New Opportunities for Improving Funding for iCCM through the Global Fund Application

Informational Session

7 December, 2022

Co-hosted by the iCCM, Commodities, and Quality of Care subgroups

Image credit: Kate Holt/MCSP Ghana

CHILD HEALTH TASK FORCE

Steps you can take to act on new Global Fund financing opportunities:

- Discuss this policy shift across malaria, child health, supply chain, community health, and other relevant stakeholders to determine whether **financing non-malaria iCCM medications through the next round of Global Fund grants** is appropriate in your country.
- Encourage Ministries of Health to mobilize their own, complementary resources for these commodities, to **help meet the co-financing (*domestic resource contribution*) requirement in their Global Fund grant**.
  - Secure financial commitments *as early as possible* during concept note development.
  - Ensure that child health, supply chain, and community health stakeholders, not just malaria stakeholders, are engaged *throughout* the grant proposal development process.

    → Including CHWs and local NGOs!

Photo: Abt Associates.

Speakers

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Co-chair CRSPC

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Community Health Preparation of R7 Funding Requests to the Global Fund

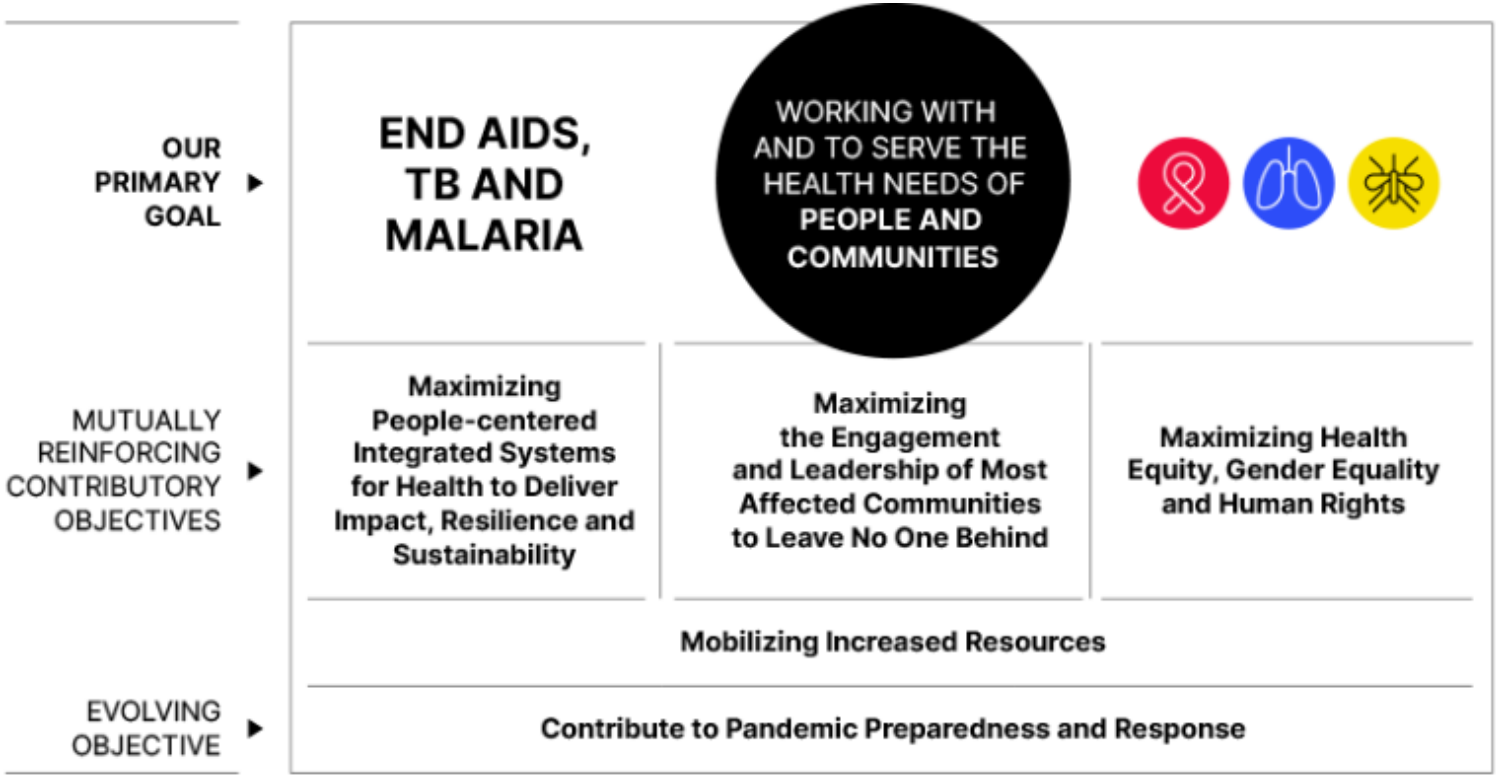
Community Health Task Force webinar
December 7, 2022

Dr. Nicholas Oliphant, Global Fund

Contents

1 Communities at the center

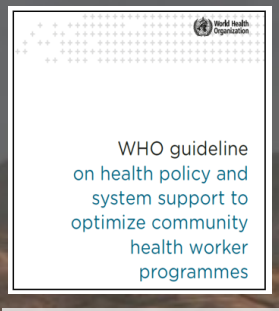
Communities are at the center of the new GF strategy… And community systems & responses are at the center of all we do

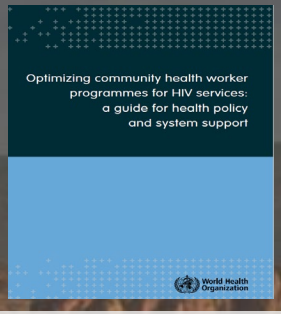


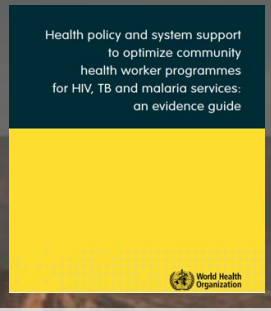
CHWs are a key part of community systems and responses

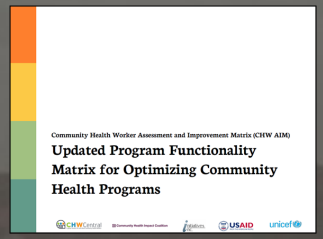
#CHWsCount #PayCHWs #CountCHWs

CHWs are effective, particularly when well supported. There is strong normative guidance built on robust evidence showing what needs to be done.









And there is a wealth of country experience showing the HOW

- **Sustainable financing in Zambia:** MOH developed a sustainable financing pathway & government has progressively taken on costs of the Community Health Assistants
- **Planning in Sierra Leone:** MOH used a health labor market assessment and geospatial modelling to reduce the right size and retarget the CHW workforce. CHWs reduced by 40% BUT in the right places, resulting in ~$3.8M in annual savings for reinvesting in systems strengthening
- **Supervision in Mali:** Dedicated supervision with 360 feedback and digital tools for CHW supervisors has been scaled nationally and shown large increases in CHW performance, service quality, stock availability

#CHWsCount #PayCHWs #CountCHWs

2 CHW voices

What do CHWs want from GF funding?...quotes

“CHWs like me need better and more support urgently. Fair pay, training, recognition – these are the things that motivate us as professionals”
Bupe Sinkala, Community Health Worker and Mentor Mother, Zambia

“Any time community health is discussed, CHWs should be in the room.”
Euniter Nyasita, Community Health Worker, Kenya

“I’m sure if 70% of the health workforce of CHWs were men, we would have had fair pay a long time ago…It is high time for CHWs to be counted, paid, supported and empowered.”
Margaret Odera, Community Health Worker and Mentor Mother, Kenya

“Supervision is one of the core needs together with equipment, trainings and payment that CHWs should be provided with in order to achieve in the community.”
Ouma Hadouba, Community Health Worker, Kenya

3 Three key shifts on CHW programming

Three key shifts for CHW programming in 2023-2025

By the Strategy's mid-point (3 years), our ambition is to see progress in three areas:

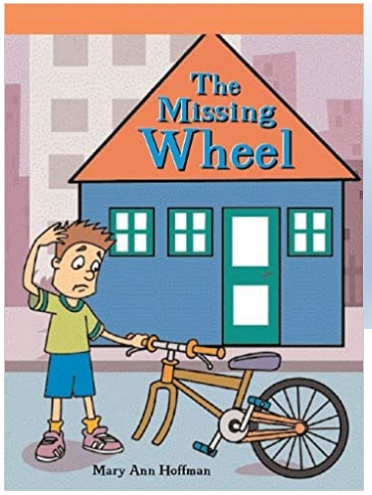
1. **A shift toward larger** scale investments

2. **A shift away from piece-meal approaches** to comprehensive and well-designed investments across systems components

3. **A shift away from short-term** toward more medium/long-term investment spanning funding cycles and aligned to sustainable financing pathways for CHWs in the context of broader HRH and health sector planning

In three words: Bigger, Better, Longer

Phased Approach: from building systems readiness, to scale, to institutionalization and sustainability



STEP 1
Get your foundations right: **build systems readiness** for scale and catalytic partnerships **before considering scaling further**

STEP 2
Scale community services through well trained, equipped, paid, supervised, and protected CHWs

STEP 3

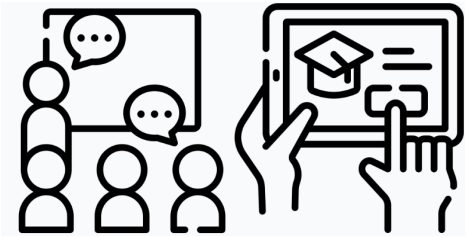
Institutionalize and ensure **sustainability**

Investments across systems components to support readiness to scale

Governance, policy, planning & coordination

Remuneration

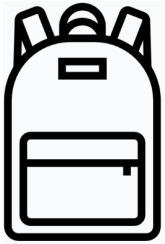
Training and accreditation



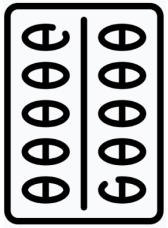
Supportive supervision

Referral

Equipment

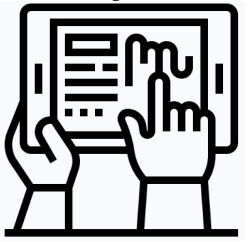


Commodities



PPE

Info systems



Community engagement

4 Non-malaria iCCM medicines

Non-malaria iCCM medicines

See page 72-73 (Annex 3) of **RSSH Information Note** for eligibility requirements

Global Fund will now support non-malaria medications for iCCM where CHWs provide malaria case management, where iCCM is part of the package of services CHWs are allowed to provide, and where the eligibility criteria are met.

