This document provides malaria programme implementation guidance for National Malaria Control Programmes and partners in support of the development of Concept Notes to be submitted to The Global Fund.

Malaria Implementation Guidance in support of the preparation of Concept Notes for the Global Fund

Roll Back Malaria Harmonization Working Group

2014

Abbreviations

ACT	-	Artemisinin-Based Combination Therapy
AMP	-	Alliance for Malaria Prevention
ANC	-	Antenatal Care
BCC	-	Behaviour Change Communication
CBO	-	Community-Based Organization
CCM	-	Country Coordinating Mechanism
CSO	-	Civil Society Organization
CSS	-	Community Systems Strengthening
FBO	-	Faith-Based Organization
GPARC	-	Global Plan for Artemisinin Resistance Containment
GPIRM	-	Global Plan for Insecticide Resistance Management
HSS	-	Health Systems Strengthening
HWG	-	Harmonization Working Group (of Roll Back Malaria)
iCCM	-	integrated Community Case Management
IDP	-	Internally Displaced Person
IPTi	-	Intermittent Preventive Treatment in Infants
IPTp	-	Intermittent Preventive Treatment in Pregnancy
IRS	-	Indoor Residual Spraying
ITN	-	Insecticide-Treated Net (used interchangeably with LLIN)
LLIN	-	Long-Lasting Insecticidal Net (used interchangeably with ITN)
M&E	-	Monitoring and Evaluation
MNCH	-	Maternal, Newborn and Child Health
MPR	-	Malaria Programme Review
NGO	-	Non-Governmental Organization
OCHA	-	Office for the Coordination of Humanitarian Affairs
PR	-	Principal Recipient
PSM	-	Procurement and Supply Management
RBM	-	Roll Back Malaria
RDT	-	Rapid Diagnostic Test
SMC	-	Seasonal Malaria Chemoprevention
TRP	-	Technical Review Panel
VfM	-	Value for Money
VPP	-	Voluntary Pooled Procurement
WHO	-	World Health Organization
WHOPES	-	WHO Pesticide Evaluation Scheme

Notes on Document Organization

Links to document locations on the internet are included for convenience and follow up. All documents referred to and available are also included in the accompanying library for each referenced section. Footnotes are included as endnotes at the end of the document except for context-specific clarifications.

Contents

Purpose of this Document

This document summarises key implementation guidance from the RBM partnership and complements the normative technical guidance from WHO. The document is designed to provide key background information and implementation guidance for countries completing their New Funding Model Concept Notes.

Recommendations for Filling out Concept Notes

The following items reflect lessons learned collected by the Harmonization Working Group from past experience with the development of Global Fund applications.

- **Guidelines**. We strongly suggest that you keep the Global Fund Concept note development guidelines and other supporting guidance documents by your side at all times, and refer to them often. Please also use the checklists provided for you in the concept note template

Link to the Concept Note Form and Guidance

- **Gap Analysis**. We strongly recommend that a comprehensive gap analysis is carried out during preparation of the concept note. We have found from past experience that this helps with prioritization of activities and identification of needs and gaps. This gap analysis should include an explanation of the key underlying assumptions and should be attached in annex to the proposal. Tables should summarise all interventions for which funding is being requested, such as long-lasting insecticidal nets (LLINs), artemisinin-based combination therapy (ACTs), rapid diagnostic tests (RDTs) and microscopy supplies, Seasonal Malaria Chemoprevention (including estimates of need for sulfadoxine pyrimethamine + amodiaquine (SP-AQ), indoor residual spraying (IRS), integrated Community Case Management (iCCM) (including costs for community health worker programmes) and additional programme requirements such as monitoring and evaluation, programme management and behaviour change communication. Countries identify needs, what is already financed and gaps in coverage. All numbers in this table should relate to the size of the population groups targeted or number of commodities required, not the financial need for the interventions. A programmatic and financial gap analysis is now a compulsory component of the malaria concept note (see HWG gap analysis guidance and iCCM gap analysis in the Library).
- **Universal coverage**[1]. Countries should budget for 100% coverage of LLINs and/or IRS and full access to case management including diagnostic testing and treatment. This same principle holds for interventions targeting specific groups, e.g. IPTp and SMC.
- **Comments from Technical Review Panel (TRP).** It is essential that each country directly responds to the comments made by the TRP from the last Global Fund submission and from the Global Fund secretariat during more recent phase 2 negotiation processes.
- **Impact of prevention coverage on ACT forecasting**. After the 100% vector control utilization target is reached, countries should budget for reductions in ACT consumption. Where in-country data exists, we strongly recommend that this should be used for quantification of commodity needs. Where data are unavailable, as an interim recommendation, we suggest a 10% reduction in ACT

[1] Universal coverage means access to, and use of, LLINs or IRS.

procurement for the year following the achievement of universal coverage. Assuming coverage is maintained, 20% reduction can be assumed for the year after that, and 30% the year after that. This is an interim solution recommended by the RBM Harmonization Working Group. It is recommended that countries collect data to refine forecasts in future years.

- **Reducing ACT consumption as a result of increased parasitological diagnosis**. Increases in parasitological diagnosis will decrease ACT consumption. This must take into account slide positivity rates and parasitological diagnostic testing coverage. See gap analysis for additional information.

- **Reducing ACT consumption as a result of Seasonal Malaria Chemoprevention (SMC)**. Countries should factor in a reduction in ACT consumption in areas targeted with SMC (at least 50% reduction of malaria fever in children less than five years of age once universal coverage of SMC is planned and implemented). The percentage reduction in ACT consumption may differ by sector. For example if the public sector has reached greater coverage and uptake of diagnostics compared to that of the private sector, it is expected that different reductions will be made to ACTs across the two sectors.

- **Selection of Principal Recipients**. Although dual track financing is not a requirement, it is recommended by the Global Fund and must be well justified where this is not selected.

Link to Dual Track Financing Information Note

- **Presentation of the Concept Note**. The TRP takes, on average, three hours to read and decide on each submission. Graphs, maps, and visuals are effective ways of communicating information to the TRP, and helps avoid any translation errors. The executive summary is also a vital resume and should be the last section prepared in order to capture all final figures and proposed interventions. Please note that any changes (last minute) made in any section of the Concept Note should be updated accordingly in the executive summary.

- **The concept note asks specific questions about human rights and gender equality, and how these may affect access to health services**. To ensure concept notes are robust, these questions should be answered based on consultation with domestic or regional experts in these areas, and with representatives of communities who are directly affected by malaria, during the country dialogue. To achieve maximum impact, national disease programmes should be based on consultation with affected communities and programmes should be adapted to meet their specific needs and to respect their rights. The Global Fund's information notes on human rights, gender equality and Community System Strengthening (CSS) can provide additional guidance. Global Fund country teams may also be able to assist applicants in obtaining technical support in these areas.

- **"Value for Money (VfM**)" should be considered throughout the concept note development process. The concept of value for money represents the maximum benefit over a defined time period with the resources available. This can be segmented into three components:
  - **Effectiveness** - describes the ability of a program to achieve its outcome and impact objectives, while also considering equity, quality, and sustainability,
  - **Efficiency** - implementing activities at the minimum possible cost, through minimizing the cost of inputs and maximizing the productivity of resources,

- **Additionality** - indicates whether the financing requested is non-duplicative and will produce additional outcomes beyond what is possible with existing resources.

Link to Value for Money Information Note – Global Fund

- **Ongoing Country Dialogue** Country dialogue is a process that is country-owned and led, which forms part of and builds upon existing coordination mechanisms in health and development that are already taking place in many countries between governments, donors, technical partners, civil society, and key affected and most-at-risk populations. Country coordinating mechanisms (CCMs) take a leading role in coordinating the discussions around the submission of the Global Fund concept note. Work on national strategies and resource mobilization should be ongoing and form the basis of this country dialogue to identify a country's prioritized needs and ultimately prepare the submission of concept notes to the Global Fund. **It is essential that funding for malaria is maintained** commensurate to the disease burden within the country. The Harmonization Working Group (HWG) stands ready to provide support to countries during the country disease split discussions, to ensure that a strong case is made for sustaining resources for malaria control.

Objectives, Targets and Milestones

In 2011, RBM adopted new objectives, targets and milestones for 2011-2015. The two main objectives of relevance are: Reduce global malaria deaths to near zero by end 2015; and reduce malaria cases by 75% by end 2015 (from 2000 levels). RBM recommends that the new targets and milestones be referenced in the concept note.

The key driver of reducing deaths to near zero will be achieving universal access to diagnostic testing and treatment. In the public sector this implies procuring sufficient RDTs, microscopy and ACTs. In some countries, as many as 30% of malaria cases are diagnosed and treated at the community level. Full access therefore also requires achieving universal access to case management of malaria at community level. While many applicants have already been concentrating on the public sector (at least to health facility level), extending service provision to the community level may be relatively new for some. In countries where private sector service delivery is significant additional measures may be needed to assure access through the private sector.

With regard to the second objective (reduction of cases), all countries have been driving toward universal coverage with preventive measures, especially LLINs. Enough preventive interventions (LLINs/IRS) should be built into the proposal to fully sustain universal coverage or to achieve it where this goal has not yet been reached. Where universal coverage has been achieved, it will be important to convey a clear strategy for maintaining universal coverage.

Increasing evidence of artemisinin and insecticide resistance means that, in order to achieve the targets by 2015, it will be important to establish routine resistance monitoring. Funding should be built into the proposal for monitoring artemisinin resistance, in accordance with the Global Plan for Artemisinin Resistance Containment (GPARC), as well as insecticide resistance monitoring and management in accordance with the Global Plan for Insecticide Resistance Management (GPIRM).

The Roll Back Malaria Partnership is currently updating the Global Malaria Action Plan, to be called - *GMAP II*. The plan may eventually present revised targets but the current targets should continue to be used until GMAP II is available in 2015.

National Strategic Plans

The Global Fund strongly encourages countries to base funding requests on quality national strategic plans developed through national systems. National strategic plans should be developed using an inclusive, multi-stakeholder process and should be jointly assessed through a credible, independent, multi-stakeholder process that uses internationally-agreed frameworks. The Global Fund's New Funding Model relies heavily on the availability of technically sound, validated National Strategic Plans.

Many countries have existing National Strategic Plans for malaria on five-year planning cycles that began in 2010 and several have implemented a mid-term review in the past year. The Concept Notes should reflect clearly, and be consistent with, the relevant National Strategic Plans for the proposed implementation period. Since the National Strategic plans have gone through a rigorous process of review prior to development and validation by all the partners in-country it will be important to use the plan as an anchor for adding legitimacy to the concept notes. For some countries it may be necessary to extrapolate the plan for an additional year to fit with the 2014-2016 timeline of the concept notes. It is important to note that annual reprogramming will allow flexibility in the implementation of the programme outlined in the concept note, especially for countries that need to extrapolate their existing strategic plans. If the Concept Note deviates from the Strategic Plan it will be extremely important to provide a solid rationale for the deviation and explain how and why the National Strategic plan is not followed. It will be important to justify the difference and address related technical issues and partnership buy-in to the changes in order to overcome expectations that the Concept Note will reflect the National Strategic Plan. Clearly the landscape for malaria control is changing rapidly, both in terms of the technical and financial resources available, and the epidemiology. If these represent valid reasons for deviations from the strategic plan then they should be cited and related evidence and analysis should be provided. The HWG will provide an opportunity for peer review of National Strategic Plans in the coming months.

