



15 December, 2022

CRSPC Guidance on the GF Funding application process

Implications of the Replenishment outcome

- The Global Fund Replenishment fell short of the US\$18 billion target. The outcome of this is that country allocations will be strained.
- Inflation is impacting country economies, especially in Africa, and costs of commodities and delivery of services in increasing.
- In real terms countries will be faced with making hard prioritization decisions given the increased costs of doing business, whilst trying to address the increased threats of drug, parasite and insecticide resistance.
- It is estimated that sustaining the existing life saving interventions will account for over 75% of the malaria allocation to countries.

RBM Support to Countries

- To ensure timely submission of high quality Funding Request and to avoid gaps in implementation, the CRSPC will provide a comprehensive package of support to countries, based on a tried and tested country-led approach.
- Several TAs are ongoing to update MPRs/NSPs, CRG assessment (malaria matchbox), and addressing other outstanding TRP comments, and any additional support required in these areas should be submitted as soon as possible
- Starting early January 2023, TA will be provided to countries in a coordinated manner through international and local consultants. CRSPC will also support countries to facilitate in-country stakeholders consultation meetings
- Mock TRPs are planned (Window 1: Feb 21-23; Window 2: May 2-4; window 3: July 19-21)
- Remote expert review of final draft funding applications and grant making process.

Programme Split and RSSH

- There are several country examples from NFM3 where there was a significant and disproportionate reallocation of resources away from malaria for RSSH that led to gaps in essential services for malaria and where RSSH investments did not necessarily prioritize malaria's key health systems strengthening needs.
- We recommend using the gap analysis as a key tool in your discussions on the programme split and be prepared to advocate for malaria RSSH needs to be prioritized.
- Make sure you are well versed on what interventions and support can be included under RSSH including both direct and indirect RSSH investments that are critical to the malaria response.
- Notify us as soon as possible, if in-country discussions on allocation shifts will create significant programmatic gaps in malaria, are disproportionate, or are not adequately addressing malaria's RSSH needs

Essential Points: Increasing Emphasis on Sub-National Tailoring

- Explain how the country dialogue prioritised interventions based on a detailed analysis of the country epidemiological stratification. Describe how and why the prioritisation was made
- Use the sub-national stratification where possible to support better targeting of packages of malaria interventions for highest impact. Examples from the current grant period include expanded SMC coverage; microstratification of urban areas to allow for ITN targeting to higher burden areas and away from low burden areas.
- Consider what you need to strengthen delivery of malaria services as issues such as access to care, cultural, socioeconomic, geographic and other factors differ sub-nationally
- Where countries have reduced the burden of malaria due to vector control, the underlying endemicity before scale-up of vector control should be highlighted, so it is clear why vector control needs to be sustained, if you need to justify sustaining the intervention. Where a country is withdrawing vector control, highlight why this will not lead to an upsurge and/or how you will mitigate the impact of any potential upsurges

Sustain (and accelerate) the Gains

- Prioritisation of essential interventions in the allocation: Ensure key priority interventions are included in the allocation request as much as is possible. Application forms now highlight if an intervention is a continuation from the current grant, a scale-up of coverage or is new.
- Be sure to express above allocation needs in the Prioritized Above Allocation Request (PAAR) to allow for the immediate reprogramming of savings during grant making and programming of additional resources potentially freed up through the portfolio optimisation process throughout the grant cycle.
- **The Emergency Fund:** in the event of an emergency and where reprogramming is not possible – an emergency fund request can be made to the GF. Do not include a request for emergency stocks in the funding request (but include sufficient buffer stocks based on the experiences during the COVID-19 pandemic).

Gap Analysis - Cross cutting

- Buffer stock:
 - ITNs - for countries where the census is greater than 5 years old, we recommend including a 10% buffer, or for countries to use data from previous campaigns
 - Case management use consumption and experiences during the COVID-19 pandemic to justify a buffer amount
- Highlight where key and vulnerable populations are included in the gap analysis including IDPs, refugees etc
- Use the NEW commodity prices from the GF and note any increases in costs related to recent inflation. Continue to order early as lead times continue to be longer than pre-Covid
- Use the country stratification to explain how GF resources have been prioritized and why. This can be used to help address the value for money questions, but also ensure that issues around equity are addressed – ensure you have defined your populations at risk and show that they are being prioritized.
- Include insecticide, drug and parasite resistance testing in the allocation if these are not funded elsewhere

Vector Control

- If PBOs or IG2 nets were distributed in the current cycle, countries should plan to sustain the current coverage in the new grant and budget for further scale up, including the additional costs in PAAR if they cannot be covered in the allocation.
- If countries are considering introducing or expanding IRS, the Global Fund will want to understand the long-term plans for sustainability
- Entomological surveillance, entomological capacity and monitoring are critical to decisions on VC choices and should be included in the allocation
- Strong evidence on differential usage is still required for non-standard LLIN specifications
- Include resources for digitalization of campaigns and where possible look for opportunities for this to be integrated with other malaria and health campaigns

Case Management

- Do not forget to describe how case management is being managed through the public and private sector, and community level (CRSPC can provide TA in 2023 for the development of private sector engagement strategies).
- The ACT gap analysis now asks for details on types of ACTs as part of resistance management
- Do not forget to focus on quality of care, rational and feasible scale up of iCCM, and engagement of the private sector where it makes sense.
- For iCCM and CHWs, ensure there is a clear strategy and long-term plans including for the non-malaria commodities – there is now a CHW and non-malaria commodities at community level gap analysis template, and these commodities (e.g. antibiotics, ORS) can now be procured through the GF as long as the requirements are met.

RSSH and Malaria:

- All pillars of RSSH are needed for malaria services to be successful
- Opportunities exist for integration of health activities with malaria campaigns (ITN, IRS and SMC) but need to be based on context, target population and operational considerations
- Main RSSH needs focused on case management (CM), malaria in pregnancy (MIP), supply chain and surveillance
 - Improving access to care (CM and MIP/ANC): community systems and private sector – looking at what makes sense to prioritize based on where people seek care and mapping service availability
 - Quality of care: for both case management and malaria in pregnancy
 - ✓ Focus on what is being done and how it is done (i.e. patient-centered care)
 - Last mile distribution
 - Data for decision-making: quantity, quality, timeliness, completeness and use at all level

Filling out the Forms

- Consider including a summary table highlighting what is being prioritised by major intervention in the allocation and above allocation
- For Programme Continuation countries, you can include expanded implementation where stratification points to expanding (or reducing) an intervention will lead to higher impact e.g. you do not have to maintain the same scale

Essential Points:

- Where country progress has stagnated, highlight the underlying causes and highlight what is being done through this grant, to accelerate progress.
- Remember that the costs of health systems are needed to carry out malaria interventions - include them, and include this amount in the RSSH contribution e.g. iCCM, CHWs etc
- Refer to the TRP comments from the last round – and highlight how any concerns raised by the TRP -or management conditions – have been addressed
- Don't forget to fully implement the current grant to maximise the use of the resources currently available

Essential Points: Watch out!

- Where equity, human rights and gender equality issues and key vulnerable populations are identified, be sure to also describe how these are being addressed in the implementation of the grants which should be considered as an integral part of subnational tailoring
- Try to stick to the page limits and answer the question being asked! But if there is insufficient space to describe a complex issue – exceed the limit!
- Remember - transition does not mean transition from malaria programming! . Rather transition from GF funding to National sources to maintain malaria programming
- Let us know if there are problems with the in-country allocation discussions!
- Remember there are malaria specific requirements too e.g. iCCM, M&E etc
- Where you are scaling up – provide evidence that the rate of scale up is feasible and not at the expense of more impactful, implementable interventions



15 December, 2022

Thank you!

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Case Management and Chemoprevention Gap Analysis

Malaria diagnosis and Treatment – key assumptions in gap analysis

- The defined needs of Artemisinin-based Combination Therapy (ACTs) and malaria diagnostic tests (microscopy and Rapid Diagnostic Tests (RDTs)) are influenced by the disease epidemiology and coverage of the health system.
- It is critical that the most up to date evidence based, and rational assumptions be used.
- For Community Case Management, ensure complementarity between the malaria and non-malaria commodity gap analysis sheets.

Malaria Treatment

- To estimate the projected requirement of ACTs by year, ACT consumption data are preferred where available, but epidemiological estimates can also be used, or a combination of the two.
- The proportional contribution to access (service delivery access by sector) from each sector: public, community case management and private sector should be estimated and broken down by each sector. This share by sector may change over time, for example, with shifts in treatment seeking in the public or private sector.

		2023	2024	2025	2026	Assumptions
Total number of expected malaria cases (public, private and community level) A	#	13,000,000	13,390,000	13,791,700	14,205,451	Insert the number of suspected malaria cases annually based on national (local) epidemiological and consumption estimates
Public Sector Health Facility	%	0.65	0.65	0.65	0.65	Insert the % of total cases expected through public sector health facility (e.g. public sector facilities account for 65% of case management)
Public Sector Health Facility B1	#	8,450,000	8,703,500	8,964,605	9,233,543	Insert the total number of ACTs required through the public sector health facility e.g. public sector facilities account for 65% of case management therefore multiply the total number of malaria cases in row 10 (A) X 0.65
Community Case Management	%	0.05	0.05	0.15	0.15	Insert the % of total cases expected through iCCM (e.g. iCCM accounts for 5% of case management in 2023 and 2024 but expands to 15% in 2025 and 2026)
Community Case Management B2	#	650,000	669,500	2,068,755	2,130,818	Insert the total number of ACTs required through iCCM e.g. iCCM accounts for 5% -15% of case management therefore multiply the total number of malaria cases in row 10 (A) X 0.05 in 2024, and X 0.15 in 2025 and 2026
Private Sector	%	0.30	0.30	0.20	0.20	Insert the % of total cases expected through the private sector e.g. private sector accounts for 30% in 2023 and 2024, and 20% in 2025 and 2026
Private Sector B3	#	3,900,000	4,017,000	2,758,340	2,841,090	Insert the total number of ACTs required through the private sector e.g. private sector accounts for 30% of case management therefore multiply the total number of malaria cases in row 10 (A) X 0.3 in 2023 and 2024, and 0.2% in the following years

Malaria Treatment

- The proportion of malaria cases that are to be treated with ACTs should be aligned with the targets in the NSP and this should include the different coverage targets for each sector (e.g., public health facilities 100% of malaria cases targeted, iCCM 100%, private sector 15%). Do not include the malaria cases that are not accessing care and are not reached, for example, if you do not have a programme that targets the informal private sector, do not include these in your target.

Target coverage						Take account of the different coverage target for each sector (e.g. public health facilities 100% of malaria cases targeted, iCCM 100%, private sector 15%)
National target coverage of malaria cases %	%					
Public Sector Health Facility C1	%	100.00%	100.00%	100.00%	100.00%	Insert the % target for public sector health facility coverage (should be close to 100%)
Community Case Management C2	%	100.00%	100.00%	100.00%	100.00%	Insert the % target through iCCM (e.g. 100% of iCCM)
Private Sector C3	%	15.00%	15.00%	20.00%	20.00%	Insert the % target through the private sector e.g. 15% of private sector targeted in first two years and 20% targeted in following 2 years

Malaria Treatment

Multiply the number of ACTs required by each sector by the proportion of malaria cases in each sector.

Total number of ACTs needed							
3.1.1	Number of treatments required D	#	9,685,000	9,975,550	11,585,028	11,932,579	Add the total number of ACTs in public health facilities, community level and private sector
3.1.2	Buffer	#	15.00%	15.00%	15.00%	15.00%	Include a buffer in accordance with national policy (should not exceed 30%)
3.1.3	TOTAL ACTs required D1	#	11,137,750	11,471,883	13,322,782	13,722,466	Total ACTs required including buffer = Public +community +private sector ACTs
3.2.1	Public Sector Health Facility E	#	8,450,000	8,703,500	8,964,605	9,233,543	Multiply the number of public sector malaria cases (B1) by the target coverage (C1)
3.2.2	Buffer	#	15.00%	15.00%	15.00%	15.00%	Include a buffer in accordance with national policy (should not exceed 30%)
3.2.3	Public Sector Health Facility Total ACTs required E1	#	9,717,500	10,009,025	10,309,296	10,618,575	Total required E1= E+(Exbuffer%)
3	Community Case Management F	#	650,000	669,500	2,068,755	2,130,818	Multiply the total number of iCCM malaria cases (B2) by the target coverage C2)
3	Buffer	#	15.00%	15.00%	15.00%	15.00%	Include a buffer in accordance with national policy (should not exceed 30%)
3.2.2	Community Case Management Total ACTs required F1	#	747,500	769,925	2,379,068	2,450,440	Total required F1= F+(Fxbuffer%)
3.2.3	Private Sector G	#	585,000	602,550	551,668	568,218	Multiply the number of private sector malaria cases (B3) by the target coverage (C3)
3	Buffer	#	15.00%	15.00%	15.00%	15.00%	Include a buffer in accordance with national policy (should not exceed 30%)
3	Private Sector total ACTs required G1	#	672,750	692,933	634,418	653,451	Total required G1= G+(Gxbuffer%)

Malaria Treatment

- Estimate the total number of ACTs financed, by sector, through domestic and external resources, subtract the number of ACTs financed from the number required to calculate the gap by sector.
- Highlight the number of ACTs to be financed through the Global Fund Allocation. Note any outstanding gap and consider funding this through the GF Prioritised Above Allocation

Malaria Treatment

- For countries deploying more than one ACT, note the breakdown in the gap analysis table. This should be based on the targets set in the national strategic plan, from sub-national stratification and tailoring and from antimalarial drug resistance strategies and action plans and may be targeting specific age groups, such as children under five years of age or geographical areas. If resources are insufficient - include any gaps in the prioritized above allocation request.
- Take into account any changes as a result of the impact of COVID/Ukraine crisis on delivery costs, commodity costs and on domestic and donor funding support.
- Ensure that costs for antimalaria drug efficacy studies are included in the allocation

Severe Malaria

- For the total number of severe malaria cases, use the number of estimated malaria cases in the ACT gap analysis. Use local data to define the proportion of uncomplicated malaria cases that are estimated to progress to severe disease. This should be less than 5%.
- Insert the % of severe malaria cases to be targeted in the National Strategic Plan
- Multiply the total number of severe cases by the target coverage in the NSP
- Insert the proportion of severe malaria cases managed (pre-referral treatment, e.g. rectal artesunate) through community case management and /or primary health care level. Multiply the proportion of severe malaria cases managed (pre-referral treatment, e.g. rectal artesunate) through community case management and /or primary health care level by the total number of severe cases
- Insert the proportion of severe malaria cases managed at facility level. Multiply the proportion of severe malaria cases managed at facility level by the total number of severe malaria cases
- Include what is already financed through domestic and external resources, and allocate the gaps to the GF allocation.

Diagnosis

- Insert the number of suspected malaria cases annually based on epidemiological estimates and consumption data and extrapolate to account for population increases. Calculate the total number of RDTs and microscope slides required annually.
- Insert the national targets for diagnostic coverage based on the targets in the National Strategic Plan. Be sure to account for different diagnostic coverage by sector for example noting the percentage access to care through public health facilities, at community level and through the private sector. Diagnostic coverage at public, private and community levels will then need to be incorporated.
- The number of RDTs and microscopy slides required is calculated by factoring in overall need, national targets, and reductions as a result of vector control, and relative proportion covered by microscopy or RDTs.
- Calculate the number of RDTs/microscopy slides already financed or available over the projected period by sector.
- Subtract the number of RDTs/microscope slides financed from the total number required to calculate the gap by sector.

Seasonal Malaria Chemoprophylaxis (SMC)

- Good quantification of supplies is a key determinant of successful implementation of SMC. Estimating the quantity of drugs requires a close approximation of the number of children targeted by age group. If such estimates are not available but the fraction of children in this age group in the population is known, the quantity of SMC drugs can be estimated. Population data can be obtained from the most recent national census or demographic and health survey or the national bureau of statistics.
- The number of tablets is the product of the expected number of children in the targeted area(s) and the number of doses given during the transmission season.
- For the gap analysis, highlight the number of children to be reached (noting the targeted age groups), the number of SMC cycles, and then the number financed (through domestic and external resources), the need to be met through the GF allocations and any outstanding gaps. Consider covering any outstanding gaps through the Global Fund Prioritised Above Allocation Request.

IPTp

For the IPTp gap analysis, highlight the number of pregnant women to be reached (through ANC, and where applicable, through community health workers).

Factor in expected increases in population coverage.

Note also the coverage of ANC, and factor in any expected increases in ANC coverage.

Note what is financed through domestic and external resources, the need to be met through the GF allocations and any outstanding gaps.

Consider covering any outstanding gaps through the Global Fund Prioritised Above Allocation Request



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UNHCR
The UN Refugee Agency

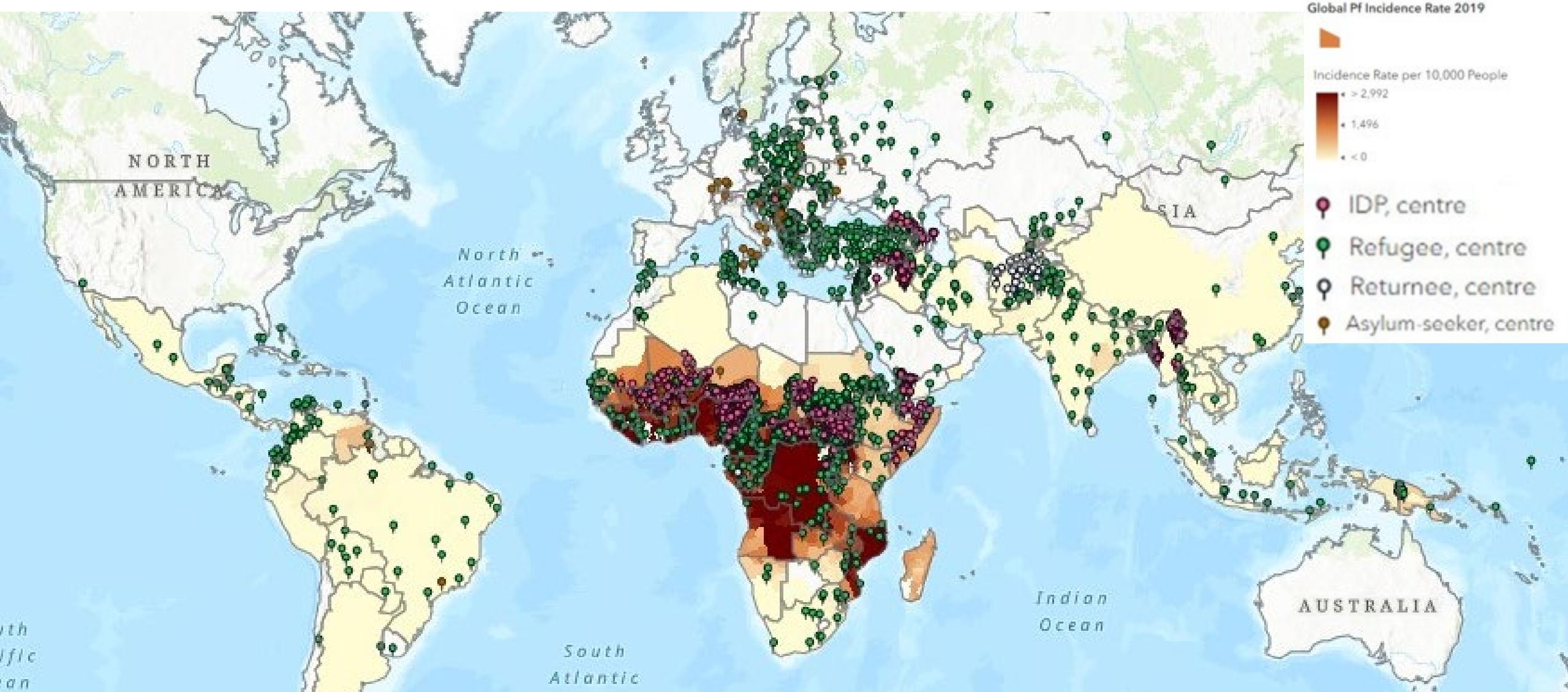
Assessing the Inclusion of Displaced Populations in Global Fund Applications 2020-2022



Disease risk is increased among displaced populations

- Malaria, HIV/ AIDS and TB present unique risks to the world's **103 million forcibly displaced people**
- Forcibly displaced populations are often at greater risk of disease due to
 - High levels of mobility
 - Living conditions that increase exposure to disease or disease vectors
 - Decreased access to health services often caused by ongoing conflict, collapse of health system, ethnic, cultural, linguistic or other barriers
 - Weakened immunity because of multiple infections and malnutrition
 - Movement between low and high transmission zones
 - Increased risk of gender-based and sexual violence

Overlap of Global *P. falciparum* Incidence and Displaced Populations



Methodology:

•Keyword search terms:

- Refugee
- Internally displaced person
- IDP
- Returnee (classified as refugees)
- Displaced
- Displacement
- Mobile (exclude nomadic, semi-nomadic, migrant)
- Asylum seeker
- Venezuelan
- Humanitarian conflict
- Noncitizen
- People/person of concern
- Foreigner
- Stateless

•Eligibility:

- Countries that qualify for GF allocation at time of application
- Countries with at least one approved grant
- Refugee/IDP population greater than 10,000 at time of application

•Scoring: Based on keyword search, applications were labeled and scored

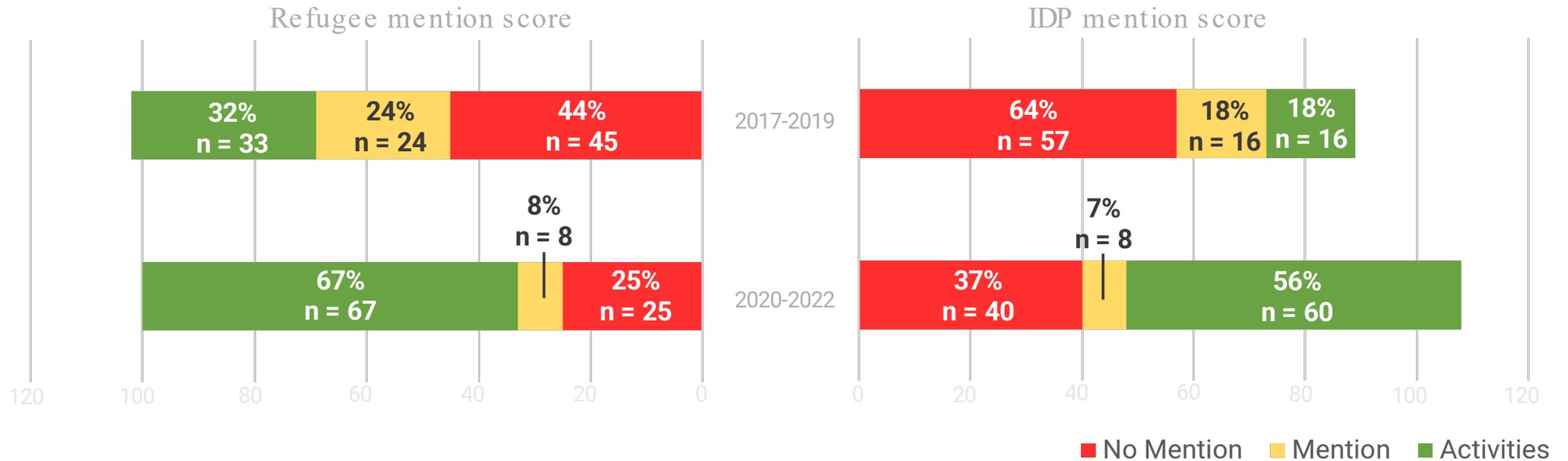
Activities – included specific activities that focused on refugees/IDPs

