Lunch Break

Pause déjeuner

Pausa para almoço

For technical difficulties: Please use Zoom chat or contact the supplier at info@plbe.info

Maximizing impact with scarce resources: Planning difficult choices

Introduction to the economics of malaria intervention choices

Dr. Catherine Pitt
Professor of Health Economics

Session: Maximizing impact with scarce resources

Tuesday, 24 February 2026

SMC Alliance & Alliance for Malaria Prevention Joint Annual Meeting

Kampala – Uganda

Internal

Objectives of this session

In 20 minutes, I cannot teach a course on health economic evaluation!

By the end of this session, I hope you will:

1. Approach difficult malaria intervention choices with an economic mindset:
    1. Clearly frame the choices (options): objectives and scope of costs
    2. Assess options incrementally
2. Critically consider economic evidence
3. Resolve to commission and use high quality economic evaluations to inform decisions

Internal

What is (health) economics?

- Economics is the science of **CHOICE**
  - Resources are limited – by definition, everywhere
  - Our "wants" are unlimited – e.g. health for all
  - Choices can be implicit (maintain the status quo) or explicit
  - Choices can be made by individuals or institutions

- Economists are concerned with . . .
  - **Efficiency** – maximising outcomes given scarce resources
  - **Equity** – fairness in the distribution of costs and benefits
  - **Preferences** – respecting individual and institutional values in decision-making

- **Not only** about money!

Internal

Asking economic questions

How can we cut our GC8 budget?

Perhaps, but some better questions would be:

How can we minimise the harms of reduced malaria investments?

How can we maximise health and equity with the resources available?

If the resource envelope changes, what interventions should we add, subtract, or change?

How can we advocate for more resources for malaria by demonstrating the efficiency and value of investments in malaria interventions (vs. other investments)?

What is health economic evaluation?

- A systematic comparison of two or more potential **future** courses of action in terms of their expected **costs** and **health effects** – informed by the best available evidence
- A highly developed, codified analytical framework
  - CHEERS reporting checklist (akin to CONSORT)
  - IDSI reference case – methodological specifications
- Widely used:
  - e.g. in Ethiopia and Malawi to support basic health benefits package design
  - In evaluating malaria interventions – but scope for wider use in decision-making

Effect measures determine type of econ evaluation

Type of economic evaluation

Incremental cost per . . .

. . . SMC or PMC course delivered, person-year of protection

- Process outcome – no indication of health impact

→ Cost analysis

. . . malaria case averted, reduction in infection prevalence

- Intermediate health outcome – disease-specific, not comparable with investments for other diseases

→ Cost-effectiveness analysis (CEA)

. . . death averted, life-year gained

- Final health outcome – but only addresses mortality

. . . disability-adjusted life-year (DALY) averted, QALY gained

- Combines morbidity and mortality into a single metric
- **Comparable across health conditions**

→ Cost-utility analysis (CUA)

Key questions to frame an economic evaluation

What are the **objectives** of our malaria intervention package?

Buying products?

Delivering products?

Malaria elimination?

Reducing malaria cases?

Reducing malaria infections?

Reducing malaria deaths?

Reducing malaria DALYs (a measure of cases, disability, and deaths)?

- Objectives indicate the appropriate measure of effect
- Economic evaluation guidelines call for DALYs or QALYs as standard

What are the **options**?

Define the **interventions – and packages of interventions**

- Who, what, where, when, why, for how long, how often, etc
- A product – a tablet, a bed net – is not an intervention!

Define the **geographical units** for intervention targeting

- What granularity is feasible and acceptable for targeting? Regions, districts, villages?
- Consider diseconomies and data demands in fine-grade targeting

➢ An economic evaluation compares the costs and effects of options *incrementally* with each other

Whose **costs** and which **costs** count?

Perspective

*Public provider (donor+domestic gov't)?

Societal?

Donors?

Local governments?

Domestic governments?

Health insurance?

Households?

Type of cost

Financial costs = money → important for budgeting

***Economic costs = value of resources → important for guiding choices**

Scope of cost

Preventive intervention only?

***Intervention + downstream costs of case management**

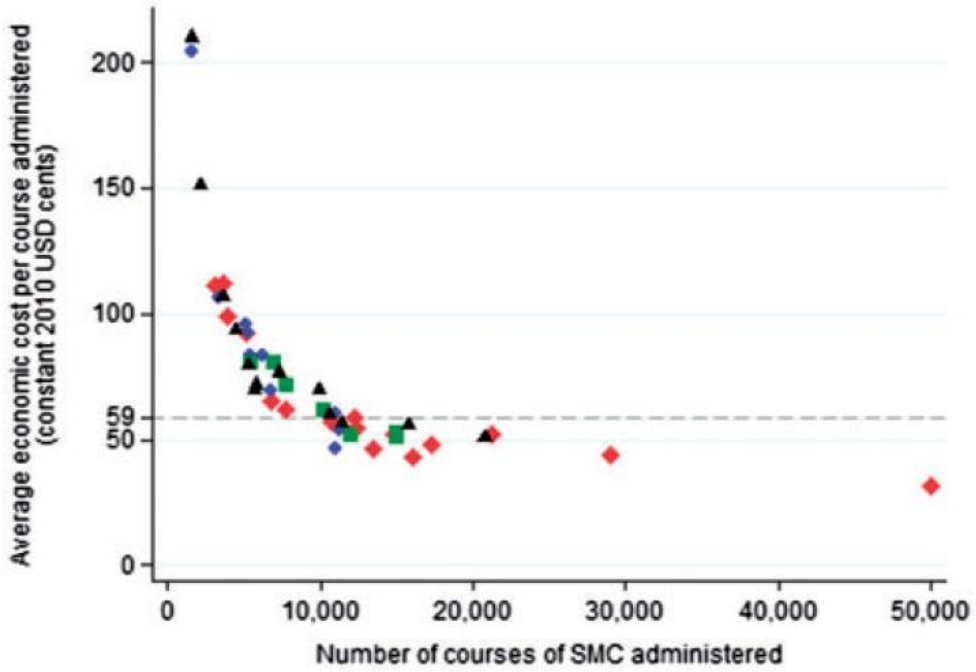
➢Need to consider all costs that may be different between interventions

What are the signs of a good economic evaluation?

- Clarity about the intervention
- Transparency and appropriateness of scope of costs and effects
- Exploration of variation (heterogeneity) in costs and effects – ideally including cost functions
- Assessment of uncertainty of conclusions
- Adherence to reference case and reporting guidelines

Internal

Intervention cost analyses can generate useful insights for planning and innovation to increase efficiency – e.g. economies of scale



Health Policy and Planning, 32, 2017, 1256–1266
doi: 10.1093/heapol/czx084
Advance Access Publication Date: 24 July 2017
Original Article

OXFORD

Large-scale delivery of seasonal malaria chemoprevention to children under 10 in Senegal: an economic analysis

Catherine Pitt,[1,*] Mouhamed Ndiaye,[2] Lesong Conteh,[3] Ousmane Sy,[2] El Hadj Ba,[4,5] Badara Cissé,[2,5] Jules F Gomis[4], Oumar Gaye,[2] Jean-Louis Ndiaye[2] and Paul J Milligan[5]

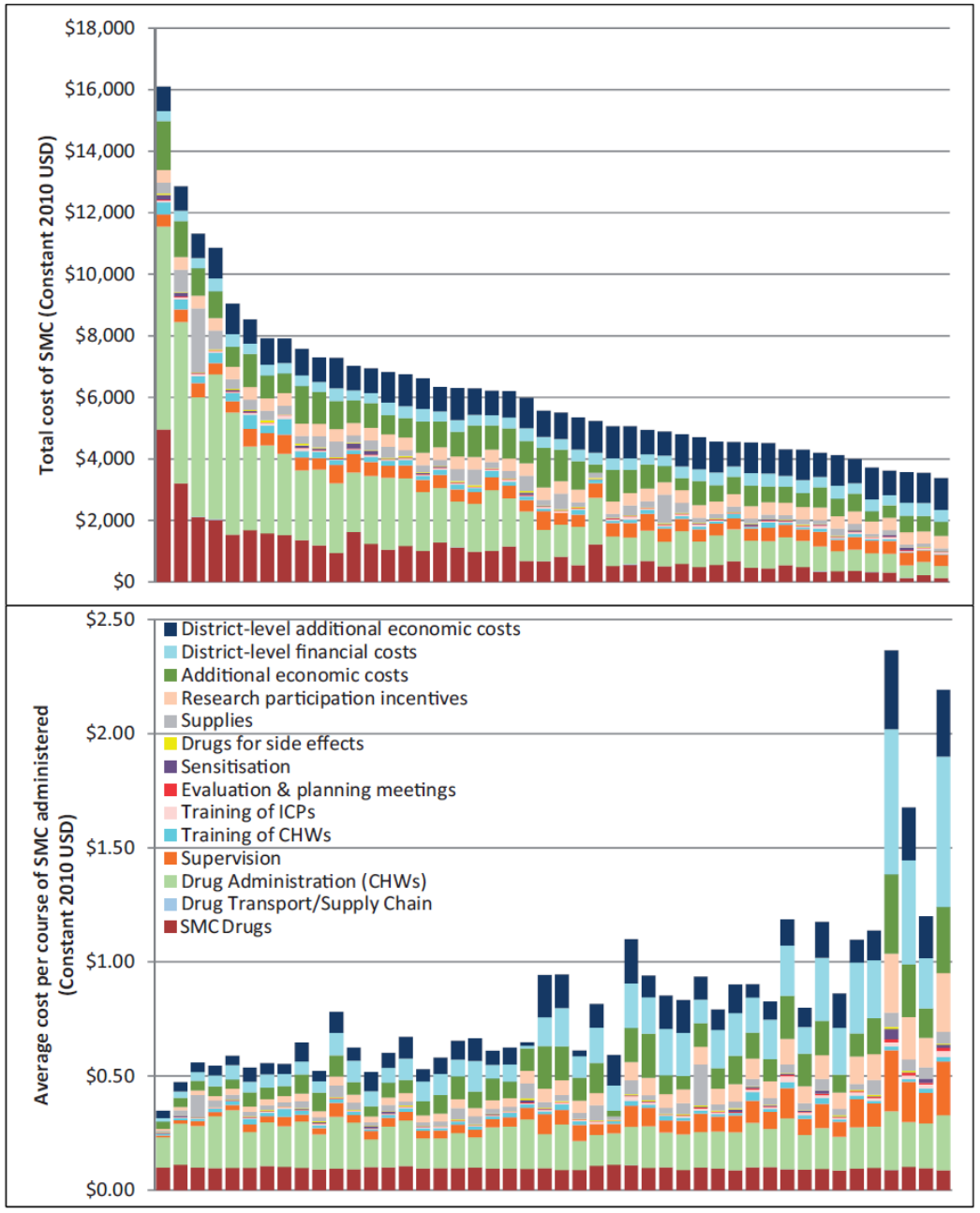
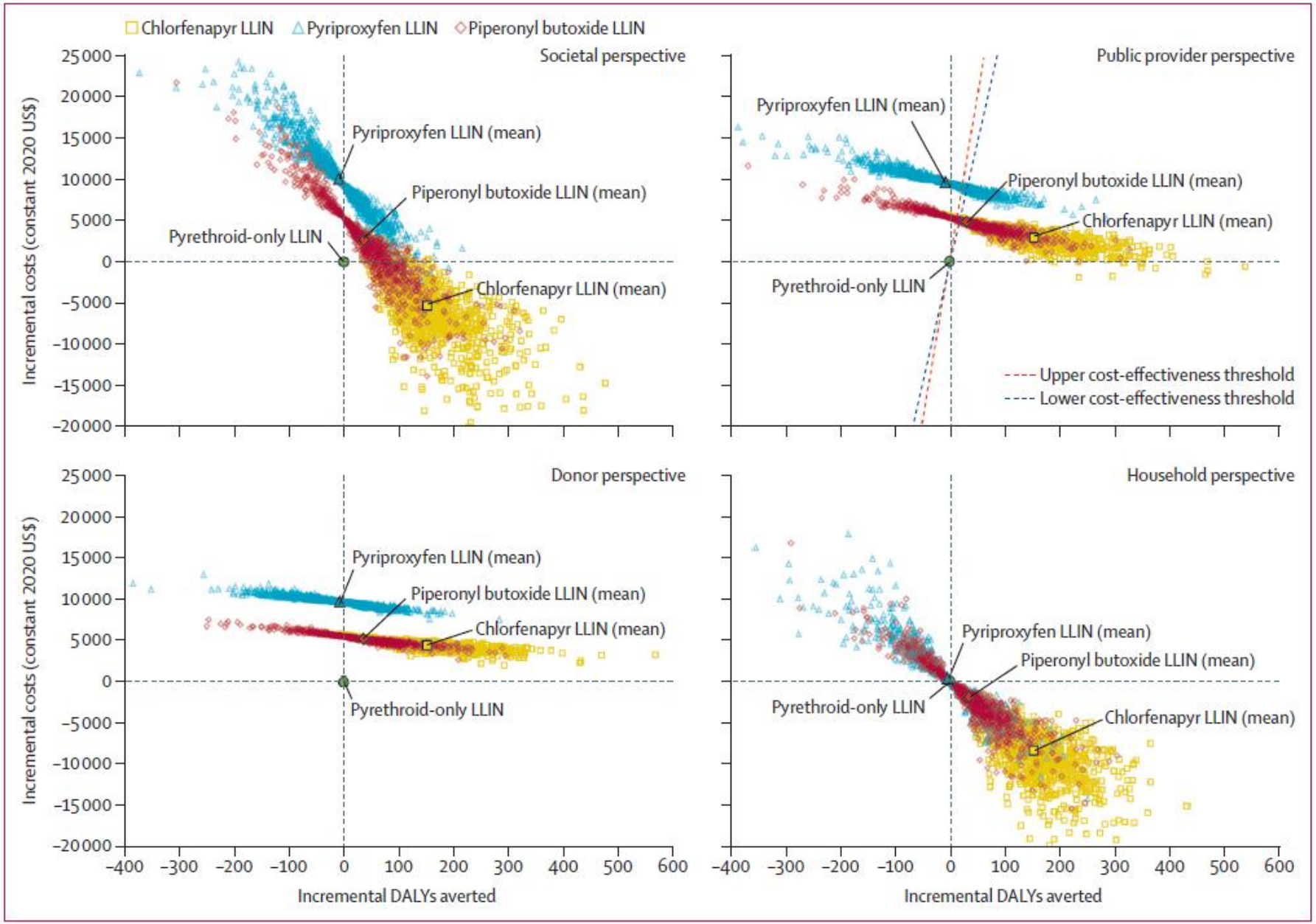


Figure 1. Total and average costs by health post with cost drivers. Health posts are ordered (left to right) in both graphs from largest to smallest total economic costs, including research participation incentives. District-level costs have been divided evenly across the health posts within each district. As total costs decrease, the average cost per course administered tends to increase, although there is some variation in this trend.

Different cost perspectives may produce different conclusions



Effectiveness and cost-effectiveness against malaria of three types of dual-active-ingredient long-lasting insecticidal nets (LLINs) compared with pyrethroid-only LLINs in Tanzania: a four-arm, cluster-randomised trial

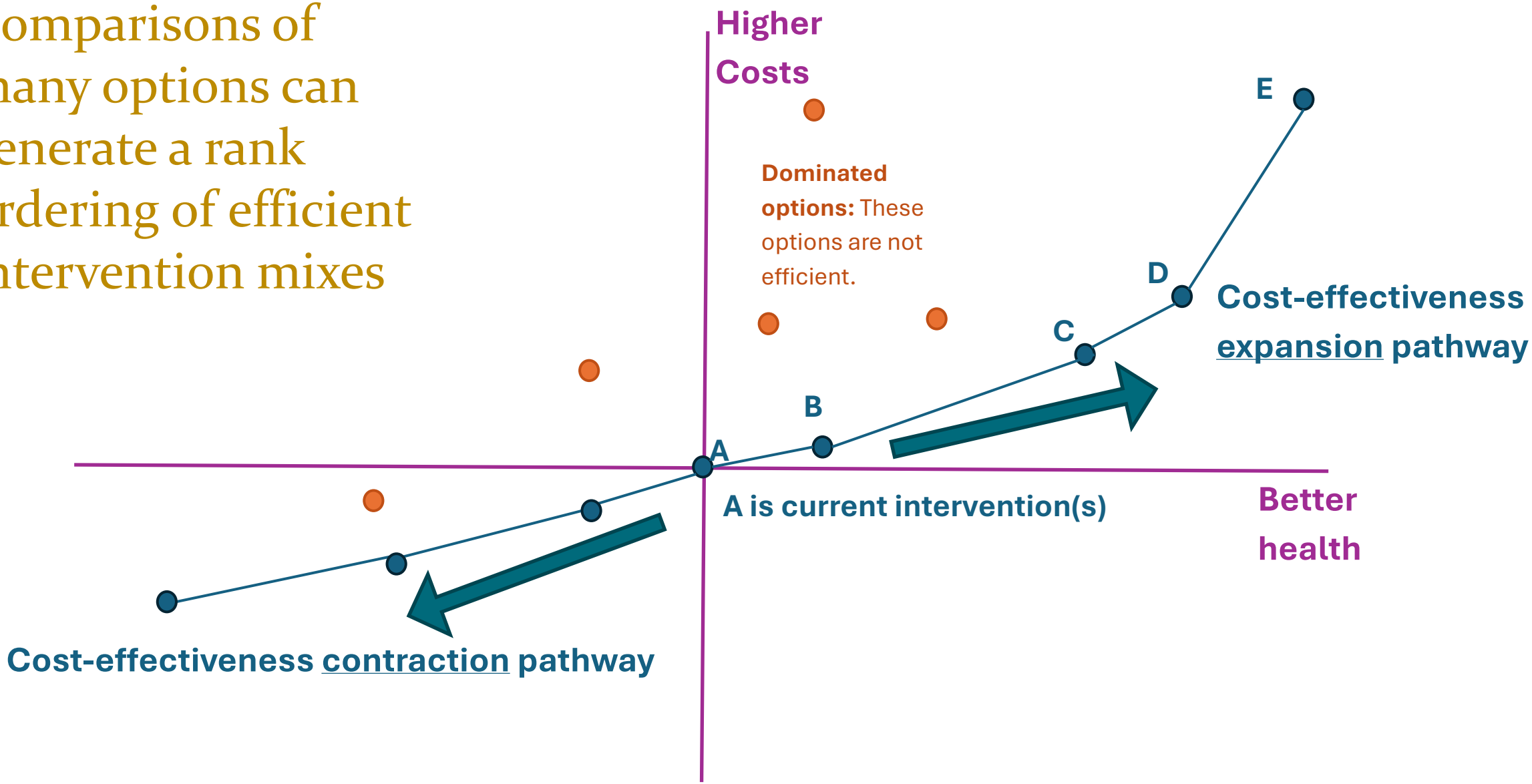
Jacklin F Mosha, Manisha A Kulkarni*, Eliud Lukole, Nancy S Matowo, Catherine Pitt, Louisa A Messenger, Elizabeth Mallya, Mohamed Jumanne, Tatu Aziz, Robert Kaaya, Boniface A Shirima, Gladness Isaya, Monica Taljaard, Jacklin Martin, Ramadhan Hashim, Charles Thickstun, Alphaxard Manjurano, Immo Kleinschmidt, Franklin W Mosha, Mark Rowland, Natacha Protopopoff*

Lancet 2022; 399: 1227–41

Figure 2: **Cost-effectiveness of dual-active-ingredient LLINs relative to pyrethroid-only LLINs over a 2-year period**
Cost-effectiveness planes are shown separately for societal, donor, public provider, and household perspectives. The public provider perspective combines costs borne by donors with costs borne by the public health service in providing LLINs and malaria diagnoses and treatments. Each data point reflects a single iteration in the Monte Carlo simulation; 1000 iterations were conducted. LLIN=long-lasting insecticidal net. DALYs=disability-adjusted life-years.

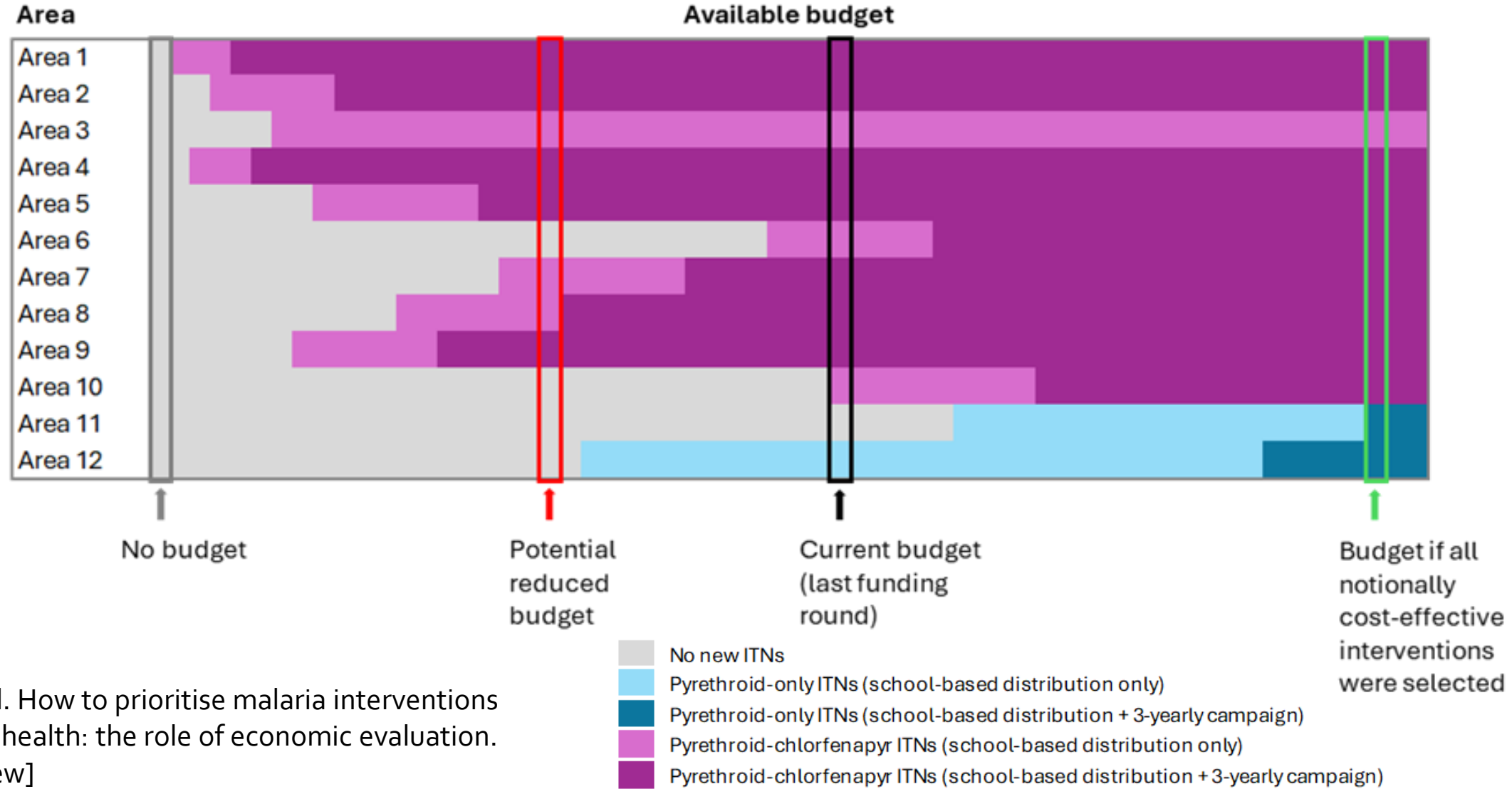
The cost-effectiveness plane

Comparisons of many options can generate a rank ordering of efficient intervention mixes



Expansion pathways for each geography can support sub-national tailoring (SNT)

Figure 2. Optimal intervention sets that maximise health benefits at different budgets: a stylised example of ITN distribution



Bath, D. et al. How to prioritise malaria interventions to maximise health: the role of economic evaluation. [Under Review]

PMC Compass

Cost-effectiveness analyses can be used to create a rank ordering of options for intervention mixes across geographies

PMC Compass

Informing choices to maximise the health impact of perennial malaria chemoprevention

Click here for more information on how to use this app

THE PLUS PROJECT

Main page Economics Health impact SP resistance and efficacy User input

Select PMC-eligible country

Cameroon

Model whole country or a specific admin-1 unit?

