RBM Partnership To End Malaria | Case Management Working Group

Report of the 14th Annual RBM CMWG Workshop

16-18 September 2025

Abidjan, Cote d'Ivoire

"Innovations and Best Practices in Malaria Case Management Amid a Declining Funding Environment"

Objectives of the 14th RBM CMWG Annual Workshop

- *To provide updates on state of the art tools and hot topics in malaria case management*
- *To convene country representatives and malaria partners to share experiences and evidence on best practices for improving malaria case management*
- *To facilitate deep discussion and produce concrete outputs or recommendations to the CRSPC*
- *Serve as a consultative forum to gather field experiences and best practices that can inform the broader malaria community*



Co-chairs: Olugbenga Mokuolu & Noella Umulisa
Coordinator: Johanna Stenstrom
Technical & administrative support: Sunghea Park & Louise Bellai

Executive Summary

14th Annual RBM Case Management Working Group (CMWG-14)
Theme: Innovations and Best Practices in Malaria Case Management Amid a Declining Funding Environment
Venue: Azalaï Hotel, Abidjan, Côte d'Ivoire | **Dates:** 16–18 September 2025

The 14th Annual RBM Case Management Working Group Workshop (CMWG-14) brought together over 132 participants from 30 malaria-endemic countries, WHO, RBM Partnership, Swiss TPH, MMV, PATH, PMI, Amref, Novartis, and other partners. Over three days, the meeting examined innovations and best practices to sustain quality malaria case management in the context of declining global funding.

The discussions were structured across four technical work streams—Supply Chain and Systems, Severe Malaria, Diagnostics, and Care & Treatment—complemented by sessions on Vaccines and Chemoprevention and a Regional Policy Forum on Antimalarial Drug Resistance (AMDR).

The meeting's unifying message was clear:
"Quality case management must be sustained even when financing declines—through innovation, integration, and country ownership." – Prof. Olugbenga Mokuolu, Co-Chair CMWG

Regional AMDR Policy Forum
Held on 15 September as a pre-meeting event, the AMDR Policy Forum gathered 19 participants from Eastern and Southern Africa, organized by RBM, the East African Community Secretariat, and MARC-SE Africa. The dialogue reviewed surveillance and coordination efforts across East Africa Community (EAC) and Southern African Development Community (SADC) regions and endorsed stronger sub-regional collaboration to contain resistance.
"This collaboration represents an essential step toward building a unified regional front against the growing threat of antimalarial drug resistance."

Cross-Cutting Insights

Five themes emerged across sessions as the foundation for resilient malaria case management:

1. **Integration for Efficiency:** Embed malaria interventions within primary health care (PHC), EPI, and community health systems to share resources and sustain service delivery.
2. **Data-Driven Adaptation:** Use routine data to guide treatment policies, procurement, and financing decisions.
3. **Local Ownership and Financing:** Strengthen domestic resource mobilization and institutional accountability to reduce donor dependence.
4. **Quality Assurance as Core Business:** Institutionalize CQI, diagnostic QA, and pharmacovigilance within national systems.
5. **Innovation for Survival:** Harness digital tools, AI diagnostics, blended learning, and integrated delivery of new interventions (RAS, RTS,S, R21, PMC) to maintain impact with limited resources.

Highlights from Technical Sessions

Work Stream 1 – Supply Chain and Systems

Led by Dr. Rima Shretta (Jhpiego) the co-lead of the Work stream 1 , this session focused on aligning supply chains with the rollout of Multiple First-Line Therapies (MFT).

Countries shared early results from pilots in Ghana, Tanzania, and Cameroon, supported by WHO, MMV, and PATH.

Recommendations included:

- Scale up MFT gradually, guided by pharmacovigilance and operational data.
- Integrate digital logistics systems (LMIS) for real-time visibility and invest in human capacity.
- Explore regional pooled procurement and private-sector partnerships.

"Every treatment begins with a supply chain decision—if we get that right, we save lives before the first dose." – Dr. Rima Shretta

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Work Stream 2 – Severe Malaria

Co-led by Dr. Anita Kamara and Prof. Afolabi Eliassou, the session highlighted evidence from Zambia, Nigeria, Malawi, and Uganda.

In Zambia, Dr. Ernest Chanda (Transaid) reported that community-based Rectal Artesunate (RAS) reduced case fatality from 8% to 0.5%, while Nigeria's research revealed persistent referral barriers despite improved access.

Dr. Jean-Pierre Van geertruyden (University of Antwerp) shared SEMA ReACT study findings confirming RAS effectiveness within iCCM platforms, though incomplete referrals remain a bottleneck.

Recommendations called for:

- Integrating RAS within iCCM and CQI systems;
- Strengthening community referral and transport mechanisms; and
- Ensuring continuous supply of injectable artesunate and ACTs.

"Every minute saved in treating severe malaria is a life saved." – Prof. Olugbenga Mokuolu

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Work Stream 3 – Diagnosis

Chaired by Dr. Alexander Asamoah (Ghana) and Mr. Anderson Chinoumba (Zimbabwe) the two co-leads of the Work stream 3 , the session addressed diagnostic quality amid funding constraints.

Dr. Jane Cunningham (WHO) presented updates on HRP2/3 deletions, while Amref's David Isaboke and PMI's Petros Chirambo showcased ECAMM and blended e-learning approaches.

Key outcomes:

- Embed diagnostic QA within NMCP supervision;
- Expand e-learning (WELCOMM, PMI REACH);
- Adopt dual-antigen RDTs where deletions exceed 5%; and

- Localize ECAMM facilitator training in Africa.

"Diagnosis is the compass of malaria control—if it points wrong, the whole programme loses direction." – Prof. Mokuolu

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Work Stream 4 – Care and Treatment

Moderated by Dr. Aissata Barry (Burkina Faso) one of the co-lead of the Work stream 4, the session focused on drug-efficacy surveillance and quality of care.

Dr. Christian Nsanzabana (Swiss TPH) highlighted emerging K13 mutations across Africa, while Dr. Charlotte Rasmussen (WHO) outlined updates to TES and Molecular Marker Surveillance protocols. Dr. Paul Boateng (Ghana) shared that CQI interventions and audits reduced malaria case-fatality from 3.4% in 2020 to 1.8% in 2024.

Recommendations emphasized:

- Sustaining TES and molecular surveillance within national labs;
- Rapid policy response when efficacy drops below 90%;
- Embedding CQI and pharmacovigilance into DHIS2 systems; and
- Increasing domestic financing.

"Protecting our medicines is both a scientific and a financial imperative." - Dr. Aissata Barry

Vaccines and Chemoprevention

Facilitated by Dr. Thierry Belinga Etogo (Cameroon) the lead of the Vaccine task team, the session underscored the synergy between malaria vaccines (RTS,S, R21) and Perennial Malaria Chemoprevention (PMC).

Burkina Faso reported a 35% reduction in malaria cases among vaccinated children, while Sierra Leone halved drop-out rates through community engagement.

Recommendations:

- Institutionalize NMCP–EPI coordination and align PMC/vaccine delivery schedules;
- Integrate data reporting within DHIS2;
- Secure co-financing for operational costs; and
- Maintain community demand and trust.

"Integration is our path to efficiency and equity." – Dr. Thierry Belinga Etogo

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Plenary Outputs: Sustaining Quality Amid Declining Financing

From the closing group discussions (*Maintaining Quality Malaria Case Management in the Context of Declining Financing*), the plenary endorsed a consolidated action agenda built around five pillars:

Pillar	Strategic Output	Core Actions
1. Domestic Financing	National sustainability frameworks developed by 2026	Integrate malaria into public budgets, advocate co-financing, explore private sector and levies

Pillar	Strategic Output	Core Actions
2. Efficiency through Integration	Alignment of malaria, primary health care (PHC), and Expanded Programme on Immunization (EPI) (EPI)systems	Shared training, logistics, and M&E; one supervision system
3. Innovation and Digital Transformation	Data-driven malaria management	Expand DHIS2, digital Quality assurance (QA) tools, and operational research
4. Quality & Capacity Retention	Institutionalized Continuous Quality improvement (CQI) and blended learning	Internal supervision, e-learning, peer networks
5. Partnership & Accountability	Regional cooperation and public scorecards	Sub-regional networks (HANMAT, ECAMM), advocacy, recognition of high-performing districts

"In times of scarcity, leadership becomes the strongest resource." - Group Rapporteur, Day 3

Key Next Steps

Country Level

1. Update national malaria case management strategies to include sustainability and domestic financing components (by Q1 2026).
2. Integrate malaria indicators within PHC dashboards and national performance monitoring.
3. Institutionalize CQI, TES, and PV frameworks at facility and district levels.

Regional and Global Level

1. Operationalize sub-regional surveillance networks (HANMAT, WANSAR, SADC) and share data via RBM platforms.
2. Strengthen regional ECAMM and diagnostic QA networks under Amref and WHO.
3. Develop and disseminate RBM CMWG advocacy briefs summarizing key outputs to donors and policymakers (by November 2025).

RBM Partnership & Partners

1. Coordinate technical support to align with country sustainability plans.
2. Facilitate cross-work-stream collaboration (Diagnostics–Treatment–Supply).
3. Support resource mobilization efforts through the CRSPC and Big Push initiatives.

