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AMP Annual Partners' Meeting

Day 2 – 8 April 2025

Réunion annuelle des partenaires de l'APP

Jour 2 – 8 avril 2025

Rethinking the ITN status quo: Maximizing the impact on malaria

Repenser le cadre d'utilisation des MII: pour un impact renforcé contre le paludisme

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Meeting will begin shortly – la réunion va bientôt commencer

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Interpretation / Interprétation

Please select your language now – Veuillez sélectionner votre langue maintenant

You may choose between: English or French

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In person participants:

- 1 headphone and receiver per person
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Participants en personne :

- 1 casque et récepteur par personne
- Chaîne anglaise : Sélectionner 1
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Remote participants:

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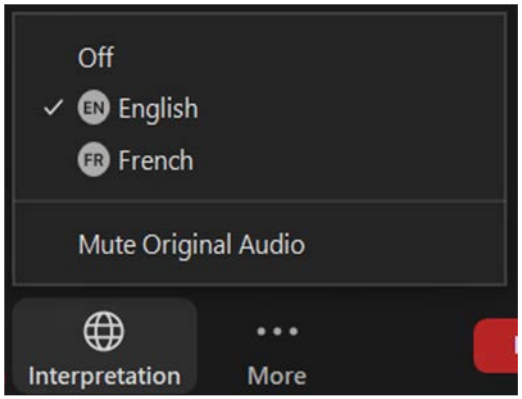
Participants à distance :

- Chaîne anglaise : Sélectionner 1
- Chaîne française : Sélectionner 2



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Annual Partners' Meeting

Rethinking the ITN status quo: Maximizing the impact on malaria

Day 2: Assessing effectiveness and impact

ITN distribution channel selection and optimizing channels in use

Tuesday, April 8th

Channel selection to address emerging gaps within evolving funding context (1)

- When considering channel selection to address emerging gaps within an evolving funding context, it's crucial to adopt a strategic and adaptable approach.
- The most effective ITNs should continue to be selected according to insecticide resistance profiles.
- NMPs are encouraged, i**n line with use of data for decision-making** at sub-national levels, to explore optimal channel mixes to ensure sustained ITN access and use.

- **Selection of both ITN type and the optimal mix of ITN distribution channels is critical to maximizing impact.**

Channel selection to address emerging gaps within evolving funding context (2)

The main objective of channel selection is to provide guidance for NMPs and partners to

1. Assess existing distribution channel capacity, effectiveness and efficiency in reaching and maintaining equitable access in the targeted populations.
2. Understand strengths and limitations of each channel and distribution strategy.
3. Determine the optimal ITN distribution channel and mix based on data and local context.

For more information
https://allianceformalariaprevention.com/resource-library/resource/insecticide-treated-nets-itn-distribution-best-practice-update/

Optimizing Channels Selected and in Use

Channel: ITN Mass Distribution Campaigns

Campaigns have been a key channel for rapidly scaling up access to ITNs. Generally, mass campaigns achieve high and equitable access to ITNs across populations.

Operational considerations: Campaign distribution strategies need to be tailored to the operational context. E.g. a door-to door approach in a hard-to-reach area may be most appropriate, while fixed site distribution may be best for a community in a more accessible area. Distribution in low burden areas, where needed, needs to be as cost-effective as possible to allocate scarce resources where they are needed.

Epidemiological and entomological considerations: Tailored strategies based on malaria epidemiological, entomological, and human-behavioural data are important for prioritizing resources to optimize ITN access.

Timing: ITN campaigns are typically planned with an interval of 30—36 months.

Optimizing Channels Selected and in Use

Channel: ITN Mass Distribution Campaigns

Operational efficiencies are critical within the current context

- Where operational costs are limited, learning from previous campaigns can inform efficiencies, e.g., Exploring options to
  - Leverage existing digital data from past ITN or other health campaigns to support key campaign activities
  - Use routine data to inform planning, quantification, and logistics
  - Return to consideration for
    - Integrated/targeted campaigns (including under five campaigns)
    - Changing ITN allocation approaches, raising the HH ITN cap
  - Combine microplanning and HH registration?
  - Strengthen planning and monitoring through strategic use of WhatsApp or other platforms to facilitate information sharing
  - Use virtual tools and meetings to support health system actors to gather data with lower costs

Optimizing resources = Saving lives

Assessing Channels Selected and in Use

Channel: ITN Distribution through Routine Health Services (e.g., ANC/EPI)

PMI VectorLink – Assessment Approach used for the four assessments

To be explored: Adaptation for implementation through existing communication channels and meetings

Evaluation questions

- To what extent is continuous ITN distribution implemented according to existing international best practice and national guidelines?
- What improvements could deliver immediate, mid-term and long-term efficiencies?

Adapted methods

- Desk review to inform development of discussion guide
- Teamwork approach (using WhatsApp and other tools) for data collection and analysis – leverage planned meetings with regional and district health authorities

Link: https://www.continuousdistribution.org/wp-content/uploads/2022/03/ITN-CD-Assessment-Toolkit.pdf

Assessing Channels Selected and in Use

Channel: ITN Distribution through Routine Health Services (e.g., ANC/EPI)

PMI VectorLink – Assessment Approach

To be explored: Adaptation for implementation through existing communication channels and meetings

Analysis Framework

ITN Continuous Distribution Assessment Framework

	Central	Region / District	Health facility
Exploration of all potential continuous distribution channels			
Planning and coordination		... and health system level	
Beneficiary identification			
Quantification and ITN supply			
Storage, transport and stock management			
ITN Distribution			
Personnel and capacity strengthening			
Supervision			
Data management	Learnings organized according to distribution function...		
Communication			

Cameroon Teamwork Approach

Sites		*Yaoundé* *North and Extreme North Regions* *Lagdo et Yagoua Health Districts*
Teams		***North**: Salomon Patchoke/NMCP, Mary Kante/PMI VectorLink, Laure Moukam, ACMS* ***Exteme North**: Raymond Tabue/NMCP, Eloi Oboussou, VectorLink (and AMP) Consultant, Albertine Lele/ACMS*
Interviews	**Central**	*Interviews with: NMCP, DSF, PLMI, WHO, UNICEF, PSM, Malaria No More*
	Region / District	*Interviews with:* - *Governor, Regional Technical Coordinator, and FPSP in Garoua ; Representative of the Governor, Regional Health Director and Regional Technical Coordinator in Maroua* - *District health team, Sous-Prêfet and Mayor in Lagdo* - *District health team, Malaria Focal Point, Surveillant Général, ANC lead in Yagoua*
	Health facilities	*Interviews with Health center directors and CHWs in Djippordé, Mayo Bocki, and Badankali (Lagdo) and in Dana, Yagoua, Gabaraye-Widigue (Yagoua)*

Optimizing Channels Selected and in Use

Channel: ITN Distribution through Routine Health Services (e.g., ANC/EPI)

Improving ITN access through routine health services ITN distribution

PMI VectorLink – Highlights of results from in-depth process assessments in four countries

- **Planning**: Develop or finalize and disseminate ITN distribution guidelines, instructions at all levels
- **Clarify eligibility instructions:** Clarifying which priority groups are eligible; reduce administrative burdens impeding receipt of ITNs (e.g., ID card requirements)
- **Supply chain**: Reinforce ITN requisition and "pull" systems, establish stock alert systems, minimum stock level indicators; add ITNs into national eLMIS (e.g. ZAMMSA)
- **Transport and storage** : Ensure last-mile ITN transport; collaborate with municipalities for ITN storage and transport, provide recognition and support

Optimizing Channels Selected and in Use

Channel: ITN Distribution through Routine Health Services (e.g., ANC/EPI)

Improving ITN access through routine health services ITN distribution

PMI VectorLink – Highlights of results from in-depth process assessments in four countries

- **Training:** Integrate on-the-job ITN training and modules with other health service delivery training (e.g., IPTp, case management)
- **Communication**: Provide malaria communication tools in health centers, for CHWs to promote ITN use
- **Supervision**: Include data verification checks during supervision visits to review and compare the number of ITNs received, the number distributed, the number in stock, and the numbers of beneficiaries seen
- **Data management**: Streamline the number of tools to track ITN stock and distribution

Note: AMP Toolkit for ITN distribution through routine health services (soon to be in progress), please reach out if you are interested in collaborating and/or providing country inputs.

Assessing Channels Selected and in Use

Channels: ITN School-Based Distribution (SBD) and Community-Based Distribution (CBD)

Key considerations: PMI VectorWorks Question table to guide choices (More on Day 3)

- Would it be practical for health facilities or community groups to conduct LLIN distribution as outreach activities? (Consider logistics and experience with running outreaches: Has it been possible to maintain outreach activities previously?)
- Is primary school attendance fair to good in some areas of the country?
- Even if attendance is not high, is primary school enrolment fair to good in some areas of the country?
- Are there any functioning community-based networks that could be modified to oversee LLIN distributions?
- Do you have serious concerns about feasibility or cost of ensuring a supply chain through any channel?

Other key considerations

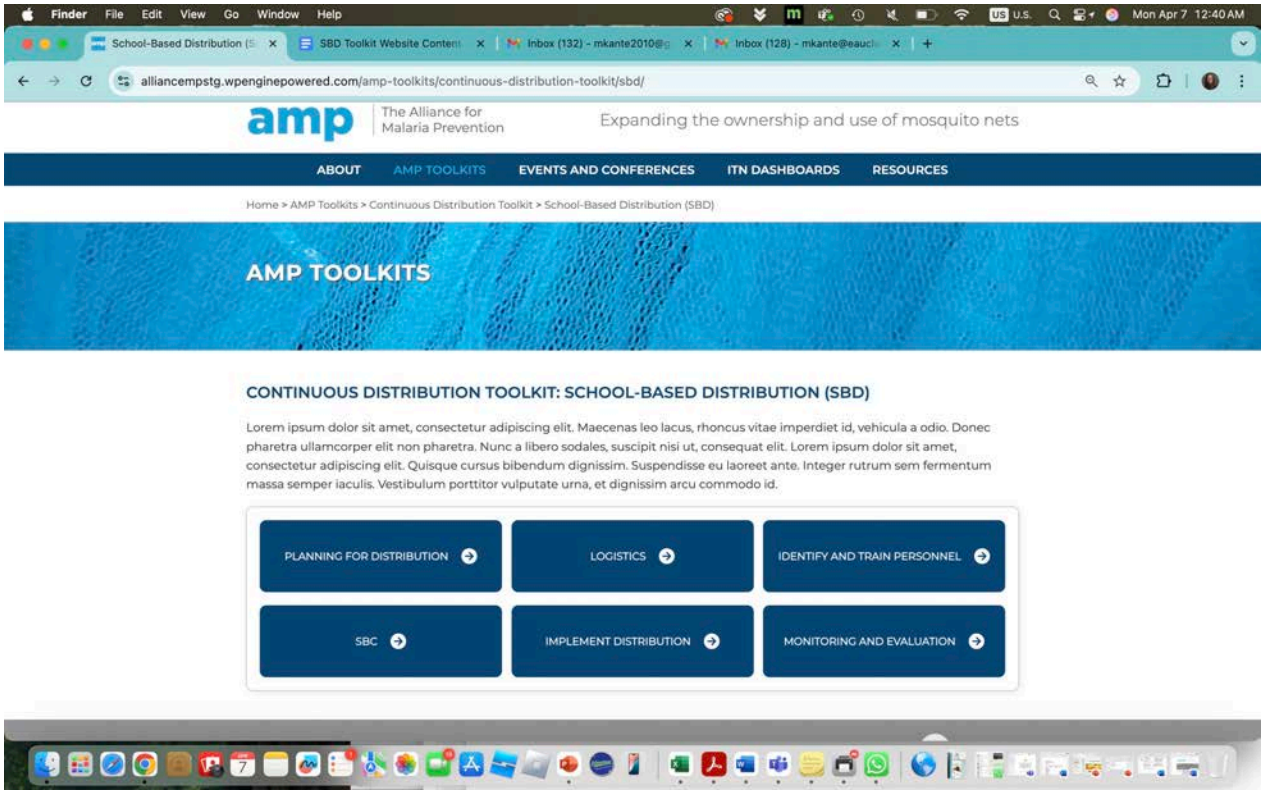
- Storage and logistical feasibility
- Channel efficiency
- Understand access to and quality of CHW networks and options to incorporate ITNs
- Considerations for flexibility and providing ITNs as needed
- Exploring the combination of iCCM and ITN distribution

Optimizing Channels Selected and in Use

Channel: ITN School-Based Distribution (SBD)

Progress on the ITN SBD Toolkit

The AMP Continuous Distribution Working Group has developed the draft ITN SBD toolkit, which will soon be available.



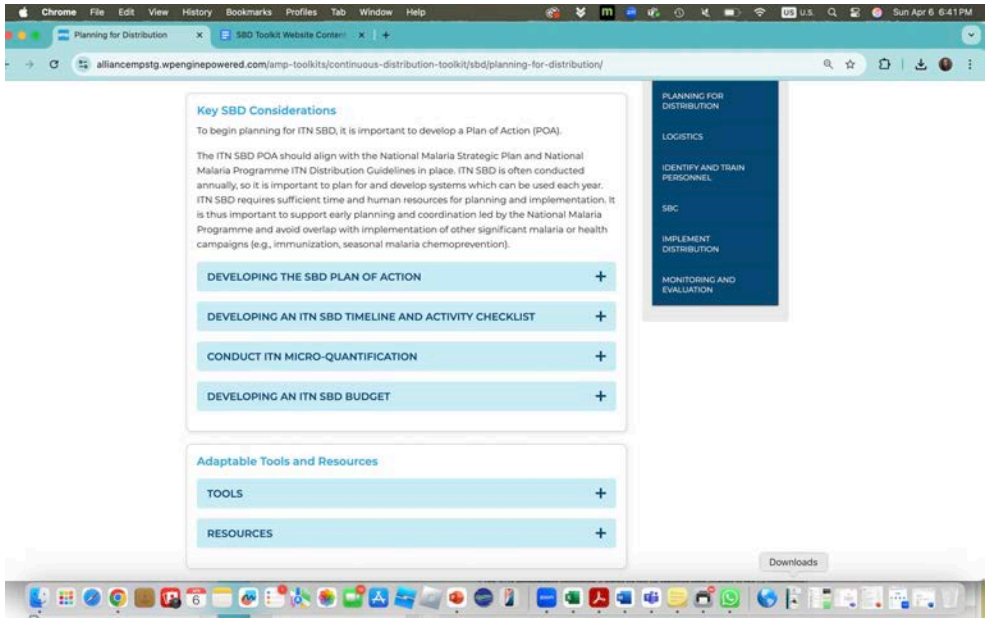
Optimizing Channels Selected and in Use

Channel: ITN School-Based Distribution (SBD)

Progress on the ITN SBD Toolkit

ITN SBD toolkit annexes – Adaptable tools

- **Plan of Action** template
- **Risk Assessment and Mitigation Plan** Guide and Excel Template
- **Terms of reference** (TORs) for ITN SBD human
- **Budget and Planning Checklist** for planning details, timeline and budgeting considerations
- **Timeline**



Optimizing Channels Selected and in Use

Recognizing country experiences and expertise

- **Burundi:** PNILP developed an approach to identify HHs with ITN gaps piloted in 2 districts.
- **Madagascar**: Building on a CHW program in place, the NMCP had included *Distribution communautaire continue* as part of its NMSP to fill in gaps in ITN access between campaigns.
- **Zanzibar**: Integrated ITN community distribution with reproductive and child health distribution. Health facilities serve as decentralized points for storage and issuing ITNs, as well as reporting and management of voucher/coupon supply.
- As will be presented next, following a pilot study and data analysis began, **Zimbabwe**, undertook ITN distribution through community channel using a coupon system (since 2017).

