AFRICAN CONSTITUENCY BUREAU
FOR THE GLOBAL FUND

OVERVIEW OF THE ACB

AFRICAN VOICE FOR THE GLOBAL FUND
FIGHTING HIV/AIDS, TUBERCULOSIS AND MALARIA IN AFRICA.

BACKGROUND & CONTEXT

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- Africa bears the bulk of the disease burden(**over 70%HIV,24%TB & over 94% Malaria)**
- The Global Fund invests **about 73% of its resources to fight HTM in Africa**

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- Africa's **representation was initially sub-optimal** in governance discourses of the GF: Decision to establish ACB in Johannesburg in 2012

- Officially launched in Addis Ababa, Ethiopia, on the 1st of March 2017.

- Brings together the **two African constituencies, WCA and ESA**, represented in Global Fund governance bodies (board and committees).

4

- Formed to:
  - *Ensure effective **engagement, representation and participation** of African constituencies in Global Fund processes*
  - *Enhance the **capacity of the African constituencies to shape/influence** Global Fund policies and processes*

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HIV/AIDS

- In 2020, every day there are 4000 new HIV Infections (ADULTS AND CHILDREN) : 60% are in sub-Saharan Africa
- Adolescent girls and young women (aged 15 to 24 years): 25% of HIV infections, despite representing just 10% of the population.
- Western and Central Africa: more than half of pregnant women living with HIV who are not on treatment.

TUBERCULOSIS

- Home to 17 of the 30 high TB burden countries in the world
- 44% of people with TB were undiagnosed or not reported.
- Drug-resistant TB : a public health crisis with only one in three patients accessing treatment
- 44% of the overall TB response: unfunded
- only 22% of existing resources come from domestic sources.

MALARIA

- 95% of malaria cases and 96% of deaths are concentrated in SSA
- 80% of all malaria deaths estimated to be among children under the age of five.
- The region contributed to over 95% of the increase in Malaria cases and deaths between 2019 and 2020

ACB MISSION & VISION((2022-2025)

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THE ACB VISION: "An Africa free of the burden of HIV/AIDS, tuberculosis and malaria"

MISSION: To influence global health policies towards increasing investment to end the three epidemics and support the attainment UHC and SDGs in Africa

STRATEGIC OBJECTIVES

- **SO1**: To ensure that African priorities and interests are reflected in the Global Fund governance decisions

- **SO2**: To develop innovative strategic partnerships that support the amplification of African Governments' policy positions in global health platforms, and enhance sustainability

- **SO3**: To purposefully structure a sustainable Bureau with capacity to adequately support Africa's delegations to achieve their Global Health policies and priorities.

OUR
CORE ACTIVITIES

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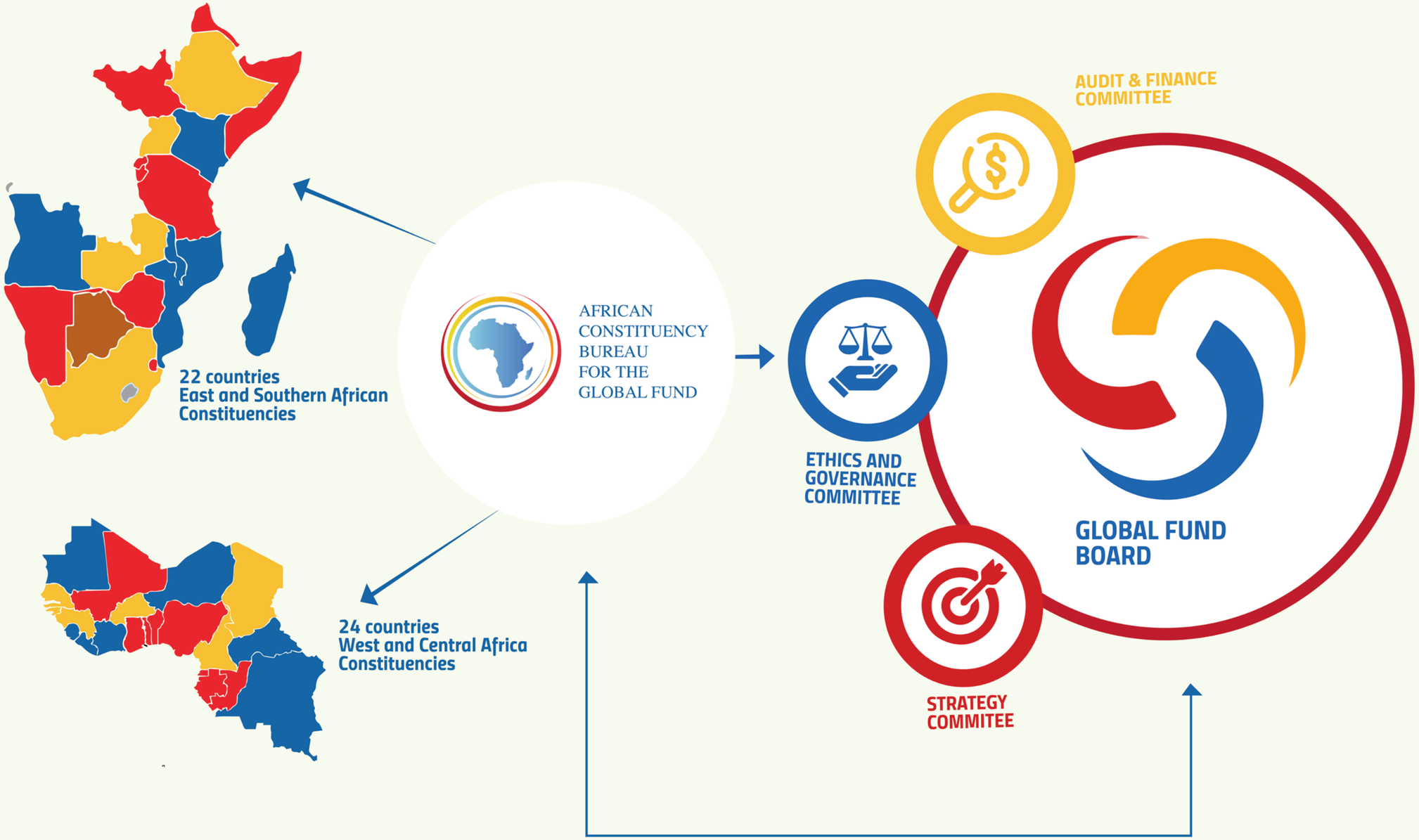
FOR THE GLOBAL FUND

a) Prepping and strategizing : African representatives in the Global Fund board and committees to enable them effectively represent the continent

b) Ensuring consensus on African priorities and positions in GF: Engage with African stakeholders, including implementers such as the Ministries of Health, Country Coordinating Mechanisms, and other relevant African leaders and experts

What does the African Constituencies Bureau do?



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OUR CORE ACTIVITIES continued…

c. Advocacy: Engagements with other stakeholders to ensure buy-in of African priorities and positions in global health platforms;

d. Policy research: package evidence (policy briefs, newsletter publications, brochures, summaries of board and committee papers, constituency statements, talking points, etc.) and arguments to fit diverse audiences

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AFRICAN VOICE FOR THE GLOBAL FUND
FIGHTING HIV/AIDS, TUBERCULOSIS AND MALARIA IN AFRICA.

ISSUE 1: **FEB 2021**

MALARIA RESURGENCE

#AFRICANVOICE4GF

FACTSHEET

"SUB SAHARAN AFRICA CARRIES A DISPROPORTIONATELY HIGH SHARE OF THE GLOBAL MALARIA BURDEN"

Sub Saharan Africa carries a disproportionately high share of the global malaria burden. In 2018, the region was home to 93% of malaria cases and 94% of malaria deaths .Since 2002 there there has been a significant reduction in malaria mortality. From 2010 to 2019, malaria mortality rates reduced by about 36%, according to the World Malaria report 2020. In the last three years Progress is slowing, and, in some places, the number of cases and deaths are once again starting to rise.

KEY ASKS TO ADDRESS MALARIA RESURGENCE

PROVIDE SUPPORT to actions that raise communication and awareness:
- Strengthen communication and awareness in the community about malaria; and
- Strengthen community-based interventions at all levels by also involving the youth.

STRENGTHEN COMMUNITY SURVEILLANCE systems related to malaria and integrate with the national electronic systems;

ORGANIZE CONSULTATIONS with communities to identify their areas of needs with regards to malaria;

IMPROVE CROSS-BORDER collaboration to combat the spread of malaria, including optimal prevention among vulnerable populations such as refugees; prevention among vulnerable populations such as refugees;

MONITOR AND ADAPT to resistant insecticides and mosquito nets;

STRENGTHEN THE MONITORING and distribution systems for malaria by maintaining the quality of stocks and effectiveness of the mosquito nets;

STRENGTHEN THE QUALITY ASSURANCE for diagnosis and treatment;

STRENGTHEN PROVISION OF INTERMITTENT Preventive Treatment (IPT) for pregnant women;

IMPROVE THE PROVISION OF TREATED NETS to also cater for vulnerable populations such as prisoners, refugees, internally displaced persons, etc.;

STRENGTHEN MULTI-SECTOR INTERVENTION and ensure coordination of structures dedicated to malaria control;

ADVOCATE AND MONITOR the progress of the malaria vaccine.

COMMUNITY ENGAGEMENT is a key driver for Malaria elimination!

LET'S STOP CROSS-BORDER MALARIA TRANSMISSION by facilitating collaboration among health ministers, national malaria programs, and partners

[1]https://www.who.int/news-room/fact-sheets/detail/malaria
[2]https://www.theglobalfund.org/en/blog/2019-04-25-malaria-resurgence-is-a-very-real-risk/

#AfricanVoice4GF

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FIGHTING HIV/AIDS, TUBERCULOSIS AND MALARIA IN AFRICA.

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HIV/AIDS AMONG ADOLESCENT GIRLS & YOUNG WOMEN (AGYW) POLICY RESEARCH

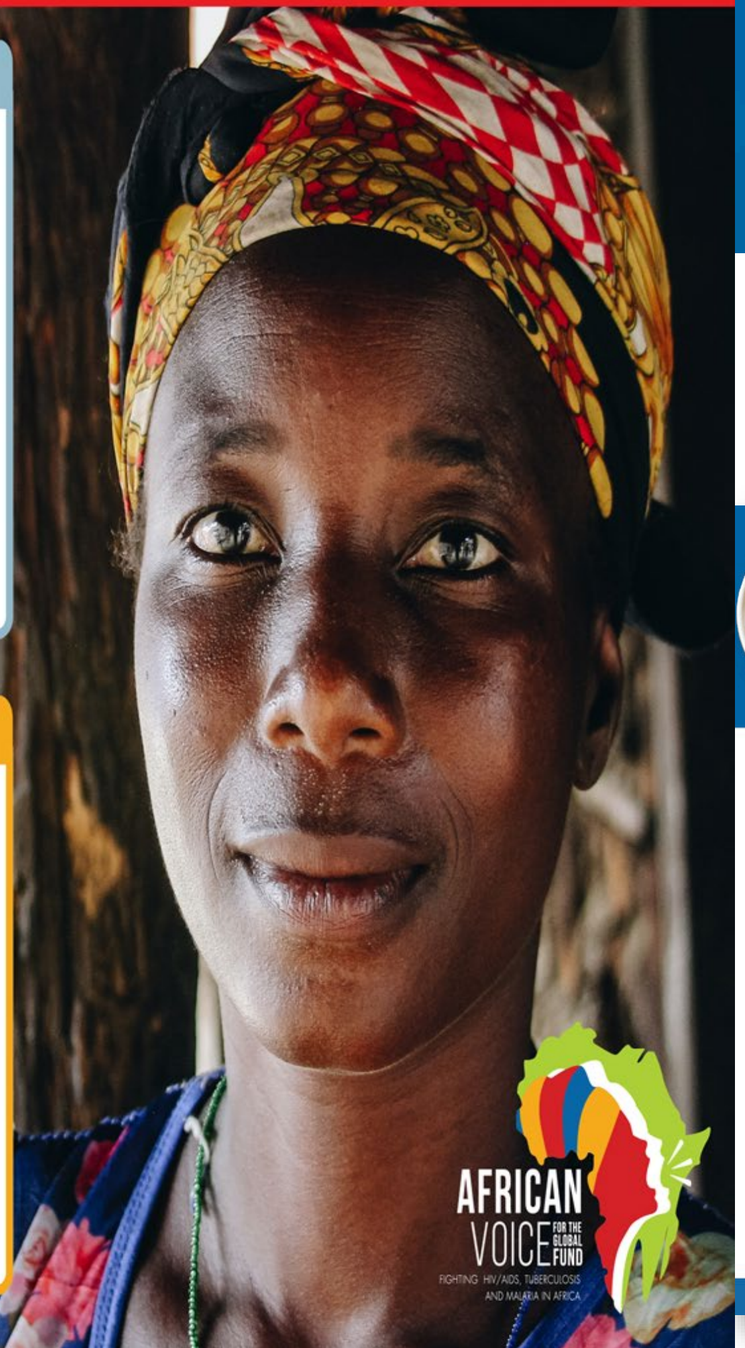
#AfricanVoice4GF

FACTS & KEY FINDINGS

- **ESA is the area with higher prevalence of HIV compared to WCA and where vulnerability is generally higher among the young population.** However, in the region, AGYW are twice as likely to be living with HIV than young men of the same age .Specifically adolescent girls and young women accounts for 30% of new infections . This figure is higher than the global average recorded in recent year, which was reported to be 25%.
- **Unequal gender norms often limit the access of women to HIV information and services, and put them at risk of gender-based discrimination** and violence, including harmful practices, such as child, child and forced marriage and female genital mutilation, that may increase the risk of contracting HIV.
- **Structural drivers of HIV include laws and policies that fail to support the rights of women and girls to health, including HIV services, or to prevent discrimination and violence against them.** Structural drivers also include lack of access to education and employment which could have provided them with the resources to prevent HIV and to access treatment.

POLICY RECOMMENDATIONS FOR GLOBAL FUND INCLUDE:

- **Promoting gender transformative and rights-based approaches by supporting actions that promote gender equality,** address structural barriers, abandon harmful gender norms and improving access, quality and friendliness of services for HIV prevention among AGYW
- **Supporting at scale interventions that empower AGYW through access to information and education and other appropriate means to negotiate for safer sex,** delay sexual debut, and know the whereabouts of HIV services, including where Prevention of Mother to Child Transmission (PMTCT), are accessed
- **Scaling up the practice of engaging men and boys and mobilizing the community** for social and behavioural change which has been proven to be an effective strategy for HIV prevention among AGYW.
- **Promoting the participation of women's organizations and networks of PLHIVs,** adolescent girls and young women so that their voices guide policies and programs aiming to enhance behaviours, biomedical, and structural interventions for adolescent girls and young women.



POLICY ISSUES

AFRICAN CONSTITUENCY BUREAU
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PRIORITY POLICY ISSUES

- Development of people-centered and integrated Resilient and Sustainable Systems for Health (RSSH)

- Sustainable financing

- NextGen Market Shaping **(local manufacturing)**

- Improving Grants performance in **West and Central Africa**

- Challenging Operating Environments related policies

- embedment of gender equality, human rights and equity

- Country Ownership & Accountability of partnerships

- Cohesion of African voices in Global Health governance platforms

OUR VALUE PROPOSITION

- ACB is the only constituency-based policy dialogue platform with governmental support that authentically speak on behalf of the Member Countries

- Pan African policy think-tank (continental reach)

- African-led and staffed

OUR CURRENT ORGANOGRAM

EXECUTIVE DIRECTOR
JOSEPHAT KAKOMA

Policy & Programmes Manager
AARON MULAKI

Finance & Admin Manager
AWEL M. SETARGEW

Policy Analysis Lead
DJESIKA AMENDAH

Advocacy & Communication Lead
FASSIKA ALEMAYEHU

Finance Officer
MULUMAR GADISSA

Liason /Driver
EPHREM DEMISSIE

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FOR THE GLOBAL FUND

TECHNICAL PARTNERS

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

World Health Organization
REGIONAL OFFICE FOR Africa

African Union
AFRICAN UNION COMMISSION/
REGIONAL ECONOMIC COMMUNITIES,

UNITED NATIONS
UN AGENCIES

Aidspan

POLICY
THINK
TANKS

CIVIL
SOCIETY

CURRENT FUNDERS

BILL & MELINDA GATES foundation

EXPERTISE FRANCE

L'INITIATIVE
sida, tuberculose, paludisme

Foreign & Commonwealth Office

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

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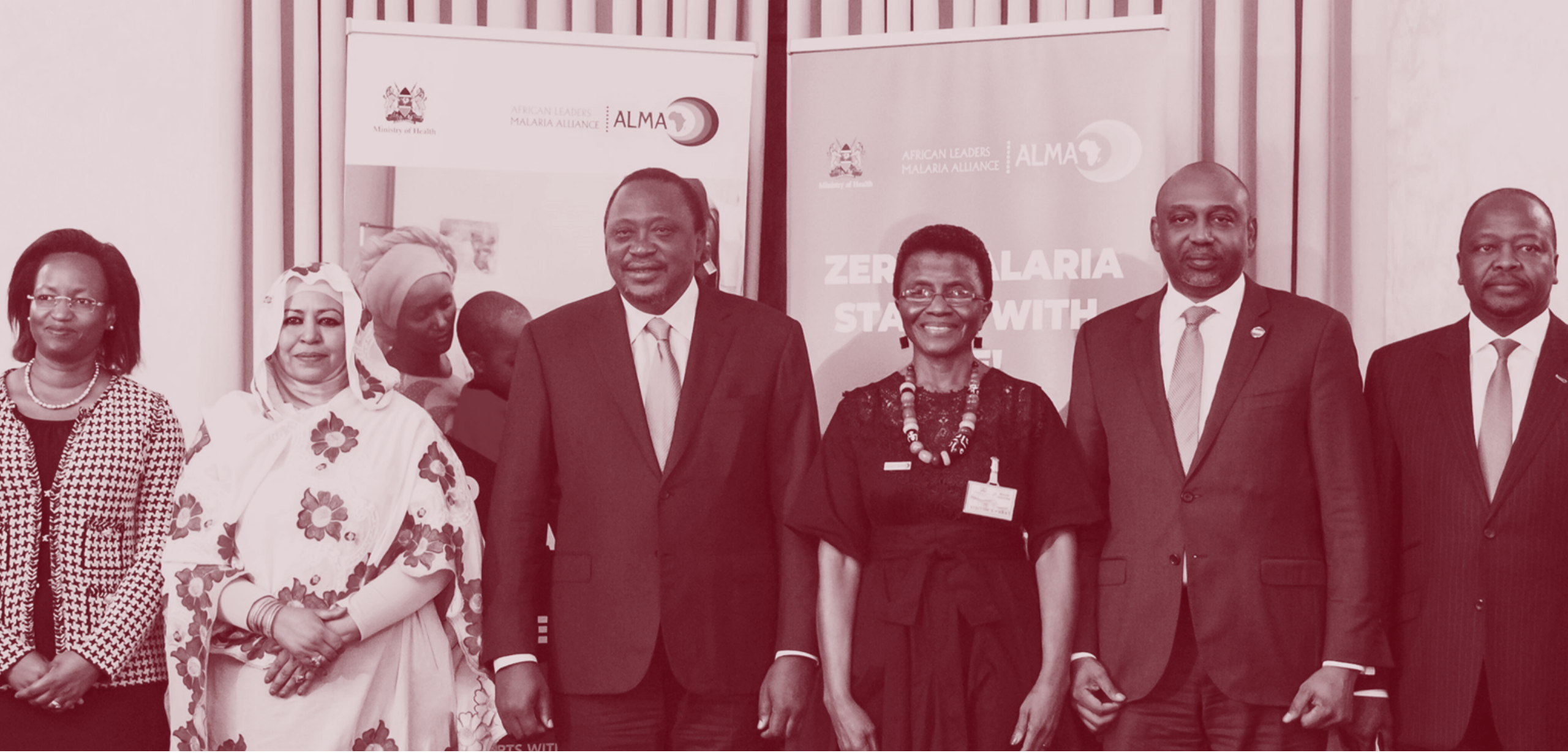
AFRICAN CONSTITUENCY BUREAU FOR THE GLOBAL FUND

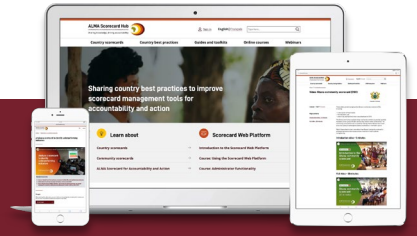
5 YEARS ANNIVERSARY 2017-2022

LET'S ENGAGE
THANK YOU

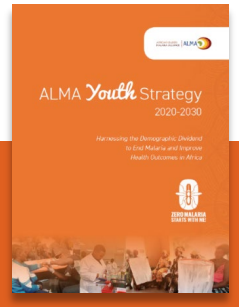


AFRICAN LEADERS
MALARIA ALLIANCE
ALMA

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)



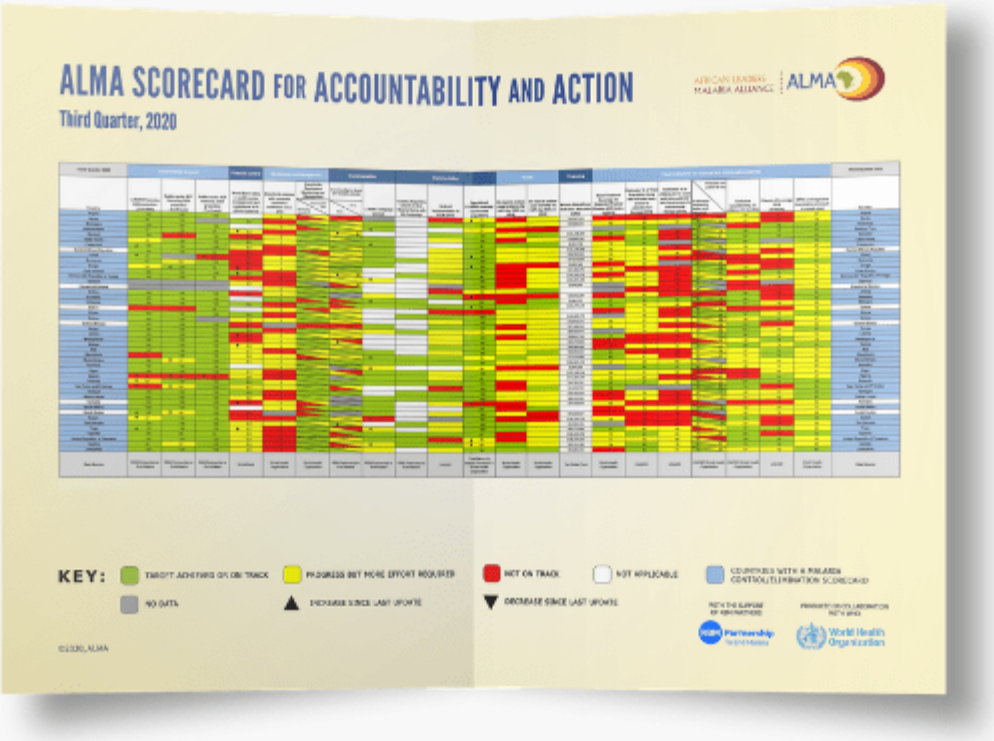
Creation of national Malaria Youth Armies to recruit and engage youth leaders to champion the fight against malaria

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

Enhanced regional coordination on malaria through Regional Economic Communities

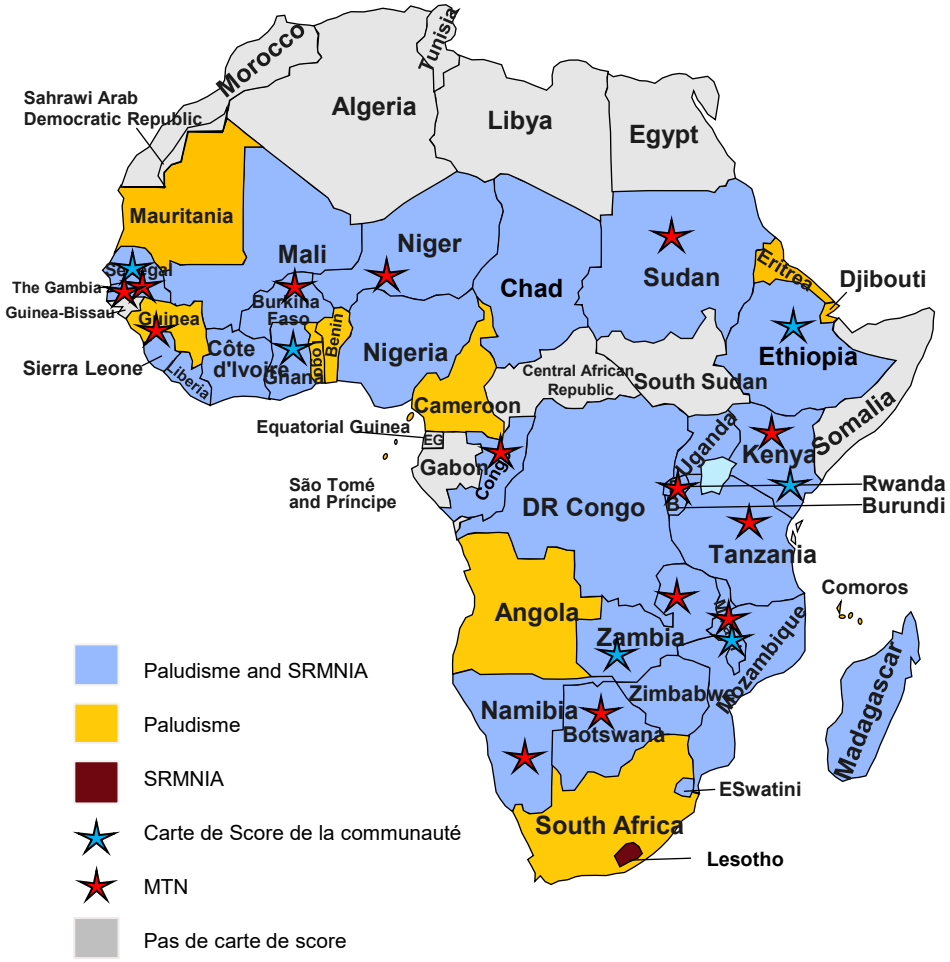
Renewed commitment to local manufacturing of commodities

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

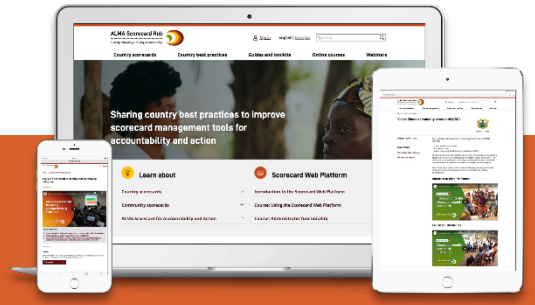
- Social accountability tool mobilising communities to be more active participants in health systems strengthening
- On a quarterly basis, community votes and scores indicators related to quality of care to produce scorecard
- Community and health facility staff develop joint action plans to address 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	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



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: CIFF CHILDREN'S INVESTMENT FUND FOUNDATION

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

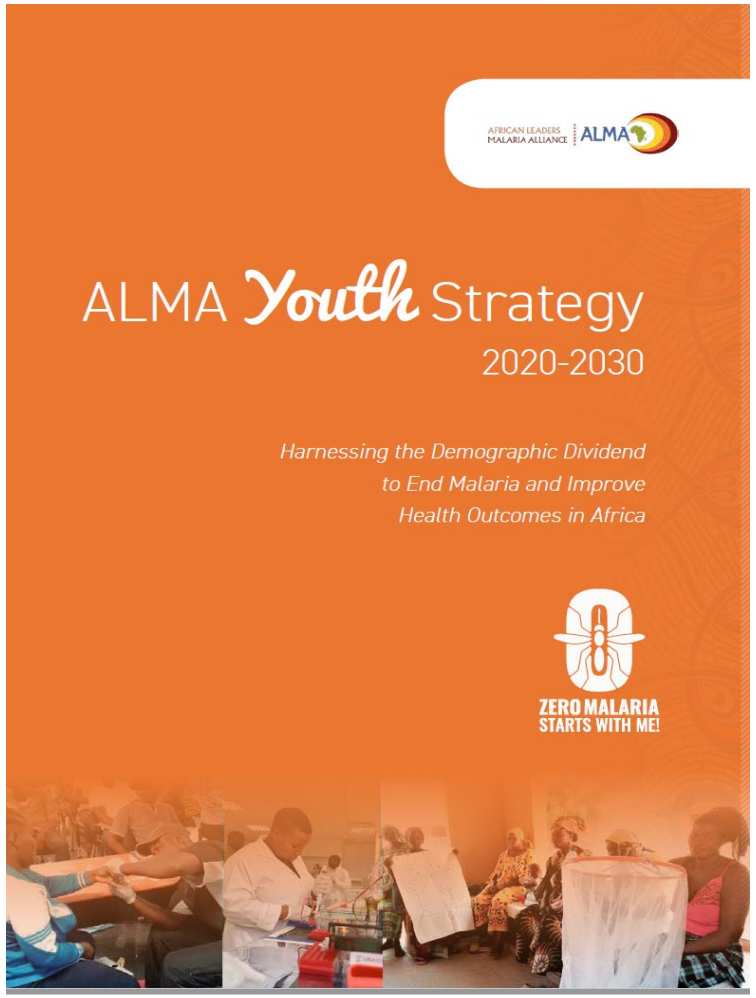
16 malaria scorecard best practices

15 RMNCAH scorecard best practices

8 community scorecard best practices

7 neglected tropical disease scorecard best practices

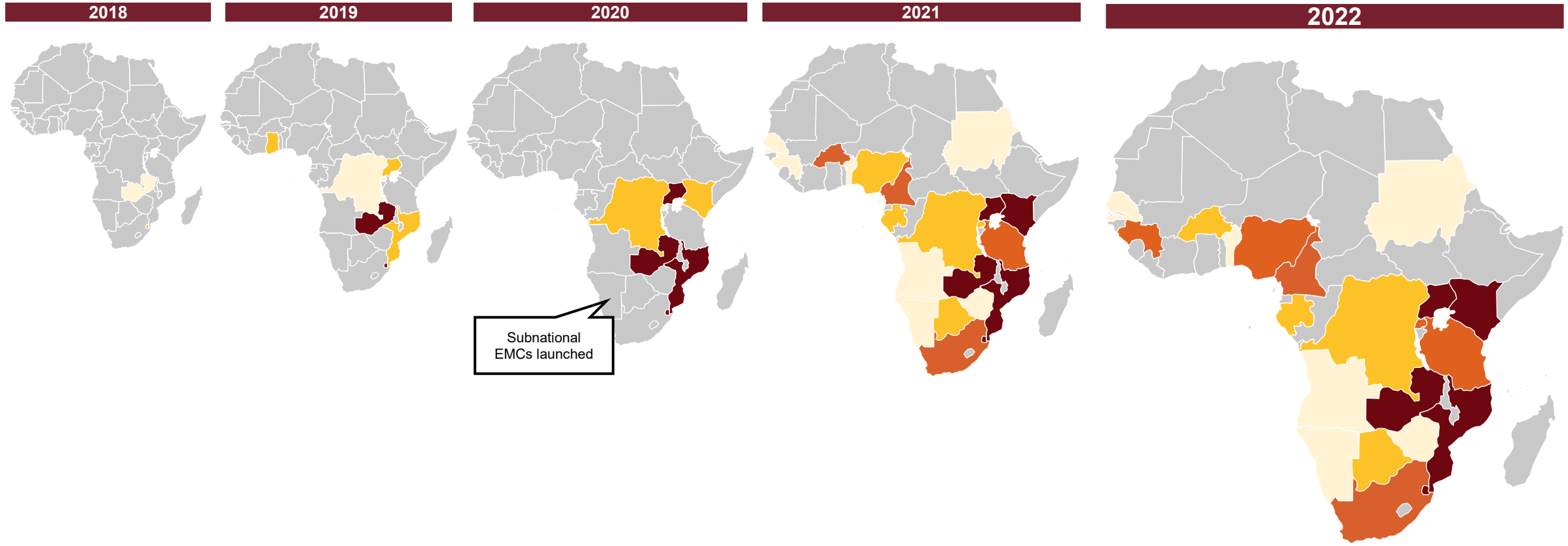
ALMA has launched a continental Youth strategy and advisory council



ALMA Youth Advisory Council

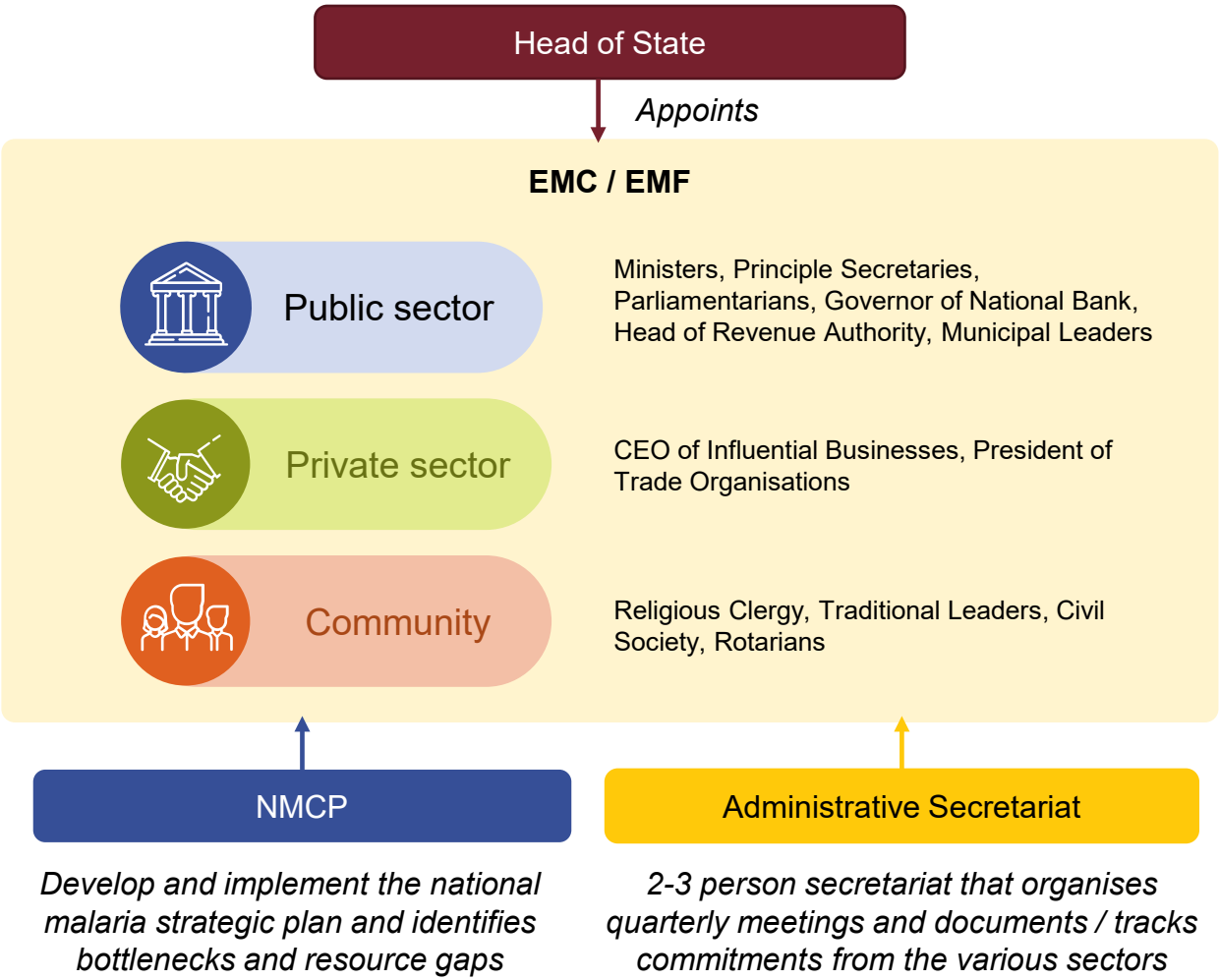
National Malaria Youth Armies are launching across the continent to mobilise a new generation of advocates and leaders

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



Designing | Advanced Planning | Announced | Operational

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



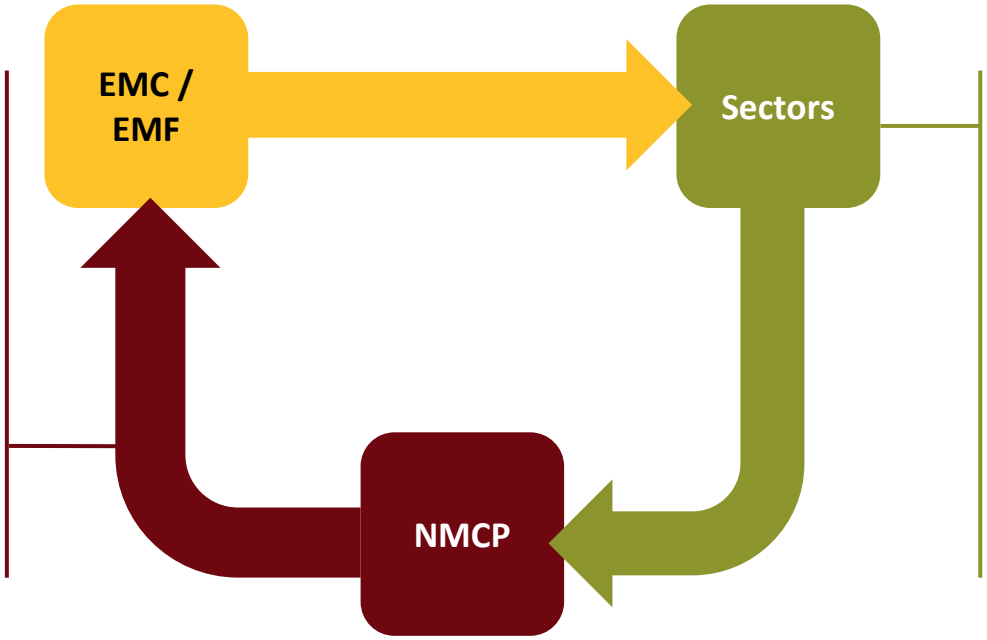
EMCs are a forum of senior leaders that meet quarterly to review the status of malaria control and elimination (including via the national scorecard).

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

NMCP escalates challenges to the EMC / EMF

- Resource gaps
- Operational bottlenecks
- Recommended actions for other sectors to take
- Recommended policy changes



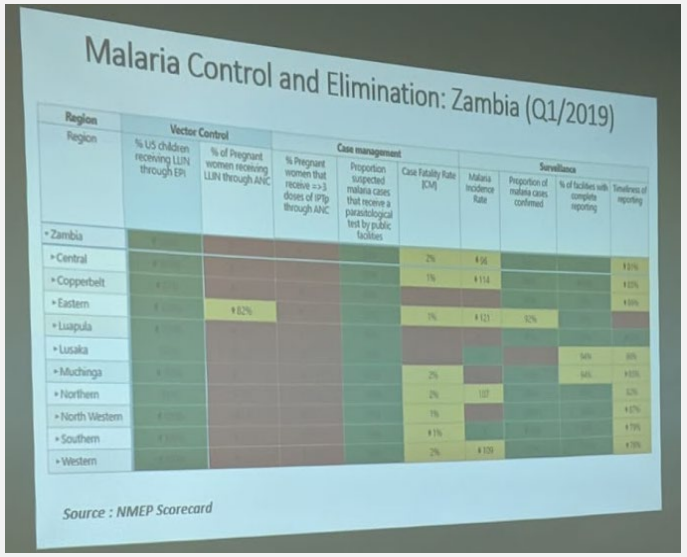
EMC / EMF members engage their sectors to mobilise commitments

- **Advocacy:** Advocate for malaria to remain high on each sector's agenda
- **Action:** Take action to help implement the national malaria strategic plan
- **Resource Mobilisation:** Mobilise financial and in-kind resources to close gaps
- **Accountability:** Promote mutual accountability within and across sectors for ending malaria

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



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

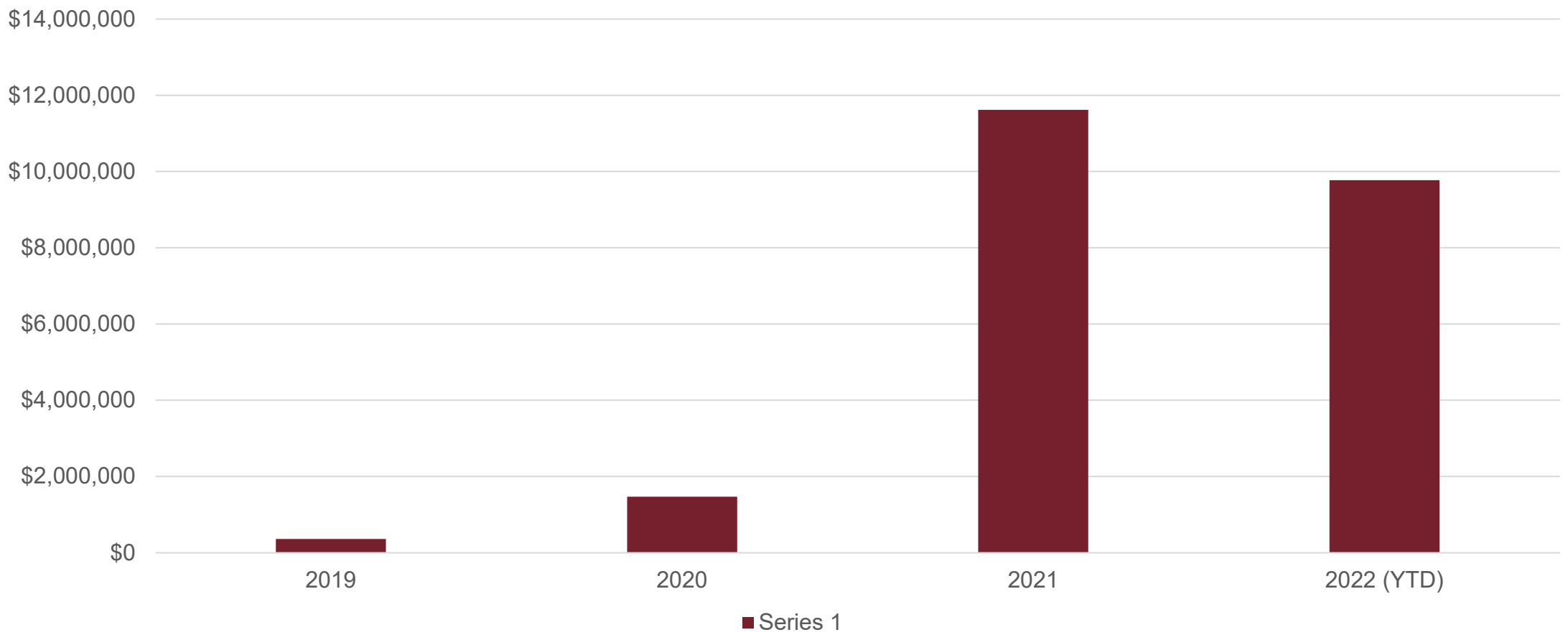
EMC engagement

- 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



Eswatini

- Procured antimalarials following a nationwide stockout to avoid disruptions to case management
- Funded salaries for IRS operators during the 2020/21 campaign
- Organised a national Youth Celebration featuring Yvonne Chaka Chaka and launched Malaria Youth Army
- Selected as a vehicle to channel $100,000 in excess COVID-19 resources to strengthen the health sector

Zambia

- Mobilised >$8 million USD in financial & in-kind resources to date
- Continue to execute a mass media messaging campaign, including with weekly broadcasts on TV and radio
- Faith Leaders Advocating for Malaria Elimination (FLAME) continues to convene inter-faith leaders to drive advocacy and mobilise financial and in-kind resources
- Hosted a private sector round table during World Malaria Day to sensitise many top private sector executives

Mozambique

- Mobilised >$8 million USD in financial and in-kind resources to close gaps under the national malaria strategic plan
- Provided funding for IRS, SBCC, and other activities during the most recent malaria season
- Launched the malaria youth army and parliamentary forum on malaria
- Organised a donor conference in partnership with the Ministry of Health and Goodbye Malaria to commemorate World Malaria Day

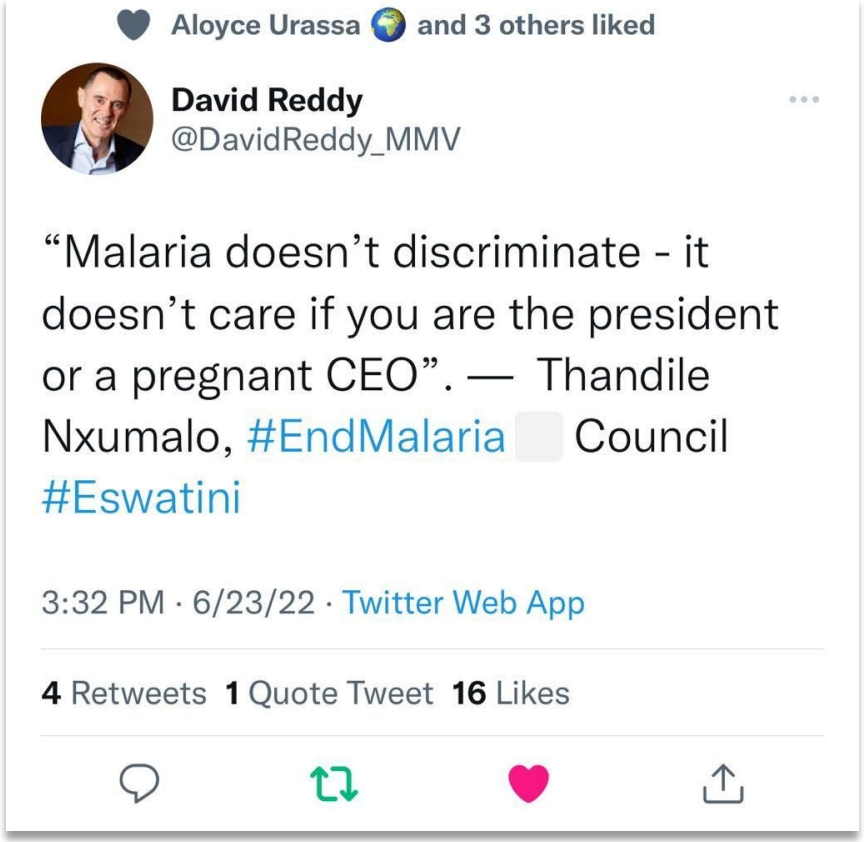
Uganda

- Organised a national communications campaign to raise the visibility and awareness of malaria
- Supported trainings of private sector pharmacy and health workers on malaria best practices in more than 25 districts, including ongoing trainings in regions where there is a malaria upsurge
- Jointly launched ZMBLI in partnership with Ecobank Uganda
- Working to mobilise resources to close operational gaps ahead of the 2023 LLIN campaign

Kenya

- Finalised memorandum of understanding with SC Johnson to provide resources for SBCC, vector control, and local manufacturing of malaria commodities
- Organised round table with CEOs of 6 largest media houses to discuss supporting SBCC and resource mobilisation
- Engaging with other executives and foreign embassies (e.g., Israel) to discuss additional resource investments
- Supported the launch of the Kenya Youth Army and the Great Lakes Malaria Initiative

EMCs announced collective commitment to mobilise $100m USD during the Kigali Summit



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

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

AUDA-NEPAD AFRICAN UNION DEVELOPMENT AGENCY

MMV Medicines for Malaria Venture

- 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)

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

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	✓	✓	✓	✓ *E8 Scorecard*
ECOWAS	✓	✓	✓ *Parliamentarian engagement*	✓
ECCAS	✓	✓	✓	*Preliminary discussions underway*
EAC	✓	✓ *Great Lakes Malaria Initiative*		✓
IGAD	✓	✓	*Malaria TWG reactivated as part of IGAD structure*	

- **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**

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

BILL & MELINDA GATES foundation

BMGF OVERVIEW

CRSPC West Africa Meeting

Seynude Jean-Fortune Dagnon

Malaria SPO, Strategic Partnership and Country Engagement, SPACE
Western and Central Africa, based in Abuja

Thierry Fouapon

Malaria team, Seattle

July 27, 2022

WHAT DOES BMGF DO?

- We are a **funding agency** that supports partners around the world to do excellent work, largely in the global health and development space
- Our **malaria funding** supports

-large international organizations (e.g., WHO - $30M, GFATM - $760M),

-product development partners (e.g., MMV, IVCC) and

-providers of technical and other support (e.g., CHAI, ALMA, RBM Secretariat) across Africa

- We do not provide direct funding to NMCPs, but work with partners who provide various services to country programs (e.g., campaign digitization, surveillance strengthening, modeling and analytics, molecular work, operational research)

Program Strategies
41

Direct Grantee Support
$5.8B

Countries
134

Employees
1,763

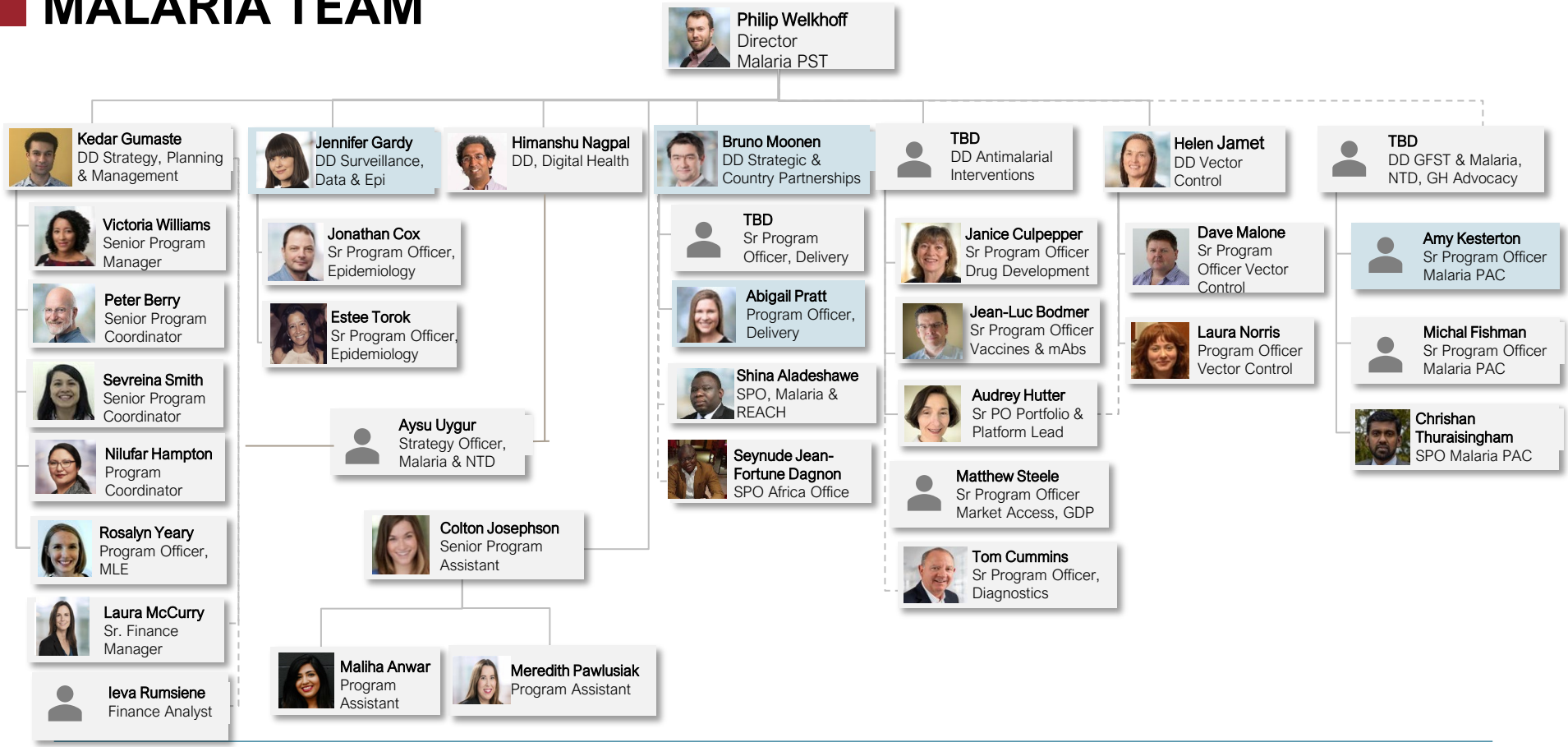
Grantees
1,357

No. of Grants
2,136

U.S. States
49

Alumni
1,965

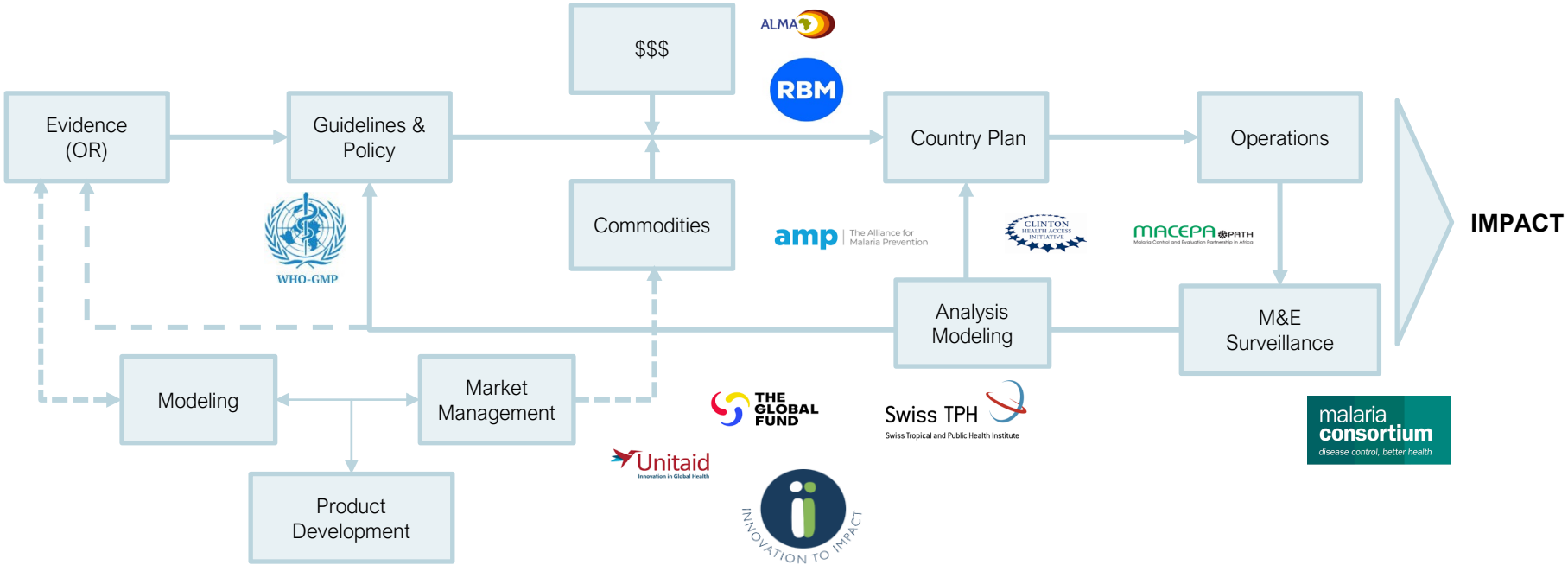
MALARIA TEAM



 |

WE ARE A SMALL FUNDER IN DELIVERY, SO WE SPEND ON KEY PARTS OF THE MALARIA ECOSYSTEM

Because we represent < 3% of global malaria funding, we rarely directly invest in commodities or operations as our funding would only be marginally incremental. We do catalytic investments.



OUR GOAL IS TO ERADICATE MALARIA

① DRIVE DOWN BURDEN

In the short- and medium- term, scale surveillance + data-driven sub-national optimization, chemoprevention & case management in high burden settings to reduce deaths and cases

② SHORTEN THE ENDGAME

Enabling environment for winning endgame in high endemic SSA by investing in next-generation surveillance systems and R&D today

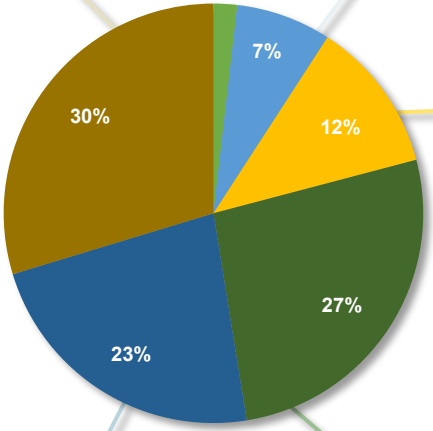
③ GET AHEAD OF RESISTANCE

Mitigate the emergence of drug & insecticide resistance by developing a robust pipeline of AIs and analyzing entomological and genetic data to quickly respond to threats

BMGF MALARIA INVESTMENT PORTFOLIO OVERVIEW

ANTIMALARIAL INTERVENTIONS
- develop novel non-ART combinations for case management
- new chemoprevention regimens
- target discovery and development of 2nd generation vaccines
- monoclonal antibodies for improved seasonal/annual protection.
- improved rapid tests with lower limits of detection
- RDTs robust to hrp2/3 deletions
- endectocides

ADVOCACY
- sustained political will, leadership and accountability for malaria as a global health priority
- increased financing
- country-level momentum & resource mobilization.



DATA & DIGITAL INNOVATION
- expanding molecular surveillance
- expanding mathematical and geospatial modeling
- campaign digitization
- strengthen routine data collection, reporting and response.(support malaria data repository)

VECTOR CONTROL
- novel insecticide active ingredients for use in new ITNs and IRS products
- novel insecticide delivery systems, e.g. ATSBs
- innovative vector surveillance.
- self-limited and gene drive approaches to suppress or replace mosquito populations

Over 2022-5, the Malaria PST has an approved budget of **$1.16B, with a 2022 budget of $274M**

COUNTRY SUPPORT & DELIVERY INNOVATION
- support for data-driven national strategic plans
- strengthened surveillance systems
- improving access to quality care in the public and private sectors
- optimizing chemoprevention
- global, regional and country partnerships

*Funds capacity building, conference/convening support, *ad hoc* special projects

INVESTMENTS IN SURVEILLANCE, SUPPORT NMCPS TO USE HIGH-QUALITY DATA FOR PLANNING AND DECISION-MAKING

Collect → Manage & Store → Analyze → Use

TOOLS & METHODS

DIGITAL TOOLS & DATA INTEGRATION PLATFORMS: Digital & mobile tools to improve data collection; data integration platforms to facilitate management & insight

STRATIFICATION & SUB-NATIONAL TAILORING: Data-driven strategic planning and GFATM application development

MALARIA MOLECULAR SURVEILLANCE: Amplicon sequencing, WGS, and other molecular methods to interrogate biological threats to case management, assess population diversity and structure, and distinguish local from imported infections. Includes parasite and vector work.

NMCP SUPPORT

ENTOMOLOGICAL SURVEILLANCE: Support improved collection and analysis of entomological data, and integration with routine epidemiological data

SURVEILLANCE STRENGTHENING & TECHNICAL ASSISTANCE: Through TA partners, support surveillance assessments and targeted systems strengthening, including improving in-country analytical and modeling capacity

PRIVATE & COMMUNITY SECTORS: Improving CHW and intervention coverage data quality and accessibility

EOC: Emergency Operations Centers for x-disease integration, surveillance, and intervention campaigns

POLICY

Support the development & uptake of toolkits, technical guidelines, and normative guidance through collaboration and information-sharing with WHO, GFATM, PMI and other global partners

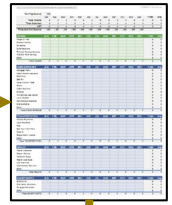
National Strategic Plan
Sub-National Tailoring of Intervention Mixes

Prioritized Costed Implementation Plan
(Line Item BUDGET)

STPH

Modeling and Epi Analysis

CHAI, WHO, RBM



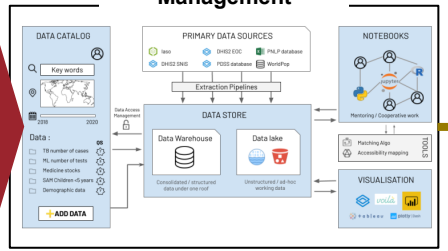
CHAI, WHO, RBM

CRS, CHAI, …

Data Sources

Routine HMIS
Entomological
Molecular
Coverage (digitized campaigns)
LMIS
HR
CGRs

Data Integration & Management

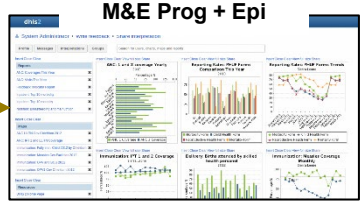


Zenysis

GFATM?
Others?

Help to develop methods and tools for data driven prioritization/budget optimization

M&E Prog + Epi



Univ Oslo, CHAI, MACEPA

Expenditure

WHY DIGITAL HEALTH INNOVATION AND ROLL OUT IS SO IMPORTANT FOR US?

THE BENEFIT OF DIGITAL TOOLS

- Helping us proactively identify and address gaps in our intervention coverage,
- Giving us real-time data into the quality of campaign implementation (such as granular SMC coverage data)
- Increasing accountability through mobile payment systems and real-time supervision
- Beyond campaigns, the case management domain is ripe for improvement through digitization: statistics that we now collect through the routine system are of highly variable quality.
- Providing the malaria community with the tools and information needed to drive higher accountability and improve interventions effectiveness

EXAMPLES

- Digitization of SMC campaign (Benin, Nigeria)
- Digitization of ITNs mass campaign (Benin, Nigeria)
- Expansion due other diseases (ONCHO in Benin)
- Single integrated multi-diseases platform

STRATEGIC PARTNERSHIPS AND COUNTRY ENGAGEMENT INVESTMENTS FOCUS ON

1. Supporting data- and evidence-based national/sub-national **strategy development**, operational planning, and execution to maximize impact of donor and government resources
   - We support WHO GMP, RBM, GFATM, AMP/IFRC at the global/regional level
   - We provide embedded support to NMCPs through our anchor partners CHAI and MACEPA
   - Exploring opportunities to have donors fund against 1 costed prioritized operational plan based on HBHI/SNT approach
2. Scaling adoption of **chemoprevention** to rapidly reduce morbidity and mortality
   - OR on iPTi and SMC in newly eligible areas.
3. Improving **quality of care** in the public sector (including community delivery) and private sector
   - Partly through TSU support (public sector) and OR in private sector
   - Landscaping CHW in collaboration with UNICEF
4. Supporting key initiatives to advance the collective, **regional efforts** to reduce burden and eliminate malaria (MOSASWA, E8, RMEI, RAI)

PARTNERS IN THE WEST AFRICAN REGION

- **CHAI** (Benin, Burkina Faso, Senegal)
- **MACEPA** (Mali, Senegal Gambia)
- **CRS** (Benin, Nigeria)
- **SPEAK UP AFRICA Senegal** (Benin..)
- **ECOBANK** Zero Malaria Business Leadership Initiative (Benin, Burkina Faso, Senegal,)
- **BLUE SQUARE** (Burkina Faso, Niger, Mali, Cote d'Ivoire)
- **PAMCA** (Burkina Faso)
- **Pathogens genomics Diversity Networks Africa, PDNA** (Cote d'Ivoire, Cape Verde, Gambia, Ghana, Guinea, Niger, Nigeria)
- This list is NOT exhaustive

WHAT ARE WE EXCITED ABOUT? HOW CAN WE HELP YOU?

- We are excited to see NMCPs use **stratification and sub-national tailoring** to develop your NSPs and Global Fund applications. We encourage you to use the RBM Dashboard to request support,

- Our funded technical support partners are ready to help you.

- We are excited about the **flexibility in the new WHO guidelines** that allows countries to tailor recommendations to their specific local contexts. We can connect you with partners who can help you adapt and scale interventions

WHAT ARE WE EXCITED ABOUT? HOW CAN WE HELP YOU?

- We are excited about WHO's upcoming **resistance strategy** and the opportunities that will be created for coordinated regional and continental surveillance. We can help you be a part of these surveillance networks and to use molecular capacity for tracking drug resistance.

- We are excited about the increasing use of **digital tools**, especially for campaign digitization, and can connect you with the partners and platforms to implement this in your country

- We are excited about **capacity-strengthening** initiatives in the analytics and modeling space. We can help you find local or regional data scientists and modelers to connect with.

Djeredjef, Thank You, Merci

BILL & MELINDA GATES *foundation*

www.gatesfoundation.org

THE GLOBAL FUND

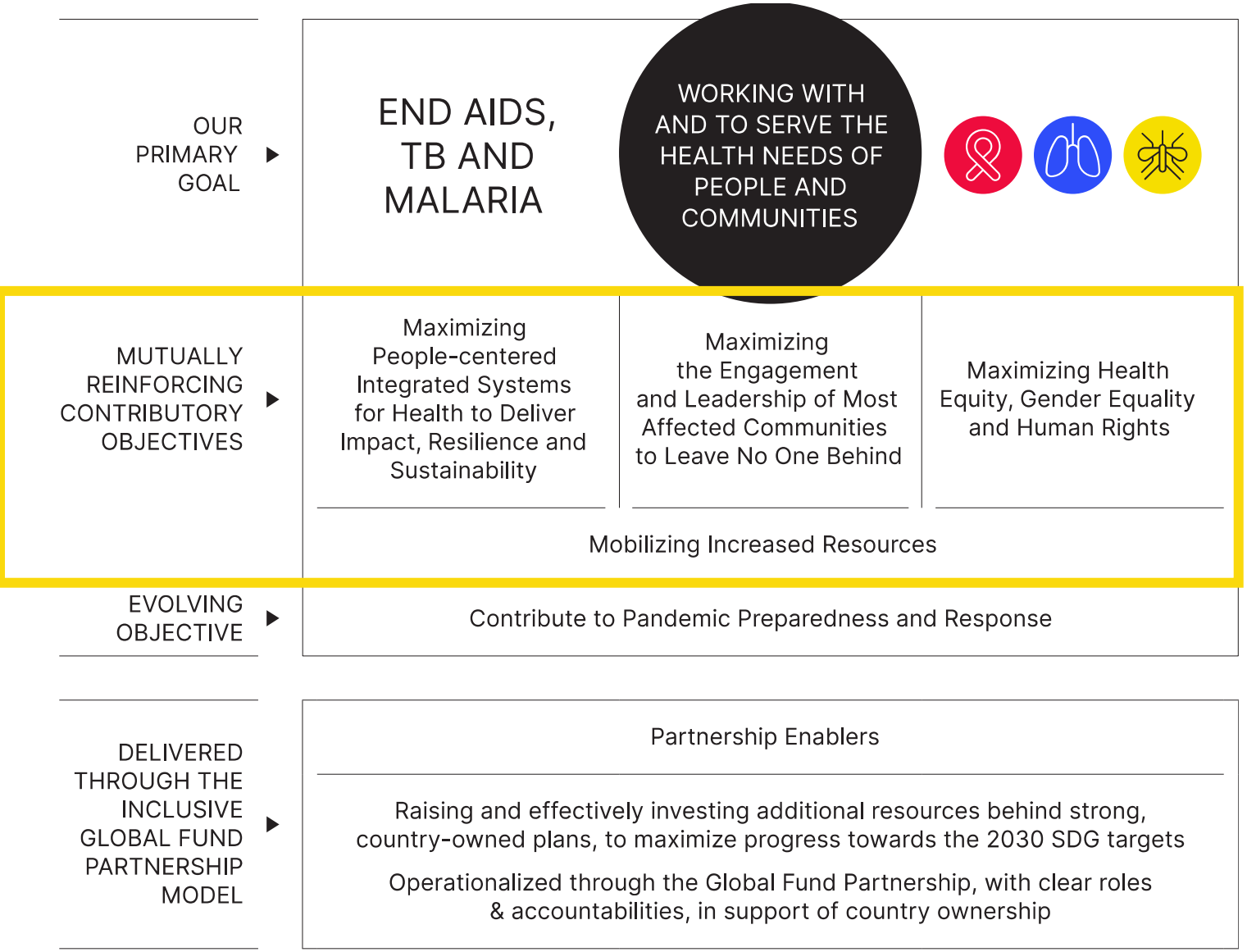
Equity
Community Engagement
Human Rights
Gender

Alistair Shaw, Community, Rights and Gender Department
28.07.2022

Agenda

1. **CRG Direction**
   Alistair Shaw
2. **Introduction to the Malaria Matchbox and EHRGE Principles**
   Dr Denise Njama-Meya
3. **Panel on Country Experience from Matchbox Implementation**
   Olivia Ngou
4. **Training on Designing Programmatic Approaches to Address Identified Barriers**
   Dr Denise Njama-Meya

The Global Fund Strategy Framework



- **Strategy's primary goal** is to end AIDS, TB, and Malaria.
- 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**

Improved service quality and health services that maximize the engagement of most affected communities, and maximize equity, human rights and gender equality.

- Scale up comprehensive programs and approaches to **remove human rights and gender-related barriers**
- **Strengthen data systems and effective use of data**, including from community-led monitoring, for decision making at all levels.
- **Collect, analyze and use disaggregated quantitative data** at national and sub-national levels to identify drivers of inequity and inform people-centered, equitable responses
- 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 multisectoral collaboration** 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.

