Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Concept Note for Early Applicants

This concept note template is to be completed by early applicants invited to request funding from the Global Fund in 2013 during the transition to the new funding model. For more information on how to complete the concept note, please refer to the Concept Note Instructions.

The concept note details the applicant's request for Global Fund resources in a disease area (and/or health and community systems strengthening) for the next three year period. The concept note should articulate an ambitious and technically sound response, drawing from the Health Sector Strategic Plan, National Strategic Plans and other appropriate documentation. It should include a prioritized full expression of demand to maximize impact against the disease(s).

There are five different sections of the concept note:

Section 1: How the application development process complies with CCM Eligibility Requirements.

Section 2: An explanation of the country's epidemiological situation and the current legal and policy environment, and how the National Strategic Plan responds to the country disease context.

Section 3: How existing and anticipated programmatic gaps of the National Strategic Plan have been identified.

Section 4: How the funds requested will be strategically invested to maximize the impact of the response.

Section 5: How the program will be implemented.

This concept note is specifically designed for early applicants and does not represent the final template to be used for the full roll-out of the new funding model. The concept note template will be revised to reflect feedback received during the transition phase.

OVERVIEW: Summary Information			
Applicant Information			
Country	**Myanmar**		
Applicant Type	**CCM**	**Component**	**Malaria**
Funding Request Start Date	**2013**	**Funding Request End Date**	**2016**

Funding Request Summary			Currency of Funding Request		USD
Component:			Malaria		
	A=Existing (Global Fund grants)	B= Incremental Funding Request (Indicative)	C= Funding Request (above indicative)	A+B= Existing and total Incremental Indicative Funding Request	A+B+C = Full Request
2013	**11,772,504.90**	0	**491,344.00**	**11,772,504.90**	12,263,849
2014	**11,148,054.30**	0	**21,828,473.51**	**11,148,054.30**	32,976,528
2015	**11,393,965.80**	0	**21,514,959.05**	**11,393,965.80**	32,908,925
2016	0	**26,040,000.00**	**6,010,653.77**	**26,040,000.00**	32,050,654
Years 1-4 Totals:	**34,314,525.00**	**26,040,000.00**	**49,845,430.33**	**60,354,525.00**	110,199,955.33

Confirmation of Program Split for Indicative Funding

This question is only relevant for early applicants invited to submit funding requests for more than one disease.

During country dialogue, the applicant will decide how best to distribute indicative funding across relevant disease programs and HCSS. Please provide the original indicative program split as communicated by the Global Fund and if relevant, the split approved by the Global Fund following country dialogue.

Program	Original Indicative Program Split Amount (USD)	Approved Program Split Amount (USD)
HIV	39.5 million	39.5 million
Malaria	26 million	26 million

Tuberculosis	24 million	24 million
HCSS		
Total Indicative Funding	89.5 million	89.5 million

SECTION 1: CCM Eligibility Requirements and Dual Track Financing

Two of the six CCM Eligibility Requirements relate to application development and Principal Recipient (PR) selection processes and will be assessed as part of the concept note:

a. **Requirement 1 –** Application development process

b. **Requirement 2** - The Principal Recipient(s) selection process.

For each Requirement, applicants must provide evidence of compliance and attach relevant supporting documentation. Please also fill in and attach the **CCM Endorsement** (Attachment 1).

1.1 Application Development Process (Requirement 1)

Please describe:

a. The **documented and transparent process** undertaken by the CCM to **engage** a broad range of stakeholders, including non-CCM members, in the application development process.

b. The efforts made to engage **key population groups**[1], including most-at-risk populations[2], as active participants in the country dialogue and application development process.

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a) The Myanmar CCM (M-CCM) engaged a broad range of stakeholders, including non-CCM members in the application development process. The M-CCM follows as established procedure in developing applications: the M-CCM Secretariat together with relevant Technical Strategy Groups (TSG) of the M-CCM organizes information briefings, consultations, workshops, and proposal writing working group meetings to produce draft proposals or concept notes for review and endorsement by the M-CCM. For the development of this New Funding Model (NFM) Concept Note, the Malaria TSG conducted a series of meetings in 2012 and 2013 (27 September 2012, 6 March and 1 April 2013- Attachment A, B, C).

During a TSG meeting on 27 September 2012 the principle of concept note was developed. The draft of first round concept note was reviewed and concurred by TSG

[1] **Key population groups** include: women and girls, men who have sex with men, transgender persons, people who inject drugs, male and female and transgender sex workers and their clients, prisoners, refugees and migrants, people living with HIV/AIDS, adolescents and young people, vulnerable children and orphans, and populations of humanitarian concern (Guidelines and Requirements for Country Coordinating Mechanisms).

[2] For the purpose of the transition to the new funding model (GF/B28/DP5), most-at-risk populations will be defined as subpopulations, applying to HIV, malaria and tuberculosis, within a defined and recognized epidemiological context:

1) That have significantly higher levels of risk, mortality and/or morbidity;
2) Whose access to or uptake of relevant services is significantly lower than the rest of the population; and
3) Who are culturally and/or politically disenfranchised and therefore face barriers to gaining access to services.

members through e-mail communications. Subsequently the malaria concept note was endorsed by M-CCM on 18 October 2012 prior to submission to GFATM on 23 October 2012 (along with Concept notes for HIV and TB). The Malaria Concept Note was reviewed by the Global Fund Technical Renewal Panel in February 2013. M-CCM/ Chair received an invitation letter from the Global Fund on 1 March 2013 to become an early applicant in the New Funding Model.

In 2013 following the dialogue with GF country team a meeting was conducted by CCM secretariat on 6 March 2013 for all TSG chairs and conveners. The Malaria TSG meeting was immediately conducted on 6 March 2013 to prepare for submission of Concept Note as an early applicant and the Mekong Regional Concept Note on artemisinin resistance containment. The working group consisted of some TSG members participated in the NFM training workshop conducted by GFATM country team on 14-15 March and 18-19 March 2013. The working group drafted the Malaria Concept Note (offline and online portal).

The Malaria TSG meeting was conducted on 1 April 2013 where TSG members and partners reviewed the draft NFM concept note and provided feedback. The main discussion was on key interventions (scale-up ITN/LLIN and case detection, and expansion of Volunteer network) and harmonization of the Country split Concept Note with the upcoming Mekong Regional Containment Concept Note.

The process was transparent and inclusive of a broad range of stakeholders (local NGO, international NGO, bilateral partners, CBO, UN agencies and government). The M-CCM and TSG are multi-sector forums (M-CCM member list and TSG member list: Attachment D).

b) As mentioned above, M-CCM members consisted of a broad range of stakeholders. Malaria TSG members representing organization related to implementation of malaria control projects in the country. Key population at risk of malaria were clearly defined from malaria database of the National Malaria Control Programme (NMCP-VBDC) and supported by implementing partners who have extensive experience in field work and have exposure to population at risks including underserved population**.**

1.2 Principal Recipient (PR) Nomination and Selection Process (Requirement 2)

Please describe:

a. The documented and transparent **process and criteria** used to nominate any new or continuing PR(s).

b. How any **potential conflict of interest** that may have affected the PR(s) nomination process was **managed**.

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The PRs nominated for the Concept Note are the same ones from the previous GF grants for HIV, TB and Malaria: UNOPS and Save the Children. There is no new PR.

For a summary of the documented and transparent process and criteria used to nominate PRs for Round 9, (Attachment E: 4th M-CCM meeting minutes).

1.3 Dual-track Financing

Dual-track financing refers to a proposed implementation arrangement that involves both government and non-government sector PRs. If this funding request does not reflect dual-track financing, please explain why. If your funding request includes dual-track financing, please leave this section blank.

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This funding request does not reflect dual-track financing as Myanmar does not have a

government sector PR. UNOPS acts as a PR on behalf of government. However, it is anticipated that given the current changes in Myanmar, a transition to government sector PR is being considered. Technical assistance will be provided to the National Malaria Control Programme and government sector to enable the transition to take place.

SECTION 2: Country Context

2.1 Country Disease Context

Explain the current and evolving epidemiological situation of the disease in your country. Refer as appropriate to the Performance and Impact Profile provided by the Global Fund, as well as other recent program reviews or relevant sources. Highlight the concentration of burden among specific population groups and/or geographic regions and any recent disease pattern changes (incidence or prevalence).

