Joint Annual Meetings of the SMC Alliance and the Alliance for Malaria Prevention

KAMPALA, UGANDA — 24-27 FEBRUARY 2026

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

Panel discussion Integration of health services: When and how does it work best? Opportunities, pathways and practical limits for malaria prevention campaigns

Integration of Health Service Delivery

- [WHO Framework on Integrated People-Centred Health Services (IPCHS)](#) calls for shifting health systems from disease-specific, fragmented care to holistic, coordinated delivery across the life course. It prioritizes primary care, aiming to improve quality, access, and efficiency, thereby driving progress toward Universal Health Coverage.

- Five core components/ strategies for implementation:

- **Engaging and empowering people and communities:** Involving individuals in their own care and decision-making processes.

- **Strengthening governance and accountability:** Ensuring policy frameworks support integration and holding systems accountable for results.

- **Reorienting the model of care:** Shifting focus from merely treating illnesses in hospitals to preventative, promotive, and comprehensive care (including mental health and NCDs) closer to the community.

- **Coordinating services:** Aligning care across different providers, levels of care, and sectors (e.g., integrating HIV/TB with primary care).

- **Creating an enabling environment:** Reforming health systems management, financing, workforce training, and information systems (like Electronic Medical Records) to support, rather than hinder, integration.

Uganda's experience with Integration

- **Engaging and empowering people and communities:** Continuous

- **Strengthening governance and accountability:** Aligned policies NDP IV, MOH Strategic plan, Malaria Elimination Strategic Plan. Champions MOH Top Leadership

- **Reorienting the model of care:** PS released a circular to all districts, Orientation meeting, Guidelines for integration, Roadmap for Health services and systems integration, Health Systems maturity Framework, Trainings at all levels National to District, Health Facility, Community.

- **Coordinating services:** Integration Task Forces and Advisory Committees, District work plans, Health Facility Activity plans to bring actors together

- **Creating an enabling environment:** Reforming health systems management, Digitisation (Electronic Medical Records), workflow reorganization – Laboratory, engagement of partners, realignment of financing- USG, GC8, Relationship building

THE REPUBLIC OF UGANDA
Ministry of Health

What do we mean by "integration"?

"**Integration**" in health is approached in different ways, from collaboration or partial integration to co-delivery of interventions, where appropriate.

Integrated health campaigns do *not* necessarily mean co-delivery of all the interventions - *partial integration* can include *governance, health workforce, monitoring, tools, guidelines, technologies* etc.

02
Coordinated/Collaborative Planning (Low Level)
Programs share information, calendars, or communication strategies to avoid overlap, even if they deliver separately

01
No Integration (Vertical)
Programs are completely independent, with separate planning, logistics, and delivery

03
Partial Integration (Mid Level)
Programs share specific operational or administrative components to improve efficien without combined delivery at the service poin (e.g., shared training, census information, microplanning data, social mobilization efforts).

04
Co-delivery (High Level)
Two or more interventions are delivered simultaneously to the same person at the same time and place, resulting from the coordination of all key components

World Health Organization

From Guidance to Impact
A Blueprint for Campaign Effectiveness

With countries adopting the revised WHO malaria guidelines (August 2025) and preparing for Global Fund GC8, the Collaborative Action Strategy (CAS) from the Health Campaign Effectiveness (HCE) Coalition offers a practical, country-led roadmap for collaborative and integrated malaria campaign planning.

What is the HCE Coalition?

The HCE Coalition is a first-of-its-kind cross-campaign alliance of ministries of health, multilateral agencies, donors, and implementing partners across malaria neglected tropical diseases, nutrition, polio, and other vaccine-preventable diseases. We are working to transform health campaigns from fragmented, vertical efforts into collaborative, government-led systems that strengthen primary health care and deliver better outcomes.

What is the Collaborative Action Strategy (CAS)?

A practical, customizable blueprint that helps Ministries of Health, funders, and implementing partners improve campaign effectiveness at national, subnational, and district levels. It offers 12 evidence-based recommendations across the campaign lifecycle:

- Planning & implementation
- Monitoring, evaluation, research, learning & adaptation (MERLA)
- Campaign financing

Photo Credit: Task Force for Global Health

Want to Learn More?

Scan the QR code to get a copy of the CAS recommendations, see our supporting tools, and to join our community.

Contact us:
campaigneffectiveness@taskforce.org

Co-delivery / integration of interventions:

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

Réunion annuelle de l'Alliance SMC 2026

Kampala– Uganda

24 – 27 février 2026

MODÈLE D'INTÉGRATION DE LA CAMPAGNE DE CHIMIOPREVENTION DU PALUDISME SAISONNIER AVEC LA DISTRIBUTION DE SEL DE REHYDRATATION PAR VOIE ORALE ET ZINC

DISTRICT SANITAIRE MOULKOU, MAYO KEBBI EST

Dr. Kodbessé Boulotigam
Coordonnateur Adjoint/PNLP

Dr. Hassane Moussa Mahamat
Point Focal CPS Tchad

Dr. Justine Nagorngar
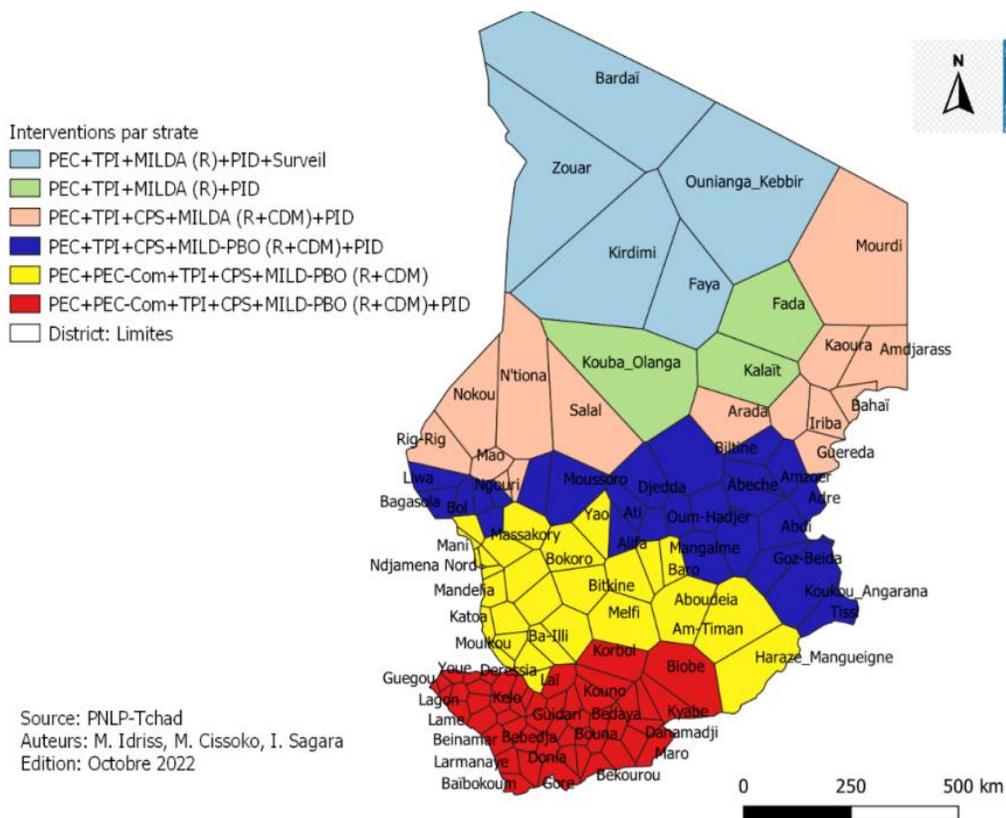Directrice Pays Malaria Consortium

PLAN

- Section 1: Vue globale des interventions de lutte contre le paludisme au TCHAD

- Section 2: Integration CPS/SRO-ZINC

Section 1: Vue globale des interventions de lutte contre le paludisme au TCHAD

Cadre d'intervention


Interventions par strate
- PEC+TPI+MILDA (R)+PID+Surveil
- PEC+TPI+MILDA (R)+PID
- PEC+TPI+CPS+MILDA (R+CDM)+PID
- PEC+TPI+CPS+MILD-PBO (R+CDM)+PID
- PEC+PEC-Com+TPI+CPS+MILD-PBO (R+CDM)
- PEC+PEC-Com+TPI+CPS+MILD-PBO (R+CDM)+PID
- District: Limites

Source: PNLP-Tchad
Auteurs: M. Idriss, M. Cissoko, I. Sagara
Edition: Octobre 2022

Données du paludisme (PNLP, 2024) :

* 1ère cause de consultation **(47%),** d'hospitalisations **(34%)** et de mortalité **(31%)**

* **3 948 682** cas de paludisme suspectés enregistrés

* **3 725 416** cas de paludisme testés (94,35%)

* **2 556 012** cas de paludisme confirmé (68,61%)

* **2 265 100** cas de paludisme traités (88,62% des cas confirmés)

* Personnes les plus touchées : enfants de moins de cinq (5) ans **38,73%**

Prévention

* **560 411** MILDA distribuées en routine par les formations sanitaires

* **9 713 825** MILDA distribuées lors de la CDM2023 (4 157 219 ménages), **CDM2026 en cours**

* **684 549** chambres pulvérisées pour couvrir 1 190 466 personnes dans les arrondissements de **N'Djamena**, soit 63,76%

* Proportion de FE ayant reçu le **TPI3** : **42%**

Zone éligible CPS
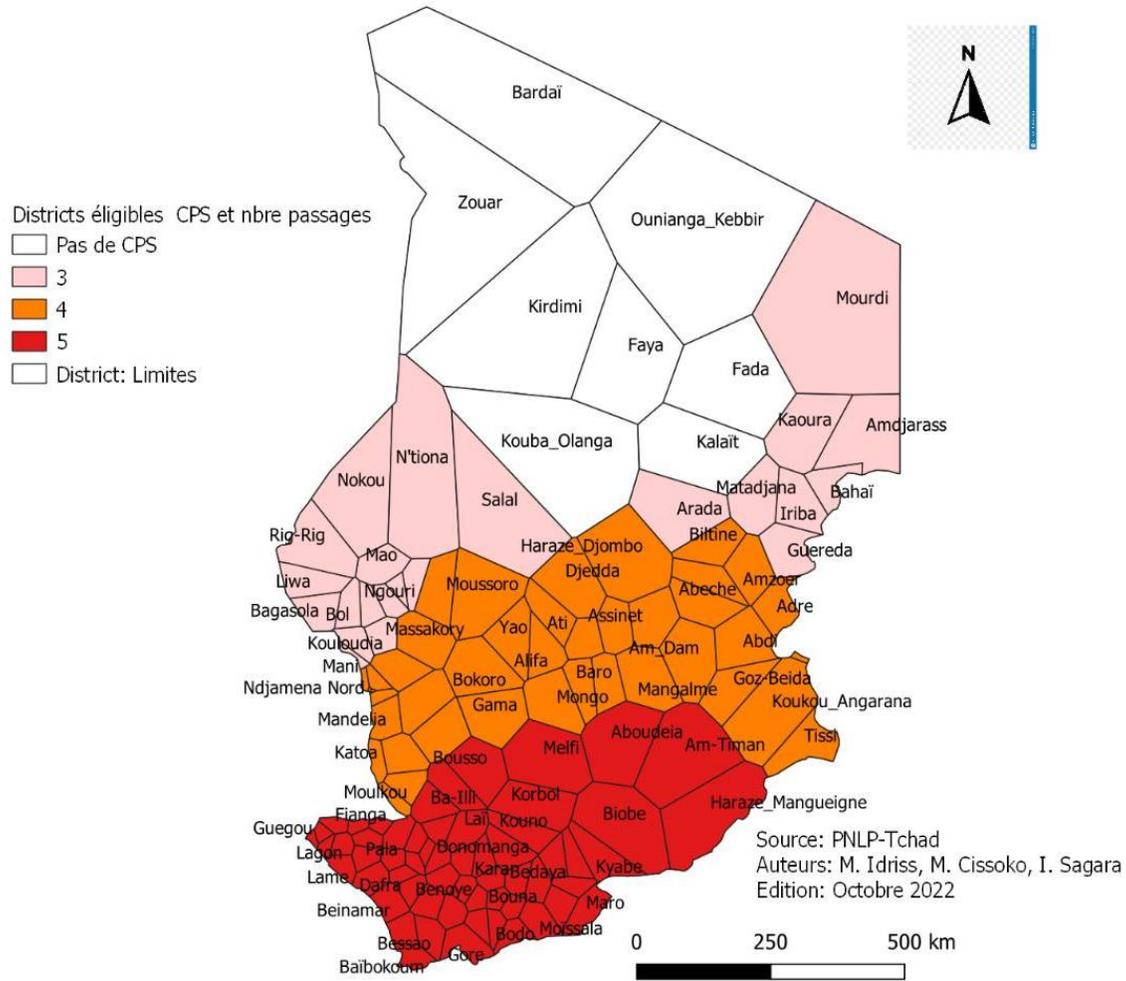
Couverture CPS 2025

RESULTAT GLOBAL DE LA CPS 2025

La couverture nationale de la CPS 2025 :

- Cible 2025 micro planifiée : **1 325 245 soit 18,82%**

- Enfants dénombrés **1 726 264**

- Nombre des enfants ayant reçu au moins trois cycles : **1 627 330 soit 94,26%**

- La proportion des enfants qui ont eu des effets indésirables : **0,13%**

Ces chiffres représentent les données collectées auprès des 49 DS soutenus par le FM, Malaria Consortium, Unicef et MSF France.

- La campagne est entièrement digitalisée dans 27 districts sanitaires sur les 49.
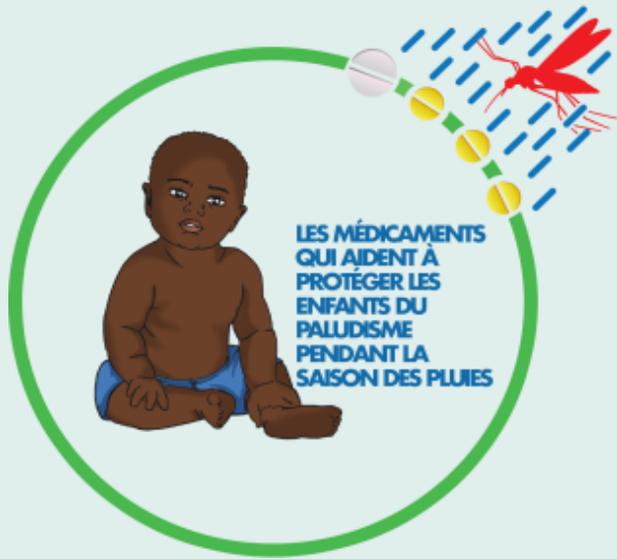
SMC CHAD 2026

TOTAL DS ÉLIGIBLES	DS COUVERTS	GAP DS
141	85	56

LES MÉDICAMENTS QUI AIDENT À PROTÉGER LES ENFANTS DU PALUDISME PENDANT LA SAISON DES PLUIES

Integration CPS/SRO-ZINC

CONTEXTE ET JUSTIFICATION

- **Fardeau sanitaire élevé** : maladies diarrhéiques, cause majeure de morbidité et de mortalité chez les enfants de moins de 5 ans (UNICEF, SMART 2024).

- **Utilisation d'une plateforme existante** : couplage avec la CPS.

- **Partenariat stratégique** : Co-développé par PNLP & Clear Solutions & Malaria Consortium.

- **Accent sur l'éducation sanitaire** : distribution porte-à-porte par les ASC avec un accent sur la sensibilisation des parents des enfants à l'utilisation correcte du SRO-Zinc, renforçant ainsi leur capacité de prise en charge à domicile de cas de diarrhée simple.

OBJECTIFS DU PROJET

- **Réduire la morbidité et la mortalité infantiles** liées aux maladies diarrhéiques et au paludisme chez les enfants moins de 5 ans dans le district sanitaire de Moulkou ;

- **Introduire un modèle intégré et efficient** de distribution couplée de CPS et SRO-Zinc ;

- **Renforcer les capacités communautaires** à gérer les épisodes diarrhéiques simples à domicile ;

- **Tester la faisabilité opérationnelle** de l'intégration du SRO-Zinc dans la campagne CPS, en identifiant les défis et les opportunités d'amélioration ;

- **Générer des données probantes** pour orienter une éventuelle extension nationale du projet.

ETAPES DE MISE EN OEUVRE

- **Phase 1, cycle 1 (Test pilote, 21–24 juillet 2025)** : Mise en œuvre à petite échelle dans le CS de Moulkou urbain pour tester la faisabilité du modèle intégré CPS + SROZ, identifier les défis opérationnels et recueillir les retours des ASC et des gardiens/nes d'enfants.

- **Phase 2, cycle 4 (extension,19-22 octobre 2025)** : Déploiement élargi dans les huit autres centres de santé du district sanitaire de Moulkou.

- **Phase de recherche:** évaluation avant et après le cycle 4 avec intervention (Moulkou) et sans intervention (Guelendeng).

POPULATION CIBLE

- Tous les enfants âgés de **0 à 59 mois** (CPS de 3 à 59 mois).