Whole country

Generate results

Download outputs

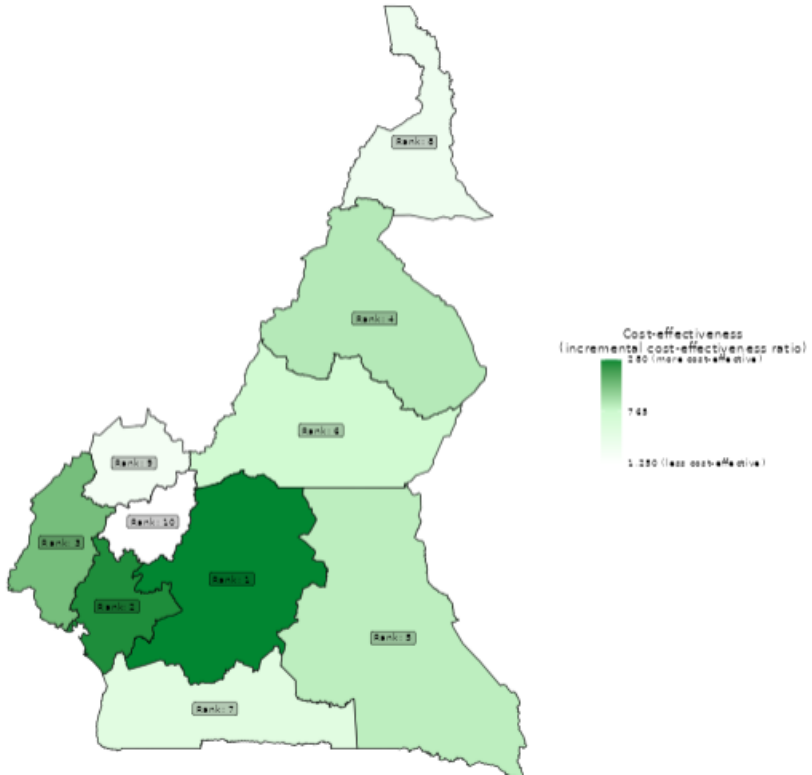
Ranked prioritisation of PMC delivery options by admin-1 unit

This table shows the ranked prioritisation of PMC options. The first option is the most cost-effective choice. For a given investment, the first option will avert the most deaths. The second option is less efficient than the first option. We compare different delivery schedules to the currently implemented package of interventions in the selected country, and to each other. We then rank the interventions in order in which they should be added to existing malaria control activities in the selected country. This ranking is based on its cost-effectiveness which incorporates health impact and implementation costs. All costs are presented in 2024 USD.

ICERs include economic costs of implementation, with start-up costs annualised at 3% over 7 years. The costs of co-designing a PMC implementation approach specific to country context has not been included.

Interpreting ICERs: If implementation in the first region in a country is shown as not cost-effective, but other regions in the same country are shown as cost-effective lower in the ranking, then it would not be cost effective to implement only in the first region in the country, but it would be cost-effective to implement in the first and second (and potentially more regions) simultaneously.

Table: ranked prioritisation of PMC delivery options | Map: cost-effectiveness by admin-1 unit



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Search:

Country	Region (admin-1)	PMC delivery strategy (vs. comparator)	Additional clinical malaria cases averted	Additional hospitalisations averted	Additional deaths averted	Additional DALYs averted	Financial (budget) cost of SP+consumables	Cumulative financial (budget) cost of SP+consumables	Additional economic cost savings to public providers from reduced treatment	Cumulative economic cost savings to public providers from reduced treatment	Ad co impl an
All	All	All	All	All	All	All	All	All	All	All	All
Cameroon	Centre	PMC co-delivery with EPI only vs No PMC	23648	1496	322	1727	132598	132598	-168508	-168508	
Cameroon	Littoral	PMC co-delivery with EPI only vs No PMC	10213	751	162	783	101229	233827	-78601	-247109	
Cameroon	Sud_Ouest	PMC co-delivery with EPI only vs No PMC	7135	432	93	514	51446	285273	-49762	-296871	
Cameroon	Nord	PMC co-delivery with	4626	295	62	330	51821	337094	-33139	-330001	

PMC Compass

Learn more about PMC Compass

Plus Project Results
Interactive discussions + dinner
7pm Wednesday
Speke Ballroom

PMC Innovations panel
9am Friday
Victoria Ballroom

PMC Compass

Internal

Objectives of this session (recap)

By the end of this session, I hope you will:

1. Approach difficult malaria intervention choices with an economic mindset:
    1. Clearly frame the choices (options): objectives and scope of costs
    2. Assess options incrementally
2. Critically consider economic evidence
3. Commission high quality economic evaluations to inform decisions

Internal

A few final words . . .

- Economic thinking can help decision-makers maximise achievement of their objectives with the resources available to them

- NMPs have access to donor, domestic government, household, and other resources - all should factor into strategic planning and advocacy

- Chemoprevention and vector control can save lives, reduce resource use for case management, and increase productivity – important to consider all these health and economic gains in choosing interventions and advocating for investment

- Greater donor flexibility could allow scarce resources to be used more efficiently – allowing for innovation and adaptation in meeting programme objectives – and to support countries in pursuing their objectives.

Webale nnyo
Merci
Thank you
Obrigada

www.lshtm.ac.uk/study

Internal

SMC Alliance/AMP Annual Meetings 2026

MAP ITN-CM allocation tool: exploring prevention and case management under limited resources

Tasmin Symons

Talk outline

History of tool

Current functionality
(GC7 reprioritisation use case)

Potential future functionality and use cases

Internal

History of tool: GC7 reprogramming

- May 2025:
  - Major concern about disruption to GC7 funds for planned ITN campaigns in 2025/2026;
  - Countries potentially facing urgent reprogramming under reduced budgets
- Reprogramming raises many questions about optimal strategies and trade-offs
- One potentially common scenario:
  - Maintain case management everywhere
  - Reduce planned ITN distribution (e.g. subnational withdrawal; demographic targeting, household capping)
- This would raise two immediate operational questions:
  - Where should the ITNs be withdrawn? (maximize savings while minimizing cases?)
  - What would be knock-on effect on ACT/RDT commodity needs?
- Partners asked MAP to develop a simple tool to help explore these trade-offs
  - Brought together two pre-existing models:
    - ITN coverage model: predicts coverage trajectory given different distribution scenarios
    - Geospatial prevalence/incidence model: estimates impact of changing coverage on case burden

Internal

Talk outline

History of tool

Current functionality
(GC7 reprioritisation use case)

Potential future functionality and use cases

Internal

GC7 reprioritisation tool: current functionality

We have developed a simple tool which allows users to

- Configure ITN distribution strategies, starting from current planned distributions.
- Quantify the change in ITN volumes required and compare to available/feasible volume.
- Gain insight into plausible change in case management commodity need, relative to current plans.
- Work with MAP to update/refine input data and simulated distribution strategies.

The tool is not a case management quantification tool, nor a forecast.

Internal

Brief Methodology: MAP ITN and burden models used for this tool

Given scenarios of ITN volumes, we produce estimated change in malaria cases through a two-step modelling process:

- We generate scenarios of ITN coverage (use) given burn-in distribution volumes, estimated ITN attrition rates, and the scenario volumes
- We estimate impact on malaria cases via MAP *Pf*PR and clinical incidence models, given these ITN coverage scenarios.

Estimated change in case management need is assumed to **relatively** track change in estimated community-level burden – so e.g. 20% more cases overall means a 20% increase in cases attending health facilities.

Internal

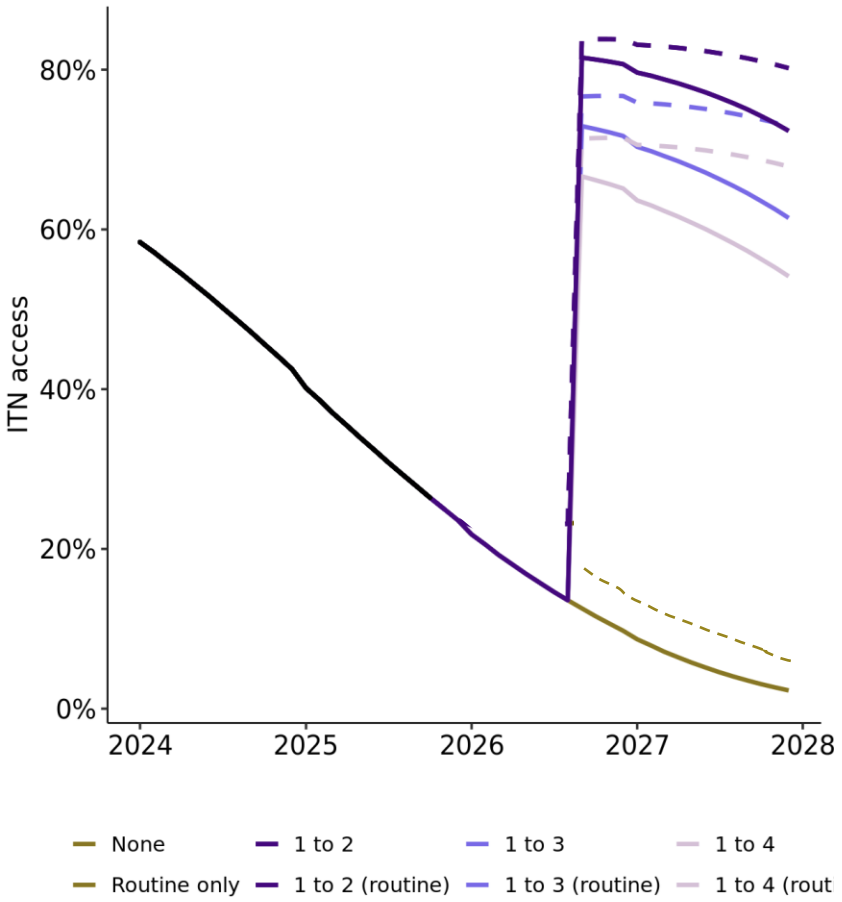
Brief Methodology: MAP ITN and burden models used for this tool

After burning in financed ITN distributions to Q2 2025, we simulated a range of possible scenarios of coverage to December 2027 for each Admin2.

Different campaign strategies were simulated according to the table below. In addition to these, routine distribution was simulated.

Number of ITNs by household size

ITN Distribution ratio	1 person	2 person	3 person	4 person	5 person	6 person	7 person
1:2	1	1	2	2	3	3	4
1:3	1	1	1	2	2	2	3
1:4	1	1	1	1	2	2	2



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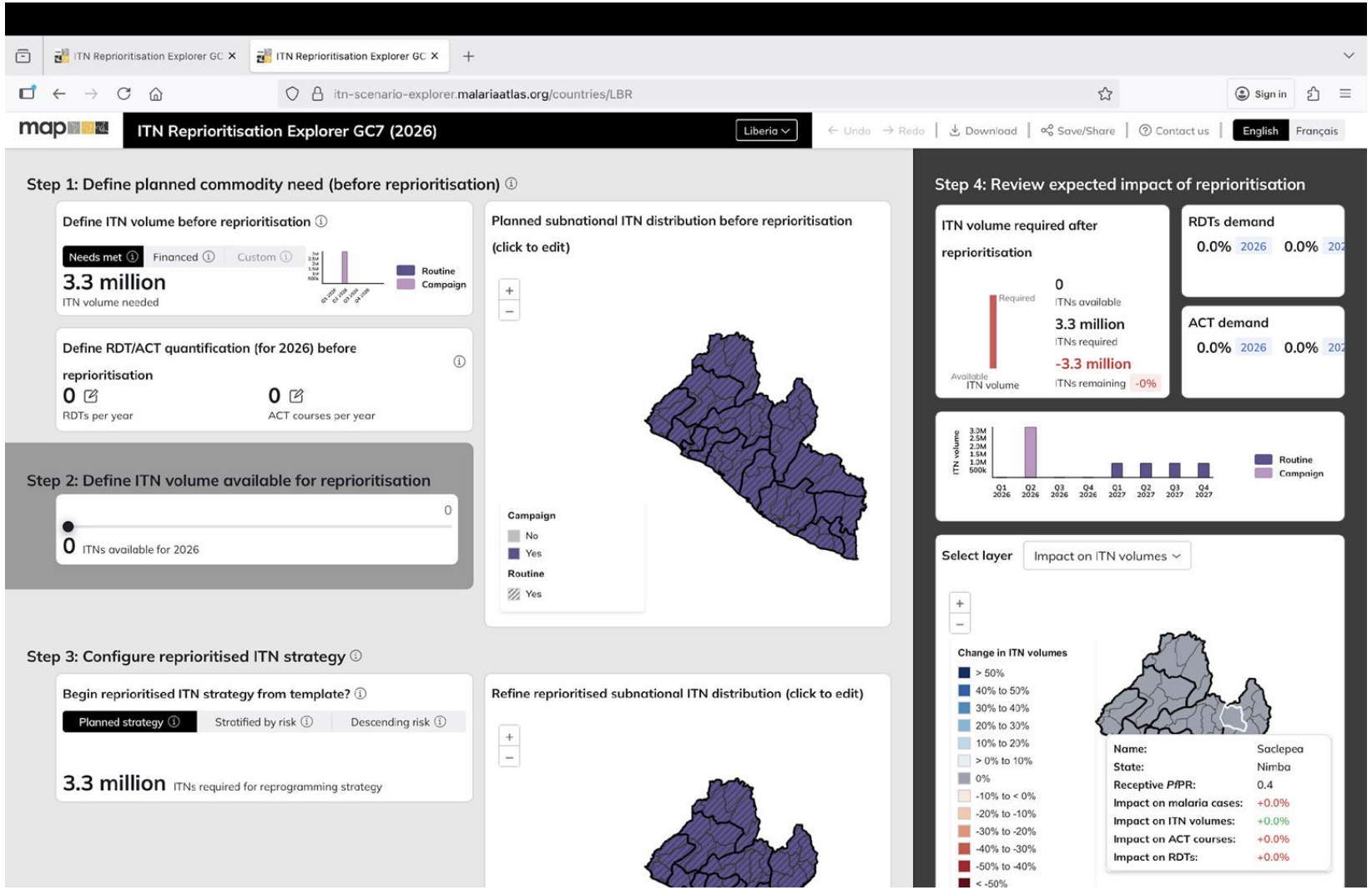
GC7 ITN reprogramming tool



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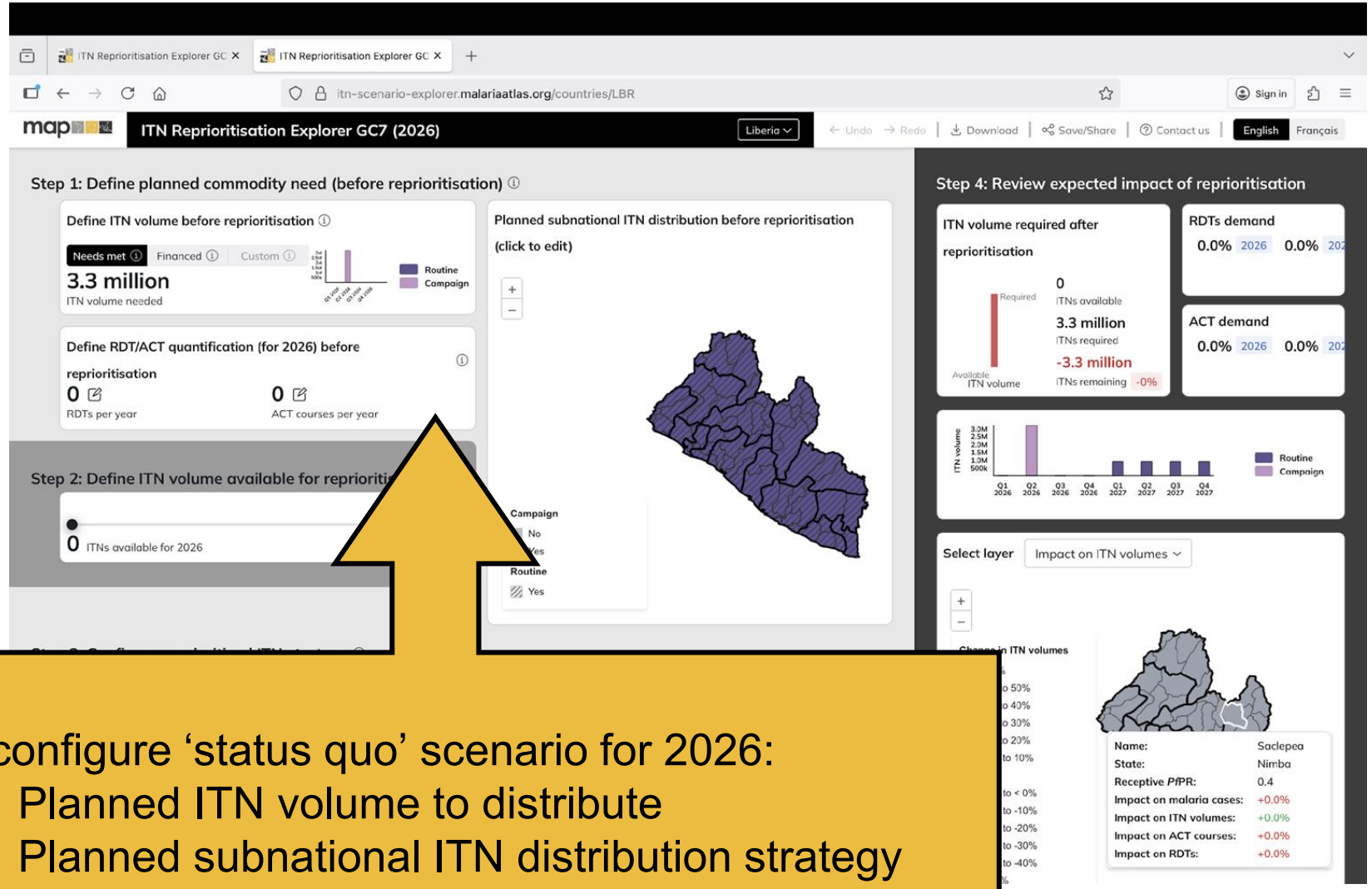
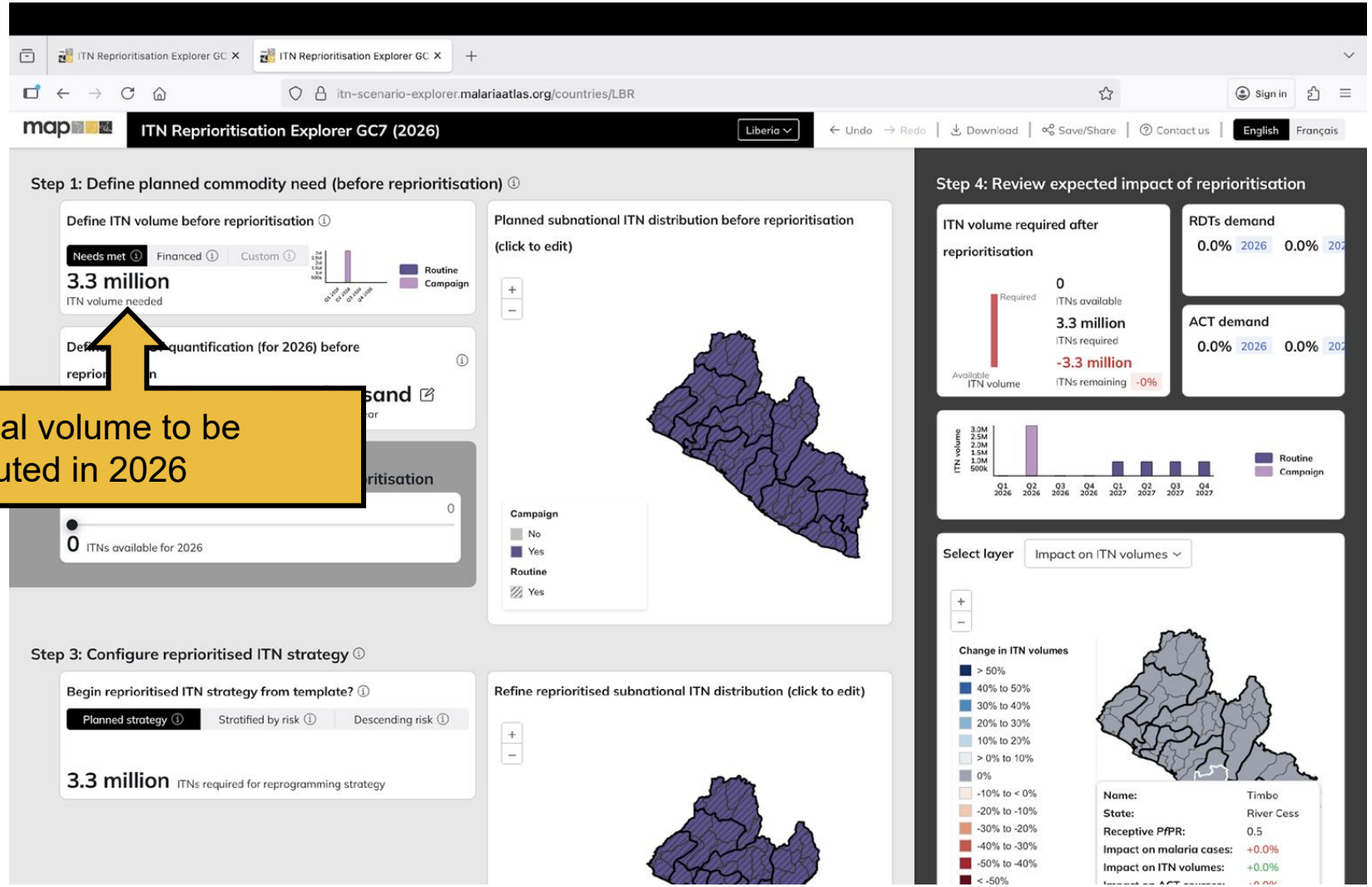


First, configure ‘status quo’ scenario for 2026:

- Planned ITN volume to distribute
- Planned subnational ITN distribution strategy
- Planned ACT/RDT quantification

Internal

GC7 ITN reprogramming tool



National volume to be distributed in 2026

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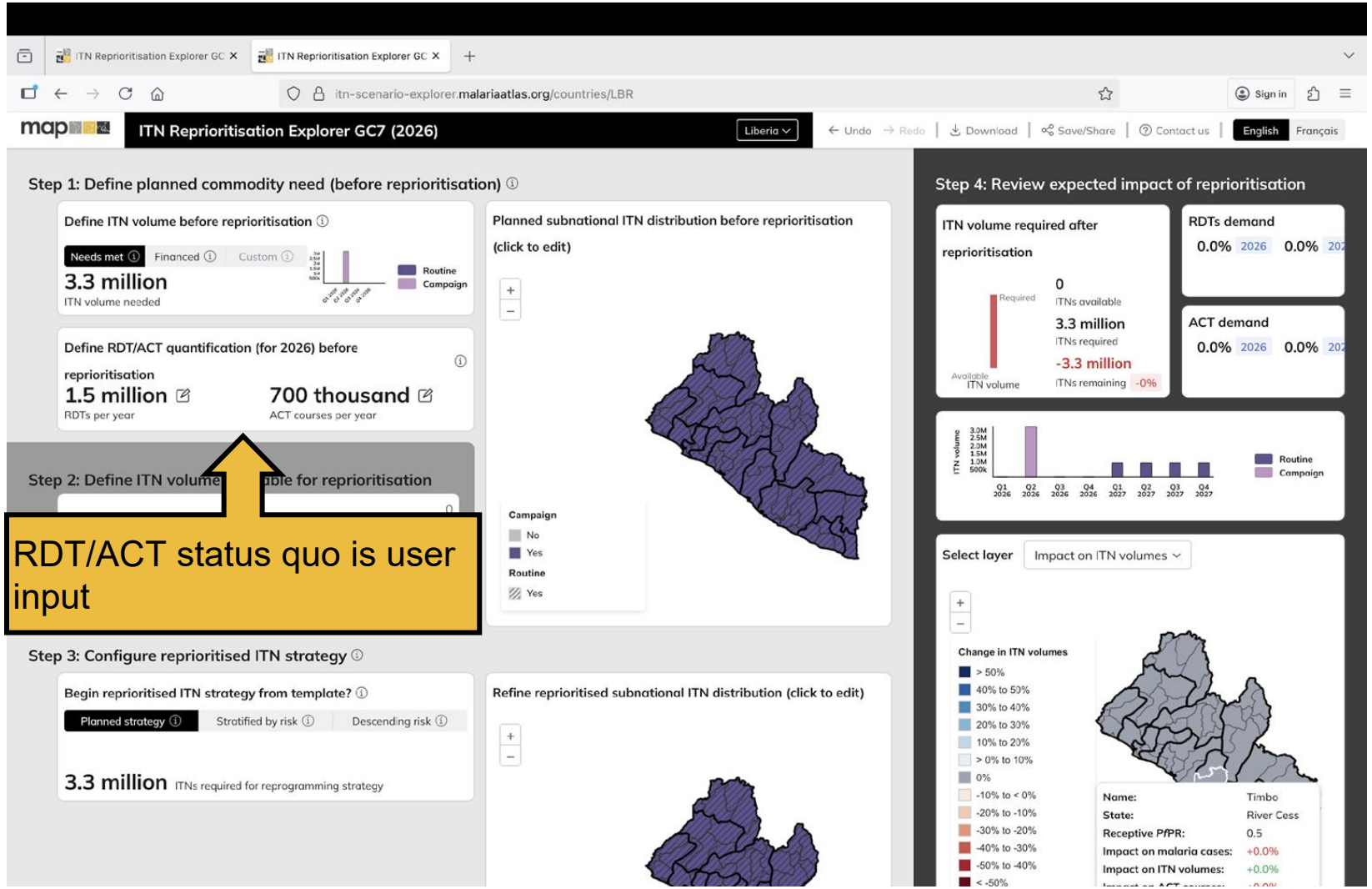

