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SMC Alliance

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

KAMPALA, UGANDA — 24–27 FEBRUARY 2026

Prof. Jean Louis Abdourahim Ndiaye

A carrier dedicated to African children and public health

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The Republic of Uganda

Seasonal Malaria Chemoprevention(SMC) Programming & Implementation in East and South African Countries- Uganda Experience

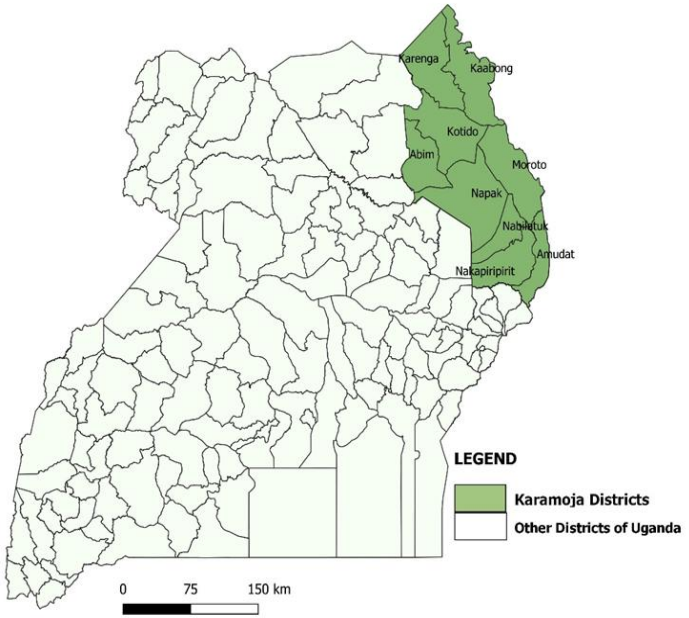
Digitized tools and integration for improved efficiencies and outcomes of Malaria prevention services in a changing environment.

Ministry of Health –National Malaria Elimination Division(NMED)
Presentation to;

The SMC Alliance &AMP Joint Meetings:

Venue: Speke Resort Munyonyo

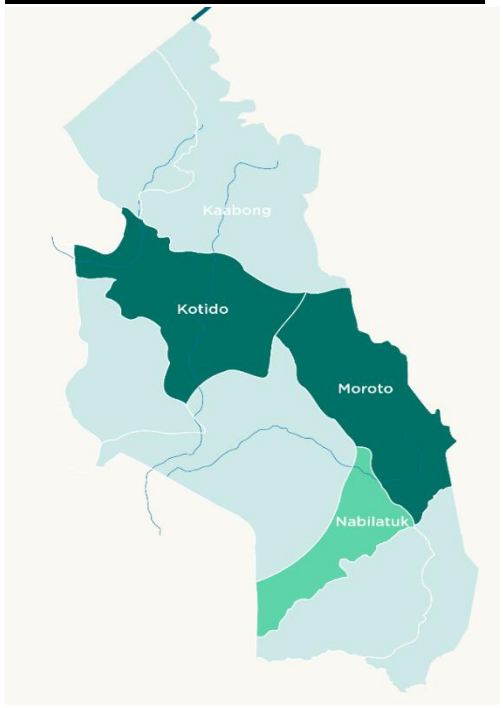
Date : Tuesday 24th February 2026



Seasonal Malaria Chemoprevention implementation progress from 2021 to 2025

Round –One(1) 2021

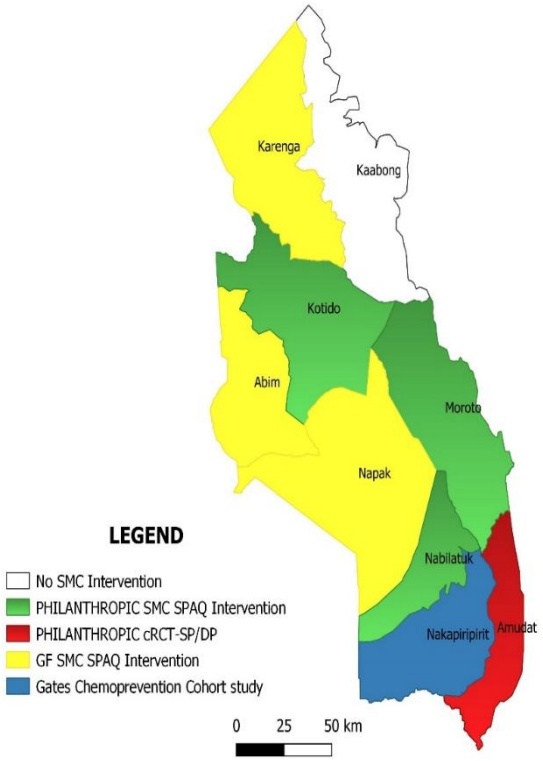
Target :80,000



Children reached: 83,100 (103%)

Round –Two(2) 2022

Target :230,000



Children reached: 211,600(92%)

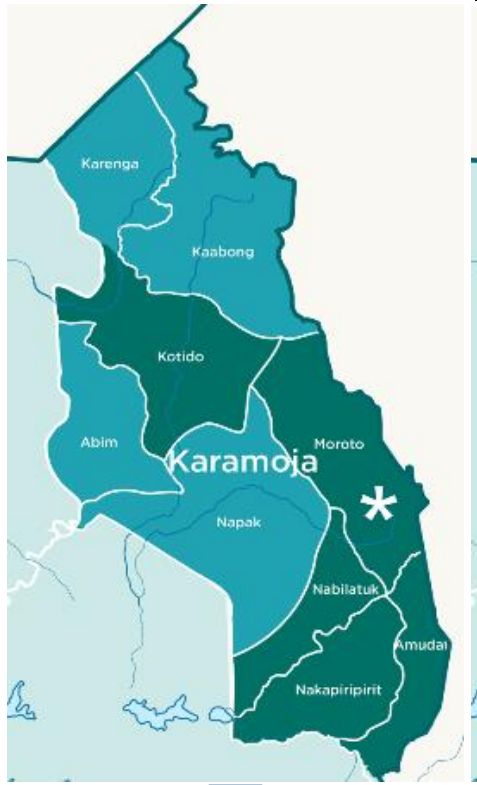
Round- Three(2) 2023

Target :250,000

Children reached: 261,136 (102%)

Round- Four(4) 2024

Target :280,000



Children reached: 286,635 (101.5%)