- **Zones d'intervention** :

  - **Cycle 1** (Moulkou Urbain) : **2 837**

  - **Cycle 4** (8 autres CS) : **10 539**

- **Total estimé : 13 376**

ACTIVITÉS RÉALISÉES (1)

Avant cycle 1

- Réunion préparatoire PNLP, DSP, DS, MC
- Discussions leaders communautaires, ASC, RCS, DS
- Formation (Moulkou Urbain) des ECD, RCS, ASC Suprox et crieurs
- Sensibilisation (radio, mosquées, églises)

Pendant cycle 1

- Distribution (2 SRO + 10 cp zinc/enfant)
- Supervision
- Briefing et debriefing
- Réunion de coordination
- Collecte de données

Public

ACTIVITÉES RÉALISÉES (2)

- Restitution au niveau du DS
- Evaluation cycle 1: DS, ASC, RCS, Superviseurs.
- Réunion programmatique à Bongor (PNLP, MC, DSR, DSC, DSP, DS, CS)
- Mise à jour des modules de formation
- Répartition de taches entre ASC
- Enquête fin de cycle (LQAS)

- Refresher training: ASC de 8 CS, RCS, DS
- Distribution (1 co-pack/enfant) dans 8 CS
- Supervision +++
- Briefing et debriefing

Après cycle 1

Avant et pendant cycle 4

ACTIVITÉS RÉALISÉES (3)

- Restitution au niveau du DS

- Validation

Après cycle 4

RÉSULTATS

CONNAISSANCE ET GESTION DE LA DIARRHÉE AU NIVEAU COMMUNAUTAIRE

- **Perception de la Diarrhée**

La diarrhée : une maladie grave comparable au paludisme et à la malnutrition, touchant particulièrement les enfants de moins de cinq ans surtout à certaines périodes de l'année.

- **Connaissance et utilisation du SRO-Zinc**

Le SRO est bien connu et utilisé dans la communauté, tandis que le zinc est moins familier.

- **Outils de sensibilisation**

Les fiches d'instructions: claires et adaptées aux personnes alphabétisées, des supports visuels sont recommandés pour les personnes non- alphabétisées.

- **Intégration de SRO-Zinc à la CPS**

L'intégration de la distribution de SRO-Zinc à la campagne CPS a été accueillie favorablement par la communauté et le personnel de santé.

RÉSULTATS_CYCLE 1

- **Couverture et acceptation élevées:** la couverture administrative était de 106 % des enfants, avec une forte acceptation des SRO et du Zinc.

Age	Population cible SRO-Zinc	Population cible CPS	Enfant ayant reçus SRO-Zinc (%)	Enfant ayant reçus CPS (%)
0-59 months	2 837	2 680	2 997 (106%)	2 894 (108%)

- **Supervision et évaluation rapide:** les supervisions ont montré un respect du protocole, et les communautés ont apprécié de recevoir des traitements contre le paludisme et la diarrhée en une seule visite

RÉSULTATS DONNÉES DU CYCLE 4 (SRO-Zinc)

Centres de santé	Cible	Nombre d'enfants ayant reçu de SRO-Zinc			Couverture
	0-59 mois	0-11 mois	12-59 mois	0-59 mois	0-59 mois
AL AFIA (PRIVE)	848	264	1000	1264	**149.06%**
BAHAWALIASSOU	1302	301	1122	1423	**109.29%**
GUIZANDJORO	1942	496	1629	2125	**109.42%**
KOUMAKAYAM	1011	233	758	991	**98.02%**
NGOURNAIDA	1615	376	1547	1923	**119.07%**
SARKAYE	1185	292	1149	1282	**108.19%**
SOUDIO	638	192	498	690	**108.15%**
TCHIKALI	1998	460	1821	2281	**114.16%**
MOULKOU DISTRICT	**10 539**	**2 614**	**9 524**	**11 979**	**113.66%**

RÉSULTATS DONNÉES DU CYCLE 4 (CPS)

Centres de santé	Cible	Nombre d'enfants ayant reçu de CPS			Couverture
	3-59 mois	3-11 mois	12-59 mois	0-59 mois	3-59 mois
AL AFIA (PRIVE)	801	228	1 000	1228	153%
BAHAWALIASSOU	1231	265	1 122	1387	113%
GUIZANDJORO	1834	399	1 631	2030	111%
KOUMAKAYAM	955	188	758	946	99%
NGOURNAIDA	1526	309	1 547	1856	122%
SARKAYE	1120	259	1 149	1408	126%
SOUDIO	602	126	498	624	104%
TCHIKALI	1887	426	1 821	2247	119%
MOULKOU DISTRICT	**9 956**	**2 200**	**9 526**	**11 726**	**118%**

RÉSULTATS ENQUÊTES MÉNAGE PAR LES ASC CYCLE 4

Centres de santé	Diarrhée dans les 4 dernières semaines			Prévalence diarrhée	Traitement de la diarrhée				
	0-11	12-59	0-59	0-59 mois	SRO	Zinc	ATB	Autres	Référence
AL AFIA (PRIVE)	9	19	28	**2.22%**	2	0	25	1	0
BAHAWALIASSOU	83	53	136	**9.56%**	0	0	47	52	0
GUIZANDJORO	40	54	94	**4.42%**	0	0	32	42	7
KOUMAKAYAM	5	5	10	**1.01%**	10	10	0	2	0
NGOURNAIDA	25	27	52	**2.70%**	0	0	10	25	0
SARKAYE	16	10	26	**2.03%**	0	0	16	10	0
SOUDIO	28	29	57	**8.26%**	0	0	3	13	0
TCHIKALI	34	40	74	**3.24%**	0	5	47	21	0
MOULKOU DISTRICT	**240**	**237**	**477**	**3.98%**	**12**	**15**	**180**	**166**	**7**

DIFFICULTÉS/SOLUTIONS

Difficultés/défis	Solutions
Charge de travail très élevée des ASC (CPS+SRO-Zinc)	Fiche de répartition de tâches
Modules de formation plus théoriques	Modules de formation plus pratiques avec jeux de rôles
Durée de formation des ASC très courte	Formation en un jour pour le volet CPS et un jour pour SRO-Zinc
Poids des médicaments très élevé à transporter	Participation communautaire : disponibilité de vélos par la communauté aux ASC

LEÇONS APPRISES

- **Faisabilité de l'intégration:** L'intégration du SRO-Zinc dans le CPS est faisable et bien acceptée par les communautés.

- **Forte relation de partenariat**: PNLP, DSR, DSC, OMS, MC, DSP, district, centres de santé.

- **Engagement communautaire**: participation communautaire, soutien par la disponibilité de velos pour les ASC.

- **Briefing et debriefing**: correction des manquements et solutions en temps reel.

- **Performance des equipes**: supervision, coordination, planification

- **Formation et outils**: formation pratique, aides memoires, repartition de taches entre les ASC.

- **Rôle des ASCs:** les ASCs jouent un rôle crucial dans la distribution et la sensibilisation, malgré une charge de travail accrue et des défis.

PROCHAINES ÉTAPES

- Partage de résultat de la recherche sur la faisabilité-impact CPS/SRO-Zinc (mars 2026)

- Partage le rapport final du projet

- Extension du projet dans 26 districts sanitaires dans 2 provinces (MKE et MKO)

COÛTS GLOBAL DE L'INTÉGRATION

La phase pilote de la co-administration CPS/SRO-Zinc est de 57 878 USD

MERCI, AKPE, THANK YOU, OBRIGADO, GRACIAS, شكرا

Utilisation du système des agents de santé communautaire pour la prestation de services intégrés

Réunion annuelle de l'Alliance SMC et
AMP Kampala, 24-27 février 2026

MINISTÈRE DE LA SANTÉ
RÉPUBLIQUE DU BÉNIN

Introduction (1/2)

Bénin

Situé en Afrique de l'Ouest

- *114 763 km2*

- *12 606 998 habitants en 2025*

- *12 départements*

- *77 communes*

- *34 zones sanitaires*

- *546 Arrondissements*

- *5292 villages/quartiers de Villes*

- *1911 formations sanitaires*

Introduction (2/2)

Au Bénin, plusieurs **programmes de lutte** contre les maladies endémiques ou prioritaires s'appuient sur des **campagnes de masse** pour atteindre leurs objectifs.

- Recours à des acteurs communautaires

- Résultats divers: discordance couverture administrative et couverture issu du monitorage

MIILD

CPS

Onchocercosis (MDA)

Programme de lutte contre le Paludisme

Programme de lutte contre les MTN

Programme elargi de vaccination

Programme de nutrition
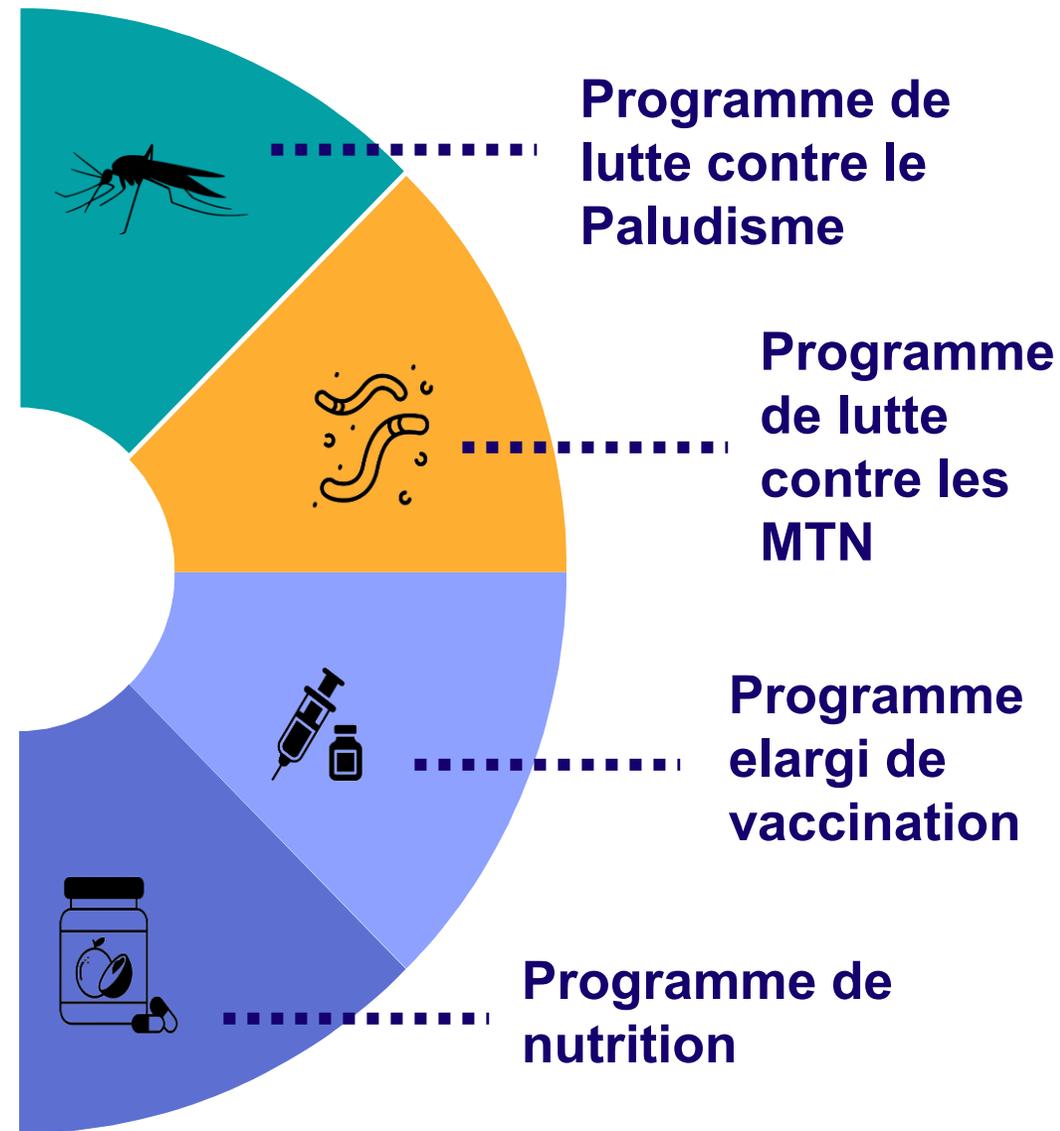
Expérience du Bénin dans la mise en oeuvre des campagnes digitalisées (1/3)

Avant 2020 :

- Collecte manuelle (outils papiers) des données des interventions communautaires
- Cette approche avait plusieurs limites :

Faible visibilité des activités terrain

Les autorités sanitaires ne disposaient d'aucune vue en temps réel sur les activités des relais, limitant la supervision, la réactivité et la prise de décision en temps utile.

Retards dans la transmission des rapports

Les rapports passaient par plusieurs niveaux manuels avant d'être transmis
Incomplétude
Erreur

Manque de données consolidées

Les informations collectées sur papier étaient difficiles à agréger, rendant l'analyse globale difficile.
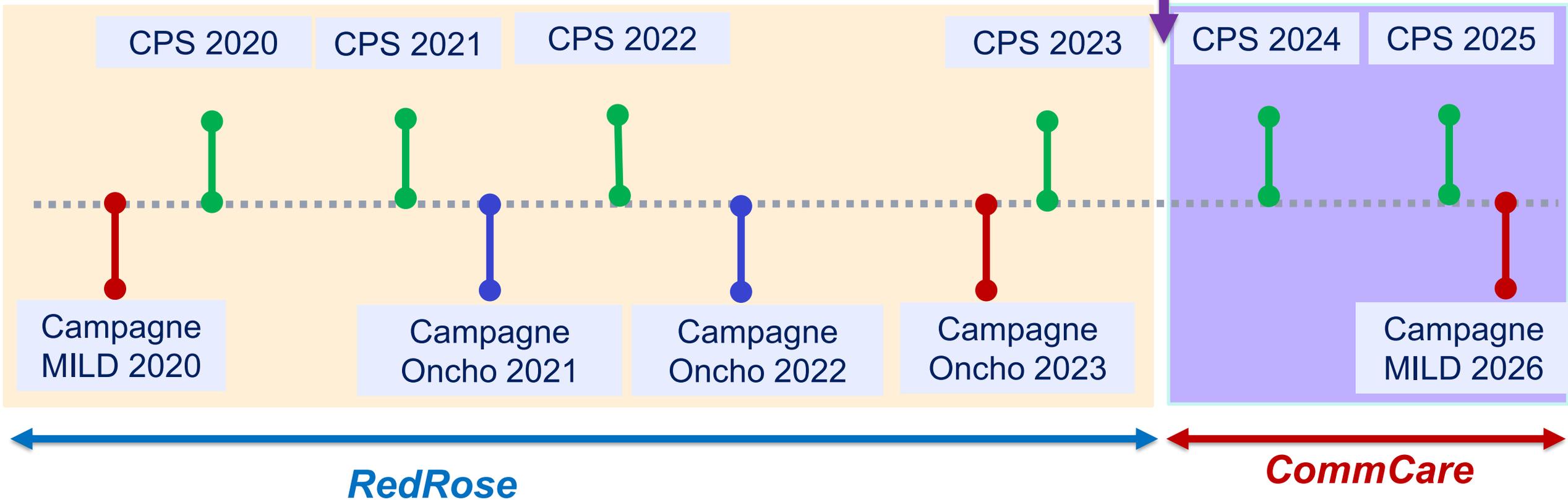
Paiement

Difficultés de justification du travail réalisé par les acteurs

Paiement maladroit

Expérience du Bénin dans la mise en œuvre des campagnes digitalisées (2/3)

Expérience du Bénin dans la mise en œuvre des campagnes digitalisées (3/3)

Quels étaient les nouveaux challenges à partir de 2020?

- Intégration des services de santé préventifs, promotionnels et curatifs

- Disposition d'une plateforme numérique unique pour toutes les campagnes de santé

- Réduction de coût des campagnes

- Amélioration de la couverture administrative

Ces challenges ont conduit à la mise en place du Politique Nationale de santé communautaire (PNSC) en 2023

Structure de Politique Nationale de Santé Communautaire au Bénin (1/3)

La PNSC a mis en place deux types d'acteurs clés :

- **Les Relais Communautaires (RC)** chargés de:
  - prévention, promotion de la santé, mise en œuvre du one health
  - mobilisation sociale, IEC/CCC en communauté
  - recensement des événements vitaux (naissances, décès) au sein de leur communauté.
  - Mise en œuvre des activités de masse et campagnes

- **Les Agents de Santé Communautaire Qualifiés (ASCQ) :**
  - Profil plus technique (agents de santé formés, infirmiers, sage femmes),
  - assurent le volet curatif et référence des cas
  - traitent les cas simples de **paludisme**, **diarrhée** et **pneumonie** chez les enfants de moins de 5 ans via la Prise en Charge Intégrée des Maladies de l'Enfant (PCIME).
  - Superviseur direct des RC

Structure de Politique Nationale de Santé Communautaire au Bénin (2/3)

01 ASCQ pour 40 RC
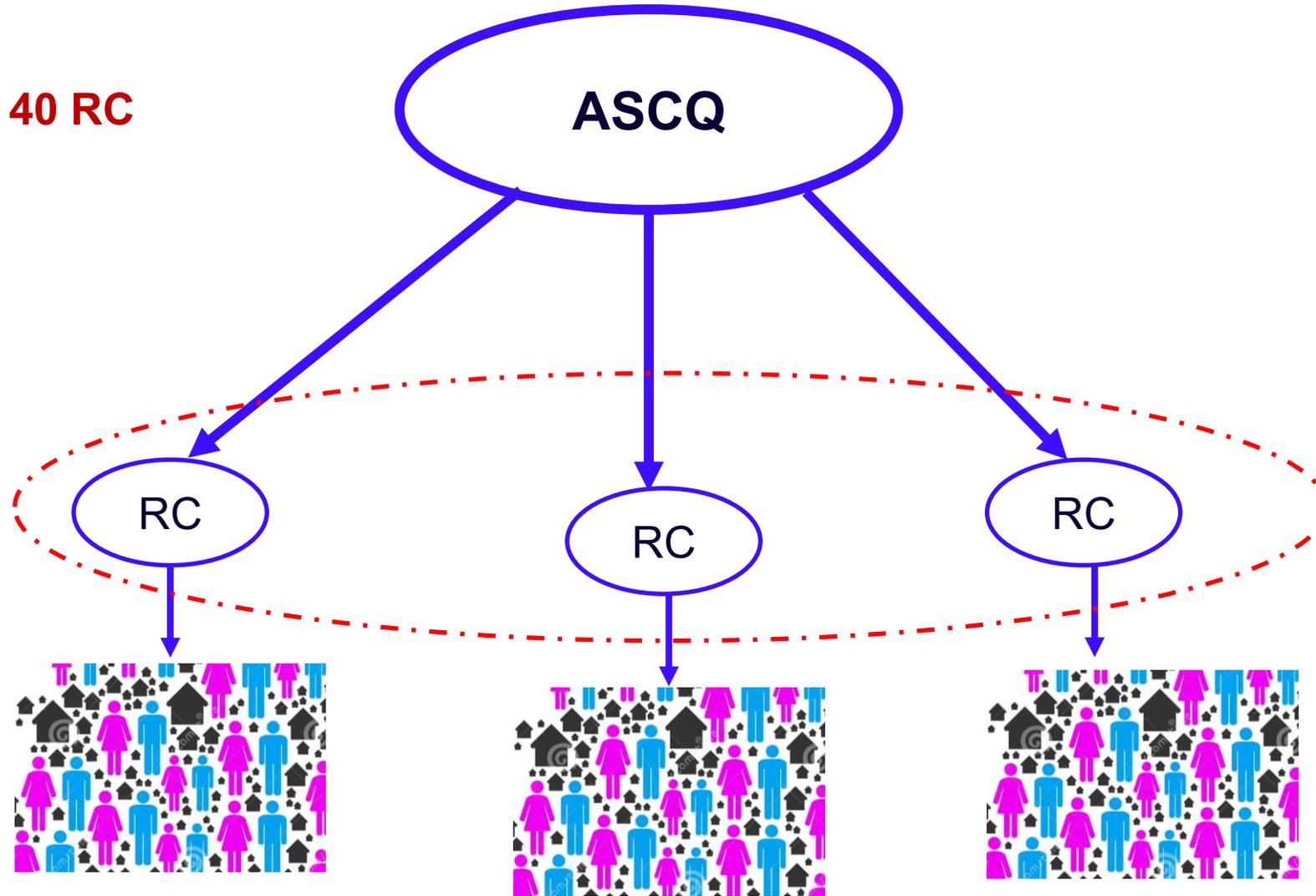
Grappe (200 ménages environs)

Structure de Politique Nationale de Santé Communautaire au Bénin (3/3)

1 **Connus par les communautés:** Choisis dans les zones qu'ils desservent, ce qui facilite l'acceptation sociale et l'accès aux ménages.