In your response, describe:

a. **Key affected populations** that are epidemiologically important and may have disproportionately low access to prevention and treatment (and for HIV and TB, care and support services).

b. Factors that may cause **inequity in access to services** for treatment and prevention, such as gender norms and practices, legal and policy barriers, stigma and discrimination, poverty, geography, conflict and natural disasters.

c. **System-related constraints** at the national, sub-national and community levels in reducing the burden of the disease.

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Most of malaria transmission in Myanmar occurs in forested foothill zones and international borders. Based on ecological determinants of malaria and long-term malaria data, the country has been divided into areas of no risk, low, moderate and high risk for malaria. Approximately 75% of population resides in malaria risk villages. Eighty out of the 284 malaria endemic townships already considered high risk of malaria. Although malaria burden is consistently decreasing in Myanmar, the country has one of the highest malaria burdens in SE Asia. Malaria is one of the priority diseases in the country, with a morbidity of 10.6/1,000 population and mortality of 1.2/100,000 population *(Health in Myanmar 2011)*.

Approximately, a 23% reduction in malaria morbidity was observed in 2011 compared to 2010, the lowest malaria morbidity in the last 5 years. It is estimated that 632,000 malaria cases – 557,000 blood-confirmed and 75,000 probable cases – were reported in 2011 (*Source: PR UNOPS and PR Save the Children*). The disease, however, continues to be underreported, as the above figures were estimated from the reports of the NMCP and NGO partners of the GFATM Round 9 grant, but data from several NGOs and the private sector are still missing. Case detection has been scaled-up since 2007 with the financial support of the Three Diseases Fund, the GFATM Round 9 (since 2011), and the introduction of rapid diagnostic tests that can detect *P. falciparum* and *P. vivax* malaria (Combo RDT).

Malaria mortality continues to decline. The total number of malaria deaths in 2011 was 581 as compared to 3331 in 1999 and 1261 in 2007. The proportion of *P. falciparum,* decreased from 83% in 1999 to 71% in 2007 to 68% in 2011 (*source: NMCP August 2012)*. While the number of malaria deaths is most likely underestimated, it is believed that the declining

trend is a true picture of the malaria mortality in the country, as the reporting system has remained unchanged. The case fatality rate has been reduced by 50% (from 3.23% in 1999 to 1.6% in 2011), reflecting the impact of the scale up of case detection and treatment in the country. *P. falciparum* resistance to various antimalarial drugs has been observed in Myanmar. In 2009-2010, early signs of *P. falciparum* resistance to artemisinin, characterized by prolonged parasite clearance time, were reported in at least three States/Regions (Mon, Tanintharyi and Bago-East) and suspected evidence of artemisinin resistance was reported in Kachin, Kayah and Kayin States. Though the country detected only early signs, lessons learned from Thailand-Cambodia indicated that the resistant strains might have spread from these two countries through population movement. As an emergency response a strategic framework to contain the resistance strains was developed and endorsed in 2011 and containment actions were initiated in mid-2011. Emerging artemisinin resistance is seen as a regional and global threat, with fears that strains may spread to other parts of the country, especially as there is a lack of detection through regular drug resistance monitoring at sentinel sites.

The external evaluation of the NMCP was conducted during 30 July – 9 August 2012. The review team acknowledged the tremendous effort in malaria control in Myanmar over the past 6 years which resulting in a rapid increase in intervention coverage and improving timely service delivery at the village level (Ref: Report of the Ext Evaluation-Attachment F). The review team reported the evidence of a significant reduction in the malaria incidence consequent to increased intervention coverage in several states/regions.

A) Key affected populations: Most malaria cases and deaths probably occur among people residing in villages near or in the forests, foothills. Forest, rubber and palm oil plantation, and mining-related malaria transmission persists in many parts of the country, particularly at its international borders. These people are usually national races living from subsistence agriculture supplemented by forest activities, such as cutting bamboo or rattan or production of charcoal. Generally, in villages located within 1-kilometer distance from the forest malaria transmission occurs in the village itself during part of the year, with all age-groups being at risk. In villages located at somewhat greater distance from the forest, the risk is usually confined to adult men, who enter the forest periodically for agriculture, forest produce gathering, hunting etc. Malaria data base in 2011 indicated that male cases accounted for some 65% of total blood confirmed cases. The other major risk group is internal migrants, who are often induced by economic opportunities such as logging or mining in forested areas or road or dam construction etc.

B) Factors that may cause inequity to services for treatment and prevention: There are several population groups, which are poorly served by the health system and malaria services such as those living in remote border areas, migrant populations, forest workers and miners where malaria transmission is intense. Many of them are internal and external migrants who usually have limited access to malaria prevention and control. Major factors include distance from health facilities and poor awareness of malaria and its prevention.

C) system related constraint:

Firstly; Myanmar is classified as a “low income” country by the World Bank and a “least developed country” by the United Nations, with a Gross National Income per capita in 2009 of USD 379.60. The health sector in Myanmar has long been underfunded, with public spending at levels under 1 percent of GDP. Total spending on health stands at 1.3 percent (2011) of GDP, or US$ 2 per person per year. Out-of-pocket payments constitute about 85 percent of total spending on health, followed by public spending (around 10 percent) and external development assistance (around 5 percent). Overall development assistance is the second lowest per capita amongst low-income countries. This is further complicated by the

internal conflict that caused extensive damage, these limited resources have translated to very low levels of basic services.

Secondly; The physical barrier which is due to nature of the disease which is very much related to forest settings. This includes long distance between residences of population at risk of malaria and health facilities, road cut off during rainy seasons. Malaria volunteer network was established in order to improve access of treatment and prevention to these hard-to- risk population.

Thirdly: Health system challenges seriously undermine the capacity of the public sector in Myanmar to deliver basic health services. Inadequate funding for the health sector is a fundamental problem, but that is not the only concern.[3] Shortage of essential drugs and supplies poses one of the main barriers to provision of basic services. The supply chain system is not well developed, and there are problems with storage and distribution of supplies, especially to facilities at township level and below. The health information has many weaknesses and there are gaps in data from the community level and from hard-to-reach areas. Analysis and use of data at township level is limited. There are significant gaps in knowledge, and not much is known about health-seeking behavior. A multiplicity of programmes and projects, with separate planning, management and monitoring arrangements, contributes to inefficiencies and fragmentation in service delivery. Users have little influence on decisions about or delivery of health care. Much of the growing private sector is unregulated. Shortage of trained medical staff poses a particular challenge, one that is only exacerbated by low levels of remuneration, low morale and high turnover in rural areas. In-service training is mainly provided by projects and programs, and poorly coordinated. The heath infrastructure is poor, and many facilities require upgrading and refurbishment. Public hospitals lack many of the basic facilities and equipment. Transport is inadequate to ensure effective service delivery, supervision and monitoring, and referral for mothers and children who need emergency care.[4]

2.2 National Strategic Plan

Briefly describe your National Strategic Plan and how it addresses the country disease context described in 2.1.

In your response, please describe:

a. The **goals, objectives and priority interventions** of the National Strategic Plan, placing emphasis on their **on-going relevance** and any planned or needed revisions over the lifetime of the Funding Request.

b. The **current stage of implementation** of the National Strategic Plan and the country processes for reviewing the Plan. If you are in the last 18 months of the period covered by the National Strategic Plan, please explain the process and timeline for the development of a new plan.

c. The **main findings of, and response to,** any recent assessments and/or program reviews.

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[3] Pe Thet Khin, Minister of Health, Myanmar, listed the country's most pressing challenges to be a severe shortage of health care workers and qualified health educators, inadequate health care facilities and substandard maternal and child health care. "We need to have a strong, well trained and motivated workforce," said Pe Thet Khin, who characterized the quality of health care education in his country as "compromised," a word he also used to describe the health care provided at the more-than 900 medical facilities throughout the country. Quote from the address by Pe Thet Khin at Johns Hopkins on April10, 2012, last accessed http://www.jhsph.edu/news/stories/2012/Pe_Thet_Khin_visit.html on September 30, 2012 at 11a.

[4] Multi Donor 3MDG Fund, Description of Action, 2012-2016

The Global Fund Round 9 phase II and programmes proposed in this NFM Concept Note are fully aligned with the National Strategic Plan for Malaria 2011-2015.