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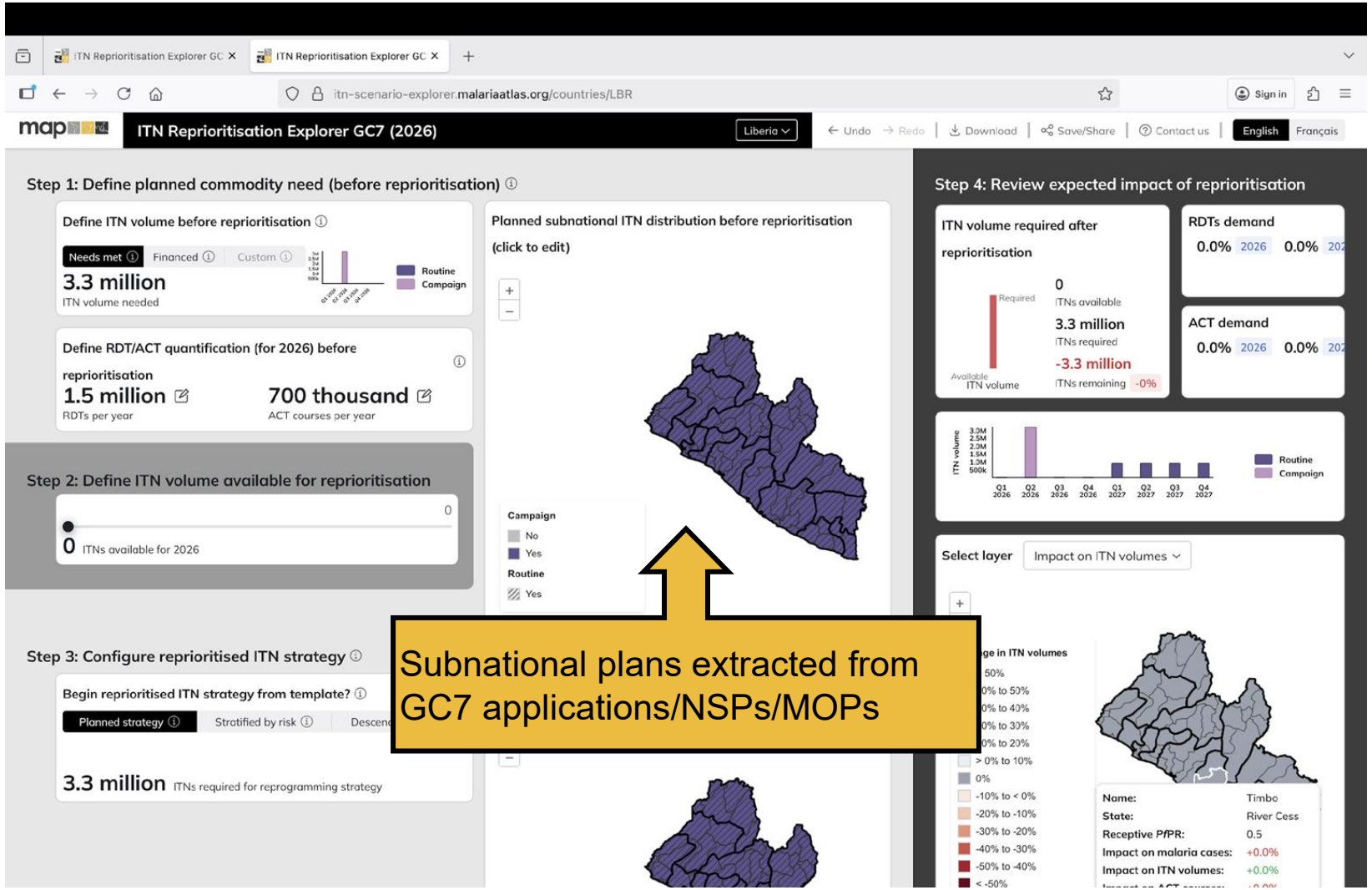

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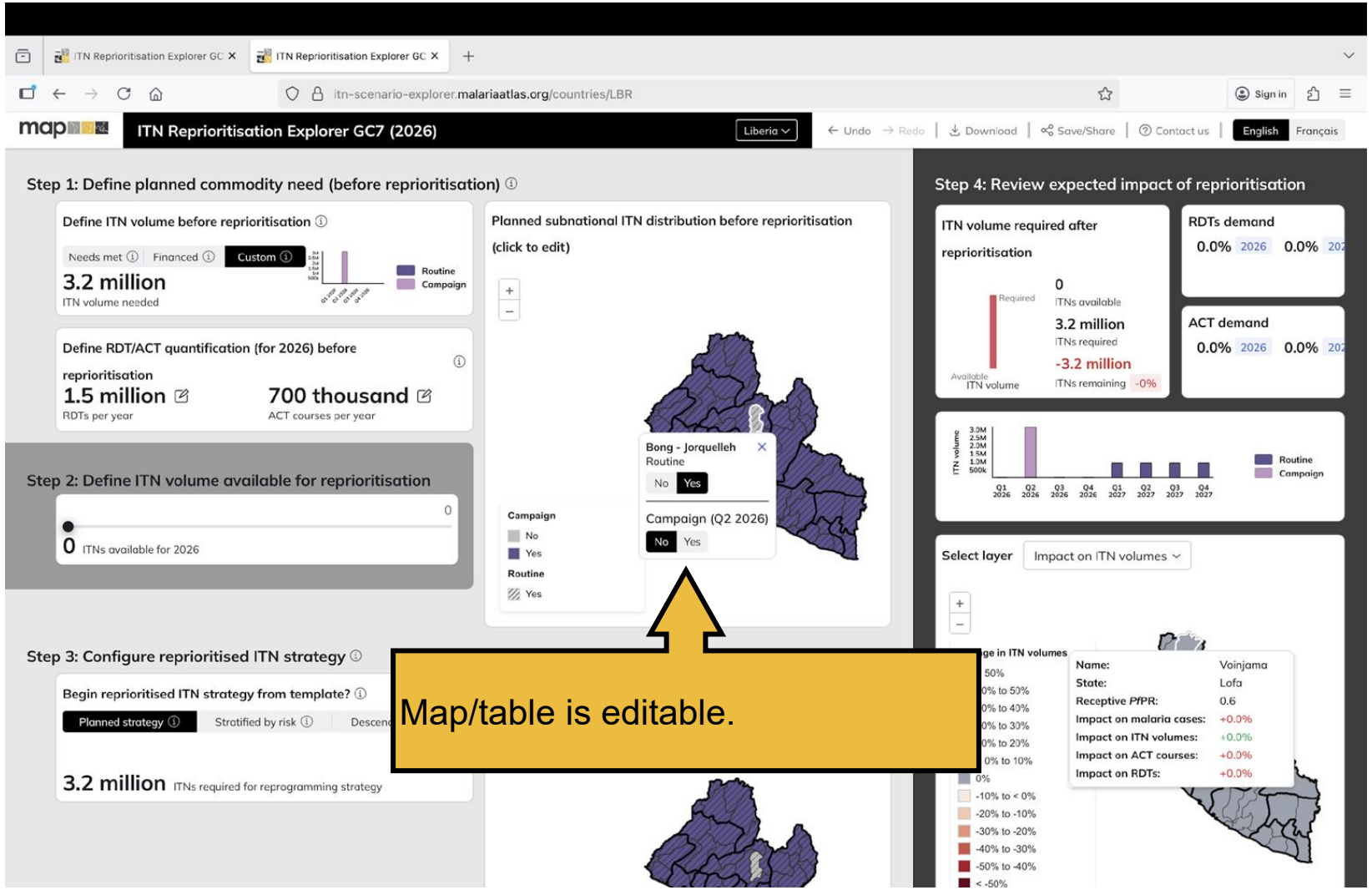

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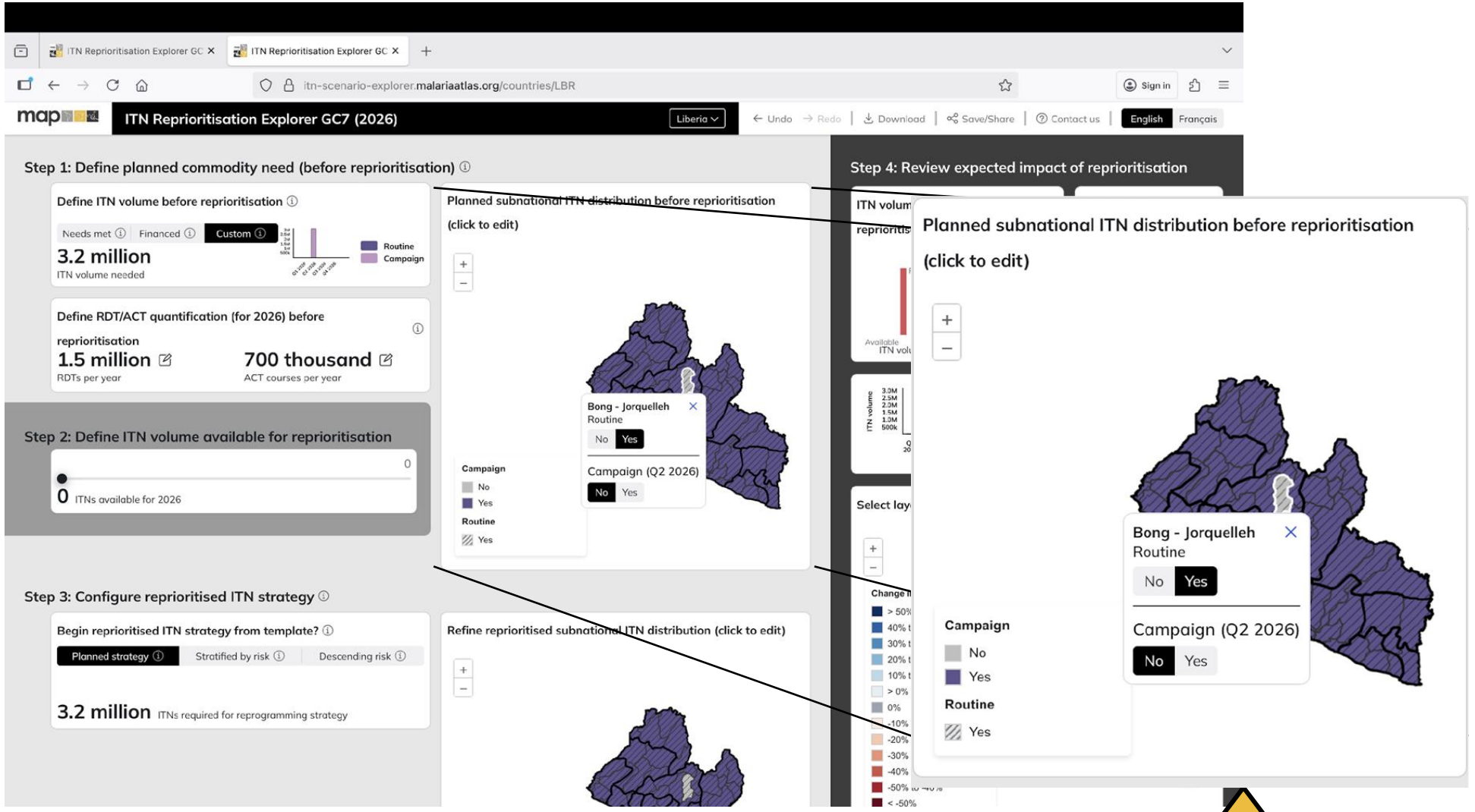

with details on campaign timing

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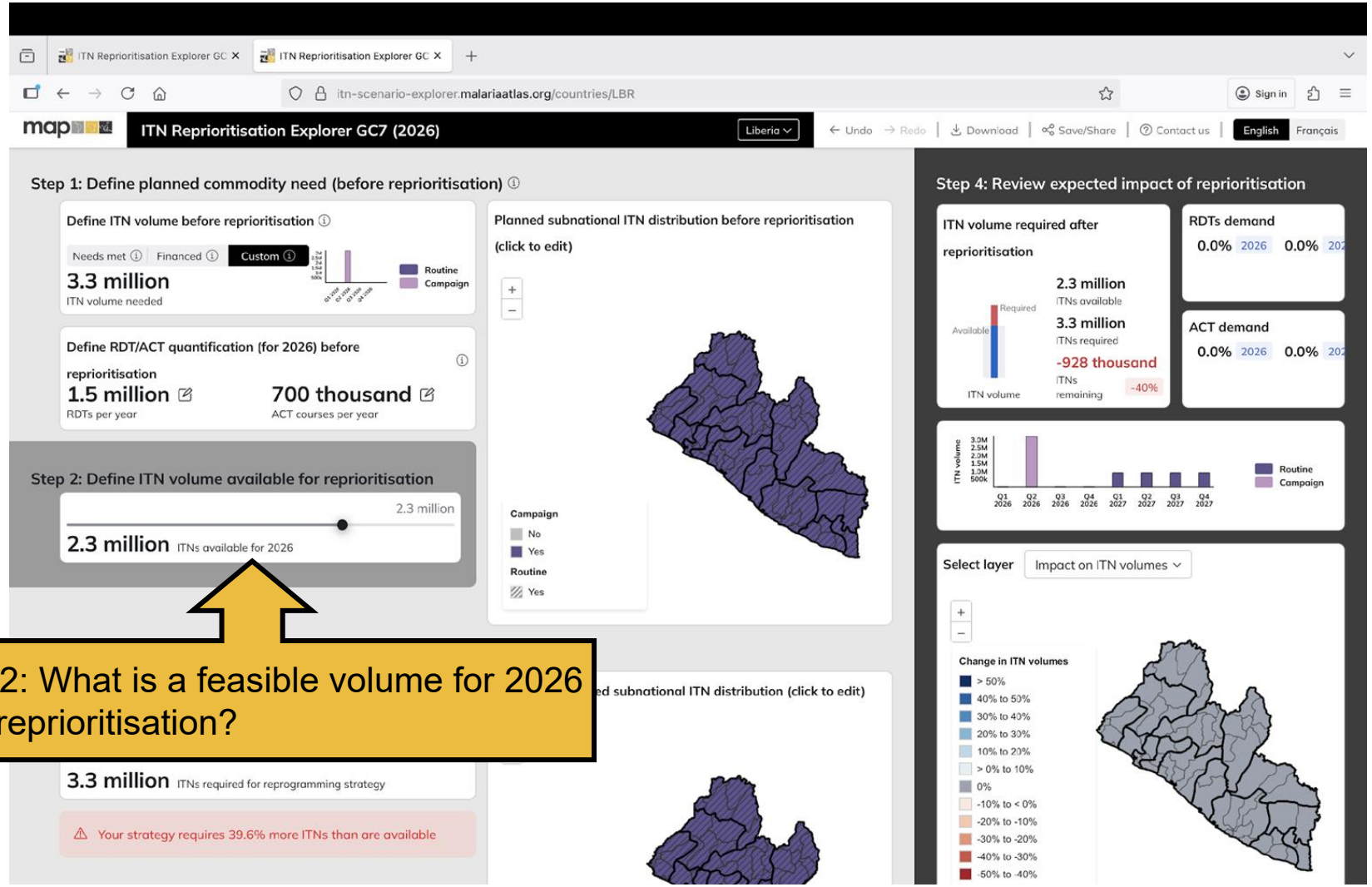
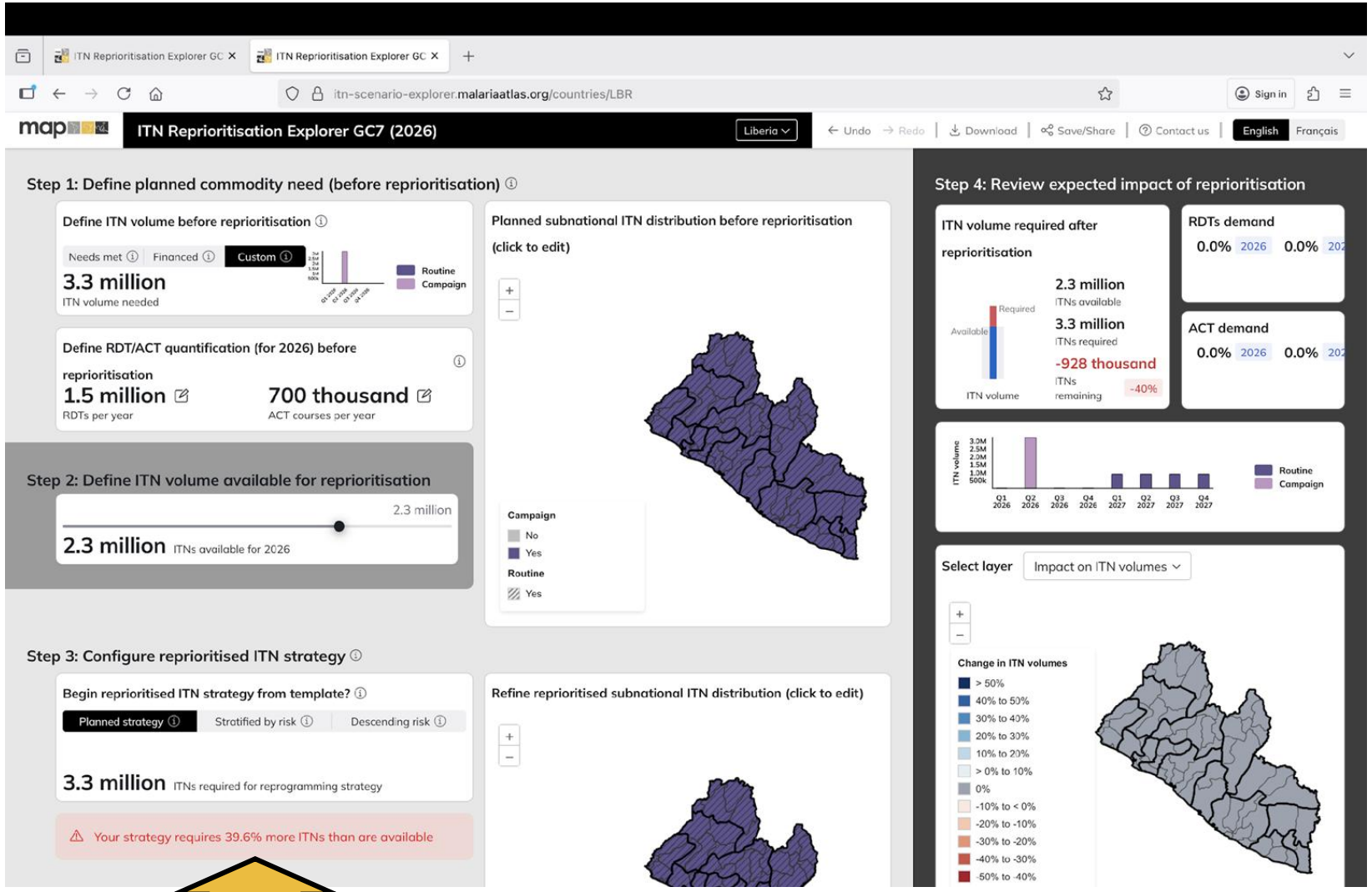
GC7 ITN reprogramming tool



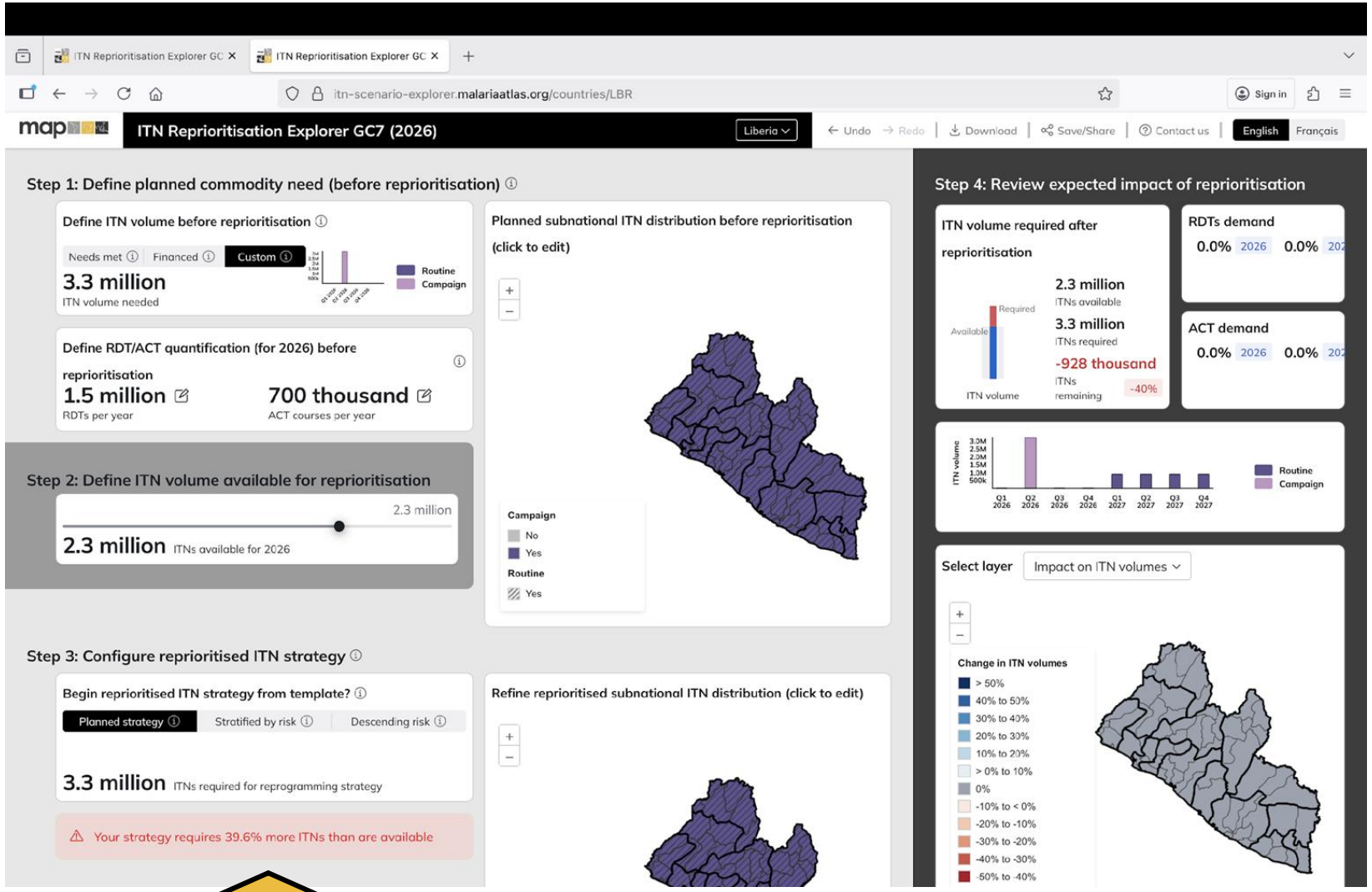
Step 2: What is a feasible volume for 2026 post-reprioritisation?