Round- Five(5) 2025

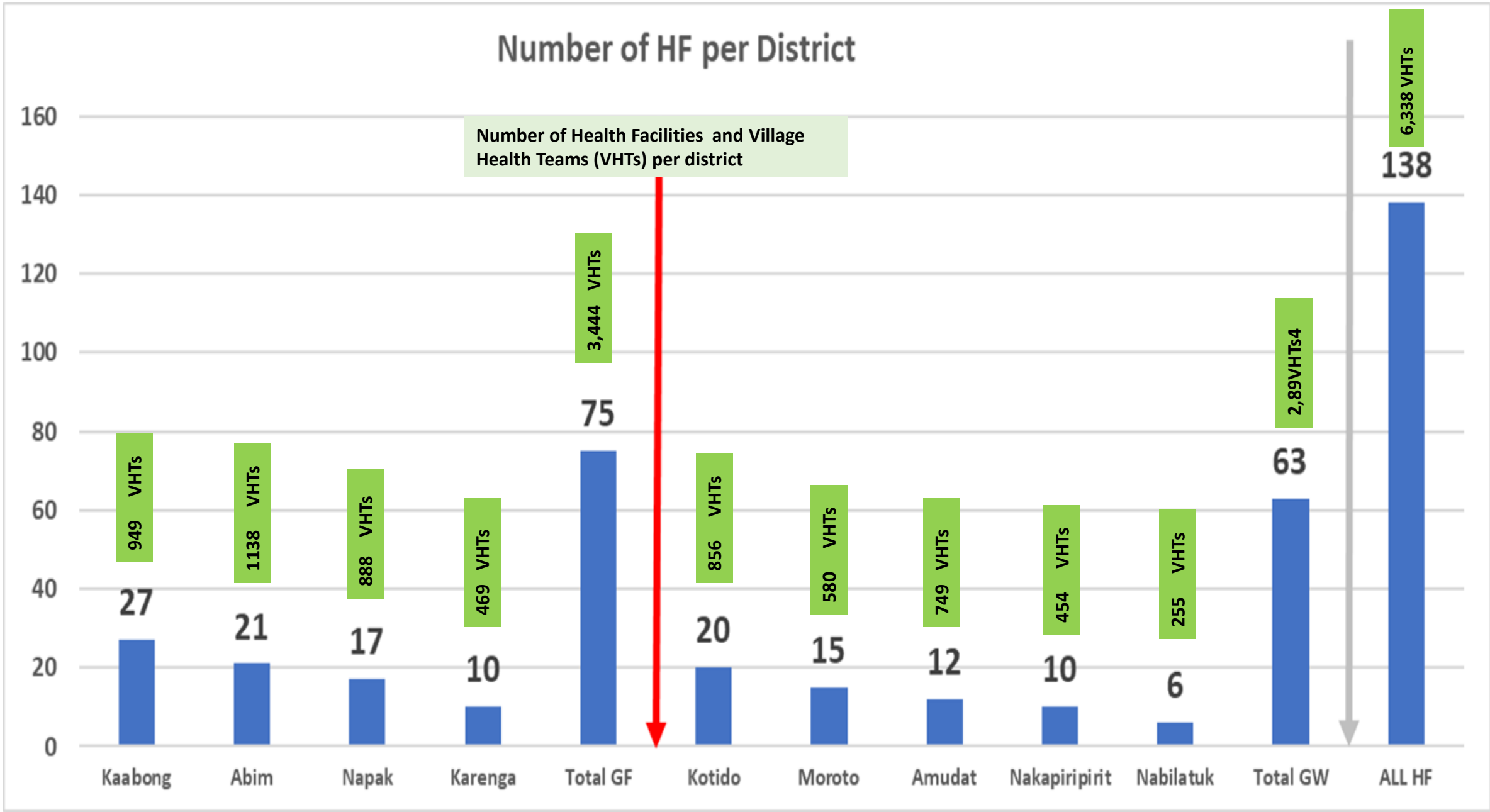
Target :394,328

Children reached: 381,809 (97%)

Intergration has been a key approach to SMC implementation since its inception, there has been progressive adaptation of digitized tools from 2023 and expansion of scope to include age 5-10 years in 4 districts in 2025.

Seasonal Malaria Chemoprevention adaptation process

	Processes/key steps	Context	Adjustments /means of adaptation
1	Planning and enumeration	Disparities in data (projected UBOS data)	Planning is based on district led data collection through routine enumeration.
2	Procurement and supply chain management.	SPAQ and most of the SMC related supplies are not part of the existing essential medicines list.	Sought for the DGHS authorization for the expedited inclusion of SPAQ into the essential medicines list
3.	Community engagement	New geography for SMC implementation, with highly mobile communities.	Engaged key influential groups that are highly recognized by the community; Manyata, kraal, cultural, and political leaders
4	Training	No existent capacity to implement SMC within the set timeline.	Expedited guidelines' development and dissemination through cascaded trainings from National ,district Health Facility &Village levels
5.	SP+ AQ administration	Mode of delivery was door-to-door using exiting community health workers called Village Health Teams (VHTs) - HC I in the health structure.	Engaged local and technical leadership to identify and recruit reliable, trusted and effective VHTs
6	Improved case management and Pharmacovigilance.	Weak pharmacovigilance efforts under case-management Vs needed level of safety monitoring associated with SMC	Adapted the National Pharmacovigilance system to monitor for anticipated side effects and adverse events associated with SMC.
7.	Support supervision and quality assurance.	Inadequate competent and committed health workforce to supervise and reinforce quality of SMC implementation.	Promoted and embraced a district led support supervision.
8	Monitoring and evaluation	No SMC country specific impact assessment indicators.	DHIS-2 Malaria indicators adapted for impact assessment.
9	Payments of Supervisors,HWs and VHTs	Having to pay all actors at the various levels of implementation on time to minize chances of demotivation	Utilized the cashless payment approach to reach all actors on time.



Number of VHTs and Health Facilities supporting SMC has not changed since the start of full scale implementation in 2023 to 2025; Note the 4 districts Napak, Abim, Karenga &Kaabong are currently covering the age group of 5-10 years

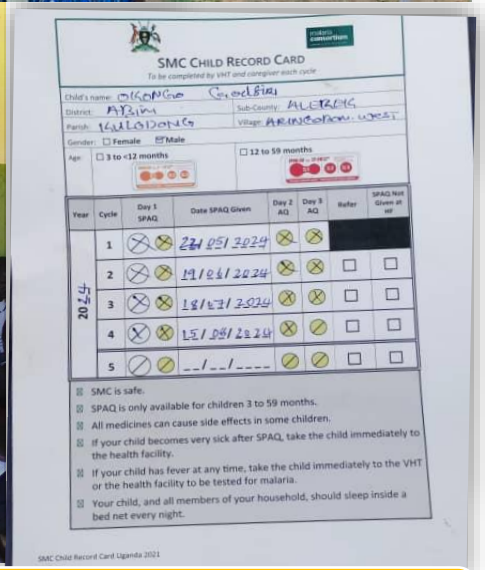
INTERGRATION – a)SUPPLY CHAIN MANAGEMENT

Delivery ,storage and reverse logistics management of SMC & ICCM commodities is done concurrently.

b) Community sensitization , mobilization & engagement:

Using the various channels (Media, community dialogues, interpersonal communication etc integrated messages for all Malaria interventions are shared with communities during SMC implementation

Intergration –Trainings, guidelines and tools.



1) Guidelines &tools designed to facilitate delivery of other services ;Integrated community case Management, immunization ,ITNs' use.

2) Trainings are not focused on SMC as standalone but include modules that facilitate the delivery of other: Malaria interventions, diseases.

Support Supervision

During supervision, the teams follow up the performance of other interventions; ITNs hang up and use.

Integrating other Interventions into SMC Implementation

Picture –one(1)

Picture –Two(2)

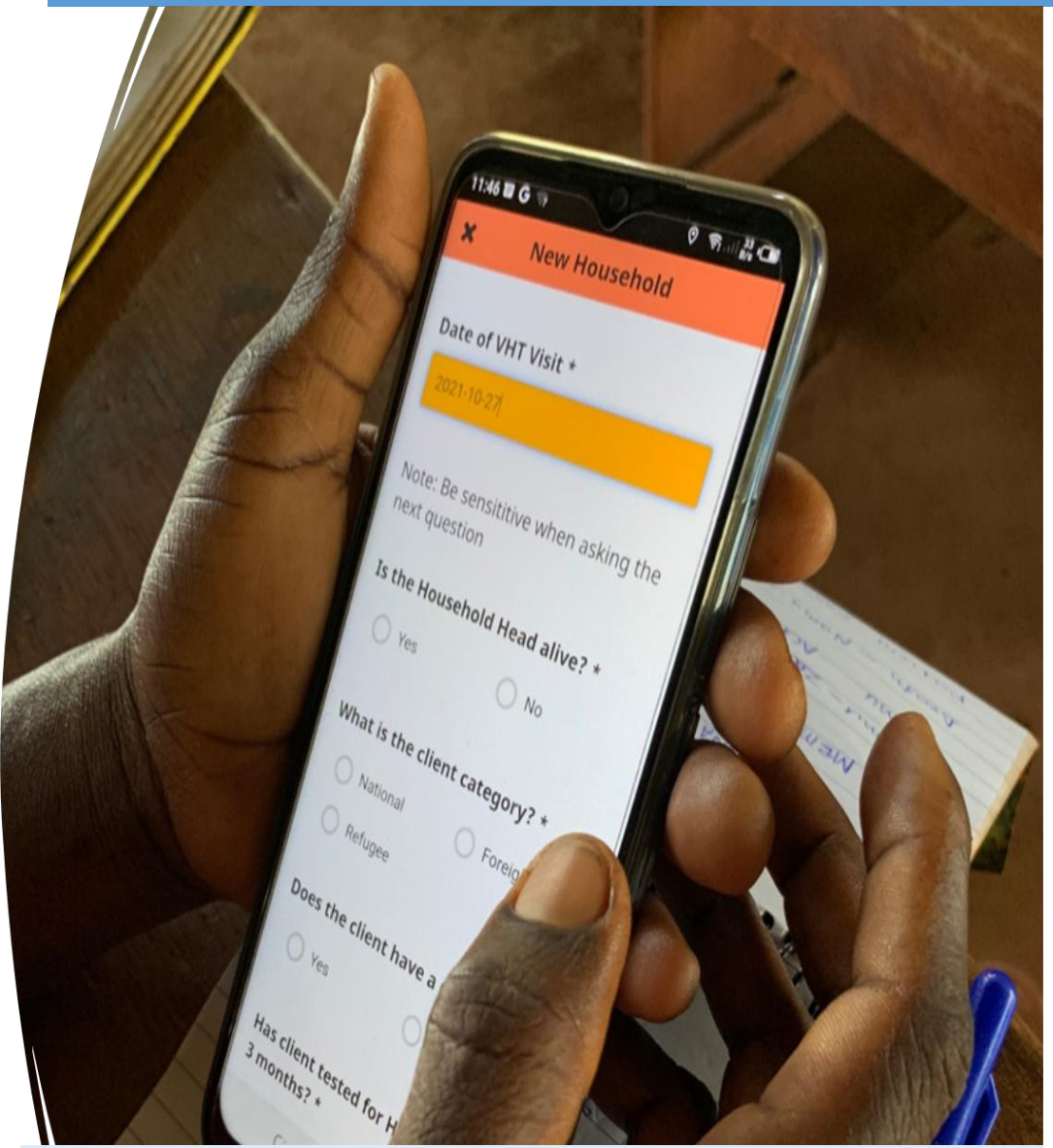
Picture Three(3)