The National Strategic Plan (NSP) for the period 2011-2015 was developed by the National Vector Borne Disease Control (VBDC) Programme of the Ministry of Health (MOH) in collaboration with bilateral and multilateral development partners, NGOs and INGOs. It draws on the policy and strategy documents on health and malaria control issued by the MOH and development partners. It is guided by the Myanmar National Health Policy and the Regional Strategy for Malaria Control for South-East Asia (WHO/SEARO), which was updated in 2005.

The analysis of various background documents and reference materials, including the output of the Expanded Malaria Technical and Strategy Consultative Meeting in April 2009 provided an invaluable source of information for developing the Strategic Plan.

Generally the NSP in Myanmar is in accordance with the recommendation of the WHO Global Malaria Programme (GMP). They also reflect the Regional Strategy for Malaria Control in the WHO Region for South-East Asia (WHO/SEARO 2005)

In 2010, due to the emergence of Artemisinin resistance in several states/regions at the border with Thailand a strategy to contain resistance was developed through consultation with partners. The Myanmar Artemisinin Resistance Containment Framework (MARC) was endorsed in April 2011.

The MARC is regarded as a part of the National Malaria Control Strategy. The interventions under the containment operations are primarily targeted in the artemisinin affected areas.

The NSP was updated through consultative process of the Malaria Technical Strategic Group (TSG) in September 2012 incorporating the Myanmar Artemisinin Resistance Containment (MARC) Framework.

A) The followings are goal, objectives and key interventions of the NSP:

Goal
The Goal of malaria control in Myanmar is to reduce malaria morbidity and mortality by at least 50 per cent by 2015 (baseline: 2007 data), and contribute towards socio-economic development and the Millennium Development Goals.

Objective 1

By 2015, at least 80% of the people in high and moderate risk villages in 284 malaria endemic townships (212 priority townships) are protected against malaria by using ITNs/LLINs complemented with another appropriate vector control methods, where applicable. In artemisinin resistance affected areas, the target coverage is 100% of total population at risk

Objective 2
By 2015, malaria cases in each township receive quality diagnosis and appropriate treatment in accordance with national guidelines preferably within 24 hours after appearance of symptoms.

Objective 3
By 2015, in 284 malaria endemic townships (270 priority townships) the communities at risk actively participate in planning and implementing malaria prevention and control

interventions.

Objective 4
By 2015, the Township Health Department in 284 malaria endemic townships (270 priority townships) are capable of planning, implementing, monitoring and evaluating malaria prevention and control program with management and technical support from higher levels.

Key interventions

1) **Protection by the use of LLINs**

a. For high and moderate risk villages: distribution of LLINs to achieve full coverage of at risk populations through mass campaigns.
b. For high risk villages in the event of resource constraints: distribution of LLINs to achieve full coverage of populations at risk through mass campaigns.
c. For high and moderate risk villages: mass retreatment of available mosquito nets with insecticide and preferably long-lasting insecticidal retreatment kits.
d. For all population at risk in artemisinin resistance affected areas (Tier 1: of MARC framework): distribution of LLINs or retreatment of nets with long lasting insecticide retreatment kits and aim at 100% population coverage. Priority is given to migrant population.

All high and moderate risk villages in the 212 priority Townships will be targeted. For the artemisinin resistance affected areas, Tier 1 areas (with strong evidence of resistance) are of highest priority. The zonation of areas according to artemisinin resistance should be updated on yearly basis. As fund is always insufficient, for full coverage of entire population at risk, LLIN delivery will be provided for full coverage in stratum 1a. (High risk). The number of LLINs required will be based on 1 LLIN per two and a half persons[5].

2) **Personal protection**: Other preventive measures (Insecticide treated blankets, mosquito repellents, etc) for special groups such as forest related workers and those engaged in rubber tapping will be studied.

3) **Selective application of indoor residual spraying (IRS)**: IRS will be done in development project sites, resettlement areas and other epidemic prone areas to prevent and contain malaria outbreaks. The IRS will be applied in combination with ITN/LLIN in artemisinin resistance areas in order to achieve highest protection.

4) **Strengthening and expanding case management in the public sector**: The key activities are supply of Combo (Pf & Pv) RDTs to all health facilities in malaria risk areas in each Township as well as services managed by NGOs, CHWs and other volunteers.

5) **Quality assurance system for RDTs and microscopy quality contro**l: Only pre-qualified Combo RDTs should be procured for use. A system has already been started on checking received lots of RDTs and collection of samples in the field.

[5] Due to financial constraints, beside prioritization of geographical areas, the target coverage was adjusted. The target net coverage which was set in 2009 could not fully follow WHO guideline but was adjusted to meet with the available resource. Instead of having one ITN/LLIN per 2 persons it was planned to start with having at least one ITN/LLIN per household (1 net per 5 persons) and subsequently one ITN/LLIN per 2.5 persons (average 5 persons/HHs). In the artemisinin resistance areas (MARC areas) where the highest protection should be rapidly achieved, a higher coverage (1 net/2 persons) was set as more fund was made available in 2011. It is anticipated that coverage could be increase enormously in all endemic areas to meet with WHO standard as more funds (NFM, etc) are available. For procurement purpose, in order to ensure target coverage of net per WHO guideline, it is proposed to calculate 1 net for 1.8 persons.

6) **Provision of antimalarial medicines**: Antimalarial drugs recommended as per national policy for treatment of malaria will be provided.

7) **Training on malaria case management** for the different categories of health staff in the public sector.

8) **Establishing/empowering Village health volunteers (VHV)** on diagnosis and treatment in areas where access to health facilities is difficult.

9) **Operating mobile clinics/outreach services** in selected areas to reach out to remote communities.

10) **Expansion of appropriate case management by improving the practices of the private sector**

11) **Behavior Change Communication**

(Detailed interventions in the attached NSP)

B) The current stage of implementation: The Country has developed the present NSP (2011-2015) in 2009 and is now in the third year of its time frame with the recent updating in September 2012. Due to the additional year (2016) of the present Concept Note that goes beyond the timeframe of the present NSP and rapid changing of malaria situation as well as potential decline of malaria incidence following injection of powerful intervention, there is a plan to review and update NSP in late 2013 or early 2014.

C) The main findings of and response to any recent assessments and or/programme impact reviews: The external evaluation of NMCP was conducted in August 2012. The annual evaluation of the Myanmar Artemisinin Resistance Containment (MARC) was conducted in June 2012. Moreover, WHO Global Malaria Programme (GMP) is preparing a Mekong Regional Emergency Response to Artemisinin Resistance (ERAR) through regional consultation and will be launched in April 2013. The recommendations of these evaluations provide basis for the next revision of the NSP.

Key recommendations of External Programme Review (August 2012)

1. Strengthen the VBDC/NMCP at central and state/regional levels:
2. Finalize the National Strategic Plan and prepare an integrated Annual Malaria Operational Plan to include all implementing partners at central, state/regional and township levels.
3. Sustain current intervention coverage levels and rapidly expand coverage to highly endemic, currently poorly served areas and populations and high-risk groups
4. Stringently monitor the impact of the MARC project on malaria transmission in the states/regions

etc

2.3 Implementation of the National Strategic Plan

Please describe the **implementation progress** of your National Strategic Plan, referring as appropriate to the Performance and Impact Profile provided by the Global Fund as well as any recent evidence from program reviews, evaluations and relevant surveillance surveys.

In your response, include:

a. The **priority interventions** that are currently being implemented.

b. The **outcome and impact** achieved to date by these priority interventions.

c. The **key stakeholders** involved in the implementation.

d. Any **limitations** of the response to date and the **lessons learned** informing the design of future interventions.

e. Any **limitations** in **national data systems** to measure and demonstrate impact.

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a) Priority interventions that are currently being implemented:

In the NSP, there are three priorities interventions contributing to reduction of malaria morbidity and mortality; 1) Malaria prevention through scaling up ITN/LLIN; 2) Strengthening and expanding case management in the public and private sector and community volunteers; 3) Activities on behavioural change communication (BCC) and a supportive intervention, i.e. 4) capacity building at all levels including community volunteers.