Where a country does not have a national strategic plan, or where one is no longer current, then an investment case may be presented in the concept note in support of the funding request, with a plan of action on how and when the NSP will be completed.

Key Implementation Issues

Vector Control

Universal coverage with LLINs or IRS remains the goal for all people at risk of malaria

Long Lasting Insecticidal Nets (LLINs)

In order to maintain universal coverage of LLINs, countries should apply a combination of mass, free LLIN distributions and continuous free distributions through multiple channels, in particular antenatal and immunisation services. Mass campaigns should be repeated normally at an interval of three years unless there is reliable observational evidence that a shorter or longer interval could be appropriate. Continuous distribution channels should be functional before, during, and after the mass distribution campaigns to avoid any gap in universal access to LLINs.

WHO recommendations for achieving universal coverage with LLINs

Campaign Distribution of LLINs

Quantifying needs for procurement

WHO and the HWG recommend that in planning LLIN procurement quantities, the aim should be to distribute enough LLINs to achieve 100% coverage of the entire population at risk of malaria with 1 net for every 2 people (where other vector control interventions are not being implemented). Countries should develop a clear plan as to how this is to be achieved. When carrying out a universal coverage campaign, nets should be given to households at the rate of 1 net for every 2 household members, rounding up in the case of an uneven number of people. The procurement ratio must be adjusted to allow for this rounding up, and this implies a quantification factor of population/1.8.

Recent experiences in a number of countries suggest that campaigns targeted to vulnerable groups only followed by a "mop-up" campaign at a later time present tremendous challenges in quantification and implementation and should be avoided if possible. WHO is currently preparing guidance on targeting LLINs in resource-limited settings.

Population coverage <40% or information not available: Where population coverage with LLINs less than 24 months old is below 40%, or where population coverage cannot be estimated through an existing net tracking system but is assumed to be low, existing LLINs should not be taken into account and mass distribution quantification should be based on the 1 LLIN to 1.8 persons calculation.

Population coverage > 40%: Where surveys or other data indicate that population coverage levels of LLINs less than 24 months old are estimated to be above 40%, a more detailed quantification for net procurement should be conducted. The quantification methodology should consider the following factors: estimated numbers of previously distributed LLINs nets over the past 2 years, by year, preferably by district; likely condition of LLINs accounting for loss at the rates described in the table below based on the age of the net.

Loss rates of nets. Several studies on the durability and effective life of different nets in different settings are currently underway based on the recently published WHO guideline. Countries that have specific data on the viability or durability of nets in their country can use this to estimate number of viable nets and remaining life. Where there is no country-specific data, rates of loss can also be calculated as 8% of the distributed nets during the first year since distribution, 20% during the second year, and 50% during the third year. After three years, nets should no longer be considered viable. The rates of loss presented here are estimates based on data currently available, and may change over time as more data become available.

Example Calculation for 2014

Year Nets Distributed	2012	2013	2014
Quantity Distributed through ANC/EPI	50,000	100,000	10,000
Quantity Lost by 2014	50,000*.5=25,000	100,000*.2=20,000	10,000*.08= 800
Proportion remaining available in 2014	1 - 0.5=0.5 (e.g. 50% loss)	1 - 0.2=0.8 (e.g.20% loss)	1 - 0.08=0.92 (e.g. 8% loss)
Nets existing each year by 2014	25,000	80,000	9,200
Total existing nets 2014			114,200

Countries should include in their work plans, and funding requests to the Global Fund, the collection and analysis of data on LLIN survival according to recent WHO recommendation and guidance.

WHO guidance on LLIN Longevity

Quantifying population coverage where no survey data are available

In situations where no survey data are available to provide LLIN coverage information, it may be necessary to calculate estimated population coverage in order to make quantification and procurement decisions.

1. Calculate the quantity of LLINs remaining that was distributed through the continuous system or through a recent campaign as per the above example.
2. Once the number of existing nets has been determined (in the example above, 114,200 LLINs are remaining in 2014), it should be multiplied by 1.8 to estimate the number of people covered (114,200*1.8 = 205,560).
3. The percentage of the population covered is estimated by dividing the nets remaining (114,200) by the total population divided by 1.8 (2,000,000/1.8) and multiplying by 100 (= 10%).
4. In this example, with 10% population coverage, the country should ignore existing nets and calculate needs for procurement by dividing the total population by 1.8.

Accounting for existing nets: In some cases, such as when a targeted campaign has recently taken place or population coverage with LLINs is expected to be >40% coverage of LLINs less than 24 months old, it may be necessary to account for existing nets during the household registration exercise. In these cases, countries are advised to undertake an assessment to determine the actual situation with previously distributed nets. The assessment allows for a data-driven decision on whether accounting for existing nets will be cost-effective given the number of LLINs expected in households and the percentage actually found and in good condition; and, where the percentage of nets found in good condition is high enough that accounting for existing nets is thought to be cost-effective, it allows for a better means of quantification based on the percent of nets found versus what would have been expected according to the predicted loss rates presented above.

Key lessons learnt for planning and budgeting

The Alliance for Malaria Prevention toolkit for planning and implementation of mass LLIN distribution campaigns is available at:
www.allianceformalariaprevention.com/resources.php.

Coordination

- Key planning meetings should be budgeted for, including early and regular coordination between central and peripheral levels (e.g. travel for participation in meetings, costs for phone/email communication.
- In general at least three core sub-committees, which report to the national coordinating committee, will be needed: technical (including M&E), logistics and communications.

International procurement

- Consider ordering nets that are not individually wrapped, but wrapped in bales for campaigns to avoid managing waste generated by plastic net packaging.

- Rectangular nets should be procured for campaigns unless there is country-specific evidence that conical nets will significantly increase utilization. Selection of conical nets will require strong, independent justification, which may lead to delays in procurement pending approval from the Global Fund.
- To avoid having to split bales early in the supply chain, procure bales of 50 or 25 that can be kept intact beyond the district level.
- Ensure that activities such as advertising the call for tenders, publishing results of bid analysis, meetings of procurement committees etc. are planned and budgeted.
- Allow sufficient time for quality assurance of net batches prior to shipment.
- Ensure all international procurement is done at the same time to ensure materials are available well before the campaign. This may include materials for hang up (such as strings and nails, which can be packaged with the nets if included in the LLIN specifications).
- Based on past campaign experiences, quality of population data and available storage at central and peripheral levels, determine net delivery locations. Consider delivery by the supplier to lower levels of the supply chain (e.g. region or district). Where there are concerns regarding the validity of population figures, and pre-positioning of LLINs will be based on household registration data, delivery should be to a central warehouse or only decentralized to regional level to allow for adjustments in quantities to lower delivery points as data is collected.
- If storage is a major problem, consider purchasing containers in which the nets have been transported. When planning procurement, adjust the number of bales to match the container's capacity.

Logistics

- If costs for clearing customs and initial warehousing are not the responsibility of the supplier as part of the LLIN procurement, they need to be included in the logistics budget. Port costs will vary and scanning of containers, container inspection, administrative fees and insurance should all be considered.
- Countries are responsible for the goods acquired using the Global Fund financing and should ensure that they have reviewed the Standard Terms and Conditions for grant agreements, particularly article 20, which refers to "insurance and liability for loss, theft or damage". Countries should ensure that insurance for LLINs acquired is planned and budgeted for during transport and storage.[2]
- Plan and budget to rent warehouses, to make small repairs to warehouses (compliant with international standards if they are being used to store Global Fund-funded nets) and for payment of warehouse managers and security staff for the duration of the storage period at each step in the supply chain.
- Plan and budget for identification and training of logistics focal points and warehouse managers at each step in the supply chain (e.g. regional, district, health facility). All personnel will need to be trained to ensure that they are familiar with and can properly use the tracking tools (waybills, stock sheets, etc.) to ensure accountability throughout the entire logistics operation. Ensure that the costs of printing the tracking tools (e.g. waybills, stock sheets) are included.

[2] This may be done by including insurance as a requirement in the call for tenders for transport or storage (copies of the insurance documents should be submitted with bids), or by undertaking a call for tenders specifically for all risk property insurance and comprehensive general liability insurance with financially sound and reputable insurance companies.

- Supervision and verification missions for the central logistics team and the regional/district logistics personnel are key to ensure adequate management. Plan and budget for all transport of LLINs, including: (1) repositioning of nets at regional or district level based on household registration data; (2) repositioning of nets during the LLIN distribution (in case of over or understocking in certain areas, population movements, etc.); and (3) reverse logistics at the end of the distribution to move nets back up the supply chain.
- Commodity management assessment, to examine the effectiveness of the training and the tools for monitoring LLIN movement through the supply chain and assessing any losses, should be planned and budgeted for from the outset.

Microplanning

- Budget for micro planning (including training) for all levels (central, regional, and district) to ensure accurate information is collected from the operational level and verified. Microplanning should take place early (4-6 months before distribution).
- Microplanning budgeting should include: (1) training of the central level team that will be supporting the workshops at the peripheral levels; (2) transport of the central level team to the peripheral level; (3) any costs for collection of data from the lowest level (e.g. health post); (4) participation of peripheral MoH and partner staff in the micro planning workshops; (5) management of microplanning templates; (6) validation of microplans and budgets at the central level; (7) communication of final budgets to district or operational level.
- Microplanning for the household registration is very important to accurately determine the number of personnel required based on the local context, including accounting for hard-to-reach or isolated areas and populations.

Communication

- Communication (advocacy, social mobilization, behaviour change communication) is a necessary part of a successful campaign, before, during and after the campaign (pre-household registration through to post-distribution net hanging, care and repair). A rational communication plan should be developed based on local evidence and data.
- For effective communication, plan and budget for training and job aids to ensure that messages are clear and consistent.
- Include planning for production and dissemination of mass media materials (radio, banners, etc.), Pre-testing of communication materials is essential and should be included in the plan, timeline and budget.
- Supervision and monitoring are important to assess the reach and effectiveness of communication activities and should be budgeted for appropriately.

Household registration / beneficiary identification

- For stand-alone universal coverage campaigns not using a door-to-door distribution include funding for household registration/beneficiary identification (normally door-to-door registration of households).
- Add a 10% margin of error to the estimated number of households in the macro planning (to be refined during micro planning). This Use urban and rural household size for more accurate macro planning.
- One person (or team) can cover 20-25 households per day in rural areas and 25-30 households in urban areas. Registration needs in urban areas are significantly different from rural areas, and it can take much longer than

anticipated. Be sure to budget for the training of all personnel involved. Determine the number of training days and ensure that there is sufficient time for practical exercises with data collection and summary tools. Budget for whatever method will be used to identify beneficiaries during the distribution (e.g. vouchers, bracelets or other means).

- Plan and budget for chalk, stickers or cards that can be used to identify visited households to avoid duplication.