Optimizing Channels Selected and in Use

Other Channels – Direct distribution to vulnerable populations, Market-based and other options

Key considerations: PMI VectorWorks Question table to guide choices (More on Day 3)

- In the opinion of the stakeholder group, will some of the population be willing and able to pay for LLINs?
- Is there an existing retail net market that could be supported to expand and sell good-quality LLINs?
- Is there an existing retail market for other goods that has potential to be supported to distribute LLINs?

Other considerations

- Promotion of ITN culture and use
- Consider market-based options
  - Market facilitation to encourage pharmaceutical and FMCGs sales, e.g., in urban areas no longer covered by institutional distribution
  - Social marketing with low or non-subsidized sales

Future perspectives

The context continues to evolve.

Country-led expertise and experience will best guide the approaches to the questions and issues arising from the changes.

Coordination, creative approaches, optimizing the right mix of channels, assessing and strengthening each channel uses will all be necessary to maximize impact on malaria and save lives.

Questions for further reflection

- What are your impressions of and thoughts on the optimizing channels selected and in use presented?
  - Which proposed items may work better?
  - Or which may not be feasible?

- Which other ideas and innovations for operational efficiencies are you considering, or would propose for consideration?

- Quelles sont vos impressions et réflexions sur les canaux d'optimisation sélectionnés et utilisés présentés?
  - Quelles propositions pourraient être plus efficaces ?
  - Ou lesquelles pourraient ne pas être réalisables ?

- Quelles autres idées et innovations en matière d'efficacité opérationnelle envisagez-vous ou proposeriez-vous?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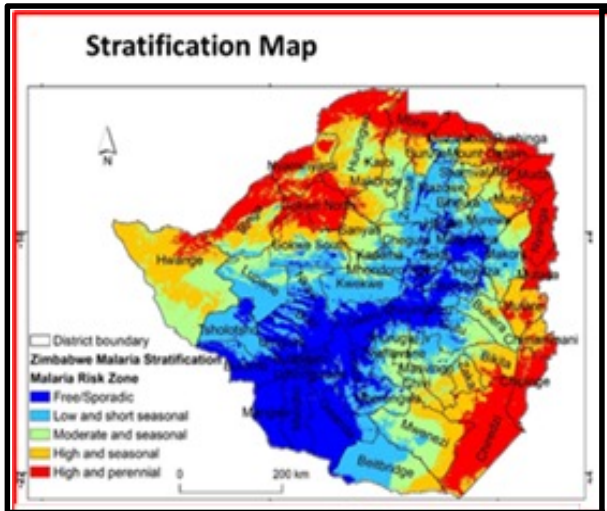
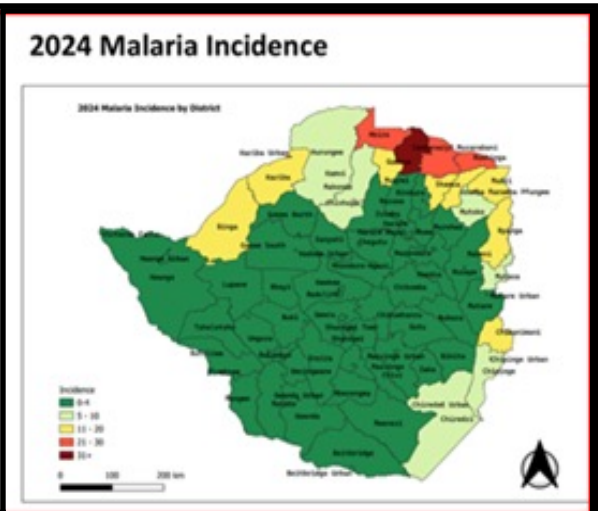
Assessment and selection of channels for ITN distribution in Zimbabwe

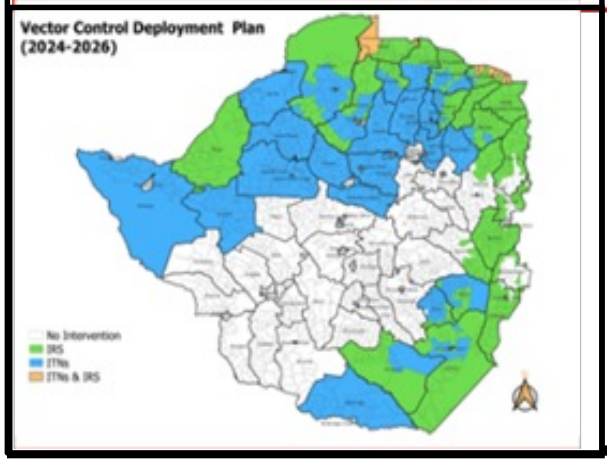
W. Chauke

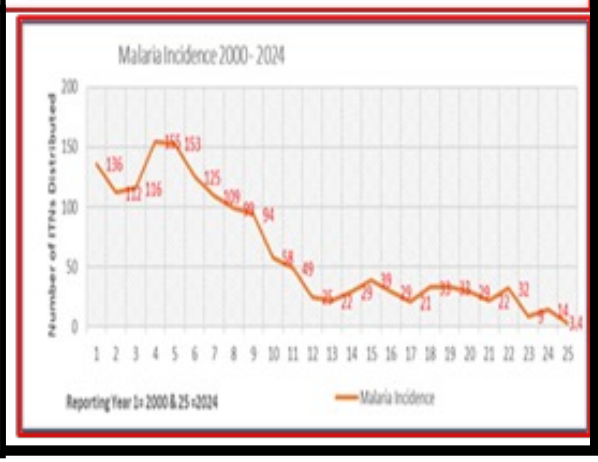
National Malaria Control Program, Zimbabwe

Malaria and Vector Control, Zimbabwe









- Zimbabwe is residence to above 15 million people (2022 census)
- **67.5%** live in known malaria transmission areas
- There are 5 transmission strata in the country (stratification map)
- Deployment of core vector control interventions is targeted based on the malaria burden – IRS targets areas with API of **≥5/1000** and ITNs in areas with **<5/1000** population (***NMSP 2024-2026***)
- Burden remains along the borders
- There is hope for malaria elimination in Zimbabwe should current funding levels and coverage be maintained (***API 2024 was 3.4/1000 population***)

Malaria Control Strategies in Zimbabwe

Malaria Control Measures in Zimbabwe

Vector Targeting Measures

- IRS
- LLINs
- LSM
- Environmental management
- House screening

Parasite Targeting measures in humans

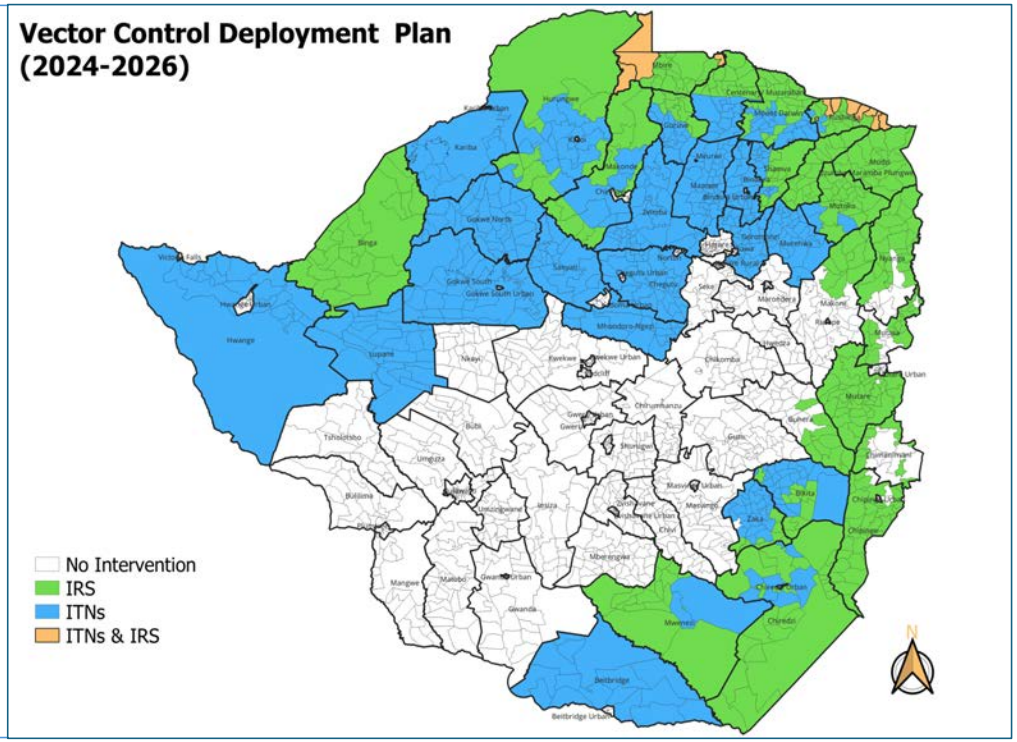
- Diagnosis & treatment
- IPTp
- MDA

Cross cutting methods

- SBCC
- Epidemic preparedness, detection & response
- Surveillance, Monitoring, Evaluation & Operational Research
- Programme management, Coordination, Partnerships

ITN Distribution – 1

- One of the core vector control interventions
- 48% of the population is targeted by ITNs and 23% IRS with 24% having no interventions (very low malaria burden – reactive response)
- Targeted mass ITN rolling campaign done to replace ITNs distributed 3 years back



ITN Distribution – 2

- 3 channels used – ANC, EPI and community
- ANC, EPI and Community are done continuously including in campaign years to address gaps in sleeping spaces
- Continuous distribution at facility level (ANC and EPI) and at the community level (Community Coupon system) is done in between campaigns following mass distribution to ensure universal access to ITNs by targeted communities
- Both CD channels (ANC, EPI and Community) were implemented starting 2017 on completion of pilot project

1. ITN Community Based Distribution by VHW

2. Centralized/fixed site Mass Campaign

3. Facility based EPI CD channel

The Process of Selecting Ideal CD Channels

- 2015 to mid 2017 – country conducted a pilot study for CD to determine channels for efficient delivery of ITNs
- Four channels tested: School targeting grades 3s and 7s annually, ANC, EPI (measles rubella vaccination) and community

Rationale for school channel

- Vulnerability with reasonable level of responsibility (grade 3)
- Grade 7, replacement of ITNs at 3 years and at exit of primary school

Rationale for ANC/EPI channels

- Vulnerability of pregnant women
- Motivation for institutional booking and deliveries
- Motivation for primary vaccination completion marked by measles vaccination

Rationale for community channel

- To cover the general population needs where pregnant women, school children and under 1 year olds are not available.
- Cover new sleeping spaces and ITN attrition

Pilot study: Scope and indicators measured

- 36 months study that sought to:

a. determine the value of CD post ITN distribution

- Number of people that received ITNs through CD post ITN Campaign

b. determine the CD channels that would optimize access to ITNs in between campaigns

- Number of ITNs distributed through each channel
- Availability of ITNs at H/H level by distribution channel

c. Assess ITN adequacy and utilization at H/H level

- Number of ITNs per at H/H level
- Number of people per ITN
- Number of people sleeping under ITNs

- Observation was that (i) H/H with legible school children had more nets than required (ii) More ITNs were found still in their packaging due to over supply (iii) Push system over supplied ITNs compared to demand as per need from the community

Decision to Select Community Channel viz School Channel

At close of the pilot study, data analysis was done using NetCalc application

- ✓ A consultant was engaged to take the country through the application
- ✓ Country need for CD was done, including anticipated coverage
- ✓ Contribution for each channel to the country need was determined from the pilot, mirroring results from NetCalc
- ✓ School channel was noted to have been over supplying ITNs compared to all other channels
- ✓ ANC and EPI only could not meet the country need
- ✓Community channel was a perfect match as an additional channel as it did not oversupply ITNs

- In 2017, the country adopted the community channel as one of the CD methods
- Community channel uses coupon system (1 coupon = 1 net or 1 sleeping space)

2022: Assessment of ITN distribution channels

- Zimbabwe conducts community distribution in the years between mass campaigns, to offset the loss of nets post-campaign, including creation of new sleeping arrangements
- Quantification for community was calculated for 2020-2023 to replace 8% of nets in the 1st year post-campaign, 20% of nets in the 2nd year, and 50% of nets in the 3rd year.
- This is the typical loss rate of nets post-campaign but is different from recommendations for continuous distribution.

RBM CRSPC Guidance

- In November 2022, RBM CRSPC issued guidance for countries (*CRSPC Guidance Note on malaria gap analysis tools*).
- Mass campaigns – no change in guidance:
  - Population in target area for the campaign /1.8
  - Consider including a 10% buffer if the census is more than 5 years old or use previous campaign data to justify a buffer.
- Continuous distribution

- "For community distribution between campaigns, quantification recommendations are available at the same link above, in the Scenario 3 section." pp 4

Minimum quantifier (population x quantifier, annually) to sustain ITN access at or above specified target level							
		Scenario 2 (full continuous distribution strategy)			Scenario 3 (continuous distribution between mass campaigns)		
		Targeted ITN access level:					
Country Code	Retention time (years)	70%	80%	90%	70%	80%	90%
DJI	1.0	29%	36%	43%	27%	34%	37%
LBR	1.0	28%	36%	46%	27%	35%	39%
SSD	1.0	29%	37%	44%	28%	35%	38%
TCD	1.0	29%	36%	44%	27%	35%	38%
AGO	1.1	27%	35%	45%	25%	32%	39%
BEN	1.1	28%	36%	43%	26%	33%	40%
MRT	1.1	23%	42%	46%	21%	27%	38%
BDI	1.3	25%	32%	41%	19%	26%	36%
ETH	1.3	25%	32%	38%	19%	26%	27%
MWI	1.3	24%	32%	41%	19%	26%	35%
MOZ	1.3	24%	31%	40%	18%	26%	35%
ZMB	1.3	24%	32%	41%	19%	26%	35%
COD	1.4	24%	30%	37%	17%	24%	25%
GNB	1.4	20%	33%	40%	13%	19%	34%
SEN	1.4	20%	34%	41%	14%	20%	35%
GIN	1.5	20%	30%	38%	11%	16%	31%
SLE	1.5	23%	30%	36%	16%	22%	24%
BFA	1.6	22%	28%	34%	14%	20%	21%
GMB	1.6	17%	27%	37%	8%	14%	28%
MDG	1.6	23%	27%	36%	12%	19%	26%
RWA	1.6	24%	28%	37%	13%	20%	28%

Zimbabwe-specific quantification guidance from CRSPC

- Given CD is done between campaigns in Zimbabwe, we look at Scenario 3 here
- Assuming the target is 80% ITN access, the quantification factor for CD is population x 5% in each year between campaigns.

