COMMONWEALTH PARTNERSHIPS FOR ANTIMICROBIAL STEWARDSHIP

CALL FOR APPLICATIONS: QUESTIONS AND ANSWERS

1 WHO IS MANAGING THE PROGRAMME?

THE TROPICAL HEALTH AND EDUCATION TRUST

The Tropical Health and Education Trust (THET) is a global health organisation managing programmes across low- and middle-income countries (LMICs) to strengthen health systems, working to achieve better access to quality healthcare. We do this through a model of Health Partnerships, i.e., partnerships between health institutions from the UK and LMICs, working together to co-develop responses to locally identified health system priorities. THET has been managing programmes to strengthen health systems and Human Resources for Health (HRH) for over 30 years.

THE COMMONWEALTH PHARMACISTS ASSOCIATION

An accredited organisation of the Commonwealth, the Commonwealth Pharmacists Association (CPA) is a registered charity (CIO) and membership body; leading and developing the pharmacy profession to benefit the people of the Commonwealth. The CPA work is focused on LMIC countries in the Commonwealth and is underpinned by its core charitable objectives to: build strong and diverse collaborative networks between pharmacists and health networks; develop and improve the quality of pharmacy practice; create platforms to share knowledge and educational resources in order to continually develop the knowledge and skills of the pharmacy profession.

2 WHAT IS THE FLEMING FUND?

The Department of Health and Social Care (DHSC)'s Fleming Fund is a UK aid programme supporting up to 25 countries across Africa and Asia to tackle antimicrobial resistance (AMR), a leading public health threat across the world. The Fleming Fund invests in strengthening surveillance systems through a portfolio of country grants, regional grants and fellowships managed by Mott MacDonald, and global projects managed by DHSC partners.

3 WHAT IS A HEALTH PARTNERSHIP?

Health partnerships are long-term partnerships between UK health institutions and their counterparts in LMICs. Partnerships aim to improve health services and systems in LMICs through the reciprocal exchange of skills, knowledge and experience between partners in the UK and LMICs.

Health partnerships often begin through an informal or personal connection between individuals in two institutions. It is the process of widening this connection, deciding to work on a project together and understanding the need to formalise and institutionalise the relationship that marks the beginning of a health partnership.

Health partnerships seek to address priority gaps and needs identified by the LMIC partners, and usually focus their activities on a series of projects. Often the projects implemented by health partnerships support human resources for health development through the training and education of healthcare workers in the LMIC partner institutions. Activities, especially when the partnership has been well-established over a number of years, can then broaden to include strengthening aspects of a health system, such as clinical pathways and policies, and a scale up of their activities.

THET has developed nine Principles of Partnership (PoPs), which are hallmarks of good practice for health partnerships and the way they manage projects, such as working consistently within local and national plans and planning and implementing projects together with a clear commitment to joint learning.

Through the UK Foreign, Commonwealth and Development Office (then DFID)-funded Health Partnership Scheme, which THET managed, it has been possible to demonstrate that this model of partnership and capacity development offers an effective, sustainable and value for money approach[1] to strengthening national capacities, whilst also resulting in the strengthening of health systems in LMICs and improved leadership skills among the UK workforce[2].

4 PARTNERSHIP ELIGIBILITY

4.1 WHAT ARE THE DIFFERENCES BETWEEN ESTABLISHED AND NEW HEALTH PARTNERSHIPS?

ESTABLISHED PARTNERSHIPS

In the context of this programme, we define an established health partnership as one that has been working together for over six months, is formalised and institutionalised, and can clearly demonstrate adherence to THET's Principles of Partnership.

NEW PARTNERSHIPS

A new partnership has either been working together for less than 6 months or has not yet started working together but has intentions to do so. It does not need to demonstrate adherence to all of THET's Principles of Partnership but must demonstrate a commitment to do so and have a clear strategy of how the partnership will become formalised and institutionalised. For guidance on setting up a health partnership, please refer to THET's Guidance for New Health Partnerships.

Both new and established health partnerships are eligible to apply under this Call for Applications.

4.2 HOW CAN THET AND CPA HELP MATCH UP ORGANISATIONS INTERESTED IN NEW PARTNERSHIPS OR THOSE INTERESTED IN BEING INVOLVED IN AN ESTABLISHED PARTNERSHIP?

THET and CPA are keen to support institutions that are not currently part of a Health Partnership to form one and to help existing Partnerships that lack expertise in a certain area to find further partners. To help institutions who completed the initial Expression of Interest (EOI) survey to find a UK partner, we are asking for UK institutions who are interested in forming or joining a partnership, to please complete the new UK institutions short survey here. UK institutions should complete this survey outlining the expertise they are looking for and which country they are hoping to work in.

THET will circulate this information on a weekly basis to the institutions who completed the initial EOI form, and it is the individuals' responsibility to follow up on this. Institutions are of course welcome to develop their own partnerships independently of THET.

Please note that the survey will close on Sunday 6th November 2022, to allow partners enough time to establish a relationship before submitting an application.

4.3 WHAT TYPE OF INSTITUTIONS CAN BE PART OF A HEALTH PARTNERSHIP UNDER THIS PROGRAMME?

In the context of this programme, the Lead UK Partner must be:

- An NHS Hospital/Trust or
- A UK health training/education or academic institution (e.g. a University, a Medical College, a Faculty of Public Health etc.) or
- A UK regulatory body (e.g. General Pharmaceutical Council, Healthcare Improvement Scotland etc.) or

[1] See evaluation of the Health Partnership programme.
[2] See International Health Partnerships: how does the NHS benefit?

