malaria consortium

Coverage and quality of seasonal malaria chemoprevention supported by Malaria Consortium with philanthropic funding or co-funding in 2025:

Results from Burkina Faso, Chad, Nigeria, South Sudan, Togo and Uganda

April 2026

Established in 2003, Malaria Consortium is a leading non-profit organisation dedicated to improving health and saving lives in communities affected by malaria and associated health inequities. Our work is rooted in providing responsive, contextualised solutions within communities, enabling them to thrive. Grounded in research and implementation science, and working closely with governments and partners, we drive innovation to narrow the gap in health outcomes and create tangible, scalable and sustainable impact.

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Contents

Acronyms and abbreviations

ACCESS-SMC	Achieving Catalytic Expansion of Seasonal Malaria Chemoprevention in the Sahel
AQ	amodiaquine
AI	artificial intelligence
CI	confidence interval
DHS	Demographic and Health Surveys
DIDM	data-informed decision-making
DOT	directly observed therapy
EoC	end-of-cycle
EoR	end-of-round
FCT	Federal Capital Territory
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
IDP	internally displaced person
KOICA	Korea International Cooperation Agency
LGA	local government area
LQAS	lot quality assurance sampling
MOE	margin of error
M&E	monitoring and evaluation
PPS	probability proportional to size
SA	supervision area
SMC	seasonal malaria chemoprevention
SP	sulfadoxine–pyrimethamine
SPAQ	sulfadoxine–pyrimethamine and amodiaquine
SRS	systematic random sampling
WHO	World Health Organization
UNICEF	United Nations International Children's Emergency Fund

Executive summary

Background

Malaria remains a leading cause of morbidity and mortality among young children in sub-Saharan Africa, where transmission typically intensifies during the rainy season. Since 2012, the World Health Organization (WHO) has recommended seasonal malaria chemoprevention (SMC) as a preventive intervention designed to protect at-risk populations during periods of peak transmission in areas where malaria transmission is highly seasonal. It involves the intermittent administration of a single dose of sulfadoxine–pyrimethamine (SP) together with three daily doses of amodiaquine (AQ), together referred to as SPAQ, to eligible children at 28-day intervals throughout the high transmission season. Evidence from research and real-world implementation indicates that SMC is safe, feasible, effective and cost-effective when delivered at scale across diverse epidemiological and geographical contexts.

Malaria Consortium remains committed to rigorous monitoring and evaluation (M&E) of its SMC programme to track performance and generate evidence to inform decision-making and programme improvement. This report outlines M&E methods used across countries and areas supported through philanthropic funding and presents 2025 estimates of key coverage and quality indicators. It also highlights the methodological, contextual and programmatic implications of key findings and offers recommendations to strengthen M&E approaches and programme implementation in 2026 and future rounds.

Malaria Consortium's SMC programme in 2025

Malaria Consortium supported the delivery of SMC as an implementing partner in seven countries in 2025 through full philanthropic funding or co-funding. As estimated through country-specific microplanning processes, a total of 14,807,271 children aged 3–59 months were targeted, including in Burkina Faso (2,224,461), Chad (269,411), Nigeria (11,854,712), South Sudan (82,700), Togo (203,228) and Uganda (172,759). In Mozambique, the 2024/25 SMC round in philanthropically supported districts was cancelled due to political unrest and operational challenges. The total target population for 2025 was therefore substantially lower than the 17,074,746 children targeted during the 2024 campaign, primarily due to the cancellation of planned SMC distribution in Mozambique, as well as the transition of some health districts to support from The Global Fund in Chad. Several programmatic adaptations were implemented in 2025, including the use of SMC as a platform to co-deliver vitamin A supplementation and oral rehydration solution with zinc, and to support the identification and referral of under-immunised children, among other integration efforts.

Methods

The programme's M&E framework continues to guide a standardised M&E methodological approach across supported countries. Administrative coverage was estimated using numerators derived from

routine monitoring data recorded on SMC tally sheets or through SMC campaign digitalisation tools, while denominators were based on target population estimates derived from 2025 microplanning data.

In addition to administrative coverage, more precise estimates of SMC coverage and quality were obtained from data derived from two types of post-cycle household coverage monitoring surveys:

- End-of-cycle (EoC) surveys, using the lot quality assurance sampling (LQAS) methodology, typically conducted within one week after each SMC cycle, except the final cycle. These surveys enabled the identification of areas with lower coverage or quality and supported rapid corrective actions in subsequent cycles.
- End-of-round (EoR) surveys typically conducted within one month after the final cycle. Designed to produce country-level representative estimates across all countries (with additional state-level representativeness in Nigeria), these surveys enabled a comprehensive assessment of programme performance across all cycles of the annual round.

Main findings

Administrative coverage

In 2025, the programme reached an estimated 15,561,666 children across cycles and supported countries. Considering the estimated 14,807,271 target population, this represented an overall administrative coverage of 105.1 percent. Administrative coverage exceeded 100 percent in the majority of countries, reflecting a usual trend in which reported reach surpassed target populations. In Burkina Faso, coverage was 122.5 percent, with 2,725,378 children reached against a target of 2,224,461. In Chad, coverage was 102.8 percent (276,890 reached of 269,411 targeted), while Nigeria and South Sudan both reported just over 102.0 percent coverage (12,111,449 /11,854,712 and 84,512/82,700, respectively). Coverage was slightly below target in Togo (98.0 percent; 199,088/203,228) and Uganda (95.1 percent; 164,349/172,759). Observed variation across countries may reflect differences in implementation contexts, the accuracy of target population estimation methods and potential programmatic challenges, which are explored in more detail later in the report.

Coverage estimates from end-of-cycle and end-of-round surveys

Findings from household surveys in 2025 indicate that the SMC programme maintained high levels of coverage and adherence to quality standards across all supported countries. Day 1 SPAQ coverage exceeded 90 percent in most cycles and countries, with directly observed therapy (DOT) and adherence to day 2 and 3 AQ doses also consistently high. Receipt of SPAQ in all planned cycles of the round was fairly high but still reflects gaps in coverage across the full round's schedule. Results, expressed as percentages with 95 percent confidence intervals (95% CIs) for key indicators by cycle and country are highlighted in the **Table 0** below, and presented, interpreted and discussed in greater detail in the main report:

Table 0: Summary of 2025 SMC coverage results from EoC and EoR surveys by country and cycle

Country	Cycle no.	Target population	Day 1 SPAQ (95% CI)	Day 1 DOT (95% CI)	Adherence to day 2 and 3 AQ (95% CI)	Receipt of SMC in all cycles (95% CI)	
Burkina Faso	cycle 1	2,224,461	97.3 (88.9–99.4)	99.4 (98.0–99.8)	98.8 (96.2–99.6)	83.8 (81.4–85.9)*	86.6 (83.0–89.6)#
	cycle 2		98.6 (97.9–99.1)	93.5 (88.3–96.5)	99.5 (99.0–99.7)		
	cycle 3		97.2 (94.4–98.6)	97.3 (95.2–98.5)	99.4 (98.9–99.6)		
	cycle 4		97.4 (96.2–98.3)	95.9 (91.4–98.1)	98.9 (98.0–99.4)		
	cycle 5		96.3 (95.2–97.1)	95.8 (94.6–96.7)	98.8 (98.1–99.3)		
Chad	cycle 1	269,411	96.5 (94.5–97.8)	79.7 (75.2–83.6)	89.4 (84.7–92.7)	82.8 (76.5–88.0)+	91.5 (89.8–92.9)*
	cycle 2		93.5 (87.0–96.9)	83.1 (78.7–86.7)	89.6 (85.0–92.9)		
	cycle 3		96.5 (94.6–97.7)	93.4 (91.5–94.9)	95.0 (92.5–96.7)		
	cycle 4		98.6 (97.9–99.1)	97.6 (96.7–98.3)	97.4 (96.4–98.1)		
Nigeria	cycle 1	11,854,712	85.1 (82.2–87.5)	86.2 (84.4–87.9)	96.4 (95.8–96.9)	90.2 (89.3–91.1)*	80.2 (79.4–81.0)#
	cycle 2		92.1 (90.8–93.3)	88.8 (87.4–90.1)	97.2 (96.8–97.6)		
	cycle 3		92.4 (90.5–94.0)	89.2 (87.9–90.4)	97.2 (96.6–97.8)		
	cycle 4		93.4 (92.0–94.6)	89.1 (87.2–90.7)	98.0 (97.6–98.3)		
	cycle 5		92.7 (92.3–93.2)	92.9 (92.5–93.4)	96.2 (95.9–96.6)		
South Sudan	cycle 1	82,700	85.6 (76.6–91.5)	96.7 (93.6–98.3)	97.5 (95.0–98.8)	81.7 (79.7–83.7)	
	cycle 2		88.4 (80.8–93.2)	97.4 (95.8–98.4)	95.4 (91.1–97.7)		
	cycle 3		86.6 (78.8–91.8)	99.0 (97.5–99.6)	97.6 (94.7–98.9)		
	cycle 4		90.3 (84.4–94.2)	97.7 (88.9–99.6)	98.8 (97.4–99.5)		
	cycle 5		92.1 (90.6–93.3)	99.4 (98.8–99.7)	99.5 (98.9–99.8)		
Togo	cycle 1	203,228	97.0 (94.4–98.4)	85.8 (79.2–90.6)	95.0 (90.2–97.5)	87.8 (86.0–89.4)	
	cycle 2		98.0 (95.5–99.2)	84.7 (70.9–92.7)	97.3 (94.9–98.6)		
	cycle 3		97.0 (92.6–98.9)	82.7 (73.6–89.2)	95.1 (90.9–97.4)		
	cycle 4		97.8 (94.8–99.1)	84.8 (72.4–92.2)	95.0 (89.9–97.6)		
	cycle 5		97.5 (96.5–98.2)	94.3 (93.0–95.4)	99.2 (98.6–99.5)		
Uganda	cycle 1	172,759	98.7 (95.3–99.7)	96.5 (89.2–98.9)	98.8 (97.8–99.4)	92.3 (90.8–93.6)	
	cycle 2		98.2 (92.7–99.6)	96.7 (80.3–99.5)	98.1 (94.9–99.3)		
	cycle 3		98.5 (95.8–99.5)	94.7 (76.8–99.0)	98.2 (92.5–99.6)		
	cycle 4		97.8 (93.5–99.3)	97.7 (89.0–99.5)	98.8 (97.2–99.4)		
	cycle 5		98.4 (97.6–98.9)	94.2 (92.9–95.3)	99.2 (98.6–99.5)		

+Areas that received three SMC cycles; *those that received four cycles; # those that received five cycles; DOT: directly observed therapy

Conclusion

In 2025, SMC coverage and quality were generally high during most cycles across supported countries. Nevertheless, some areas and cycles experienced relatively lower coverage and quality, likely reflecting a combination of programmatic or contextual challenges. These highlight important performance gaps and opportunities for efforts to strengthen programme delivery in 2026 and future campaigns, while the strong performance observed in many settings also presents an opportunity to consolidate existing gains. While the methods used are robust and have been strengthened through recent improvements, some methodological limitations remain and present opportunities for further improvements.

1. Introduction

Malaria remains the leading cause of morbidity and mortality in sub-Saharan Africa, particularly among young children and pregnant women.[1] Since 2012, the World Health Organization (WHO) has recommended seasonal malaria chemoprevention (SMC) as a chemoprevention strategy in areas where transmission is highly seasonal.[2,3] It is intended to protect children against *Plasmodium falciparum* malaria during periods of peak transmission through intermittent administration of courses of sulfadoxine–pyrimethamine (SP) and amodiaquine (AQ), together known as SPAQ.[3] The objective is to maintain therapeutic antimalarial drug concentrations in the blood throughout the period of highest risk of malaria incidence, morbidity and death. A growing body of evidence from randomised controlled trials, observational studies and large-scale programme implementation indicates that SMC is safe, operationally feasible, effective and cost-effective in protecting children across diverse epidemiological and geographical contexts.[4–7]

In practice, SMC is delivered in yearly rounds of three to five cycles during periods of peak malaria transmission, typically coinciding with the rainy seasons, with distribution periods 28 days apart. It typically involves the distribution of SPAQ through door-to-door delivery by trained community distributors, often volunteers from the communities they serve, recruited and trained specifically for SMC campaigns. In some places, SMC medicines are distributed by existing community health workers with additional training on SMC. Distribution occurs over a period of three to four days per cycle, with a full course of SPAQ comprising one single dispersible tablet of SP and three daily dispersible tablets of AQ. On the first day, a dose of SP and the first dose of AQ (‘day 1 SPAQ’) is administered by or under the supervision of community distributors to ensure that the tablets are correctly dispersed in water and that the child fully ingests all of the dispersed tablets without spitting them out or vomiting. This is referred to as directly observed therapy (DOT). Community distributors leave a blister pack with the two remaining tablets with caregivers and provide instructions on how to administer the remaining two doses of AQ once per day over the following two days (‘day 2 AQ’ and ‘day 3 AQ’). Children who vomit or spit out the medicines within 30 minutes should be re-dosed once. For further details of the programmatic delivery model, refer to the 2025 SMC Philanthropy Report.[8]

1.1 Malaria Consortium’s philanthropic SMC programme in 2025

In 2025, Malaria Consortium supported SMC delivery as an implementing partner with philanthropic funding in Burkina Faso, Chad, Nigeria, South Sudan, Togo and Uganda (**Figure 1**). Based on microplanning estimates, a total of 14,807,271 children were targeted across the six countries. Philanthropic funding was also used to support selected activities or commodities in other areas of Burkina Faso and Togo where Malaria Consortium did not serve as the implementing partner. Target population numbers for those areas are not reported here. As a result, the number of districts and target population figures reported for both countries may differ from those in the 2025 Philanthropy

Report, which provides a detailed account of how Malaria Consortium used philanthropic funding and co-funding for SMC in 2025.[2]

It is important to note that target population figures reported in the annual philanthropy reports and those reported in the coverage reports for the same calendar year are not identical, for two main reasons. First, in Mozambique, the peak malaria transmission season, and therefore SMC campaign activities, spans two calendar years, typically from December to March. In the annual SMC philanthropy report, target population figures are assigned to the calendar year in which the high transmission season begins, in line with global convention. In contrast, the SMC coverage report presents data for the season ending in the reporting year, as coverage data for that season are not yet available at the time of reporting. Accordingly, while the 2025 SMC Philanthropy Report includes target population figures for the 2025/26 round in Mozambique (1,636,200), the 2025 SMC Coverage Report reflects the 2024/25 round (0, due to the cancellation of the round in philanthropically supported districts). Second, the scope of reporting differs. The annual SMC philanthropy report includes all areas where philanthropic funding supported SMC delivery. By contrast, the annual SMC coverage report is limited to areas where Malaria Consortium directly supported SMC implementation as the implementing partner, since household surveys are typically only conducted and Malaria Consortium is only directly accountable for programme performance in those areas. This means that target population figures from two health districts in Burkina Faso (total target population: 116,356) and 16 districts in Togo (total target population: 433,796), where Malaria Consortium was not the implementing partner during the SMC round are not included in this report.

The total target population reported here is substantially lower than the 17,074,746 children reported in the 2024 Coverage Report.[9] This reduction was primarily driven by two factors. In Mozambique, the 2024/25 SMC round in philanthropically supported districts was cancelled due to political unrest, cyclone damage and unresolved payment disputes from the previous season. As a result, the target population fell to 0, compared with 1,482,649 in the 2023/24 round. In Chad, the scale of philanthropic SMC support decreased from 1,437,037 in 2024 to 269,412 in 2025. This followed GiveWell's 2023 decision to phase out funding for SMC in Chad, based on its assessment at the time that the programme's cost-effectiveness fell below its funding threshold.[10] GiveWell revised its model in 2024 and now estimates SMC in Chad to be above the threshold. However, planning timelines meant that, in 2025, operations could only continue in 10 districts that had not secured alternative funding.[11]

Several programmatic adaptations were implemented in 2025, including the use of SMC as a platform to co-deliver vitamin A supplementation and oral rehydration solution with zinc, and to support the identification and referral of under-immunised children, among other integration efforts. A detailed account of these adaptations are provided in the 2025 Philanthropy Report.[8]

Figure 1. Countries where Malaria Consortium supported SMC as implementing partner in 2025

Of the total target population, 2,224,461 eligible children were targeted in 27 health districts across six provinces in Burkina Faso; 269,411 in 12 health districts across two provinces in Chad; 11,854,712 in 154 local government areas (LGAs) across eight states and the Federal Capital Territory (FCT) in Nigeria; 82,700 in two counties in one state in South Sudan; 203,228 in seven districts in one region in Togo; and 172,759 in five districts in one sub-region of Uganda.

Countries and sub-national units where Malaria Consortium supported SMC as an implementing partner using philanthropic funding in 2025, dates of SMC rounds and estimated target populations are shown in **Table 1**.

Table 1: SMC areas and target population supported by Malaria Consortium as implementing partner with philanthropic funding, 2025

Country	Period of SMC round	Sub-national areas covered	Target population
Burkina Faso[1]	June – October 2025	27 health districts in six provinces: Djôrô (formerly Centre Sud), Guiriko (formerly Hauts Bassins), Kadiogo (formerly Centre), Koulsé (formerly Centre Nord), Oubri (formerly Plateau Central) and Tannounyan (formerly Cascades)	2,224,461
Chad	July – October 2025	12 health districts in two provinces: Barh el Gazel and Mayo Kebbi Est	269,411
Mozambique	2024/2025 round was cancelled		
Nigeria	May – October 2025	154 local government areas (LGAs) in eight states (Bauchi[2], Borno, Kebbi, Kogi, Nasarawa, Oyo, Plateau and Sokoto) and the FCT	11,854,712
South Sudan[3]	June – October 2025	Two counties in one state: Northern Bahr el Ghazal	82,700
Togo[4]	June – October 2025	Seven districts in one region: Savanes	203,228
Uganda	May – September 2025	Five districts in one sub-region: Karamoja	172,759
		Programme total	**14,807,271**

[1] Malaria Consortium also procured SMC medicines for two health districts that were otherwise supported by UNICEF. Target population figures for those health districts (116,356) are not included in this table as Malaria Consortium did not act as implementing partner.
[2] Most implementation costs for two SMC Impact project LGAs in Bauchi (target population 314,372) were covered by philanthropic funding. KOICA funding was used to cover procurement and international freight for SMC medicines, as well as to support aspects of training and administration of SMC medicines.
[3] Philanthropic funding covered all implementation costs and procured medicines, while UNICEF donated a portion of the SMC medicines used in 2025.
[4] Philanthropic funding covered most implementation costs, with UNICEF contributing the cost of two SMC cycles. The Global Fund procured the SMC medicines. Malaria Consortium also acted as temporary implementing partner with philanthropic funding in four districts in another region for pre-round implementation activities (planning, procurement of non-medical commodities, community engagement and training) to bridge a gap caused by a temporary freeze of PMI funding. Implementing partner responsibilities were handed over to another partner once PMI funding had been restored at the beginning of the round, and target population figures for those districts (122,232) are not shown here. In addition, Malaria Consortium used philanthropic funding to support selected activities in 12 districts where the majority of costs were covered by the Global Fund (target population 311,564). As Malaria Consortium did not act as implementing partner in these districts, those target population figures are not included in this table.

