Malaria Ministerial Conference:
“Tackling malaria in countries hardest hit by the disease”

Yaoundé, Cameroon, 6 March 2024

Country profiles

Contents

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Burkina Faso

Background

Malaria remains a major public health problem in Burkina Faso. According to the annual national health statistics (SNIS), malaria accounted for 38% of consultations, 63% of hospitalizations and 18% of deaths in health facilities in 2022. Pregnant women and children under 5 are the most vulnerable groups. From a socioeconomic point of view, malaria constitutes a real obstacle to sustainable human development due to its impact on life expectancy, children's education, productivity, family and national savings.

Several factors contribute to the persistence of malaria in Burkina Faso, including low levels access to sanitation, declining antimalarial drugs and resistance of vectors to insecticides, unfavourable attitudes and practices among the population.

During last decade, Burkina Faso has made the control of malaria a major national priority through demonstrated political will and subscription to global initiatives to combat malaria such as the HBHI approach, the "Zero malaria, I'm committed" initiative and the initiative for the malaria elimination in the Sahel (SaME).

To reflect its political will and commitment to accelerate progress in the fight against malaria, the Government established the PNLP in 2022 as the Permanent Secretary for Malaria Elimination by 2030 (SP/Palu). The SP/Palu guides control efforts through strategic plans developed in accordance with the National Health Development Plan.

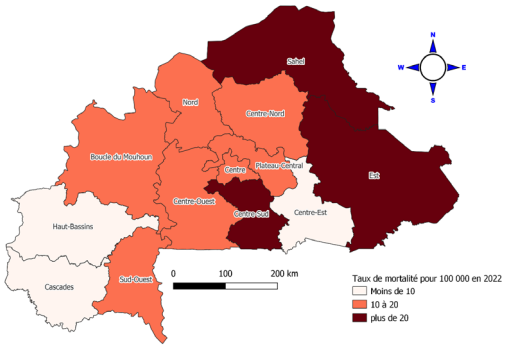
The major interventions carried out are among other:

- Universal coverage with LLINs (one for every two people). In 2022–2023, more than 14 million new generation LLINs (PBO, IG2) were distributed in 68 out of 70 districts.
- Free seasonal malaria chemoprevention (SMC) campaign for children aged 3–59 months during transmission season. In 2022, 4.1 million children (94%) benefited from SMC.
- In 2016, Burkina Faso adopted a free healthcare policy for children under 5 and pregnant women, explaining the relatively low related mortality.

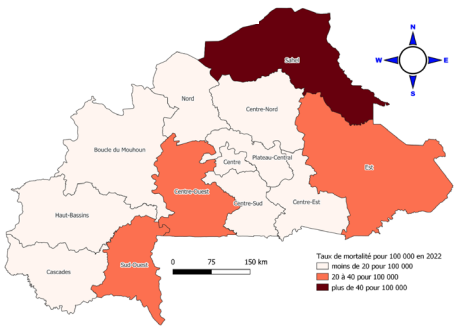
Eight provinces accounted for about 70% of reported cases and deaths in 2022

Province	No. of cases	No. of deaths	% attributed in cases
Centre	**1,400,565**	**451**	**12.0%**
Centre Est	**1,266,586**	**315**	**10.9%**
Hauts Bassins	**1,153,436**	**427**	**9.9%**
Centre Ouest	**1,149,260**	**239**	**9.9%**
Est	**1,066,290**	**461**	**9.1%**
Nord	**923,649**	**315**	**7.9%**
Boucle du Mouhoun	**869,288**	**341**	**7.5%**
Centre Nord	**838,534**	**477**	**7.2%**
Sud Ouest	799,050	367	6.9%
Plateau Central	687,998	154	5.9%
Centre Sud	624,498	56	5.4%
Cascades	513,591	132	4.4%
Sahel	363,930	508	3.1%
Total	**11,656,675**	**4,243**	**100%**

Malaria parasite prevalence (MIS, 2022)



Malaria mortality rate (DHIS2, 2022)



Intervention coverage and financing

Estimated national coverage of key interventions

	2015*	2021	2022
Population at risk of malaria	15,215,330	21,500,559	22,184,452
% of population owning an ITN	90%	83%	
% of children < 5 years and pregnant women sleeping under an ITN	75%, 77%	67%, 71%	
Last mass ITN campaign year			2022
% of population covered with mass ITN campaign			80%
% of population covered by IRS			0%
% of febrile children < 5 years for whom advice and treatment was sought	61%	75%	
% of febrile children < 5 years sought care for fever who received diagnosis	48%	87%	
% of febrile children < 5 years who took a combination with artemisinin	14%	41%	27%
% of febrile children < 5 years sought care in private sector	6%	5%	

** Survey data from MIS 2014*

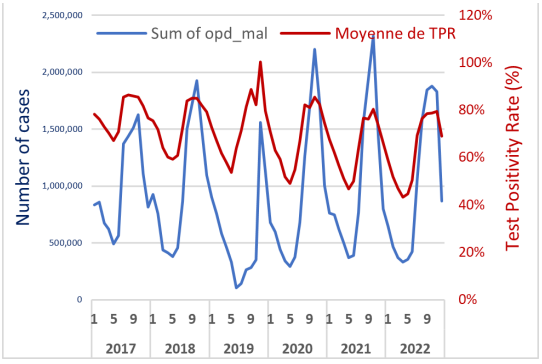
Financing for malaria (US$)

	2021	2022	% baseline (2015)	% in 2022
Total national budget	4,288,313,333	4,865,248,333		13
Total national health budget	456,666,667	523,466,667		15
Total malaria budget	109,109,292	200,375,266	100	84
Domestic funding for malaria	20,097,896	26,673,554	18	33
Global Fund*	79,697,043	59,908,531	-314	-25
PMI*	24,000,000	24,000,000	-132	0
Other external funding*	7,789,126	7,665,729	528	-2
Total funding gap	**-22,474,774**	**82,127,453**		

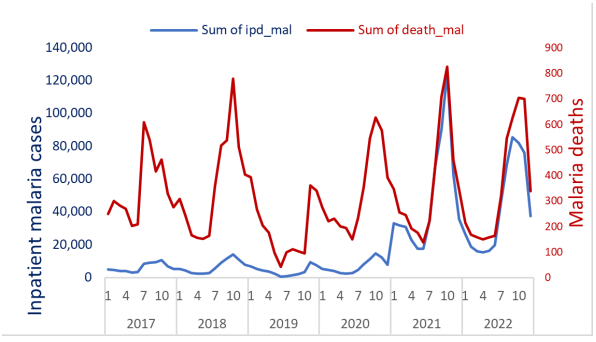
** Contribution reported by countries*

Trends key impact indicators

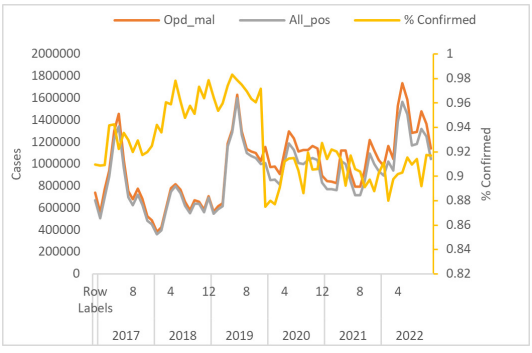
Outpatient and malaria test positivity rate, all ages, 2017–2022



Inpatient malaria cases and deaths, 2018–2023



Outpatient malaria cases and testing rate (%), 2017–2022



Impact indicators

	Baseline 2015	Target 2022	Reported 2022	% change (target vs. reported 2022)	% change (2022 vs. baseline)
Estimated malaria cases*	7,848,131		8,019,213		2%
Estimated malaria deaths*	21,617		16,669		-23%
Malaria parasite rate	46%	27%	14%	-48%	-69%
Malaria cases	8,286,453		11,656,675		40%
Malaria cases per 1000	547	266	525	98%	-4%
Inpatient malaria cases	450,042		539,488		20%
Inpatient malaria incidence per 10,000	297		243		-18%
Malaria deaths	5,379		4,243		-23%
Malaria deaths per 100,000	35.0		19.1		-47%

* *World malaria report 2023*

Major drivers of malaria mortality in the country

1. **Inadequate capacity to manage severe malaria (skill, staff, facilities)**
2. **Inadequate care-seeking behaviour and compliance**
3. **Stock outs of diagnostics and medicines**
4. **Poor access to early diagnosis and treatment**
5. **Inadequate referral system**
6. **Biological threats (including HRP2 deletion and suspected drug resistance)**

Reasons for stalling, ranked by descending importance

Burkina Faso is experiencing active conflict and terrorism threats since 2016, resulting in closure of health facilities, population displacements and the occurrence of stock outs due to difficulties in supplying health facilities with inputs such as RDT, ACT and labile blood products. This limits the optimal case management of malaria. Added to this is the difficulty of access to higher levels of care (district or regional hospital) for effective management of severe cases.

As of November 2023, 37% of the health facilities had closed, depriving more than 3.7 million people of access to health care.

Other reasons for stalling include:

- Suboptimal management of malaria cases at community level
- Non-implementation of certain prevention interventions, such as IRS, SMC extension to children aged older than 5 years as well as the number of SMC cycles

Health system performance

Health systems	Performance	Comments
Health sector plan (year) and vision putting UHC at the centre	Satisfactory	
Information system (decisions are largly data-driven and evidence-based)	Satisfactory	
Stakeholders participation in policy, action and M&E	Satisfactory	
Existence of multisectoral collaboration	Satisfactory	
Involvement of civil society including vulnerable and marginalized populations	Unsatisfactory	
Private sector engagment and regulation	Unsatisfactory	
Availability and coverage of community health insurance	Inexistent	
Legislation and regulation, and ensuring compliance	Inexistent	

Strengths/opportunities

The Permanent Secretary for Malaria Elimination reports directly to the office of the Minister of Health, which translates into:

- Diligence in processing files regarding malaria-related activities
- Greater autonomy in decision-making in the context of implementing interventions
- A stronger focus on malaria as a health priority
- Better interactions with other central departments, which improves decision-making for the fight against malaria
- The enthusiasm of technical and financial partners

Lessons from the COVID-19 pandemic

- Covid-19 and public health measures have had an impact on malaria programmes, with a drop in coverage of prevention services, promotion and care services, leading to a decline in performance indicators.
- Malaria diagnosis and treatment in cases of fever, particularly in children, are highly dependent on the availability of health services and personnel, which is itself compromised by the suspension of "non-essential" services and the fear of staff in the absence of Personal Protective Equipment or hand-washing devices. Finally, when services are available, use of health services is negatively influenced by fear of Covid-19 diagnosis and quarantine, or of contracting the disease in health centres.
- Lack of appropriation and maintenance during periods of calm has turned hand-washing facilities into mosquito nests, with the risk of increasing malaria and dengue fever cases. Overall, the continuity of routine services has gradually resumed after a decline in supply and use. Awareness-raising activities and the implementation of distribution campaigns have been maintained, while taking measures to protect the staff involved and the beneficiaries.

As innovations during Covid-19

- Elaboration of a PNLP /CPS contingency plan
- Adoption of working session by teleconferences
- Systematic inclusion of COVID-19 control aspects in the development of communication materials
- Continued management of malaria cases at community level by ASBCs
- Pre-transfer treatment of severe malaria cases by ASBCs in the Sahel region
- Electronic register in health facilities to identify and refer suspected cases of COVID

Lessons learned

- Maintenance of all malaria control interventions with the adoption and application of a contingency plan (preventive measures against the Covid-19 pandemic among the population, targets and health workers) has enabled us to continue offering care to our populations.

