



ECOWAS Malaria control Programs and partners meeting mid-term review and planning meeting in Bamako, Mali 21st July 2016 SMC special session report

Introduction

Taking the opportunity of ECOWAS Malaria control Program Managers and Partners mid-term review and planning meeting in Bamako, WARN SMC Working Group has organized a special session on SMC on 21st July the main objective of this special session was to convene all stakeholders interested in SMC including eligible countries and partners to provide updates on the 2015 SMC campaign results and on major SMC projects. More specifically the following agenda points were discussed.

- Coordination of SMC strategy in the region by WARN/ SMC Working Group.
- Countries presentations on SMC : 2015 campaign results and 2016 SMC campaign planning and implementation status : challenges and ways forward
- Updates on UNITAID Funded ACCES SMC project + Feedback from London meeting.
- Ongoing research on M&E (ACCESS SMC countries and Senegal).
- UNICEF SMC activities.

1. Coordination of SMC activities at regional level

Despite very limited resources the SMC Working Group is operational and has been able to conduct the following activities

- Provide discussion platform to countries eligible to SMC for the exchange of experiences
- Provide Technical Support, especially for SMC pharmacovigilance, M&E and quantification through conference calls and training workshops on PV
- Communicate with countries to help them align their SMC campaigns planning and implementation with WHO recommendations for SMC planning, implementation and monitoring& evaluation
- Develop SMC 2014 and 2015 campaigns reports
- Countries presentations on SMC : 2015 campaign results and 2016 SMC campaign planning and implementation status : challenges and ways forward
- Present status and progress of SMC implementation in WARN and CARN countries at international scientific conference and meetings

2. Countries presentations on SMC: 2015 campaign results and challenges and outlook of 2016 Campaign

This session was dedicated to allowing countries that implemented SMC during 2015 campaign to share their results. The presentations were also focused on the focused on campaigns challenges, pharmacovigilance, on specific issues including, effective SMC implementation periods, technical and funding partners, 2015 planning Vs Implementation, pharmacovigilance, lessons learned and an update of on 2016 planning outlook.

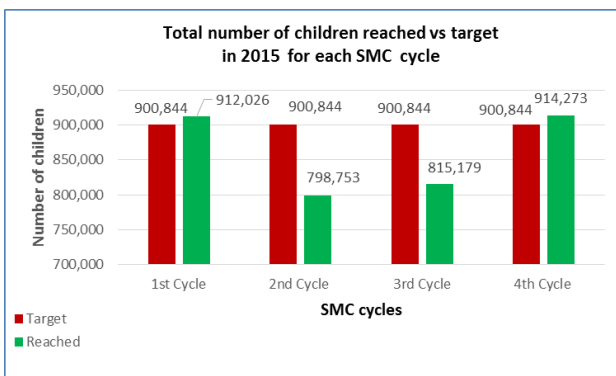


In total eight countries namely **Burkina Faso, Gambia, Guinea, Ghana, Mali, Niger, Nigeria, Senegal and Togo** presented their results, **Guinea Bissau and Mauritania** were present as observers.

a) BURKINA_FASO

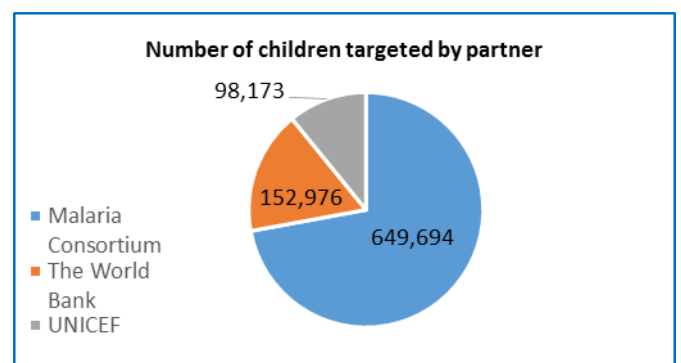
➤ **2015 SMC campaign results: challenges and lessons learnt**

Burkina Faso has implemented the seasonal Malaria chemoprevention for the consecutive second year (2014 and 2015). 2015 SMC campaign covered 17 districts in twelve regions country wide with **900,844** under five children targeted. In each of the district covered by the intervention, 4 cycles of SMC has been administrated and the results are outlined in the table below. For this campaign the country enjoyed both technical and financial support of many partners for the campaign including WAHO through the World Bank funded Neglected Tropical disease and Malaria in Sahel project.



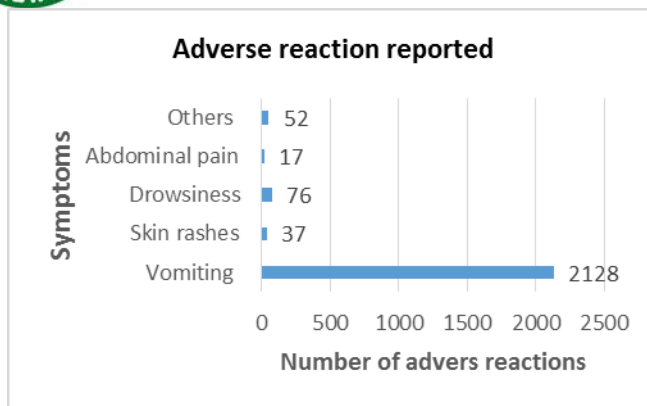
In terms of technical and financial support, the country has received support, from many partners. The repartition of these partners by number of districts and corresponding number of children is outlined in the summary table and the graph below.

Partners	Districts	children Targeted
Malaria ¹ Consortium	11	649,694
The World Bank	04	152,976
UNICEF	02	98,173
Total	17	900,843



In terms of pharmacovigilance, only minor drug adverse reactions has been noted: skin rashes, vomiting abdominal pain, drowsiness and others. The graph below shows the distribution of adverse reactions reported by symptom.

¹ Under the UNITAID Funded ACCESS SMC Project covering seven Sahel countries: Burkina- Chad- Gambia- Guinea- Mali- Niger-Nigeria.



Despite some impressive progress in SMC implementation, there are still challenges that need to be addressed and lessons learnt from the campaign.