Distribution

- The number of people required for the distribution will depend on the distribution strategy: For door-to-door distribution, estimating the number of personnel required should be based on the recommendations above for the household registration; For fixed site distribution, it is recommended that urban sites have a minimum of six persons (including increased security personnel for crowd control) and rural sites have a minimum of four persons.
- Budget for crowd control. If necessary, include rope and sticks in the budget to create organized lines for maintaining order. Security/police enforcement in urban areas may be necessary.
- Ensure that there is a separate training for the LLIN distribution (independent of household registration to ensure correct use of data collection tools and clear and consistent messaging to beneficiaries.
- Plan and budget for necessary tools at distribution sites (cutting instruments for metal around bales, scissors, boxes for collection of vouchers, wristbands or other identification, etc.).
- If LLINs are not procured “naked” or with biodegradable packaging, plan and budget for waste management (disposal or destruction).

Supervision, monitoring and data management

- Include sufficient quantities of data collection and summary tools for each level (volunteer, supervisor, health facility, district, region, and central) in the budget.
- Supervision is key to ensure quality implementation as well as to take immediate corrective action where data collection forms are not being filled correctly. Plan for supervisionand budget appropriately.
- Monitoring is important to ensure coverage of all households during registration and participation of households during the LLIN distribution. Plan and budget for monitors, including their training and the monitoring tools they will use.
- Data management is difficult and represents a bottleneck in campaigns. It is important to plan early for the data management system, especially if it will involve use of cell phones instead of paper based registration and if technical support will be required to design and implement the data management system. If there are existing data managers at district or regional level, budget for their time to be allocated to assisting with the LLIN campaign data management at all phases to facilitate collation and synthesis of data.
- Ensure there is budgeting for end of day meetings and information tallying to ensure monitoring of stocks and triggering redistribution in case there are too many or too few nets.
- In- and end- process monitoring is important for gauging the strengths and weaknesses of the planning and implementation of the campaign. Countries should consider including a budget for independent monitoring.

Evaluation

- Post-campaign evaluations should be included in the budget for the LLIN campaign unless another population-based survey (such as MIS, MICS or

DHS) is planned that can capture, or be modified to capture, the necessary information for the National Malaria Control Program, partners and donors.

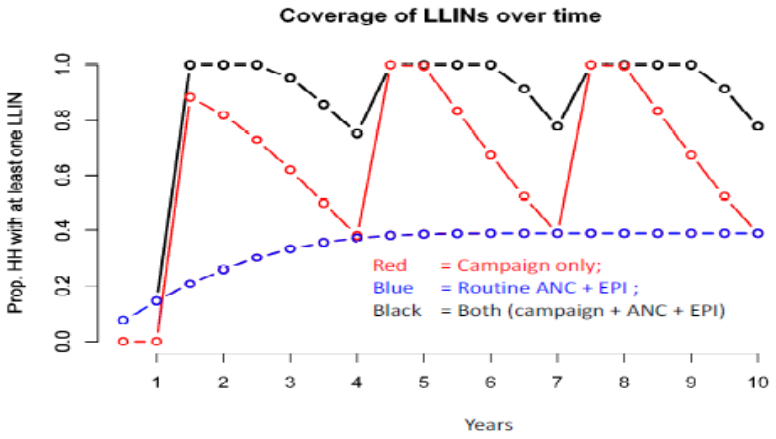
- The post-campaign evaluation should feed into the overall communications plan for ensuring high utilization and regular care and repair of LLINs.

Continuous Distribution of LLINs

Whilst universal coverage campaigns achieve universal and equitable coverage in a short time, if they are not complemented by routine delivery, coverage drops quickly (figure 1). A combination of campaigns with continuous delivery will ensure consistently high coverage rates. Quantification for continuous delivery should include: (1) ANC and EPI delivery to pregnant women and infants; and (2) replacement of nets lost due to age, disrepair, etc. A variety of continuous distribution channels, including community-based, are important to increase the options for households to replace LLINs.

In many African countries, ANC and EPI coverage is relatively high. However, innovative solutions are needed where access and quality of these services are low. Delivery of LLINs through both ANC and EPI will help sustain a high level of coverage after a campaign for targeted populations. However, additional systems for continuous LLIN delivery - such as through the private sector, subsidized sales, schools, and/or community based distributions, are needed. Until these methods have been established and are functioning at a level to sustain universal coverage over time, countries should plan for mass distribution every three years to maintain full population coverage.

Figure 1: The advantages and disadvantages of campaign and continuous distribution systems. With a single campaign, coverage rises rapidly to high levels, but then declines, so with a series of recurrent campaigns, coverage fluctuates in a zig-zig pattern, with significant gaps in coverage between campaigns (Red line). With continuous distribution through antenatal (ANC) and immunisation (EPI) channels, coverage rises more slowly but then reaches a stable level (Blue line). If LLINs are delivered through both regular campaigns and ANC or EPI, then high levels of coverage can be sustained with only small gaps in coverage (Black line).



LLIN campaigns: M&E Best Practices

- Support the National Campaign M&E Plan: Evaluation methods, data collection, and tools should be consistent with the national plan. M&E planning should be integrated into the design of the campaign from the beginning
- Collect data in a manner that ensures timely application
- Prioritize “need to know” data over “nice to know” data: M&E efforts related to mass distribution campaigns should be focused on collecting the minimum

data required to adequately and responsibly monitor and evaluate the quality of campaign implementation.

- Partners with specific, but non-essential, data needs should communicate them early in the process and pay for collection of the additional data.
- Use Existing Guidance to Inform Partner Organization M&E Needs: State-of-the-art monitoring and evaluation guidelines for monitoring mass distribution campaigns currently exist, and partners should work to ensure that national M&E efforts meet the currently recommended standards.
- Estimating ITN access vs use to plan for interventions (see below).

Estimating LLIN Use vs. Access

The recommended indicators for ownership and use of ITN have recently been revised to include "households with at least one ITN for every two people" and "proportion of population with access to an ITN within the household". These are described in the RBM document "Household Survey Indicators for Malaria Control".

Recent survey reports from nationally representative surveys do not yet include these new indicators. Programmes tend to use the comparison of information on "proportion of households with at least one ITN" and "use of ITN last night by children under five and/or pregnant women". Such comparisons at first glance often suggest a huge gap in use and may lead to the conclusion that existing nets are not being utilized and that a focus on BCC programmes is needed. However, recent re-analysis of survey data using these new indicators[i] strongly suggests that in most cases the problem is not utilization but rather lack of access to LLINs. What can countries do to solve this problem? The first option should be to attempt to recalculate the new indicators from the actual data set of the most recent nationally representative survey. This can be done by any experienced statistician as all the information is available in standard surveys (DHS, MIS, MICS4). The RBM document "Household Survey Indicators for Malaria Control" as well as a recent publication[ii] provide detailed information for the calculations. If recalculation of the data is not possible the following approach can be used to estimate "access of population to ITN within the household":

1. From the most recent survey report the number of ITNs that existed in the country or region at the time of the survey is estimated by multiplying the "mean number of ITN (or LLIN) per household" which is usually found in the "ITN ownership" table of the survey report with the number of households at the time of the survey in the country or region taken from the best census projections available.

   Number of ITN=mean ITNs per household x number of households

2. Using the total population at the time of the survey from the same census projections the access indicator is then calculated as followsiii:

   % access to ITN=1.64 x number of ITNs / population x 100

3. An alternative approach that can be used if census estimates are considered unreliable or do not exist is to calculate access from the "proportion of households with at least one ITN" based on the study previously mentioned (footnote 1):

   % access to ITNs = % with at least one ITN x 0.77

The next step is to estimate the proportion of the general population using an ITN the previous night if this information is not included in the survey report. There is no systematic way to do this but experience has shown that the ITN use of the population in most cases is between 5 and 10 percentage-points lower than for children under five so deducting 10 percentage points from the rate of children should work reasonably well if the child use rate is 30% or more. If it is lower than 30% a deduction of 5 percentage points is preferable:

% population ITN use= % child ITN use – 10%-points if ≥ 30%

% population ITN use= % child ITN use – 5%-points if < 30%

Finally, using the estimates previously calculated, the proportion of population using ITN, provided they have access, is calculated as follows:

% population ITN use if access = % population ITN use / % access to ITN/100

If this rate is 70% or higher, i.e. the use gap is 30% or lower, utilization of ITN can be considered satisfactory, if it is lower, the time of the survey needs to be taken into account. If it was in the rainy season and the rate of ITN use if access is below 70% BCC interventions should be considered a priority. If it was in the dry season (especially in a country with strongly seasonal malaria transmission) a rate of 50% or less should be considered an indication for the need of additional BCC intervention. It should be kept in mind, however, that these are general recommendations and in each country situation all additional information from other sources should also be taken into account.

Indoor Residual Spraying (IRS)

WHO published a revised guidance document in 2013: Indoor residual spraying: An operational manual for IRS for malaria transmission, control and elimination.

The key issues for IRS are summarised in the WHO Policy Brief accompanying this document. Note that some new policy recommendations have been introduced in response to evidence that insecticide resistance, especially pyrethroid resistance, is spreading rapidly in most parts Africa. The main questions about IRS: *"Where to do it?"; "What insecticide to spray?"; "How often?"* and *"What other interventions to use in combination?"* must be seen through the perspective of insecticide resistance management. The most basic resistance management strategy is to spray different classes of insecticides in rotation on an annual basis. An alternative is to combine interventions that use different insecticides, e.g. pyrethroids on LLINs and spraying with a non-pyrethroid. Spraying the same insecticide repeatedly year after year in the same places is to be avoided, as is the combination of high LLIN coverage with pyrethroid-based IRS. Monitoring for insecticide resistance must be a high priority in all countries' national strategic plans. The bare minimum is to identify a few sentinel sites and conduct comprehensive tests on an annual basis. In countries where pyrethroid resistance is already present, or is reported in a neighbouring country, more frequent testing in a larger number of locations is necessary. A detailed outline of the methods used for insecticide resistance monitoring, including number of sites and frequency, as well as the strategies used to delay resistance from evolving or to respond to it in cases where it has been detected should be outlined in a national insecticide resistance monitoring and management strategy. Development of a national insecticide resistance monitoring and management strategy can be budgeted for as part of a Global Fund grant (see the Global Plan for Insecticide Resistance Management (GPIRM).

In addition to monitoring insecticide resistance, it is important that the quality of the insecticides used is controlled to ensure that they are effective. Independent quality assurance needs to be planned and adequate time needs to be allocated for the controls to be implemented prior to the insecticides being used.

WHO is currently reviewing the added value of using LLINs and IRS in combination. Pending the outcomes of this review, the HWG recommends strongly that combining IRS and LLINs should never be considered as a remedy for poor implementation of a programme normally based on one of the two interventions. Additionally, the HWG recommends that any programme that invests in combined use of the two methods should include a strong evaluation component to justify the additional resources.

Larval Source Management

Larval control, or Larval Source Management (LSM), is an exacting operation that requires very strong quality assurance and entomological monitoring. Unless it is planned properly it can limit the probability of grant approval from the TRP. WHO has issued a clear position statement - *that LSM should only be considered as a complementary measure when the larval habitats are "Few, Fixed and Findable".* In 2013 WHO Published Larval source management – a supplementary measure for malaria vector control, an operational manual that should be consulted if a programme is considering the use of larval control.

Case Management

For more information on case management please see WHO normative guidance document (insert link). HWG recommends that public sector, private sector and community level are targeted as appropriate to achieve maximum coverage.

