Malaria Programmatic Gap Analysis:

Guidance Note November 2022

## Introduction

A comprehensive programmatic gap analysis outlines the programmatic requirements needed to fully implement the strategic plan of a national malaria programme. It also identifies components already funded and highlights any outstanding financial gaps for which funding is being sought. The analysis covers key malaria control interventions including vector control (Insecticide Treated Nets (ITNs) and Indoor Residual Spraying (IRS)), case management (diagnostic testing and treatment), preventive chemotherapy (Intermittent preventive treatment in pregnancy (IPTp), seasonal malaria chemoprevention (SMC)) as well as supportive activities needed to effectively deploy and monitor these interventions such as management capacity, training, social and behavior change and monitoring and evaluation. The gap analysis follows an evidence-based approach to planning and programing based upon the targets and strategies outlined in the malaria national strategic plan (NSP).

## Definition

***Programmatic gap*** defined by the services and commodities needed to cover the gap between the current coverage and the planned objectives for a given malaria intervention. The services cover both technical and supportive activities.

***Financial gap*** represents the difference between the available financial resources (or projected available resources) and the total resources needed to fill the programmatic gaps. A comprehensive programmatic gap analysis is required to inform the resource estimate for the financial gap analysis.

## Guiding principles

***Evidence-based***: Accurate and detailed data/information are needed to ensure a credible gap analysis. The relevant evidence includes the following:

1. Historical data and experience from previous programme implementation
2. Population and epidemiological data disaggregated by age group, and geographic location (population per district, urban and rural, etc.)
3. Up to date information on the implementation status of current interventions
4. Information on the national funding landscape, both actual and promissory, is needed to derive a credible financial gap analysis from a programmatic analysis

***Harmonization and alignment***: the gap analysis is based on the national strategic plan. Partner coordination, harmonization and information sharing will facilitate consensus on the programmatic and financial gaps. The Programmatic Gap analysis is an integral part of the programme planning and implementation cycle and is not a stand-alone exercise. It should be updated regularly when new information becomes available.

***Equity***: While assessing coverage of interventions, it is important for the national malaria programme to identify any disparity relating to gender, geographic location, particular population groups or age groups to make sure that the recommended implementation strategies are comprehensive and equitable. Particular attention should be given to the very vulnerable populations and the hard-to-reach groups such as refugees and internally displaced people (IDPs).

***Transparency and accountability***: Transparent information sharing between the malaria programme and partners will avoid duplication of efforts, effective use of resources and ensure mutual accountability.

## Methods for malaria programmatic gap analysis

The RBM Partnership Country Regional Support Partnership Committee (CRSPC) recommends all countries undertake a comprehensive programme performance review that will be the basis for an evidence-based National Strategic Plan. In order to facilitate the gap analysis, the CRSPC recommends the development of a multiyear implementation/business plan, and an annual operational plan (to guide the day-to-day work) from the NSP. The results from country sub-national stratification and tailoring processes should be used to justify the prioritization of interventions and geographical areas particularly when resources are insufficient to cover all needs. The following steps are recommended:

1. Identify the programmatic need

* Use accurate national population and malaria epidemiological data, update the malaria stratification and population at risk (by age group, sex and geographic distribution). Where the population census is more than five years old, considering adding a 10% buffer
* Use targets and interventions outlined in the national strategic plan, and based on the best available epidemiological information, including subnational stratification, identify geographical areas and vulnerable populations that will benefit from each intervention and delivery approach
* Develop SMART[[1]](#footnote-1) objectives and indicators (the performance framework from the national strategic plan should be the main reference)
* Develop a multiyear implementation plan with quantified annual targets
* Describe the service delivery approaches or strategies to deliver the key interventions
* Quantify the commodities needed for each intervention. Note that tools developed by RBM partners as well as guidance from the CRSPC partners and WHO can assist in the quantification exercise
* Identify the detailed activities to be undertaken and timeframe (technical and supportive activities)

2. Identify what is currently financed. Assess the commodities, activities and interventions already covered through existing systems and resources including the identification of all partner contributions

3. Identify the gap - Identify the commodities and activities (technical and supportive) that still need to be covered

4. Prioritise new resources towards the most impactful cost-effective interventions. This prioritization exercise should take into account the latest recommendations from WHO, the national strategic plan, the results of country sub-national stratification and tailoring exercises, and country implementation experience.

