

KEY MESSAGES

Roll Back Malaria

Affordable Medicines Facility - malaria Monitoring and Evaluation (M&E) Workshop

10 -11 June 2009, Dar es Salaam, Tanzania

- The draft M&E Framework was reviewed /discussed and accepted by countries. The final version of the Framework will include points of emphasis and clarifications made during the country consultation workshop.
- More specifically, countries asked a number of questions, sought points of clarification and made suggestions. Key messages from this country consultation on the AMFm M&E Framework are summarized in the below (i.e. not in order of priority).

Issue 1: Public sector oversight of first line buyers in the private sector

It was suggested there was a ‘missing link’ in terms of public sector knowledge of first line buyers activity – particularly concerning private-for-profit first line buyers. The need for information about first line buyer activity was pointed out so that commodity flows (i.e. artemisinin-based combination therapy) and the rollout of supporting interventions could be coordinated.

Response: Information about first line buyer purchases will be openly available to all on a public website. This means public sector country representatives can easily track ACT volumes and date of purchase by buyer. Where first line buyers supply a number of different AMFm countries, data will be disaggregated by country. This will be a ‘live’ tracking tool and the website will be updated within five days of an order being approved.

Public sector stewardship is important – including for the private for profit. However, it is important not to over manage or stifle private-for-profit sector innovation and activity. Countries are encouraged to build on their first line buyer arrangements – not limit or reduce them.

Issue 2: What is the purpose of public sector monitoring visits to a sample of registered private-for-profit outlets?

Response: The purpose of these monitoring visits is to build up monitoring processes and structures of the private-for-profit sector. If AMFm Phase 1 is globally rolled out, then countries will have wider responsibility for monitoring ACT availability and price and use.

In AMFm Phase 1, the monitoring and reporting requirements for this are modest. This is deliberate – i.e. it creates room and time for countries during AMFm Phase 1 to plan and develop approaches to more comprehensive monitoring of the private-for-profit sector, in the event of a global roll out of AMFm.

Issue 3: Serious design failures of AMFm (i.e. ‘red flags’)

In accordance with an earlier Global Fund Board decision¹, AMFm Phase 1 will be globally rolled out unless serious design failures are identified during AMFm Phase 1. Two items were raised for discussion during the workshop concerning the definition and scope of what constitutes an AMFm design failure (or ‘red flag’):

(a) Monotherapies

The need to include the ‘crowding out’ or reduction of oral artemisinin monotherapies as a performance measure of AMFm was encouraged. It was suggested this should be included as a ‘red flag’ along with ACT price and availability.

Views were also expressed that expectations of what constitutes a reasonable market shift should be realistic as the data collection period is short (i.e. approximately twelve months). It was suggested that difficulties with AMFm market impact (i.e. the ‘crowding out’ monotherapies), at the country level, could be considered a ‘yellow flag’ (i.e. cautionary or warning alert) and not a ‘red flag’ (i.e. serious design failure)

Response Volumes and ratios of oral artemisinin monotherapies will be assessed as part of the independent evaluation. The ‘crowding out’ of monotherapies will be included as a red flag in terms of the evaluation of AMFm because this is an important AMFm objective. This is now included in Draft 2 of the Framework which was prepared after Draft 1 was sent to workshop participants.

However, interpretations of the extent of these market shifts will take into account the limited time period of AMFm Phase 1 implementation.

(b) How many ‘red flags’ will signify a failure of AMFm?

Response The following will be considered design failures of AMFm if they occur:

- Serious price violations (i.e. co-payment mechanism does not result in significant price reductions of ACTs to the end user)
- Serious lack of ACT availability
- Limited market changes to volume of monotherapies available in outlets selling or providing anti-malarial treatment (across all sectors) in comparison to the volume of ACTs.

(c) How are thresholds set for red flags?

Response ACT price availability and use will be measured ‘before’ and ‘after’ the introduction of AMFm Phase 1. These findings will be compared with how much progress would have been expected via ‘business as usual’. This assessment will be made on a country by country basis as country contexts and circumstances differ. Also, the design of the independent evaluation allows for a comparison with 2-3 countries where AMFm is *not* being implemented to enable a comparison of ACT price, availability and use.

Issue 4 **There was a request to include in the independent evaluation ‘exit interviews’ from outlets that sell /distribute anti-malarial treatment. Such interviews may provide**

¹ Global Fund Board Decision Point (GF/B17/DP8). Annex 1 to *Principles for AMFm Policy Framework, Implementation & Business Plan*.

another method by which to understand consumer behavior and explore issues around dispensing /selling practice

Response This will be considered when revising the draft Framework. In order to obtain a fuller picture of consumer and dispensing behavior, the independent evaluation will survey: (i) anti-malarial stock in outlets (all sectors); (ii) ACT market share (% all purchases) through exit interviews and; (iii) malaria treatment seeking behavior at the household level (i.e. to determine ACTs as % of all treatments). Data from all three sources will be included in the independent evaluation.

Exit interviews can tell us whether or not ACTs are increasing as a proportion of purchases at these formal private outlets, and this is very important. But they don't tell the full story. For instance, those who choose to use private drug shops (particularly formal registered outlets) differ in ways - known or unknown - from those who do not use them. By definition, the sample has a selection bias. For instance, due to the 'fluid' and amorphous nature of the informal private sector it will be difficult to conduct 'exit interviews'

Data from exit interviews at private sector outlets help to answer the following question: *"What is the socio-economic distribution of those who use anti-malaria treatment from private drug shops?"* It does not answer the following question: *"What is the socio-economic distribution of those who use anti-malaria treatment from any source?"* In order to answer the latter, it is important to include data from household surveys and from other facilities in addition to private-for-profit drug shops.

Issue 5: Guidance was sought on a range of grant matters

(a) Clarification was sought on the use of Service Delivery Areas (SDAs) from the host grant regarding AMFm Country Applications

Response Countries are advised to use the same SDAs for their AMFm Country Application as those in the host grant. If there are new activities proposed in the AMFm Country Application that fit under existing SDAs, then they should be listed there with their associated indicators. If new activities are not covered by host grant SDAs, then new SDAs can be created, as appropriate, to cover those new activities.

(b) Is an advance grant disbursement possible whilst grant amendment negotiations are being completed?

Response In principle this is possible. However, this needs to be discussed and agreed with the respective Global Fund Portfolio Manager and considered on a country by country basis.

(c) Could weak AMFm Phase 1 implementation and progress impact negatively upon the GF host malaria grant in terms of future decisions about renewal?

Response: AMFm Phase 1 is a learning phase. Phase 2 review panels will be aware of this and will not penalize a host grant for any AMFm specific challenges that effect grant performance.

A number of broader country application and grant related points were also made:

- Successful AMFm Country Applications will be funded via a grant amendment to an existing GF malaria grant (i.e. a 'host' grant). Where AMFm activities overlap with activities of the host grant, explanations of AMFm activities can be minimal as long as they are clear. This is because a more detailed description and program justification was presented to the Technical Review panel when the host grant application was originally reviewed.
- Make plans as simple as possible. All AMFm Phase 1 activities will occur within a two year period. Therefore ensure that interventions are essential and related to AMFm objectives
- Highlight any changes that are made to the amended performance framework for the host grant. Make it clear through the use of tables or text what are additional activities to the host grant for AMFm.