Due to the recent emergence of Artemisinin resistance in several eastern borders the Framework on Myanmar Artemisinin Resistance Containment (MARC) was developed and endorsed as part of the NSP in 2011. In principle, MARC Framework proposed intensification of malaria control and added several containment specific interventions that are in line with the Global Plan on Artemisinin Resistance Containment (GPARC) 2011 (*e.g., reduction of drug pressure by phasing out artemisinin monotherapy by subsidized price ACT in private sector, strengthen drug regulatory action of FDA, targeting migrant population and applying malaria protection for outdoor transmission settings, etc*).

The Phase II Rd 9 and the present NFM Concept Note are very much aligned within the scope of NSP and the MARC framework.

b) Outcome and impact achieved by these priority interventions:

It was observed that morbidity and mortality of malaria is declining (ref to Section 2.1). . Approximately, a 23% reduction in malaria morbidity was observed in 2011 compared to 2010, the lowest malaria morbidity in the last 5 years. The total number of malaria deaths in 2011 was 581 as compared to 3331 in 1999 and 1261 in 2007**.** While the number of malaria deaths is most likely underestimated, it is believed that the declining trend is a true picture of the malaria mortality in the country, as the reporting system has remained unchanged. The case fatality rate has been reduced by 50% (from 3.23% in 1999 to 1.6% in 2011), reflecting the impact of the scale up of case detection and treatment in the country.

Coverage of key interventions significantly increased. **Coverage of ITN/LLIN** (% HH with at least one ITN/LLIN) increase from 19.9 % in 2011 (prior to GFATM Round 9 net distribution in Phase I) to some 74 % by end of Phase I in 2012 (*Ref Periodic Net Survey 2012*). However, it is important to note that LLIN coverage in Myanmar is also affected by the fact that the national malaria programme can only cover **high-risk areas** (Stratum 1a), leaving behind many townships at moderate and lower risk (stratum 1b, 1c). In addition, new WHO guidelines suggesting a shorter life for LLINs will also mean a gap in the LLIN coverage 1 to 2 years earlier than anticipated (e.g., in 2014 or 2015 all LLINs distributed in 2011 will be expired and replacement of new LLIN is required). This along with the need for scale up in an extended geographical coverage (from **226** townships in Phase I to **270** townships in Phase II as recommended by the Malaria Technical Strategic Group), could mean a large gap in LLIN coverage, which the programme hopes to cover through additional funding from the GFATM NFM, 3MDGF grants and other sources

Regarding cases management; in spite of issues at the start of the grant that produced delays in procurement and distribution of commodities, both PRs and their SRs have been able to keep up with their targets, except for diagnosis (blood slides) and treatment (with

ACTs and Chloroquine) due to the decrease in malaria caseload (Ref CCM renewal request for Phase II)

The Malaria Technical Strategic Group (TSG) recommended in a meeting on 4 May 2012 that the programme is scaled up to reach underserved and highly endemic malaria areas not previously reached during Phase I in order to obtain even higher impact in malaria morbidity and mortality

c) Key stakeholders involved in implementation:

Implementing partners includes the National Malaria Control Programme (NMCP) under the Vector Borne Disease Control (VBDC) structure of the Department of Health, Ministry of Health, local NGOs and international NGOs, UN agencies (IOM, UNICEF and WHO for technical assistance), Donors (JICA). Besides there is a network of malaria implementing partners under the USAID President Malaria Initiative (PMI) that work in several border states/regions.

d) Limitations of the response to date and lessons learned:

The main factor is limitation of budget proposed in the Original Round 9 Proposal. Due to the fact that Phase I round 9 covered only 226 townships and it was proposed (TSG's recommendation) to expand geographical areas to 270 townships the existing Phase II budget is only sufficient for modest expansion of case management in new townships but not for malaria prevention which are primarily limited within the 226 townships. On top of that, the original Round 9 proposed to focus on malaria prevention among population living in high-risk areas leaving a large number of unprotected population. With regard to the recent emergence of Artemisinin resistance, it is impossible to reprogramme the existing Phase II grant to cope with the newly emerged problem as the existing grant is not sufficient for essential containment activities. With the great opportunity of the New Funding Model, the responses to the above issues are feasible.

The key lessons learned are that with the proven effective interventions malaria morbidity and mortality could be brought down swiftly; the high community acceptance to the priority interventions; the implementing partners are well responsive to implementation and could align themselves to the GFATM funding modalities.

e) Any limitations in national data systems:

Underreporting of malaria cases and deaths is main limitation. Malaria cases found in private sector are not included in the national malaria database and reports from NGOS were only started to be sent to the NMCP in 2012. Malaria deaths that occurred outside health facilities are not reported in to the HMIS.

Data quality issues and risks have been observed by both PRs and recommendations have been drafted for their next M&E plans and actions in the next three years. WHO has continued its coordination and technical assistance role, advising the national malaria control programme in the monitoring and evaluation of the program, its accomplishments and recommendations for its operational plans and in the emergence of artemisinin resistance. .

2.4 Enhancing TB/HIV Collaborative Activities

If you are submitting a **TB and/or HIV concept note(s)**, you must describe the scope and status of on-going TB/HIV collaborative activities.

a. How the funding requests will strengthen TB/HIV collaborative activities.

b. The linkages between the respective national TB and HIV programs in your country.

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Not applicable

SECTION 3: Programmatic Gap

Please complete the **Programmatic Gap Table** in Attachment 2 by identifying the gaps in coverage for three to six priority program areas consistent with the National Strategic Plan, and which will be addressed through the applicant's funding request.

All numbers in this table should relate to the size of the population groups targeted by the priority program areas, and not the financial need for the program areas.

3.1 In accordance with the **Programmatic Gap Table** in Attachment 2, describe the **assumptions, methodology and sources** used in estimating the programmatic gaps.

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As clearly mentioned in the section 2.3 b, there is a need to expand the geographical areas in Round 9 Phase II grant especially for the malaria prevention with special emphasis on the urgent need to respond to the rapid emergence of artemisinin resistance. The national effort to delay the spreading of artemisinin resistance was initially supported by the Three Diseases Fund (3DF) to kick-start the intensified effort to address resistance during mid 2011-2012 (total 31.8 million USD), and it is proposed to expand programme geographical coverage from 226 Townships in Phase I to priority 270 Townships in Phase II. The country will also receive fund from 3MDG (second phase of 3DF) focused on addressing artemisinin resistance in 2013 to complement the GF Round 9. The areas covered by 3MDG will be limited to resistance affected areas (52 Townships in Tier 2 & 2 of MARC Framework) whereas the Full request under NFM (including existing Phase II grant) will cover the entire country (270 Townships or beyond).

The M-CCM through TSG recommendations strongly supported the above principle and the support was reflected in the Malaria concept note submitted to GF in October 2012.

In this present NFM Concept Note it is proposed to seek support from GFATM to scale up the following interventions in 270 priority Townships (on top of what proposed in the Phase II – CCM request for renewal).

1) Rapid scale up LLIN/ITN to reach universal coverage of all people living in **high, moderate** and **some selected low risk areas** with threat of artemisinin resistance; and
2) Expand diagnosis and treatment services to hard-to-reach people living in **high risk** malaria areas; and
3) Essential **supportive interventions** such as Behavioral Change Communicatoins (BCC), intensified surveillance, capacity building and operational research

LLIN distribution

Based on the National Strategic plan for Malaria Control (2011-2015) in which MARC Framework as an integral part and the current achievements in Round 9 Phase I, and population breakdown by malaria risk areas programmatic gaps were identified for the

period 2013-2016; (Area stratification 2011–Table 14 of NSP is attached below and Attachment G)

Table 14: Population Living Under Various Malaria Risk Areas In State/Region (2011)