Case Management in the Public Sector

Quantification of ACTs and RDTs[3]

The quantification of malaria products is challenging. Malaria epidemiology and case management are rapidly changing due to the scale-up of malaria diagnostics with microscopy and RDTs and the use of preventive measures with LLINs, and IRS. Quantification for diagnostics and ACTs should be based on updated epidemiological data. Any quantification—whether using consumption or morbidity method----needs to factor these changes into the projected consumption of ACTs and RDTs. Consult the programmatic gap analysis to ensure that what you have in the concept note is consistent with what is in the programmatic gap analysis. Provision must be made for all service delivery areas including through the iCCM and private sector outlets. In compliance with the T3 (Test, Treat and Track) strategy, setting up a robust surveillance system should be considered an integral part of malaria case management.

Case Management in the Private Sector

The private sector plays an important role in malaria case management; on average 50% of patients with suspected malaria access care here. Despite the importance as a delivery channel, patient access to high-quality, affordable malaria treatments and diagnosis has been limited. Hosted by the Global Fund, the Affordable Medicines Facility – malaria (AMFm) was launched in 2010 to address this treatment access

[3] Adapted from: *Manual for Quantification of Malaria Commodities: Artemisinin-Based Combination Treatments and Rapid Diagnostic Tests for Diagnosis and First-Line Treatment of Plasmodium Falciparum Malaria*. MSH, 2011.

gap in 8 pilots across 7 countries[4]. The novel financing mechanism applied an ex-factory gate subsidy alongside supporting interventions to increase availability, affordability and use to quality-assured ACTs. In less than 2 years, there were steep declines in retail price and significant increases in access both indicators use would increase across most pilots.

In 2012, the Global Fund Board voted to integrate the AMFm into the core Global Fund structures and renamed it to the Private Sector Co-payment Mechanism (PSCM). The PSCM, described in detail below, builds on the lessons learned from the AMFm and expands the mechanism to all countries. During the drafting of the concept note, countries will need to evaluate the role of the private sector and ensure the strategy for expanding access to treatment and diagnosis is appropriately reflected in the national strategy to meet country and global targets (i.e., universal access). Further, the strategies for increasing access to treatment and diagnosis will vary by country as a number of factors will determine the speed, scale and scope of private sector initiatives like health seeking behaviour, epidemiology, regulatory policies and market dynamics like price elasticity (willingness to pay) among others.

Private Sector Co-Payment Mechanism:

Private Sector Co-payment Mechanism (PSCM, or "Co-payment Mechanism") is a financing model to expand access to artemisinin-based combination therapies (ACTs) in the private sector,[5] particularly in countries where the private retail sector is a major provider of malaria case management. It is based on the results of the Phase 1 Independent Evaluation, which showed that the combination of price negotiations, a subsidy provided directly to manufacturers, and large-scale mass communications led to rapid and large changes in price, availability, and market share of quality-assured ACTs. The Co-payment Mechanism model is comprised of three elements:

1. **Price negotiations**: Regular negotiations by the Global Fund Sourcing Department at the global-level with manufacturers to establish maximum allowable ex-factory prices of quality-assured ACTs procured using Global Fund grant resources.
2. **Subsidies provided directly to manufacturers**: Further reductions of the price paid by first-line buyers[6] through a partial payment made directly to manufacturers using grant funds for the procurement of ACTs (a "co-payment");[7] and
3. **Supporting interventions**: Country-level activities funded by the grant to facilitate the safe and effective scale-up of access to ACTs in the private sector. The following activities represent the minimum bundle of activities identified by the AMFm Phase 1 Independent Evaluation as essential to achieve the greatest impact, effectively monitor grant performance, and comply with relevant quality-assurance policies-

[4] Cambodia, Ghana, Madagascar, Niger, Nigeria, Tanzania (including Zanzibar) and Uganda.

[5] An assessment by technical partners of the feasibility to include diagnostic testing in the Co-payment Mechanism is currently underway, and some countries have requested funding for scaling up diagnostic testing in the private sector. The results of this study will help shape operationalization of the co-payment mechanism for diagnostic testing, in addition to any early experience of these countries. Based on this work, this OPN may be amended for the inclusion of co-payments for malaria diagnostic tests or a separate OPN will be developed subsequently.

[6] First-line buyers for the Co-payment Mechanism include international, regional and national buyers/importers from the private not-for-profit and for-profit sectors who purchase ACTs directly from the manufacturer.

[7] A partial payment is made by the Global Fund directly to manufacturers on behalf of eligible first-line buyers to cover a proportion of the ex-factory price of quality-assured ACTs plus freight and insurance. The first-line buyer is responsible for any remaining costs of the ACTs not covered by the co-payment plus all direct in-country supply-chain costs, including distribution and storage.

- Mass communication campaigns to increase public awareness about the co-payment and important attributes of co-paid products, such as assured quality, effectiveness and reduced price, and reduce information asymmetry between retailers and buyers, thereby mitigating risks of profiteering. These messages may complement existing campaigns to improve malaria case management and the use of ACTs in the public and private sectors.
- Private sector provider training.
- Quarterly monitoring of retail price and availability implemented by an independent entity in order to guide management decisions on implementation of the Co-payment Mechanism by the PR and Co-payment Task Force.[8]
- Policy and/or regulatory changes at the country level may be necessary, including: banning sales and importation of artemisinin monotherapies and other sub-standard treatments, supporting over-the-counter status of ACTs, enabling procurement and distribution of ACTs at lower levels, establishing a suggested retail price, commitment from the government on granting of waivers for import duties and taxes and facilitating policies related to drug marketing.
- Post-shipment quality control testing of co-paid products in the supply chain (consistent with the Global Fund's Quality Assurance Policy).

The Global Fund has issued an Operational Policy Note (OPN) that will provide further guidance on establishing a PSCM into existing and future grants. Grant funds are used for the subsidy provided directly to manufacturers and supporting interventions including: communication campaigns, training, monitoring, development and implementation if policy and regulatory changes, and quality control. All other direct in-country costs should be borne by the private sector. A key area of interest is the management and implementation arrangements that are proposed to manage the proposal. Here a good description of the implementation arrangements, the coordination mechanism, and the overall impact or effect of the existing health systems is necessary. In cases where previous grants have been awarded, a history of the implementation arrangements, lessons learned and any modifications should also be communicated, Demonstration of absorptive capacity is also a key qualitative factor in terms of receiving a malaria allocation. The proposal's chances are enhanced when there is clarity in the responsibilities and activities of the key implementers' capacity to deliver.

The Co-payment Mechanism can be used for quality-assured ACTs only and is limited to private for-profit and private not-for-profit first-line buyers. Public sector entities will continue accessing ACTs through traditional grant procurement channels. A feasibility assessment was conducted in 2013 by WHO that determined it would be operationally possible to expand this mechanism to include RDTs. However, the Global Fund and technical partners continue to evaluate the timeline, process and need for such an effort. In advance of a global mechanism being established for RDTs, several countries are in the process of piloting subsidies and low-cost (non-subsidized) RDTs and lessons and best practices should be drawn from these initiatives.[9]

[8] Standard, validated methodologies exist that permit a systematic approach to data collection and analysis without a hefty price tag for monitoring availability and price at the retail level; examples of the tracking survey approach used across AMFm Phase 1 pilots are available.

[9] Ongoing efforts to expand access to RDTs in the private sector includes: Angola, Cambodia, Kenya, Liberia, Madagascar, Myanmar, Nigeria, Tanzania, Uganda and Zanzibar.

Lastly, it should be noted that the PSCM is not the only approach/mechanism that countries can use to increase access to treatment and diagnosis. PRs should examine all possible approaches with the Global Fund and look to learn from other countries like Angola, Cambodia, Liberia and Myanmar, all of whom have worked to increase access to ACTs outside the AMFm (or PSCM) but through Global Fund money.

Link to Information Note on Private Sector Co-payment Mechanism in the New Funding Model

Seasonal Malaria Chemoprevention (SMC)

Seasonal Malaria Chemoprevention (SMC) is an approach endorsed by WHO in 2012. The updated WHO policy recommends SMC for preventively treating children during the malaria transmission season, in the Sahel sub-region in Africa.[10] SMC consists of providing three to four monthly treatment courses of sulfadoxine-pyramethamine + amodiaquine (SP+AQ) to children under-five during the long rainy season.[11] This policy change was in response to a body of evidence from successful field studies that showed SMC prevents approximately 75% of all malaria episodes and 75% of severe malaria episodes.[2] Countries where SMC is a strategic option for malaria control should include it in their concept notes. As SMC is a new intervention for most implementing countries, costs for adoption of the SMC strategy should also be included, in addition to the cost of the commodities and its implementation. Specific costs include: development of national guidelines and manuals, health worker training, and start-up costs associated with the delivery mechanism(s) each country employs. (For more detail, please refer to the WHO SMC Implementation Field Guide.)

Maternal, New-born and Child Health (MNCH)

The Global Fund is committed to maximizing the impact of its investments beyond AIDS, TB and malaria on health systems and on women and children. Since the 21st Board Meeting of April 2010, the Global Fund has recognized that to improve overall outcome and sustainability of Global Fund contributions to disease-specific country-led programmes, financing also has to be directed in such way that it improves overall maternal, new-born and child health (MNCH). The Board decision[iv] specifically states that:

- The Board encourages countries and partners, as a matter of urgency, to work together in the context of opportunities presented through grant reprogramming and changes to the Global Fund grant architecture to urgently scale up investments in maternal and child health in the context of the Global Fund's core mandate
- Exploring options to maximize synergies with maternal and child health, the Board strongly encourages CCMs to identify opportunities to scale up an integrated health response that includes maternal and child health in their applications for HIV/AIDS, TB, malaria and health systems strengthening.

We recommend cutting and pasting the above section into your concept note if you choose to include any of these activities.

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[10] WHO Global Malaria Programme (March 2012). *WHO Policy Recommendation: Seasonal Malaria Chemoprevention (SMC) for Plasmodium falciparum malaria control in highly seasonal transmission areas of the Sahel sub-region in Africa.*

[11] Sahelian sub-regions recommended for SMC are those with a clinical attack rate greater than 0.1 per transmission season in the target age group, or areas with >10 of 100 under-fives experiencing clinical malaria during the rainy season.

Three strategic MNCH delivery platforms to accelerate malaria control interventions: Integrated Community Case Management (iCCM), Expanded Programme of Immunization, and Antenatal Care (ANC)

The following MNCH interventions can be included as part of HSS, CSS and/or as a core part of activities in the concept note depending on the country context, priorities and strategies as they have a particular importance for the scale up of malaria prevention and treatment interventions. Countries should look for opportunities to use Global Fund grants to support the existing health-care system by addressing any weaknesses in policy dissemination, capacity development, quality of service delivery, community engagement, and supply chain management, to support improved outcomes for their entire populations but in particular those pregnant women and children under five who are the most vulnerable to disease.