Challenges

- The estimation of targets materialized by coverage higher than total population targeted in all the cycles
- Insufficient harmonization between National Malaria Control Program and partners and among partners themselves for SMC planning and implementation
- Remuneration of Community Health Workers
- Ascertaining of 3rd and 4th dose of SMC drugs to be taken at home
- SMC pharmacovigilance
- Predictability of partners effective support in bridging the gaps
- Difficulties in coordinating multiple community based health interventions

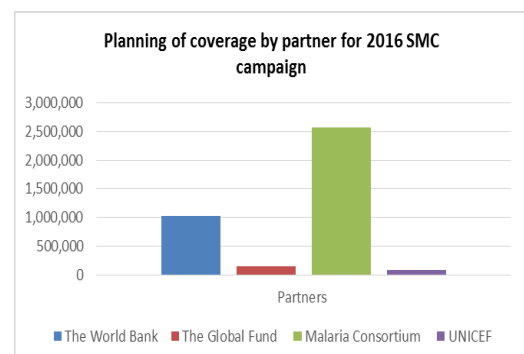
Lessons learnt

- ✓ There is a need to harmonize partners intervention
- ✓ There is a need to simplify data collection forms, especially when various community based health interventions are combined
- ✓ Good tolerance of SMC drugs
- ✓ The success of the campaign relays on a good planning involving all stakeholders with friendly usable data collection materials for community health workers
- ✓ Need to train all actors at all levels and inform workers from private health facilities
- ✓ There is a good tolerance of SMC drugs

➤ Outlook of 2016 SMC campaign planning in Burkina Faso

This year, the country plans to extend the coverage of the campaign to new districts. The “Neglected Tropical Diseases and Malaria Project in Sahel” launched by the World Bank and the West Africa Health Organization (WAHO) will support SMC delivery through the project Malaria component. The Global Fund will also support fund SMC delivery through the NFM. In addition to these new funding partners, the SMC traditional partners including UNICEF, Malaria Consortium will extend the number of districts covered and thus the number of children who will benefit of SMC.

Partners	Districts	Total Target	3-11 Months	12-59 months
The World Bank	20	1,030,563	172583	857980
The Global Fund	4	155,992	25621	130371
Malaria Consortium	31	2,576,067	416584	2159483
UNICEF	2	81,822	12,797	69,025
TOTAL	57	3,844,444	627,585	3,216,859



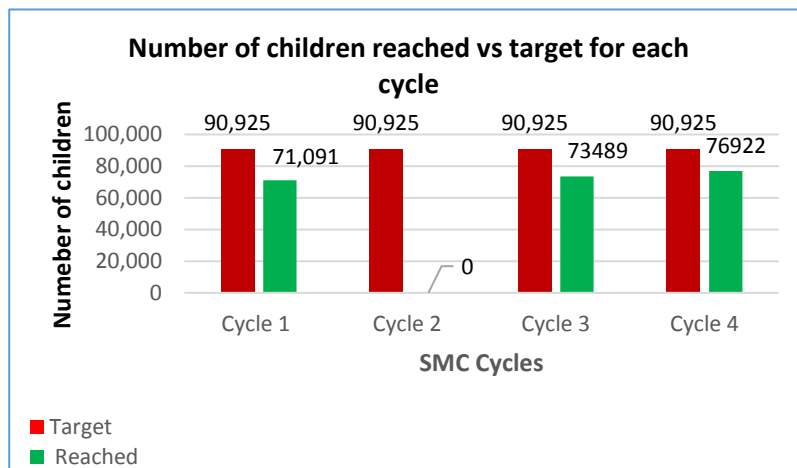


The initial planning of the country was to cover all the 70 districts. For 2016 campaign there is **a gap of 13 districts** that will not be covered.

b) GAMBIA

➤ 2015 SMC campaign results: challenges and lessons learnt

In the Gambia, SMC has been delivered in two regions: the Upper and the Central River Regions comprise of 7 and 10 districts respectively. 90,925 fix cohort of children have been targeted by the campaign and four cycles of SMC drugs have been administrated in all the districts covered by the campaign. Technical Assistance have been provided by UNICEF and WHO and funding and technical Assistance by Catholic Relief Services through the UNITAID Funded ACCESS SMC project which the Gambia is part of. The graph below outlines the campaign results by children targeted vs coverage per cycle.



Pharmacovigilance in general and for SMC in particular remains weak in the Gambia.

Since the last LLINs mass distribution campaign, the Gambia uses NetSuite, an electronic system to collect and analyse community based malaria interventions data. This System has been maintained and adapted to the tracking of information on SMC campaigns as well but has revealed some weaknesses.

Bottlenecks

- Initial design of NetSuite did not allow for loose pill tracking
 - Inability to have data of loose pills in NetSuite
 - Both complete and partially consumed blisters entered as consumption data
- Poor internet connectivity at regional level
 - Difficulty for timely posting of data at regional level
- Some of the NetSuite users are not very conversant with the system resulting in wrong entries
- Late delivery of SMC drugs in-country
- Supplied three different badge numbers for 12-59mths dosage
- Difficulty in tracking SMC drugs based on badge numbers
- Late reporting of end of cycle consumption data

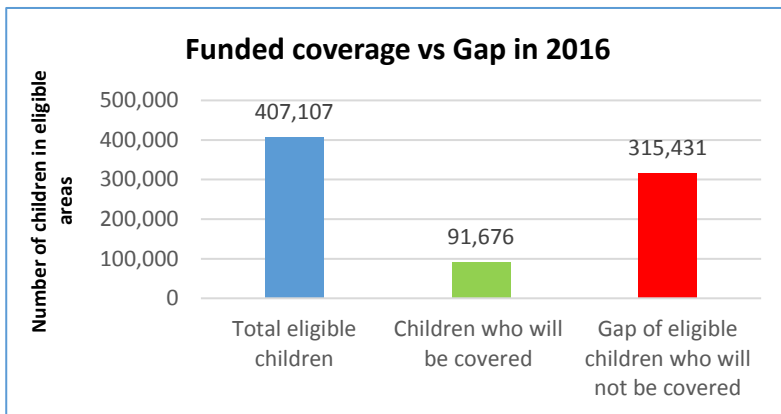
Lessons learnt

- ✓ Use of pill crusher was found to be relatively cheap, simple to use, fast in crushing, requiring minimal energy to crush, light to carry from door to door and protects against wastage during crushing
- ✓ Redesigning iForm to distinguish between refusal and exclusion by giving reasons for refusal helped in capturing some of the side effects
- ✓ Using religious and influential leaders to sensitize communities on date of distribution helped in ensuring that communities wait to receive SMC before going to the farms
- ✓ The use of the iPad for on spot data collection at community level



➤ **Outlook of 2016 campaign planning**

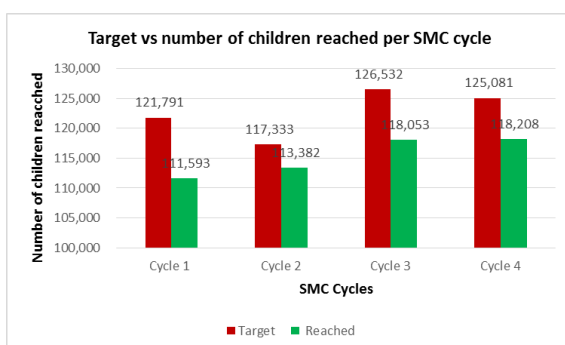
Districts /Region	Planning for coverage per age range (months)			Implementation partners
	Target	3-11 months	12-59 months	
1. Upper River	48,159	8,222	39,937	CRS ACCESS SMC
2. Central River	43,517	7,625	35,892	CRS ACCESS SMC
3. Western 2	76,406	11,467	64,939	GAP
4. Lower River	16,249	2,766	13,483	GAP
5. North Bank East	22,136	3,814	18,322	GAP
6. North Bank West	22,358	3,778	18,580	GAP
7. Western 1	178,282	26,757	151,525	GAP
Total	407,107	64,429	342,678	



c) GHANA.

