The UN COVID-19 Response and Recovery Multi-Partner Trust Fund
(UN COVID-19 MPTF)

Proposal

Proposal Title: Covid-19 Emergency Response for Continuity of Maternal and New-born Health Services

Amount: 1,000,000USD.

I. Immediate Socio-Economic Response to COVID-19

Malawi's population, estimated at 17.6 million in 2018, has an annual growth rate of 2.8 percent and is projected to reach 41.2 million by 2050. The population is youthful, with 47 percent below the age of 15.[1] By the age of 18, 47 percent of girls are married and 29 percent aged 15-19 have begun childbearing contributing to 25 percent of all pregnancies annually. Poverty is widespread, exacerbated by high fertility and high dependency rate of 91 percent. Malawi registers some of the highest annual birth rates in the world. Each year approximately 520,000 births are recorded according to 2019 trends. The average number of births per women is 4.2 and the number of women of reproductive age is 4.3 million according to the 2018 population and housing census. A significant 11 percent of these women are classified as having disabilities. An estimated total of 90 percent of women in Malawi give birth with assistance of a skilled health provider at a health facility.

Malawi ranks 145/188 on the *Gender Inequality Index* reflecting high levels of inequality in reproductive health, women's empowerment, and economic activity. Maternal mortality remains relatively high at 439 per live 1,000 live births.[2] Teenage pregnancy is 10 percentage points higher in rural over urban areas and adolescent girls in the poorest households are nearly three times as likely as those in the wealthiest households to have begun childbearing (15 percent versus 44 percent). Levels of gender-based violence are high, although Malawi has made improvements in the legal and policy frameworks to ensure women empowerment. Gender inequality, negative social norms and weak accountability systems affect access to health justice and realization of sexual and reproductive health and rights.

This is supported by the Rapid analysis conducted by CARE International that confirms with the scale of the COVID-19 pandemic it means that resources are already being diverted from existing health services to support responses to the crisis. In some contexts, this may lead to a shortage of health professionals, financial resources, and medication to support critical SRHR services. Further, reductions in SRHR services will have a greater effect on patients who rely on free or subsidized care; particularly women, girls, and/or other marginalized groups living in poverty and/or those already facing other barriers to SRHR health care. Contexts with weak health systems, poor access to SRHR services, restrictive laws, and unequal gender norms often have poor reproductive and maternal health care, which is exacerbated when scarce resources are diverted to outbreak responses

Health facilities in the 28 districts of Malawi remain undersupplied with relevant equipment and supplies for the care of pregnant women during antenatal, Labour and Delivery and Postnatal period. Although there are improvements in access to health services in districts, these centres are prone to stock outs of essential medicine and supplies for managing obstetric complications as well as shortage of trained personnel to provide the required comprehensive and basic signal functions in designated emergency obstetric care settings. This is due to the major shift of priority in health financing towards addressing the impending COVID-19 crisis. As a

[1] The National Statistical Office- Malawi. 2018 Population and Housing Census.
[2] The National Statistical Office- Malawi. 2015/16. Demographic Health Survey.

result, in the unwrapping of a virus emergency these facilities will quickly be overwhelmed, and the women and girls will be adversely affected because of the reproductive and productive roles they play.

On 2 April 2020 the Government of Malawi reported the first three COVID-19 cases. As of 23 April 2020, a total of 33 confirmed cases and three deaths were reported to the WHO[3]. Although government has introduced measures to limit the spread of the virus, it is likely the virus will spread exponentially. According to calculations of the COVID-19 mortality calculator, at a rate of 10 percent infection rate, potentially 6,000 deaths can be expected.[4] A similar number of deaths can be forecasted because of the negative impact of the virus on health services including SRHR services according to academic studies of Ebola in West Africa.[5]

In such a situation, pregnant women are extremely vulnerable as there is a real possibility that their access to crucial health services will be severely restricted. Currently, while the government has prepared a total of 11 treatment centres across the country, there is no space designated to isolate pregnant women in antenatal, labour and delivery rooms; including provision of comprehensive obstetric care services like caesarean section nor postnatal care with new-born babies. The healthcare facilities ability to provide a safe space for maternal care including labour and deliveries and caesarean section are likely to come under critical pressure in the event of the spread of the virus including the availability of equipment and supplies.