- A UK professional membership association (e.g. a Royal College/Society etc.).

In the context of this programme, the Lead LMIC Partner must be:

- A public/not-for-profit hospital (e.g. a regional hospital, etc.)
- A health training/education or academic institution (e.g. a University, a Medical College, a Faculty of Public Health etc.) or
- A regulatory body (e.g. a Pharmacy Council etc.).
- A professional membership association (e.g. a Pharmacists Association/Society etc.).

Additionally, please note that:

- Private not-for-profit health institutions cannot be a Lead partner but can be an additional partner.
- While community pharmacies cannot be a Lead partner, project implementation can take place in community pharmacies, therefore they are eligible as an additional partner.
- Non-governmental organisations (NGOs) are not eligible to apply as Lead partner for this grant call, however, we acknowledge that some Health Partnerships have a charitable arm to support fundraising activities, and these charitable entities are eligible to have a role as Managing Agent for a grant. The applicants must be able to show that the project will be delivered by the eligible UK and LMIC health institutions and not the NGO.
- NGOs are not eligible as LMIC Lead partner institutions unless they are a not-for-profit clinic or hospital.
- Private for-profit institutions are not eligible to apply, except community pharmacies as stated above.

4.4 ARE MULTI-COUNTRY PARTNERSHIPS ELIGIBLE FOR A CWPAMS 2 GRANT?

Yes, applicants can submit proposals for multi-country partnerships as long as they are in the eight priority countries.

4.5 ONE OF THE LEAD PARTNERS WAS PART OF A CWPAMS PROJECT BUT WILL NOW WORK WITH A DIFFERENT PARTNER. WHICH CATEGORY SHOULD THEY APPLY TO?

They should apply under Category C. This would be considered a 'start-up' project.

4.6 THE PARTNERSHIP WAS PREVIOUSLY FUNDED THROUGH CWPAMS, BUT WILL NOW EXPAND THEIR WORK TO ANOTHER COUNTRY OR BRING IN AN ADDITIONAL PARTNER. WHICH CATEGORY SHOULD THEY APPLY TO?

They should apply under Category B, this would be considered an existing project. If they are planning to involve new sites or partners using the hub and spoke approach, they should apply under Category A.

4.7 IS IT POSSIBLE FOR VARIOUS HOSPITALS OR HEALTH PARTNERSHIPS TO DO A JOINT BID AND THEREFORE FOR VOLUNTEERS AND HEALTH WORKERS FROM VARIOUS HOSPITALS AND OTHER HEALTH INSTITUTIONS TO BE INVOLVED?

Yes, this grant stream allows for multi-partner partnerships. The application form has space for including additional partners. If someone from another institution wishes to provide technical input to a project on an individual basis, their institution does not need to be listed as a partner (however if the individual will be part of the outcome that brings benefit back to the NHS, the application will need to consider how they can demonstrate this if their institution is not formally involved).

Please note this is different to applying in Category A, as a hub and spoke model.

4.8 HOW CAN WE PROMOTE THE HEALTH PARTNERSHIP APPROACH TO OUR EMPLOYERS?

Volunteers from the NHS can accrue a number of benefits. The first round of CwPAMS partnerships reported the following benefits:

- Improved leadership skills: promotions to management positions and opportunities to contribute to senior working groups
- Opportunities to develop global networking opportunities and share bi-directional learning

- Professional skills development, including project and financial management, negotiating, teamwork, networking, and improved technology skills
- Involvement in global health fellowships
- Improved enthusiasm and motivation for pharmacy work, contributing to increased staff wellbeing
- Adding to the international research portfolio and reputation of the NHS institution, as well as increased awareness and understanding of AMS and AMR

Examples of feedback from UK volunteers who were part of the CwPAMS Extension programme are highlighted below.

If you would like information to support discussions with employers around the benefits of participating in CwPAMS please contact CPA via amr@commonwealthpharmacy.org

5 REQUIRED CWPAMS TOOLS

At various stages of the programme, different categories will be required to use and submit different CwPAMS tools, as outlined below. These tools can be found here.

Application stage	**CwPAMS 1 grant holder**	**CwPAMS Extension grant holder**	**No prior involvement with CwPAMS**
Category A	Draft AMS Action Plan for hub Baseline AMS Assessment Tool for hub (updated from CwPAMS 1 if necessary)	AMS Action Plan for hub Baseline AMS Assessment Tool for hub (re-submit tool from end of CwPAMS Extension and update if necessary)	N/A
Category B	*For each target institution:* Draft AMS Action Plan Baseline AMS Assessment Tool (updated from CwPAMS 1 if necessary)	AMS Action Plan *For each new target institution:* Baseline AMS Assessment Tool (re-submit tool from end of CwPAMS Extension and update if necessary)	*For each target institution:* Draft AMS Action Plan Baseline AMS Assessment Tool
Category C	N/A	N/A	For each target institution: Baseline AMS Assessment Tool
Implementation stage	**CwPAMS 1 grant holder**	**CwPAMS Extension grant holder**	**No prior involvement with CwPAMS**
Category A	AMS Assessment Tool for each new spoke site AMS Action Plan updated for the hub New Action Plan for each spoke site		N/A
Category B	AMS Action Plan AMS Assessment Tool		
Category C	N/A	N/A	AMS Action Plan

5.1 OUR PARTNERSHIP WILL IMPLEMENT THE PROJECT IN MORE THAN ONE INSTITUTION. DO WE NEED TO COMPLETE THE CWPAMS AMS ASSESSMENT TOOL FOR EACH ONE?