2 **Formés à l'utilisation d'Alafiacomm (conçu par Dimagi)** : Ils ont été formés à la collecte numérique via Alaficaomm,.

3 **Disponibles dans toutes les zones sanitaires**: présents dans chaque zone sanitaire, assurant une couverture territoriale complète.

Storyline
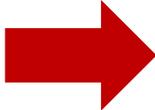
Collecte manuelle	→	Besoin de digitaliser	→	Plateforme Unique: Alafiacomm	→	Politique Nationale de santé comm

CHALLEN_{GE}s

Performance d'un système intégré (1/2)

Intégrer la santé communautaire et les campagnes dans un seul système présente de nombreux avantages, tant sur le plan opérationnel que stratégique.

1 Harmonisation des outils et des pratiques

Un seul système pour les RC, ASCQ facilite la standardisation des flux de travail, des formulaires et des indicateurs.

2 Optimisation des ressources humaines

Les RC formés pour le suivi des ménages sont aussi mobilisables pour les campagnes, ce qui évite de recruter/former à nouveau pour chaque campagne.
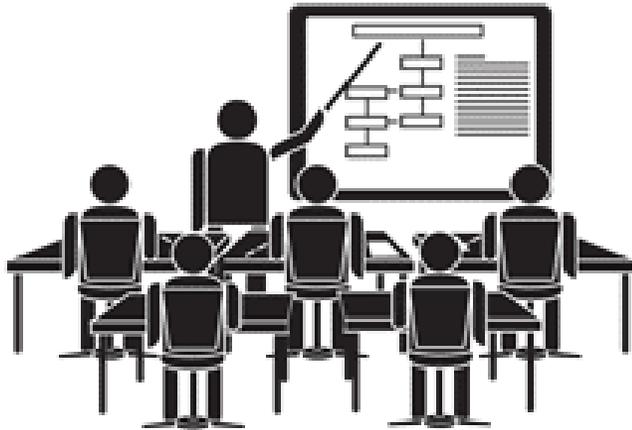
3 Meilleure couverture réelle des cibles

Le RC est plus proche des ménages de sa grappe

4 Réduction des coûts et meilleure durabilité

Un seul système = moins de maintenance, moins de serveurs, moins de formations multiples. La digitalisation devient plus durable financièrement.
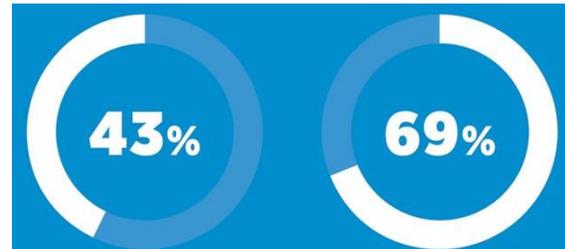
Performance d'un système intégré (2/2)

Quelques évidences pratiques

Formations

- Les RC sont formés une fois pour les paquets d'interventions
- Pas besoins de les former à chaque campagne comme à l'ancienne
- Réduction de coût de MEO

Couverture de intervention

43%   69%

- Pas d'évidence dans l'amélioration des couvertures des interventions en termes d'augmentation
- Assurance de couvrir tous les ménages avec RC
- Satisfaction des ménages d'avoir les prestations de service à domicile

Réduction de coûts

- Plus de recensement en prélude aux campagnes MIILD, CPS, Oncho
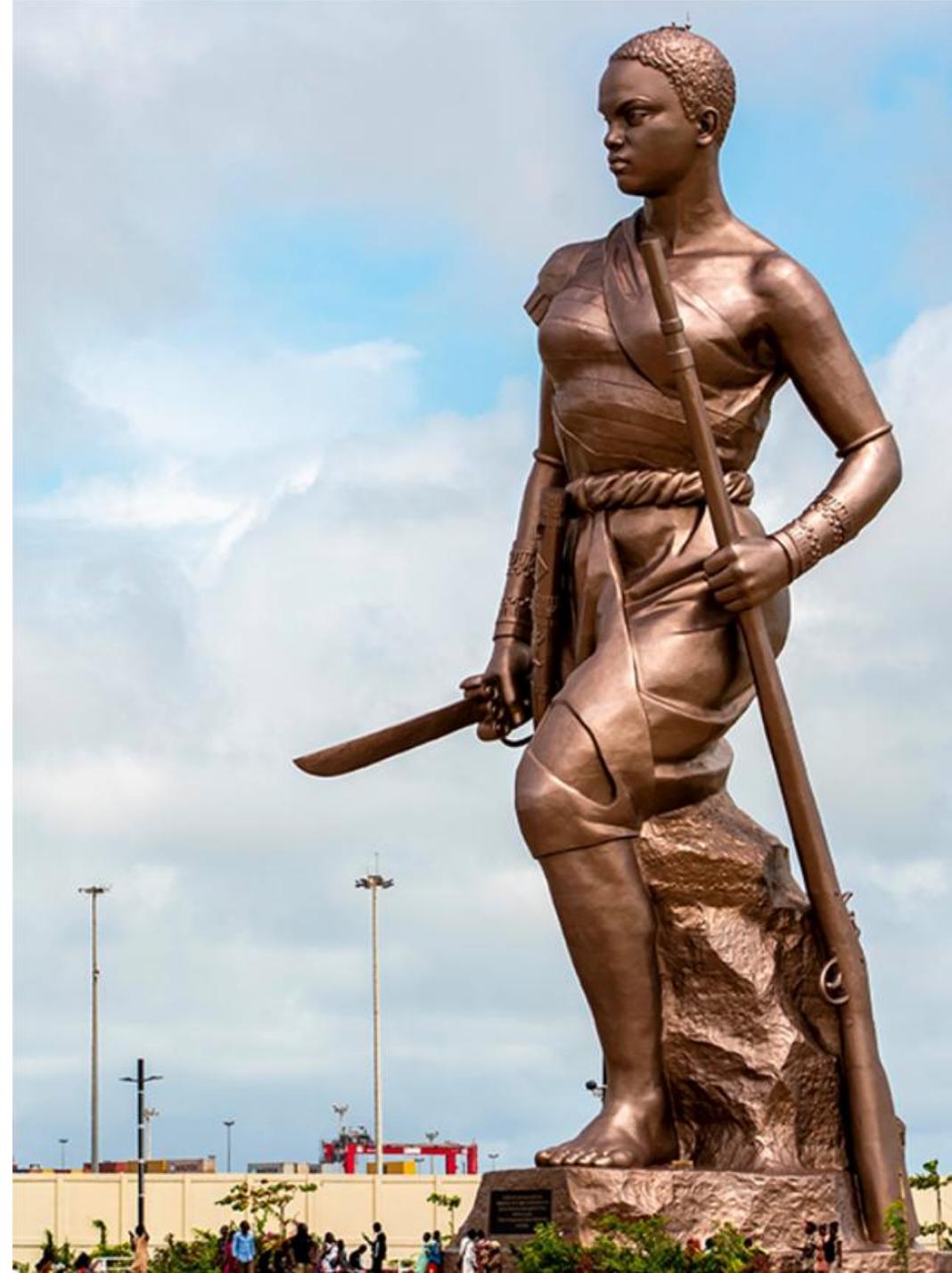- Absence pour le moment d'analyse formelle de comparaison de coût de MEO

Défis

- Besoins complémentaires de RC et ASCQ (pléthore dans certaines grappes)

- Le développement de module complémentaire pour soutenir les campagnes

- Le transfert de compétence

- La rémunération des ASC après le retrait de l'USAID dans certaines zones

- L'interopérabilité avec le DHIS2

Conclusion

- Stratégie integration des services avec les acteurs communautaires bonne dans sa conception

- Il rapproche les soins des ménages

- Garantit une couverture optimale et réelle des interventions

- Réduit inélutablement les coûts de mise en oeuvre

Merci de votre aimable attention

Discussion - Questions & Answers

Discussion - Questions et réponses

Discussão – Perguntas e respostas

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

Adaptations to achieve outcomes in complex operating environments

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

Digitalization of ITN and SMC campaigns in Complex Operating Environments (COE)

Global findings and five country case studies

Presented by Brenden Williams, Co-Chair, Humanitarian and At-Risk Populations (HARP) Working Group

Led by inputs from national malaria programmes and partners in Burundi, Chad, Mali, Nigeria, Pakistan, Somalia, and South Sudan

Developed by Mary Kante, Founder, Eau Claire Consulting

Examining the Use of Digital Technologies to Facilitate ITN and SMC Campaigns in COEs

Context

- HARP Working Group (WG) mandate – To improve the operational delivery, access to, and use of ITNs for internally displaced persons (IDPs) and refugees.

- CRS' Global Malaria Strategy, Priority Area 5 – To position multisectoral approaches as a global best practice for reducing malaria, particularly in humanitarian and emergency contexts.

- Recommendation of the HARP WG multi-sectoral roundtable meetings to address the challenges of malaria prevention in humanitarian relief settings – to collect and share data for evidence-based decision-making and accountability.

Objectives of the Review

- Identify and synthesize key trends, successes, and challenges for improving digital technology for monitoring COEs, ensuring the strategic allocation of resources, and enabling stakeholders to track progress and quantify the malaria needs of IDPs and refugees.

Methods

Literature review
- Compiled key relevant findings from the literature review were compiled in MS Excel, including information from national malaria programmes (NMP) and key project partners, including AMP, CRS, and the United Nations Development Programme (UNDP). These included case studies, MS PowerPoint presentations from meetings and webinars, handbooks, and landscaping reports.

Key informant interviews (KII)
- Organized and conducted with 24 key informants, including NMP Coordinators, AMP ITN digitalization consultants, and partners including UNICEF, UNDP, Against Malaria Foundation (AMF), eGov Foundation, Malaria Consortium, and Clinton Health Access Initiative (CHAI).

- Provided an overview of experiences with different digital technology solutions.

- Represented a range of COEs at national and sub-national levels and a range of geographic regions and partners.

Case studies
- Five case studies developed to provide in-depth overviews of NMP-led exploration, design, implementation, and continuous improvement for digitalization across key components of ITN and SMC campaign distribution.

Key Findings

Successes in the development and extension of digital technology for ITN and SMC campaigns

- *Improved Data Quality and Decision-Making*. NMPs are leading the use of real-time digital dashboards to identify and correct registration errors mid-campaign, ensuring accurate data-driven decisions that were previously impossible with paper reporting.

- *Enhanced Operational Efficiency and Campaign Equity*. Digital mapping and tracking tools have significantly increased campaign coverage and equity, successfully reaching remote or difficult terrains in countries like Nigeria and Mali.

- *Cost-Effectiveness and Resource Optimization.* Moving to digital platforms generates long-term savings by reducing logistical costs—such as a 90% reduction in printing—and preventing over-procurement through more accurate population estimates.

- *Building Local Capacity and Collaboration.* The transition to digital systems fosters national ownership by training local government staff to manage technical operations, reducing reliance on external support and improving the user experience for field volunteers.

Key Findings

Overcoming challenges in extending digital technology for ITN and SMC campaigns

- *Human Resource and Capacity Gaps*. To address digital literacy gaps and high staff turnover, programs are deploying specialized technical support groups from Ministries of Health to provide continuous, on-the-ground training for field teams.

- *Connectivity and Infrastructure*. Persistent power and network barriers are being overcome through robust offline application functionality and the provision of solar-powered charging solutions for volunteers in remote areas.

- *Security and Privacy*. In high-risk or conflict zones, teams mitigate security threats by employing local data collectors, using protective gear for devices, or pivoting to hybrid paper-based systems where mobile phone use poses a physical risk.

- *Data issues*. To tackle challenges like duplicate registrations and naming inconsistencies, programs are initiating pilot phases to refine app functionality and streamline data cleaning processes before full-scale rollout.

- *Interoperability and Scalability*. Countries are breaking down "data silos" by integrating campaign tools into national platforms like DHIS2, allowing household registries to be reused across different health interventions like immunizations and SMC.

Case Studies

Review of Technology to Facilitate ITN and SMC Campaigns

Photo by Nanhassengar Emmanuel Nagorngar, PNLP Tchad

Case Studies

Country	Case Study
Burundi	*Tsinda Malariya – Defeat Malaria* *Burundi's use of the DIGIT HCM platform to promote ITN access and campaign efficiency*
Chad	*Use of Mobile Device Management, KoboCollect, DHIS2, and Power BI to mitigate flooding and security challenges during the 2023 ITN Campaign*
Mali	*Strengthening ITN and SMC campaigns in Mali through DHIS2, where security allows*
Pakistan	*Pakistan's leadership in Designing and Implementing the Digitalization of ITN Campaign Microplanning with DHIS2*
Somalia	*Somalia's Digital Transformation for Malaria Vector Control: Pioneering ITN Distribution and Innovative Use of DHIS2*

Burundi: DIGIT HCM for ITN distribution (Tsinda Malariya)

Background and ITN Campaigns
- Recent campaigns face complex challenges, including internal displacement from climate-related floods and an influx of over 40,000 refugees from the DRC in early 2025.

Digitalization of Campaigns
- The 2025 "Tsinda Malariya" initiative uses the DIGIT HCM open-source platform to manage micro-planning, household registration, ITN distribution and monitor supply chain.

Addressing Identified Challenges
- *Fuel shortages limiting electricity*: Volunteers received power banks or linked to facilities with solar-powered charging.
- *High staff turnover and digital literacy gaps*: Census-trained officers were paired with 11,485 community health workers for on-the-job capacity building.

Results and Achievements
- During the 2025 pilot distribution coverage reached 97%.
- Digitization effectively reduced the time required for household registration to just 8.5 days.

Lessons learned
- Important to complement initial theoretical training with practical training, i.e., scanning barcodes on bales rather than paper

Chad: Use of technology in mitigating flooding, security challenges

Background and ITN Campaigns
- Chad is Africa's fifth-largest country and hosts more than 1.2 million refugees and 300,000 internally displaced persons (IDPs) while facing significant climate vulnerability.

Digitalization of Campaigns
- Transitioned in 2023 to a fully digital solution integrating three cloud-based platforms: KoboToolbox for household data, DHIS2 for analysis, and PowerBI for visualization.

Addressing Identified Challenges
- *Heavy rains and floods*: To protect expensive hardware, staff were provided with specialized rain gear and carrying cases.

Results and Achievements
- The transition demonstrated that a nationally led, digitalized campaign could be implemented within standard timelines even in highly complex regions.

Lessons Learned
- *Continuous improvement*: Incorporated user feedback and applied lessons from a 2022 SMC pilot to reinforce the digital platform for operational realities.
- *Standardized Infrastructure*: Moving to cloud-based systems (DHIS2/PowerBI) proved more effective than maintaining local physical servers in a fragile environment.

Mali: Strengthening ITN, SMC campaigns with DHIS2

Background and ITN Campaigns
- 2023 campaign split into two phases due to security and logistical constraints.
- Mali implements annual SMC during the rainy season.

Digitalization of Campaigns
- Began as 10-district pilot for 2022 SMC campaign, with lessons applied to the 2023 ITN campaign.
- Will ensure interoperability with wider DHIS2 which Ministry of Health is adopting in 2025.

Addressing Identified Challenges
- *Security*: In northern Mali, carrying digital devices in public is a security risk; digitalization is thus restricted to "office-based" supply chain management and supervision to protect staff.
- *Cultural Context*: Digital tools helped identify multi-generational households (sharing one compound) that did not fit standard definitions, allowing ITN allocation adjustments.