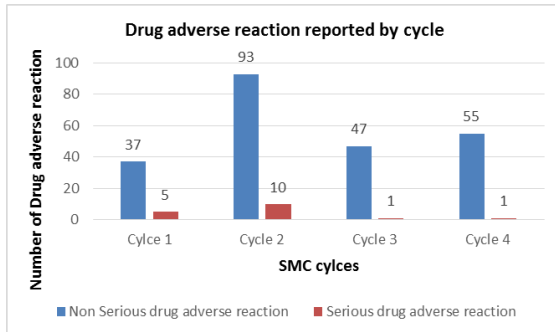
➤ **2015 SMC campaign results: challenges and lessons learnt**

In Ghana, 2015 SMC campaign has been the first one in the country and targeted northern Ghana. The intervention covered 11 districts and targeted **121,791** children in the Upper West region. Four cycles of SMC drugs administration has been done with the technical and financial support of DFID the Global Fund and WHO. The graph below shows a summary of number of children target versus number of children covered in each cycle of SMC.





The pharmacovigilance of SMC in Ghana have been reported during the campaign but the symptoms have not been communicated. The distribution of SMC drugs adverse reaction by cycle is shown in the graph below.



2015 SMC campaign bottlenecks and lessons learnt in Ghana.

Bottlenecks

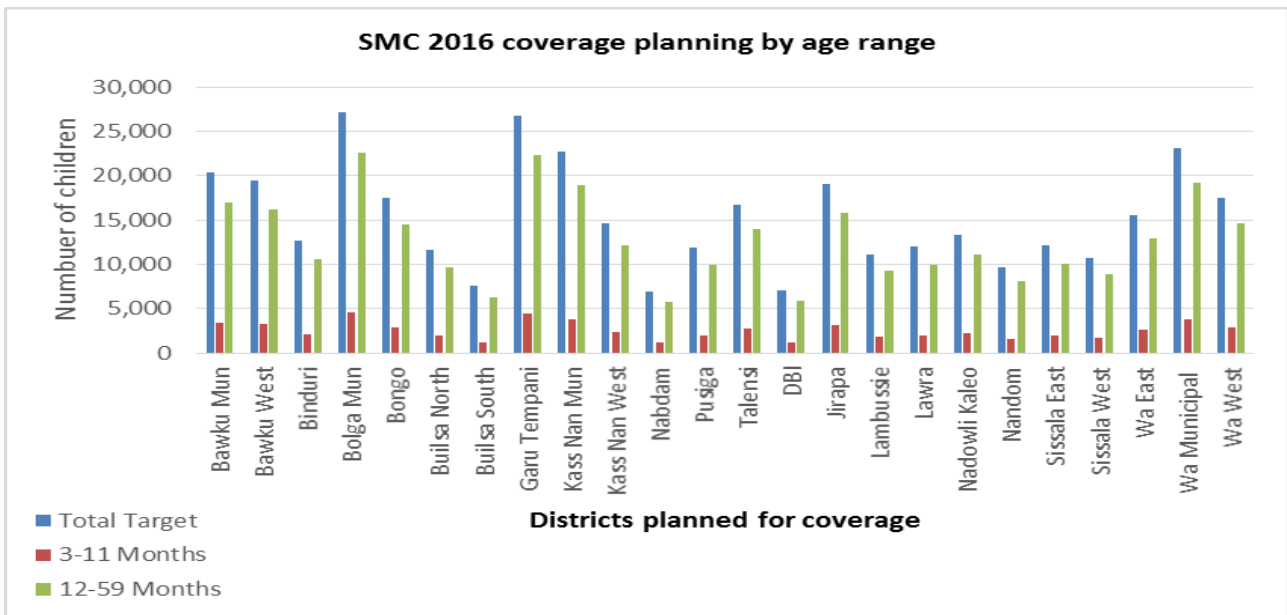
- *Breaking of drugs for lower ages created a lot of wastage.*
- *Tracking of children transiting in and out of target age group as well as in and out of a particular district*
- *Volunteers finding it difficult to get children due to farming activities*
- *Difficulty in dosing children who had not eaten*
- *Caregivers often forget to give remaining dose of medicine to child*

Lessons learnt

- ✓ *Active community involvement necessary for success*
- ✓ *Door to door offered opportunity to improve on other disease surveillance thus leading to the detection of suspected cases of measles*
- ✓ *Social mobilization activities resulted in renewed commitment towards community health programs*

➤ **Outlook of 2016 SMC planning in Ghana**

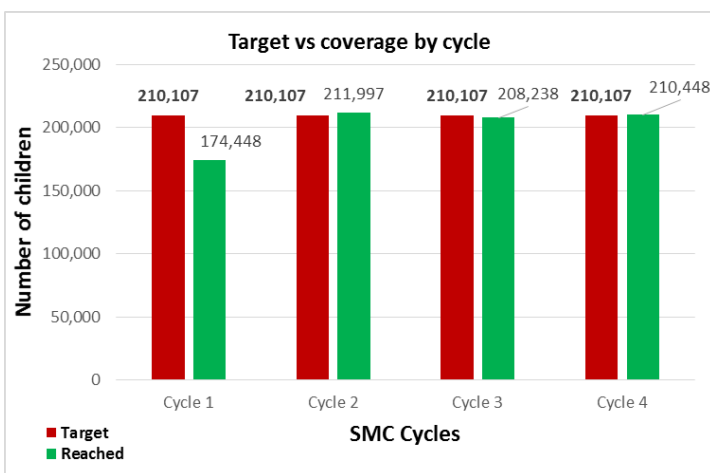
In Ghana the funding/ drugs available is for 2016 SMC campaign is only for two cycles. The number of districts to be covered will be extended to 24 districts in upper east and upper west regions for a total number of 366,768 children aged 3-59 months targeted for the campaign.



