GF/B20/7
Attachment 1

SUMMARY OF THE M&E TECHNICAL FRAMEWORK

1. Introduction

The Monitoring and Evaluation (M&E) Technical Framework sets out the approach to monitoring, operational research and independent evaluation of Phase 1 of the Affordable Medicines Facility Malaria (AMFm). It defines outputs and outcomes sought for the AMFm, which consists of two main components: (i) price reductions through manufacturer negotiations and buyer co-payments; and (ii) supporting interventions. Each component is a means to an end, which is the achievement of the stated goals of the AMFm.

The Technical Framework consists of nine sections. Following the Framework *Overview, Section 1* sets the scene with background information about traditional approaches to the financing of ACTs (i.e., the status quo), the AMFm approach and the purpose of the Technical Framework. *Section 2* explains what is measured. *Section 3* addresses how this will be done. In the next three chapters, core components of the Framework are individually examined: the monitoring of supporting interventions (*Section 4*), operational research (*Section 5*) and the independent evaluation (*Section 6*). Remaining chapters address "markers of clear failure (red flags) in the AMFm design", responsibilities and key events for the independent evaluation, and a timeline of those key events (*Sections 7-9* respectively).

It is envisaged that the Framework document will be used by a range of stakeholders. Principal amongst these are participating countries but also technical and development partners, contractors and the broader international health community. It may be of interest to policy makers whose malaria-endemic countries are not included in Phase 1 of AMFm but who stand to benefit from a potential global roll-out after Phase 1. Finally, the Global Fund Secretariat will also find it a useful reference**.**

AMFm Phase 1 will be independently evaluated per Global Fund Board decisions of November 2008 and May 2009. The results of this evaluation will assist the Board's decision in 2011 to expand, modify or terminate AMFm as a line of business within the Global Fund. To this end, the Framework lists evaluation questions and details design, methods, indicators, "red flags" and the responsibilities of respective parties for the independent evaluation. Guidance on performance measures and issues of design and implementation are also covered for additional components of the Framework that either support or otherwise inform the evaluation of AMFm.

2. Objectives

Phase 1 of the AMFm includes monitoring, operational research and an independent evaluation, with the following objectives by component:

- **In-country monitoring of supporting interventions (SIVs)[1]:** to keep track of implementation progress on supporting interventions, identify problems that require the attention of managers, and inform subsequent decisions and action.

- **Operational research (OR):** to enable learning by doing and alleviate constraints on implementation via studies whose findings will be applicable to the local context. The emphasis is on applied knowledge, in a particular country context. Additionally, OR involving multiple countries will be undertaken to examine cross-cutting issues for AMFm. Countries are responsible for the conduct or commissioning of county specific operational research (OR). The Global Fund Secretariat will contract out multi-country OR studies to leading research and academic institutions, to be selected by competitive tender.[2]

- **Independent evaluation**: to determine whether, and to what extent, AMFm Phase 1 achieves its objectives. This is the principal deliverable to be considered by the Board in 2011. Data analysis for the Independent Evaluation will be undertaken by an independent contractor to be selected by competitive tender. This contractor will not be responsible for in-country monitoring of supporting interventions and operational research but will have access to data from both sources.

3. Broad limitations of the M&E Technical Framework

The Technical Framework strives for an approach that is fit-for-purpose. It emphasizes relevance to the objectives of the AMFm Phase 1 and seeks a credible balance between methodological purity and pragmatism, which is necessitated by real-life constraints. These constraints include time (i.e., Phase 1 is very time-limited) and the need to promote country ownership of monitoring while respecting their explicit request to minimize additional M&E data collection, reporting requirements and work burden while they are busy implementing AMFm Phase 1. Phase 1 AMFm will contribute to the strengthening of local systems for monitoring, operational research and evaluation. However, the M&E work stream of AMFm Phase 1 is neither intended, nor designed, to solve all the deep-seated and long-standing weaknesses in systems for country monitoring, operational research and evaluation. The Technical Framework is constructed as a sensible balance of these multiple yet sometimes contradictory desires. Ultimately, it is important to recognize that this large scale complex intervention is being evaluated at national level in a range of diverse health systems. It is not a controlled experiment in a laboratory with passive subjects. This is an ambitious evaluation which presents scientific and measurement challenges. Components of the Framework address and manage this in different ways within the bounds of knowledge, available tools and what is feasible in terms of time and resources.

