The Global Fund
To Fight AIDS, Tuberculosis and Malaria

STANDARD CONCEPT NOTE

Investing for impact against HIV, tuberculosis or malaria

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

Section 1: A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.

Section 2: Information on the national funding landscape and sustainability.

Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.

Section 4: Implementation arrangements and risk assessment.

IMPORTANT NOTE: **Applicants should refer to the Standard Concept Note Instructions to complete this template.**

SUMMARY INFORMATION			
Applicant Information			
Country	**Malawi**	**Component**	**Malaria**
Funding Request Start Date	**1 January 2016**	**Funding Request End Date**	**31 December 2017**
Principal Recipient(s)	**1 Ministry of Health** **2 World Vision Malawi**		

Funding Request Summary Table

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.

1.1 Country Disease, Health and Community Systems Context

With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight:

a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.

b. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.

c. Key human rights barriers and gender inequalities that may impede access to health services.

d. The health systems and community systems context in the country, including any constraints.

2-4 PAGES SUGGESTED

a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.

Malawi is a landlocked country bordered by Tanzania to the North, Zambia to the West, and Mozambique to the East and South. Based on 2008 census figures, the population in 2015 is projected to be 16.3 million, of which 51% is male and 49% is female. It is estimated that 17% of the total population are children less than five years old and 5% of the population are pregnant women (NSO, 2008). Malawi is a high malaria transmission country with all of its three regions and 28 administrative districts at risk of malaria. Currently the country is still in the control phase and standard malaria control interventions are applied in all the districts.

Malaria vectors, parasites, transmission

The primary species of mosquitoes responsible for malaria transmission are members of the *Anopheles funestus* group. *Anopheles gambiae* s.s. and *Anopheles arabiensis* are also present and may predominate in some areas or at certain times of the year. Of particular note, *An. Arabiensis* appears to be the predominant vector species in the far northern areas of Malawi. *Plasmodium falciparum* is the most common parasite that causes malaria in Malawi, accounting for 98% of infections and all severe disease and deaths. The *Plasmodium malariae* and *Plasmodium ovale* infections are identified much less frequently, sometimes occurring as mixed infections with *P. falciparum*. *P. vivax* infections are very rare (MSP, p.6).

Geographic distribution of transmission

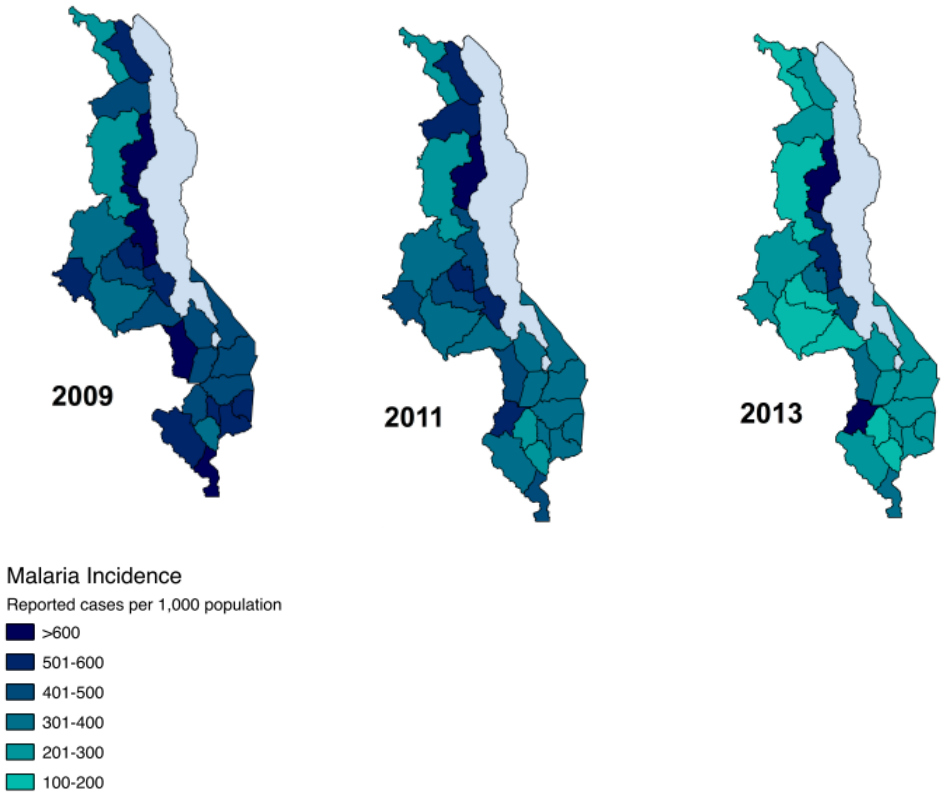
The entire population lives in high malaria transmission areas; only 0.2% of the population lives in areas regarded as hypoendemic where the *P. falciparum* prevalence rate among children age 2-10 years of age is less than 10% (Okira et al, 2014). Transmission is perennial in most areas and peaks during the annual rains that typically begin in November and last through April. The

highest transmission areas are found along the hotter, wetter, and more humid low-lying areas (lakeshore, Shire River valley, and central plain), while the lowest transmission areas fall along the highland areas of Rumphi, Mzimba, Chitipa, and parts of Dedza and Ntcheu districts (Kazembe, 2006; Okira et al, 2014).

Current status and burden of malaria

Generally, Malawi has seen changes in its malaria trend as a result of the high investment in malaria control and improvement in data collection. Nationally, malaria incidence has consistently decreased in recent years despite district-level variations. Figure 1, based on Health Management Information System (HMIS) data from 2009-2013, shows the decrease in malaria cases by district between 2009 and 2013. While the decrease in cases could be attributed to interventions, it should be noted that the number of suspected malaria cases was reduced by the introduction of Rapid Diagnostic Tests (RDTs) in 2011. Despite these reductions in malaria incidence, even areas with the least burden in Malawi record between 100-200 cases per 1,000 population (HMIS). Given this high burden throughout the country, Malawi is still in the control phase of malaria in which universal coverage of interventions is needed.

Figure 1: Malaria Disease Trend in Malawi: 2009-2013



Source: Malawi HMIS 2009, 2011, 2013.

Consistent with the decrease in the malaria incidence, the number of malaria-related deaths in Malawi has declined by almost 37% in recent years, from a peak of 8,802 deaths (65.1 per 100,000 population) in 2009 to 3,723 deaths (24.3 per 100,000 population) in 2013 (HMIS).

Malawi has conducted three Malaria Indicator Surveys (MIS) in 2010, 2012 and 2014 that have recorded overall declining trends for anemia and parasite prevalence among children less than five years of age. A substantial decrease in the prevalence of severe anemia in this age group

was noted between 2010 and 2014, from 12% in 2010 to 6% in 2014. In terms of malaria parasite prevalence, there has been an overall decrease from 43% in 2010 to 33% in 2014.

Malaria infection during pregnancy is also a major public health problem, with substantial health risks for the mother, her fetus, and the neonate. In high transmission areas like Malawi, pregnant women often experience asymptomatic infection, which is linked to maternal anemia and low birth weight babies.

b. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.

The vast majority of Malawi's population (approximately 85%) lives in rural areas. Currently, 46% of the rural population lives more than five kilometers from the nearest health facility and is considered hard-to-reach (Child Health Strategy 2014). Malaria prevalence by microscopy among children under five years of age is more than three times higher in rural areas (37%) than in urban settings (11%) (Preliminary report MIS 2014). The prevalence of severe anemia is also higher among children under five years of age living in rural areas compared to those living in urban areas, at 7% and 5% respectively (Preliminary report MIS 2014). Household ownership of at least one insecticide-treated net (ITN) is slightly lower in rural households (69%) than in urban households (75%), and there is a lower percentage of the household population with access to ITNs in rural households (50%) than in urban households (60%) (Preliminary report MIS 2014). Among pregnant women and children under five years of age in all households, those living in rural areas were less likely than their urban counterparts to sleep under an ITN the previous night (60% versus 73%, respectively, for pregnant women and 67% versus 71% for children under five years of age) (Preliminary report MIS 2014).

c. Key human rights barriers and gender inequalities that may impede access to health services.

There are no known major human rights barriers that impede access to malaria health services in Malawi. The Constitution of Malawi notes that the State shall take all necessary measures for the realization of the right to development, including equal opportunity for all in their access to basic resources such as health. The Constitution also states that Malawi will provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care. However, certain culture practices such as lack of equal access to resources by women, high illiteracy among women and household decision-making regarding seeking health care may pose barriers to access to health care by women, especially in rural areas.

d. The health systems and community systems context in the country, including any constraints.

The Ministry of Health (MoH) is a government agency that, through its various departments, sets the agenda for health in Malawi in collaboration with stakeholders. The MoH has a decentralized system which operates through five Zonal Offices. Zonal Offices provide technical support to District Health Management Teams (DHMTs) in the planning, delivery and monitoring of health service delivery at the district level and facilitate central hospitals' supervision of districts in line with the Malawi Health Sector Strategic Plan (HSSP 2011-2016).

In Malawi, health services are delivered within the following levels of care: tertiary, secondary, and primary. District hospitals provide secondary care services and central hospitals provide tertiary care services. Primary care is delivered through village clinics in rural hard-to-reach areas and health centers where curative, maternity, and preventive services are offered as defined in Essential Health Package (EHP). EHP is a selection of health services to be provided free of charge to cover diseases and conditions that affects the majority of the Malawians. These conditions are: Vaccine-preventable diseases; acute respiratory infections; perinatal

conditions; malaria; tuberculosis; sexually transmitted infections; diarrhoea diseases; Schistosomiasis; malnutrition; ear, nose, and skin infections; perinatal conditions; and common injuries (HSSP 2011-2016).

Community case management of malaria is implemented in the context of the Integrated Community Case Management (iCCM) strategy. In Malawi, iCCM is implemented in all the 28 districts. Currently there are 9,776 HSAs out of which 3,746 have been trained in iCCM; of these, 3330 (88.9%) are running functional village clinics for the treatment of malaria, diarrhea, pneumonia, eye infections and malnutrition in the hard-to-reach areas. Hard-to-reach areas are defined as areas greater than 8 km from a health center in difficult terrain, and rural areas. There is a scale-up plan to reduce the radius from 8 km to 5 km from a health facility. This will create additional 1,600 hard-to-reach areas and, in turn, 1,600 additional HSAs will be required to man these new areas. One HSA serves a population of 1,000 persons (Child Health Strategy 2014-2020).

In 2012, WHO and UNICEF released a Joint Statement on Integrated Community Case Management, which presents the latest evidence on iCCM, describes the necessary program elements and support tools for effective implementation, and lays out actions that countries and partners can take to support the implementation of iCCM at scale.

District hospitals and Christian Health Association of Malawi (CHAM) hospitals provide general services, Primary Health Care (PHC) services, and technical supervision to lower units. CHAM operates 36% of health facilities, mainly in rural areas, and charges user fees for non-essential services (HSSP 2011-2016); however, malaria testing and treatment are part of essential services and are therefore offered free. The Government of Malawi (GoM) has a memorandum of understanding with CHAM and pays for certain program-specific essential medicines and all local staffing costs in CHAM facilities. District hospitals also provide in-service training for health personnel and other support to community-based health programs in the provision of EHP.

The tertiary level consists of central hospitals offering specialized services.

The for-profit private health sector plays a minimal role in the provision of health services. It is estimated that the private sector provides 4% of total health services in Malawi (HSSP 2011-2016). Given the limited role of the private sector in Malawi and the need to prioritize existing resources to focus on CHAM and public facilities, the National Malaria Control Programme (NMCP) is not currently focusing efforts on engaging the private sector.

Key Constraints of the Health System

1. Supply chain management

The Central Medical stores trust has the mandate for procuring, storing and distribution of health commodities. However, due to inadequate capacity and security challenges at CMST, procurement, storage and distribution of malaria commodities procured by the Global Fund and other donors is currently managed through a parallel system. The use of parallel supply chains is a temporary measure while CMST undergoes improvements in commodity storage distribution and management. NMCP continues to focus on minimizing or eliminating stock outs of malaria commodities at service delivery points and strengthening supply planning and commodity management through planning, training, and supportive supervision.

2. Human resources

The continued shortage of trained health workers and the skill mix needed to meet the health needs of the growing population remains the most significant barrier in improving the health status of Malawians and achieving the three health-related Millennium Development Goals. Currently, the overall vacancy rate for the Ministry of Health remains at 47%. Specifically, the overall vacancy rate for Allied Clinical Health Professionals, which include Clinical Officers and Medical Assistants, among others, is 69%; Allied Health Technical Services, which includes

Laboratory and Radiography cadres, is 52%; Pharmacy is 88%; Nursing Services is 68%; and Preventive Health Services including HSAs is 36%.

In 2014, the MoH revised the definition of hard-to-reach areas (from a radius of 8 km to 5 km from a health facility) to increase health service access in rural areas, which will increase the need for additional HSAs to be trained by the iCCM program and redeployed into the newly identified areas. Further challenges faced at the community level include attrition of staff, Health Surveillance Assistants (HSAs) not residing in their catchment areas, and insufficient training for HSAs who are provided with minimal supportive supervision and mentorship.

3. Infrastructure and accessibility to services

Malawi faces challenges in infrastructure relating to patient accessibility to care. Health clinic accessibility within an 8 km radius is estimated at 81% of the population (HSSP 2011-2016). The majority of health facilities in Malawi operate with functioning water (79%), electricity (81%) and/or communication systems (90%), yet gaps remain (HSSP 2011-2016). In some rural places, the health facilities are not available or not functional. In others, the challenge is to provide health support to widely dispersed populations (HSSP 2011 – 2016). In high-density urban areas, although health services can be physically within reach of the poor and other vulnerable populations, health services are sometimes provided by unregulated private providers who do not deliver EHP services.

