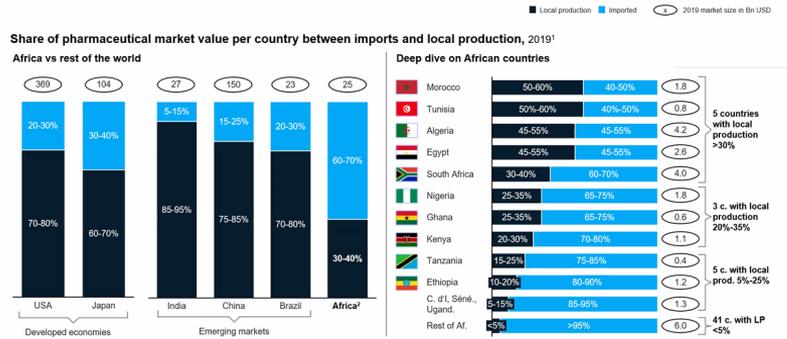




African manufacturing

African market

- Today, Africa disproportionately relies on imported medicines: **COVID-19 has heightened concerns about supply insecurity**
- The continent overall has ~375 drug makers, to serve a population of around 1.3 bill people¹
- African population set to triple by 2050.²
- **Top three African markets** (Kenya, South Africa, Nigeria) import significant pharma products
- Vast majority of pharma mfg do not meet Int GMP standards and major international partners continue to maintain limited investment



Notes: 1. <https://www.mckinsey.com/industries/public-and-social-sector/our-insights/should-sub-saharan-africa-make-its-own-drugs>
 2. <https://www.weforum.org/agenda/2020/01/the-children-s-continent/>
 3. https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_ACONF1-en.pdf

Key drivers

Upstream

- **Vertical integration** – due to supply security constraints there is a willingness for manufacturers to invest in backward and forward integration strategies
- **Manufacturing hubs** – international drive to establish regional manuf hubs
- **Need to diversify** - over 70% of WHO prequalified manufacturers based in India
- **International investment** - €1 billion European Commission initiative on manufacturing and access to vaccines, medicines and health technologies in Africa
- **2021 WHO Resolution** “Strengthening local production of medicines and other health technologies to improve access³”



Downstream

- **AU with support from Africa CDC** aims to establish vaccine development and manufacturing capacity and capability in Africa for public health security
- **AfCTA ratification** - 40 African countries are onboard to reduce trade costs
- **TRIPS Agreement** - LDCs and Technology Transfer – we should see a “speeding” up of tech transfer as LDCs set up incentives and create more viable markets
- **Early signs of national protectionism** – Govt introduced import bans (Nigeria) to ensure national supply security and protect manuf
- **AfDB Pharmaceutical Technology Foundation** - focused on promoting and broker alliances between foreign and African pharmaceutical companies.

MMV Engagement with African manufacturing



Ongoing work

- MMV is supporting local manufacturers in **Kenya and Nigeria** to produce WHO- PQ'd chemopreventive medicines since 2017.
 1. In Nigeria, MMV is supporting both Emzor and Biogaran/Swipha to achieve WHO Prequalification of medicines used for IPTp, IPTi, and SMC.
 2. In Kenya, MMV is supporting Universal Corp (UCL) to achieve first time WHO prequalification of SP for IPTp.
- MMV is working with partners to support two **South African** pilots:
 1. Chemical Process Technologies Pharma – to build API manufacturing capacity, funded by BMGF.
 2. Nelson Mandela University – to develop a scalable, rapid and green continuous flow process, funded by the API Cluster.

Committed funders



BILL & MELINDA
GATES foundation



A close-up photograph of two young children with dark skin and hair, smiling warmly at the camera. They are wearing green clothing with yellow trim. The image is the background for a text overlay.

**MALARIA:
HELP DEFEAT IT!**

MMV Disclaimer

This presentation contains certain forward-looking statements that may be identified by words such as 'believes', 'expects', 'anticipates', 'projects', 'intends', 'should', 'seeks', 'estimates', 'future' or similar expressions, or by discussion of, among other things, vision, strategy, goals, plans, or intentions. It contains hypothetical future product target profiles, development timelines and approval/launch dates, positioning statements, claims and actions for which the relevant data may still have to be established. Stated or implied strategies and action items may be implemented only upon receipt of approvals including, but not limited to, local institutional review board approvals, local regulatory approvals, and following local laws and regulations. Thus, actual results, performances or events may differ from those expressed or implied by such statements.

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THE ROLE OF MULTISECTORAL ACTORS IN THE SUSTAINABLE FIGHT AGAINST MALARIA

MSWG PRESENTATION TO RBM EARN ANNUAL MEETING

PETER KWEHANGANA MBABAZI

CO-CHAIR MSWG

FINANCE & MULTISECTORAL PARTNERSHIP COORDINATOR

MINISTRY OF HEALTH UGANDA

9th June 2022

MSWG PURPOSE & RATIONALE

Multisectoral collaboration is key in light of the challenges faced in malaria control and elimination including insecticide and drug resistance, mobility of populations, risk perception, sustainable human settlements, poverty, disasters (natural & man-made), outdoor transmission, climate change and funding shortfalls.

- To end malaria for good, we need the concerted action of different stakeholders across different sectors beyond the health sector, as well as intra-sectoral collaboration.
- The SDGs calls for action to transform societies gives further impetus for a Multi-sectoral Working Group (MSWG).
- The MSWG was established under the umbrella of the RBM Partnership to End Malaria, following approval by the RBM Board in April 2018.
- The MSWG convenes and coordinates RBM Partnership members around a multi-sectorial action in the field of malaria to facilitate learning and share best practices from the field.

MSWG PURPOSE & RATIONALE

The MSWG brings together different stakeholders across different sectors including; health, science and technology, oil & gas, international cooperation (cross border), housing, infrastructure, extraction industries, water and sanitation, environment, food and agriculture, education, immigration, tourism, customs, security, finance, trade, political, private, civil society, labour, research & development, media, information & communications technology, social protection and justice.

The aim is to align partners in their actions for new interventions as well as putting new life into those that already exist, and coordinate and manage these in new and innovative ways.

MSWG Co-Chairs

Dr Graham Alabaster UN-Habitat, Switzerland

Mr Peter Kwehangana Mbabazi Ministry of Health Uganda

MSWG Secretariat/Coordinator

Dr Konstantina Boutsika Swiss TPH, Switzerland

MSWG TORS

- The Terms of References (TORs) as approved by the RBM Board are available in English and French.
- The structure is in line with the structure of other RBM Working Groups, following the Working Group Standard Operating Procedures (SOPs).
- The governance of the MSWG ensures adequate participation of malaria-affected countries and demonstrates a self-financing and self-convening capacity.
- The coordination of the MSWG is guaranteed through the financial support of the Swiss Agency for Development and Cooperation (SDC) to the Swiss Tropical and Public Health Institute (Swiss TPH) which is hosting the MSWG Secretariat.

MSWG KEY MANDATES & RESULTS

Mandate; Convene, Coordinate, Mobilise Resources,
Facilitate communication

Results

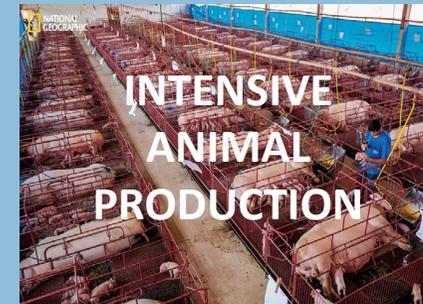
1. Develop systems and tools to conduct national appraisal of malaria determinants and inequalities.
2. Promote the development of national multi-sectoral malaria action plans
3. Promote 'malaria-smart' innovative approaches to apply multi-sectoral interventions at
4. large scale for sustainable impact on malaria.
5. Develop the framework for monitoring the implementation of multi-sectoral malaria action
6. plans at different levels.



RECENT ACTIVITIES OF MSWG

- **Finalisation of MS Framework documents:**
 - RBM Multisectoral Action Guide to End Malaria (Completed)
 - RBM Multisectoral Action Framework for Malaria (with UNDP) Under final Edits
- **Further development of Two Flagship programmes and Resource Mobilisation:**
 - Healthy Cities Healthy People
 - Pathfinder Endeavours
- **Additional work**
 - Links to other VB diseases (Dengue, and other Aedes-transmitted viral diseases, in cities are a growing threat to the health and development of tropical urban environments)
 - Support to WHO on Joint WHO/UN-Habitat Urban Malaria Report
 - Focus on data collection and monitoring:
housing/Infrastructure/Planning approvals

OUR WORLD IS CHANGING FAST...



**INCREASED
INTERACTIONS AT THE
HUMAN-ANIMAL-
ENVIRONMENTAL
INTERFACE**

WHY FOCUS ON URBAN AND PERI-URBAN SETTINGS?

- **Urbanisation:** From 2000 to 2030 the world's urban population is expected to increase from 2.7 billion to 5.1 billion people – i.e. 60% of global population
- **Environment:** Urban malaria and vector-borne disease risk varies according to types of construction, waste management, drainage, ditches and water storage that can create breeding sites for vectors
- **Urban vs rural:** WHO has recognised the different response required for the response to malaria in urban areas vs rural, to address rapid urban population growth and evolving malaria transmission dynamics in malaria endemic countries*
- **Multiple benefits of action:** Multi-sector response required to tackle malaria in cities will also help tackle other vector borne diseases, NTDs and TB

WHY WORK WITH CITY LEADERS?

Many of the indirect (i.e. non health) interventions to tackle vector borne disease fall under the direct responsibilities of local governments

TYPE	INTERVENTION
Environmental modification	<ul style="list-style-type: none">• Improving drainage• Draining swamps• Dredging to increase water flow• Making embankments• Land reclamation• Deforestation/afforestation• Flood control• Improved sanitation including better water storage and provision and good maintenance of piped water• General infrastructure development – e.g., construction of roads
Social/preventive	<ul style="list-style-type: none">• House/window screening• Improved housing• House inspections to identify and remove breeding sites



HEALTHY CITIES, HEALTHY PEOPLE

- The *purpose* of this initiative is to **support a network of city leaders** and link them with international health advocates. This initiative responds to the Commonwealth Local Government Forum ‘**Call to Action on Sustainable Urbanisation Across the Commonwealth**’ and the CHOGM Communiqué 2018.
- The initial *objective* was to agree a ***Common Position and Commitment to Action***, with a focus on the role city leadership can play in galvanising action beyond the health sector.
- The *longer-term aim* is to **mobilise substantial and sustainable support for urban health investment across the Commonwealth**, and create a *network* with a strong focus on vector-borne diseases and NTDs.
- Particular attention needs to be given to secondary cities which often lack the political power, resources and support of national capitals and commercial centres.

Healthy Cities, Healthy People: Partners

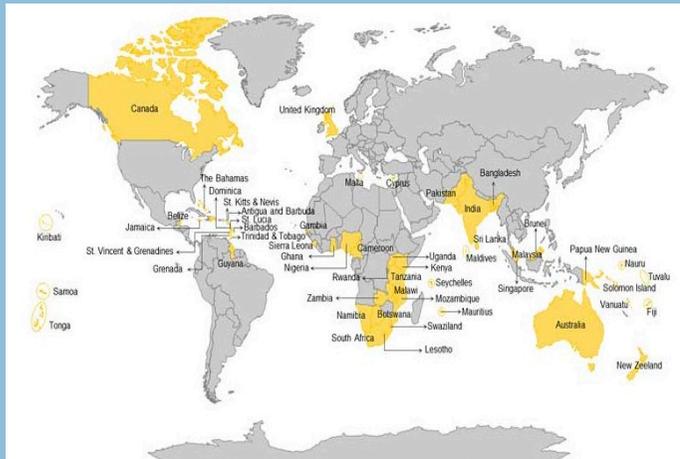
Partner Organisations



Potential Collaborators



Commonwealth outreach to urban leaders (CLGF)

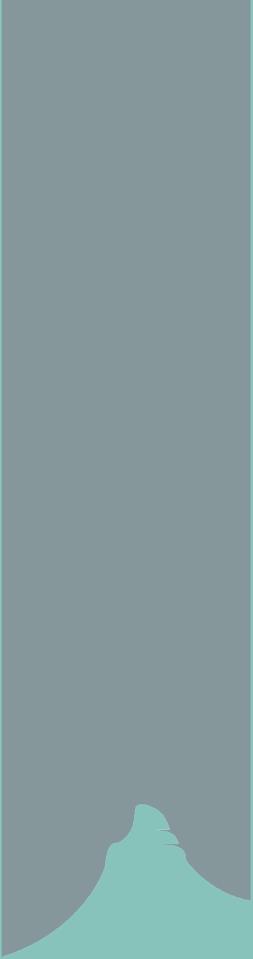


- Hosted series of regional meetings with 20+ countries represented, plus further consultations.
- Covid-19 highlights role of mayors/city leaders, but most lack authority and resources they need.
- Environmental factors must be addressed, investment in prevention has never been more critical
- Keen to join forces with Francophone Mayors & beyond



NEXT STEPS

- UN Habitat and CLGF are seeking resources to support city leaders with technical assistance, enabling them to build the case for investment, identifying opportunities to access sub-sovereign finance and other resources for infrastructure development and capacity building.
- A new financing mechanism has been developed. Which links the creation of a challenge fund for demonstration projects WITHIN current and planned larger scale investments
- Work plan is being developed under Commonwealth Sustainable Cities Network to link leaders with each other and with technical expertise. Widening the network to collaborate with Francophone partners and beyond.
- We are currently looking for resources to developing pilot projects to take to Commonwealth leaders at CHOGM, World Health Assembly, World Urban Forum etc



THE PATHFINDER ENDEAVOUR

THE PATHFINDER ENDEAVOUR

Overriding theme: ‘leave no one behind and sustainability’

Action theme (vision): ‘a malaria free world’

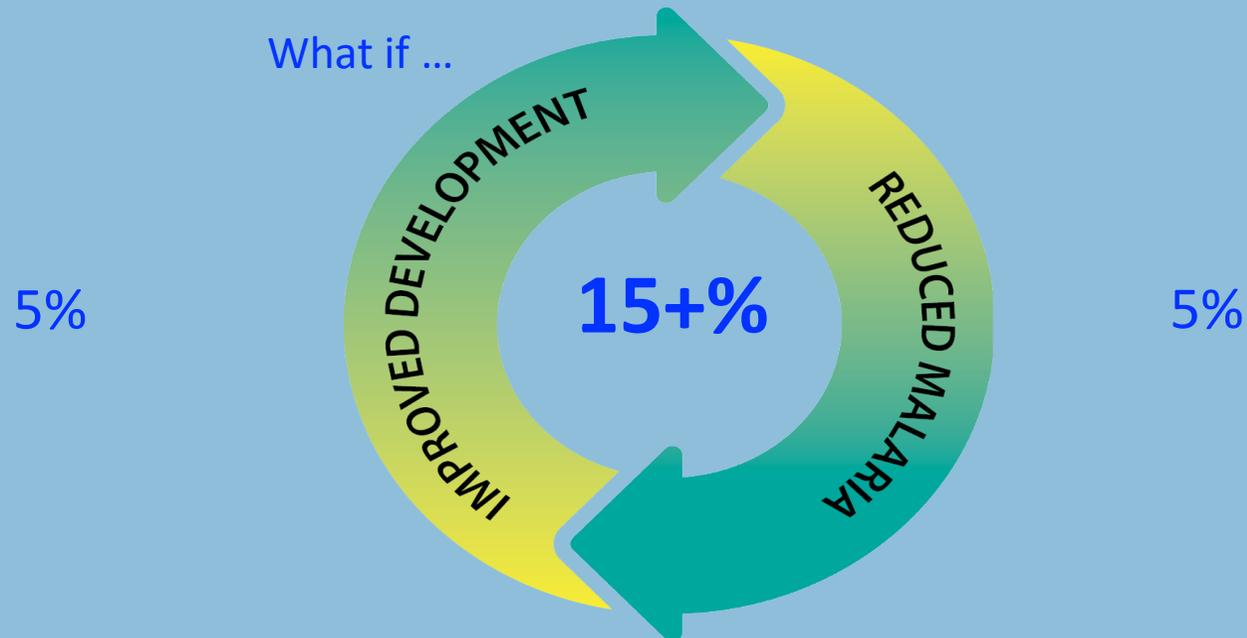
Collaborative theme: ‘co-benefits’

“Do what you do best – but do it malaria-smart”

- Make development work for malaria control and malaria control work for development
- The RBM Multisectoral Working Group For Malaria
- Comprehensive Multisectoral Action for Malaria

PATH FINDER PROJECT OUTCOMES

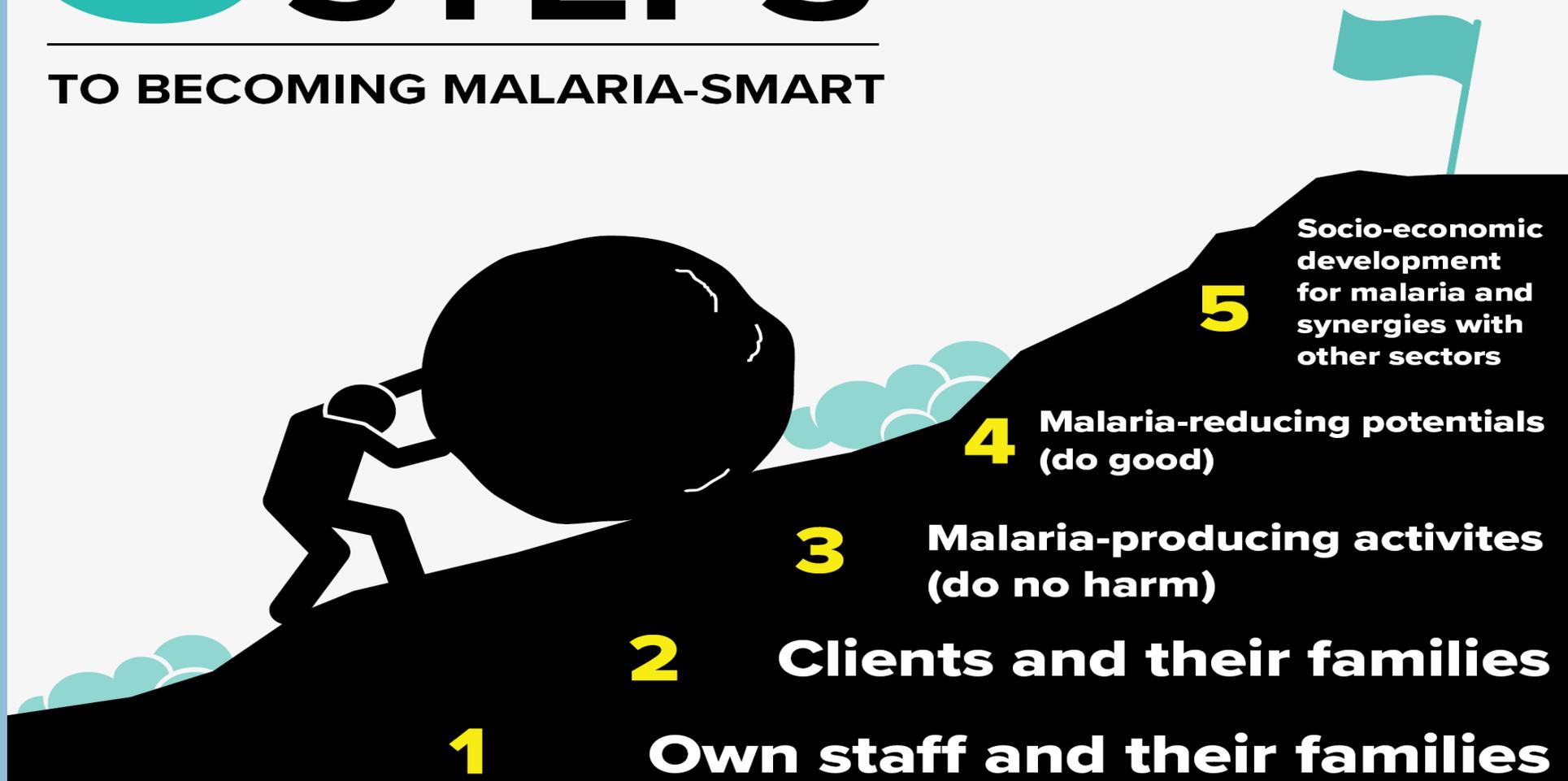
- malaria-critical indicators across all 17 SDGs improved by 5%?
- reach of conventional malaria interventions improved by 5%?



5 STEPS

TO BECOMING MALARIA-SMART

**SUSTAINABLE
ELIMINATION**



MUTUAL ACCOUNTABILITY

Within participating districts and countries

- Political, technical, and public

Across participating districts and countries

- Resources and progress against plans and targets

Two malaria-critical indicators for each of the 17 SDGs



All relevant global technical strategy for malaria indicators

COLLABORATIVE JOURNEY

Development partners

- Multilateral
- Bilateral
- NGO/CSO
- Academia

Champion teams

Within each country

- MoLG / MoPI
- MoH/NMCP
- Lead Development Partner

Within each district

- Local government officer
- Health officer [NMCP]
- Development partner present in district

EXPLORE THE PATH

Methods of work: training; provision of toolbox; peer review, cross-learning and -support; adapting; planning, budgeting, and target setting; and analysing, learning, adjusting.....

	2022						2023						2024					
	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6
Pre-assignment					R													
Phase I:						X					R							
Phase II:							X				R							
Phase III:												X					R	
Phase IV:													X					R

Documentation and analysis: systematic and continuous reporting, real-time monitoring, participatory analysis and review

Pre-assignment

Rapid appraisal, 'hardest' districts (*development & malaria*), commitment, nominate 5



Phase I

Understand local situation and determinants, select 3 districts per country, anchor in local ownership, Step1 and Step2



Phase II

Add Step3 and Step4



Phase III

Add Step5



Phase IV

Sustain and institutionalize

“Unlock Synergy”

Use existing structures, tools, programmes and resources better

Nothing to Lose – only Gain

Comprehensive multisectoral action for malaria complements and amplifies conventional malaria and selective sectoral approaches

Thank You for your Attention !

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Global Fund Updates:

Overview of the Upcoming Global Fund Allocation Cycle

Commodities Planning

C19RM

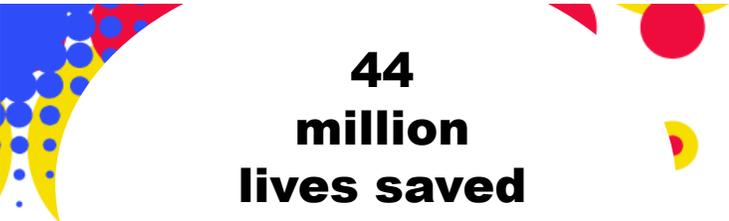
Southern Africa National Malaria Program Managers and Partner Meeting,
Harare

05-08 July 2022

Background: Global Fund Strategy

Our Progress

As of end 2020:



44 million lives saved



21.9 million people on antiretroviral therapy for HIV in 2020



4.7 million people with TB treated in 2020



188 million mosquito nets distributed in 2020

\$3.3 billion approved for >100 countries to fight COVID-19 (as of end of 2021)

Where we are now

We are off track to meet the Sustainable Development Goal (SDG) 3 targets.

3 GOOD HEALTH AND WELL-BEING

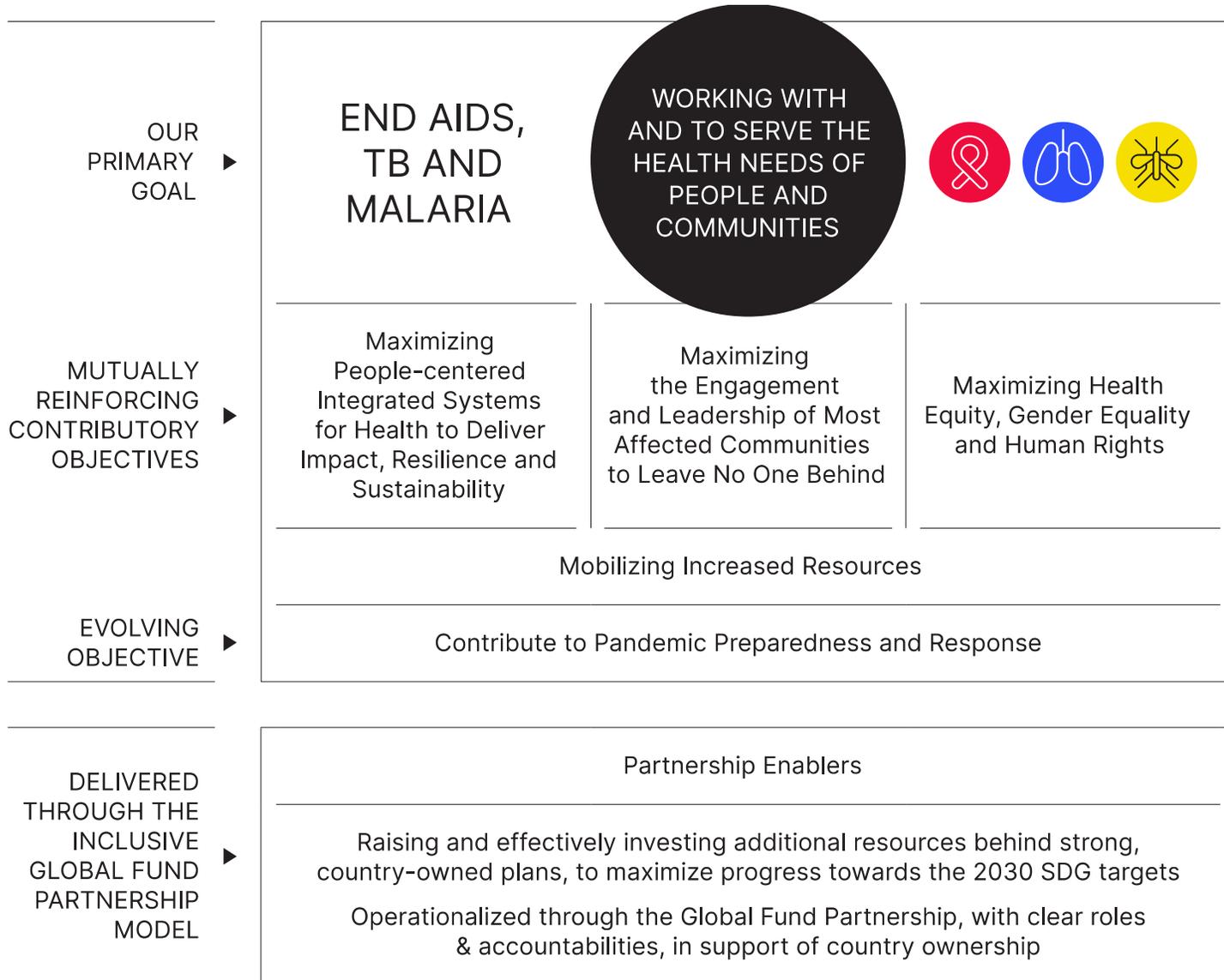


Our Future

New Global Fund Strategy to accelerate impact toward the 2030 horizon.



The Global Fund Strategy Framework



- **Strategy’s primary goal** is to end AIDS, TB, and Malaria.
- **People and communities are at the heart** of our Strategy.
- Achievement of the primary goal is **supported by 4 mutually reinforcing contributory objectives** and an **evolving objective**.
- Partnership Enablers outline **roles and accountabilities** of all stakeholders.

What is different about this new Strategy?

1 Across all three diseases, **an intensified focus on prevention.**

2 Greater **emphasis on integrated, people-centered services.**

3 A more systematic approach to **supporting the development and integration of community systems for health.**

4 **A stronger role and voice for communities** living with and affected by the diseases.

5 Intensified action to **address inequities, human rights and gender-related barriers.**

6 **Greater emphasis on programmatic and financial sustainability.**

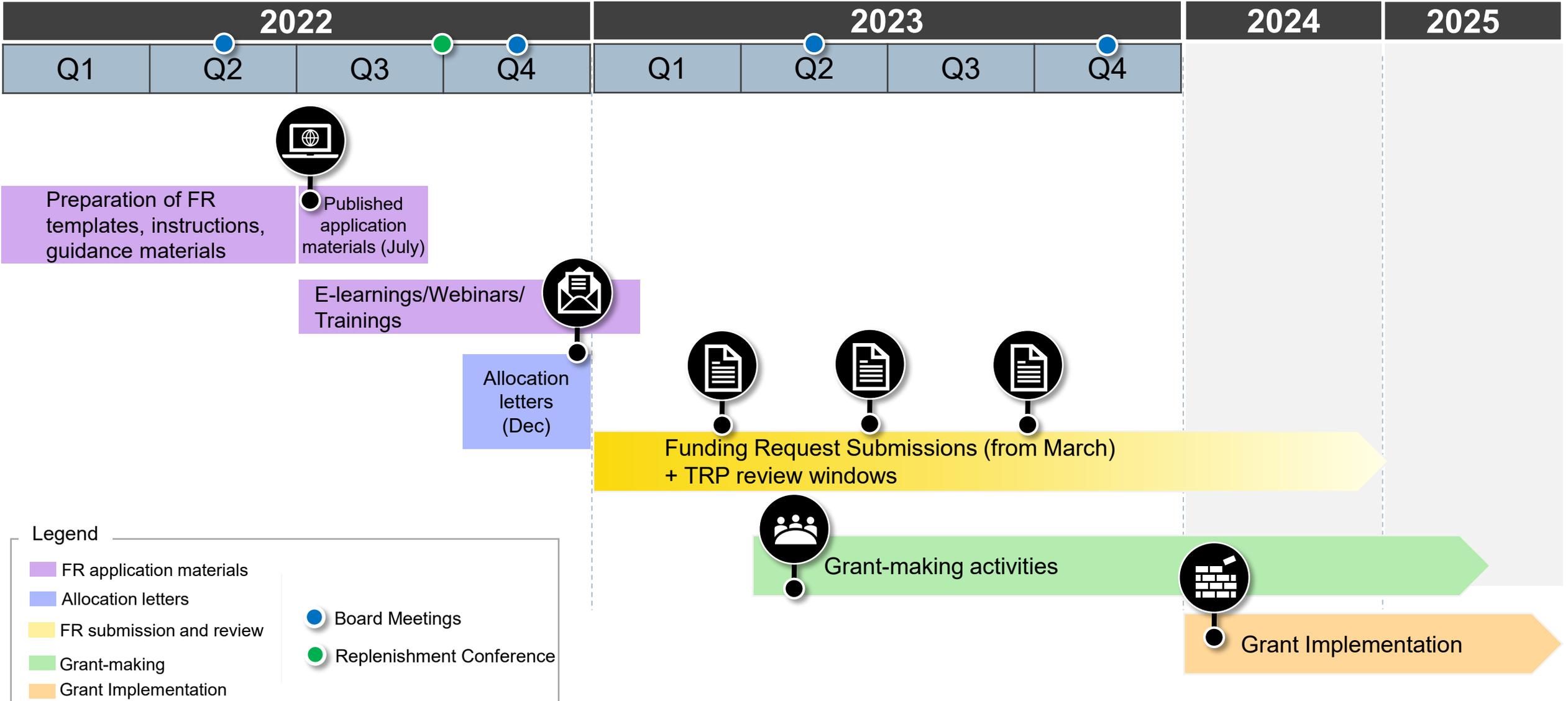
7 Greater focus on **accelerating the equitable deployment of and access to innovations.**

8 Much greater **emphasis on data-driven decision-making.**

9 Explicit recognition of the role **the Global Fund partnership** can and should play in **pandemic preparedness and response.**

10 **Clarity on the roles and accountabilities** of Global Fund partners across every aspect of the Strategy.

2023-2025 Funding Cycle Timeline



Preview: Upcoming malaria information note

Purpose:

- Complements normative guidance to assist with preparation of the FR
- Recommendations on priority interventions and strategic investments aligned to NSPs to achieve impact.
- Includes GF considerations around program essentials, procurement and other requirements

Outline:

- 1. Investment Approach**
- 2. Prioritized Interventions**
 - 1. Evidence based decision making**
 - 2. Prevention**
 - 3. Case Management**
 - 4. Elimination**
 - 5. Cross-Cutting Areas**

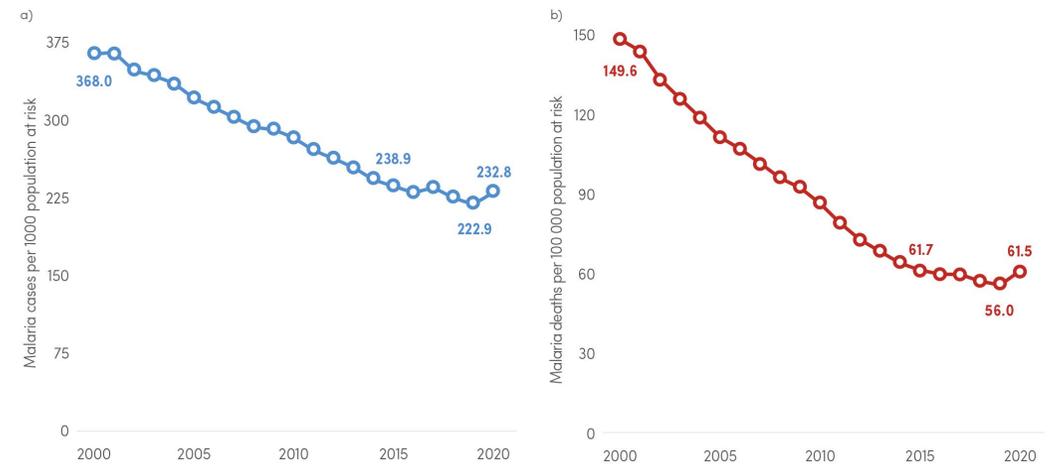
Additional resources: Upcoming webinars, elearning and additional information notes for RSSH, VfM, Malaria CRG.

Malaria Strategy Objectives 2023-2028

1. Implement malaria interventions, tailored to sub-national level, using granular data, and capacitating decision-making and action
2. Ensure optimal and effective vector control coverage
3. Optimize Chemoprevention
4. Expand equitable access to quality early diagnosis and treatment of malaria, through health facilities, at the community level and in the private sector, with accurate reporting
5. Drive towards elimination and facilitate prevention of reestablishment of malaria

FIG. 3.3.

Trends in a) malaria case incidence (cases per 1000 population at risk) and b) mortality rate (deaths per 100 000 population at risk), 2000–2020; and c) malaria cases by country in the WHO African Region, 2020 *Source: WHO estimates.*



WHO: World Health Organization.

WMR 2021: Observed reduction in overall cases and deaths between 2000 and 2017, stagnated through 2019 and increasing in the context of the COVID-19 pandemic and disruption in malaria services.

What should national programs be working on now in preparation for NFM4?

- Map out **key stakeholders, plans & timelines for country dialogue** – consider early engagement with RSSH and community stakeholders to ensure their support and participation
- Liaise with **CCM** on timelines for key discussions including CCM elections
- Review any **unaddressed TRP recommendations**
- Map out timelines and support needed for **strategy and review processes** (ex. MPR, NSP updates)
 - Consider what additional support may be required for a SNT NSP and GF funding request
- Start on your **programmatic gap analysis**
 - Ensure you have it ready for discussions on the program split
 - Highlight any commodities needed for NFM4 that may need to be procured in NFM3 (especially accounting for longer lead times) and notify your CTs of these needs
- Think through **implementation arrangements and any potentially needed revision** (to discuss with CTs)

1. Implement malaria interventions, tailored to sub-national level, using granular data, and capacitating decision-making and action

Use of local data and contextual info to determine appropriate mix of interventions & delivery strategies for optimum impact on transmission and burden of disease for a given area, such as a district, health facility catchment or village.

Suggested activities to prepare:

- Map out necessary **reviews/NSP etc., timelines**
- Consider what **staff and equipment needed for malaria data** repositories (MDR), data collection, analysis, retro evals, program reviews, NSP, stratification, SNT, NFM4 FR.....
- Consider hiring **data specialist/manager and data analyst under SME team** from **now** at least until grant-making (ideally longer)
- **Identify critical gaps** in the above and ask GF and partners for support ASAP
- Highlight any **potential bottlenecks foreseen** between now and FR development (for CT/partner support)

We do NOT expect that every country will have a fully SNT plan by NFM4 FR –we want to be able to understand what data they have, how they are using, how we can help them use it better, etc so that eventually all countries can have a quality SNT strategy and can operationalize it.

2. Ensure optimal and effective vector control coverage

Promote evidence-based decision-making, varied sub-nationality as appropriate, for intervention type and product class selection, delivery model and frequency; with a focus on ensuring sustained high coverage of effective tools amongst at risk populations

Suggested activities to prepare:

- Ensure you have **up-to-date data**, or plans to collect it, sub-nationally as far as possible: ento (including insecticide resistance); IRS/ITN coverage; ITN durability, attrition and use.
- These data – combined with epi data and operational considerations – will be vital to determine plans for:
 - appropriate intervention type (IRS or ITN) by sub-national areas
 - within ITNs - appropriate product class, delivery model and frequency - varied sub-nationally as appropriate
 - **With many places facing pyrethroid resistance and data showing ITN durability <3y; programmes will need to consider both the appropriate *number* of nets and the appropriate *type* of nets. Varying the approach sub-nationally will likely be critical to getting the balance right.**
- Start planning for any **2023 campaigns and identify any TA needs ASAP**
- If **orders not yet placed for 2023** (ITNs & IRS) – place ASAP
- Signal to CT any **needs for 2024 commodities** that may require pre-ordering (quantity, products, delivery timelines) and work with SO/MT to deal with NFM3/4 transition bottlenecks
- Signal any **TA needs** (to partners and CT)

3. Optimize Chemoprevention

Support data driven intervention selection and implementation modality

New WHO recs: SMC age/location; Perennial malaria chemoprevention; cIPTp; IPTsc; malaria vaccine

Suggested activities to prepare :

- Explore/understand **new WHO guidance** to see what may be relevant and feasible in your country context
- Consider in-country **subnational variations to adapt interventions**, implementation, etc.
- Ensure **2022/3 campaigns adequately planned and rolled out**
- Work with SO/MT on **pre-ordering drugs for 2024 campaigns** to address NFM3/4 transition bottleneck
- Note new WHO recommendation on RTSS, but TGF does not fund vaccine procurement at the moment, refer to WHO/GAVI guidance

4. Expand equitable access to quality early diagnosis and treatment of malaria, through health facilities, at the community level and in the private sector, including accurate reporting

Suggested activities to prepare:

- Assess **commodity stocks** given any changes in consumption and longer lead times – signal any upcoming gaps and adjust buffer stock as relevant
- Ensure sufficient **buffer stocks to cover NFM3/4 transition** – taking account of longer lead times
- Analyze **access to care/care-seeking (and barriers)** to feed into future scale up plans ex. Access barriers assessments, private sector strategy development, georeferencing, etc.
- Ensure **inclusion of refugees, IDPs and mobile populations** in quantification and strategy
- Plan for development of a **private sector strategy** (which includes parasitological testing)
- Analyze **quality of care metrics** to develop **targeted approaches** for continuous quality improvement
- Engage **PHC, community health and other RSSH stakeholders** now to ensure coordination for both scale up and quality improvement priorities for NFM4
- Start considering **antimalarial resistance mitigation strategies** (awaiting WHO guidance) and consider PfHRP2/3 gene deletion surveys if not already completed.

5. Drive towards elimination and facilitate prevention of re-establishment of malaria

Suggested activities to prepare:

- Continue to **target sub-nationally to reduce hot spots/foci**
- Consider **synergistic opportunities for acute febrile illness surveillance** (malaria, Covid 19, HIV, TB)
- Consider how to address **hard to reach populations, mobile and migrant populations and forcibly displaced populations**
- Map out **advocacy needed for increased domestic financing**
- Continue to focus on **enhancing and optimizing vector control and case management, building the surveillance capacity to detect, characterize and monitor all cases, accelerating transmission reduction; and preventing re-establishment of malaria**

Cross-Cutting Considerations

- Community leadership and engagement
- Equity, gender equality and human rights
- Social and Behaviour Change
- Pandemic Preparedness and Response
- Environment and Climate Change
- Urban Malaria
- Challenging Operating Environments (COE)
- Malaria Emergencies
- Program Management
- Sustainability of malaria response

Catalytic Investments for the 2023-2025 Allocation

Malaria specific (yellow) and cross-cutting

End Malaria	Biologic threats in malaria case management in Africa
	E2030: Drive towards elimination and facilitate prevention of reestablishment
	Malaria Elimination in Southern Africa
	Resistance to Artemisinin Initiative (RAI)
	Regional Coordination and targeted Technical Assistance (RCTA)
	Addressing vector control threats and opportunities: supporting country readiness for an expanding toolbox
Maximizing People-centered Integrated Systems for Health	Empowering regional reference laboratories and national diagnostic networks
	Data
	Equitable access to quality health products through innovation, partnership, and promoting sustainable sourcing and supply chains at global, national and community levels (NextGen Market Shaping)
	Incentivizing RSSH quality and scale
	Effective community systems & responses (CS&R) contributing to improved health outcomes, equitable access to integrated people-centered quality services
Maximizing Health Equity, Gender Equality and Human	Community engagement
	Scaling up programs to remove human rights and gender related barriers
Mobilizing Increased Resources	Health Financing
End AIDS, TB, Malaria	Emergency Fund

Total funding per Catalytic Investment will depend on final outcomes of the 7th replenishment

Procurement Updates for Malaria Commodities

Update on delivery times

Challenges

- **Delayed shipments** due to lack of containers, port closures and/or vessels
 - Suppliers required to store commodities for longer periods (storage cost implications)
 - Full supplier warehouses can lead to production delays
- **Freight cost increases** as well as in-country transport cost increases put pressure on grant budgets

Lead times

<https://www.theglobalfund.org/en/sourcing-management/health-products/>

- ACTs ~7 months
- RDTs ~7-9 months
- SPAQ ~ 12 months
- Insecticides for IRS ~11.5 months
- Pyrethroid-only ITNs ~7months
- Pyrethroid-PBO ITNs ~ 12.5 months
- Dual a.i. ITNs ~12 months but early enquiries vital

→ Despite Herculean efforts from NMPs/PRs, Supply Operations, suppliers, and CTs we are still seeing campaign delays due to delayed receipt of ITNs

Changes in commodity prices

Malaria Rapid Diagnostic Tests (RDTs)

- Prices of the most commonly procured malaria tests (***Pf* only**) has **decreased**, whilst the **reference prices of *Pf/Pv* and *Pf/PAN* tests have slightly increased.**

Antimalarial medicines: no reference price increase – some price decreases:

- Artemether/Lumefantrine 20/120mg 6 tablet dispersible 30 blister: 5% decrease
- Artemether/Lumefantrine 20/120mg 12 tablet dispersible 30 blister: 6% decrease
- Artesunate 60mg powder for solution for injection - 1 vial: 7% decrease
- AQ + S/P 153mg+500/25mg 3+1 tablet dispersible co-blistered 50 blister: 7% decrease

Insecticide-treated Nets (ITNs):

- **Pyrethroid-only ITNs have increased** by 6% on average (15 cents per net)
- **Pyrethroid-PBO ITNs have increased** by 7% on average (22 cents per net)

Insecticides for Indoor residual spraying (IRS):

- **Small increases for certain** products like pirimiphos-methyl (Actellic®) increased by 3%.
- *(note that insecticides in water-soluble sachets are currently unavailable due to quality concerns and therefore no longer included in the price list. These insecticides are available in non-soluble sachets)*

Changes in commodity prices (con't)

Links to detailed reference prices (all linked from the category sub-pages available from <https://www.theglobalfund.org/en/sourcing-management/health-products/> or <https://www.theglobalfund.org/en/covid-19/health-product-supply/>)

- Malaria
 - [Antimalarial Medicines](#)
 - [Insecticide Treated Nets](#)
 - [Indoor Residual Spraying](#)
 - [Rapid Diagnostic Tests](#)

- Covid-19
 - [Personal Protective Equipment](#) - note overall price reductions of 16% in Q1 2022
 - [Laboratory and health equipment](#) – including sequencing equipment, X-ray, cold chain and waste management
 - [Freight, Insurance, Quality Assurance/Quality Control Indicative Reference Costs](#)
 - [Procurement Services Agent Fees](#)

Potential mitigating actions

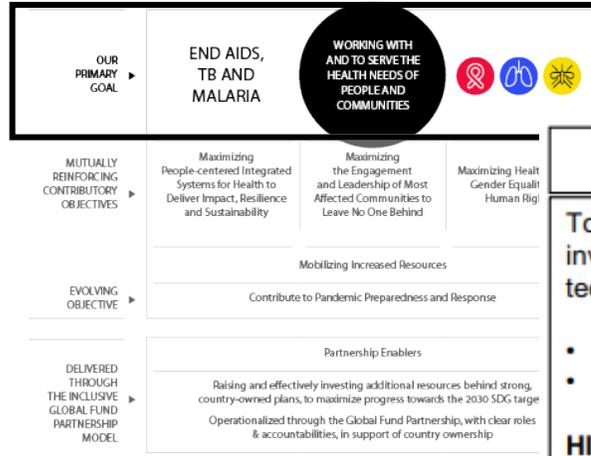
- **Increase in freight costs due to C19 can now be included in C19RM reprogramming**
- **Early procurement!** And even earlier flagging of interest if for Pyrethroid-PBO or dual a.i. nets.
- **Stagger shipments** of bulky items in smaller lots requiring fewer containers at once
- **Clarify delivery period** rather than only a delivery date
- Improve **communication/collaboration** between procurement service agent, freight forwarders and PRs
- Ensure any **waivers/port clearance bottlenecks** are addressed early
- **Re-evaluate in-country supply chain costs** early to identify any funding gaps
 - If related to C19 perturbations, discuss with your CT whether these gaps can be funded through C19RM reprogramming

Thank you!
Questions?

EXTRA SLIDES

The Global Fund Strategy Framework

Primary Goal



Under the primary goal, there are sub-objectives (bullet points) that describe the specific areas focus needed to achieve this goal.

End AIDS, TB and Malaria

To reach the ambitious SDG targets for HIV, TB and malaria, the Global Fund will support catalytic, people-centered HIV, TB and malaria (HTM) investments tailored to maximize impact, equity, quality and build sustainability according to local context, based on country-owned plans and aligned with technical partner guidance, including through:

- Redoubled focus on HTM incidence reduction
- Addressing structural barriers to HTM outcomes

HIV

- Accelerate access to and effective use of precision combination prevention, with behavioral, biomedical and structural components tailored to the needs of populations at high risk of HIV infection, especially key and vulnerable populations (KVP)
- Provide quality, people-centered diagnosis, treatment and care, to improve well-being for people living with HIV (PLHIV), prevent premature mortality and eliminate HIV transmission
- Advocate for and promote legislative, practice, program and policy changes to reduce HIV-related stigma, discrimination, criminalization, other barriers and inequities and uphold the rights of PLHIV and KVP

TB

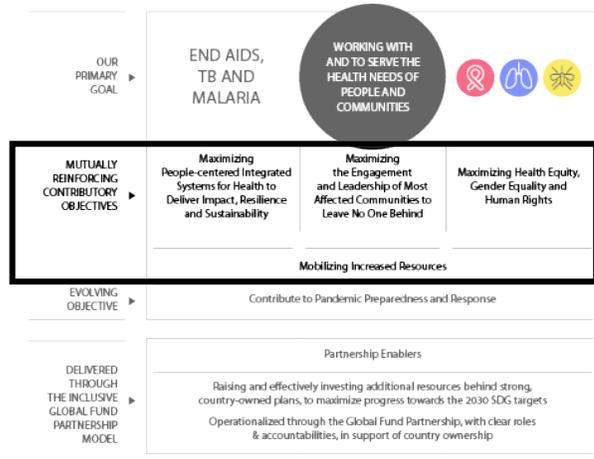
- Focus on finding and treating all people with DS-TB and DR-TB through equitable, people-centered approaches
- Scale up TB prevention with emphasis on TB preventive treatment and airborne infection prevention and control
- Improve the quality of TB services across the TB care cascade including management of comorbidities
- Adapt TB programming to respond to the evolving situation, including through rapid deployment of new tools and innovations
- Promote enabling environments, in collaboration with partners and affected communities, to reduce TB-related stigma, discrimination, human rights and gender-related barriers to care; and advance approaches to address catastrophic cost due to TB

Malaria

- Ensure optimal vector control coverage
- Expand equitable access to quality, early diagnosis and treatment of malaria, through health facilities, at community level and in the private sector
- Implement malaria interventions, tailored to sub-national level, using granular data and capacitating decision-making and action
- Drive toward elimination and facilitate prevention of reestablishment
- Accelerate reductions in malaria in high burden areas and achieve sub-regional elimination in select areas of sub-Saharan Africa to demonstrate the path to eradication

The Global Fund Strategy Framework

Mutually Reinforcing Contributory Objectives

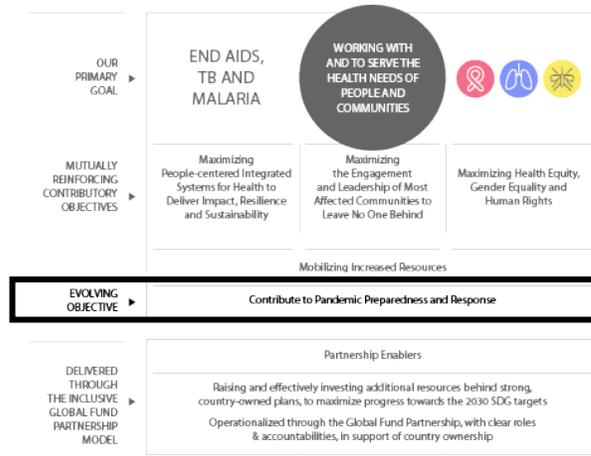


Achievement of our primary goal will be underpinned by **4 mutually reinforcing contributory objectives** that must be concurrently and synergistically pursued to achieve our aims.