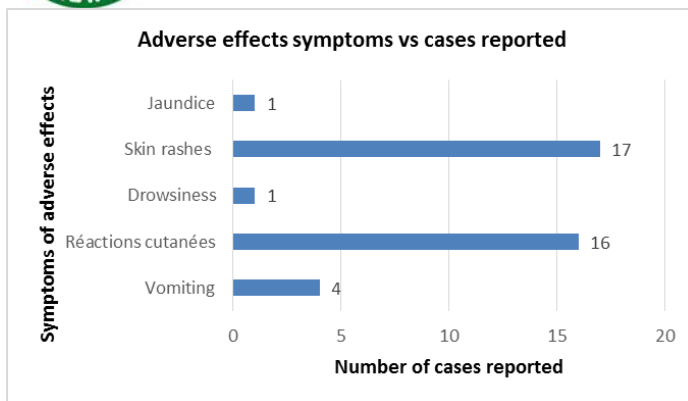
d) GUINEA

➤ **2015 SMC campaign results: challenges and lessons learnt**

Fist SMC campaign conducted in 2015. Six districts in three regions: Boke, Labe and Faranah with a total number of 210,107 eligible children were targeted. Four SMC drugs administration cycles were done in each district. This campaign have been implemented with the technical and financial support of Catholic Relief Services as part of the ACCESS SMC project. The coverage vs target for each cycle is summarized in the graph below.



The pharmacovigilance system has reported the following drug adverse effects by symptoms



The bottlenecks and the lessons learnt during this campaign were:

Bottlenecks

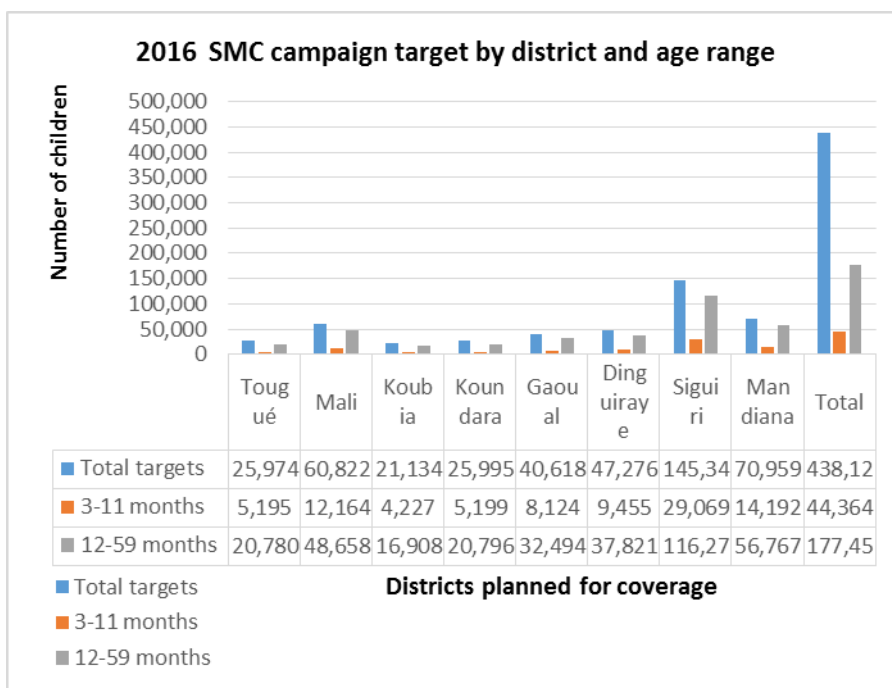
- Delivery of SMC in a context of Ebola
- Difficulties in crushing the pills
- Difficulties in managing drugs adverse effects linked to SMC drugs administrations
- No plan for the management of patients referred by community health workers

Lessons learnt

- ✓ Strong adherence of population
- ✓ Need to involve administrative and health authorities
- ✓ Strong mobilization of the populations due to advocacy

➤ **Outlook of 2016 SMC campaign in Guinea**

For 2016 campaign SMC will be extended to two additional districts in Guinea. The number of district that will be covered during the campaign will be eight with a total number of 438, 123 children targeted. The campaign will be funded by UNITAID ACCESS SMC project through the Catholic Relief Services (CRS).

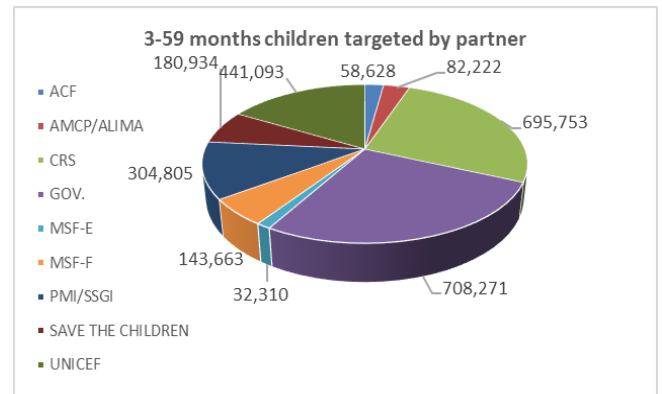
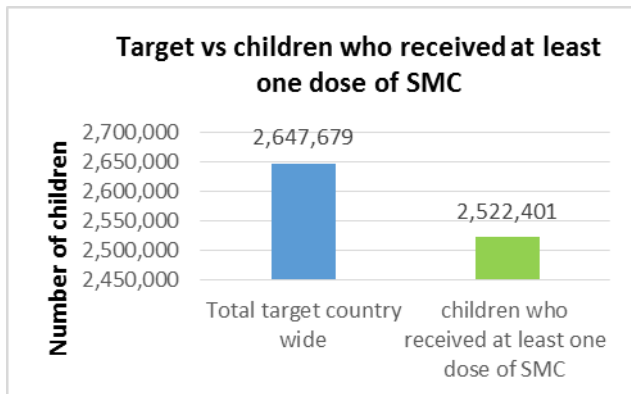


e) MALI



➤ **2015 SMC campaign results: challenges and lessons learnt**

This 2015 SMC campaign has been the third consecutive one in Mali. In 2015 2,647,679 children aged 3-59 months were targeted in 49 regions/districts country wide. The number of cycles planned for each region/district was four but the effective number of cycles done varies from a districts to another because of many constraints. The global results of 2015 SMC campaign in Mali and the partners that supported this campaign are summarized in the figures below.



In terms of pharmacovigilance six minor adverse effects and one serious adverse effect have been reported: the minor adverse effect consisted in abdominal pains (03) and vomiting (03) while the serious one consisted in one anasarca. All drug adverse effects have been registered in vigibase.