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Cameroon

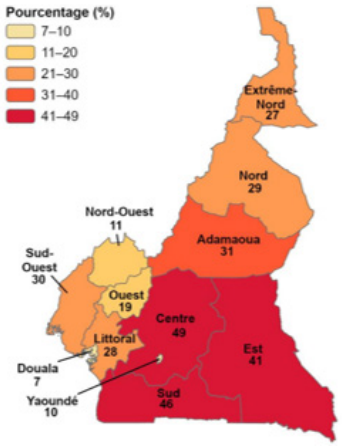
Background

Over the period 2015–2021, a reduction in mortality was recorded, while with regard to morbidity, the downward trend in prevalence contrasts with the increase in incidence. The contributing factors to the drop in prevalence and mortality were among others the improvement the level of education of women, improving the use of the mosquito nets in households by the most vulnerable (children under 5 years of age), implementation of the seasonal malaria chemoprevention in the North and Far North regions, improvement of home hygiene limiting exposure to mosquitoes.The increase in incidence over the period could be explained by the improvement in the following aspects: (i) the routine epidemiological surveillance system; (ii) parasitological diagnosis; (iv) the contribution of community health workers in the collection of data on malaria cases.

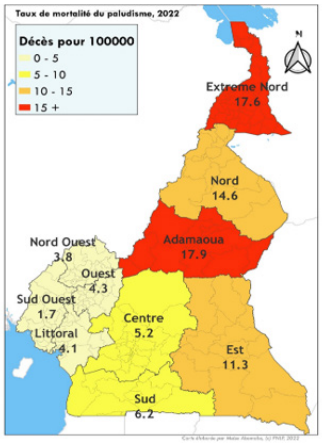
Five regions accounted for ≥ 75% of reported cases and deaths in 2022

Region	No. of cases	No. of deaths	% attributed in cases
Centre	**651,174**	**268**	**19.6%**
Far North	**608,676**	**892**	**18.3%**
North	**426,431**	**451**	**12.8%**
Littoral	**404,848**	**180**	**12.2%**
East	**273,129**	**157**	**8.2%**
West	237,508	101	7.1%
South West	217,219	33	6.5%
Adamawa	213,934	272	6.4%
North West	197,863	71	5.9%
South	96,599	56	2.9%
Total	**3,327,381**	**2,481**	**100%**

Malaria parasite prevalence (MIS, 2022)



Malaria mortality rate (DHIS2, 2023)



Intervention coverage and financing

Estimated national coverage of key interventions

	2015	2017	2023
Population at risk of malaria	22,179,707	24,863,337	27,686,430
% of population owning an ITN		59%	64%
% of children < 5 years and pregnant women sleeping under an ITN		60%, 58%	61%, 63%
Last mass ITN campaign year			2022
% of population covered with mass ITN campaign			
% of population covered by IRS		0%	0%
% of febrile children < 5 years for whom advice and treatment was sought		61%	56%
% of febrile children < 5 years sought care for fever who received diagnosis			27%
% of febrile children < 5 years who took a combination with artemisinin		7%	19%
% of febrile children < 5 years sought care in private sector			64%

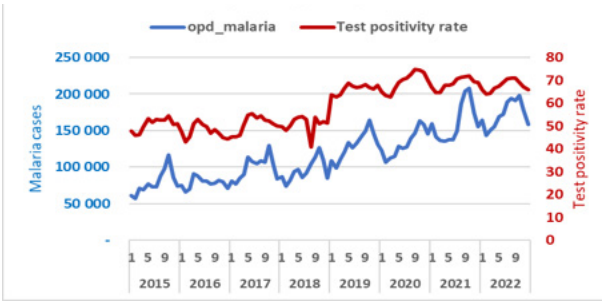
Financing for malaria (US$)

	2021	2022	% baseline (2015)	% in 2022
Total national budget				
Total national health budget	355,067,222	432,347,656		22%
Total malaria budget	96,093,152	176,482,912		84%
Domestic funding for malaria	4,271,194	7,693,564		80%
Global Fund*	30,204,729	54,769,683		81%
PMI*	23,644,752	21,104,214		-11%
Other external funding*		23,520		-
Total funding gap	**37,972,477**	**92,891,930**		

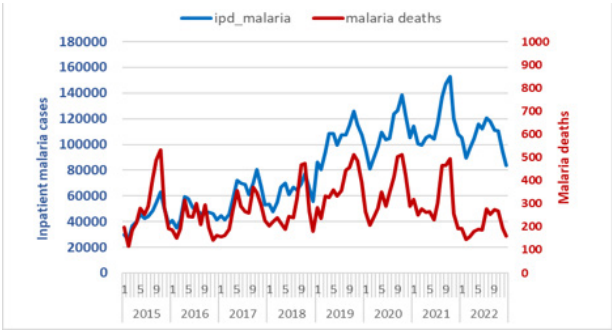
** Contribution reported by countries*

Trends key impact indicators

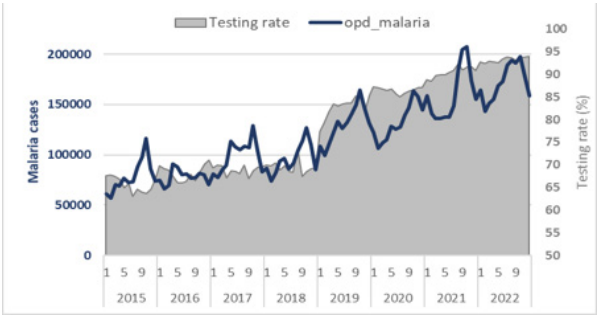
Outpatient and malaria test positivity rate, all ages, 2015–2022



Inpatient malaria cases and deaths, all ages, 2015–2022



Outpatient malaria cases and testing rate, 2015–2022



Impact indicators

	Baseline 2015	Target 2022	Reported 2022	% change (target vs. reported, 2022)	% change (2022 vs. baseline)
Estimated malaria cases*	5,963,352		6,459,013		8%
Estimated malaria deaths*	12,200		12,587		3%
Malaria parasite rate	57%	27%	66%	144%	16%
Malaria cases	1,793,899		3,327,381		85%
Malaria cases per 1000	81	38	120	216%	49%
Inpatient malaria cases	519,059		1,263,686		143%
Inpatient malaria incidence per 10,000	234		456		95%
Malaria deaths	3,440		2,481		-28%
Malaria deaths per 100,000	16	7	9	21%	-42%

* *World malaria report 2023*

Major drivers of malaria mortality in the country

1. **Stockouts of diagnostics and medicines**
2. **Low effectiveness of vector control as a result of insufficient use of LLINs and insecticide resistance**
3. **Poor access to early diagnosis and treatment and poor referral system**
4. **Inadequate care-seeking behaviour and low compliance to treatment**
5. **Insufficient capacity to manage severe malaria (skill, staff, facilities)**
6. **Biological threats (including HRP2 deletion)**
7. **Mortality is highest in four regions:**
   - Far North and Adamawa regions have seasonal transmission of malaria and populations with decreased immunity are highly affected during malaria transmission seasons. Although the Far North region benefits from SMC, only children under 5 years are eligible. Furthermore there is geographical inaccessibility to health services due to a great number of remote communities and low community health workers coverage.
   - Center and East regions have perennial transmission but experience low in malaria intervention coverage: LLINs (Center) and quality care (East & Center) linked to weak health systems in rural areas.

Reasons for stalling, ranked by descending importance

1. **Insufficient political commitment and ownership: insufficient and low mobilization of resources for malaria and low involvement of community leaders**
2. **Inadequate health infrastructure: insufficient equipment of health facilities for management of severe malaria**
3. **Inadequate access to early diagnosis and treatment: low coverage in operational health facilities and community health workers**
4. **Inadequate domestic funding: low funding of health sector, slow release of domestic fund due to public contract procedures**
5. **Inadequate health care seeking behaviour and compliance: low health literacy and extensive use of unregulated private sector**
6. **Inadequate procurement and supply chain management leading to prolonged and widespread stock outs in malaria commodities**
7. **Low coverage of community-based interventions: only about 9000 out of over 15,000 community health workers planned**
8. **Suboptimal impact of interventions: low efficacy of tools (LLINs) and strategies (SMC)**
9. **Mosquitoes insecticide resistance**
10. **Weak multisectoral collaboration: low involvement of private sector and low appropriation of malaria control by agriculture, town planning, education sectors**

Health system performance

Health systems	Performance	Comments
Health sector plan (year) and vision putting UHC at the centre	Satisfactory	The launch of the UHC reform by the Minister of Public Health has helped increase access to malaria services through improved planning, supervision and monitoring of health facilities, as well as better supply of commodities, surveillance and evidence-based decisions at all levels. However, malaria services remain expensive for the majority of the population living under poverty thresholds causing late care seeking and inadequate quality of care. There is also inadequate involvement of other sectors in awareness raising vector control and resource mobilization for quality case management.
Accountability and transparency	Satisfactory	
Existence of multisectoral collaboration	Unsatisfactory	
Stakeholders participation in policy, action and M&E	Satisfactory	
Information system (decisions are largely data-driven and evidence-based)	Excellent	
Private sector engagement and regulation	Unsatisfactory	
Availability and coverage of community health insurance	Unsatisfactory	
Involvement of civil society including vulnerable & marginalized pop	Satisfactory	
Legislation and regulation, and ensuring compliance	Satisfactory	

Strengths/opportunities

- Good coverage of households planned during LLINs and SMC campaigns
- Availability of a vector resistance management plan to insecticides
- Development of normative documents on case management and their dissemination at the operational level
- Development of a national strategic plan for community health 2021–2025
- Improvement in the confirmation rate of malaria diagnosis
- Total or partial subsidy of inputs to improve financial accessibility to services for the most vulnerable
- Existence of personnel responsible for logistics management at all levels of the health pyramid (PF GAS regions/ district);
- Data reporting system is perfectly integrated in the National Health Information System (HMIS)
- Holding of data review and validation meetings is effective at central and regional level
- Improved data quality
- Successful automation of intervention monitoring data management systems through the Dhis2 platform
- Development and implementation of a communications plan
- Engagement of decision-makers at the highest level through the “Stop Malaria” initiative
- The existence of strategic and technical coordination entities for management and monitoring of the strategic plan
- Availability of qualified human resources dedicated to the program at the central level and at the decentralized level
- Political will in favour of the fight against malaria corroborated by the provision of co-financing funds

Lessons from the COVID-19 pandemic

- Lessons learnt from the COVID 19 pandemic include the power of political commitment and leadership in evidence-based policy development and implementation, rapid scale-up of interventions and the use of data analytics to guide investments. The data systems put in place to monitor and respond to the pandemic such as daily reports, data analysis meetings and communication using dashboards can be leveraged for malaria response. Furthermore, the collaborative frameworks established between the Ministry of Public Health and other sectors, including One Health platforms can be leveraged to have more involvement of these sectors and strengthen multisectoral actions. The community participation and private sector involvement in health can also be built upon to ensure greater resource mobilization for malaria.