In Burkina Faso and Nigeria, four cycles were delivered in some areas while five were delivered in others, and in Chad some areas received three cycles while others received four. This reflects malaria stratification recommendations based on the duration of the peak transmission season, which generally increases from north to south. Five cycles were delivered in all supported areas in South Sudan, Togo and Uganda. Notably, in Chad, unlike in previous years when all supported districts received four cycles, four cycles were delivered in 10 of the 12 supported health districts in 2025, while two districts, Salal and Michemire, received three cycles in line with updated stratification following a recent national stratification exercise.[12]

1.2 Objectives of this report

This report summarises estimates of coverage and quality of SMC implementation in areas supported by Malaria Consortium through philanthropic funding as an implementing partner in 2025. Its objectives are as follows:

- Outline methods employed by Malaria Consortium for monitoring coverage and quality in areas supported in 2025.
- Provide a summary of estimates of programme coverage and quality in each cycle delivered across supported countries in the period under review.
- Examine the methodological, contextual and programmatic implications of the findings and provide recommendations for refining M&E methods and programmatic approaches in 2025 and future SMC rounds.

2. Methods

Malaria Consortium remains committed to rigorously monitoring and evaluating the performance of its SMC programme. This enables the tracking of progress against intended reach, coverage, quality and impact, while identifying successes and areas where improvements can be made. It also enables accountability for partners and stakeholders. A framework was developed to guide the programme's current M&E approaches, allowing the programme to strengthen and harmonise M&E methods, tools and processes across countries and implementation settings.[13] The framework specifies a range of indicators for each of the programme's seven core performance objectives: supply and demand, fidelity, acceptability, safety, coverage, quality and decision making. Depending on indicators, different M&E methods are employed including quantitative, qualitative and mixed methods designs. In line with the objectives outlined earlier, this report focuses on M&E aspects pertaining to programme coverage and quality.

In practice, in countries with sub-national variation in the number of cycles, as in Burkina Faso and Nigeria, areas receiving five cycles generally start the SMC round earlier than areas implementing four cycles. As such and for the purposes of this report, the first cycle in areas receiving five cycles is referred to as 'cycle 1', while 'cycle 2' refers to the second cycle in those areas and the first cycle in those where four cycles were delivered. Accordingly, the final cycle is referred to as 'cycle 5' across all supported areas in Burkina Faso and Nigeria, regardless of the total number of cycles delivered. Therefore, estimates from administrative data and surveys shown under cycle 1 for Burkina Faso and Nigeria include only data from five-cycle areas, while subsequent cycles combine each cycle in five-cycle areas with the corresponding previous cycle in four-cycle areas. In Chad, however, all districts began their SMC rounds simultaneously, regardless of the number of cycles received. As such, cycles 1 and 2 refer to the first and second cycles across all districts, while cycle 3 refers only to districts receiving four cycles, and cycle 4 refers to the final cycle in all districts (i.e. either cycle 3 in districts receiving three cycles or the cycle 4 in those receiving four). Thus, estimates from administrative data and surveys shown under cycle 3 for Chad include only data from the end-of-cycle survey in four-cycle districts, while the cycle 4 combines data relating to cycle 3 in three-cycle districts and cycle 4 in four-cycle districts.

2.1 Administrative coverage

Administrative coverage was estimated using numerators and denominators derived from appropriate data sources. Numerators were determined using data from either paper-based tally sheets or campaign digitalisation tools. Where paper-based SMC tally sheets remained in use, they were completed and submitted by SMC community distributors to estimate the quantity of SPAQ courses distributed per team of community distributors as a proxy for the number of children reached, after adjusting for SPAQ re-dosing and wastage. These data were aggregated at district and higher administrative levels during SMC distribution periods.

We continue to support campaign digitalisation efforts to replace paper-based tally sheets, with the aim of refining estimates of the number of children reached in each cycle. In 2025, the campaign was digitised to varying degrees in Burkina Faso, Chad, Nigeria and Togo. Where campaign digitalisation tools were used, community distributors recorded treatments delivered at household level using mobile devices, enabling real-time capture of individual child records and reducing reliance on aggregated proxies. These systems allow for automated aggregation, deduplication and validation of records, improving the accuracy and timeliness of estimates of the number of children reached.

Denominators were defined using target population estimates derived from microplanning data for the 2025 round. As part of target population estimation methods during microplanning, efforts are made to account for projected population growth, migration and the expected population of newly eligible three-month-olds joining the cohort of eligible children in the later cycles of the round. Limitations in current methods are acknowledged in the next paragraph and later in the discussion section.

Administrative coverage was calculated by dividing the total number of SPAQ courses distributed in a given cycle by the estimated target population of children 3–59 months. It is thus expressed as a percentage of the target population, both overall (3–59 months) and disaggregated by age group, i.e. 3–11 months and 12–59 months, reflecting the two age-based formulations of SPAQ. Further details of the administration coverage estimation methods are described later in **Section 2.4.**

It is important to note that administrative coverage estimated using this method may exceed 100 percent in some cycles. This may be due to several factors, including inaccuracies in the denominator (target population estimates) during microplanning, a higher-than-expected number of newly eligible three-month-olds joining the cohort of eligible children in the latter cycles of the round and unforeseen population movements such as by nomadic populations or internally displaced populations. Other reasons why administrative coverage may exceed 100 percent include the administration of SMC medicines to ineligible children, or the non-exclusion of SPAQ re-dosing or wastages when tallying and aggregating data reported by community distributors, all of which could inflate the numerator (number of children reached in each cycle).

Notwithstanding these limitations, administrative data remain the only available source that provides an estimate of the absolute number of children reached, which is not possible using survey data. Moreover, the near real-time availability of these data supports logistical and programmatic decision-making during SMC implementation. Another advantage of administrative data is that they capture coverage in inaccessible areas, where survey data are not available. As surveys do not include these areas, they may not fully reflect performance across all areas covered.

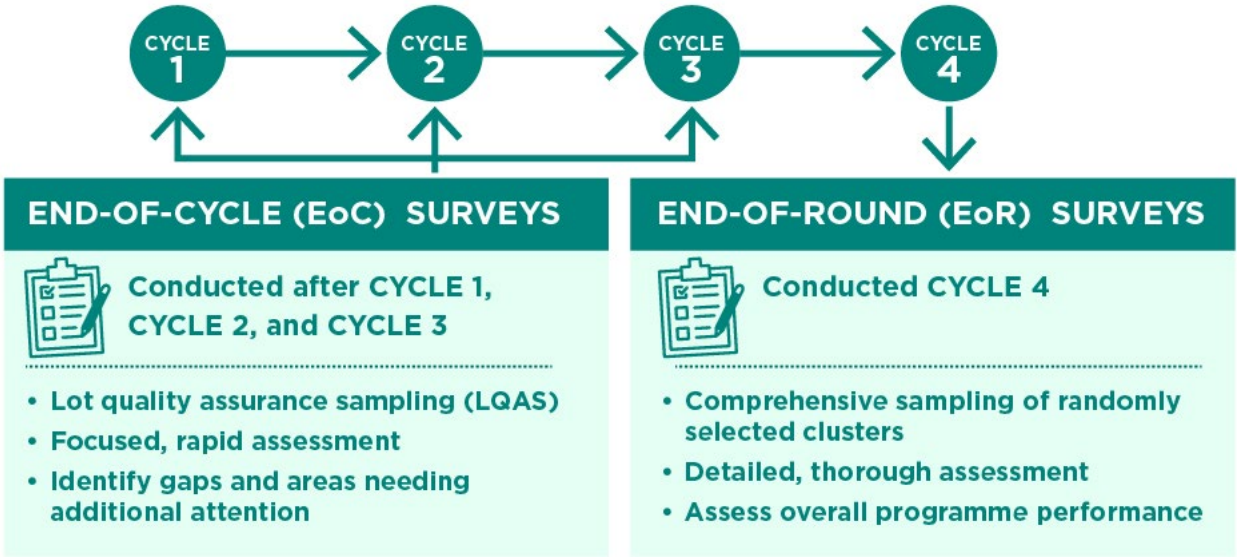
2.2 Household coverage and quality monitoring surveys

To facilitate more reliable measures of programme coverage and quality, particularly given numerator and denominator challenges that often affect the accuracy of administrative coverage

estimates, Malaria Consortium conducts two types of post-cycle household surveys: end-of-cycle (EoC) surveys following all but the final monthly cycles, as well as independent and more comprehensive end-of-round (EoR) surveys conducted following the final cycle. For example, in an area receiving four cycles, an EoC survey is conducted following each of the first three cycles, while an EoR survey is conducted following the fourth cycle (**Figure 2**). Both survey types enable collection of data for monitoring coverage and quality of SMC implementation.

The main difference lies in their purpose and analytical design. EoC surveys are intended to identify implementation issues and inform timely corrective actions at local levels, typically at subdistrict or lot level. They therefore use the LQAS design and associated analytical methods. In contrast, EoR surveys are designed to provide robust, comprehensive estimates of coverage and programme quality at national level across the full round. They therefore follow a methodological approach aligned with standard demographic and health surveys. While the two survey types differ in purpose, sampling design, local-level representativeness and timing, they both use similar multi-stage household sampling approaches and their country-level estimates are therefore broadly comparable.

Figure 2. EoC and EoR survey design and timing in a typical four-cycle round



In the context of both EoC and EoR surveys, SMC coverage can be defined in various ways. While receipt of the first dose of SP and AQ (day 1 SPAQ) is commonly used as a primary coverage indicator (conceptually equivalent to the coverage measured using administrative data), this alone is insufficient to provide full protection throughout the high transmission season. As such, coverage estimates should be interpreted alongside indicators such as the proportion of households visited by distributors, caregiver-reported administration of day 2 and day 3 AQ, and the proportion of children who received SPAQ across all monthly cycles. Indicators such as DOT on day 1, completion of the full three-day course and sources of SPAQ received, are more appropriately considered indicators of programme quality rather than coverage. Additional indicators, including the proportion of ineligible children aged 60–119 months who received SPAQ (as a measure of the extent if appropriate

exclusion of age-ineligible children) and the extent to which eligible children obtained SPAQ outside standard home-based distribution channels, further reflect programme performance and delivery quality. Unless otherwise specified, all EoC and EoR survey estimates of coverage and quality presented in this report are based on caregiver self-report.

2.2.1 End-of-cycle surveys

These surveys are routinely conducted after all but the final SMC cycle of the round so that data from each can be collected and processed before the next cycle to identify issues within smaller discrete local areas, and to inform changes or improvements to SMC delivery (**Figure 2**).

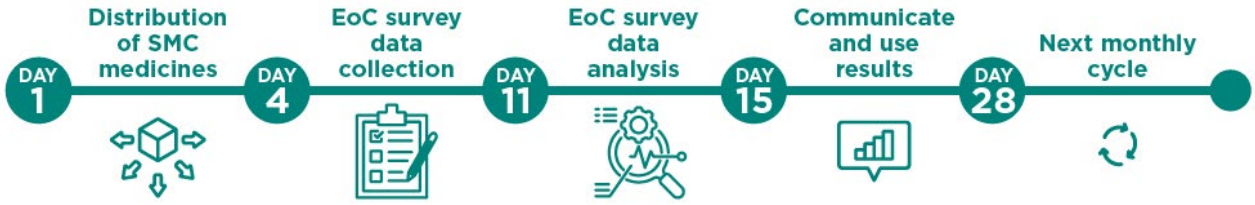
Surveys were conducted by teams of data collectors who received relevant training on both methodological procedures and the ethical standards required for household surveys of this nature. Field supervision is provided by Malaria Consortium M&E and technical staff, often with support from national malaria programmme personnel. Data collectors are recruited directly by Malaria Consortium as independent contractors, typically selected through an open process based on criteria such as data collection competences and being able to speak the local language. Individuals involved in SMC delivery, including community distributors and district-level supervisors were considered ineligible to work as data collectors.

Rationale and design

End-of-cycle surveys continued to employ LQAS methods, which has been recommended for monitoring health interventions as it provides a simple, rapid method to assess performance at the local level.[14] As an efficient sampling method, LQAS enables rapid monitoring of a programme against pre-determined targets, while facilitating timely generation of local evidence to aid decision-making for programme improvement. In the context of public health programmes such as SMC, LQAS entails the subdivision of programme implementation areas into smaller functional areas typically at the sub-district level (such as health facility catchment areas) referred to as 'supervision areas' (SAs).[15] In that sense, SAs are defined as the lowest administrative levels at which programmatic decision-making capacity exists. The method requires a relatively small sample per SA to allow for hypothesis testing of whether a predetermined standard for a particular indicator, e.g. percentage coverage, has been met in a given SA. Although with limited precision, the smaller sample size per SA allows for surveys to be rapidly completed and for hypothesis testing to be performed with minimal risks of alpha and beta errors to inform programmatic decisions and improvements from cycle to cycle.[15]

EoC LQAS surveys need to be conducted in a timely manner to maximise the use of their findings to identify areas of suboptimal coverage or quality and support rapid corrective actions in subsequent cycles **(Figure 3**).

Figure 3. EoC and LQAS survey milestones and typical timeline



Malaria Consortium's SMC M&E framework defines decision criteria and targets for 16 priority indicators (**Table 2**). The framework was developed following a consultative process involving Malaria Consortium staff at global and country offices.[13] Decision criteria are defined as proportions of units (i.e. sampled households within each SA) below which action is considered necessary to improve programme delivery. Targets, on the other hand, are defined as proportions of units per SA in which a standard is met such that no further improvement is considered necessary.

Based on results from previous surveys, programme requirements and maximum alpha and beta errors of 10 percent, a 'lot size' of 25 compounds per SA was found to be the minimum such that the sample was sufficient to run hypothesis tests for each of the indicators to determine whether required standards had been met.[16] Finally, decision rules were calculated based on the lot size, decision criteria and targets. These decision rules defined a threshold number of compounds, out of a lot size of 25, which were required to have met a standard for each SA. Hence, if the number of compounds meeting a standard fell below the decision rule for an indicator in a given SA, this indicated that actions were necessary to improve programme performance related to that indicator in that particular SA before the next SMC cycle. For example, given a decision rule of 22, if fewer than 22 out of 25 caregivers in a SA reported administering day 2 and day 3 AQ to their eligible children, this issue was flagged and reported for further actions to be considered to increase adherence to the full three-day course of SMC. Such remedial actions could include improved distributor training or community sensitisation on the importance of day 2 and day 3 AQ doses before the next SMC cycle.

Through aggregation of results across multiple SAs, LQAS can also provide a representative summary of coverage at higher administrative levels, such as state or country level. As such, the interpretation of these findings is similar to that of conventional cluster surveys on the assumption that SAs are selected through random sampling and that they are of approximately equal population size to ensure a representative sample. This report presents the EoC results aggregated across SAs to provide country-level (or state-level, in the case of Nigeria) summary estimates for key coverage and quality indicators.

EoC survey objectives and indicators

As in previous years, EoC surveys using LQAS methods had two main goals, the first of which was to determine whether SAs had met each of the priority indicator targets. The second goal was to provide summaries of key indicators at above-SA levels, including district/LGA, state/region/province and country levels. **Table 2** outlines the priority coverage and quality indicators assessed in EoC

surveys, with their LQAS specifications. This report however focuses on a selected set of key coverage and quality indicators as highlighted in the results section.

Table 2: List of key indicators assessed by EoC surveys, by unit of analysis, denominator and LQAS specifications: Decision criteria, targets, errors, lot size and decision rules

Indicator with targets	Unit of analysis	Denominator	Decision criterion	Target	α error	β error	Selected lot size	Decision rule (below is failure)
Households with eligible children visited	Household	Households with eligible children	80%	100%	<0.0001	0.0982	25	23
SPAQ administered to eligible child (day 1)	Child	Households with eligible children	80%	100%	<0.0001	0.0982	25	23
Eligible child received three-day complete course of SPAQ (inc. day 2 and day 3 AQ)	Child	Eligible children provided SPAQ (day 1)	75%	95%	0.0341	0.0962	25	22
SPAQ administration observed by a community distributor (day 1)	Child	Eligible children provided SPAQ (day 1)	75%	95%	0.0341	0.0962	25	22
SMC child record card retention	Child	Eligible children provided SPAQ (day 1)	80%	100%	<0.0001	0.0982	25	23
All SPAQ doses received marked on card	Child	Eligible children provided SPAQ (day 1)	80%	100%	<0.0001	0.0982	25	23
Caregiver accepted SMC administration (not refused)	Child	Compounds reached	90%	100%	<0.0001	0.0718	25	25
SMC awareness (heard of SMC)	Caregiver	Households with eligible children	80%	100%	<0.0001	0.0982	25	23
SMC knowledge (purpose of SMC)	Caregiver	Households with eligible children	80%	100%	<0.0001	0.0982	25	23
SMC knowledge (age eligibility for SMC)	Caregiver	Households with eligible children	70%	90%	0.098	0.0905	25	21
SMC knowledge (importance of age eligibility for SMC)	Caregiver	Households with eligible children	70%	90%	0.098	0.0905	25	21
SMC knowledge (importance of administering AQ on day 2 and day 3)	Caregiver	Households with eligible children	70%	90%	0.098	0.0905	25	21
SMC knowledge (what to do in case of an adverse event)	Caregiver	Households with eligible children	70%	90%	0.098	0.0905	25	21
Confidence in SPAQ efficacy	Caregiver	Households with eligible children	75%	95%	0.0341	0.0962	25	22

2.2.2 EoC LQAS survey sampling and data collection procedures

To maximise representativeness, EoC surveys followed a multi-stage sampling approach. In the first stage, lots or SAs were selected with probability proportional to population size (PPS) in locations where it was not feasible to sample all eligible SAs. Health facility catchment areas were defined as SAs for sampling and data-informed decision-making (DIDM) purposes using LQAS methods, except in Borno state (Nigeria) and Uganda, where administrative wards were used.

In the second stage, 25 eligible households were selected per SA, in line with the predetermined optimal LQAS lot sample size (**Table 2**), using systematic random sampling. Two approaches were applied depending on the availability of household listings. Where listings were available, the starting household was randomly selected using a random number generator, typically Microsoft Excel-based or another statistics package. Subsequently, 24 additional eligible households were selected from the list by applying a sampling interval, which was determined by dividing the total number of households in each SA by 25. In places where it was not feasible to list households, an alternative approach, the 'spin-the-pen' method, was used.[17] This involved spinning a pen in a central location in each selected SA to determine the starting household, with the remaining households selected along the indicated direction using a context-specific interval. Ineligible households (those without at least one SMC-eligible child) were skipped. Given that up-to-date household lists were rarely available, the spin-the-pen method was the predominant approach.

In each selected household, after obtaining consent from residents for participation in the survey, a roster of all children 3–119 months was made in SurveyCTO software, an electronic data collection platform, and their first name, age and sex were recorded. One child, aged 3–59 months, was then automatically selected at random from the roster using a randomisation algorithm in SurveyCTO. Only one eligible child was sampled per household to avoid overrepresentation of households with multiple eligible children. In all surveys, an ineligible child aged 60–119 months was opportunistically sampled, if present in the household, to allow for estimation of summary statistics for the proportion of overage non-eligible children who received day 1 SPAQ. Households in which residents refused or were unable to participate, or without a child aged under five years, were resampled.

Similar sampling approaches, including the sampling of 25 households per SA, were followed in all countries, with context-specific adaptations for each country as outlined below. All eligible sub-national administrative units covered were included in survey sampling frames except otherwise stated. Administrative units excluded for any reason, such as insecurity or inaccessibility due to severe flooding, were noted in each country's sampling section. For each cycle and survey, SAs were randomly sampled from frames containing all eligible areas, except in Uganda, where all SAs in supported districts were included. Consequently, the representativeness of survey samples may vary between cycles in countries where not all SAs were sampled.