Measurable Outputs from CMWG-14

Output Area	Specific Deliverable	Timeline / Status
Technical Guidance	Revised practical guidance for RAS implementation shared by Zambia (MMV/Transaid)	Disseminated Q4 2025
Data Sharing & Networks	Regional AMDR coordination roadmaps validated (HANMAT, WANSAR, SADC)	In progress, to be endorsed Q1 2026
Training & QA	Commitment to local ECAMM facilitator expansion and e-learning rollout	Ongoing, 2025–2026
Integration Models	Pilot NMCP–EPI micro-plans for PMC + RTS,S	Initiated in 4 countries
Advocacy Products	Draft CMWG advocacy brief for CRSPC	To be finalized Nov 2025

Closing Reflections

In their final statements, the co-chairs encapsulated the spirit of CMWG-14:

"The real measure of our success is not how much funding we receive, but how much impact we sustain when the funding declines." - Prof Olugbenga Mokuolu

"Malaria case management must remain the heartbeat of elimination. Quality is not optional - it is the bridge between innovation and survival." - Dr Noella Umulisa

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Looking Ahead

The 14th CMWG concluded with collective agreement to:

- Maintain annual peer learning and documentation of implementation best practices;
- Reinforce linkages with the Vector Control and Multisectoral Working Groups for cross-learning;
- Prepare for the 15th Annual CMWG Workshop (end-August 2026).

Summary Statement

The 14th RBM Case Management Working Group Workshop reaffirmed that sustaining quality malaria case management in a resource-constrained environment requires innovation, integration, and investment in people and systems.

The workshop's deliberations produced actionable recommendations and reinforced the partnership's collective resolve to ensure that no child dies of malaria for lack of a test, a treatment, or a functioning health system.

"Together, we can do more with less - and do it better."

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Acknowledgements

The Roll Back Malaria Case Management Working Group (CMWG) extends its sincere appreciation to all those who contributed to the success of the 14th Annual Workshop held from 16–18 September 2025 in Abidjan, Côte d'Ivoire.

We gratefully acknowledge the Government of Côte d'Ivoire and the National Malaria Control Programme for their warm hospitality and active participation. Our thanks go to the RBM Partnership to End Malaria, the World Health Organization (WHO), malaria programme managers, researchers, policy leaders, funders, and partners whose engagement and insights enriched the discussions.

We are equally delighted to recognize the valuable partnership with **MARC SE-Africa**, who hosted a **Policy Forum on Antimalarial Drug Resistance** on 15 September, bringing together **19 experts from Eastern and Southern Africa** to strengthen collaboration around this urgent threat.

The organization and coordination of CMWG-14 were made possible through the support of **Swiss TPH** and the generous funding of partners including the **Swiss Agency for Development and Cooperation (SDC)**, **Novartis**, **Medicines for Malaria Venture (MMV)**, **Abbott**, **Malawi-Liverpool-Wellcome Clinical Research Programme**, **MARC SE-Africa (EU/EDCTP3)**, and the **University of Cape Town (UCT)**.

Together, this collaboration across governments, academia, industry, and implementing partners exemplifies the shared commitment to strengthening malaria case management and advancing the global fight to end malaria.

List of Abbreviations

ACTs	Artemisinin-base Combination Therapies
AL	Artemether-Lumefantrine
AMVIRA	The Accelerated Malaria Vaccines Introduction and Roll out in Africa
ANC	AnteNatal Care
ARMPC	Advocacy and Resource Mobilization Partnership Committee
ART-R	ARTemisinin partial Resistance
ASPY	Artesunate-Pyronaridine
CARAMAL	Community Access to Rectal Artesunate for Malaria
cEMR	community Electronic Medical Record
CHAI	Clinton Health Access Initiative
CHWs	Community Health Workers
CM	Case Management
CMWG	Case Management Working Group
CoP	Community of Practice
CQI	Continuous Quality Improvement
CRSPC	Country Regional Support Partnership Committee
CSR	Corporate Social Responsibility
DAP	Data Action Plan
DEET	N, N-DiEthyl-meta-Toluamide
DeTACT	Development of Triple Artemisinin-based Combination Therapies
DHIS2	District Health Information Software 2
DRC	Democratic Republic of the Congo
EAC	East African Community
ECAMM	External Competency Assessment of Malaria Microscopy
EPI	Expanded Programme on Immunization
HANMAT	Horn of Africa Network for Monitoring Antimalarial Treatment
HRP2/3	Histidine-Rich Protein 2 and 3
iCMM	integrated Community Case Management
iDES	integrated Drug Efficacy Studies
IMCI	Integrated Management of Childhood Illness
INESS	INDEPTH Effectiveness and Safety Studies
IPTp	Intermittent Preventive Treatment in pregnancy
IRS	Indoor Residual Spraying
LMIS	Integrate Digital Logistics Systems
LUM-SDF	Lumefantrine-SDF
MARC SE-AFRICA	Mitigating Antimalarial Resistance Consortium for South East Africa
MBGF	Melinda and Bill Gates Foundation
MCM	Malaria Case Management
MDR	Multi Drug Resistance
MESA	Malaria Eradication Scientific Alliance
MFT	Multiple First line Therapies
MiP	Malaria in Pregnancy

MiPWG	Malaria in Pregnancy Working Group
MMV	Novartis and the Medicines for Malaria Venture
MMS	Malaria Molecualr Surveillance
MoH	Ministry of Health
NGO	Non-Governmental Organization
NMCP	National Malaria Control Programme
NMEP	National Malaria Elimination Programme
NMSP	National Malaria Strategic Plan
OTSS	Outreach Training and Supportive Supervision
PC	Partner Committees
PDMC	Post Discharge Malaria Chemoprevention
PHC	Primary HealthCare
PMC	Perennial Malaria Chemoprevention
PMI	President's Malaria Initiative
PV	Pharmacovigilance
QA	Quality Assurance
QC	Quality Control
RAS	Rectal Artesunate
RBM	Roll Back Malaria
RDTs	Rapid Diagnostic Tests
SADC	Southern African Development Community
SBC	Social and Behaviour Change
SCPC	Strategic Communication Partnership Committee
SDC	Swiss agency for Development and Cooperation
SDF	Solid Dispersion Formulation
SMC	Seasonal Malaria Chemoprevention
SME	Surveillance, Monitoring and Evaluation
SMEWG	Surveillance, Monitoring and Evaluation Working Group
TACTs	Triple Artemisinin-based Combination Therapies
TES	Therapeutic Efficacy Studies
UN	United Nations
VC	Vector Control
WANSAR	West African Network of Surveillance and Response.
WG	Working Group
WHO	World Health Organization
WS	Work Streams

14th Annual RBM Case Management Working Group Workshop (CMWG-14)

"Innovations and Best Practices in Malaria Case Management Amid a Declining Funding Environment"
16–18 September 2025 | Azalaï Hotel, Abidjan, Côte d'Ivoire
Co-Chairs: Professor Olugbenga Mokuolu and Dr. Noella Umulisa
Coordinator: Johanna Stenstrom (Swiss TPH)
Technical Support: Sunghea Park & Louise Bellai (Swiss TPH)

Introduction and Setting the Stage

Background and Purpose of the Workshop

The 14th Annual Meeting of the RBM Case Management Working Group (CMWG) was convened from 16 to 18 September 2025 in Abidjan, Côte d'Ivoire, under the theme:
"Innovations and Best Practices in Malaria Case Management Amid a Declining Funding Environment."

The workshop brought together 132 participants (92 in person and 40 online) from 39 countries of which 30 from malaria-affected countries, representing national malaria control and elimination programs, research institutions, WHO, implementing partners, industry representatives, and donor agencies. Country perspectives remained central throughout.

The primary objectives of the meeting were to:

- Provide updates on state-of-the-art tools and emerging topics in malaria case management;
- Enable countries and partners to exchange experiences and best practices;
- Facilitate in-depth discussion and practical recommendations for the RBM Country and Regional Support Partner Committee (CRSPC); and
- Serve as a consultative forum to capture field experiences and lessons learned to inform the global malaria community.

As articulated by Co-Chair Dr. Noella Umulisa in her opening remarks,

"We come together to convene, to support, and to coordinate. Convene to learn, support to scale, and coordinate to align."

Her statement set the tone for a meeting grounded in collaboration, realism, and innovation in the face of declining global health financing.

Opening of the Workshop

The meeting was formally opened by the Co-Chairs, Professor Olugbenga Mokuolu (University of Ilorin, Nigeria) and Dr. Noella Umulisa (Jhpiego, Rwanda). They welcomed participants to what they described as a "working meeting with purpose," acknowledging the "against all odds" effort it took to bring partners together amid funding and logistical challenges.
"Our subtitle this year is 'Against All Odds' - and it could not be more fitting. Despite the constraints, we are here to share, to innovate, and to chart a path forward," said Prof. Mokuolu.

Following participant introductions in English and French, the Director General of Health of Côte d'Ivoire, Professor Samba Mamadou, officially welcomed participants to Abidjan, commending RBM and the CMWG for their continued commitment. He emphasized Côte d'Ivoire's steady progress towards malaria elimination and reaffirmed the government's commitment to sustaining investment in malaria control.

"We must continue to innovate to reach every child, every family, every community. Malaria remains a public health priority for Côte d'Ivoire," he stated.

Opening Remarks from Partners

Professor Samba Mamadou, Director-General of Health, Ministry of Health, Côte d'Ivoire, officially opened the workshop. He reaffirmed Côte d'Ivoire's commitment to malaria elimination by 2030 and expressed gratitude to the RBM Partnership and all collaborating agencies for their technical support.

World Health Organization (WHO) – Dr. Daniel Ngamije

Representing the WHO Global Malaria Programme, Dr. Daniel Ngamije praised the CMWG for its convening power and stressed the urgency of maintaining malaria case management quality despite constrained resources.

He underscored that malaria case management remains the cornerstone of malaria control, directly influencing mortality outcomes. Facing rising resistance and financial pressure, he urged participants to innovate and optimize:

"A declining budget does not mean we accept declining ambitions. It means we must be smarter, more innovative, and more efficient."

