**Notes from a phone conversation with Melanie Renshaw, Chief Technical Advisor for African Leaders Malaria Alliance (ALMA) and Co-Chair, Roll Back Malaria Harmonization Working Group (HWG), October 16, 2012**

**Summary**: We spoke with Melanie Renshaw concerning funding and other gaps in malaria control efforts. We want to understand where the gaps are most pressing, particularly for long-lasting insecticide-treated-net (LLIN) distributions but also the nature of the funding gap for other health commodities such as malaria treatments (ACTs) and diagnostics (RDTs).

Dr. Renshaw recommends that donors work with established national distribution programs and their partners, avoiding imposing extra monitoring and evaluation and reporting requirements as much as possible. Funding gaps are significant and known for each country through the year 2015.

**Note:** This is a set of summary notes compiled by GiveWell in order to give an overview of the major points made by Melanie Renshaw in conversation.

**The African Leaders Malaria Alliance (ALMA)**

ALMA is an alliance of 46 African Heads of State and Governments working together to address the malaria burden in Africa. This includes tracking progress in reaching universal coverage with key malaria interventions including LLINs, identifying gaps and bottlenecks and facilitating action. ALMA meets every 6 months, usually on the sidelines of African Union meetings. ALMA issues Scorecards on a quarterly basis to the heads of state to track progress across key malaria and tracer MNCH indicators including financial aps to achieve universal coverage of LLINs other malaria commodities and track operational coverage of LLINs. ALMA works with partners to try to cover funding gaps and address key bottlenecks.

**Bottlenecks that countries face in net distribution**

The biggest bottleneck is usually a lack of funding. These gaps are most often filled with bilateral government aid, through World Bank and Global Fund reprogramming and though other organizations such as the UN Foundation. Sometimes other NGOs contribute as well.

Difficulties concerning tenders also occur from time to time. Many countries handle their own procurement or use VPP, but on occasion, ALMA has worked together with UNICEF to make use of UNICEF's long-term arrangements with manufacturers to ensure rapid LLIN procurement.

Another frequent bottleneck is moving from Global Fund phase 1 to phase 2. Funding is dispensed according to phases and in order to release funding for the next phase of a program, the GF requires documentation. This process can take several months. The RBM Harmonization Working Group (HWG) works with countries to try and speed up this process by providing support for reporting on disbursements and preparation of documentation for phase 2..

**Country capacity in distribution programs**

By and large, most countries have the capacity to figure out who needs nets and to make sure that nets get to those who need them. Logistics, planning and micro planning can be difficult, especially in countries with limited infrastructure, and in some cases can cost almost as much or even more than the

nets themselves, but the vast majority of country programs manage this effectively, with partner support where necessary. Programs that have funding only for nets often end up with insufficient resources to cover all programming requirements which can lead to less well run distributions. It is essential to make sure that all parts of a program are funded in advance. In the vast majority of cases campaigns are done well.

Most countries perform post-campaign monitoring to evaluate net coverage and use. Net retention is high: WHO state that over 80%-96% of distributed nets are used. It is rare that people do not use nets at all, and typically this will only occur if there is no culture of net use and difficult circumstances for hanging nets such as in nomadic populations.

**The evidence behind campaign effectiveness**

Distribution effectiveness estimates and retention and usage figures are based largely on post campaign monitoring and evaluation, such as coverage surveys and malaria indicator surveys. This is supplemented by nationally representative surveys such as the DHS, MICS or MIS. One problem sometimes encountered with these surveys is that when they are done in the dry season, when people are using nets less it can look as though net use is lower than in reality it is. Nevertheless, surveys of this kind are showing upward trends in net use.

**Monitoring insecticide resistance and other factors**

There is no documented case of insecticide resistance leading to operational failure of LLIN programs yet but monitoring of resistance status is relatively inexpensive and should be prioritized. There was a case of insecticide resistance affecting the failure of an indoor residual spraying program in South Africa in the early 2000s. Donors looking to support this monitoring work could consider financing WHO to build their monitoring and oversight capacity for the implementation of Global Plan for Insecticide Resistance Management (GPIRM). Another important area for monitoring is net durability to identify whether it is more cost effective to buy more durable nets that last longer or to use less strong cheaper nets. WHO has been developing proposals for research to answer this question.

**Recommendations for donors interested in supporting net distributions**

The Roll Back Malaria (RBM) Harmonization Working Group (HWG) has worked with countries to identify gaps through 2015 so the nature of funding gaps is well known. Where to fund depends on how much a donor is able to give. There is an 80 million LLIN total gap this year and next. It is preferable that donors fund entire packages, rather than just the commodity, and that they accept the national distribution plan without putting in requests for additional monitoring and evaluation. Donors need to trust that countries and their distribution partners are doing a good job making sure that programs run smoothly and effectively. If donors ask for additional monitoring work they create parallel systems of monitoring and evaluation which are often unnecessary and duplicative given the strong evaluation systems of organizations such as the Global Fund, and can raise transaction costs to the point at which they outweigh the benefits. This is a particular risk when programs have numerous donors, say 30 or 40, some of whom may have donated 20,000 or 50,000 nets, and who then demand separate monitoring requirements for their portion of the nets.

There are plenty of partners to choose from for net donations including UNICEF, the UN Foundation, and a number of NGOs. UNICEF and UNF buy into national systems and are thus particularly good candidate recipients for net donations. Smaller NGOs such as Nets for Life, which has good

programming at the community level, and Nothing But Nets, which works with UNF, are also effective.

**Gaps for RDTs and ACTs**

Gaps for both RDTs and ACTs are significant and growing due to the absence of new funding from the Global Fund over 2011 and 2012. Commodity costs make up the majority of the funding gap because distributions usually use the existing public health systems, and thus create limited additional costs. Funding of RDTs is still behind ACTs. Support to the roll out ACTs in the private sector remains essential, but this requires more investment, particularly in diagnosis.

**Integrated Community Case Management (ICCM)**

There are a number of countries where ICCM could be scaled up. Potential partners working on ICCM include UNICEF, WHO, CHAI and PSI. Deciding what malaria work to support, whether net distribution or diagnosis and treatment, and how, whether in the private or public sector, should depend in part on country specific situations. In Nigeria, the private sector has significant gaps that need to be filled, and a large proportion of the population seek treatment through the private sector, while in Kenya and Tanzania for example, investment in ICCM in the public sector might be a better option. It depends to a degree on the strength of the national health service. Supporting ICCM may be easier in general because it has a clearly defined process of how it is done, the levels of training necessary, etc. In private sector work on ACTs and RDTs, the approach must be more experimental and innovative and there is no clearly defined guideline on expanding diagnostic capacity.