All survey questionnaires were administered using SurveyCTO (version 2.82.3) with data uploaded daily to a remote server. The 2025 survey questionnaires were based on those from previous years,

with country-specific adaptations to reflect differences in administrative units or programmatic terminology, or to capture additional variables for specific research questions or contextual information. For instance, surveys in Burkina Faso and Togo included questions on routine immunisation, including malaria vaccines, to evaluate the use of the SMC platform to identify zero-dose children and link them to existing routine immunisation services. In Chad, questions on diarrhoea prevalence and use of oral rehydration solution and zinc (ORSZ) were added to monitor a pilot integration of ORSZ co-distribution with SMC in selected health districts, with similar ORSZ questions incorporated into the surveys in Burkina Faso and South Sudan. In Nigeria, questions on vitamin A supplementation were included in certain cycles in Bauchi state to assess the effectiveness of VAS co-delivery with SMC in that state.

Interviews were typically conducted in the country's official language using the adapted questionnaires. Where respondents spoke local languages, data collectors provided on-the-spot translation from English, French or Portuguese. Informed consent was obtained from all participants in line with the ethical standards required for household surveys of this nature. Caregivers and heads of household were briefed on the survey, its purpose and the nature of the questions. Privacy and confidentiality were maintained during the interviews, and all responses were recorded anonymously.

Burkina Faso (cycles 1, 2, 3 and 4)

A multi-stage sampling approach was followed as described earlier under **Section 2.2.2.** In the first stage, 85 SAs were randomly sampled using PPS methods from the total number of SAs (represented by health facility catchment areas) in the health districts supported by Malaria Consortium in 2025. To enhance representation of sub-SA sampling units, stratification was applied by selecting three settlements at random from the catchment area of each of each selected SA, followed by the sampling of eight or nine compounds from each within-SA stratum (settlement) to give a total of 25 compounds sampled per SA. In each SA selected, 25 households were sampled, giving a total sample size of 2,1250 households in each EoC survey (**Table 3**).

As up-to-date household lists were unavailable and comprehensive household listing was not feasible as part of the survey, the spin-the-pen method was used to select households within participating villages and localities. Sampling of eligible and ineligible children within selected households was as described in **Section 2.2.2**.

An ineligible child aged 60–119 months was opportunistically sampled, if present in eligible households, to allow for estimation of summary statistics for the proportion of overage non-eligible children who received SPAQ.

It is important to note that in cycle 1, SAs were selected only from among the 296 health facility catchment areas in 12 health districts where five cycles of SMC were delivered. In subsequent cycles, SAs were randomly selected from a list of 803 health facility catchment areas in all 27 districts supported by Malaria Consortium as an implementing partner. For this reason, the sampling frame

and coverage estimates from the cycle 1 EoC survey were not comparable with those of the subsequent cycles. Districts determined to be inaccessible due to insecurity or other operational constraints during survey periods were excluded from survey sampling frames, as was the case for the districts of Barsalogho, Kongoussi, Mangodara and N'dorolla in all cycles.

Table 3: Sampling frame for 2025 end-of-cycle surveys, Burkina Faso (e.g. cycle 4)

Province	Health district	Number of supervision areas	Target number of households sampled
Tannounyan (formerly Cascades)	Banfora	2	50
	Sindou	1	25
Kadiogo (formerly Centre)	Baskuy	6	150
	Bogodogo	19	475
	Boulmiougou	12	300
	Nongremassom	5	125
	Signonguin	5	125
Koulsé (formerly Centre Nord)	Boussouma	2	50
	Kaya	4	100
Djôrô (formerly Centre Sud)	Kombissiri	1	25
	Manga	2	50
	Po	2	50
	Sapone	1	25
Guiriko (formerly Hauts Bassins)	Dafra	5	125
	Dande	1	25
	Do	7	175
	Hounde	3	75
	Karangasso Vigue	1	25
	Lena	1	25
	Orodara	1	25
Plateau Central	Bousse	1	25
	Ziniare	2	50
	Zorgho	1	25
Total	**n= 23**	**85**	**2,125**

Chad (cycles 1, 2 and 3)

Survey sampling frames were representative of the 12 health districts across the two provinces where Malaria Consortium supported SMC, namely: Barh El Gazal and Mayo Kebbi Est. All health districts were divided into SAs of approximately equal population size, each covering the catchment areas of an average of three health centres. Each health district was classified as either urban or rural and sampling was carried out independently within those two strata. Within each SA, three settlements (e.g. villages or urban wards in the case of N'Djamena) were randomly selected, from which eight to nine households were randomly sampled to give a total of 25 per SA (**Table 4**). Due to unavailability of up-to-date lists of households in each SA, sampling of households within each

selected SA followed the spin-the-pen method described earlier. Selection of eligible children and opportunistic sampling of ineligible children at the household level followed the methods described in **Section 2.2.2** above. The sampling frame covered all health facility catchment areas in which SMC was delivered in the two provinces, with the exception of Katoa health district which was inaccessible due to flooding and was excluded from sampling frames in cycles 1–3.

Table 4: Sampling frame for 2025 end-of-cycle surveys, Chad (e.g. cycle 1)

Province	Health district	Number of supervision areas	Target number of households sampled
Mayo Kebbi Est	Biliam Oursi	3	5
	Bongor	12	300
	Gam	4	100
	Guelendeng	10	0
	Katoa	0	0
	Kim	2	50
	Koyom	5	125
	Moulkou	3	5
Barh El Gazal	Chaddra	6	150
	Michemire	3	75
	Moussoro	5	125
	Salal	3	75
Total	**n=12**	**56**	**1400**

Nigeria (cycles 1, 2, 3 and 4)

In the first stage, between 10 and 20 health facilities were randomly selected from each LGA in proportion to the LGA's population size. The catchment areas of these facilities were considered SAs for the purposes of the EoC surveys. Three settlements were randomly selected from the catchment area of each of these three health facilities and eight or nine compounds were sampled from each to give a total of 25 compounds sampled per health facility catchment area (**Table 5**). In the second stage, the spin-the-pen method was used to systematically select 25 eligible households in each participating SA as described previously in **Section 2.2.2.** The selection of eligible children and the opportunistic inclusion of ineligible children at the household level also followed the methods described in **Section 2.2.2.**

Sampling units in areas determined to be inaccessible were excluded from survey sampling frames. Across all states, exclusions were driven mostly by insecurity, with some areas affected by flooding or a combination of both, which limited safe access for survey teams. In nearly all cases, exclusions involved only specific wards, settlements or communities within LGAs rather than entire LGAs, allowing surveys to proceed in accessible areas; for example, Bula Ward was the only area excluded

in Tafawa Balewa LGA (Bauchi) during cycles 3–4, and Ajilari in Mafa LGA (Borno) was excluded in cycle 1, rather than the whole LGAs.

Table 5: End-of-cycle survey sampling frame for a typical cycle in 2025, Nigeria (e.g. cycle 3)

State	Number of health facility catchment areas/wards sampled	Target number of households sampled
Bauchi	322	8,050
Borno	344	8,600
FCT	274	6,850
Kebbi	225	5,625
Kogi	239	5,975
Nasarawa	147	3,675
Oyo	60	1,500
Plateau	325	8,125
Sokoto	241	6,025
Total	**2,177**	**54,425**

South Sudan (cycles 1, 2, 3 and 4)

From the total 53 bomas which constituted the SAs (23 in Aweil South and 30 in Aweil West counties), approximately 40 were randomly selected every cycle, approximately 20 in each county. In each selected boma, 25 eligible households were sampled **(Table 6)**. Since up-to-date household lists were not available for each SA in South Sudan, households within the selected SAs were systematically sampled using the spin-the-pen technique, as described earlier. The process for sampling eligible children and opportunistically sampling ineligible children at the household level adhered to the sampling approach outlined in **Section 2.2.2**.

Where there was an influx of populations, including SMC eligible children, displaced by the humanitarian situation in neighbouring Sudan, the internally displaced person (IDP) camp in that area was included in the survey sampling frame. This was achieved by purposively selecting the IDP camp as an independent SA during LQAS surveys, as was the case in Wedwil Primary Healthcare Unit (PHCU) (**Table 7**).

Table 6: Sampling frame for 2025 end-of-cycle surveys, South Sudan (e.g. cycle 1)

County	Health facility	Number of supervision areas	Target number of households sampled
Aweil South	Achuan	1	25
	Ajiith-Bok	1	25
	Akach	1	25
	Ametwer	1	25
	Hongwekdit	1	25

	Jar-Ajiep	1	25
	Mading-Chan	1	25
	Majak-Goi	1	25
	Majook-Abyei	1	26
	Makuac-Amiir	1	25
	Malith-Kuel	1	26
	Mangar-Lual	1	25
	Mayom-Achuil	1	24
	Mayom-Lach	1	25
	Panadhot	1	25
	Pankuac	1	25
	Riang-Akeer	1	25
	Riang-Mankuek	1	24
	Riang-Mawel	1	25
	Tiaraliet	1	25
Aweil West	Abyei	1	25
	Achana	1	25
	Aguat	1	25
	Ajuet-Alel	1	25
	Ajuet-Toch	1	25
	Akeuic	1	25
	Amudho	1	25
	Anyuopjang	1	25
	Chimel-Dit	1	25
	Chimel-Makem	1	25
	Chimel-Thii Boma	1	25
	Mabior	1	25
	Majook-Adim	1	25
	Majook-Dengdit	1	25
	Marial Baai	1	25
	Mayom Akuakrel	1	25
	Nyamlel Thii	1	24
	Nyinboli	1	25
	Refugee Camp	1	26
	Wedwil	1	25
	Wut Giir	1	25
Total	**41**	**41**	**1025**

Togo (cycles 1, 2, 3 and 4)

In Togo, philanthropic funding supported EoC surveys in all 23 SMC-implementing districts. However, for the purposes of this report, only data from the seven districts where Malaria Consortium acted as the implementing partner are included (**Table 7**). In contrast, EoR survey estimates are based on data from all 23 districts to preserve statistical precision. Sampling followed a multi-stage process as

described in **Section 2.2.2**, with the first stage involving the selection of SAs defined at the locality level. Notably, localities in Kpendjal district were excluded from the sampling frame due to insecurity. Three villages were randomly selected from each locality and eight or nine compounds were sampled from each village, giving a total of 25 households per locality.

As up-to-date household lists were unavailable and comprehensive household listing was not feasible as part of the survey, the spin-the-pen method was used to select households within participating villages and localities. Sampling of eligible and ineligible children within selected households is as described in **Section 2.2.2**. Kpendjal district was excluded from all surveys due to insecurity-related inaccessibility.

Table 7: Sampling frame for 2025 end-of-cycle surveys, Togo (e.g. cycle 1)

Region	Health district	Number of health facilities	Number of supervision areas	Target number of households sampled
Savanes	Cinkasse	3	3	75
	Kpendjal	0	0	0
	Kpendjal Ouest	2	2	50
	Oti	1	1	25
	Oti-Sud	3	3	75
	Tandjouare	3	9	75
	Tone	8	8	200
Total	**n=7**	**20**	**26**	**500**

Uganda (cycles 1, 2, 3 and 4)

EoC surveys were conducted in the five districts where Malaria Consortium supported SMC as an implementing partner with philanthropic funding: Amudat, Nakapiripirit, Moroto, Kotido and Nabilatuk. As in previous years, SAs were defined at the level of wards. Three villages were randomly selected from each ward and eight or nine compounds sampled from each to give a total of 25 compounds sampled per SA (**Table 8**). As up-to-date lists of households in each SA were unavailable and it was not feasible to conduct household comprehensive listings as part of the survey, the spin-the-pen method was used to systematically select eligible households within participating wards. The selection of eligible children, along with the opportunistic sampling of ineligible children at the household level, was based on the methods described in **Section 2.2.2**.

Table 8: Sampling frame for 2025 end-of-cycle surveys, Uganda (e.g. cycle 1)

Region	Health district	Number of supervision areas	Target number of households sampled
Karamoja	Amudat	10	250
	Kotido	16	400
	Moroto	12	300

	Nabilatuk	6	150
	Nakapiripirit	12	300
Total	**n=5**	**56**	**1,400**

2.2.3 End-of-round surveys

EoR surveys were conducted following the last cycle in all countries where Malaria Consortium supported SMC implementation during 2025. The surveys were conducted independently by local evaluation firms selected by Malaria Consortium through a competitive open bidding process. The firms were as follows:

- Burkina Faso: Institut Supérieur des Sciences de la Population (ISSP)
- Chad: BEATI Expertise Technique
- Nigeria: Sydani Group
- South Sudan: Dev-com Consult Limited
- Togo: Africa Synergy Group Plus Sarl
- Uganda: Afrotech Management Consult Limited.

Rationale and design

EoR surveys are conducted after the final cycle to provide a comprehensive assessment of SMC coverage and quality across the full round. Unlike EoC surveys, which are designed to inform rapid, localised decision-making between cycles, EoR surveys provide representative estimates at national level, or across all programme-supported areas, and at state level in Nigeria. As described earlier under EoC surveys, different survey designs are used to serve complementary purposes within the SMC M&E framework. While EoC surveys use LQAS methods to support local programme improvement, EoR surveys follow standard cluster survey designs similar to those used in demographic and health surveys and malaria indicator surveys. This approach enables the generation of statistically robust estimates of key indicators at the country level.

The key coverage and quality indicators assessed were similar to those described earlier under EoC surveys (**Table 2**). However, due to their timing after the final cycle, EoR surveys enable the measurement of additional indicators, including coverage in earlier cycles alongside the final cycle, thereby allowing estimation of cumulative coverage across all cycles. Additional indicators assessed in EoR surveys also include selected programme and health outcomes, such as the occurrence of fever and confirmed malaria episodes in the month following the final cycle.

2.2.4 End-of-round survey sampling and data collection methods

Unlike EoC surveys which are conducted usually one week following the cycle, EoR surveys are typically conducted one month following the final cycle. This is particularly to enable the collection of data on fever and malaria occurrences in the 28 days following the final cycle. EoR survey data collectors were generally selected through an open process, managed by the external contractor and overseen by Malaria Consortium. Contractors conducted interviews with the data collectors. During these interviews, the contractor ascertained whether the data collectors met key criteria such as

being able to speak the local language and verified whether they were involved in SMC delivery in any capacity. Individuals involved in SMC delivery were considered ineligible to work as survey data collectors.

To ensure precise estimation of coverage and other indicators at the country level with a maximum of ±5 percent margin of error (MOE), surveys required a sample of 75 clusters per country, each comprising 20 households. That resulted in a total of 1,500 households with eligible children for each country (per state in Nigeria, resulting in a total of 13,500 households across the nine supported states). The sample size was determined based on the following parameters and assumptions:

- Estimated coverage rate: 75–80 percent
- Confidence level: 95 percent
- Margin of error: ±5 percent
- Number of households in each cluster: 20
- Inter-cluster correlation: 0.2
- Design effect: 4.8
- Non-response rate: 5 percent

Similar to the EoC surveys, EoR surveys employed multi-stage random sampling of households in areas covered by Malaria Consortium's philanthropic SMC programme. They were intended to achieve a representative sample of the target population at country level, or all administrative units within countries supported by Malaria Consortium's philanthropic SMC programme, and at state level in Nigeria.

The first stage of sampling involved the selection of survey clusters with PPS methods. Clusters were typically defined at the level of health facility catchment areas, or census enumeration areas such as in Nigeria. Where administrative units and their constituent clusters were excluded for any reason, such as insecurity or inaccessibility as a result of severe flooding, it was noted under each country's sampling section. The second stage involved the selection of 20 eligible households within the selected cluster using systematic random sampling methods similar to those described earlier for EoC LQAS surveys. In places where comprehensive cluster-level household lists were available or where household listing was feasible as part of surveys, as was the case in Nigeria and Uganda, the starting household was selected from the list using a random number generator. Subsequently, 19 additional households were selected from the list by applying a sampling interval determined by dividing the total number of households in each cluster by 20.

Alternatively, the spin-the-pen method was used in places where it was not feasible to list households, as was the case in Burkina Faso, Chad, South Sudan and Togo. This involved spinning a pen in a central location in each selected SA to determine the starting household. Subsequently, 19 additional households were selected by walking in the direction indicated by the pen and applying a sampling interval determined in several ways depending on geographical the size of the cluster.

In each selected household, an eligible child was selected using methods similar to those described earlier for EoC LQAS surveys. Only one eligible child was sampled per household to avoid overrepresentation of households with multiple eligible children. In all surveys, except those in Uganda, an ineligible child aged 60–119 months was sampled opportunistically, when present in the household, to allow for estimation of summary statistics for the proportion of overage non-eligible children who received day 1 SPAQ. In Uganda, older ineligible children were sampled independently to enable a more representative sample of older children. Households in which residents refused, were unable to participate or lacked a child under five years were resampled. Ineligible households encountered in the sampling sequence were skipped.

Sampling protocols aimed to achieve a self-weighted sample with clusters selected using the PPS methods. All district-level administrative units were represented in the EoR sampling frames, from which 75 survey clusters were selected in each country using PPS sampling methods. Replacements were made for selected clusters that were within areas deemed inaccessible due to insecurity or other reasons, such as in Burkina Faso and Togo. Similar sampling approaches, including the sampling of 20 households per survey cluster, were followed in all countries, with context-specific adaptations as outlined for each country below.

Survey questionnaires and data collection methods were similar to those described for EoC surveys in **Section 2.2.2**. However, EoR surveys enable the measurement of additional indicators, including coverage in earlier cycles alongside the final cycle, thereby allowing estimation of cumulative coverage across all cycles, as well as selected programme and health outcomes, such as the occurrence of fever and confirmed malaria episodes in the month following the final cycle. As in previous rounds, additional variables were included in EoR surveys to support further analyses aimed at better understanding programme performance, such as the addition of questions on routine immunisation, malaria vaccines, vitamin A supplementation and ORSZ to evaluate the use of the SMC platform to deliver other interventions, as described **in Section 2.2.2**. As with EoC surveys, interviews were typically conducted in the country's official language using questionnaires provided by Malaria Consortium. Where necessary, data collectors provided on-the-spot translation into local languages from the English, French or Portuguese questionnaires. Similar sampling approaches, including the selection of 20 households per survey cluster, were applied across all countries, with context-specific adaptations as outlined below.

Burkina Faso

The EoR survey sampled from districts supported by Malaria Consortium as implementing partner in 2025, distributed across six provinces. To ensure that the sample was representative at the country level, 75 clusters represented by health facility catchment areas were selected with probability proportional to population size from a list of all health facility catchment areas in all 23 of the 27 health districts where Malaria Consortium supporting SMC delivery as an implementing partner in 2025. The remaining four: Barsalogo, Mangodara, Boulsa and N'Dorola health districts were excluded due to insecurity (**Table 9**). To ensure representativeness in terms of the number of four- and five-

cycle districts and type of residence (urban and rural), cluster selection was stratified accordingly. Four strata were thus formed: health facilities in four-cycle health districts located in rural areas, health facilities in four-cycle health districts located in urban areas, health facilities in five-cycle health districts located in rural areas and health facilities in five-cycle health districts located in urban areas. For health facilities covering more than three villages or smaller communities, three of those were randomly selected with equal probability.