Mention – mentioned their population of refugees/IDPs but did not specify activities

No Mention – no mention of the refugees/IDPs

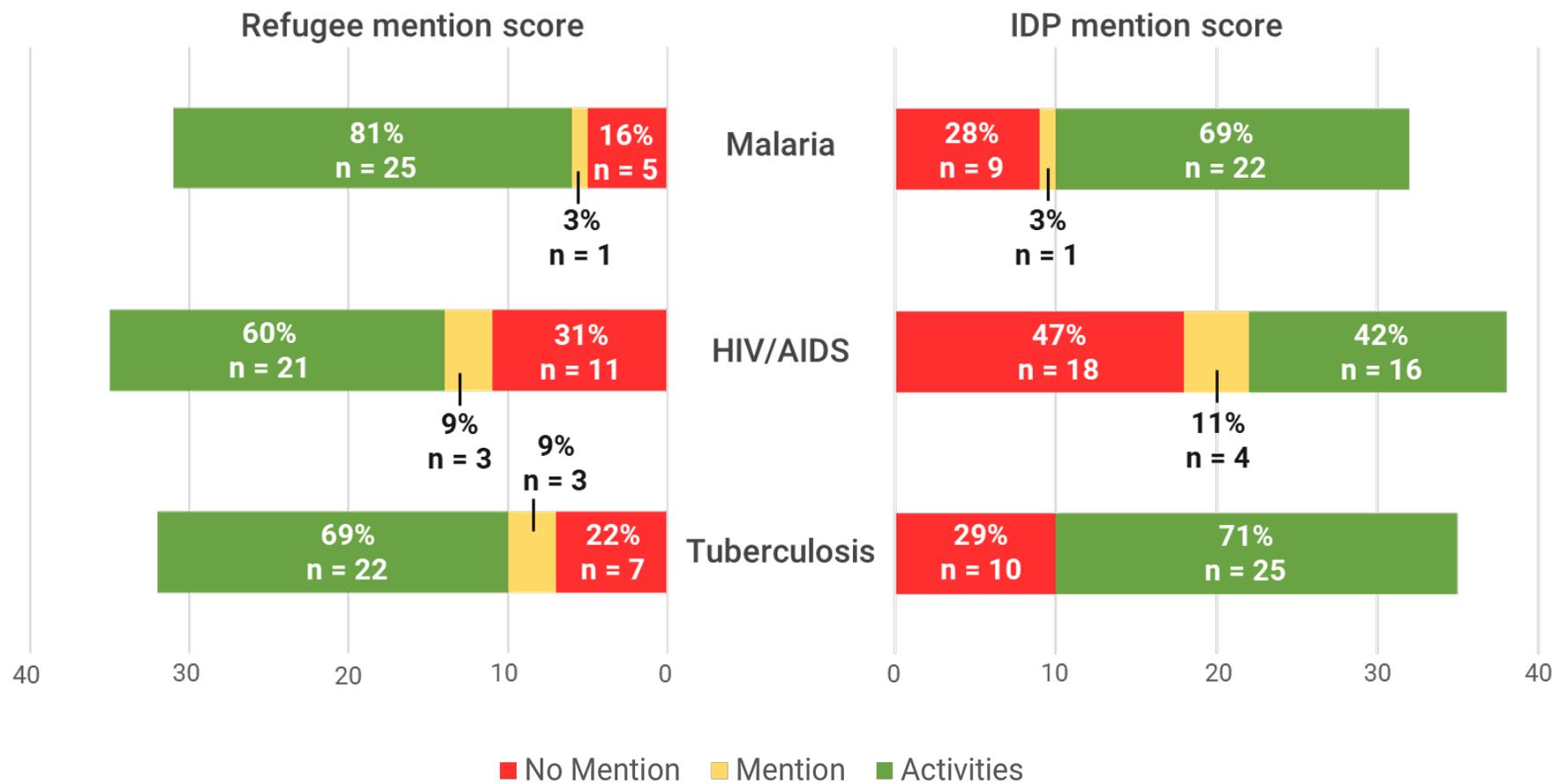
•Study Size:

- Refugee analysis – 100 applications, 37 countries
- IDP analysis – 107 applications, 40 countries

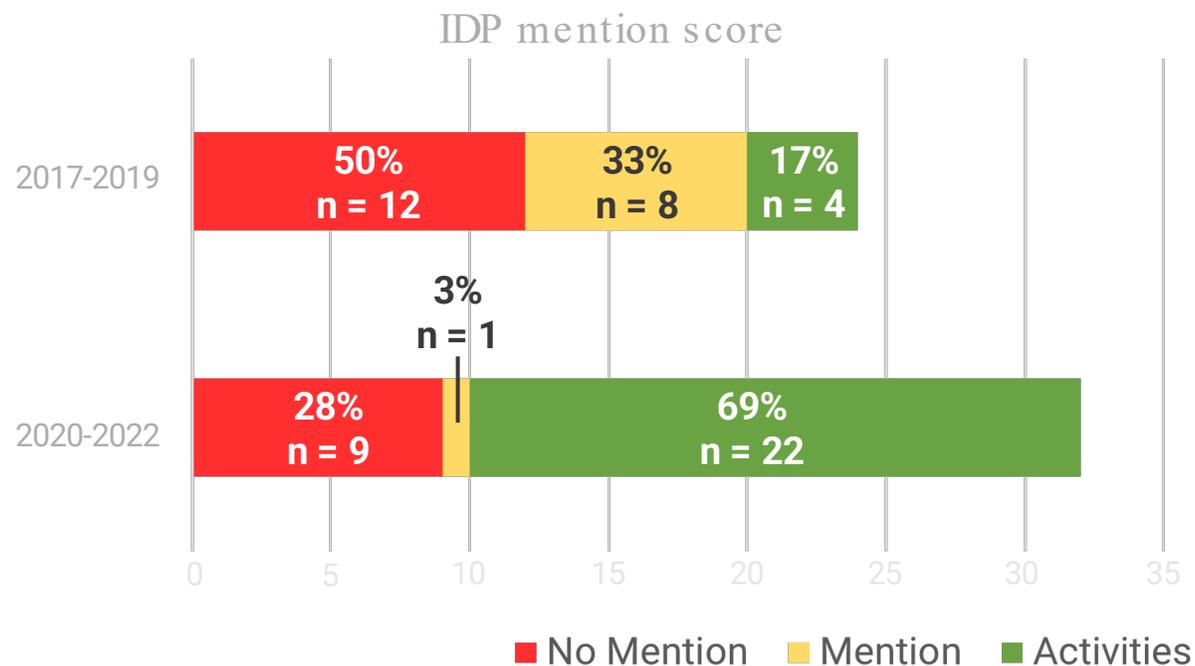
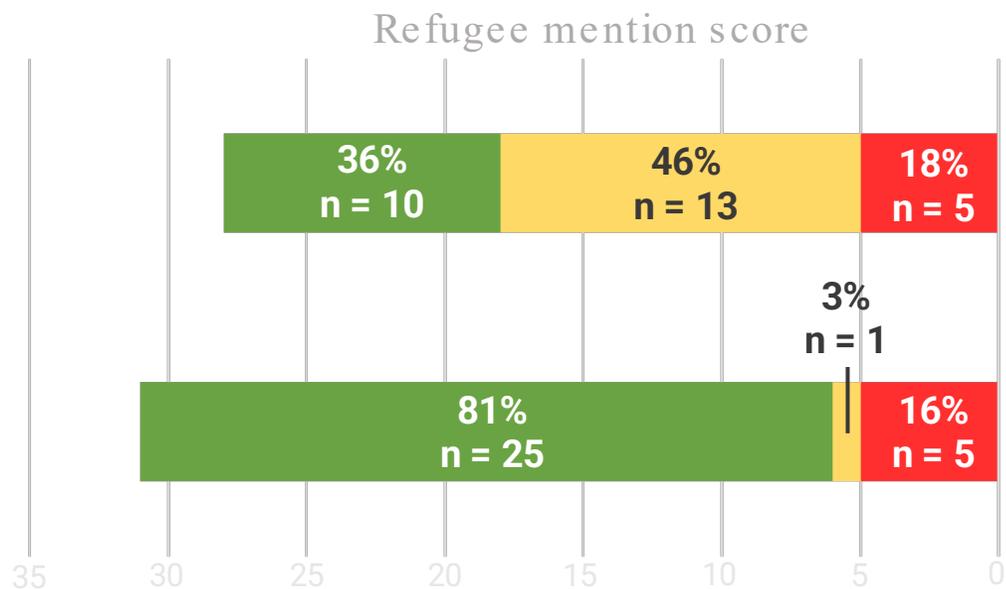


Since the last funding cycle:

- Refugee and IDP mention has increased substantially across the 3 diseases
- The number of applications mentioning displaced populations without detailing activities targeting them has decreased



Overall, refugee and IDP inclusion in GF applications has improved across the three diseases.



Refugee and IDP inclusion in malaria funding requests has improved substantially.

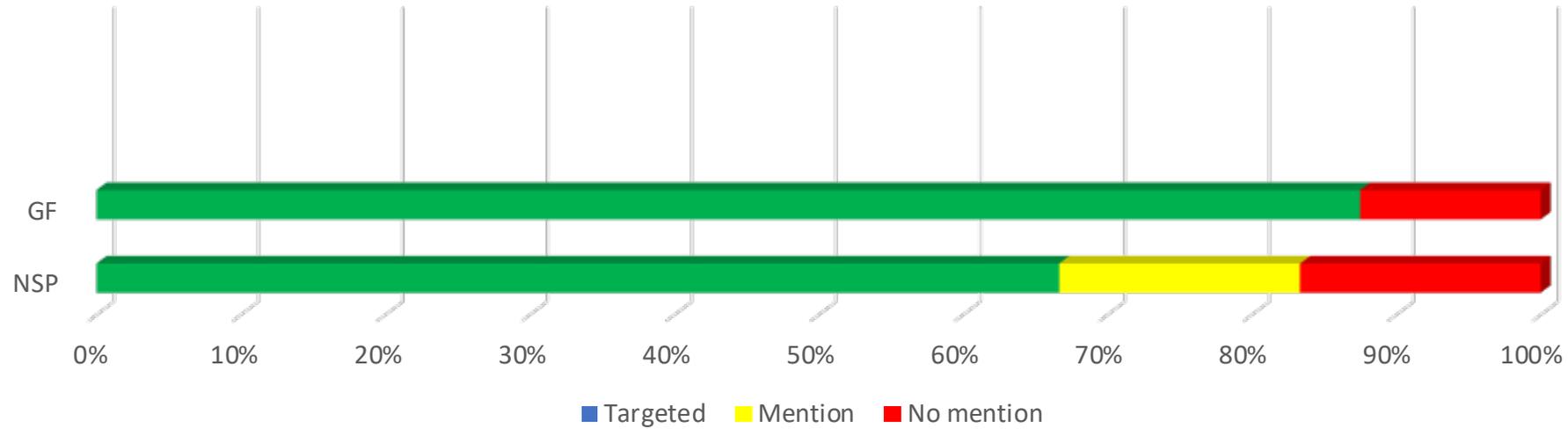
Since the last funding cycle:

- Inclusion of specific activities for refugee and IDPs has increased substantially
- Virtually no funding requests mentioned displaced populations without detailing targeted activities for them

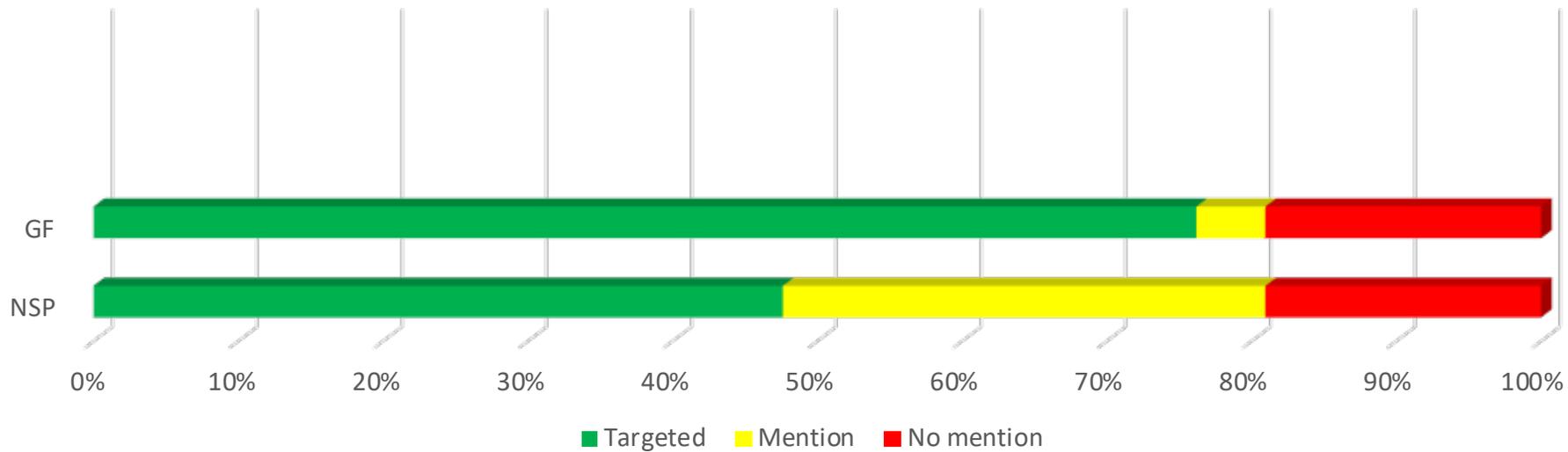
Conclusions : Malaria analysis

- Inclusion of both refugee and IDP populations in malaria funding requests has improved substantially since the previous analysis in 2019.
- There was a notable decrease in the proportion of countries failing to mention or include tailored activities for IDPs.
- Only two of the 63 malaria applications mentioned refugees and IDPs without detailing specific programming activities for malaria.

Refugee Inclusion in NSPs and Global Fund (2020-2022) malaria applications



IDP Inclusion in NSPs and Global Fund (2020-2022) malaria applications



Scorecard Sample

REFUGEE AND INTERNALLY DISPLACED PERSONS INCLUSION IN GLOBAL FUND FUNDING APPLICATIONS 2020-2022

September 2022



Eastern Horn of Africa and Great Lakes

Malaria, HIV/AIDS and tuberculosis (TB) present unique risks to refugees and internally displaced persons (IDPs) in Eastern Horn of Africa and Great Lakes Region. High levels of mobility, inadequate living conditions with increased exposure to diseases or vectors, and reduced access to health services due to ongoing conflict and socio-economic, cultural, language or gender barriers, all contribute to increased risk of exposure. Furthermore, sustained conflict and crisis can cause the collapse of primary health systems, limit activities to prevent the transmission of malaria, TB, and HIV, and disrupt the delivery of vital medical commodities.

As one of the largest financiers of global health programs, The Global Fund to Fight AIDS, TB and Malaria is a vital source of support to ensure refugees and IDPs have access to quality disease prevention, treatment and care services.

5.1 M
Refugees

12.7 M
IDPs

2021 Year-End Data

HUMANITARIAN SITUATION: REGIONAL OVERVIEW

The region of the Eastern Horn and Great Lakes includes Burundi, Djibouti, Ethiopia, Kenya, Rwanda, Somalia, South Sudan, Sudan, Tanzania, and Uganda. By the end of 2021, the East and Horn of Africa and the Great Lakes region hosted 4.9 million refugees and asylum seekers and 12 million internally displaced people. The region hosts 67 percent of the refugees on the African continent and 23 percent of the global refugee population. The region also has over 12 million IDPs, particularly in Sudan, South Sudan, Ethiopia, Somalia, and Burundi (UNHCR).

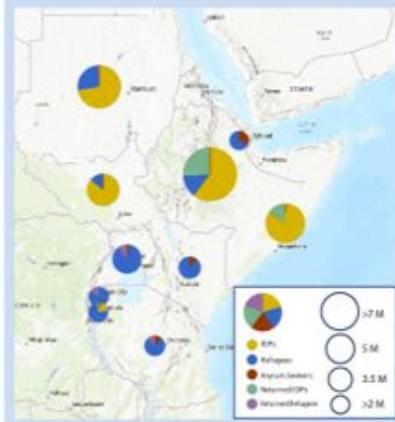
The Horn of Africa region is experiencing one of the worst drought situations in decades, following four failed rainy seasons. This has caused food insecurity to skyrocket, resulting in high levels of acute malnutrition, stunting, and anemia and fueling further displacement. Over 3.3 million refugees (or 72 percent of refugees in the region) in Burundi, Djibouti, Ethiopia, Kenya, South Sudan, Rwanda, Uganda, and the United Republic of Tanzania have faced reductions in food rations in 2021 and 2022 due to the drought. This continues to exacerbate the regional rates of malnutrition. Furthermore, COVID-19 overstretched the region's health systems and delayed the delivery of essential services such as childhood immunizations and seasonal malaria prevention, particularly for rural or displaced populations.

The conflict situation that began in the Tigray region of Ethiopia in 2020 has escalated, causing widespread displacement both internally in the country and across national borders. More than 20 million people are to be targeted for humanitarian assistance and protection this year, nearly three-quarters of whom are women and children (OCHA).

In Somalia, 2.97 million Somalis continue to be internally displaced within the country. Political instability and a civil war that has lasted for decades have contributed to the displacement of more than 601,000 Somali refugees and asylum seekers to Djibouti, Ethiopia, Kenya, and Yemen.

South Sudan continues to face the largest and most underfunded refugee crisis in Africa, with the Regional Refugee Response Plan only 17% funded in 2021. Two out of three South Sudanese refugees are under the age of 18.

POPULATIONS OF CONCERN: E HORN OF AFRICA & GREAT LAKES



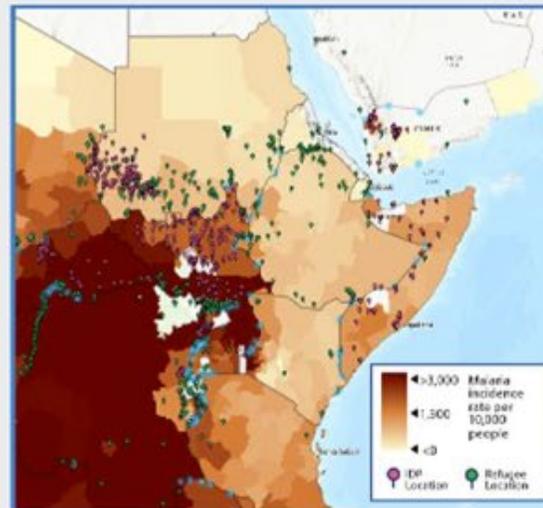
THE THREE DISEASES AND DISPLACED POPULATIONS



MALARIA

Malaria remains a leading cause of morbidity and mortality among refugees and IDPs. Almost two-thirds of refugees, internally displaced persons, returnees and other persons affected by humanitarian emergencies live in malaria endemic regions.

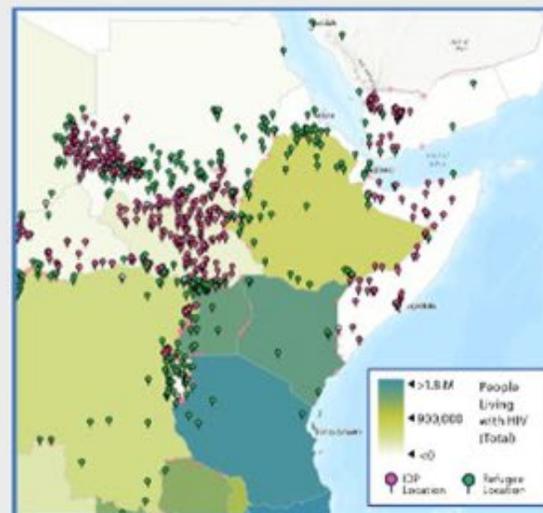
Refugee and IDP camps are often sited on marginal lands that promote breeding sites for malaria vectors, and travel may take refugees through or to areas of higher malaria endemicity than their place of origin. Pregnant women and young children are particularly at risk of severe illness and death due to malaria.



HIV/AIDS

Refugees and IDPs do not increase HIV transmission rates in the host country. In fact, historical evidence shows that refugees have often migrated from countries with lower HIV prevalence to countries with higher HIV prevalence.

However, displacement increases a community's vulnerability to HIV and exposes PLHIV to serious risks, including interruption of treatment and malnutrition. Estimates indicate that as much as 68% of adults and 84% of children living with HIV are not able to receive continuous HIV treatment in emergency settings.





RECOMMENDATIONS

- Conduct conversations about refugee and IDP inclusion in national plan creation, grant proposal development, and implementation processes. Include representatives of displaced populations and humanitarian agencies in these conversations.
- Measure key intervention coverage of displaced populations, identify financial and programmatic gaps, and ensure that data are provided to/linked with national program data.
- Utilize information on refugee and IDP population size and mapping of displacement versus malaria prevalence to target interventions for these populations in their concept notes.
- Countries with existing and new displaced populations should adapt their activities and interventions for these populations in their new funding applications.