In order to increase access to EHP services, the MoH has encouraged District Health Offices (DHO) to sign Service Level Agreements (SLAs) with CHAM and other private health facilities to remove user fees for most vulnerable populations. Evidence shows that the removal of user fees in CHAM facilities has resulted in an increase in the number of patients seeking care in these facilities (HSSP 2011-2016).

4. Monitoring and evaluation

Health Management Information System (HMIS) and Logistic Management Information System (LMIS) are the main data sources for malaria-related indicators. With regard to HMIS, in 2012, Malawi switched from a paper-based to a web-based electronic District Health Information System (DHIS) II, which resulted in improved data management and quality. Although DHIS II data management is electronic at the district level, data is still paper-based at health centers and manually transferred to the district, where it is then entered into the web-based electronic system. Some of the key indicators reported through DHIS II include the number of malaria cases (presumed and confirmed) at the facility level, the number of inpatients deaths and other morbidity-related indicators. Since 2014, at the community level, one of the indicators reported on through DHIS II is the number of unconfirmed malaria cases.

Despite some improvements associated with moving to a web-based electronic HMIS, there are still limitations such as timeliness, completeness, and accuracy of data, as well as difficulties capturing data from integrated community case management through HSAs. Currently, one of the challenges is linking the number of cases and the amount of antimalarial commodities consumed (ACTs and mRDTs) as DHIS II is not linked to LMIS reporting.

The Logistic Management Information System (LMIS) is used to monitor the amount of commodities distributed and used by all health facilities. One of the key indicators monitored through the LMIS is the proportion of facilities reporting stock out of key antimalarial commodities. LMIS reporting rates have increased from 62% in January 2011 to 85% in December 2013 (HTSS LMIS report). As is the case with DHIS II reporting, timeliness of reporting is a key challenge with the LMIS, given that data from lower levels is still paper-based and must be entered into the electronic system at the district level. In addition to LMIS, the NMCP is working closely with iCCM and partners to implement the cStock system. cStock is an electronic Logistics Management Information System (eLMIS) tool that re-supplies health products and enables HSAs in hard-to-reach areas to report in a timely manner. In the intervention districts where cStock was piloted, it has significantly improved visibility into and

management of product availability at the community level for CCM, reproductive health, malaria, and HIV testing. cStock has been approved by MoH for nation-wide scale up and is being implemented by 3075 HSAs in hard-to-reach areas.

As noted above, there is a discrepancy between the number of malaria cases reported in the HMIS, the number of courses of artemisinin combination therapy (ACTs) and the number of mRDTs used as reported in the LMIS. For example, in 2013 over 9.2 million courses of ACTs and about 4.5 were consumed as reported in the LMIS. In the same year, only about 3.9 million presumed and confirmed uncomplicated malaria cases were reported at the facility level. In the past (including the year 2013), the reported number of malaria cases (presumed and confirmed) did not include cases seen at the community level. Since 2014 community reported has been included in DHIS II as such the 2014 reported cases will be higher than the 2013 and hence the number ACTs consumed and will be closer to the number of cases treated.

NMCP recently undertook an assessment to determine additional factors driving the discrepancy between the antimalarial commodities and identify programmatic opportunities to improve the data collection, reporting, and case management of malaria. For the assessment, 10 teams of data collectors visited 45 facilities selected from a pool of facilities with higher than average increase in ACT use in 2014 compared to 2013. At each facility, a focus group discussion was conducted and data collectors recorded case data, ACT and RDT stock levels, and consumption data from registers, stock cards, and reporting forms. At the time of writing this concept note, data collection was completed and analysis is in progress.

The preliminary results from the assessment indicate that indeed the number of ACTs consumed is higher than both mRDTs and the number of malaria cases (presumed and confirmed). The results indicate that the number of ACTs is about 20 and 50 percent higher than mRDTs and malaria cases respectively. Some of the reasons contributing to this are what has been cited above.

A final issue from the preliminary results is that health workers are not correctly reporting malaria cases, due to poor reporting from village clinics, lack of staff for data recording, or patients not being appropriately captured in registers because staff members are overwhelmed or overworked. The iCCM funding requested for cStock in this concept note will continue to improve commodity reporting from village clinics, as cStock had not yet been rolled out to a majority of village clinics in the period for which data was collected. The zonal M&E review meetings and training and data quality audits funded by Global Fund existing grants will, in part, emphasize the importance of proper data collection.

In addition to the funds requested in this concept to strengthen the reporting of data from the village clinics (through community case management), the NMCP will continue to review the national data collection systems and processes at all level facilities and will develop a detailed plan of action to improve case reporting from health facilities.

Though not common, a few focus groups reported issues of pilferage, theft, or other misuse of ACTs. Even if limited, this is a major concern. NMCP will work with MoH and other units in the Government of Malawi to improve accountability and security of commodities.

When the analysis is completed, NMCP will work with partners to develop and fund a plan that improves ACT and RDT use, accountability for commodities, as well as data recording and reporting. This preliminary analysis provides no indication that the quantification estimates used for this concept note are incorrect.

References:

1. Malawi Malaria Indicator Survey (MIS) 2012. Lilongwe, Malawi, and Calverton, Maryland, USA: NMCP and ICF International.

2. WHO World Malaria Report 2013. Retrieved from http://www.who.int/malaria/publications/country-profiles/profile_mwi_en.pdf October 2014.

3. National Statistical Office (NSO) and UNICEF. 2008. Malawi Multiple Indicator Cluster Survey 2006, Final

Report. Lilongwe, Malawi: National Statistical Office and UNICEF.

4. Kazembe, Lawrence N., Immo Kleinschmidt, Timothy H. Holtz, and Brian L. Sharp. "Spatial analysis and mapping of malaria risk in Malawi using point-referenced prevalence of infection data." International Journal of Health Geographics 5, no. 1 (2006): 41.

5. Okiro EA, Noor AM, Malinga J, Mitto B, Mundia CW, Mathanga D, Mzilahowa T, Snow RW (2014). An epidemiological profile of malaria and its control in Malawi. A report prepared for the Ministry of Health, the Roll Back Malaria Partnership and the Department for International Development, UK. March, 2014. Malawi Child Health Strategy For Survival and Health Development of Under-five Children in Malawi, 2014-2020.

6. Malawi Health Sector Strategic Plan (MSP), 2011 – 2016: *Moving towards equity and quality.*

1.2 National Disease Strategic Plans

With clear references to the current **national disease strategic plan(s)** and supporting documentation (include the name of the document and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas.

b. Implementation to date, including the main outcomes and impact achieved.

c. Limitations to implementation and any lessons learned that would inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.

d. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.

e. For standard HIV or TB funding requests[1], describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.

f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

4-5 PAGES SUGGESTED

a. Key Goals, Objectives and Priority Program Areas

National Malaria Strategic Plan (2011–2016)

The Malawi National Malaria Strategic Plan (MSP) 2011-2016 sets out the vision, goals, objectives, strategies, and cost-effective interventions that will enable the NMCP to maintain universal coverage and have equitable distribution of key malaria interventions. The MSP was updated in 2014 to build upon the successes achieved, challenges, and lessons learned during the implementation from 2001-2005 and 2005-2010, as well as from the first two years of implementation of the current plan. The MSP has also been revised to align with the six-year Health Sector Strategic Plan (HSSP) 2011-2016, which emphasizes malaria as a priority disease burden to address. The 2011–2016 MSP has the following strategic goals, objectives, and priority interventions:

[1] Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

Strategic Goal: To reduce malaria incidence from 332/1000 in 2012 to 150/1000 by 2016 and malaria deaths by at least 50% of 2012 levels by 2016.

Strategic Objectives:

1. By 2016, at least 80% of the population will be protected by one or more malaria preventative interventions
2. By 2016, all suspected malaria cases presenting to a health worker will be tested and treated according to the national guidelines
3. By 2016, at least 80% of the population will be practicing positive behaviors to prevent and control malaria
4. By 2016, the systems for surveillance, monitoring, evaluation and operational research will provide the information necessary to guide programmatic decision-making effectively.
5. By 2016, program performance will be enhanced for effective coordination and management at all levels of health service delivery

Priority Areas: The priority areas of the MSP are vector control using long lasting insecticide treated nets (LLINs) as the main intervention; case management focusing on provision of commodities for diagnosis and treatment; behavior change and communication (BCC) to support implementation of the vector control; and case management, surveillance, monitoring and evaluation and program management. A brief summary of the strategy for each intervention is described below (see the MSP 2011-2016 attached for more detail):

1. Vector control (MSP pg. 30-31)

The main vector control interventions include nation-wide LLIN distribution and the use of indoor residual spraying (IRS) in targeted high- burden areas. As outlined in Malawi's HSSP 2011-2016, the use of LLINs is the primary strategy and most effective tool for preventing malaria, especially given Malawi's high usage of nets. This strategy aims to achieve universal coverage with LLINs with the objective of increasing household ownership of at least one LLIN from 58% in 2010 to 90% by 2016 and population-wide net usage from 51.8% in 2014 to 80% by 2015. The country has a two-pronged strategy for LLIN distribution: (1) free routine distribution through ANC to pregnant women and newborn babies and (2) periodic mass campaigns targeting universal coverage, which is defined as one net for every two people every two to three years.

The IRS program was initiated in one district in 2007 and later expanded to include seven highly endemic districts along the lakeshore and the lower Shire valley. The aim of IRS was to disrupt malaria transmission in target areas characterized by high malaria disease burden and transmission areas. In these high-burden districts, both LLINs and IRS were implemented as an integrated vector management (IVM). However, due to financial constraints and emerging resistance to pyrethroids, IRS implementation has been scaled down over years. In view of these challenges, plans are underway to map out nationwide vector resistance, which will facilitate the implementation of IRS as a component of the Vector Control Strategy.

2. Larval source management

Malawi recognizes LLINs and IRS as the main malaria vector control interventions. However in selected areas where it is deemed appropriate, larval source management (LSM) will be used as a complimentary strategy.

3. Diagnosis and Treatment (MSP pg. 32-33)

Provision of diagnosis and treatment services at all levels of the health system is a key

intervention. Prompt treatment with effective ACTs reduces malaria-related morbidity and mortality. RDT coverage improves appropriate case management and better understanding of the malaria burden in Malawi, both of which lead to better value for money.

4. Provision of Intermittent Preventive Treatment in Pregnancy (MSP pg. 32)
Sulphadoxine / pyrimethamine (SP) and equipment for intermittent preventive treatment in pregnancy (IPTp) will be procured and distributed to all antenatal care (ANC) service delivery points. According to new malaria in pregnancy guidelines, SP should be provided to pregnant women at all antenatal care ANC visits after the first trimester.

5. Surveillance, Monitoring and Evaluation and Operational Research (MSP pg. 35-36)
A strong national monitoring and evaluation system enables reliable and regular information on progress in preventing and controlling malaria in the entire country.

6. IEC/BCC (MSP pg. 33-35)
Information, Education, and Communication (IEC) and Behavior Change Communication (BCC) are crucial in all intervention areas, especially to accompany the LLIN mass distribution campaign, since beneficiaries should be able to see the need to utilize the interventions and seek treatment promptly. The IEC/BCC strategies to be employed include mass and interpersonal communication.

7. Vector Surveillance and Insecticide Resistance (MSP pg. 30)
This plan seeks to establish a national entomological profile that explores vector ecology and behavior, species composition, and distribution. Resistance of anopheline vectors to insecticides has been documented in many parts of Malawi. Entomological monitoring and surveillance has provided evidence of emergence and expansion of resistance of An. funestus to pyrethroids (permethrin, deltamethrin, lambda-cyhalothrin) and carbamates (bendiocarb and propoxur) throughout the country. However, *An. funestus* has remained completely susceptible to organophosphates (malathion and pirimiphos-methyl). The program is considering the introduction of organophosphates for IRS while continuously monitoring insecticide resistance.

8. Program Management (MSP pg. 36-38)
Strong program management is very important for effective malaria program delivery and to achieve key objectives. The MSP intends to build the capacity of NMCP staff and health workers at all levels of health care delivery. Activities include targeted training and participation in international and national technical forums.

b. Implementation to date, main outcomes, and impact

A recent mid-term review of the performance of the 2011-2016 MSP recorded improvements in implementation. Table 1.1, below, summarizes the implementation to date and impact achieved. Note that program management and M&E activity level indicators are not included in this table, as the focus is outcome level indicators only.

Effective and Prompt Diagnosis and Treatment: In 2007, NMCP switched the recommended treatment for uncomplicated malaria from SP to ACTs. In 2011, NMCP also revised its policy to require confirmation of clinical diagnosis of malaria at all levels of the health care system using RDTs and microscopy. In 2014, NCMP revised the malaria treatment guidelines to include Parenteral Artesunate as the preferred treatment for severe malaria.

Vector Control: The current LLIN policy includes free distribution of LLINs for pregnant women at their first visit to the ANC clinic and for newborn babies in health facilities at delivery or at their first clinic visit if an LLIN was not received at birth. In the past 5 years, over 6 million LLINs have been distributed in Malawi through routine channels. In addition, 5.6 million LLINs were distributed through the mass campaign conducted in 2012. In November-December 2014, a mini LLIN campaign was conducted in which 1.2 million LLINs were distributed in 6 districts as part of the bigger mass distribution campaign planned for 2015.

Prevention of malaria in pregnancy: IPTp has been the standard of care in Malawi since 1993. SP is used for IPTp. The previous national policy guidance required a pregnant mother to take at least 2 doses of SP during ANC visits. In line with WHO guidance, in 2014, Malawi revised the national IPTp policy to recommend that eligible pregnant women receive SP at each scheduled ANC visit, with all pregnant women receiving a minimum of 3 doses during pregnancy. Routine nets for pregnant women and IPTp are mainly covered by Global Fund and PMI.