1. Integrated Community Case Management (iCCM)

One of the strongest opportunities to use Global Fund financing to support RMNCH activities relates to iCCM. Many countries, through increased and sustained malaria control activities are now seeing that the percentage of fevers due to malaria is decreasing. As a result, many countries are facing the issue of how to manage RDT-negative (non-malaria) febrile cases, some of which are due to pneumonia or other life-threatening illnesses. In 2012 WHO and UNICEF released a Joint Statement on integrated Community Case Management, which presents the latest evidence on iCCM, describes the necessary programme elements and support tools for effective implementation, and lays out actions that countries and partners can take to support the implementation of iCCM at scale[v]. Delivering interventions for the three diseases together has been shown to improve timeliness of treatment, quality of care and efficiency in the treatment of childhood illnesses. In addition, integrated delivery represents good value for money as it maximizes the impact of Global Fund investments. Studies have shown that integrating pneumonia diagnosis and treatment with malaria results in a significant decrease in inappropriate use of anti-malaria medicines. Thus iCCM reduces the risk of inducing and spreading drug-resistant malaria parasites and would significantly increase the proportion of appropriately administered antibiotic treatments for non-severe bacteria pneumonia.[vi] [vii]

The Global Fund will fund most components of an iCCM platform, as outlined in the table below. Given the relatively low costs of commodities not financed by the Global Fund – respiratory timers, oral rehydration salts, zinc and antibiotics – these are seen as an excellent investment opportunity for governments and other development partners to show their commitment to improving child survival outcomes. Further, the Global Fund has also initiated discussion with UNICEF, the RMNCH Trust Fund, private foundations and other interested partners regarding the co-financing of non-malaria commodities to complement the Global Fund financed iCCM platform to ensure that comprehensive intervention packages are put in place. Further updates on potential co-financing opportunities will be included in revised versions of this document, but it is highly recommended that in-country opportunities are also actively pursued and negotiated as early as possible – in order to ensure synchronous delivery of malaria and non-malaria commodities.

Essential ingredients of iCCM and eligibility for Global Fund support

Essential iCCM Components	Global Fund Supported
Training and salary costs for community health workers	Yes, provided that these community health workers are also directly involved in malaria management
RDTs for malaria diagnosis	Yes
ACTs for malaria treatment	Yes
Respiratory timers for pneumonia diagnosis	No*
Antibiotics for pneumonia treatment and ORS and zinc for diarrhoea treatment	No*
Supportive supervision	Yes
Supply chain system strengthening	Yes
Health information system strengthening	Yes

*.Commodities not funded by the Global Fund provide a co-funding opportunity for governments or other development partners to invest into the iCCM platform.

The Global Fund has also issued an information note encouraging applicants to include community systems strengthening initiatives in proposals wherever relevant to improve health outcomes.[viii] The Global Fund has also issued an information note encouraging applicants to include community systems strengthening (CSS) initiatives in proposals wherever relevant to improve health outcomes[ix] The note defines the Global Fund's commitment to supporting community led responses including involvement in service delivery, as well as the overall purpose and scope of CSS investments which are designed to support this role. The malaria modular framework includes a CSS module which is made up of four interventions, all of which are relevant for an effective and sustainable iCCM response. Countries will need to evaluate whether an integrated approach between malaria and iCCM is merited by considering treatment seeking behavior and disease overlaps. This will help the country determine how to optimize limited resources within the Global Fund grant for malaria and non-malaria fever case management.

2. Expanded Programme of Immunization

Immunizations constitute the single most important point of contact of under-five children with the health system – especially routine immunizations. Effective integration of malaria interventions such as LLIN distribution with immunization services could significantly increase coverage and impact overall child health outcomes and this may be included in Global Fund concept notes.

3. Antenatal Care (ANC) and Malaria in Pregnancy

Antenatal care constitutes the main point of contact of pregnant women with the health system. The majority of pregnant women, at least 7 out of 10 in most developing countries, have at least one antenatal contact with a skilled health professional. However, to achieve the full life-saving potential of ANC, at least four visits and a package of proven high impact interventions including intermittent preventive treatment (IPTp), LLINs, information sharing and case management are required.

Efforts should be made to provide LLINs to women as early in pregnancy as possible and to provide IPTp at every ANC visit, beginning in the 2nd trimester. Not only is IPTp-SP lifesaving and easy to implement, it is also highly cost effective for both prevention of maternal malaria and reduction of neonatal mortality. IPTp-SP as a key intervention for pregnant women, combined with LLIN use and effective case management, should remain a priority across stable malaria transmission countries. The April 2013 WHO Policy Brief (see annexes) states:

Starting as early as possible in the second trimester, IPTp-SP is recommended for all pregnant women at each scheduled antenatal care (ANC) visit until the time of delivery, provided that the doses are given at least one month apart. SP should not be given during the first trimester of pregnancy; however, the last dose of IPTp-SP can be administered up to the time of delivery without safety concerns.

A number of countries do take some advantage of this contact point to contribute towards meeting or sustaining their universal coverage goals. However, it is vital to expand and strengthen ANC service delivery to ensure that pregnant women have sufficient access to malaria protection and/or treatment. ANC is a key "missed opportunity" to further malaria control objectives. Investing in addressing some of the main ANC challenges such as: late initial contact, low quality of care and inadequate commodities to administer full requirements of IPTp and LLIN could increase coverage, address malaria in pregnancy and improve MNCH outcomes. Most of the opportunities described above have not yet been used to the fullest extent as many countries are still struggling to reach and maintain universal coverage targets. There are therefore still important investments to be made in strengthening the ANC platform to ensure that the gains made thus far do not regress.

What can be integrated into Global Fund proposals?

Applicants are encouraged to request funding for interventions that primarily benefit one or more of the three diseases, but also have linkages to broader MNCH-related outcomes. Such interventions may be included either within a disease-specific concept note, e.g. malaria, or under the HSS-specific concept note. The applicant should ensure that any proposed HSS and/or MNCH interventions are linked primarily to the targeted disease(s).The proposal should also explicitly explain how these interventions will also contribute to improving MNCH-related outcomes.

The following are some of the main components that can be considered for inclusion in Global Fund proposals. **When thinking about all of them, though, the explicit link to the malaria control effort and/or TB and HIV/AIDS activities must be made.**

Human resources for health: Availability of skilled and motivated front-line staff (e.g. community health workers and supervisors) is essential for effective delivery at scale of MNCH services, particularly for populations without easy access to health facilities. Interventions to be considered for Global Fund proposals can include, but should not be limited to: hiring, remuneration, motivation and training of health and community workers to build a critical mass for service delivery particularly in geographic and programmatic areas of greatest deprivations. The CSS module provides options for strengthening human resources in the community sector when this is relevant to the overall application.

Supervision: On-the-job support of service providers through supervision is important to keep staff trained, interested and motivated; monitor performance and maintain quality of care. Interventions to be considered for Global Fund proposals can include, but should not be limited to, the hiring of supervisors, purchasing of equipment such as motorcycles for supervision of community health workers in remote villages and payment of stipends.

Demand creation and behaviour change: It is critical to understand and address barriers to demand in order to ensure that key interventions and approaches undertaken are equitable, relevant and acceptable to the local community. Examples of such barriers can include lack of knowledge, financial constraints, opportunity costs, social/cultural/ religious norms, beliefs about the aetiology of disease, limited

autonomy for decision-making among caregivers, and the perceived acceptability and benefit of an intervention. Activities to be considered for Global Fund proposals can include, but should not be limited to, qualitative and quantitative assessments of the most relevant demand-side barriers (e.g., through focus group discussions and/or household surveys), as well as collaborative approaches to prioritise and implement solutions to the barriers (e.g. through mass media, community mobilization and interpersonal communication strategies).

Monitoring and strategic information: Regular review of data with key public, private and civil society stakeholders is essential to foster accountability as well as use of data for timely local decision-making. Interventions to be considered for Global Fund proposals can include, but should not be limited to, improvement of community monitoring systems (under the CSS module) and vital registrations, integration into HMIS, assessment and improvement of data quality, recruitment and remuneration of data clerks, monitoring meetings of stakeholders and management teams, and performance-based incentives to reward good performance. Innovations such as m-health technologies can also be included based on evidence and good implementation and scale-up plans for the introduction of this intervention. Proposed interventions should contribute to a clearly presented strategy with direct links to improving monitoring and contributing to the availability of strategic information.

Infrastructure, equipment and supplies: Optimal delivery of certain services such as antenatal care and treatment of malaria, HIV and other maternal and childhood illnesses require the availability of basic infrastructure, medical equipment and essential commodities. Interventions to be considered for Global Fund proposals can include, strengthening of supply chain particularly the “last mile/kilometre” of the supply chain to ensure reliable availability of essential commodities at the point of treatment (CHW level) and supporting systems for procurement and replenishment of equipment and supplies such as solar systems, bicycles, test kits, and job aids and decision support items (educational materials, registers, referral cards, etc) If included, the applicant should explicitly explain how these infrastructure, equipment and commodities would contribute to improving disease-specific outcomes.

Cross Cutting Issues

Programme Management

RBM has promoted the concept of “the three ones” – one strategic plan, one monitoring and evaluation system and one coordinating mechanism, since the early days of the partnership. This paradigm is as important as ever today. The need for a strong coordinating mechanism is particularly crucial as programmes are increasingly complex in addressing new, emerging issues and sub-national programming. It is important that the malaria control programme is adequately staffed to coordinate and manage the complex partnerships and programmes that they are planning to implement. A human resources gap analysis showing the existing and proposed organizational structures, current staffing, staffing needed to manage proposed programming (with justification) corresponding to the proposed structure, and identification of gaps needing to be filled by proposed funding will help to support funding for human resources needs.

Procurement and Supply Chain Management

Malaria health products include: (i) pharmaceutical products; (ii) durable and non-durable in-vitro diagnostic products, microscopes and imaging equipment; (iii)

mosquito nets; and (iv) consumable/single use health products (including, insecticides, general laboratory items and injection syringes) – all of which can be financed out of the grant funds.

Procurement and supply management refers to all activities required to ensure the continuous and reliable availability of sufficient quantities of quality-assured, effective health products to end-users, procured at the lowest possible prices in accordance with applicable laws (Global Fund, 2012). Presenting clear approaches to health products management (including management of potential risks) in the concept note and grant development is critical to the success of grant implementation. The coordination of all PSM-related activities is critical to ensure timely delivery of quality health products to avoid treatment disruption, stock outs, or delays in distribution campaign of nets. A PSM coordination mechanism, such as a working group or task force, is strongly recommended.

Applicants should demonstrate that the systems and the people to manage PSM activities, in compliance with the Global Fund policies and requirements, are in place. r, if they are not, present clear plans for building the required systems and capacity based on the review of the systems strength and weaknesses. PSM systems should:

- forecast malaria product requirements and translate those requirements into procurement or supply plans;
- provide timely and transparent procurement of quality pharmaceuticals and health products;
- manage products according to product requirements, preventing diversion, expiries and waste;
- comply with quality assurance requirements, including monitoring the quality of the products throughout the supply chain
- provide reliable and secure storage and distribution;
- encourage appropriate use;
- capture and transmit data on consumption and stock status at all levels of the system; and,
- coordinate, monitor and mitigate any potential risks in PSM activities

Applicants should develop a mapping of PSM arrangements highlighting responsibilities of each stakeholder involved in the health products management including:

Quantification: As mentioned under the section on key issues raised by the TRP, forecasting and quantification has often been perceived as weak, especially for ACTs and RDTs. The malaria environment is extremely dynamic through the provision of increased LLINs which are reducing malaria burden and RDTs which are showing which fevers are or are not due to malaria. Therefore, quantifications should adjust forecasts based on past consumption or morbidity to reflect these changes. Good reference tools include the Manual for Quantification of Malaria Commodities: Artemisinin-Based Combination Treatments and Rapid Diagnostic Tests for Diagnosis and First-Line Treatment of *Plasmodium falciparum* Malaria.