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République démocratique du Congo

Contexte

Le paludisme reste la principale cause de morbidité et de mortalité en RDC et continue d'être endémique. Avec près de 25 millions de cas et 22 000 décès en 2021, la RDC représente 12% des cas de paludisme et 13% des décès dans le monde. Entre 2018 et 2021, le nombre de cas (confirmé+présumé) est passé de 18,2 millions à 26,5 millions (+ 45.6%), bien qu'une partie de cette augmentation puisse être attribuée à l'augmentation du nombre de tests au cours de cette période (+22.6 %).

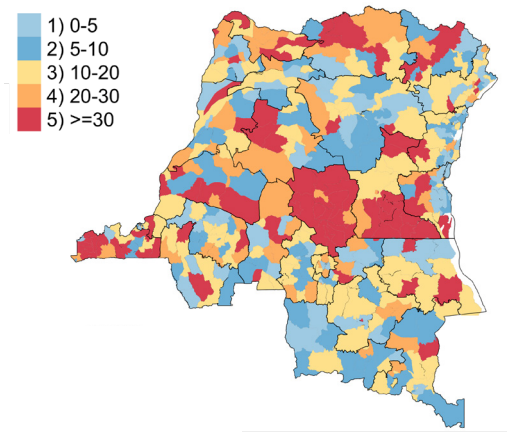
Les statistiques montrent que 64% des cas de paludisme sont signalés dans les 10 provinces de HBHI : Kinshasa, Sud-Kivu, Nord-Kivu, Ituri, Kasaï, Tanganyika, Kasaï-Oriental, Kongo-Central, Haut-Katanga et Kasaï-Central. Le vecteur prédominant est l'*An. gambiae*, tandis que le *P. falciparum* est l'espèce principale et la plus prévalente au pays suivi du *P. ovale* et du *P. malariae*. Les enfants de moins de 5 ans représentent 50% des cas de paludisme et près de 70% de l'ensemble des décès.

Le plan stratégique 2020-2023 fini et le plan stratégique 2024-2028 débutant préconisent des stratégies de lutte, notamment l'utilisation de la MII, le diagnostic des cas de paludisme par le TDR et la microscopie, le traitement avec les ACT pour le paludisme simple et l'artésunate injectable pour les cas de paludisme grave. De nouvelles interventions sont préconisées en rapport avec la prévention (chimioprévention du paludisme pérenne qui a commencé dans quatre ZS en pilote, la chimioprévention du paludisme saisonnier au sud du pays et la vaccination). Les défis à relever restent notamment la résistance des anophèles aux insecticides d'imprégnation des moustiquaires, la faible durabilité des MII, la rupture de stock des intrants antipaludiques, la faible capacité de mobilisation des ressources, et la faible qualité des données du paludisme.

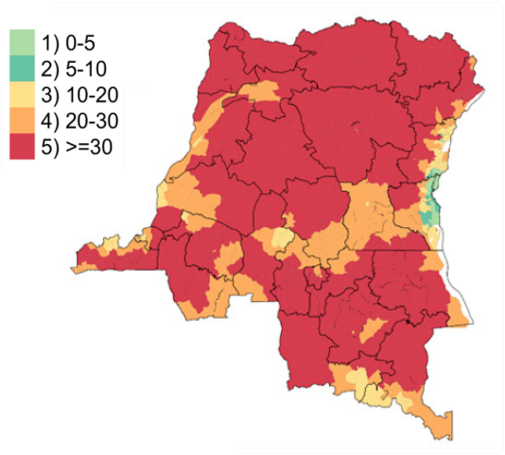
14 provinces représentant ≥70% des cas et des décès, 2023

Province	No. de cases	No. de décès	% attribués des cas
Kinshasa	**2,120,243**	**1,209**	**8%**
Nord Kivu	**2,018,859**	**1,252**	**7%**
Ituri	**1,692,306**	**2,339**	**6%**
Sud Kivu	**1,642,199**	**860**	**6%**
Sud Ubangi	**1,623,525**	**695**	**6%**
Kasai Central	**1,616,428**	**735**	**6%**
Kongo Central	**1,552,582**	**2,121**	**6%**
Kasai	**1,345,878**	**2,155**	**5%**
Kwilu	**1,185,551**	**972**	**4%**
Kasai Oriental	**1,083,673**	**348**	**4%**
Mongala	**1,062,466**	**467**	**4%**
Tshopo	**1,028,765**	**1,072**	**4%**
Haut Katanga	**910,601**	**579**	**3%**
Lomami	**886,077**	**603**	**3%**
Equateur	845,345	485	3%
Haut Lomami	842,949	620	3%
Haut Uele	781,577	1,438	3%
Maniema	773,349	1,348	3%
Kwango	715,792	536	3%
Tanganyika	684,004	448	2%
Lualaba	644,297	434	2%
Maindombe	643,697	546	2%
Sankuru	616,716	1,145	2%
Nord Ubangi	556,550	491	2%
Tshuapa	470,438	811	2%
Bas Uele	313,895	635	1%
Total	**27 657 762**	**24 344**	**100%**

Taux de mortalité (/100,000 hbts) due au paludisme, médiane de 2020-2022



Prévalence parasitaire paludisme (MIS, 2022)



Couverture et financement des interventions

Estimation de la couverture nationale des interventions clés

	2014	2018	2021
Population exposée au risque de paludisme	91,613,485	102,711,933	115,169,571
% de la population possédant une MII (année MIS)	70%	63%	
% d'enfants de moins de 5 ans et de femmes enceintes dormant sous une MII	56%	51%	
Dernière année de campagne de distribution de MILD			
% de la population couverte par la campagne			
% de la population couverte par la pulvérisation intradomiciliaire d'insecticide à effet rémanent (PID)			
% d'enfants fébriles qui ont cherché à se faire soigner pour leur fièvre	57%	46%	
Proportion d'enfants fébriles de moins de 5 ans ayant consulté pour de la fièvre et ayant reçu un diagnostic	29%	31%	
Proportion d'enfants fébriles de moins de 5 ans ayant cherché à se faire soigner et ayant été traités par ACT	6%	42%	
Pourcentage d'enfants fébriles de moins de 5 ans ayant cherché à se faire soigner dans le secteur privé	ND	26%	

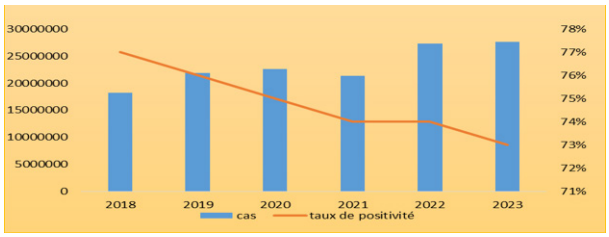
Financement de la lutte contre le paludisme (US$)

	2021	2022	% de référence (2015)	% en 2022
Budget national total				
Budget national total pour la santé				
Budget total pour le paludisme	210,766,249	267,417,731		27%
Financement national pour le paludisme	1,427,241	44,001,352		2983%
Fonds mondial*	104,336,236	202,490,399		94%
PMI*	70,289,620	47,407,407		-33%
Autres financements externes*	32,000,000	32,000,000		0%
Déficit de financement total	**2,713,152**	**-58,481,427**		

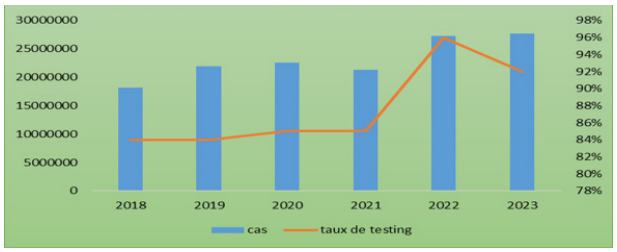
** Contribution rapportée par les pays*

Tendances indicateurs d'impact clés

Cas de paludisme et taux de positivité, 2018-2023



Cas de paludisme et taux de testing, 2018-2023



Indicateurs d'impact

	Référence 2018	Objectif 2021	Rapporté 2021	% de changement (objectif vs rapporté 2021)	% de changement (2021 vs référence)
Estimation du nombre de cas de paludisme*	28,621,752		30,781,802		8%
Estimation du nombre de décès dus au paludisme*	78,205		71,017		-9%
Taux de parasites du paludisme**	31%	25%	NA		
Cas de paludisme	18,208,440		21,345,031		17%
Cas de paludisme pour 1000	184		185		1%
Cas de paludisme chez les patients hospitalisés	1,816,040		2,084,427		15%
Incidence du paludisme chez les patients hospitalisés pour 10 000	198		180		-9%
Décès dus au paludisme	18,030		22,729		26%
Décès dus au paludisme pour 100 000	18		20		11%

** Rapport mondial sur le paludisme 2023 ; ** MICS 2018, autres données du rapport national*

Principaux facteurs de mortalité due au paludisme dans le pays

1. **Référence tardive des cas de paludisme grave vers les structures de niveau supérieur**
2. **Rupture de stock des médicaments prise en charge des cas de paludisme grave**
3. **Insuffisance des équipements et matériels de réanimation (oxygène, sang ...)**
4. **Insuffisance de personnel formé en prise en charge des cas de paludisme**
5. **Séquestration des malades par les structures de premier échellon**
6. **Amélioration de la notification des décès dans le DHIS.2**

Raisons de la stagnation (lenteur des progrès), classées par ordre décroissant d'importance

1. **Faible appropriation de la lutte par la communauté**
2. **Faible approvisionnement en intrants de lutte contre le paludisme**
3. **Accès difficile aux soins pour certaines communautés**
4. **Faible couverture des interventions de lutte contre le paludisme**
5. **Non respect de la politique nationale de lutte contre le paludisme par le secteur privé**

Performance du système de santé

Système de santé	Performance	Commentaires
Plan (annuel) et vision du secteur de la santé plaçant la couverture de santé universelle au centre des préoccupations	Satisfaisant	
Responsabilité et transparence	Non satisfaisant	
Existence d'une collaboration multisectorielle	Non satisfaisant	
Participation des parties prenantes à la politique, à l'action et au suivi et à l'évaluation	Satisfaisant	
Système d'information (les décisions sont largement fondées sur des données et des preuves)	Satisfaisant	
Engagement et réglementation du secteur privé	Non satisfaisant	
Disponibilité et couverture de l'assurance maladie communautaire	Non satisfaisant	
Participation de la société civile, y compris des populations vulnérables et marginalisées	Non satisfaisant	
Législation et réglementation, et garantie de conformité	Satisfaisant	

Points forts/opportunités

- Le secteur santé est retenu parmi les priorités du gouvernement
- Engagement politique pour les investissements dans le cadre de la santé
- Adoption par le gouvernement de la Couverture Santé Universelle
- Engagments des bailleurs des fonds principaux
- Appui des partenaires techniques et financiers

Leçons tirées de la pandémie de COVID-19 dans le pays

La RDC a été aussi frappée par la pandémie de COVID-19. En réponse à cette pandémie, la RDC a mis en place un Comité National de Coordination sous la supervision de la Présidence de la République. Le comité National de Coordination a mené des actions importantes :

- Formation des prestataires
- Approvisionnement des kits COVID
- Collecte journalière des données
- Sensibilisation de la population pour le respect des règles barrières

Malaria Ministerial Conference:
"Tackling malaria in countries hardest hit by the disease"

Yaoundé, Cameroon, 6 March 2024

Mali

Contexte

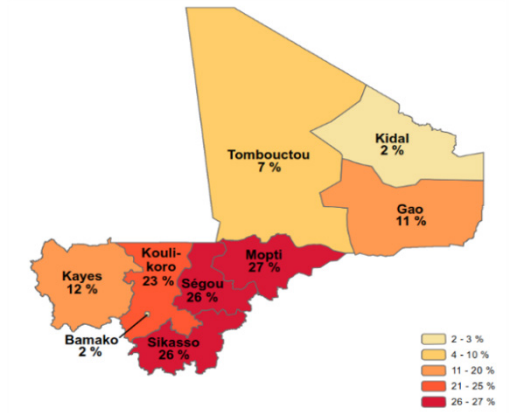
Le Mali fait partie des 11 pays à charge élevée du paludisme et a souscrit à l'initiative "D'une charge élevée à un impact fort" (*High Burden High Impact* - HBHI) dont le lancement a eu lieu à Bamako le 30 mars 2021 sous la présidence de Mme la Ministre de la Santé et du Développement social. En effet, le paludisme est la première cause de morbidité (43%) et de mortalité (27%) en 2022 (DHIS2). Les enfants de moins de 5 ans et les femmes enceintes sont les couches les plus affectées. Les résultats de l'Enquête Démographique et de Santé du Mali (EDSMVI, 2018) montraient que 16 % des enfants de 6-59 mois et 63 % des femmes présentaient une anémie.

