FINAL EVALUATION OF THE COMIC RELIEF GSK 'FIGHTING MALARIA, IMPROVING HEALTH' PARTNERSHIP

COMIC RELIEF

gsk

FINAL REPORT
Final Evaluation of the Comic Relief GSK 'Fighting Malaria, Improving Health' Partnership

Project	Final Evaluation of the Comic Relief GSK 'Fighting Malaria, Improving Health'
Evaluation period	2016 - 2021
Countries	Ghana, Tanzania, Sierra Leone, Mozambique, Cambodia, Laos and Myanmar
Region	Africa and Asia
Evaluation team	Dr Ngozi Akwataghibe, Team leader Dr Peter Hayombe, African Region Evaluation Advisor Dr Em Sovannarith, Mekong Sub-Region Evaluation Advisor Hubal Pfumtchum, Quality Assurance, project coordinator
Timing	August 2020 – July 2021

Oversee Advising Group (OAG)
info@myoag.org | www.myoag.org

10 July 2021

Acknowledgments

This report for the Final Evaluation of the Comic Relief / GSK 'Fighting Malaria, Improving Health' Partnership was developed by Dr Ngozi Akwataghibe, Team Leader; Dr Peter Hayombe, Africa Regional Coordinator; and Hubal Pfumtchum, Quality assurance, Project Coordinator - the core Evaluation Team of the Oversee Advising Group.

The Evaluation team appreciates the excellent support given by Comic Relief throughout the evaluation period. Our sincere thanks goes to Ruth Davison, CEO of Comic Relief and other Comic Relief staff whom we interviewed during the data collection phase of the evaluation. We are especially grateful to André Clarke and Lucie Graham for several meetings, reflections and clarifications that made the process easier for us. Our thanks also goes to Ben Sadek for his support especially relating to the advocacy and communications element of the Partnership. We also appreciate Rachel Karikari for ensuring that we had the documents needed during the analytical phase.

We appreciate the GlaxoSmithKline partners for the time they spent interviewing with us. Special thanks goes to Kerry O'Callaghan, Mark Bradely and Minne Iwamoto for their reflections and support during the evaluation period.

We are grateful to the national consultants – Dr Olufela, Dr Severin Kabakama, Ernest Chimuka - and Dr Em Sovannarith (the regional consultant for the GMS), for their valuable support during the data collection period and for their reflections in meetings which enabled us understand the different countries' contexts better.

Affirmation

The contents of this report are the sole responsibility of the Contractor and should not be construed as reflecting the views of Comic Relief.

Hubal Pfumtchum
Co-Founder, Oversee Advising Group (OAG)
info@myoag.org | www.myoag.org

Table of Contents

List of tables

List of figures

Acronyms

ACT	Artemisinin Combination Therapies
ADDOs`	Accredited Drug Dispensing Outlets
ADDRO	Anglican Diocesan Development and Relief Organization
ALMA	Alliance of Leaders
AMiF	Afya Micro-Finance Company
APHFTA	Association of Private Health Facilities in Tanzania
ARHR	Alliance for Reproductive Health Rights
AU	African Union
BBC	British Broadcasting Corporation
BMGF	Bill and Melinda Gates Foundation
BOI	Bank of Indicators
CEOs	Chief Executive Officer
CHAI	Clinton Health Access Initiative
CHWs	Community Health Workers
CMAM	Community Based Management of Acute Malnutrition
COVID-19	Corona Virus Disease 2019
CSO	Civil Society Organizations
DAC	Development Assistance Committee
DHIS-2	District Health Information System 2
DOC	Drivers of Change
GF	Global Fund
GHS	Ghana Health Service
GMS	Greater Mekong Sub-region
GSK	GlaxoSmithKline
GTS	Global Technical Strategy
HIV	Human Immunodeficiency Syndrome
HPA	Health Poverty Action
HSS	Health Systems Strengthening
IRC	International Rescue Committee
ISS	Sector Integrated Surveillance System
JHBSPH	Johns Hopkins Bloomberg School of Public Health
KCL	Kings College London
KGHP	Kings Global Health Partners
LC	Learning Coordinators,
LMICs	Low and Medium Income Countries
LSHTM	London School of Hygiene and Tropical Medicine
MCMOM	Malaria Case Management Operations Manual
MEL	Monitoring, Evaluation and Learning
MoHS	Ministry of Health Services
mRDT	Malaria Rapid Diagnostic Test
MSC	Most Significant Change
MTR	Mid Term Review
NGOs	Non-Governmental Organizations
NMCP	National Malaria Control Programmes
OECD	Economic Co-operation and Development
OOR	On Our Radar
OTSS	Outreach Training and Supportive Supervision

PAG	Partnership Advisory Group
PHC	Primary Health Care
PPE	Personal Protective Equipment
PSI	Population Services International
RDTs	Rapid Diagnostic Tests
RFP	Request for Proposals
SBCC	Social Behaviour Change Communication
SDG	Sustainable Development Goal
SISMA	Seismic Information System for Monitoring and Alert
SSI	Semi-Structured Interviews
T-MARC	Tanzania Marketing and Communications
TAP	Treat and Prevent malaria
TB	Tuberculosis
TCDC	Tanzania Communication and Development Center
ToC	Theory of Change
UK	United Kingdom
USAID	US Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction and Background

Comic Relief and GlaxoSmithKline (GSK) formed a five year £22million partnership to fight malaria and strengthen health systems in some of the countries most affected by the disease. Activities from 2016 to 2021 were jointly funded by GSK and Comic Relief, which contributed £17 million and £5million respectively to the Partnership. Comic Relief was in charge of grant management while communication and advocacy activities in the UK and in focus countries were jointly managed by GSK and Comic Relief. The Partnership awarded grants to 25 organisations on the frontline in four malaria-endemic countries in sub-Saharan Africa – Sierra Leone, Ghana, Tanzania and Mozambique - and three countries across the Greater Mekong Sub-region (GMS) – Cambodia, Laos and Myanmar. These grants supported diverse set of organisations, made up of international and local Non-Governmental Organizations, with each funded-partner delivering projects designed to meet different community and national needs in the fight against malaria. The core focus of the Partnership was to improve malaria control through health systems strengthening in four key pillars: 1) Supply of Good Quality Primary Health Care; 2) Demand for and access to Primary Health Care; 3) Better surveillance and Information Systems; and 4) Improved awareness of malaria and the work of the Partnership

This report is focused on the results of the final evaluation of the achievements and outcomes of the Partnership and Comic Relief's approach to grant making and management conducted from November 2020 to May 2021. The evaluation determined the **relevance and coherence** of the funded partners' projects in addressing the priority issues of malaria elimination and health systems strengthening; assessed the **effectiveness** of the Partnership in relation to the programme's intended outcomes; and the **sustainability** of the projects' efforts to tackle malaria and strengthen health systems in the focus countries; and reviewed the effectiveness of Comic Relief's grant making, **grant management and partnership approach.**

Methodology

A **pre-test/post-test approach** was used for evaluation. A cross-sectional, exploratory study using mixed methods, in focal Comic Relief-GSK project areas was conducted as the endline assessment. Baselines were constructed from the programme's information package including projects' monitoring data. Quantitative methods included secondary analysis of funded partners' monitoring data and available country level data in order to assess changes attributable to the project in terms of expected outcomes. Qualitative methods consisted of an extensive document review and Semi-Structured Interviews (SSI) with key partnership stakeholders including Comic Relief; GSK ; funded partners in the five geographies as well as government and private sector stakeholders.

Results

Relevance

The Partnership's coherence with global priorities was demonstrated by the degree of its alignment with the World Health Organization (WHO)'s Global Technical Strategy (GTS) 2016–2030. The non-prescriptive approach in grant making enhanced relevance at the country levels. Overall, the Partnership's funded projects addressed the contextual realities in the focal countries using tailored approaches and innovative tools and solutions to address the problem of malaria elimination and reduction. The scoping exercise by London School of Hygiene and Tropical Medicine (LSHTM) set the stage for this.

Effectiveness

Overall within the five years, over 6.3 million people were reached; with about 3,668,699 people benefitting directly from the Partnership. At the output and outcomes levels, majority of the projects showed consistent

progress across most of their quantitative indicators. There was evidence of effectiveness in achieving intended outcomes including increasing the number of people who accessed improved diagnostic services; improved quality of referral services and treatment services; and the number of health care providers with greater capacity to prevent, diagnose or treat malaria. By 2021, the number of people who had accessed improved diagnostic services in Tanzania, Sierra Leone, GMS and Ghana due to the Partnership's interventions was 1,659,301. Similarly, 969,172 people had accessed improved quality of treatment services across the programme's five focal geographies.

The programme also contributed to reduction in malaria prevalence in intervention areas. For instance, in Sierra Leone, malaria prevalence in Tonkolili was 68.3% in 2017. The 2020 malaria indicator survey conducted by the National Malaria Control Programme (NMCP), estimated malaria prevalence in Tonkolili at 35.2%. The Empowering Communities to Treat and Prevent malaria (TAP) project was implemented by Concern Worldwide in 25 out of 91 communities in Tonkolili and had a significant influence on community behaviour. Similarly, the prevalence of Malaria in Geita region of Tanzania was over 50% at baseline (2017) of the Association of Private Health Facilities in Tanzania (APHFTA) Malaria project and at endline in 2021 is now below 20%.

Top five achievements of the partnership include:

- **Improved capacity of health workers** in the public, private sectors and community levels and across the four pillars. This was seen as a key change by national and provincial government stakeholders and the funded partners and was attributed to extensive trainings and frequent supervisions supported by funded partners. By 2021, 4,046 community health workers including volunteers; 3,385 private sector health care providers and 2,768 Primary level government health staff had been trained by funded partners in the five geographies.
- **Increased awareness and knowledge of Malaria** leading to improved health seeking behaviour. Innovative Social Behaviour Change Communication (SBCC) strategies were implemented in all the countries. Community level approaches which amplified community voices saw some quick wins. By 2021, funded partners' monitoring data displayed 1,443,800 people with increased knowledge of malaria prevention, diagnosis and /or treatment; and 2,600,116 people applying their malaria prevention, diagnosis or treatment knowledge and demonstrating health seeking behaviour.
- **Private informal sector was strengthened and integrated better into the formal health system** by the Partnership. A core innovation of the Partnership was the work done with the private informal sector - partnerships with the formal private sector are more usual and integration of data from private sector into the public sector is atypical. The private informal (health) sector in several countries were strengthened by the funded projects – examples include private community providers in Cambodia; private outlet providers in Myanmar; accredited drug dispensing outlets (ADDOs) and autonomous laboratories in Tanzania; and licensed chemical sellers in Ghana. Capacities were built, referrals between private and public parties were improved; and information management and surveillance systems were strengthened. The integration of private sector data into public sector data was an important gap filled by the Partnership in some geographies including Tanzania, GMS and Ghana.
- **The Partnership showed some evidence of broader health systems strengthening**. In Sierra Leone, the NMCP scaled up International Rescue Committee (IRC)'s project from 38 to 100 pharmacies and used the model for other healthcare initiatives beyond Rapid Diagnostic Tests (RDTs) and the malaria sector. In Tanzania, the Clinton Health Access Initiative (CHAI) project influenced the NMCP to position the intervention for scale up via a Global Fund Application. The integrated approach - which led to the expansion of a new modified drug register introduced by CHAI beyond the four project intervention regions to seven more regions in collaboration with the NMCP and other partners - was a plus for health

systems strengthening. Capacity was also strengthened beyond the malaria sector. In Myanmar, Population Services International (PSI) worked in 16 project townships located along the Indian border where the government was not able to support. The project strengthened capacity of more than 850 community private providers in malaria and TB, HIV, Leprosy, Diarrhoea, and infectious diseases.

- **The Partnership's overall advocacy and communications strategy and activities enabled several achievements** - the communications strategy supported the communities in telling their own stories and sharing their own experiences. Through this the partnership created a over 70 case studies and a series of films all supporting the goal of spreading awareness. **The advocacy grants in particular, contributed to setting the malaria agenda** at national and international levels. The grants mobilized important political, social and (to a limited extent) financial **verbal commitments** from decision makers and political leaders. However, these had not yet been translated to significant national level policy change or release of funding to the sector by the end of the Partnership. **The advocacy efforts of the other funded partners seemed more effective in securing policy change and contributing to strategic direction in the various contexts.** For instance, PSI contributed to changes made to the Myanmar national malaria advocacy policy - a new advocacy policy for the national programme was introduced in order to raise funds through the regional advocacy workshop for Cambodia, Lao and Myanmar. The Community Based Management of Acute Malnutrition (CMAM) Surge approach used by Concern Worldwide in Sierra Leone was adopted in the country's next 5-year malaria strategy. It appeared that advocacy efforts yielded better outcomes when combined with implementation focused on the other three pillars. This may be because the evidence generated from project outcomes were more effective in convincing decision makers to take action.

Drivers of Change

The successes achieved in the five geographies have been through integrated efforts and mobilization of international and local resources, including collective learning driven research on malaria.

- The **integrated approaches** – were the most effective – these included projects that focused on febrile case management and not just malaria.
- Projects that were **already embedded** in the contexts especially due to long interaction with the NMCP before the Partnership achieved stronger outcomes.
- **Flexibility** of projects to address problems on the ground responsively enhanced effectiveness. For instance, projects were able to re-direct funds rapidly, to tackle emerging problems such as Dengue and COVID-19 outbreaks. This responsiveness was driven by the **flexibility of Comic Relief's grant management style**
- **Collaboration with government stakeholders** at national, regional and provincial levels was crucial in enabling transformation. Achieving a participatory process of generating evidence drove change.
- In the collaboration between Comic Relief and GSK, The **Partnership Advisory Group (PAG)** was an innovative model – it provided oversight, guidance and direction to the programme; and was a driving force of the Partnership.

COVID-19 limitations and adaptations

COVID-19 pandemic was a major challenge to project activities. This was especially the case for advocacy funded partners. Convenings, meetings were disrupted by the pandemic and the subsequent national emergency declarations in the different geographies. Also the pandemic created a distraction for many of the national, provincial and local government stakeholders. Ministry of Health staff became more focused on addressing the health challenges resulting from the pandemic and malaria ranked low on the priority scale. The funded projects adapted in different ways. Advocacy groups used online communications to

reach out to prospective targets. Funded partners collaborated with government stakeholders to respond immediately to the outbreak. Funded partners secured approvals from Comic Relief to re-assign their budgets to purchase emergency Personal Protective Equipment (PPE). The funded partner Health Poverty Action (HPA) was the first NGO to get PPE for malaria workers in their target areas in Cambodia. Kings College London (KCL) in Sierra Leone supported the reestablishment of the infectious disease unit built during Ebola time and quickly managed the COVID-19 testing with the laboratory staff in Connaught. In Ghana, Anglican Diocesan Development and Relief Organization (ADDRO) intensified their household visit strategy, sensitizing volunteers and project officers to implement this safely. ADDRO also received support from Comic Relief to help procure PPEs for facilities in their intervention communities, the Ghana Health Service, volunteers, and ADDRO staff.

Key Learnings and reflections

What worked well

The Partnership contributed to re-positioning the malaria agenda at national and international levels; advocated strongly for mobilizing funding for the malaria sector, stimulated research and development through its collective learning initiatives, improved access to cost-effective health interventions at country levels, supported national policy and strategies and strengthened the capacity of health service delivery. At the start of the COVID-19 pandemic with the lockdowns, the Partnership's adapted advocacy initiatives contributed to keeping malaria on the agenda in several focal countries in the face of shifted priorities.

The Partnership's strategy of starting with a **scoping exercise** carried out by an academic institution positioned it for success. The fact that scoping was carried out by a reliable third party increased its credibility. It set the stage for a **properly structured partnership** – designed intentionally to avoid several pitfalls recognized in literature.

The **flexibility of Comic Relief's grant management** including on the budget lines, **created space for the funded projects to provide innovative solutions** to emerging problems during implementation. This allowed the projects to adapt quickly and still achieve some milestones during the COVID-19 pandemic. This was a useful model as evidenced by funded partners who had other donor support and reported delays in months before they could achieve what they did with Comic Relief within weeks of the pandemic.

What could have been done better

Comic Relief's **non-prescriptive approach** to grant making allowed the individual projects in the partnership to adjust easily to contextual realities, thereby ensuring relevance; it also made them more flexible and responsive, However, it also had disadvantages: though the Partnership's Bank of indicators (BOI) reflected international standards, many of the funded projects in their choices used indicators that were not in the BOI and which also did not align with international standards. It is also **important to strengthen monitoring, evaluation and learning** within these kinds of partnerships. The BOI should have been used in order to achieve aggregation of outcomes which would have yielded more evidence of the overall outcome of the Partnership's initiatives and provided more lessons on what works or does not work.

The collective learning mechanism provided organisations with an opportunity to draw on the extensive pool of knowledge from across the Partnership portfolio of projects while boosting their own skills and knowledge around generating evidence relevant for their context and stakeholders. It was a good innovation and led to the development of several useful knowledge products. However, the success of that component was hampered because of the way it was structured. **The purpose, structure and potential benefits of the collective learning component should have been clearly defined and introduced to the funded partners at the time of the Request for Proposals**. This would have enabled the organizations to ascribe importance to it and assign the relevant resources (human and financial) and time to it.

There were many elements that provided opportunities for sustainability of the Partnership's initiatives. However, a barrier to sustainability is that **most of the funded projects did not have systematic exit strategies** and transition plans were not in place.

Conclusion

The collaboration between Comic Relief and GSK provides an example of a successful global health partnership – bringing together two different but complementary organizations who leveraged their collective strengths to achieve a common global health goal. The Partnership Advisory Group was an innovative model and a driving force of the Partnership.

The Partnership had a model of strong collaboration with governments including the National Malaria Control Programmes and embedded a number of its initiatives into existing structures within the health systems. Community level approaches made quick gains in the intervention areas due to amplification of community voices and empowered communities who took responsibility for action and displayed action oriented behaviour. Improved capacity of health workers in the public, private sectors and community levels and across the Partnership pillars was a solid achievement. The combination of this and the strengthening of surveillance systems, including the integration of data from the private sector into the public sector, led to some broader health systems strengthening. However, health systems strengthening was limited due to integral weaknesses within the health systems beyond the scope of the programme. There were potentials for sustainability but challenges as well. It is hoped that the momentum created by the Partnership will be maintained by the wide variety of stakeholders at national, district, provincial and community levels with whom the funded partners collaborated.

Recommendations

Target Audience	Recommendations
Comic Relief	1. Future partnerships should ensure that in the **Theory of Change** – the intersection between key pillars/domains and the assumptions which are tested are reflected clearly both in narrative text and in the TOC illustration. This will enable better understanding of the non-linear nature of the issues and set the stage for better harmonisation of funded projects. 2. **Collective Learning:** • Should be defined clearly, structured and introduced to applicants at the level of Request for Proposals (RFP) and embedded into their contracts with time and budgetary allocations. • Consider • the inclusion of collective learning products such as peer reviewed publications as deliverables linked to disbursements – this will motivate more commitment to the process by the funded partners. • Funded partner feedback mechanisms should be integrated into the collective learning process; and during implementation, the coordinators should ensure that feedback loops are always closed in order to maximize the utility. 3. **Review the project reporting template and make it more analytical**: Though most of the funded partners liked the light touch of the reports, Comic Relief could consider gaining more out of the annual reports by structuring the template with more critical analytical questions. This could also

	drive the learning agenda right from the first year of implementation – by adding questions that reflect on possibilities for collective learning and what themes the partners would be keen on collaborating on. 4. **Ensure better harmonization of funded partners and projects**: • We recommend budgetary allocation to a workshop with all the funded partners at the start of the Partnership. This will enable them to become acquainted with each other early enough in the Partnership. This may involve choosing an appropriate location they would all go to for a few days. It has the advantage that they could present their planned projects including the intervention areas and establish a network right from the start of the projects. • Consider more alignment of project intervention areas to ensure that different solutions are leveraged by different pillars. The discussions about how best the projects could be positioned within specific intervention areas to ensure better harmonisation could be held with national and local government stakeholders during the scoping exercise. 5. **Consider restructuring the learning coordination function:** Future partnerships should either 1) disaggregate the M&E role from the learning role and provide two different positions to relevant experts; or 2) Structure a comprehensive MEL role which incorporates building capacity of the funded partners throughout the Partnership as well as at the outset/initial planning stages. • For the M&E aspect, this will enable clearer understanding of the impact measurement of the overall programme; better use of the Partnership's M&E tools by the funded partners; and better choice of indicators for project monitoring. • Ensuring that the learning coordinators are focused entirely on the collective learning component would enable a quick kick off of the activities and probably better facilitation fo the process. 6. **Calls for advocacy concept notes and grants should be done at the same time as other funded projects**. During that time, it would be useful to review potentials for collaborations between advocacy grants and other funded projects.
GSK	**Future partnerships should leverage the Partnership Advisory Group model** for their operational and strategic processes. Effective communications between partners can be structured right from the start of the partnership: • Meaningful engagement and clear communication for the organizations to understand each other as quickly as possible. . For instance, clarity on different types of communications that would be expected; mapping out communications goals and objectives and being clear about the difference

	between organizations and the significance of that within the Partnership would enable clear understanding from the start.
Funded Partners	1. **The micro-financing strategies should be sustained**. However the private sector needs to be motivated with strategies that highlight their gain in order to continue. Extrinsic motivation can be enhanced through financial strategies that outlast the projects and intrinsic motivation via Associations and awards for contribution to health care in the public sector. 2. **Ensure you have an exit-strategy from the start** and a transition plan (Comic Relief should ask for this more explicitly at the beginning of the project). Exit strategies and transition plans should be **tailored to the contexts** and could include the following: • Beyond collaboration with the NMCP stakeholders at national levels, ensure that project initiatives are anchored at the local government (district and provincial) levels. The capacity built at the provincial level in the CUAMM project in Mozambique enabled the government stakeholders to continue some of the project activities after the project's exit. • Secure additional institutional (including NMCP) support to explore the possibility of initiatives involving community stakeholders such as young advocates to register as non-profit organizations; and provide fundraising training before the funded projects' exit. • Connect community champions and change agents to networks. For instance, networking meetings with civil society organisations, non-governmental organisations, and government agencies can be organized to link change agents and community champions with local networks they can work with beyond the projects' lifespan.
Other existing and potential donors – for future funding opportunities	We recommend **a review of the CR/GSK Partnership model as a best practice example** in Global Health Partnerships. Several elements should be put into consideration while structuring such partnerships: 1. The partnerships should be long-term (preferably not less than five years); 2. Scoping studies at the start will position programmes for relevance and coherence with the contexts. A good strategy would be to prioritize organizations that are already established within the contexts for funding; but it is important to ensure that other partners that have the potential to work well within the contexts are also considered. 3. Flexibility in grant making creates an enabling environment for innovative solutions; 4. A partnership advisory group supports strategic direction, enables clear communications and drives success.

	5. Organizations should maintain an awareness that strategic shifts may occur over the long term and build in the flexibility to ensure that the partnership goal is kept in focus. 6. Collective Learning is a good strategy; has the possibility of contributing to the evidence base and generating knowledge / learning products for advocacy. However, it should be structured properly and introduced early in the programme.

1. INTRODUCTION

Comic Relief is a large United Kingdom (UK) grant maker whose aim is to create a just world that is free from poverty. As one of the world's leading healthcare companies, GlaxoSmithKline (GSK) has for decades worked to improve health globally and reduce the impact of diseases that disproportionately affect the poorest people in the world. Together, they formed a five year £22million partnership to fight malaria and strengthen health systems in some of the countries most affected by the disease. Comic Relief and GSK believe that one of the best ways to fight malaria is to help strengthen local and national health services and improve their ability to combat the disease. The expectation is that once the spread of malaria is controlled, its devastating impact on health systems will diminish, i.e. health systems will be less stretched as the burden of malaria reduces, so that resources are more readily available for other key drivers of poor health. These, in turn, will lead to better overall health for people living in poverty; and whole communities will have the chance to thrive.

Activities from 2016 to 2021 were jointly funded by GSK and Comic Relief, which contributed £17 million and £5million respectively to the Partnership. Comic relief was in charge of Grant management while Communication and advocacy activities in the UK and in focus countries were jointly managed by GSK and Comic Relief. The Partnership awarded 27 targeted grants to 25 organisations on the frontline in four malaria-endemic countries in sub-Saharan Africa – Sierra Leone, Ghana, Tanzania and Mozambique - and three countries across the Greater Mekong Sub-region (GMS) – Cambodia, Laos and Myanmar. These grants supported diverse set of organisations, made up of international and local Non-Governmental Organizations (NGOs), with each funded-partner delivering programmes designed to meet different community and national needs in the fight against malaria. Beyond grant making, the partnership aimed to inspire global action on malaria by sharing compelling stories of impact and empowering a generation of advocates.

Over nine million people were reached by the Partnership, with an emphasis on targeting women and children under-5 as well as on frontline health workers; and an overarching view of strengthening health systems.

2. BACKGROUND

This section describes the Partnership, specifically the intervention logic and theory of change, the four key Partnership elements, funded partners and their projects.

