Sahel malaria elimination initiative (SaME) : Draft joint work plan 2019

Contents

Glossary

Case of malaria
Occurrence of malaria infection in a person in whom the presence of malaria parasites in the blood has been confirmed by a diagnostic test

Active case detection
Detection by health workers of malaria cases at community and household levels, sometimes in population groups that are considered at high risk. Active case detection can consist of screening for fever followed by parasitological examination of all febrile patients or as parasitological examination of the target population without prior screening for fever.

Case detection
One of the activities of surveillance operations, involving a search for malaria cases in a community.

Passive case detection
Detection of malaria cases among patients who, on their own initiative, visit health services for diagnosis and treatment, usually for a febrile illness

Malaria elimination
Interruption of local transmission (reduction to zero incidence of indigenous cases) of a specified malaria parasite in a defined geographical area as a result of deliberate activities. Continued measures to prevent re-establishment of transmission are required.

Case investigation
Collection of information to allow classification of a malaria case by origin of infection, i.e. imported, indigenous, induced, introduced, relapsing or recrudescent

List of abbreviations/acronyms

ACT	Artemisinin Combination Therapy
ALMA	African Leaders Malaria Alliance
CHW	Community Health Worker
ECOWAS	Economic Community of West African States
CEMAC	Central African Economic and Monetary Community
SMC	Seasonal malaria chemoprevention
HD	Health District
GTS	Global Technical Strategy
HBHI	High Burden High Impact
HDI	Human Development Index
LLITN	Long-lasting insecticide-treated net
OCEAC	Organization of Coordination for the Fight against Endemic Diseases in Central Africa
SDG	Sustainable Development goals
WHO	World Health Organization
OMVS	Senegal River Basin Development Authority
CCMm	Community Case Management
IRS	Indoor residual spraying (IRS)
PMI	US President Malaria initiative
NMCP	National Malaria Control Programme
NSP	National Strategic Plan
RBM	RBM Partnership to End Malaria
SaME	Sahel Malaria Elimination Initiative
SMCF	Sahel Malaria Control Fund
RDT	Rapid diagnostic test
AU	African Union
WAHO	West African Health Organisation

Introduction

Malaria in the countries of the Sahel Malaria Elimination Initiative (SaME), like the majority of countries on the continent south of the Sahara, is one of the main reasons for consultations and hospitalization and one of the main causes of death. This disease is a heavy burden on the socio-economic development of the countries where it is prevalent and one of the reasons why these populations continue to be trapped in poverty.

Thus, to tackle this pandemic effectively and achieve its elimination by 2030 in accordance with the Global Technical Strategy for Malaria 2016-2030, countries must ensure political leadership at the highest level, combine their efforts to mobilize resources and rational management of prevention programmes, then strengthen their intersectoral and cross-border collaboration.

It is against this background that the Sahel Malaria Elimination Initiative (SaME) was created. This initiative is a subregional platform for collaboration launched on 31 August 2018 in Dakar, Senegal by the Ministers of Health of eight countries in the Sahel region (Burkina Faso, The Gambia, Cabo Verde, Mauritania, Mali, Niger, Senegal and Chad), to accelerate the elimination of malaria in the Sahel region. This regional initiative will contribute to accelerating the realisation of the global vision of a world without malaria.

This joint work plan shared by the member States has been prepared to serve as the basis for planning in the countries concerned in the framework of this initiative.

1. Background of the SaME initiative

To strengthen their intersectoral and cross-border collaboration and contribute to achieving the Sustainable Development Goals (SDG) by 2030, several initiatives have been introduced to mark the commitment of authorities at the highest level in African States to the prevention of malaria.

Among the most recent, the initiative for the elimination of malaria in the Sahel was born in 2007 with the launch by the African Ministers of Health during the African Union Conference.

Then, in 2013, the Ministers of Health of six countries, including The Gambia, Mali, Mauritania, Niger, Senegal and Chad, signed the "Nouakchott Declaration" aimed at accelerating the elimination of malaria in the Sahel. Burkina Faso and Cabo Verde joined the initiative in 2014.

In June 2017, mandated by the Governments of the eight countries to draw up a regional coordination framework for this initiative, the WHO, in collaboration with the RBM Partnership and the Government of Monaco, united the national malaria prevention programme coordinators of the countries concerned. This allowed them to reflect on the appropriate mechanisms to stimulate joint action and an effective response in the subregion, so as to accelerate the vision of a malaria-free Africa.

Following up on the recommendations from the Monaco meeting, the WHO and the RBM Partnership, in collaboration with the eight Member States, worked to produce a roadmap in 2018 which set out four main action points:

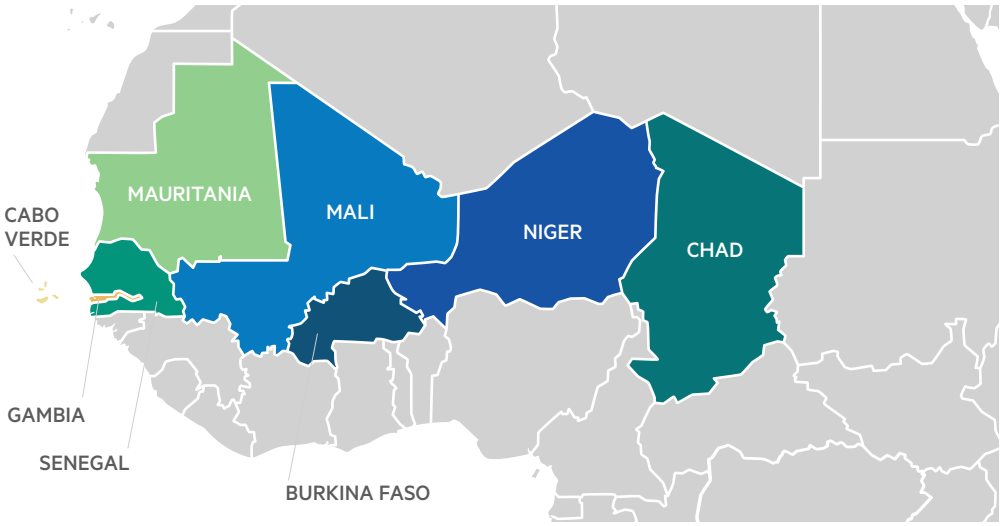
1. Design of a subregional strategy to accelerate the elimination of malaria in the Sahel region;
2. Approval of the Declaration by the official launch of the Initiative by the Ministers of Health of the eight countries concerned;
3. Updating of national strategic plans for the prevention of malaria so as to include key elements likely to produce an appropriate response;
4. Elaboration of a resource mobilization strategy centred on identifying and engaging potential partners and powerful advocacy to the Member States to increase their financial contributions.

2. Profile of the SaME countries

2.1. Geographical situation

The SaME countries are situated in the Sahel-Sahara belt extending over a distance of more than 4,500 Km between Cabo Verde and Chad.

Figure 1 : Map of SaME countries



2.2. Demographic data

The population at risk of malaria in the eight Sahel countries was some 98,082,241 inhabitants in 2018.

2.3. Ecosystems, environments and climates

Several climate zones can be distinguished in the majority of the SaME countries with variable rainfall. The rainfall is higher in the southern parts of the countries which record the largest number malaria cases during this period. The rainy season there is relatively short which makes these countries eligible for SMC.

The current climate changes could modify certain parameters (rainfall, temperature,...) and lead to an increase in larval sources. This could have as a consequence an increase in the incidence of malaria cases.

2.4. Development indicators and poverty

According to the Human Development Index (HDI), which evaluates countries' level of human development in 2018, Cabo Verde is the only country where the HDI is average (0.65); all the other seven countries have a low HDI, ranging from 0.35 for Niger to 0.52 for Mauritania, according to the 2018 data.

2.5. Socio-economic and security situation

In the majority of these countries, the populations mainly come from rural areas and live off agriculture, fishing and livestock. These include nomadic populations, essentially consisting of livestock farmers in transhumance seeking pasture for their livestock.

For some years, the security situation in these countries has been unstable due to the recent rise in terrorism in the subregion. Five of the eight countries belong to the G5 Sahel Force charged with combating terrorism in these States.

