THE ALMA SCORECARD FOR ACCOUNTABILITY AND ACTION: DOCUMENTATION OF EXPERIENCES AND PROGRESS
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1. Background

The African Leaders Malaria Alliance (ALMA) is a coalition of 49 African Heads of State and Government, working across country and regional borders to eliminate malaria from the continent. Launched in 2009 at the 64th session of United Nations General Assembly, the alliance provides a forum for high-level advocacy, action and follow-up on malaria commitments and goals. ALMA is led by a chairperson, a position held by one of the member Heads of State and Government for a renewable term of one to two years and supported by a secretariat. The secretariat is guided by a steering committee of Africa’s Permanent Representatives (Ambassadors) to the UN in New York. The operations of the Secretariat are based in Dar-es-Salaam, and registered in the United Republic of Tanzania. To support the Steering committee and mobilize resources, the Secretariat is a USA 501 (c) (3) organization. Both have Independent Boards of Directors.

ALMA works closely with the African Union, the Roll Back Malaria Partnership, the World Health Organization, and other global and regional health and development stakeholders and partners. Since its inception, ALMA members have been committed to strengthening transparency and accountability for malaria control among member countries. As such, ALMA has developed a robust framework for accountability to support countries’ efforts to meet malaria targets by monitoring performance, and acting on identified challenges in all ALMA member countries that have malaria. The ALMA Africa Scorecard for Accountability and Action which was developed at the request of Heads of State and Government is a central pillar of this framework. The ALMA secretariat is responsible for producing and disseminating the Africa scorecard and accompanying country reports, as well as coordinating its review by Heads of State and Government and Ministers of Health, and following up on recommended actions, as described in detail in this report.

The ALMA Scorecard has played an important role in guiding high-level decision-making, advocacy, resource mobilization and action aimed at consolidating malaria control and fast-tracking the continent’s movement towards elimination. Focus on the rapid identification of and response to emerging issues at high level has enabled the ALMA Scorecard for Accountability and Action to uniquely contribute to the fight against malaria.
2. Development of the Africa wide ALMA scorecard for action and accountability

The ALMA scorecard for action and accountability was developed primarily for Heads of State and Government as a mechanism to facilitate tracking of progress and strengthening accountability for malaria control and elimination across the continent. The scorecard tool has three complementary components:

- The scorecard which displays country-level performance against key malaria and MNCH indicators for 46 malaria-endemic countries in Africa – highlighting successes and shortfalls in progress in performance.
- The inclusive country led bottleneck analysis and in-house action tracking mechanism.

Country quarterly reports which provide a summary of performance for each country and document and track recommended actions to address identified bottlenecks.

Development of the scorecard

Shortly after the launch of ALMA, Heads of State and Government requested the ALMA secretariat to develop a tool to guide periodic review of the malaria situation across member states with the aim of strengthening transparency and ensuring action, at their level, to address bottlenecks to progress in malaria control in individual countries and across the continent. The scorecard approach was identified as an ideal mechanism because of its ability to synthesize and succinctly present a large amount of data and information in an uncomplicated visual form and thus provide a clear and dynamic snapshot of performance.

The next major step in the development process was the selection of a set of indicators most relevant for high-level intervention to be tracked at the country level for each of the 46 endemic countries. The selection of the first set of scorecard indicators, defining a basis for their subsequent revision, and design of the scorecard template was an iterative process with frequent consultation with countries, stakeholders and key partners.

Consultations held with Heads of State and Government, Ministers of Health and Malaria Control Programmes focused on identification of indicators drawn from country strategic plans and regional and global strategies. Impact; the ability of an indicator to drive required action; and availability of up to date data from internationally published sources, were the main criteria applied to indicator selection. Regional and global partner consultations were held with countries, and a number of partners including the World Health Organization (WHO), the Roll Back Malaria partnership (RBM), the Bill and Melinda Gates Foundation (BMGF), US President’s Malaria Initiative (PMI), the World Bank, Malaria Control and Elimination Pathway in Africa (MACEPA) and the Children’s Investment Fund Foundation (CIFF).

These consultations provided critical input on alignment of the scorecard with global and partner strategies and the larger global health context and contributed greatly to the identification of internationally accepted data sources and established data sharing arrangements. Where data sources for selected indicators were not available, these indicators were put “on-hold” to be activated when validated data sources became available. Indicators were thus categorized into waves: wave one indicators met all the criteria deemed important for the scorecard and had credible and routinely updated data sources whilst future wave indicators were those without regularly updated validated data sources.

Design features of the scorecard tool: The Heads of State and Government are the targeted primary consumers of the scorecard, which was designed to be as concise yet informative as possible. An intuitive traffic-light colour scheme was chosen to reflect indicator performance with interpretation as described in the table below. In addition to the three traffic light colours, grey is used when an indicator is not applicable or data are not available.

<table>
<thead>
<tr>
<th>Colour</th>
<th>Interpretation</th>
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<tbody>
<tr>
<td>Green</td>
<td>Target achieved or performance is on track</td>
</tr>
<tr>
<td>Yellow</td>
<td>Progress made but more effort needed</td>
</tr>
<tr>
<td>Red</td>
<td>Performance not on track</td>
</tr>
<tr>
<td>Grey</td>
<td>Indicator is not applicable/data unavailable</td>
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The scorecard was designed to fit on a single sheet. Visualization of the performance for all 46 African countries with Malaria on a single sheet facilitates inter-country comparisons and identification of cross-cutting issues.

During the development phase, it was anticipated that the scorecard would need to easily adapt to changes in malaria control and elimination priorities and the changing data landscape. Indicators were assigned as wave one (current), wave two or three (future) as follows.