Table 1.1 ***Implementation to date, main outcomes, and impact (all data from Preliminary Report MIS 2014)***

Thematic Area	Outcomes
Effective and Prompt Diagnosis and Treatment (see MSP pg. 19)	• 92% of children with fever took a first line antimalarial drug AL • Percent of under-5 children with fever with access to an anti-malarial within 24 hours of onset of symptoms increased from 22% in 2010 to 33% in 2014[2]
Vector Control (see MSP pg. 19)	• 70% of households own at least one ITN • Of households owning at least one ITN, 72% slept under a net the night before the survey was conducted • Among the overall household population, 53% slept under a net the night before the survey was conducted • 67% of children slept under an ITN the night before the survey was conducted • 62% of pregnant women slept under an ITN the night before the survey was conducted • Among households that own at least one net, 87% of children under five slept under an ITN the night before the survey was conducted • Among households that own at least one net, 85% of pregnant women slept under an ITN the night before the survey was conducted
Prevention of malaria in pregnancy (see MSP pg. 20)	• 64% of pregnant women in Malawi receive at least 2 doses of SP • 13% of pregnant women receive at least 3 doses of SP
BCC and Advocacy (see MSP pg. 20)	• 72% of women recognize fever as a symptom of malaria • 82% of women report mosquito bites as a cause of malaria • 84% of women report mosquito nets as a prevention method

Impact indicators:

1. All-cause mortality of children under five years of age decreased from 133 to 112 per 1,000 population (DHS 2004, 2010).
2. Prevalence of severe anemia in children under five years of age decreased from 12% to 6% (MIS 2010, 2014).
3. Malaria parasite prevalence in children under five years of age decreased from 43% to

[2] This is a problematic indicator because it measures seeking behaviour rather than accessibility to malaria treatment.

33% (MIS 2010, 2014).

4. Deaths due to malaria decreased from 65 to 24 per 100,000 population (HMIS 2009, 2013).

c. Limitations to implementation and lessons learned

The table below summarizes the limitations to implementation and the lessons learned from the mid-term review of the MSP conducted in early 2014.

Table 1.2: Limitations to Implementation and Lessons Learned

Intervention	Limitations to Implementation	Lessons Learned/Way Forward
Effective and Prompt Diagnosis and Treatment (see MSP pg. 22-23)	• Limited quality assurance and quality control on RDTs • Incomplete reporting and timeliness of data provided by health facilities on morbidity and consumption data to facilitate programmatic decision making • Access to treatment within 24 hours of onset of symptoms of malaria for children under five years of age is only 33% (Preliminary Report MIS 2014) • Low RDT usage compared to ACT consumption	• NMCP has identified partners in country and internationally to implement additional QA activities • Increased monitoring of compliance to malaria diagnosis and treatment protocols including use of RDT at SDPs RDTs are now available at all health facilities to support diagnosis • Plans are underway to introduce RDTs in 2015 at the community level • Will improve reporting rates through existence of DHIS II and plans for the introduction of the e-LMIS • IEC/BCC will increase prompt care-seeking behavior
Vector Control (see MSP pg. 21-22)	• IRS coverage reduced due to funding constraints • The growing threat of vector resistance to pyrethroids leaves more expensive spraying with organophosphates as the only option	• NMCP is exploring the possibility of expanding IRS spraying with organophosphates through public-private sector partnerships and intensified resource mobilization domestically • Plan for insecticide resistance study
Prevention of malaria in Pregnancy (see MSP pg. 23-24)	• Health workers are not yet trained on new malaria in pregnancy guidelines • Low proportion of women starting ANC visits early enough in pregnancy to allow for 3 doses of SP	• The presence of District Malaria and Safe Motherhood Coordinators also provide an opportunity for better collaboration and coordination at the district level • Health workers will be trained on malaria in pregnancy by in-country partners • Increased collaboration with Reproductive Health Unit to improve uptake of focused antenatal care
BCC and Advocacy (see MSP pg. 24)	• Low frequency of malaria-specific BCC messaging • High-impact BCC strategies such as interpersonal communication strategies are costly	• Continue to collaborate with the Health Education Unit to develop IEC materials and disseminate to media outlets • Use of community mobilization groups on malaria-specific messaging
Surveillance, M&E and Operational Research (see MSP pg. 25)	• Inadequate capacity for data management and analysis at district and health facilities • Limited use of data for decision-making and planning at all levels	• Continued on-the-job training of health workers on data management • Enhanced use of supportive supervision to facilitate data for decision making at lower levels of the health system • Routine data quality audits on HMIS and LMIS
Program Management	• Inadequate resources for all needed malaria interventions	• NMCP will harness government support for malaria program activities

(see MSP pg. 25-26)	• District Malaria Coordinators do not work full-time on malaria • Inconsistent inclusion of malaria control activities in District Implementation Plans • Inadequate office space for NMCP to enable hiring of new staff, resulting in heavy workloads for staff managing several technical areas	• NMCP will engage the private sector to co-invest in malaria control • MoH will lobby for additional office space so that NMCP can hire additional staff to manage technical areas

The limitations identified above during the mid-term review as well as issues raised during the consultative stakeholder meetings formed the basis for prioritization of activities requested in the NFM.

d. Main areas of linkage to national health strategy

The Malawi Growth and Development Strategy (MGDS) 2011-2016 outlines how Malawi will achieve the United Nations Millennium Development Goals (MDGs) and provides the national framework to promote social and economic growth and reduce GoM's dependency on aid. In line with the MGDS, the health sector through the Sector Wide Approach (SWAp) governance structure developed a second generation 6-year Health Sector Strategic Plan (HSSP) 2011-2016 whose overall goal is to improve the quality of life of all Malawians by reducing the risk of ill health and the occurrence of premature deaths. The HSSP has placed an emphasis on malaria as one of the priority disease burdens to be addressed. As referenced above, the MSP has been revised to align with the 6-year Health Sector Strategic Plan (HSSP) 2011-2016. Improved access to malaria prevention and treatment contribute directly to achieving MDGs 4, 5 and especially 6.

e. Country process for reviewing and revising the National Malaria Strategic Plan

The Ministry of Health, with support from partners, conducted a midterm review (MTR) of the 2011-2016 MSP to assess the progress of implementation and make recommendations for better performance and impact. The MoH in collaboration with the Malaria Technical Working Group developed a concept note and a roadmap outlining the MSP's mid-term review process and plans for financial and technical support. The performance of the MSP was measured through thematic reviews, desk reviews and the Strength Weakness Opportunity Threat (SWOT) Analysis. The thematic reviews were done by specific strategic area i.e. vector control, M&E, case management, BCC and program management. The main findings were presented to stakeholders, followed by extensive discussions where conclusions on major issues were made and formed the basis of the revision of the MSP.

The development of the revised MSP 2011-2016 was consultative involving most malaria stakeholders in the country, including government, bilateral and multilateral partners, NGOs, faith-based organizations, academic institutions, and the private sector. The World Health Organization (WHO) Inter-country Support Team from Harare provided technical assistance to conduct an epidemiological review which contributed to the revised MSP.

Beyond reviewing the current MSP, there are plans to review the MSP in 2016 during the Malaria Program Review to assess progress toward reaching the targets. At this time, the NMCP and stakeholders will also develop the 2017-2021 MSP in line with the HSSP 2017-2021.

f. Lessons learned from iCCM

The Child Health Strategy 2013-2017 implements the community case management of Malaria

at community level.

A number of systematic reviews have been conducted on the iCCM. One major study was an external evaluation of the Integrated Health Systems Strengthening (IHSS) Program in Malawi, undertaken by the Medical Research Council, South Africa in partnership with the University of the Western Cape and Save the Children-US. The results of the study reported improvements in the iCCM period in the 10 Catalytic Initiative districts. It further showed that with regard to rates of care-seeking for fever and ORS use, the average annual rate of increase in coverage were significantly higher in the iCCM period in comparison to the pre-iCCM period.

Since the introduction of iCCM, ACTs coverage rose to 53% in 2012. In addition, care-seeking for pneumonia was comparable between the pre-iCCM and iCCM periods: both periods reflected annual rates of increase of approximately 4%. With regard to impact on equity, a narrowing of the gap between the richest and poorest wealth quintiles and between geographically inaccessible (i.e. rural/urban) areas has been noted. There is consistently better coverage for ITN, while nearly equal access was observed throughout for care-seeking for fever, including antimalarials/ACTs.

In sum, the following key lessons have been learned:

- HSAs remain relevant as the first point of contact at the community level for the management of sick children. Most under-five children get treatment and care within 24 hours of onset of symptoms.
- Community BCC, IEC, and advocacy are very essential for behaviour change and uptake of interventions.
- Data management using cStock is essential for effective monitoring of implementation and monitoring of stock outs at community level. Strengthening of community-based data collection tools and the rolling out of cStock needs to be supported.
- Health system supports are essential to keep HSA's level of performance desirable this includes vigorous monitoring, supervision and mentorship, cStock, deployment, and follow up. Adequate supervision strengthens CCM implementation at the HSA/catchment area level.
- Continuous and consistent availability of medicines and supplies is key to iCCM implementation.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources that are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease Program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the national Program and how this funding request fits within this, briefly describe:

a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).

b. How the proposed Global Fund investment has leveraged other donor resources.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

1-2 PAGES SUGGESTED

a. The availability of funds for each area and the source of such funding (government and/or donor)

Table 2.1a below illustrates the expected financial contributions from the Government of Malawi and all significant health sector development partners for malaria during the grant implementation period. Malaria funding needs for 2014-2016 were taken from the MSP costing estimates and represent the full expression of demand for malaria programs in Malawi. Funding needs were extrapolated to 2017 based on the assumptions used throughout the costing of the MSP, extensive stakeholder consultation, projected population growth, inflation and taking into account the effects of current and proposed interventions on malaria incidence.

Table 2.1a: Financial Contributions for Malaria Control by GoM and Development Partners in Malawi, Available Funds, and Needs (USD)

Entity	2014	2015	2016	2017	TOTAL
Government of Malawi	$971,092	$1,295,779	$4,445,074	$7,049,180	**$13,761,125**
PMI	$21,316,789	$18,643,289	$19,233,333	$18,133,333	**$77,326,744**
World Vision	$284,966	$417,781	$121,047	$121,047	**$944,841**
CHAI	$733,675	$1,367,896	$1,212,136	$601,940	**$3,915,647**
WHO	$100,000	$100,000	$100,000	$100,000	**$400,000**
Others	$323,924	$301,164	$119,982	$129,032	**$874,102**
Total available support	**$23,730,446**	**$22,125,909**	**$25,231,572**	**$26,134,532**	**$97,222,459**
Malawi malaria funding needs	**$35,303,831**	**$96,068,099**	**$54,721,446**	**$54,894,184**	**$240,987,560**
Financial gap	**$11,573,385**	**$73,942,190**	**$29,489,875**	**$28,759,652**	**$143,765,101**

Table 2.1b below illustrates the expected financial contributions from the Government of Malawi and all significant health sector development partners for iCCM during the grant implementation period. The iCCM funding needs for 2014-2017 were taken from the Child Health Strategy 2014-2020. The request to Global Fund for ICCM is based on extensive gap analysis (using the iCCM gap analysis tool), discussion with all key partners and the ultimate aim is to improve the sustainability of ICCM in the longer term to expand coverage for malaria, pneumonia and diarrhea treatment for children under 5 years old. This need does not include the estimated cost of malaria commodities, but does include the estimated cost of the other iCCM commodities.

Table 2.1b: Expected Financial Contributions for iCCM by Development Partners in Malawi

Available Funds/Needs (USD)	2014	2015	2016	2017	TOTAL
Government of Malawi	$30,000	$60,000	$645,853	$645,853	**$1,381,706**
CIDA	$800,000	$2,600,000	$2,600,000	$2,600,000	**$8,600,000**
USAID/PMI	$310,000	$310,000	$310,000	$310,000	**$1,240,000**
UNICEF	$761,685	$500,186	$0	$0	**$1,261,871**
USAID/MCH	$200,000	$200,000	$200,000	$200,000	**$800,000**
WHO	$80,000	$80,000	$80,000	$80,000	**$320,000**
DFID	$0	$200,000	$0	$0	**$200,000**
Total available support	**$2,181,685**	**$3,950,186**	**$3,835,853**	**$3,835,853**	**$13,803,577**
iCCM Delivery funding needs	**$5,567,244**	**$10,364,752**	**$7,594,031**	**$7,695,759**	**$31,221,786**
Financial gap	**$3,385,559**	**$6,414,566**	**$3,758,178**	**$3,859,906**	**$17,418,209**

Table 2.1a and Table 2.1b show a gap of $143,765,101 for the malaria program, and $17,418,209 for the iCCM program – a total gap of $161,183,310 from 2014 – 2017 without existing or proposed Global Fund contributions.

Table 2.1c below outlines the financial contributions from the Government of Malawi and donors by intervention area from 2014-2017, including the Global Fund contributions through existing grants [Round 9 and Transitional Funding Mechanism (TFM) Malaria Round 7 grant]. Even taking into account in country and external resources, there is still a gap of $87,264,538. Due to time lag between when the funding for commodities is received and when commodities actually reach the country, the value of commodities carried over into 2014 are reflected in the table 2.1c below in order to convey an accurate commodity gap. These amounts are not reflected in the above tables as they are not attributed to any particular donor; however they represent the cost of commodities brought forward that might include the buffer stocks.