**Table 1: Generic programmatic gap analysis**

| **Priority intervention**  | **Historical** | **Mid-term** | **End term** |
| --- | --- | --- | --- |
|  | ***-2Y*** | ***-1Y*** | ***Y1*** | ***Y2*** | ***Y3*** | ***Y4*** | ***Y5*** |
| **A: Country annual needs (E.g., ITN, IRS, RDT, ACT etc.)**  |  |  |  |  |  |  |  |
| **B: Extent of annual need already planned to be met under the existing program and resources** |  |  |  |  |  |  |  |
| B1. Government |  |  |  |  |  |  |  |
| B2. External Resources |  |  |  |  |  |  |  |
| B2.1. Global Fund  |  |  |  |  |  |  |  |
| B2.2. Other partners (name them) |  |  |  |  |  |  |  |
| B2.3 3. Other partners (name them) |  |  |  |  |  |  |  |
| B total  |  |  |  |  |  |  |  |
| **C: Expected total gap in achieving targets (= A – B)**  |  |  |  |  |  |  |  |

The gap analysis should be carried out for all main interventions and service delivery areas identified in the national strategic plan. The numbers in the programmatic gap analysis table are related to the size of the population groups targeted by the priority interventions, not the financial need for the interventions. The financial gap analysis will be done as a second stage in the process.

# Specific guidance notes for gap analysis

## ITN gap analysis

1. Note the total population
2. Define the targeted population High, sustained coverage requires both periodic mass campaigns and continuous distribution of nets. Priority should be given to routine distribution of ITNs through antenatal clinics or the expanded programme for immunization to ensure sustained ITN access for the most biologically vulnerable populations..
3. Mass campaigns
* Define the population living in malarious areas to be targeted for campaigns. The targeted population will vary depending 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 assumptions if you are not using the population projected from the census. For example, “Registration from the previous campaign is being used with an adjustment of -2% to account for poor registration in some areas; the adjusted population from the previous campaign is projected using the national population growth rate of 3%.”
* In the majority of countries, campaigns are carried out every three years. Countries using rolling campaigns or more frequent campaigns should reflect the proportion of the population to be covered each year. Where campaigns are proposed on a more frequent basis, include data on ITN longevity (durability monitoring data) to justify campaign spacing.
* 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). If historical data show that a different factor should be used, include a justification for the different factor
* 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.
1. Continuous Distribution
* WHO and the RBM Partnership recommend nets are also distributed through continuous distribution channels to maintain coverage between campaigns including schools, health facilities (distribution through ANC on first visit by pregnant women and to infants through routine EPI, usually alongside DPT3 or measles vaccination), communities (through community health workers) and others to ensure ITN access among specific population groups such as IDPs and refugees.
* For full scale school distribution (instead of mass campaigns), the annual ITN need can be quantified by using 15%-22% of the population (with more detailed recommendations for specific countries available [here](https://eur02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhtmlpreview.github.io%2F%3Fhttps%3A%2F%2Fgithub.com%2Fhkoenker%2FQuantification%2Fblob%2Fmaster%2Foutput%2FScenario_2_and_3_Quantifiers_Table_Full_Version.html&data=05%7C01%7Cmarcy.erskine%40ifrc.org%7C8b1a4c9662ba4fded1be08dab5be96a4%7Ca2b53be5734e4e6cab0dd184f60fd917%7C0%7C0%7C638022127419403366%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=UvqxwM02aMpv%2BARAOd17gB1LXEBAo20iuogXn6boLj8%3D&reserved=0) in the Scenario 2 section). For school distribution between campaigns, quantification recommendations are available at the [same link above](https://eur02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhtmlpreview.github.io%2F%3Fhttps%3A%2F%2Fgithub.com%2Fhkoenker%2FQuantification%2Fblob%2Fmaster%2Foutput%2FScenario_2_and_3_Quantifiers_Table_Full_Version.html&data=05%7C01%7Cmarcy.erskine%40ifrc.org%7C8b1a4c9662ba4fded1be08dab5be96a4%7Ca2b53be5734e4e6cab0dd184f60fd917%7C0%7C0%7C638022127419403366%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=UvqxwM02aMpv%2BARAOd17gB1LXEBAo20iuogXn6boLj8%3D&reserved=0), in the Scenario 3 section. The resulting number of ITNs should then 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. As enrollment rates can vary throughout the country, it’s possible that 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.

Note: Ensure that all assumptions for school-based distribution are well-described in the gap analysis table assumption section, including choice of grades, frequency and type of ITN.