The campaign bottlenecks and the lessons learnt were:

Bottlenecks

- Planning difficulties (overlap with other national campaigns cation (NTDs, Vaccination.)
- Insufficient community based mobilization in urban areas
- Insufficient interpersonal communication particularly in the management of adverse effect and the way forward
- Delays in communication the results at all levels
- Insufficiency in adverse effects management

Lessons learnt

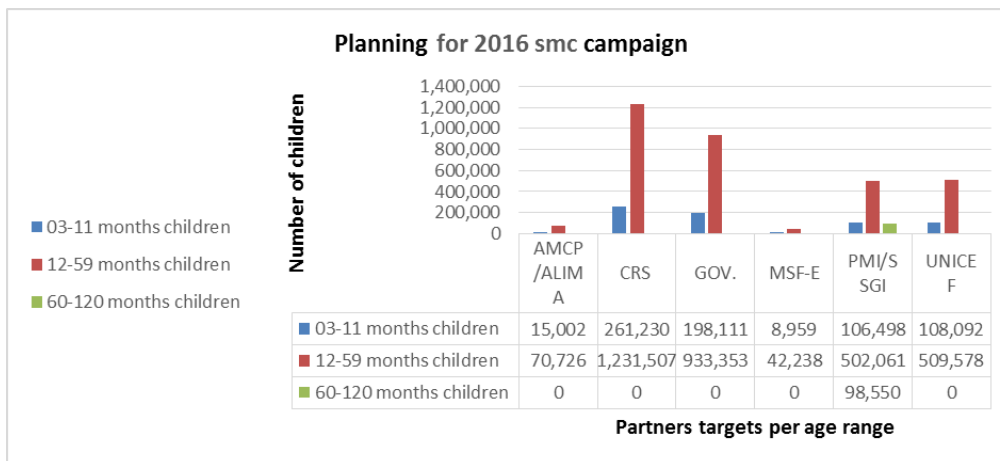
- ✓ Concertation amongst structures involved under the leadership of the Ministry of Health cabinet
- ✓ Use of other ways for mobilization such as mosques and associations,
- ✓ Change of distribution sites during the campaign
- ✓ Radio broadcasting
- ✓ Provision of memory aide to distribution agents
- ✓ Funding support to districts for data collection and transmission

➤ **Outlook of 2016 SMC campaign in Mali.**

For 2016 campaign, SMC planning and implementation will be supported by the same partners as 2015 except ACF, Save the children and MSF France. In total 65 districts country wild an eligible population of 3987355 are planned for coverage. This year's campaign will also extend SMC to **60-120 months** children as a pilot project in 3 districts (Kita, Sefeto and Sagabari). 2016 will also be the first year of World Bank funded Neglected Tropical Diseases and Malaria project implementation which Mali is eligible for.



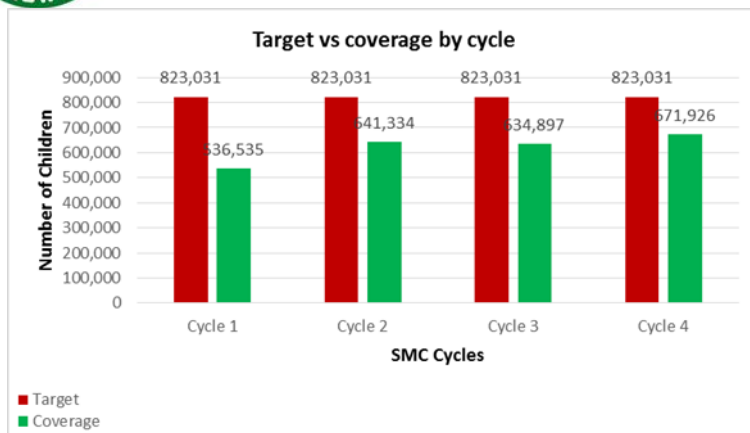
Funding and technical partners	Number of Districts covered	03-11 months children	12-59 months children	60-120 months children
AMCP/ALIMA	2	15,002	70,726	0
CRS	20	261,230	1,231,507	0
GOV.	15	198,111	933,353	0
MSF-E	5	8,959	42,238	0
PMI/SSGI	12	106,498	502,061	98,550
UNICEF	11	108,092	509,578	0
TOTAL	65	697,892	3,289,463	98,550



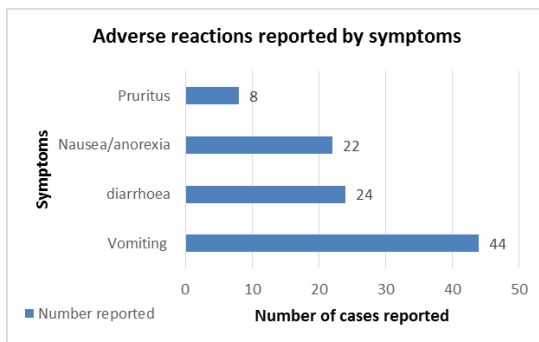
f) NIGER

➤ **2015 SMC campaign results: challenges and lessons learnt**

In Niger, 2015 SMC campaign has been by CRS through UNITAID funded ACCESS SMC project, MSF-Belgium, MSF- France and UNICEF. In addition to the UNITAID Funded ACCESS SMC project, the World Bank will be supporting SMC implementation in Niger in 2016 through the Sahel countries Malaria and Neglected tropical disease project. Four cycles of SMC drugs have been administered in 14 districts and 3 cycles in 2 districts. In total 16 districts with eligible 823,031 children were targeted for the campaign. This year's campaign will be combined with severe malnutrition screening



In terms of pharmacovigilance, only minor effects including vomiting, diarrhoea, Nausea/anorexia, and pruritus have been reported. All the patients showing these symptoms were treated by implementing partners and recovered.



Bottlenecks

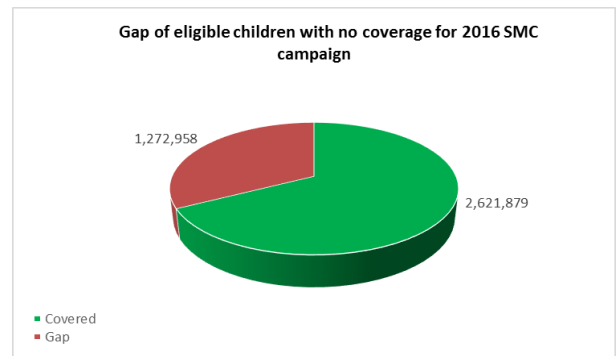
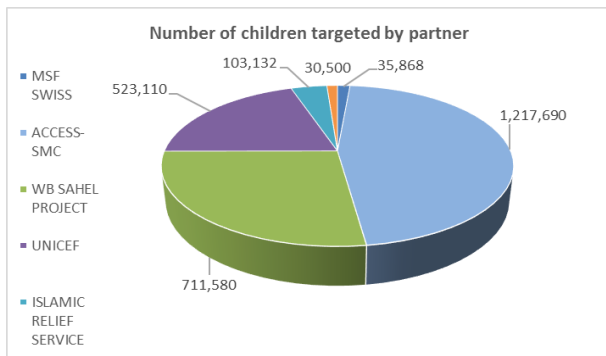
- *Delays in the payment of community health workers (by ASSUSSU);*
- *Distribution point far from beneficiaries ;*
- *In some village, refusal of the populations to go to the distribution points*
- *Micro plans not respected at district level;*
- *Delays in getting the funding available;*
- *Heavy work load of distributor in the field*