Within each selected cluster, 20 households with at least one child aged 3–59 months were sampled. The spin-the-pen method was used to systematically select eligible households within participating survey clusters as described elsewhere in **Section 2.2.4.** In each selected household, eligible children were sampled using similar methods as illustrated in **Section 2.2.4**. This resulted in a total sample of 1,500 households (75 clusters × 20 households) with one child sampled per household. Ineligible children aged 60–119 months were opportunistically sampled for the estimation of summary statistics for the proportion of overage non-eligible children who received SPAQ.

Table 9: Sampling frame for 2025 end-of-round surveys, Burkina Faso

Province	Health district	Number of clusters	Target number of compounds surveyed
Tannounyan (formally Cascades)	Banfora	2	40
	Sindou	1	20
Kadiogo (formally Centre)	Baskuy	2	40
	Bogodogo	9	180
	Boulmiougou	12	240
	Nongremassom	6	120
	Signoguin	4	80
Koulsé (formally Centre Nord)	Boussouma	3	60
	Kaya	7	140
Nazinon (formally Centre Sud)	Manga	4	80
	Po	3	60
Guiriko (formally Hauts Bassins)	Dafra	5	100
	Do	6	120
	Hounde	3	60
	Karangasso Vigue	1	20
	Lena	1	20
Oubri (formally Plateau Central)	Ziniare	2	40
	Zorgho	4	80
Total	**n=18**	**75**	**1,500**

Chad

The EoR survey in Chad was conducted in all 12 supported health districts across two provinces. The sampling frame comprised all health facility catchment areas within these districts (**Table 10**). A multi-stage sampling approach was used, as described earlier in **Section 2.2.4**. In the first stage, 75 clusters, defined as health facility catchment areas, were selected using PPS. In the second stage, 20 households with at least one child aged 3–59 months were selected within each cluster using the spin-the-pen method, as described in Section 2.2.4, due to the absence of household listings. In the third stage, one eligible child aged 3–59 months was selected per household, and an ineligible child aged 60–119 months was opportunistically sampled where present, following procedures described in Section 2.2.4. This resulted in a total sample of 1,500 households (75 clusters × 20 households).

Table 10: Sampling frame for 2025 end-round surveys, Chad

Province	Health district	Number of clusters	Target number of compounds surveyed
Kebbi Mayo Est	Biliam Oursi	3	60
	Bongor	14	280
	Gam	5	100
	Guelendeng	10	200
	Katoa	3	60
	Kim	3	60
	Koyom	6	120
	Moulkou	6	120
Barh El Ghazal	Chaddra	7	140
	Michemire	5	100
	Moussoro	9	178
	Salal	4	80
Total	**n=12**	**75**	**1,500**

Nigeria

The EoR survey in Nigeria was conducted across nine supported states and was designed to be representative at state level. The sampling frame comprised all enumeration areas within supported states, with selected areas in Borno state excluded due to insecurity (**Table 11**). A total of 75 enumeration areas, cluster units, were selected in each of the eight states and the FCT, with probability proportional to population size. Due to insecurity, clusters in areas such as Mainok, Ngamdu, Wajiro Burgumma and Wasaram Wards in Kaga LGA (Borno state) were excluded from the sampling frame. At the second stage, 20 eligible households were selected from each selected cluster using a systematic random sampling method. This was preceded by preparation of a household listing to generate a household sampling frame. Where applicable, a mapping update of the clusters was also conducted to ensure that new changes to the existing map were reflected since the last population census was held. These sampling methods are explained in greater detail by the

national protocol, based on the updated 2025 protocol, produced by Malaria Consortium in partnership with the Nigerian National Malaria Elimination Programme.[18]

With each cluster, the starting household was selected from the list of households using a random number generator. Subsequently, 19 additional households were selected from the list by applying a sampling interval determined by dividing the total number of households in each cluster by 20 until the target cluster size of 20 was achieved. This resulted in a total sample of 13,500 households (nine states × 75 clusters × 20 households). The sampling of ineligible children followed the opportunistic process described in **Section 2.2.4** to allow for estimation of summary statistics for the proportion of overage non-eligible children who received SPAQ.

Table 11: Sampling frame for 2025 end-of-round surveys, Nigeria

State	Number of clusters sampled	Target number of compounds surveyed
Bauchi	75	1,500
Borno	75	1,500
FCT	75	1,500
Kebbi	75	1,500
Kogi	75	1,500
Nasarawa	75	1,500
Oyo	75	1,500
Plateau	75	1,500
Sokoto	75	1,500
Total	**675**	**13,500**

South Sudan

The EoR survey in South Sudan was conducted in Aweil South and Aweil West counties in Northern Bahr el Ghazal state. The sampling frame comprised all bomas within the supported counties (**Table 12**). A multi-stage sampling approach was used, as described earlier in Section 2.2.4. In the first stage, 75 clusters, defined as bomas, were selected using PPS. In areas with internally displaced populations, IDP camps were included in the sampling frame and, where necessary, purposively selected as separate clusters. In the second stage, 20 households with at least one child aged 3–59 months were selected within each cluster using the spin-the-pen method, as described in Section 2.2.4, due to the absence of household listings. In the third stage, one eligible child aged 3–59 months was selected per household, and an ineligible child aged 60–119 months was opportunistically sampled where present, following procedures described in Section 2.2.4. This resulted in a total sample of 1,500 households (75 clusters × 20 households)

Table 12: Sampling frame for 2025 end-of-round surveys, South Sudan

County	Number of clusters	Target number of compounds surveyed
Aweil South	35	700
Aweil West	40	800
Total	**75**	**1,500**

Togo

As previously described, EoR survey data considered in this report cover all 23 SMC-implementing districts in 2025 to preserve statistical precision, unlike EoC surveys for which data from only the seven districts where Malaria Consortium supported implementation are included. Kpendjal district was excluded due to insecurity (**Table 13**). A multi-stage sampling approach was used, as described earlier in Section 2.2.4. In the first stage, 75 clusters were selected using PPS from a list of localities and their populations provided by the National Malaria Control Programme. In the second stage, 20 households with at least one child aged 3–59 months were selected within each cluster using the spin-the-pen method, as described previously. In the third stage, one eligible child aged 3–59 months was selected per household, and an ineligible child aged 60–119 months was opportunistically sampled where present, following procedures described in **Section 2.2.4**. This resulted in a total sample of 1,500 households (75 clusters × 20 households).

Table 13: Sampling frame for 2025 end-of-round surveys, Togo

Region	Health district	Number of clusters (health facilities) sampled	Target number of compounds surveyed
Centrale	Blitta	3	60
	Mo	2	40
	Sotouboua	3	60
	Tchamba	4	80
	Tchaoudjo	5	100
Kara	Assoli	2	40
	Bassar	3	60
	Binah	2	40
	Dankpen	4	80
	Doufelgou	2	40
	Keran	3	60
	Kozah	7	140
Plateaux	Amou	2	40
	Anie	4	80
	Est Mono	4	80
	Ogou	5	100
Savanes	Cinkasse	3	60

	Kpendjal	0	0
	Kpendjal-Ouest	2	40
	Oti	2	40
	Oti-Sud	3	60
	Tandjoare	3	60
	Tone	7	140
Total	**n=23**	**75**	**1,500**

Uganda

The EoR survey in Uganda was conducted in five districts supported by Malaria Consortium in 2025. The sampling frame comprised all sub-district wards within supported districts (**Table 14**). A multi-stage sampling approach was used, as described earlier in **Section 2.2.4**. In the first stage, 75 clusters, defined as sub-district wards, were selected using PPS. In the second stage, household listings were used to select households within each cluster. A total of 20 households with children aged 3–59 months and 15 households with children aged 60–119 months were selected using systematic random sampling, with a random starting point and fixed sampling interval, as described in Section 2.2.4.

In the third stage, one child was selected per household. Unlike other countries, children aged 60–119 months were sampled independently rather than opportunistically, resulting in a more representative sample of older children. This resulted in a total sample of 1,500 households for children aged 3–59 months (75 clusters × 20 households), with additional households sampled for older children.

Table 14: Sampling frame for 2025 end-of-round surveys, Uganda

Region	Health district	Number of clusters	Target number of compound surveyed
Karamoja	Amudat	15	525
	Kotido	20	700
	Moroto	15	525
	Nabilatuk	10	350
	Nakapiripirit	15	525
Total	**n=5**	**75**	**2,625**

2.3 Data quality assurance and methodological improvements

In 2025, efforts continued to strengthen the quality, reliability and usefulness of M&E data across the programme. These efforts focused on improving the accuracy of administrative data, refining

household survey methodologies and strengthening data quality assurance processes throughout the data lifecycle. Reliable data are essential for accurately estimating programme coverage and performance, and for supporting DIDM by enabling the identification of genuine gaps and areas requiring improvement in intervention delivery.

Efforts continued to be made to refine target population estimation methods across countries, not only to strengthen microplanning but also to provide more precise denominators for calculating administrative coverage. Likewise, the use of campaign digitalisation, though to varying degrees in Burkina Faso, Chad, Nigeria and Togo, has helped refine numerators (estimates of the number of children reached in each cycle) used in calculating administrative coverage. We have demonstrated through programme experience that digitalisation can support more accurate estimation of administrative coverage, with evidence showing that coverage derived from digitalised data aligns more closely with survey-based coverage than estimates from paper-based records.[19] Additional efforts were made to strengthen administrative data quality assurance and data management, alongside growing recognition of the value of digitalised administrative data for real-time or near real-time decision-making and logistical optimisation during SPAQ distribution. While the extent to which campaign digitalisation improves data quality is still being assessed, the increasing use of digital tools for administrative data collection offers important opportunities to strengthen the completeness, accuracy and timeliness of data reported by community distributors, thereby improving the estimation of administrative coverage and supporting more responsive programme management. We will, therefore, continue to explore such opportunities in future campaigns.

Over the past five years, methodological improvements have been made to the household survey approach, including refinements to sampling procedures, strengthened data quality assurance measures and improvements to data analysis, as described in previous years' reports.[8] In 2025, further efforts were made to consolidate progress towards greater standardisation and harmonisation of survey implementation across countries. This included a pre-round methodological workshop to facilitate cross-country learning and the sharing of best practices for survey planning, household sampling, data quality assurance measures and data analysis.

There was a continued commitment to DIDM in 2025, particularly through the use of data from LQAS hypothesis testing to identify coverage and quality gaps at the SA level in each cycle and to guide the implementation of corrective actions to address such gaps. As part of strengthened DIDM, the timely conduct of surveys following each cycle's SPAQ distribution enabled the completion of data collection and analysis in good time, with EoC surveys conducted within one week of the preceding cycle in nearly all instances. This allowed for up to two weeks before the subsequent cycle to communicate results to stakeholders at the SA level and engage with them on actions to improve SMC delivery before and during the succeeding cycle.

Several measures were implemented to strengthen the validity, accuracy and consistency of household survey data. These included regular training of survey data collectors, real-time data

auditing and the use of global positioning system (GPS) tracking to verify interview locations and duration. Data validation checks were embedded within the electronic data collection forms to flag implausible values, such as out-of-range ages, prompting data collectors to verify or correct entries before proceeding. Hidden variables were also used to monitor interviews for the duration of sensitive survey segments, particularly those relating to caregiver recall of children's medication doses. In addition, potentially eligible households where caregivers were unavailable during the initial visit were revisited to minimise bias associated with excluding such households.

As survey-derived coverage and quality measures primarily rely on caregiver reports, several steps were taken to reduce the risk of recall bias. These included conducting surveys within one week of SPAQ distribution to shorten recall periods and the use of anchoring techniques to assist respondents' recall by linking the most recent SPAQ distribution to specific timeframes, local events or holidays. Visual aids were also used during interviews, such as showing caregivers pictures of SMC blister packs or SPAQ administration, to prompt better recall and minimise confusion with other orally administered interventions such as vitamin A supplementation. Cross-validation techniques were also employed by asking the same questions in different ways to check for consistency in responses.

The reliance of survey data on caregiver reports also introduces a potential risk of social desirability bias. Several measures were implemented to minimise this risk, including training enumerators to maintain a neutral and non-judgemental approach during interviews, assuring respondents of the anonymity and confidentiality of their responses and reassuring them that their answers would not have any punitive consequences. Anchoring techniques and cross-validation, including asking the same question in different ways, were also used to enhance the reliability and consistency of responses. Although SMC child record cards provided to caregivers by community distributors could potentially be used to validate a child's SMC coverage status, their retention and use remain variable across supported areas. For these reasons, and as in previous reporting periods, SMC child record cards were not used to measure programme coverage for the purposes of this report.

As another example of efforts to strengthen data quality, we supported the national malaria programme in Togo by deploying data managers to improve data quality and strengthen data use across the programme. This initiative is described in greater detail in the 2025 Philanthropy Report.[8]

2.4 Data analysis

As alluded to earlier, cycle definitions were harmonised across countries with sub-national variation in the number and timing of cycles to enable consistent reporting. Unless otherwise stated, all results presented in this report refer to these harmonised cycle definitions.

For each cycle, administrative coverage was calculated by dividing the total number of SPAQ courses distributed, used as a proxy for the number of children reached, by the estimated target population of children aged 3–59 months. To estimate overall administrative coverage for the full SMC round in

each country, the numerator was defined as the mean number of children reached per cycle. This was calculated by summing the number of children reached across all cycles and dividing by the total number of cycles, thereby standardising for repeated monthly treatments. The resulting mean was then divided by a common target population, determined during pre-round microplanning and applied consistently across all cycles, to generate overall administrative coverage. In countries with sub-national variation in the number of cycles, such as Burkina Faso, Chad and Nigeria, the mean number of children reached per cycle was first calculated separately for each stratum defined by the number of cycles received, for example four-cycle and five-cycle districts in Burkina Faso. These stratum-specific means were then combined to derive the overall mean number of children reached per cycle for the country. This value was used as the numerator and divided by the common denominator to estimate overall administrative coverage for such countries. Administrative coverage was expressed as a percentage of the target population, both overall for children aged 3–59 months and disaggregated by age group, 3–11 months and 12–59 months, reflecting the two age-specific SPAQ formulations.

Data from both EoC and EoR household surveys were collected using SurveyCTO software (version 2.80). Once data collection was completed, data were exported, processed and analysed using Stata (version 16). To generate estimates that are representative at the country level for each cycle, post hoc weighting was applied. This approach ensures unbiased, representative estimates by accounting for the complex and hierarchical sampling design of surveys: sampling of children within clusters, which were nested within lower sub-national administrative units, which were themselves nested within higher-level sub-national administrative units. Population sizes at the cluster, district (LGA in Nigeria or county in South Sudan) and regional levels (state in Nigeria and provincial in Burkina Faso and Chad) were used to compute selection probabilities and sampling weights at each level. The data was set up in Stata using the svyset command, specifying primary sampling units (clusters), stratification (region, state or province) and finite population correction based on cluster size. Weighted country-level estimates of coverage and other indicators, in addition to state-level estimates in the case of Nigeria, with their 95 percent confidence intervals (95% CIs) were then computed using the svy: proportion command and logit transformation functions in Stata.

3. Results

3.1 Administrative coverage

Estimates of administrative coverage by cycle using data from SMC tally sheets and mean coverage across all cycles delivered, disaggregated by age group and number of cycles received based on data from SMC tally sheets, are shown in **Table 15** for Burkina Faso, Chad, South Sudan, Togo and Uganda and in **Table 16** for Nigeria.

In 2025, an estimated 15,561,666 children were reached per cycle across supported countries. Considering an estimated 14,807,271 target population, this represented an overall administrative coverage of 105.1 percent, ranging from 95.1 percent in Uganda to 122.5 percent in Burkina Faso.

Administrative coverage exceeded 100 percent in a majority of the countries. While the total coverage appears high, variations in administrative coverage were observed across countries. Burkina Faso recorded the highest administrative coverage at 122.5 percent, indicating that the number of children reported as reached (2,725,378) substantially exceeded the target population of 2,224,461. Administrative coverage also exceeded 100 percent in Chad (102.8 percent), Nigeria (102.2 percent) and South Sudan (102.2 percent). Relatively lower, but over 95 percent administrative coverage were reported in Togo (98.0 percent) and Uganda (95.1 percent). At the state level in Nigeria, coverage exceeded 100 percent in all states and the FCT (ranging from 100.2 percent in the FCT to 108.9 percent in Sokoto), with the exception of Oyo state where it was 99.4 percent.

Table 15: Administrative coverage by country, cycle and age group in 2025

Country		Age group (months)	Target population	cycle 1		cycle 2		cycle 3		cycle 4		cycle 5		Mean	
				Courses	Coverage	Courses	Coverage	Courses	Coverage	Courses	Coverage	Courses	Coverage	Courses	Coverage
Burkina Faso	Districts with four cycles	3–11	280,535	n/a	n/a	274211	97.7	286,902	102.3	292,673	104.3	298,988	106.6	288,194	102.7
		12–59	1,172,581	n/a	n/a	1540716	131.4	1,558,472	132.9	1,585,007	135.2	1,611,629	137.4	1,573,956	134.2
		3–59	1453116	n/a	n/a	1814927	124.9	1,845,374	127.0	1,877,680	129.2	1,910,617	131.5	1,862,150	128.1
	Districts with five cycles	3–11	145,600	130,503	89.6	137,466	94.4	142,320	97.7	148,024	101.7	153,482	105.4	142,359	97.8
		12–59	625,745	683,786	109.3	711,767	113.7	723,710	115.7	736,647	117.7	748,432	119.6	720,869	115.2
		3–59	771,345	814,289	105.6	849,233	110.1	866,030	112.3	884,671	114.7	901,914	116.9	863,228	111.9
	All districts	3–11	426,135	130,503	89.6	411,677	96.6	429,222	100.7	440,697	103.4	452,470	106.2	430,553	101.0
		12–59	1,798,326	683,786	109.3	2,252,483	125.3	2,282,182	126.9	2,321,654	129.1	2,360,061	131.2	2,294,825	127.6
		3–59	2,224,461	814,289	105.6	2,664,160	119.8	2,711,404	121.9	2,762,351	124.2	2,812,531	126.4	2,725,378	122.5
Chad	Districts with three cycles	3–11	5,098	4,933	96.8	5,047	99.0	5,010	98.3	n/a	n/a	n/a	n/a	4,997	98.0
		12–59	20,391	19,944	97.8	20,309	99.6	20,538	100.7	n/a	n/a	n/a	n/a	20,264	99.4
		3–59	25,489	24,877	97.6	25,356	99.5	25,548	100.2	n/a	n/a	n/a	n/a	25,260	99.1
	Districts with four cycles	3–11	48,783	49,235	100.9	50,521	103.6	51,299	105.2	52,910	108.5	n/a	n/a	50,991	104.5
		12–59	195,140	206,579	105.9	209,922	107.6	211,094	108.2	209,718	107.5	n/a	n/a	209,328	107.3
		3–59	243,923	255,814	104.9	260,443	106.8	262,393	107.6	262,628	107.7	n/a	n/a	260,320	106.7
	All districts	3–11	53,882	54,168	100.5	55,568	103.1	56,309	104.5	50,981	94.6	n/a	n/a	54,257	100.7
		12–59	215,529	226,523	105.1	230,231	106.8	231,632	107.5	202,147	93.8	n/a	n/a	222,633	103.3
		3–59	269,411	280,691	104.2	285,799	106.1	287,941	106.9	253,128	94.0	n/a	n/a	276,890	102.8
South Sudan		3–11	14,721	12,979	88.2	13,728	93.3	14,213	96.6	13,491	91.7	14,258	96.9	13,734	93.3
		12–59	67,979	66,685	98.1	70,522	103.8	71,328	105.0	71,732	105.6	73,619	108.3	70,778	104.2
		3–59	82,700	79,664	96.4	84,250	101.9	85,541	103.5	85,223	103.1	87,877	106.3	84,512	102.2
Togo		3–11	31,668	28,765	90.8	30,061	94.9	31,325	98.9	29,346	92.7	25,989	82.1	29,098	91.9
		12–59	171,560	161,699	94.3	165,469	96.4	169,773	99.0	175,469	102.3	177,536	103.5	169,990	99.1
		3–59	203,228	190,464	93.7	195,530	96.2	201,098	99.0	204,815	100.8	203,525	100.1	199,088	98.0