Maximizing People-centered Integrated Systems for Health to Deliver Impact, Resilience and Sustainability	Maximizing the Engagement and Leadership of Most Affected Communities to Leave No One Behind	Maximizing Health Equity, Gender Equality and Human Rights
<p>To catalyze sustainable HTM and broader health outcomes and in support of UHC, the Global Fund will strengthen RSSH by supporting countries and communities to:</p> <ul style="list-style-type: none"> • Deliver integrated, people-centered quality services • Strengthen and reinforce community systems and community-led programming, integrated within national health and social systems • Strengthen generation and use of quality, timely, transparent, and disaggregated digital and secure data at all levels, aligned with human rights principles • Strengthen the ecosystem of quality supply chains to improve the end-to-end management of national health products and laboratory services • NextGen market shaping focus on equitable access to quality health products through innovation, partnership, and promoting sustainable sourcing and supply chains at global, national and community levels • As part of Global Fund efforts to strengthen country oversight of the overall health system, better engage and harness the private sector to improve the scale, quality and affordability of services wherever patients seek it • Deepen partnerships between governments & non-public sector actors to enhance sustainability, transition-readiness and reach of services, including through social contracting 	<p>To deliver greater impact and ensure the HTM response is responsive to and led by those living with and most affected by the 3 diseases, the Global Fund will reinforce community leadership by:</p> <ul style="list-style-type: none"> • Accelerating the evolution of CCMs and community-led platforms to strengthen inclusive decision-making, oversight and evaluation throughout Global Fund-related processes • Evolving Global Fund business processes, guidelines, tools and practices to support community-led organizations to deliver services and oversight, and to be engaged as providers of technical expertise • Supporting community- and civil society-led advocacy to reinforce the prioritization of health investments and drive toward UHC • Expanding partnerships with communities living with and affected by emerging and related health areas to support more inclusive, responsive and effective systems for health 	<p>To improve HTM outcomes and drive more equitable access to health services, the Global Fund will support countries and communities by:</p> <ul style="list-style-type: none"> • Scaling up comprehensive programs and approaches to remove human rights and gender-related barriers across the portfolio • Supporting comprehensive SRHR programs and their strengthened integration with HIV services for women in all their diversity and their partners • Advancing youth-responsive programming, including for AGYW and young KVP and their partners • Deploying quantitative and qualitative data to identify drivers of HTM inequity and inform targeted responses, including by gender, age, geography, income and for KVP • Leveraging the Global Fund's diplomatic voice to challenge laws, policies and practices that limit impact on HTM
Mobilizing Increased Resources		
<p>To strengthen the scale, sustainability, efficiency and effectiveness of health financing for national and community responses the Global Fund will work across the partnership to:</p> <ul style="list-style-type: none"> • Increase international financial and programmatic resources for health from current and new public and private sources • Catalyze domestic resource mobilization for health to meet the urgent health needs for SDG 3 • Strengthen focus on VfM to enhance economy, efficiency, effectiveness, equity & sustainability of Global Fund-supported country programs & systems for health • Leverage blended finance and debt swaps to translate unprecedented levels of debt and borrowing into tangible health outcomes • Support country health financing systems to improve sustainability, including reducing financial barriers to access and strengthening purchasing efficiency 		

The Global Fund Strategy Framework

Evolving Objective



The new Strategy responds directly to the dramatic changes in the global health context by introducing an evolving objective on PPR.

We will bring the Global Fund partnership’s expertise and inclusive model to this global priority, alongside the important work with our partners.

Contribute to Pandemic Preparedness and Response (PPR)

Working collaboratively with actors across the global health architecture under an evolving objective, the Global Fund will leverage its core strengths and HIV, TB and malaria capacities and contributions to RSSH, community leadership and engagement, and equity, gender equality and human rights to build pandemic preparedness and response capabilities and contribute to resilient and sustainable systems for health.

Approach

- Leveraging the Global Fund partnership model and principles to contribute to PPR, strengthen the resilience of HIV, TB and malaria programs and contribute to wider systems strengthening and resilience.

Focus

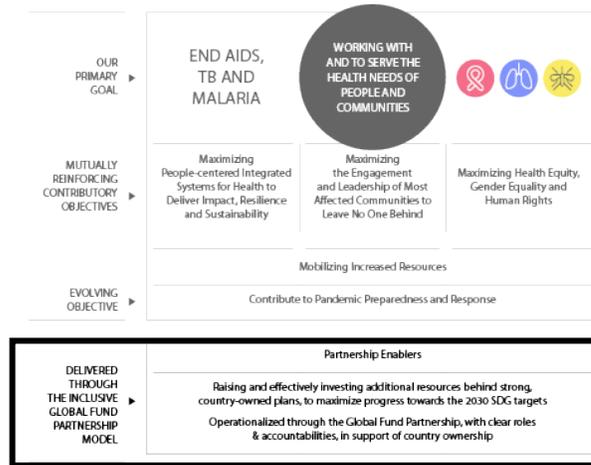
- Scaling up investments that build the resilience of HTM programs to current and future threats
- Building front-line capacity for detection and rapid response to epidemics and pandemics at facility and community levels
- Scaling up and integration of community systems capacity for detection and response
- Strengthening disease surveillance systems, including the use of real-time digital data and detection capacity
- Strengthening laboratory systems, supply chains and diagnostic capacity to meet HTM program demand and respond to outbreaks
- Addressing the threat of drug and insecticide resistance, and encouraging climate, environmentally-sensitive and One Health approaches
- Leveraging the Global Fund’s platform to build solidarity for equitable, gender-responsive and human rights-based approaches
- Championing community and civil society leadership and participation in pandemic preparedness and response planning, decision-making and oversight

We will contribute to building **pandemic preparedness** by supporting countries to strengthen the resilience of their systems for health and HTM programs.

Our work in **pandemic response** is well defined by our existing programs and C19RM.

The Global Fund Strategy Framework

Partnership Enablers and M&E Framework



Partnership Enablers

- The Global Fund model is based on the **core principles of country ownership and partnership.**
- Achievement of the Strategy’s goal and objectives depends on the collaboration of **all partners, working together, each with distinct, complementary roles and accountabilities.**
- These roles and accountabilities are **described in the Partnership Enablers** section of the Strategy.

Achievement of the Strategy’s aims will be measured through a comprehensive and accountable M&E Framework,

including key performance indicators, as well as through global partner plans and the SDG 3 goals and targets.

Next Steps



- It is important for **all stakeholders** in the Global Fund partnership **to consider which changes they can make** to deliver our Strategy's goals and objectives – as guided by the roles and accountabilities in the Partnership Enablers section.
- The **Secretariat is also working to update relevant policies, guidelines, materials and tools** for the next cycle of grants.
- We look forward to **working together to achieve our vision** of a world free of the burden of AIDS, TB and malaria with better, equitable health for all.

Resources

- Global Fund Strategy (2023-2028): [عربي](#) | [English](#) | [Español](#) | [Français](#) | [Português](#) | [Русский](#)
- Executive Summary: [English](#) | [Español](#) | [Français](#) | [Italiano](#) | [日本語](#) | [Português](#) | [Русский](#) | [Deutsch](#) | [عربي](#) | [中文](#)
- Strategy Framework: [عربي](#) | [English](#) | [Español](#) | [Français](#) | [Português](#) | [Русский](#)
- For more information please see: <https://www.theglobalfund.org/en/strategy/>

WHO Malaria Technical Updates

RBM/CRSPC National Malaria and Partners Annual Meeting (SARN)



Harare, 05 July 2022

Dr. Peter OLUMESE,
Global Malaria Programme
WHO, Geneva, Switzerland.

Global **Malaria** Programme



**World Health
Organization**

- **The Global Malaria Picture**
 - 87 countries and territories
 - Half world at risk (3.2 billion)
- **highly concentrated in sub-Saharan Africa**
 - Globally, there were an estimated 241 million cases of malaria \approx 95% in Africa
 - Globally, 627 000 deaths - 96% in Africa,
 - malaria was the 4th highest cause of death among children in Africa (10% of child death in sub-Saharan Africa), - claiming the life of 1 child every 2 minutes.

GTS: Vision, goals, milestones and targets

Vision: A world free of malaria			
Goals	Milestones		Targets
	2020	2025	2030
1. Reduce malaria mortality rates globally compared with 2015	≥40%	≥75%	≥90%
2. Reduce malaria case incidence globally compared with 2015	≥40%	≥75%	≥90%
3. Eliminate malaria from countries in which malaria was transmitted in 2015	At least 10 countries	At least 20 countries	At least 35 countries
4. Prevent re-establishment of malaria in all countries that are malaria-free	Re-establishment prevented	Re-establishment prevented	Re-establishment prevented

GTS: -Progress towards first milestone point (2020)

Goals	Milestones		Targets
	2020	2025	2030
1. Reduce malaria mortality rates globally compared with 2015	At least 40% ❌	At least 75%	At least 90%
2. Reduce malaria case incidence globally compared with 2015	At least 40% ❌	At least 75%	At least 90%
3. Eliminate malaria from countries in which malaria was transmitted in 2015	At least 10 countries ✓	At least 20 countries	At least 35 countries
4. Prevent re-establishment of malaria in all countries that are malaria free	Re-establishment prevented ✓	Re-establishment prevented	Re-establishment prevented

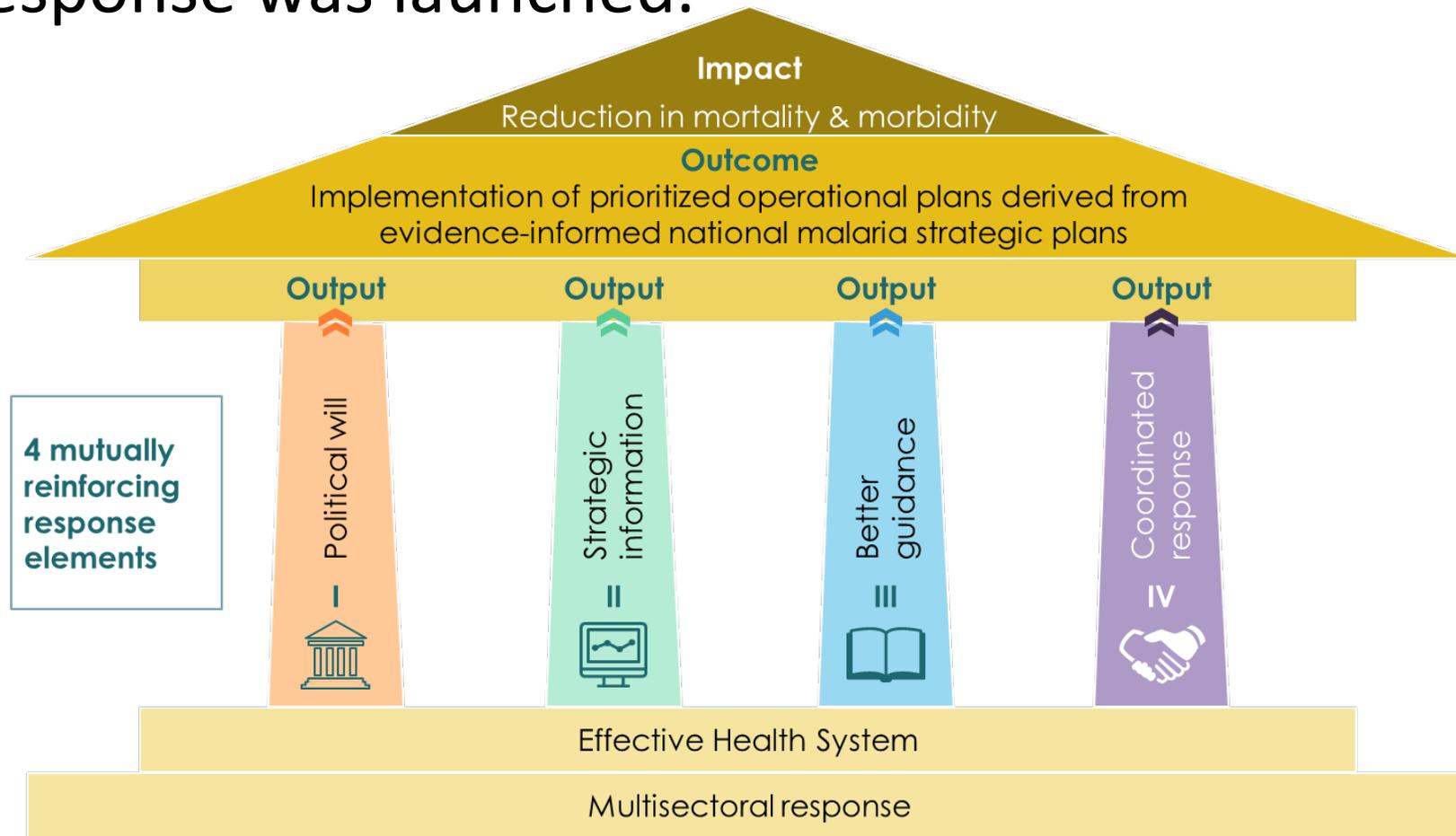
Global Technical Strategy for malaria 2016-2030

- Mortality reduction
 - 18% reduction achieved, **but 22% off track**
- Malaria cases
 - 3% reduction achieved, **but 37% off track**

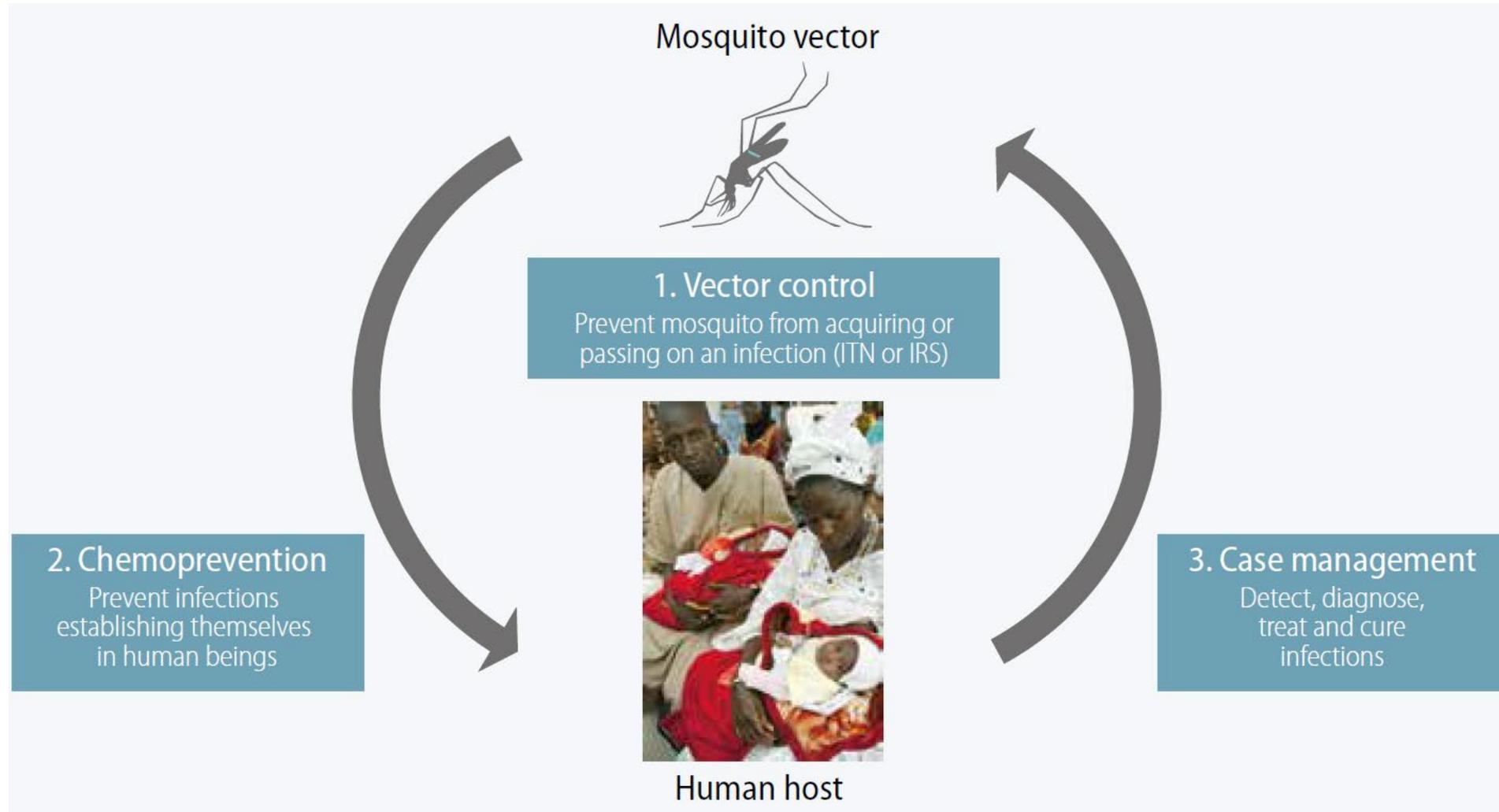
Off track to meet global targets

To get back on track, in 2018,

High Burden to High Impact: a targeted malaria response was launched.



Main malaria prevention and treatment strategies



Key antimalarial interventions & strategies

Prevention

- Insecticide-treated mosquito nets
- Indoor Residual Spraying

Preventive Chemotherapy

- IPT in pregnancy (IPTp)
- Perennial Malaria Chemoprevention (PMC /IPTi+)
- SMC
- IPT in School Children
- Post Discharge malaria chemoprevention
- MDA

Malaria vaccine

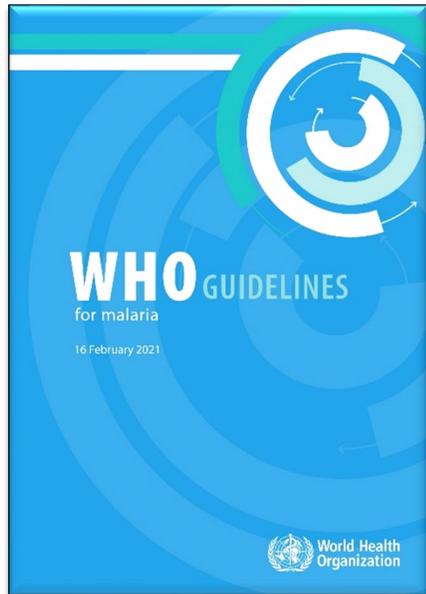
Diagnosis & Treatment

- Parasite based diagnosis
 - Microscopy
 - Rapid Diagnostic Tests
 - Artemisinin-based combination therapies (ACTs)
 - Severe Malaria
 - Artesunate
- Case management service delivery areas::
- Health facilities
 - Community Case Management
 - Private sector

Surveillance, M & E

- Routine HMIS
- Malaria surveillance and response systems
- Household surveys
- Health Facility Surveys

Strengthening health systems in endemic countries



- WHO Guidelines for Malaria (2021)
 - These consolidated guidelines replace 2 guideline documents on the WHO website: the Guidelines for the treatment of malaria, 3rd edition and the Guidelines for malaria vector control.
 - The sections in the WHO Guidelines for malaria includes
 - Prevention (Vector control, preventive chemotherapies and Vaccine)
 - Case Management
 - Elimination and prevention of re-introduction
 - Surveillance
 - As new evidence becomes available, the recommendations will be reviewed and updated, where appropriate, **using WHO's transparent and rigorous guideline development process.**
- Published in February 2021;
- Latest update – 3rd June 2022, and will be undated on a living basis
- Available online: <https://www.who.int/publications/i/item/guidelines-for-malaria>

Malaria Prevention

Global **Malaria** Programme



**World Health
Organization**



Entomology and Vector Control





- **Pyrethroid-only nets (2019)**

- WHO recommends pyrethroid-only long-lasting insecticidal nets (LLINs) that have been prequalified by WHO for deployment for the prevention and control of malaria in children and adults living in areas with ongoing malaria transmission.

- **Pyrethroid-PBO nets (Conditional recommendation for; 2022)**

- WHO suggest deploying pyrethroid-PBO nets instead of pyrethroid-only LLINs for the prevention and control of malaria in children and adults in areas with ongoing malaria transmission where the principal malaria vector(s) exhibit pyrethroid resistance

- **Indoor residual spraying (2019)**

- WHO recommends IRS using a product prequalified by WHO for the prevention and control of malaria in children and adults living in areas with ongoing malaria transmission.



Strong recommendation for , High certainty evidence

Insecticide-treated nets: Humanitarian emergency setting (2022)

WHO recommends that insecticide-treated nets (ITNs) be deployed for the prevention and control of malaria in children and adults in areas with ongoing malaria transmission affected by a humanitarian emergency.

Conditional recommendation for , Very low certainty evidence

Indoor residual spraying: Humanitarian emergency setting (2022)

WHO suggests deploying indoor residual spraying (IRS) for the prevention and control of malaria in children and adults in areas with ongoing malaria transmission affected by a humanitarian emergency.



- **Larviciding (2019)**

- WHO conditionally recommends the regular application of biological or chemical insecticides to water bodies (larviciding) for the prevention and control of malaria in children and adults living in areas with ongoing malaria transmission as a supplementary intervention in areas where optimal coverage with ITNs or IRS has been achieved, where aquatic habitats are few, fixed and findable, and where its application is both feasible and cost-effective.

- **House screening (2021)**

- WHO conditionally recommends the use of untreated screening of residential houses for the prevention and control of malaria in children and adults living in areas with ongoing malaria transmission.



- **Topical repellents (2019)**

- WHO conditionally recommends against the deployment of topical repellents for the prevention and control of malaria at the community level in areas with ongoing malaria transmission.

- **Insecticide-treated clothing (2019)**

- WHO conditionally recommends against deployment of insecticide-treated clothing for the prevention and control of malaria at the community level in areas with ongoing malaria transmission; however, insecticide-treated clothing may be beneficial as an intervention to provide personal protection against malaria in specific population groups.



- **Areas** with on-going malaria transmission
 - Irrespective of both the pre-intervention and the current level of transmission, **the scale-back of vector control is not recommended**. Universal coverage with effective malaria vector control of all persons in such should be pursued and maintained
- **Areas** where malaria transmission has been interrupted
 - The scale-back of vector control should be based on a detailed analysis that includes assessment of **receptivity**, **vulnerability**, active disease surveillance, capacity for case management and vector-control response

Areas - determined by availability of reliable disaggregated active disease surveillance data and feasibility for decisions on vector-control implementation, and not necessarily based on administrative boundaries

Receptivity - ability of an ecosystem to allow transmission of malaria

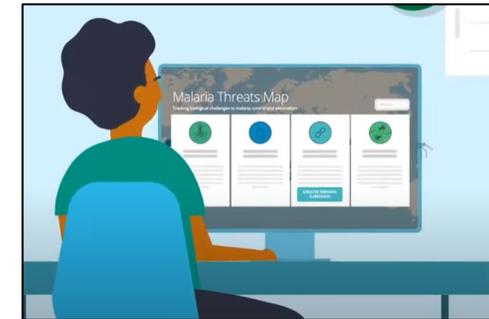
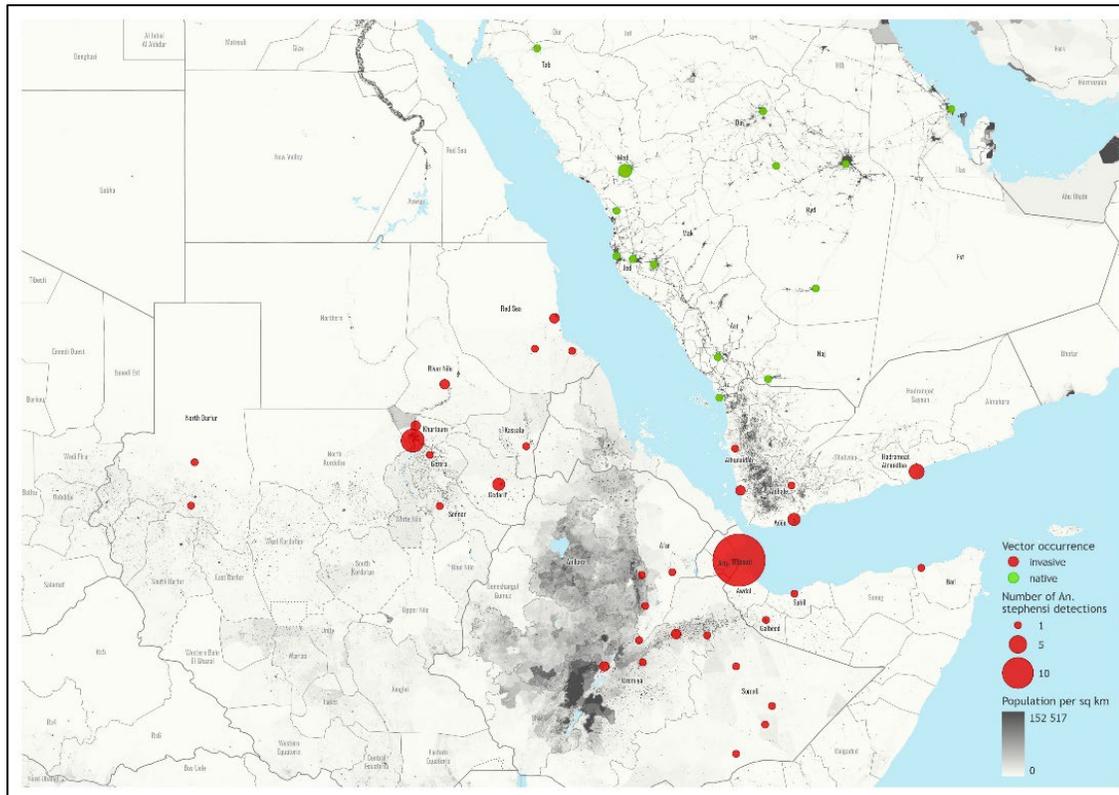
Vulnerability - frequency of influx of infected individuals or groups and/or infective anophelines

Updates on *An. Stephensi*: Surveillance



Malaria Threats Map

- Invasive vector theme created in 2019 and populated with *An. stephensi* detections, after validation with international experts. New data added when received by WHO.



Malaria Threats Map: tracking biological challenges to malaria control and elimination: https://youtu.be/dU_xrzpbupU
Malaria Threats Map: helping countries address critical threats for malaria control and elimination: <https://youtu.be/mkggiD0DKwY>
Malaria Threats Map: supporting research efforts: <https://youtu.be/VP-pc9oN0dM>



Vector alert (2019; English, French, Arabic)

- <https://apps.who.int/iris/handle/10665/326595>

Translation of identification key by M. Coetzee *Malaria J* 2020 19:70

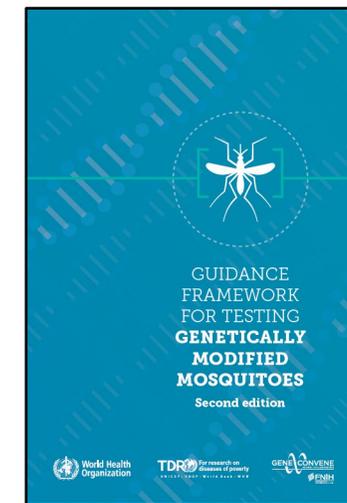
- <https://www.who.int/fr/publications-detail/WHO-UCN-GMP-2021.04> (French version)
- Arabic translation & layout ongoing

Genetically modified mosquitoes (GMMs)

- Developed and published WHO position statement on evaluation of genetically modified mosquitoes (2020): <https://www.who.int/publications/i/item/9789240013155>
- Contributed to development of guidance on ethics and vector borne diseases (2021): <https://www.who.int/publications/i/item/978924001273-8>
- Revised framework for evaluation of GMMs jointly with FNIH and TDR (2021): <https://www.who.int/publications/i/item/9789240025233>

World Malaria Report 2021

- Includes an annual *An. stephensi* update since 2019





Interventions under assessment by WHO

<https://www.who.int/groups/vector-control-advisory-group/summary-of-new-interventions-for-vector-control>

Currently some promising interventions for *An. stephensi* control are:

- **Genetic manipulation** (Oxitec *An. stephensi* construct is most advanced but also least sophisticated in this category): In this case, mosquitoes carry a self-limiting gene that prevents female offspring from surviving, allowing for male-only production. Males released into the field mate with wild female mosquitoes. Reduction of the target population is achieved as the female offspring of these encounters cannot survive. Male offspring survive, carrying a copy of the self-limiting gene. The self-limiting gene can thereby persist but declines over time, offering potentially multiple but still self-limiting generations of suppression.
- **Spatial repellent:** Contains volatile chemicals that disperse in air under ambient conditions; the device can be placed inside or around houses. The volatile chemicals introduced into the air repel mosquitoes from entering the treated space and/or disrupt human biting and feeding habits, possibly impacting their survival and reproductive behaviour.
- **Bait stations (e.g. ATSBs):** The bait station placed on outdoor walls of houses. It has 3 components: an attractant, sugar and an active ingredient that kills mosquitoes. A protective membrane covers and protects the bait from rain, dust and serves as a barrier to pollinators but allows mosquitoes to feed through it.

Preventive Chemotherapies

Global **Malaria** Programme



**World Health
Organization**

Chemoprevention recommendations – shift in approach

- The updated chemoprevention recommendations provide greater flexibility to NMPs to adapt control strategies to suit their settings.
- We no longer specify strict age groups, transmission intensity thresholds, numbers of doses or cycles, or specific drugs.
- NMPs are encouraged to consider local data to determine how best to tailor chemoprevention strategies to local needs and determine which age groups should be targeted where, for how long, how frequently, and with which drugs.

Intermittent preventive treatment of malaria in pregnancy (IPTp)

Strong recommendation for , Moderate certainty evidence

Updated

Intermittent preventive treatment of malaria in pregnancy (2022)

In malaria-endemic areas, pregnant women of all gravidities should be given antimalarial medicine at predetermined intervals to reduce disease burden in pregnancy and adverse pregnancy and birth outcomes.

- *SP has been widely used for malaria chemoprevention during pregnancy and remains effective in improving key pregnancy outcomes.*
- *IPTp-SP should start as early as possible in the second trimester and not before week 13 of pregnancy.*
- *Doses should be given at least one month apart, with the objective of ensuring that at least three doses are received.*
- *ANC contacts remain an important platform for delivering IPTp. Where inequities in ANC service and reach exist, other delivery methods (such as the use of community health workers) may be explored, ensuring that ANC attendance is maintained and underlying inequities in ANC delivery are addressed.*
- *IPTp is generally highly cost-effective, widely accepted, feasible for delivery and justified by a large body of evidence generated over several decades.*

Perennial Malaria Chemoprevention (former IPTi)

Conditional recommendation for,
moderate-certainty evidence

Updated

In areas of moderate to high perennial malaria transmission, children belonging to age groups at high risk of severe malaria can be given antimalarial medicines at predefined intervals to reduce disease burden.

- Perennial malaria chemoprevention (PMC) schedules should be informed by the age pattern of severe malaria admissions, the duration of protection of the selected drug, and the feasibility and affordability of delivering each additional PMC course (see “Practical info”).
- Sulfadoxine-pyrimethamine (SP) has been widely used for chemoprevention in Africa, including for PMC. Artemisinin-based combination therapies (ACTs) have been effective when used for PMC, but evidence is limited on their safety, efficacy, adherence to multi-day regimens, and cost-effectiveness in the context of PMC.
- Previously, PMC was recommended in infants (<12 months of age) as intermittent preventive treatment (IPTi). Since the initial recommendation, new data have documented the value of malaria chemoprevention in children aged 12 to 24 months.
- The Expanded Programme on Immunization (EPI) platform remains important for delivering PMC. Other methods of delivery can be explored to optimize access to PMC and integration with other health interventions.
- Moderate to high perennial malaria transmission settings are defined as areas with *P. falciparum* parasite prevalence greater than 10% or an annual parasite incidence greater than 250 per 1000 [29]. These thresholds are indicative and should not be regarded as absolutes for determining applicability of the PMC recommendation.

Seasonal Malaria Chemoprevention

Strong recommendation for, moderate-certainty evidence

Updated

In areas of seasonal malaria transmission, children belonging to age groups at high risk of severe malaria should be given antimalarial medicines during peak malaria transmission seasons to reduce disease burden.

- Eligibility for seasonal malaria chemoprevention (SMC) is defined by the seasonality of malaria transmission and age groups at risk of severe malaria. Thresholds for assessing these criteria change over time and location. Malaria programmes should assess the suitability of SMC based on the local malaria epidemiology and available funding. The added value of a seasonally targeted intervention is likely to be greatest where transmission is intensely seasonal.
- Monthly cycles of sulfadoxine-pyrimethamine plus amodiaquine (SP+AQ) have been widely used for SMC in African children under 5 years old and have been shown to be efficacious, safe, well tolerated, available and inexpensive [182].

Intermittent preventive treatment of malaria in school-aged children (IPTsc)

Conditional recommendation for , Low certainty evidence

New

Intermittent preventive treatment of malaria in school-aged children (2022)

School-aged children living in malaria-endemic settings with moderate to high perennial or seasonal transmission can be given a full therapeutic course of antimalarial medicine at predetermined times as chemoprevention to reduce disease burden.

- *IPTsc has been evaluated in children aged 5–15 years. The burden of malaria and benefits of IPTsc may vary across this age range, but evidence is limited.*
- *National malaria programmes can consider IPTsc if resources allow for its introduction among school-aged children without compromising chemoprevention interventions for those carrying the highest burden of severe disease, such as children < 5 years old.*
- *Schools may provide a low-cost means to deliver chemoprevention to school-aged children. However seasonal variation in malaria transmission and the timing of school terms, as well as equity concerns, may mean alternative delivery channels are needed to maximize impact.*
- *First- and second-line malaria treatments should not be used for IPTsc if safe and effective alternatives are available (see “Practical info”).*
- *The dosing schedule for IPTsc should be informed by the local malaria epidemiology and timed to give protection during the period of greatest malaria risk (see “Practical info”).*
- *Moderate to high malaria transmission settings are defined as areas with *P. falciparum* parasite prevalence greater than 10% or an annual parasite incidence greater than 250 per 1000 [31]. These thresholds are indicative and should not be regarded as absolutes for determining applicability of the IPTsc recommendation.*

Conditional recommendation for , Moderate certainty evidence

New

Post-discharge malaria chemoprevention (PDMC)

Children admitted to hospital with severe anaemia living in settings with moderate to high malaria transmission should be given a full therapeutic course of an antimalarial medicine at predetermined times following discharge from hospital to reduce re-admission and death.

- *PDMC should be given to children following admission with severe anaemia [138] that is not due to blood loss following trauma, surgery, malignancy or a bleeding disorder.*
- *PDMC implementation should be tailored to admissions of children with severe anaemia and consider the duration of protection of the selected antimalarial, and the feasibility and affordability of delivering each additional PDMC course (see “Practical info”).*
- *Moderate to high perennial malaria transmission settings are defined as areas with a *P. falciparum* parasite prevalence greater than 10% or an annual parasite incidence greater than 250 per 1000 [31]. These thresholds are indicative and should not be regarded as absolute for determining applicability of the PDMC recommendation.*

Support for National adoption and adaptation

- IPTp at community level
 - New field manual will be developed (2022)
- PMC (IPTi+)
 - Adoption and Implementation Guide available for IPTi
 - Pilots underway to inform expansion of IPTi beyond the current recommendation and transition to PMC.
 - Adoption Framework and Implementation Guide to be developed (2022)
- SMC
 - Adoption and Implementation Guide / Field Manual available
 - update in the pipeline before the end of the year (2022)
- IPTsc (school children)
 - Adaptation and implementation guidance to be developed
- PDMC (post discharge)
 - Adaptation and implementation guidance to be developed

Mass Drug Administration (MDA)

Technical area	Strength & evidence	For/against	Recommendation	New/update
MDA	Conditional, low-certainty	For	MDA in moderate-high transmission for short-term <i>P. falciparum</i> burden reduction	New
MDA	Conditional, low-certainty	For	MDA in emergency settings for short-term <i>P. falciparum</i> burden reduction	New
MDA	Conditional, low-certainty	For	MDA to reduce <i>P. falciparum</i> transmission in very low to low transmission	New
MDA	Conditional, very low-certainty	Against	MDA to reduce <i>P. falciparum</i> transmission in moderate to high transmission	New
MDA	Conditional, very low-certainty	For	MDA with antimalarial medicine to reduce <i>P. vivax</i> transmission	New
MDA	Conditional, very low-certainty	Against	MDA with 8-aminoquinoline alone to reduce <i>P. vivax</i> transmission	New

Conditional recommendation for

Conditional recommendation against

Malaria Vaccine

Strong recommendation for , High certainty evidence

Malaria vaccine (2021)

The RTS,S/AS01 malaria vaccine should be used for the prevention of *P. falciparum* malaria in children living in regions with moderate to high transmission as defined by WHO.

- *The RTS,S/AS01 malaria vaccine should be provided in a four-dose schedule in children from 5 months of age.*
- *Countries may consider providing the RTS,S/AS01 vaccine seasonally, with a five-dose strategy, in areas with highly seasonal malaria or with perennial malaria transmission with seasonal peaks.*
- *Countries that choose to introduce the vaccine in a five-dose seasonal strategy are encouraged to document their experiences, including adverse events following immunization.*
- *RTS,S/AS01 malaria vaccine should be provided as part of a comprehensive malaria control strategy.*

Malaria Case Management



Global **Malaria** Programme



World Health
Organization



- Malaria diagnosis (clinical & parasitological confirmation)
- Prompt and effective treatment :
- Support intervention for effective case management
 - Monitoring resistance of antimalarial medicines (therapeutic efficacy monitoring)
 - Pharmacovigilance



- All suspected malaria cases should have a parasitological test (microscopy or RDT) to confirm the diagnosis.
- Deployment of both microscopy and RDTs should be supported by a quality assurance programme
 - The results of parasitological diagnosis should be available within less than two hours of the patient presenting. In the absence or delay, patients with suspected severe malaria, and other high-risk groups, should be treated on clinical grounds.



- Treat children and adults with uncomplicated *P. falciparum* malaria (excluding pregnant women in their first trimester*) with an ACT.
 - artemether plus lumefantrine; artesunate plus amodiaquine; artesunate plus mefloquine; dihydroartemisinin plus piperazine; artesunate plus sulfadoxine-pyrimethamine; artesunate plus pyronaridine*
- Reducing transmissibility of treated *P. falciparum* infections
 - In low transmission areas, give a single dose of 0.25mg/kg primaquine along with ACT to patients with *P. falciparum* malaria (excluding pregnant and breastfeeding women and infants aged <6 months) to reduce transmission. G6PD testing is not required.

* Ongoing revision



- Treat pregnant women in the first trimester with seven days of quinine plus clindamycin (*use an ACT if quinine is not available or adherence to 7 days quinine not assured*). – **Currently under review***
- Treat infants weighing less than 5 kg with an ACT dosed at the same mg/kg target as for children weighing 5 kg
- In people who have HIV/AIDS avoid AS+SP if on treatment with co-trimoxazole and avoid AS+AQ if on treatment with efavirenz.
- Treat travelers returning to non-endemic settings with uncomplicated *P. falciparum* malaria with an ACT

*** Ongoing revision**



- In areas with chloroquine susceptible *P. vivax*, treat using either an ACT (*excluding pregnant women in their first trimester*) or chloroquine.
- In areas with chloroquine resistant *P. vivax*, treat with an ACT (*excluding pregnant women in their first trimester*).
- Treat pregnant women in their first trimester with CQ resistant *P.vivax* malaria with quinine



- The G6PD status of patients should be used to guide the administration of primaquine for relapse prevention
- Where status is unknown and G6PD testing is unavailable, the decision to prescribe primaquine must be based on an assessment of the risks and benefits of treating versus not treating
- To prevent future relapse, treat people with vivax or ovale malaria (excluding pregnant or women breastfeeding, infants < 6 months of age, and people with G6PD deficiency) with a 14-day* course (0.25-0.5mg/kg daily) of primaquine in all transmission setting
- In people with moderate G6PD deficiency, consider relapse prevention with primaquine 0.75 mg base/kg once a week for 8 weeks under close medical supervision.
- In women who are pregnant or breastfeeding, consider weekly chemoprophylaxis with chloroquine until delivery and breastfeeding is complete, then treat with 14 days of primaquine to prevent future relapse.

* Ongoing revision



- **Therapeutic objectives**
 - Main objective is to prevent the patient from dying
 - Secondary objectives are to prevent disabilities and prevention of recrudescent infection
- **Death from severe malaria often occurs within hours of onset of symptoms or admission to hospital**
 - Essential that therapeutic concentrations of a highly effective antimalarial are achieved as soon as possible
- **Management of severe malaria comprises four main areas**
 - Clinical assessment of patient
 - Specific antimalarial treatment
 - Additional treatments (managements of other complications), and
 - Supportive care



- Treat all patients with severe malaria (including infants, pregnant women in all trimester, and lactating women) with intravenous or intramuscular artesunate for at least 24 hours and until able to tolerate oral medication.
- After at least 24 hours of parenteral therapy, AND able to tolerate oral therapy, complete treatment with three-days of an ACT
- Children weighing less than 20 kg should receive a higher dose of artesunate (3 mg/kg/dose) than others (2.4 mg/kg/dose) to ensure an equivalent drug exposure.
- If artesunate is not available, use artemether in preference to quinine for treating severe malaria



- **Pre-referral treatment**

- In settings where complete treatment of severe malaria is not possible, but injections are available, give children and adults a single dose of intramuscular artesunate and refer to an appropriate facility for further care. Use artemether or quinine if artesunate is not available
- In settings where intramuscular injections are unavailable, treat children below the age of six years with a single dose of rectal artesunate and refer immediately to an appropriate facility for further care.
- Where referral is not possible after the initial treatment,
 - pre-referral medication should be continued until the patient can tolerate oral medication, then,
 - administer a complete course of an effective ACT



- CCM of malaria delivered as part of integrated CCM (iCCM), which includes the treatment of pneumonia and diarrheal diseases.
- Trained community providers (CHWs, Medicine Sellers or Retailers) should be provided with:
 - Rapid Diagnostic Tests (RDTs)
 - ACTs for treatment of uncomplicated malaria.
 - Rectal artemisinin suppositories for pre-referral treatment of severe malaria.
 - Information, Education and Communication materials.
 - simple patient registers and reporting forms.



- On-going policy reviews
 - Treating in the 1st trimester of pregnancy – Use of ACTs
 - Use of artesunate+pyronaridine in the treatment of malaria
- Reviews in the pipeline
 - Tafenoquine for anti-relapse treatment for vivax malaria
- Malaria diagnosis
 - Evaluations of *Pfhrp* 2/3 gene deletions and implications for case management and policy
 - G6PD quantitative point of care test

MALARIA ELIMINATION / PREVENTION OF RE-INTRODUCTION



Global **Malaria** Programme



**World Health
Organization**

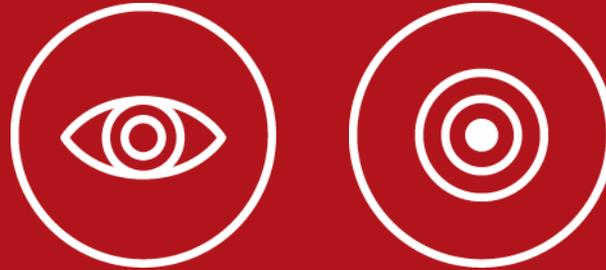
Malaria Elimination Guidelines



Technical area	Strength & evidence	For/against	Recommendation	New/update
Elimination	Conditional, very low-certainty	For	Targeted drug administration to reduce transmission in low/very low transmission	New
Elimination	Conditional, moderate certainty	Against	Mass testing and treatment to reduce malaria transmission	New
Elimination	Conditional, very low-certainty	Against	Testing and treatment of people at increased risk to reduce transmission	New
Elimination	Conditional, low-certainty	For	Reactive drug administration to people near malaria cases to reduce transmission	New
Elimination	Conditional, very low-certainty	For	Testing and treatment of people near malaria cases to reduce transmission	New
Elimination	Conditional, very low-certainty	For	Reactive indoor residual spraying near malaria cases to reduce transmission	New
Elimination	Conditional, very low-certainty	Against	Routine test and treatment of people at points of entry to reduce importation	New
Elimination	Conditional, very low-certainty	For	Testing and treatment of groups from endemic areas to reduce importation	New



Surveillance





Surveillance definition:

Public health surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice.

One of the 3 pillars of the GTS is to Transform malaria surveillance into a core intervention



Strong surveillance enables programmes to optimise their operations, by empowering programmes:

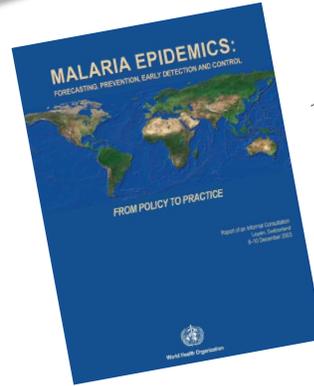
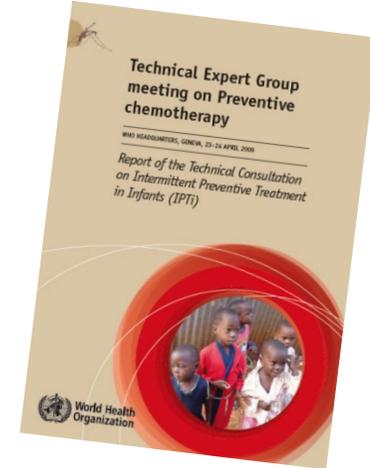
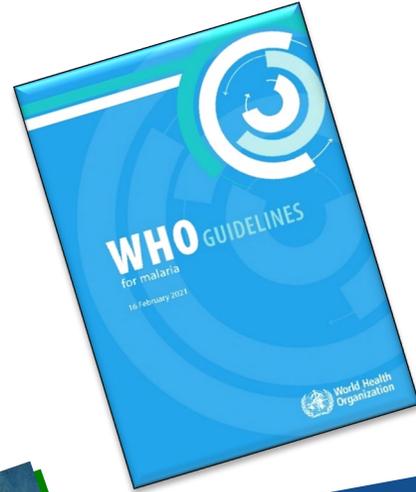
- To advocate investment from domestic and international sources, commensurate with the malaria disease burden in a country or sub-national level
- To allocate resources to populations most in need in order to achieve the greatest possible public health impact
- To access regularly whether plans are progressing as expected and where adjustments are needed
- To account for the impact of the resources and demonstrate value for money
- To periodically evaluate the overall programme objectives and achievement and thus plan accordingly

Malaria surveillance



Pillar 3 of the GTS 2016-2030
 Transform Malaria Surveillance into a Core Intervention

	High	Moderate	Low	Very Low	Zero	Maintaining Zero
Case detection	Passive case detection	Passive case detection	Passive case detection	Passive + Active case detection		
Recording	Outpatient and inpatient registers	Outpatient and inpatient registers	Outpatient and inpatient registers	Individual patient forms		
Reporting frequency	Monthly	Weekly	Weekly	Real Time		
Resolution of reported data	Aggregate case by age	Aggregate case by age	Aggregate case or line listing by age	Case reports with recommended details on patient history		
Data use: health facility	Data analysed and displayed weekly	Data analysed and displayed weekly	Data analysed and displayed weekly	Data analysed and displayed in real time		
Data use: district	Data analysed and displayed monthly	Data analysed and displayed monthly	Data analysed and displayed weekly	Data analysed and displayed weekly		
Data use: province & national	Data analysed and displayed monthly or quarterly	Data analysed and displayed monthly	Data analysed and displayed monthly	Data analysed and displayed weekly		
Response time	Monthly	Monthly or weekly	Weekly	Case & foci investigation within 48 hours, foci response within 7 days		
Feedback frequency to lower level	Annually	Quarterly	Monthly	Every two weeks		
Surveillance system monitoring	Annually	Quarterly	Monthly	Every two weeks		



Keep our eye on the prize: a world free of malaria

Thank you

Data Initiative & Global Malaria Dashboard updates



M
Dash

Agenda

- RBM Dashboards: addressing bottlenecks via near real time data
 - Reminder of Guiding Principles
- Demo on some of the existing Dashboards/Data
 - Applying for TA online
 - Global Fund proxy for absorbance
- Upcoming Data/Dashboards
 - Weather Data
- Participating in the Initiative
 - Reporting
 - Commenting
 - Country dashboards
- Discussion and questions



Data Initiative is one of the strategic enablers of the RBM 2021-2025 strategic framework that:

Fills a GAP existing on data centric global coordination:

1. Countries have limited opportunities to bring current challenges to the attention of the global stakeholder ecosystem.
2. Malaria Community had little visibility on near real time data on bottlenecks.
3. Information available often scattered across many websites often requiring advanced IT skills.

Cross-cutting Strategic Enablers	
Data-sharing and use	SE1: Open and timely sharing of quality data to drive decision-making, build transparency and foster accountability.

Strategic Objectives and Strategic Actions	SO1. Optimize the quality and effectiveness of country and regional programming
	1.1 Support countries in the design of quality, prioritized programmes
	1.2 Support countries in the use of real-time subnational data in planning, implementation and monitoring
	1.3 Facilitate timely access to implementation support to address bottlenecks and gaps
	1.4 Support building local management and technical capacity
	1.5 Support countries to strengthen multi-stakeholder partnership coordination at the national and subnational level
	1.6 Leverage regional alliances and initiatives to ensure cross-border and cross-sectoral coordination and coherence

6 Guiding Principles

Country-centricity

Countries escalate challenges

Data ownership

Respect country data ownership

Future action orientation

Monitoring with focus on empowering future country capacities

Global Action focus

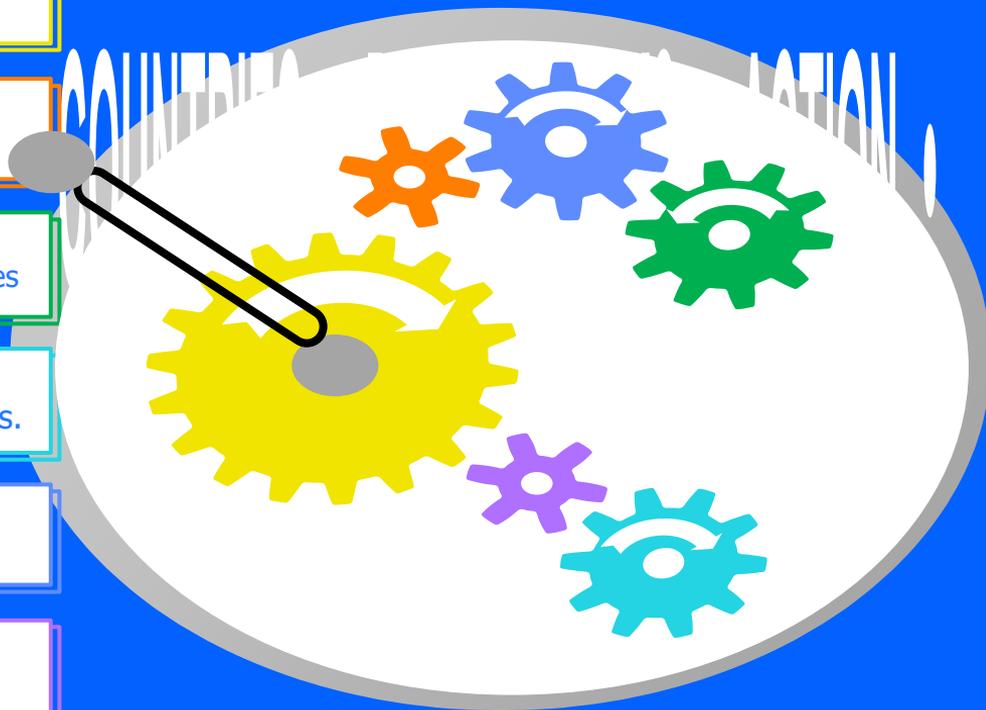
Data and action driven response from global stakeholders.

Continuous data improvement

Best available data with minimum quality flaws;

Process evolution

Continuously improve dashboards and associated processes



Country centricity & Global Action focus: Practical Implementation

1

Data is added to the diverse trackers by countries/partners

Other data (e.g., GF, Technical Assistance) directly connected to Dashboards via API

2

Data is cleaned and triangulated for consistency

Automatic workflows insure consistency in country names, reported stocks and pipeline verified with donors data

3

Data is updated in Dashboard and a new QA done

A new QA is done in data not received via API.