Yes – a separate CwPAMS AMS assessment tool should be completed for each delivery institution that will be part of the CwPAMS programme, i.e. separate forms are required for each institution. If, for example, a partnership will work with two healthcare facilities, then two separate forms should be submitted. Healthcare facilities that have been part of CwPAMS should also complete a CwPAMS AMS Assessment tool.

5.2 WHAT IF WE ADD SPOKE SITES DURING THE PROGRAMME?

For partnerships applying as a hub & spoke, we expect you to have an idea of the spokes that will be included in the project, but you should work with all spoke sites to complete an AMS Assessment tool in the inception phase of your partnership (after the grant is approved). A CwPAMS AMS Assessment tool should be completed and submitted during the programme when additional spoke sites are linked to hubs, to identify priority areas for AMS specific to that site.

6 CAN YOU PROVIDE MORE DETAILS ON THE HUB AND SPOKE MODEL APPROACH?

Previous CwPAMS grant holders are invited to apply to be a Centre of Excellence (CoE) for their country or region (or they are also welcome to apply under Category B instead). These CoEs will embody a hub and spoke model, with the larger hub institution responsible for disseminating training and capacity building to other local health facilities (spokes).

The focus will be on long-term sustainability, gradually reducing the reliance on UK expertise by supporting in-country experts to provide relevant local knowledge and expertise with regards to AMR/AMS through a culture of behaviour change and quality improvement.

Hub and spoke model FAQ:

1. *Might CwPAMS award more than one Centre of Excellence grant in a particular country?*

   Yes, this is feasible, provided there is no duplication or potential implementation challenges. THET and CPA will review this when considering the overall approach and coordination across the country.

2. *Can the spoke institutions apply for separate CwPAMS funding?*

   No, an institution which is a spoke within a larger application should plan to conduct all proposed project activities as part of the hub and spoke model.

3. *Are institutions that were part of CwPAMS 1, but not CwPAMS Extension, eligible for hub and spoke funding?*

   Yes, institutions which were part of any previous rounds of CwPAMS are eligible for this category of funding.

4. *What do hub sites need to be able to demonstrate in their application to be successful?*

   - Evidence of a resilient AMS programme and team, demonstrated through previous CwPAMS programme outcomes.
   - Demonstration of the principles of AMS within the LMIC institution and the partnership relationship continuing outside of the CwPAMS funding period.
   - A developed AMS Action Plan from the hub site.
   - Clear objectives for the hub and spoke project.
   - A detailed project plan for the hub including roles and responsibilities of the partnership leaders and evidence of engagement from planned spoke sites.
   - Evidence of capacity from the hub site and lead UK institution to undertake the hub and spoke project.
   - Evidence of engagement with relevant local and national stakeholders with plans to inform best practices.
   - Hub sites should be able to demonstrate how they would be a Centre of Excellence for laboratory and surveillance capacity development or developing an AMS Champion training scheme. In addition, hub sites should also consider incorporating quality improvement and behaviour change methodologies; branching out to Community Pharmacy services; and enhancing substandard and falsified antimicrobial detection and reporting within the model they propose.

7 SCOPING STUDIES

The Call is designed around the Fleming Fund's strategic priorities and recommendations from the scoping studies conducted by the CPA. **The scoping studies for each country can be found here**.

7.1 CAN YOU MAKE ANY FURTHER SUGGESTIONS ABOUT HOW WE CAN STRENGTHEN OUR PROJECT AND ALIGN IT WITH THE SCOPING STUDIES?

AMS educational needs and skills development will not be sufficient to enhance AMS capacity in low resource settings. Projects should therefore reflect and address other aspects of health worker capacity and the local and national healthcare environment and context. This could be informed by behavioural science including approaches to address barriers to behaviour change.

In terms of healthcare workers, the project should consider:

- Whether healthcare workers have the motivation to act on AMR and whether they perceive it as important to adopt AMS.
- Whether they have the managerial support, workplace culture and resources to act.
- Whether other building blocks of the health system such as leadership are sufficiently developed.

In terms of the local healthcare environment, the project should demonstrate an understanding of the local health system, particularly within the community in which it is based, considering:

- The existing constraints of the health facilities and potential barriers to effective AMS.
- The priorities, the needs of the community, and what would motivate and deter them from being involved in an AMS partnership.
- What activities are already taking place and how your project can build on this.
- How other initiatives might relate to the data the project gathers and how this is considered in the evaluation.

Strategies should not only draw on the knowledge and priorities of the LMIC partners, but where appropriate also the knowledge of other local institutions, such as community groups, NGOs, government agencies and research bodies.

Further support for behaviour change approaches is outlined under Section 14.

8 PROJECT OBJECTIVES

8.1 CAN YOU GIVE EXAMPLES OF WHAT YOU EXPECT US TO ACHIEVE FROM OUR PROJECT ACTIVITIES?

The following outlines CwPAMS 2 programmatic outcomes, and the types of evidence from different project activities that contribute to these outcomes:

1. Quality antimicrobial consumption data is used to inform and develop AMS interventions

   For example:

   - Strengthened record-keeping and data collection, including on prescribing practice, antimicrobial use, antimicrobial resistance, in targeted health facilities.
   - Evidence of the use of the data to inform decision-making.
   - Evidence of how AMS interventions are contributing to improvements in the management of antimicrobials.
   - Health facilities participate in the Point Prevalence Survey on antimicrobial use.
   - WHO AMS guidance being adopted (and where appropriate) adapted in the health facility (and beyond).