Lessons learnt

- ✓ *Involve all partners in planning processes*
- ✓ *Chevauchement des activités (JMC, JNV, Revue PAA)*
- ✓ *Non implication des autorités administratives, coutumières et religieuses dans certain DS/CSI;*
- ✓ *mobilisation sociale est essentielle pour la réussite de la CPS dans certains DS (medias; crieurs etc...);*

➤ **Outlook of 2016 SMC campaign in Niger**

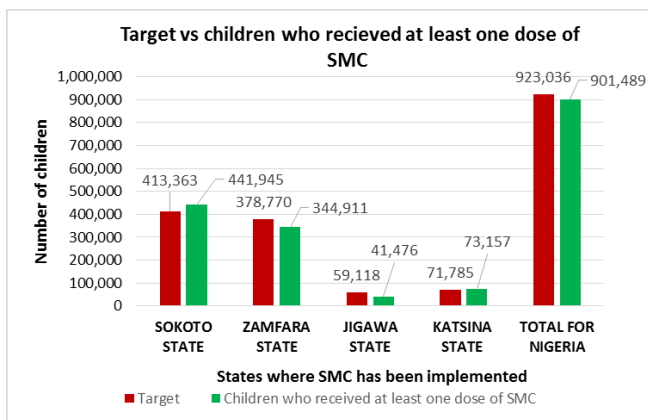
For 2016 campaign 32 districts with 2,621,879 children are planned for coverage.



g) NIGERIA

➤ 2015 SMC campaign results: challenges and lessons learnt

In 2015 SMC has been implemented in three States: **Katsina, Jigawa, Sokoto and Zamfara States** of northern Nigeria. In total, 19 LGAs with 923,036 children have been targeted and four cycles of SMC drugs administration done in each LGAs. In terms of partners, the campaign has been supported by Malaria Consortium through the UNITAID funded ACCESS SMC project and DFID. Because of lack of funding, not all the LGAs in the States have need covered by the campaign.



Preliminary results of surveillance data from Katsina and Jigawa states where no SMC was implemented in 2015 but had benefited from 2013 – 2014 rounds did not show any evidence of rebound in malaria cases. Further analysis are on-going.

The pharmacovigilance system is a weak point. Therefore has it not been able to capture and report all the drug adverse reactions observed during the campaign. Only one minor adverse reaction (vomiting) has been reported which does not reflect the reality in the field.

The bottlenecks and lessons learnt in the campaign were:

Bottlenecks

- Lack of resources to implement in other eligible states
- Difficulty in administering non dispersible SPAQ tablet
- Inadequate Female CHWs to enter restricted households
- Poor reporting of ADR
- Weak support from states and LGAs

Lessons learnt

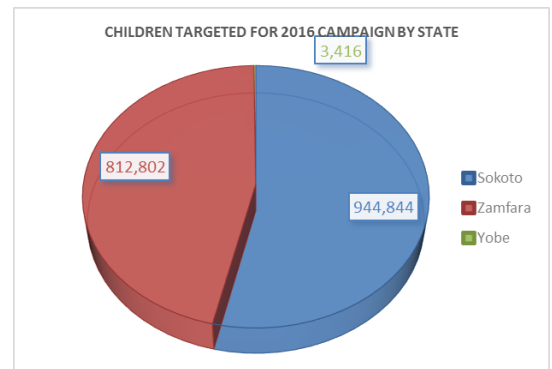
- ✓ Strong acceptance of the intervention contributed to the success of the campaign
- ✓ Early planning and engagement of relevant stakeholders is key to a smooth campaign
- ✓ House to House approach is the most effective delivery approach
- ✓ Town Announcers are the most effective channels of passing MDA information in the areas covered



➤ **Outlook of 2016 SMC campaign in Nigeria**

SMC campaign will cover three states in 2016 namely Sokoto, Zamfara that benefited of the intervention in 2015 and where all the LGAs will be covered. The new State to which the intervention will be extended is Yobe State where only one LGA will be covered. The partners that will support the campaign are Malaria Consortium through the UNITAID ACCESS SMC project for Sokoto and Zamfara. The implementation in Yobe State will be supported by MSF Spain (OCBA) and the Federal Government of Nigeria.

States	Target	3-11 months	12-59 months
Sokoto	944,844	179,520	765,324
Zamfara	812,802	154,432	658,370
Yobe	3,416	751	2,665
TOTAL	1,761,062	334,703	1,426,359

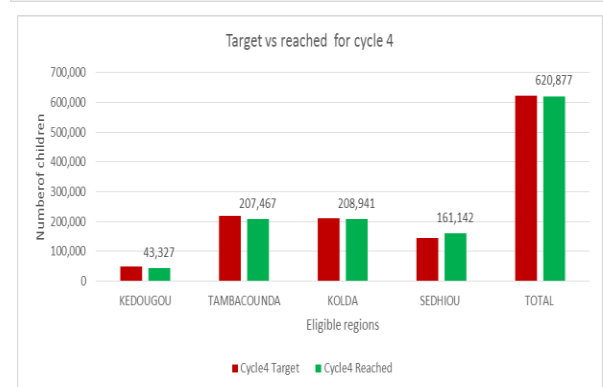
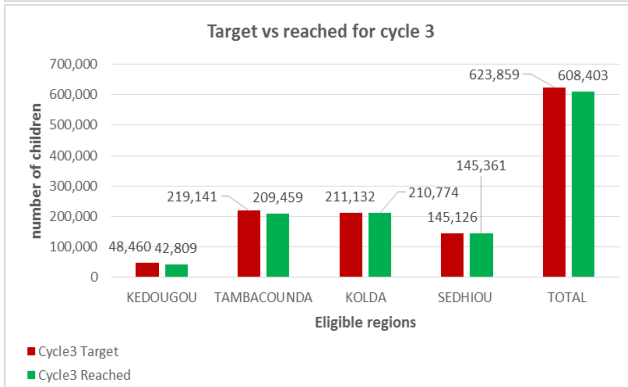
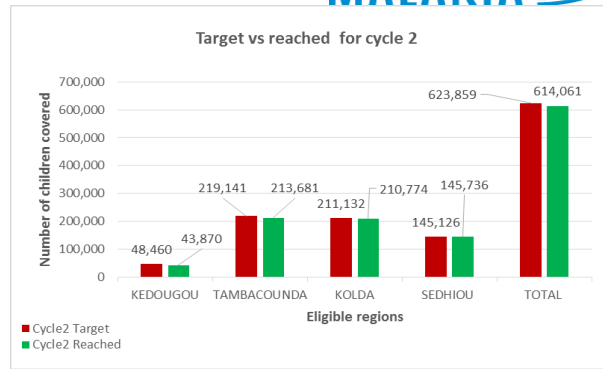
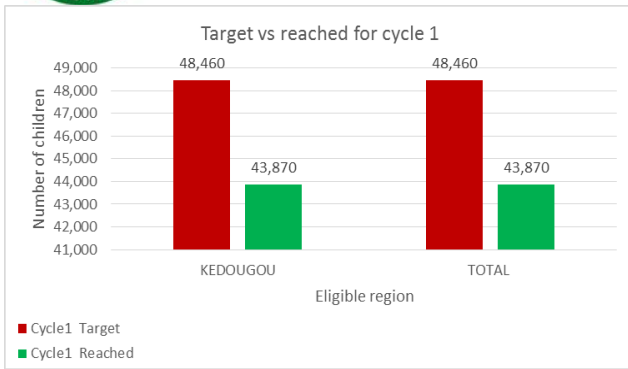