2.1 The intervention logic of the Programme

The design of the Partnership and its embedded Theory of Change (TOC) are consistent with existing evidence at global, regional and country levels. This evidence-based focus of the intervention logic and the emphasis on understanding the local contexts enabled initiatives that were aligned with national priorities and local realities. The Partnership TOC was developed by Comic Relief and GSK and was informed by the London School of Hygiene and Tropical Medicine (LSHTM) Scoping review and exercise. The stakeholders assessed how the Partnership could best complement and enhance access to healthcare and current malaria interventions in malaria endemic countries. The core focus of the Partnership was to improve malaria control through Health Systems Strengthening. With that in view, LSHTM recommended investing in packages of interventions that address malaria control via four key pillars:

Pillar One: Supply of Good Quality Primary Health Care

Pillar Two: Demand for and access to Primary Health Care

Pillar Three: Better surveillance and Information Systems

Pillar Four: Improved awareness of malaria and the work of the Partnership

The TOC was illustrated in detail and is displayed in figure 1 below:

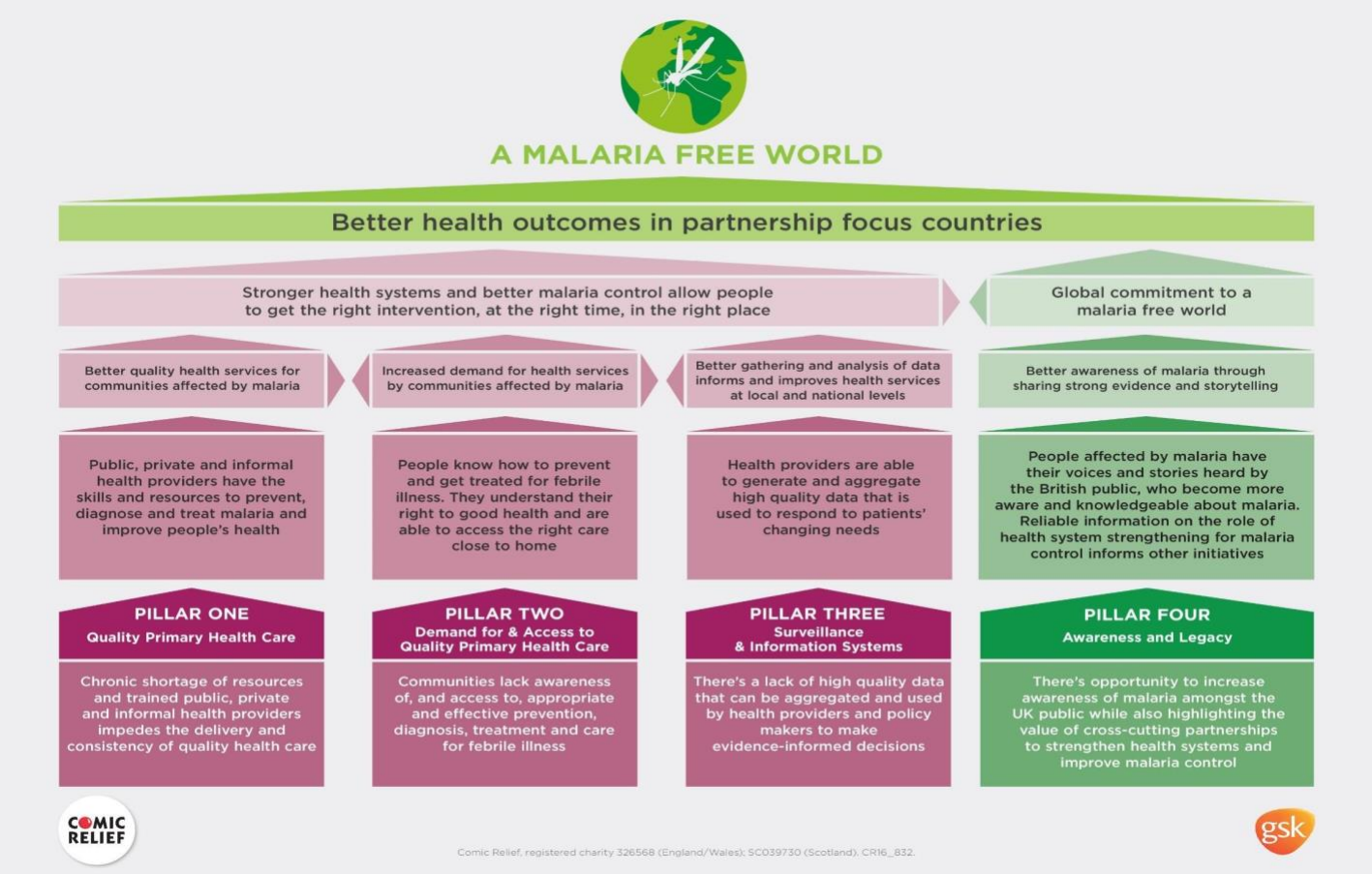

Figure 1 Partnership Theory of Change

It is noteworthy that the TOC did not show the links between the pillars - in order to display the non-linear nature of the issues being addressed. However, funded partner projects were encouraged to address more than one pillar, which displayed an understanding that in practice the pillars were intertwined to a considerable extent. The key assumptions of the TOC were also not detailed.

The Partnership was designed to achieve the outcomes in its TOC through four key elements:

a) **Grant making and Management** - The Partnership provided strategically targeted grants cutting across all four pillars in the TOC, to several organizations. The main focus in grant making was in supporting projects that worked across individual and community levels, with some projects also aiming to influence decision and policy makers at district or national levels.

b) **Monitoring, Evaluation and Learning (MEL) within and across grants** – The Partnership emphasized a MEL approach to enable effective and sustainable delivery. Learning Coordinators provided direct MEL support and capacity building to funded partners (during the start up phase of the programme) and facilitated collective learning (and documentation) both within the five geographies and across thematic areas.

c) **Brand and Communications** - The communications strategy aimed to represent and amplify community voices and using a storytelling approach conveyed messages relating to the Partnership and malaria advocacy to key UK audiences.

d) **Advocacy and Awareness legacy**- Advocacy was an integral element of the Partnership and aimed to highlight the value of the Partnership model in addition to active malaria prevention and control promotion. A key aim was to empower and amplify the voices of communities affected by malaria to raise awareness of the need for malaria control and the Partnership's success stories.

2.2 Funded Partners and their Projects

A summary table of the funded partners and their project areas are presented in Table 1. Annex 1 details the funded partners, highlighting the funding received and the duration of the grants.

Table 1 : Funded partners

Country / Region	Funded Partners
GMS	Malaria Consortium; PSI; HPA
Sierra Leone	IRC; On our Radar; BBC Media Action; Kings Global Health Partners; Restless Development; Health Poverty Action
Tanzania	T.MARC; APHFTA; ALMA; CHAI; TCDC
Ghana	ADDRO; Results UK; Speak Up Africa; ARHR
Mozambique	PIRCOM; CUAMM; MANHICA; *NWETI*

3. GOAL, OBJECTIVES, DESIGN AND SCOPE OF THE EVALUATION

3.1 Overall Purpose of the Evaluation

The purpose of this evaluation was to assess the achievements and outcomes of the Partnership and to assess Comic Relief's approach to grant making and management. To do this, the evaluation focused on addressing the following four objectives:

3.2 Evaluation objectives

- Determine the **relevance and coherence** of the funded partners' projects in addressing the priority issues of malaria elimination and health systems strengthening
- Understand the **effectiveness** of the Partnership in relation to the programme's intended outcomes
- Assess the **sustainability** of the projects' efforts to tackle malaria and strengthen health systems in the focus countries
- Evaluate the effectiveness of Comic Relief's grant making, **grant management and partnership approach**

3.3 Key Evaluation Questions

The key evaluation questions are detailed in Annex 2

4. EVALUATION APPROACH AND METHODOLOGY

4.1 Evaluation design

A **pre-test/post-test approach** was used for evaluation. We conducted a cross-sectional, exploratory study using mixed methods, in focal Comic Relief GSK project areas as the endline assessment. We (re)-constructed baselines where available from the projects' monitoring data. The evaluation questions for the

end-line study are elaborated in the evaluation framework in Annex 3, and were derived from the evaluation TOR, meetings with Comic Relief and the inception webinars with funded partners.

4.2 Evaluation methods

We used mixed methods to answer the evaluation questions.

Quantitative methods – We conducted secondary analysis of funded partners' monitoring data and available country level data in order to assess changes attributable to the project in terms of expected outcomes.

Qualitative methods – This consisted of an extensive Document review and Semi -Structured Interviews (SSI) with key partnership stakeholders - Comic Relief; GSK ; funded partners in the five geographies as well as other relevant partners (government and private sector stakeholders; young researchers/advocates etc.). The SSI were used to explore if the programme worked in the different contexts and with the planned implementation structures and processes. We explored the uptake of the funded projects' interventions; as well as the facilitators and barriers to projects' effectiveness.

Most Significant Change (MSC) tool - The MSC tool focused on the directions and changes as valued by the various stakeholders. Stakeholders selected the changes which were appreciated from their own perspectives. We used story telling of stakeholders answering the key question: "looking back over this period, in your perception, what do you think the most significant change was in the fighting malaria partnership or funded projects?"

5. SAMPLING, DATA COLLECTION AND ANALYSIS

5.1 Sampling Strategy

The evaluation team adopted a non-probability sampling method to select respondents from all levels based on availability and level of involvement in the Partnership. For the SSI, we carried out purposive sampling using the criteria of function, location etc. Partnership stakeholders including funded partners were recruited with the help of their respective organizations – we aimed to recruit those who were considered most knowledgeable about the Partnership or project activities and outcomes; and where applicable, those who have stayed longest on the Partnership or projects. We selected government and private sector stakeholders, based on the criteria of level of interaction with the funded partners. We aimed to interview at least one National Malaria Control Programmes (NMCP) stakeholder in each geography in addition to one regional or provincial government stakeholder; where relevant, parliamentarians were sampled. A total of 58 stakeholders were interviewed. Annex 5 provides the details of the sampled participants.

5.2 Data collection

Data collection was carried out by the Evaluation team lead, the Africa and GMS regional coordinators; and the national consultants and took place from November 2020 to March 2021. Data was collected from a wide variety of stakeholders - Comic Relief, GSK, Funded Partners, Learning Coordinators; Government including, NMCP, provincial and district level stakeholders; stakeholders from the private (informal) sector; and Youth advocates or young researchers. The interviews were carried out using topic guides (detailed in Annex 4) and most were conducted via virtual platforms. Where feasible, national consultants held face-to face interviews. Informed consent was obtained before the SSI and the interviews were all audio-taped and transcribed. In compliance with Comic Relief research policy, the study was designed and conducted in a manner that respected and protected the rights, confidentiality, impartiality, privacy, accountability, respect and welfare of respondents.

5.3 Data analysis and triangulation

The secondary data analysis of the funded projects' data was carried out and while attribution of outcomes in the intervention areas could not be ascribed solely to the projects' activities and outputs, we were able to explore and establish causality at contribution level. This was done by establishing pathways to change which linked directly to projects via triangulation of the information from the secondary data analysis with qualitative interviews from NMCP and other government stakeholders as well as funded partners. Qualitative transcripts were analysed using an inductive approach and open thematic coding. Transcripts were read and coded using common themes and sub-themes according to the evaluation framework. Analysis was conducted iteratively using a three-pronged approach: "noticing, collecting, and thinking[1]". During analysis, cross thematization was used to compare the emerging information with secondary data and document analysis; and data from all three sources were triangulated.

6. RESULTS

The findings from the evaluation are presented according to the evaluation objectives.

6.1 Relevance and Coherence

6.1.1 Alignment with Global Strategies and Priorities

The Partnership was intentionally structured to meet these Organisation for Economic Co-operation and Development / Development Assistance Committee (OECD/ DAC) criteria. The strategy of the Partnership was to integrate efforts with existing global, national and local initiatives in order to improve malaria control via health systems strengthening. The Partnership's coherence with global priorities is demonstrated by the degree of its alignment with the World Health Organization (WHO)'s Global Technical Strategy (GTS) 2016–2030.[1] In describing the need for a post-2015 technical strategy, the GTS stated that *"malaria interventions are highly cost-effective and demonstrate one of the highest returns on investment in public health. In countries where the disease is endemic, efforts to reduce and eliminate malaria are increasingly viewed as high-impact strategic investments that generate significant returns for public health, help to alleviate poverty, improve equity and contribute to overall development."* The direction of the Partnership's funds towards malaria elimination in seven focal countries was highly relevant to this call for global action. Furthermore, the GTS identified three pillars that buttress strategies for malaria elimination including ensuring access to malaria diagnosis and treatment; accelerating efforts towards elimination of malaria; and transforming malaria surveillance into a core intervention. Funded partners' interventions in the Partnership addressed all these elements.

6.1.2 Alignment with Regional and National Strategies and Priorities

The WHO encouraged that the GTS pillars could be tailored to national and sub-national settings to increase the effectiveness of elimination programmes.[1] In order to adapt the GTS to the African context, the Framework for implementing the Global Technical Strategy for Malaria 2016–2030 in the African Region[2] was developed. Similarly in the GMS, the Strategy for malaria elimination 2015–2030[3] was developed. Both frameworks recommended alignment of strategies with contextual realities.

The Partnership's non-prescriptive approach in grant making enhanced relevance at the regional and country levels. For instance, it is well documented that malaria transmission in the GMS is mostly seen in remote areas such as forest areas and communities who live and depend on the forest, such as migrant workers and subsistence farmers.[4], [5] The Partnership's GMS funded projects were mainly focused on those areas, many of which were not reached by the weak health systems.

[1] Seidel J V. Qualitative data analysis. Qualis Research. 1998.

"In addition, our health system is still not fit into the demand of community and their requirements. HPA's project has been responding well to the existing gaps which the national malaria control programme could not respond to effectively, including establishing the remote surveillance along the border to Lao and Vietnam in order to effectively cover tracing malaria cases as well as forest workers." **NMCP stakeholder, Cambodia**

Overall, the context of the GMS countries appeared to have ensured a greater level of relevance and coherence with the national priorities and programmes. In order to avoid duplication of efforts, the government seemed to maintain a tight control over which intervention areas and project activities were approved. A quote from a funded partner illustrates this:
"*We have worked in other countries, including in Sub Saharan Africa and in Latin America. And one of the distinctions around the malaria work we have here in Southeast Asia is that it is very closely partnered with the government, everything is approved, everything is centrally managed.*" **Funded Partner, HPA, Laos and Cambodia**

Overall, the Partnership's funded projects used tailored approaches and innovative tools and solutions to address the contextual realities of malaria elimination and reduction.
The scoping exercise by LSHTM set the stage for this in several ways:

- Contextual issues related to the five geographies were captured and gaps in malaria prevention and control were identified both through the scoping review and via in-country consultations with national stakeholders.
- The scoping researchers also examined the landscape of the countries – identifying potential partners for funding. These organizations were then invited to submit concept notes or applications for grants.
- Essentially, the scoping research identified key areas where the Partnership funding could make a difference and how relevance could be achieved. Concept notes and proposals for grants which were selected for funding were initiatives which would not be implemented in silos but would support health systems.
- During scoping, insights on the Partnership's TOC pillars were also tested with various national government stakeholders.

Funded projects had a systematic and detailed process of engagement and working with a broad range of government stakeholders

- Funded partners collaborated with a wide variety of stakeholders including NMCP implementers, policy makers, parliamentarians, presidents and first ladies.
- There was also a high level of integration of the funded projects with other donor funded projects within the countries especially Tanzania and GMS. Also at the provincial level, in Mozambique, a funded partner was integrated in the platform of groups of partners working in the health area at the level of the province of Nampula. This forum was coordinated by the provincial health directorate.

Funded projects exerted influence on policy and strategic direction at national levels
Several funded projects were successful at influencing policy changes and strategic directions within the national malaria control programmes and the ministries of health:

- The Private Sector Integrated Surveillance System (ISS) implemented by several funded projects (CHAI, APHFTA, TCDC, T-MARC) and other donor projects in Tanzania was so effective that it

influenced malaria strategic direction. Collective learning in Tanzania produced a **policy brief** based on the outcomes of the project and used this as an advocacy tool, recommending the nationwide roll out of the ISS. During the Stakeholders' Buy-In Meeting held in Dar Es Salaam on 21st February 2020, the government stakeholder described the value of the work done by the Partnership.

> "*The National Malaria Control Programme (NMCP) is so pleased with innovation that the Comic Relief and GlaxoSmithKline funded partners have come up with - a designed integrated surveillance system…The product is well aligned with the NMCP's current strategy as it has upgraded surveillance to become a core intervention together with malaria case management and vector control.*" - **NMCP Deputy Programme Manager, Tanzania.**

- Population Services International (PSI) contributed to changes made to the Myanmar national malaria advocacy policy - a **new advocacy policy** for the national programme was introduced in order to raise funds through the regional advocacy workshop for Cambodia, Lao and Myanmar.
- The Community Based Management of Acute Malnutrition (CMAM) Surge approach used by Concern Worldwide in Sierra Leone was **adopted in the country's next 5-year malaria strategy**. "*We collaborated very closely with the ministry to make sure that we were all still on the same page with the priorities. And that has been evidenced by the fact that our approach has been included in their next five-year strategy.*" - **Funded Partner, Concern Worldwide Sierra Leone**.
- Malaria Consortium (MC) established a **coordination mechanism between two vertical programmes** (Disease Control/NMCP and Public Health/Child Health) under the Ministry of Health Services (MoHS), Myanmar that allowed an operational framework to introduce integrated services to Malaria Volunteers (MVs), ensuring ownership from both departments.

6.2 Effectiveness

This section details the progress made against outcome indicators, key achievements of the Partnership through the funded projects including the advocacy grants; the Drivers of Change (DOC); the MSC according to the stakeholders and the COVID-19 pandemic adaptations and issues.

6.2.1 Projects' Outcomes

Overall, according to the monitoring data, the programme reached about 6,313,602 individuals; and 3,668,699 people benefitted directly from the Partnership. Figure 2 shows the details. In this section, we focus on the outcome indicators 1 and 2 from the aggregated data, however the subsequent section on the Partnership's achievements highlight other outcome indicators.

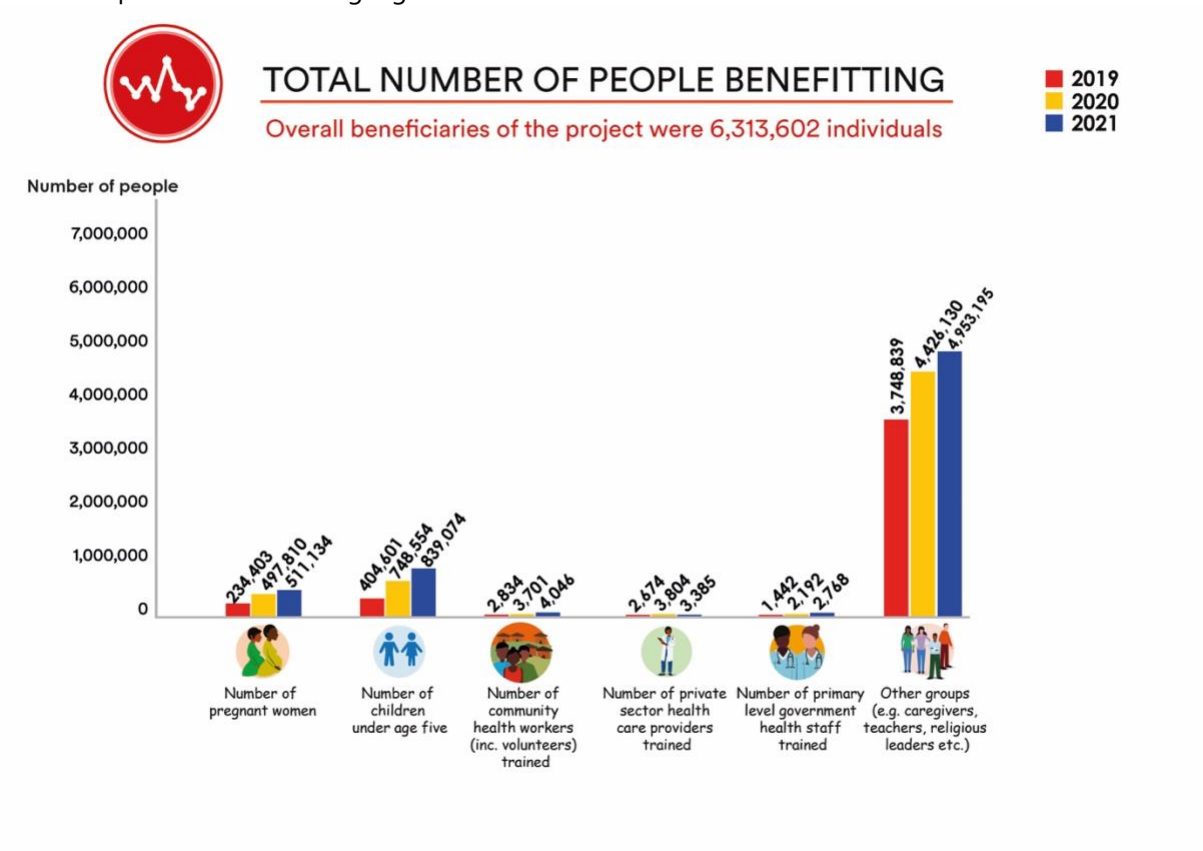

Figure 2 - Number of people who benefitted from the Programme

At the output and outcomes levels, majority of the projects showed consistent progress across most of their quantitative indicators. Some indicators with more aggregated outcomes are highlighted in this section. Figure 3 displays the performance of outcome indicators 1.1 -1.5.

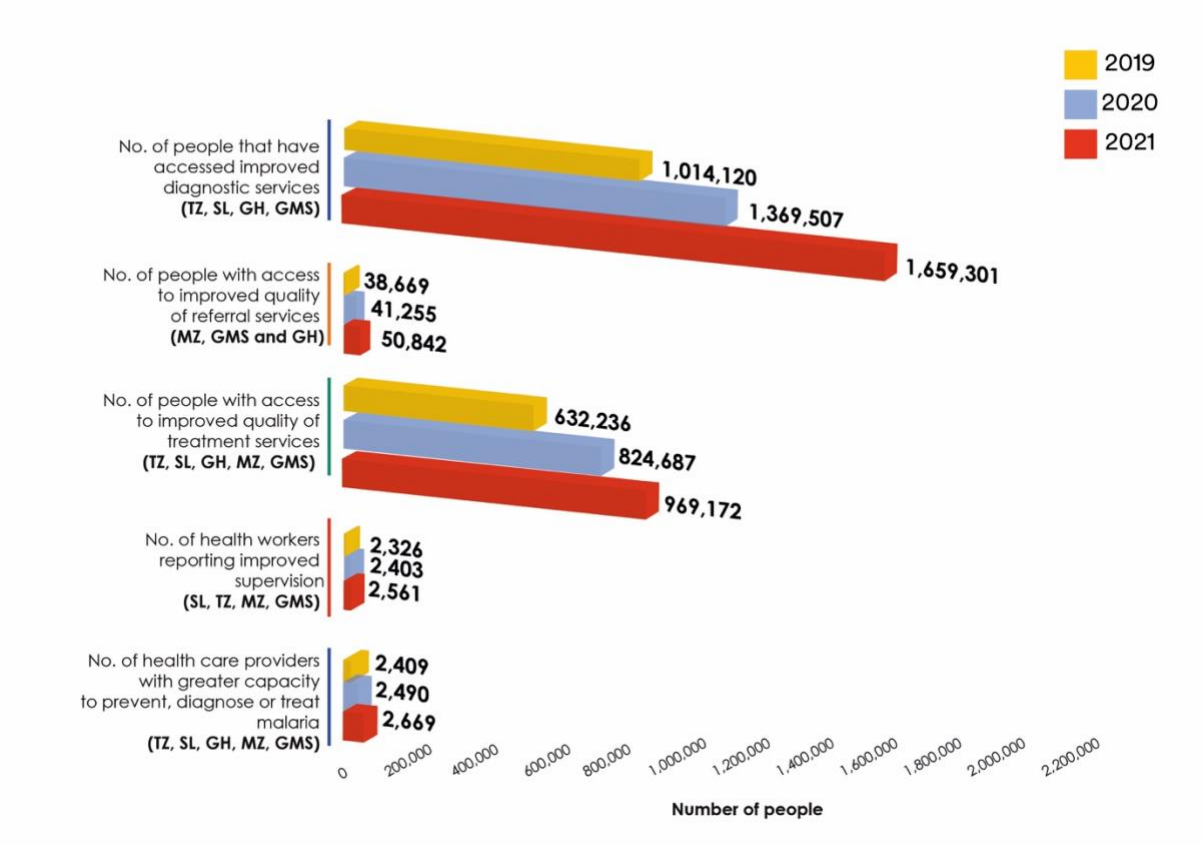

Figure 3 - Performance of outcome indicators 1.1 -1.5

Outcome Indicator 1.1 - Number of people that have accessed improved diagnostic services

The global malaria morbidity and mortality rates in many countries continue to be high despite a wide coverage of malaria interventions. Reducing mortality through prompt diagnosis and treatment is thus the cornerstone for the control of malaria - by taking advantage of the simple-to-perform malaria rapid diagnostic test (mRDT) and highly efficacious artemisinin combination therapies (ACTs).[6] Prompt access is fundamental to the reduction of malaria mortality among children <5 years of age and as recommended by WHO, prompt treatment should be sought within 24 hours of the onset of fever and anti-malarial medicines taken after confirmation of malaria using appropriate diagnostic tests.[7]

Outcome indicator 1.1 was implemented to increase the proportion of the population that had access to improved diagnostic services. Figure 3 presents the indicator performance across four geographies; Tanzania, Sierra Leone, Greater Mekong Subregion (GMS) and Ghana. This indicator was implemented by six funded partners - CHAI, APFTA, KCL, HPA, PSI and ADDRO. In 2019 a total of 1,014,120 people had access to improved diagnostic services and by 2021 they had reached a cumulative total of 1,659,301.