The risks of sporadic intercommunal conflicts in some of these countries add to this threat.

This situation thus seriously affects the movement of people and goods in these areas, as well as the implementation of health programmes, malaria in particular.

2.6. Analysis of health systems

All the SaME countries have a pyramidal health system comprising three levels: central level, intermediate level and peripheral level.

In all the Sahel countries, the public sector is better developed and looks after the majority of the populations seeking care.

The private sector, although it has developed considerably in recent years, is chiefly established in the main towns. This sector is generally not well managed by the health authorities.

The traditional sector exists and is recognised by the various Ministries of Health.

In the community sector, there is generally little evidence of community involvement. This sector is not very effective because of limited human and financial resources and little encouragement to communities to take responsibility in most of the countries.

Although some countries have drawn up Strategic Development Plans for human resources for health, the various categories of staff are still inadequate in terms of both quantity and quality.

In addition, the capacity of the health systems remains weak, and it has been noted that, among other things, there are broken supply systems marked by interruptions of anti-malarial inputs, in varying proportions depending on the country.

3. Analysis of the malaria situation in the SaME countries

3.1. National and international political commitment

All the countries have signed up to the elimination of malaria by 2030 and have mentioned it in their national malaria prevention policies.

The National Strategic Plans (NSP) of all the countries are in line with the sectoral policy documents and national health development plans.

All the SaME countries have a political commitment renewed by their countries' highest authorities concerning the prevention of malaria.

However, integration of malaria control with other government sectors is still insufficient.

Only in Cabo Verde is there a legal commitment to the prevention of malaria. Of these eight countries, Senegal, Mali, Mauritania and The Gambia maintain cross-border relations in the framework of the Senegal River Basin Development Authority (OMVS). In the framework of the Malaria and Neglected Tropical Diseases (NTD) project in the Sahel, Burkina Faso, Mali and Niger are carrying out joint cross-border activities.

3.2. National malaria prevention programmes

In the countries, all the national programmes have drawn up NSP, of which the implementation periods vary from one country to another. The programmes operate in accordance with defined organizational charts, however, there are insufficient financial resources and human capacities to eliminate malaria according to the lines that need to be funded as defined in the framework of elimination of malaria. Indeed, according to the 2017 framework for the elimination of malaria, to attain its objectives, the programme must be structured to implement its operational plans by assigning roles and responsibilities to basic personnel in a malaria prevention programme. In the NSP of the programmes, this basic personnel does not always conform to that defined in the elimination framework.

3.3. Malaria prevention strategies

The various strategies and interventions to combat malaria are adapted to the national contexts of the countries, especially prevention, such as case management with emphasis on surveillance for the countries in the course of elimination..

The strategies to combat malaria are implemented in countries at different levels. Thus the levels of universal coverage of LLITN, IRS and RDT and diagnostic and treatment are different from one country to another.

LLITN campaigns have been organized every three years in the SaME countries for several years. Routine LLITN distributions to children and pregnant women are complementary to mass distributions.

IRS is hardly used in the countries except Cabo Verde.

The implementation of SMC began as a pilot scheme, then became large scale in the majority of the SaME countries with the exception of Mauritania where this strategy has not yet started. In all the countries except Senegal, it concerns children aged 3 to 59 months. In the case of Senegal, the age range covered is up to 10 years.

In all the countries, diagnosis of malaria cases is done with the aid of RDT and GE, and the treatment is based on therapeutic compounds of artemisinin.

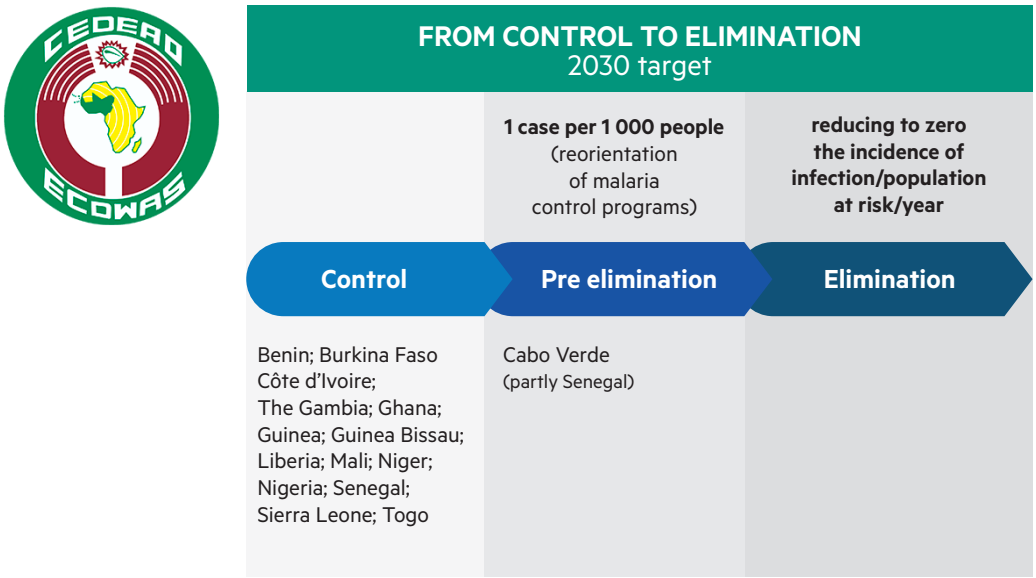
Active detection of cases in the countries as pre-elimination are still rarely carried out Training of health personnel in the countries is essentially focused on case management and prevention strategies, but very little on surveillance.

Thus surveillance and entomological monitoring in these countries must be further strengthened in all these countries to allow Cabo Verde, the Gambia, Mauritania and Senegal, which are on the road to elimination of malaria, and other Sahel countries, which are at the stage of accelerating reduction of the burden of malaria, to really achieve elimination by 2030.

However, various factors affect the quality of these prevention, diagnostic and treatment services for the elimination of malaria, such as inadequate training and supervision, lack of integration of interventions and programmes, lack of involvement of the private sector and communities in malaria surveillance.

Moreover, advocacy activities, social mobilization and communication for behaviour change are hardly used.

Figure 2 : Situation of Sahel countries in the continuum towards elimination of malaria



3.4. Epidemiology of malaria in the SaME countries

An gambiae is the principal vector of malaria found and Plasmodium falciparum the principal parasite.

Tests for therapeutic effectiveness of anti-malarial drugs are carried out as well as sensitivity studies of vectors to insecticides, even if in the majority of the countries these studies are not regular.

In the majority of cases, the countries have not prepared their management plan for resistance to insecticides.

All the countries have determined the epidemiological facies of malaria based on the available data. Like Niger, some of them do not have evidence of parasitic prevalence (NSP Niger 2017-2021).

However, in other countries, stratifications were prepared for years ago and have become outdated. Apart from Burkina Faso and the Gambia which are considered as countries with a single stratum, the other countries have several strata of malaria transmission.

As far as the district level is concerned, Chad, Burkina Faso, Mali and the Gambia have planned their epidemiological stratifications in their NSP.

Not all the country NSP of the eight Sahel countries are oriented towards elimination in accordance with the strategic framework for the elimination of malaria. Indeed, according to this strategic framework, all the countries, including those where malaria is a heavy burden, can define the elimination of malaria as an objective and adapt their interventions to accelerate in this direction. However, only the NSP of Cabo Verde, Mauritania, the Gambia and Senegal (the northern zone) have defined the objectives of elimination and strengthened surveillance of cases in the framework of elimination of malaria to varying degrees, as they are approaching the recommended elimination thresholds. The lack of a standard definition of epidemic thresholds of malaria adapted to the different epidemiological facies can be seen in Mauritania, a failure to update alert and epidemic thresholds in Chad or a lack of any mention of the threshold in the NSP of Burkina Faso.

3.5. Morbidity and mortality

Of these eight countries, Cabo Verde, Mauritania, the Gambia and certain districts in the North of Senegal are in the malaria pre-elimination phase.

The other countries, although having falling morbidity and mortality data, are still in the control phase of the diseases.

Indeed, according to the situation analysis report on the malaria landscape in the eight countries targeted by the SaME, containing data from the World Health Report 2017, a fall in the indicators concerned has been observed over several years, although with an increased incidence of cases in certain countries.