[1] As defined in The Report of the Affordable Medicines Facility – Malaria Ad Hoc Committee to the Board of the Global Fund to Fight AIDS, Tuberculosis & Malaria. Eighteenth Board Meeting, November 2008. Available at: http://www.theglobalfund.org/documents/board/18/GF-B18-07_ReportAMFmAdHocCommittee.pdf

[2] Global Fund funded multi-country OR activity will be determined on the basis of consultation with partners who are planning a programme of AMFm related OR activity.

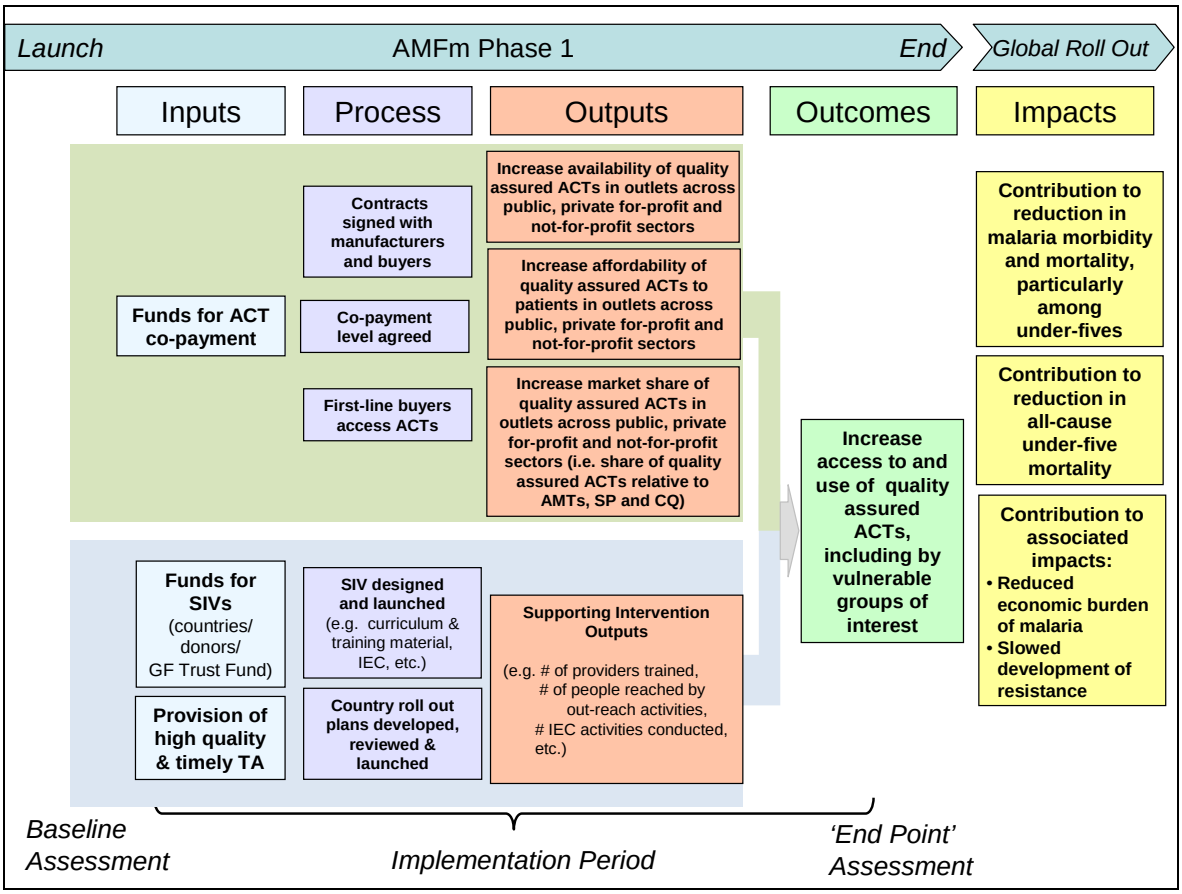
4. What is being measured?