In the qualitative interviews, the achievements in this outcome indicator were attributed to the increased knowledge among health care providers of the national malaria diagnosis and treatment guidelines, increased availability of the testing kits and anti-malaria drugs in health facilities and the regular supportive supervision provided through the Partnership.

Outcome Indicator 1.2 - Number of people with access to improved quality of referral services

Monitoring implementation of the "test and treat" case-management policy for malaria is an important component of all malaria control programmes in Africa and beyond. Unfortunately, routine information systems are commonly deficient to provide necessary information.[8] An effective case management strategy

requires that appropriate measures be taken to ensure access to appropriate, effective treatment at each level of health care, including the private sector and communities, as close to the patients as possible. Further, the Malaria Case Management Operations Manual by WHO highlights that it is important to use standard treatment guidelines, the availability and delivery of effective antimalarial medicines, health education and training and monitoring of clinical staff at all levels of health care delivery.[9]

Outcome indicator 1.2 was implemented in Mozambique, GMS, Sierra Leone, Tanzania and Ghana by CHAI, MC, HPA, IRC, Nweti and ADDRO . In terms of performance, there was no indicator at the endline which exceeded or reached the target score. The findings however demonstrated that the number of people reached at the endline was significantly high compared to the baseline scores. In 2019 a total of 38,669 people had access to improved quality of referral services and by 2021 they had reached a cumulative total of 50,842.

Outcome Indicator 1.3 - Number of people with access to improved quality of treatment services

The quality of malaria care remains poor and varies widely in endemic low and medium income countries (LMICs). The identified challenges include prescription of treatments regardless of malaria test results, suggesting that presumptive diagnosis is still commonly practiced among cases of suspected malaria, rather than the WHO recommendation of 'test and treat.' [10,11] To reach the 2030 global malaria goal of reducing mortality rates by at least 90%, there is the need for more focus on improving the quality of malaria care. Surprisingly, there is meagre literature on the extent to which poor quality care impedes the reduction of malaria mortality – this is partly because of the poor documentation about the quality of malaria care in LMICs.[11] However few studies have examined these issues[12,13,14,15,16,17] though there is poor comparability of the quality of care data across countries. However, it is clear that perceived and actual quality of care administered at all levels of health care are major determinants of health outcomes and consumer's choice of treatment provider. Studies indicate that health services from both public and private providers in LMICs are of questionable quality, with long waiting times, inaccurate diagnosis, inappropriate prescription and advice and frequent drug stock-outs.[12-17,18]

Outcome indicator 1.3 included interventions implemented to try and improve the quality of malaria care. in the five geographies. The commitment of agencies and institutions on improving the quality of malaria treatment is evident from the number (12) of funded partners that implemented this outcome indicator in the Partnership: ADDRO, ARHR, PSI, HPA, CUAMM, Nweti, APHFTA, CHAI, T-MARC, Concern, KCL and HPA in all the five geographies. In 2019 a total of 632,236 people had access to improved quality of treatment services and by 2021 they had reached a cumulative total of 969,172.

Indicator 1.4 - No. of health workers reporting improved supervision

Improving the quality of malaria case management and diagnostic services is essential if health outcomes are to be significantly improved. One way doing this as implemented by many organizations and partners cross the globe include outreach training and supportive supervision (OTSS) programme which seeks to promote quality within and across health facilities by strengthening communication and relationships, focusing on the identification and resolution of problems, helping to optimize the allocation of resources, and empowering health providers to monitor and improve their own performance. Similar to OTSS programme, outcome indicator 1.4 included a component of strengthening the quality of malaria case management through health worker supervision. In 2019 a total of 2,326 health workers reported improved supervision and by 2021 they had reached a cumulative total of 2,561. The indicator was implemented in four countries Sierra Leone, Tanzania, Mozambique and GMS by eight funded partners - IRC, CUAMM, CHAI, Manhica Foundation, MC, HPA and PSI - and the performance is displayed in figure 3 above.

Outcome Indicator 1.5 - No. of health care providers with greater capacity to prevent, diagnose or treat malaria

One key factor to the success and sustainability of a national malaria control programme is the organizational and management capacity of the program. Management capacity includes health workers' ability to offer quality care to malaria clients by meeting the expected standards and ensuring that relevant infrastructure for diagnosis and treatment of malaria is in place.[19] Despite such interventions to improve the management capacity, developing countries' health systems however still face a challenge of health workforce capacity. Outcome indicator 1.5 therefore includes interventions to improve capacity of health care providers to prevent, diagnosis and treat malaria. In 2019, 2409 health care providers reported greater capacity to prevent, diagnose or treat malaria (see figure 3) and by 2021, that number had reached 2669. The programmes were implemented in the five geographies.

Outcome Indicators 2.1, and 2.2 measured knowledge increase and its demonstrable application / behaviour change respectively. The performance of both indicators is illustrated in figure 4.

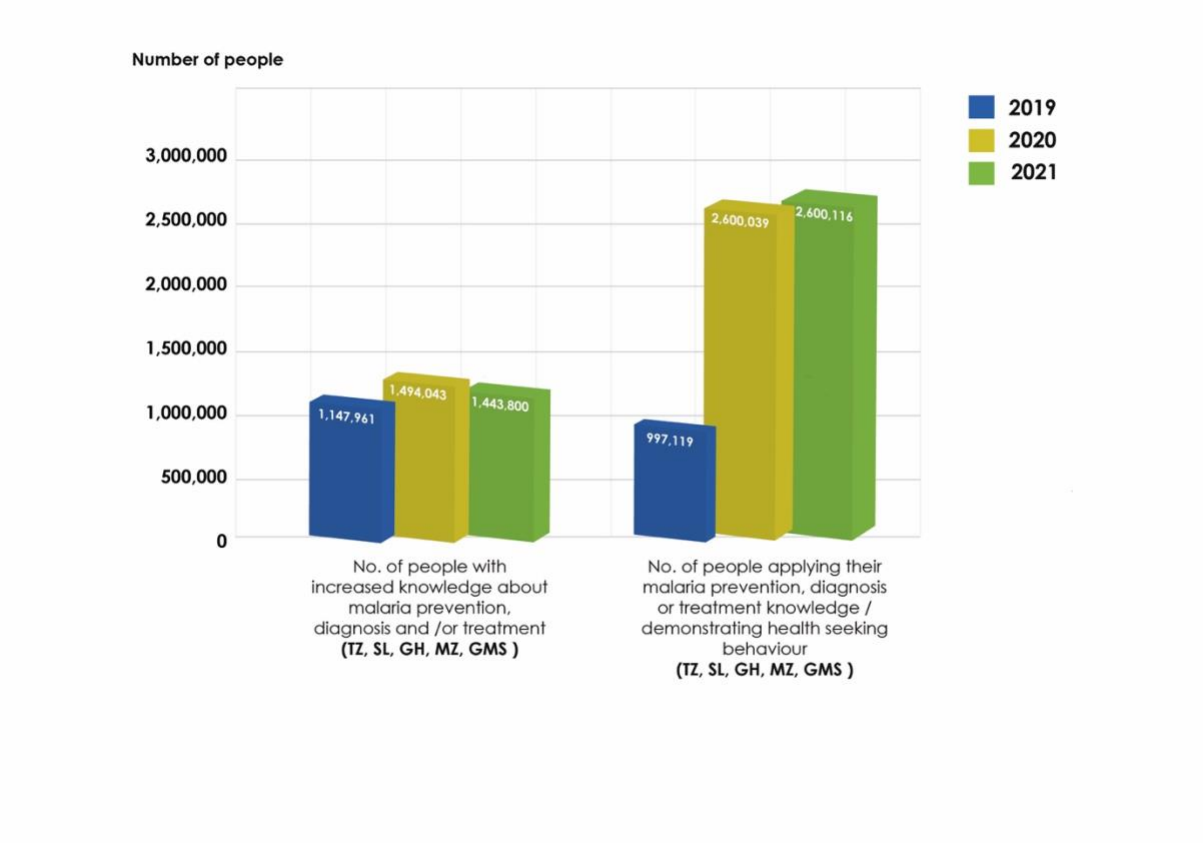

Figure 4 - Performance of outcome indicators 2.1 and 2.2

Outcome Indicator 2.1 - Number of persons with increased knowledge about malaria prevention, diagnosis and /or treatment

WHO estimated that 228 million cases and 405,000 malaria-related deaths occurred in 2018. Improving knowledge of malaria causes and symptoms, and the overall perception towards malaria and its preventive measures is thus vital for malaria control. Unfortunately, there are inconsistent and conflicting reports regarding the levels of malaria knowledge and associated factors worldwide.[20] WHO also documented that having a good knowledge regarding malaria causes, signs and symptoms, mode of transmission and preventive measures led to the use of malaria prevention strategies and improved health-seeking

behaviour.[21] Moreover, successful malaria elimination requires active engagement and participation of communities to recognize malaria symptoms and the development of prompt treatment-seeking behavior for early diagnosis and appropriate treatment.[22] Interventions to increase knowledge about malaria prevention, diagnosis and treatment were implemented across the five programme geographies and figure 4 illustrates the indicator performance. The number of people with increased knowledge about malaria prevention, diagnosis, and or treatment in all the geographies increased from 1,147,961 in 2019 to 1,443,800 by 2021. The decline between 2020 and 2021 were ascribed partly to population fluctuations in the GMS intervention areas due to COVID-19.
Figure 5 highlights the example of BBC Media Action in Sierra Leone.

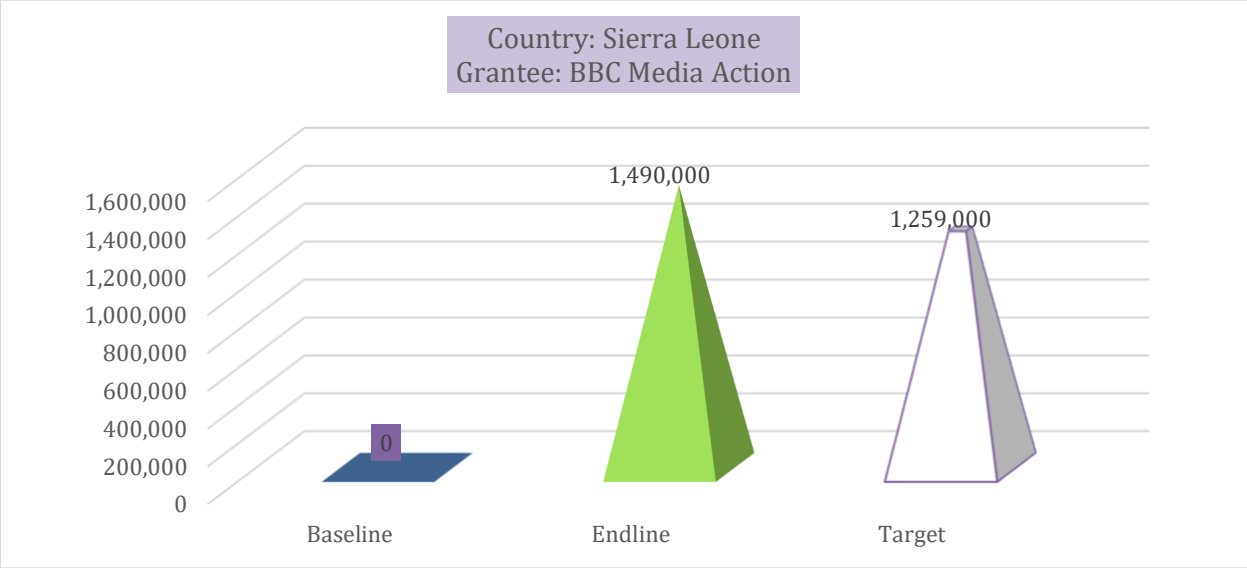

Figure 5 - Adult population in Sierra Leone who could recall hearing BBC Media Action radio spots

As shown in figure above, the adult population in Sierra Leone who could recall hearing BBC Media Action radio spots was 1,490,000. This was higher than the target population of 1,259,000 people. This demonstrated the reach of the key messages. Correspondingly, in one of the Sierra Leone funded projects (HPA), 31,762 people knew where to access a malaria test and the recommended anti-malaria drugs which was more than the targeted 22,301 – displaying effectiveness of funded partners' sensitization strategies.

Outcome Indicator 2.2 - No. of people applying their malaria prevention, diagnosis or treatment knowledge/demonstrating health seeking behaviour

Early treatment seeking is believed to be a critical behaviour that influences the success and sustainability of malaria control effort.[23] However, literature has documented very slow progress in this perspective, unlike the achievements of prevention (vector control), due to a number of reasons such as; healthcare inaccessibility, inadequate knowledge and poor attitude towards malaria, poor socio-economic status, rural residence and accessibility to trained providers. The programme interventions to increase the proportion of people applying early treatment or health seeking behaviors for malaria were implemented in the five geographies. Interestingly more people demonstrated health seeking behaviour than number of people with reported increased knowledge of malaria. This indicator was implemented in all the five geographies by 13 funded partners - CUAMM, PIRCOM, Nweti, Manhica Foundation, MC, HPA, TCDC, AFPHTA, Concern, Restless Development, T-MARC, PSI, and BBC Media Action. By 2021, funded partners' monitoring data displayed 2,600,116 people applying their malaria prevention, diagnosis or treatment knowledge and

demonstrating health seeking behaviour increased from 997,119 to 2,600,116 (see figure 4). This is likely because not all funded partners who used outcome indicator 2.2 for their measurements, also used 2.1.

Contributions to the reduction in malaria morbidity and mortality

There was evidence of reduction in malaria morbidity and mortality across the Partnership intervention areas in the five geographies. Where available, country level data showed the contribution of the Partnership. E.g., in Sierra Leone, malaria prevalence in Tonkolili was 68.3% in 2017. The 2020 malaria indicator survey conducted by the NMCP, estimated malaria prevalence in Tonkolili at 35.2% (see Figure 6). The Empowering Communities to Treat and Prevent malaria (TAP) project was implemented by Concern Worldwide in 25 out of 91 communities in Tonkilli and had a significant influence on community behaviour. The TAP project directly affected 16189 women and children; and 412 health workers. It also coincided with the Zero Malaria Starts With Me and other initiatives within the communities. Qualitative interviews noted that attribution to the funded project was difficult because of the collaborative way of working with the government. For instance, according to the funded partner, hospital attendances also increased due to direct government initiatives. However the funded project had lots of anecdotal stories and case studies of how / and where traditional healers and influential women directly influenced people going early to health facilities or even assisted them to get to a health facilities. These, in addition to project monitoring data provided some links to the project's contribution to the overall increase in hospital attendance.

Similarly, the prevalence of Malaria in Geita region of Tanzania was over 50% at baseline (2017) of the APHFTA Malaria project and at endline in 2021 is now below 20% (see Figure 6 below). The 'Harnessing on the Private Sector's Potential in the Fight against Malaria in Geita Region in Tanzania' project was implemented by APHFTA in collaboration with Afya Micro-Finance Company (AMiF). The project lasted from January 2017 to March 2021. The NMCP stakeholder described the reduced malaria morbidity and mortality in the Geita region and alluded to the contribution of the APHFTA malaria project to the strides made.

"So, you can see there is a very huge diminishing of death rate and it could be not clearly said that it is only due to APHFTA but it could be due to all stakeholders who are supporting on malaria prevention but also APHFTA, they are part of that." **NMCP stakeholder, Geita, Tanzania**

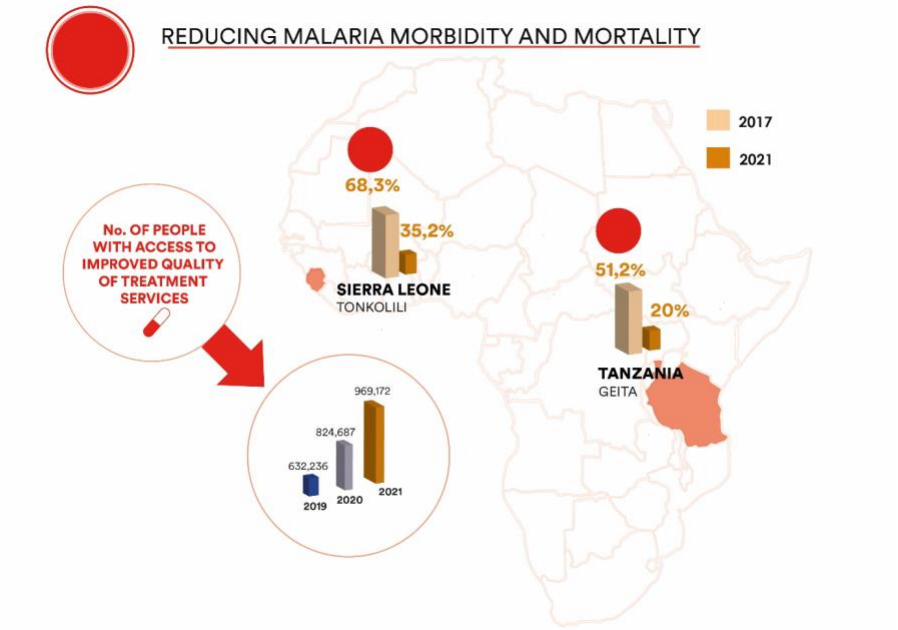

Figure 6 - Reducing malaria morbidity and mortality

More specific provincial and district level malaria prevalence data could not be obtained for many of the funded projects because of government protocols and restrictions on access to country-level (DHIS-2) data. However, qualitative interviews held with implementing and government stakeholders frequently reported these reductions in malaria morbidity and mortality.

"With the assistance of HPA from CR, currently the incidence of malaria morbidity and mortality are decreased to some extent due to the fact that communities, villagers, forest mobile workers participated in this project leading to improved awareness of malaria, changed health seeking behavior to the appropriate care, testing and treatment follow-up of the disease." **Cambodian NMCP Stakeholder**

"*So now majority of forest workers can access to the government hospital for severe malaria treatment and there is reduced mortality*." **Private Community Provider in Cambodia**

6.2.2 Key achievements of the Partnership

The Partnership achieved positive outcomes across the four pillars of the TOC. The top five achievements are detailed below:

1. **Improved capacity of health workers in the public and private sectors and community levels and across Pillars 1-4.**

This was seen as a key change by national and provincial government stakeholders and the funded partners and was attributed to extensive trainings and frequent supervisions supported by funded partners. This was also highlighted as an important achievement in the project monitoring data across all the grants. By 2021, 4,046 community health workers including volunteers; 3,385 private sector health care providers and 2,768 Primary level government health staff had been trained by funded partners in the five geographies.
Figure 7 displays the categories and number of people trained.

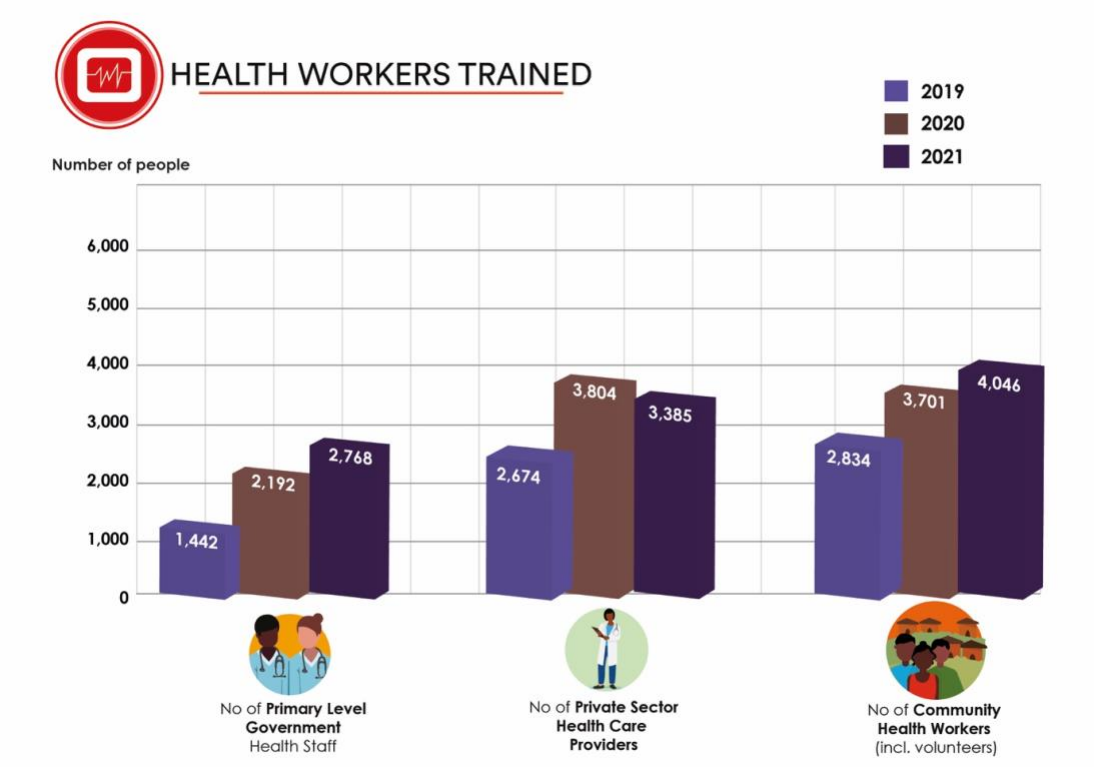

Figure 7 -- Categories and number of health workers trained

Capacity was also strengthened beyond the malaria sector. In Myanmar, PSI worked in 16 project townships located along the Indian border where the government was not able to support. The project strengthened capacity of more than 850 community private providers in malaria and TB, HIV, Leprosy, Diarrhoea, and infectious diseases. Figure 5 displays different categories of health workers trained in the projects.

Pillar 3 (Better surveillance and Information Systems) showed the most effectiveness in this area of capacity strengthening especially in Tanzania, GMS, Mozambique and Ghana. Evidence of improved data gathering and use of data for decision-making, improved reporting rate and timelines of reporting of health facilities was seen in over 97% of the participating health facilities (also see Figure 8) Key progress was made in several areas within the pillar including:

- Laboratory analysis and data management capability
- Data generation (Quality and Quantity) – fed into the DHIS2 and other government platforms
- Digital (mobile) data collection solutions
- Decentralization of Seismic Information System for Monitoring and Alert (SISMA) and improvement of data flow
- Use of data for decision making

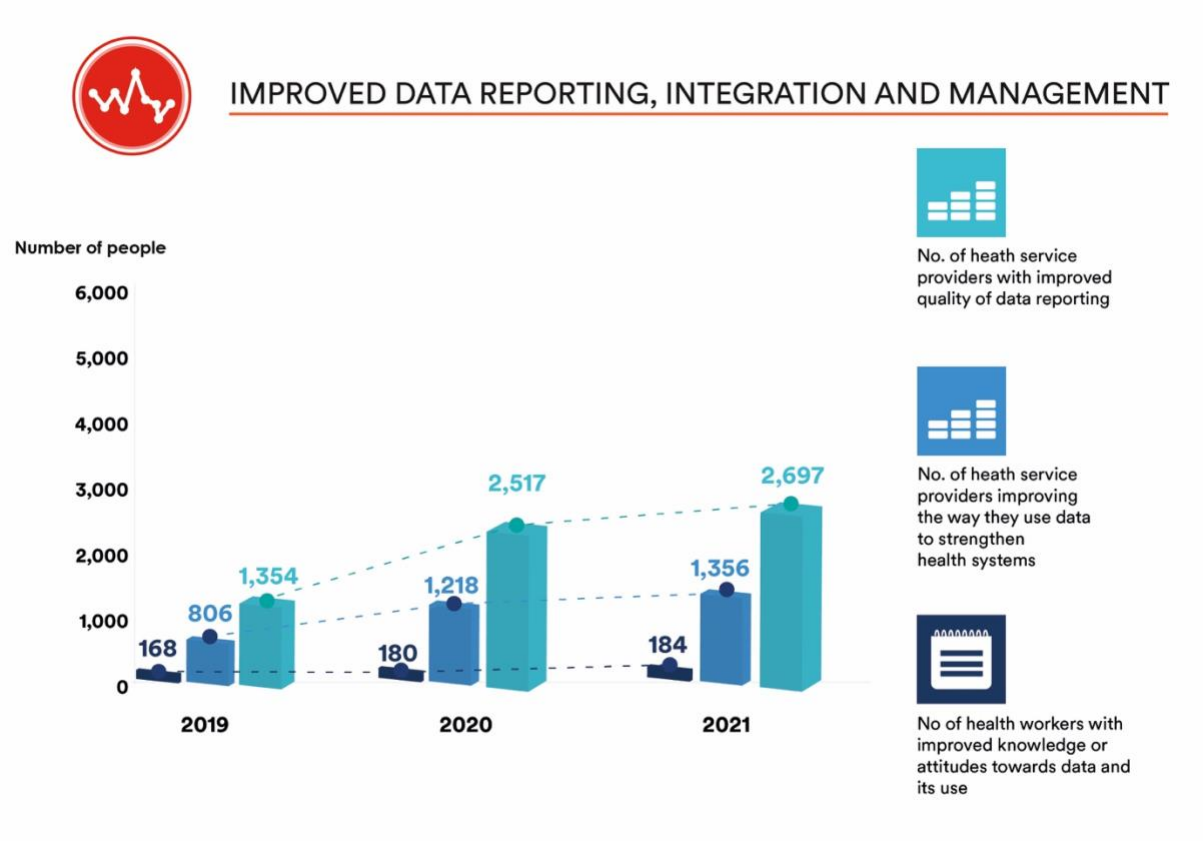

Figure 8 - Health workers with improved data reporting, integration and management skills (outcome indicators 3.1 - 3.3)

2. **Increased awareness and knowledge of malaria leading to improved health seeking behaviour.**

Innovative SBCC strategies were implemented in all the countries.