GC7 ITN reprogramming tool



And what implications does this have?

GC7 ITN reprogramming tool



Tool responds in real time to user input

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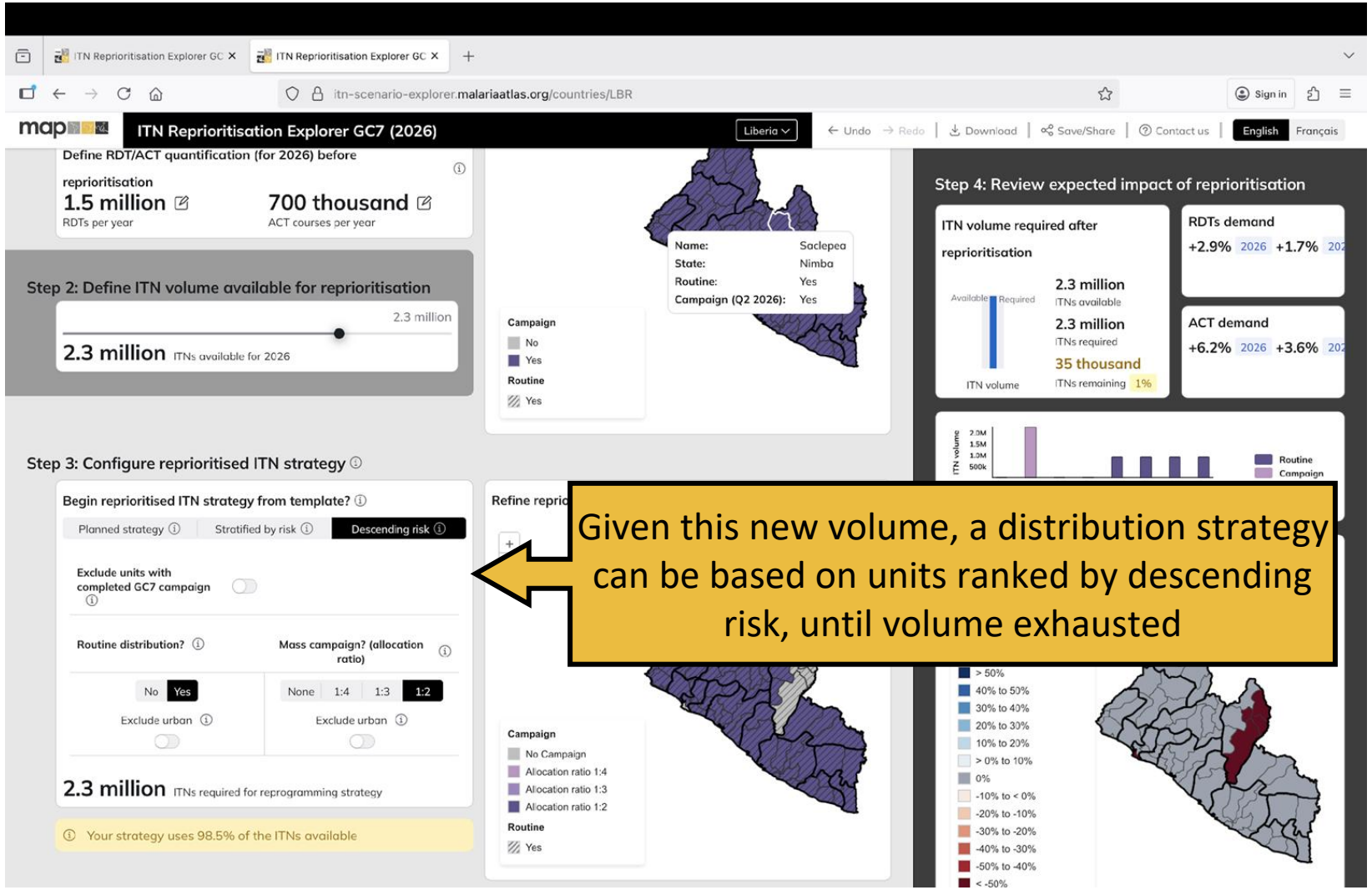

Given this new volume, a distribution strategy can be based on units ranked by descending risk, until volume exhausted

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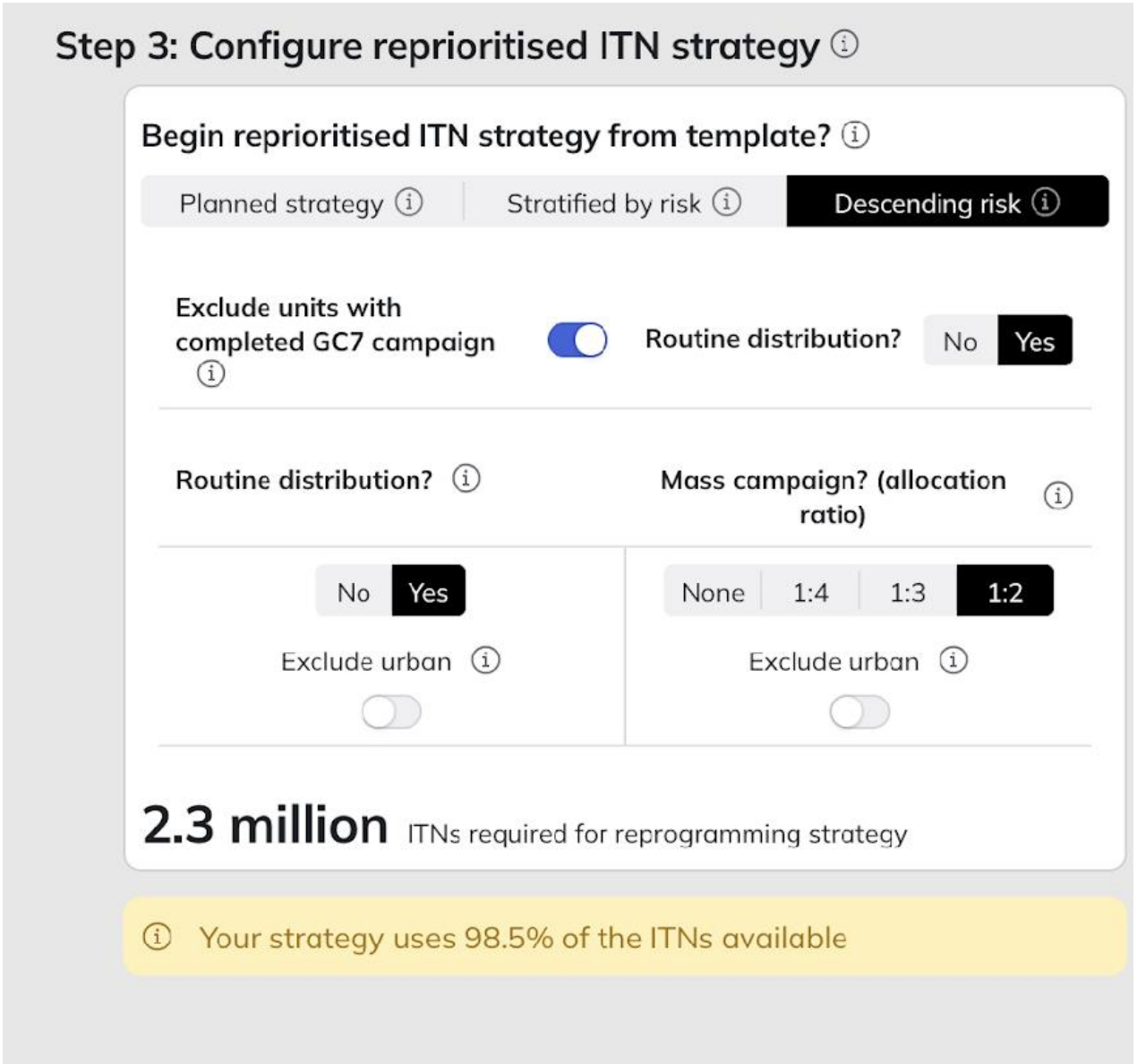

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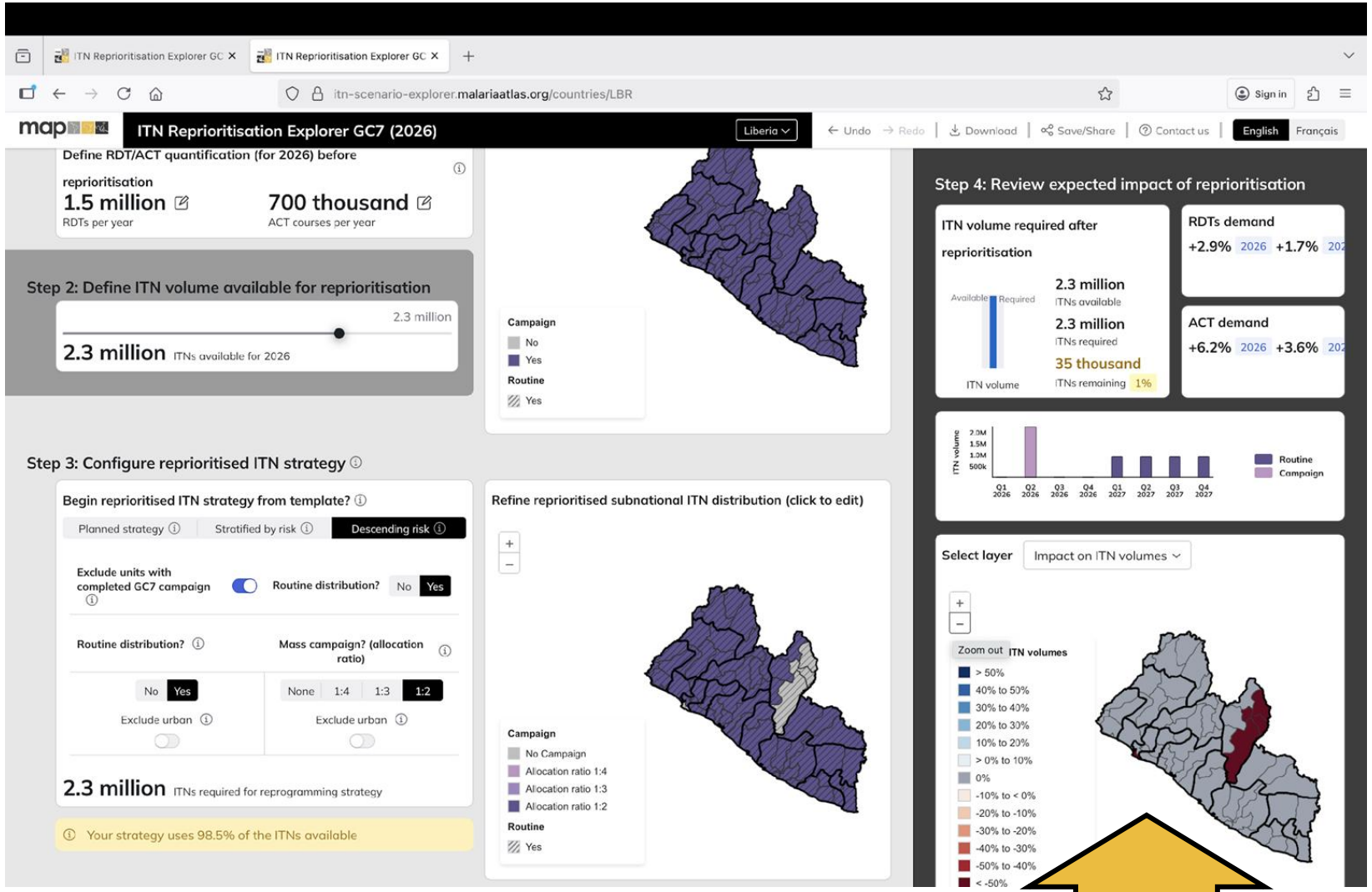

Changing ITN volumes distributed, sub-nationally

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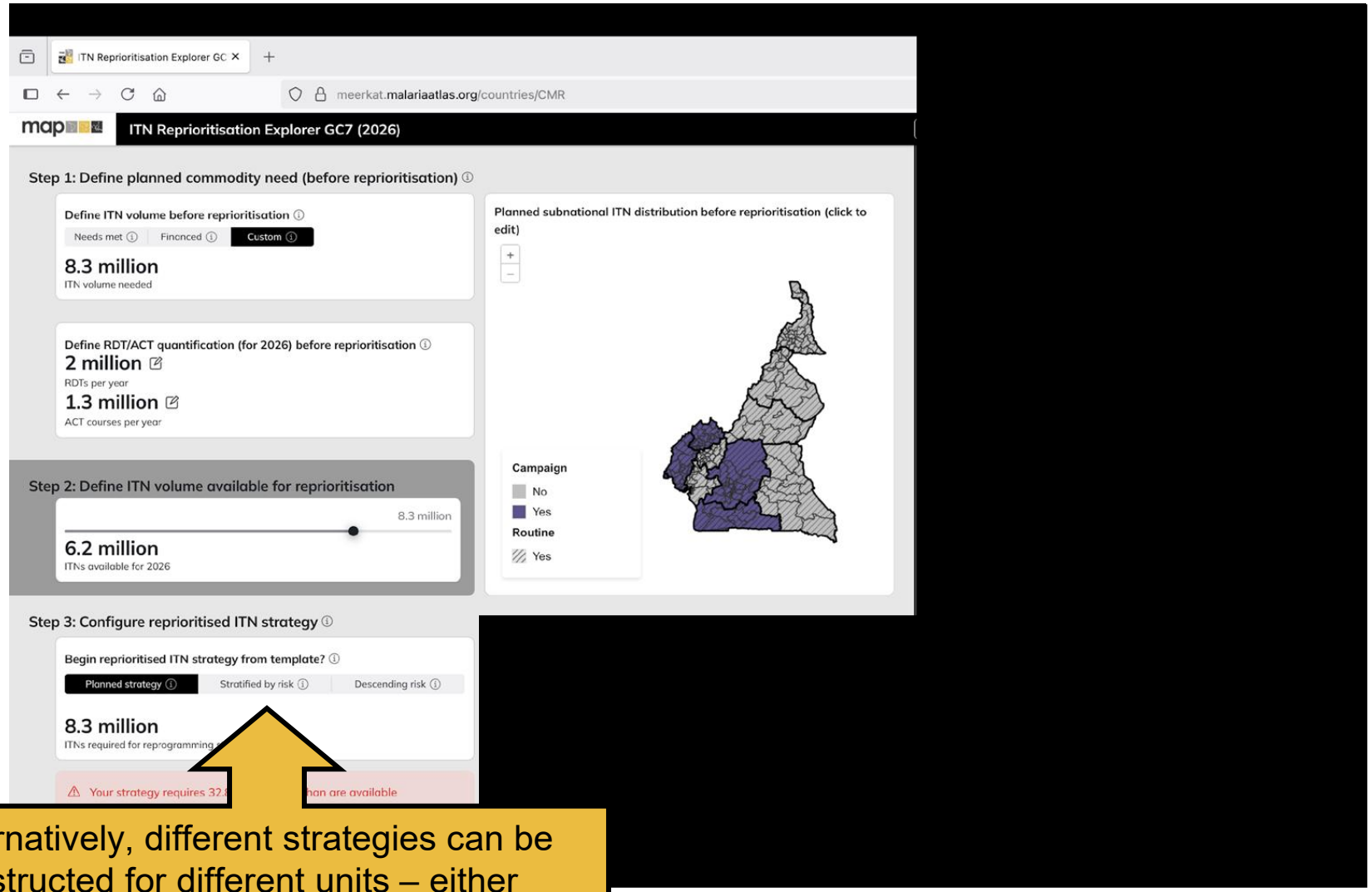
GC7 ITN reprogramming tool



Alternatively, different strategies can be constructed for different units – either manually or by risk strata

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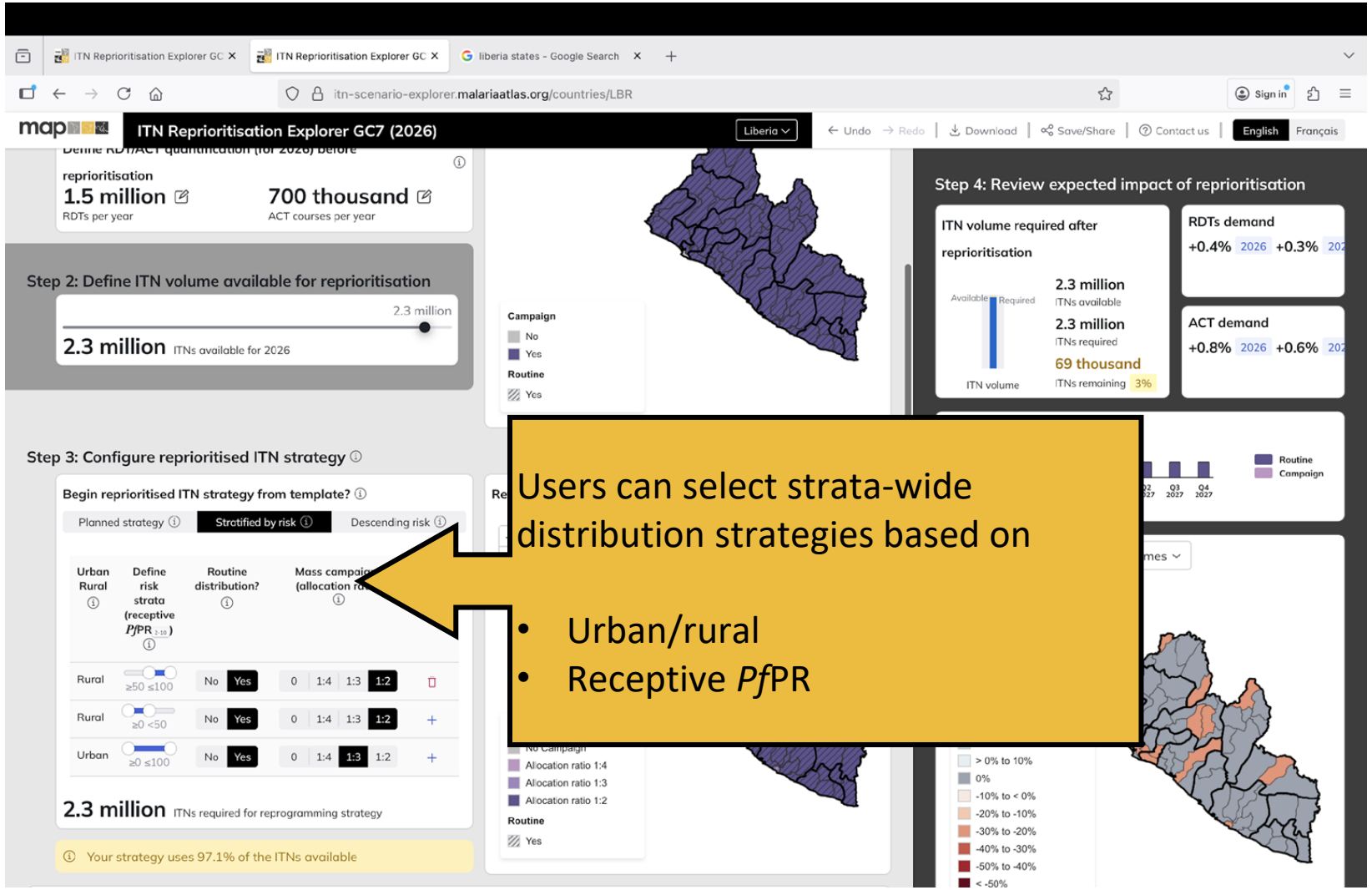
GC7 ITN reprogramming tool



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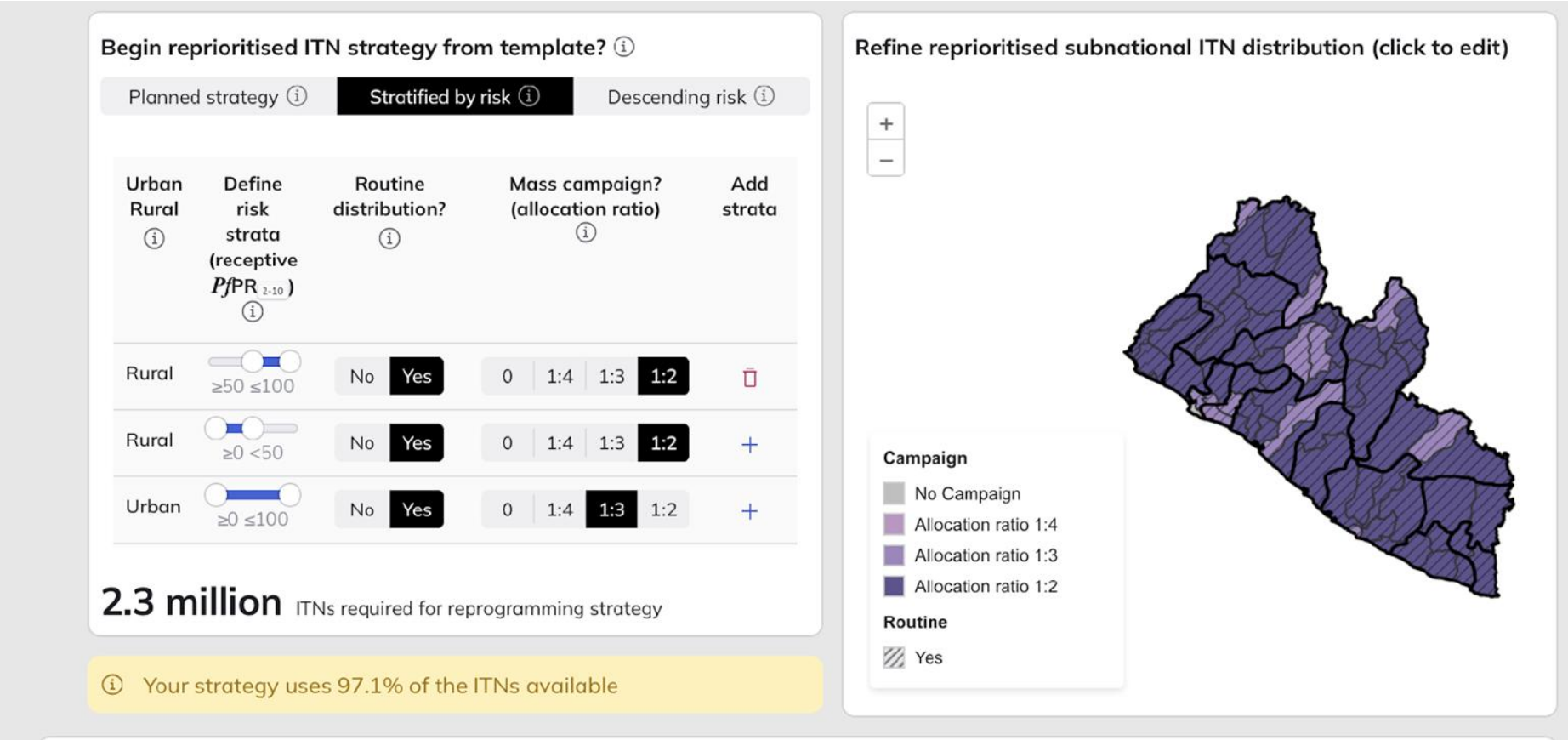