Picture 1: VHTs screen for fever , test and treat Malaria , Diarrhea and Pneumonia and do referrals for those with danger signs.

Picture 2: During the House to house SPAQ administration for SMC, the identified Zero dose and under immunized children are vaccinated by Vaccination teams .

Picture 3: SMC delivery as a platform for mapping and targeting Malaria Hot spot & underserved areas with Community

Digitization:



One of the Health workers collecting and submitting SMC Support supervision data

Support supervision tools ;

- Ministry of health, district and health facility tools are digitized .
- During SMC VHT supervisors report electronically.
- Data is collected by ODK and it populates into a dashboard and used to monitor the SMC implementation process.

End of round (EOR) and End of Cycle Survey(EOC)

- These are conducted electronically .

Ministry of Health repository.

- SMC data submitted to the electronic malaria data repository at MOH.

All community health interventions are to be integrated with in the current Electronic community health system(e-CHIS).

- e- CHIS is now available in 20 districts with about 15,000 VHTs.

Plan to fully digitize SMC, ICCM ,ITNs, immunization and nutrition.

Key Achievements ; Integration

1. Improved services' delivery and utilization.

- Case Management –screening of sick children ,test, treat and linkage /referral integrated into SMC implementation
  - Prompt care and treatment seeking by children with fever, better access to care.
  - Timely and completed referral for patients with danger signs and fever causing illnesses.
- Immunization – during enumeration 240,523 children in2,929 village at risk children (Underimmunised,zero dose identified & reached
  - **20,071 (8%) children who missed OPV3;**
  - **10,396 (4%)** children who missed DPT1
  - **20,416 (9%)** children who missed IPV2
  - **21,149 (9%)** children who missed MR1;
  - **54,435 (23%)** children who missed MR2
- Reduce ITNs abuse /misuse & better care
  - House holds with their ITNs hanged up.
  - Improved ITNs Care
  - Identification and linkage of Pregnant women and children < 5years to ANC/EPI clinics for ITNs under routine distribution.

2. Reduced stock –outs especially at community level.

- ICCM commodities
  - Improved availability and access to ICCM commodities especially anti-malarials. (stock outs are greatly minimised)
  - Facility –community distribution of commodities

3. Improved data /information management and utilization

- Malaria Vaccine data Validation integration into SMC implementation improved the capture of data into DHIS2
  - There was 16% increase in Malaria Vaccine data captured into DHIS-2.
- Enhanced quantity and quality of documentation and reporting collection and report.
  - Distributed HMIS tools & reduced stock outs of data tools
  - Health facility data quality assessments

4) Community sensitization ,mobilization and engagement

- Increased frequency of engaging and sensitizing communities and the leaders.
  - Better acceptability of SMC , other malaria interventions and vaccination.
  - Increased demand and utilization.

5) Supervision ,monitoring and oversight

- SMC delivery /implementation as an opportunity to identify and address health systems and performance gaps
  - Use of and updating of Malaria surveillance board .
  - Implementation status for previous actions/recommendations
  - Follow up CMEs , health education sessionsetc.

Key achievements

Adaptation of digitized tools

Improved oversite and monitoring the quality of SMC implementation.

- Digitized tools and dash board facilitate timely identification and response to implementation gaps .
- Improves the quality SMC implementation

Contribution to readily available alternatives of data sources.

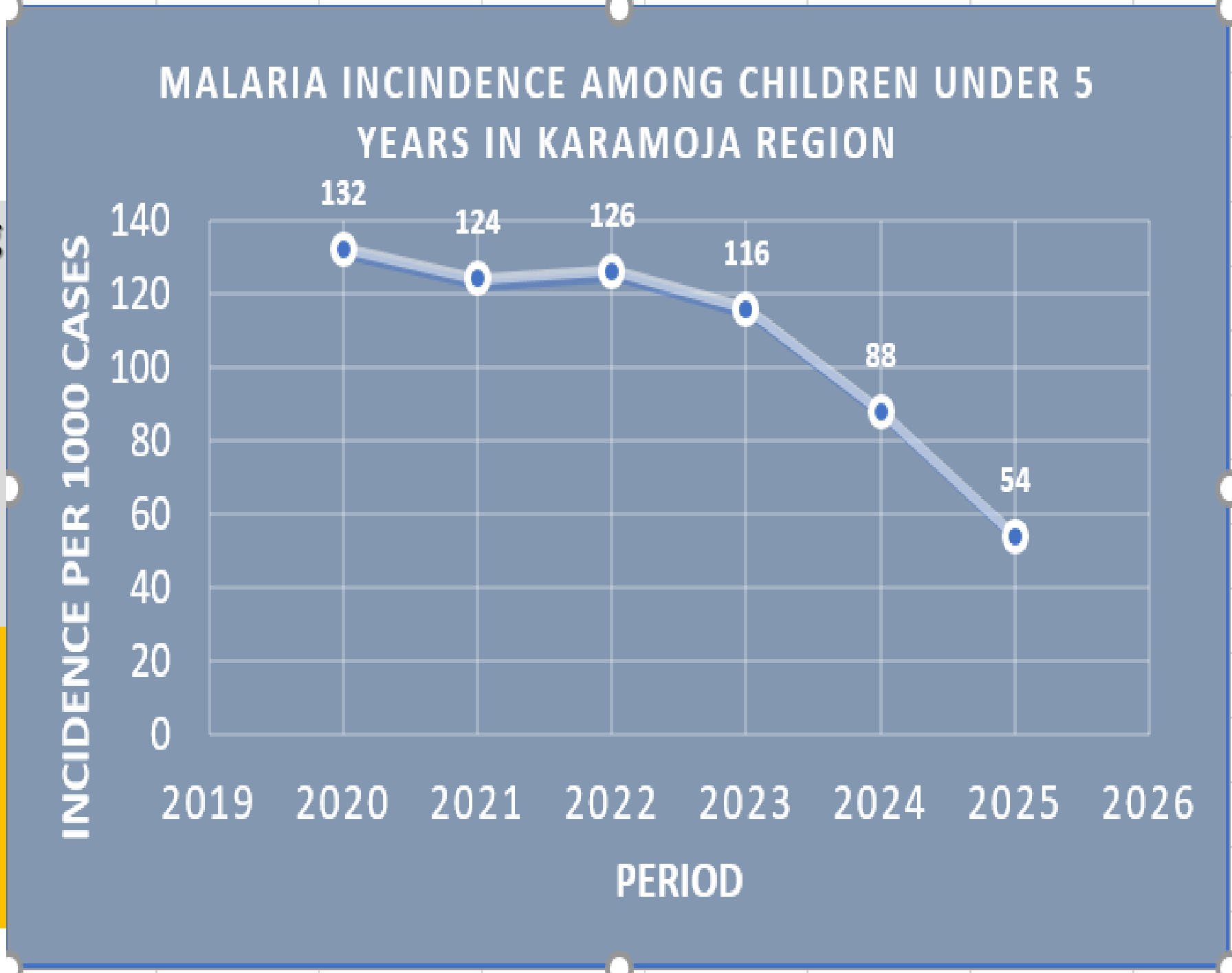
- **Data collected during campaigns (SMC) through digitized tools supports planning and decision making for;**
  - **Other Malaria interventions-ITNs, ICCM**
  - **Other diseases' program interventions –Immunization, Nutrition etc.**

Improved information /data managements and utilization.