Table 2.1c: Donor Financial Contributions by Intervention Area in Malawi (USD)

Available Funds (USD)	Total Needs 2014 - 2017	2014 -2017			Funding Brought Forward	Financial Gap (USD)
		Domestic	External excluding Global Fund	Global Fund Existing Grants		
ACT (Commodity CIP)	$31,131,192	$2,295,551	$11,985,000	$2,351,120	$6,824,519	$7,675,002

RDT (Commodity CIP)	$19,713,241	$4,267,628	$6,550,000	$0	$4,304,597	$4,591,016
LLINs (Commodity CIP)	$56,913,576	$0	$14,719,000	$40,542,077	$0	$1,652,500
IPTP (including in-country distribution and warehousing)*	$621,063	$0	$596,881	$0	$0	$24,182
Injectable Artesunate	$17,950,894	$0	$7,561,654	$3,085,000	$1,114,843	$6,189,397
Other pharma commodities (quinine and ASAQ)	$2,253,817	$932,831	$0	$1,320,986	$0	$0
IRS and Larvaciding	$34,617,987	$3,850,000	$0	$0	$0	$30,767,987
iCCM	$31,221,786	$1,381,706	$12,421,871	$0	$0	$17,418,209
BCC	$8,141,365	$830,698	$6,470,000	$170,280	$0	$670,387
SMEOR	$7,767,977	$0	$5,303,899	$795,184	$0	$1,668,894
Program Management	$30,572,105	$468,677	$15,478,221	$1,601,318	$0	$13,023,889
PSM	$31,304,343	$1,115,740	$14,796,679	$11,501,729	$307,119	$3,583,076
Total available support (USD)		**$15,142,831**	**$95,883,206**	**$61,367,694**	**$12,551,078**	
Total Needs	**$272,209,346**					
Financial gap (USD)						**$87,264,538**

**Note: There are 32 months of stock of SP in country, and thus the need is fully met for SP.*

b. How the proposed Global Fund investment has leveraged other donor resources

The Global Fund NFM request will leverage existing GoM and health sector development partner contributions to maximize malaria prevention and control efforts. Existing partner commitments partially fund each intervention area described in the Malawi MSP. On top of planned annual commitments to malaria and iCCM, the Government of Malawi is also contributing an additional USD $10.15 million from 2015-2017 as part of the NFM counterpart financing, which is detailed in Section 2.2. Thus, the Global Fund NFM request is prioritized to address critical remaining gaps and complement existing GoM and partner contributions for ACTs, RDTs, and Injectable Artesunate to fully meet national need for these commodities, as well as contribute to M&E needs.

GF NFM requested funds for case management commodities will ensure existing GoM and donor commitments to strengthen health worker capacity will result in improved malaria case management. For example, development partner support for the roll-out of parenteral artesunate at health facility level and RDTs at community level will lay the groundwork for appropriate use of Global Fund-procured malaria commodities. Existing Global Fund resources will continue to support monitoring and evaluation and will build upon GoM and health sector development partners' investments to strengthen routine disease surveillance systems and conduct periodic evaluations through national level surveys. This will enable Malawi to collect more robust, timely, and accurate data for improved program management. Existing Global Fund resources will support mass campaign BCC interventions, complementing more significant investments from other partners and improving the uptake and utilization of preventive and case management interventions.

Overall, Global Fund NFM resources will be targeted to maximize impact and to create a balanced portfolio in combination with other donor commitments.

c. For program areas that have significant funding gaps, planned actions to address these gaps

For the funding period of 2014-17, the main gaps have been identified in the areas of

commodities, IRS, iCCM and Program Management. If the request for Global Fund NFM allocation is approved, the needs for priority commodities (ACTs, RDTs and injectable artesunate) in 2015, 2016, and 2017 will be fully met. Government commitment to malaria will cover the highest priority gaps in Program Management and BCC. Given the high cost of IRS spraying with organophosphates, and in the absence of adequate vector insecticide resistance data, MoH will pursue this activity when such data is available. Larval source management is also not requested in this application; alternative funding sources will be arranged by government. Regarding malaria program areas not fully covered by NFM allocation, domestic, and/or external resources, the MoH will lobby for resources from non-traditional partners.

iCCM has a significant gap of $17,418,209; however, the majority of this gap pertains to non-malaria commodities that are not eligible for this CN. To address part of the gap, the GoM will contribute $1,171,706 to iCCM for non-malaria commodities as part of the total $10.15 million counterpart financing for malaria. In addition, iCCM will work closely with partners, primarily UNICEF, SIDA and Save the Children to address the priority underfunded activities.

Malawi will face a major challenge in 2018 when the nation implements another mass distribution campaign for LLINs. Although this falls outside the NFM funding period, Malawi will address this need through various channels, including exploring government, bilateral, and multilateral support, and future Global Fund proposal opportunities.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. Indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	☒Yes ☐ No	
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	☒ Yes ☐ No	
iii. Increasing government contribution to disease program	☒Yes ☐ No	

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and

indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

The Government of Malawi has been gradually increasing financing for malaria control activities over the years. Specifically, the GoM has invested in the procurement of commodities for severe malaria and indoor residual spraying activities. This forms part of counterpart financing as shown in the financial gap analysis and counterpart finance template, attached.

Malawi is required to provide additional $21.5 million beyond current levels of spending over the next three fiscal years to satisfy the counterpart financing requirement. In addition to the requirement, Malawi is providing $8.5 million more to reach a total of $30 million government contribution. The counterpart financing contribution is split between Health Systems Strengthening (HSS), which will receive $11.5 million, malaria, which will receive $10.15 million and ART commodity buffer, which will receive $8.5 million.

Malawi intends to invest the HSS contribution in the following areas:

1. Procurement and supply chain management (PSM)
2. Human resource management (HRM)
3. Service delivery (laboratory)
4. Policy and Governance

Total GoM budgetary allocations to the Malaria Program were $971,092 in 2013-14 and $1,295,779 in 2014-15. Budgetary allocations to Malaria in the 2015-16 and 2016-17 financial years are $4,445,074 and $7,049,180 respectively, highlighting the increase in government contributions to malaria. Government contributions to iCCM were $30,000 in 2013-2014 and $60,000 in 2014-2015. During the period of the NFM, government contributions to iCCM also increased, with an allocation of $645,853 for both 2015-2016 and 2016-2017. Of this total government contribution to malaria and iCCM from 2014-2017, $10.15 million consists of counterpart financing, $3,759,778 which will be given for 2015- 2016 and $6,390,222 for 2016-2017.

The $10.15 million counterpart financing allocated to malaria will cover malaria commodities, BCC, Program Management and iCCM. Specifically, $2,295,551 will cover the ACT need for 2017; $4,267,628 will cover the remaining RDT need for 2016 and 2017; $830,698 will cover BCC needs for 2016 and 2017; $468,677 will cover Program Management needs for 2016 and 2017; $1,115,740 will cover PSM costs associated with the ACTs and RDTs procured under counterpart financing in 2016 and 2017; and $1,171,706 will be contributed to iCCM for non-malaria commodities in 2016 and 2017. In addition to the counterpart financing, the GoM continues to provide annual resources for indoor residual spraying and procurement of severe malaria ancillary supplies and commodities.

Crosscutting Health System Strengthening activities to be financed by the GoM investment have been detailed in the joint TB/HIV Concept Note for Malawi and detailed in Section 3.

The Government of Malawi counterpart financing investments will be tracked through the GoM Mid-Term Expenditure Framework (MTEF). GoM expenditure figures for Malaria will be tracked through a separate Malaria Program Ledger, expenditure returns for the Malaria Program, and MoH financial Reports. Appropriate controls, such as disaggregation of tasks throughout an expenditure process, are in place to ensure quality data.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems**.** It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs.

A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant's funding request.

Complete a programmatic gap table (Table 2) detailing the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.

1-2 PAGES SUGGESTED – ***only for modules that are difficult to quantify***

The programmatic gap tables have been completed based on MSP 2011-2016. Section 3.2 addresses the needs for case management commodities (ACTs, RDTs and injectable artesunate for severe malaria). Coverage targets in the programmatic tables have been aligned with the MSP to estimate needs. Funding for commodities by GOM and development partners over the period of this proposal has also been identified to determine the funding gaps for key programmatic areas and commodities.

This section provides details of interventions that are difficult to quantify. These are: information education and communication (IEC), behavioural change communication (BCC) and advocacy; surveillance monitoring evaluation and operational research (SMEOR); procurement supply management (PSM); and program management. The summary of the costs compared to the available funds allocated to malaria is presented to provide the gap for each intervention.

a. IEC, BCC and Advocacy

Activities in this thematic area cover Objective 3 of the MSP: promoting positive behavior change of the general population for prevention and control of malaria. The main activities are social mobilization, advocacy, interpersonal and mass communication, motivation of service providers, and social behavior change communication. Due to the endemicity of malaria in Malawi and the fact that everyone is at risk, the whole population will be the target for these activities. Given donor support from PMI for mass communication and IPC in selected districts and government support through counterpart financing for mass communication, as well as existing Global Fund contributions to mass communication, the unfunded highest priority BCC activities remaining are in interpersonal communication. Accordingly, these activities are being requested in above allocation funding. Table 3.1 below outlines the total needs, available funding, and gaps for this work area. The 2014 surplus will be utilized in 2015 and reduces the total financial gap in the NFM period 2015-2017.

Table 3.1 Total needs, available funds and gaps for IEC, BCC and Advocacy

IEC, BCC and Advocacy	2014	2015	2016	2017	TOTAL
Total need	$1,392,599	$2,235,656	$2,147,074	$2,366,035	**$8,141,364**
External excluding Global Fund (non-GF), and domestic	$1,470,000	$1,700,000	$2,001,587	$2,129,111	**$7,300,698**
Global Fund Existing Grants	$85,140	$85,140	0	0	**$170,280**
Financial gap	**($162,541)**	**$450,516**	**$145,487**	**$236,924**	**$670,387**

b. Surveillance Monitoring Evaluation and Operational Research (SMEOR)

There is a strong need for strengthening systems for surveillance monitoring, evaluation, and operational research. The strengthened systems will increase the availability of reliable and regular information on the progress made in preventing and controlling malaria in the entire country in order to measure outputs, outcome and impact.

While M&E is not being requested in the NFM allocation, priority M&E activities from 2015-2017 are being covered through existing funding. Round 9 funding ($118,587) only covers quarterly data audits and training of malaria and HMIS coordinators. An additional savings of $1,238,388 that is already in country from the existing grants will cover the following key M&E activities: 1.) review meeting (training) for key staff on data collection, management and analysis for 2015-2017; 2.) zonal malaria review meetings for 2015-2017; and 3.) Post-marketing surveillance for 2016 and 2017. The funding for these activities are shown in Table 3.2 below in the 'Global Fund Existing Grants' line.

There is partner support for M&E activities as shown below in Table 3.2 PMI is the major contributor to M&E and funds the following activities: household-level surveys (DHIS and MIS); operational research studies; End Use Verification (EUV) exercises, which monitor commodity stock and usage; entomological monitoring; and activities for strengthening routine surveillance in addition to those being requested above with existing GF funding.

All M&E activities supported by partners including Global Fund are not adequately captured in the MSP. However, there is strong coordination in country to make sure that there is no duplication of M&E activities.

Table 3.2 Total needs, available funds and gaps for SMEOR

SMEOR	2014	2015	2016	2017	TOTAL
Total need	$2,103,104	$1,594,978	$2,536,447	$1,533,448	**$7,767,977**
External excluding Global Fund (non-GF) and domestic	$1,545,000	$1,143,899	$2,293,981	$1,191,851	**$6,174,731**
Global Fund Existing Grants	$676,597	$486,144	$428,981	$441,851	$2,033,573
Financial gap	**($118,493)**	**($35,065)**	**($186,515)**	**($100,254)**	**($440,327)**

c. Procurement supply management (PSM)

The success of the MSP will depend on the availability of essential commodities and supplies, such as LLINs, ACTs, RDTs and Injectable Artesunate. PSM is part of objective 5 of the MSP, which focuses on program management as well as objectives 1 and 2 focusing on procurement of commodities. As shown below in Table 3.3, donors provide PSM funding for the commodities they procure. The PSM costs associated with Global Fund procurements of commodities are requested in allocation and have been estimated at 17% of the cost of commodities requested. The main goal of PSM is to have uninterrupted supplies of health and non-health products for malaria prevention and treatment. Main activities include in-country storage and distribution of commodities, which will be critical to avoid stock outs of life-saving commodities. The surplus of US$5,918,758 in 2014 has been factored into the need for subsequent years thereby reducing the total need to US$3.2 million instead of US$9.1 million.

Table 3.3 Total needs, available funds, and gaps for PSM

PSM	2014	2015	2016	2017	TOTAL
Total need	$3,877,543	$16,699,059	$5,305,342	$5,063,878	$30,945,822
External excluding Global Fund (non-GF) and domestic	$4,277,363	$3,760,186	$3,700,475	$4,481,514	$16,219,538
Global Fund Existing Grants	$5,518,938	$5,982,791	0	0	$11,501,729
Financial gap	**($5,918,758)**	**$6,956,082**	**$1,604,867**	**$582,364**	**$3,224,555**

d. Program Management

Effective malaria control relies on strong program management including leadership capacity. This addresses objective 5 of the MSP that ensures that there is improved capacity at the national program management level and down to the district level. Donor support in program management covers a portion of the need for trainings of health workers, technical assistance to NMCP and program operations support. In addition, Global Fund supplements program operations support. Within allocation, $1.2 million will be requested to cover grant management for World Vision as PR. Despite this support, there are still gaps in program management, as indicated in Table 3.4 below, which will be requested in above allocation.

Table 3.4 Total needs, available funds and gaps for Program Management

Program Management	2014	2015	2016	2017	TOTAL
Total need	$7,300,079	$8,699,095	$6,051,247	$8,521,684	**$30,572,105**
External excluding Global Fund (non-GF) and domestic	$4,176,336	$5,143,483	$3,790,790	$3,769,120	**$16,879,729**
Global Fund Existing Grants	$671,122	$930,196	0	0	**$1,601,318**
Financial gap	**$2,452,621**	**$2,625,416**	**$2,260,457**	**$4,752,564**	**$12,091,058**

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

4-5 PAGES SUGGESTED

1.) Malaria Programmatic and Funding Gap

Table 3.2.1 below summarizes malaria needs and gaps for the 2014-2017 by intervention area without Global Fund contributions. In order to be in line with the implementation period of the concept note, the costing of the 2011-2016 MSP and partner contributions by intervention have been extrapolated and projected through 2017.

Larvaciding, IRS, and IPTp have not been included in this table because they are not requested under the NFM as highlighted in section 2. LLINs are not included in this table since funding needs have been met by PMI and existing Global Fund commitments; thus, funding for LLINs is not requested in this concept note.

