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**Analysis of Malaria Proposals submitted
to the Global Fund to fight AIDS,
Tuberculosis and Malaria (GFATM),
Rounds 1 – 4**

**Recommendations for Round 5 Proposals
(format and guidelines)**

Dirk H. Mueller

Kara Hanson

Health Economics and
Financing Programme

London School of Hygiene
& Tropical Medicine



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Roll Back Malaria Partnership

1. Introduction and Methods

The Roll Back Malaria Partnership requested the London School of Hygiene & Tropical Medicine (LSHTM) to analyse the malaria components of proposals to the Global Fund to fight AIDS, TB and Malaria (GFATM) from the first 4 rounds. This was initiated in order to allow a clear and uniform classification of proposed activities, and disaggregated analysis of the budgeted amounts by activity and line item.

In order to summarise the content of the GFATM proposals, LSHTM was provided with a MS-Excel database, which had been designed by the Centers for Disease Control and Prevention (CDC), Atlanta. In agreement with RBM, this database was modified prior to data entry in order to meet the focus of the analysis. Emphasis in the design and modification of the database was put on budgetary information, the allocation of funds to various partners and the services and activities emphasised in the proposals (Box 1).

Entering the data from the proposals into the database took place between September and mid-November 2004. All proposals classified under the "Malaria" component were included.¹ The proposals were primarily downloaded from the GFATM website², while a few missing proposals were sent via e-mail from RBM. Round 4 proposals were entered first, followed by Rounds 3, 2 and 1. The reason for this was that the database was initially set up using the GFATM guidelines and recommendations for Round 4 proposals. During the data entry process, it was noted that the proposal format had evolved from round to round, and that proposals from earlier rounds lacked some of the information that was requested in the Round 4 proposal format. The deviation between the database format and the proposal format was particularly marked for Round 1 proposals. Information on unmet need, for instance, was available in proposals of Rounds 3 and 4 but not earlier rounds. Information about the allocation of funds to partners was less disaggregated in Round 1 proposals than in later rounds, when the category of "Civil Society" was further divided into "NGOs", "Religious Organisations", and "People living with Malaria". The differences in proposal formats over the four rounds restrict, to a certain extent, their comparability. In this analysis, we have adjusted for these differences as much as possible, and, in

Box 1: Categories and variables of the RBM – GFATM database

General information

- Country
- WHO Region
- Round
- Total amount requested
- Total unmet need, total funds available and total funds needed (per year and in total)
- Number of years included calculation of unmet need
- Gross National Income (GNI)
- Category of GNI
- Population size
- Start and end date of intervention planned

Categories and Service Areas (as well as Coverage indicators) of planned services

- Prevention
 - ITN distribution, availability & usage
 - Indoor Residual Spraying
 - Malaria in pregnancy: Intermittent presumptive chemoprophylaxis/ chemotherapy
 - Epidemic containment
 - IEC
- Treatment & Care
 - Prompt effective treatment (incl. children and severe cases)
 - Drug resistance
 - Home management
- Support of environment & cross-cutting aspects
 - Health System strengthening
 - Coordination/partnership development
 - Monitoring & Evaluation, Research
 - Procurement/supply management

Allocation of Budget towards

- Human Resources
- Infrastructure & Equipment
- Training
- Commodities/Products
- Drugs
- Planning/Administration
- Monitoring & Evaluation
- Procurement/Supply management
- Technical assistance

Allocation of funds towards partners as

- Academia
- Government
- NGOs
- Private sector
- Religious environment
- Multi-/bilateral partners

Quantities & Costs of

- Commodities/Products
- Drugs

¹ Two proposals classified as "integrated" (Afghanistan (round 2) and Honduras (round 1)) were identified as including a malaria sub-component but excluded from the database.

² <http://www.theglobalfund.org/search/default.aspx?lang=en>

cases where this was not possible, have refrained from making direct comparisons across rounds.

In the proposals, data on budgetary information were usually presented in a table and therefore standardised across countries.

The classification of objectives, impact and coverage indicators, and the description of services to be provided was more open-ended and therefore less uniform across countries. Throughout the period, RBM's Monitoring and Evaluation Resource Group (MERG) was working to define uniform indicators and measures for RBM national plans, and these were reflected in revisions to the Round 4 proposal guidelines, which provided a list of possible coverage and impact indicators and service categories. However, some countries formulated their own indicators. Deviation from the standard indicators should not be interpreted as reflective of the quality of the proposals. Nonetheless, there is inevitably tension between the need to compare progress across countries using standardized indicators, and the use of country-specific indicators, which might better reflect the country's own information systems, and historical monitoring of malaria programmes.

To be entered into the database, information on indicators had to be classified in a standardised way and therefore required judgement about whether the indicator was the same or different from the ones in the database. Generally, when an indicator was unrelated to the proposed indicator list, it was not recorded in the database. If it appeared to be similar in content to one of the proposed indicators, the best match was sought but to indicate that it was not identical to the proposed indicator it was marked with a question mark.³ Since the format of the database was derived from the GFATM guidelines/recommendations for Round 4 proposals, the best fit between the database and the coverage and impact indicators was seen for that round, and there was a higher degree of deviation in earlier rounds.

Assessment of the quality of proposals was not formally part of this analysis. However, from the detailed review of proposals it is clear that there was substantial variation in the completeness of information, correct calculation and logical consistency of data. Overall, the later rounds showed a higher degree of completeness and consistency with the recommendations of the GFATM. Particularly in the first round, information on services or activities planned as part of the proposal were often not outlined in the same detail as in later rounds, and as in Round 4 in particular. All four rounds contained some proposals in which the total funding requested did not match with the sum of individual budget categories indicating internal inconsistency in the budgetary aspects of the proposal.

The descriptive analysis in this report focuses on summarising information about proposed activities (classified by 12 service areas, each of which falls into one of 3 categories, see Box 1 and Tables 2 and 3), coverage and impact indicators, mode of delivery of Insecticide Treated Nets (ITNs), and analysis of the budget requested. The categorisation of proposed activities in this report and the database follows the format of the GFATM Round 4 Proposal Form. Activities are divided into 3 broad *categories* (*Prevention; Treatment and Care; Support environment and Cross-cutting aspects*) and 12 *service areas*. For instance, the service area "Insecticide treated nets, ITN", falls into the category of *Prevention* and the service area "Health systems strengthening" is categorised under *Support Environment and Cross-cutting aspects*. In some proposals, the proposed activities were not clearly classified under specific service areas and categories and therefore had to be inferred from the description of the services.

As most of the data that we present are highly skewed, we use the median and range as measures of central tendency, rather than the mean, which can be distorted by a small number of very skewed observations. An exception is the information on budget shares presented in Figures 2 to 7, where we use the mean budget share in order for the budget shares to add up to 100% and for the disaggregations to be comparable.

³ For instance, Kenya's (Round 4 proposal) indicator "Percent of febrile people receiving antimalarial treatment within 24 hours of onset" was classified as being similar, but not identical to, the GFATM indicator "No. of patients receiving correct diagnosis and treatment" (therefore indicated with a "?1" in the database). The Uganda (Round 2) proposal indicator "Proportion of households having at least one mosquito net which has been treated with insecticide within the last six months or has been factory pretreated using long lasting technology" was coded as being similar, but not identical to, the GFATM indicator "No of households owning an ITN" (therefore indicated in the database with a "?1").

2. Results

2.1. General Information

A total of 83 proposals to the GFATM containing a malaria component were evaluated. Of these, 12 (14.5%) were submitted for the first round, 28 (33.7%) for Round 2, 20 (24.1%) for Round 3 and 23 (27.7%) for the Round 4. The vast majority of proposals (49 in total, 59%) of all rounds were submitted by countries in the WHO Region of sub-Saharan Africa. Three of the proposals were submitted by multiple countries which formed an international collaboration to fight malaria in their region (Americas-Andean multi-country proposal, West-Pacific Islands multi-country proposal and Africa multi-country proposal of the Lubombo Spatial Development Initiative area). Most proposals (66, 83%) were submitted by countries classified as Low Income Countries (LIC), 13 (16%) were submitted by Lower Middle Income Countries (LMIC) and 1 by an Upper Middle Income Country (UMIC).⁴

Across the four rounds a total of US\$ 2.08 billion was requested from the GFATM, of which 53.7% was requested in Round 4. 68.6% of the total was requested from countries within the WHO Africa Region. The median request per country was US\$ 11.0 million (range 0.8 million – 261.1 million), with a gradual increase in the total request across rounds. Table 1 shows the median requests per country and per person, disaggregated by Round.