2020-2022 TRP Observation Report

- **45+ countries received CRG-related TRP comments** on NFM3 malaria funding requests, **including 6 west African grants**
- Responses to inequities were insufficient. Only 55% addressed gender-related barriers and 62% focusing on human rights
- Insufficient inclusion of, and funding for, community-led approaches and interventions. Where included, most were in the PAAR
- Too few funding requests leveraged multisectoral partnerships to address structural determinants of health outcomes
- Many funding requests consistently failed to include allocation budgets to reach, at scale, populations at greatest risks of disease and those hardest to reach.
- Too few funding requests considered the wider determinants of poor health, in particular racial, indigenous and ethnic inequities in access to services
- Insufficient use of Malaria Matchbox Tool assessments to inform improved delivery of people-centered and equitable services

https://www.theglobalfund.org/en/updates/2022/2022-07-20-technical-review-panel-observations-report/

2023-2025 Equity, Human Rights and Gender Equality

What's new?

- Funding request **should include an analysis of available data to demonstrate and address any known barriers to access and uptake of malaria services**. Funding for implementation of the Malaria Matchbox or other similar tools can be included where analyses have not been undertaken or to improve understanding of how to address identified issues.
- Equity, human rights and gender equality considerations should be included in the sub-national tailoring analysis and incorporated into the implementation approach to ensure people- and population-centred service delivery.
- Priorities from civil society and communities that were identified during funding request development will need to be described, including whether they were included in the request or in the PAAR
- Applicants are encouraged to explore the potential of community-led monitoring

2023-2025 Guidance Materials (available Q3 2022)

- Malaria Guidance Note, Modular Framework
- RSSH Guidance Note, Community System Strengthening Technical Brief
- Human Rights, Gender and Equity Technical Brief
  - Outlines examples of high-risk populations, inequities, and barriers
  - Suggests possible intervention adaptations to address identified inequities and barriers

Current version:
November 2019
Revised version:
Available Q3 2022

Technical Assistance on Community Engagement, Human Rights and Gender

Human Rights, Gender and Equity Technical Assistance

- Aimed at supporting countries to assess and adapt programs in response to human rights and equity-related barriers equity assessments (inc. Malaria Matchbox)
  - Conducting the Malaria Matchbox (or related equity assessment)
  - Link and embed equity assessment finding within MPRs, NSP revisions and NFM4 funding requests.
  - Available to all countries, particularly those that have received CRG-related TRP comments during NFM3
  - Generic ToR available, and requests to be submitted through RBMs Technical Assistance Dashboard ( )

Community Engagement Short-Term Technical Assistance

- Aimed at meaningful engagement of communities in GF processes
  - Track A: CRG assessment to generate strategic information to inform NFM4 funding request development, or NFM3 program reviews to ensure community perspectives inform improvements under NFM4
  - Track B: Community consultations, and coordinating input from communities and civil society
  - Track C: Costing support
- Available to communities and civil society, and CCMs in some situations.
- Requests to be submitted through crgta@theglobalfund.org *6 months prior* to NFM4 application window

Training for NMCP Managers and Staff
on CRG and Malaria

- Face-to-face training alongside regional/country meetings (2-3 hours)
- Online e-Learning format (2-3 hours)
- Focus:
  - Build knowledge on the issues of equity, gender and human rights in the context of malaria programming
  - Build capacity to identify key inequities and barriers affecting malaria outcomes, and how to identify actions to address those barriers
- Quiz and certificate available from RBM upon successful completion

https://endmalaria.org/resources-trainings/community-human-rights-and-gender-malaria-programming-malaria-program-managers

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

https://endmalaria.org/sites/default/files/Malaria%20Matchbox%20Tool_en_web.pdf

RBM Partnership To End Malaria

THE GLOBAL FUND

Training on community, human rights and gender in malaria programmes

Annual meeting of the National Subregional Malaria Control Programme and partners
RBM CPSR Meeting, 26-29 JULY 2022
Dakar, Senegal

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

Training Overview

Session 1: Overview of Malaria epidemiology and programming.

Session 2: Conducting an assessment of community, gender and human rights related barriers to accessing malaria services.

Session 3: Designing Programmatic Approaches and Interventions.

Learning Objectives

Build knowledge

- Equity,
- Gender and
- Human Rights

Build capacity

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

RBM Partnership To End Malaria

THE GLOBAL FUND

SESSION 1:INTRODUCTION

Malaria epidemiology and programming

- Understanding malaria epidemiology in a country is a critical component in programming.

- Malaria epidemiology varies widely over relatively small geographic areas, and this variation has implications for national programs.

- Severity of malaria infection depends not only on the species of malaria parasite but also on the level of malaria-specific acquired immunity of the individual.

- 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

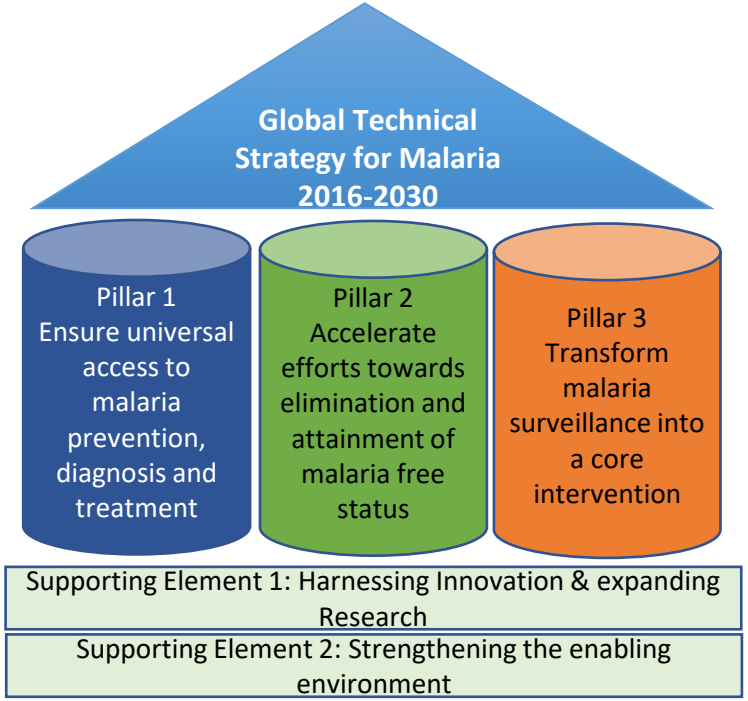
Risk factors		
Poverty	Accessibility barriers	Social exclusion
Literacy barriers	Human rights barriers	Economic opportunities
Financial barriers	Cultural norms	Complex emergencies
Physical barriers	Psycho-social barriers	

Underserved populations

Populations impacted by conflict e.g., refugees and internally displaced populations		
Populations living in remote areas facing geographical barriers to services		
Women and children from poor settings	Indigenous populations	Prisoners
Undocumented workers	Ethnic minorities	Migrant Workers

- Globally there has been **tremendous progress since 2000** in reducing the burden of malaria.

- Scaling up access to effective preventive strategies has **prevented over 1.5 billion malaria cases and 7.6** million deaths globally.



Most countries are not on track to achieving the <u>Global Technical Strategy for malaria</u> milestones.

Ensuring universal access to malaria services through addressing equity, gender and human rights issues in malaria programming is essential to enable countries get back on track.

MALARIA SERVICES FOR ALL

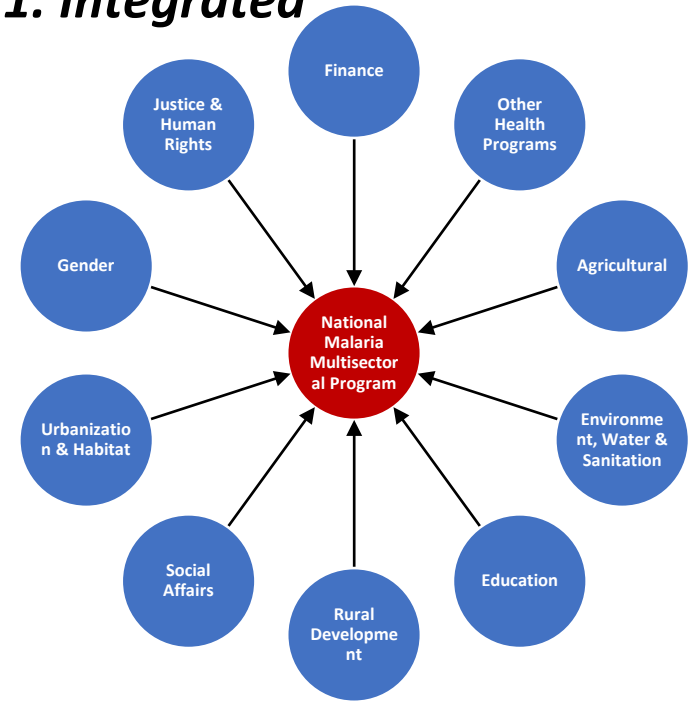
Summary

- National malaria strategies focus largely on the biological factors, however **there is a need to strengthen the focus on additional factors – particularly socio economic and cultural factors.**
- Insufficient levels of access to and uptake of lifesaving malaria tools and interventions in high risk and underserved populations creates a higher risk of malaria morbidity and mortality.
- Identifying the high risk and underserved populations and the barriers they may be facing can inform the design and implementation of malaria interventions.
- **Engagement of high risk and underserved populations is critical to a successful malaria response.**
- Success of malaria strategies, vector control and case management interventions, should be evaluated by their impact. This will be determined by effective population coverage for affected populations and successful individual access and uptake.

Effective malaria control strategies

Effective malaria control strategies should include interventions that are:

1. Integrated



2. Equitable

3. People-centred

Successful malaria strategies

4. Community Systems Strengthening:

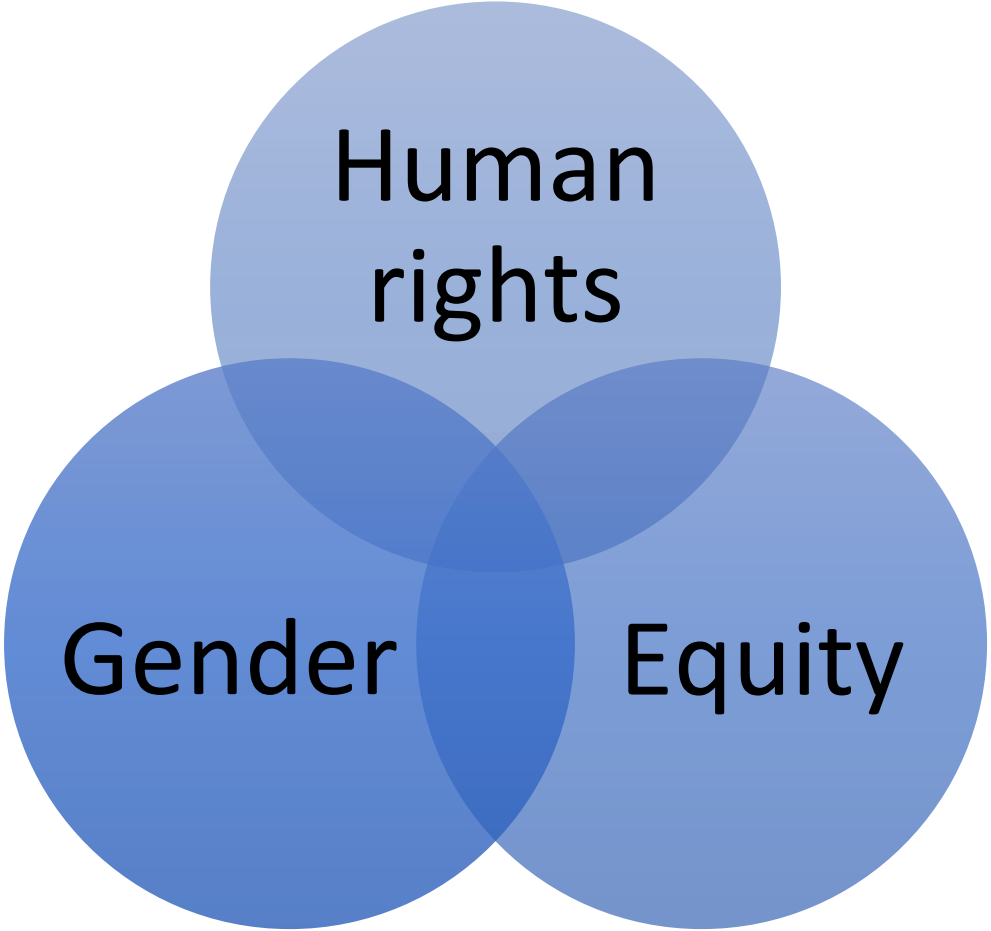
- Involvement of communities is essential to ensure the services provided meet the demands of the populations served and consider potential barriers.

- 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.

Defining key concepts



What are human rights?

Human rights in the context of malaria

Promoting Human rights can:

- Can help overcome barriers to malaria service access.
- Can create optimal conditions for the uptake of essential malaria prevention and treatment services.
- Can empower individuals and communities to ensure that national and subnational responses address their malaria need.
  - ❖ Understanding and adapting malaria programming to consider the social and structural determinants of health.
  - ❖ Supporting effective community dialogue and engagement, including at risk and underserved populations, ensuring their involvement in the strategic development of actions to obtain local and feasible solutions to identified barriers to malaria services.

Human rights-based approach in malaria programming

- Malaria is a human rights issue. The right to health includes the right to accessible and quality medical care including malaria prevention and treatment services.
- Malaria is preventable and controlled through an integrated package of effective interventions (ITNs, IRS, SMC, IPTp, SBC, timely diagnosis and treatment).
- 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.
- Understanding how to adapt and provide inclusive, non-discriminatory malaria services will: increase programmatic effectiveness; improve cost-effectiveness; provide optimal individual outcomes; increase community benefit of malaria control efforts.

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

Availability

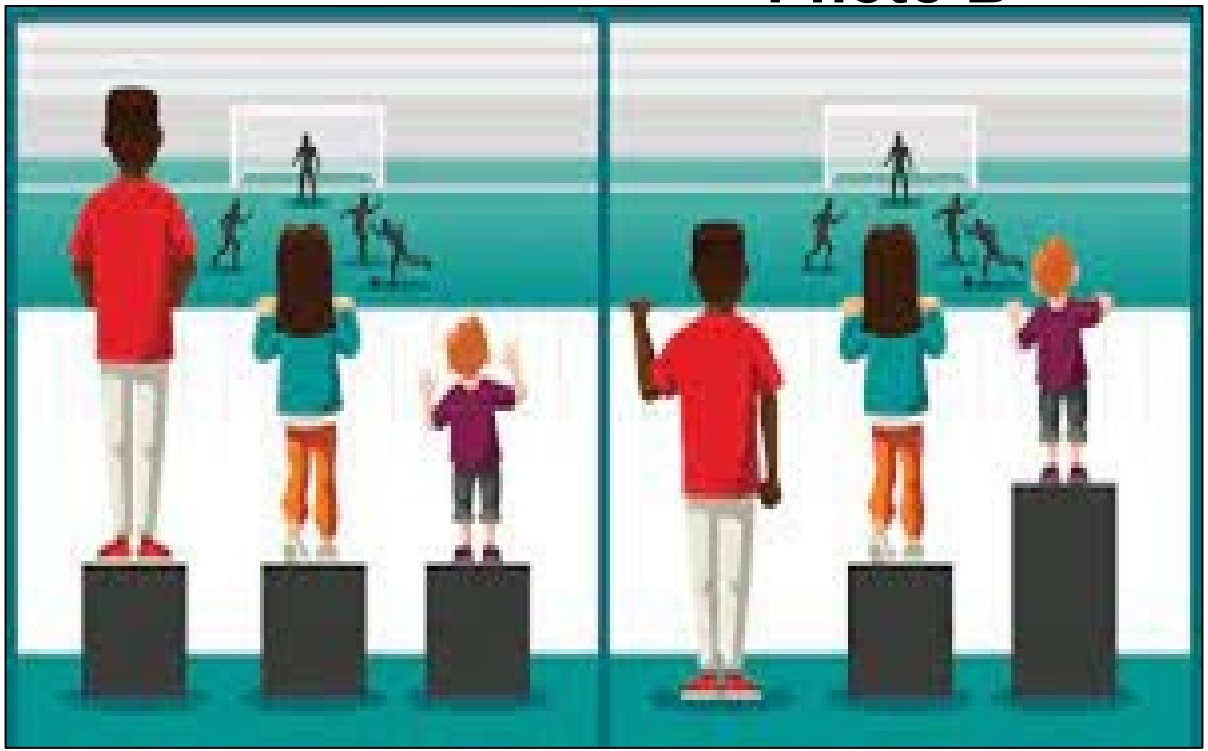
Accessibility

Acceptability

Quality

Photo A

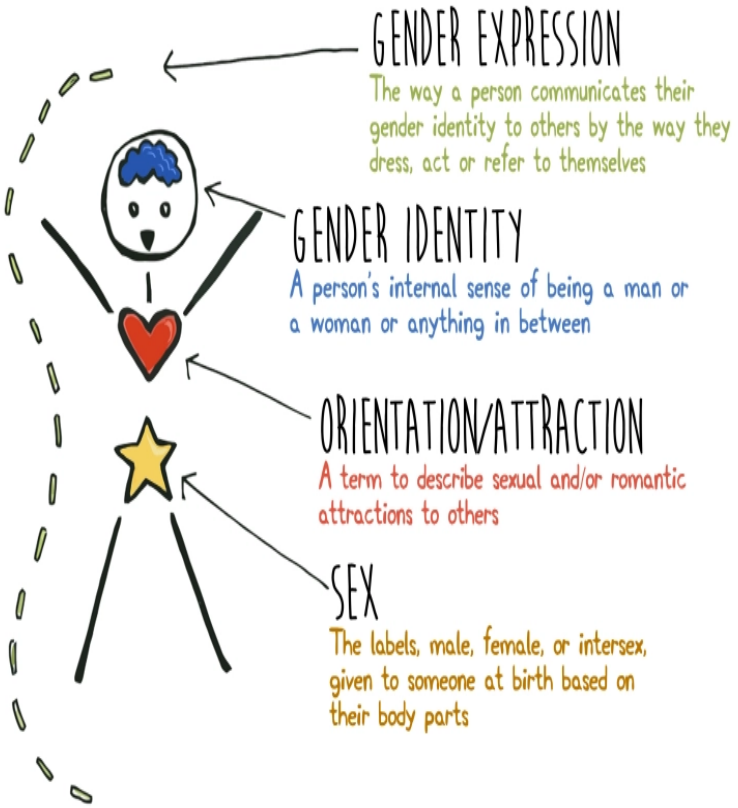
Photo B



Which photo represents Equity and which one equality?

What is Gender?

- A social construct that relates to women, men, girls, boys and gender diverse communities.
- Norms, behaviours and roles associated with being a woman, man, girl, boy, or non – traditional gender identity as well as relationships with each other.
- Gender varies from society to society and can change over time (WHO).
- Gender is different from sex.



Why does Gender matter in malaria programming?

Gender in malaria programming

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.

RBM Partnership To End Malaria

THE GLOBAL FUND

SESSION 2: CONDUCTING AN ASSESSMENT ON COMMUNITY, HUMAN RIGHTS AND GENDER (CRG) RELATED BARRIERS TO ACCESSING MALARIA SERVICES -THE MALARIA MATCHBOX TOOL

What is the Malaria Matchbox Tool?

Overview of the Malaria Matchbox Tool

- It is an equity assessment toolkit.

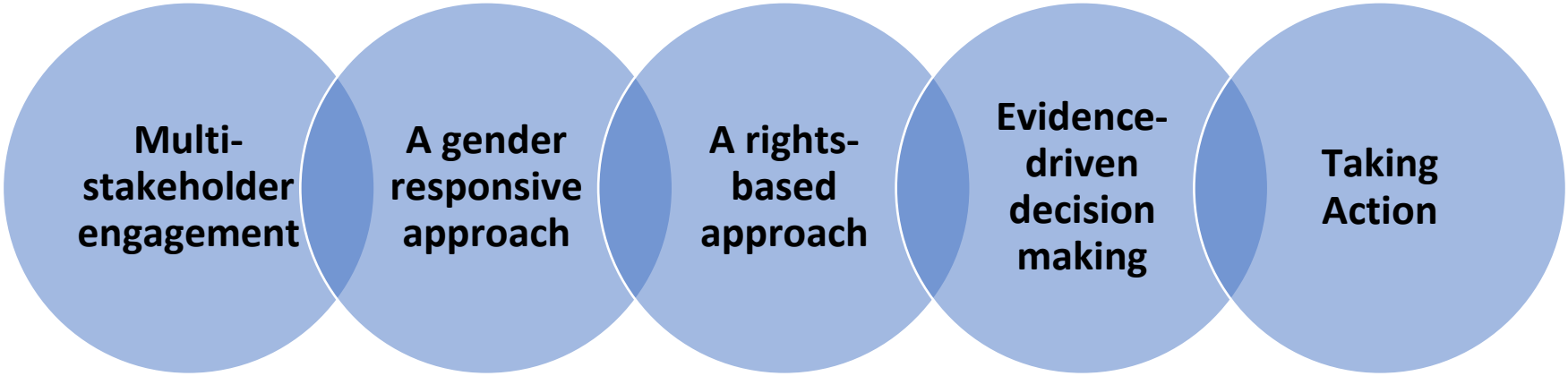
- Used to help identify:
  1. **Who** are the populations, groups or individuals most affected by malaria (high-risk and underserved).
  2. **What** are the key social rights and gender related barriers disproportionately affecting malaria outcomes in those populations.
  3. **How** their malaria programmes 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	Engage stakeholders	Form the assessment team	Planning and budgeting	Development of the research proposal
• Understand what the country's specific needs are. • Identify if/how the tool can be placed in the national malaria strategic planning process	• Led by the national malaria program. • Multisectoral participation. • Map key stakeholders. • Secure commitment at all levels.	• Select a team with diverse skills. • Ensure clear terms of reference. • 5-7 core members with dedicated time.	• 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.	• Develop the full proposal. • Develop data collection tools. • Obtain ethical approval. • Obtain informed consent.

Assessment Phase

Module 1: Desk review

Module 2: Assessing barriers to access and use of services

Module 3: Identifying gender and age-related barriers

Module 4: Data analysis and validation

Module 5: Action planning


QUESTIONS
ANSWERS


10 min

RBM Partnership To End Malaria

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COUNTRY EXPERIENCES IN CONDUCTING THE MALARIA MATCHBOX ASSESSMENT

Olivia Ngou

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.

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.

1. 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*

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.

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.

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SESSION 3

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

Develop actions to address barriers and improve equity in malaria programming

- Identify actions that can address the identified barriers.
- Identify concrete programmatic changes or new interventions.
- Consider current best practices and global recommendations.
- Identify the scope and level of action/changes.
- Multisectoral engagement.

Module 5: Methodology

- Prioritize the actions to be taken.
- Mainstream the actions.
- Develop the final assessment report including an action work plan

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

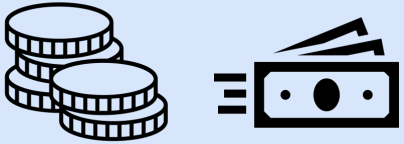
Program Area 1: Monitoring and reforming laws, policies and guidelines

- 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.

What laws, policies, strategies and guidelines exist that may be barriers?

Country X is a malaria endemic country that has been able to dramatically reduce its malaria burden and has a goal of malaria elimination by 2024. In 2009 the majority of confirmed cases reported were from and confined to provinces bordering the neighboring countries especially on the TM border where there is a continuous influx of migrants. The country reports over 4.9 million international migrants including migrant workers both registered migrants with work permits, illegal migrants with temporary registration, undocumented migrants with no work permits and conflict displaced populations in addition to patients who cross the border to seeking health care in country X. **What actions can the program take to consolidate recent gains and progress towards malaria elimination?**

Barriers related to laws, policies and guidelines and possible actions

Barriers	Actions
User fees 	• Provision of vouchers. • National health insurance programs for informal sector. • National subsidies. • Removal of user fees.
Laws and policies 	• 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.

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.

Program Area 2: What are example of barriers to ITN use and possible actions

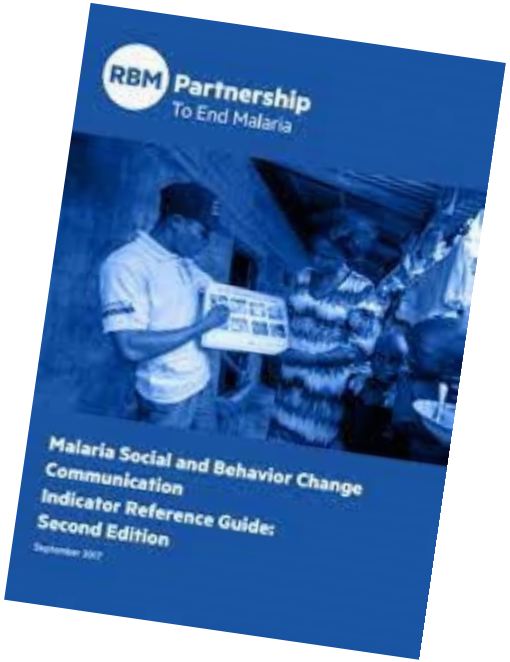
Examples of barriers to ITN use and possible actions (1)

Barriers	Action
Gender or age - related barriers	1.Develop gender- and age-specific SBCC strategies. 1.Ensure adequate number of nets are provided to each household. 1.Recruiting and training more females to support the ITN mass campaign distribution.
Socially or legally excluded populations	1.Targeted ITN distribution. 1.Community dialogue and engagement. 1.Establish innovative registration techniques. 1.Multisectoral engagement.

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

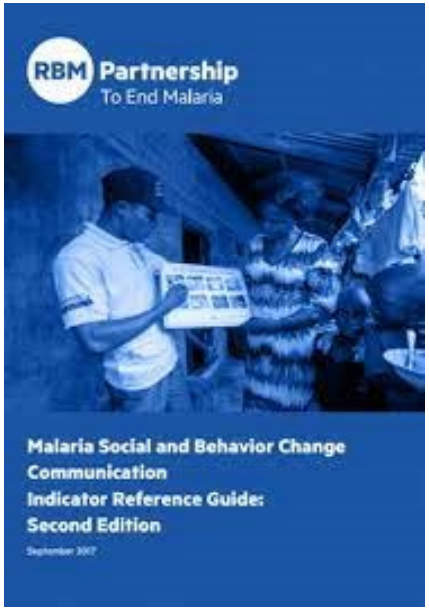
Barriers	Action
Limited ITN access in hard-to-reach populations	1.Altered distribution strategies. 1.Alternative transport measures where roads are bad. 1.In flooded areas, consider use of boats. 1.War torn zones require multi-sectoral engagement and strong coordination with all stakeholders. 1.In emergency situations integrate ITN distribution with distribution of other essential items e.g. food. 1.Plan targeted ITN distribution to specific vulnerable or high-risk populations.
Low literacy/language diversity barriers	1.Messages are translated to the local language. 1.Pictorial messaging in the case of limited literacy. 1.Messaging adapted to take into consideration specific cultural beliefs, barriers.

Program Area 3: Barriers to IRS



Program Area 3: Example of 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: 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.	• Provide safe and alternative transportation for CHWs and of SMC commodities. • Provide alternative innovative distribution strategies.
Language and literacy barriers	• 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	• 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	• Use of community/village health workers. • Provision of innovative safe transport e.g. bicycle ambulances. • Introduction of Mobile malaria clinics.
Language Barriers	• 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.
- 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.

Case Study:Community-based monitoring

Background: In 2018, the Ministry of Health of Ghana and the Ghana Health Service, with support from Africa Leaders Malaria Alliance (ALMA), developed a Community Scorecard (CSC) to enhance the health sector's ability to gather public feedback on the delivery of health services, guide decision making processes between service providers and community members, and empower communities to take a more active role in health systems.

Impact: The CSC monitoring and accountability tool has:

- Led to greater community involvement and local contributions to improve local infrastructure and service delivery.
- Re-engaged communities to see themselves as contributing to the quality of service-delivery.
- Provided important client feedback to national, regional, and district level health managers, allowing them to identify gaps in the health system and systematically address bottlenecks.
- Been instrumental in important decision making at the lower level to improve healthcare services as well as catalyse actions by district officers.

Source: https://scorecardhub.org/best-practices/ghana-community-scorecard-tool-overview/

Module 5: Conclusion

- Conduction the malaria matchbox assessment is essential.
- 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.
- Support is available (online, RBM CRSPC).

MERCI!
THANK YOU

Après tout, où commencent les droits de l'homme universels? Dans les petits endroits, près de chez nous – si près et si petits qu'ils ne peuvent être vus sur aucune carte du monde. Tels sont les endroits où chaque homme, femme et enfant cherche l'égalité de justice, l'égalité des chances et l'égalité de dignité, sans discrimination.

—Eleanor Roosevelt, États-Unis, 1958

Président de la Commission des


QUESTIONS
ANSWERS

RBM Partnership To End Malaria

CRSPC - Le Point

July 2022

Comité de partenaires en charge du soutien régional et par pays

Le CRSPC offre une plateforme d'engagement de la communauté du Partenariat RBM, pour coordonner l'aide aux pays et aux régions dans l'exécution de leurs programmes de contrôle et d'élimination du paludisme.

L'aide répond à la demande des pays et est adaptée aux besoins, aux capacités existantes et au soutien des partenaires.

Le CRSPC utilise un mécanisme de triage pour assurer que l'aide ne fasse pas concurrence ou ne soit redondante aux mécanismes qui fonctionnent déjà efficacement.

Les consultants sont recrutés dans la région où ils opèrent (collaboration Sud-Sud).

CRSPC - Rôles et responsabilités

	Rôle du CRSPC	Exemple d'aide apportée
1 **Stratégies techniques et plans de mise en œuvre**	Coordonner l'aide à l'élaboration et à la validation de stratégies de contrôle et d'élimination du paludisme techniquement solides et réalistes, sous la conduite des pays, ainsi que de plans financiers durables.	▪ Examen des programmes de lutte contre le paludisme ▪ Mise à jour des plans stratégiques contre le paludisme ▪ Stratégies et plans régionaux
2 **Résoudre les goulots d'étranglement de la mise en œuvre**	Coordonner un système d'avertissement précoce qui **identifie les goulots d'étranglement** de manière proactive aussi bien que réactive et mettre en œuvre un mécanisme de réponse rapide qui aide les pays à surmonter ces difficultés.	▪ Atténuation de COVID-19 ▪ Planification et mise en œuvre de campagnes (MILD, CPS, IRS) ▪ High Burden High Impact - D'une charge élevée à un fort impact ▪ Urgences et recrudescences ▪ Zéro Palu ! Je m'engage !
3 **Mobilisation de ressources**	Coordonner et apporter assistance technique et aide à la mise en œuvre d'analyses complètes des écarts financiers, à l'élaboration de propositions de financement et de demandes d'investissement, à l'encouragement de coalitions nationales et à la coordination de l'engagement avec les bailleurs de fonds à tous les niveaux pour résoudre les goulots d'étranglement et les insuffisances.	▪ Analyses d'écart financier ▪ Demandes de financement au Fonds mondial ▪ Identification des souplesses au sein des sources de financement existantes ▪ Innovation financière, notamment à travers les Fonds pour l'élimination du paludisme

1 Aider les pays à concevoir des programmes priorisés de qualité, au niveau national et régional

Aide apportée

Impact

Soutenir la conception de programmes priorisés de qualité au niveau du pays

- En collaboration avec l'OMS, CRSPC aide les pays à élaborer leurs PSN et à effectuer leurs MPR.
- Le CRSPC aide aussi les pays de mise en œuvre de l'outil Malaria Matchbox à identifier et résoudre les obstacles CDG.

- Aligner la planification contre le paludisme sur le programme plus large de la santé et du développement et soutenir la mobilisation de ressources.
- Occasion d'incorporer un ensemble de nouveaux outils et de pratiques exemplaires, y compris la stratégie d'accès assuré à tous.
- Permettre aux pays de concevoir leurs politiques, de se fixer de nouveaux objectifs et d'améliorer leurs systèmes de coordination, y compris l'incorporation de la programmation CDG.

Renforcer la capacité régionale en Afrique et en Asie du Sud-Est

- Organismes régionaux, y compris la GLMI et l'IGAD, soutenus dans l'élaboration des plans stratégiques contre le paludisme, des activités de coordination, etc.
- Recrutement de personne contact dans la CAE pour renforcer la capacité régionale.

- Aligner la planification contre le paludisme sur le programme plus large de la santé et du développement et soutenir la mobilisation de ressources.
- Intégrer le paludisme au programme des communautés économiques régionales, y compris au niveau du Chef de l'État, du ministère et au niveau technique.

2 Favoriser un accès rapide à l'aide à la mise en œuvre pour résoudre les goulots d'étranglement et les insuffisances

Soutenir la conception de programmes priorisés de qualité au niveau du pays

Aide apportée

- Une aide à la mise en œuvre est apportée aux pays par l'intermédiaire de consultants internationaux et locaux et la facilitation du dialogue local par aide au financement des coûts de rencontre locaux.

Aide apportée :

- Planification de campagnes MII (à travers l'AMP)
- Planification de campagnes CPS et IRS
- Aide à la résolution des recrudescences et des urgences
- Atténuation d'impact de la COVID-19
- Élaboration de stratégies de communication et de changement des comportements
- Lancement et mise en œuvre de campagnes « Zéro Palu ! Je m'engage »
- Aide à l'élaboration de stratégies de prise en charge des cas dans le secteur privé

Impact

- L'aide apportée a permis d'atténuer l'impact de la COVID-19.

COVID-19 continue de perturber les programmes de lutte contre le paludisme

Les délais de livraison des produits sont toujours au moins deux mois plus longs qu'avant COVID-19 et les pays se sont trouvés confrontés à des ruptures de stocks dans la prise en charge des cas et à des retards affectant les campagnes.

Les pays signalent que les ressources domestiques initialement destinées à la lutte contre le paludisme ont été détournées vers la lutte contre la COVID-19.

Le coût de livraison des produits a augmenté, de même que le coût des produits en 2022 – concernant en particulier les MILD.

Assistance du CRSPC

Suivi des produits essentiels : Suivi de disponibilités dans les pays (CTA, TDR, artésunate, MILD, produits d'IRS et CPS) et effort de résolution des goulots d'étranglement en comblant les écarts dès leur apparition, par mobilisation de ressources, transport aérien de produits et fractionnement des livraisons en collaboration étroite avec la PMI et le Fonds mondial et encouragement des achats précoces.

Résolution des goulots d'étranglement : Contrôles multipartenaires réguliers avec les pays pour suivre et résoudre les problèmes à mesure de l'apparition des goulots d'étranglement des programmes de lutte contre le paludisme en temps réel, en faisant face aux recrudescences, en aidant les pays à reprogrammer et à mobiliser les ressources pour combler les écarts et en favorisant la collaboration sur l'ensemble du partenariat.

Plaidoyer : Au besoin, liaison au niveau politique pour prévenir les retards de campagne et maintenir les programmes contre le paludisme.

2 Aide aux pays dans la mise en œuvre HBHI

Les pays ont continué à mettre en œuvre les principales activités sur les quatre grands axes d'intervention :

- Volonté politique
- Information stratégique d'impact
- Meilleures orientations, politiques et stratégies
- Riposte nationale coordonnée contre le paludisme

L'évaluation HBHI se poursuit.

Tous les pays HBHI d'Afrique utilisent leurs outils de gestion de carte de score contre le paludisme.

Le **Mozambique** et l'**Ouganda** ont lancé leurs conseils et fonds pour l'élimination du paludisme. La **Tanzanie**, le **Nigeria**, le **Cameroun**, le **Burkina Faso** et la **RDC** sont presque prêts au lancement, pour maintenir le paludisme parmi les hautes priorités du programme national de financement et de développement.

Meilleur engagement parlementaire dans la lutte contre le paludisme, par ex. en Tanzanie.

Stratification sous-nationale intégrée aux PSN, MPR et demandes de financement au FM pour TOUS les pays HBHI.

Campagne « Zéro Palu ! Je m'engage » lancée dans 9 pays HBHI.

De meilleures ressources ont permis le passage aux moustiquaires PBO et l'élargissement de la CPS et des ASC.

3 Aide à la mobilisation et priorisation des ressources domestiques et autres : mises à jour des analyses d'écart

Aide apportée

- Le CRSPC aide les pays à préparer leur analyse des écarts.
- L'analyse des écarts de pays compilée par le CRCPC est publiée sur le site Web de RBM.

Impact

- L'analyse des écarts indique que 95 % des pays de haute et moyenne endémie ont mobilisé suffisamment de ressources pour combler leurs écarts de MILD, IRS, CPS et prise en charge des cas, mais il reste à examiner l'impact de l'augmentation des coûts des produits et de livraison.

Insuffisances de produits prioritaires

	2022	2023
MILD	39m	61m
CTA	56m	68m
TDR	27m	24m

Aide à la demande de financement du FM

- Pour assurer la soumission en temps utile de propositions de financement de qualité et éviter les écarts de mise en œuvre, le CRSPC offrira une enveloppe d'assistance complète aux pays, basée sur une approche éprouvée dirigée par le pays.
  - Rencontre d'orientation à la demande de financement au FM pour informer les pays sur l'approche différenciée et préparer des plans d'assistance technique détaillés (décembre 2022)
  - Assistance technique de consultants internationaux à l'élaboration des demandes de financement
    - Analyse des écarts (nous recommandons d'entreprendre l'analyse dès maintenant !)
    - Résolution des commentaires restants du Comité technique d'examen, concernant la question CDG et la mise en œuvre de l'outil Malaria Matchbox
    - Mise à jour des MPR/PSN (aide en collaboration avec l'OMS)
    - Élaboration de la demande de financement
- Fonds aux pays au soutien des consultations internes, du dialogue au niveau du pays et du recrutement de consultants locaux.
- Simulations de rencontres avec le Comité technique d'examen pour faciliter l'évaluation par les pairs des projets de demandes au niveau du pays.
- Un examen d'expert à distance des projets finaux de demande de financement sera assuré par les membres du CRSPC.
- Une assistance est planifiée pour aider les pays à obtenir rapidement la signature (octroi) de subvention.

Activités prioritaires pour 2022-2023

Veiller à ce que les pays disposent de fonds, de capacités et d'une volonté politique suffisants pour mettre en œuvre leur plan national.

1

Stratégies techniques et plans de mise en œuvre

- Aide aux MPR et PSN
- Aide à la mise en œuvre de Malaria Matchbox
- Aide aux Communautés économiques régionales pour renforcer la mise en œuvre des initiatives régionales et la coordination
- Documentation des meilleures pratiques

2

Aide à la mise en œuvre

- Aide continue aux pays pour atténuer l'impact de la pandémie de COVID-19, concernant notamment la résolution des recrudescences du paludisme, la mise en œuvre des campagnes et la résolution des ruptures de stocks
- Aide à la résolution des goulots d'étranglement
- Partage des données pour faciliter la résolution collective des problèmes
- Aide à la mise en œuvre de l'initiative HBHI et des campagnes Zéro Palu ! Je m'engage !

3

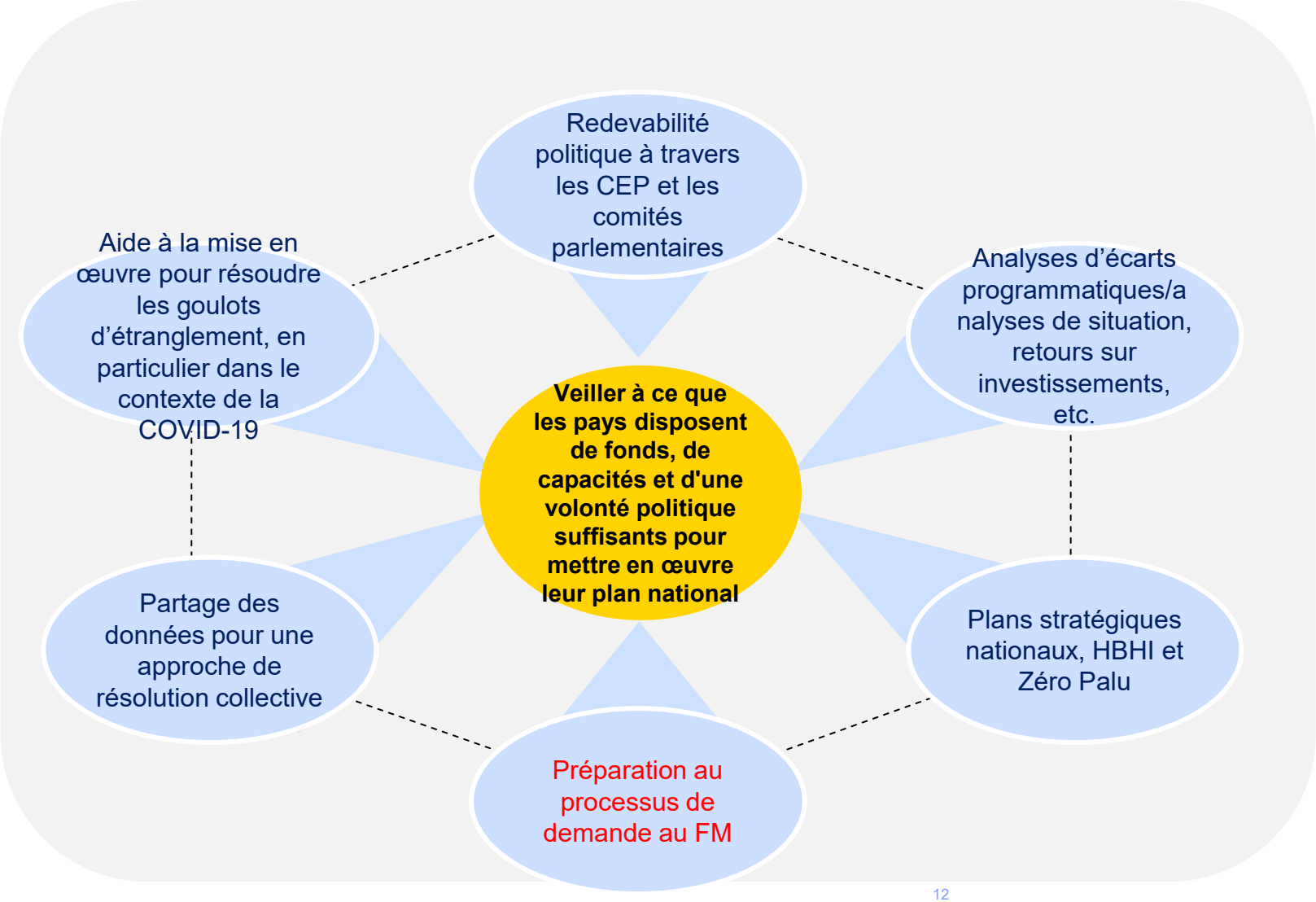
Mobilisation de ressources

- Aide aux pays pour entamer le processus NMF4 des demandes de financement au FM, concernant le paludisme et les RSSH (ASC/données pour la prise de décision) et le positionnement du paludisme parmi les priorités PPS
- Redevabilité politique à travers les CEP et les comités parlementaires
- Mobilisation de ressources domestiques

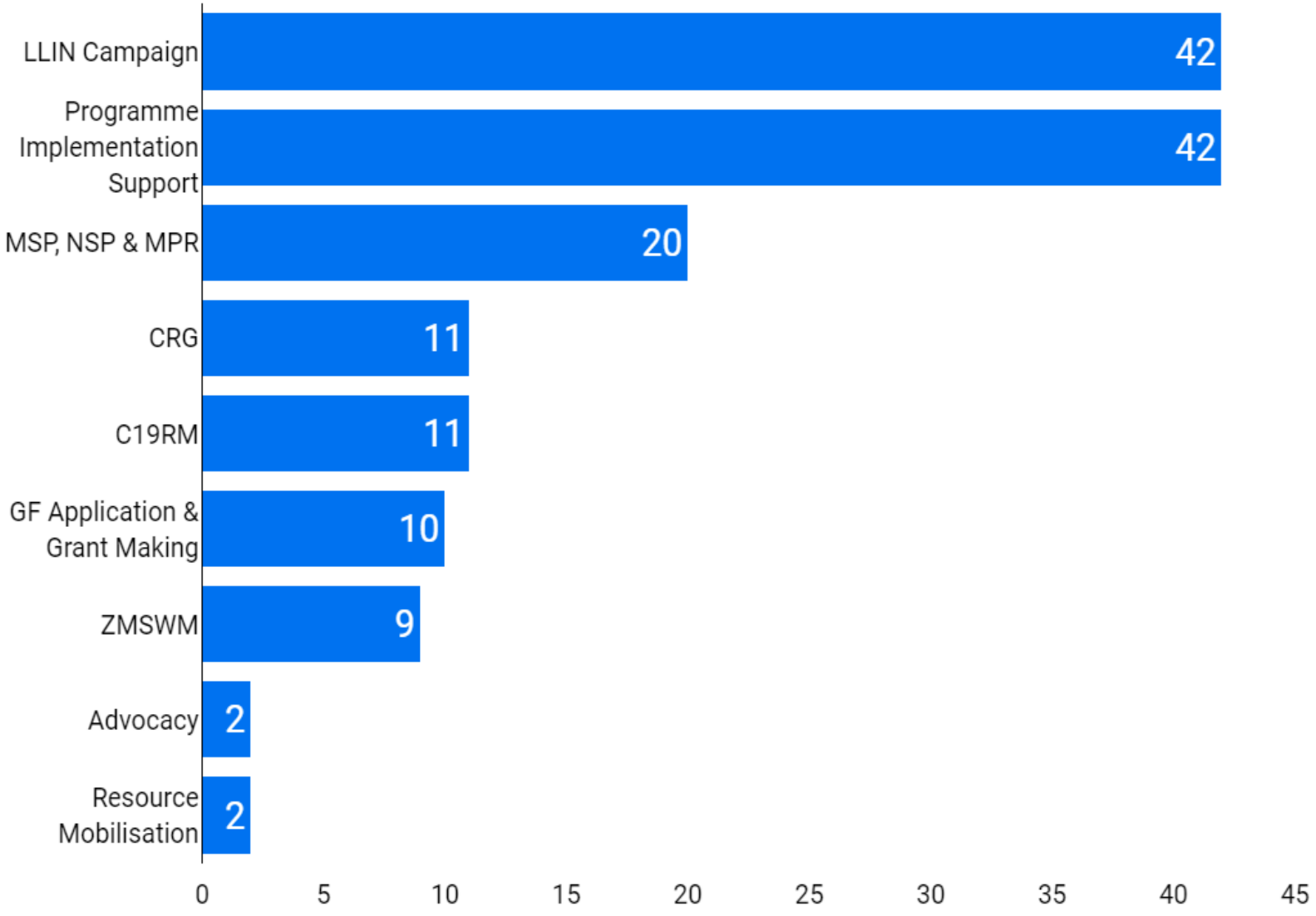
Rencontres sous-régionales des programmes et partenaires du CRSPC

- Ces rencontres donneront aux pays l'occasion d'échanger leurs meilleures pratiques et de résoudre ensemble leurs difficultés concernant l'atténuation d'impact de la COVID-19 sur la lutte contre le paludisme.
- Elles seront aussi l'occasion d'informer les pays sur les outils actuels de prévention et de contrôle du paludisme, les perspectives d'une meilleure planification et mise en œuvre – mises à jour de l'OMS et autres partenaires.
- Facilitent le processus de planification des besoins d'assistance technique.
- Occasion de faire le point sur la mise en œuvre du FM, le processus de demande au FM, les analyses d'écarts et les initiatives mondiales, régionales et continentales.

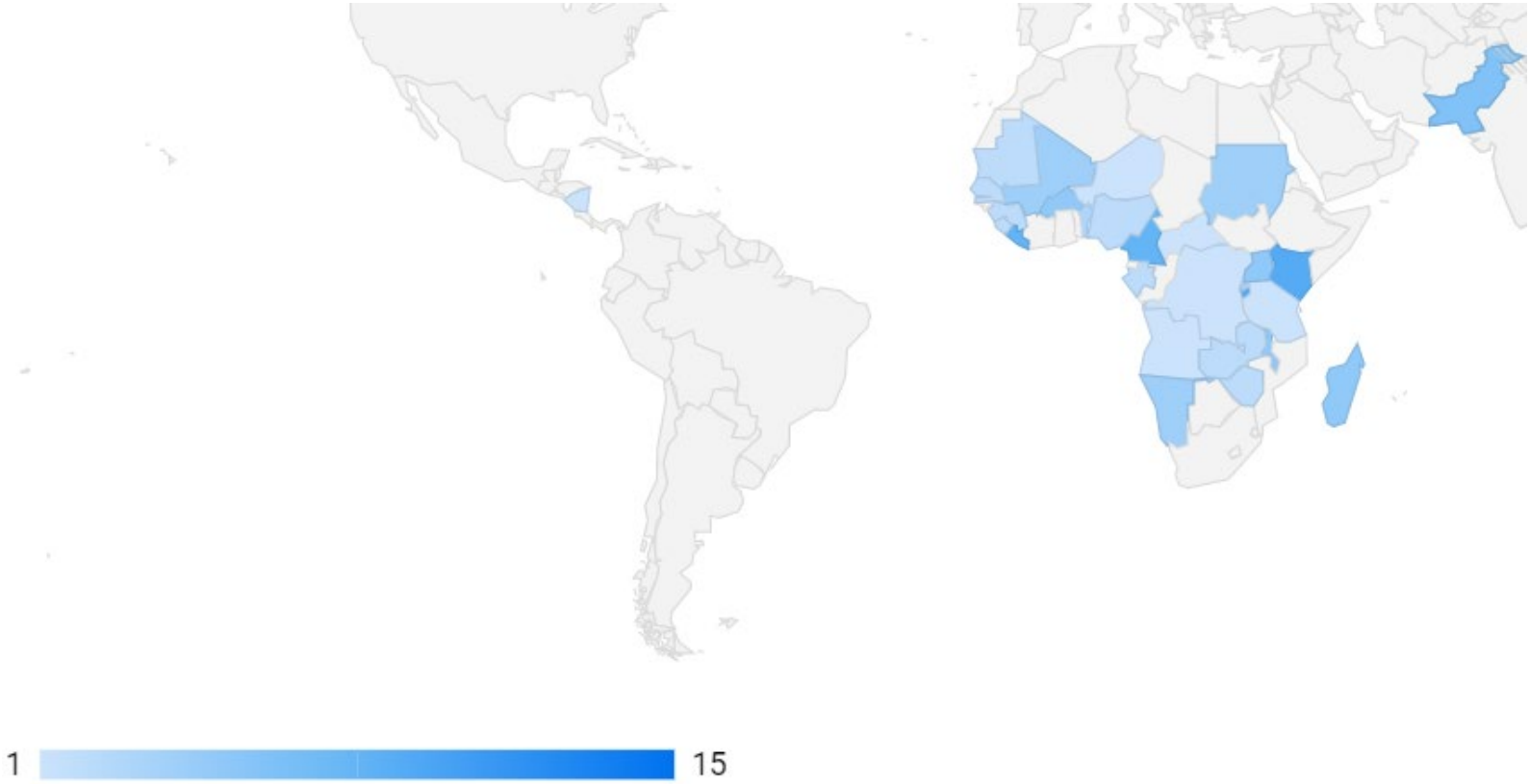
Priorités du CRSPC en 2022



Répartition de l'assistance technique 2021 - 2022 par pays et domaine d'intervention



Répartition de l'assistance technique dans les pays d'endémie palustre, 2021 - 2022



Processus d'assistance technique

- Commencer par épuiser le potentiel de capacités différentes au niveau national et régional.
- AT sur plan AT annuel, possibilité de demande de nouvelle AT
  ✓ Formule de demande d'AT et mandats
- Soumettre les besoins d'AT (e-mail, lettre) à notre équipe sous-régionale. L'AT peut aussi être soumise en ligne à travers le tableau de bord RBM Global Malaria Dashboard
  ✓ Le moment est important surtout s'il faut prévoir des déplacements
  ✓ Envoyer les besoins d'AT sous MPR, PSN, à l'OMS
- Mise à jour d'état de mise en œuvre de l'AT, retour et conclusion

Calendrier de l'assistance technique

- Consultants internationaux (des listes) - demande d'assistance technique au moins un mois avant la date de début réelle de l'assistance technique….
- Consultants locaux - Le CRSPC transférera les fonds vers le pays au ministère de la santé ou aux organisations des Nations Unies. Dans les deux cas, les pays sont tenus d'élaborer une note conceptuelle et de signer un accord avec l'UNOPS. Ce processus prendra au moins 1 à 2 mois.
- Associez la personne responsable du programme local de lutte contre le paludisme ou le consultant local au consultant international dans le cadre d'un effort de renforcement des capacités locales.
- Si le domaine d'assistance nécessite différents domaines d'expertise, le CRSPC peut recruter des consultants via un processus d'examen rapide - cela peut prendre jusqu'à 3 semaines.

Liste de consultants

SN	Domaine d'expertise
1	Haut expert paludisme au sens large
2	Consultants en planification et mise en œuvre de campagne MII de masse
3	Consultants en CCSC
4	Consultant en mobilisation de ressources
5	Consultants en matière de plaidoyer
6	Consultants en matière de communauté, droits et genre
7	Expert en santé numérique
8	Consultants RSSH

Axes de travail du CRSPC

- Mobilisation de ressources domestiques
  - Propositions de financement du FM et signature de subvention
  - Mobilisation de ressources domestiques et plaidoyer
- Aide à la mise en œuvre
  - Alliance pour la prévention du paludisme (AMP)
  - Aide à la résolution des goulots d'étranglement de mise en œuvre
  - CPS
- Examen des programmes et plans stratégiques nationaux
- Représentation régionale des gestionnaires de programme
  - Afrique de l'Est
  - Afrique de l'Ouest
  - Afrique centrale
  - Afrique australe
  - Amériques : – liaison avec l'OPS
  - Asie du Sud-Est : – liaison avec l'OMS/SEARO
  - Méditerranée orientale : – liaison avec l'OMS/EMRO
  - Pacifique occidental : – liaison avec l'OMS/WPRO

Groupes de travail RBM

- Groupe de travail sur la prise en charge des cas
- Groupe de travail sur le paludisme pendant la grossesse
- Groupe de travail sur la surveillance, le suivi et l'évaluation
- Groupe de travail sur l'engagement multisectoriel
- Groupe de travail sur la communication pour le changement social et comportemental
- Groupe de travail sur le contrôle des vecteurs

TA status

Benin	Strengthening of programatic aspects as per international best practices	Not requested
Benin	Malaria vaccine: Support for the implementation of the Vaccine in Benin	Not requested
Benin	Support for LLIN mass distribution campaign planning	completed
Burkina Faso	Conduct a survey on probable causes of malaria increase in Burkina Faso	Not requested
Burkina Faso	Conduct a survey on minimum health care services and determination of key actors in the implementation COE areas	Not requested
Burkina Faso	Digitalization of 2022 LLIN universal mass distribution campaign	In discussion with the country
Burkina Faso	Support for the implementation of 2022 LLIN mass distribution campaign	Requested
Burkina Faso	Logistics planning for 2022 LLIN universal mass distribution campaign	completed
Burkina Faso	Communication and risks management plan for 2022 LLIN universal mass distribution campaign	completed
Burkina Faso	Develop an implementation plan for ZMSWM at the decentralized level	Not requested
Burkina Faso	Finallize the stratification of health care and prevention intervention quality beyond the health district	Not requested

20

TA status

Cabo Verde	Launch of the ZMSWM campaign	completed
Cote d'Ivoire	2020 -2021 LLIN mass distribution campaign post evalutation	Not requested
Cote d'Ivoire	Retrospective evaluation of malaria control interventions	Not requested
Cote d'Ivoire	Mid-term review of 2021-2025 NSP	Not requested
Cote d'Ivoire	Round table for ressource mobilization	Not requested
Equatorial Guinea	Support for Malaria Programme Review	Not requested
Gabon	LLIN mass distribution campain planning	Not requested
Gambia	Malaria Surveillance Guidelines and SoPs and new data collection tool for elimination	completed
Gambia	support the launching of Zero Malaria Starts with Me" Campaign in the Gambia	Not requested
Gambia	Support the stratification of malaria epidemiology	Not requested
Gambia	Develop the malaria Business Plan	Not requested
Gambia	Conduct the impact evaluation post SMC, and Establishment of a Pharmaco-vigilance System	Not requested
Guinea	Support for 2022 LLIN mass distribution campaign programmatic aspects planning	completed
Guinea	Support for 2022 LLIN mass distribution campaign logistics planning	completed
Guinea	Support for the development of a Malaria pre-elimination plan	Not requested
Guinea	Support for the final review of 2018-2025 NSP	Not requested

TA status

Guinea Bissau	Support the estimations of Malaria cases for 2022&2023 and subsequent gap analysis	Requested
Guinea Bissau	Support the Malaria National Strategic Plan Mid Term Review	Not requested
Liberia	Support of the development of a malaria Business Plan 2021-2025	Not requested
Liberia	Support the preparation and launching of Zero Malaria Starts with Me Initiative	Not requested
Liberia	TA support to update population and malaria case estimations for 2022-2024	Not requested
Liberia	Support the adoption of the HBHI approach	Not requested
Mali	Final review of 2018-2022 NSP and development of a new NSP for the period 2023- 2027	Not requested
Mali	Evaluation of SMC delivery and impact in Mali	Not requested
Mauritania	Support for the implementation of new malaria control strategies (IRS,SMC)	completed
Mauritania	Support for the implementation of new malaria control strategies (IRS,SMC)	Requested
Mauritania	Support for the improvement of malaria commodities supply systems	Not requested
Mauritania	Support for the development of resource mobilization plan for malaria control	Not requested

Nigeria	Consultant to train staff on the use of data analytics tools and platforms (M&E)	Not requested
Nigeria	Support Planning/ Malaria Programme Mid-term Review (PM)	Not requested
Nigeria	Support Warehousing and distribution of malaria commodities for oversight functions of service providers (PSM)	Not requested
Nigeria	Support Supply Chain Operation Reference Model (SCOR)	Not requested
Nigeria	Capability on maturity model in supply chain for performance evaluation of malaria supply management	Not requested
Niger	Digitalization of LLIN mass distribution and SMC campaigns	Not requested
Niger	Final review of 2017-2021 NSP & Development of a new NSP and M&E plan for the period 2022 -2026	Requested
Niger	New Generation LLIN mass campaign and routine distributions	Not requested
Senegal	Support in the planning and implementation of the ITN distribution	completed
Senegal	Support for the development of a Malaria Elimination plan	Not requested
Sierra Leone	LLINs School based Distribution	Not requested
Sierra Leone	Support the ITN mass distribution campaign Logistics and SBCC planning aspects	Ongoing
Togo	Zero Malaria Starts with me action plan preparation and official launch	Not requested
Togo	Stratification of Malaria interventions	Requested
Togo	Development of a malaria advocacy plan and training of actors in advocacy	Not requested
Togo	Planning of 2023 LLIN mass distribution campaign activities	Not requested
Togo	Performance review of 2017-2022 extented to 2023 NSP	Not requested

amp | The Alliance for Malaria Prevention

Global ITN presentation

CRSPC SRN meetings
2022


rumours
geospatial tools
insecticide resistance
Urban
Success
rumours
C19RM
IDP
tired
COVID-19
flexibility
virtual
coordination
funding applications
climate
SBC
Teams
ITN quality
Gender
PPE
Success
together
PPE
funding
Teams
funding applications
CD
COVID-19
waste management
Integration
IDP
overcoming bottlenecks
SBC
waste
climate
Teams
denominator
PNCM
Insecurity
durability
Gender
digitalisation
adaptations
insecticide resistance
new ITN types
together
Pandemic
Urban
Gender
Success
waste
MOP
Pandemic
leadership
access
new ITN types
overcoming bottlenecks
insecticide resistance
complexity
Microplannning
Partnership
PNCP
durability
ITN quality
virtual
rumours
Insecurity
PNCP
MOP
hard-to-reach
funding applications
denominator
nmcp
PNCP
leadership
climate
virtual
Partnership
MOP
tired
TA
access
complexity
flexibility
durability
Pandemic
priorities
priorities
CD
IDP
TA
supply chain
priorities
flexibility
tired
leadership
PNCM
new ITN types

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

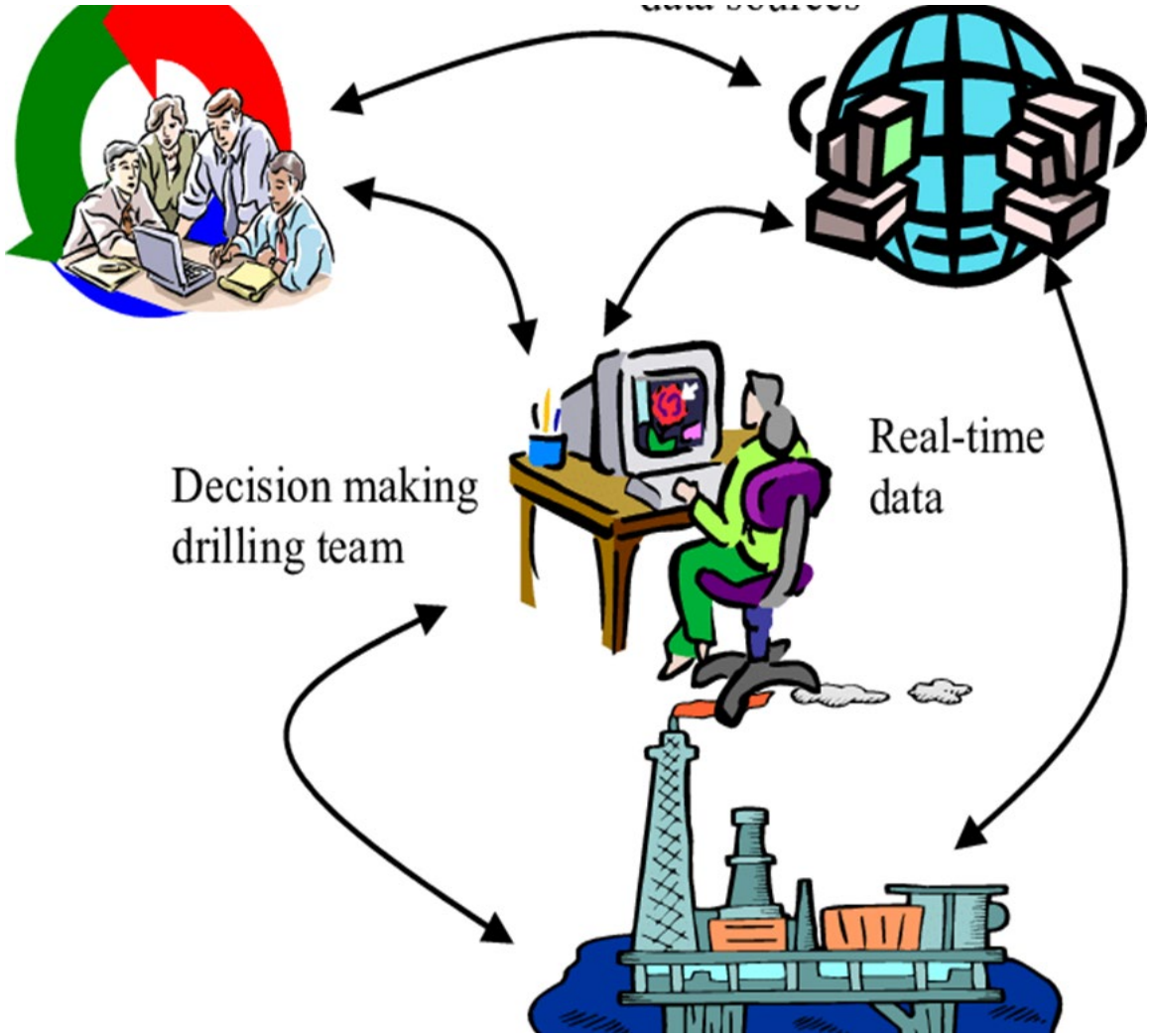
ITN campaigns and digital tools

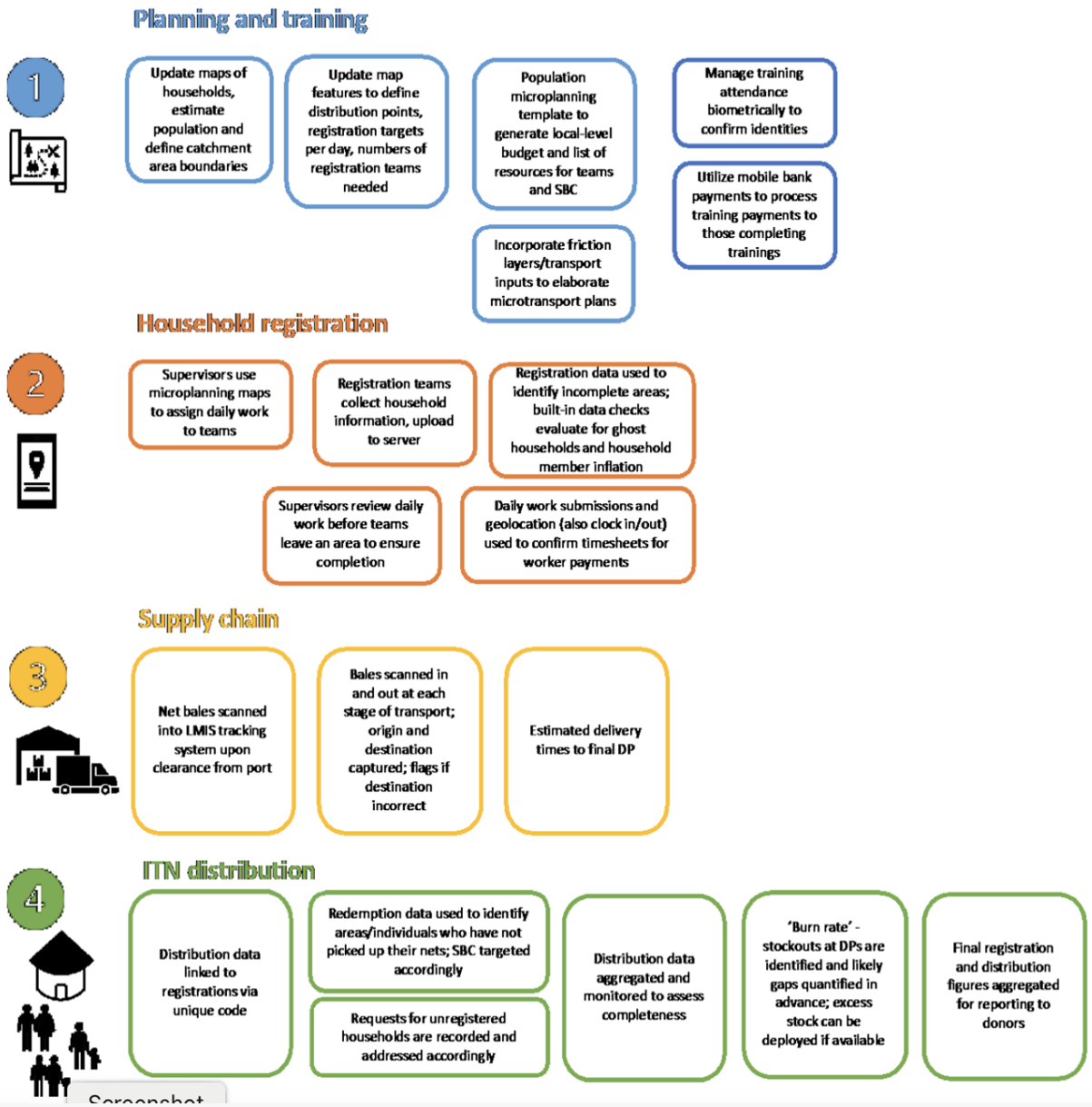
Background

- 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



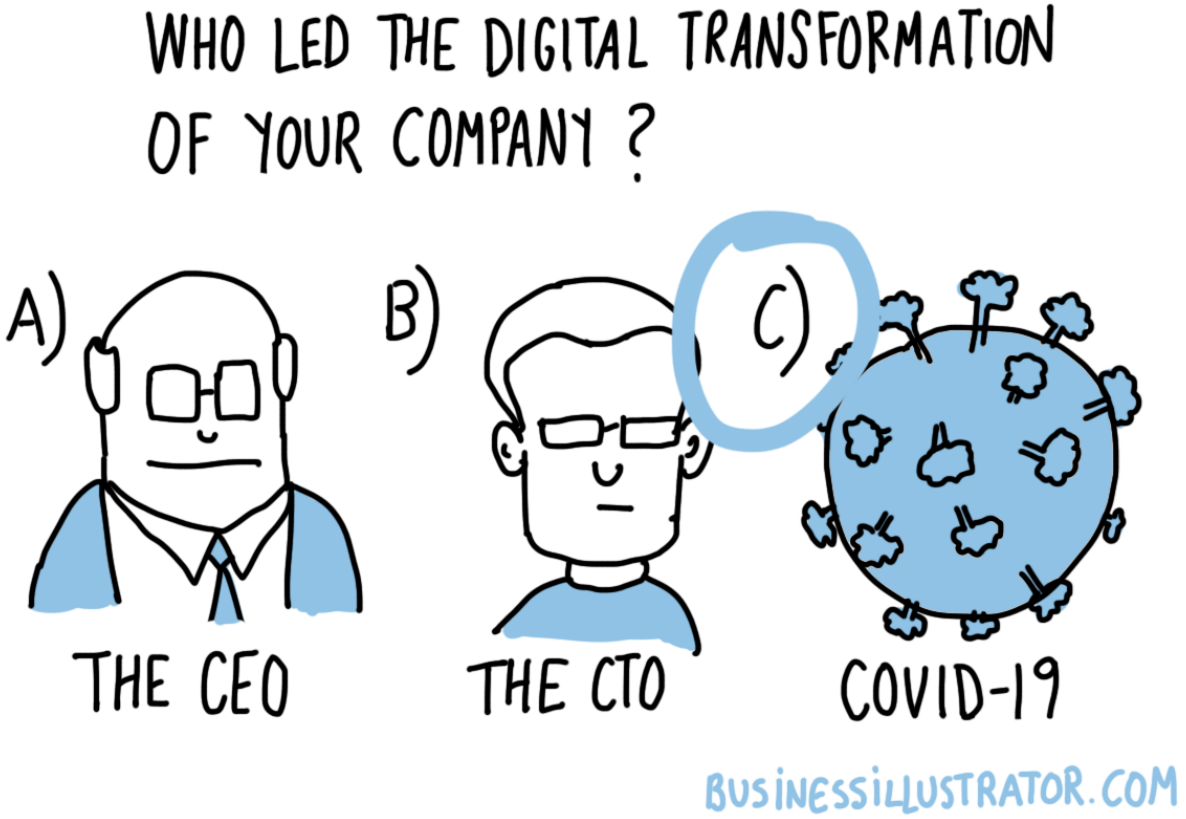


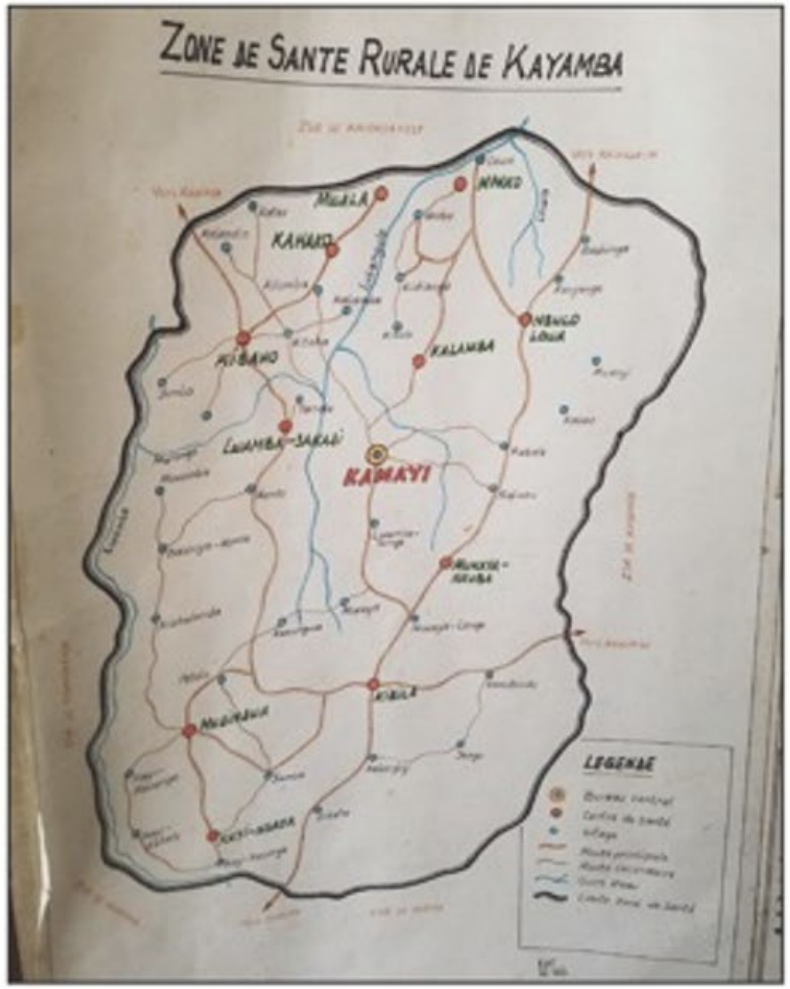
Expanding our digitalization to "The Wish List" will improve our campaign efficiency