Le taux d'incidence est passé de 133‰ en 2018 à 172‰ en 2022 (DHIS2). Pour les enfants de moins de 5 ans, il est passé de 224‰ à 250‰ pendant la même période.

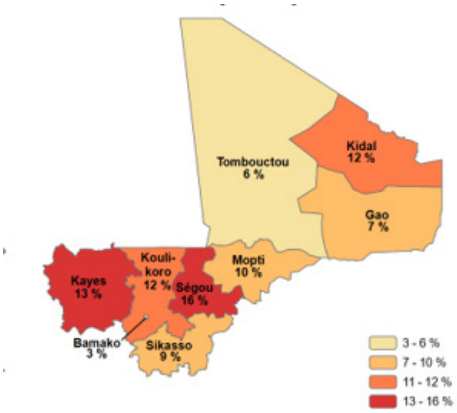
Quatre régions représentant ≥70% des cas et des décès, 2023

Région	No. de cas	No. de décès	% attribués des cas
Koulikoro	**835,942**	**240**	**25.1%**
Sikasso	**669,229**	**288**	**20.1%**
Ségou	**503,939**	**161**	**15.1%**
Mopti	**417,383**	**181**	**12.5%**
Kayes	315,340	153	9.5%
Bamako	303,939	51	9.1%
Gao	127,115	28	3.8%
Tombouctou	122,918	79	3.7%
Menaka	20,074	2	0.6%
Taoudenni	11,582	2	0.3%
Kidal	6,230	4	0.2%
Total	**3,333,691**	**1,189**	**100%**

Prévalence parasitaire du paludisme chez les enfants de 6-59 mois par région selon l'EIPM 2021



Pourcentage d'enfants de 6–59 mois avec un niveau d'hémoglobine <8 g/dl



Couverture et financement des interventions

Estimation de la couverture nationale des interventions clés

	2015	2018	2021
Population exposée au risque de paludisme	17,818,996	19,599,288	21,309,775
% de la population possédant une MII (année MIS)	93%	98%	91%
% d'enfants de moins de 5 ans et de femmes enceintes dormant sous une MII	71% ; 78%	79%; 84%	73% ; 75%
Dernière année de campagne de distribution de MILD			2023
% de la population couverte par la campagne			99%
% de la population couverte par la pulvérisation intradomiciliaire d'insecticide à effet rémanent (PID)		90%	87%
% d'enfants fébriles qui ont cherché à se faire soigner pour leur fièvre	53%	50%	60%
Proportion d'enfants fébriles de moins de 5 ans ayant consulté pour de la fièvre et ayant reçu un diagnostic	28%	31%	39%
Proportion d'enfants fébriles de moins de 5 ans ayant cherché à se faire soigner et ayant été traités par ACT	8%	6%	5%
Pourcentage d'enfants fébriles de moins de 5 ans ayant cherché à se faire soigner dans le secteur privé			

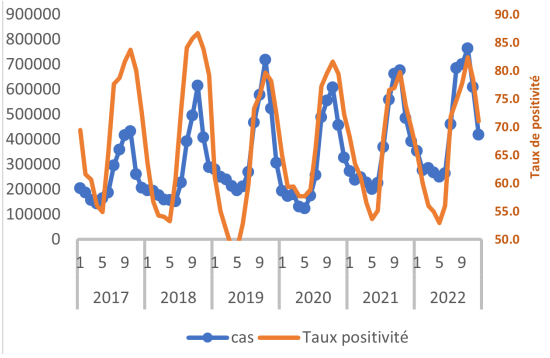
Financement de la lutte contre le paludisme (US$)

	2021	2022	% de référence (2015)	% en 2022
Budget national total	5,729,951,832	5,616,176,462		-2
Budget national total pour la santé	282,788,202	305,420,000		8
Budget total pour le paludisme	68,275,159	50,173,155		-27
Financement national pour le paludisme	15,376,934	5,420,173		-65
Fonds mondial*	20,123,411	11,015,856		-45
PMI*	30,713,500	33,384,500		9
Autres financements externes*	2,061,314	352,625		-83
Déficit de financement total				

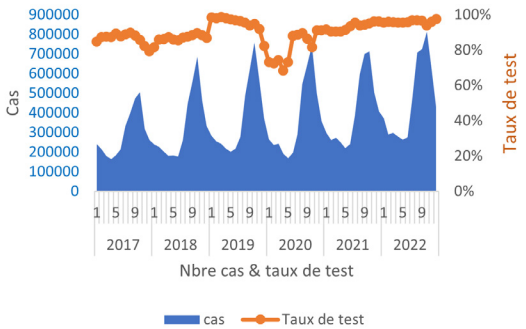
** Contribution rapportée par les pays*

Tendances indicateurs d'impact clés

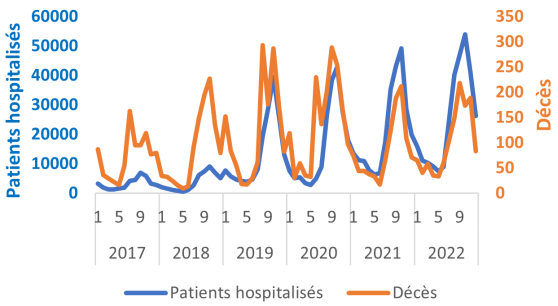
Taux de positivité des consultations externes et des tests de dépistage du paludisme, tous âges confondus



Cas de paludisme en consultation externe et taux de dépistage (%)



Décès dus au paludisme chez les patients hospitalisés



Indicateurs d'impact

	Référence 2018	Objectif 2021	Rapporté 2021	% de changement (objectif vs rapporté 2021)	% de changement (2021 vs référence)
Estimation du nombre de cas de paludisme*	7,710,138		7,744,735		0%
Estimation du nombre de décès dus au paludisme*	19,821		19,716		-1%
Taux de parasites du paludisme	19%	20%	19%	5%	0%
Cas de paludisme	2,345,481		3,204,130		37%
Cas de paludisme pour 1000	133	71	150	-111%	13%
Cas de paludisme chez les patients hospitalisés	-		249,756	-	
Incidence du paludisme chez les patients hospitalisés pour 10 000	5		117	-22.40%	2198%
Décès dus au paludisme	1,001		1,480	-0.48%	48%
Décès dus au paludisme pour 100 000	5		7	-0.40%	30%

* *Rapport sur le paludisme dans le monde 2023*

Principaux facteurs de mortalité dus au paludisme dans le pays

1. **Recours tardifs aux soins**
   Le recours tardif aux soins favorise la survenue des cas compliqués et des décès surtout au niveau des populations à faible revenu et dans les zones dépourvues de structures de soins et celles d'accès difficile. Les communautés, par le biais des ASCO, contribuent à la mise en oeuvre des activités de masse comme les campagne CPS et MILD. Les ASC également assurent la prise en charge des cas au niveau communautaire.
2. **Non respect des directives de prise en charge par certains prestataires**
3. **Ruptures occasionnelles des stocks de médicaments et intrants**
4. **Insuffisance dans la qualité de mise en œuvre des interventions à base communautaire**
5. **Insuffisance de la qualité des soins**
6. **Faible prise en compte des établissements privés dans la formation et la supervision**

Raisons de la stagnation (lenteur des progrès), classées par ordre décroissant d'importance

1. **Faible mobilisation des ressources internes**
2. **Amenuisement des financements extérieurs**
3. **Faible implication des établissements de santé privés à but lucratif dans la mise en œuvre de la politique de gratuité de la prise en charge des cas de paludisme**
4. **Insuffisance de la qualité des données**
5. **Ruptures occasionnelles des stocks d'intrants antipaludiques au niveau des établissements de santé**

Performance du système de santé

Système de santé	Performance	Commentaires
Plan (annuel) et vision du secteur de la santé plaçant la couverture de santé universelle au centre des préoccupations	Satisfaisant	La mission du PNLP est d'assurer un accès équitable et universel aux interventions de lutte contre le paludisme à toute la population
Responsabilité et transparence	Satisfaisant	
Existence d'une collaboration multisectorielle	Non satisfaisant	Faible implication des aux secteurs (assainissement, agriculture, éducation) dans la lutte contre le paludisme
Participation des parties prenantes à la politique, à l'action et au suivi et à l'évaluation	Satisfaisant	Existence d'un groupe technique surveillance, suivi-évaluation fonctionnel
Système d'information (les décisions sont largement fondées sur des données et des preuves)	Satisfaisant	Stratification périodique de l'épidémiologie du paludisme à travers les données de routine et d'enquête, et adaptation des interventions selon les strates
Engagement et réglementation du secteur privé	Non satisfaisant	Faible participation du secteur privé dans le financement et la mise en œuvre des interventions de lutte contre le paludisme
Disponibilité et couverture de l'assurance maladie communautaire	Non satisfaisant	Existence par endroit de mutuelles de santé de caisse de solidarité villageoises , mais insuffisante pour assurer une bonne couverture d'assurance communautaire
Participation de la société civile, y compris des populations vulnérables et marginalisées	Satisfaisant	
Législation et réglementation, et garantie de conformité	Satisfaisant	La lutte contre est intégré dans le système de santé dont la mise en œuvre des activités est réglementée par la politique sectorielle de santé

Points forts/opportunités

- Adhésion de la communauté à faciliter les activités de lutte contre le paludisme
- Volonté politique qui fait du de la lutte contre le paludisme une priorité
- Accompagnement des partenaires techniques et financiers
- Existence des organisations à base communautaires (ASC, relais ,GSAN…)
- Le Mali bénéficie de l'appui des partenaires techniques et financiers comme (PMI, Fonds mondial, OMS, …) et tous ces partenaires accompagnent le pays dans sa politique de l'offre et l'utilisation des services par les communautés (ASC, autres plateformes communautaire)