Results and Achievements
- SMC: coverage increased from 60% in 2022 to 95% in 2024.
- ITN: achieved a 99.26% distribution rate across 46 districts.

Lessons Learned
- *Device Quality:* Procurement is a hurdle; over 20% of initial devices had operating system problems, highlighting the need for rigorous hardware testing before deployment.

Pakistan: Leadership in designing and implementing the digitalization of ITN campaign microplanning with DHIS2

Background and ITN Campaigns
- Floods (2022) caused malaria cases to quadruple, particularly along border with Iran and Afghanistan.
- Operating environments are highly complex due to violent extremism, tribal feuds, and a massive influx of refugees in border areas.

Digitization of Campaigns
- DHIS2 used for microplanning, household registration, using coupons, and ITN distribution.

Addressing Identified Challenges
- *Security Concerns*: In high-risk areas, the program uses *Hit and Run* strategies (rapid door-to-door distribution) and recruits personnel from local communities to build trust and ensure safety.

Results and Achievements
- The 2024 ITN campaign achieved a coverage rate of 93%.

Lessons Learned
- *Integrated Surveillance*: Leveraging Pakistan's experience using DHIS2 for flood monitoring and malaria surveillance made the transition to ITN campaign modules faster and more cost-effective.
- Due to these successes Pakistan intends to conduct cost-comparisons across all campaigns since 2018 to further refine the economic efficiency of digital tools.

Somalia: Pioneering ITN Distribution and Innovative Use of DHIS2

Background and ITN Campaigns
- Somalia has several COE contexts due to fragility, natural disasters (droughts and El Niño flooding), and significant population displacement.

Digitalization of Campaigns
- DHIS2 for household registration, geospatial tracking of distribution sites, and a "Last Mile Monitoring" app to track stock from procurement to district warehouses.

Addressing Identified Challenges
- *Security & Robbery:* Field staff navigate risks of phone theft and interference from armed groups by engaging district commissions for security support.
- *Data Duplication:* To address the lack of national ID systems and common naming conventions, technical teams use close ground-level coordination to eliminate duplicate registrations.

Results and Achievements
- The digital system allows for spot checks via household phone numbers to confirm they received the correct number of ITNs.

Lessons Learned
- *Local Context Nuance:* It is critical for technical developers (often based externally) to maintain dialogue with local teams to capture Somali-specific needs, such as the different categories of IDPs.

Thank You

Digitalization of ITN and SMC campaigns in COEs

✉ brenden.williams@crs.org

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no bounds®

CRS

SMC Annual Alliance Meeting - 2026

Implementing SMC in a complex operating environment

(Refugee & IDP Camps Populations in South Sudan)

Contents

1) South Sudan Context

2) Why SMC is Critical in Refugee & IDP Camps

3) SMC performance in 2025

4) The Opportunities to deliver cost effective SMC in South Sudan if Scaled up

5) Key Operational Challenges in South Sudan

6) Lessons Learned from Implementation

South Sudan Context

**South Sudan gained independence** in 2011 from Sudan after a referendum ending two decades of civil war

High child mortality persists at 98.7 deaths per 1,000 live births

Malaria is the leading cause of morbidity and mortality responsible for up to 49% of outpatient visits and 30% of inpatient admissions.

Conflict, floods, and displacement have created overcrowded camps with limited access to health services, increasing malaria exposure for children.

Northern Bahr el Ghazal
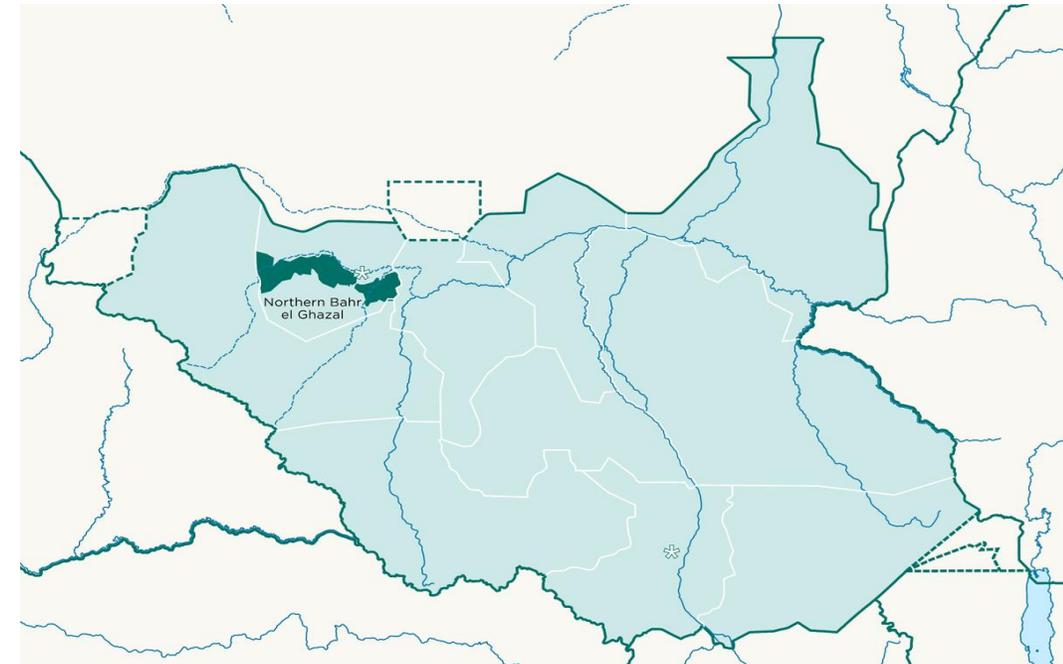
■ Philanthropic funding
✳ Malaria Consortium office

SMC was Funded by GiveWell

Context Cont.

- Crisis erupted in Sudan in 2023

- Over 2 million IDPs & refugees, plus large influxes of returnees from Sudan, strain the already fragile systems.

- SMC is implemented in Wedweil Refugee settlement by Malaria Consortium (2023–2025)

SMC in Refuge Community in South Sudan

Approach

- Door to Door Delivery (5 cycles)
- Use of Community Health & Refugee Volunteers (identified from the refugees) for ownership
- Integration with Existing Humanitarian Services
- Use of Community Platforms for Sensitization
- Reference to UNHCR Data for planning
- Multi Language Communication (Arabic, English)

Seasonal Transmission

Especially in Northern Bahr el Ghazal (NBeG) where peak transmission is (June–November)
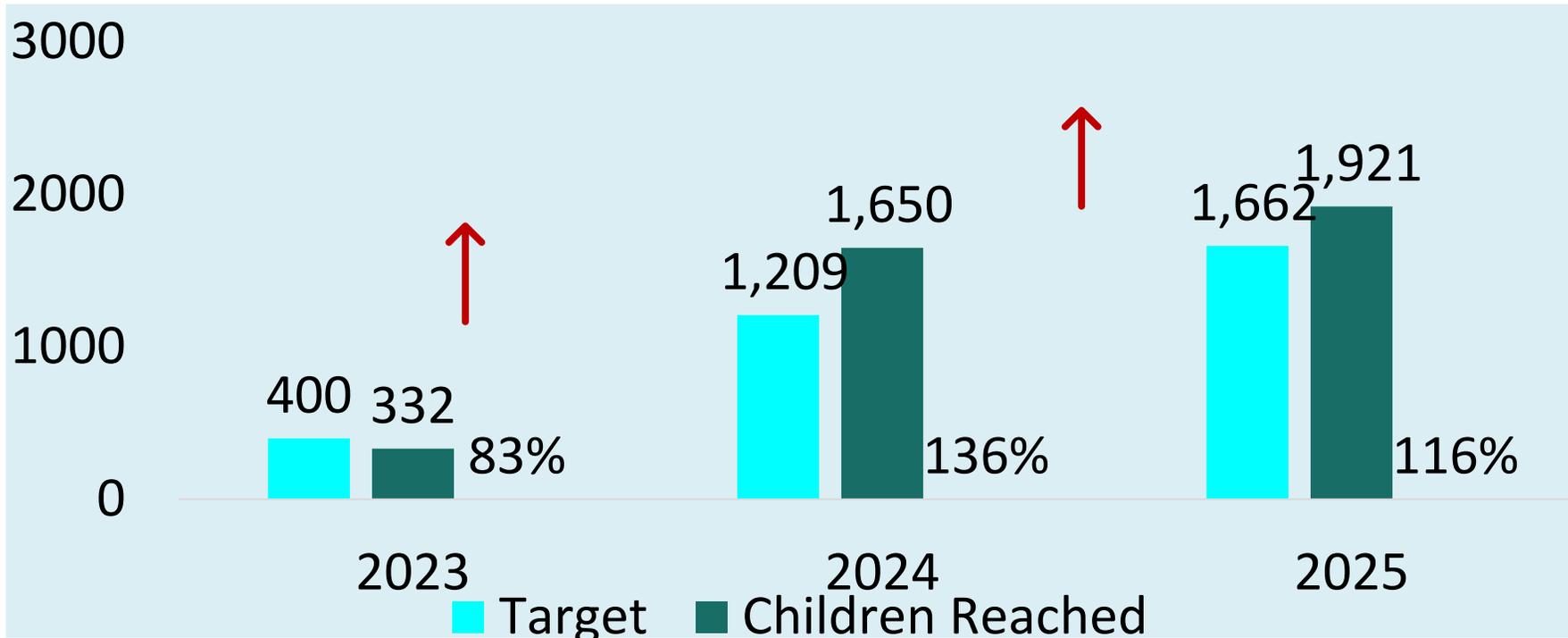
Coverage Scope (Quality)

- Administrative coverage
- Household survey coverage
- Data quality and program performance indicators as part of its multi-country SMC programme
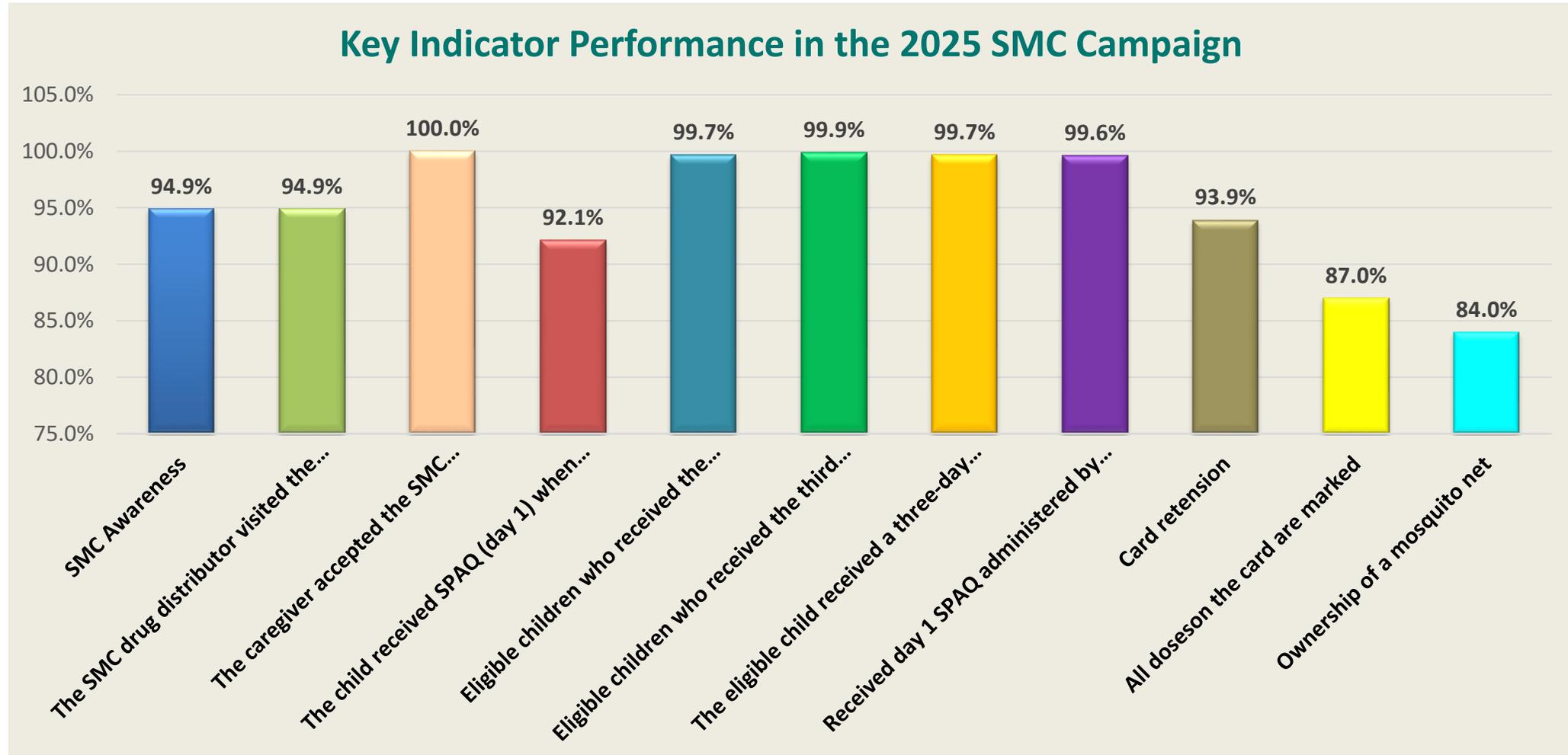
Why SMC is Critical in Refugee & IDP Camps

❏ **Limited Access to Health & WASH**: Overcrowded camps + fragile health systems = poor access to healthcare, clean water, sanitation, and protection services. <u>SMC ensures reliable malaria prevention where services are weakest</u>

❏ **Severe Food Insecurity & Climate Shocks:** Conflict, displacement, market collapse, and flooding destroy shelters and livelihoods, leaving families without food or safe water thus heightening malaria vulnerability

❏ **High Insecurity:** Armed clashes and restricted movement block humanitarian access, leaving displaced families without essential services or protection

❏ **Humanitarian Crises Increase Malaria Burden:** Over 2 million IDPs & refugees, plus large influxes from Sudan, strain already fragile systems. <u>SMC is implemented in Wedweil Refugee settlement by Malaria Consortium (2023–2025)</u>

❏ **SMC Benefits:** Reduces uncomplicated & severe malaria in children under 5, providing continuous protection during peak season (June–October/November)

SMC intervention in Wedweil Refugee Settlement 2023-2025

Performance of SMC in 2025 campaign

Key Indicator Performance in the 2025 SMC Campaign

- SMC Awareness: 94.9%
- The SMC drug distributor visited the...: 94.9%
- The caregiver accepted the SMC...: 100.0%
- The child received SPAQ (day 1) when...: 92.1%
- Eligible children who received the...: 99.7%
- Eligible children who received the third...: 99.9%
- The eligible child received a three-day...: 99.7%
- Received day 1 SPAQ administered by...: 99.6%
- Card retension: 93.9%
- All doseson the card are marked: 87.0%
- Ownership of a mosquito net: 84.0%

End of round survey 2025

Quotes about SMC

"When I heard that South Sudan will not have an SMC Campaign, I was shattered. This is because I had firsthand evidence of the positive effect of SMC – My medical expenditure on malaria reduced because my children were beneficiaries"

Director General, Northern Bahr el Ghazal

Quotes cont.

"I believe these drugs are very useful. When my child completed the doses, she didn't get sick anymore, which was a relief for me. I would never intentionally prevent my child from taking these drugs, especially since they are free and effective in keeping her healthy."

Caregiver, Wedweil Refugee Settlement

SMC Challenges in South Sudan

❑**Limited Funding & No SMC Planned for 2026 -** Funding gaps have halted 2026 SMC implementation, threatening continuity of protection for children in high-burden counties

❑**Limited Surveillance Capacity -** Weak routine surveillance systems reduce accuracy of burden estimates and planning. Ongoing partner-supported initiatives (e.g., Optimizing Malaria Surveillance Project) aim to strengthen data quality and use

❑ **Concerns on ASAQ & SP Resistance -** Concerns over SP resistance and ASAQ use may affect continued SMC implementation. MoH and partners are working towards adaptation of multiple first line treatment and conducting studies to inform decisions.

❑**Insecurity & Restricted Access -** Armed conflict, road insecurity, and large-scale displacement exacerbated by refugee influx from Sudan, limit access to communities, disrupt supply chains, and impede SMC delivery

The Opportunities to deliver cost effective SMC in South Sudan if Scaled up

- ❑ **Strong Community Health Workforce** - Existing Boma Health Workers & supervisors already experienced in door-to-door SMC delivery since 2022 → ready, low-cost workforce for rapid expansion

- ❑ **High Feasibility & Community Acceptance** - Strong acceptance in Aweil and refugee settings; trusted community workers make scale-up easy and cost-efficient

- ❑ **Operational Capacity in Hard-to-Reach Areas** - Teams have delivered SMC successfully in flood-prone, insecure, and remote areas — achieving >100% coverage even under pressure

- ❑ **Robust Partnerships with MoH & Health Agencies** - Strong collaboration with MoH/NMCP, UNICEF, and humanitarian partners provides a supportive platform for wider expansion

- ❑ **Proven Scalability Beyond Pilot Sites** - Evidence shows SMC is feasible, safe, and scalable - ready for expansion to additional states and refugee populations beyond Wedweil Camp.

