Investing in our future

The Global Fund

To Fight AIDS, Tuberculosis and Malaria

CCM Request for Interim Funding

30th July 2013

GENERAL PROGRAMME INFORMATION

Applicant	NATIONAL AIDS COMMISSION
Country	MALAWI
Component	HIV AND AIDS
Implementation Period start date	1 JULY 2014
Implementation Period end date	30 JUNE 2015

1.1 EPIDEMIOLOGICAL SITUATION AND COUNTRY CONTEXT

1.1.1 PLEASE BRIEFLY DESCRIBE ANY CHANGES TO THE DISEASE EPIDEMIOLOGICAL SITUATION AND THE COUNTRY CONTEXT THAT IS LIKELY TO AFFECT PROGRAMME IMPLEMENTATION OR STRATEGIES. PLEASE ALSO COMMENT ON THE POPULATION SIZE, DISEASE BURDEN AND MORTALITY (WHERE DATA IS AVAILABORATORYLE, DISAGGREGATE THE DATA BY AGE, SEX, AND KEY POPULATIONS, AS REQUIRED).

The estimated population of Malawi is 16 million (mid 2013) of which 49% are under 15 years old. The fertility rate is high (Total Fertility Rate of 5.7[1]) and a decline in child and HIV-related mortality. The population is projected to grow rapidly and exceed 17 million by 2015[2]. Economic activity depends almost exclusively on agriculture with tobacco, tea, and sugar as its most important export crops. Agriculture represents 31% of GDP and represents about 80% of all exports. Nearly 90% of the population engages in subsistence farming. The agricultural sector contributes approximately 64% to the total income for the rural population, 65% of the manufacturing sector's raw materials, and approximately 87% of total employment. In 2012, the IMF per capita GDP figures placed Malawi as the 2nd lowest country in the world with projections that Malawi would remain within the low income bracket through 2020.[3] In addition, Malawi has experienced sharp changes primarily due to the devaluation of the Malawi Kwacha in May 2012. This triggered an increase in inflation, reaching a high of approximately 39% in February 2013. Inflation has retreated slightly since then and presently is slightly over 30%. Correspondingly, most Malawians have experienced difficulty in purchasing basic commodities, including foodstuffs, and services.

Malawi faces a generalized HIV epidemic driven predominantly by heterosexual transmission. The first serological evidence for HIV in Malawi was collected in the early 1980s and the first case of HIV/AIDS was reported in 1985[4]. HIV prevalence increased sharply through the 1980s and 1990s, reaching a peak of 16% in 1999 and now has stabilized to 11% among 15–49-year-olds. About 1.1 million children and adults are currently estimated to be living with HIV.[5] Prevalence varies substantially by sex, age, urban-rural, geographic and socio-economic characteristics. National HIV prevalence is 13% in women and 8% in men (aged 15-49). The Southern Region accounts for 45% of the population and has the highest HIV prevalence (15.6% in adults 15-49), followed by the Central Region (7.2%); and the northern region (6.5%). Urban HIV prevalence in adults is estimated at 17% while the rural prevalence is 9%.[6]

[1] 2010 Malawi Demographic and Health Survey. National Statistics Office, Zomba
[2] United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, CD-ROM Edition.
[3] World Bank, Indicators, 2012
[4] Malawi Modes of Transmission Analysis and HIV Prevention Response.Distribution of new HIV infections in Malawi for 2013: Recommendations for prevention strategies. National AIDS Commission, Lilongwe (2013)
[5] Global report: UNAIDS report on the global AIDS epidemic 2012
[6] 2013 Malawi Spectrum Model (National AIDS Commission / UNAIDS)

The Behavioural Surveillance Survey conducted in 2006 reported high HIV prevalence among certain population groups, including truck drivers, male vendors, fishermen, male and female school teachers, male and female police officers, female border traders, and female sex workers.[7] Prevalence in some of these sub-populations differed significantly by region. The survey confirmed high risk behaviour among these populations, with large proportions having multiple partners and only a small proportion using condoms with their non-casual partners. The 2013 Modes of Transmission Analysis for Malawi suggests that most new infections occur in long term married or cohabiting relationships, but that high risk groups, while small in size, may contribute significantly to onward transmission. While the total population in Malawi has grown by almost 5 million between 2002 and 2012, the annual number of new HIV infections (adults and children) has declined from 112,000 to 66,000 in the same period. About 55,000 (83%) of new infections in 2012 were in adults over 15 years old. The annual number of children infected from their mothers has declined dramatically from 28,000 in 2002 (before ART/PMTCT scale-up) to 22,500 in 2010 (before implementation of Option B+) to 11,000 in 2012 – a reduction of over 50% in the last 2 years alone. The majority of new adult infections (56%) are thought to occur among people in long-term sexual relationships, followed by casual heterosexual relationships (17%). About 6% of new infections among adults are thought to occur among clients of sex workers. [8]

The impact of the HIV epidemic continues to be severe and 46,000 HIV-related deaths are estimated to have occurred in 2012 (including those already on ART). 35,000 (76%) of these deaths were among adults and 11,000 (24%) among children.[6] Based on current eligibility criteria (CD4 count ≤350), 470,000 adults (aged 15 years and above) and 100,000 children were estimated to be in need for ART in 2012. Following 2013 WHO recommendations for the definition of ART eligibility (CD4 count ≤500 for children aged 5 years and above and adults, universal treatment for children under 5 and for discordant couples), the population in need for ART will increase to 826,000 for adults and to 116,000 for children.[6]

In 2011, with support from the Global Fund, Malawi started implementation of its innovative integrated ART/PMTCT guidelines, which incorporated Option B++ for PMTCT, ART and primary care in a simplified service delivery model.[9] The initiation of lifelong ART for all HIV infected pregnant and breastfeeding women, regardless of clinical stage or CD4 count (Option B++) was developed and first implemented by Malawi and has now – based on Malawi's demonstrated success – been formally recommended by WHO. [10] Option B++ has been a game-changer for Malawi's HIV programme, resulting in a more than 7-fold increase of ART coverage among pregnant women and leading to a doubling of the number of PMTCT/ART sites to over 641 within the first 9 months of implementation.[11] An estimated **12,600 new infant infections have been prevented** by Option B+ in Malawi in 2012 alone.

The new integrated approach, comprised of the family-care programme model, includes implementation of a new pre-ART programme for those not yet eligible for ART, routine offering of voluntary family planning (FP) to pre-ART and ART patients, integrated mother-infant pair follow-up, and primary-care elements including screening and management of STIs and TB. ART eligibility has been revised to include all persons (adults and children >5 years) with CD4<350 cells/mm^3 for those who otherwise does not qualify based on pregnancy or

[7] BBSS. (2006). Biological and Behavioural Surveillance Survey 2006. NAC.
[8] Know-your-Epidemic Report, January 2009
[9] Integrated HIV Programme Report January – March 2013. Government of Malawi, Department for HIV and AIDS
[10] Schouten, E.J., A. Jahn, et al. Prevention of mother-to-child transmission of HIV and the health-related Millennium Development Goals: time for a public health approach. The Lancet, 2011. 378(9787): p. 282-284.
[11] Chimbwandira, F., et al, Impact of an Innovative Approach to Prevent Mother-to-Child Transmission of HIV — Malawi, July 2011–September 2012. Morbidity and Mortality Weekly Report, 2013. 62(8): p. 148-151.

other factors. The WHO recommended ART regimen (TDF/3TC/EFV in a once-daily FDC) has been the standard first line regimen for all adult patients since July 2013.

Malawi has been able to maintain leadership in sub-Saharan Africa in making gains in fighting the HIV epidemic. The 2012 CHAI analysis indicated that Malawi has an extremely efficient and inexpensive HIV treatment programme.[12] Between 2001 and 2011, it has been estimated that HIV incidence among adults aged 15-49 years in Malawi decreased by 73%.[5] Malawi ranks among the highest in surpassing the *programmatic tipping point*, with a ratio of 0.3 new infections compared to new ART initiations (PEPFAR AIDS Blueprint). In addition to the tremendous progress made in integrating and decentralizing HIV treatment services through Malawi's public health system, Malawi continues to lead the public health community through innovative programmes that will increase access to services. Progress is being made with the introduction of viral load monitoring, setting up a sample transport system and creating strong linkages between communities and facilities to ensure retention and adherence to lifetime treatment.

Malawi is one of the best examples for true country ownership of its national HIV Programme. This has been possible through the Global Fund's firm commitment as the key funder for the PMTCT and ART programme, allowing the MOH to develop and implement one set of national guidelines and one standard national M&E system that is used by all sites in the country. Since 2003, the Global Fund has committed a total of USD 527.8 million to Malawi's core response to HIV/AIDS and to-date has disbursed USD 473.5 million (90%).

1.2 PROGRAMME PERFORMANCE

1.2.1 DESCRIBE TRENDS OVER TIME IN TERMS OF IMPACT, OUTCOME AND COVERAGE IN THE COUNTRY (WHERE DATA IS AVAILABORATORYLE, DISAGGREGATE THE RESULTS AGE, SEX, AND KEY POPULATIONS, AS NECESSARY). INCLUDE COMPARISON OF RESULTS AGAINST NATIONAL TARGETS AND GLOBAL TARGETS (SUCH AS MDGS).