Community level approaches which amplified community voices saw some quick wins. For instance, in Mozambique, problems identified using the community score cards in the NWETI project were tackled. An example was the provision of mosquito nets in the maternity section of a health unit. The project's social responsibility pillar involved dialogues between communities and health providers. The problem was identified by the communities who could not understand why they were encouraged to sleep under nets but nets were not provided for their pregnant women who went to the health units to deliver their babies. In trying to address it, it was discovered that the issue was a simple logistic problem that could be readily solved - mosquito nets were available but had not been placed on the beds. In less than 15 days, the head of the health unit ensured that the nets were put up on all the beds in the health unit. Formative research on the score card approach showed changes - increased percentages of people with knowledge about the symptoms, causes and the importance of accessing care in the health units and the importance of sleeping under a mosquito net; improvement in people's attitudes in terms of the intention to change behaviour around these aspects.

In the GMS, **mobile malaria workers and village malaria volunteers were instrumental in improving community awareness and knowledge.** In Myanmar, the PSI stakeholder reported that most changes were seen in Pillar 2 - more community members were aware of malaria testing and treatment. This improvement was attributed to community private providers who conducted the awareness activities regularly in the remote villages.

In Tanzania, the T-MARC project used **community health workers (CHWs) - they adapted (and adopted) an interpersonal communication toolkit for the CHWs in collaboration with the NMCP**, SBCC unit. The project also collaborated with civil society organizations (CSO) to ensure that local realities were addressed. However, for this project, performance of the indicators was better for knowledge than for practice. TCDC also used CSOs and seemed to have more positive outcomes -the project saw increases in the knowledge indicators in the regions of 90-95% and increased health seeking behaviour but the issue was highlighted of possibility of relapse to old behaviours.

In Sierra Leone, Ghana and Tanzania **young advocates / researchers, designed advocacy plans with local leaders and contributed to effectiveness in this pillar.** Similarly, Citizen Journalists (Reporters' Network) in Sierra Leone were reported to have motivated behaviour change in communities.

However **funded partners working on Pillar 2 were frustrated when the health care services failed the sensitized community members.** Several funded partners implemented interventions aimed at Pillar 1 (Supply of Good Quality Primary Health Care) and they were not always located in the same intervention areas as the SBCC projects. Also, several issues such as stock-outs and infrastructural problems constrained Pillar 1. Several funded partners described how increased awareness and increased demand for services were achieved but the stock-outs or poor quality of health care created a bottleneck and limited the achievements.

"*And now people are saying, 'No we don't need to go in' because last time they went, there was no drugs. And there were other partners who were responsible for influencing the supply chain but there's nobody in position*." **Funded Partner, Restless Development, Sierra Leone.**

"We want to push people to go early to the health facilities. When they have signs and symptom of malaria, they go there, they don't get the right support. When it comes to stockout, they don't get the right treatment, so they get disappointed, then you have that set back." **Funded Partner - TCDC -Tanzania**

3. Private informal sector was strengthened and integrated better into the formal health system by the Partnership.

An innovation of the Partnership was the work done with the private informal sector. Considering that it is well documented that informal providers comprise a substantial proportion of all providers; and are the source of a large percentage of health care delivered in South East Asia and Sub-Saharan Africa,[24], [25],[26] the programme's work to strengthen the sector and integrate their data into the public sector is vital.

The funded partner ADDRO implemented a community-based malaria control project in six regions in Ghana across twelve sub-districts and 344 communities. The project supported the chemical sellers in the intervention areas with the procurement of Rapid Diagnostic Tests to alleviate the costs for the populace. The licensed chemical sellers who were not fully rooted into the health system received supervision and training from the Ghana Health Service (GHS). The GHS also collected data from them and assessed the way they managed malaria issues. This key aspect of the project strengthened the informal private sector. The project outcome indicators showed improvements from baseline -from around 60% to 90%.

In Tanzania, accredited drug dispensing outlets (ADDOs) and autonomous laboratories had their capacities built; referral between public and private parties improved; and the digital surveillance system was strengthened, and the data integrated with national level data. The system also had an automated performance feedback, based on the data; and a dashboard that showed the scorecard of each ADDOs based on the set performance agreed on with them. Several funded partners were involved in this project including CHAI, TCDC, T-MARC and APHFTA.

In the GMS, HPA in Laos and Cambodia; and PSI in Myanmar collaborated with the private informal sector. A positive outcome due to advocacy efforts of PSI was the recognition of the malaria informal private providers by the government in Myanmar.

"Therefore, currently community private providers are considered as part of the formal health system, this is the big achievement." **Funded Partner – PSI – Myanmar**

The integration of private sector data into public sector data supported quality and completeness of national level data. The capacity built in the private sector on data management was reported frequently in the intervention areas as exemplified by the quote below:

"*PSI has trained me to accurately record all malaria cases by using the mobile appliance, so now the information is transferred up to the national level.*" **Private Outlet Provider Myanmar**

Strengthening the informal private sector, and forming linkages with the public sector increases the probability of a greater proportion of the general population receiving better quality care and appropriate referrals.

4. The Partnership showed some evidence of broader Health Systems Strengthening

According to the WHO, Health Systems Strengthening (HSS) is "any array of initiatives that improves one or more of the functions of the health systems and that leads to better health through improvements in access, coverage, quality or efficiency."[27]Chee et al noted that HSS is "about permanently making the systems function better, not just filling gaps or supporting the systems to produce better short term outcomes" (p87).[28] The Partnership showed some evidence of broader HSS. For instance, the structure of the collaboration with the NMCP resulted in HSS in Cambodia. The national malaria elimination programme pooled the partners collaboration, funding, expertise, strategic approaches in order to have higher synergy.

In Sierra Leone, IRC worked in collaboration with the NMCP and the Pharmaceutical Association of Sierra Leone. 38 pharmacies in the private sector were part of this collaboration. The decision was made to supply them with free RDTs for population testing and then if people were positive for malaria, they could choose

to buy ACTs from the pharmacies or go to the hospitals for the free ACTs. This increased the number of people getting tested and turned out to be a win-win. **The NMCP scaled up the project to 100 pharmacies and used the model for other things beyond RDTs.** Nevertheless, the NMCP stakeholder noted the importance of mentorship to maintain the success of the model:

"We have to continuously mentor them, remind all their roles and responsibilities, remind them that they signed an MOU, and the MOU must not be violated. Again, we are not going to punish them. We do it in a way that both parties will be comfortable, but for us at this point it has been challenging for us, it has been challenging." **NMCP stakeholder, Sierra Leone**

In Tanzania, the CHAI project influenced the NMCP to position the intervention for scale up via a Global Fund Application. The integrated approach - which led to the expansion of the modified drug register beyond the four project intervention regions to seven more regions in collaboration with the NMCP and other partners was a plus for HSS.

"So, for us seeing the NMCP integrating the system even their interest in scaling up the autonomous laboratory side. They have already conducted the training countrywide, with the Global Fund money and introducing the system that we have." **Funded Partner, CHAI, Tanzania**

Overall, HSS was limited because most of the countries had weak health systems and there were problems beyond the scope of the Partnership. For instance, the health system in Sierra Leone was described as 'quite rudimentary' by a stakeholder, with a 60% shortfall in health care staff for all levels; with no organized in-service training and hardly any maintenance plan. Additionally, there was no electricity or running water in most healthcare facilities. As a funded partner aptly noted:

"It's very hard to do a broader health system strengthening approach, when the very basics are missing." **Funded Partner, Sierra Leone**

5. **The Partnership's Advocacy and Communications efforts were effective in contributing to malaria agenda setting and building support toward action; and driving change in the various contexts.**

The malaria advocacy model by the Centre for Communications Programmes JHBSPH (2008) was used in the analysis of the advocacy and communication initiatives. The model (Figure 7) highlights that advocacy processes operate to mobilize political, financial, and social commitment for social or policy change. Advocacy for malaria contributes to shifting beliefs and "norms"— creating an awareness of the need for stakeholders to fight malaria at individual, community, and political levels.

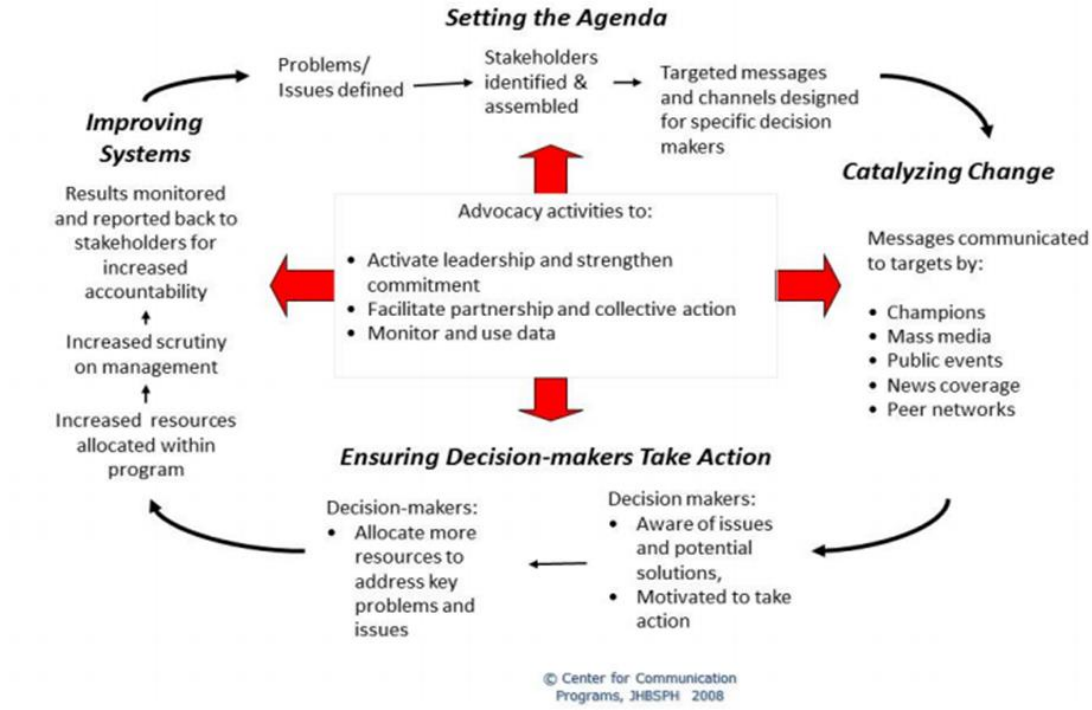

Figure 9- Malaria Advocacy Model

The Partnership addresses advocacy in three ways: via its **advocacy and communications strategy;** via the **advocacy efforts of funded partners** and via the **dedicated advocacy grants**.

- Of the three components, **the advocacy efforts of the funded partners were most effective in catalysing change and contributing to policy and strategic direction in the various contexts.** Some of these successes have been highlighted in the section on relevance. It appeared that **advocacy efforts yielded better outcomes when combined with implementation focused on the other three pillars.** This may be because of the evidence generated by project outcomes which are more effective in convincing decision makers to take action. An example is the adoption of the CMAM Surge approach by the Sierra Leone NMCP.
- For the **partnership communication strategy**, a five year framework was constructed to provide clear communications focus for each year in highlighting stories of the partnership's aims and impact. Over the five years several achievements have been recorded:
    - **The Partnership's communications strategy supported the communities in telling their own stories and sharing their own experiences.** Through this the partnership created a host of case studies and a series of films all supporting the goal of spreading awareness. The advocacy products included over 70 case studies with personal quotes from project workers and people supported by grantees; a **photo library**, with images ranging from testing kits, lab, school settings, health workers in action, parents at home; and **series of films**, all of which featured community voices telling their own stories in their own words
    - **The Partnership has extended the narrative in several ways:**
        - By telling **stories of how malaria impacts the community in different ways**; including highlighting different perspectives on education (pupil, teacher and parent), family finances, the burden on doctors/health care workers.
        - **More than 500 pieces of media coverage** (international, national and regional) with a partner reference or content embedded

  - **UK National exclusive features** - Daily Mirror, Daily Telegraph, HELLO!, First News, TheSun.co.uk, MarieClaire.com and HuffingtonPost.co.uk as well as series of regional online pieces, and podcast placement

- **For the advocacy grants. all the partners contributed to setting the agenda** by identifying problems and defining the issues that had to be addressed; the funded partners identified and assembled the relevant stakeholders and targeted messages and channels were designed for different stakeholders.

The **case study of BBC Media Action** is used to demonstrate how the funded grants focused on advocacy effected changes.

BBC Media Action addressed a gap noted in the National Malaria Strategic plan, namely, low positive behavioural practice of Sierra Leoneans. They developed the 'Ministry discussions' and 'Town Hall' which regularly brought community stakeholders, service providers, government officials to a roundtable discussion.

"*The stakeholders would come up with some action point right there, then follow up those actions and implement those actions right from there*." **Funded Partner BBC Media Action, Sierra Leone.**

The case discussed at the roundtable was the military hospital in Freetown which had a laboratory. In the discussions, the community and government officials produced actions and used that to build the laboratory structure which then served the hospital and the community.

For the advocacy project (End-Malaria Fund), support was garnered towards the prioritization of malaria in Mozambique. The end-malaria fund is country owned and country led. ALMA's main role was to facilitate and realize the malaria elimination vision for the country; strengthen and support the NMCP, working in collaboration to achieve the country's regional initiatives.

"One of the key reasons why we've created this fund is also to close some of the operational gaps or challenges that the country faces…the fund is entirely informed by the NMCP." ALMA worked together with the NMCP to discuss priorities, develop the concept notes, advocacy and other communications materials that were given to other government and private sector stakeholders; and organizing events like the launch and broader engagements. The funds support different kinds of regional and country initiatives and priorities. The board of directors of the funds are senior leaders who have been tasked with becoming lead champions for ZERO Malaria (Comiza Comigo). They have CEOs, senior religious leaders and other people outside the health sector who have been sensitized and trained to talk about the campaign and actively think about how they can raise the visibility of the initiative and sustain it especially in the face of COVID-19. Essentially, the fund sensitized political leaders, private sector leaders, civil society leaders, community leaders on the need to end malaria so that they prioritize it.

"We have 32 major international and national companies that have basically pledged their commitments and support for the campaign which wouldn't have happen without the Fund." – **Funded Partner, ALMA, Mozambique**

In some cases (such as Malaria No More, Results UK) the focus was more on regional (Africa, Commonwealth) and global priorities, with direct advocacy efforts targeted at the UK government – in order to keep malaria high on the agenda at those levels. At local levels, communities were galvanized via citizen journalism and integrated efforts. This applied to On Our Radar (OOR), Results UK, Speak Up Africa and Restless Development. The Youth Advocates were important change agents and were mentored via a systematic mentoring programme. A visible product by this group is an electronic book consisting of 25 articles. This has garnered recognition for the young advocates in all three countries (Tanzania, Ghana, Sierra Leone) and the African Union (AU). An unintended positive effect is an Accountability Mechanism that was developed because of integrated advocacy efforts by OOR and BBC Media Action.

In terms of ensuring that decision makers take action, **the advocacy grants made strides in creating awareness of the issues and the potential solutions among policy makers, parliamentarians, high level government stakeholders such as presidents and first ladies.** There was evidence of motivation to take action displayed in statements of commitment of improved funding for malaria. However, the COVID-19 pandemic disrupted the momentum that was gained by the projects and stalled planned activities and events. This was the most important challenge mentioned by all the advocacy funded partners and this limited actual action by decision makers to allocate more resources to address key problems. The quote below from a funded partner describes the difficulty clearly:

"There is no substitute for face to face. I think we would have got far more, even though we have done our best in this virtual world. I know no campaign, which you can do virtually without personal interaction. If you do not have the physical presence, no campaign succeeds." **Funded partner, Results UK**

We complemented analysis with the framework of Coe and Schlangen (2019) *Finding and following the natural pathways in advocacy evaluation* -to make sense of the outcomes of the Partnership's advocacy efforts. The Advocacy grants teamed up with a wide variety of actors and interacting with a range of other factors and realities at the country levels. An appropriate inquiry recommended by the framework was how the contribution of the advocacy activities fit in the wider mosaic of influences. The projects have implemented several innovative strategies that have gained visibility within Ministries of Health, Parliaments, Private Sector Corporations, the African Union and even with UK audiences. **Of key importance was the amplification of community voices and the use of change agents and citizen journalists at community levels.** These innovations and the intensity with which the activities have been implemented are bound to yield returns but probably after the projects have ended. The extent of contribution of the Partnership advocacy efforts may only be known later – the expectation is that the wide variety of sensitized citizens and government stakeholders will continue the momentum generated by the projects.

"So, I think the usefulness of the advocacy grants was that it really gave some of the partner organizations an opportunity to amplify the voices. And this was part of the principles and the theory of change of our partnership – it is that we wanted, to help the global malaria efforts. And one of the ways to do that is really, to amplify community voices." **Comic Relief Stakeholder**

6.2.3 Drivers of Change

The Partnership created desired change in varying extents across the four pillars. There were several elements that drove this.

1. Integrated Approaches – were the most effective

Funded projects which used more integrated approaches were the most effective. These included:

- ✓ Projects that focused on febrile case management and not just malaria – the rationale is that the pathway of diagnosis and treatment is the same. This was seen with funded projects in the GMS (Malaria Consortium), Sierra Leone (KSLP), and Tanzania (CHAI)
- ✓ Collaborations beyond the partnership and beyond the malaria sector yielded strong gains For instance, the ISS in Tanzania with CHAI, APHFTA, TCDC, T-MARC, USAID, GF and NMCP
- ✓ Working with a multidisciplinary team and integrating different departments (KSLP in Sierra Leone)
- ✓ Reporters' Network – collaboration between OOR, Results UK, Speak Up Africa, Restless Development, BBC Media Action and Concern Worldwide
- ✓ Innovative Community SBCC (integrated) strategies – PIRCOM, ARHR, Manhica; Concern; etc.

2. **Projects already embedded in the contexts before the Partnership achieved stronger outcomes**

Projects that were positioned within the contexts especially due to long interaction with the NMCP were able to navigate bureaucratic protocols more easily and had less delays at the start of their projects. Case studies in Sierra Leone and Tanzania represented organisations who were already embedded in the local health system, at the primary level (CHAI, TCDC, HPA) and tertiary level (KSLP). Funded partners were known to and trusted by government health units and viewed as integral for the implementation of their strategic plans. From this position funded partners were cognisant of the political and health system needs, capabilities and priorities and at the same time were influential in shaping them.[29]

"CHAI has been very, very strongly bonded by NMCP, because of the work that we have been doing for so many years." **Funded Partner, CHAI**

3. **Flexibility of projects to address problems on the ground responsively enhanced effectiveness**

Projects that were flexible and able to adapt quickly to challenges experienced during implementation were more effective. This flexibility was enabled by Comic Relief's flexible approach to grant-making. For instance, this was highlighted by a government stakeholder in Mozambique - The key driver of change was perceived as CUAMM's flexibility - not sticking to what was articulated in the project documents but addressing the needs identified on ground as they came up in order to ensure that the entire malaria programme within the province worked well.

"I also felt that it is a very flexible project because there are other projects that have been supporting the malaria programme, but they are totally rigid projects. If the subject is to buy anti-malarial drugs, you cannot do anything else. But this project of the GSK /CR partnership was not like that, although they had little budget, they managed to balance. Because ..while you close a gap there is always another one coming and at that moment it is urgent, you need something to be able to solve that situation. So, the CUAMM project had this flexibility."– **Provincial Government Stakeholder Cabo Delgado**

4. **Collaboration with government stakeholders at national, regional and provincial levels was crucial**

Strong engagement with the government throughout the project and strong commitment of the government to the project and programme were seen as the main drivers of change. The close coordination with the Ministry of Health, provincial health directorate, district services, health units and community health workers was key to the majority of projects. As described by a funded partner in Mozambique:

"In other words, working within and through the system made the project task easy because at certain moments they felt that the project is for them and not Fundaçao Manhica ou GSK/CR project." **Funded Partner, Manhica Mozambique.** The grantee described that the openness of the Ministry and provincial directorates in allowing the project to seat in the planning and strategic decisions was instrumental to the success of the project.

5. **Achieving a participatory process of generating evidence drove change**

Working with communities (using community change agents, peer to peer networks; citizens rights advocacy), health workers etc. to generate evidence was an important driver of change for many projects especially those focused on SBCC and advocacy.

6.2.4 Most significant changes according to various stakeholders

We reviewed the MSC resulting from the Partnership from the perspectives of the different stakeholders. The frequently reported perceptions of the most remarkable changes caused by the Partnership are presented in Table 2. One of the change is an outlier. The stakeholders' perceptions of the MSC intersected in some but not all areas. The differences also highlighted the variations in what had made the most impression on the different categories of stakeholders.

Table 2 Most Significant Changes according to the stakeholders

Stakeholders	Perceived most significant changes	Statements
Governments	**1.** Improved Technical Capacity. **2.** The best practice of community surveillance. **3.** Heightened interest in the private sector.	*The project created many changes in technical capacity, which was our main difficulty. So, with frequent training and supervision, it helped colleagues a lot to have a strengthened technical capacity. That is why even now that the project is no longer here, but we still have the same pace.* ***Government Stakeholder Mozambique***
Funded Partners	**1.** Improved Surveillance; Quality improvement of data reporting; **2.** Integration of community level stakeholders into malaria interventions; Improved Community Voice; **3.** Improved health seeking behaviour (Increased knowledge and awareness). **4.** Improved Testing in the Private sector; More people testing for malaria before treatment	*The big funders for malaria are the Global Fund, and PMI. They do a lot of technical support and a lot of research on malaria but they don't do a lot of community work . So what the partnership has done is filled in the gap in areas where they were never reached by.* **T-MARC Tanzania**
CR /GSK	**1.** Improved Community awareness. **2.** Improved awareness of malaria **3.** How to communicate issues of development differently to a UK audience	*I'll be the only person to say this, the influence that the visit that I took the BBC on to Sierra Leone with GSK, to talk about how you can communicate issues of development differently to a UK audience that has had a profound and lasting effect on Comic Relief and I believe that will influence how other INGOs speak and the kinds of films and content they put out, no one expected that to be an outcome and it's enormous and that visit was pivotal.* **CR Stakeholder** *So, it's reawakened in some senses, people's attention to malaria as an ongoing public health issue that needs attention. So that that to me is been very positive. Obviously, it's not perfect by any means, you know, the channels available are limited and people's attention span is limited. –* ***GSK stakeholder***

6.2.5 COVID-19 pandemic adaptations and limitations

Some of the projects ended before the COVID-19 pandemic. For other projects that were still running the COVID-19 pandemic was a major challenge to project activities. This was especially the case for advocacy funded partners. Convenings, meetings were disrupted by the pandemic and the subsequent national

emergency declarations in the different geographies. Though many advocacy funded partners continued engaging stakeholders on an individual basis, the necessary scale needed to create a thrust was lost or markedly reduced.

Also the pandemic created a distraction for many of the national, provincial and local government stakeholders. Ministry of Health staff became more focused on addressing the health challenges resulting from the pandemic and malaria ranked low on the priority scale. Regular supportive supervision by the government and other institutions were stalled. An added impediment was that there was reduced health care seeking behaviour because of fear of contracting COVID-19. Funded partners who were implementing in Pillar 2 reported loss of gains in their achievements due to this.

Adaptations

Funded projects adapted in different ways. **Advocacy groups used online communications to reach out to prospective targets.** Some funded grants had to stop activities completely at the start of the pandemic. For instance, CHAI had four months delay on their project; Manhica spent seven months without working but **Comic Relief helped them reassign some budget towards Personal Protective Equipment (PPE).** This was done for the other funded grants as well. Remote monitoring was done; amidst other COVID protocols.