Sr	State/ Region	High Risk			Moderate Risk			Low Risk			No Risk			TOTAL	
		Ward/ Village	Population	%	Ward/ Village	Population	%	Ward/ Village	Population	%	Ward/ Village	Population	%	Ward/ Village	Population
1	Kachin	33/ 1028	889414		51/ 31	382648		26/ 33	242156		17/0	106282		127/1092	1620700
2	Kayah		125142	41.7		94645	31.6		79692	26.6			0		299679
3	Kayin	803	540424	37.0	559	490057	33.6	475	429613	29.4	0	0	0	0	1460104
4	Chin	200	315031	66.1	164	150745	31.6	59	10898	2.3			0	474	476674
5	Mon	138	64111	3.04	197	154030	7.3	664	1006066	47.7	382	886696	42.0	1381	2110903
6	Rakhine	1494	692795	22.0	1249	1070952	34.0	1251	1383901	43.9	0	0	0	3994	3147648
7	ESS	0	104878	17.1	0	81522	13.3	0	425573	69.5	0	0	0	0	611973
8	SSS	101/ 3410	1503126	63.07	46 / 761	688945	28.9	8 / 456	191288	8.0			0	154 / 4772	2383359
9	NSS		704848	34.3	858	809956	39.4	588	217891	10.6	29	321043	15.6	0	2053738
10	Sagaing	0	1804327	34.9	0	976025	18.9	0	2384757	46.2	0	0		0	5165109
11	Tanintharyi	750	624339	44.5	357	402197	28.6	148	293528	20.9	33	83571	5.9	1289	1403835
12	Bago E	360	228338		351	265641		712	566864		1474	1844236		2897	2905079
13	Bago W	0/ 953	423853	21.2	0/744	317063	15.8	0/ 1429	677745	33.9	99/686	580184	29.0	99/3794	1998845
14	Magway	757	418991	9.6	2483	2049902	46.8	601	566555	12.9	1140	1343339	30.7	4981	4378787
15	Mandalay	0/ 1257	1083479	17.3	65/61	238809	3.8	61/ 177	1644091	26.2	273/2207	3313277	52.7	408/5528	6279656
16	Yangon	154	89537	1.5	68/1841	42636	0.7	258/0	37501	0.6	326/2067	5799539	97.1	2477	5969413
17	Ayarwaddy	1637	769503	12.2	712	515090	8.2	1625	734282	11.6	7554	4298104	68.0	10510	6316979
	Grand-total		10382136	21.4		8731473	17.9		10892501	22.4		18576371	38.2		48582481

Source: Vector Borne Disease Control, Ministry of Health, 2012: Population size is based on HMIS

Prioritization of LLIN intervention: The top priority is given to LLIN distribution to population living in **high risk areas** (stratum 1a) and followed by **moderate risk areas** (stratum 1b) through out the country (270 Townships).

Therefore, the areas under this priority intervention (LLINs) include high risk areas of all 14 state/regions (=17 sub-state/regions in Table14) with special emphasis on 6 states/regions in the resistance affected areas (i.e. Bago-East, Mon, Tanintharyi and Kayah, Kayin and Kachin) (*Ref MARC Framework-map below and Attachment H*). With more fund available in subsequent years LLINs will be distributed to population in **low risk areas** with threat of artemisinin resistance (*classified as Tier 1&2 area or areas with evidence of artemisinin resistance in the MARC Framework*) as the aim of containment is to eliminate all artemisinin resistant *P.falciparum* and even all *P. falciparum* from all areas in Tier 1, and 2 regardless of level of malaria transmission.

Map of Townships in Tiers 1,2,3

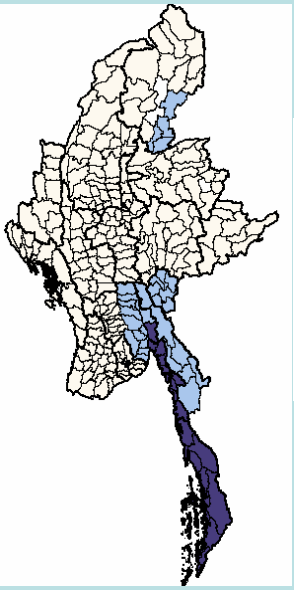

Table 1 - Overview of tiers

Tier	Area	No. of townships	Justification
1	Tanintharyi All 10 townships Mon: All 10 townships Bago East: Shwegyin township.	21	Strong evidence of suspected resistance. Widespread ecological and social risk factors. Intensive population movement.
2	Kayin State: All 7 townships Kayah State: All 7 townships Bago East: Remaining 13 townships Kachin: 4 townships	31	Unclear evidence of suspected resistance; Near suspected resistance areas in Myanmar, Thailand and China
3	Rest of country		

Expansion of case management:

It is proposed to expand diagnosis and treatment services to hard-to-reach people living in **high risk** malaria areas. The Round 9 Phase II has already proposed to expand geographical areas of this intervention from 226 Townships to 270 Townships. However, within these target townships there are underserved communities – hard-to-reach population which will not be covered if the same approach in Phase I and Phase II is applied. It is therefore proposed to seek additional support from NFM to increase access of this intervention. The approach is based on assumption that populations in high and moderate risk areas who live outside a 2-3 radius from health facilities will have limited access to malaria diagnosis and treatment services. Expansion of treatment services will be done through:

1) Expansion of village health volunteers from existing 8424 VHVs to 12,637 VHVs (50% increase). The new volunteers will be established in the hard-to-reach areas classified as above. Transport subsidy will also be provided to volunteers to subsidize their expenditures when visiting for report submission at health facilities and to compensate the loss of their income on that day.
2) Mobile clinics will be organized by public and private sectors to supplement the village health volunteers and existing health facilities.

The above approaches will be applied in high-risk areas in 270 townships

With the proposed expansion of case detection and treatment it is proposed to increase blood test (blood films and RDTs) from 1,735,938 blood test in 2013 to app. 2.5 million blood test in 2016 and treatment of 827,580 cases in 2013 to some 1 million cases in 2014 and 2015 annually. We anticipate to see decline of cases in 2016 (app 930,000 cases) or earlier.

Essential supportive interventions

Behavioral change communication (BCC) will be an integral part of the above two priority interventions. The cost of this intervention is integrated with the two priority interventions.

Disease surveillance will continued to be intensified as in Phase I and further expanded in

phase II.

Capacity building such as training of staff at all level is planned and integrated into the two key interventions.

Advanced activities that contribute to drug resistance containment will be co-supported by 3MDG fund in 2013 and Mekong Regional Containment Concept Note

Scenarios of different funding levels

The following table (full details shown in Attachment I) display the scenarios of different level of available fund:

		2013	2014	2015	2016	Total budget required (with full scheme expanded case management)
Scenario	No. of useful LLINs in place	4,243,503	5,943,503	6,992,525	7,500,000	
1	% of population in High risk (Stratum 1a) covered with LLINs	61%	85%	98%	100%	108.57 m. USD
2	% of population in Moderate risk (Stratum 1b) covered with LLINs	0%	0%	0%	4%	1.63 m. USD

Therefore with total funding of **110.2 m USD** (= Phase II grant plus NFM) for 4yrs the target coverage of LLINs should reach 98% and 100% in population in high risk areas in 270 Townships by 2015 and 2016, respectively.

If remaining of 1.6 **m USD** will increase the coverage of LLINs to 4% of the population in moderate risk areas. Townships under moderate areas that have border with high risk areas will be selected for this intervention. Financial gap remains and will be filled up by other funding sources.

In this exercise, due to financial constraint we do not propose to include population in low risk areas in Tier 1,2 (Artemisinin resistance areas) as it is of lower priority and may be covered by other funding sources (Mekong Regional Containment Concept Note, etc)

The Programmatic Gap Table (Attachment 2) along with the Attachment I on *"Justification of LLINs request from NFM Concept Note"* identified the gaps in target coverage for programme areas to be addressed through the funding request.

SECTION 4: Funding Request to the Global Fund

Please complete the questions below together with the **Modular Template** in Attachment 3.

4.1 Funding Request within the Indicative Funding Amount

Please describe how indicative funding requested and any existing Global Fund financing will be invested (or reprogrammed) during the funding request period to maximize impact. In your response, include:

a. The

objectives and expected outcomes of the funding request, and how the outcomes have been estimated and will contribute to achieving greater impact. Please refer to available local evidence of effectiveness of the programs being proposed.

b. The **proposed modules and interventions** of the funding request in order of priority, in addition to the rationale for their **selection** and **prioritization**.

c. For **consolidated funding requests**, explain how current interventions will be adapted, discontinued or extended to maximize impact.

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We are requesting full funding request for malaria, beyond the Indicative Funding amount.

Total fund requested is **110.2 USD** for the period 2013-2016.