- **Utilizing digitized tools helps timely documentation and reporting.**
- **Prompts data utilization and action**

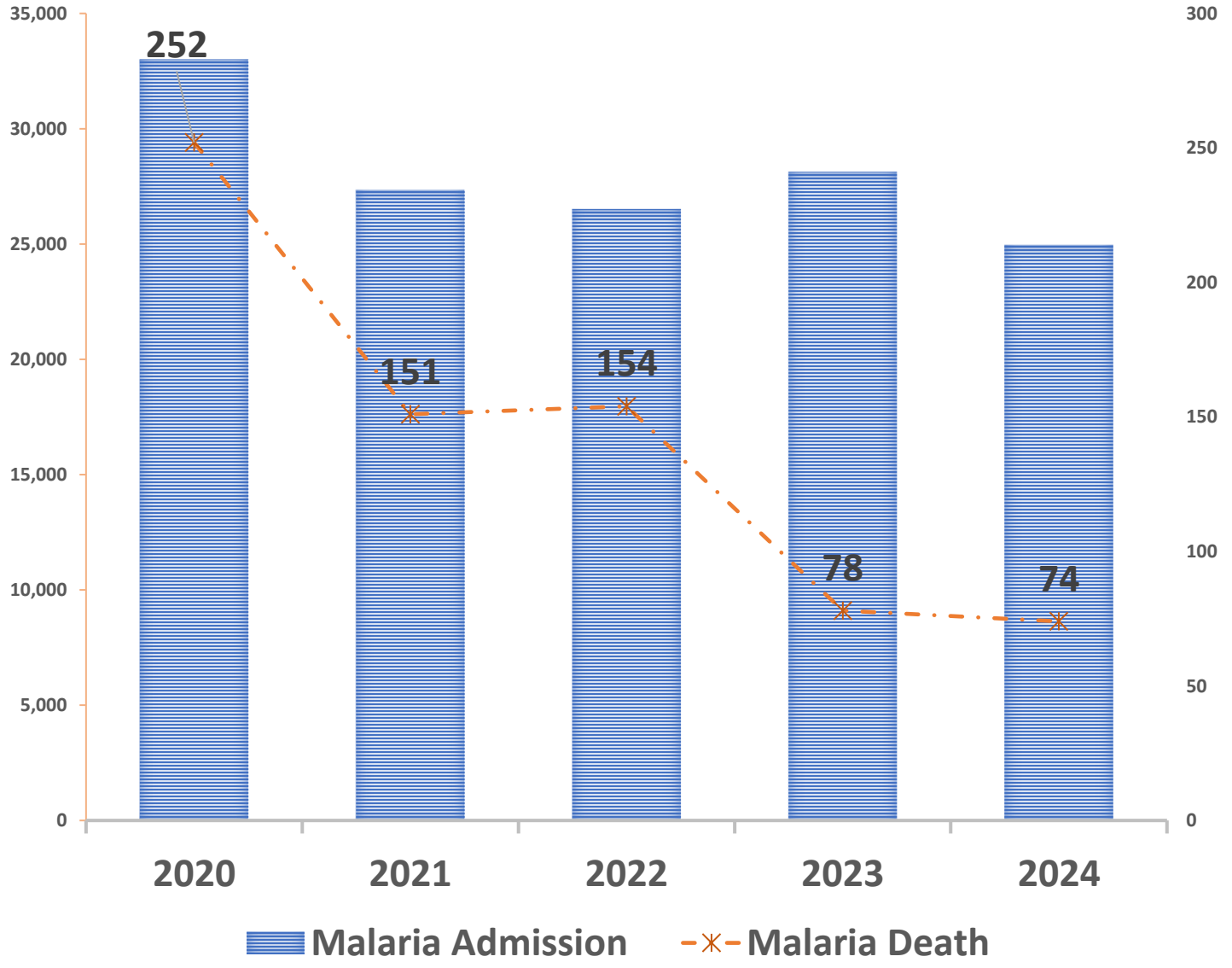
Note: These were achieved with minimal or no additional resources.

Malaria Incidence among Children < 5 Yrs in the 9 districts within Karamoja region (2024-2025):

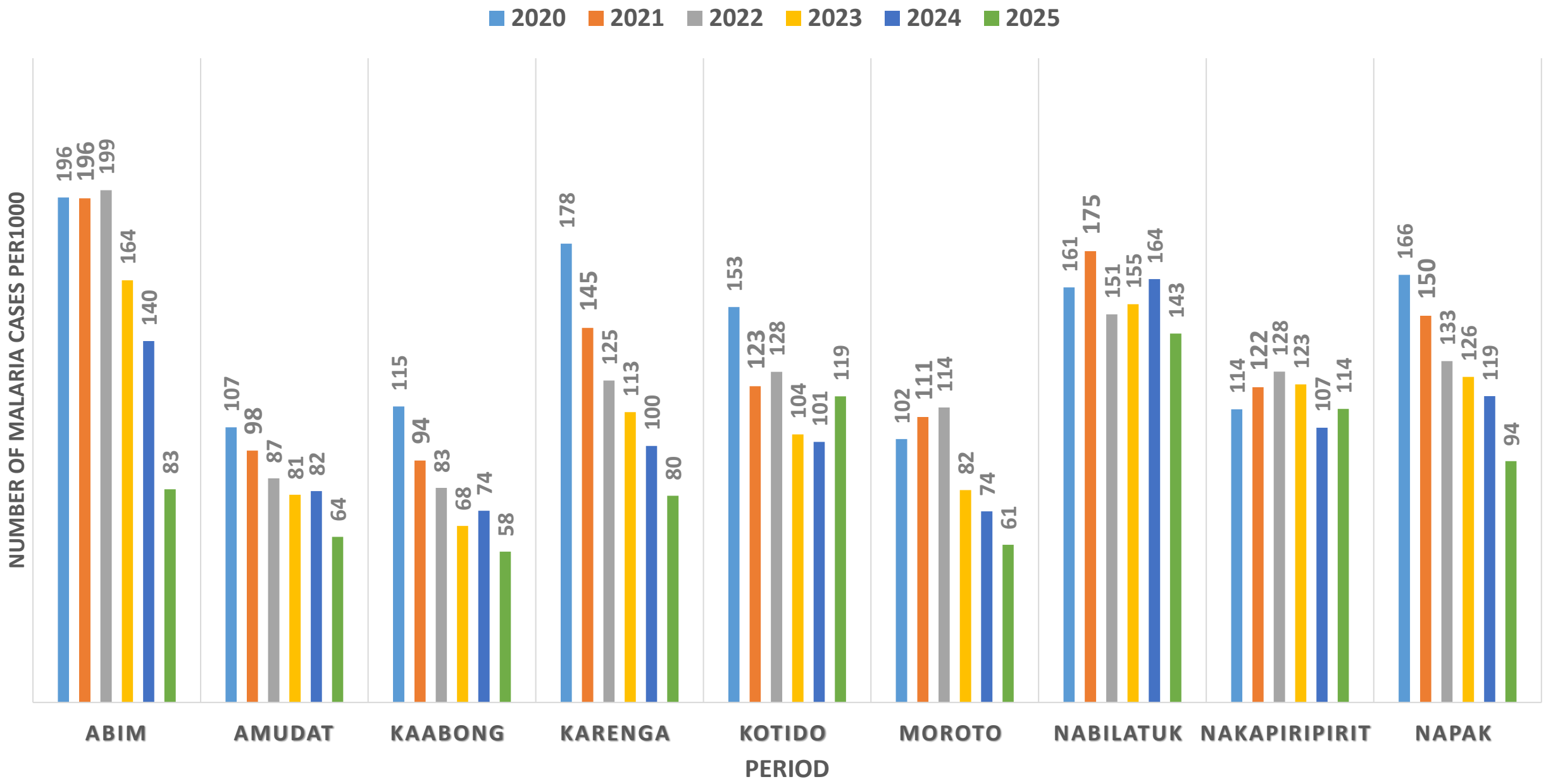


Reduction in malaria deaths for U5s

- **Mortality rates have reduced from 76% in 2020 before SMC to 29.6% in U5s by the 4th year of SMC implementation**



MALARIA INCIDENCE AMONG CHILDREN U5 PER DISTRICT -KARAMOJA REGION



Lessons learnt

Proper planning and coordination contributes to acceptability and successful implementation of integrated SMC campaigns.