According to the WHO World Report 2017, there were an estimated 24,436,100 cases in 2014 and 26,974,200 in 2016. Three countries have the largest number of estimated cases. These are Burkina Faso, Mali and Niger which alone account for 88% of the estimated cases for the eight Sahel countries. The number of deaths due to malaria notified fell by 46%, from 17,161 in 2010 to 9,627 in 2016, but the notification rates were low in the eight Sahel countries. The estimated number of deaths due to malaria rose from an estimated 85,290 deaths in 2014 to an estimated 72,790 deaths in 2016; the same countries from which come 82% of the estimated deaths.

Children under the age of 5 years and pregnant women pay the highest price in terms of morbidity and mortality compared with the rest of the population.

Cabo Verde recorded the lowest number of reported cases of malaria among the eight Sahel countries in 2016, with 75 cases confirmed by the RDT while the estimated number of deaths due to malaria was lower at 10 in 2016.

The morbidity and mortality data by country are shown in the following table.

Compared with the eight Sahel countries, the countries of West Africa which record the highest number of presumed and confirmed cases are Nigeria, Ghana and Côte d'Ivoire (World Malaria Report, 2017).

Figure 3 : Cas de paludisme rapportés confirmés par TDR, 2010-2017 (World Malaria Report, 2018)

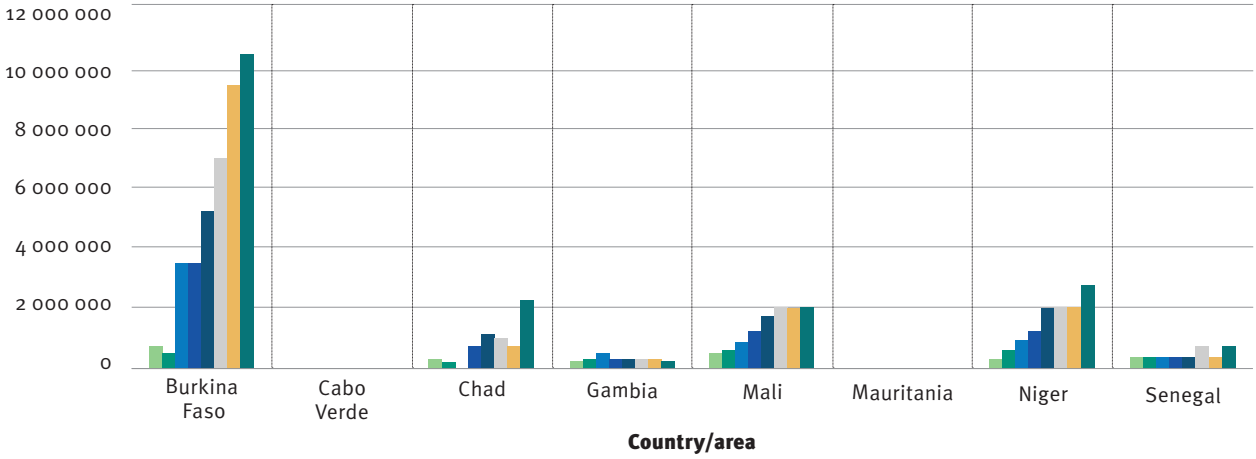
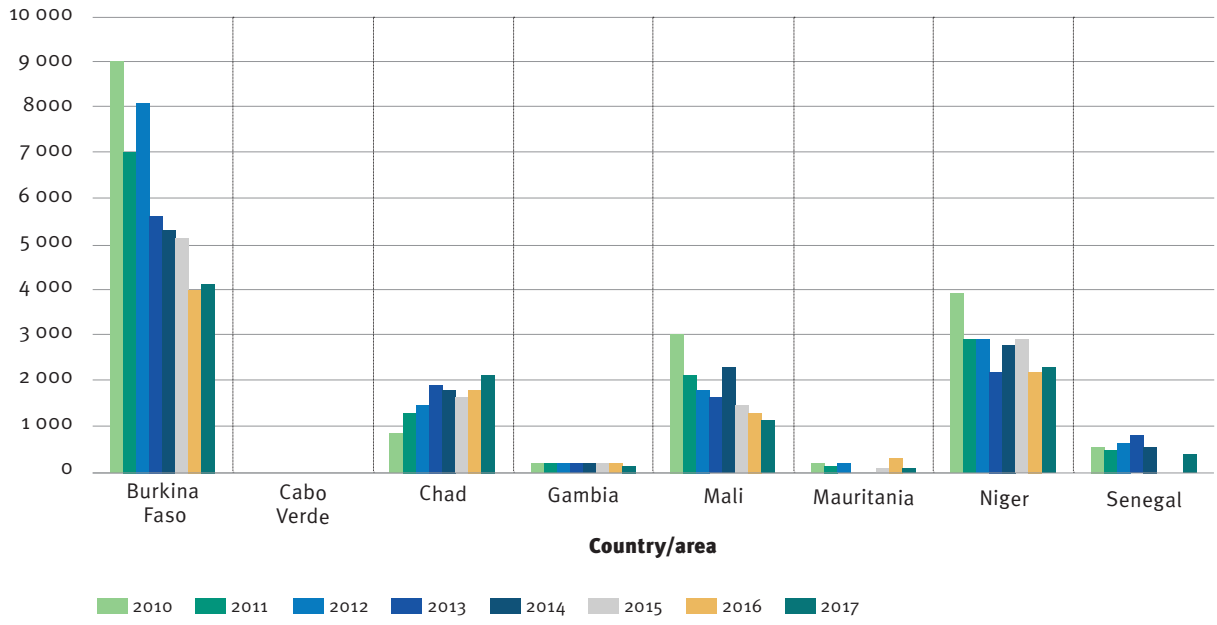


Figure 4 : Cas de décès estimés par pays, 2010-2017 (World Malaria Report, 2018)



3.6. Trends in certain malaria prevention indicators

An improvement in the coverage indicators can be seen in the countries, although they have not reached universal coverage for all the strategies.

With regard to universal access to malaria diagnosis, the number of RDT kits rose from 16,197,031 in 2014 to 23,788,710 in 2016. Burkina Faso, the Gambia, Mali, Niger and Senegal accounted for 95.3% of the number of RDT spread across the eight Sahel countries.

The number of confirmed case rose by 86% compared with 2010, from 2,030,473 to 14,718,032 in 2016. The number of LLITN distributed or sold rose by 25% from 25% 17,411,096 in 2014 to 23,369,181 in 2016. The proportion of the population with access to insecticide-impregnated mosquito nets was over 50% in the Sahel countries with the exception of Mauritania (11%) in 2016.

The proportion of the population with access to an LLITN rose from 54% in 2014 to 80% in 2016 in Mali. In Senegal, it rose from 74% in 2014 to 83% in 2016.

Cabo Verde is the only country to have achieved 100% IRS coverage. That could be explained by the fact that Cabo Verde has an inter-ministerial anti-vectoral committee chaired by the Prime Minister, which meets twice a year.

The percentages of children aged 3 to 59 months protected against malaria (4 doses in 4 SMC courses) during the high malaria transmission season preceding the survey was 91% in 2015 in Burkina Faso and in Senegal for the age group under 10 years. The lowest percentage was 44% in Mali in the same year.

3. 7. “Scorecard” tool for the control and elimination of malaria

Created by the coalition of African Heads of State and Government for a collective and coordinated response to complement efforts to get rid of malaria in Africa by 2030, ALMA has developed a continental Scorecard for Accountability and Action which allows monitoring of results, identifying bottlenecks and acting in a more targeted way. Following up on the success of the latter, and at the request of the Heads of State, ALMA has also supported countries in developing their national scorecards for the control and elimination of malaria based on national and regional indicators which are regularly updated and incorporated in the existing management and decision-making processes. All the SaME countries now have an updated scorecard which allows them to define the real bottlenecks and take appropriate measures/recommend appropriate actions.