Figure 1 presents an overview of the *output* and *outcome* results sought for AMFm Phase 1. The Independent Evaluation will assess to what extent these outputs/outcomes are achieved. The evaluation will *not* be able to assess the long term impacts of AMFm Phase 1 due to the limited duration of the first phase. Country monitoring of AMFm supporting interventions via routine Global Fund grant performance practice will determine to what extent specified outputs are achieved for these activities.

While these two streams appear to be relatively independent at the input, process and output levels, they converge at the outcome and impact level. In other words, longer-term, population-based outcomes and impact of the AMFm will depend on interactions between ACT price reductions and supporting interventions.

Findings from both country-specific and multi-country operational research, as well as important contextual information, will feed into the independent evaluation.

Figure 1: AMFm Phase 1 Results Framework*



* AMT= artemisinin monotherapy; CQ=chloroquine; IEC=information/education/communication; SP=sulfadoxine-pyrimethamine; TA = technical assistance, SIV = Supporting Interventions

5. Design

The Framework consists of the following components:

(5a) Monitoring of supporting interventions: Countries will design supporting interventions as part of their AMFm Phase 1 implementation plans. Indicators and targets for these activities are included in the Performance Framework of the country Global Fund grant related to AMFm. To assist countries and the comparability of information across countries, a list of established performance indicators will be provided by the Global Fund Secretariat, as part of the M&E Technical Framework, and countries can select from and/or build on these indicators. Indicators are agreed with countries during the grant amendment process, with reporting requirements similar to routine Global Fund country grant practice.

(5b) Operational research (OR): Two types of OR will be conducted under AMFm Phase 1.

- *Country-specific OR:* Countries will identify and either perform or commission operational research for their own use during Phase 1. The operational research questions should be directly relevant to the objectives of the AMFm and barriers to the achievement of these objectives. Therefore, specific operational research topics are expected to fall into one of the following broad categories:

    (i) Constraints on the availability of co-paid artemisinin-based combination therapies (ACTs) through public, private for-profit and not-for-profit channels;

    (ii) Factors that keep the retail prices of co-paid ACTs higher than those of chloroquine (CQ) and sulfadoxine-pyrimethamine (SP) (i.e., prices paid by patients across all sectors);

    (iii) Factors that prevent a significant increase in the market share of ACTs relative to monotherapies (i.e., artemisinin-based monotherapies (AMTs), CQ, SP and amodiaquine (AQ)) across all sectors; and

    (iv) Barriers to access and use of co-paid ACTs by vulnerable socio-economic groups of interest to the AMFm (e.g., the poor, children and rural residents), including issues of appropriate use of ACTs and compliance with the full course of treatment.

- *Multi-country OR*: This research will focus on cross-cutting topics spanning multiple AMFm countries. These topics will be identified by the Global Fund Secretariat, in consultation with technical partners in the Harmonization Working Group (HWG) of the Roll Back Malaria Partnership (RBM). The design, conduct and evaluation of these studies will be contracted out to expert academic and research institutes and will be subject to a competitive tendering process.

It is essential that these operational research studies are conducted; however, it is not crucial that they be financed by the Global Fund. The Global Fund Secretariat is consulting with the Clinton Foundation, the World Health Organization's Special Programme for Research and Training in Tropical Diseases (TDR) and others to explore coordinated options for parallel or joint financing for this work stream. Coordination of research funding and activity will be central to ensuring that current key knowledge gaps are addressed. Whilst there will be a range of studies relevant to

AMFm Phase 1, it is important to note that only a single independent evaluation report will be submitted to the Global Fund Board for its consideration.

