Summary framework of GiveWell / Good Ventures funding toward Malaria Consortium

Background

In 2017, Malaria Consortium will implement the last SMC season with UNITAID funding under the ACCESS-SMC project, with a focus on three countries, Burkina Faso, Nigeria and Chad. These three countries have had more difficulties transitioning to other funding sources (either domestic of international from sources such as the Global Fund, PMI or the World Bank). The three above-mentioned countries make up, together with Mali and Niger, the bulk of the SMC eligible children in line with WHO guidelines, with Nigeria alone accounting for over 11M eligible children, of which only 1.7 are currently covered by ACCESS-SMC. In the whole Sahel region, over 12M children are still left out from SMC programs.

The original ACCESS-SMC grant was expected to fund two seasons in seven countries[1] (2015 and 2016), but UNITAID accepted [we hope] to support one last additional season in the three above-mentioned countries in light of the needs. In Nigeria and Burkina Faso in particular, the gaps are still significant.

While UNITAID accepted also to support an endline survey to establish the prevalence of molecular markers of resistance to SMC drugs after three years of SMC at scale (they funded a baseline survey in 2015), they are less inclined to support key monitoring and evaluation costs, in particular coverage surveys and extra efforts/activities to improve monitoring in Chad and Nigeria. These extra monitoring activities are intended to help perform a better analysis of the discrepancies around coverage surveys and administrative data, which in all countries have been significant.

GiveWell / Good Ventures funding priorities

Two dimensions of support have been prioritized under the framework for targeting the 5 million US Dollars awarded in February 2017 and subsequent ongoing funding:

- Operational support to SMC implementation, through expansion of Malaria Consortium involvement in areas previously covered by other donors but left unserved in 2017, or new areas not yet covered by any donors. The extent of this new operational support was constrained by the timing of the funding confirmation with respect to the season [and capacity at the provider], which both affected the maximum amount of drugs that could be procured, produced, shipped and delivered in time for the 2017 season (approximately 1.6M blisters).
- Monitoring and evaluation support, specifically though the execution of multiple coverage surveys and enhanced in-process monitoring,

a. Operational support

Three countries have been prioritized for this support:

Nigeria:

Since 2013, Nigeria was supported first by Bill & Melinda Gates Foundation and then through other one-off funding to implement SMC in six LGAs in the States of Katsina and Jigawa. Through the funding provided by GiveWell supporters, Malaria Consortium will support these 6 LGAs that did not have any

[1] Burkina Faso, Chad, Guinea, Mali, Niger, Nigeria and the Gambia.

funding in 2017, so that the SMC delivery can recommence in these areas previously supported. In the meantime, Malaria Consortium will continue to support through ACCESS-SMC all the 37 LGAs in the two States of Zamfara and Sokoto. The combined effort provides support to approximately 1.7M children. The details for the GiveWell focus areas are as follows:

Nigeria		**Target 2017**		
State	**LGA**	**Pop 3-11**	**Pop 12-59**	**Pop 3-59**
Jigawa	Kazaure	8,048	34,426	42,474
	Roni	3,878	16,589	20,467
Katsina	Baure	9,838	42,085	51,924
	Dutsi	5,981	25,586	31,567
	Maiadua	10,025	42,886	52,911
	Mashi	8,628	36,907	45,535
TOTAL		**46,398**	**198,479**	**244,876**

Support will take the form of drugs (approximately 1.2M of the dispersible SP+AQ blisters procured), logistics costs, operational support through training, incentives and formative supervision directed at community drug distributors, as well as the health workers and officials that are meant to supervise them, and the standard monitoring framework (including distribution data collection and monitoring tools). Funding will also cover minimum dedicated MC staff for these non-ACCESS-SMC areas, as well as part of some shared staff.

Burkina Faso:

Burkina Faso is the third most populous country in terms of SMC eligibility behind Nigeria and Niger, with significant gaps in geographical coverage, but excellent performance where they managed to secure adequate funding. While large swathes of the country have managed to benefit from consistent funding for SMC, in other areas one-off funding has only provided intermittent coverage. Thanks to large amount of drugs left over from various partners' activities in 2016, Burkina Faso has drugs enough to cover over 370,000 extra children, but no operational costs to do so. Thus, Malaria Consortium through GiveWell / Good Ventures funding will support three districts that have were touched by SMC in previous years, but which had no secured support for 2017, as well as five more new priority districts for SMC. The details are available in the table below.