- Health facilities adopt policies for AMS based on findings of partnership.
- Evidence of uptake of clinical tools and training resources in partner health facilities and in other locations.
- Improved linkage of laboratory and / or hospital data with clinical practice.
- Available local, up-to-date surveillance/ microbiology data to inform antibiograms specific to region / country.
- Share and learn about respective mechanisms for identifying & reporting sub-standard and falsified (SF) medicines.
- Improved awareness of detection and reporting for SF antimicrobial medicines among health care teams.
- Publications of national level research.

2. LMICs, regions, institutions and workforce have improved structures, knowledge and practice related to AMS through a One Health approach, making progress against AMR National Action Plans

   For example:

   - Improved prescribing practice, which might be demonstrated by a reduction in prescriptions for antimicrobials, reduced consumption of broad-spectrum antibiotics, increased adherence to treatment guidelines.
   - Improvements in the gathering of data on the use of antimicrobials and of antimicrobial resistance, such as through measuring overall consumption, as well as auditing use.
   - Improvements in the use of microbiology data.
   - Development or upskilling of an AMS team/programme and antimicrobial champions to promote change at managerial level, including participation in AMS Leadership Fellowship.
   - Development of AMS mechanisms and tools to support clinical decision making.
   - Enforcement of protocols, policies, strategies associated with improved AMS.
   - Training on AMS that considers all health workers involved providing antimicrobials - this could include other healthcare professionals in the hospital as well as community outreach.
   - Strengthened role for and recognition of the importance of pharmacists in tackling AMR.
   - Increased multi-disciplinary team working together on common aim of AMS.
   - Improved flow of data between local delivery sites and national stakeholders.

3. NHS institutions benefit through improved knowledge and capabilities of UK volunteers through bidirectional learning

   For example:

   - Evidence of the strengthened capabilities and competencies of NHS volunteers, including:
     - Increased awareness of AMR in a global context
     - Increased leadership, communication and pedagogy skills
     - Ability to handle complex budgets and manage projects
     - Problem solving in situations with limited budgets available
   - Evidence of how these strengthened capabilities are being used in the NHS.
   - Evidence of new practices around AMS being adopted back in the NHS.

8.2 DO WE NEED TO UNDERTAKE A POINT PREVALENCE SURVEY DURING OUR PROJECT?

Yes, every partnership must demonstrate that they have undertaken a point prevalence survey (PPS) at each main site, including community health care institutions. If a PPS has been undertaken within the last year, then the partnership should plan to undertake another PPS later in the project. PPS data should be used to inform AMS Action Plans. Training on undertaking PPS and how to use the data to facilitate change will be provided by the CPA.

Healthcare institutions which are based in a community setting should consider the use of the new global point prevalence survey (GPPS) outpatient module. This module will be launched shortly by the Global PPS team.

Category A partnerships

- The hub site must undertake a PPS.
- Each spoke site must undertake a PPS, this can be supported by the hub.

Category B existing CwPAMS partnerships

- Each main LMIC healthcare facility must undertake a PPS.

Category B (new to CwPAMs) and Category C partnerships

- Each new CwPAMS partnership should plan to undertake a PPS within the first six months of the project.

Which PPS methodology should we use?

The CPA has close links with the Global PPS team and the GPPS methodology has been utilised in CwPAMS 1 and Extension. Whilst the WHO-PPS has been developed since the initial CwPAMS grant call and partnerships, The CPA has worked with the Global-PPS team during the SPARC (Surveillance and Prescribing support for Antimicrobial Stewardship Resource Capacity Building programme - run in parallel to the CwPAMS Extension programme) and has developed an adapted SPARC PPS tool which incorporates the aspects of the WHO tool which were missing from the GPPS methodology. The CPA team will encourage the use of this adapted tool during CwPAMS 2 as it allows immediate access to facility level data analysis which the WHO does not facilitate. However, if a partnership has been nominated by their Ministry to undertake a WHO–PPS we will support this and adopt a flexible approach. This will allow partnerships to explore and adapt their plans if additional PPS tools (e.g. community PPS) or other Ministry preferences become apparent.

What are the expectations for enhancing the detection and reporting substandard and falsified antimicrobials?

Substandard and falsified medicines (SF) pose a risk for the development of AMR as well as presenting a harm to people taking them. Proposals should look for ways to improve awareness of how to detect SF antimicrobials and the harm that these can cause whilst promoting reporting to the National Medicines Regulatory Authority in keeping with country specific mechanisms. This work should align with recommendations from WHO. The CPA team will provide technical support and guidance for this element of the programme.