(5c) Independent Evaluation: The main assessment parameters of the independent evaluation are:

- **Availability** of quality assured ACTs in outlets[3] across the public, private[4] for-profit and private not for-profit sectors;
- **Affordability** of quality assured ACTs to patients in outlets across the public, private for-profit and not for-profit sectors (i.e., where anti-malarials are dispensed for a fee);
- **Use** of ACTs, including by vulnerable groups of interest (e.g., poor people, children, rural residents); and
- **Market share** ("crowding out") of quality assured ACTs relative to monotherapies and other undesirable anti-malarial treatments (e.g., AMTs, SP, CQ, AQ).[5]

In addition, the independent evaluation will: (a) examine ACT market dynamics (i.e., trends in, interactions among, and factors influencing demand, supply and price of ACTs) and; (b) appraise the structural, managerial and financial requirements for a potential global roll out of AMFm.

The Independent Evaluation at the country level will use a pre/post intervention design, with participating countries as the interventions sites and two or three non-participating countries, serving as comparators for the level of ACT availability, affordability, use and market share in countries where AMFm is not being implemented. The intervention under evaluation is the AMFm which consists of cheaper ACTs made possible by manufacturer negotiations and buyer co-payments, in conjunction to a raft of supporting interventions. Data for key parameters of the evaluation will be collected via baseline and end point surveys of: (a) outlets; and (b) households. The independent evaluation will draw upon evidence from different components of the M&E framework, with some activities undertaken by countries, and other activities undertaken by contracted parties.

Benchmarking: For all items related to service delivery and quality of care, the AMFm will be assessed against its objectives within the bounds of national treatment guidelines and World Health Organization (WHO) guidelines. For all counterfactuals, the benchmarks will be real-life counterfactuals (i.e, not hypothetical ideals), on the same scale, with multi-country diversity, and measured by the same indicators within the same period of implementation.

Key features of the Independent Evaluation are:

[3] Outlets dispensing anti-malarials (free or for a fee) across all sectors (public, private for-profit and not for-profit) will be surveyed.

[4] The term private sector refers to both the formal and informal private, unless specified otherwise in this document.

[5] In the AMFm context, "crowding out" refers to displacing undesirable monotherapies with quality assured ACTs for the treatment of uncomplicated malaria. However, please note that the AMFm objective to "crowd out" CQ and SP is modified: (i) in areas where *P. vivax* transmission requires that CQ remain available for treatment purposes; and (ii) in areas of high transmission where SP is recommended for intermittent preventive treatment for pregnant women. The modification is done to take these policies into account.

Baseline and End Point Surveys: As explained, a pre/post assessment of AMFm will be undertaken via surveys of outlets and households in AMFm participating countries and in two to three non-participating countries.

The responsibilities for data collection for baseline and end point surveys are different from the responsibilities for multi-country data analyses. These tasks will be done by different organizations. Indicators and datasets will be standardized across the three organizations to ensure the comparability of findings within the same country (over time) and across countries.

Conduct of Meta-Analyses of Country Data: An Independent Evaluator will be selected by the Global Fund Secretariat via a process of competitive tendering. It is envisaged that this contractor will be different from those organizations undertaking the baseline and end point surveys (i.e., Data Collection Contractors). This Independent Evaluator will have value-adding responsibilities for: standardizing data collection protocols in collaboration with and across all Data Collection Contractors; conducting the meta-analyses of country survey data;[6] providing an independent assessment of data quality; and identifying "red flags" (serious failures of AMFm design) if and where they occur. The Independent Evaluator will prepare and submit a report on evaluation findings to the AMFm Ad Hoc Committee.