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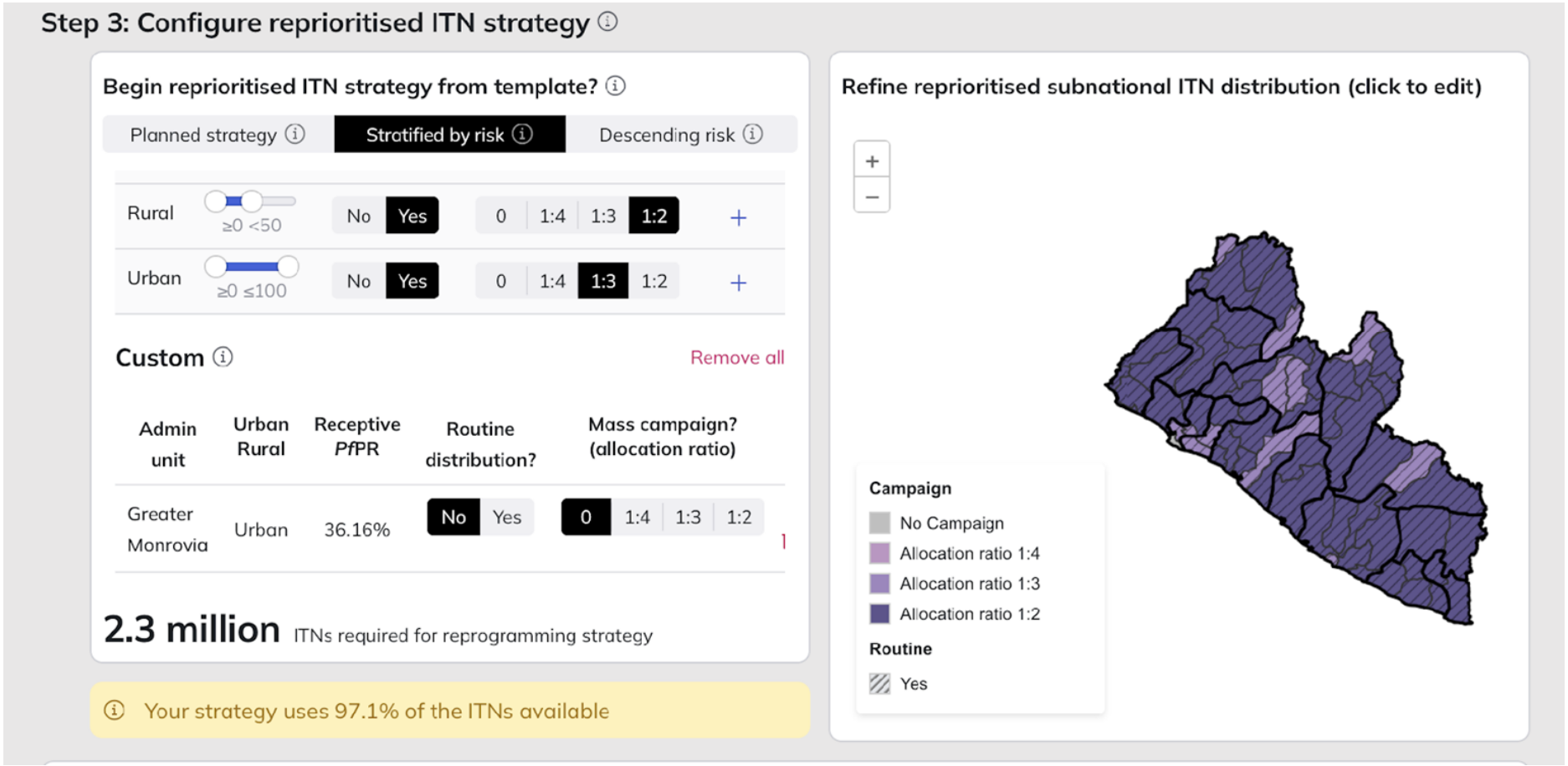

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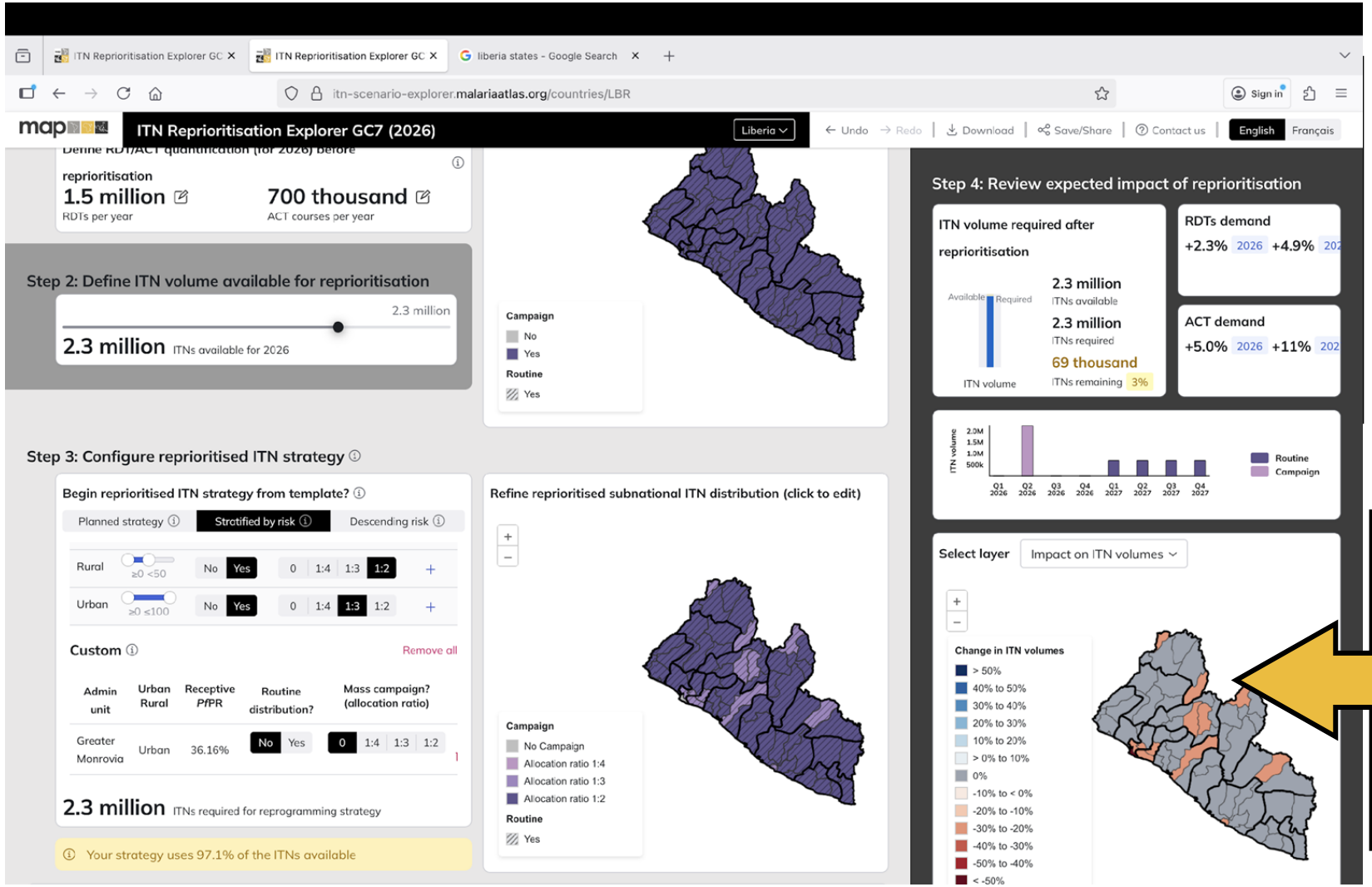
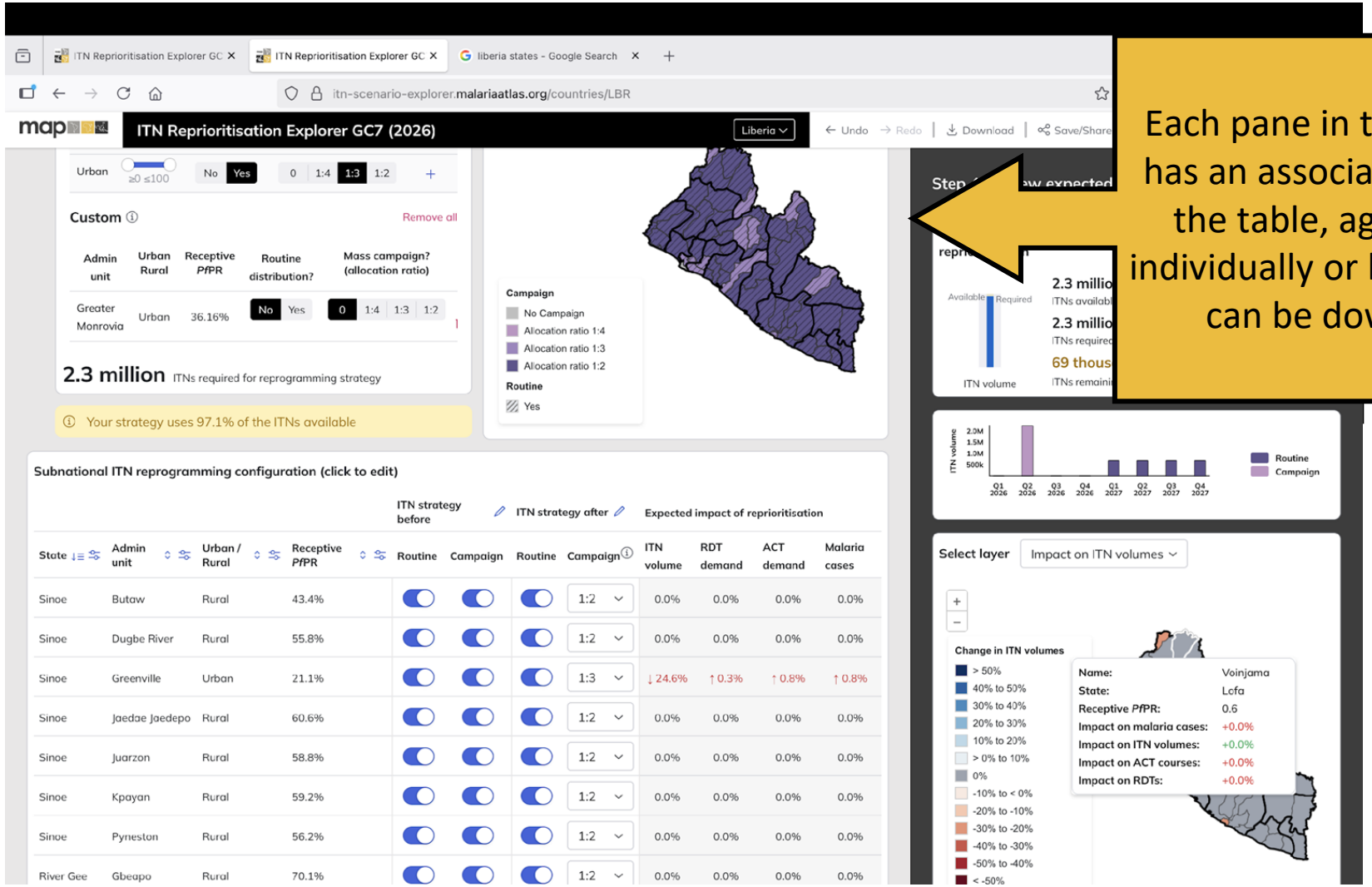


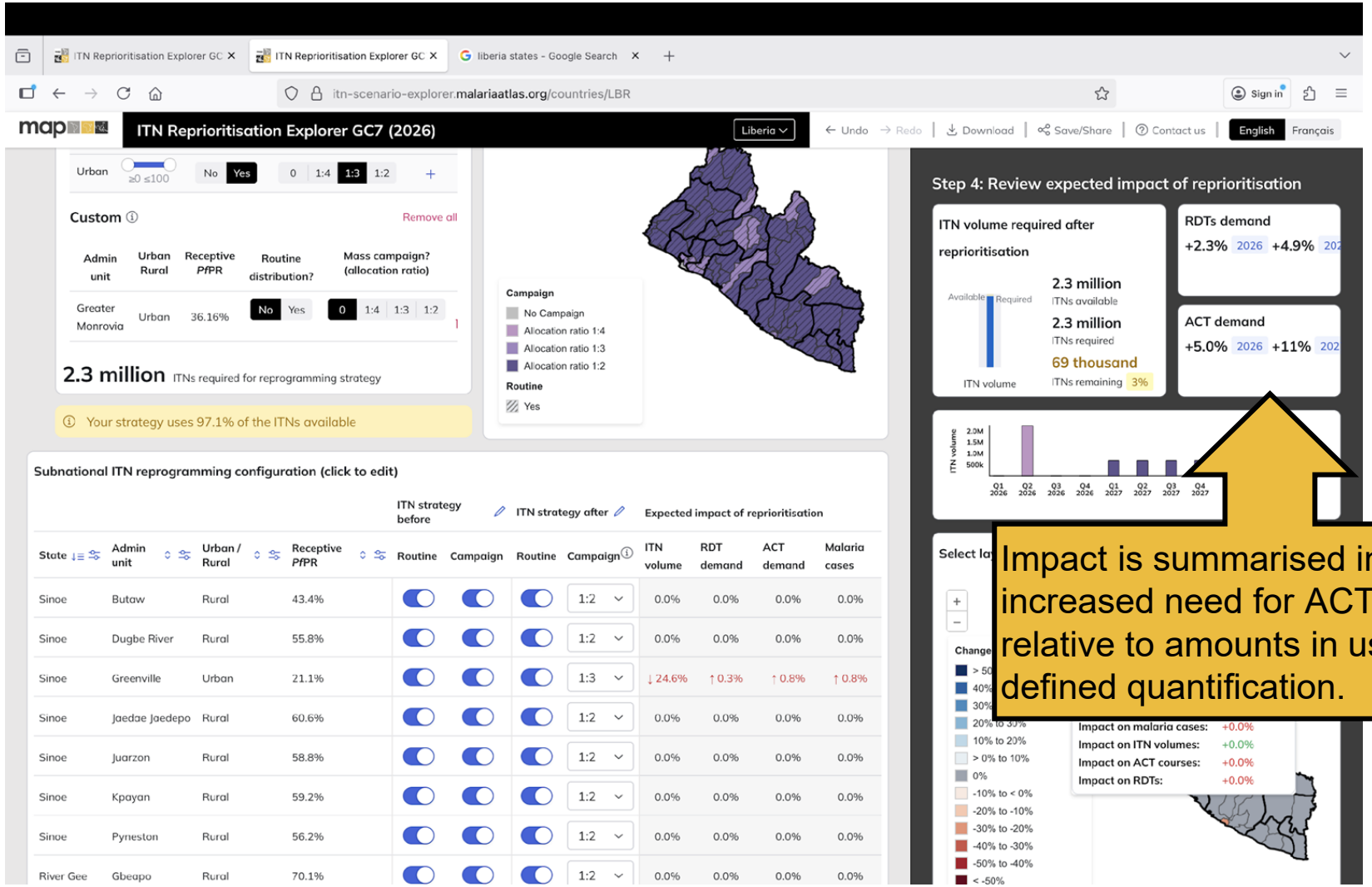
Summarised change in distributed volumes, subnationally

GC7 ITN reprogramming tool



Each pane in the dashboard has an associated column in the table, again editable individually or by groups. This can be downloaded.

GC7 ITN reprogramming tool



Talk outline

History of tool

Current functionality
(GC7 reprioritisation use case)

Potential future functionality and use cases

Internal

Limitations and future utility

This tool was developed for specific use case, but overall user interface and functionality is generic. It combines two core functionalities:

Coverage modelling:

- Scenarios of ITN distribution volumes translated to population coverage scenarios, accounting for:
  - Pre-existing nets in households
  - Effects of household size on net ownership and use
  - Local ITN attrition rates and use given access
- Currently, we do not account for:
  - Costings and distribution channels:
    - Scenarios configured by overall input volumes, not budget envelope
    - But there are distribution budget implications for e.g. routine vs mass campaign channels
  - Age-structured coverage
    - Targeting achieved by routine channels (i.e. we assume routine nets distributed across whole population)

Clear pathway to extension in collaboration with partners

Impact modelling:

- Epidemiological model converts ITN coverage scenarios into disease burden, accounting for variation in:
  - Efficacy of ITNs, including impact of insecticide resistance and next-generation nets
  - Receptive transmission potential in the absence of vector control
  - Context of other intervention coverages
- Currently, we do not account for:
  - Age-structured impact, including differential impact of age-targeted distributions
  - Changing coverage of other vertical interventions, e.g. SMC

Longer-term R&D required in collaboration with partners

Internal

amp | The Alliance for Malaria Prevention

SMC Alliance

Discussion - Questions & Answers

Discussion - Questions et réponses

Discussão – Perguntas e respostas

Chemoprevention adaptations to work within a reduced funding environment

For technical difficulties: Please use Zoom chat or contact the supplier at info@plbe.info

Reunião Anual da Aliança SMC 2026

Kampala – Uganda

24–28 fevereiro 2026

ADAPTAÇÃO AO TRABALHO NUM AMBIENTE COM RECURSOS REDUZIDOS

Guiné-Bissau

Internal

ABORDAGEM DA QPS NA GUINÉ-BISSAU

- **ADMINISTRAÇÃO : CAMPANHA DE MASSA PELOS AGENTES SAÚDE COMUNITÁRIA;**
- **ESTRATEGIA : PORTA À PORTA;**
- **DURAÇÃO : 6 DIAS POR MÊS;**
- **PERIODO : AGOSTO À NOVEMBRO;**
- **DISTRIBUIÇÃO DOS MEDICAMENTOS: 3 DOSES OBSERVADAS PELOS AGENTES DE SAÚDE COMUNITÁRIA;**
- **DISTRIBUIÇÃO DE MII PARA AS CRIANÇAS ALVOS E ZONAS DESPRIORIZADAS DE QPS.**

Internal

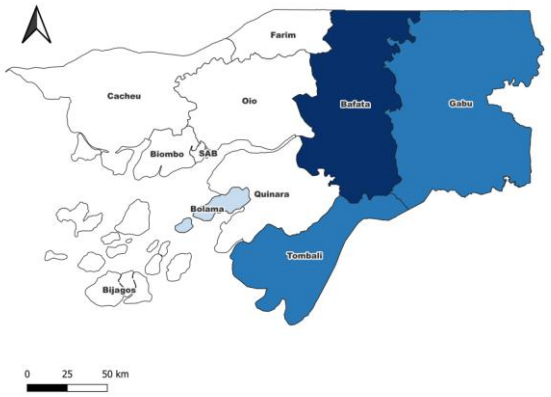
REGIÕES ALVOS DA CAMPANHA 2025

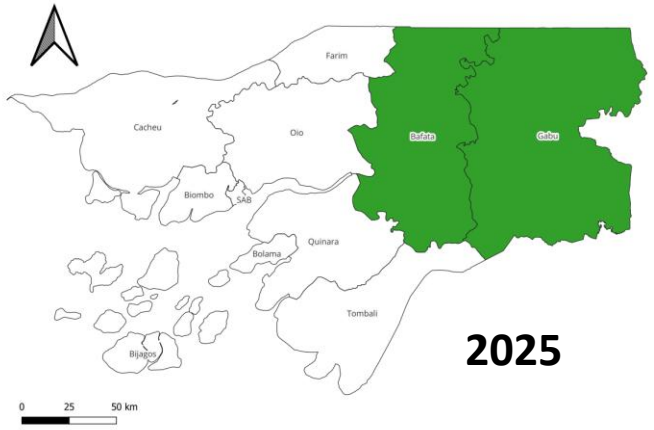
CAMPANHA QPS 2025
REGIÕES ALVOS: BAFATÁ E GABÚ

2 REGIÕES

33 ÀREAS SANITARIAS

2024





2025

ALVOS DE 3-59 MESES
110 032

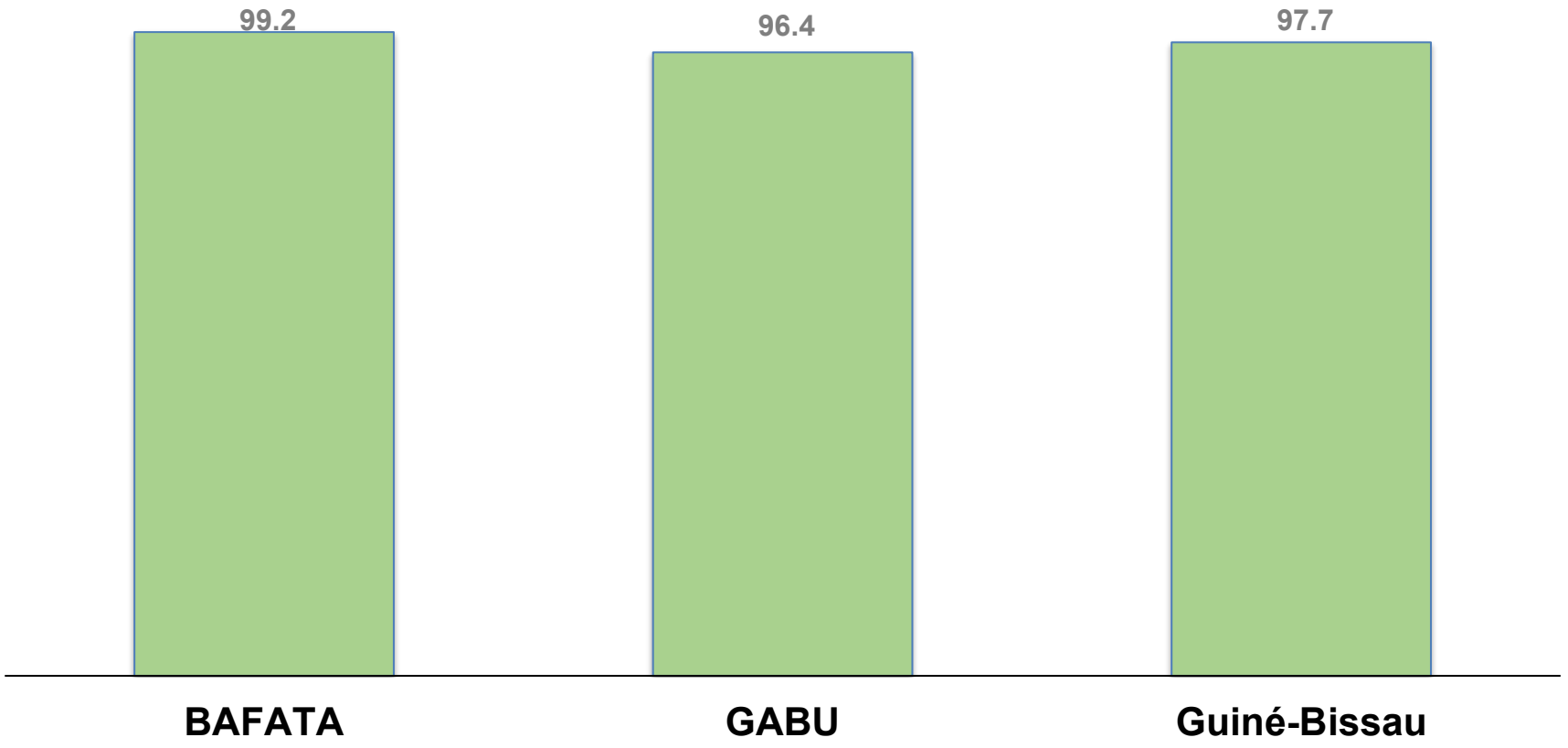
4 RONDAS
Agosto à Novembro

Regiões	Total de crianças alvos	3-11 meses	12-59 meses	Total de crianças atingidos com 4 rondas	3-11 meses	12-59 meses	% das crianças atingidas	*% de MII distribuidas*
Bafata	*54 461*	10 024	44 438	*54 008*	7 640	46 368	*99,2*	*100*
Gabu	*55 571*	10 228	45 343	*53 546*	8 629	44 917	*96,4*	*100*
TOTAL	***110 032***	**20 252**	**89 781**	***107 554***	**16 269**	**91 285**	***97,7***	***100***

Fonte: DHIS2

Internal

COBERTURA DAS CRIANÇAS COM 4 TRATAMENTOS NA CAMPANHA 2025



Fonte: DHIS2

Internal

LIÇÕES APRENDIDAS EM 2025

- **DISTRIBUIÇÃO DOS MII PARA AS CRIANÇAS QUE FORAM ADMINISTRADAS MEDICAMENTOS SPAQ;**
- **USO DA PLATAFORMA WHATSAPP PARA EFEITO DE RESTITUIÇÃO DIARIA COM OS RESPONSAVEIS DAS AREAS SANITARIAS;**
- **IDENTIFICAÇÃO DAS CRIANÇAS SUBVACINADAS E NÃO VACINADAS DURANTE QPS;**

Internal

ADAPTAÇÃO AO TRABALHO NUM AMBIENTE COM RECURSOS REDUZIDOS

- **DISTRIBUIÇÃO DE REDES MOSQUITEIRAS SEM CUSTOS ADICIONAIS PELOS ASC;**
- **LIMITAÇÕES DE FINANCIAMENTO IMPEDIRAM A IMPLEMENTAÇÃO DA QPS EM TODAS AS REGIÕES DE ALTA INCIDÊNCIA;**
- **IMPLEMENTAÇÃO DA DISTRIBUIÇÃO DE MILDAS COMO MEDIDA DE SUBSTITUIÇÃO NAS ZONAS DESPRIORIZADAS (BOLAMA,TOMBALI E CARAVELA);**
- **INTEGRAÇÃO DAS ATIVIDADES DE COM OUTRAS INSTITUIÇÕES**