9 WHAT ASPECTS YOU ARE LOOKING FOR IN THE FINANCIAL MANAGEMENT EXPERIENCE SECTION OF THE APPLICATION FORM?

In this section of the proposal, we would like to see clear evidence of the existing (for established partnerships) or proposed (for new partnerships) financial management and counter fraud processes that are in place between all partners. We also expect the financial management roles and responsibilities to be outlined in a Memorandum of Understanding (MoU) between partners (for new partnerships, this can be developed within the first three months of the project). An example of wording in a MoU may include:

In respect of finance and any required transfer of monies we will work within the code and confines of the 'THET Finance Toolkit for Health Partnerships' (and the bullet points below). There is a strong commitment and trust within the partnership, and we anticipate no difficulties in this respect:

Responsibilities: XXXX (name of partner organisation) will:

- *Provide oversight of the whole project, managing timelines and processes as well as budget management.*
- *Co-ordinate reporting required for the project*
- *Carry out regular internal audit and/or systems review, as well as external audit*
- *Keep all payment request forms and receipts kept on file*

- *Update the record of transactions regularly*
- *Confirm appropriate staff members assigned to authorise expenditure, with the person authorising payments being different to the person requesting its purchase.'*

We would also expect the partnership to have considered:

- Record keeping (e.g., keeping and access to all receipts, financial documents kept on file)
- Bank transfer and exchange rate (e.g., taking note of bank transfer costs, keeping track of exchange rate)
- Payment authorisation: clear and appropriate segregation of duties e.g., list of authorised signatories)
- Asset management (e.g., keeping a record of what is owned)
- Procurement (if partnerships are purchasing items of significant value)
- Counter fraud measures and general financial policies and processes (e.g., a finance policy that covers controls, checks and balances)

10 CAN YOU DEFINE THE PARTNERSHIP AND PROJECT CRITERIA MORE CLEARLY?

Please note, not all these requirements apply to Category C applicants.

10.1 PARTNERSHIP REQUIREMENTS

*Stakeholders in both the UK and LMIC, **including pharmacy teams on both sides,** are actively involved in project design and management.*

Your partnership should not only involve the active engagement of the LMIC lead partner, but should also engage with relevant stakeholders and institutions within the relevant country health systems (and in the community where relevant), recognising the importance of a wide range of expertise from multidisciplinary teams in both the LMIC and the UK. THET will look for evidence that the partnership has engaged with the institutions that can provide the access, knowledge and influence to achieve changes in line with the aim of this grant stream.

The partnership has a clear understanding of other health partnerships and health actors operating in the field and is taking opportunities for learning and collaboration, as well as avoiding duplication.

You will need to show that you know what other health partnerships and health actors in the country of operation are already working on in relation to the issues you are looking to address and ensure that there is no duplication or significant overlap between their work and your proposed project. The project should consider other ongoing or previous initiatives that could be built upon, in particular in relation to the themes of this grant stream. THET would also expect you to demonstrate strategic thinking, identifying opportunities for your partnership to work with others to enhance your impact and learn from others.

The partnership demonstrates commitment to the Principles of Partnership (PoPs).

You will need to give us an indication of when, why and how the partnership was first established and a sense of how it has evolved since its inception (not just a description of lead individuals or one of the partners involved, but how the partnership as a whole has evolved).

The partnership has the capacity to deliver the project.

- THET will look at the capacity, knowledge and skills your partnership has to successfully complete the project. This is not limited to clinical expertise, but also includes experience in project management, financial management, education and working internationally in similar low-resource settings.
- You will also have to demonstrate a commitment to equal level team working between different cadres of healthcare workers.

10.2 PROJECT REQUIREMENTS

The project clearly contributes to the overall aims of this CwPAMS 2 programme.

- Please see Section 2 'Focus countries and theme' of the Call for Applications document for more details on the purpose of the CwPAMS 2 and the priorities identified in the 2022 scoping studies.

The project has a clear goal that is achievable within the limited resources and time available.

- THET and CPA will need to see a description of your project including the types of activities, expected changes and/ or results and the project goal that align with the overall aims of CwPAMS.
- THET and CPA will look for information demonstrating that the type of activities and approaches that you plan to implement are relevant to the project goal and changes you expect to achieve, and measurable within the project timeframe.

The approach to the project is appropriate and relevant to the local context.

- THET and CPA will look for evidence that you have consulted with agencies and organisations that are crucial for planning and implementing your project. This may include government bodies, National Pharmacy Associations and community-based organisations.
- Applicants should consider the method which they are using to deliver their project and whether this is appropriate for the local context. For example, this could be thinking about the appropriateness and sustainability of equipment or the accessibility of training tools. For example, if partnerships would like to use the AMS Explainer Animation Videos within training or within the health facility, partnerships could explore the interest in adapting the videos into different local languages for different contexts.

*The project uses a UK team of multidisciplinary NHS volunteers **including pharmacists**, with clear learning objectives for each of the volunteers, and can demonstrate volunteers' engagement with the programme.*

- In your application, THET and CPA will look for evidence that your project utilises multidisciplinary NHS volunteers which must include pharmacists.
- Your application should be explicit about what UK volunteers involved in the project can gain through their involvement to improve their leadership skills and what they expect to learn for their own professional and personal development. This could cover clinical and non-clinical knowledge, skills and experience and how their volunteering experience could help them improve their work back in the UK.

The project has a clear methodology and resources for measuring success and considers evaluation in its approach.

- You will have to demonstrate that you have a system of procedures and adequate resources in place to collect and analyse information to be able to determine the successes of your work and monitor progress achieved by your project against expected objectives.
- The partnership should consider the economic case, progress monitoring, and behaviour change.
- Your approach should also demonstrate how progress will be monitored in order to change trajectory in response to unanticipated outcomes as required.
- Measuring improvements in clinical pharmacy capacity and culture should be considered within the evaluation approach.