(5d) Comparators

Comparator (non-AMFm) countries: The merit of considering comparator countries is that it allows comparisons to be made between ACT availability, affordability, use and market share in countries where AMFm is, and is not, implemented. Consequently, this permits certain inferences to be made regarding observed changes and the possible "added value" of the AMFm. However, given the eligibility restrictions for countries participating in Phase 1, combined with the quasi-experimental design of the evaluation, conclusions drawn will be more limited than those based on a conventional experimental design, which compares "cases" and "controls." Nonetheless, the use of comparison countries increases appreciably the confidence with which observed changes may be attributed to the AMFm intervention, albeit with specific caveats.

Alternative financing platforms: The Independent Evaluator will assess the extent to which AMFm Phase 1 meets its objectives. In addition, the Independent Evaluator will draw comparisons between the AMFm and alternative financing platforms that support access to antimalarials on a large scale in multiple countries. The comparison will use similar measures of (i) affordability, (ii) accessibility, (iii) market share, (iv) use and (v) cost-effectiveness.

The principal alternative financing platform to which the AMFm Phase 1 will be compared is the Global Fund's traditional (rounds-based, non-AMFm) approach to financing. The Independent Evaluator will compare the traditional approach and AMFm Phase 1, using similar measures of performance that are presented in Sections 6.3 and 6.4 of the Monitoring and Evaluation Technical Framework (attached herewith as Attachment 2). Traditional grants approved by the Global Fund Board at about the same time as those under the AMFm could provide suitable comparators of performance during a *concurrent* time period.

[6] Significant efforts will be made by the Independent Evaluator undertaking the multi-country data analysis, in conjunction with the contractors implementing the surveys, to ensure standardization of survey data collection methods, to render a meta-analysis feasible. The need for survey contractors to recognize the authority of the Independent Evaluator conducting the overarching analysis (who must also respect the provisions for data ownership and rights to publication by those who collected the data) is of paramount importance and will be explained during the negotiation and commissioning phase with each contractor.

The Independent Evaluator will also compare the historical trajectory of performance under traditional grants with the trajectory of performance under the AMFm. The Independent Evaluator will have access to the complete dataset from which the conclusions of the Five-Year Evaluation on ACT access were drawn, for the purpose of facilitating comparative analyses in a timely and transparent fashion.

Direct comparisons between performance under the traditional and AMFm financing platforms will provide opportunities to decide which approach (or combination of approaches) to financing better serves the twin objectives of expanding access to ACTs and displacing undesirable monotherapies from the market. The reports of all comparative analyses will be available in the public domain.

6. Markers of "clear failure (red flags) in the AMFm design"

Red flags (i.e., serious failings of AMFm design) have been identified. They are defined by core objectives of AMFm Phase 1 and measured by proposed indicators. Red flags are identified, justified and explained in the AMFm M&E Framework document.

In brief, three red flags are proposed:

(i) **Lack of ACT availability**
(ii) **ACT price violations**
(iii) **Failure to gain market share**

Other potential red flags are considered, and reasons for their non-adoption explained in detail in the full text of the Monitoring and Evaluation Technical Framework.

7. Responsibilities & Major Events During the Independent Evaluation

The Global Fund Secretariat, as mandated by the Global Fund Board, is responsible for managing day-to-day operations of AMFm Phase 1, commissioning the Independent Evaluation of AMFm Phase 1, and managing related contracts. An independent Expert Advisory Group (EAG), chaired by Professor Barry Bloom (former Dean, Harvard School of Public Health), has been convened by the Global Fund Secretariat to advise the Global Fund Secretariat on the design of the independent evaluation and draft reports from the independent evaluation. The rationale is to assure timely and high-quality advice from a body that is dedicated to the specific challenges of the AMFm, with a mix of skills that is customized for the specific purpose of the AMFm, and which has a finite lifespan. The EAG has no role in the contractual processes for the independent evaluation, which is the responsibility of the Global Fund Secretariat. All products from the Secretariat are subject to AHC oversight as noted in the following paragraph.