The GOM is a signatory to the 2011 UN Political Declaration on HIV&AIDS. The Malawi HIV program has documented successes and growth in several key areas. The PMTCT and ART coverage remain a key priority of Malawi's national response to the HIV and AIDS epidemic. Following implementation of the new integrated PMTCT/ART Programme in July 2011, the number of patients alive on ART increased by 145,885 (56%), reaching 422,866 in March 2013.[9] Out of these, 37,186 (9%) were children and 385,680 (91%) were adults. Among adults retained on ART, 137,664 (36%) were males and 248,016 (64%) were females. Based on the latest Spectrum estimates for the population in need of ART in Malawi, the current ART coverage is 36% for children, 63% for men and 65% for women. This is a remarkable achievement for adult ART coverage and confirms that ART access is gender balanced among adults. However, the relatively low paediatric ART coverage requires further efforts in the scale-up of early infant diagnosis and access to treatment for children.

The estimated annual HIV incidence (15-49 years) declined by 46% from 1.47% before ART roll-out in 2004 to 0.68% in 2013.[6] Most of this decline is probably driven by increased ART coverage among the HIV infected population. This is consistent with recent evidence from Malawi, showing that ART reduces HIV transmission by 96% among discordant couples.[13] Malawi's focus on increasing ART coverage for prevention of transmission among adults is also supported by recent evidence from a population cohort in South Africa that attributed a

[12] Facility-based unit costing for antiretroviral treatment in five sub-Saharan African countries. Available Laboratory from: http://www.healthmetricsandevaluation.org/sites/default/files/seminar/Maaya%20Sundaram%20presentation_101211.pptx

[13] 1. Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. N Engl J Med 2012; 365(6):493-505.

38% reduction of HIV incidence among adults to an increase of ART coverage to a level similar to that reached in Malawi in 2012.[14]

The integrated ART/PMTCT approach and the adoption of a CD4 count threshold of 350 for ART eligibility in 2011 has further accelerated ART access and resulted in earlier initiation on treatment.[9] The quarterly National HIV Programme reports clearly demonstrate the improvement of short and long-term treatment outcomes. Early mortality on ART has declined from 11% in 2005 to 3% in 2013. The latest quarterly programme report confirmed the 12-month ART retention target of 80%. A further improvement of ART outcomes is expected from the adoption of the key 2013 WHO recommendations for ART eligibility (universal treatment for discordant couples and children under 5; raising the CD4 count threshold to 500), which are expected to be implemented from January 2014. The revision of the national PMTCT/ART guidelines is currently underway and preparations for implementation are expected to start in September 2013.

One of the main drivers of the expansion of the ART programme has been the implementation of PMTCT Option B+ that commenced in July 2011. In the first quarter of 2013, 78% (127,167 of 163,522) of women at ANC s had their HIV status ascertained this percentage only is slightly below WHO's target of 85%. Of those tested 10,282 (8%) were HIV+. In total 18,588 were ascertained to be HIV+ and 11,120 women were on ART during pregnancy (this accounts for 60% against a target of 63%).

The rapid scale-up of PMTCT and ART has been supported by the expansion of HIV Testing and Counselling (HTC) services. There are now 824 static and 534 mobile HCT sites. This represents a substantial increase (46%) from December 2011 when there were 565 static HCT and 241 mobile HCT. The SSF performance framework has set ambitious HTC targets of 694,799 in the first quarter of 2013. In this period 460,559 (66.2%) persons were tested and counselled for HIV. Of the 460,559, 41,321 (9%) were HIV+; 170,334 (37%) people tested for the first time.

Another key area where success has been registered is with respect to behaviour change interventions. The country has implemented multiple interventions ranging from mass media campaigns to interactive personal communication among others. For example, the introduction of Life Skills Education as an examinable subject in 2010 in Primary and Secondary Schools will ensure that 4 million young people are fully knowledgeable in HIV and AIDS issues. This coupled with youth friendly health services provided in health centres and youth clubs countrywide should ensure a fully empowered crop of the youth that are able to make necessary adjustments on sexual behaviours by delaying sexual debut, reducing multiple sexual partnerships and are able to consistently and correctly use condoms. Results from the 2004 and 2010 DHS have since shown that there has been some level of good progress in as far as a positive change of behaviour is concerned. For example, the 2004 DHS showed that the proportion of sexually active women (15-49 years) having sex with more than one partner (non-regular partner) in the last 12 months was at 8.3%, whereas the 2010 DHS shows that this is currently at 0.7% and that for men has also decreased from 26% to 9.2%, respectively.

A third major success of the National HIV Programme is the TB/HIV Integration. 386,790 patients were retained on ART of which 93% were screened for TB at their last visit which is above the national target of 91%. TB patients screened for HIV was 93% surpassing the target of 85%. In terms of pre-ART care, 17,845 (44%) of 40,674 patients retained in pre-ART were isoniazid preventive therapy (IPT) by the end of March 2013.

[14] Tanser, F., T. Bärnighausen, E. Grapsa, J. Zaidi and M.-L. Newell, High Coverage of ART Associated with Decline in Risk of HIV Acquisition in Rural KwaZulu-Natal, South Africa. Science, 2013. 339(6122): p. 966-971.

The Multi-country Analysis of Treatment Costs of HIV&AIDS found that the average treatment cost was $136 per person per year, including the cost of ARVs.[15] The cost impact of the transition to the tenofovir-based first line regimen in 2013 and a gradual scale-up of viral load monitoring were modelled and yielded an anticipated treatment cost estimate of $230 per person per year, still low when compared to the other four countries analysed in the study. This confirms that Malawi continues to deliver one of the most cost-efficient national treatment programs in the world.

Regarding challenges, the main challenge is with respect to the achievement of the HTC targets detailed above. The main reason posited for not achieving the PF targets for the SSF was the management of the supply of test kits affected testing in the last 2 years, as evidenced by the percentage of women tested at ANC. Mitigating measures to address the supply chain issues include a directive from the MOH to all facilities to treat HIV test kits as controlled commodities, improved security of pharmaceutical agents and Laboratory reagents through the 3 key system, the on-going reform of Central Medical Stores Trust (CMST) and improved logistics and stock monitoring system. Possible concerns over adherence to testing protocol and quality of test results are currently being addressed through a national re-training of all HTC providers in an intensive skills training, professional registration of all re-certified HTC providers and strengthened supervision and proficiency testing implemented during integrated quarterly PMTCT/ART site supervision. HTC provider performance will be systematically monitored by the Department for HIV and AIDS within MOH using unique counsellor IDs and professional log-books.

1.2.2 DESCRIBE OVERALL GRANT PERFORMANCE RATING AND RESULTS ON CORE SERVICES BASED ON LATEST PU/DR, E.G.

- FOR HIV GRANTS: INCLUDE PERFORMANCES ON NUMBER OF PEOPLE ON ART, PMTC, HCT, TB/HIV
- FOR TB GRANTS: INCLUDE TB PATIENTS TREATED (INCLUDING MDR-TB AND TB/HIV SERVICES)
- FOR MALARIA GRANTS: INCLUDE NETS DISTRIBUTED, MALARIA CASES TREATED, AND IPT

Table 1: Overall Grant Performance

<table>
<tr>
<td>Overall Grant performance rating (key performance framework indicators only)</td>
<td>Since the implementation (June 2012) the PR has so far submitted 3 Progress Updates and Disbursement Requests (PU/DRs). The performance rating of B1 was received for the July disbursement for both programmatic and procurement of health products. According to the latest Management Letter (July 2013), the overall average performance on all indicators is 75% with all Top 10 indicators averaging around 78%. The latter, which includes 7 of the 12 output indicators include;
<table>
<tr><th>Indicator</th><th>Intended Target to date</th><th>Actual Result to date</th><th>% Achievement</th></tr>
<tr><td>1. number of visits by young people to youth-friendly Sexual and Reproductive Health/HIV services</td><td>500,000</td><td>1,388,000</td><td>278%</td></tr>
<tr><td>2. percentage of HIV infected pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission in accordance with national</td><td>62%</td><td>52%</td><td>92%</td></tr>
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[15] MATCH Study, released in 2012 by Clinton Health Access Initiative (CHAI)

	protocols			
	3. number of eligible adults and children currently receiving antiretroviral therapy	401,438	404,982	101%
	4. percentage of TB patients with known HIV status	85%	93%	109%
	5. number of vulnerable young people trained in vocational skills	800	819	102%
	6. number of HIV tests conducted per year	1,113,299	960,960	86%
	7. number of new students enrolled in medical, nursing, pharmacy, Laboratory and premedical training	432,670 (95%)	321,164	52%

While good progress has been achieved on the majority of indicators, performance on some has largely been affected by low availability of health commodities for HTC, STI and CPT. The PR is currently working with partners on medium and long term measures to strengthen procurement and supply chain management system at central and health facility levels. In addition lack of recruitment of pre-service training students in Year 1 reflected zero progress on the "*Number of new students enrolled in medical, nursing, pharmacy, laboratory and premedical training"*. A total of 261 students are currently enrolled under the RCC grant, recruitment of students under the consolidated SSF grant is yet to be done.

The current SSF grant has made a significant contribution towards impact, particularly in the areas of PMTCT and ART. The impact indicator on **Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy** has seen a considerable decrease in HIV related deaths in the first three months of treatment from 11% in 2005 to 0.5% in 2013.