In view of this and coupled with the fact that in rural areas women must travel long distances to access health facilities, option to use alternative means to deliver their babies will most likely increase such as traditional birth attendants. At both policy and service delivery level Malawi has insufficient resources both space as well as equipment and supplies to handle the COVID-19 crisis; an issue that has also been highlighted in the nation COVID-19 health sector response plan; especially those for pregnant women with critical needs[6] Whilst globally, there are early indications, that the virus might be in some small number of cases transmitted vertically from mother to foetus as yet there is not strong evidence it causes increased risk of miscarriage or is teratogenic.[7] At service delivery level however, the risks are significant for pregnant women and the wider community. Further, the current national COVID-19 response budget allocation did not take into consideration of the specific needs of the maternal and new-born clients. Recognizing gender inequality in the COVID-19 response as a cross-cutting determinant of health and identifying different pathways through which these inequalities impact Maternal and Neonatal (MNH) health ((MNH) are critical components when planning and implementing programmes that affect the health of women including adolescents. It also involves non-health sector interventions (such as those within education, water and sanitation, and energy and environment sectors) since programmes beyond the health sector make important contributions to reducing gender inequalities and improving outcomes for women, children and adolescents.

II. Solutions proposed

This proposal responds to the need for pregnant women to access basic maternal and new-born health services during the COVID-19 by delivering three outputs: 1) protocols and guidelines established to ensure compliance of facilities for the treatment of pregnant women during COVID-19; 2) strengthened continuity of maternal and new-born care services including comprehensive obstetric emergency services during COVID-19; and 3) increased access to information, support and referral systems.

These will provide coordinated support to the healthcare system in Malawi ensuring that pregnant women access antenatal, labour and deliveries (including caesarean section to those in need) and post-natal care during the critical period of Covid-19.

[3] WHO. Coronavirus Dashboard. Accessed 12 April 2020. https://who.maps.arcgis.com/apps/opsdashboard/index.html#/error/OAUTH_0024

[4] Potential impact of COVID-19 in human mortality calculator. Accessed 16 April 2020. https://public.tableau.com/views/COVID-19mortalitycalculator/COVID-19mortalitycalc?:display_count=y&:showVizHome=no

[5] Sochas, L, Channon, AA and Nam, S. 2017. Counting indirect crisis-related deaths in the context of a low-resilience health system: the case of maternal and neonatal health during the Ebola epidemic in Sierra Leone. In Health Policy Plan. 2017 Nov 1;32(suppl_3):iii32-iii39.

[6] Ministry of Health. Launch of the National Covid-19 Preparedness and Response Plan. 9 April 2020. Lilongwe.

[7] Royal college of Obstetricians and Gynecologists. 2020. Coronavirus (Covid-19) Infection in Pregnancy. Information for Healthcare Professionals. Updates available at https://www.rcog.org.uk/en/guidelines-research-services/coronavirus-covid-19-pregnancy-and-womens-health/

Output 1: Protocols and guidelines established to review guidelines and ensure compliance of facilities for the treatment of pregnant women during Covid-19. At policy level WHO will review and adapt existing global and regional guidelines and facilities to ensure these are in line with WHO standards for use by health professional and for the safe treatment of pregnant women during Covid-19. Further proper virtual orientation of the newly developed protocols and translation where necessary will be done. The process of adaptation will be done within the shortest period in view of the urgency of the situation we are in which requires immediate updates on MNH care management by health workers.