* If the country is using other channels such as community-based distribution, 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](https://eur02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhtmlpreview.github.io%2F%3Fhttps%3A%2F%2Fgithub.com%2Fhkoenker%2FQuantification%2Fblob%2Fmaster%2Foutput%2FScenario_2_and_3_Quantifiers_Table_Full_Version.html&data=05%7C01%7Cmarcy.erskine%40ifrc.org%7C8b1a4c9662ba4fded1be08dab5be96a4%7Ca2b53be5734e4e6cab0dd184f60fd917%7C0%7C0%7C638022127419403366%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=UvqxwM02aMpv%2BARAOd17gB1LXEBAo20iuogXn6boLj8%3D&reserved=0) in the Scenario 2 section). For community distribution between campaigns, quantification recommendations are available at the [same link above](https://eur02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhtmlpreview.github.io%2F%3Fhttps%3A%2F%2Fgithub.com%2Fhkoenker%2FQuantification%2Fblob%2Fmaster%2Foutput%2FScenario_2_and_3_Quantifiers_Table_Full_Version.html&data=05%7C01%7Cmarcy.erskine%40ifrc.org%7C8b1a4c9662ba4fded1be08dab5be96a4%7Ca2b53be5734e4e6cab0dd184f60fd917%7C0%7C0%7C638022127419403366%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=UvqxwM02aMpv%2BARAOd17gB1LXEBAo20iuogXn6boLj8%3D&reserved=0), 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 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 if necessary.
* 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.
1. Total number of nets required. The total number of ITNs required is calculated by adding the campaign nets (usually once every three years, unless the country has adopted a programme of rolling campaigns) and the continuous nets in all years.
2. Calculate the number of nets 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 nets required minus number of nets 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). Also highlight ITN gaps to other donors.
6. Calculate the total number of nets financed.
7. Highlight the outstanding gap.

**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. Note whether gaps are for the full cost of the PBO/dual ITNs or for the cost difference between these ITNs compared to pyrethroid only ITNs.

## IRS gap analysis

Define the objective of IRS within the goals of the national malaria programme

* To 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
1. Note the total population
2. Define the targeted population for IRS.
	* Based on the programme need and objectives the IRS strategy may be universal coverage of all malaria risk districts and populations or selected and targeted coverage of a few districts or sub-districts. The population size will increase annually based on population growth rates
* Define the number of households in IRS targeted areas. Traditional housing and urban housing vary with regards to size, surfaces and appropriate type of insecticide to be used
* Quantify the average area of sprayable surface (m2) of structures and number of structures in target areas.
* Define the number of IRS cycles per year. The assumption depends on malaria transmission and insecticide duration of effective action. In areas of seasonal malaria transmission one spray round is sufficient but areas with transmission seasons longer than 8 months or two seasonal peaks, more than one spray round may be necessary.
* Once the target districts and populations to be protected, structures to be sprayed, and cycles per year are determined, guidance and tools are available to calculate the human and financial resources required for insecticide, equipment, personnel, operational costs, waste management, monitoring and evaluation, etc. Refer to the WHO operational manual on Indoor Residual House Spraying (https://www.who.int/publications/i/item/9789241508940)
* Quantify IRS chemical needs for every year of the implementation plan. This is calculated based on total number of households and the total sprayable surface area. This is also based on type of insecticide used and the concentration of active ingredients dosage required per meter squared and the number of sachets/bottles required per household. Look at the insecticide manufacturers’ guidelines and product labels for more specific guidance. Costs should include transport, storage and disposal.
* Quantify IRS spray hand compression pumps and repair kits needs for every year of the implementation plan. This is calculated based on the inventory of stock of working spray pumps and those requiring repairs and the expected number of spray teams to be deployed. Standard spare kits are available from manufacturers for 4, 6, 8 or 10 IRS operations teams
* Quantify IRS protective equipment kit needs for every year of the implementation plan. This is calculated based on the inventory of stock of protective kit per spray operator and the expected number of spray operators to be deployed
* Quantify the operational and administrative costs of the annual spray campaign. This will include all personnel costs such as spray operators’ salaries and supervisors’ per-diems, transport (vehicle purchase/rental, maintenance and fuel) as well as rental, security and refurbishment costs for the warehouses, staging areas, and washing areas and related waste management requirements
* Quantify annual cascade training and supervision costs. This is based on an annual national training course for training of trainers, provincial training course for supervisors and district training courses of IRS spray operators. Supervision includes monthly supervision to all spray teams by district supervisors and provincial and national supervisors visit to all districts at least once in a spray cycle. This will include facilitators and supervisor travel and per-diems, materials, food, facility rental etc.
* Community mobilization includes human and financial resources needed for preparatory community meetings, information campaigns, and the door-to-door community mobilizers to accompany the spray teams for house preparation
* IRS monitoring and reporting costs. Production of daily, monthly and annual spray reports on houses sprayed, population covered, insecticides used and in stock, spray pumps in stocks and need for repair, protective gear in stock, transport used, financing allocated and used, etc. Quality assurance of spraying (monitoring durability, etc.) in various spray sites during and post campaign. Vector sentinel sites should be a minimum of one site per million population and representatively situated in different transmission eco-epidemiological areas. Annual bioassays should be conducted after each spray cycle. Annual insecticide susceptibility testing should be conducted before each spray cycle
1. Determine what funding and support will be committed through domestic resources and partners and what gap remains. Assess the commodities, logistics, human resources and activities already covered with the existing national systems and resources. Assess what is available for IRS service delivery from the national program and the health system. Meet with partners and stakeholders to assess their level of planned specific IRS delivery contributions
2. Estimate the expected annual gaps that still need to be covered for commodities, logistics, human resources and activities
3. Specify what will be funded through the GF malaria allocation and consider placing outstanding gaps into the GF Prioritised Above Allocation Request.
4. Note which insecticide is being used and indicate if this will be changed during the funding cycle and if so, to what.