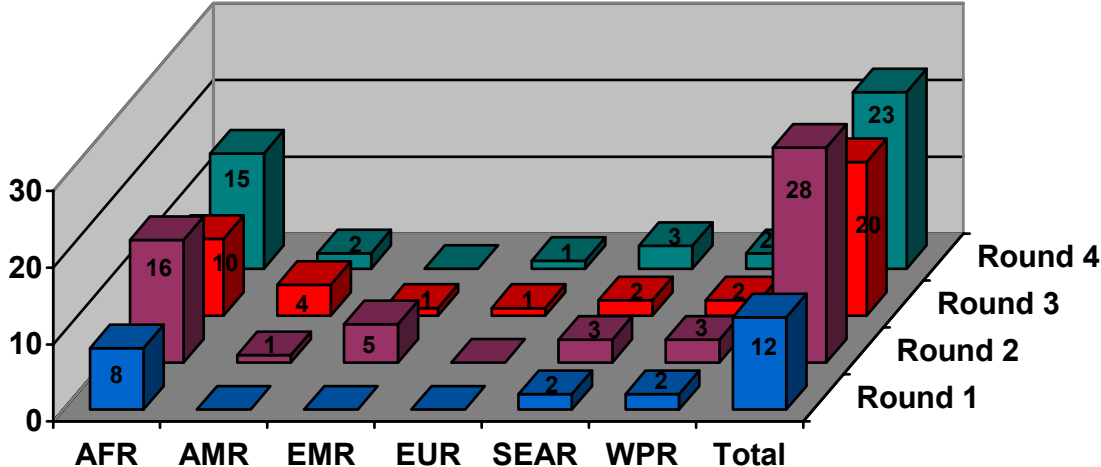
Table 1: Median requests per country and median requests per person by Rounds

Round	No. of proposals	Median request per country and range (million US\$)	Median request per person and range (US\$)
1	12	6.8 (0.8 – 53.9)	0.3 (0.005 – 3.8)
2	28	9.7 (1.9 – 76.9)	1.1 (0.05 – 4.1)
3	20	13.0 (0.8 – 53.9)	1.2 (0.01 – 9.8)
4	23	14.5 (1.7 – 261.1)	2.5 (0.10 – 22.2)
Total	83	11.0 (0.8 – 261.1)	1.1 (0.005 – 22.2)

The median duration of activities described in the proposals was 61 months (SD 12 months), with a range of 12 to 62 months. The duration varied marginally between rounds and regions: The Western Pacific (WPR), South East Asian (SEAR), African (AFR) and American (AMR) WHO Regions all show similar medians of 61, whereas the European (EUR) and the Eastern Mediterranean Region (EMR) had shorter durations with 43 and 49 months, respectively.

⁴ Classification used in the World Development Report 2004

Figure 1: Number of proposals per Round and WHO Region



Round 3 and 4 proposals included information about the gap between required and available resources for malaria control activities (“total unmet need”⁵). Unmet need could be evaluated for 35 proposals (most from Round 4, with a smaller number from Round 3; fewer Round 3 proposals had completed this section of the proposal) which specified the unmet need for a particular duration. The unmet need per year ranged from US\$ 0.34 million to US\$ 59.8 million with a median of US\$ 2.92 million; when measured per 1000 population, unmet need amounted to a median of US\$ 415.6, with a range of US\$12.9 to US\$ 5336.

2.2. Objectives and services to be delivered and their indicators

The coverage of categories and service areas is tabulated by round in Table 2 and by WHO region in Table 3.

Most proposals included some preventive measures in their proposed activities: Out of the 83 proposals analysed, only 4 (4.8%) did not mention any service area in the category of *Prevention*; a further 2 (2.4%) did not mention preventive service areas explicitly but described some service areas that could be considered as preventive; all other proposals explicitly mentioned services in the category *Prevention* as part of their proposal.

Eight proposals (9.6%) did not include any service area in the category of *Treatment or Care*, a further 2 (2.4%) described treatment or care activities under other headings or objectives. All other proposals mentioned *Treatment* explicitly as part of the proposal strategy.

Of 83 proposals, 58 (69.9%) described service areas that would be subsumed under *Support of Environment and Cross-cutting aspects*. *Support of Environment and Cross-cutting aspects* were absent from 21 (25.3%) proposals, and in 4 proposals (4.8%) items of this area were not mentioned explicitly but subsumed under other headings. Within the category of *Support of environment and cross cutting aspects*, “Coordination/Partnerships” and “Supply Management” were particularly infrequently mentioned in proposals (in both cases less than 25%). “Monitoring and Evaluation” was slightly more common but fewer than 40% of proposals mentioned this service area. There appears to be an increasing trend of including the service area “Health Systems strengthening” over the 4 rounds (from 66.7% in Round 1 to 74.9% in Round 4). Of 49 proposals of the Africa WHO-Region, 17 (34.7%) did not explicitly mention any service areas under the category of *Support of Environment and Cross-cutting aspects* as part of their proposal. In the

⁵ The format for this information changed between Round 3 and Round 4 proposals. In Round 3, the GFATM request was included in the funds available (“met need”), while in Round 4, the GFATM request was not included in the resources available and therefore counted towards the “unmet need”. In order for the proposals of the two rounds to be comparable, the information from Round 3 proposals was adjusted to include the GFATM request in the “unmet need”.

West-Pacific WHO-Region, 4 out of 9 proposals (44.4%) did not contain any services under this category.

Both *Treatment & Care* and *Prevention* were mentioned in most proposals (90.4% and 92.8%, respectively). Among those categories, the service areas “insecticide treated nets” and “treatment” were mentioned most frequently (86.8% and 89.2%, respectively). “Resistance testing” and “indoor residual spraying” were the least frequently mentioned service areas. Insecticide treated nets, malaria in pregnancy, and indoor residual pregnancy all show decreasing trends in frequency over the 4 rounds.

Overall, the mean number of services areas described in each proposal was 5.7 (SD 1.8), out of which a mean of 1.1 were not explicitly mentioned but could be deduced from the text or description.

As would be expected from the design of the database, which followed GFATM Round 4 proposal guidelines, the consistency between coverage indicators used in the proposals and those in the database was much higher in Round 4 proposals than in those of earlier rounds. In Round 4, a mean of 9.1 coverage indicators matched those in the GFATM guidelines (with a mean of 5.3 not literally matching but similar to the ones proposed). For Rounds 1, 2 and 3, the mean numbers of matching coverage indicators were 5.6, 5.8 and 6.2, respectively.

Coverage indicators for the service areas “insecticide-treated nets” and “treatment” were the most consistent with those in the guidelines. Some of the coverage indicators (“Patients receiving correct diagnosis and prompt treatment”, “No. of households owning an ITN”, “No. of children under 5 using ITNs”, and “No. of pregnant women using ITNs”) matched in more than 50% of the proposals.

The differences between the indicators proposed in the Round 4 guidelines and those actually adopted were specifically marked for all service areas subsumed under the category of *Support of environment and cross-cutting aspects*. Only the “No. of staff trained in home management” matched in more than 20% of the proposals (with an increasing trend over time). Close to 20% of the proposals chose the indicator of “No. of networks/partnerships involved” (19.3%). Indicators relating to Monitoring and Evaluation and supply or procurement of drugs and commodities were rarely adopted in the country proposals.

All coverage indicators and the degree of consistency with proposals of all 4 Rounds are given in Table A2 in the Appendix.

Table 2: Categories and Service areas described in the proposals by Rounds (the number in brackets indicates proposals that do not mention the category/service explicitly)

Category Service area	Round 1 (12 proposals)	Round 2 (28 proposals)	Round 3 (20 proposals)	Round 4 (23 proposals)	Total (83 proposals)
Prevention	11 (1) 91.7%	28 (1) 100%	19 (0) 95%	21 (0) 91.3%	79 (2) 95.2%
Insecticide treated nets	11 (1) 91.7%	26 (1) 92.9%	17 (2) 85%	18 (0) 78.3%	72 (4) 86.8%
Malaria in pregnancy	8 (1) 66.7%	15 (1) 53.6%	10 (0) 50%	10 (0) 43.5%	43 (2) 51.8%
Epidemic containment	3 (2) 25%	13 (1) 46.4%	8 (2) 40%	6 (2) 26.1%	30 (7) 36.1%
Indoor resid. Spraying	4 (0) 33.3%	10 (3) 35.7%	4 (0) 20%	5 (0) 21.7%	23 (3) 27.7%
IEC	10 (7) 83.3%	17 (8) 60.7%	10 (1) 50%	16 (0) 69.6%	53 (16) 63.9%
Treatment & Care	10 (1) 83.3%	26 (1) 92.9%	18 (0) 90%	21 (0) 91.3%	75 (2) 90.4%
Treatment	10 (2) 83.3%	24 (3) 85.7%	19 (1) 95%	21 (0) 91.3%	74 (6) 89.2%
Resistance testing	5 (2) 41.7%	1 (1) 3.6%	2 (1) 10%	10 (0) 43.5%	18 (4) 21.7%
Home Management	2 (1) 17.7%	14 (4) 50%	5 (3) 25%	10 (2) 43.5%	31 (10) 37.4%
Support Environm't & cross-cutting aspects	8 (2) 66.7%	23 (1) 82.1%	15 (0) 75%	16 (1) 69.6%	62 (4) 74.7%
Health systems	8 (1) 66.7%	20 (5) 71.4%	14 (10) 70%	17 (4) 73.9%	59 (20) 71.1%
Coordination /Partnerships	3 (1) 25%	6 (2) 21.4%	5 (3) 25%	6 (1) 26.1%	20 (7) 24.1%
Monitoring & Evaluation /Research	6 (2) 50%	8 (1) 28.6%	8 (4) 40%	10 (2) 43.5%	32 (9) 38.6%
Supply Management	5 (1) 41.7%	3 (1) 10.7%	2 (2) 10%	7 (0) 30.4%	17 (4) 20.5%
Mean No. of service areas listed (SD) #	6.3 (2.1)	5.5 (1.9)	5.2 (1.4)	5.9 (2.0)	5.7 (1.8)
Mean No. of not explicitly mentioned service areas (SD)	1.8 (1.4)	1.1 (1.2)	1.5 (0.94)	0.48 (0.67)	1.1 (1.1)

Number in brackets in this and the following row indicate Standard Deviations.