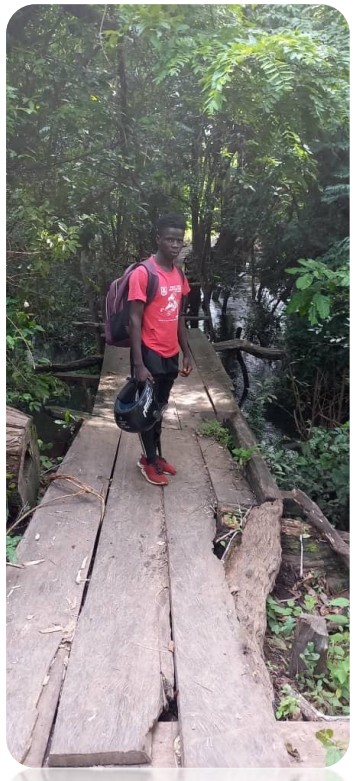
Internal

PRESPECTIVAS QPS EM 2026

- **USO DE RELATORIO DA ESTRATIFICAÇÃO PARA DEFINIR REGIÕES E AREAS PARA IMPLEMENTAÇÃO DA CQPS;**
- **MELHORAR SUPERVISÃO DE PROXIMIDADE ATRAVES DE APLICATIVO KOBOCOLLECT;**
- **EXTENSÃO DE RONDAS DA CAMPANHA E DA FAIXA ETARIA.**

Internal

ZONAS DE DIFICIL ACESSO



Responsaveis de areas sanitarias e supervisores das equipas das areas de dificil acesso

Internal

Merci, Thank you, Obrigado

CAMEROUN CPS: PLAN D'ATTENUATION POUR SURMONTER L'ORDRE D'ARRET DES TRAVAUX DU PMI/USAID

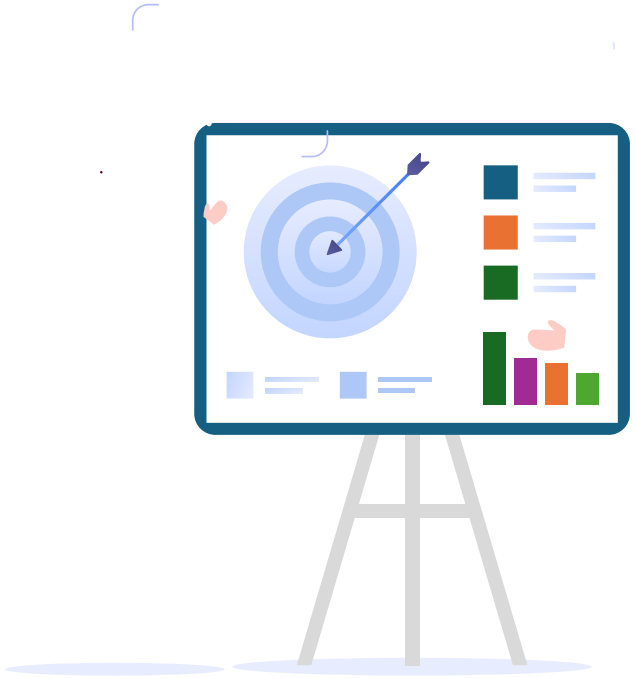
Présentée par :

Dr ZEH MEKA ALBERT

Secrétaire Permanent, PNLP-Cameroun

In

Plan



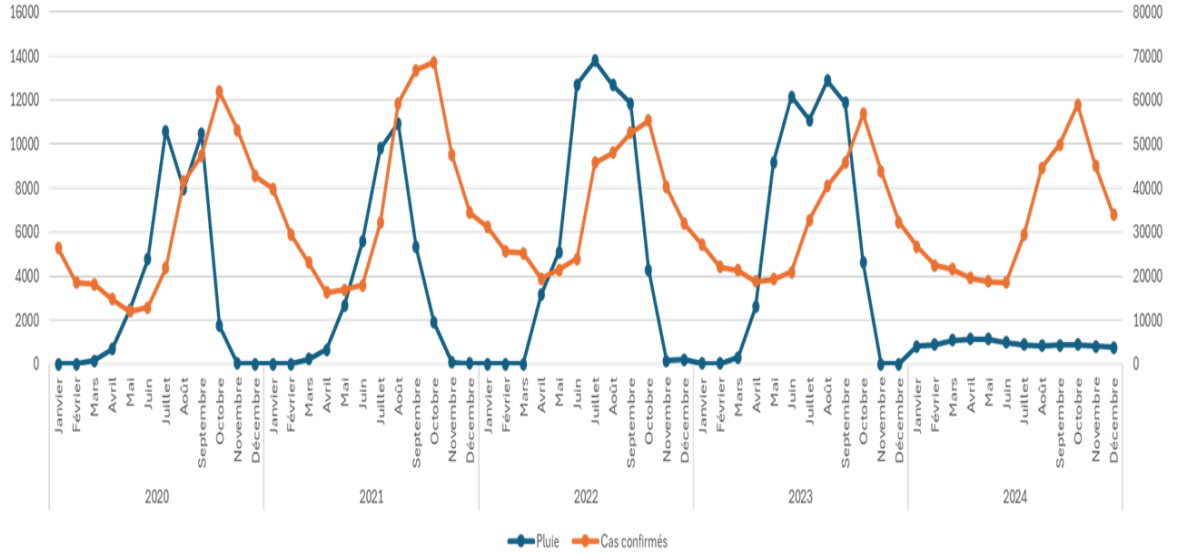
- Introduction
- Contexte
- Mesures de mitigation
- Leçons apprises & conclusion

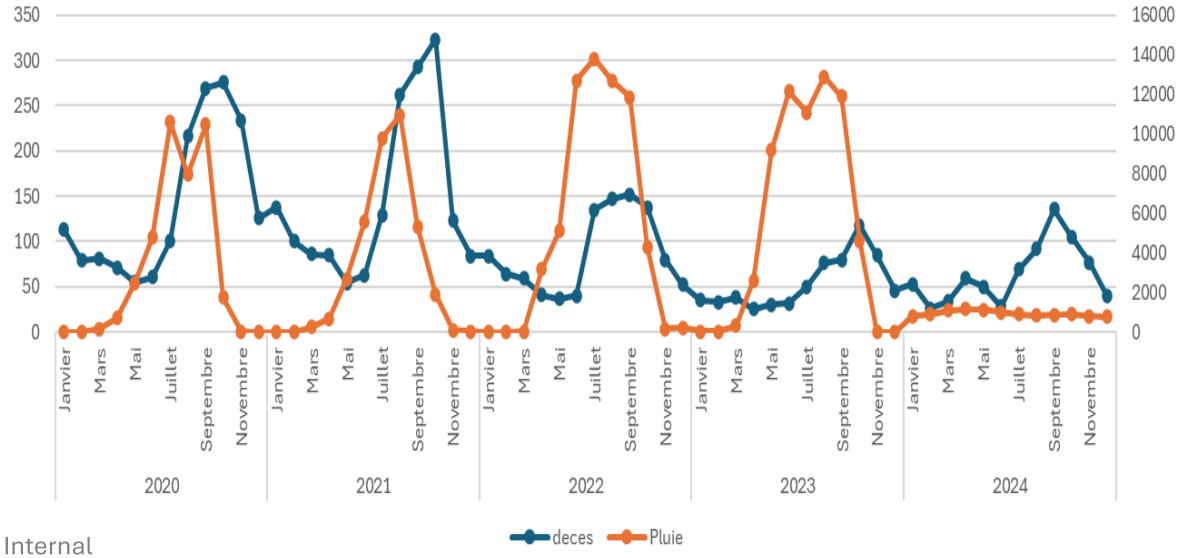
Introduction (1/4)

- Le paludisme demeure une **priorité de santé publique au Cameroun**, avec un profil **endémo-épidémique** et de fortes **disparités régionales**.
- Le fardeau est variable selon les régions, liée à des facteurs climatiques, géographiques, et socio-économiques;
- **Groupes les plus affectés** : enfants de moins de 5 ans, femmes enceintes, populations rurales et pauvres.
- **Sud du pays :** transmission **continue** tout au long de l'année.
- **Régions du septentrion :** transmission **saisonnière** (4 à 5 mois), avec la majorité des **cas et décès**, surtout chez les **enfants de moins de 5 ans.**

Internal

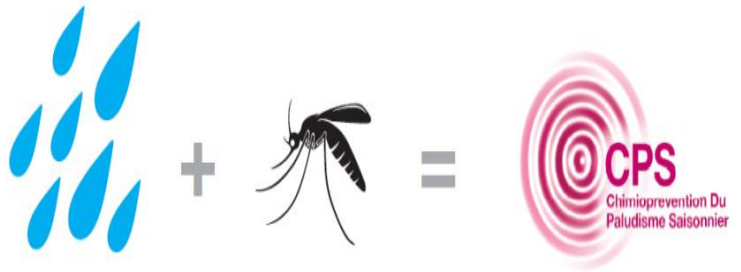
Introduction (2/4)





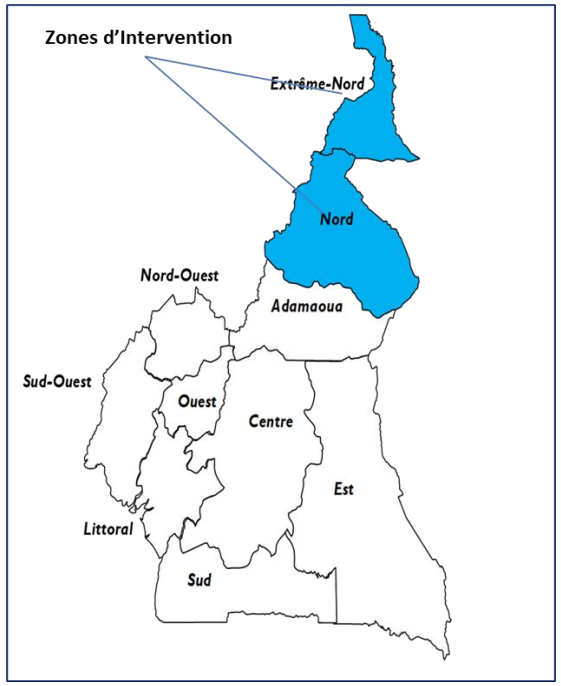
Dans les régions de l'Extrême-Nord et du Nord,

- **Corrélation pluie–paludisme :** les pics de cas confirmés coïncident avec la **saison des pluies** qui créent des **gîtes larvaires** favorables à la reproduction d'*Anophèles*.
- **Enfants <5 ans :** pics de cas et de décès alignés sur la période de fortes pluies.
- **Saisonnalité :** pics de pluie observés **chaque année entre juillet et octobre**.

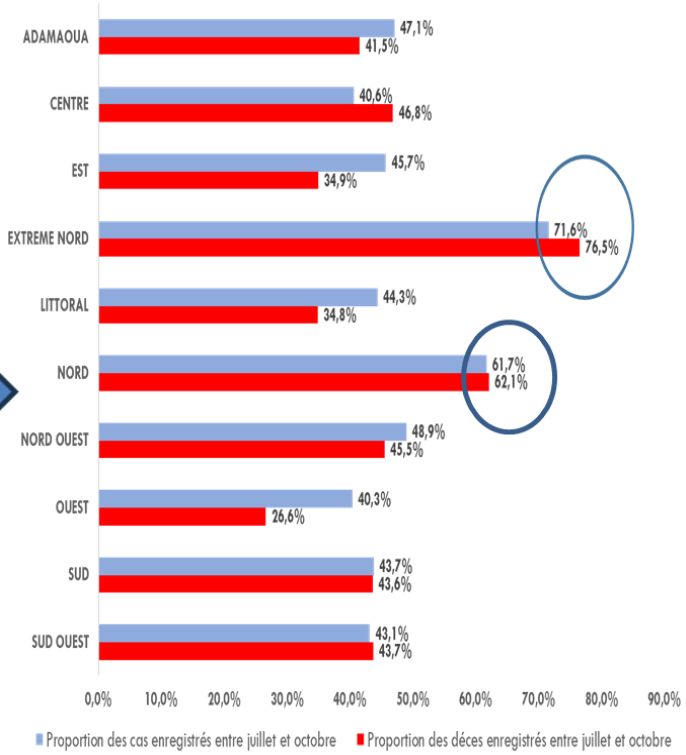


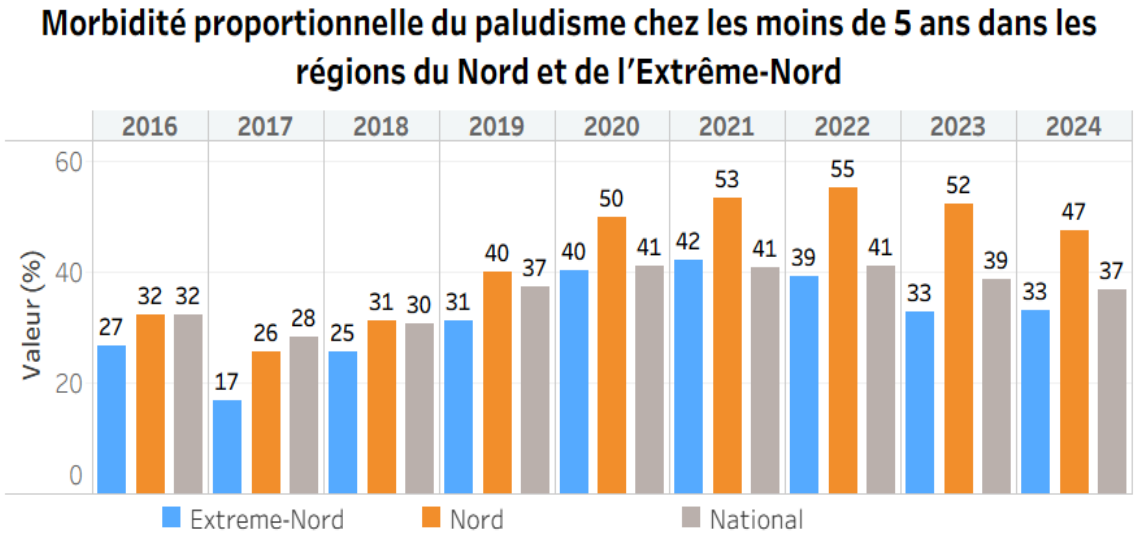
Internal

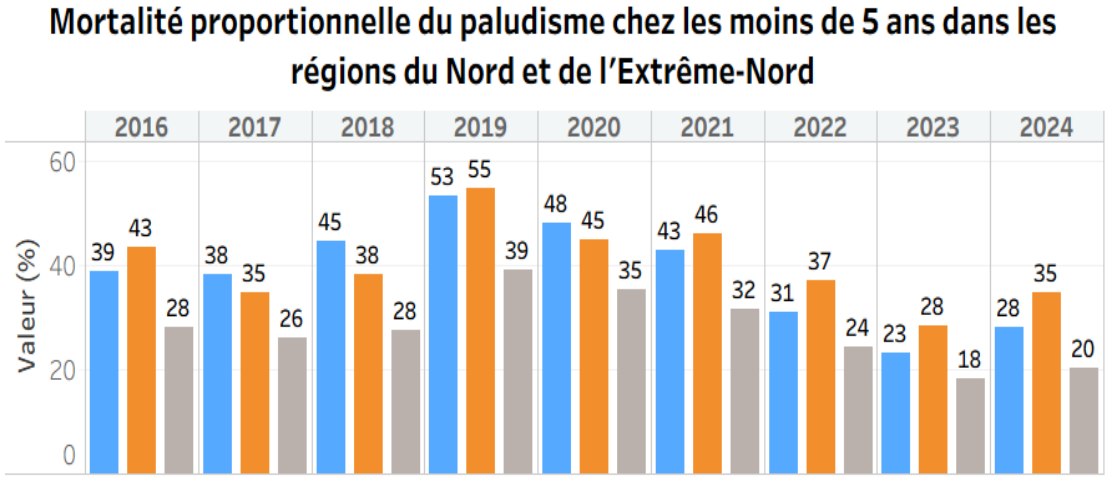
Introduction (3/4) : Critères d'éligibilité



2015



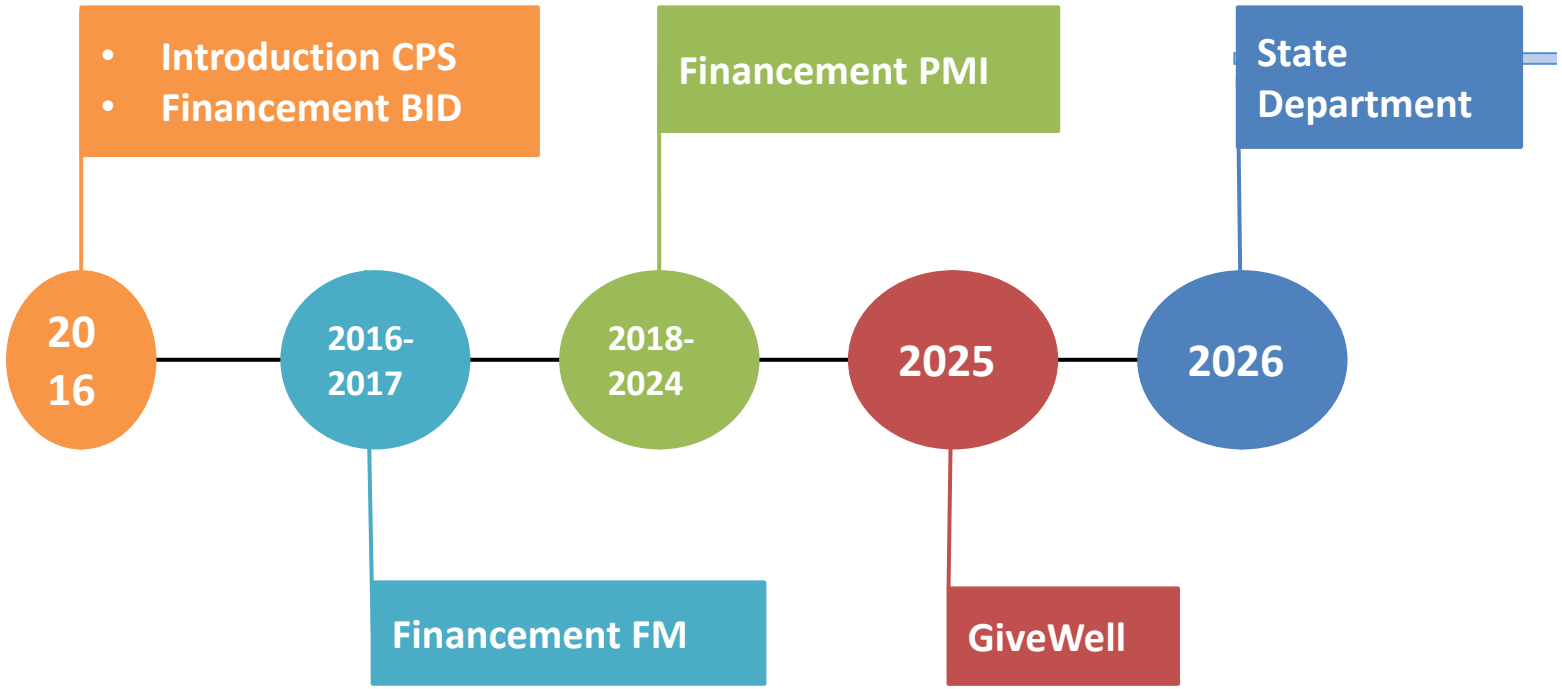




- La transmission du paludisme et la majorité (> 60 %) des cas cliniques de paludisme surviennent pendant une courte période d'environ 4 mois ;
- Le taux d'attaque clinique du paludisme est supérieur à 0,1 attaque par saison de transmission dans le groupe d'âge cible ;
- Le SP + AQ reste efficace (> 90 % d'efficacité).

Internal

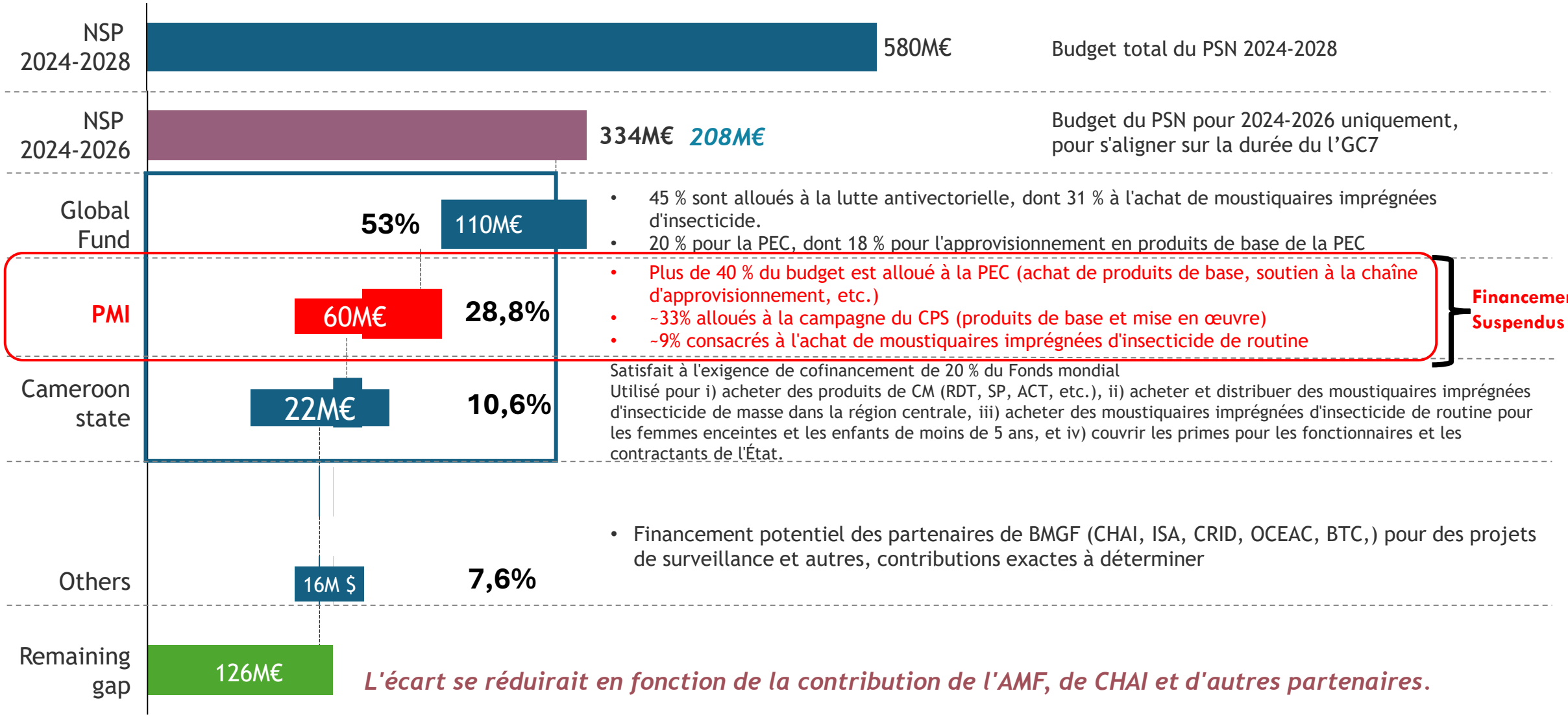
Contexte (1/4): Evolution des financements de la CPS au Cameroun



- **2018-2024: >125 millions €** financements cumulatifs de PMI
- Baisse notable des décès chez les enfants <5 ans : **30%**(Extrême Nord); 44% (Nord)

Réduction des financements, passant d'environ 3 millions € à 2,3 millions € en 2026

Contexte (2/4): Paysage du financement du PSNLP 2024 - 2026

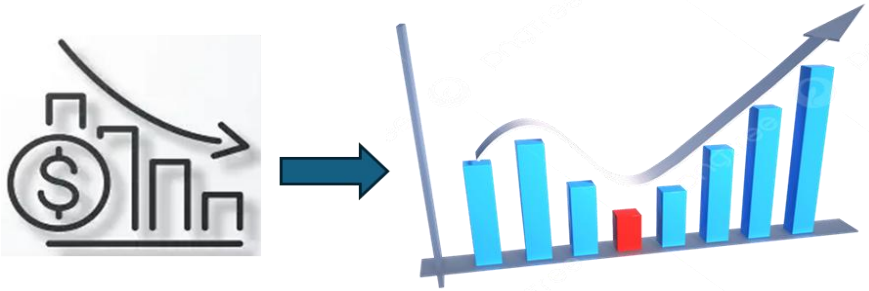


Source : Paysage de financement du FG, MOP du PMI

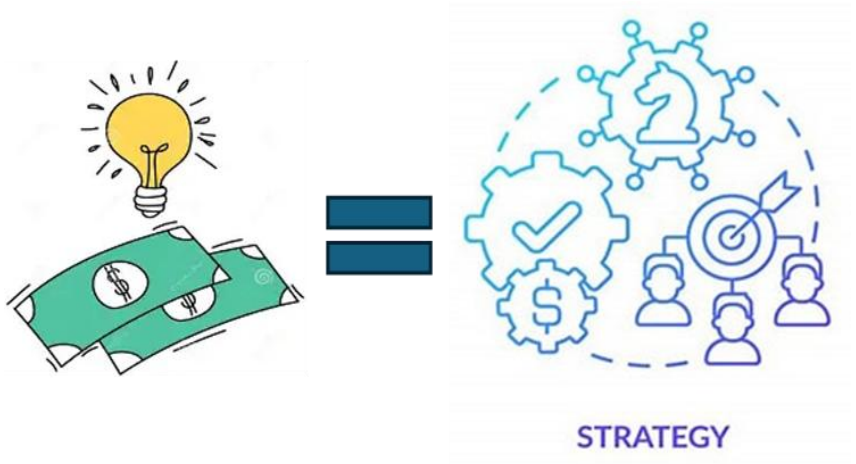
Internal

Contexte: Conséquences potentielles du gel des financements américains (3/4)

Menace sur la continuité des activités de lutte
L'arrêt prévu des financements PMI à partir de février 2025 aurait pu compromettre la disponibilité des services essentiels tels que la campagne de CPS, affectant fortement la santé publique dans ces régions.