Lessons Learned from Implementation in camps

- ❑ **Entry into camps through camp leadership –** Facilitates coordination and collaboration with existing partners and trust building

- ❑ **Use of Community Health & Refugee Volunteers (identified from the refugees)-** Fosters for ownership

- ❑ **Integration with Existing Humanitarian Services-** Maximizes uptake

- ❑ **Use of Community Platforms Increases Reach** - Market Days & Schools effectively engage wider groups especially male caregivers, and boost targeted SMC messaging

- ❑ **Peer Learning Strengthens Quality** - Knowledge sharing harmonizes approaches and improves consistency in service delivery

- ❑ **Operational Flexibility is Essential** - Adjusting micro-plans for flooding, insecurity, and shifting populations prevents missed children and maintains coverage

The Director Preventive Medicine *(holding brown book)* poses for a photo Boma Health Workers Wedweil Refugee Settlement during Cycle 4 of the SMC Campaign (Sept 2025)

Special Thanks to GiveWell

Together, we can create a world free of malaria

CONTACT US
info@malariaconsortium.org

VISIT
www.malariaconsortium.org

Discussion - Questions & Answers

Discussion - Questions et réponses

Discussão – Perguntas e respostas

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

REPÚBLICA DE MOÇAMBIQUE
MINISTÉRIO DA SAÚDE
DIRECÇÃO NACIONAL DE SAÚDE PÚBLICA
PROGRAMA NACIONAL DE CONTROLO DA MALÁRIA

Distribuição de RTIs em Cabo Delgado - Adaptação para situações de ciclone e de conflito político armado

Uganda, 25 de Fevereiro de 2026

Conteúdo da apresentação

- Objectivo da Apresentação

- Situação da Malária a nível Global e Nacional

- Contextualização

- CCU após passagem do Ciclone Chido

- Cobertura da Campanha no Distrito de Mecúfi

- CCU nas áreas em conflitos político militar

- Cobertura da Campanha Zonas em Conflitos

- Principais Desafios

- Lições aprendidas

Objectivo da apresentação

Partilhar boas práticas e estratégias de implementação e monitoria da campanha de distribuição de redes mosquiteiras em situação de emergências após passagem do ciclone Chido e em zonas de conflitos político militar.
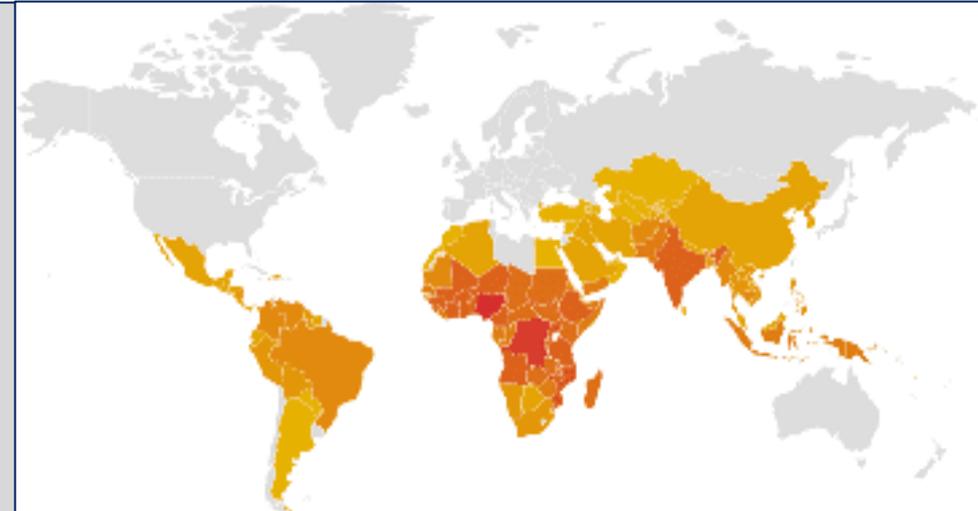
Situação da Malária a nível Global e Nacional

Mundo
- **282** milhões de casos **e 610.000** mortes por malária em todo o Mundo, **Moçambique (3,6%) (WHO, 2025)**

Casos de malária
- No ambulatório: 12.855.953 (SISMA)
- No internamento: 73.963 (SISMA);
- Óbitos intra-hospitalares: 496 (SISMA)

#	Indicadores – anuais	2024	2025	Evolução
1	Casos de malária	11.622.449	12.855.953	**11%**
2	Casos < 5 anos	4.855.015	5.243.008	**8%**
3	Mulheres grávidas que receberam 4 ou mais doses de TIP	1.438.238	1.489.431	**4%**
4	Mulheres grávidas que receberam Rede Mosquiteira			

Contextualização

- Campanha de Cobertura Universal (CCU) de RTIs, Ciclo 2025-2026 iniciou na província de Cabo Delgado, e teve um forte envolvimento na componente da mobilização Social.
- Engajamento político - dirigida por Sua Excia Governador da Província.

30 de Janeiro a 03 de Fevereiro de 2025

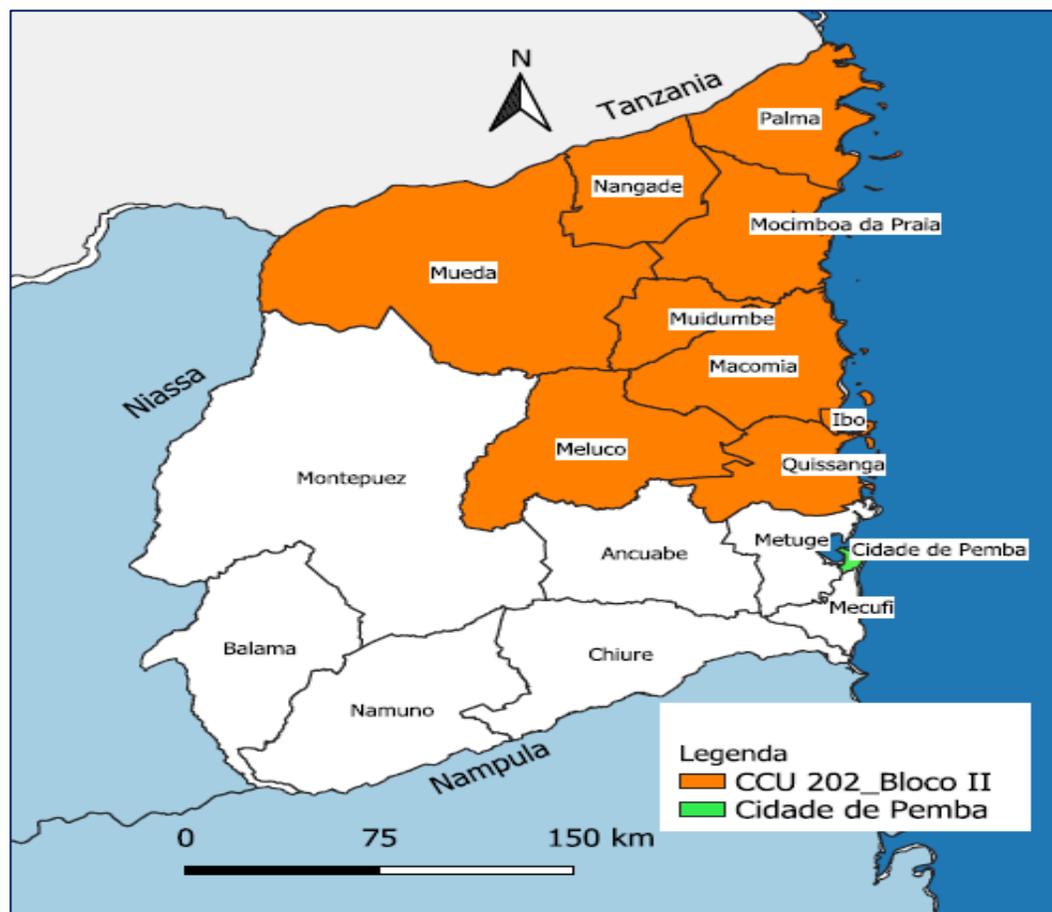- **Mecufi (apos o cyclone Chido)**

24 a 28 de Março de 2025
- **Ancuabe, Balama, Chiúre, Metuge, Montepuez e Namuno**

08 a 12 de Abril de 2025
- **Ibo, Macomia, Meluco, Mocimboa da Praia, Mueda, Muidumbe, Nangade, Palma e Quissanga**

08 a 12 de Abril de 2025

- **Pemba**

CCU após passagem do Ciclone Chido

- **Mecúfi** após a passagem do ciclone Chido que atingiu Moçambique a 15/12 de 2024 (com velocidade de ventos até 220 km/h),
- Foram adaptadas e modificadas as 13 etapas PD.

Estratégia PD

Na fase de registo eram 3 instrumentos-chave para o registo dos AF:
- Telemóvel
- Senha
- Autocolantes (Verdes e vermelhos)

Durante o registo de AF:

- Registo casa a casa e em forma de digitalização acompanhada de scan do QR code da senha;

Durante a distribuição:

- Em forma de PD, recebia-se a senha pelo receptor para confirmar com scan do QR code o nome do AF e depois passava para o distribuidor;
- O distribuidor fazia o scan da senha e depois fazia o scan da rede e dispensava a mesma para AF.
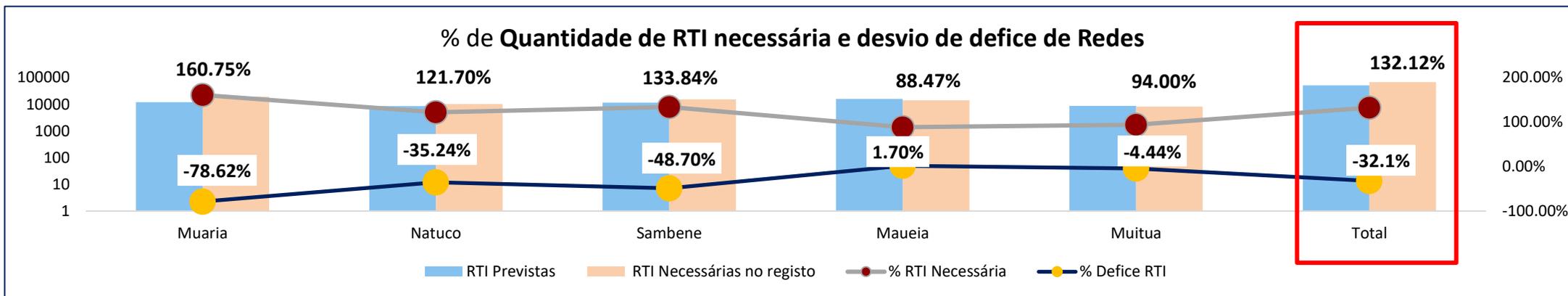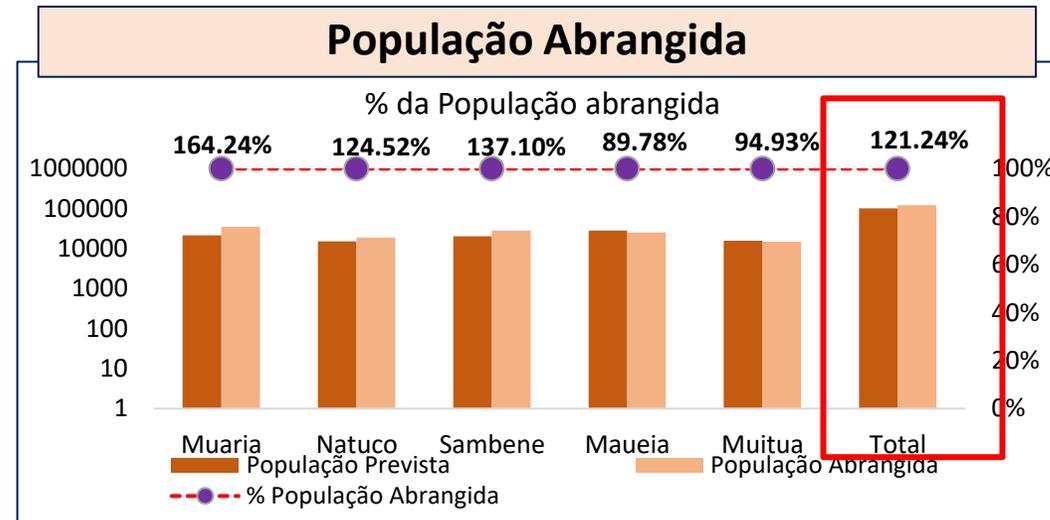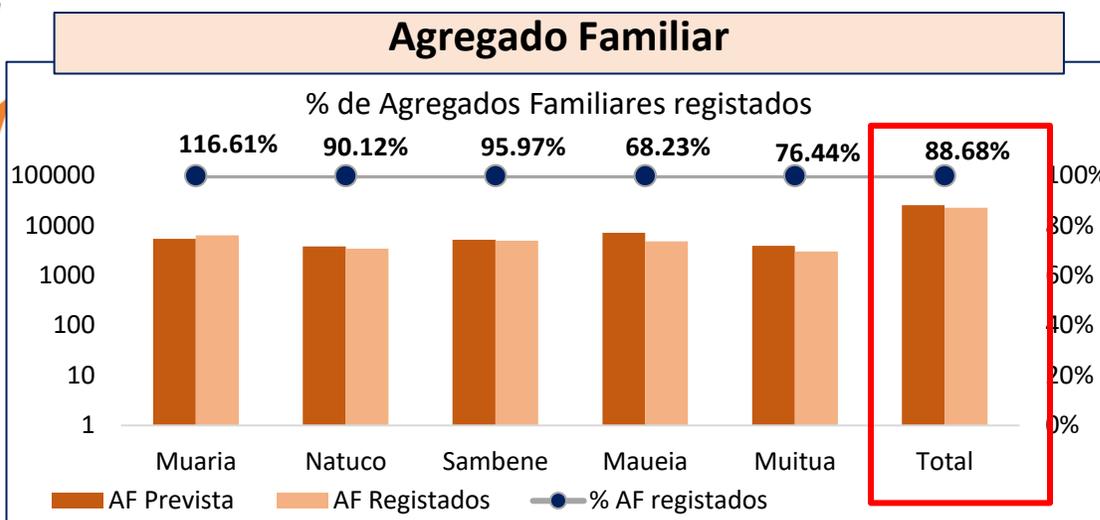
A digitalização da CCU foi baseada na plataforma Salama.

Dispositivos: Telefones Samsung A03 Core
Software gestor de dispositivos móveis: Scalefusion

- Imagens de áreas destruídas (acima)
- Após de recepção de RTI no PD (abaixo)

Adaptação pós Ciclone

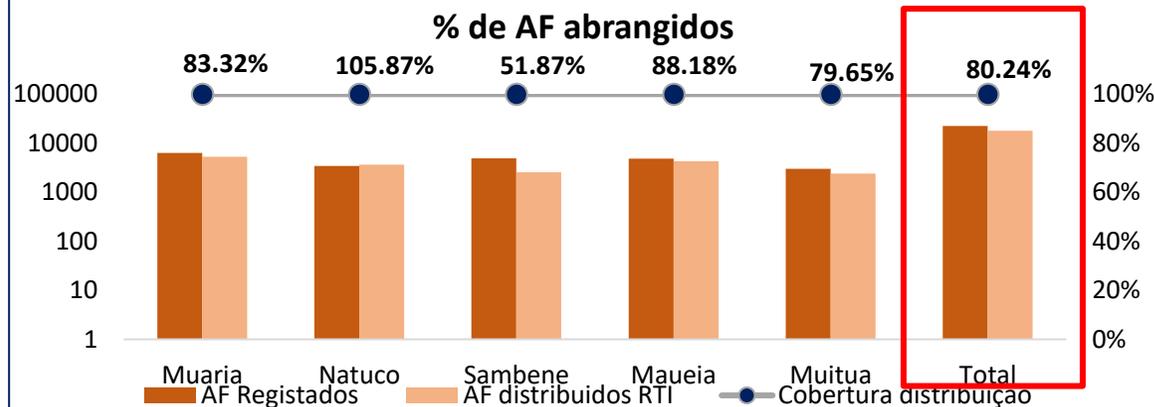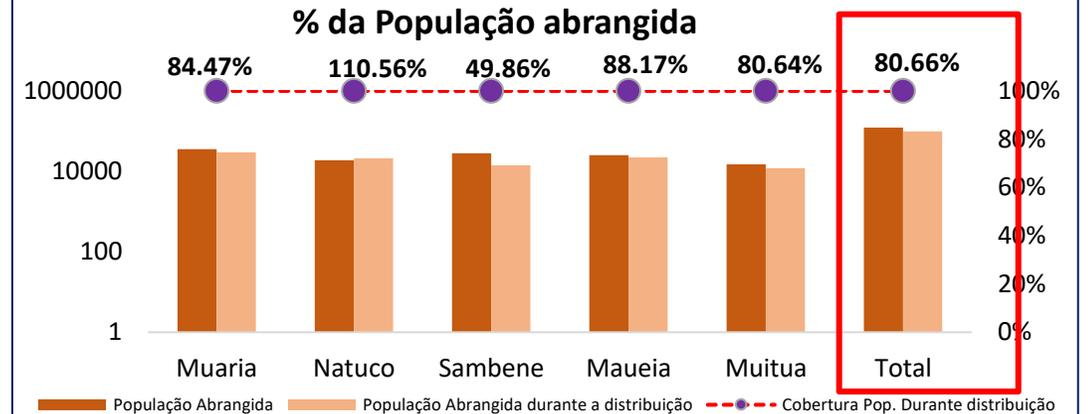| N	Fases da CCU - Abordagem de emergência	Adaptações
1	Engajamento com as lideranças	Adaptada aos encontros regulares DPS/SPS e PNCM
2	ToT e Microplanificação Provincial	Virtual com a equipa de coordenação provincial apenas
3	Capacitação dos Jornalistas	Formação local, jornalistas sem formação
4	Advocacia com as lideranças distritais	Diálogos comunitários através comités de saúde
5	Formação de monitores locais para o registo dos AF	Realizada na sede do distrito em etapa única
6	Formação de registadores para mobilização e registo dos AF	Sem modificação
7	Registo dos AF	Redução de tempo de registo dos AF (de 7 para 4 dias)
8	Ajuste do microplano distrital (geral e logística)	Considerou-se a informação do registo de AF para a distribuição
9	Formação das equipas de distribuição	Redução de tempo de registo dos AF (de 2 para 1 dia)
10	Distribuição de RTI Logística Reversa e Gestão de resíduos sólidos	Manteve-se a estratégia de PD com a redução do tempo (de 7 para 5 dias)