4

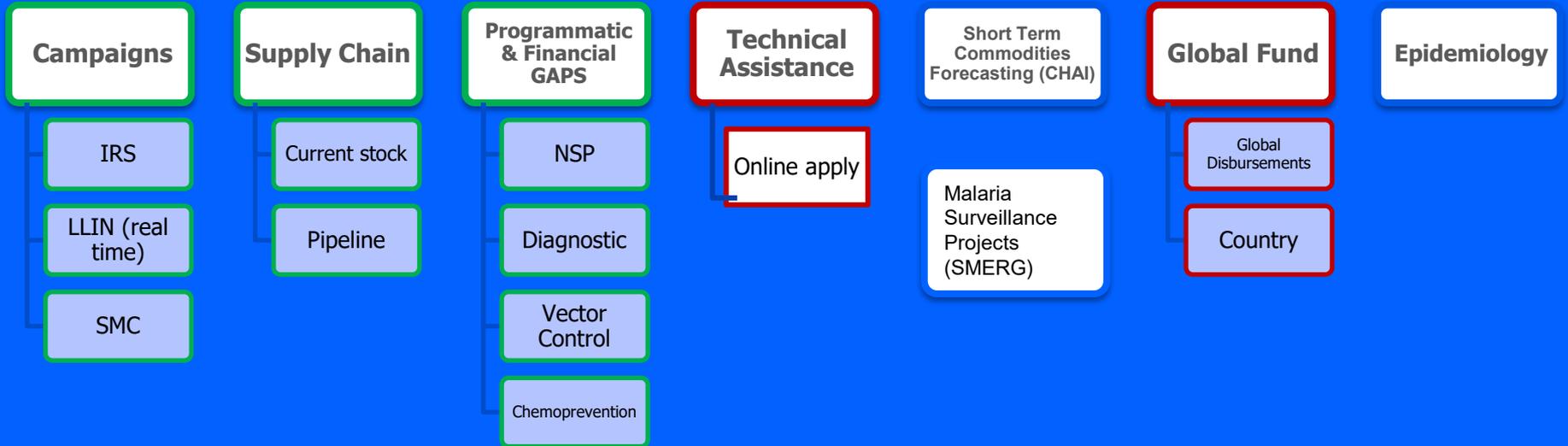
Main bottlenecks discussed on biweekly basis for solutions

Quarterly call with Donors and stakeholders to address bottlenecks not solvable during CRSPC calls
One on one country discussions held

Public Data from Partners is made public and available.

We encourage you to publicly share data with the different involved partners including CRSPC/Data Initiative

Available Dashboards



All data here publicly available (registration needed)

- **Updated Quarterly**
- **Real Time**
- **Yearly/On demand**

Coming Next



The Alliance for
Malaria Prevention



**Weather
forecasting
(IRI)**

**Mass Campaign
tracker**

**Country Targets
and
achievements**

**Country
dedicated
Dashboards**

Enhanced visualization capabilities
and user experience

Demo

<https://endmalaria.org/dashboard>

Contributing to the Data Initiative

- Reporting on GAPS/Campaign & Commodity status
- GF Absorbance Proxy Validation
- Raising voices via the Country Dashboards
- Providing feedback
- Add notifications
- Sharing the link

Sara.gonzaleza@endmalaria.org

Marsha.Deda@endmalaria.org



THE ROLE OF MULTISECTORAL ACTORS IN THE SUSTAINABLE FIGHT AGAINST MALARIA

MSWG PRESENTATION TO RBM SARN ANNUAL MEETING

PETER KWEHANGANA MBABAZI

CO-CHAIR MSWG

FINANCE & MULTISECTORAL PARTNERSHIP COORDINATOR

MINISTRY OF HEALTH UGANDA

Date 7th July 2022

MSWG PURPOSE & RATIONALE

- Multisectoral collaboration is key in light of the challenges faced in malaria control and elimination including insecticide and drug resistance, mobility of populations, risk perception, sustainable human settlements, poverty, disasters (natural & man-made), outdoor transmission, climate change and funding shortfalls.
- To end malaria for good, we need the concerted action of different stakeholders across different sectors beyond the health sector, as well as inter-sectoral collaboration.
- The SDGs calls for action to transform societies gives further impetus for a Multi-sectoral Working Group (MSWG).
- The MSWG was established under the umbrella of the RBM Partnership to End Malaria, following approval by the RBM Board in April 2018.
- The MSWG convenes and coordinates RBM Partnership members around a multi-sectorial action in the field of malaria to facilitate learning and share best practices from the field.

NEED FOR MALARIA MULTISECTORAL ACTION

- **Engaging beyond the health sector:** developing ambitious national responses to the Malaria- related targets included in the SDGs will require action across all government departments, as well as the engagement of civil society and the private sector.
- **Delivering commitments:** critical for delivering the national commitments set for example:
- **Implementing health-in-all-policies,** whole- of-government and whole-of-society approaches for addressing Malaria;
- **Setting national targets for Malaria;**
- **Developing and strengthening national multisectoral policies and plans** and incorporating Malaria into the national development agenda and plans;
- **Raising awareness about the national public health burden** caused by Malaria and the relationship between Malaria, poverty and social and economic development.

MSWG PURPOSE & RATIONALE

- The MSWG brings together different stakeholders across different sectors including; health, science and technology, oil & gas, international cooperation (cross border), housing, infrastructure, extraction industries, water and sanitation, environment, food and agriculture, education, immigration, tourism, customs, security, finance, trade, political, private, civil society, labour, research & development, media, information & communications technology, social protection and justice.
- The aim is to align partners in their actions for new interventions as well as putting new life into those that already exist, and coordinate and manage these in new and innovative ways.

MSWG Co-Chairs

1. Dr [Graham Alabaster](#) UN-Habitat, Switzerland
2. Mr [Peter Kwehangana Mbabazi](#) Ministry of Health Uganda

MSWG Secretariat/Coordinator

1. Dr [Konstantina Boutsika](#) Swiss TPH, Switzerland

MSWG TORS

- The Terms of References (TORs) as approved by the RBM Board are available in English and French.
- The structure is in line with the structure of other RBM Working Groups, following the Working Group Standard Operating Procedures (SOPs).
- The governance of the MSWG ensures adequate participation of malaria-affected countries and demonstrates a self-financing and self-convening capacity.
- The coordination of the MSWG is guaranteed through the financial support of the Swiss Agency for Development and Cooperation (SDC) to the Swiss Tropical and Public Health Institute (Swiss TPH) which is hosting the MSWG Secretariat.

MSWG KEY MANDATES & RESULTS

Mandate; Convene, Coordinate, Mobilise Resources, Facilitate communication

Results:

1. Develop systems and tools to conduct national appraisal of malaria determinants and inequalities.
2. Promote the development of national multi-sectoral malaria action plans
3. Promote 'malaria-smart' innovative approaches to apply multi-sectoral interventions at
4. large scale for sustainable impact on malaria.
5. Develop the framework for monitoring the implementation of multi-sectoral malaria action plans at different levels.

RECENT/PLANNED ACTIVITIES OF MSWG

- **Finalisation of MS Framework documents:**
 - RBM Multisectoral Action Guide to End Malaria (Completed)
 - RBM Multisectoral Action Framework for Malaria (with UNDP) Under final Edits
- **Further development of Two Flagship programmes and Resource Mobilisation:**
 - Healthy Cities Healthy People
 - Pathfinder Endeavours
- **Additional work**
 - Links to other VB diseases (Dengue, and other Aedes-transmitted viral diseases, in cities are a growing threat to the health and development of tropical urban environments)
 - Support to WHO on Joint WHO/UN-Habitat Urban Malaria Report
 - Focus on data collection and monitoring: housing/Infrastructure/Planning approvals

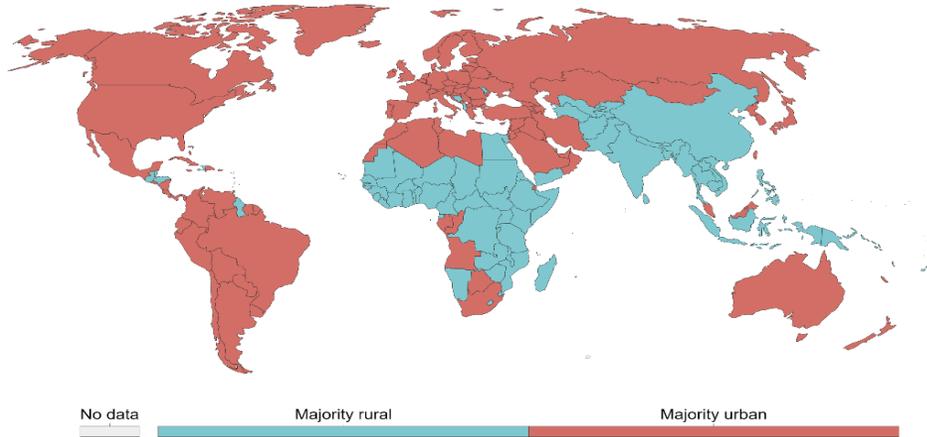
GLOBAL RURAL-URBAN SETTLEMENT TRENDS 2000-2050

2000

Do more people live in urban or rural areas?, 2000

Share of the population which live in urban versus rural areas. Here, 'majority urban' indicates more than 50 percent of the population live in urban centres; 'majority rural' indicates less than 50 percent. Urban populations are defined based on the definition of urban areas by national statistical offices. This is based on estimates to 2016, combined with UN projections to 2050.

Our World in Data



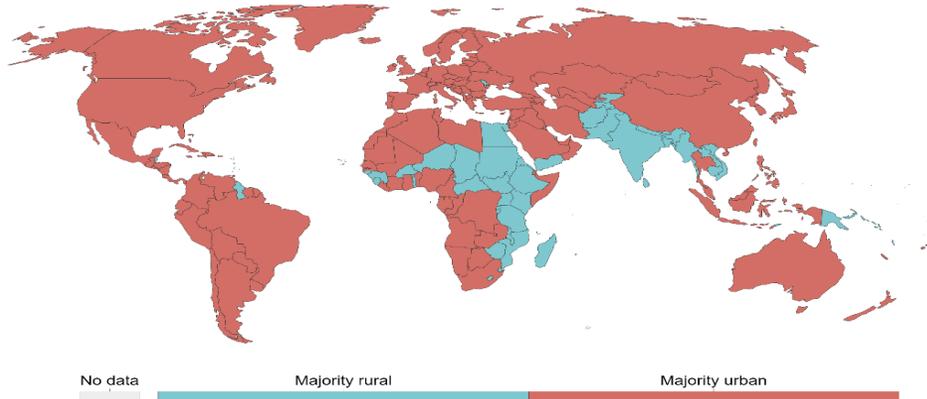
Source: OWID based on UN World Urbanization Prospects (2018) & Historical Sources (see Sources tab)
OurWorldInData.org/urbanization • CC BY

2030

Do more people live in urban or rural areas?, 2030

Share of the population which live in urban versus rural areas. Here, 'majority urban' indicates more than 50 percent of the population live in urban centres; 'majority rural' indicates less than 50 percent. Urban populations are defined based on the definition of urban areas by national statistical offices. This is based on estimates to 2016, combined with UN projections to 2050.

Our World in Data



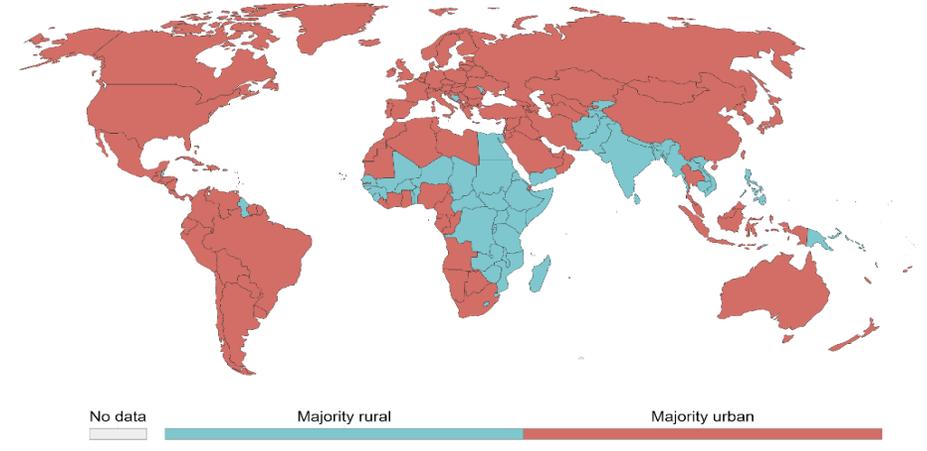
Source: OWID based on UN World Urbanization Prospects (2018) & Historical Sources (see Sources tab)
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2021

Do more people live in urban or rural areas?, 2021

Share of the population which live in urban versus rural areas. Here, 'majority urban' indicates more than 50 percent of the population live in urban centres; 'majority rural' indicates less than 50 percent. Urban populations are defined based on the definition of urban areas by national statistical offices. This is based on estimates to 2016, combined with UN projections to 2050.

Our World in Data



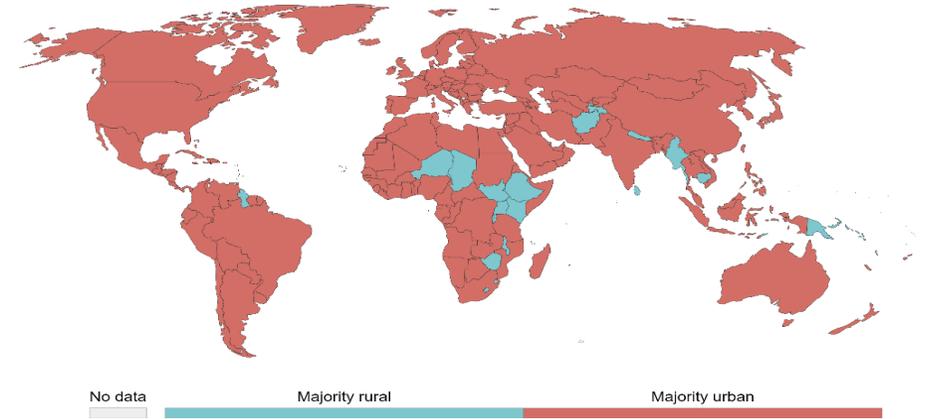
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2050

Do more people live in urban or rural areas?, 2050

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Our World in Data



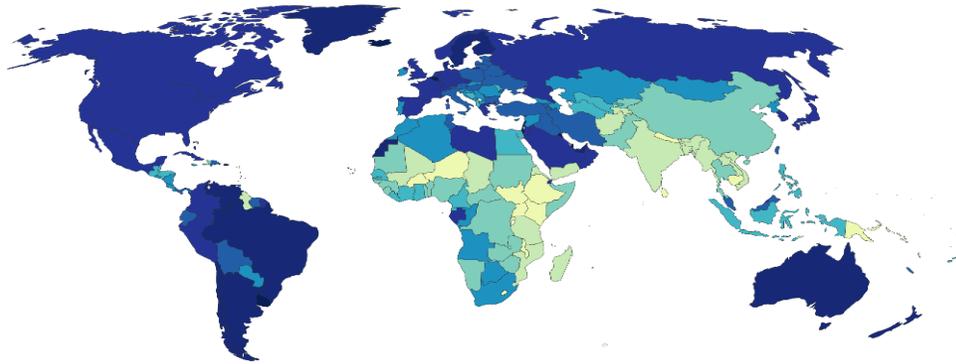
Source: OWID based on UN World Urbanization Prospects (2018) & Historical Sources (see Sources tab)
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GLOBAL URBAN SETTLEMENT SHARE TRENDS 2000-2050

2000

Share of the population living in urban areas, 2000
Share of the total population living in urban areas, with UN urbanization projections to 2050.

Our World
in Data

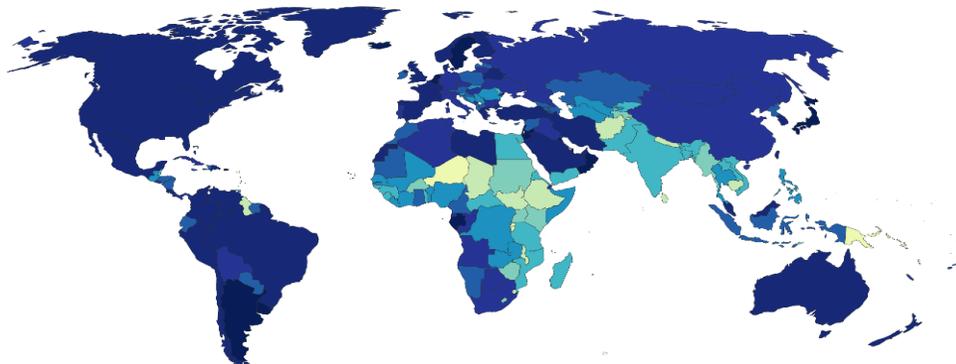


Source: OWID based on UN World Urbanization Prospects 2018 and historical sources (see Sources) OurWorldInData.org/urbanization • CC BY
Note: Urban areas are defined based on national definitions which can vary by country.

2030

Share of the population living in urban areas, 2030
Share of the total population living in urban areas, with UN urbanization projections to 2050.

Our World
in Data

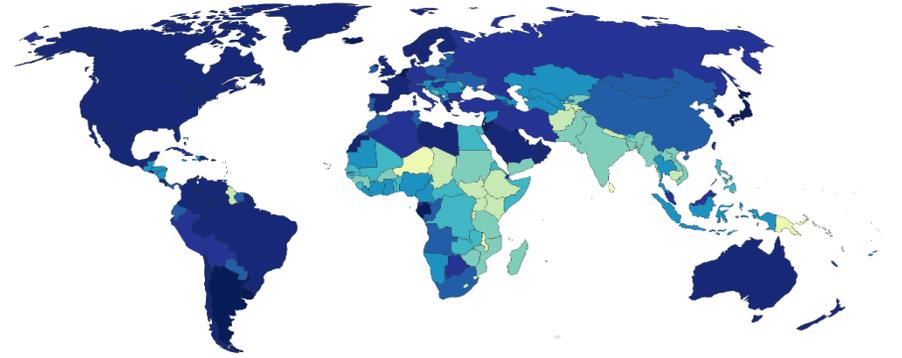


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2021

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Our World
in Data

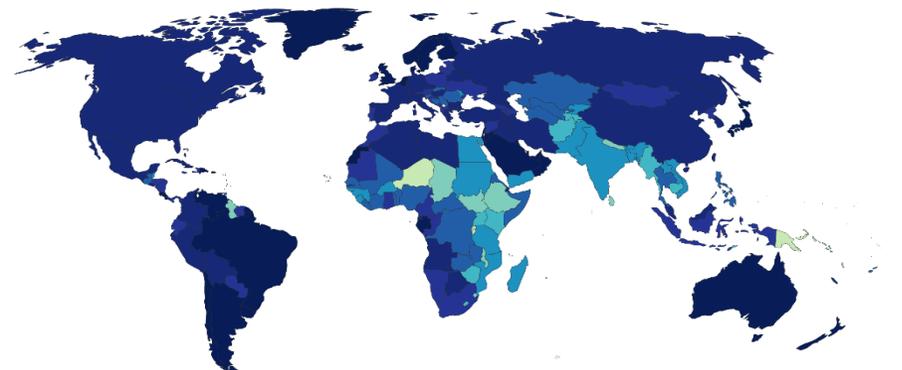


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2050

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Share of the total population living in urban areas, with UN urbanization projections to 2050.

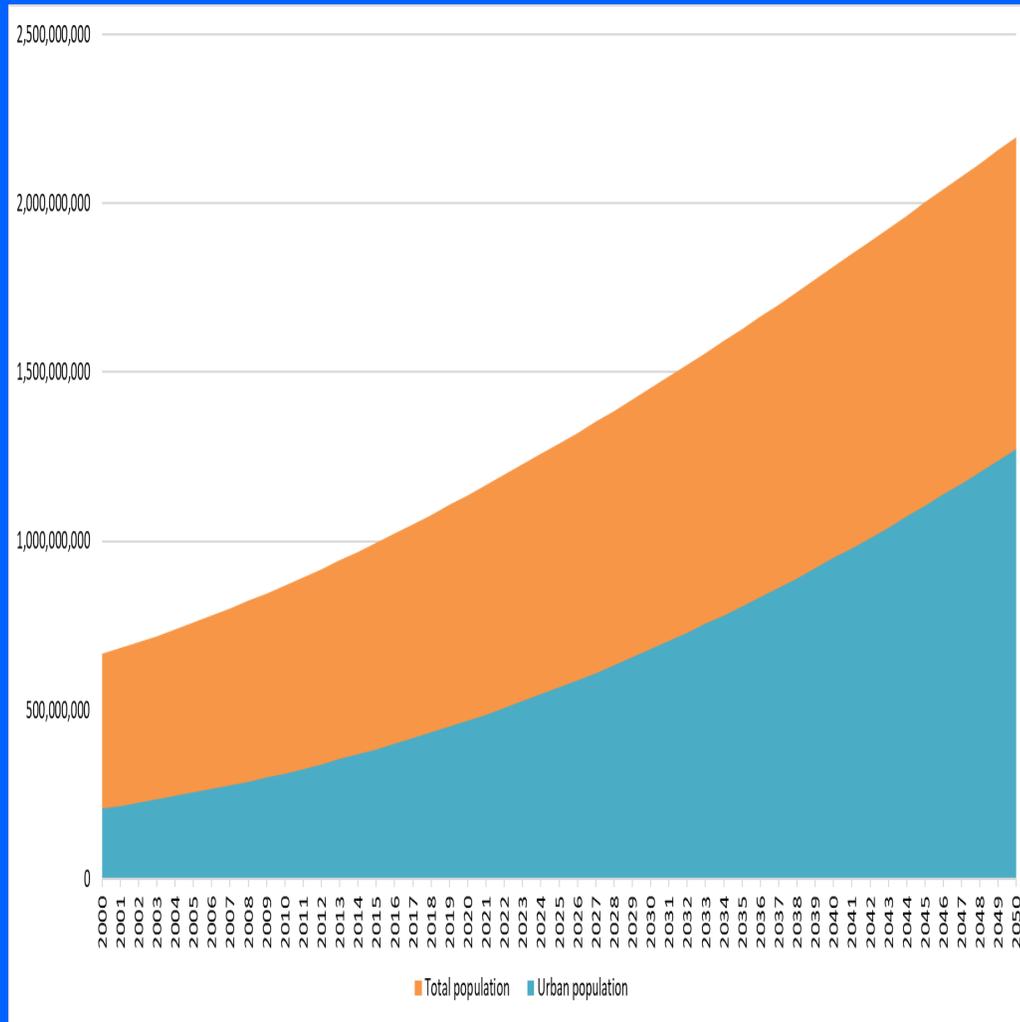
Our World
in Data



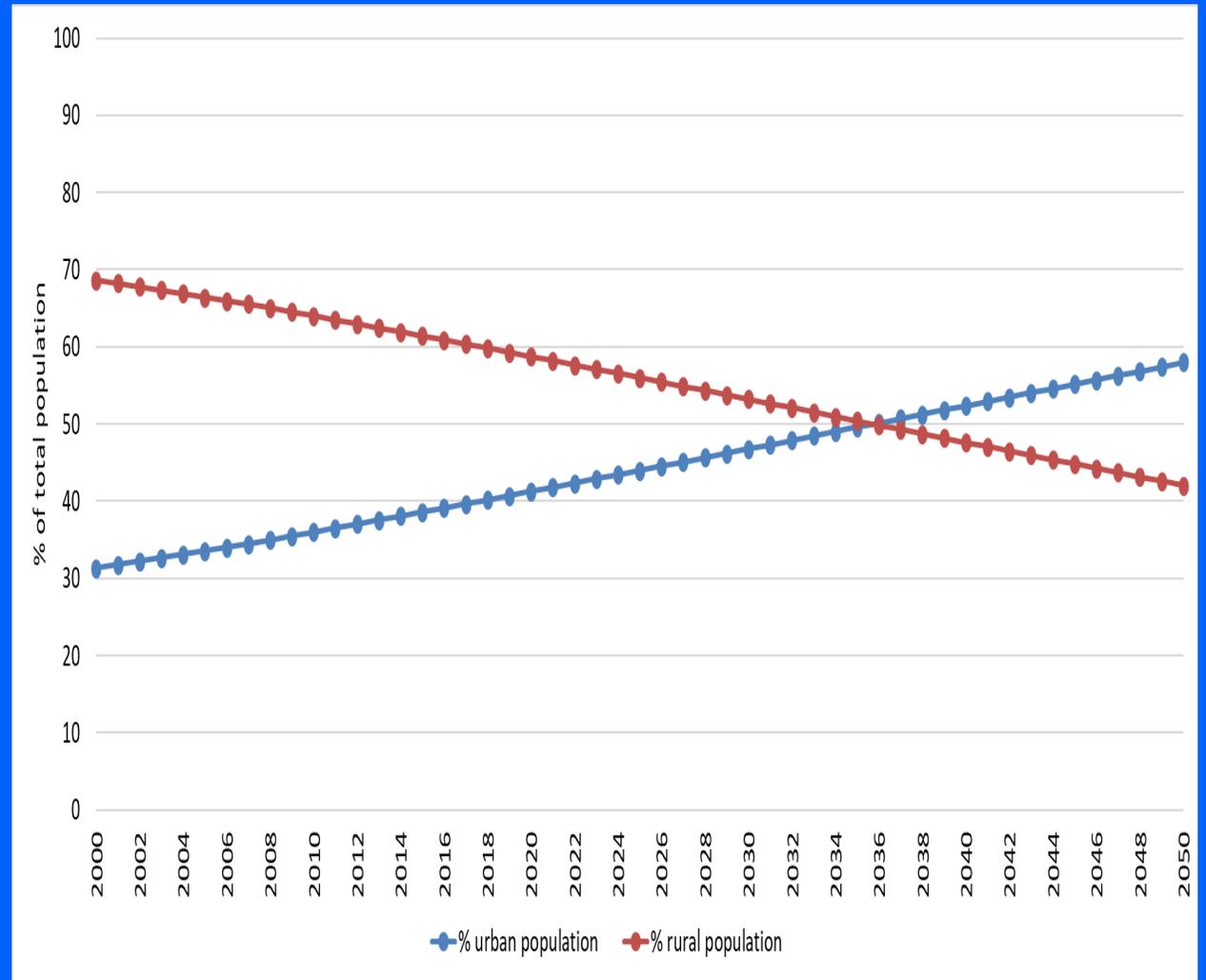
Source: OWID based on UN World Urbanization Prospects 2018 and historical sources (see Sources) OurWorldInData.org/urbanization • CC BY
Note: Urban areas are defined based on national definitions which can vary by country.

Rapid Urban Population Growth in malaria endemic countries

Population count, SSA



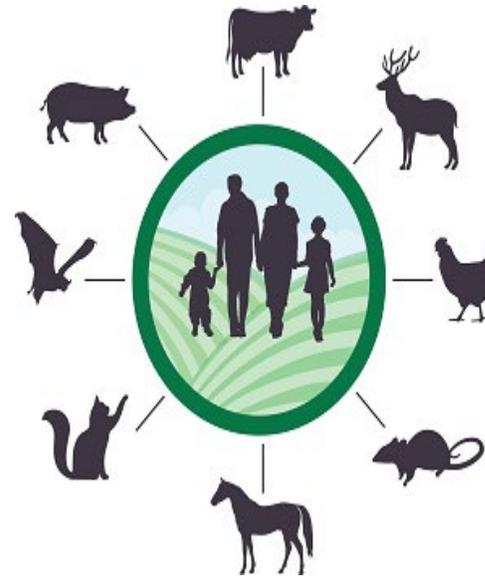
% urban, rural, SSA



In the 10 highest burden countries in SSA, 43% of population already in urban areas in 2020

The tables will turn in 2036

OUR WORLD IS CHANGING FAST...



INCREASED INTERACTIONS AT THE HUMAN-ANIMAL-ENVIRONMENTAL INTERFACE



WHY FOCUS ON URBAN AND PERI-URBAN SETTINGS?

- **Urbanisation:** From 2000 to 2030 the world's urban population is expected to increase from 2.7 billion to 5.1 billion people – i.e. 60% of global population
- **Environment:** Urban malaria and vector-borne disease risk varies according to types of construction, waste management, drainage, ditches and water storage that can create breeding sites for vectors
- **Urban vs rural:** WHO has recognised the different response required for the response to malaria in urban areas vs rural, to address rapid urban population growth and evolving malaria transmission dynamics in malaria endemic countries*
- **Multiple benefits of action:** Multi-sector response required to tackle malaria in cities will also help tackle other vector borne diseases, NTDs and TB

*WHO technical consultation on the burden of and response to malaria in urban areas (Malaria Policy Advisory Group 13-15 April 2021)

WHY WORK WITH CITY LEADERS?

Many of the indirect (i.e. non health) interventions to tackle vector borne disease fall under the direct responsibilities of local governments

TYPE	INTERVENTION
Environmental modification	<ul style="list-style-type: none">• Improving drainage• Draining swamps• Dredging to increase water flow• Making embankments• Land reclamation• Deforestation/afforestation• Flood control• Improved sanitation including better water storage and provision and good maintenance of piped water• General infrastructure development – e.g., construction of roads
Social/ preventive	<ul style="list-style-type: none">• House/window screening• Improved housing• House inspections to identify and remove breeding sites

Table extracted from WHO technical consultation on the burden of and response to malaria in urban areas (Malaria Policy Advisory Group 13-15 April 2021)

HEALTHY CITIES, HEALTHY PEOPLE

- The *purpose* of this initiative is to **support a network of city leaders** and link them with international health advocates. This initiative responds to the Commonwealth Local Government Forum ‘**Call to Action on Sustainable Urbanisation Across the Commonwealth**’ and the CHOGM Communiqué 2018.
- The initial *objective* was to agree a ***Common Position and Commitment to Action***, with a focus on the role city leadership can play in galvanising action beyond the health sector.
- The *longer-term aim* is to **mobilise substantial and sustainable support for urban health investment across the Commonwealth**, and create a *network* with a strong focus on vector-borne diseases and NTDs.
- Particular attention needs to be given to secondary cities which often lack the political power, resources and support of national capitals and commercial centres.

Healthy Cities, Healthy People: Partners

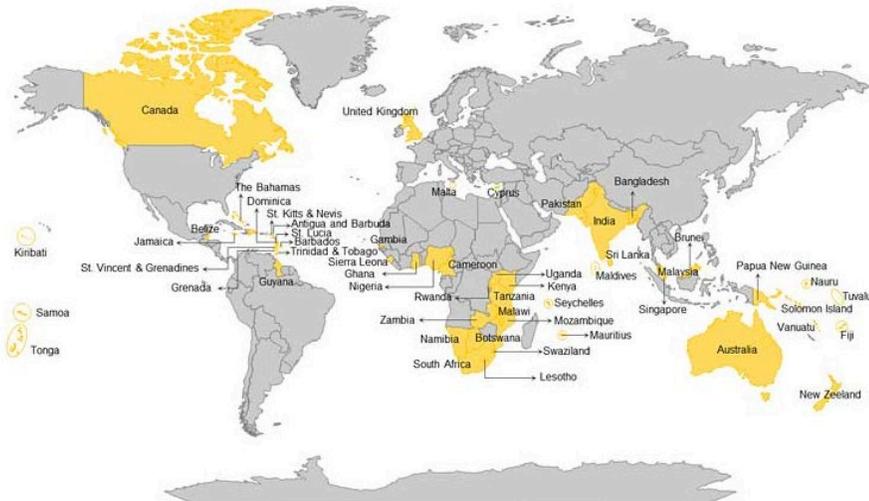
Partner Organisations



Potential Collaborators



Commonwealth Local Governments Forum (CLGF)



- Hosted series of regional meetings with 20+ countries represented, plus further consultations.
- Covid-19 highlights role of mayors/city leaders, but most lack authority and resources they need.
- Environmental factors must be addressed, investment in prevention has never been more critical
- Keen to join forces with Francophone Mayors & beyond

NEXT STEPS

- UN Habitat and CLGF are seeking resources to support city leaders with technical assistance, enabling them to build the case for investment, identifying opportunities to access sub-sovereign finance and other resources for infrastructure development and capacity building.
- A new financing mechanism has been developed. Which links the creation of a challenge fund for demonstration projects WITHIN current and planned larger scale investments
- Work plan is being developed under Commonwealth Sustainable Cities Network to link leaders with each other and with technical expertise. Widening the network to collaborate with Francophone partners and beyond.
- We are currently looking for resources to developing pilot projects to take to Commonwealth leaders at CHOGM, World Health Assembly, World Urban Forum etc

THE PATHFINDER ENDEAVOUR

- ***Overriding theme:*** ‘leave no one behind and sustainability’
- ***Action theme (vision):*** ‘a malaria free world’
- ***Collaborative theme:*** ‘Mutual-benefits’

”Do what you do best – but do it malaria-smart”

- Make development work for malaria control and malaria control work for development

“Unlock Synergy”

- *Use existing structures, tools, programmes and resources better*

Nothing to Lose – only Gain

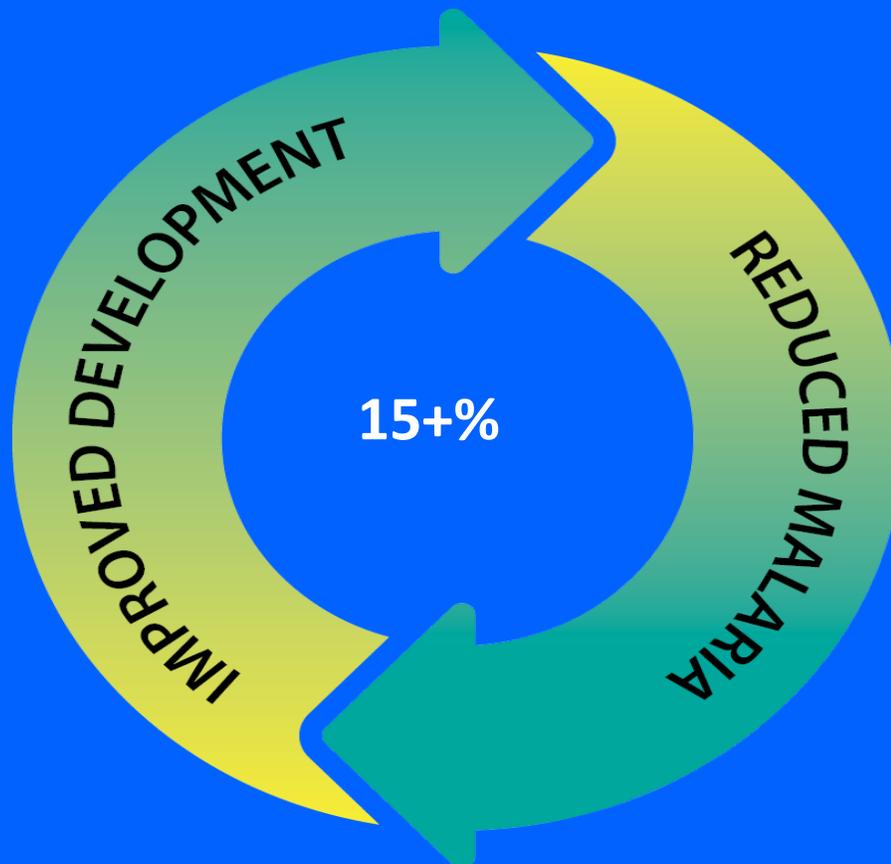
- Comprehensive multisectoral action for malaria complements and amplifies conventional malaria and selective sectoral approaches

THE PATHFINDER ENDEAVOUR OUTCOMES

What if ...

Malaria-critical indicators across all 17 SDGs improved by 5%?

5%



Reach of conventional malaria interventions improved by 5%?

5%

MALARIA SMART SECTORS

5 STEPS

TO BECOMING MALARIA-SMART

SUSTAINABLE
ELIMINATION



MUTUAL ACCOUNTABILITY

Two malaria-critical indicators for each of the 17 SDGs

- 1. Within participating districts and countries**
 - Political, technical, and public
 - Local government officer
 - Health officer [NMCP]
 - Development partner present in district
- 2. Across participating districts and countries**
 - Resources and progress against plans and targets
 - MoLG / MoPI
 - MoH/NMCP
 - Lead Development Partner

All relevant global technical strategy for malaria indicators



EXPLORE THE PATH

Methods of work: training; provision of toolbox; peer review, cross-learning and -support; adapting; planning, budgeting, and target setting; and analysing, learning, adjusting.....

	2022												2023												2024					
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6
Pre-assignment					R																									
Phase I:						X					R																			
Phase II:											X							R												
Phase III:																			X				R							
Phase IV:																											X			R

Documentation and analysis: systematic and continuous reporting, real-time monitoring, participatory analysis and review

Pre-assignment
Rapid appraisal, 'hardest' districts
(*development & malaria*),
commitment, nominate 5



Phase I

Understand local situation and determinants, select 3 districts per country, anchor in local ownership, Step1 and Step2



Phase II

Add Step3 and Step4



Phase III

Add Step5



Phase IV

Sustain and institutionalize

Crosswalk GF Strategy 2023-2028 to the Pathfinder Endeavour

GF-Strategy – Mutually reinforcing contributory objectives	The Pathfinder Endeavour
<p>Maximizing People-centered Integrated Systems for Health to Deliver Impact, Resilience and Sustainability</p>	<p>The first two steps of the “<i>Five steps to becoming malaria smart</i>” aim at raising a sustainable and equitable health systems response to the needs of sectoral actors, communities and population groups in districts</p> <p>The two malaria critical indicators for each of the 17 SDGs, include two broad indicators that are also critical to UHC (SGD3.8.1 & 3.b.1)</p>
<p>Maximizing the Engagement and Leadership of Most Affected Communities to Leave No One Behind</p>	<p>Focus on district and community / population group levels and reaching the furthest behind first.</p> <p>Political, technical, and public accountability with direct real-time engagement of citizens and communities</p>
<p>Maximizing Health Equity, Gender Equality and Human Rights</p>	<p>Addressing the determinants of health inequity, gender inequality and discrimination are cornerstones – and among the root causes for differential exposure, vulnerability, access, and health service outcomes.</p>
<p>Mobilizing Increased Resources</p>	<p>Focus on unlocking synergies, co-benefits, and better use of existing resources across all sectors and actors in each district – more value for the same money – regardless of their source, primary purpose, and who controls them.</p>

MAINSTREAMING MALARIA IN MULTISECTORAL PLANS

UGANDA EXPERIENCE

Guidance on Multisectoral Partnerships

3 Pertinent questions in Multisectoral Partnerships that guides Uganda experience:

1. What do we mean by 'Multisectoral Action Against Malaria'?

- Interventions initiated and carried out by sectors other than the health sector that can work in synergy with and enhance the impact of health sector investments,
- Expand the benefits of malaria investments to other sectors,
- Reduce the strain on health systems and economies

2. How do actions outside the health sector get in the way of progress?

Identified and classified all the sectors into

- Malaria transmission enhancing sectors; Extraction/Mining, Agriculture
- Malaria prevention and control sectors; Education, Local Government
- Facilitating sectors; Finance

3. How can we work together to end Malaria?

Engagement process included

Activities: Consultations, tool adaptations, workplan development, consensus building workshops,

Examples: Budget Call Circular, Music Dance Drama, MAAM Book series, Malaria Free Uganda, UPFM, AMICALL etc.

Presidential Commitment



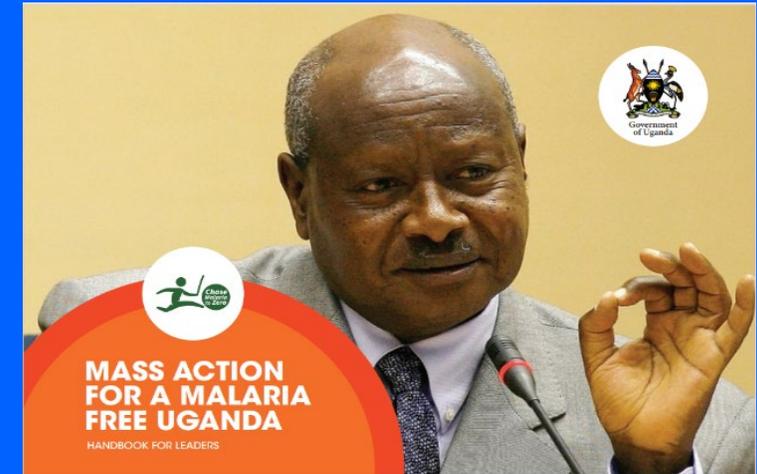
Empowerment for Malaria free Uganda starts with You!

MAAM Handbook for Leaders (2019)

<https://www.afro.who.int/publications/mass-action-malaria-free-uganda-handbook-leaders>

- Developed in reference to the Mass Action Against Malaria (MAAM), a **multisectoral implementation approach** of bringing everyone on board in the fight against malaria.
- MAAM aims to attain Uganda’s vision of a malaria free Uganda with a slogan – “**Am I malaria free today?**”
- Meant for leaders at all levels including the president, parliamentarians, civil servants, religious and cultural leaders, ..., community leaders and households.
- Developed to **guide you on your role** in the fight against malaria for a healthy and productive nation
- MAAM aims to **reach every household** with malaria interventions.

National level



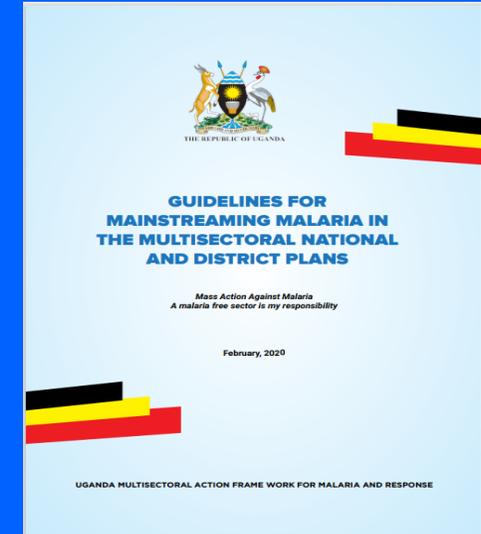
Household level



MAINSTREAMING MALARIA INTO MULTI-SECTORAL NATIONAL AND DISTRICT PLANS, UGANDA (2020).

<https://www.afro.who.int/publications/guidelines-mainstreaming-malaria-multisectoral-national-and-district-plans>

To provide guidance to Ministries, Departments, and Agencies (MDAs) in mainstreaming of malaria control as a cross cutting issue in their plans and budgets in compliance with the Budget call Circular issued by the Permanent Secretary & Secretary to the Treasury (PSST) MoFPED starting with Financial Year 2020/21 budgets and over the medium term.



“I would like to appeal to the Private sector, Rotarians, Philanthropists and Individuals to contribute to the Malaria Free Uganda fund. Together we can achieve a malaria free Uganda by 2030” (Rt. Honourable Dr. Ruhakana Rugunda – Prime Minister of Uganda)



“This guidance is critical towards strengthening and streamlining efforts by all Malaria multisectoral partners in sustainable malaria financing” (Dr. Diana Atwine, Permanent Secretary – MoH, Uganda).



“I therefore call upon all the Government MDAs and LGs, our valued partners - the Development Cooperation Agencies, NGOs, CSOs, and the private sector to use this document as a reference tool or a resource for effective malaria mainstreaming of malaria in your respective activities” Hon. Dr. Ruth Jane Aceng – Minister of Health, Uganda.

Rethinking Malaria: Multi-sectoral Engagement for Effective National Response to Malaria and Health System strengthening

BUDGETARY FRAMEWORK TRANSLATE POLITICAL WILL TO SUSTAINABLE RESOURCES

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Ministry of Finance, Planning & Economic Development
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Kampala
Uganda

In any correspondence on this subject please quote No. BFD/18/17/2022

13th September 2019

All Accounting Officers (Central Government, Missions Abroad & Local Governments Votes),

All Chief Executive Officers of State Owned Enterprises and Public Corporations

THE FIRST BUDGET CALL CIRCULAR (1ST BCC) ON PREPARATION OF THE BUDGET FRAMEWORK PAPERS (BFPs) AND PRELIMINARY BUDGET ESTIMATES FOR FINANCIAL YEAR 2020/2021

A. INTRODUCTION

- Section 9(3) of the Public Finance Management (PFM) Act 2015 (Amended) requires that, for every financial year, the Minister of Finance Planning and Economic Development should prepare a Budget Framework Paper that is consistent with the National Development Plan and Charter of Fiscal Responsibility.
- In line with the above, Section 9(1) of Public Finance Management (PFM) Act 2015 (Amended) requires every Accounting Officer, in consultation with the relevant stakeholders, to prepare a Budget Framework Paper for the Vote, taking into consideration balanced development as well as gender and equity responsiveness. This should be submitted to the Minister of Finance Planning and Economic Development by 15th November. This is meant to facilitate analysis, consolidation of the National Budget Framework Paper (NBFP) and onward submission to

III. Malaria Mainstreaming

57. Whereas Uganda has experienced a reduction in malaria prevalence, it is one of the leading killer diseases and largely affects the strength of labor force through sickness and time taken to treat and care for those affected. As part of the budget preparation for FY 2020/21, Accounting Officers are advised to plan for a malaria free environment by ensuring that resources are earmarked for bush clearing around the offices as well as sensitization of staff to adopt malaria preventive measures, among other budget cross cutting actions, in their homes.

58. Furthermore, in the development of work plans where the intended intervention(s) have a community focus, the issue of malaria prevention should be incorporated. The Permanent Secretary, Ministry of Health is advised to issue a guideline on specific details related to malaria prevention by 25th September, 2019 to guide Accounting Officers in the course of preparing their work plans and detailed budget estimates for FY 2020/21.

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Website: www.health.go.ug



Office Of The Permanent Secretary
Ministry Of Health
P.O. Box 722
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KAMPALA, UGANDA

IN ANY CORRESPONDENCE ON THIS SUBJECT PLEASE QUOTE NO. ADM.105/309/15

25th September, 2020

Permanent Secretary/ Secretary to the Treasury
Ministry of Finance Planning & Economic Development
P. O. Box 8147
Kampala, Uganda



Dear Colleague,

RE: REQUEST FOR CONTINUED INCLUSION OF MALARIA AS CROSS CUTTING ISSUE IN BCC 2021/2022 & BEYOND AND SUBMISSION OF GUIDELINES FOR MAINSTREAMING MALARIA IN NON-HEALTH SECTORS.

As you are aware that Global Fund to fight HIV, TB, & Malaria, awarded a total of USD \$260,024,950 for Malaria control in Uganda, and an additional USD \$3,000,000 as matching funds (available on investing an equal amount). There is a potential addition called Prioritized Above Allocation (Conditional to availability of additional funds/savings) of \$38,918,197, for the period January 2021 to December 2023. Please note that the Ministry of Finance, Planning and Economic Development (MoFPED) is the PR1 with TASO as PR2 for these funds.

However, the Global Fund Technical Review Panel (TRP), an independent review panel, came up with recommendations (conditional precedents) among others, issue number 6; **Need to identify additional GOU financing for malaria interventions**

It was observed that Uganda is a hyper-endemic malaria country situated within a transmission belt that makes disease control challenging. Its proximity to the Congo Basin, climate change, pressure on eco-systems, and influx of refugees, are also making the country vulnerable to malaria epidemics.

The TRP recommended that the MoFPED to work together with the Secretariat during grant implementation, to ensure malaria is included in the GOU's planning, including technical analyses, around a long-term strategy for transition in external support for critical disease programs.

In our response, we stated that the GOU has agreed to continue mainstreaming Malaria as a cross-cutting issue, referring to the recent Budget Call Circular (2020/2021) of 13th September 2019, where malaria was included in the cross-cutting issues to be integrated in multispectral work plans and budgets (see page 13 of the Call Circular). The Malaria community remains profoundly appreciative of this commitment.

Therefore, we hereby solicit the continuity of the same in the BCC 2021/2022 and beyond. In addition, we wish to request for a system for tracking Malaria funding to be included in the chart of accounts in line with the Guidelines on page 23.

In this regard, the MOH has established **Malaria Free Uganda**, a private sector initiative, to raise funds that will complement Government of Uganda's efforts towards the elimination of malaria in Uganda by 2030. With regards to your request, we have published the **Guidelines for Mainstreaming Malaria in the Multispectral National and District plans. The guidelines provide guidance on how to mainstream Malaria in non-health sector plans.** We humbly request that you mention the use of guidelines by all sectors and circulate it alongside the BCC 2021/2021.

The purpose of this letter therefore is to request you to re-affirm your commitment and possibly increase the budget for supporting Malaria control in writing to The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) and provide a system for tracking Malaria funding in multisectoral workplans.

Dr Diana Atwine
PERMANENT SECRETARY

Cc: Hon Minister of Health
Cc: Hon Minister of State, Primary Health Care
Cc: Hon Minister of State, General Duties
Cc: Managing Director, National Medical Stores

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Ministry of Finance, Planning & Economic Development
Plot 2-12, Apollo Kagwa Road
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Kampala - Uganda

In any correspondence on this subject please quote No. BFD 86/307/01

15th February, 2021

All Accounting Officers (Central and Local Government Votes) and,
All Chief Executive Officers of State Owned Enterprises and Public Corporations

THE SECOND BUDGET CALL CIRCULAR ON FINALISATION OF DETAILED BUDGET ESTIMATES AND MINISTERIAL POLICY STATEMENTS (MPSs) FOR FINANCIAL YEAR 2021/2022

A. INTRODUCTION

- The Second Budget Call Circular for FY 2021/2022 is issued in line with Section 11(b) of the Public Finance Management (PFM) Act, 2015 (Amended).
- In line with the above and as required under Section 9 (8) of the PFM Act 2015, Cabinet and Parliament respectively approved the National Budget Framework Paper (NBFP) for FY 2021/2022 with recommendations. Accordingly, we have embarked on the process of finalization of the Budget for FY 2021/2022.
- The Budget for FY 2021/2022 is anchored on the Third National Development Plan (NDP III), the Budget Strategy approved in the National Budget Framework Paper for FY 2021/2022, the NRM Manifesto 2021 – 2026 and the twelve strategic policy intervention areas by H.E. The President.
- Section 13 (3) of the PFM Act 2015 requires Detailed Budget Estimates to be presented in Parliament by 1st April for review, approval and appropriation by Parliament by 31st May. Similarly, Section 13 (7) of the PFM Act, 2015 requires the Minister of Finance, Planning and Economic Development to present the proposed Budget Estimates in Parliament accompanied by a Certificate of Compliance (CoC) issued by the National Planning Authority. Accordingly, Accounting Officers should submit copies of the following documents, to the National Planning Authority (NPA), by Thursday, 11th March 2021 for review and issuance of the Certificate of Compliance:
 - Approved Ministries, Departments and Agencies (MDA) Strategic Plan (2021/2022 – 2025/2026);
 - MDA BFPs for FY 2019/2020 and 2020/2021;
 - Ministerial Policy Statements (MPS) for FY 2019/2020;
 - Annual Performance Report for FY 2019/2020; and
 - MDA Project Specific Progress Reports for FY 2019/2020.