Uganda	3–11	40,155	37,350	93.0	39,011	97.2	39,228	97.7	40,579	101.1	39,825	99.2	39,199	97.6
	12–59	132,604	119,149	89.9	124,042	93.5	126,140	95.1	127,791	96.4	128,630	97.0	125,150	94.4
	3–59	172,759	156,499	90.6	163,053	94.4	165,368	95.7	168,370	97.5	168,455	97.5	164,349	95.1

Table 16: Administrative coverage by Nigerian state, cycle and age group (tally sheet method) in 2025

Country and state		Age group (months)	Target population	cycle 1		cycle 2		cycle 3		cycle 4		cycle 5		Mean	
				Courses	Coverage	Courses	Coverage	Courses	Coverage	Courses	Coverage	Courses	Coverage	Courses	Coverage
Nigeria	Bauchi	3–11	403,884	412,937	102.2	427,148	105.8	426,294	105.5	427188	105.8	427,240	105.8	424,162	105.0
		12–59	1,726,115	1,723,166	99.8	1,744,737	101.1	1,739,430	100.8	1744462	101.1	1,744,704	101.1	1,739,300	100.8
		3–59	2,129,999	2,136,103	100.3	2,171,885	102.0	2,165,724	101.7	2,171,650	102.0	2,171,944	102.0	2,163,462	101.6
	Borno	3–11	466,386	474,274	101.7	474,124	101.7	474,016	101.6	473,944	101.6	n/a	n/a	474,090	101.7
		12–59	1,994,521	2,002,213	100.4	2,002,208	100.4	2,002,017	100.4	2,002,043	100.4	n/a	n/a	2,002,121	100.4
		3–59	2,460,907	2,476,487	100.6	2,476,332	100.6	2,476,033	100.6	2,475,987	100.6	n/a	n/a	2,476,211	100.6
	FCT	3–11	186,431	185,558	99.5	186,548	100.1	186,682	100.1	191,322	102.6	186,608	100.1	187,344	100.5
		12–59	797,066	795,785	99.8	797,062	100.0	797,294	100.0	813,875	102.1	796,350	99.9	800,074	100.4
		3–59	983,497	981,343	99.8	983,610	100.0	983,976	100.0	1,005,197	102.2	982,958	99.9	987,418	100.4
	Kebbi	3–11	263,547	270,932	102.8	278,361	105.6	274,141	104.0	273,501	103.8	n/a	n/a	274,234	104.1
		12–59	1,125,968	1,114,866	99.0	1,127,669	100.2	1,126,340	100.0	1,125,773	100.0	n/a	n/a	1,123,662	99.8
		3–59	1,389,515	1,385,798	99.7	1,406,030	101.2	1,400,481	100.8	1,399,274	100.7	n/a	n/a	1,397,896	100.6
	Kogi	3–11	230,886	232,139	100.5	237,403	102.8	243,370	105.4	239,742	103.8	235,254	101.9	237,582	102.9
		12–59	986,512	939,593	95.2	988,808	100.2	1,006,805	102.1	1,011,353	102.5	985,420	99.9	986,396	100.0
		3–59	1,217,398	1,171,732	96.2	1,226,211	100.7	1,250,175	102.7	1,251,095	102.8	1,220,674	100.3	1,223,978	100.5
	Nasarawa	3–11	196,808	205,437	104.4	206,208	104.8	206,386	104.9	206,634	105.0	205,273	104.3	205,988	104.7
		12–59	840,977	850,120	101.1	851,898	101.3	852,725	101.4	852,931	101.4	848,158	100.9	851,167	101.2
		3–59	1,037,785	1,055,557	101.7	1,058,106	102.0	1,059,111	102.1	1,059,565	102.1	1,053,431	101.5	1,057,155	101.9
	Oyo	3–11	49,281	49,273	100.0	49,291	100.0	49,225	99.9	48,721	98.9	48,122	97.6	48,927	99.3
		12–59	210,622	209,575	99.5	209,546	99.5	209,853	99.6	209,476	99.5	209,052	99.3	209,501	99.5
		3–59	259,903	258,848	99.6	258,837	99.6	259,078	99.7	258,197	99.3	257,174	98.9	258,428	99.4

	Plateau	3–11	182,765	196,554	107.5	200,250	109.6	202,490	110.8	203,726	111.5	203,547	111.4	201,314	110.1
		12–59	780,593	796,928	102.1	804,602	103.1	810,543	103.8	813,710	104.2	813,773	104.3	807,912	103.5
		3–59	963,358	993,482	103.1	1,004,852	104.3	1,013,033	105.2	1,017,436	105.6	1,017,320	105.6	1,009,226	104.8
	Sokoto	3–11	267,822	302,750	113.0	305,300	114.0	307,600	114.9	307,750	114.9	n/a	n/a	305,850	114.2
		12–59	1,144,528	1,224,250	107.0	1,230,250	107.5	1,236,100	108.0	1,236,700	108.1	n/a	n/a	1,231,825	107.6
		3–59	1,412,350	1,527,000	108.1	1,535,550	108.7	1,543,700	109.3	1,544,450	109.4	n/a	n/a	1,537,675	108.9
	Total	3–11	2,247,810	2,329,854	103.6	2,364,633	105.2	2,370,204	105.4	2,372,528	105.5	1,306,044	104.5	2,359,491	105.0
		12–59	9,606,902	9,656,496	100.5	9,756,780	101.6	9,781,107	101.8	9,810,323	102.1	5,397,457	101.0	9,751,958	101.5
		3–59	11,854,712	11,986,350	101.1	12,121,413	102.2	12,151,311	102.5	12,182,851	102.8	6,703,501	101.7	12,111,449	102.2

n/a: not applicable

3.2 Coverage surveys

This section presents the results of EoC and EoR surveys in Burkina Faso, Chad, Nigeria, South Sudan, Togo and Uganda.

3.2.1 Households with eligible children visited by a community distributor

Tables 17–19 show proportions of households visited by a community distributor in each cycle for which a survey was conducted, with 95% CIs and sample sizes.

Household coverage improved over successive cycles, surpassing 90 percent in most countries in later cycles. Chad, Nigeria, and South Sudan recorded coverage below 90 percent in the earlier cycles, but showed improvement over time, reaching above 90 percent by the final cycles. Within Nigeria, coverage remained high across most states, with Borno, Sokoto, Oyo, Nasarawa and Plateau achieving over 95 percent in multiple cycles, while Kebbi and Bauchi showed modest variability and the Federal Capital Territory consistently recorded lower, fluctuating coverage below 85 percent.

Table 17: Proportions of households with eligible children visited by a community distributor by country and survey

Data source	Number of households sampled	Proportion of households covered	95% CI
Burkina Faso (districts receiving five cycles)			
EoC: cycle 1	1,999	97.5	90.3–99.4
Burkina Faso (all districts)			
EoC: cycle 2	2,125	98.2	96.4–99.1
EoC: cycle 3	2,225	98.5	96.7–99.4
EoC: cycle 4	2,124	99.0	97.3–99.6
EoR: cycle 5	1,500	98.7	97.9–99.1
Chad (all districts)			
EoC: cycle 1	1,472	86.0	82.0–89.2
EoC: cycle 2	1,396	89.7	83.6–93.7
Chad (districts receiving four cycles)			
EoC: cycle 3	1,918	95.3	92.4–97.1
Chad (all districts)			
EoR: cycle 4	1,496	98.3	97.5–98.9
Nigeria (states with five cycles)			
EoC: cycle 1	27,966	88.7	86.6–90.6
Nigeria (All states)			
EoC: cycle 2	43,201	93.9	92.6–94.9
EoC: cycle 3	39,839	94.1	92.2–95.5
EoC: cycle 4	41,313	94.8	93.5–95.8
EoR: cycle 5	13,500	94.9	94.5–95.3
South Sudan			

EoC: cycle 1	1,025	88.1	79.6–93.3
EoC: cycle 2	1,028	92.5	88.1–95.4
EoC: cycle 3	1,024	93.1	88.6–96.0
EoC: cycle 4	1012	94.9	91.1–97.1
EoR: cycle 5	1,500	94.5	93.2–95.5
Togo			
EoC: cycle 1	500	98.7	97.0–99.4
EoC: cycle 2	500	98.0	95.1–99.2
EoC: cycle 3	500	98.8	95.3–99.7
EoC: cycle 4	500	98.6	95.4–99.6
EoR: cycle 5	1,500	98.5	97.7–99.0
Uganda			
EoC: cycle 1	1,400	99.3	93.9–99.9
EoC: cycle 2	1,400	98.6	90.1–99.8
EoC: cycle 3	1,404	99.3	95.1–99.9
EoC: cycle 4	1,400	98.2	94.5–99.4
EoR: cycle 5	1,500	98.9	98.3–99.3

Table 18: Proportions of households with eligible children visited by a community distributor by Nigerian state and survey (states with four cycles)

Data source	Number of households sampled	Proportion of households covered	95% CI
Borno			
EoC: cycle 1	3,897	98.5	97.2–99.2
EoC: cycle 2	3,852	97.8	95.4–98.9
EoC: cycle 3	3,569	99.5	98.9–99.8
EoR: cycle 4	1,500	98.3	97.5–98.9
Kebbi			
EoC: cycle 1	5,620	93.8	91.8–95.4
EoC: cycle 2	5,617	96.6	95.0–97.7
EoC: cycle 3	5,622	96.9	95.4–97.8
EoR: cycle 4	1,500	93.9	92.5–95.0
Sokoto			
EoC: cycle 1	5,793	95.1	93.4–-96.4
EoC: cycle 2	5,623	98.2	97.5–98.7
EoC: cycle 3	5,772	96.2	94.8–97.3
EoR: cycle 4	1,500	98.2	97.4–98.8

Table 19: Proportions of households with eligible children visited by a community distributor by Nigerian state and survey (states with five cycles)

Data source	Number of households sampled	Proportion of households covered	95% CI: LCI
Bauchi			
EoC: cycle 1	7,845	89.0	87.1–90.6
EoC: cycle 2	7,713	93.6	91.9–95.0
EoC: cycle 3	4,701	94.7	92.6–6.3
EoC: cycle 4	6,581	95.1	93.6–96.3
EoR: cycle 5	1,500	90.8	89.2–92.2
FCT			
EoC: cycle 1	1,525	81.0	74.1–86.4
EoC: cycle 2	1,525	83.0	76.8–87.8
EoC: cycle 3	1,525	79.5	69.6–86.8
EoC: cycle 4	1,525	81.4	75.5–86.1
EoR: cycle 5	1,500	82.5	80.5–84.4
Kogi			
EoC: cycle 1	5,624	94.1	91.7–95.8
EoC: cycle 2	5,574	96.2	94.7–97.3
EoC: cycle 3	5,547	97.3	96.1–98.1
EoC: cycle 4	5,598	97.5	96.4–98.3
EoR: cycle 5	1,500	96.1	95.0–97.0
Nasarawa			
EoC: cycle 1	3,605	94.4	91.3–96.5
EoC: cycle 2	3,627	97.1	95.1–98.3
EoC: cycle 3	3,600	98.9	98.3–99.3
EoC: cycle 4	3,627	99.0	98.4–99.4
EoR: cycle 5	1,500	97.4	96.5–98.1
Oyo			
EoC: cycle 1	1,501	97.8	95.1–99.0
EoC: cycle 2	1,502	98.9	96.9–99.6
EoC: cycle 3	1,500	99.5	98.5–99.8
EoC: cycle 4	1,099	98.4	96.2–99.3
EoR: cycle 5	1,500	99.4	98.9–99.7
Plateau			
EoC: cycle 1	7,866	92.6	90.6–94.3
EoC: cycle 2	7,950	96.4	95.0–97.4
EoC: cycle 3	7,874	97.6	96.6–98.3
EoC: cycle 4	7,920	97.3	96.3–98.1
EoR: cycle 5	1,500	97.5	96.5–98.2

3.2.2 Day 1 SPAQ provided to eligible children aged three to 59 months

Results from EoC and EoR survey showing coverage in terms of day 1 SPAQ provided by community distributors across cycles and countries are presented in **Tables 20**–**22**.

Across countries, coverage of day 1 SPAQ administration was consistently high across implementation cycles, generally exceeding 95 percent in Burkina Faso, Togo and Uganda, with only minor fluctuations between cycles. Chad and South Sudan started from comparatively lower cycle 1 levels (93.5 percent and 85.6 percent, respectively) but showed steady improvements over successive cycles, reaching ≥92 percent by the final cycle. In Nigeria, coverage increased from 85.1 percent in cycle 1 to above 92 percent from cycle 2 onward, remaining relatively stable through subsequent cycles. Across Nigeria's states, coverage was high across most settings, with several states achieving ≥97 percent in multiple cycles, while others showed modest variability across cycles. The FCT recorded lower coverage throughout, ranging from 70.5 percent to 80.9 percent across cycles. The particularly low coverage in cycle 1 contributed to the relatively lower country-level coverage in that cycle compared with others.

Table 20: Proportions of eligible children (3–59 months) who received day 1 SPAQ by country and survey in 2025

Data source	Number of children sampled	Proportion of children covered	95% CI
Burkina Faso (districts receiving five cycles)			
EoC: cycle 1	1,999	97.3	88.9–99.4
Burkina Faso (all districts)			
EoC: cycle 2	2,125	98.6	97.9–99.1
EoC: cycle 3	2,225	97.2	94.4–98.6
EoC: cycle 4	2,124	97.4	96.2–98.3
EoR: cycle 5	1,500	96.3	95.2–97.1
Chad (all districts)			
EoC: cycle 1	1,472	96.5	94.5–97.8
EoC: cycle 2	1,396	93.5	87.0–96.9
Chad (districts receiving four cycles)			
EoC: cycle 3	1,918	96.5	94.6–97.7
Chad (all districts)			
EoR: cycle 4	1,496	98.6	97.9–99.1
Nigeria (states with five cycles)			
EoC: cycle 1	27,966	85.1	82.2–87.5
Nigeria (All states)			
EoC: cycle 2	43,201	92.1	90.8–93.3
EoC: cycle 3	39,839	92.4	90.5–94.0
EoC: cycle 4	41,313	93.4	92.0–94.6

EoR: cycle 5	13,500	92.7	92.3–93.2
South Sudan			
EoC: cycle 1	1,025	85.6	76.6–91.5
EoC: cycle 2	1,028	88.4	80.8–93.2
EoC: cycle 3	1,024	86.6	78.8–91.8
EoC: cycle 4	1012	90.3	84.4–94.2
EoR: cycle 5	1,500	92.1	90.6–93.3
Togo			
EoC: cycle 1	500	97.0	94.4–98.4
EoC: cycle 2	500	98.0	95.5–99.2
EoC: cycle 3	500	97.0	92.6–98.9
EoC: cycle 4	500	97.8	94.8–99.1
EoR: cycle 5	1,500	97.5	96.5–98.2
Uganda			
EoC: cycle 1	1,400	98.7	95.3–99.7
EoC: cycle 2	1,400	98.2	92.7–99.6
EoC: cycle 3	1,404	98.5	95.8–99.5
EoC: cycle 4	1,400	97.8	93.5–99.3
EoR: cycle 5	1,500	98.4	97.6–98.9

Table 21: Proportions of eligible children who received day 1 SPAQ, by Nigerian state and survey (states with four cycles)

Data source	Number of households sampled	Proportion of children covered	95% CI
Borno			
EoC: cycle 1	3897	97.4	94.3–98.9
EoC: cycle 2	3,852	97.2	94.0–98.8
EoC: cycle 3	3,569	99.3	98.6–99.7
EoR: cycle 4	1,500	97.2	96.2–97.9
Kebbi			
EoC: cycle 1	5,620	92.4	90.3–94.2
EoC: cycle 2	5,617	95.5	93.8–96.8
EoC: cycle 3	5,622	96.3	94.9–97.4
EoR: cycle 4	1,500	93.6	92.2–94.7
Sokoto			
EoC: cycle 1	5,793	94.7	93.0–96.1
EoC: cycle 2	5,623	97.6	96.7–98.2
EoC: cycle 3	5,772	96.1	94.7–97.2
EoR: cycle 4	1,500	97.9	97.0–98.5

Table 22: Proportions of eligible children who received day 1 SPAQ, by Nigerian state and survey (states with five cycles)

Data source	Number of households sampled	Proportion of children covered	95% CI
Bauchi			
EoC: cycle 1	7,845	88.6	86.6–90.4
EoC: cycle 2	7,713	93.0	91.4–94.4
EoC: cycle 3	4,701	94.1	92.1–95.7
EoC: cycle 4	6,581	94.3	92.8–95.5
EoR: cycle 5	1,500	92.3	90.8–93.5
FCT			
EoC: cycle 1	1,525	70.5	62.4–77.5
EoC: cycle 2	1,525	77.9	71.7–83.1
EoC: cycle 3	1,525	73.4	64.3–80.9
EoC: cycle 4	1,525	76.3	70.2–81.6
EoR: cycle 5	1,500	80.9	78.8–82.8
Kogi			
EoC: cycle 1	5,624	90.8	88.4–92.8
EoC: cycle 2	5,574	94.0	92.3–95.4
EoC: cycle 3	5,547	95.8	94.4–96.9
EoC: cycle 4	5,598	96.0	94.7–96.9
EoR: cycle 5	1,500	89.4	87.7–90.9
Nasarawa			
EoC: cycle 1	3,605	92.4	89.1–94.8
EoC: cycle 2	3,627	95.0	92.8–96.6
EoC: cycle 3	3,600	97.8	96.5–98.6
EoC: cycle 4	3,627	97.4	96.0–98.4
EoR: cycle 5	1,500	95.9	94.7–96.8
Oyo			
EoC: cycle 1	1,501	96.1	92.5–98.0
EoC: cycle 2	1,502	97.7	96.0–98.7
EoC: cycle 3	1,500	98.8	97.6–99.4
EoC: cycle 4	1,099	97.3	94.2–98.8
EoR: cycle 5	1,500	91.2	89.7–92.5
Plateau			
EoC: cycle 1	7,866	91.8	89.8–93.4
EoC: cycle 2	7,950	95.5	94.0–96.6
EoC: cycle 3	7,874	96.9	95.9–97.7
EoC: cycle 4	7,920	96.5	95.4–97.3
EoR: cycle 5	1,500	96.3	95.2–97.1

Table 25 shows day 1 SPAQ coverage of eligible children by cycle based on retrospective reporting by caregivers during EoR surveys following the last cycle of SMC delivery.