- Wave one indicators: met the criteria of indicator selection at the time of the scorecard development or review and selected for immediate tracking.
- Wave two indicators: met most selection criteria but were either not an immediate priority for tracking, but anticipated to become increasingly important in the short to medium term; or lacked current data sources but systems for data collection from validated sources were expected in the short to medium term.
- Wave three indicators: either highly desirable but with no data sources and no credible mechanisms for data collection expected in the near-medium term; or anticipated to become a priority for malaria control or elimination in the longer-term.
A system to review and update indicator waves was embedded into an annual scorecard indicator analysis and review process. As such future-wave indicators have been activated to become current wave indicators over the period of use of the scorecard.

Following initial stakeholder consultations and tool development, a scorecard prototype with 13 indicators was developed. The majority of the data used to populate the prototype scorecard were from periodic national surveys such as the Demographic Health Survey (DHS) and Multi Indicator Cluster Surveys (MICS) updated every two to five years, or from periodic reviews. The scorecard prototype was shared with Heads of State and Government whose critical feedback included the need for more current and actionable data. As a result, indicators with data updated at least annually, and preferably quarterly, were prioritised. Heads of State and Government also requested for the addition of tracer Maternal, Newborn and Child Health Indicators to reflect the overall performance of country health systems on the rest of the health development goals. After consultation with RMNCAH partners including UNICEF and WHO/MCA on appropriate indicators, actionable RMNCH indicators were selected from the eleven indicators recommended by the Commission on Information and Accountability for Women’s and Children’s health (COIA) and added to the scorecard.

The scorecard prototype was also shared with Ministers of Health and partners and their input fed into the next iteration of the scorecard development. An example of partner contributions to the scorecard design is the arrow feature. At a feedback meeting hosted by RBM, partners from MACEPA suggested the addition of arrows to indicate change in performance from one period to the next. An upward arrow indicates improved performance compared to the previous period while a downward arrow indicates a decline in performance compared to the previous period. Absence of an arrow indicates no significant difference in performance across the two consecutive periods. This link between current and previous performance enhances analysis and interpretation of the scorecard.

The finalized first scorecard – which was for the period Quarter three (July-August) of 2011 - was endorsed by all key stakeholders and launched by the founding chair of ALMA former President Jakaya Mrisho Kikwete of the United Republic of Tanzania. At the launch of the scorecard tool ALMA members agreed to review the scorecard bi-annually during the ALMA fora held during the African Union Summits of January and July each year.

**Development of quarterly country reports**

Country reports were developed by the ALMA secretariat in 2010 and in 2011. These were aligned with the ALMA Scorecard. The All Africa scorecard provides a performance tracking mechanism while individual country reports, produced quarterly with every scorecard, provide more in-depth information on the malaria situation in each country, highlighting both progress and priority corrective actions required to address identified shortfalls in performance. The country reports are structured into clear sections which include a summary of country performance, identified challenges, and documentation of recommended actions to address challenges as well as the implementation status of previously issued recommended actions. In addition to country-specific reports, an overview report is produced with every scorecard update. The report summarizes key issues from the scorecard and areas highlighted by the ALMA chair and Heads of State and Government. This report is shared with the ALMA chair every quarter.

**Summary and key experiences from the development of the scorecard**

The scorecard and accompanying country reports together, provide a robust approach to strengthening action and accountability for malaria control and elimination as they engage the highest political level in the accountability process. After a rigorous eleven-month development process, the first ALMA scorecard, with 10 malaria indicators grouped into five categories (policy, financial control, commodities financed, implementation and impact) and 4 MNCH indicators was launched in September 2011. Prior to its launch, the scorecard was shared with Heads of State and Government during the January and July 2011 ALMA Fora, setting the stage for future scorecard reviews. Heads of State and Government requested that the scorecard be issued quarterly and agreed to review it bi-annually together with quarterly reports bi-annually at future ALMA fora.

The scorecard was also shared with Ministers of Health at the May 2011 Roll Back Malaria ministerial session and subsequent scorecard review meetings have been held during the World Health Assembly and at annual WHO Africa Regional Committee meetings.

Data used to populate the scorecard is drawn from published sources including the Roll Back Malaria gap analyses and Alliance for Malaria Prevention, UNAIDS, WHO policy and impact data, World Bank CPIA Cluster D, UNICEF, WHO malaria impact data and Countdown to MNCH 2030. Country reports informed by analysis of the scorecard, are produced for each of the 46 countries every quarter.

**Key highlights from the development of the scorecard**

Below are success factors from the ALMA scorecard for action and accountability development process that have played an important role in its overall successful implementations:

- Active engagement of Heads of State and Government
over the course of the development process ensured that the tool adequately met their needs and led to commitment to its subsequent use at that level. The high level of ownership of the scorecard and action tracking mechanism by Head of State and Government has been critical to its successful implementation.

- Collaboration with key health and development partners not only contributed to the quality of the scorecard and action tracking mechanism but also galvanized support for its use by important players in the global community and created strong partnerships which the scorecard and larger accountability mechanism continues to rely on.

- The considerable effort put into content and design features of the scorecard tool has enabled its efficient use and added-value when compared to other review mechanisms. The scorecard remains intuitive, concise, adaptable to changing priorities and has served as a template to other monitoring and accountability mechanisms.

- The deliberate use of prioritized actionable indicators, near real-time data and active action tracking continues to keep the scorecard relevant. The utilization of the existing data for the scorecard indicators has widened the use and contributed to improving quality of information from various sources.

3. Implementation of the ALMA scorecard and action tracking mechanism

The scorecard and country reports have been produced and utilized every quarter since quarter three of 2011. The ALMA secretariat is responsible for updating and disseminating the scorecard and country reports. The secretariat also coordinates Heads of State and Government scorecard review during ALMA Fora, and holds discussions on issues arising with Ministers of Health, country malaria control programmes and maternal and child health programs and partners.

Figure One: Snapshot of the first ALMA scorecard: Quarter three, 2011
The scorecard update process includes assembling existing data and uploading it to the scorecard tool. This is followed by an analysis of performance and the development of country reports and an overview quarterly report.