RESOURCES

- [UNHCR Global Trends Report: Forced Displacement in 2021](#)
- [IDMC Global Report on Internal Displacement 2022](#)
- [Conflicts, Crises and Displaced People: How the Global Fund Works in Challenging Operating Environments](#)
- [UNHCR Emergency Handbook: Health in Camps](#)
- [UNAIDS: HIV in Humanitarian Emergencies](#)
- [Alliance for Malaria Prevention Operational guidance for ITN distribution in complex operating environments \(COE\)](#)
- [Global Fund: Technical Brief on TB, Gender, and Human Rights 2020](#)
- [Global Fund: Frequently Asked Questions 2023-2025 Allocation Period](#)
- [UNF Analysis: Inclusion of Displaced Populations in Global Fund Funding Applications, 2002-2019](#)
- [Tuberculosis prevention and care among refugees and other populations in humanitarian settings: an interagency field guide](#)



METHODOLOGY

Eligibility

The following criteria were used to determine eligibility for this analysis:

- Countries that qualified for Global Fund allocation at the time of application
- Countries with at least one approved grant
- Countries with a Refugee and/or IDP population greater than 10,000 at the time of application

Scoring

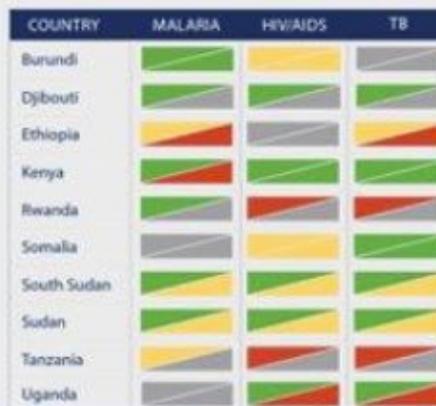
Based on keyword search, applications were labeled:

- **Activities:** Included specific activities that focused on refugees/IDPs
- **Mention:** Mentioned the country's population of refugees/IDPs but did not specify activities targeting those populations
- **No Mention:** Did not mention or reference refugees/IDPs in the country

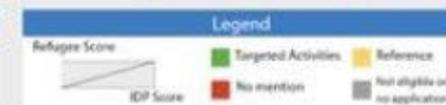


REFUGEES AND IDP INCLUSION IN GLOBAL FUND FUNDING REQUESTS

2017-2019 Funding Cycle



2020-2022 Funding Cycle



Analysis

The inclusion of targeted activities for IDPs and refugees across the three disease areas improved in the 2020-2022 funding cycle compared to the previous cycle. All countries in the region included targeted malaria activities for refugees and IDPs, except one, which included targeted activities for IDPs, a notable improvement from previous applications. Similarly, the majority of countries in the region included targeted TB activities for refugees and IDPs, except for three countries (Rwanda, Somalia and Ethiopia) who referenced but did not include specific activities for either refugees or IDPs. Of the three disease areas, HIV funding requests in the region had the lowest inclusion rate of targeted activities for refugees and IDPs. However, compared to the past funding cycle, there was an uptick in the number of countries who included targeted HIV activities for refugees and/or IDPs, most notably in Burundi, Uganda, Sudan and South Sudan.

Malaria funding requests across the region had the highest rate of targeted activities for refugees and IDPs. Compared to the previous funding cycle, six countries added targeted malaria activities for either refugees and/or IDPs where eligible. There was only one country in the region that did not include targeted malaria activities for both refugees and IDPs. Across the three disease areas, many country applications moved from little to no mention of refugees and/or IDPs in the 2017-2019 applications to strong inclusion of targeted activities for these vulnerable populations in the 2020-2022 applications. As the Eastern Horn and Great Lakes region has high rates of ongoing displacement and large refugee and IDP populations, it is essential for all countries in the region to continue to maintain and increase the inclusion of targeted HIV, TB, and malaria activities for both refugee and IDP populations in the next cycle of Global Fund funding applications.

Looking ahead to the NFM4 funding cycle:

- Conduct conversations about refugee and IDP inclusion in national plan creation, grant proposal development, and implementation processes with representatives and community leaders from refugee, IDP and other displaced populations in addition to humanitarian agencies.
- Inclusion is not enough: overcoming socio-economic, cultural and language barriers.
- Leverage inclusive community-based workforce for social behavior change communications, case management, referral and treatment adherence support
- Expand use of Global Fund emergency grant funds and re-programming during grant cycle to address the evolving needs of new displaced populations.





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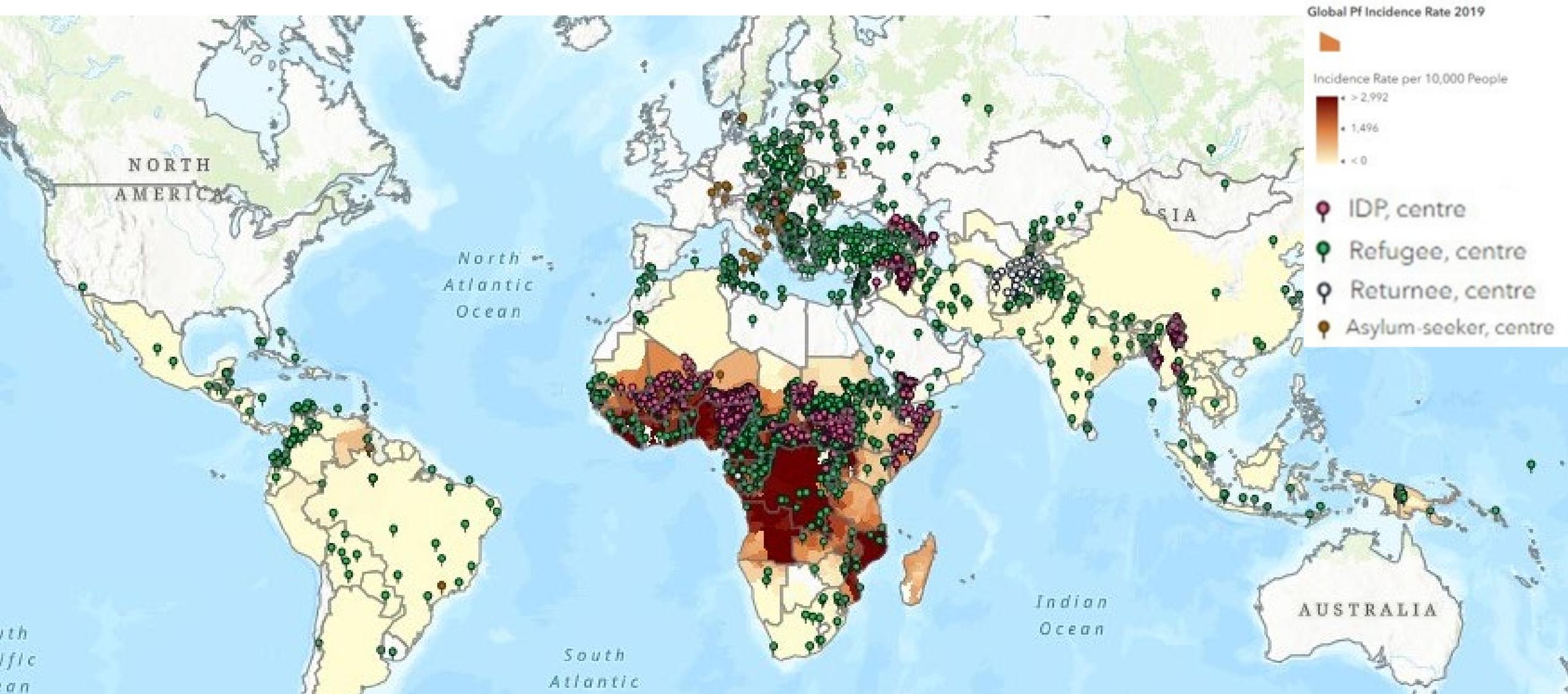
Assessing the Inclusion of Displaced Populations in Global Fund Applications 2020-2022



Disease risk is increased among displaced populations

- Malaria, HIV/AIDS and TB present unique risks to the world's **103 million forcibly displaced people**
- Forcibly displaced populations are often at greater risk of disease due to
 - High levels of mobility
 - Living conditions that increase exposure to disease or disease vectors
 - Decreased access to health services often caused by ongoing conflict, collapse of health system, ethnic, cultural, linguistic or other barriers
 - Weakened immunity because of multiple infections and malnutrition
 - Movement between low and high transmission zones
 - Increased risk of gender-based and sexual violence

Overlap of Global *P. falciparum* Incidence and Displaced Populations



Methodology:

•Keyword search terms:

- Refugee
- Internally displaced person
- IDP
- Returnee (classified as refugees)
- Displaced
- Displacement
- Mobile(exclude nomadic, semi-nomadic, migrant)
- Asylum seeker
- Venezuelan
- Humanitarian conflict
- Noncitizen
- People/person of concern
- Foreigner
- Stateless

•Eligibility:

- Countries that qualify for GF allocation at time of application
- Countries with at least one approved grant
- Refugee/IDP population greater than 10,000 at time of application

•Scoring: Based on keyword search, applications were labeled and scored

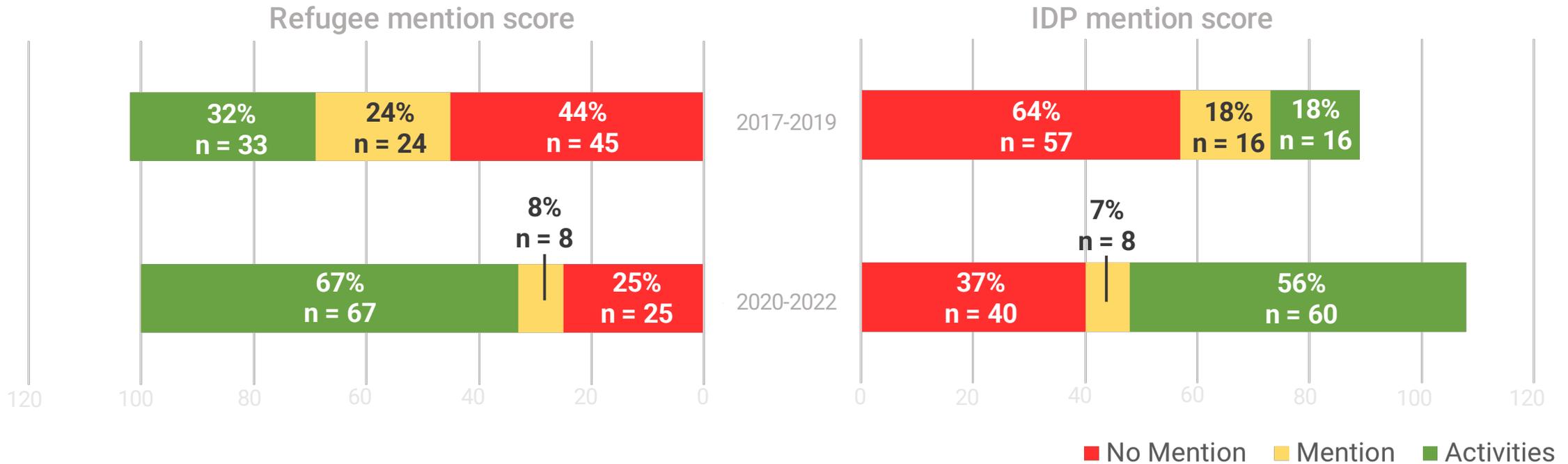
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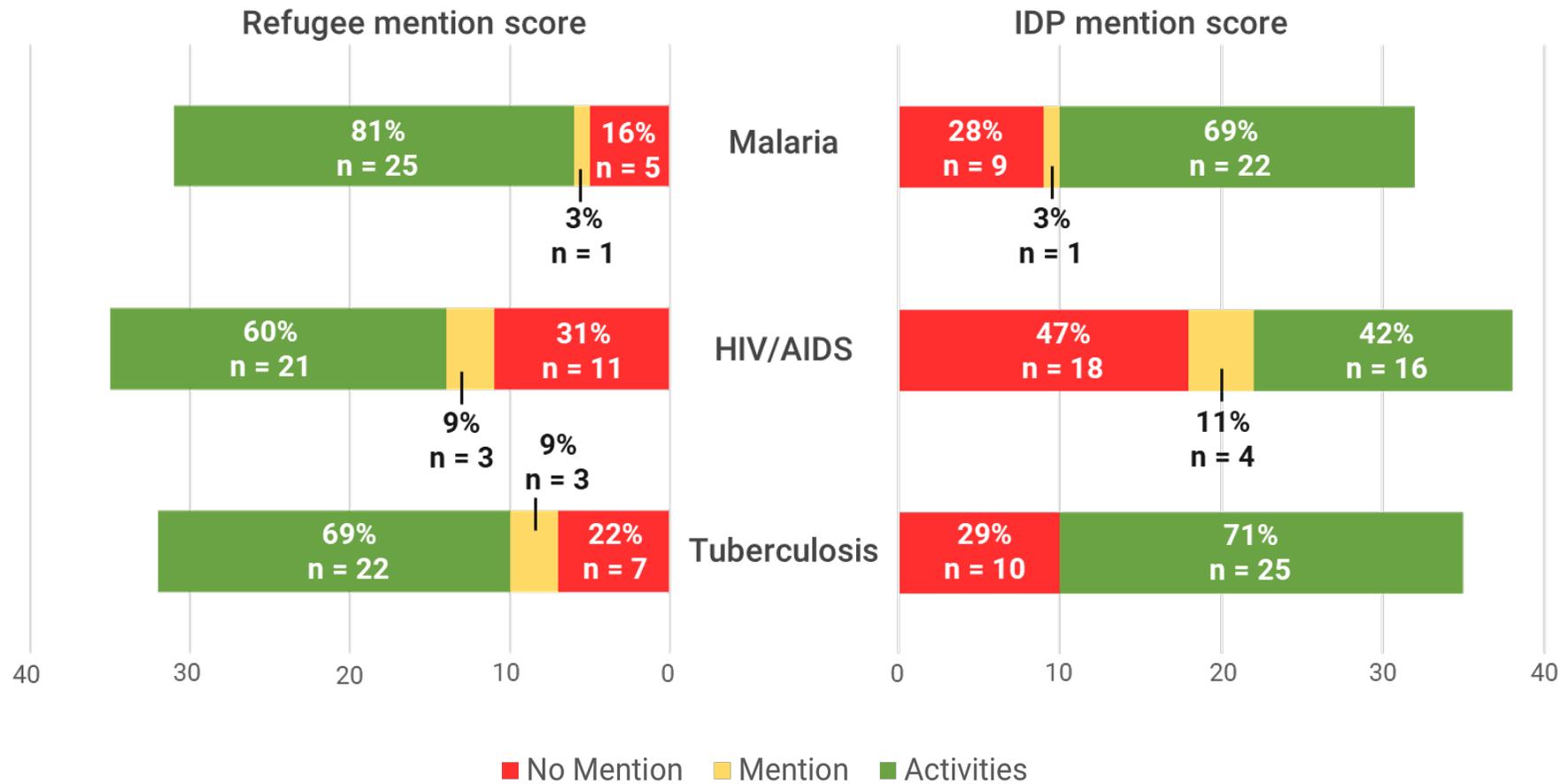
•Study Size:

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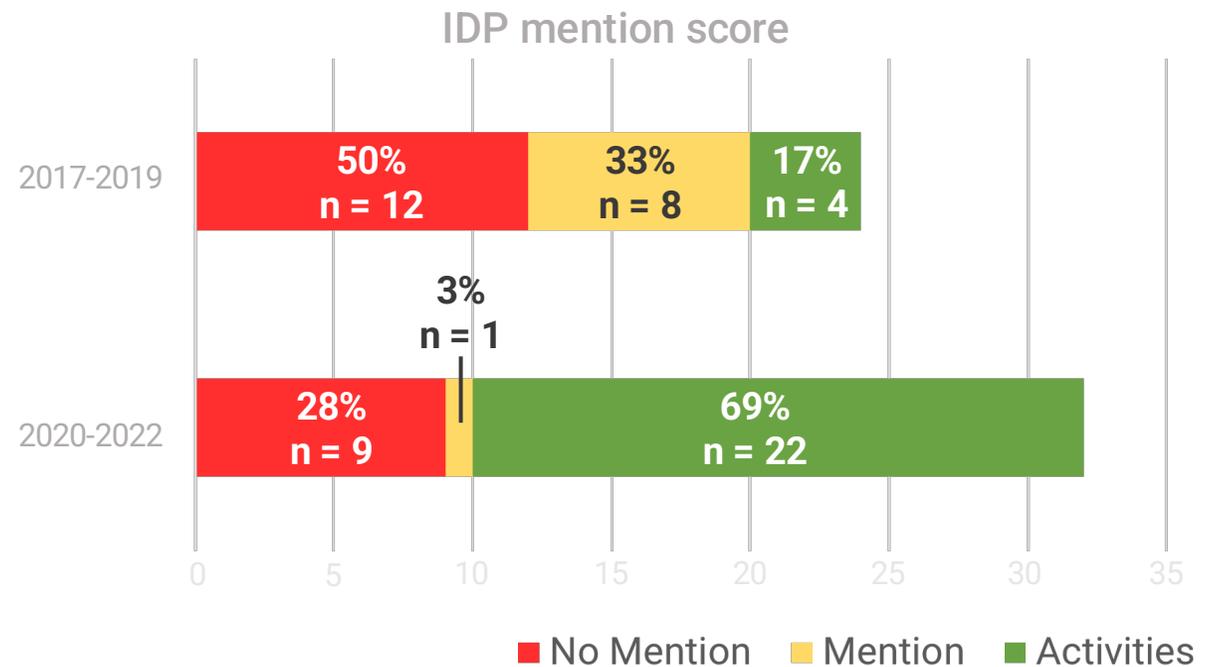
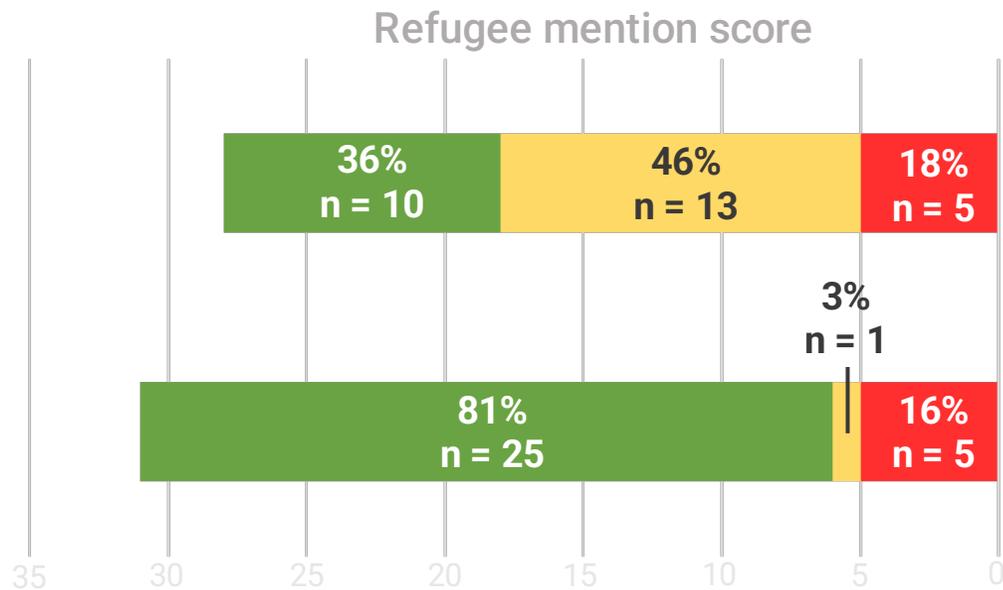


Since the last funding cycle:

- Refugee and IDP mention has increased substantially across the 3 diseases
- The number of applications mentioning displaced populations without detailing activities targeting them has decreased



Overall, refugee and IDP inclusion in GF applications has improved across the three diseases.



Refugee and IDP inclusion in malaria funding requests has improved substantially.

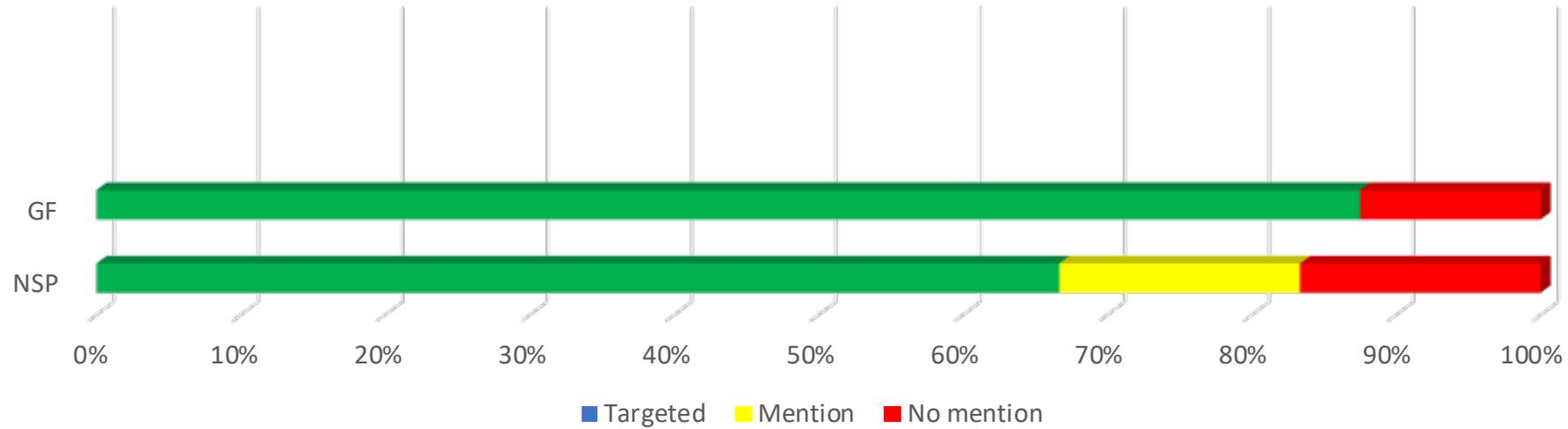
Since the last funding cycle:

- Inclusion of specific activities for refugee and IDPs has increased substantially
- Virtually no funding requests mentioned displaced populations without detailing targeted activities for them

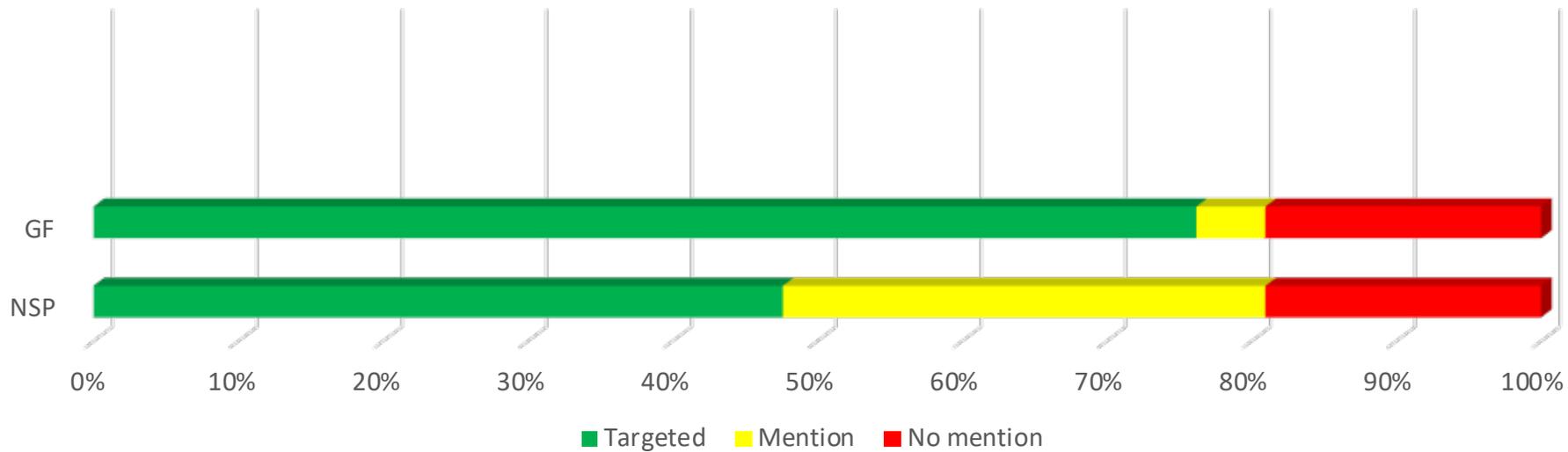
Conclusions: Malaria analysis

- Inclusion of both refugee and IDP populations in malaria funding requests has improved substantially since the previous analysis in 2019.
- There was a notable decrease in the proportion of countries failing to mention or include tailored activities for IDPs.
- Only two of the 63 malaria applications mentioned refugees and IDPs without detailing specific programming activities for malaria.