Output 2: Strengthened continuity of maternal and new-born health services during COVID-19. This output will support provision of maternal and new-born health services in 28 districts including 11 COVID-19 treatment centres, 4-central hospitals and 24 district hospitals. Out of these facilities, through this project, 4 central hospitals and 8 COVID-19 treatment centres will be refurbished in order to provide comprehensive obstetric care services. Additionally, tents will be provided to all of the 24 district hospitals plus 10 health centres in 5 selected districts (i.e. 2 centres per selected district). These service delivery facilities will be strengthened by providing essential equipment and supplies and supporting healthcare professionals providing maternal and new-born care services including labour and births for pregnant women during COVID-19 in line with WHO guidelines for treatment and treatment facilities. This will include putting in place appropriate screening and separation units and refurbishment of existing structures to create separate theatre space for caesarean section. These will enable healthcare workers to provide consistent quality maternal and new-born care services, while effectively managing the COVID-19 infection risk. Resources for the separation of physical health spaces and continued access to antenatal, postnatal and deliveries for women will be provided. This will ensure adequate facilities for screening, triage and isolation for protocols to be carried out. Support for establishing sites for maternity and new-born care facilities in designated COVID-19 treatment centres will be provided that includes the procurement of tents, equipment in the delivery units as well as delivery kits and supplies providing a secure environment for the healthcare of pregnant women. Where there will be no readily available space to be refurbished, isolation tents will be used in all targeted district hospitals and health centres and COVID-19 treatment centres to ensure separation between infected and non-infected women, and infected patients and non-infected pregnant women. There will also be waste and water management systems for these maternity and new-born units with water tanks installed in all targeted treatment centres to support hygiene standards crucial to combatting the spread of the virus. To ensure safety of health workers, additional personal and protective equipment and infection prevention supplies will also be provided. Recruitment of 290 additional staff to increase staffing in the COVID-19 centres for labour and delivery (174 clinical staff; 116 support staff) will strengthen the health sector's ability to manage the health needs of pregnant women. Further, additional risk allowance per approved government rates will be factored in for all staff in their place of work.

Output 3: Increased access to information, support and referral systems. A helpline established to provide access to information and a remote referral pathway for pregnant women to reach the health facilities. This output will enable a helpline for pregnant women that provides a range of support services including Covid-19 information provision, counselling, referral pathways and support services. The helpline will also ensure prompt information and services on Gender Based Violence. In addition to this is the use of rapid SMS to ensure women are aware of their services available. To ensure that there is good flow of information towards accessing screening services as well as, right information on covid-19, the project will also enhance awareness raising in the community through community based organisations in particular women's organisations and community radios in providing real time information on covid 19 towards prevention and access to services at health facilities.

Lastly, using HeforShe platform, the project will work with men and boys towards addressing gender norms and barriers to ensure support for women so that they effectively seek out the services and reach clinics - use of the COVID-19 HeforShe @home model. This is because beyond specific health interventions, men and boys are instrumental to shifting gender norms towards gender equality. Engaging men as agents of change in Maternal and new-born health is key on the promotion of positive fatherhood, advocacy against discrimination of women in sexual and reproductive health

issues, promoting equal burden of unpaid care work and changing attitudes and behaviours that are a cause and consequence of sexual and GBV inequality. For example, the HeForShe76 solidarity movement – which UN Women launched in 2014 – offers a systematic approach and targeted platform in which Malawi men can engage and become change agents working to achieve gender equality.[8]

III. What is the specific need/problem the intervention seeks to address?

Evidence from the region and globally suggests a significant impact of Covid-19 that is especially acute in health systems that lack resources, clear policy direction and comprehensive health systems. This requires clear procedures and allocation of resources to strengthen services to pregnant women that meet their critical need for healthcare services protected from the pressures of the impact of the virus on the healthcare system more generally. Screening, detection and isolation of patients is essential to prevent the spread of the disease, but with a fragile health system unable to respond fully and the needs of these women is unmet and they are excluded from services entirely exposed to far higher risks of births in communities, outside of safe health spaces. Compounding this challenge, without adequate direction, pregnant women in have demonstrated that they either face obstacles attending or are reluctant to attend clinics for maternal health services because of either a lack of transport or a fear of the risk of contracting the virus.[9] Furthermore, women may have the wrong or inadequate information about being allowed to access the maternal health services during lockdown and thus may choose to deliver at home in fear of breaking the rules. This is likely to lead to the increase of home births which will carry an increased risk of community infections and complications in birth including deaths for both the mother and the new-born. The expected number of deliveries in six months is 260,000 deliveries which translates into expected number of deliveries per month of 44,000.

Policies and public health efforts do not adequately address the gendered impacts of disease outbreaks, including the covid19 as well as the availability of specific COVID-19 treatment centres for pregnant women and the availability of adequate equipment and supplies. Recognising the extent to which disease outbreaks affect women and men differently is a fundamental step to understand the primary and secondary effects of a health emergency on women. Women's demand for health services is determined not only by individual attributes such as knowledge and skills and financial means, but also by relationship within the household members, social networks, communities and broader social and structural policies and norms. Gender relations influence social relations between and among men and women. They can determine hierarchies between groups based on norms and can contribute to unequal power relations. Gender relations of power constitute the root causes of gender inequality and are among the most influential of social determinants of health. Gender related barriers to health services may increase during the Covid outbreak due to for example difficulties in accessing information, reaching clinics or increased domestic violence due to lockdown measures.