Leçons tirées de la pandémie de COVID-19 dans le pays

- Réticence de la population pour la fréquentation des services
- Instauration des mesures barrière ; instauration de l'obligation de la présentation d'un résultat négatif à l'entrée et à la sortie
- Pays engagé pour faire face à l'épidémie à travers la création des centres spécifiques pour le diagnostic et la prise en charge
- Gratuité des tests rapide et de la prise en charge à toute la population
- Exonération des produits et EPI
- Activation du Département des opérations d'urgence avec la mise en place de plusieurs sous-commissions avec élaboration et partage quotidien du rapport de situation
- Diffusion des messages de sensibilisation à tous les canaux (radio, télévisions, réseaux sociaux, affiches…)
- Intégration des données Covid dans le système de surveillance
- Continuité des activités à travers le télétravail
- Implication des leaders communautaires dans les activités de sensibilisation et de mobilisation sociale
- Actions entreprises conforme à la réglementation (respects des mesures barrières, mouvements des populations, approvisionnement etc.…)
- Dès la confirmation des premiers cas le pays a entrepris des mesures de lutte telles que la distanciation physique, arrêt des activités de masse/ regroupements, la mise en place des centres de traitement,
- L'adaptation des directives au contexte Covid a permis d'assurer la continuité des activités comme la mise en œuvre des campagne
- Renforcement des stock des intrants et médicaments au niveau national pour éviter les ruptures

Malaria Ministerial Conference: "Tackling malaria in countries hardest hit by the disease"

Yaoundé, Cameroon, 6 March 2024

Mozambique

Background

The entire population of Mozambique (approximately 32.4 million in 2023) is at risk of malaria, with 77% of the population living in districts with 2023 incidence above 100 cases per 1,000 population. Despite significant investment and progress in malaria control over years, the disease remains a major public health burden in Mozambique. In 2016, the Malaria Strategic Plan (MSP) baseline year, there were just over 8.5 million new cases of malaria reported, with 10% of those cases diagnosed at the community level by the community Health Workers (APEs). Malaria cases increased annually between 2016 and 2020, with nearly 10 million total malaria cases reported in 2017, 10.3 million in 2018, 10.9 million in 2019, 11.3 million in 2020, 10.1 million in 2021, 12.4 million in 2022, and 13.2 million in 2023. The number of reported cases decreased for the first time in 2021 to 10.1 million. Crude incidence decreased by 12.5% from 2020 to 2021, from 375 cases per 1,000 in 2020 to 328 cases per 1,000 in 2021, 392 cases per 1,000 in 2022, and 408 cases per 1,000 in 2023. Between 2017 and 2023, APEs on average identified 12% of cases.

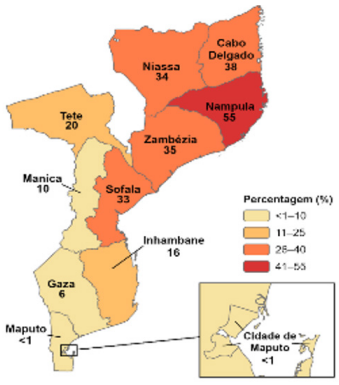
Parasitological confirmation of malaria has remained significantly high over the past five years, with annual blood examination rate (ABER) as high as 67% in 2019, with slight decreases at 65% in 2020 and 63% in 2021, and then 73% in 2022 and 77% in 2023. Meanwhile, the test positivity rate (TPR) has remained stable during that time (57% in 2017, 55% in 2018 and 2019, 58% 2020, 52% in 2021, 53% in 2022, and 53% in 2023). The drop in incidence in 2021 coincides with a drop in TPR. This would suggest that the drop in incidence is not caused by a decrease in testing or care seeking.

Although the number of malaria reported deaths has been decreasing in the past years, malaria remains an important cause of child mortality in Mozambique. In 2017, 1,114 inpatient malaria deaths were reported, 970 in 2018, 734 in 2019, 563 in 2020, 406 in 2021, 423 in 2022, and 356 in 2023. It should be noted that there is evidence of underreporting of malaria deaths.

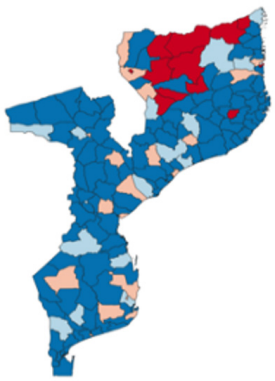
Five provinces/states accounting for ≥70% of cases and ≥50% deaths in 2023

Province/State	No. of cases	No. of deaths	% attributed in cases
Zambezia	**3,748,376**	**13**	**28%**
Nampula	**2,415,131**	**75**	**18%**
Sofala	**1,467,980**	**38**	**11%**
Cabo Delgado	**1,270,188**	**41**	**10%**
Manica	**1,101,634**	**9**	**8%**
Niassa	963,887	111	7%
Inhambane	925,877	15	7%
Tete	847,111	21	6%
Gaza	445,460	6	3%
Maputo Provincia	42,080	10	0%
Maputo Cidade	12,536	12	0%
Total	**13,240,260**	**351**	**100%**

Malaria parasite prevalence (DHS, 2022)



Malaria mortality rate (DHS, 2023)



Intervention coverage and financing

Estimated national coverage of key interventions

	2015	2017	2023
Population at risk of malaria	25,727,908	31,616,078	32,419,747
% of population owning an ITN	47.9	57%	57%
% of children < 5 years and pregnant women sleeping under an ITN			71%, 22%
Last mass ITN campaign year			2022-2023
% of population covered with mass ITN campaign	4%	28%	53%
% of population covered by IRS	14%	18%	20%
% of febrile children < 5 years for whom advice and treatment was sought			64%
% of febrile children < 5 years sought care for fever who received diagnosis			51%
% of febrile children < 5 years who took a combination with artemisinin	36%	32%	42%
% of febrile children < 5 years sought care in private sector			2%

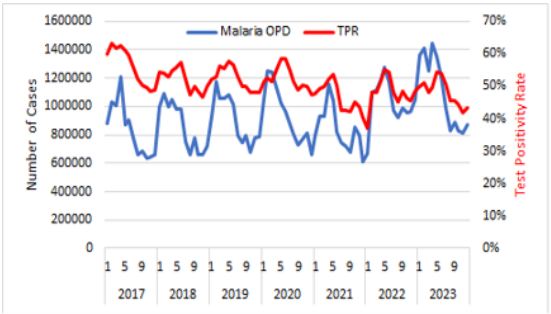
Financing for malaria (US$)

	2022	2023	% baseline (2015)	% in 2022
Total national budget				
Total national health budget	513,800,000	567,600,000		10%
Total malaria budget				
Domestic funding for malaria	4,411,149	4,411,149		0%
Global Fund*	29,295,280	27,660,406		-6%
PMI*	29,000,000	29,000,000		0%
Other external funding*	29,295,280	27,660,406		-6%
Total funding gap	**-92,001,708**	**-88,731,961**		

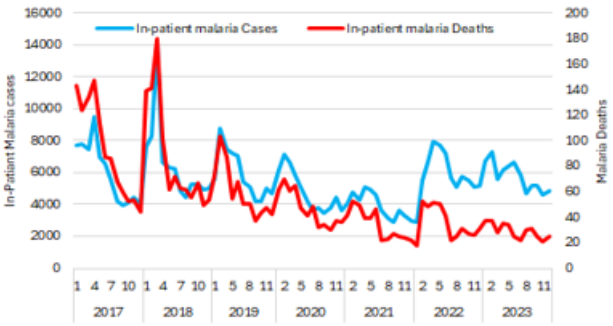
** Contribution reported by countries*

Trends key impact indicators

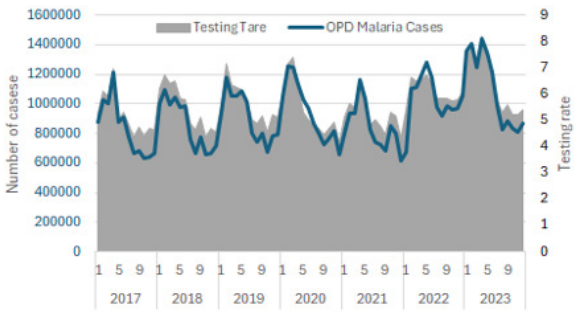
Outpatient and malaria test positivity rate, all ages, 2017–2023



Inpatient malaria cases and deaths, all ages, 2017–2023



Outpatient malaria cases and testing rate (%), 2017–2023



Impact indicators

	Baseline 2015	Target 2022	Reported 2023	% change (target vs. reported, 2023)	% change (2023 vs. baseline)
Estimated malaria cases*	9,389,988		10,442,873		11%
Estimated malaria deaths*	22,210		21,551		-3%
Malaria parasite rate	38%	24%	32%	35%	-16%
Malaria cases	6,418,526	4,742,412	13,240,260	179%	106%
Malaria cases per 1000	249	150	408	172%	64%
Inpatient malaria cases	85,785	28,454	69,195	143%	-19%
Inpatient malaria incidence per 10,000	33	9	2.1	-77%	-94%
Malaria deaths	2,467	948	351	-63%	-86%
Malaria deaths per 100,000	10	3	1.1	-64%	-89%

* *World malaria report 2023*

Major drivers of malaria mortality in the country

1. **Late seeking of health care**
2. **Stockouts of diagnostics and medicines**
3. **Inadequate referral system**
4. **Inadequate referral system**
5. **Bilological threats (including HRP2 deletion)**

Reasons for stalling, ranked by descending importance

1. **Hard natural disasters**
2. **Military insurgency in Cabo Delgado province**
3. **Inadequate domestic funding**
4. **Inadequate health care seeking behaviour and compliance**
5. **Inadequate community-based interventions (e.g. iCCM)**
6. **Suboptimal impact of interventions**

Health system performance

Health systems	Performance	Comments
Health sector plan (year) and vision putting UHC at the centre		
Accountability and transparency	Satisfactory	
Existence of multisectoral collaboration	Unsatisfactory	
Stakeholders participation in policy, action and M&E	Inexistent	
Information system (decisions are largely data-driven and evidence-based)	Satisfactory	
Private sector engagement and regulation	Inexistent	
Availability and coverage of community health insurance	Inexistent	
Involvement of civil society including vulnerable & marginalized pop	Satisfactory	
Legislation and regulation, and ensuring compliance	Inexistent	

Strengths/opportunities

- Political commitment (President prioritizes malaria)
- Existence of the malaria fund
- Good external partners support
- Malaria vacine
- Implementation of MDA, SMS, PQM and ITNs mass campaign

Lessons from the COVID-19 pandemic

- Enhanced surveillance and epidemic response
- Political commitment and ownership
- Health equity focus
- Flexible regulatory processes
- Data sharing, surveillance and use
- Public health awareness
- Innovative technologies
- Community engagement
- Rapid response

Malaria Ministerial Conference:
"Tackling malaria in countries hardest hit by the disease"

Yaoundé, Cameroon, 6 March 2024

Niger

Contexte

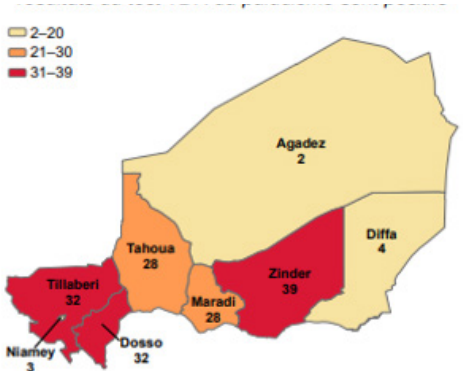
Au Niger, les objectifs fixés dans le PSN 2017-2021 ont été atteints pour certaines interventions comme la couverture des campagnes MILDA et celle de la CPS, le traitement des gites larvaires répertoriés avec les bio larvicides, les cas de paludisme confirmés ayant reçu un traitement ACT seul et les acquisitions de la plupart des intrants par rapport aux besoins exprimés. Certains indicateurs n'ont pas évolué pendant ces cinq années et sont restés en deçà des objectifs fixés. Il s'agit des activités de routine (MILDA par an chez les enfants <1 an, MILDA par an chez les FE, couverture TPI3 et Cas de paludisme confirmés ayant reçu un traitement par Artésunate injectable) et les activités de prise en charge et de communication pour un changement de comportement au niveau communautaire.