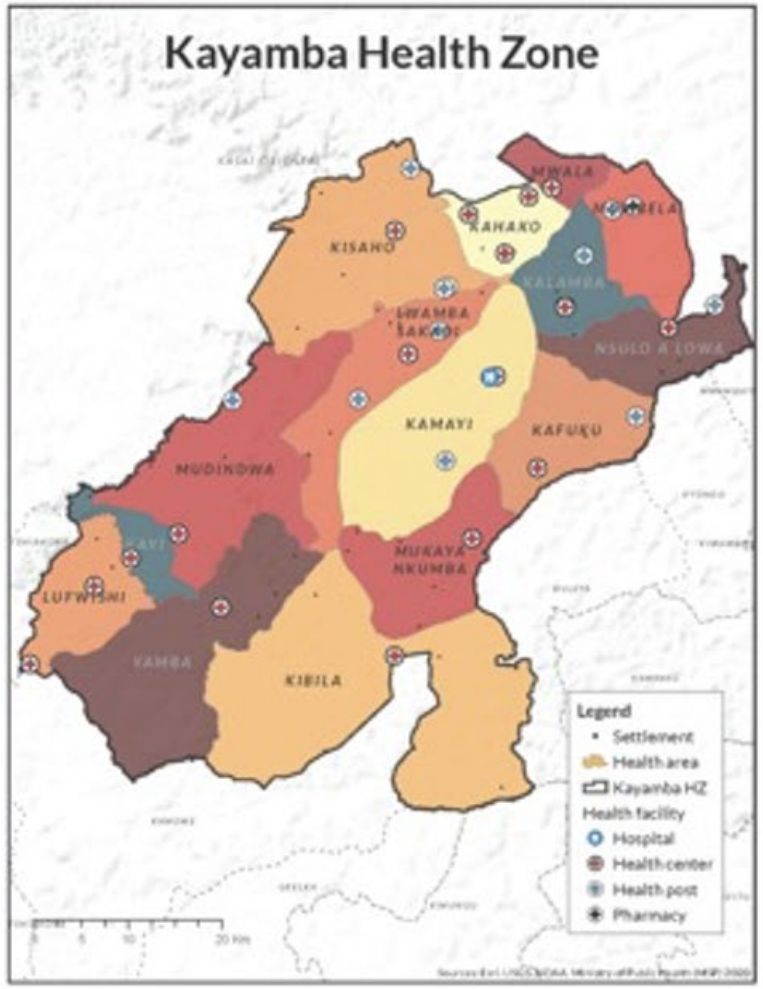
https://allianceformalariaprevention.com/wp-content/uploads/2021/06/AMP_Improving_Efficiency_Digital_Tools_21052021.pdf

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







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

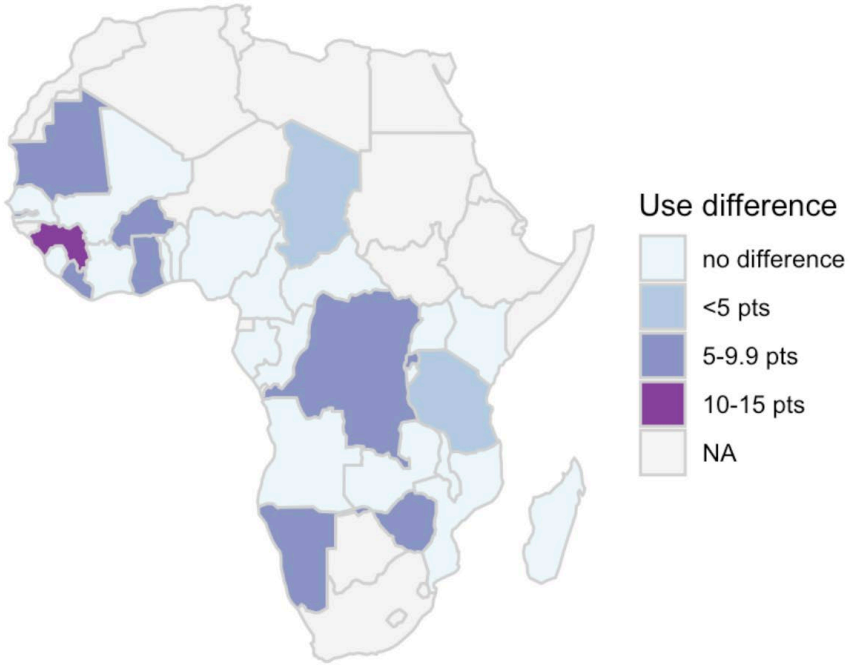
Digitalization tools: Available end July

- 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

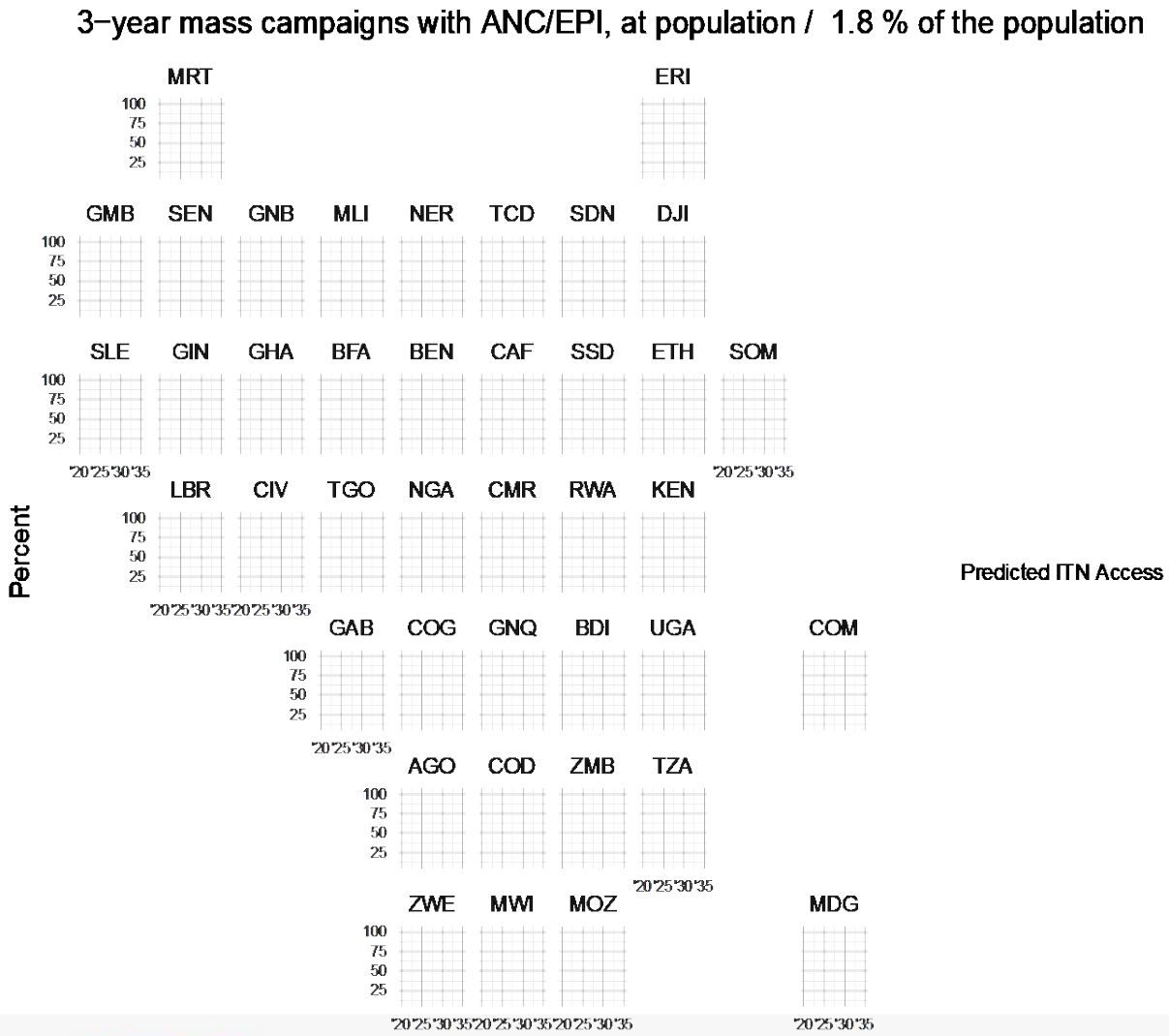


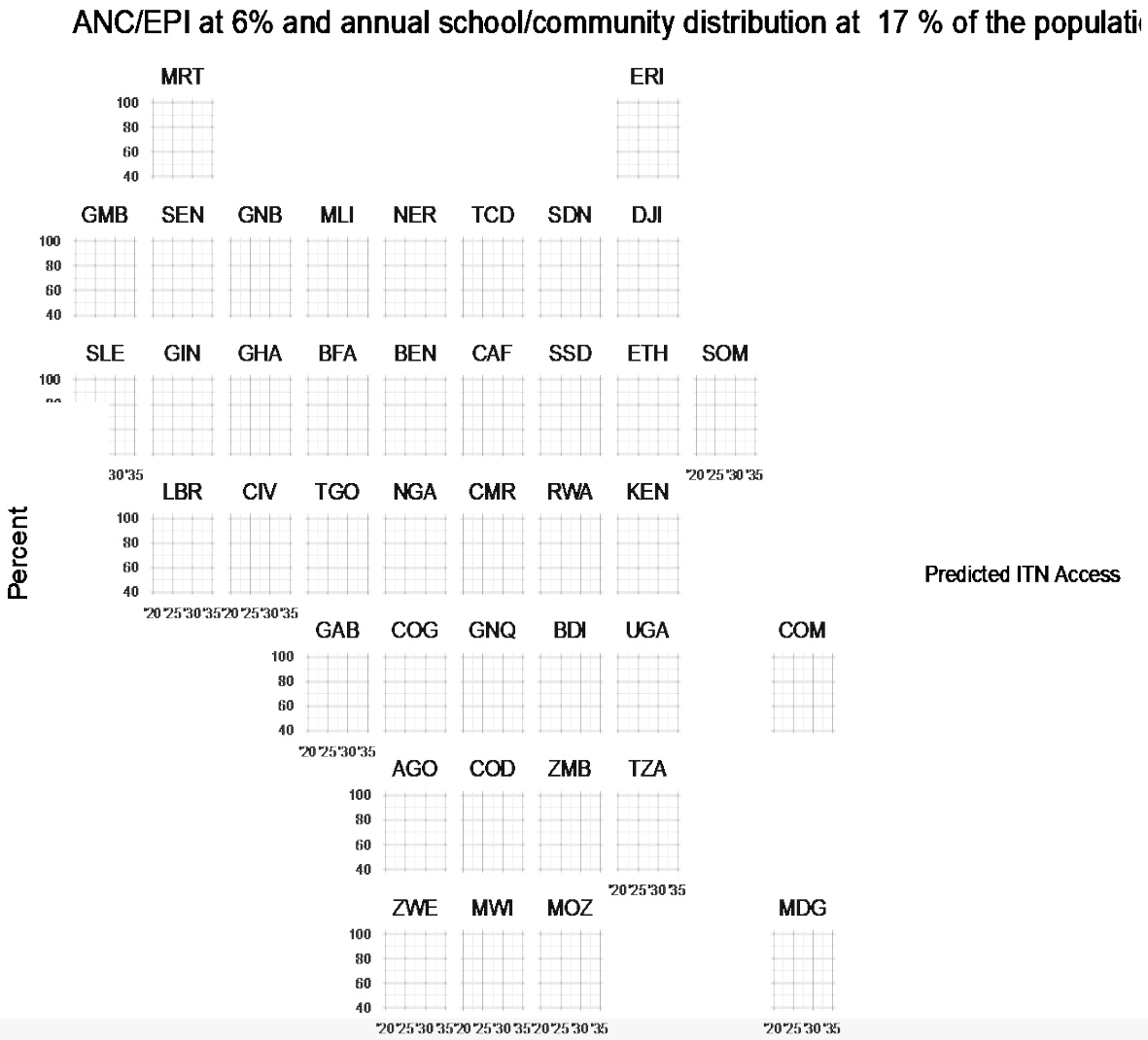
Programmes may wish to procure ITNs of a particular textile

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

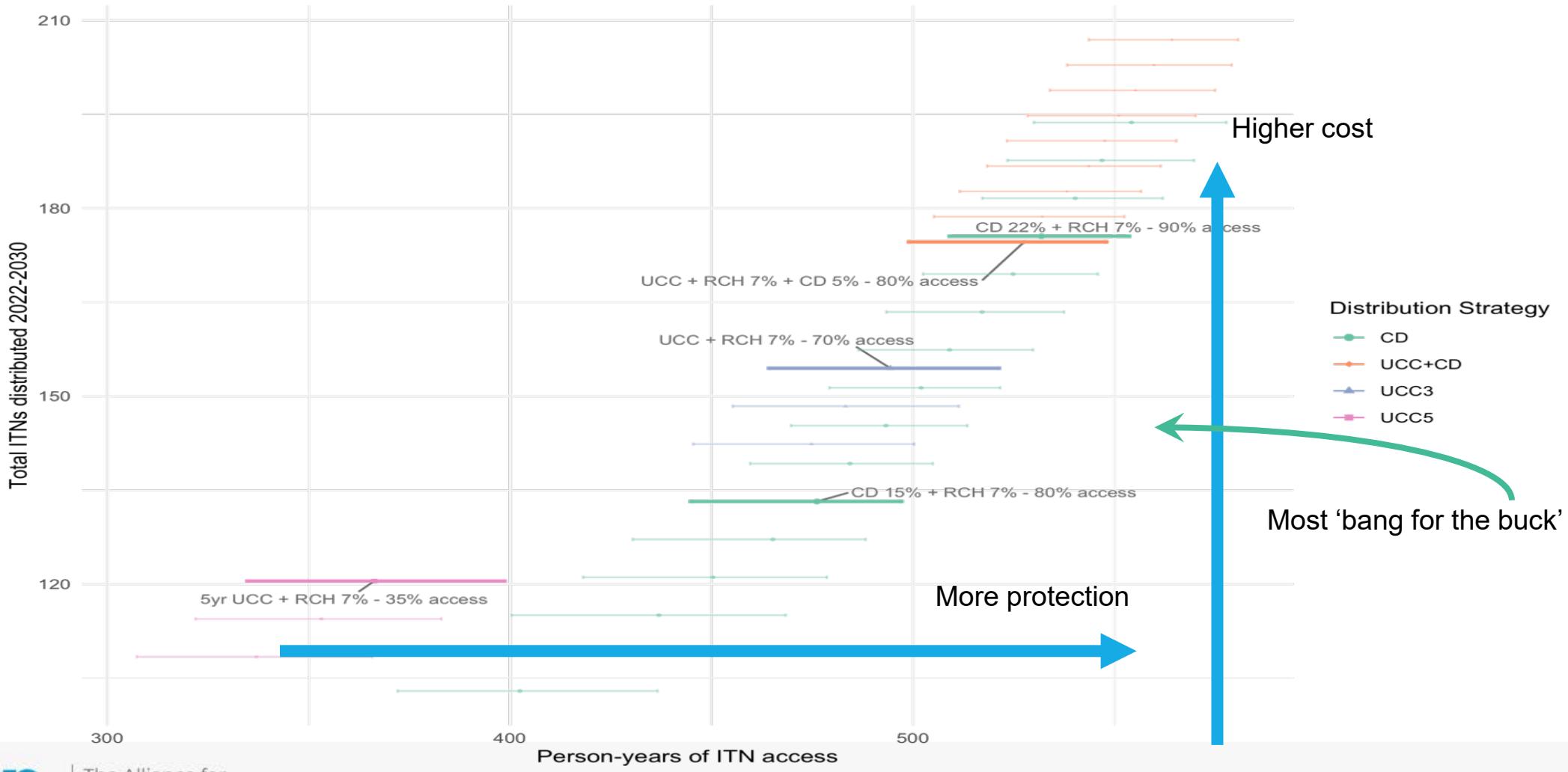
https://net-textile-use-reports.netlify.app

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





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

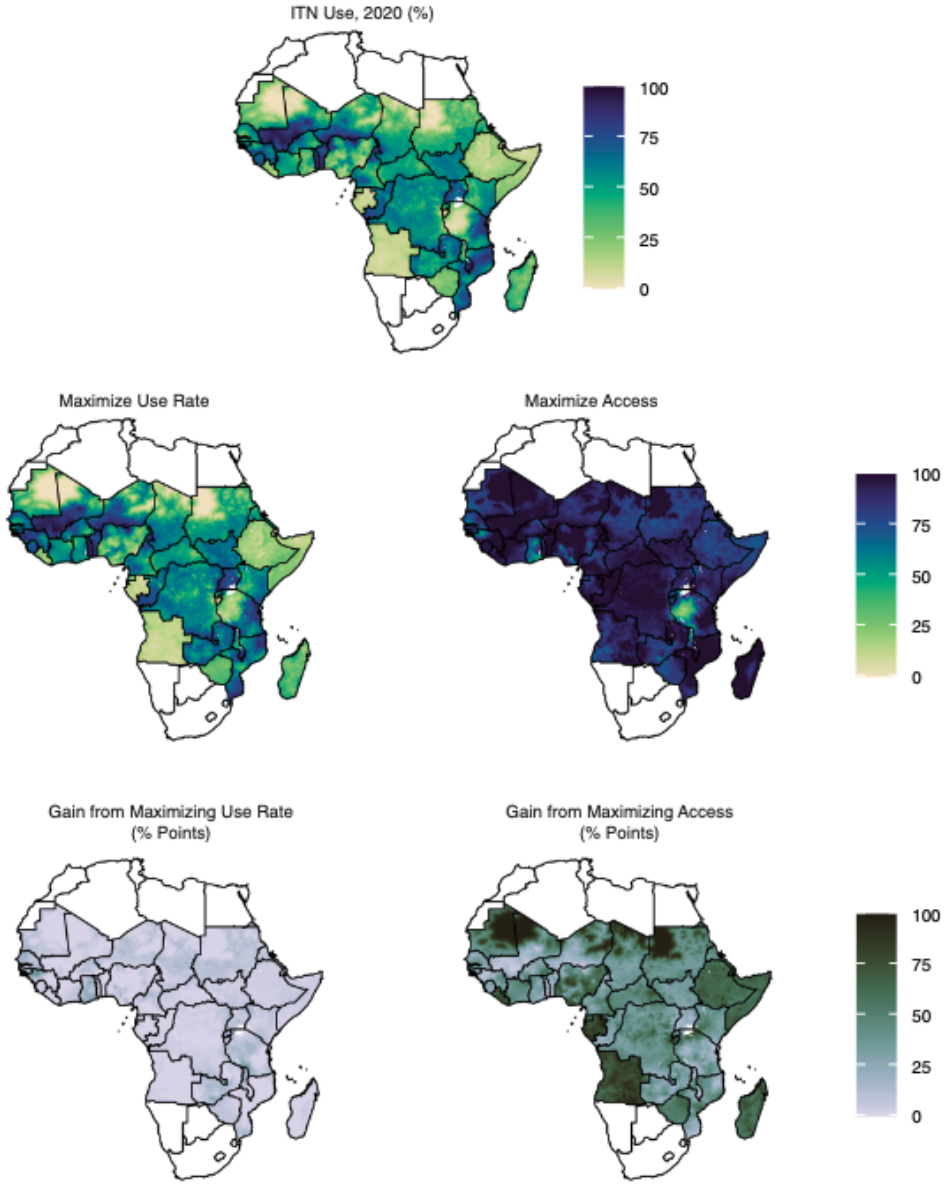
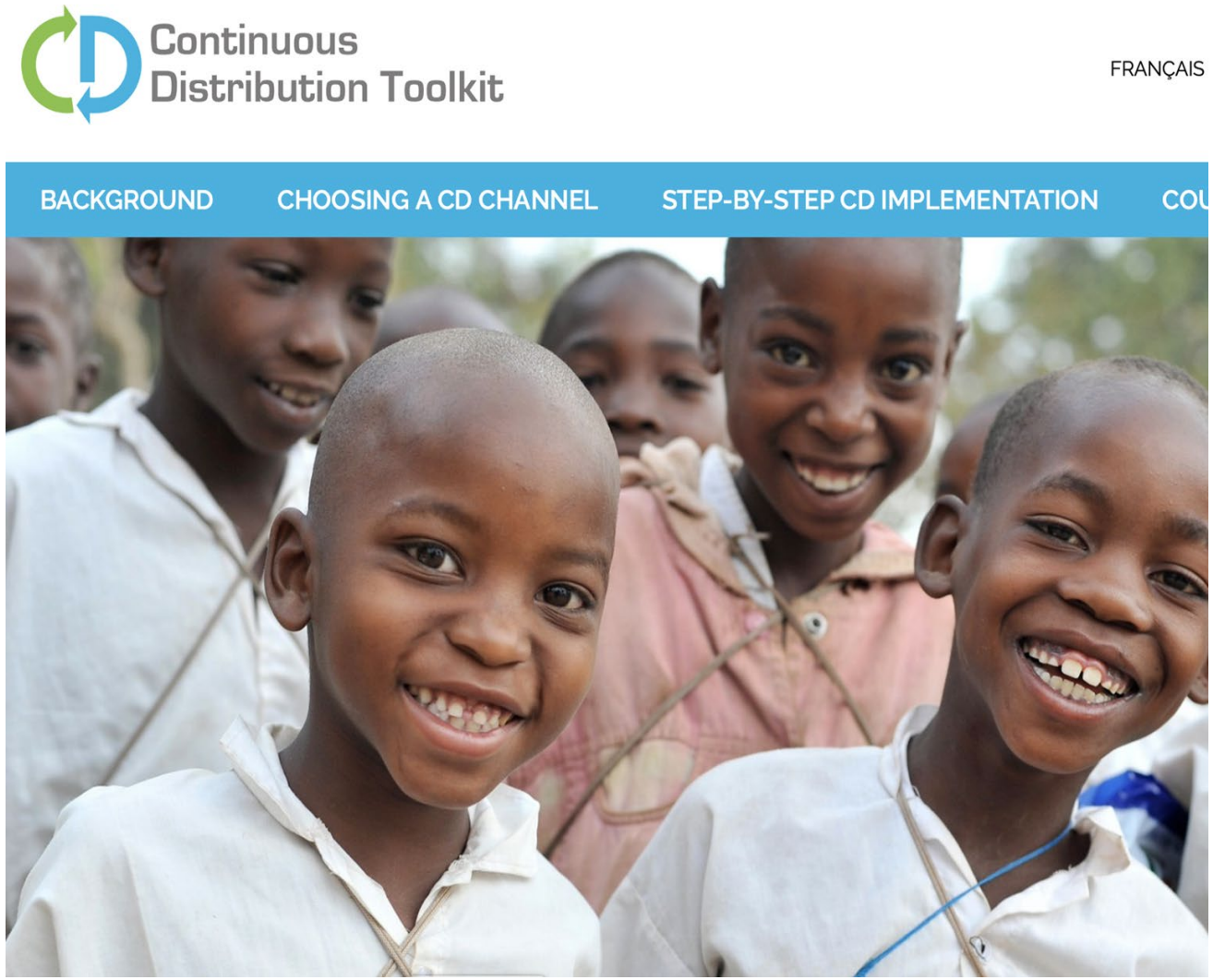


Fig. 6 Magnitude of change in insecticide-treated net (ITN) use possible from increasing use rate versus increasing access. The top row shows estimated ITN use in 2020. The second row shows what use could be if access remained unchanged and the use rate were set to 100% (left), compared to if the use 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

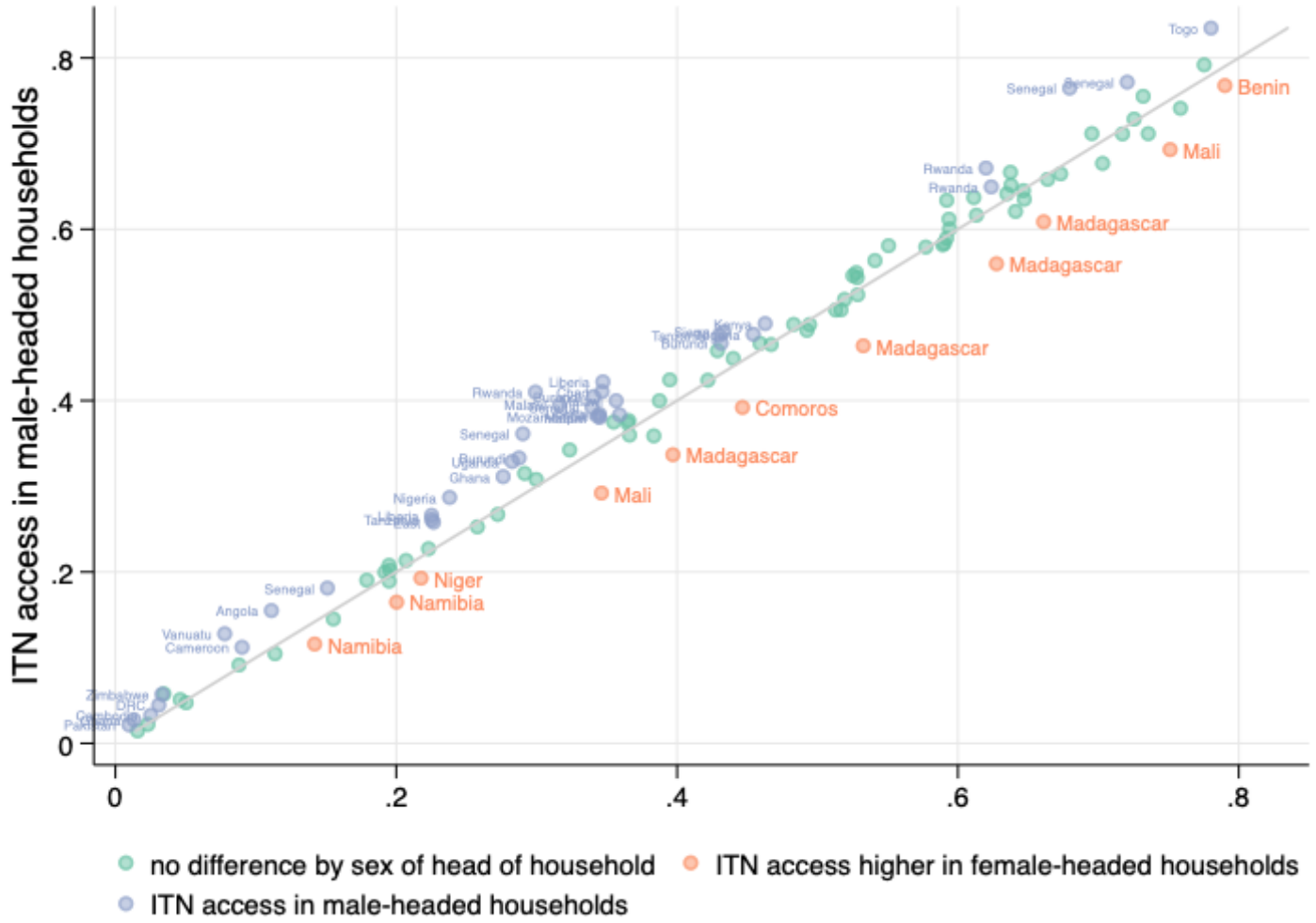
  (MS Word Chapter Setup Template (allianceformalariaprevention.com)

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/resources/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

Kilian *et al. Malar J* (2021) 20:29
https://doi.org/10.1186/s12936-020-03570-5

Malaria Journal

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 Obi[2], Paul Mansiangi[3], Ana Paula Abílio[4], Khamis Ameir Haji[5], Estelle Guillemois[6], Vera Chetty[6], Amy Wheldrake[6], Sean Blaufuss[7], Bolanje Olapeju[7], Stella Babalola[7], Stephen J. Russell[6] and Hannah Koenker[7]

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.

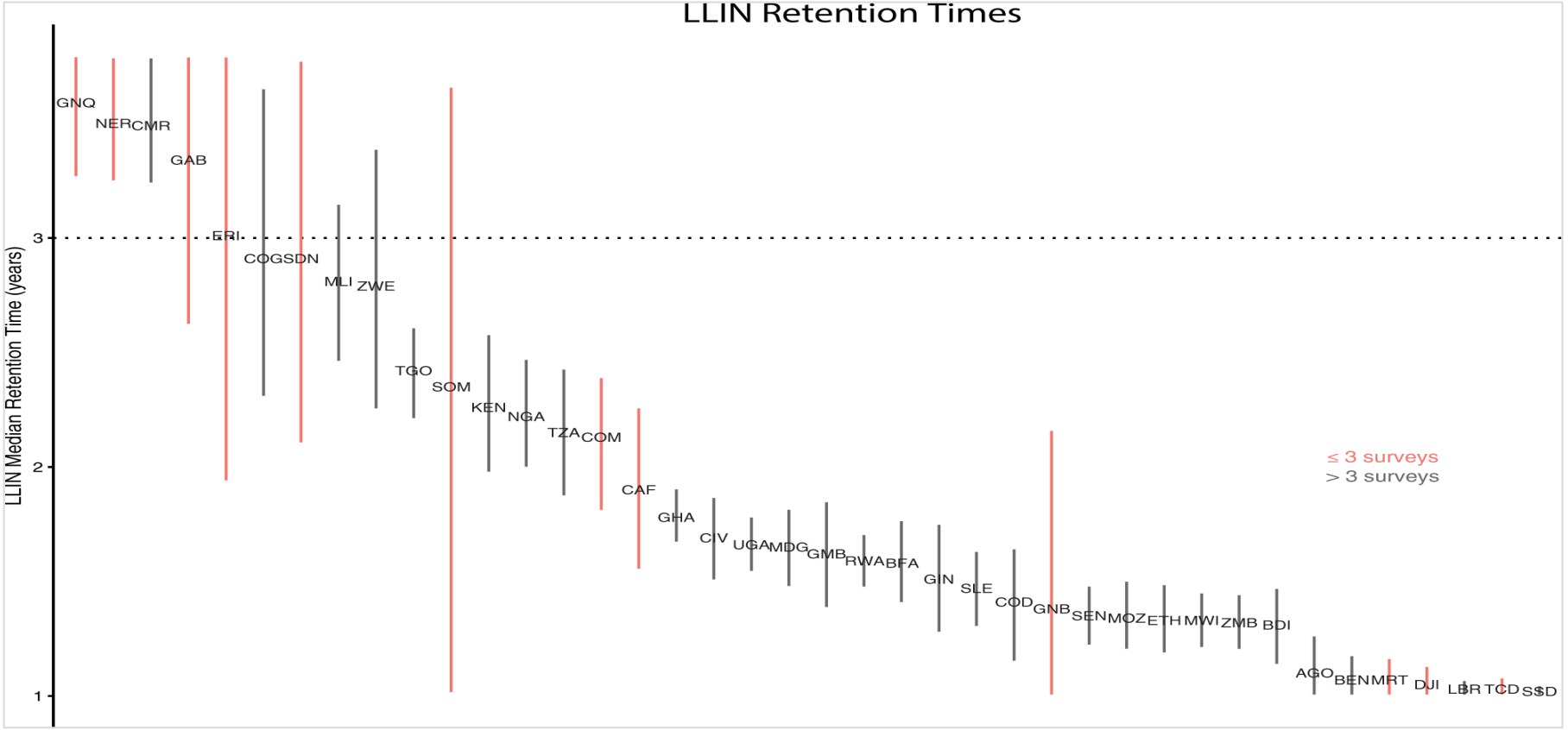
Keywords: LLIN physical durability, Textile resistance to damage

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

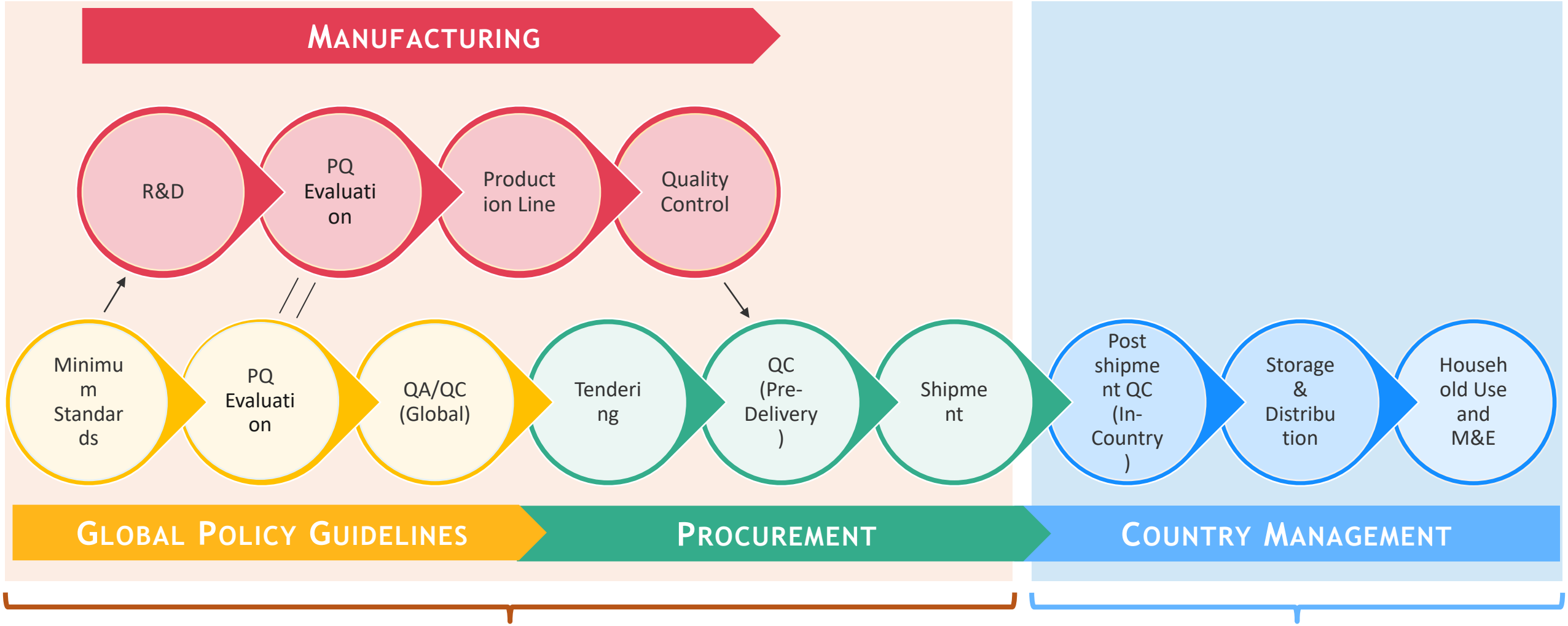
" …..the bulk of existing evidence supports the notion that median net retention is commonly lower than 3 years."

"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



Pre-Shipment
(covered in first convening)

Post-Shipment
(covered in second convening)

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

technical definition

the degree to which nets meet the chemical and physical properties defined by their specifications

QUALITY

common definition

whether nets do what we expect under normal usage conditions (remain physically and chemically active for 3 years)

Does meeting the technical definition lead to meeting the performance expected in the common definition?

Key themes: Global Policy

GLOBAL POLICY

	TOP CHALLENGES	PRIORITIZED SOLUTIONS
Minimum Standards	• Need to develop **specifications** that link net quality to performance	• Build the "foundation" for ITN attributes. Inclusion of **textile integrity** to specifications
PQ Evalua-tion	• **Update testing guidance** to reflect new products	• Update and disseminate testing guidelines
QA/QC	• **Insufficient QA/QC testing infrastructure** - testing methodologies and different laboratories not perceived to deliver consistent results	• Review capacity of GLP facilities for testing ITNs • Review QA of pre/post - shipment lab testing infrastructure

Key themes: Manufacturing

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

Key themes: Procurement

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

	Top Challenges	Prioritized Solutions
Post shipment inspect-ion	• **Non-standardized post-shipment testing** may cause rejection of good products or acceptance of poor products	• Develop **harmonized guidance on pre- and post delivery inspection** criteria and SOPs
Port delays & storage	• No guidelines exist for warehousing • **Delays and storage at port** including customs clearance and distribution related delays	• Definition of and guidance on optimal storage conditions (net specific where necessary) • Advocacy to facilitate **rapid customs clearance**
Distribut-ion strategy	• Lack of clear distribution strategy/microplans and delays in distribution at different levels perhaps leading to inappropriate storage	• 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


rumours
geospatial tools
insecticide resistance
Urban
Success
rumours
C19RM
IDP
tired
COVID-19
flexibility
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funding applications
climate
SBC
Teams
ITN quality
Gender
PPE
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CD
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waste management
Integration
IDP
overcoming bottlenecks
SBC
waste
climate
Teams
denominator
PNCM
Insecurity
durability
Gender
digitalisation
adaptations
insecticide resistance
new ITN types
together
Pandemic
Urban
Gender
Success
waste
MOP
Pandemic
leadership
access
new ITN types
overcoming bottlenecks
insecticide resistance
complexity
Microplannning
Partnership
PNCP
durability
ITN quality
virtual
rumours
Insecurity
PNCP
MOP
hard-to-reach
funding applications
denominator
nmcp
PNCP
leadership
climate
virtual
Partnership
MOP
tired
TA
access
complexity
flexibility
durability
Pandemic
priorities
priorities
CD
IDP
TA
supply chain
priorities
flexibility
tired
leadership
PNCM
new ITN types

New Nets Project: Operational issues and key findings

New Nets Project consortium

IVCC

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

psi
Healthy lives. Measurable results.

- 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

PATH

- Cost-effectiveness determination from pilot implementations

LSTM
LIVERPOOL SCHOOL OF TROPICAL MEDICINE

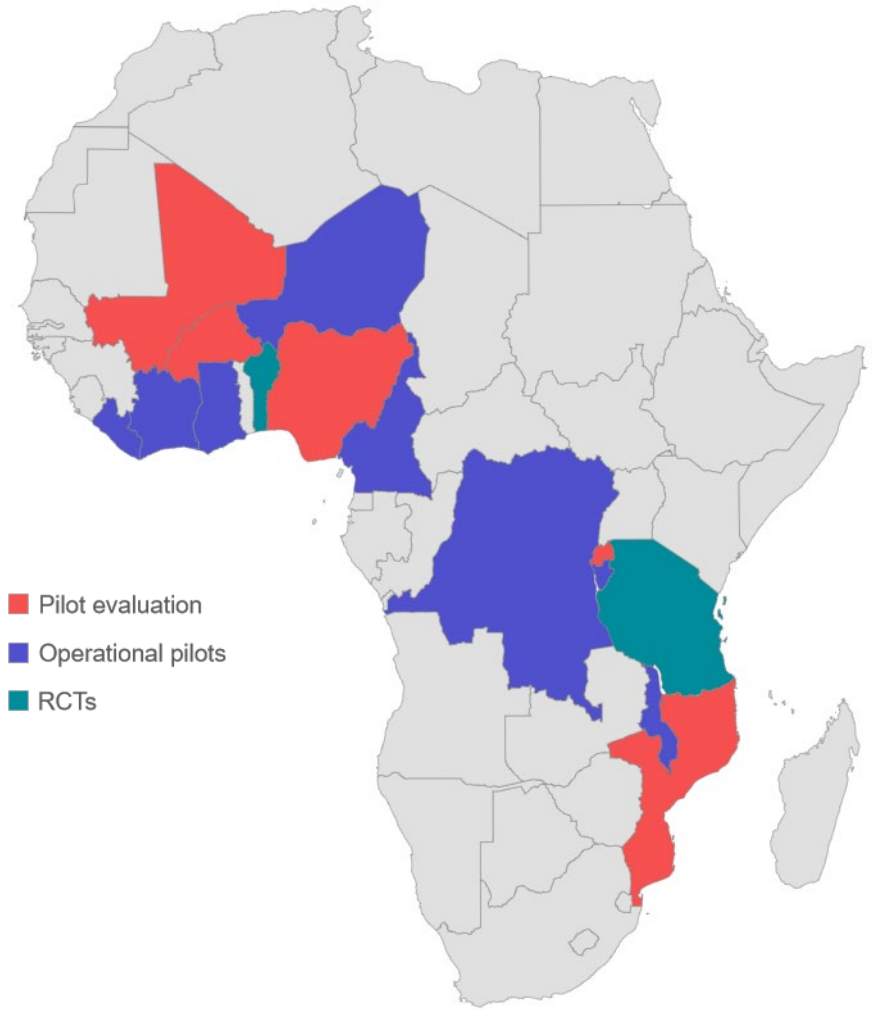
- Entomological correlates of epidemiological impact

Tulane University

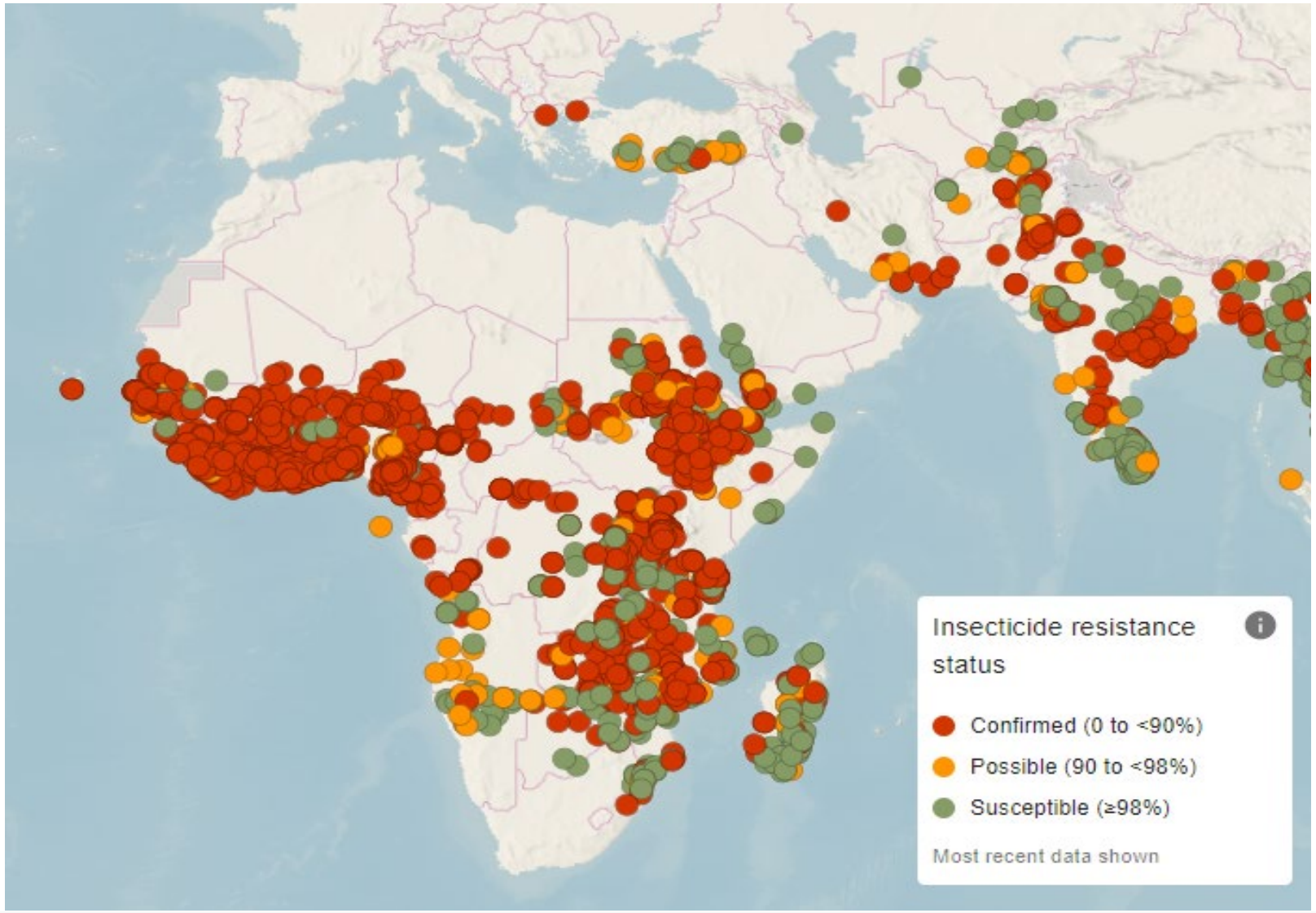
- Cost effectiveness study design and data collection

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

- 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

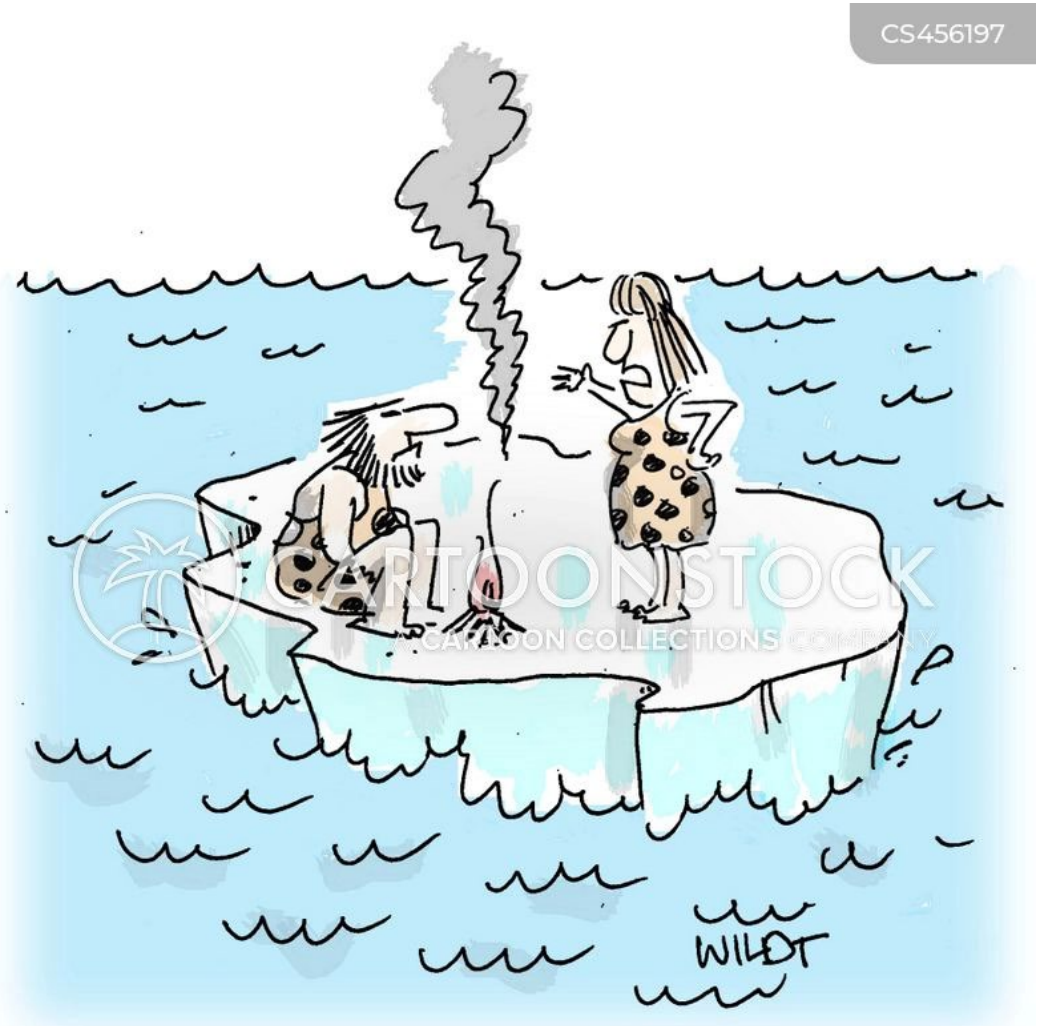
The New Nets Project (NNP: funded by Unitaid and the Global Fund and primed by IVCC) helps to pilot the next generation of nets, **dual-active ingredient ITNs**

Pyrethroid-only	Pyrethroid + Synergist	Pyrethroid + Chlorfenapyr	Pyrethroid + Pyriproxyfen
Standard ITNs	PBO ITNs	Interceptor® G2 ITN	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



"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

Contacts

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- New Nets Project
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Présentation mondiale sur les MII

Réunions SRN du comité CRSPC de 2022


rumours
digitalisation
COVID-19
Pandemic
nmcp
complexity
supply chain
priorities
flexibility
PNCP
MOP
access
new ITN types
insecticide resistance
Microplannning
Partnership
Insecurity
denominator
climate
waste
funding applications
ITN quality
Gender
PPE
Teams
IDP
CD
PNCM
SBC
C19RM
COVID-19
virtual
TA
durability
tired
Urban
Success
coordination
together
Integration
leadership
Pandemic
hard-to-reach
complexity
Insecurity
waste management
overcoming bottlenecks
adaptations
funding applications

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

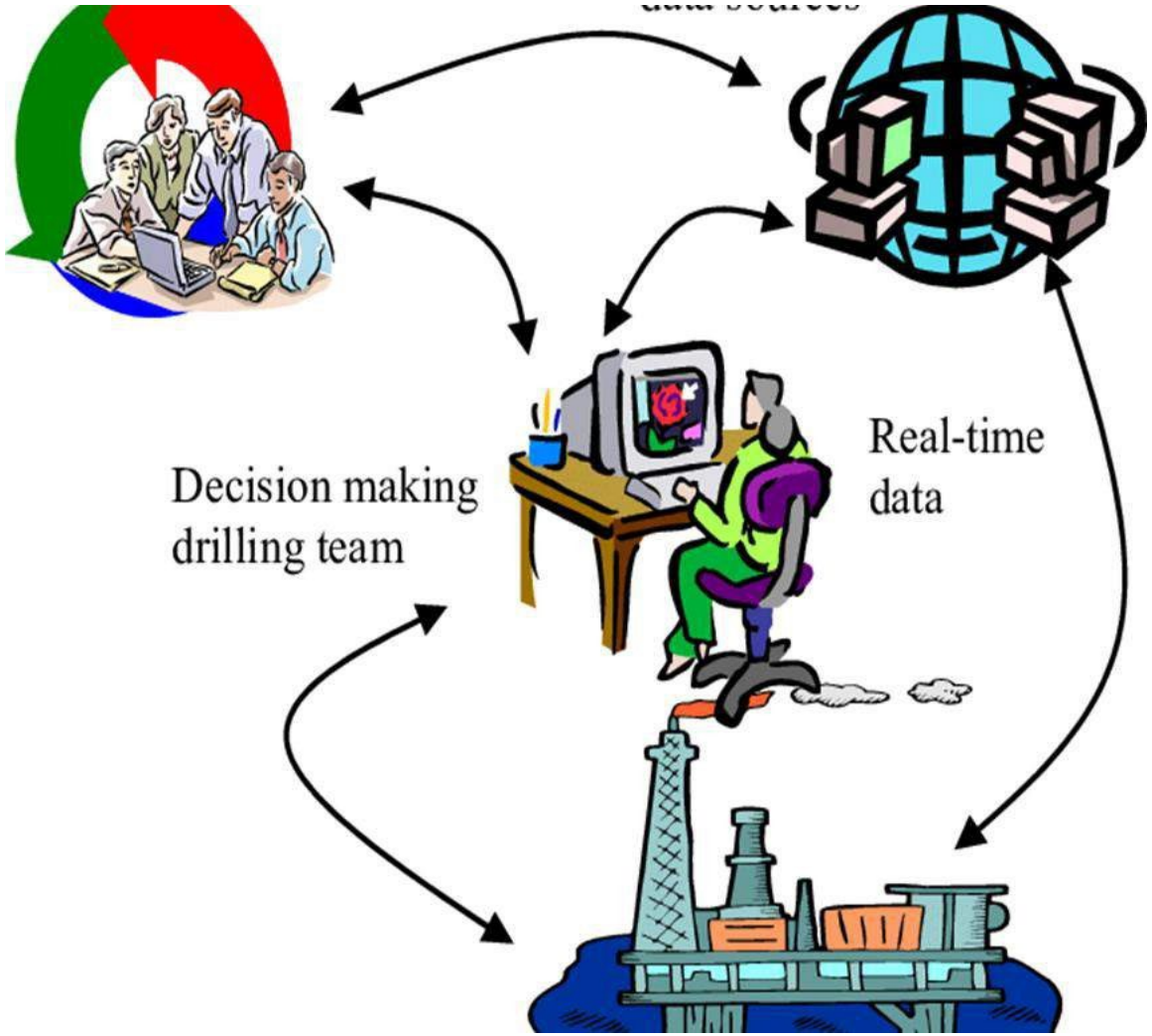
Campagnes de distribution de MII et outils numériques

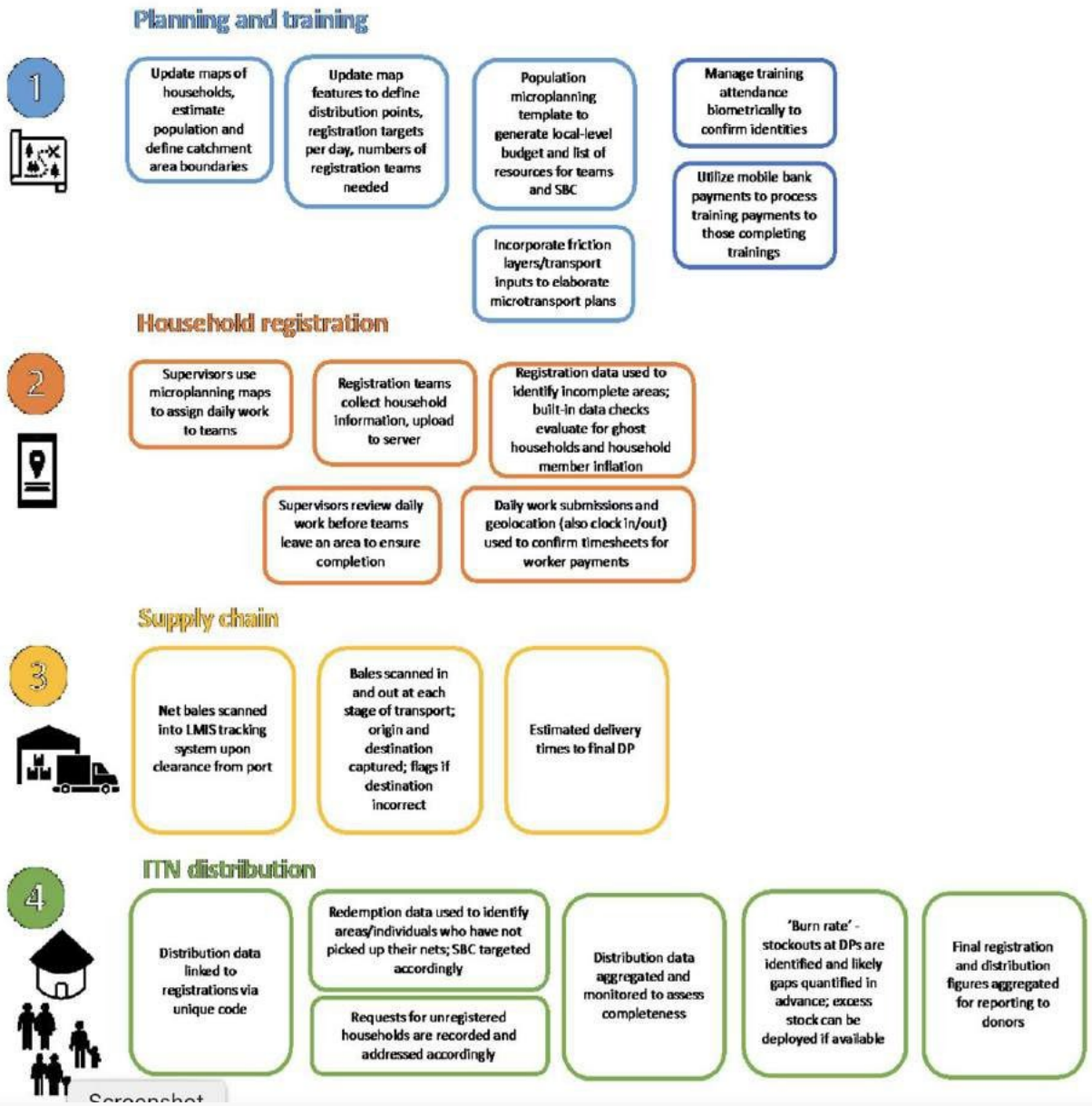
Contexte

- 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 11 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



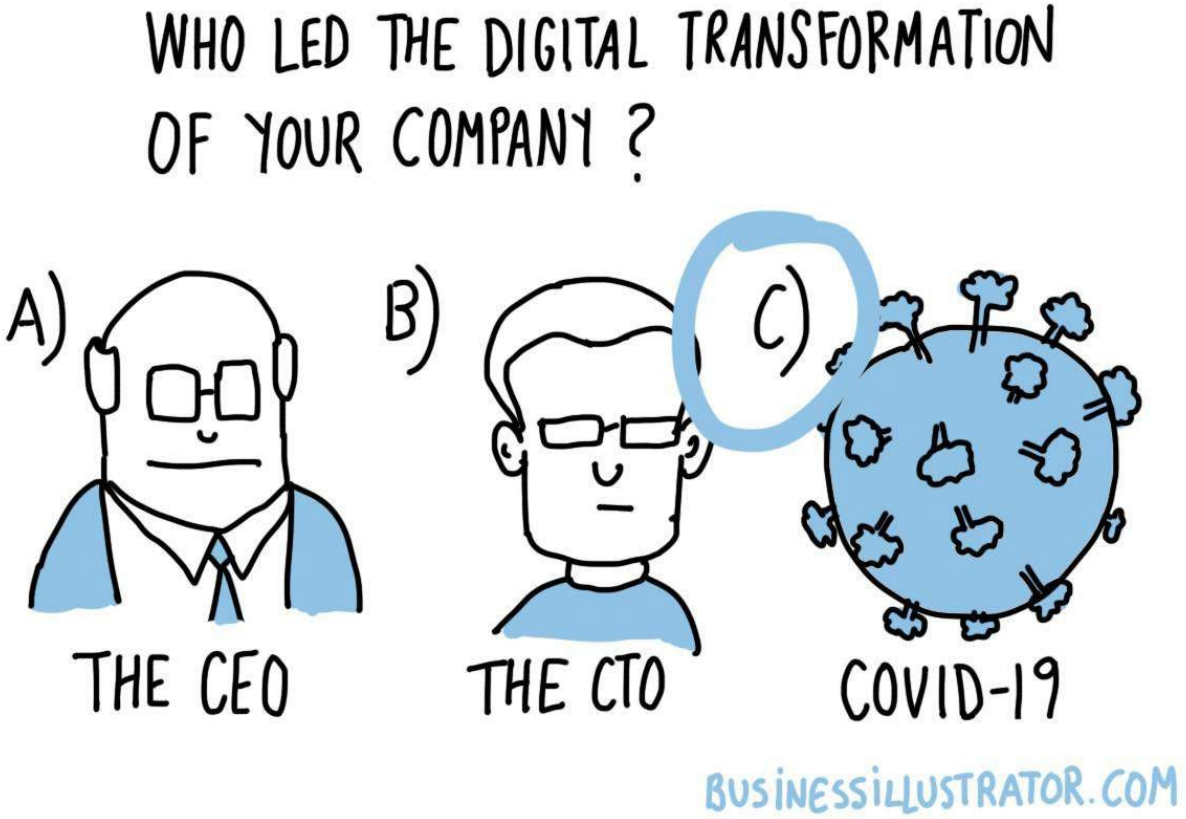


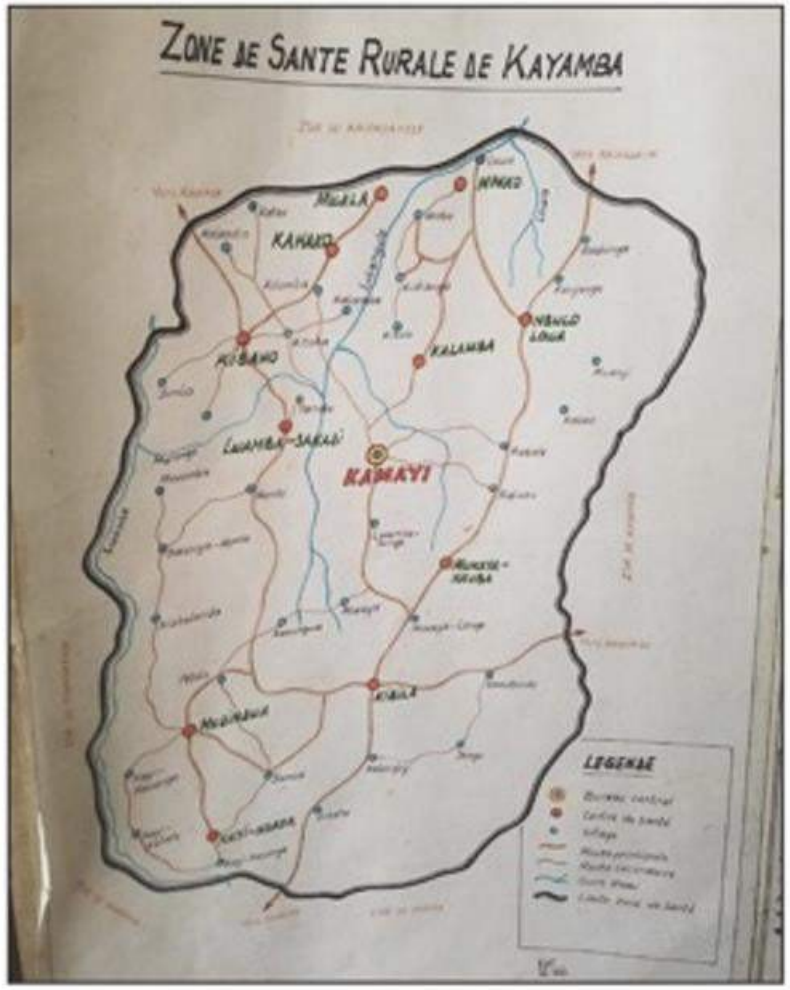
Étendre notre numérisation à la « liste de souhaits » améliorera l'efficacité de nos campagnes

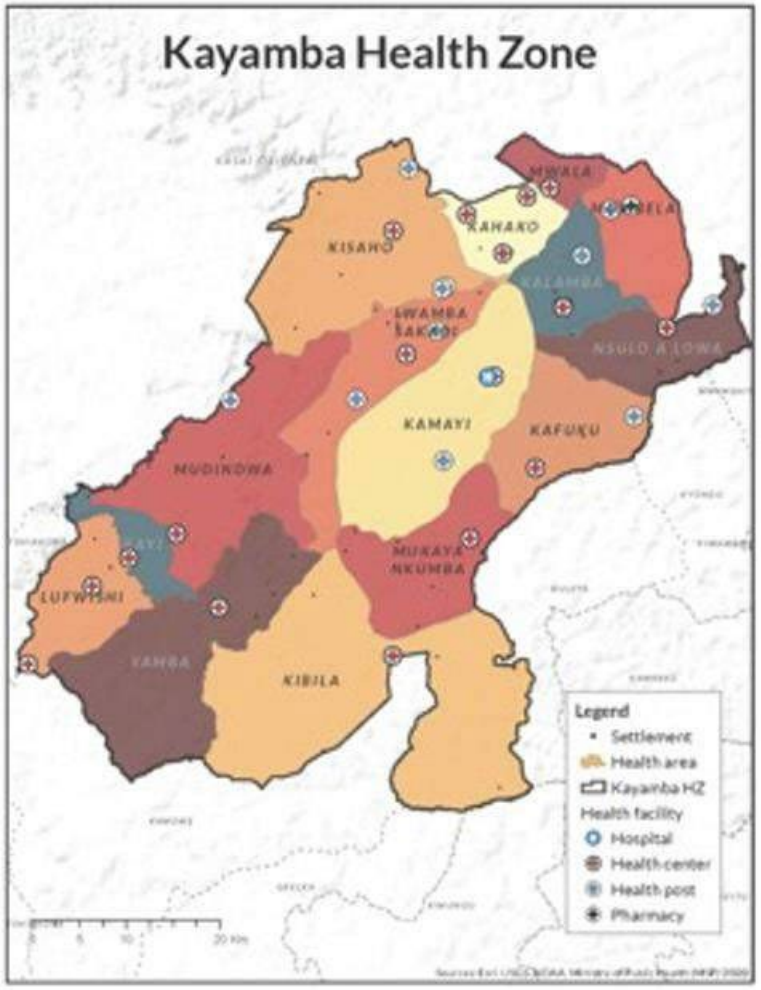
https://allianceformalariaprevention.com/wp-content/uploads/2021/06/AMP_Improving_Efficiency_Digital_Tools_21052021.pdf

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.