The support can include funding for:

- Antibiotics for pneumonia (restricted to first line treatment for pneumonia in children under 5 years of age as per national protocol for iCCM)
- Oral rehydration salts (ORS) and zinc for diarrhea for children under 5 years of age as per national protocol for iCCM

Non-malaria iCCM medicines eligibility requirements (1/2)

See page 72-73 (Annex 3) of **RSSH Information Note** for eligibility requirements

All countries applying for this support are required to include the following components (whether funded by the Global Fund or another partner) and provide details in the funding request.

1. Investments only for non-malaria medications for children under 5 years of age (not for older children nor adults).
2. Investments for the aforementioned commodities only for the community platform.
3. Investment by the Global Fund (or other funding sources) in the appropriate diagnostic equipment (e.g., rapid diagnostic tests, respiratory timers) and training at community level to ensure timely quality diagnosis of malaria, pneumonia and diarrhea per national iCCM protocols.

Non-malaria iCCM medicines eligibility requirements (2/2)

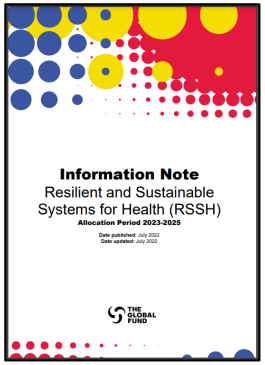
See page 72-73 (Annex 3) of **RSSH Information Note** for eligibility requirements

4. Investment by the Global Fund (or other funding sources) in antimicrobial resistance (AMR) monitoring and stewardship as outlined in Annex 4. Similar to therapeutic efficacy monitoring for antimalarials, the expectation is drug selection will be guided by routine efficacy monitoring within the health system.
5. Investments by the Global Fund (or other funding sources) covering the systems components needed for quality CHW service delivery, including adherence to the iCCM protocol, rational drug use and referral and counter referral systems (refer to the CHW Gap Table and the required systems components in the table Investments in health policy and systems support to optimize CHWs in the above Section 4.5 ‘Human Resources for Health and Quality of Care.’

5 Key resources and overview of the CHW Programmatic Gap Table

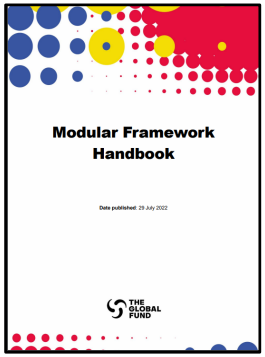
Key RSSH Resources for Funding Requests

Updates for the 2023-2025 Allocation Period



RSSH Information Note

Provides guidance to applicants preparing funding requests for RSSH. Information Notes for HIV, TB and malaria are available here.



Modular Framework

The Modular Framework is aligned with the revised Global Fund RSSH Information Note and Critical Enablers.

Additional Resources

1. Global Fund Strategy (2023-2028) (link)

With an emphasis on priorities for integrated people centered care.

2. Technical Briefs (link)

3. Global Guidelines

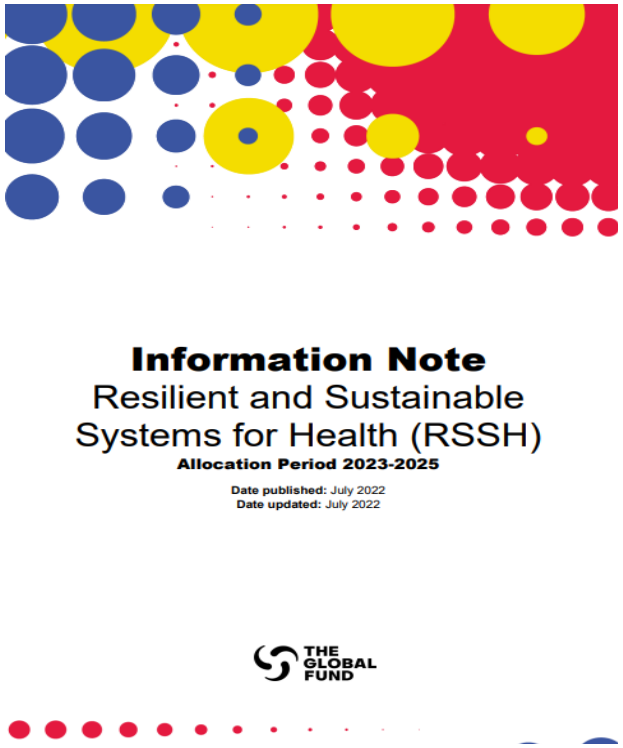
- Current international guidance/guidelines including WHO recommendations (see slide 44)

Translations are in process for all Global Fund materials.

RSSH: Critical Approaches for HRH and Quality of Care, incl. CHWs

(1) A package of more effective interventions to improve HRH performance	• Quality of care data to inform HRH performance improvement interventions • More and better supervision and quality improvement: integrated technical content, as feasible and relevant; reviews quality of care data; uses problem-solving; includes CHWs • Better training: skills- and competence focused; delivered on site; integrated where feasible and relevant; innovative and more efficient approaches e.g., blended learning; complemented by mentoring/supervision • Support to institutionalization: e.g., strengthen quality of pre-service training and continuous professional development programs, with focus on integrating disease-specific content; strengthening leadership and management, supervision of supervisors.
(2) Catalyze support for integrated HRH strategic planning supporting country workforce development (including CHWs)	• HRH analysis used for HRH strategic planning (inc. sustainable financing) • Optimization of HRH distribution e.g., workload-based assessments and geospatial analysis • Integration of CHWs within broader HRH strategic planning and shift from short-term to medium- and long-term support, spanning funding cycles, within sustainable financing plans • Strengthen data systems for HRH including CHWs to enable planning
(3) Enhance system readiness to scale CHWs aligned with WHO guidance	• **New** - CHW Programmatic Gap Tables: systematic identification of investment gaps across health systems components needed for CHWs to be effective, ensuring existing CHWs are fully supported across systems components (readiness to scale) before scaling further. • **New** - provision of non-malaria medications for iCCM (antibiotics, zinc, ORS) for children under 5 where eligibility requirements are met (Annex 3).

Updated GF application materials, technical information notes and tools related to CHWs



RSSH Information Note Section 4.5 Human resources for health and quality of care (pages 26-37)

- Education and production of new health workers, including CHWs
- Recruitment, remuneration and deployment of new and existing HRH, including CHWs
- Interventions to improve health workers' performance, including CHWs
- Governance and capacity building for quality of care
- HRH planning, management and governance, including for CHWs

Table 1 (Page 36) summarizes investments in health policy and systems supports to optimize CHWs in alignment with WHO guidelines

Also see section 4.3 Community systems and responses (pages 16-20) where CHWs are employed by CLO/CBOs

Summary of CHW investments across systems components (page 36 in RSSH Information Note)

Governance, policy, planning & coordination

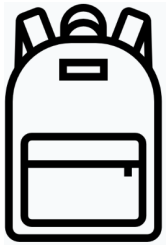
Remuneration

Training and accreditation

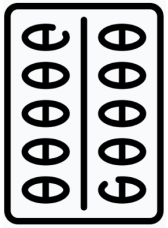
Supportive supervision

Referral

Equipment



Commodities



PPE

Info systems

Community engagement

CHW Programmatic Gap Table

Click link below for to the CHW Programmatic Gap Table (on the Global Fund website with all other Programmatic Gap Tables)

CHW Programmatic Gap Table

- Supports key shift toward well-designed investments across systems components by identifying funding gaps and potential priorities for GF investment
  - Remuneration
  - Pre-service training and certification
  - In-service training
  - Supervision
  - Equipment
  - PPE
  - Commodity costs (NB: non-malaria commodities for iCCM in a separate tab)
  - Referral / counter-referral
  - HMIS, surveillance and M&E

Web link to the CHW Programmatic Gap Table

https://www.theglobalfund.org/media/12198/fundingrequest_programmaticgap-rssh_table_aa.xlsx

Example calculations for suspected pneumonia

English: Choose the language in the Instructions tab (line B6)
Français: Veuillez choisir la langue sur l'onglet Instructions (rangée B6)
Español: Seleccione el idioma en la hoja Instructions (fila B6)

Latest version updated 29 July 2022

Carefully read the instructions in the "Instructions" tab before completing the programmatic gap analysis table.
The instructions have been tailored to each specific module/intervention.

CHW Programmatic Gap Table 10 - non-malaria iCCM commodities (first line antibiotics for simple pneumonia among as part of iCCM)

Priority Module	**Malaria - Case management**				
Selected coverage indicator	**Proportion of children 2-59 months with suspected pneumonia (fast breathing) that received first line antibiotic treatment in the community**				
Current national coverage					
Insert latest results	25%	**Year**	2022	**Data source**	
Comments	2022 results from 2022 Annual Review. 25% of annual target covered by UNICEF in 2022				

Consumption-based method or incidence-based method

		Year 1 2024	Year 2 2025	Year 3 2026	Comments / Assumptions
Current estimated country need					
A. Total estimated suspected pneumonia cases (community)	#	412,440	463,995	515,55	Assumptions for 2024: Number of CHWs = 8,000; population in areas with CHWs = 6,000,000 (8,000 CHWs x 750 population per CHW; Note: Must be linked to scale of CHWs (i.e. areas with CHWs). If data available on population in areas covered by CHWs is available in the HMIS/DHIS2 or other source, this can be used); % of the population 2-12 months = 9% (census or other data source); % of the population 12-59 months = 31% (census or other data source); incidence of suspected pneumonia = 68 per 1,000 children 2-12 months and 202 per per 1,000 children 12-59 months; estimated suspected pneumonia cases among children 2-59 months in areas with CHWs = 412,440. Calculation: 36,720 among children 2-12 months + 375,720 among children 12-59 months ((68 incidence among 2-12 months x 540,000 children 2-12 months) / 1,000) + ((202 x 1,860,000 / 1,000) Assumptions for 2026: Number of CHWs = 9,000; population in areas with CHWs = 6,750,000 (9,000 CHWs x 750 population per CHW; Note: Must be linked to scale of CHWs (i.e. areas with CHWs). If data available on population in areas covered by CHWs is available in the HMIS/DHIS2 or other source, this can be used); % of the population 2-12 months = 9% (census or other data source); % of the population 12-59 months = 31% (census or other data source); incidence of suspected pneumonia = 68 per 1,000 children 2-12 months and 202 per per 1,000 children 12-59 months; estimated suspected pneumonia cases among children 2-59 months in areas with CHWs = 463,995. Calculation: 41,310 among children 2-12 months + 422,685 among children 12-59 months ((68 incidence among 2-12 months x 607,500 children 2-12 months) / 1,000) + ((202 x 2,092,500 / 1,000) Assumptions for 2026: Number of CHWs = 10,000; population in areas with CHWs = 7,500,000 (10,000 CHWs x 750 population per CHW; Note: Must be linked to scale of CHWs (i.e. areas with CHWs). If data available on population in areas covered by CHWs is available in the HMIS/DHIS2 or other source, this can be used); % of the population 2-12 months = 9% (census or other data source); % of the population 12-59 months = 31% (census or other data source); incidence of suspected pneumonia = 68 per 1,000 children 2-12 months and 202 per per 1,000 children 12-59 months; estimated suspected pneumonia cases among children 2-59 months in areas with CHWs = 515,550. Calculation: 45,900 among children 2-12 months + 469,650 among children 12-59 months ((68 incidence among 2-12 months x 675,000 children 2-12 months) / 1,000) + ((202 x 2,325,000 / 1,000)