Table 3.2.1: Summary of Programmatic Funding Gap for Key Malaria Interventions Only

Intervention	Resource	2014	2015	2016	2017	Total
ACTs	Total Need	$9,459,528	$8,498,609	$6,945,771	$6,227,283	$31,131,191
	Financed Non –GF	$11,024,519	$3,385,000	$2,200,000	$4,495,551	$21,105,070
	GF Existing grants	$689,800	$1,661,320	0	0	$2,351,120
	Gap	**($2,254,791)**	**$3,452,289**	**$4,745,771**	**$1,731,732**	**$7,675,001**
RDT	Total Need	$3,254,565	$5,023,421	$5,879,851	$5,555,404	$19,713,241
	Financed Non –GF	$3,254,565	$4,700,033	$3,664,926	$3,502,702	$15,122,225
	GF Existing grants	0	0	0	0	$0
	Gap	**$0**	**$323,388**	**$2,214,925**	**$2,052,702**	**$4,591,016**
Injectable Artesunate	Total Need	$286,917	$6,369,591	$5,898,878	$5,395,507	$17,950,894
	Financed Non –GF	$1,726,000	$2,784,010	$2,586,798	$1,579,690	$8,676,498
	GF Existing grants	$0	$3,085,000	0	0	$3,085,000
	Gap	**($1,439,083)**	**$500,581**	**$3,312,080**	**$3,815,817**	**$6,189,396**
PSM Costs	Total Need	$3,877,543	$16,699,059	$5,305,342	$5,063,878	$30,945,822
	Financed Non –GF	$4,277,363	$3,760,186	$3,700,475	$4,481,514	$16,219,538
	GF Existing grants	$5,518,938	$5,982,791	0	0	$11,501,729
	Gap	**($5,918,758)**	**$6,956,082**	**$1,604,867**	**$582,364**	**$3,224,555**

2.) Integrated Community Case Management (iCCM) Programmatic and Funding

Gap

Table 3.2.2 highlights the iCCM gap analysis for the needs, financial contributions, and gaps for interventions being requested.

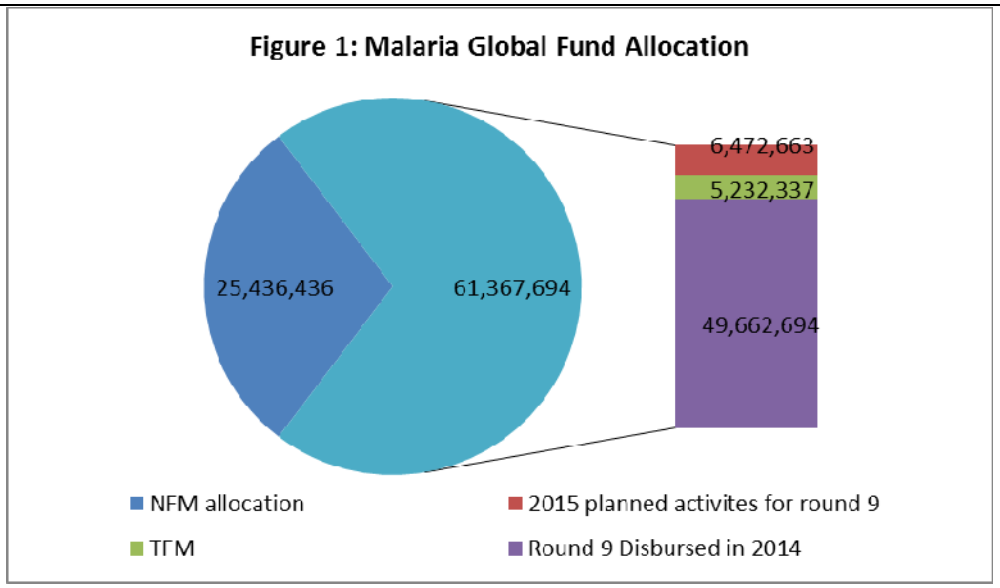
In 2014, the MoH revised the iCCM definition of hard-to-reach areas (from a radius of 8 km to 5 km from a health facility) to increase health service access in rural areas. As a result of this, the MoH proposes to recruit new HSAs in 2015. With this change, 1,600 new HSAs will need basic training, training on iCCM treatment guidelines, and start-up job aids and supplies. These costs associated with the HSA expansion in 2015 explain why there is a higher cost in 2015. In the subsequent years, only replenishment of supplies and follow-up trainings will be maintained; hence the costs for 2016 and 2017 are lower than those in 2015.

Table 3.2.2: Summary of Programmatic Funding Gap for the Key iCCM Interventions

Intervention	Resource	2015	2016	2017	Total
iCCM Delivery Costs (includes training, supervision, BCC)	Need	$2,565,102	$2,589,267	$2,594,109	$7,748,477
	Financed	$2,520,000	$1,820,000	$1,820,000	$6,160,000
	Gap	**$45,102**	**$769,267**	**$774,109**	**$1,588,477**
HSAs Tools and Enablers	Need	$2,151,009	$2,151,009	$2,151,009	$6,453,026
	Financed	$260,000	$260,000	$260,000	$780,000
	Gap	**$1,891,009**	**$1,891,009**	**$1,891,009**	**$5,673,026**
HSA Recruiting, Training, Data, and Program Management	Need	$2,880,000	$0	$0	$2,880,000
	Financed	$0	$0	$0	$0
	Gap	**$2,880,000**	**$0**	**$0**	**$2,880,000**

3.) Allocation funding

According to the CCM program split, a total sum of $86,804,130 has been budgeted for under the indicative funding envelope for the NFM, including funding from existing grants. However, $61,367,694 is committed funds from Round 9 and TFM. Of this, a total of $49,662,694 has been disbursed, $6,472,724 is for Round 9 planned activities, and $5,232,337 is from TFM as shown in figure 1 below. Round 9 funds are being used primarily for procurement of 9,061,350 LLINs for the 2015 mass distribution campaign and 2,000,000 million ACTs, with associated PSM costs. Other activities such as monitoring and evaluation, program management and BCC have been covered only for 2015 from the existing grants of Round 9 funding and TFM. The subsequent needs for 2016 and 2017 for these three areas have been requested in the above allocation.



The remaining $25,436,436 is being requested under this concept note. This amount includes a total NFM allocation of $17,822,695 (which includes the original allocation of $16,622,695 plus an additional $1,200,000 from the program split) as well as $7,613,741 savings from existing grants**.** The table below summarizes the funding requirement for all areas that are requested under the allocation from 2015 to 2017.

Table 3.2.3: NFM Allocation Request

Intervention Area	Allocation funding request (USD)			
	2015	2016	2017	Total
Procurement of ACTs	$1,197,499	$4,745,771	$1,731,732	$7,675,002
Procurement of RDTs	$323,389	$2,214,926	$2,052,702	$4,591,017
Procurement of injectable artesunate	$0	$2,821,916	$3,367,480	$6,189,396
Total for Commodity cost	**$1,520,888**	**$9,782,613**	**$7,151,914**	**$18,455,415**
PSM (Drug and Commodity Logistics)	$345,685	$1,663,044	$1,215,825	$3,224,554
iCCM	$825,619	$858,596	$872,251	$2,556,466
Program Management	$400,000	$400,000	$400,000	$1,200,000
Total for Supportive/ operational cost	**$1,571,304**	**$2,921,640**	**$2,488,076**	**$6,981,020**
Totals per year	**$3,092,192**	**$12,704,253**	**$9,639,990**	**$25,436,436**

As table 3.2.3 above highlights, this request prioritizes commodity procurement, given their life-saving nature and the availability of non-Global Fund resources to support M&E and BCC. The request also includes the commodity-associated PSM costs, as well as iCCM and PR management fees for World Vision International.

4.) Intervention Areas

Given the significant number of MSP activities to be funded, a prioritization matrix was developed to differentiate between activities that should be considered as within allocation and above allocation. The decision matrix covered the importance of the activity and level of committed funding for activities. Based on the agreed-upon decision matrix, procurement of ACTs, RDTs and injectable artesunate, as well as some aspects of iCCM and Program

Management, were prioritized to be funded within allocation since they were categorized as 'vital, but not fully funded'.

Procurement of ACTs and Injectable Artesunate

ACTs are prioritized in this concept note because they are life-saving and the first-line treatment for uncomplicated malaria in Malawi. The programmatic analysis has shown that after accounting for partner and government contributions, there is ACT gap of $1,197,499 in 2015, $4,745,771 in 2016, and $1,731,732 in 2017. The NFM request will meet 100% of these gaps for 2015, 2016 and 2017.

Injectable artesunate is prioritized in this concept since it is the new preferred treatment for severe malaria in Malawi and will contribute to a reduction in malaria mortality, especially for under 5 children. Accounting for existing Global Fund grants and contribution from partners, there is a gap of 1,410,958 vials in 2016 ($2,821,916) and 1,683,740 vials of injectable artesunate in 2017 ($3,367,480). The NFM request will meet 100% of the remaining gaps for 2016 and 2017.

Table 3.2.4 below shows a total of $16,308,480 that is being requested for ACTs and injectable artesunate, including PSM costs, from 2015-2017.

Table 3.2.4: Procurement of ACTs and Injectable Artesunate

Intervention Area	Allocation funding request (USD)			
	2015	2016	2017	Total
a) Procurement of ACTs	$1,197,499	$4,745,771	$1,731,732	**$7,675,002**
b) Procurement of injectable artesunate	$0	$2,821,916	$3,367,480	**$6,189,396**
c) PSM cost (ACTs and Injectable Artesunate)	$290,709	$1,286,507	$866,866	**$2,444,082**
Total	**$1,488,208**	**$8,854,194**	**$5,966,078**	**$16,308,480**

Procurement of Malaria Rapid Diagnostic Tests (RDTs)

In line with the MSP, which aims for universal diagnosis, RDTs are prioritized in order to ensure rational consumption of ACTs. After considering government and donor contributions, the programmatic gap analysis shows RDT gaps of 646,777 RDTs in 2015 ($323,389); 4,429,852 RDTs in 2016 ($2,214,926); and 4,105,404 RDTs in 2017 ($2,052,702). The NFM allocation will meet 100% of the RDT need for those years.

Therefore, a total of $5,371,489 is being requested in Table 3.2.5 below to meet RDT commodity and PSM needs for 2015-2017.

Table 3.2.5 Procurement of Malaria Rapid Diagnostic Tests (RDTs)

Intervention Area	Allocation funding request (USD)			
	2015	2016	2017	Total
Procurement of RDTs	$323,389	$2,214,926	$2,052,702	**$4,591,017**
RDTs PSM cost	$54,976	$376,537	$348,959	**$780,472**
Total	**$378,365**	**$2,591,463**	**$2,401,661**	**$5,371,489**

Program Management

World Vision has been selected as the civil society PR to manage the Malaria NFM envelope. In order to successfully manage NFM activities for iCCM and BCC, $1.2 million has been requested in Table 3.2.6 below for World Vision PR fees under program management. This will cover project salaries, travel (monitoring and implementation), strategic project activities and administrative costs.

Table 3.2.6 Program Management (PR fees)

Intervention Area	Allocation funding request (USD)			
	2015	2016	2017	Total
Program Management (PR fees)	$400,000	$400,000	$400,000	**$1,200,000**
Total	**$400,000**	**$400,000**	**$400,000**	**$1,200,000**

Integrated Community Case Management (iCCM)

iCCM is aware that not all expenditures, such as non-malaria commodities and infrastructure costs, are eligible Global Fund support. After looking at gaps in eligible expenditures and existing partner and government contributions, in-country stakeholders have identified delivery costs as the priority area for funding. For the iCCM in Malawi to be strengthened at the community level, the following essential components of a community delivery platform for iCCM are requested within the allocation (see Table 3.2.7):

1. iCCM refresher training on revised malaria treatment guidelines.

This refresher training will focus on the 3,746 existing HSAs operating village clinics in hard-to-reach areas. Currently, HSAs utilize presumptive treatment, resulting in over treatment of patients with ACTs. The new guidelines state that there must be universal diagnosis in Malawi, including at the community level. The updated guidelines have also included rectal artesunate as the pre-referral treatment for severe malaria at the community level to reduce malaria mortality. Thus, this training will cover the revised malaria treatment guidelines at the community level, with a focus on introducing malaria RDTs to ensure rational diagnosis and rectal artesunate to enable reductions in mortality. While the focus of the training will be on malaria, since no iCCM training has taken place since 2011, HSAs also need to receive refresher information on other iCCM diseases, including pneumonia and diarrhea.

As a result of this training, there will be: improved diagnosis and classification, thereby enabling rational use of anti-malarials; reductions in mortality for under five children as a result of the use of rectal artesunate for pre-referral treatment of severe malaria; better classification of pneumonia to ensure rational usage of antibiotics; and improvement in the management of dehydration at the community level.

2. iCCM M&E and Data Management

For data management, this request intends to implement a rigorous system for monitoring and evaluation of all iCCM activities through the District Health Information System 2 (DHIS2) platform. Currently, the HMIS generates data from the facility level only and does not accurately reflect disease burden at the community level. This request includes funding to strengthen community level reporting in the national level HMIS to better facilitate planning and decision-making and reduce the use of a separate data system for the community. Data Quality Assessments (DQA) will also be conducted for select HSAs to improve the quality of community-level data.

The M&E activity to be conducted is integrated supervision of all HSAs. This will consist of

on-the-job mentorship of HSAs to improve management of iCCM diseases and provision of services, including on: RDT use and adherence, use of timers for pneumonia and general case management.

3. Supply Chain for Community Case Management

Currently, community-level disaggregated consumption data cannot be distinguished from health facility data in LMIS. The aim of supply chain for community case management is to increase availability of key medicines and commodities for treatment and management of sick children at the community level.

cStock provides detailed community-level consumption and stock management data, and is vital to monitor community stock and consumption and maintain consistent product availability for community health commodities. cStock has significant impact in improving data visibility of commodities at the community level, as well as enabling communication between HSAs and facilities on the availability of commodities. Through cStock, reporting on commodities has significantly improved from 43% to 97%. Availability of tracer iCCM medicines, such as ACTs, ORS and antibiotics increased from 27% to 85% availability (SC4CCM Endline Evaluation Report). A detailed description of cStock and its benefits is included in the attached Supply Chain for Community Case Management (SC4CCM) Endline Evaluation Report.