Minimum quantifier (population x quantifier, annually) to sustain ITN access at or above specified target level

		Scenario 2 (full continuous distribution strategy)			Scenario 3 (continuous distribution between mass campaigns)		
		Targeted ITN access level:					
Country Code	Retention time (years)	70%	80%	90%	70%	80%	90%
ZWE	2.8	10%	16%	22%	0%	5%	12%

District X	2023	2024	2025	2026	2027
Population	400k	412k	425k	437k	450k
Quantification approach	Pop / 1.8 (campaign)	Pop * 5% (CD)	Pop * 5% (CD)	Pop / 1.8 (campaign)	Pop * 5% (CD)
ITNs for CD/mass	222,220	20,600	21,250	242,780	22,500

2024-2026 ITN quantification based on new RBM recommendations

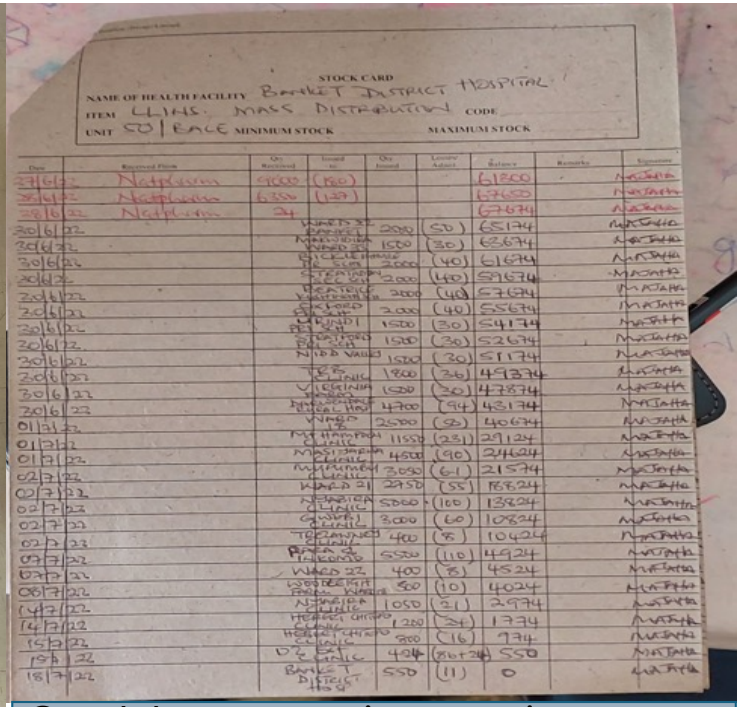
Unit	Community Channel	2024	2025	2026	Total
Population	Population targeted for mass campaign : use 51% of the projected endemic population (A)	6,145,591	6,207047	6,269,117	18,621,755
ITNs	ITNs quantified for NFM4 Funding Request for community channel: multiply the population (A) by 5%	307,280	310,352	313,456	**931,088**
	EPI	208,950	211,040	213,150	**633,140**
	ANC	235,069	237,420	239,794	**712,282**
	Total	**751,299**	**758,812**	**766,400**	**2,276,510**

Key Findings and Recommendations Community channel

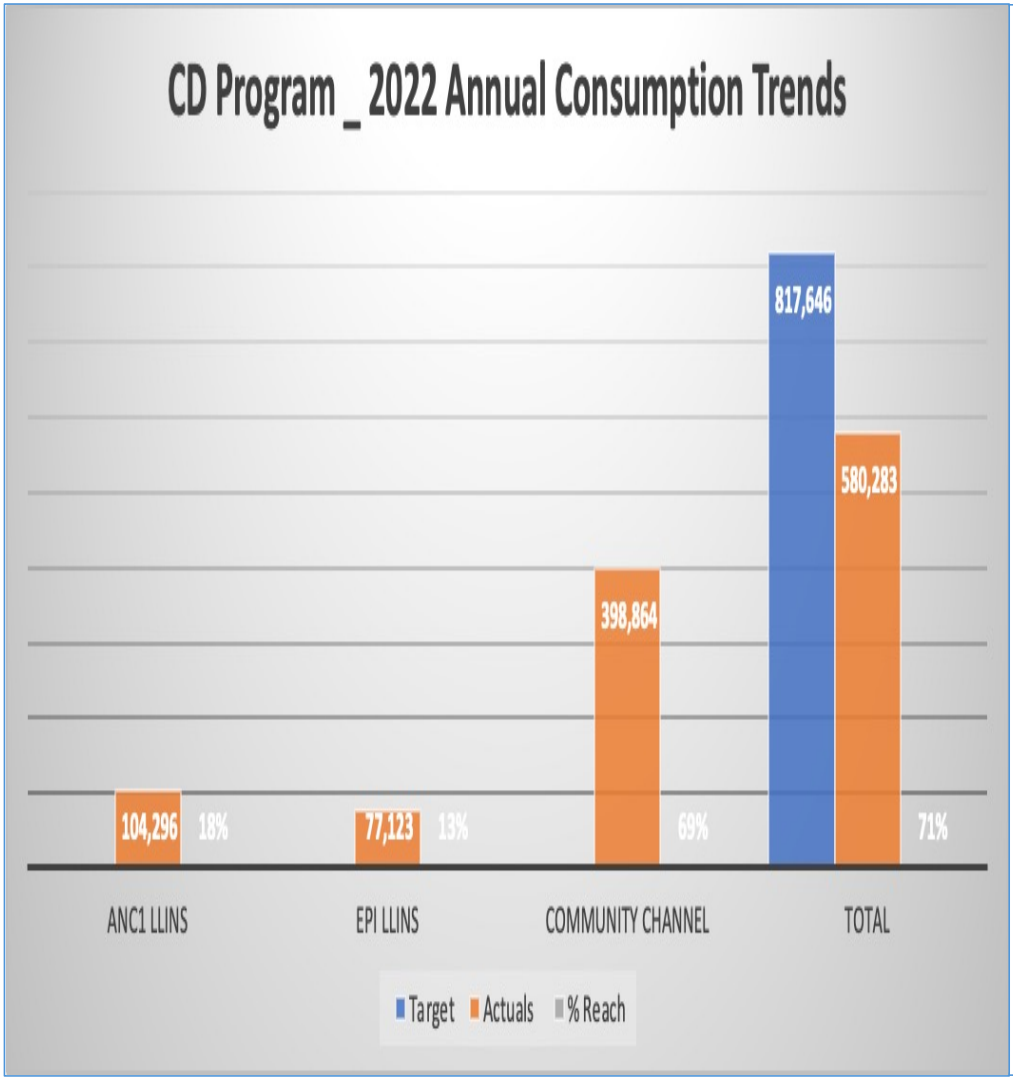
Assessment criteria	Observations	Recommendation	Action	Progress
Strengths	• Coupon system – criteria for eligibility/prioritizing • Reporting system	Emphasis to service providers that none should be missed.	DEHOs initiate regular reminders via feasible channels	Done. Regular reminders being done by both DEHO, DNO and ITN IPs
Areas of improvement	• Storage at outreach: VHWs are given few quantities of nets but no clear formula for allocations • Redemption of ITNs at facilities: Service providers do not review the coupons • Coupon eligibility criteria boxes sometimes not checked • Redemption of ITNs at outreach points: It solely relies on the VHW's perception • Districts do not review and analyze data • Limited supervision from district level • CD LLINs not recorded in the store books	• Need a clear guidance on quantities to be given to VHW • Orientation to district teams, service providers and VHWs • Clear guidance on type and level of analysis of data • Facility and household level monitoring	• A guide to determine quantities to be given to VHW • Job aids to guide coupon verification process prior to issuing ITNs to a beneficiary	Done. Based on population served, a VHW gets between 50 and 100 ITNs per month for the hard to reach communities. Trainings on CD done to cover recommended actions.

Key Findings and Recommendation

LLINs delivery and storage



Good documentation practice: copies of LLINs delivery are available. LLINs are recorded in store cards



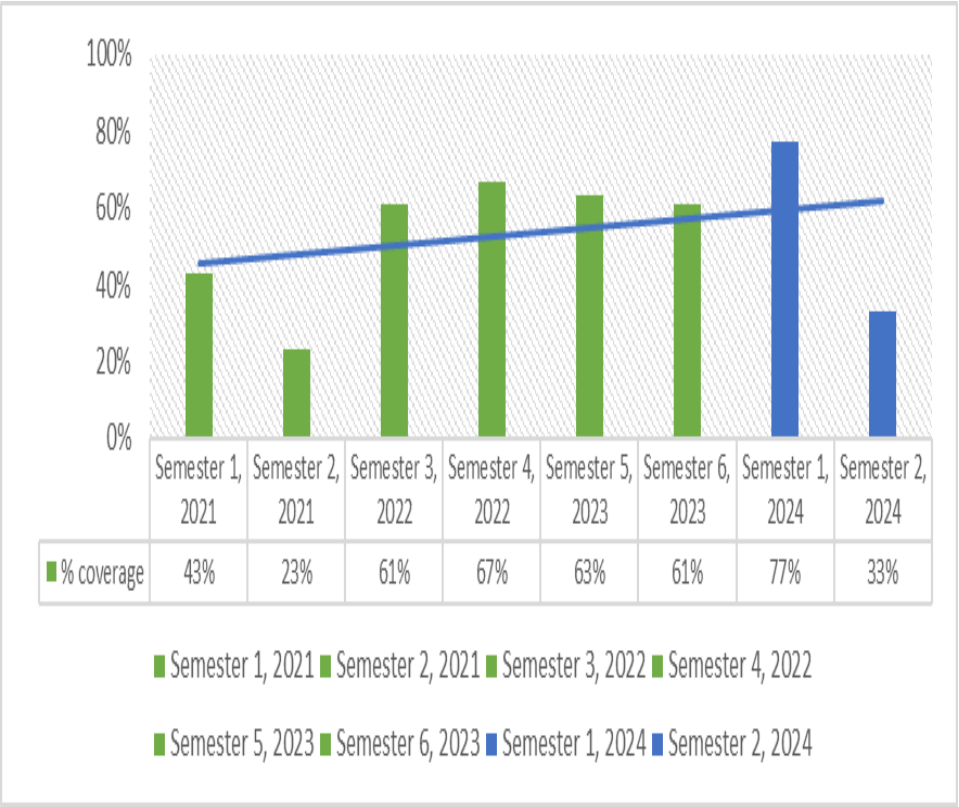
Findings from 2022 field assessment

- Overall, Zim distributed 71% of LLINs targetd for 2022.
- More LLINs (69%) were issued through the community channel as compared to ANC1+EPI which together count for 31%.

Questions

- Low coverage on ANC1 + EPI?
  - *Missed out? - YES, no formal column for ITNs in ANC register leading to poor records*
  - *Data quality? – YES (recording omissions)*
  - *LLIN stockouts? – YES, at times due to delays in requesting or deliveries*
  - *Quantifications? – NO*
- More LLINs through community channels
  - *Mass campaign missed out? - NO*
  - *Loose coupon redemption criteria? - NO*
  - *Data issue? Etc. – NO (more community [91.5%] than targeted 1st ANC and EPI = 8.5%)*

Impact of improved quantification and appropriate selection of channels



Year	Jan-June (peak season)	Jul-Dec
2021	43%	23%
2022	61%	67%
2023	63%	61%
2024	77%	33%

- 2022 saw an increase in CD coverage, a jump from 43% to 61%
- A steady increase was noted from 2022 through 2024 during peak transmission, from 61% to 77%
- The country had a countrywide shortage of ITNs in 2024 (July to October)

Lessons learnt

- **Community Channel**
- Have a strong community-based malaria component
- Use the structure to integrate ITN distribution
- Strengthen support systems for tracking performance and compliance for community level
- Engage community members for demand creation
- Collection points to be as close to the target population as possible.
- Have a consistent product supply to retain community confidence – keep the promise.

- **ANC/EPI channels**
- Data collection tools at service levels should be well defined and should have mandatory fields
- Integrate ITNs during outreach services for improved access and prevent missed opportunities
- Ensure a consistent supply of ITNs to avoid stock outs which may contribute to missed opportunities
- Strengthen interdepartmental collaboration i.e. Maternal and Child Health with NMCP for enhanced programme performance thorough supervision

Conclusion

- The adoption of the community channel over the school channel has made it possible for the community to determine their needs and minimise over subscription of ITNs which often results in misuse – community channel is demand driven instead of push system.
- The CBD system has also improved the ITN collection/coupon redemption rates, leading to more people accessing ITNs. Distance to health facilities is no longer a barrier or demotivator for collection of CD ITNs.
- With improvement in quantification for the community channel, there is more equitable distribution of ITNs across the targeted populations.
- The country envisions increasing distribution of ITNs as the country realizes significant decline in malaria cases to below 5 per 1000 population, a strategic criteria for the deployment of ITNs in Zimbabwe.

END!

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Discussion
Questions & Answers

Discussion
Questions et réponses

Remote participants:
Kindly use the Zoom Q&A feature to submit comments and ask questions, specifying the name of the speaker to whom the question is directed.

Participants à distance :
Nous vous prions d'utiliser la fonction Q&A sur Zoom pour soumettre vos commentaires et poser vos questions, en précisant le nom de l'orateur à qui la question est adressée.

Factors influencing routine ITN distribution and lessons learnt

Annual Partners' Meeting of the Alliance for Malaria Prevention

Gulshod Allabergenova, Monitoring & Evaluation Team Leader

UNDP-Global Fund Partnership and Health Systems Team (GFPHST)

8 April 2025

Agenda

- ❑ Background
- ❑ Overview of the programmatic performance of ITN distribution in 2022-2024
- ❑ Factors negatively influencing continuous ITN distribution
- ❑ Factors positively influencing continuous ITN distribution
- ❑ Lessons learnt
- ❑ Q&A

Background

- UNDP is the Principal Recipient of the Global Fund country-specific grants in 24 countries and 3 multi-country grants, with the total of 30 grants under management at present.
- 9 of these grants are implementing malaria interventions in the GC7 funding cycle.
- The continuous ITN distribution - a focus area since GC6 (due to its importance and numerous challenges).
- The 2023 Knowledge Exchange webinar.

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ITN distribution through mass campaigns in UNDP-GF grants in 2023

- In 2023, **14.9 million** ITNs were distributed through mass campaigns in 8 countries. 7 out of 8 countries have reported good or excellent, with an average of **95%** target achievement.
- Nearly **95%** of the total result is attributable to ITN distribution in Chad (9.71 million), Angola (2.84 million), and Guinea-Bissau (1.36 million).