Example of consumption-based method

		Year 1	Year 2	Year 3	Comments / Assumptions
		2024	2025	2026	
Current estimated country need					
A. Total estimated suspected pneumonia cases (community)	#	412,440	463,995	515,550	

Assumptions for 2024:

- Average number of suspected pneumonia cases 2-59 months per CHW per year (2022 latest data) = 51.555
- Planned CHWs providing iCCM = 8,000
- Estimated suspected pneumonia cases 2-59 mo in communities with CHWs providing iCCM = 412,440 (8000 x 51.555)

Note: Need to disaggregate this into cases among children 2-11 months and 12-59 months and put this in the comments. Quantification of firstline antibiotics will be based on these two age groups.

Example of incidence-based method

		Year 1 2024	Year 2 2025	Year 3 2026	Comments / Assumptions
Current estimated country need					
A. Total estimated suspected pneumonia cases (community)	#	412,440	463,995	515,550	

Assumptions for 2024:

- Planned number of CHWs providing iCCM = 8,000
- Population in communities with CHWs providing iCCM = 6M (8000 CHWs x 750 population per CHW, from HMIS or planning norm)
- % of pop 2-11 months = 9% (census)
- Population 2-11 months = 540,000
- % of pop 12-59 months = 31% (census)
- Population 12-59 months = 1,860,000
- Incidence pneumonia among children 2-11 months = 68 per 1,000 (HMIS)
- Incidence pneumonia among children 12-59 months = 202 per 1,000 (HMIS)
- Calculation: ((68 incidence 2-12 months x 540,000 children 2-11 months)/1000) + ((202 x 1,860,000)/1000)
- Estimated suspected pneumonia cases children 2-59 months in communities with CHW trained on iCCM = **412,440 (36,720 among children 2-11 mo + 375,720 among children 12-59 months)**

Consider adjusting down to account for imperfect careseeking to CHWs. May be 80% **in communities with CHWs providing iCCM**

Example calculations for diarrhea

English: Choose the language in the Instructions tab (line B6)
Français: Veuillez choisir la langue sur l'onglet Instructions (rangée B6)
Español: Seleccione el idioma en la hoja Instructions (fila B6)

Latest version updated 29 July 2022

Carefully read the instructions in the "Instructions" tab before completing the programmatic gap analysis table.
The instructions have been tailored to each specific module/intervention.

CHW Programmatic Gap Table 11 - non-malaria iCCM commodities (oral rehydration salts and zinc for treatment of diarrhea months of age as part of iCCM)

Priority Module	**Malaria - Case management**				
Selected coverage indicator	**Proportion of children 2-59 months with diarrhea that received oral rehydration salts and zinc treatment in the community**				
Current national coverage					
Insert latest results	25%	**Year**	2022	**Data source**	
Comments	2022 results from 2022 Annual Review. 25% of annual target covered by UNICEF in 2022				

Consumption-based method or incidence-based method

		Year 1	Year 2	Year 3	Comments / Assumptions
		2024	*2025*	*2026*	
Current estimated country need					
A. Total estimated diarrhea cases (community)	#	7,920,000	8,910,000	9,900,000	Assumptions for 2024: Number of CHWs = 8,000; population in areas with CHWs = 6,000,000 (8,000 CHWs x 750 population per CHW). Note: Must be linked to scale of CHWs (i.e. areas with CHWs). If data available on population in areas covered by CHWs is available in the HMIS/DHIS2 or other source, this can be used); % of the population 2-59 months = 40% (census or other data source); incidence of diarrhea among children 2-59 months = 3,300 per 1,000 children 2-59 months; estimated diarrhea cases among children 2-59 months in areas with CHWs = 7,920,000. Calculation: (3300 incidence among 2-59 months x 2,400,000 children 2-59 months) / 1,000). Provide in the comments the estimated diarrhea cases among children 2-6 months and 6-59 months to aid with quantification of zinc tablets for each age group (this can be done by multiplying the % of the 2-59 population that is 2-6 months and then 6-59 months by the incidence, assuming the same incidence unless you have more detailed incidence data). Assumptions for 2025: Number of CHWs = 9,000; population in areas with CHWs = 6,750,000 (9,000 CHWs x 750 population per CHW). Note: Must be linked to scale of CHWs (i.e. areas with CHWs). If data available on population in areas covered by CHWs is available in the HMIS/DHIS2 or other source, this can be used); % of the population 2-59 months = 40% (census or other data source); incidence of diarrhea among children 2-59 months = 3,300 per 1,000 children 2-59 months; estimated diarrhea cases among children 2-59 months in areas with CHWs = 8,910,000. Calculation: (3300 incidence among 2-59 months x 2,700,000 children 2-59 months) / 1,000). Provide in the comments the estimated diarrhea cases among children 2-6 months and 6-59 months to aid with quantification of zinc tablets for each age group (this can be done by multiplying the % of the 2-59 population that is 2-6 months and then 6-59 months by the incidence, assuming the same incidence unless you have more detailed incidence data). Assumptions for 2026: Number of CHWs = 10,000; population in areas with CHWs = 7,500,000 (10,000 CHWs x 750 population per CHW). Note: Must be linked to scale of CHWs (i.e. areas with CHWs). If data available on population in areas covered by CHWs is available in the HMIS/DHIS2 or other source, this can be used); % of the population 2-59 months = 40% (census or other data source); incidence of diarrhea among children 2-59 months = 3,300 per 1,000 children 2-59 months; estimated diarrhea cases among children 2-59 months in areas with CHWs = 9,900,000. Calculation: (3300 incidence among 2-59 months x 3,000,000 children 2-59 months) / 1,000). Provide in the comments the estimated diarrhea cases among children 2-6 months and 6-59 months to aid with quantification of zinc tablets for each age group (this can be done by multiplying the % of the 2-59 population that is 2-6 months and then 6-59 months by the incidence, assuming the same incidence unless you have more detailed incidence data).

Example of consumption-based method

		Year 1	Year 2	Year 3	Comments / Assumptions
		2024	*2025*	*2026*	
Current estimated country need					
A. Total estimated diarrhea cases (community)	#	7,920,000	8,910,000	9,900,000	

Assumptions for 2024:

- Average number of diarrhea cases 2-59 mo per CHW per year (2022 latest data) = 990
- Planned CHWs providing iCCM = 8,000
- Estimated diarrhea cases 2-59 mo in communities with CHWs providing iCCM = 7,920,000 (8,000 x 990)

Note: Need to disaggregate this into cases among children 2-5 months and 6-59 months and put this in the comment. Quantification of zinc needs will be based on these two age groups.

Example of incidence-based method

		Year 1	Year 2	Year 3	Comments / Assumptions
		2024	2025	2026	
Current estimated country need					
A. Total estimated diarrhea cases (community)	#	7,920,000	8,910,000	9,900,000	

Assumptions for 2024:

- Planned number of CHWs providing iCCM = 8,000
- Population in communities with CHWs providing iCCM = 6M (8000 CHWs x 750 population per CHW, from HMIS or planning norm)
- % of pop 2-59 months = 40% (census)
- Population 2-59 months = 2,400,000
- Incidence diarrhea among children 2-59 months = 3,300 per 1,000 (HMIS)
- Calculation: ((3,300 incidence 2-59 months x 2,400,000 children 2-59 months)/1000)
- Estimated diarrhea cases children 2-59 months in communities with CHW trained on iCCM = **7,920,000**

Note: Need to disaggregate this into cases among children 2-5 months and 6-59 months and put this in the comment. Quantification of zinc needs will be based on these two age groups.

Consider adjusting down to account for imperfect careseeking to CHWs. May be 80% **in communities with CHWs providing iCCM**

6

Tips for country dialogue + additional material in annex (Global Fund 101)

Tips for community health / RSSH

- **Engage early in country dialogue**: contact CCM, GF country team, national programs (malaria, HIV, TB), broader MOH, financial and technical partners, CSOs
- **Seek TA support early**: CCM, Africa CDC, UNICEF, USAID, RBM, L'Initiative/Expertise France, GF
- **Familiarize yourself** with the Core Information Notes for RSSH and HIV, TB, and Malaria including RSSH 'Critical Approaches' and HTM 'Program Essentials'
- **Participate in trainings** by GF Access to Funding Team: contact CCM for info
- **Prepare** draft/final 'CHW programmatic gap table' and 'RSSH priorities and gaps annex' to inform program split discussions for program split discussions
- **Identify your key CH needs for inclusion for funding prioritization and link these to results/impact for HTM as critical enablers.**
- **Participate country dialogue**: Ensure CH particiation in RSSH country dialogue & ensure CH/RSSH partners participate in the malaria, TB, & HIV country dialogues. Ensure HTM participation – particularly CH champions – in RSSH dialogue
- **Participate in mock TRPs** for RSSH and 3 diseases: Request CCM for dates

TA support available

- Country Coordinating Mechanism (CCM)
- UNICEF Country Office
- USAID
- RBM
- L'Initiative/Expertise France
- GF (Strategic Initiatives, Project BIRCH)
- GF Nicholas.oliphant@theglobalfund.org can help connect you with TA sources

THE GLOBAL FUND

Thank you!