The National Response Plan under the heath cluster Health Cluster main objective of national COVID-19 Plan is to prevent, rapidly detect and effectively respond to any COVID-19 outbreak to reduce morbidity and mortality in the country. Hence to ensure access to information, it will important to raise awareness among stakeholders on COVID-19 amongst the general public and targeted vulnerable groups- women and men in the rural areas, but also capacity building of health workers on gender.

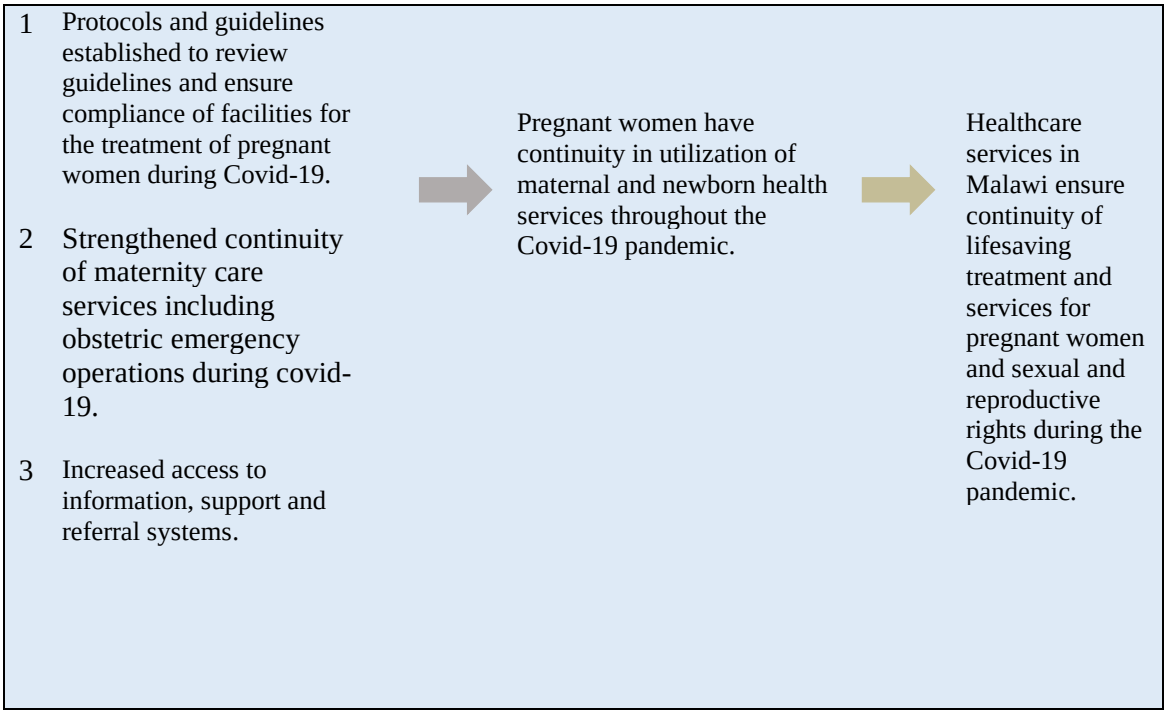
IV. How does this collaborative programme solve the challenge? Please describe your theory of change.

Results chain

Outputs	Outcome	Impact

[8] Promoting gender Equality in SRMCAH Programming guide. UNW June 2019

[9] UNFPA India. 2020. Maternal Health During the Time of Covid. The UNFPA India analysis identified a reluctance of women to approach healthcare facilities because of the fear of infection.



While the country has available protocols and guidelines for the management of maternal and newborn health services in general, there is no readily available guidelines and protocols managing COVID-19 positive women. The available protocols will ensure effective and quality provision of care and proper guidance to the service providers. **As such, IF** the Malawi health sector COVID-19 response categorizes a special management of pregnant women during antenatal, labour and delivery and postnatal care including the provision of comprehensive obstetric care services, **THEN** the chances of spreading the virus to non-infected women while receiving obstetric care will be minimized. This will therefore mean that spread of the virus through health facility care will be avoided, hence averting more cases of maternal morbidity and mortality cases in Malawi. Moreover, **IF** the women can receive continuous information on where to access services and are provided with referral for further care, **THEN** the impact of COVID-19 on women will be mitigated even though they are exposed to increased risk of sexual abuse and gender based violence due to the restricted movements enforced and potential lockdowns. Therefore, the results chain contributes to an impact that national and local health services are better able to manage the COVID-19 pandemic by ensuring continuity of lifesaving treatment and services for pregnant women and sexual and reproductive rights during the COVID-19 pandemic.