**ALMA Scorecard update and country report production**

Data for the vast majority of scorecard indicators originate from the countries. These data, under various international health data arrangements, are sent from countries to a final data holding organization such as the WHO, World Bank etc, where they are processed and released in different reports and updates including the annual World Malaria Report, UNAIDS Global AIDS report and World Bank Indicators. The ALMA scorecard benefits from these arrangements and uses these data after they have been provided to the final data holding agencies. Currently, scorecard data are sourced from RBM, The World Bank, WHO, The Alliance for Malaria Prevention, UNICEF, UNAIDS and Countdown to 2030: Maternal Newborn Child Survival. The ALMA secretariat receives data after completion of data processing and quality assurance. Indicator performance bands (presented visually as red, yellow and green) are defined by thresholds set by the data owners in line with globally agreed targets that are used by countries. To ensure timely access and dialogue around data, the ALMA secretariat has formed strong linkages with holding organizations. A data expert within the secretariat is responsible for receiving data, follow-up queries and the scorecard update. Completed scorecards are produced in English, French, Arabic, Spanish and Portuguese.

An in-depth analysis of performance is carried out following completion of the scorecard update. This involves reviewing each country’s performance for all indicators, comparisons with previous periods and across countries. This analysis results in the identification of country-specific and cross-cutting country-wide issues. Inadequate performance identified by an underperforming (red) indicator or declined performance identified by a downward arrow, trigger a bottleneck analysis to identify root causes and drivers of suboptimal performance. This process often includes consultation with affected countries and may include discussions with country and international partners and an assessment of contextual factors which contribute to a supportive environment for malaria control and MNCH.
performance. Bottleneck analyses inform the formulation of appropriate time-bound recommended actions to address areas of under-performance.

The final stage of the scorecard update process is the development of country quarterly reports which as described in section II above include the following sections:

- **Summary of country performance** – this section is an extract of country-specific metrics from the larger scorecard and includes a summary of the country’s malaria epidemiology.
- **Progress** – this section highlights high performing indicators and factors in the country that have enabled good performance.
- **Key challenges identified** – this section highlights major challenges and risks to progressive malaria control.
- **Recommended actions** – this section includes specific recommendations to address sub-optimal performance based on current performance and a summary of the status of implementation of previously issued recommendations.

The ALMA secretariat engages countries and partners in between issuance of country reports to track the implementation of recommended actions. Responses are then accessible to the ALMA secretariat personnel responsible for updating country reports. The response rate to recommended actions has increased over the period of implementation of the scorecard. Each quarter, over 80% of due recommended actions are acted upon and reported to the ALMA secretariat.

**Evolution of the scorecard and country reports**

The scorecard is adaptable to changing malaria control and elimination priorities and to the data landscape. Over the first five years of its implementation 25 indicators have been tracked at different periods as needed, with only seven tracked in their original form throughout the five year period. This indicator movement is more a reflection of adaptability to changing priorities than changes in data availability. Examples of reasons for indicator changes are given below:

- **Achievement of targets and new follow-up priorities:** Between 2011 and 2015 the status of oral artemisinin monotherapy ban was tracked as an important policy prerequisite for effective malaria case management. By the end of 2015 all but one country had made progress in enacting policies to ban artemisinin based monotherapy and this indicator was dropped in 2015. Similarly related to malaria case management, several countries did not have the adequate policy environment to support community case management of malaria with ACTs in 2011. An indicator on the scorecard documented that, in 2011 29 of the 46 countries were green on this indicator. By the end of 2015, only two countries were still lacking in policy and the indicator was replaced in 2016 by a new indicator to track the scale of implementation of integrated community case management.

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<tr>
<th>Previous Key Recommended Action</th>
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<tr>
<td>Objective</td>
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<td>Vector control</td>
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<table>
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<tr>
<th>New Key Recommended Action</th>
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<tbody>
<tr>
<td>Objective</td>
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<tr>
<td>Address funding</td>
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Figure Three: Extract of a country report showing recommended actions and illustrating tracking of action implementation

The ALMA secretariat engages countries and partners in between issuance of country reports to track the implementation of recommended actions. Responses to recommendations are sent from countries to the ALMA secretariat through various channels including communications from offices of Heads of State and Government and various ministry of health programmes, email and in-person communications between the secretariat and country programs and through the web-based ALMA application (app). The ALMA app was developed in 2012 to provide an electronic mechanism through which countries access their country reports and directly input responses to recommended actions. Country had made progress in enacting policies to ban artemisinin based monotherapy and this indicator was dropped in 2015. Similarly related to malaria case management, several countries did not have the adequate policy environment to support community case management of malaria with ACTs in 2011. An indicator on the scorecard documented that, in 2011 29 of the 46 countries were green on this indicator. By the end of 2015, only two countries were still lacking in policy and the indicator was replaced in 2016 by a new indicator to track the scale of implementation of integrated community case management.
Shifting global and country programme focus: The scorecard has been adapted to align with shifts in global goals and targets. In 2011, attaining high coverage of mother-to-child therapy to prevent pediatric HIV infection was a major challenge for many countries. Significant progress was made across the globe and continent within the next 4 years (by the end of 2015, the number of countries which were “red” on this indicator had decreased from 30 to 10 and those that either reached their PMTCT targets of where on track to do so (green) increased from 8 to 22) and new global goals for treatment and care of HIV/AIDS were adopted in 2015 including universal antiretroviral therapy for all HIV-infected populations. The PMTCT indicator on the scorecard was thus dropped after Q4, 2015 and replaced the next quarter by two indicators tracking ART coverage in the general population and in children. Similarly, for malaria, Indoor Residual Spraying was incorporated into the indicator for LLIN coverage to “LLIN/IRS coverage” following increased implementation of this intervention across malaria endemic countries.