Risque élevé de recrudescence des cas et décès
Sans le soutien financier, la progression réalisée depuis 2018 aurait été inversée, menaçant d'augmenter à nouveau le nombre de cas graves et de décès liés au paludisme chez les populations vulnérables.

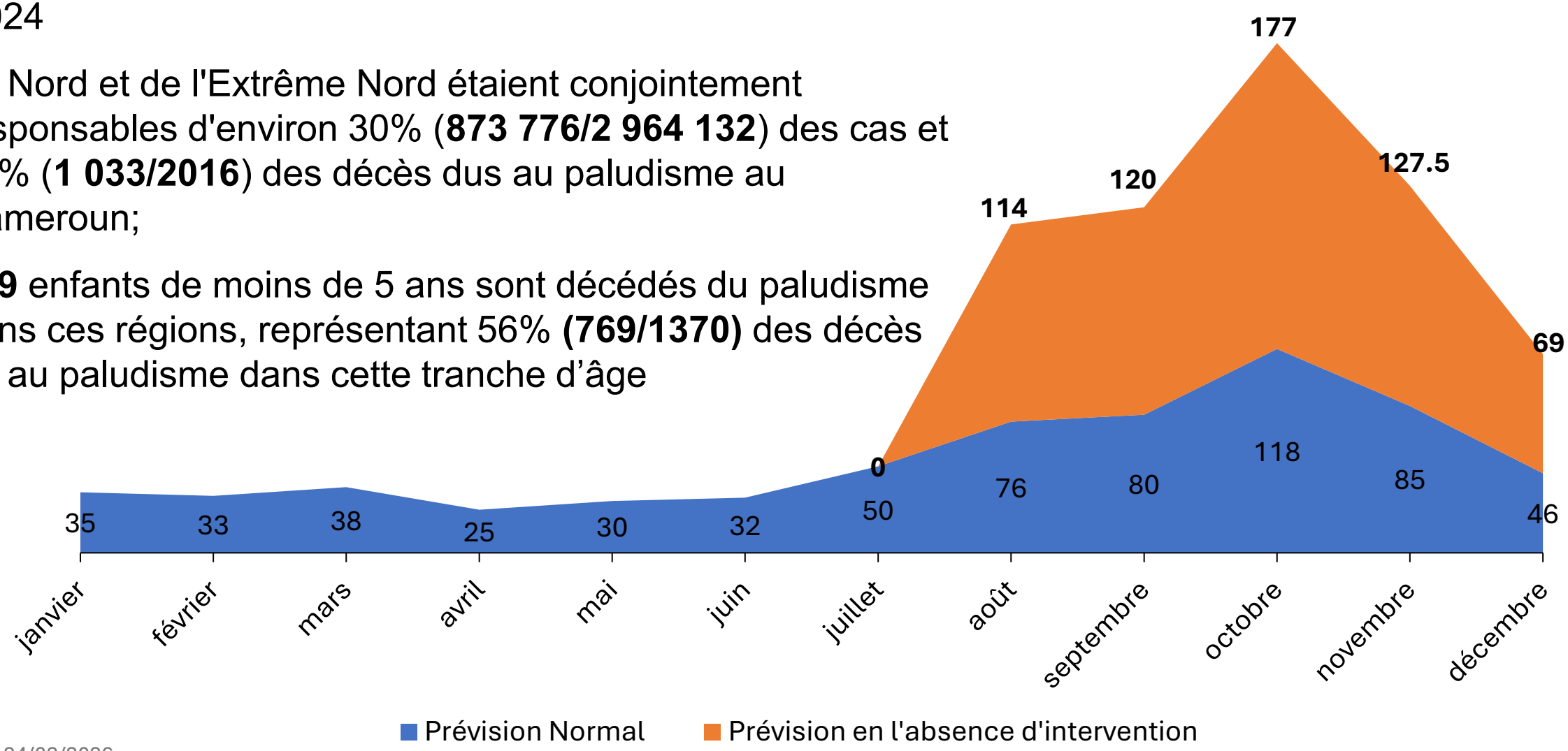


Nécessité de stratégies alternatives
- Maintien des interventions essentielles
- Renforcement des capacités locales
- Mobilisation communautaire et partenariats
- Urgence d’élaborer des stratégies durables

Contexte: Conséquences potentielles du gel des financements Américains: évolutions prévisionnelle des décès en 2025 (4/4)

En 2024

- Le Nord et de l'Extrême Nord étaient conjointement responsables d'environ 30% (**873 776/2 964 132**) des cas et 51% (**1 033/2016**) des décès dus au paludisme au Cameroun;
- **769** enfants de moins de 5 ans sont décédés du paludisme dans ces régions, représentant 56% **(769/1370)** des décès dû au paludisme dans cette tranche d'âge



Mesures de mitigation en contexte de financement limité: Planification (1/3)

01

Gouvernance

- Décision MINSANTE: Continuité des services
- Système de gestion d'incident

02

RH en santé

Maintien des Agents de santé communautaires

03

Produits de santés

- Redéploiement des intrants
- Suivi des commandes

04

Prestations de services

Continuité des services dans les formations sanitaires et en communauté

05

Information sanitaire

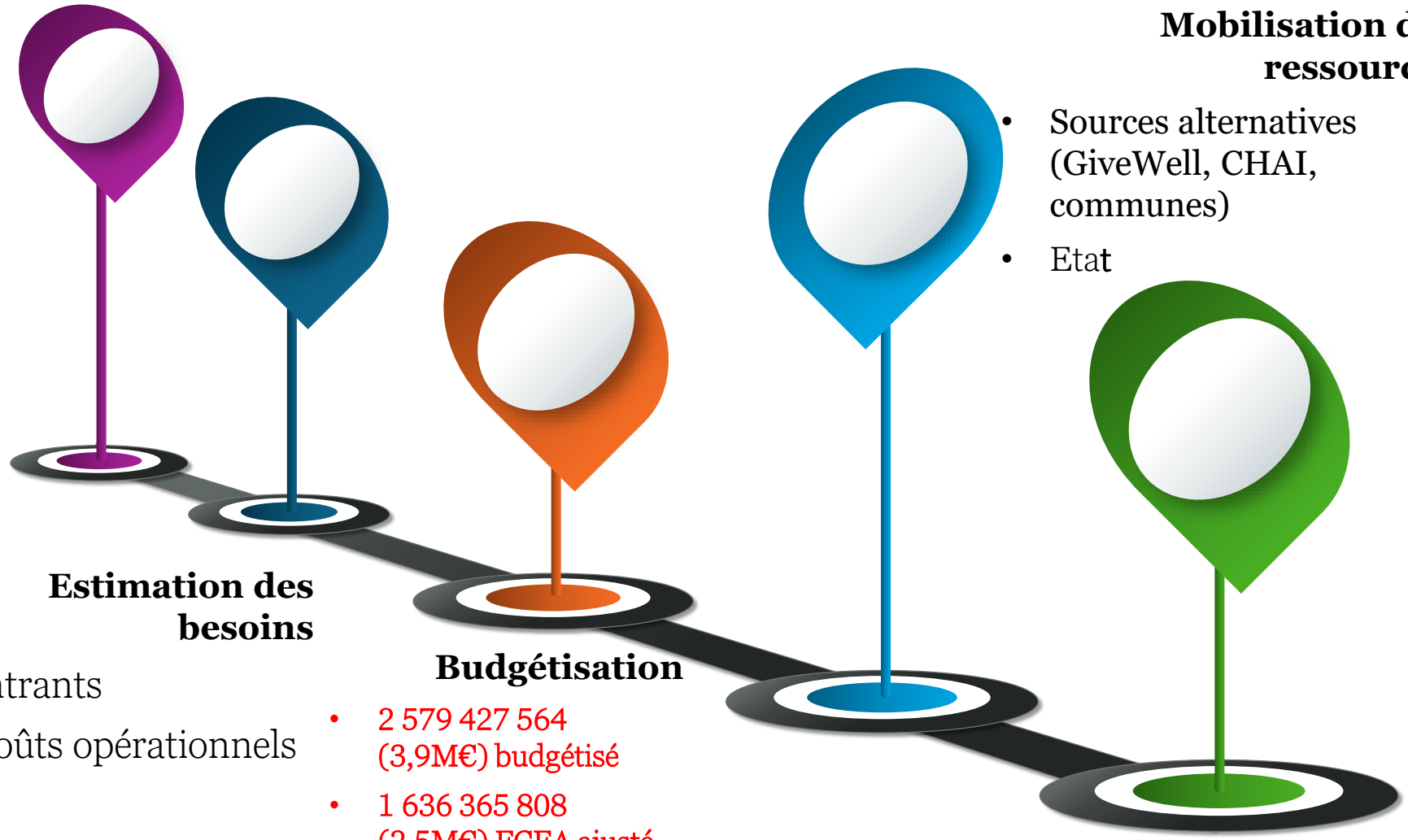
- Continuité des activités
- Transfert des bases de données

06

Financement

- Elaboration d'un plan de contingence budgétisé (Etat)
- Sources alternatives de financement (GiveWell, Communes)

Mesures de mitigation en contexte de financement limité: Planification (2/3)



Analyse situationnelle

Estimation des besoins

- Intrants
- Coûts opérationnels

Budgétisation

- 2 579 427 564 (3,9M€) budgétisé
- 1 636 365 808 (2,5M€) FCFA ajusté
- 1 000 000 000 (1,5M €) validé

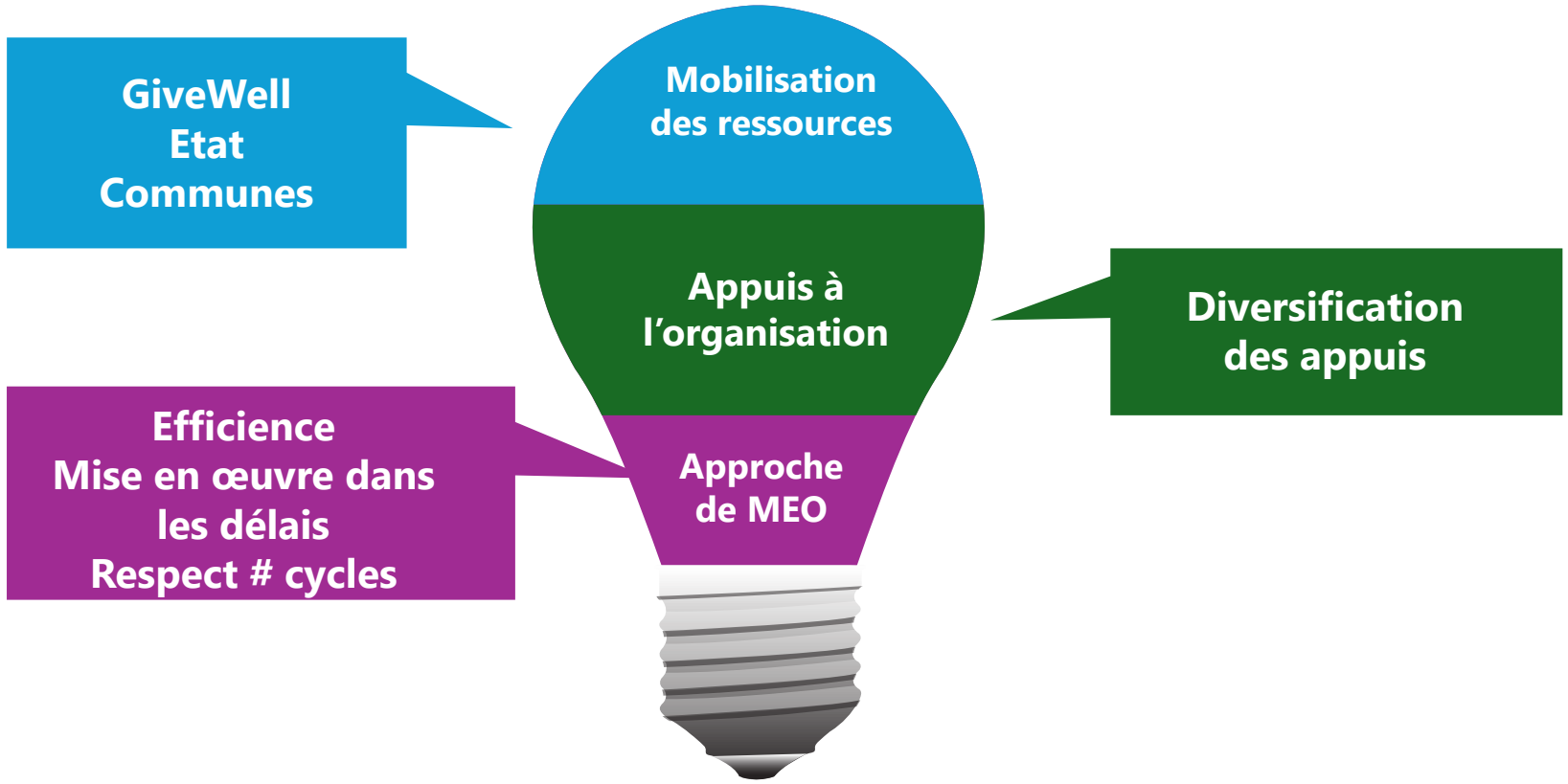
Mobilisation des ressources

- Sources alternatives (GiveWell, CHAI, communes)
- Etat

Pérennisation

Engagement de la société civile, les parlementaires (caucus des parlementaires)

Mesures de mitigation en contexte de financement limité: Résultats (3/3)



Couvertures optimales

89,5 % des enfants ont complété les **3 doses**

Internal

Leçons apprises & conclusion

Leçons apprises

- **La flexibilité programmatique/efficience est essentielle** pour maintenir la CPS en contexte de choc financier.
- **Les partenariats non traditionnels** (OSC, secteur privé) sont déterminants pour la continuité des interventions.
- **L'intégration progressive dans le système de routine** renforce la résilience et la durabilité de la CPS.

Conclusion

- Le contexte de financement limité a servi de catalyseur pour repenser la mise en œuvre de la CPS au Cameroun.
- Les adaptations mises en place ont permis d'assurer la continuité de l'intervention tout en posant les bases d'un **plan de pérennisation de la CPS à l'horizon 2030**, avec une intégration renforcée dans le système de santé de routine et une mobilisation accrue des financements domestiques publics et privés.

« Chaque franc investi dans la CPS génère un impact mesurable : couverture élevée, continuité des services, mobilisation domestique et apprentissages durables pour la pérennisation. »

Remerciements

GiveWell

Bluesquare

jhpiego

CLINTON HEALTH ACCESS INITIATIVE

PNLP
PROGRAMME NATIONAL DE LUTTE CONTRE LE PALUDISME

Internal

REPUBLIQUE DU NIGER
« Fraternité - Travail - Progrès »

MINISTERE DE LA SANTE ET DE L'HYGIENE PUBLIQUE

SECRETARIAT GENERAL

DIRECTION GENERALE DE LA SANTE PUBLIQUE

PROGRAMME NATIONAL DE LUTTE CONTRE LE PALUDISME

PROGRAMME NATIONAL
DE LUTTE CONTRE LE PALUDISME

Adaptation de la CPS 2025 au Niger face à la contrainte budgétaire : lignes directrices pour rationaliser les coûts et renforcer les résultats.

Fonds mondial

La foi ne connaît pas de limites / CRS

Plan de présentation

I. Données générales
II. Adaptation de la CPS 2025 au Niger face à la contrainte budgétaire
III. Principaux Résultats
IV. Innovations
V. Conclusion/Recommandations

Internal

I. Données générales

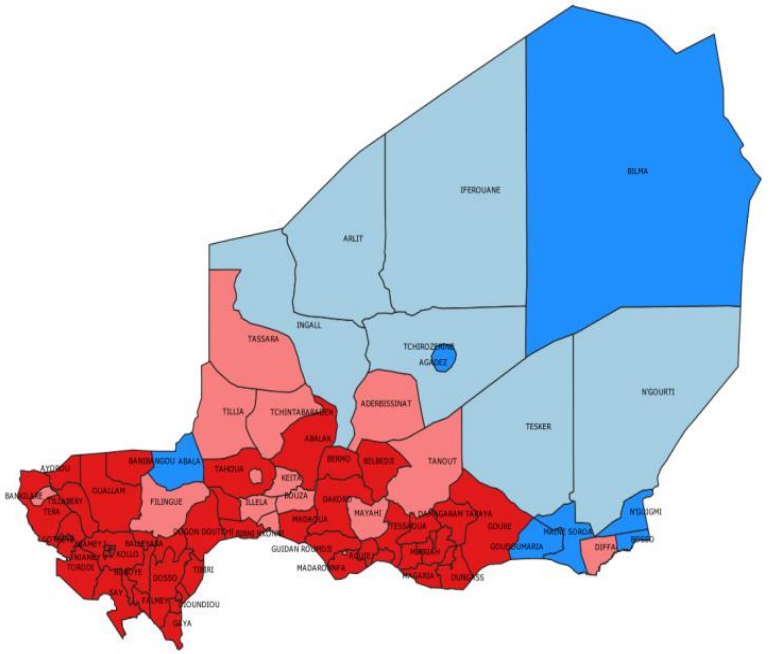
Internal

DONNEES GENERALES 2/2

- Pays HBHI, SaMe
- Principale morbidité et mortalité en 2024 avec 33,85% des cas, les enfants de moins de 5 ans représentent 47 % des cas.
- Principales victimes: enfants 0-59 mois avec 63% des décès et les femmes enceintes ;
- Le pic de transmission a lieu de juillet à octobre, corrélé à la pluviométrie
- Quatre strates épidémiologiques:
  - Très faible ;
  - Faible;
  - Modérée;
  - Haute .
- Principal espèce plasmodial : P. *falciparum* à 99,1 %;
- Principal vecteur de transmission : An. *gambiae* 98, 9%

Niveau de transmission

- Tres faible
- Faible
- Moderée
- Haute



Internal

II. Adaptation de la CPS 2025 au Niger face à la contrainte budgétaire

Internal

Rappel du contexte d'Adaptation

- Changements importants dans le paysage du financement externe des programmes de santé mondiaux, qui ont eu un impact considérable sur les services vitaux pour la lutte contre le Paludisme, la Tuberculose et le VIH et sur les systèmes de santé et communautaires.
- **Cas du Niger**: Reduction de l'allocation Fonds mondial GC7 (2024-2026) pour le reste de la période de mise en œuvre d'un montant de **4,602,457euros** dont **805,201 euros (0.7% de l'allocation Paludisme)** pour le paludisme, impliquant la suppression de certaines activités (Mobilisation sociale CPS, Prise en charge de relais mobilisateurs CPS, leaders, formations..)

Internal

Adaptation 1/2

- Mobilisation du financement public pour couvrir 05 districts additionnels d'Agadez avec une couverture de 72/72 districts (coûts opérationnels 74M) ;
- Contribution communautaire : mobilisation sociale communautaire après la suppression de la composante « mobilisation sociale » : soutien des chefs traditionnels et religieux; relais mobilisateurs ;
- Contribution Communautaire pour la fourniture d'intrants après la suppression des indemnités journalières pour les agents et les chauffeurs chargés de l'approvisionnement ;

Internal

Adaptation 2/2

- Ratissage post-campagne basé sur une méthode d’échantillonnage suivant des données théoriques de consommation
- Inventaire post- campagne basé sur une méthode d'échantillonnage suivant les données de consommation théoriques
- Mutualisation de la supervision dans le cadre de l'OTSS (Outreach Training and Supportive Supervision) afin d'améliorer la qualité de la prise en charge des cas de paludisme dans les établissements de santé (cas simples, cas graves et paludisme pendant la grossesse), y compris le diagnostic biologique du paludisme.

Internal

III. Principaux résultats

Internal

Principaux Résultats 1/2

Tableau N° I : Enfants ayant reçu une CPS complète par district (3 ou 4 ou 5 passages)

Districts	Dénominateur (Résultat 1er passage)			Résultats au dernier passage selon le cas (3 ou 4 ou 5 passages)			
	3-11 mois	12 - 59 mois	Total	3-11 mois	12 - 59 mois	Total	Couverture
Agadez	25 000	106 405	131 405	24 163	108 084	132 247	100,6
Diffa	39 974	144 685	184 659	38 248	140 471	178 719	96,8
Dosso	116 619	499 636	616 255	103 192	482 438	585 630	95,0
Maradi	203 880	897 598	1 101 478	169 382	793 441	962 823	87,4
Niamey	58 802	246 806	305 608	55 319	239 192	294 511	96,4
Tahoua	209 506	842 985	1 052 491	188 070	800 090	988 160	93,9
Tillabéri	161 123	676 399	837 522	130 020	606 403	736 423	87,9
Zinder	232 130	930 725	1 162 855	209 089	845 160	1 054 249	90,7
Total Niger	1 047 034	4 345 239	5 392 273	917 483	4 015 279	4 932 762	91,5

Internal

Principaux Résultats 2/2

Tableau N° II : Proportion d'enfants ayant reçu une CPS complète par district (3 ou 4 ou 5 passages) de 2023 à 2025

Régions	An 2023	An 2024	An 2025
Agadez	95,96	76,35	100,6
Diffa	92,41	89,53	96,8
Dosso	90,19	88,68	95,0
Maradi	76,96	91,38	87,4
Niamey	88,22	96,28	96,4
Tahoua	87,84	90,94	93,9
Tillabéri	79,08	91,69	87,9
Zinder	76,91	80,67	90,7
Total Niger	82,33	88,79	91,5

Internal

IV. INNOVATION

Internal

Identification et destruction des gites larvaires domestiques

Tableau N°III Identification et destruction des gites larvaires domestiques par région

Régions	Nbre des personnes sensibilisées	Nbre de Gites Identifiés	Nbre de Gites Détruits	Pourcentage de Gites détruits	0bjectif destruction gites larvaires
Agadez	420 020	102 436	76 310	74%	
Diffa	847 671	133 868	122 567	**92%**	
Dosso	1934048	500 026	398010	79,60	**80%**
Maradi	1 531 096	994 466	722 874	**73%**	
Niamey	1 358 136	376 325	278 385	73,97%	
Tahoua	4 125 009	766 696	645 611	84%	
Tillabéri	797 943	154 410	123 902	80,24	
Zinder	5 340 677	1 254 027	1 033 304	82,40%	
Total	**16 354 600**	**4 282 254**	**3 400 963**	**79,42%**	

Internal

Conclusion/Recommandations

Internal

Conclusion/Recommandations

- Dans un contexte de changements permanents dans le paysage du financement externe des programmes de santé mondiaux, il est nécessaire de:
- continuer les efforts dans la mobilisation des ressources locales via l'organisation des activités de plaidoyer pour une plus grande implication des communautés dans la lutte contre le paludisme ;
- Idenfier et mettre en œuvre des stratégies innovantes d'integration des activités impliquant une réduction des couts opérationnels et assurant l'impact

Internal

PROGRAMME NATIONAL
DE LUTTE CONTRE LE PALUDISME

MERCI DE VOTRE AIMABLE ATTENTION

Fonds mondial

La foi ne connaît pas de limites
CRS

Inter

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Discussion - Questions & Answers

Discussion - Questions et réponses

Discussão – Perguntas e respostas

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Coffee Break

Pause café

Pausa para café

ITN campaign adaptations to work within a reduced funding environment

AMP Meeting 2026
Maximizing Impact, Minimizing Cost: Lessons from an Optimised ITN Mass Campaign, Pilot in Morogoro, Tanzania

Peter Gitanya, NMCP

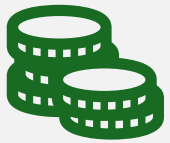
Monday, 24th February 2026

Classical TMC –implementation before optimization

- **Macroplanning**…. Physical meeting for 2 days
- **Microplanning**…..physical meeting for 3 days
- Logistics and supply chain management…retained by using a private or public organization. i.e. MSD
- **Training**… 2 days regional training, 3 days training, and 5 days wards training (cascade training model)
- **Data, supervision, and monitoring**. Using a digitalized system, for follow about 10 days
- **Social and behaviour change**…. Using private contractors, i.e., conduct PA and other community sensitization methods.