In providing policy, service provision and outreach services targeted specifically at pregnant women, the outputs will fill a crucial gap in national health services for vulnerable pregnant women supporting services including: 1) protecting maternal health workforce, 2) providing safe and effective maternal and neonatal care and 3) maintaining and protecting maternal health systems. Such approach is most appropriate, since it aims to supplement and reinforce the existing health systems and capacities rather than replacing them, yet also helps adapt them to the new reality of the COVID-19 context in Malawi. Such an approach combining guideline development, service provision, and access support can also contribute to laying a ground for "Building Back Better" and longer term recovery process, in which residual COVID-19 infection risk is expected to continue for an extended period of time. The solution is devised based on the data particularly related to maternal and newborn mortality and morbidity, and its impact can be measured by following the relevant data trends available from the health facilities. Innovation is applied in every aspects of the facility reinforcement so as to ensure safe continuation of service provisions while preventing and controlling potential COVID-19 infection. Moreover, human rights based approach is also applied, putting rights and dignity of the women and mothers at the centre of the response, striving to ensure universal access to sexual and reproductive health rights in accordance with the international standards including those outlined in the International Conference on Population and Development (ICPD) Programme of Action. Human rights principles of accountability, non-discrimination, participation and inclusion are applied in ensuring universal access and provision of quality, affordable health care as well. The project directly supporting SRHR of women and adolescent girls contributes to promoting gender equality and women's empowerment significantly.

V. Documentation

The National plan of combating COVID-19 has been included on the WHO partner portal as indicated by the websites below:

Government of Malawi. 2020. National Covid-19 Preparedness and Response Plan (March - June 2020). Accessed 23 April 2020. http://mw.one.un.org
UN Malawi COVID-19 Update Situation Update No. 5. http://mw.one.un.org/reports-and-publications/
UN Malawi COVID-19 Update Situation Update No. 4. http://mw.one.un.org/reports-and-publications/
UN Malawi COVID-19 Update Situation Update No. 3. http://mw.one.un.org/reports-and-publications/
UN Malawi COVID-19 Update Situation Update No. 2. http://mw.one.un.org/reports-and-publications/
UN Malawi COVID-19 Update Situation Update No. 1. http://mw.one.un.org/reports-and-publications/

VI. Target population

(a) Expected number of deliveries in six months – 260,000 deliveries which translates into expected number of deliveries per month – 44,000.

i) Scenario-1: If up to two percent pregnant women become infected that means – isolated/safe delivery space for around 1,000 infected women per month, and continuation of safe delivery space for 43,000 non-infected women per month.

ii) Scenario-2: If up to five percent pregnant women get infected that means – isolated/safe delivery space for around 2,000 infected women per month, and continuation of safe delivery space for 42, 000 non-infected women per month.

iii) Scenario-3: If up to 10 percent pregnant women get infected that means – isolated/safe delivery space for 4,000 infected women per month, and continuation of safe delivery space for 40,000 non-infected women per month

iv) Scenario-4: If up to 25 percent pregnant women get infected that means – isolated/safe delivery space for 10,000 infected women per month, and continuation of safe delivery space for 100,000 non-infected women per month.

(b) All women of childbearing age including adolescent girls.
(c) Men and young boys in all communities.