Funded partners collaborated with government stakeholders to respond immediately to the outbreak. This was especially the case with HPA in Cambodia. HPA secured approval from Comic Relief to use some of their funding to purchase emergency PPE. This was also agreed with the local government officials who expedited the approval process. The funded partner was the first NGO to get PPE for malaria workers in their target areas. These target areas at that time were porous borders with lots of internal migrants and therefore particularly vulnerable. The government officials were notably happy with HPA's proactive move and particularly expressed gratitude to HPA for being so quick.

For KCL in Sierra Leone, COVID-19 pandemic was a major challenge. The project had to quickly put in a new screening process. **They re-established the infectious disease unit built during Ebola time and quickly managed to do the COVID-19 testing, they supported the laboratory staff as well**, because during COVID, the majority of those were reposted. The pandemic also caused a significant reduction in patient numbers - with the people just coming from Ebola, there was a fear of the unknown so the health seeking behaviours of patients changed in the community.

In Ghana, **only smaller meetings could be organized and ADDRO intensified their household visit strategy.** Most of the volunteers intensified their household visits, project officers at that time could not organize meetings, so, they also participated in the household visits. ADDRO also organized meetings with various community opinion leaders, and sensitized them. ADDRO also received support from Comic Relief to help procure PPEs for facilities in their intervention communities, the GHS, volunteers, and ADDRO staff.

Furthermore, **CR's grant management approach enabled the funded partners to restructure their programmes easily to accommodate the realities of the COVID-19 pandemic**. A number of the funded partners attributed their ability to address the COVID-19 related problems encountered in their contexts quickly due to Comic Relief's flexible approach to grant management. The reaction to COVID-19 and the quick response such as pro-actively extending project timelines were considered quite positive.

"I think the strength of the partnership was its flexibility. We also work on the Global Fund projects in these areas where we've had to coordinate. And the difference in flexibility and speed has been incredible. We can do things in Comic Relief, with their support much, much faster. The approval processes and the restrictions you have to go through under the Global Fund makes it very, very difficult to respond, which is why when COVID-19 hit that we could immediately communicate with Comic Relief, and immediately allocate savings in the budget to PPE and we got that done within the space of a few weeks. Whereas with the Global Fund, we also had something very similar, but it took three months." ***Funded Partner, HPA, GMS***

"Comic Relief is open to adaptation and that helps especially in the face of unpredictable situations such as the lassa fever outbreak and the COVID-19 pandemic." ***Funded Partner, Concern, Sierra Leone***

6.3 Sustainability and resilience

6.3.1 Opportunities for sustainability

Innovative community level and digital solutions have been used by the projects in the Partnership to improve access to and quality of care as well as surveillance and information systems while driving the advocacy agenda to keep malaria high on the country and global priorities. While there is evidence of effectiveness of the Partnership in achieving its desired outcomes, there is the question among all the stakeholders of how sustainable the interventions are especially since the funding provided by the Partnership is no longer available.

It is clearly documented that to achieve malaria elimination, approaches need to have a long-term goal of sustainability.[30] Birkholz et al[21] described sustainable malaria control as long-term effort(s) focused on reducing malaria morbidity and mortality through integrated, innovative and transdisciplinary approaches. Literature[31, 32, 33]shows that this in turn requires sustainable support and investment from the government, the establishment of an effective surveillance and response systems, better use of technology in case detection and epidemiology, operational research and capacity building. Schiff *et al.* highlight the need for stakeholders to keep in mind that some of the key tools that contribute to the successes are transient and need to be integrated into the local public health infrastructures at the time of implementation. Other studies note the importance of participatory approaches - iterative approach to knowledge co-creation with end-users and generating sustainable solutions to contextual problems in collaboration with communities.[21, 34]

We examined **opportunities for sustainability** within the different Partnership contexts.

1. **The successes achieved in the five geographies have been through integrated efforts and mobilization of international and local resources** including collective learning driven research on malaria. Certainly, these achievements have been driven by the Partnership funding but also because of the national programmes, considerable public interest, leadership of CR/GSK and other international agencies, CSOs, and major funding organizations (USAID, BMGF, Global Fund). This intentionality of the Partnership to ensure integration of efforts and collaboration across a broad range of global, regional, national and local malaria actors presents a key opportunity for sustainability. The interest of the Partnership in being part of the collective movement in the elimination of malaria was highlighted in the SSI with several GSK and CR stakeholders who emphasized that the focus is in increased awareness of malaria and not on the awareness of the Partnership's work. In the GMS for instance, the government

coordination models ensure that the project design and implementation have clear sustainability elements. Though this tight control created difficulties and delays for the funded partners (and may have limited creativity), it presents an opportunity for sustainability. This was detailed aptly by a funded partner:

> *"We don't deliver the services ourselves. If you went to anyone, any of the participants who received malaria testing or treatment, or whom we have engaged in awareness sessions, I would bet 99 times out of 100 they would not link HPA to any of those things because what HPA has been doing is strengthening the government's ability to do those things. This is exactly what we want and it's something that my communications manager keeps struggling with because she wants to communicate what HPA has been doing. But none of the people there would say HPA has done anything. They would say, oh, no, but that was a government thing. Which is exactly what we want because that means that we can leave and the government system continues and that means that the expectations that people have are of the government system, not of HPA, or Comic Relief."*
> ***Funded Partner, HPA, GMS***

2. **The capacity built in malaria programmes relating to data management - data compilation, recording and analysis has persisted beyond some projects** in Mozambique, GMS and Tanzania. The processes in place have continued as the normal routine. This is the case in Cabo Delgado province in Mozambique. The government stakeholder also described that some faulty provincial malaria indicators had been changed due to the influence of the CUAMM project and they had 'fought' to retain the new indicators even after the project closure and had succeeded.

   "We continue with our culture of analyzing information. Each person in charge of the health unit feels he or she owns the information. All these were instilled by the CUAMM project. And even now that the project has left the Province, we continue to 'push the boat'." **Government stakeholder, Cabo Delgado, Mozambique**

3. **Some projects were well embedded within the contexts; and some of the innovative tools implemented by the Partnership have been integrated in the NMCP. Subsequently, some funded partners' work were scaled up by the government**. As an example, CHAI was well established in Tanzania, extensively collaborating with the NMCP stakeholders. CHAI worked to integrate the surveillance system within the government structure, building capacity of the ministry and the Pharmacy council to take over the project. Positioning the interventions into the public health sector through the country government Global Fund application (which also includes the mRDTs in ADDOs) paints a clear picture of how the project's interventions have the buy-in of the government and the willingness of the NMCP to continue the work and to sustain the gains made.
4. **The micro-financing initiatives by APHFTA in collaboration with AMiF is a model that presents an opportunity for sustainability.** After the project, there is still the financial motivation for the different stakeholders to maintain the model and even scale up. The gender empowerment element of the project is also key. Most of the ADDOs and chemical sellers that benefited from micro-financing within the partnership were women. Empowering women through financial inclusion is an important

strategy to shift power dynamics within communities and has the potential to transform decision making in favour of the female gender which in turn enhances gender equality.[35],[36] Achieving gender equality and empowering women is a Sustainable Development Goal and providing affordable financial services to women is essential to achieving this global target.[37]

5. **Intrinsic sustainability elements highlighted by different funded partners include motivation of community level stakeholders** who had been empowered to take ownership of several SBCC strategies. There was evidence of amplification of the voice of community members, responsibility for action and action oriented behaviour. Also they frequently reported change in mindset of the government towards the private sector holds the potential for sustained engagement and integration of the sector into the public malaria space :

   "We have seen that even the thinking, the mindset that has been changed from the NMCP to focus on the fact that even the private sector can do better things and we feel strengthened. We are in a comfortable zone, showing that whatever we have planned, the government has taken on board." **Funded Partner, CHAI Tanzania**.

   The transformational element of this change in mind set was also seen in Ghana where the GHS integrated and trained the (ADDRO) volunteers. Similarly, in the GMS, the private sector received formal recognition by the government – something quite novel.

6.3.2 Barriers to sustainability

Several issues act as barriers to the sustainability of the gains made by the funded projects.

1. The key concern is that **government health funding is still limited** and for all the African countries in the Partnership, the level of funding is still below the agreed 2001 Abuja Declaration on health spending.[38]

"When you look at the recent national strategic plan developed for the year 2020 to 2025, there is a funding gap. So there has always been a funding gap. There are interventions that have been outlined, strategies that have been outlined to be able for us to reach the goals that we intend to achieve. However, there are funding gaps at each level." **NMCP Stakeholder, Ghana**

2. Additionally **most of the health systems are weak and the sustained funding gap impedes strengthening of the health systems**. This is the root of the poor quality of health care reported frequently in the interviews by stakeholders in all the five geographies. This issue presents the possibility that some of the progress within the malaria sector achieved by the Partnership may be stalled or lost.

"We strengthened the drug shops and autonomous laboratories case management and with the provision of quality referrals to the public health facilities. So, the question comes if you make this investment in the drug shops, how about these places where we refer our patients, will they face the same high quality of febrile illness management?" **Funded Partner CHAI, Tanzania**

"The limited availability of drugs - stock outs, it was so hard to say to the people go to the health facility; go to the community worker and then they were responding – but the health worker doesn't have drugs." **Funded Partner CUAMM - Mozambique**

3. **Financial limitations also present barriers to the sustainability of the Partnership's private sector initiatives.** Financial capital is needed to ensure quality operations of the **micro-financing initiatives** such as the project with the ADDOs and the autonomous labs. Due to limited resources, some ADDOs dropped out from the project (about 200 in 48 months). Relatively minor issues that could be solved with minimal funding created bottlenecks. For instance, some of the registers provided by CHAI for the ADDOs were full but there was no funding to replace the registers. The ADDOs have been taught by

the project how to improvise and CHAI has advocated to the Pharmacy Council to see if the registers can be produced and sold at a cheaper rate to the ADDOs.

"So, we believe that when it will reach a point when nothing will be done in the Pharmacy Council, it might end up that the ADDOs will continue using improvised books and at the end, it might affect the quality of the data. That is what we don't want to see from the drug shops." **Funded Partner CHAI, Tanzania**

4. **Relative low priority given to advocacy and SBCC** – also seen in the gap in government funding for those components - are barriers to sustainability. **Lack of available funds for communication** was reported by government stakeholders - most programmes focused on drugs, commodities and net distribution. Also human resources for communications were limited. Though all the projects collaborated with the NMCP, it is to be noted that in many cases, the government stakeholders were more focused on coordination of partners on ground rather than on continuing implementation of the activities of those who have left.
   The risk of people reverting to their original behaviours because of the low priority to SBCC at the government levels noted in the interviews.

5. **Many funded partners did not have systematic exit strategies** and some gains were reported in the interviews to have already been lost after the end of a project. There was **no evidence of a transition plan by any of the funded partners**. In the interviews one of the government stakeholders perceived that the malaria programme in the province was not yet stable enough to function well without the additional support provided by the project. This lack of confidence was expressed frequently in the course of the interview:

   "I feel that with the absence of this project we are going to have problems. We are still trying to stabilize ourselves but we don't know if we will be able to do what the project was doing because we really need support, whether in material or otherwise." **Government Stakeholder, Mozambique**

   Similar views were expressed by several stakeholders (funded partners and private sector stakeholders) who felt that the projects had not lasted long enough for the withdrawal of the donor funds.

   "Since 3 years, HPA has supported the malaria system, skills/capacity have been much improved in regard to health information system, malaria testing, treatment and malaria supplies management. Without the support CR, some challenges will be faced including logistic management, remote surveillance of malaria among mobile forest workers. If the donor would continue for a few more years that would be better in order to strengthen the government health system effectively." **Private Community Provider, Cambodia**

   "Three years is too short of time, to have the impact we would have desired. What we can only leave now, after three years is some pieces of evidence on how this approach has been successful and trust that the system would continue because it's out of our hands." **Funded Partner, ARHR Ghana**

   Nice experiment but could have done more- the time was not long enough. **Funded Partner, CUAMM, Mozambique**

6.4 The Partnership model and approach

6.4.1 Introduction and Framework for Analysis

Brinkerhoff, defines partnership as "a form of intersectoral and multi-actor collaboration which differs from other governance, management, and coordination models by its emphasis on mutuality of shared goals

and outcomes across actors or organizations involved."[39] Partnerships have become increasingly popular in global health due to the belief that the complexities within the space cannot be tackled by a single organization; and the increasing awareness that public-private partnerships can improve the effectiveness, efficiency, effectiveness, and acceptability of decision-making processes and the subsequent solutions.[40] Buse et al[41] in their review of Global health partnerships noted that they were particularly effective at placing specific health issues on national and international agendas and mobilizing funding for health issues, stimulating research and development, improving access to cost-effective health interventions, supporting national policy and strategies and strengthening the capacity of health service delivery. This global recognition of the partnership approach to development is evidenced by the inclusion of 'Partnership' as a Sustainable Development Goal.[42]

However, there is still some scepticism from many authors who question whether global health "partnerships" actually operate as genuine partnerships or are mostly window dressing or rhetoric.[43, 44, 45,46] Nevertheless, as the size and scope of the global health agenda has grown in the past decades, so also have global health partnerships grown in number and scope.[47] However not many of these partnerships have been evaluated.[33] This evaluation of the Comic Relief / GSK partnership therefore contributes to the meagre evidence base by providing more insight into what works or does not within such partnerships.

The conceptual framework by Brinkerhoff[48] has been used to evaluate multiple development partnerships and we have used it to reflect on the Comic Relief / GSK partnership model. The framework highlights five elements to evaluate – context, partnership structure, partnership process, and outcomes, or the added value of the partnership. The effectiveness of the partnership is determined based on the completeness, quality, relevance, and responsiveness of the process.

6.4.2 The Structure, Process and Added Value of the Partnership

The partnership between Comic Relief and GSK was a unique blend. **GSK's role in Global Health is using science and innovation to develop new medicines and vaccines** for infectious diseases that disproportionally impact low- and middle-income countries. **The organisation then works with others in partnership to strengthen health systems and support local communities**. GSK believes that collaboration and partnership across different organisations is key in Global Health. **Comic Relief is an experienced grantmaking organization and its role as an expert in the field of communication, storytelling and public engagement with strong models and mechanisms was leveraged.** Comic Relief has a depth of experience advocating for global health and public health initiatives to enhance awareness. The Partnership brought together two organizations with complementary experiences and areas of focus. In the Partnership, Comic Relief had independence over the grant making and grant management.

The Partnership Advisory Group (PAG) consisted of Comic Relief and GSK staff and had the role of providing oversight, guidance, direction and reviewing the progress of the programme. The strategic parameters of the Partnership were fairly well defined and therefore the PAG meetings were frequently an operational engagement but there were often key decisions/advice on direction of actions that were taken to the PAG for a steer.

The PAG provided a space where Comic Relief and GSK could catch up on a quarterly basis on the latest developments in each organization, the funded projects, learning, advocacy, communications etc. The GSK and Comic Relief stakeholders were of the view that the PAG was an innovative model. The respondents frequently reported that the partnership had been successful and that the PAG had been a driving force.

"I think people were nervous, you know, it was the first time we've done something like this. I think it's worked better than most of us thought (laughs). There has been good commitment on both sides to the PAG and I think the PAG is what's really kept it going, the PAG has had some of the same people on it the whole time. We had more turnover on our side." **Comic Relief Stakeholder**

"We play to each other's strengths. That has worked really well and the PAG itself as an entity has worked extremely well. Quite frankly, in the time that I've been involved in the PAG, it has been a really very open discussion platform, where we can really have a good understanding of the programme and it's progress, to provide advice to what needs to be done and provide remedial action where it is required. It's been working really well." **GSK stakeholder**

The stakeholders noted that the **long term nature of the Partnership was a strength** and had facilitated success. Both organizations had shifted strategic direction during the course of the Partnership but the programme was still considered important to both parties. The long term nature of the collaboration (both organizations understood how to work with each other) enabled the changes to be managed while keeping the partnership focus in view.

"Strengthening Global Health Systems was a central strategic priority for Comic Relief when we started but not now, we now talk about early childhood development targeting those who are under five. So that is a shift, the programme still fitted, but it didn't fit squarely and similarly GSK went through a strategic repositioning and obviously are still in the middle of some big changes and whereas this absolutely fitted five, six years ago when it was originally conceived, I think it fits in different ways now, and that's always challenging." **Comic Relief Stakeholder**

6.4.3 The Effects of the Mid-Term Review of the Partnership

The mid-term review (MTR) of the partnership was conducted between December 2018 and April 2019. The evaluation focused on reviewing the Partnership model, approach and architecture and made several actionable recommendations. This resulted in several strategic shifts within the Partnership:

- One of the recommendations was to clarify individual staff's roles and responsibilities for specific activities; but **the recommendation to strengthen the communication between Comic Relief and GSK** was mentioned most frequently in the interviews**.** The MTR was highly appreciated by both organizations - it answered questions about how Comic Relief and GSK could work more closely and in a more coordinated manner with each other. The review enabled a shift in the mode of engagements between the two organizations - improving communication and understanding of perspectives so that both partners could work towards a common goal. The recommendations were considered a turning point in the Partnership leading to a richer experience and more ease of progress.

  "Yeah, I think that midterm review was really brilliant, actually critical to do, really well done, and really well received by GSK and by Comic Relief, but particularly, I was impressed with how GSK received it. Many of the things I had observed, were really highlighted there - that the misconceptions perhaps of

what kinds of communications we would have, how soon we could get different types of stories out, you know, you can't talk about having influenced wider change, when you've only been doing some programmatic interventions for a few months. So, I think that did really help. The allocation of roles or responsibilities was useful as well but I would say under the surface of that review, more critical was an understanding of why had we slightly got the wrong expectations of each other, and how did we realign those?" **Comic Relief Stakeholder**

- Another issue spurred by the mid-term review was **the dedicated advocacy grants** – this increased the Partnership's advocacy efforts. The MTR recommended that At least two grants focusing on activities under Pillar 4 in two focus countries made and that the overall investment under Pillar 4 should be increased significantly. Considering that increased awareness and advocacy was highlighted as the fourth pillar of the Partnership in the theory of change, the expectation is that the advocacy grants should have been introduced earlier, especially given that it takes time to get the desired results within that pillar.

Overall, the MTR was considered to have positioned the partnership for greater success.

"*But I felt that that was a change in the partnership in that it I felt like in the latter part of the partnership that really was strengthened."* **GSK stakeholder**

6.4.4 Comic Relief grant management and ways of working together

Comic Relief as the grant maker of the programme was involved at the scoping, start up and grant management phases. During the start-up phase of the programme, a learning coordination firm was contracted to support Comic Relief, applicants and funded partners to ensure robust and appropriate MEL systems.

The perspectives of the funded partners regarding Comic Relief's grant management were captured. Common themes in the respondents' perspectives have been highlighted in this section. In a few cases, less frequently mentioned views have been presented.

Flexible grant management - All the funded partners were appreciative of Comic Relief's grant management style. The most frequently used adjective to describe it was 'flexible' – respondents stated that this enabled them to be innovative and to address issues easily. They could negotiate on technical issues. Respondents stated that they felt trusted by Comic Relief. The stakeholder ascribed the degree of relevance and coherence of the programme to Comic Relief's grantmaking and management approach:

"In that regard I will actually give credit to the team at Comic Relief that have given us significant flexibility and ownership to make sure that what's resulted from this work will be tailored and fit to the country's needs and be directly responsive to it." **Funded Partner, ALMA, Mozambique**

Comic Relief's approach enabled the funded partners' to respond speedily to the COVID-19 lockdowns in the different contexts. This was widely appreciated by both the partners and the government stakeholders. This flexible approach also reduced logistical delays since issues could be quickly assessed and addressed, sometimes in creative ways.

"*So being not rigid, has been creating much more conducive environment for CHAI to keep on coming up with innovations just to try to keep coming up with the solutions in the public health."* **Funded Partner, CHAI, Tanzania**

Supportive Supervision - Comic Relief was perceived by funded partners' as very supportive of their work, willing to communicate and understand any changes that needed to be made and open to accommodating solutions to emerging problems.

"*It was an organization that gave us the freedom to work as we thought we should work to achieve the results as long as we communicate and justify why we wanted to do it one way and not the other.*" **Funded Partner NWETI, Mozambique**

Supportive supervision was provided virtually and occasionally in-person. The funded partners perceived having Comic Relief stakeholders come into the country to speak directly to the government as really good.

"Not just to throw the money, but at least to be seen physically, of course before corona. We feel that we are working with somebody that uh really, they're interested to see changes, rather than just uh it could be like throwing the money and say, give us the value for money for that. So, I think they're so different from other donors." **Funded Partner CHAI**

Good Logistical Support - Funds were disbursed on time, an aspect that was highly valued by many funded partners. Everything discussed and agreed on was executed on time – there was no administrative or managerial hitches from Comic Relief.

"*And the other important aspect that is worth mentioning that contributed to the success of the project, is the issue of disbursements. We have never had problems with disbursements of funds - Comic Relief was very religious about it"* **Funded Partner NWETI, Mozambique**

Budget lines could be re-aligned where necessary to address urgent needs - a move highly appreciated by many funded partners and which they considered enabled them to be more effective – this was especially seen at the start of the COVID-19 pandemic.

Communication and Reporting – Funded partners reported frequently that there was good communication between them and Comic Relief. The grant maker would always ask questions; project reports were reviewed quickly and feedback provided.

Though majority of funded partners found the reporting template and requirements provided by Comic Relief easy to work with, a few partners highlighted issues that had to be addressed in the project management documents.

"They want to have a very simple document that is universally applicable and that can be very difficult because they work with such a range of partners, in a range of contexts. But I think it'd be very good if they can strengthen that side of things to make it much more clearer, or at least allow us to adapt it for our own specific needs.

Comic Relief is very communications orientated. Throughout the grant there were lots of requests on us to provide photos and case studies and videos and a lot of stuff like that and that's fine, that's great and we would love to do that. A lot of the time, it was very difficult to do because we didn't have the human resources to do it." **Funded Partner GMS**

This highlights the importance of reviewing some demands made on funded partners in the course of the projects. While visibility of projects' effectiveness is useful and can lead to an increase in awareness of malaria, it can create a burden on available resources and may need to be structured and reimbursed differently.

Partner Coordination - Another area underscored by several funded partners for improvement was in the coordination of the funded partners by Comic Relief. The funded partners would have appreciated having more regular meetings with Comic Relief to discuss strategies; the opportunity to see other partners in

other countries face-to face; and visiting another country within the Partnership to see how they were tackling issues around malaria.

"The only thing that I think Comic Relief could do better, is the issue of ensuring coordination between the partners. Because we have similar experiences from other organizations that finance interventions in other areas and when there are 3, 4, 5 partners, they try to ensure the coordination issue. I think that the issue of coordination needs to be improved. example, for a meeting with the national malaria program, all partners may not be there in terms of strategic areas, but for example, I would have difficulty talking about what CUAMM has done, about what another funded partner did. The approach is good, but to make this approach efficient and effective, I think that the issue of coordination is something that needs to be improved. **Funded Partner Mozambique**

6.4.5 Collective Learning including the learning coordination function

Defining the Partnership Collective Learning

The Partnership aimed to promote collective learning between funded partners and across the different geographies. The approach to collective learning was to support organisations to explore and learn from their work; to enable the development of a body of learning for the malaria sector across multiple contexts; and to learn from practice and experience across those different contexts.[49] The principles of collective learning adopted by the Partnership included: collaboration, connectivity; inclusivity; local ownership and leadership; openness and transparency; responsiveness and utility. According to a learning coordinator, Comic Relief communicated that the collective learning would be **very bottom up, partner led, and a way of organizations getting together and deliberating on what would be the most useful thing to learn and present to others for the benefit of the malaria story** in the country or the region and to work collaboratively together on the chosen theme.

"In hindsight, in order for that to have happened, it would have just required a lot more time." **Learning Coordinator**

The Learning Coordination Role

The first phase of the work done by the learning coordination function was providing **monitoring and evaluation support** to organizations who were applying for funding for the Comic Relief GSK malaria partnership grants. Seven MEL Advisors supported the partners to complete start-up forms, and provided general advice on setting up their proposed MEL systems. They provided feedback and guided the organizations through the process of developing a MEL framework for their projects. Generally, this support seemed to have gone well but a particular critique stood out:

"I found the M&E system for the partnership unusable. Instead of having a traditional log form, there was this start-up form, there was a lot of back and forth and back and forth. I mean, it was nearly the end of the first year of implementation before that was agreed upon, which is just as an implementer an absolute nightmare." **Funded Partner**

MEL support to the funded partners did not extend beyond the start-up phase. It is possible that the M&E system had flaws but this was not reported by many of the funded partners. It may be useful for the Parnership to reflect more on the MEL capacity needs of the funded partners and how appropriate support could have been provided.

The initial role of the learning coordinators in terms of supporting individual organizations and their individual projects ceased at the end of their submission of their proposals. The learning coordinators started shifting away from this role by the end of 2017 and eventually focused mainly on providing collective learning support. The collective learning scoping visits to the different countries took place around that time (between August and December 2017). The in-country scoping visits aimed to enable the learning

coordinators introduce and explain the Partnership's collective learning ambitions and see if there was partner appetite to participate; and also allowed the coordinators to provide direct MEL support to some of the partners who were entering the start-up phase of their projects at that time.