Fase de Registo_Mecúfi

Agregado Familiar

% de Agregados Familiares registados

	Muaria	Natuco	Sambene	Maueia	Muitua	Total
% AF registados	116.61%	90.12%	95.97%	68.23%	76.44%	88.68%

Legend: AF Prevista, AF Registados, % AF registados

População Abrangida

% da População abrangida

	Muaria	Natuco	Sambene	Maueia	Muitua	Total
% População Abrangida	164.24%	124.52%	137.10%	89.78%	94.93%	121.24%

Legend: População Prevista, População Abrangida, % População Abrangida

% de **Quantidade de RTI necessária e desvio de defice de Redes**

	Muaria	Natuco	Sambene	Maueia	Muitua	Total
% RTI Necessária	160.75%	121.70%	133.84%	88.47%	94.00%	132.12%
% Defice RTI	-78.62%	-35.24%	-48.70%	1.70%	-4.44%	-32.1%

Legend: RTI Previstas, RTI Necessárias no registo, % RTI Necessária, % Defice RTI

Registo	População			Agregados familiares			Redes Mosquiteiras		
Provincia	População Prevista	População registada	% População registada	AF Previstos	AF Registados	% AF Registados	Redes Planificada	Redes necessária	% Redes necessárias
Mecúfi	101 561	123 130	**121%**	25 400	22 525	**89%**	50 779	67 087	**76%**

Fonte: Salama

Fase de Distribuição_Mecúfi

Agregado Familiar

% de AF abrangidos

AF Registados | AF distribuidos RTI | Cobertura distribuição

Valores: 83.32% (Muaria), 105.87% (Natuco), 51.87% (Sambene), 88.18% (Maueia), 79.65% (Muitua), 80.24% (Total)

Poulação Abrangida

% da População abrangida

População Abrangida | População Abrangida durante a distribuição | Cobertura Pop. Durante distribuição

Valores: 84.47% (Muaria), 110.56% (Natuco), 49.86% (Sambene), 88.17% (Maueia), 80.64% (Muitua), 80.66% (Total)

% de RTI distribuidas

RTI Necessárias no registo | RTI Distribuidas | % RTI distribuidas

Valores: 81.57% (Muaria), 106.34% (Natuco), 48.85% (Sambene), 85.61% (Maueia), 78.90% (Muitua), 78.23% (Total)

Distribuição	População			Agregados familiares			Redes Mosquiteiras		
Provincia	População Planificada	População alcançada	% População alcançada	AFPrevistos	AF Beneficiados	% AF beneficiados	Redes Planificada	Redes Distribuídas	% Redes Distribuídas
Mecúfi	123 130	102 376	**83%**	22 525	18 638	**83%**	67 087	54 111	**81%**

Fonte: Salama

CCU nas áreas em conflitos político militar

Distritos de Bloco II (Ibo, **Macomia**, Meluco, Mocímboa da Praia, Mueda, Muidumbe, Nangade, Palma e Quissanga): 08 a 12 de Abril de 2025.

Mista : Porta a Porta (PP) e Posto fixo adaptado (PD)	
Composição da equipa:	• **Registador/mobilizador – Membro Permanente** • **Distribuidor e Guia – Equipa apoio, membros da comunidade**
Instrumentos-chave	• **Telemóvel** • **Autocolante (Verde)**

A distribuição das RTI foi executada com apoio de segurança nacional.

Parceria das Forças Armadas de Defesa de Moçambique (FADM), das Forças Amigas do Ruanda e da Polícia da República de Moçambique (PRM).

Articulação multissectorial, o Governo Distrital e lideranças locais, garantiu a integridade das equipas e do material através de escoltas militares.

A digitalização da CCU foi baseada na plataforma Salama.

Dispositivos: Telefones Samsung A03 Core
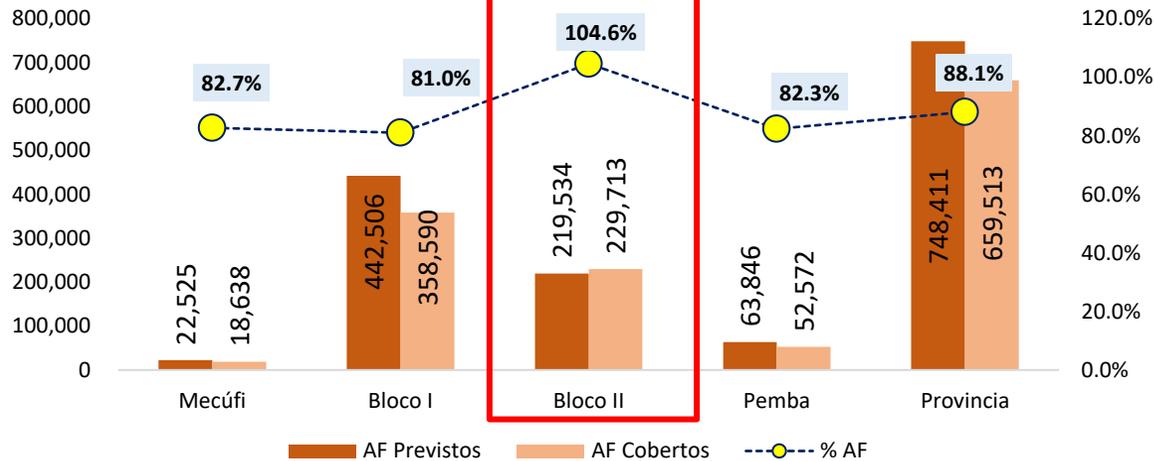**Software gestor de dispositivos móveis**: Scalefusion

Adaptação das fases_Zonas em conflitos

N	Fases da CCU	Adaptações
1	Reunião de engajamento com as lideranças provinciais e distritais	Sem adaptação
2	ToT e Microplanificação Provincial	Sem modificação
3	ToT provincial para implementação Capacitação dos Jornalistas	Sem adaptação
4	Advocacia com as lideranças distritais Mobilização distrital para o registo e distribuição	Sem adaptação
5	Formação de Monitores locais para o registo dos agregados familiares e distribuição das RTI Formação dos fiéis de armazém Comunitários	Sem adaptação
6	Mobilização para o Registo e distribuição dos Agregados Familiares:	Exclusivamente feita pela liderança local e sem formação, apenas partilha de mensagens-chave
7	Formação de registadores para para mobilização, registo e distribuição Pré-posicionamento das RTI	Realizada na sede do distrito. Para o efeito de pré-posicionamento foram usadas camionetas como armazéns móveis em áreas menos seguras e em escolas ou US onde oferecesse mais segurança.
8	Registo e distribuição das RTI Logística Reversa e Gestão de resíduos sólidos	Estratégia mista, áreas segura implementada estratégia porta a porta e áreas inseguras implementada posto fixo adaptado sem uso de senhas Recolha das equipas no campo mais cedo
9	Sem adaptação	Sem adaptação
10	Balanço distrital	Sem adaptação
11	Mobilização pós-distribuição	Sem adaptação

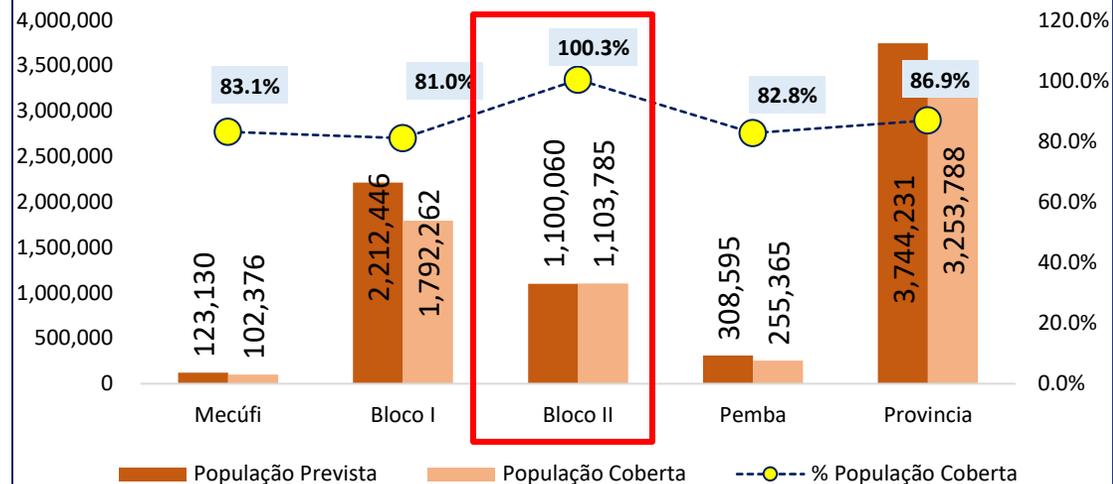# Registo e Distribuição_Zona de Conflitos
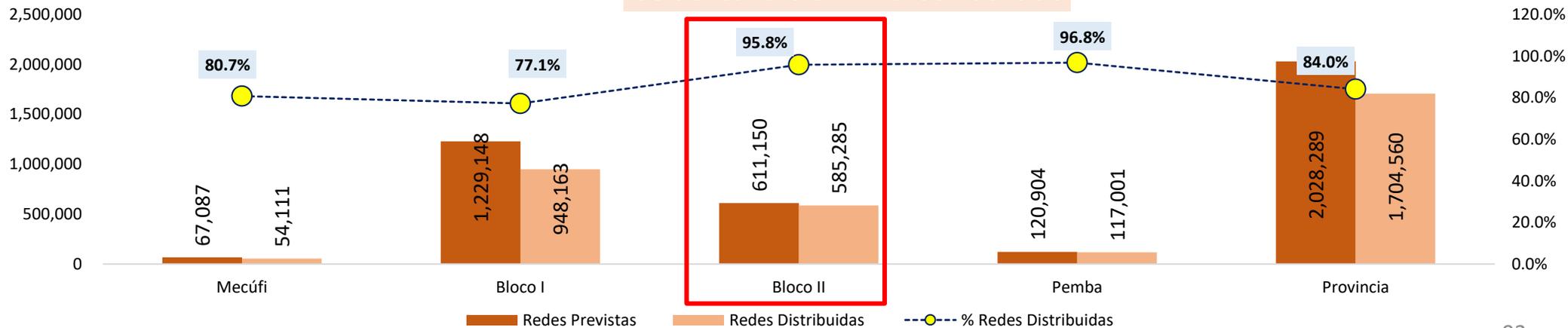
Agregado Familiar

% de Agregados distribuídos RTI

Legend: AF Previstos | AF Cobertos | % AF

Valores:
- Mecúfi: 22,525 / 18,638 — 82.7%
- Bloco I: 442,506 / 358,590 — 81.0%
- Bloco II: 219,534 / 229,713 — 104.6%
- Pemba: 63,846 / 52,572 — 82.3%
- Provincia: 748,411 / 659,513 — 88.1%

População Abrangida

% da População abrangida durante a distribuição

Legend: População Prevista | População Coberta | % População Coberta

Valores:
- Mecúfi: 123,130 / 102,376 — 83.1%
- Bloco I: 2,212,446 / 1,792,262 — 81.0%
- Bloco II: 1,100,060 / 1,103,785 — 100.3%
- Pemba: 308,595 / 255,365 — 82.8%
- Provincia: 3,744,231 / 3,253,788 — 86.9%

Cobertura de RTI distribuídas

Legend: Redes Previstas | Redes Distribuidas | % Redes Distribuidas

Valores:
- Mecúfi: 67,087 / 54,111 — 80.7%
- Bloco I: 1,229,148 / 948,163 — 77.1%
- Bloco II: 611,150 / 585,285 — 95.8%
- Pemba: 120,904 / 117,001 — 96.8%
- Provincia: 2,028,289 / 1,704,560 — 84.0%

Fonte: Salama 20.04.2025

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Cobertura nas_Zonas em Conflitos

Registo e Distribuição		População			Agregados familiares			Redes Mosquiteiras		
Blocos	Distritos	População Prevista	População alcançada	% População alcançada	AF Previstos	AF Beneficiados	% AF beneficiados	Redes Previstas	Redes Distribuídas	% Redes Distribuídas
Bloco II	Ibo	29 909	30 876	**103%**	5 981	7 913	**132%**	16617	12562	**76%**
	Macomia	151 162	163 917	**108%**	30 235	32 253	**107%**	83978	87204	**104%**
	Meluco	46 187	48 857	**106%**	8 755	9 986	**114%**	25657	26723	**104%**
	Moc. Praia	171 821	183 189	**107%**	34 366	34 127	**99%**	95459	96017	**101%**
	Mueda	274 759	248 754	**91%**	54 955	51 659	**94%**	152646	132267	**87%**
	Muidumbe	119 109	111 749	**94%**	23 823	22 445	**94%**	66172	59911	**91%**
	Nangade	113 675	118 412	**104%**	22 735	27 893	**123%**	63158	64379	**102%**
	Palma	130 334	123 909	**95%**	26 063	28 285	**109%**	72405	66769	**92%**
	Quissanga	63 104	74 122	**117%**	12 621	15 152	**120%**	35058	39453	**113%**
Total		**1 100 060**	**1 103 785**	**100%**	**219 534**	**229 713**	**105%**	**611 150**	**585 285**	**96%**

Principais Desafios

Zona com Ciclone

Coordenação

- Remoção e/ou encurtamento em algumas fases
- Vias de acesso intransitáveis por causa das chuvas
- Passagem de mensagens chave deficiente
- Estimação de recursos
- Deficiente pagamentos dos actores comunitários
- Distribuição anteriores de alimentos não abrangente
- Falta de recursos adicionais (finanças e RTI)
- Incertezas na garantia de uso da RTI
- Falta de armazéns intermediários para RTI

M&A e digitalização

- Indisponibilidade de rede móvel e de electricidade;
- Definição de denominadores para indicadores
- Dificuldade na sincronização de dados e monitoria da campanha durante a implementação

Zonas de Conflitos

Coordenação

- No acesso aos locais inseguros
- Disponibilidade de viaturas para locais inseguros
- Logística para escoltar militares
- Incertezas na garantia de uso da RTI
- Falta de armazéns intermediários para RTI

M&A e digitalização

- Disponibilidade de rede móvel e de electricidade
- Dificuldade na sincronização de dados e monitoria da campanha durante a implementação
- Registadores sem o perfil necessário (habilidades de manejo de dispositivos para registo)
- Definição de denominadores para indicadores

.

Lições aprendidas

Zona com Ciclone

- Planificar a presença das forças de segurança para garantir distribuição ordeira nas zonas afetadas por desastres
- Elaborar protocolo específico para responder casos de emergência complexas
- Adaptação e flexibilidade para o ajuste a situações de emergências
- Necessidade de um instrumento orientador para implementação de campanha em locais de emergência

Zonas de Conflitos

- O envolvimento e engajamento da liderança a todas fases da campanha
- Planificar a presença das forças de segurança para garantir distribuição ordeira nas zonas de conflito político militar
- Necessidade de um instrumento orientador para implementação de campanha em locais conflitos político militar

Recomendações

- Elaboração de manual de implementação de campanhas em contexto de ciclone e de conflito político militar

- Plano de resposta a emergência para redução de tempo de resposta

- Reforçar o engajamento para maior apoio do governo na movimentação para zonas de ciclone e conflitos político militar

- Envolver activamente as equipas de FDS nas fases de formação, registo e distribuição de RTI nas zonas de ciclone e conflito político militar

Agradecimentos para:

Results and lessons learned in providing SMC in Kalobeyei and Kakuma refugee camps in Northwest Kenya