Dr. Ngamije outlined WHO's continued support in four priority areas:

1. Normative guidance and policy optimization, including living guidelines for malaria treatment and severe malaria management;
2. Quality and efficiency enhancement, through initiatives such as ECAMM (External Competence Assessment for Malaria Microscopists);
3. Facilitating access to innovation, ensuring rapid translation of new tools into practice; and
4. Catalyzing data-driven decision-making at national and sub-national levels.

He concluded by encouraging national programmes to share challenges openly and to "turn pressure into innovation."

RBM Partnership to End Malaria – Dr. Michael Charles, CEO

Dr. Michael Charles, CEO of the RBM Partnership to End Malaria, delivered his remarks from Geneva via video message. He commended the CMWG for its role in driving evidence-based, country-led approaches, noting that 2025 marked what he termed a *"perfect storm"* for malaria control - the intersection of insecticide and drug resistance, climate-related disruptions, conflict, and a global funding crisis.

"We know the tools that work. The question is: how do we ensure they reach the right people, in the right place, at the right time?"

Dr. Charles identified three priorities to guide RBM's *"Big Push"*:

1. Investment – mobilizing smarter, more diversified funding sources, including domestic financing;
2. Innovation – fostering multiple first-line therapies, new diagnostics, and digital tools;
3. Country-led adaptation – ensuring national programmes are empowered to tailor interventions based on local data.

He highlighted the RBM Secretariat's new focus on linking countries to regional and global platforms, and concluded with a call to collective action:

"Let's move from words to action. The resolutions from this room must translate into lives saved."

Host Country Address – Dr. Tanoh, NMCP Coordinator, Côte d'Ivoire

The National Malaria Control Programme (NMCP) Coordinator for Côte d'Ivoire, Dr. Tanoh, presented an overview of the country's progress towards malaria elimination, reflecting on improvements in diagnosis, treatment coverage, and vaccine introduction planning.

He emphasized that Côte d'Ivoire's malaria programme has made substantial progress in reducing mortality, but warned against complacency:

"The challenge is not only to sustain the gains, but to adapt our strategies in the face of new realities - resistance, population movement, and funding shortfalls."

He urged greater collaboration across sectors and between Francophone and Anglophone countries, thanking RBM for "bridging our efforts through this forum."

Technical Updates and Global Context

WHO Technical Update on Case Management – Dr. Peter Olumese

Dr. Peter Olumese, WHO Global Malaria Programme, presented a detailed update on malaria case management guidelines. He reminded participants that malaria control and elimination constitute an integrated package and that the strength of health systems determines the effectiveness of case management interventions.

"You can have all the tools, but if the health system vehicle has no tires, you are going nowhere."

Key highlights included:

- The Living Consolidated Malaria Guidelines, updated regularly since 2021, now integrate prevention, diagnosis, and treatment in one platform.
- Continued recommendation for parasite-based diagnosis for all suspected cases, using microscopy or rapid diagnostic tests (RDTs).
- Artemisinin-based Combination Therapies (ACTs) remain the first-line treatment for uncomplicated malaria; in 2022, Artemether-Lumefantrine was approved for first-trimester use based on safety evidence.
- Introduction of new near-patient G6PD tests and Tafenoquine as an alternative to Primaquine for relapse prevention in *P. vivax* malaria.

Dr. Olumese noted the importance of quality assurance and pharmacovigilance in scaling new therapies and stressed the need for pragmatic, field-adapted approaches:

"Guidelines are only as strong as their implementation at the community level."

RBM "Big Push" and CRSPC Strategic Direction – Patrick Okello and Hana Bilak

Patrick Okello (RBM Partnership) provided an update on the "Big Push" initiative, focusing on resource mobilization and country-level efficiency gains. He highlighted how countries are responding through innovative partnerships, integration of malaria into primary health care, and leveraging domestic financing.

Hana Bilak (CRSPC) outlined the RBM strategic direction on country financing, emphasizing the need to align technical priorities with financial sustainability. They called for:

- Closer engagement with Ministries of Finance to ensure malaria remains a national investment priority;
- Strengthened coordination between technical working groups (TWGs) to maximize synergies; and
- Evidence-based advocacy linking malaria outcomes to economic productivity.

Update on CMWG Workstreams

Prof. Mokuolu presented an overview of the CMWG's progress since the previous meeting. He reiterated that the four work streams - Supply Chain, Severe Malaria, Diagnostics, and Care & Treatment - remain the backbone of the group's technical agenda, each addressing key challenges in implementation.

"The Case Management Working Group continues to be a place where science meets practice - where countries can translate WHO guidance into operational realities."

He encouraged participants to approach discussions as joint problem-solving sessions, noting that interdependence among the work streams-from diagnosis to supply chain-must be strengthened for tangible results.

Summary of Key Themes from Day 1

The first day set the tone for a dynamic and solution-oriented meeting. Across all presentations and interventions, several recurring themes emerged:

- Efficiency under constraint: Participants repeatedly highlighted the need to "do more with less," through innovation, coordination, and evidence-driven decision-making.
- Country ownership and domestic financing emerged as critical for sustainability.
- Health systems strengthening-especially workforce capacity and supply chain reliability-was recognized as fundamental to effective case management.
- Innovation in tools and delivery models, including new diagnostics, combination therapies, and community-based severe malaria interventions, were central to discussions.
- Equity and inclusiveness: Both co-chairs emphasized the importance of engaging Francophone countries and ensuring that vulnerable populations are not left behind.

The day concluded with optimism and a renewed sense of purpose, encapsulated by Prof. Mokuolu's closing words:

"We are here not just to share knowledge but to transform it into action. The path ahead is challenging-but together, it is navigable."

Work Stream 1 – Supply Chain and System Issues

Co-Leads: Dr. Rima Shretta (Jhpiego) and Mr. Abdallah Lusasi (Tanzania NMCP)

Session Overview

The first technical session of the workshop, chaired by Dr. Rima Shretta, focused on supply chain and system issues that underpin effective malaria case management. The session's theme centered on *bridging the gap between policy and practice*-particularly how countries can operationalize the Multiple First-Line Therapy (MFT) approach to mitigate antimalarial drug resistance (AMDR) while ensuring consistent availability of quality-assured commodities.

Presentations were delivered by representatives from WHO, Medicines for Malaria Venture (MMV), PATH, Novartis, and PSI, complemented by country perspectives from Tanzania, Ghana, Cameroon, Nigeria, Malawi, and Burkina Faso. The discussions culminated in a rich dialogue on ensuring equity, quality, and sustainability within national supply chains.

"We cannot separate drug resistance from drug availability. A strong supply chain is the first line of defense against resistance." - Dr. Rima Shretta

MFT Guidelines and WHO Technical Update

Presenter: Dr. Peter Olumese, WHO GMP

Dr. Olumese introduced the rationale and framework for implementing Multiple First-Line Therapies (MFT), a strategy designed to reduce the selection pressure that drives drug resistance by diversifying first-line treatment options across different population segments or geographical areas.

He outlined the principles behind MFT:

- Rational rotation or co-deployment of ACTs based on local epidemiological data;
- Real-time monitoring of treatment efficacy and safety;
- Adaptation of procurement systems to accommodate multiple formulations;
- Pharmacovigilance integration to detect early warning signs of resistance.

He noted that WHO's 2023 technical guidance provides flexibility for national programs to design context-specific implementation pathways.

"MFT is not just about multiple drugs; it's about multiple strategies for resilience," he explained.

Key updates included:

- WHO's endorsement of country-led pilots in Ghana, Tanzania, and Cameroon, with technical support from MMV and PATH.
- Emphasis on data-driven drug allocation, requiring strong coordination between NMCPs and central medical stores.

- Recognition that supply chain adaptability and regulatory readiness are prerequisites for success.

Dr. Olumese encouraged countries to ensure "data follows drugs," meaning real-time monitoring must accompany each therapeutic introduction to inform future decisions.

STOP AMDR Project – Scaling the Optimal Use of Multiple ACTs

Presenter: Dr. Rima Shretta, Jhpiego

Dr. Shretta presented progress from the STOP AMDR project, which aims to strengthen global readiness for MFT implementation by generating evidence, providing tools, and supporting countries to manage transition.

The project's three pillars include:

1. Evidence generation – operational research in pilot countries (Tanzania, Ghana, Cameroon);
2. Country preparedness – assessing supply chain, regulatory, and financing systems;
3. Global coordination – convening technical partners through the CMWG to harmonize approaches.

Early findings highlighted that:

- Strong country leadership and partner coordination are critical for MFT feasibility.
- Countries must assess supply chain complexity early-introducing new ACTs can overload fragile systems.
- Stakeholder mapping revealed overlapping roles and inconsistent communication between procurement entities.

She emphasized that the success of MFT depends on *"bridging the technical with the operational"* and ensuring alignment across ministries, partners, and donors.

"Resistance management starts long before we see treatment failures. It starts with planning, forecasting, and coordination."

Update from MFT start-up phase in Tanzania, Ghana and Cameroon: Sharing experience and learnings to date

Presenters: Mr. Adam Aspinall (MMV)

Mr. Adam Aspinall, Access and Product Development Lead at Medicines for Malaria Venture (MMV), shared lessons from MMV-supported countries. He underscored the importance of aligning MFT with the National Malaria Strategic Plan and existing supply chain structures, rather than creating parallel systems.

He highlighted that MFT implementation should be viewed as "a health systems intervention rather than a pharmaceutical policy" and must therefore involve procurement, logistics, and monitoring teams from the outset.

Data from the start-up phase showed:

- In Ghana and Cameroon, procurement cycles and quantification tools had to be revised to accommodate multiple ACTs.