Table 3: Categories and Service areas described in the proposals by WHO Regions (the numbers in brackets indicate proposals that do not mention the category/service explicitly)

Category Service area	AFR (49 propos.)	AMR (7 propos.)	EMR (6 propos.)	EUR (2 propos.)	SEAR (10 propos.)	WPR (9 propos.)
Prevention	46 (0) 93.9%	6 (1) 85.7%	6 (0) 100%	2 (0) 100%	10 (0) 100%	9 (1) 100%
Insecticide treated nets	42 (0) 85.7%	4 (1) 57.1%	6 (0) 100%	1 (1) 50%	10 (0) 100%	9 (2) 100%
Malaria in pregnancy	37 (2) 75.5%	1 (0) 14.3%	3 (0) 50%	0 (0) 0%	2 (0) 20%	0 (0) 0%
Epidemic containment	36 (1) 26.5%	6 (4) 85.7%	4 (0) 66.7%	2 (1) 100%	3 (0) 30%	2 (1) 22.2%
Indoor resid. Spraying	10 (0) 20.4%	1 (1) 14.3%	3 (1) 50%	1 (0) 50%	6 (0) 60%	2 (1) 22.2%
IEC	28 (12) 57.1%	5 (0) 71.4%	4 (2) 66.7%	2 (1) 100%	7 (0) 70%	7 (1) 77.8%
Treatment & Care	46 (0) 93.9%	4 (0) 57.1%	6 (1) 100%	1 (0) 50%	10 (0) 100%	8 (1) 88.9%
Treatment	45 (4) 91.8%	5 (0) 71.4%	6 (1) 100%	1 (0) 50%	10 (0) 100%	7 (1) 77.8%
Resistance testing	10 (0) 20.4%	2 (0) 28.6%	2 (2) 33.3%	0 (0) 0%	2 (1) 20%	2 (1) 22.2%
Home Management	24 (6) 49.0%	0 (0) 0%	2 (0) 33.3%	0 (0) 0%	2 (2) 20%	3 (2) 33.3%
Support of Environ- ment & Cross-cutting aspects	32 (1) 65.3%	7 (0) 100%	6 (0) 100%	2 (0) 100%	10 (2) 100%	5 (1) 55.6%
Health systems	32 (11) 65.3%	6 (3) 85.7%	5 (1) 83.3%	2 (1) 100%	8 (2) 80%	6 (2) 66.7%
Coordination /Partnerships	9 (2) 18.4%	4 (3) 57.1%	1 (1) 16.7%	2 (0) 100%	3 (1) 30%	1 (0) 11.1%
Monitoring & Evaluation /Research	18 (4) 36.7%	7 (2) 100%	3 (1) 50%	1 (1) 50%	2 (0) 20%	1 (1) 11.1%
Supply Management	11(2) 22.5%	1 (1) 14.3%	2 (1) 33.3%	0 (0) 0%	1 (0) 10%	2 (0) 22.2%
Mean No. of service areas listed (SD)	5.7 (1.9)	6.0 (1.7)	6.8 (2.3)	6.0 (0)	5.6 (1.8)	4.7 (1.7)
Mean No. of not explicitly mentioned service areas (SD)	0.9 (1.0)	2.1 (1.1)	1.7 (1.0)	2.5 (0.7)	0.6 (1.0)	1.3 (1.7)

2.3. Type of ITN and mode of distribution

Given the substantial international interest and debate about ITN distribution schemes, this was an area which we examined directly. However, the proposals contain non-standardized descriptions of distribution systems which are difficult to analyse. The database uses categories extracted from the proposals, but these categories are difficult to interpret because they are not mutually exclusive. Part of the problem arises from confusion in the proposals between the type of delivery and degree of subsidy, which is a financing issue. For example, it is possible for social marketing (delivery mode) to provide subsidised commodities. Similarly, vouchers are a mechanism for delivering a subsidy. The proposal format does not provide any definition of what is meant by the different delivery modes, and proposals do not themselves specify how they are using a particular term. We found that proposals are often not explicit about the mode of delivering ITNs. Where multiple modes are described, it is not possible to tell from the proposals whether different mechanisms are to be used for different population subgroups. It is therefore impossible from these proposals to distinguish and standardise the modes of delivery accurately. The following description is only meant to give an indication of the range of methods applied.

25 countries mentioned “free delivery” in their proposal (in 6 of these “free delivery” was not mentioned explicitly but inferred from the text of the proposal). “Social Marketing” was referred to in 29 countries (3 of which were not explicitly mentioned). “Voucher schemes” were planned or already applied in 7 proposals (all explicit). Commercial Marketing of ITNs was mentioned in 10 proposals (2 of which were not explicitly mentioned). 8 countries referred to subsidies in delivering ITN (at least to part of the population, 1 proposal was not explicit). In 5 proposals, cost-recovery was mentioned. 7 proposals mentioned some other method of distribution that was not part of this list. In another 15 country proposals, the mode of delivery was not specified. The total number of observations regarding modes of distribution exceeds the total number of proposals engaging in ITN, because some proposals engage in two or more methods of delivery at the same time (Table 4).

It would have been useful to identify and analyse the types of nets that are being procured by country programmes (factory pre-treated, untreated, long-lasting, etc). The detailed “total cost-commodity” and “total quantity – commodity” sheets of the database provide for a breakdown by type of net. However, this information is not consistently reported in the proposals. Where the information was available to complete these tables in the database we did so, but we do not report summarised findings in this report because of the partial coverage of this information in the proposals and database.

Table 4: Mode of delivery of Insecticide treated bednets by Round

Mode of delivery	Round 1	Round 2	Round 3	Round 4	Total
Free	2	9	4	10	25 (23.6%)
Social Marketing	4	10	10	5	29 (27.4%)
Voucher Scheme	2	2	1	2	7 (6.6%)
Commercial Marketing	2	3	1	4	10 (9.4%)
Subsidies	1	2	2	3	8 (7.6%)
Cost recovery	1	2	0	2	5 (4.7%)
Other	2	2	2	1	7 (6.6%)
Unknown	3	5	4	3	15 (14.2%)
Total	17	35	24	30	106

2.4. Budgetary analysis

In this section we analyse the budgetary information provided in the proposals. Two important issues are raised by the analysis presented here. The first relates to changes in the budget categories used in the proposals for the different rounds, which affects the comparability of the proposals of different rounds. The second concerns the appropriate method of presenting the results given the skewed nature of the budgetary data.

The GFATM guidelines for Round 4 divide the budget into 7 “line item” categories: *Human Resources, Infrastructure & Equipment, Training, Commodities & Products, Drugs, Planning & Administration* and *Other*. A second “functional” budget classification scheme was also provided in Round 4: *Monitoring and Evaluation, Procurement and Supply Management, and Technical Assistance*. The allocations to these latter three items were permitted to overlap with those in the main line item classification – for example, funds requested under the “Drugs” line item could include the same resources requested under the “Procurement and Supply Management” function. Adjustments are therefore needed to ensure that resources are not double-counted when calculating budget shares.

In Rounds 2 and 3 an additional line item category *Monitoring and Evaluation* was included which, unlike Round 4, was separate and additional to the other categories.⁶ This category did not appear at all in the Round 1 proposal format.

In order to make the budget categories comparable over all rounds, we have therefore omitted the 3 functional categories in Round 4, since the budgets allocated to these items are included in the line item breakdown. For Rounds 2 and 3 we have included the budget for *Monitoring and Evaluation* in the *Other* category. No change has been made to the budget information from Round 1 proposals. Through these adjustments we have made the budgets from Rounds 2-4 comparable to those in Round 1. However, these differences in the disaggregation of budget data mean that comparisons across rounds must be made with care.