L'amélioration de notre micro-planification accroîtra notre capacité à toucher tout le monde et à éviter les doublons et le gaspillage de ressources limitées

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

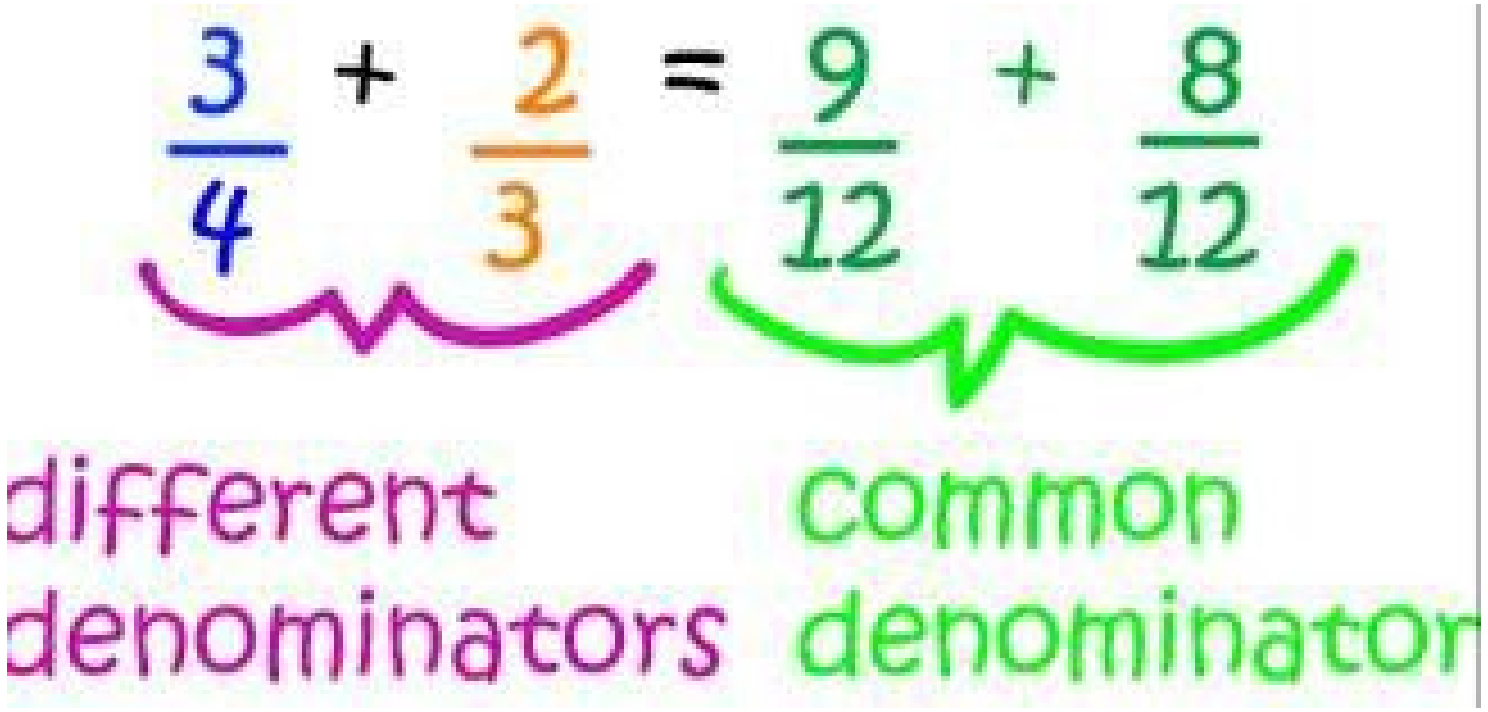
Repenser l'intégration pour une utilisation plus efficace des données, des informations et des ressources au sein des programmes de santé et entre eux

Le pilotage de projets dans différents contextes et pour différentes activités (CPS, pulvérisation intra-domiciliaire) 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



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

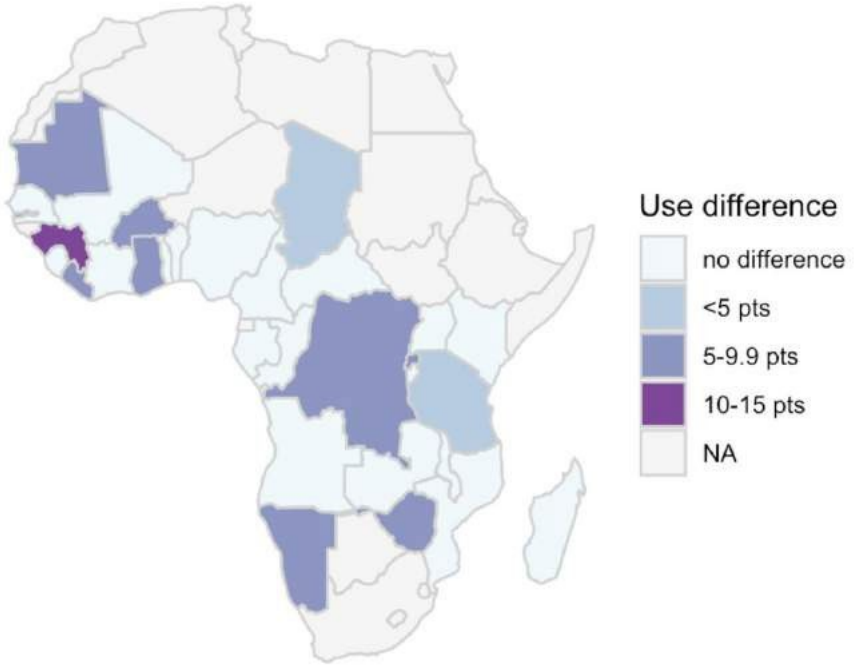
Outils pour la numérisation : disponibles fin juillet

- 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



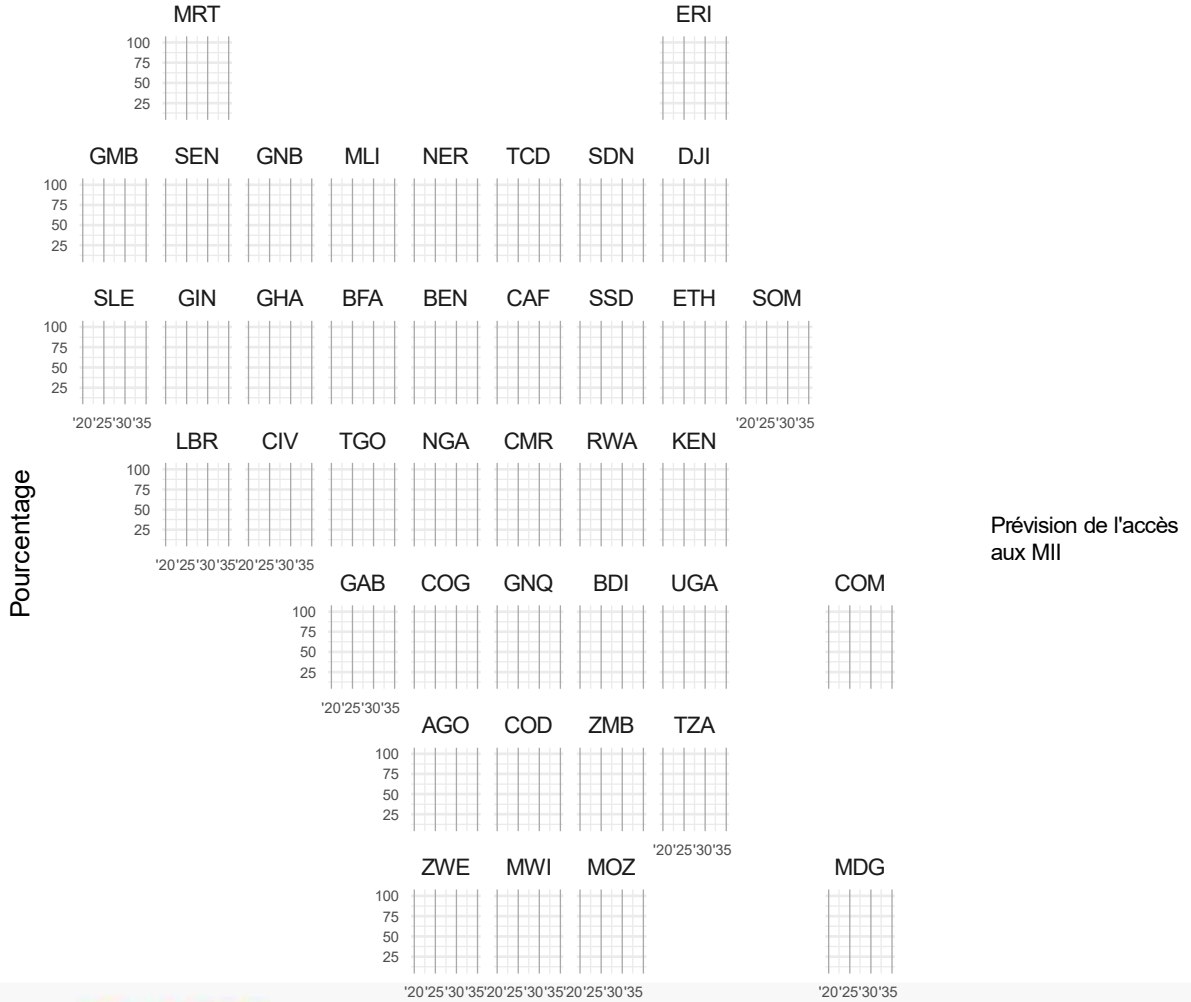
Les programmes souhaitent parfois seprocurer des MII d'un textile particulier.

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.

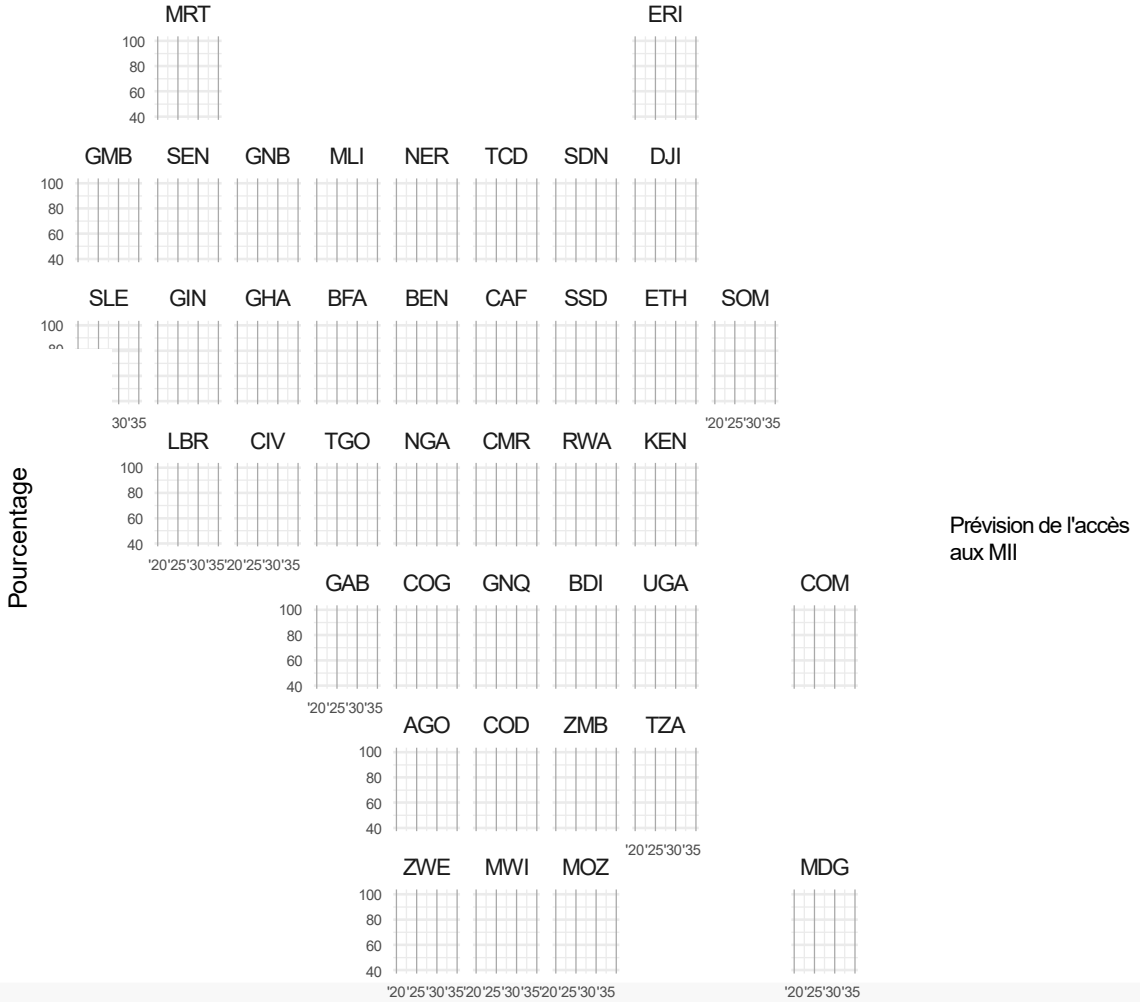
https://net-textile-use-reports.netlify.app

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

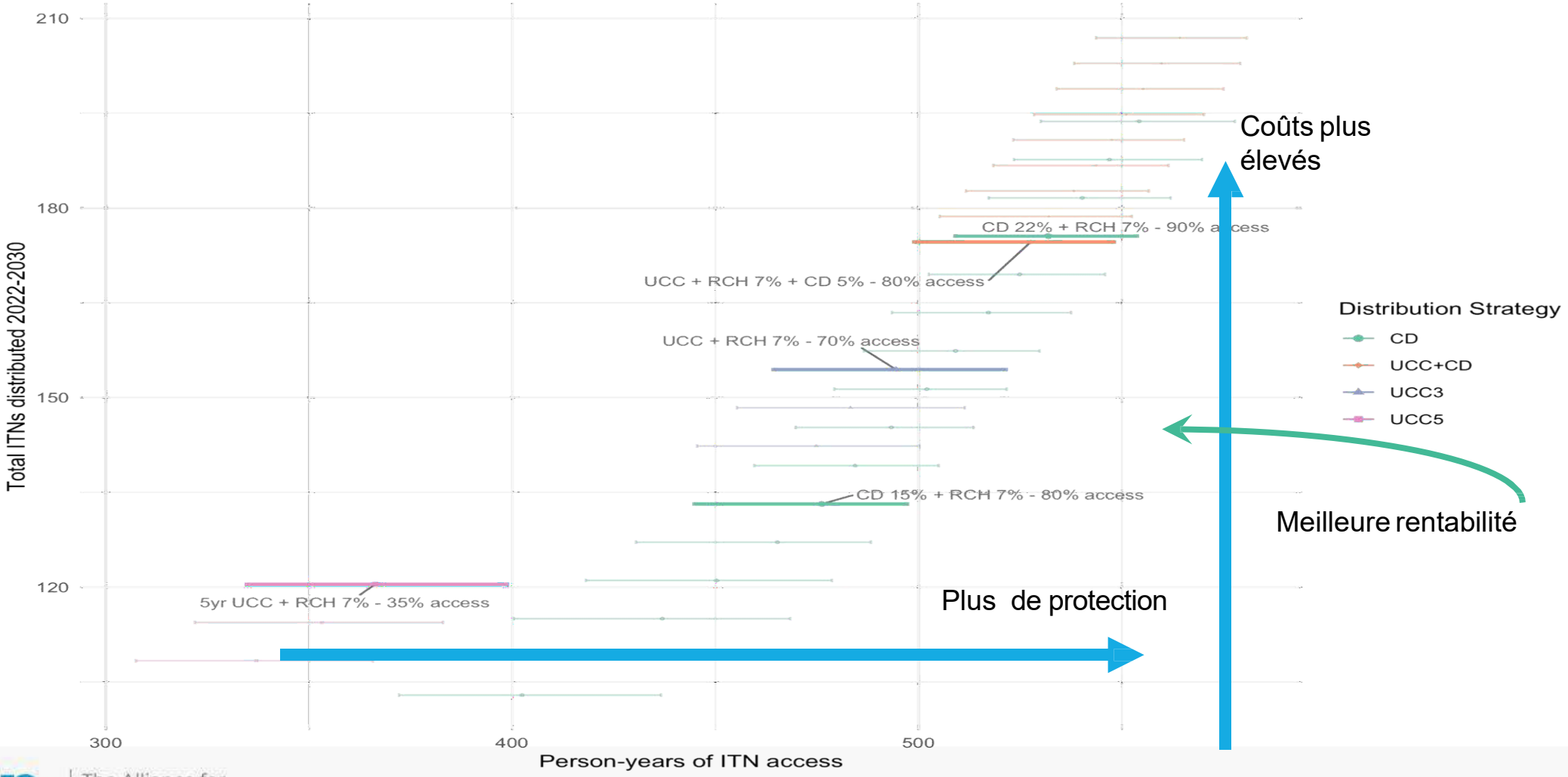
Campagnes de distribution massive sur trois ans avec soins prénataux/programmes élargis d'immunisation, à 1,8% de la population



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

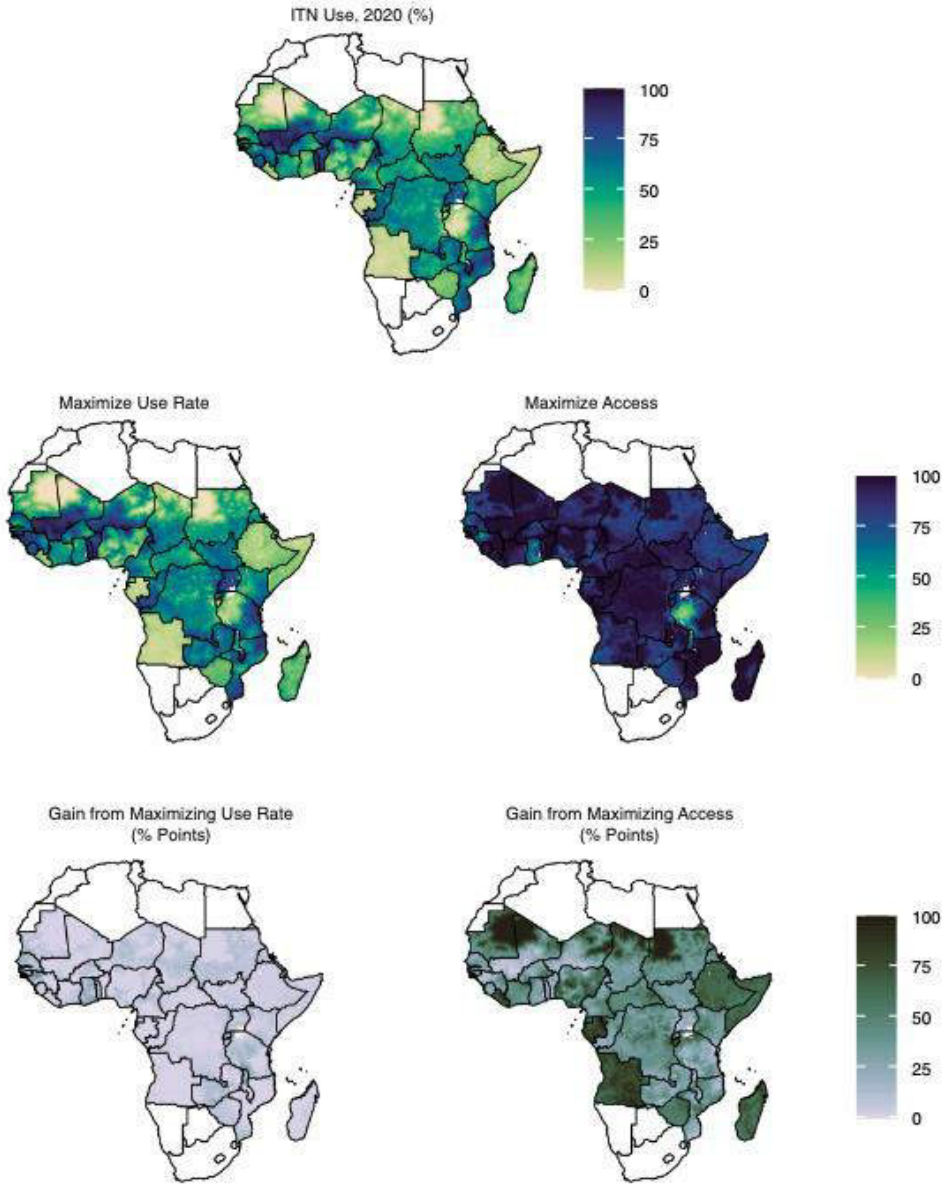
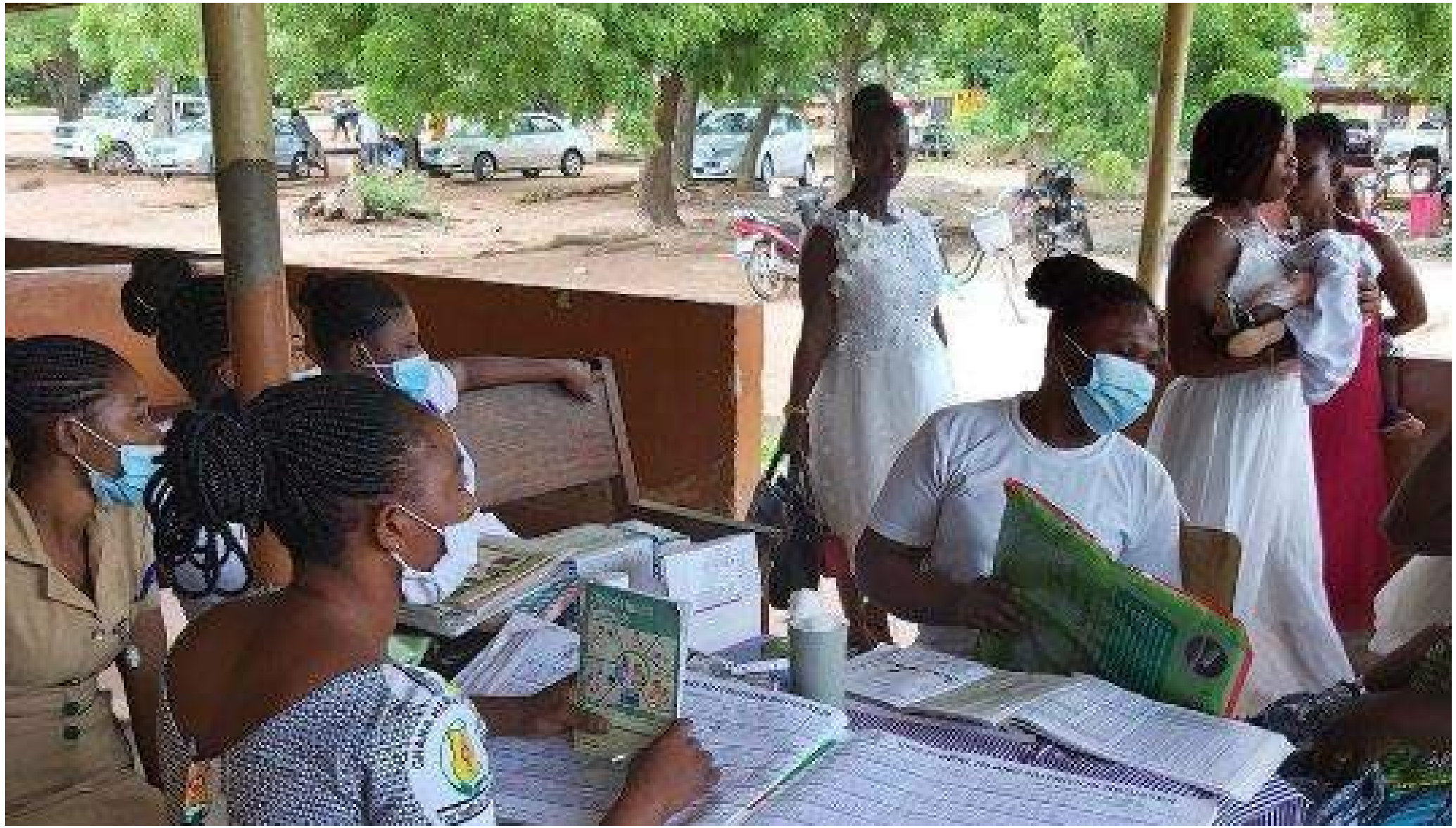


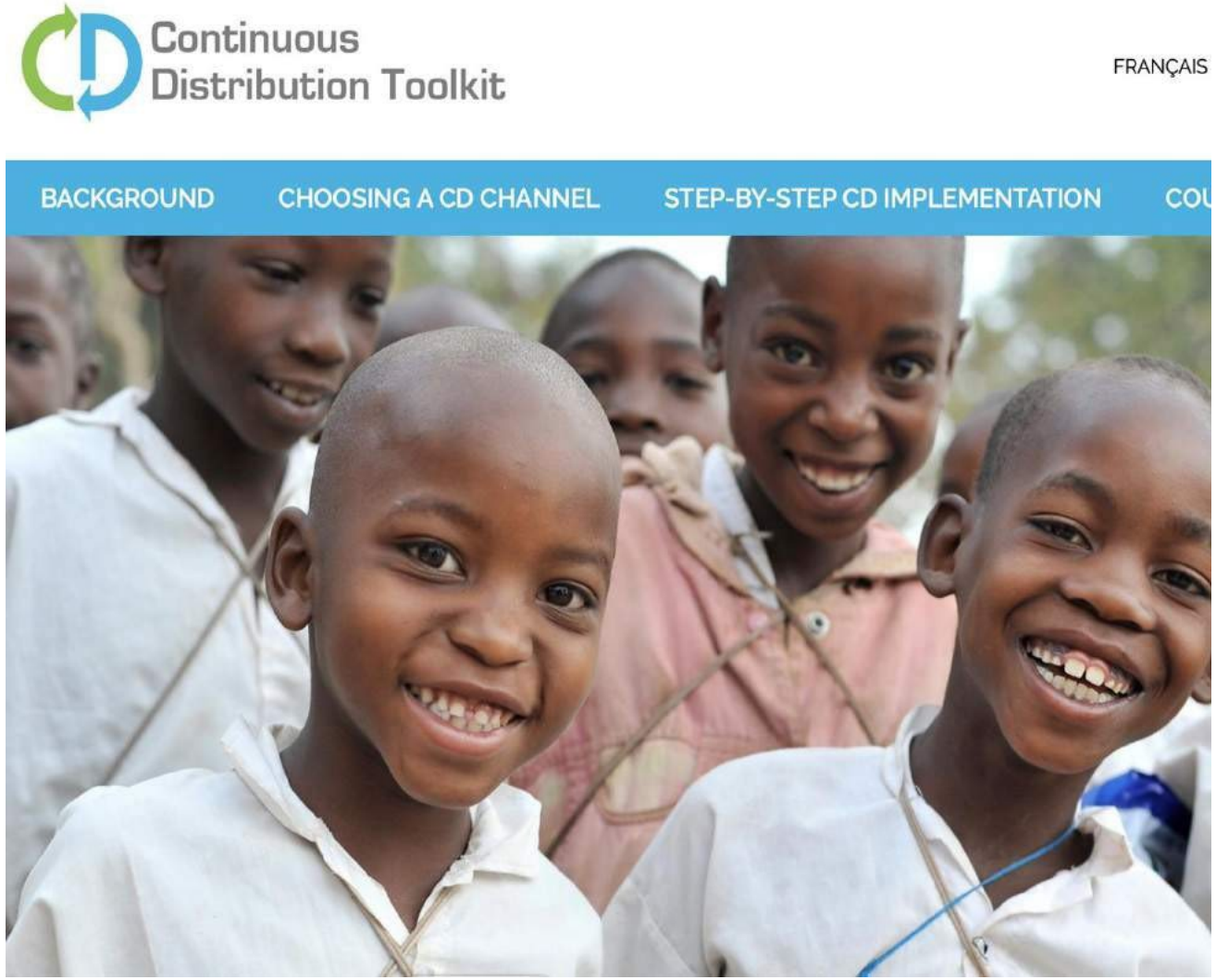
Fig. 6 Magnitude of change in insecticide-treated net (ITN) use possible from increasing use rate versus increasing access. The top row shows estimated ITN use in 2020. The second row shows what use could be if access remained unchanged and the use rate were set to 100% (left), compared to if the use 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.



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)

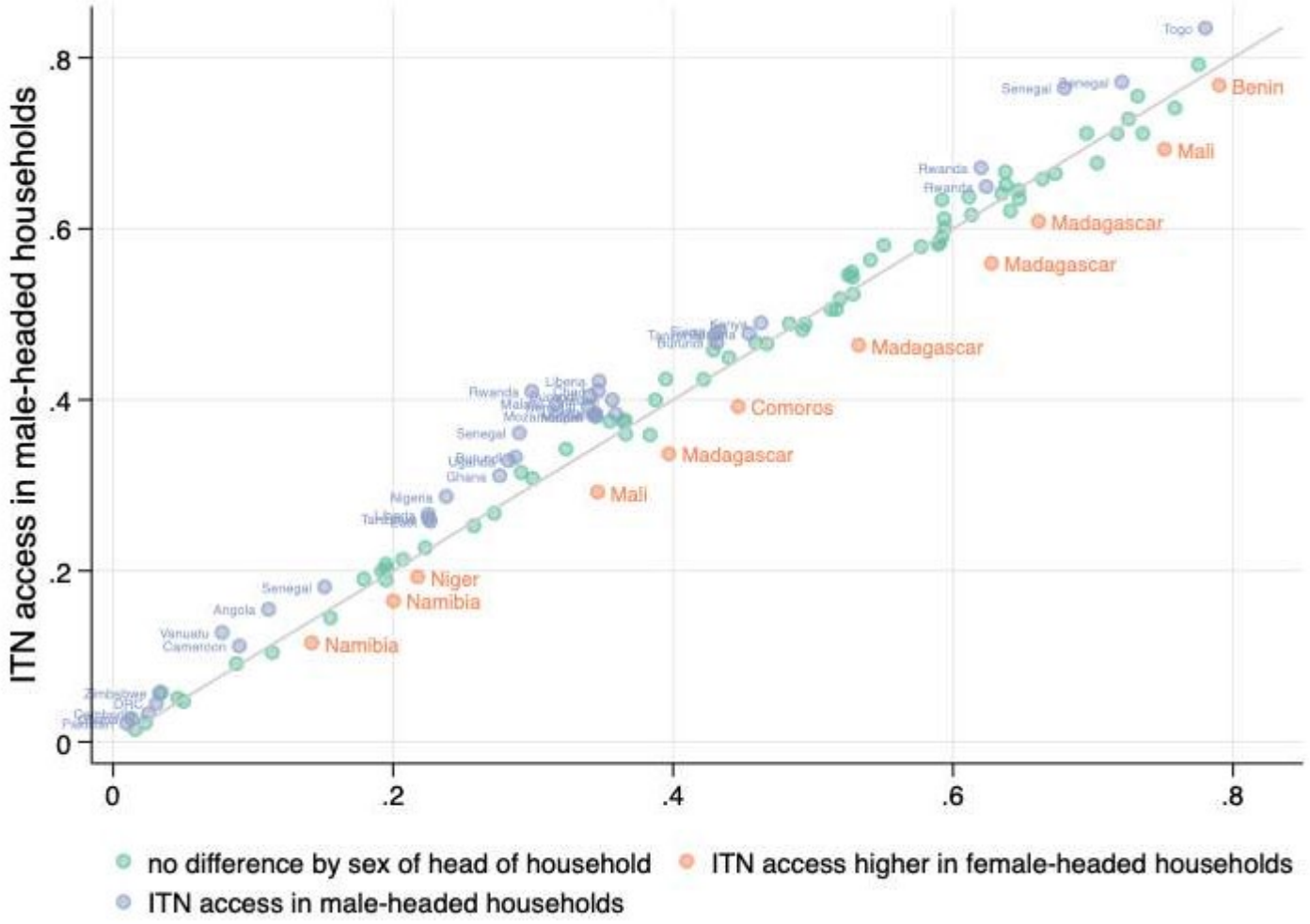
Distribution communautaire :

- 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

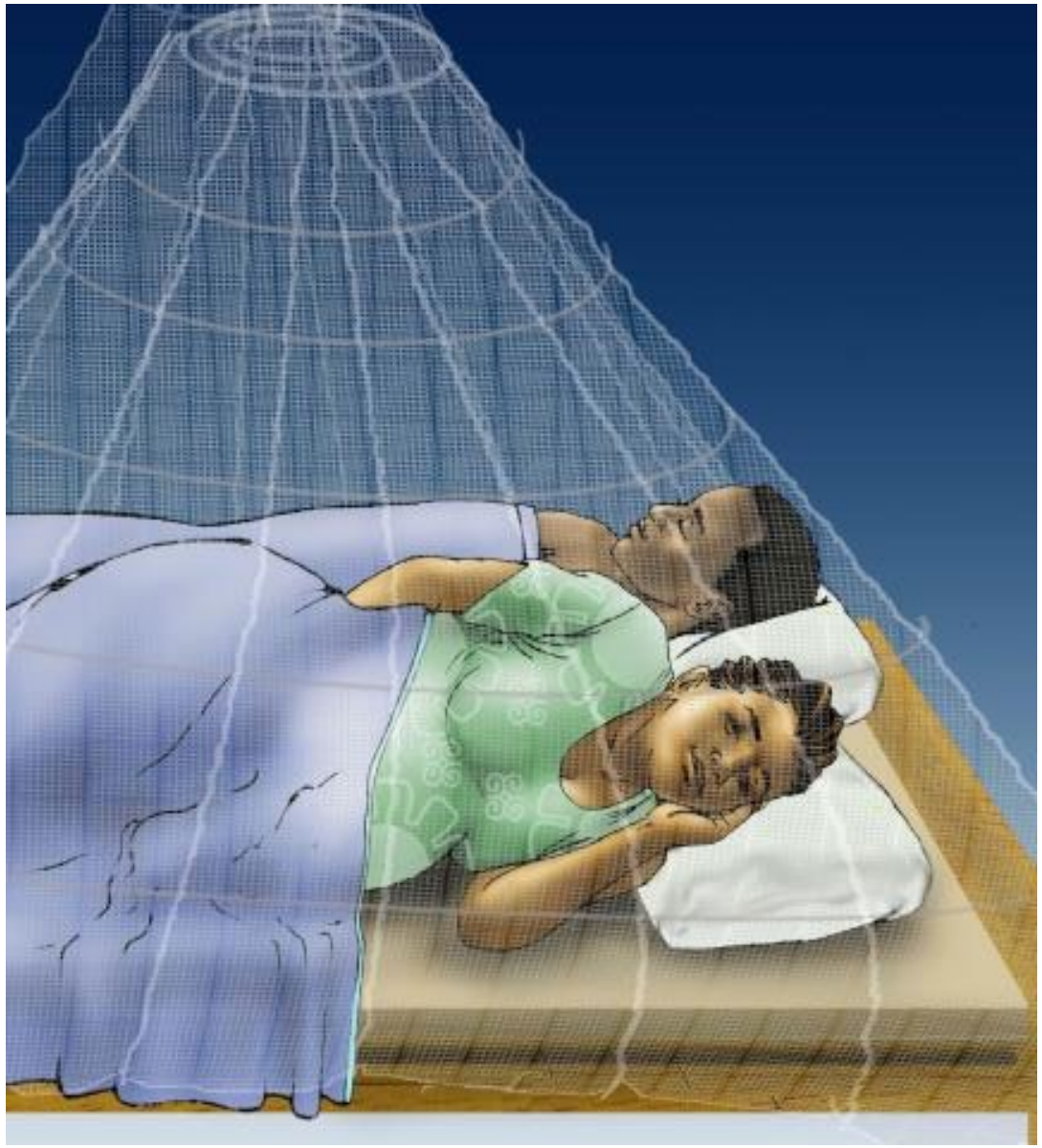
https://malariabehaviorsurvey.org

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

Kilian et al. Malar J (2021) 20:29
https://doi.org/10.1186/s12936-020-03570-5

Malaria Journal

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 Obi[2], Paul Mansiangi[3], Ana Paula Abílio[4], Khamis Ameir Haji[5], Estelle Guillernois[6], Vera Chetty[6], Amy Wheldrake[6], Sean Blaufuss[7], Bolanje Olapeju[7], Stella Babalola[7], Stephen J. Russell[6] and Hannah Koenker[7]

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.

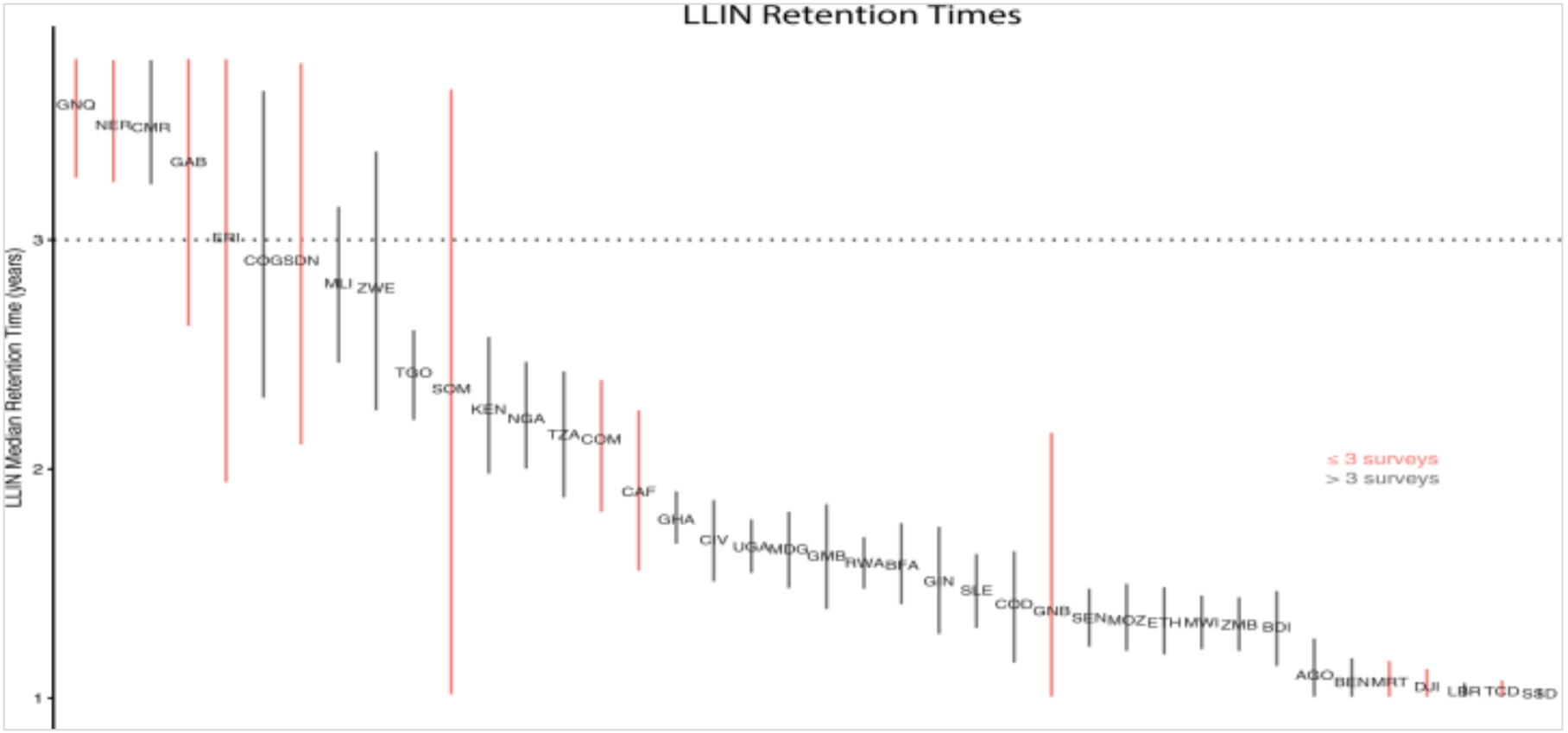
Keywords: LLIN physical durability, Textile resistance to damage

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

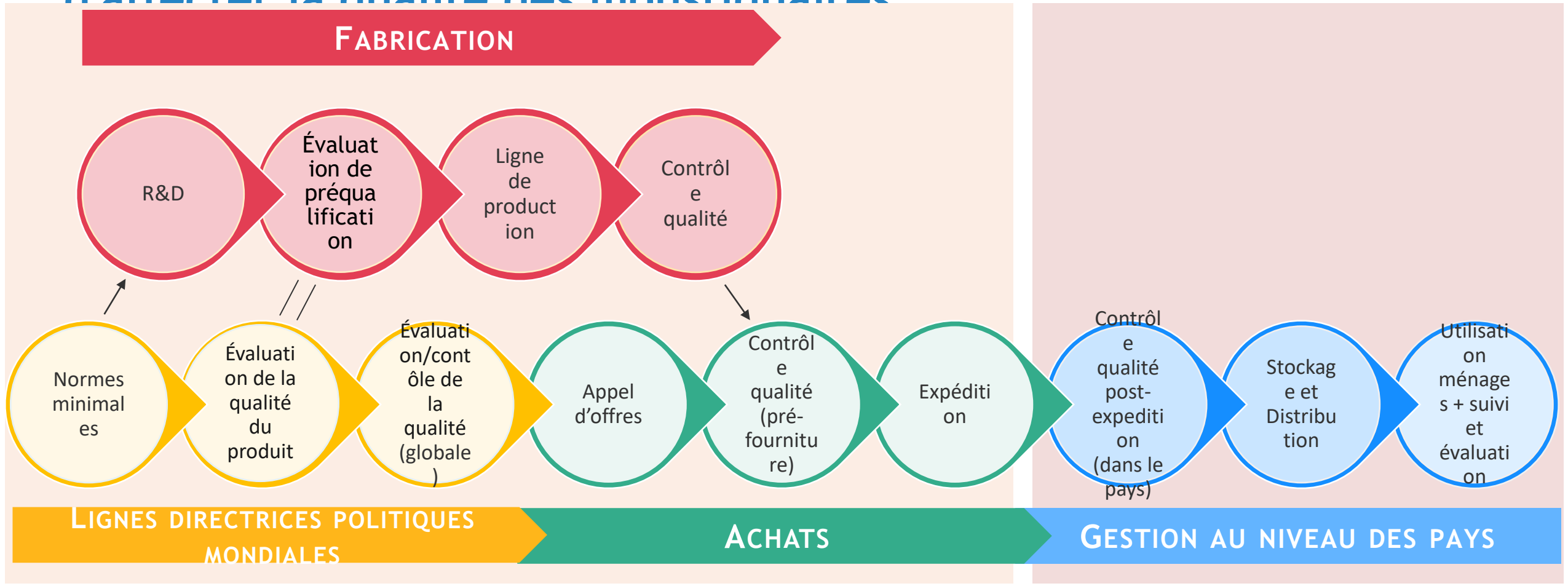
« […] la majorité des preuves existantes indique que la rétention moyenne des moustiquaires est généralement inférieure à 3 ans. »

« 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. »



Bertozzi-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



Pré-expédition
(couverte dans la première phase d'organisation)

Post-expédition
(couverte dans la seconde phase d'organisation)

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

POLITIQUE MONDIALE

	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 MII Intégration de **l'intégrité textile** aux spécifications
Évaluation de préqualification	• **Mise à jour des orientations relatives aux tests** pour tenir compte des nouveaux produits	• Mise à jour et diffusion des lignes directrices de test
Assurance/Contrôle 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 MII • Réviser l'assurance qualité de l'infrastructure de test en laboratoire pré- et post-expédition

Thèmes essentiels : fabrication

FABRICATION

	Principaux défis	Solutions privilégiées
R & D	• 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**	• **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
Évaluation de préqualification	• Identifier comment les spécifications des produits peuvent être associées aux attributs qui améliorent la performance sur le terrain	• 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
Assurance/Contrôle qualité	• Charge d'inspection et manque de processus de qualité harmonisés	• Les acheteurs s'alignent sur les processus de qualité et s'accordent sur les attributs clés à tester

mes essentiels : achats

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
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-expedition. 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 niveau des pays

	Principaux défis	Solutions privilégiées
Inspection post-expédition	• **Les tests non normalisés post-expédition** peuvent entraîner le rejet de produits valides ou l'acceptation de produits de mauvaise qualité	• Mise en place d'**orientations harmonisées concernant les critères d'inspection pré- et post-fourniture** et les procédures opérationnelles normalisées
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	• Définition des conditions de stockage optimales et orientations à cet égard (propres aux moustiquaires lorsque nécessaire) • Sensibilisation pour faciliter **des formalités douanières rapides**
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	• 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

Thèmes essentiels : éléments t

ÉLÉMENTS TRANSVERSAUX

	Principaux défis	Solutions privilégiées
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	• **Élaboration d'un glossaire clair** de termes, à transmettre aux groupes de parties prenantes essentiels
Confiance des parties prenantes	• **La confiance** parmi les différents groupes de parties prenantes concernant la qualité des MII doit être renforcée	• **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
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	• 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


rumours
digitalisation
COVID-19
Pandemic
nmcp
ITN
quality
insecticide resistance
funding applications
climate
new ITN types
Microplannning
Partnership
Insecurity
denominator
flexibility
priorities
complexity
supply chain
access
virtual
PNCP
MOP
TA
IDP
CD
PNCM
Gender
waste
SBC
C19RM
Teams
PPE
Urban
tired
durability
leadership
Pandemic
coordination
together
Success
Integration
funding
COVID-19
climate
waste management
Insecurity
overcoming bottlenecks
hard-to-reach
adaptations
digitalisation
funding applications

Projet Nouvelles moustiquaires : problèmes opérationnels et résultats clés

Consortium du Projet Nouvelles moustiquaires

IVCC

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

psi
Healthy lives. Measurable results.

- 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

LSTM

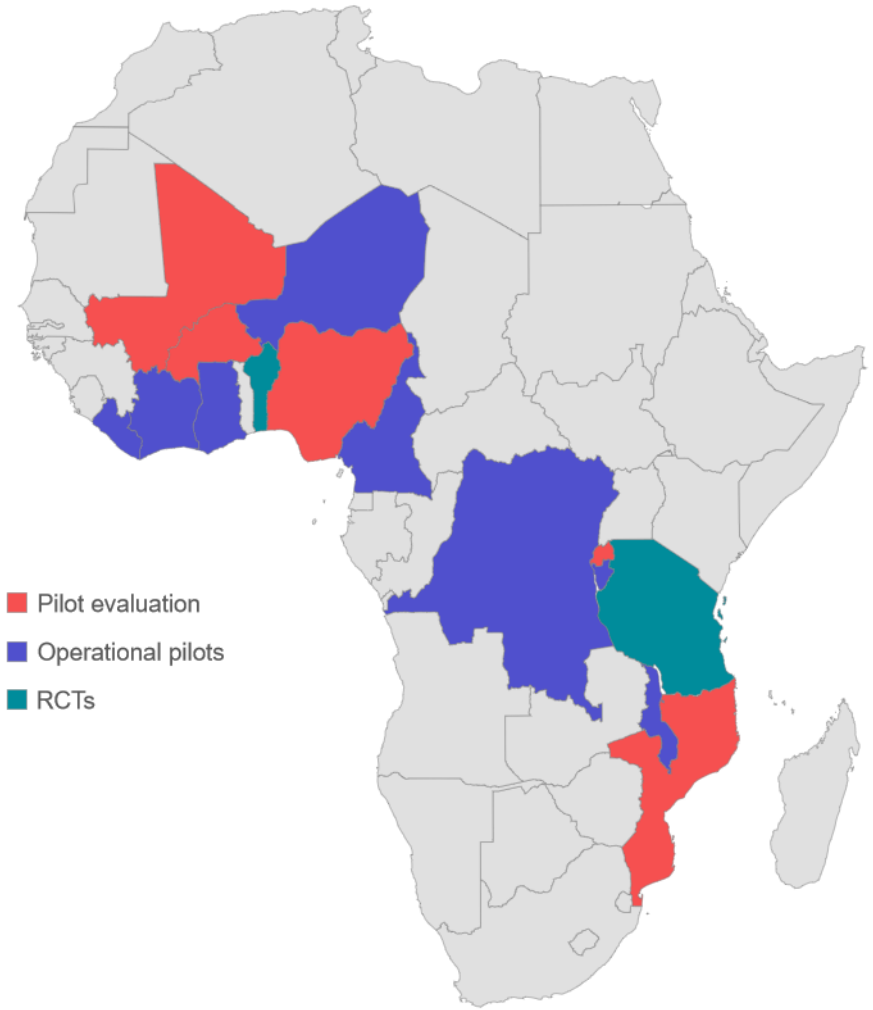
- Corrélats entomologiques de l'impact épidémiologique

Tulane University

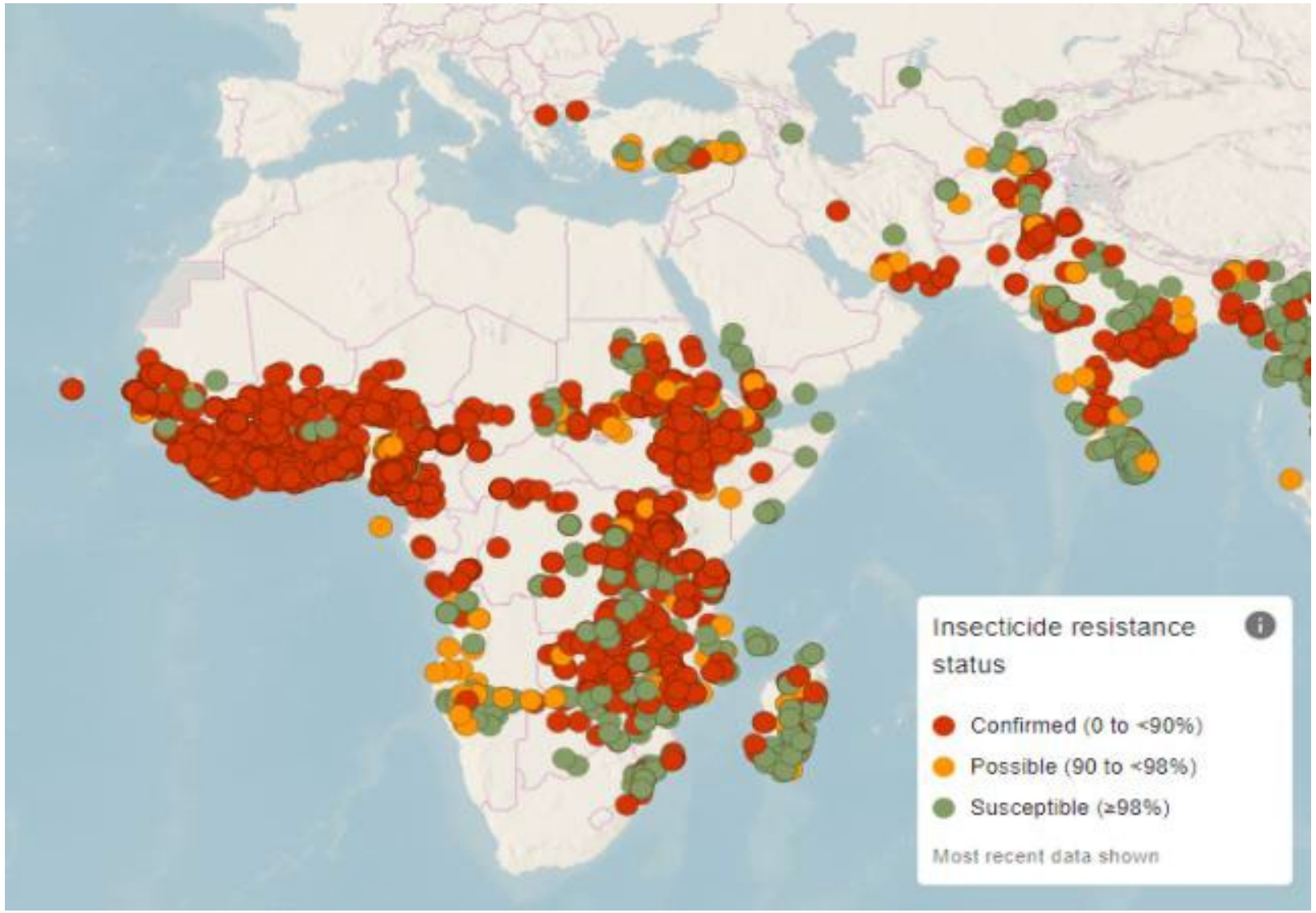
- Conception de l'étude sur la rentabilité et collecte des données

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

- 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

The New Nets Project

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	Pyréthroïde + synergiste	Pyréthroïde + Chlorfénapyr	Pyréthroïde + Pyriproxyfène
MII classiques	MII imprégnées de PBO	MII G2 Interceptor®	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 **améliorera 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

"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*

	Gurue (MII classiques)		Cuamba (MII IG2)		Mandimba (MII RG)	
	2020	2021	2020	2021	2020	2021
Proportion de la population ayant dormi sous une moustiquaire la nuit précédente (CI 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%)
Accès de la population aux MII (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%)
Utilisation en fonction de l'accès*	**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

	Gurue (MII classiques)		Cuamba (MII IG2)		Mandimba (MII RG)	
	2020	2021	2020	2021	2020	2021
Prévalence du paludisme pour les enfants de moins de 5 ans (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%)

- **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*

	Chemba (MII classiques)		Guro (MII IG2)		Changara (MII imprégnées de PBO)	
	2020	2021	2020	2021	2020	2021
Proportion de la population ayant dormi sous une moustiquaire la nuit précédente (CI 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%)
Accès de la population aux MII (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%)
Utilisation en fonction de l'accès*	**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

	Chemba (MII classiques)		Guro (MII IG2)		Changara (MII imprégnées de PBO)	
	2020	2021	2020	2021	2020	2021
Prévalence du paludisme pour les enfants de moins de 5 ans (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%)

- **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%)
	5 — 10			**54,5%** (47,1% – 61,7%)			**36,1%** (29,3% – 43,4%)			**19,9%** (14,5% – 26,3%)

- **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%)	
Banfora 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 MII


Crédits PMI VectorWorks

Contact

Assistance technique

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Outil de suivi des MII et outils numériques

robert.opoku@ifrc.org

Projet Nouvelles moustiquaires

giovanni.dusabe@ifrc.org

Groupe de travail sur la distribution continue

Jmiller@psi.org

ballakandeh@yahoo.co.uk

amp | The Alliance for Malaria Prevention

RBM Partnership To End Malaria

Social and Behavior Change
Working Group

RBM SBC Working Group

Mariam Nabukenya Wamala, RBM SBC WG Co-Chair
Anna McCartney-Melstad, Co-Chair CRSPC CReMA

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

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
- SBC encompasses: Advocacy, community and social mobilization, Social behavior change communication (IPC, multi-level mass and social media campaigns IEC Materials), operational and behavior surveys
- Demand creation for products and services
- Appropriate use
- Change in underlying social norms
- Political , Structural ,Social, cultural, religious, gender, economic, ecological issues

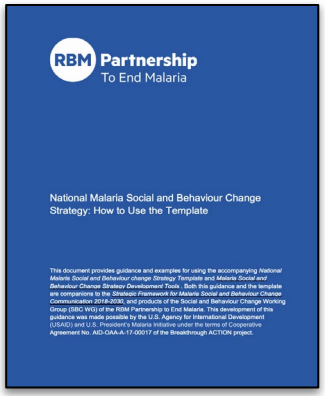
SBC Working Group Outcomes

- 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

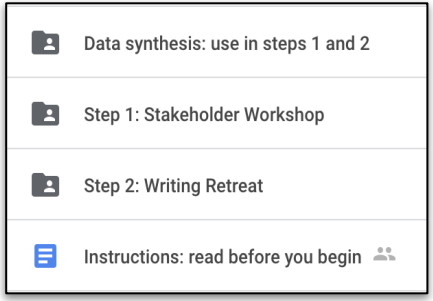
SBC Challenges for Malaria

- 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 SBC activities
- Poor health provider attitude
- Structural challenges

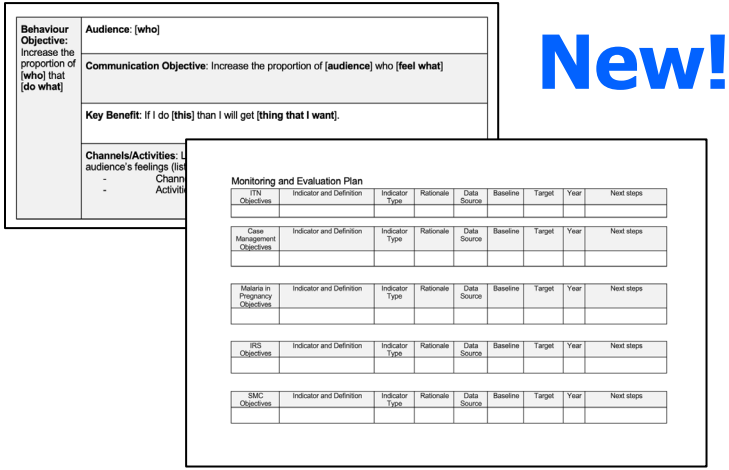
National Malaria SBC Strategy Toolkit



Template and Guidance for National Malaria SBC Strategies
EN | FR | PT



Malaria SBC Strategy Workshop Package
EN | FR | PT



New!

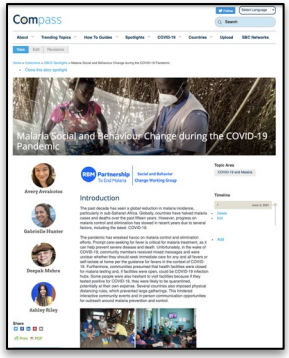
Guidance for SBC for Low-Moderate Malaria Transmission Zones
EN | FR | PT

Find them all on www.endmalaria.org

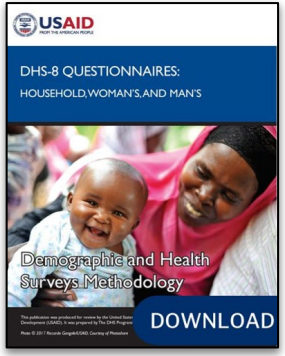
Recent Activities

All resources available on endmalaria.org!

- **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 reasons for adopting or resisting 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 lead healthier lives.

SBC may include communication and non-
throughout this toolkit. Social and behavio
to impact individual, family, and communit
behaviors and health practices.

CHWs can use SBC to influence a pers
prevent malaria in their communities
they serve and are trusted by community
are well-positioned to share information a
behaviors that can prevent malaria and im

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 comprises information, education, and communication (IEC); behavior change communication (BCC); and Interpersonal communication (IPC). IEC 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 tailored sharing of ideas, thoughts, and feelings between two or more people to address the reasons people behave the way they do. Over time, IEC, IPC, and BCC 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?

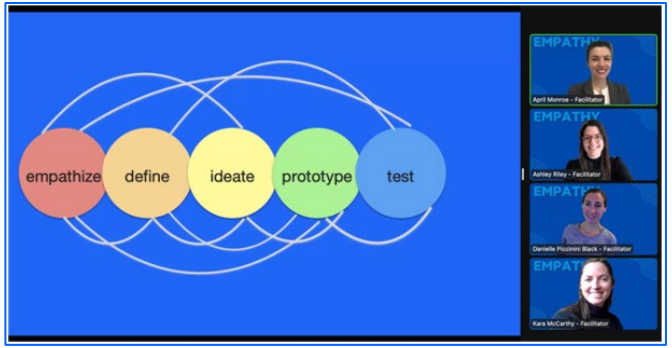
New Workstream: RTS,S Vaccine

- **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



SBC WG Annual Meeting | 2022 Virtual Forum

- **September 28 - 29 (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

- Mory Camara - Mali - Francophone Ambassador
- Ibrahima Sanoah - Guinea - Francophone Ambassador and Steering Committee
- Ida Savadogo - Burkina Faso - Francophone Ambassador

Thank you! Merci! Obrigado!

Thank you - Stay in Touch!

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High Burden High Impact (HBHI) : a targeted malaria response

EVALUATION OF THE GLOBAL APPROACH

Presentation to CRSPC | July 2022

World Health Organization

RBM Partnership To End Malaria

Plan of the presentation

- HBHI Background
- HBHI evaluation rationale
- HBHI objectives & approach
- Evaluation objectives & questions
- Evaluation methods & process
- Evaluation Findings
- Recommendations
- Next steps
- Acknowledgment

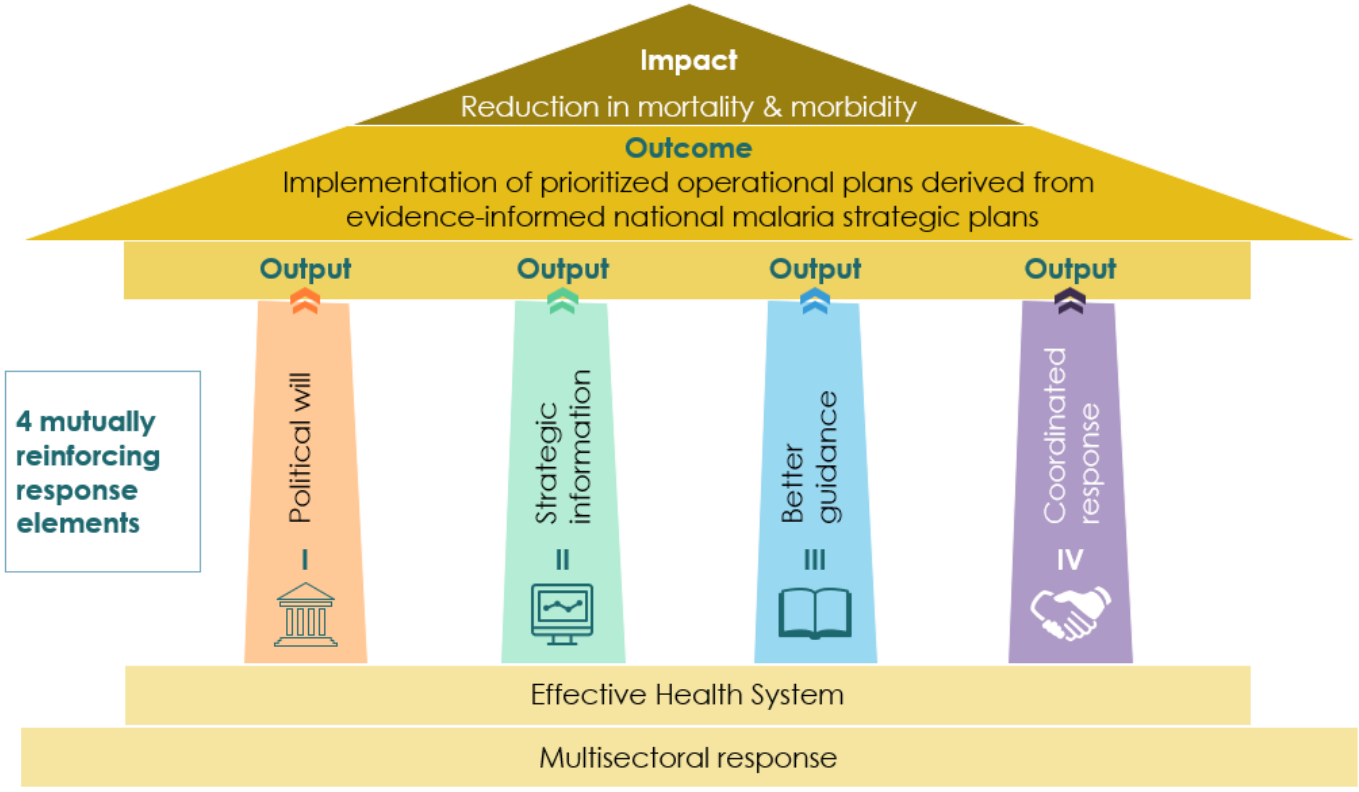
HBHI : Background

- 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

I **Political will** to reduce malaria deaths

II **Strategic information** to drive impact

III **Better guidance,** policies and strategies

IV 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

I Evaluating the process of **global implementation**

II Evaluating **country impact**, barriers to success and best practices

III Scaling up all **4 HBHI elements** in countries

IV 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 → **Interviews** → **Recommendations**

Qualitative research methods

- Desk review of HBHI documents
- HBHI Country consultations
- Questionnaire design for different interview formats
- Completed in early March

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

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.

1. WHO consultants will collect data from the remaining HBHI countries and learn from the first phase of the evaluation.

1. 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 Partnership To End Malaria

D'une charge élevée à un fort impact (High Burden High Impact)

Une riposte ciblée contre le paludisme

RESULTATS DE L'EVALUATION DE L'APPROCHE GLOBALE

Réunion CRSPC/RBM | Dakar, 26-29 Juillet 2022

https://www.who.int/fr/publications-detail/WHO-CDS-GMP-2018.25

- Joshua Levens (Consultant)
- Dr Hilaire Zon (Consultant)

World Health Organization

RBM Partnership To End Malaria

PLAN PRESENTATION

- Aperçu de l'approche
- Justification de l'évaluation
- Objectifs de l'évaluation
- Questions de l'évaluation
- Méthodes de l'évaluation
- Résultats
- Recommandations
- Prochaines étapes
- Remerciements

L'approche ''High Burden High Impact (HBHI)'' ''D'une charge élevée à un fort impact''

- Burkina Faso
- Cameroun
- RDC
- Ghana
- Mali
- Mozambique
- Niger
- Nigeria
- Ouganda
- Tanzanie
- Inde[2]

- Approche lancée en 2018 par l'OMS & Partenariat RBM **pour accélérer les progrès dans la lutte contre le paludisme & atteindre l'objectif d'élimination**

- Focus : **Améliorer les réponses/interventions de santé publique** dans les 11 pays endémiques ayant les charges les plus élevées de paludisme

1 11 pays où la charge du paludisme est la plus élevée concentrent 70 % des cas ayant entraîné un décès
2 Toutes les augmentations rapportées du nombre de cas de paludisme par rapport à l'année précédente sur l'ensemble des 10 pays africains où la charge du paludisme est la plus élevée, qui vont du chiffre estimé de 131 000 cas supplémentaires au Cameroun au chiffre estimé de 1,3 million de cas supplémentaires au Nigeria. Seule l'Inde a progressé dans son effort pour réduire la charge de la maladie, avec une réduction de 24 % par rapport à 2016.

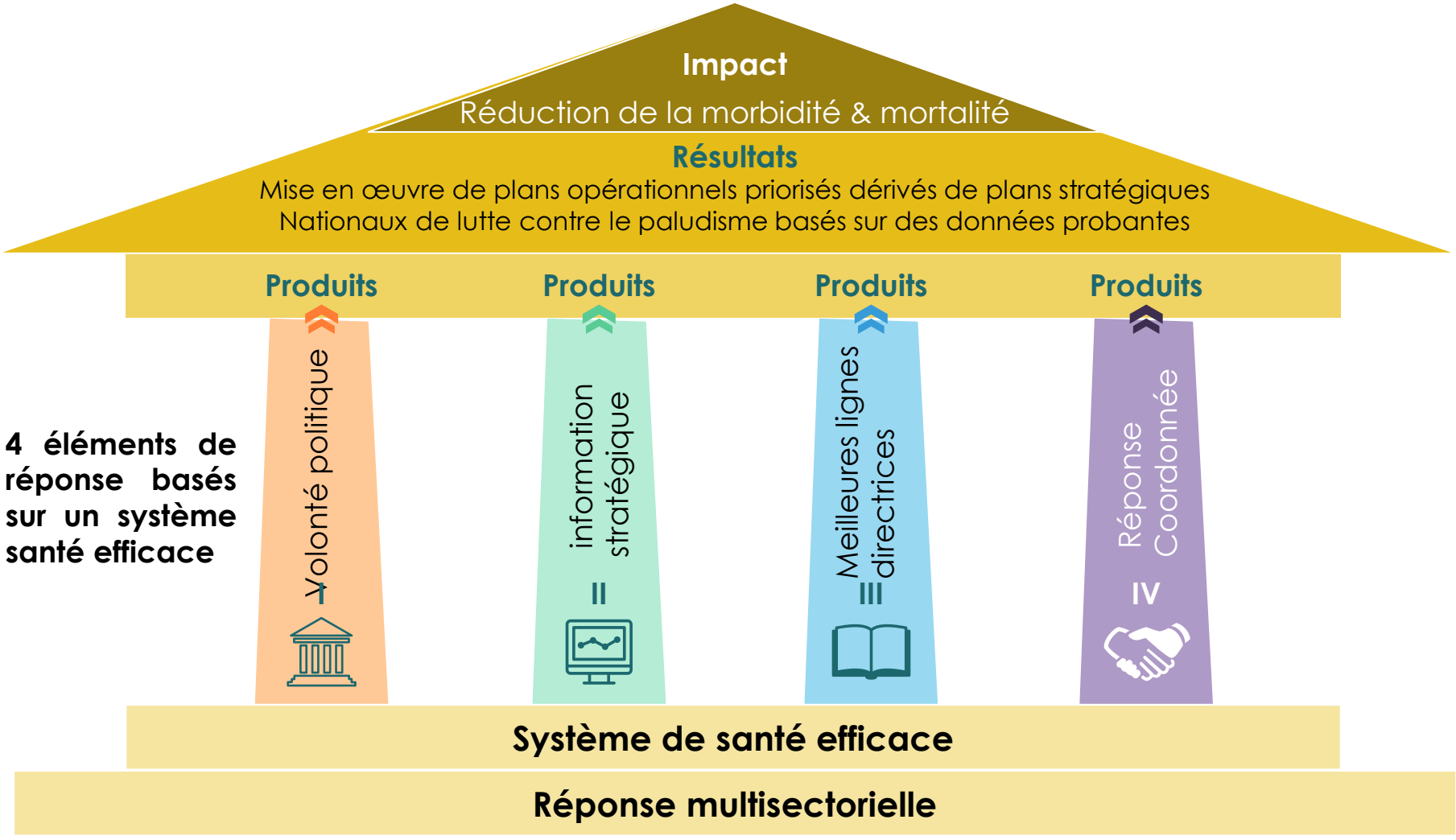
L'approche ''High Burden High Impact (HBHI)'' ''D'une charge élevée à un fort impact''

Une approche holistique :

- Appui sur **4 éléments/piliers fondamentaux** avec des actions tangibles à travers **la mise en œuvre des Plans Stratégiques Nationaux (PSN)** pour l'obtention de résultats concrets.

- Ré-focalisation **pour accélérer les progrès** vers l'atteinte des **objectifs de la Stratégie Technique Mondiale** de lutte contre le paludisme

L'approche ''High Burden High Impact (HBHI)''
''D'une charge élevée à un fort impact''



Pourquoi évaluer l'approche HBHI maintenant ?