Burkina Faso	**Target 2017**		
	Pop 3-11	**Pop 12-59**	**Pop 3-59**
Mangodara	6,748	35,925	42,673
Koungoussi	11,023	58,928	69,951
Dafra	10,197	39,431	49,628
Lena	2,257	11,781	14,038
Gourcy	6,678	35,486	42,164
Séguenega	6,405	35,572	41,977
Yako	12,440	66,105	78,545
Boussé	5,286	27,613	32,899
TOTAL	**61,034**	**310,841**	**371,875**

The nature of this support will be similar to the one in Nigeria, with the exception of drugs (which are already available): logistics and operational support, training, incentives and formative supervision support to the required monitoring activities. Dedicated and shared staff are also part of this support framework.

Guinea Bissau:

This is a new country for Malaria Consortium, and the choice was linked to discussions held in February between the MoH / NMCP representative and Malaria Consortium ACCESS-SMC team in Ouagadougou during the joint Malaria Consortium / WHO / WAHO consultation meeting on SMC (13-15 February 2017). The original plan was to support two regions for a total of 80,000 children, and approximately 400,000 dispersible SP+AQ blisters were directed to Guinea Bissau. However, eventually the MoH managed to secure funding for half of this target (one region), and as a consequence the support in Guinea Bissau will be limited to the region of Gabu in the East of the country, targeting approximately 40,000 children under 5. The drugs that will be left over from the current order will have expiration date beyond 2019, so they will be available for use in 2018.

The nature of this support will be similar to that in Nigeria, including drugs procurement, logistics and operational support, training, incentives and formative supervision support to the required monitoring activities. Support will be channeled through an Italian NGO (AIFO), which has operational presence at primary healthcare level in Gabu, while a dedicated Malaria Consortium Liaison Technical Advisor based in country will provide coordination, technical support and supervise the monitoring framework.

Overall, the comprehensive SMC implementation support in what we call internally "GiveWell Districts" will target approximately 650,000 children, and its approximate cost is estimated at 2.3M USD for 2017 (with some carryover costs in 2018 for operational close-out, data analysis and reporting).

b. M&E support

Besides the full operational support in the countries above, gaps have been identified in a number of M&E areas, due to a phasing out of support for established activities (such as coverage surveys) and/or because of quality assurance gaps identified during the 2015 and 2016 seasons, but not accepted as part of the UNITAID support for 2017. The following activities are thus supported through GiveWell funding to complement ACCESS-SMC funding for SMC.

Coverage surveys:

In general, UNITAID is phasing out its support for coverage surveys, since while they recognize that there are wide differences in coverage across countries, at the regional level they're satisfied with the data coming from both administrative and survey data. However, in specific countries like Nigeria and Chad, where the discrepancies appear extremely large between survey and administrative coverage data, Malaria Consortium not only planned to continue this coverage evaluation, but to expand it to each SMC cycle. P in 2015 and 2016 ACCESS-SMC carried out end-of-round surveys after the full four cycles, in collaboration with LSHTM and local research firms or institutions, which, while useful to a measure, left uncertainty about the overall reliability of the results. As a consequence, Malaria Consortium planned

for 2017 to carry out coverage surveys following each cycle, so that the results could be better used to triangulate coverage information with cycle-specific administrative and in-process monitoring data.GiveWell / Good Ventures funding will support four coverage surveys in Chad, Nigeria and Burkina Faso. Considering an estimated cost for each survey of approximately 40,000 USD, it is estimated that such surveys (carried out by independent firms or research institutions) will total roughly 480,000 USD in 2017.

Also, to finalize the independent evaluation framework started under ACCESS-SMC, LSHTM will be also contracted in the role of technical advisory organization, supporting the revision of the evaluation protocols (whose amendments require a revised ethical approval), additional technical supervision of field surveyors, and the analysis and interpretation of results in collaboration with Malaria Consortium technical team. The role of LSHTM is expected to require roughly 300,000 USD over one year (July 2017 – June 2018, expected end date for the finalization of more nuanced analysis of coverage data.