Procurement: Applicants should define their procurement strategy, including the roles and responsibility for procurement - whether managed directly by the principle recipient, a sub-recipient, national entity or a contracted procurement agent /qualified agency. The strategy should describe systems for managing procurement of quality products, and ensuring that procurement is timely and transparent. If capacity could be an issue, one option is to propose using a procurement service agent, such as the Global Fund Pooled Procurement Mechanism, described below, while building the capacity of the existing system.

Storage and distribution systems: Applicants should describe the inventory management and distribution systems that will maintain the quality of the malaria products, prevent waste and expiries, account for the products as they move through the different levels in the system, secure the supply chain for preventing leakage or diversion, and reliably deliver the products when required. Countries should demonstrate that adequate storage and distribution systems are available, and if not available at the time of submission how building this capacity will be addressed. The roles and responsibilities for storage and distribution should be specified, including past management experience, and any required technical assistance to build capacity should be included, based on the challenges identified.

Information systems: Applicants should specify how PSM data, including consumption, stock on hand, and stock outs, are collected, reported and used to support PSM operations and monitoring of PSM activities. Systems reporting PSM data and case management data can be separate or together, but the data should be regularly compared. Past information management experience should be detailed. Where challenges in the information systems have been identified, they should be described and plans to build capacity should be outlined including any required technical assistance.

Budgeting: In addition to the commodity costs, budgets should cover associated management costs such as freight and insurance, customs clearance, storage, distribution, quality assurance including quality control, PSM monitoring and reporting, technical assistance, and capacity building activities costs - according to identified needs.

PSM arrangements and procurement plan

To prepare the NFM concept note, refer to the Guide to the Global Fund's Policies on Procurement and Supply Management of Health Products available on the Global Fund website. The guide outlines the policies and principles that govern the procurement and supply management of health products financed by the Global Fund. A description of the PSM arrangements is required after the Concept Note has been approved during the grant making phase and before the signature of the grant. Templates and guidance will be available on the Global Fund website at the application guidance pages. PSM activities should be carefully planned in collaboration with key stakeholders, and should include specific timelines with clear-cut roles and responsibilities. Milestones and targets should be realistic and aligned with fund disbursement. It is also vital to include risk mitigation processes in the plan as part of ongoing PSM system improvement. The submission of a national pharmaceutical supply chain master plan may help to build the request for support in PSM and system strengthening activities,

Understanding the procedures of suppliers, procurement agents and others involved in procurement will enable more informed supply planning to ensure lead times are accounted for and built into implementation plans. Additional information is available from USAID: Guidelines for managing the Malaria Supply Chain, 2011.

The Pooled Procurement Mechanism (PPM)

Voluntary Pooled Procurement (VPP) was a procurement mechanism established by the Global Fund in 2009 to address bottlenecks and challenges in the Procurement and Supply Chain, including the delivery of health products to PRs and countries. Under the VPP, the Global Fund facilitated the procurement of core health products for Principal Recipients using the services of Procurement Services

Agents (PSAs). The Voluntary Pooled Procurement (VPP) was enhanced to create the Pooled Procurement Mechanism (PPM). The enhanced PPM will enable further aggregation of order volumes from participating PRs to leverage the Global Fund's market influence, in order to secure assured quality products, obtain best pricing and delivery outcomes, including reduced lead-times) for critical health products. In addition, it will promote a sustainable market for key health products.

All Global Fund grants are eligible to access the PPM, and whilst the process is optional, there might be certain PSM challenges or risks that might warrant the Global Fund to strongly encourage/recommend a PR to use the PPM.

Principal Recipients who elect to use the PPM are usually requested to use the service for the procurement of all core products (ACTs, LLINs and RDTs)). The Global Fund has contracted Procurement Service Agents (PSAs) to facilitate the procurement of LLINs, insecticide retreatment kits, diagnostics tests and ACTs (or other anti-malarial pharmaceuticals) for malaria grants. The PSAs offer a full range of services, including purchasing, quality control, shipping and delivery of commodities to designated delivery points. There are two delivery options for PPM orders for LLINs: (a) delivery to a first port of entry or (b) delivery to the state/regional levels. The PPM will not deliver beyond state/regional levels, and PRs requiring assistance beyond this level should request additional technical support to ensure rapid, efficient and equitable delivery of health products to intended beneficiaries. In addition, PRs can request inspection, sampling and/testing services, coordinating mandatory pre-shipment inspections, assistance with customs clearing and temporary warehousing. Even when using the PPM, the PRs still have the responsibility to undertake rational quantifications and forecasting including product specifications, obtain in-country approvals and required documents to facilitate the ordering and delivery processes, and make sure that commodities are independently quality assessed. All LLINs purchased under PPM have to be WHOPES-Phase II recommended, while selection of ACTs (and other anti-malarial pharmaceuticals) is guided by the Global Fund's Quality Assurance policy for pharmaceutical products.

Information about Voluntary Pooled Procurement

Behaviour Change Communication (BCC)

The Technical Review Panel (TRP) has identified behaviour change communication (BCC) as a key area of weakness in many proposals. Many BCC components faced significant criticism and, in some cases, rejection, because of a lack of technical quality necessary to merit approval. Overall TRP recommendations are:

- BCC proposals should adopt approaches that are evidence-based, results-oriented and context-specific
- Any BCC proposal should include an M&E plan with appropriate output and outcome indicators.
- BCC proposals should build on existing BCC platforms (MCH, CSS)

The Malaria Advocacy Working Group of RBM has developed a Strategic Framework to help countries improve their BCC components.

Strategic Framework for Malaria Communication at the Country Level

Background

BCC is an interactive, researched and planned process that focuses on influencing the target audience to adopt a desired behaviour. Whether you are targeting

politicians to advocate for increased malaria funding, or a pregnant woman in a village to sleep under an LLIN, the fundamentals are the same. Programmes need to identify the individual and collective behaviours and norms their target population need to exhibit to ensure uptake of interventions; conduct research on the target population to identify motivations, beliefs, influences, enablers, barriers and drivers on adopting the desired behaviour, design programs that address these aspects and then evaluate the program for effectiveness. Included in this is Social and community mobilization - the process of creating wider participation, coalition-building, and ownership to raise awareness of and demand for a particular program.

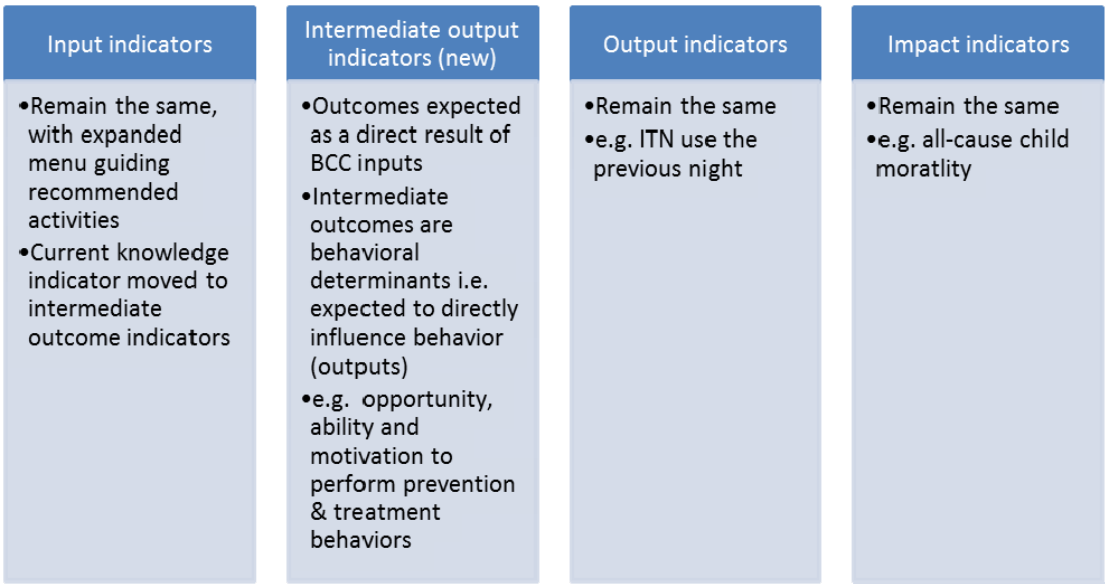
Guidance for Proposal Writing Teams:
There are a number of steps that need to be considered to develop a balanced, evidence based BCC program. These include:

- A clearly defined national **communication strategy** focusing on evidence-based approaches and results oriented that support the national malaria control strategy and its interventions.
- Use research to identify the **participant groups** and the current or future desired **behaviours** they need to exhibit to ensure uptake and use of an intervention (e.g. sleeping under a net every night, prompt treatment seeking behaviour).
- Research the current behaviours of the target group with regard to your intervention, and identify key determinants (e.g. their motivations, beliefs, perceptions and influences - i.e. social/community support; dialogue/interaction with service providers) that may affect adoption of the desired behaviour.
- Only when the determinants of key behaviours are identified and understood should interventions and materials be designed to address.
- Establishing dialogue with families and communities – community interaction instead of putting all the efforts in message dissemination/delivery is also a key investment that will yield vital outcomes in terms of encouraging behaviour change.
- BCC interventions must be evaluated to ensure the interventions are affecting a positive or even negative uptake of the desired behaviour.
- Results from evaluations should be utilized in subsequent rounds of programming.

Guidance on BCC indicators for Global Fund grants:
Efforts are being made to develop guidance to address the issues that the TRP has encountered in previous rounds with regards to problematic BCC sections. However, some interim advice is given below:

- Where BCC is implemented to support malaria control efforts, indicators at the impact (e.g. all-cause child morality) and outcome (e.g. ITN use) levels of the performance framework remain the same. Supplemental output indicators should be developed for inclusion in the objectives section of the performance framework.
- These indicators should measure the effect of exposure to BCC activities on key behavioural and social change determinants (e.g. social norms) – an intermediate step between exposure to activities and behavioural outcomes such as ITN use.
- These approaches should integrate BCC evaluation into large-sale household surveys which are typically the tool to measure malaria grant outcomes and impact. Robust analysis approaches such as multivariate regression and propensity score matching will be discussed in the above-mentioned guidance.

Illustrative indicators



Advocacy

Advocacy denotes activities designed to create an enabling environment that prioritizes malaria high on the political and developmental agenda; foster political will; commit resources for malaria interventions; and hold authorities accountable for goals and targets that are set. New efforts to expand advocacy and funding for malaria programmes are encouraged in the New Funding Model.

With changes in the development landscape and resource mobilization discussions that place countries and regional bodies front and center in the campaign against malaria, the action and focus for malaria advocacy and messaging is increasingly at the country level. The MAWG is developing an Advocacy Resource Mobilization for Malaria (ARMM) Toolkit in a paper and online format for national level malaria stakeholders to use to conduct targeted advocacy to mobilize resources for malaria.