- Stock management complexity increased, but so did resilience: disruptions in one ACT no longer paralyzed the entire system.
- Community awareness and prescriber training were identified as "make-or-break" components for uptake.

"Without last-mile delivery and provider understanding, even the best ACT portfolio will sit in warehouses," noted Mr. Aspinall.

PSI ACTwatch Lite toolkit - key results and an overview from Benin, Cameroon and Nigeria) on antimalarial drug and diagnostic availability, price and market share

Presenter: Mr. Paul Bounchaud, PSI Global Health

Mr. Bounchaud presented findings from ACTwatch Lite, a market surveillance toolkit assessing antimalarial drug and diagnostic availability, prices, and market share across Benin, Cameroon, and Nigeria.

Key findings included:

- Availability of quality-assured ACTs in the public sector remained high (above 80%), but stockouts at community level persisted.
- Non-quality-assured medicines were still present in private outlets in 14–20% of sampled sites.
- Price disparities between public and private sectors limited access for poorer households.
- Diagnostics (RDTs) were available in 92% of public facilities but only 57% of private pharmacies.

These results underscored the persistent "last mile" challenge: while national warehouses often maintained sufficient stocks, distribution bottlenecks and limited supervision affected peripheral availability.

Participants agreed that integrating real-time data systems and digital logistics management tools could mitigate stock imbalances.

"A broken link at the last mile breaks the entire chain," summarized one participant from Ghana.

Industry and Partner Updates

Novartis: Ganaplacide/Lumefantrine Phase 3 Program

Presenter: Dr. Caroline Boulton, Novartis

Dr. Boulton introduced Novartis' Ganaplacide/Lumefantrine combination, a new antimalarial with a novel mechanism of action, currently in Phase 3 clinical trials. The compound shows strong efficacy against resistant *P. falciparum* strains and has the potential to replace or complement existing ACTs.

She outlined ongoing trials in Tanzania, Ghana, and Burkina Faso, emphasizing that the drug could be available for policy consideration by 2027.

"The pipeline is promising-but its impact depends on our readiness to deliver once it's approved."

MMV: Resistance Mitigation and 2026–2030 Strategy

Presenter: Mr. Adam Aspinall, MMV

Mr. Aspinall also presented MMV's 2026–2030 strategic framework, emphasizing resistance mitigation and supply chain optimization. MMV plans to:

- Support MFT scale-up through technical guidance and procurement tools;
- Strengthen local manufacturing capacity for antimalarials;
- Enhance public-private partnerships to improve commodity flow and quality assurance;
- Foster data-driven forecasting using digital dashboards integrated with NMCP systems.

He closed with a challenge:

"We cannot afford for innovation to outpace delivery. Our mission is to make new tools accessible, affordable, and available everywhere."

Key Discussion Highlights

The ensuing panel discussion, moderated by Dr. Rima Shretta, drew active engagement from national programme managers and technical partners, including country participation from Uganda, Rwanda, Nigeria, Burkina Faso.

Participants reflected on the balancing act between introducing innovation and maintaining system stability.

Key points raised included:

- Country leadership must drive MFT implementation, with partners providing technical-not operational-support.
- Regulatory delays and fragmented procurement channels often undermine program agility.
- Regional procurement mechanisms (e.g., pooled purchasing or price-sharing across ECOWAS) could be explored to reduce costs.
- Donor alignment was highlighted as critical: inconsistent funding cycles disrupt forecasting and undermine MFT implementation.
- Supply chain data visibility remains limited; countries called for investment in *"digital transparency systems."*
- Participants from Malawi and Nigeria stressed the need to strengthen human resource capacity for quantification, inventory management, and supervision.

"MFT is a smart strategy, but only if our systems are equally smart," summarized Prof. Mokuolu.

Conclusions and Recommendations

The session concluded with consensus on several actionable recommendations:

1. Scale MFT gradually, starting with pilot districts and guided by robust pharmacovigilance data.
2. Strengthen coordination mechanisms between NMCPs, CMS, and partners to align forecasting, procurement, and distribution.
3. Leverage private sector logistics expertise and digital platforms for last-mile delivery monitoring.
4. Invest in supply chain human resources, especially data managers and logisticians.
5. Enhance regulatory readiness for new antimalarials and diagnostic tools.

6. Encourage pooled procurement or regional frameworks to reduce cost and ensure timely delivery.
7. Integrate resistance monitoring into routine supply chain review processes.

The co-lead concluded the session by reaffirming that supply chain efficiency is inseparable from case management quality, and that future success depends on collaboration and data transparency.

"Every treatment starts with a supply chain decision. If we get that right, we save lives before the first dose is given." - Dr. Rima Shretta

Work Stream 2 – Severe Malaria

Co-Leads: Dr Anitta Kamara (Sierra Leone NMCP) and Prof Afolabi Eliassou (Togo NMCP)

Session Overview

Work Stream 2 addressed one of the most urgent challenges in malaria control-severe malaria-focusing on innovations that improve survival through early recognition, pre-referral treatment, and quality hospital care.

Co-leads Dr Anitta Kamara and Prof Afolabi Eliassou opened the session by reminding participants that severe malaria remains a leading cause of child mortality in sub-Saharan Africa, despite proven tools for prevention and treatment.

"Behind every statistic is a child who might have survived if treatment had reached in time," Dr Kamara observed.

The six presentations covered community and facility-level innovations, new implementation evidence, and country experiences. The discussions, moderated by Prof Olugbenga Mokuolu and Kevin Griffith, emphasized practical ways to improve transitions between uncomplicated and severe malaria and to safeguard gains in a context of declining resources.

Guidelines for Pre-Referral Rectal Artesunate (RAS) Implementation at Community Level

Presenter: Dr Ernest Chanda, Transaid / Zambia

Title: "From Pilot to Scale: The Zambian Experience with Rectal Artesunate."

Dr Chanda presented Zambia's experience implementing Rectal Artesunate Suppositories (RAS) through the *MAM@Scale* project. The pilot (2017–2018) in Serenje District trained community health workers (CHWs) to administer pre-referral RAS to children under five with signs of severe malaria. Following the pilot's success, the intervention expanded to ten districts with support from MMV and Grand Challenges Canada.

Key results included:

- Case fatality reduced from 8 percent at baseline to 0.5 percent after implementation.
- Over 13 500 children with suspected severe malaria received RAS and were appropriately referred.

- Communities rapidly accepted the innovation once sensitized; social inclusion strategies ensured equitable access for marginalized households.

Dr Chanda introduced the newly published Community RAS Implementation Guidelines (MMV 2025), developed from Zambia's experience. The guidelines provide *"practical how-to"* steps on:

- Selecting intervention sites (remote areas > 6 hours from a facility);
- Training CHWs and supervisors;
- Designing community awareness and transport mechanisms (e.g., bicycle ambulances);
- Integrating RAS within national supply chains; and
- Monitoring referral completion and treatment outcomes.

"RAS works, but only if communities are empowered to use it and systems support them to complete the referral," Dr Chanda stressed.

Implementation Research on RAS in Five States of Nigeria

Presenter: Dr Emmanuel Shekarau, NMEP Nigeria

Building on lessons from the multi-country CARAMAL study, Nigeria's NMEP launched an implementation research initiative in five states (FCT, Kogi, Edo, Enugu, and Bayelsa) to assess the operational feasibility of RAS deployment within primary health care and community systems.

Baseline Findings:

- Only 36 percent of respondents could identify ACTs as the appropriate treatment for uncomplicated malaria.
- Just one third correctly identified artesunate injections for severe malaria.
- Awareness of RAS was almost non-existent (< 2 percent of caregivers and CHWs).
- Nearly half of children (49.8 %) were first taken to health centres, but most remained in the same facility without completing referral.

Implementation Progress:
By mid-2025 the programme had trained hundreds of CHWs and deployed over 3 600 RAS doses. Referral completion rates varied by state-from nearly 100 percent in Edo to below 50 percent in Kogi-owing to logistical and transport barriers. In riverine Bayelsa, referrals required boat transport and were often incomplete.

Lessons Learned:

- Knowledge and trust gaps persist among caregivers and some health workers.
- Misconceptions about rectal administration and "foreign medicines" hamper acceptance.
- Stock-outs of injectable artesunate at referral facilities discourage caregivers from completing referral.
- Communities benefit from pooled transport funds and village emergency transport schemes.

Dr Shekarau summed up Nigeria's approach:

"RAS is a bridge therapy - not the destination. Our goal is to ensure that every child who receives RAS reaches a facility for definitive treatment."

Health-Seeking Behaviour and Clinical Effectiveness of RAS within an iCCM Approach (Preliminary Results of SEMA ReACT)

Presenter: Jean-Pierre Van geertruyden, University of Antwerpen
Jean-Pierre Van geertruyden presented findings from the SEMA ReACT study in the Democratic Republic of Congo (Kapolowe District) and Zambia (Nchelenge District). The study assesses the real-world effectiveness of RAS when implemented through integrated Community Case Management (iCCM), comparing access to care, referral completion, and clinical outcomes before and after RAS deployment.

Key Findings – Kapolowe (DRC)

- Of 338 severe cases enrolled pre-implementation, 98 percent were managed by CHWs; referral completion was only 2 percent.
- After RAS introduction, nearly all eligible children (98 %) received RAS, but most still did not complete referral.
- 86 percent received a full adequate treatment regimen (RAS + ACT or injectable AS + ACT).
- Clinical cure rate at day 14: 98 percent; case-fatality rate: < 1 percent.