The Global Challenge – The ”implementation cost” squeeze

Donor funding is plateauing



Traditional mass campaigns are effective but expensive and resource-heavy

The question: How do we maintain 80%+ ITNs access with shrinking budgets?

The “Optimization”

- Moving from “Business as usual” to ”Lean & Efficient” but maintaining accountability
- In July 2025, a team of experts from NMCP and other stakeholders met to review and agree on the best possible way of optimising ITN Targeted mass campaign (TMC) implementation processes to reduce operational costs
- It was recommended to:
  - Continue with continuous distribution channel (RCH (ANC & EPI)
  - Implement and optimize TMC

Operational cost: modified mass campaign

Activity	Initial costs	Optimized costs	Remarks
Macro & micro quantification	0.000	0.000	
Planning & Coordination Meetings	233	233	
Advocacy Meetings (Regional & Council)	508	508	
CHMTs Training	1,644		Removed 100% shift to virtual meetings
Ward level training	4,442	4,442	
Household Registration	7,979		Removed 100% (modified registration approach)
Data entry and validation		2,793	New activity
Pre-alert meetings	-	-	
Printing	854		Already committed
ITNs issuing	6,594	6,594	
Community engagement	4,970	1,242	Reduced by 75%
Monitoring & Supervision	6,009	3,004	Reduced by 50%
Total per council	33,132	18,816	

43% reduction after optimizing the operations

A case study of Morogoro – a pilot

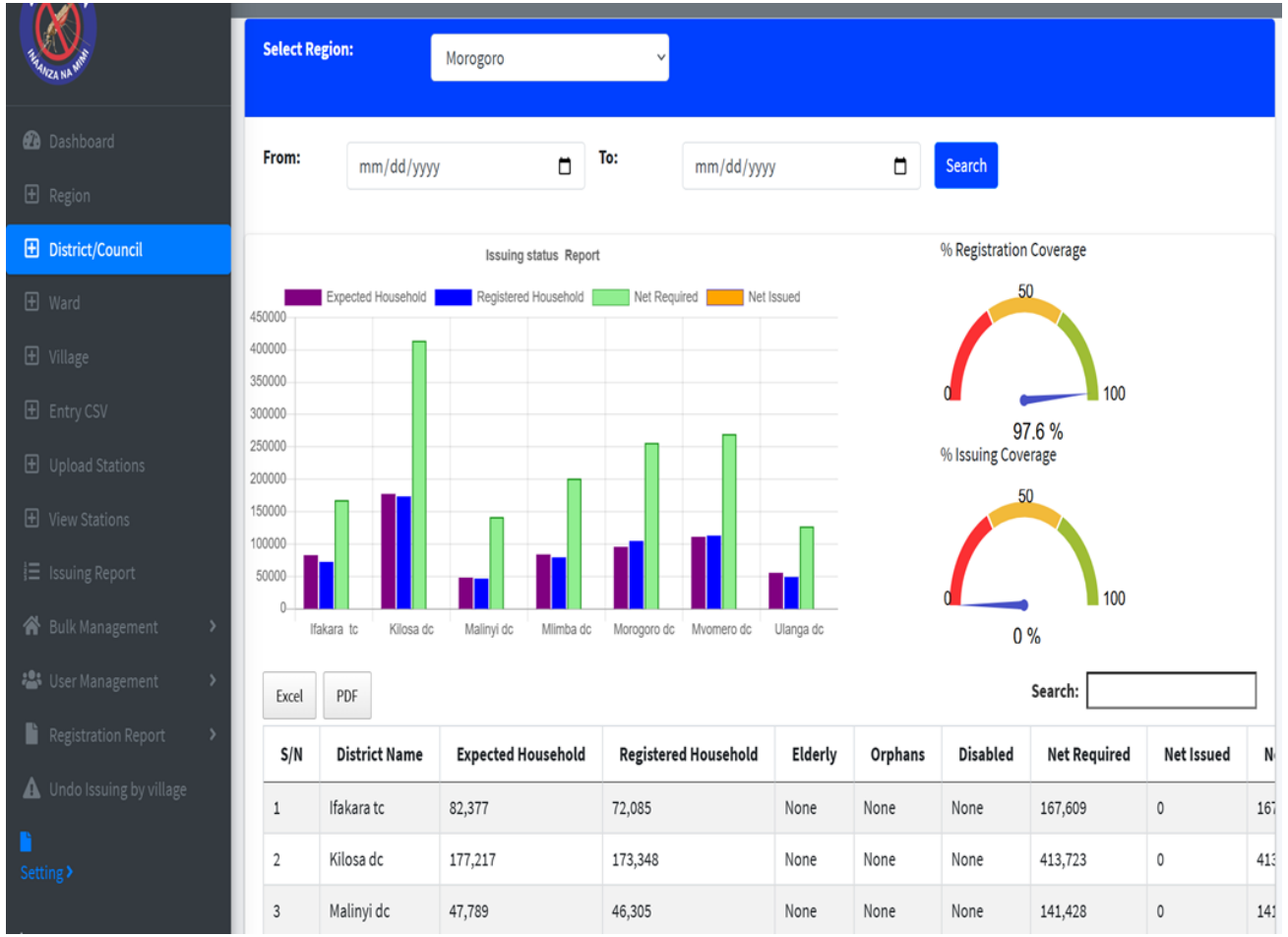
- An optimised TMC is currently piloted in the Morogoro region
- Involving 7 high and moderate-malaria-burden councils
- Expecting to distribute **1,474,146 ITNs**
- HR (Data clerks) burden reduced by half, resulting in a huge cost saving

Expected coverage in Morogoro

Sn	Council	Population	Households	Number of ITNs
1.	Ifakara TC	301,170	82,377	173,507
2.	Kilosa DC	639,862	177,108	368,632
3.	Malinyi DC	233,456	47,798	134,497
4.	Mlimba DC	303,360	83,279	174,769
5.	Morogoro DC	402,082	99,140	231,644
6.	Mvomero DC	437,345	110,516	251,959
7.	Ulanga DC	241,512	55,245	139,138
	Total	**3,315,397**	**655,463**	**1,474,146**

Household Registration as of 24th February 2026

- The optimization has not compromised the process
- Data for the households registration obtained from bulk registration after data collected by the village hamlets under the supervision of Village executive officers (VEOs) is submitted to the CHMT for data entry into the TMC-MIS
- Currently, the HHR is 97.6%



What worked really well

- Advocacy is very important, both at the regional and council levels, to get buy-in and ownership from the regional and council leaders
- District Human Resource Officers are very key in the mobilisation of the WEOs and VEOs to ensure campaign success
- Ward councillors are influential in the whole TMC implementation process, especially during household registration and ITNs issuing
- The use of local community leaders (e.g., Maasai) is very influential in their communities
- A good cooperation of the RHMTs and CHMTs has facilitated the household registration process

It wasn’t all smooth

- Most villages lack proper household documentation, leading hamlet leaders to go door to door to obtain up-to-date data
- In some cases, WEOs and VEOs had to use their own money to pay hamlet leaders and others for data collection and entry
- Some community members refused to register because of beliefs and myths about nets
- There is also double work involved, registering households on paper and then transferring the data to a digital system
- In some villages, hamlet leaders called community members to register at the VEOs' office, which required long walks and led to low turnout

Recommendations

- Budget for data clerks is key to ensuring timely and quality data entry into TMC – MIS

- Optimisation requires more pre-planning time, but less execution time. Start organising data ahead of the implementation phase

- Local SBC is mandatory to get buy in of the community members

Wayforward

- With the support of PMI Evolve, NMCP, and MoH, we are upgrading the TMC – MIS to:
  - Host the optimized TMC module for easier data entry, synchronization, and visibility
  - A module to determine ITN access for the nets distributed through TMC

Thank you

2026 Joint SMC Alliance & AMP Meeting

Applying Cost Optimization Measures: What Worked and What Didn't Work

Presented by:

National Malaria Elimination Program

Nigeria

February 2026

Outline

- Introduction
- Strategic planning and prioritization
- Adapting campaign implementation
- Resource optimization strategies
- What worked and what didn't work

Introduction

- SMC and ITN campaigns are community-based and target children aged 3–59 months and households within the community.
- Malaria control efforts in Nigeria face major funding constraints due to declining global resources and increasing population to reach with interventions.
- Sustained commitment, innovative approaches, and integration into the broader health system are needed for malaria impact.
- Nigeria is continually exploring ways to enhance the efficiency of campaign implementation
- Integrated interventions can improve coverage, sustainability, comprehensive protection, and cost-effectiveness when well planned and implemented.

Strategic planning & prioritization

- Effective campaign implementation in the context of declining funding requires strategic planning, prioritization and flexibility, including assessing and optimizing campaign procedures and timelines
- Optimization considerations included:
  - Review the number of campaign implementation days
  - Reviewing campaign parameters (DP structure, CMD/CDD daily targets, number of town announcers, CMD supervisors, LGA teams, TTAs, and national oversight)
  - Scaling down of some campaign activities such as trainings, meetings and orientations
  - Deploying virtual platforms for trainings and meetings

Resource optimization strategies

Campaign Coordination

- Adjustments were made to most of the quantifications for campaign tools
- Some items were either removed/quantity adjusted/unit cost adjusted
- Number of security outfits reduced from 3 to 2 per LGA (police, civil defence, or vigilante as applicable within the LGA)
- Overall adjustment for all campaign personnel activity days for both national and state-level personnel to reflect the reduction in the number of campaign implementation day
- Out of station allowance adjusted to 50% across several state-level personnel

Waste management - EOLIN & ITN waste

- Cost reduced from N4,000 to N3,000 per distribution point

Adapting campaign implementation

Trainings

- National Training of Trainers was changed from in-person to virtual
- State level and LGA level training was reduced from 2 days to 1 day
- CMD training days reduced from 5 to 2 (1 day per batch of CMDs)
- LGA team participants reduced from 5 to 4 people, to include the LGA malaria focal person, logistician, health educator and M&E officer
- Cost of stationaries for participants was removed
- LGA TAs and TTAs training changed from in-person to virtual
- Training of DP supervisors was removed and role of DP supervisor merged with either the DP recorder or DP distributor
- Distribution point team training days reduced from 2 to 1 day

Adapting campaign implementation

Household mobilization/SPAQ administration

- Days for household mobilization and SPAQ administration reduced from 5 to 4 days
- Daily target increased from 65 to 100 children per day
- This helped to reduce the number of CMDs and TTAs significantly

ITN distribution

- ITN distribution reduced from 5 to 4 days
- DP target adjusted from 1500 to 3000/300 to 750 ITNs per day
- Reduced the number of DPs and DP personnel

Resource optimization strategies

SBC Activities

- Participants reduced from 2 reps per CSO to 1 rep per CSO and days reduced from 2 to 1 day
- Orientation session with community leaders, religious/traditional leaders, school health coordinators, and union leaders was removed
- Media parley was removed →should be funded by the state
- Orientation removed → should be funded by the state including the ICCC review meetings
- Number of town announcers reduced from 4 to 2 ward supervisors, and 10 working days.

ITN Logistics

- Role of LGA conveyors was removed as well as cost of the orientation
- Transporter engaged by the 3PLs through the 4PLs will ensure accountability of the ITNs through the supply chain

Resource optimization strategies

Campaign Monitoring and Supervision

- CMD supervisors was adjusted from 1 per 5 CMD teams to 1 per ward
- Supervision process strengthened with the use of technology for a data-driven monitoring process
- Campaign Monitoring Team (CMT) was reduced from 3 per LGA to 2 per LGA
- Cycle 1 end of round assessment was removed → leverage the end process assessment for ITN campaigns and expand the scope to cover the SMC component

Results of adaptation & optimization measures

- For Kaduna campaign, following the adaptation and optimization of the campaign processes, restructuring of personnel lead to the reduction in overall personnel from 29,433 to 19,863
- The team was able to review the campaign budget **from $3,913,229 (N4,695,875,356) to $1,771,902 (N2,126,281,917)**
- This resulted in a budget efficiency of **$2,141,328 (N2,569,593,439) (54%).**
- Additionally, there was an overall 10% savings on the Kaduna budget from the approved grant budget
- Sustained coverage for both interventions despite limited funding
- Reduction in the overall number of implementation days from 42 to 28

What worked

- Effective coordination due to stakeholders collaboration and commitment at national and state level
- Strategic planning and prioritization helped adapt campaigns to a declining funding landscape
- Use of virtual platforms for trainings and meetings reduced expenses while maintaining strong coordination
- Personnel restructuring (e.g., Kaduna State workforce reduction) lowered operational costs.
- Resource optimization measures such as reviewing CMD/CDD targets and quantification parameters

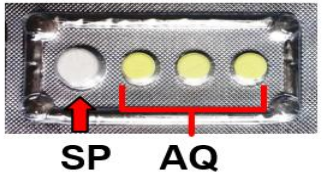
What didn't work

- Scaling down trainings, meetings, and orientations, while cost-saving, resulted in:
  - ✓ Sub optimal understanding of training modules due to limited training time
  - ✓ Weaker supervision in some areas reduced implementation quality
- Following adjustments, distribution point personnel were too low, and daily targets were significantly too high
- Reduced number of distribution points caused a low turn out of beneficiaries in some DPs due to distance.
- Mismatch between resources deployed and actual field needs in some areas and more resources were required
- Personnel reductions and compressed timelines overburdened remaining staff due to high targets
- Low morale of campaign personnel

Conclusion

For future campaign implementation, there is need to;

- Streamline campaign operations and processes to ensure reduced cost without compromising quality and impact
- Utilize technology to optimize resources
- Explore opportunities to integrate with other health interventions
- Continue to document lessons learned for improved campaign implementation



Key partners and stakeholders

msh
Management Sciences for Health

Faith knows no bounds® CRS

malaria consortium
disease control, better health

State SMEPs

SFH
Society for Family Health
...Creating Change, Enhancing Lives

Thank you for your time and attention!

Assemblée annuelle des partenaires de l'Alliance pour la Prévention du Paludisme (APP) 2026

OPTIMISATION DES COUTS OPÉRATIONNELS POUR LA CDM, LES LEÇONS APPRISES ET LES RECOMMANDATIONS POUR LE FUTUR

OUGANDA DU 24 au27 Fév 2026

PRINCIPAUX RESULTATS DE LA CDM

INDICATEURS	QUANTITE	COUVERTURE
Populations dénombrées	27 491 694	
Ménages théoriques	6 246 092	
Ménages dénombrés	7 298 236	116,8 % (taille moyenne = 3,8)
Ménages ayant reçus leurs MILDA	7 070 525	96,9 %
MILDA prépositionnées	14.828.137	92% du stock disponible
MILDA disponibles pour la distribution	16.084.580	
Nombre de MILDA distribuées aux ménages	14 763 528	soit plus de 99% du stock prépositionné
Stocks restant en fin de campagne	1.337.147	8,31% du stock disponible
Nombre de gites larvaires identifiées	3 051 396	
Nombre de gites larvaires détruits	2 622 903	86,95%

Public

DIFFICULTES MAJEURES ET IMPACT SUR LA CDM

- Campagne nationale : 16+ millions de MILDA
- Couverture optimale à maintenir
- Contexte sécuritaire complexe
- Des retards de livraison des MILDA dans les zones à haut défi sécuritaire
- Arrivée tardive de certains stocks de MILDA dans le pays MILDA PMI/USAID (750 000 MILDA)
- Incertitudes de financement (PMI / USAID)
- Réduction drastique des coûts opérationnels par le FM (environ 40%)
- Suppression de certaines activités

Question centrale :

Comment preserver l'impact sanitaire tout en maîtrisant les coûts ?

Public

Principaux moteurs de coûts

- Logistique & transport
- Ressources Humaines
- Adaptations sécuritaires: détours logistiques, stocks tampons
- Supervision

Ces éléments représentent les principaux moteurs d’escalade budgétaire

Public

Ce qui a amélioré l'efficience

- Stratification des approches
- Reamenagement budgetaire
- Redimensionnement des equipes et rationalisation des activites
- Renforcement de la coordination
- Priorisation des zones à défis sécuritaires dans la livraison des MII aux pays, associée à l'initiative des entrepôts tampons, a favorisé l'approvisionnement en MII et la mise en œuvre de la distribution dans ces zones.

Public

DIFFICULTES ET APPROCHES D'OPTIMISATION

N°	ELEMENTS	ADAPTATION
1	Les mesures restrictives du Fonds Mondial (réduction drastique des coûts opérationnels environ 42%)	✓ Révision des stratégies ✓ stratification, ✓ distribution porte à porte ✓ Dénombrement/distribution communautaire
		❖ **REDIMENSIONNEMENT DES EQUIPES** • 40 ménages/jour/Eq en milieu urbain au lieu de 30 • 30 ménages/jour/Eq en milieu rural au lieu de 25
		❖ **RATIONALISATION DE LA CHARGE DU TRAVAIL DES EQUIPES** • 4 volontaires/site en milieu urbain au lieu de 6 • 3 volontaires/site en milieu urbain au lieu de 4 • Forfait de 10 jours distribution communautaire

Public

DIFFICULTES ET APPROCHES D'OPTIMISATION

No	ELEMENTS	ADAPTATION
2	❖ **Retard dans l'allocation des ressources pour l'exécution des activités** ❖ **Incertitude financement (PMI/ USAID)** ❖ **Suppression d'activités (**du monitorage indépendant, Plaidoyers (central , régional Districts et CSPS dotation en mégas pour la connexion) ❖ **Coûts élevés du transports des MILDA dans le zones à défis sécuritaire** ❖ **Arrivée tardive des MILDA de PMI (750.000)**	• **Réaménagements budgétaires** • Réduction durée des formations de 1 à 2 jours • Réduction durée supervision de 5 jours • Réduction du nombre de superviseurs • Diminution du nombre des participants aux formations • Reduction du nombre des ateliers • Recours à d'autres PTF • Recours au budget de l'Etat • Utilisation de l'URL Free pour palier au manque de mégas ❖ **Renforcement de collaboration, mobilisation de ressources locales** • Intégration à des convois militaires • Transports aériens dans certaines zones • Participation des communautés dans le transport des MILDA • Implication ONG humanitaires • Priorisation de livraison dans les zones à défis sécuritaires • Entrepôts tampons

Public

STRATIFICATION DU TERRITOIRE ET APPROCHES DE DISTRIBUTION CDM 2025

Public

Approches de distribution

Stratification et approche

Strates	Milieux urbains (Ouaga et Bobo) I	Autres Milieux urbains à sécurité stable II	Autres Milieux urbains à Forts défis sécuritaires III	Milieu rural à sécurité stable IV	Autre Milieu rural à Forts défis sécuritaires V
Stratégies de dénombrement/ distribution	Distribution couplée au dénombrement de porte à porte **AVEC** site de distribution (distribution au lendemain du dénombrement)	Distribution en SF décalée de 4 semaines du dénombrement par porte à porte	Distribution couplée au dénombrement de porte à porte **SANS** site de distribution (MILDA remise aux ménages par les EPP)	Distribution en SF décalée de 4 semaines du dénombrement par porte à porte	Distribution communautaire
Total DS/strate	**7**	**26**	**13**	**37**	**29**

Public

Caractéristiques des strates et approche de distribution

ELEMENTS	APPROCHE	STRATE	DUREE
Dénombrement	Porte à porte	**1, 2, 3 et 4**	**15 jours**
Distribution	Site fixe - 3000 ménages en zone urbaine - 1200 en zone rurale	**1, 2 et 4**	- **15 jours = strate 1** - **6 jours = strate 2 et 4**
Dénombrement /distribution	Porte à porte	**3 et 5**	**15 jours**
Dénombrement /distribution	communautaire	**5**	**10 Jours**

plusieurs villages/secteurs de moins de 1200 ménages pourraient avoir un même site de distribution

Public

OPTIMISATION DANS UN CONTEXTE DE RESSOURCES LIMITEES

ELEMENTS	MONTANTS (CFA)	MONTANTS (dollars)
Budget initial	**9 604 747 727**	**16.558.910**
Budget revisé	**7 673 369 495**	**13.229.947**
Budget exécuté	**5 542 420 354**	**9.555.897**
Ecart (reduction de **42,30%)**	**4 062 327 373**	**7.004.013**

Public

Principales leçons apprises

N°	Leçons apprises
1	Explorer l'utilisation des opportunités qu'offrent les TIC (visioconférence) pour la tenue des sessions des instances de coordination.
2	Redimensionner certains ateliers d'élaboration des documents en y favorisant les sessions internes de mise à jour des documents et le travail en mode virtuel. Cela permettra d'affecter les ressources disponibles aux activités essentielles de terrain.
3	Rendre obligatoire l'évaluation préalable des capacités de stockage des districts avant l'acheminement des MII, afin de réduire les pertes, les surcoûts logistiques et les retards de distribution.
4	Veiller à reproduire les outils 6 à 12 mois avant le dénombrement/distribution tout en s'assurant de leur qualité.
5	Piloter une approche "Bring Your Own Device (BYOD)" (apporter votre propre appareil) dans des zones sélectionnées, afin de réduire les coûts et renforcer l'appropriation des outils numériques par les acteurs opérationnels.

Public

Principales leçons apprises

N°	Leçons apprises
6	La priorisation des zones à défis sécuritaires dans la livraison des MILDA aux pays, associée à l'initiative des entrepôts tampons a favorisé l'approvisionnement en MILDA et la mise en œuvre de la distribution dans ces zones.
7	Intégrer un scénario sécuritaire dans les budgets
8	Budgétiser la digitalisation comme investissement avec ligne dédiée
9	Planifier la logistique inverse dès le départ
10	Impliquer les communautés à la mise en œuvre de la CDM permet de mobiliser des contributions en ressources financières, humaines et matérielles utiles à la réalisation de certaines activités (transport des MII, équipes supplémentaires de volontaires.

Public

DEFIS MAJEURS DE LA LUTTE ANTI VECTORIELLE AU BURKINA FASO

- Gestion de la résistance des vecteurs aux insecticides
- Surveillance de anopheles stephensi
- Mobilisation accrue des ressources endogènes
- Le maintien de l'accès de toutes les populations aux MILDA dans un contexte d'insécurité
- Quantification des MILDA et des ressources humaines nécessaires pour les approches de distribution en porte à porte

Public

conclusion

- Malgré les énormes difficultés rencontrées, la CDM 2025 est restée marquée par un succès rendu possible par des facteurs dont les plus plausibles sont :

- L'engagement très appréciable des acteurs à tous les niveaux du système de santé sous l'impulsion des nouvelles autorités et sous le remarquable leadership du SP/Palu avec le soutien indéfectible des PTF ;

- Le parfait attelage entre la forte capacité de résilience et l'engagement patriotique des acteurs nationaux les amenant à faire plus avec peu de ressources.

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Discussion - Questions & Answers

Discussion - Questions et réponses

Discussão – Perguntas e respostas

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Meeting will begin shortly – la réunion va bientôt commencer - A reunião começará em breve