h) SENEGAL

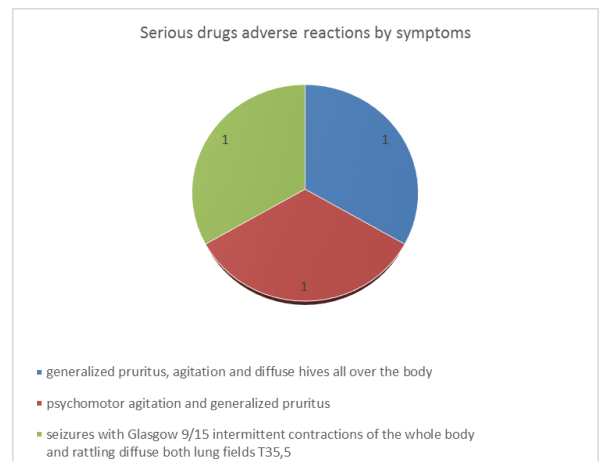
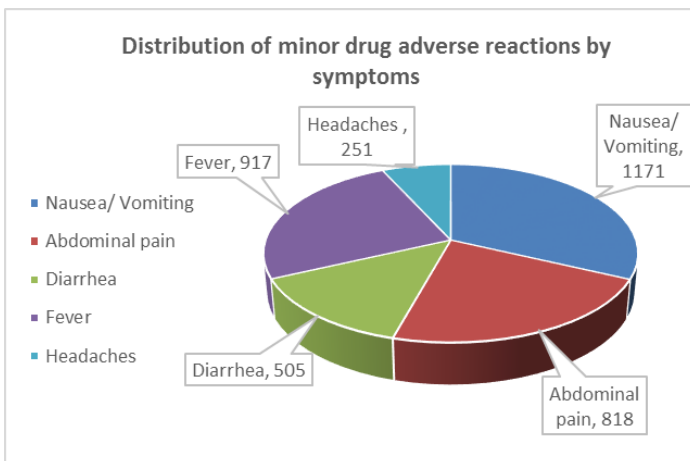
➤ **2015 SMC campaign results: challenges and lessons learnt**

SMC has been implemented in 4 regions: Tambacounda, Kedougou, Sedhiou and Kolda. These four regions represents 16 districts with 623,859 eligible children. The target include up to 120 months children. The decision to extend the intervention to older children is based on the results of epidemiological surveillance studies that have demonstrated that children up to 120 months bear the same risk of getting malaria than 3-59 months children. The risk becomes low for children over 120 months because of their capacity to develop an immunization against malaria parasite. Because of the variety in the duration of the pick of transmissions in the eligible regions, four cycles of SMC drugs administration have been done in Kedougou where the rainy season starts earlier. In the other three regions (Kolda, Sedhiou and Tambacounda) 3 cycles have been done.

Technical Assistance and funding have been received by the Program from USAID/PMI, UNICEF and the Department of Parasitology of the University Cheikh Anta Diop of Dakar (UCAD).



In terms of pharmacovigilance, 3362 minor adverse effects and 3 serious adverse effects have been reported. As of 19 Jul.2106. 1049 have been recorded in vigibase.



For the 2015 SMC campaign in Senegal, there was no bottleneck. However during the campaign some lessons have been learnt:

Lessons learnt

- ✓ Early planning and ordering of commodities is key to the success of the campaign
- ✓ Resources should be made available at the operational level ahead of the campaign start
- ✓ CHW should be trained and supervised on a regular basis
- ✓ Health facilities should you be involved for pharmacovigilance
- ✓ Cases of drugs adverse reactions should be handle and funded by partners implementing SMC. No fees should be requested from benefiting population.



➤ **Outlook of 2016 SMC campaign planning in Senegal**

In Senegal, SMC will be implemented in Senegal in the same regions and districts than 2014 and 2015 campaigns. The number of cycle will also be maintain. The total number of children targeted for 2016 campaign is 640,260 with 3-120 months age range.

Regions	Planning of coverage by age range (months)					Technical and funding partners	Comments
	Districts	Target	3-11 months	12-59 months	60-120 months		
SEDHIOU	3	150,021	19,503	77,511	53,007	PMI/USAID	3cycles(Aug-Oct)
KOLDA	3	213,192	27,715	110,149	75,328	PMI/USAID	3cycles (Aug-Oct)
TAMBACOUNDA	7	226,975	29,507	117,271	80,198	PMI/USAID	3cycles (Aug-Oct)
KEDOUGOU	3	50,072	6,509	25,871	17,692	PMI/USAID	4 cycles (jul-Oct)
TOTAL	16	640,260	83,234	330,801	226,225	PMI/USAID	

i) TOGO

➤ **2015 SMC campaign results: challenges and lessons learnt**

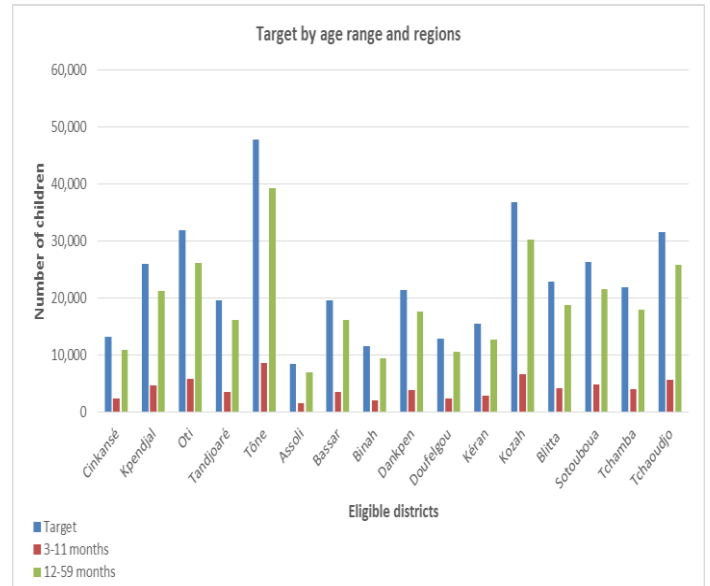
After two consecutive years (2013&2014) of SMC implementation, Togo did not implement the intervention 2015 despite having obtained the required funding and technical assistance for the planning from UNICEF. This is due to the insufficiency of SMC drugs in the global market in quality and quantity. Epidemiological surveillance studies have demonstrated that there is an increase of Malaria cases in 3-59 months children) in the regions that benefited of the intervention in 2013 and 2014.