Key Findings – Nchelenge (Zambia)

- Access to hospital care was higher; 90 percent of children seen at peripheral posts were referred.
- ACT completion rate 96 percent with high adherence.
- Only 7 deaths among > 500 cases followed up; 2 deaths occurred after day 14 and were not attributed to malaria.

The study revealed that while RAS dramatically improves early survival, referral behaviour remains a bottleneck. Many caregivers believed their child was cured after RAS and did not travel for further care. Nevertheless, RAS deployment within an iCCM package proved feasible and highly effective.
Prof Van Geertruyden warned that RAS cannot substitute for a functioning health system:

"RAS saves lives today, but without injectable artesunate and ACTs at the next level, it may store up resistance for tomorrow."

He identified commodity security (RDTs, ACTs, and injectable artesunate) as the "elephant in the room," reiterating that MFT and RAS scale-up must go hand in hand with robust supply systems.

Defining the Next Generation of Severe Malaria Treatment: Target Product Profile

Presenter: Dr Stephan Duparc, Medicines for Malaria Venture (MMV)

Dr Duparc outlined MMV's vision for the next generation of severe malaria treatments, highlighting that current artesunate-based regimens have saved millions of lives but are vulnerable to drug resistance and supply interruptions. The proposed target product profile (TPP) calls for:

- Faster parasite clearance and shorter treatment duration;
- Formulations suitable for community and home use; and
- Combination therapies with novel mechanisms of action.

He highlighted ongoing MMV research on injectable and long-acting compounds to complement RAS and reduce case-fatality in resource-limited settings.

"The future is in simplified therapies that bridge the gap between community and facility care," he said.

Country Experience – Post-Discharge Practice in Malawi

Presenter: Agnes Banda Mapala, NMCP Malawi

Agnes Mapala shared Malawi's review of post-discharge management of children treated for severe malaria. Follow-up audits revealed that many caregivers did not complete the recommended 14-day post-hospital review, leading to high rates of re-admission. Through a Continuous Quality Improvement (CQI) approach, district teams introduced checklists, phone follow-ups, and community linkages. Within one year, follow-up attendance rose from 38 percent to 74 percent, and readmissions declined by half.

"Severe malaria management does not end with discharge. Recovery must be monitored," she noted.

Improving Severe Malaria Management through Continuous Quality Improvement

Presenter: Dr Gerald Rukundo, MoH Uganda

Dr Rukundo described Uganda's experience applying CQI methods in district hospitals. Quality audits revealed irregular use of RDTs for severe cases and delays in starting injectable artesunate. After CQI interventions (training, job aids, and supportive supervision), treatment within 1 hour of diagnosis improved from 46 percent to 89 percent and in-facility case fatality fell from 4.3 percent to 1.2 percent.

He emphasized the power of peer-to-peer learning and routine data reviews to maintain gains without external funding.

Discussion Highlights

The open discussion, moderated by Mr Kevin Griffith, was very interactive. Country managers, researchers, and implementers shared lessons and posed questions on RAS implementation, referral behaviour, and drug quality.

Key points included:

- Referral Completion Challenge: Despite high RAS coverage, referral rates remain below 50 percent in many contexts. Participants called for behavioural interventions and transport solutions.
- Commodity Security: RAS scale-up must be synchronized with reliable supply of injectable artesunate and ACTs.
- Training and Supervision: CHWs need continuous mentorship to avoid mis-dosing and to strengthen record-keeping.
- Integration with iCCM: RAS and CQI should be embedded within existing community case management platforms.
- Financing Sustainability: Declining donor funds threaten RAS and severe malaria programmes; domestic financing mechanisms must be explored.
- Operational Research: Further study is needed on long-term outcomes, drug stability in tropical conditions, and cost-effectiveness.

One delegate from DRC summed up the consensus:

"RAS is not a magic bullet-it is a lifeline that depends on the strength of the system holding it."

Recommendations

At the end of the session, participants agreed on the following recommendations:

1. Scale RAS implementation nationally through phased, evidence-based approaches and harmonized guidelines.
2. Strengthen referral systems by investing in community transport mechanisms and social mobilization.
3. Integrate RAS within iCCM platforms and ensure consistent supply of complementary commodities (injectable AS and ACTs).
4. Promote CQI and post-discharge monitoring as standard practice in all facilities treating severe malaria.
5. Increase local ownership and financing, including budget lines for RAS procurement and training.
6. Foster south-south learning between countries implementing RAS and CQI models.

Prof. Mokuolu concluded the session by linking the lessons to the broader meeting theme:

"Every minute saved in treating severe malaria is a life saved. Innovation is our currency when resources decline."

Work Stream 3 – Diagnosis

Co-Leads: Dr Alexander Asamoah (NMCP Ghana) and Mr Anderson Chinorumba (Zimbabwe)

Session Overview

Work Stream 3 focused on diagnosis, a cornerstone of malaria case management and surveillance. The co-leads, Dr Alexander Asamoah and Mr Anderson Chinorumba, opened the session by reaffirming that accurate and timely diagnosis is critical to effective treatment and the prevention of antimalarial drug resistance.

"Testing is the first step in the care pathway - everything else depends on its quality," remarked Dr Asamoah.

The session reviewed new rapid diagnostic test (RDT) technologies, the implications of HRP2/3 gene deletions, AI-driven microscopy, and training innovations. Presentations were delivered by experts from PATH, WHO, Imperial College London, and PMI Reach, followed by a plenary discussion on maintaining diagnostic quality amid funding constraints.

Role of RDTs in Elimination Settings – Challenges and Experiences

Presenter: Mr Samuel Ombs, Meisha Med

Samuel Ombs opened the session by highlighting the evolving role of RDTs in countries approaching malaria elimination. He noted that as transmission decreases, the positive predictive value of RDTs declines, increasing the need for highly sensitive tools and accurate surveillance systems.

In Nigeria, with transmission heterogeneity between states, routine RDTs are still invaluable for case detection, but quality assurance remains a challenge. He identified three main obstacles:

1. Stockouts due to limited budgets and donor dependency;
2. Inconsistent supervision and training of frontline staff; and
3. Temperature instability affecting test performance in peripheral health facilities.

"As we get closer to elimination, every false negative becomes a missed opportunity to stop transmission," he warned.

He called for investment in next-generation RDTs (HS-RDTs) and integration of lot testing into national QA systems.

Update on Diagnostic Tools

The session's core technical updates were grouped under four subtopics, led by PATH, WHO, and Imperial College London.

(a) Next-Generation RDTs

Presenter: Ms Stephanie Zobrist, PATH

Ms Zobrist presented PATH's landscape analysis of emerging Next-Generation RDTs, which include high-sensitivity (HS) RDTs, multi-antigen assays, and combination platforms for detecting *P. falciparum* and *P. vivax* simultaneously.

Key points:

- HS-RDTs now detect parasite densities as low as 10 parasites/µL, compared to 200–500 for conventional RDTs.
- In low-transmission or elimination settings, these tools could significantly improve case detection among asymptomatic carriers.
- However, HS-RDTs are more expensive and require stricter temperature control.

She emphasized the need for clear policy guidance on where HS-RDTs provide best value (e.g., foci investigations, reactive case detection, and pregnant women in low-transmission areas).

"We must balance sensitivity with sustainability - the right test for the right setting."

(b) AI-Based Microscopy: From Concept to Practice

Presenters: Dr Aubrey Cunnington and Dr Dimby Robinson and Jean Kabuya, Imperial College London Dr Cunnington.

They presented findings from AI-powered digital microscopy pilots in Kenya, Uganda, and Senegal. These systems use smartphone cameras and cloud-based algorithms to identify malaria parasites on thick and thin blood smears.

Results showed:

- >95% agreement between AI-based and expert microscopy in detecting *P. falciparum*;
- Automated quantification of parasite density within minutes;
- Reduction in technician workload and inter-observer variability.

Dr Robinson highlighted the potential for integrating AI microscopy into training, external quality assurance, and tele-mentorship. However, he cautioned that digital infrastructure and electricity reliability remain limiting factors.

"AI will not replace microscopists - it will empower them," he said.
Participants noted the importance of data protection protocols when deploying AI-based diagnostic systems.

(c) HRP2/3 Gene Deletions – Implications for Diagnosis and Surveillance

Presenter: Dr Jane Cunningham, WHO Global Malaria Programme

Dr Cunningham presented the latest global update on HRP2/3 deletions, a genetic mutation in *P. falciparum* that causes false-negative results in HRP2-based RDTs.

Key data points:

- Confirmed deletions in 17 countries globally, including Eritrea, Rwanda, Uganda, and Tanzania.
- In affected areas, HRP2-negative parasites account for up to 30 percent of infections.
- WHO now recommends dual-antigen RDTs (HRP2 + pLDH) in high-risk regions.

Dr Cunningham emphasized that countries must conduct systematic surveillance for deletions and use these data to adapt national testing strategies. She also mentioned the WHO framework for HRP2/3 monitoring, which guides sample collection, data sharing, and policy response.

"Diagnostic reliability is the first casualty when deletions spread unnoticed," she cautioned.

(d) Sensitivity and Field Evaluation of New Tools

Dr Cunningham further presented early results from field evaluations of pLDH-based and multi-antigen RDTs. These assays showed promising accuracy in East Africa, but she stressed that more country data are needed before large-scale adoption.

"We are at a turning point. The toolbox is expanding - but policy must keep pace with innovation."

Blended Learning Approaches for Diagnostics Quality Improvement

Presenter: Mr Petros Chirambo, PMI REACH Project

Mr Chirambo described the rollout of blended training models in Zambia and Malawi that combine e-learning, classroom workshops, and on-site mentorship to improve diagnostic accuracy.