En 2022, le PNLP a révisé les directives nationales de lutte contre le paludisme pour prendre en compte l'évolution des strates épidémiologiques du paludisme et les nouvelles directives globales de l'OMS. Le système de surveillance a été adapté en fonction du niveau de transmission du paludisme dans les différentes zones du pays. Ce système de surveillance comprend aussi la surveillance entomologique et parasitologique soutenues par des sites sentinelles. Le renforcement du système de surveillance du paludisme repose sur le renforcement du système d'information de routine et des capacités des acteurs à tous les niveaux. L'intégration des données du paludisme PNLP dans le DHIS2 a permis au PNLP une meilleure organisation de la collecte à tous les niveaux et une analyse rapide pour renseigner les indicateurs du paludisme.

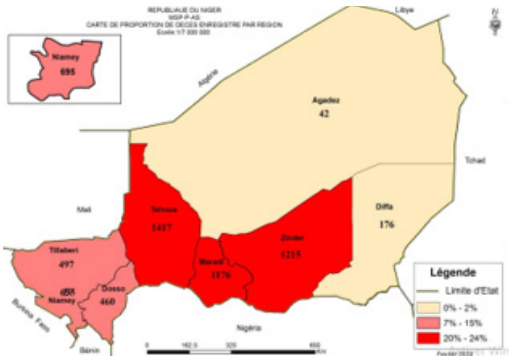
Quatre régions représentant ≥80% des cas et ≥75% des décès, 2022

Région	No. de cases	No. de décès	% attribués des cas
Zinder	**1,299,053**	**1,215**	**24%**
Tahoua	**1,109,516**	**1,417**	**21%**
Maradi	**1,046,868**	**1,176**	**20%**
Tillaberi	**816,299**	**497**	**15%**
Dosso	491,579	460	9%
Niamey	386,487	695	7%
Diffa	123,699	176	2%
Agadez	83,652	42	2%
Total	**5,357,153**	**5,678**	**100%**

Prévalence des parasites du paludisme (MIS, 2021)



Taux de mortalité due au paludisme



Couverture et financement des interventions

Estimation de la couverture nationale des interventions clés

	2015	2021	2022
Population exposée au risque de paludisme	18,528,764	23,591,981	24,465,624
% de la population possédant une MII (année MIS)		80%	
% d'enfants de moins de 5 ans et de femmes enceintes dormant sous une MII		86%; 90%	96%; 58%
Dernière année de campagne de distribution de MILD			
% de la population couverte par la campagne		80%	
% de la population couverte par la pulvérisation intradomiciliaire d'insecticide à effet rémanent (PID)		0%	
% d'enfants fébriles qui ont cherché à se faire soigner pour leur fièvre		81%	
Proportion d'enfants fébriles de moins de 5 ans ayant consulté pour de la fièvre et ayant reçu un diagnostic		73%	
Proportion d'enfants fébriles de moins de 5 ans ayant cherché à se faire soigner et ayant été traités par ACT		30%	
Pourcentage d'enfants fébriles de moins de 5 ans ayant cherché à se faire soigner dans le secteur privé		8%	

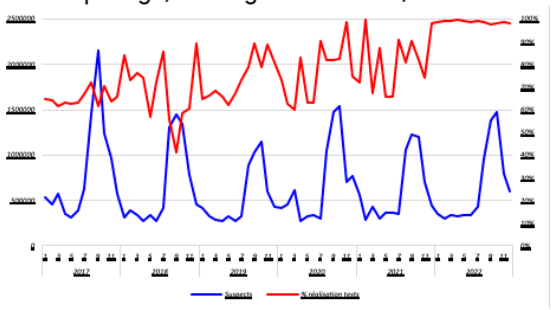
Financement de la lutte contre le paludisme (US$)

	2021	2022	% de référence (2015)	% en 2022
Budget national total	4,375,831,831	4,427,049,159		1%
Budget national total pour la santé	205,280,687	216,281,936		5%
Budget total pour le paludisme	594,847	188,136		-68%
Financement national pour le paludisme	239,374	515,193		115%
Fonds mondial*	16,918,835	32,957,346		95%
PMI*	8,477,913	4,950,623		-42%
UNICEF*	6,117	239,029		3807%
OMS	84,059	126,032		50%
COVID-19	0	413,107		
Déficit de financement total	**25,726,298**	**39,201,330**		**52%**

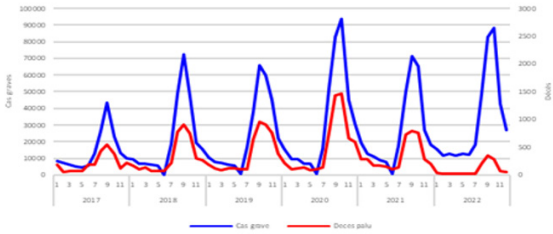
** Contribution rapportée par les pays*

Tendances indicateurs d'impact clés

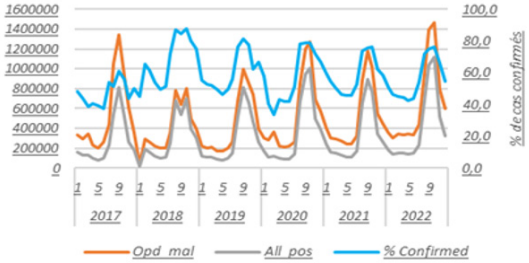
Taux de positivité des consultations externes et des tests de dépistage, tous âges confondus, 2017-2022



Cas de paludisme et décès en milieu hospitalier, tous âges confondus, 2017-2022



Cas de paludisme en consultation externe, cas de paludisme confirmés et taux de dépistage, tous âges confondus, 2017-2022



Indicateurs d'impact

	Référence 2018	Objectif 2022	Rapporté 2022	% de changement (objectif vs rapporté 2022)	% de changement (2022 vs référence)
Estimation du nombre de cas de paludisme*	8,073,585		7,723,787		-4%
Estimation du nombre de décès dus au paludisme*	31,452		34,109		8%
Taux de parasites du paludisme	99%				
Cas de paludisme	3,787,683		5,357,153		41%
Cas de paludisme pour 1000	204		219		7%
Cas de paludisme chez les patients hospitalisés	180,546		384,854		113%
Incidence du paludisme chez les patients hospitalisés pour 10 000	97		157		62%
Décès dus au paludisme	1,650		5,678		244%
Décès dus au paludisme pour 100 000	9		2		-78%

* *Rapport sur le paludisme dans le monde 2023*

Principaux facteurs de mortalité dus au paludisme dans le pays

1. **Absence de lutte integrée contre le vecteur**
   L'insuffisance d'assainissement de l'environnement, absence de traitement des gites larvaires, de pulvérisation intra et extra habitations ne permet pas la reduction de la population anophilaire dans le pays.
2. **Augmentation de la qualité du diagnostic**
3. **Retard dans l'utilisation des services**
4. **Insuffisance d'ACT au niveau communautaire**
5. **Faible capacité dans la gestion des cas graves (personnel, compétences...)**
6. **Insecurité**
   L'insécurité dans certaines zones ont conduit à la fermeture des plusieurs formations sanitaires augment le risque de décès

Raisons de la stagnation (lenteur des progrès), classées par ordre décroissant d'importance

1. **Absence de lutte integrée contre le vecteur, faible couverture sanitaire**
   Le défi principal est la mise en œuvre de la lutte anti larvaire, la PIH/PEH, Le ravitaillement régulier des formations sanitaires en intrants ainsi que le ravitaillement des relais communautaires pour palier à la faible couverture sanitaire. Le rehaussement du financement de l'Etat
2. **Soutiens et alignements inadéquats des partenaires**
3. **Financement intérieur insuffisant**
4. **Comportement et observance inadéquats en matière de recours aux soins de santé**
5. **Gestion inadéquate de la chaîne d'approvisionnement**
6. **Insuffisance des Relais Communautaires**
7. **Insuffisance des structures de santé**

Performance du système de santé

Système de santé	Performance	Commentaires
Plan (annuel) et vision du secteur de la santé plaçant la couverture de santé universelle au centre des préoccupations	Satisfaisant	Le plan prend en compte le recouvrement de coûts. Mise en place de l'INAM (Institut National d'Assistance médicale)
Responsabilité et transparence	Satisfaisant	
Existence d'une collaboration multisectorielle	Satisfaisant	
Participation des parties prenantes à la politique, à l'action et au suivi et à l'évaluation	Satisfaisant	
Système d'information (les décisions sont largement fondées sur des données et des preuves)	Satisfaisant	
Engagement et réglementation du secteur privé	Non satisfaisant	Insuffisance d'appropriation de la production de l'information sanitaire par le secteur privé
Disponibilité et couverture de l'assurance maladie communautaire	Non satisfaisant	
Participation de la société civile, y compris des populations vulnérables et marginalisées	Satisfaisant	Il n'y a pas de population marginalisée dans la lutte contre le paludisme
Législation et réglementation, et garantie de conformité	Satisfaisant	

Points forts/opportunités

- **Engagement des autorités administratives et coutumières**
  Les autorités font de l'amélioration de la santé des populations leur priorité.
- **Orientation du PSN 2023-2026 sur la lutte intégrée contre les vecteurs**
- **Accompagnement des partenaires externes**
- **Accompagnement de la société civile**
  La société civile accompagne le ministère de la sensibilisation de la population pour une meilleure utilisation des services de santé.
- **Accompagnement des parlementaires**
  L'accompagnement des partenaires extérieurs permet de disponibiliser les intrants dans le pays

Leçons tirées de la pandémie de COVID-19 dans le pays

- La pandémie de la COVID-19 qui a entravé la mise en œuvre de certaines activités
- L'insécurité entrainant le déplacement massif des populations, et la fermeture des structures sanitaires
- Les inondation dues aux changements climatiques avec des crises alimentaires et nutritionnelles, et des épidémies. Ainsi la moindre urgence humanitaire affecte la lutte contre le paludisme
- Le partage, la surveillance et l'utilisation des données pour la prise de décision dans la lutte contre le paludisme

Malaria Ministerial Conference:
"Tackling malaria in countries hardest hit by the disease"

Yaoundé, Cameroon, 6 March 2024

Sudan

Background

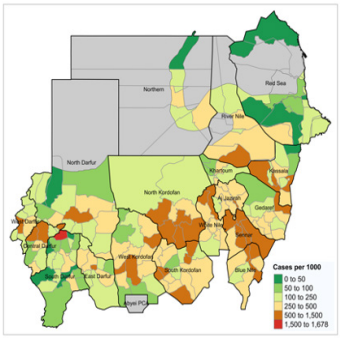
On 15 April 2023, the security situation in Sudan exploded due to armed clashes between the Rapid Support Forces (RSF) and the Sudanese Armed Forces (SAF), forcing more than 5.5 million people to flee their houses to neighbouring states in search of safety and shelter. The situation severely impacted the health system, leaving many hospitals out-of-service and shutting down most health facilities in war-affected areas. The growing number of displaced people seeking medical care caused an increase on the demand for health care services in the relatively stable states, where public hospitals and primary health care facilities recorded increased numbers of outpatient and inpatient attendances.