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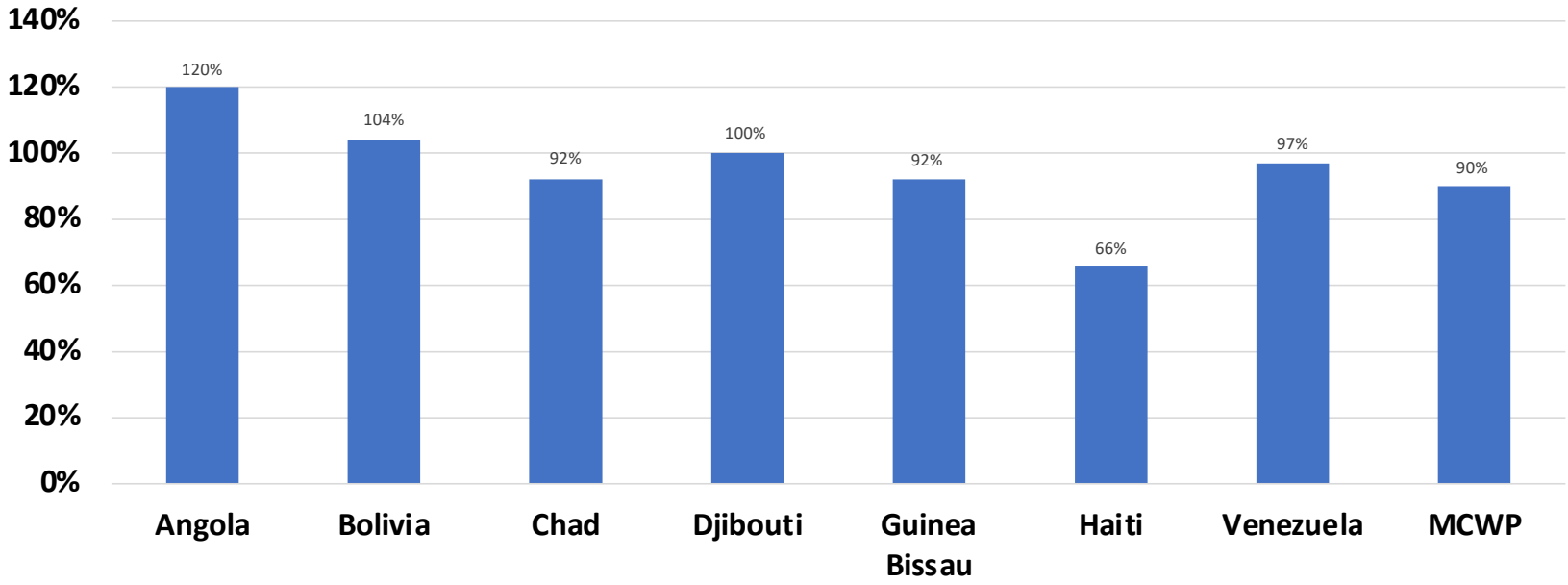

Programmatic performance (achievement ratio) of <u>continuous ITN distribution</u> to targeted risk groups – in 2022, 2023 & 2024

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GF Grant in:	S1_2022	S2_2022	S1_2023	S2_2023	S1_2024	S2_2024*
Afghanistan	116%	120%	88%	127%	78%	94%
Angola	15%	*Not due for reporting*		19%	22%**	91%
Burundi	78%	80%	90%	75%	77%	83%
Chad	20%	43%	54%	79%	69%**	94%
Guinea-Bissau	56%	54%	26%	45%	46%	75%
Haiti	25%	17%	24%	21%	17%	46%
Multi-country Western Pacific(MCWP)	*Not due for reporting*	77%	*Not due for reporting*	70%	*Not due for reporting*	100%
Venezuela	*Not due for reporting*	0%	*Not due for reporting*	36%	26%	120%

** The 2024 performance calculation is based on the PR-reported data (subject to the GF verification).*
*** Last GC6 period.*

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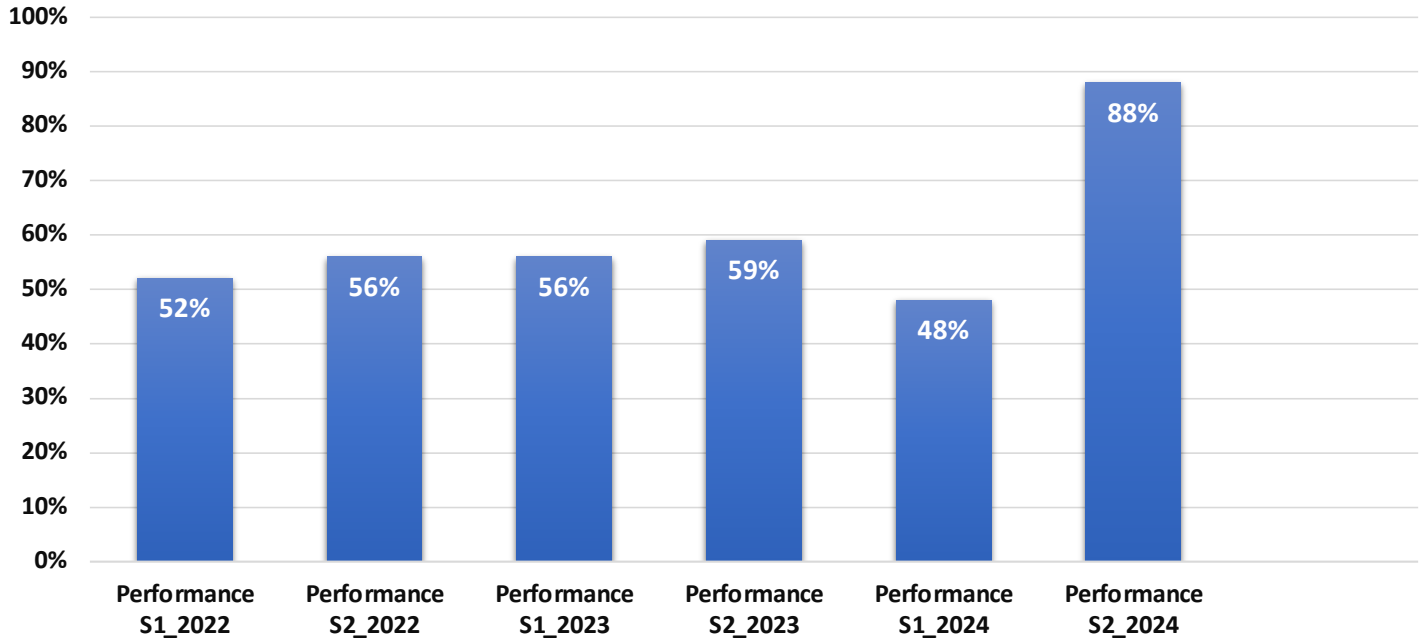
Continuous ITN distribution - average performance across the portfolio in 2022-2024



Factors negatively influencing continuous ITN distribution*

- ❑ Low coverage of ante-natal and immunization services
- ❑ Gaps in data collection tools and data entry deficiencies
- ❑ Sub-optimal stakeholder coordination and guidance to service providers
- ❑ Shortages and stock-outs of ITNs
- ❑ Fuel shortages (hampering the distribution, monitoring and supervision)
- ❑ Ambitious target-setting (impact of mass distribution in some countries)
- ❑ Differences in target beneficiaries between the program design and actual implementation

** Based on the key challenges reported by the PRs of Global Fund grants.*

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Remedial actions/measures taken or planned to address key challenges

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❑ **Addressing the low coverage of ante-natal and immunization services:**

Deploy strategies for boosting ANC and immunization attendance:

- community mobilization through radio communication campaigns and
- solutions to involve traditional healers.

❑ **Addressing ambitious target-setting:**

- Critically review the target setting assumptions and identify room for improvement.
- Initiate discussions with the donor based on the analysis of trends.

❑ **Ensuring alignment between targeted beneficiaries and actual beneficiaries**

Remedial actions/measures taken or planned to address key challenges

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❑ Addressing the Gaps in data collection tools and data entry deficiencies

- Enhancing data analysis and quality support activities at various levels of implementing partners.

- Conducting quarterly or biannual formative supervision on data quality.

- Printing and disseminating tools for reporting ITNs distribution data for all target populations (e.g. children under one year old).

Country example (Guinea-Bissau):

Issue: Continuous ITN distribution has historically shown low performance, particularly among children.

Diagnosis: In Semester 2 2024, the PMU, jointly with the National Malaria Program (NMCP), identified data gaps in DHIS2 compared to the monthly reports of the DRS (regional health directions).

Solution: a "data catch-up"(updating) process was initiated during regional monthly meetings in Q4 2024 and Q1 2025, and data updated in DHIS2.

Outcome: Data completeness improved, leading to an improved indicator performance.

Remedial actions/measures taken or planned to address key challenges

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❑ **Other remedial actions:**

- Routine and joint supervision activities.
- Quarterly distributions of ITNs from the main warehouse to health facilities.
- Seeking funds reallocation to enhance district-level supervision and problem resolution for distribution activities.

Factors positively influencing continuous ITN distribution*

- ❑ **Good coordination** between PR, NMCP (PNLP), SRs, and WHO (*"One team" approach*). The approach includes engaging a Primary Health Care Provider as an implementer and ITN distribution through midwives (Afghanistan).
- ❑ Support a **stronger collaboration** between NMCP (PNLP) and the Immunization Program, as well as the Maternal and Child Health Program (Guinea-Bissau).
- ❑ **Engage stakeholders at all levels** – using modern technologies. Setting up WhatsApp groups at different levels – (1) connecting central level with provincial malaria focal points and (2) district-level groups linking up Health Facility managers.
- ❑ **Timely reporting** (Monthly technical and consumption report) by health facilities combined with **regular data analysis** and **follow-up** both at provincial and central level (comparing set targets and ANC visits) (Afghanistan).
- ❑ **Clear guidelines** on the target groups, and **specific instructions** and forms on **distribution** and **recording** (multiple grants).

** Based on successful experiences reported by the UNDP PRs*.

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Country examples

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❑ **Clear guidelines on the target groups, and specifics of distribution and recording.**

Country example (Chad):

Issue: Continuous ITN distribution continuous had weak performance.

Diagnosis of one of the root causes: The ITN distribution was not systematically done during the first contact with the target populations at the health facilities.

Solution: Special circular was issued by the Secretary-General of the MoH in mid-2023 with a clear explanation of the issue, its impact and concrete guidance

Outcome: The S2 2023 performance on this indicator went up from 54% to 79%

Note: The improved outcome is attributable to a number of corrective measures implemented in response to detected obstacles.

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SECRÉTARIAT D'ÉTAT
SECRETARIAT GENERAL
PROGRAMME NATIONAL DE LUTTE CONTRE LE PALUDISME
VISA ADMINISTRATEUR-GESTIONNAIRE

Unité-Travail-Progrès

N°392/PT/PMT/MSPP/SE/SG/PNLP /2023

N'Djamena, le 21 JUIN 2023

Note de service
À l'attention des Délégués Provinciaux de la Santé publique et de la Prévention

Objet : Distribution des MILDA aux groupes cibles

Messieurs les Délégués,

Les données des activités de lutte contre le paludisme indiquent un grand écart entre le nombre de femmes enceintes venues à la CPN et celui de MILDA qui leur ont été distribuées. À titre d'exemple, en 2022, sur 664 518 femmes enceintes enregistrées à la CPN1, 263 413 seulement ont bénéficié d'une MILDA chacune, soit 40%, alors que 1 086 640 MILDA ont été mises à la disposition des FOSA pour les deux (02) groupes.

Cette situation résulte du fait que de nombreux agents attendent la fin du processus de vaccination et de suivi de la grossesse avant de remettre les MILDA aux bénéficiaires. Cette approche ne favorise donc pas la lutte contre le paludisme dans la population des femmes enceintes et des enfants de 0 à 11 mois. C'est pourquoi nous vous recommandons de bien vouloir instruire que les MILDA leur soient remises dès le premier contact.

Je compte sur votre sens de responsabilité pour une bonne protection des populations cibles contre le paludisme.

Le Secrétaire général du Ministère de la Santé publique et de la Prévention

DABSOU GUIDAOUSSOU

Lessons learnt

- ❑ Involvement of the key actors in the process of programming and *throughout* implementation is essential.
- ❑ Investment in developing / revising data collection and reporting forms usually pays off!
- ❑ Regular data analysis and follow-up helps diagnose bottlenecks and catalyse improvements.
- ❑ Monitoring of ITN availability and distribution practices provides useful inputs to enhance implementation and to shape future programming.
- ❑ Monitoring longer-term epidemiological trends helps prioritizing the target groups and geographies in the context of limited resources.
- ❑ Reviewing and re-validating target-setting assumptions is encouraged.

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Acknowledgment for contributions

- UNDP Afghanistan – Dr Ahmadwalid Sediqi, Malaria Programme Officer and Dr Sayeddaoud Mahmoodi, Monitoring & Evaluation (M&E) Associate
- UNDP Chad – Ms Aicha Mohamed Ali, M&E Specialist and Mr Ole Bagamla, M&E Analyst
- UNDP Guinea Bissau – Ms Ghislaine Grasser, M&E Specialist

- Q&A
- Feedback and suggestions

AMP 2025 Annual Partners' Meeting

Implementation performance of ITN distribution through the Health Facilities in Tanzania: five years (2018-2022) experience

Mövenpick Hotel & Residences Nairobi
Sarit Centre | Nairobi | Kenya

Presenter; M. P. Gitanya
NMCP, Tanzania

April 2025

Presentation outline

- Overview
  - ✓ National ITN strategic approach
  - ✓ Background
- Methodology
- Results
- Discussion /conclusion
- Recommendation

National ITN strategic approach

The strategy

Goal Deploy vector control interventions (ITNs) aimed at contributing towards the reduction of malaria disease burden (NMCP 2021-2025)

Strategy Ensure universal access (>80%) ITNs according to malaria transmission settings via; (Health facilities (ANC & EPI), school net programs, and mass campaign) ITN distribution channels.

Aim

- Reduce prevalence from 8.1% settings to <3.5% by 2025 (TDHS 2022)
- Eliminate Malaria by 2030

Background

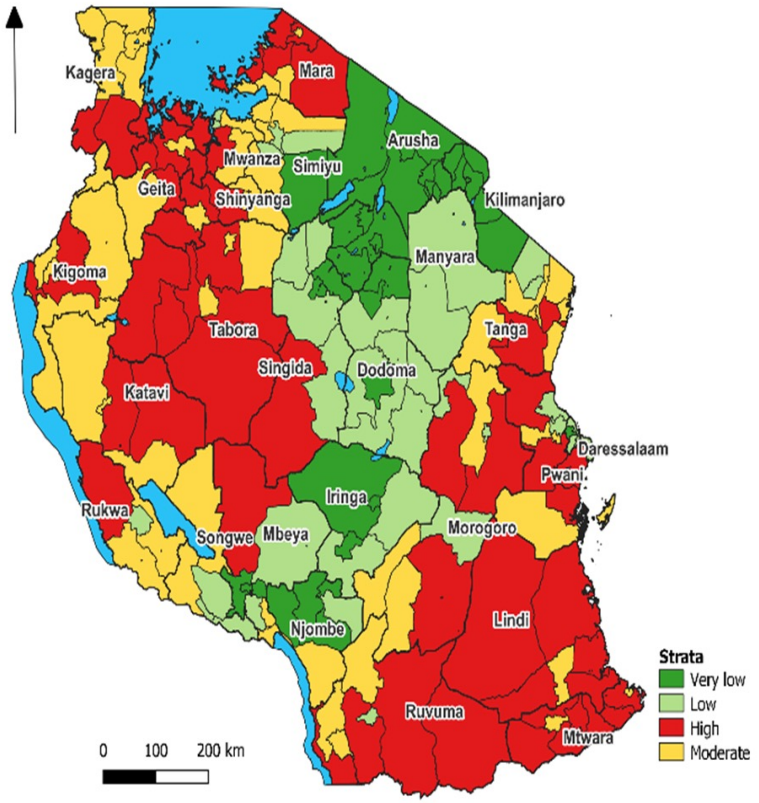
- Global efforts to lessen the malaria burden in low-income countries include the distribution of Insecticide-treated nets (ITNs) (*Bhatt S, et al. 2015.)*
- Routine ITN distribution through reproductive and child health services (RCH) at health facilities helps to increase and sustain optimal ITN access (at least 80%) *(Miller JE, et al.. 2022)*
- Routine ITN distribution targets vulnerable populations: pregnant women (PW) during their 1st antenatal clinic (ANC) and infants during their 1st dose of measles-rubella vaccination at the Expanded Program for Immunization (EPI)
- Re-introduced in the year 2016 in mainland Tanzania
- All HFs with RCH services issue ITNs to all PW and infants (100%)

Background ...