4.2 Funding Request above the Indicative Funding Amount

Building on the applicant's funding request in 4.1, please describe and prioritize the funding request above the indicative amount, including:

a. The **additional gains, objectives** and **outcomes** that could be realized to achieve specific national goals or objectives.

b. What the **additional proposed modules and interventions** are in order of priority. Explain the rationale for this prioritization.

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a) The objective of the full funding request is to scale-up the national malaria control programme particularly to expand geographcial coverage for malaria prevention (LLIN/ITN), diagnosis and treatment services and some supportive interventions during 2013-2016.

The detailed outcomes, indicators are displayed in Modular template (Attachment 1)

b) Proposed modules and interventions

- Vector control
  - LLINs- mass campaign
  - Other vector control measures
  - ACSM (advocacy, communication, social mobilization)
  - Entomological monitoring
- Case Management
  - Active case detection, investigation and vigilance
  - Facility-based treatment

- Integrated community case management
-

- Monitoring and evaluation (M&E)
  - Administrative and finance data sources
  - Analysis review and transparency
  - Routine reporting
  - Surveys
- Programme management
  - Programme management

As clearly mentioned in section 3.1 (ref Scenario table) the indicative funding (26 m. USD) together with Phase II grant (31 m. USD) makes a total of 62 m USD could enable the programme to expand LLIN and case treatment and other supportive activities in some 80% of population in high risk areas in 270 endemic townships.

With more fund available, i.e, Full Funding request up to 110 m. USD the programme will be able to scale up the above mentioned priority interventions to cover all population in high risk areas and 41% of moderate risk areas (with full coverage of case management in 270 endemic townships by 2016.

c) The current interventions under Round 9 will be consolidated with those proposed under this New Funding Model.

4.3 Commitment to Sustainability and Additionality

Financial sustainability is important to ensure continuity of impact. In particular, implementing country governments must fulfill their obligations to sustain and increase contributions to the national response. The counterpart financing requirements of the Global Fund are set forth in the Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization (ECFP).

Please complete the **Financial Gap Analysis and Counterpart Financing Table** in Attachment 4.

a. Indicate whether the **counterpart financing requirement** has been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

b. Describe whether and how this funding request to the Global Fund will be complemented by **additional funding commitments from the Government.**

c. Describe how this funding request to the Global Fund can leverage **other donor resources**.

Minimum threshold government contribution to disease program

The CCM assumes that 2011 level of government spending will be, at the minimum, maintained in subsequent years. Applying the same assumption, the Country Team used government spending data published by WHO and the Ministry of Health to calculate the counterpart financing share. Based on current levels of government spending, the counterpart financing share is 10% and meets the minimum threshold of 5% for low income countries.

Stable or increasing government contribution to disease program

Available data on NMCP expenditures indicate that government health expenditures and malaria expenditures have significantly increased over time. With the prevailing government political and economic reform, it is confident that the Government contribution to malaria control programme will continue to increase.

Stable or increasing government contribution to health sector

In an effort to address the funding crisis, the government has quadrupled the health budget for 2012-2013 from 92 billion kyat to 368 billion kyat.[6] Out of pocket expenditure is the primary source of funds for health spending in Myanmar, accounting for 81% of the total health expenditure in 2010. External resources contributed to 9% of total health expenditure in 2010 (Global Health Expenditure Database, WHO). Despite significant increases over time, till recently government spending was around 10% of the total health expenditure. Total health expenditure has been about 2% of GDP, one of the lowest in the world. As part of the planned health sector reforms, the country is aiming to attain universal coverage by increasing total health expenditure to around 4% -5% of the GDP through tax based financing and social health insurance and bringing down out-of-pocket expenditure to 30-40% of total health expenditure (Ministry of Health, Health in Myanmar, 2012). In 2012-13 fiscal year, government has made a four-fold increase in budget allocation to health sector in line with the government's reform agenda. Share of health in government budget, which was historically about 1%, has now increased to around 3%. Given that the economy is projected to grow at over 6% (World Economic Outlook, IMF, 2012), resources are likely to be available for moving ahead with planned reforms of the health sector.

4.4 Focus of Proposal

This question is **not** applicable for Low Income Countries.

If the applicant is a **Middle Income Country,** describe how this request meets the Focus of Proposals requirement according to the threshold based on the income classification for the country.

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NOT Applicable

SECTION 5: Implementation Arrangements

5.1 Principal Recipient Information

Complete this section for each nominated Principal Recipient. For more information on Minimum Standards refer to the Concept Note Instructions.

PR 1 Name	**United Nations Office for Project Services** (UNOPS)	**Sector**	**MALARIA**
Does this PR currently manage a Global Fund grant(s) in this disease/HCSS area?		☒Yes	☐No
Minimum Standards		**CCM assessment**	

[6] Source: The Lancet, Volume 379, Issue 9834, Page 2313, 23 June 2012, doi:10.1016/S0140-6736(12)60998-2

1. The Principal Recipient demonstrates effective management structures and planning	Meets minimum standards. PR fulfils GF staffing requirements including professionals competitive at international level (e.g. Programme Coordinator, Finance Officer, M&E Officer, Procurement specialist, Logistics Officer, Quality Assurance Officer). Regarding procurement, PR conducts the procurement for both pharmaceuticals and other health products as approved by GF based on the PSM capacity assessment carried out in August 2012. A procurement and logistics monitoring sheet is being shared with CCM, all the stakeholders and partners every Monday. The LMIS submitted by the PR to the GF has now been approved. Latest quantitative indicator rating by GF for Malaria equalled B1 (P7/2012).
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)	Meets minimum standards. FPPM and PMPM submitted and approved financial and programmatic oversight plans for SRs. Quarterly reports of findings are submitted to GF including measures to address identified issues. PR provides status updates of capacity building of SRs in the area of financial management and other LNGO capacity building workshops. Summary reports on desk reviews and field visits to identify and address weaknesses. Regarding required SR M&E responsibilities, PR embarked on RDQAs, on-site data validation with submission of periodic reports, programme review meetings etc. that support indicator and target revision. PR monitors SR compliance with set agreements on eligibility of expenses.
3. There is no conflict-of-interest for the selection of the Principal Recipient(s) and Sub-Recipients	No conflict of interest has been reported by the parties concerned in terms of PR and SR selections by the CCM. A MoU has been developed between the two PRs describing how they would co-ordinate and determining the roles and responsibilities of each party in January 2011.
4. The program-implementation plan provided in the concept note is sound	Meets minimum standards. The plan of implementation provided in the concept note is aligned to the National Strategic Plan and is supported by all the stakeholders including the NMCP and WHO
5. The internal control system of the Principal Recipient is effective to prevent and detect misuse	Meets minimum standards. The internal

or fraud	control system is considered effective to detect misuse and fraud. This system is implemented through such mechanisms as: A code of conduct to which all personnel subscribe; clear delegations of authority which limit an individual from processing incompatible transactions; regular reports and reconciliations to UNOPS Regional Office; financial declarations for identified personnel; robust recruitment systems which require a thorough background check; a financial management information system (Atlas) with embedded strong and proven controls, and periodic reviews and audits by HQ for PR operations and PR compliance reviews for SRs operations.
6. The financial-management system of the Principal Recipient is effective and accurate	Meets minimum requirements. The financial-management system of the PR is considered as effective and accurate. The system can handle large budgets, and can easily produce accurate income and expenditure reports in the format desired by most donors
7. The central warehouse and the warehouses for key regions have capacity, appropriate conditions and security to store health products, and to maintain their quality	Meets minimum requirements. Renovation work of central NAP and VBDC warehouses was completed and highly appreciated during the inaugurated by HE the Minister and the General manager of the GF on 17 August 2012. The renovation work of the 3 TB warehouses of NTP Central, Lower Myanmar and National TB Reference Lab was also completed in December 2012. Besides the above, Latha warehouse originally used as Central NAP has also been renovated for NAP, For total number of 41 warehouses, ART clinics and TB/HIV sites of all three National Programmes in the States/Regions, ,iIt is expected to complete the work only by June 2013. Six new warehouses were built with financial and administrative support of the Embassy of Japan. The renovated warehouses now have enough capacity, appropriate storing conditions and access control environment. Overall 20 trainings on LMIS including TOTs were successfully completed by December 2012. LMIS trainings for malaria staff and TMOs were provided to all the States and

	Regions at their respective locations.