Emergence of new threats: In Q1 2016, in response to the growing concerns of emerging resistance to insecticidal chemicals used for vector control, two malaria indicators were added to track the development and spread of resistance within and across countries and country response plans.

Changes in data availability: Though the data source for an indicator tracking tariffs for malaria commodities ended at the end of 2012; considerable progress was made in the two years that the indicator was tracked.

Whilst the structure of country reports has been well received and has not changed significantly since initiation of the reports, the content details have evolved in order to improve the quality and impact of the reports. Initially, recommended actions were broad, with the idea that countries would pick up on general recommendations and use country-context to refine and act on them. Recommendations were also not time-bound. This was associated with suboptimal action and persistence of bottlenecks. The recommended actions format was therefore revised to become more structured, specific, actionable and time-bound in 2012. Additionally, the ALMA secretariat began engaging country teams and partners in consultations, as needed, to ensure recommended actions were attainable and appropriate for the identified bottleneck. Country reports have also borrowed features from the scorecard. Colour coding was introduced into the section tracking the status of recommendation action implementation to enhance action tracking and execution to show easily what actions remain pending.

Dissemination and utilization of the ALMA scorecard and country reports

Every quarter, through the ALMA steering committee, each country Head of State and Government receives an updated scorecard and country report. The scorecard and reports are concurrently shared with Ministers of Foreign Affairs and International relations and Ministers of Health. Additionally, the secretariat holds quarterly meetings with the ALMA chair and chair of the steering committee to brief them on progress made and issues arising. Scorecards produced in English, French, Portuguese, Spanish and Arabic are posted online on the ALMA website (alma2030.org) for public review.
Review of the ALMA scorecard by Heads of State and Government

Bi-annually since 2010, ALMA Heads of State and Government meet to discuss progress and major issues in malaria control and elimination on the continent. The ALMA fora are held on the sidelines of African Union summits of January and July. In January, the forum is convened by the ALMA chair and is an ALMA meeting. Review of the ALMA scorecard for action and accountability is a standing agenda item at this meeting and ALMA awards for excellence are presented to countries identified as having made significant progress towards their malaria goals. In July the forum addresses HIV/AIDS malaria and TB. The July summit was initially jointly convened with AWA and is now convened by AWA. ALMA participates in the forum and provides support when requested.

Figure Four: Heads of State and Government discussions at ALMA Fora meetings
Attendance of these meetings by Heads of State and Government, country delegations, ministers, the AU leadership, UN leadership and other key partners is high, and participation is active. ALMA fora have led to unprecedented action for malaria initiated by African leaders. Issues addressed and actions triggered have spanned key areas of malaria control including fast-tracking enabling policies to support effective malaria case management and widen access to malaria commodities, increasing domestic financing and sourcing external funding for malaria control. Additionally, during ALMA fora African leaders have consistently committed to using their positions to support actions aimed at accelerating progress towards elimination of malaria on the continent. At the January 2015 forum, Heads of State adopted the malaria elimination agenda and in July 2016 they adopted of the catalytic framework to end AIDS, TB and eliminate Malaria in Africa by 2030.

Country reports follow up

Key issues identified by the scorecard and documented in country reports are discussed with Ministers of Health during the Annual World Health Assembly and WHO African Regional Committee meetings. Scorecard sharing forums, coordinated by the ALMA secretariat, include plenary ministerial sessions and bilateral meetings to discuss country-specific challenges and recommended actions. The secretariat also engages National Malaria Control Programmes and partners on emerging issues and to follow up on pending recommended actions.

Summary from the first five years of implementation of the scorecard and country reports

Implementation of the ALMA scorecard for action and accountability with accompanying country reports has been highly successful to-date. The scorecard mechanism has led to high level of stakeholder engagement and actions that have contributed to moving malaria control and elimination in Africa forward. Operationalization of the scorecard at the Heads of State and Government level provides a particularly unique role for the scorecard in the fight against malaria in Africa as does the structured generation and tracking of targeted actions. Systems for highlighting and following up on issues arising and recommended actions with stakeholders are well recognized and continue to evolve as needed.

The scorecard has been well received by Heads of State and Government and other stakeholders despite the appearance of ranking countries by performance. This is likely due to the Heads of State and Governments initial involvement in the development of the tool and a clear understanding of its purpose. Peer reviews at the Heads of State and Government level and cross-country comparisons have been constructive and collaborative and have led to positive change.

Notable factors that have enabled the successful implementation and impact of the scorecard are summarized here:

- Significant effort and meticulous detail put into the timely production, analysis and interpretation of the scorecard and production and follow-up of country reports has maintained high quality and reliability of the scorecard and accountability mechanism and enabled smooth operationalization.

- The dynamicity of the scorecard, as illustrated by the changes in indicators tracked, has enabled continuous relevance in an evolving malaria control environment. Additionally, whilst decision making around changing indicators is based on robust discussions, no unnecessary delays have been experienced between the identified need for indicator changes and effected changes in the scorecard.

- Active involvement of Heads of State and Government in bi-annual reviews of the scorecard has been tremendously useful in keeping malaria control high on national regional and the global agendas. These reviews have further led to bold decisions including the resolution to eliminate malaria on the continent and tangible action including increasing finances allocated to health and malaria from national budgets, and game-changing solutions to resolve bottlenecks including pooled procurement mechanisms.

- Heads of State and Governments combined meetings on HIV/AIDS, malaria and TB control have provided a forum for wider health sector discussions at this level, effectively bring together disease experts and health funders. This has enhanced integrated action for disease control in Africa. Discussion of all three major diseases together has also enabled efficient use of Heads of States time and decisions made in these meetings.

- The ALMA chairperson plays a critical role in identifying opportunities to strengthen malaria control, rallying other African leaders to actively participate in resolving bottlenecks where their involvement is needed and leading resource mobilization efforts. The ALMA chair is regularly apprised of issues and challenges facing malaria control and elimination as necessary. To-date, the chairs have initiated action through peer discussions or engaging with other global leaders, international organizations and other stakeholders.