In September 2018 at a technical meeting of the SaME countries in Senegal, in collaboration with the various partners present, ALMA supported the SaME in the elaboration of a project for a subregional accountability tool on the elimination of malaria to monitor progress achieved and identify measures to be taken to remove bottlenecks. The tool will be used for joint surveillance and accountability, providing a subregional insight into malaria trends and progress in the implementation of each country’s policies. Priority indicators for surveillance of the prevention of malaria and the implementation of the elimination programme have been selected, and a discussion has been organized to identify the mechanism for assigning responsibility for and monitoring of actions for the SaME. The scorecard will be incorporated in SaME’s coordination structure, which is currently under discussion with WAHO and the RBM partnership.

3.8. Financing of the prevention of malaria

Financing for prevention of malaria is inadequate despite the requests for financing accepted by the Global Fund aimed at filling the financing gaps.

Furthermore, mobilization of resources for the implementation of the NSP interventions is weak, except in the case of Mali.

According to data in the World Report 2017, there has been a slight increase in the amount allocated to malaria, which rose from 150.3 million US dollars in 2014 to 154.6 million in 2016.

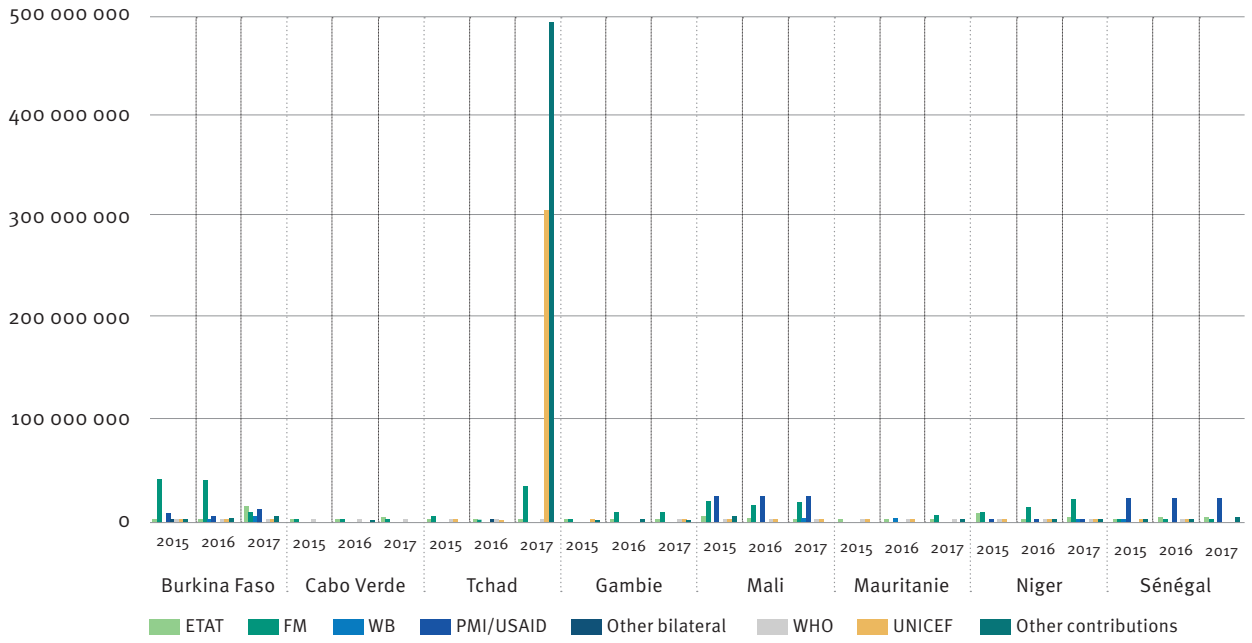
In 2016, the three main donors which supported the financing of the prevention of malaria in the eight Sahel countries are the Global Fund (USD 84,429,391), PMI/USAID (USD 55,455,900 and the World Bank (USD 18,036,634).

The percentage contributions varies depending on the country and years, but can reach 90% in some countries (Chad in 2016, Burkina Faso in 2015, Mali...).

Only the State contributions in Cabo Verde are higher than those of the partners. However, there has been an increase in State budgets for the prevention of malaria in Burkina Faso, Cabo Verde, Mali, Mauritania and Senegal.

There is no resource mobilization plan in the countries and the public-private partnership is under-developed.

Figure 5 : Contributions of partners to the prevention of malaria



4. Coordination and governance structures

A coordination mechanism associated with an existing subregional mechanism brings better outcomes in terms of coordination. A similar management and coordination mechanism between the countries in the region is important to advance the work of the Initiative and efforts in the eight countries.

The Sahel Malaria Elimination Initiative (SaME) is supported by the Ministers of Health of the region and its partners, notably the World Health Organization (WHO), the Economic Community of West African States (ECOWAS), the African Leaders Malaria Alliance and the RBM Partnership against malaria. The SaME coordination mechanism is hosted by the West African Health Organization (WAHO), a specialized agency of ECOWAS.

The principal institutions/organs responsible for the management and implementation of the Initiative as defined in the SaME Coordination Platform Framework 2018 comprise:

- Heads of State
- ECOWAS
- The SaME Ministerial Forum;
- The SaME Technical Committee;
- The West African Health Organization;
- The SaME Secretariat;
- The SaME Ambassador.

5. Reminder of the recommendations of the SaME countries in 2018

The following table shows the recommendations made by the SaME countries in 2018.

Table IV : Recommendations of the SaME countries

COUNTRY	RECOMMENDATIONS
Burkina Faso	• Prepare a regional strategic plan for the elimination of malaria in the 8 Sahel countries (RBM/WHO) • Advocate to the Global Fund to obtain financing above the allocated amount (SMC, LLITN routine, training/retraining of health workers to the PEC,....) 2019 & 2020 (RBM) • Advocate to the Malaria Consortium to continue the financing of the implementation of the SMC in certain health districts in the country in 2019 & 2020 (RBM) • Advocate to the World Bank to continue the financing of the implementation of the SMC in certain health districts in the country in 2019 & 2020 (RBM) • Advocate for WHO/RBM/PMI technical assistance for mid-term review of NSP 2016-2020 and stratification in terms of morbidity (RBM/OMS/PMI)
Cabo Verde	**Politicians:** • Greater commitment to the prevention of malaria, notably the challenge of eliminating the disease. • Increased financial commitment to the prevention of malaria by the national counterpart. • Adoption of the principal international slogans on the challenges of prevention. • Adoption of international standards, rules and approaches to the elimination of malaria • Facilitation of agreements for cross-border epidemiological surveillance. • Facilitation of the creation of regional coordination. **Partners:** • Technical assistance/revision of plans and new plans, taking account of challenges of elimination. • Financial support to the implementation of National Strategic Plans. • Support for sharing of good practices between countries. • Support for the establishment of regional/subregional coordination. • Facilitation of the elaboration of a regional resource mobilization plan for prevention
Gambia	**WHO and RBM** should put in place mechanisms for • adequate preparation by the country team (draft bulletins already prepared) • Proactive monitoring of support provided to countries to meet the challenges identified • A data sharing platform should be established to allow countries to share data. **Countries** should envisage conducting surveillance evaluations to: • Identify the problems affecting the quality, availability of surveillance data • Design strategies to resolve these problems • Should best practices be shared?
Mali	**Country:** • Update the epidemiological facies; • Disseminate regulatory documents; • Create a legal framework conducive to the elimination of malaria; • Organize round tables for resource mobilization with partners involved in the prevention of malaria including strengthening the partnership with the private sector. **Partners:** • Support the programme with decision-makers on mobilization of State Advocate ; • Advocacy to the Global Fund to ease the "Zero Cash" Policy (WHO, RBM); • Support financing of the NSP

COUNTRY	RECOMMENDATIONS
Mauritania	• Advocate for the commitment of the Government to the prevention of malaria and its elimination • Elaboration of a budgeted plan for community communication for mobilization in favour of the elimination of malaria • Strengthen input supply chains • Strengthen collaboration with maternal and infant health services • Strengthen cross-border collaboration for the prevention and control of malaria in border areas • Improve the quality of data on malaria • Strengthen supply chains systems for inputs to combat malaria • Provide continuing training for public and private sector health workers on interventions for the prevention of malaria including surveillance • Update the epidemiological facies in the country.
Niger	**State:** Increase the budget line allocated to prevention of malaria **Partners:** Support the country with technical assistance for the update of the epi0demiological facies and elaboration of certain regulatory documents (mid-term review; elimination plan, resource mobilization plan)
Senegal	Not mentioned in the SaME Country Recommendations document 21.09.2018
Chad	Not mentioned in the SaME Country Recommendations document 21.09.2018

6. The “Zero Malaria Starts with Me” campaign

The “Zero Malaria Starts With Me” campaign was launched by His Majesty Mswati III of Eswatini and His Excellency, Mr Macky Sall, President of the Republic of Senegal, and approved by African Union leaders in July 2018 at the 31st African Union Summit in Nouakchott in Mauritania.