Internally displaced people moved between areas with variable risk of malaria: some were displaced from areas of lower risk to resettlement areas with higher transmission risk, while others were displaced from areas with higher transmission to areas with lower transmission. The displacement of medical staff, along with the abrupt cessation of vector control efforts and programmes to contain malaria compounded the risk of malaria outbreaks among both displaced and host communities.

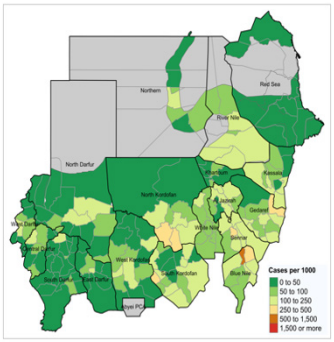
Seven states accounting for ≥70% of cases and ≥34% deaths, 2022

State	No. of cases	No. of deaths	% attributed in cases
Aj Jazirah	**222,039**	**123**	**16.4%**
Sennar	**160,479**	**179**	**11.8%**
Khartoum	**147,120**	**144**	**10.9%**
White Nile	**125,102**	**25**	**9.2%**
Blue Nile	**124,170**	**63**	**9.2%**
Gedaref	**118,832**	**60**	**8.8%**
River Nile	**87,603**	**5**	**6.5%**
North Darfur	83,660	36	6.2%
East Darfur	63,521	9	4.7%
North Kordofan	45,027	169	3.3%
West Kordofan	36,641	298	2.7%
Central Darfur	34,523	83	2.5%
Northern	29,972	56	2.2%
Kassala	27,514	213	2.0%
West Darfur	27,077	9	2.0%
South Darfur	9,471	36	0.7%
South Kordofan	8,720	248	0.6%
Red Sea	4,318	4	0.3%
Total	**1,355,789**	**1,760**	

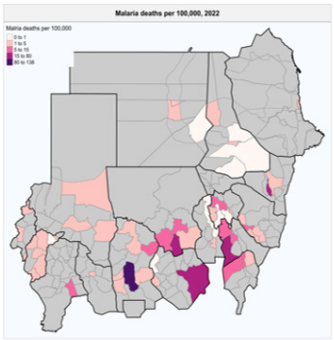
Malaria incidence per 1000 (estimated)



Malaria incidence per 1000 (reported)



Malaria mortality rate



Intervention coverage and financing

Estimated national coverage of key interventions

	2022
Population at risk of malaria	46.9 million
% of population owning an ITN, operational coverage from 2022 campaign*	94%
% of children < 5 years and pregnant women sleeping under an ITN**	43.9% /44.4%
Last mass ITN campaign year	2022
% of population covered with mass ITN campaign	94%
% of population covered by IRS***	0%
% of febrile patients seeking care for fever within 24 hours**	48%
% of febrile patients who sought care for fever who received diagnosis**	31%
% of febrile children < 5 years who took a combination with artemisinin**	30%
% of febrile patients who sought care in private sector**	30%

** The current coverage level is unknown and loss of ITNs is expected due to the large population displacements in 2023 and still ongoing;*
*** MIS 2016; *** IRS coverage is 0% due to financial gaps*

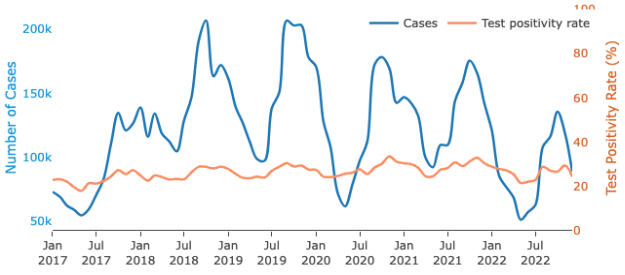
Financing for malaria (US$)

	2021	2022	% baseline (2015)	% in 2022
Total national budget				
Total national health budget				
Total malaria budget	83,000,000	179,000,000		116
Domestic funding for malaria	7,500,000	6,399,120		-15
Global Fund*	18,743,685	71,271,711		280
PMI*	0	0		-
Other external funding*	1,249,098	2,316,517		85
Total funding gap	**55,507,217**	**99,012,652**		**78**

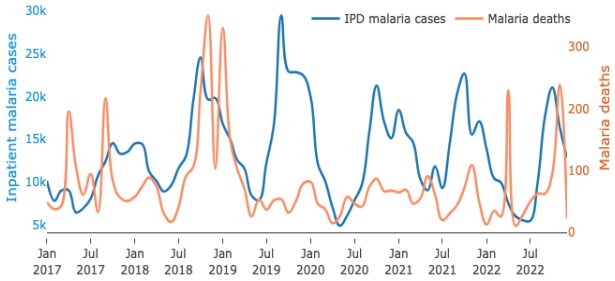
** Contribution reported by countries*

Trends key impact indicators

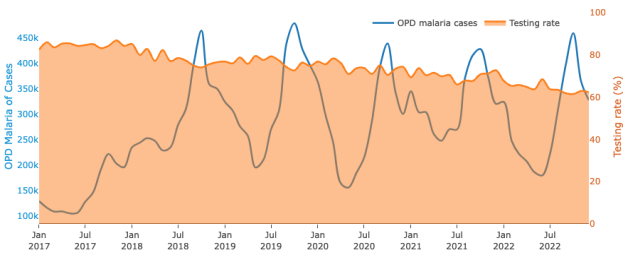
Outpatient and malaria test positivity rate, all ages, 2017–2022



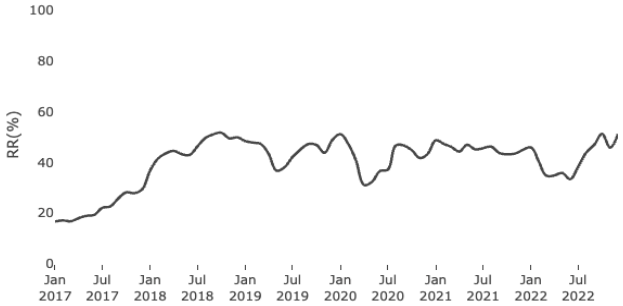
Inpatient malaria cases and deaths, all ages, 2017–2022



Outpatient malaria cases and testing rate, 2017–2022



Percentage of health facilities reported (reporting rate), by months, 2017–2022



Impact indicators

	Baseline 2021	Target 2022	Reported 2022	% change (target vs. reported, 2022)	% change (2022 vs. baseline)
Estimated malaria cases*	2,906,886		2,784,704		
Estimated malaria deaths*	6,733		6,680		
Reported malaria cases (presumed & confirmed)	3,815,616	3,624,835	3,624,835		5%
estimated malaria cases (SNT 2023)	7,620,657	7,257,769	6,534,222		14%
Confirmed malaria cases (microscopy or RDTs)/1000 persons	38	36	34		11%
Inpatient malaria deaths/100,000 population	8	4	4		50%
Inpatient malaria deaths/ total inpatient deaths	8	8	10		-20%
Test (slide + microscopy) posivity rate	28	0	25		10%

* *World malaria report 2023.*

Reasons for stalling, ranked by descending importance

1. **long-term political unrest and economic instability**
2. **Inadequate external funding**
3. **Inadequate domestic funding**
4. **Inadequate health infrastructure**
5. **Inadequate procurement and supply chain management**
6. **Inadequate access to early diagnosis and treatment**
7. **Inadequate community-based interventions (e.g. iCCM)**
8. **Inadequate health care seeking behavior and compliance**
9. **Suboptimal impact of interventions**
10. **Inadequate leadership, coordination and accountability**
11. **Inadequate partner support and alignment**
12. **Inadequate political commitment and ownership**

Health system performance

Health systems	Performance	Comments
Health sector plan (year) and vision putting UHC at the centre	Satisfactory	
Accountability and transparency	Satisfactory	
Existence of multisectoral collaboration	Satisfactory	
Stakeholders participation in policy, action and M&E	Excellent	
Information system (decisions are largely data-driven and evidence-based)	Unsatisfactory	The national malaria programme is using available evidence for decision, however data quality remain a major challenge.
Private sector engagement and regulation	Unsatisfactory	
Availability and coverage of community health insurance	Unsatisfactory	
Involvement of civil society including vulnerable & marginalized pop	Unsatisfactory	
Legislation and regulation, and ensuring compliance	Unsatisfactory	

Strengths/opportunities

- Political commitment (President prioritizes malaria)
- Good external partners support
- Presence of a national network of malaria experts
- Commitment of the NMCP team at national and state levels

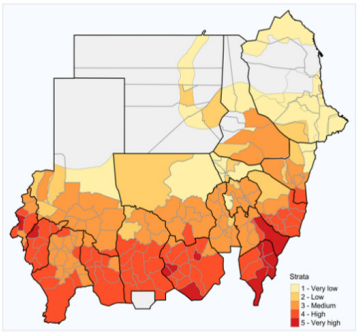
Lessons from the COVID-19 pandemic

- The virtual and teleworking culture development
- Use of online platforms for training

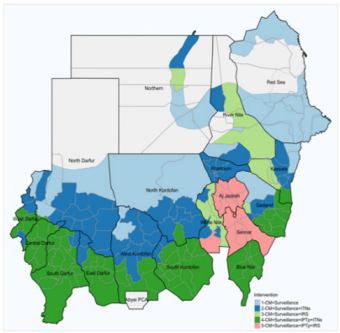
Work done since the adoption of the HBHI approach

In June 2022, the NMCP with the lead of the PHC director presented the HBHI initiative to the health emergency higher council as an approach which provides a useful mechanism for the programme to translate the stated political commitment into resources and tangible actions that will save more lives. The NMCP presented the HBHI assessment tool and log frame to start the operationalization of this initiative in the country. With support from WHO, the NMCP carried out the first subnational burden estimation, followed by subnational tailoring of malaria interventions, to guide a better use of local data for a tailored deployment of interventions for maximum impact. The results were used as the main guidance for planning of the new Global Fund grant cycle 7.

Morbidity + all cause under 5 mortality

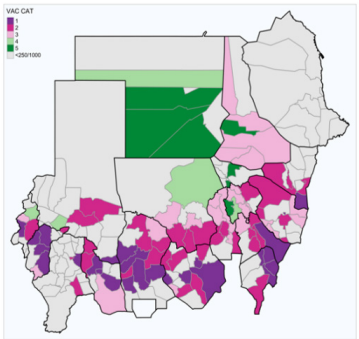


Strategic mix intervention



Global Fund allocation 2024-26

Use of vaccine analysis in GAVI application



FMOH, from the domestic resources during the current emergency setting, is focusing on the continuity of services particularly the mortality reduction guided by the best available data through the implementation of the malaria mentorship programme and the rollout of the newly introduced malaria vaccine.