VII. Who will deliver this solution?

- Three UN Organizations; namely UNFPA (the lead and executing agency), WHO and UN Women will be delivering the results proposed by this initiative. The work will be done in close collaboration with the Ministry of Health, under the leadership of the Reproductive Health Directorate, as well as selected Non-Governmental organizations (NGOs) implementing partners. Key staff will be included in the project implementation: At UNFPA, a SRHR coordinator who will be responsible for the actual day to day technical support into the project in direct linkage with WHO and UN Women. The coordinator will also be responsible for the collaboration with MoH at both district and central level to ensure timely delivery of quality services.
- ***Monitoring and Evaluation arrangement:*** The activity work plan and the Results Framework will provide the basis for all monitoring and reporting activities of the project. Due to the restrictions in movement that are currently being observed worldwide due to the covid-19 pandemic, existing online Government systems such as digital health information system and other customized online monitoring tools will be used to track the performance of the project at implementation level. Key monitoring activities that will be undertaken include monthly district implementation reports/update;

online monthly progress review meetings; and quarterly progress reporting. Online monthly progress review meetings will be undertaken to track progress on the ground and resolve operational challenges in a timely manner. Online monthly progress review meetings will bring together all RUNOs (UNFPA, WHO and UN Women); Ministry of Health Headquarters and District Health Officers to share lessons, implementation progress, operational challenges and devise ways for improving implementation performance.

- All RUNOS in collaboration with Ministry of Health will ensure that accurate baseline and targets for all the indicators in the Results Framework are populated before the project kicks off. Additionally, RUNOs and the Ministry of Health will ensure that the work plan has quantifiable deliverables that will be tracked during monthly online progress review meetings. A team of M&E Officers from the 3 RUNOs in collaboration with Ministry of Health will develop progress reporting templates that will be used by all target districts for reporting of progress. The District Health Offices will be responsible for preparation and submission of monthly reports/updates in line with the agreed reporting templates as well as participate in monthly online progress review meetings.
- All implementation progress reports will be reviewed by RUNOs to ensure that they meet the minimum quality standards. On agreed intervals, RUNOs will be producing and submitting implementation progress reports to the donor clearly highlighting the status of implementation and progress towards achievement of planned results in line with the results framework.

Cover Page

<table>
<tr><td>Contacts</td><td>Resident Coordinator or Focal Point in his/her Office
Name: Santiago Quinones
Email: santiago.quinones@one.un.org
Position: SDG Acceleration Fund Coordinator
Telephone: +265 993000540</td></tr>
<tr><td>Description</td><td>This initiative responds to the need for pregnant women to access basic maternal and new-born health services during the Covid-19 through three outputs: 1) protocols and guidelines established to review and ensure compliance of facilities for the treatment of pregnant women during Covid-19 2) strengthened continuity of maternal and new-born care services including comprehensive obstetric emergency services during covid-19; and 3) Increased access to information, support and referral systems.

These will provide coordinated support to the healthcare system in Malawi ensuring that pregnant women access antenatal, labour and deliveries (including caesarean section to those in need) and post-natal care during the critical period of Covid-19.</td></tr>
<tr><td>Universal Markers</td><td>Gender Marker:
a) Have gender equality and/or the empowerment of women and girls as the primary or principal objective.</td></tr>
<tr><td rowspan="2">Fund Specific Markers</td><td>Human Rights Based Approach to COVID19 Response
Yes</td></tr>
<tr><td>Fund Windows
Window 1: Enable Governments and Communities to Tackle the Emergency</td></tr>
<tr><td>Geographical Scope</td><td>Regions: Southern Africa
Country: Malawi</td></tr>
<tr><td>Recipient UN Organizations</td><td>UNFPA; UN Women: WHO</td></tr>
<tr><td>Implementing Partners</td><td>Catholic Commission for Justice and Peace (CCJP) and Men for Gender Equality (MGEN)</td></tr>
<tr><td>Programme and Project Cost</td><td>
<table>
<tr><th>Budget</th><th>Agency</th><th>Amount</th><th>Comments</th></tr>
<tr><td>Budget Requested</td><td>UNFPA
UN Women
WHO</td><td>$ 720,000
$200,000
$80,000</td><td></td></tr>
<tr><td>In-kind Contributions</td><td></td><td>230,000</td><td>The UN agencies and MoH have existing staff who will contribute time to the project including space of work and vehicles amounting to USD230,000</td></tr>
<tr><td>Total</td><td></td><td>$ 1,230,000</td><td></td></tr>
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<tr><td>Comments</td><td></td></tr>
<tr><td>Programme Duration</td><td>Start Date: May to December 2020.</td></tr>
<tr><td></td><td>Duration (In months): 8-months</td></tr>
<tr><td></td><td>End Date: 31st December 2020.</td></tr>
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Results Framework