As mandated by the Global Fund Board, the AMFm Ad Hoc Committee has oversight of the implementation and independent evaluation of AMFm Phase 1. Based on findings generated by the Independent Evaluation, the AMFm Ad Hoc Committee will make recommendations to the Global Fund Board, at the end of Phase 1, on the future direction of AMFm within the Global Fund. As mandated by the Global Fund Board, the Technical Evaluation Reference Group (TERG) will provide "guidance with regard to the technical parameters of the design of the independent evaluation of the AMFm, under the oversight of the AMFm Ad Hoc Committee." The AMFm Ad Hoc Committee will consult with the Technical Evaluation Reference Group (TERG) accordingly. The Global Fund Secretariat will support the work of the AMFm Ad Hoc Committee and the TERG in relation to the Independent Evaluation of AMFm Phase 1.

At the country level, the Principal Recipient(s) has oversight responsibility for grant performance (including Global Fund grants for AMFm supporting interventions). The implementation of supporting interventions is subject to routine grant performance via standard Global Fund governance.

The Technical Framework concludes with a listing of key events for the independent evaluation, along with a timeline. **The timeline is based on Global Fund Board decisions in effect as of July 2009. The Global Fund Secretariat reserves the right to amend this timeline and other aspects of the AMFm Phase 1 M&E Technical Framework to comply with future decisions of the Global Fund Board, should the need arise. Such amendments may include but not be limited to: the scope or scale of the independent evaluation, the timing of end-point assessments, and the structure and contents of the evaluation framework**

GF/B20/7
Attachment 2

Extracts from the AMFm "Phase 1" Monitoring and Evaluation Technical Framework

Refer to the full AMFm Phase 1 Monitoring and Evaluation Technical Framework to see how AMFm objectives, evaluation questions and some illustrative indicators, at the output and outcome level, map onto each other.

Independent Evaluation Questions

Table 1 lists specific evaluation questions based on AMFm objectives.

Table 1: AMFm Objectives by Independent Evaluation Questions

AMFm Objective	Independent Evaluation Questions
1. Increase ACT Availability	Q 1.1 Has the AMFm mechanism helped increase the availability of quality assured ACTs to patients across public, private for-profit and not-for-profit sectors, in rural/urban areas?
2. Increase ACT Affordability	Q 2.1 Has the cost of quality assured ACTs to patients been reduced at public, private for-profit and not-for-profit outlets in rural/urban areas to a price comparable to the price of most popular anti-malarials?
3. Increase ACT Use	Q 3.1 Has the AMFm mechanism helped increase use of quality assured ACTs, including among vulnerable groups, such as poor people, rural residents and children?
4. "Crowd out" AMTs, CQ, SP	Q 4.1 Has the AMFm mechanism helped increase the market share of quality assured ACTs relative to all anti-malarial treatments in the public, private for-profit and not-for-profit sectors in rural/urban areas?

Evaluation questions addressing other topics of special interest are listed in Table 2.

Table 2: Evaluation Questions for Market Impact Study & Institutional Analysis

Additional Study Topic	Evaluation Questions
5. ACT market dynamics	Q 5.1 What are the plausible effects of AMFm Phase 1 on ACT market dynamics (trends in, interactions among, and factors influencing demand, supply and price of ACTs) at the regional and global levels?
6. Institutional analysis (regarding the scalability of AMFm)	Q 6.1 This study will define functions, institutional and financial requirements for a potential global roll-out of AMFm, with emphasis on the following question: "What will it take to run a global phase of AMFm?" It will identify options for managerial and institutional systems and structures for a potential global roll out of AMFm.

Indicator Framework for the Independent Evaluation

Outlet and household surveys will use a select number of pre-agreed indicators to answer core evaluation questions (Table 3). These indicators are based on earlier work undertaken by the RBM Task Force on AMFm[1] and are subject to modification and further standardization on the basis of technical discussions with survey organizations and the Independent Evaluator conducting the multi-country data analysis. They may be modified to take account of the feasibility of data collection. Any subsequent modifications to individual indicators will not compromise the assessment of the evaluation questions. However, if it becomes clear that parts of the evaluation cannot be done because of severe capacity constraints at the country level, those parts of the evaluation will be scaled down to fit with realities. Such decisions will be made on a case by case basis and documented.