Grant disbursements against budget

As indicated above, a total of 3 disbursement requests have been submitted to date, out of the year one signed grant amount of US$179,239,647. Of the total grant amount, US$127,334,986.59 has been disbursed for procurement of health products, representing **71%** of the Year 1 grant budget. As can be noted in the PU/DRs, disbursements for non-health product related activities were not made during this grant implementation period, largely due to outstanding CPs and STCs, as discussed below.

Conditions Precedent and Special Terms and Conditions

The signed grant agreement had a total of seven (7) Conditions Precedent (CPs) and seven (7) Special Terms and Conditions (STCs). The PR has so far managed to provide documentation for all CPs and 6 STCs. The response from the GLOBAL FUND is as follows:

Condition Precedent	GLOBAL FUND response
Disbursement for capacity building activities	No longer relevant since the PT has reprogrammed 93% of the budget ring-fenced for capacity building towards procurement of ARVs
Disbursement of grant for funds for storage facilities infrastructure activities	Currently under review by the LFA
Disbursement of grant for funds by PR for in country supply chain management (SCM)	CP is fulfilled
Disbursement of grant savings amount for programme activities and procurement of health products	CP is fulfilled
Disbursement of grant for SR activities	CP is in progress

		1st and 2nd Lots of audits: From a total number of 188 grants, 177 final audit reports have been issued, 2 drafts reports have also been issued, 6 are at field work stage and 3 were not audited-two because they were not funded and one because it is not functional. 3rd Lot of audits: Out of the 74 audits, 35 audits were finalized and final reports have been issued; 19 drafts have been sent to GROs for management comments before finalization of audits, while 20 audits are in progress. It is expected that the audits will be finalized by end August 2013. Recovery Plan was develop to address issues in 1st and 2nd lot audits, including recovery of resources not properly accounted for. So far, MK 43,417,985.30 out of MK121, 740,924.53 has been recovered. Follow ups are still being made to GROs that have outstanding audit issues.
	Use of funds for training activities	CP is in progress – no funds will be disbursed by PR until approval by the GLOBAL FUND on the training plan
	Use of funds for training activities advanced Education Trainees	Not met
	Special Condition	GLOBAL FUND Response
	Cost breakdown of the storage services and distribution activities	SC is now fulfilled
	PR to provide GLOBAL FUND with cash balances for Round 7 and Round 1 RCC	SC in progress
	Suitable storage facilities for all commodities	SC is now fulfilled
	PR to provide construction schedule	SC is now fulfilled
	Advanced Education trainee	SC was not met
	GLOBAL FUND discrete Account	SC is ongoing and will be monitored by LFA
	Compliance with OIG report	SC ongoing and progress has been made to date
Management Actions	The last ML had a number of issues for the PR to address. These largely relate to SR Management and Financial Management. Key among these to be fulfilled by the PR was completion of SR audits, reduction of SRs and recovery of funds from ineligible expenses amongst SRs. The PR has shared the plan for completion of SR audits and the recovery plan for ineligible expenses by SRs with the CCM and the Global Fund. The PR also developed a Capacity Building Action Plan, which analyzed the major capacity constraints at PR and SR levels, in order to facilitate grant management and performance improvements. The PR will ensure implementation of this plan in order to ensure improved performance during the remaining grant period as well as the envisaged Phase 2.	

1.2.3 COMMENT ON THE FINANCIAL CONTRIBUTIONS OF THE GRANT TO THE OVERALL SPENDING IN THE COUNTRY FOR THE DISEASE PROGRAMME, BOTH ABSOLUTE AMOUNT AND PERCENT. (DATA SHOULD BE DRAWN FROM OFFICIAL COUNTRY DOCUMENTS, WHICH CAN AND WILL BE VERIFIED. PLEASE SPECIFY THE SOURCE OF DATA)

This Interim Funding will allow Malawi to continue its successful implementation of the HIV Treatment programme for another year. The majority of funding from this proposal will be applied to procurement and distribution of ARVs and other commodities necessary for the implementation of the public health programme. Other donors, such as PEPFAR, UNICEF, DFID and CHAI will continue to support 'wraparound' costs for the implementation and quality improvement of the HIV treatment programme and costs for other programmes such as behavioural and biomedical prevention programmes, community based care and support programmes, Health Systems Strengthening, supply chain management, and pre-service and in-service training. In the near future, Malawi looks forward to submitting a more full application under the New Funding Model.

For the FY2013-2014, the Global Fund SSF grant is the leading source of funds for Malawi's HIV response. Of the $195.7M budgeted for the year FY2013-2014, the SSF grant accounts for approximately 38%, or $73.5M. The US Government is the second largest financer contributing $56M, or 27% of total funding. The GOM has budgeted $8M for HIV in FY2013-14. The $115M in Interim Funding from the Global Fund for FY 2014-15 would increase the funding envelope for Malawi's HIV response from $113M of budgeted resources for the year to $228M, or by approximately 50%.

The $115M of Global Fund Interim Funding for the FY2014-2015 will be allocated to the integrated ART and PMTCT, HTC, STI, Blood Safety and Opportunistic Infection interventions. A total of $19.8M has been committed by partners directly support these interventions in FY 2014-2015 (not including funding planned for cross-cutting systems that support all health activities). Of the $16.4M currently budgeted for integrated ART and PMTCT, 61% is committed by the USG, 10% by MSF-F, 7% by DREAM, 6% by CIDA and 4.5% by the World Bank. The total budget will be allocated to support health commodities (8.3%), planning and operations (9.8%), 14.3% technical assistance (15.1%), training, human resources (17.9%), research and M&E (22.9%), and the balance will support other activities including referrals, health equipment, supply chain management etc.

Regarding the HTC budget of $2.81M, 55% is committed by DFID, 34% by the USG, and 4% by the World Bank. The allocation of the resources is as follows: commodities (11.7%), planning and operations (6.4%), technical assistance (8.2%), training (48.32%), human resources (4.2%), research and M&E (4.39%), and the balance will support other activities including communication, health equipment, infrastructure etc. With respect to the STI Case Management budget of $0.05M, 48% is committed by the World Bank and 32% is committed by the GOM. Almost all the budget (99%) will support health commodities, and the balance will support activities like training, research and M&E etc. Out of the $0.002M currently budgeted for Blood Safety, 67% is committed by the GOM, 35% by the World Bank, and 18% by DFID. The entire budget will support planning and operating costs. The $0.58M allocated for Opportunistic Infections, 55% is committed by MSF-F and 26% by DFID. The budget will be used to support health commodities (74%), research and M&E (21%) and planning and operating costs (5.5%).

In addition, to the GOM funding directed specifically to HIV disease programs (as detailed above), the majority of government funding goes to cross-cutting systems, such as health workforce and infrastructure. See section 3.1 on counterpart financing for more detail. Tables 2a and 2b illustrate the planned HIV funding from the GOM and discrete partners for FY 2013-14 and FY 2014-15, as reported by the Ministry of Health Resource Mapping Database at July 2013.

Table 2a: HIV Program areas total resource envelope with contributions from large donors[16] [17]

HIV Program Areas	FY 2013-14										
	Total Resources	GOM	Global Fund	USAID	CDC	World Bank	DFID	MSF-B	MSF-F	CHAI	Other
Cross-Cutting HIV Activities	$47,684,810	$5,443,440	$2,491,368	$10,218,859	$7,223,843	$3,058,720	$3,370,926	$4,248,094	$963,569	$579,255	$10,086,736
HIV Biomedical Prevention (incl. STI)	$26,867,967	$1,642,575	$5,354,509	$7,647,199	$5,358,896	$2,450,562	$1,553,002	$375,938	$41,943	$464,464	$1,978,880
HIV Behavioural Prevention	$16,757,464	$257,449	$988,392	$9,761,890	$220,185	$282,467	$2,251,651	$-	$6,506	$-	$2,988,925
HIV Care and Treatment	$83,287,012	$355,404	$60,568,934	$4,927,146	$6,121,246	$237,485	$274,856	$38,169	$4,256,714	$2,031,404	$4,475,652
HIV Laboratory Services (excl. HTC)	$15,874,809	$58,829	$3,425,975	$237,602	$2,737,046	$80,992	$2,146,139	$1,284,945	$1,675,447	$2,932,186	$1,295,648
HIV Impact Mitigation (multi sectoral approach)	$5,258,462	$294,228	$720,048	$1,428,260	$146,713	$9,774	$224,567	$-	$-	$-	$2,434,873
Grand Total	**$195,730,525**	**$8,051,924**	**$73,549,226**	**$34,220,955**	**$21,807,929**	**$6,120,000**	**$9,821,141**	**$5,947,147**	**$6,944,179**	**$6,007,309**	**$23,260,714**
HIV Program Areas	**FY2014-15**										
	Total Resources	**GOM**	**Global Fund (Interim Fund.)**	**USAID**	**CDC**	**World Bank**	**DFID**	**MSF-B**	**MSF-F**	**CHAI**	**Other**
Cross-Cutting HIV Activities	$43,179,319	$5,575,692	$-	$10,133,046	$7,223,843	$3,048,027	$3,018,895	$3,672,945	$963,569	$608,001	$8,935,301
HIV Biomedical Prevention (incl. STI)	$25,824,598	$1,557,313	$6,077,610	$7,186,284	$5,358,896	$2,321,424	$1,553,232	$433,066	$20,972	$229,126	$1,086,676
HIV Behavioural Prevention	$15,254,073	$262,141	$1,002,035	$9,011,243	$220,185	$288,178	$2,002,422	$-	$6,506	$-	$2,461,364
HIV Care and Treatment	$119,627,757	$395,606	$98,866,881	$4,828,792	$6,121,246	$268,225	$276,682	$28,560	$4,021,822	$411,404	$4,408,538
HIV Laboratory Services (excl. HTC)	$20,365,383	$128,232	$9,049,709	$158,709	$2,737,046	$184,371	$1,566,005	$1,439,128	$1,675,447	$2,132,186	$1,294,551
HIV Impact Mitigation (multi sectoral approach)	$3,805,120	$321,146	$-	$1,428,260	$146,713	$9,774	$223,758	$-	$-	$-	$1,675,470
Grand Total	**$228,056,251**	**$8,240,129**	**$114,996,234**	**$32,746,335**	**$21,807,929**	**$6,120,000**	**$8,640,993**	**$5,573,699**	**$6,688,315**	**$3,380,717**	**$19,861,900**