Successful advocacy is characterized by country-specific strategies based on sound technical grounds, and embedded within the social network of private business leaders and government leaders in endemic countries. One persistent challenge in mobilizing resources for malaria at the country level is a lack of national-level advocates consistently working on the ground in endemic countries. As such, the ARMM Toolkit will provide guidance and resources for a variety of malaria stakeholders at the country level, particularly technical implementers, in order to increase their capacity in conducting effective advocacy for this purpose. This resource is particularly relevant now, in light of the emerging post-MDG objectives, and as national governments are being called upon to use more domestic resources to aid in reducing the disease burdens in their countries.

Health Systems Strengthening (HSS)

An effectively performing health system is key to achieving broadly defined national health sector goals. Some illustrative examples of high-level goals may include:

improving population's health status, enhancing health sector's responsiveness to customers' needs, reducing infant, under-5 and maternal mortality.

Some examples of what can be financed through the health systems funding platform include:

- Scale-up availability, increase accessibility and improve quality of **service delivery**
- Produce, distribute and retain skilled **health workforce**
- Strengthen **procurement & supply chain management system**
- Strengthen **health information systems**

HSS objectives can be achieved by a wide range of activities, which can be designed either at disease-specific or cross-cutting levels. With the disease-specific HSS approach, proposed activities are usually aimed at strengthening certain areas of the health system with specific disease outcomes in mind (e.g. procurement and distribution of rapid diagnostic tests for malaria). The scope of cross-cutting HSS activities covers broader health system areas affecting more than one disease outcomes simultaneously (e.g. upgrading primary care facilities, revising medical and nursing school curricula, building health workers capacity in the integrated management of childhood illnesses (IMCI) etc.). Countries applying for HSS support should consider cross-cutting HSS interventions and should also provide a convincing justification of how the proposed activities improve the health system's performance in terms of outcomes related to more than one of the three diseases (HIV/AIDS, TB, malaria – for Global Fund financing) and/or outcomes related to MNCH, with special emphasis on immunization (for GAVI financing). While it is not necessary for each proposed HSS intervention to encompass all the above health outcome areas, it is necessary for them to be cross-cutting, in that they should go beyond any single health outcome area.

Successful HSS components are built around the following principles:

- Provide adequate justification;
- Explain in-country review of gaps and weaknesses to demonstrate how the health system constitutes bottlenecks in achieving disease outcomes (Strong HSS requests are based on a gap analysis of the national health sector strategy);
- Demonstrate the benefits to disease outcomes, as well as broader health outcomes;
- Describe the linkages and interactions that exist between different components of the health system;
-

Information Note: GLOBAL FUND'S INVESTMENTS IN HEALTH SYSTEMS STRENGTHENING

TRP Comments on HSS

- Describe relationship/links to previous grants and other sources of funding
- Make sure proposed activities are scheduled to occur art a realistic pace.
- Analyze health systems, including gaps
- Choose strategies that are feasible and likely to succeed
- Develop an integrated approach for addressing diseases where appropriate (e.g., Information Systems)
- Provide evidence of how and why approaches will work
- Limit workshops, meetings and research activities to the essential
- Show links to women and children's health

Community Systems Strengthening (CSS)

Many services can be delivered in community-based settings and by civil society organizations. The goal of community systems strengthening is to develop the roles of key communities in the design, delivery, monitoring and evaluation of services and activities. Applicants are strongly encouraged to include community systems strengthening interventions in their proposals. Such activities seek to expand capacity but must also be accompanied by resources to support extensive and meaningful community engagement, not only in service delivery (such as case management and behavior change) where appropriate, but also in monitoring the performance of malaria programs at local and national level, and advocating for improved access and accountability where necessary.

The Malaria Framework includes a module for CSS. The module is made up of the four following interventions:
Intervention 1: Community- based monitoring for accountability
Intervention 2: Advocacy for social accountability
Intervention 3: Social mobilization, building community linkages, collaboration and coordination
Intervention 4: Institutional capacity building, planning and leadership development in the community sector

Applicants are encouraged to plan CSS interventions in order to support the community sector role in the program. Further information can be obtained from the CSS Information Note.

Information Note: Community Systems Strengthening

Removing legal barriers to access
Malaria is a disease of poverty and inequality that, in various regions, may disproportionately affect women, children, indigenous populations, rural populations, national minorities, or mobile populations (migrants, internally displaced people, etc). Availability, accessibility (including economic accessibility), appropriateness and quality of malaria services are fundamental parts of the right to health.

All programmes supported by the Global Fund must respect human rights, including the right to informed consent for medical treatment, the right to health information, and the right to non-discrimination on the basis of gender, ethnic identity, or other identity.

Intersecting human rights may create barriers to progress on realizing full coverage of malaria programs. These may include, for example, gender inequality, and lack of access to information. Where these barriers are identified, they should be addressed through costed and planned interventions in Global Fund programs. For more information, please consult the Human Rights Information Note.

Information Note: HUMAN RIGHTS INFORMATION NOTE

Monitoring and Evaluation/Surveillance

It is important to demonstrate capacity to monitor the targets set out in the Concept Notes as well as to establish monitoring and evaluation capacity for general programme management. Increasingly, monitoring and evaluation is needed for tracking insecticide and treatment resistance. Monitoring and evaluation is also

critical for programme evolution and identifying when and where transmission is sufficiently reduced to warrant focussed effort at transmission reduction. Some key considerations in developing the monitoring and evaluation section include –

- Appropriate target setting and monitoring. Particularly in the area of case-management, we often see the use of absolute numbers rather than proportions to set targets and monitor progress. In some cases this has resulted in good progress (low number of cases) being interpreted as poor performance. This point also applies more generally across the indicators that have been used in performance frameworks.
- Use indicators as outlined in the World Malaria Report. In order for data to be generalizable across countries it is important to use common indicators.
- It is important to carefully consider the appropriate methodology for collecting data. Approaches include surveys, routine surveillance and HMIS systems, depending upon the opportunities available in each context. If surveys are needed, they should be rationalized so that they are conducted after major interventions (not before) and in reasonable intervals (rather than having a MIS conducted immediately after a DHS, for example).

Household Survey Indicators for Malaria Control

Some examples of items budgeted in support of monitoring and evaluation include:

- Revision of outpatient registers to include key malaria data variables
- Revision of the malaria page on a DHIS-II platform
- Briefing on revised reporting tools for health workers, district level HMIS coordinators, and district level Malaria coordinators
- Annual data quality audits by the NMCP
- Support for internet connectivity at district level
- Motorcycles and fuel for district HMIS coordinators.

Populations Affected by Humanitarian Emergencies

Rationale: Up to 30% of malaria deaths in Africa occur in the wake of war, local violence or other emergencies. Countries impacted by chronic humanitarian crisis are also of strategic importance. The massive population displacement that usually accompanies humanitarian crises is likely to lead to an increase in malaria morbidity and mortality. Resource limitations, inaccessibility, insecurity, inadequate infrastructures and lack of capacity are barriers to carrying out effective malaria control and prevention programmes in such settings. Humanitarian emergencies can undermine pre-existing malaria control measures and lead to a collapse of health services. To achieve malaria control objectives, especially in the scale-up and sustained control stages, dedicated and tailored efforts to control malaria in humanitarian emergencies must be made as these situations may devolve quickly and lead to a loss of the benefits achieved.

Definition: Populations affected by humanitarian emergencies. Humanitarian emergencies refer to either man-made conflicts or natural disasters that result in a large part of a population being displaced and/or unable to carry out their normal lives due to the breakdown or incapacitation of infrastructures and cut-off from accessing essential needs and services. Populations affected by humanitarian emergencies include displaced persons such as refugees and Internally Displaced Persons (IDPs), their hosting communities, returning displaced populations, as well as non-displaced populations living in areas affected by conflict and/or natural disasters. Conflicts and/or disasters can have long-term

consequences, such as protracted displacement situations in which populations remain dependant on external assistance.

Epidemiology of malaria in humanitarian crisis

Conflicts and/or natural disasters have the potential of altering the epidemiology of malaria. In areas where significant advances have been achieved in reducing the transmission and disease burden due to concerted control efforts, humanitarian emergencies are likely to halt and even revert such progression because of interruptions to the control programme interventions. Large scale population movements can lead to an increased risk of epidemics as displaced populations can move from areas of low endemicity to areas of high endemicity and vice versa. Natural disasters, especially floods and heavy rainfall increase the likelihood of epidemics or lead to a medium to long-term amplification of transmission.

Response to humanitarian emergencies and malaria programmes in humanitarian settings

The response to humanitarian emergencies is coordinated by the Office for the Coordination of Humanitarian Affairs (OCHA) and structured within 11 clusters covering key technical areas and assistance aspects of the coordinated humanitarian response. WHO has been mandated to lead the health cluster and work closely with UNHCR who is in charge of providing assistance to refugees through collaboration with NGOs.

Humanitarian funding mechanisms are in place thanks to the central emergency relief fund and CAP/FLASH appeals to make available the initial resources needed to enable the provision of essential assistance during emergencies and the stabilisation phase. Agencies such as ECHO and OFDA play a significant role in the funding arena, and various other agencies including UNICEF are responsible for rapid response mechanisms, especially provisions of essential commodities. However, because of limited funding but overwhelming needs, such initial response mechanisms usually aim to cover the essential needs at the level of minimum international standards in humanitarian settings and for a limited time only. In endemic areas, malaria case management is included under primary health care while prevention (LLINs and IRS) is handled by a non-health cluster. The Interagency Emergency health kit recommends the use of a co-formulated ACT such as artemether-lumefantrine in case a country has not yet implemented ACTs as part of national treatment protocols and confirmation of all malaria cases. Insecticides for IRS and LLINs must be those recommended by the WHO Pesticide Evaluation Scheme (WHOPES) and must be independently quality assured before shipment.

Why include these populations into Global Fund proposals

In order to sustain universal coverage and move towards zero malaria deaths by 2015 as set out by the Global Malaria Action Plan (GMAP), malaria control and prevention programmes should embrace all vulnerable populations. Humanitarian funding mechanisms most commonly only cover the essential needs for a limited time. Global Fund grants on the other hand are situation unspecific and less time sensitive, hence can be shaped to bridge vital funding gaps between humanitarian short-term funding and long-term funding to pursue strategic objectives such as those of the Global Fund and RBM.

Considerations for proposal writing

Agree with stakeholders and CCM members to include populations of humanitarian concern such as displaced persons and refugees as part of the target populations in the proposal, especially in areas where refugee and IDP camps have been long-established. This will help ensure that there are sufficient commodities to cover both

the host and “visiting” populations. Ensure also that interventions for refugees and IDPs are gender-responsive, as women and girls often face greater barriers to accessing health services in refugee and IDP settings. In refugee-hosting countries and countries with IDP populations, ensure that these are part of the national malaria strategic plan; if not negotiate to have an addendum including that or make it clear that in targeting universal coverage this includes the targeting of all populations including the displaced. Countries affected by recurring natural disasters (floods, draughts, Tsunamis, earthquakes etc) or latent and/or acute conflicts should furthermore make provisions in their proposals for contingency plans that alleviate the effects of such situations.

Arguments to support these notions can be made on technical (epidemiological) grounds and with reference to humanitarian populations in the GMAP. It should furthermore be emphasised that the inclusion of disaster or conflict affected populations does not take away resources from programming needs for non-affected populations, but rather includes additional resources.