SMC Alliance Annual Meeting

David Ekai, Turkana County Malaria Coordinator

Why SMC in Turkana

Turkana Administrative Map

- Turkana County is the largest county in Kenya and borders Uganda to the west and Sudan and Ethiopia to the North
- Experiences less than 15 cm of rainfall each year and as a result, many families in Turkana are semi-nomadic, moving with their herds in search of pasture
- Turkana has one of the highest malaria burdens and has demonstrated seasonality with 65% of the cases occurring between June and October
  - Prevalence rate of 39%, vs national average of 6%, with substantial seasonal surges.
  - 474/1000 confirmed malaria cases vs a national average of 81/1000
- Kakuma and Kalobeyei one of the largest refugee camps in Africa with **308,415** registered refugees and asylum seekers (UNHCR 2025)
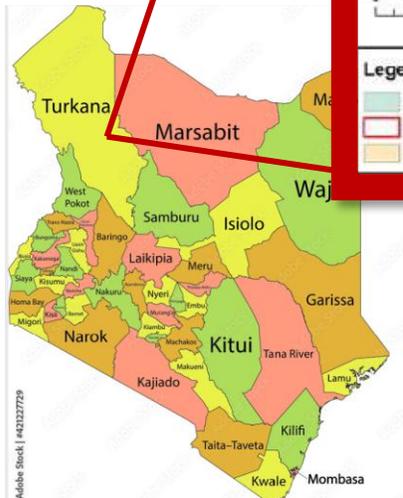
Current Turkana Malaria Epidemiological Profile
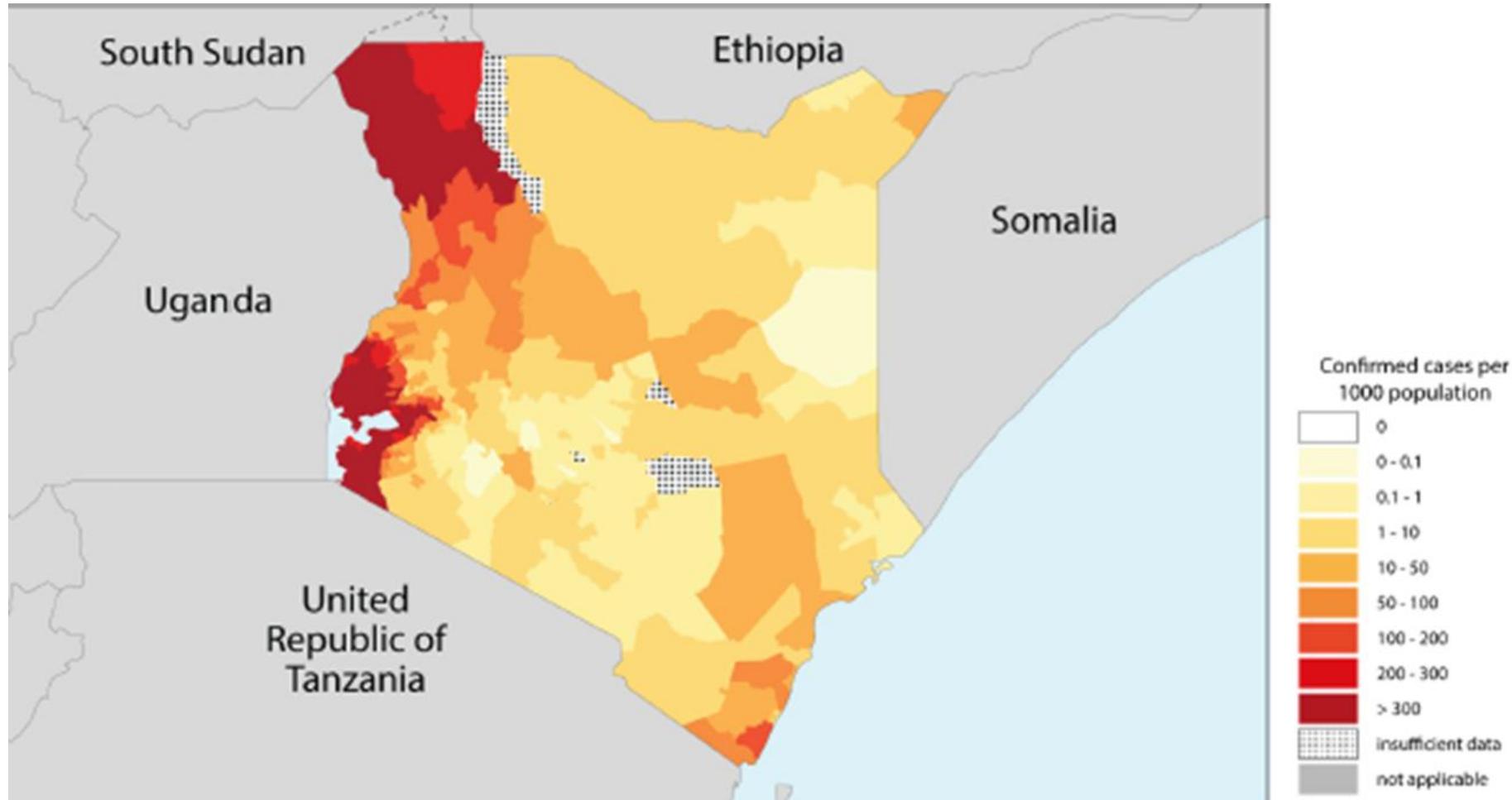
Introduction of SMC in Turkana County (in 2024)

- SMC has been implemented by the National Malaria Program and County Government of Turkana, and supported by CRS, and Moi and Duke University since 2024

- In 2024, the results of a pilot in Turkana Central were very positive with:
  - 37,767 (98% of target) children under five reached with SMC
  - 97% of children reached with at least one cycle of SMC
  - 71% of children received all 5 cycles

- An evaluation post-campaign revealed that SMC reduced the incidence of malaria by 71% in Turkana Central compared to Turkana North sub-county.

- Purposeful evidence-based policy advocacy resulted in the inclusion of SMC in the Kenya National Malaria Policy and Strategic Plan (2023 – 2027)

- These achievements led to a second round of SMC in Turkana Central and an expansion of SMC in Kakuma and Kalobeyei (Turkana West)

Malaria trends in Kakuma and Kalobeyei 2023-2025
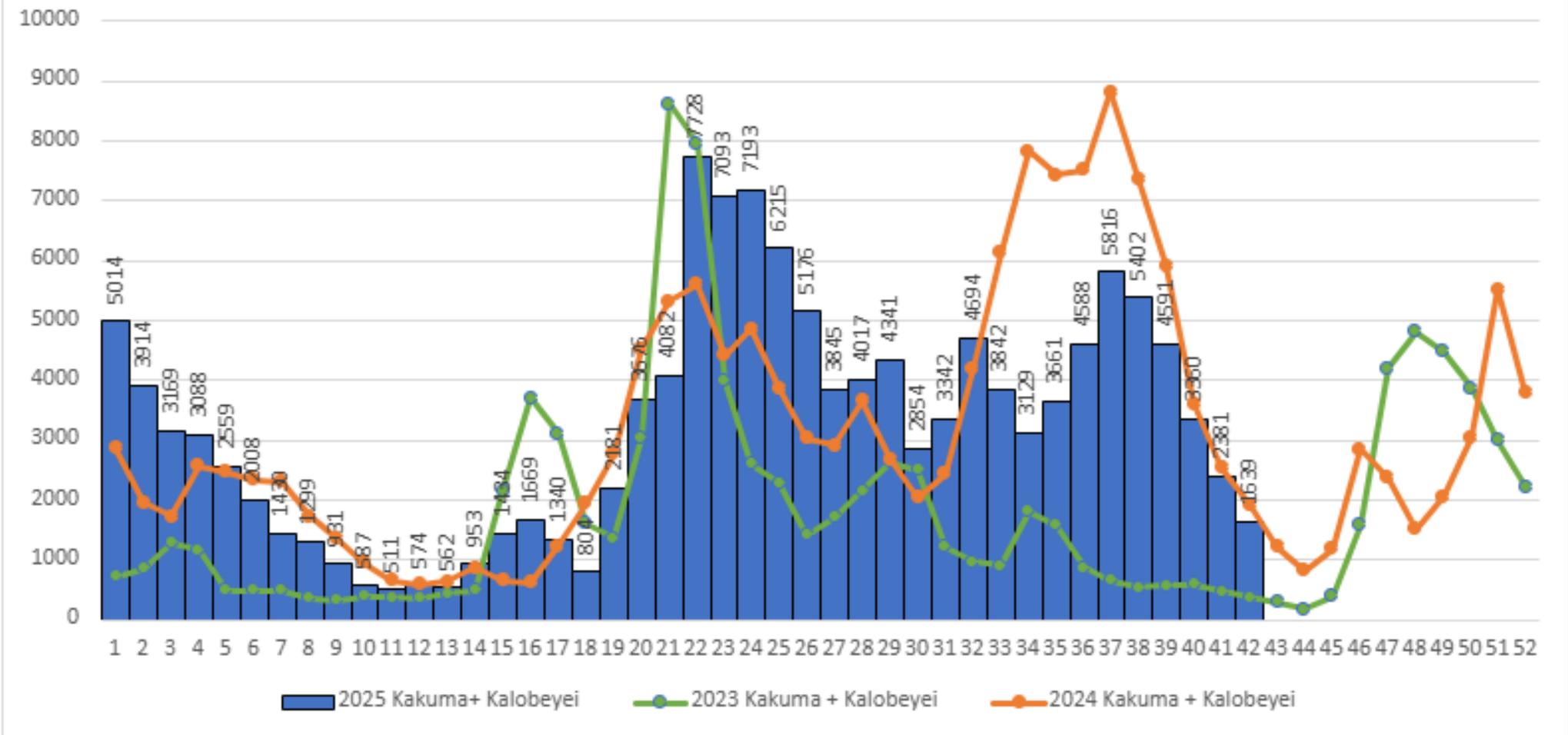
SMC in Kakuma and Kalobeyei

- In 2025, further collaboration with UNHRC, IRC and Kenya Red Cross led to the expansion of SMC in Kakuma and Kalobeyei refugee camps.

- The intervention specifically targeted a total of **33,958 children aged 3 to 59 months**.

- Key distribution approaches included door-to-door and fixed-point delivery by trained Community Health Promoters (CHPs), under the supervision of Community Health Assistants and Health Facility In-charges.

- **SPAQ** - Sulphadoxine Pyrimethamine (SP) and amodiaquine (AQ) – was administered among children aged **3-59 months** for 4 **monthly cycles** between July and October 2025.

- SMC Workforce – Supervisors, 242 CHPs, 25 HCWs across 7 HFs

Deputy governor administering SPAQ to eligible child at Natukobenyo during SMC launch In Turkana West Sub County.

Kakuma & Kalobeyei (2025): 35,623 Children U5
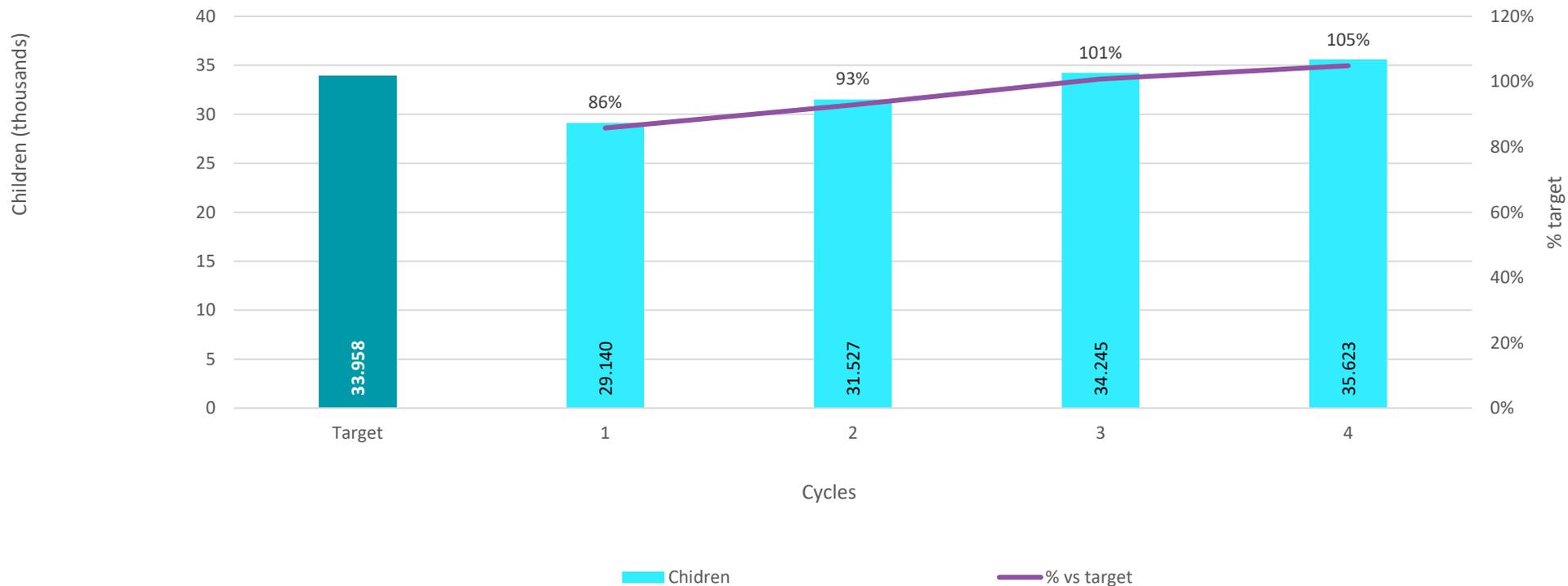
Key adaptations and lessons learned

COMMUNITY DISTRIBUTORS (CHP)

- CHPs are not from Kenya; they are from different countries; move in and out of the camps, speak different languages
- CHPs are highly skilled professionals (unlike in other areas of Kenya)
- Continuous refresher training for CHPs after every cycle
- Addressing myths and misconceptions through CHPs to boost community acceptance

COMMUNITY ENGAGEMENT

- Community entry meetings through village elders, church leaders through CHPs from the different communities.
- Use of public address (PA) systems in languages spoken in the camps in key community points
- Digital platforms, particularly WhatsApp groups for timely campaign information
- Drugs stored in UNHCR/IRC Warehouses

SERVICE DELIVERY

- Door to door distribution main delivery model
- Use of mobile fixed points in strategic community points worked well for the densely populated refugee camps
- Timing of distribution – across the weekend to achieve higher coverage
- Early repositioning of SPAQ drugs and tools before the SMC cycle begins.

ADVOCACY AND PARTNERSHIPS

- Collaborated with UNHCR and other partners to expand SMC into Turkana West Subcounty.
- Engagement meetings with key stakeholders such as the School Management, block leaders and religious leaders
- Partnership with FilmAid to air tailored audio-visual messages in high-traffic areas

QUALITY ASSURANCE

- CHPs collected primary campaign data using manual registers.
- Supervision undertaken using digital tools to monitor CHPs.
- Data spot checks to verify data quality, adherence to dosing protocols and caregiver follow up dosing (Day 2 and Day 3).
- Daily debrief meetings at the facility with all CHPs.

Challenges

- Migration of refugees within and outside the camp
- Minimal supervision due to logistical and security challenges
- Poor marking of SMC cards by caregivers and some CHPs
- Poor screening of some children for contraindications by CHPs
- Insecurity in parts of Kakuma
- Rains affected accessibility in some blocks in Kakuma
- Multiple languages/communities in the camp

Key steps & Recommendations

- **Resource mobilization and increased partnerships** to support the expansion of SMC to include **host community children** in Turkana West

- **Impact and economic evaluation studies** in the refugee camp to document key adaptations and inform scale up.

- **Integration of SMC with other Primary Health Care services** including nutrition, immunization with a focus on Zero Dose children and missed children

- **Age group expansion** to include children 5-9 years **(rising cases among children over five across the county)**

Thank you

Outline

1- Background

2- Campaign planning

3- Data, digital tools and monitoring

4- Success factors
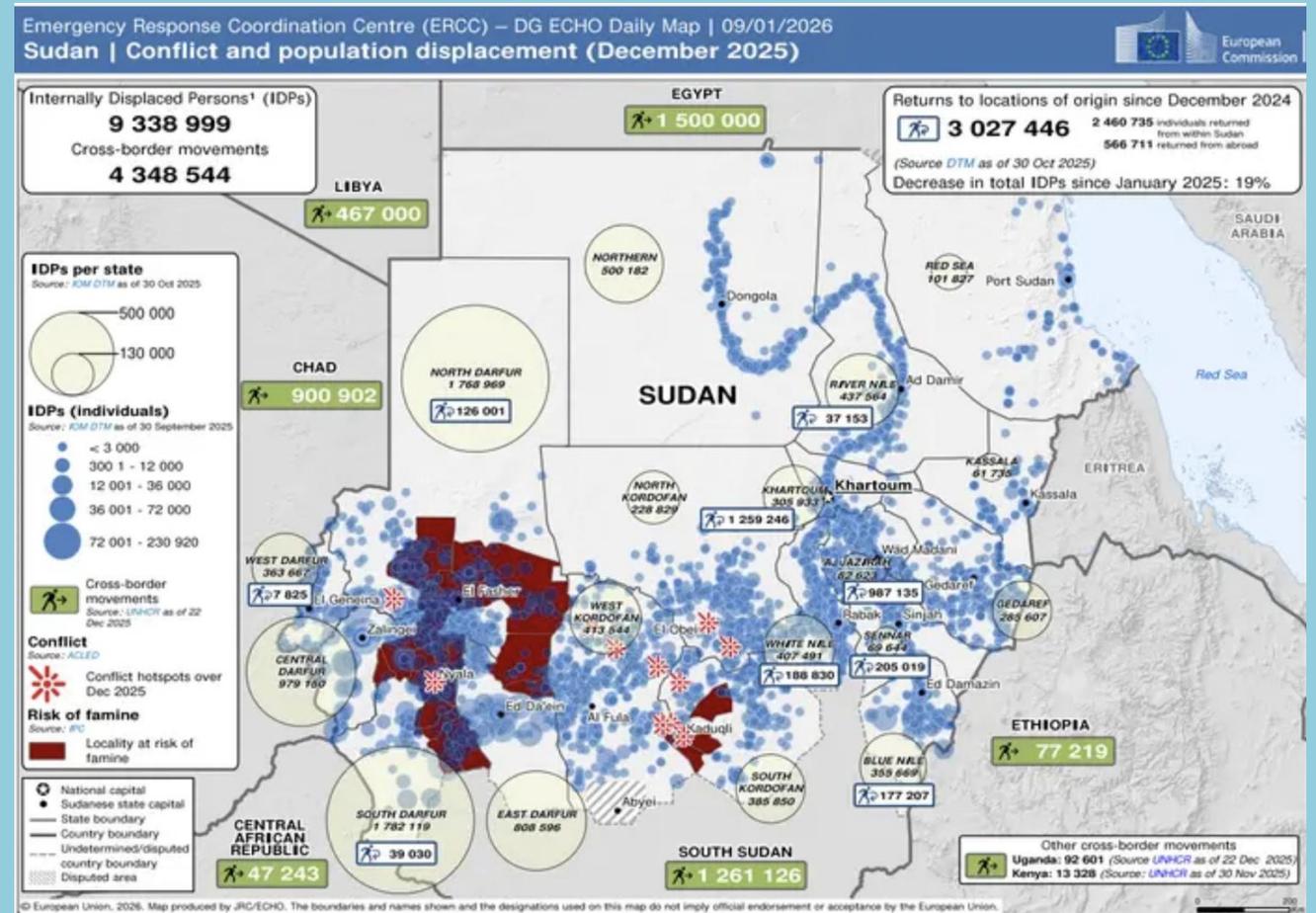
5- Challenges

6- Lessons learned
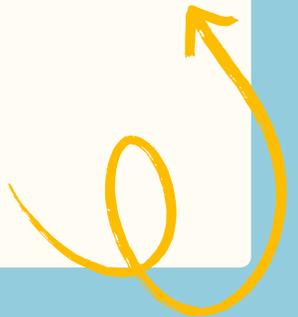
Campaign goal and targets