[16] The USAID and CDC columns represent a portion of USG funding through the PEPFAR program, which also includes funding for US Peace Corps, US Department of Defense and US Department of State. The Resource Mapping Database collects information reported by USG partners and does not reflect the entire amount of USG HIV/AIDS funding in country. USG PEPFAR resources in Malawi for October 2012 – September 2013 were $70 million and are anticipated to be $75 million for October 2013 – September 2014.

[17] Other includes 85 different partners in FY 2013-14 and 86 different partners in FY 2014-15 including DREAM, SIDA, Peace Corps, CIDA, UNAIDS, UNICEF, UNDP, NIH, Norway, UNICEF, Department of Defence, Partners in Health, World Vision, Partners in Hope, Red-Cross, Oxfam, Trocaire, GIZ, FICA, UNA (UBRAF), WHO, Johnson and Johnson, Mulanje Mission Hospital, ILO, and Irish Aid..

Table 2b: HIV Program areas total resource envelope with contributions from large donors[18]

HIV Program Areas	FY 2013-14										
	Total Resources	GOM	Global Fund	USAID	CDC	World Bank	DFID	MSF-B	MSF-F	CHAI	Other
Cross-Cutting HIV Activities	$47,684,810	11.42%	5.22%	21.43%	15.15%	6.41%	7.07%	8.91%	2.02%	1.21%	21.15%
HIV Biomedical Prevention (incl. STI)	$26,867,967	6.11%	19.93%	28.46%	19.95%	9.12%	5.78%	1.40%	0.16%	1.73%	7.37%
HIV Behavioural Prevention	$16,757,464	1.54%	5.90%	58.25%	1.31%	1.69%	13.44%	-	0.04%	-	17.84%
HIV Care and Treatment	$83,287,012	0.43%	72.72%	5.92%	7.35%	0.29%	0.33%	0.05%	5.11%	2.44%	5.37%
HIV Laboratory Services (excl. HTC)	$15,874,809	0.37%	21.58%	1.50%	17.24%	0.51%	13.52%	8.09%	10.55%	18.47%	8.16%
HIV Impact Mitigation (multi sectoral approach)	$5,258,462	5.60%	13.69%	27.16%	2.79%	0.19%	4.27%	-	-	-	46.30%
Grand Total	**$195,730,525**	**4.11%**	**37.58%**	**17.48%**	**11.14%**	**3.13%**	**5.02%**	**3.04%**	**3.55%**	**3.07%**	**11.88%**

HIV Program Areas	FY 2014-15										
	Total Resources	GOM	Global Fund (Interim)	USAID	CDC	World Bank	DFID	MSF-B	MSF-F	CHAI	Other
Cross-Cutting HIV Activities	$43,179,319	12.91%	-	23.47%	16.73%	7.06%	6.99%	8.51%	2.23%	1.41%	20.69%
HIV Biomedical Prevention (incl. STI)	$25,824,598	6.03%	23.53%	27.83%	20.75%	8.99%	6.01%	1.68%	0.08%	0.89%	4.21%
HIV Behavioural Prevention	$15,254,073	1.72%	6.57%	59.07%	1.44%	1.89%	13.13%	-	0.04%	-	16.14%
HIV Care and Treatment	$119,627,757	0.33%	82.65%	4.04%	5.12%	0.22%	0.23%	0.02%	3.36%	0.34%	3.69%
HIV Laboratory Services (excl. HTC)	$20,365,383	0.63%	44.44%	0.78%	13.46%	0.91%	7.70%	7.08%	8.24%	10.49%	6.37%
HIV Impact Mitigation (multi sectoral approach)	$3,805,120	8.44%	-	37.54%	3.86%	0.26%	5.88%	-	-	-	44.03%
Grand Total	**$228,056,251**	**3.61%**	**50.42%**	**14.36%**	**9.56%**	**2.68%**	**3.79%**	**2.44%**	**2.93%**	**1.48%**	**8.71%**

[18] Malawi Ministry of Health Resource Mapping database, July 2013

SECTION 2: PLANNED ACTIVITIES FOR THE IMPLEMENTATION PERIOD

2.1 ANALYSIS OF TARGETS, RESOURCE NEEDS AND GAPS FOR THE IMPLEMENTATION PERIOD

2.1.1 PROVIDE ANALYSES OF THE RESOURCES AVAILABORATORYLE (FROM ALL SOURCES) VIS-À-VIS PROPOSED TARGETS AT COVERAGE, OUTCOME AND IMPACT LEVEL.

As noted in section 3, $113M is currently budgeted by the GOM and discrete partners to support the HIV response in FY2014-15. Table 3a and 3b provide greater detail on the interventions being supported by the GOM and partners. Of the $113M being directed to the HIV response, $93.6M of that is supporting the strategic actions detailed in Malawi's National Strategic Plan for HIV&AIDS. HIV funding that does not support an NSP strategic action is primarily technical assistance and administrative/operating expenses of financing and implementing partners. Funding directed to support the NSP is being implemented to achieve the goals and targets detailed in the NSP M&E framework.

More than 90% of the national HIV response in Malawi is funded through donors. The Global Fund is the major funder of the programme and funds core segments of the national response, including ARVs and other commodities. Option B++ and phased scale-up of the new treatment regimen have been undertaken through the Round 1 RCC grant. Malawi has struggled in getting Global Fund grants for HIV over the last three years; with postponement of Round 11, end of the Round 5 grant in 2011 and streamlining of the Round 7 grant into the RCC Phase I grant, the entire Malawi programme is being sustained by the Round 1 RCC grant (now the SSF grant).

Table 3a: HIV programmatic interventions supported by GOM and other funders in FY 2014-1519

Sub - Function	Intervention	GOM	Other funders	Total
Cross-Cutting HIV Activities	No Detail Required	$3,543,674	$39,635,645	$43,179,319
HIV Behavioral Prevention	Behavior Change Communication	$67,851	$10,872,771	$10,940,622
	Community Mobilisation	$636	$1,342,149	$1,342,784
	Condom Procurement and Distribution	$1,535	$1,967,097	$1,968,632
HIV Biomedical Prevention (incl. STI)	Blood Safety	$566	$1,859	$2,426
	HIV Testing and Counseling	$6,755	$2,805,371	$2,812,127
	Medical Male Circumcision	$-	$12,589,390	$12,589,390
	PMTCT (Not Including ARVs, EID)	$1,763	$4,304,296	$4,306,059
	Post Exposure Prophylaxis	$302	$341	$642
	STI Case Management (e.g. Syphilis)	$310	$50,482	$50,792
HIV Care and Treatment	ART	$49,372	$11,998,207	$12,047,578
	Home Based Care	$1,656	$666,349	$668,005
	Nutritional Support Associated with ART	$135,428	$809,178	$944,606
	Opportunistic Infections	$998	$580,998	$581,995
	Other Cross Cutting HIV Care and Treatment Activities	$28,391	$5,388,404	$5,416,794
	TB HIV	$946	$1,086,505	$1,087,450

[19] Malawi Ministry of Health Resource Mapping database, July 2013

Sub - Function	Intervention	GOM	Other funders	Total
HIV Impact Mitigation (multi-sectoral approach)	Educational Support	$767	$579,852	$580,619
	Gender Equality and Sensitivity	$7,105	$385,676	$392,781
	Legal and Policy Advocacy	$101,108	$770,176	$871,284
	Psychosocial Support	$3,833	$1,228,113	$1,231,946
	Social Cash Transfer and other General Poverty Reduction	$29,608	$350,745	$380,353
	Stigma Reduction	$7,731	$151,022	$158,753
	Vocational Support and Employer Practices	$164,477	$24,908	$189,384
HIV Laboratory Services (excl. HTC)	CD4 testing	$-	$3,207,333	$3,207,333
	Cross-Cutting Laboratory and Diagnostics	$5,318	$3,594,633	$3,599,951
	Early Infant Diagnosis (EID)	$-	$2,275,449	$2,275,449
	Viral load testing	$-	$2,232,942	$2,232,942
Grand Total		**$4,160,129**	**$108,899,888**	**$113,060,017**

Table 3b: NSP Strategic Actions supported by GOM and other funders in FY 2014-1520