- The effectiveness of ANC and EPI ITN distribution channels in issuance rates has yet to be assessed and documented for publication over time in mainland Tanzania.

- Aim of the study
  - Analyzed the historical rates of ITNs' issuing through HFs at ANC and EPI from January 2018 to December 2022

- *On the right, Tanzania malaria burden stratification map-2023*



Methodology

- Monthly health facility data on routine ITN health facility distribution was retrospectively extracted from DHIS-2 for all 26 regions of mainland Tanzania

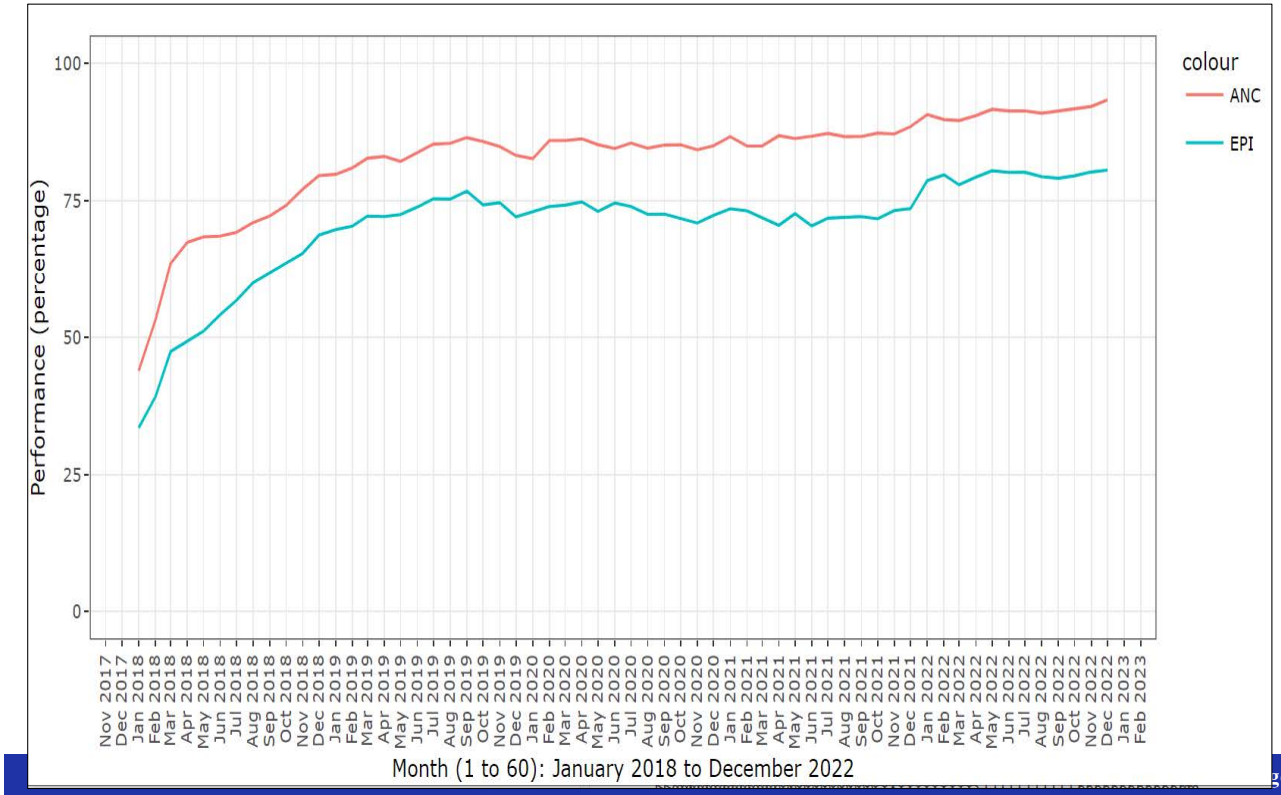
- A total of 6790 health facilities were included in the analysis

- Performance was categorized as "good" if all (100%) women or infants at a particular health facility who attend ANC or EPI received ITNs, or "poor" if some or all women or infants did not receive ITNs in a given month separately
- Descriptive and inferential statistical analyses were conducted to assess the health facilities' performance (issuing rate) on ITN distribution at ANC and EPI across;
    - times, regions, facility level, facility ownership (public/private), settings (rural/urban), and malaria transmission strata over the five years.

- Using "R" a generalized estimating equation was used to model the marginal performance trend over time for ANC and EPI separately

Results

General trend for ANC and EPI issuance rate from January 2018 up to December 2022



- In most regions, performance improved markedly in the first year but later gradually increased
- Region-wise, Ruvuma region had the best performance across the years, almost 100%, while the Dar es Salaam region had the lowest performance for both ANC and EPI respectively.
- Significant increase in the performance of ITN distribution, however with variation between ANC and EPI
- Issuing rates started at 44% and 34% in 2018 and increased to 93% and 80% in 2022 for ANC and EPI, respectively
- Average issuance rate of 83% and 70% ($p<0.001$) for ANC and EPI respectively

Results…

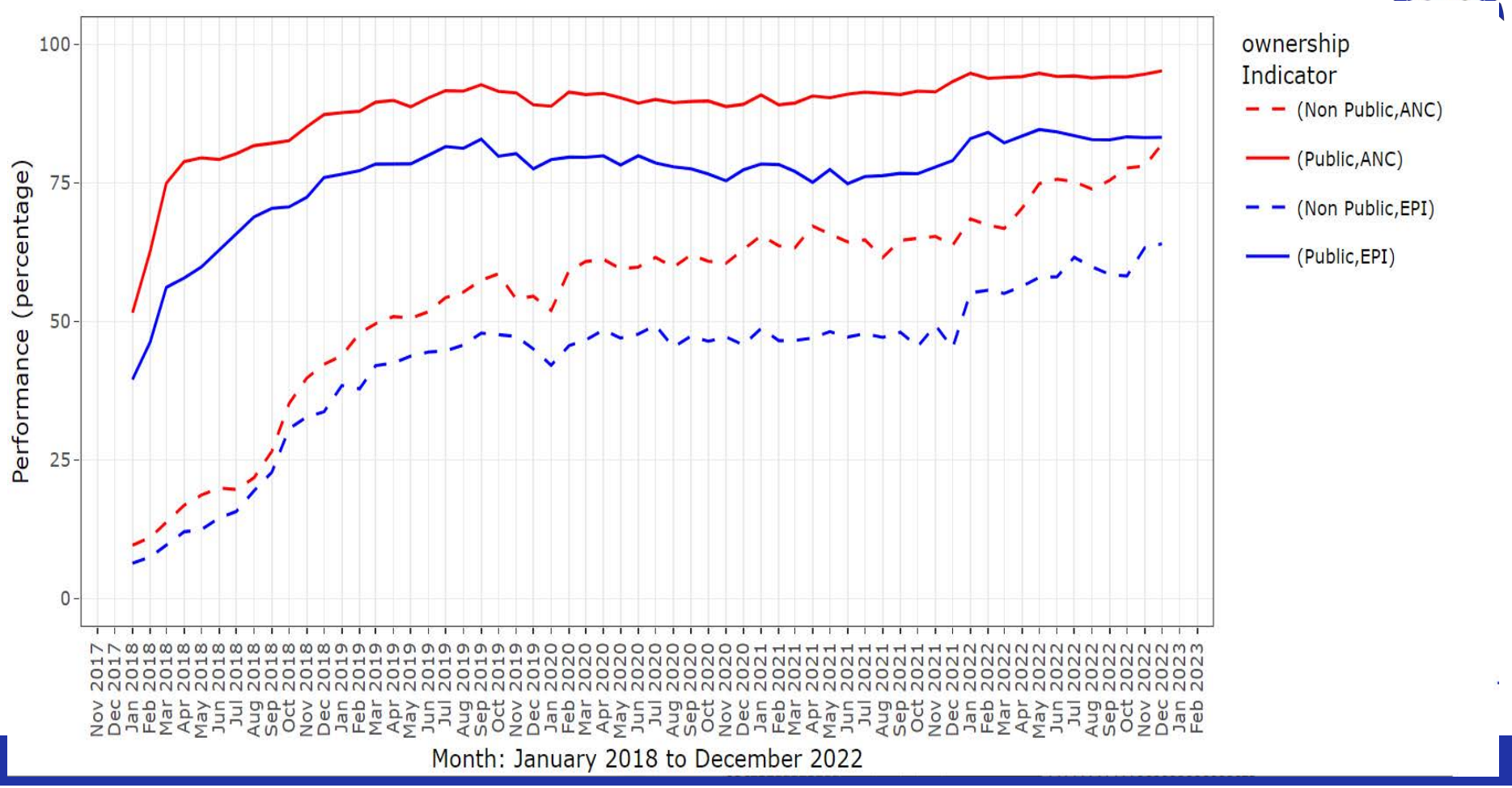
- Surprisingly, rural areas had higher performance (72%) during ANC visits compared to urban areas (51%) ($p<0.001$)

- Across epidemiological strata, ITN issuing rates during EPI activities were notably higher in high (79%), moderate (76%), and very low (65%) compared to low (54%) transmission epidemic strata ($p<0.001$)

- Dispensaries and health centers performed better than hospitals and clinics for ANC and EPI issuance ($p<0.001$)

- Over the five-year average, the public facilities performed better for both ANC (88%) and EPI (76%) compared to private facilities (53% and 42%, respectively; $p<0.001$)

Monthly trend of ANC and EPI ITN issuance rate by facility ownership (public and private) from January 2018 to December 2022



Discussion/conclusion

By 2022, Tanzania substantially improved the ITN issuance rate via ANC and EPI in all health facilities compared to 2018

There was an increase in ITN issuing rates over five years for both ANC and EPI, with strong acceleration in 2018, followed by more gradual improvements until reaching 93% and 80% in 2022 for ANC and EPI, respectively

Further efforts are needed to achieve 100% performance across the regions

Future studies to explore the reasons for differences among analyzed variables in ITN issuing rates will help to understand additional characteristics of high-performing facilities

Discussion/conclusion…

- However, the observed ANC and EPI ITN distribution did not achieve the set National (NMCP) goal of 100% ITN issuance rate, because of various factors, similar to other studies (*Nuñez L, et al 2023*), that impeded optimal ITN distribution performance at facilities, such as:
  - Inadequate data documentation
  - Facility ITN stockouts
  - Health facility ownership (public & private)
  - Facility-level i.e. hospitals, health centres, dispensaries, and clinics
  - Facility settings (urban & rural), and
  - Malaria risk epidemiological strata

Recommendations

Mentorship and orientation

1

Region and council health teams should regularly conduct mentorship and orientation to the health facility providers and facilitate the logistics management process

Quarterly data review

2

Quarterly data review should be an ongoing activity to strengthen stock management and improve data quality

Further studies

3

To identify the facilitators and barriers to ITN issuance rate and use that would provide valuable contributions of ITNs in malaria control

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All Financing & Implementing Partners

Research Institutions

All Others ..

TVCA

PORALG, MoFP & MoEVT

Community

Regional/District Teams

Distribution scolaire de MII et plan de passage à échelle

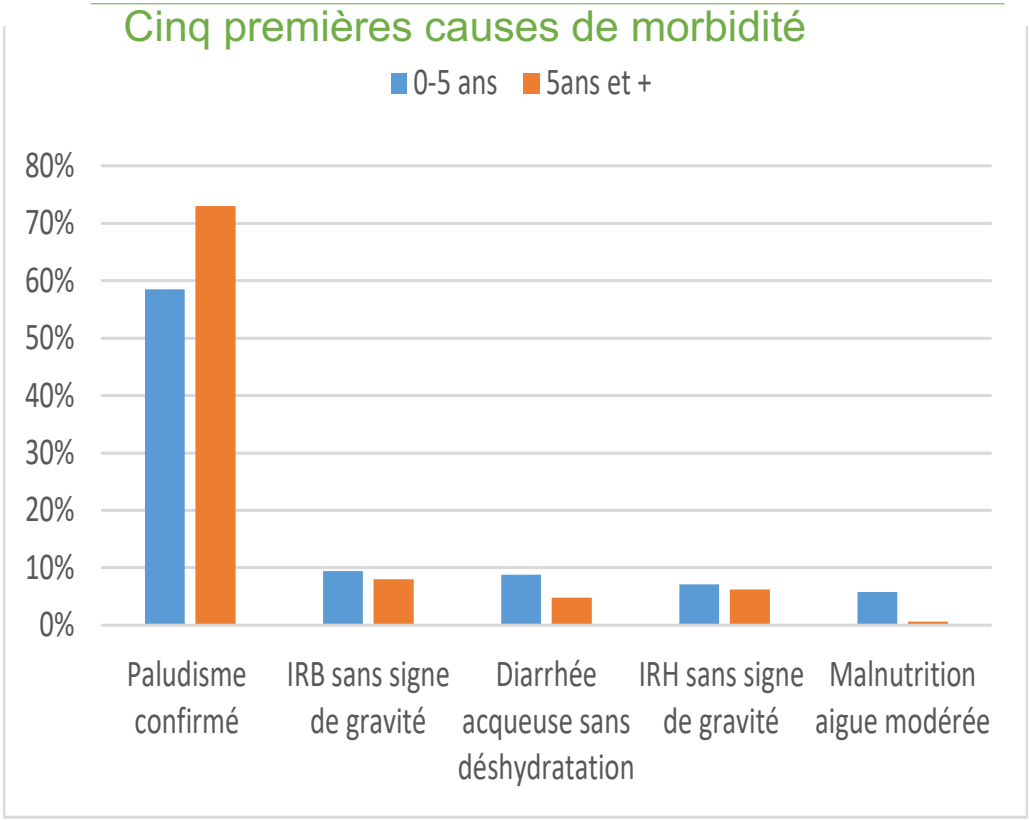
Dr Pascal BAKAMBA, Cooronnateur PNLP
Dr Marcel LAMA, Assistant Technique
Mattieu AWI, World Vision International
Dr Patrick BONGO, Croix Rouge Francaise