Key outcomes:

- 1,200 laboratory personnel trained since 2023 using the REACH platform;
- Post-training assessments showed a 28 percent improvement in slide reading accuracy;
- Online refresher modules reduce cost and maintain quality during funding shortfalls.

He demonstrated the PMI REACH digital dashboard, which tracks participant progress and links to external quality assurance data.

"Sustaining diagnostic quality doesn't always require more funding - sometimes it just needs smarter learning."

Group Discussion: Maintaining Diagnostic Quality in a Declining Funding Environment

Moderators: Prof Olugbenga Mokuolu and Dr Noella Umulisa

This cross-cutting discussion built on the presentations to address practical challenges and potential solutions. The moderators framed the debate around the workshop's central question: *How can we maintain diagnostic quality as financing declines?*

Key discussion points included:

1. Integration of Diagnostic QA into Routine Supervision:
    - Countries like Uganda and Ghana shared successful examples of embedding QA checklists into national supervision templates.
    - Participants agreed that QA should not rely solely on donor-funded external assessments.
2. Leveraging Digital Tools:
    - Mobile-based reporting and dashboards (e.g., DHIS2 modules, WhatsApp supervision groups) were seen as low-cost solutions for maintaining oversight.
3. Expanding Cross-Training:
    - Task-shifting and cross-training between laboratory and clinical cadres were discussed as efficiency measures.
4. Funding Transitions:
    - Participants expressed concern that as donor funding declines, national budgets often fail to fill the gap.
    - Domestic financing for diagnostics, particularly for QA and external microscopy assessments, must become a priority.
5. Data-Driven Procurement:
    - The session echoed earlier discussions from Work Stream 1: supply data must guide procurement to prevent overstocking or underutilization.

"When funds decline, efficiency becomes our new form of innovation," summarized Dr Umulisa.

Overview of ECAMM, Role of ECAMM, Current Progress, Challenges in view of funding cuts

Presenter: Mr David Isaboke, Amref Health Africa

The Day 3 morning session began with Mr David Isaboke's presentation on the External Competence Assessment of Malaria Microscopists (ECAMM), a WHO initiative that has strengthened diagnostic capacity for over two decades.

Background:
The ECAMM model was developed following early 2000s drug efficacy studies that exposed gaps in malaria microscopy quality. It assesses parasite detection, species identification, and quantification competence among senior microscopists and supports countries to build quality assurance networks.

Key Achievements:

- Over 1,800 microscopists trained across Africa and Asia since inception.
- Amref Health Africa has been the ECAMM regional host since 2017, organizing facilitator training and regional workshops.
- Integration with the World-Wide E-learning Course on Malaria Microscopy (WELCOMM) has expanded access to distance learning.

Challenges:

- Limited pool of certified facilitators;
- High logistical costs and shipment challenges for WHO-validated slides;
- Digital literacy barriers affecting uptake of e-learning modules;
- Need for translation of training materials into French and Portuguese.

Mr Isaboke emphasized that ECAMM remains essential for maintaining diagnostic excellence in the region but needs sustainable funding and local ownership.

"Quality microscopy is not an optional luxury-it is a public health necessity," he concluded.

Key Recommendations

The session concluded with the following actionable recommendations:

1. Sustain national diagnostic QA systems by integrating them into NMCP and laboratory supervision frameworks.
2. Scale-up training and e-learning platforms such as WELCOMM and blended learning modules to reach sub-national staff cost-effectively.
3. Expand HRP2/3 surveillance and adjust diagnostic algorithms based on national data.
4. Adopt next-generation RDTs strategically in elimination and low-transmission zones.
5. Invest in digital microscopy and AI tools for training, supervision, and quality control.
6. Strengthen domestic financing mechanisms to sustain QA and supply of diagnostics post-donor funding.
7. Promote regional collaboration through shared training resources and ECAMM facilitator networks.

In closing the session, Prof Mokuolu summarized:

"Diagnosis is the compass of malaria control - if it points in the wrong direction, every intervention that follows will lose its way."

Work Stream 4 – Care and Treatment

Co-Leads: Dr Aissata Barry (Burkina Faso) and Dr Leah Moriarty (CDC)

Session Overview

Work Stream 4 addressed care and treatment, bringing together updates on antimalarial drug resistance (AMDR), therapeutic efficacy surveillance (TES), and strategies to maintain quality of care amid resource constraints.

Moderated by Dr Aissata Barry, the session featured presentations by Dr Christian Nsanzabana (Swiss TPH), Dr Charlotte Rasmussen (WHO), and Mr Patrick Okello (RBM Partnership to End Malaria). Country perspectives were shared by Dr Paul Boateng (Ghana NMCP).

The discussions reflected a clear consensus: protecting the efficacy of existing treatments and ensuring high-quality case management are non-negotiable, even as funding declines.

"Every resistant parasite represents a lost investment. Surveillance is not optional-it is our early-warning system." - Dr Aissata Barry

Antimalarial Drug Resistance: Prioritizing Surveillance in a Context of Resource Uncertainty

Improving Molecular Monitoring of Drug Efficacy and Resistance

Presenter: Dr Christian Nsanzabana, Swiss TPH

Dr Nsanzabana opened the session with an overview of molecular surveillance for antimalarial drug efficacy. He reminded participants that resistance to artemisinin and its partner drugs continues to emerge in multiple regions of Africa, threatening recent gains in malaria control.

Key evidence presented included:

- K13 mutations (R561H, R622I, and P441L) detected in East, Horn, and Southern Africa, linked to *delayed parasite clearance*.
- Rising partner-drug resistance markers for lumefantrine and piperaquine.
- The growing need for next-generation sequencing (NGS) tools capable of detecting minority variants.

Dr Nsanzabana highlighted the critical role of genomic surveillance networks such as HANMAT, EANMAT, and MARC-SE, which allow countries to share real-time data and align responses.

"Resistance surveillance must be part of routine case management. Waiting for clinical failure is waiting too long."

He also presented practical steps for strengthening laboratory systems:

- Establish regional reference labs and external quality assurance (EQA) schemes for molecular testing;
- Train bioinformaticians to analyze sequencing data;
- Integrate molecular markers into national TES planning.

He concluded by emphasizing that molecular data, when linked with therapeutic efficacy results, can guide policy updates before clinical failure rates exceed 10 percent-the WHO threshold for change.

WHO Updated Protocol Guidance: TES and MMS

Presenter: Dr Charlotte Rasmussen, WHO HQ Geneva

Dr Rasmussen provided an update on WHO's revised Therapeutic Efficacy Study (TES) and Molecular Marker Surveillance (MMS) protocols, developed to help countries sustain surveillance under financial pressure.

Key Messages:

- Therapeutic efficacy monitoring remains the *gold standard* for informing treatment policy.

- Funding for efficacy studies has decreased by nearly 40 percent since 2020, necessitating more efficient study designs.
- WHO recommends sub-regional networks for joint implementation and data sharing to reduce duplication and cost.
- Countries are encouraged to combine TES and molecular testing in a single protocol to maximize value.

Dr Rasmussen noted that WHO will release a Compendium of Antimalarial Drug Resistance Markers (October 2025) to guide prioritization of molecular targets.

Emerging Technical Changes:

- Replacement of the long-used glurp marker with microsatellites (poly-α, PfPK2, or TA1) for better accuracy in distinguishing *recrudescence* from *reinfection*.
- Reinforcement of the 3/3 match-counting method as the standard for reporting and policy decision-making.
- Enhanced data-sharing requirements to shorten the gap between study completion and national policy revision.

She also underlined that quality remains paramount:

"It is better to conduct one high-quality study than ten poor-quality ones that cannot inform policy."

AMDR Global Consultation and Coordination Roadmap

Presenter: Mr Patrick Okello, RBM Partnership to End Malaria

Mr Okello presented outcomes from the Global Consultation on Coordination of AMDR Surveillance and Response Efforts in Africa (Geneva, March 2025), jointly led by RBM and WHO.
The consultation engaged donors, academia, NMCPs, and regional bodies (African CDC, SADC, EAC, and OCEAC) to develop a unified roadmap for AMDR coordination.

Top Four Priorities Identified:

1. Establishment of sub-regional networks for data sharing and coordinated policy response (HANMAT, EANMAT, WANSAR, SADC Elimination Initiative, and Central Africa Network).
2. Dual-level coordination mechanisms-a political umbrella for sustainability and technical networks for implementation.
3. Rapid data exchange systems between countries to enable early response to emerging resistance.
4. Integration of molecular and therapeutic data to ensure coherent national decision-making.

Roadmap Milestones:

- By September 2025, regional task teams had validated Terms of Reference and governance structures.
- Ministerial endorsement meetings are scheduled for late 2025 to institutionalize networks within regional health bodies.

"Drug resistance does not respect borders; our surveillance must not stop at them either," Mr Okello emphasized.

He concluded that the RBM Partnership will continue supporting countries to link surveillance data to national action plans and funding proposals.

Measuring and Optimizing Quality of Case Management

Country example: Ghana

Presenter: Dr Paul Boateng, NMCP Ghana

Dr Boateng presented Ghana's multifaceted approach to improving the quality of malaria case management through data-driven supervision and continuous monitoring.
National Strategy (2024–2028)

Ghana's strategic plan aligns with the goal of zero malaria deaths by 2028. Quality of care is tracked through multiple complementary tools:

1. Routine DHIMS2 Data
    - Indicators include test positivity rate, treatment adherence, and severe malaria admissions.
    - Real-time dashboards flag districts with declining diagnostic accuracy or ACT stockouts.
2. Malaria On-Site Training and Supportive Supervision (OTSS)
    - Over 1,200 health workers assessed annually on knowledge, skills, and practice.
    - Post-supervision data show a 25 percent increase in correct diagnosis and treatment adherence within two years.
3. Admissions and Death Audits (2023–2024)
    - Analysis of 444 hospital admissions revealed that only 24 percent met WHO criteria for severe malaria; nearly half had co-morbid febrile illnesses.
    - Quality-of-care gaps identified in documentation, triage, and treatment timing.