The second analytical issue in this section concerns the appropriate measures of central tendency. As with other data in the proposals, the budget data are skewed to the right with a small number of very large proposals which distort the mean amounts requested. However, in order to make comparisons across proposals, the budget shares for any country proposal need to add to 100%. To achieve this we have had to use the mean budget share. In Figures 2, 4 and 6, the simple mean budget share across the different proposals is presented. In Figures 3, 5 and 7, the mean budget shares are weighted by the total size of the budget, so that they show the different budget shares for the aggregate amounts requested across countries and rounds. In the text we report median budget shares. Figures 2 and 3 disaggregate budget shares by Round; Figures 4 and 5 disaggregate by WHO region; and Figures 6 and 7 disaggregate by GNI class (upper middle income countries UMIC; lower middle income countries LMIC; and low income countries LIC). Caution should be exercised when interpreting the data stratified by WHO region, as the European region consists of only 2 proposals. Similarly, the disaggregation by GNI class (Figures 6 and 7) should be interpreted carefully as there is only one proposal in the UMIC category.

Overall, the highest share of funds was allocated to *Commodities & Products*: The median allocation over all rounds and regions is 33.9% of the total budget. The median allocation for this category in US\$ is 3,284,001 (with a range of US\$ 0 to US\$ 49,858,956). There appears to be no major difference in the share of the total budget across the four rounds. With respect to regional differences, the proposals in the WHO Region South East Asia have a particularly high budget share allocated towards this category with a median of 46.6% whereas the 2 proposals of the European WHO Region have the lowest budget share allocated to commodities with a median of 15.9%.

While *Drugs* account for a median allocation of only US\$ 774,256 (range US\$ 0 to US\$ 136,526,417) they present the highest mean allocation (US\$ 7,405,302) indicating the skewed nature of this variable. *Drugs* account for a median share of 7.7% of the total budget. Their share of the budget has risen consistently over the four rounds from a median of 0% in Round 1 to 7.0%,

⁶ In addition, one proposal of Round 3 (Angola) also used a separate category “*Logistics*”, which was treated like *Monitoring and Evaluation* in Rounds 2 and 3, i.e. as separate, mutually exclusive category.

8.0% and 21.3% in Rounds 2, 3 and 4, respectively. When comparing across regions, the highest median (14.4%) is found in the African WHO Region, the lowest in the West Pacific and European Regions (0.3% and 0.4%, respectively).

Human Resources account for a median share of 6.3% of the total budget and a median allocation of US\$ 573,076 (range US\$ 0 to US\$ 11,318,228). *Training* activities were allocated a median of US\$ 743,301 (US\$ 0 to US\$ 176,621,000) and represent a median share of 8.7% of the budget. Together, *Human Resources* and *Training* thus sum up to a median of 15.0% of the total budget. There is no clear pattern in either category between rounds. The African, Eastern Mediterranean and South East Asia WHO Regions appear to have lower shares of their budget allocated towards *Human Resources* and *Training* but massively higher budget shares of *Commodities & Products* and *Drugs* (see Figure 4). The West Pacific WHO Region countries allocate a small share towards *Human Resources* alone but a higher budget share towards *Training*. The highest shares allocated towards *Human Resources* and towards *Training* appear to be allocated in the American and the 2 proposals of the European WHO Regions. When weighted by the size of the proposal, the difference between regions in terms of *Human Resources* and *Training* on the one hand and *Commodities* and *Drugs* on the other appears even more pronounced (see Figure 5). When stratified by GNI classes, LIC appear to allocate substantially less to *Human Resources* but more to *Drugs* and *Commodities*. While the share allocated by LIC towards *Human Resources* appears even lower in the weighted than in the unweighted data, the allocation towards *Training* by LIC increases substantially in the weighted picture, so that there is no difference between LIC and LMIC in the sum of the *Training* and *Human Resource* categories.

Administration (with a median share of US\$ 490860, range US\$ 0 to US\$ 16,829,112) accounts for a median share of the total budget of 4.76%. Together, Round 4 proposals appear to have doubled the share of the total budget allocated towards *administration* both in terms of the median and mean (from a median of 4.7% in Round 3 to 8.5% in Round 4). No clear pattern is to be observed between regions.

The category *Other*, comprising all other budget items not included in the other categories (and for this part of the analysis including *Monitoring & Evaluation*, *Supply Management* and *Technical Assistance* in Rounds 1-3) amounts to a median of US\$ 855,985 (range US\$ 0 to US\$ 22,232,970). As a share of the total budget, a median of 8.9% is allocated to this category. The share allocated towards the category *Other* is substantially less in Round 4 than in earlier rounds (with a median of 4.11%). This is, however, most probably artefactual, due to the change in budgeting procedures in Round 4, with *Monitoring & Evaluation*, *Supply Management* and *Technical Assistance* included under the applicable line items. It appears that proposals from the European, South East Asian, American and West Pacific WHO Regions allocate substantially higher budget shares towards *Other* than the other two regions, particularly in the weighted figure.

Figure 2: Cost-profile of budget line items by Rounds (unweighted)

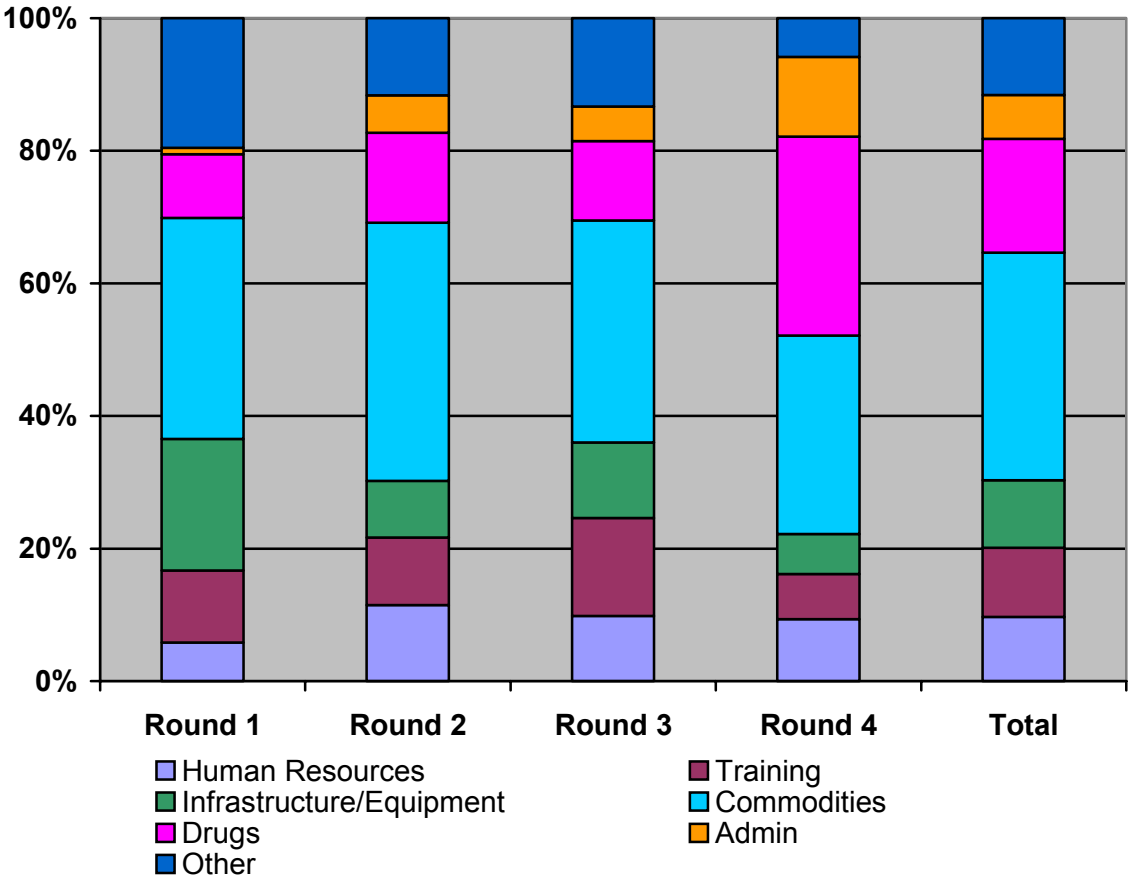


Figure 3: Cost-profile of budget line items by Rounds (weighted by budget of proposal)