EoR estimates of day 1 SPAQ coverage were consistently high, generally exceeding 90 percent across all cycles. Coverage increased over successive cycles in Burkina Faso, reaching 96.3 percent by cycle 5, while Chad showed a similar upward trend, peaking at 98.6 percent in cycle 4. Togo and Uganda maintained high and progressively increasing coverage, with Uganda reaching 98.4 percent by cycle 5. In Nigeria, coverage remained relatively stable around 92 percent across cycles 1–3, increased to 96.2 percent in areas with four cycles, and was slightly lower (91.0 percent) in areas implementing five cycles at the final round. South Sudan showed moderate variability across cycles, with coverage ranging from 88.6 percent to 93.7 percent before returning to 92.1 percent in the final cycle.

Results from EoR surveys (**Table 23**) can be assessed against those obtained from EoC surveys (**Table 20**).

Table 23: Proportions of eligible children (3–59 months) who received day 1 SPAQ by country, EoR survey

Number of cycles	Number of children sampled	Proportion of children covered	95% CI
Burkina Faso			
EoR: cycle 1	440	91.4	88.3–93.7
EoR: cycle 2	1,500	91.1	89.6–92.5
EoR: cycle 3		95.0	93.8–96.0
EoR: cycle 4		93.5	92.2–94.7
EoR: cycle 5		96.3	95.2–97.1
Chad (all districts)			
EoR: cycle 1	1,496	94.3	93.0–95.3
EoR: cycle 2		94.1	92.7–95.1
Chad (districts receiving four cycles)			
EoR: cycle 3	1,316	96.7	95.6–97.6
Chad (all districts)			
EoR: cycle 4	1,496	98.6	97.9–99.1
Nigeria (all states; total, weighted proportion)			
EoR: cycle 1	13,500	92.4	92.0–92.9
EoR: cycle 2		92.5	92.1–93.0
EoR: cycle 3		92.0	91.5–92.4
Nigeria (areas with four cycles)			
EoR: cycle 4	4,500	96.2	95.6–96.7
Nigeria (areas with five cycles)			
EoR: cycle 5	9,000	91.0	90.4–91.6
South Sudan			
EoR: cycle 1	1,500	93.7	92.3–94.8

EoR: cycle 2		92.5	91.1–93.8
EoR: cycle 3		92.0	90.5–93.3
EoR: cycle 4		88.6	88.9–90.1
EoR: cycle 5		92.1	90.6–93.3
Togo			
EoR: cycle 1	1,500	93.7	92.3–94.8
EoR: cycle 2		93.2	91.8–94.4
EoR: cycle 3		93.6	92.2–94.7
EoR: cycle 4		94.5	93.2–95.5
EoR: cycle 5		97.5	96.5–98.2
Uganda			
EoR: cycle 1	1,500	95.0	93.8–96.0
EoR: cycle 2		96.1	95.0–97.0
EoR: cycle 3		97.0	96.0–97.8
EoR: cycle 4		97.5	96.6–98.2
EoR: cycle 5		98.4	97.6–98.4

3.2.3 Spitting and vomiting of day 1 SPAQ among eligible children

Based on data from the EoR survey, the proportion of eligible children reporting partial or complete vomiting of day 1 SPAQ in the last cycle was generally low but varied across countries (**Table 24**). South Sudan and Uganda recorded the lowest proportions (0.9 percent and 2.7 percent, respectively), while Nigeria also reported relatively low levels (4.6 percent). Higher proportions were observed in Burkina Faso (7.4 percent), Chad (9.8 percent), and Togo (10.7 percent), indicating moderate variability in reported vomiting across countries.

Table 24: Proportions of eligible children (3–59 months) who reported spitting or vomiting of day 1 SPAQ, by country (EoR survey)

Data source	Number of eligible children sampled	Proportion of eligible children (day 1 SPAQ vomiting/spitting)	95% CI
Burkina Faso			
EoR: cycle 5	1,426	7.4	6.2–8.9
Chad			
EoR: cycle 4	1,475	9.8	8.4–11.5
Nigeria			
EoR: cycle 5	12,683	4.6	4.2–5.0
South Sudan			
EoR: cycle 5	1,381	0.9	0.6–1.6
Togo			
EoR: cycle 5	1,462	10.7	9.2–12.4
Uganda			
EoR: cycle 5	1,476	2.7	2.0–3.7

3.2.4 Re-dosing after spitting or vomiting of day 1 SPAQ among eligible children

Across countries, the proportion of eligible children who were re-dosed after vomiting day 1 SPAQ in the last cycle varied (**Table 25**). Chad recorded the highest proportion (96.6 percent), while moderate levels were observed in Nigeria (64.6 percent) and Burkina Faso (61.3 percent). Lower proportions were reported in South Sudan (53.9 percent) and Uganda (45.0 percent), with the lowest observed in Togo (32.7 percent), indicating considerable variability in re-dosing practices across countries.

Table 25: Proportions of eligible children (3–59 months) who received SPAQ re-dosing after spitting or vomiting of day 1 SPAQ, by country (EoR survey)

Data source	Number of eligible children sampled	Proportion of eligible children covered (re-dose after day 1 SPAQ vomiting)	95% CI
Burkina Faso			
EoR: cycle 5	106	61.3	51.6–70.2
Chad			
EoR: cycle 4	145	96.6	91.9–98.6
Nigeria			
EoR: cycle 5	520	64.6	60.4–68.6
South Sudan			
EoR: cycle 5	13	53.9	25.8–79.7
Togo			
EoR: cycle 5	156	32.7	25.7–40.5
Uganda			
EoR: cycle 5	40	45.0	30.1–60.9

3.2.5 Proportion of eligible children who received a full three-day course of SPAQ

Completion of the full three-day SPAQ course among children who received day 1 SPAQ was consistently high, generally exceeding 95 percent in most cycles across countries (**Tables 26–28**). Burkina Faso, Uganda and Togo maintained very high completion rates (≥98 percent in most cycles), while South Sudan also achieved similarly high levels, reaching 99.5 percent by the final cycle. Chad showed a marked improvement from lower initial levels (89.4 percent) to 97.4 percent by the final cycle. In Nigeria, completion remained consistently high (96–98 percent) across implementation cycles, with a slight decline to 96.2 percent in the final cycle of the round.

At state level in Nigeria, completion was ≥97 percent across cycles in Borno, Kebbi, Sokoto, Kogi, Nasarawa, Oyo and Plateau states during implementation cycles, while lower end-of-round estimates were observed across states, ranging from 66.1 percent in the FCT to 87.3 percent in Borno state.

Table 26: Proportions of eligible children (3–59 months) who received a full three-day course of SPAQ among those who received day 1 SPAQ, by country and survey

Data source	Number of children sampled	Proportion of children received full course	95% CI
Burkina Faso (districts receiving five cycles)			
EoC: cycle 1	1,922	98.8	96.2–99.6
Burkina Faso (all districts)			
EoC: cycle 2	2,079	99.5	99.0–99.7
EoC: cycle 3	2,159	99.4	98.9–99.6
EoC: cycle 4	2070	98.9	98.0–99.4
EoR: cycle 5	1,444	98.8	98.1–99.3
Chad (all districts)			
EoC: cycle 1	1,429	89.4	84.7–92.7
EoC: cycle 2	1,340	89.6	85.0–92.9
Chad (districts receiving four cycles)			
EoC: cycle 3	1,861	95.0	92.5–96.7
Chad (all districts)			
EoR: cycle 4	1,475	97.4	96.4–98.1
Nigeria (states with five cycles)			
EoC: cycle 1	25,451	96.4	95.8–96.9
Nigeria (All states)			
EoC: cycle 2	40,764	97.2	96.8–97.6
EoC: cycle 3	38,182	97.2	96.6–97.8
EoC: cycle 4	39,545	98.0	97.6–98.3
EoR: cycle 5	12,518	96.2	95.9–96.6
South Sudan			
EoC: cycle 1	885	97.5	95.0–98.8
EoC: cycle 2	915	95.4	91.1–97.7
EoC: cycle 3	895	97.6	94.7–98.9
EoC: cycle 4	919	98.8	97.4–99.5
EoR: cycle 5	1,381	99.5	98.9–99.8
Togo			
EoC: cycle 1	484	95.0	90.2–97.5
EoC: cycle 2	489	97.3	94.9–98.6
EoC: cycle 3	484	95.1	90.9–97.4
EoC: cycle 4	488	95.0	89.9–97.6
EoR: cycle 5	1,462	99.2	98.6–99.5
Uganda			
EoC: cycle 1	1,381	98.8	97.8–99.4

EoC: cycle 2	1,370	98.1	94.9–99.3
EoC: cycle 3	1,379	98.2	92.5–99.6
EoC: cycle 4	1,362	98.8	97.2–99.4
EoR: cycle 5	1,476	99.2	98.6–99.5

Table 27: Proportions of eligible children (3–59 months) who received a full three-day course of SPAQ among those who received day 1 SPAQ, by Nigerian state and survey (states with four cycles)

Data source	Number of households sampled	Proportion of children received full course	95% CI
Borno			
EoC: cycle 1	3,775	99.3	98.7–99.6
EoC: cycle 2	3,696	98.9	98.2–99.3
EoC: cycle 3	3,524	99.4	98.9–99.7
EoR: cycle 4	1,500	87.3	85.5–88.9
Kebbi			
EoC: cycle 1	5,188	97.4	96.7–98.0
EoC: cycle 2	5,358	97.1	96.2–97.8
EoC: cycle 3	5,405	97.2	96.3–97.9
EoR: cycle 4	1,500	85.5	83.7–87.2
Sokoto			
EoC: cycle 1	5,484	97.2	96.3–97.9
EoC: cycle 2	5,480	97.8	97.1–98.3
EoC: cycle 3	5,539	98.1	97.2–98.7
EoR: cycle 4	1,500	88.3	86.6–89.9

Table 28: Proportions of eligible children (3–59 months) who received a full three-day course of SPAQ among those who received day 1 SPAQ, by Nigerian state and survey (states with five cycles)

Data source	Number of households sampled	Proportion of children received full course	95% CI
Bauchi			
EoC: cycle 1	6,939	97.0	96.3–97.6
EoC: cycle 2	7,159	96.4	95.6–97.0
EoC: cycle 3	4,433	96.8	95.8–97.6
EoC: cycle 4	6,185	97.9	97.3–98.3
EoR: cycle 5	1,500	75.3	73.0–77.4
FCT			
EoC: cycle 1	1,231	93.0	90.5–94.9
EoC: cycle 2	1,269	93.4	90.8–95.4
EoC: cycle 3	1,230	92.6	87.1–95.8
EoC: cycle 4	1,260	95.1	92.9–96.6

EoR: cycle 5	1,500	66.1	63.6–68.4
Kogi			
EoC: cycle 1	5,174	98.0	97.4–98.5
EoC: cycle 2	5,305	98.0	97.2–98.6
EoC: cycle 3	5,342	98.3	97.6–98.8
EoC: cycle 4	5,399	98.3	97.6–98.8
EoR cycle 5	1,500	68.0	65.6–70.3
Nasarawa			
EoC: cycle 1	3,381	97.4	96.0–98.3
EoC: cycle 2	3,482	97.6	96.1–98.5
EoC: cycle 3	3,514	98.9	98.1–99.3
EoC: cycle 4	3,524	98.8	97.8–99.3
EoR: cycle 5	1,500	81.1	79.1–83.0
Oyo			
EoC: cycle 1	1,444	96.5	94.7–97.8
EoC: cycle 2	1,465	98.3	97.3–99.0
EoC: cycle 3	1,480	99.3	98.0–99.7
EoC: cycle 4	1,069	98.5	97.1–99.2
EoR: cycle 5	1,500	71.6	69.3–73.8
Plateau			
EoC: cycle 1	7,282	97.7	97.1–98.2
EoC: cycle 2	7,637	98.5	98.1–98.8
EoC: cycle 3	7,649	98.3	97.8–98.7
EoC: cycle 4	7,640	99.0	98.7–99.3
EoR: cycle 5	1,500	86.9	85.1–88.5

3.2.6 SPAQ administration directly supervised by community distributors adhering to DOT

Adherence to DOT for day 1 SPAQ among children who received day 1 SPAQ showed greater variability than other indicators but generally improved over successive cycles across countries. Burkina Faso and South Sudan maintained consistently high DOT adherence (≥95 percent across most cycles), while Uganda also recorded high levels throughout (94–98 percent). Chad started from lower baseline levels (79.7 percent) in cycle 1 but showed marked improvements by the final cycle, reaching 97.6 percent. In Nigeria, DOT coverage increased progressively from 86.2 percent in cycle 1 to 92.9 percent at end-of-round. Togo recorded a performance of 85.8 percent in Cycle 1. Although its performance declined slightly in the subsequent cycles, it rebounded to 94.3 percent in the final cycle.

At state level in Nigeria, DOT adherence was consistently high (≥93 percent) across cycles in Borno, Kebbi, Sokoto, Kogi, Nasarawa, Oyo and Plateau states during implementation cycles, while lower but improving levels were observed in Bauchi state and the FCT, particularly at earlier cycles. End-

of-round estimates were generally comparable to or higher than end-of-cycle estimates across most states, with some variability observed.

Table 29: Proportions of eligible children (3–59 months) who received day 1 SPAQ by community distributors adhering to DOT among those who received day 1 SPAQ by community distributors during home visits, by country and survey

Data source	Number of children sampled	Proportion administered SMC by DOT	95% CI
Burkina Faso (districts receiving five cycles)			
EoC: cycle 1	1,922	99.4	98.0–99.8
Burkina Faso (all districts)			
EoC: cycle 2	2,079	93.5	88.3–96.5
EoC: cycle 3	2,159	97.3	95.2–98.5
EoC: cycle 4	2070	95.9	91.4–98.1
EoR: cycle 5	1,444	95.8	94.6–96.7
Chad (all districts)			
EoC: cycle 1	1,429	79.7	75.2–83.6
EoC: cycle 2	1,340	83.1	78.7–86.7
Chad (districts receiving four cycles)			
EoC: cycle 3	1,861	93.4	91.5–94.9
Chad (all districts)			
EoR: cycle 4	1,475	97.6	96.7–98.3
Nigeria (states with five cycles)			
EoC: cycle 1	25,451	86.2	84.4–87.9
Nigeria (all states)			
EoC: cycle 2	40,764	88.8	87.4–90.1
EoC: cycle 3	38,182	89.2	87.9–90.4
EoC: cycle 4	39,545	89.1	87.2–90.7
EoR: cycle 5	12,518	92.9	92.5–93.4
South Sudan			
EoC: cycle 1	885	96.7	93.6–98.3
EoC: cycle 2	915	97.4	95.8–98.4
EoC: cycle 3	895	99.0	97.5–99.6
EoC: cycle 4	919	97.7	88.9–99.6
EoR: cycle 5	1,381	99.4	98.8–99.7

Togo			
EoC: cycle 1	484	85.8	79.2–90.6
EoC: cycle 2	489	84.7	70.9–92.7
EoC: cycle 3	484	82.7	73.6–89.2
EoC: cycle 4	488	84.8	72.4–92.2
EoR: cycle 5	1,462	94.3	93.0–95.4
Uganda			
EoC: cycle 1	1,381	96.5	89.2–98.9
EoC: cycle 2	1,370	96.7	80.3–99.5
EoC: cycle 3	1,379	94.7	76.8–99.0
EoC: cycle 4	1,362	97.7	89.0–99.5
EoR: cycle 5	1,476	94.2	92.9–95.3

Table 30: Proportions of eligible children (3–59 months) who received day 1 SPAQ by community distributors adhering to DOT among those who received day 1 SPAQ by community distributors during home visits, by Nigerian state and survey (states with four cycles)

Data source	Number of households sampled	Proportion administered SMC by DOT	95% CI
Borno			
EoC: cycle 1	3,775	97.5	95.9–98.5
EoC: cycle 2	3,696	97.5	96.5–98.3
EoC: cycle 3	3,524	98.0	96.2–98.9
EoR: cycle 4	1,458	97.1	96.0–97.8
Kebbi			
EoC: cycle 1	5,188	95.1	93.6–96.3
EoC: cycle 2	5,358	94.9	92.9–96.4
EoC: cycle 3	5,405	93.7	90.9–95.7
EoR: cycle 4	1,404	97.2	96.1–97.9
Sokoto			
EoC: cycle 1	5,484	93.8	91.4–95.5
EoC: cycle 2	5,480	94.2	92.0–95.9
EoC: cycle 3	5,539	94.7	92.5–96.2
EoR: cycle 4	1,468	93.7	92.4–94.9

Table 31: Proportions of eligible children (3–59 months) who received day 1 SPAQ by community distributors adhering to DOT among those who received day 1 SPAQ by community distributors during home visits, by Nigerian state and survey (states with five cycles)

Data source	Number of households sampled	Proportion administered SMC by DOT	95% CI
Bauchi			
EoC: cycle 1	6,939	79.9	76.9–82.5
EoC: cycle 2	7,159	71.4	68.1–74.4
EoC: cycle 3	4,433	73.6	69.3–77.6
EoC: cycle 4	6,185	76.8	73.4–79.8
EoR: cycle 5	1,384	91.8	90.2–93.1
FCT			
EoC: cycle 1	1,231	84.7	77.8–89.7
EoC: cycle 2	1,269	83.3	75.1–89.2
EoC: cycle 3	1,230	86.1	79.9–90.6
EoC: cycle 4	1,260	76.4	65.3–84.8
EoR: cycle 5	1,213	91.7	90.0–93.1
Kogi			
EoC: cycle 1	5,174	95.1	93.5–96.3
EoC: cycle 2	5,305	96.4	95.0–97.4
EoC: cycle 3	5,342	95.2	93.7–96.3
EoC: cycle 4	5,399	95.8	94.3–96.9
EoR cycle 5	1,341	85.3	83.3–87.1
Nasarawa			
EoC: cycle 1	3,381	92.4	89.3–94.7
EoC: cycle 2	3,482	95.4	93.6–96.7
EoC: cycle 3	3,514	95.1	92.4–96.9
EoC: cycle 4	3,524	96.8	95.2–97.8
EoR: cycle 5	1,438	92.9	91.5–94.1
Oyo			
EoC: cycle 1	1,444	94.3	90.8–96.5
EoC: cycle 2	1,465	96.1	92.8–97.9
EoC: cycle 3	1,480	97.3	94.9–98.6
EoC: cycle 4	1,069	96.5	91.7–98.6
EoR: cycle 5	1,368	95.7	94.5–96.6
Plateau			
EoC: cycle 1	7,282	93.1	91.6–94.4
EoC: cycle 2	7,637	94.8	93.3–96.0
EoC: cycle 3	7,649	94.4	92.9–95.6
EoC: cycle 4	7,640	93.9	92.6–95.1
EoR: cycle 5	1,444	90.4	88.7–91.8

3.2.7 Receipt of SPAQ by eligible children outside of home visits by community distributors

Results from EoR survey showing receipt of SPAQ by eligible children from sources outside of home visits in the final cycle of the round, and the sources of SPAQ across countries are presented in **Table 32**.