5. The purpose of this Circular therefore, is to the following:

Page 1 of 17

Malaria

62. Whereas Uganda has experienced a reduction in malaria prevalence, it is one of the leading killer diseases and largely affects the strength of labor force through sickness and time taken to treat and care for those affected. As part of the budget preparation for FY 2021/2022, Accounting Officers are advised to plan for a malaria free environment by ensuring that resources are earmarked for bush clearing around the offices as well as

Page 15 of 17

sensitization of staff to adopt malaria preventive measures, among other budget cross cutting actions, in their homes.

63. Furthermore, in the development of work plans where the intended intervention(s) have a community focus, the issue of malaria prevention should be incorporated. The Permanent Secretary, Ministry of Health has issued and disseminated the Guidelines on specific details related to malaria. These are expected to guide Accounting Officers in the course of preparing their work plans and detailed budget estimates for FY 2021/22.

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Ministry of Finance, Planning & Economic Development,
P.O. Box 8147
Kampala, Uganda

In any correspondence on this subject please quote No. BFD/18/17/2022

15th February 2022

All Accounting Officers (Central and Local Government Votes) and,
All Chief Executive Officers of State Owned Enterprises and Public Corporations

THE SECOND BUDGET CALL CIRCULAR ON FINALISATION OF THE BUDGET FOR FINANCIAL YEAR 2022/2023

A. INTRODUCTION

- The Second Budget Call Circular for FY 2022/2023 is hereby issued pursuant to Part III, Section 10 – 13 of the Public Finance Management Regulations, 2016.
- The National Budget Framework Paper (NBFP) for FY 2022/2023 – 2026/2027 was approved by Parliament on 28th of January 2022 respectively, with recommendations in line with Sections 9 (5 & 8) of the Public Finance Management (PFM) Act, 2015.

NDP III. Unlike other budget output codes, this has been created as a special purpose code that can be used across all the 20 Programmes of the NDP III.

106. You are advised effectively to allocate 0.1% of your total budget (excluding pension, gratuity and transfers) towards various HIV/AIDS interventions as per the HIV/AIDS mainstreaming Guidelines issued by Uganda AIDS Commission. All Accounting Officers are instructed to clearly use the Budget output code to outline and cost their HIV / AIDS related activities for the FY 2022/23 including: Counselling, Social support, Awareness Campaigns, Workplace policies and Care and treatment.

Malaria Mainstreaming

107. Whereas Uganda has experienced a reduction in malaria prevalence, it is one of the leading killer diseases and largely affects the strength of labor force through sickness and time taken to treat and care for those affected. As part of the budget preparation for FY 2020/21, Accounting Officers are advised to plan for a malaria free environment by ensuring that resources are earmarked for bush clearing around the offices as well as sensitization of staff to adopt malaria preventive measures, among other budget cross cutting actions, in their homes.

108. Furthermore, in the development of work plans where the intended intervention(s) have a community focus, the issue of malaria prevention should be incorporated. The Permanent Secretary, Ministry of Health issued the Guidelines on specific details related to malaria prevention to guide Accounting Officers in the course of preparing their work plans and detailed budget estimates for FY 2022/2023.

109. A copy of the Guidelines can be accessed on the link [ati](#)

Gender and Equity Budgeting

110. The mainstreaming of gender and equity issues remains one of the government's primary commitments under the Sustainable Development Goals (SDGs). Section 9(6) of the PFM Act 2015 requires the Minister of Finance, Planning, and Economic Development to certify that MALG budgets are gender and equity responsive in consultation with the Equal Opportunities Commission (EOC).

Page 26 of 28

Recent High level Political Engagement



NATIONAL NEWS
Friday, September 3, 2020

By Betty Anamukirori

PRESIDENT MUSEVENI COMMITS TO STRENGTHENING MALARIA FIGHT

President Yoweri Kaguta Museveni has made strong commitments in the fight to end malaria infections in Uganda. Speaking at a global malaria webinar organised by Harvard University in the US and Makerere University and a host of other sponsors, the President admitted that much as malaria consumes a lot of resources and does a lot of damage to the economy, there has been laziness in the fight to eliminate the disease.

"We are used to just managing the problem of malaria and our medical service was biased towards curative care. The preventive measures are not emphasised," he said, noting that once he gets the figures on the gains the country will make when it moves from the curative approach to prevention, he will launch a full war against the disease.

"I am ready to launch a full war against the mosquitoes and plasmodium (the parasite that causes malaria) so that we are free from malaria," Museveni said.

According to the 2019 WHO World Malaria report, Uganda has the third highest global malaria burden (5%) and the eighth highest number of deaths (5%). The country has the highest proportion of malaria cases in East and southern Africa, standing at 23.7%.

Research evidence shows that Uganda has a stable, perennial malaria transmission in 95% of the country with *Anopheles gambiae* s.l. and *Anopheles funestus* s.l. being the most common malaria vectors.

In the fight against the disease, Uganda has employed a multi-pronged approach involving the use of insecticide-treated mosquito nets, larviciding and indoor residual spraying.

Museveni said: "We have been tirelessly handling malaria. The disease has lived with us for centuries and we haven't been as scared of it as we have been of COVID-19."

He said just like other diseases, one needs to understand human behaviour and society to control malaria.

Citing the country's successful war against the guinea worm and tuberculosis, Museveni underscored the importance of behavioural change and agents that cause the diseases.

"With the guinea worm, we eliminated the biological water that was the end of Guinea worm. The same with malaria; we are looking at larviciding, the killing of the larvae to lessen the mosquitoes, the use of insecticide-treated mosquito nets and spraying the walls," he said.

He said the multi-pronged approach is the right way to deal with mosquitoes, stating that other treatment approaches such as the use of quinine and chloroquine have been short-lived since the plasmodia mutate into more resistant variants.

The President's remarks came after a submission by scientists that the only way to eliminate malaria is through community engagement and use of evidence up-to-date data.

Globally, 40 countries and territories have been granted a malaria-free certification from WHO – El Salvador in 2021, China in 2021, Algeria in 2019, Argentina in 2019, Paraguay in 2018 and Uzbekistan in 2018.

Earlier, Prof. George F. the director-general, Center for Disease Control and Prevention and vice-president Chinese National Science Foundation, noted China was able to eliminate malaria due to the leadership right from the level to the central government. He said China relied on its surveillance reports and science based on evidence in its fight.

In Sri Lanka, that eliminates malaria in 2012, Prof. Emerita of Colombo University, Kamala Mendis, said empowering people at the local level, having a good technical governance structure with a strong political will, and research played a big role in kicking out the disease.

In response, Museveni said the Government has emphasised and supported science research, especially in universities and institutions such as Uganda Virus Research Institute (UVRI).

He called for a collaborative response, especially among African countries, through ensuring that there is division of labour to quicken the pace of scientific researches and ensure efficiency.

He also stated that besides behavioural change sensitisation, there is need to adopt force in enforcement of preventive measures in communities.

PHOTO: PPHU

President Museveni speaking during webinar on rethinking malaria in Africa in the context of COVID-19

MPs want sh235b for malaria fight

By Henry Sekanjako

MPs have asked the Government to ringfence sh235b for indoor residual spraying of mosquitoes to fight malaria in the country.

The MPs, under their body, Uganda Parliamentary Forum on Malaria, proposed that the money is ringfenced for five years, starting with the Financial Year 2021/2022 to 2025/2026.



Asuman Basalirwa

"We have seen that while the other current malaria needs have been met by donor funding, there is a glaring gap in indoor residual spraying, which is the most effective way to fight malaria," Asuman Basalirwa (Bugiri Municipality), the chairperson of the forum, said.

The MPs urged the Government to consider increasing funding for the fight against malaria, saying it has left the fight to donors.

They called upon Parliament to review and update the Public Finance Management Act 2015 to include the finance and health ministries to issue certificate of compliance for mainstreaming malaria in multi-sectoral budgets before the budget is approved.

"We call upon the permanent secretary/secretary to the treasury, through the accountant general, to introduce a budget tracking system to

Government had neglected killer diseases, such as malaria, and concentrated more on COVID-19, leaving many Ugandans dying.

Jovah Kamateka, the Woman MP for Mitoma district, said there is need for government to sensitise Ugandans about malaria in order to reduce the number of deaths.

"The Government needs to allocate sufficient funds for malaria. It remains the number one killer in Uganda. We need to ensure that the budget for malaria is increased to reduce the death rate," Kamateka said.

Uganda has the third highest number of malaria cases and the seventh highest number of deaths globally.

Children and pregnant women are the most at risk population.

According to the MPs, malaria stands in the way to Uganda achieving middle-income status.

The MPs said malaria has not been prioritised in the current national budget framework paper, yet the most risk population are children and pregnant women, who constitute 60% of their constituents.

The MPs assured Ugandans that indoor residual spraying is a safe method of fighting malaria as has been tested and proven by health experts.

Ministry allows international schools to reopen for finalists

MAAM INITIATIVE AT SUB-NATIONAL LEVELS: MAAM DISTRICT TASK FORCES SUPPORTING DISTRICT AND COMMUNITY HEALTH TEAMS



Health Minister, Dr Ruth Aceng, launching District MAAM Task Force at a district headquarter



District MAAM Task Force at Lira



Mass awareness and social mobilization activities



The Armed Forces were not left out

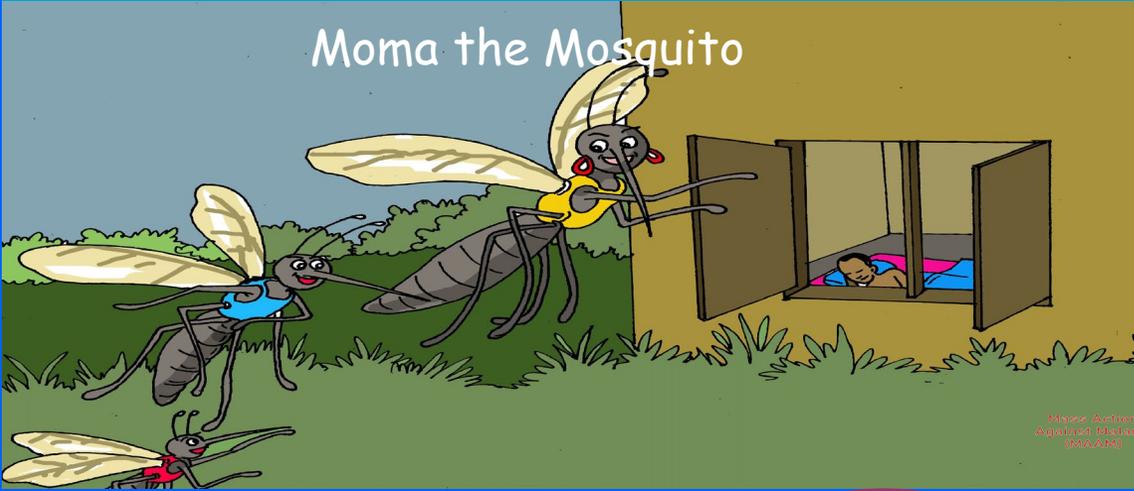


National School MAAM MDD Competitions

MAAM Malaria Free Schools (Primary school Series)

Mass Action Against Malaria

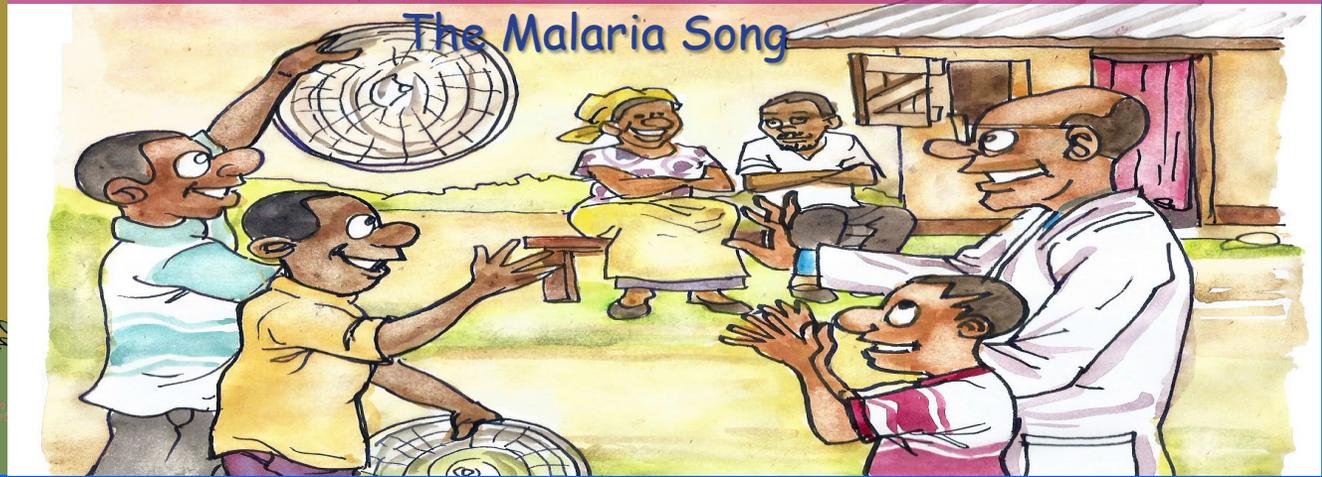
Moma the Mosquito



Mass Action Against Malaria

Book 2

The Malaria Song



Mass Action Against Malaria

BOOK 3

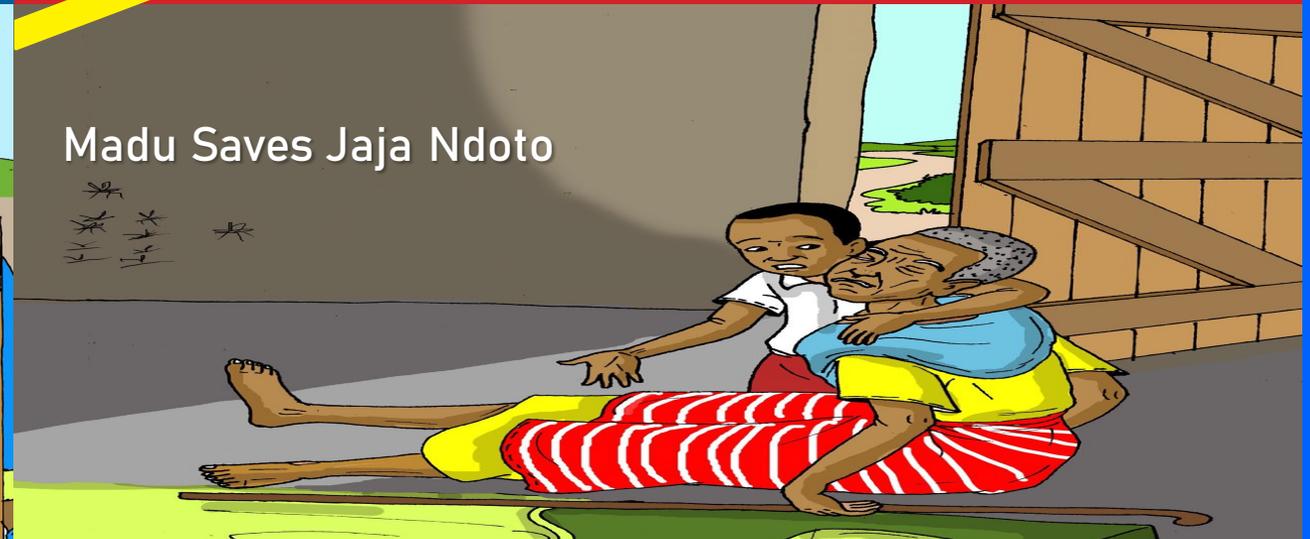
My New Pink Mosquito Net



Mass Action Against Malaria

Book 4

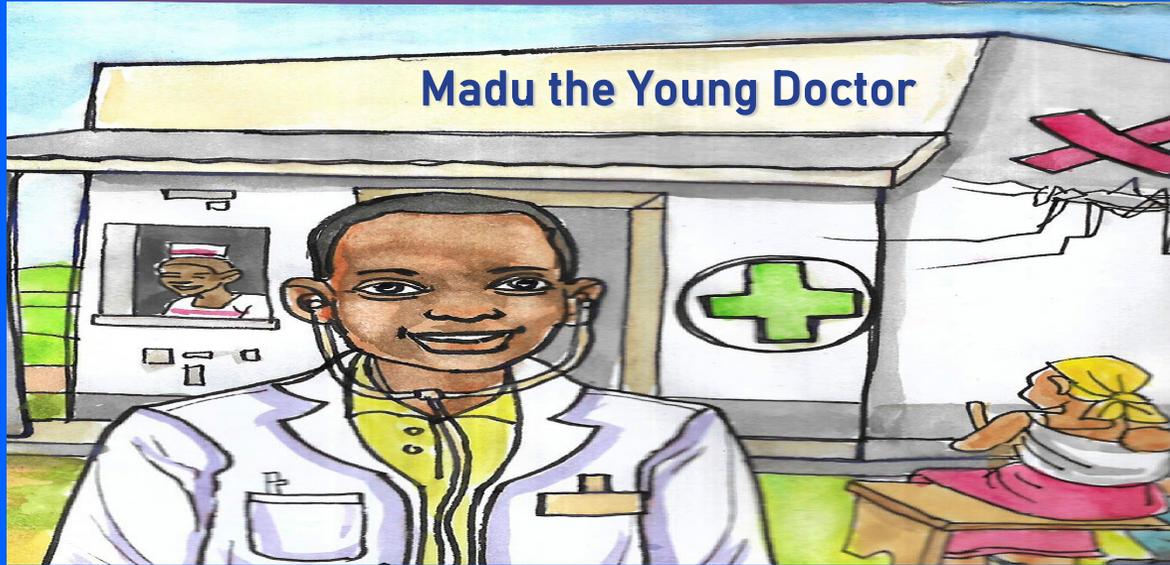
Madu Saves Jaja Ndoto



MAAM Malaria Free Schools (Primary school Series & Instructors)

Mass Action Against Malaria

Book 5



Mass Action Against Malaria

Book 6



Mass Action Against Malaria

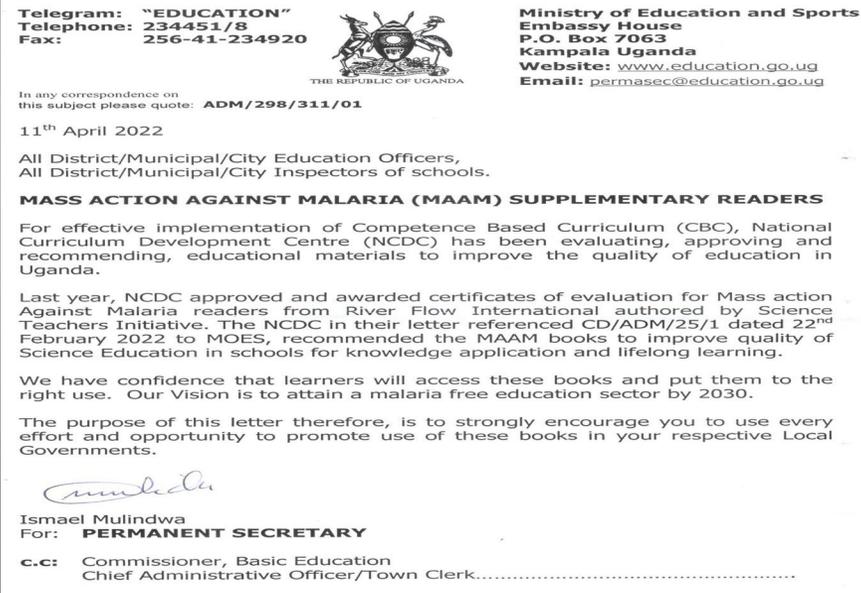
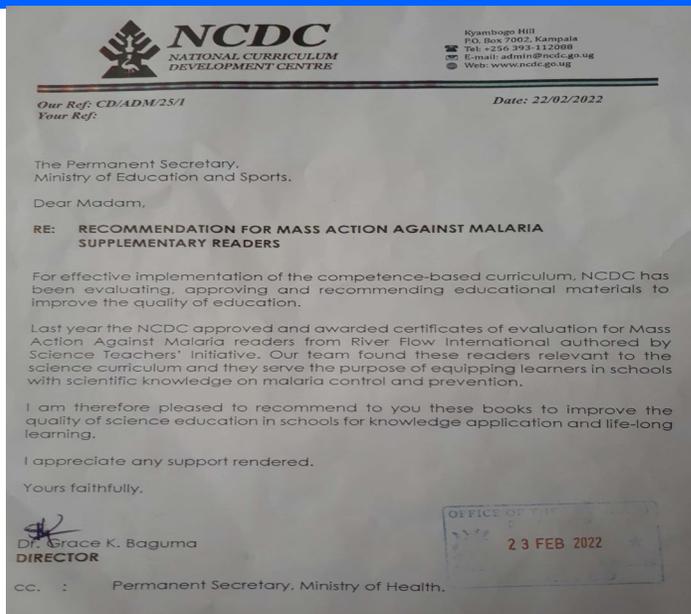
Book 7



Malaria Smart School/ Home Model
A HAND BOOK FOR MALARIA CHAMPIONS



Ministry of Education Implement MAAM in Schools/NCDC Approve MAAM Books



Telegram: "EDUCATION"
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**Ministry of Education and Sports
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CIRCULAR NO.20/2018

The Chief Administrative Officers/Town Clerks
Executive Director, Kampala City Council Authority

NATIONAL EFFORTS TO STRENGTHEN SCHOOL HEALTH; MASS ACTION AGAINST MALARIA AND MUSIC DANCE AND DRAMA

On September 1st to 8th 2018, the Ministry of Health in collaboration with Ministry of Education and Sports successfully held the National Music Dance and Drama (MDD) competitions for Secondary and Primary schools respectively. Both Ministries agreed to use edutainment (education through entertainment) channel of MDD competitions in schools to transform and equip learners with knowledge and skills as change agents to fight malaria

Ministry of Health aims to achieve a **Malaria Free Uganda by 2030** through Mass Action Against Malaria (MAAM). To that effect the of Ministry of Education and Sports aims to achieve **Malaria Free Schools** because Malaria is the number one cause of Morbidity, Mortality, poor academic performance, and drop out in schools. Community surveys in Uganda have shown that children aged 5 to 15 years had the highest malaria prevalence and these are all of the school going age.

District Education Officers (DEOs) and Head Teachers are very critical in the dissemination of Health information and practices to the learners and the communities they serve and we would like to appreciate the support and cooperation they provided during the implementation of the National Roll-out of HPV vaccination, Distribution of Long Lasting Insecticidal Treated Nets in selected schools, De-worming, Development of school Health Micro-Plans between health facilities and catchment schools and Participation in Child Health Days.

The purpose of this circular is to bring to your attention the following health promotion activities to be conducted in your schools:

- i) Establishment of clubs to discuss health issues affecting learners including: malaria, HIV/AIDS, Tuberculosis, Immunisable diseases, Non Communicable Diseases, Diarrheal diseases (WASH) and nutrition.

- ii) School Management Committees/Board of Governors to ensure the following malaria control interventions are properly implemented:
 - a. Indoor Residual Spraying (IRS) for both dormitories and classrooms & toilets conducted during the holidays
 - b. Screening of the windows and ventilators
 - c. Encouraging learners to use protective clothing to limit mosquito bites (long sleeves and trousers in the evenings/night)
 - d. Clearing bushes around schools and homes.
 - e. Draining any stagnant water (Draining gutters, broken containers, covering water drums/containers) to destroy breeding sites for mosquitoes
- iii) Work with the nearest health facility to develop a schedule for providing health education talks and referral mechanisms for learners in case of complicated malaria and other medical conditions of concern.
- iv) Follow up cases of school absentees to establish reason and provide possible support where required.

We would like to emphasize the need for updated appropriate messages, regular supportive supervision and continuous monitoring and evaluation to identify gaps in the implementation and address them in a timely manner to ensure malaria free schools by 2020.

We look forward to your support and cooperation

[Signature]
Dr. Daniel Nkaada
For: **PERMANENT SECRETARY**

Copy: District /Municipal Education Officers,
" Director, Education and Social Services, KCCA.
" District /Municipal Inspectors of Schools
" Board of Governors Chairpersons,
" School Management Committee chairpersons,
" Head Teachers.

Telegram: "EDUCATION"
Telephone: 234451/8
Fax: 256-41-234920

**Ministry of Education and Sports
Embassy House
P.O. Box 7063
Kampala Uganda
Website: www.education.go.ug
Email: permasec@gmail.com**

CIRCULAR NO. 15

The Chief Administrative Officers/Town Clerks
Executive Director, Kampala City Council Authority

NATIONAL EFFORTS TO STRENGTHEN THE MASS ACTION AGAINST MALARIA THROUGH SCHOOLS DURING THE MONTH OF APRIL

The Ministry of Education and Sports in collaboration with the Ministry of Health have rolled out the Mass Action Against Malaria (MAAM) with the overall objective of achieving a **Malaria Free Uganda by 2030**. The program is intended to achieve a **Malaria Free School environment** since Malaria is the number one cause of morbidity, mortality, poor academic performance and drop outs in schools. Community surveys have shown that children of school going age (5 to 15 years) have the highest Malaria prevalence.

In 2018, the Ministry of Health joined the National Music Dance and Drama (MDD) competitions for Secondary and Primary schools to promote the fight against Malaria. Both Ministries agreed to use edutainment (education through entertainment) channel of MDD competitions in schools to transform and equip learners with knowledge and skills as change agents to fight Malaria. However with the outbreak of the Covid-19 epidemic in 2020, the program was halted due to various concerns.

One of the measures to continue implementing the MAAM program, the two ministries wish to use the Malaria month of April to educate and sensitize schools about Malaria prevention and control. The District Education Officers (DEOs) and Head Teachers are very critical in the dissemination of Health information and practices to the learners and the communities they serve.

The purpose of this circular is to bring to your attention the following health promotion activities to be conducted in your schools during the Malaria month of April;

- i). Activation of Science Clubs to discuss Malaria prevention and control measures to learners. These discussions should also include other common diseases such as HIV/AIDS, Tuberculosis, Immunisable diseases, Non Communicable Diseases, Diarrheal diseases (WASH) and nutrition.

- ii). School Management Committees/Board of Governors should ensure the following Malaria control interventions are properly implemented:
 - a. Indoor Residual Spraying (IRS) for dormitories, classrooms and toilets
 - b. Clearing bushes around schools and homes that can aid the breeding of mosquitoes,
 - c. Draining any stagnant water (draining gutters, broken containers, covering water drums/containers) to destroy breeding sites for mosquitoes.
 - d. Screening of the windows and ventilators of school facilities,
 - e. Encouraging learners to use protective clothing to limit mosquito bites (long sleeves and trousers in the evenings/night)

We look forward to your support and cooperation.

[Signature]
Ismael Mulindwa
For: **PERMANENT SECRETARY**

c.c: Director, Education and Social Services, KCCA
Commissioner, Basic Education
District /Municipal Education Officers,
District /Municipal Inspectors of Schools
Board of Governors Chairpersons,
School Management Committee Chairpersons
Head Teachers.

Conclusions/ Recommendation

- Malaria is both a **result** and a **cause** of a lack of development and should be seen as a development issue.
- The **Malaria Multisectoral Action Framework** adds this development dimension, by making actions **outside** the health sector **essential components** of malaria control
- Multisectoral Partnerships contributes to the current need for sustainable domestic resource mobilization.
- National Malaria Programmes need to have Multisectoral engagement Objective in their strategic plans
- CRSPC to recruit Consultants for supporting countries on Multisectoral engagement (Trained by MSWG)
- MSWG to develop performance indicators for multisectoral engagement
- Annual SRN meetings should have Multisectoral engagement progress reporting

Thank you, find out more visit
[https://endmalaria.org/our-work-working-
groups/multi-sectoral-action](https://endmalaria.org/our-work-working-groups/multi-sectoral-action)

SADC Malaria Report 2022 Prep

Quantitative Data Collection

Epidemiological
data – Control

Epidemiological
data -
Elimination

Intervention
data

Finance data

Covid-19 data
(2020-March
2022)

Qualitative Data Collection

Interventions

Achievements

Challenges

Lessons
learnt

Best Practices
with high
quality pictures

Interventions

2017

2018

2019

2020

2021

Country
Year
Month
Estimated population (mid-year)
Pop at risk of malaria
Total Positive cases that received treatment / ACTs
Number of Positive Cases Treated at Community Level
Number of cases treated at Facility level
Population targeted for mass LLINs
of LLINs distributed (mass)
of LLINs distributed (CD)*
Administrative coverage of LLINs (1 LLIN per 2 people) - mass
Total LLINs distributed (mass + CD)
Population targeted for IRS
Population protected by IRS
% popn targeted protected by IRS
No of Rooms targeted for IRS
No. of rooms sprayed
% rooms targeted sprayed
Number of pregnant women who receive three or more doses of IPTp
Number of expected pregnancies
IPT3 Coverage
Budget available - External sources (Partners)
Budget available - Government (\$)
Total funding needed (from strategic plan costing) (\$)

Control Epi
Data
Jan 2021-
Mars 2022

COUNTRY NAME
Year
Month
Population @risk
All-cause outpatient
All-cause admission
All-cause deaths
Suspected cases
Outpatient malaria cases (confirmed + presumed)
Malaria inpatients
Malaria deaths
Tested (Mic+RDT)
Positive (Mic+RDT)
P. falciparum (Mic)
P. vivax (Mic)
Mixed (Mic, P.f + P.v)
Other (Mic)
P. falciparum (RDT)
P. vivax (RDT)
Mixed (RDT)
Cases Treated
Report completeness rate

SUBNATIONAL
Level 1/Province/Region
Population @risk
Total cases tested
OPD Confirmed malaria cases
Outpatient malaria cases (confirmed + presumed)
Malaria inpatients
Malaria deaths
Cases Treated
Report completeness rate

Elimination
Epi Data
Jan 2021-
Mar 2022

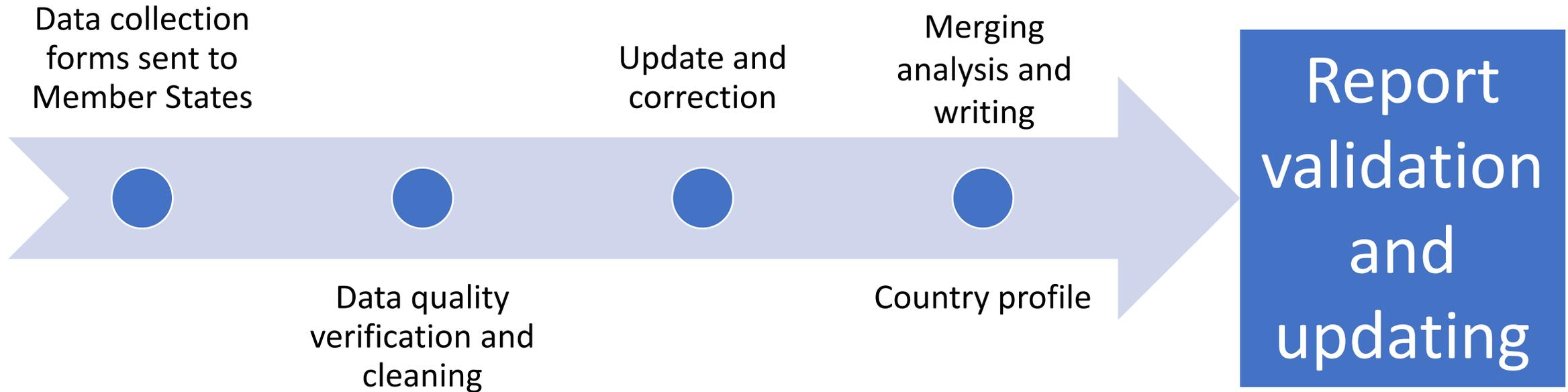
COUNTRY NAME
Year
Month
Population @risk
All-cause outpatient
All-cause admission
All-cause deaths
Suspected cases
Outpatient malaria cases (confirmed + presumed)
Malaria inpatients
Malaria deaths
Tested (Mic+RDT)
Positive (Mic+RDT)
P. falciparum (Mic)
P. vivax (Mic)
Mixed (Mic, P.f + P.v)
Other (Mic)
P. falciparum (RDT)
P. vivax (RDT)
Mixed (RDT)
Cases Treated
Report completeness rate

SUBNATIONAL
Level 1/Province/Region
Population @risk
Total cases tested
OPD Confirmed malaria cases
Outpatient malaria cases (confirmed + presumed)
Malaria inpatients
Malaria deaths
Cases Treated
Report completeness rate

Elimination
Data
Jan 2021-
Mar 2022

Number of health facilities reporting
positive cases investigated
cases classified
local cases
imported cases
foci identified (new or changed status)
Number of new foci investigated
Number of foci classified
foci classified as active
foci classified as non-active or cleared-up (with intervention)
foci classified as naturally malaria free (we need more country feedback if this is needed)
foci with response
foci responded with MDA
foci responded with IRS
foci responded with LLIN/hummock
foci responded with larviciding
foci responded with combination of intervention
cases notified within 24hrs (after diagnosis)
cases investigated within 3 days (after diagnosis)
foci investigated within 3-5 days (after diagnosis)
foci with response within 7 days (after diagnosis)
Report completeness rate

Report development processes



Outline for documenting best practices

Title of the best practice should be concise and reflect the practice being documented.

Introduction should provide the context of and justification for the practice, and address the following issues:

- ✓ What was the problem that needed to be addressed?
- ✓ Which population was affected?
- ✓ How did the problem impact on the population?
- ✓ Which objectives were achieved?

Implementation of the practice

- ✓ What were the main activities carried out?
- ✓ When and where were the activities carried out?
- ✓ Who were the key implementers and collaborators?
- ✓ What were the resource implications?

Results of the practice – outputs and outcomes

- ✓ What were the concrete results achieved with regard to outputs and outcomes?
- ✓ Was an assessment of the practice carried out? If yes, what were the results

Lessons learnt

- ✓ What worked really well – what facilitated this?
- ✓ What did not work – why did it not work?

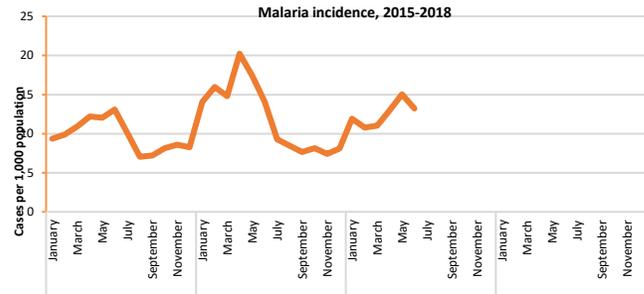
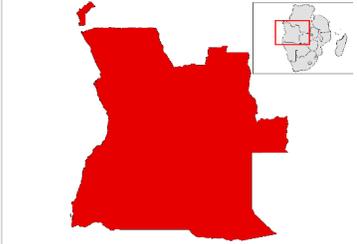
Conclusion

- ✓ How have the results benefited the population?
- ✓ Why may that intervention be considered a “best practice”?
- ✓ What recommendations can be made for those intending to adopt the documented “best practice” or how can it help people working on the same issue(s)?



ANGOLA

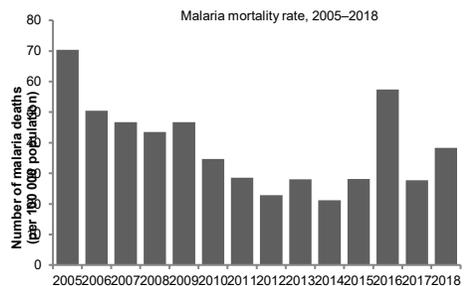
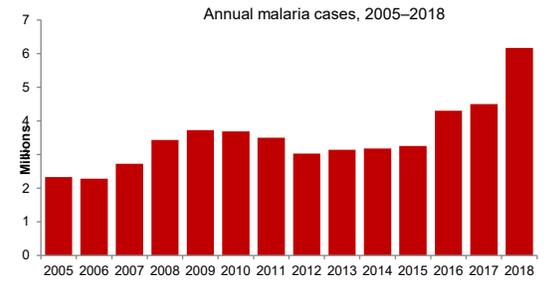
Angola has scaled up vector control interventions in the last years. There has been an improved case management that has seen a reduction in malaria related deaths. Malaria funding has continued to increase from the xxxx



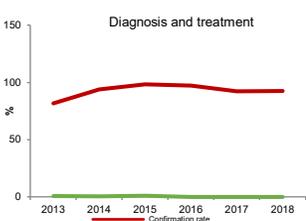
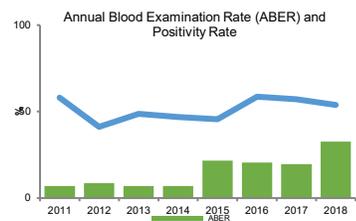
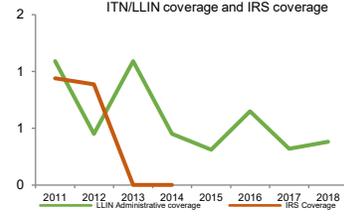
ENTOMOLOGY

- XX is the main vector specie in the country
- No resistance has been detected since xxx
- The country conducts xxxx testing regularly and this is done on LLINs

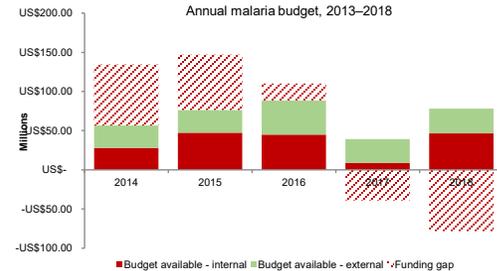
EPIDEMIOLOGY



INTERVENTIONS



MALARIA FUNDING



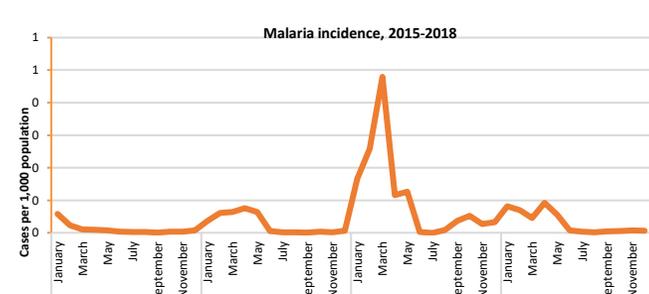
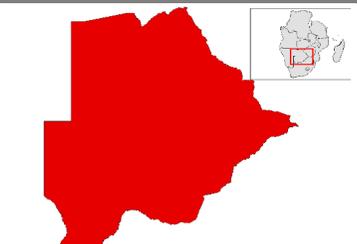
IMPACT

	2015	2016	2017	2018
Number of confirmed malaria cases	3,254,270	4,301,146	4,500,221	6,169,557
Number of malaria deaths	7832	15997	7729	11814
REPORTING COMPLETNESS				
	2015	2016	2017	2018
% reporting completeness	81%	80%	0%	0%



BOTSWANA

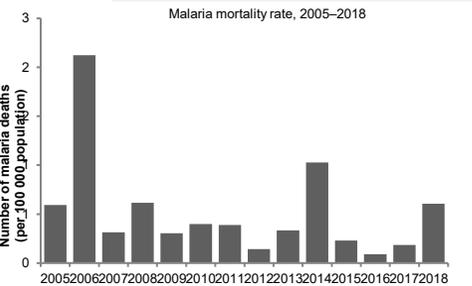
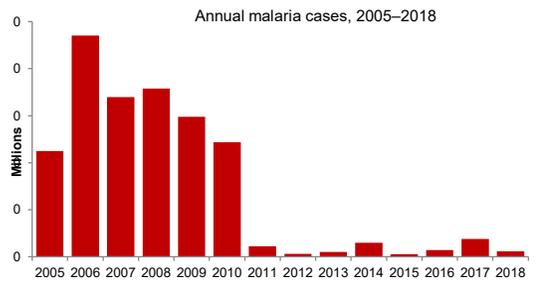
Botswana has scaled up vector control interventions in the last years. There has been an improved case management that has seen a reduction in malaria related deaths. Malaria funding has continued to increase from the xxxx



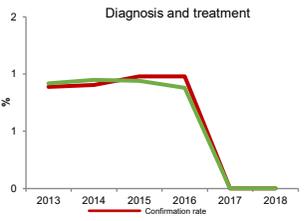
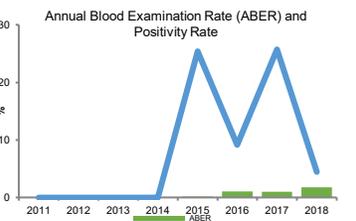
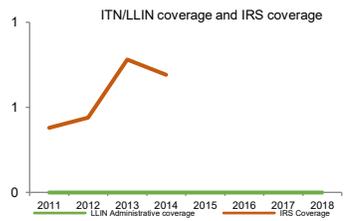
ENTOMOLOGY

- XX is the main vector specie in the country
- No resistance has been detected since xxx
- The country conducts xxxx testing regularly and this is done on LLINs

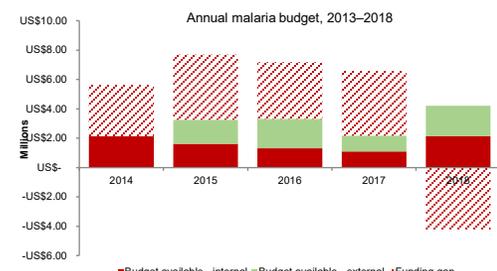
EPIDEMIOLOGY



INTERVENTIONS



MALARIA FUNDING



IMPACT

	2015	2016	2017	2018
Number of confirmed malaria cases	291	721	1,902	592
Number of malaria deaths	5	2	4	9
REPORTING COMPLETNESS				
	2015	2016	2017	2018
% reporting completeness	81%	80%	0%	0%

Forms Received

COUNTRY	INTEVENTIONS	CONTROL	ELIMINATION
ANGOLA	NO	NO	NA
BOTSWANA	NO	NO	NO
COMOROS	YES	NA	NO
DEMOCRATIC REPUBLIC OF CONGO	NO	NO	NA
ESWATINI	YES	YES	YES
MADAGASCAR	YES	YES	NA
MALAWI	YES	YES	NA
MOZAMBIQUE	YES	YES	NA
NAMIBIA	YES	YES	YES
SOUTH AFRICA	YES	YES	YES
TANZANIA ML	YES	YES	NA
ZAMBIA	NO	NO	NA
ZANZIBAR	YES	YES	YES
ZIMBABWE	YES	YES	YES

Data Issues identified

- General data not complete (Common Denominator)
 - Mid year Population/ Population at risk/All Cause attendance/admission /deaths
- Incomplete templates (Zero vs Blank)
- Deaths vs Inpatients/Admission
- Treated cases / Positive cases and Presumed
- Cases notified/investigated and classified

Thank you

SADC Malaria Elimination Agenda Update

**Dr. Joseph Mberikunasje
Regional Malaria Coordinator, Harare, 5-8 July 2022.**

Guiding Documents

- SADC Protocol on Health
- Windhoek Malaria Elimination Declaration
- SADC Malaria Strategic Plan 2022-2030
- GTS 2016-2030
- AIM 2016-2030

Guiding Principles

1. *“Comprehensive, whole of society investment approach” to malaria programming*, that is, focus on and pay equal attention to implementing a triple response to priority diseases malaria (technical response; health systems response; and multi-sectoral response)
2. *Enhanced investment efficiency in intervention approaches*, that is, achieving more with available resources; through (a) informed identification of high risk or priority districts, communities or populations, and (b) malaria interventions tailored to local contexts.
3. *Area or community protection approach*, that is, targeted deployment of malaria prevention interventions at high enough coverage level (effective coverage, saturation) to induce community effect

Strategic Framework

Vision: To have a malaria free SADC region

Mission: To strengthen the efforts of Member States in accelerating, scaling up cost effective, equitable, evidence based and universally accessible malaria interventions through a unified response.

Goal: To eliminate malaria in all SADC countries by 2030

Objectives

- 1) To advocate for the **creation of enabling environment** to achieve malaria elimination by 2030 in the SADC region.
- 2) To **ensure adequate resources** for the acceleration of malaria elimination in SADC countries.
- 3) To achieving and maintain **high quality universal access** and coverage of **key effective and appropriate malaria interventions** for all MS by 2030.
- 4) To strengthen **robust, real-time surveillance, Monitoring and Evaluation Systems** for evidence-based decision making by 2024.
- 5) To accelerate and achieve malaria elimination from the national borders of all SADC member states by 2030.

Malaria Work Plan Implementation Update

Planned Activities

Focus Area	Main Activity	Progress made to date	Comment
Strengthening Coordination	Finalize and cost SADC MSP 2022-2030	Done. Total cost for is around usd 38 million	Final document to be translated into French and Portuguese languages and launched on the next SADC Malaria Day
	Conduct Rapid Programme Capacity Assessment	Completed	MS Strategic Plans and Malaria Review reports and MS Key Informants used..
Strengthen Programme Capacity	Conduct Quarterly review and planning meetings	2 held so far Work	Meetings used to provide technical updates, allow for cross- learning and peer reviewing and TA needs.

Planned Activities Ct.

Focus Area	Activity	Progress So Far	Comment
Accountability	Development of SADC Malaria Report Annual	Data collection Underway	Validation meeting for the draft report planned for end of August-September before finalization and presentation to Ministers in November
Cross Border Collaboration	Development of a Malaria Cross border Framework, SOP, or Minimum Standards framework for use by MS	Underway, Consultant engaged, linked with partner organizations	Final Framework to be tabled for approval by Health Ministers in November 2022. MS TWG required to work with the consultant

SADC Malaria Programmes Capacity Assessment Report

Key Elements Assessed

1. Dedicated, stable, comprehensive programme structure-(Governance system how it links all levels- policies, budgets allocation and implementation. Programme level ,Reach skills sets & partnerships)
2. Dedicated predictable and sustainable financing- (Financing landscape, patterns, sustainability)
3. Effective Targeting of Appropriate Interventions- (availability and use of robust Surveillance, and Health Management Information Systems and Updated Malaria Risk Stratification)
4. Effective and consistent deployment of appropriate high impact Interventions - (What is done, Where, When and how often, why and at What population



PILLARS	ASSESSMENT (%)
Dedicated Structures Assessment	88
Predictable Financing	67
Effective Targeting	81
Deployment of High Impact Interventions	79



PILLARS	ASSESSMENT %
Dedicated Structures Assessment	85
Predictable Financing	63
Effective Targeting	65
Deployment of High Impact Interventions	80



PILLARS	ASSESSMENT %
Dedicated Structures Assessment	85
Predictable Financing	81
Effective Targeting	70
Deployment of High Impact Interventions	80



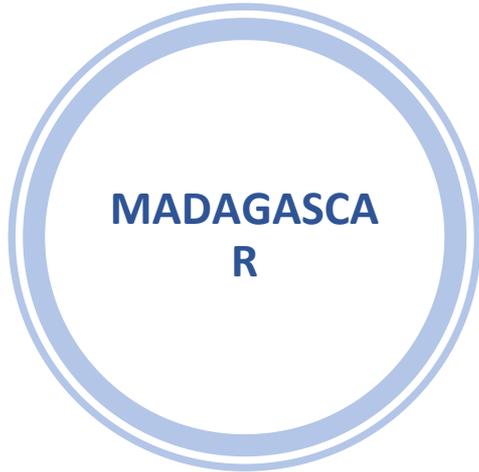
PILLARS	ASSESSMENT %
Dedicated Structures Assessment	80
Predictable Financing	63
Effective Targeting	90
Deployment of High Impact Interventions	85



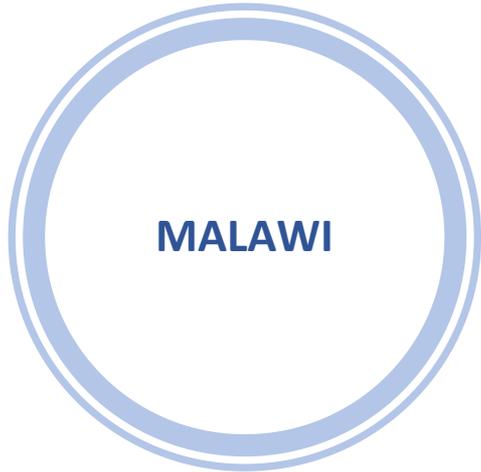
PILLARS	ASSESSMENT %
Dedicated Structures	75
Predictable Financing	56
Effective Targeting	55
Deployment of High Impact Interventions	60



PILLARS	ASSESSMENT %
Dedicated Structures	90
Predictable Financing	88
Effective Targeting	100
Deployment of High Impact Interventions	80



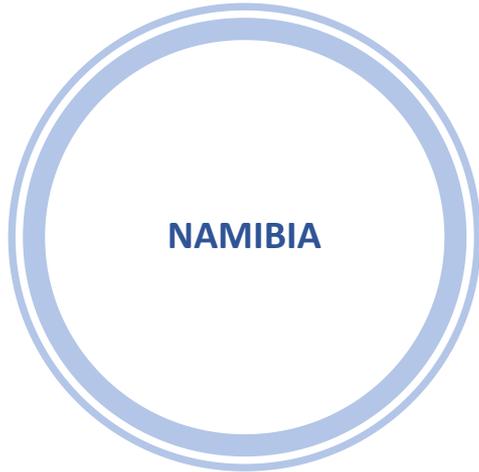
PILLARS	ASSESSMENT%
Dedicated Structures	95
Predictable Financing	75
Effective Targeting	100
Deployment of High Impact Interventions	80



PILLARS	ASSESSMENT %
Dedicated Structures	90
Predictable Financing	63
Effective Targeting	75
Deployment of High Impact Interventions	70



PILLARS	ASSESSMENT %
Dedicated Structures	85
Predictable Financing	63
Effective Targeting	70
Deployment of High Impact Interventions	85



PILLARS	ASSESSMENT %
Dedicated Structures	85
Predictable Financing	81
Effective Targeting	100
Deployment of High Impact Interventions	70



PILLARS	ASSESSMENT %
Dedicated Structures	100
Predictable Financing	100
Effective Targeting	95
Deployment of High Impact Interventions	85



PILLARS	ASSESSMENT %
Dedicated Structures	90
Predictable Financing	63
Effective Targeting	80
Deployment of High Impact Interventions	75



PILLARS	ASSESSMENT %
Dedicated Structures	95
Predictable Financing	69
Effective Targeting	75
Deployment of High Impact Interventions	80



PILLARS	ASSESSMENT %
Dedicated Structures	90
Predictable Financing	69
Effective Targeting	65
Deployment of High Impact Interventions	85



PILLARS	ASSESSMENT %
Dedicated Structures	90
Predictable Financing	63
Effective Targeting	90
Deployment of High Impact Interventions	90

Recommendations

1. The malaria endemic Member States n with normative support from WHO should address the issue of HR skill sets, reach and stability to enable continuous and sustained attention to malaria elimination tasks for all levels(explicit regional standards on qualifications and numbers).
1. The region needs to strengthen resource mobilization both domestic and international to achieve levels of resources needed by programmes to achieve their targets (Only four countries had evidence of resource mobilization plans in their reports)

Recommendations Cont`d.

3. The Member States to prioritize updating their malaria risk stratification exercises and consistently deploy malaria elimination interventions in line with the WHO Annual Parasite Incidence criteria to scale.

4. SADC Secretariat working with MS and ALMA to develop a scorecard based on the key elements to enable high level tracking of support to these.