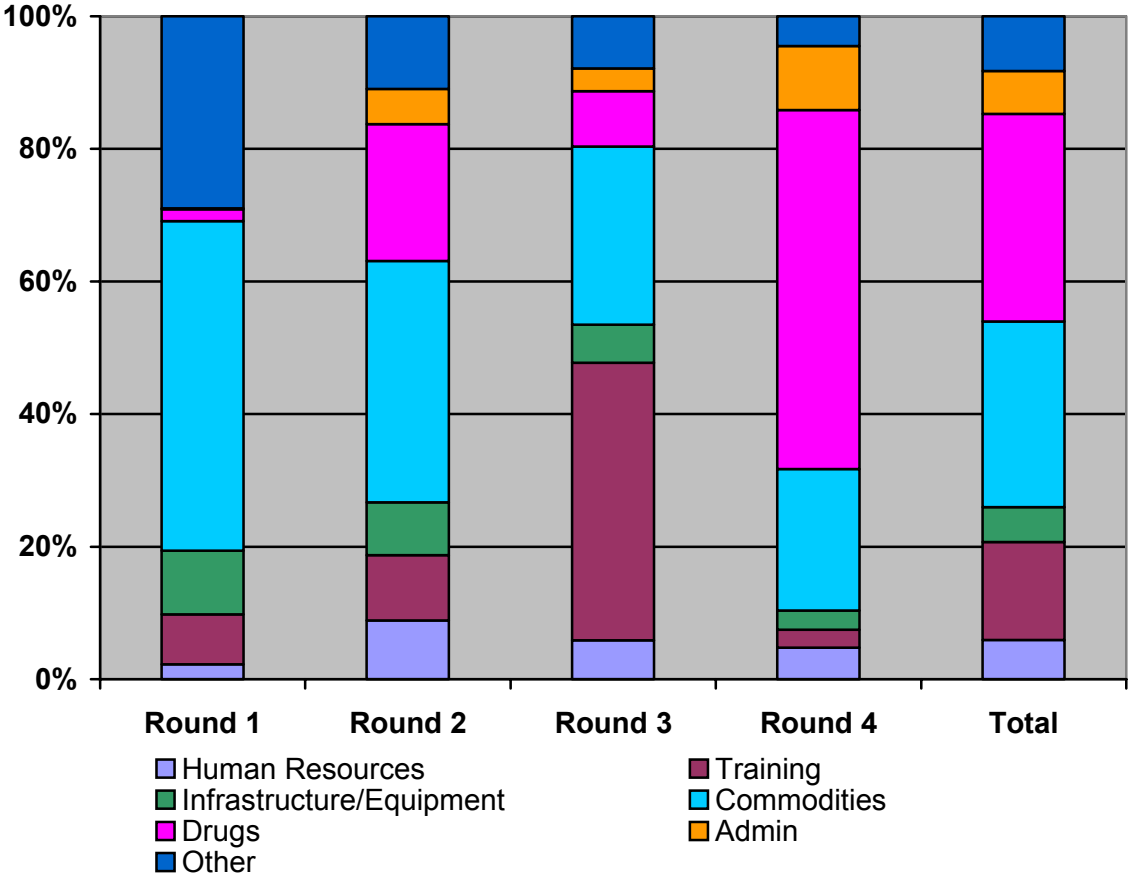


Figure 4: Cost-profile of budget line items by WHO Regions (unweighted)

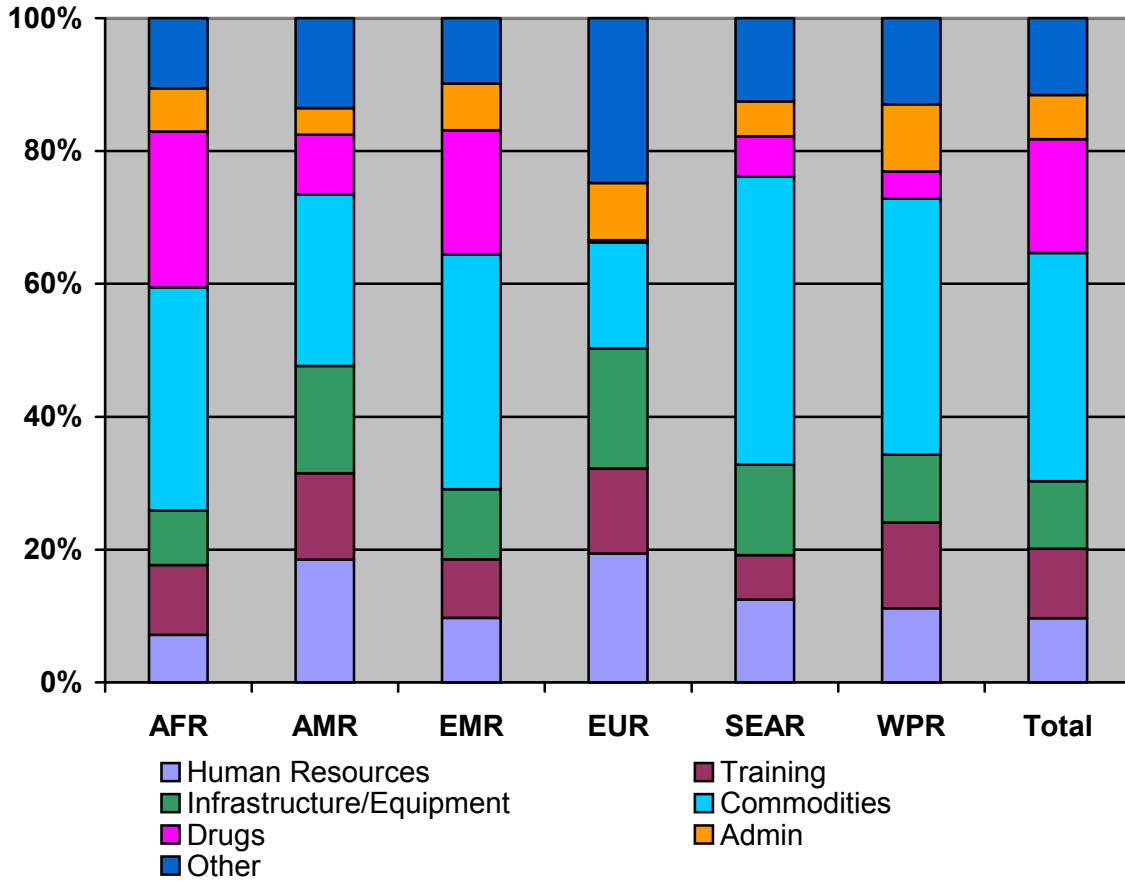


Figure 5: Cost-profile of budget line items by WHO Regions (weighted by budget of proposal)