The total support to coverage surveys (a total of 12) is thus estimated at just under 800,000 USD.

<u>Enhanced field monitoring activities and tools</u>

A range of supportive initiatives to improve the SMC monitoring framework was identified and will be supported through GiveWell / Good Ventures funding in 2017 to improve delivery (or its tracking and quality assurance) in ACCESS-SMC areas. These include:

i. *Field data quality / monitoring staff:*
   Six temporary staff are being recruited in Chad and, 37 (one per LGA) in the states of Sokoto and Zamfara, in order to improve supervision and monitoring and make sure that administrative data received is reflective or the real distribution process in the field. In addition, in Nigeria, independent monitors will carry out in-process monitoring during the cycles (while this role in Chad will be played by the six temporary staff mentioned above).

   Low coverage figures in Chad and Nigeria from coverage surveys may create doubts on the reliability of administrative data. By including hands-on supervisors / monitors to random-check distribution areas, the expectation is that we will be able to clear the air around potential misrepresentations of administrative coverage in the past two years.

   Other efforts will be also supported in terms of improving supervision by local officials and health workers and other categories of supervisors (such as teachers in Nigeria to supervise CHW teams), through increased logistics support.

ii. *Enhance monitoring tools:*
   New SMC child cards (which are normally distributed for multiple years) will be printed, which will include a unique identifier of 7 figures. These identifiers will be reported into improved tally sheets, and collected at district/LGA levels in all target countries. The cost of reproducing these tools was not fully represented in the UNITAID budget, and not budget expansion was agreed. But as we consider these minor variations paramount for improved monitoring and child tracking, we will use some of the GiveWell / Good Ventures funding to support the reproduction of such tools.

The overall cost of this extra support is estimated at 400,000 USD. This is mostly focused on Nigeria and Chad, where the gaps are larger, and concerns on coverage and reach more significant.

Overhaul of Malaria Consortium SMC monitoring and data management framework:

Recognizing the limits of our previous data management and monitoring tools at central level, we decided to move to a more coherent SMC data management framework. In the last two years, with SMC being a new intervention at scale, Malaria Consortium has learnt by doing what are the basic tools and parameters to consider for adequate management of the massive amount of SMC data generated through a mass drug administration campaign to millions of children. While in the past two years all data were available, they were often spread across a number of formal and informal platforms, including country's HMIS, Malaria Consortium spreadsheets for SMC datasets, partners' data and an LSHTM repository.

In light of the renewed effort to better control and analyze SMC data, Malaria Consortium decided to contract Dharma for the establishment of a comprehensive platform for the storage, management and analyses of SMC data, including both administrative data and ad-hoc evaluation data such as those generated by coverage surveys. The estimated cost of this setup and platform management is approximately 100,000 USD for the current year (mostly related to setup, training and including 40,000 USD of license). Yearly license of 40,000 USD in subsequent years will need to be embedded in any future SMC proposal.

Summary budget for GiveWell / Good Ventures support

The table below provides a summary of the expected funds utilization under the GiveWell / Good Ventures framework.

Country-based costs	
Nigeria	
"GiveWell Districts"	1,065,000
Monitoring support in ACCESS-SMC areas	350,000
Coverage evaluation	160,000
Total Nigeria	**1,575,000**
Burkina Faso	
"GiveWell Districts"	940,000
Monitoring support in ACCESS-SMC areas	35,000
Coverage evaluation	160,000
Total Burkina Faso	**1,135,000**
Chad	
"GiveWell Districts"	-
Monitoring support in ACCESS-SMC areas	120,000
Coverage evaluation	160,000
Total Chad	**280,000**
Guinea Bissau	
"GiveWell Districts"	380,000
Monitoring support in ACCESS-SMC areas	-
Coverage evaluation	-
Total Guinea Bissau	**380,000**
Total country-based	**3,370,000**
Above-country costs	
LSHTM TA Work on coverage surveys	**300,000**
Malaria Consortium data management overhaul	**100,000**
Drugs procurement & delivery	**550,000**
Other global coordination costs	**50,000**
Total above-country	**1,000,000**
Contribution to Overheads @ 10%	**437,000**
Grand total estimate	**4,807,000**
Expected absorption	*96%*