## Gap Analysis for Malaria Diagnosis and Treatment

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 scientific, evidence based, and rational assumptions be used. Note that not all assumptions in the table might be applicable to your local situation. Disregard assumptions that are not relevant to your national context. Similarly, be sure to include other assumptions which might not be listed in the table but that you consider relevant to your context. You must explain the rationale for all assumptions made.

For Community Case Management, ensure complementarity between the malaria and non-malaria commodity gap analysis sheets.

## Treatment

1. In order 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.
2. 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.
3. Multiply the number of ACTs required by each sector by the proportion of malaria cases in each sector.
4. 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.
5. Breakdown the required number of ACTs by age group in accordance with packaging requirements. The ACT gap at the end of the worksheet represents the total number of MALARIA TREATMENTS. To determine the financial gap, you would need to allocate this total requirement into treatment courses per appropriate age group. For example, if the ACT in use in country Y is artemether plus lumefantrine, the total treatment calculated should be sub-divided according to the four treatment pack sizes for the different age groups. The country population profile and the proportion of cases in each age group should be used to make this division. The financial gap is then determined by applying the respective pack specific prices to the needs.
6. For countries deploying more than one ACT, note the breakdown in the gap analysis table. This should be based on targets set in the national strategic plan, and from sub-national stratification and tailoring and may be targeting specific age groups, such as children under five years of age or geographical areas.

## Severe Malaria

1. 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
2. Multiply the total number of severe cases by the target coverage in the NSP
3. Insert the proportion of severe malaria cases managed (pre-referal treatment, e.g rectal artesunate) through community case management and /or primary health care level. Multiply the proportion of severe malaria cases managed (pre-referal treatment, e.g rectal artesunate) through community case management and /or primary health care level by the total number of severe cases
4. 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
5. Include what is already financed through domestic and external resources, and allocate the gaps to the GF allocation.

## Diagnostic testing

1. 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.
2. 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.
3. 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.
4. Calculate the number of RDTs/microscopy slides already financed or available over the projected period by sector.
5. Subtract the number of RDTs/microscope slides financed from the total number required to calculate the gap by sector.

## Community Health Workers and non-malaria iCCM commodities

The GF CHW tables are included in the gap analysis document – please refer to the GF RSSH Info Note for instructions. <https://www.theglobalfund.org/media/4759/core_resilientsustainablesystemsforhealth_infonote_en.pdf>

## Specific guidance notes for preventive chemotherapy

## Seasonal Malaria Chemoprophylaxis (SMC)

In areas of seasonal malaria transmission, children belonging to age groups at high risk of severe malaria should be given antimalarial medicines during peak malaria transmission seasons to reduce disease burden. Eligibility for seasonal malaria chemoprevention (SMC) is defined by the seasonality of malaria transmission and age groups at risk of severe malaria. Thresholds for assessing these criteria change over time and location. Malaria programmes should assess the suitability of SMC based on the local malaria epidemiology and available funding. The added value of a seasonally targeted intervention is likely to be greatest where transmission is intensely seasonal. Monthly cycles of sulfadoxine-pyrimethamine plus amodiaquine (SP+AQ) have been widely used for SMC in African children under 5 years old and have been shown to be efficacious, safe, well tolerated, available and inexpensive