National Strategic Plan - Strategic Action	2014-2015 Funding		
	GOM	Other funders	Total
1.1 Reduce HIV transmission between heterosexual couples	$103	$197,820	$197,923
1.2 Provide universal HIV testing & counseling	$13,871	$2,257,403	$2,271,274
1.3 Target young people with interventions	$366	$979,367	$979,734
1.4 Scale up VMMC & neonatal circumcision	$-	$10,514,683	$10,514,683
1.5 Reduce pediatric infections by access to effective PMTCT programme	$-	$-	$-
1.6 Supply male and female condoms to all programmes	$77	$2,448,971	$2,449,048
1.7 Disseminate behaviour and social change initiatives	$34,840	$6,898,031	$6,932,871
1.8 Reduce transmission of and morbidity from STI	$2,408	$814,976	$817,384
1.9 Prevent unwanted pregnancies among PLHIV	$-	$99,892	$99,892
1.10 Provide timely access to ART (CD4)	$-	$158,817	$158,817
1.11 Implement prevention programmes for MARP	$1,912	$20,333	$22,245
1.12 Promote prevention with positives	$362	$409	$771
1.13 Deliver EID programmes	$-	$140,236	$140,236
1.14 Prevent infections from unintended exposure	$2,619	$314,195	$316,814
1.15 Prevent HIV transmission through blood products	$1,499	$2,302	$3,800
2.1 Scale up available Laboratory of high quality ART services	$42,500	$16,203,754	$16,246,255
2.2 Scale up available Laboratory of high quality PMTCT services	$1,161	$6,507,213	$6,508,373
2.3 Implement a national pre-art action plan	$13,812	$32,086	$45,898
2.4 Improve nutritional status of PLHIV	$102,312	$4,485,119	$4,587,430
2.5 Improve access to quality community based care	$8,450	$2,429,902	$2,438,352
3.1 Improve programme management & coordination	$79,297	$4,595,639	$4,674,937
3.2 Secure funding to implement national response	$9,728	$152,369	$162,097
3.3 Develop capacity of CMS & other supply chain services	$-	$78,156	$78,156
3.4 Expand infrastructure & human capacity of health facilities	$23,353	$10,377,347	$10,400,701
3.5 Develop local council capacity	$10,945	$33,756	$44,702
3.6 Support NAC to oversee programme implementation	$815,350	$4,081,876	$4,897,226
3.7 Develop capacity of Laboratory services	$-	$37,550	$37,550

[20] Malawi Ministry of Health Resource Mapping database, July 2013

National Strategic Plan - Strategic Action	2014-2015 Funding		
	GOM	Other funders	Total
4.1 Provide affected people with services to mitigate impact	$1,329,944	$2,307,369	$3,637,312
5.1 Reduce stigma and discrimination	$12,333	$58,592	$70,925
5.2 Promote gender sensitivity in all programme interventions	$851	$42,245	$43,096
5.3 Promote a protective environment for PLHIV	$5,439	$524,799	$530,238
5.4 Facilitate participation of vulnerable people in programmes	$-	$58,102	$58,102
5.5 Promote PLHIV access to services	$-	$315,000	$315,000
5.6 Advocate for enforcement of legal and social rights of PLHIV	$-	$208,769	$208,769
6.1 Integrate HIV & AIDS programmes into all enterprises	$95,209	$4,431,598	$4,526,807
7.1 Provide evidence to warrant high impact interventions	$37,854	$6,243,724	$6,281,578
8.1 Equip private and public sectors to participate	$79,499	$944,429	$1,023,928
9.1 Strengthen M&E capacity	$35,220	$1,250,938	$1,286,157
9.2 Develop and maintain effective HIV information systems	$5,541	$558,673	$564,215
Grand Total - NSP Support	**$2,766,856**	**$90,806,439**	**$93,573,295**
NSP Not Applicable	**$1,393,273**	**$18,093,449**	**$19,486,722**

2.1.2 COMMENT IF THE TARGETS WILL BE ACHIEVABLE WITH ADDITIONAL RESOURCES EXPECTED TO BE AVAILABORATORYLE THROUGH INTERIM FUNDING. PLEASE HIGHLIGHT ANY REMAINING GAPS.

The recently released, WHO guidelines increased the CD4 threshold from 350 to 500 cells/microliter. The recommendation in this regards is under review in Malawi and when adopted it will lead to an immediate surge in current pre-ART clients initiating ART (i.e. those between CD4 350 and 500). In addition, the increase in universal access to ART from 2 years to 5 years will potentially increase the number of children initiating ART. The targets (adults- 526,854; Children – 50,204; and HIV+ pregnant women – 50,000) included in this proposal have taken into account the above. Furthermore, during the implementation period (1 July 2014 to 30 June 2015), routine viral load monitoring will be strengthened. To enable monitoring of adherence as well as treatment failure, additional resources will be required for staff, equipment, consumables and reagents. These will be supported by PEPFAR, USAID, CDC, CHAI, DFID and UNICEF. The support provided by the partners will include access to clinical monitoring, CD4 testing, access to PITC, quarterly ART/PMTCT supervision to all sites, training of ART/PMTCT providers and strengthening of the supply chain at all levels of the health care system

The success of the treatment programme is attributed to the combination of various public health approaches that have simplified and standardized treatment options. Quarterly supervision teams visit all PMTCT/ART sites, and data is collected and validated by a team at the central level. Support that is fundamental to the programme includes the development of the new national guidelines; Option B++ curriculum; training of 3,895 nurses and clinical officers to support roll-out of Option B++; development of the national clinical mentoring programme, implementation of community level support for treatment and effective facility-community linkages that supports access and quality in outcomes.

Financial and technical support is provided to the HIV Department in the Ministry of Health (SR) under the SSF grant and different funding partners to support the national quarterly M&E supportive supervision visits to all ART sites and placement of technical advisors to fill staffing gaps. Key systems strengthening inputs include supporting the development of an efficient electronic medical record system, improving Laboratory capacity and strengthening the supply-chain management system for HIV commodities.

With the above in place, the ARVs procured with the Global Fund resources will support the increased number of clients on ART beyond 2014. The resources will also address the gap left by UNITAID hence achieve the targets for the number of children on ART[21].

The Percentage/number of HIV infected pregnant women who receive anti-retroviral treatment to reduce the risk of mother-to-child transmission will depend on the proportion of women at ANC whose HIV status is ascertained. It is estimated that there will be a 10% increase from 67% in 2013/2014 to 77% in 2014/2015 in the proportion of women whose HIV status is ascertained.

The early identification of mothers and fostering retention in the treatment programme will be improved through Health System Strengthening interventions for HTC and integrated ART/PMTCT. To minimise drop outs in the PMTCT and ensure more HIV+ pregnant and breastfeeding women are on ART, support for the finalization of IEC materials for PMTCT and ART has been secured from partners.

Usage of modern family planning methods among HIV infected women will double from 60,725 (22%)[22] in 2012/2013 to 40% by the end of the grant implementation period (June 2015). This will be made possible with the integration of Family Planning (FP) into the ART/PMTCT clinic, referrals and linkages to modern FP methods and through partner support. Provider Initiated HIV testing and counselling, and linkages to care will be provided at all family planning service provision points.

The number of children under 12 months testing using DNA-PCR will be 55,000 by June 2015. This target will be achievable through early identification of children (including exposed infants) in all care settings with linkages to PITC, care and retention and adequate sample transportation.

This proposal seeks additional funding to support the procurement of testing commodities to support the HIV testing and counselling programme. The Global Fund Interim Funding will enable the programme to reach the target of testing 2.8 million people over the 2014/2015 implementation period. Partner support has been sought to support health system strengthening interventions as highlighted in section 2.2.

The Health Technical Support Services (HTSS) Diagnostics Department in the Ministry of Health is currently supporting the roll out of the national viral load (VL) testing to ensure national coverage to all zones. There are currently five Laboratories providing Viral Load testing. These are; Mzuzu Central Hospital, Queen Elizabeth Central Hospital, Mzimba South District Hospital, Kamuzu Central Hospital and Dream Centre Laboratory in Blantyre. The optimal viral load capacity is currently estimated at 117,000 tests per year with a potential 5% increase after the procurement of additional equipment in July 2014-June 2015. Procurement of additional molecular Laboratory equipment is underway to enable the ministry to increase coverage in Zomba Central Hospital and Partners in Hope clinic in Lilongwe. This is expected to increase the viral load testing capacity by 5%.

With the current estimation of over 40,000 PLHIV in the pre-ART and the expected increase of clients undergoing HTC and the need for continued monitoring of HIV+ patient/clients to ascertain their eligibility for ART, the Laboratory will be performing 80,000 CD4 tests every six months. All patients in pre-ART will be

[21] See Annexure 1: Gap Analysis

[22] MoH/HIV&AIDS Programme{"status":"TOOLBAR_READY","toolbarId":207743773} Report. 31 March 2013

required to have a CD4 test per six months; hence an estimated 160,000 CD4 tests will be conducted during the interim funding period (July 2014-June 2015). Apart from the conventional platforms for CD4 testing, procurement of 80 point of care CD4 PIMA machines is underway by CHAI and these will be distributed to most peripheral sites. The estimated annual output for these is 40,000 tests for the same period.

For the scale up of CD4 monitoring additional funds are required to support procurement of CD 4 equipment, Early Infant Diagnosis (EID) and viral load monitoring reagents. During the implementation period the Ministry of Health with the support from partners, will continue implementing health systems strengthening activities such as the integrated quarterly supervision to all ART/PMTCT sites, mentoring and supply chain strengthening activities to ensure that commodities are delivered to all sites. With the additional funding all targets detailed in the integrated implementation plan and budget and performance framework will be achieved during the 2014/2015 implementation period.