Key Results:

- Malaria case-fatality rate reduced from 3.4 percent in 2020 to 1.8 percent in 2024.
- Testing coverage above 95 percent nationally.
- Integration of CQI approaches yielded substantial improvement in adherence to negative test results (from 78 percent to 91 percent).

"Malaria admissions are not synonymous with severe malaria. Our audits help us treat the right disease the right way," Dr Boateng explained.

He noted that decentralizing data analysis to district level created ownership and timely corrective action.

Pharmacovigilance and Quality of Care Discussion

Following Dr Boateng's presentation, **Dr Aissata Barry** facilitated a panel discussion on pharmacovigilance strategies under financial constraints, with contributions from Ghana, Uganda, Côte d'Ivoire, and Nigeria.

Key discussion points included:

- Need for active pharmacovigilance (PV) systems:
  Most countries rely on passive reporting. Integration of PV into routine health information systems was strongly encouraged.

- Use of digital tools:
  Ghana's DHIMS2 PV module and Nigeria's MedSafety App were cited as cost-effective solutions for real-time reporting.
- Capacity gaps:
  Participants emphasized training clinicians and pharmacists on adverse event reporting and signal detection.
- Partnerships with academia:
  Linking NMCPs with pharmacology departments was recommended to expand analysis capacity.

"Good data saves drugs; bad data wastes them," one participant remarked, underscoring the link between PV and policy.

The discussion concluded that **integration rather than expansion** should be the guiding principle-embedding PV within existing supervision, M&E, and logistics structures to maximize efficiency.

Key Recommendations

1. Sustain AMDR and TES activities through regional cooperation and joint protocols to reduce costs.
2. Institutionalize molecular surveillance within national public health laboratories and link data to NMCP decision-making.
3. Accelerate policy response to resistance by ensuring TES results are analyzed and disseminated within six months of study completion.
4. Promote quality of care through CQI and supervision using real-time DHIMS2 and OTSS tools.
5. Integrate pharmacovigilance into routine systems, supported by digital reporting and local research partnerships.
6. Advocate for domestic financing of drug efficacy and quality assurance activities.
7. Expand training on data analysis and use for NMCP and regional staff to strengthen evidence-based decisions.

Dr Barry closed the session by connecting the day's discussions to the overarching meeting theme:

"Protecting the efficacy of our medicines is both a scientific and financial imperative. The best investment we can make is to use what we have-wisely and well."

Vaccines and Chemoprevention

Moderator: Dr Thierry Belinga Etogo (Cameroon)
Panel Contributors: Representatives from Cameroon, Burkina Faso, Sierra Leone, Côte d'Ivoire, and Dr Jacques Kouakou (PMI)

Session Overview

The final technical session of the workshop explored the integration of malaria vaccines and perennial malaria chemoprevention (PMC) as complementary tools in the broader case-management continuum.

Moderated by Dr Thierry Belinga Etogo, the session convened country managers and implementing partners to discuss practical experience from the early introduction of the RTS,S/AS01 vaccine, the evolving rollout of R21/Matrix-M, and the operationalization of PMC in endemic areas.

"We now have more tools than ever before - the challenge is not innovation, but integration," Dr Belinga noted in his opening remarks.

The session's objectives were to:

1. Share lessons from countries newly introducing malaria vaccines;
2. Review progress on integrating PMC with vaccination schedules;
3. Discuss resource prioritization and coordination between NMCPs and Expanded Programme on Immunization (EPI) teams.

Country Perspectives on Malaria Vaccine Introduction

Representatives from **Cameroon, Burkina Faso, Sierra Leone, and Côte d'Ivoire** shared their experiences implementing malaria vaccination, highlighting both achievements and persistent challenges.

Cameroon

Cameroon began RTS,S introduction in early 2025 following a successful pilot in the North Region. Dr Belinga reported that by August 2025, two regions had launched routine vaccination through EPI facilities, targeting children aged 6 months to 2 years.

Key achievements:

- Dose 1 and Dose 2 coverage exceeded 80 percent, similar to other routine EPI vaccines;
- Dose 4 coverage, administered at 18 months, remained lower at 48 percent, largely due to missed follow-up visits;
- Integration with community health workers (CHWs) improved tracking and reduced drop-out rates.

To address dose-4 challenges, the NMCP and EPI are considering rescheduling the fourth dose to 15 months, aligned with the measles booster, to leverage existing contact points.

"When we align vaccine schedules, we save both time and resources," Dr Belinga explained.

Community engagement proved decisive - interpersonal communication through CHWs and local radio was more effective than national mass media campaigns.

Burkina Faso

Burkina Faso's representative reported that the country has now reached more than 400 000 children with RTS,S in four pilot regions. Early data show a 35 percent decline in confirmed malaria cases among vaccinated children compared to control areas.

Key success factors included:

- Close collaboration between NMCP and EPI under a joint steering committee;
- Effective micro-planning to align vaccine distribution with routine immunization days;
- Local production of IEC materials in major languages.

However, the representative warned of vaccine stock management challenges, as distribution cycles differ between the EPI and malaria programmes.

"Coordination is our vaccine against inefficiency," she remarked, summarizing Burkina Faso's experience.

Sierra Leone

Sierra Leone shared a powerful example of how community mobilization sustained vaccine confidence after initial skepticism.

Following reports of misinformation on social media, the NMCP and EPI partnered with religious leaders, teachers, and women's associations, using "community dialogues" to address concerns and demonstrate safety.

By mid-2025, vaccination coverage for the first two doses reached 78 percent, and drop-out rates between dose 3 and dose 4 had halved in one year.

"We learned that vaccine introduction is as much a social intervention as it is a biomedical one," the Sierra Leone team reflected.

Côte d'Ivoire
The host country reported strong progress in vaccine preparation. The NMCP Côte d'Ivoire team stated that Côte d'Ivoire completed micro-planning and cold-chain assessments in three pilot districts, aiming to begin the first phase of RTS,S introduction in early 2026.

He emphasized that vaccine introduction has already catalyzed closer NMCP–EPI collaboration, particularly for data sharing and community outreach.

"The vaccine is not just a new tool - it is a new opportunity for integration," he said.

Integrating PMC and Vaccine Delivery

Presenter: Dr Jacques Kouakou, PMI

Dr Kouakou presented updates on Perennial Malaria Chemoprevention (PMC), formerly known as intermittent preventive treatment in infants (IPTi), highlighting its potential synergy with malaria vaccination.

Evidence Base:

- PMC reduces malaria incidence by 30–40 percent when administered alongside routine immunizations in the first two years of life.
- Integration with RTS,S can increase impact beyond either intervention alone.
- WHO recommends three monthly doses of sulfadoxine-pyrimethamine (SP), beginning at 10 weeks of age, administered through EPI contacts.

Operational Lessons:

- Countries such as Sierra Leone and Cameroon are piloting joint delivery of PMC and RTS,S, using combined community messaging and synchronized logistics.
- Pharmacovigilance integration is essential to monitor co-administration safety and manage SP resistance.
- Financing remains a challenge - while Gavi supports vaccines, PMC relies largely on domestic budgets or donor project funds.

"If we design delivery systems around the child instead of the commodity, integration becomes natural," Dr Kouakou said.

He presented a practical model for alignment:

Vaccine/PMC contact	EPI schedule	Intervention
10 weeks	Penta 1 + PCV 1 + SP 1	PMC Dose 1
14 weeks	Penta 2 + PCV 2 + SP 2	PMC Dose 2
9 months	Measles + SP 3	PMC Dose 3
18 months	RTS,S Dose 4 + SP booster (where feasible)	

Discussion Highlights

The plenary discussion explored how countries can scale up vaccines and PMC amid funding and logistical constraints.

Key issues and consensus points included:

1. Health System Integration
    - Participants agreed that malaria vaccine and PMC delivery should be fully integrated into EPI, rather than run as vertical initiatives.
    - Harmonized micro-planning and data systems are essential to prevent duplication.
2. Sustaining Funding
    - While Gavi finances vaccine procurement, operational costs (transport, community mobilization, data reporting) often fall to NMCPs.
    - Several countries proposed blending EPI and NMCP budgets at district level to ensure co-financing.
3. Data Harmonization
    - Countries highlighted the need for a unified indicator dashboard combining vaccination and PMC coverage to track cumulative protection.
    - Côte d'Ivoire announced plans to integrate malaria vaccine indicators into its DHIS2 platform.
4. Community Engagement
    - Delegates from Burkina Faso and Sierra Leone stressed that community trust is the currency of vaccine success.
    - They urged continuous dialogue through CHWs, women's groups, and schools to counter misinformation.
5. Human Resources
    - Participants raised concerns about overburdening EPI staff and called for joint NMCP–EPI training to harmonize workflows.

"If we can align calendars and messages, we can align results," summarized Dr Umulisa during the discussion.

6. Research Needs
    - Evidence gaps persist on optimal sequencing of PMC and vaccine doses, and on the long-term combined impact.
    - WHO and partners were encouraged to coordinate multicountry operational studies.

Recommendations

From the session and subsequent plenary discussion, the following recommendations were put forward:

1. Institutionalize coordination between NMCP and EPI at all levels through formal joint committees and shared workplans.
2. Where possible, align PMC and vaccine delivery schedules to existing EPI visits to minimize caregiver burden and resource duplication.