Data informed decision-making guides the mapping of underserved and mobile communities and targeting of interventions like SMC and malaria vaccination to increase coverage.

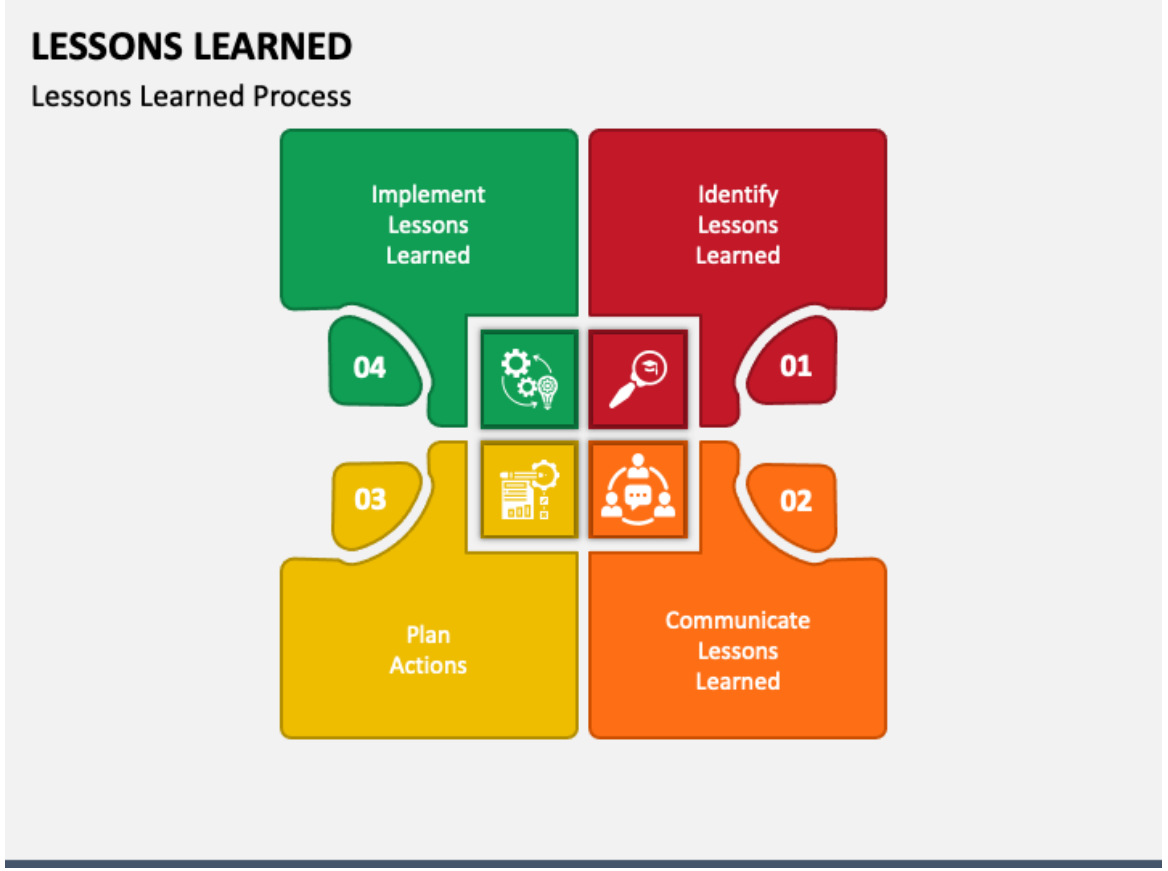
Use of existing health structure for implementation of new intervention is critical for ownership and sustainability

Provision of required tools and guidelines motivates sub-national health teams to willingly deliver integrated services during campaigns .

`Use of digitized tools during campaigns is possible if existing electronic structures are utilized and frontline providers are well facilitated .

Data during SMC and other campaigns is reliable alternative source of data for planning other health interventions.

Well planned & implemented integrated campaigns are efficient and effective



Challenges

- Sub-optimal adaptation of digitized tools – some of the data collection under SMC is still paper based.
- Limited sharing and access to the data collected during the integrated campaigns with resultant inadequate use.
- Capacity gaps: lack of phones, inadequate skills, and low level of education among VHTs makes training difficult.
- Stakeholder hesitancy to deliver integrated campaigns for fear of compromising the quality of implementation & achievement of targets .
- Currently available guidelines and tools are not fully adjusted to accommodate the integration approach.
- Limited knowledge and understanding of the integrated approach to programming.
- Cost per child for SMC implementation is still high compared other countries with high number of children

Recommendations

Deploy bottom-up approach of planning and proper coordination to ensure successful delivery of integrated campaigns.

Guidelines and tools should be revised to support the delivery of integrated campaigns

Capacitate sub-national teams to support integrated service delivery and utilize digitized tools /embrace digitized service delivery.

Make information from the campaigns especially for those that integrated and digitized accessible to improve utilization.

Government should appropriate funds for digitization of integrated health service delivery in the national budget.

Engaging decision-makers for sustained support for malaria elimination: A case for Uganda

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Discussion - Questions & Answers

Discussion - Questions et réponses

Discussão – Perguntas e respostas

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SMC Alliance

Group photo & Coffee Break

Photo de groupe & Pause café

Foto em grupo & Pausa para café

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

WHO Malaria Technical Updates

- *Malaria Prevention strategies*

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

Kampala, Uganda 24-27 February 2026

Dr. Peter OLUMESE,
Technical Lead, Malaria Case Management
Malaria & NTD Department
WHO, Geneva, Switzerland.

World Health Organization

Key antimalarial interventions & strategies

Prevention

- Insecticide-treated mosquito nets
- Indoor Residual Spraying
- Larviciding

Preventive Chemotherapy

- IPT in pregnancy (IPTp)
- Perennial Malaria Chemoprevention
- Seasonal Malaria Chemoprevention
- IPT in School Children
- Post Discharge malaria chemoprevention
- Mass Drug Administration

Malaria vaccine

Diagnosis & Treatment

- Parasite based diagnosis
  - Microscopy
  - Rapid Diagnostic Tests
- Artemisinin-based combination therapies (ACTs)
- Severe Malaria
  - Artesunate

Case management service delivery areas::

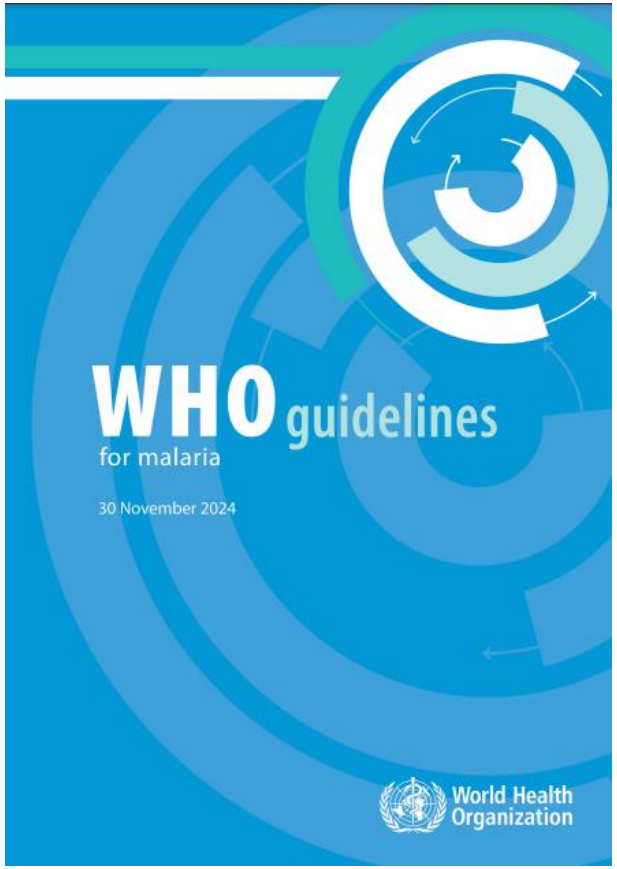
- Health facilities
- Community Case Management
- Private sector