- Discussions around the scorecard and country reports...
have in several instances led to unique collaborations bringing together a broad range of stakeholders and collective action to respond to arising issues. Such collaborations have led to innovative highly effective solutions. This has included reprogramming of World Bank IDA resources for malaria, pooled procurements, solving procurement bottlenecks for ACTs, frontloading Global Fund resources, market shaping for new commodities, and facilitating local manufacture in Africa.

4. Case studies illustrating the ALMA scorecard and accountability mechanism contribution to malaria control in Africa

An independent evaluation of the ALMA Scorecard for accountability and action concluded that the scorecard is a “platform to effect positive development change”. This section provides detailed examples of how the ALMA Scorecard and accountability mechanism has contributed to addressing bottlenecks and constraints to progress in malaria control.

Influencing policy

Artemisinin monotherapy ban and Community Case Management of Malaria:

In 2007, member states of the World Health Assembly adopted a resolution to progressively withdraw artemisinin-based monotherapies in order to mitigate the risks of development of artemisinin resistance. In response to this, malaria endemic countries were encouraged to introduce regulations to ban oral artemisinin-based monotherapies. At about the same time, countries were also encouraged to develop policies to support the implementation of community management of malaria with ACTs in order to expand access to effective and timely malaria treatment. Indicators to monitor the artemisinin monotherapy ban status in each country and policy for CCM were tracked by the scorecard between Q3 2011 and Q4 2015 and used as bases for driving action to stimulate countries to develop these important policies for malaria treatment.

ALMA in partnership with WHO and RBM worked closely with countries to ensure the development of regulatory measures to stop marketing monotherapies and promote the use of artemisinin combination therapy and by Q4 2015, only one country remained red on this indicator.

The ALMA Secretariat engaged countries lacking policy through quarterly reports and regular meetings with Ministers of Health to discuss progress and challenges. Additionally, in 2012, President Ellen Johnson-Sirleaf in her then capacity as ALMA chair, wrote to all countries who had not introduced policy change encouraging them to do so and in 2012 and 2013 ALMA Awards for Excellence were given to countries which had banned monotherapies and those which had introduced CCM. These actions significantly raised awareness to the issue and likely accelerated movement towards banning monotherapies and introducing ACTs and CCM in Africa. Between the 3rd quarter of 2011 and the end of 2015 the number of countries with no CCM policy decreased from 21 to 8.

Substantial movement in these policy indicators led to both indicators being dropped in Q1 2016. An indicator on the implementation of Integrated Community Case Management (ICCM) of childhood illnesses was added to the scorecard in Q1 2016 as a follow up indicator after all countries had established enabling policies.

Removal of taxes/tariffs on antimalarial commodities

In 2000 under the Abuja Declaration, African Leaders made a commitment to remove tariffs on all antimalarial commodities in order to reduce the cost of these life-saving commodities and thus widen their access. In the 10 years that followed this resolution, only four countries took action to remove all relevant tariffs. In response to the lack of action, the Bill and Melinda Gates Foundation and RBM launched the Malaria Taxes and Tariffs Advocacy Project (M-TAP) in 2009 to advocate for change. Based on data provided by M-TAP, a tariffs indicator was included in the quarterly reports in 2010 and in the scorecard in 2011. Between 2010 and 2012, more countries removed tariffs on all antimalarial commodities than had done so in the previous decade. To help stimulate this action ALMA, in January 2011, gave awards to the initial four countries that removed tariffs on all antimalarial commodities as a way of encouraging other countries to take similar action. Less than one year after this Angola, Burundi, Mozambique and Rwanda also achieved green status in the scorecard by removing the tariffs. In Liberia, President Johnson-Sirleaf issued an executive order before the 2012 January Summit of the African Union (AU) to remove tariffs on all malaria commodities. In the third quarter of 2012, Cameroon removed tariffs on all essential antimalarial commodities followed by The Gambia and Sierra Leone. The indicator was dropped from the scorecard after Q4 2012 as the M-TAP project, from which data were drawn, came to a close.

Addressing gaps for scale-up of malaria interventions

Pooled procurement of LLINs through the ALMA bulk tender

Sustained progress in malaria control relies heavily on
optimal coverage of malaria control interventions. As such, significant resources are spent on ensuring high LLIN coverage at country level. Despite this, there are continued challenges in increasing and sustaining high LLIN coverage. Constraints faced by countries include high and variable cost, complex and time consuming procurement processes, lengthy advance payment requirements and long lead times between procurement and delivery. Fluctuations in the adequacy of financing for, and coverage of LLINs are tracked in the ALMA scorecard using data from RBM.

Quarterly reports in 2010 identified key resource gaps for LLINs. Following this, ALMA Heads of State and Government made a request for efforts to accelerate coverage with key malaria commodities, specifying pooled procurement as an option to take advantage of economies of scale. The ALMA secretariat coordinated a LLIN pooled procurement initiative leveraging funding from the Global Fund, World Bank and DFID, and UNICEF expertise in bulk procurement. This led to the purchase of 24 million LLINs, accounting for 25% of all LLINs procured globally in 2011, the largest single procurement of malaria commodities for Africa. Countries with challenges in scale-up and replacement were targeted and invited to opt-in. Five countries (Kenya, Sierra Leone, DRC, Zambia and Nigeria) agreed and benefited from this purchase. Throughout the process, the ALMA Secretariat worked with Ministers of Health and Finance to represent countries and partnered with UNICEF Supply Division to manage the operational aspects of the tender. All beneficiary countries received their full LLIN requirements at lower cost and between 6-12 months shorter compared to what was quoted to individual countries. This accelerated access to nets for 48 million people and significantly contributed to achieving universal coverage targets. This experience demonstrated the potential for substantial reductions in price and lead-times, provided countries with experience and confidence in pooled procurement and has been instructive to similar initiatives undertaken subsequently by other players. The ALMA secretariat shared experiences and benefits of bulk procurement and this kind of innovative financing with countries and partners and encouraged meaningful engagement of decision makers in subsequent pooled procurement initiatives. The Global Fund has since become the leading agency for LLIN bulk procurement and continues to advocate for increased domestic funding for malaria and several countries including Zambia, Chad and Niger have enhanced domestic resource commitments towards funding procurement of malaria commodities.