Refugee Inclusion in NSPs and Global Fund (2020-2022) malaria applications



IDP Inclusion in NSPs and Global Fund (2020-2022) malaria applications



Scorecard Sample

REFUGEE AND INTERNALLY DISPLACED PERSONS INCLUSION IN GLOBAL FUND FUNDING APPLICATIONS 2020-2022

September 2022



Eastern Horn of Africa and Great Lakes

Malaria, HIV/AIDS and tuberculosis (TB) present unique risks to refugees and internally displaced persons (IDPs) in Eastern Horn of Africa and Great Lakes Region. High levels of mobility, inadequate living conditions with increased exposure to diseases or vectors, and reduced access to health services due to ongoing conflict and socio-economic, cultural, language or gender barriers, all contribute to increased risk of exposure. Furthermore, sustained conflict and crisis can cause the collapse of primary health systems, limit activities to prevent the transmission of malaria, TB, and HIV, and disrupt the delivery of vital medical commodities.

As one of the largest financiers of global health programs, The Global Fund to Fight AIDS, TB and Malaria is a vital source of support to ensure refugees and IDPs have access to quality disease prevention, treatment and care services.

5.1 M
Refugees

12.7 M
IDPs

2021 Year-End Data

HUMANITARIAN SITUATION: REGIONAL OVERVIEW

The region of the Eastern Horn and Great Lakes includes Burundi, Djibouti, Ethiopia, Kenya, Rwanda, Somalia, South Sudan, Sudan, Tanzania, and Uganda. By the end of 2021, the East and Horn of Africa and the Great Lakes region hosted 4.9 million refugees and asylum seekers and 12 million internally displaced people. The region hosts 67 percent of the refugees on the African continent and 23 percent of the global refugee population. The region also has over 12 million IDPs, particularly in Sudan, South Sudan, Ethiopia, Somalia, and Burundi (UNHCR).

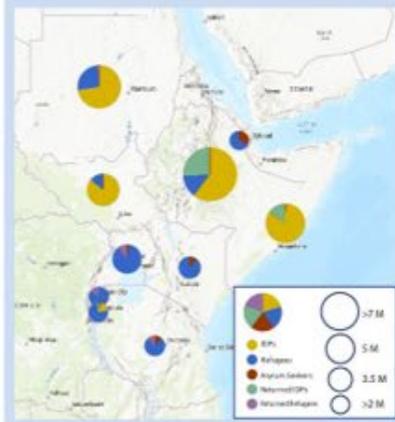
The Horn of Africa region is experiencing one of the worst drought situations in decades, following four failed rainy seasons. This has caused food insecurity to skyrocket, resulting in high levels of acute malnutrition, stunting, and anemia and fueling further displacement. Over 3.3 million refugees (or 72 percent of refugees in the region) in Burundi, Djibouti, Ethiopia, Kenya, South Sudan, Rwanda, Uganda, and the United Republic of Tanzania have faced reductions in food rations in 2021 and 2022 due to the drought. This continues to exacerbate the regional rates of malnutrition. Furthermore, COVID-19 overstretched the region's health systems and delayed the delivery of essential services such as childhood immunizations and seasonal malaria prevention, particularly for rural or displaced populations.

The conflict situation that began in the Tigray region of Ethiopia in 2020 has escalated, causing widespread displacement both internally in the country and across national borders. More than 20 million people are to be targeted for humanitarian assistance and protection this year, nearly three-quarters of whom are women and children (OCHA).

In Somalia, 2.97 million Somalis continue to be internally displaced within the country. Political instability and a civil war that has lasted for decades have contributed to the displacement of more than 601,000 Somali refugees and asylum seekers to Djibouti, Ethiopia, Kenya, and Yemen.

South Sudan continues to face the largest and most underfunded refugee crisis in Africa, with the Regional Refugee Response Plan only 17% funded in 2021. Two out of three South Sudanese refugees are under the age of 18.

POPULATIONS OF CONCERN: E HORN OF AFRICA & GREAT LAKES



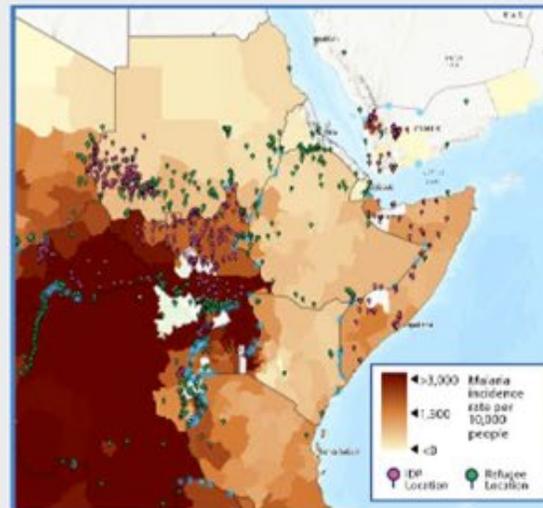
THE THREE DISEASES AND DISPLACED POPULATIONS



MALARIA

Malaria remains a leading cause of morbidity and mortality among refugees and IDPs. Almost two-thirds of refugees, internally displaced persons, returnees and other persons affected by humanitarian emergencies live in malaria endemic regions.

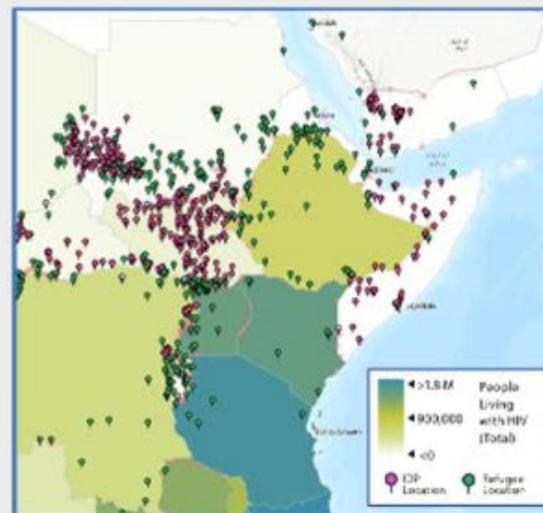
Refugee and IDP camps are often sited on marginal lands that promote breeding sites for malaria vectors, and travel may take refugees through or to areas of higher malaria endemicity than their place of origin. Pregnant women and young children are particularly at risk of severe illness and death due to malaria.



HIV/AIDS

Refugees and IDPs do not increase HIV transmission rates in the host country. In fact, historical evidence shows that refugees have often migrated from countries with lower HIV prevalence to countries with higher HIV prevalence.

However, displacement increases a community's vulnerability to HIV and exposes PLHIV to serious risks, including interruption of treatment and malnutrition. Estimates indicate that as much as 68% of adults and 84% of children living with HIV are not able to receive continuous HIV treatment in emergency settings.





RECOMMENDATIONS

- Conduct conversations about refugee and IDP inclusion in national plan creation, grant proposal development, and implementation processes. Include representatives of displaced populations and humanitarian agencies in these conversations.
- Measure key intervention coverage of displaced populations, identify financial and programmatic gaps, and ensure that data are provided to/linked with national program data.
- Utilize information on refugee and IDP population size and mapping of displacement versus malaria prevalence to target interventions for these populations in their concept notes.
- Countries with existing and new displaced populations should adapt their activities and interventions for these populations in their new funding applications.



RESOURCES

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METHODOLOGY

Eligibility

The following criteria were used to determine eligibility for this analysis:

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- Countries with a Refugee and/or IDP population greater than 10,000 at the time of application

Scoring

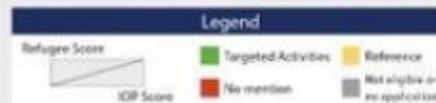
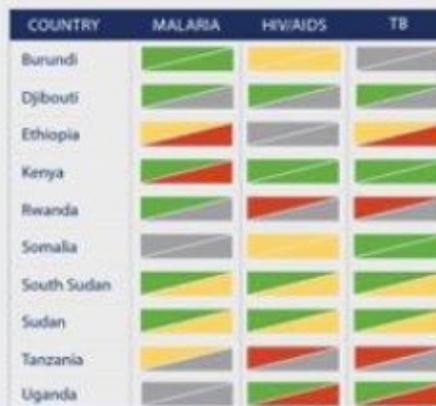
Based on keyword search, applications were labeled:

- **Activities:** Included specific activities that focused on refugees/IDPs
- **Mention:** Mentioned the country's population of refugees/IDPs but did not specify activities targeting those populations
- **No Mention:** Did not mention or reference refugees/IDPs in the country

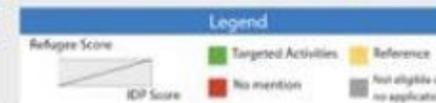


REFUGEES AND IDP INCLUSION IN GLOBAL FUND FUNDING REQUESTS

2017-2019 Funding Cycle



2020-2022 Funding Cycle



Analysis

The inclusion of targeted activities for IDPs and refugees across the three disease areas improved in the 2020-2022 funding cycle compared to the previous cycle. All countries in the region included targeted malaria activities for refugees and IDPs, except one, which included targeted activities for IDPs, a notable improvement from previous applications. Similarly, the majority of countries in the region included targeted TB activities for refugees and IDPs, except for three countries (Rwanda, Somalia and Ethiopia) who referenced but did not include specific activities for either refugees or IDPs. Of the three disease areas, HIV funding requests in the region had the lowest inclusion rate of targeted activities for refugees and IDPs. However, compared to the past funding cycle, there was an uptick in the number of countries who included targeted HIV activities for refugees and/or IDPs, most notably in Burundi, Uganda, Sudan and South Sudan.

Malaria funding requests across the region had the highest rate of targeted activities for refugees and IDPs. Compared to the previous funding cycle, six countries added targeted malaria activities for either refugees and/or IDPs where eligible. There was only one country in the region that did not include targeted malaria activities for both refugees and IDPs. Across the three disease areas, many country applications moved from little to no mention of refugees and/or IDPs in the 2017-2019 applications to strong inclusion of targeted activities for these vulnerable populations in the 2020-2022 applications. As the Eastern Horn and Great Lakes region has high rates of ongoing displacement and large refugee and IDP populations, it is essential for all countries in the region to continue to maintain and increase the inclusion of targeted HIV, TB, and malaria activities for both refugee and IDP populations in the next cycle of Global Fund funding applications.

Looking ahead to the NFM4 funding cycle:

- Conduct conversations about refugee and IDP inclusion in national plan creation, grant proposal development, and implementation processes with representatives and community leaders from refugee, IDP and other displaced populations in addition to humanitarian agencies.
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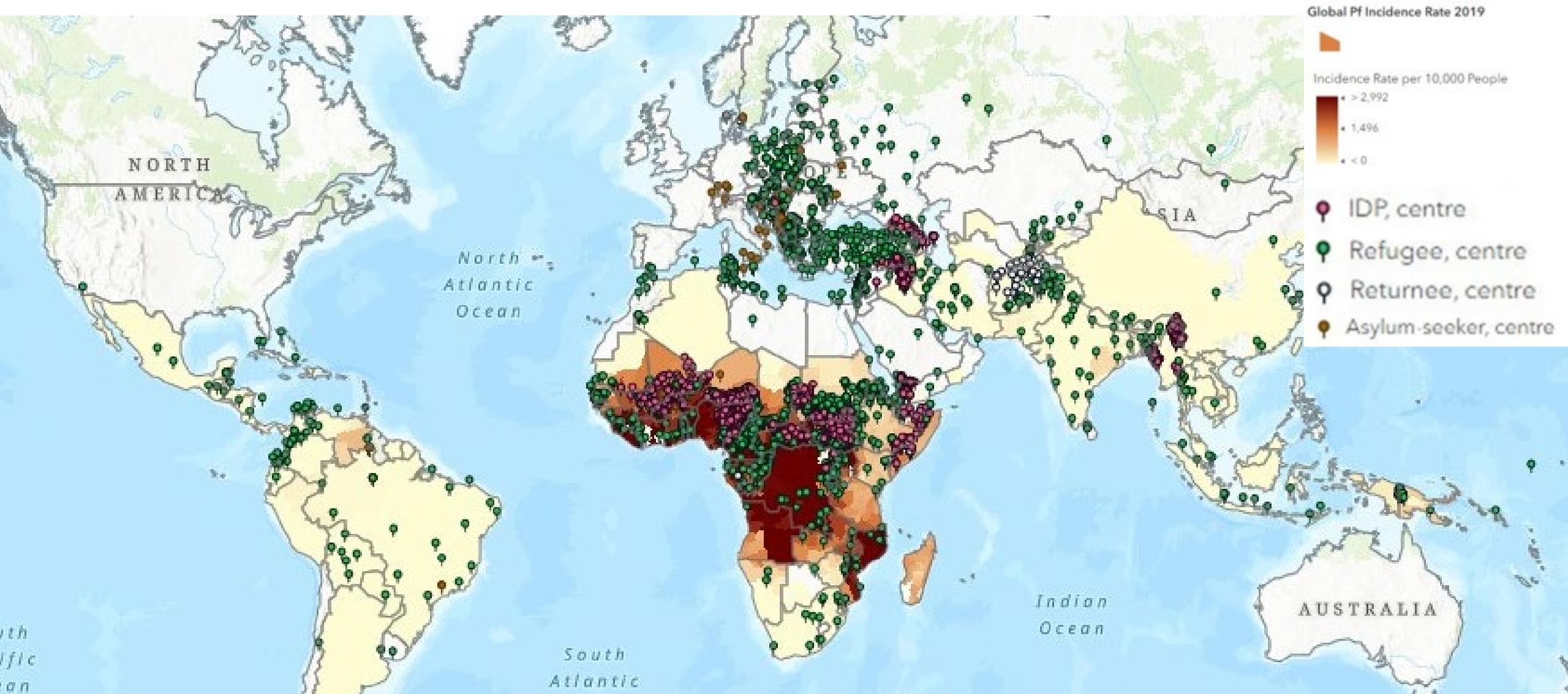
Assessing the Inclusion of Displaced Populations in Global Fund Applications 2020-2022



Disease risk is increased among displaced populations

- Malaria, HIV/AIDS and TB present unique risks to the world's **103 million forcibly displaced people**
- Forcibly displaced populations are often at greater risk of disease due to
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 - Living conditions that increase exposure to disease or disease vectors
 - Decreased access to health services often caused by ongoing conflict, collapse of health system, ethnic, cultural, linguistic or other barriers
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 - Movement between low and high transmission zones
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Overlap of Global *P. falciparum* Incidence and Displaced Populations



Methodology:

•Keyword search terms:

- Refugee
- Internally displaced person
- IDP
- Returnee (classified as refugees)
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- Displacement
- Mobile(exclude nomadic, semi-nomadic, migrant)
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- Foreigner
- Stateless

•Eligibility:

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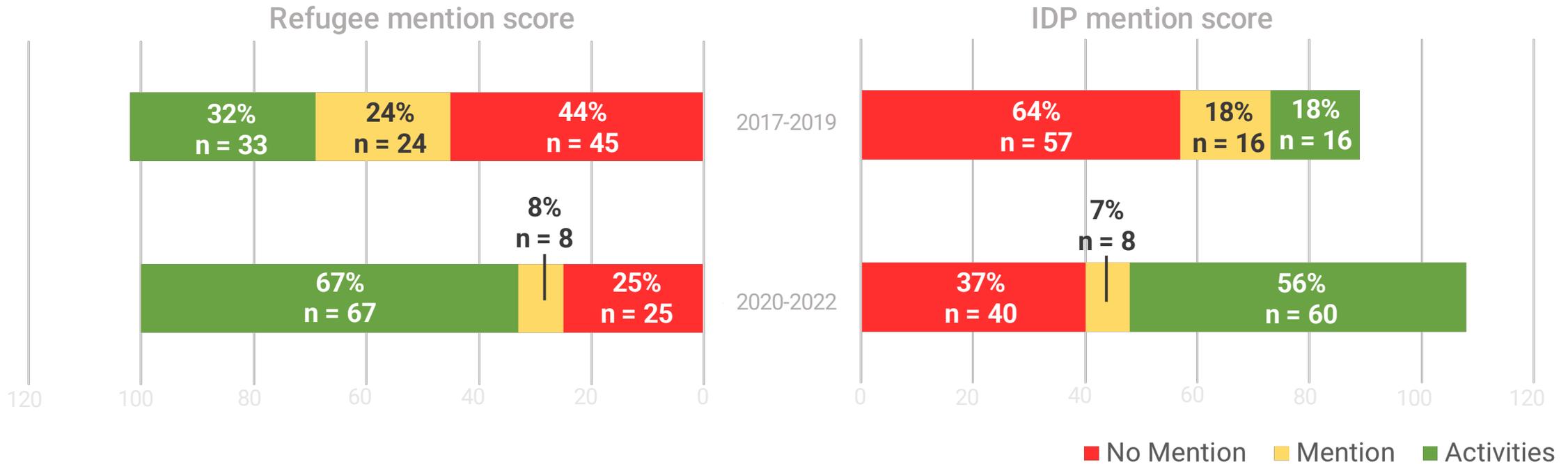
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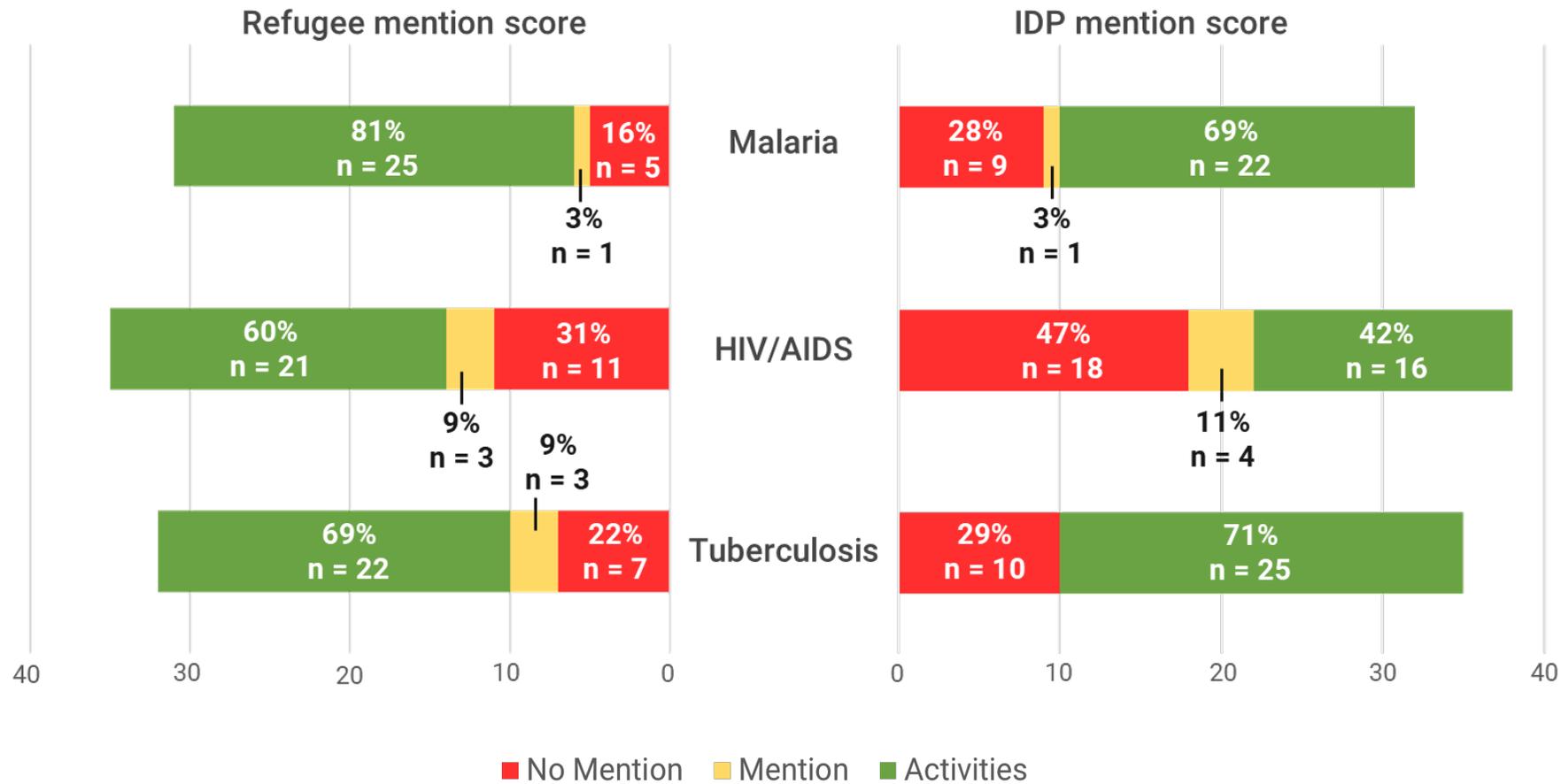
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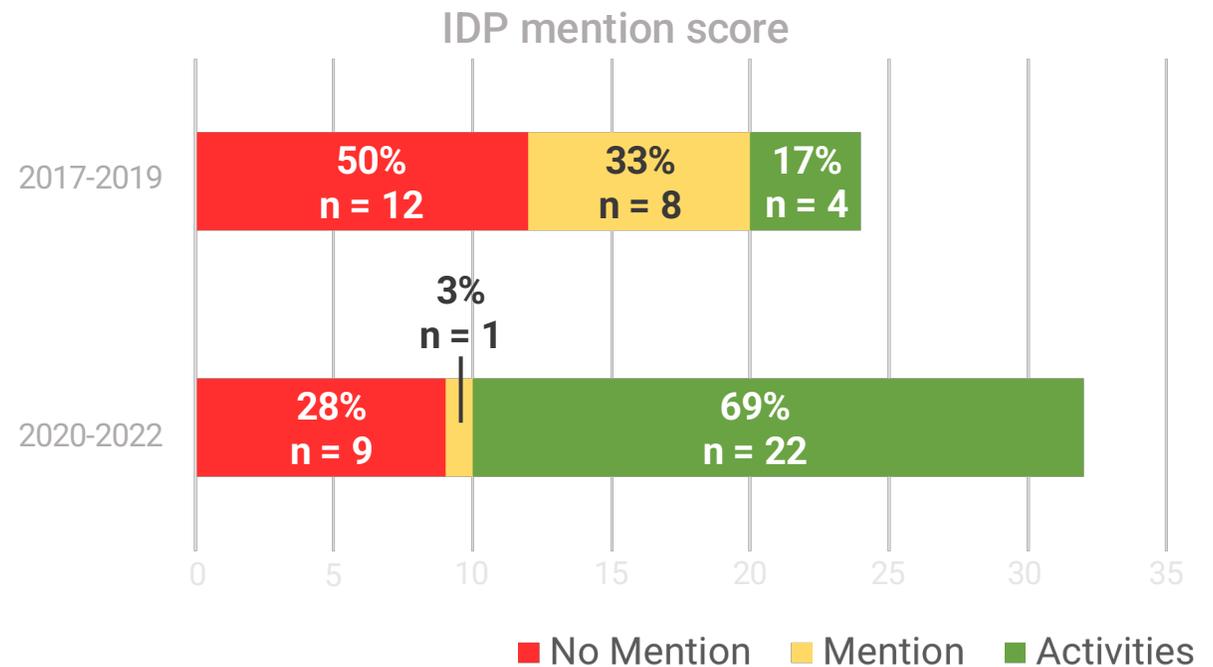
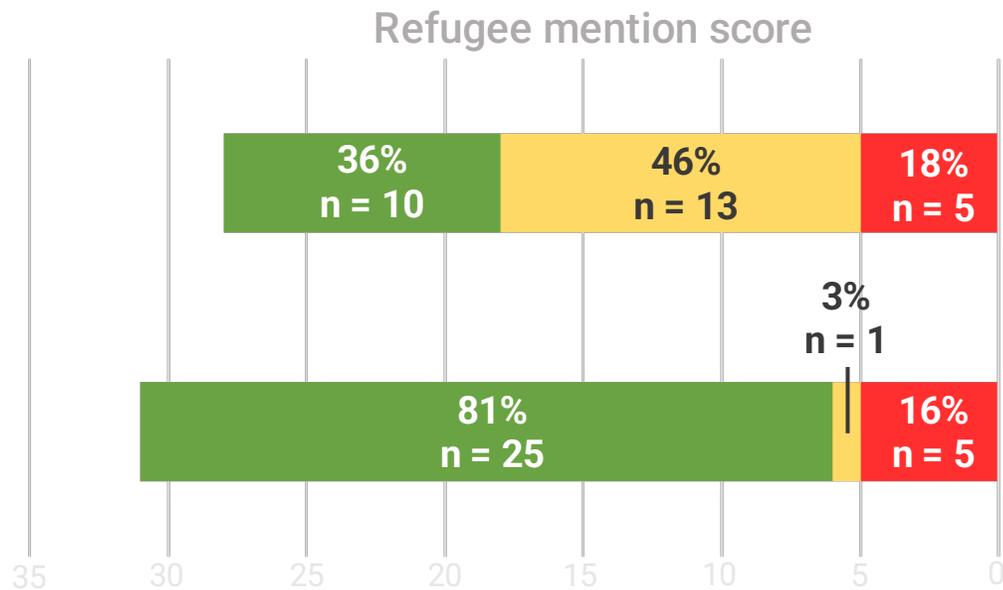


