Insights from implementing the first seasonal malaria chemoprevention campaign in Mozambique

The project

Malaria Consortium has been a leading implementer of seasonal malaria chemoprevention (SMC) since 2013. We have scaled up SMC delivery considerably since then and begun to explore SMC implementation in new geographies. In 2021, we reached 20 million children through our support to national malaria programmes in Burkina Faso, Chad, Mozambique, Nigeria, Togo and Uganda.

Until recently, SMC had only been adopted and scaled up in Sahelian countries of West and Central Africa. This was largely due to concerns over widespread resistance to the antimalarial medicines used in SMC in many parts of East and southern Africa. However, it has been suggested that SMC may retain its protective effect even in areas where resistance is high.

To assess whether SMC can be an effective malaria prevention strategy in Mozambique, Malaria Consortium initiated a two-year hybrid effectiveness-implementation study in Nampula province in 2020, in partnership with the National Malaria Control Programme (NMCP) and the Centro de Investigação em Saúde da Manhiça. The first phase explored the feasibility and acceptability of delivering SMC outside of the Sahel, while the second phase focuses on demonstrating impact.[1]

Background

SMC is a highly efficacious and effective community-based intervention to prevent malaria infections in areas where the malaria burden is high and transmission occurs mainly during the rainy season. It involves administering monthly courses of antimalarial medicines during the peak transmission period to children 3–59 months. It has been demonstrated that SMC is cost-effective because it can be delivered safely at scale, achieving high coverage.[2,3]

Mozambique accounts for four percent of global malaria cases and deaths and the disease is highly endemic in the country.[4] A mid-term review of its Malaria Strategic Plan 2017–2022 recommended SMC as a strategy to accelerate impact in the highest-burden locations.

Approach and impact

Between November 2020 and February 2021, we implemented four monthly SMC cycles in the districts of Malema and Mecuburi in Nampula province — which is among the provinces with the highest malaria prevalence [5] — reaching around 81,000 children. This is the first time SMC has been implemented in Mozambique.

After each implementation cycle, district decision makers met to evaluate cycle results of coverage, quality of implementation, successes achieved and challenges. They then discussed an action plan to improve the subsequent cycle using the findings. All changes were documented to inform SMC implementation in the future. Results from phase one suggest that SMC is safe, feasible and well accepted in Nampula, and high coverage was achieved among the target population.[6] SMC also seems to ensure high protection from malaria among eligible children.

This insight brief focuses on the lessons learnt from implementing SMC in Mozambique. Full research study results will be published in due course.

Lessons learnt

- **Community mobilisation carried out by *lider-guias* (guide leaders) was most effective**. *Lider-guias*, recognised authorities in the community, help promote acceptability of SMC by visiting people in their homes. Previously, mass campaigns have used town announcers on motorbikes to share information about the campaign with the public, but their geographic coverage was limited and messages were not always audible. Data from a household survey conducted in the study area after SMC cycle three showed that 65 percent of caregivers had heard about SMC through *lider-guias* versus 50 percent through town announcers.
- The involvement and **engagement of key actors in the Ministry of Health** (from the national, provincial and district level) allowed programme ownership by all stakeholders, which contributed to a high acceptability of SMC. Ministry officials, together with Malaria Consortium staff, participated in the kick-off/macro-planning meetings and were closely involved in decision-making.
- **Rumour management strategies** were essential to tackle concerns related to COVID-19 and SMC. Community distributors could escalate concerns to *lider-guias* to be addressed during the household visits and mitigate concerns in the community.
- **Daily oversight and analysis of administrative data** by supervisors at the health facilities ensured adaptive support plans were implemented among distribution teams on a daily basis. To overcome distances between health facilities and communities, supervisors were able to identify meeting points mid-way, where distribution teams could convene to collect and deposit data/materials.

Recommendations

- The number of *lider-guias* should be adjusted according to the size of the target population, the area that needs to be covered, the number of distribution teams and the working days in each cycle. Adjusting the coverage area to match the number of *lider-guias* would allow them greater oversight of their teams and the quality of work. This will ensure better coverage and leadership overall.
- Town announcer numbers should be increased proportional to the size of each implementation area to ensure sufficient coverage.
- Community engagement should continue to take place through door-to-door mobilisation via *lider-guias* at least three days prior to the start of the campaign and each cycle. This will better facilitate knowledge exchange.
- The benefits of employing more SMC implementers to strengthen community engagement need to be weighed up against budget implications. For sustainable scale-up and value for money, existing community and health system structures need to be utilised, where appropriate.

References

1. Malaria Consortium. Assessing the feasibility, acceptability and impact of seasonal malaria chemoprevention in Mozambique. London: Malaria Consortium; 2020.
2. ACCESS-SMC Partnership. Effectiveness of seasonal malaria chemoprevention at scale in west and central Africa: An observational study. The Lancet, 2020; 396 (10265): 1829–40.
3. Gilmartin C, Nonvignon J, Cairns M, Milligan P, Bocoum F, Winskill P, et al. Seasonal malaria chemoprevention in the Sahel subregion of Africa: A cost-effectiveness and cost-savings analysis. The Lancet Global Health, 2021; 9(2): e199-e208.
4. World Health Organization. World malaria report 2021. Geneva: WHO; 2021.
5. National Institute of Health, Mozambique and ICF. Inquérito Nacional sobre Indicadores de Malária (Malaria Indicator Survey). Maputo, Mozambique and Rockville, Maryland: NIH and ICF; 2018.
6. Malaria Consortium. Exploring the implementation of seasonal malaria chemoprevention in Mozambique: Results from an end-of-round coverage survey in Nampula province, 2020–2021. London: Malaria Consortium; 2021.

Acknowledgement: This project was supported by philanthropic donations for SMC received by Malaria Consortium. It also received funding from the Bill & Melinda Gates Foundation.

Contact: info@malariaconsortium.org

FightingMalaria

MalariaConsortium

www.malariaconsortium.org

3 GOOD HEALTH AND WELL-BEING

malaria consortium

disease control, better health