Surveillance, M & E

- Routine HMIS
- Malaria surveillance and response systems
- Household surveys
- Health Facility Surveys

Strengthening health systems in endemic countries

Main malaria prevention and treatment strategies



** Not developed following the WHO guidelines development process*

World Health Organization

Malaria Prevention

World Health Organization

Vector Control

Interventions recommended for large-scale deployment

Strong recommendation for , High certainty evidence

Pyrethroid-only nets (2019)

Pyrethroid-only long-lasting insecticidal nets (LLINs) should be deployed for the prevention and control of malaria in children and adults living in areas with ongoing malaria transmission.

Conditional recommendation for , Moderate certainty evidence

Pyrethroid-PBO ITNs (2022)

Pyrethroid-PBO ITNs instead of pyrethroid-only LLINs can be deployed for the prevention and control of malaria in children and adults in areas with ongoing malaria transmission where the principal malaria vector(s) exhibit pyrethroid resistance.

Strong recommendation for , Moderate certainty evidence

Pyrethroid-chlorfenapyr ITNs vs pyrethroid-only LLINs (2023)

Pyrethroid-chlorfenapyr ITNs should be deployed instead of pyrethroid-only LLINs for prevention of malaria in adults and children in areas with pyrethroid resistance.

Interventions recommended for large-scale deployment

Conditional recommendation for , Moderate certainty evidence

Pyrethroid-chlorfenapyr ITNs vs pyrethroid-PBO ITNs (2023)

Pyrethroid-chlorfenapyr ITNs can be deployed instead of pyrethroid-PBO ITNs for prevention of malaria in adults and children in areas with pyrethroid resistance.

Conditional recommendation for , Moderate certainty evidence

Pyrethroid-pyriproxyfen ITNs vs pyrethroid-only LLINs (2023)

Pyrethroid-pyriproxyfen ITNs can be deployed instead of pyrethroid-only LLINs for prevention of malaria in adults and children in areas with pyrethroid resistance.

Conditional recommendation against , Moderate certainty evidence

Pyrethroid-pyriproxyfen ITNs vs pyrethroid-PBO ITNs (2023)

Pyrethroid-pyriproxyfen ITNs are not recommended for deployment over pyrethroid-PBO ITNs for prevention of malaria in adults and children in areas with pyrethroid resistance.

Interventions recommended for large-scale deployment

Strong recommendation for , Very low certainty evidence Updated

Indoor residual spraying (2025)

IRS should be deployed for the prevention and control of malaria in children and adults living in areas with ongoing malaria transmission.

IRS is considered to be an appropriate intervention where:

- the majority of the vector population feeds and rests indoors;
- people mainly sleep indoors at night;
- the malaria transmission pattern is such that the population can be protected by one or two rounds of IRS per year; and
- the majority of structures are suitable for spraying.

Deploying ITNs and IRS

Conditional recommendation for , Moderate certainty evidence

Prioritize optimal coverage with either ITNs or IRS over combination (2019)

The co-deployment of ITNs and IRS is not recommended for prevention and control of malaria in children and adults in areas with ongoing malaria transmission. Priority should be given to delivering either ITNs or IRS at optimal coverage and to a high standard, rather than introducing the second intervention as a means to compensate for deficiencies in the implementation of the first intervention.

Practice Statement

Access to ITNs or IRS at optimal coverage levels (2019)

Access to effective vector control using ITNs or IRS at optimal coverage levels should be ensured for all populations at risk of malaria in most epidemiological and ecological settings.

No scale-back in areas with ongoing local malaria transmission (2019)

In areas with ongoing local malaria transmission (irrespective of both the pre-intervention and current level of transmission), vector control interventions should not be scaled back. Ensuring access to effective malaria vector control at optimal levels for all inhabitants of such areas should be pursued and maintained.

Interventions recommended for Humanitarian emergency

Strong recommendation for , High certainty evidence

Insecticide-treated nets: Humanitarian emergency setting (2022)

WHO recommends that insecticide-treated nets (ITNs) be deployed for the prevention and control of malaria in children and adults in areas with ongoing malaria transmission affected by a humanitarian emergency.

Conditional recommendation for , Very low certainty evidence

Indoor residual spraying: Humanitarian emergency setting (2022)

WHO suggests deploying indoor residual spraying (IRS) for the prevention and control of malaria in children and adults in areas with ongoing malaria transmission affected by a humanitarian emergency.

Supplementary interventions

Conditional recommendation for , Low certainty evidence

Larviciding (2019)

Insecticides can be regularly applied to water bodies (larviciding) for the prevention and control of malaria in children and adults as a supplementary intervention to ITNs or IRS in areas with ongoing malaria transmission where aquatic habitats are few, fixed and findable.

Conditional recommendation for , Low certainty evidence

House screening (2021)

Screening of residential houses can be used for the prevention and control of malaria in children and adults in areas with ongoing malaria transmission.

Conditional recommendation for , Moderate certainty evidence New

Spatial emanators (2025)

Spatial emanators can be deployed for the prevention and control of malaria in children and adults in areas with ongoing malaria transmission.

Recommendations against use

Conditional recommendation against , Low certainty evidence

Topical repellents (2023)

The deployment of topical repellents in areas with ongoing malaria transmission is not recommended if the aim is to prevent and control malaria at the community level.

Conditional recommendation against , Very low certainty evidence

Space spraying (2019)

Space spraying is not recommended for the prevention and control of malaria in children and adults in areas with ongoing malaria transmission; IRS or ITNs should be prioritized instead.

Conditional recommendation against , Low certainty evidence

Insecticide-treated clothing (2019)

Deployment of insecticide-treated clothing is not recommended for the prevention and control of malaria at the community level in areas with ongoing malaria transmission; however, insecticide-treated clothing may be beneficial as an intervention to provide personal protection against malaria in specific population groups.

Preventive Chemotherapies

World Health Organization

Chemoprevention Strategies

- ✓ Intermittent Preventive Treatment of Malaria in Pregnancy (IPTp)
- ✓ Seasonal Malaria Chemoprevention (SMC)
- ✓ Perennial Malaria Chemoprevention (PMC)
- ✓ Intermittent Preventive Treatment of Malaria in school children (IPTsc)
- ✓ Post Discharge Malaria Chemoprevention (PDMC)
- ✓ Mass Drug Administration (MDA)

Intermittent preventive treatment of malaria in pregnancy (IPTp)

Strong recommendation for , Moderate certainty evidence

Intermittent preventive treatment of malaria in pregnancy (2022)

In malaria-endemic areas, pregnant women of all gravidities should be given antimalarial medicine at predetermined intervals to reduce disease burden in pregnancy and adverse pregnancy and birth outcomes.

Remark:

- Sulfadoxine-pyrimethamine (SP) has been widely used for malaria chemoprevention during pregnancy and remains effective in improving key pregnancy outcomes.
- IPTp-SP should start as early as possible in the second trimester and not before week 13 of pregnancy.
- Doses should be given at least one month apart, with the objective of ensuring that at least three doses are received.
- Antenatal care (ANC) contacts remain an important platform for delivering IPTp. Where inequities in ANC service and reach exist, other delivery methods (such as the use of community health workers) may be explored, ensuring that ANC attendance is maintained and underlying inequities in ANC delivery are addressed.
- IPTp is generally highly cost-effective, widely accepted, feasible for delivery and justified by a large body of evidence generated over several decades.

Perennial Malaria Chemoprevention (former IPTi)

Conditional recommendation for , Moderate certainty evidence

Perennial malaria chemoprevention (2022)

In areas of moderate to high perennial malaria transmission, children belonging to age groups at high risk of severe malaria can be given antimalarial medicines at predefined intervals to reduce disease burden.