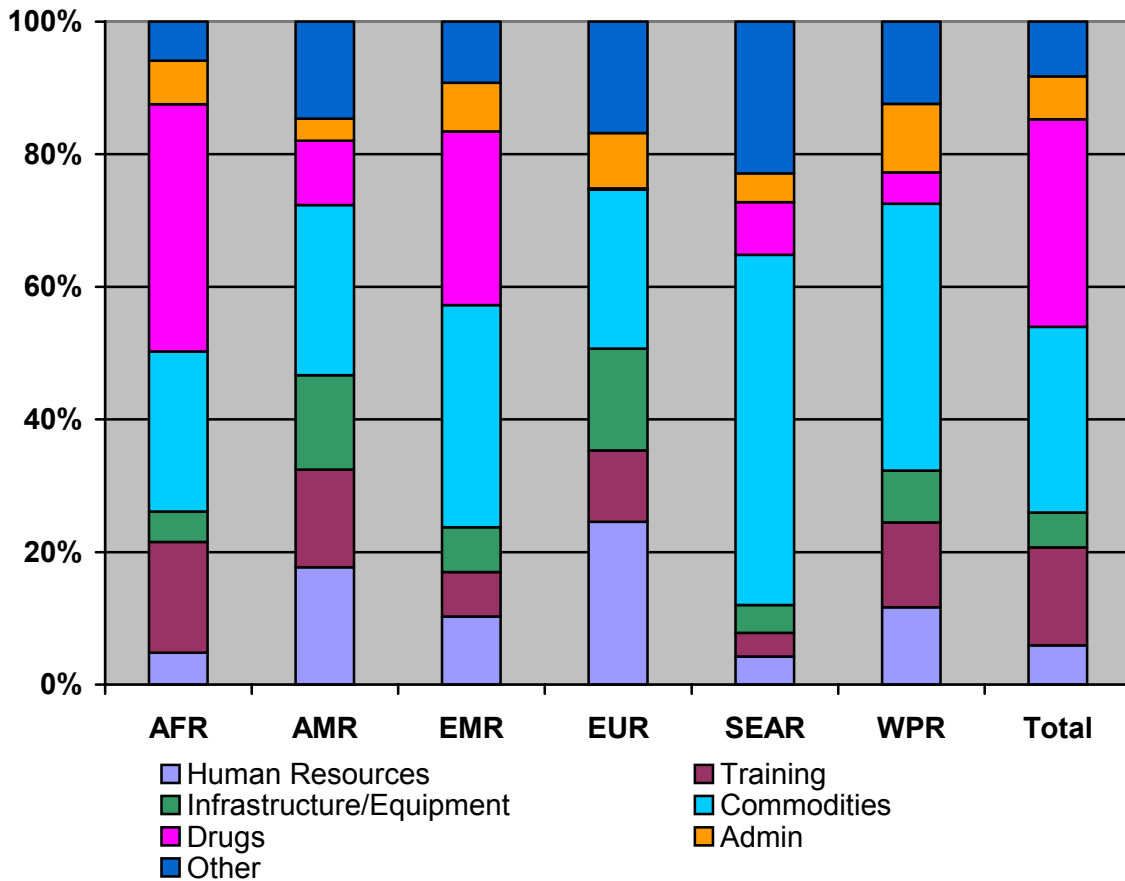


Figure 6: Cost-profile of budget line items by GNI class (unweighted)⁷

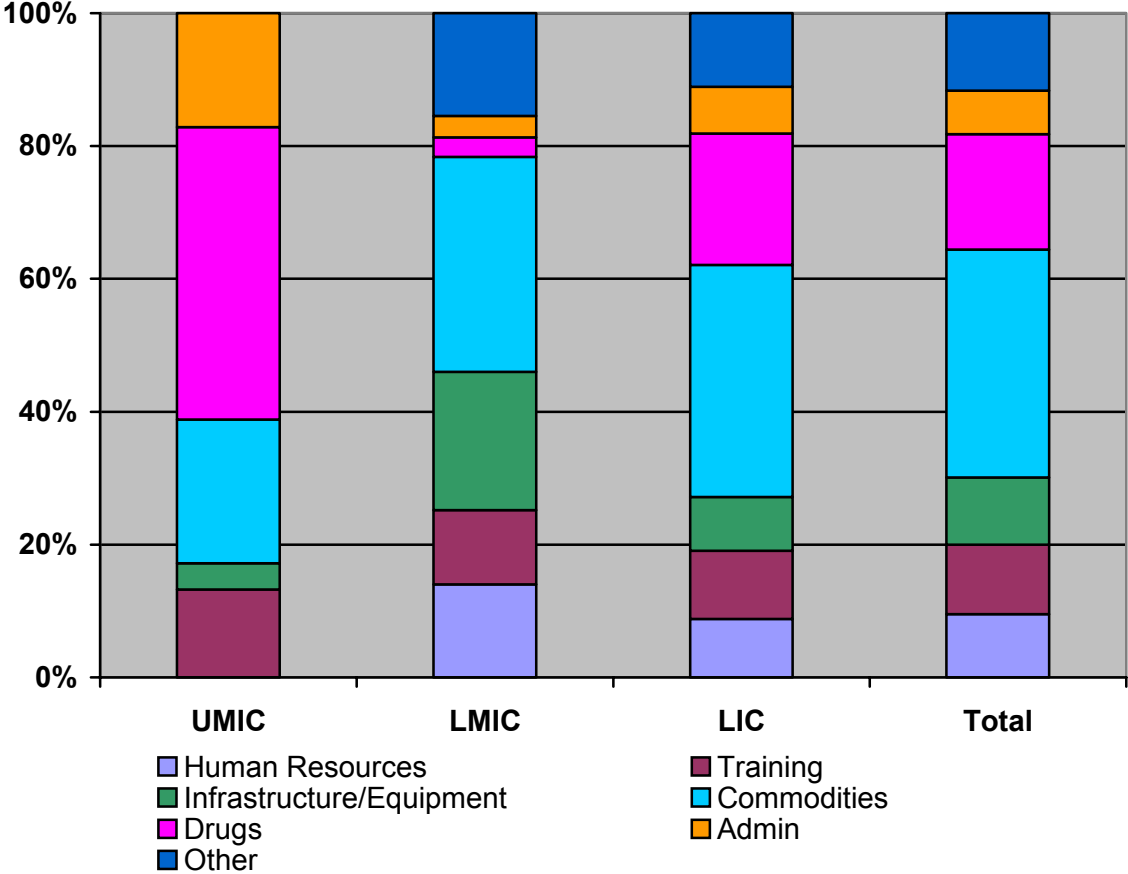
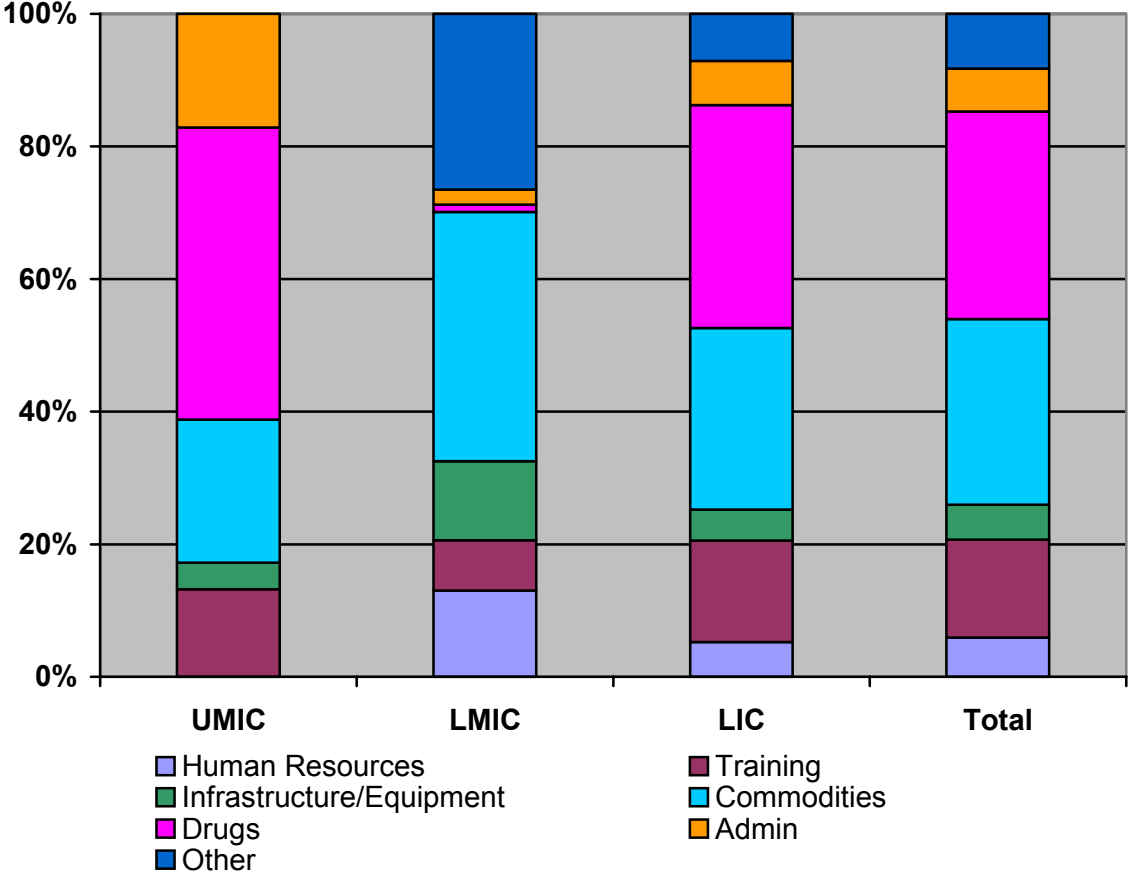


Figure 7: Cost-profile of budget line items by GNI class (weighted by budget of proposal)⁵



⁷ Note that UMIC category only comprises one proposal, findings should be interpreted with caution!

2.5. Allocation of budget shares towards implementing partners

Countries submitting a proposal to the GFATM are requested to state in the proposal the percentage of the overall budget that will be allocated to different implementing partners. In Rounds 2-4, partners are divided into 8 categories: *Government*, *NGOs*, *Private Sector*, *Academic Institutions*, *Organisations of People living with Malaria*, *Religious Organisations*, *Multi- or Bi-lateral Partners* and *Other partners*. In Round 1, only five categories were applied, omitting *Academic Institutions*, *People living with Malaria*, *Religious Organisations* and *NGOs* but including a category for *Civil Society*. For the analysis, we used the Round 4 classification scheme and subsumed the shares attributed to *Civil Society* in Round 1 into the category of *NGOs*. This reclassification may introduce a degree of bias since “Civil Society” groups might also include those which in later rounds might have been categorised as *Academia*, *People living with Malaria* or *Religious Organisation*. However, we feel that the category of *NGOs* best matches with the old term *Civil Society*; *NGOs* were also the most important (in terms of receipt of funds) of the civil society groups in Rounds 2-4 (see below).

As in the case of the budget shares, it has been necessary to use mean shares allocated to different partners in order for the shares to add to 100%.

Generally, the highest share was assigned to *Government* institutions with a mean of 48.3% across all rounds. *NGOs* were the next largest recipients with an overall mean of 28.9%. All other categories fell below 10%: the *Private Sector* was allocated 9.1%, *Religious Organisations* 3.5%, *Academia* 2.8%, *People living with Malaria* 2.4% and *Multi- /Bi-lateral partners* 1.9%. *Other partners* amounted to a mean share of 3.2% of the budget. For more detailed information, see Tables 5 and 6.