**Age group:** Most research studies have evaluated SMC in children aged 3–59 months. SMC has also been shown to reduce the incidence of clinical malaria in children <10 years old. The age group targeted for SMC should be informed by the local age pattern of severe malaria admissions. The cost-effectiveness of SMC will become less favourable as programmes expand to age groups at lower risk of severe disease and areas of lower malaria transmission.

**Dosage:** Children in age groups at increased risk of severe disease should be given a complete course of antimalarials, at their recommended treatment dose, as SMC. The drug dosage should be determined by the child’s weight wherever possible, with dosing according to age only in situations where the child’s weight is unknown.

**Frequency:** The number of cycles should be informed by the duration of the high-transmission season, based on the local malaria epidemiology, and the length of preventive efficacy of the selected drug combination. SMC should be used to protect children during the entire high-transmission season. Current evidence supports monthly administration of SMC for 3–4 cycles in shorter transmission settings, and up to six cycles have been evaluated in settings with longer transmission seasons

**Delivery:** SMC can be provided through door-to-door or fixed-point delivery.

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 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

In malaria-endemic areas, pregnant women of all gravidities should be given antimalarial medicine at predetermined intervals to reduce disease burden in pregnancy and adverse pregnancy and birth outcomes.  Sulfadoxine-pyrimethamine (SP) has been widely used for malaria chemoprevention during pregnancy and remains effective in improving key pregnancy outcomes. IPTp-SP should start as early as possible in the second trimester and not before week 13 of pregnancy. Doses should be given at least one month apart, with the objective of ensuring that at least three doses are received. Antenatal care (ANC) contacts remain an important platform for delivering IPTp. Where inequities in ANC service and reach exist, other delivery methods (such as the use of community health workers) may be explored, ensuring that ANC attendance is maintained and underlying inequities in ANC delivery are addressed.

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

## Specific guidance notes for M&E, Programme management, and Advocacy and BCC gap analysis

1. The list provided in the respective worksheets for monitoring and evaluation, programme management, advocacy and SBC are all indicative. This is not meant to be comprehensive as these support mechanisms differ significantly between and within countries.
2. Ensure you reflect the specific activities as per your National Strategic Plans. Ensure that evidence-based approaches to SBC are used. Depending on the local situation consider a combination of monitoring and evaluation mechanisms including routine data through HMIS, LMIS etc. as well as surveys such as MIS’s. Also include essential activities such as insecticide resistance monitoring, drug resistance monitoring and ITN durability monitoring.
3. Determine the average cost per unit to fully undertake each of the activities and use that to derive the total cost per activity per year.
4. As the costing of most of these activities are country specific, there is the need to justify the cost of these support activities in your financial gap analysis.

# Method for conducting the malaria financial gap analysis

The financial gap analysis should be based on needs identified under the programmatic gap analysis for each intervention.

* Quantify the cost of commodities needed for each intervention.[[2]](#footnote-2)
* Summarise the cost of commodities already covered with existing resources

*Both information from domestic funding and international partners will be taken into account*

* Identify the cost of commodities that still need to be covered
* Quantify the cost of the detailed activities to be undertaken and timeframe (technical and supportive activities)
* Assess the cost of activities already covered with the existing resources
* Identify the cost of the activities that still need to be covered

*Both information from domestic funding and international partners will be taken into account. Unit cost for commodities and activities will always take into account international standards and local operational cost*

**Table 2: Summary budget gap analysis**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|   | **2023** | **2024** | **2025** | **2026** |
| Total need $ |   |   |   |   |
| Domestic resources |   |   |   |   |
| External resources (insert name) |   |   |   |   |
| External resources (insert name) |   |   |   |   |
| Financial gap | 0 | 0 | 0 | 0 |

1. SMART – Specific Measurable Achievable Relevant Time-bound [↑](#footnote-ref-1)
2. For GF sourcing information see: ACTs: <http://www.theglobalfund.org/en/sourcing/acts/>

ITNs: [http://www.theglobalfund.org/en/sourcing/ITNs/](http://www.theglobalfund.org/en/sourcing/llins/) [↑](#footnote-ref-2)