Launch of the Partnership's Collective Learning

The Partnership's collective learning component was described in the baseline report of the Learning coordination function of June 2016. However, the Partnership's collective learning expectations were not defined or communicated to applicants at that time. The learning coordinators noted that that was Comic Relief's decision. However, applicant organizations were encouraged by the MEL advisors to set time and budget aside for the proposed collective learning activities. It appeared that because of the lack of clarity about the purpose, structure and definition of the collective learning component, funded partners did not consider this an important element and therefore did not assign the necessary resources to it. The official communication document to the funded partners introducing the collective learning component was dated May 2018, approximately two years after the Partnership had commenced.

The interviews of the funded partners highlighted these issues: the partners considered that the collective learning came late in the project phases and highlighted that it should have been introduced from the start of the project. Many reported that they had not allocated enough time and human resources for such an activity which made it difficult. They noted that the purpose of the collective learning should have been explained earlier. Lack of understanding of the value of collective learning at the beginning was a barrier. Also a lot of meetings and activities were involved for the different partners and made it seem like a burden.

"Even though it's a very brilliant idea, it came late and no one had it integrated in their own projects. I think it was almost like a two-- three years' work. It started ideas in 2018, while people were trying to catch up with their own project, so everyone was like, this is like an additional thing." **Funded Partner, Tanzania**

The learning coordinators were also of the view that the time the collective learning was introduced presented a limitation:

"*This meant that the ambition of what the collective learning could accomplish at that point was quite limited. The partners were busy and limited in what they were able to commit to..*"

Collective Learning – Perceived Value and Challenges

Collective Learning was described by all the stakeholders including the funded partners as good and important. A perceived key value of the collective learning was the multi-sectoral approach. Having the chance of gaining insight into new approaches used by others was considered to be supportive of the funded partners' wider work. There was also a perceived added value of having different partners implementing a variety projects within this partnership - though this did not refer specifically to the collective learning but there was insight into the methodologies and innovations of the other funded partners' projects and this was considered useful.

"They were bringing out methodologies and raising awareness around Malaria using innovative ways through the church so for me it was very interesting, like PIRCOM and then also I like research component like the colleagues from Manhiça in southern Mozambique there is a research center. So I feel that what was innovative in this partnership was that, we were managing to bring together several talents of different sources of the health system engaging different levels of the care." **Funded Partner Mozambique**

"I think it was genuinely welcomed by organizations to know that they were supported to talk with and learn from other organizations on the malaria platform in their country and to work with them in a collaborative way, and to know that they were being encouraged to genuinely learn and think about what they were learning and not just constantly deliver, deliver, deliver and report on outcomes for accountability purposes. That was something that Comic Relief does differently from other donors that grantees really did seem to genuinely welcome."
Learning Coordinator

Some funded partners succeeded in developing learning products while others did not. For instance, in Ghana, AHRH, KHRC, ADRRO and government partners produced a research paper which explored Ghana's Implementation of the Test, Treat and Track Policy for Malaria. Similarly, in Tanzania, APHFTA, CHAI, T-MARC and TCDC with other partners developed a technological solution relating to the surveillance system in Tanzania and produced a policy brief on integrated data collection and reporting from the private sector and SBCC interventions.

Several elements contributed to the outcomes of the collective learning exercise in the different geographies.

- **Learning Coordinator Facilitation** - All the funded partners were satisfied with the facilitation of the learning coordinators. The support they provided were highly appreciated by the funded partners - however, the partners found the quantity (not the quality) of support inadequate. Overall among the funded partners in many of the countries, the commitments of the learning coordinators was frequently mentioned.

  "Well, I worked a lot with Tetra Tech and they were very responsive, I mean, willing to go the extra mile to make sure we were able to produce this even after with follow up meetings, you know, what can we get from what we've done? They were also very involved with that so I think it's been good so far." **Funded Partner, Ghana**

  Most of the challenges described by the funded partners were logistical – delay of funds from Tetra Tech for the collective learning was mentioned several times resulting in funded partners sometimes having to use their own resources.

  The learning coordinators had the perception that **external facilitation was critical to success** because the partners were busy. They noted that there was an intense level of effort and engagement needed to coordinate the partners to deliver the products.

- **Responsiveness of the Funded Organizations** - Success ingredients according to the perspective of the learning coordinators included the capacity of the partners, interest to engage and their commitment of collective learning.

  "I think the biggest lesson, and this is something that we had shared with Comic Relief, at the beginning of the programme, which is that you can't make people learn, people have to want to learn and organizations have to let them want to learn." **Learning Coordinator**

- **Collective learning worked differently in the various contexts for varied reasons** - In Ghana, one of the three funded partners had the most capacity and willingness to take things forward. However, the learning coordinators noted that the success in delivering a learning output would not have happened without external facilitation. This was not because the partners did not have the capacity but mostly because within the limited timeframe, extensive support was required. In Tanzania, the strong drive from one of the organisations ensured that the project was championed and essentially steered the process. In Sierra Leone, the partners were many but according to the learning coordinators were just too busy to participate. Though they were all in the same city, there appeared to be *"no capacity, no attention to engage in another thing"*. In Mozambique, the partners were based in different parts of the country and meeting together was more challenging. The learning coordinators also noted that though GMS was regarded as one geography, that structure did not work for the collective learning. Two of the organizations were in Myanmar, and HPA which was based in Laos and Cambodia though considered as one project, did not see themselves as such. Several funded partners especially in the GMS and Mozambique also highlighted the challenges in coordination of the different organizations because of the geographical distance between the partners.
- **Identifying a common agenda for collective learning** – This proved to be a challenge for partners in Mozambique and the GMS. In the interviews funded partners noted that there would have been added value if the projects could have complemented each other within the same regions. This was highlighted in two geographies.
  "It is better to tell the colleague who is coordinating this that she will not be able to build the project's learning as such because the intervention pillars of each partner were different, they did not cross, no you can't do this at the end, you can't force it…" **Funded Partner Mozambique**

- **Language barriers** – The learning coordinators highlighted language as a barrier to collective learning. This was relevant in the GMS and in Mozambique, though only the partners in Mozambique referred to it. *"I would say that when you work in a country where they speak Portuguese you need someone speaking Portuguese otherwise everything becomes super tough and unnecessarily tough."* **Funded Partner, Mozambique**
  There was a local (Cambodian) learning facilitator in the GMS and that seemed to have worked better for that group.

- **Local Facilitation –** The was a divergence of views about the effectiveness of local facilitation. The learning coordinators were of the opinion that local facilitation had not worked though they noted that the facilitators had put in some good effort. However many funded partners appreciated the roles of the local facilitators. It is possible that though the coordination by the local facilitators did not always translate to development of outputs, the funded partners felt comfortable relating with them. A critical comment by a funded partner described **perceived poor communication between the external and local consultants**:

  "And we realized that these people did not communicate with each other. What happened was that one came and said one thing and two days later another person came and said something else. It

seems that there was no continuity in terms of programmatic orientation, especially in the exercise of "learning". Comic Relief made a great effort to document, for learning, but I think we were not very successful in the learning component because of this lack of guidance, coordination." **Funded Partner, Mozambique**

- **Funded Partner Feedback Mechanism -** The learning coordinators in their final report highlighted the lack of a structured partner feedback mechanism as a hindrance to the success of collective learning. This was an important point. A partner feedback mechanism integrated into collective learning would have been useful- it could have enabled issues to be captured early and addressed. Closing the feedback loop would have been motivating to the funded partners and could have sustained their interest in the process better. A review of the technical proposal submitted by the learning coordinators on collective learning showed that a structured partner feedback mechanism had not been proposed. It would have been useful to propose this from the outset as it may have enabled a better collective learning experience for the funded partners.

7. KEY LEARNINGS AND REFLECTIONS

7.1 What worked well

The Comic Relief / GSK Partnership displayed the effectiveness required by documented evidence on Global Health Partnerships. The partnership contributed to placing malaria on national and international agendas; advocated for mobilizing funding for the malaria sector, stimulated research through its collective learning initiatives, improved access to cost-effective health interventions at country levels, supported national policy and strategies and strengthened the capacity of health service delivery.

The collaboration model of the partnership – using international and national actors, NGOs and local actors to address global malaria and national malaria efforts is in line with the global direction for effective health partnerships as detailed in literature. The Partnership used diverse organizations with different approaches to implement a wide variety of interventions and innovations. This worked quite well within the different contexts and there was evidence of integration with government initiatives, alignment with national strategies, plans and policies and opportunities were created for sustainability of the Partnership's initiatives.

The Partnership's strategy of starting with a scoping exercise carried out by an academic institution positioned it for success. The scoping study was also described a strength of the partnership by stakeholders in the interviews. The fact that it was carried out by a reliable third party increased its credibility. It set the stage for a properly structured partnership – designed intentionally to avoid several pitfalls recognised in literature. Buse et al[10] noted that a commonly reported flaw in Global Health partnerships is their vertical disease specific nature. Though the CR/GSK Partnership was focused mainly on malaria, the scoping ensured that the projects were well integrated into the health systems and no project was implemented in silos. Some funded projects went a step beyond that and addressed febrile case management holistically. The Partnership was also structured to avoid other challenges documented in literature such as the proclivity of global health partnerships to skew national priorities, poor harmonization with country systems, poor accountability and transparency.[10]

The flexibility of Comic Relief including on the budget lines created space for the funded projects to provide innovative solutions to emerging problems during implementation. This allowed the projects to adapt quickly and still achieve some milestones during the COVID-19 pandemic. **This also points to trust exhibited by Comic Relief for the partners** and their acknowledgment that those on the 'field' are better placed to identify what needs to be done. This is a useful model – many donor organizations are more stringent with the issues relating to budget – as evidenced by funded partners who had other donor

support and reported delays in months before they could achieve what they did with Comic Relief within weeks of the pandemic. This responsiveness by Comic Relief enabled the responsiveness of the projects at various levels – an issue frequently highlighted by government stakeholders.

Overall, Comic Relief's non-prescriptive approach to grant making had several advantages – it allowed the individual projects in the partnership to adjust easily to contextual realities, thereby ensuring relevance. However it also had disadvantages.

7.2 What could have been done better.

1. Though the Bank of indicators (BOI) reflected international standards, **many of the funded projects in their choices used indicators that were not in the BOI and which also did not align with international standards.** The projects' indicators should have allowed for international comparison. For instance, for MVs, CHWs, ADDOs, Chemical sellers, indicators needed to reflect country-specific goals, but where possible should also have been consistent with international malaria indicators so that comparisons could be made in the evaluation. Additionally, the BOI recommended which indicators should be in numbers and which should be in proportion but some these were not always reflected at the projects' indicator levels thereby making comparability between projects difficult. Lessons could have been gleaned by comparing project outcomes in different contexts.

   Though the non-prescriptive nature of the Partnership has its advantages, it is also important to strengthen monitoring, evaluation and learning within these kinds of partnerships. The BOI should have been used in order to achieve aggregation of outcomes which would have yielded more evidence of the overall outcome of the Partnership's initiatives and provided more lessons on what works or does not work. Nevertheless, it is important to note that there is a clear tension here. The BOI was developed to support funded partners measure their work based on what they and the communities they served value; this highlights the issue of less conventional realist-based methods of measurement versus more traditional approaches and which would serve such funded projects better. Certainly for the advocacy grants, the traditional methods of measurement were not appropriate. Nonetheless, if future partnerships intend to measure impact of programmes, there is not much room for wiggle because of the rigour needed to demonstrate impact.

2. **The funded projects could have been harmonized better to ensure that there was more complementarity and stronger thrust of collective outcomes within the same regions.** Many of the funded partners in the same country did not know each other and also did not know enough about the projects being implemented by others. This gap was seen clearly when the collective learning was eventually introduced and caused some delays in the uptake of that activity. This lack of harmonisation was also seen at the level of implementation of projects. Partners implementing demand side interventions could have leveraged interventions on the supply side being implemented by other funded partners within the same region. This was a missed opportunity. There are several things that may have contributed to this:
   a) The theory of change was good but did not show the links between the different pillars. This would have highlighted the non-linear nature of the interventions more clearly. Though funded partners were encouraged to implement within more than one pillar, the interventions chosen were not always complementary enough to ensure that the continuum of behaviour change, demand and supply could be addressed in such a way that beneficiaries did not lose the gains of the interventions.
   b) However, it should be noted that in many countries especially in the GMS, the choice of intervention areas was determined to a large extent by the government. The coordination roles played by the governments in the various countries were different, so the approvals needed to intervene in some areas could also have affected harmonization. Additionally, the focus of the

government and partners is usually to avoid duplication of efforts and this may have contributed to choices of location.

Nevertheless, the model of the funded partners implementing diverse interventions across a wide range of localities also had the advantage that many areas and many issues were covered by the Partnership.

3. The collective learning mechanism provided organisations with an opportunity to draw on the extensive pool of knowledge from across the Partnership portfolio of projects while boosting their own skills and knowledge around generating evidence relevant for their context and stakeholders. It was a good innovation and led to the development of several useful knowledge products which can be used to advocate policy and strategy changes. However, the success of that component of the Partnership was hampered because of the way it was structured. **The purpose, structure and potential benefits of the collective learning component should have been clearly defined and introduced at the time of the Request for Proposals**. This would have enabled the organizations to ascribe importance to it and assign the relevant resources (human and financial) and time to it. Many funded partners expressed regret that the collective learning was not started early enough – it was an exercise they felt they could have benefitted greatly from.
4. **The MEL capacity needs of the funded partners may not have been sufficiently addressed in the Partnership.** This was seen in their choice of indicators and in the difficulties displayed with collective learning. There may be a need to reflect on the value of building capacity in the funded partners – making sure that organizations really understand what MEL means and what they would need to budget for and the sort of data that they would need to collect for both monitoring and evaluating impact and also for learning. This will provide a foundation for generating learning at an aggregate level in the Partnership. If there is interest in assessing impact across the whole programme, then being clear on a bank of indicators and the reporting frameworks to be used is necessary. That would need to be a lot more stringent; but could lead to a legacy achieved in that area.
5. **Advocacy grants were started late** – considering that it takes time to achieve the necessary momentum that would translate to actions by decision makers. The MTR was very useful in highlighting this gap and CR/GSK were responsive in ensuring that grants were made available to drive this component. However, the consequence of this late start was magnified by the COVID-19 pandemic. Since the grants had started in 2019, they had not achieved enough momentum to create the level of policy influence that would generate actual release of funds into the sector. Nonetheless, there was clear evidence of contribution to agenda setting at the country and Africa regional levels and to the credit of the funded grants, a lot of activities were implemented in a short space of time before the pandemic struck. Indeed, some of the momentum achieved was lost due to COVID-19. The success of the advocacy efforts of the other funded grants display the usefulness of evidence generation in convincing decision makers to take action. A case could be made that the integration of advocacy efforts with implementation of the other pillars was a more effective model; but more time would be needed for the implementation of the dedicated advocacy grants before a valid conclusion can be made.

7.3 Sustainability

There were many elements that provided opportunities for sustainability of the Partnership's initiatives especially the **integration of funded projects with government structures and programmes** even beyond the malaria sector. However, an important barrier to sustainability was that **most of the projects did not have a systematic exit strategies and transition plans were not in place.** A lot of the activities will end with the projects - many funded partners (and some government stakeholders) considered that they would need more time because of the relative short time of implementation. For some in the GMS, getting approvals consumed a significant portion of their time. Many of the projects made quick gains but

whether those gains would be sustained without consistent activities on ground was not always clear. Nevertheless, the expectation is that the vast array of knowledge and skills strengthened; as well as the attitudes and behaviours changed in the communities as a result of the projects' activities will last beyond the programme. However, it is of note that sustainable behaviour change takes many years or even decades to accomplish.[50]

A good point is that all the projects collaborated with the NMCP - some more than others - and those that had their activities embedded in the health system - are more likely to be sustainable. Again this depends to a large extent on the NMCP. It is to be noted that the NMCP is focused a lot on their coordination roles (many partners / donors in all the countries) - so at the microlevel, there is the possibility that a lot of the interventions implemented will fall through the cracks because the level of attention needed may not be available. **Many of the projects worked with community level volunteers, chemical sellers, young researchers /advocates** and experienced good outcomes because of these types of stakeholders. **Many of those stakeholders were motivated more intrinsically (e.g. the sense of being valued and contributing something important) than extrinsically (e.g. via financial incentives) - which is a good thing.** However, meetings and discussions (and possibly refresher trainings) are usually needed to keep the momentum going for these types of groups and that requires even minimal funding which the NMCP does not have for those types of activities. Nonetheless, the **intrinsic elements such as motivation of informal private providers and community stakeholders and the responsibility for action displayed by the latter group present a potential for longevity of some of the Partnership's achievements.**

For the informal sector - the projects have shown their value within the health sector through the support of the Partnership. Various NMCP stakeholders reported as much in the interviews and most of the private sector data was fed into the formal health sector further buttressing the evidence. However, without integration of these informal providers into the country malaria policies and strategies, the momentum would also be lost. These groups of providers require profit and the win-win strategy implemented by some projects in the partnership in collaboration with the NMCP needs to be advocated to ensure continuity. As things stand at the moment, many funded partners hope things will continue to ensure sustainability but it is not always clear if they will.

7.4 Limitations

A limitation in this final evaluation is the lack of aggregated baseline data for the Partnership. However, this is a common problem in many projects. Bamberger (2009) noted the need for reconstruction of baselines in many projects even though "project monitoring, impact evaluation, results-based management and effects assessment are all based on the comparison of observed changes in the project population with the situation prior to the launch of the project."[2] While some of the funded partners conducted baseline studies for their projects, many did not. In any case, the projects are quite varied as already noted, so aggregation would still have been challenged. Though the decision for the MTR to be focused on the Partnership model was intentional, it would have useful for the endline evaluation if it had also focused on outputs and outcomes of the Partnership. We would then have been able to use the findings of the MTR as a reference point beyond the Partnership model.

The possibility of social desirability and recall bias in answers given during the SSI is a limitation. However, we expect that validity of the findings has been increased by triangulation of qualitative data from the SSI with findings of the desk review and secondary quantitative data.

[2] Michael Bamberger (2009) Strengthening the evaluation of programme effectiveness through reconstructing baseline data, Journal of Development Effectiveness, 1:1, 37-59, DOI: 10.1080/19439340902727610

8. CONCLUSION AND RECOMMENDATIONS

8.1 Conclusion

The partnership between Comic Relief and GSK provides an example of a successful Global Health Partnership – bringing together two different but complementary organizations who leveraged their collective strengths to achieve a common global health goal. The Partnership Advisory Group was an innovative model and a driving force of the Partnership.

The Partnership had a model of strong collaboration with governments including the National Malaria Control Programmes and embedded a number of its initiatives into existing structures within the health systems. Community level approaches made quick gains in the intervention areas due to amplification of community voices and empowered communities who took responsibility for action and displayed action oriented behaviour. Improved capacity of health workers in the public, private sectors and community levels and across pillars was a solid achievement. The combination of this and the strengthening of surveillance systems, including the integration of data from the private sector into the public sector, led to some broader health systems strengthening. However, health systems strengthening was limited due to integral weaknesses within the health systems beyond the scope of the programme. There was some potential for sustainability but challenges as well. It is hoped that the momentum created by the Partnership will be maintained by the wide variety of stakeholders at national, district, provincial and community levels with whom the funded partners collaborated.

Future partnerships should leverage the scoping exercise at the start, to explore what would make collective learning work in different project contexts.

8.2 Recommendations

Target Audience	Recommendations
Comic Relief	1. Future partnerships should ensure that in the **Theory of Change** – the intersection between key pillars/domains and the assumptions which are tested are reflected clearly both in narrative text and in the TOC illustration. This will enable better understanding of the non-linear nature of the issues and set the stage for better harmonisation of funded projects. 2. **Collective Learning:** a. Should be defined clearly, structured and introduced to applicants at the level of Request for Proposals (RFP) and embedded into their contracts with time and budgetary allocations. b. Inclusion of a collective learning product such as peer reviewed publication as a deliverable linked to disbursements will motivate more commitment to the process by the funded partners. c. The international facilitators should be supported in the countries by strong local facilitators in order to address the 'quantity' element of the facilitation. d. Funded Partner Feedback Mechanisms should be integrated into the collective learning process; and during implementation, the

coordinators should ensure that feedback loops are always closed in order to maximize the utility.

e. For future partnerships that have collective learning high on the agenda, careful considerations should be given in the beginning to the choice of organizations for funding. It may be useful during the application stage to identify who the champions for collective might be within each organization, the capacity in the culture for learning within the organizations; and if that capacity doesn't exist, to assess whether the partnership would invest time and money building it or whether that would be a requirement flagged to the organization at that early stage.

3. **Review the project reporting template and make it more analytical** - Though most of the funded partners liked the light touch of the reports, Comic Relief could consider gaining more out of the annual reports by structuring the template with more critical analytical questions. This could also drive the learning agenda right from the first year of implementation – by adding questions that reflect on possibilities for collective learning and what themes the partners would be keen on collaborating on.

4. **Ensure better harmonization of funded partners and projects**:

   a. We recommend budgetary allocation to a workshop with all the funded partners at the start of the Partnership. This will enable them to become acquainted with each other early enough in the Partnership. This may involve choosing an appropriate location they would all go to for a few days. It has the advantage that they could present their planned projects including the intervention areas and establish a network right from the start of the projects. Many of such networks have yielded more benefits beyond specific Partnerships.

   b. Using diverse projects to implement different interventions is a good innovation but consider more alignment of project intervention areas to ensure that different solutions are leveraged by different pillars. The discussions about how best the projects could be positioned within specific intervention areas to ensure better harmonisation could be held with national and local government stakeholders during the scoping exercise.

5. **Consider restructuring the learning coordination function** – Future partnerships should either 1) disaggregate the M&E role from the learning role and provide two different positions to relevant experts; or 2) Structure a comprehensive MEL role which incorporates building capacity of the funded partners. This role should also focus on ensuring that funded partners understand the need to evaluate impact across the the whole programme, the importance of a bank of indicators; relevant data that needs to be

	collected to assess outcomes and impact and for learning; and the use of reporting frameworks 6. **Calls for advocacy concept notes and grants should be done at the same time as other funded projects**. During that time, it would be useful to review potentials for collaborations between advocacy grants and other funded projects.
GSK	1. **Future partnerships should leverage the Partnership Advisory Group model** for their operational and strategic processes. Effective communications between partners can be structured right from the start of the partnership by: • Meaningful engagement and clear communication for the organizations to understand each other as quickly as possible. For instance, clarity on different types of communications that would be expected; mapping out communications goals and objectives and being clear about the difference between organizations and the significance of that within the Partnership would enable clear understanding from the start. • Discussions on needs and expectations of both organizations at the early stage should be encouraged. **2.** Engagement with the government stakeholders by Comic Relief and GSK were very much appreciated by the funded partners and increased their credibility with the governments. **Structuring more of such visits into the Partnership is recommended.**
Funded Partners	3. **The micro-financing strategies used are an innovation of the Partnership and should be sustained**. However the private sector needs to be motivated with strategies that highlight their gain in order to continue. Extrinsic motivation can be enhanced through financial strategies that outlast the projects and intrinsic motivation via Associations and awards for contribution to health care in the public sector. 4. **Ensure you have an exit-strategy from the start** and a transition plan (Comic Relief should ask for this more explicitly at the beginning of the project). Exit strategies and transition plans should be **tailored to the contexts** and could include the following: • Beyond collaboration with the NMCP stakeholders at national levels, ensure that project initiatives are anchored at the local government (district and provincial) levels. The capacity built at the provincial level in the CUAMM project in Mozambique enabled the government stakeholders to continue some of the project activities after the project's exit. • Secure additional institutional (including NMCP) support to explore the possibility of initiatives involving community stakeholders such as young

	advocates to register as non-profit organizations; and provide fundraising training before the funded projects' exit. • Connect community champions and change agents to networks – for instance, networking meetings with civil society organisations, non-governmental organisations, and government agencies can be organized to link change agents and community champions with local networks they can work with beyond the projects' lifespan. 5. **Ongoing Advocacy efforts can be sustained by developing strategies to retain young advocates/researchers** – many of them may go on to jobs at the end of the projects. However, their communities still reach out to them as focal persons for issues. These change agents can keep the momentum going with minimal financial investments (for meetings and refresher trainings) which they can also be trained to attract through grants; and intrinsic motivational strategies (awards, networks etc.)
Other existing and potential donors – for future funding opportunities	We recommend **a review of the CR/GSK Partnership model as a best practice example** in the Global Health Partnerships. Several elements should be put into consideration while structuring such partnerships: 7. The partnerships should be long-term preferably not less than five years; 8. Scoping studies at the start will position programmes for relevance and coherence with the contexts. A good strategy would be to prioritize organizations that are already established within the contexts for funding; but it is important to ensure that other partners that have the potential to work well within the contexts are also considered. 9. Flexibility in grant making creates an enabling environment for innovative solutions; 10. A partnership advisory group supports strategic direction, enables clear communications and drives success. 11. Organizations should maintain an awareness that strategic shifts may occur over the long term and build in the flexibility to ensure that the partnership goal is kept in focus. 12. Collective Learning is a good strategy; has the possibility of contributing to the evidence base and generating knowledge / learning products for advocacy. However, it should be structured properly and introduced early in the programme.