No clear pattern was detected across the 4 rounds. *Multi-/Bi-lateral partners* saw a substantial increase in their budget share in Round 4. This may, possibly, be due to revised Round 4 guidelines asking for the share of this category to be indicated more explicitly than in earlier rounds. A higher amount is also allocated to *People living with Malaria* in Round 4 than in Rounds 2–3.

With respect to regional differences, the private sector was allocated substantially higher mean amounts in the African and American WHO Region (11.5% and 11.8%, respectively) compared to all other regions. *NGOs* appear to have been assigned a higher mean share in the Eastern Mediterranean WHO Region (41.9%) compared to all other regions. By far the highest mean share of the overall budget that was to be allocated to government institutions is in the 2 proposals of the European WHO Region with a mean of 71.7% allocated towards government. Otherwise, no clear patterns were observed in terms of regional differences.

Table 5: Mean allocation of budget shares (in percent, SD in brackets) towards implementing partners by Rounds (not weighted by size of proposals)

Partner	Round 1 (10 proposals)	Round 2 (28 proposals)	Round 3 (17 proposals)	Round 4 (23 proposals)	Total (78 proposals)
Government	56.4 (36.4)	49.0 (25.4)	44.4 (23.6)	46.8 (29.1)	48.3 (27.4)
NGOs	33.0 (35.0)	27.3 (23.0)	30.4 (27.2)	28.0 (21.3)	28.9 (24.8)
Private Sector	8.6 (14.0)	9.6 (13.4)	9.6 (21.5)	8.5 (18.7)	9.1 (16.8)
Faith based organisations	0 (0)	3.5 (9.6)	5.3 (12.9)	3.8 (7.5)	3.5 (9.2)
Academic institutions⁸	0.1 (0.2)	3.39 (5.6)	2.5 (3.2)	3.5 (4.4)	2.8 (4.5)
People living with Malaria	0 (0)	3.3 (8.7)	0 (0)	4.0 (10.8)	2.4 (7.9)
Multi-/Bi-lateral Partners	1.2 (3.3)	0 (0)	0.8 (3.3)	5.3 (13.8)	1.9 (8.0)
Other partners	0.9 (2.8)	4.6 (11.9)	6.2 (15.5)	0.4 (1.0)	3.2 (10.3)

Table 6: Mean allocation of budget shares (in percent, SD in brackets) towards implementing partners by WHO Regions (not weighted by size of the proposals)

Partner	AFR (45 proposals)	AMR (7 proposals)	EMR (5 proposals)	EUR (2 proposals)	SEAR (10 proposals)	WPR (9 proposals)
Government	45.0 (29.2)	45.1 (19.6)	33.5 (26.4)	71.7 (11.8)	55.4 (27.0)	57.3 (24.6)
NGOs	27.1 (24.5)	32.0 (28.5)	41.9 (38.3)	15.0 (7.1)	31.4 (22.2)	28.8 (23.2)
Private Sector	11.5 (19.7)	11.8 (17.7)	6.9 (10.7)	0 (0)	5.8 (11.2)	2.5 (5.3)
Faith based organisations	3.7 (7.5)	0.3 (0.7)	9.0 (18.9)	0 (0)	0.9 (2.2)	5.6 (16.7)
Academic institutions	3.3 (5.1)	5.4 (3.3)	1.2 (2.2)	0 (0)	2.3 (4.0)	0.5 (1.0)
People living with Malaria	1.6 (6.9)	4.0 (10.6)	5.2 (7.5)	0 (0)	3.5 (11.1)	3.0 (9.1)
Multi-/Bi-lateral Partners	2.7 (10.1)	0 (0)	0 (0)	6.9 (9.7)	0.1 (0.3)	1.2 (3.5)
Other partners	4.7 (13.3)	1.4 (2.4)	2.3 (3.2)	0 (0)	0.7 (2.3)	1.2 (2.9)

⁸ Academic institutions was not included as a category in Round 1, but one proposal (Sri Lanka) explicitly altered the format to make an allocation of resources to universities.

3. Key Findings and Conclusions

The database accompanying this report is a comprehensive representation of the data contained in the Round 1-4 proposals. In this report, we restrict ourselves to a subset of the variables which during the analysis showed the most interesting patterns. Of particular note is the high variability of amounts requested per proposal as well as per capita among rounds. Overall, Round 4 proposals accounted for more than half of the total and the per capita request. One reason for this finding may be the increase in drug cost as more countries adopt Artemisinin-Based Combination therapy (ACT), or the higher costs associated with long-lasting insecticide-treated nets (LLINs).

3.1. Nature of services focused on in the proposals

Most activities in the GFATM applications from all rounds and regions focus on activities related to the categories of *Prevention* and *Treatment & Care*. Service areas within the category of *Support environment and Cross-cutting aspects* are much less commonly included in the proposals.

Within this latter category, *Support environment and Cross-cutting aspects*, the service areas “Supply-management”, “Coordination/partnership building” and “Monitoring and Evaluation” appear to receive the least focus in proposals. Within this category, however, the specific service area “Health Systems Strengthening” seems to be increasingly common in later proposals, indicating that this aspect may be becoming more important to countries over time.

Within the category of prevention, activities involving ITNs are most frequently proposed, though with a decreasing trend over rounds. Countries may be submitting new proposals for different activities (e.g. ACTs) in later rounds while they are still implementing activities from earlier rounds. Indoor residual spraying is proposed only in relatively few countries, and with a diminishing trend.

3.2. Analysis of Budgetary Data

The budgetary data confirm some of the trends observed in the indicators and categories/service areas described. Most of the funds are programmed for commodities (such as ITNs) with a slightly diminishing trend over time, and for drugs with a dramatically increasing trend. The latter can be associated with the change of drug regimes towards more expensive ACTs. The median allocations of the total budget towards Human Resources and Training sum up only to roughly 15% of the proposed budgets, indicating the lower priority attached to Human Resources. This low priority is particularly marked for the Africa, South East Asia and the Eastern Mediterranean WHO Regions, all of which have especially low investment in human resources and training but high shares of the budget planned for commodities and drugs. Stratified by GNI, LIC also tend to invest less in Human Resources/Training than in commodities and drugs.

3.3. Allocation of budget shares to implementing partners

The allocation of budget shares to implementing partners does not indicate very surprising or unexpected trends. The highest share is allocated towards partners within government. NGOs seem to play a major role as well. The private sector has very limited involvement in activities related to GFATM proposals, and this has remained constant over time.

4. Recommendations for GFATM proposals, Round 5 (format and guidelines)

4.1. Consistency of budgetary data throughout the proposal

Our review of applications indicates that the *total amount requested* frequently does not match the sum of the disaggregated budgetary data presented in the section on *budget information*. In some cases this is due to inconsistency in format of numbers (e.g. 1 million/ 1,000,000); but more frequently the sums simply do not add up to the total.

We recommend that the guidelines encourage writers of proposals to pay particular attention to the consistency of number format and amounts calculated.

4.2. Completeness of the proposal

The quality of the proposals in terms of the completeness of information reported is very uneven. This applies frequently to the fields for principal recipient (left blank), the unmet need (partly or totally omitted, or not clearly expressed), and description of services/implementation and strategy. The description of services and strategies was particularly problematic for ITN distribution programmes (see below). For instance, many proposals do not specify whether they will apply any form of subsidy (and if so, whether the subsidy is full (free net) or partial), and which part of the population will benefit. Moreover, sometimes more than one mode of delivery is reported, but the distribution of funds/activities among them and the population targeted with each method are not specified.

We suggest that writers be encouraged to check carefully the completeness of all information, particularly where this concerns strategic aspects such as mode of delivery of ITN

4.3. Lack of general (standardised) data on the endemicity/morbidity/mortality of Malaria in the particular country/region

While almost all countries describe the current situation in terms of the endemicity, most proposals do not specify the size of the *population at risk*, nor general or disaggregated morbidity/mortality data. Where such information is given, the source is often not specified. This makes it very difficult to address the question of the adequacy of the amounts budgeted for different interventions or, indeed, variations across proposals in the amounts requested per person covered.

We suggest that a standardised section containing basic epidemiological information on the disease in the respective country/region be presented in a table. The source of the data should be identified.

4.4. Variable degree of disaggregation and explanation of the itemised costs

The degree to which costs are described and explained is highly variable among proposals: Some are very disaggregated and detailed (e.g. *tubes of Nivea cream*) while others mention categories of items (e.g. *spraying equipment*). The interpretation of budget information is particularly difficult for drugs (e.g. SP), where it is often not specified whether these will be for preventive or curative purposes or whether the medication is for first line treatment or reserved for severe cases. A similar difficulty occurs for insecticide, where it is not specified whether it is to be used for treating nets or indoor spraying.