Through the requested funding, it will be possible to maintain implementation of cStock in 29 districts to ensure reliable community stock and consumption data. Currently, 3,075 HSAs out of a total targeted 4,000 HSAs have been trained on cStock and the requested funds will permit the training to be rolled out to all HSAs operating village clinics. Other costs include server hosting costs; server maintenance costs; system administration capacity building for district staff; dashboard administration capacity for national level staff; cStock dashboard navigation for the district IMCI Coordinators; HMIS Officers and Pharmacy Technicians, support to National Product availability Team (monthly meetings); and communication.

The expected impact of cStock is that it will contribute to reducing child morality by ensuring that key commodities are available at the community level at the time needed. Through continuation of cStock, the high rates of reporting on commodities and availability of tracer iCCM medicines will remain high to sustain the gains already made.

The activities requested will result in improvements in the delivery of iCCM through improved care-seeking behavior, client satisfaction and demand for services, since HSAs remain relevant the first point of contact at community level for the management of sick children, particularly under five children to ensure they receive treatment and care within 24 hours of onset of symptoms. The HSAs will also emphasize on net usage every night. The request will also help strengthen collection of reliable community stock and consumption information and improved M&E systems at the community level in hard-to-reach areas.

These three iCCM priority areas result in a total request of US$2,556,466 from 2015-2017, which will be requested in allocation funding. This request represents roughly 10% of new funding allocation.

Table 3.2.7: iCCM Delivery Costs Request within Allocation

Intervention Area	Allocation funding request (USD)			
	2015	2016	2017	Total
iCCM refresher training on revised malaria treatment guidelines	$303,135	$311,947	$320,760	**$935,842**

iCCM M&E and Data Management	$222,940	$222,940	$222,940	**$668,820**
Supply chain at community level	$299,544	$323,709	$328,551	**$951,804**
Subtotal within allocation	**$825,619**	**$858,596**	**$872,251**	**$2,556,466**

Health System Strengthening (HSS)

Strong health systems are crucial for a well-functioning and effective health delivery services. The Government of Malawi is committed to strengthening health systems as evidenced by the HSSP outcomes for improved equity and efficiency of the health system and health reforms currently underway, and strengthening the performance of the health system to support the delivery of EHP services. Following the CCM's recommendation, the HSS component of the request has been included in a joint HIV/TB NFM application. Malaria has also identified additional HSS activities requested within the malaria NFM allocation, specifically iCCM activities, that are classified as HSS. Therefore, this section details the HSS interventions requested in the malaria CN, and also provides a summary of what has been included in the joint HSS (in the HIV/TB NFM CN) application that will address some of the key health system constraints highlighted in Section 1 of this concept note.

iCCM activities requested within allocation in this malaria CN are identified as HSS since these activities target several diseases, including malaria, diarrhoea and pneumonia. A total of $2,556,466 of the malaria NFM envelope is earmarked for HSS, since all iCCM activities in Table 3.2.6 are considered as HSS. The iCCM refresher training on revised malaria treatment guidelines is considered as HSS since it covers malaria, diarrhoea and pneumonia. The iCCM M&E and data management activity is classified as HSS since it looks at integrating community level data, which includes all diseases, into the bigger national data system as well as supervises HSAs on data collection for several diseases. Finally, the request for community level supply chain management, specifically continuation of cStock, is an HSS activity since cStock is part of supply chain management for both malaria and non-malaria commodities, such as ORS and zinc.

In the joint HIV/TB NFM application, there are four key modules to be strengthened as part of HSS:

1) Procurement and supply chain management (PSM)
2) Human resource management (HRM)
3) Service delivery (laboratory)
4) Policy and Governance

Only interventions that are financed by the GoM under WTP or within allocation are detailed here. Additional requests above the allocation are included in more detail under the HIV/TB Concept Note.

The majority of HSS activities identified will be paid for by the Government of Malawi as part of its Willingness-to-Pay contribution. This includes supporting expansion of medicines storage infrastructure for priority districts (PSM), Human Resources Management, and service delivery largely focusing on strengthening lab services.

1. Procurement and Supply Chain Management

PSM HSS activities will be largely funded under Willingness To Pay with a smaller amount proposed under above allocation funding.

Specifically, PSM HSS activities for WTP, the Government of Malawi will support storage improvements at 200 priority health facilities. During the implementation period funds are being sourced to cover procurement of HIV commodities which will have to be procured, stored and distributed in accordance with National and Global Fund, PSM and Quality Assurance guidelines. The PR has identified strengthening health facility storage

infrastructure as a key intervention that will lead to improved quality of logistics data of medicines including HIV/TB commodities.

2. Human Resource Management

HRM strengthening activities will be financed by GoM (WTP), within allocation and above allocation funds. The HRH request from within the allocation is for three specific activities that support cross-cutting TB, HIV, and malaria programs:

i. in-service trainings to update health care workers on current standards of practice, including HIV/TB integration;

ii. additional training of TB staff on how to administer ART for HIV; and;

iii. support for an orientation for all new HCW and a semi-annual refresher training.

The Government of Malawi HRH interventions under willingness to pay will focus on four key areas to holistically support HRH development:

i. support for quality training institutions;

ii. support for pre-service education scholarships to supplement those from other development partners;

iii. support for an in-service mentorship program; and

iv. support for scaling up the Integrated Human Resources Information systems (IHRIS) for tracking production, deployment and retention of health care workers.

The expected outcomes of this investment include: all staff will be trained in current management of TB and HIV. 100 medical assistants, 50 clinical officers, 50 pharmacy assistants, and 50 laboratory assistants will be newly trained. 24 clinical officers will be upgraded to bachelor's degrees. Fifty HCW accommodations in remote and hard-to-fill posts will have water and electricity.

3. Service Delivery

Service Delivery strengthening activities are strengthened by above allocation funding and by the GoM under WTP. The Government of Malawi has committed to using WTP funds to strengthen lab and quality assurance services through four strategies:

i. investing in maintenance service contracts for lab equipment;

ii. increasing sample transport;

iii. ensuring drugs are appropriate and effective when supplies reach the country; and;

iv. assuring quality lab services through blind checks and proficiency tests for personnel.

Investment in lab services is expected to lead to greater access to quality lab services across the country.

4. Policy and Governance

A small amount within allocation has been set aside to strengthen Policy and Governance by funding consultations for an updated infectious disease control portion of the Public Health Act to address the changing realities of infectious diseases in Malawi, including HIV, TB, and malaria.

It is expected that this investment will allow organisation to have a legal mandate to enforce appropriate control of infectious diseases.

Above Allocation Funding

Due to limited resources, BCC, M&E, Program Management and iCCM activities that were identified in the aforementioned prioritization matrix as 'important, but not fully funded' are being requested in above allocation. The remaining activities that were designated as 'fully funded' or 'lower priority and not fully funded' are not included in this concept note.

These above allocation supporting activities are critical in order to improve uptake of malaria control interventions, monitor the impact of the interventions, and improve management of malaria control activities. Table 3.2.8 outlines the above allocation request.

Table 3.2.8: Above allocation funding request in order of priority

Intervention Area	Above Allocation funding request (USD)			
	2015	2016	2017	Total
M&E	$177,999	$213,853	$188,840	$580,692
Trainings	$1,466,850	$1,452,450	$3,326,895	$6,246,194
Program Management	$103,000	$228,783	$109,273	$441,056
BCC	$151,315	$134,636	$160,530	$446,481
iCCM Training	$192,000	$0	$0	$192,000
iCCM HSA Pre-Service Training	$2,688,000	$0	$0	$2,688,000
iCCM BCC	$106,920	$106,920	$106,920	$320,760
Total	**$4,886,084**	**$2,136,642**	**$3,892,457**	**$10,915,184**

For the above allocation malaria request, M&E activities are the top priority, followed by case management trainings, program management and then BCC. ICCM activities are prioritized below.

1.) **Monitoring and evaluation:**

The M&E activities requested in above allocation aim to strengthen routine data collection and reporting systems to promote the use of information for evidence-based planning and decision making. Specific activities requested, ordered by level of priority with the highest priority listed first, complement existing activities supported by GOM and development partners: 1.) HMIS data quality audits to compare national and facility level data; 2.) drug efficacy studies; 3.) insecticide resistance studies; 4.) studies to identify the distribution of malaria parasite species; 5.) conducting additional entomological profiles; 6) malaria research dissemination meetings to ensure the most up-to-date malaria information in country is shared with all partners to shape future interventions; and 7) Collaborate with Pharmacy Medicines and Poisons Board to make sure pharmacovigilance and post marketing systems are functional. A total of $580,692 has been requested to cover these activities from 2015 – 2017.

~~1.)~~2.) **Training**

Training activities requested in order of priority include: 1.) orienting tutors in health training institutions to update training modules on malaria; 2.) training additional health workers (including auxiliary nurses and patient attendants) based at health facilities on RDTs; 3.) training a core team of microscopists in the WHO/AMREF accreditation to support QA/QC implementation; and 4.) conducting in-service refresher trainings for all health workers in malaria case management. These activities will improve the capacity of health workers both in pre-service and in-service to ensure proper management of malaria cases in accordance with the updated guidelines. A total of $6,246,194 has been requested under the above allocation funding request in order to implement the training on case management activities listed above.

2.)3.) **Program management:**

Program management activities requested in above allocation, listed in order of priority, include: 1.) developing a slide bank to improve proficiency testing of microscopists; 2.) QA/QC manual for malaria diagnosis. These activities will support post-marketing surveillance and pharmacovigilance, which are critical to ensure that anti-malarial commodities being used in Malawi are of good quality and safe for patient use. The third priority activity requested is international conference attendance fees for NMCP staff to ensure staff maintain skills and remain aware of the cutting edge of malaria research and programs.

A total of $441,056 has been requested under the above allocation funding request in order to implement the program management and case management activities listed above.

4.) **BCC**:

A total amount of $446,481 is being requested in above allocation for interpersonal communication (IPC) activities, which are critical in improving or increasing intervention utilization by the general community. While mass communication (which is being covered by counterpart financing) is important to generally target large audiences with malaria messages, IPC is a necessary complement since it works directly on behavior change at the individual level. IPC will also enable first-hand feedback on whether mass communication messages are understood or need to be adjusted. Due to high illiteracy levels especially among women, IPC will be tailored towards women to ensure that they receive malaria messages and information that may not have been accessible to them during mass communication. Currently, development partners are supporting IPC in 15 districts, leaving 14 districts with insufficient coverage.

The above allocation request for BCC focuses on interpersonal communication in these non-funded districts to compliment the IPC activities. Given that the activities listed below are all complementary, all are prioritized at the same level of importance. The specific interpersonal communication activities requested include:

i. development, pre-testing, and production of interpersonal media tools to facilitate interpersonal communication at the household and peer level;
ii. orientation of District Health Education Officers on IPC to ensure they become behavior change agents; and
iii. Orientation of partners and health workers on implementation of IPC.

Since there is no specific section for BCC requested activities within the modular template, these activities are requested under the Program Management section of the modular template. IPC will target rural populations, specifically women. These activities will seek to achieve maximum impact by directly involving the beneficiaries of IPC interventions, such as community volunteers and IEC Focal Persons, in the development of the tools. IPC interventions will be implemented by HSAs given the focus on rural populations.

3.)5.) **iCCM:**

iCCM activities requested in above allocation have been prioritized by level of importance. The first priority is the $192,000 requested to support six-day iCCM training. This training will complement the pre-service training for the 1,600 new HSAs so that HSAs to become oriented on iCCM so they can run village clinics. This training also includes orientation of health facility staff as supervisors and trainers to like the HSA to the clinic system. The

target and policy is to train two health workers per health centre.

The second priority activity requested for iCCM in above allocation is the HSA pre-service training. Based upon the new Child Health Strategy 2014-2020, which recommends that physical access to health services be improved by reducing the average distance to a health facility from 8 km to 5 km (approximate walking distance of 1 hour), the number of HSAs trained in iCCM required to meet the needs has increased by 1,600. This training will target these new 1,600 HSAs in hard-to-reach areas. The new 1,600 HSAs will be trained on how to assess and treat under-five children with malaria, pneumonia and diarrhoea. These HSAs will also be trained in supply chain management and cStock. Malawi thus requests $2,688,000 for the 12-week HSA basic (pre-service) training. By recruiting and training 1,600 new HSAs, as well as providing the 6-day iCCM training to 1,000 existing HSAs already working in communities, the expected impact is the extension of reach of services to an additional 780,000 children aged 2-59 months (each of the 2,600 HSAs reach an average population of 300 children under 5), providing a platform for expanding malaria case management.

The final priority is the $320,760 requested to support community iCCM BCC activities. Utilization rates of HSAs is low in some areas, therefore, one priority activity will be to promote demand for iCCM services. Malawi is requesting funding to support IPC activities to increase utilization and promote care-seeking behaviors. Village Health Committees, supported by HSAs, will be conducting IPC to community groups such as breast-feeding or hygiene and sanitation groups to promote the use of iCCM services in the community. Activities included are: community gatherings and advocacy meetings, production of IEC materials, interpersonal communication skills and other prevention measures. BCC will improve client satisfaction with health services, which in turn increases and improves care-seeking behavior. IPC for iCCM will be conducted alongside malaria IPC activities and integrated wherever possible.

Therefore, the total above allocation request for iCCM activities is of **$3,200,760**. The total incentive funding requested to sustain the gains made so far is **$10,915,184.**

3.3 Modular Template

Complete the modular template (Table 3). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:

a. Explain the rationale for the selection and prioritization of modules and interventions.

b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

3-4 PAGES SUGGESTED

a. Explain the rationale for the selection and prioritization of modules and interventions.