- The campaign aims to achieve universal population access to effective ITNs in the targeted areas and sustain correct and consistent use, care and repair of ITNs at 90% by 2025

- The campaign targets 141 localities across 14 states

- The total number of nets targeted for distribution is 15,654,185
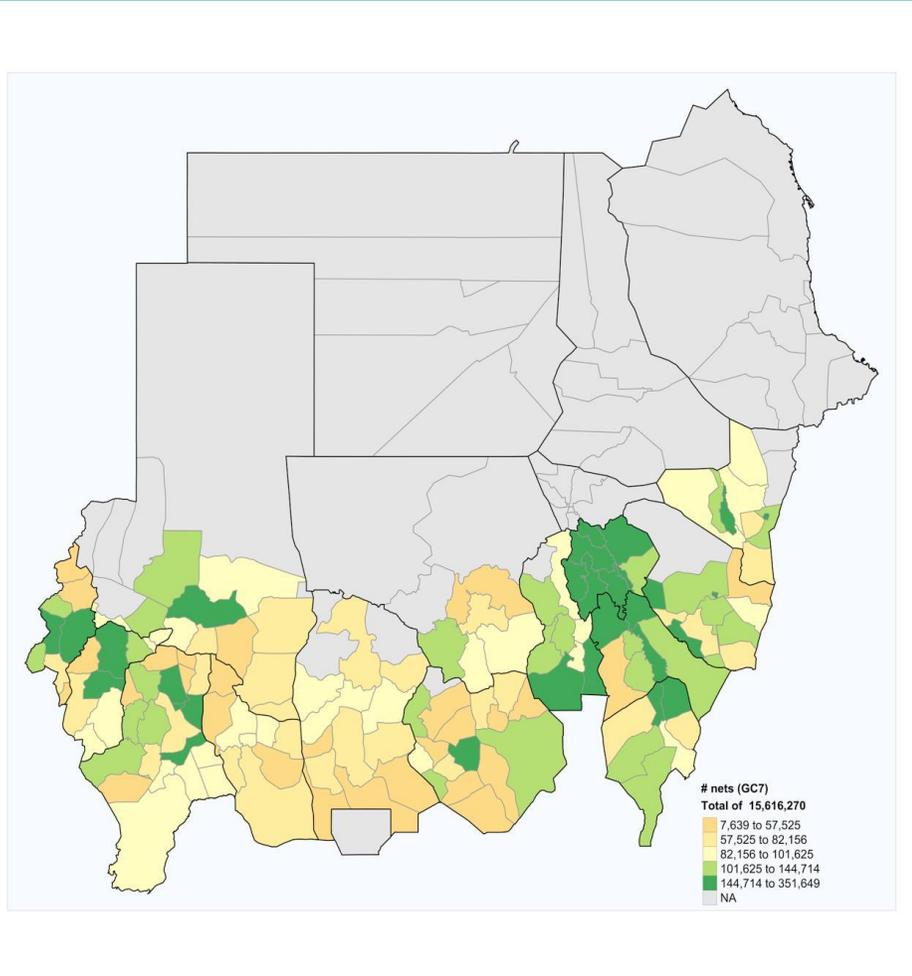
Context: Sudan Conflict

- Sudan has been experiencing armed conflict between the Sudanese Armed Forces (SAF) and the Rapid Support Forces (RSF) since April 2023, and the conflict continues to this day

- The conflict has led to a massive displacement of people from affected states to safer states and across the borders (more than 9 million IDPs, 4 million refugees as of December 2025)

Emergency Response Coordination Centre (ERCC) – DG ECHO Daily Map | 09/01/2026
Sudan | Conflict and population displacement (December 2025)

Campaign planning: Key challenges linked to context

The planning took place under difficult and complex circumstances due to the war, including:
- Difficulty in obtaining accurate population data due to population movement
- Deteriorating security situation in most of the targeted states
- Large and continuous displacement between states and localities
- Instability of health personnel at sub-national levels
- Difficulties with ITN transport within the scheduled timeframe; supply chain disruptions, including border closures or customs delays
- Weak communication and internet networks
- Restricted physical access to certain localities due to road insecurity, checkpoints and/or damaged infrastructure
- Banking and cash liquidity constraints affecting payments to suppliers and field staff
- Competing humanitarian priorities, especially in areas facing food insecurity or outbreaks
- Misinformation or rumors reducing local government and community acceptance or participation

Campaign implementation arrangements to align to context

Stable accessible states

Implemented by: State MOH directly
Major challenge: Massive IDP influx
Planning lead: FMOH, SMOH with NCTC
Personnel: Existing MOH staff

Unstable and less accessible states

Implemented by: UNICEF (as neutral UN agency) and SMOH and local implementing partners (NGOs)
Major challenge: Access & security
Planning lead: UNICEF-FMOH coordinating with SMOH
Personnel: Selected jointly by FMOH, UNICEF, SMOH

Campaign strategy to align to context

- Two-phase strategy with reduced time between household registration and ITN distribution at fixed sites
- Microplanning done post-household registration to allow for ITN positioning to be based on the most realistic population figures possible
- Allocation of nets planned at 1 net for 2 people with no cap
- Planning for distribution points included fixed and mobile sites to ensure population access to nets in targeted areas

Distribution point –East Darfur

Campaign strategy and planning

Adaptation	How It Worked
Integrated microplanning + household registration	Mitigated the challenge of inaccurate population data; reduced time and cost
Payment mechanism	Payment through financial companies used to overcome absence of banking facilities in conflict states
UNICEF delivered nets to states	Ensured nets reached targeted locations including cross-line
Virtual SST training	Provided venues and internet access for participants to gather in one location to ensure ability to participate.
Joint personnel selection	Coordinated by FMOH, UNICEF and MOH in conflict states
Local MOH participation in planning	State teams assessed situation, provided available data, and agreed on best implementation approach in conflict states
Stronger local community engagement	Guarantee community ownership and participation in security and organization of distribution

Campaign implementation

Due to delays in the arrival of nets and the security situation in some states, the campaign was divided into three phases

Phase 1:
April to June 2025
- Gedaref
- Blue Nile
- White Nile
- South Kordofan (Eastern Part)

Phase 2:
July to Oct 2025
- Kassala
- Gezira
- Sennar
- North Kordofan
- South Darfur
- East Darfur
- Central Darfur
- West Darfur

Phase 3:
February to March 2025
- North Darfur
- West Kordofan
- South Kordofan (Western Part)

Key issues faced during the campaign – 1

- Targeted stable states were hosting a large number of IDPs from conflict states, thus increasing their population

- As a result of the population increase in the targeted stable states, the distribution strategy was changed from one net per two persons to capping the distribution of available nets

- Budget limitations affected campaign activities; local governments and communities contributed by providing storage facilities, transporting the nets, vehicles, fuel, and hospitality for supervisors and volunteers

Distribution point –White Nile
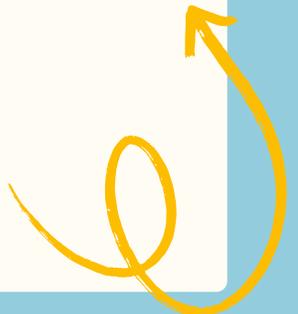
Key issues faced during the campaign – 2

- Unstable population numbers and ongoing population movement led to a revision of the ITN allocation in some states and localities, affecting ITN access in households
- High cost of transport due to increased fuel prices
- Difficulties in movement during the rainy season in all states
- Dynamic security situation and continuous adaptation of plans
- In some areas, the campaign was delayed until roads were reopened

Nets transport- South Darfur

Transport of nets in Um Dukhun –C. Darfur

Solutions: The local contribution

- Partners and national organizations, contributed to supporting the campaign by providing personnel and printing services to address shortages
- Ministry of Health's platform was activated to disseminate information and address rumors
- State MOH coordination with the Humanitarian Aid Commission, partners, national organizations, camp leaders, community leaders and shelter managers
- Local governments contributed to the transportation and security of personnel and nets

Contribution of SRC to transport nets in Central Darfur

Successes from the campaign

- The availability of qualified MOH personnel with experience in managing campaigns in the affected states
- Good coordination with all stakeholders, including UNICEF, FMOH and the MOH in the affected states
- Early participation of MOH staff in the affected states during the planning process allowed for the utilization of their experience and suggestions
- The selection of UNICEF to lead the campaign in the affected states was highly appropriate because UNICEF is an UN agency that accepted by all parties


تدشين توزيع الناموسيات المشبعة بمحلية ام روابة من إدارية ودعشانا

Successes from the campaign – 2

- Partners in national and non-governmental organizations contributed to supporting the campaign
- Local communities played a clear role in the campaign by hosting volunteers, providing hospitality, and sometimes transporting the nets
- Community leaders, religious leaders, and other influential individuals facilitated campaign activities and awareness efforts
- Ongoing communication between the national level and the affected states teams through regular meetings
- Alternative means of transportation were used instead of cars, such as animals and boats.
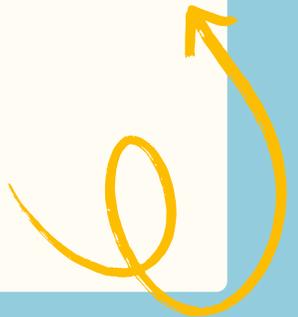
Successes from the campaign – 3

Local contributions to the campaign cost:
- State-level storage facilities are provided by MOH
- Communities provided transportation support when needed
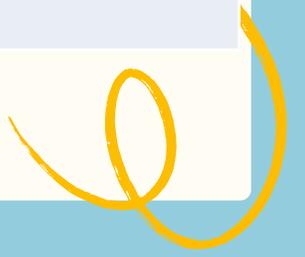- Personnel extra time was donated
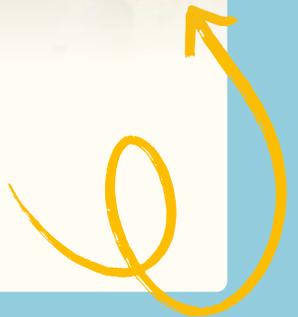
Phase 1: Nets distributed by states

No.	State	Nets targeted for distribution	Nets distributed	%
1	White Nile	1,089,025	1,086,287	99.7
2	Blue Nile	786,990	786,900	100.0
3	El Gadaref	1,404,451	1,682,300	119.8
4	North Kordofan	444,573	415,038	93.4
5	South Kordofan(Eastern Sector)	470,978	616,450	130.9
	Total	4,196,017	4,586,975	109.3

Phase 2: Nets distributed by states

No.	State	Net targeted for distribution	Nets distributed	%
1	Kassala	1,211,500	1,209,590	99.8
2	Sennar	826,996	826,946	100.0
3	Gezira	1,681,621	1,714,648	102.0
4	South Darfur	2,081,522	2,079,500	99.9
5	West Darfur	1,031,059	987,771	95.8
6	East Darfur	645,167	641,141	99.4
7	Central Darfur	949,455	685,832	72.2
	Total	8,427,320	8,145,428	96.7

ITN tracking survey results for Phases 1 & 2

No.	Indicator	%
1	Proportion of population that slept under an insecticide-treated net the previous night.	53.6%
2	Proportion of children under five years old who slept under an insecticide-treated net the previous night.	53.2%
3	Proportion of households with at least one insecticide-treated net for every two people.	43.7%
4	Proportion of households with at least one mosquito net	95.8%

Coverage by ITNs distributed in 2025

% Coverage of LLINs distributed by state in 2025

Legend
- States Not targeted
- State under implementation
- States /Localities Not implemented
- 1 - 72%
- 73 - 102%
- 103 - 131%
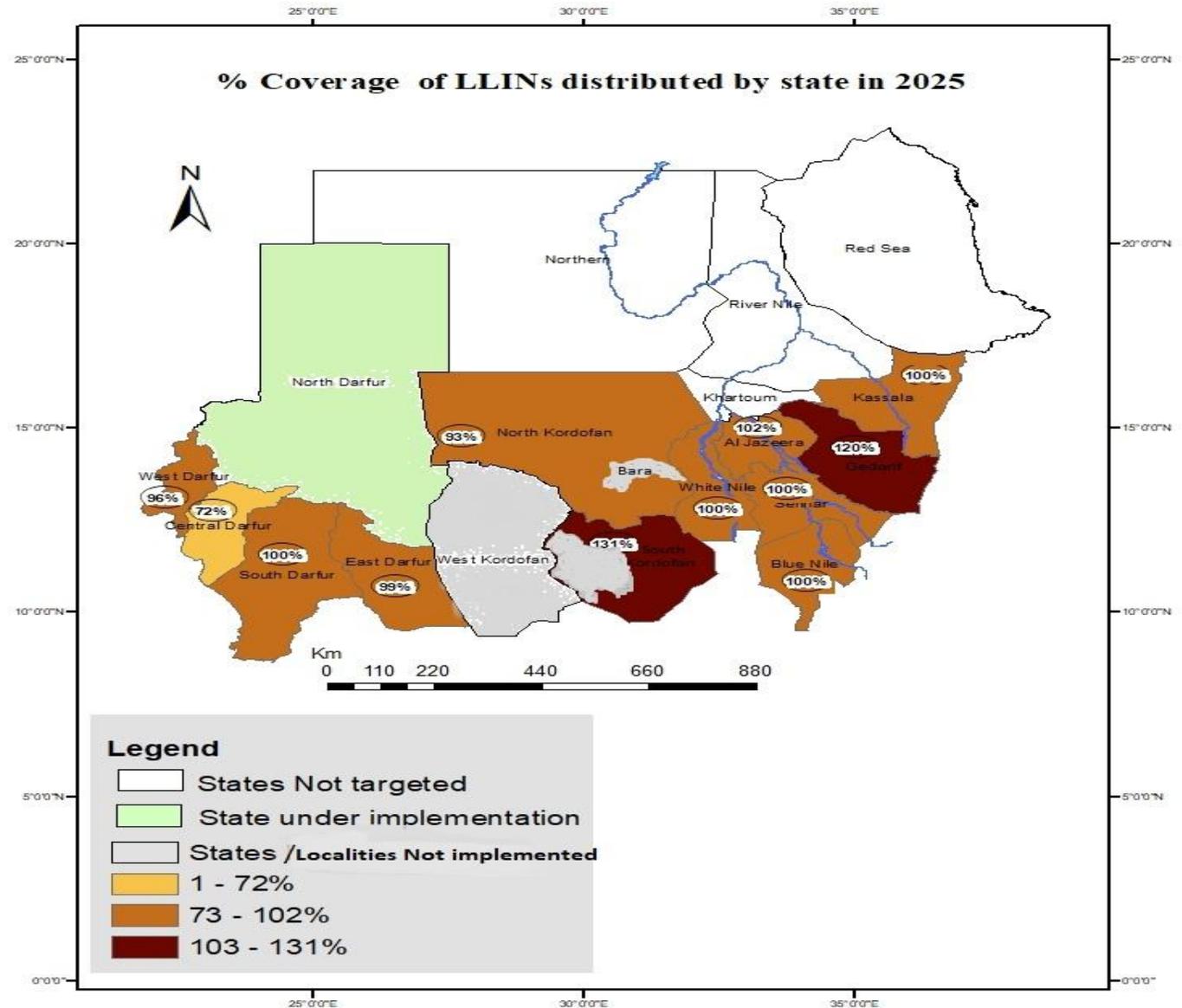
Phase 3 – Adjusting strategies to context

Context:
- Targeting two unstable states (North Darfur and West Kordofan), in addition to the remaining localities in South Kordofan from Phase 1
- Implementation is not possible to start in West and South Kordofan due to the security situation and ongoing military operations
- Campaign activity in North Darfur is currently suspended pending authorization from the state's Humanitarian Aid Commission

Adjustments:
- Alternative plan was developed to utilize the remaining nets from West and South Kordofan for distribution to IDPs from these states in three safer states (North Kordofan, White Nile, and Northern state)
- Remaining nets will be put into the routine system in states where the malaria vaccine is being rolled out to encourage attendance for first dose

Lesson learned – Summary – 1

Differentiated implementation models work: Dividing states into safe (led by FMOH/SMOH) and conflict-affected (led by UNICEF) ensured continuity of implementation.

Early involvement of state MOH teams improves ownership and feasibility.

Strong national–state coordination mechanisms reduce misunderstandings and operational gaps.

Integrating microplanning with HHR improves accuracy, reduces cost, and saves time in unstable population contexts.

Flexible allocation strategies (capping vs. 1 net per 2 persons) are necessary in displacement-heavy settings.

Lesson learned – Summary – 1

Phased implementation allows adaptation to security and supply constraints.

Local storage and transport support significantly reduce operational bottlenecks.

Local government and community contributions can compensate for budget shortfalls.

Contingency redistribution plans are essential (e.g., reallocating nets to IDPs in safer states when access is denied).

Engagement of community leaders and religious leaders improves acceptance and uptake.

Conflict programming requires continuous adaptation rather than fixed planning models.

Thank YOU !

Discussion - Questions & Answers

Discussion - Questions et réponses

Discussão – Perguntas e respostas

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

Joint Annual Meetings of the SMC Alliance and the Alliance for Malaria Prevention

KAMPALA, UGANDA — 24-27 FEBRUARY 2026

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