Since the last funding cycle:

- Refugee and IDP mention has increased substantially across the 3 diseases
- The number of applications mentioning displaced populations without detailing activities targeting them has decreased



Overall, refugee and IDP inclusion in GF applications has improved across the three diseases.



Refugee and IDP inclusion in malaria funding requests has improved substantially.

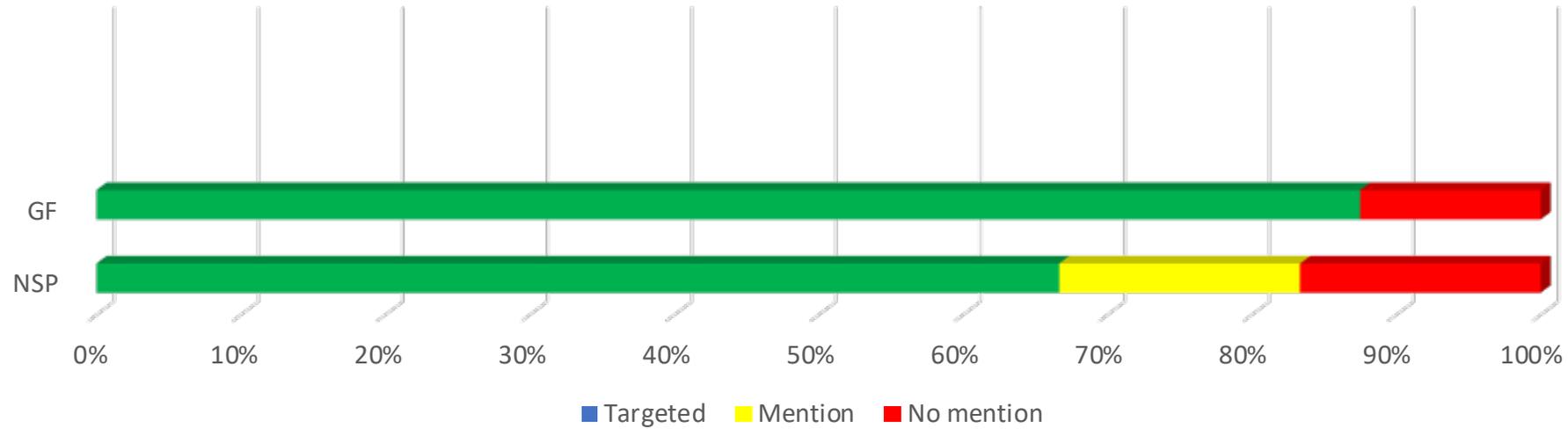
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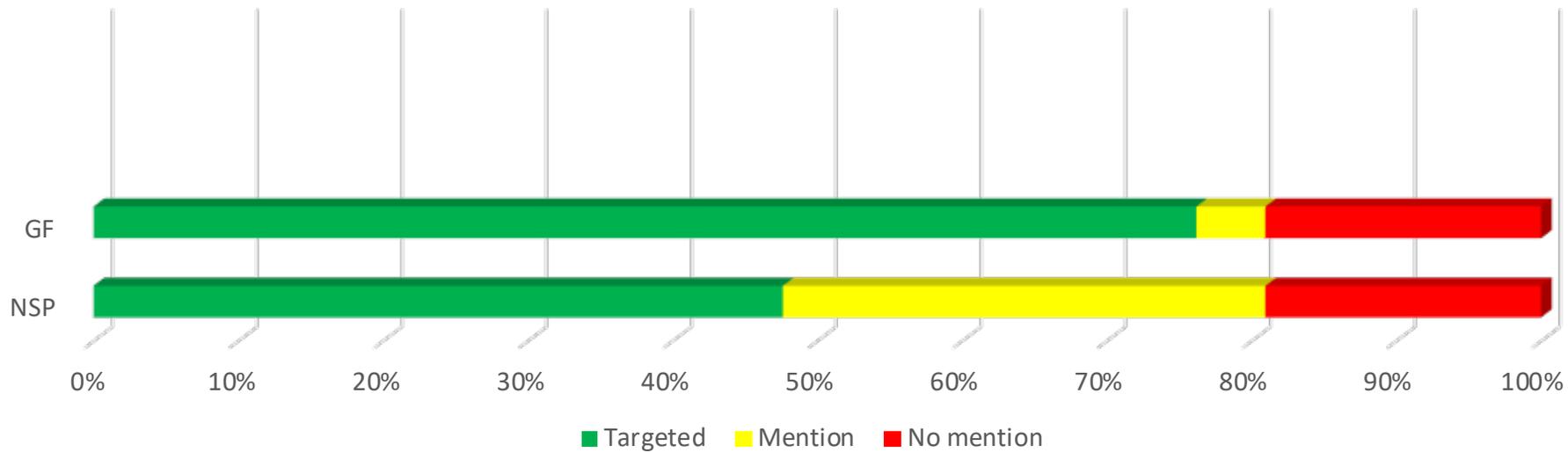
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Refugee Inclusion in NSPs and Global Fund (2020-2022) malaria applications



IDP Inclusion in NSPs and Global Fund (2020-2022) malaria applications



Scorecard Sample

REFUGEE AND INTERNALLY DISPLACED PERSONS INCLUSION IN GLOBAL FUND FUNDING APPLICATIONS 2020-2022

September 2022



Eastern Horn of Africa and Great Lakes

Malaria, HIV/AIDS and tuberculosis (TB) present unique risks to refugees and internally displaced persons (IDPs) in Eastern Horn of Africa and Great Lakes Region. High levels of mobility, inadequate living conditions with increased exposure to diseases or vectors, and reduced access to health services due to ongoing conflict and socio-economic, cultural, language or gender barriers, all contribute to increased risk of exposure. Furthermore, sustained conflict and crisis can cause the collapse of primary health systems, limit activities to prevent the transmission of malaria, TB, and HIV, and disrupt the delivery of vital medical commodities.

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5.1 M
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12.7 M
IDPs

2021 Year-End Data

HUMANITARIAN SITUATION: REGIONAL OVERVIEW

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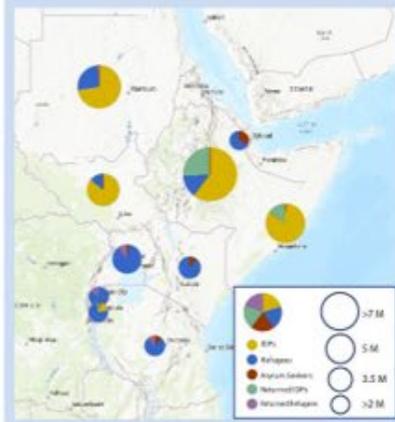
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POPULATIONS OF CONCERN: E HORN OF AFRICA & GREAT LAKES



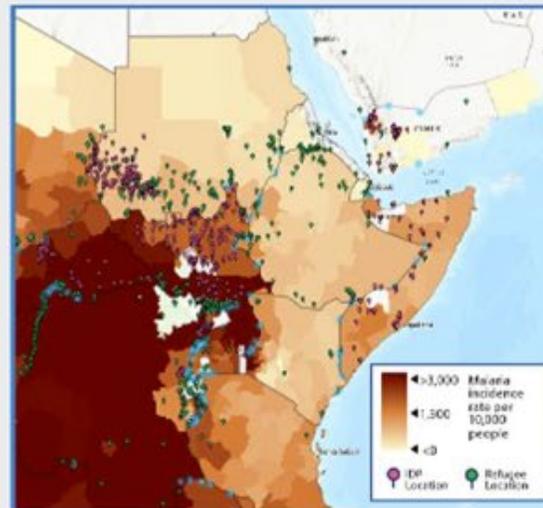
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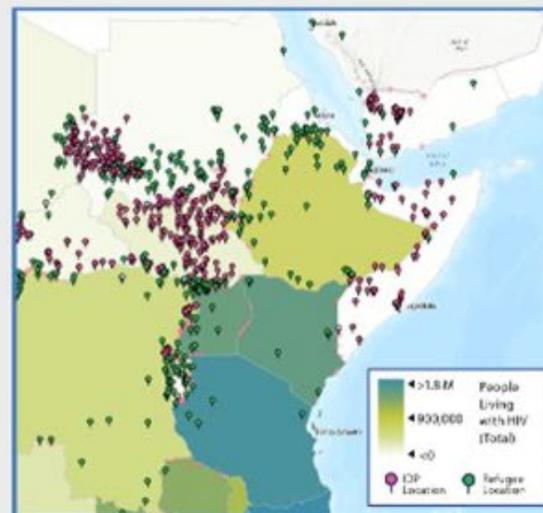
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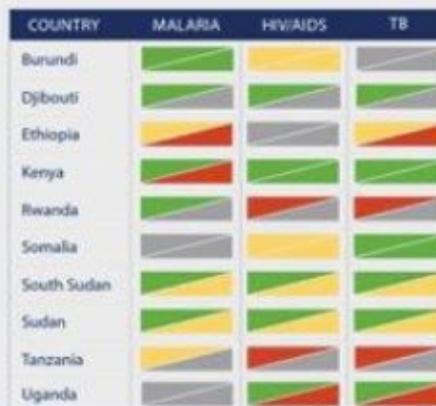
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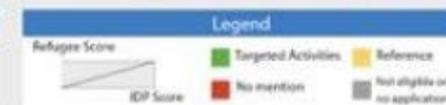


REFUGEES AND IDP INCLUSION IN GLOBAL FUND FUNDING REQUESTS

2017-2019 Funding Cycle



2020-2022 Funding Cycle



Analysis

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UNHCR
The UN Refugee Agency

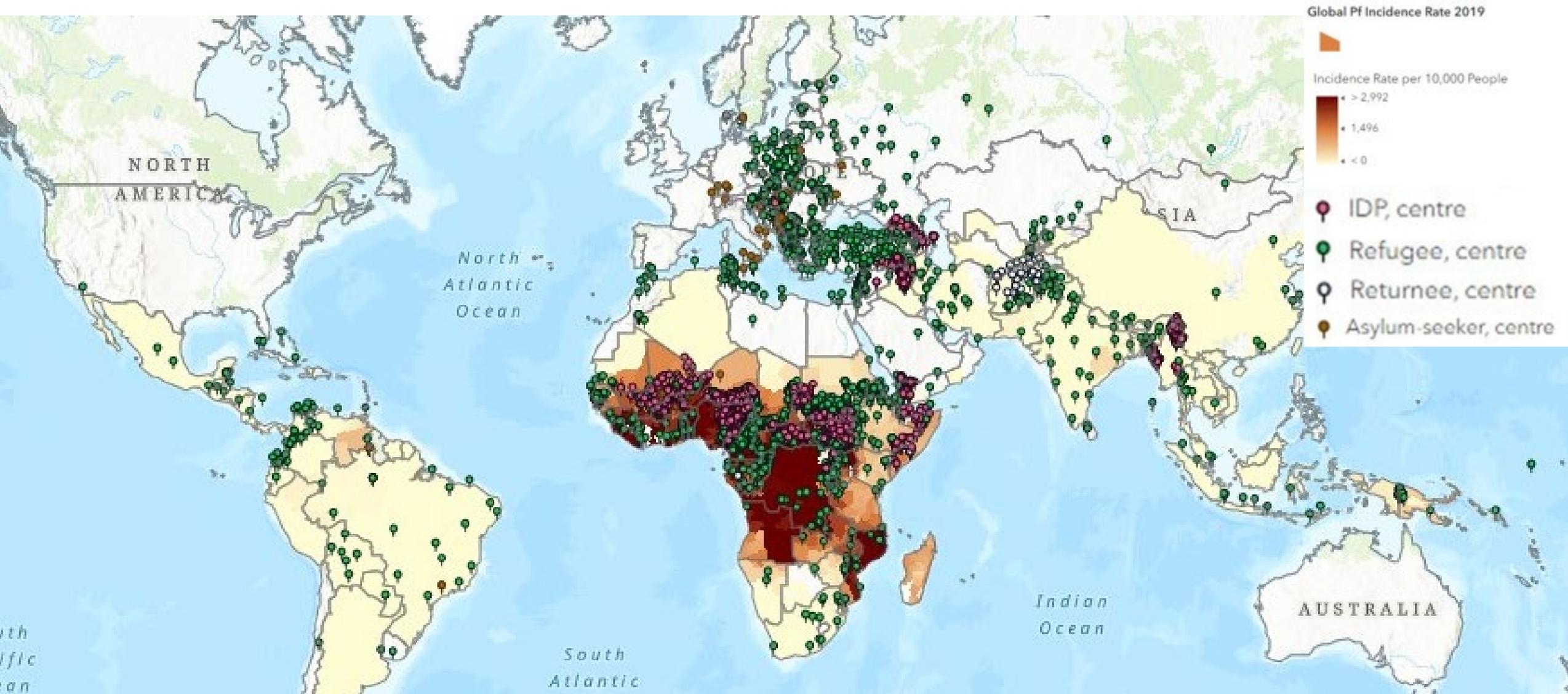
Assessing the Inclusion of Displaced Populations in Global Fund Applications 2020-2022



Disease risk is increased among displaced populations

- Malaria, HIV/AIDS and TB present unique risks to the world's **103 million forcibly displaced people**
- Forcibly displaced populations are often at greater risk of disease due to
 - High levels of mobility
 - Living conditions that increase exposure to disease or disease vectors
 - Decreased access to health services often caused by ongoing conflict, collapse of health system, ethnic, cultural, linguistic or other barriers
 - Weakened immunity because of multiple infections and malnutrition
 - Movement between low and high transmission zones
 - Increased risk of gender-based and sexual violence

Overlap of Global *P. falciparum* Incidence and Displaced Populations



Methodology:

•Keyword search terms:

- Refugee
- Internally displaced person
- IDP
- Returnee (classified as refugees)
- Displaced
- Displacement
- Mobile(exclude nomadic, semi-nomadic, migrant)
- Asylum seeker
- Venezuelan
- Humanitarian conflict
- Noncitizen
- People/person of concern
- Foreigner
- Stateless

•Eligibility:

- Countries that qualify for GF allocation at time of application
- Countries with at least one approved grant
- Refugee/IDP population greater than 10,000 at time of application

•Scoring: Based on keyword search, applications were labeled and scored

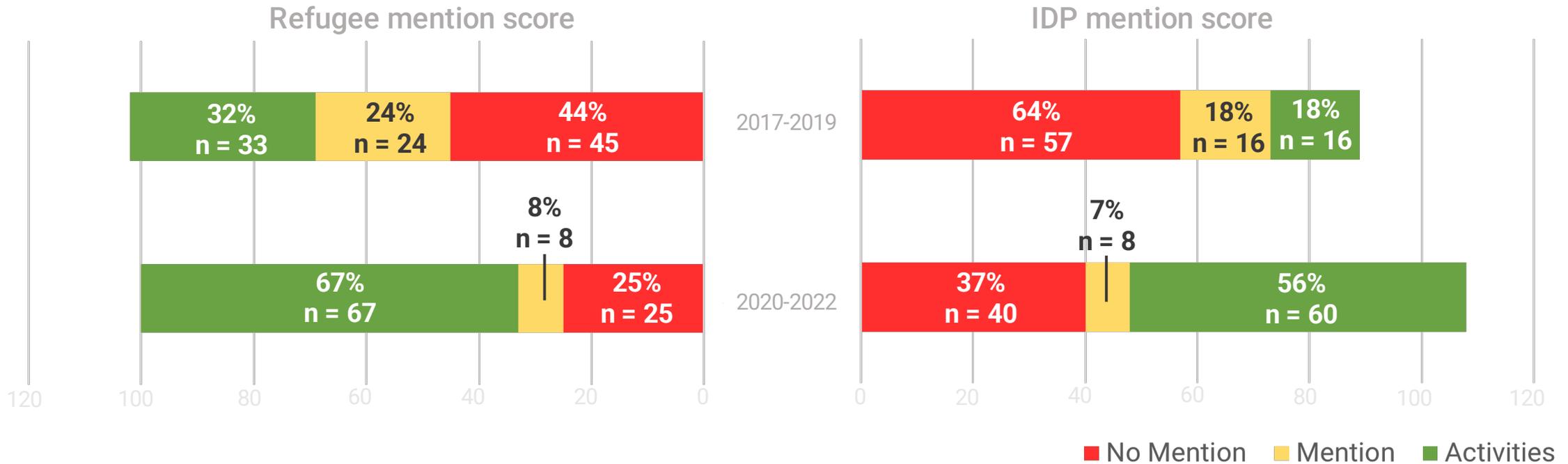
Activities – included specific activities that focused on refugees/IDPs

Mention – mentioned their population of refugees/IDPs but did not specify activities