The project demonstrates value for money.

- FCDO defines value for money (VfM) as *maximising the impact of each pound spent to improve poor people's lives.*[3] THET will look for evidence that your project demonstrates the different elements of VfM assessment including economy (keeping costs low), efficiency (getting the most out of an activity for the money spent and in a timely way), effectiveness (maximising the change achieved), and equity (addressing the greatest needs). For more information, please refer to our VfM and Health Partnerships website page.

The project is based on recognised good practice and is informed by available literature and resources.

- In addition to good practice on AMS, THET will look for evidence that your project adheres to international guidelines and best practice for international development and good project management. These should relate, among others, to Safeguarding, Duty of Care, Fraud, Bribery and Corruption, and Procurement. Please find more information on this page.

The project takes account of existing national plans and strategies and responds to the country's priorities identified in the scoping recommendations

[3] https://www.gov.uk/government/publications/dfids-approach-to-value-for-money-vfm

- THET will look for evidence that your project is in line with the LMIC national health priorities, policies and strategies stated by the government where your project will be implemented. In this case, reference to published government policies are helpful to include in your application.

The project pays careful attention to gender equality and social inclusion (GESI) issues, e.g. access of women, girls and people with disabilities to capacity development and services, and takes a GESI sensitive approach.

- You will need to describe the specific barriers that women, girls and people with disabilities face in accessing health workforce strengthening initiatives (as health workers) or accessing health services (as service users). You will need to explain how you will tackle these barriers and how excluded /marginal groups will be able to influence the projects.[4] Please refer to the **Gender Equality and Social Inclusion toolkit** for further information. The **CwPAMS GESI AMS Training webinar** has a lot of useful information and can be accessed on YouTube here: https://www.youtube.com/watch?v=ROoRLBPrRXg
- Please refer to the GESI checklist below to inform the project design and implementation.

GESI-Assessment Scale
GESI Unequal: perpetuates gender and other forms of inequality by reinforcing unbalanced norms, roles and relations.
GESI Blind: Does not consider gender and other forms of inequality.
GESI Sensitive: Considers gender and other forms of inequality but takes no remedial action to address it.
GESI Specific: Considers gender and other forms of inequality and takes remedial action to address it but does not change underlying power relations.
GESI Transformative: Addresses the causes of gender-based and other forms of inequality by transforming harmful norms, roles and relations through the inclusion of strategies to foster progressive changes in power relationships.

11 WHAT DO YOU MEAN BY "THE CHANGES YOU EXPECT TO SEE BY THE END OF THE PROJECT"?

The **goal** refers to the overall change to which your project will contribute, within the scope of the health partnership. It must be SMART (specific, measurable, achievable, relevant, time-bound). The project goal refers to the overall change that your project will bring about as a result of your outputs and outcomes. References to national or regional goals may be helpful, but it needs to be clear how these are relevant to the project and how project activities, outputs and outcomes feed into this goal.

Please formulate the goal in a single sentence.

Outcomes are the intended changes you expect to see as a result of your project. An outcome is something that does not exist before the project but needs to happen to be able to achieve the project goal. They should be a direct result of the outputs and the activities achieved through the project. Outcomes can be considered as mid-term or intermediate results or long-term results and ideally are to be achieved within the project timeframe. Outcomes are usually expressed as learnings, changes in behaviour, benefits or other effects that happen as a result of a project.

For example, an outcome of a health worker training would be evidence of improved practice in the workplace as a result of learning new knowledge and skills. An indicator could be x/% of trained health demonstrating better practice 3 months after capacity development.

Outputs are changes which are achieved immediately after implementing an activity. Outputs are normally measured through quantitative data.

An example of an output would be health workers showing improved knowledge after they attend a training workshop. The indicators for this output could then be the number of health workers trained, and the number of health workers demonstrating improved knowledge post training.

[4] According to the United Nations Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Indicators are signs of progress – they are used to show whether the project is on its way to achieving its objectives and goals. Each output, outcome and goal statement should have at least one indicator which will allow progress towards achieving that change statement to be demonstrated and measured. Good indicators should be clear and concise, focusing on a single issue that provides relevant information and data which is feasible to collect. Indicators should be SMART (specific, measurable, achievable, relevant, time-bound).

Please see the example below to help guide you in completing section 4.1 of the application form.

Project goal: X *hospital has a sustainable AMS programme that reduces the inappropriate antimicrobial use, increases compliance to clinical guidelines, and decreases resistant pathogen strains.*
Expected changes by the end of the project:

1. *At least 75 staff report or demonstrate improved antimicrobial prescribing practices 3 months after training.*
2. *Agreed actions from first audit are complete.*
3. *Hospital has taken part in the Global Point Prevalence Surveys.*
4. *Second AMS audit shows improved AMS processes and increased guideline compliance that is reflected with microbiology data.*

Example of defining SMART objectives:

Defining SMART objectives for your Link

SMART objectives help you to add precision to your stated intentions so that those involved in implementation have a clearer idea of what they need to do. The task of monitoring and evaluation is also made easier with SMART objectives. This section provides a worked example of how to make objectives SMART.

A NON-SMART objective: To provide training to midwives at Kiguri District Hospital (DC) to reduce the numbers of caesarean sections performed.

SPECIFIC: To provide training to midwives at Kiguri DC **on how to safely use forceps to manage delayed second stage labour using WHO protocols** to reduce the numbers of caesarean sections performed.