Table 3: AMFm Phase 1 Evaluation Questions & Indicators

Evaluation Questions	Indicators
Q 1.1 Has the AMFm mechanism helped increase the availability of quality assured ACTs[2] to patients across public, private[3] for-profit and not-for-profit sectors in rural /urban areas?	(1.1) Proportion of outlets in rural /urban areas that have any anti-malarials in stock at the time of survey visit (1.2) Proportion of outlets in rural /urban areas that have non-artemisinin monotherapy or non-artemisinin combination therapy in stock at the time of survey visit (1.3) Proportion of outlets in rural /urban areas that have artemisinin monotherapy in stock at the time of survey visit (1.4) Proportion of outlets in rural / urban areas that have non-quality assured ACTs in stock at the time of survey visit (1.5) Proportion of outlets in rural / urban areas that have quality assured ACTs in stock at the time of survey visit (1.6) Number and percentage of rural / urban outlets with no reported stock outs of nationally recommended anti-malarial drugs, lasting more than one week, at any time, during the last 1 month (1.7) Proportion of the rural /urban population living in areas that have access to a full course of an adult treatment with a quality assured ACT (1.8) Proportion of the rural / urban population living in areas that have access to a full course of a child treatment with a quality assured ACT

[1] Roll Back Malaria. AMFm Working Group. Monitoring & Evaluation and Operational Research. Affordable Medicines Facililty – malaria. Technical Proposal to Increase Access to Malaria Medicines. Background Paper 3. November 2007.
[2] The quality of drug storage conditions and drug expiry dates will also be assessed during outlet surveys.
[3] The term private sector includes both the formal and informal private sector.

Evaluation Questions	Indicators
2.1 Has the cost of quality assured ACTs to patients been reduced at public, private for-profit and not-for-profit outlets in rural/urban areas to a price comparable to the price of most popular anti-malarials?	(2.1) Median cost to patients[4], of a full course of treatment (adult/child) with quality assured ACTs, in rural /urban outlets (2.2) Median cost to patients[4], of a full course of treatment (adult/child) with non-quality assured ACTs, in rural /urban outlets (2.3) Median cost to patients[4] of a full course of treatment (adult/child) with artemisinin monotherapy, in rural / urban outlets (2.4) Median cost to patients [4] of a full course of treatment (adult/child) with other anti-malarials (CQ, SP) in rural / urban outlets (2.5) Cumulative percentage mark up between retail median price of a full treatment course with quality assured ACTs (adults) and wholesaler median price
Q 3.1 Has the AMFm mechanism helped increase use of ACTs,[5] including among vulnerable groups, such as poor people, rural residents and children?	(3.1) Proportion of children (by age band), with fever in the past 2 weeks who received ACT treatment by source of provider (3.2) Proportion of children (by age band), with fever in the past 2 weeks who received ACT treatment within 24 hours of fever onset by source of provider (3.3) Proportion of children (by age band), with fever in the past 2 weeks who received any antimalarial treatment by source of provider (3.4) Proportion of adults (>15 years) with fever in the past 2 weeks who received ACT, by source of provider (3.5) Proportion of adults (>15 years), with fever in the past 2 weeks who received ACT within 24 of fever onset by source of provider (3.6) Proportion of adults (>15 years) with fever in the past 2 weeks treated with any antimalarial by source of provider (3.7) Proportion of households in poor areas with one or more inhabitants with fever in the past 2 weeks treated with ACTs, by source of provider (3.8) Proportion of households in poor areas with one or more inhabitants with fever in the past 2 weeks who received ACT treatment within 24 hours of fever onset, by source of provider (3.9) Proportion of households in poor areas with one or more inhabitants, with fever in the past 2 weeks treated with any anti-malarial, by source of provider Notes: (a) These indicators will be disaggregated by the socio-economic status of households. Wherever feasible, measures of absolute poverty (based on country poverty lines) will be used in preference to measures of relative poverty (see Section 6.6. for rationale). Administrative areas may be classified based on relative poverty and sampled accordingly. Survey participants will be requested to provide self-reported responses to questions regarding household assets. For measures of relative poverty, either household income quintile or household wealth quintile will be used for disaggregation. (b) The indicators of use will also be disaggregated by provider compliance with prescriptions of correct dosages for the right duration, and by patient