Responding to emergencies

Mobilizing emergency finances for malaria control amidst the West African Ebola epidemic

In 2014, the ALMA Chair highlighted concerns over declining coverage of health interventions in Ebola affected countries as a result of health system break-downs. Further, suspected malaria cases were at increased risk of acquiring Ebola due to overlapping symptoms of the two infections and the potential for malaria patients being suspected of, or misdiagnosed with Ebola and being isolated with Ebola confirmed patients in treatment centers. It was therefore imperative that malaria prevention and treatment interventions be widely deployed to reduce malaria and inadvertent Ebola transmission. ALMA worked with the Global Fund, WHO and other partners to secure emergency funds for Mass Drug Administration for malaria and LLIN distribution in Liberia and Sierra Leone whilst World Bank and other resources were secured to support the health systems of the three Ebola affected countries.

Mitigating ACT stock-outs

In 2012, following requests for support from countries, the ALMA Secretariat alerted global partners when the Affordable Medicine Facility - malaria (AMFm) roll-out led to demand for ACTs outstripping supply, long delivery times in certain countries and subsequent ACT stock outs. An ACT taskforce was established with ALMA participation to ensure equitable distribution of ACTs.

Gaps in financing for essential commodities tracked through the scorecards are at an all-time low, with gaps to sustain universal coverage in 2016 less than 45m LLINs, and 50m ACTs. Countries had secured sufficient resources for the procurement and distribution of 151 m LLINs, 315 m RDTs and 297m ACTs. The ALMA Secretariat continues to advocate for increased domestic funding for malaria and several countries including Zambia, Chad and Niger have enhanced domestic resource commitments towards funding procurement of malaria commodities.

Strengthening collective action to address risks to malaria control and elimination

Managing threats associated with shifts in Global Fund funding mechanisms

In 2014 the Global Fund instituted a new funding model to replace the previous rounds-based system in order to better align funding with national budgeting cycles and priorities. However, whilst the required restructuring was underway, shortfalls in financing threatened malaria control gains in some countries. This challenge was quickly highlighted by the scorecard as a serious emerging problem. Funding gaps of over 30% in many countries were shown by the Q1 and Q2 2013 scorecards. This period was associated with the lowest level of available funding for projected LLIN needs (17/43 countries had sub-optimal financing for projected needs). The ALMA
secretariat worked with the Global Fund Secretariat and Roll Back Malaria to advocate for an interim funding model to meet this financial shortfall in priority countries. As a result, over US$700 million was awarded to affected countries to sustain malaria control gains, and approximately 90 million LLINs were procured to sustain coverage.

With the introduction of the Global Fund new funding model, the ALMA secretariat worked with key RBM partners to table the need for shorter duration concept notes for select countries to the Global Fund Board and then worked with the Global Fund Secretariat to identify the key countries in need of shorter duration grants. Shorter duration grant submissions were approved by the Global Fund Board and several priority high burden countries benefited from this arrangement including Ghana, Mozambique, Nigeria, Sudan, Uganda and Zimbabwe. As a result of this collaborative initiative, the scope and scale of essential interventions was sustained in high burden countries.

With the introduction of the Global Fund New Funding Model, there was a potential risk of a reduction of funding for malaria as a result of inadequate allocation at the global fund level or diversion of malaria allocations to the other diseases at the country level. To monitor this threat, the ALMA Secretariat introduced an indicator on the Global Fund provisional allocation for malaria into the ALMA Scorecard in 2014 and secured commitment from Heads of State and Government and their Ministers of Health to maintain the recommended funding allocated for malaria rather than divert any amount to the control of either of the other diseases. ALMA tracked the allocations to malaria and reported back to Heads of State on a regular basis. Within one year of the launch of the New Funding Model, 42 countries in Africa were supported to submit their malaria concept notes and over 90% of proposals were submitted, at a value of US$3.8 billion. This represented maintenance of overall malaria financing. By end 2015, none of the countries had diverted resources away from malaria.

The positive effects of this collective action have been reflected in the ALMA scorecard. Increasing LLIN/IRS coverage has been shown from 2014 – 2016. The number of countries with green status (over 80% coverage) in this indicator increased from 27 in Q2 2014 to 34 by Q2 2016 whilst those with red status (less than 40% coverage) decreased from 9 to 3 (figure six).
Recognizing progress and commitment

The ALMA Awards for Excellence:

Annually at the January ALMA forum, ALMA awards for excellence are given to countries that have made significant gains towards their malaria goals in recognition of progress. Awardees are chosen by an independent selection committee with membership from the WHO, Roll Back Malaria (RBM), the private sector, civil society and academia and awards are presented to Heads of State by the UN Secretary General and the chair of the African Union Commission. Specific actionable best practices are chosen each year as bases for the nomination of awardee countries. Evidence from the ALMA Scorecard for Accountability and Action and country quarterly reports as well as other reputable sources such as the annual World Malaria Report (WHO) are used to assess progress and identify best practices. Appendix one shows the 30 awardee countries to-date and criteria of awards for each year. ALMA awards recognize progress but also serve as an advocacy mechanism by ensuring that key issues remain high on the continent’s agenda, and have led to renewed commitment for malaria control. Significantly, in almost all awardee countries, receipt of awards has led to increased domestic financing for malaria. For example in 2016, the Mali government provided US$3.1 million above the regular allocation to malaria, 5.1 million additional antimalarial treatments and 200,000 additional LLINs after the country received an award for “Most improved in malaria control 2011-2015.” Similarly after receiving an ALMA award in 2015, the Head of State of Togo offered US$ 1.55 million for the operational cost of a national LLIN campaign. Togo also contributed US$1 million to the Global Fund. ALMA awards have also been associated with increased political interest and involvement in malaria control from the Head of State and government.