Questions? Please contact

Nicholas.oliphant@theglobalfund.org

Annex

THE GLOBAL FUND

Global Fund 101

The Global Fund Strategy 2023-2028

Fighting Pandemics and Building a Healthier and More Equitable World :
Global Fund Strategy (2023-2028)

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Executive Summary

download in عربي | 中文 | Deutsch | English | Español | Français | Italiano | 日本語 | Português | Русский

Strategy Framework

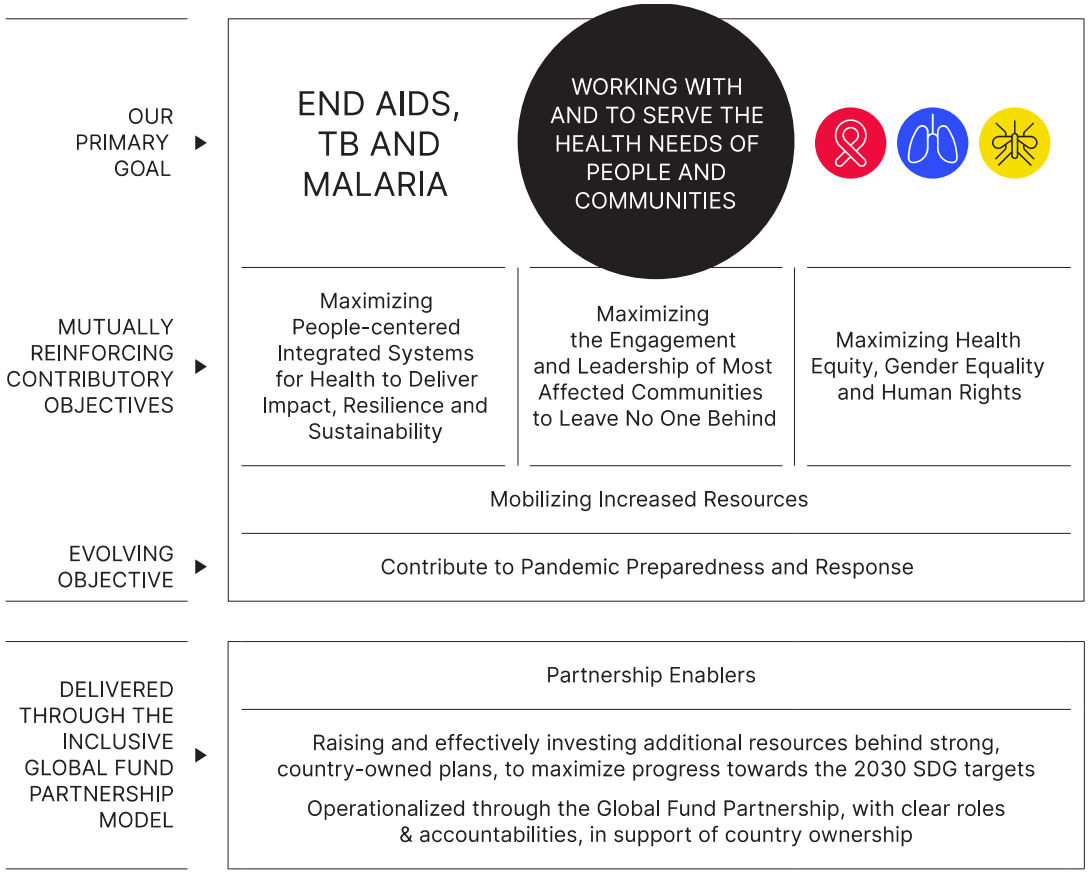
download in عربي | English | Español | Français | Português | Русский

Strategy Overview Presentation

download in عربي | English | Español | Français | Português | Русский

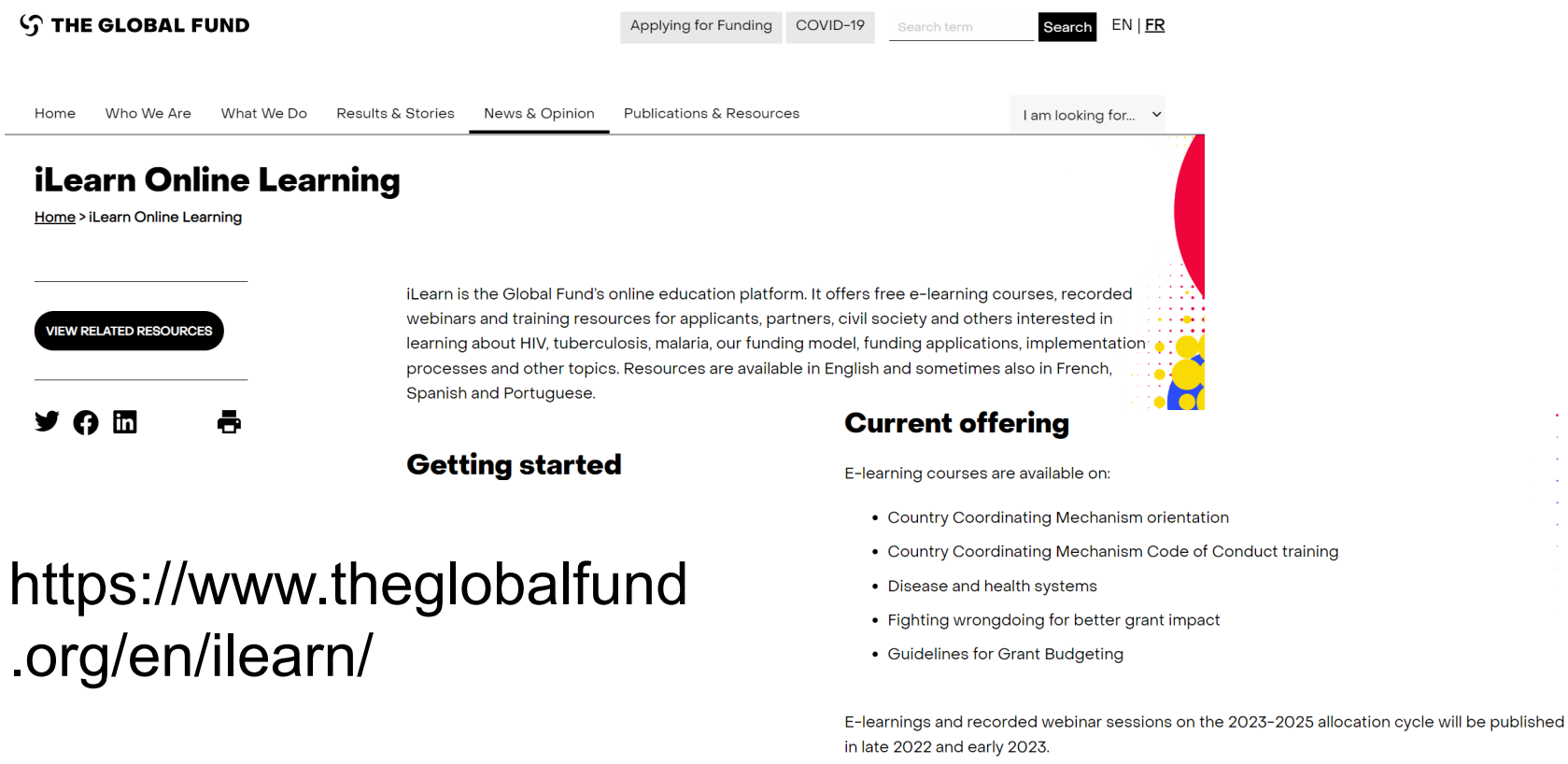
https://www.theglobalfund.org/en/strategy/

The Global Fund Strategy Framework



- **Strategy's primary goal** is to end AIDS, TB, and Malaria.
- **People and communities are at the heart** of our Strategy.
- Achievement of the primary goal is **supported by 4 mutually reinforcing contributory objectives** and **an evolving objective**.
- Partnership Enablers outline **roles and accountabilities** of all stakeholders.

Register on iLearn to learn the basics about the Global Fund



https://www.theglobalfund.org/en/ilearn/

Steps to watch webinars on iLearn

- To watch the webinar and the accompanying slides in question, along with other previous sessions, please head to the iLearn platform.
- From there, you can log in under "Other Users", or create an account, it's quite quick. Then log in and click on "2023-2025 Webinars & eLearnings" (Here is the direct link).
- On the right hand side you will find the Webinars section with not only the link to register for future webinars, but also the links to previous webinars and the slides.

2023-2025 Allocation Period Training Series

Recordings for past events are viewable on the iLearn platform

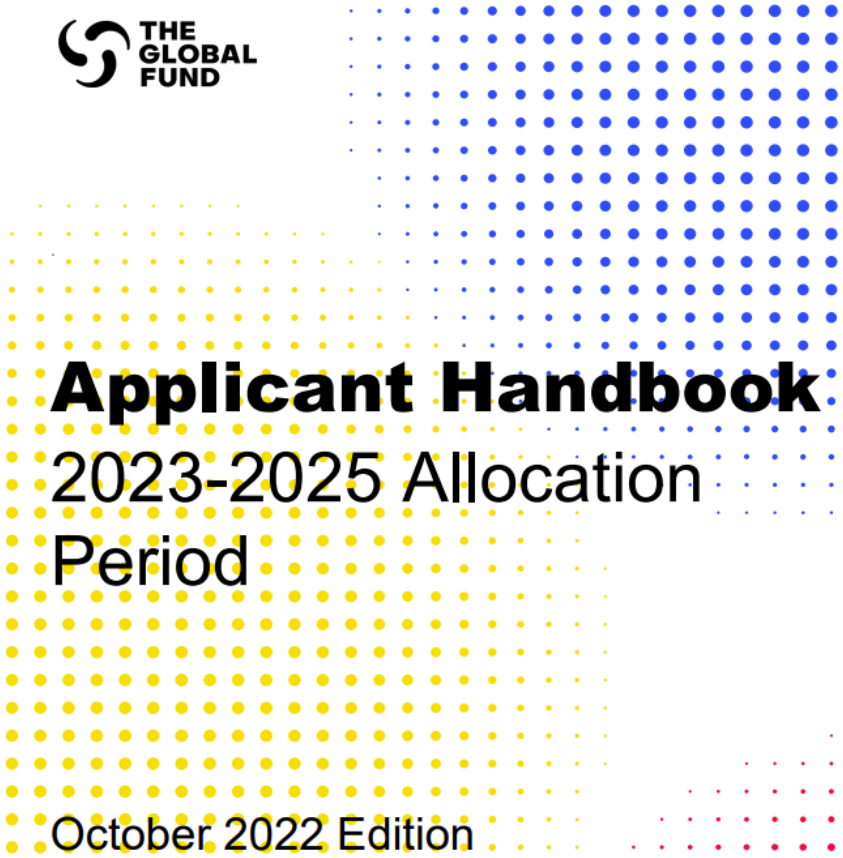
Session	Date
Applying for Funding in 2023-2025: Detailed overview	22 September
Applying for Funding in 2023-2025: What has changed	23 September
Country Dialogue Expectations: Including Program Split	5 October
High-Impact & Core Portfolios: Applying with the Full Review and Program Continuation Application Approaches*	25 October
Focused Portfolios: Applying with the Tailored for Focused and Transition Application Approaches*	2 November
Applying with the Tailored for National Strategic Plans Application Approach*	9 November
Updates to Information Notes – including Program Essentials and Critical Approaches	24 November
Sustainaibility, Transition and Co-Financing, and Innovative Financing	30 November
Allocations: Overall Outcome	7 December
Matching Funds	13 December

Submission Dates

The expected submission window deadlines and subsequent Technical Review Panel meeti
are listed below. Additional windows will be shared here, once finalized.