Selection and Prioritization of Modules and Interventions:
The country's malaria policy promotes the use of a combination of proven interventions as described in the MSP. The entire country need for malaria for 2014-2017 has been identified in the costing of the MSP. For this funding request, due to funding limitations and the need to target resources to where they will achieve the most results, the priority is funding for life-saving commodities. The rationale for prioritization is as explained in section 3.2 above.

The priority modules have been selected based on global best practices, lessons learned in Malawi from prior interventions, and available epidemiological data. Priority interventions are outlined below.

1. Procurement of ACTs and Injectable Artesunate

Taking into account both the burden of malaria in Malawi and the limited resources, access to prompt and effective diagnosis and treatment remains the highest priority. In this regard, Malawi requests resources for procurement of first-line ACT (*lumefantrine artemether*) to treat uncomplicated malaria cases, and injectable artesunate for the treatment of severe malaria in accordance with the newly updated guidelines.

2. Procurement of Malaria Rapid Diagnostic Tests (RDTs)
In 2011, Malawi adopted the Test, Treat and Track (3Ts) policy, requiring every suspected case of malaria to be tested before treatment. This policy was accompanied by the introduction of RDTs to facilitate diagnosis. Procurement of RDTs will enable proper diagnosis to thereby ensure rational use of ACTs and value for money since only those with confirmed malaria cases will be given ACTs. Without the RDTs requested, universal diagnosis will not be possible, resulting in irrational usage of ACTs and risking early parasite resistance to ACTs.

The usage of RDTs is currently only at the health facility level. Through the allocation request, it is expected that testing at the facility level will be maintained and RDTs will be rolled out at the community level through the iCCM program to ensure universal diagnosis in Malawi.

3. BCC

The rationale for selecting interpersonal communication was that it is currently underfunded as compared to mass communication that focus on creating awareness of the importance of malaria interventions. Interpersonal communication is a vital complement to mass communication since it focuses specifically on achieving behavior-change. Increasing

investments in commodities must be matched with personal behavioral change: Individuals need timely access and need to know how to use these commodities for effective malaria control. An investment in BCC will bridge the gap between knowledge and practice to improve access and utilization of malaria services.

4. Monitoring & Evaluation

As stated in 3.2, the M&E activities requested in above allocation are intended to strengthen routine data collection and reporting systems to promote the use of information for evidence-based planning and decision-making. The activities requested complement existing activities. Additionally, above allocation funding would allow quarterly zonal review meetings to review implementation of malaria programs and use data for decision-making.

The Ministry of Health recognizes that the current health system is faced with many challenges ranging from incomplete or inaccurate data, missing registers, and poor record management, among others. As part of ensuring the quality of the data, NMCP, in collaboration with the appropriate unit within the Ministry of Health, will undertake data validation and data quality audits at community, facility, and central levels to check for malaria data consistency and accuracy. NMCP will encourage and support District Health Management Teams (DHMTs) to conduct malaria data validation on a regular basis. To provide on-the-job training and support to data clerks and other health facility staff, NMCP will conduct supervision visits to facilities on a quarterly basis. NMCP will continue to support HMIS Coordinators with fuel so they can promptly follow-up with facilities that do not submit malaria data on time. NMCP will ensure that the reporting rates for community management of malaria cases through DHIS II are improved through strengthening of supportive supervision at that level.

In order to regularly monitor the efficacy of the ACTs, drug efficacy studies will continue to be conducted. As part of the Vector Control Strategy implementation, insecticide susceptibility studies will also continue to be conducted. This will help us understand vector susceptibility to insecticides, changing trends of resistance and their operational implications which will eventually guide the program on the choice of insecticide for vector control. While PMI has committed to provide funding for Therapeutic Efficacy Studies, discussions are still ongoing and there is a possibility that resources may be reprogrammed. Therefore, since not all of the above activities have committed donor funding, we propose them for above allocation funding.

The rationale for selecting these activities is to contribute to strengthening the routine surveillance system to generate consistent quality data to assist Malawi in stratifying the malaria burden. Thus, a strong M&E system is necessary to ensure prioritization of malaria interventions in Malawi.

5. Training

The rationale for selecting trainings (including for tutors, clinicians and health workers) is to ensure that commodities procured by both partners and the Global Fund are properly utilized at all levels of healthcare to ensure value for money. Capacity building of health workers will enable national targets, including universal diagnosis, to be met as stipulated in the MSP.

~~5.~~6. Program Management

Through the within allocation request, World Vision will be provided funding to manage NFM activities as co-PR, including requested activities for iCCM and BCC.

The program management activity funding requested above allocation is for international conference attendance fees for NMCP staff. This activity was selected because it is important that NMCP be up to date on the most recent developments in malaria to ensure that Malawi's malaria interventions reflect global best practices.

~~6.~~7. Integrated Community Case Management (iCCM)

In Malawi, iCCM is implemented in all 28 districts. Currently there are 9,771 HSAs who are offering services in respective catchment areas, Using the 8 km radius and considering geographical barriers, there are 4,000 hard-to-reach areas. Of these, 3,746 areas have HSAs trained in iCCM, representing 94% coverage. Each HSA serves a population of 1,000. However, in order to improve coverage, Malawi now recommends that establishment of village clinics be reduced from the current 8km radius to 5km. This then means that the total number of hard to reach areas has increased to 6,000. Currently with 3746 HSAs in village clinics, we are able to cover 62.4% of the targeted under five children. With the additional 2600 HSAs coverage will improve to 90%. Of the children managed at village clinic which on average each HSA treats 56% are malaria, 23% pneumonia. The additional funding will cover an additional 780,000 under five children.

There are several existing and planned methods for coordinating iCCM activities and commodities. The Health Technical Support Services Medicines Committee (HTSSMC), which includes MOH, development partners and all donors, reviews drug utilization reports, coordinates the procurement and distribution of drugs in Malawi. The Ministry of Health maintains an HSA database which is used to track and coordinate the implementation of iCCM. A micro-planning exercise is planned for 2015, as well, which will expand and improve the management of data and information for iCCM, including for commodities. The cStock application is also used to improve community-level malaria data and the utilization of data for decision-making.

The following priority activities are proposed within allocation for delivery of ICCM:

a) **iCCM refresher training on revised malaria treatment guidelines**: HSAs remain relevant as first points of contact at the community level for the management of sick children, since most under 5 children get treatment and care within 24 hours of onset of symptoms. Through this training, HSAs will be trained on how to ensure proper diagnosis of malaria by using RDTs, as well as the use of rectal artesunate to treat severe malaria. The HSAs also emphasize net usage every night and other key preventive messages. Therefore, the activities requested will result in improved delivery of iCCM through increased care-seeking behavior, client satisfaction and demand for services

b**) iCCM M&E & Data Management:** Program monitoring and evaluation for the iCCM program needs to be strengthened through training of HSAs and health center staff data quality assessment. Currently the HMIS generates facility level data only and does not accurately reflect the disease burden at the community level. This request therefore includes funding to strengthen community level reporting in the national level HMIS. Of particular importance is the need to introduce Data Quality Assessment (DQA) at both community and facility levels, as it is essential to improving data quality and strengthening the implementation and utilization of DHIS2 at district and national level.

c) **Supply Chain at the Community Level:** The MoH and partners in Malawi have embarked on aggressive system enhancement that will make data collection more efficient and improve information management to support transparency, accountability,

and evidence-based iCCM program management. Essential components to strengthen cStock will include refresher courses for HSAs, SMS costs, and server management and supervision monitoring (including the dashboard). These components will strengthen collection, management, and efficient utilization of service data for effective delivery of the iCCM Program and improved health outcomes.

In addition to these to continue sustaining the gains, the following priority activities are proposed above allocation for delivery of ICCM:

a) **Basic Training of additional HSAs:** This aims at supporting a 12-week basic training for HSAs to increase the coverage of HSAs by 1,600.
b) **Specialized training of iCCM HSAs:** This aims to reduce the radius of village clinics from 8 km to 5 km. This funding will support six-day training for HSAs to become specialized in iCCM to be able to implement village clinics.
c) **Community BCC**: Finally, a request to support community BCC activities, to include community gatherings and advocacy meetings, production of IEC materials for promotion of ITN usage, interpersonal communication skills, and other prevention measures., It also supports mobility for the HSAs, strengthening of Village Health Committees, and client service satisfaction to improve care-seeking behaviour.

b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

The funding being requested under this proposal is targeted at using high-impact and proven malaria interventions. In both the allocation and above allocation funding, Malawi is asking to cover the needs for these intervention areas to adequately control malaria.

The following are the requested interventions within allocation and their intended impact:

1. Procurement of ACTs and Injectable Artesunate

In pursuing an aggressive strategy of ensuring adequate supply of commodities for prompt and effective treatment in 2015-17, the proposal has budgeted within allocation for 100% of the need for ACTs and injectable artesunate. By ensuring the entire population has access to ACTs, we will reduce malaria morbidity and mortality. Injectable artesunate is an important life-saving commodity that will significantly reduce the number of malaria-reduced deaths in Malawi, particularly for children under five and pregnant women. The use of injectable artesunate over quinine will also help reduce the workload of health workers since it is easier to administer. Overall, these commodities will enable Malawi to meet the MSP target of reducing malaria morbidity and mortality by 50% by 2016.

2. Procurement of RDTs

The request includes the procurement of RDTs within allocation funding. The impact expected from meeting the full expected need for RDTs is to ensure that all suspected cases are tested before treatment, thus reducing misdiagnosis and irrational use of ACTs with the goal of bringing ACT consumption data closer to HMIS confirmed case data. Procurement of RDTs will enable Malawi to meet the MSP target that by 2016, all suspected malaria cases presenting to a health worker will be tested and treated according to the national guidelines.

3. iCCM

In general, funds requested for iCCM within allocation will reduce presumptive diagnosis through the introduction of RDTs at the community level, enhance data utilization by HSAs, and ensure that the population has increased access to iCCM services. Currently, there is presumptive diagnosis of malaria cases at the community level resulting in irrational use of ACTs. The rollout of RDTs at the community level will help reduce the overconsumption of ACTs in Malawi to ensure that all levels of the health system, including the community level, are confirming diagnosis before giving ACTs.

For the pre-service training requested within allocation, the expected impact will be: improved diagnosis and classification, thereby enabling rational use of anti-malarials; reductions in mortality for under five children as a result of the use of rectal artesunate for pre-referral treatment of severe malaria; better classification of pneumonia to ensure rational usage of antibiotics; and improvement in the management of dehydration at the community level.

For the integrated supervision of all HSAs, the intended impact includes: improved management of iCCM diseases and provision of services, including on: RDT use and adherence, use of timers for pneumonia and general case management.

For supply chain for community case management, the expected impact of cStock is that it will contribute to reducing child morality by ensuring that key commodities are available at the community level at the time needed. Through continuation of cStock, the high rates of reporting on commodities and availability of tracer iCCM medicines will remain high to sustain the gains already made.

The following are the requested interventions above allocation and their intended impact:

1. BCC

The anticipated impact of the interpersonal communication activities requested above allocation is that there will be increase in use of malaria interventions. For example, the percentage of Malawians seeking prompt treatment with anti-malaria treatments within onset of fever will increase, as will the usage of ITNs as an effective malaria prevention measure. This will enable Malawi to meet the MSP target of 80% of the population practicing positive behaviors to prevent and control malaria. Moreover, this will also empower populations to demand RDT testing before treatment to meet the MSP target of universal diagnosis.

2. M&E

As mentioned, the request for M&E activities above allocation will enable accurate data to inform stratification and improved prioritization of malaria interventions. Improved M&E will also provide better monitoring and data reporting. This will improve accountability for proper commodity use at the facility and community levels, enabling more value for money by moving away from the current approach that covers the entire country with all malaria interventions regardless of their epidemiological patterns. Interventions will be targeted to selected areas depending on epidemiological patterns. The requested M&E interventions will meet the M&E target for ensuring that by 2016, the systems for surveillance, monitoring, evaluation and operational research will provide the information necessary to effectively guide programmatic decision-making.

3. Training

Case management trainings are expected to improve the capacity of healthcare workers to better management of malaria cases to contribute to a reduction in malaria-related morbidity and mortality.

~~3.~~4. Program Management

The anticipated impact of program management activities is to ensure more effective implementation of malaria interventions at all levels of the health system. Additionally, the HSS requests included in the Joint HIV/TB Concept Note will strengthen HR, infrastructure, supply chain management and financial management for more efficient running of disease programs. The requested program management interventions will meet the target of enhancing program performance by 2016 for effective coordination and management at all levels of health service delivery. Quality assurance activities are also included here and will result in improved quality of health services provided, contributing to a reduction in malaria-related mortality. Client satisfaction in health facility services will also support health-seeking behaviors, including prompt treatment for malaria.

~~4.~~5. iCCM

The iCCM activities requested in above allocation are expected to extend the reach of services to an additional 780,000 children aged 2-59 months (each of the 2,600 HSAs reach an average population of 300 children under 5), providing a platform for expanding malaria case management..

3.4 Focus on Key Populations and/or Highest-impact Interventions
This question is not applicable for low-income countries.
Describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below: a. If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions. b. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.
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SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

4.1 Overview of Implementation Arrangements

Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s).

b. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.

c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.

d. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.

e. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.

1-2 PAGES SUGGESTED

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s).

In line with dual-tracking financing arrangement under the New Funding Model (NFM), the Country Coordinating Mechanism (CCM) has nominated the Ministry of Health to be the Government Principal Recipient (PR) and World Vision International (WVI) to be the non-government PR for this grant. MoH will implement the biomedical component of the grant while WVI will be responsible for the non-biomedical interventions, including community mobilisation. The MoH will be responsible for malaria interventions at primary, secondary, and tertiary health facilities while World Vision Malawi (WVM) will be accountable for iCCM implementation at community level program as well as for iCCM community mobilization. WVI will receive funds as PR and will collaborate in the implementation of iCCM interventions to be done by the IMCI Unit (excluding cStock which will be sub-granted as described in section 4).

b. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.