At its launch, the Heads of State and Government present recognized the importance of the campaign to achieve the African Union’s objectives concerning the elimination of malaria by 2030, defined in the 2015 Catalytic Framework to End Aids, TB and Malaria. Indeed, this campaign relies on the best practices and lessons drawn from the experience of the continent’s countries and focuses on four key objectives to achieve the elimination of malaria:

1. Engaging government leaders, the private sector and civil society in order to keep the prevention of malaria at the top of States political agenda;
2. Maintain and increase funds allocation to control and elimination of malaria in both the public and private sector;
3. Increase awareness and ownership of the prevention of malaria at community level;
4. Increase awareness and ownership of the prevention of malaria at community level

The elimination of malaria is possible, however countries must adopt and try to accomplish these four objectives if we wish to succeed in this goal.

In addition, the ten African countries most affected reported 3.5 million more cases in 2017 compared with 2016. In response, in November 2018, the WHO and the RBM Partnership launched a new impetus to get back on track to reach the various milestones of the Global Technical Strategy (GTS), the targeted response known as “High Burden High Impact” (HBHI).

The objective of HBHI is to reaffirm commitment and refocus activities in the countries most affected, notably Burkina Faso, Mali and Niger, to accelerate progress through four response elements: 1) political will; 2) strategic use of information; 3) better orientation; and 4) a coordinated response.

7. Workplan

7.1. Objectives

The general objective of this work plan is to accelerate the elimination of malaria in the Sahel region.

The specific objective are to:

1. Harmonize the implementation of strategies, interventions, directives and policies for the prevention/elimination of malaria in the SaME;
2. Consolidate cross-border coordination/collaboration between the eight countries and all the SaME stakeholders in the prevention of malaria;
3. Increase awareness, prioritization and national and regional commitment to the elimination of malaria through the implementation of the "Zero Malaria Starts With Me" campaign;
4. Strengthen management capacities of national programmes for the elimination of malaria in the SaME countries.

For each strategy, the activities are listed in the following table.

7.2. Description of activities

In order to achieve these objectives, activities common to the eight countries are described below.

7.2.1. Objective 1: Harmonize the implementation of strategies, interventions, directives and policies for the prevention/elimination of malaria in the SaME

1. Carry out mass LLITN distribution campaigns in cross-border areas

LLITN distribution campaigns are organized every three years in the endemic countries. However, the dates of organization of these campaigns do not systematically coincide from one country to another. Indeed, in some countries, the distribution campaigns will take place this year, 2019, while others will be organized in 2020.

For the implementation of this activity at cross-border level, countries must agree on common periods. Inter-country team exchanges of teams will take place at the level of cross-border health districts to participate in campaigns in neighbouring countries. This would allow cross-border health districts to exchange the conduct of campaigns and share their experiences.

2. Carry out seasonal malaria chemoprevention

Levels of implementation of SMC vary in the eight SaME countries. Indeed, some countries implement this intervention on a large scale while others do so in a small number of health districts.

Most of the countries which have eligible health districts implement SMC for children aged 3 to 59 months.

As for LLINT distribution campaigns, countries must agree common periods to organize these SMC campaigns. However, the synchronization must take account of transmission zones so as not to start too late in zones with early seasonal transmission or too soon in zones with late seasonal transmission.

For these campaigns too, inter-country team exchanges should take place at cross-border health district level.

Table V: Presentation of activities by strategy

OBJECTIVES	STRATEGIES	ACTIVITIES
Objective 1	Maintain universal LLITN cover	• Carry out mass LLITN distribution campaigns in cross-border areas
	Universal SMC coverage in eligible districts	• Carry out seasonal malaria chemoprevention (SMC) in children aged 3 to 59 months in all eligible cross-border health districts
	IRS in areas at risk of epidemic	• Carry out IRS in cross-border heath districts at risk of epidemic
	Diagnostic and treatment coverage	• Provide detection and management of malaria cases by community health workers in cross-border areas
	Strengthening epidemiological and entomological surveillance in districts with low transmission	• Provide active detection of malaria cases in cross-border health districts as pre-elimination • Provide entomological surveillance
	Strengthening the alert and response system to malaria epidemics in areas at risk	• Provide early detection of malaria case in cross-border health districts • Ensure a response to epidemics in areas at risk of epidemic
	Joint coordination of interventions for the prevention and elimination of malaria	• Ensure harmonization and joint implementation of intervention to prevent/ eliminate malaria
Objective 2	Strengthen inter-country coordination/ collaboration	• Establish a coordination platform or mechanism and an effective coordination system for all the stakeholders in the implementation of inter-country initiatives • Organize cross-border cooperation frameworks • Participate in regional and continental summits (African Union, ECOWAS, OCEAC, WAHO, CEMAC)
Objective 3	Strengthen communication and advocacy at regional level	• Celebrate successes of countries close to elimination and those which have significantly reduced the incidence of the disease • Provide and expand platforms to engage champions and ambassadors to keep malaria at the top of the political agenda and expand subregional scorecards • Mobilize cross-border populations through engagement activities and competitions • Strengthen the production and use of the national scorecard of the SaME countries and expand the use of the subregional scorecard to strengthen accountability, action and advocacy • Establish an effective system for coordination and monitoring of the use of the SaME subregional scorecard
Objective 4	Strengthen management of supplies of essential commodities for the prevention of malaria	• Create the Sahel Malaria Commodities Fund (SMCF)
	Strengthen monitoring and evaluation of programmes	• Strengthen the inter-country malaria surveillance system • Improve the quality of data on malaria • Establish a system for sharing epidemiological and programmatic data at SaME level
	Strengthening human and financial resources capacity of programmes	• Develop human capacities • Ensure supervision of health workers in health training and at community level • Mobilize financial resources • Develop collaboration ties between the SaME Secretariat and multinational end malaria councils against malaria at country level

3. Carry out IRS in cross-border heath districts at risk of epidemic

The IRS, although planned in the strategic plans of some SaME countries, are not performed in the majority of cases due to a lack of financial resources.

In the heath districts at risk of malaria epidemic, the IRS must be performed in the event of an epidemic to limit the spread of the disease. The cross-border health districts in an epidemic will be informed on a daily basis by the health authorities of the countries concerned by this emergency in order to ensure that they make the appropriate arrangements.

4. Provide detection and management of malaria cases by community health workers in cross-border areas

The eight countries do not all have the same level of implementation of the community strategy, notably the management of cases of malaria by the CHW. Countries such as Burkina Faso, Senegal, Mali and the Gambia have a wider coverage of community interventions than the other countries. For the latter, there is a lack of financial resources to sustain the gains from management of cases at community level and extend its implementation to districts not yet covered.

This management at SaME level will require training of cross-border CHW on diagnosis and treatment.

5. Provide active detection of malaria cases in cross-border health districts as pre-elimination

In countries where some cross-border health districts are in pre-elimination, such as Senegal, the Gambia and Mauritania, active detection of cases must be notified to the cross-border health authorities of the countries where the cases come from, in the event of imported cases.

In addition, cross-border community epidemiological surveillance must be strengthened on both sides of the border. This community surveillance will require training of community health workers at cross-border level; it will be integrated in case management.

The effectiveness tests of anti-malarial drugs will be carried out according to the similarity of the epidemiological zones at the same time so that the results are comparable from one country to another.

6. Provide entomological surveillance

Entomological surveillance is an essential element for countries on the path to elimination. This surveillance will identify the vector species concerned, their densities, their behaviour, seasonality and allow vector mapping.

In addition, studies on vector resistance to insecticides must be carried out in a concerted manner between countries in the cross-border zones.