ANNEX 1 – FUNDED PARTNERS

Country / Region	Funded Partners	Period	Funds
GMS	Malaria Consortium	01/07/17-15/02/2020 =2	£1,150,746
	HPA	01-Aug-17-01/08/2020 =3	£1,000,000
	PSI	01-Jul-17-15/01/2020 =2	£395,203
Sierra Leone	IRC	01-Sep-17-01/11/2019 = 2	£330,939
	On our Radar	01-Oct-17-01/09/2019 =2	£205,988
	BBC Media Action	01-Oct-17-31/08/2020 =2	£750,071
	Kings Global Health Partners	01-Sep-17-01/07/2020 =2	£366,838
	Restless Development	01-Jan-18-01/03/2020 = 2	£268,776
	Health Poverty Action	01-Sep-17-01/11/2020 = 3	£435,076
	Concern Worldwide	01-Oct-17-01/12/2020 = 3	£750,000
Tanzania	T-MARC	01-Aug-18-01/11/2020 = 3	£822,249
	APHFTA	01-Jan-17-01/09/2020 = 3	£995,675
	ALMA*	01-07-2019 – 28/05/2021 = 4	£320,000
	CHAI	01/11/2016-5/11/2020 = 3	£955,328
	TCDC	01/11/2016-01/07/2020 = 3	£890,497
Ghana	ADDRO	01/07/2020-01/08/2021 = 4	£992,012
	Speak Up Africa	01-Jun-2019 – 30-Apr-2021	£409,728
	ARHR	31/03/2020-01/03/2021= 3	£395,203
Mozambique	PIRCOM	01-Jan-17-01/03/2020 = 3	£537,323
	CUAMM	01-Jan-17-01/03/2020= 3.5	£774,491
	MANHICA	01-Jan-17-01/09/2020 = 3.5	£1,190,761
	NWETI	01-Mar-17-31/03/2020 =3	£997,851
	ALMA*	01-Dec-2019 – 30-Apr-2021 = 3	£250,000
UK	Results UK	01-Jul-19 – 01-Mar-2021= 4	£414,119
	Malaria No More	01-Jul-19 – 30-Apr-2021	£510,110

ANNEX 2: KEY EVALUATION QUESTIONS

Relevance and Coherence

- To what extent were the interventions delivered funded partners in line with the Partnership Theory of Change and objectives?
- To what extent did the interventions correspond with the priorities, needs and practical requirements of the focus countries?
- How did the work of the Partnership align with, stay relevant to (or distinct from) national, regional and global movements / agendas on malaria and global health, e.g. Universal Health Coverage?

Effectiveness

- How effective were malaria interventions as an entry point for broader Health System Strengthening in the focus countries?
- To what extent, and in what ways, did the interventions contribute to Health System Strengthening in the focus countries?
- To what extent did the various interventions address the gaps identified at baseline and achieve the intended outcomes?

Sustainability and Resilience

- What elements (intrinsic and/or extrinsic) denote sustainability in the various interventions?
- To what extent did the interventions strengthen local capacity, ownership and leadership such that they are resilient to chronic and acute shocks beyond the life of the Partnership?
- To what extent has using malaria as an entry point contributed to health systems strengthening that show signs of continuing beyond the life of the Partnership?
- How did the Coronavirus disease (COVID) -19 pandemic affect malaria programming related to the Partnership in the focus countries?

The Partnership Model

1. To what extent has the partnership model, principles, governance and other key elements enhanced the delivery of the Partnership's goals?
    - learning coordinator function – to understand whether the MEL strategy (with its focused on collective learning and research), has facilitated and supported funded partners effectively in collective level learning and contributed to individual project MEL systems
    - grant making and management approaches – to understand whether scoping, application and grant management processes facilitate improved programme delivery;
    - the role of the Advocacy and Communications working group and activities – to understand how this work has contributed to the overarching Partnership goals;

ANNEX 3 : EVALUATION FRAMEWORK

Specific Objectives / sub-objectives	Specific evaluation questions	Data Collection & information sources	Data analysis
A. RELEVANCE: Determine the relevance and coherence of the funded partners' projects in addressing the priority issues of malaria elimination and health systems strengthening			
A1 To assess the alignment of the funded partners' projects to country realities and to national, regional and global priorities	1. How robust was the Partnership's theory of change and how was it adapted to the result chain and programme logic? 2. To what extent were the interventions delivered by the funded partners in line with the Partnership Theory of Change and objectives? 3. To what extent did the various Country Statement Documents (national malaria strategies and plans) inform the programme? 4. To what extent was the programme informed by the specific gaps identified by the National Malaria Control Programmes (NMCP) in the focal countries? 5. To what extent were the activities and outputs of the programme consistent with the intended results? 6. To what extent did the funded partners' projects capitalize on opportunities for cross-sectoral integration? 7. Were the intervention choices based on an assessment of options and a sound evidence base? 8. Are the programme's resources and services designed to effectively respond to identified needs, problems and risks? 9. To what extent did the Scoping conducted contribute to the relevance and appropriateness of the chosen interventions.	• Desk Review ○ Programme's documents and reports, • Monitoring and Evaluation records, • Baseline, Midline, Endline and other studies • Technical guidelines • Semi-structured interviews with funded partners • Key informant interviews with all relevant stakeholders, including CR, GSK, Learning Coordinators, NMCP and other relevant (provincial and district level) government stakeholders, • Stakeholder workshops	Descriptive analysis Thematic analysis Analysis of Theory of Change (ToC) of the Programme and its assumptions
B EFFECTIVENESS: Understand the effectiveness of the Partnership in relation to the programme's intended outcomes			
B1 To assess the extent to which the Partnership's Interventions has been implemented effectively	1. To what extent were the implemented activities consistent with the programme design? 2. What are the factors that either enabled or undermined programme implementation fidelity? 3. To what extent did the various interventions address the gaps identified at baseline and achieve the intended outcomes? 4. How did private sector partnerships influence the achievement of the intervention results? 5. How did the focus on the private including the informal sector in several focus countries (Sierra Leone, GMS, Ghana) influence outcomes?	• Secondary data from population surveys – DHIS-2 • Desk Review • Programme's documents and reports, • Monitoring and Evaluation records, • Baseline, Midline, Endline and other studies • Technical guidelines • Semi-structured interviews with funded partners and their local (including private sector) partners	Descriptive analysis Thematic analysis

	6. How did the community level projects contribute to Partnership's intended outcomes? 7. Has the Partnership achieved its planned targets thus far? 8. What enablers and barriers (internal and external) have facilitated the Partnership to achieve or not achieve planned results? 9. To what extent were the recommendations by the mid-term review taken up by the programme?	• Key informant interviews with all relevant stakeholders, including CR, GSK, Learning Coordinators, NMCP and other relevant (provincial and district level) government stakeholders, relevant private sector partners • Stakeholder workshops	
B2 To assess to the extent to which the Partnership's interventions have led to institutional and capacity strengthening	1. How effective were malaria interventions as an entry point for broader Health System Strengthening in the focus countries? 2. To what extent, and in what ways, did the interventions contribute to Health System Strengthening in the focus countries? 3. What are the perceptions of the government and private sector partners regarding strengthening of their institutional capacities across pillars 1-4? 4. To what extent did monitoring, evaluation and accountability mechanisms inform the programme's learning and adjustment? 5. What was the added value of having different partners implement a variety of projects within the same partnership? What was the collective / shared learning? 6. Were there any positive or negative unintended effects identified during the programme's implementation? How were they addressed?	• Secondary data from population surveys – DHIS-2 • Desk Review • Programme's documents and reports, • Monitoring and Evaluation records, • Baseline, Midline, Endline and other studies • Technical guidelines • Semi-structured interviews with funded partners • Key informant interviews with all relevant stakeholders, including CR, GSK, Learning Coordinators, NMCP and other relevant (provincial and district level) government stakeholders, relevant private sector partners • Stakeholder workshops	Secondary data analysis Descriptive analysis Thematic analysis Causal contribution analysis Triangulation of different data sources
C SUSTAINABILITY – Assess the sustainability of the projects' efforts to tackle malaria and strengthen health systems in the focus countries			
C1 To assess the extent to which mechanisms are in place to ensure the sustainability of Partnership projects' gains	1. What elements (intrinsic and/or extrinsic) denote sustainability in the various interventions? 2. To what extent did the interventions strengthen local capacity, ownership and leadership such that they are resilient to chronic and acute shocks beyond the life of the Partnership? 3. Do the projects' design include appropriate sustainability and exit strategies (including promoting national/local ownership, use of local capacity, etc.) to support positive changes, including gender and equity related, after the end of the intervention? 4. To what extent did the projects support national processes such as strategic plans, policy development, development of	• Desk Review • Programme's documents and reports, • Monitoring and Evaluation records, • Baseline, Midline, Endline and other studies • Technical guidelines • Semi-structured interviews with funded partners • Key informant interviews with all relevant stakeholders, including CR, GSK, Learning Coordinators, NMCP and other relevant (provincial and	Descriptive analysis Thematic analysis

	laws/legislations, guidelines as proxies of supporting sustainable efforts 5. To what extent has using malaria as an entry point contributed to health systems strengthening that show signs of continuing beyond the life of the Partnership? 6. What are alternative implementation modalities which could be utilized moving forward?	district level) government stakeholders, relevant private sector partners • Stakeholder workshops	
C2 To assess the extent to which the malaria programmes related to the partnership have displayed resilience in the face of COVID-19 pandemic	1. How did the COVID-19 pandemic affect malaria programming related to the Partnership in the focus countries? 2. Has the partnership strategy led to improved efficiencies, including during emergencies within the focal (interventions) areas? 3. Have the programmes responded in a timely and relevant manner in the COVID-19 crises? 4. How has risk been managed?	• Monitoring and Evaluation records, • Semi-structured interviews with funded partners • Key informant interviews with all relevant stakeholders, including CR, GSK, Learning Coordinators, NMCP and other relevant (provincial and district level) government stakeholders, relevant private sector partners • Stakeholder workshops	Descriptive analysis Thematic analysis
D PARTNERSHIP'S MODEL : Evaluate the effectiveness of Comic Relief's grant making, grant management and partnership approach			
D1 To what extent has the Learning coordinator function enhanced the delivery of the Partnership's goals?	1. To what extent did the MEL strategy (with its focus on collective learning and research), facilitate and support funded partners effectively in collective level learning? 2. To what extent did the Learning coordinator function contribute to the Collective Learning and MEL of the Partnership? 3. What is the perceived value of the collective learning to different stakeholders 4. To what extent was the collective learning component of the Partnership integrated with the Advocacy and Communication elements?	• Desk Review • Programme's documents and reports, • Monitoring and Evaluation records, • Baseline, Midline, Endline and other studies • Technical guidelines • Semi-structured interviews with funded partners • Key informant interviews with all relevant stakeholders, including CR, GSK, Learning Coordinators, • Stakeholder workshops	Descriptive analysis Thematic analysis Causal contribution analysis Triangulation of different data sources
D2 To what extent has CR Grant making and management approaches enhanced the delivery of the Partnership's goals?	1. To what extent did the scoping processes facilitate improve programme design and delivery? 2. Were the expectations of the NMCP articulated during scoping met by the programme? 3. How useful were the in-country consultations carried out during the scoping? 4. To what extent did the application processes facilitate improved programme delivery?	• Desk Review • Programme's documents and reports, • Monitoring and Evaluation records, • Baseline studies • Technical guidelines • Semi-structured interviews with funded partners, CR, GSK, Learning Coordinators,	Descriptive analysis Thematic analysis Causal contribution analysis Triangulation of different data sources

	5. To what extent did the multiple rounds of grant making (impact grants, advocacy grants and top-up grants) enhance the delivery of the Partnership's goals? 6. To what extent did CR grant management processes (post grant making i.e the 6 and annual reporting and feedback, the monitoring visits, use of grant management systems, and top-up processes) facilitate improved programme delivery? 7. How did CR and GSK work together to achieve the Partnership's goals? a. How did the PAG model work? What were some of the individual organizational strategic priorities that were adopted? b. To what extent did the PAG model strengthen CR-GSK communications? Were the expectations met? What worked or did not work so well? c. How did the partnership communication management clarify the individual staff roles and responsibilities for specific activities as recommended in the MTR? 8. What are some of the partnership success stories? What were the challenges that hindered effectiveness	• Stakeholder workshops	
D3 To what extent has the role of the Advocacy and Communications working group and activities enhanced the delivery of the Partnership's goals?	1. To what extent has the Partnership advocacy strategy enhanced programme visibility and awareness of malaria? How? 2. To what extent have innovative or alternative modes of strengthening advocacy and awareness creation been explored and exploited to maximize results in the different contexts? 3. How has the role of the Advocacy and Communications working group and activities contributed to the overarching Partnership goals	• Desk Review • Programme's documents and reports, • Semi-structured interviews with funded partners • Key informant interviews with all relevant stakeholders, including CR, GSK, Learning Coordinators, BMGF	Descriptive analysis Thematic analysis Causal contribution analysis Triangulation of different data sources

ANNEX 4: INFORMED CONSENT AND TOPIC GUIDES

Informed Consent - Interview - Final Evaluation of the Comic Relief GSK 'Fighting Malaria, Improving Health' Partnership.

OAG is conducting the Final Evaluation of the Comic Relief GSK 'Fighting Malaria, Improving Health' Partnership. This consent form explains the evaluation and the role of participants in the study. Please consider this information and take as much time as you need. If you have questions at a later time, you can ask any of the members of the evaluation team.

The **purpose of this evaluation** is to assess the achievements and outcomes of the Partnership and to assess Comic Relief's approach to grant making and management. To do this, the evaluation will focus on addressing the following four objectives:

- Determine the **relevance and coherence** of the funded partners' projects in addressing the priority issues of malaria elimination and health systems strengthening
- Understand the **effectiveness** of the Partnership in relation to the programme's intended outcomes
- Assess the **sustainability** of the projects' efforts to tackle malaria and strengthen health systems in the focus countries
- Evaluate the **effectiveness** of Comic Relief's grant making, grant management and partnership approach

Voluntary Participation

We are inviting you to participate in this study because you are a Comic Relief or GSK staff
Your participation in this study is entirely voluntary. It is your choice whether to participate or not. You may change your mind and stop participating at any time.

Procedures

We would like to ask you some questions relating to the Comic Relief GSK 'Fighting Malaria, Improving Health' Partnership. Your perceptions of the achievements and outcomes of the Partnership; how things worked out – what facilitated changes and how? What were the barriers faced? And areas for improvements.
To make sure that I don't forget or change what you are saying to me I ask for your permission to tape and write down the conversation. Everything that will be recorded and written down will be confidential. Please note that you can refuse to give your permission to this.

Duration

The interview will last for about 60-90 minutes

Benefits

There are no direct benefits to you from being in the study.

Risks, discomforts and rights to withdraw

There are no obvious physical, psychological, social, economic, legal, and emotional risks in participating in this study. Participation in this study is voluntary. During the interview, you are allowed to refuse to answer any question and you are allowed to stop the interview at any time. There are no consequences should you decide not to continue with the interview.

Confidentiality and Privacy

The information that you give us is completely confidential. We will not associate your name with anything that you say. We will not use personal identifiers for the information obtained. Privacy will be assured during this interview by having it here (or virtually).

Do you have any questions? **Do you consent to the interview?**

Topic Guide – Interviews with Comic Relief and GSK stakeholders

I'd like to start by having you briefly describe your role and responsibilities within the Partnership (as a Comic Relief and/or Advocacy and communications group; GSK staff and/ or PAG member)

First Objective - relevance and coherence of the funded partners' projects in addressing the priority issues of malaria elimination and health systems strengthening

1. Alignment of the funded partners' projects to country realities and to national, regional and global priorities
    a. How would you describe the way malaria elimination issues were addressed by the Partnership and by the funded partners? (Probe for how the four pillars were addressed)
    b. What is your perception of the scoping exercise carried out by the LSHTM? (Probe for who did what, who took decisions, Probe for perceptions of usefulness/importance of the scoping exercise, ask for reasons;)
    c. What is your perception of the extent to which the programme was informed by the specific gaps identified by the National Malaria Control Programmes (NMCP) in the focal countries? (Probe for perceived value of the collaboration for the focal countries as a whole and for the country malaria programmes and health systems; ask for reasons and examples)

Second Objective - the effectiveness of the Partnership in relation to the programme's intended outcomes

2. During these past five years, how would you describe changes due to the funded partners' projects' in the focal areas? (Probe for changes relating to the four pillars - Supply of Good Quality Primary Health Care; Demand for and access to Primary Health Care; Better surveillance and Information Systems; Improved awareness of malaria and the work of the Partnership)
3. How can these changes been explained - what do you think has made it possible for these changes to happen? Why? What else?
4. What do you think has made it difficult for changes to happen? Why? What else?
5. What is your perception of the value of using malaria interventions as an entry point into the countries' health systems? (Probe for different country experiences); Did this work better for any Pillar compared to others?
6. What, in your opinion, was the added value of having different partners implement a variety of projects within the same partnership? What was the collective / shared learning?
7. What is the strength of the Partnership and what could be improved?
8. What external (national, provincial, district, community level) and internal (organizational) contextual factors have been of influence on the programme (positive and negative)?
9. Is there any indication that the Partnership projects have led to broader health systems strengthening? How? (Probe for institutional and local capacity strengthening) ? How?
10. What is according to you the Most Significant Change that has taken place as a result of the Comic Relief GSK 'Fighting Malaria, Improving Health' Partnership?

Third Objective - **the sustainability** of the projects' efforts to tackle malaria and strengthen health systems in the focus countries

In this section ask specifically for the positive changes as a result of the Partnership that have been described by the respondents in the previous sections

11. In your opinion, what are the things which can make these achievements continue working even if there is no outside help? (Probe for intrinsic and extrinsic elements - examples of change of mind-set; the use of local resources/ capacities and /or networks that are (or can be) effectively applied to sustain the achievements of the response. Ask for examples of how the countries / communities has demonstrated ownership and capacity to self-support in the project)

Fourth Objective – The Partnership's model

- **Comic Relief's grant making, grant management and partnership approach**

12. In your opinion, to what extent did the scoping processes facilitate improved programme design and delivery? (Probe for the scoping exercise, in-country consultations and the application process)
13. Do you think this way of working (scoping, in-country consultations and the application process) was useful? Why? Why not?
14. What is your perception of the extent to which CR grant management processes facilitated programme delivery?
15. What is your perception about the 3-4 rounds pf grant making? What lessons were learned as the rounds progressed?
16. What in your opinion was the usefulness of having additional grants after the initial grants? (Probe for impact grants, advocacy grants and top-up grants)
17. To what extent did CR grant management processes (post grant making i.e the 6 and annual reporting and feedback, the monitoring visits, use of grant management systems, and top-up processes) facilitate improved programme delivery?
18. How did CR and GSK work together to achieve the Partnership's goals?
    a. How did the PAG model work? What were some of the individual organizational strategic priorities that were adopted?
    b. To what extent did the PAG model strengthen CR-GSK communications? Were the expectations met? What worked or did not work so well?
    c. How did the partnership communication management clarify the individual staff roles and responsibilities for specific activities as recommended in the MTR?
19. What are some of the partnership success stories? What facilitated or hindered effectiveness?
20. In your opinion, how could things have been done differently? (Probe for specific issues highlighted)
21. To what extent were the recommendations made during the mid-term review including improving Partnership principles awareness implemented? (Probe for different recommendations and the challenges/successes of uptake)

- **Learning Coordinator function**

22. In your opinion, to what extent did the MEL strategy (with its focus on collective learning and research), facilitate and support funded partners effectively in collective level learning?
23. What is your perception of the extent to which the 'collective learning' contributed to the overall project? (Probe for what worked well and what did not work so well)
24. What, in your opinion, are alternative modalities which could have been utilized in the MEL strategy?
25. To what extent have the recommendations of the mid-term review regarding maximizing the benefits of the learning strategy and aggregation of outcomes been implemented? (Probe for challenges and successes)

- **Advocacy and Communications working group and activities**

26. How has the role of the Advocacy and Communications working group and activities contributed to the overarching Partnership goals? (Probe for Partnership visibility and awareness of malaria)
27. To what extent have innovative or alternative modes of strengthening advocacy and awareness creation been explored and exploited to maximize results in the different contexts?

Topic Guide – Interviews with Learning Coordinators

I'd like to start by having you briefly describe your role and responsibilities within the Partnership as a Learning Coordinator

First Objective - relevance and coherence of the funded partners' projects in addressing the priority issues of malaria elimination and health systems strengthening

1. Alignment of the funded partners' projects to country realities and to national, regional and global priorities
    a. How would you describe the way malaria elimination issues were addressed by the Partnership? (Probe for how the four pillars were addressed)
    b. What is your perception of the extent to which the programme MEL tools including the bank of indicators aligned with the national and local malaria programme indicators; ask for specific examples)

Second Objective - the effectiveness of the Partnership in relation to the programme's intended outcomes

2. During these past five years, how would you describe changes due to the funded partners' projects' in the focal areas? (Probe for changes relating to the four pillars - Supply of Good Quality Primary Health Care; Demand for and access to Primary Health Care; Better surveillance and Information Systems; Improved awareness of malaria and the work of the Partnership)
3. How can these changes been explained - what do you think has made it possible for these changes to happen? Why? What else?
4. What do you think has made it difficult for changes to happen? Why? What else?
5. What, in your opinion, was the added value of having different partners implement a variety of projects within the same partnership? What was the collective / shared learning?
6. What is the strength of the Partnership and what could be improved?
7. What external (national, provincial, district, community level) and internal (organizational) contextual factors have been of influence on the programme (positive and negative)?
8. Is there any indication that the Partnership projects have led to broader health systems strengthening? How? (Probe for institutional and local capacity strengthening)? How?
9. What is according to you the Most Significant Change that has taken place as a result of the Comic Relief GSK 'Fighting Malaria, Improving Health' Partnership?

Third Objective - **the sustainability** of the projects' efforts to tackle malaria and strengthen health systems in the focus countries

In this section ask specifically for the positive changes as a result of the Partnership that have been described by the respondents in the previous sections

10. In your opinion, what are the things which can make these achievements continue working even if there is no outside help? (Probe for intrinsic and extrinsic elements - examples of change of mind-set; use of local resources/ capacities and /or networks that are (or can be) effectively applied to sustain the achievements of the response. Ask for examples of how the countries / communities has demonstrated ownership and capacity to self-support in the project)

Fourth Objective – The Partnership's model

- **Comic Relief's grant making, grant management and partnership approach**

11. In your opinion, to what extent did CR grant management processes facilitate improved programme delivery?

- **Learning Coordinator function**

12. In your opinion and given your experiences with the Partnership Learning Coordination function, what was the value of the collective learning?
    a. Which approach to facilitating collective learning would you consider most practical and achievable given the time and resource constraints of partners? (Probe for differences in approach for countries or regions)
13. What is the extent to which the collective learning component of the Partnership was integrated with the advocacy element? How could effectiveness have been improved? What could have been done differently?
14. All the countries and regions had external facilitation and financial support to enable Collective Learning - Why were some funded partners more effective in developing collective learning outputs compared with other countries? What does this mean for the learning coordinator role?
15. Contextual issues seemed to have influenced the effectiveness of using in-country Collective Learning Leads according to the LC report. How could things have been done differently to ensure that in-country facilitation would work better?
16. In your opinion (and given that malaria control is not a sensitive topic) why was there so much reluctance from the funded partners to share information across different countries and regions?
17. In your opinion, how should the learning outputs be amplified or leveraged by Comic Relief in the future?
18. In the proposal for the Learning Coordinator function developed by the MEL organization– what elements were included?
    a. Why was there no structured/ formal partner feedback mechanism linked to the Learning Coordinator role? Was this proposed to Comic Relief? (Probe for why the LC did not design one proactively?);
    b. Would it have been possible to include a systematized pause and reflect model with CR-GSK in the proposal? If yes, why was this not done?
    c. Was the need for disaggregation of MEL capacity support and collective learning roles highlighted or proposed? Why? Why not? What were the assumptions and risks captured in the proposal?
19. To what extent were the recommendations of the mid-term review regarding maximizing the benefits of the learning strategy and aggregation of outcomes implemented? (Probe for challenges and successes)

Topic Guide – Interviews with Funded Partners

I'd like to start by having you briefly describe your role and responsibilities within the Partnership as a funded partner

First Objective - relevance and coherence of the funded partners' projects in addressing the priority issues of malaria elimination and health systems strengthening

1. Alignment of the funded partners' projects to country realities and to national, regional and global priorities
    a. Please can you give an overview of your project? (Probe for pillars addressed)
    b. What are the main issues you face as an implementer /technical support / facilitator in your funded project?
    c. How do you work together with government stakeholders?
    d. How would you describe the capability at national/regional/provincial and health facility levels to deliver on expected outputs/ expected/ planned results regarding the malaria programme? (Probe for competencies, resources - both financial and human resources; for health facilities also probe for staffing and workload, availability of drugs, RDTs and other commodities, awareness and advocacy for malaria)
    e. What is your perception of the extent to which the Partnership and your project was informed by the specific gaps identified by the National Malaria Control Programmes (NMCP) in the country where you work? (Probe for perceived value of the collaboration for the focal countries as a whole and for the country malaria programmes and health systems; ask for reasons and examples)
    f. How would you describe the way malaria elimination issues were addressed by the Projects? (Probe for how the relevant pillars were addressed);
    g. To what extent were the interventions delivered by your project in line with the Malaria programming requirements and objectives of the country? Please give examples

Second Objective - the effectiveness of the Partnership in relation to the programme's intended outcomes

2. During these past (*relevant number*) years, how would you describe changes due to your projects' in the focal areas? (Probe for changes relating to the four pillars - Supply of Good Quality Primary Health Care; Demand for and access to Primary Health Care; Better surveillance and Information Systems; Improved awareness of malaria and the work of the Partnership)
3. How can these changes been explained - what do you think has made it possible for these changes to happen? Why? What else?
4. What do you think has made it difficult for changes to happen? Why? What else?
5. What is your perception of the value of using malaria interventions as an entry point into the countries' health systems? (Probe for different country experiences); Did this work better for any Pillar compared to others?
6. What, in your opinion, was the added value of having different partners implement a variety of projects within the same partnership? What was the collective / shared learning?
7. What is the strength of the Partnership? What could be improved?
8. What external (national, provincial, district, community level) and internal (organizational) contextual factors have been of influence on the programme (positive and negative)?
9. Is there any indication that the Partnership projects have led to broader health systems strengthening? How? (Probe for institutional and local capacity strengthening) ? How?