➤ **Outlook of 2016 SMC campaign planning in Togo**

In 2016 SMC will be implemented in Togo with the technical and funding support from UNICEF and the Global Fund. Three regions: Central region, Kara region and Savanes Regions with 16 districts. The total number of children planned for coverage is 366,667.



Regions	Target	3-11 months	12-59 months
Cinkansé	13,130	2,358	10,772
Kpendjal	25,911	4,654	21,257
Oti	31,834	5,718	26,116
Tandjoaré	19,634	3,527	16,107
Tône	47,862	8,597	39,265
Assoli	8,413	1,511	6,902
Bassar	19,562	3,514	16,048
Binah	11,447	2,056	9,391
Dankpen	21,360	3,837	17,523
Doufelgou	12,849	2,308	10,541
Kéran	15,370	2,761	12,609
Kozah	36,807	6,611	30,196
Blitta	22,834	4,101	18,733
Sotouboua	26,278	4,720	21,558
Tchamba	21,841	3,923	17,918
Tchaoudjo	31,535	5,664	25,811
Total	366,667	65,860	300,747



The country presentations have been followed by discussions in plenary session. The key point of the discussions include:

- The estimation of targeted population in a difficult context: Some countries maintain the same cohort of children for all cycles while other update the number of children targeted for each cycle
- Smooth transition of major SMC scale up project ending soon
- The combination of SMC with other community based public health interventions
- The combination of dispersible and non-dispersible SMC drug for 2016 campaign in some countries
- The harmonization of partners intervention with the National Malaria control programs in SMC eligible areas
- The promotion of drug loans between countries to avoid delays in the intervention implementation
- SMC drugs adverse reaction case management
- The resources mobilization to fill the gaps

3. Updates on UNITAID Funded ACCESS SMC project

- 2016 SMC campaign will be last year of SMC planning and delivery supported by UNITAID funded ACCESS SMC project in the 7 countries covered.
- The third year of the project (2017) will be dedicated to the project impact evaluation
- The total number of treatment purchased by the project will increase from 14.7 million treatments in for 2015 campaign to 30 million treatments in 2016 and the number of children targeted by the project in the its operating countries doubled.
- The number of WHO approved SMC treatment courses has been increased from 16.8 million treatment courses in 2015 campaign to 67 million treatment courses for 2016 campaign



- A child friendly dispersible formulation has been introduced in the market for 2016 campaign and beyond.
- Continuous increase of administrative coverage across cycles in the countries and districts where SMC delivery has been supported by the project.
- Presentation of the Access SMC Online quantification tool dedicated to helping countries, SMC supporting and private sector partners decision making.

4. Monitoring and Evaluation research in SMC eligible countries and Senegal

The UNITAID ACCESS-SMC project is doing extensive monitoring in 7 countries (Burkina Faso, Chad, Gambia, Guinea, Mali, Niger, Nigeria) and an SMC Welcome Trust / PMI funded monitoring project in Senegal is using essentially the same methods since 3 years. Ghana and Togo should come on board by using same protocols for morbidity surveillance and drug resistance with sentinel's sites, case control studies for SMC efficacy, passive pharmacovigilance and coverage with household surveys. However, longer term monitoring is needed, funded independently since SMC implemented by a patchwork of partners and funding agencies and therefore difficult to coordinate monitoring and to standardise sampling methods.

5. UNICEF SMC activities

UNICEF has been strongly committed in supporting SMC planning and implementation since its recommendation by the WHO in 2012. Many countries including Burkina Faso, Chad, Guinea, Guinea Bissau, Mali, Niger and Senegal received technical support and funding for SMC from UNICEF. However the Organization does not have specific budget for SMC but rather tries its best to fill funding and provide technical support in the development of normative documents and planning the intervention. Therefore, SMC eligible countries are strongly encouraged to approach UNICEF country offices and inform them on the gaps that they may have in SMC for both operational costs and drugs. They may also require Technical Assistance for SMC planning and implementation from UNICEF.

Conclusion and recommendations

The special session on SMC have been a good opportunity for all implementing countries to present their results, bottleneck and challenges and share experience and best practices. For partners it has also been an opportunity to better understand countries expectations in terms of support and SMC activities regional level coordination. Form the presentations and discussions the key areas that for which countries need supports include: The estimation of target population for SMC, the setup of a sound pharmacovigilance system, the coordination of partners interventions, the strengthening of SMC activities coordination at regional level and the availability of WHO approved drugs in sufficient quantity to meet the demand.



SMC Special Session recommendation

Before the session closure, the following recommendations have been made

- ❖ WARN&CARN SMC Working Group to be part of the World Bank funded Neglected Tropical Diseases and Malaria project steering committee
- ❖ The Seasonal Malaria Chemoprevention is a valuable intervention for malaria control in < 5 and under 10 years old children. No significant resistance to SMC drugs is anticipated before 5 to 10 years. Therefore, SMC eligible countries governments and partners are encouraged to rapidly scale up the intervening where suitable.
- ❖ SMC eligible countries and supporting partners to strengthen coordination of SMC planning and delivery in order to ensure the coverage of districts that benefited of the intervention in the past before extending to new districts as per WHO recommendations for SMC planning, implementation and Monitoring & Evaluation
- ❖ WARN, WAHO and the other partners should make a strong advocacy for the adoption and reflexion of SMC in Benin Malaria control policy documents for the northern part of the country bordering Burkina Faso and Niger and therefore shares the same criteria of eligibility.
- ❖ A strong advocacy should be made by countries and partners to ensure WHO recommended SMC drugs in sufficient quantities for countries not part of scale up projects such as ACCESS SMC project and the World Bank Neglected Tropical Diseases and Malaria Sahel project
- ❖ Partners to help countries in strengthening SMC pharmacovigilance systems and funding for harmonized M&E activities
- ❖ For a maximum coverage, door to door, fix point and mobile distribution strategies should be combined
- ❖ WARN SMC Working Group should to help with information sharing among SMC countries to facilitate and encourage drug loans between countries