- Les pays HBHI ont enregistré des succès & aussi des reculs depuis le lancement de l'approche. L'évaluation a exploré **comment l'approche conceptuelle peut être améliorée** à travers une meilleure compréhension de ces études de cas;

- Ce sont des **opportunités pour étendre l'approche HBHI** & l'évaluation permettra d'orienter le processus d'extension par la capitalisation des expériences à ce jour;

- Cette évaluation **N'EST PAS** une évaluation de la performance des pays. Elle s'est focalisée sur **le processus & la valeur ajoutée de l'approche HBHI,** ainsi que les opportunités pour l'améliorer.

Objectifs de l'Evaluation

4 objectifs de recherche

I. Evaluation de **l'impact au niveau pays**, les obstacles aux succès & bonnes pratiques

II. Evaluation des **processus globaux** d'appui à la mise en œuvre

III. Evaluation de l'application **de toutes les composantes de** l'approche

IV. Evaluation de l'extension de l'approche **à d'autres pays endémiques**

1 Burkina Faso, Cameroon, DRC, Ghana, India, Mali, Mozambique, Niger, Nigeria, Tanzania, Uganda

Questions d'Evaluation

QE1	**Impact sur le niveau de performance du pays :** Dans quelle mesure les objectifs du programme national de lutte contre le paludisme du pays ont été impactés par l'approche HBHI ?
QE2	**Processus Globaux de mise en œuvre :** Dans quelle mesure les processus globaux d'appui à la mise en œuvre de l'approche HBHI ont facilité l'atteinte des objectifs de lutte contre le paludisme dans les pays?
QE3	**Application des composantes de l'approche HBHI :** Comment les exemples de bonnes pratiques et les leçons apprises de la mise en œuvre de l'approche HBHI peuvent-ils informer/orienter l'extension des 4 composantes ?
QE4	**L'extension de l'approche HBHI à d'autres pays:** Comment les exemples de bonnes pratiques et les leçons apprises de la mise en œuvre de l'approche HBHI peuvent-ils informer/orienter l'extension de l'approche à d'autres pays endémiques ?

Méthodologie de l'Evaluation

Type d'étude

Recherche Qualitative

- Revue des documents sur l'approche HBHI
- Consultations des pays HBHI
- Elaboration de Questionnaire pour les # interviews
- Réalisé en Mars 2022

Interviews

Modalités d'interview

- Interview des Informateurs/personnes clés au niveau global et niveau pays
- Enquête électronique (Anglais, Français & Portugais) pour les partenaires
- Interview des Coordonnateurs PNLP
- Réalisé en Juin 2022

Recommandations

Aspects à améliorer

- Coordination globale
- Ressources pour l'assistance technique
- Appui politique
- Application des bonnes pratiques dans des contextes nouveaux

Méthodologie de l'Evaluation

Domaines & focus de l'évaluation

- Expérience & niveau d'implication des participants dans la mise en œuvre de l'approche HBHI
- Focus sur leurs principaux domaines d'expertises en mettant en exergue les bonnes pratiques, défis & leçons apprises
- Domaines d'expérience & implication dans la mise en œuvre de l'approche HBHI :
  - **Volonté Politique**
  - **Information Stratégique**
  - **Meilleures lignes directrices, Politiques & stratégies**
  - **Coordination du programme**
- Actions multisectorielles pour le paludisme
- Intégration du système de santé

Méthodologie de l'Evaluation

Domaines & focus de l'évaluation

- Processus des programmes de routine
  - *Développement demande de subvention au FM*
  - *Processus du MOP - PMI*
  - *Revue Programme/Elaboration des PSN*
  - *Carte de Score - ALMA*

- Processus globaux de HBHI
  - *Coordination*
  - *Assistance Technique*
  - *Lancement de HBHI dans les pays*

- **5 pays concernés (1ère phase évaluation): Burkina Faso, RDC, Mozambique, Nigeria, Ouganda**

Résultats : Impact global sur la performance des pays

- "L'approche d'une charge élevée à un fort impact'' **n'est pas nouveau.** Elle offre une plateforme utile pour :

  - ✓ Engagement politique avec un leadership national;
  - ✓ Englobler/rehausser des initiatives existantes de lutte contre le paludisme;
  - ✓ Encadrer/orienter le développement de PSN & revue des programmes;
  - ✓ Fournir des justifications pour les interventions proposées dans les requêtes de financement au Fonds Mondial;

- Bien que **la stratification infranationale & l'adaptation au contexte local ont aidé à prioriser les interventions**, certains répondants ont relevé la difficulté de prioriser quand les ressources sont insuffisantes :

❖ *"Il n'y avait pas de méthodologie adéquate pour prioriser les interventions recommandées en cas d'insuffisance des ressources."* **– Partie Prenante du niveau global**

Résultats : Volonté Politique

- **La Volonté Politique est fondamental** pour les pays en vue d'accélérer & maintenir les progrès dans la lutte contre le paludisme.

- Certains acteurs reconnaissent que le concept **''Volonté Politique'' devrait être revu & défini de manière opérationnelle** par les pays.

- **Quelques exemples/cas positifs en lien avec la volonté politique :**

  - ✓ Augmentation financement pour la lutte contre le paludisme au niveau décentralisé ;
  - ✓ Plus grande disponibilité ressources humaines & financières, équipements pour la lutte contre le paludisme dans tous les secteurs ;
  - ✓ Engagement des leaders politiques pour des politiques & actions en faveur de la lutte contre le paludisme ;
  - ✓ Redevabilité & utilisation des résultats pour plus d'engagement ;
  - ✓ Engagement & participation de nouveaux champions ;
  - ✓ Elevation du statut & visibilité des programmes de lutte contre le paludisme, ainsi que les efforts de financements.

Résultats : Volonté Politique

Quelques exemples de progrès Pilier ''Volonté Politique''

- *" L'érection du Programme de lutte contre le Paludisme en Division et la promotion du Coordonnateur au titre de Commissaire Adjoint a permis au programme d'être plus visible et au Commissaire d'être plus influent et écouté lors des réunions de la haute direction "* – **Partie Prenante de l'Ouganda**

- *" En 2018, la campagne MILDA a été réalisée dans un Etat sans l'appui du Gouvernement Central. En 2021, le Gouvernement Central a apporté un financement de 18 M Naira (USD 43,000) ainsi que des magasins pour les MILDAs et les intrants pour la CPS "* – **Partie Prenante du Nigeria**

- *" Les plans de l'approche d'une charge élevée à un fort impact élaborés par les pays ont aidé à intégrer les efforts déjà réalisés et susciter une reconnaissance politique, telle que i) la mise en place des Fonds pour l'Elimination du Paludisme, ii) l'utilisation de la carte de score (malaria scorecards), iii) une stratégie multisectorielle plus élaborée et vi) la campagne Zéro Paludisme, je m'engage."* **– Partie Prenante du niveau global**

Résultats : Information Stratégique

- "L'approche d'une charge élevée à un fort impact ", les outils & l'assistance technique pour **mesurer l'impact à travers l'information stratégique a été bien accueillie** par les différentes parties prenantes.

- **Les domaines couverts dans le cadre de l'information stratégique sont :**
  - ✓ Développement of des entrepôts de données sur le paludisme
  - ✓ Digitalisation des outils de campagne (ex : MILDA, CPS)
  - ✓ Stratification du paludisme au niveau le plus détaillé possible
  - ✓ Développement des intervention mixtes/strates géographiques
  - ✓ Revue régulière des données de DHIS2 & Carte de score (Malaria scorecard)

❖ *"Le processus & outils de l'approche HBHI ont permis aux pays de s'asseoir autour d'une table et de réaliser un diagnostic critique et honnête de la situation du paludisme et d'obtenir un consensus sur la priorisation et les progrès à réaliser."* – **Partie Prenante du Nigeria**

Résultats : Meilleures Lignes Directrices, Politiques & Stratégies

- **Amélioration continue & mise à jour des directives/politiques/stratégies** sont reconnues par les parties prenantes comme **primordial pour maintenir les progrès.**

- **Les pays ont noté des progrès dans les domaines suivants :**

  - ✓ Développement & mise à jour de nouvelles politiques, énoncé d'objectifs, aide-mémoire, outils pour la collecte & analyse des données

  - ✓ Développement des capacités au niveau périphérique pour la prestation de services & reportage des données

  - ✓ Développement de nouveaux PSN selon l'approche HBHI

❖ *"L'approche d'une charge élevée à un fort impact", a eu un impact significatif sur les objectifs du pays en ce qui concerne le développement de meilleurs politiques & stratégies"* – **Partie Prenante du Burkina Faso**

Résultats : Coordination du Programme

- Programmes ont **coordonné de manière effective** les partenaires externes dans un certain nombre de pays, avec des défis dans d'autres;

- L'engagement & coordination des autres Ministères, Départements & Agences (secteur non santé) **requiert différentes dimensions politiques & organisationnelles** que la coordination avec les partenaires externes;

- Certaines parties prenantes affirment que **la coordination du programme marchait bien déjà** & peu de travail reste à faire

- **Défis dans la coordination du programme avec HBHI :**

  - ✓ Compréhension limitée du contenu et objectif de l'approche HBHI
  - ✓ Partage de l'information & engagement entre/parmi les partenaires pays et au niveau global sont insuffisantes
  - ✓ Implication inadéquate du secteur privé
  - ✓ Manque de coordination au niveau décentralisé

❖ *''Il y'a un manque de structure fédératrice qui réunit ensemble toutes les parties prenantes & leurs partenaires au niveau communautaire.''* – **Partie Prenante RDC**

Résultats : Actions Multisectorielles

- **Les Conseils & Fonds d'Elimination du Paludisme ont été identifiés comme des mécanismes efficaces** pour engager les secteurs non santé & intégrer les besoins du paludisme dans les budgets & plan de travail des Ministères, Départements & Agences des différents secteurs.

- L'approche HBHI **n' a pas été perçue comme une feuille de route/tremplin** d'amélioration de ce domaine en raison des barrières suivantes :

  - ✓ Motivation pour les autres secteurs à rejoindre une collaboration
  - ✓ Inexistence de plateformes de dialogue multisectoriel sur le paludisme
  - ✓ Financement pour des plans multisectoriels & pour le suivi-évaluation

❖ *" Les interventions du secteur non-santé dans le PSN sont entre autres : Formation des enseignants sur le paludisme; Formation sur l'utilisation des insecticides & résistance; développement de la surveillance entomologique multisectorielle & plan national de gestion de la résistance."* – **Partie Prenante Burkina Faso**

Résultats : Intégration du Système de Santé

- Les parties prenantes reconnaissent largement que **le succès dans la lutte contre le paludisme repose sur une effective intégration avec les autres services**

- Constat que la plupart des programmes de lutte contre le paludisme **sont structurés et incités financièrement à fonctionner comme des programmes verticaux**

- Les efforts **d'intégration du paludisme au RSS** dans les requêtes au FM **ne semblent pas avoir réalisé l'effet désiré d'intégration** dans la planification stratégique & la mise en œuvre. Exemples d'intégration du SS :

  - ✓ Développement conjoint de requête de financement Paludisme & SS
  - ✓ Inclusion du concept de programmation intégrée dans le curricula de formation des institutions de formation médicale
  - ✓ Changement de la structure organisationnelle des programmes des maladies (décloisonnement)

❖ *"Nous avons perfectionné l'art de la planification verticale, mais les autres doivent comprendre que la spécialisation ne dénie pas votre capacité de tirer profit et utiliser les autres comme levier."* - **Partie Prenante du Nigeria**

Résultats : Niveau de Satisfaction avec l'Approche HBHI

- Les parties prenantes des pays étaient **largement satisfaites du cadre conceptuel de l'approche HBHI :**

  - ✓ Il englobe les composantes nécessaires d'un programme efficace de lute contre le paludisme. En fait, plusieurs ont indiqué **que l'approche était aussi valable pour les pays avec une charge modérée/faible de paludisme**

  - ✓ Il comprend de manière effective les activités & initiatives déjà en cours. L'approche **offre un cadre pour la communication** avec les leaders nationaux aussi bien qu'avec les donateurs internationaux

  - ✓ Tous les pays de l'approche HBHI **ont bénéficié d'une augmentation comparative de leurs allocations du FM pour le paludisme**, du fait que l'approche HBHI a orienté les requêtes de financement et les interventions mixtes proposées.

❖ *"L'approche d'une charge élevée à un fort impact" est une fantastique idée. L'OMS & RBM ont capacité les pays pour une analyse critique de la mise en œuvre de leur programme et rechercher des solutions endogènes."* **– Partie Prenante du Nigeria**

Résultats : Préoccupations avec l'Approche HBHI

- **Incompréhensions autour du contenu & objectifs de l'approche**. HBHI a été considéré **comme projet # approche holistique** pour une réponse adaptées au fardeau du paludisme. Ce qui a entrainé au départ des frustrations & insatisfaction avec le processus de HBHI. Toutefois, ces incompréhensions ont été mitigées lors de la phase de mise en œuvre;

- Plusieurs parties prenantes espérait **que le lancement de l'approche HBHI serait accompagnée par un flux séparé de financements** (approche projet paludisme)

- **L'approche n'a pas connu une implication de tous les partenaires** au niveau global & semble être supporté par l'OMS, RBM & ALMA

- Le cadre conceptuel de **l'approche est approprié** mais **l'appui technique & financier étaient particulièrement concentrés** dans certains domaines (information stratégique) au détriment des autres (coordination, intégration du SS)

❖ *Les pays ont sollicité des ressources additionnelles pour mettre en œuvre de nouvelles approches, mais les financements n'étaient pas souvent disponibles.* – **Partie prenante du niveau global**

Résultats : Recommandations

- **Coordination efficace doit être élargie pour impliquer tous les partenaires au niveau global, y compris au stade des réunions préparatoires;**

- **Impliquer les parties prenantes dans l'approche HBHI du niveau communautaire, aussi bien le programmes nationaux & leadership politique;**

- **Communiquer de manière efficace sur l'approche HBHI, les différents piliers & les mécanismes de soutien;**

- **Déployer de manière appropriée les interventions et initiatives de lutte contre le paludisme en cours à travers l'approche HBHI. Cela ne requiert pas un changement du processus de développement des PSNs ou un démarrage de nouveaux "projets HBHI".**

❖ *"Les pays ne doivent pas considérer l'approche HBHI comme une chose parallèle/différente, mais la principale chose."* – **Partie prenante du Nigeria**

Prochaines Etapes

1. Résultats du Mozambique seront inclus avec ceux du Burkina Faso, RDC, Nigeria, Ouganda & Partie Prenantes du niveau global & résumé dans un rapport

2. Collecte des données par les Consultants OMS dans les autres pays de l'approche HBHI : Cameroun, Ghana, Mali, Niger, Tanzanie & Inde pour documenter les leçons apprises de la 1ère phase de HBHI

3. Recommandations globales : guider l'amélioration & mise à l'échelle de l'approche HBHI

Remerciements

- Aux participants à l'enquête : Burkina Faso, RDC, Mozambique, Nigeria, Ouganda & Parties Prenantes du niveau global

- Comité de pilotage de l'évaluation (OMS, RBM & ALMA)

- Consultants RBM/ALMA

Merci pour votre attention

World Health Organization

RBM Partnership To End Malaria

RBM CRSPC West Africa National Malaria Programmes and Partners Annual Meeting

Jessica Rockwood – IPHA / MESA Consultant

Dakar, Senegal 26 - 29 July 2022

MESA

ISGlobal
Barcelona Institute for Global Health

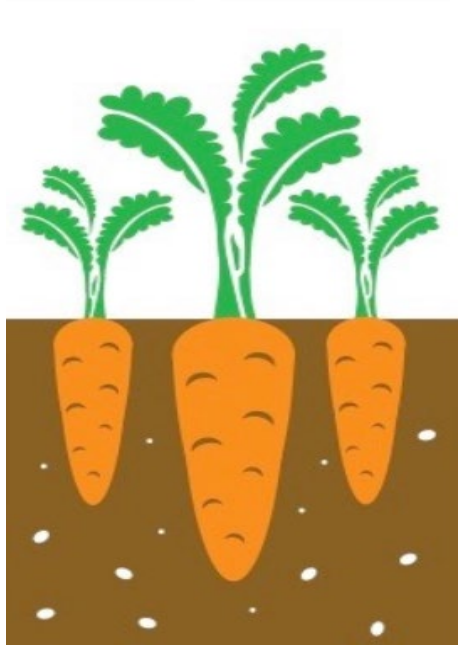
Sharing knowledge & catalysing research towards a malaria free world

- **Mapping the landscape of active malaria research projects** including **Operational Research**

- 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. Collaboratively seeking solutions

MESA Track: ongoing and completed malaria research



Completed research & published results

Relevant
Accessible
Visible
Shareable
"Referenceable"

Ongoing research

Relevant
Accessible?
Visible?
Shareable?
"Referenceable"?

MESA TRACK

A living database which captures research projects and institutions' portfolios in malaria elimination and eradication.

Operational Research (OR) and country focus

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 problema 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 West Africa Region

Burkina Faso, 90 Total projects, $455M Total Funding

Mali, 78 Total projects, $318M Total Funding

Senegal , 53 Total projects, $70.6M Total Funding

Ghana, 49 Total projects, $506M Total Funding

Nigeria, 45 Total projects, $587M Total Funding

The Gambia, 41 Total projects, $128M Total Funding

Benin, 36 Total projects, $229M Total Funding

Côte D'Ivoire, 16 Total projects, $160M Total Funding

Sierra Leone, 10 Total projects, $66.8M Total Funding

Liberia, 8 Total projects, $72.8M Total Funding

Guinea, 7 Total projects, $188M Total Funding

Niger, 7 Total projects, $350M Total Funding

Guinea Bissau, 4 Total projects, $3.13M Total Funding

Togo, 3 Total projects, $5.88M Total Funding

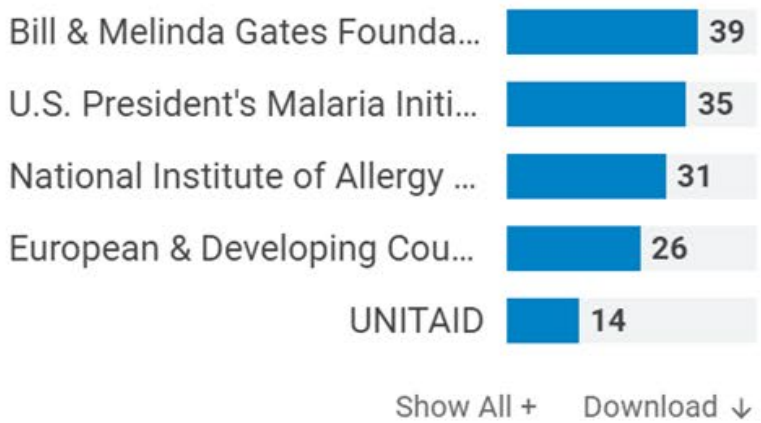
Mauritania, 2 Total projects, Not known Total Funding

Cape Verde, 1 Total project, Not known Total Funding

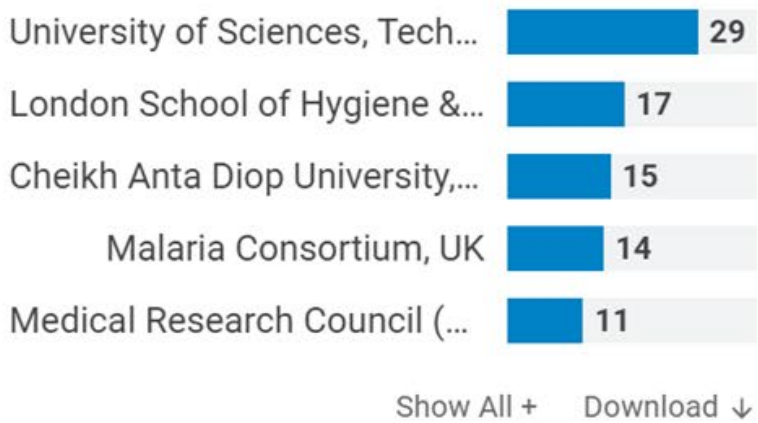
Summary of projects in MESA Track from the West Africa Region

TOTAL PROJECTS	TOTAL FUNDING	PROJECT SITES
324	$1.22B	114
46 active	$263M active	64 active

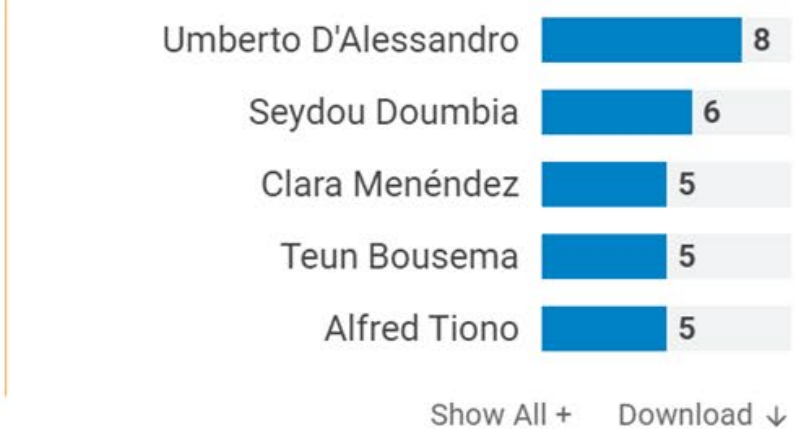
Funding Sources



Principal Institutions



Principal Investigators



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 revisión 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!!

An. Stephensi Deep Dive

Objectives

1. Describe the geographic scale and scope of ongoing *An. stephensi* research
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.

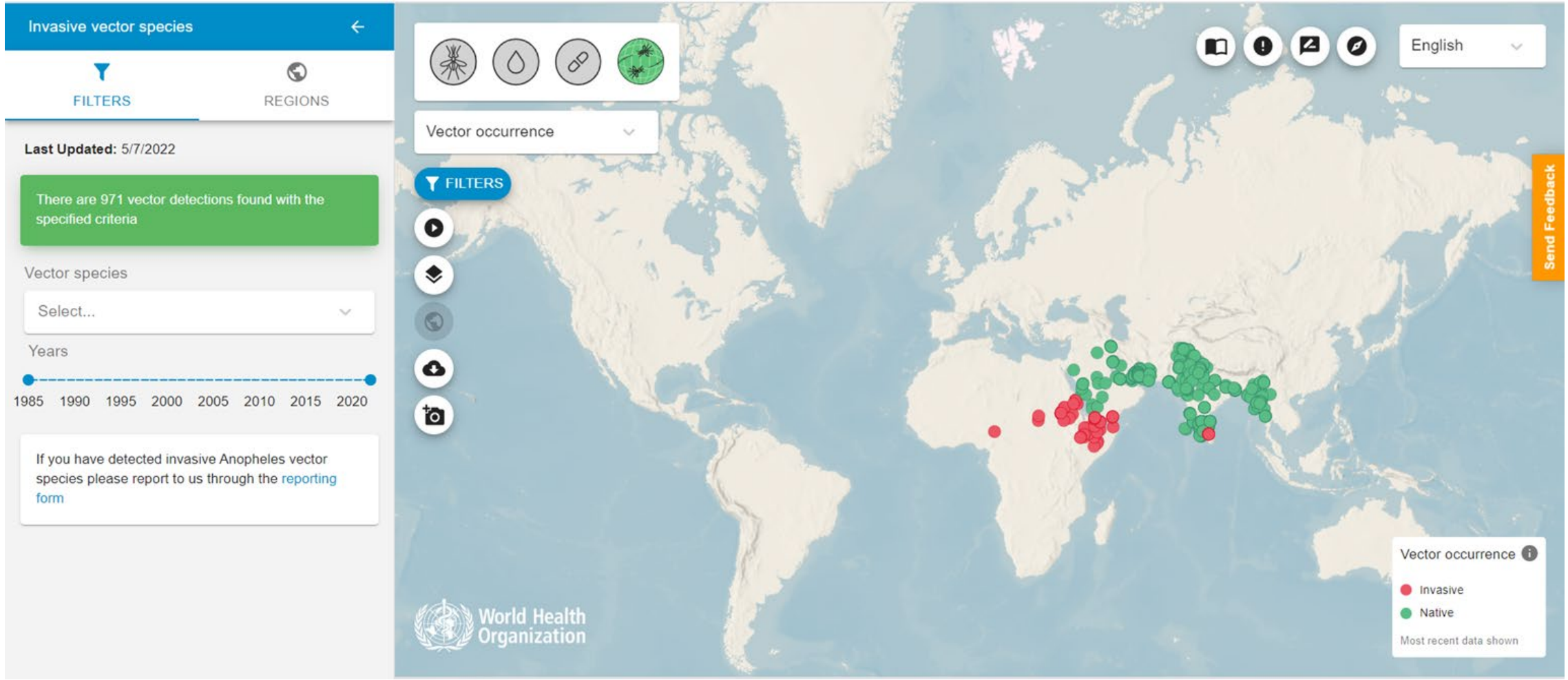
https://mesamalaria.org/mesa-track/deep-dives/anopheles-stephensi

Anopheles stephensi

Anopheles stephensi, an invasive and efficient urban vector, was historically considered an Asian malaria vector. However in 2012, it was detected for the first time in the city of Djibouti in the Horn of Africa. In 2019, WHO released a vector report warning of the invasion and spread of Anopheles stephensi mosquitoes to parts of Eastern Africa and Sri Lanka, and outlined steps to take in-country to combat this. This urban vector has now been detected in West Africa. There is still much to be understood about the factors propagating its expansion, composition, dynamics, distribution and behaviour in its new environments. A clear understanding of these factors is vital to elucidating which type of interventions to develop and where such interventions should be targeted.

22 JUL 2022

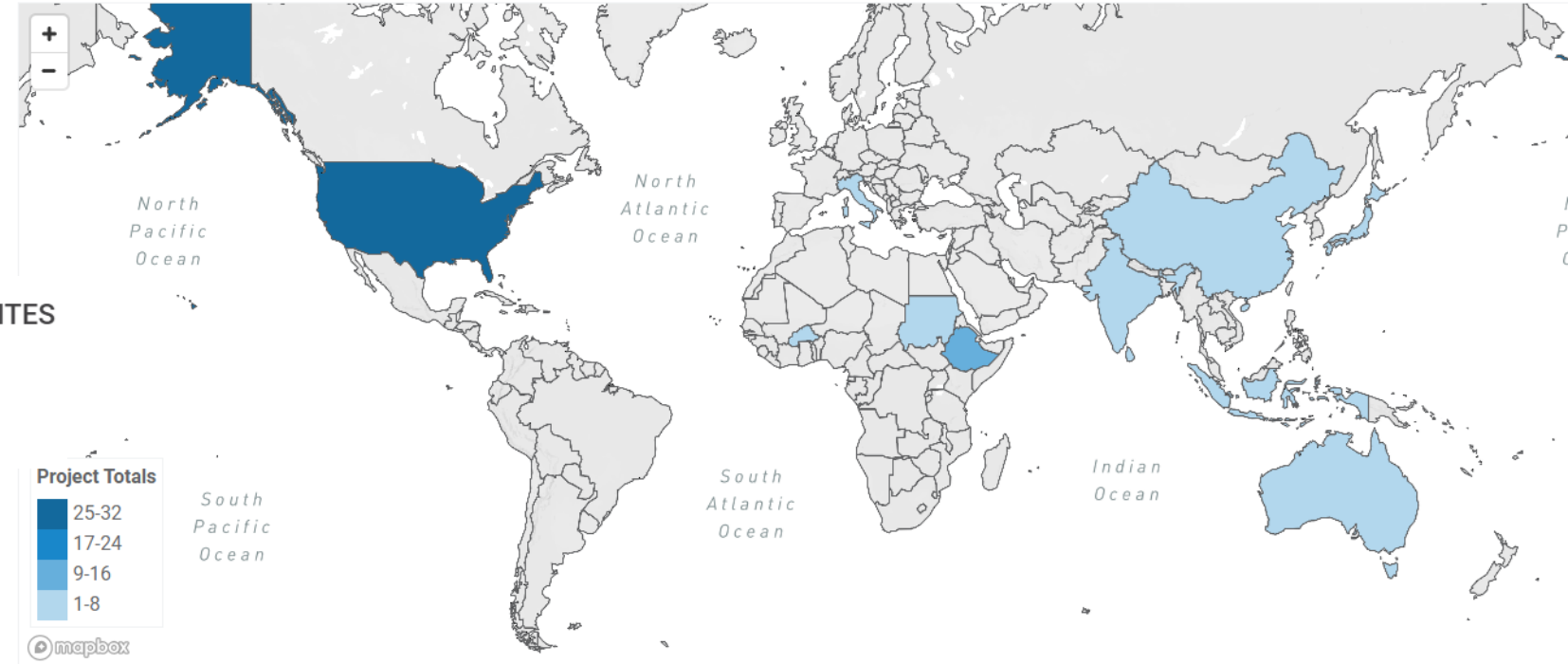
An. stephensi Invasive vector species (WHO Malaria threats map)



Information Source: WHO Malaria Threats Map.

An. stephensi Deep Dive (ongoing projects curated in MESA Track)

Project Sites



TOTAL PROJECTS	TOTAL FUNDING	PROJECT SITES
55	$65.4M	12
13 active	$17.0M active	5 active

Funding Sources

National Institute of Allergy and Inf...	24
Japan Society for the Promotion o...	6
National Science Foundation of Sri...	2
Seattle Children's Research Institut...	2
National Institute of Food and Agri...	2

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Principal Institutions

Sanaria, USA	5
Virginia Tech, USA	5
University of Maryland, USA	3
University of California Davis, USA	3
QIMR Berghofer Medical Research,...	3

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Principal Investigators

Peter F. Billingsley	5
Zhijian Jake Tu	4
Shirley Luckhart	3
James McCarthy	3
Anthony Amade James	2

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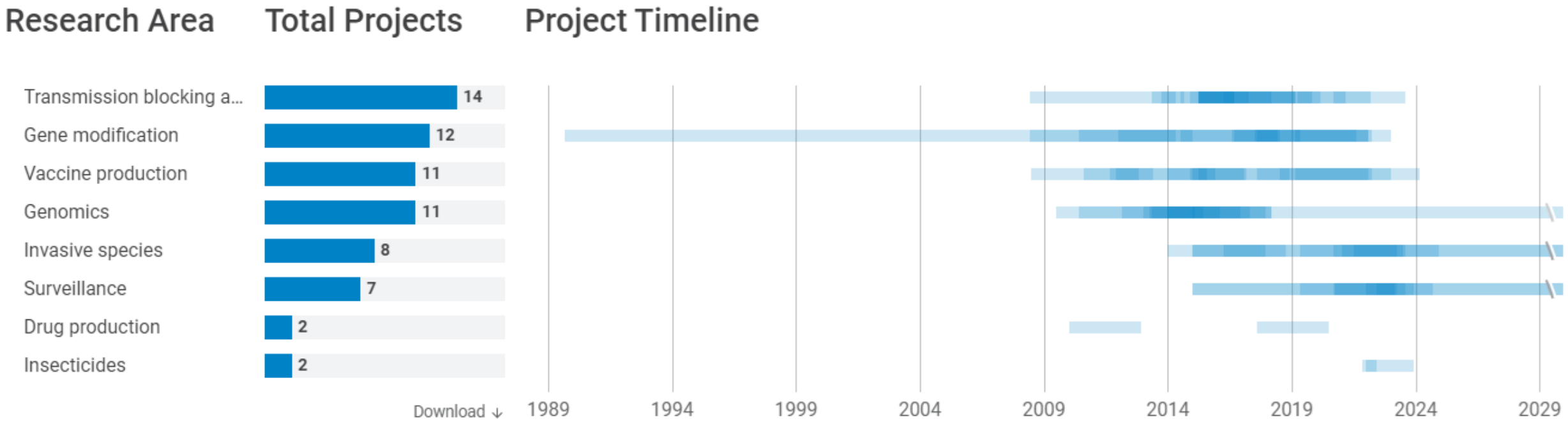
MESA

An. stephensi Deep Dive (ongoing projects curated in MESA Track)



ISGlobal

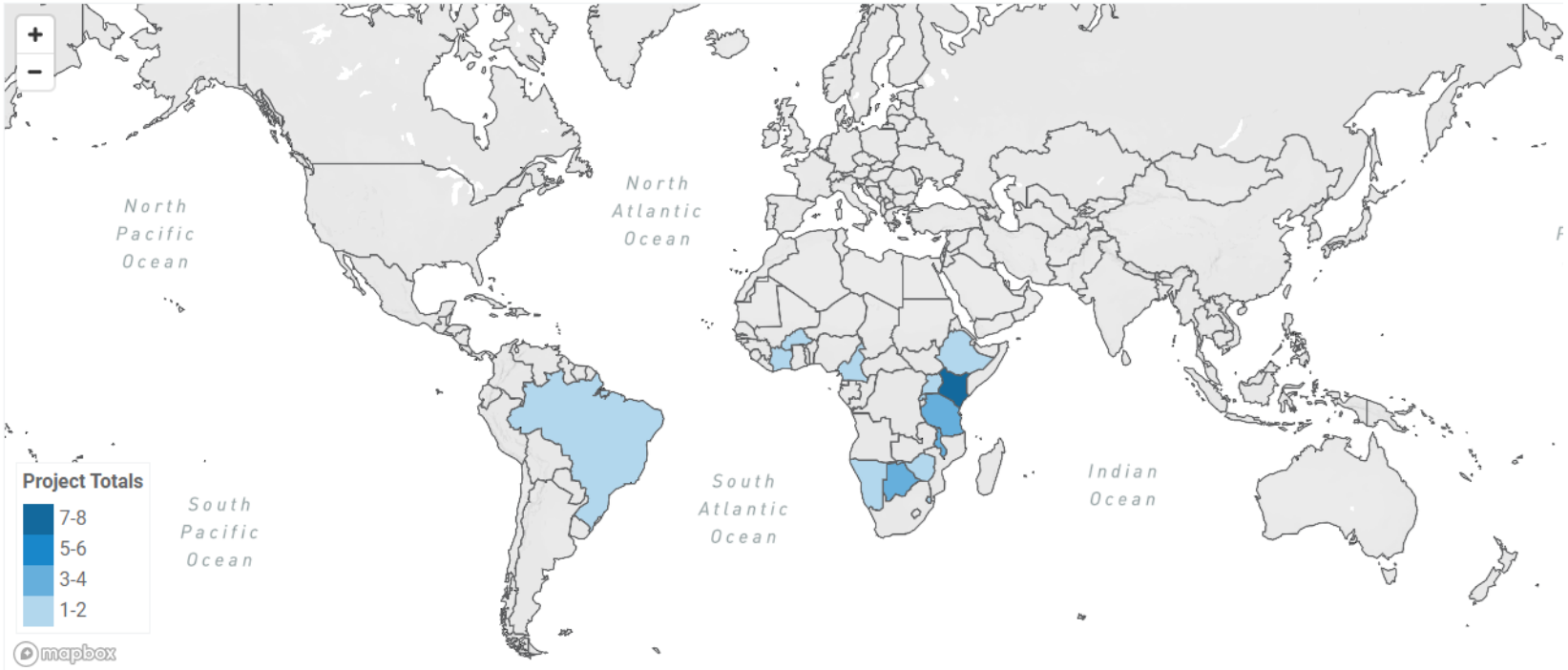
MESA

Larval Source Management Deep Dive

Larval source management

While long-lasting insecticide-treated nets and indoor residual spraying remain the backbone of malaria vector control, larval source management (LSM), which includes larviciding, has gained renewed interest as an additional intervention for the malaria toolbox. This deep dive compiles the landscape of recent and ongoing research in larviciding and provides an overview of the projects' characteristics.

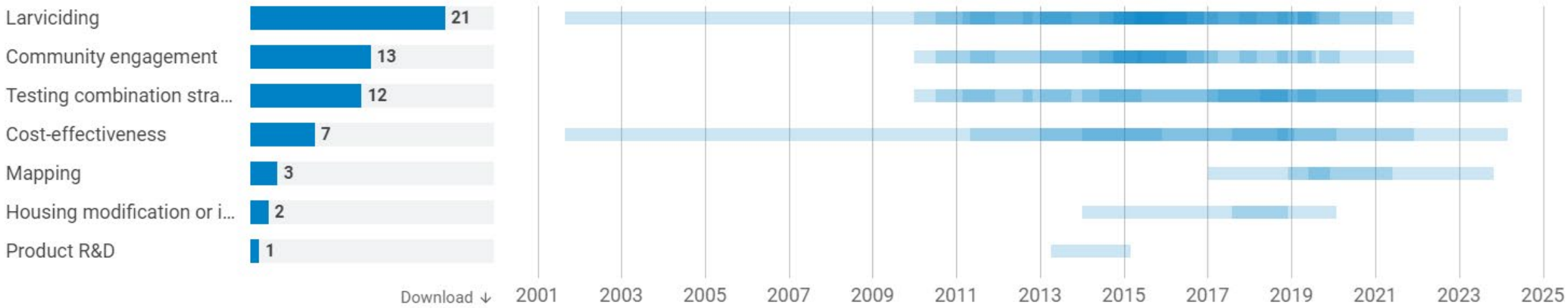
Project Sites



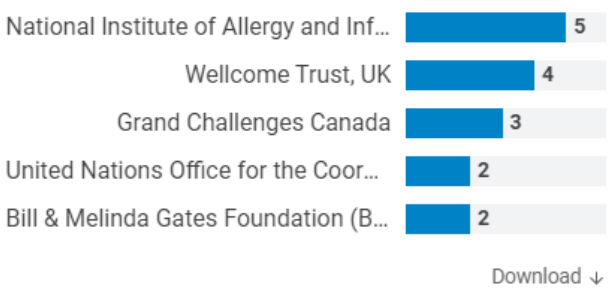
TOTAL PROJECTS	TOTAL FUNDING	PROJECT SITES
31	$33.0M	16
3 active	$7.79M active	3 active

Larval Source Management Deep Dive

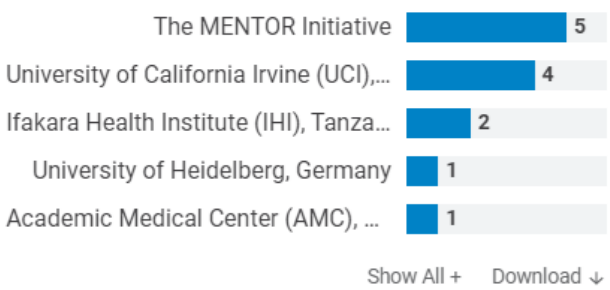
Research Area | Total Projects | Project Timeline



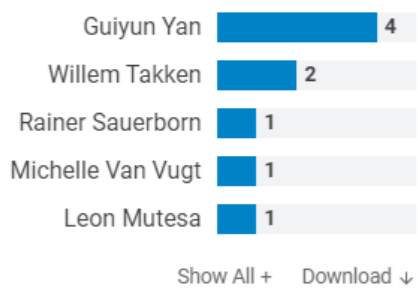
Funding Sources



Principal Institutions



Principal Investigators



Thank you

Kindly contact MESA for your country projects portfolio update or submit your projects at:

https://mesamalaria.org/mesa-track

MESA focal point:
Nana Aba Williams
nana.williams@isglobal.org

MMV update

Western Africa National Malaria Programmes and Partners Annual Meeting
Dakar, Senegal, July 26 – 29, 2022

Dr André Tchouatieu

Director, Access & Product Management

Malaria Chemoprevention

28 July 2022

MMV

Medicines for Malaria Venture

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

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Agenda

- MMV's impact and model
- R&D Pipeline
- Severe Malaria products
- ACT resistance mitigation strategies
- Malaria chemoprevention extension
- African manufacturing

MMV-supported products have saved an estimated 3 million lives since 2009

COARTEM DISPERSIBLE

450 million treatment courses[1] delivered by Novartis to more than 50 countries

Saving an estimated >969,000 children's lives

Artesunate INJECTED

255 million vials of Injectable Artesunate delivered since 2011[2]

Saving an estimated 1.36 million additional lives[3]

SP-AQ

Reducing uncomplicated and severe malaria episodes by 75%[4]

Protecting over 44 million children in 2021 – reducing uncomplicated and severe malaria by 75%[5]

ARTESUNATE RECTAL CAPSULES

7.6 million capsules delivered since 2017

Halving disability and death[6]

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

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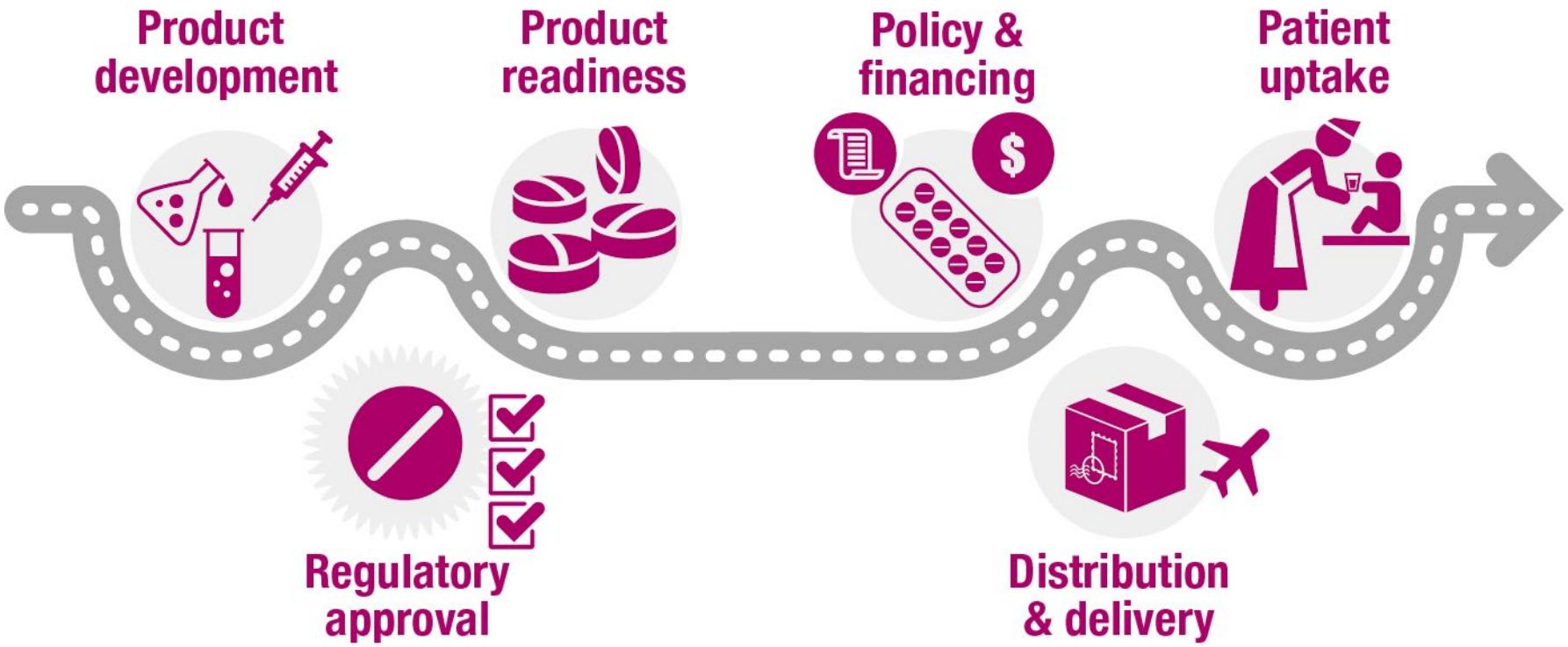
Access > The road to health impact



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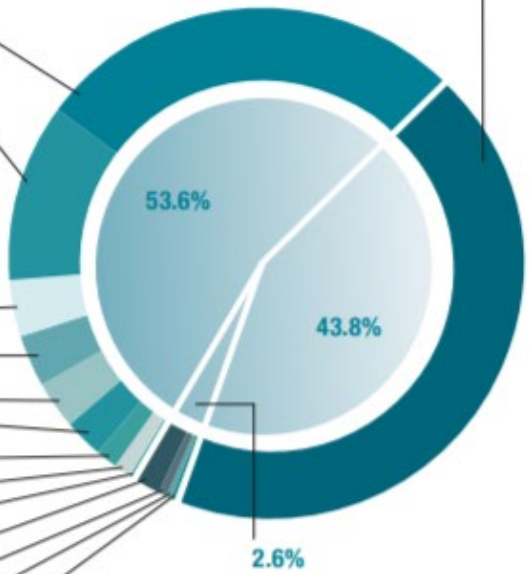
PPP; a way to finance new medicines

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%



Medicines for Malaria Venture

MMV-supported projects

Research

Lead optimization

- **Phenotypic Lead** Mitsubishi Tanabe
- **Pf Carl series** Calibr
- **GWT1** Eisai
- **Molecular Target** DDU Dundee
- **Azabenzimidazole** UNICAMP
- **Irresistibles** GHDDI
- **YRS** Takeda
- **ATP4 series** Drexel
- **Miniportfolio** Novartis
- **4-aminoquinoline** LSTM and University of Liverpool
- **Molecular Target** UCB
- **DHODH** Broad
- **DHODH** UTSW/ UW/ Monash
- **Phenotypic Lead** Merck KGaA-UCT
- **Whole cell actives H3D**

Candidate profiling

- **MMV072** Eisai

Translational

Preclinical

- **MMV371** Janssen
- **MMV183** (TropIQ)
- **GSK701** GSK
- **MMV609** Uni. of Kentucky
- **GSK484** GSK
- **IWY357** Novartis

Human volunteers

- **Atoguanil** Ipca
- **MMV533** (Sanofi)
- **INE963** Novartis

Product development

Patient exploratory

- **Ganaplacide-Lumefantrine** Novartis
- **Cipargamin** Novartis
- **ZY19489+ ferroquine** Zydus
- **M5717+ Pyronaridine** Merck KGaA/ Shin Poong

Patient confirmatory

- **Dihydroartemisinin-piperaquine dispersible** Alfasigma
- **Artemether lumefantrine <5kg** Novartis
- **Sulfadoxine-pyrimethamine** Emzor Pharmaceutical
- **Primaquine dispersible** B&O Pharm
- **Artemether-lumufantrine-amodiaquine FDC** Tridem

Regulatory review

- **Sulphadoxine-pyrimethamine** Universal Corporation
- **Sulphadoxine-pyrimethamine** Swipha/Biogaran

Access

Approved/ERP

- **Artemether-lumefantrine dispersible** Novartis — APPROVED 1
- **Artesunate for Injection** Fosun Pharma — APPROVED 2
- **Artesunate for Injection** Ipca — APPROVED 3
- **Dihydroartemisinin-piperaquine** Alfasigma — APPROVED 4
- **Pyronaridine-artesunate** Shin Poong — APPROVED 5
- **Pyronaridine-artesunate granules** Shin Poong — APPROVED 5
- **Artesunate-amodiaquine** Sanofi — APPROVED 6
- **Artesunate-mefloquine** Cipla — APPROVED
- **Sulphadoxine-pyrimethamine+ amodiaquine dispersible** Fosun Pharma — APPROVED 7
- **Sulfadoxine-pyrimethamine+ amodiaquine dispersible** S Kant — APPROVED 8
- **Artesunate rectal capsules** Cipla — APPROVED 9
- **Artesunate rectal capsules** Strides Pharma — APPROVED 10
- **Tafenoquine** GSK — APPROVED 11
- **Tafenoquine paediatric** GSK — APPROVED 1

MMV support to projects may include financial, in-kind, and advisory activities.

Footnotes: Included in MMV portfolio after product approval and/or development. DND*i* 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. | APPROVED 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: Supyra® 9: 100mg Artesunate Rectocaps; 10: Artecap™; 11: *Kozenis or Krintafel* (Trademarks owned or licensed by GSK)

MMV Medicines for Malaria Venture

Key products for severe malaria

Cipla

Strides Shasun

FOSUN PHARMA
Innovation for Good Health

ipca

MacLeods obtained WHO prequalification on April 13, 2021

Artemether 80mg injectable (Sanofi) WHO prequalified on August 29, 2019

www.severemalaria.org

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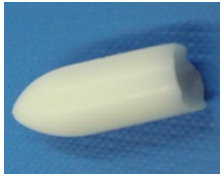
Suppository vs. Softgel Capsule

- 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

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 for 12 months
- Additional continuing education was minimal for HSAs

Full report available on www.severemalaria.org

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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	
Unconsciousness	
Recent history of convulsions	
Convulsions observed	
Repeated vomiting/vomiting everything	
Unable to eat/suckle	
Lethargy	
Severe anaemia	

Please provide the required follow up care for suspected severe malaria.

With thanks _____ Signature *(Referring HSA)*

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

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Key findings from severe malaria case management assessments

- Angola
- Liberia
- Mali
- Uganda
- DRC

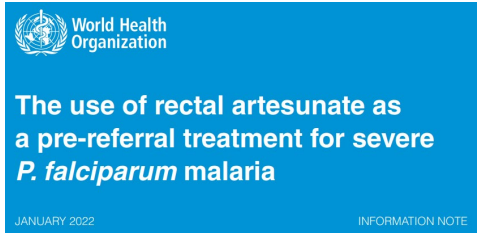
Full reports available on www.severemalaria.org

Context of Severe Malaria Global Stakeholder Meeting 8-9 February 2022

Rising malaria mortality[1]

Reports of artemisinin resistance in Africa[2]

CARAMAL project: challenges and deficiencies along the cascade of care[3]



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

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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

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

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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 clinics
  - 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….

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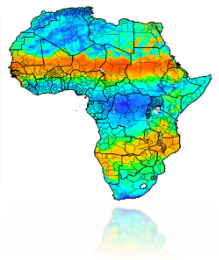
MMV has supported 2 Multiple First Line Treatment pilots in order to inform future policy and implementation.

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

Chemoprevention:

Use of antimalaria medicines to prevent occurrence of clinical malaria in endemic countries



SMC

Monthly administration of Sulfadoxine Pyrimethamine and amodiaquine (SPAQ) to children 3mths – 5 years) during the malaria transmission season (highly seasonal)

SP-IPTi (PMC)

Intermittent Preventive Treatment in infancy with SP (SP-IPTi) is the administration of a full therapeutic course of SP delivered through the Expanded Program on Immunization (EPI) – usually at 10 weeks, 14 weeks, and ~9 months of age

IPTp – SP

IPTp with sulfadoxine-pyrimethamine (IPTp-SP) in all areas with moderate to high malaria transmission in Africa to all pregnant women starting as early as possible in the second trimester; at least 3 doses of SP during her pregnancy, given at least 1 month apart – SP can safely be administered up until the time of delivery.

PDMC

(post discharge chemoprevention) ?

Preventing the occurrence of malaria in patient coming out of severe aneamia in malaria endemic countries

MDA?

For short term reduction of the malaria burden

From SMC to SEAMACE

(**SEA**sonal **MA**laria **C**hemoprevention **E**xtension)

Improve coverage (3-59 months)

Age extension (10 yrs?) Campaign duration (5 mths?)

Geographic extension Anticipation on SPAQ resistance

Building a path to elimination in seasonal transmission settings

SMC Continuum

MMV Medicines for Malaria Venture

Chemoprevention key priorities

Area of strategic focus	Project	Why it matters	Target
Structuring a framework for SMC stakeholders	SMC Alliance	Gathering all partners and SMC implementing countries to coordinate all SMC activities.	Development and validation of the 2021 work plan and drat an activity report by YE 2021
Expanding the outreach of SMC for an improved impact	SMC-IMPACT project	exploring potential new avenues for SMC use	Project launch, including start of Gambia and Guinea pilots WHO and an advisory group sign-off a definitive dose for 5-10 yrs age group Select manufacturer to define a drug development plan for a new higher-dose formulation of both SP+AQ, targeted to the 6-10yo age group
	OPT-SMC	Allowing countries to develop solutions for an optimized SMC implementation through operational research	5 countries have submitted a design for an operational research by YE 2021 2 newsletters developed by YE 2021
	Atoguanil BA study	developing alternatives to SPAQ to anticipate on resistance and expand geographically	Top line data for go / No go decision available by YE 2021 Led by R&D
Building path to Elimination	Ivermectin perceptions Market research	Investigate how malaria prevention using ivermectin is perceived and accepted in countries that trialed the intervention and those that did not.	Full report available by YE 2021

MMV Organizational goal

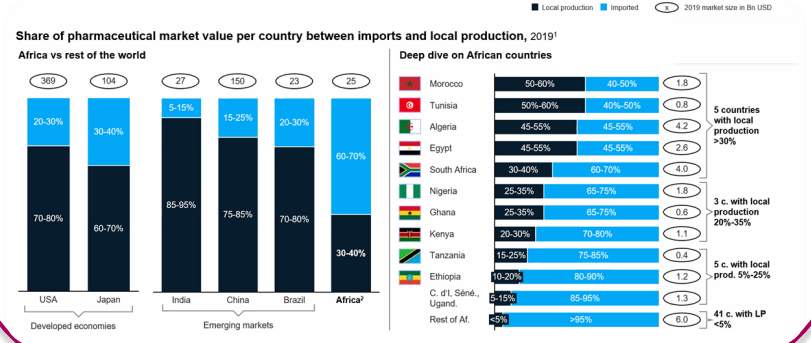
Pilot countries for supporting scale up of IPTi

Projects /Lead partner	Funder	Start date	Design	Countries	MMV's role
ICARIA/ IsGlobal	BILL & MELINDA GATES foundation "la Caixa" Foundation	2020	Increase the age limit to 2 years	**Sierra Leone**	User-friendly patient leaflet (incl. pre-testing)
MULTIPLY/ IsGlobal	EDCTP	2021	Increase IPTi coverage through the Expanded Programme on Immunisation (EPI) and vit A supplementation including mobile-outreach clinics to facilitate access of hard-to-reach populations facing socio-economic and/or geographic barriers. Up to 6 to 7 administrations up to 2 years of age	University of Lomé in **Togo**, COMAHS in **Sierra Leone** and Fundação Manhiça in **Mozambique**	Generic packaging (perforated blister + add coms tools (e.g., envelop) and user-friendly patient leaflet (incl. pre-testing) Development of IEC tools as part of SBCC Campaign and country adaptation
IPTi+/ PSI	Unitaid	2021	Up to 2 year of life Health providers through regular EPI + CHWs	**Cameroon, Cote d'Ivoire, Benin, and Mozambique**	Generic packaging (perforated blister + add coms tools (e.g., envelop) and user-friendly patient leaflet (incl. pre-testing) Design workshop participation to share learning and experience with SP IPTp project
Malaria Consortium	BILL & MELINDA GATES foundation	2021 (4 yrs)	1st year of life, if Nigeria's EPI platform expands to 15 months, so will this propose scope of activity. Modelling - Northwestern Uni, Illinois. Reduction of clinical outcomes in the three different arms - powered to measure 20% reduction in three EPI points and 30% in five points.	**Nigeria -** study sites (Ebonyi and Osun state)	Development of SP Job aid, facilitation of SP procurement

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 people[1]
- 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



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 access[3]

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.

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

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.


MALARIA:
HELP DEFEAT IT!
Photographer: Natalia Szczygielska

THE GLOBAL FUND

Global Fund Updates:

Overview of the Upcoming Global Fund Allocation Cycle

Commodities Planning

C19RM

Western Africa National Malaria Program Managers and Partner Meeting, Dakar

26-29 July 2022

March 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

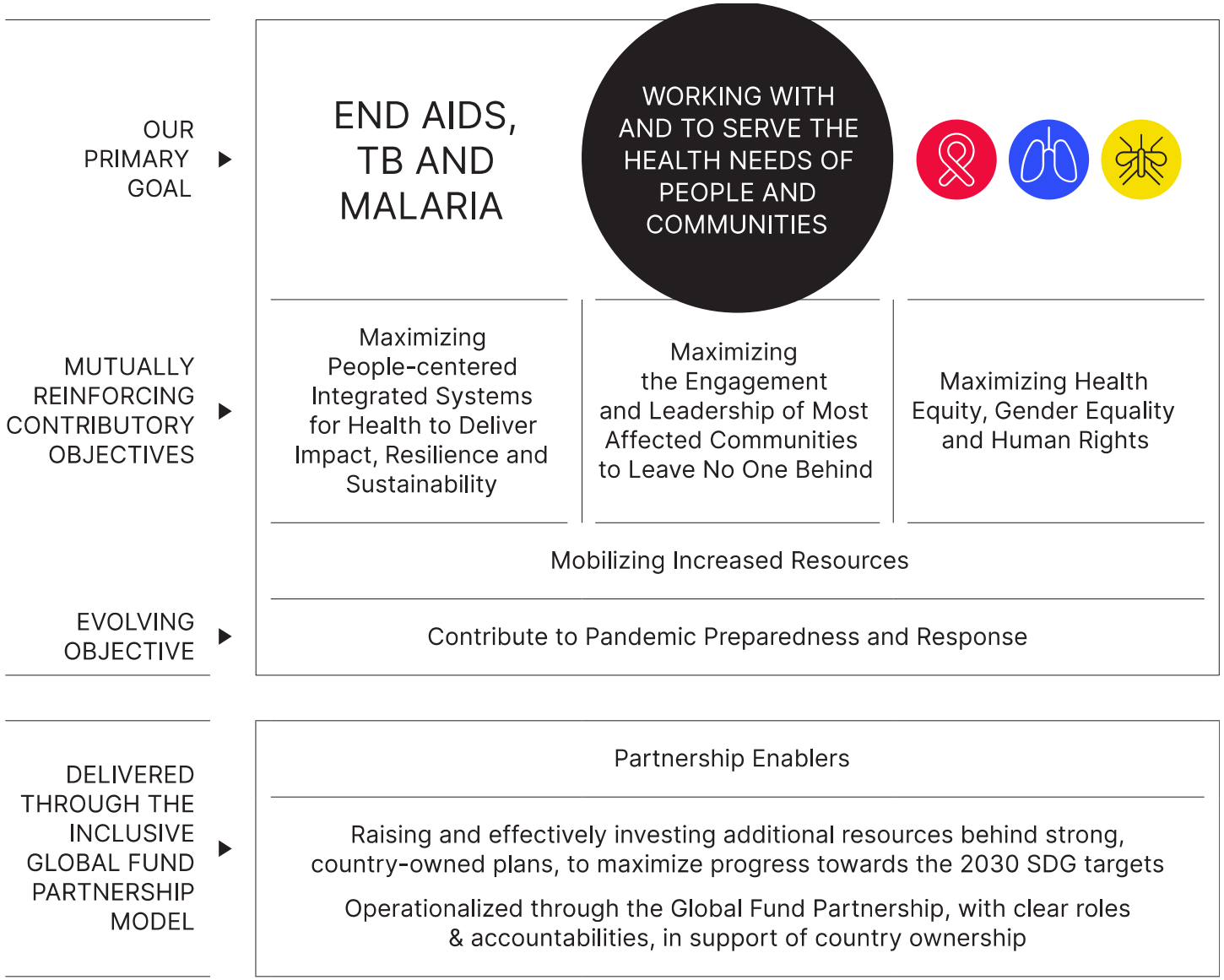
We are off track to meet the **Sustainable Development Goal (SDG) 3 targets**.

3 GOOD HEALTH AND WELL-BEING

Our Future

New Global Fund Strategy to accelerate impact toward the 2030 horizon.

The Global Fund Strategy Framework

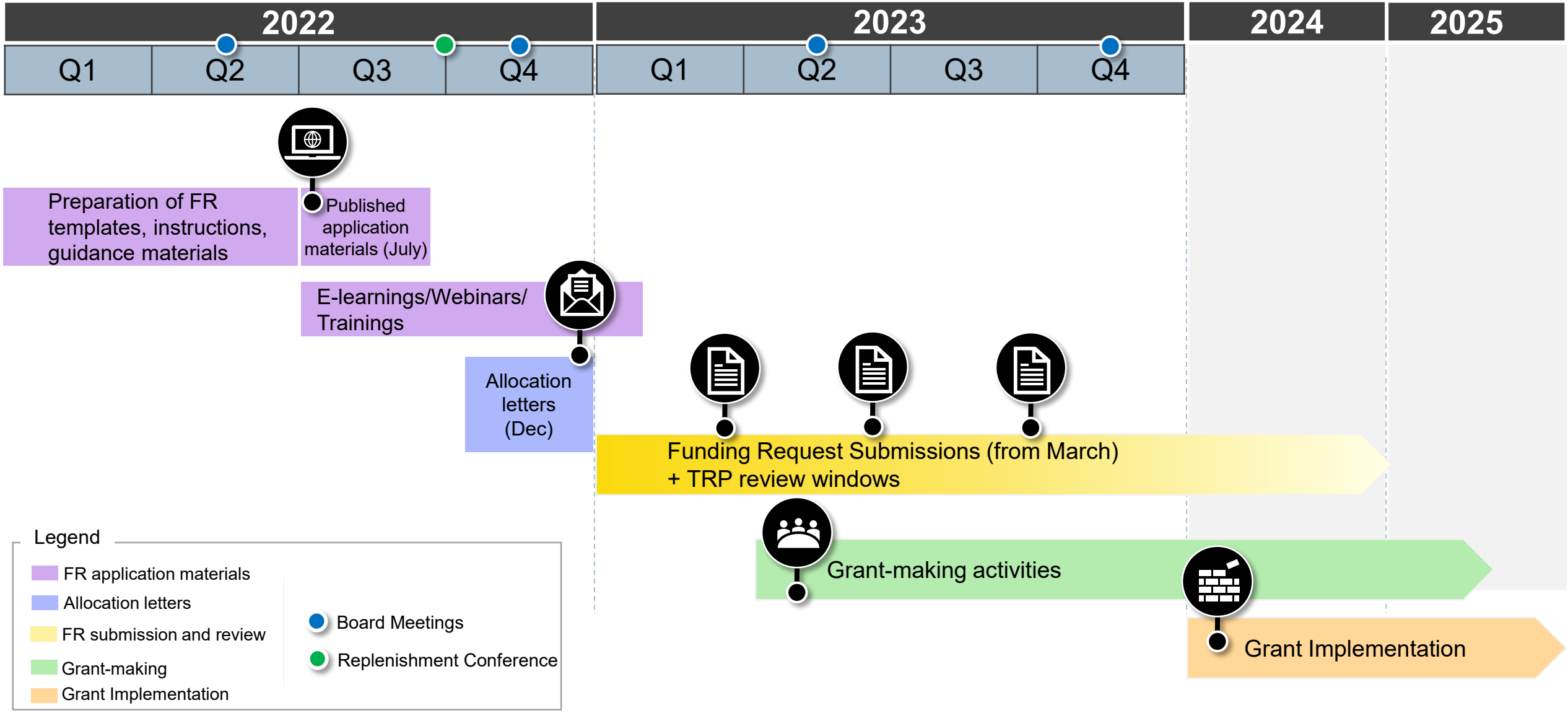


- **Strategy's primary goal** is to end AIDS, TB, and Malaria.
- **People and communities are at the heart** of our Strategy.
- Achievement of the primary goal is **supported by 4 mutually reinforcing contributory objectives** and **an evolving objective**.
- Partnership Enablers outline **roles and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

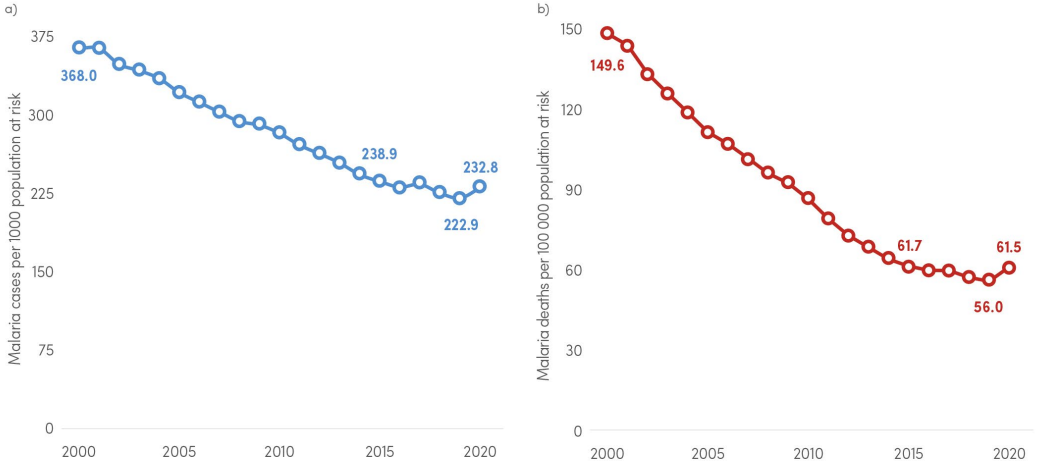
3. Optimize Chemoprevention

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 GF Supply operations (SO)/ Malaria Team (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 ~ 8 months
- Insecticides for IRS ~9 months
- Pyrethroid-only ITNs ~7 months
- Pyrethroid-PBO ITNs ~ 10 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

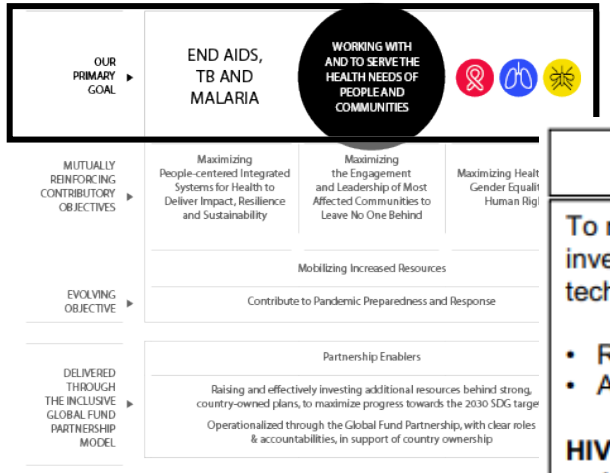
- **Increase in freight costs due to C19 can now be included in C19RM reprogramming**
- **Early procurement!** And even earlier flagging of interest if for Pyrethroid-PBO or dual a.i. nets.
- **Stagger shipments** of bulky items in smaller lots requiring fewer containers at once
- **Clarify delivery 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

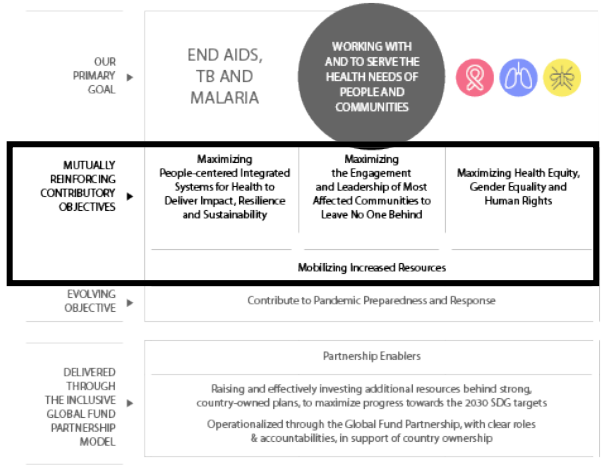
- Focus on finding and treating all people with DS-TB and DR-TB through equitable, people-centered approaches
- Scale up TB prevention with emphasis on TB preventive treatment and airborne infection prevention and control
- Improve the quality of TB services across the TB care cascade including management 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

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

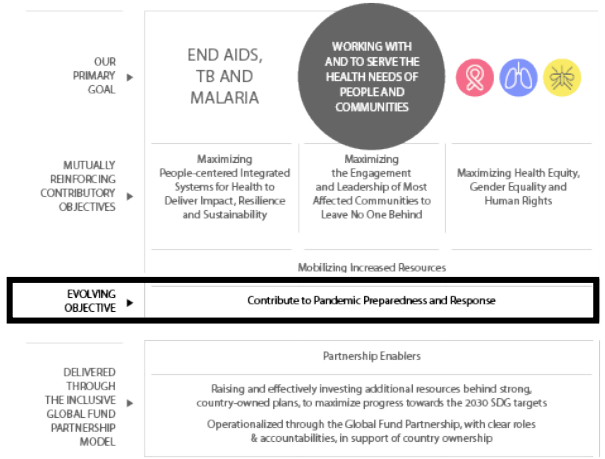
Mobilizing Increased Resources

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

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.

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.

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

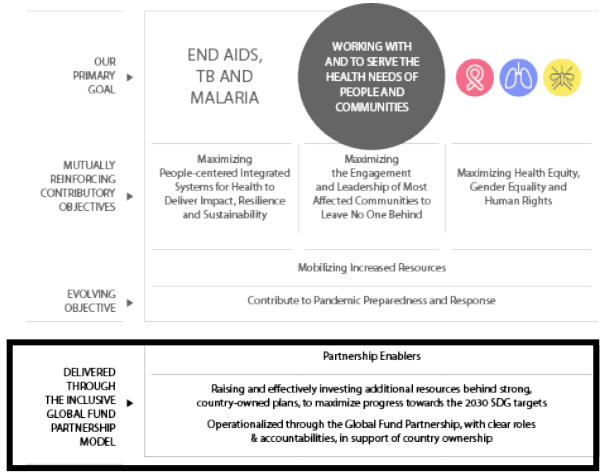
- Leveraging the Global Fund partnership model and principles to contribute to PPR, strengthen the resilience of HIV, TB and malaria programs and contribute to wider systems strengthening and resilience.