The Malawi's HIV response has been operating within a resource gap for many years. The NSP lists an extensive suite of activities with comprehensive costing, but represents a funding level Malawi will struggle to achieve. Malawi has been able to operate within the resource gap by prioritizing activities within the NSP to ensure funding is going to commodities and activities that are truly essential. As the Global Fund interim funding of $115m was not sufficient to cover all of Malawi's commodity needs as detailed in the NSP, a decision was made by the CCM to prioritize the essential commodities that were previously covered by the ending Global Fund SSF and UNITAID Paediatric ARV grants. For those commodities selected for inclusion in the interim application, there will be no gap if interim funding is secured. The unfilled gaps listed in Table ___ do not represent a threat to Malawi's HIV response.

Table 4: Remaining Gap

Detailed Gap	Commodity Gap		Interim Funding Budget	Remaining 2013-2015 gap	Comments
	2013-2014	2014-2015			
ARV commodity	-	(75,764,604)	75,764,604	-	
CD4 Consumables	-	(699,084)	750,200	51,116	• Need for CD4 consumables under quantified in gap analysis
CD4 Equip	(647,270)	(715,770)	670,000	(693,040)	
Condoms & Family Planning	(1,538,476)	(4,462,571)	2,961,349	(3,039,698)	
CPT	(2,025,484)	(7,993,744)	4,315,886	(5,703,341)	
EID Consumables	-	(1,089,604)	1,214,320	124,716	• Need for EID consumables under quantified in gap analysis
HBC Kits	(342,995)	(756,000)	-	(1,098,995)	
HIV Test Kits	(1,609,014)	(6,082,218)	3,306,476	(4,384,757)	
Medical Supplies and Lab Consumables/Reagents	(1,775,114)	(3,804,945)	2,510,502	(3,069,557)	
OI Drugs and Other Drugs	(6,018,149)	(8,092,462)	729,071	(13,381,539)	• OI drugs/other drugs are very highly costed in the NSP ($10 pppy for all ART and pre-ART patients)
STI Drugs and Test Kits	(779,302)	(2,066,368)	1,395,344	(1,450,327)	
Viral Load Consumables	-	(3,400,787)	1,967,616	(1,433,171)	
Gap	(14,735,804)	(114,928,158)	95,585,368	(34,078,594)	

2.1.3 DESCRIBE KEY ISSUES/LIMITATIONS TO ASSESS PROGRAMMEMATIC GAPS, AND LACK OF EVIDENCE ON ANY OF THE PROPOSED INTERVENTION AREAS/APPROACHES. (REFLECT DATA)

The proposed interventions have been informed by evidence of impact. For example, the policy for universal ART for discordant couples was informed by the HPTN 052 Study. The systematic review of programme performance and the available Laboratory evidence on transmission and maternal survival in 2010, led to the development of the Option B++ policy in Malawi. The rationale for this policy was published in the Lancet in 2011 and WHO has subsequently adopted it in their 2013 Guidelines. Since the introduction of Option B++ in July 2011, there has been a 700% increase in ART coverage amongst pregnant women.

2.2 PROPOSED ACTIVITIES FOR THE IMPLEMENTATION PERIOD

2.2.1 DESCRIBE WHAT IS BEING PROPOSED TO BE SUPPORTED BY ADDITIONAL FUNDING AND HOW IT IS LINKED TO THE EXISTING PROGRAMMES. – FOCUS ONLY ON THE REQUEST

The interim funding application is a 'gap-filler' between the current SSF grant and a comprehensive proposal that Malawi will write under the New Funding Model in 2014. As such, this application covers the most crucial need of the national HIV programme: health commodities. The proposal details four main categories where commodities are needed: ART/PMCTC, HTC, STI and Blood Safety.

The partnership between the GOM, the Global Fund and other donors has resulted in a robust national HIV programme. There is strong in-country donor harmonization and continuous engagement with the GOM on all health issues. Donors and GOM meet frequently in various forums to strategize, problem solve and generally hold each other accountable.

Continued support from the Global Fund for the national public health based HIV programme and HIV commodities has allowed Malawi to develop a coherent and strategic HIV programme which maximizes the core strengths of all donors. In-country partners, such as PEPFAR, CHAI, DFID and UNICEF focus their support on building capacity of the Ministry of Health, strengthening various aspects of the national health system, providing technical assistance as needed and ensuring the optimal functioning of the Global Fund grants in country. Section 3.3.1 details support from other donors.

A. ART/PMTCT

The interim funding will allow Malawi to continue its successful HIV Treatment programme till the end of June 2015. Majority of funding from this proposal will be allocated to costs of procurement and distribution of ARVs, OI drugs and other commodities necessary for the implementation of the national HIV programme. The interim funding will also allow Malawi to take into account the recent WHO Guidelines and further strengthen its national response. Malawi will: i) increase the CD4 threshold from 350 to 500 cells/microliter; ii) increase universal access to ART from 2 years to 5 years; iii) increase access to CD4, and iv) increase routine viral load monitoring. The activities proposed for the implementation period 2014/2015 are:

- Procure ARV's to increase the number of adult clients on ART from 385,950 to 526,854 by June 2015.
- Procure paediatric ARV's to fund the gap left by UNITAID. It is planned that number of children receiving ART will increase from 37,214 to 50,204.

- Procure HIV test kits to ensure adequate stocks for testing pregnant and breastfeeding women. It is planned that 95% of all pregnant women will be tested for HIV by 30th June 2015.
- Procure Family Planning commodities. Along with USAID and UNFPA, the Global Fund interim funds will be used by the Department of HIV and AIDS to procure condoms and Depo-Provera to ensure availability of Laboratory of family planning commodities for HIV+ women.
- Procure OI medications for treatment and prophylaxis.
- Procure DNA-PCR reagents to strengthen early identification of HIV infection in children. By June 2015, 52,250 (80%) of children under 12 months will be tested using DNA-PCR
- The procurement of CD4 test kits, reagents and machines will ensure adequate access to CD4 testing
- Procure reagents for viral load monitoring to detect ART failure early.
- Procurement and supply chain related costs for the Global Fund approved procurement agent are also included. This includes quality assurance of procured medicines using a WHO pre-qualified Laboratory and in country logistics costs for warehousing and distribution. (During the implementation period, the PR will finalize the integration of Malaria and HIV supply chains, and a single warehousing and distribution service provider will be secured through a competitive procurement process.)

B. HTC

The rapid scale-up of PMTCT and ART has been supported by the expansion of HIV Testing and Counselling (HTC) services. The HTC programme continues to pursue the achievement of the HTC targets through capacity building of HTC providers, quality assurance of HTC provision and community mobilization activities to encourage testing. The HTC programme has set a target of **2.8 million** clients to be tested during the implementation period. Funds are being sourced through this interim funding application for the procurement of testing commodities to support this HTC initiative during the 2014-2015 periods.

C. STI Management

The GLOBAL FUND Interim Funding will support the procurement of STI drugs and syphilis test kits that will be used to treat STI cases according to national guidelines and screening pregnant women, respectively. The Voluntary Medical Male Circumcision programme implemented in Malawi includes screening for STIs to ensure that prophylaxis for HIV exposure and STIs are distributed. The NSP target of STI cases treated according to national guidelines for 2014/15 is **53%**. This target will be maintained and will be met.

D. Blood Safety

The Malawi Blood Transfusion Service (MBTS) has the responsibility to supply adequate safe blood and blood products and promote the appropriate clinical use of blood and blood products. These strategies include recruitment and retention of voluntary non-remunerated blood donors, screening of donated blood for HIV and other infections, component preparation, maintenance of the blood cold chain; promotion of the appropriate clinical use of blood and blood products and quality assurance. MBTS will ensure that blood donation meets the annual need of 80,000 units. To process the blood MBTS will require 150,000 blood bags and 80,640 test reagents to test for HIV, Hepatitis B and Syphilis respectively.