No Mention – no mention of the refugees/IDPs

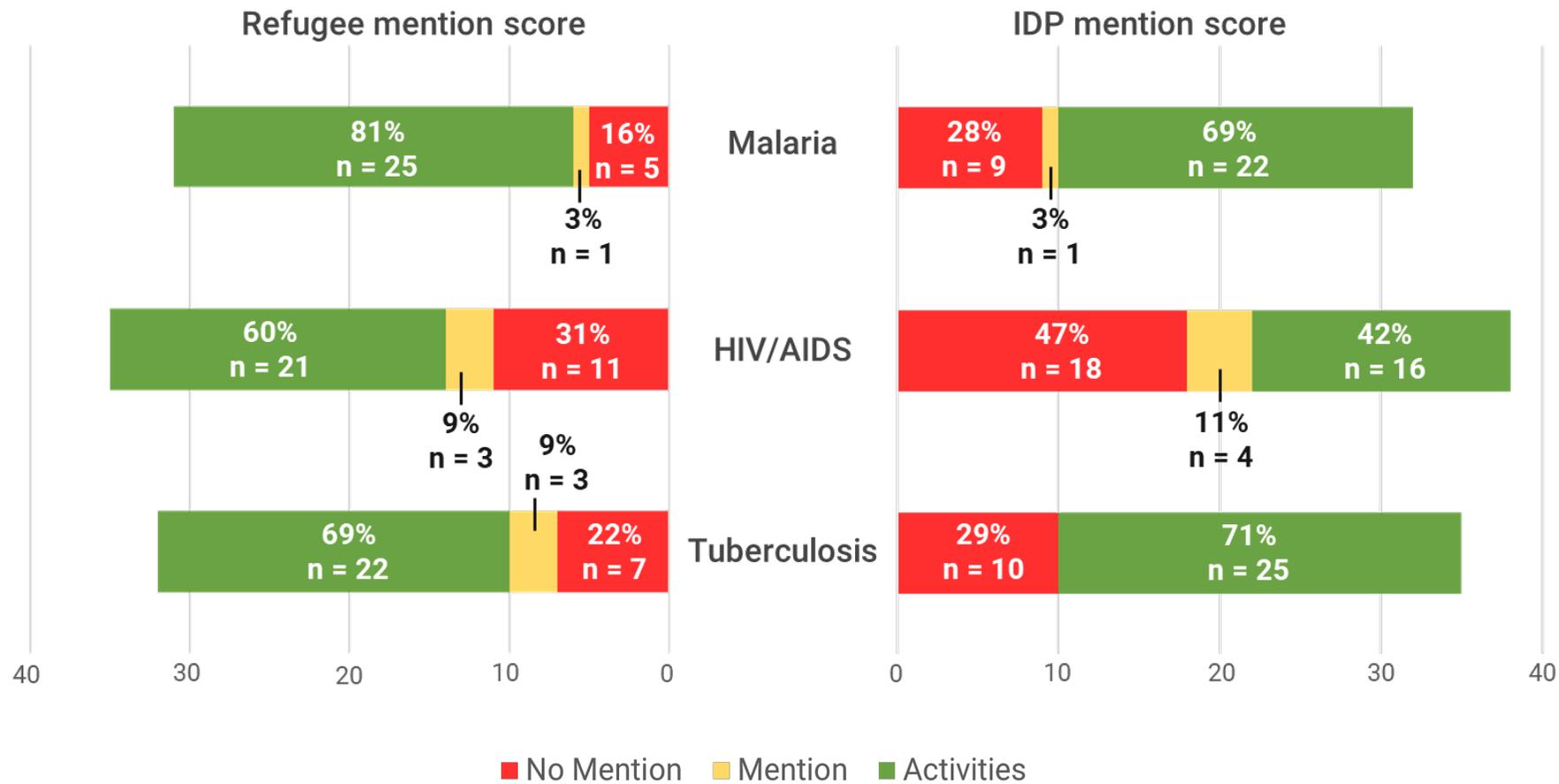
•Study Size:

- Refugee analysis – 100 applications, 37 countries
- IDP analysis – 107 applications, 40 countries

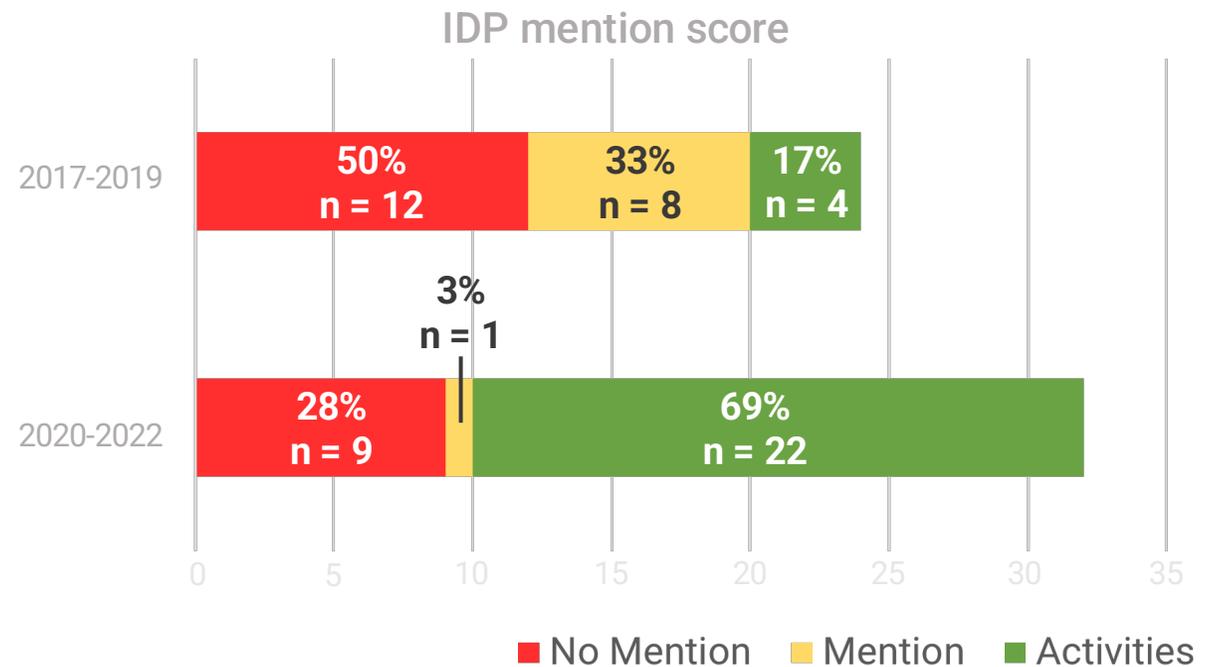
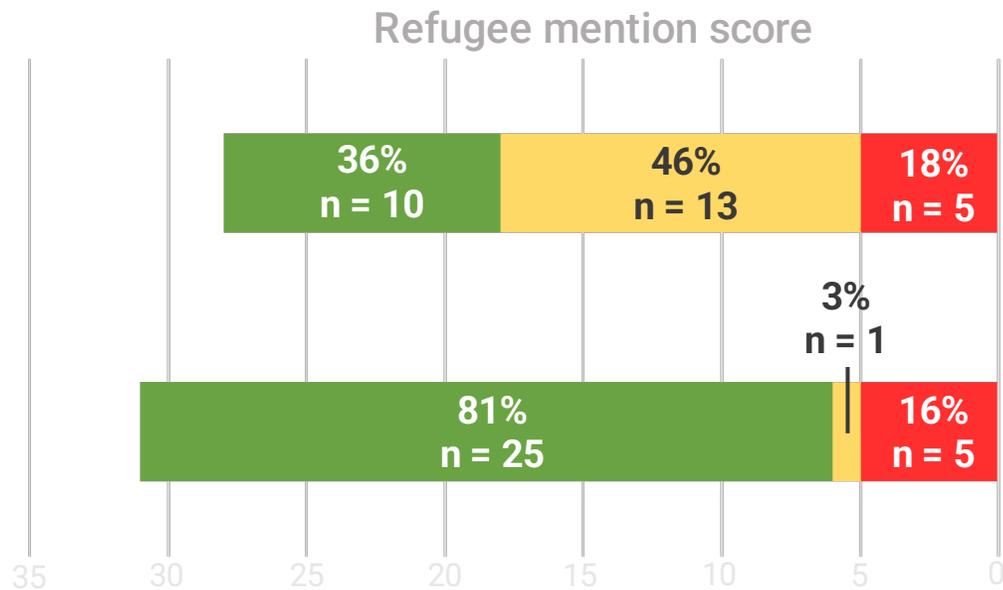


Since the last funding cycle:

- Refugee and IDP mention has increased substantially across the 3 diseases
- The number of applications mentioning displaced populations without detailing activities targeting them has decreased



Overall, refugee and IDP inclusion in GF applications has improved across the three diseases.



Refugee and IDP inclusion in malaria funding requests has improved substantially.

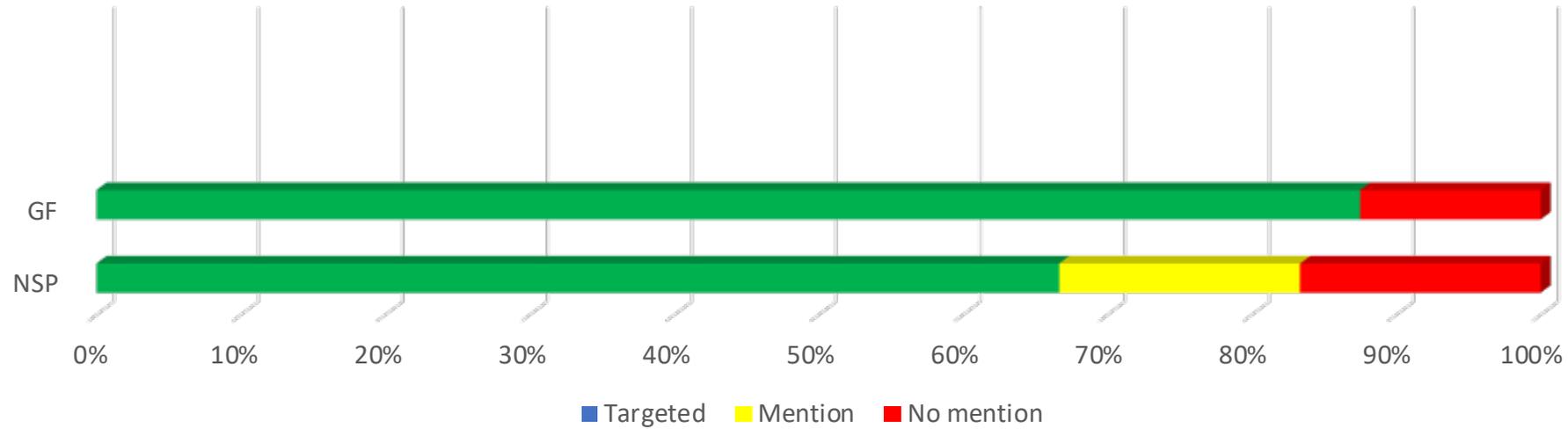
Since the last funding cycle:

- Inclusion of specific activities for refugee and IDPs has increased substantially
- Virtually no funding requests mentioned displaced populations without detailing targeted activities for them

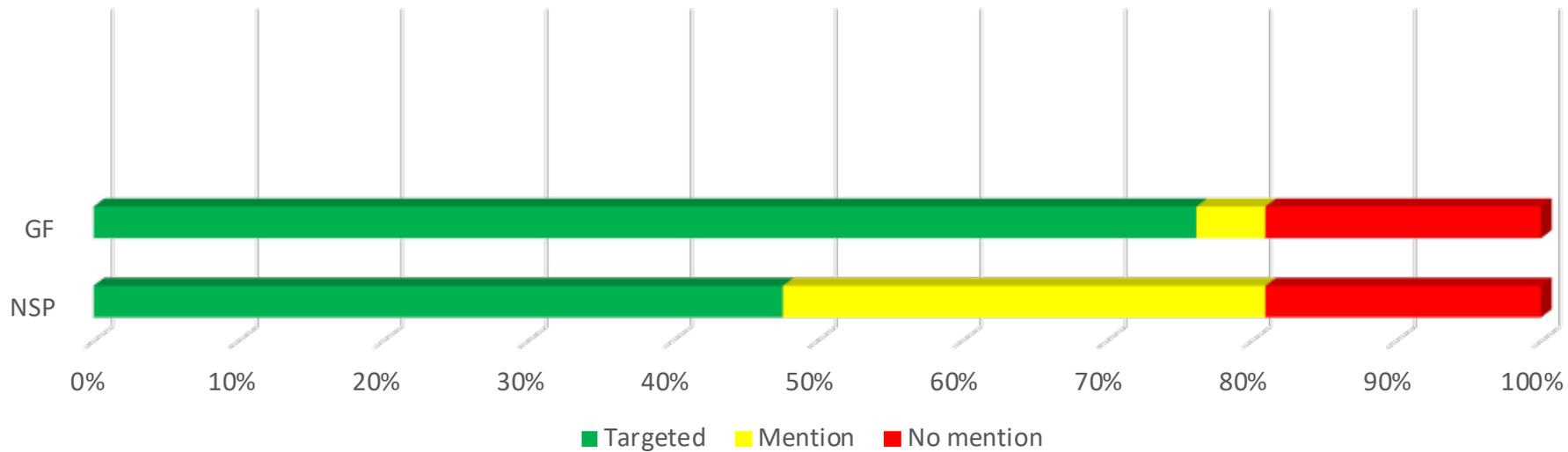
Conclusions: Malaria analysis

- Inclusion of both refugee and IDP populations in malaria funding requests has improved substantially since the previous analysis in 2019.
- There was a notable decrease in the proportion of countries failing to mention or include tailored activities for IDPs.
- Only two of the 63 malaria applications mentioned refugees and IDPs without detailing specific programming activities for malaria.

Refugee Inclusion in NSPs and Global Fund (2020-2022) malaria applications



IDP Inclusion in NSPs and Global Fund (2020-2022) malaria applications



Scorecard Sample

REFUGEE AND INTERNALLY DISPLACED PERSONS INCLUSION IN GLOBAL FUND FUNDING APPLICATIONS 2020-2022

September 2022



Eastern Horn of Africa and Great Lakes

Malaria, HIV/AIDS and tuberculosis (TB) present unique risks to refugees and internally displaced persons (IDPs) in Eastern Horn of Africa and Great Lakes Region. High levels of mobility, inadequate living conditions with increased exposure to diseases or vectors, and reduced access to health services due to ongoing conflict and socio-economic, cultural, language or gender barriers, all contribute to increased risk of exposure. Furthermore, sustained conflict and crisis can cause the collapse of primary health systems, limit activities to prevent the transmission of malaria, TB, and HIV, and disrupt the delivery of vital medical commodities.

As one of the largest financiers of global health programs, The Global Fund to Fight AIDS, TB and Malaria is a vital source of support to ensure refugees and IDPs have access to quality disease prevention, treatment and care services.

5.1 M
Refugees

12.7 M
IDPs

2021 Year-End Data

HUMANITARIAN SITUATION: REGIONAL OVERVIEW

The region of the Eastern Horn and Great Lakes includes Burundi, Djibouti, Ethiopia, Kenya, Rwanda, Somalia, South Sudan, Sudan, Tanzania, and Uganda. By the end of 2021, the East and Horn of Africa and the Great Lakes region hosted 4.9 million refugees and asylum seekers and 12 million internally displaced people. The region hosts 67 percent of the refugees on the African continent and 23 percent of the global refugee population. The region also has over 12 million IDPs, particularly in Sudan, South Sudan, Ethiopia, Somalia, and Burundi (UNHCR).

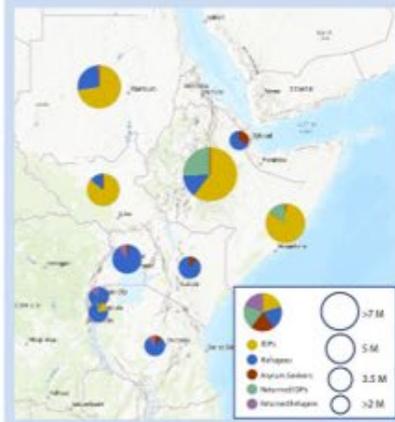
The Horn of Africa region is experiencing one of the worst drought situations in decades, following four failed rainy seasons. This has caused food insecurity to skyrocket, resulting in high levels of acute malnutrition, stunting, and anemia and fueling further displacement. Over 3.3 million refugees (or 72 percent of refugees in the region) in Burundi, Djibouti, Ethiopia, Kenya, South Sudan, Rwanda, Uganda, and the United Republic of Tanzania have faced reductions in food rations in 2021 and 2022 due to the drought. This continues to exacerbate the regional rates of malnutrition. Furthermore, COVID-19 overstretched the region's health systems and delayed the delivery of essential services such as childhood immunizations and seasonal malaria prevention, particularly for rural or displaced populations.

The conflict situation that began in the Tigray region of Ethiopia in 2020 has escalated, causing widespread displacement both internally in the country and across national borders. More than 20 million people are to be targeted for humanitarian assistance and protection this year, nearly three-quarters of whom are women and children (OCHA).

In Somalia, 2.97 million Somalis continue to be internally displaced within the country. Political instability and a civil war that has lasted for decades have contributed to the displacement of more than 601,000 Somali refugees and asylum seekers to Djibouti, Ethiopia, Kenya, and Yemen.

South Sudan continues to face the largest and most underfunded refugee crisis in Africa, with the Regional Refugee Response Plan only 17% funded in 2021. Two out of three South Sudanese refugees are under the age of 18.

POPULATIONS OF CONCERN: E HORN OF AFRICA & GREAT LAKES



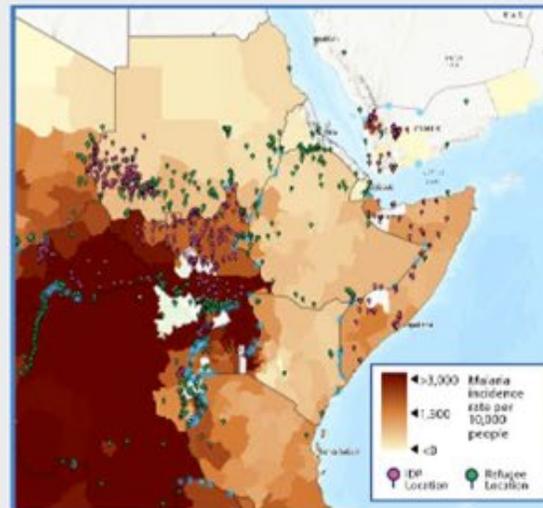
THE THREE DISEASES AND DISPLACED POPULATIONS



MALARIA

Malaria remains a leading cause of morbidity and mortality among refugees and IDPs. Almost two-thirds of refugees, internally displaced persons, returnees and other persons affected by humanitarian emergencies live in malaria endemic regions.

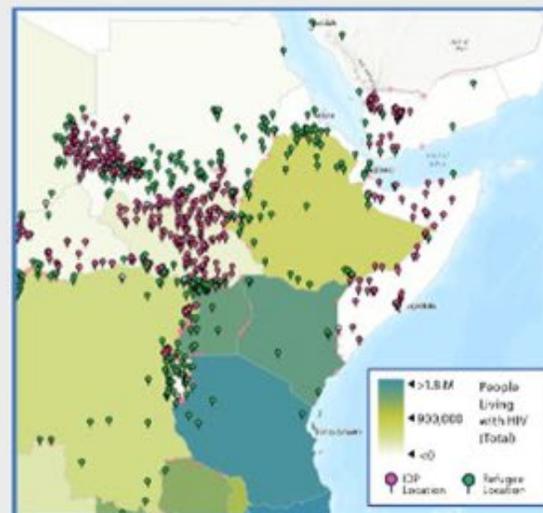
Refugee and IDP camps are often sited on marginal lands that promote breeding sites for malaria vectors, and travel may take refugees through or to areas of higher malaria endemicity than their place of origin. Pregnant women and young children are particularly at risk of severe illness and death due to malaria.



HIV/AIDS

Refugees and IDPs do not increase HIV transmission rates in the host country. In fact, historical evidence shows that refugees have often migrated from countries with lower HIV prevalence to countries with higher HIV prevalence.

However, displacement increases a community's vulnerability to HIV and exposes PLHIV to serious risks, including interruption of treatment and malnutrition. Estimates indicate that as much as 68% of adults and 84% of children living with HIV are not able to receive continuous HIV treatment in emergency settings.





RECOMMENDATIONS

- Conduct conversations about refugee and IDP inclusion in national plan creation, grant proposal development, and implementation processes. Include representatives of displaced populations and humanitarian agencies in these conversations.
- Measure key intervention coverage of displaced populations, identify financial and programmatic gaps, and ensure that data are provided to/linked with national program data.
- Utilize information on refugee and IDP population size and mapping of displacement versus malaria prevalence to target interventions for these populations in their concept notes.
- Countries with existing and new displaced populations should adapt their activities and interventions for these populations in their new funding applications.



RESOURCES

- [UNHCR Global Trends Report: Forced Displacement in 2021](#)
- [IDMC Global Report on Internal Displacement 2022](#)
- [Conflicts, Crises and Displaced People: How the Global Fund Works in Challenging Operating Environments](#)
- [UNHCR Emergency Handbook: Health in Camps](#)
- [UNAIDS: HIV in Humanitarian Emergencies](#)
- [Alliance for Malaria Prevention Operational guidance for ITN distribution in complex operating environments \(COE\)](#)
- [Global Fund: Technical Brief on TB, Gender, and Human Rights 2020](#)
- [Global Fund: Frequently Asked Questions 2023-2025 Allocation Period](#)
- [UNF Analysis: Inclusion of Displaced Populations in Global Fund Funding Applications, 2002-2019](#)
- [Tuberculosis prevention and care among refugees and other populations in humanitarian settings: an interagency field guide](#)



METHODOLOGY

Eligibility

The following criteria were used to determine eligibility for this analysis:

- Countries that qualified for Global Fund allocation at the time of application
- Countries with at least one approved grant
- Countries with a Refugee and/or IDP population greater than 10,000 at the time of application

Scoring

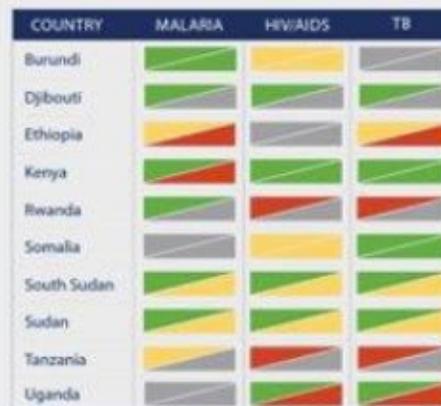
Based on keyword search, applications were labeled:

- **Activities:** Included specific activities that focused on refugees/IDPs
- **Mention:** Mentioned the country's population of refugees/IDPs but did not specify activities targeting those populations
- **No Mention:** Did not mention or reference refugees/IDPs in the country

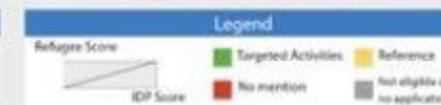


REFUGEES AND IDP INCLUSION IN GLOBAL FUND FUNDING REQUESTS

2017-2019 Funding Cycle



2020-2022 Funding Cycle



Analysis

The inclusion of targeted activities for IDPs and refugees across the three disease areas improved in the 2020-2022 funding cycle compared to the previous cycle. All countries in the region included targeted malaria activities for refugees and IDPs, except one, which included targeted activities for IDPs, a notable improvement from previous applications. Similarly, the majority of countries in the region included targeted TB activities for refugees and IDPs, except for three countries (Rwanda, Somalia and Ethiopia) who referenced but did not include specific activities for either refugees or IDPs. Of the three disease areas, HIV funding requests in the region had the lowest inclusion rate of targeted activities for refugees and IDPs. However, compared to the past funding cycle, there was an uptick in the number of countries who included targeted HIV activities for refugees and/or IDPs, most notably in Burundi, Uganda, Sudan and South Sudan.

Malaria funding requests across the region had the highest rate of targeted activities for refugees and IDPs. Compared to the previous funding cycle, six countries added targeted malaria activities for either refugees and/or IDPs where eligible. There was only one country in the region that did not include targeted malaria activities for both refugees and IDPs. Across the three disease areas, many country applications moved from little to no mention of refugees and/or IDPs in the 2017-2019 applications to strong inclusion of targeted activities for these vulnerable populations in the 2020-2022 applications. As the Eastern Horn and Great Lakes region has high rates of ongoing displacement and large refugee and IDP populations, it is essential for all countries in the region to continue to maintain and increase the inclusion of targeted HIV, TB, and malaria activities for both refugee and IDP populations in the next cycle of Global Fund funding applications.

