January 4th, 2010

Terms of Reference – Technical Assistance for Chad LLIN Scale Up

Dates: January 17th – February 1st, 2011 (16 days total)

Consultant: Mr. Cédric Mingat

Background:
Chad is the recipient of funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) round 9 for "Scale Up of the Prevention Measures using Insecticide-Treated Mosquito Nets". The proposal is complementary to the GFATM round 7 grant which is focused on provision of LLIMNs to pregnant women and children under five through routine services, in addition to provision of ACTs for treatment of malaria. The GFATM round 9 proposal aims to complete the round 7 proposal by expanding the target group beyond the most vulnerable populations to the entire population at risk in an effort to reach universal coverage and, subsequently, the 2010 RBM and 2015 Millennium Development Goal (MDG) targets.

The specific objectives of the GFATM round 9 proposal are:

1. Reach universal coverage in LLIMNs for the entire population living in high-risk districts by 2011 and maintain this coverage until 2014 and beyond;
2. Increase the rate of utilization of LLIMNs to 80% by 2014 through the organization of advocacy and communication activities for behavioral change via the media and community outreach services;
3. Strengthen the capacity for managing the fight against malaria through training and allocating to the community networks resources for monitoring interventions at the community level.

Implementation of the GFATM round 7 grant began on March 1, 2009. The round 7 proposal included ACTS, RDTs and LLIMNs. The ACTs and RDTs will cover 100% of health districts where malaria is present. The LLIMNs are destined to cover 80% of children under five and pregnant women.

A number of challenges have hindered implementation of the round 7 grant, as well as provision of effective health services generally:

- Limited capacity of the NMCP to ensure effective coordination of organizations involved in the fight against malaria;
- Limited supervision of structures for the implementation of national strategies, in particular health centers and district and regional hospitals;
- At regional level, deficiencies in human resources (quantity and quality), as well as logistical problems, limit capacity to support health delegations in the districts for training, supervision and procurement of drugs;
- At the health district level, 82% are operational (availability of a senior district doctor, means of transportation for supervision and a district hospital) and 76% of areas of responsibility are operational;
- Population access to health facilities is approximately 30%.

As per the round 9 proposal, "to the problem of the distance between villages and health centers, and the inaccessibility of certain districts during the rainy season, is added the shortage of qualified health-care providers, the issue of financial accessibility to health care, the low level of health education of the village community. These constraints limit the offering of basic quality health care to the population."

LLIMN Scale Up

The total population of Chad is 10,154,300 (2008) and the average household size is 6 persons. The population growth rate is 3.1% per annum. In the GFATM round 9 proposal, LLIMN needs have been estimated on the basis of one LLIMN for every 2 persons and the plan is to equip each household with an average of 3 LLIMNs. The proposal indicated that the LLIMN scale up campaign would take place in 2010, though this is now delayed to 2011. Procurement of LLIMNs will be done through the GFATM's Voluntary Pooled Procurement (VPP) system for accelerated procurement with delivery to district level.

The current plan for the LLIMN scale-up is:

- Recruitment of 6,956 community liaisons (10 community liaisons per area of responsibility);
- Training of trainers at central level, followed by training of district instructors (2 per district), followed by training of community liaisons (all trainings scheduled for 2 days);
- Community liaisons, following training, will be responsible for awareness raising and census of households for 3 days;
- Issuance of identification cards to households during the census for redemption for LLIMNs;
- During distribution, 10 distribution points will be operational in each area of responsibility (e.g. 1 distribution point per community liaison);
- Each community liaison will census an average of 86 households per day for the three days of the issuance of identification cards and will distribute an average of 629 LLIMNs.

Technical Assistance Needs
Chad has never done a mass distribution of LLIMNs and, based on the information provided in the GFATM round 9 proposal, has weak health infrastructure and capacity to plan and implement the mass campaign.

Given the information available in the proposal, it is clear that there is need for a campaign strategy to be defined more clearly, with an associated timeline and budget. In addition, the logistical challenges presented by the country indicate that logistics support to build the capacity of the NMCP and the implementing partners will be important.

Terms of Reference:

1. To work with NMCP and partners to further define the campaign implementation strategy: roles and responsibilities of actors involved, method for allocating nets to households and household identification, method for distribution.
2. To work with NMCP, Direction Générale de l'Action Sanitaire Régionale (DGASR) and in-country partners to develop a plan of action, chronogram of activities and budget for the mass distribution of LLINs. The plan of action will include a clearly defined implementation strategy and provide guidance/tools for districts for their respective micro-planning.
3. To identify potential gaps in human resources technical capacity and make recommendations regarding potential personnel supports.
4. To share tools and supports from past campaigns in various countries related to social mobilization, training, data collection and in-process monitoring.
5. To contribute to the preparation of the training of actors involved at different levels (especially community liaisons) in the mass distribution
6. To provide a list of next steps and timing for any further technical support to the mass distribution.
7. To build capacity at NMCP and with partners through work with staff in order to facilitate further roll out of mass LLIN campaigns.

Deliverables from the consultancy

1. Final plan of action for the campaign with a clearly defined implementation strategy (allocation of LLINs to households, identification of beneficiaries, distribution strategy), including a timeline of activities and a budget.
2. End of mission report detailing:

a. State of campaign logistics planning on arrival and activities engaged in, including key partners met with and any travel undertaken.
b. Campaign plan of action, timeline and budget. Consultant will identify potential constraints with the PoA and possible solutions that could be examined.
c. Inputs and recommendations for the campaign planning and implementation. This will include support needed for local teams and recommendations to NMCP for next steps to ensure a successful campaign.
d. Inputs and recommendations for roll out of future campaigns, including development of capacity (NMCP and partners) for roll out of the campaigns. The consultant will highlight any major issues that could constrain the efforts of NMCP and partners to scale up malaria prevention in the country.
e. Gaps in human resources and periods for additional support from AMP or other partners.
f. List of immediate next steps and recommendations for advancing campaign planning.

Timeline for deliverables:
It is proposed that an initial planning mission takes place in January 2011. Two consultants (one strategy and one logistics) have been identified to come to the country and work on developing a realistic timeline for the deliverables required. The same consultants will be made available based on the timeline developed to complete all deliverables of the consultancy.