The ALMA Scorecard as a template for other scorecards

The experience of developing and successfully implementing the ALMA scorecard for action and accountability has led to requests for ALMA’s support in developing similar management tools for other areas of health. The ALMA secretariat has supported the development of regional scorecards including the Malaria Elimination scorecard and the SADC (Southern Africa Development Community) malaria E8 regional elimination scorecard; as well as country-level scorecards and action tracking mechanisms for RMNCAH, Nutrition and Malaria.
Between 2012 and 2015, the ALMA secretariat in partnership with USAID, UNICEF, UNFPA, WHO and numerous other country partners, supported 25 countries in the development and implementation of country Reproductive, Maternal, Newborn, Adolescent and Child Health (RMNCAH) scorecards to track progress, monitor performance and resolve bottlenecks towards MDGs 4 & 5; strengthening accountability and action for maternal and child health. The scorecards profile key RMNCH indicators and are used to monitor and act on performance at national and sub-national levels. The development of RMNCAH scorecards is a country-led process and implementation is integrated into existing country national and subnational review and accountability mechanisms. The ALMA secretariats support to the development of RMNCAH scorecards has largely been around introducing and applying the principles of the ALMA scorecard and action tracking mechanism to these country scorecards, training staff at national and subnational levels; supporting the optimal use of the tools through support visits and documentation and sharing of best practices across countries. RMNCAH scorecards have greatly enabled identification and targeted action to resolve bottlenecks towards attaining country and global MNCAH targets and goals. The scorecards have highlighted and brought visibility to country RMNCAH priorities, widened stakeholder engagement including at top political level, and enhanced transparency. The broad dissemination and dialogue around RMNCAH performance and bottlenecks has strengthened evidence-based action plans and improved RMNCAH programmes outcomes. The scorecards have enhanced communication and interactions between technical teams and political and managerial leaders and between different levels of country health systems (National, sub-national and community). RMNCH scorecards have empowered health teams and partners working at subnational level to strengthen their programmes and achieve progress towards national RMNCH priorities.

RMNCAH scorecards have triggered action for impact. Several countries have realized improved performance in key indicators and underperforming regions using the scorecard to enhance resources, build capacity, and mentor. Countries have been able to target and ensure that the right areas enjoy the allocation of additional resources, revised policy and strategy, and enhanced technical and political support for health. The experience gained and methods developed during this process, is being used to inform and support the development and use of national malaria control and elimination scorecards as well as continued support for RMNCAH scorecards.

In 2014 a collaboration between the ALMA secretariat and The Southern African Development Community (SADC) led to the development of the SADC Malaria Elimination 8 Scorecard. SADC Ministers of Health, approached ALMA to work with them on a malaria elimination scorecard for their Elimination 8 countries. The SADC Elimination 8 scorecard was launched in May 2014. Building on this success, the Chair of ALMA, then H.E President Armando Guebuza of Mozambique directed the ALMA Secretariat to develop the ALMA 2013 Scorecard towards Malaria Elimination.

In September 2014, the ALMA secretariat was requested by H.E. President Jakaya Mrisho Kikwete of the United Republic of Tanzania to assist the country in the development of a multi-sectoral nutrition scorecard. In February 2015, ALMA, in partnership with USAID UNICEF and others successfully assisted the Government of Tanzania in developing a nutrition scorecard which spans seven Ministries and includes 24 national- and sub national regional-level indicators.

In August 2015 the ALMA secretariat, with support from the Bill and Melinda Gates foundation and other malaria partners, supported the Kingdom of Swaziland in the development of the first country-level malaria elimination scorecard. Subsequently the ALMA secretariat in 2016 supported 12 additional countries in the development of country-level malaria elimination and/or control scorecards. Like the RMNCH scorecards, these scorecards are country-driven and track indicators at national and sub-national levels. All ALMA member countries are expected to develop and implement malaria scorecards with the support of ALMA and other partners. Country malaria elimination and/or control scorecards are supporting national malaria control programs to routinely monitor progress against priority malaria indicators drawn from strategic plans and global targets and goals, as well as identify and resolve bottlenecks. Scorecards are well integrated into quarterly review mechanisms at national and sub-national levels with a focus on identifying and swiftly acting on underperforming indicators or regions. The use of country malaria scorecards has already led to action including in the areas of capacity-building for malaria control and elimination programs including strengthening of surveillance and data collection at sub-national level and advocacy for finances, among others. Furthermore the scorecards are informing malaria control planning in several countries and the development of dedicated malaria elimination councils to provide high-level leadership and oversight as countries progress towards eventual elimination.
5. Conclusion

The African Leaders Malaria Alliance provides an avenue through which Africa’s top leadership participate in the acceleration and consolidation of malaria control and movement of the continent towards eventual elimination. Strengthening action and accountability for malaria at continental and country level has been major area of focus for the alliance and the ALMA scorecard for action and accountability has played a pivotal role in this regard. The scorecard has been used to continuously apprise Heads of State and Government of the status of malaria control and progress towards elimination in malaria endemic countries; and guide their action. The scorecard has highlighted progress such as increased financing and intervention coverage and decreased disease burden across the continent. It has also played a critical role in identifying emerging challenges and bottlenecks to malaria control such as threats to financing and sustained intervention coverage and related gains. Majorly, influence and action from Heads of State and Government has led to an enabling policy and regulatory environment for malaria control, increased domestic financing for health and malaria control in particular, and innovations around scaling-up and maintaining malaria control interventions. The scorecard and country reports have also been successfully used to engage Ministries of Health at leadership and technical level and partners to address identified bottlenecks. Importantly, as a result of its use at multiple levels, the scorecard has brought together all key players in malaria control at global, continental and national levels and this has contributed to unprecedented collective action and gains in malaria control.