MEASURABLE: To provide training to **all (8)** midwives at Kiguri District Hospital **through theoretical sessions with audited attendance and hands-on training with log book-recorded cases** to reduce **the incidence of caesarean sections due to delay in second stage labour by 50%. This will be recorded for a period after the training and compared to a similar period prior to the training.**

ACHIEVABLE: *This depends on the time scale of the support and the number of deliveries. To train all 8 midwives with hands-on expertise in six weeks is unrealistic – it would be more reasonable to train 1 or 2 and build from there. It is also not appropriate to set a specific target (50%) for reduction in Caesarean Section. It is better to measure the result and then hopefully demonstrate improvement.*

RELEVANT: *Local data shows that caesarean delivery rates at Kiguri DH are 30% which is higher than expected for this population. The increased CS rate increases maternal morbidity and mortality in this patient group by increasing the risk of abdominal sepsis (with 2 in 5 experiencing wound infection post abdominal delivery) and uterine scar rupture in subsequent pregnancy delivering in rural setting. Therefore reduction of CS by any auditable intervention presents a possible health gain. Especially if this can be delivered in a cost-effective way.*

TIME-BOUND: To provide training **between March and December 2009** to midwives at Kiguri District Hospital.

A SMART objective:

To provide training to midwives at Kiguri District Hospital on how to safely use forceps to manage delayed second stage labour using WHO protocols. Training will be carried out between March and December 2009. At least 2 midwives will receive in-depth training and the remaining ones will receive an introductory session. This will be done through theoretical sessions with audited attendance and hands-on training with log book-recorded cases. This will be recorded for a period after the training and compared to a similar period prior to the training. The aim is to reduce the incidence of caesarean sections due to delay in second stage labour.

12 PLEASE EXPLAIN HOW TO FILL OUT THE BUDGET TEMPLATE

Budget lines should be broken down where possible using the Unit type, cost, quantity and duration columns. For example, for three participants travelling four times during the programme: Unit type = Flight, Unit cost = £600, Quantity = 3, Duration = 4. This would come to £7,200. Extra rows can be added under each section if necessary - please pull down the formula in column F if you do, and amend the subtotal column.

Please use the Comment section (column J) to provide further explanations on the costs. If you have secured matched funding for the project, please detail this in the 'Additional income' section at the bottom of the budget.

We would advise that you allocate 1.5% of the budget for contingency, such as bank charges and exchange rate or other fees.

13 APPLICATION PROCESS

13.1 LETTERS OF SUPPORT

We require a letter of support (on letterhead) from each lead organisation involved in the project. As health partnerships should be institutionalised, those who should sign the letter should be in a senior position and have the authority for releasing staff to engage in the project.

14 SUPPORT FOR GRANT HOLDERS

14.1 WHAT SUPPORT CAN BE EXPECTED FROM THET AND CPA?

In addition to grant giving, THET provides support for project planning, resolving project management challenges, reporting and monitoring evaluation and learning. CPA and THET also provide support through learning events, publications, online resources and policy and advocacy work.

All partners will also benefit from an inception workshop covering:

- The Fleming Fund and the role this project has in supporting its aims.
- The principles of effective international development and partnership (including THET's Principles of Partnership).
- Project planning.
- Monitoring and evaluation and the specific focus on the monitoring and evaluation of this programme.
- Best practice for financial management.
- Current initiatives and good practice in relation to AMS in LMICs.
- CwPAMS tools and resources.
- Embedding dissemination and shared learning

CPA will provide technical leadership for the programme and support partnerships on key issues relating to AMR, AMS, pharmacy and IPC. They will signpost to key specific / relevant tools, resources (e.g. antimicrobial prescribing app) and documents providing oversight and mitigating risks of duplication. The CPA will appoint a named point of contact, an in country technical consultant (IPCC) who will work with the CPA AMR technical team to support each partnership. This includes overarching support / advice with baseline assessments, technical preparation of health partnerships, action plan development and partnership activities in-country. CPA will provide additional guidance, support and training on the SF antimicrobials element of this programme, ensuring partnerships are clear on expectations and alignment to WHO guidance. CPA will also be working with health partnerships to co-ordinate and deliver training for AMS hospital leads and regional AMS committee leads.

Additional CPA Support

Optional additional technical assistance may also be requested if needed by partnerships and the budget will need to account for this provision. Such technical assistance may include Continuous Quality Improvement (CQI) training in response to antimicrobial data. If this is required, please discuss your individual requirements and budget plans with CPA prior to application submission. For those partnerships who have been selected for the Centre of Excellence Programme, the CPA will provide support in capacity building for the hub and spoke model, with hub institutions receiving additional face to face training to support decision making for AMS activities, including training in topics such as GPPS data implementation and antibiogram development. CPA will assist in the coordination of training resources produced by hubs, providing technical check/ formalising resources produced and facilitating the

sharing of these resources further. Training would be supported by the Change Exchange, a clinical microbiologist and surveillance expert and the THET/CPA team.

AMS Leadership Fellowship

Based on the success of the Chief Pharmaceutical Officers Global Health (ChPOGH) Fellowships made available to NHS pharmacists that were part of the previous CwPAMS partnerships, an AMS leadership programme for African pharmacists has been carefully scoped out and co-designed by CPA with key stakeholders to ensure relevance to the African healthcare context. It is a 12-month programme that will run alongside CwPAMS 2, and it is anticipated that it will run from October 2023 – October 2024.

