

June 2021

Ranking of SMC spending opportunities

1. Implement a “basic” SMC delivery model¹ following current WHO policy recommendations² in areas of Burkina Faso, Chad, Nigeria and Togo where SMC implementation started within the last two seasons (to ensure continuous SMC implementation for a minimum of three years);
2. Implement a “basic” SMC delivery model following current WHO policy recommendations in *all areas* of Burkina Faso, Chad, Nigeria and Togo currently supported by Malaria Consortium’s SMC programme;
3. Continue to implement a “high-quality” SMC delivery model³ following current WHO policy recommendations in all areas of Burkina Faso, Chad, Nigeria and Togo currently supported by Malaria Consortium’s SMC programme for which alternative funding sources are not available;
4. Test the protective efficacy of SMC in Mozambique and Uganda, using a “high-quality” delivery model and conducting appropriate research;
5. Assuming positive research results, support the phased scale-up of SMC to eligible areas in Mozambique and Uganda for which alternative funding sources are not available;
6. Support expansion to new geographies in Nigeria for which alternative funding sources are not available (where endorsed by national malaria control programmes and eligibility based on robust stratification data);
7. Support implementation of five monthly SMC cycles in areas supported by Malaria Consortium’s SMC programme in Burkina Faso, Chad, Nigeria, Togo, Mozambique and Uganda (where endorsed by national malaria control programmes and eligibility based on robust stratification data);
8. Support the gradual scale-up of digital platforms in areas supported by Malaria Consortium’s SMC programme in Burkina Faso, Chad, Nigeria, Togo, Mozambique and Uganda;
9. Assuming positive research results in Mozambique and Uganda, support research and gradual scale-up of SMC in other suitable areas of East and Southern Africa for which alternative funding sources are not available;

¹ Basic SMC delivery would be limited to procurement of medicines and essential commodities, as well as payments to SMC implementers. Planning, training, supervision and monitoring would be limited to essential activities.

² WHO currently recommends four monthly cycles of SMC during the peak malaria transmission season, targeting children 3-59 months in areas where on average more than 60% of clinical malaria cases occur within a maximum of four months (characterised by more than 60% of the average annual rainfall falling within three months).

³ High-quality SMC delivery involves quality assured and more intensive planning, training, supervision and monitoring. It also involves community engagement and evaluation (for example in the form of coverage surveys). Malaria Consortium currently uses a “high-quality” implementation model across our SMC programme.

10. Allocate around 3% of the annual philanthropic SMC budget to SMC-related research;⁴
11. Allocate around 1% of the annual philanthropic SMC budget to SMC-related external relations;
12. Support expansion of SMC to older children in areas supported by Malaria Consortium's SMC programme in Burkina Faso, Chad, Nigeria, Togo, Mozambique and Uganda (where endorsed by national malaria control programmes);
13. Expand Malaria Consortium's SMC programme to support a "high quality" SMC delivery model to areas not mentioned above.

⁴ Note that conducting research on the protective efficacy of SMC in Mozambique and Uganda has been allocated a higher priority, i.e. this statement refers to increasing the research budget further up to a limit of around 3%.