To ensure effective coordination of the grant, two PRs will form coordinating committees at National and District levels. At district level, there will be monthly meetings between MOH and WVM district Health teams. This platform will allow joint planning for increased synergy and coordination of activities. At National level, the two PRs will hold quarterly review and planning meetings. This meeting will be comprised by WVM Senior Management and Senior Leader team members (National Director, National Health Technical Manager, Grants Manager, M&E Manager and Finance Director and Grants Finance Manager). The Director for the Malaria Control Program, MoH Directors, and other relevant senior officers will be key member of this forum. This meeting will inform quarterly reporting meeting with the CCM or from time to time as called for by the CCM.

c. The type of sub-recipient management arrangements likely to be put into place and

whether sub-recipients have been identified.

World Vision

In the current arrangement WVM has only been allocated 3 key components (within allocation) which include ICCM trainings, ICCM M&E including data management, and supply chain for community case management (using cStock). The first two components in the Concept Note will not be sub granted. WVI will receive funds as PR and will collaborate in the implementation of iCCM interventions to be done by the IMCI Unit (excluding cStock which will be sub-granted as described in section 4). For example, training of health surveillance assistants on iCCM will be facilitated by World Vision in collaboration with Integrated Management of Childhood Illness (IMCI) secretariat and respective District Health Offices. This is to ensure compliance to national standards for training of these health staff. World Vision will identify SR(s) to implement the third component; supply chain for community case management (using cStock); monitoring, operations and maintenance to at most 2 SRs. WVM will also partner with ICCM (without sub granting) in the MoH to carry trainings of HSAs under ICCM. World Vision will therefore be responsible for managing these two components.

WVM recognizes that there are other stakeholders who have been managing supply chain for community case management (using cStock) and would be better placed to implement this component. Once identified, WVM will sub grant this component to the SR(s) to manage. The SR will get fund and sign a contract with WVM. The selected SR will be identified by World Vision Malawi (WVM) will through a competitive and transparent process comprising call and submission of expressions of interest and a capacity assessment. WVI will screen all sub recipient organizations and their top officials using watchDOGPro. The screening will be done initially and then every 12 months thereafter throughout the life of the award. (Different frequencies will be required based on sub recipient's risk rating.) The process of identifying SRs will begin mid-January. A contractual agreement will be arranged between WVI and successful SRs in which the PR will disburse funding to SRs on the basis of performance. A monitoring and evaluation plan will be developed in line with the national malaria M&E plan to facilitate SR management and reporting. WVM will hire a Sub granting and project Coordinator who will be responsible for managing selected SRs.

WVM has physical presence in 26 out of the 28 districts. This will allow for WVM to closely monitor SRs through its program managers. Where WVM is not present physically, the PR will identify a reputable local NGO in that district as an intermediate SR selected using the above procedure. These SRs and WVM managers will perform a quarterly routine desk and field review and analysis of all narrative and performance reports submitted by the sub-recipient to assess sub-grant performance achievements against targets and challenges, and to assess data quality and effectiveness.

Ministry of Health

The Ministry of Health, Malaria Control Programme will not have any sub recipients as it will directly implement its activities which contracting suppliers to supply various commodities including drugs.

d. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.

World Vision

At national level the WVM sub granting/project Coordinator will be responsible for coordinating with the IMCI Secretariat the implementation of the component. Coordination will occur through quarterly project reviews where all selected SRs, WVM and MoH including ICMI will meet to review and jointly plan for implementation of activities. As highlighted above WVM Area Program Managers based in each of the districts with support from Zonal Health Technical Coordinators will manage the ICCM trainings in collaboration with the district health offices.

World Vision recognizes that the IMCI Unit has the mandate and authority to develop training models and protocols for standardized implementation of the ICCM interventions. WVM will therefore coordinate with the IMCI Unit in MoH to request for training modules, ICCM protocols, reporting tool and master trainers to support all training sessions. At district level WVM will work with Ddistrict Health Offices to support monitoring of the training sessions and HSA work post the training sessions.

For the Supply Chain for Community Case management component (using cStock) WVM will work with MoH and a recruited SR. The WVM will work with IMCI unit to train HSAs in the use of cStock. An SR will be recruited to manage the cStock platform; operations, running costs and maintenance. At District level WVM Area Programme managers will work with district health officers to monitor the use of cStock by HSAs and district Health Information Systems Office.

Ministry of Health

The Ministry of Health, Malaria Control Programme will not have any sub recipients as it will directly implement its activities which contracting suppliers to supply various commodities including drugs.

e. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.

Malaria is endemic in Malawi and the whole population is targeted. Cognizant of the skewed impact of the malaria disease burden on women, women's groups and key populations will be deliberately targeted with interventions to ensure maximum impact.

4.2 Ensuring Implementation Efficiencies

Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants.

Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM.

In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

1 PAGE SUGGESTED

Currently the Malawi CCM is overseeing 3 Global Funds grants, namely HIV SSF, TB TFM Grant and Round 9 Malaria and FTM Grants. The HIV will phase out at the end of June, 2015 while the TB and Malaria grants will end in December 2015. These are summarised in Table 4.2.1 below:

Table 4.2.1: Portfolio of GFATM grants in Malawi showing overlap with NFM

Grant Number	Principal Recipient (PR)	Year					
		2012	2013	2014	2015	2016	2017
MLW-H-NAC	National AIDS Commission	$265,315,984					
MLW-708-G06-T	Ministry of Health						
MLW-911-G08-M	Ministry of Health			$61,367,694			

This proposal is expected to start in July, 2015 and will build on the gains made by the existing malaria grant. As such there will be no overlapping or duplication of activities with the existing malaria grant. The CCM will also submit a joint TB/HIV funding request also expected to start in July, 2015.

From a program management perspective, components of the three disease programs managed by MoH are coordinated under two directorates, namely HIV and Preventive Health services. While there is a synergistic approach between TB and HIV in the joint TB/HIV funding request, this proposal provides for only malaria specific training, monitoring and evaluation and supportive supervision to health facilities. HSS activities are included in the joint TB/HIV funding request. The non-government PR will conduct these activities in close collaboration with MoH.

4.3 Minimum Standards for Principal Recipients and Program Delivery

Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.

PR 1 Name	Ministry of Health	**Sector**	**Government**
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a crosscutting health system strengthening grant(s)?		☒Yes ☐No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and		The PR has described a comprehensive management structure outlining functions of various technical and administrative levels. The PR also describes	

planning	establishment of a lean, efficient and cost-effective dedicated unit responsible for managing and supervising grant implementation and reporting to the Global Fund through the Secretary for Health.
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)	The PR has mentioned SRs that it supports and a brief description of how the support is provided.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	The PR has described a robust internal control system with seven commonly accepted control objectives. It provides assurance that, if properly implemented, can prevent and detect misuse and fraud.
4. The financial management system of the Principal Recipient is effective and accurate	The PR has a financial management system composed of a series of tools and processes that permit the control, conservation, allocation and investment the organization's or program's resources. For management of the Global Fund grants, the PR maintains a SUN System Accounting software that records transactions and balances, making clear reference to the budget and work plan of the grant agreements.
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	The PR has indicated that it will utilize the CMST which is legally autonomous but is technically supervised by the PR. CMST has a central receiving warehouse in Lilongwe and three regional warehouses. Ongoing CMST's structural, operational and financial management reforms supported by Government and partners have built capacity to gain operational efficiencies and ensure best practice in public sector medicines warehousing and distribution management
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	Through CMST regional sites, the PR distributes medicines and supplies to over 600 health facilities in 28 districts every month. There is a monthly Health facility/District medicines order/requisition cycle that allows CMST to operate a monthly medicine distribution cycle through the Regional Medical Stores covering all health facilities in all districts
7. Data-collection capacity and tools are in place to monitor program performance	The PR has mentioned existence of a health management information system.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	The PR has a Central Monitoring and Evaluation Department (CMED) under the Directorate of Planning and Policy Development which is responsible for tracking and generating reports on all Health Management Information System (HMIS) indicators for the health sector. The department also provides support to all departments and districts in reporting, monitoring and evaluation
9. Implementers have capacity to comply with quality requirements and to	The PR works in collaboration with The Pharmacy Medicines and Poisons Board (PMPB) of Malawi

monitor product quality throughout the in-country supply chain	which is the country's regulatory authority responsible for product registration, site inspection, import control and post marketing surveillance for health commodities. PMPB operates a National Drug Quality Control Laboratory. Additional arrangements exist to work with WHO prequalified laboratories. (include how MoH ensures product quality throughout the in-country supply chain)

PR 2 Name	World Vision Malawi	**Sector**	**Non-Government**
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a crosscutting health system strengthening grant(s)?		☐Yes ☒No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		The PR described both technical and structural capacities to manage a nationwide grant.	
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)		The PR has several SRs for non Global Fund grants. Previously, the PR managed two grants from National AIDS Commission. The PR has adequate trained and qualified staff to manage SRs across the country.	
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud		The PR has vibrant internal control systems implemented in conformity with policies as provided in their finance manual. The finance manual gives guidance on cash management, reporting, procurement, sub-granting, among others. The policy is compliant with global Generally Accepted Accounting Principles (GAAP). WVM further has an Internal Audit system and Risk Mitigation Office locally.	
4. The financial management system of the Principal Recipient is effective and accurate		WVM uses Sun System accounting package. Sun Systems is a financial management and accounting software with a core accounting functionality covering all aspects of financial management, including general ledger, consolidation, corporate allocations, multi-currency, fixed assets and budget management. The system produces detailed expense and financial reports for each project implemented by WVM. Each project is identified by a unique number. It is therefore practical for tracking funding, producing reports, and analyzing finances for each project separately.	
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products			
6. The distribution systems and transportation arrangements are efficient to ensure continued and			

secured supply of health products to end users to avoid treatment/program disruptions	
7. Data-collection capacity and tools are in place to monitor program performance	WVM has a full–fledged M&E Unit which undertakes to ensure program/project quality and effectiveness. The Unit is staffed with a National Manager and five DME coordinators who facilitate baselines and are adept at program/ project design planning and evaluations.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	The WVM National Office has instituted a comprehensive M&E system for all its components to ensure that there is real time data collection for reporting. The WVM Quality Assurance (QA) Team leads in the monitoring, evaluation and reporting processes. The team is competent in designing project monitoring plans, data collection tools, data quality validation, partner capacity building in monitoring and evaluation and in compiling program reports. The team is decentralized and anchored by zonal Quality Assurance (QA) coordinators in regions across the country. In each region the QA coordinators are supported by development facilitators who are based in the communities. The system is able to collect and report countrywide data down to the community level on a monthly basis. Additionally, the M&E team has vast expertise in conducting assessments including Lot Quality Assurance Sampling (LQAS) which is a cost effective tool for conducting assessments.
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	

4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance

a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers' capacity, and past and current performance issues.

b. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request.

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Risk Rating	Description of risk	Proposed risk-mitigation measures
	Financial performance: Lack of compliance with Global Fund Audit arrangements	MoH has enhanced grant management by replacing the previous Excel-based accounting system with a SUN System Accounting software that will correctly and promptly record all transactions and balances, making clear reference to the budget and work plan of the grant agreements. The MoH has a full time dedicated accountant who manages the financial aspects of the grant and is supported by a team of the Fiscal Agent. In order to enhance and sustain the current system, the MoH will introduce within the Ministry, a fully dedicated Global Fund Support Unit responsible for Global Fund Grant management. Within the World Vision Malawi Finance department there is specific section called Grants finance which is charged with grants compliance. For the proposed grant, the section will be guided by WVI global centre guidelines for managing global funds GRT19C-G03 and GRT19C-G04 which spells out audit procedure for global fund grants. Further to this guideline WVM has sub granting standards that will guide selection and management of SRs to ensure that will ensure sound financial management. For this purpose all SR will be dully assessed to ensure existing capacity or reasonable potential for capacity building.
	Pharmaceutical and Health Product Management Weak PSM capacity and PSM arrangements at program level Delay in contracting a WHO prequalified laboratory for Quality Control Services Non-availability of a strong PSM coordination	There are two logistics officers posted to the program at the national level in order to improve capacity. The program also get support from JSI- Deliver on PSM issues Procurement of WHO prequalified laboratory is in the process and will be concluded by the end of the year. This arrangement will improve QC Currently there is a parallel supply chain of malaria products involving Bollore, JSI deliver, and CMST. This is a temporary arrangement while strengthening CMST. A coordination mechanism for all the players will be put in place. The coordination will be done through meetings with all those involved in PSM

Risk Rating	Description of risk	Proposed risk-mitigation measures
	M&E System No routine monitoring system for stock-outs of malaria main commodities at facility level and Certain facilities visited during the review were treating more than 30% of the cases without performing a parasitological confirmation test and it was noted the misuse of up to 20% of RDTs due to inadequate training of health workers. The review noted over reporting and under reporting by SDPs due to lack of supervision by higher levels and delayed reporting by facilities (only 21% of facilities reported on time)	The system for reporting stock outs for malaria commodities are through health facility reports. This is dependent on reporting rates. Efforts are underway to improve reporting rate through support supervision and end user verification There are plans to train Health workers on use of mRDTs. It is expected that once the trainings are done, there will be an improvement in adherence to policy on diagnosis There is a plan for quarterly supervision from headquarters to district and district to health centers. The major challenge has been lack of funds. But starting from last quarter of 2014, supervisory visits will be done as planned. We hope this will improve reporting rate from SDPs
	Outstanding conditions precedent and special conditions	On outstanding CPs and SCs the ministry is addressing them through Financial improvement plan and Grants management plan.

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE
Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

- ☐ Table 1: Financial Gap Analysis and Counterpart Financing Table
- ☐ Table 2: Programmatic Gap Table(s)
- ☐ Table 3: Modular Template
- ☐ Table 4: List of Abbreviations and Annexes
- ☐ CCM Eligibility Requirements
- ☐ CCM Endorsement of Concept Note