Window	Applicant Submission Deadline	TRP Meeting
1	20 March 2023	April-May 2023
2	29 May 2023	July 2023
3	21 August 2023	September-October 2023

Understand the GF application process



Read the applicant handbook as a starting point: https://www.theglobalfund.org/media/4755/fundingmodel_applicanthandbook_guide_en.pdf

And read the FAQ https://www.theglobalfund.org/media/12199/core_2023-2025cycle_faq_en.pdf

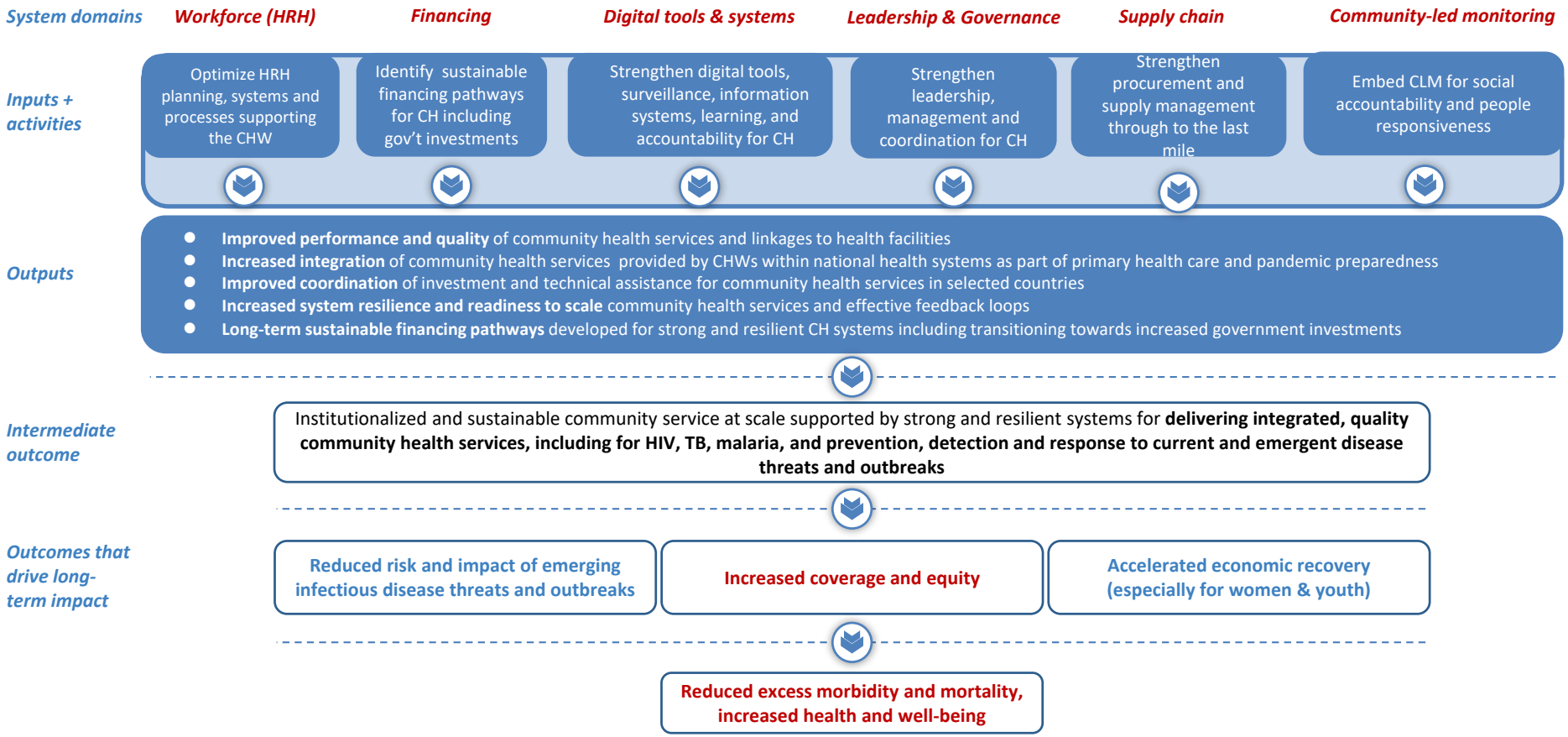
Other useful information to understand the GF application process here https://www.theglobalfund.org/en/applying-for-funding/design-and-submit-funding-requests/applicant-guidance-materials/

Tips for community health / RSSH

- **Engage early in country dialogue**: contact CCM, GF country team, national programs (malaria, HIV, TB), broader MOH, financial and technical partners, CSOs
- **Seek TA support early**: CCM, Africa CDC, UNICEF, USAID, RBM, L'Initiative/Expertise France, GF
- **Familiarize yourself** with the Core Information Notes for RSSH and HIV, TB, and Malaria including RSSH 'Critical Approaches' and HTM 'Program Essentials'
- **Participate in trainings** by GF Access to Funding Team: contact CCM for info
- **Prepare** draft/final 'CHW programmatic gap table' and 'RSSH priorities and gaps annex' to inform program split discussions for program split discussions
- **Identify your key CH needs for inclusion for funding prioritization and link these to results/impact for HTM as critical enablers.**
- **Participate country dialogue**: Ensure CH particiation in RSSH country dialogue & ensure CH/RSSH partners participate in the malaria, TB, & HIV country dialogues. Ensure HTM participation – particularly CH champions – in RSSH dialogue
- **Participate in mock TRPs** for RSSH and 3 diseases: Request CCM for dates

Additional resources on CHW programming

Theory of Change for CHW programming



Summary of CHW investments across systems components (page 36 in RSSH Information Note)

Table 1: Investments in health policy and systems support to optimize CHWs

Investments in health policy and systems support to optimize CHWs	Global Fund Eligibility
HRH: Governance, leadership capacity, coordination, policy & planning for CHWs (including as part of broader HRH), HRH analysis, development & maintenance of CHWML hosted in a registry, mobile/digital CHW payroll systems.	Yes*
HRH: Selection, competency-based pre-service training & certification & maintenance of certification for CHWs, competency-based in-service training for CHW supervisors, and other district, regional, or national/program staff with roles requiring training to support CHWs, strengthening institutions/systems that provide training for CHWs	Yes*
HRH: Remuneration (e.g., salary, allowances see the Global Fund Budgeting Guidance) costs for CHWs and CHW supervisors based on contracting agreement (written agreement specifying role & responsibilities, working conditions, remuneration, workers' rights)	Yes*
HRH: Supportive supervision, including salaries for CHW supervisors and costs for implementation of supportive supervision of CHWs, as well as for supportive supervision of CHW supervisors	Yes*
Community engagement: Support to community engagement in CHW planning, selection, CLM, problem-solving	Yes*
Equipment: Transportation (e.g., bicycle or motorcycle inc. maintenance and fuel or transportation allowance), backpack, uniform, rain gear and boots, flashlight, thermometer, shakir tape, respiratory timers for respiratory illness	Yes*
Commodities: RDTs for malaria diagnosis, ACTs for malaria treatment and rectal artesunate for pre-referral treatment of severe malaria	Yes, iCCM intervention in the case management module for malaria
Commodities: Firstline antibiotics for pneumonia treatment and ORS and zinc for diarrhea treatment for children under 5 years of age as per national protocol for iCCM; see **Annex 3** for eligibility criteria	Yes, iCCM intervention in the case management module for malaria
Commodities: Condoms, lubricant, PrEP, PEP, POC EID, RDTs, and others for HIV services relevant to the CHW role	Yes, relevant modules for HIV
Referral and counter-referral system: Allowances for transportation and meals for patients, caregivers and CHW	Yes, relevant disease module if system for single-disease or RSSH module if for multiple diseases
Supply chain system: Last mile distribution to health facility or CHW (can be done as part of CHW supervision),	Yes*
Health management information system, surveillance and M&E: Registers, paper-based job aides, routine reporting forms, mobile digital health tools (e.g., phones/tablets, sim cards, communications allowance) for CHWs and CHW supervisors	Yes*
Health finance: Development of and support for sustainable financing pathways for CHWs	Yes*
Yes*, if HIV, TB, or malaria services are in the package of services CHWs deliver (preferably all relevant to population needs are integrated in the package of services)	

Non-malaria iCCM medicines eligibility requirements (1/2)

See page 72-73 (Annex 3) of **RSSH Information Note** for eligibility requirements

All countries applying for this support are required to include the following components (whether funded by the Global Fund or another partner) and provide details in the funding request.

1. Investments only for non-malaria medications for children under 5 years of age (not for older children nor adults).
2. Investments for the aforementioned commodities only for the community platform.
3. Investment by the Global Fund (or other funding sources) in the appropriate diagnostic equipment (e.g., rapid diagnostic tests, respiratory timers) and training at community level to ensure timely quality diagnosis of malaria, pneumonia and diarrhea per national iCCM protocols.