10. What is according to you the Most Significant Change that has taken place as a result of the Comic Relief GSK 'Fighting Malaria, Improving Health' Partnership?

Third Objective - **the sustainability (and resilience)** of the projects' efforts to tackle malaria and strengthen health systems in the focus countries

In this section ask specifically for the positive changes as a result of the Partnership that have been described by the respondents in the previous sections

11. In your opinion, what are the things which can make these achievements continue working even if there is no outside help? (Probe for intrinsic and extrinsic elements - examples of change of mind-set; use of local resources/ capacities and /or networks that are (or can be) effectively applied to sustain the achievements of the response. Ask for examples of how the countries / communities has demonstrated ownership and capacity to self-support in the project)
12. How did the COVID-19 pandemic affect malaria programming related to the Partnership in your country?
13. In your opinion did the malaria programme respond in a timely and relevant manner to the COVID-19 crises? Also how did the funded project respond? ((Probe for any contributions by the funded partners' projects to the responses)

Fourth Objective – The Partnership's model

Comic Relief's grant making, grant management and partnership approach

14. What is your perception of the extent to which CR grant management processes facilitated or hindered programme delivery?

Learning Coordinator function

15. In your opinion, what was the value of the collective learning and research?
16. What is your perception of the quality of facilitation and support you received for the collective level learning? What worked well and what did not work so well? Please give some examples.
17. What in your opinion, were the enablers of and barriers to the effectiveness of the collective learning? Please give specific examples
18. What is your opinion about how things could have been done differently to achieve better results?
19. Was there any output to the collective learning? To what extent did the outputs of the collective learning support your wider work?

Advocacy and Communications working group and activities

20. What advocacy activities did you carry out in your project? Which stakeholders did you engage? What worked well or what did not work so well? Why?
21. What is your view about the extent to which the Partnership advocacy strategy has enhanced programme visibility and awareness of malaria in-country? How?

Topic Guide – Interviews with Funded Partners – Advocacy grants

I'd like to start by having you briefly describe your role and responsibilities within the Partnership as a funded partner with an advocacy grant

First Objective - relevance and coherence of the funded partners' projects in addressing the priority issues of malaria elimination and health systems strengthening

1. Alignment of the funded partners' projects to country realities and to national, regional and global priorities
    a. Please can you give an overview of your advocacy project?
    b. What are the main issues you face as an advocacy partner?
    c. How do you work together with government stakeholders?
    d. How would you describe the capability at national/regional/provincial and health facility levels to deliver on expected outputs/ expected/ planned results regarding advocacy for the malaria programme? (Probe for prioritization, awareness and advocacy for malaria; resources - both financial and human resources; policy makers / leadership interests and motivation; accountability elements)
    e. What is your perception of the extent to which the Partnership and your project was informed by the specific gaps identified by the National Malaria Control Programmes (NMCP) in the country where you work? (Probe for perceived value of the Partnership for the focal countries as a whole and for the country malaria programmes and health systems; ask for reasons and examples)
    f. What is your perception of the extent to which the Partnership and your project was informed by specific gaps identified by global actors? (Probe for interface with the UK government)
    g. How would you describe the way malaria advocacy within the focal country has been addressed by your project? (Probe for stakeholders (and champions) identification; design of targeted messages and channels for specific decision makers; motivation of leadership)
    h. To what extent were the interventions delivered by your project in line with the Malaria programming requirements and objectives of the country? Please give examples

Second Objective - the effectiveness of the Partnership in relation to the programme's intended outcomes

2. During these past (*relevant number*) years, how would you describe changes due to your advocacy project activities in the focal areas? (Probe for changes relating to improved awareness of malaria and the work of the Partnership; how leadership was activated and commitments obtained; whether decision makers allocated more resources (human or financial) to advocacy; monitoring and use of data in advocacy)
3. How can these changes been explained - what do you think has made it possible for these changes to happen? Why? What else?
4. Which, in your opinion, advocacy activities yielded the most value? What was unique about these activities that made them effective?
5. What do you think has made it difficult for changes to happen? Why? What else?
6. What external (national, provincial, district, community level) and internal (organizational) contextual factors have been of influence on the Partnership and your advocacy project (positive and negative)?

7. Is there any indication that the Partnership projects have led to broader health systems strengthening? How? (Probe for institutional and local capacity strengthening) ? How?
8. What is according to you the Most Significant Change that has taken place as a result of Advocacy activities of the Comic Relief GSK 'Fighting Malaria, Improving Health' Partnership?

Third Objective - **the sustainability (and resilience)** of the projects' efforts to tackle malaria and strengthen health systems in the focus countries

In this section ask specifically for the positive changes as a result of the Partnership that have been described by the respondents in the previous sections

9. In your opinion, how have the advocacy activities contributed towards achievements lasting beyond the life of this Partnership (Probe for intrinsic and extrinsic elements - examples of change of mind-set; use of local resources/ capacities and /or networks that are (or can be) effectively applied to sustain the achievements of the response. Ask for examples of how the countries / communities has demonstrated ownership and capacity to self-support in the project)
10. How did the COVID-19 pandemic affect malaria programme advocacy related to the Partnership in your country?
11. In your opinion did the malaria programme respond in a timely and relevant manner to the COVID-19 crises? ((Probe for any contributions by the funded partners' projects to the responses)

Fourth Objective – The Partnership's model

- **Comic Relief's grant making, grant management and partnership approach**

12. How have CR grant management processes facilitated or hindered your advocacy activities ? Please give specific examples
13. What have been the strengths and weaknesses of the CR-GSK Partnership's approach to the advocacy portfolio? Please give specific examples
14. How do you feel your work and achievements have fed into the Partnership's wider advocacy and communications work? Has there between greater awareness of your work as a result of the CR-GSK Partnership staff's wider work? If so, how?

Topic Guide – Interviews with National, Regional and Provincial Government Stakeholders

I'd like to start by having you briefly describe your role and responsibilities as a NMCP, regional or provincial malaria programme stakeholder

First Objective - relevance and coherence of the funded partners' projects in addressing the priority issues of malaria elimination and health systems strengthening

1. Alignment of the funded partners' projects to country realities and to national, regional and global priorities
    a. How would you describe use of malaria services by your communities? Are there differences for different groups? For the poor?
    b. What are the main issues you face as a policy maker / an implementer in the malaria programme? (Probe for national strategies, how the structures work)
    c. How would you describe the capability at national/regional/provincial and health facility levels to deliver on expected outputs/ expected/ planned results regarding the malaria programme? (Probe for competencies, resources - both financial and human resources; for health facilities also probe for staffing and workload, availability of drugs, RDTs and other commodities, awareness and advocacy for malaria)
    d. How did you work together with the funded partner(s)?
    e. What is your perception of the extent to which the project(s) was informed by the specific gaps identified by the National Malaria Control Programmes (NMCP) in your country? (Probe for perceived value of the collaboration with the funded partners' projects for the country malaria programmes and health systems; ask for reasons and examples)
    f. How would you describe the way malaria elimination issues were addressed by the Projects? (Probe for how the four pillars were addressed); To what extent were the interventions delivered by the funded partners in line with the Malaria programming requirements and objectives of the country?

Second Objective - the effectiveness of the Partnership in relation to the programme's intended outcomes

2. During these past *(relevant number)* years, how would you describe changes due to the funded partners' projects' in your country/ region/province? (Probe for changes relating to the four pillars - Supply of Good Quality Primary Health Care; Demand for and access to Primary Health Care; Better surveillance and Information Systems; Improved awareness of malaria and the work of the Partnership)
3. How can these changes been explained - what do you think has made it possible for these changes to happen? Why? What else?
4. What do you think has made it difficult for changes to happen? Why? What else?
5. What is your perception of the value of using malaria interventions as an entry point into the countries' health systems? (Probe for different country experiences); Did this work better for any Pillar compared to others?
6. In your perception, what difference have the activities of the advocacy partners (e.g. Zero Malaria Starts with Me campaigns, youth advocacy, scorecard and accountability work etc) made to the (political including financial) prioritisation of malaria across the government?
7. What external (national, provincial, district, community level) and internal (organizational) contextual factors have been of influence on the programme (positive and negative)?

8. Is there any indication that the Partnership projects have led to broader health systems strengthening? How? (Probe for institutional and local capacity strengthening)? How?
9. What is according to you the Most Significant Change that has taken place as a result of the Comic Relief GSK 'Fighting Malaria, Improving Health' Partnership?

Third Objective - **the sustainability (and resilience)** of the projects' efforts to tackle malaria and strengthen health systems in the focus countries

In this section ask specifically for the positive changes as a result of the Partnership that have been described by the respondents in the previous sections

10. In your opinion, what are the things which can make these achievements continue working even if there is no outside help? (Probe for intrinsic and extrinsic elements - examples of change of mind-set; use of local resources/ capacities and /or networks that are (or can be) effectively applied to sustain the achievements of the response. Ask for examples of how the countries / communities has demonstrated ownership and capacity to self-support in the project)
11. How did the COVID-19 pandemic affect malaria programming related to the Partnership in your country?
12. In your opinion did the programme respond in a timely and relevant manner to the COVID-19 crises? ((Probe for any contributions by the funded partners' projects to the responses)

Topic Guide – Interviews with Private (informal) sector stakeholders

I'd like to start by having you briefly describe your role and responsibilities as a private (informal) sector stakeholder **(be specific about function)** involved in malaria control and elimination

First Objective - relevance and coherence of the funded partners' projects in addressing the priority issues of malaria elimination and health systems strengthening

1. Alignment of the funded partners' projects to country realities and to national, regional and global priorities
    a. How would you describe use of malaria services by your communities? Are there differences for different groups? For the poor?
    b. What are the main issues you face as a private sector provider/ implementer in the malaria programme? (Probe for how the structures work; challenges; context)
    c. How would you describe the capability at national/regional/provincial and health facility levels to deliver on expected outputs/ expected/ planned results regarding the malaria programme? (Probe for competencies, resources - both financial and human resources; for health facilities also probe for staffing and workload, availability of drugs, RDTs and other commodities, awareness and advocacy for malaria)
    d. How would you describe your capacity to contribute to the malaria programme?
    e. How did you work together with the funded partner(s)?
    f. How would you describe the way malaria elimination issues were addressed by your project?
    g. To what extent were the interventions delivered by the funded partners in line with the Malaria programming requirements and objectives of the country?

Second Objective - the effectiveness of the Partnership in relation to the programme's intended outcomes

2. During these past *(relevant number)* years, how would you describe changes due to the funded partners' project in your country/ region/province? (Probe for changes relating to the relevant pillars - Supply of Good Quality Primary Health Care; Demand for and access to Primary Health Care; Better surveillance and Information Systems; Improved awareness of malaria and the work of the Partnership)
3. How can these changes been explained - what do you think has made it possible for these changes to happen? Why? What else?
4. What do you think has made it difficult for changes to happen? Why? What else?
5. What external (national, provincial, district, community level) and internal (organizational) contextual factors have been of influence on the programme (positive and negative)?
6. What is according to you the Most Significant Change that has taken place as a result the CR-GSK project you have been involved in?

Third Objective - **the sustainability (and resilience)** of the projects' efforts to tackle malaria and strengthen health systems in the focus countries

In this section ask specifically for the positive changes as a result of the Partnership that have been described by the respondents in the previous sections

7. In your opinion, what are the things which can make these achievements continue working even if there is no outside help? (Probe for intrinsic and extrinsic elements - examples of change of mind-set; use of local resources/ capacities and /or networks that are (or can be) effectively applied to

sustain the achievements of the response. Ask for examples of how the countries / communities has demonstrated ownership and capacity to self-support in the project

8. How did the COVID-19 pandemic affect malaria programming related to your project in your country? In your opinion did the programme respond in a timely and relevant manner to the COVID-19 crises? (Probe for any contributions by the funded partners' projects to the responses)

How did the pandemic affect your project activities? How did you respond to it? (Probe for the difficulties and opportunities).

ANNEX 5: STAKEHOLDERS SAMPLED FOR INTERVIEWS

Stakeholders	Number to be sampled
Funded Partners	23
Comic Relief	4
GSK	3
Learning Coordinators	2
Government (National; Regional or Provincial)	10
Private (informal) sector	5
Parliamentarians	2
Advocacy specific stakeholders as Youth advocates or young researchers	4
Total	

REFERENCES

[1] Global technical strategy for malaria 2016-2030. World Health Organization. ISBN 978 92 4 156499 1 (NLM classification: WC 765) © World Health Organization 2015. Available from URL: https://www.who.int/docs/default-source/documents/global-technical-strategy-for-malaria-2016-2030.pdf?sfvrsn=c82afcc_0

[2] WHO Manual for developing national malaria strategic plans 2015-2030. Available from URL: https://www.afro.who.int/publications/manual-developing-national-malaria-strategic-plans

[3] WHO. Strategy for Malaria Elimination in the Greater Mekong SubRegion 2015-2030 Available from URL: https://apmen.org/sites/default/files/all_resources/Strategy%20for%20Malaria%20Elimination%20in%20the%20GMS%20%282015-2030%29.pdf

[4] Kaehler, N., Adhikari, B., Cheah, P.Y. *et al.* Prospects and strategies for malaria elimination in the Greater Mekong Sub-region: a qualitative study. *Malar J* **18,** 203 (2019). https://doi.org/10.1186/s12936-019-2835-6

[5] Nofal SD, Peto TJ, Adhikari B, Tripura R, Callery J, Bui TM, et al. How can interventions that target forest-goers be tailored to accelerate malaria elimination in the Greater Mekong Subregion? A systematic review of the qualitative literature. Malar J. 2019;18:32.

[6] WHO *World Malaria Report 2015.* 2015. [Accessed October 3, 2018]. Available from: http://www.who.int/malaria/publications/world-malaria-report-2015/wmr2015-without-profiles.pdf?ua=1. [Ref list]

[7] Simba, D. O., Warsame, M., Kakoko, D., Mrango, Z., Tomson, G., Premji, Z., & Petzold, M. (2010). Who gets prompt access to artemisinin-based combination therapy? A prospective community-based study in children from rural Kilosa, Tanzania. *PLoS One*, *5*(8), e12104.

[8] Zurovac, D., Githinji, S., Memusi, D., Kigen, S., Machini, B., Muturi, A., ... & Nyandigisi, A. (2014). Major improvements in the quality of malaria case-management under the "test and treat" policy in Kenya. *PLoS One*, *9*(3), e92782.

[9] https://www.who.int/malaria/publications/atoz/malaria_case_management_operations_manual.pdf

[10] Norman, F. F., Comeche, B., Chamorro, S., & López-Vélez, R. (2020). Overcoming challenges in the diagnosis and treatment of parasitic infectious diseases in migrants. Expert review of anti-infective therapy, 18(2), 127-143.

[11] Macarayan E, Papanicolas I, Jha A. The quality of malaria care in 25 low-income and middle-income countries *BMJ Global Health* 2020;**5:**e002023
[12] Nayyar GML, Breman JG, Newton PN, et al. Poor-quality antimalarial drugs in Southeast Asia and sub-Saharan Africa. Lancet Infect Dis2012;12:488–96.doi:10.1016/S1473-3099(12)70064-6
[13] Amexo M, Tolhurst R, Barnish G, et al. Malaria misdiagnosis: effects on the poor and vulnerable. Lancet2004;364:1896–8.doi:10.1016/S0140-6736(04)17446-1
[14] McMorrow ML, Masanja MI, Abdulla SMK, et al. Challenges in routine implementation and quality control of rapid diagnostic tests for malaria--Rufiji District, Tanzania. Am J Trop Med Hyg2008;79:385–90.doi:10.4269/ajtmh.2008.79.385
[15] Onwujekwe O, Hanson K, Uzochukwu B. Do poor people use poor quality providers? Evidence from the treatment of presumptive malaria in Nigeria. Trop Med Int Heal2011;16:1087–98.
[16] Reyburn H, Mbatia R, Drakeley C, et al. Overdiagnosis of malaria in patients with severe febrile illness in Tanzania: a prospective study. BMJ2004;329:1212.doi:10.1136/bmj.38251.658229.55
[17] Bell D, Wongsrichanalai C, Barnwell JW. Ensuring quality and access for malaria diagnosis: how can it be achieved?Nat Rev Microbiol2006;4:682–95.doi:10.1038/nrmicro1474
[18] Worrall, E., Basu, S., & Hanson, K. (2005). Is malaria a disease of poverty? A review of the literature. *Tropical Medicine & International Health*, *10*(10), 1047-1059.

[19] Rosensweig F, Kalson D, and Kayuni S, 2008: Review of Management and Organizational Capacity of the National Malaria Control Program in Malawi. Health systems 2020
[20] WHO. Malaria, Key Facts. Geneva, World Health Organization, 2020. https://www.who.int/news-room/fact-sheets/detail/malaria (accessed January 31, 2020).
[21] WHO. Prevention and control of malaria epidemics. Geneva, World Health Organization, 2013. https://www.who.int/malaria/publications/atoz/epidemics_tg.pdf. Accessed 10 Jan 2020.
[22] Yasuoka, J., Kikuchi, K., Nanishi, K., Ly, P., Thavrin, B., Omatsu, T., & Mizutani, T. (2018). Malaria knowledge, preventive actions, and treatment-seeking behavior among ethnic minorities in Ratanakiri Province, Cambodia: a community-based cross-sectional survey. BMC public health, 18(1), 1-11.
[23] D'Acremont V, Bosman A. WHO informal consultation on fever management in peripheral health care settings: a global review of evidence and practice. Geneva: World Health Organization; 2013. pp. 759–764.

[24] Bloom G, Standing H, Lucas H, Bhuiya A, Oladepo O, Peters DH. Making health markets work better for poor people: the case of informal providers. Health Policy Plan. 2011;26:i45–52.
[25] Sudhinaraset M, Ingram M, Lofthouse HK, Montagu D. What is the role of informal healthcare providers in developing countries? A systematic review. PLoS ONE. 2013;8:e54978.
[26] Sieverding, M., Beyeler, N. Integrating informal providers into a people-centered health systems approach: qualitative evidence from local health systems in rural Nigeria. *BMC Health Serv Res* **16,** 526 (2016). https://doi.org/10.1186/s12913-016-1780-0
[27] World Health Organisation. Health Systems Strengthening Glossary; 2019. Available from URL; https://www.who.int/healthsystems/hss_glossary
[28] Chee G, PIelemeier N, Lion A, Gonnor C. Why differentiating between health system support and health system strengthening is needed. *Int J Health Plann Manage*. 2013;**28**(1):85-94.
[29] LSTM – FMIH Health Systems Strengthening Lessons
[30] Birkholtz, LM., Bornman, R., Focke, W. *et al.* Sustainable malaria control: transdisciplinary approaches for translational applications. *Malar J* **11,** 431 (2012). https://doi.org/10.1186/1475-2875-11-431
[31] Hu, T., Liu, YB., Zhang, SS. *et al.* Shrinking the malaria map in China: measuring the progress of the National Malaria Elimination Programme. *Infect Dis Poverty* **5,** 52 (2016). https://doi.org/10.1186/s40249-016-0146-5

[32] Shiff, C., Thuma, P., Sullivan, D. *et al.* Designing a sustainable strategy for malaria control?. *Malar J* **10,** 220 (2011). https://doi.org/10.1186/1475-2875-10-220
[33] Ramsay, A., Olliaro, P. & Reeder, J.C. The need for operational research and capacity-building in support of the Global Technical Strategy for Malaria 2016–2030. *Malar J* **15,** 235 (2016). https://doi.org/10.1186/s12936-016-1302-x
[34] Michael Macdonald, Thomas Putzer. Human-Centered Design and Sustainable Malaria Interventions Global Health: Science and Practice Jun 2019, 7 (2) 148-149; **DOI:** 10.9745/GHSP-D-19-00189

[35] Empowering Women Through Financial Inclusion: A Study of Urban Slum
Shivangi Bhatia, Seema SinghFirst Published December 31, 2019 Research Article
https://doi.org/10.1177/0256090919897809
[36] Batliwala, S. (2007). Taking the power out of empowerment—An experiential account. *Development in Practice*, 17(4–5), 557–565.
[37] Holloway, K., Niazi, Z., Rouse, R. (2017). *IPA women's economic empowerment through financial inclusion: A review of existing evidence and remaining knowledge gaps*. New Haven, CT: Innovations for Poverty Action.
[38] WHO. Abuja Declaration https://www.who.int/healthsystems/publications/abuja_declaration/en/
[39] Brinkerhoff JM. Global public policy, partnership, and the case of the World Commission on Dams. *Public Adm Rev*. 2002; 62(3): 324–336. DOI: 10.1111/1540-6210.00182
[40] Shelley KD, Kamya C, Mpanya G, et al. Partnership and Participation-A Social Network Analysis of the 2017 Global Fund Application Process in the Democratic Republic of the Congo and Uganda. *Ann Glob Health*. 2020;86(1):140. Published 2020 Nov 5. doi:10.5334/aogh.2961

[41] Buse K, Harmer AM. Seven habits of highly effective global public–private health partnerships: Practice and potential. *Soc Sci Med.* 2007;64(2):259–271. doi: 10.1016/j.socscimed.2006.09.001.
[42] United Nations. Goal 17 - United Nations Partnerships for SDGs platform. Partnerships for SDGs. https://sustainabledevelopment.un.org/partnerships/goal17/.
[43] Kamya C, Shearer J, Asiimwe G, et al. Evaluating Global Health Partnerships: A Case Study of a Gavi HPV Vaccine Application Process in Uganda. *Int J Heal Policy Manag*. 2016; 6(6): 327–338. DOI: 10.15171/ijhpm.2016.137
[44] Buse K, Harmer AM. Seven habits of highly effective global public–private health partnerships: Practice and potential. *Soc Sci Med*. 2007; 64(2): 259–271. DOI: 10.1016/j.socscimed.2006.09.001
[45] Brinkerhoff JM. Partnership for International Development: Rhetoric or Results? Boulder, CO: Lynne Rienner Publishers; 2002.
[46] Brinkerhoff JM. Assessing and improving partnership relationships and outcomes: A proposed framework. *Eval Program Plann*. 2002; 25(3): 215–231. DOI: 10.1016/S0149-7189(02)00017-4
[47] Kamya C, Shearer J, Asiimwe G, et al. Evaluating Global Health Partnerships: A Case Study of a Gavi HPV Vaccine Application Process in Uganda. *Int J Health Policy Manag*. 2017;6(6):327-338. Published 2017 Jun 1. doi:10.15171/ijhpm.2016.137

[48] Brinkerhoff JM. Assessing and improving partnership relationships and outcomes: a proposed framework. *Eval Program Plann.* 2002;25(3):215–231. doi: 10.1016/s0149-7189(02)00017-4.
[49] Tetra Tech International Development. Learning Coordinator Final Report– September 2020
[50] OECD iLibrary Applying Evaluation Criteria Thoughfully. **Understanding the six criteria: Definitions, elements for analysis and key challenges.** Available Online https://www.oecd-ilibrary.org/sites/543e84ed-en/1/3/4/index.html?itemId=/content/publication/543e84ed-en&_csp_=535d2f2a848b7727d35502d7f36e4885&itemIGO=oecd&itemContentType=book&_ga=2.226467290.17300677.1623946593-1862111879.1620899797#section-d1e4964

About the partners

Comic Relief is a charity based in the UK which strives to create a just world free from poverty. Our mission is to drive positive change through the power of entertainment. Find out more at **www.comicrelief.com**

GSK is a science-led global healthcare company with a special purpose: to help people do more, feel better, live longer. For further information please visit **www.gsk.com/about-us**