Table 4: Activities to be implemented as part of the Interim Funding Application

SERVICE DELIVERY AREA	MAIN ACTIVITY	SUB-ACTIVITY
HTC	Provide HTC through number of delivery models	Number of tests conducted
		Procurement of HIV tests
		Implement quarterly proficiency testing for all service providers
		Conduct quality control testing at all HTC sites
		Procure Micro-vials for creation of QA / PT samples for CHSU and all HIV testing sites for national EQA programme
		Procure Vironostika Gold standard and Enzynost
STI	Screening and treating STIs according to national protocols	Treatment of STI cases according to national guidelines
		Screen pregnant women at ANC and provide treatment for syphilis
		Distribute male condoms
		Procure syphilis test kits
		Procure STI medicines
		Procure syphilis test kits
		Procure male condoms
Blood Safety	Screening of blood according to national screening guidelines	Screen blood units collected by MBTS
		Procure blood testing reagents for HIV, Hepatitis B, hepatitis C and syphilis
		Procure blood collection bags
Integrated ART/PMTCT	Expand the provision of integrated pre-ART, PMTCT, ART and OI services	Provide ARVs to adults
		Provide ARVs to children
		Procure of ARVs for adults
		Procure of Paediatric ARVs
		Procure PEP
		Procure OI medicines
	Provision of PMTCT drug regimens drugs and commodities for PMTCT	Provide ARVs to pregnant women
		Provide Family planning services
		Implement early infant diagnosis program
		Procurement of Depo-provera
Viral Load Testing	CD4 Testing during pre-ATR stage	Conduct CD4 tests during pre-ART
		Procure CD4 test kits
		Procure of CD 4 machines
		Procure RNA-PCR Reagents
		Procure DNA-PCR Reagents
	Viral load testing six months after initiation	Conduct periodic viral load testing six months after initiation
		Procure reagents and supplies for chemistry auto-analysers
		Procure reagents and supplies for haematology
		Procure reagents and supplies for haemacue machines
		Conduct testing to determine virological failure on second-line ART for adults
		Conduct testing to determine virological failure on LPV/r-based regimens (first-line or second-line) Infants and children
		Procure Laboratory consumables
		Procure blood bags
		Conduct genotypic testing of samples (Laboratory test)

2.2.2 DESCRIBE HOW THE FUNDING IS ADDITIONAL TO OR HOW IT FITS THE CURRENT SCOPE AND SCALE OF THE SUPPORTED PROGRAMME(S) (NOTE: PLEASE OUTLINE THE CHANGES TO THE PERFORMANCE FRAMEWORK I.E. THE IMPACT ON TARGETS, REGIONAL COVERAGE, OR THE DIVERSITY/QUALITY OF THE SERVICE PACKAGES).

For **Reprogramming,** clearly indicate changes to the existing programme and describe proposed new/additional activities.
For **Extensions,** clearly explain what activities are proposed to be extended and how they link to the existing programme.

This Interim Funding Application is strictly focused on critical service delivery areas that will enable Malawi to continue implementation of its highly successful Integrated HIV Programme and key supportive and preventive services (HIV testing and counselling, pre-ART, PMTCT/ART, Blood safety, STI treatment and prevention, Post-exposure prophylaxis, HIV Laboratory services, HIV surveillance). The proposed Performance Framework is an extension of the key SSF indicators and the targets follow the trajectory laid out in the current monitoring plan.

Malawi has completed the decentralization of PMTCT/ART services to all 650 health facilities during the first half of the SSF grant period. In the Interim Funding period, the National Programme will continue to focus on improving the performance of SDAs that have been identified as relative bottlenecks in the current programme:

- Improved scale and quality of Provider Initiated Testing and Counselling in all health facilities and access to scheduled CD4 count monitoring for pre-ART patients in order to increase timely ART access, which will lead to a further improvement of short and long-term ART outcomes. This impact will be evident in an increased ART retention and survival rate. 12-, 24-, 36-, 48-, 60-, 72- and 84-month ART survival and retention is routinely measured at all facilities each quarter and the 12-month retention rate has been included as a key impact indicator in the Performance Framework. Improved performance of PITC at ANC will further improve access to Option B++, which is reflected in the targeted increase of the ART coverage among pregnant women from 67% in 2012 to 77% at the end of the implementation period.
- Increased paediatric ART coverage through simplification of eligibility criteria (extension of the 'universal test & treat' policy for children from under 2 to under 5 years, following 2013 WHO recommendations). This performance improvement is reflected in the target of 50,471 children to be retained alive on ART by June 2015, which is equivalent to an increase of the estimated paediatric ART coverage from 36% in 2012 to 52% at the end of the implementation period (2013 Spectrum estimates).
- Continued scale-up of scheduled viral load (VL) monitoring for ART patients to ensure timely identification of treatment failure and access to 2nd line ART. VIRAL LOAD monitoring outputs will be directly measured in the PF through the number of VIRAL LOAD results dispatched in the implementation period.

SECTION 3: ELIGIBILITY REQUIREMENTS, PARTNERSHIPS AND MANAGEMENT RISKS

3.1 COUNTERPART FINANCING REQUIREMENTS[23]

3.1.1 DESCRIBE WHETHER THE COUNTERPART FINANCING REQUIREMENTS HAVE BEEN MET (PLEASE NOTE THAT THE COUNTERPART FINANCING REQUIREMENT TABLE IS INCLUDED IN THE FINANCIAL TEMPLATE PROVIDED WITH THE CCM INVITATION PACKAGE). IF NOT, PROVIDE JUSTIFICATION WHICH INCLUDES ACTIONS PLANNED DURING THE IMPLEMENTATION PERIOD TO MOVE TOWARDS REACHING COMPLIANCE (FOR EXAMPLE ACTIONS TO IMPROVE GOVERNMENT CONTRIBUTIONS AND/OR HEALTH SPENDING ASSESSMENT TO PROVIDE BETTER DATA).

Based on the counterpart financing template (see Table 7), which has been populated using the Malawi Ministry of Health Resource Mapping database, the GOM reaches a counterpart financing level of 18% over the life of the Global Fund SSF grant. This exceeds the 5% requirement for low income countries. GOM resources are defined as all government resources earmarked directly for HIV programmatic activities, as well as 50% of government funding directed to cross-cutting Health Systems Strengthening activities. As the HIV response receives approximately 50% of programmatic health spending in-country, it was believed appropriate to allocate 50% of the budget for systems strengthening activities (HR, infrastructure, M&E, Information Systems) to the HIV response.

In FY2013-14, GOM applied 12% of the national budget towards health. Though the denominator for this figure is not yet known for FY2014-15, the GOM has budgeted $4.1M for HIV-specific activities in the year, which will cover 2% of HIV programme costs. However, in addition to this HIV-specific spending, the GOM will provide 37% of financial and in-kind support to cross-cutting health systems that are essential in maintaining a functioning health system through which HIV-specific spending can be most effective (see Table 5).

The GOM's planned spending on HIV (which includes 50% of GOM's planned spending on cross-cutting health systems) for the FY 2014-15 is approximately $26M. Therefore, the GOM would accomplish a counterpart financing level of 23% for FY 2014-15 is $115M was granted by the Global Fund. GOM of Malawi is committed to providing a strong essential health package to support the delivery of HIV services as signified by the intensive spending on cross-cutting health systems. In addition to ensuring Malawi has a strong health systems foundation for HIV response, it has further committed $2M per year in co-financing for the NAC pool to support NAC coordinated HIV activities.

The GOM is aware that Malawi's heavy reliance on donor funding poses a risk to the sustainability of the health sector and is currently exploring options to generate more internal revenue for health, as well as the HIV response specifically, through development of the Health Financing Strategy and the HIV Financing Strategy. The HIV Financing Options have been prioritized and presented to Parliament and will be pursued in 2014. All innovative financing mechanisms together would generate $46.1M in the base year (2012-13) or 33% of the HIV financing gap, and $71.2M in FY 2020-21.

[23] http://www.theglobalfund.org/en/activities/renewals/counterpartfinancing/

Table 5: Cross-cutting Health Systems total resource envelope with contributions from government

Cross-cutting Health Systems Areas	FY13-14		
	Total Resources	GOM Contribution	% GOM
Health Workforce (salaries, allowances, trainings)	$ 68,297,383	$ 30,923,536	45.28%
Health Facility Infrastructure and Systems	$ 20,483,300	$ 6,357,294	31.04%
Laboratory Infrastructure and Systems	$ 4,539,917	$ 928,306	20.45%
Supply Chain Management	$ 2,290,159	$ 605,719	26.45%
Monitoring and Evaluation	$ 2,995,364	$ 336,205	11.22%
Health Financing	$ 3,366,185	$ 319,339	9.49%
Information Systems	$ 2,368,809	$ 152,686	6.45%
Policy Development	$ 5,417,596	$ -	0.00%
Total:	**$109,758,713**	**$39,623,086**	**36.10%**

Cross-cutting Health Systems Areas	FY14-15		
	Total Resources	GOM Contribution	% GOM
Health Workforce (salaries, allowances, trainings)	$ 73,799,344	$ 34,153,923	46.28%
Health Facility Infrastructure and Systems	$ 21,923,584	$ 6,993,023	31.90%
Laboratory Infrastructure and Systems	$ 5,014,231	$ 1,021,136	20.36%
Supply Chain Management	$ 1,993,573	$ 666,291	33.42%
Monitoring and Evaluation	$ 2,992,503	$ 369,089	12.33%
Health Financing	$ 3,429,339	$ 351,273	10.24%
Information Systems	$ 2,390,662	$ 165,849	6.94%
Policy Development	$ 5,356,411	$ -	0.00%
Total:	**$116,899,648**	**$43,720,584**	**37.40%**

3.2 FOCUS OF PROPOSAL REQUIREMENT[24]

This question is not applicable for Low Income Countries.

3.2.1 DESCRIBE WHETHER THE FOCUS OF PROPOSAL REQUIREMENT HAS BEEN MET PER THE THRESHOLD BASED ON THE INCOME CLASSIFICATION FOR THE COUNTRY.

NOT APPLICABLE

3.3 PARTNERSHIPS

3.3.1 PLEASE INDICATE THE TECHNICAL ASSISTANCE (TA), IF ANY, ALREADY RECEIVED OR CONFIRMED TO BE CONDUCTED IN THE IMPLEMENTATION PERIOD.