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

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/

Fonds Mondial:

Aperçu du prochain cycle d'allocation

Planification des produits

C19RM

Reunion Annuelle des Programmes Palu d’Afrique de l’Ouest et des Partenaires, Dakar

26-29 Juillet 2022

Contexte : Stratégie du Fonds mondial

Nos progrès

A partir de fin 2020 :

44 millions vies sauvées

21.9 million personnes sous traitement antirétroviral contre le VIH en 2020

4.7 million de personnes atteintes de tuberculose traitées en 2020

188 million moustiquaires distribuées en 2020

$3.3 billion approuvé pour >100 pays pour combattre le COVID-19 (à partir de fin 2021)

Où nous sommes maintenant

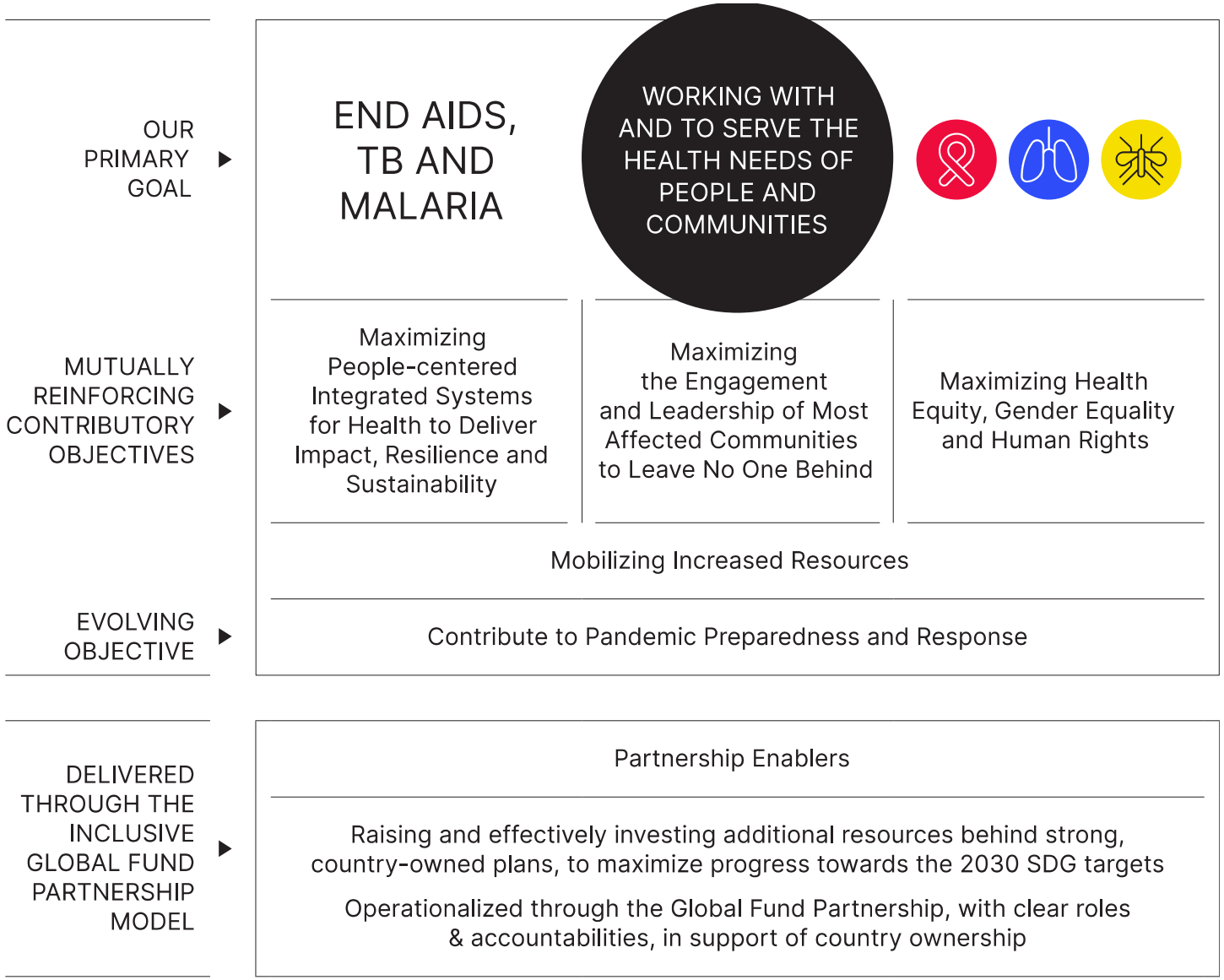
Nous ne sommes pas sur la bonne voie pour atteindre les cibles de l'objectif de développement durable 3 (ODD).

3 GOOD HEALTH AND WELL-BEING

Notre avenir

Nouvelle stratégie du Fonds mondial pour accélérer l'impact à l'horizon 2030.

Le cadre stratégique du Fonds mondial

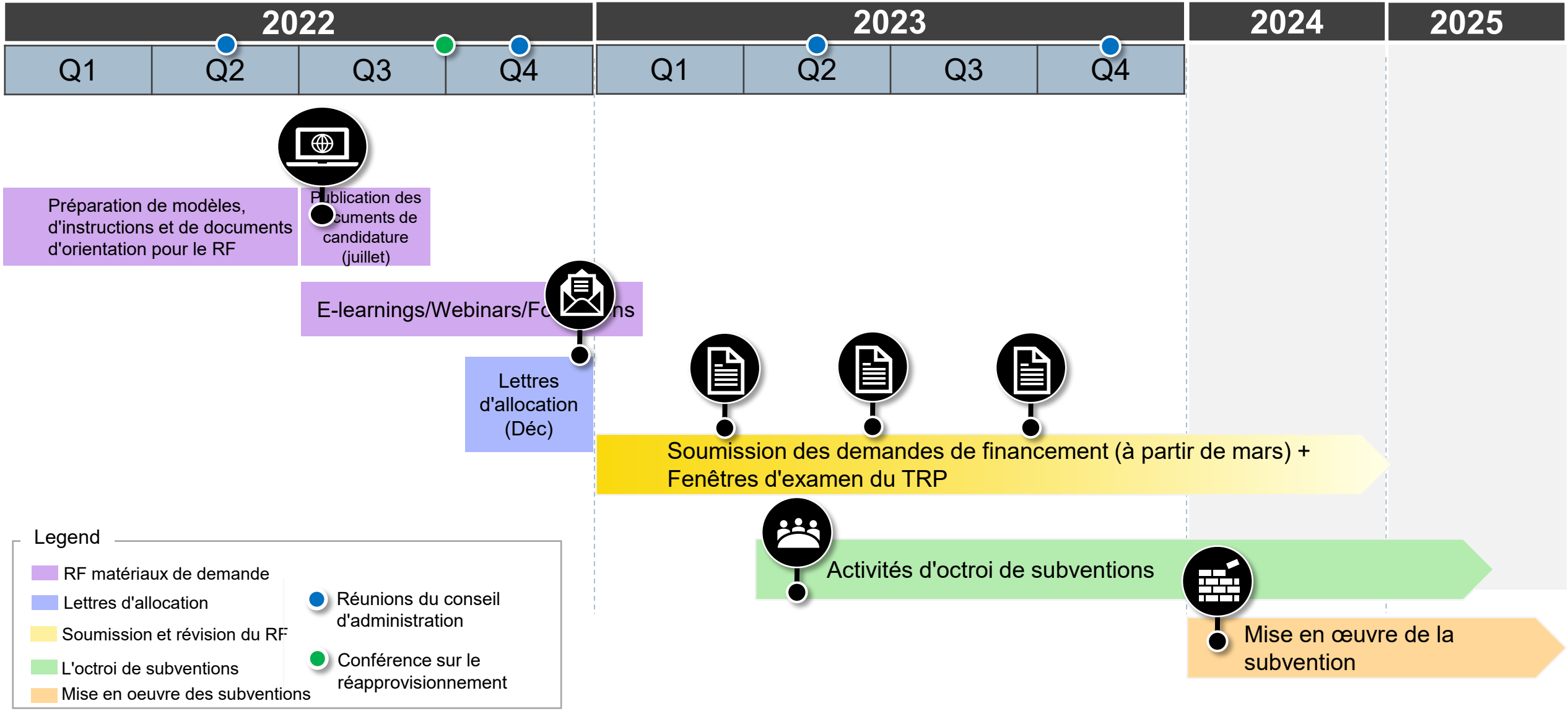


- L'objectif principal de la stratégie est de mettre fin au SIDA, à la tuberculose et au paludisme.
- Les personnes et les communautés sont au cœur de notre stratégie.
- La réalisation de l'objectif principal est soutenue par quatre objectifs contributifs se renforçant mutuellement et un objectif évolutif.
- Les catalyseurs du partenariat décrivent les rôles et les responsabilités de toutes les parties prenantes.

Qu'est-ce qui est différent dans cette nouvelle stratégie ?

1	Dans les trois maladies, l'accent est mis sur la prévention.
2	Une plus grande importance accordée aux services intégrés et centrés sur les personnes.
3	Une approche plus systématique pour soutenir le développement et l'intégration des systèmes communautaires pour la santé.
4	Un rôle et une voix plus forts pour les communautés vivant avec et affectées par les maladies.
5	Intensification des actions visant à lutter contre les inégalités, les droits de l'homme et les obstacles liés au genre.
6	Un accent accru sur la durabilité programmatique et financière.
7	Mettre davantage l'accent sur l'accélération du déploiement et de l'accès équitables aux innovations.
8	Une plus grande importance accordée aux décisions fondées sur les données.
9	Reconnaissance explicite du rôle que le partenariat du FM peut et doit jouer dans la préparation et la réponse aux pandémies.
10	Clarté sur les rôles et les responsabilités des partenaires du Fonds mondial dans tous les aspects de la stratégie.

Calendrier du cycle de financement 2023-2025



Aperçu : Prochaine note d'information sur le paludisme

Objectif :

- Complète les orientations normatives pour aider à la préparation du RF
- Recommandations sur les interventions prioritaires et les investissements stratégiques alignés sur les PSN pour obtenir un impact.
- Inclut les considérations du FM concernant les éléments essentiels du programme, les achats et autres exigences.

Aperçu:

- **Approche d'investissement**
- **Interventions classées par ordre de priorité**
- **Prise de décision fondée sur des données probantes**
- **Prévention**
- **Gestion de cas**
- **Élimination**
- **Domaines transversaux**

Ressources supplémentaires : Prochains webinaires, apprentissage en ligne et notes d'information supplémentaires pour RSS, VfM, HRG Palu.

Objectifs de la stratégie de lutte contre le paludisme 2023-2028

1. Mettre en œuvre des interventions contre le paludisme, adaptées au niveau infranational, en utilisant des données granulaires et en renforçant les capacités de prise de décision et d'action.

2. Assurer une couverture optimale et efficace de la lutte antivectorielle

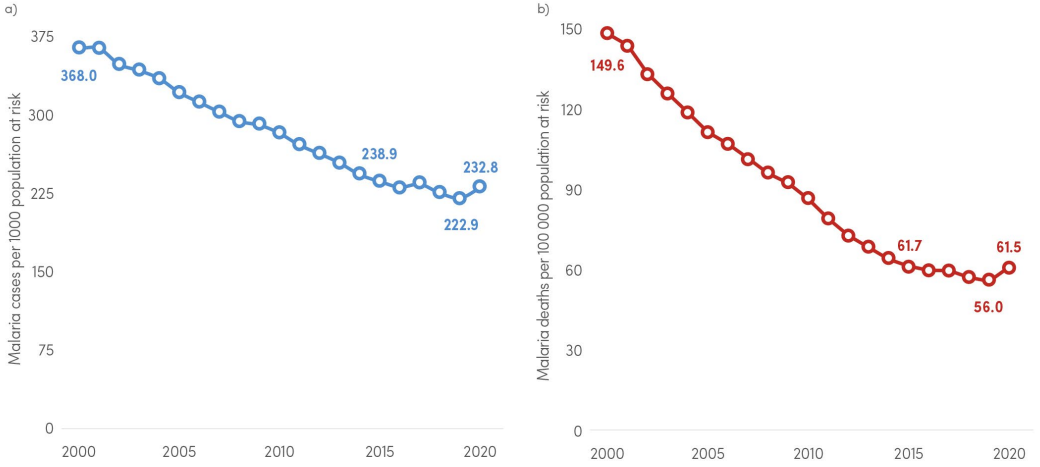
3. Optimiser la chimioprévention

4. Étendre l'accès équitable à un diagnostic précoce et à un traitement de qualité du paludisme, par le canal des établissements de santé, secteur publique, au niveau communautaire et dans le secteur privé, avec des rapports précis.

5. Progresser vers l'élimination et faciliter la prévention de la réapparition du paludisme.

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 : Réduction observée du nombre global de cas et de décès entre 2000 et 2017, stagnation jusqu'en 2019 et augmentation dans le contexte de la pandémie de COVID-19 et de la perturbation des services de lutte contre le paludisme.

Sur quoi les programmes nationaux devraient-ils travailler maintenant en vue de la NFM4 ?

- Définir les principales parties prenantes, les plans et les calendriers pour le dialogue national - envisager un engagement précoce avec le RSS et les parties prenantes de la communauté pour assurer leur soutien et leur participation.
- Assurer la liaison avec la ICN/CCM sur le calendrier des discussions clés, y compris les élections de la ICN/CCM.
- Examiner toutes les recommandations du TRP non traitées.
- Établir le calendrier et le soutien nécessaires pour les processus de stratégie et de révision (ex. RPP, mises à jour du PSN).Réfléchir au soutien supplémentaire qui pourrait être nécessaire pour une demande de financement PSN (a la adaptation infranational (AI)) et FM.
- Commencez votre analyse des lacunes programmatiques
  - Veillez à ce qu'elle soit prête pour les discussions sur le partage du programme
  - Mettez en évidence tous les produits nécessaires pour la NFM4 qui pourraient devoir être achetés dans la NFM3 (en tenant compte notamment des délais d'approvisionnement plus longs) et informez vos EPs/CTs de ces besoins.
- Réfléchissez aux dispositions de mise en œuvre et à toute révision potentiellement nécessaire (à discuter avec les EPs/CTs).

1. Mettre en œuvre des interventions contre le paludisme, adaptées au niveau infranational, en utilisant des données granulaires et en renforçant la capacité de prise de décision et d'action.

Utilisation de données locales et d'informations contextuelles pour déterminer la combinaison appropriée d'interventions et de stratégies de mise en œuvre afin d'obtenir un impact optimal sur la transmission et la charge de morbidité dans une zone donnée, telle qu'un district, un centre de santé ou un village.

Activités suggérées pour se préparer :

- Dresser la carte des révisions nécessaires, du PSN, etc. et des calendriers.
- Réfléchir au personnel et à l'équipement nécessaires pour les référentiels de données sur le paludisme (EDP), la collecte et l'analyse des données, les évaluations rétroactives, les revues de programme, le PSN, la stratification, la AI/SNT, NFM4 RF.....
- Envisager d'embaucher un spécialiste/gestionnaire de données et un analyste de données au sein de l'équipe des PME, au moins jusqu'à l'octroi de la subvention (idéalement plus longtemps).
- Identifier les lacunes critiques dans ce qui précède et demander le soutien du FM et des partenaires dès que possible.
- Mettre en évidence tout goulot d'étranglement potentiel prévu entre maintenant et le développement du FR (pour le soutien de la EP/CT/des partenaires).

Nous ne nous attendons PAS à ce que chaque pays dispose d'un plan AI/SNT complet d'ici NFM4 RF - nous voulons être en mesure de comprendre quelles sont les données dont ils disposent, comment ils les utilisent, comment nous pouvons les aider à mieux les utiliser, etc. afin qu'au final tous les pays puissent disposer d'une stratégie AI/SNT de qualité et la rendre opérationnelle.

2. Assurer une couverture optimale et efficace de la lutte antivectorielle

Promouvoir la prise de décision fondée sur des données probantes, en faisant varier la sous-nationalité le cas échéant, pour le choix du type d'intervention et de la classe de produits, du modèle de prestation et de la fréquence ; en s'attachant à garantir une couverture élevée et durable des outils efficaces parmi les populations à risque

Activités suggérées pour se préparer :

- Assurez-vous de disposer de données actualisées, ou de plans pour les collecter, au niveau infranational dans la mesure du possible : ento (y compris la résistance aux insecticides) ; couverture PID/MII ; durabilité, attrition et utilisation des MII.
- Ces données - combinées aux données épidémiologiques et aux considérations opérationnelles - seront essentielles pour déterminer les plans concernant:
  - le type d'intervention approprié (PID ou MII) par zone infranationale
  - dans le cas des MII, la classe de produits, le modèle de distribution et la fréquence appropriés, en fonction de la situation sous-nationale.
  - Avec de nombreux endroits confrontés à la résistance aux pyréthrinoïdes et des données montrant une durabilité des MII <3y ; les programmes devront considérer à la fois le nombre approprié de moustiquaires et le type approprié de moustiquaires. La variation de l'approche au niveau sous-national sera probablement essentielle pour trouver le bon équilibre.
- Commencez à planifier les campagnes 2023 et à identifier les besoins en assistance technique dès que possible.
- Si des commandes n'ont pas encore été passées pour 2023 (MII et PID) - les passer dès que possible.
- Signalez au EP/CT tout besoin de produits de base pour 2024 qui pourrait nécessiter une précommande (quantité, produits, délais de livraison) et travaillez avec les equipes palu et logistique du FM pour traiter les goulets d'étranglement de la transition NFM3/4.
- Signaler tout besoin d'assistance technique (aux partenaires et à la EP/CT)

3. **Optimiser la chimioprévention**

Soutenir la sélection d'interventions fondées sur des données et les modalités de mise en œuvre

Nouvelles recommandations de l'OMS : âge/localisation des CPS ; chimioprévention du paludisme pérenne ; TIPc ; TIP etudiant scolaire ; vaccin antipaludéen.

Activités suggérées pour se préparer :

- Explorer/comprendre les nouvelles orientations de l'OMS pour voir ce qui peut être pertinent et faisable dans le contexte de votre pays.
- Tenir compte des variations infranationales dans le pays pour adapter les interventions, la mise en œuvre, etc.
- S'assurer que les campagnes 2022/3 sont planifiées et déployées de manière adéquate.
- Travailler avec les equipes du palu et logistique du FM sur la commande préalable de médicaments pour les campagnes de 2024 afin de résoudre le problème de la transition vers les NFM3/4.
- Prendre note de la nouvelle recommandation de l'OMS sur le RTSS, mais le FM ne finance pas l'achat de vaccins pour le moment, se référer aux directives de l'OMS/GAVI.

4. Élargir l'accès équitable à un diagnostic précoce et à un traitement de qualité du paludisme, par des établissements de santé publics, au niveau communautaire et dans le secteur privé, y compris l'établissement de rapports précis.

Activités suggérées pour se préparer :

- Évaluer les stocks de produits compte tenu de tout changement dans la consommation et de l'allongement des délais - signaler tout manque à venir et ajuster le stock de reserve le cas échéant.
- Assurer des stocks de reserve suffisants pour couvrir la transition NFM3/4 - en tenant compte des délais plus longs.
- Analyser l'accès aux soins/la recherche de soins (et les obstacles) pour alimenter les futurs plans d'intensification, ex. Évaluation des obstacles à l'accès, développement de la stratégie du secteur privé, géoréférencement, etc.
- Veiller à inclure les réfugiés, les personnes déplacées et les populations mobiles dans la quantification et la stratégie.
- Planifier le développement d'une stratégie pour le secteur privé (qui inclut les tests parasitologiques).
- Analyser les mesures de la qualité des soins afin de développer des approches ciblées pour une amélioration continue de la qualité.
- Engager dès maintenant les SSP, la santé communautaire et d'autres parties prenantes du RSS pour assurer la coordination des priorités d'extension et d'amélioration de la qualité de la NFM4.
- Commencer à envisager des stratégies d'atténuation de la résistance aux antipaludiques (en attendant les directives de l'OMS) et envisager des enquêtes sur la délétion du gène PfHRP2/3 si ce n'est pas déjà fait.

5. Favoriser l'élimination et faciliter la prévention de la réintroduction du paludisme.

Activités suggérées pour se préparer :

- Continuer à cibler au niveau sous-national pour réduire les points chauds/foyers.
- Envisager des possibilités de synergie pour la surveillance des maladies fébriles aiguës (paludisme, Covid 19, VIH, tuberculose).
- Réfléchir à la manière d'aborder les populations difficiles à atteindre, les populations mobiles et migrantes et les populations déplacées de force.
- Définir le plaidoyer nécessaire à l'augmentation du financement national
- Continuer à se concentrer sur l'amélioration et l'optimisation de la lutte antivectorielle et de la gestion des cas, sur le renforcement de la capacité de surveillance pour détecter, caractériser et suivre tous les cas, sur l'accélération de la réduction de la transmission et sur la prévention du rétablissement du paludisme.

Considérations transversales

- Leadership et engagement communautaires
- Équité, égalité des sexes et droits de l'homme
- Changement social et comportemental
- Préparation et réponse aux pandémies
- Environnement et changement climatique
- Paludisme urbain
- Environnements opérationnels difficiles (COE)
- Urgences liées au paludisme
- Gestion du programme
- Durabilité de la réponse au paludisme

Investissements catalytiques pour l'allocation 2023-2025

Spécifique au paludisme (jaune) et transversal (vert)

Éliminer le paludisme	Les menaces biologiques dans la gestion des cas de paludisme en Afrique
	E2030 : S'orienter vers l'élimination et faciliter la prévention de la réintroduction.
	Élimination du paludisme en Afrique australe
	Initiative sur la résistance à l'artémisinine (RAI)
	Coordination régionale et assistance technique ciblée
	Faire face aux menaces et aux opportunités du contrôle des vecteurs : soutenir la préparation des pays à une boîte à outils en expansion

Renforcer les laboratoires de référence régionaux et les réseaux de diagnostic nationaux
Données
Accès équitable à des produits de santé de qualité grâce à l'innovation, au partenariat et à la promotion de chaînes d'approvisionnement durables aux niveaux mondial, national et communautaire (NextGen Market Shaping)
Encourager la qualité et l'échelle du RSS
Améliorer les systèmes et les réponses communautaires contribuant à l'amélioration des résultats en matière de santé et à l'accès équitable à des services de qualité intégrés et centrés sur les personnes.
Engagement communautaire
Mise à l'échelle des programmes afin de supprimer les obstacles liés aux droits de l'homme et au genre.
Financement de la santé
Fonds d'urgence

Le financement total par investissement catalytique dépendra des résultats finaux de la 7e reconstitution des ressources.

Mise à jour de la passation pour les produits de lutte contre le paludisme

Mise à jour des délais de livraison

Défis:

- Livraisons retardées en raison du manque de conteneurs, de la fermeture des ports et/ou des navires.
  - Les fournisseurs doivent stocker les marchandises pendant de plus longues périodes (coûts de stockage).
  - Les entrepôts pleins des fournisseurs peuvent entraîner des retards de production
- L'augmentation du coût du fret et du transport à l'intérieur du pays pèse sur les budgets des subventions.

Les temps de livraison

https://www.theglobalfund.org/en/sourcing-management/health-products/

- TCAs ~7 mois
- TDRs ~7-9 mois
- SPAQ ~ 8 mois
- Insecticides pour PID ~9 mois
- Pyrethroid MII ~7 mois
- Pyrethroid-PBO MII ~ 10 mois
- Dual a.i. MII ~12 mois mais des enquêtes précoces sont indispensables

→ Malgré les efforts herculéens des PNLP/RP, du service des approvisionnements, des fournisseurs et des EP/CT, nous constatons toujours des retards dans les campagnes en raison de la réception tardive des MII.

Changements dans les prix des produits

Tests de diagnostic rapide du paludisme (TDR):

- Les prix des tests de paludisme les plus couramment achetés (Pf uniquement) ont diminué, tandis que les prix de référence des tests Pf/Pv et Pf/PAN ont légèrement augmenté.

Médicaments antipaludiques : pas d'augmentation du prix de référence - quelques baisses de prix:

- Artemether/Lumefantrine 20/120mg 6 comprimés dispersibles 30 blister : Diminution de 5%.
- Artemether/Lumefantrine 20/120mg 12 comprimés dispersibles 30 blister : 6% de diminution
- Artesunate 60mg poudre pour solution injectable - 1 flacon : 7% de reduction
- AQ + S/P 153mg+500/25mg 3+1 comprimés dispersibles co-blister de 50 : 7% de réduction

Moustiquaires imprégnées d'insecticide (MII):

- Les MII pyréthrinoïdes ont augmenté de 6% en moyenne (15 cents par moustiquaire)
- Les MII pyréthrinoïdes-PBO ont augmenté de 7 % en moyenne (22 cents par moustiquaire).

Insecticides pour la pulvérisation résiduelle à l'intérieur (PID):

- Légères augmentations pour certains produits comme le pirimiphos-méthyl (Actellic®) qui a augmenté de 3%.
- (Notez que les insecticides en sachets hydrosolubles sont actuellement indisponibles pour des raisons de qualité et ne figurent donc plus dans la liste de prix. Ces insecticides sont disponibles en sachets non solubles)

Changements dans les prix des produits (cont)

Liens vers des prix de référence détaillés (tous liés aux sous-pages de la catégorie disponibles à partir de https://www.theglobalfund.org/en/sourcing-management/health-products/ ou https://www.theglobalfund.org/en/covid-19/health-product-supply/)

- Paludisme
  - Antimalarial Medicines (medicaments)
  - Insecticide Treated Nets (MII)
  - Indoor Residual Spraying (PID)
  - Rapid Diagnostic Tests (TDR)

- Covid-19
  - Personal Protective Equipment - (EPP) noter des réductions de prix globales de 16% au 1er trimestre 2022
  - Laboratory and health equipment – (equipment laboratoire et sante) y compris les équipements de séquençage, les rayons X, la chaîne du froid et la gestion des déchets. sequencing equipment, X-ray, cold chain and waste management
  - Freight, Insurance, Quality Assurance/Quality Control Indicative Reference Costs (fret et assurance qualité)
  - Procurement Services Agent Fees (honoraires des agents de services d'approvisionnement)

Mesures de mitigation potentielles

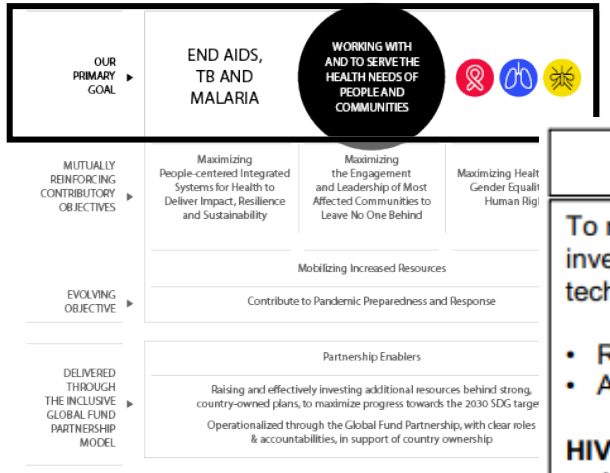
- **L'augmentation des coûts de fret due au C19 peut maintenant être incluse dans la reprogrammation du C19RM**
- Achat précoce ! Et signalement encore plus précoce de l'intérêt s'il s'agit de Pyréthroïde-PBO ou de moustiquaires à double action/nouvelle génération.
- Échelonner les expéditions d'articles volumineux en lots plus petits nécessitant moins de conteneurs en une fois
- Clarifier la période de livraison plutôt que de se limiter à une date de livraison.
- Améliorer la communication/collaboration entre l'agent du service des achats, les transitaires et les RP.
- S'assurer que les dérogations et les goulots d'étranglement en matière de dédouanement sont traités rapidement.
- Réévaluer rapidement les coûts de la chaîne d'approvisionnement dans le pays afin d'identifier les éventuels déficits de financement.
  - Si cela est lié aux perturbations du C19, discutez avec votre EP/CT pour savoir si ces lacunes peuvent être financées par la reprogrammation du C19RM.

Merci!
Des 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

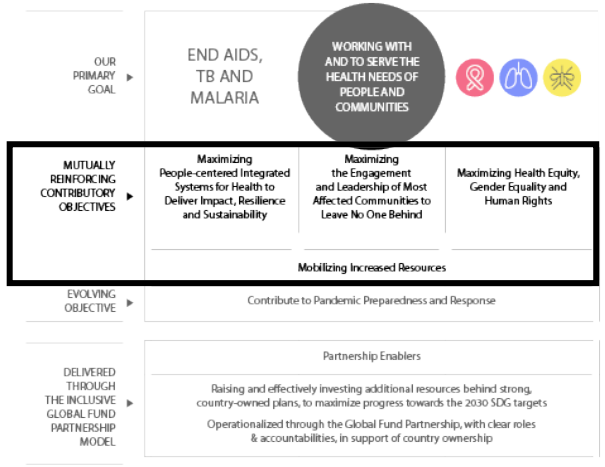
- Focus on finding and treating all people with DS-TB and DR-TB through equitable, people-centered approaches
- Scale up TB prevention with emphasis on TB preventive treatment and airborne infection prevention and control
- Improve the quality of TB services across the TB care cascade including management 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

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

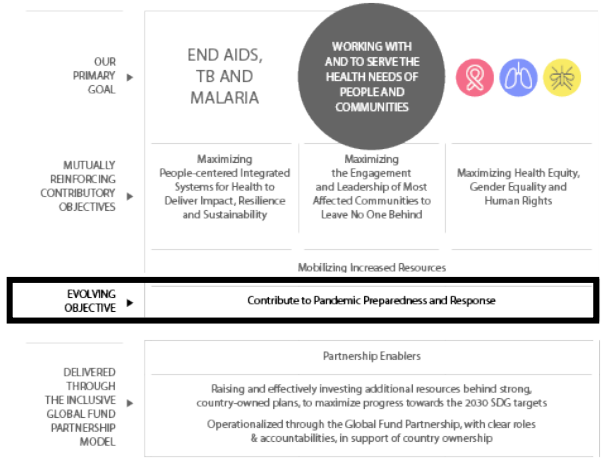
Mobilizing Increased Resources

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

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.

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.

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

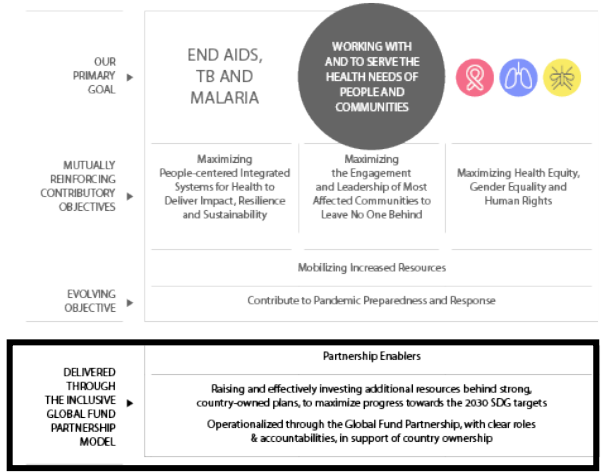
- Leveraging the Global Fund partnership model and principles to contribute to PPR, strengthen the resilience of HIV, TB and malaria programs and contribute to wider systems strengthening and resilience.

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

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/

RBM Partnership
To End Malaria

Objectives and Outcomes

Southern Africa National Malaria Programmes and Partners Annual Meeting
Senegal, Dakar, 26-29 July 2022

Western Africa National Malaria Programmes and Partners Annual Meeting

- It is a 4 days meeting
- Hybrid meeting (virtual and in person)
- Participants
    - All Countries in Western Africa region
    - REC
    - Partners

Specific Objectives

- Engage the National Malaria Programmes and partners to review the progress, identify malaria programme implementation bottlenecks, challenges, share best practices and propose solutions in the context of COVID-19;
- Track progress and lessons learned in the process of the implementation of High Burden to High Impact approach, and continental wide campaigns such as Zero malaria starts with me;
- Track the impact of COVID-19 and the status of commodities availability and preparedness for 2022;
- Update on the latest developments in malaria;

Specific Objectives

- Update the country specific programmatic and financial gap analysis which will serve as tool for additional resource mobilisation including portfolio optimisation;
- Identify and prioritize the malaria program implementation bottlenecks for technical support during 2022/2023;
- Orientation on the next cycle of Global Fund application planning and support.
- Orient National Malaria Programmes, partners, CCMs and CSOs on community rights and gender approach and the malaria matchbox tool;

Methodology

- Technical updates from RBM and Partners
- Country presentations and discussions
- Updates on the next Global Fund application cycle
- Overall plenary sessions
- Planning Technical Assistance needs for 2022 and 2023
- Targeted sessions and one on one follow ups
- Orientation / training on Community, Rights and Gender /Malaria Matchbox

Outcomes

- Peer learning experiences and Best practices shared
- Updated on new developments and policy directions regarding malaria interventions, practices etc
- Updated on the direction and expectations for the next Global Fund application cycle which starts in 2023
- Identified the Technical Assistance needs for 2022 and 2023 and proritise those to be completed in 2022
- Orientated on Community, Rights and Gender /Malaria Matchbox and on how to mainstream this aspect in your plans

RBM Partnership
To End Malaria

Thank you

WHO Malaria Technical Updates

RBM/CRSPC National Malaria and Partners Annual Meeting (SARN)

Dakar, 26 July 2022

Dr. Peter OLUMESE,
Global Malaria Programme
WHO, Geneva, Switzerland.

Global **Malaria** Programme

World Health Organization

Estimated malaria cases & deaths (2020)

- **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 ≈ 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 comparted 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

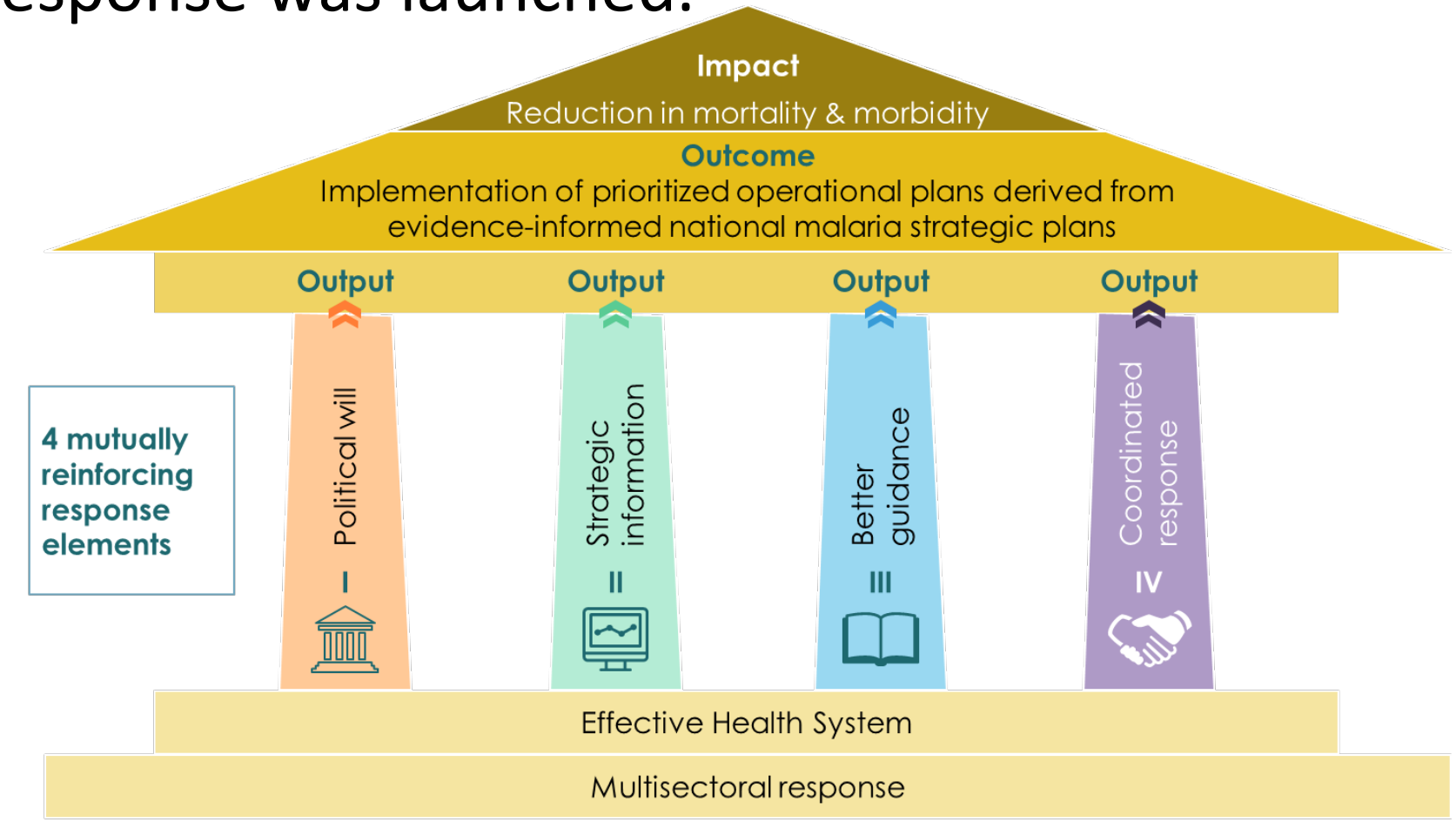
Global Technical Strategy for malaria 2016-2030

- Mortality reduction
  - 18% reduction achieved, but 22% off track
- Malaria cases
  - 3% reduction achieved, but 37% off track

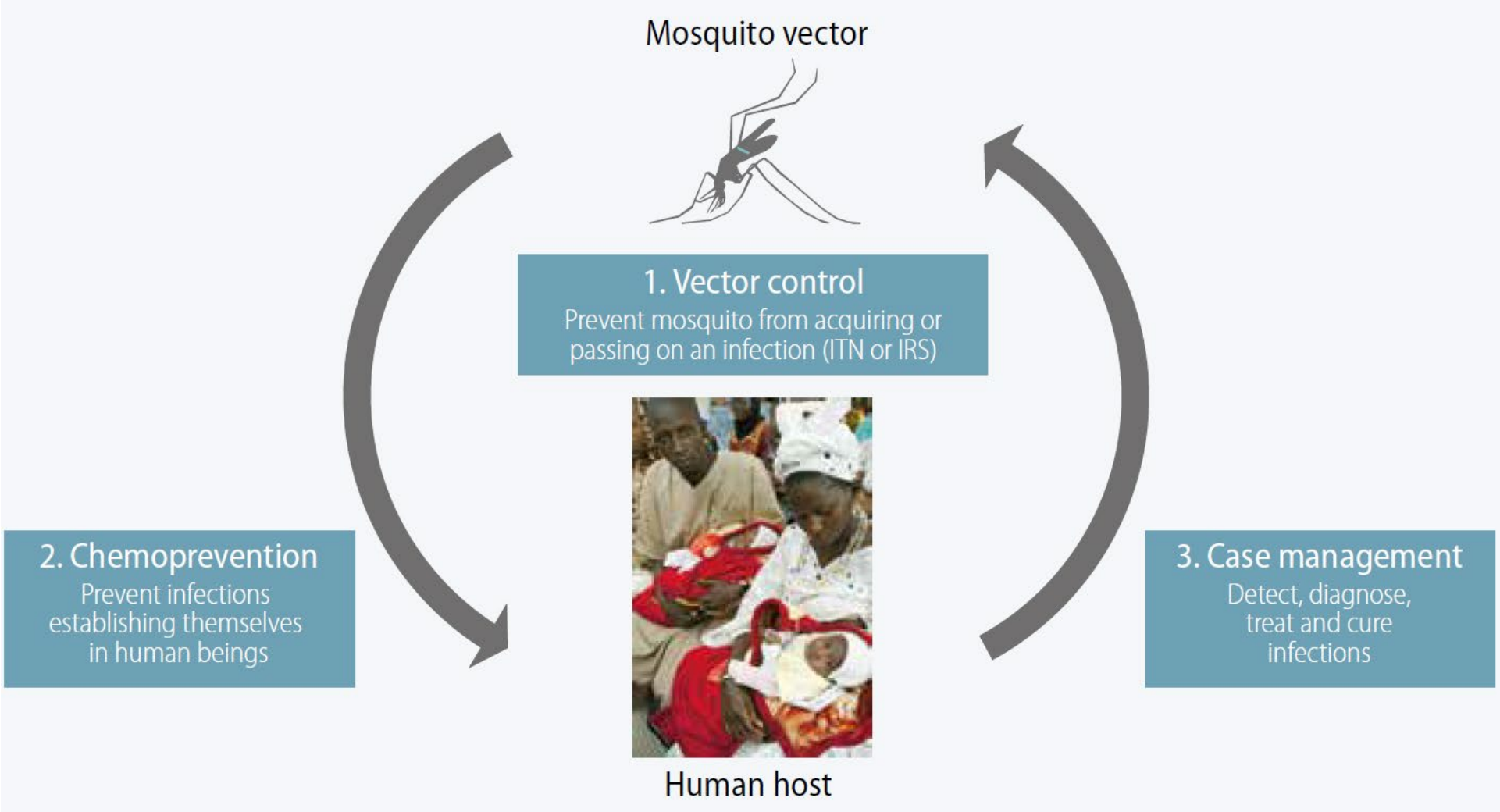
Off track to meet global targets

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::

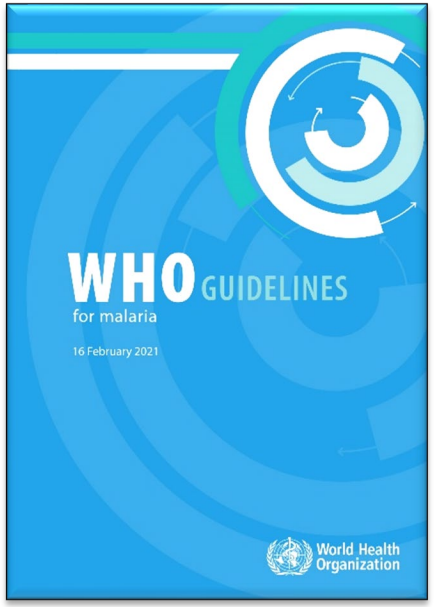
- Health facilities
- Community Case Management
- Private sector

Surveillance, M & E

- Routine HMIS
- Malaria surveillance and response systems
- Household surveys
- Health Facility Surveys

Strengthening health systems in endemic countries

Main malaria prevention and treatment strategies



- 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

Interventions recommended for large-scale deployment

- **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.

Interventions recommended for Humanitarian emergency

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.

Supplementary interventions

- **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.

Recommendations against use

- **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.

Potential risks associated with scale-back of vector

- 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

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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*

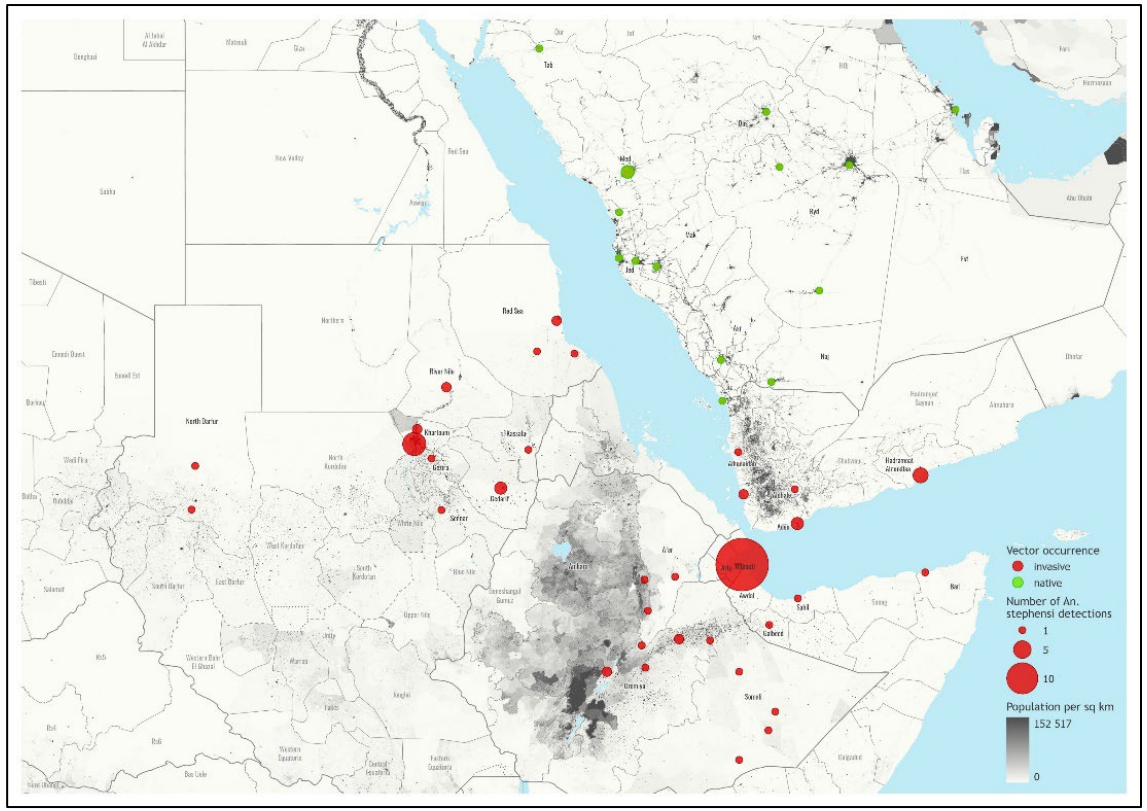
Receptivity *- ability of an ecosystem to allow transmission of malaria*

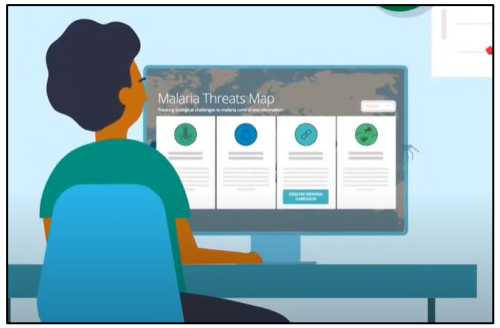
Vulnerability *- frequency of influx of infected individuals or groups and/or infective anophelines*

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/mkggjD0DKwY
Malaria Threats Map: supporting research efforts: https://youtu.be/VP-pc9oN0dM

Guidance & Communication Documents

Vector alert (2019; English, French, Arabic)

- https://apps.who.int/iris/handle/10665/326595


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 urbanisation. 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 Iran. Until 2015, the reported distribution of *An. stephensi* was confined to certain countries in South-East Asia and large parts of the Arabian Peninsula. Since then, the vector has been reported from Djibouti (2012), Ethiopia (2016), Sri Lanka (2017) and most recently from the Republic of the Sudan (2019). In the Horn of Africa, the vector seems to be spreading from its first site of detection (Djibouti) to neighbouring countries. *An. stephensi* typically breeds in containers or cisterns with clean water, and the vector appears to quickly adapt itself to the local environment (including cryptic habitats such as deep wells); it also survives extremely high temperatures during the dry season, when malaria transmission usually reaches a seasonal low. In addition, the genetic background of introduced *An. stephensi* seems to confer resistance to multiple insecticide classes, posing potential challenges to its control.

The World Health Organization (WHO) considers the spread of *An. stephensi* to be a major potential threat to malaria control and elimination in Africa and southern Asia. This vector alert has been developed to urge WHO Member States and their implementing partners – especially those in and around the Horn of Africa, the Republic of the Sudan and surrounding geographical areas, and in Sri Lanka – to take immediate action, as outlined below.

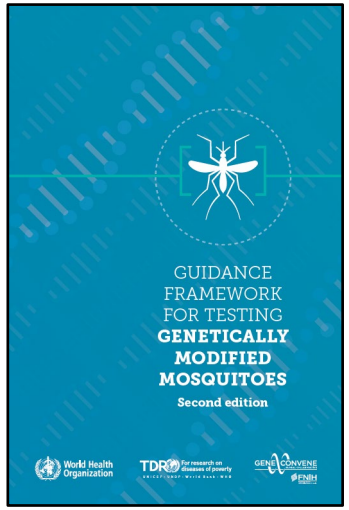
World Health Organization

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


GUIDANCE FRAMEWORK FOR TESTING **GENETICALLY MODIFIED MOSQUITOES**

Second edition

World Health Organization

TDR

GENEVA CONVENE

FNIH

World Malaria Report 2021

- Includes an annual *An. stephensi* update since 2019

Potential new interventions

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.*

Post-discharge malaria chemoprevention (PDMC)

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 *P. falciparum* burden reduction	New
MDA	Conditional, low-certainty	For	MDA in emergency settings for short-term *P. falciparum* burden reduction	New
MDA	Conditional, low-certainty	For	MDA to reduce *P. falciparum* transmission in very low to low transmission	New
MDA	Conditional, very low-certainty	Against	MDA to reduce *P. falciparum* transmission in moderate to high transmission	New
MDA	Conditional, very low-certainty	For	MDA with antimalarial medicine to reduce *P. vivax* transmission	New
MDA	Conditional, very low-certainty	Against	MDA with 8-aminoquinoline alone to reduce *P. vivax* 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

Components of malaria case Management

- Malaria diagnosis (clinical & parasitological confirmation)
- Prompt and effective treatment :
- Support intervention for effective case management
  - Monitoring resistance of antimalarial medicines (therapeutic efficacy monitoring)
  - Pharmacovigilance

Malaria Diagnosis

- 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.

Treatment of uncomplicated falciparum malaria

- 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 piperaquine; 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

Treatment of falciparum Malaria in special populations

- 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

Treatment of uncomplicated non-falciparum Malaria

- 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

PREVENTING RELAPSE IN *P. VIVAX* OR *P. OVALE* MALARIA

- 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

Severe malaria

- 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

Treatment of severe malaria

- 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

Treatment of 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

Community Case Management of Malaria

- 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.

Reviews and other issues in the pipeline

- 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 Pf*hrp* 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

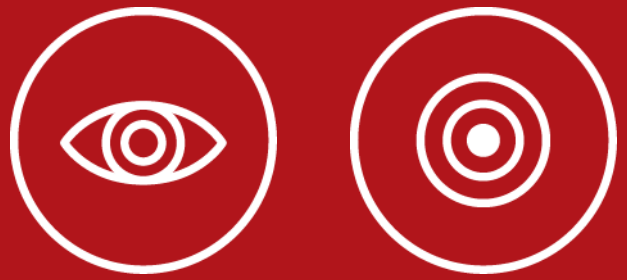
Malaria Elimination Guidelines

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

Conditional recommendation for

Conditional recommendation against

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

Surveillance for malaria

Strong surveillance enables programmes to optimise their operations, by empowering programmes:

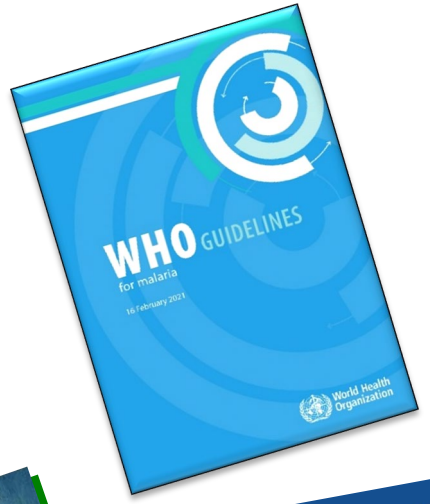
- To advocate investment from domestic and international sources, commensurate with the malaria disease burden in a country or sub-national level
- To allocate resources to populations most in need in order to achieve the greatest possible public health impact
- To access regularly whether plans are 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

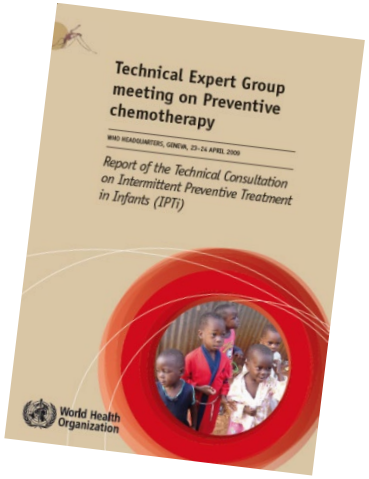
Malaria surveillance

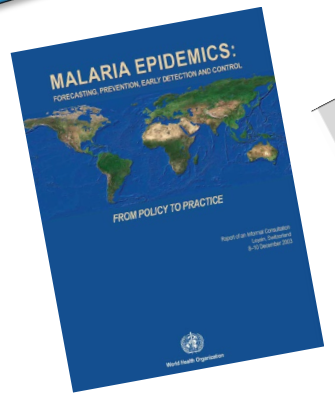
Pillar 3 of the GTS 2016-2030

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		


WHO GUIDELINES
for malaria
16 February 2021
World Health Organization


Technical Expert Group meeting on Preventive chemotherapy
WHO HEADQUARTERS, GENEVA, 23–24 APRIL 2009
Report of the Technical Consultation on Intermittent Preventive Treatment in Infants (IPTi)
World Health Organization


MALARIA EPIDEMICS:
FORECASTING, PREVENTION, EARLY DETECTION AND CONTROL
FROM POLICY TO PRACTICE


DISEASE SURVEILLANCE FOR MALARIA CONTROL
AN OPERATIONAL MANUAL


SEASONAL MALARIA CHEMOPREVENTION
WITH SULFADOXINE–PYRIMETHAMINE PLUS AMODIAQUINE IN CHILDREN
A FIELD GUIDE

Thank you

RBM Partnership
To End Malaria

Les Bonnes Pratiques du Malaria Matchbox
Le Processus & Mise en Oeuvre
Lessons des pays

Olivia Ngou, Specialist public health & community engagement & advocacy

The Malaria Matchbox

Le Malaria Matchbox vise à mettre en lumière les différents types d'obstacles auxquels les populations sont confrontées pour accéder et utiliser les services de lutte contre le paludisme, en particulier la prévention et le traitement.

Ces obstacles peuvent être **socioculturels, financiers, physiques ou liés à des questions de genre.** il est essentiel de faire en sorte que les besoins spécifiques des personnes correspondent aux **réponses au paludisme qui sont centrées sur la personne, basées sur les droits et sensibles au genre.**

Le Malaria Matchbox s'efforce d'accroître l'apprentissage et la collaboration entre les pays et les approches intégrées et multisectorielles qui contribueront à faire avancer l'agenda pour en finir avec le paludisme.

Les Bonnes Pratiques Malaria Matchbox dans les pays

Phase 0 | la planification

L’engagement des pays est essentiel – Leçons tirées

- **Veiller à ce que le projet soit piloté par le PNLP, dont le leadership et l'engagement en temps sont essentiels pour mener le processus et impliquer les parties prenantes ;** le chef du PNLP doit désigner un point focal au sein du PNLP pour le projet (Niger, Rwanda, Nigeria, Zimbabwe).
- **Mettre en place le comité de pilotage du projet avec des membres de divers secteurs pour assurer une approche multisectorielle :** Des représentants du gouvernement, du ministère de la Santé, du PNLP/NMEP, des ministères concernés tels que le ministère de la Femme et de la Famille, des partenaires de la santé, de l'OMS, du PMI, des agences des Nations Unies, de la société civile, des chercheurs et du secteur privé (Nigeria) ou **s'appuyer sur un comité de pilotage existant**, tel que celui de l'Instance de coordination nationale du Fonds mondial (Rwanda).
- **Recruter un consultant local en plus du consultant international, ayant une expérience dans des projets similaires de collecte de données pour soutenir le projet et collaborer avec le point focal et l'équipe du PNLP**.
- **Organiser régulièrement des réunions virtuelles ou en présentiel avec les membres du comité** de pilotage (par exemple : une fois par mois et selon les besoins) pour recueillir les commentaires, les recommandations, la validation à chaque étape (Nigeria, Rwanda, Zimbabwe - virtuellement via Zoom une fois par mois).

Phase 1: Phase de mise en oeuvre

The Rapport de demarrage (Revue de la littérature)

- **Les consultants effectuent une revue documentaire** afin de définir le contexte du pays et d'acquérir une compréhension initiale des déterminants de la santé, en particulier des services de lutte contre le paludisme ainsi que de la cartographie/identification des groupes les plus vulnérables**.**

- **Dans plusieurs pays, les rapports initiaux comprenaient** : la situation générale du paludisme, le contexte politique et les programmes du pays en termes de parité dans la lutte contre le paludisme et l'identification des inégalités dans la couverture des services de protection contre le paludisme.

- **La sélection des sources de données est essentielle :** Engagement des partenaires des PNLP et de la santé à fournir des rapports nationaux et des documents pertinents qui facilitent cette phase. Les documents peuvent inclure : Les PSNs, les rapports annuels des PNLP, les notes conceptuelles et les rapports sur le paludisme des NFM, les rapports des TRP, les EDS, les MIS/MICS, le recensement de la population et des habitations, la base de données sur l'équité en matière de santé de l'OMS, les bases de données communautaires

- **Le rapport initial fournit des recommandations préliminaires** et indique quelles sont les données manquantes dans l'étude documentaire, ainsi que les données à collecter pour répondre à la question sur l'évaluation.

Bonnes Pratiques |Collecte des donnees

La préparation est primordiale

- **Les outils de collecte de données ne doivent pas être longs ou complexes,** mais les questions doivent aller droit au but. Pour garantir la qualité des données, il convient de réduire le temps alloué aux personnes interrogées.

- **La qualité des données est cruciale** : la sélection des collecteurs de données et leur formation doivent être bien préparées.

- **Certains pays ont recruté des agents de collecte de données qui travaillent déjà avec les PNLP** et qui ont l'habitude de recueillir des données au niveau de la communauté, du district et du pays dans le cadre de projets liés au paludisme ou à la santé.

- **Les PNLP doivent présenter formellement agents de collecte de données à tous les groupes ciblés** qui participeront à la collecte de données afin de s'assurer de la disponibilité des personnes, des partenaires, des fonctionnaires et du personnel de santé.

- **L'engagement des dirigeants des OSC et des communautés** dans la mise en place des groupes de discussion est essentiel pour garantir une participation et une adhésion totales.

- **L'utilisation des langues locales** pendant les groupes de discussion permet un meilleur engagement des communautés. Le recours à des traducteurs peuvent être nécessaires dans certains cas.

Bonnes Pratiques | Analyse des donnees

Il s'agit d'une évaluation QUALITATIVE

- Il est important de suivre les meilleures méthodes d'analyse pour ce type d'évaluation, l'outil Malaria Matchbox propose une série de méthodologies.
- Les données doivent être synthétisées, validées et les obstacles identifiés et documentés. Un guide est disponible dans l'outil Malaria Matchbox.
- L'analyse peut être effectuée par les consultants (de nombreux pays ont utilisé cette approche).
- L'analyse peut être effectuée par les consultants avec l'implication des collecteurs de données ou des partenaires désignés dans les groupes de travail (Zimbabwe).
- Le rapport d'analyse des données doit être revu par le comité de pilotage et par le PNLP pour commentaires avant la finalisation.
- L'analyse des données doit présenter les faits, les principaux résultats et proposer des recommandations clés sur la manière d'éliminer les obstacles identifiés.

Quelques Exemples de resultats issus de l’analyse des donnees du Matchbox dans les pays

Defis et lacunes des programmes actuels

- **L'engagement insuffisant des PDI et des réfugiés (eux-mêmes)** dans la conception et la mise en œuvre des interventions contre le paludisme : Peu, voire aucun participant déplacé ou réfugié n'a évoqué son implication dans l'élaboration ou la mise en œuvre des interventions contre le paludisme**.**

- **Engagement limité ou inexistant des guérisseurs traditionnels dans la prévention et le traitement du paludisme :** Les résultats de l'évaluation ont été très clairs sur les préférences des PDI et des réfugiés pour les remèdes traditionnels et les guérisseurs traditionnels comme interlocuteurs privilégiés en cas de maladie (pour toutes les maladies et non pas seulement le paludisme).

- **Des efforts insuffisants pour lever les obstacles linguistiques et culturels aux activités d'information et de sensibilisation relatives au paludisme :** Parmi les réfugiés, un certain nombre de participants ont évoqué les barrières linguistiques comme l'un des principaux facteurs du faible niveau de connaissance et de sensibilisation aux risques du paludisme.

- **Une absence d'intégration et de coordination entre les secteurs de la santé et de l'humanitaire :** Comme l'a noté le rapport d'évaluation, malgre le fait qu’un grand nombre et une variété tout aussi grande d'acteurs gouvernementaux et non gouvernementaux sont impliqués, La coordination et la collaboration restent inégales, y compris entre les entités nationales et étatiques**.**

Defis et lacunes des programmes actuels

- **Une proposition limitée des methodes de prévention et de contrôle du paludisme :** Comme l'illustrent les résultats de l'évaluation, la fourniture de MILD reste la principale stratégie de prévention du paludisme, malgré les difficultés que cela soulève pour les populations mobiles ou instables vivant dans des endroits où les abris sont inadéquats.

- **Des ressources limitées par rapport aux besoins de la population :** De nombreux participants ont noté le défi que représente le manque de ressources nécessaires pour répondre de manière adéquate aux besoins des deplaces internes et des réfugiés. Ceci inclut la couverture des interventions de base telles que les MILD, mais aussi des réponses adaptées qui sont plus spécifiques aux PDI ou aux réfugiés : ex. moustiquaires, programmes SBCC dans leurs langues locales.

- **Une attention insuffisante à l'influence du genre et des normes de genre :** Alors que de nombreux participants, en particulier les informateurs clés des organisations ou les prestataires de services, ont pu décrire l'influence du genre et des normes de genre sur les interventions de prévention et de contrôle du paludisme, peu d'entre eux, voire aucun, n'ont parlé des moyens de remédier à ces effets.

Analyse des obstacles liees a l’equite

- Défis liés aux connaissances générales, aux attitudes et aux pratiques des desplaces internes et des réfugiés en ce qui concerne le paludisme, y compris les questions de langues ;

- Attitudes et croyances négatives spécifiques concernant les interventions contre le paludisme, en particulier les moustiquaires imprégnées d'insecticide à longue durée d'action (MILD) ; par exemple, la couleur de la moustiquaire, le fait d'être piégé ou le risque de suffocation ;

- Tendances liées aux croyances traditionnelles qui affectent l'accès aux FOSA;

- Accessibilité physique et financière pour les déplacés internes et les réfugiés ;

- Expériences négatives des les déplacés internes des réfugiés avec les établissements de santé ; les communautés ne se sentent pas bien accueillies.

- L'influence des normes de genre sur l'accès des femmes et des enfants aux services de lutte contre le paludisme, y compris la violence sexuelle et sexiste ; et

- D'autres facteurs environnementaux, notamment les tensions entre les personnes déplacées, les réfugiés et les communautés environnantes.

ANALYSE DES DONNEES ET PROPOSITIONS DES INTERVENTIONS A MENER

Obstacle à l'équité	Recommandations préliminaires
Aborder l'influence des normes de genre	▪ Par le biais d'interventions de mobilisation communautaire, engagez les leaders parmi les les déplaces internes à promouvoir les services de lutte contre le paludisme et à combattre les mythes et les idées fausses sur la résilience des hommes au paludisme.
	▪ Renforcer les efforts visant à intégrer les éléments de prévention et de lutte contre le paludisme dans les efforts déployés pour atteindre les femmes et les enfants dans les contextes humanitaires pour répondre à leurs besoins en matière de santé et de survie.
	▪ Travailler avec les communautés de déplacés internes et de réfugiés pour trouver des solutions aux préoccupations concernant le genre des travailleurs de la santé (communiquer les horaires lorsque les femmes sont de service, par exemple ; recruter des femmes comme travailleuses communautaires).
	▪ Revoir les stratégies, les politiques et les directives relatives à la prestation de services de lutte contre le paludisme dans les situations de conflit et pour les personnes déplacées et les réfugiés, afin de s'assurer qu'elles tiennent compte de tous les aspects du genre et de son influence sur l'adoption, la couverture et l'efficacité des interventions contre le paludisme.
Contrôle et responsabilité	▪ Améliorer la disponibilité de données désagrégées sur les efforts de prévention et de contrôle du paludisme dans certaines régions.
	▪ Améliorer la sensibilité et la spécificité des systèmes de suivi actuels pour évaluer les progrès réalisés dans la réduction ou la suppression des obstacles à l'équité pour les personnes déplacées et les réfugiés.

PROPOSITIONS DES INTERVENTIONS A MENER

Obstacle à l'équité	Recommandations préliminaires
Barrières socioculturelles et linguistiques	▪ Recruter des agents de santé communautaires parmi les personnes déplacées et les réfugiés ; leur dispenser une formation et un encadrement en matière de prévention et de lutte contre le paludisme ; les déployer pour travailler dans les camps et les communautés d'accueil.
	▪ Engager les membres des camps de déplacés et de réfugiés à participer à la conception et à la mise en œuvre des interventions de CCC
	▪ Veillez à ce que les interventions de CCC Intègrent et traitent les attitudes et croyances problématiques concernant la prévention du paludisme, en particulier les MILD.
Croyances et pratiques traditionnelles pour le traitement du paludisme et faible connaissance du paludisme	▪ Travailler avec les guérisseurs traditionnels, les herboristes et les vendeurs locaux pour les impliquer dans la prévention et le contrôle du paludisme, y compris le soutien aux références des établissements de santé.
	▪ Dans le cadre d'interventions de CCC adaptées, abordez les croyances et pratiques néfastes concernant la prévention et le contrôle du paludisme, en particulier pour les femmes et les jeunes enfants.
	▪ Encouragez les prestataires de soins de santé à respecter les pratiques traditionnelles tout en promouvant la nécessité de se rendre également dans les établissements de santé pour un diagnostic et un traitement rapides du paludisme.

PROPOSTION DES INTERVENTIONS A MENER

Obstacle à l'équité	Recommandations préliminaires
Barrières physiques et écologiques (y compris la prévention et la sécurité)	▪ Entreprendre un travail de mobilisation communautaire dans les camps de déplacés et de réfugiés afin de promouvoir l'appropriation par la communauté d'un environnement sûr et sécurisé. ▪ Intervenir auprès des autorités locales, y compris les forces de protection, les agences humanitaires et autres, pour attirer l'attention sur les problèmes de sûreté et de sécurité et les résoudre.
	▪ Renforcer la fourniture d'interventions de prévention et de contrôle du paludisme dans les communautés, notamment par le biais de modalités de sensibilisation mobiles.
	▪ Développer les alternatives aux MILD pour une prévention et un contrôle efficace du paludisme parmi les populations mobiles et celles vivant dans des abris temporaires.
Obstacles financiers	▪ Dans le cadre des interventions de CCS, fournissez des informations sur les services gratuits de lutte contre le paludisme et sensibilisez les gens aux frais d'utilisation illicites et autres frais inappropriés pour les produits de prévention et de traitement du paludisme.

Engagement les parties prenantes Elaboration du plan d’action national

Participation des parties prenantes a l’atelier national

Cette phase permet une approche multisectorielle pour définir des réponses adaptées aux défis et obstacles identifiés dans le rapport d'analyse des données.

- Le PNLP, avec le soutien des consultants, organise un atelier de 3 à 5 jours avec des participants clés des niveaux national, régional, du district et de la communauté.
- Il est essentiel d'inclure des représentants de la communauté dans les ateliers, en particulier des groupes les plus vulnérables identifiés ou qui ont pris part aux évaluations.
- Inclure divers partenaires de divers secteurs et ministères connexes (exemple : Ministère des femmes et des familles, de l'environnement, de l'agriculture, du travail, etc.)
- Organisations ou agences/ONG/OSC travaillant avec les groupes vulnérables.
- Partenaires techniques et financiers de la lutte contre le paludisme
- PR, SR, SSR sur le paludisme
- Experts en droits de l'homme et en genre

Le plan d’Action national

- Décrit les défis et les obstacles identifiés par les groupes vulnérables
- Propose des interventions/actions clés pour réduire ces obstacles
- La période de mise en œuvre de ces actions
- Le coût de chaque intervention
- Les parties qui peuvent soutenir ces interventions ou les inclure dans leur travail actuel ou leur source de financement

Apres la mise en oeuvre du Mathcbox

NIGERIA Quelques Feedback

- L'évaluation de Malaria Matchbox a permis de développer un plan d'action pour combler les lacunes dans l'accès des personnes déplacées aux services de lutte contre le paludisme.

- Cette évaluation a atteint son objectif car elle a permis d'identifier la vulnérabilité au paludisme liée à l'équité, d'évaluer les effets des barrières liées à l'équité sur l'accès, l'utilisation et la pérennisation des services de paludisme parmi la population marginalisée (principalement les personnes déplacées).

- Elle a également été en mesure d'évaluer les interventions et les efforts déjà mis en œuvre pour réduire ces obstacles et s'est efforcée d'identifier les possibilités de renforcer davantage ces interventions.