We suggest that the guidelines give a clearer indication of the degree of detail with which items should be identified. For drugs and insecticide, it would be helpful to specify how they will be used (e.g. presumptive treatment vs. curative treatment). To achieve this greater consistency it might be useful for countries to adopt standardised costing guidelines, such as the new RBM costing tool.

4.5. Comprehensive description of ITN delivery systems

Many audiences at national and international level are interested in how countries are proposing to deliver ITNs. In the current proposals it is often difficult to identify the specific mode of financing and delivery proposed. We suggest that a clear distinction be drawn between *overall approach* (e.g. public sector distribution, social marketing, vouchers), the *mode of delivery* of the ITN (and, where relevant, the voucher) (e.g. public, private commercial, NGO, employer-based) and the *mode of financing* (fully subsidised, co-financed with user contribution). These could be used to

provide a typology of delivery modes in which the categories are exhaustive and mutually exclusive. Where countries are using more than one mode at the same time, it would be helpful to clarify this, together with the populations that the different approaches are targeting (e.g. social marketing, general population; free nets to pregnant women delivered through public health facilities).

In addition, more careful specification of the type of net being procured (factory pre-treated, untreated, LLIN) would enable more complete analysis of the demands likely to arise as a of GFATM-funded activities.

4.6. Completeness and consistency in reporting the unmet need

In order to view the proposed activities within the country's overall strategy to combat malaria, complete and standardised reporting on the *total*, *met* and *unmet need* would be of great value. More clarity would be achieved by all countries indicating their unmet need for the same time period even if the duration of proposed activities is shorter. For Round 5, for instance, countries may be asked to report total, met and unmet need per year for 5 years, starting in 2006. Guidance could be given in the proposal form or the guidelines on how the need should be calculated as currently there appear to be substantial discrepancies between countries in stating (and providing details about) their need.

A discrepancy between unmet need and total amount requested may arise where a proposal does not request the full amount calculated as total unmet need. In this case it would be helpful if countries outline their strategy for covering the balance of unmet need that will not be covered by the GFATM request.

5. Annex

Table A1: Numbers of Proposals by WHO Region and Round (frequencies given for WHO Regions)

Round	WHO Region						Total
	AFR	AMR	EMR	EUR	SEAR	WPR	
1	8	0	0	0	2	2	12
	66.7%	0%	0%	0%	16.7%	16.7%	100%
2	16	1	5	0	3	3	28
	57.1%	3.6%	17.9%	0%	10.7%	10.7%	100%
3	10	4	1	1	2	2	20
	50%	20%	5%	5%	10%	10%	100%
4	15	2	0	1	3	2	23
	65%	8.7%	0%	4.4%	13%	8.7%	100%
Total	49	7	6	2	10	9	83
	59%	8.4%	7.2%	2.4%	12.1%	10.8%	100%

Table A2: Numbers and Percent of matching Coverage Indicators by Round (SD in brackets)

Coverage Indicator	Round 1 (12 proposals)	Round 2 (28 proposals)	Round 3 (20 proposals)	Round 4 (23 proposals)	Total (83 proposals)
No. of ITN staff trained	0 (0) 0%	0 (0) 0%	1 (0) 5%	6 (0) 26.1%	7 (0) 8.4%
No. of nets distributed	2 (0) 16.7%	0 (0) 0%	4 (2) 20%	11 (3) 47.8%	17 (5) 21.5%
No. of sites testing insecticide resistance	3 (2) 25%	2 (0) 7.1%	1 (1) 5%	2 (0) 8.7%	8 (3) 9.6%
No. of households owning ITNs	7 (3) 58.3%	12 (4) 42.9%	12 (4) 60%	13 (1) 56.5%	44 (12) 53%
No. of children <5 using ITNs	7 (2) 58.3%	17 (2) 61.7%	11 (1) 55%	12 (0) 52.2%	47 (5) 56.6%
No. of pregnant women using ITNs	7 (3) 58%	19 (3) 68.9%	9 (0) 45%	9 (0) 39.1%	44 (6) 53%
No. of staff trained on Malaria in pregnancy	0 (0) 0%	0 (0) 0%	0 (0) 0%	3 (1) 13%	3 (1) 3.6%
No. of pregnant women on IPT	3 (1) 25%	11 (2) 39.3%	8 (0) 40%	8 (0) 34.8%	30 (3) 36.1%
No. of pregnant women on IPC	2 (0) 16.7%	4 (0) 14.3%	3 (0) 15%	1 (0) 4.4%	10 (0) 12.1%
No. of staff trained on epidemic coverage	0 (0) 0%	2 (1) 7.1%	2 (0) 10%	2 (0) 8.7%	6 (1) 7.2%
Epidemics detected within 2 weeks & under control	0 (1) 8.3%	6 (2) 21.4%	6 (0) 30%	5 (1) 21.7%	18 (4) 21.7%
No. of staff trained on IRS	0 (0) 0%	0 (0) 0%	1 (1) 5%	1 (0) 4.4%	2 (1) 2.4%
No. of homes & areas sprayed with insecticide	3 (3) 25%	7 (3) 25%	5 (4) 25%	5 (2) 21.7%	20 (9) 24.1%

No. of staff trained in IEC	0 (0) 0%	1 (0) 3.67%	2 (1) 10%	6 (1) 26.1%	9 (2) 10.8%
No. of targeted areas with IEC services	2 (2) 16.7%	3 (3) 10.7%	1 (1) 5%	10 (2) 43.5%	16 (8) 19.3%
No. of staff trained on treatment	3 (1) 25%	4 (2) 14.3%	4 (1) 20%	11 (1) 47.8%	22 (5) 26.5%
Patients receiving correct diagnosis & treatment	5 (2) 41.7%	18 (5) 64.3%	14 (10) 70%	14 (4) 60.9%	51 (21) 61.5%
No. of facilities w/o stockouts	4 (0) 33.3%	11 (4) 39.3%	7 (3) 35%	13 (2) 56.5%	35 (9) 42.2%
No. of children w/ access to treatment	6(3) 50%	10 (3) 35.7%	8 (5) 40%	10 (2) 43.5%	34 (13) 41%
No. of severe cases w/ access to treatment	2 (1) 17.7%	8 (3) 28.6%	7 (5) 35%	9 (0) 39.1%	26 (9) 31.3%
No. of staff trained in drug resistance testing	0 (0) 0%	0 (0) 0%	0 (0) 0%	3 (0) 13%	3 (0) 3.6%
No. of sites for drug resistance testing	3 (2) 25%	5 (3) 17.9%	2 (1) 10%	8 (1) 34.8%	18 (7) 21.7%
No. of staff trained in home management	0 (0) 0%	0 (0) 0%	0 (0) 0%	6 (1) 26.1%	6 (1) 7.3%
No. of caretakers recognising signs & symptoms of malaria	1 (1) 8.3%	9 (2) 32.1%	5 (2) 25%	10 (3) 43.5%	25 (8) 30.1%
No. of staff trained in health system coverage	1 (1) 8.3%	4 (2) 14.3%	4 (2) 20%	8 (1) 34.8%	17 (6) 20.5%
% of budget spent on health infrastructure	1 (1) 8.3%	0 (0) 0%	0 (0) 0%	1 (0) 4.4%	2 (1) 2.4%
% of patients accurately referred	1 (1) 8.3%	0 (0) 0%	1 (1) 5%	1 (0) 4.4%	3 (1) 3.6%
No. of staff trained in coordination & partnerships	0 (0) 0%	0 (0) 0%	1 (1) 5%	2 (1) 8.7%	3 (2) 3.6%
No. of networks/partnerships involved	2 (1) 16.6%	4 (1) 14.3%	3 (30) 15%	7 (1) 30.4%	16 (6) 19.3%
No. of staff trained in M&E	1 (1) 8.3%	0 (0) 0%	1 (1) 5%	2 (0) 8.7%	4 (2) 4.8%
% of budget spent on M&E	0 (0) 0%	0 (0) 0%	0 (0) 0%	2 (0) 8.7%	2 (0) 2.4%
No. of staff trained in procurement	0 (0) 0%	0 (0) 0%	0 (0) 0%	4 (1) 17.4%	4 (1) 4.8%
% service delivery points w/ sufficient drugs	0 (0) 0%	5 (2) 17.9 %	1 (1) 5%	3 (0) 13%	9 (3) 10.8%
% reduction in unit cost(s) of drug(s)/commodities	0 (0) 0%	0 (0) 0%	0 (0) 0%	1 (0) 4.4%	1 (0) 1.2%
Mean No. of matching coverage indicators (SD)	5.6 (2.1)	5.8 (2.7)	6.2 (2.9)	9.1 (5.3)	6.8 (3.8)
Mean No. of not explicitly mentioned indicators (SD)	2.4 (2.3)	1.7 (1.1)	2.5 (1.4)	1.3 (1.5)	1.9 (1.5)