These studies must be carried out in the same periods so that the results are comparable.

To ensure this surveillance, the capacities for entomological monitoring of the eight countries will be strengthened.

7. Provide early detection of malaria case in cross-border health districts
In areas where some health districts have low transmission, detection of possible epidemics must be notified to the neighbouring countries so that they can prepare for a possible response in the event that the epidemic spreads to their territory.

Early detection will consist of establishing an active case surveillance system based on notification case by case and improving early warning based on meteorological data.

8. Ensure a response to epidemics in areas at risk of epidemic
The response will consist of strengthening surveillance and pre-positioning treatment and prevention kits in the health districts concerned.

At the end of the epidemic, evaluation meetings will be organized at a cross-border level to analyse and restore data on the response. This will allow capitalizing on the experiences for the elaboration/ update of response plans.

9. Ensure harmonization and joint implementation of intervention to prevent/eliminate malaria
An advocacy and communication document will be developed to mobilize political decision-makers and all stakeholders on effective interventions to eliminate malaria in the SaME. The NMCP and stakeholders of the region will benefit from specific aspects of the interventions for prevention/ elimination of malaria and management of programmes for the harmonization of interventions. The strategies, directives and protocols on prevention/elimination of malaria will be developed and harmonized throughout the region.

7.2.2. Objective 2: Consolidate cross-border coordination/collaboration between the eight countries and all the SaME stakeholders in the prevention of malaria
1. Establish a coordination platform or mechanism and an effective coordination system for all the stakeholders in the implementation of inter-country initiatives
A solid partnership and collaboration mechanism for all the inter-country initiatives will be established to ensure good coordination of interventions for the prevention/elimination of malaria. This platform will ensure documentation of activities and experiences in collaboration in inter-country and cross-border experiences.

2. Organize cross-border cooperation frameworks
To ensure good coordination/collaboration for activities in the SaME countries, cooperation frameworks in the form of meetings to share information between cross-border regions/provinces will be organized before the joint implementation of campaigns and implementation of cross-border activities in general. The responsible managers of the areas concerned will be responsible for leading these cooperation frameworks in collaboration with health services managers within their areas of responsibility.

These cooperation frameworks will also allow for monitoring of the interventions.
Frameworks for cooperation with the defence and security forces, in particular, ministries of armed forces, to exchange views on the security aspects and support to the health services in carrying out their work of combating malaria at cross-border level.

3. Participate in regional and continental summits
To strengthen coordination of interventions between the SaME countries and those of the continent in prevention of malaria, the SaME countries will participate in various summits art regional and continent level (African Union, ECOWAS, OCEAC, WAHO, CEMAC).

7.2.3. Objective 3: Increase awareness, prioritization and national and regional commitment to the elimination of malaria through the implementation of the "Zero Malaria Starts With Me" campaign;

1. Celebrate successes of countries close to elimination and those which have significantly reduced the incidence of the disease

Through communication via the social networks, the website www.zeromalaria.africa and the national and regional press, the efforts and successes of countries will be regularly communicated so as to raise awareness among populations of the fight against malaria and also encourage citizens, leaders and enterprises in the private sector to engage in the fight.

2. Provide and expand platforms to engage champions and ambassadors to keep malaria at the top of the political agenda and expand subregional scorecards

The regional platforms, meetings and assemblies will be used to expand messages of champions and influential people previously identified at regional level. These messages will be able to increase raising the awareness of regional actors and will also seek to encourage them to act to eliminate malaria. Subregional meetings of mayoral networks will also allow involving local and national elected representatives at a subregional level. The scorecard will also be an advocacy tool to judge efforts, successes and challenges of each of the countries.

3. Mobilize cross-border populations through engagement activities and competitions

Advocacy will be directed to the administrative authorities (governors/prefects) and local elected representatives (mayors) of cross-border localities to strengthen their involvement in the organization of surveillance campaigns and activities. Advocacy will also be directed towards the defence and security forces to support the security of activities to prevent malaria in zones ta risk and ensure the security of inputs.

Civil society or subregional networks will be more involved in the prevention of malaria.

4. Strengthen the production and use of the national scorecard of the SaME countries and expand the use of the scorecard and establish an effective system for coordination and monitoring of the use of the SaME subregional scorecard

In order to monitor the performance of the various SaME countries towards the elimination of malaria, a dashboard will be developed.

The national scorecards for the control and elimination of malaria prepared from the national and regional indicators will be strengthened and updated regularly and integrated in the existing management and decision-making process to facilitate comparisons and increase transparency and accountability of actions at national level. This dashboard will present the main indicators on prevention of malaria in the form of tables, graphs or maps with analyses and comments.

This will allow the countries in the region to define the real bottlenecks and take appropriate measures/recommend appropriate actions to eliminate malaria in their respective countries and the region.

A regional scorecard will be produced and strengthened to monitor the performance of the various SaME countries in the elimination of malaria, and a dashboard will be developed with the main indicators on prevention of malaria to ensure the accountability of the countries in the region. The scorecard will also be an advocacy tool to allow the efforts. Successes and challenges of each country to be measured and strengthen accountability and action. To develop this dashboard and scorecard, a validation workshop will be organized with the support of ALMA.

7.2.4. Objective 4: Strengthen management capacities of national programmes for the elimination of malaria in the SaME countries

1. Create a Sahel Malaria Commodities Fund (SMCF)

Budgets, purchases and supplies of essential commodities will be coordinated at regional and national level. Each country will provide a statement of its needs for inputs and the required characteristics to the SaME, which will be responsible for making group purchases and monitoring supply. This will allow preferential prices from suppliers.

For this purpose, a Sahel Malaria Commodities Fund (SMCF) will be created with the objective of filling the critical gap in essential commodities to prevent malaria (SMC, LLITN, RDT and ACTs) in the region to reduce morbidity and mortality from malaria.

The SMCF would provide the opportunity to increase national financing through a renewable funding mechanism to which the SaME States could contribute and allow monitoring of their domestic contributions.

The SMCF open to all donors would provide the opportunity to coordinate donors' support, quantification and budgeting efforts. It would allow exchanges of commodities between countries to mitigate shortages and overstocks at national level.

The SMCF would also ensure supply chain management and quality assurance for products up to the last kilometre.

2. Strengthen the inter-country malaria surveillance system

To improve the surveillance system, countries will have to ensure the establishment and use of a standardized system of reporting of key indicators for monitoring and rapid action. A regional malaria surveillance system will be developed and linked to the national systems to include updated epidemiological data for prevention and response to epidemiological anomalies of malaria.

3. Improve the quality of data on malaria

To improve the quality of data, countries must ensure regular collection, analysis and distribution of epidemiological data from the cross-border regions/provinces for their regions. However, these data will be shared with cross-border countries in the form of regular epidemiological bulletins. The creation of a website will also be planned as well as peer quality control of data of the health districts.

4. Establish a system for sharing epidemiological and programmatic data at SaME level

A system for sharing epidemiological and programmatic data at SaME level will be established and regularly updated to allow sharing and discussion of data at joint review meetings of key indicators of all the stakeholders in all the countries of the region to report on progress and challenges in achieving the objective of elimination of malaria.

5. Develop human capacities

Human capacities represent the main trump cards of the national programmes to eliminate malaria. Thus, human capacities will be developed in various fields such as epidemiological and entomological surveillance, data management, and resource mobilization etc. for health workers and at community level.

6. Ensure supervision of health workers in health training and at community level
To strengthen the capacities of health workers in health teams and at community level, supervision will be organized regularly in the cross-border health districts.

7. Mobilize financial resources for the elimination of malaria
Internal mobilization of financial resources will be through advocacy for the creation of a malaria budget line at State level and towards influential people such as members of parliament, mayors.

8. Develop collaboration ties between the SaME Secretariat and multinational end malaria councils against malaria at country level
In order to ensure sufficient resources are available to achieve the elimination of malaria, national councils of the malaria fund will be stabilized at national level with ALMA support. This will allow mobilizing local funds to cover all the strategies, even cross-border collaboration and establish links with the SaME Secretariat.

The activities describe above are summarized in the following table.

7.3. Planning an implementation mechanisms
The planning of activities (LLITN and SMC campaigns and surveillance) in cross-border zones will be by mutual agreement between countries at joint planning meetings.