Looking ahead to the NFM4 funding cycle:

- Conduct conversations about refugee and IDP inclusion in national plan creation, grant proposal development, and implementation processes with representatives and community leaders from refugee, IDP and other displaced populations in addition to humanitarian agencies.
- Inclusion is not enough: overcoming socio-economic, cultural and language barriers.
- Leverage inclusive community-based workforce for social behavior change communications, case management, referral and treatment adherence support
- Expand use of Global Fund emergency grant funds and re-programming during grant cycle to address the evolving needs of new displaced populations.





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15 December, 2022

Vector Control Gap Analysis

ITNs

High, sustained coverage requires periodic mass campaigns and continuous distribution of nets

Mass campaigns

- Define the population living in malarious areas to be targeted for campaigns
 - The targeted population depends on the epidemiology, NSP prioritization and planned targeting. Note the assumptions in the narrative: for example, targeting does not include major urban areas with very low burden but does include refugee populations
- Insert details of the quantification assumptions if you are not using the population projected from the census. For example, “the adjusted population from the previous campaign is projected using the national population growth rate of 3%”
- In most countries, campaigns are carried out every three years.
 - Countries using rolling campaigns should reflect the proportion of the population to be covered each year
 - Countries proposing a more frequent campaign cycle should include data on ITN longevity (durability monitoring data) to justify campaign spacing; **NOTE:** it is expected the additional funding required for a two-year campaign will have to come from outside of the Global Fund allocation, such as from government funding but if this is not possible, make a very strong justification in the funding application

Campaigns

- Estimates of net requirements for campaigns are based on 1 net for 2 persons in malaria endemic areas. Based on experiences throughout Africa, and to account for people living in households with an odd number of family members, WHO and the RBM Partnership recommend you use a calculation of the target population (A) divided by 1.8 (A/1.8)
- For countries where the census is greater than 5 years old, consider including a 10% buffer, or use data from previous campaigns to justify a buffer amount. Remember to include the date of the census and any underlying assumptions
- If historical data show that a different quantification factor should be used, include a justification for the different factor

Mass Campaign						
		2023	2024	2025	2026	
3.1	Programmatic need for campaigns: population of target area (A) #			5,253,125		Campaign every three years. Countries using rolling campaigns or more frequent campaigns should reflect the proportion of the population to be covered each year
3.2 a	Number of nets required (Mass campaign distribution) #	-	-	2,918,403	-	Target is 1 net for 2 people. Use: 1 net for 1.8 people to account for odd number of people in households, adapt based on data from most recent campaign
3.2 b	(optional) For countries where the census is greater than 5 years old, consider including an up to 10% buffer #	-	-	291,840	-	If the census is > 5 years old the country can consider including a buffer up to 10% or use data from previous campaigns to justify a buffer amount. INSERT date of census
3.3	Total Campaign need (B) #	-	-	3,210,243	-	

Continuous Distribution (CD)

- WHO and the RBM Partnership recommend nets are distributed through CD channels (schools, health facilities, communities) to maintain ITN access between campaigns, including for specific population groups such as IDPs and refugees
- **All malaria-endemic countries should include routine distribution of ITNs such as distribution through ANC on first visit by pregnant women and to infants through routine EPI, usually alongside DPT3 or measles vaccination)**
- School distribution:
 - For full scale (instead of mass campaigns), the annual ITN need can be quantified by using 15%-22% of the population
 - For between campaigns, quantification recommendations are available at this [link](#), in the Scenario 3 section
 - The resulting number of ITNs should be compared to the primary-school population and numbers of enrolled students in the various grades, using enrollment data from the Ministry of Education
 - Select the number of grades that best matches the numbers of ITNs to be distributed in schools.
 - NOTE: As enrollment rates can vary throughout the country, some regions may need to use more grades to deliver the ITNs than other regions. If up-to-date enrollment information is not available in time for the planning process, the previous year's enrollment data can be used as a best estimate. In this case, a small (~2%, or calculated based on fluctuations in enrollment in previous years) buffer stock of ITNs can be delivered to each school to ensure all pupils in targeted grades receive an ITN

ITN gap analysis: CD

- If other channels such as community-based distribution are being used, the total annual continuous distribution ITN need (through any non-ANC/EPI channel) can also be quantified by using 15%-22% of the population (with more detailed recommendations for specific countries available [here](#) in the Scenario 2 section)
- For community distribution between campaigns, quantification recommendations are available at the [same link above](#), in the Scenario 3 section.
- If implementing school and community channels in the same location, quantify only once, i.e. multiply the population by 22% and divide the nets among the channels

Note: Ensure that all assumptions for community-based distribution are well-described in the gap analysis table assumption section, including who will ensure distribution, frequency and type of ITN

- If proposing specific channels for targeting of IDPs and refugees, these should also be included and quantified in the gap analysis and the CRSPC can provide guidance as necessary

ITN gap analysis: CD

- To calculate the number of nets required through ANC, multiply the population living in malaria endemic areas by the percentage of pregnant women in the population (this is usually around 4-5%)
 - Factor in current ANC coverage, with increases over time based on planned improvements in access to care, as well as population increases
- To calculate the number of nets required through EPI, multiply the population in malaria endemic areas by the percentage of children under 1 (this is usually around 4%)
 - Factor in current EPI coverage, with increases over time based on planned improvements in access to care and population increases
 - If you are targeting children under five years of age through child health clinics instead of children under 1 through EPI, modify as appropriate
- Adding the ITNs needed for EPI and ANC, and where applicable, for school-based distribution, community-based distribution or channels to reach IDPs, refugees, etc. gives the total number of nets planned for distribution through continuous distribution systems

ITN gap analysis: CD

Continuous Distribution							
		2023	2024	2025	2026		
4.1	Continuous distribution: ITNs required for distribution through schools (C)	#	1,025,000	1,050,625	1,076,891	Insert number of ITNs required for distribution through school campaigns	row 18
4.2 a	Continuous distribution: Number of pregnant women through ANC in all malarious (A) areas (multiply population by % pregnant women) (A*I4)	#	225,000	230,625	236,391	242,300	Insert the number of pregnant women by multiplying population by % of pregnant women
4.2 b	Insert ANC coverage.	%	85%	90%	95%	100%	Where ANC coverage is less than universal insert % of pregnant women covered and factor in scale up
4.2 c	Total nets required for ANC (D)	#	191,250	207,563	224,571	242,300	Multiply ANC coverage by number of pregnant women living in malarious areas
4.3 a	Continuous distribution: children under 1 in all malarious areas through EPI clinics (multiply population by % children under 1) (A*J4)	#	200,000	205,000	210,125	215,378	Insert the number of infants by multiplying population by % of infants
4.3 b	EPI coverage	%	75%	80%	85%	90%	Where EPI coverage is less than universal insert % of infants covered and factor in scale up
4.3 c	Total nets required for EPI (E)	#	150,000	164,000	178,606	193,840	Multiply EPI coverage by number of infants living in malarious areas
4.4	Insert other methods of distribution such as community based, s IDPs, refugees etc. as relevant (F)	#	85,000	85,000	89,000	92,000	Insert number of ITNs expected to be distributed through continuous mechanisms and specify the channels and note who is being targeted
4.5	Total ITNs required for non-mass campaign distribution (F = C+D+E)	#	426,250	456,563	492,177	528,141	

ITN gap analysis: Total number of nets needed

1. Total number of nets required. The total number of ITNs required is calculated by adding the campaign nets + the CD nets in all years.
2. Calculate the number of ITNs already financed.
 - ITN needs planned to be met under other programmes (domestic resources, partners other than the Global Fund) are summed to show what is currently funded or expected to be funded
3. The expected annual gap in achieving targets is calculated from the number of ITNs required - number of ITNs funded.
4. Insert the number of nets to be funded through the Global Fund grant.
5. For the GF, consider including any gap in ITNs in the Prioritised Above Allocation Request (PAAR) and also highlight ITN gaps to other donors for resource mobilization.
6. Calculate the total number of ITNs financed.
7. Highlight the outstanding gap.

ITN gap analysis: Total number of nets needed

		2023	2024	2025	2026			
	Total number of ITNs required G	426,250	456,563	3,702,420	528,141	In this example the campaign is in 2025	row 22	
7.1	ITNs funded by domestic resources (H1)	#	400,000	200,000	200,000	100,000	Insert number of nets funded through domestic resources	row 24
		%	94%	44%	5%	19%		row 25
7.2	ITNs funded from external resources by external donors (H2)	#	26,250	50,000	2,500,000	50,000	Insert names of external donors	row 26
		%	6%	11%	68%	9%		row 27
7.3	Total ITNs planned to be met under other programmes (H)	#	426,250	250,000	2,700,000	150,000	Existing number of nets financed or pledged	row 28
		%	100%	55%	73%	28%		row 29
8	Expected annual gap in achieving targets (number of nets required minus number of nets funded) (G-H=I)	#	-	206,563	1,002,420	378,141	subtracted the number of nets financed from the number of nets required	row 31
		%	0%	45%	27%	72%		row 32
9	Request to be financed through GF funding proposal within allocation (J)	#	0	206,563	1,002,420	0		row 34
		%	0%	6%	27%	0%		row 35
10	ITNs to be financed from allocation amount and other resources (K = H+J)	#	426,250	456,563	3,702,420	150,000		row 36
		%	100%	100%	100%	28%		row 37
11	Outstanding gap (L)	#	0	0	0	378,141		row 38
		%	0%	0%	0%	72%		row 39
12	Prioritised Above Allocation request	0	30,313	0	378,141	Include priority gaps in PAAR - in this example - all gaps are included in PAAR		

Types of ITNs

PBO ITNs: From the total number of ITNs, insert the number of PBOs required based on resistance data and sub-national tailoring

- Note the number of PBOs already financed and highlight the number of PBO ITNs to be funded through the GF allocation

Dual active ingredient ITNs: From the total number of ITNs insert the number of dual active ingredient (AI) ITNs required based on resistance data and sub-national tailoring

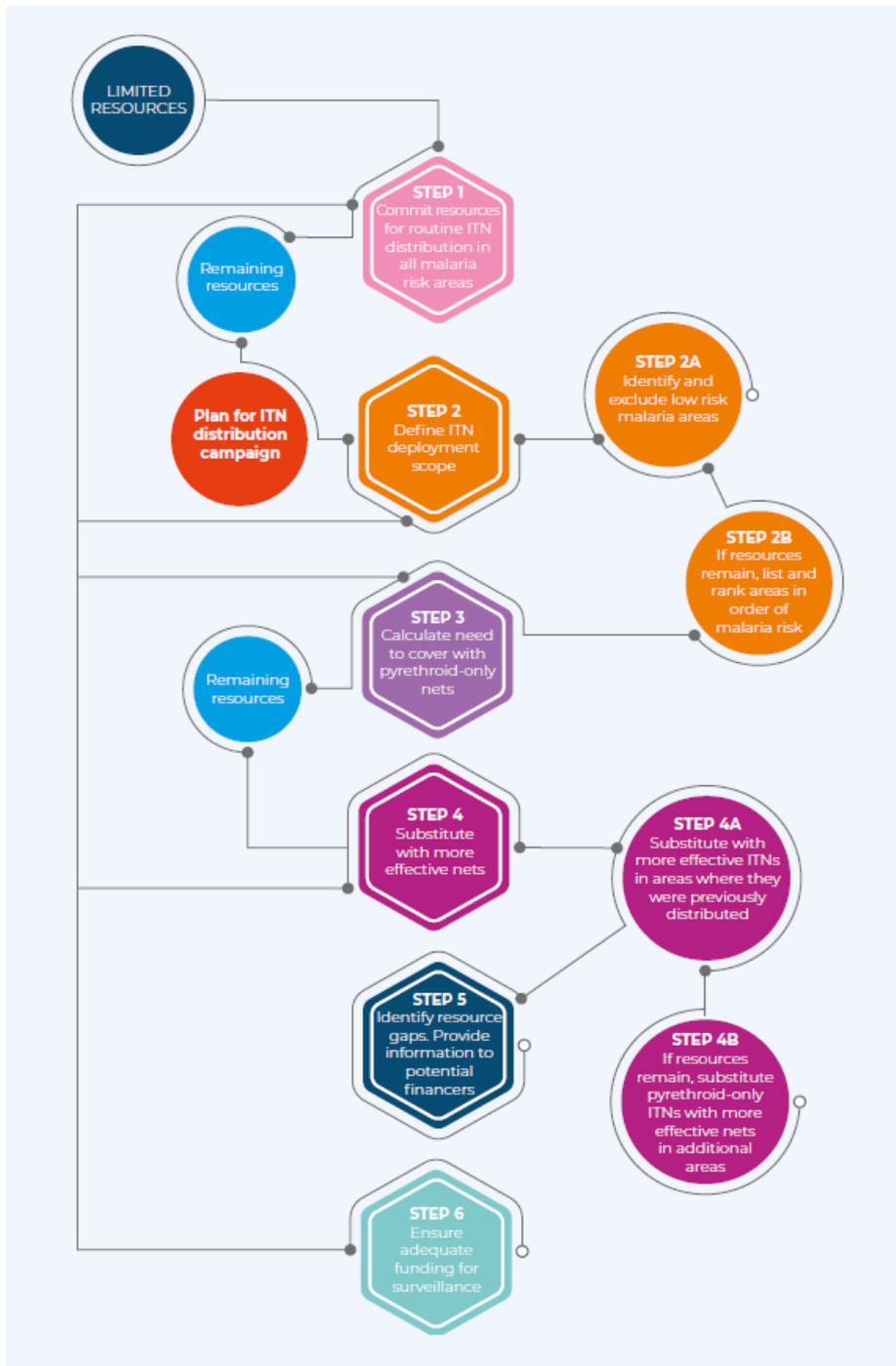
- Note the number of dual AI nets already financed and highlight the number of dual AI ITNs to be funded through the GF allocation

Note any outstanding gaps and consider including these in the PAAR

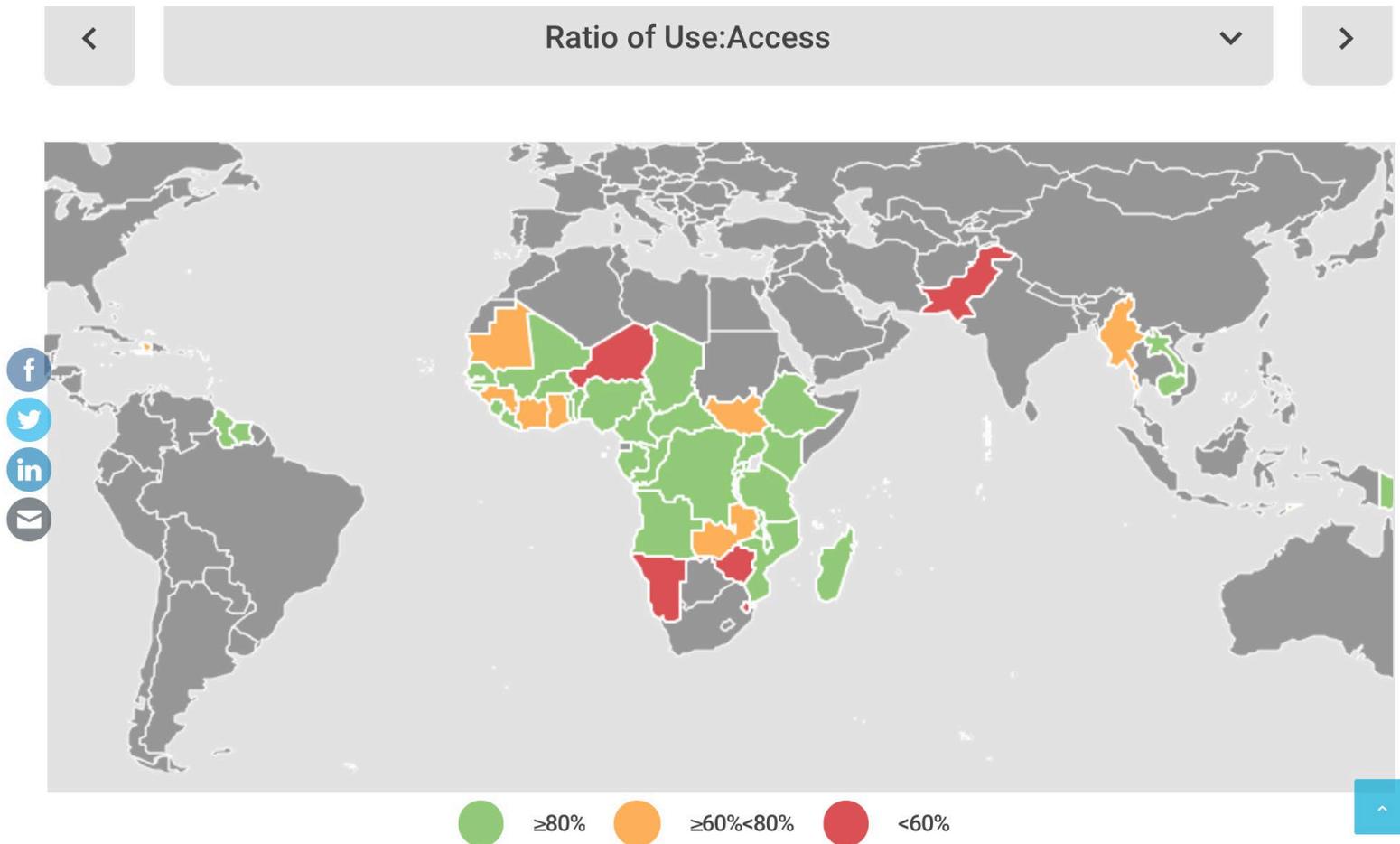
- Indicate whether gaps are for the full cost of the PBO/dual AI ITNs or for the cost difference between these ITNs compared to pyrethroid only ITNs

Types of nets								
Total ITNs required		#		456,563	3,702,420	528,141	Inserted from row 27 above	
PBO nets								
14	Of total net need, number that should be PBO nets (M1)	#		85,000	1,000,000	85,000		row 41
		%		19%	27%	16%		row 42
15	Total PBOs funded by other sources (government or external partners)(M2)	#		85,000	350,000	85,000		row 43
		%		100%	35%	100%		row 44
16	Remaining gap in PBO nets (M1-M2)	#		-	650,000	-		
		%		0%	18%	0%		
17	Total number of PBO nets funded through the allocation amount (M3)	#			350,000			row 45
		%		0%	35%	0%		row 46
18	Final gap for PBO nets (M1-M2-M3)	#		-	300,000	-	Please note whether a) the gap is for the whole cost of the ITN, OR b) the gap is to cover the price increment from a pyrethroid-only ITN	row 47
		%		-	0			row 48
19	Prioritised Above Allocation request	#			300,000		Please note whether a) the gap is for the whole cost of the ITN, OR b) the gap is to cover the price increment from a pyrethroid-only ITN	
Dual Ingredient Nets								
20	Of total net need, number that should be dual active ingredient ITNs (N1)	#		200,000	1,500,000	200,000		row 49
		%		44%	41%	38%		row 50
21	Total dual active ingredient ITNs funded by other sources (government or external partners)(N2)	#		100,000	500,000	100,000		row 51
		%		50%	33%	50%		row 52
22	Remaining gap in dual active ingredient ITNs (N1-N2)	#		100,000	1,000,000	100,000		
		%		50%	67%	50%		
23	Total number of dual active ingredient ITNs nets funded through the allocation amount (N3)	#		0	500,000	0		row 53
		%		0%	33%	0%		row 54
24	Final gap for dual active ingredient ITNs (N4)	#		100,000	500,000	100,000	Please note whether a) the gap is for the whole cost of the ITN, OR b) the gap is to cover the price increment from a pyrethroid-only ITN	row 55
		%		50%	33%	50%		row 56
	Prioritised Above Allocation request	#					Please note whether a) the gap is for the whole cost of the ITN, OR b) the gap is to cover the price increment	

ITN Decision tree



ITN campaigns and CD: Use available data to maximize limited resources



ITN campaigns: Key messages

- Ensure early/timely procurement for meeting campaign timelines (ITNs, digitalization equipment or other international procurement)
- Where a campaign will include distribution of different types of ITNs, such as standard, PBO and/or Dual AI ITNs, plan and budget for issues specific to multi-product campaigns (differentiating bales of different types of nets by colour, identifying additional warehousing to avoid mixing net types, reinforcing SBC where new ITN types are being introduced and determining the transition of ITN types through CD channels)
- Plan for appropriate storage of ITNs at all levels of the supply chain; to the maximum extent possible, ITNs should not be stored in containers after arrival in-country
- If previous campaigns have had extensive lateral movements of nets following delivery to decentralized levels (e.g. districts), consider delivery of a percentage of nets to the decentralized levels and hold back the remaining nets for transport when data is available to better define needs; this may be particularly applicable to COE contexts

ITN campaigns: Key messages

- Microplanning should take place early (4-6 months before distribution) and should include participants from the implementation level to ensure that plans developed will reach everyone targeted with ITNs
 - Consider introducing the use of geospatial technology (mapping) to improve campaign planning; leverage on other work under the Ministry of Health (e.g. EPI)
- A rational SBC plan should be developed based on local evidence and data; ensure rumour management plans are prepared for deployment as needed
- For COE/insecure contexts, consider costs for adaptations from standard approaches/operational modalities and for security of personnel, particularly last mile workers (e.g. visibility, identification) to ensure that all target groups are reached, including IDPs, refugees and last mile populations
- Plan and budget for independent monitors for household registration and/or ITN distribution, including their training, deployment, tools and reporting
- Plan and budget for waste management; engage private sector partners early to look at options for recycling of plastic waste

ITN campaigns: Key messages

- Include costs for clearing customs and initial warehousing if these are not the responsibility of the supplier, as well as all delivery costs to end user
- Review campaign and LFA reports for critical recommendations that may have cost implications and budget accordingly (e.g. not the same cost per net as the previous campaign)
- Prioritize “need to know” data over “nice to know” data; focus on collecting necessary data to adequately monitor the quality of implementation
- Develop a rational, detailed and achievable payment plan
- Updated guidance available on the [AMP Toolkit - The Alliance for Malaria Prevention](#)

ITN campaigns: Key messages

- Include costs for digitalization of the campaign:
 - Consider scope and scale as well as components for digitalization and experience with similar technology-based approaches
 - Consider previous investments and any identified gaps to be filled through a modified or different platform
- Consider how the system proposed will benefit the ITN mass campaign and other aspects of the malaria programme/other health programmes
 - Digitalization may be considered an RSSH investment if the platform is cross-cutting; in this case, please discuss with your GF CT
- Budget above the previous campaign cost per net to ensure all areas of the campaign are adequately covered
- If digitalization has previously been deployed, ensure that the proposal and budget include an inventory of existing devices and, as needed, a rationale for why a new procurement for the full quantity needed is required

CD of ITNs: Key messages

- Ensure planning based on country-specific data, including durability data and data from sub-national levels: countries are not homogenous in terms of presence of functional CHW networks, school attendance, routine health facility attendance, etc.
 - Ensure that plans for CD channels include sufficient data to justify the selection to move to full or partial CD distribution
 - Ensure that the number of ITNs and the funding will sustain delivery through the selected channels over the full three-year period of the grant
- Focus sufficient attention during the planning and budgeting on areas that create risks for successful implementation of CD: financing, procurement and supply management
- Request support through the CRSPC or use existing resources (<https://continuousdistribution.org/background/introduction-to-continuous-itn-distribution/>) to ensure high-quality, realistic plans that will achieve and sustain ITN targets

CD of ITNs: Key messages

Planning and coordination:

- It is important to develop or update ITN distribution guidelines and instructions; share these with all health staff involved in continuous distribution and monitor their implementation
- Effective CD often requires reinforcing collaboration across MOH divisions (e.g. EPI, RMNCH, M&E, communication and other departments) as well as other Ministries (e.g. Education, Regional Development)
- Regional and district health coordination meetings should be leveraged to identify and manage stock-outs or overages
- Determine how data will be collected, collated, transmitted and analyzed to ensure both needed programmatic adjustments and high levels of transparency and accountability to prevent, detect, and mitigate the impact of fraud, theft, or diversion of ITNs
 - Undertake a data audit of available ITN data collection tools
 - Streamline the number of tools to track ITN stock and distribution
 - Ensure availability of standard ITN data collection tools
 - Develop data verification checks to review and compare key ITN indicators
 - Foster data use
- Plan for sufficient SBC to manage community expectations and perspectives regarding how nets are targeted, eligibility, etc.