Non-malaria iCCM medicines eligibility requirements (2/2)

See page 72-73 (Annex 3) of **RSSH Information Note** for eligibility requirements

4. Investment by the Global Fund (or other funding sources) in antimicrobial resistance (AMR) monitoring and stewardship as outlined in Annex 4. Similar to therapeutic efficacy monitoring for antimalarials, the expectation is drug selection will be guided by routine efficacy monitoring within the health system.
5. Investments by the Global Fund (or other funding sources) covering the systems components needed for quality CHW service delivery, including adherence to the iCCM protocol, rational drug use and referral and counter referral systems (refer to the CHW Gap Table and the required systems components in the table Investments in health policy and systems support to optimize CHWs in the above Section 4.5 ‘Human Resources for Health and Quality of Care.’

Case Studies

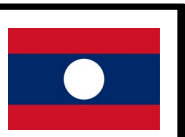
Supporting Primary Care

Mali
UHC Health System Reforms

Global Fund support focused on institutionalizing CHWs

- Optimized the scale-up and targeted deployment of additional community health workers (CHWs) through geospatial modelling and updating of national strategic plans.
- Provided investments across health policy and systems to support optimizing CHWs in alignment with WHO guidance.
- Supported the development of a long-term sustainable financing pathway for CHWs following a historic decree by the Government of Mali, officially recognizing CHW as health workers and the first level of the Malian health system.

Results: Shift towards comprehensive planning, sustainable financing, institutionalization of CHWs within the health system and an optimized CHW program linked to primary care.



Laos PDR
Joint financing for PHC

Global Fund support focused on joint financing for primary health care reforms

- Participated in a joint investment, tri-partite arrangement with Government of Lao DPR and World Bank.
- Contributed funding to align targets for both the World Bank program and national priorities.
- Implemented by MoH, using payment-for-results and disbursement-linked indicators.

Results: Improved health outcomes, including for HIV, TB and malaria

TA support available

- Country Coordinating Mechanism (CCM)
- UNICEF Country Office
- USAID
- RBM
- L'Initiative/Expertise France
- GF (Strategic Initiatives, Project BIRCH)
- GF Nicholas.oliphant@theglobalfund.org can help connect you with TA sources

Normative guidance on CHWs programming

Normative guidance on CHW programming

Title	Year	Link
WHO guideline on health policy and system support to optimize community health worker programmes	2018	Link
Optimizing community health worker programmes for HIV services: a guide for health policy and system support	2021	Link
Health policy and system support to optimize community health worker programmes for HIV, TB and malaria services: an evidence guide	2020	Link
The role of community health workers in COVID-19 vaccination: implementation support guide	2021	Link
Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic	2020	Link
Community Health Worker Assessment & Improvement Matrix	2018	Link

Countries are encouraged to draw lessons from this guidance and adapt it to their context. Support for all types of CHWs should align with WHO normative guidance on CHWs.

KPI S5: Systems readiness index for CHWs

KPI S5: Systems readiness for CHWs

Percentage of countries with improvement in scores for system readiness for community health workers from latest baseline

Characteristics

- Outcome
- Level 1 - global and in-country
- Subset of portfolio-priority countries
- New GF data source
- Countries showing progress

Definition

Formula:

- Numerator: # of countries that showed statistically significant improvement in scores compared to latest baseline
- Denominator: Total # countries in cohort

Target: 100% countries improved scores compared to latest baseline (2023,2025) by mid Strategy (i.e 2025) and end of Strategy (2028)

Cohort: Select cohort of 18-20 priority countries for focused RSSH measurement. 120 Health Facilities assessed in each country.

Baseline: 2023 results used as baseline for 2024,2025 results. 2025 results used as baseline for 2026-2028 results

Data source: Targeted health facility assessment (HFA)

Reporting

Reported: Annually (Spring), assessed against mid strategy (2025) and end of strategy period (2028) target

Interpretation of results (progress towards target): **Green** if projected mid/end Strategy results at target or within margin of 10% (relative to target); **amber** if below target by a margin of 11%-20%; **red** if below target by a margin of 21% or more

Disaggregation reported for this KPI: Country (and any corresponding categorization: region, portfolio type, etc), type of health facility (primary, secondary tertiary), assessment criterion

Complementary insights: Refer to M&E framework for relevant complementary information

Rationale for selection

Important: KPI measures readiness of key systems components needed for CHWs to work effectively, with the capacity to surge (e.g., in the case of pandemics) and readiness to scale, as well as for CHWs to enjoy the benefits of decent working conditions which is key to achieving the new GF Strategy objectives.
Integrated: Draws from WHO normative guidance
Accountable: GF contributes to KPI performance as focus is on assessing facilities with GF investment
Actionable: Allows for monitoring the progress on improving systems readiness for scale and capacity to surge CHW service delivery and would trigger actions based on its performance, including ability to focus on particular countries / regions and individual criteria that are under-performing
Available: Data will be available on an annual basis through HFA

Considerations

- Inclusion of CLOs/CBOs within sampling frame to capture CHWs (e.g., peers) attached to CLOs/CBOs as part of disaggregation
- The KPI is based on an average of scores across questions with available answers. Therefore, the relative weight of each question might vary across facility/country/year depending on response rates

KPI S5: Systems readiness for CHWs

Additional details

Assessment criteria

Assessment criteria	Possible answers	Score
Received integrated supportive supervision during the period	Yes/No/Null response	Yes = 1 No = 0
Have a contract specifying their scope of work, expected full-time equivalent (FTE) or expected hours per month/week/day, a level of financial remuneration that does not fall below the national minimum wage (pro-rated to their expected %FTE), timing of financial remuneration (e.g., monthly), rest days, annual leave, paid sick leave, holidays, and health insurance	Yes/No/Null response	Yes = 1 No = 0
Paid per their contract (amount, frequency, timeliness) during the period	Yes/No/Null response	Yes = 1 No = 0
Had no stockouts of commodities, equipment or job aids (e.g., registers, reporting forms per country norms) needed for their work during the period	Yes/No/Null response	Yes = 1 No = 0

Methodology overview

- Country score on system readiness for CHWs is calculated as:
  Numerator: # Positive responses (i.e., number of "Yes" responses) across all respondents and Health Facilities
  Denominator: # responses (excluding null responses) across all respondents and Health Facilities

- Country score will be an indication of the extent to which health workers feel systems enable them to work effectively. Disaggregation of country score can identify aspects of the system that are not working well, or the type of health facilities where there is an issue.

- Country score in a given year is then compared to the last baseline score to see if there is a statistically significant improvement. Country is assessed as meeting the KPI requirement if there is a statistically significant improvement.

KPI S5: Systems readiness for CHWs

Illustration

Measure: % countries with improvement in scores for system readiness for community health workers from latest baseline

Numerator (N): # of countries that showed significant improvement in scores compared to latest baseline
Denominator (D): # of countries in cohort

Step 1 — **Calculate country score** across all health facilities based on all responses received from respondents

Step 2 — **Assess if country scores improved** for each country in the portfolio **compared to latest baseline** (i.e. 2023 or 2025)

Step 3 — **Determine KPI Result** as # countries that showed improvement divided by total # of countries in cohort

Step 4 — **Calculate projected KPI performance** at upcoming milestone (mid-strategy 2025, or end strategy 2028)

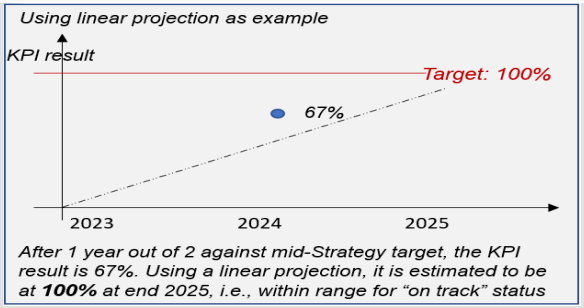
KPI performance (progress towards target)		
On track	🟢	Projected result at target or lower by 10% (relative to target)
At risk	🟡	Projected result below target by margin of 11%-20%
Off track	🔴	Projected result below target by margin of 21% or more

Illustrative example for 2024

Steps	Criteria	Response 1	R 2	R3	R 4	R 5	R 6	Country A Score
Step 1	Q1	1	1	1	0	0	0	**65% (11/17)***
	Q2	1	1	0	0	1	1	
	Q3	1	1	1	NA	0	1	
	**Overall score: 11 positive (=1) answers out of 17 non "N/A" answers*							

Step 2	Country	2024 Score	2023 Baseline	Improvement in scores compared to 2023**
	Country A	65%	60%	Yes
	Country B	46%	56%	No
	Country C	75%	55%	Yes
	*** Improvement has to be statistically significant (z-test for proportions, 95%)*			

Step 3	**KPI result**	**67%** (=2/3) against 100% target
Step 4	**Projected KPI performance in 2025**	*Using linear projection as example*



*After 1 year out of 2 against mid-Strategy target, the KPI result is 67%. Using a linear projection, it is estimated to be at **100%** at end 2025, i.e., within range for "on track" status*

KPI Result interpretation:
67% countries in cohort showed significant improvement in scores compared to 2023 results

KPI performance		
On track	🟢	Projected result at target or lower by 10% (relative to target)

Maturity model for CHW programming across systems components

Maturity model: Interventions across systems domains

	FOUNDATIONS FOR SCALING INTERVENTIONS		GOOD TO GREAT INTERVENTIONS	
	FROM . . .	. . . TO	FROM . . .	. . . TO
System domain	Non or partially functional domain	Functional domain		Highly functional & moving towards sustainability
Financing	Fragmented, insufficient and inconsistent funding, with little domestic investment	Funding sources aligned to government plan and priorities, resources sufficient for costed plan, plan is on government budget, no user fees		Transition and sustainability plan with commitments against it, community health financing integrated into sector finance strategy and budgets demonstrating gov't commitment
Workforce (HRH)	Sporadically trained, irregularly supervised, and poorly distributed volunteer workforce lacking role clarity	Workforce with clear roles & responsibilities, fair pay, robust training, dedicated supportive supervision, supports for referral, & equitable distribution to close coverage and quality gaps		Workforce with clear career pathway and robust HRH system supports integrated into sector workforce planning
Leadership & governance	Unclear roles, accountabilities and coordination across actors without cohesive national policy	Oversight and coordination systems functioning to achieve national CH policy with targets		MoH leading well-functioning teams who implement coordinated, approaches refined by ongoing learning
Digital tools & systems	Data collection is not standardized or consistent and unidirectional	Standardized digital tools & data feedback loops integrated into national systems, inc. community event-based surveillance		Quality data and analysis used for decisions across levels (CHWs - national)
Supply chain	Irregular ordering processes and frequent lasting supply stock outs	Regular procurement with essential supply management processes in place		Procurement forecasting and advanced supply management practices used