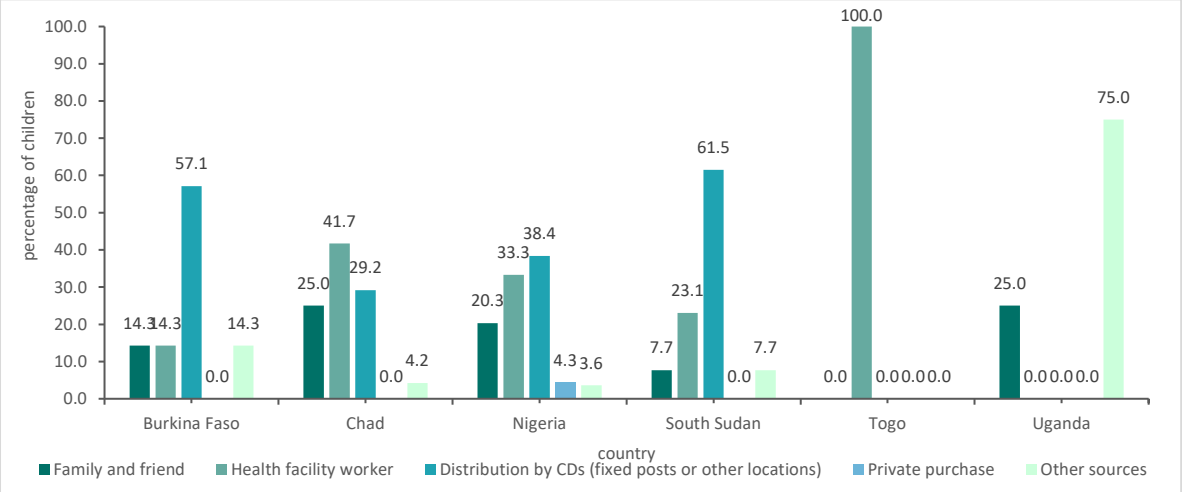
Receipt of SPAQ by eligible children outside of home visits in the last cycle was minimal across countries, with proportions below 2 percent in all settings. Burkina Faso, Togo and Uganda recorded very low levels (≤0.5 percent), while slightly higher proportions were observed in Nigeria (0.9 percent) and South Sudan (0.9 percent). The highest proportion was reported in Chad (1.6 percent), though still representing a small minority of cases.

Common sources of SPAQ received outside home visits include personnel at local health facilities, community distributors operating fixed distribution points, and SMC distributors delivering medicines in informal settings outside the caregiver's home, such as streets, markets or workplaces **(Figure 4**). Some of these sources may be considered legitimate channels for SPAQ distribution depending on the context and programme implementation arrangements. Outside these channels, the most common sources of SMC medicines included family or friends, unofficial fixed distribution points run by unaffiliated individuals, and private purchase of SMC medicines.

Table 32: Receipt of SPAQ by eligible children outside of home visits by community distributors by country

Data source	Number of eligible children sampled	Proportion of eligible children covered	95% CI
Burkina Faso			
EoR: cycle 5	1,444	0.5	0.2–1.0
Chad			
EoR: cycle 4	1,475	1.6	1.1–2.4
Nigeria (all states; total, weighted proportion)			
EoR: cycle4/ cycle5	12,518	0.9	0.8–1.1
South Sudan (Aweil South and West counties; weighted proportion)			
EoR: cycle 5	1,381	0.9	0.5–1.6
Togo			
EoR: cycle 5	1,462	0.1	0.0–0.5
Uganda (Amudat, Nakapiripirit, Moroto, Kotido and Nabilatuk districts; Karamoja sub-region)			
EoR: cycle 5	1,476	0.1	0.0–0.5

Figure 4: Sources of SPAQ received by eligible children outside of home visits by community distributors by country



3.2.8 Day 1 SPAQ received by eligible children over the course of the SMC round

Tables 33–35 show the proportions of eligible children by country and state by number of day 1 SPAQ received across all planned cycles during the 2025 SMC campaign.

Across countries, the distribution of the number of SMC cycles in which eligible children received day 1 SPAQ showed that most children received treatment in all scheduled cycles, with full-cycle coverage exceeding 80 percent in most countries. Burkina Faso, Togo and Uganda recorded high proportions of children receiving all cycles (≥83.8 percent in four-cycle settings and ≥86.6–92.3 percent in five-cycle settings), while South Sudan and Chad also achieved similarly high levels (81.7 percent and up to 91.5 percent, respectively). In Nigeria, the proportion of children receiving all cycles was high in areas with four cycles (90.2 percent) but lower in areas with five cycles (80.2 percent). The proportion of children who did not receive SPAQ in any cycle was generally low across countries, ranging from 0.3 percent in Chad (four-cycle districts) to 2.7 percent in South Sudan.

At state level in Nigeria, the proportion of children receiving all scheduled cycles was ≥89 percent in Borno, Kebbi, Sokoto and Plateau, while lower levels were observed in Kogi, Oyo and Bauchi states (77.7–81.0 percent), and lowest in the FCT (68.3 percent). The proportion of children who did not receive SPAQ in any cycle was highest in the FCT (10.0 percent) and generally lower in other states, ranging from 0.5 percent in Plateau to 4.7 percent in Kebbi.

Table 33: Proportions of eligible children (3–59 months) who received day 1 SPAQ by community distributors by number of cycles during 2025 (EoR survey), by country

Number of cycles	Number of children sampled	Proportion of eligible children covered	95% CI
Burkina Faso (districts with four cycles)			
None	1,060	1.0	0.5–1.8
One		1.7	1.0–2.7
Two		2.8	1.9–4.0

Three		10.7	8.9–12.7
Four		83.8	81.4–85.9
Burkina Faso (districts with five cycles)			
None	440	0.5	0.1–1.6
One		2.7	1.4–4.7
Two		1.4	0.5–2.9
Three		3.0	1.6–5.0
Four		5.9	3.9–8.5
Five		86.6	83.0–89.6
Chad (districts with three cycles)			
None	180	0.6	0.0–3.1
One		9.4	5.6–14.7
Two		7.2	3.9–12.0
Three		82.8	76.5–88.0
Chad (districts with four cycles)			
None	1,316	0.3	0.1–0.8
One		1.4	0.9–2.2
Two		2.1	1.4–3.0
Three		4.7	3.6–6.0
Four		91.5	89.8–92.9
Nigeria (areas with four cycles; total, weighted proportion)			
None	4,500	2.4	2.0–2.9
One		1.4	1.1–1.8
Two		1.5	1.1–1.9
Three		4.5	3.9–5.1
Four		90.2	89.3–91.1
Nigeria (areas with five cycles; total, weighted proportion)			
None	9,000	2.5	2.2–2.9
One		2.3	2.0–2.6
Two		2.9	2.6–3.3
Three		3.9	3.5–4.3
Four		8.2	7.6–8.8
Five		80.2	79.4–81.0
South Sudan (Aweil South and West, weighted proportions)			
None	1,500	2.7	2.0–3.7
One		1.1	0.6–1.7
Two		2.8	2.0–3.8
Three		3.1	2.3–4.1
Four		8.5	7.2–10.1
Five		81.7	79.7–83.7
Togo			

None	1,500	0.7	0.4–1.3
One		1.3	0.8–2.1
Two		2.3	1.6–3.2
Three		3.9	3.0–5.0
Four		3.9	3.0–5.0
Five		87.8	86.0–89.4
Uganda			
None	1,500	0.7	0.3–1.2
One		0.9	0.5–1.5
Two		1.3	0.8–2.0
Three		1.5	1.0–2.3
Four		3.4	2.5–4.4
Five		92.3	90.8–93.6

Table 34: Proportions of eligible children (3–59 months) who received day 1 SPAQ by community distributors by number of cycles during 2025 (EoR survey), by Nigerian state (states with five cycles)

Number of cycles	Number of children sampled	Proportion of eligible children covered	95% CI
Bauchi			
None	1,500	0.6	0.3–1.1
One		2.7	1.9–3.6
Two		4.5	3.5–5.7
Three		6.1	4.9–7.4
Four		7.8	6.5–9.3
Five		78.3	76.2–80.4
FCT			
None	1,500	10.0	8.5–11.6
One		4.3	3.4–5.5
Two		4.7	3.7–5.9
Three		4.8	3.8–6.0
Four		7.8	6.5–9.3
Five		68.3	65.9–70.7
Kogi			
None	1500	1.5	0.9–2.2
One		1.2	0.7–1.9
Two		1.9	1.3–2.8
Three		3.4	2.5–4.4
Four		11.0	9.5–12.7
Five		81.0	78.9–83.0
Nasarawa			
None	1,500	0.8	0.4–1.4

One		1.0	0.6–1.6
Two		1.8	1.2–2.6
Three		3.1	2.3–4.1
Four		8.1	6.7–9.6
Five		85.3	83.4–87
Oyo			
None	1,500	1.8	1.2–2.6
One		3.5	2.7–4.6
Two		3.8	2.9–4.9
Three		4.6	3.6–5.8
Four		8.5	7.2–10.1
Five		77.7	75.5–79.8
Plateau			
None	1,500	0.5	0.2–1.0
One		0.9	0.5–1.6
Two		0.7	0.4–1.3
Three		1.4	0.9–2.1
Four		5.8	4.7–7.1
Five		90.6	89.0–92.0

Table 35: Proportions of eligible children (3–59 months) who received day 1 SPAQ by community distributors by number of cycles during 2025 (EoR survey), by Nigerian state (states with four cycles)

Number of cycles	Number of children sampled	Proportion of eligible children covered	95% CI
Borno			
None	1,500	1.5	1.0–2.3
One		0.9	0.5–1.6
Two		0.9	0.5–1.6
Three		5.7	4.6–7.0
Four		90.9	89.3–92.3
Kebbi			
None	1,500	4.7	3.7–5.9
One		0.5	0.2–1.0
Two		1.7	1.1–2.5
Three		3.7	2.8–4.8
Four		89.3	87.7–90.9
Sokoto			
None	1,500	1.0	0.6–1.6
One		2.8	2.0–3.8
Two		1.8	1.2–2.6
Three		4.0	3.1–5.1
Four		90.4	88.8–91.8

3.2.9 SPAQ provided to ineligible children aged five years and above

Table 36 and **Table 37** show the proportions of ineligible children aged 60–119 months who received SPAQ, based on data from EoR surveys.

The proportion of ineligible children aged 60–119 months who received day 1 SPAQ in the last cycle varied substantially across countries. Chad recorded the highest proportion (61.9 percent), while moderate levels were observed in Nigeria (22.9 percent) and South Sudan (16.7 percent). Lower proportions were reported in Burkina Faso (12.6 percent), Togo (9.9 percent), and Uganda (9.1 percent), indicating variability in inclusion errors across countries.

At state level in Nigeria, the proportion of ineligible children receiving SPAQ ranged widely, from 10.5 percent in Oyo and 11.4 percent in Kebbi to higher levels in Nasarawa (29.0 percent), Sokoto (34.3 percent) and Borno (40.6 percent) states. Intermediate levels were observed in Bauchi (24.0 percent), Plateau (23.1 percent) and Kogi (21.7 percent) states, and the FCT (20.6 percent).

Table 36: Proportions of ineligible children (60 –119 months) who received day 1 SPAQ (EoR survey) by country

Data source	Number of ineligible children sampled	Proportion of ineligible children covered	95% CI
Burkina Faso			

EoR: cycle 5	910	12.6	10.6–15.0
Chad			
EoR: cycle 4	231	61.9	55.4–68.0
Nigeria			
EoR: cycle 5	3,775	22.9	21.6–24.3
South Sudan			
EoR: cycle 5	240	16.7	12.4–22.0
Togo			
EoR: cycle 5	655	9.9	7.9–12.5
Uganda			
EoR: cycle 5	1,125	9.1	7.5–10.9

Table 37: Proportions of ineligible children (60–119 months) who received day 1 SPAQ (EoR survey), by Nigerian state

Data source	Number of ineligible children sampled	Proportion of ineligible children covered	95% CI
Bauchi			
EoR: cycle 5	454	24.0	20.3–28.2
FCT			
EoR: cycle 5	457	20.6	17.1–24.5
Kogi			
EoR: cycle 5	180	21.7	16.2–28.3
Nasarawa			
EoR: cycle 5	283	29.0	24.0–34.6
Oyo			
EoR: cycle 5	561	10.5	8.2–13.3
Plateau			
EoR: cycle 5	640	23.1	20.0–26.6
Borno			
EoR: cycle 4	387	40.6	35.8–45.6
Kebbi			
EoR: cycle 4	446	11.4	8.8–14.7
Sokoto			
EoR: cycle 4	367	34.3	29.6–39.4

4. Discussion

Target populations across the SMC programme in 2025

A total of 14.8 million children were targeted for SMC delivery across the seven supported countries in 2025, with five countries maintaining the same scale as in 2024. However, this total target population was substantially lower than the 17.1 million targeted in 2024 for reasons

outlined previously.[9] Consistent with the 2024 report, this report includes target population figures only for areas where Malaria Consortium acted as the SMC implementing partner with philanthropic funding. This differs from earlier reports, which presented target populations for all areas supported with philanthropic funding or co-funding, regardless of Malaria Consortium's implementation role. The 2025 Philanthropy Report provides a detailed account of how Malaria Consortium used philanthropic funding and co-funding for SMC in 2025.[8]

Administrative programme coverage

Across the seven countries, high levels of administrative coverage were maintained in 2025, with overall coverage estimated at 105.1 percent, ranging from 95.1 percent in Uganda to 122.5 percent in Burkina Faso. As in prior years, estimates exceeded 100 percent in most countries and Nigerian states. Estimates above 100 percent likely reflect persistent numerator and denominator issues. One key numerator factor is the administration of SMC medicines to ineligible children, which can occur due to limited availability of home-based official birth and health records.[22, 23] Factors such as stunting and undernutrition may further challenge community distributors' ability to accurately exclude older children, inflating the numerator (number of children reached) and leading to overestimated coverage.[23] In such cases, one would expect the percentage of overaged children who received SPAQ to be substantial. This is supported by the observation that countries like Togo and Uganda with the lowest, more plausible administrative coverage also had the lowest percentage of ineligible older children receiving SPAQ in 2025. Additional numerator issues may arise from tallying errors when aggregating data across multiple levels, especially with paper-based tally sheets. Denominator factors could also have contributed to this, including potential underestimation of the target population size. Target population estimates may not fully account for population movements, particularly among nomadic and internally displaced populations.

As in previous years, within-country variation in administrative coverage persisted, particularly in Nigeria, where estimates ranged from 94.4 percent in Oyo to 108.9 percent in Sokoto. These variations likely reflect differences in target population accuracy, population dynamics, administrative data collection tools, accessibility of eligible children and community distributors' ability to correctly determine a child's age and eligibility.

Recent improvements to administrative coverage estimation methods, including through microplanning processes and campaign digitalisation, are described in **Section 2.3**. Programme experience demonstrates that digitalising campaign data can enhance the accuracy of administrative coverage estimates, with digitalised data aligning more closely with survey-based coverage than paper-based records.[19] We are still yet to fully understand the extent of these benefits, and we will continue to learn from further digitalisation experiences. Looking ahead, we will maintain our commitment to continuing to refine our administrative coverage estimation methods, tools and processes as discussed later in **Section 4.1.**

SMC programme coverage among eligible children based on household survey data

Across supported countries, the SMC programme maintained consistently high coverage and adherence to key quality standards during the 2025 campaign. As in previous years, day 1 SPAQ coverage exceeded 90 percent in nearly all cycles and often surpassed 95 percent, reflecting strong programme reach and effective household delivery, while the relatively lower coverage in South Sudan aligns with historical trends of slightly lower performance compared with other countries. The 2025 results, however, represent a somewhat improved picture compared with earlier campaigns. For example, day 1 SPAQ coverage was below 90 percent in all but one cycle in 2023 and in all cycles in 2024. The outlook in 2025 nonetheless reflects the continued challenging operational context, including limited accessibility to some communities due to heavy flooding, as well as broader operational challenges associated with the country's humanitarian setting.

It is encouraging to see that high levels of coverage were maintained despite the integration initiatives in several settings in 2025. These included the co-distribution of VAS with SMC in Bauchi state in Nigeria, co-distribution of ORSZ in Chad and the use of SMC community distributors to identify and refer zero-dose and under-immunised children in Burkina Faso, Togo and Uganda. These programmatic adaptations are described in greater detail in the 2025 Philanthropy Report.[8] These findings highlight the robustness of SMC's operational systems, indicating its potential to support broader public health objectives while maintaining strong household-level reach and quality of delivery. It is also notable that coverage remained high despite cost-optimisation efforts introduced in response to global funding constraints. While areas supported through philanthropic funding were not under the same immediate pressure to reduce costs as some programmes funded through other sources, efforts were made to align operations with neighbouring areas facing tighter budgets, as highlighted in the Philanthropy Report.[8] Moreover, it equally encouraging that high levels of SMC coverage were sustained in the context of malaria vaccine roll-out. This is supported by findings from our previous secondary analysis of survey data which showed that SMC coverage and quality were similarly high between districts where the malaria vaccine was first introduced and those where it had not yet been introduced in Burkina Faso in 2024.[24] This suggests that SMC can coexist effectively with newer malaria prevention tools such as malaria vaccines, reinforcing the case for integrated malaria prevention strategies.

Across Nigerian states, day 1 SPAQ coverage was also consistently high, with the exception of the FCT, mirroring trends seen in previous years. Coverage remained below 80 percent in all but the final cycle, although improved in the last two cycles, likely as a result of strategies implemented to improve uptake during cycle 4. However, the relatively lower performance compared with other states in Nigeria continues to reflect the influence of geographical and programmatic factors that constrain coverage when delivering SMC in complex urban settings.[20] The effect of the FCT's lower performance is evident in the weighted country-level estimates for Nigeria, particularly in cycle 1 where coverage was the lowest at only 70.5 percent. Despite efforts over a number of years to adapt the strategy to urban settings, there has not been much success so far. Looking ahead, it will

be important to continue refining the programmatic strategies and context-specific adaptations implemented in 2025 and prior years in order to improve SMC uptake in the FCT in future campaign rounds.

It is important to note that administrative data indicated coverage levels close to or exceeding 100 percent even in settings where survey-derived day 1 SPAQ coverage was lower, such as South Sudan and the FCT in Nigeria. In both settings, survey estimates showed coverage below 90 percent while administrative coverage exceeded 100 percent. As estimates derived from surveys are generally more reliable than those from administrative data, the relatively lower coverage levels observed in the surveys likely provide a more accurate reflection of programme performance. As outlined previously, several factors may contribute to discrepancies between survey and administrative coverage estimates, including limitations in the accuracy of both numerators and denominators used in administrative coverage estimation. Survey data are not constrained by denominator issues common with administrative data. Numerator issues such as the misclassification of children's ages can occur when community distributors experience difficulty accurately determining children's eligibility during household visits, resulting in ineligible children being included in administrative counts. Such issues are less likely to occur in surveys, as survey data collectors tend to be more literate and numerate than community distributors and receive specific training on the ascertainment of children's ages, including the use of anchoring techniques that help caregivers recall children's birth months and years by linking them to local events, time periods or holidays. Furthermore, the electronic data collection tools used in surveys include built-in validation features that help confirm a child's age and eligibility. Together, these features contribute to the greater reliability of survey-derived coverage estimates.

Similar to 2024 and previous years, the proportion of day 1 SPAQ doses administered under DOT remained above 90 percent in most cycles. Relatively lower DOT adherence was observed in cycle 1 in Chad (79.7 percent), while Togo recorded sub-90 percent values across most cycles. DOT adherence was also lower than 80 percent in most cycles in Bauchi state in Nigeria. These patterns may reflect a combination of programmatic and contextual factors, including reduced motivation among community distributors due to delayed payments, as in the case of Togo. It is nevertheless encouraging that DOT adherence generally improved in later cycles of the campaign, suggesting that the factors contributing to lower DOT levels earlier in the campaign may have been addressed as implementation progressed. Encouragingly, we did not observe similar lower DOT trends in other settings where integration was implemented. Burkina Faso, Uganda and Kebbi state in Nigeria also leveraged SMC delivery to identify and refer underimmunised children in 2025, yet all maintained very high levels of DOT adherence.