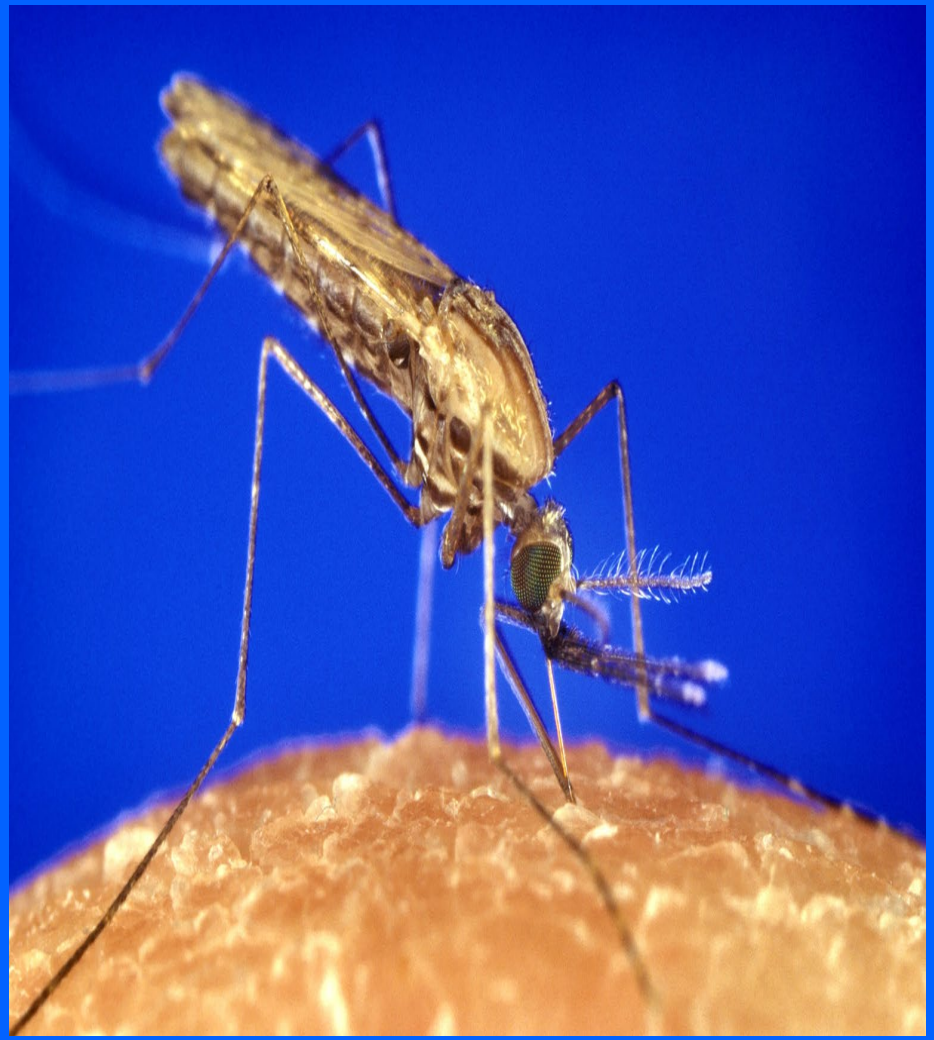
- L'évaluation du coût des interventions a été un défi, car elle nécessitait des informations exhaustives en provenance du terrain et d'autres facteurs à évaluer et à prendre en compte.

Data Initiative & Global Malaria Dashboard updates

RBM Partnership To End Malaria

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

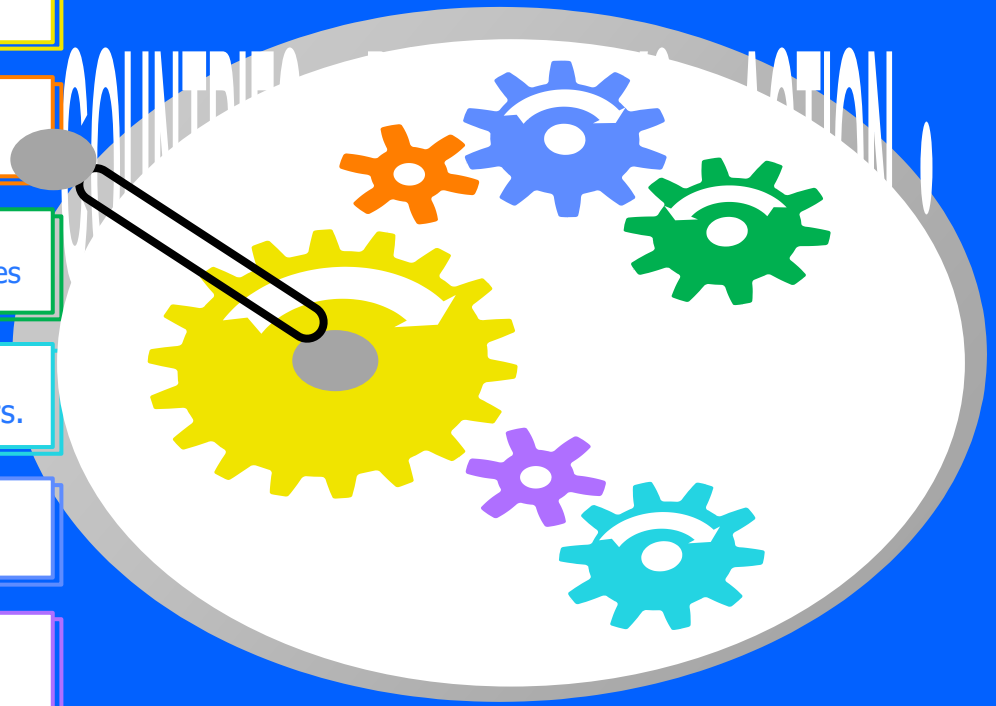
Data ownership
Respect country data ownership

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

- **Campaigns**
  - IRS
  - LLIN (real time)
  - SMC
- **Supply Chain**
  - Current stock
  - Pipeline
- **Programmatic & Financial GAPS**
  - NSP
  - Diagnostic
  - Vector Control
  - Chemoprevention
- **Technical Assistance**
  - Online apply
- **Short Term Commodities Forecasting (CHAI)**
  - Malaria Surveillance Projects (SMERG)
- **Global Fund**
  - Global Disbursements
  - Country
- **Epidemiology**

All data here publicly available (registration needed)

- **Updated Quarterly**
- **Real Time**
- **Yearly/On demand**

Coming Next

International Research Institute for Climate and Society
Earth Institute | Columbia University

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

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RBM Partnership To End Malaria

Vector Control Working Group

July 28th 2022

Updates from Vector Control Working Group:

Including new tools and threat of *Anopheles stephensi*

VCWG Co-Chairs and Secretariat
(Corine Ngufor, Justin Mcbeath and Konstantina Boutsika)

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Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Agency for Development and Cooperation SDC

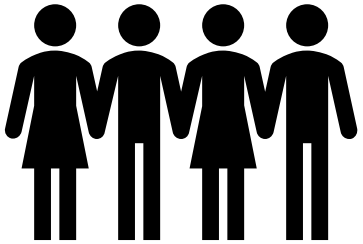
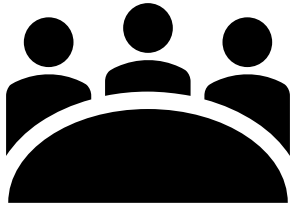
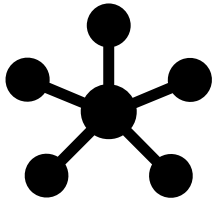
The coordination of the VCWG is secured by the Swiss Agency for Development and Cooperation (SDC) funds through the GlobMal project at Swiss Tropical and Public Health Institute

https://endmalaria.org/our-work-working-groups/vector-control

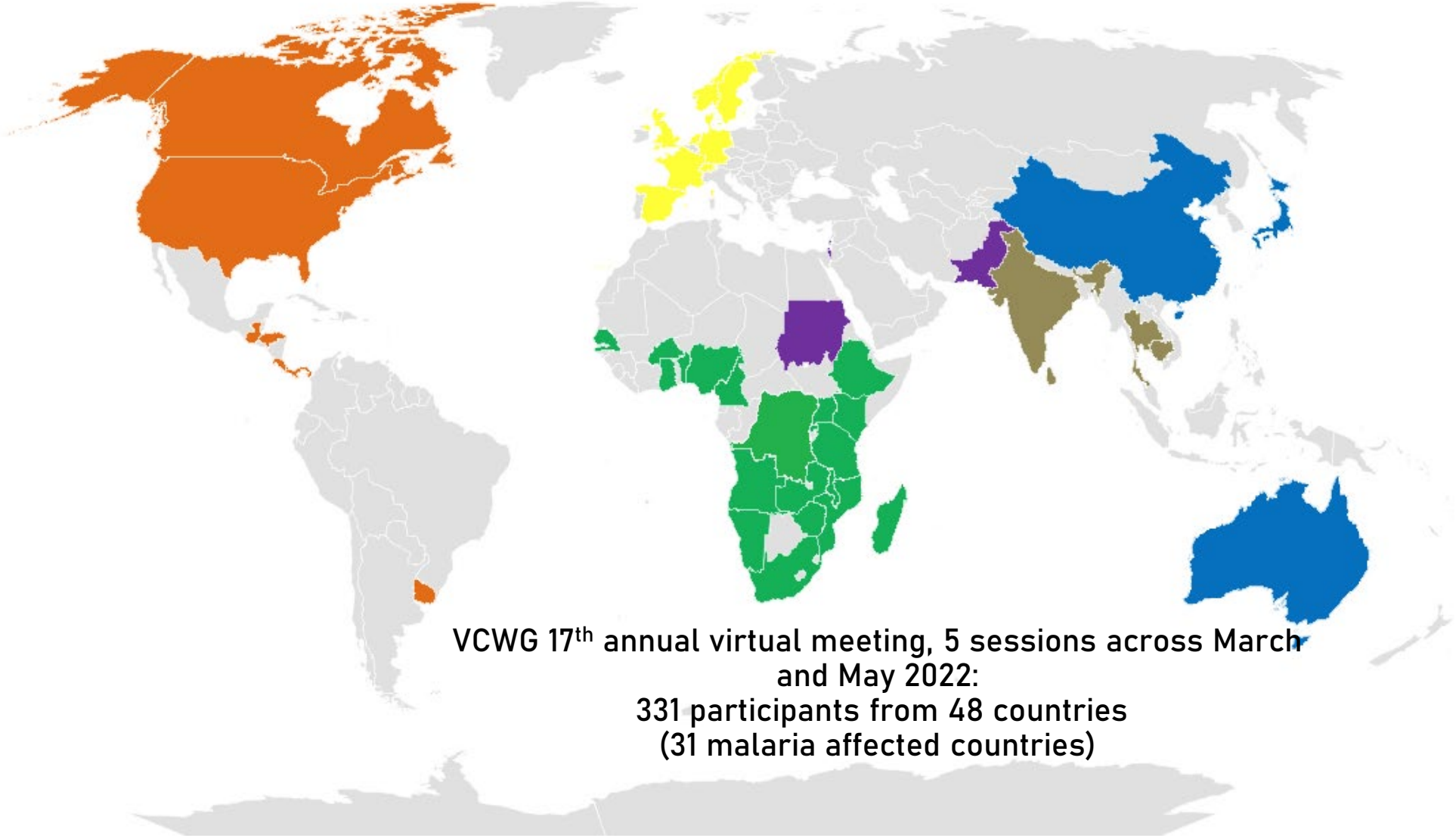
Objectives of the Vector Control Working Group

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 Reach – virtual annual meetings 2022



VCWG 17th annual virtual meeting, 5 sessions across March and May 2022:
331 participants from 48 countries
(31 malaria affected countries)

https://endmalaria.org/our-work-working-groups/vector-control

RBM Partnership To End Malaria

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Vector control

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.

Co-Chairs

Dr Corine Ngufor LSHTM/CREC, UK & Benin
Mr Justin McBeath Bayer, United Kingdom

Working Group Secretariat

Dr Konstantina Boutsika Swiss TPH, Switzerland

Related content

17th annual meeting of the Vector Control Working Group
16th annual meeting of the Vector Control Working Group
Vector Control in Humanitarian Emergencies
15th annual meeting of the Vector Control Working Group

VCWG is organized around 3 workstreams; each with three themes of output. Task Teams focus on topics under each of these themes in each Workstream

WS 1: Enhancing the Impact of Core Interventions

WS 2: Expanding the Vector Control Toolbox

WS 3: Implementing the Global Vector Control Response

1. Identify gaps, capacity needs and research priorities
2. Policy clarification and evaluation pathways
3. Operational scale up and support

Specific workplans for each workstream

WS1: Enhancing the Impact of core interventions (LLINs and IRS)

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Mary Kante, Eauclaire consulting; mkante@eauclaireconsulting.co

2030 Vision of success – key points

Effective ITNs and IRS available

- Ability to collect and interpret data to make robust product choice decisions
- Dual-AI LLIN availability
- Robust supply chains for new ITNs and IRS
- More durable nets
- Providing nets on schedule

Threats of Insecticide resistance

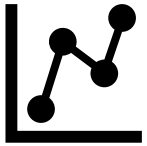
- Better understanding of IRM and how to respond
- Improved methods of vector identification
- Enough Modes of Action for IRS rotations
- Effective management of IR

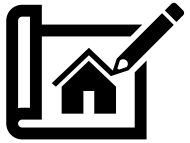
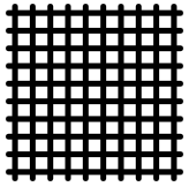
Sustainability

- Domestic funding
- Human centred design in manufacture of ITNs and IRS
- NMCPs taking a lead role to develop guidance and best practices
- Local manufacturing, enterprising and better waste management

Workstream 1:
Enhancing the Impact of core interventions (LLINs and IRS)

Task Team 1	Task Team 2	Task Team 3	Task Team 4
▪ Using data to inform optimal selection of core interventions. ▪ Lead: Sarah Burnett, PATH	▪ Addressing biological threats; new insecticides for vector control (for IRS and ITNs) ▪ Leads: Christen Fornadel, IVCC and Julia Mwesigwa, PATH	▪ Capacity building, localization, and private sector involvement for sustainable vector control ▪ Leads: S. Asiedu, AGAMAL and M. Chouaibou, PSI	▪ Addressing non-biological threats: ITN quality, access and use, durability/replacement ▪ Leads: TBD



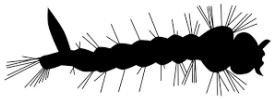



Workstream 2: Expanding the vector control toolbox

Co-leads:
Sheila Ogoma, VectorLink
Derric Nimmo, IVCC: derric.nimmo@ivcc.com

Three current task Teams

Task Team 1	Task Team 2	Task Team 3
▪ Larval Source Management ▪ Leads: Jennifer Armistead, PMI and Prosper Chaki, IHI / PAMCA	▪ Innovations in vector control and surveillance ▪ Leads: TBD	▪ Anthropology and Human Centered Design ▪ Leads: April Monroe, JHUCCP



WS2: Task Team 1 - Larval Source Management : (Jen Armistead and Prosper Chaki)

Priorities for 2022:

Gather and consolidate existing knowledge and gaps pertaining to LSM implementation:

- ✓ Tools for habitat characterization and coverage
- ✓ Larvicide delivery (conventional vs aerial)
- ✓ Product optimization (residual effect, cost, cost-effectiveness)
- ✓ Implementation framework and tools
- ✓ Monitoring and evaluation framework and tools

Conduct a landscape analysis to:

- ✓ Identify countries currently implementing LSM
- ✓ Highlight challenges, success stories, and best practices, with special attention to use of drones/AI technology
- ✓ Identify and document perspectives from current and potential funders/stakeholders

Organize convenings for LSM stakeholders, including national programs, researchers, donors, private sector, etc.:

- ✓ Webinar
- ✓ PAMCA symposium (September, Rwanda)
- ✓ ASTMH symposium (IVCC) and/or side meeting (November, Seattle)
- ✓ Knowledge exchange between countries and regional bodies (APMEN, PAMCA, AMCA, Mosquito Abatement Districts)

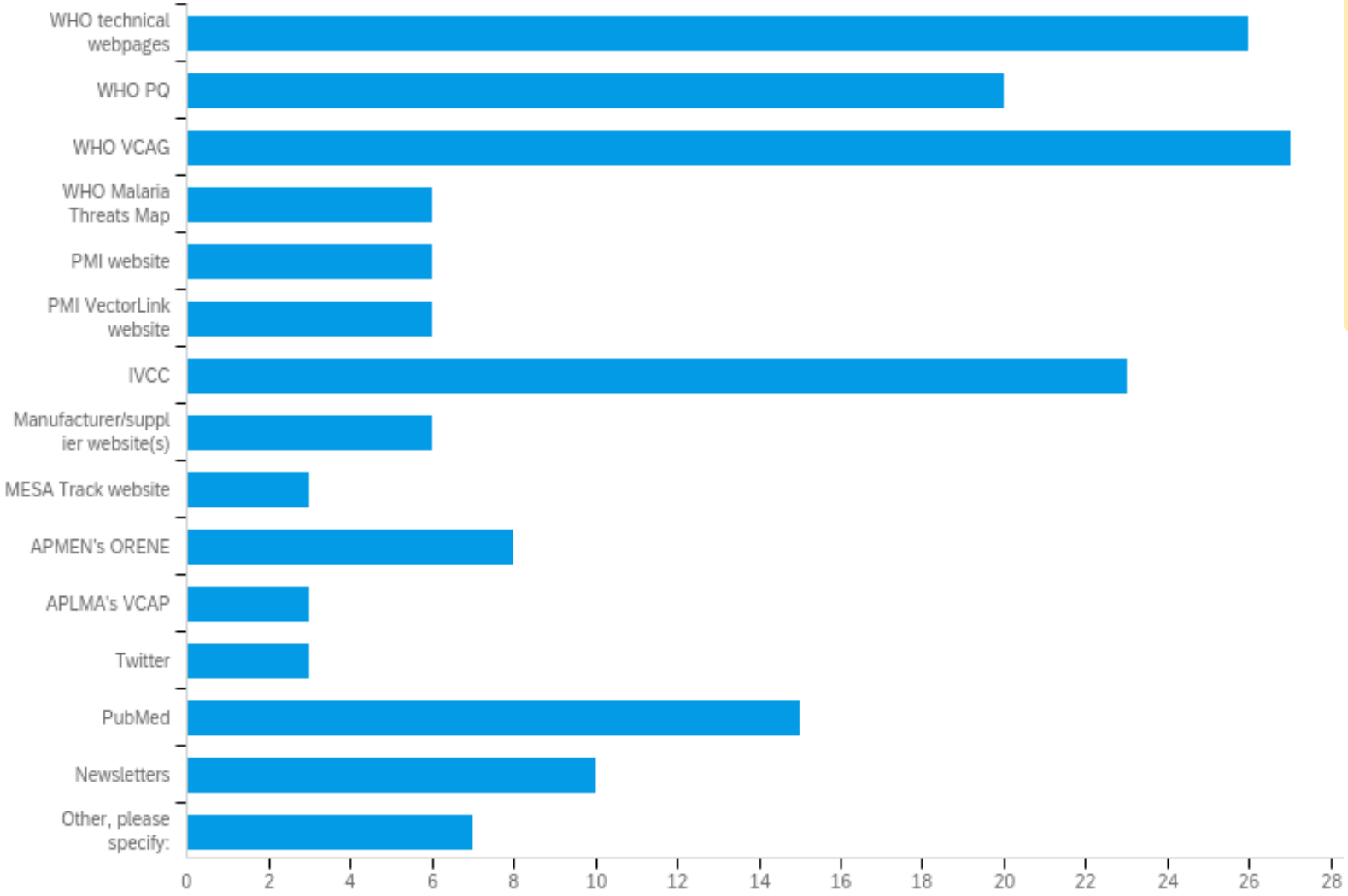
WS2: Task 2 – Innovations in vector control

- <u>Objectives of Task Team</u>

  - Develop and maintain an inventory of new vector control tools

  - Develop framework for actively sharing updates on new tools including VCAG updates

  - Elevate NMCP operational research questions for VC beyond ITNs and IRS



There are a range of different vector control innovations currently under development or evaluation

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

Many of them are dramatically different from current core interventions e.g. Attractive targeted sugar baits.

VCWG role in supporting the visibility of such new tools and facillitating dialogue which supports their optimized introduction.

Westham Co – Attractive targeted sugar bait (ATSB)

- 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.

WS 2: Task Team 3 - Anthropology and Human Centred Design

For a tool to be successful, the affected population must perceive benefit, believe in it and adopt it

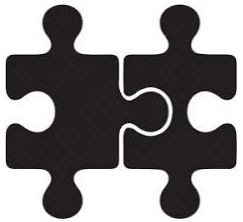
Objectives

- Provide platform for engagement and exchange among professionals and groups working on vector control and human behavior
- Document lessons learned, best practices, and information gaps for considering human behavior in vector control
- Support opportunities to expand understanding and application of human-centered approaches among professionals and organizations working in the vector control field

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

Task Team 1	Task Team 2	Task Team 3
▪ Integrated Vector Management ▪ Leads: TBD	▪ Capacity and collaboration ▪ Leads: TBD	▪ Anopheles stephensi response ▪ Leads: TDB



In response to requests from our members VCWG convened *An stephensi* focus meetings in Dec 2021 and Feb 2022; purpose of 'landscaping' and identifying gaps.

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 complement activities of other groups without overlaps?

Objectives of Meeting 2

- Insights from Asian countries.
- Identify research and product development gaps
- Explore Multi Sectoral Working Group (MSWG) linkage
- Identify potential actions

Outcome of VCWG focus meetings on *An stephensi* threat

	Key areas identified	Observations from VCWG An stephensi meetings	VCWG support activities	Status
1	Capacity building	➢ Need to enhance surveillance system capacity to detect the extent of the threat.	✓ Increase visibility of capacity building efforts already underway by other organisations (e.g. WHO, PMI etc)	▪ Targeting partners with online inventories of training courses covering *An stephensi* e.g GVH, PAMCA etc
2	Research	➢ 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.	✓ Identify research gaps and support broader visibility of research groups working on this topic and their findings.	▪ Working with MESA-track and Academia ▪ Organise webinars to share research results when they become available e.g CEASE project
3	Coordinated action	➢ Need for support 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	✓ Develop a VCWG led consensus statement which is signed onto by key organisations as a complement to other visibility initiatives. ✓ Encourage higher level political motivation to recognize the urgency and mobilise alternative funding sources beyond malaria vector control. ✓ Engage other sectors beyond health and Vector Control (linkage to MSWG)	• <u>Consensus statement underway, led by VCWG and supported by key members/partners</u>
4	Innovative approaches	➢ More guidance needed on suitability of interventions beyond LLINs and IRS	✓ Identify tools/approaches which are relevant to tackling An. stephensi. ✓ Obtain insights from Asian countries dealing with this problem; share across VCWG Membership. ✓ Explore possibilities of dealing with this as an invasive species – what lessons learnt from this type of threat?	▪ Working with partners from India and Sri Lanka to compile and share any existing guidelines. ▪ Identifying other invasive species groups that may have valuable insights to share.

WS3: Capacity and Collaboration

Massive Open Online Course – Insecticide Resistance Management

The Resistant Mosquito: Staying Ahead of the Game in the Fight against Malaria

- Starting date: Monday 25 July 2022
- FutureLearn link https://www.futurelearn.com/courses/the-resistant-mosquito-staying-ahead-of-the-game-in-the-fight-against-malaria
- Free participation (click on Join with limited access)
- Duration: 3 weeks

- We recommend sign up from 25th July onwards. You have three weeks free access window from the date you sign up!

- After Monday 15 August please use the Tales link (for free) https://tales.nmc.unibas.ch/en/the-resistant-mosquito-43/

- 42 steps; various formats/activities (e.g. video/article/quiz/ etc)
- Case studies from Ghana, Tanzania, Zambia, Sri Lanka.
- Trailer (2 min 39 sec) on YouTube https://www.youtube.com/watch?v=ZrsRrWyY184

- For questions: konstantina.boutsika@swisstph.ch

Join our Massive Open Online Course

University of Basel Swiss TPH

Funded by IVCC

Funded by UKaid from the British people

RBM Partnership
To End Malaria

Thank you, find out more visit endmalaria.org @EndMalaria

World Health Organization

Plans for rolling out the malaria vaccine

West Africa National Malaria Programmes and Partners Annual Meeting, Dakar, Senegal, 26- 29 July 2022

WHO recommendation on use of the first malaria vaccine

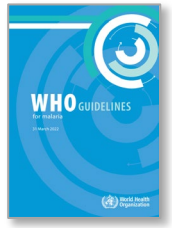
World Health Organization

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/WER9709



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

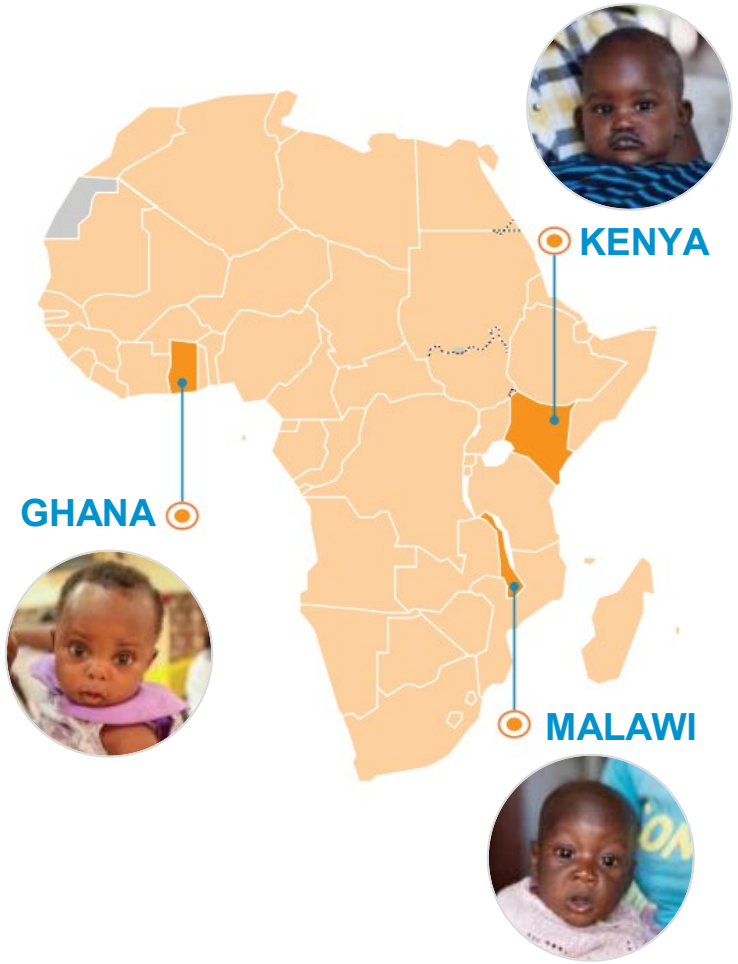
Malaria Vaccine Implementation Programme
https://www.who.int/initiatives/malaria-vaccine-implementation-programme

NITAG Resource center
https://www.nitag-resource.org/

Summary findings from the ongoing Malaria Vaccine Implementation Programme (MVIP)

World Health Organization

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

** 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*

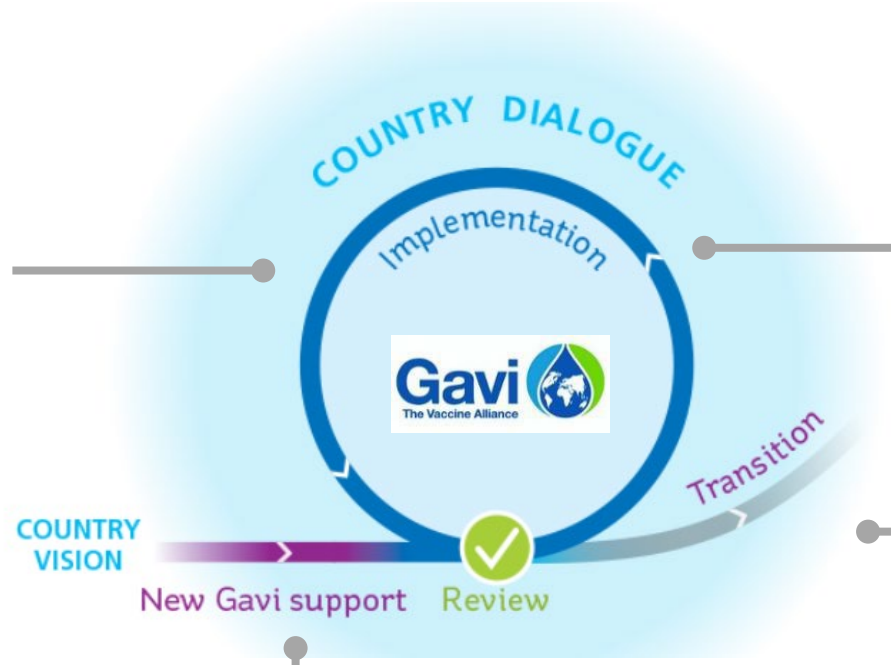
- December 2021: **Gavi Board approved support for a malaria vaccine programme** for eligible countries
- **Gavi Support guidelines available here:** French / English
  - General Gavi requirements for new vaccine support apply, including co-financing*
  - Some additional malaria vaccine programme requirements [available in the **Gavi Vaccine Funding Guidelines** – French p.37 / English, p.31], for example:
    - Role of the vaccine within comprehensive malaria control strategy and sub-national stratification of areas according to categories of need in the Framework for allocation of limited supply (to be described in addendum)
- Application deadlines: 13 September for pilot countries and Expression of interest (EOI) for all other countries; January 2023; subsequently usually three times per year (available here)
- Information on supply and price expected upon completion of UNICEF's first malaria vaccine tender (coming weeks)

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**

Framework for the allocation of limited malaria vaccine supply

Available on WHO website

Governance principles

Transparency

Inclusiveness & participation

Accountability

Ethical principles for allocation

First priority principle: Greatest need
Allocate the vaccine to countries with areas of greatest need, where the malaria disease burden in children and the risk of death are 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 MVIP countries: MVIP 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:
Initially, if there are unmet vaccine requests for greatest need (category 1) areas across multiple countries, no single country should receive more than 20% of the total available supply

Key implications for countries

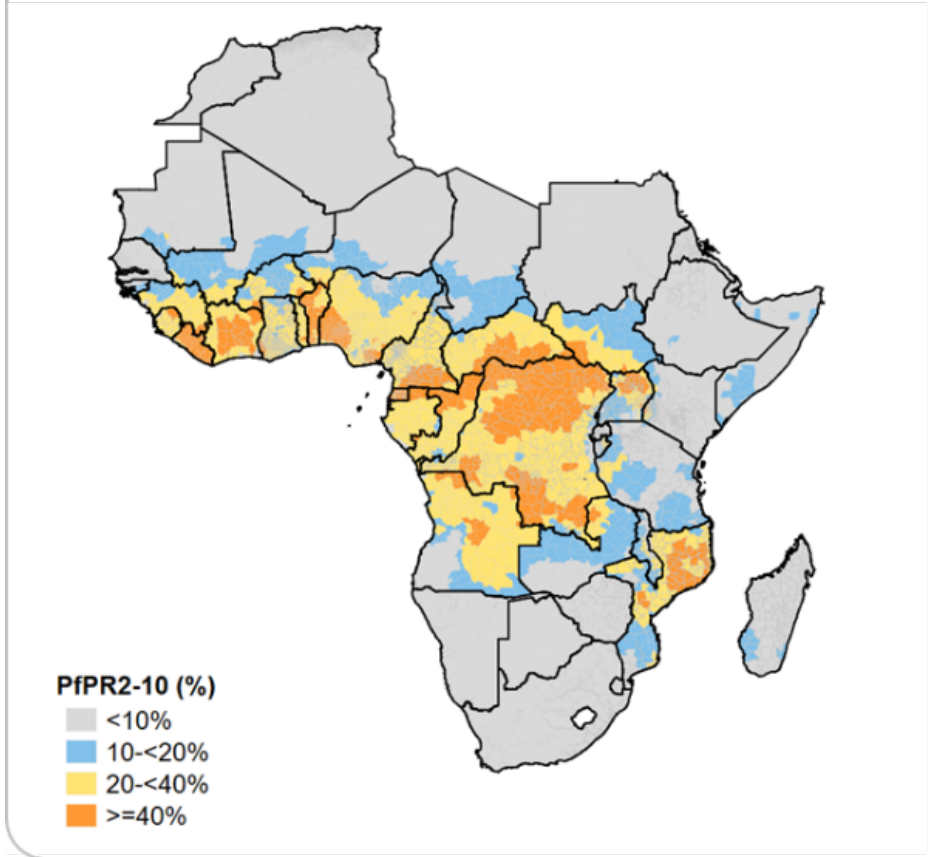
World Health Organization

- No country is excluded by the Framework (no *a priori* list of eligible countries).
- All countries will have to consider a phased approach to vaccine implementation, starting in areas with highest need, with expansion after supply increases.
- For the application to Gavi:
  - Countries, including countries participating in the MVIP, will be invited to present the **full scope** of desired vaccine roll-out in regions with moderate to high transmission (i.e. supply-unconstrained).
  - **Present a sub-national stratification of areas according to the categories of need** in the Framework, based on best available local evidence.
  - Provide more details on the proposed **scope of the first phase** of vaccine roll-out that would be implemented in greatest need areas while there is limited supply.
- To help manage expectations and support decision-making and planning, countries will be informed through a dialogue about the potential initial allocation quantities.

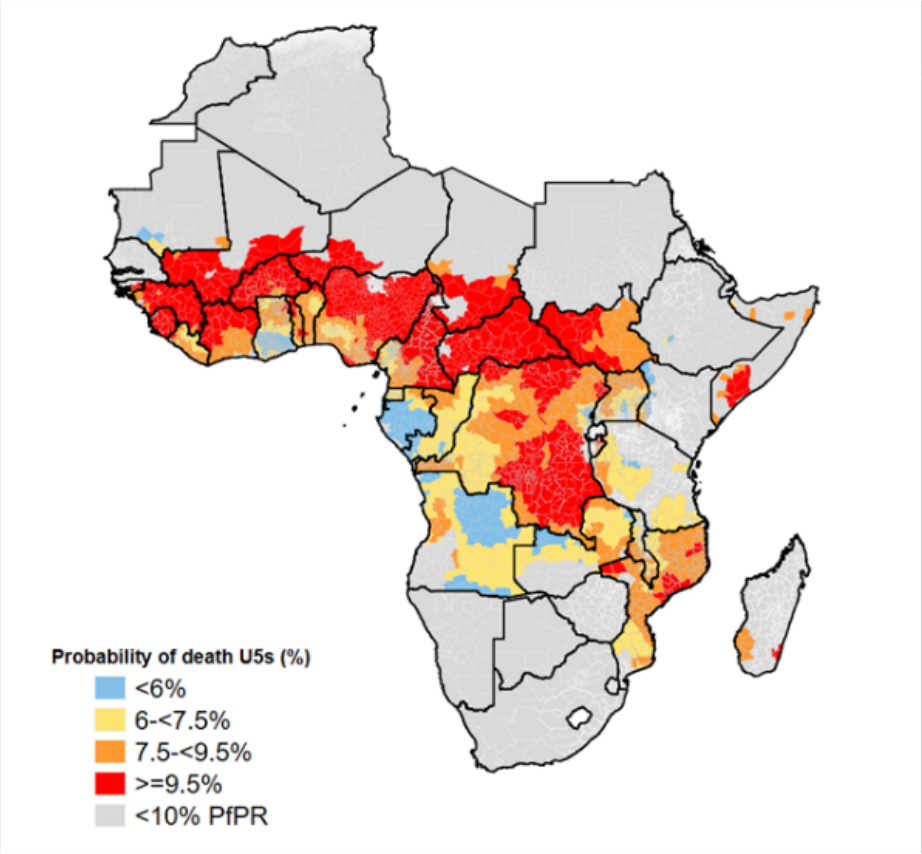
Illustration of "need" classification

World Health Organization

Estimated prevalence of *P. falciparum* infections in children aged 2-10 years

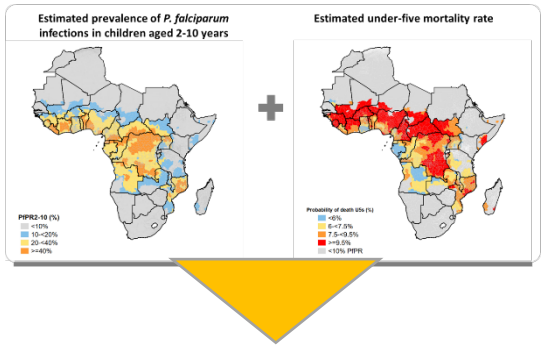


Estimated under-five mortality rate



Sources:
District level mean estimates of *Pf*PR 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



World Health Organization

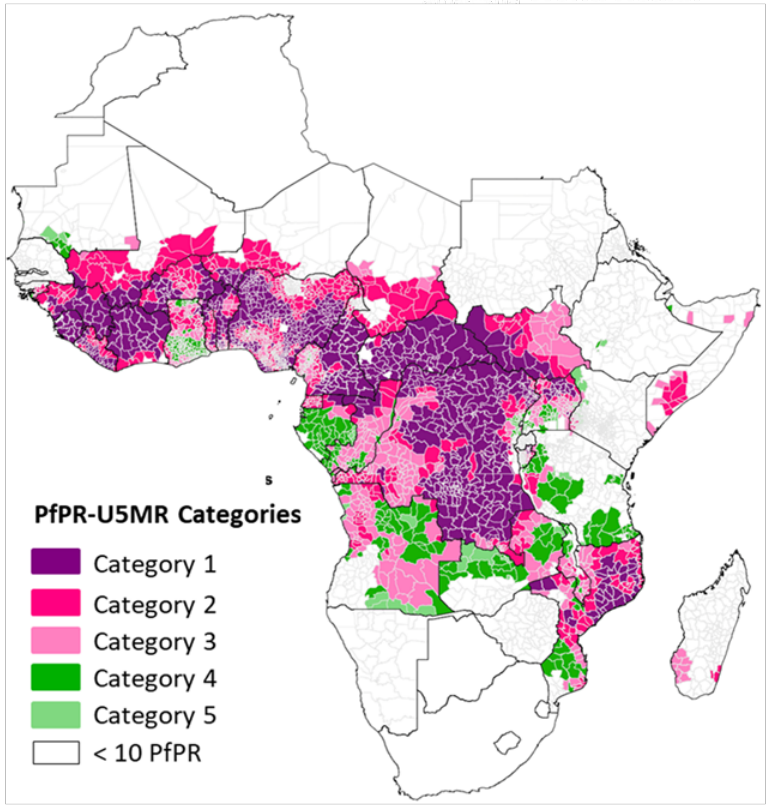
Composite classification of malaria prevalence and all-cause under-five mortality as proxy for "need"

Indicative. Countries will present their own data

Maps are illustrative based on global estimates. Countries will identify areas of highest burden and need within its own borders based on best available local evidence and the broader context of sub-national tailoring of malaria interventions

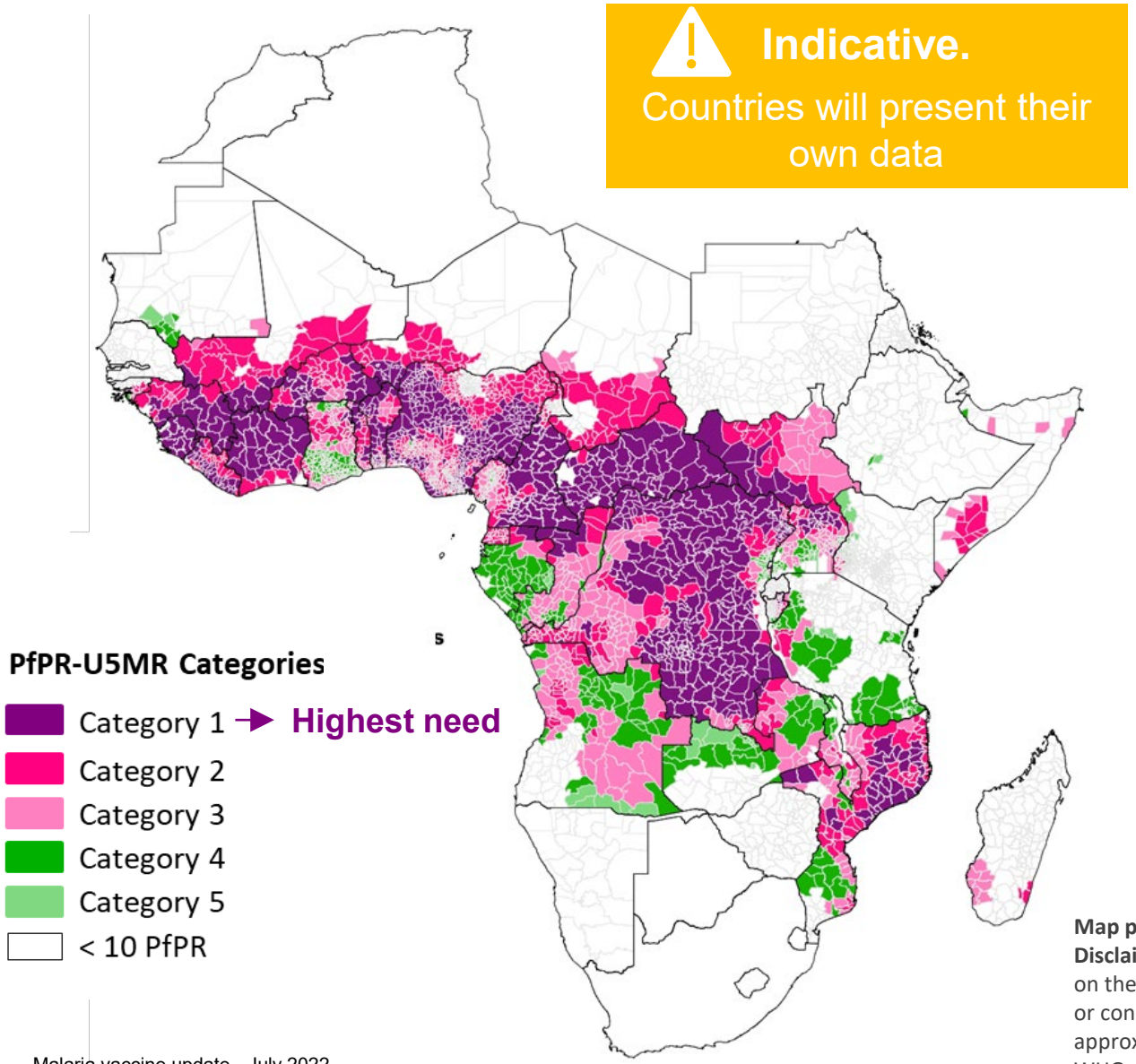
Composite classification of malaria prevalence and all-cause under-five mortality as proxy for "need"

Category	Possible combinations: Malaria prevalence		All-cause under-five mortality
1 Greatest need	PfPR 20-<40%	&	U5MR >=9.5%
	PfPR >=40%	&	U5MR >=9.5%
	PfPR >=40%	&	U5MR 7.5-<9.5%
2	PfPR 10-<20%	&	U5MR >=9.5%
	PfPR 20-<40%	&	U5MR 7.5-<9.5%
	PfPR >=40%	&	U5MR 6-<7.5%
3	PfPR 10-<20%	&	U5MR 7.5-<9.5%
	PfPR 20-<40%	&	U5MR 6-<7.5%
	PfPR >=40%	&	U5MR <6%
4	PfPR 10-<20%	&	U5MR 6-<7.5%
	PfPR 20-<40%	&	U5MR <6%
5	PfPR 10-<20%	&	U5MR <6%



Categories of need:
Composite classification of malaria prevalence and under-five mortality

World Health Organization

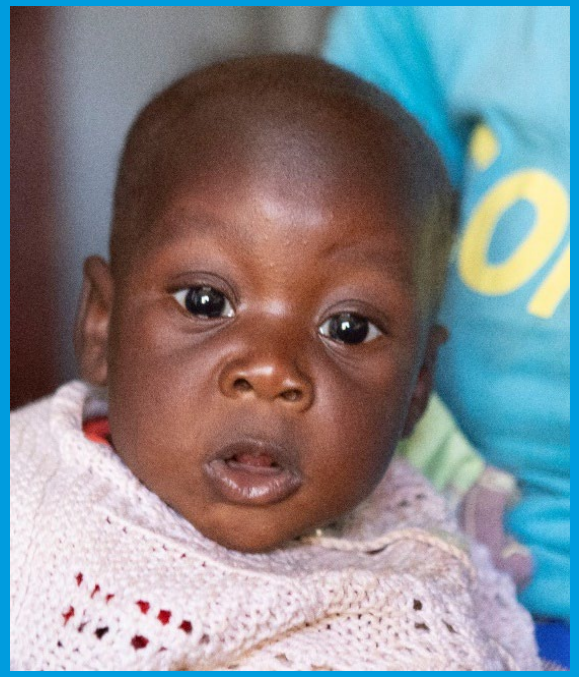


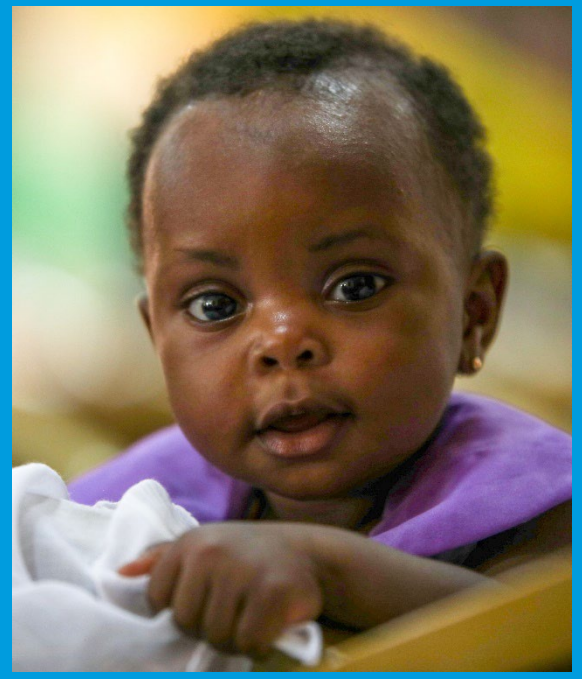
Indicative.
Countries will present their own data

- Countries should describe the full scope of needs – all categories – in their Gavi application.
- Firm vaccine allocation decisions by Gavi will initially be **limited to category 1** (greatest need) areas.
- In addition, no single country can initially receive more than 20% of total available supply at the global level.
- If supply is insufficient to satisfy all category 1 areas, the second priority principle ("maximize health impact") will be applied to establish the country order of priority

Map production: Global Malaria Programme (GMP), World Health Organization (WHO)
Disclaimer: The designations used on this map do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

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)

SMC Alliance updates

JULY 29, 2022

Establishment of SMC Alliance

The SMC Alliance established in 2021, under the auspices of RBM, to bring together all stakeholders interested in supporting SMC. This includes NMCP representatives, NGOs, donors, and the research community. The group meets monthly, holds an Annual Meeting, and produces an annual report.

Co-chairs:

- Erin Eckert, RTI International
- Eugene Kaman Lama, NMCP Guinea

Secretariat:

- Andre Marie Tchouatieu, MMV

Subcommittees:

- Research
- M&E
- Advocacy and communication

SMC Alliance

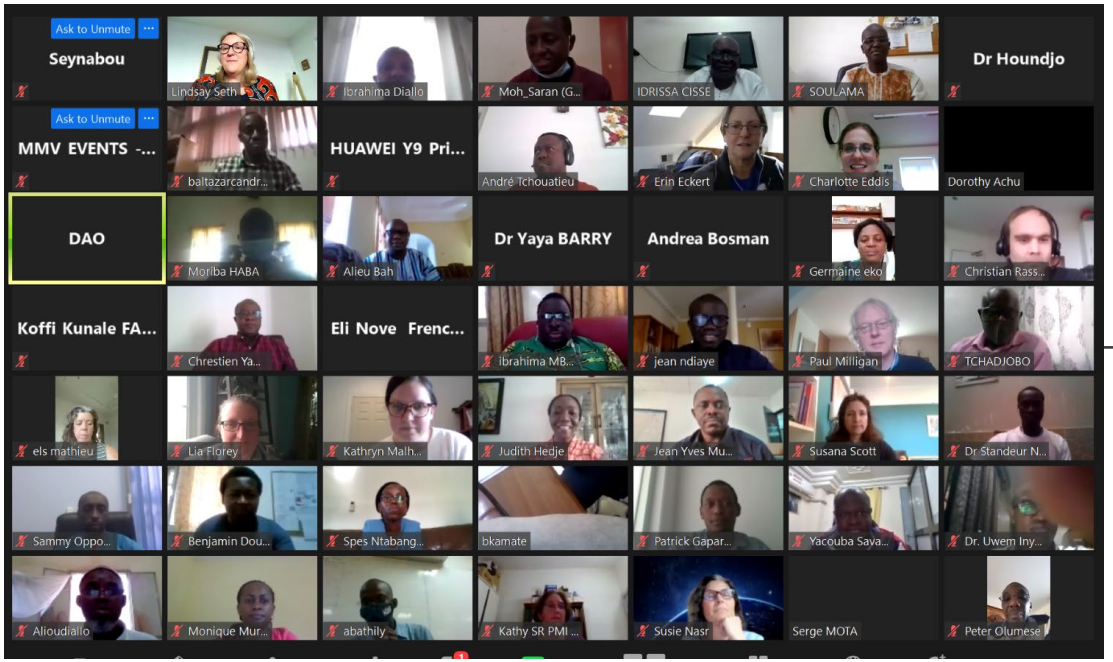
Activities in 2021 - 2022

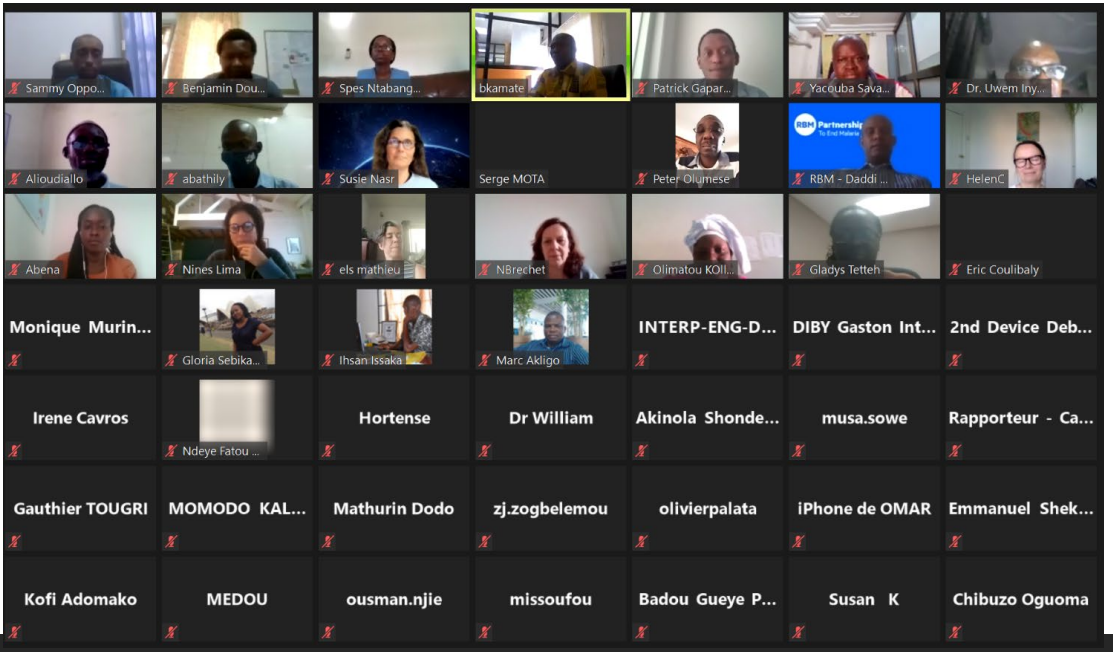
- Compiling SMC data for World Malaria Report 2021
- Catalyzing additional funding for countries in need:
  - About 8,000,000 USD for Borno state in Nigeria
- Providing technical support and answering questions from country teams
- Tracking countries readiness for SMC campaign 2021
- IMPACT-SMC project launch in 4 countries
- OPT-SMC project ongoing in 13 countries
- Regular monthly meetings for SMC discussions and countries updates
- Specific activities of the sub-groups (to be presented shortly)

SMC Alliance

Annual Meetings (virtual)

March 9 – 11, 2021
March 1-3, 2022



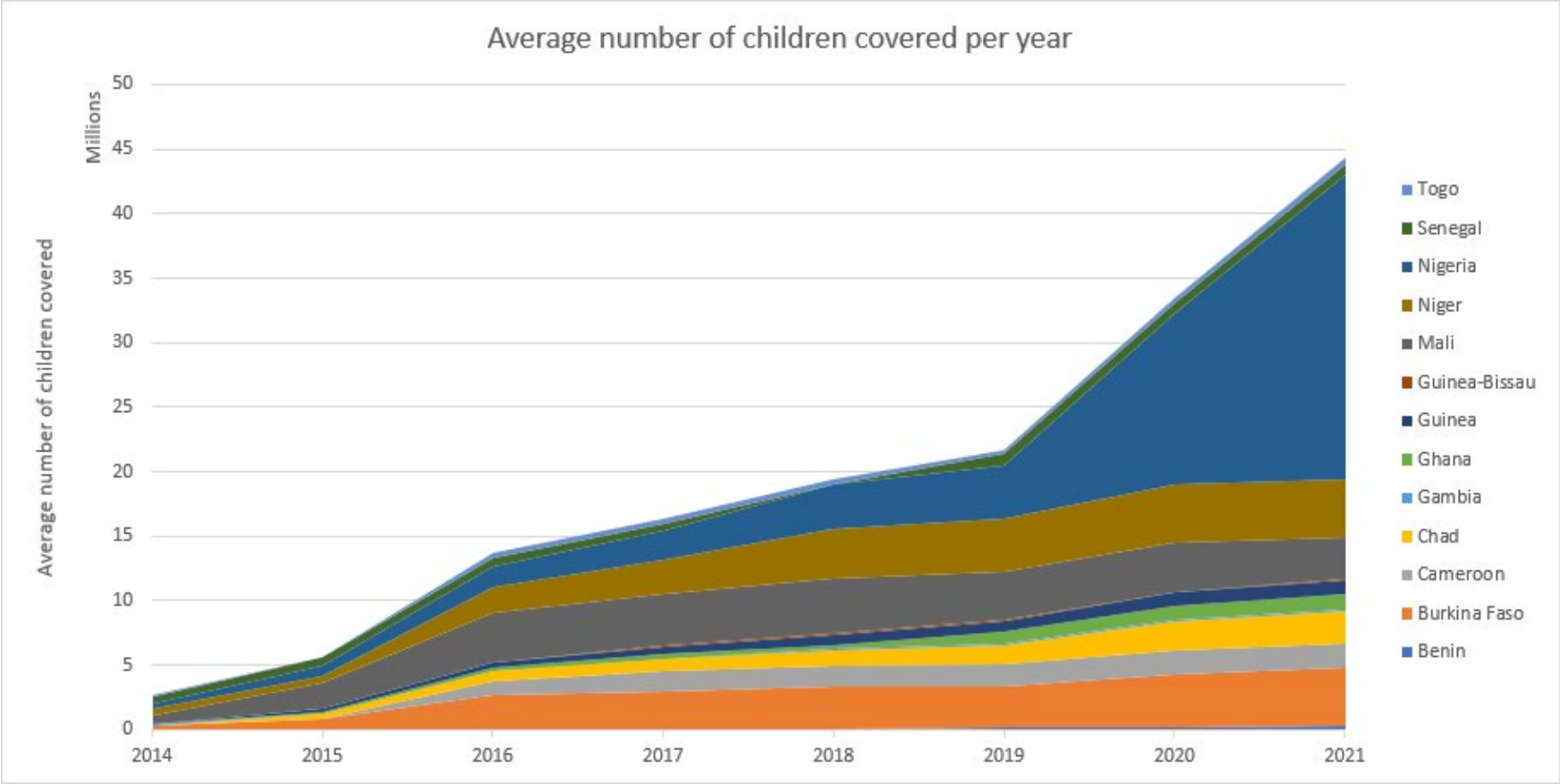


4th and 5th SMC review and planning meeting

With a minimum of **115 participants** connected simultaneously each

SMC Alliance

Trend in SMC: average number of children covered since 2014



Two projects

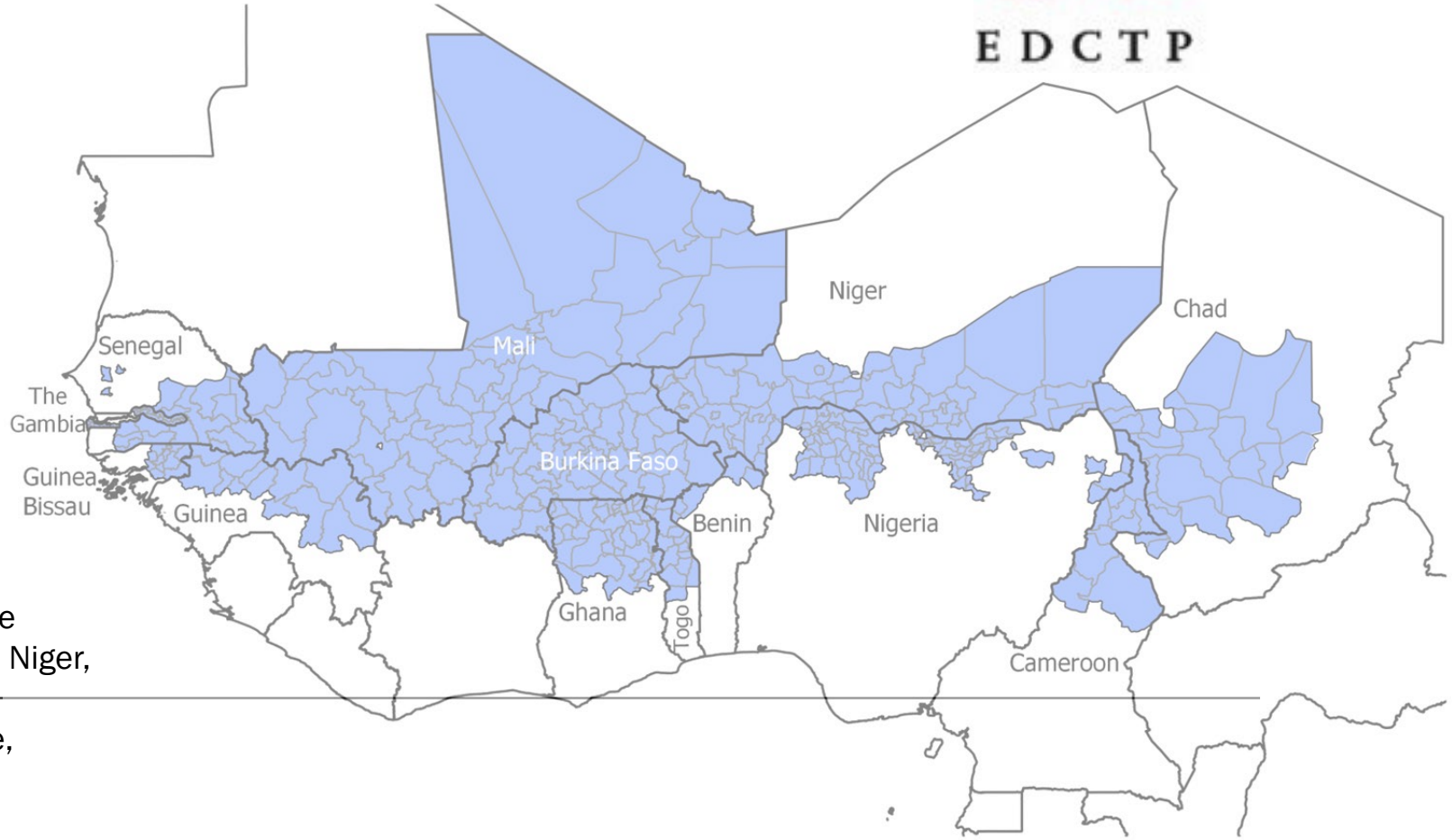
OPT SMC

SMC IMPACT

OPT-SMC

Optimizing Seasonal Malaria Chemoprevention in West and Central Africa

EDCTP



NMCPs from Benin, Burkina Faso, Cameroon, Chad, The Gambia, Ghana, Guinea, Guinea Bissau, Mali, Senegal, Niger, Nigeria and Togo

University of Thies : Jean Louis Ndiaye, Ibrahima Mbaye, Fatimatou Bintou, Amadou Seck, Ndeye Fatou Diop

LSHTM: Paul Milligan, Susana Scott, Lucy Bell

WHO/TDR : Corinne Merle

MMV : Andre Tchouatieu, Abena Poku-Awuku

UNIVERSITE DE THIES

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

MMV Medicines for Malaria Venture

TDR For research on diseases of poverty
UNICEF • UNDP • World Bank • WHO

SMC Alliance

Objectives of OPT-SMC

Strengthening the capacities of the NMPs implementing SMC:

- To define research priorities for **optimizing SMC effectiveness**
- To **conduct IR/OR projects** for improving SMC effectiveness:
- interpret and make use of malaria surveillance data
- target effectively (high risk populations and periods of the year)
- monitor delivery, uptake and effectiveness

Promote inter-country collaboration, sharing of information and expertise

OPT-SMC
Optimizing Seasonal Malaria Chemoprevention in West and Central Africa

Countries NMCP projects:

OPT-SMC
Optimizing Seasonal Malaria Chemoprevention in West and Central Africa

Monitor and Evaluate

- Ghana: To determine the coverage of SMC and knowledge of malaria among caregivers
  - Presented at ASTMH 2021
- Benin: A case-control study to assess the effectiveness of SMC
  - Analysis is on going
- Niger: Adapting the target groups for Seasonal Malaria Chemoprevention
  - Ongoing
- Senegal: Cost effective analysis of SMC – DOT3
  - Finalising proposal ready for ethics submission

Barriers to uptake: Qualitative studies

- Guinea: Adapting delivery to reach children in mining areas by
  - Increasing number of distributors and reducing workload increased costs but reaching areas not previously covered
  - Submitted to ASTMH 2022
- Nigeria : Barriers and facilitators to SMC uptake
  - Submitted to ASTMH 2022
- Burkina Faso : Evaluating the determinants for poor SMC coverage in urban areas
  - 4 urban and 4 rural districts will be compared, Ethics approved, for 2022 SMC campaign

Developing New Strategies

- Mali : Evaluation of SMC using 3 approaches
  - Routine SMC (1st dose given by CHW – Doses 2& 3 given by caregivers)
  - SMC - DOT (3 doses DOT by CHW)
  - SMC Plus (1st dose by CHW. Doses 2 & 3 by caregivers followed up by volunteers
  - Started this 2022 SMC campaign
- Cameroon: Effectiveness of using household leaders to improve adherence during SMC
  - Stated this 2022 SMC campaign

Projects in development stages

- Togo
- Chad
- The Gambia
- Guinea Bissau
- Mauritania?

EDCTP

MMV
Medicines for Malaria Venture

TDR For research on diseases of poverty
UNICEF • UNDP • World Bank • WHO

OPT-SMC
Optimizing Seasonal Malaria Chemoprevention in West and Central Africa

L'HUMILITE MON CHOIX, L'EXCELLENCE MA VOIE
UNIVERSITE DE THIES

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

NMCP: Benin, Burkina Faso, Cameroon, Chad, Ghana, The Gambia, Guinea, Guinea Bissau, Mali, Niger, Nigeria, Senegal, Togo and Mauritania

SMC-IMPACT

MMV
Medicines for Malaria Venture

SMC Impact

KOICA Korea International Cooperation Agency

Global Disease Eradication Fund | KOREA

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

CRS CATHOLIC RELIEF SERVICES

malaria consortium
disease control, better health

Objectives

Contributing to cover the remaining gaps for the current eligible target

Contribute to the body of evidence about

- Efficacy and cost effectiveness of increasing SMC to 5-10 years old
- Additional impact of adding one month of SMC coverage during the transmission season

Development of SPAQ presentation for 5-10 years old; in anticipation of the eligibility of this target group to SMC

Contributing to increase knowledge about Pyramax® and introduction in malaria endemic countries as an alternative therapeutic solution

Key achievements in 2021

>1 MILION SMC TREATMENTS DISTRIBUTED; ~ 400.000 CHILDREN REACHED

2021	Treatment administered	Children reached	% VS target
Gambia	56,498	14,124	110%
Nigeria	1,076,978	269,244	>100%
Mali (additional cycle)	74,274	74,274	101%
Guinea (additional cycle)	41,140	41,140	92%

Impact achievements so far

- PRELIMINARY POSITIVE IMPACT ON MALARIA INCIDENCE

Countries	LGAs / District	Annual reduction rate vs 2020	SMC season reduction rate vs 2020	
Nigeria	Ningi	31.99%	21.74%	
	Tafawa Balewa	20.85%	19.20%	
		5th SMC month reduction cases	5th SMC month severe malaria reduction rate	5th month Reduction in positivity rate
Guinea	Dabola	36%	65%	26%

SMC Alliance

SMC Alliance
Research sub group

Terms of Reference

2 co-chairs elected :

Prof Jean Louis Ndiaye from the Université de Thiès, Senegal

Dr Susana Scott from the London School of Hygiene & Tropical Medicine, UK

secretariat: Kevin Baker and Erica Viganó From Malaria Consortium

Aim of the group to

- map evidence gaps and research priorities;
- present study protocols and research findings;
- gather feedback and advice from peers on study design and interpretation of results;
- identify opportunities for dissemination of evidence and promote the use of evidence to inform SMC implementation
- identify opportunities for research funding

Initial Focus areas

To map out existing SMC research projects as well as planned studies

To compile SMC-related research priorities among the national malaria control and elimination programmes of SMC-implementing countries, implementing partners, funding agencies and communities

To explore the possibility of creating a repository for SMC- related research publications.

At all times to serve as a platform for the SMC community to present research findings, exchange ideas and good practices, and discuss opportunities for disseminating research results

Achievements in 2021

ASTMH symposium

~~Implementing malaria chemoprevention campaigns during the COVID-19 pandemic~~

Chaired by Kevin Baker from Malaria Consortium, with 4 presentations from SMC Alliance members as follows:

- Results from a mixed methods study in two states in Nigeria to assess the quality of infection prevention and control measures practiced during delivery of SMC (Malaria Consortium Nigeria)
- Integration of SMC and malnutrition screening in Niger, prior to and during the COVID-19 pandemic, analysis of routine data collected since 2016 (Catholic Relief Services Niger)
- Implementing Directly Observed Treatments for Three days (DOTS3) for SMC during the COVID-19 pandemic in Senegal (National Malaria Programme Senegal)
- Results from a malaria MDA amongst displaced populations in Cabo Delgado province in Mozambique (Centro de Investigação em Saúde de Manhiça)

SMC Alliance

CPS Alliance

Plans for 2022

- Aim to expand membership further in 2022 and encourage participation especially from colleagues with an interest in SMC research in SMC-implementing countries
- Continue to create a repository using the MESA Track, a database of malaria projects hosted by IS Global
- Start the research priority setting exercise: using the eDelphi method
- Continue to hold presentations on SMC research - all welcome to join

SMC Alliance

CPS Alliance

SMC Alliance
Monitoring & Evaluation sub group

The following M&E resources are available on the SMC Alliance Website

English: https://www.smc-alliance.org/resources/seasonal-malaria-chemoprevention-monitoring-evaluation-toolkit

French: https://www.smc-alliance.org/fr/ressources/bo%C3%AEte-%C3%A0-outils-de-suivi-et-d%C3%A9valuation-de-la-cps

pdf 573.74 KB

Chapter 1: Performance Framework

DOCX 99.94 KB

Chapter 2: Adverse Drug Reaction Monitoring

docx 53.46 KB

Chapter 3: Community health workers

docx 29.44 KB

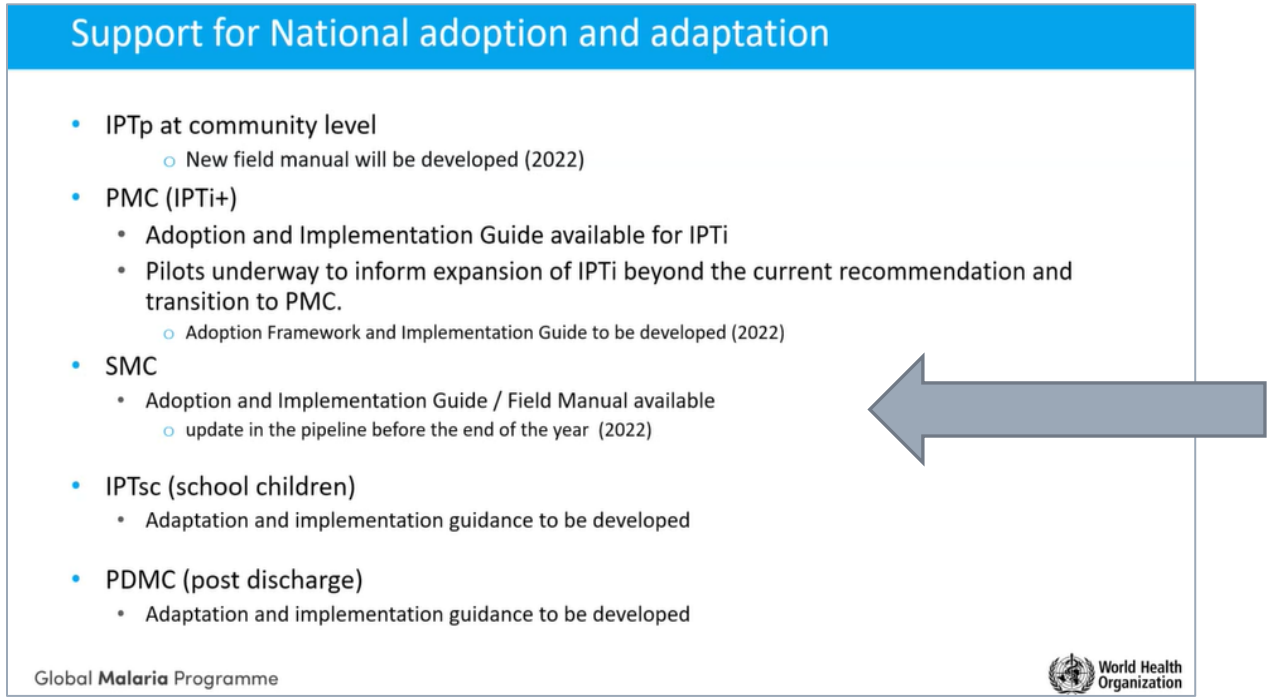
Chapter 4: Draft Summary Report

SMC Alliance

CPS Alliance

SMC M&E Sub-Group Activities in 2022

- Incorporate feedback received from Country Consultations into the Performance Framework
- Continue with other sections of the SMC M&E Toolkit / updating the SMC Field Manual
- Support the World Malaria Report 2022 SMC chapter



SMC Alliance

CPS Alliance

SMC Alliance
Communication and advocacy sub-group

Communications and advocacy sub-group

- **Obective:** Set up in April 2022 to share best practices, lessons learnt, and challenges in communicating about and advocating for SMC.
- **Co-chairs:** Abena Poku-Awuku (MMV) and Mohammed Bala (NMEP of Nigeria)
- **Immediate tasks :**
  - maintaining the SMC Alliance website,
  - support communications around the M&E toolkit,
  - coordinate a joint publication to celebrate the 10-year anniversary of WHO's policy recommendation for SMC.