Proposal Process	**Action Point**
Transparent proposal development processes	Ensure that actors concerned with refugees and emergencies are included in the concept note development process and country dialogue. It may be useful to identify a focal point to ensure that refugee and emergency issues are sufficiently highlighted
Principal Recipient(s) or sub recipients	Where appropriate identify key organisations to act as PR or SR for humanitarian populations/issues
Malaria program	Highlight the importance of including ALL populations in the coverage models of the malaria program in order to reach the goals set out in the malaria strategic plan
Efforts to resolve health system weaknesses and gaps	Humanitarian situations are most likely to interrupt health care infrastructure and delivery of services. In response, humanitarian actors mobilise resources to cover gaps. It must be emphasised, however, that such resources are time limited and not targeted at re-building a complex infrastructure. Gaps will need to be addressed through health system strengthening approaches to re- establish functioning service delivery and care capacities.
Epidemiological profile of target populations	Ensure inclusion of geographic locations and populations (known or estimated) affected by humanitarian crises
Priorities	Ensure that populations affected by humanitarian situations are included in the programmatic analysis and prioritisation process
Links to non-Global Fund sourced support	Ensure linkages with the work of humanitarian actors and other organisations supporting displaced populations, emergency situations and humanitarian needs to show additionality.
Strengthening M&E systems	Humanitarian and emergency monitoring and surveillance systems are available and are most likely in place during humanitarian interventions. Explain how humanitarian partners will contribute to the improvement of the M&E systems in the country to overcome gaps and/or strengthen reporting into the national impact measurement systems framework
Financial gap analysis	Include the contributions of other donors and organisations supporting emergency and refugee/displaced programmes
Budget and M&E plan	Ensure that funds in support of humanitarian emergencies and refugees/displaced programmes are clearly identified; including resources requested from the Global Fund as well as external contributions.

Further reading:
Humanitarian response mechanisms: The Humanitarian Reform Process: Cluster Approach
http://www.humanitarianreform.org

Minimum international Standards in disaster response: The Sphere Project and Handbook (www.sphereproject.org/)

Malaria control in Emergencies.
Malaria Control in Complex Emergencies: An Inter-agency Field Handbook
Global Malaria Action Plan

General Issues Raised by the Technical Review Panel and Encountered During Implementation

Strong proposals include a good description of the process by which the proposal was developed, and the TRP values consultative proposal development processes that include key stakeholders from all sectors, public, private and civil society. It is also important to request funds to support sound and feasible technical interventions which are consistent with national strategic plans and in line with global disease control targets and best practices. Coherency, sound analysis, well-articulated goals, specific objectives and a good description of the interventions; beneficiaries and sustainability are key assets to the overall success of the proposal.

Technical concerns raised include poor quantification of ACTs and RDTs, particularly relating to observed changes in epidemiology or disease burden. For example, the quantification of drug procurement based solely on estimates of incidence without consideration of systems and capacities is seen as inappropriate, whilst in equal measure, estimates for commodities must take into consideration the expected drop in malaria incidence following scaling up of preventive interventions.

As regards **pharmacovigilance,** countries are encouraged to include this as part of the Health Systems Strengthening (HSS) requests rather than include this within disease-specific proposals. In response to the GPARC, proposals should include a system for monitoring drug resistance and resources to update treatment policies, and ensure quality assurance for drugs as part of HSS proposal requests.

On vector control, good malaria epidemiological stratification of the country, with clear demarcation of where the different vector control strategies will be deployed is seen positively by the TRP. Maps of baseline transmission risk can help inform targeting of vector control interventions and identification of efficiency opportunities. It is also vital to have in place initiatives to monitor insecticide resistance. In cases where IRS and LLINs are proposed as joint and/or concurrent interventions, country-specific evidence is required to show the added value of using both interventions in the same place, including for insecticide resistance containment. On LLINs, poor articulation of how quantities were determined; poor definition of target populations and lack of information on distribution methodologies are all issues that tend to contribute to poor proposal ratings.

An important part of the proposal is the section on **budgets**. In the worst rated proposals, the TRP usually states that, there are discrepancies in the budget, financial gap analysis are poorly done, there is a lack of details, and in some cases unit costs are over and above standard known costs. Issues such as inconsistencies in calculations, inflated costs, lump sum figures and poor budgeting decrease the level of proposal's credibility and do not receive good reviews from the TRP. Frequently these inconsistencies are due to last minute changes prior to submission,

which then undermine the harmonization of budget figures across the proposal. Last minute changes are therefore strongly discouraged.

Countries should conduct feasibility studies/operational research before they re-orient their control programs to malaria elimination, especially those countries which have reached the epidemiological threshold for elimination.

With regards to **BCC/IEC**, the perennial issue relates to the provision of evidence of the effectiveness of the intervention. Positive reviews include sound and evidence based activities, integrated strategies, which demonstrate the intended impact on the population, with strong qualitative and quantitative evidence of impact. If such evidence does not exist in your country, then the evidence generation can be included in the early time frame of your proposal. The TRP recommends that countries should ensure that requested BCC components adopt approaches that are evidence-based and context-specific to their country. Any BCC component should include a Monitoring and Evaluation plan with appropriate output and outcome indicators. BCC components should build on existing BCC platforms, such as MNCH and CSS.

Proposals need to have well-articulated activities and sound measurable indicators building on a comprehensive implementation strategy rooted in a well-developed national M&E plan and framework. Objectives, service delivery areas and indicators should, be aligned to the broad national strategic orientation, and contribute to this as well as answering to the specific needs of the proposal. It also helps to analyze the strengths and weaknesses of the national system and devise ways to strengthen the M&E system to benefit the data quality and timeliness of reporting. A good understanding of the different levels of indicator formulation and measurement (input, process, output and impact) are an asset. The establishment of baselines and how indicators will be assessed and measured are necessary points to include in submissions. Care must be taken to streamline and coordinate to benefit from planned surveys and studies.

Of equal importance is a need to clarify the procurement system in place and proposed. The proper quantification of needs with realistic values is important; focus must be placed on a good description of the procurement arrangements, its strengths and weaknesses. In cases where inherent and persistent PSM weaknesses are the order of the day, the TRP sees value in opting for the Global Fund's VPP system.

A key area of interest is the management and implementation arrangements that are proposed to manage the proposal. Here a good description of the implementation arrangements, the coordination mechanism, and the overall impact or effect of the existing health systems is necessary. This should include identification of the different sectors that will be involved in implementing programs and interventions, such as community sector organizations, representatives of indigenous groups and national minorities, or faith-based organizations for certain interventions. In cases where previous grants have been awarded, a history of the implementation arrangements, lessons learned and any modifications should also be communicated back to the Global Fund. Demonstration of absorptive capacity is also a key qualitative factor in terms of receiving a malaria allocation. The selection of principal and sub-recipients must show transparency and cross sectional representation, from Government, faith-based, civil society and the private sector where applicable. The proposal's chances are enhanced when there is clarity in the responsibilities and activities of the key implementers' capacity to deliver. The national architectural platform for programme implementation, such as SWAPs and others must be highlighted, especially where that implementation arrangement will affect the proposal.

Additional Resources

- Interagency Guidelines: *Operational Principles for Good Pharmaceutical Procurement.* WHO http://www.who.int/3by5/en/who-edm-par-99-5.pdfwww.who.int/medicines/library /par/who-edm-par-99-5/who-edm-par-99-5.htm
- Interagency Guidelines: *A Model Quality Assurance System for Procurement Agencies.* Recommendations for quality assurance systems focusing on prequalification of products and manufacturers, purchasing, storage and distribution of pharmaceutical products, WHO/PSM/PAR/2007.3, available at http://www.who.int/medicines/publications/ModelQualityAssurance.pdf
- The list of pesticides recommended by WHOPES (insecticides for internal residual spray, insecticides for treatment of mosquito nets, long-lasting insecticidal mosquito nets and mosquito larvicides) is available at http://www.who.int/whopes/en
- WHO Guidelines for Procuring Public Health Pesticides. WHO/HTM/NTD/WHOPES/2012.4, is available at http://www.who.int/whopes/resources/en/,
- *Guidance for Reinforcing and/or Establishing Pharmaceutical Quality Control Systems and Related Stock Management Activities in Countries Supported by the Global Fund,* available at http://www.theglobalfund.org/WorkArea/DownloadAsset.aspx?id=7045
- All information related to the *Global Fund Quality Assurance Policy for Diagnostic Products,* is available at http://www.theglobalfund.org/en/procurement/quality/diagnostics/
- All information related to the *Global Fund Quality Assurance Policy for Pharmaceutical Products,* is available at http://www.theglobalfund.org/en/procurement/quality/pharmaceutical/
- *Quick Facts on Procuring Rapid Diagnostic Tests* available at http://www.theglobalfund.org/en/procurement/
- *Procurement for Impact:* http://www.theglobalfund.org/en/p4i/
- *Global Fund Information Note: Community Systems Strengthening, July 2011.* www.theglobalfund.org/documents/rounds/11/R11_CSS_InfoNote_en/
- *WHO/UNICEF Joint Statement (2012). Integrated Community Case Management (iCCM): an equity-focused strategy to improve access to essential treatment services for children. UNICEF, New York*
- *WHO/UNICEF (2011). Integrated Management of Childhood Illness/Caring for Newborns and Children in the Community. Manual for the Community Health Worker: Caring for the sick child in the community.*
- *iCCM Benchmarks Matrix – as published in McGorman L et al. A Health Systems Approach to Integrated Community Case Management of Childhood Illness: Methods and Tools. Am. J. Top. Med. Hyg., 87 (Suppl 5), 2012, pp. 69-76*

[i] Koenker & Kilian: Recalculating the net use gap: a multi-country comparison of ITN use versus ITN access, PLOS ONE 2013 (submitted)

[ii] Kilian et al.: Universal coverage with insecticide-treated nets – applying the revised indicators for ownership and use to the Nigeria 2010 Malaria Indicator Survey data, Malaria Journal, 2013, 12:314

[iii] Kilian et al.: Estimating population access to insecticide-treated nets from administrative data: correction factor is needed, Malaria Journal, 2013, 12:259

[iv] The Global Fund to fight AIDS, TB and Malaria. Scaling up investments in women and children to accelerate progress towards MDGs 4, 5 and 6. May 2010

[v] WHO/UNICEF Joint Statement (2012). Integrated Community Case Management (iCCM): an equity-focused strategy to improve access to essential treatment services for children. UNICEF, New York.

[vi] Yeboah-Antwi K, Pilingana P, Macleod WB, Semrau K, Siazeele K, et al. (2010) Community Case Management of Fever Due to Malaria and Pneumonia in Children Under Five in Zambia: A Cluster Randomized Controlled Trial. PLoS Med 7(9): e1000340. doi:10.1371/journal.pmed.1000340

[vii] Yeboah-Antwi K, Pilingana P, Macleod WB, Semrau K, Siazeele K, et al. (2010) Community Case Management of Fever Due to Malaria and Pneumonia in Children Under Five in Zambia: A Cluster Randomized Controlled Trial. PLoS Med 7(9): e1000340. doi:10.1371/journal.pmed.1000340

[ix] Global Fund Information Note: Community Systems Strengthening, July 2011. www.theglobalfund.org/documents/rounds/11/R11_CSS_InfoNote_en/