SAMR 2022 Development Progress Update

- Support for lead Consultant secured through the RBM
- Consultant working under the guidance of WHO AFRO
- Template developed and sent out
- Member States submitting Data
- Next Steps - data cleaning, merging, analysis
- Capturing of best practices- Consultant to share the criteria

Best Practices for The Region

Area Identified	Member States
Improving access to services, ownership & sustainability through increased use of Community based workers and structures (prevention services, testing and treatment, monitoring)	Angola, Botswana, Madagascar, Zambia & Zimbabwe
Strengthened Entomology surveillance-rooftop surveys, sentinel based routine monitoring	Mauritius, Mozambique, Zimbabwe

Best Practices for The Region

Area Identified	Member States
Development of robust Commodity Tracking tools and platforms	Mozambique,Zambia, Zimbabwe
Unlocking domestic financing- formation of innovative financing mechanism (EMCs/EMF)	Zambia, Eswatini,Mozambique
Strengthening/operationalizing effective cross-border collaboration	URT Mainland, MOSASWA,E8 MS

Development of Progress Tracking Tools- e.g Regional Scorecards

2020	Epidemiology									Vector Control		Financing	Policy					Management	
	Number of Confirmed Malaria Cases	Malaria Incidence Rate	Indigenous Malaria Incidence Rate	Reported Indigenous Malaria Cases	Reported Malaria Deaths	Test Positivity Rate (%)	Proportion of suspected Cases Tested (%)	Completeness of Reporting (%)	Proportion of Confirmed Cases Treated as per Guidelines (%)	IRS Operational Coverage (%)	LLINs Operational Coverage (%)		National Public Sector Financing (%)	Surveillance			Diagnosis		Treatment
Malaria Is A Notifiable Disease (YES/NO)												Case And Foci Investigation And Case Classification Is Conducted		Case Reporting From The Private Sector Is Mandatory	Quality Assurance Oversight By National Reference Laboratory	Treatment of cases with primaquine	National malaria elimination committee is in place		
FRONT-LINE COUNTRIES																			
Botswana	927 ↑	0.39 ↑	0.36 ↑	868 ↑	11 ↑	8.3 ↑	94.2	86.5	98	76.5	97	11.4	YES	YES	YES	YES	BOTH	YES	
Eswatini	322 ↓	0.95 ↓	0.69 ↓	235	4 ↑	1.3	100	89 ↓	100	92.0 ↑		10.5	YES	YES	YES	YES	BOTH	YES	
Namibia	13,633 ↑	5.40 ↑	7.30 ↑	12,581 ↑	43 ↑	10.0 ↑	99	90	96	62.0 ↑		12.0	YES	YES	YES	YES	BOTH	YES	
South Africa	8,126 ↓	0.84 ↑	0.33 ↑	3,173	38 ↓		100	96	100	89.0 ↑		13.0	YES	YES	YES	YES	BOTH	YES	
SUB-NATIONAL ELIMINATION DISTRICTS																			
Mozambique ¹	55,072 ↓	26.40 ↓	26.40 ↓	55,072 ↓	6 ↓	19.5 ↑	100	97	98	99.0 ↑	100		YES	NO	NO	YES	NO	YES	
Zambia ²	172,200 ↑	144.30 ↑			37 ↑	38.2 ↑	97	93	97	94.0 ↑	98.9		YES	YES	IN PROGRESS	YES	NO	YES	
Zimbabwe ³	12,992 ↑	2.00 ↑	1.00 ↑	6,960 ↑	78 ↑	23.3 ↑	100	99	97	93.0			YES	YES	NO	YES	BOTH	YES	
SECOND-LINE COUNTRIES																			
Angola	7,348,858 ↑	254.00			11,757 ↑	52.1	95.8	84	100 ↑	92.0		4.6	YES		YES	YES	BOTH		
Mozambique	11,318,685	377.00			563 ↓	58.0	100	96	97	98.0	75 ↓	12.3	YES			YES		YES	
Zambia	7,060,622 ↑	427.00 ↑			1,971 ↑	56.3 ↑	96	97	98	87.4	97	8.8	IN PROGRESS	IN PROGRESS	IN PROGRESS	YES		YES	
Zimbabwe	447,381 ↑	32 ↑			400 ↑	32.0 ↑	98	97	99	93.0	100	10.7	YES	YES		YES	BOTH	YES	

Challenges

1. Inadequacy of Human Resources for Health within the Member States programmes
2. Inadequate financing of Malaria Strategic Plans
3. Delays in Procurements for malaria commodities
4. Delayed response to Malaria epidemics
5. Limited participation of MS in regional activities

Key Priority Capacity Strengthening Needs for the Future

1. Regional Trainings for Malaria programme technical staff on
 - a. Elimination
 - a. Unpacking WHO Guidelines-IRS, IPTp etc and tracking coverage
1. Peer Learning/Exchange visits between/among Member States, where needed.
1. MS Thematic Working Groups to facilitate the Technical Committee work and Troika

Thank You!



**Social and Behavior Change
Working Group**

RBM SBC Working Group

Mariam Nabukenya Wamala, RBM SBC WG Co-Chair
Ashley Riley, RBM SBC WG Secretariat

RBM Partnership
To End Malaria

Social and Behavior
Change Working Group



Co-chairs: Mariam Nabukenya Wamala & Gabrielle Hunter

Social & Behavior Change Working Group

Core objectives

1. Technical guidance: Promote theory-informed, evidence-based programming focused on **behavior change** at the country level
2. Coordination and networking: Forum for exchange of malaria SBC best practices and experiences
3. Making the case: Be a voice to call for political, social, and financial resources to SBC as a core component of malaria control that cuts across all technical areas

**Engagement in English,
French, and Portuguese**

**50+ Countries
1000+ Members**

SBC WG Steering Committee



Nabukenya Mariam
Wamala, Co-Chair
Uganda



Gabrielle Hunter,
Co-Chair
US



Angela Acosta
US



Avery Avrakotos
US



Shelby Cash
US



Debora Freitas Lopez
US



Taonga Mafuleka
Malawi



Ibrahima Sanoh
Guinea



Naomi Serbantez
Tanzania

Francophone Ambassadors



**Jemima
Andraimihamina,**
Madagascar



**Mory
Camara,** Mali



Ida Savadogo,
Burkina Faso



**Ibrahima
Sanoh,** Guinea



Jean Jacques Brou,
Point of Contact

Lusophone Ambassadors



**Sergio
Tsabete,**
Mozambique



Suse Emiliano,
Angola



**Debora Freitas
López,** Point of
Contact

Social & Behavior Change Working Group

- Malaria interventions are highly dependent on human behavior
- Demand creation for products and services
- Appropriate use
- Change in underlying social norms
- Social, cultural, religious, gender, economic, ecological issues
- SBC encompasses: Advocacy, community and social mobilization, IPC, multi-level mass and social media campaigns, operational and behavior surveys

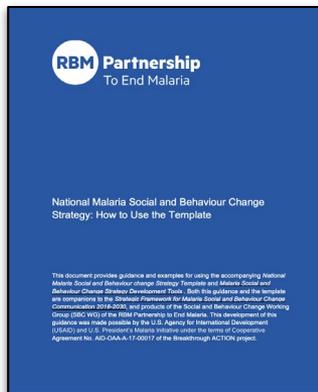
SBC Working Group Outcomes

- Engagement in English, French, and Portuguese
 - 50+ Countries
- New norms have formed
- Development of guiding resource documents
- Evidence based implementation
- Collaboration with all technical working groups
- Growing funding landscape
- Technical Assistance – Template for WG
- Political commitment for SBC resources
- Built capacity among NMCP and partners

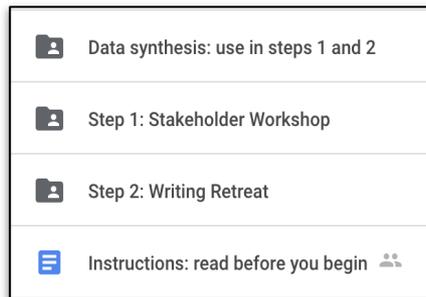
SBC Challenges for Malaria

- Low risk perception and low self efficacy
- Behavior relapses
- Socio-economic challenges at community level
- Limited funding for SBC
- Slow adaptation to emerging technologies
- Lack of continuity of activities
- Poor health provider attitude
- Structural challenges

National Malaria SBC Strategy Toolkit



**Template and Guidance
for National Malaria SBC
Strategies**
EN | FR | PT



**Malaria SBC
Strategy Workshop
Package**
EN | FR | PT

Behaviour Objective: Increase the proportion of [who] that [do what]	Audience: [who]
	Communication Objective: Increase the proportion of [audience] who [feel what]
	Key Benefit: If I do [this] then I will get [thing that I want].
Channels/Activities: List audience's feelings (list Channels - Activities)	

New!

Monitoring and Evaluation Plan								
Objectives	Indicator and Definition	Indicator Type	Rationale	Data Source	Baseline	Target	Year	Next steps
ITN Objectives								
Case Management Objectives								
Malaria in Pregnancy Objectives								
IRS Objectives								
SBC Objectives								

**Guidance for SBC for Low-
Moderate Malaria
Transmission Zones**
EN | FR | PT

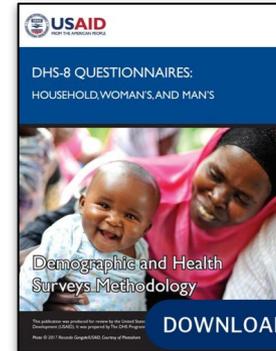
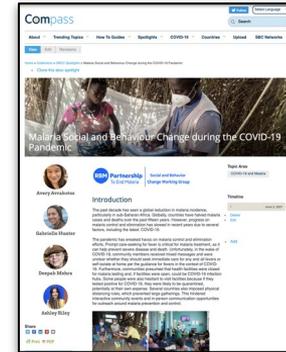
Find them all on www.endmalaria.org

Recent Activities

[All resources available on endmalaria.org!](https://endmalaria.org/)

- **Malaria SBC during COVID-19**
 - Curated case studies showcasing successful implementation of malaria SBC in the context of COVID-19
 - Updated Guidance for Malaria SBC during COVID-19 (2022)

- **MIS SBCC Module**
 - Added SBC data interpretation guide to a collection of resources for the MIS



Community Health Worker Toolkit

- **Objective:** Develop a package of 6 modules which can be adapted to country-specific contexts.
- **Purpose:** A resource for supervisors of CHWs to train them in malaria SBC.
- **Status:** In development

Module 1: Principles of Social and Behavior Change

Module 1 Objectives

- Define social and behavior change and service communication
- Understand principles of social and behavior change
- Recognize barriers to adopting or modifying social and behavior change
- Learn the role of community health workers at each level of health care

Defining Social and Behavior Change

How can a community health worker (CHW) improve the health outcomes of individuals and groups in their community? In many cases, simply providing health education throughout communities is not enough. For example, a CHW can tell someone that sleeping under an insecticide treated net will prevent malaria. However, sometimes this is not enough for that person to begin consistently sleeping under a net.

Social and Behavior Change (SBC) is an interactive process that enables individuals, families, and communities to adopt and sustain healthy behaviors, such as seeking care for fever or sleeping under a mosquito net. SBC aims to positively change behaviors by shifting knowledge, perceptions, attitudes, beliefs, and social norms in communities. SBC enables individuals, families, groups, communities, and countries to increase control of their health to best behavior lives.

SBC may include communication and non-communication approaches throughout the toolkit. Social and behavior change approaches aim to impact individual, family, and community behaviors and health practices.

CHWs can use SBC to influence a part prevent malaria in their communities. They are and are trained to communicate are well-positioned to share information of behaviors that can prevent malaria and

Module 2: Social and Behavior Change Approaches

Module 2 Objectives

- Understand social and behavior change approaches for community health workers
- Identify platforms community health workers can use for social and behavior change
- Prioritize social and behavior change approaches for community health workers

Social and Behavior Change Approaches for Community Health Workers

There are many SBC approaches CHWs can use to improve malaria outcomes in their communities. In this module, you'll learn about a few key approaches for CHWs, approaches that are most effective for CHWs and when implemented in a combination with an array of approaches. Each of the approaches below allows CHWs to impact each behavioral determinant introduced in Module 1.

Communication Approaches

Social and behavior change communication (SBCC) uses communication to impact individual, family, and community decisions to improve personal and community behaviors and health practices. SBCC combines information, education, and communication (IEC), behavior change communication (BCC), and interpersonal communication (IPC). SBCC combines information, education, and communication to empower families, groups, and people to make healthy decisions, change their behaviors, and create a healthy community. IPC is the shared sharing of ideas, thoughts, and feelings between two or more people to address the reasons people behave the way they do. Over time, BCC, IPC, and SBCC have evolved into SBCC.

There are many communication approaches CHWs can use in their communities to promote social and behavior change in their communities.

Service Communication

Service communication uses SBC to positively influence health-related behaviors throughout the entire continuum of care, including before, during, and after health care services. Strong service

Implementing Social and Behaviour Change with Zero Malaria Starts with Me

- Showcases ZMSWM and SBC **complementary roles**
- Guidance on integrating ZMSWM into larger, more comprehensive SBC strategy
 - **Five Recommended Actions**
- Recent webinar: In-depth introduction to the SBC WG's Guidance and Sharing of country examples
 - **Recording available on Springboard soon**



Guidance available in EN | FR | PT

5 Recommendations Actions for Integrating ZMSWM with SBC strategies

1. Follow a defined strategic process

- Is there an evidence-based process that guides strategy development?

2. Determine key behaviors

- What specific behaviors are being promoted?

3. Determine the target population

- In what segment of the population is the key behavior more or less likely to be practiced?

4. Conduct formative research on the target audience

- What influences whether members of the target population practice the key behaviour?

5. Conduct continuous monitoring of key behaviors and known determinants

- Are the program activities having the intended effect?

New Workstream: RTS,S Vaccine

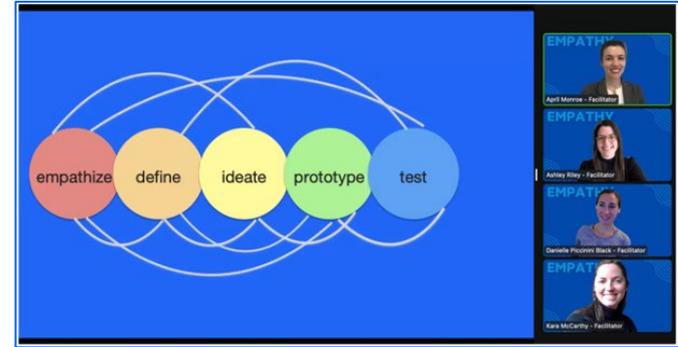
- **New Workstream:** June 2022 launch
- **Expected Deliverable:** Guidance on SBC for RTS,S vaccine implementation
- **Key Steps:**
 - Capture learnings from RTS,S pilot experience, as well as COVID vaccine introduction
 - Review technical reports and literature
 - Hold key informant interviews
 - Draft and revise guidance



Global Health Technologies Coalition

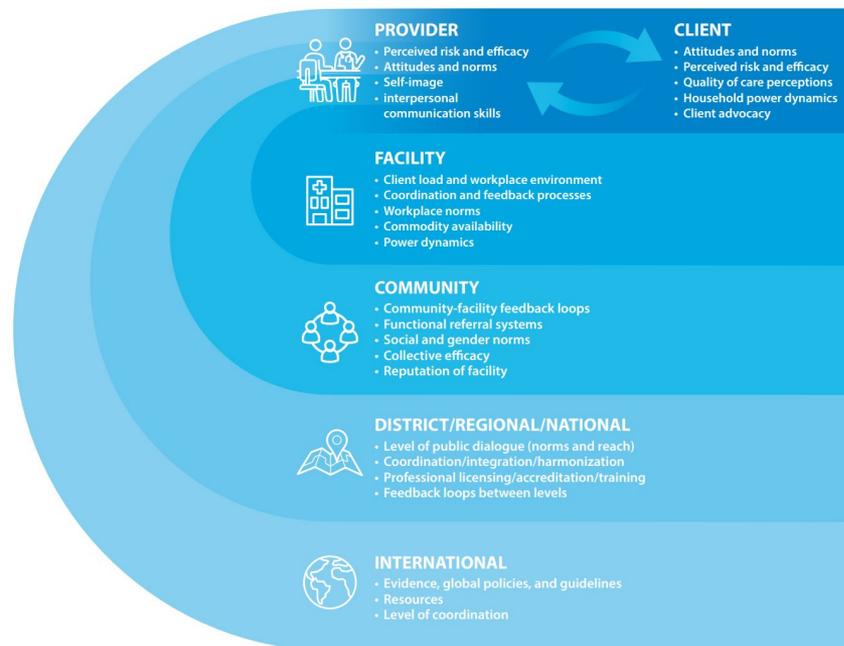
Human-Centered Design with VCWG

- HCD: A framework for fully understanding the needs, desires, and constraints of end users and key stakeholders
 - End users drive the path forward
- Co-hosted by SBC WG and VCWG
 - Johns Hopkins Center for Communication Programs
 - SC Johnson
- 3 workshops in March/April '22
 - Interactive, introduction to HCD
 - 3.5 hours of learning sessions and group work
- Purpose: Explain the importance of a human-centered mindset and identify potential applications of HCD in malaria control



July General Call - Register Today!

- **July 14, 2022**
 - **8-11 am EDT | 12-15:00 GMT | 13-16 West Africa | 14-17 Central Africa | 16-18 East Africa**
- **Technical Presentation:** The influence of psychosocial factors on provider fever case management in health facilities in Benin
 - Dr. Stella Babalola, Johns Hopkins Center for Communication Programs



SBC WG Annual Meeting | 2022 Virtual Forum

- **September 21 - 22 (on Zoom)**
 - 8-11 am EDT | 12-15:00 GMT | 13-16 West Africa | 14-17 Central Africa | 16-18 East Africa
- **Technical Presentations**
 - Panel Discussions
 - Lightning Presentations in Breakout Rooms
- **SBC WG Workstream Updates and Future Directions**
- **RBM WG Updates**



Special Recognitions - Regional

- Dr. Baltazar Candrinho - Moçambique
- Dr. José Franco Martins - Angola
- Fortunate Manjoro - Zimbabwe
- Sergio Tsabete - Moçambique (Lusophone Ambassador)
- Suse Emiliano - Angola (Lusophone Ambassador)
- Jemima Andraimihamina - Madagascar (Francophone Ambassador)
- Taonga Mafuleka - Malawi (Steering Committee)

Thank you! Merci! Obrigado!

Thank you - Stay in Touch!

Website: www.bit.ly/RBMSBCWG

Email List: www.bit.ly/RBM_SBCWG_EMAIL

Contacts:

Ashley Riley (ashley.riley@jhu.edu), Secretariat

Mariam Nabukenya Wamala (nabukem@yahoo.com), Co-Chair

Gabrielle Hunter (gabrielle.hunter@jhu.edu), Co-Chair

Task Team 2: Capacity and Cooperation

The Resistant Mosquito: Staying Ahead of the Game in the Fight against Malaria

- **Massive Open Online Course** on Insecticide Resistant Management
- **Free participation**
- Duration: 3 weeks
- Starting date: **Monday 25 July 2022**
- 42 steps, mixture of videos, animations, articles, quizzes, discussions, activities
- Case studies in Ghana, Tanzania, Zambia, Sri Lanka.
- On FutureLearn & Tales, link will follow
- Video trailer (2 min 39 sec) on YouTube or Vimeo
<https://www.youtube.com/watch?v=ZrsRrWyY184>
<https://vimeo.com/700720175>





Surveillance Practice and Data Quality Committee

July 2022

Before getting started...

Good morning!

Welcome to the SMERG's Surveillance Practice and Data Quality Committee presentation.

My name is Baltazar Candrinho, Myself and Arantxa Rocca we are Co-leaders for this group.

Before we are getting started, let's have a look at the objectives of this specific committee:

Overall Objectives



Disseminate information on implementing partners' current use of surveillance operational tools and improve implementation and partner coordination relating to their use and uptake.

Dynamically track surveillance initiatives and the implementation of related tools and practices.

Document the advantages and disadvantages of surveillance and data quality tools and activities, as well as the lessons learnt from their implementation.

Identify the operational surveillance priorities of national malaria control programs (NMCPs) to further support the uptake and adaptation of tools.

SMERG SP&DQ Committee Progress



Establishment phase

Decision taken during 31st SMERG Meeting in September 2020. ToR drafted, feedback collected in February and March 2021. Membership announcement in April. The committee is kicked off in May 2021. The governance is in place as of day one.



RBM SMERG SP&DQ Newsletter

Quarterly newsletter launched in August 2021 and on track. Three issues published in total. Last issue was open 973 times. Next issue will be disseminated in June 2022.



Malaria Routine Data in Action Webinar Series

Quarterly webinars launched in September 2021 and on track. Three series were realized. Next episode is under planning for June 2022.



Implementing Partners: Surveillance Projects Dashboard

First data collection was from beginning of October until mid November 2021. First landscape analysis were prepared and presented during 32nd SMERG Meeting. The questionnaire remains open.



NMCP Operational Surveillance Tracker

Design completed. Preparations ongoing. Coming soon!



Future Plans

Under discussion within committee

SMERG SP&DQ Committee Progress

100%



Establishment phase

Decision taken during 31st SMERG Meeting in September 2020. ToR drafted, feedback collected in February and March 2021. Membership announcement in April. The committee is kicked off in May 2021. The governance is in place as of day one.

Decision taken during 31st SMERG Meeting

Terms of References
From 19th February to 5th March

Call for membership,
8-12th March

Co-leads announcements,
23rd of April.

September 2020

May 2021

Informative Webinar
27th January

Terms of References
Finalization and dissemination
5th April

Committee Kick Off Meeting,
6th May

Please remember: The membership is a volunteer and open process. New members will be always welcomed.

SMERG SP&DQ Committee Progress

100%



RBM SMERG SP&DQ Newsletter

Quarterly newsletter launched in August 2021 and on track. Four issues published in total. The third issue was open 973 times, the fourth one is under monitoring

Total Opens

- First issue: 657
- Second issue: 890
- Third issue: 973
- Fourth issue: ongoing

Opinion Corner hosted by:

- First issue: Molly Robertson & Medoune Ndiop, SMERG co-chairs
- Second issue: Richard Maude, APMEN SRWG Co-Chair
- Third issue: Anna Winters, SMERG Community Health Committee
- Fourth Issue: Yazoume Ye, PhD, Vice President, Malaria Surveillance and Research Technical Director, PMI Measure Malaria Project (PMM)

Partners Corner hosted by:

- First issue: Jhpiego
- Second issue: Malaria Consortium
- Third issue: PSI
- Fourth Issue: CHAI

Country Corner hosted by:

- First issue: Adilson DePina, Cabo Verde
- Second issue: Perpetua Uhomoibhi, Nigeria
- Third issue: Lessons learned from Burkina Faso, DRC, Cameroon, Ghana
- Fourth Issue: Cambodia

Reading Suggestions: links & openings:

- First issue: 1 link, 123 openings
- Second issue: 24 links, 372 openings
- Third issue: 6 links, 197 openings
- Fourth Issue: Ongoing (disseminated in June)

If you did not have time to read yet

- [SP&DQ Committee Newsletter Issue #4](#)
- [SP&DQ Committee Newsletter Issue #3](#)
- [SP&DQ Committee Newsletter Issue #2](#)
- [SP&DQ Committee Newsletter Issue #1](#)

SMERG SP&DQ Committee Progress

100%



Malaria Routine Data in Action Webinar Series

Quarterly webinars launched in September 2021 and on track. Three series were realized. Next episode is under planning for June 2022.

Episode #1

- **Moderator:**
 - Dr Khoti Gausi, **WHO**
- **Panelists:**
 - Dr Adilson DePina, **Cabo Verde**
 - Dr Daniel Kyabayinze, **Uganda**
 - Dr Bridget Shandukani, **South Africa**
 - Dr Wahjib Mohammed, **Ghana**
- **Panel Discussion:**
 - What are the developments in Malaria SME context you witnessed during last 5 years in your country?
 - What are your current challenges related Malaria surveillance practices and data quality in your country?

Episode #2

- **Moderator:**
 - Dr Laura Anderson, **WHO**
- **Panelists:**
 - Dr Gauthier Tougri, **Burkina Faso**
 - Dr Alain Bokota, **DRC**
 - Dr Jean Fosso, **Cameroon**
 - Dr Wahjib Mohammed, **Ghana**
- **Panel Discussion:**
 - Piloting WHO Surveillance Assessment Toolkit
 - Findings and Recommendations

Episode #3

- **Moderator:**
 - Yazoume Ye, **ICF-SMERG**
- **Presenters:**
 - Julie Gutman, **CDC**
 - Kemi Tesfazghi, **PSI**
 - Gillian Stresman, **LSHTM**
- **Presentations:**
 - *AJTMH supplements initiative: Aim & How it works? & Next steps*
 - *Routine health facility- and antenatal care-based surveillance: challenges and opportunities*
 - *Generating and integrating private sector case reporting and response into national systems in the Greater Mekong Subregion*
 - *Optimizing routine malaria surveillance data in urban environments: A case study in Maputo City, Mozambique*

SMERG SP&DQ Committee Progress

75%



Implementing Partners: Surveillance Projects Dashboard

First data collection was from beginning of October until mid November 2021. First landscape analysis were prepared and presented during 32nd SMERG Meeting. The questionnaire remains open..

Questionnaire built and reviewed by the committee members in August-September period

APMEN Secretariat supported the initiative's dissemination by reaching out 9 of their members across their geography.

An **interim dashboard** was built and shared with the committee members.
Decision taken as to simplify the dashboard before opening to public.

August 2021

March 2022

Maintenance

SMERG Secretariat disseminated the questionnaire across all SP&DQ Committee members on 16th October 2021. The secretariat made follow up and reminders twice including the deadline extension until 15th November.

First landscape analysis prepared about who is doing, what and where in the scope of surveillance and data quality. The results presented during 32nd SMERG Meeting in November.

The simplified dashboard went live at RBM site on 9th March.

SMERG SP&DQ Committee Progress

75%



Implementing Partners: Surveillance Projects Dashboard

First data collection was from beginning of October until mid November 2021. First landscape analysis were prepared and presented during 32nd SMERG Meeting. The questionnaire remains open..

Malaria Surveillance Projects | RBM Partnership to End Malaria

Dashboards

Campaigns ▾

Supply Chain

Global Fund ▾

Technical Assistance

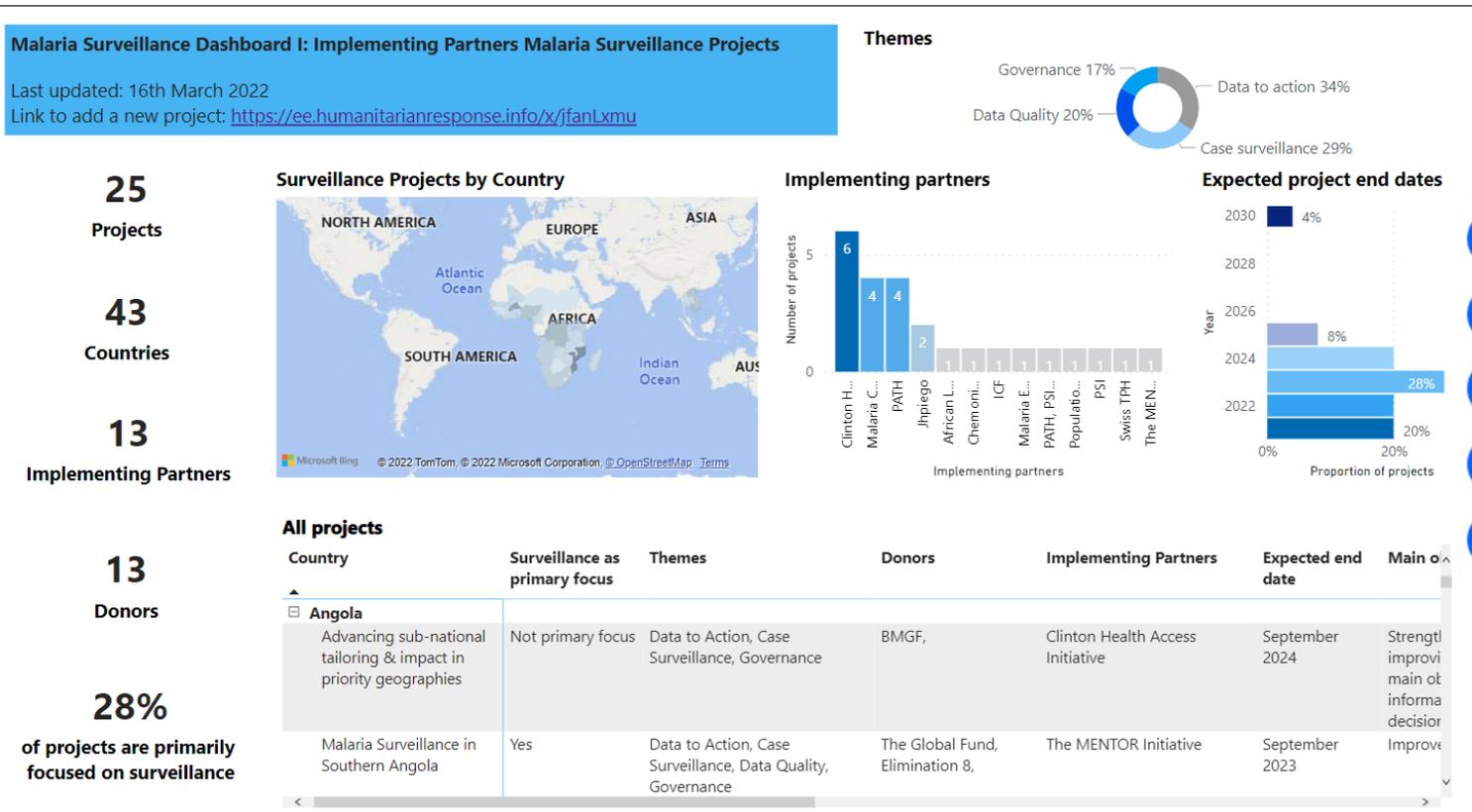
Malaria Epidemiology Dashboard

Programmatic and Financial GAPS

Forecasting of Global Malaria Commodities

Malaria Surveillance Projects

Notifications ▾



SMERG SP&DQ Committee Progress

75%



Implementing Partners: Surveillance Projects Dashboard

First data collection was from beginning of October until mid November 2021. First landscape analysis were prepared and presented during 32nd SMERG Meeting. The questionnaire remains open..

Keep using it!

[RBM SMERG Surveillance Practice & Data Quality Committee: Systematic tracker | Implementing partners questionnaire \(humanitarianresponse.info\)](#)

Please remember the questionnaire is kept open anytime.

You may add your new projects anytime

OR

You can share it with the implementing partners whose projects are not yet in the dashboard

Any ideas are
welcome on
engaging more
partners!

NMCP Operational Surveillance Tracker

25%



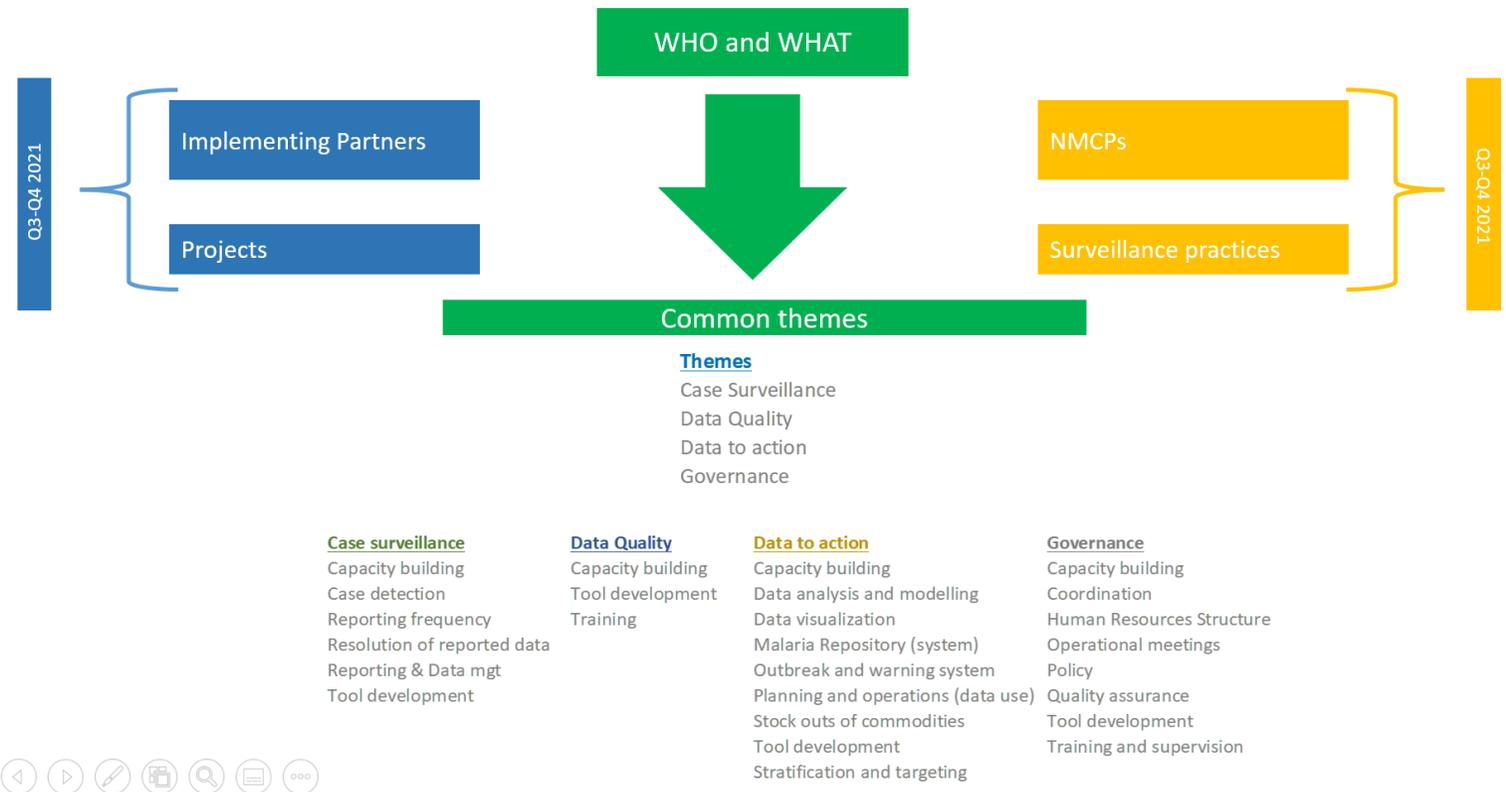
NMCP Operational Surveillance Tracker

Design completed. Preparations ongoing. Coming soon!

Before deep dive questionnaire...

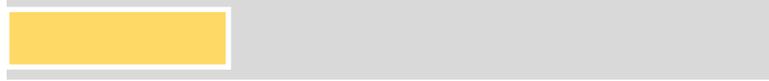
A little background and reminder..

A platform for systematic SP&DQ tracking



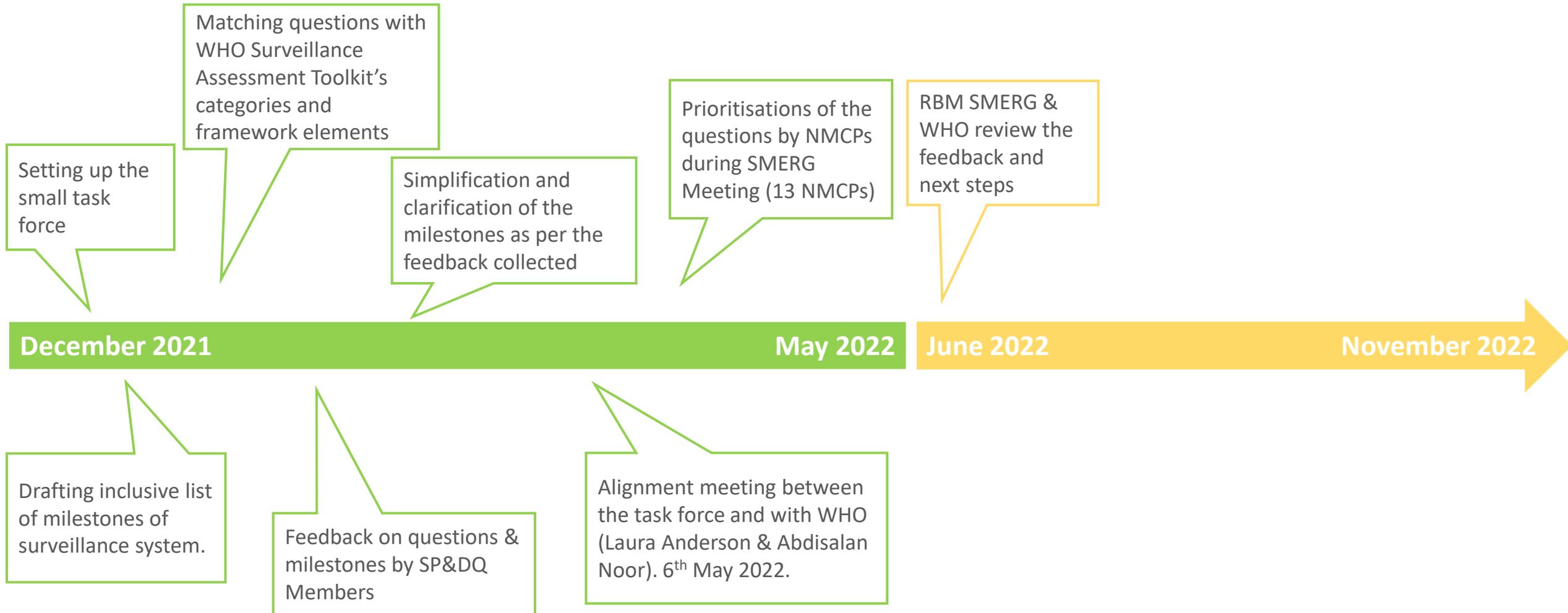
SMERG SP&DQ Committee Progress

25%



NMCP Operational Surveillance Tracker

Design completed. Preparations ongoing. Coming soon!



Questions ranked by NMCPs (13) feedback – Top 10

WHO toolkit categories	WHO framework elements	#	Questions	NMCP Rating (13)	Non-NMCP Rating (10)	Rank #
CONTEXT AND INFRASTRUCTURE	INFORMATION SYSTEMS	3	Does the country has some information system into which malaria variables are routinely reported?	4.8	4.2	1
TECHNICAL AND PROCESSES	RECORDING	13	Do you use standardised recording tools at all levels of the health system?	4.8	4.7	2
TECHNICAL AND PROCESSES	REPORTING	14	Do you use standardised reporting tools at all levels of the health system?	4.8	4.0	3
CONTEXT AND INFRASTRUCTURE	INFORMATION SYSTEMS	9	Is data from the information system available at health facility level at all administrative	4.7	3.9	4
TECHNICAL AND PROCESSES	DATA QUALITY ASSURANCE	23	At national level, are malaria surveillance in national databases assessed for quality (i.e. DQA conducted on completeness, timeliness, accuracy)?	4.6	3.8	5
CONTEXT AND INFRASTRUCTURE	SURVEILLANCE SECTORS & STRATEGIES	1	Do all sectors of the health system report malaria cases?	4.5	4.0	6
CONTEXT AND INFRASTRUCTURE	INFORMATION SYSTEMS	8	Is data from the information system available disaggregated by age/ sex at all administrative levels?	4.5	4.0	7
TECHNICAL AND PROCESSES	ANALYSIS	18	Is there a dedicated person responsible for conducting data analyses at subnational levels?	4.5	4.2	8
CONTEXT AND INFRASTRUCTURE	SURVEILLANCE GUIDELINES & SOPs	2	Are there guidelines available for malaria surveillance?	4.4	3.6	9
CONTEXT AND INFRASTRUCTURE	INFORMATION SYSTEMS	4	Is the malaria information system capable of producing reports and visualizations?	4.4	4.6	10

Questions ranked by NMCPs (13) feedback – Top 11-20

WHO toolkit categories	WHO framework elements	#	Questions	NMCP Rating (13)	Non-NMCP Rating (10)	Rank #
TECHNICAL AND PROCESSES	REPORTING	15	Does reporting occurs at the frequency expected given the country/ areas status on the transmission continuum? (e.g. high burden areas report monthly, elimination area report immediately)	4.3	3.7	11
BEHAVIOR (STAFF AND GOVERNANCE)	GOVERNANCE	27	Is there a functional (met in the last 3 months) SM&E Working Group at central level?	4.3	3.3	12
BEHAVIOR (STAFF AND GOVERNANCE)	SUPERVISION	29	Is there a supervision plan in place where supervisors check data quality (using a checklist or other outlined procedure) and share feedback?	4.3	3.7	13
CONTEXT AND INFRASTRUCTURE	INFORMATION SYSTEMS	6	If CHWs are reporting, are data from CHWs routinely integrated?	4.1	4.4	14
TECHNICAL AND PROCESSES	DATA QUALITY ASSURANCE	21	At intermediary levels, are malaria surveillance data routinely reviewed for quality (i.e. rDQA conducted on completeness, timeliness, accuracy) before being submitted to the next level?	4.1	4.1	15
TECHNICAL AND PROCESSES	ANALYSIS	17	Do you produce routine malaria bulletins summarising epidemiological and programmatic data?	4.0	3.9	16
TECHNICAL AND PROCESSES	DATA QUALITY ASSURANCE	22	At intermediary levels, are data review meetings held to review data quality indicators (completeness, timeliness, accuracy) ?	4.0	4.2	17
BEHAVIOR (STAFF AND GOVERNANCE)	SURVEILLANCE STAFF PROFICIENCY	28	Do you have training mechanisms in place for malaria surveillance and data quality?	4.0	3.7	18
CONTEXT AND INFRASTRUCTURE	INFORMATION SYSTEMS	10	Is there a georeferenced masterlist of operating HFs updated regularly?	3.9	3.9	19
CONTEXT AND INFRASTRUCTURE	INFORMATION SYSTEMS	7	If the private sector is reporting, are data from the private sector routinely integrated?	3.6	4.3	20

Non prioritized Questions by NMCPs (13) feedback

WHO toolkit categories	WHO framework elements	#	Questions	NMCP Rating (13)	Non-NMCP Rating (10)	Rank #
TECHNICAL AND PROCESSES	REPORTING	16	Data reported is aggregated to the level expected given the country/ areas status on the transmission continuum (e.g. high burden areas report aggregate cases by sex and age category, elimination areas report individual level notification age, sex, residence, travel history and case classification)	3.6	3.4	21
CONTEXT AND INFRASTRUCTURE	INFORMATION SYSTEMS	5	Does the country have an integrated national electronic malaria database which collects information on cases, interventions, commodities and finances, with subnational disaggregation of data e.g national malaria data repository?	3.5	4.0	22
CONTEXT AND INFRASTRUCTURE	INFORMATION SYSTEMS	11	Is there a georeferenced masterlist of operating CHWs updated regularly?	3.4	3.3	23
CONTEXT AND INFRASTRUCTURE	FINANCIAL SUPPORT	12	What is the proportion of malaria surveillance costs were funded (by domestic and/or donor funding) in the current or previous NSP period? Where 'costs' including HR, equipment, maintenance, other technical support etc.	3.4	3.1	24
TECHNICAL AND PROCESSES	RESPONSE SYSTEMS	24	Is there an SOP or formalized system to trigger outbreak detection/ respose from surveillance data?	3.4	3.8	25
TECHNICAL AND PROCESSES	RESPONSE SYSTEMS	26	Is there an SOP or formalized system to trigger vector control activities from surveillance data?	3.1	2.9	26
TECHNICAL AND PROCESSES	DATA QUALITY ASSURANCE	19	At the facility level, are there automated quality control mechanisims built in to the system? (e.g. automated or biut in checks at data entry (e.g. data validation rules to flag mistakes and missing data), data verification reports/ audit trails, etc.)	3.0	4.0	27
TECHNICAL AND PROCESSES	RESPONSE SYSTEMS	25	Is there an SOP or formalized system to trigger ACD from surveillance data?	2.9	2.8	28
TECHNICAL AND PROCESSES	DATA QUALITY ASSURANCE	20	In elimination settings is there a mechanism or process to avoid duplicate entry of records (e.g. when there are multiple data points such as case detection at the facility followed by case investigation)?	2.6	2.9	29

Outcomes of alignment meeting with WHO

Date: 6th May 2022

Participants: WHO: Abdisalan Noor and Laura Anderson; SMERG SP&DQ Committee: Richard Maude, Arnaud Le Menach, Katelyn Woolheater, Ann-Sophie Stratil and Arantxa Roca-Feltrer

Language and Communication	Frequency	WHO Online Version	The longer vision
<ul style="list-style-type: none">• NMCP Operational Surveillance Tracker is a SUBSET of the WHO Surveillance Toolkit. It has been adopted with this purpose by RBM.• The tracker will also facilitate further uptake of the WHO surveillance toolkit and will be utilising the guidelines and tools from the toolkit.• Consistent messaging on where this tool fits in is critical to avoid confusion on potentially parallel or duplicative tools.	<ul style="list-style-type: none">• The idea is to conduct a baseline for all countries and then update the information (and associated RBM dashboards) annually.• Some questions (once answered at baseline) might not require to be updated annually. These aspects are expected to be discussed at the NMCP SMERG side meeting in Kigali (SMERG annual meeting).	<ul style="list-style-type: none">• The long list of indicators are not interfering with the WHO toolkit framework• This is not a priority now as we first need to finalise the tool, identify the 20 key milestones/indicators to better assess to what extent current WHO toolkit captures the key elements of this tracker.	<ul style="list-style-type: none">• These subset of indicators/milestones will therefore facilitate the development of action plans as well as help advocate for alignment between NMCP needs and Implementing partners activities (donor investments).• The outputs of this tracker should be used to inform/develop SM&E Operational Plans aiming at monitoring the surveillance systems as well as identifying key actions needed to address key operational challenges/gaps.

SMERG SP&DQ Committee Progress

0%



Future Plans

Under discussion within committee

New focus areas?

Mapping out the advantages and disadvantages of surveillance and data quality tools and activities?

Addressing NMCPs training needs?
Building online training specific to surveillance and data quality?

Monthly Best Practices from Countries to increase awareness and interaction?

Emerging current surveillance themes like novel techniques molecular, genetic, modelling, entomological surveillance programs with epidemiological surveillance programs.

SP&DQ Committee can collate a list of these training resources and assess gaps

APMEN is developing data quality assessment as well as GIS training. It is at very early stage. They might be interested to make it generalizable. Considering to have online materials by keeping in mind language challenges.
**APMEN and Telethonkids will have the side discussion to synergize their GIS trainings.*

Network and engagement opportunity for academic partners
Showcase specific case studies via specific webinars or newsletters

YouTube video series

Collaboration across partners: Mapping available trainings and assessing gaps for NMCPs

Emerging new techniques and Engaging academia

Keeping the momentum and increasing synergy across NMCPs and partners

Revitalization across NMCPs (TA)



Thanks for listening. Please remember we are open to new members! You can address to the SMERG co-chairs and secretariat to join!



Establishment phase

Decision taken during 31st SMERG Meeting in September 2020. ToR drafted, feedback collected in February and March 2021. Membership announcement in April. The committee is kicked off in May 2021. The governance is in place as of day one.



RBM SMERG SP&DQ Newsletter

Quarterly newsletter launched in August 2021 and on track. Three issues published in total. Last issue was open 973 times. Next issue will be disseminated in June 2022.



Malaria Routine Data in Action Webinar Series

Quarterly webinars launched in September 2021 and on track. Three series were realized. Next episode is under planning for June 2022.



Implementing Partners: Surveillance Projects Dashboard

First data collection was from beginning of October until mid November 2021. First landscape analysis were prepared and presented during 32nd SMERG Meeting. The questionnaire remains open.



NMCP Operational Surveillance Tracker

Design completed. Preparations ongoing. Coming soon!



Future Plans

Under discussion within committee



Thanks



Back up

First Feedbacks collected from NMCPs via consultation meeting in August

Creating this new initiative

- Once the benefits are clearly stated, NMCPs agreed on the value of this initiative.
 - *Learning about lessons learned, best practices, and challenges of other countries*
 - *Improving the implementation of surveillance and data quality tools*
 - *Informing the implementing partners about countries' operational surveillance needs*
 - *Improving coordination across partners and countries*
 - *Identification of the operational surveillance priorities of national malaria control programs (NMCPs) to support advocating for those priorities within the SMERG platform*
 - *Identification of possible areas of complementarity or opportunities for leveraging from others initiatives taking place at regional/national/sub-national level.*
- Duplication of resources and efforts is a problem in the countries. Sometimes it is difficult for NMCPs to bring the partners together.
- The coordination is a real issue. It would be great to create a mechanism where partners seat and talk to each other.
- The implementing partners' questionnaire is also key for NMCPs for these aspects.
- It was also highlighted that it is key to emphasize to countries and NMCPs the benefits of contributing and using the information collected through this exercise

Questionnaire

- You might need to go in deeper on YES/NO questions to understand WHAT and track the changes over the years.
- Granularity: routine data assessments are key. Important to know how many states/provinces conduct data quality assessments at sub-national levels (e.g. capture # of districts that conduct RDQA). These types of indicators can be use to prospectively track growth or deterioration of these components over time)
- It would be important to understand for NMCPs what are the systems that are very effective, whether they are integrated and useful for country staff.
- Another suggestion was to include the proportion of malaria budgets that are going onto Surveillance and DQ activities as that would be an important indicator to track over time as well

First Feedbacks collected from NMCPs via consultation meeting in August

Working model

- As next step, it was suggested that a phase-approach is followed. Once the questionnaire is updated, the committee can pilot it with a few countries including a more in depth questionnaire to better understand what specific tools and approaches are used and inform how to best collect the information from other countries. This pilot would then inform the design of a full consolidated questionnaire that is then applied to all countries during the rollout phase.