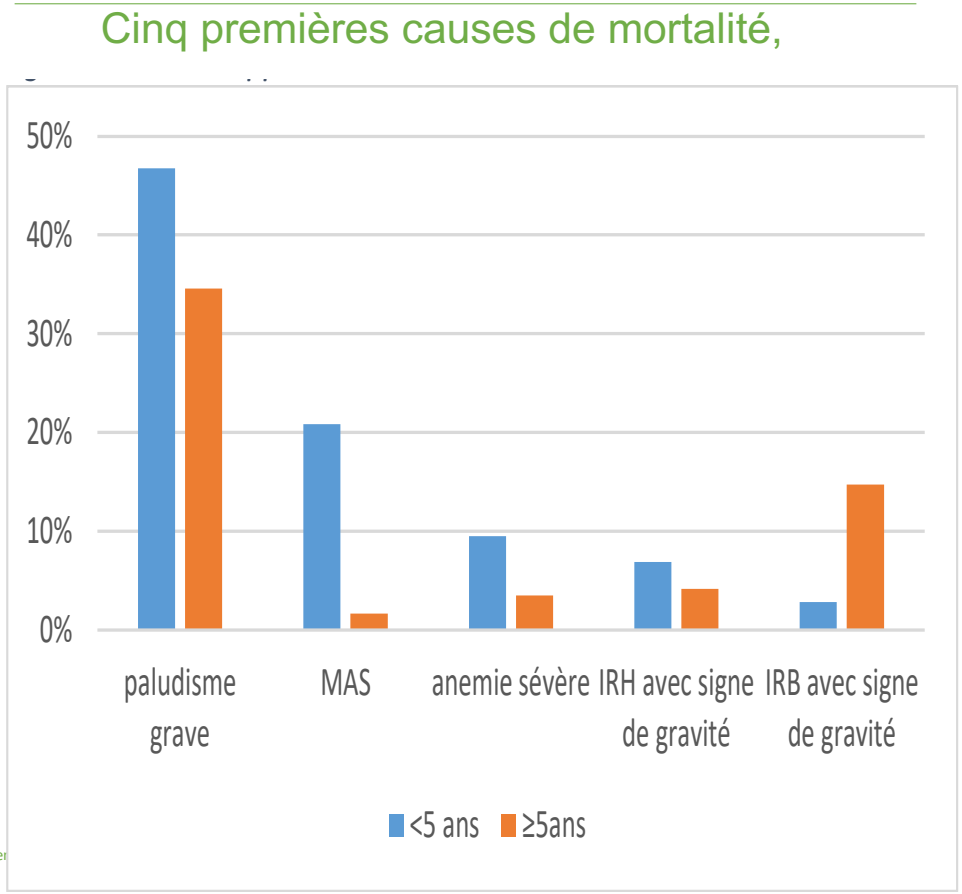
Plan de présentation

- Contexte
- Objectifs de la distribution dans les écoles
- Mise en œuvre de la distribution scolaire
- Résultats
- Prochaines étapes
- Conclusions

Contexte: morbidité et mortalité

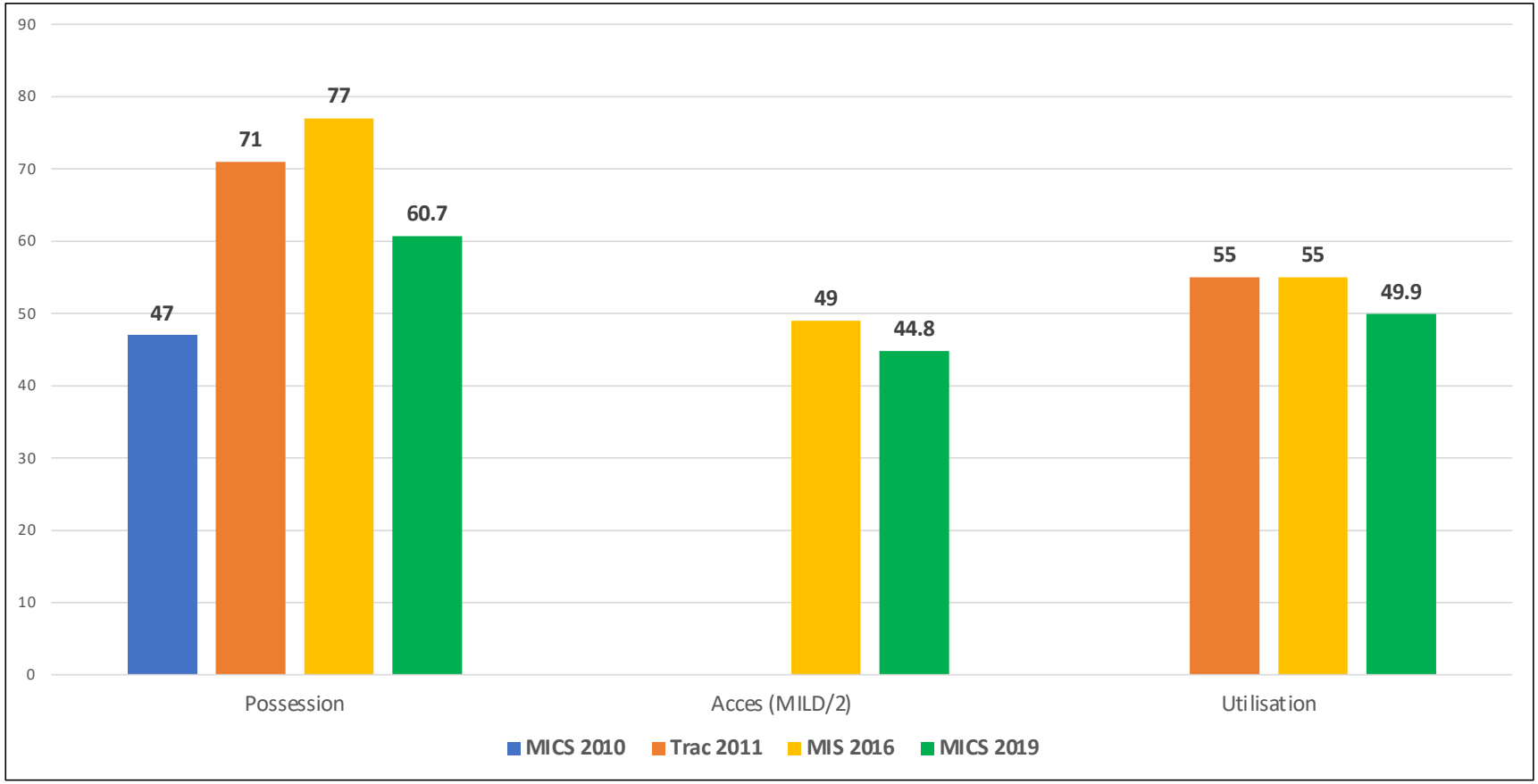
- **Paludisme: Transmission haute et stable dans tout le pays**





Source: SNIS 2021

Contexte: Couverture en MII



Contexte: Durabilité des MII et approches de rattrapage pertes de MII

- **Pertes de MILD (OMS):**
  - Un an: 8%
  - Deux ans: 20%
  - Trois ans: 50%
- **Raisons de perte*:**
  - Déchirée: 63%
  - Donnée aux parents: 34%
  - Autres utilisations: 1%

*Koenker et al. Malaria Journal 2014, 13:464, http://www.malariajournal.com/content/13/1/464

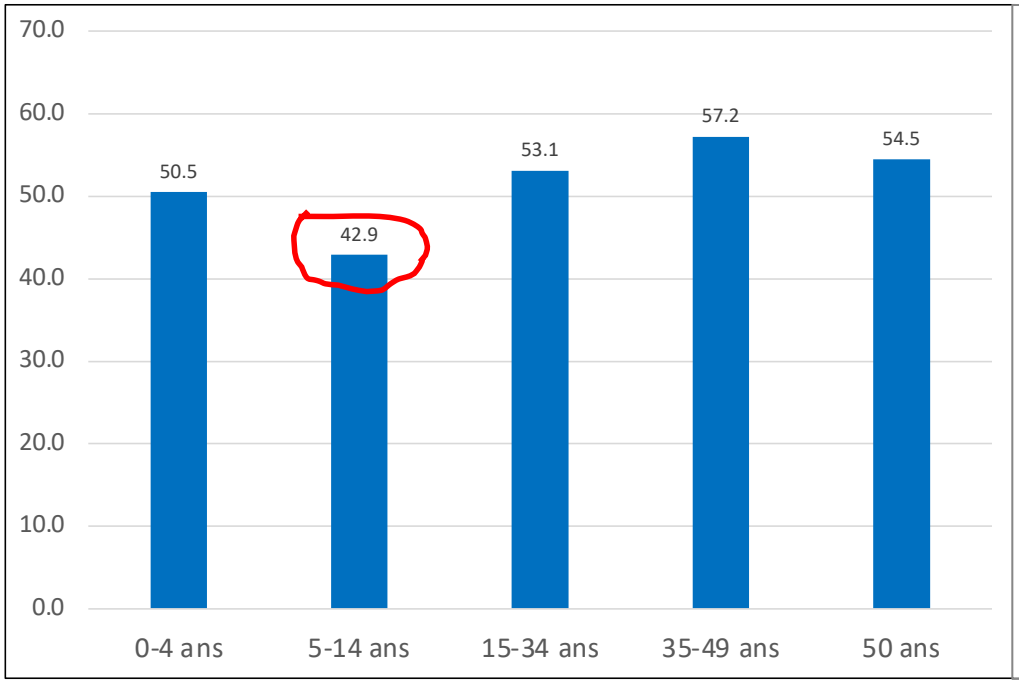
Durée	Bonne condition	Efficacité insecticide
18 mois	77%	90%
24 mois		68%
32 mois	32%	52%

Castellanos *et al. Malar J (2021) 20:219* https://doi.org/10.1186/s12936-021-03722-1

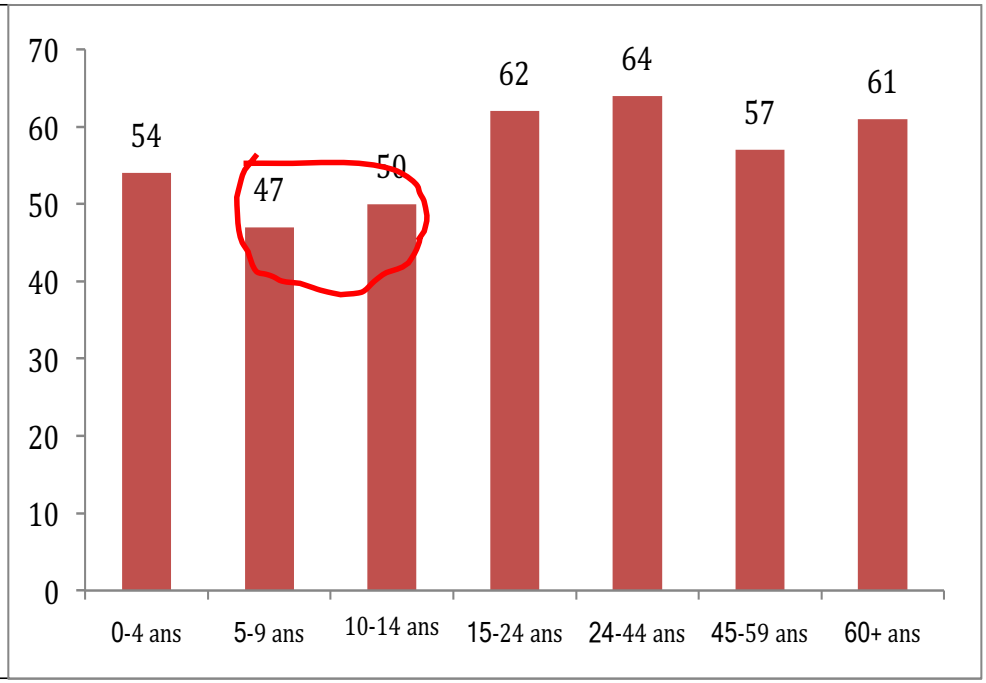
- **OMS**: *« …pour garantir une couverture universelle (…en MILD…), les pays doivent appliquer une stratégie associant des distributions de masse et des distributions continues gratuites par le biais de canaux multiples… Les canaux de distribution continue doivent être fonctionnels avant, pendant et après les campagnes de distribution de masse afin d'éviter toute carence dans l'accès universel aux MILD.* »
- **Canaux de distribution de routine recommandés:**
  - Consultations pré et post natales, Vaccination,
  - Ecoles,
  - Distribution Communautaire, etc.

Contexte: Utilisation de MII, RCA

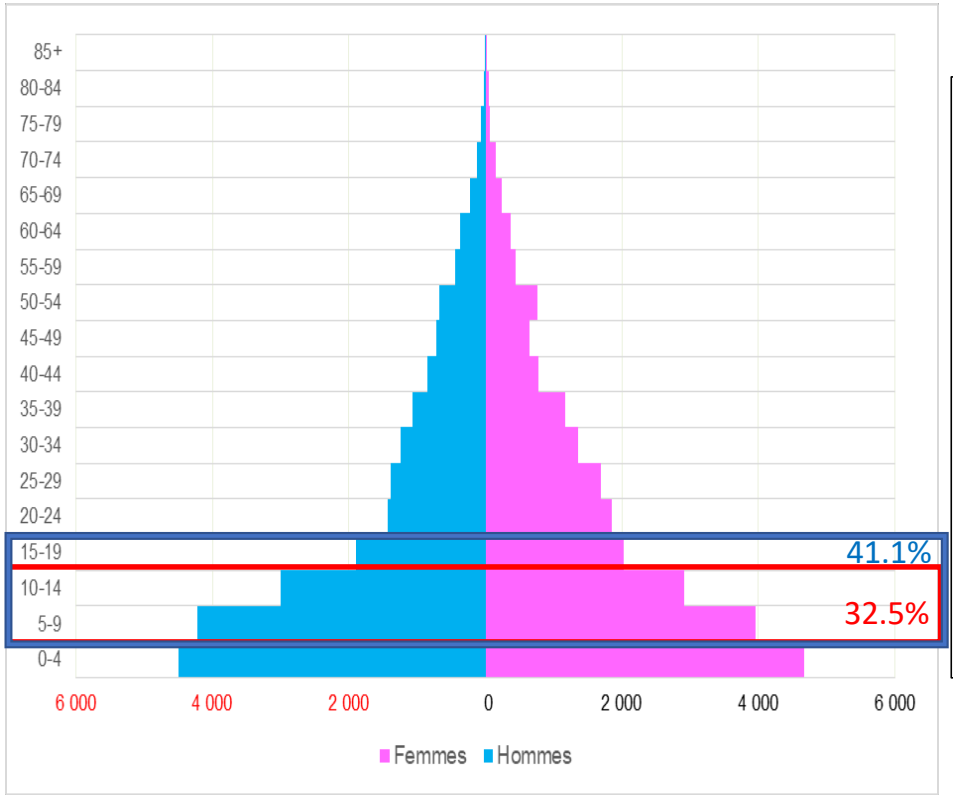
MICS 2019



MIS 2016



Contexte: Pyramide des âges



Sourcea: MICS 2019

Critères de succès

- **Taux de scolarisation moyen** entre 50 % et 80 % (OMS):
  - ➢ UNESCO:
  - 5,4% au pré-primaire
  - ***87,2% au primaire*** *(72,6% selon le MICS 2019)*
  - 21,8% au secondaire 1er cycle et
  - 8,9% au secondaire 2ème cycle.
- **Portée des écoles dans la communauté:**
  - Bonne car les écoles sont plus nombreuses que les FOSA (3150 écoles contre 1024 FOSA en 2022)
- **Forte implication du secteur éducatif.**