As the programme increasingly considers opportunities to integrate additional interventions and services through the SMC delivery platform, it will be important to continue closely monitoring programme coverage and quality indicators, particularly DOT adherence, as this may be one of the

indicators most sensitive to increases in workload or strain on the delivery model. In keeping with trends observed for other indicators and consistent with previous years, DOT adherence was relatively lower in the FCT in Nigeria, remaining below 90 percent in most cycles. This likely reflects the continued influence of geographical and programmatic factors that constrain effective household delivery in complex urban settings such as the FCT.

Ensuring optimal adherence to day 2 and day 3 AQ doses is essential for maximising SMC's protective effectiveness.[4] Completing the full treatment course also plays an important role in mitigating the spread of parasite resistance.[25] Consistent with trends observed in previous years, over 90 percent of children who received the first dose of SPAQ went on to complete the full three-day SPAQ course in all cycles and across all supported countries and Nigerian states in 2025. This suggests that once children are reached, the likelihood of completing the full course of SMC medicines within each cycle is very high. This likely reflects the effectiveness of current strategies aimed at improving caregivers' knowledge of the importance of administering the second and third doses of AQ and their capability to do so correctly. Lower levels of adherence to day 2 and day 3 AQ doses were nonetheless observed in some settings, most notably in Chad where adherence was below 90 percent in most cycles and in South Sudan where it remained below 90 percent in all cycles.

As previously noted and further acknowledged in **Section 4.1**, day 2 and AQ adherence estimates are based on caregiver reports and are particularly prone to social desirability bias. However, the potential for such bias is likely minimal for the reasons outlined later in **Section 4.1**. Efforts to further strengthen adherence continue to be a programmatic priority, considering the benefits in terms of protection against malaria and mitigation of the emergence and spread of parasite resistance. Previous implementation research conducted by Malaria Consortium has examined strategies to enhance adherence to SMC dosing regimens, such as the use of community-level role models in Togo to provide peer support, particularly to promote caregiver administration of the second and third doses of AQ. Findings demonstrated that this approach substantially improved adherence to the three-day course of SPAQ and related outcomes.

Retention of the cohort of eligible children throughout the SMC round, measured as the proportion receiving SPAQ in each of the three to five planned cycles, is critical to ensuring optimal protection during the high transmission season. In 2025, coverage of children receiving SMC in all cycles exceeded 80 percent in most settings. Compared with 2024, there were notable improvements in cohort retention in Burkina Faso, Chad, Nigeria and South Sudan, with a stable outlook in Togo and Uganda, likely reflecting their already higher levels in 2024. Despite overall improvements, South Sudan and the FCT in Nigeria continued to lag behind. These patterns are consistent with cycle-specific coverage trends and previously described delivery challenges. As in previous years, the proportion of children who did not receive SPAQ in any cycle was generally low, below 1 percent in most countries. However, it was higher in South Sudan at around 3 percent and highest in the FCT in Nigeria at 10 percent, consistent with lower performance across other coverage indicators in

these settings. Although relatively small, these proportions may represent children who are systematically missed throughout the round, underscoring the need to strengthen adherence and follow-up to improve retention across multi-cycle campaigns and ensure equitable access. Our multi-country analyses to explore the extent and factors associated with cohort retention identified several child, caregiver and health system factors as key predictors of retention.[26] Understanding these factors is crucial for designing targeted interventions to improve and sustain high levels of retention, equitable coverage and protection throughout the SMC round. A journal manuscript providing further detail of the findings has been developed and will be published over the coming months.

Spitting and vomiting of day 1 SPAQ and subsequent re-dosing

In this 2025 report, an additional indicator was introduced to capture spitting and vomiting following day 1 SPAQ administration. Full ingestion of SMC medicines without spitting or vomiting over the complete three-day course is critical to ensure effectiveness and minimise the risk of antimalarial resistance.[27] The proportion of eligible children reported to have spat out or vomited their day 1 SPAQ doses during the final cycle was generally low, with the lowest levels observed in South Sudan, Uganda and Nigeria (all below 5 percent), and relatively higher proportions in Burkina Faso (7.4 percent), Chad (9.8 percent), and Togo (10.7 percent). Children who vomit or spit out the medicine within 30 minutes should be re-dosed once.[8] Among those reported to have spat out or vomited their dose, the majority received a replacement dose in most settings, with the highest proportion in Chad (96.6 percent). Moderate levels were observed in Nigeria (64.6 percent) and Burkina Faso (61.3 percent), while lower proportions were reported in South Sudan (53.9 percent) and Uganda (45.0 percent). Redosing was lowest in Togo (32.7 percent), despite recording the highest occurrence of spitting and vomiting. Overall, these findings underscore the need to strengthen community distributors' adherence to standard protocols and ensure optimal redosing where appropriate in all supported areas. These findings are consistent with patterns observed in our previous analyses from the 2020 and 2022 rounds.[27] It is important to note that caregiver reports on spitting and vomiting as well as data collectors' interpretation of these reports, are subjective and may vary across locations. This can make it difficult to accurately determine the extent of spitting and vomiting, and how soon after administration of day 1 SPAQ they occurred. In some cases, children may have spat out or vomited only a small portion of the dose, which may not have warranted re-dosing. It is also important to emphasise that the current data apply only to day 1 and may not be generalisable to day 2 and day 3 AQ administration. Efforts will be made to harmonise the operationalisation of this indicator across countries in future surveys.

Receipt of SMC outside of home visits by community distributors

In line with previous years, very few eligible children received SPAQ through channels other than home visits by community distributors or recognised sources such as health facilities across supported countries in 2025. Many instances of receipt of SPAQ outside household visits tend to be those administered by health facility staff or community distributors at fixed points, such as during inaccessibility to households due to heavy flooding, when reaching caregivers who were absent

during door-to-door visits or febrile children referred to health facilities for testing who subsequently tested negative, all of which are considered official distribution channels. Among other sources, family members or friends were the most common providers of SMC medicines. Overall, the share of children obtaining SPAQ through unofficial channels remained below one percent during the final cycle of 2025, with the exception of Chad, where it reached 1.6 percent (**Table 32**).

Receipt of SMC by ineligible children aged five years and older

The proportion of ineligible older children receiving day 1 SPAQ in the final cycle of the 2025 round varied widely across countries, ranging from 9.1 percent in Uganda to 61.9 percent in Chad. In some countries, these proportions were similar to those observed in previous years, while in others notable differences were seen. In Chad, the proportion increased substantially from 37 percent in 2024 to nearly 62 percent in 2025. However, this level of reported overage treatment is programmatically implausible, as it is unlikely that sufficient excess SPAQ would be available to cover such a large number of ineligible children. We therefore consider it more likely that this reflects a data quality issue with the indicator, with some data collectors in the Chad EoR survey potentially misinterpreting the question as referring to whether older children had ever received SPAQ, rather than during the current campaign. Efforts will be made to strengthen data collector training, particularly on more complex indicators, to minimise such misinterpretation in future rounds. In Nigeria, the proportion of ineligible children receiving day 1 SPAQ rose from 8 percent in 2024 to 23 percent in 2025. By contrast, it declined in Uganda from 18 percent in 2024 to 9 percent in 2025 and in South Sudan from 28 percent in 2024 to 12 percent in 2025, likely reflecting additional efforts in both countries to minimise overage treatment.

These results indicate that receipt of SMC medicines by ineligible children remains a common occurrence with notable between-country variations. Administering SPAQ to older children is likely to result in underdosing, provide insufficient protection against malaria, and create a potential risk of contributing to drug resistance. A previous analysis conducted by Malaria Consortium showed that the majority of ineligible children who received SMC medicines were five and six-year olds.[21] While this may indicate that the risks of underdosing and contribution to drug resistance are lower than if children were predominantly older than five years, it remains crucial to minimise exposure of ineligible children to SMC medicines and any associated risks.

It should also be noted that estimates of SMC coverage among ineligible children may not fully reflect the true extent of overage administration due to sampling limitations. In most countries, older children were sampled opportunistically from households with eligible children, likely resulting in overestimation of SMC receipt, whereas in Uganda older children were sampled independently, producing more representative estimates. Estimates from 2025 and previous years in Uganda have consistently shown lower overage treatment relative to other countries. Although the exact extent of SMC administration to ineligible children remains uncertain, findings from 2025 and previous years consistently show that overage treatment is a widespread issue. This, combined

with inaccurate population denominators and population movement, may contribute to the higher-than-expected administrative coverage estimates observed, which exceeded 100 percent in some cases.

Comparability of survey results between locations and over time

In general, survey results are comparable across cycles within the same country, between different countries in the same year, and across years, particularly with respect to the general sampling and analysis methods. However, it is essential to recognise that comparability can be affected by several factors. First, survey results may not be fully comparable across multiple years within the same country in cases where programme scale has changed or adaptations to the delivery model have been implemented. Second, comparisons between cycles may be constrained by differences in sampling frames across cycles, such as when certain districts are excluded from the frame due to insecurity, flooding or other accessibility challenges. These variations in sampling coverage can influence the representativeness of the results and should be considered when interpreting trends over time or between locations.

The time elapsed between the delivery of day 1 SPAQ and the coverage surveys may have influenced our results through recall bias and could explain differences in coverage estimates between EoC and EoR surveys. This is particularly evident when comparing EoC results from earlier cycles with coverage estimates based on retrospective self-reports by caregivers for the same cycles, as shown in **Table 20** and **Table 23**. Across all countries, coverage estimates for earlier cycles derived from EoR survey data tended to be lower than those obtained from EoC surveys for the corresponding cycles. Given the retrospective nature of EoR estimates and the greater potential for recall bias, the EoC survey estimates for these cycles should be considered more reliable. By contrast, there are generally no substantial differences in coverage and quality estimates between EoC surveys for earlier cycles with EoR surveys for the final cycle.

Furthermore, when interpreting survey estimates, it is important to note that EoC and EoR surveys may differ in representativeness. For example, in Togo, estimates derived from EoC surveys include data from the seven districts where Malaria Consortium supported implementation, whereas EoR survey estimates include data from all 23 districts to preserve statistical precision, as explained previously.

4.1 Methodological strengths and limitations

Malaria Consortium's SMC M&E methods have several notable strengths. As described in **Section 2.3**, continued efforts were made to strengthen the quality, reliability and usefulness of monitoring and evaluation data across the programme. These included refining target population estimation methods to improve microplanning and provide more precise denominators for administrative coverage, alongside the increasing use of campaign digitalisation in Burkina Faso, Chad, Nigeria and Togo to improve estimates of the number of children reached. Administrative data quality assurance and data management processes were also strengthened, with growing recognition of

the value of digitalised data for real-time or near real-time decision-making during SPAQ distribution. Methodological improvements to household surveys also continued, including greater standardisation of survey implementation across countries and the use of LQAS hypothesis testing to identify coverage and quality gaps at the SA level and guide corrective actions. Additional quality assurance measures included training of survey teams, real-time data auditing, GPS verification of interviews and built-in validation checks in electronic data collection tools.

Another notable strength is the use of independent evaluators to conduct comprehensive EoR coverage surveys. This approach helps promote objectivity and transparency in M&E processes by providing an external assessment of programme performance, reducing potential biases that may arise from internal reporting. Independent evaluators also enhance the credibility of findings among stakeholders, support robust validation of coverage and quality data, and provide additional insights that can inform programme improvements and decision-making for subsequent cycles.

Malaria Consortium places great value on the utilisation of programme data to guide decision-making and tailoring programme improvements.[28,29] In this regard, data-informed decision-making (DIDM) is one of the core objectives of Malaria Consortium's SMC programme. To foster DIDM within the SMC delivery model, the programme's M&E framework defines measurable indicators for tracking the use of data for decision-making.[13] Further progress was achieved in the use of data to drive decision-making and programmatic improvements in 2025 through the widespread development and operationalisation of country-specific DIDM plans, and stronger use of LQAS and other programmatic data sources to identify coverage and quality gaps in each cycle and guide corrective actions in subsequent cycles. The timely conduct of surveys following each cycle's SPAQ distribution facilitated the rapid completion of data collection and analysis, and provided sufficient time, often up to two weeks before the subsequent cycle, to communicate results to stakeholders at the SA level and engage with them to implement actions to improve SMC delivery before and during the succeeding cycle. A manuscript presenting a multi-country analysis evaluating the effectiveness of repeated LQAS hypothesis testing in facilitating DIDM and improvements in programme delivery has been developed and is expected to be published later in 2026. This will build on previously published evidence on our DIDM approaches, including a case study of how LQAS was used to drive decision-making and improvements in SMC delivery in Nigeria,[28] a conference presentation detailing the adaptation and use of the LQAS methodology across Malaria Consortium's SMC programme[29] and a spotlight on country-specific case studies of DIDM experiences in Togo and Uganda during the 2024 round.[8]

Our methods are nonetheless not without limitations. Firstly, target populations used for calculating administrative coverage continue to rely largely on official population estimates, which have variable levels of accuracy. Efforts have been made to triangulate official population figures with alternative sources where available, including the use of local administrative records and microplanning data from other public health campaigns, such as routine immunisation outreach data used to refine target population estimates in Nigeria. Continued use of digitalisation also

presents opportunities to use data on the number of children reached in the previous round to inform more accurate estimates of the target population for subsequent rounds. Further investments in campaign digitalisation may help harness this opportunity more widely. However, we are yet to fully understand the exact extent of this potential benefit, and further learning is expected as digitalisation efforts expand across supported areas.

Secondly, while spin-the-pen methods are considered a pragmatically useful alternative to systematic random sampling where household lists are unavailable, they have known drawbacks, including the potential overrepresentation of centrally located households. If such households differ systematically from more peripheral households, such as in terms of accessibility or demographic characteristics, this could affect the representativeness and accuracy of coverage estimates. Such methods may also introduce selection bias due to their non-random starting point and direction, which can affect the representativeness of the sample. The predominant use of spin-the-pen methods in our surveys therefore presents a potential source of bias. While the magnitude of this risk is uncertain, we have introduced specific adaptations to minimise bias, including within-cluster segmentation and the use of pre-specified sampling intervals and skipping logic. Additional measures will include more stringent use of SurveyCTO geocoordinate dashboards to validate and support adherence to sampling protocols. We are also exploring alternative approaches, including more comprehensive household and target population enumeration, as well as the use of satellite imagery or geospatial tools to enable more systematic household selection. However, these approaches are likely to be resource-intensive or constrained in operational feasibility. We will continue to consult with in-country partners and stakeholders to identify best use cases for household mapping as well as the most feasible, cost-efficient ways of doing so.

Another important limitation of our survey methods is their reliance on caregiver self-reporting. Consequently, survey findings may be subject to both recall and social desirability biases. Potential recall bias is likely minimal given the several measures implemented to mitigate it, as described in **Section 2.3.** Measures to reduce social desirability bias have also been outlined previously in that section. While the risk of social desirability bias is likely minimal for some indicators, such as day 1 SPAQ coverage, it may be more likely for others, including adherence to day 2 and day 3 AQ doses. The use of SMC child record cards or SPAQ blister packs to estimate coverage could provide an additional source of verification. However, their use currently has limited feasibility due to inconsistent retention by caregivers, which reduces their reliability for determining coverage or validating caregiver responses. Previous checks suggest that this kind of bias is likely limited, as card-derived estimates and checking of SPAQ blister packs (wherever available) tend to be broadly comparable with levels observed in caregiver-reported survey data. Nonetheless, we acknowledge that this approach may not provide robust validation, as children whose cards or blister packs are retained may be systematically different from the wider population of eligible children. Continued efforts to improve the distribution, retention and use of SMC child record cards may provide additional opportunities to strengthen validation of coverage estimates in the future.

While survey results are broadly comparable due to recent standardisation efforts, comparability across surveys remains constrained by several factors acknowledged earlier, including differences in sampling frames, scale of implementation and the number of cycles conducted within and across countries. Efforts to further harmonise survey design, indicators, including those measuring spitting and vomiting, and analytical approaches across programmes, including continued cross-country methodological exchanges and standardised analytical protocols, may help strengthen comparability in future rounds.

Some areas were excluded from the survey sampling frames due to inaccessibility, primarily related to insecurity and, in some cases, flooding. We acknowledge that such exclusions may affect the representativeness of the estimates, particularly if the omitted areas were more likely to have had lower or no coverage, potentially leading to slight overestimation of programme performance. However, these exclusions were relatively limited across countries and typically affected only specific wards, settlements or communities rather than entire LGAs or districts, meaning that the overall impact on national and programme-level estimates is likely to be limited.

Lastly, although coverage and quality estimates from EoC surveys are often broadly consistent with those from EoR surveys, the latter may be more susceptible to recall bias. EoR surveys are typically conducted a month after the final cycle to enable the collection of data on fever and malaria episodes occurring within 28 days following the final cycle, whereas EoC surveys are usually conducted within one week of SPAQ distribution. This longer recall period in EoR surveys may partly explain the somewhat lower levels of day 1 SPAQ coverage sometimes observed for final cycles compared with earlier cycles, as seen in some instances in previous years. However, this pattern was not evident in 2025, which may reflect the effectiveness of recall bias mitigation measures, including the use of anchoring techniques, visual prompts and cross-validation questions during interviews.

4.2 Conclusions and considerations for future direction

Malaria Consortium's SMC delivery with philanthropic funding maintained high administrative coverage across all supported countries in 2025. Findings from EoC and EoR household surveys indicate that programme coverage and adherence to SMC quality standards were generally high, with receipt of day 1 SPAQ and completion of the full three-day course exceeding 90 percent in most locations and cycles. These results also highlight the sustainability of high coverage and quality in newer SMC geographies in East and southern Africa. Coverage gaps persist, particularly for indicators such as the receipt of SPAQ in all planned cycles. While overall programme delivery remained strong, certain areas experienced declines in coverage due to factors including insecurity and operational challenges in new or complex urban settings. These limitations present opportunities to adapt and optimise SMC delivery, coverage and quality in 2026.

Further efforts will be made in 2026 to consolidate the improvements to M&E systems described in **Section 2.3**. These will include continued exploration of opportunities to refine target population

estimation methods; expand campaign digitalisation to strengthen the accuracy and timeliness of administrative data; improve our understanding of reliability of digitally collected administrative data; strengthen data quality assurance throughout the data lifecycle; and reinforce the use of LQAS and other programmatic data to support DIDM and programme improvement. Existing methodological limitations outlined in the previous section also present opportunities to further strengthen M&E approaches in 2026 and future campaigns. Key areas for improvement include exploration of more systematic household sampling approaches, including the potential use of household enumeration, satellite imagery and geospatial tools; and further strengthening of survey methods to validate caregiver-reported data, including improved distribution and retention of SMC child record cards. Additional efforts will focus on further minimising potential social desirability bias through strengthened interview techniques and data validation methods.

We are also cognisant of the potential role of artificial intelligence (AI) in strengthening M&E systems, including for data quality audits, anomaly detection, predictive analytics to identify areas at risk of low coverage, optimisation of microplanning and resource allocation, and the generation of actionable insights to support data use for programme improvement. Additional potential applications include automated data cleaning, real-time decision support dashboards, and the analysis of qualitative data to better understand barriers to uptake. Looking ahead, we will remain open to exploring appropriate and high-impact use cases for AI deployment, in alignment with organisational policies and global M&E best practices.

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