8. The distribution process can handle the requisition of supplies to avoid treatment / program disruptions	Meets minimum requirements. In order to avoid over/under estimation of supplies in 2012, PR forecasted the requirement considering stock in hand, pipeline supplies and expected consumption until arrival of the next orders. PR tries to minimise the stock out by encouraging borrowing among SRs. Borrowing must not take place without the prior approval of the PR and borrowed supplies need to comply with the GF QA policy. Stock Management Software has been developed and now being pilot tested by National T.B Programme and Pyi Gyi Khin in order to have a better maintenance of stocks and timely reports. The PR is also working on the preparation of the distribution plan in consultation with the National Programs, other SRs and WHO. With the implementation of the LMIS, the storage and distribution system and reporting is expected to improve. Inventory management has already improved a lot even in States/Regions and the information is being correctly filled in the stock cards/ledger.
9. Data-collection capacity and tools are in place to monitor program performance	Meets minimum standards. Updates on progress in using the Malaria M&E tool have been provided to GF in January 2012. The PR uses the national system to avoid creating parallel and sustainably system. The routine Malaria reporting and recording system is functioning well. However, the PR documented several concerns: (1) risk related data security as there is weak back up system, (2) the data management system is continue to be paper-based at state/region and below, (3) minimal data management trainings for township level staff. Despite difficulties to collect and submit documentation of a high volume of activities with vast coverage, PR provides aggregated training reports from States and Regions along with PUDR as supporting documents. FFAs directly monitor activities during disbursement visits. Attendance sheets can

	be viewed by LFA for specific trainings at the locality.
10. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	Meets minimum standards. For instance, routine stock out reports are received by NMCP from 5969 sites (P7/2012) through routine malaria information system database as a result from PR monitoring visits applying a checklist. The PR, through its Programme and M&E Unit (Performance Management Unit) also conducted RDQAs, on-site data validation, program reviews and monitoring visit for the SRs. A Database Management workshop was held in May 2012 involving WHO, NMCP and UNOPS. Each Quarter a review is held with all SRs to share lessons and review results and M&E related matters. Further, a Phase II preparation workshop was conducted with all SRs in June 2012 to draft the Phase II PF with revised indicators and targets. During Phase I, remarkable improvement in timely submission of programmatic reports have been achieved by all SRs while reporting from security compromised states/regions has been a challenge.
11. The CCM actively oversees the implementation of the grant, and intervenes where appropriate	Meets minimum standards. CCM is informed in due time of the implementation of the grant through its Technical Support Group and regular CCM meeting. Moreover, M-CCM organizes in a bi-annual basis field visit to project sites to identify best practices and bottle necks regarding GFATM implementation. CCM also has a dash board and a website to monitor and report the progress of the grants.
12. A quality-assurance plan is in place to monitor product quality throughout the in-country supply chain	Meets minimum standards. Appropriate systems/procedures are being put in place to ensure compliance with the requirement to conduct random sampling and quality control testing of health products throughout the supply chain (WHO pre-qualifications or ISO 17025 standards for laboratories). A team headed by one representative of the FDA was formed in November 2011 and TOR established for in-country quality monitoring of pharmaceuticals. The team finalized the SOPs and first sampling plan for testing of selected pharmaceuticals during the first meeting in June 2012. Samples of different key and sensitive pharmaceuticals were

	withdrawn from Yangon and Sagaing state and sent to TUV SUD Singapore a WHO prequalified laboratory for test/analysis. The TUV SUD declared all the drugs samples are of standard quality. The PR is in the process of establishing a LTA with a qualified Lab.

SECTION 5: Implementation Arrangements			
5.1 Principal Recipient Information			
Complete this section for each nominated Principal Recipient. For more information on Minimum Standards refer to the Concept Note Instructions.			
PR 1 Name	Save the Children	**Sector**	**MALARIA**
Does this PR currently manage a Global Fund grant(s) in this disease/HCSS area?		☒Yes	☐No
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		Yes, the PR demonstrated effective management structures and planning in regard to management letters sent by GFATM. Save the Children has a team of 30 international and national staff fully dedicated to the management of GFATM grants in Myanmar. The latest GFATM rate for the PR has been A1, A2 and B1 for the Tuberculosis, Malaria and HIV grants respectively	
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)		Yes, the PR has the capacity and system for effective management of SRs as demonstrated during the first two years of the grant	
3. There is no conflict-of-interest for the selection of the Principal Recipient(s) and Sub-Recipients		No conflict of interest has been reported so far by the concerned committed for selection of PR and SR	
4. The program-implementation plan provided in the concept note is sound		The plan provided in the concept note was developed in coordination with the second PR and all stakeholders and is considered to be sound	
5. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud		The internal control system is considered effective to detect misuse and fraud	
6. The financial-management system of the Principal Recipient is effective and accurate		The financial-management system of the PR is considered as effective and accurate	

7. The central warehouse and the warehouses for key regions have capacity, appropriate conditions and security to store health products, and to maintain their quality	The warehouse network for GF project was assessed during the first six months of 2011 and recommendations for improvement where put in place during the last six month of 2011. Moreover, Save the Children PR regularly monitors, through filed visits, warehousing and storage capacity of SRs at central and township level.
8. The distribution process can handle the requisition of supplies to avoid treatment / program disruptions	A good distribution system is in place. No disruption of key medicines has taken place during the period 2011-13. Moreover, the PR has put in place a supply chain system that identifies over stock of supplies that can be redirected to other SRs in urgent need or pharmaceuticals.
9. Data-collection capacity and tools are in place to monitor program performance	Data collection mechanism has been in place since beginning of phase I and functioning
10. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	Routine reporting is in place to report performance in time and accurately as confirmed by management letters sent for the previous reporting periods
11. The CCM actively oversees the implementation of the grant, and intervenes where appropriate	CCM is informed in due time of the implementation of the grant through its Technical Support Group and regular CCM meeting. Moreover, M-CCM organizes in a bi-annual basis filed visit to project sites to identify best practices and bottle necks regarding GFATM implementation
12. A quality-assurance plan is in place to monitor product quality throughout the in-country supply chain	Save the Children coordinates QA/QC of key pharmaceuticals with the Food and Drug Administration (FDA) in order to avoid duplication of QA/QC systems. It is expected that GFATM QA/QC plans will be presented to FDA and subsequently approved.

5.2 Current or Anticipated Risks to Program and PR(s) Performance

In reference to the Minimum Standards above and risk assessments conducted (if applicable), describe current or anticipated risks to the program and nominated PR(s) performance, as well as the proposed mitigation measures (including technical assistance) included in your funding request.

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- Timely clearance for import license and tax exemption of pharmaceutical and health products (under Save the Children) cannot be achieved without increased government commitment to support abstention of import permits

- Identification of new implementing partners (Sub-recipients) to scale-up coverage
- Unpredictable accessibility to certain parts of country (post-conflict and conflict areas; remoteness.)
- Scale-up needs to be staggered: need time for procurement and funding to set up programme expansions
  Some overlaps may happen in planning stage for government services and for NGO. Those risk of overlapping are however resolved before implementation, at the Township level, as coordination mechanism has been installed at field level between SRs, under the leadership of the National Malaria Control Programme.

Proposed mitigation measures:

Increased government commitment to support programme implementation. M-CCM will play lead role in coordinating increased collaboration among existing and new implementing partners to expand to areas previously inaccessible or not covered. It is anticipated that increased resources from GF, donors and government will enable the national malaria response to be scaled up to reach targets set by the National Strategic Plan

5.3 Overview of Implementation Arrangements

Please provide an overview of the proposed implementation arrangements for the funding request. In your response, please describe as appropriate:

a. If more than one PR is nominated, how co-ordination will occur between PR(s).

b. Whether Sub-Recipients (SRs) have been identified and the type of management arrangements likely to be put into place.

c. How coordination will occur between each nominated PR and its respective SR(s).