Contexte: avantages des écoles

- Les élèves sont un groupe facile à définir et à retrouver
- La portée des écoles au sein des communautés est meilleure que les FOSA,
- Enseignants: personnel instruit ayant de bonnes relations avec les communautés
- Enseignants: promoteurs de Changement Social et Comportemental
- Espace de stockage: suffisant dans les écoles et meilleur qu'aux FOSA
- La qualité des registres scolaires ne nécessite de pré-recensement
- Liens entre éducation et santé: renforcement des programmes de santé scolaire
- Elèves: ambassadeurs au sein de leur famille et de leurs communautés

Tanzanie	CPN/PEV	Ecoles
Cout par MII distribuée	$ **7.50** par MII distribuée pour 3 million de MII	$ **9.48** par MII distribuée pour </= 500000 MII $ **9.64** par MII pour 900 MII (DRC 2017)
		$ **1.58 par MII distribuée /3000000 MII**
Cout par personne protegée	$ **1.25** per PYP pour 3 million de MII	$ **3.64** par PYP </= 500000 MII $ **1.5** par MII pour 900 MII (DRC 2017)
		$ **0.60 per PYP/3000000 MII**

Objectifs de la distribution dans les écoles

But: Réduire la morbidité de paludisme

Objectifs:

- Contribuer à rattraper les pertes de MII entre campagnes
- Améliorer la couverture des enfants d'âge scolaire
- Réduire le coût de la distribution des MII

Mobilisation de ressources:

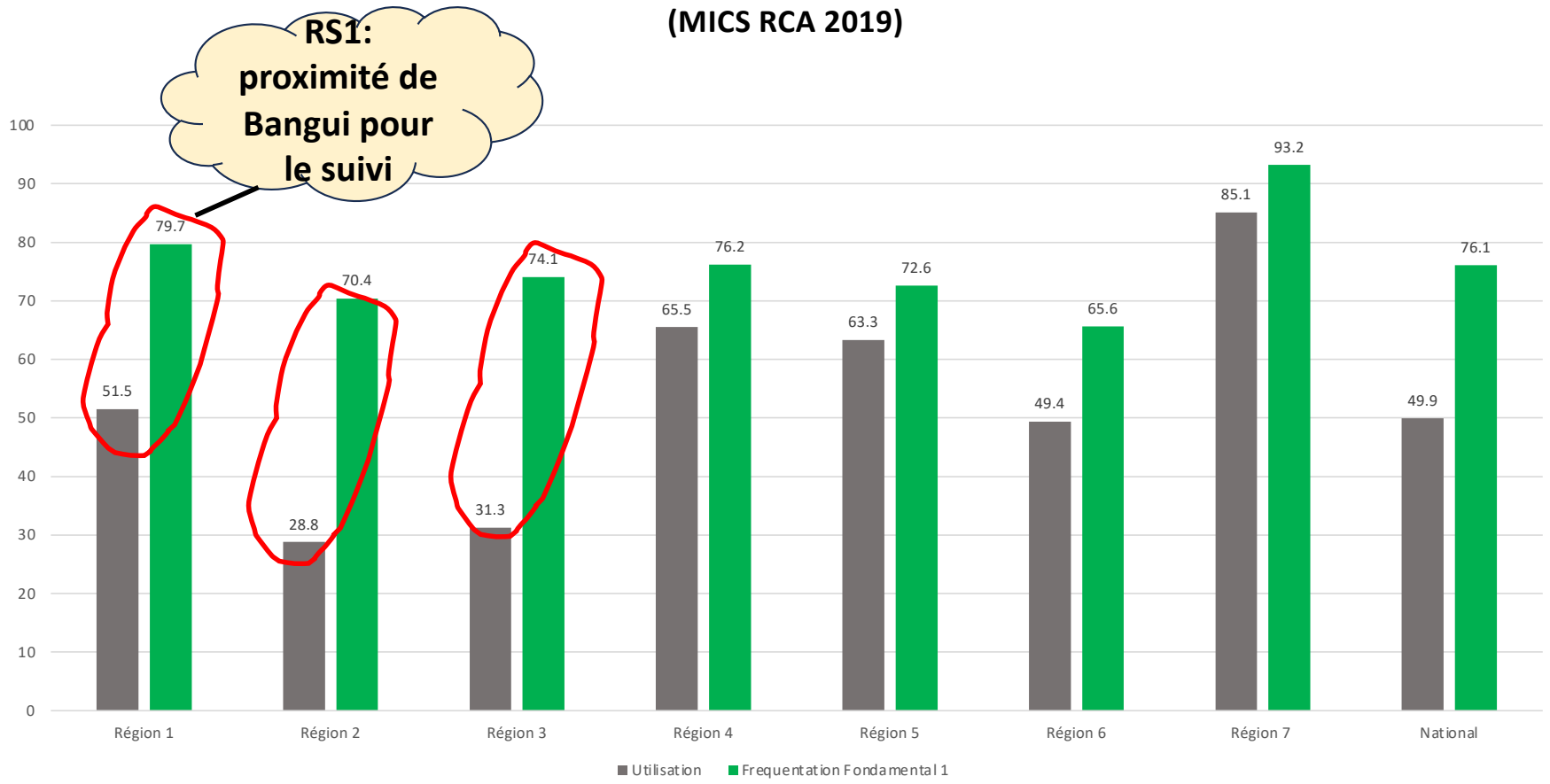
- Plaidoyer sur la base des évidences pour inclusion dans la Note Conceptuelle du GC7
- Approbation du CCM pour mise en œuvre
- Approbation du Technical Review Panel (TRP) comme une approche innovante aux cotés de la Campagne Nationale, la Distribution et du TPIg communautaire
- Plaidoyer auprès de l'UNICEF pour appui en Valises médicales pour les « Points Palu »

Mise en œuvre: Approche

- La distribution de MII est gratuite
- Distribution annuelle avant saison de pluies et fermeture des classes
- Distribution dans tout le Fondamental 1 (publique, privées et communautaires)
- Distribution a tous les élèves (filles/garçons)
- Distribution dans les classes impaires: CI, CE1 et CM1
- Une (1) MII par élève eligible et enseignant dans l'école,

- Distribution par les enseignants en une journée
- Supervision par le District Sanitaire et l'Inspection Académique,
- MII distribuées à tous les élèves présents des classes éligibles,
- Les élèves absents ont trois (3) jours pour récupérer leurs MILD,
- Dans les écoles chaque élève reçoit une MII tous les deux (2) ans en conformément à la durabilité estimée des MII.

Mise en œuvre: Choix des sites pilotes



Mise en œuvre: Lancement officiel

- Journee Mondiale de lutte contre le Paludisme 25 avril 2024
- Très Haut Patronage du Chef de l'Etat
- Lancement dans le DS de Bimbo dans la RS 1.
  - Remise de MII à des élèves
  - Remise de kit de prise en charge du paludisme aux enseignants
  - Démarrage de la distribution dans les écoles de Bimbo.

Résultats: Micro-planification

Région Sanitaire	Districts Sanitaire	Sous-préfectures (Circonscriptions)	Inspecteurs Accadémiques	Chef de Circonscriptions	Nombre Secteurs scolaires	Ecoles	Classes éligibles	Nombre Total d'élèves	Nombre d'élèves éligibles	Besoins en MILD (Unités)	Besoins en MILD (Avec marge)	Besoins en MILD (B/50)
1	Bimbo	Bimbo	1	1	2	155	302	65,478	34,642	34,642	38,117	762
	Bégoua	Bégoua	1	1	2	88	200	49,911	26,619	26,619	29,285	586
		Damara	0	1	1	25	73	12,694	6,869	6,869	7,560	151
		Bogangolo		1	1	15	28	2,775	1,520	1,520	1,672	33
	Mbaïki	Mbaïki	1	1	5	102	300	37,995	23,300	23,300	25,637	513
		Mongoumba		1	1	21	62	6,815	3,843	3,843	4,227	85
	Boda	Boda		1	2	28	73	10,222	6,190	6,190	6,811	135
		Boganangone		1	1	20	59	9,330	5,192	5,192	5,714	115
		Boganda		1	1	8	22	2,711	1,711	1,711	1,882	36
Total RS 1	**04 DS**	**09 SP**	**3**	**9**	**16**	**462**	**1,119**	**197,931**	**109,886**	**109,886**	**120,905**	**2,417**

Résultats : Ressources humaines et Ecoles

Personnels	Nombre formé
Personnels santé : 5% (177)	
• Central et Districts	12
• Agents de sante	139
• Sous Préfecture	22
• Partenaire: WVI	4
Personnels éducation: 95% (3220)	
• Inspection ---Secteurs	29
• Directeurs	462
• Enseignants	2729
Total personnels formés	**3397**

Région Sanitaire 1	District Sanitaire	Sous Préfecture	Ecoles		
			Recensées	Couvertes	%
	Bimbo	Bimbo	155	155	100
	Begoua	Begoua	88	91	103
		Damara	25	25	100
		Bogangolo	15	15	100
	Mbaiki	Mbaiki	102	102	100
		Mongoumb	21	21	100
	Boda	Boda	28	28	100
		Boganangone	20	20	100
		Boganda	8	8	100
	4 DS	**9 SP**	**462**	**465**	**101%**

Résultats : Elèves et MII

Région Sanitaire 1	District Sanitaire	Sous Préfecture	Elèves			Moustiquaires imprégnées		
			Eligibles	Ayant reçu MII	%	Reçues	Distribuées	%
	Bimbo	Bimbo	34642	37514	87	35053	31853	91
	Begoua	Begoua	26619	28907	98	28668	27800	97
		Damara	6869	6929	68	7550	6929	92
		Bogangolo	1520	1535	96	1583	1485	94
	Mbaiki	Mbaiki	23300	24899	99	25568	24355	95
		Mongoumba	3843	4285	98	3843	4133	96
	Boda	Boda	6190	6339	99	6684	6339	95
		Boganangone	5192	4392	98	5800	4392	76
		Boganda	1711	1616	100	1850	1616	87
	4 DS	**9 SP**	**117853**	**111620**	**95%**	**116556**	**111620**	**95%**

Résultats: Contraintes

Difficultés/contraintes	Approches de solutions
Conflit avec les vacances et les examens scolaires	- Impliquer le secteur éducatif dès le début pour planifier la distribution au plus tard en mai
Sous information des acteures sur certains aspects	- Partager les informations avec les DS a temps, y compris sur les directives
Stockage non adapté au niveau de certaines écoles	- Visiter les écoles pour valider les informations et lieux de stockage des MII
Sollicitation de distribuer les MII à tous les élèves	- Communiquer suffisamment sur les critères d'éligibilité
Ecoles privées ne donner les informations exactes	- Meilleure communication directe avec les écoles privées
Insuffisance de personnel enseignant dans les écoles	- Utiliser les ressources humaines disponibles
Difficultés de convoyage des MII dans certaines localités inaccessibles	- Mettre à contribution la Société Civile, les SR et les moyens de transport locaux (moto, pirogue)
Indicateurs de santé et éducation caduques	- MIS en cours de planification
Manque de ressources pour l'évaluation	- **Evaluation intégrée dans le MIS planifie**

Résultats: Leçons apprises

- Une bonne planification est primordiale à la réussite des activités et évite des pressions lors de la mise en œuvre
- L'appropriation par tous les acteurs, en particulier le secteur scolaire, est cruciale
- La distribution des MII dans les écoles ne devrait pas être sous-estimée comme une petite ou simple activité
- Une bonne budgétisation est nécessaire pour éviter des gaps financiers
- L'expérience de CDM contribue à l'amélioration et à la réussite des activités de distribution de MII dans les écoles
- La distribution dans les écoles entraine un engouement population et même politique

Prochaines étapes: documentation et chronogramme

- Finalisation des documents pour passage à échelle :
  - Finalisation du plan de suivi/évaluation
  - Intégration de la prise en charge du paludisme par les Point Palu/Maître Palu
  - Partage de la documentation avec le Fonds mondial pour soumission au TRP
- Revue et approbation des documents par le TRP pour la phase d'extension

Période	Activités principales
Décembre 2024	Ateliers d'information des acteurs de l'éducation
Décembre 2024	Formation formateurs centraux et régionaux de l'éducation et la santé
Mars 2025	Micro-planification dans Régions Sanitaires 1 et 2
Mars-Avril 2025	Formation des enseignants et agents de santé des RS 1 et 2
Mars-Avril 2025	Acheminement et prépositionement des MII
Mai 2025	Distribution de MII dans les écoles des RS 1 et 2
Janvier-Mai 2025	Suivi/évaluation de la distribution
Juin-Juillet 2025	Rapport de la distribution dans les RS 1 et 2
2026	**Extension de la mise en œuvre dans la RS3 dans le cadre du GC7**

Prochaines etapes: Mise en place “Points Palu”

- Lancement des **« Points Palu »** et **« Maitre Palu »** dans les écoles aux JMP 2024
- Remise de valises médicales aux enseignants des écoles de Bimbo par le Chef de l’Etat
- 2669 enseignants formes comme des ASC pour prise en charge paludisme simple
- Introduction progressive de la prise en charge des autres maladies de l’enfant
- **UNICEF** fourni 471 sacs comme Valises Médicales pour les **« Maitres Palu » de la RS1**

Conclusions

Les écoles sont une opportunité inestimable pour réaliser et maintenir la couverture universelle avec les MII aux cotés des autres approches et réduire de façon notable la morbidité et la mortalité liées au paludisme et la mortalité toutes causes confondues, en impliquant les enfants d'âge scolaire qui sont moins couverts par les interventions conventionnelles de lutte contre le paludisme.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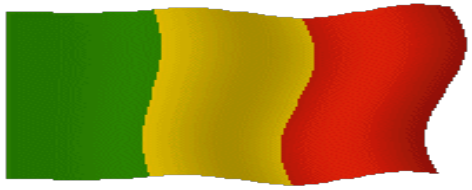

Distribution communautaire de moustiquaires imprégnées d'insecticides : cas du nord du Mali

Dr Aïssata **Koné,** Directrice PNLP Mali
Dr Mady **Cissoko,** PNLP Mali

Réunion annuelle des partenaires de l'APP 2025

7 – 8 avril 2025 Nairobi | Kenya

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CRS CATHOLIC RELIEF SERVICES

LE FONDS MONDIAL

Plan de presentation

- Introduction
- Analyse sécuritaire
- Macroplanification - Coordination - microplanification
- Approche de la campagne
- Transport des MII
- Paiement et résultats
- Leçons apprises
- Recommdantions
- Défis
- Conclusion

Magasin de stockage des MII au niveau central

Introduction

- La distribution de Moustiquaires Impreignées d'Insecticides (MII) est une des interventions efficace de lutte contre le paludisme
- Les principales sources d'approvisionnement : campagne (75 %) et routine (25 %) EDS 2023-24
- En 2023 : planifié une campagne nationale dans les 10 régions en 2 phases
- La Phase 1 a concerné les régions du sud : 22 millions de personnes et 10,8 million de MII
- La Phase 2 n'a pas pu se faire en 2023 pour des raisons sécuritaires

Introduction

- Face à l'urgence sanitaire de poursuivre la distribution des MII pour les populations vulnérables
  - ✓risque de flambées épidémiques de paludisme
  - ✓ populations déplacées internes massives
- Comité national de coordination a mandaté le PNLP de proposer une approche adaptée avec l'appui de tous les partenaires
- sur la base de son experience de 2019 le PNLP a élaboré des directives de distribution communautaire de MII pour les régions concernées