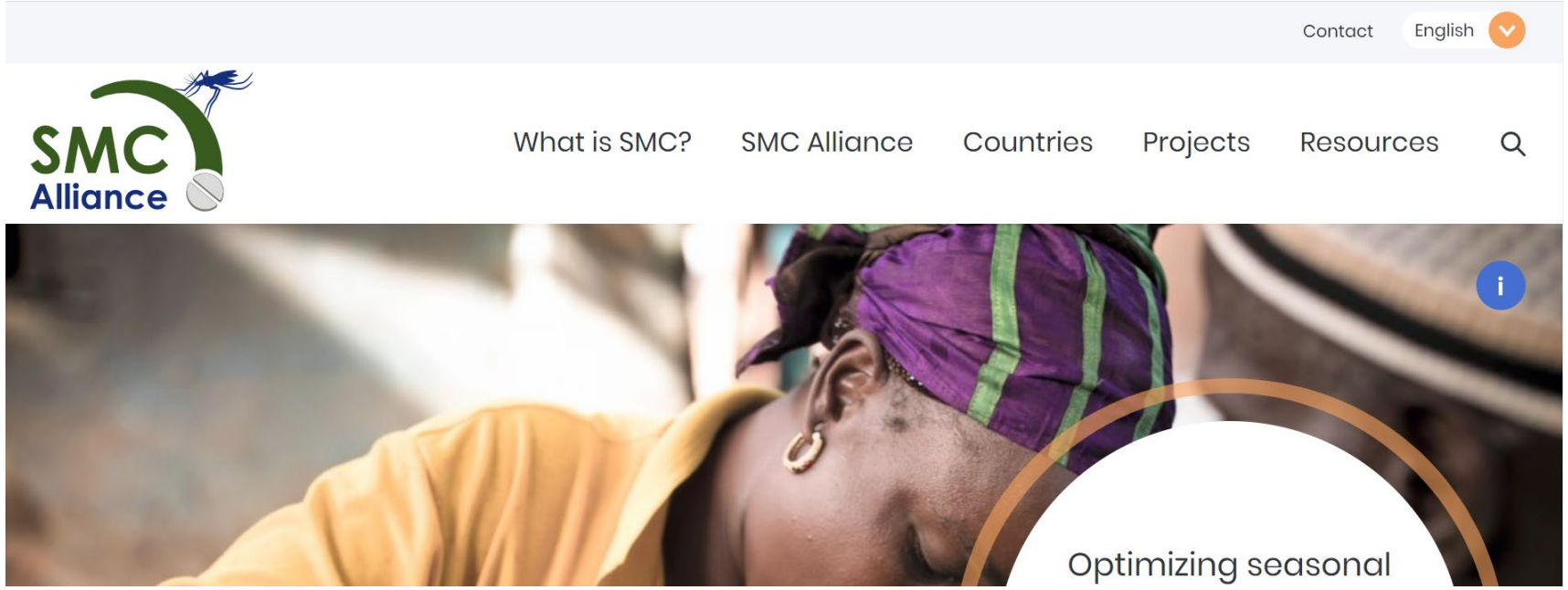
SMC Alliance

SMC Alliance web site launch

April 25, 2021

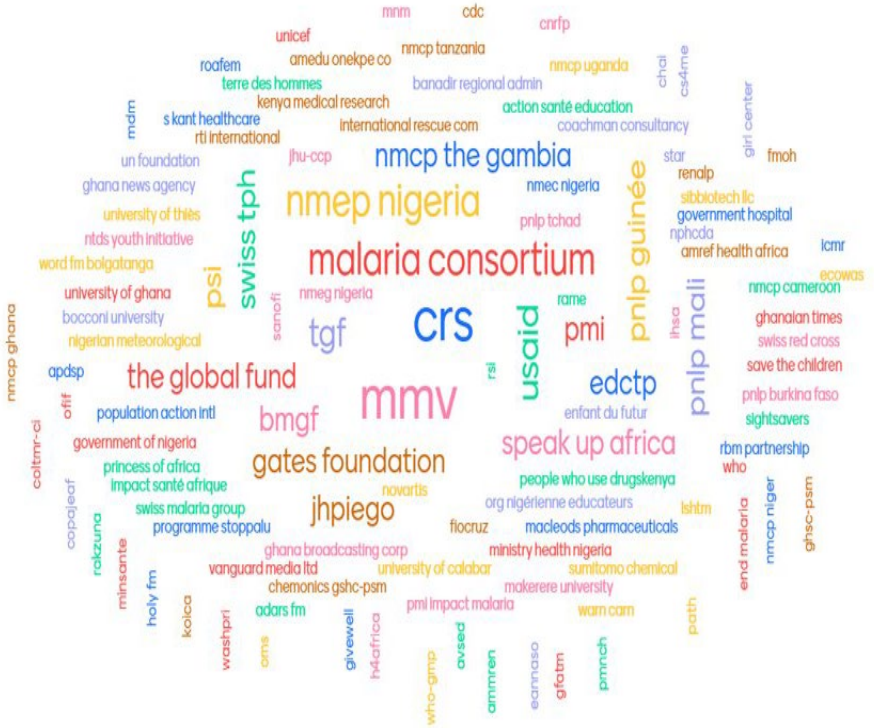
Launch of SMC Alliance Website on World Malaria Day 2021

https://www.smc-alliance.org/



Virtual panel discussion

May 18, 2021



Published in the Lancet child and adolescent : https://www.thelancet.com/pdfs/journals/lanchi/PIIS2352-4642(22)00007-4.pdf
Published in Health policy watch : https://healthpolicy-watch.news/97669-2/

Activities undertaken and to come

Developed communication and advocacy content for World Malaria Day 2022

Developed an advocacy piece celebrating 10 years of SMC on Health Policy Watch

Developing a communication piece using materials from all partners to further mark 10 years of SMC; this will be launched in Q4 2022 / Q1 2023

Tentative: Organize an event / workshop to discuss WHO's new policy on SMC

SMC Alliance Plans for 2022

- Compiling SMC data for World Malaria Report 2022
- Catalyzing additional funding for countries in need
- Providing technical support to countries for updated guidance on SMC implementation
- Tracking countries readiness for SMC campaign 2022
- Regular monthly meetings for SMC discussions and countries updates
- Support activities of subgroups (M&E, research, coms & advocacy)
- Produce 2021 annual report
- Identify new SMC countries and contribute to their readiness for implementation in 2023
- Contribute to understanding and dissemination of the updated WHO chemoprevention guidelines

Next SMC Alliance Annual Meeting

Conakry, Guinea

Feb 28 to March 2nd 2023

Please note the dates

Thank you for your collaboration

Contact tchouatieua@mmv.org for any further information

RBM Partnership
To End Malaria

MISE À JOUR DU SMERG

Médoune Ndiop
NMCP Sénégal, coprésident du MERG

Changement de nom et de direction

- **Changement de nom :** Le MERG est maintenant officiellement le Groupe de référence pour la surveillance, le suivi et l'évaluation (SMERG)
  - Nous avons suggéré de ce changement de nom pour mettre l'accent sur la surveillance, qui est maintenant une intervention de base.
  - Le SMERG collaborera avec tous les partenaires pour mettre en œuvre les composantes de surveillance en collaboration avec l'OMS/GMP
- **Direction SMERG**

  Le SMERG est co présidé, par :
  - Molly Robertson (GF)
  - Medoune Ndiop (NMCP, Sénégal).

Pratiques de surveillance et qualité des données

- **Le comité SP&DQ :** Le Comité sur la pratique de surveillance et la qualité des données (SP&DQ) a été créé dans le cadre du SMERG pour se concentrer sur la surveillance et plus particulièrement sur les initiatives de surveillance opérationnelle.
- **Co-leads du Comité :**

  Dr Arantxa Roca, ancienne coprésidente du SMERG

  Dr Baltazar Candrinho du PNLP Mozambique.

- **Objectif du comité :**
  - Améliorer la visibilité des initiatives de surveillance
  - Partager avec les partenaire et les PNLP les meilleures pratiques d'amélioration de la qualité des données
  - Accompagner les NMCP et les partenaires pour une meilleure harmonisation dans l'application des guides et directives de l'OMS en matière de surveillance.

Pratiques de surveillance et qualité des données (*suite)*

Objectifs spécifiques :

- Diffuser, par l'entremise du SMERG, des renseignements sur l'utilisation actuelle des outils opérationnels de surveillance par les partenaires de mise en œuvre, et améliorer la mise en œuvre et la coordination des partenaires en ce concerne leur utilisation et à leur adoption

- Partager avec les PNLP et les partenaires de façon dynamique à travers des webinaires les initiatives dans la mise en œuvre des outils de OMS et RBM.

- Fournir des mises à jour au SMERG chaque fois que nécessaire.

- Documenter les avantages et les difficultés opérationnelles de mise en oeuvre des directives et outils de suivi de qualité des données de l'OMS et RBM.
- Identifier, les priorités opérationnelles de surveillance des PNLP afin de leur fournir des conseils et recommendations pour une meilleure adaptation des outils.

Réalisation du comité : Sondage d'évaluation des besoins des PNLP

Objectif du sondage

- Mieux comprendre les besoins en matière de surveillance, de suivi et d'évaluation du paludisme au niveau des programmes nationaux
- Obtenir des recommandations des PNLP sur les outils utiles et nécessaires
- Mieux comprendre comment le SMERG peut répondre aux besoins des PNLP

Résultats du sondage

- Le résultat préliminaire a été présenté lors de la dernière réunion du SMERG (les diapositives sont accessibles à Link)

Prochaines étapes

- Organisation de réunion de réflexion
- Organisation de Webinaires

Réalisations du SMERG liées à la COVID-19

- Élaboration du document d'orientation sur la surveillance, l'évaluation et l'analyse des données de routine liées au paludisme pendant la pandémie de COVID-19 (https://endmalaria.org/our-work-working-groups/monitoring-and-evaluation)

- Organisation d'une série de webinaires en anglais, en français et en portugais avec les membres pour les orienter sur le document d'orientation.Les enregistrements de ces webinaires sont disponibles sur les liens suivants :

Anglais https://drive.google.com/file/d/19lcqVhR0R96nKW8c4aPRsIlA1ldmuu0L/view?usp=sharing

Français https://drive.google.com/file/d/1yih0YZemg-levO4x4-ABtvjPBMeOi1Lh/view?usp=sharing

Portugais https://drive.google.com/file/d/18h11eaV4UYf57_IUav_m855cwUYLd-Ca/view?usp=sharing

Organisation de la 33e réunion annuelle du SMERG au Rwanda en mode Hybride

- **Réunion tenue du 17 au 20 mai 2022**
- **Thème de la réunion 2022 :**

  Rationaliser nos Système de Suivi Evaluation et Surveillance pour soutenir les gains et répondre pleinement aux priorités émergentes en matière de contrôle et d'élimination du paludisme.
  Que devons-nous continuer de faire ?
  Que devons-nous faire différemment ?
- **Organisation de Visite de terrain :**

  Objectif de la visite d'étude : *Comprendre le système de surveillance du paludisme au Rwanda – Surveillance au niveau communautaire – Leçons apprises, défis et succès.*
- **Rapport de la réunion :** Sera partagé dans les semaines à venir

Participants: 59 pour 20 pays avec une bonne participation des PNLP : Burundi, Cameroon, Central African Republic, Chad, Congo (DRC), Ghana, Madagascar, Nigeria, Rwanda, Sudan, Zambia, Zanzibar

Partenaires et managers des PNLP sur le terrain à Kigali.

RBM Partnership
To End Malaria

Merci.
Pour en savoir plus sur le SMERG, visitez www.endmalaria.org

The need to deliver malaria interventions: Goals, Challenges & Opportunities (UNICEF)

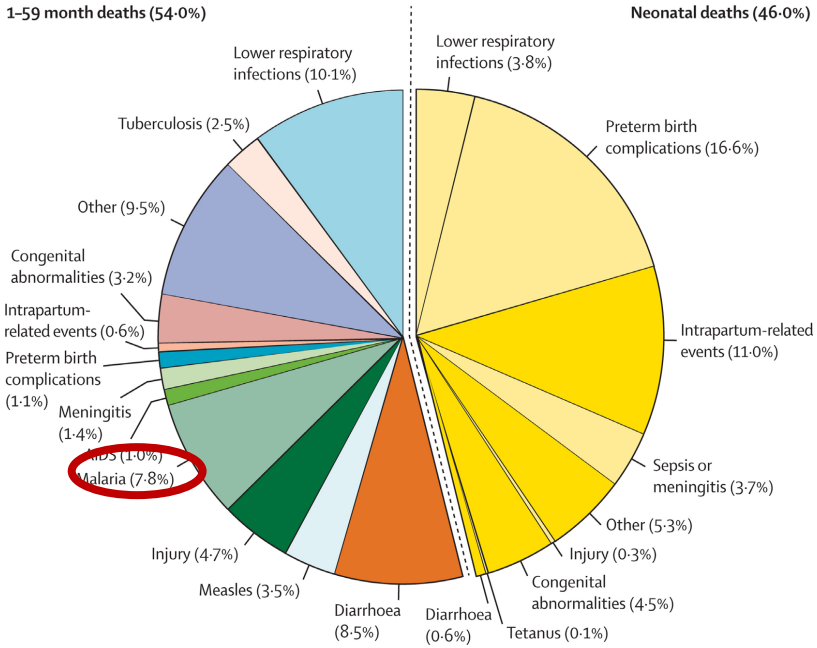
Valentina Buj, Global Malaria & Health Partnerships Advisor
UNICEF/Health

July 2022

unicef | for every child

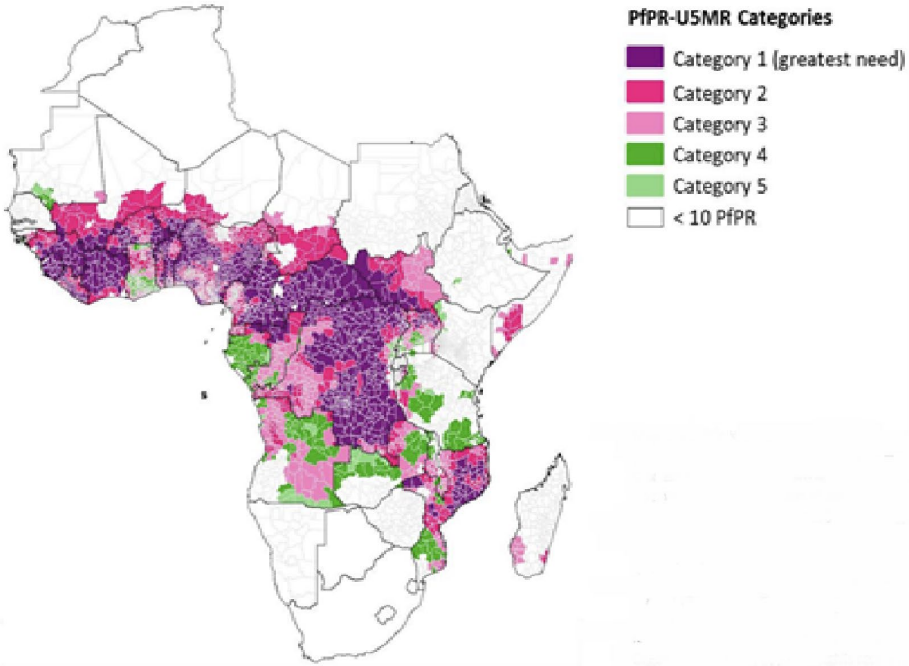
What are >5 M children under-5 dying of ?

Worldwide: Malaria accounts for **7.8%** **of global deaths** in under-fives



Source: https://childmortality.org/reports

Categories of need: Composite classification of malaria prevalence & under five mortality (SSA)



Source: WHO, Framework for the allocation of limited malaria vaccine supply

More than one third of child deaths are attributable to undernutrition

Source: Global causes of child deaths - CHERG, WHO UNICEF estimates

unicef

Why are children under five and pregnant women at greater risk?

- Socio-Economic:
  - ❑ Poverty
  - ❑ Marginalization

- Biologic:
  - ❑ Lack of natural immunity
  - ❑ Malnutrition

@UNICEF/UNI05909/Rich

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UNICEF: Multi-sectoral entry points for malaria delivery

EPI

-SMC (integrated campaigns)

-IPTi now PMC

-**Malaria Vaccine**

Communication & C4D

- RCCE

Nutrition

- Sahel Famine Response
- Stunting Taskforce
- Folic Acid

WASH

- Environmental interventions
- Vector elimination strategies

Health Systems Strengthening

- **Integration**
- **Community health workers**
- **Primary Health care delivery**

Education

- Sensitization
- Continuous LLIN distribution

Early Childhood Development & Adolescents

- Severe malaria
- Adolescent pregnancies

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Disease Risk in COEs

@UNICEF/UNI26740/Holt

- Globally, **426 million children – nearly 1 in 5 – live in conflict zones** that are becoming more intense and taking a heavier toll

- **122 million people** in 21 malaria-endemic countries needed assistance due to health and humanitarian emergencies in 2020–2021, not including the COVID-19 pandemic

unicef

UNICEF & Emergencies

- UNICEF strives to save lives and protect rights as defined in the **Core Commitments for Children (CCCs) in Humanitarian Action.**
- UNICEF focuses its efforts on systematically reducing vulnerability to disasters and conflicts for effective prevention of and **response to humanitarian crises to ensure rapid recovery and building community resilience to shocks that affect children**.

UNICEF **responded to 483 new and ongoing humanitarian crises in 153 countries in 2021,** compared with 455 in 153 countries in 2020.

Key actions:

- early identification of priorities & strategies to **build resilience** on emergency to development spectrum
- **rapid deployment** of qualified staff and clear accountabilities for the response.
- In collaboration with MoHs, UNICEF country offices, NGO & academic partners, UNICEF's Chid Health Unit is **documenting lessons learned & providing evidence on best practices** on the role and impact of community health workers and other community actors in complex & insecure environments.

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UNICEF in Complex Operating Environments

1) ***strengthening resilient health facility and community systems in chronically unstable settings;***
2) ***ensuring continuation of essential health services, esp. diagnosis and treatment, during acute emergencies.***

UNICEF provides technical support and capacity development to country offices, partners & national authorities to:

- ***Design risk-informed programming;***
- ***Compile and create evidence on implementation*** of health programs in challenging environments, including how to improve emergency preparedness and response;
- Develop operational guidelines to review existing guidance on and operational experiences with HIV and infant feeding in emergencies;
- Support ***strengthening community systems*** in chronic and emergency settings;
- ***Monitor activities***, linking to existing HMIS & community-based reporting platforms.
- Develop ***strong procurement systems*** in emergencies and challenging operating environments.
- ***Leveraging integrated service delivery platforms***

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Malaria and Poverty

- Poor rural populations in malaria-endemic areas often cannot afford the housing and bed nets that would protect them from exposure to mosquitoes.
- Education/lack the knowledge: cultural beliefs result in use of traditional, ineffective methods of treatment.
- Human activities can create breeding sites for larvae (standing water in irrigation ditches, burrow pits)
- Agricultural work such as harvesting (also influenced by climate) may force increased nighttime exposure to mosquito bites
- Raising domestic animals near the household may provide alternate sources of blood meals for *Anopheles* mosquitoes and thus decrease human exposure
- War and migrations (voluntary or forced) may expose non-immune individuals to an environment with high malaria transmission.

Malaria and Climate Change

- Experts have identified malaria as one of the diseases most sensitive to climatic factors.
- Altered patterns of flooding are giving rise to more stagnant pools of water (breeding sources for mosquitoes)

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UNICEF's Malaria Strategy: Alignment with GTS & AIM (2016-2030)

- **Increasing investment and resource mobilization**
  - Domestic resources, alignment w/ GFF & GFATM
- **Integrating malaria into health systems**
  - Alignment w/ UNICEF HSS & PSM efforts, including community-based systems
  - Support & use of MNCH platforms (ANC, EPI, CHWs)
- **Advocacy** – aligning with EWEC/APR
- **Targeting vulnerable/marginalized populations as part of UNICEF's equity agenda**
- **Improving quality and use of data, and monitoring results**
  - EQUIST, DHSS, MICS, APR scorecards, m-health/RapidPro etc

- **Strengthening and facilitating cross-sectoral engagement** in the malaria response (e.g. nutrition, WASH, education)
- **Strengthening social/BCC & community engagement**: C4D

unicef


Thank You
Merci
Obrigado
Asante Sana
unicef
Faire reculer le paludisme
Hacer retroceder el paludismo
Roll Back Malaria
unicef
for every child

Le besoin de accélérer le progressé pour finir avec l'épidémie du paludisme: Goulots d'étranglement & opportunités (UNICEF)

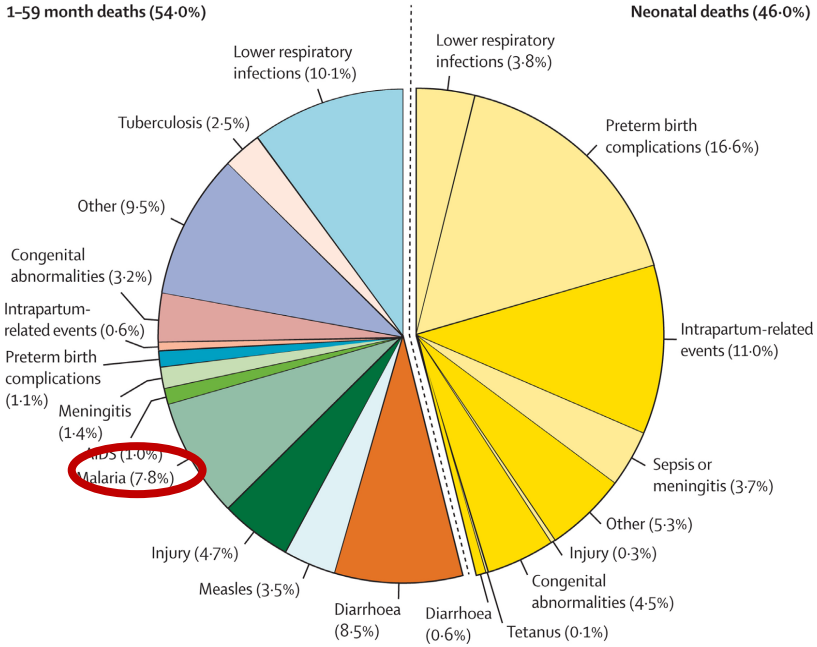
Valentina Buj, Global Malaria & Health Partnerships Advisor
UNICEF/Health

July 2022

unicef | for every child

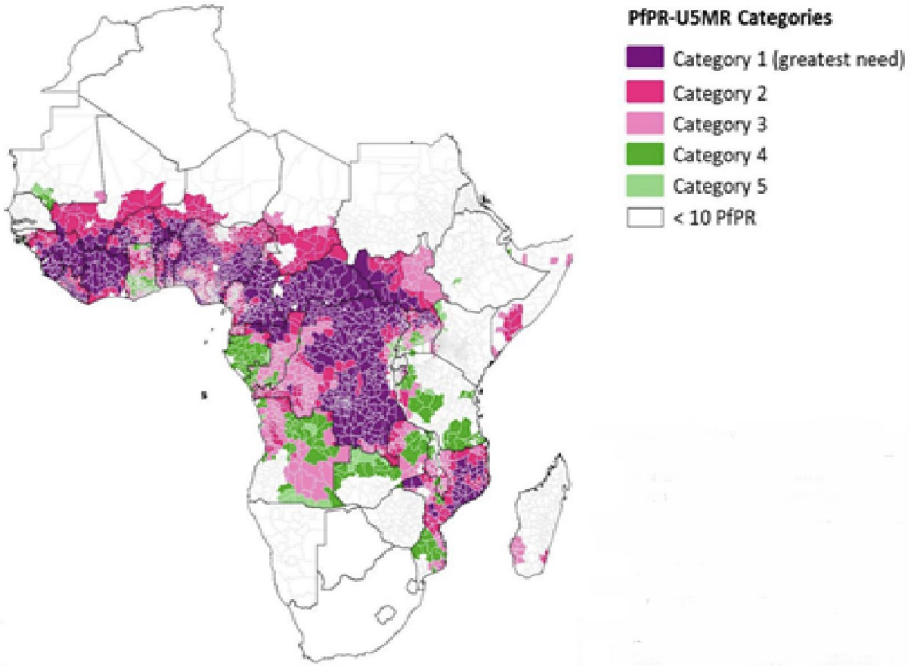
De quoi meurent >5 millions d'enfants de moins de 5 ans chaque annee?

Global: Le paludisme cause **7.8% du mortalite global** chez les enfants moins de cinq ans



Source: https://childmortality.org/reports

Ou faut-il agir: Classification composite du prevalence de paludime & mortalite chez les moins de cinq ans (SSA)



Source: WHO, Framework for the allocation of limited malaria vaccine supply

Plus de un tier du mortalite infantile est du au mal- ou sous-nutrition

Source: Global causes of child deaths - CHERG, WHO UNICEF estimates

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Pourquoi est-ce qe le risqué est plus eleve chez les femmes enceinte et les enfants moins de cinq ans?

- Socio-Economique:
  - ❑La pauvreté
  - ❑ Marginalisation

- Biologique:
  - ❑ Manque d'immunité naturel
  - ❑ Malnutrition

@UNICEF/UNI05909/Rich

UNICEF: Points multi-sectoriels pour la mise en oeuvre

EPI

-SMC (campagnes integrees)

-IPTi now PMC

-Le vaccine paludeen

Communication & C4D

- RCCE

Nutrition

- Response aux famine
- Distribution du Vit A

WASH

- Interventions environnementaux
- Stratégies d'élimination du vecteur

Renforcement du système de sante

- Intégration
- Agents du sante communautaire
- Sante primaire

Education

- Sensitization
- Distribution continue du MILDA

Early Childhood Development & Adolescents

- Paludisme severe
- La grossesse precoce (adolescent)

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Le Paludisme dans de situations d'urgence

@UNICEF/UNI26740/Holt

- À l'échelle mondiale, 426 millions d'enfants - **soit près d'1 sur 5** - vivent dans des zones de conflit qui s'intensifient et font des ravages

- **122 millions *de personnes dans 21 pays*** où le paludisme est endémique ont eu besoin d'aide en raison d'urgences sanitaires et humanitaires en 2020-2021, sans compter la pandémie de COVID-19

unicef

UNICEF & Emergencies

- L'UNICEF s'efforce de sauver des vies et de protéger les droits tels que définis dans les **Principaux engagements pour les enfants (CCC)** dans l'action humanitaire.
- L'UNICEF concentre ses efforts sur la réduction systématique de la vulnérabilité aux catastrophes et aux conflits pour une prévention et une **réponse efficaces** aux crises humanitaires afin d'assurer un relèvement rapide et de renforcer la résilience des communautés aux chocs qui affectent les enfants.

L'UNICEF a répondu à 483 crises humanitaires nouvelles et en cours dans 153 pays en 2021, contre 455 dans 153 pays en 2020.

Actions clés :

- identification précoce des priorités et des stratégies pour renforcer **la résilience sur le spectre de l'urgence au développement**
- un déploiement rapide de **personnel** qualifié et des responsabilités claires pour la réponse.
- En collaboration avec les ministères de la santé, les bureaux de pays de l'UNICEF, les ONG et les partenaires, l'unité de santé infantile de l'UNICEF documente les leçons apprises et fournit des preuves sur les **meilleures pratiques** concernant le rôle et l'impact des agents de santé communautaires et d'autres acteurs communautaires dans des environnements complexes et peu sûrs.

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L'UNICEF dans les environnements opérationnels complexes

1) ***renforcer les structures de santé résilientes et les systèmes communautaires dans des contextes chroniquement instables ;***
2) ***assurer la continuité des services de santé essentiels, en particulier. diagnostic et traitement, lors des urgences aiguës.***

L'UNICEF fournit un soutien technique et un renforcement des capacités aux bureaux de pays, aux partenaires et aux autorités nationales pour :

- Concevoir une programmation tenant compte des risques ;
- Compiler et créer des preuves sur la mise en œuvre de programmes de santé dans des environnements difficiles, y compris sur la **manière d'améliorer la préparation et la réponse aux situations d'urgence** ;
- Élaborer des directives opérationnelles pour examiner les directives existantes et les expériences opérationnelles en matière de VIH et d'alimentation du nourrisson dans les situations d'urgence ;
- **Soutenir le renforcement des systèmes communautaires** dans les contextes chroniques et d'urgence ;
- Surveiller les activités, en se connectant aux HMIS existants et aux plateformes de **rapport communautaires**.
- Développer des **systèmes d'approvisionnement solides** dans les situations d'urgence et les environnements opérationnels difficiles.
- Tirer parti des plateformes de **prestation de services intégrées**

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Malaria et la Pauvrete

- Les populations rurales pauvres des zones d'endémie palustre souvent **n'ont pas les moyens** de s'offrir un logement et des moustiquaires qui les protégeraient de l'exposition aux moustiques.
- Éducation/manque de connaissances : les croyances culturelles entraînent l'utilisation de méthodes de traitement traditionnelles inefficaces.
- Les activités humaines peuvent créer des gîtes larvaires (eau stagnante dans les fossés d'irrigation, les terriers)
- Les travaux agricoles tels que la récolte (également influencés par le climat) peuvent forcer une exposition nocturne accrue aux piqûres de moustiques
- L'élevage d'animaux domestiques à proximité du foyer peut fournir d'autres sources de repas sanguins pour les moustiques anophèles et ainsi réduire l'exposition humaine
- La guerre et les migrations (volontaires ou forcées) peuvent exposer les personnes non immunisées à un environnement où la transmission du paludisme est élevée.

Malaria et le changement climactique

- Les experts ont identifié le paludisme comme l'une des maladies les plus sensibles aux facteurs climatiques.
- La modification des schémas d'inondation donne lieu à davantage de mares d'eau stagnante (sources de reproduction des moustiques)

UNICEF's Malaria Strategy: Alignment with GTS & AIM (2016-2030)

- **Accroître les investissements et la mobilisation des ressources**
  - Ressources nationales, alignement avec GFF & GFATM
  - Intégrer le paludisme dans les systèmes de santé
  - Alignement avec les efforts de l'UNICEF en matière de RSS et de PSM, y compris les systèmes communautaires
- **Appui & utilisation des plateformes SMNI (ANC, EPI, CHWs)**
- **Plaidoyer – alignement avec des programmes globales**
  - Cibler les populations vulnérables/marginalisées dans le cadre du programme d'équité de l'UNICEF
- **Améliorer la qualité et l'utilisation des données, et surveiller les résultats**
  - EQUIST, DHSS, MICS, tableaux de bord APR, m-santé/RapidPro, etc.

- **Renforcer et faciliter l'engagement intersectoriel dans la riposte au paludisme** (par exemple, nutrition, WASH, éducation)
- **Renforcer l'engagement social/CCC et communautaire : C4D**

unicef


Thank You
Merci
Obrigado
Asante Sana
unicef
Faire reculer le paludisme
Hacer retroceder el paludismo
Roll Back Malaria
unicef
for every child

WEST AFRICAN HEALTH ORGANIZATION
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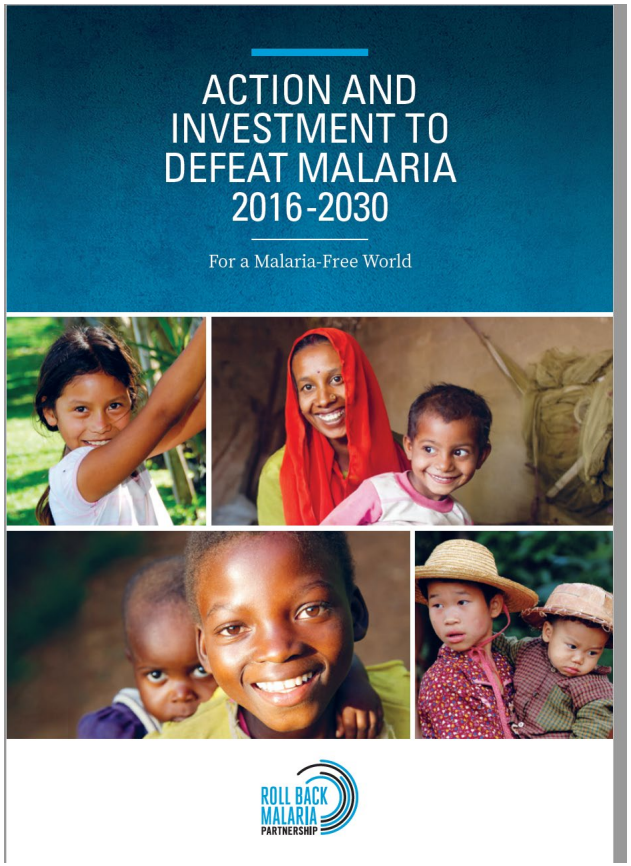
Regional perspectives of malaria and best practices in cross-border coordination and collaboration

Annual CRSPC NMCP Managers Meeting, 29 July 2022

Highlighted in global and regional initiatives

Multisectoral and Cross-border Collaboration Needed!

August 17, 2022



Making progress in the fight against malaria requires:

"working together, building inclusive partnerships within and across boundaries and sectors to address inequalities everywhere, and promoting dignity and prosperity for all mankind"

https://endmalaria.org/sites/default/files/RBM_AIM_Report_0.pdf

Cross-border collaboration in the GTS

World Health Organization

GLOBAL TECHNICAL STRATEGY FOR MALARIA 2016–2030

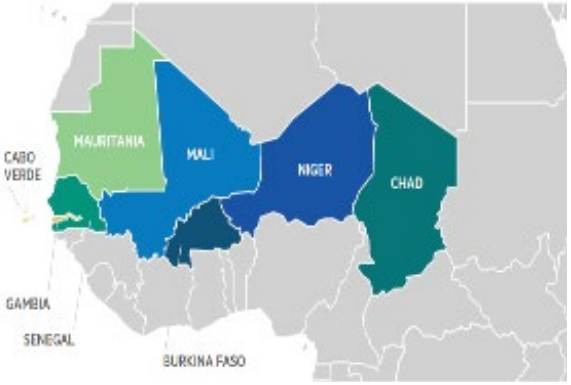
- **Improve government stewardship and cross-border collaboration of malaria programmes**

- Effective cross-border collaboration between national programmes must be initiated and strengthened in order to ensure optimal coverage of intervention in these areas

Key Sahel Malaria Elimination Ministerial Priorities

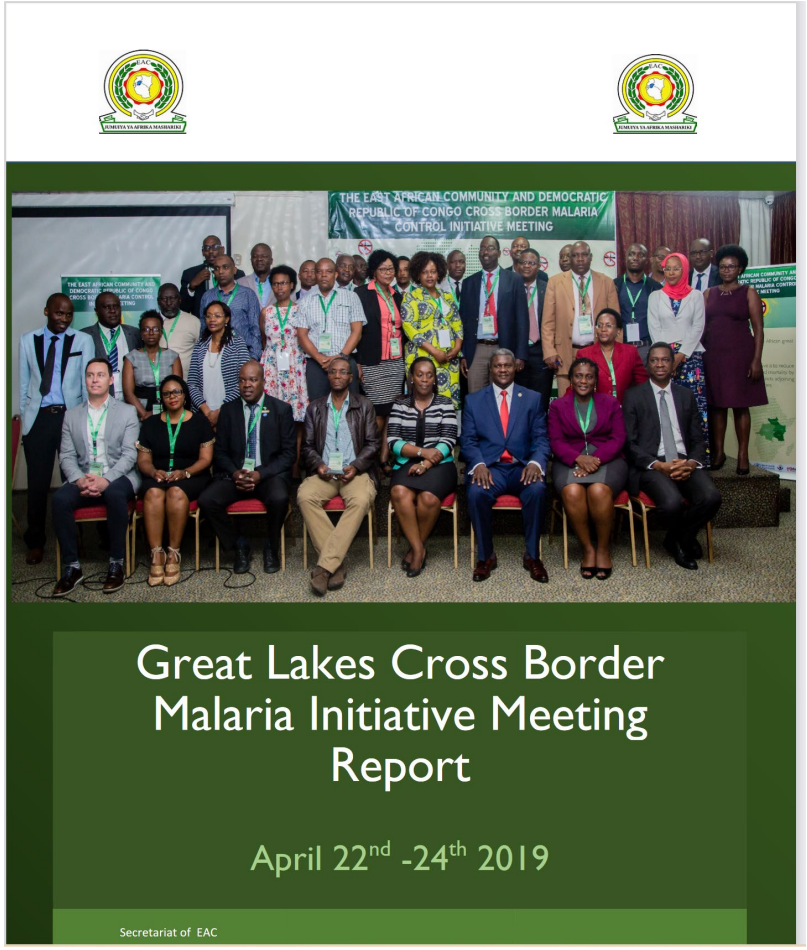
August 17, 2022

1. Scale-up universal coverage of malaria control interventions
2. Mobilise financing for malaria elimination
3. **Strengthen cross border collaboration**
4. Fast track the introduction of innovative technologies to combat malaria
5. Develop a sub-regional scorecard to track progress towards elimination by 2030



Cross-border collaboration in the Great Lakes Region

August 17, 2022

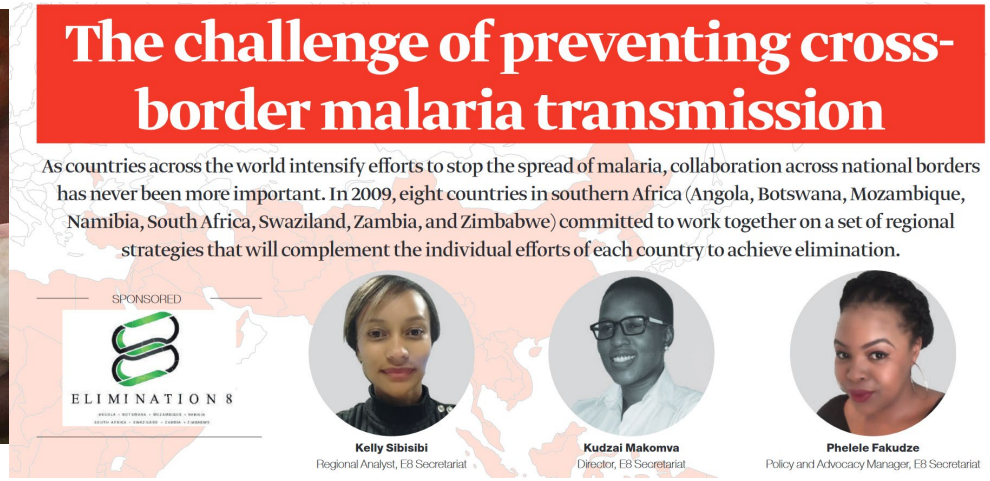


"All the countries in the Great Lakes Region are aggressively pursuing national malaria control strategies aiming at ending malaria within their respective borders. However, countries targeting malaria elimination cannot achieve their targets as long as high transmission remains within the region"

Dr Diane Gashumba, Hon. Minister of Health Rwanda

Cross-border collaboration in the E8 Initiative

August 17, 2022



The challenge of preventing cross-border malaria transmission

As countries across the world intensify efforts to stop the spread of malaria, collaboration across national borders has never been more important. In 2009, eight countries in southern Africa (Angola, Botswana, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe) committed to work together on a set of regional strategies that will complement the individual efforts of each country to achieve elimination.

SPONSORED

ELIMINATION 8

Kelly Sibisibi
Regional Analyst, E8 Secretariat

Kudzai Makomva
Director, E8 Secretariat

Phelele Fakudze
Policy and Advocacy Manager, E8 Secretariat

Core objectives of the E8 malaria elimination regional strategy include the promotion of regional coordination, high level advocacy, policy harmonisation, prevention of cross-border transmission, and sustainable financing.


The Global Fund
To Fight AIDS, Tuberculosis and Malaria
INDIA – BHUTAN CROSS BORDER COLLABORATION
MEETING ON MALARIA ELIMINATION
VENUE: HOTEL GRAND KUKU, GELEPHU : BHUTAN
DATE: 2 - 3 SEPTEMBER 2019

Rationale

Rationale 1/2

- Malaria prevalence is often higher in cross-border areas than in other areas due to:
  - lower access to health services
  - treatment-seeking behaviour of marginalized populations that typically inhabit border areas
  - difficulties in deploying prevention programmes to hard-to-reach communities, often in difficult terrain
  - constant movement of people across porous national boundaries
- Crucial in the strengthening of surveillance activities for rapid identification of any importation or reintroduction of malaria

Wangdi et al 2015

Rationale 2/2

- Malaria elimination cannot be achieved and sustained in isolation by any country without adequate attention to malaria in cross-border areas
- Cross-border transmission
  - Areas with high endemicity have a high potential to spread across borders, while some low endemicity areas have the potential for outbreaks
  - Even in countries that had hitherto been malaria-free and those nearing elimination, there is a threat of re-establishment and resurgence
- Health services along international borders are often weaker
  - Poorly staffed than in more central areas
  - Remote areas
  - Security concerns and tensions
- People living in border areas
  - Socioeconomically vulnerable and marginalized
  - Reduced access to health care and social services

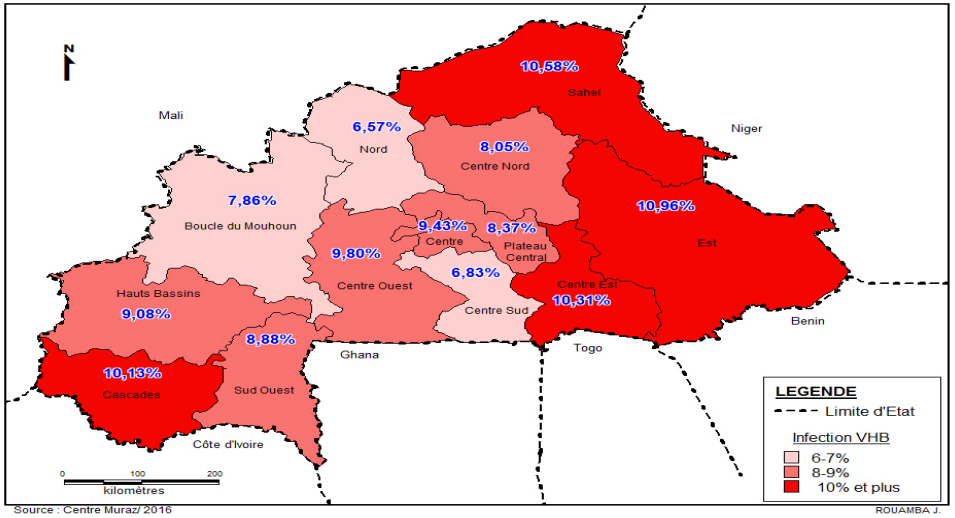
Policy framework

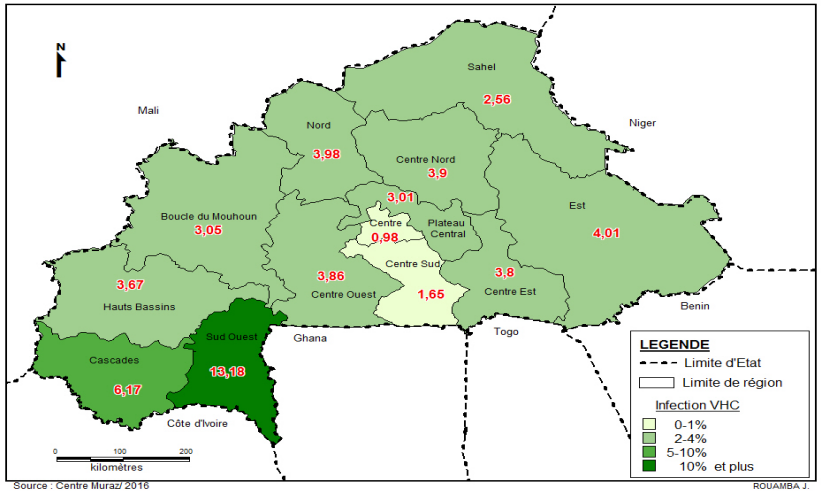
Framework

August 17, 2022

- People-centred or disease-centred?
- Common predisposing factors for diseases
- Diseases e.g. neglected tropical diseases (NTDs), HIV, hepatitis, epidemic-prone diseases
- Port health or One health?
- Infrastructure; services?
- Movement of people, animals and goods
- Target population: resident, mobile
- Which borders? – land, riverine, air
- Scope of services – continuum of health services

Prevalence of Hepatitis B and C in Burkina Faso, 2016





National HBV prevalence = 9.1%

1.8 million HBV carriers

National HCV prevalence = 3.6%

750,000 HCV carriers

Meda et al 2018

WAHO Support for Construction of Bo-Waterside Health Center

August 17, 2022

MONROVIA — The Director General of the West African Health Organization WAHO, Professor Stanley Okoro has participated in the Commissioning Program of the BO-Waterside Health Center located in Liberia's western County of Grand Cape Mount. Liberia's President Dr. George Manneh Weah, a high powered Sierra Leonean Delegation, chiefs, elders, women and youth groups graced the event which took place on Friday, March 26, 2021.

https://frontpageafricaonline.com/news/liberia-pres-weah-west-african-health-organization-dedicate-bo-waterside-health-center/

- WAHO contributed about US$440,000 US towards completion of the health facility
- Facilities
  - Ante Natal Care/Post Natal Care/EPI Department
  - Out-Patient Department
  - Utilities
  - Laboratory Operating Theater
  - Consultation Rooms
  - Emergency Room
  - Pediatric, Male and Female Wards
  - Isolation and Short-Stay Wards
  - Pharmacy
  - Staff Quarters (2-bedroom duplex)
  - Water Tower Generator House.
- Facility is strategically placed at the LBR-SLE border, to improve cross-border surveillance and service coverage


KFW
USAID
CORRIDOR
GRANDE CAMPAGNE DE MOBILISATION SUR LA PLANIFICATION FAMILIALE ET LE DEPISTAGE VIH
NOEUD 5 : FRONTIERE KODJOVIAKOPE (TOGO) - FRONTIERE AFLAO (GHANA)
DATE : du 13 au 15 Janvier 2020
MASSIVE MOBILIZATION CAMPAIGN ON FAMILY PLANNING AND HIV/AIDS SCREENING
KODJOVIAKOPE (TOGO) - AFLAO (GHANA) HUB N° 5
DATE : 13-15 January 2020


Jointly Welcome you to the Kenya and Tanzania
ss-Border Launch of Trachoma Mas Drug Administration July 2022

Cross-border Malaria Activities

- Support services
  - District-to-district planning, coordination and review meetings
  - District-to-district level sharing of malaria data
  - Strengthening of surveillance and M&E
  - Private sector reporting
- Periodic epidemiological analysis of each border district
  - Service delivery
  - IEC/BCC in identified locations
  - Synchronized implementation of interventions - LLIN distribution, IRS by districts
  - Diagnosis and case management of malaria at border posts
  - Follow-up of treatment compliance
  - Population screening
- Initiation of case/focus investigation, classification and response

WHO 2019

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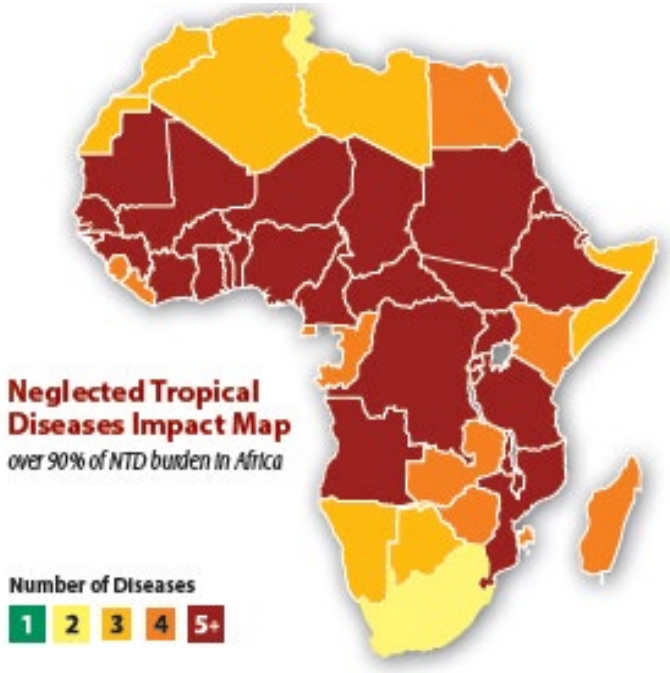
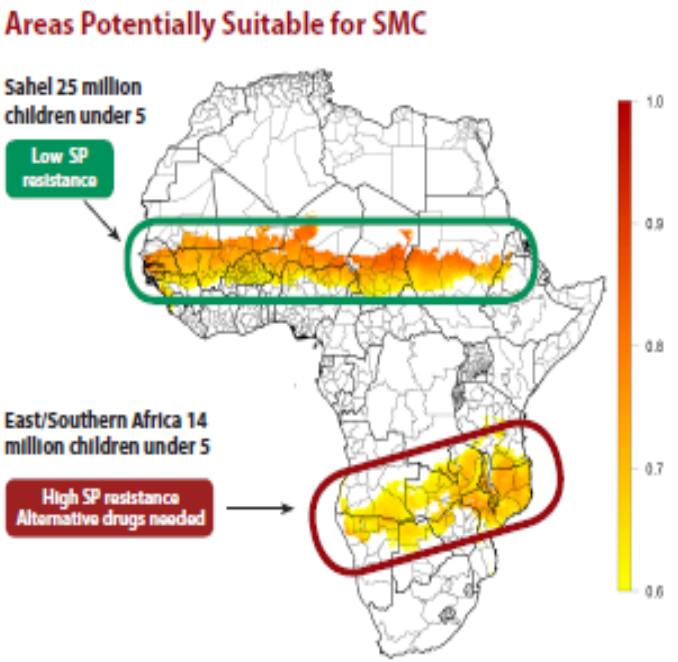
ORGANIZAÇÃO OESTE AFRICANA DA SAÚDE

SMC/NTD Project 2016-2020

Seasonal Malaria Chemo-prevention and NTD

August 17, 2022





SMC: Seasonal Malaria chemo-prevention

Fiche signalétique du projet

Titre du projet	Paludisme et Maladies Tropicales Négligées au Sahel
Objectif de Développement du Projet (ODP)	Accroître l'accès et l'utilisation des services à base communautaire harmonisés pour la prévention et le traitement du paludisme et de certaines maladies tropicales négligées dans les zones transfrontalières des pays bénéficiaires
Période de mise en œuvre et budget (BM)	2016-2020 : 121 millions US$. (OOAS $ 10 M)
Couverture géographique	56 DS frontaliers: Burkina Faso (20), Mali(19) Niger (17)
Partenaires	OMS, CAMEG-BF, OOAS (Coordination Régionale)
Principales stratégies d'intervention	IEC/Diagnostic et Tt du paludisme à base communautaire (CPS),Tt intégré des MTN, Tt conséquences réversibles MTN

SMC/NTD Project (PMTN Project)

- World-Bank funded project of 2016-2020 in 3 countries: Burkina Faso, Mali, Niger
- Increase access to and use of harmonized community-based services for the prevention and treatment of malaria and certain NTDs in cross-border areas of beneficiary countries
- Strategies :
  - IEC/BCC interventions
  - Integrated treatment of NTDs
  - Treatment of the reversible consequences of NTDs
  - Community-based malaria diagnosis and treatment
  - Seasonal Malaria Chemo-prevention (SMC)

Measures at Regional Level

GINGER CREDES

PROJET PALUDISME ET MALADIES TROPICALES NEGLIGEES AU SAHEL

MISSION D'APPUI À L'OOAS DANS LE SOUTIEN ET LA COORDINATION DES COMITÉS TRANSFONTALIERS DANS LES TROIS (03) PAYS (BURKINA FASO, MALI ET NIGER)

MANUEL POUR L'EXECUTION DES ACTIVITES TRANSFRONTALIERES AU NIVEAU DES DISTRICTS FRONTALIERS

THE WORLD BANK
IBRD • IDA | WORLD BANK GROUP

- Established cross-border committees in the three project beneficiary countries
- Organize regional joint planning meeting for the implementation of interventions in the countries
- Organize planning and evaluation meeting for cross-border activities
- Developed Manual of Procedures for the execution of cross-border activities in border health districts
  - specifies the procedures and methods for planning, implementing and monitoring and evaluating cross-border activities
- Support visits by WAHO
- Joint synchronized cross-border supervision

Measures at Country Level: Niger

- Cross-border planning meeting for activities with Burkina Faso, Mali and Niger in Tillabéry
- Organization of workshops to harmonize data collection tools
- Development of supervision plans for teams at the border
- Synchronized launch of campaigns
- Campaign evaluation meeting with all stakeholders

Photo : Equipe de distributeurs de médic. CPS au Niger (Tillabéry) en 2019

Photo : Réunion transfrontalière pour la CPS entre le Niger et le Mali à Ansongo (au Mali) en 2019


Projet Paludisme et Maladies Tropicales Négligées au Sahel
(P/MTN)
THE WORLD BANK
Réunion d'évaluation et de planification des activités transfrontalières,
entre le Burkina Faso, le Mali et le Niger dans le cadre de l'organisation
des campagnes de la Chimio-prévention du Paludisme Saisonnier (CPS)
02 - 04 avril 2018 \ Dosso, Niger
« Ensemble pour l'élimination du Paludisme et des Maladies Tropicales Négligées au Sahel »
PROJET
« Paludisme et Maladies Tropicales Négligées au Sahel »
(P/MTN)
DRSP Adjoint Dosso

Centralized Drugs Supply at CAMEG

August 17, 2022

Management of campaign inputs with CAMEG Redeployment of inputs from one country to another to compensate for the delay in delivery by CAMEG

Service delivery outputs

- 100% coverage for ≥ 3 rounds of CPS in children < 5 years old
- 81% (70% expected) of children < 5 years who had fever during the last 2 weeks preceding LQAS and who received an RDT for malaria
- 100% of health districts having organized an annual integrated treatment of Schisto and helminthiasis for the benefit of school-age children (5-14 years)
- 100% (90% expected) of health districts having initiated SMC campaigns
- >21,374,179 beneficiaries, including 2,956,870 (51%) women beneficiaries of CPS and 6,675,341 (51.1%) women beneficiaries of MDA/MTN
- > 6060 cases of Trichomatous Trichiasis operated on;
- > 1160 cases of operated hydroceles;
- > 90% coverage rate in preventive chemotherapy among the eligible population for onchocerciasis, schistosomiasis, helminthiasis, lymphatic filariasis and trachoma

Project Evaluation report 2021

Best Practices

- Cross-border meetings for coordination and monitoring of the epidemiological situation (BFA, MLI, NER)
- Strengthening of cross-border surveillance of malaria and NTDs
- Joint launch of cross-border campaign
- Establishment of mixed inter-country teams in border areas
- Joint supervision of at border level
- Joint campaign evaluation meetings between border districts
- Regular community engagement
- Integration: SMC with nutrition; malaria and NTDs

Challenges

- Difficulty in scheduling synchronized campaigns
- Occurrence of the COVID-19 pandemic
- Insecurity in the border regions of Mali, Burkina Faso and Niger
- Insufficient resources to scale up results
- Absence of published policy framework on cross-border collaboration in malaria or health

Lessons Learned

- Joint planning of activities allows better organization of the campaigns
- Joint inter-country supervision during campaigns allows for better sharing of experience
- Dissemination of sensitization messages through local media helped with community buy-in
- Centralised procurement of inputs allows rapid redeployment of drugs and logistics as needed

Next Steps

- Review and update tools and procedures
- Develop integrated cross-border health policy
- Solicit funding under new project funded by African Development Bank covering NTDs in cross-border areas
- Developed a resource mobilisation plan for the Sahel Malaria Elimination Initiative, with support of ALMA

Senegal-Gambia Collaboration

Collaboration: Senegal and border countries

- Context
  - National Malaria Control and Elimination Plan (Strategic Plan 2021-2025: objective of reducing malaria morbidity and mortality by 75% compared to 2019)
  - Common borders with 5 countries: Mali, Mauritania, Guinea Bissau, Guinea and Gambia
  - Significant cross-border migration
  - 29 border health districts out of 79 (36.7%)
- Activities between Senegal and The Gambia
  - Establishment of 57 Prise en charge à domicile (PECADOM) sites in 3 border districts
  - Synchronized distribution of LLINs in 2019 and 2022
  - Establishment of a platform for data exchange and sharing
  - Sharing of case investigation tools (SOPs) in the pre-elimination zone to harmonize case investigation procedures
  - Convening of exchange meetings at the operational level in border district

Launch of LLIN campaign at the Senegal -Gambia border, 2022

August 17, 2022

Launch of synchronized distribution of LLINs – World Malaria Day 2022

NMCP Senegal 2022

Conclusions

Improving cross-border collaboration

- Conscious determination to prioritise cross-border collaboration in national programmes
- Disaggregate national data by border districts
- Include cross-border collaboration in existing grants and mutually agree funding arrangements
- Monitoring cross-border activities is included in the Sahel Malaria Elimination Initiative scorecard
- Regional support: technical guidance; coordination

Summary

- Cross-border collaboration an essential component of regional and global malaria elimination initiatives
- Malaria elimination cannot be achieved and sustained in isolation by any country
- Cross-border populations experience multiple diseases and tend to have limited access to care
- Experiences with cross-border collaboration: a PMTN project 2016-2020 and on-going collaboration between Senegal and Gambia
- Facilitators: High political will; joint planning, coordination, supervision; regular availability of logistics; data sharing
- Opportunity for bilateral or multilateral cooperation within the region
- Need for strengthened surveillance in cross-border districts

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ORGANISATION OUEST AFRICAINE DE LA SANTE
ORGANIZAÇÃO OESTE AFRICANA DA SAÚDE

Thank you

Merci

Obrigado

Acknowledgments: some adapted RBM slides; SMC country presentations; WAHO PMTN Project

Presentation on the Zero Malaria Business Leadership Initiative

ZERO MALARIA

BUSINESS LEADERSHIP INITIATIVE

CRSPC West Africa Meeting – July, 2022

THE PRIVATE SECTOR:
A PILLAR IN THE FIGHT AGAINST MALARIA

Impact on the Economy

Malaria reduces GDP growth by up to 1.3% per year.

Staff absentism, reduced productivity, and lower purchasing power of existing and potential clients.

Companies have a direct interest in participating in malaria control and elimination efforts.

Contributing to National Development Efforts

Companies can contribute to meeting malaria targets, have a direct impact on the well-being of the population and create more favorable conditions for long-term social and economic development.

Through their contributions, companies can strengthen their image and reputation

Securing new sources of financing is essential.

Even if the Global Fund's target of $18 billion is met, there will still be a 22% ($28.6 billion) financial gap for the implementation of national TB, HIV and malaria control programs.

Finding new partners and funding sources is critical to meeting malaria reduction targets.

About the initiative

ZERO MALARIA | BUSINESS LEADERSHIP INITIATIVE

Led by Ecobank Group and Speak Up Africa and in collaboration with the RBM Partnership to End Malaria, the *Zero Malaria Business Leadership Initiative* supports the second pillar - private sector engagement - of the *Zero Malaria Starts with Me* campaign, which was launched in 2014 in Senegal and endorsed by the African Union in 2018.

The *Zero Malaria Business Leadership Initiative* was launched in July 2020 and aims to stimulate private sector engagement in the fight against malaria in Africa.

Initial project implementation period: 2020-2023

RBM Partnership To End Malaria

Ecobank The Pan African Bank

SpeakUpAfrica.

Objectives

- Promote private sector resource mobilisation for national malaria control and elimination efforts in Africa.
- Create a network of business leaders committed to contributing to advocacy and communications efforts in the fight against malaria.
- Leverage Ecobank's networks, clients and partners to bring new resources & partnerships to the table.

ZERO MALARIA | BUSINESS LEADERSHIP INITIATIVE

Intervention Countries

- Phase 1 (launched in 2020-2021)

Senegal

Burkina Faso

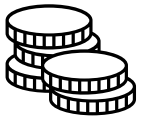
Benin

- Phase 2 (launch in 2022)

Ghana

Uganda

HOW CAN COMPANIES CONTRIBUTE?

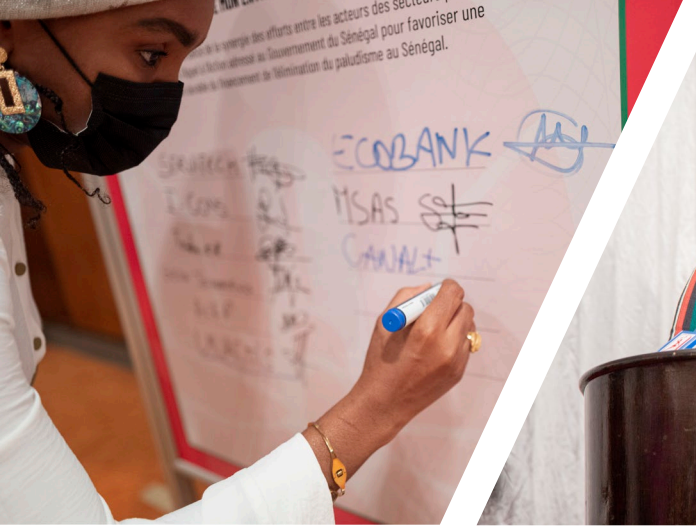


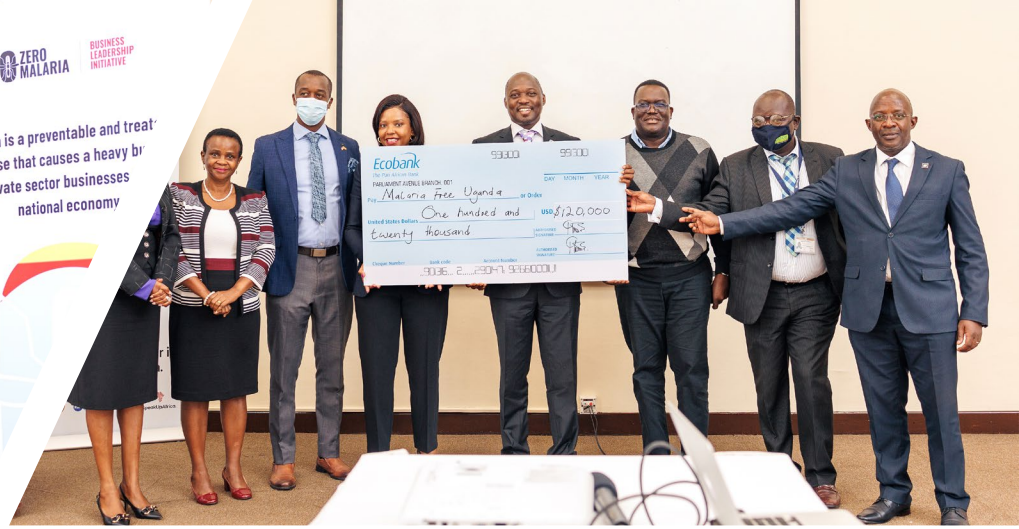
1. Contributing financially to the *Zero Malaria Fund* to help fill gaps in the national strategic plan. Companies may be eligible for the Ecobank matching scheme ($120,000 per country).

2. Contributing in-kind to meet a specific need of the national strategic plan (e.g. mass communications, community sensitisation, transport/logistics, provision of malaria commodities).

3. Implementing a programme for staff and their families (e.g. provision of mosquito nets, access to rapid diagnostic tests, case management, awareness raising etc.).

4. Implementing a malaria control project in a geographically defined area according to the needs of the NMCP (e.g indoor residual spraying (IRS), mosquito nets, intermittent preventive treatment (IPT), awareness raising campaigns etc.)





National Advocacy Events

- Official launch events and private sector roundtables held in each country.
- Major multi-sector advocacy event in Benin hosted by Vice President.
- Development of multi-sectoral national advocacy strategies in each country.
- Engagement of Parliamentarians in Ghana and Benin with a view to establishing parliamentary caucus' / networks.
- Participation in National Corporate Social Responsibility Forum in Benin
- Engagement of umbrella organisations in Senegal and Benin

Sensitization and communication

- Multi-sectoral TV discussions organised in each country.
- Thought-leadership: series of op-eds and interviews with private sector leaders.
- Series of text messages sent (total of 4.5 million) by telecom. company MTN (value of $34,000).
- Distribution of cash collection boxes & communication materials in participating companies' work sites.
- ZMBLI Day: Ecobank Benin staff wear branded t-shirts every Thursday.

Zero Malaria Champion : Hon. Ake Natonde (Benin)

- Parliamentarian, President of the Commission on Education and Social Affaires; Head of the High-School of Commerce and Management
- Engaged as champion since 2021, bridging public and private sectors
- Donation of 1000 mosquito nets
- Facilitated engagement with 20 parliamentarians with a view to setting up a parliamentary malaria network
- Facilitated advocacy opportunities with the parliamentary budget commission
- Governmental malaria provision increased by almost 40% from 2021-2022 (1.3 billion CFA → 1.8 billion CFA)

ZÉRO PALU ! | LES ENTREPRISES S'ENGAGENT

"Le paludisme est un tueur silencieux mais que l'on peut éliminer en faisant porter nos voix. Aujourd'hui, nous sommes dans un contexte où les ressources externes deviennent de plus en plus rares et où le secteur privé à l'échelle des pays impaludés doit jouer son rôle. En tant que Champion du programme « ***Zéro Palu*** », je lance un appel à mes collègues Députés pour qu'ensemble nous soutenions les entreprises dans leur élan de contribuer à l'élimination du paludisme au Bénin."

Honorable AKÉ NATONDÉ
Député à l'Assemblée nationale
Président de la Commission de l'éducation, de la Culture, de l'emploi et des affaires sociales
Promoteur de la Haute École de Commerce et de Management (HECM)

Examples of companies' contributions

1. Canal+ (Senegal & Regional)
2. IAMGOLD (Senegal)
3. ICONS (Senegal)
4. Univers Bio Médical (Burkina Faso)
5. Camp Guezo Pharmacy (Benin)
6. Pharmaquick by ABT
7. SMEs contributing to the *Zero Malaria Fund* in Benin

1. Canal+
(Senegal & Regional)

- Engagement since 2021
- Donation of 1000 mosquito nets
- Co-production of a documentary on the fight against malaria and the « Zero Malaria Ensemble » concert in April 2021
- Free broadcasting of sensitization videos throughout francophone Africa and in Senegal (in local language)
- Reach: over 60 million viewers
- Total approximate value of in-kind contributions: $140,000

2. IAMGOLD (Senegal)

- Mining company operating in highest burden zone of Senegal (Kedougou)
- Implementing a malaria projet in zone of Saraya, including indoor residual spraying, door-to-door sensitation & community mobilisations, provision of medications.
- Cost of projet : $48,000

3. ICONS (Senegal)

- Construction company operating in many regions of Senegal, including in one of the highest burden regions, Kolda.
- Signature of 3 year MOU to support NMCP's National Strategic Plan.
- Action plan for 2022 includes:
  - Contributing to transport of mosquito nets for mass distribution campaign;
  - Training of community relays on malaria testing and treatment;
  - Provision of bicycles to facilitate travel of community relays between villages;
  - Conducting community sensitization activites.
- Cost of action plan : $12,000

4. Univers Bio Medicale (Burkina)

- Donation of 100,000 rapid diagnostic tests
- Value of $70,000

5. Camp Guezo Pharmacy (Benin)

- One of biggest pharmacy chains in Benin
- Program to protect employees (104 mosquito nets provided)
- Zero Malaria Champion Dr Annabelle Hounkponou Ekue, MD of Camp Guezo Pharmacy, invited 15 other companies to participate.

6. Pharmaquick by ABT

- Significant reduction in price of mosquito nets.
- 129 000 nets sold
- Value of contribution: $250 000

PHARMAQUICK®

INDUSTRIE PHARMACEUTIQUE

7. SMEs contributing to the *Zero Malaria Fund* in Benin

- Polyclinique St Vincent de Paul
- Pharmaquick By ABT
- ACIS SAS
- $20,000 now available for NMCP budget gaps
- 7 companies currently implementing annual action plans

Summary of Results (2021-2022)

- $600 000 as Ecobank matching funds across 5 countries.
- $550 000 mobilised from private sector companies in financial or in-kind contributions
- 40 companies committed to supporting fight against malaria between 2022
- Network of 5 business leaders committed as champions of the fight against malaria.

Looking forward

- Next phase of the campaign in 2023, possibility of launching in new countries (depending on funding).
- Continue to follow up with companies engaged in initial 5 countries and seek to engage new companies.
- Explore ways to reach larger numbers of companies through umbrella organisations.

Through multi-sectoral action we can achieve a malaria-free Africa, improve the living conditions of millions and drive social and economic development!

ZERO MALARIA | BUSINESS LEADERSHIP INITIATIVE