Each partnership is encouraged to nominate at least one (and a maximum of two) African pharmacists from their partnership, and the partnership should consider setting aside £250 per successful candidate to support them in their in-country expenses related to the training (such as internet access). For new partnerships, we would encourage nomination to take place after the inception phase and the expenses fees budgeted into the second part of the programme. More information on this programme will be available shortly and the call for nominations will be released in July 2023.

It is also anticipated that the CHPOGH Fellowship, available for UK NHS pharmacists, will also run for a third time supported by Health Education England and CPA. Further details to follow.

Additional Behaviour Change support

Partnerships will also be offered the opportunity to receive bespoke support from health psychologists with expertise in behaviour change, overseen by Manchester Implementation Science Collaboration's Change Exchange. They will travel with the partner to implementation sites and use behavioural science methods and theories to support teams in understanding and driving changes in practice. You can read further about their work in Globalization and Health.

Partners who wish to access this support should include in the budget **£4,000 per expert**. This will cover costs for travel, visa, vaccination, travel insurance costs for the behaviour change experts. It is recommended that at least two experts are budgeted for. Please include this in the specific category of the proposal budget template. Support to develop and deliver baseline assessments and evaluation frameworks will also be available from the CwPAMS team and partners.

Additional THET support

As well as the usual project management advice THET provides to all grant holders, following learning from CwPAMS 1 THET is offering grant holders the option of accessing draw-down support directly from a consultant employed by THET who can provide aspects of project administration on behalf of the partnership. Funds for this support would need to be budgeted for by the applicant. **The daily rate for the consultant is £160**. Partnerships who wish to involve this support should consider how many days of work they anticipate requiring and outline this in the specific category of the proposal budget template. The delivery of these project management activities could include (though is not limited to):

- Project coordination including meeting organisation and facilitation
- Volunteer management
- Stakeholder engagement and management
- Support with monitoring and evaluation including data collection and analysis
- Reporting (narrative and financial)
- Financial tracking and re-budgeting
- Policy drafting (e.g., safeguarding, gender equality and social inclusion)
- Risk management
- Procurement

15 COULD YOU PROVIDE MORE INFORMATION ON THE GRANT HOLDER REQUIREMENTS FOR THE DURATION OF THE PROGRAMME?

CONTRACTING PERIOD

- Complete THET's due diligence process
- Finalise budget
- Sign grant agreement (including a certificate of agreement to share PPS data on Antimicrobial Consumption and Resistance)

INCEPTION PERIOD

- Attend a half-day pre-commencement workshop held virtually
- LMIC project team to attend in-person in country inception event (expected to be held in May 2023). UK partners are also welcome to attend these meetings in person. If so, please budget for this.
- Attend inception project meeting with grant manager
- Finalise workplan
- Develop Monitoring, Evaluation, and Learning plan (MEL), including GESI objective
- Signed MoU between Lead partners (if not already in place)
- Develop policies if not already in place (e.g. safeguarding, procurement and fraud, bribery and corruption policies)
- Category A grant holders: Attend a training session for capacity building for the hub and spoke model

PROJECT IMPLEMENTATION

Partnerships are expected to complete all the required activities listed in Section 6 in the Call for Application document.

THROUGHOUT THE PROJECT:

- **Project progress meetings, every six months** virtual meetings with THET and CPA to track progress and identify challenges/delays.
- **Reporting, every six months:** financial, narrative and MEL data reports to be submitted every 6-months to THET and CPA.
- **Financial audit:** for organisations in receipt of £75,000 or above, THET will conduct a financial audit at least once during the project.
- **Annual review meetings:** LMIC lead partners are expected to attend two annual in-country review meetings in the capital (UK partners are also welcome to attend in person).
- **Events throughout the programme:** Partners will be expected to attend a sharing and learning event at the end of the programme and any other virtual programme trainings offered as part of the programme.

REPORTING:

- **Final narrative report (due end of January 2025):** partnerships will be expected to report to THET and CPA on any indicators that are relevant to their project, although support to gather the volunteering data (see 'Volunteers survey' below) is compulsory. In addition to the volunteering data and the required indicators mentioned in Q4.1 of the application form, we expect grant holders to report on the following core indicators in their MEL plan and report:
    - # of LMIC healthcare staff trained in AMS, antimicrobial prescribing practice and consumption surveillance (based on WHO competency framework)
    - # of LMIC healthcare staff demonstrating improved knowledge after training
    - # of LMIC healthcare staff trained in AMS continue to practice their new knowledge / skills
    - # of new or revised documents related to AMS and antibiotic prescribing developed
    - # of guidelines and protocols rolled out in the LMIC healthcare institutions through an awareness campaign, training, printing and sharing
    - Total number of volunteering days contributed by NHS staff to strengthen AMS in LMIC healthcare institutions
    - All data must be disaggregated by cadre and gender.

- **Final financial report (due end of January 2025):** partnerships will be expected to submit a financial report to THET, including a list of itemised transactions. They will also be required to provide some receipts, in line with THET's spot-checking policy.

VOLUNTEERS SURVEY:

- Partners will be required to support the dissemination of a Volunteer Post-Placement survey amongst its NHS volunteers as part of the programme's wider evaluation to assess UK volunteers' experiences and personal and professional benefits from volunteering as part of CwPAMS 2.

For any other questions, please contact the THET Programmes Team at grants@thet.org.