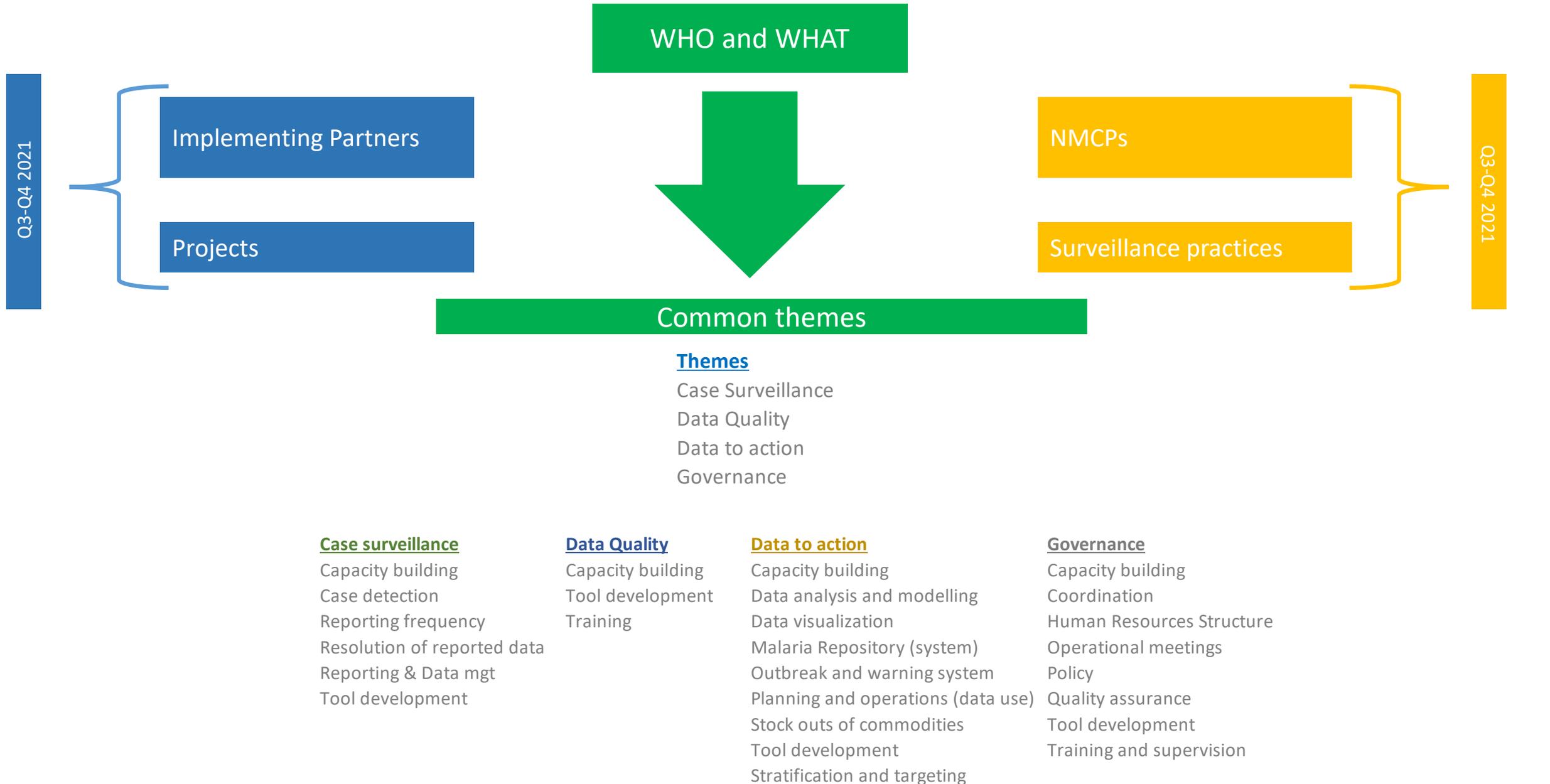
Length and timing

- NMCPs agreed that once teams in countries understand the benefits of this tracker, an annual questionnaire no longer than one hour to fill will be welcomed.
- The timing is also important. Please avoid making data collection during the rain season where the teams are busy with SMC programs, bed net distribution etc.
- Early Q1 for each year was a proposed timing from the group.

Other

- It was suggested that to improve consistency of reporting, additional information on what is meant for each component/section/question is needed (e.g. explanatory narrative, describing acronyms (eg. HMIS), etc).
- It was suggested to tracking higher level transmission risk data would be useful but as long as it is information that is readily available from the countries.
- Some comments about how the data could be analyzed were made. For example, countries could be grouped based on Surveillance maturity level profiles, so that priorities could be more easily identified, etc

A platform for systematic SP&DQ tracking



CRSPC - Southern Africa Technical Support Updates

Gen. (Dr) Kaka Mudambo
Coordinator ESA

TA Plan and Status of Implementation 1

Country	Activity	TA Start Date	Category	TA Status
Angola	Development of Resource Mobilization Strategy for the Angola National Malaria Strategic Plan (2021-2025)	Jan-2022	Res Mob	Requested
Angola	Development of Malaria Social and Behaviour Change Strategy for the Angola National Malaria Strategic Plan (2021-2025)	Feb-2022	Implementation	Requested
Angola	Develop a plan of organic structure and statute of the NMCP	Jan-2022	Implementation	Requested
Angola	Development of an Updated Malaria Operational Plan for Southern Angola 2021-2025	Feb-22	Implementation	Requested
Angola	Support for LLINs 2022 mass campaign	Mar - Apr-2022	Implementation	Completed
Botswana	KAPB study on malaria	Jan - Jun-2022	Implementation	
Comoros	Malaria programme review (MPR)	Aug-22	MPR	
Comoros	Development of NSP	Oct-22	NSP	
Eswatini	Finalization of if IVM guidelines			
Eswatini	Conducting a GAP analysis of the National Malaria Programme Strategic Plan and adhoc Programme interventions	Aug-2022	Implementation	Requested
Madagascar	SBCC - support for the implementation of asocio-anthropological study in selected sites	Oct-2022	Implementation	
Madagascar	SBCC - Designing the right tools and approaches for the outreach approach.	Nov-2022	Implementation	

TA Plan and Status of Implementation 2

Country	Activity	TA Start Date	Category	TA Status
Madagascar	Development of the National Plan for the Management of Resistance of Malaria Vectors to Insecticides	Oct-2022	Implementation	
Madagascar	Development of the national vector control plan	Jun-2022	Implementation	
Madagascar	Malaria programme review (MPR)	Jul-2022	MPR	
Madagascar	Development of the national malaria strategic plan 2023-2027	Aug-2022	NSP	
Malawi	Planning of 2021 ITNs mass campaign implementation (Macroplanning, Microplanning, Household registration, Review and Report writing)	Aug-2021 - Apr-2022	Implementation	Completed
Malawi	Cost benefit analysis of key malaria interventions	Q2 2022	Res Mob	
Malawi	Economic benefits of malaria elimination in Malawi	Q3 2022	Res Mob	
Malawi	Malaria burden stratifications and prioritization of interventions	Q4 2022	Implementation	
Mozambique	Support for Malaria Programme Review (MPR)	Q3 2022	MPR	
Mozambique	Support for evaluation of impact	Q3 2022	Implementation	
Mozambique	Development of new Malaria Strategic Plan	Q4 2022	NSP	
Namibia	Programme End term review- Strategic plan 2017-2022	Sep-2022	MPR	
Namibia	Assessment of Government of the Republic of Namibia (GRN) spending on Malaria	Sep-2022	Res Mob	

TA Plan and Status of Implementation 3

Country	Activity	TA Start Date	Category	TA Status
South Africa	Midterm review strategic plan	Apr -Jun-22	MPR	
South Africa	Operationalisation of cross-border committees	Apr -Jun-22	Implementation	
Zambia	Drafting of the 2022-2026 NMESP	Feb - Mar-2022	NSP	Completed
Zambia	Drafting of the 2022-2024 Malaria Operational Plan	Feb - Mar-2022	NSP	Completed
Zambia	Development of the Monitoring and Evaluation Plan of the NMESP	Feb - Mar-2022	NSP	Completed
Zambia	Development of communication strategy	Jan - Mar-2022	Implementation	
Zambia	Strengthen Community - Based IRS Delivery Model	Feb - Apr-2022	Implementation	
Zambia	Fund raising and Proposal writing	Q4 2022	Res Mob	
Zanzibar	Malaria programme review (MPR)	Jun-22	MPR	
Zanzibar	Development of NSP	Aug-22	NSP	
Zimbabwe	Launch of Zero Malaria Starts with me campaign	Q1 2022	Implementation	On going
Zimbabwe	Support for the development of a new national malaria strategic plan	Q1 2022	NSP	On going
Zimbabwe	Support for development of the National Malaria Vector Surveillance Strategic Plan	Q1 2022	Implementation	Requested
Zimbabwe	Support for the development of Malaria Social and Behaviour Change Communication Strategy for the Malaria Prevention and Elimination Strategic Plan	Q1 2021	Implementation	On going

TA Plan and Status of Implementation 4

Country	Activity	TA Start Date	Category	TA Status
E8	E8 Regional Surveillance Assessment for Southern Africa Malaria Elimination Eight	1 Nov 2021 - 28 Feb 2022	Implementation	Completed
E8	Conduct a malaria matchbox assessment for regional cross-border initiatives, interventions and activities	Sep-2022	CRG	On going
E8	Review the national investments in malaria elimination across the SADC region. Develop template for the annual financing report as a reportable deliverable to Ministers of Health	Mar-2022	Res Mob	
E8	Update the E8 Resource Mobilization Strategy and workplan	Sep-2022	Res Mob	
E8	E8 Strategic Plan streamlining between E8 and SADC strategies	Sep-2022	NSP	
E8	Conduct a timely review and assessment of the successes, challenges and lessons learned from past and present efforts to address sub-optimal IRS coverage, including the potential for adopting alternative sustainable and cost- effective vector control strategies	Dec-2022	Implementation	
E8	Support the E8 Secretariat in improving grant management services, risk management and grant performance	Dec-2022	Implementation	
E8	Support for costing of the E8 Regional Malaria Strategic Plan (2021 – 2025)	1 Feb - 1 Mar-2022	Implementation	Completed

TA Plan and Status of Implementation 5

Country	Activity	TA Start Date	Category	TA Status
SADC	RBM Secondment of 1 malaria technical expert to SADC Secretariat	Jan-2022	Implementation	Completed
SADC	Technical meeting of National Malaria Programme Manager for the dissemination of the Windhoek Declaration & the SADC regional malaria elimination strategy	May-2022	Implementation	
SADC	Development of the SADC Annual malaria report 2022	Sep-2022	Implementation	On going
SADC	Support for SADC NMCP Institutional Assessments	Mar-Apr-2022	Implementation	Completed
SADC	SADC support for Finalization and Costing of SADC MSP	Apr - Jun-2022	Implementation	Completed
SADC	Support for development of a Cross Border Malaria Summary of Procedures (SOP)/Minimum Standards/Matrix/Framework	Apr - May-2022	Implementation	Requested
MOSASWA	Global Fund application development	Mar - May 2022	Implementation	Completed
MOSASWA	Support for holding consultative meeting to review draft Global Fund Application	Apr-2022	Implementation	Completed
WHO/CRSPC	Assessment of HBHI implementation process in Mozambique	Q1	Implementation	Completed
WHO/CRSPC	Assessment of HBHI implementation process in Uganda	Q1	Implementation	Completed

Challenges

1. Requests (delayed, short notice, incomplete, postponement, where to direct - WHO/RBM and funds recipient)
2. Delayed submission of narrative and financial reports
3. Lack of feedback on the performance of consultant
4. Non communication/ delayed response/ Personnel changes

Way Forward

- NMCPs should devise tracking system
- TA focus areas in 2022
 - ✓ Comments made by the GF TRP such as Malaria matchbox implementation
 - ✓ MPR
 - ✓ NSP
 - ✓ Bottlenecks resolution
- Update the TA plan for the 2022
- Identify the TA needs for 2023

Thank you

Unitaid Malaria Portfolio

Southern Africa National Malaria Programmes and Partners
Annual Meeting - Harare, Zimbabwe, 05-08 July 2022

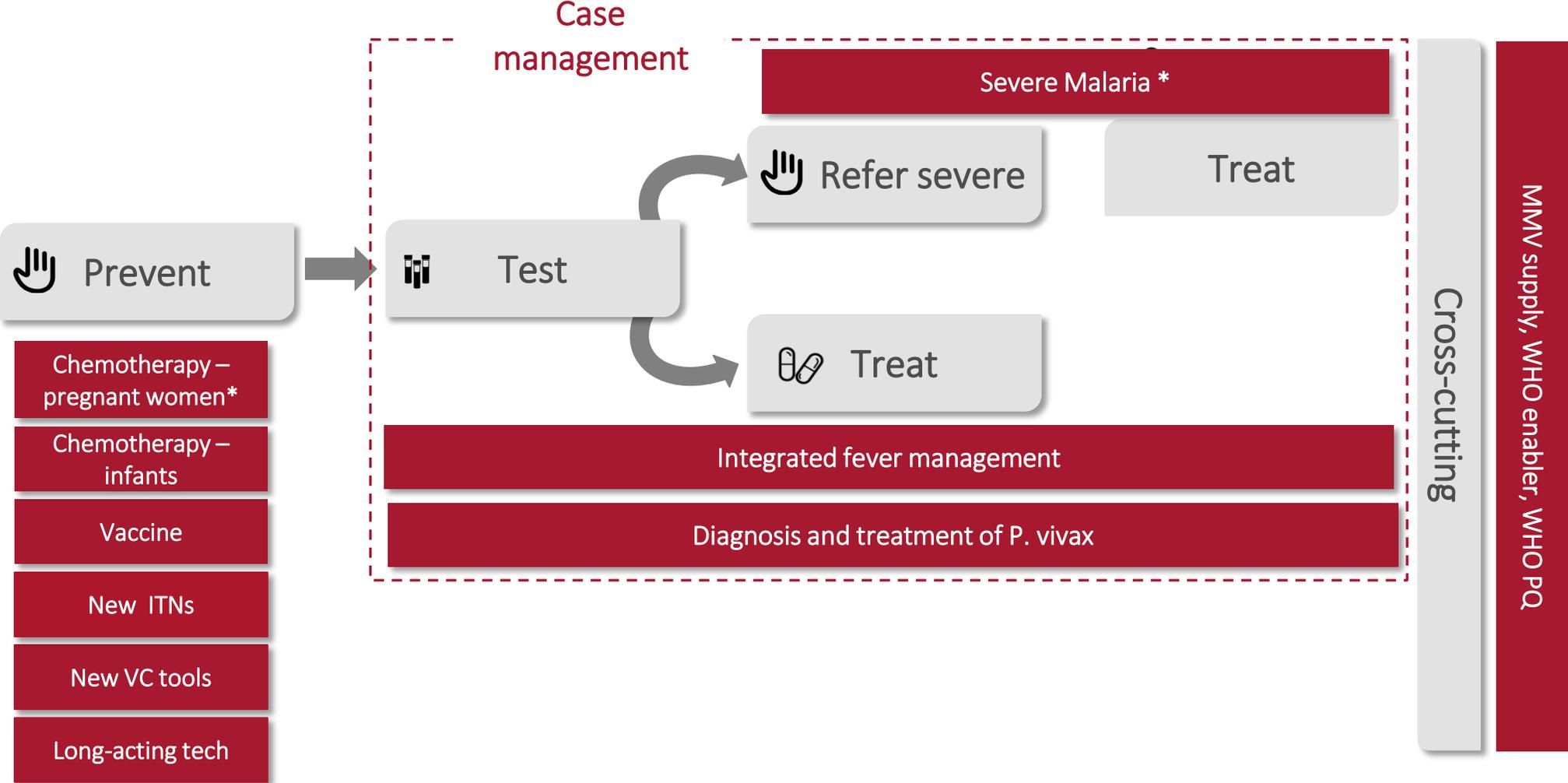


Unitaid accelerates equitable access to innovative health products

Access areas	Innovation & Availability	Quality	Affordability	Supply & Delivery	Demand & Adoption
Examples of Unitaid interventions	Late stage product development/ reformulations	Prequalification	Price negotiations	Distribution optimization	Global Policy & Guidelines
	Post registration clinical trials	In-country registration	Pooled procurement	Technical Assistance/Incentives to manufacturers	Country Policy and Guidelines
		Local manufacturing	Volume guarantee	Capacity building	Large-scale pilots
			Co-pay	Forecasting	Evidence generation: feasibility, cost-effectiveness
			Intellectual Property		Behavior change

Active portfolio

Unitaid's current malaria portfolio (US\$ 327 million)

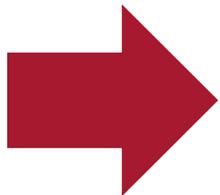


*Recently closed

TIPTOP: Transforming IPT for Optimal Pregnancy



 Lead Grantee	Jhpiego
 Grant Period	2017 - 2022
 Grant Value	US\$ 50M
 Project countries	DRC, Madagascar, Mozambique, Nigeria



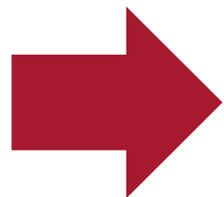
 **Key findings**

- **2.5–5-fold increase** in access to the recommended 3+ IPTp doses
- Community delivery did not negatively impact access to ANC –**ANC access increased in 50% of project districts**
- **C-IPTp widely accepted** by its beneficiaries in project areas
- **Low additional cost** to health system for community delivery

Intermittent Preventive Treatment in Infants Plus – IPTi+



 Lead Grantee	Population Services International
 Grant Period	2021 - 2025
 Grant Value	US\$ 35M
 Project countries	Benin, Cameroon, Cote d'Ivoire, Mozambique +DRC, Ghana, Zambia



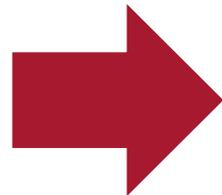
 **Grant Impact**

Catalyse uptake of enhanced IPTi strategies – including additional contacts and 2nd year of life

RTS,S: Malaria vaccine pilot implementation project



 Lead Grantee	World Health Organization
 Grant Period	2017 – 2023
 Grant Value	US\$ 13M
 Project countries	Ghana, Malawi and Kenya



 **Grant Impact** *Evaluate the feasibility of delivering the required four doses of RTS,S in real-life settings*

New Nets Project



**Lead
Grantee**

Innovative Vector Control Consortium (IVCC)



**Grant
Period**

2018-2022



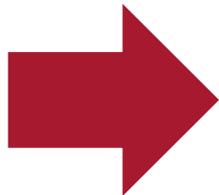
**Grant
Value**

US\$66M



**Project
countries**

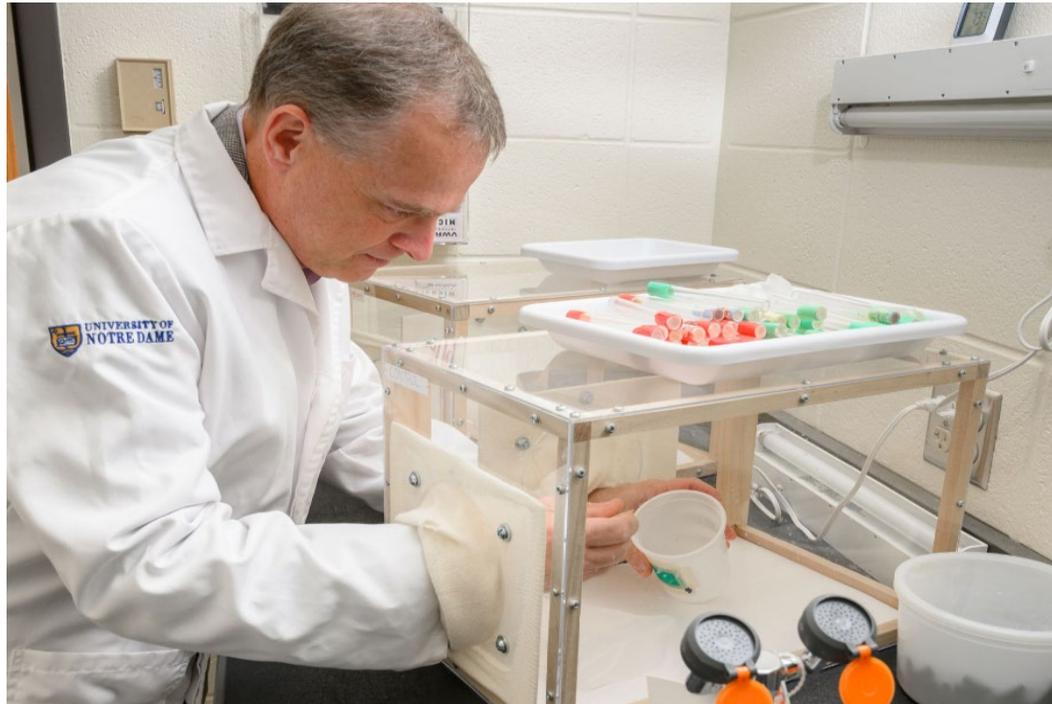
Benin, Burkina Faso, Rwanda, Mali, Mozambique,
Nigeria, Cote d'Ivoire, Liberia, Ghana, DRC, Malawi,
Niger, Cameroon, and Burundi



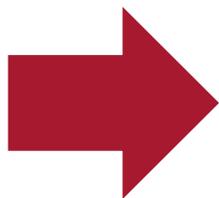
**Grant
Impact**

*Introduce new long-lasting insecticide-treated nets (LLINs)
in areas of insecticide resistance*

Advancing Spatial Repellents for Vector-borne Disease Control



	Lead Grantee	University of Notre Dame
	Grant Period	2019 - 2024
	Grant Value	US\$ 33.7M
	Project countries	Kenya, Mali, Sri Lanka, Uganda



 **Grant Impact**

Evaluate slow-release repellents that drive mosquitoes from inhabited areas

Broad One Health Endectocide-based Malaria Intervention in Africa (BOHEMIA)



**Lead
Grantee**

ISGlobal



**Grant
Period**

2019 - 2024



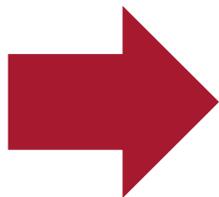
**Grant
Value**

US\$ 25M



**Project
countries**

Tanzania, Kenya



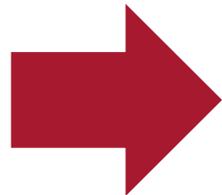
**Grant
Impact**

Develop a new complementary new-class vector control tool, ivermectin (endectocides)

Partnership for Vivax Elimination (PAVE)



	Lead Grantee	Medicines for Malaria Venture
	Grant Period	2021 - 2025
	Grant Value	US\$ 24.9M
	Project countries	Peru, Ethiopia, India, Indonesia, PNG



 **Grant Impact**

*Introduce new screening and treatment tools to support the elimination *p. vivax* malaria*

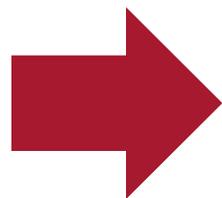
Medicines for Malaria Venture – Supply Side Grant



 **Lead Grantee** Medicines for Malaria Venture

 **Grant Period** 2017 - 2023

 **Grant Value** US\$ 5.8M



 **Grant Impact**

Overcome barriers to availability, quality and supply of medicines for severe malaria and malaria prevention

Unitaid Strategy 2023-2027

Programmatic priorities

 Cross-linkages with improving health outcomes for women and children

 HIV & co-infections

 TB

 Malaria

 Women & children's health

 Respond to global health emergencies

Sustain effectiveness of prevention & treatment

Enable TB prevention tools for high-risk groups

Introduce and optimize prevention tools

Improve access to better tools for safe pregnancy and birth for women and newborns

Optimize and enable scale of AHD packages of care

Accelerate access to new detection tools

Improve access to quality case management

Improve quality of clinical care packages for COVID-19

Drive HCV elimination through testing and prevention

Accelerate adoption of new drugs and regimens

Increase access to screen & treat for cervical cancer and STIs

Improve child survival with triage and treatment tools

Accelerate access to self-testing & integrated diagnostics

Decentralize testing and treatment for COVID-19

Long acting & new technologies

Intellectual Property, regulatory and innovative supply models

Malaria priority 1: Introduce and optimize prevention tools (vector control, chemoprevention, vaccines)

Adoption of new tools and approaches, in the most impactful combinations

Illustrative portfolio of topics & interventions

- **Short-term (current):** optimize delivery of malaria chemoprevention (IPTi) and ensure access to quality-assured drugs; evaluate new vector control tools (spatial repellents and ivermectin)
- **Mid-term (2-3 years):** optimize deployment of prevention tools e.g. through at-scale pilots, innovative delivery approaches, and generating evidence to guide policy and prioritization.
- **Long-term (4-5 years):** lay the groundwork for transformational new prevention tools (e.g. genetically modified mosquitos, long-acting technologies and vaccines)

Malaria Programmatic priority 2: Improve access to quality case management

Facilitate introduction of new tools and integrated approaches for high-risk populations

Illustrative portfolio of topics & interventions

- **Short-term (current):** invest in better tools for *Plasmodium vivax* testing and single-dose radical cure; improve integrated childhood illness management through scaling diagnostics for severe disease detection
- **Mid-term (2-3 years):** enable tools and approaches for resistance management; support the introduction and adoption of anaemia diagnostics in the pipeline with subsequent iron treatment, deployed in conjunction with malaria diagnostics and treatment
- **Long-term (4-5 years):** expand equitable access to quality case management (diagnosis and treatment) of malaria at health facilities, in the community, and in the private sector; lay the groundwork to prepare for the market entry of promising treatments



Partnership
To End Malaria

Vector Control Working Group

June 10th 2022

Updates from Vector Control Working Group: New tools and threat of *Anopheles stephensi*

VCWG Co-Chairs and Secretariat
(Corine, Justin and Konstantina)

Contacts

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Justin McBeath

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Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

**Swiss Agency for Development
and Cooperation SDC**

**The coordination of the VCWG is secured by the
Swiss Agency for Development and Cooperation
(SDC) funds through the GlobMal project at Swiss
Tropical and Public Health Institute**

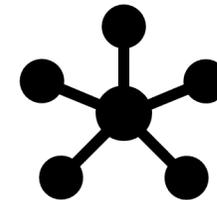
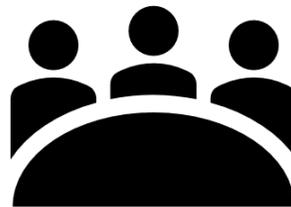
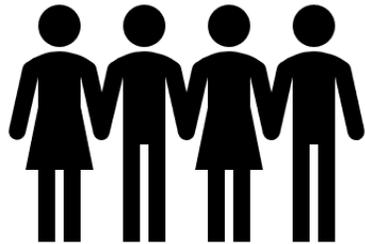
<https://endmalaria.org/our-work-working-groups/vector-control>

Objectives of the RBM - Vector Control Working Group

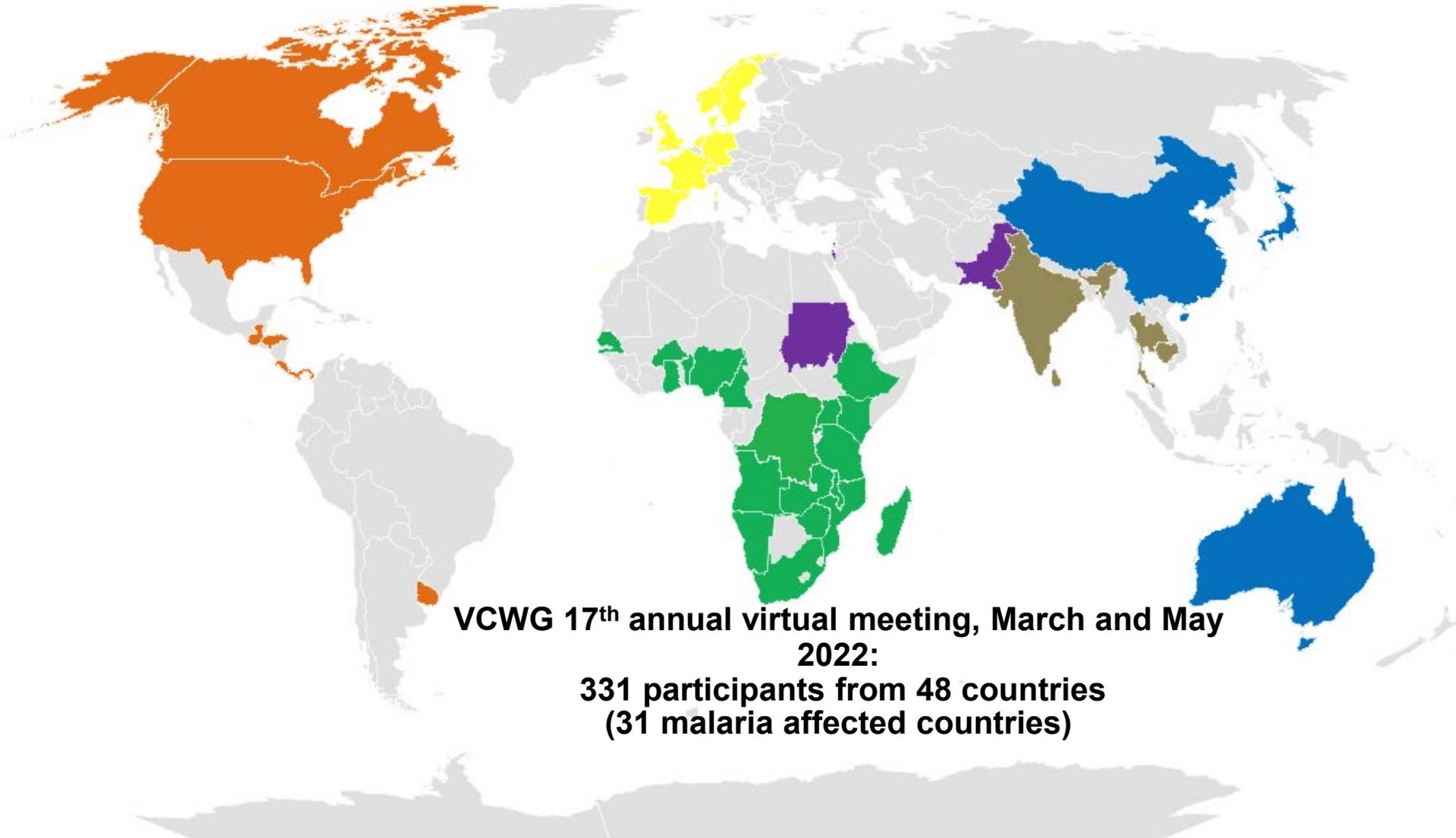
Purpose:

- To align RBM partners on best practices to reach and maintain universal coverage with effective vector control interventions.
- To support the implementation of Vector Control Guidance generated by WHO and to galvanise efforts towards achieving specific country and global malaria elimination targets.

- **Convene:** VCWG convenes meetings, workshops, and other forums to develop consensus among stakeholders
- **Co-ordinate:** VCWG supports and co-ordinates dialogue between national programs, product manufacturers, academia and implementers
- **Facilitate Communication:** VCWG has a very diverse membership, and our annual meetings and Workstream Task Teams provide unique opportunities for connection and networking around specific areas of interest.



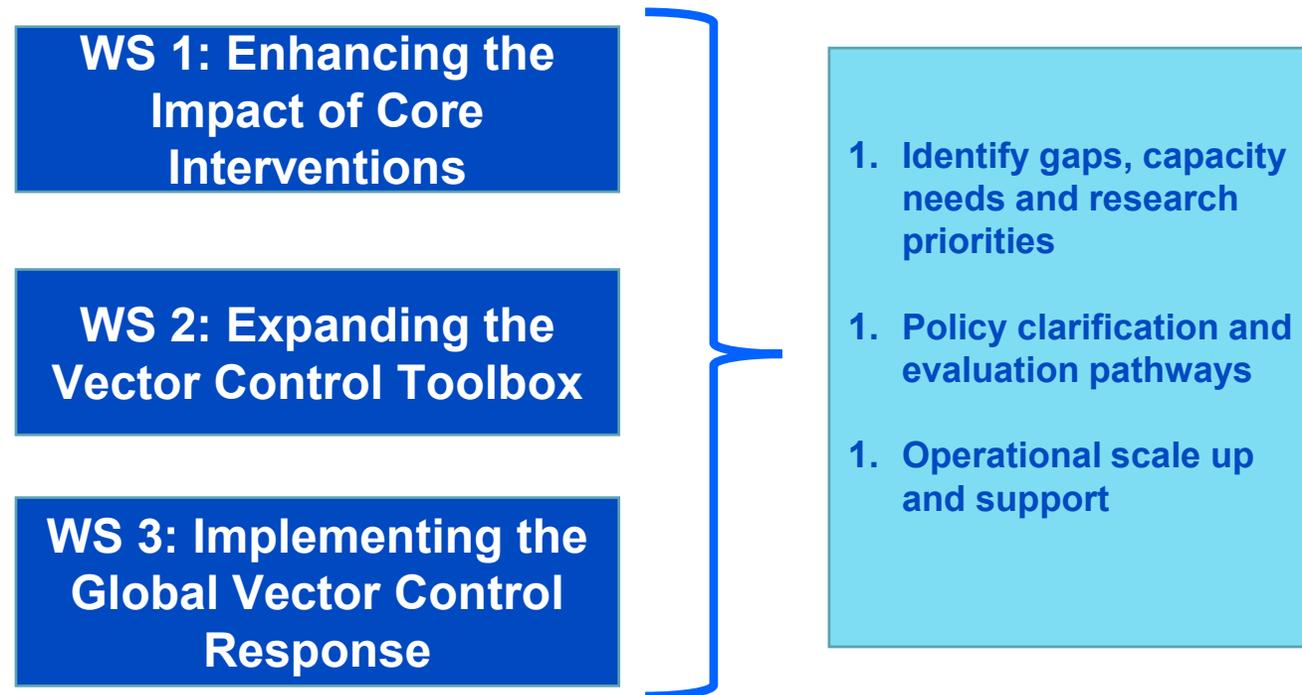
VCWG - 17th annual meeting 2022 – 5 online sessions



VCWG 17th annual virtual meeting, March and May 2022:
331 participants from 48 countries
(31 malaria affected countries)

The screenshot shows the RBM Partnership To End Malaria website. The top navigation bar is blue with the RBM logo and text 'Partnership To End Malaria'. It includes links for 'About us', 'About malaria', 'Our work', 'Resources', 'News & Events', and 'Take action'. There is also a search bar and a 'Partner portal' button. Below the navigation bar, the breadcrumb trail reads 'Our Work Working Groups » Vector control'. The main heading is 'Vector control', followed by a sub-heading: 'The purpose of the Vector Control Working Group (VCWG) is to align RBM partners on best practices to reach and maintain universal coverage with effective vector control interventions.' A large image of a child is shown with a blue overlay. To the right of the image is a vertical stack of social media icons for YouTube, Instagram, LinkedIn, Facebook, and Twitter. Below the image, there are two columns of text. The left column is titled 'Co-Chairs' and lists 'Dr Corine Ngufor' (LSHTM/CREC, UK & Benin) and 'Mr Justin McBeath' (Bayer, United Kingdom). Below that is the 'Working Group Secretariat' with 'Dr Konstantina Boutsika' (Swiss TPH, Switzerland). The right column is titled 'Related content' and lists four items: '17th annual meeting of the Vector Control Working Group', '16th annual meeting of the Vector Control Working Group', 'Vector Control in Humanitarian Emergencies', and '15th annual meeting of the Vector Control Working Group'. A red arrow points from the first item in the 'Related content' list to the left.

**VCWG is organized around 3 workstreams; each with three themes of output.
Task Teams focus on topics under each of these themes in each WS**



Detailed workplans have been developed for each workstream

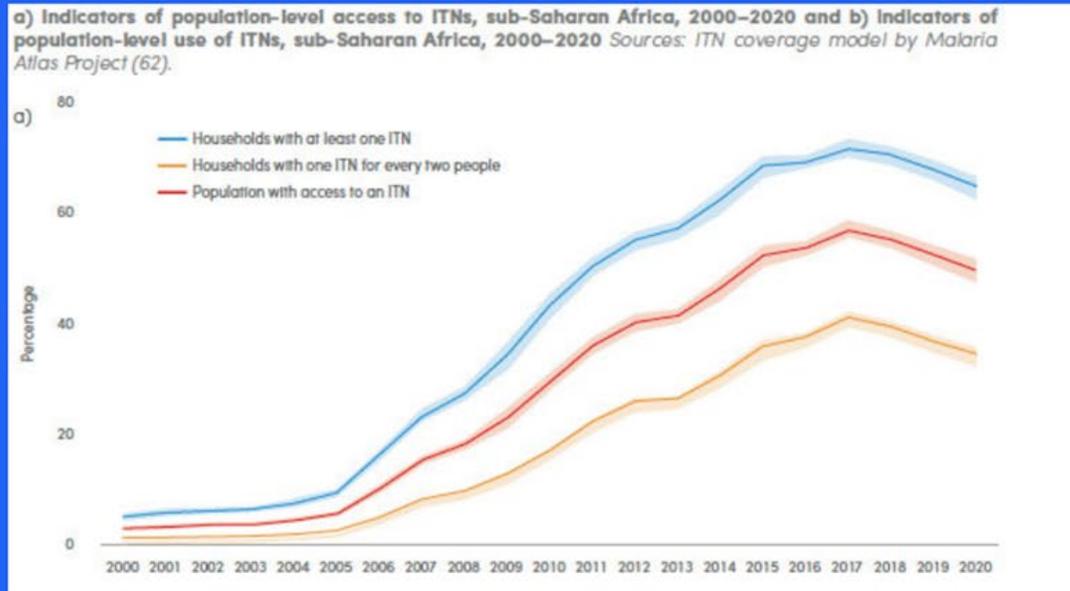
Workstream 1: Enhancing the Impact of core interventions (ITNs and IRS)

**Co-leads: Allan Were, Abt Associates; Allan Were@abtassoc.com
Mary Kante, Eauclaire consulting;
mkante@eauclaireconsulting.co**

Workstream 1: Enhancing the Impact of core interventions (ITNs and IRS)

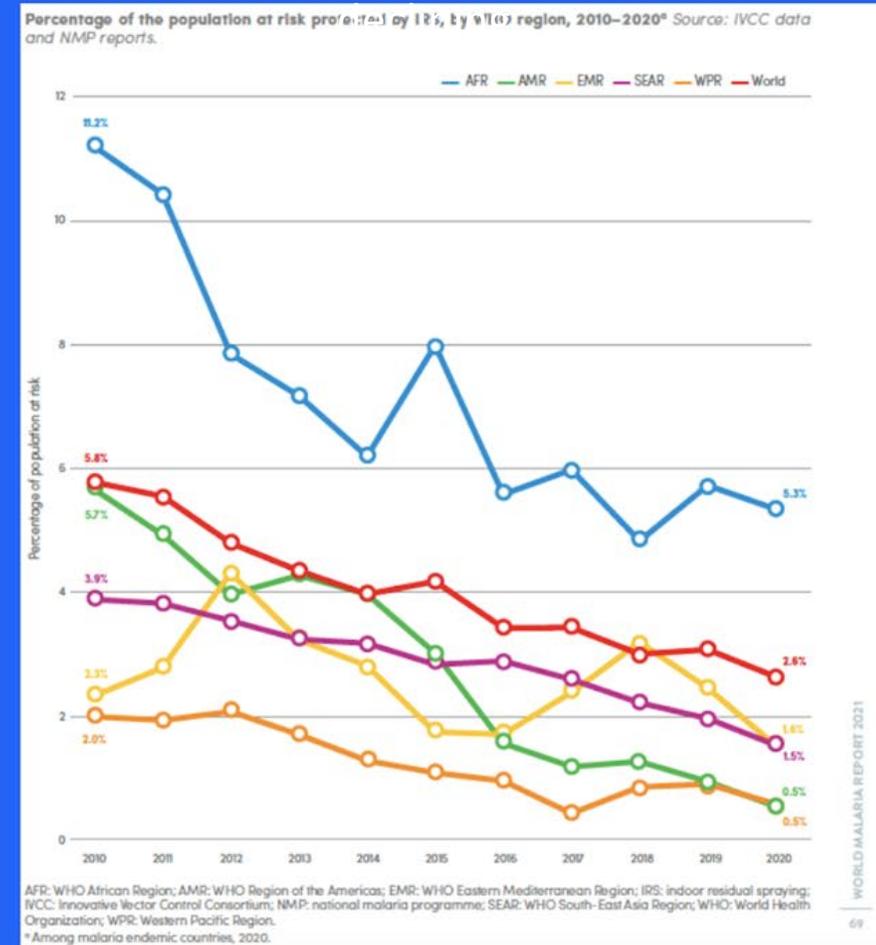
A critical juncture

ITN access declining



Source: World Malaria Report 2021

IRS coverage declining



Workstream 1: Enhancing the Impact of core interventions (ITNs and IRS)

Next generation ITNs and IRS products

Dual ITNs (Pyrethroids + new Insecticide)

1. Pyrethroid-PBO LLINs:

synergist piperonyl butoxide (PBO) enhances mortality of pyrethroid resistant mosquitoes. Ex Olyset Plus, Permanet 3.0 etc

2. Pyrethroid-pyriproxyfen LLINs:

Pyriproxyfen sterilises female mosquitoes which survive exposure to the net. Ex Olyset Duo and Royal Guard

3. Pyrethroid + chlorfenapyr LLINs:

Chlorfenapyr is a pyrrole insecticides – kills pyrethroid resistant mosquitoes. Ex. Interceptor G2.

New IRS insecticides – new modes of action

1. Pirimiphos-methyl

- Actellic 300 CS

2. Clothianidin:

Repurposed from agriculture, WHO/PQ listed.

- Fludora Fusion (clothianidin + alphacypermethrin)
- Sumishield (clothianidin only)

3. Chlorfenapyr:

Repurposed from agriculture.

- Sylando 240SC

4. Broflaniline WP:

- Vectron T500

New mode of action (Mitsui). Undergoing Phase II and III evaluation

Epidemiological trials of next generation ITNs

Tanzania trial - published

Effectiveness and cost-effectiveness against malaria of three types of dual-active-ingredient long-lasting insecticidal nets (LLINs) compared with pyrethroid-only LLINs in Tanzania: a four-arm, cluster-randomised trial



Jacklin F Masha*, Manisha A Kulkarni*, Eliud Lukole, Nancy S Matowo, Catherine Pitt, Louisa A Messenger, Elizabeth Mallya, Mohamed Jumanne, Tatu Aziz, Robert Kaaya, Boniface A Shirima, Gladness Isaya, Monica Taljaard, Jacklin Martin, Ramadhan Hashim, Charles Thickstun, Alphaxard Manjurano, Immo Kleinschmidt, Franklin W Masha, Mark Rowland, Natacha Protopopoff



1. Interceptor (pyrethroid-only)
2. Olyset Plus (pyrethroid-PBO)
3. Royal Guard (pyrethroid + pyriproxyfen)
4. Interceptor G2 (pyrethroid-CFP)



- Interceptor G2 induced 44% reduction in malaria incidence compared to standard pyrethroid LLIN over 2 years

Benin trial – NNP – ongoing UNITAID/GF via IVCC

1. Interceptor (pyrethroid-only)
2. Royal Guard (pyrethroid + pyriproxyfen)
3. Interceptor G2 (pyrethroid-CFP)



2 years follow up results available in Q2 2022

WHO VCAG review Q4 2022

WS1: Enhancing the Impact of core interventions (ITNs and IRS)

2030 Vision of success – key points

Effective ITNs and IRS available

- Ability to collect and interpret data to make robust product choice decisions
- Dual ITNs available on demand
- Robust supply chains for new ITNs and IRS
- More durable nets
- Providing nets on schedule

Threats of Insecticide resistance

- Better understanding of IR and how to respond
- Improved methods of vector identification
- Enough Ais for IRS rotations
- Effectively manage IR

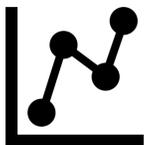
Sustainability

- Increased domestic funding
- Human centred design in manufacture of ITNs and IRS
- NMCPs taking the lead to develop global guidance and best practices
- Local manufacturing, enterprising and better waste management

Workstream 1: Enhancing the Impact of core interventions (ITNs and IRS)

Task Team 1

- Using data to inform optimal selection of core interventions.
- Lead: Sarah Bunnet/PATH



Task Team 2

- Addressing biological threats; new insecticides for vector control (for IRS and ITNs)
- Leads: Christen Fornadel, IVCC and Julia Mwesigwa, PATH



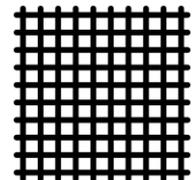
Task Team 3

- Capacity building, localization, and private sector involvement for sustainable vector control
- Leads: S. Asiedu, AGAMAL and M. Chouaibou, PSI



Task Team 4

- Addressing non-biological threats: ITN quality, access and use, durability/replacement
- Leads: TBD



Workstream 2: Expanding the vector control toolbox

Co-leads: Sheila Ogoma, CHAI: sbarasa@clintonhealthaccess.org
Derric Nimmo, IVCC: derric.nimmo@ivcc.com

Derric replaced Allison Tatarsky, UCSF

WS2: Expanding the vector control toolbox

Innovative vector control tools

- Larvicides
- **Bait stations (attractive targeted sugar baits)**
- Spatial repellents
- Systemic insecticides and endectocides
- Genetic manipulation, including gene drive and self-limiting systems
- Topical repellents
- Insecticide treated clothing
- Housing modification
- Lethal house lures (eave tubes)
- New application technologies



gene drive technology for vector control. © Imperial College, London



Attractive targeted sugar baits on a wall in Siaya County, Kenya. © IVCC

← Vector Control Advisory Group (VCAG)

Summary of new interventions for vector control

About

Meeting archives

Meeting reports

Vector Control Advisory Group (VCAG). The evaluation of epidemiological impact is complemented by an assessment of the intervention's safety, quality and efficacy, which is conducted by the WHO Prequalification Team for vector control (PQT-VC).

Interventions under evaluation by WHO

Interventions under evaluation include the following types and classes:

- [Insecticide-treated nets \(ITN\)](#)
- Chemosensory interference, specifically [spatial repellents](#), [bait station](#) and [repel and lure strategy](#)
- [Genetic manipulation](#)
- [Vector traps](#)
- [Sterilization agents](#)
- [Reduced pathogen transmission by a microorganism](#)
- [Systemic insecticides and endectocides](#)
- Housing modifications, specifically [lethal house lures](#)

Attractive targeted sugar baits



Westham Co – Attractive targeted sugar bait

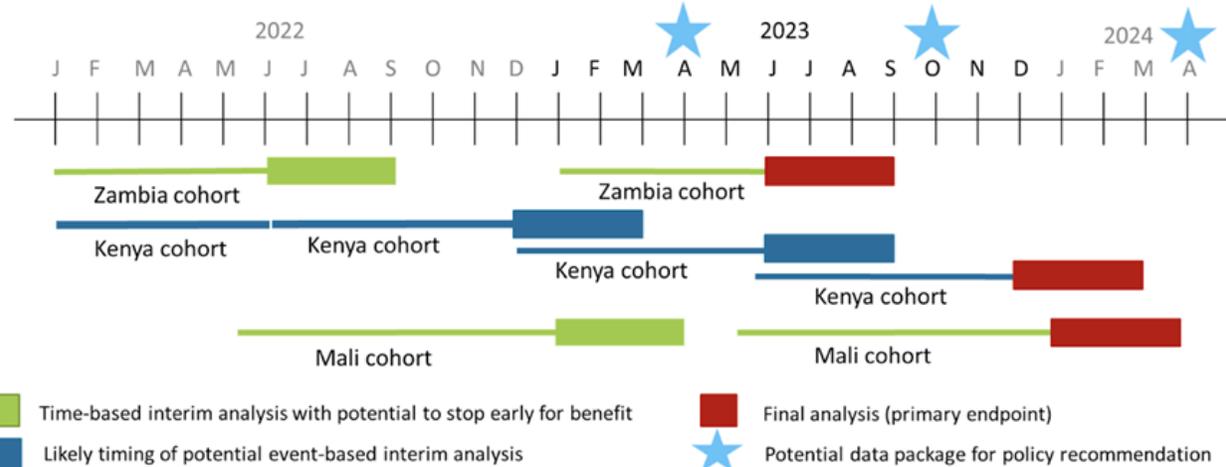
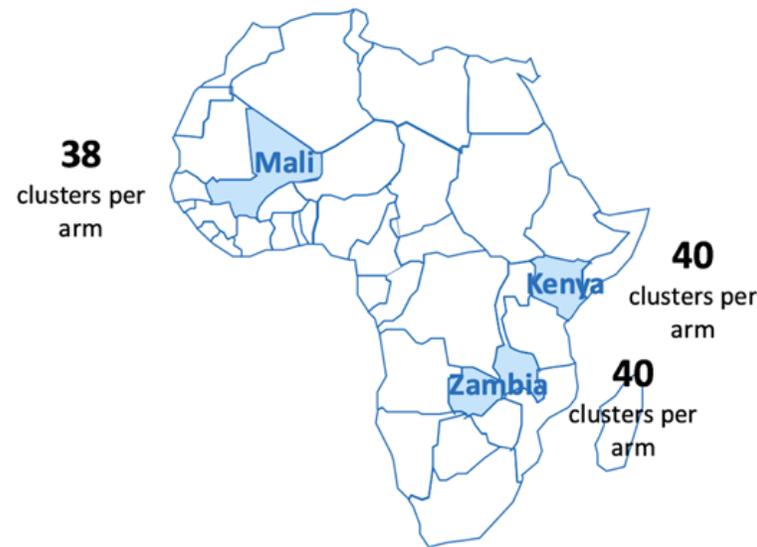
- New tool that exploits mosquito sugar feeding behaviour.
- Attract and kill – attractant, feeding stimulant and insecticide ingested by mosquito.
- Effective for up to 6 months.
- Modelling studies predict 30% reduction in malaria incidence with modest feeding rates of 2-3%
- **Promising for controlling outdoor transmission.**

STATUS OF ATSB development



Open-label two-arm cluster randomized controlled (CRCT) trial design

[ATSB + high vector control coverage (ITN/IRS) versus high vector control coverage (ITN/IRS)]



- Time-based interim analysis with potential to stop early for benefit
- Likely timing of potential event-based interim analysis
- Final analysis (primary endpoint)
- ★ Potential data package for policy recommendation

Primary outcome: incidence of malaria clinical cases (fever + positive rapid diagnostic test) measured within cohorts of children age 1-14 (5-14 in Mali). Target reduction: 30% over the time frame necessary to generate sufficient person-time (to achieve 90% power)

Secondary outcomes: time to first infection assessed among the cohort, prevalence of malaria infection among people age 12 months and older, incidence of passively reported confirmed cases among people of all ages from routine surveillance data, entomological outcomes (age structure, density, sporozoite rate, entomological inoculation rate).

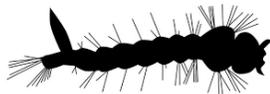
Other measures: durability monitoring, insecticide resistance monitoring, social and behavioral studies (acceptability, barriers to coverage), and economic measures (cost and cost-effectiveness)

Aiming for WHO/PQ listing in 2025

Workstream 2: Expanding the vector control toolbox

Task Team 1

- Larval Source Management
- Leads: Jenifer Armistead, PMI and Prosper Chaki, PAMCA



Task Team 2

- Innovations in vector control and surveillance
- Leads: TBD



Task Team 3

- Anthropology and Human Centered Design
- Leads: April Monroe, JHUCCP



Workstream 3: Implementing the Global Vector Control Response

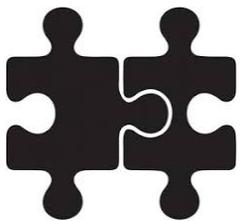
Co-leads: Chadwick Sikaala, Elimination 8, csikaala@sadce8.org
Anne Wilson, LSTM, Anne.Wilson@lstmed.ac.uk

Anne replaced Mark Hoppé, Syngenta

Workstream 3: Implementing the Global Vector Control Response

Task Team 1

- Integrated Vector Management
- Leads: TBD



Task Team 2

- Capacity and collaboration
- Leads: TBD



Task Team 3

- **Anopheles stephensi response**
- Leads: TDB



The threat of *Anopheles stephensi*

- *An stephensi* is an efficient vector of urban malaria (*falciparum* and *vivax*).
- It is spreading rapidly in the horn Africa.
- A coordinated response is required.