Financing stages description and associated interventions

System domain	Non or partially functional domain	Functional domain	Highly functional & moving towards sustainability
Financing	• Fragmented and insufficient funding through different programs/donors • No government budget line nor consistent domestic investments towards community health • Passive or little use of "strategic purchasing" • Relatively little annual or multi-year financial planning	• One government-led optimized and costed community health plan, sufficiently funded • Harmonization across majority of donors and alignment to one plan • Government contribution through defined budget lines that is not funded by user fees • Building strategic purchasing function - e.g., performance frameworks	• Community health plan + financing plan integrated into sector financing strategy • Appropriate blend of domestic and external funding at levels sufficient to fund the stated plan • Sustainability plan, and track record of increasing domestic resources • Actively managing the purchasing and performance of providers • Public financial management systems that enable subnational performance

	FOUNDATIONS FOR SCALING	GOOD TO GREAT
	FROM . . . . . TO	**FROM . . . . . TO**
Interventions	• **Costing national plan/policy:** Create or refine one costed strategic CH plan in line with the WHO guidelines & CHW AIM tool, inclusive of disease surveillance and PPR • **Optimizing for efficiency:** Conduct specific deep dive analysis to refine one aspect of the approach which is then integrated into national systems • **Domestic budget allocation:** Support advocacy around Community Health budget allocation as part of larger health finance strategy • **Budget maximization:** Identify budget maximization opportunities within government for community health	• **Strategic Purchasing:** Identify and test changes to how services are purchased to improve effectiveness and efficiency • **Financial management:** Strengthen functioning of public financial management to ensure accountability and funds allocation • **Financing and advocacy:** Increase amounts and diversity of funding sources through strategies, investment cases, etc. build advocacy and political will to gain long-term financial commitments • **Domestic investments:** Conduct analyses to create plan for how government can increase and sustain domestic investments over the medium term

Potential menu of financing interventions

FOUNDATIONS FOR SCALING → **GOOD TO GREAT**

Financing

- **Draft national plan/policy:** Create or refine a strategic CH plan in line with the WHO guidelines & CHW AIM tool
- **Cost national plan/policy:** Cost strategic national plan in line with the WHO guidelines & CHW AIM tool, inclusive of disease surveillance and PPR; develop sustainability plan (8-10 year horizon)
- **Ensure domestic budget allocation:** Support advocacy around Community Health budget allocation as part of larger health finance strategy
- **Maximize budget:** Identify budget maximization opportunities within government for community health
- **Make care accessible:** Undertake process to remove point of care user fees
- **Ensure fair compensation:** Add CHWs to the wage bill at a competitive remuneration rate relative to the respective market and ensure CHWs are remunerated for supplemental hours e.g. in pandemic response
- **Financial management:** Improve public financial management to ensure accountability and funds allocation, especially on CHW salaries/stipends
- **Financing and advocacy:** CH sustainable financing plan integrated into sector financing strategy with appropriate blend of domestic and external funding at levels sufficient to fund the stated plan; build advocacy and political will to keep CH a priority
- **Improve payment mechanisms**: track compensation to ensure CHW salaries are paid consistently and on time
- **Improve payment fairness:** Transition CHWs off payments that are predominantly in the form of performance-based incentives (PBI)
- **Introduce standard benefits:** Introduce standard employee benefits for CHWs ((housing, vacation, parental leave)
- **Strategic Purchasing:** Identify and test changes to how services are purchased to improve effectiveness and efficiency.
- **Domestic investments:** Conduct analyses to create plan for how government can increase and sustain domestic investments over the medium term

Workforce stages description and associated interventions

System domain	Non or partially functional domain	Functional domain	Highly functional & moving towards sustainability
Workforce (HRH)	• CHW inclusion in HRH workforce planning inadequate and capacity for CHW workforce planning limited • *Ad hoc* and inconsistent pre- or in-service training & certification • Limited supportive supervision or individual performance support offered • Remuneration for CHWs and their supervisors is irregular and untimely	• Optimized CH workforce planning thru HRH assessments, CHW master lists, GIS & costing • Competency-based accredited pre- & in-service training & certification meeting global guidelines, inc. PPR • Dedicated supervision supported by CHW's performance statistics and training data • Fair & on-time remuneration for CHWs, inc. for supplemental hours • Functional referral system between CHWs, facilities, and labs	• Optimized CH workforce planning integrated into broader HRH planning, HRH systems, health sector development planning, PPR planning • Ongoing targeted individualized digital trainings integrated into supervision systems • Dedicated supervisors integrated within broader HRH planning and equipped with digital tools delivering supportive and individualized coaching to ensure quality of care • Fair remuneration for CHWs delivered regularly and on-time through national payroll system • Functional referral system between CHWs, health facilities and labs integrated within lab

	FOUNDATIONS FOR SCALING	GOOD TO GREAT
	FROM . . . . . TO	FROM . . . . . TO
Interventions	• **CH workforce planning:** Use HRH labor assessments, national georeferenced CHW master lists, GIS & costing for optimizing CH workforce planning and building HRH planning capacity • **Training:** Refine curriculum, programs and accreditation process for training CHWs and supervisors • **Fair pay:** Advocate fair pay, assess & support revision of pay scale (as needed), strengthen payment & monitoring systems • **Dedicated supervision**: Launch dedicated supervisor cadre, equip with digital tool, train on data-driven QI & 360 supervision model • **Performance statistics:** Support training on and use of supervisor dashboards and other human resource management approaches	• **Optimize HRH planning:** Establish career pathways for CHWs & integrate robust HRH systems supports (inc. dedicated supervisors) into sector workforce planning, institutionalize use of optimization tools and approaches in national HRH planning • **Recruitment:** Design recruitment methods & selection criteria to maximize women's participation & overcome gender inequities • **Implement continuous training:** Targeted ongoing professional development trainings for existing CHWs and supervisors (to standardize knowledge or addressed identified specific gaps) • **Individualized coaching:** Reinforce dedicated supervisors capacity for delivering individualized, data-driven supportive coaching and QI approaches through the 360 supervision model

SOURCE: CHW AIM Tool

Potential menu of workforce interventions

FOUNDATIONS FOR SCALING → **GOOD TO GREAT**

Workforce (HRH)

- **Develop a CHW Master List:** Incorporate this list into health workforce registry
- **Plan CH workforce:** Develop 10yr plan (spanning planning cycles) for optimized scale supported by HRH labor assessment, CHW master list, GIS modelling & costing tool
- **Institutionalize CHW cadre**: Clearly define & document CHW role as formal cadre in the health system, including status as "essential workers" in the PPR context
- **Design for access:** Role of CHWs includes proactively searching for patients door-to-door and caring for patients in their homes
- **Introduce accreditation**: Introduce national competency-based accreditation for CHWs and CHW supervisors. Ensure CHWs meet a minimum standard prior to practicing.
- **Design training:** Introduce initial training curriculum for CHWs and supervisors
- **Design recruitment:** Design CHW recruitment methods and selection criteria to include competency-based demonstration (rather than formal education requirements) and ensure community involvement
- **Dedicated supervision**: Launch dedicated supervisor cadre, equipped with digital tools, trained in data-driven supportive coaching and QI for delivering 360 supervision model (group supervision, patient feedback audits, CHW shadowing & one-on-one feedback)
- **Performance statistics:** Support training on and use of supervisor dashboards and other human resource management approaches
- **Fair pay**: Advocate fair pay, assess & support revision of pay scale (as needed), strengthen payment & monitoring systems
- **Assess transport and referral:** Ensure CHWs have means for transport and have a functional logistics plan for referral and emergencies (transport, funds)
- **Optimize HRH planning:** Institutionalize use of optimization tools and approaches in national CH workforce and broader HRH planning
- **Introduce advancement:** Establish career pathways for CHWs. Advancement rewards good performance or achievement and is based on a fair evaluation
- **Reform recruitment:** Design recruitment methods & selection criteria to maximize women's participation & overcome gender inequities
- **Implement continuous training:** Targeted ongoing professional development trainings for existing CHWs and supervisors (to standardize knowledge or addressed identified specific gaps)
- **Institutionalize dedicated supervisor cadre:** Integrate dedicated supervisor cadre within sector planning
- **Individualized coaching**: Reinforce dedicated supervisors' cadre capacity for delivering individualized, data-driven supportive coaching and QI. For example, introduce summary statistics of CHW performance. Institutionalize the 360 supervision model through integration of SOPs within national system.
- **Introduce closed-loop referrals:** Patient is referred with a standardized form and information flows back to CHW with a returned referral form.

Leadership and governance stages description and associated interventions

System domain	Non or partially functional domain	Functional domain	Highly functional & moving towards sustainability
Leadership & Governance	• No CH policy or unclear policy mandate • Little or fragmented political support • Unclear roles and accountabilities between range of actors • Inconsistent oversight, coordination, and leadership of community health	• National CH policy with defined roles, tasks, relationship to health system, targets, implementation and M&E plans • Mobilized political support and effective multi-sectoral coalitions • Defined and mostly applied organizational and accountability relationships • Functioning ownership, oversight structures and coordination systems	• National CH policy reflected in national health sector, PHC, HRH & PPR policies & plans. • Sustained political support (e.g., Health Sector Development Plans) and multi-sectoral coalitions (e.g., Ministry of Finance, Ministry of Public Service, Ministry of Education, civil society etc.) • Clear and consistent organizational and accountability relationships • Structures and systems refined by ongoing learning and adaptation • MOH team is leading well functioning coordination structure(s)

	FOUNDATIONS FOR SCALING	GOOD TO GREAT
	FROM . . . . . TO	**FROM . . . . . TO**
Interventions	• **Leadership & management:** Build capacity of MOH on leadership, management & governance of CH system. Support South-to-South learning. Mobilize political support & effective multi-sectoral coalitions. • **Policy and planning:** Develop national CH policy with defined roles, tasks, relationship to health system, targets, implementation, organizational & accountability relationships, oversight structures and coordination systems, including integrating with IDSR and disease surveillance policies • **Monitoring & Evaluation:** Develop M&E framework for the CH system with an approach to incorporate into performance management. Strengthen community feedback & accountability	• **Subnational leadership:** Ongoing subnational learning and optimization for quality improvements based on positive deviants to improve policy and strategy iterations relevant for the context • **Leadership of change:** Advance application of change management and ongoing learning / renewal to improve CH structures and system • **Coordination mechanisms:** Reinforce role clarity, accountability systems, and mechanisms for coordination and multi-sectoral coalition building (within government and with all types of partners)

SOURCE: Schneider 2019.