Malaria Ministerial Conference:
"Tackling malaria in countries hardest hit by the disease"

Yaoundé, Cameroon, 6 March 2024

United Republic of Tanzania

Background

The United Republic of Tanzania has experienced significant declines in nationwide malaria parasite rates, dropping from 18.1% in 2008 to 14.8% in 2015, and subsequently reaching 8.1% in 2022 due to the expansion of preventive and treatment measures.

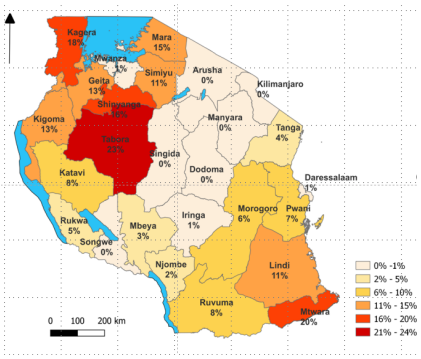
However, despite these achievements, malaria transmission has become localized and susceptible to epidemics, even with extensive intervention coverage. Approximately one third of the country, forming a "corridor" extending from the north-east to the south-west, is inhabited by a population residing in regions with low and very low malaria transmission risk, making them vulnerable to malaria outbreaks.

The country is pursuing subnational elimination in five regions with less than 1% parasite prevalence by implementing case-based surveillance, concurrently enhancing interventions to alleviate the burden in areas with moderate and high transmission rates. Persistent challenges include limited access to remote communities and the underutilization of services.

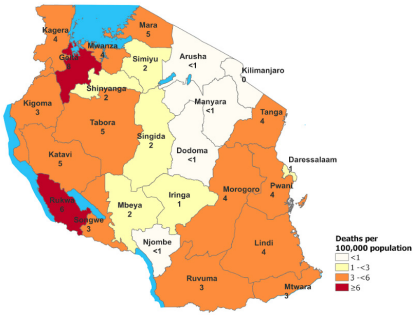
Ten regions accounted for about 75% of reported cases and 67% of reported deaths in 2023

Region	No. of cases	No. of deaths	% attributed in cases
Kagera	**397,659**	**157**	**11.3%**
Mwanza	**331,100**	**179**	**9.4%**
Kigoma	**326,157**	**83**	**9.2%**
Geita	**308,278**	**211**	**8.7%**
Tabora	**264,049**	**181**	**7.5%**
Ruvuma	**231,746**	**57**	**6.6%**
Tanga	**213,068**	**109**	**6.0%**
Morogoro	**203,991**	**110**	**5.8%**
Mara	**200,455**	**131**	**5.7%**
Mtwara	**184,562**	**42**	**5.2%**
Pwani	172,341	57	4.9%
Dar Es Salaam	130,023	84	3.7%
Lindi	124,138	41	3.5%
Shinyanga	104,431	52	3.0%
Rukwa	65,846	80	1.9%
Mbeya	63,224	46	1.8%
Katavi	51,305	46	1.5%
Simiyu	50,889	78	1.4%
Songwe	25,292	39	0.7%
Dodoma	22,801	13	0.6%
Singida	20,665	34	0.6%
Njombe	10,446	5	0.3%
Iringa	10,113	13	0.3%
Arusha	6,485	12	0.2%
Manyara	5,385	7	0.2%
Kilimanjaro	4,368	1	0.1%
Total	**3,528,817**	**1,868**	**100.0%**

Malaria parasite prevalence (MIS, 2022)



Malaria mortality rate (DHIS2, 2023)



Intervention coverage and financing

Estimated national coverage of key interventions

	2015	2017	2023
Population at risk of malaria	47,918,225	56,430,028	61,342,896
% of population owning an ITN	66%	78%	67%
% of children < 5 years and pregnant women sleeping under an ITN	54%, 54%	55%, 51%	59%, 58%
Last mass ITN campaign year			2023
% of population covered with mass ITN campaign			10%
% of population covered by IRS	6%	7%	0%
% of febrile children < 5 years for whom advice and treatment was sought	80%	75%	78%
% of febrile children < 5 years sought care for fever who received diagnosis	36%	43%	51%
% of febrile children < 5 years who took a combination with artemisinin	31%	32%	43%
% of febrile children < 5 years sought care in private sector	9%	9%	22%

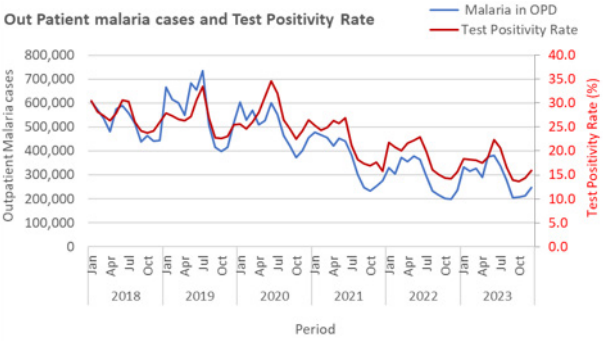
Financing for malaria (US$)

	2021	2022	% baseline (2015)	% in 2022
Total national budget	10,225,018,676	11,036,379,208	40%	8%
Total national health budget	827,947,405	868,120,643	-3%	5%
Total malaria budget	160,023,947	178,410,125		11%
Domestic funding for malaria	10,000,000	10,000,000		0%
Global Fund*	49,613,879	48,511,597		-2%
PMI*	42,000,000	44,000,000		5%
Other external funding*	15,000,000	20,000,000		33%
Total funding gap	**48,023,947**	**58,410,125**		**22%**

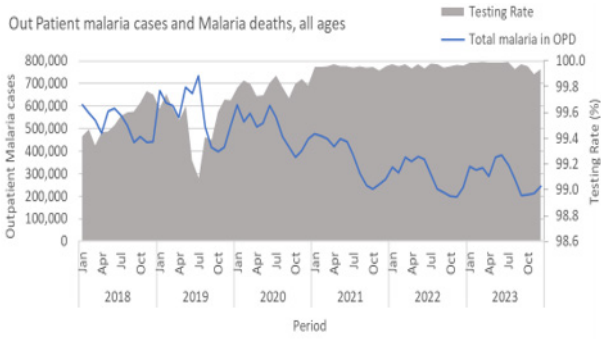
** Contribution reported by countries*

Trends key impact indicators

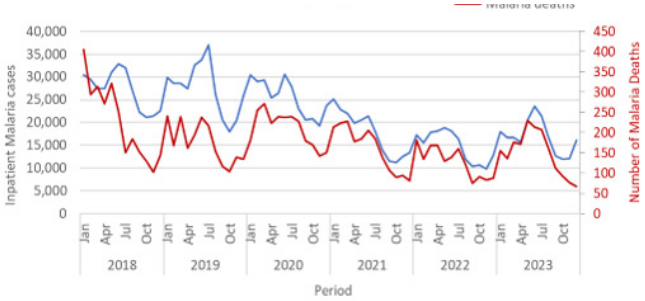
Outpatient and malaria test positivity rate, all ages, 2018–2023



Inpatient malaria cases and deaths, all ages, 2018–2023



Inpatient malaria cases and malaria deaths, all ages, 2018–2023



Impact indicators

	Baseline 2015	Target 2022	Reported 2023	% change (2023 vs. 2022 target)	% change (2023 vs. baseline)
Estimated malaria cases*	7,428,997	7,959,890			7%
Estimated malaria deaths*	23,936	26,664			11%
Malaria parasite rate	15%	5%	8%	62%	-45%
Malaria cases	7,738,575		3,528,817		-54%
Malaria cases per 1000	161	60	58	-4%	-64%
Inpatient malaria cases	529,146		202,989		-62%
Inpatient malaria incidence per 10,000	110		33		-70%
Malaria deaths	6,311		1,868		-70%
Malaria deaths per 100,000	13.2	3.0	3.0	2%	-77%

* *World malaria report 2023.*

Major drivers of malaria mortality in the country

1. **Limited access to early diagnosis and treatment particulary in rural areas**
   Some communities have limited access to an operational health facility. An average of 12% of villages are more than 10 km away from the nearest health facility and some villages have geographical barriers to health facilities.
2. **Inadequate care seeking behavior and compliance**
   Trust in the effectiveness of malaria tests and treatment has been reported to be at 45%, affecting health seeking behaviour and compliance.
3. **Inadequate coverage of interventions at the community, ie. LLIN, IPTp**
   Coverage of IRS stands at 0%.
4. **Inadequate capacity to manage severe malaria (skill, staff, facilities)**
5. **Inadequate referral system**
   This affects management of severe malaria cases.

Reasons for stalling, ranked by descending importance

1. **Inadequate health care seeking behaviour and compliance**
   Care-seeking for malaria varies by region and wealth quintile, with lower rates in the Lake and Central Highlands zones and among lower-income groups. Disparities in testing and treatment access stem from geographical and socioeconomic differences, particularly evident in the Lake Zone, Central Highlands, and Coastal Zone, leading to lower positivity rates. Additionally, individuals in the two lowest wealth quintiles encounter difficulties accessing services in these zones.
2. **Suboptimal access to early diagnosis and treatment**
3. **Inadequate funding**
   Inadequate funding, overall gap of 42%, has hindered the implementation of programme objectives. Most impacted were SBCA with a 67% gap, leadership partnership and resource mobilization with a 49% gap, SME with a 48% gap, and vector control with a 44% gap. Notably, LSM and IRS suffered the most, with gaps of 84% and 74%, respectively.
4. **Inadequate coverage of vector control interventions**

Health system performance

Health systems	Performance	Comments
Health sector plan (year) and vision putting UHC at the centre	Excellent	UHC is one of the key components of the Health Sector Strategic plan
Accountability and transparency	Excellent	Well operating accountability systems
Existence of multisectoral collaboration	Unsatisfactory	The country is in initial stages of establishing a formal malaria control multi sectoral collaboration platform
Stakeholders participation in policy, action and M&E	Excellent	NMCP coordinates all malaria stakeholders in policy development, implementation of malaria interventions and M&E. All stakeholders are engaged through Technical Working Groups
Information system (decisions are largely data-driven and evidence-based)	Excellent	Allocation of resources is data driven
Private sector engagement and regulation	Satisfactory	
Availability and coverage of community health insurance	Unsatisfactory	Less than 50% of Tanzanians are covered by health insurance
Involvement of civil society including vulnerable & marginalized pop	Unsatisfactory	
Legislation and regulation, and ensuring compliance	Satisfactory	

Strengths/opportunities

- Political commitment (President prioritizes malaria)
  Increased political will has strengthened advocacy efforts and deepened understanding of the disease, raising acceptance of interventions and accelerating malaria initiatives at high level; e.g. LSM is now championed as one of the national priority interventions. However, there remains little evidence to ascertain if the heightened political will has indeed translated into increased commitment.
- Parliamentary engagement and support malaria scorecards
- Good external partners support
- Willingness of the community to utilize interventions
- Well organized health system with structures to accommodate implementation of malaria interventions

Lessons from the COVID-19 pandemic

- Having stocks of malaria commodities for about five months in-country is key to the continued provision of malaria services during emergency situations and pandemics. Transportation of commodities was disrupted during the Covid-19 pandemic. In Tanzania malaria services were able to continue without any stock outs of commodities as the country had malaria commodities stock of five months.
- Enhanced surveillance and epidemic response is necessary to save lives.
- Proper diagnosis of patients with fever is important to ensure proper case management and prevent irrational use of medicine.