The implementation of all the planned activities will be the subject of discussion between the cross-border health districts, with strong involvement of cross-border communities and the involvement of defence and security forces to ensure the security of persons and malaria prevention inputs. Indeed, it is essential that cross-border communities work in coordination with the armed forces to identify threats so as to minimize risks in these zones.

In addition, with regard to strengthening the capacity of the human resources, exchanges will be made in the form of study tours between cross-border districts.

Communication activities by community health workers will be carried out in cross-border health districts for the benefit of the populations.

To make savings on the purchase of LLINT inputs and medicines for campaigns, grouped orders will be made for the benefit of the SaME countries.

For monitoring and evaluation of intervention s, cross-border teams will be set up.

7.4. Inter-country coordination
With regard to inter-country coordination, the regional platform will continue to provide a link with the country NMCP to identify their needs and inform ministries and heads of government who have the power to mobilize national funds.

The SaME Technical Committee whose missions include to identify and mobilize the necessary technical assistance for each of the eight countries, examine subregional dashboards and take decisions, will provide coordination between the countries. The Coordinator recruited will have the task of ensuring monitoring of all the planned activities in the work plan and report to the Technical Committee

Tableau VI : Chronogramme des activités

OBJECTIVES	ACTIVITIES	FREQUENCY	RESPONSIBLE PERSONS
O1	1. Carry out LLINT distribution campaigns in cross-border zones	Every 3 years but from 2019 if campaign	NMCP
	2. Carry out seasonal malaria chemoprevention campaigns	Every year but from 2019	NMCP
	3. Carry out IRS in health districts at risk	In case of epidemic	NMCP
	4. Ensure management of malaria cases by community health workers at cross- border level	Continuously from 2019	Health district
	5. Ensure active detection of malaria cases in cross-border health districts in pre-elimination	If cases arise	Health district
	6. Ensure entomological surveillance	Continuously from 2019	NMCP
	7. Ensure early detection of malaria epidemics in cross-border zones at risk of epidemic	In case of epidemic	Health district
	8. Ensure response to malaria epidemics in cross-border zones at risk of epidemic	In case of epidemic	Health district
	9. Ensure harmonization and joint implementation of intervention to prevent/eliminate malaria	Continuously from 2019	NMCP and SaME Technical Committee
O2	1. Establish a coordination platform or mechanism and effective system for coordination of the stakeholders in the implementation of inter-country initiatives. Advocacy for elimination of malaria	En continu dès 2019	Ministères de la Sante, PNLP et Comité technique SaME
	2. Organize cross-border cooperation frameworks	Continuously from 2019	Regions/ Provinces
	3. Participate in regional and continental summits	Continuously from 2019	SaME Technical Committee
O3	1. Celebrate successes of countries in pre-elimination and those which have significantly reduced the incidence of the disease	Continuously from 2019	NMCP and SaME Technical Committee
	2. Provide and expand platform to engage champions and ambassadors to keep malaria at the top of the political agenda and expand regional scorecards	Continuously from 2019	NMCP and SaME Technical Committee
	3. Mobilize cross-border populations through engagement activities and competitions	Continuously from 2019	Health districts and NMCPO
O4	1. Create the Sahel Malaria Control Fund (SMCF)	in 2019	SaME Technical Committee
	2. Strengthen the inter-country malaria surveillance system	in 2019	Ministries of Health, NMCP and SaME Technical Committee
	3. Improve the quality of malaria data	Continuously from 2019	NMCP
	4. Establish a system for sharing epidemiological data at SaME level	Continuously from 2019	Ministries of Health, NMCP and SaME Technical Committee
	5. Develop human capacities	Continuously from 2019	SaME Technical Committee
	6. Ensure supervision of health workers in health teams and at community level	Continuously from 2019	NMCP
	7. Mobilize financial resources for elimination of malaria	Continuously from 2019	NMCP and SaME Technical Committee
	8. Develop collaboration links between the SaME Secretariat and multinational end malaria councils and funds at country level	Continuously from 2019	Ministries of Health, NMCP and SaME Technical Committee

8. Financing of the work plan

Table VII: Financing of the work plane

OBJECTIVES	ACTIVITIES	COSTS	ASSUMED COSTS
1	1. Carrying out LLITN campaigns in cross-border zones	**235 600 USD**	Inter-country team exchanges at cross-border health district level to participate in campaigns 2 members of each NMCP will travel in the neighbouring country. There are the 9 shared borders considering the Cabo Verde has a border with Senegal There will thus be 2 teams each thus 4 per border. In total 36 (9 x 4) teams will be concerned The costs related to the travel and subsistence of these workers. Return travel except Cabo Verde: average 500 Km ticket/person x 36 x 1 USD = 18 000 USD Air ticket Cabo Verde: 400 USD x 4 = 1600 USD Subsistence: 36 persons x 600 USD/day x 10 days = 216 000 USD Total: **235 600 USD**
	2. Carrying out seasonal malaria chemoprevention campaigns	**208 000 USD**	Inter-country team exchanges at cross-border health district level to participate in campaigns 2 members of each NMCP will travel in the neighbouring country. There are the 8 shared borders. There will thus be 2 teams each thus 4 per border. In total 32 (8 x 4) teams will be concerned The costs related to the travel and subsistence of these workers. Return travel: average 500 Km ticket/person x 32 x 1 USD = 16 000 USD Subsistence: 32 persons x 600 USD/day x 5 days x 2 journeys = 192 000 USD Total: **208 000 USD**
	3. Implementing IRS in health districts at risk	**0**	Information on neighbouring health districts to health districts with epidemics by health authorities of countries concerned **No cost**
	4. Ensuring malaria case management by community health workers at cross-border level	**960 000 USD**	Training of community health workers at cross-border level Assuming that 500 CHW are operating along each border, 1,000 CHW will be trained during 5 days and will receive return travel and subsistence from their place of work to the health teams to which they are assigned. Travel costs: 1 000 x 20 USD = 20 000 USD Subsidence: 1 000 x 20 USD x 5 days = 100 000 USD Total: **960 000 USD** for the 8 countries
	5. Ensuring active detection and management of malaria cases in cross-border health districts un pre-elimination	**80 000 USD**	- Training of community health workers at cross-border level Included in the previous - Anti-malarial effectiveness tests Each country will receive a contribution of 10 000 USD to carry out these tests at the surveillance sites, i.e. **80 000 USD** for all the countries
	6. Ensuring entomological surveillance	**312 000 USD**	- Knowledge of vector species concerned Each country will receive a contribution of 20 000 USD to carry out this study, i.e. 160 000 USD for all the countries - Resistance of vectors to insecticides Each country will receive a contribution of 10 000 USD to carry out these tests at the surveillance sites, i.e. 80 000 USD for all the countries. - Training of entomologises 2 entomologists from each NMCP will received training, i.e.16 entomologists. This training will take place in a country in the subregion. Enrolment fees will be paid and the participants will have return air tickets and subsistence allowance. Enrolment fees: 16 x 2 000 USD = 32 000 USD Air ticket, return: 16 x 1 500 USD = 24 000 USD Subsistence: 16 x 1 000 USD = 16 000 USD Total : **72 000 USD**