Potential menu of leadership and governance interventions

FOUNDATIONS FOR SCALING → **GOOD TO GREAT**

Leadership and Governance

- **Improve leadership & management:** Build capacity of MOH team on leadership, management and governance of community health systems. Support South-to-South learning, including with "good to great" countries and other CH exemplars. Advocate for and mobilize political support and effective multi-sectoral coalitions
- **Policy and planning:** Develop national CH policy with defined roles, tasks, relationship to health system, targets, implementation and M&E plans, organizational & accountability relationships, oversight structures and coordination system
- **Monitoring & Evaluation:** Develop M&E framework for the CH system with an approach to incorporate into performance management. Strengthen community level feedback and accountability
- **Foster subnational leadership:** Ongoing subnational learning and optimization for quality improvements based on positive deviants to improve policy and strategy iterations relevant for the context
- **Leadership of change:** Advance application of change management and ongoing learning / renewal to improve CH structures and system
- **Coordination mechanisms:** Reinforce role clarity, accountability systems, and mechanisms of coordination and multi-sectoral coalition building (within government and with all types of partners)

Information systems stages description and associated interventions

System domain	Non or partially functional domain	Functional domain	Highly functional & moving towards sustainability
Data and Digital	• Data collection is not standardized, consistent, high quality, digitized • Data is aggregated unidirectionally, used mostly for reporting • Most systems not digitized (e.g., CHIS) • Most systems not integrated or interoperable (HMIS, CHIS, IDSR, LMIS, HRIS, etc.) and/or not built on the national georeferenced master CHW list • Community surveillance not integrated within national integrated disease surveillance & response (IDSR) system	• Standardized aggregated & disaggregated data available to CHWs & their supervisors, collected digitally • Process and systems build to encourage data use for action • Some key systems strengthened through digitization • Some key systems integrated and interoperable - e.g., CHIS & CEBS, using national georeferenced CHW list • Community-event based surveillance (CEBS) integrated within national IDSR	• High-quality data is regularly reviewed at all levels to inform decisions and actions • Key systems are strengthened through digitization (e.g., eCHIS, eLMIS, digital training, registries) • Data interoperability built to connect key systems (e.g. CHIS & HMIS, HRIS & Payroll) using national georeferenced CHW list hosted in a registry • CEBS integrated within national IDSR and functional at full scale

	FOUNDATIONS FOR SCALING	GOOD TO GREAT
	FROM . . . . . TO	FROM . . . . . TO
Interventions	• **Data collection and quality:** Create or refine standard procedures for data collection, quality checks, validation, and use at all levels (CHW to national and back) • **Digitization:** Develop national digital approach and standards for CH data as part of national digital health policy/standards. Strengthen and scale implementation of digital systems for CH data, including interoperability • **Decision support:** Improve logic, interface & data feedback loops for CHWs' digital clinical decision-making tool and dedicated supervisors' digital performance management tool • **Community surveillance:** Integrated within national IDSR	• **Government ownership:** Strengthen structures and capabilities to implement, support, oversee, and sustain the digital systems • **Data quality and use:** Advance quality assurance and data use through e-training and QI/data use coaching at all levels • **Data analysis and visualizations:** Automate data analysis with clear data visualizations linked to data use SOPs and e-training to allow easy understanding at all levels • **Data interoperability:** Data interoperability built to connect key systems (e.g. CHIS, HMIS, LMIS CEBS, IDSR, HRIS, Payroll) using national georeferenced CHW list hosted in a registry • **Community surveillance:** CEBS integrated within national IDSR and functional at full scale

SOURCE: LG Digital Health Tools for CHW programs Maturity model and Toolkit

Potential menu of information systems interventions

FOUNDATIONS FOR SCALING → **GOOD TO GREAT**

Information systems

- **Data collection:** Standardized aggregated & disaggregated data available to CHWs & their supervisors, collected digitally
- **Create or refine standard procedures for data collection, quality checks, validation, and use:** at all levels (CHW to national and back)
- **Digital standards for CH data:** Develop national digital approach and standards for CH data as part of national digital health policy/standards.
- **Digitization:** Strengthen and scale implementation of digital systems for CH data, including interoperability
- **Clinical decision support:** Improve logic, interface & data feedback loops for CHWs' digital clinical decision-making tool and dedicated supervisors' digital performance management tool
- **Community surveillance:** Integrated within national IDSR

- **Government ownership:** Strengthen structures and capabilities to implement, support, oversee, and sustain the digital systems
- **Data quality and use:** Advance quality assurance and data use through SOPs, e-training and QI/data use coaching at all levels
- **Data analysis and visualizations:** Automate data analysis with clear data visualizations linked to data use SOPs and e-training to allow easy understanding at all levels
- **Data interoperability:** Data interoperability built to connect key systems (e.g. CHIS, HMIS, LMIS CEBS, IDSR, HRIS, Payroll) using national georeferenced CHW list hosted in a registry
- **Community surveillance:** CEBS integrated within national IDSR and functional at full scale
- **Mobile money:** Set up mobile payments for CHWs and CHW supervisors

Supply chain stages description and associated interventions

System domain	Non or partially functional domain	Functional domain	Highly functional & moving towards sustainability
Supply chain	• CH sector not included in planning, forecasting, and procurement • Irregular inventory management frequent and lasting stakeouts • Irregular or low distribution systems for CH supplies to community level; facilities regularly hoard stock destined for CHWs • No standard operating procedures and policies for supply management	• CH needs included in planning, forecasting, and procurement • Inventory management allows for data visibility and rare stakeouts • Consistent distribution to community level, but not integrated into government supply systems • Essential supply management practices and policies are implemented	• CH needs in regular planning, forecasting, procurement and integrated into supply chain sector strategy/plans • Inventory management connected to forecasting, rare stockouts, sufficient buffer • Regular distribution as part of integrated government distribution • Advanced supply management practices implemented and linked to government procurement systems

	FOUNDATIONS FOR SCALING	GOOD TO GREAT
	FROM . . . . . TO	**FROM . . . . . TO**
Interventions	• **Integration:** Integrate parallel procurement channels at subnational level and address barriers to CHW stock access • **Supply chain plan/policy:** Create or refine standard CH supply chain SOPs, integrate community into the national supply chain plans in line with the WHO guidelines & CHW AIM tool which is integrated into national procurement systems • **Optimizing for efficiency and removing barriers:** Conduct specific analyses to refine approach throughout the pipeline. Identify and remove barriers to consistent stock at subnational level.	• **Forecasting:** Create and implement standard forecasting process into regular ordering protocols, including emergency response procurement that includes community sector • **Procurement and supply management:** Strengthen procurement and supply chain management (e.g., assessments, improvement plans, piloting, and scaling improvements) • **Link to national procurement systems:** Integrate community health supply chain policies and practices into the national procurement systems

SOURCE: CHW AIM Tool

Potential menu of supply chain interventions

FOUNDATIONS FOR SCALING → **GOOD TO GREAT**

Supply chain

- **Integration:** Integrate parallel procurement channels at subnational level and address barriers to CHW stock access
- **Supply chain plan/policy:** Create or refine standard CH supply chain SOPs, integrate community into the national supply chain plans in line with the WHO guidelines & CHW AIM tool which is integrated into national procurement systems
- **Optimizing for efficiency and removing barriers:** Conduct specific analyses to refine approach throughout the pipeline. Identify and remove barriers to consistent stock at subnational level.
- **Forecasting:** Create and implement standard forecasting process into regular ordering protocols
- **Procurement and supply management:** Strengthen procurement and supply chain management (e.g., assessments, improvement plans, piloting, and scaling improvements)
- **Link to national procurement systems:** Integrate community health supply chain policies and practices into the national procurement systems

RBM Partnership To End Malaria

12 December, 2022

CRSPC Guidance on the GF Funding application process

RBM Partnership Support to Countries

- To ensure timely submission of high quality Funding Requests and to avoid gaps in implementation, the CRSPC will provide a comprehensive package of support to country malaria programmes including: International consultant support, Local Consultant support and Local meeting costs for country dialogue process
- GF Malaria Orientation workshop to inform countries on GF tools and other guidance documents scheduled for 12-17 December 2022 – virtual connectivity will be provided for those not attending in-person Orientation of Malaria Programmes on Global Fund New Funding Model 4 | RBM Partnership to End Malaria
- 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 peer to peer review 'Mock TRPs' one month before each submission window - It is hoped that TB, HIV and RSSH colleagues will also participate in WHO supported mock TRPs at the same or neighbouring venues to enhance integration and co-ordination
- Remote expert review of final draft funding applications and grant making process.

Be Realistic: 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.
- Be realistic in terms of scale up plans and ground scale up plans in the context of implementation experience to date

Things to consider

- When planning for iCCM and CHW support, it is of vital importance that this is aligned with the national malaria control programme to ensure for example the same communities are being targeted for malaria and non-malaria commodities for iCCM, scale of CHW support is aligned etc
- Buffer stock: Case management use consumption data 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

Things to consider

- 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 for maximum impact.
- Make a strong case for CHWs and iCCM in the context of integration with malaria and in building pandemic preparedness and response

Case Management

- Do not forget to focus on quality of care as well as rational and feasible scale up of iCCM and CHWs
- For iCCM and CHWs, ensure there is a clear strategy and long-term plans including for the non-malaria commodities and ensure that there is complementarity in the gap analysis for malaria and CHWs/iCCM – e.g. ensure we are using the same population data, the same scale and the same targeted communities etc.
- The majority of countries will be using ACT consumption data for estimating community level needs for malaria case management, extrapolated for any increase in coverage. If epidemiological data are being used for estimating needs for the non-malaria commodities, be sure to triangulate with malaria to ensure alignment

Aligning with Malaria Treatment

- The majority of countries will be using ACT consumption data, 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. pivate 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

Essential Points: Watch out!

- Refer to the TRP comments from the last round – and highlight how any concerns raised by the TRP -or management conditions – have been addressed
- Review performance in the current grant and use this to justify requests for scale-up
- 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

RBM Partnership
To End Malaria

12 December, 2022

Thank you!

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Connect with the us

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Recordings, presentations and materials from previous meetings and webinars are available on the Events page of the Child Health Task Force website: www.childhealthtaskforce.org/events*

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**The recording and presentations from this webinar will be available on this page within a week*

Join the Child Health Task Force here: bit.ly/joinchtf & follow us on LinkedIn: www.linkedin.com/company/child-health-task-force

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