1-2 PAGES MAXIMUM

a) More than 1 PR is nominated (same as PRs in Round 9: UNOPS and Save the Children). Regular meetings are conducted to share programmatic achievements and lessons learned. PRs and M-CCM share PSM, M&E and programmatic challenges and best practices in a quarterly basis during M-CCM meetings. Technical meetings are also run between PRs and with SRs as needed. UNOPS managed the grant for local NGOs and 1 international Organization (WHO) and the National Malaria Control Programme; Save the Children managed the grant for international NGOs.

b) Sub-Recipients have previously been identified during round 9 and they will remain to be implementing the programme for the new funding mechanism. New SRs are required for expansion of services especially in new geographical areas. A transparent process will launched under the supervisions of the M-CCM.

c) PRs regularly conduct review meetings in, addition to day-to-day communication, for programmatic achievements and lessons learned. Annual procurement plan meetings and fund flow management workshops also carried out to brief SRs of latest issues. Workshops to review Standard Operating Procedures in various technical and management areas are also conducted together with the National Malaria Control Programme and SRs to seek inputs and validate the policy guidance.

5.4 Addressing Links to other Concept Notes and/or Existing Grants

If you are requesting funds for more than one component (including stand-alone HCSS) during the transition or have an on-going Global Fund grant (for another component), describe how the interventions being requested link to existing Global Fund grants or other concept notes being submitted, in particular as they relate to human resources, staffing, training, monitoring and evaluation and supervision activities.

1 PAGE MAXIMUM

All three programmes are submitting a consolidated concept note simultaneously. They are based on national strategic plans and incorporate any live Global Fund grant. While the three programmes are fairly separately managed at the central level, they come under the same directorate (Disease Control) in the Ministry of Health, of which its Director ensures coordination. At the implementation level, efforts are undertaken to maximize synergies across programmes. The malaria programme is well integrated into the general health services under the local leadership of township medical officers and state/regional health director and with support of local (general) laboratories and basic health staff. The same cadres of staff are also involved in other programmes and will provide a stepping stone for creating further linkages with other programmes such as maternal and child health. With the trend of involving more NGOs in malaria, TB and HIV programmes, supporting systems of the three programmes are converging towards each other.

Implementing NGOs also apply similar synergistic approaches, where feasible. For example, private practitioners can take part in various franchising schemes of PSI (funded by different donors) which, with proper coordination, results in increased efficiencies in training, supervision and monitoring. Even though malaria endemicity is more limited geographically, some data assistants from TB have been supporting the malaria programme and vice versa. Depending on workload and needs, this model will be further expanded.

At the PR level, administrative support services are fully merged with each PR having single human resources, finance, procurement, quality assurance and M&E units. The WHO core administrative units reinforced with cost-shared common support staff are also providing essential services to implement Global Fund-funded activities.

At the governance level, the mandate of M-CCM was already broad, overseeing the national response to the three diseases (thus not only the Global Fund activities). HSS and MNCH were earlier added and more recently M-CCM is becoming a multi-stakeholder oversight body for all health activities.

Most of the SRs in phase I of the current grant (Round 9) have initiated and assist in the creation of village health committees in all the village tracts covered by the programme. Those committees, acting as Community Based Organizations, are in charge of vector control, organization of prevention activities and will assist referral of patients for severe cases of malaria with transportation cost. The village health committees are now well established structures functioning independently from the GFATM funded programme and they are usually extending their role to supporting other health initiatives like Mother and Child Health, TB and HIV.

The **full funding request** includes Round 9 Phase II grant for malaria and additional funding for scaling priority interventions:

1) Rapid scale up LLIN/ITN to reach universal coverage of all people living in **high risk** and **moderate risk** and those who live in **low risk areas** but with potential threat of artemisinin resistance;
2) Expansion of diagnosis and treatment services to hard-to-reach population living in **high risk areas;**

Capacity building of human resources, staffing, training, surveillance, monitoring and evaluation and supervision activities for Round 9 will continue to be carried out.

Regional Artemisinin Resistance Containment Concept Note
Myanmar is eligible to participate as early applicant of NFM Concept Note of the Mekong Regional Artemisinin Resistance Containment. According to the Regional meeting held in Bangkok during 25-27 March 2013 a Regional Concept Note will be prepared for submission to GFATM for funding of 5 Participating countries (Cambodia, Lao PDR, Myanmar, Thailand and Vietnam). The tentative duration is 3 years (2013-2015). The Regional and country specific activities will be harmonized with this present Concept Note in order to avoid overlapping activities.

Myanmar Malaria Concept Note, Regional Concept Note and the 3MDG grants
It should be noted that the country specific NFM Concept Note (full funding request) will focus on intensification of malaria control in country-wide areas (i.e. 270 Priority townships) and this will certainly contribute to the artemisinin resistance containment that are currently supported by 3MDG in 2013 in 52 Townships. It is anticipated that the 3MDG will reduce it funding for containment from 2014 onward in order to move to other health programmes (MNCH and HSS areas). The basic malaria control activities (LLINs, case detection and treatment, BCC) will continue to be funded by the NFM Concept Note whereas the Containment specific activities (such as reduction of drug pressure, phasing out of artemisinin monotherapy, FDA drug regulatory actions, mapping migrant population, special interventions for migrants at worksites, monitoring of Day 3 parasitaemia, etc) that are not addressed by the present NFM Concept Note will hopefully be addressed by the Mekong Regional Containment Concept Note. As mentioned earlier, all these 3 grants (Country specific & Regional Containment Concept Notes and 3MDG grants) need to be well harmonized and workplans have to be well developed at all levels.

5.5 Women, Communities and other Key Affected Populations

Please describe how representatives of women's organizations, people living with the three diseases and other key affected populations will actively participate in the implementation of this funding request, including in interventions that will address legal or policy barriers to service access.

1 PAGE MAXIMUM

The request was made through consultative and transparency process of Technical Strategy Group (TSG) and CCM meetings. In these forums, experts, SRs and other implementing partners who have exposure to field and communities are present. Civil society, community based organizations, faith-based organization, Ministry of Social Welfare who are present in the CCM forum will review law and policies related to malaria interventions, barriers to access to treatment and prevention such as stigma and discrimination, etc. They will ensure that women, migrant population and ethnic people are not neglected and left out from the services supported by the GFATM.

5.6 Major External Risks

Please describe any major external risks (beyond the control of those managing the implementation of the program) that might negatively affect the implementation and performance of the proposed interventions.

1 PAGE MAXIMUM

- In recent years there have been dramatic improvements in settling conflicts. However, there are still areas with slumbering or full-blown conflicts. Programme development in such areas is along less organized ways and may depend on

regular or haphazard services provided by whoever is present. It can potentially lead to a total closure of activities.

- Negotiations with relevant parties have identified the challenges to project management and these have been steadily resolved during Phase I, although the requirement for establishing MOU agreements for new areas means limitations to project expansion.

- The incomplete national epidemiological data for malaria at the time of proposal design has impacted on the target settings of the grant. It also poses a challenge to planning and implementing in a comprehensive manner to tackle the disease.

- Untied indicators linked to GF projects represent a risk for the performance framework. PR Save the Children and its SRs have no control on non-GF donor commitments to SRs, with the implication that if contributions decrease or are cancelled GF performance measurement is detrimentally affected.

- Natural calamities such as cyclones or earthquakes can never be ruled out and may jeopardize implementation of planned activities in directly affected areas but also in other parts of the country (due to attention diverted to affected areas).

- Finally, fluctuations in exchange rate have negatively affected the purchasing power of the budget. The lack of national and international banking services causes considerable problems particularly in the ability to transfer funds within and external to the country.

- While the average exchange rate is becoming more stable. Inflation remains an issue and commodity prices are on the rise. The country remains unstable and there are social unrest and on-going conflicts, humanitarian crises and possibility of natural disasters. Poor physical infrastructure requires dedicated support. Inherent weaknesses in the health systems often limit the quality of services. General Elections scheduled for 2015.

ATTACHMENT 1

CCM Endorsement of Concept Note

Please attach the CCM Membership Form Attachment with signatures of all the members endorsing the concept note submitted.

ATTACHMENT 2

Programmatic Gap

The Programmatic Gap Table is a required attachment to be completed as an Excel template.

ATTACHMENT 3

Modular Template

The Modular Template replaces the performance framework, detailed budget and logical framework previously requested for Global Fund grants. Further guidance on completing the Template is available in the Concept Note Instructions.

ATTACHMENT 4

Financial Gap Analysis and Counterpart Financing Table

The Financial Gap Analysis and Counterpart Financing Table is a required attachment to be completed as an Excel template.