Remark:

- Perennial malaria chemoprevention (PMC) schedules should be informed by the age pattern of severe malaria admissions, the duration of protection of the selected drug, and the feasibility and affordability of delivering each additional PMC course (see “Practical info”).
- Sulfadoxine-pyrimethamine (SP) has been widely used for chemoprevention in Africa, including for PMC. Artemisinin-based combination therapies (ACTs) have been effective when used for PMC, but evidence is limited on their safety, efficacy, adherence to multi-day regimens, and cost-effectiveness in the context of PMC.
- Previously, PMC was recommended in infants (<12 months of age) as intermittent preventive treatment in infants (IPTi). Since the initial recommendation, new data have documented the value of malaria chemoprevention in children aged 12 to 24 months.
- The Expanded Programme on Immunization (EPI) platform remains important for delivering PMC. Other methods of delivery can be explored to optimize access to PMC and integration with other health interventions.
- Moderate to high perennial malaria transmission settings are defined as areas with *P. falciparum* parasite prevalence greater than 10% or an annual parasite incidence greater than 250 per 1000 *[30]*. These thresholds are indicative and should not be regarded as absolutes for determining applicability of the PMC recommendation.

Seasonal Malaria Chemoprevention

Strong recommendation for , Moderate certainty evidence

Seasonal malaria chemoprevention (2022)

In areas of seasonal malaria transmission, children belonging to age groups at high risk of severe malaria should be given antimalarial medicines during peak malaria transmission seasons to reduce disease burden.

Remark:

- Eligibility for seasonal malaria chemoprevention (SMC) is defined by the seasonality of malaria transmission and age groups at risk of severe malaria. Thresholds for assessing these criteria change over time and location. Malaria programmes should assess the suitability of SMC based on the local malaria epidemiology and available funding (see "Practical info"). The added value of a seasonally targeted intervention is likely to be greatest where transmission is intensely seasonal.
- Monthly cycles of sulfadoxine-pyrimethamine plus amodiaquine (SP+AQ) have been widely used for SMC in African children under 5 years old and have been shown to be efficacious, safe, well tolerated, available and inexpensive (Thwing *et al unpublished evidence)*.

Implementation field guide

- Update implementation field guide (2013) to reflect current Guidelines recommendation
  - specify age groups, transmission intensity thresholds, numbers of doses or cycles, or specific drugs.

26 May 2023

https://www.who.int/publications/i/item/9789240073692

further guidance (Field Guide 2nd ed, 2023)

- Target area:
  - malaria transmission is highly seasonal and the majority (>60%) of clinical malaria cases occur within 4 consecutive months
  - the clinical attack rate of malaria (without SMC) is at least 0.1 episodes per child during the transmission season in the target group

- Target population
  - Children in age groups at high risk of severe malaria are eligible. In most countries with intense seasonal malaria transmission, these are children below 5 years of age.

further guidance (Field Guide 2nd ed, 2023)

- Number of cycles
  - SMC courses should be given at 28-day intervals, beginning at the start of the transmission season and continuing for 3–5 cycles, depending on the local context.
    - In some settings, three cycles may be sufficient.
    - Add a fifth cycle if a month on either side of the 4-month season contributes more than 10% of the annual burden
    - Gains from adding a sixth SMC cycle appear to be minimal and not cost effective
- Recommended medicines
  - The combination of SP+AQ is currently recommended for SMC.

Intermittent preventive treatment of malaria in school-aged children (IPTsc)

Conditional recommendation for , Low certainty evidence

Intermittent preventive treatment of malaria in school-aged children (2022)

School-aged children living in malaria-endemic settings with moderate to high perennial or seasonal transmission can be given a full therapeutic course of antimalarial medicine at predetermined times as chemoprevention to reduce disease burden.

Remark:

- Intermittent preventive treatment in school-aged children (IPTsc) has been evaluated in children aged 5–15 years. The burden of malaria and benefits of IPTsc may vary across this age range, but evidence is limited.
- National malaria programmes can consider IPTsc if resources allow for its introduction among school-aged children without compromising chemoprevention interventions for those carrying the highest burden of severe disease, such as children < 5 years old.
- Schools may provide a low-cost means to deliver chemoprevention to school-aged children. However seasonal variation in malaria transmission and the timing of school terms, as well as equity concerns, may mean alternative delivery channels are needed to maximize impact.
- First- and second-line malaria treatments should not be used for IPTsc if safe and effective alternatives are available (see "Practical info").
- The dosing schedule for IPTsc should be informed by the local malaria epidemiology and timed to give protection during the period of greatest malaria risk (see "Practical info").
- Moderate to high malaria transmission settings are defined as areas with *P. falciparum* parasite prevalence greater than 10% or an annual parasite incidence greater than 250 per 1000 *[30]*. These thresholds are indicative and should not be regarded as absolutes for determining applicability of the IPTsc recommendation.

Post-discharge malaria chemoprevention (PDMC)

Conditional recommendation for , Moderate certainty evidence

Post-discharge malaria chemoprevention (2022)

Children admitted to hospital with severe anaemia living in settings with moderate to high malaria transmission can be given a full therapeutic course of an antimalarial medicine at predetermined times following discharge from hospital to reduce re-admission and death.

Remark:

- Post-discharge malaria chemoprevention (PDMC) should be given to children following admission with severe anaemia *[153]* that is not due to blood loss following trauma, surgery, malignancy or a bleeding disorder.
- PDMC implementation should be tailored to admissions of children with severe anaemia and consider the duration of protection of the selected antimalarial, and the feasibility and affordability of delivering each additional PDMC course (see "Practical info").
- Moderate to high perennial malaria transmission settings are defined as areas with a *P. falciparum* parasite prevalence greater than 10% or an annual parasite incidence greater than 250 per 1000 *[30]*. These thresholds are indicative and should not be regarded as absolute for determining applicability of the PDMC recommendation.

Overview - implementation guidance documents status update

- SMC
  - Existing Implementation Guides / Field Manuals
    - Published
- IPTp at community level
    - Published
- PMC (IPTi+)
  - In process / expected in 2026.
- IPTsc and PDMC
  - Implementation Guidance document not yet available
  - Deployment studies and experience required to develop implementation guidance documents

Mass Drug Administration (MDA) for burden reduction

Technical area	Strength & evidence	For/against	Recommendation	New/update
MDA	Conditional, low-certainty	For	MDA in moderate-high transmission for short-term *P. falciparum* burden reduction	New
MDA	Conditional, low-certainty	For	MDA in emergency settings for short-term *P. falciparum* burden reduction	New
MDA	Conditional, low-certainty	For	MDA to reduce *P. falciparum* transmission in very low to low transmission	New
MDA	Conditional, very low-certainty	Against	MDA to reduce *P. falciparum* transmission in moderate to high transmission	New
MDA	Conditional, very low-certainty	For	MDA with antimalarial medicine to reduce *P. vivax* transmission	New
MDA	Conditional, very low-certainty	Against	MDA with 8-aminoquinoline alone to reduce *P. vivax* transmission	New

Conditional recommendation for

Conditional recommendation against

Strong recommendation for , High certainty evidence Updated

Malaria vaccines (2023)

WHO recommends the use of malaria vaccines for the prevention of *P. falciparum* malaria in children living in malaria-endemic areas, prioritizing areas of moderate and high transmission.

- As of October 2023, WHO recommends two vaccines for the prevention of Plasmodium falciparum malaria in children:
  - *RTS,S/AS01 (RTS,S) in 2021, and*
  - *R21/Matrix-M (R21) in October 2023.*

How to access WHO malaria guidance

1 [WHO Global Malaria Programme website]

2 [MAGICapp]

3 [WHO Malaria Toolkit app]

Keep our eye on the prize: a world free of malaria

Thank you

amp | The Alliance for Malaria Prevention

SMC Alliance

Discussion - Questions & Answers

Discussion - Questions et réponses

Discussão – Perguntas e respostas

Panel discussion - Funding landscape

- What are the changes for funders and governments this year?
- What types of information will be needed for decision-making on financing?