Successful use of the ALMA scorecard at the continental level has led to demand for country malaria control and elimination scorecards which have been developed in 13 countries to-date with a plan of expansion to all 46 endemic ALMA member countries by 2019. Country scorecards follow the same principles of the ALMA scorecard for action and accountability. They are country-driven and track a set of prioritized actionable indicators at national and sub-national levels. These scorecards operate as management tools at technical and management levels within Ministries of Health at national and sub-national levels and are used to localize and act on bottlenecks within countries. The scorecards are also used for monitoring, advocacy and accountability for malaria beyond the health sector. It is expected that as malaria control is consolidated and more countries move towards elimination, addressing bottlenecks at the sub-national level will become increasingly important to the acceleration of continued progress at the continental level while action triggered at the continental level will likewise facilitate bottleneck resolution at national and sub-national levels. This synergistic functioning of the ALMA scorecard for action and accountability and country malaria control and elimination scorecards is expected to have a catalytic effect on the push towards malaria elimination in Africa.

The role of the ALMA scorecard for action and accountability will remain important as African countries move towards the attainment of the targets of the Global Technical Strategy and Catalytic Framework to end AIDS TB and eliminate Malaria in Africa by 2030. Heads of State and Government have demonstrated commitment to their stewardship role in the journey to a malaria-free Africa and will require real-time robust and relevant evidence to track progress and guide corrective action, where it is needed. The ALMA scorecard for accountability and action has been shown to be adaptable to changing priorities, in order to focus on the most critical drivers of progress. Evidence from the scorecard has been used to rally players in malaria control from the national to global level to address threats and test innovative solutions. Current priorities including increased domestic financing, sustained coverage of vector-control interventions and challenges such as widening insecticidal resistance, and surveillance and data collection; as well as those that will emerge, will continue to be tracked by the ALMA scorecard and by complementary country scorecards in ALMA countries.
Appendix. Summary of ALMA awards of excellence: 2011-2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Award Criteria</th>
<th>Countries receiving the Awards</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Countries that have addressed the removal of tariffs on all essential malaria commodities and banning of oral artemisinin-based monotherapies</td>
<td>Republic of Guinea, Republic of Kenya, Republic of Uganda and the United Republic of Tanzania</td>
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<tr>
<td></td>
<td>Nations that have banned the importation and use of oral artemisinin-based monotherapies, and additionally have removed tariffs on all essential commodities in the fight against malaria.</td>
<td>Burundi, Rwanda, and Mozambique</td>
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<tr>
<td></td>
<td>Countries that have made outstanding progress in malaria control over the last year</td>
<td>Benin, Cameroun, Kenya and the United Republic of Tanzania</td>
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<tr>
<td>2012</td>
<td>Nations that have banned the importation and use of oral artemisinin-based monotherapies, and additionally have removed tariffs on all essential commodities used in the fight against malaria.</td>
<td>Burundi, Rwanda, and Mozambique</td>
</tr>
<tr>
<td></td>
<td>Countries that have made outstanding progress in malaria control over the last year</td>
<td>Benin, Cameroun, Kenya and the United Republic of Tanzania</td>
</tr>
<tr>
<td>2013</td>
<td>Countries that have increased progress in performance as observed for: Removal of tariffs on antimalarial commodities; Ban status of oral artemisinin-based monotherapy; Community case management of malaria</td>
<td>Cameroon, Guinea, Kenya, Liberia, Mozambique, Rwanda and Uganda</td>
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<tr>
<td></td>
<td>Countries that have made the best performance in: Reduction in malaria mortality; Operational long-lasting insecticide-treated nets (LLINs)/IRS coverage</td>
<td>Cape Verde, Namibia, Rwanda, São Tomé and Príncipe, South Africa, Swaziland, and Zambia</td>
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<tr>
<td>2014</td>
<td>Exemplary leadership in vector control - maintaining an average of 95% coverage year round, in the implementation of Long-Lasting Insecticidal Nets and/or Indoor Residual Spraying interventions against malaria</td>
<td>Cape Verde, Madagascar, Malawi, Namibia, Rwanda, São Tomé and Príncipe, and Swaziland</td>
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<tr>
<td>2015</td>
<td>New countries that have maintained 95% coverage or above of vector control (LLINs or IRS) for each quarter of 2014</td>
<td>Burkina Faso, Burundi, Central African Republic, Chad, Comoros, Guinea, Guinea-Bissau, and The Gambia</td>
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<td></td>
<td>For championing the Reproductive, Maternal, New Born and Child Health (RMNCH) Scorecards</td>
<td>Ethiopia</td>
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<td></td>
<td>Most improved in malaria control for showing the most positive change in malaria indicators throughout 2014</td>
<td>Burundi, Central Africa Republic, Sierra Leone, South Sudan, Togo</td>
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<td>2016</td>
<td>Achieving the Malaria Millennium Development Goal Target: Excellence in Performance on Malaria Control, 2011-2015:</td>
<td>Botswana, Cape Verde, Eritrea, Namibia, Rwanda, São Tomé and Príncipe, South Africa and Swaziland</td>
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<tr>
<td></td>
<td>Most Improved in Malaria Control, 2011-2015:</td>
<td>Comoros, Guinea, Mali</td>
</tr>
<tr>
<td>2017</td>
<td>Achieving great impact on reducing malaria incidence and malaria mortality</td>
<td>Botswana, Cabo Verde, Comoros, DRC, Ethiopia, Swaziland and Uganda</td>
</tr>
<tr>
<td></td>
<td>Leadership Award</td>
<td>President Idriss Deby Itno of the Republic of Chad</td>
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