Malawi's national HIV response receives significant support from various partners. In a model of country ownership and donor harmonization, between the GOM, the Global Fund and other donors – all major aspects of the national response are funded. The Government covers functioning of the public health system, which includes health worker salaries. The Global Fund has historically funded the core of the public health system's HIV treatment programme through procurement of ARVs and related commodities. To ensure that the HIV system is functional other donors, including PEPFAR, UNICEF, World Bank, DFID and CHAI, provide the

[24] http://www.theglobalfund.org/en/activities/renewals/focus/

remaining inputs. These include improved programme management and performance, procurement of equipment such as CD-4 and GeneXpert machines, prevention of new infections through comprehensive prevention programming, and critical Health Systems Strengthening. Key systems strengthening inputs are: supporting health worker training and training institution capacity; developing an efficient electronic medical record system; improving Laboratory capacity; playing a leadership role in strengthening the supply-chain management system for HIV commodities, and working with the GOM to strengthen the Central Medical Stores (CMS).

Examples of TA provided during the implementation period include the following:

- PEPFAR is the major donor supporting the scale up of VMMC services. USAID is the primary funder of other critical prevention and care services including community support and follow up services, the creation of peer counselling and support groups and mobilization for home based care.
- USG, UNICEF, MSF, and CHAI have a presence in all districts in Malawi and are working to strengthen district based support for service delivery at the facility levels. To ensure quality HIV data is collected and corrections in quality improvements made possible, partners support the MOH's Clinical Mentoring Programme, CDC provides funding to the MOH to do quarterly supervision to all sites providing ART/PMTCT services in Malawi.
- Currently the HIV commodities are managed through a system parallel to the national health commodities management by Central Medical Stores Trust (CMST). While CMST improvements are being supported by GOM and USG, additional support from PEPFAR, in the form of a dedicated HIV Logistics TA and a support team, has led to significant strengthening of the HIV supply chain coordination from within the MOH HIV Department.
- CHAI will support the purchase of 80 Point of Care CD4 machines.

To ensure appropriate financial management and administration of Global Fund grants in the country donors provide in-country assistance by providing capacity building assistance to PRs and SRs as needed, and by ensuring that all parties on the ground, from the CCM to PRs and sub-PRs, understand the principles, rules and regulations of the Global Fund. For example, in order to improve management and coordination of the current SSF grant, the Global Fund requested that NAC conduct a capacity needs assessment, which identified several positions to be filled at NAC. The USG will support technical assistance positions: procurement, HIV programmes coordinator and a Global Fund coordinator. DFID will also provide a technical assistant for M&E throughout the implementation period.

3.3.2 DESCRIBE ANY CURRENT GAPS AND/OR NEEDS IN THE CAPACITY BUILDING THAT ARE NOT BEING MET BY THE EXISTING TA PROVIDERS.

As described in the section above, most of the areas requiring TA support are currently covered and this support is expected to continue during the implementation period of this application. However, there are other specific areas at Sub-recipient (SR) level as identified by the Capacity Building Action Plan that will require focused support. Most of the sub-recipients lack financial management and reporting capacity. While a Fiscal /Systems Strengthening Agent has been recruited in response to the Global Fund's requirements, it is envisaged that on-going capacity building at the SR level will be required due to high staff -turn over in order to ensure sustainable grant management and implementation.

3.4 GRANT RISK MANAGEMENT

3.4.1 PLEASE COMMENT ON THE MAJOR ISSUES AND POTENTIAL RISKS TO THE GRANT IMPLEMENTATION. THESE MAY BE SPECIFIC GRANT MANAGEMENT OR QUALITY OF DATA OR SERVICES RELATED ISSUES. DESCRIBE HOW YOU PLAN TO ADDRESS THOSE RISKS AND MONITOR PROGRESS IN THE IMPLEMENTATION PERIOD.

Table 6: Risk Management

No.	Risk Category	Risk Description	Rating	Trend	Risk Treatment / Action Plan Reason for Change	Progress Monitoring Indicator	Accountabilities	Timelines
1	Financial	Low absorption rate due to delayed disbursements and leading to significant undisbursed balances at the close of grant	High	⇔	PRs will intensify fulfilling conditions precedent and meeting general requirements	Percentage of CPs and STC fulfilled	NAC	31st Dec 2013
2	Supply Chain	Weak controls in management of test kits	High	⇩	Test kits have been made a controlled commodity by MoH and there is improvement in stock management and documentation.	Number of test kits distributed versus number of tests conducted	MoH	31st Dec 2013
3	Supply Chain	Delays in completion of CMST central warehouse affecting storage capacity for medical supplies	High	⇧	PR to meet requirements for unlocking GLOBAL FUND contribution to finalization of the warehouse and to ensure GOM meets commitment towards construction of the warehouse.	Completion of the CMST central warehouse	NAC/ CMST	31st Oct 2013
4	Supply Chain	Inadequate storage and warehousing space at health facility level	High	⇔	Develop a comprehensive plan to improve storage and warehousing space at health facilities	Comprehensive plan for storage and warehousing developed	MOH/CMS	31st Dec 2013
5	Supply Chain	Uncertainty over the future of MANOBEC Warehouse	Medium	⇔	PR and CMST to conclude discussions with the GOM on the future of MANOBEC Warehouse	Written commitment from GOM to support operational expenses for the warehouse	NAC/ CMST	31st Oct 2013
6	Supply Chain	Weak Logistics Management Information tracking system and parallel supply chain for HIV commodities	Medium	⇩	Training, support supervision and mentoring of pharmacy personnel in LMIS, Integration of the storage and distribution of drugs for the two diseases (Malaria and HIV),eLMIS Electronic management system to strengthen logistics information system	Officers trained, supervised and mentored in LMIS Consolidated storage and distribution of commodities; Installation of electronic LMIS system	NAC/ MOH	31st March 2015
7	SR management	Huge SR portfolio	Medium	⇔	Reduction of SR portfolio to a manageable level based on capabilities and risks Competitive selection of SR for the new grant	Reduced number of SRs	NAC	31st Dec 2013
8	Audit	Outstanding OIG recommendations	Medium	⇩	Constant follow up by the CCM on progress in meeting OIG recommendations	Percentage of OIG recommendations addressed	NAC/ MOH	31st Dec 2013
9	M&E	Under-reporting for Community Based HTC	Medium	⇔	Integrate/develop routine reporting mechanisms for Community Based HTC	Routine Community Based HTC reporting mechanisms developed	MOH/NAC	31st March 2014

SECTION 4: FINANCIAL REQUEST

Please note that the financial information required for this section is in the Financial template provided with the CCM Invitation package Renewals Financial Template_FinancialRequest_Resources-avaiLaboratoryle *– the CCM must paste a screenshot of the information to this section in the CCM Request template (Word document) by selecting the relevant cells in Excel and using Paste option in Word to insert as a picture. The Financial Request must be filled out in the Excel file only. Do not edit the table after pasting it here!*

4.1 PROVIDE JUSTIFICATION FOR THE REQUESTED INCREMENTAL AMOUNT IN LIGHT OF THE PRS ABSORPTIVE CAPACITY, PAST PERFORMANCE, ACTUAL EXPENDITURES TO DATE, BUDGET ASSUMPTIONS AND THE PROPOSED STRATEGY FOR THE IMPLEMENTATION PERIOD.

PRs Absorptive Capacity and Actual Expenditures

Expenditure on the SSF budget to Dec 2012 (based on submitted draft EFR) was US$72,187,791.02 out of a budget of US$122,757,943.38, representing 59% absorption. On the other hand, disbursements for year one budget stood at 71% of the budget. This was largely due to lack of disbursements on non-health related activities. In order to accelerate disbursement and utilisation of funds the PR is collaborating with the Global Fund to resolve all outstanding CPs and STCs. The programme will be successfully implemented during the grant period with the resolution of some of the CPs and STCs, with specific reference to PSM such as central warehousing, consolidated storage and distribution.

Budget Assumptions

The budget for the programme is based on up to date unit costs as well as realistic programme targets. The PR has been using the Global Fund's Voluntary Pooled Procurement (VPP) for procurement of health products during the SSF grant period. Recent price quotations for health products and related PSM costs have been used in order to develop a realistic budget. In addition, the targets used as the underlying assumption for the budget have been informed by the existing NSP. Wherever necessary, most recent programme data results have been used to forecast realistic targets for the implementation period.

Past Performance and Proposed Strategy

As indicated in the body of this application, the focus is largely for the support of the ART/PMTCT programme and the other critical enablers such as HTC. The resources requested will be utilised for procurement of health products and the related PSM costs to support the programme, an area where the PR has already demonstrated the capacity to absorb the committed resources. In addition, the latest performance rating for the programme was B1 (adequate) as explained under section 1.2.2 above. It is envisaged that this rating will improve with the specific focus on biomedical interventions, whose implementation arrangements and reporting mechanisms have improved over time. The Interim Funding will be used to harness and consolidate gains already achieved in the programme and maximise programme impact and outcomes through scaling up and quality improvements in the programme.

The proposal aims at scaling up programme coverage especially for ART/PMTCT and HTC. This has implications on human resource requirements, among other factors. The MoH\HIV&AIDS Department has an on-going in-service training for ART/PMTCT service providers that have been implemented alongside the growth of the programme. This approach will continue during the implementation period in order to cope with the anticipated increase in work load at the respective service delivery sites. In addition, the Ministry, with support from PEPFAR and other partners, recently embarked on an intensive training programme for HTC providers, following the recommendations from the HTC programme evaluation. This will not only increase the number of service providers, but also address quality challenges that were experienced previously.