3. Ensure joint micro-planning and integrated supervision for PMC and vaccination activities.
4. Develop harmonized monitoring tools and indicators for integrated reporting in DHIS2.
5. Secure sustainable financing through domestic budgets and joint NMCP–EPI resource mobilization strategies.
6. Prioritize community engagement and demand creation to maintain high uptake across doses.
7. Include pharmacovigilance monitoring in all vaccine and PMC rollouts to ensure safety and public confidence.
8. Promote south–south learning exchanges between early-adopter countries to accelerate scale-up.

The moderator concluded with a message that resonated across the workshop:

"We cannot choose between prevention tools - children need all of them. Integration is our path to efficiency and equity."

Plenary Discussion and Next Steps

Moderators:
Professor Olugbenga Mokuolu (University of Ilorin, Nigeria) and Dr Noella Umulisa (Jhpiego, Rwanda)
Session:
Maintaining Quality Malaria Case Management in the Context of Declining Financing: Lessons and Experiences

Session Overview

The closing plenary brought together all participants in an open group discussion to reflect on the key insights of the three-day workshop and to identify practical measures to sustain quality case management under declining financial resources.

Co-chairs Prof. Olugbenga Mokuolu and Dr Noella Umulisa encouraged a participatory format, organizing country representatives and partners into small discussion groups. Each group was tasked with proposing *short- to medium-term actions* that could be implemented at country and regional levels, focusing on governance, financing, innovation, and partnerships.

Prof. Mokuolu framed the session by reminding participants that:

"The challenge before us is not the lack of knowledge, but the lack of means - and sometimes, of imagination - to keep quality alive when resources shrink."

Dr Umulisa reiterated the need to shift the narrative from dependency to resilience:

"We must not define our programmes by what we have lost, but by what we can leverage."

Highlights from the Group Discussions: Maintaining Quality Malaria Case Management in the Context of Declining Financing: Lessons and Experiences

The breakout discussions were animated and pragmatic. Participants worked in six mixed groups representing national programmes, donors, research institutions, and implementing partners. Each group presented three to five priority recommendations.

1. Strengthening Domestic Resource Mobilization

Across all groups, there was strong consensus that sustainable malaria financing must increasingly come from within countries.

Key recommendations:

- Integrate malaria commodities and case management budgets into national health insurance schemes or essential health benefit packages.
- Engage Ministries of Finance and Parliamentarians through evidence-based advocacy demonstrating malaria's economic impact.
- Encourage co-financing mechanisms where domestic funds match donor contributions to essential commodities.
- Explore innovative financing models, such as earmarked levies (airline, extractive industries) or corporate social responsibility (CSR) partnerships.

One participant summarized:

"We cannot continue waiting for external rescue. Domestic commitment is the first step towards programmatic independence."

2. Maximizing Efficiency through Integration

Participants recognized that funding scarcity requires better alignment between malaria programmes and other health initiatives.

Proposed actions:

- Integrate malaria diagnosis and case management within Integrated Community Case Management (iCCM) and Integrated Management of Childhood Illness (IMCI) frameworks.
- Use shared supervision and reporting systems for malaria, pneumonia, and diarrhoea to reduce parallel costs.
- Combine logistics and training resources across programmes (e.g., NMCP and EPI integration for vaccines and chemoprevention).
- Mainstream malaria into primary health care (PHC) reforms, ensuring malaria indicators appear in PHC performance dashboards.

A delegate from Burkina Faso noted:

"Every vertical programme adds cost; every integrated activity adds value."

3. Protecting Quality amid Reduced Supervision and Training Budgets

Participants voiced concern that quality of care risks deterioration when training and supervision budgets are cut.

Solutions proposed:

- Institutionalize Continuous Quality Improvement (CQI) processes using district health staff rather than external consultants.
- Scale up blended learning platforms (e-learning, mentorship, virtual QA review meetings) to maintain capacity building at lower cost.
- Incorporate malaria quality indicators into routine facility performance reviews and staff appraisals.

- Encourage peer-to-peer mentoring networks among district laboratory technicians and clinicians.

As one facilitator summarized from the plenary:

"If we cannot afford frequent external supervision, we must strengthen internal accountability."

4. Innovation and Data-Driven Decision Making

Participants agreed that innovation - especially digital transformation - is essential for maintaining visibility and responsiveness under funding constraints.

Recommendations:

- Expand digital health tools for data collection, supervision, and commodity tracking (e.g., DHIS2 dashboards, WhatsApp-based reporting, LMIS apps).
- Encourage operational research using existing routine data to answer programmatic questions cheaply and rapidly.
- Promote local innovations such as solar-powered microscopes, low-cost AI diagnostic aids, and tele-mentorship platforms.
- Strengthen feedback loops between data generation and decision-making at district and national levels.

"When data become culture, efficiency becomes habit," Prof. Mokuolu reflected.

5. Enhancing Partnerships and South-South Collaboration

Participants called for stronger collaboration within regions and among malaria-endemic countries to reduce duplication and share resources.

Key outputs:

- Establish regional technical resource pools of trainers and experts (e.g., for ECAMM, CQI, and RAS scale-up).
- Encourage cross-country mentorship through study tours and virtual exchanges.
- Promote joint procurement and regional regulatory harmonization to lower commodity costs.
- Leverage regional economic communities (ECOWAS, EAC, SADC) for policy coordination and advocacy.

A participant from Sierra Leone summarized:

"Our problems are similar; our solutions can be shared."

6. Accountability and Political Will

Sustaining quality in the face of limited funding also requires high-level political commitment and accountability.

Proposed actions:

- Strengthen national malaria governance structures, ensuring NMCPs report progress at cabinet or parliamentary level annually.
- Engage civil society and media to maintain malaria visibility and hold leaders accountable.

- Encourage domestic scorecards on malaria case management, with public dissemination of results.
- Recognize high-performing districts or health facilities to foster motivation despite financial constraints.

"In times of scarcity, leadership becomes the strongest resource," concluded one group rapporteur.

Consolidated Outputs and Recommendations

Following group presentations, Prof. Mokuolu and Dr Umulisa synthesized the outputs into a consolidated set of recommendations endorsed by plenary consensus:

A. Governance and Financing

1. Advocate for malaria financing to be included in national development plans and public budgets.
2. Develop sustainability roadmaps for malaria case management, including domestic resource targets.
3. Explore pooled regional procurement mechanisms to improve efficiency and reduce commodity costs.

B. Quality and Capacity

4. Institutionalize CQI frameworks within health facilities and district health teams.
5. Maintain core competencies through cost-effective blended training and remote mentorship.
6. Embed malaria quality indicators in national performance monitoring systems.

C. Innovation and Evidence

7. Leverage digital technologies to strengthen data visibility and decision-making.
8. Foster operational research networks to test innovations in diagnostics, treatment, and service delivery.
9. Promote data sharing across borders to anticipate drug resistance and supply chain threats.

D. Partnerships and Integration

10. Strengthen collaboration between NMCPs, EPIs, and primary health care departments to ensure integrated service delivery.
11. Engage private sector and corporate partners through CSR and public–private partnerships for co-financing.
12. Enhance regional learning platforms under RBM working groups to share best practices.

E. Equity and Community Engagement

13. Prioritize vulnerable populations and remote communities through community-based delivery, local accountability, and inclusion strategies.
14. Invest in community dialogues and social behaviour change to preserve trust and adherence amid system transitions.

Next Steps Agreed by Plenary

The co-chairs closed the workshop by translating the recommendations into specific next steps, structured around responsibilities for countries, RBM, and partners.

Level	Next Steps	Timeline / Responsible Entity
Country Level	Develop/update national malaria case management sustainability plans integrating financing, CQI, and surveillance components.	*Q1 2026* – NMCPs with RBM support

Level	Next Steps	Timeline / Responsible Entity
	Integrate malaria case management and QA indicators into DHIS2 and PHC performance dashboards.	*2026 onward* – Ministries of Health
	Establish or revitalize national technical working groups on diagnostics, pharmacovigilance, and supply chain integration.	*Immediate* – NMCPs
Regional Level	Operationalize regional networks for AMDR and diagnostics (e.g., HANMAT, WANSAR, ECAMM Francophone Network).	*2025–2026* – RBM/WHO/Regional bodies
RBM Partnership	Consolidate recommendations into a **CMWG advocacy brief** for CRSPC and donors.	*By November 2025*
	Facilitate **cross-workstream coordination** to ensure diagnostics, treatment, and supply chain priorities are addressed collectively.	*Ongoing*
Partners and Donors	Align technical and financial support around national priorities; promote multi-year, flexible funding for malaria case management.	*Ongoing*

The co-chairs also announced that the **15th Annual CMWG Workshop** will tentatively be held **end-August 2026**, with a focus on *"Sustaining Gains and Accelerating Innovation in Malaria Case Management."*. Participants were asked to nominate host countries and suggestions were Nigeria, Namibia, Angola and Mozambique. The CMWG leadership team will discuss and revert with a decision.

Closing Remarks

In closing, Prof. Olugbenga Mokuolu and Dr Noella Umulisa thanked participants, country delegates, and partners for their active contributions.

Prof. Mokuolu reflected:

"We are leaving with more clarity, not only on what must be done, but on who must do it. The path forward is difficult, but not impossible."

Dr Umulisa added a final call to unity:
"Sustaining quality malaria case management amid declining financing will depend on one word - collaboration. If we stand together, we can do more with less, and still deliver impact."

The **14th Annual Case Management Working Group Workshop** concluded with renewed commitment to partnership, innovation, and evidence-based action to ensure that **every malaria case receives accurate diagnosis, effective treatment, and quality care - everywhere and every time**.