Global Malaria Programme 

Vector alert: *Anopheles stephensi* invasion and spread

Horn of Africa, the Republic of the Sudan and surrounding geographical areas, and Sri Lanka

AUGUST 2019 (UPDATED DECEMBER 2019) INFORMATION NOTE

IDENTIFIED THREAT

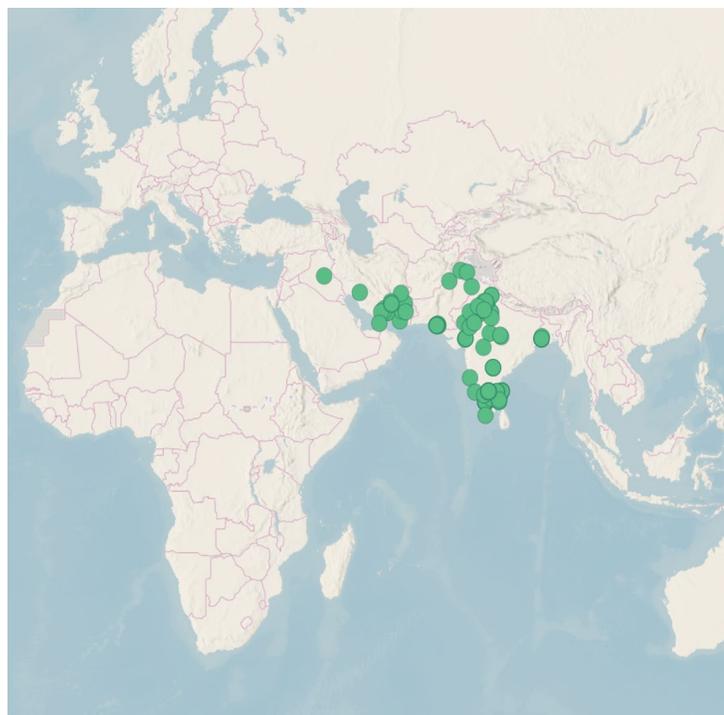
Anopheles stephensi, a highly competent vector of *Plasmodium falciparum* and *P. vivax*, is considered an efficient vector of urban malaria. In parts of India, two biological forms of *An. stephensi* – “type” and “intermediate” – have also emerged as efficient vectors in rural areas, due to changing agricultural and water storage practices and urbanization. The third form – “mysorensis” – is considered to be a poor vector, although it has been involved in malaria transmission in certain rural areas in Afghanistan and

Invasion of *Anopheles stephensi*

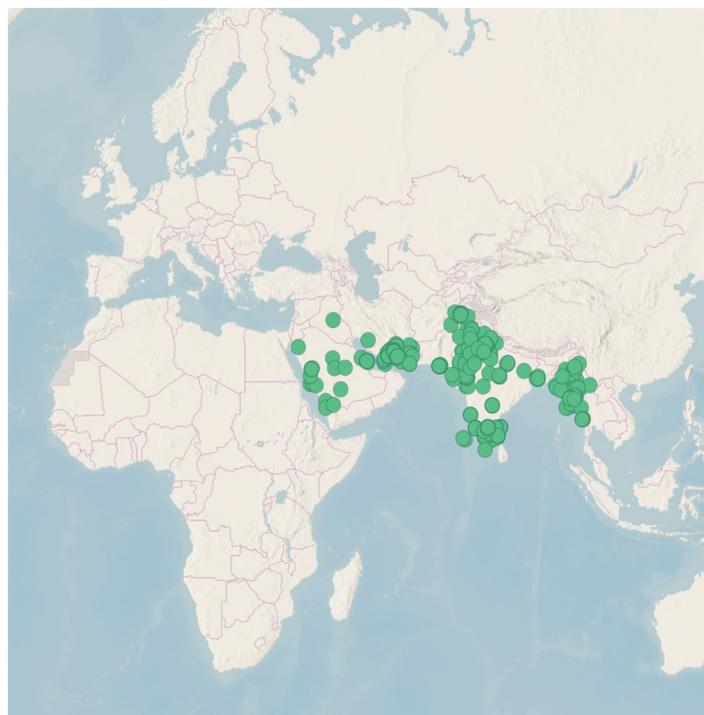
Data source: Malaria Threats Map
Map Production: Global Malaria Programme
World Health Organization



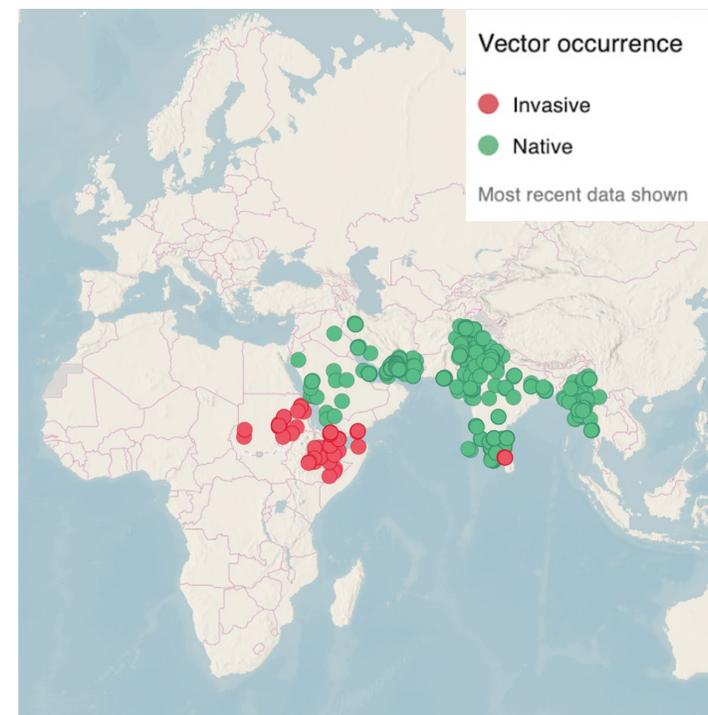
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1990



2010



2022

The threat of *Anopheles stephensi*



A new malaria vector in Africa: Predicting the expansion range of *Anopheles stephensi* and identifying the urban populations at risk

M. E. Sinka^{a,1} , S. Pironon^b , N. C. Massey^c, J. Longbottom^d , J. Hemingway^{d,1} , C. L. Moyes^{c,2} , and K. J. Willis^{a,b,2}

^aDepartment of Zoology, University of Oxford, Oxford, United Kingdom, OX1 3SZ; ^bBiodiversity Informatics and Spatial Analysis Department, Royal Botanic Gardens Kew, Richmond, Surrey, United Kingdom, TW9 3DS; ^cBig Data Institute, Li Ka Shing Centre for Health Information and Discovery, University of Oxford, Oxford, United Kingdom, OX3 7LF; and ^dDepartment of Vector Biology, Liverpool School of Tropical Medicine, Liverpool, United Kingdom, L3 5QA

Edited by Nils Chr. Stenseth, University of Oslo, Norway, and approved July 27, 2020 (received for review March 26, 2020)

RESEARCH ARTICLE

Open Access

The potential impact of *Anopheles stephensi* establishment on the transmission of *Plasmodium falciparum* in Ethiopia and prospective control measures



Arran Hamlet^{1,2*} , Dereje Dengela³, J. Eric Tongren^{4,5}, Fitsum G. Tadesse^{6,7}, Teun Bousema^{7,8}, Marianne Sinka⁹, Aklilu Seyoum³, Seth R. Irish¹⁰, Jennifer S. Armistead¹¹ and Thomas Churcher^{1,2}

Predicted 50% increase in annual P.f cases if no additional interventions are implemented

RBM – VCWG convened 2 *An stephensi* focus meetings in Dec 2021 and Feb 2022

Organisations represented at both meetings

ALMA	LSHTM	SADC-E8
APMEN	LSTM	CHAI
Armauer Hansen Research Institute, Ethiopia	Mentor Initiative	UCSF
BMGF	Manhica	Swiss TPH
US-CDC	MRC South Africa	USAID-PMO
The Global Fund	Oxford University	WHO AFRO & EMRO
IHI	PAMCA	WHO GMP
IVCC	PMI VectorLink	Wits University

Objectives of Meeting 1

- Who is doing what?
- What gaps need to be addressed?
- Is *Anopheles stephensi* adequately covered in the discussions around Urban Malaria?
- How VCWG can support activities of others?

Objectives of Meeting 2

- Insights from Asian countries.
- Identify research and product development gaps
- Multi Sectoral Working Group (MSWG)
- Identify potential actions

Outcome of VCWG focus meetings on *An stephensi* threat

	Key areas identified	Observations from VCWG <i>An stephensi</i> meetings	VCWG support activities	Status
1	Capacity building	<ul style="list-style-type: none"> ➤ Need to enhance surveillance system capacity to detect the extent of the threat. 	<ul style="list-style-type: none"> ✓ Increase visibility of capacity building efforts already underway by other organisations (e.g. WHO, PMI etc) 	<ul style="list-style-type: none"> ▪ Targeting partners with online inventories of training courses covering <i>An stephensi</i> e.g. GVH, PAMCA etc
2	Research	<ul style="list-style-type: none"> ➤ Lack of robust evidence of link between invasion of the vector and increase in malaria burden. ➤ Gaps in understanding how this mosquito is spread and its behaviour. 	<ul style="list-style-type: none"> ✓ Identify research gaps and support broader visibility of research groups working on this topic and their findings. 	<ul style="list-style-type: none"> ▪ Working with MESA-track and Academia ▪ Organise webinars to share research results when they become available.g CEASE project
3	Coordinated action	<ul style="list-style-type: none"> ➤ Need for a change of policies towards a more accelerated response; mosquito vector could become established in Africa by the time evidence is available. ➤ Balancing urgency for action with the <u>finite resources available</u> and slow time it takes to effect policy change 	<ul style="list-style-type: none"> ✓ Develop a VCWG led consensus statement which is signed onto by key organisations ✓ Encourage higher level political motivation to recognize the urgency and mobilise alternative funding sources beyond malaria vector control. ✓ Engage other sectors beyond health and VC 	<ul style="list-style-type: none"> • <u>Consensus statement underway, led by VCWG and supported by key members/partners</u>
4	Innovative approaches	<ul style="list-style-type: none"> ➤ More guidance needed on interventions to apply beyond LLINs and IRS 	<ul style="list-style-type: none"> ✓ Identify tools/approaches which are relevant to tackling stephensi. ✓ Obtain insights from Asian countries dealing with this problem; share across VCWG Membership. ✓ Explore possibilities of dealing with this as an invasive species (e.g. weeds, mammals and other insects). 	<ul style="list-style-type: none"> ▪ Working with partners from India and Sri Lanka to compile and share any existing guidelines.

Task Team 2: Capacity and Cooperation

The Resistant Mosquito: Staying Ahead of the Game in the Fight against Malaria

- **Massive Open Online Course** on Insecticide Resistant Management
- **Free participation**
- Duration: 3 weeks
- Starting date: **Monday 25 July 2022**
- 42 steps, mixture of videos, animations, articles, quizzes, discussions, activities
- Case studies in Ghana, Tanzania, Zambia, Sri Lanka.
- On FutureLearn & Tales, link will follow
- Video trailer (2 min 39 sec) on YouTube or Vimeo
<https://www.youtube.com/watch?v=ZrsRrWyY184>
<https://vimeo.com/700720175>





**Thank you, find out more
visit endmalaria.org
[@EndMalaria](#)**



Plans for rolling out the malaria vaccine

Eastern Africa National Malaria Programmes and Partners Annual Meeting – 8-11 June 2022

WHO recommendation on use of the first malaria vaccine

WHO recommends the RTS,S/AS01 malaria vaccine be used for the prevention of *P. falciparum* malaria in children living in regions with moderate to high transmission as defined by WHO

- RTS,S/AS01 malaria vaccine should be provided in a schedule of 4 doses in children from 5 months of age for the reduction of malaria disease and burden.
- Countries may consider providing the RTS,S/AS01 vaccine seasonally, with a 5-dose strategy in areas with highly seasonal malaria or areas with perennial malaria transmission with seasonal peaks.
- RTS,S/AS01 introduction should be considered in the context of comprehensive national malaria control plans.

Useful links



WHO malaria vaccine position paper

<https://www.who.int/publications/i/item/WHO-2021-malaria-vaccine-technical-paper-implementation>



WHO Guidelines for malaria
PDF version:

<https://www.who.int/publications/i/item/guidelines-for-malaria>

MAGICapp Online platform:

<https://app.magicapp.org/#/guideline/5701>



Malaria Vaccine Implementation Programme

<https://www.who.int/initiatives/malaria-vaccine-implementation-programme>



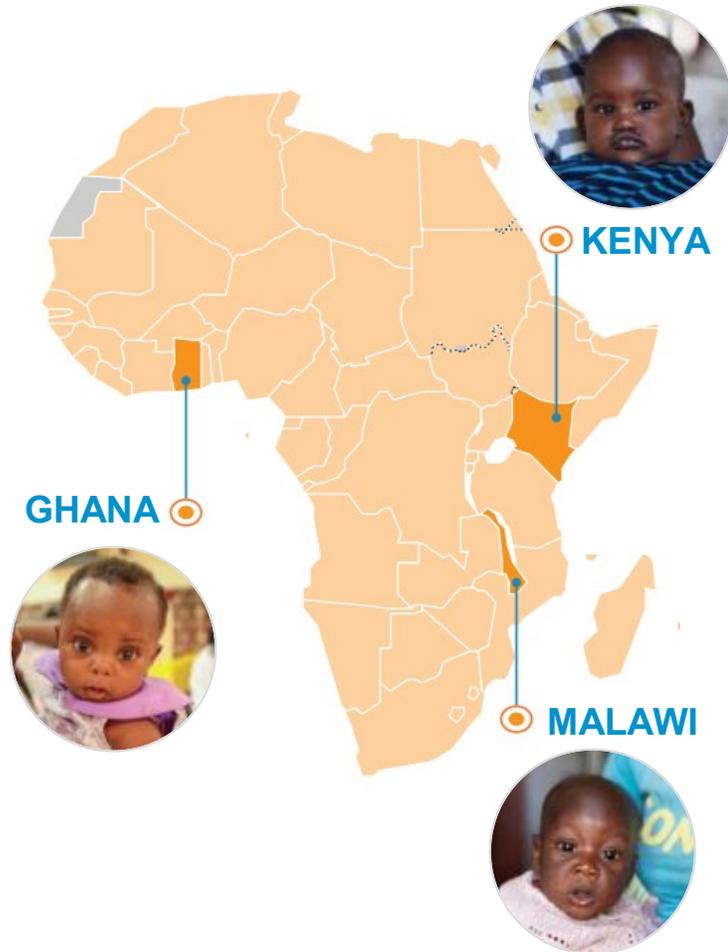
NITAG Resource center

<https://www.nitag-resource.org/>

Summary findings from the ongoing Malaria Vaccine Implementation Programme (MVIP)



24 months after first vaccination (April 2019 – April 2021)



- 1. Feasibility:** Vaccine introduction is feasible, with good uptake and coverage through the routine systems, no impact on uptake of other vaccines, insecticide-treated bed nets (ITNs), care-seeking behavior
- 2. Safety:** Vaccine is safe, with no evidence that the safety signals that were seen in the phase 3 trial were causally related to the RTS,S vaccine and no new safety signals identified
- 3. Impact:** Vaccine introduction resulted in a substantial reduction in severe malaria and all cause mortality even when introduced in areas with good ITN use and access to care
 - 30% (95% CI 8, 46%) reduction in hospitalized severe malaria
 - Preliminary data show reduction in all-cause mortality
- 4. Equity:** the vaccine is reaching children who are not using other forms of prevention such as insecticide-treated nets, increasing access to malaria prevention interventions to > 90%

Gavi support for vaccine roll-out confirmed



- December 2021: **Gavi Board approved support for a malaria vaccine programme** for eligible countries
- **Application guidelines** expected to be published by **mid July 2022**
 - General Gavi requirements for new vaccine support apply, including co-financing*
 - Some additional malaria vaccine programme requirements, e.g. Indication of how the vaccine will be included in the updated national malaria control strategy; indication of priority areas for vaccine use, per WHO technical guidance and principles in the Allocation Framework
- Application deadlines for the malaria vaccine will be communicated by Gavi (usually three times per year, available [here](#))
- Information on supply and price expected upon completion of UNICEF's first malaria vaccine tender (tentatively end June-Aug)

** Of note: Gavi's co-financing policy is currently under review; the updated policy is expected to be available after the December 2022 Gavi Board meeting*

How Gavi support works

More information available on the Gavi website: <https://www.gavi.org/programmes-impact/our-support>

Donor support is **predictable and long-term**

To renew their portfolio of Gavi support on a yearly basis, countries regularly submit monitoring and reporting data



All countries pay a share of the cost of their Gavi-supported vaccines (in line with **co-financing** policy)

The **Ministries of health take the lead** in applying for support and managing grants using national systems

Countries are encouraged to base requests on their national vision, and to align Gavi support with their own planning and financial cycles

Requests are **reviewed by an Independent Review Committee (IRC)**. Once approved, the funds and vaccines are sent to the country

Eligibility based on gross national income per capita. Gavi works closely with countries to ensure that investments support the long-term programmatic and financial sustainability of their immunisation programme. The ultimate goal is for countries to **transition out of Gavi support**

Vaccine supply will be limited in the initial years

A **Framework** is being developed to offer guidance globally on vaccine allocation between countries, and on prioritization of areas for vaccination within countries, until supply constraints can be resolved.

Implications for countries:

- No country is excluded by the Framework (no *a priori* list of eligible countries)
- Vaccine roll-out will have to be phased, starting at sub-national level in areas with highest need, with expansion after supply increases
- In-country deployment decisions should be guided by the principles of the Allocation Framework (incl. prioritizing highest need areas, impact, equity principles)
- To increase equitable access based on the foundational value of solidarity, no single country would initially receive more than 20% of available supply, as long as there are unmet needs for the highest need (category 1) areas across multiple countries

Governance principles	Ethical principles for allocation	Additional key considerations
<p>Transparency</p> <p>Inclusiveness & participation</p> <p>Accountability</p>	<p>First priority principle: Greatest need Allocate the vaccine to countries for use in areas where the need is greatest, where the malaria disease burden and risk of death is highest</p> <p>Second priority principle: Maximize health impact Allocate the vaccine to countries for use in areas where the expected health impact is greatest</p> <p>Third priority principle: Equity (Equal Results) Prioritize countries that contribute to fairness and addressing the needs of marginalised individuals and communities in their malaria vaccination programmes</p> <p>Fourth priority principle: Benefit sharing If equitable access is not possible, the country with a prior contribution to the vaccine's development should get priority</p>	<p>Honour commitments to pilot countries: pilot areas continue to get priority access to vaccine</p> <p>Ensure continuity / sustainability of access to vaccine once a programme has started</p> <p>Minimize risk of vaccine wastage and delayed use of available doses</p> <p>Allocation should not perpetuate pre-existing structural injustices</p>
<p>Foundational value: solidarity</p> <p>Thinking as a community and standing in solidarity with those most in need: As long as there are unmet needs for category 1 areas across multiple countries, no single country should receive more than approximately 20% of the total available supply</p>		

Draft Framework for the allocation of limited malaria vaccine supply

DRAFT

Governance principles

Transparency

Inclusiveness & participation

Accountability

Ethical principles for allocation

First priority principle: Greatest need

Allocate the vaccine to countries for use in areas where the need is greatest, where the malaria disease burden and risk of death is highest

Second priority principle: Maximize health impact

Allocate the vaccine to countries for use in areas where the expected health impact is greatest

Third priority principle: Equity (Equal Respect)

Prioritize countries that commit to fairness and addressing the needs of marginalized individuals and communities in their malaria vaccination programmes

Fourth priority principle: Fair benefit sharing

If everything else is equal, the country with a prior contribution to the vaccine's development should get priority

Additional key considerations



Honour commitments to pilot countries: pilot areas continue to get priority access to vaccine



Ensure continuity / sustainability of access to vaccine once a programme has started



Minimize risk of vaccine wastage and delayed use of available doses



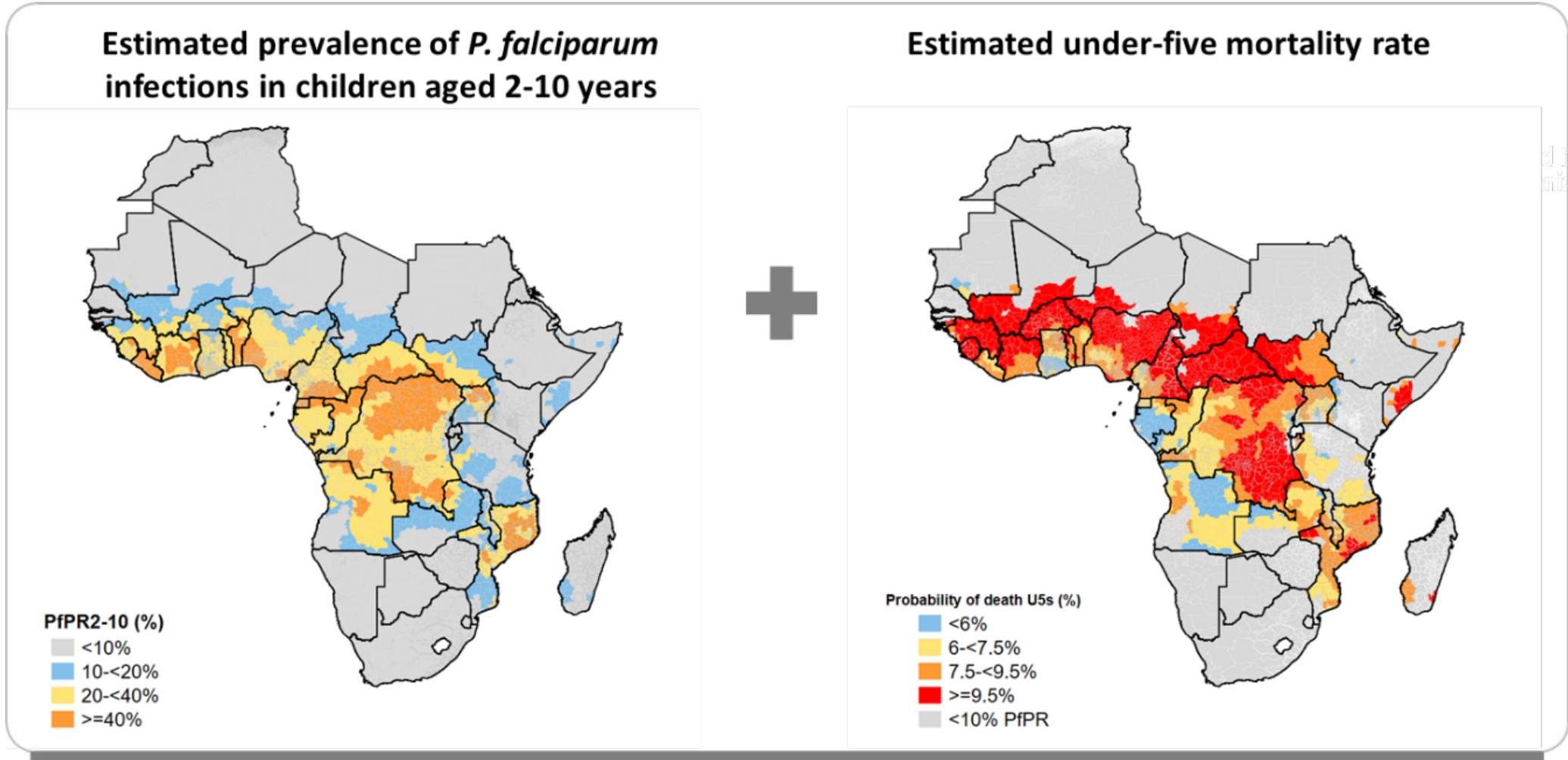
Allocation should not perpetuate pre-existing structural injustices

Foundational value: solidarity

Thinking as a community and standing in solidarity with those most in need:

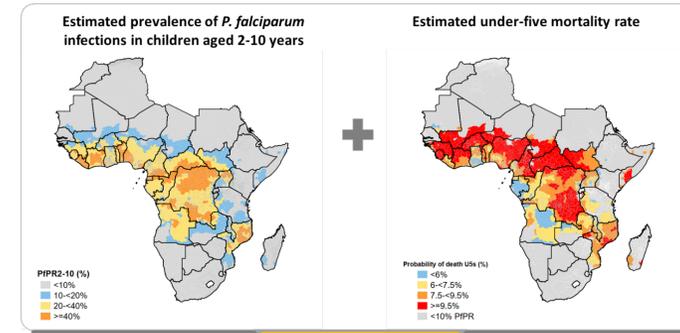
As long as there are unmet needs for category 1 areas across multiple countries, no single country should receive more than approximately 20% of the total available supply

Illustration of “need” classification



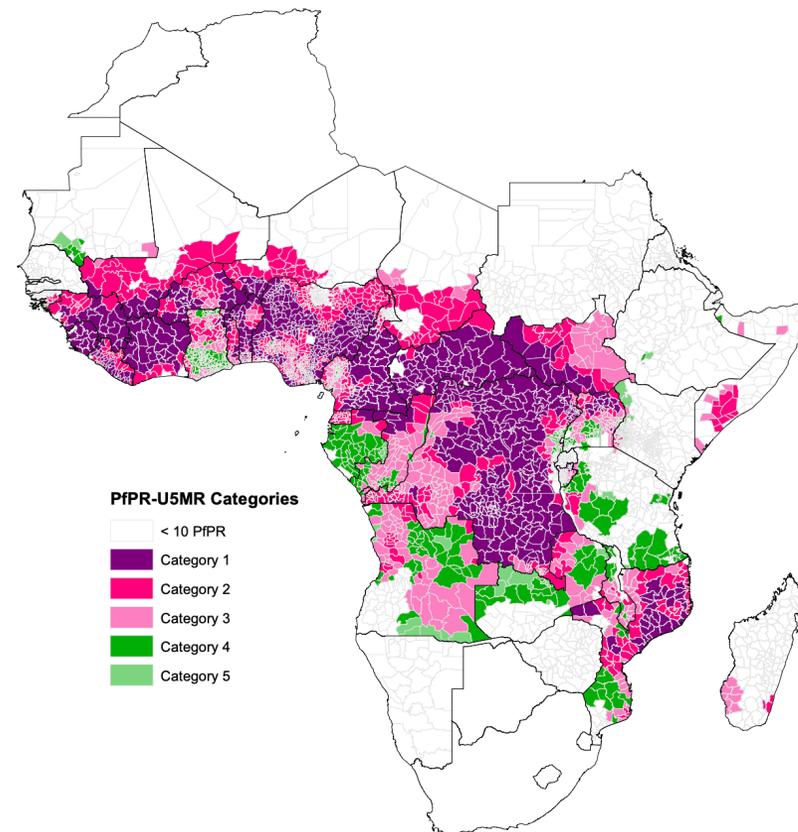
Sources:
District level mean estimates of PfPR in 2-10 year old children in 2019 (Malaria Atlas Project)
District level mean estimates probabilities of death from all-causes before the age of 5 in 2015 (IHME)

Illustration of “need” classification



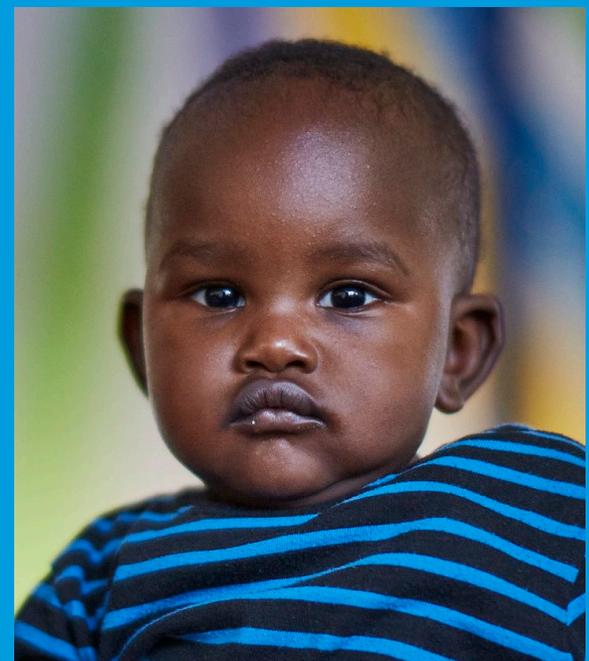
Composite classification of malaria prevalence and all-cause under-five mortality as proxy for “need”

Composite classification of malaria prevalence and all-cause under-five mortality as proxy for “need”



Category	Possible combinations	
	Malaria prevalence	All-cause under-five mortality
1 Greatest need	<ul style="list-style-type: none"> PfPR 20-<40% PfPR >=40% 	<ul style="list-style-type: none"> U5MR >=9.5% U5MR 7.5-<9.5%
2	<ul style="list-style-type: none"> PfPR 10-<20% PfPR 20-<40% PfPR >=40% 	<ul style="list-style-type: none"> U5MR >=9.5% U5MR 7.5-<9.5% U5MR 6-<7.5%
3	<ul style="list-style-type: none"> PfPR 10-<20% PfPR 20-<40% PfPR >=40% 	<ul style="list-style-type: none"> U5MR 7.5-<9.5% U5MR 6-<7.5% U5MR <6%
4	<ul style="list-style-type: none"> PfPR 10-<20% PfPR 20-<40% 	<ul style="list-style-type: none"> U5MR 6-<7.5% U5MR <6%
5	<ul style="list-style-type: none"> PfPR 10-<20% 	<ul style="list-style-type: none"> U5MR <6%

Thank you for your attention

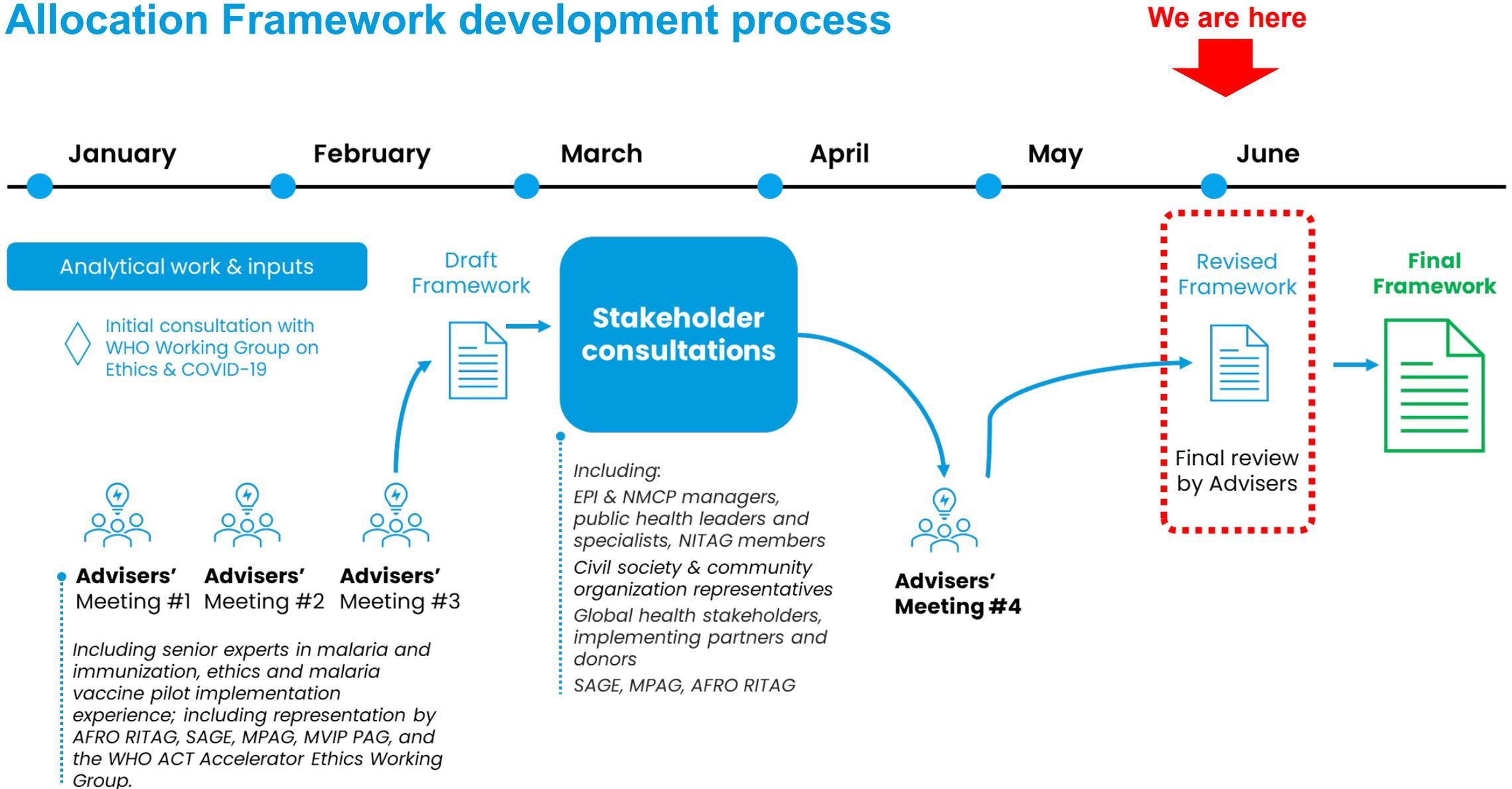


These are the first babies vaccinated with the new malaria vaccine in Malawi, Ghana, and Kenya (from left to right) in 2019, at the start of the Malaria Vaccine Implementation Programme (MVIP)

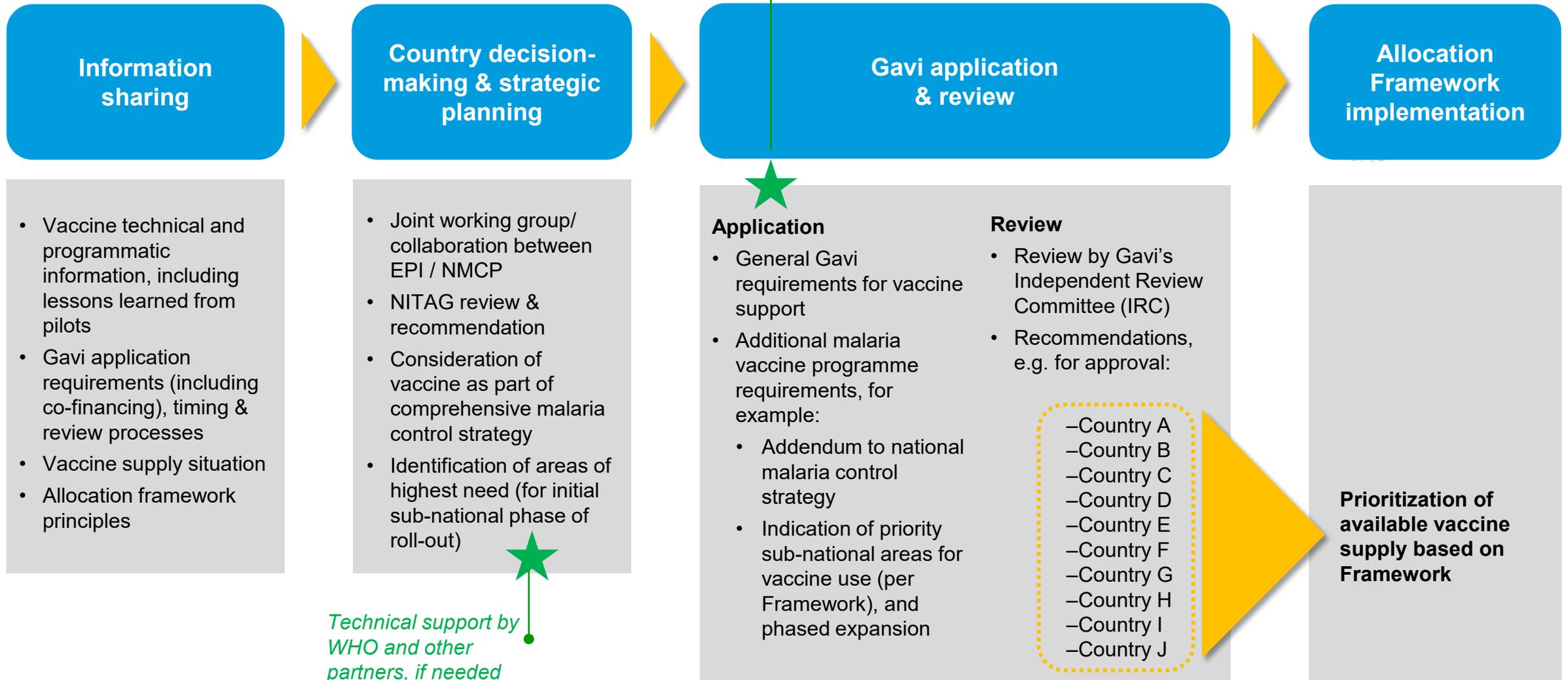
Back-up



Allocation Framework development process



Overview: Malaria vaccine decision-making and introduction process



General Gavi requirements for vaccine support

- **Funding eligibility:** Gavi support is available for countries with GNI pc below \$1660 or in the process of transitioning out of Gavi support
- **Review:** All applications are reviewed and approved (or requested for resubmission) by an Independent Review Committee (IRC)
- **Timing:** Applications are expected 12-18 months prior to introduction; introductions that do not occur within 2 years of approval require re-review by the IRC
- **Co-financing:** Vaccine support is expected to be cost-shared (between Gavi and countries) per Gavi's co-financing policy
- **Equity:** New introductions should prioritise zero-dose children and missed communities – those who persistently are unreached by immunisation and related services
- **Integration:** Where possible, introductions should be leveraged to strengthen catch-up vaccination and as opportunities for integration with other health services

Gavi application requirements

- Epidemiological rationale and target population (e.g., summary from review from NITAG or appropriate body)
- Inclusion of a detailed implementation plan: timing, projected coverage, geography
- Confirmation of cold chain readiness
- Confirmation of financial readiness (e.g., sign-off from MoF)
- Description of preparatory activities: training, social mobilisation, etc
- Link to other relevant interventions (e.g., comprehensive disease control plans; strategy for co-delivery of interventions)
- Explanation of schedule choice and delivery modalities
- Consideration of technical assistance needs

Illustrative additional malaria vaccine programme requirements

- Indication of how the vaccine will be included in the updated national malaria control strategy and national immunization strategy
- Illustration of priority sub-national areas for vaccine use, per WHO technical guidance and principles in the Allocation Framework
- Description of in-country establishment of cross-malaria & immunisation working group for both planning and execution
- Implementation plan, detailing co-delivery approaches (where relevant)
- Post-introduction monitoring plan
 - Demonstration of adequate safety monitoring activities (or plan for improvement) **as for any new vaccine introduction**

Tailoring the malaria response to subnational context



Dr Abdisalan Noor

Head, Strategic Information for Response Unit

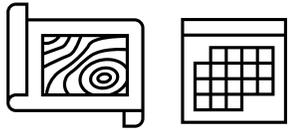
Global **Malaria** Programme



World Health
Organization

- Definitions
- Principles
- Process
- Concepts
 - Understanding and estimating effective coverage
 - Estimating the malaria baseline
 - Estimating reductions from the malaria baseline
 - Subnational tailoring of malaria interventions strategies
 - Optimization
 - Prioritization

Why the response to malaria requires subnational tailoring



- **Malaria is geographically heterogeneous**, with transmission intensity and burden varying sub-nationally, even in high burden countries.



- These variations are not only **geographic but also temporal** (seasonal and secular trends)
- This **heterogeneity is a function of variations in climatic and ecological factors** such as temperature, rainfall and humidity **but also** modulated by anthropogenic factors such as malaria interventions, health system performance, movement and migration, urbanization, agriculture, mining and other factors.



- Current malaria interventions are highly cost-effective but have **variable impact on the main burden endpoints** (infection, mild disease, severe disease and death). All the prevention interventions have **modest efficacy**, their effectiveness changes in space and time.



- Therefore, the best pathway to impact (depending on the desired burden endpoint) is **through optimized and prioritized combinations** (or intervention mixing).



- It **defines universal coverage** not to mean everything everywhere, but matching interventions to need driven by a desire to achieve the biggest possible impact with available resources.



- This must be **driven by the best possible subnational data**, and that the evidence informs a **nationally owned and governed approach to decision-making**, recognizing that social justice and equity are not secondary but primary considerations in the decision-making process.

What are the questions we are trying to answer using the SNT approach?

Where do we intervene?

Which interventions (or strategies) should we use?

Which interventions can we afford and how do we prioritize?

How and when do we deliver interventions?

How do we monitor their impact?

Definitions

Sub-national tailoring of malaria interventions – the use of **local data** and **contextual information** to determine the appropriate **mixes of interventions** and **delivery strategies**, for a given area, such as a district, health facility catchment or village, for **optimum impact on transmission and burden of disease**.

Interventions & strategies include - prevention, diagnosis, treatment, surveillance, monitoring and evaluation, delivery systems, support functions

Stratification - the process of geographically (and temporally) classifying **malaria risk** and **its determinants** into **meaningful categories** to inform the **tailored targeting** of the intervention under consideration. Eventually, this process leads to intervention (and strategy) mixes for each subnational unit. **Geospatial analysis/modeling** approaches are useful for stratification.

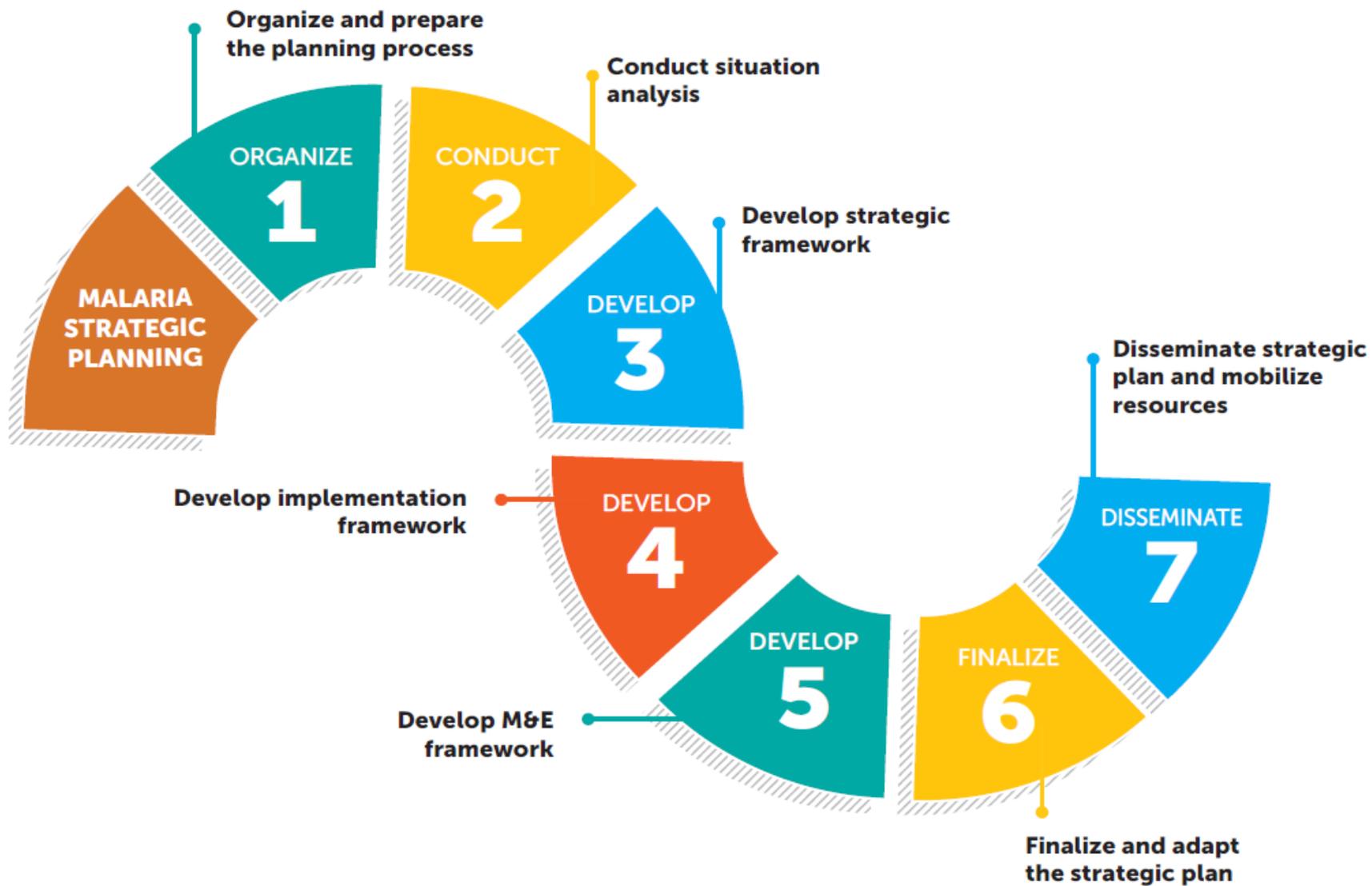
Optimization

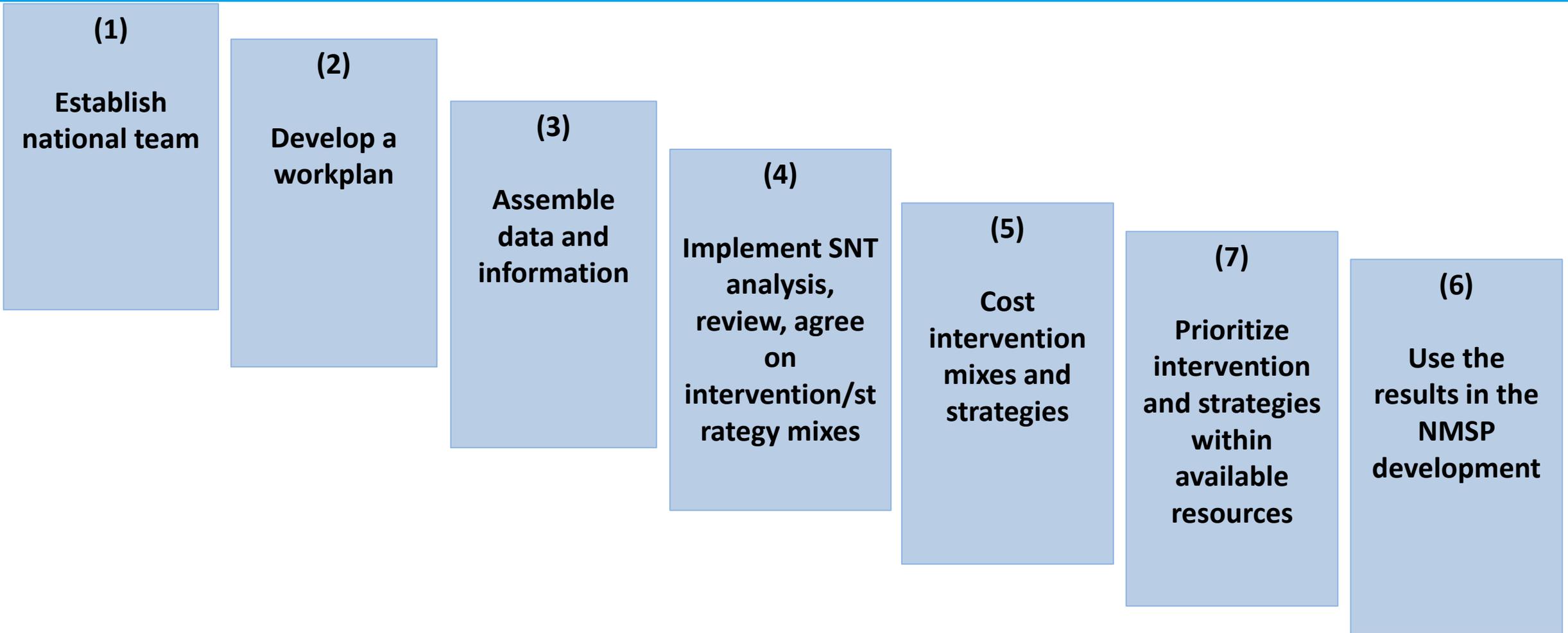
- National malaria strategic plans **ought to reflect the ambition of a country in its fight against malaria**. These targets are linked to overall **national health and development targets**.
- Therefore, the mix of interventions and strategies in these plans focus on what a country needs to do to achieve its targets and **not always constrained by the resources that are likely to be available** at the time of strategy development.
- *Optimization* was the process of ensuring that the interventions and strategies selected for NSP are most likely to lead to best possible **impact toward national targets**. These analyses should ensure that system-wide synergies are considered. **This is the basis of NSP costing.**

Prioritization

- Often, the **resources required** to fully implement national malaria strategic plans **are not available**.
- The SNT *prioritization* process aims to provide the right evidence to inform the **hard decisions countries need to make to prioritize investments for impact, social justice and equity**.
- The **difference** between the **NSP** costing and the **prioritized plan** is the **resource gap**.
- As new resources become available and context changes, the prioritization analysis will require revisions even with the lifespan of the NSP.