CD of ITNs: Key messages

Reaching beneficiaries

- Eligibility criteria need to be clarified for all populations eligible to receive ITNs for each channel
- Providing modest stipends to health personnel can support the transport of ITNs during rural outreach services

ITN supply

- A national integrated health commodity information management system / a « pull » system for all public health commodities supports availability
- Review monthly health reporting/DHIS2 data for decision-making for ITN supply and deployment

Storage, transportation, and stock management

- Annual and periodic ITN inventories should be used to identify trends in ITN stock availability and improve dispatching plans
- Last-mile ITN transport is one of the most critical elements for CD and needs to be planned for appropriately to avoid stock-outs
- Stock alert systems and minimum stock level criteria are important to ensuring ITN stock availability for CD
- Municipalities can be effectively engaged to support ITN storage and transportation, with strong collaboration

CD of ITNs: Key messages

ITN distribution

- Consider removing any unnecessary reporting or eligibility burdens for beneficiaries to receive ITNs (for example, in one country where ID cards were required, women could not always access ITNs as they did not always have ID cards)

Personnel and capacity strengthening

- Plan for periodic refresher trainings for CHWs or others involved in CD
- Include roles and responsibilities for effective ITN management in national ITN directives
- Leverage coordination meetings to reinforce use of ITN guidelines, tracking tools and key messages
- Integrate on-the-job ITN training and modules with other health service delivery training (e.g., IPTp, case management)

Supervision

- As part of supervision visits, include staff skills building and practice in correctly filling out ITN stock and data management forms
- Review and update routine supervision checklists to ensure consistent inclusion of ITN distribution, stock and data management
- Include data verification checks during routine supervision visits to review and compare the number of ITNs received, the number distributed, the number in stock, and the numbers of beneficiaries seen

IRS

- Define the objective of IRS within the goals of the national malaria programme:
 - To rapidly reduce transmission in high malaria endemic areas
 - To prevent epidemics in moderate and low transmission areas
 - To eliminate malaria from malaria foci
 - To address insecticide resistance
- Quantify the target population and average area of sprayable surface of structures and number of structures in target areas
- Define the number of IRS cycles per year and note which insecticides are being used
- Calculate the human and financial resources required for insecticide, equipment, personnel, operational costs, M&E, etc.

Insecticide Resistance

- Monitoring for insecticide resistance should be a high priority in all countries and is required to be prioritised within the GF allocation if it is not covered by other partners/resources
- A detailed outline of the methods used for insecticide resistance monitoring, including number of sites/frequency, strategies used to delay resistance or to respond to it should be outlined in a national insecticide resistance monitoring and management strategy

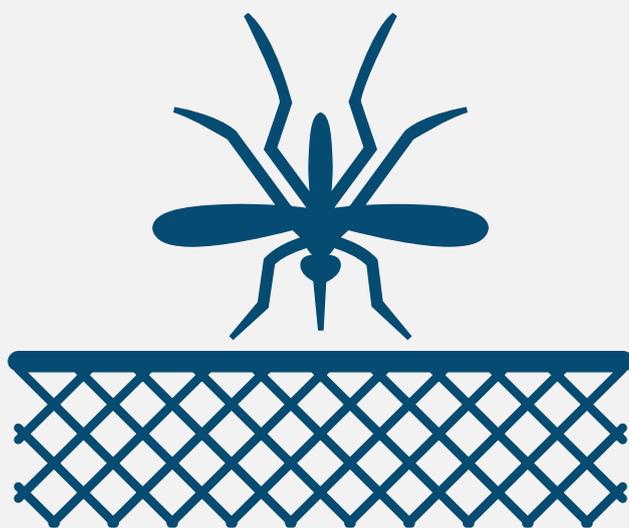
NOTE: Development of such a document can be budgeted for as part of the GF grant



15 December, 2022

Thank you!

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GUIDANCE ON ITN PRIORITIZATION

CONTEXT

In the context of limited resources, national malaria programmes may need to make prioritization decisions across all WHO-recommended interventions¹. This guidance document has been developed to support national malaria programmes on prioritization decisions specifically for insecticide-treated net (ITN) deployment scope and product choice, to be used when programmes do not have sufficient budget to deploy the most effective ITNs to all populations at risk.

This guidance does not address distribution channel decisions or other issues such as frequency of ITN distribution. Nor does it cover every choice that a national malaria programme may need to make regarding ITNs, but rather is intended as a basis to start discussion and decision-making.

Routine distribution of ITNs to vulnerable groups, such as pregnant women and children under five years of age, remains critical. It is strongly recommended that these distribution channels are maintained in all areas, regardless of the plans for campaigns. This guidance document therefore includes ensuring this coverage as the first step, and then focuses on planning for high-volume, intermittent ITN distributions. While the term “campaign” is used throughout, the guidance is applicable to other high-volume, intermittent deployment approaches such as large-scale school or community distributions.

In the last three years, more than 50 per cent of national malaria programmes have implemented a mass campaign with two or more ITN types (i.e. pyrethroid-only, pyrethroid-piperonyl butoxide (PBO), pyrethroid-chlorfenapyr or pyrethroid-pyriproxifen). The ITN types were, as far as possible, targeted to geographical areas based on local insecticide resistance data. Going forward, increasing resource constraints resulting from flatlined funding, high inflation, population growth and competing priorities exerted by other malaria interventions may require national malaria programmes to make compromises, taking prioritization decisions that balance net quantities and types, distribution channels, target populations and the relative value for money of these choices, to best optimize impact.

This guidance document aims to support programmes in developing a prioritized deployment plan that balances efforts to optimize ITN effectiveness with ensuring coverage of the most at-risk populations. The proposed prioritization process is based on best practice generated in Africa over recent years but should be used by all countries deploying ITNs.

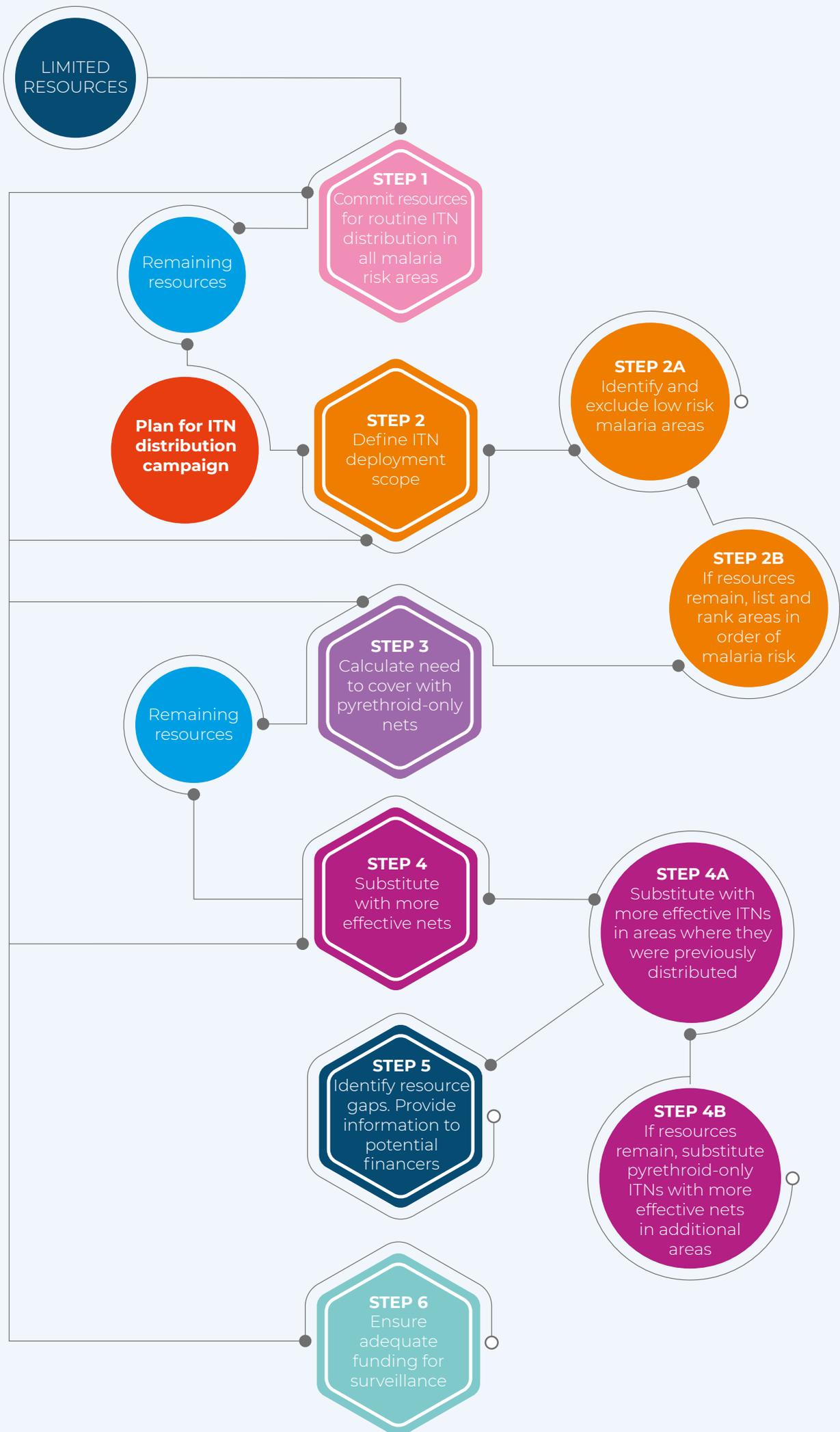
1. <https://app.magicapp.org/#/guideline/6810>

In summary this guidance works through the following steps:

1. Ensure access for vulnerable groups: commit funding for routine ITN distribution to vulnerable groups in all malaria risk areas

Then, for campaign deployment planning:

2. Define ITN deployment scope:
 - a. Identify and exclude areas of very low current and historical malaria risk
 - b. List and rank the areas for campaign ITN deployment in order of malaria risk
3. Maximize coverage: calculate the funding needed to ensure full coverage with pyrethroid-only nets. *If funding remains then:*
4. Maximize effectiveness: substitute pyrethroid-only ITNs with pyrethroid-PBO or pyrethroid-chlorfenapyr ITNs in areas of pyrethroid resistance, starting with areas that previously deployed non-pyrethroid-only ITNs and then in decreasing order of malaria risk.
5. Identify funding gaps that impede further effective coverage and make that information available to potential financiers.



STEP



Commit resources for routine ITN distribution to vulnerable groups in all malaria risk areas

- Calculate the ITN needs for continuation of routine ITN deployment to vulnerable groups (e.g. pregnant women and infants under five through antenatal care [ANC] and Expanded Programme on Immunization [EPI] routine visits). Calculate the required funding for pyrethroid-only nets at this step. These can be incrementally substituted for more effective nets at later steps in the prioritization process as geographical areas are allocated more effective nets for campaign deployment; alternatively, programmes may decide to keep one type of ITN throughout the country for routine distribution in which case the required funding for pyrethroid-PBO or pyrethroid-chlorfenapyr nets should be calculated at this step.

Then move on to campaign planning:

STEP

2

Define ITN deployment scope

2a : Identify and exclude geographic areas of very low malaria risk

- Identify areas where the current and historical risk of malaria is very low based on national programme data (including most urban areas). In Africa very low-risk areas (e.g. consider a range of one to three per cent malaria prevalence) are generally found in highly urbanized centres or in specific rural areas; the identification of “very low risk” areas should consider the complexities below:
 - i. In highly urbanized centres of large towns and cities malaria transmission is often heterogenous and hotspots of transmission may exist. Identify any such areas of higher *local* transmission (i.e. excluding hotspots linked to imported cases) and ensure they are not classified as “low risk”².
 - ii. The invasive vector *An. stephensi* is being reported from an increasing number of locations, including urban areas. To effectively control this vector, urban areas that have been invaded by *An. stephensi* will require some form of vector control. Depending on context this could include ITN distribution.
 - iii. In rural areas, very low risk areas are only found at very high altitudes, deserts, or at the edge of malaria’s geographical distribution. However, the receptivity of these regions may have changed due to activities other than malaria control, such as irrigation, mining, infrastructure development and climate change. It is therefore critical to look at recent and historical epidemiological trends to determine whether an area is of very low malaria risk and can be deprioritized.
 - iv. Use data from ITNuse.org in addition to other data to support decision-making on ITN campaign prioritization. For example, consider whether ITNs are more effective in urban areas versus use of another vector control strategy.

² The approach is explained in the WHO urban malaria framework: World Health Organization. (2022). Global framework for the response to malaria in urban areas. World Health Organization. <https://apps.who.int/iris/handle/10665/363899>. License: CC BY-NC-SA 3.0 IGO

- Use this analysis to determine areas to be excluded from campaign ITN deployment, considering the following guidance:
 - Cease campaign ITN distribution in areas with historic and current very low-risk – i.e. zero coverage provision – or areas with documented low ITN use unless action to rectify this issue has been identified and included in the budget.
 - Maintain ITN distribution in areas with persistently high or moderate malaria risk, including urban clusters of moderate to high local transmission.
 - Maintain ITN distribution in areas currently at low risk that were historically moderate or high risk (i.e. low risk has only been achieved recently through vector control).
 - Maintain ITN distribution in areas of historically low risk, where risk is increasing due to climate change or other factors.
 - After appraising vector control options for *An. stephensi*, consider whether ITN distribution in areas where *An. stephensi* has been detected should be maintained or if other alternatives such as larval source management would be more cost-effective. This decision should not be affected by historical/current malaria risk.

Note: In areas where ITNs are scaled back due to low malaria risk it is critical that robust surveillance is in place to detect epidemics and that adequate access to case management is ensured. Additional information can be found in both the WHO Guidelines for Malaria³ as well as the WHO Urban Malaria Framework⁴.

3. Best Practice Statement: No scale-back in areas with ongoing local malaria transmission (2019), WHO, Guidelines for Malaria, p. 61. <https://apps.who.int/iris/rest/bitstreams/1427681/retrieve>

4. World Health Organization. (2022). Global framework for the response to malaria in urban areas. World Health Organization. <https://apps.who.int/iris/handle/10665/363899>. License: CC BY-NC-SA 3.0 IGO

2b : List and rank the areas for campaign ITN deployment in order of malaria risk

- Divide the country into the lowest administrative levels at which different ITN types could feasibly be deployed (i.e. districts or other second-level administrative areas). Prioritization steps will consider malaria risk, so it is better at this stage to consider the *smallest* practical implementation areas (e.g. districts rather than provinces), as smaller areas are more likely to have similar levels of malaria risk. Epidemiological data plus other contextual factors – such as access to care - should be considered to help define risk.
- Rank these areas by malaria risk:
 - The aim is to assess the potential for transmission in the absence of vector control, especially what may be expected if ITNs are **not** provided. Malaria programmes should use the best available indicators and data and triangulate both current and historic data, including prevalence of infection in surveys, incidence in health facilities, transmission intensity (from entomological studies), other contextual factors, and the best estimates of well-informed and experienced staff.
 - One approach would be to draft an initial ranking based on an assessment of historical (i.e. pre-intervention or natural) transmission intensity. Note that in areas where vector control coverage is currently moderate or high, current levels of malaria incidence and prevalence should **not** be considered a reliable indicator of historical/natural transmission intensity. In areas with low burden due to vector control, the immunity in the population may be diminished and if vector control is withdrawn, resurgence/epidemics can occur.
 - Having drawn up an initial ranking based on historical endemicity or background transmission intensity, this ranking will then need to be adjusted to account for additional risk factors.
- For each location, calculate how many nets would be needed for full campaign coverage (with a quantification ratio of 1:1.8 or a modified ratio based on local data). Programmes planning to “match” the type of ITNs in their routine system with their campaign deployment plan should include an additional column quantifying the nets and associated funding for routine distribution over a period of three years in each area.

STEP

3

Maximize coverage: calculate the need to cover these at-risk areas with pyrethroid-only nets

For the points below, use the cost of a pyrethroid-only ITN and include deployment costs:

- ◉ Starting with the area with the highest risk, assign the resources needed for full ITN coverage with pyrethroid-only ITNs.
- ◉ Repeating this step, continue down the list in order of malaria risk.
- ◉ Continue until the available funding has been depleted. (It is best to end on a completely covered area, rather than a half-covered area, which would create operational difficulties).
- ◉ *If resources still remain after Step 3, move to Step 4. If not, go to Step 5.*



STEP

4

Maximize effectiveness: “substitute” pyrethroid-only ITNs with more effective nets as far as possible

- ⦿ Consider which areas in your ITN deployment plan have pyrethroid resistance. Ideally these will be provided pyrethroid-PBO or pyrethroid-chlorfenapyr ITNs following the processes in steps 4a and 4b. Recognizing that no programme is likely to have insecticide resistance data for all deployment areas, some extrapolation from adjacent areas is appropriate, including adjacent areas of neighbouring countries where relevant.
- ⦿ Allocate resources remaining after step 3 by substituting pyrethroid-only ITNs in the deployment plan in the following stepped process.
- ⦿ For the process below consider the incremental cost to substitute pyrethroid-only ITNs with pyrethroid-PBO or pyrethroid-chlorfenapyr ITNs, noting that delivery costs of ITNs to end users are already allocated in the step above.

4a : Substitute pyrethroid-only ITNs with more effective ITNs in areas where they were previously distributed

- ◉ Allocate the *additional* available resources needed to replace pyrethroid-only ITNs with pyrethroid-PBO or pyrethroid-chlorfenapyr ITNs in areas that previously received these net types, starting from highest burden areas. For programmes planning to “match” the type of ITNs in their routine system with their campaign deployment plan, allocate the additional resources needed to replace the pyrethroid-only ITNs for routine distribution with the net type to be used for the campaign.
- ◉ Continue area by area until resources are depleted.
- ◉ *If resources remain from step 4a, move to step 4b. If not, go to Step 5.*

4b : Substitute pyrethroid-only ITNs with more effective ITNs in additional areas

- ◉ Allocate the *additional* resources needed to substitute pyrethroid-only ITNs with pyrethroid-PBO or pyrethroid-chlorfenapyr ITNs in additional areas, starting from the next highest burden areas with pyrethroid resistance and expanding to neighbouring high burden districts without pyrethroid resistance data.
- ◉ For programmes planning to “match” the type of ITNs in their routine system with their campaign deployment plan, allocate the additional resources needed to substitute the pyrethroid-only ITNs for routine distribution with the net type to be used for the campaign.
- ◉ Continue area by area until resources are depleted.



STEP

5

Identify resource gaps

If either optimal coverage with any ITN, or with the most effective ITN, cannot be achieved with the available funding (taking into account all external and domestic sources) then a prioritization exercise amongst all interventions will need to be considered. If gaps persist, these additional funding needs should be identified and codified and this information should be provided to potential financiers, such as the government, PMI and/or in the Global Fund Prioritized Above Allocation Request.



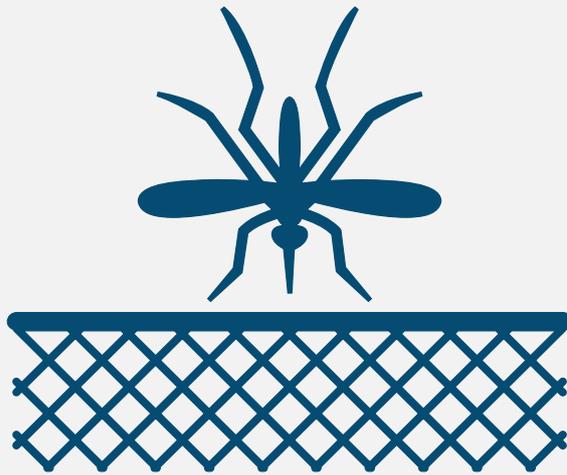
STEP

6

Ensure adequate funding for surveillance

A robust surveillance system is needed to ensure appropriate monitoring of malaria indicators to provide timely signals of potential upsurges in areas no longer receiving ITNs, as well as for routine programmatic decision-making. Allocate sufficient funding to address any surveillance strengthening needs as well as system maintenance.





AMP CONTACTS

To join the weekly AMP conference call each Wednesday at 10:00 AM Eastern time (16.00 PM CET) use the following Zoom meeting line:

<https://us06web.zoom.us/j/2367777867?pwd=a1lhZk9KQmcxMXNaWnRaN1JCUTQ3dz09>

You can find your local number to join the weekly call:

<https://zoom.us/u/acyOjklJj4>

To be added to the AMP mailing list visit:

<https://allianceformalariaprevention.com/weekly-conference-call/signup-for-our-mailing-list/>

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allianceformalariaprevention@gmail.com

For further information please go to the AMP website:

<https://allianceformalariaprevention.com>