OBJECTIVES	ACTIVITIES	COSTS	ASSUMED COSTS
	7. Ensuring early detection of malaria epidemics in cross-border zones at risk	**0**	- Daily update of malaria surveillance data **No cost** - Early warning based on meteorological data **No cost**
	8. Ensuring response to malaria epidemics in cross-border zones at risk	**176 000 USD**	- Pre-positioning of case management and prevention kits in the health districts concerned Each country will receive a contribution of 20 000 USD for each case management kit, i.e. **160 000 USD** for all the countries - Post-epidemic evaluation meetings for collection and analysis of data from the response Each country will receive a contribution of 2 000 USD for each meeting organized, i.e. **16 000 USD** for all the countries
	9. Ensuring harmonization and joint implementation of interventions for prevention/elimination of malaria	**203 500 USD**	- Development of an advocacy and communication document A consultant will be recruited to design the document. The consultant's fees will be 650 USD x 15 days = 9 750 USD. Programme managers will be invited to a workshop to validate the document. The costs relate to air travel and subsistence. Air ticker, return: 1 500 USD x 8 countries = 12 000 USD Subsistence: 2 000 USD x 5 days x 8 countries = 80 000 USD Total : **101 750 USD** - Development and harmonization of strategies, directives and protocols for the prevention/elimination of malaria throughout the region A consultant will be recruited to design the document. The consultant's fees will be 650 USD x 15 days = 9 750 USD. Programme managers will be invited to a workshop to validate the document. The costs relate to air travel and subsistence. Air ticker, return: 1 500 USD x 8 countries = 12 000 USD Subsistence: 2 000 USD x 5 days x 8 countries = 80 000 USD Total : **101 750 USD**
2	1. Establish a coordination platform or mechanism and an effective system of coordination of all the stakeholders in the implementation of inter-country initiatives.	**60 000 USD**	- Establishment of a platform **No cost** - Recruitment of an SaME coordinator The Coordinator will be recruited to monitor the SaME activities in the 8 countries Salary: 5 000 USD/month x 12 months= **60 000 USD**
	2. Organize cross-border cooperation frameworks	**300 000 USD**	- Cooperation frameworks For meetings to exchange and share information between cross-border regions/ provinces and monitor interventions, flat rate travel and subsistence will be applied. Travel: 1 000 USD return x 8 = 80 000 USD Subsistence: 5 persons x 2 x 100 USD x 8 = 20 000 USD Total : **100 000 USD** - Cooperation frameworks with defence and security forces Expense related to security if persons and inputs will be paid per data security sheet for organization of campaigns . Security fees: 25 000 USD or 200 000 USD for all the countries
	. Participate in regional and continental summits	**92 000 USD**	Summits at regional and continental level The coordinators of each NMCP will participate in the summits The coasts relate to air tickets and subsistence. Air ticket return: 1 500 USD x 5 summits x 8 countries = 60 000 USD Subsistence: 2 000 USD x 2 days x 8 countries = 32 000 USD Total : **92 000 USD**

OBJECTIVES	ACTIVITIES	COSTS	ASSUMED COSTS
3	1. Celebrate successes of countries close to elimination and those which have significantly reduced the incidence of the disease	**0**	Collection of good practices and publication of national programmes **No cost**
	2. Supply and expand platforms to engage champions and ambassadors to keep malaria at the top of the political agenda and expand subregional scorecards	**24 000 USD**	- Designation of champions and ambassadors to advocate for prevention of malaria Travel costs will be offered to these personalities Travel costs : 3 000 USD per person **24 000 USD** for all the countries
	3. Mobilize cross-border populations though engagement activities and competitions	**40 000 USD**	- Advocacy towards administrative authorities (governors/prefects) and local elected representatives Travel costs will be paid to these countries for the advocacy Travel costs : 2 000 USD per person **16 000 USD** for all the countries - Advocacy towards defence and security forces Travel costs will also be paid to these countries for the advocacy Travel costs : 3 000 USD per person **24 000 USD** for all the countries - Involvement of civil society or subregional networks in the prevention of malaria **No cost**
4	1. Create the Sahel Malaria Control Fund (SMCF)	**140 000 USD**	- Increase in national financing A lump sum to be allocated under this heading as renewable funds to which SaME States could contribute. Lump sum: **20 000 USD** - Coordination of support, quantification and budgeting efforts of donors This will allow exchange of inputs between countries to mitigate shortages or surplus stocks at national level. A lump sum is allocated to cover transport between countries in the case that such a situation occurs. Lump sum: **20 000 USD** - Support supply chains for assured quality products up to the last kilometre A lump sum is allocated to cover transport of inputs up to the last kilometre. Lump sum: **100 000 USD**
	2. Strengthen the inter-country malaria surveillance system	**0**	Establishment and use of a standardized system for reporting key indicators **No cost**
	3. Improve quality of malaria data	**79 600 USD**	- Production of regular epidemiological bulletins A contribution of 2 000 USD will be made to countries to produce epidemiological bulletins, i.e. 16 000 USD - Creation of a website A lump sum of 4 000 USD will be granted to countries, i.e. **32 000 USD** - Peer quality control of district health data 2 members of each NMCP will travel in the neighbouring country. There are the 9 shared borders considering that Cabo Verde has a border with Senegal There will thus be 2 teams each thus 4 per border. In total 36 (9 x 4) teams will be concerned The costs related to the travel and subsistence of these workers. Return travel except Cabo Verde: average 1000 Km ticket/person x 36 x 1 USD = 18 000 USD Air ticket Cabo Verde: 400 USD x 4 = 1600 USD Subsistence: 4 persons x 600 USD/day x 5 days = 12 000 USD Total : **31 600 USD**

OBJECTIVES	ACTIVITIES	COSTS	ASSUMED COSTS
	4. Establish a system for sharing epidemiological and programmatic data at SaME level	**0**	Establishment and regular update of a system for sharing epidemiological and programmatic data at SaME level **No cost**
	5. Developing human capacities	**180 000 USD**	Training in epidemiological and entomological surveillance, data management and resource mobilization 5 person per country or 40 in total will be identified for training in a country of the subregion. Enrolment fees : 40 x 2 000 USD = 80 000 USD Air ticket return: 40 x 1 500 USD = 60 000 USD Subsistence: 40 x 1 000 USD = 40 000 USD Total : **180 000 USD**
	6. Ensuring supervision of health workers in health teams and at community level	**480 000 USD**	- Supervision of health workers in health teams The health workers will be supervised by district teams. The teams will receive a fuel allowance in addition to the resources that they receive for carrying on their activity in their health area. Considering 20 cross-border health districts on average per country, the lump sum will concern 160 health districts Lump sum: 1 000 USD x 160 districts = **160 000 USD** - Supervision at community level Each of the 160 health districts will receive a fuel allowance for head nurses providing supervision of cross-border CHW. Lump sum : 2 000 USD x 160 districts = **320 000 USD**
	7. Mobilize financial resources for elimination of malaria	**0**	Creation of a budget line malaria at State level **No cost**
	8. Develop collaboration ties between the SaME Secretariat and multinational end malaria councils at country level	**0**	Establishment of national malaria funds at country level with ALMA support **No cost**
TOTAL		**3 570 700 USD**	

NB: The costs stated in this table are approximate. 1 USD = 500 USD

The budget for this work plan is estimated at 3 570 700 USD.

9. Monitoring of indicators

The outcomes and impact indicators at national level will be monitored through the national strategic plans on prevention of malaria.

The outcomes and impact indicators which will be reported in national programmes to evaluate the outcomes and impacts of the work plan activities are presented in the table below.

The indicators will be regularly reported by the countries to the SaME Technical Committee for review.

Table VIII: List of indicators

IMPACT INDICATORS
Number of active households
Incidence of malaria cases: number and rate per 1 000 persons per year
Mortality from malaria: number and rate per 100 000 persons per year
Prevalence of malaria parasites in children aged 6-59 months
Positivity rate of malaria diagnostic tests (Microscope and/or RDT)
OUTCOME INDICATORS
Proportion of persons at risk of malaria, all ages together, who slept under a LLINT the night before the survey
Proportion of the population at risk in targeted zones protected by i0ndoor residual spraying with a permanent effect during the last 12 months
Proportion of patients suspected of malaria having undergone a parasitological test
Percentage of children aged 3-59 months protected against malaria (after four courses of SMC treatments during the high transmission season preceding the survey
Percentage of districts capable of detecting and managing malaria epidemics in the 15 days following their declaration
Proportion of health teams that do not suffer from anti-malarial input stock shortages during the month
Rate of mobilization of financial resources

Conclusion

This workplan follows up on a malaria situation analysis in the eight SaME countries and complements the existing national strategic plans.

This plan seeks to accelerate the elimination of malaria in the countries concerned by 2030, in accordance with the Global Strategic Plan 2016-2030 to which they adhered. However, this plan can only meet expectations if there is significant mobilization of resources, political will and a level of participation by the actors and partners at all levels.

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- Monitoring and evaluation plans National Strategic Plans of the SaME countries
- Sahel factsheet

For more information on the Sahel Malaria Elimination Initiative (SaME), please contact: wahooas@wahooas.org