Current funding landscape

- Overall **progress has stalled** since 2015. Members states not on track to achieve target.
- **30% drop in funding** landscape
  - Global Fund 8th replenishment fell short of target.
  - Decline in Official Development Assistance for health.
- Facing a "**Perfect Storm**" of threats (humanitarian crises, resistance, climate change, rising costs….)

What next for countries?

Revenue mobilization:

- Social insurance funds
- Debt swaps
- Innovative levies
- Blended finance
- End malaria councils

A 30% reduction in funding is expected to result in a 640 million fewer ITNs, 146 million additional cases, 397,000 additional deaths (75% children under 5), and a loss of $37 billion in GDP by 2030.

2025 AU Malaria Progress Report: https://alma2030.org/

Ending malaria will inject significant economic value into African economies and trade

Retreat and forfeit millions of lives and billions in economic growth

Retreating from the goal of eliminating malaria by 2030 will have immediate and devastating consequences. Announced cuts to funding and disruptions to partner support are on track to cause:

- **Human Cost:** 146 million more malaria cases and 397,000 additional deaths.
- **Economic Cost:** $37 billion drop in Africa's GDP.
- **Trade Cost:** $229 million loss in Africa-G7 exports.
- **Waste the Future:** A $1.32 billion loss in the future earnings of Africa's youth.

If countries cannot sustain prevention activities (a worst-case scenario), the impact would be catastrophic—slashing Africa's GDP by $85 billion and nearly 377 million additional deaths by 2030.

Invest now to end malaria and unlock growth

A strategic investment that meets our 2030 global targets represents one of the most effective drivers of economic growth. For the same period, this would:

- **Save Lives:** 830 million cases avoided and save 1.9 million lives.
- **Boost Economies:** Add $152 billion to Africa's GDP.
- **Strengthen Trade:** Generate $10.3 billion in new Africa-G7 export revenue.
- **Secure the Future:** Preserve $34.2 billion in future earnings by keeping children healthy and in school.

The long-term prize is even greater: meeting global targets is projected to add $2.5 trillion to African economies by 2040.

THE ECONOMIC KNOCK-ON EFFECT OF MALARIA ON THE BROADER ECONOMY

2030 FUNDING TARGET REACHED

- +$10.3 BILLION — BOOST TO G7 TRADE REVENUE
- +$7.2 BILLION — BOOST TO AGRICULTURE
- +$3.4 BILLION — BOOST TO TOURISM
- +$35.3 BILLION — BOOST TO HEALTH SECTOR

SEVERE CUT = PREVENTION COLLAPSE

- -$3.4 BILLION — DROP TO G7 TRADE REVENUE
- -$4.3 BILLION — DROP TO AGRICULTURE
- -$2.1 BILLION — DROP TO TOURISM
- -$20.7 BILLION — DROP TO HEALTH SECTOR

Against Malaria Foundation (AMF)

1. Funding context and changes

- **Gap filler** respond to countries that have gaps, expect those to increase
- **Mass campaigns** cost effective, works well with our donor model
- **High burden** want to protect those in communities at highest risk of malaria
- **Work in partnership** AMF funds nets, GF or PMI funds distribution costs
- **Data supports decisions** such as sub-national tailoring, net type
- **Ensure nets get to those who need them** so data and monitoring a key part of what we do

2. Information needed for decisions

1. **Funding gap**
   - Understanding country's plans with funding available
   - Who will be left unprotected without further funding
2. **Malaria burden info**
   - Prevalence
   - Incidence (WHO)
   - Mortality
3. **Other info**
   - Entomology: net type
   - Net use data (and RD) – which net product
   - Net lifetime – when to replace nets
   - Specifics on country context
   - Willingness to use technology

Global Fund Grant Cycle 8

Strategic shifts to respond to the new financing environment

Current as of February 2026 – any changes will be communicated

Strategic shifts:

- Greater prioritization of the least-resourced and highest-burden countries.
- Defined, predictable transition timelines tailored to national contexts, disease burden and economic conditions.
- Optimized use of all available resources through rigorous programmatic prioritization, increased co-financing, market shaping, reinforced integration into national health systems, and community systems financing.

Programmes are encouraged to:

- **Strive to maintain current coverage of core interventions**
  - as far as possible, sub-nationally targeting the intervention mix and programmatic approaches based on best available data and taking a holistic view of available funding. Prioritise surveillance and essential data collection in GC8 to support continued prioritisation and tailoring.
- **Maintaining a strong balance between prevention and case management**.
  - Weakening prevention - particularly in high-burden rural areas with limited access to care - will drive increases in malaria cases and place avoidable strain on health systems.
- **Prioritise prevention resources to areas most in need**
  - where appropriate, deprioritize urban centers with adequate access to services - to ensure maximum impact.
- **Actively revisit and optimize ITN and SMC distribution approaches**
  - Including reviewing target areas, delivery channels, coverage goals, integration opportunities and operational and cost efficiencies.
- **Strengthen the antimalarial drug resistance response**
  - through strong surveillance and the development and operationalization of an antimalarial drug resistance strategy - which could include adoption of WHO-recommended Multiple First-line Therapies

Key info needed	Example	Source
What would the funding cover?	Procurement, distribution and monitoring costs for 3 million nets that would be distributed in x,y,z provinces through door-to-door campaigns	Implementer/ Government
What is the total program budget? What's the size of the gap?	The full campaign would cost $20m; $2m are already covered, leaving a $18m gap	Implementer/ Government + GW – other funders interviews
How effective is the program at reducing burden in study context?	We estimate ITNs reduce malaria mortality by ~45% among children under 5, based on the Pryce et al. 2018 meta-analysis	GW – desk research
What are the key differences between the context where studies were run and the context where we might fund the program?	For example: • Number of people sleeping under each net • Net loss • Net use • Net durability	Implementer – past M&E data + GW – desk research
What is the burden in the targeted geographies?	Malaria mortality rate in target areas is 0.8% among children under 5 (the highest risk group)	GW – desk research
How many additional people will be reached with the program?	We expect an additional 400k children under 5 will receive nets as a result of this program (600k children will receive nets, 1/3 of them would have received nets anyway)	Implementer – M&E and cost data + GW – desk research
What is the track record of implementing partners?	The implementers have delivered this program before at this scale in these geographies and are considered reliable partners by the government.	Implementer/ Government

Keys elements to consider while partnering with the Gates Foundation

Malaria elimination continues to be a paramount objective for the Gates Foundation. It will be achieved only if we avoid doing business as usual (SNT, financial optimization), and if innovations are effectively introduced and implemented at scale.

Gates Foundation to Spend $200 billion on 20-Year Path to Closing Down

Health Systems 08/05/2025 · Kerry Cullinan

Share this:

Bill Gates observes a device used for analyzing the nutrient qualities of rice during the Innovation Tech & Science Fair in Abuja, Nigeria, on September 4, 2024. ©Gates Archive/Andrew Esiebo

Key considerations

- Gates Foundation is sunsetting (Closing door in 2045)
- Malaria elimination remain a key priority
- GF budget : ~55% R&D, ~45%delivery
- Innovation (new funding streams, product/ technology: gene drive, LAI, Sec Gen Vacc .etc.,)
- Smarter implementation (SNT, prioritization digitization, funding optimization,)

Further collaboration with the GF

- We are not set for gap filling but for catalytic investments (no commodities procurement for e.g.)
- No direct funding but DU/HTUs in place (Senegal, DRC, Tanzania)
- Need for partners to demonstrate impact
- Data for decision-making, innovative approaches for delivery, operational research
- Cost-effective ways of tracking and demonstrating progress

Gates Foundation

Current context

- Increased pressure on prioritisation and domestic resource mobilisation
- Need for stronger alignment across funding streams and decision cycles

Countries perspectives

- Simpler navigation across funder requirements and key timelines
- Clearer understanding of complementarities across major funding streams

RBM's coordinated response

- Big Push – Pillar 6: protect malaria funding and advocate for new resources
- CRSPC: support countries on prioritisation/optimisation and domestic resource mobilisation, and
- Improve clarity and communication to National Malaria Programmes (NMCPs)

Practical example: MFIP

- Light, high-level, link-based overview of key timelines and official guidance
- Designed as a "one-stop-shop" for programs to access information from major funders' streams

Lunch Break

Pause déjeuner

Pausa para almoço

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