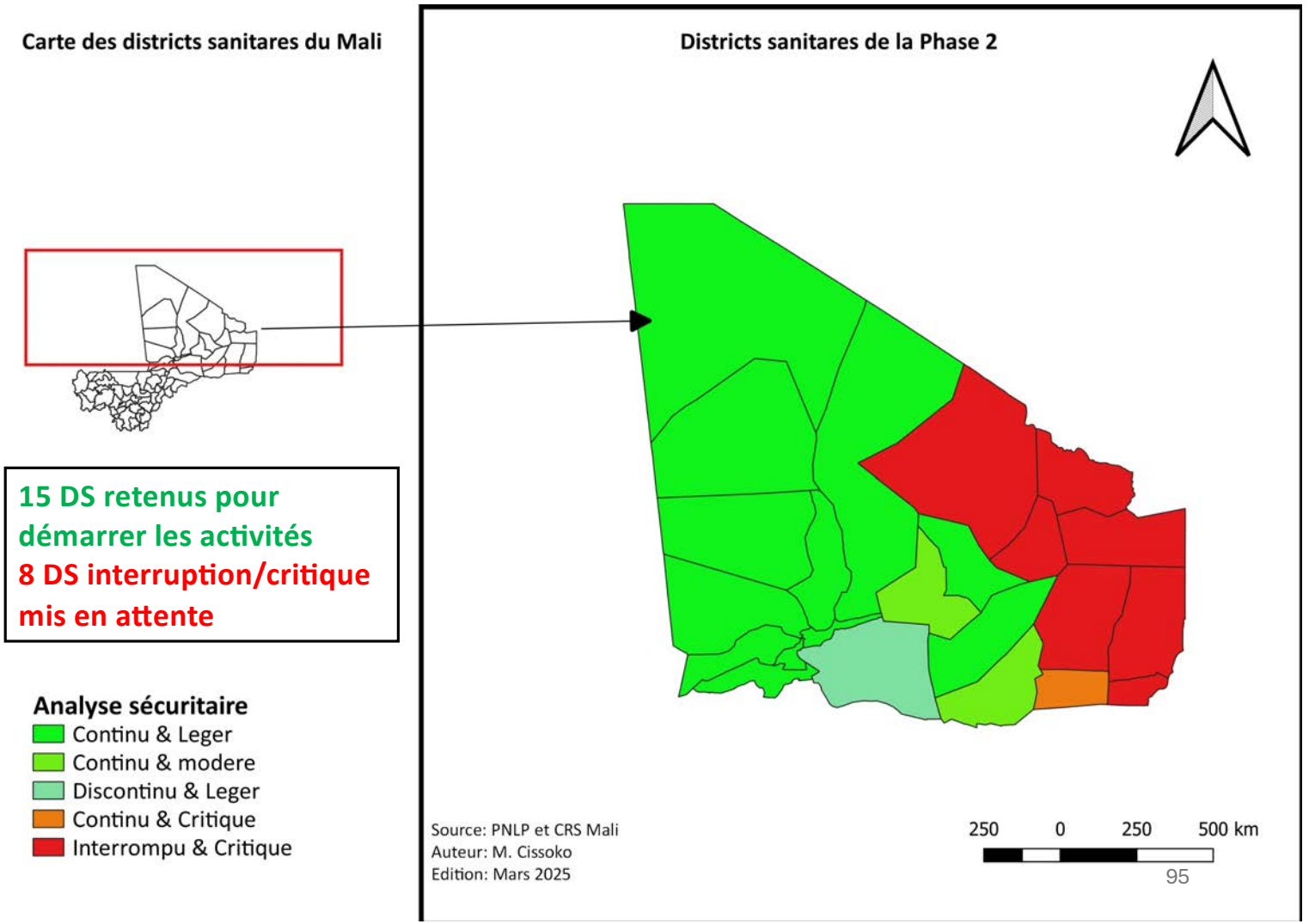
Analyse sécuritaire

Continuité du service

- disponibilité du personnel et reseau téléphonique
- mécanisme d'appro. présent

Niveau de Sécurité évalué *(structures Gouvernemantales et OCHA)*

- leger
- modéré
- critique



Macroplanification/coordination de la CDM

- Planification était basée sur les recommandations de l'Alliance pour la prévention du paludisme (Population/1.8)
- avec une marge (5% pour la CDM au Mali)
- Population projetée avec le taux d'accroissement (RGPH 2009)

La coordination a été assurée par des comités à différents niveaux avec un acte administratif :

- Central : le Ministre en charge de la santé
- Région : Gouverneur
- District : Préfet de cercle

Microplanification (1/3)

- Elle a connu une adaptation à la situation

Les 15 DS dont la situation sécuritaire permettait la distribution au 3ème trimestre 2024

- Réunion virtuelle d'orientation des équipes de la région sur le canevas de microplan
- Envoi du canevas vierge aux différentes régions
- Remplissage du canevas (ECD et région)
- Formation et microplanification des équipes régionales à Bamako en 5 jours
- Mise à jour du chronogramme de la CDM (Tous les 15 jours en fonction de l'évolution sécuritaire)
- Formation des EDC au niveau régional et partage des microplans/chronogramme

Microplanification (2/3)

Les 8 DS en attente due à la situation sécuritaire critique et relancés

- Réunion virtuelle d'orientation/formation sur l'ensemble des outils
- Remplissage du canevas (ECD et région)
- Partage continu avec le PNLP de l'analyse de la situation sécuritaire
- Mise à jour du chronogramme de la CDM (Tous les 15 jours)

Approche de la campagne

Les 15 DS à situation sécuritaire relativement stable

- **Recensement** des ménages/village/aire de santé sous la supervision des DTC
- **Validation des données** de récensement avec des échanges à distance entre le PNLP, CRS, les DRS et les DS
- **Mise en place** des MII sur la base des données de recensement
- **Redeploiement** des MII après validation des données
- **Distribution/supervision CDM par la region/district/DTC** (1 MII/2 personnes)

Les 8 DS en attente (situation sécuritaire critique)

- ***Niveau de sécurité n'a pas permis de faire le recensement***

Kidal : compte 4 DS

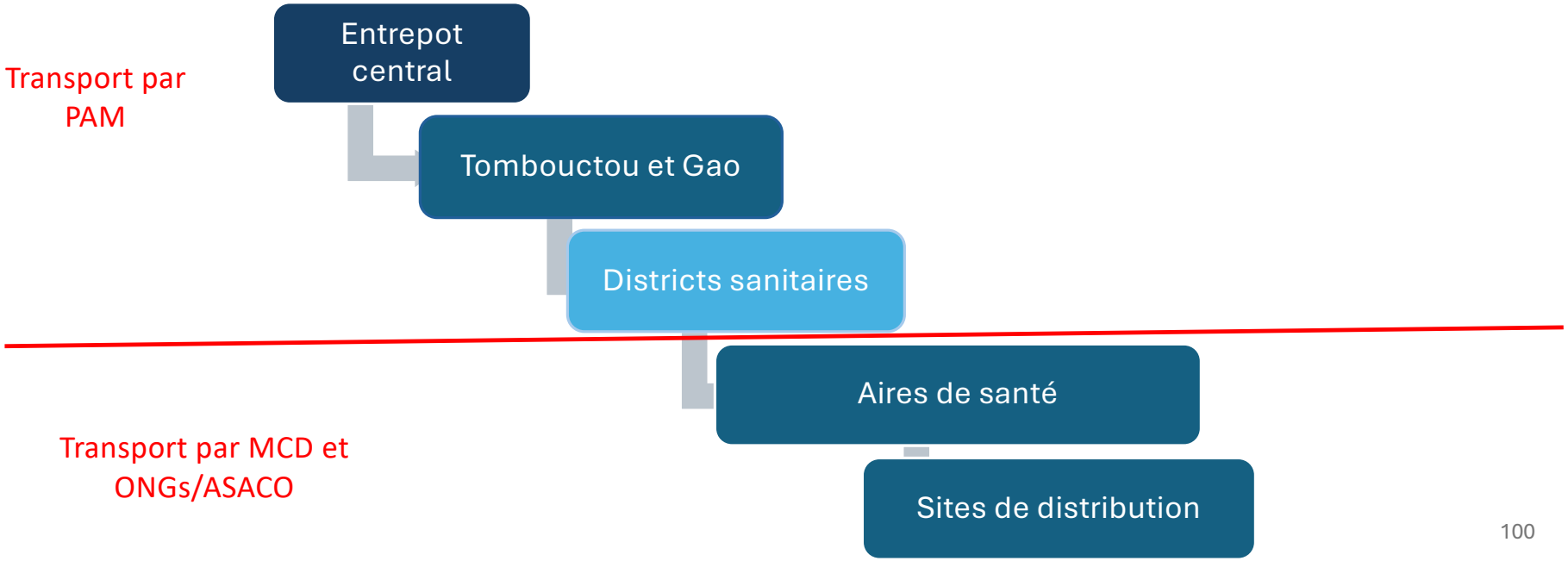
- 2 DS ont cumulé le recensement/distribution (1 MII/2 personnes) porte à porte
- 2 DS exclus de la CDM cause du niveau de sécurité critique à ce jour

Ménaka : compte 4 DS dont 3 avec un niveau de sécurité critique et un deplacement de l'ensemble des populations vers la capitale régionale.

- Distribution basée sur 3 unites de MII/ménage (porte à porte) dans les camps de PDIs et les populations autochtones de Ménaka

Transport et redeploiement des MII

- PAM a été mandaté pour assurer le transport sur la base de son expérience dans les régions concernées jusqu'au niveau district sanitaire
- Deux points d'entreposage (region de Tombouctou et Gao)

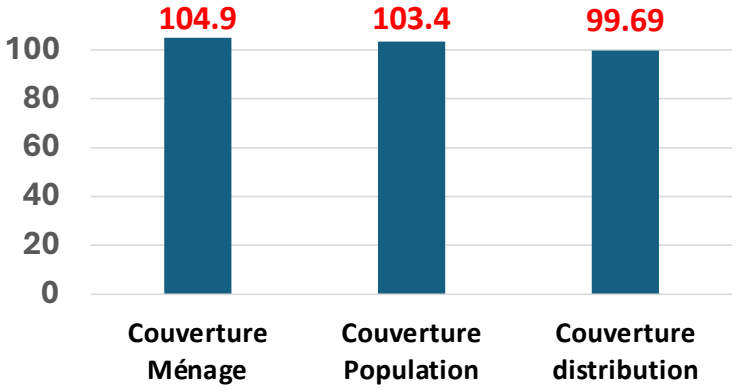


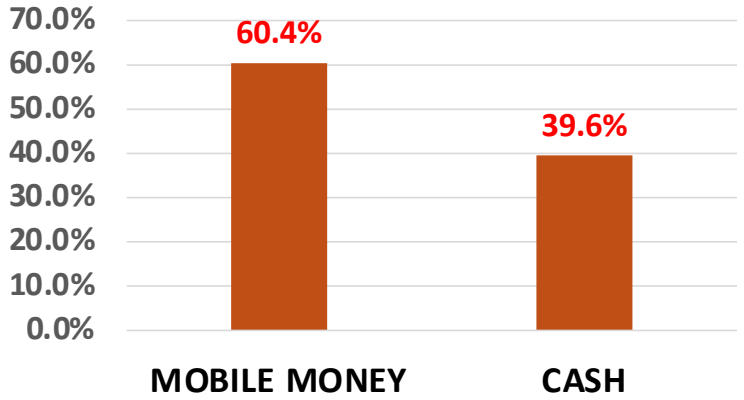
Paiement des acteurs/Calendrier/résultats

Mise en place d'un point focal et motivation du comptable de la DRS/districts

Orientation en ligne (virtuelle) sur le cheick list des documents logistiques et comptables par PNLP et CRS

Deux modalités de paiement ont été mises en place sur la base des informations collectées (disponibilité de réseau téléphone pour l'utilisation de mobile money et le paiement par cash à travers les acteurs du système)





Principales léçons apprises (1/2)

- L'appui permanent à distance du PNLP et de CRS aux équipes régionales a permis leur appropriation des outils de la campagne et une remontée des données régulièrement pour l'analyse de la situation
- L'acheminement tardif des MII de Bamako vers les différents districts sanitaires a impacté sur le démarrage de la campagne dans les régions de Tombouctou et Gao et la perte de certaines MII endommagées lors du transport fluvial (transport en août qui correspond à une période de forte pluviométrie)
- Le retard de paiement des activités de recensement a eu un impact sur le démarrage des activités de distribution
- Le modèle de recensement impliquant les leaders communautaires a permis de renforcer la participation communautaire et faciliter la validation des données par le comité local de coordination
- Le retard de démarrage de la distribution jusqu'en octobre 2024 a entrainé une augmentation des besoins avec l'accroissement de la population qui ont été compensés par le reliquat de la phase 1

Principales léçons apprises (2/2)

- La disponibilité des données de recensement des populations déplacées avec les services locaux du développement social a permis de disposer d'une base de données pour la planification de la campagne sur ces sites
- Les mouvements des populations d'Ansongo à Gao survenus après le recensement ont été prise en compte lors de la distribution sur recommandation du comité régional de la coordination
- La mise en place des stocks importants de MII de routine à Gao à cause des difficultés d'approvisionnement a été utilisée pour combler les éventuels gaps de MII avec l'autorisation de PMI

Difficultés/contraintes

- Manque de réseau téléphonique et de connexion internet dans certaines localités ;
- Accès géographique limité dans certaines localités dû à la montée du niveau d'eau fluviale ;
- Insécurité sporadique dans certains districts sanitaires.

Défis pour la CDM 2026

- Timing entre le recensement des ménages et la mise en place des MII
- Accès à ces régions concernées et ressources financières pour une évaluation de la couverture de la disponibilité et de l'utilisation des MII
- Aménер les populations à utiliser les MII après la campagne de distribution
- GAP de MII pour les 8 DS à faible transmission lors de la planification de la CDM 2026

Recommandations

- Elaborer/respecter le chronogramme de la CDM 2026 en prenant en compte les leçons apprises
- Prendre en compte les aléas climatiques pour le transport des MII
- Utiliser les canaux adaptés pour poursuivre la sensibilisation des populations sur l'utilisation des MII
- Evaluer la couverture de la possession et de l'utilisation des MII en particulier la distribution par l'approche communautaire.

Conclusion

Malgré la situation sécuritaire préoccupante dans les régions du nord, la distribution basée sur l'analyse de la fonctionnalité du système de santé et du niveau de sécurité à travers les sources fiables (Gouvernement et ONG humanitaires) a permis d'assurer avec satisfaction la distribution de masse de moustiquaires à des populations vulnérables au paludisme avec un accès limité aux soins de santé.

Remerciements

Direction Générale de la Santé et de l'Hygiène Publique/Directions régionales de la santé/Districts sanitaires

Communautés (Gouverneurs, prefets, Chefs villages/fractions/campements/ relais/leaders)

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Réunion annuelle des partenaires de l'APP 2025

Lunch Break

Pause-déjeuner

We will return shortly

A tout à l'heure

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