[4] The independent evaluation will disaggregate "patients" in terms of those who report having had access to biological diagnosis of malaria (i.e., microscopy or rapid diagnostic tests (RDTs)) versus those who did not.
[5] The classification of ACT by quality assured vs. non-quality assured will be determined insofar as possible; self-reported results from household surveys will present a challenge.

Evaluation Questions	Indicators
	compliance with consumption of correct doses for the right duration.
Q 4.1 Has the AMFm mechanism helped increase the market share[6] of quality assured ACTs relative to all anti-malarial treatments in the public, private for-profit and not-for-profit sectors in rural/urban areas?	(4.1) Total volume of ACTs sold or distributed in the last week, as a proportion of the total volume of all anti-malarials sold or distributed in the last week, via outlets across sectors in rural /urban areas (by manufacturer) (4.2) Quantity of ACT procured by first line buyers ('unit' = boxes of ACTs by type and dosage)
Q 5.1 What are the plausible effects of the AMFm Phase 1 on ACT market dynamics (trends in, interactions among, and factors influencing demand, supply and price of ACTs) at the regional and global levels?	The Independent Evaluator will be responsible for defining the indicators, specifying data sources, conducting analyses and writing the report. The key conditions are that: (i) the methods must be endorsed by a group of independent reviewers *with world-class expertise and recognition in studies of market dynamics*, and (ii) the approach must not impose undue burden of data collection on the countries.
Q 6.1 This study will define functions, institutional and financial requirements for a potential global roll out of the AMFm, with emphasis on the following question: "What will it take to run a global phase of the AMFm?" It will identify options for managerial and institutional systems and structures for a potential global roll out of the AMFm.	The Independent Evaluator will be responsible for defining the indicators, specifying data sources, conducting analyses and writing the report. The key conditions are that: (i) the methods must be endorsed by a group of independent reviewers *with world-class expertise and recognition in institutional analysis*, and (ii) the approach must not impose undue burden of data collection on the countries.

Note: This table will be expanded further to specify the full definition (numerator and denominator) of each indicator by method of data collection (e.g., household/outlet survey).

[6] "Market share" here is defined in terms of a proportion of stocks in outlets, proportion of purchases based on exit interviews and proportion of treatments used as reported from household surveys, with the emphasis being on findings from household surveys. Stocks in outlets tell us what such outlets can dispense or sell; consumers can only buy what is available for sale. The findings must be interpreted with caution with regard to factors influencing stock levels and mix of products at retail outlets. Exit interviews can tell us whether or not ACTs are increasing as a proportion of purchases at those outlets. This is useful, but it does not tell the full story. Such data is from a self-selected sample (i.e. those who choose to use private drug shops). These interviewees differ in some ways, known or unknown, from those who do not use the private shops. By definition, the samples have a selection bias. A problem arises when one tries to analyze the data by socio-economic status (SES), part of the "reaching the poor" question. Data from exit interviews at private sector outlets help to answer the following question: *"What is the SES distribution of those who use anti-malaria treatment from private drug shops under study?"* It does not answer the following question: *"What is the SES distribution of those who use anti-malaria treatment from <u>any</u> source*?" In order to answer the latter, it is important to include data from household surveys, and from other facilities, in addition to private drug shops.