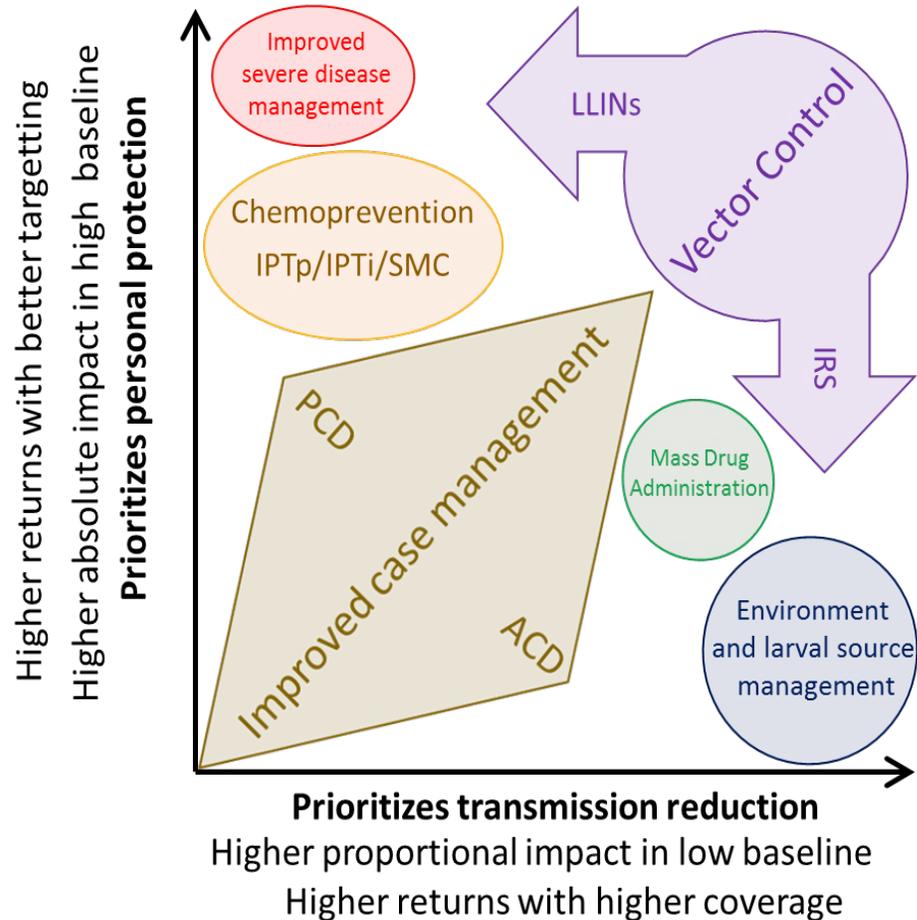
National Health Sector Planning process	Value-based health services	The Paris Declaration on aid effectiveness	The Global Technical Strategy for Malaria, 2016-2030	The High Burden to High Impact approach
<p>Part of the national priority setting process</p> <p>Responds to national health and development goals</p>	<p>Value-for-money (economy, equity, efficiency, effectiveness, cost and cost-effectiveness)</p> <p style="text-align: center;">+</p> <p>What patients and communities' value</p>	<p>Country ownership & alignment with national plans</p> <p>Inclusive partnership</p> <p>Measurable delivery</p> <p>Better coordination and efficiency</p> <p>Mutual accountability</p>	<p>Country ownership & leadership</p> <p>An elimination ambition regardless of transmission context</p> <p>Use local data and intelligence to drive impact</p> <p>Innovation, R&D</p> <p>Resilient health systems</p>	<p>Galvanizing political will</p> <p>Use strategic information to drive impact</p> <p>Better guidance, policies & strategies</p> <p>A coordinated national response</p>





Understanding and estimating effective coverage

Pathways to impact

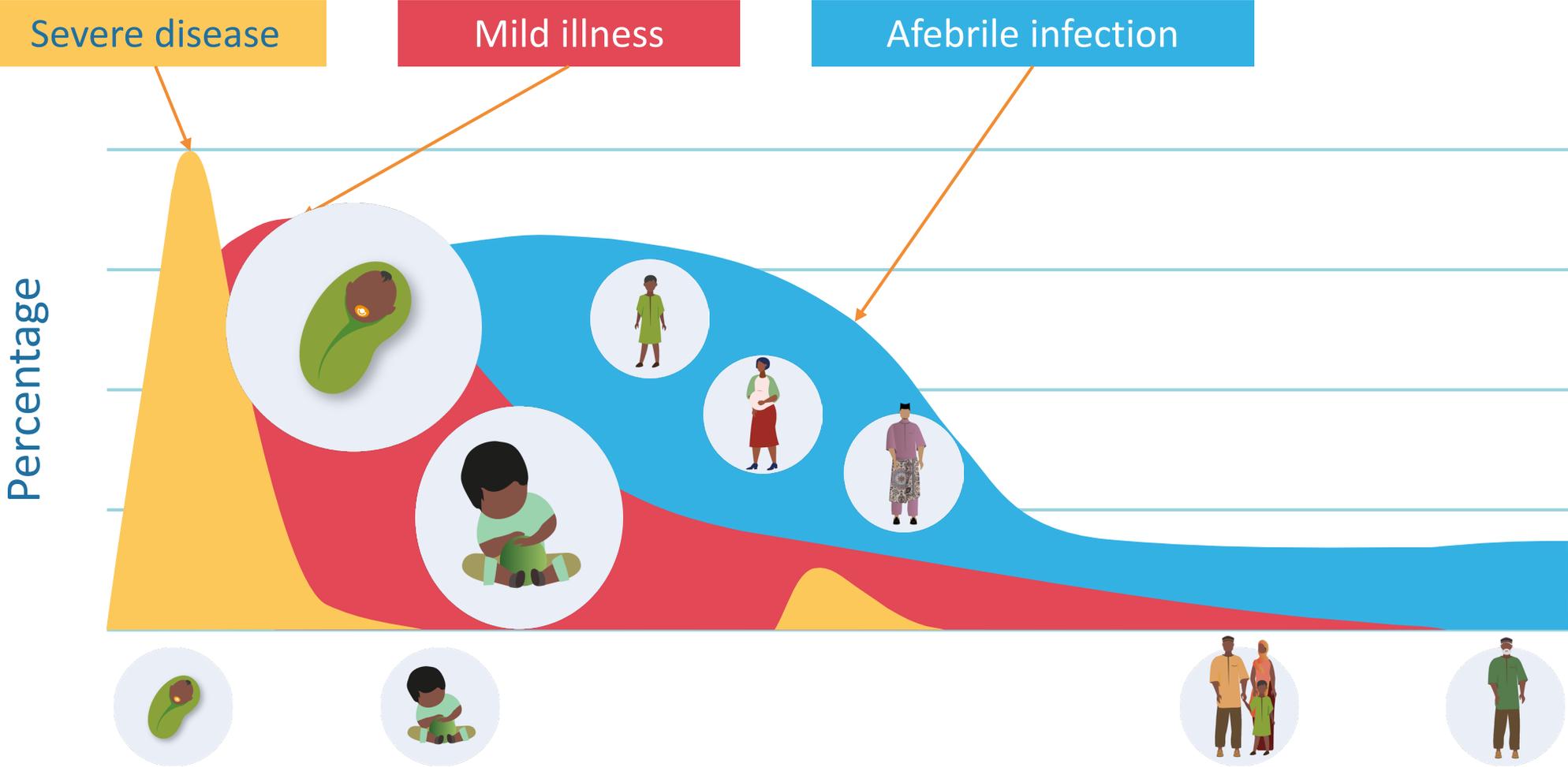


Different interventions implemented at the same coverage in the same place are also likely to have strikingly different effects, varying according to three factors:

- **Personal protection** through blocking an infectious mosquito that would otherwise feed, preventing an infectious bite from becoming an established blood-stage infection (e.g., due to prophylaxis or vaccination) or through reducing the severity of disease following a blood-stage infection
- **Impact upon onwards transmission** through preventing mosquito oviposition and emergence, reducing mosquito survivorship following emergence or in preventing mosquitoes from feeding upon infected humans.
- **Longevity and durability of effectiveness** of either personal protection, impact upon transmission or both.

These are further modulated by interactions with a changing environment e.g., urbanization, housing etc

Pathways to impact – immunity in moderate and high transmission settings



Source: Adapted from Langhorne et al., Nature Immunol, 2008

Impact endpoints - ITNs

ITNs significantly reduce (in children):

all-cause child mortality (rate ratio: **0.83**; 95% CI: 0.77–0.89; high-certainty evidence),

incidence of *P. falciparum* malaria (rate ratio: **0.55**; 95% CI: 0.48–0.64; high-certainty evidence),

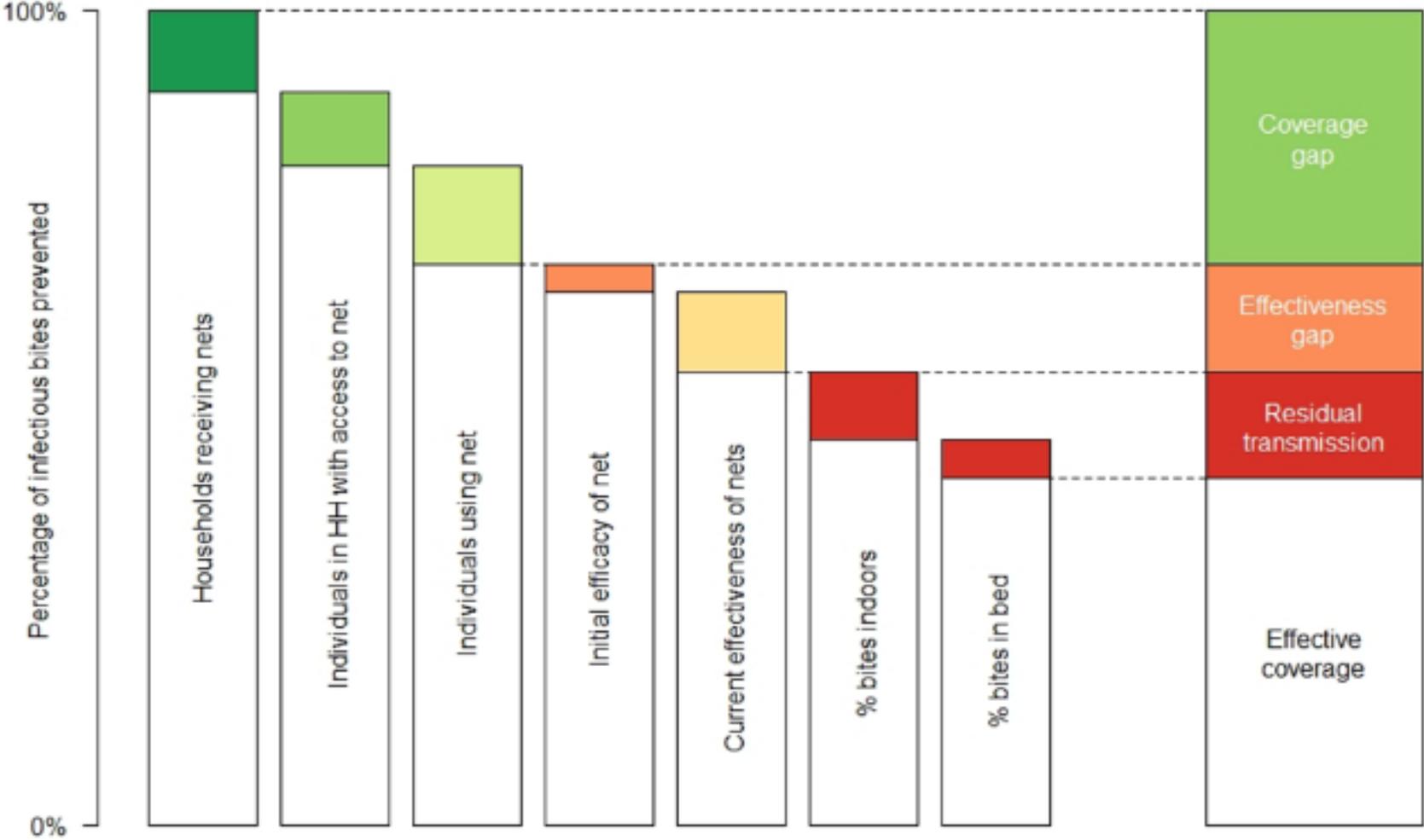
prevalence of *P. falciparum* malaria (risk ratio: **0.83**; 95% CI: 0.71–0.98; high-certainty evidence),

and **incidence of severe malaria disease** (rate ratio: **0.56**; 95% CI: 0.38–0.82; high-certainty evidence) compared to no nets.

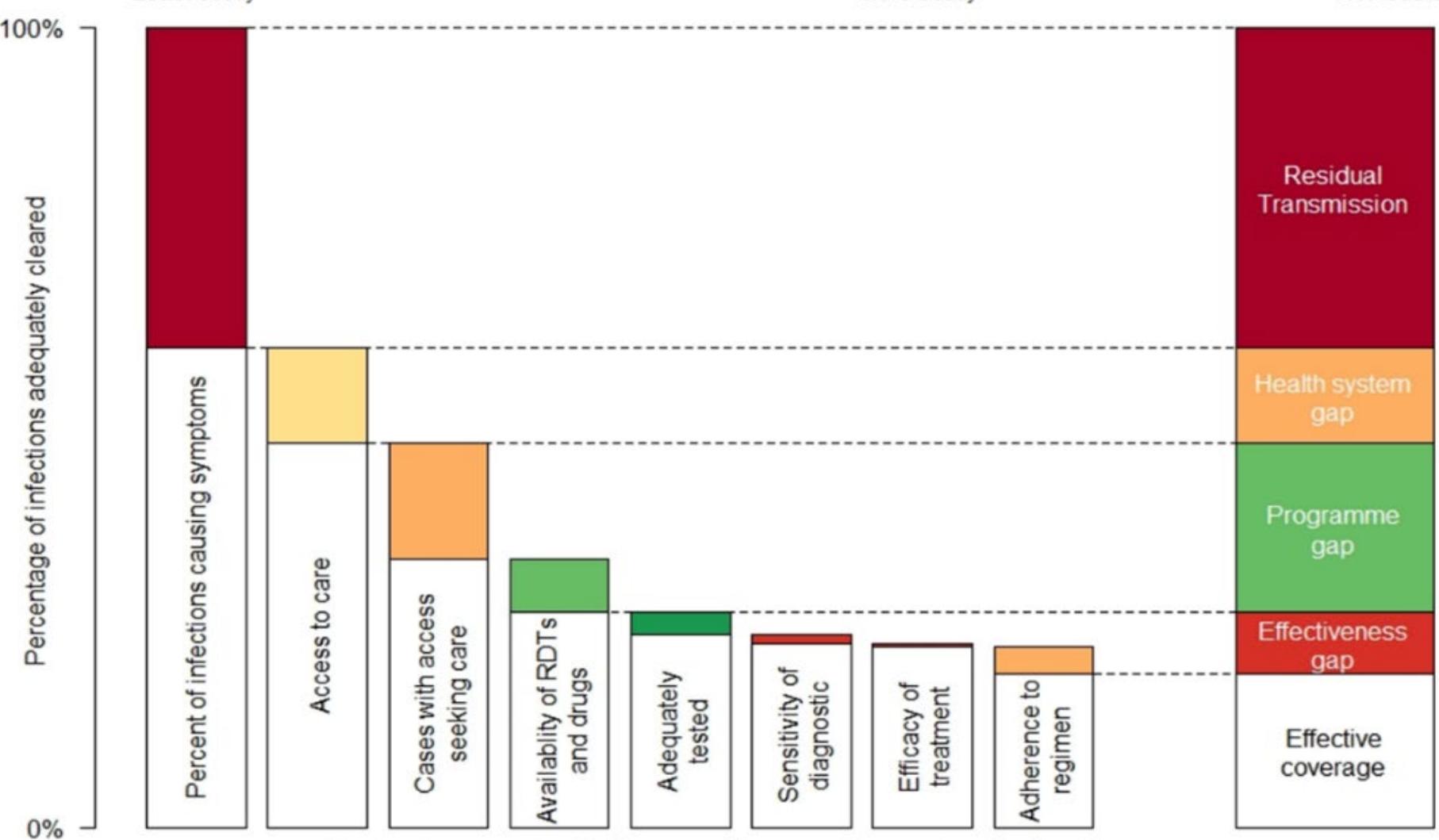
Different metrics for different interventions

- Parasite prevalence
- Cases (count and incidence)
- Severe disease (count and incidence)
- Deaths (count and rate)
- Entomological inoculation rate

Pathway to impact - ITNs



Pathway to impact – case management



Estimating effective coverage

- Household surveys
- Programmatic data
- Entomological data
- Efficacy data
- Research data
- Demographic data
- Climate data
- Socio-economic development data

*Modelling

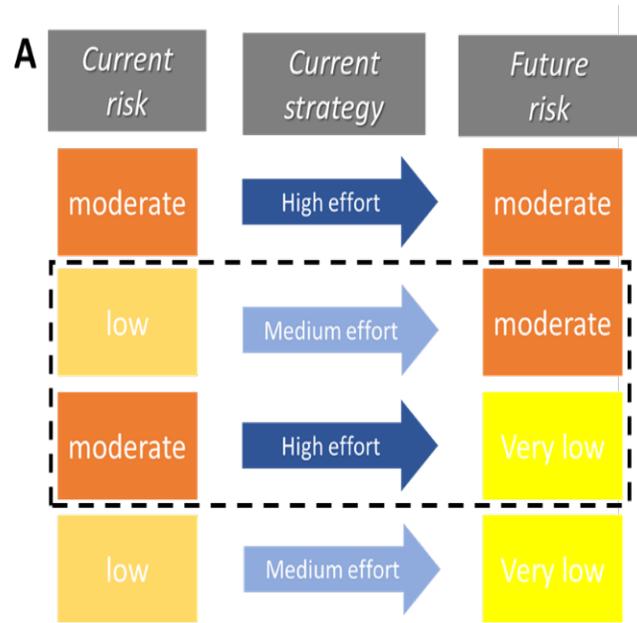
Estimating the malaria baseline

Why do we need to know the malaria baseline

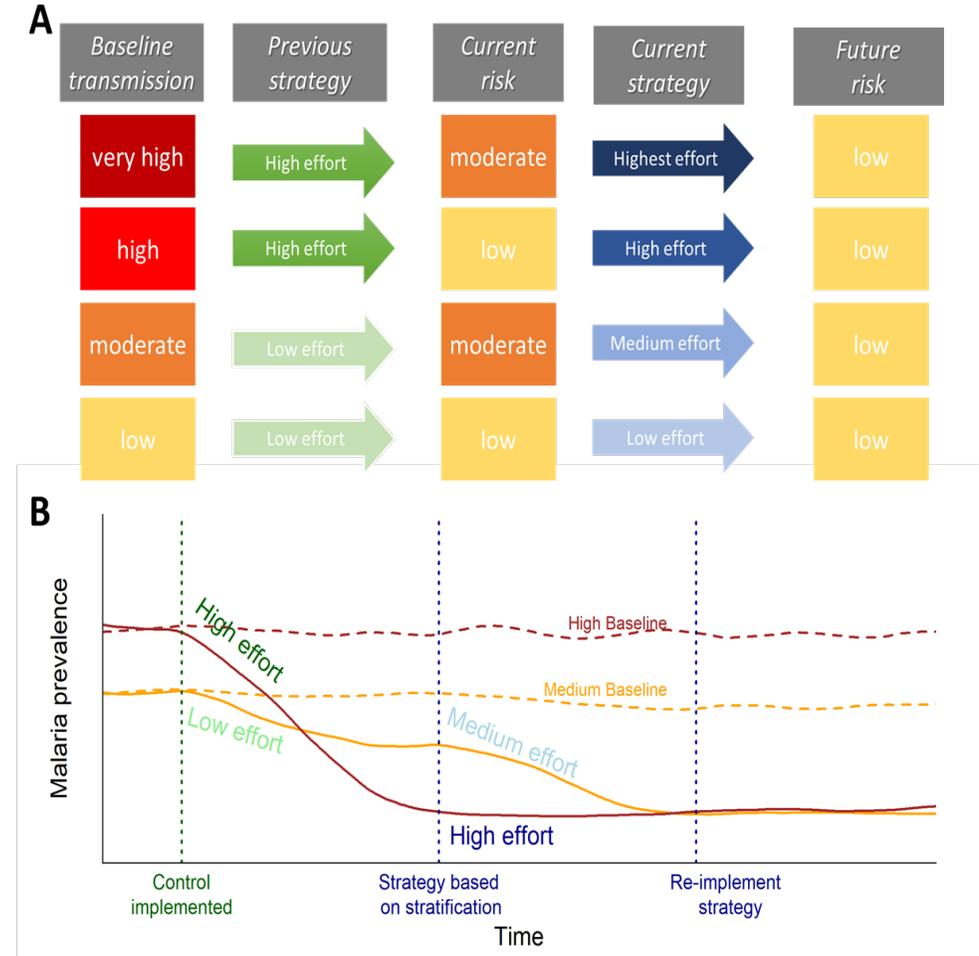
- Transmission intensity influences intervention efficacy/effectiveness
- Baseline intensity influences level of intervention coverage needed
- Not knowing the baseline may lead to decisions that result in resurgence

The risk of not accounting for the malaria baseline

Baseline transmission/risk not included



Baseline transmission/risk included

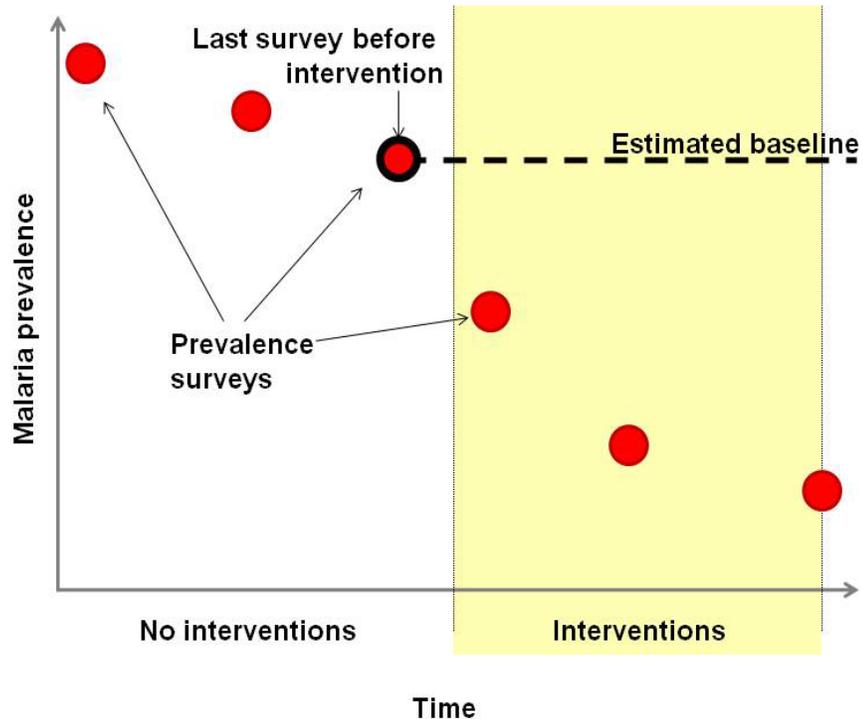


The baseline is not influenced by malaria interventions only.

Socio-economic development and related land use changes have a big impact

Estimating the malaria baseline

Baseline and current transmission and their determinants



A baseline in its strictest sense refers to the level of transmission where there are no interventions, including the provision of any effective treatment. In reality, there are few contexts where at least low levels of access to treatment has not been available.

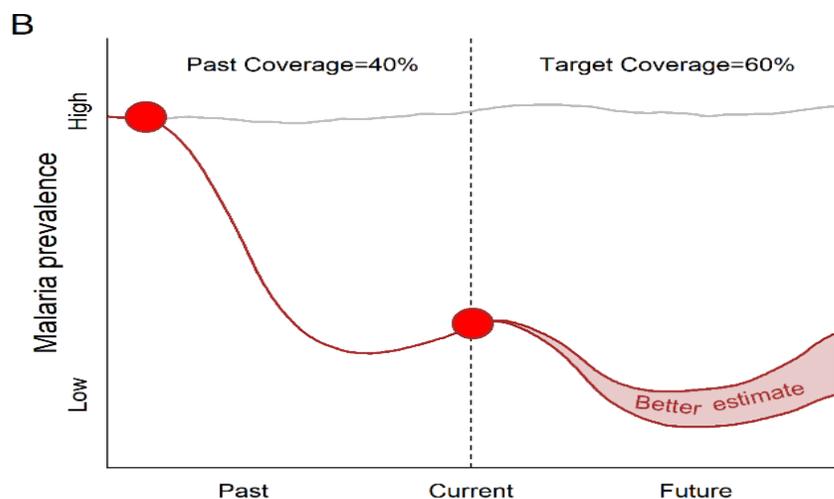
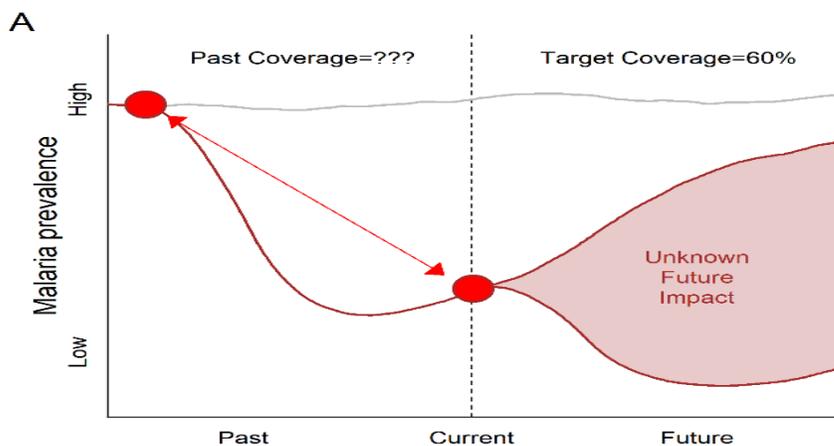
Given the possibility of changes in baseline unrelated to control measures, at least in settings where health systems are sufficiently robust that some access to effective treatment is always likely to be present, it may be most practical to use the last survey prior to the implementation of major preventative interventions (e.g. vector control or the provision of chemoprevention).

In this situation care must be made in interpreting this baseline when making strategic decisions around health system strengthening.

Estimating reductions from the baseline

Estimating reductions from baseline

Capturing what we did to get here: constructing the intervention/determinants layer



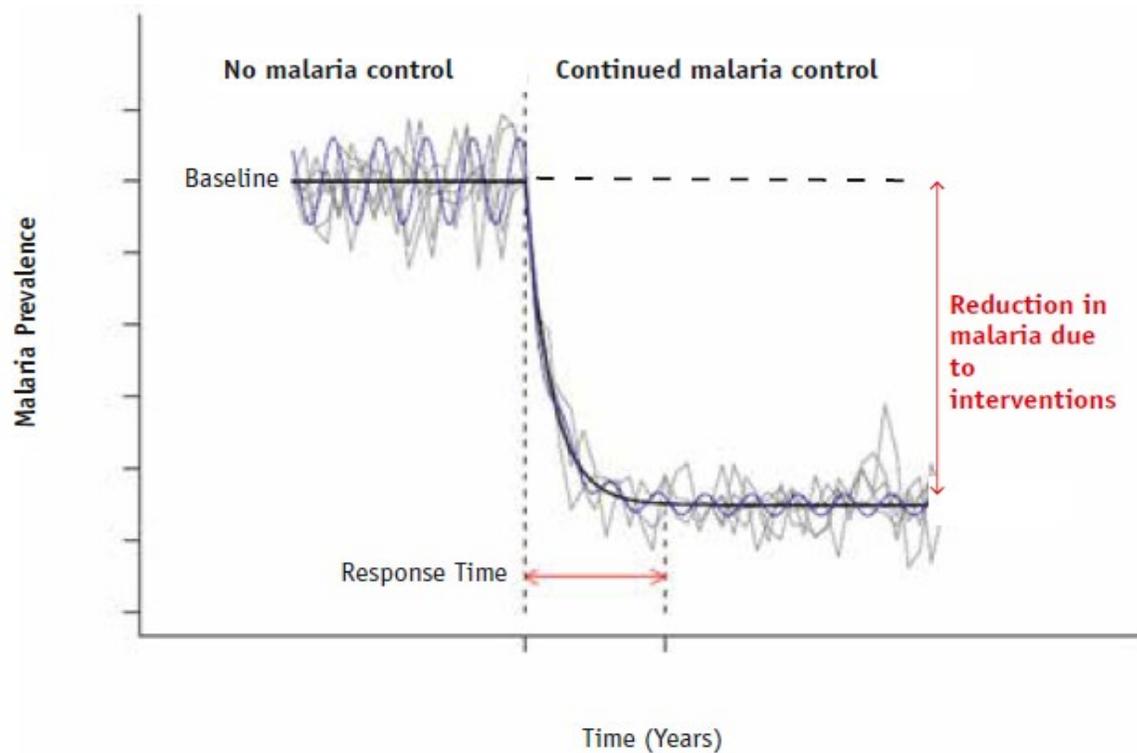
Detailed data around the previous scale-up of interventions and other determinants within a unit area are key to understanding the likely incremental impact of any future malaria intervention and its interaction with other determinants.

The amount an intervention reduces malaria from its baseline level is likely to differ greatly across operational units and will depend, for example, upon the magnitude of the baseline itself as well as the metric used to measure this baseline.

It will also depend upon the fraction of the population covered by an intervention, the extent to which it provides personal protection from infection or disease in those covered and the magnitude of impact of the intervention upon transmission.

As such, two places with very different baselines can have the same level of current risk due to variation in the effectiveness or coverage of interventions, and the effect of other determinants.

Estimating reductions from baseline



- The pre-control baseline
- The magnitude of the impact of specific interventions on transmission (efficacy to effectiveness)
- The fraction of the at-risk population in the area that can be fully protected by effective control measures
- The level of socioeconomic development and related land use changes during the intervention period
- Other factors – conflict, humanitarian emergencies etc

Information required to estimate change from baseline

- Epidemiological data
- Household survey data on interventions
- Programmatic data
- Entomological data
- Efficacy data
- Research data
- Demographic data
- Climate data
- Socio-economic development data

*Modelling

Subnational tailoring of interventions and strategies

Defining the optimal mix of interventions and strategies

a

Where do we intervene?

- Decide on operational unit
- Define criteria for intervention targeting
- Identify data needs (risk, determinants)

Adaptation of WHO recommendations, data assembly, stratification

b

Which interventions (or strategies) should we use?

- Use layers of information to identify areas that meet criteria for a specific intervention
- Repeat for all interventions
- Map your intervention mixes, quantify populations in need
- Project impact, refine mixes, optimize for NSP goals

Stratification, tailored targeting, modeling

c

Which interventions can we afford and how do we prioritize?

- Define level of available funding
- Define the 'fixed' vs 'flexible' decisions
- Work within flexible decisions to prioritize investment
- Choose the decisions with biggest impact (for a given endpoint) within available resources

Re-stratification, re-tailoring, re-modeling

d

How and when do we deliver interventions?

- Discuss this during optimization and prioritization processes as it informs effectiveness and costs
- Building cost-effectiveness into the modeling process may be useful
- Costs vs equity considerations – more expensive to under-served

e

How do we design systems to monitor their impact?

- Expect the tailoring process to be dynamic
- Define future data needs
- Identify appropriate M&E processes
- Plan for the right M&E tools across programmatic activities
- These are associated with costs and must be included in the optimization/prioritization processes

Country led stakeholder engagement to arrive at a consensus

Adapting WHO recommended malaria interventions and strategies

ITN

WHO Recommendation	Impact endpoints	Considerations for scale up	Considerations for geographic targeting	Considerations for prioritization for impact within budget
<p>i. WHO recommends deployment of pyrethroid-only long-lasting insecticidal nets (LLINs) for the prevention and control of malaria in children and adults living in areas with ongoing malaria transmission.</p> <p>ii. WHO suggests deploying pyrethroid-PBO nets instead of pyrethroid-only LLINs for the prevention and control of malaria in children and adults in areas with ongoing malaria transmission where the principal malaria vector(s) exhibit pyrethroid resistance.</p>	<ul style="list-style-type: none"> All-cause child mortality Incidence of <i>P. falciparum</i> malaria Prevalence of <i>P. falciparum</i> malaria Incidence of severe malaria disease 	<ul style="list-style-type: none"> Where the principal malaria vector(s) bite predominantly at night after people have retired under their nets. Strong and sustained community acceptability Main channel – mass campaigns Continuous channels – ANC, EPI, schools etc must be functional throughout Digital micrplanning and microdistribution platforms used for efficient targeting 	<ul style="list-style-type: none"> Malaria endemic areas – classified baseline transmission of >1% PfPR₂₋₁₀ Microstratification in urban areas – where receptivity has been modified from baseline levels, transmission is highly clustered and feasibility/acceptability may be low – overall effectiveness is likely to be low. Highly targeted approach needed 	<ul style="list-style-type: none"> Malaria endemic areas – could be redefine by increasing baseline threshold for example >5% PfPR₂₋₁₀ Equity considerations – communities that are disproportionately underserved given special consideration) Microstratification in urban areas – exclusion of all urban areas if average prevalence below the threshold of <5% PfPR₂₋₁₀ Insecticide resistance– targeting more expensive nets to highest resistance areas, or burden areas if resistance is widespread Impact analysed within the broad mixes of interventions, and by endpoint – the effect size, cost and cost-effectiveness

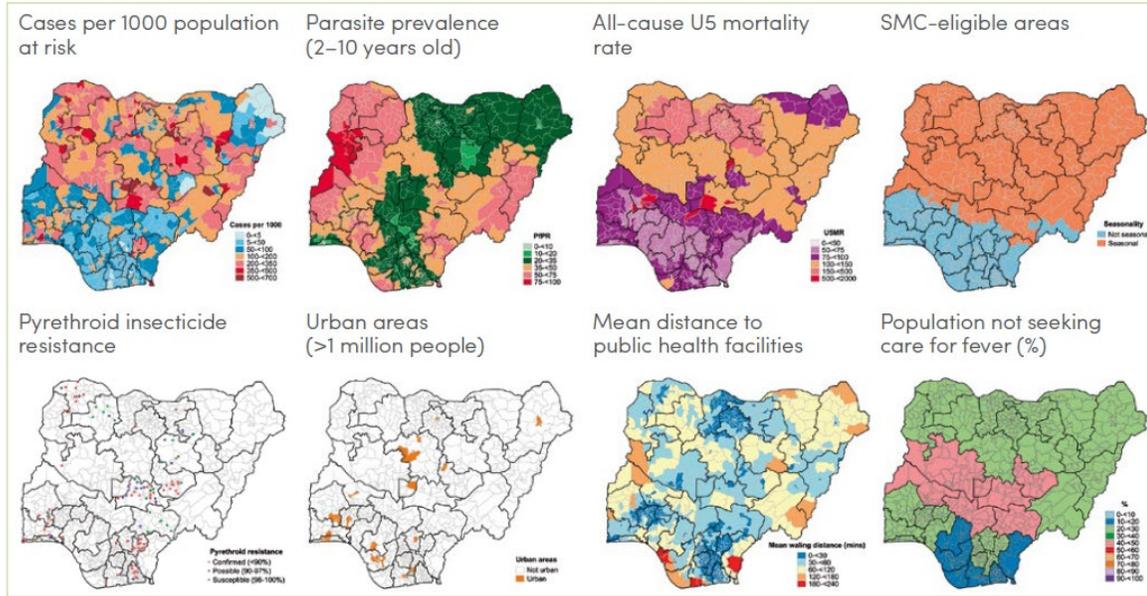
PART 2: WHO recommended malaria interventions and strategies: practical applications

SMC

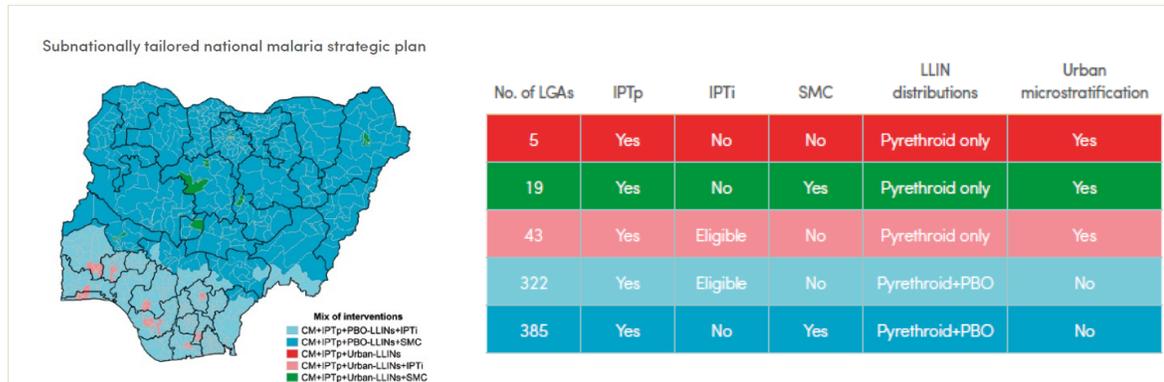
WHO Recommendation	Impact endpoints	Considerations for scale up	Considerations for geographic targeting	Considerations for prioritization for impact within budget
<p>i. In areas with highly seasonal malaria transmission in the Sahel subregion of Africa, provide seasonal malaria chemoprevention (SMC) with monthly amodiaquine + SP for all children aged < 6 years during each transmission season.</p>	<ul style="list-style-type: none"> • Incidence of <i>P. falciparum</i> malaria • Incidence of severe malaria disease • Moderately severe anaemia • All cause U5 mortality 	<ul style="list-style-type: none"> • High seasonal areas • Moderate <i>P. falciparum</i> transmission • Children 1-59 months • Administered start to end of season • In areas where AS+AQ is not first line treatment • Digital georeferenced planning and distribution tools used for efficient targeting 	<ul style="list-style-type: none"> • Moderate-high transmission: >10% PfPR₂₋₁₀ or >250 cases per 1000 • High seasonality– Consecutive months where majority of cases occur (>50%); • Length of season– seasonal range could be up to 5 months 	<ul style="list-style-type: none"> • Malaria endemic areas – could be redefine by increasing baseline threshold for example >20% PfPR₂₋₁₀ with the highest incidence or highest burden of severe malaria • Equity considerations – communities that are disproportionately underserved given special consideration. Usually correlated with highest burden • Microstratification in urban areas – include pockets of >10% PfPR₂₋₁₀ • Impact analysed within the broad mixes of interventions- by endpoint and cost effectiveness

What is the likely impact of your choices?

Stratification



Subnational tailoring of malaria interventions

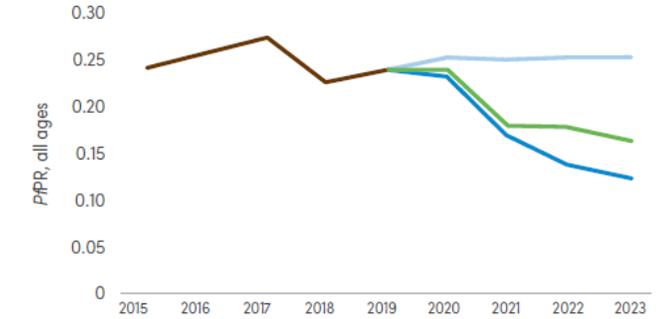


Prioritization

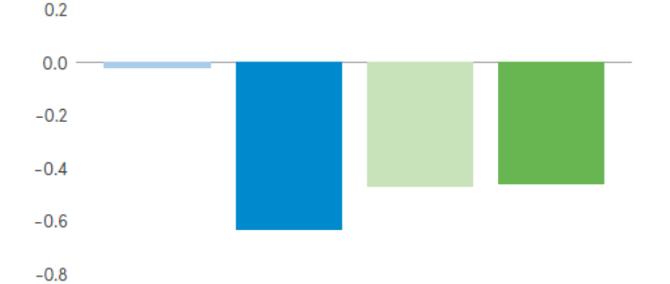
Analysis to compare the expected impact of 4 interventions scenarios:

- Business As Usual (BAU) plan
- National Strategic Plan (NSMP)
- Funding request including (with PAAR) or excluding (without PAAR) some SMC areas

Impact of new subnational targeting of interventions



Relative change in PPR (all ages): 2023 compared to 2020 BAU



Scenarios:

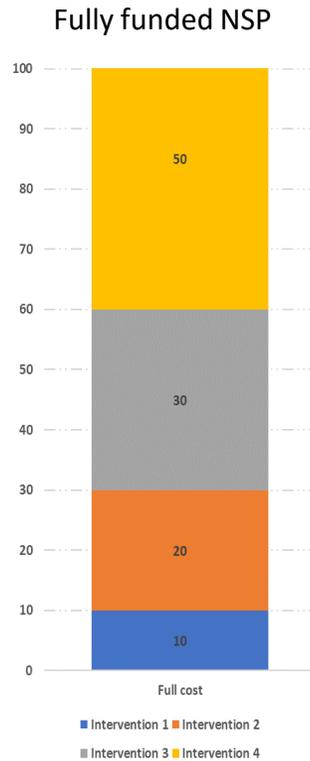
- Business as usual
- NSMP with 80% effective coverage
- Funded scenario with PAAR SMC LGAs
- Funded scenario without PAAR SMC LGAs



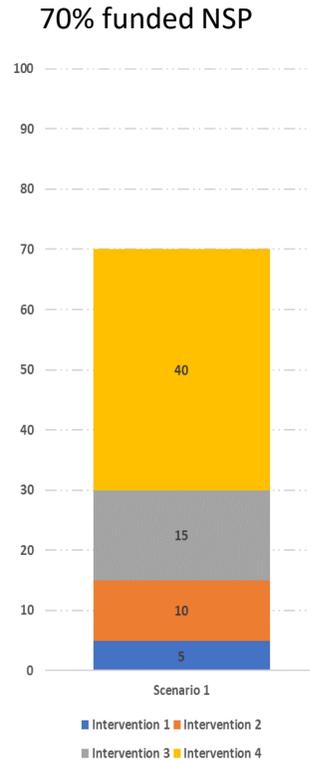
Scenario	Cases and deaths averted compared to a business as usual scenario, 2020–2023			
	Cases: all ages	Cases: U5	Deaths: all ages	Deaths: U5
Full implementation of NSMP	103 000 000	32 000 000	90 000	75 000
Funded scenario with prioritized above allocation request (PAAR) SMC LGAs	73 000 000	24 000 000	66 000	54 000
Funded scenario without PAAR SMC LGAs	71 000 000	23 000 000	64 000	53 000

Prioritization

Tailoring: stratification

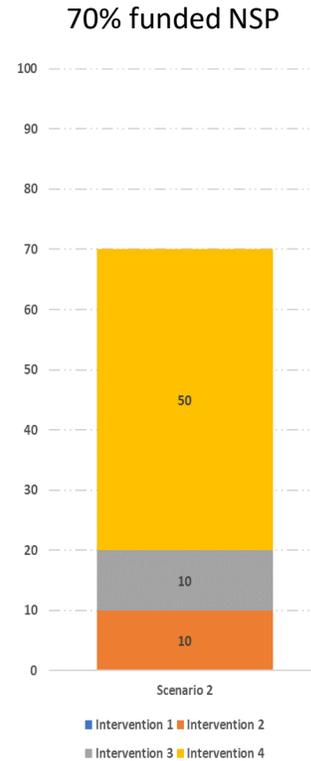


40% reduction in prevalence over 5 years



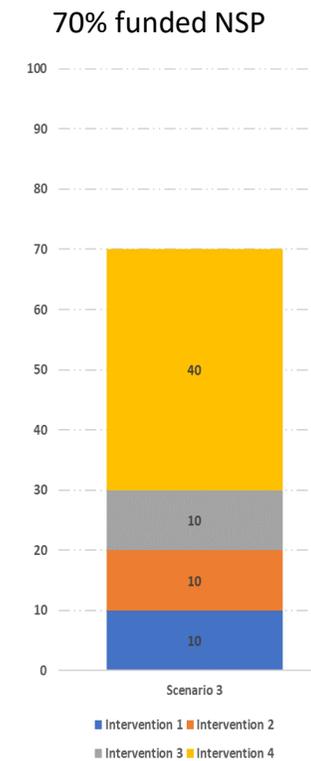
20% reduction in prevalence over 5 years

Most cost-effective (but not most equitable)



17% reduction in prevalence over five years

2nd most cost-effective (but doesn't address inequities well)



17% reduction in prevalence over five years

3rd most cost-effective (best addresses inequities)

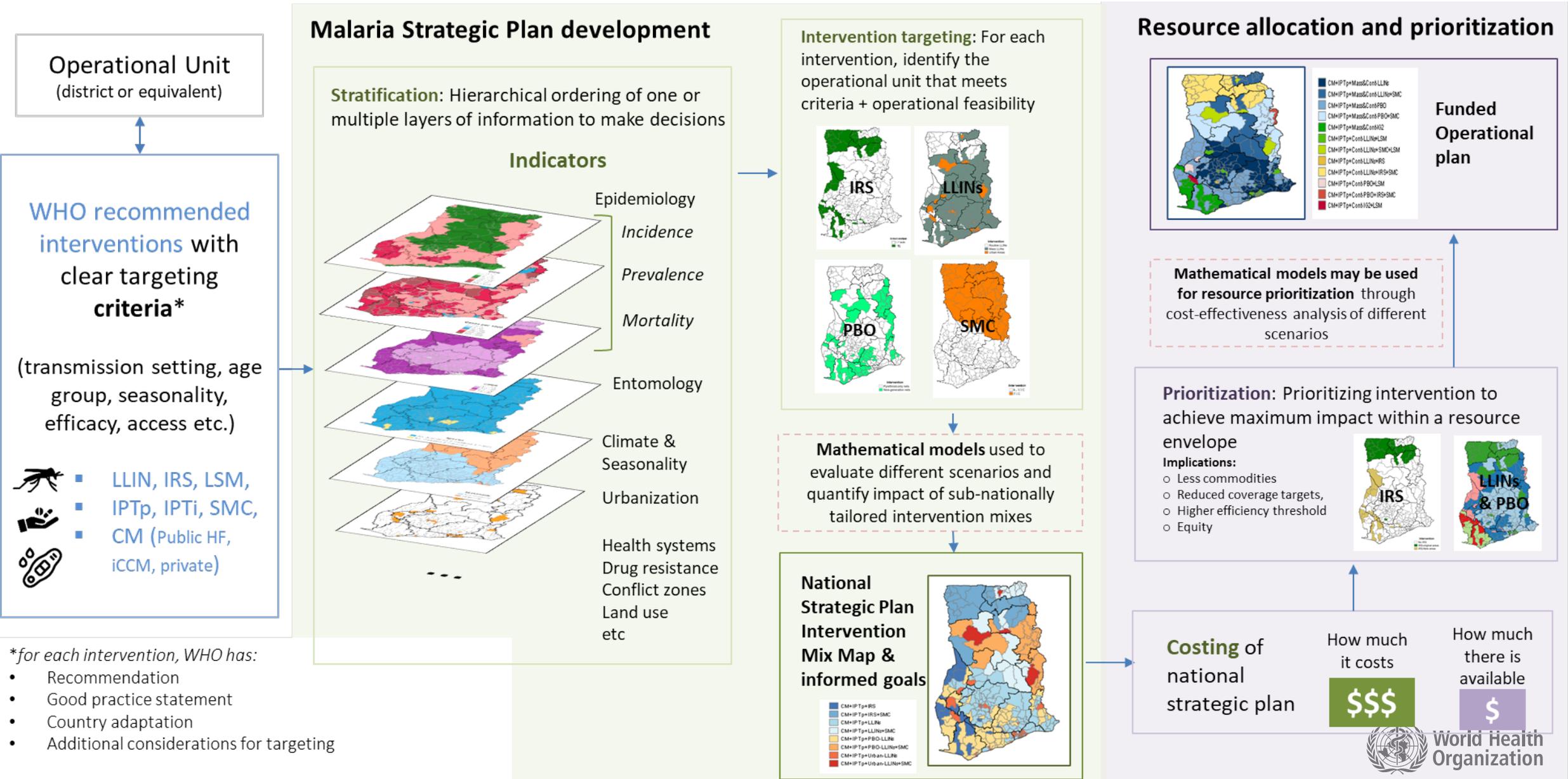
Balancing impact, cost-effectiveness and equity (and other value-based considerations)

Prioritization: modelling

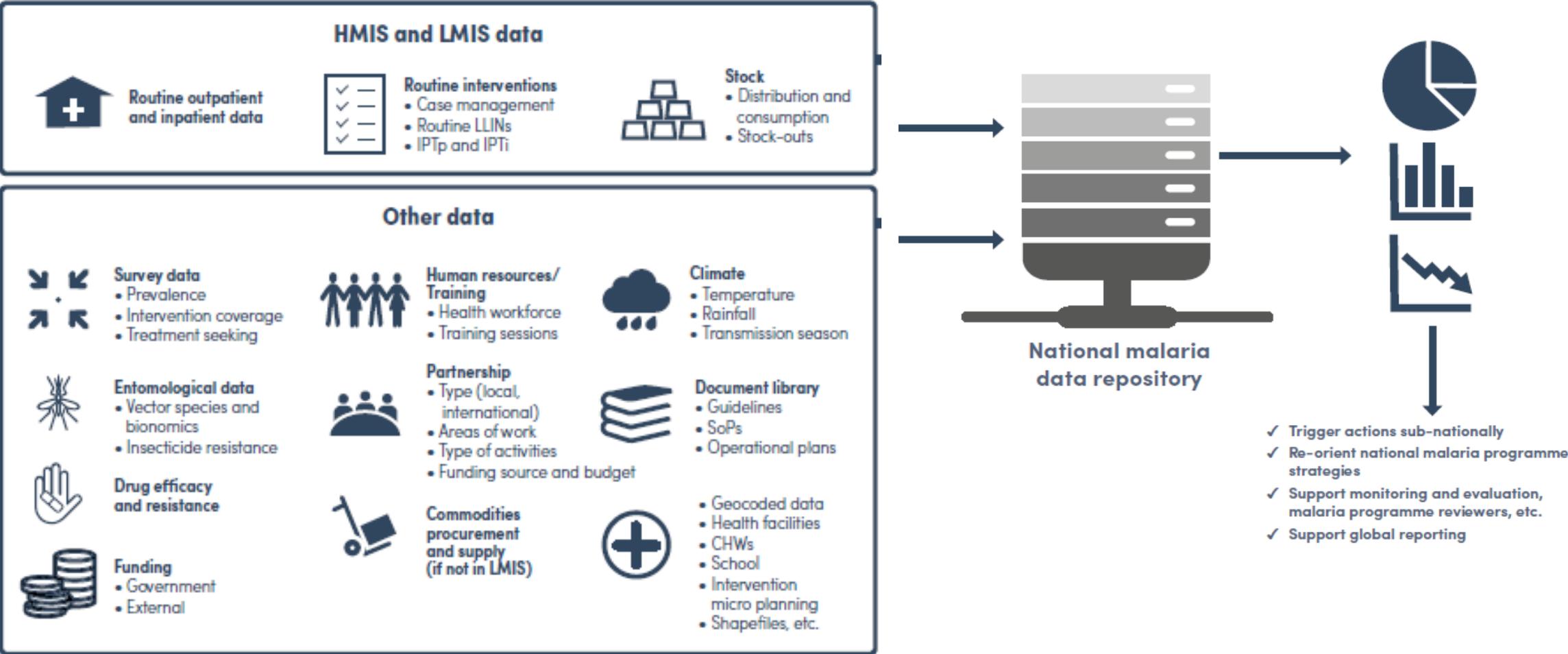
Prioritization

- High quality subnational tailoring analysis
 - High quality subnational cost data for interventions, strategies and activities linked to the subnational tailoring plan
 - A good understanding of available funding from all sources
- *Modeling are useful to project future impact of different scenarios and choose the one with highest impact given all relevant considerations

Subnational tailoring of interventions: example of Ghana



How do we monitor impact?



Important metrics

Metrics

Environmental covariates

- Rainfall
- Temperature
- Altitude
- Topology and other geographical covariates determining amenability to standing water
- Land use

Entomological measures

- Mosquito species & density
- Behaviour & biting rates

Infection prevalence

- Demographically representative population-based surveys
- Surveys of populations of interest
- Prevalence from pregnant women attending Antenatal Care (ANC) facilities

Health system

- Cases and case incidence
- Severe malaria
- Fever positivity rate

Intervention data

- Intervention distribution (location, type and timing)
- Intervention coverage, use
- Quality of care & surveillance
- Efficacy (insecticide & drug resistance, Pfhrp2 deletions)

Other metrics

- Under 5 mortality

Demographic

- Population (location, count, gender, age)

Foundational

- Subnational boundaries
- Geocoded health facilities
- Settlements and urban extents

Thank you