Window 1: Proposal Outcome					**Outcome Total Budget USD**
	Outcome: Pregnant women have continuity in utilization of Maternal and Newborn health services throughout the Covid-19 pandemic.				**USD1,000,000**
		Baseline	**Target**	**Means of verification**	**Responsible Org**
Outcome Indicator	1 Number of women who have utilized MNH services during Covid-19.	**0**	300,000	Ministry of Health	UNFPA/ MoH
	2 Number of safe births attended by skilled health personnel during Covid-19.	**0**	140,000	Ministry of Health	UNFPA/ MoH
	3. Percentage of pregnant women including adolescents attending ANC in the target facilities that attend all their scheduled ANC visits during the COVID-19 period.			Ministry of Health	UNFPA/ MoH
	4. Percentage of all designated BEMONc facilities that performed all 7 signal functions during the COVID-19 period.			Ministry of Health	UNFPA/ MoH
		Baseline	**Target**	**Means of verification**	**Responsible Org**
	Output 1.1.1: Protocols and guidelines established to review guidelines and ensure compliance of facilities for the treatment of pregnant women during Covid-19				
Output 1.1.1 Indicators	Number of copies of guidelines and protocols distributed to health centers nationwide.	0	20,000	Ministry of Health	WHO/UNFPA/ MoH

	Number of health facilities that have mechanisms in place for treatment of pregnant women during covid-19 in line with protocols and guidelines that are aligned to WHO standards.	0	46	Ministry of Health	UNFPA/ MoH
	Output 1.2.1 Strengthened continuity of maternal and new-born health services including provision of comprehensive obstetric care services operations during covid-19.				
Output 1.2.1 Indicators	Number of Covid-19 treatment centers, hospitals and health centers that have Covid-19 safe antenatal and birth facilities.	0	46	Ministry of Health	UNFPA/ MoH
	Number of safe births attended by UNFPA supported personnel during Covid-19.	0	290	Ministry of Health	UNFPA/ MoH
	Output 1. 3.1 Increased access to information, support and referral systems				
Output 1.3.1 Indicators	Number of women of childbearing age including pregnant women and adolescents accessing advice and counselling from a hotline service.	0	4,000,000	Ministry of Health	UN Women/MoH/NGO
	Number of women accessing referrals to COVID-19 treatment centers.	**0**	4,000,000	Ministry of Health	UN Women/MoH/NGO
	Number of men and boys involved in referral and information sharing on covid-19	**0**	350,000	Ministry of Health	UN Women/MoH/NGO

SDG Targets and Indicators

Sustainable Development Goals (SDGs) [select max 3 goals]			
☐	SDG 1 (No poverty)	☐	SDG 9 (Industry, Innovation and Infrastructure)
☐	SDG 2 (Zero hunger)	☐	SDG 10 (Reduced Inequalities)
☒	SDG 3 (Good health & well-being)	☐	SDG 11 (Sustainable Cities & Communities)
☐	SDG 4 (Quality education)	☐	SDG 12 (Responsible Consumption & Production)
☒	SDG 5 (Gender equality)	☐	SDG 13 (Climate action)
☐	SDG 6 (Clean water and sanitation)	☐	SDG 14 (Life below water)
☐	SDG 7 (Sustainable energy)	☐	SDG 15 (Life on land)
☐	SDG 8 (Decent work & Economic Growth)	☐	SDG 16 (Peace, justice & strong institutions)
☐	SDG 17 (Partnerships for the Goals)		

Relevant SDG Targets and Indicators

Target	**Indicator # and Description**	**Estimated % Budget allocated**
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.	**3.1.1 Maternal mortality ratio** **3.1.2 Proportion of births attended by skilled health personnel**	**80%**
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.	**5.6.2 Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education**	**20%**

Risk

Event	Categories Financial Operational Organizational Political (regulatory and/or strategic)	Level 3 – Very High 2 – Medium High 1 - Low	Likelihood 6 – Expected 5 – Highly Likely 4 – Likely 3 – Moderate 2 – Low Likelihood 1- Not Likely 0 – Not Applicable	Impact 5 – Extreme 4 – Major 3 – Moderate 2 – Minor 1 – Insignificant	Mitigating Measures (List the specific mitigation measures)	Risk Owner	
Risk1 Fiduciary risk regarding resource management	Financial	2	3	4	UNFPA Malawi applies the Harmonized Approach to Cash Transfer (HACT) in working with the national implementing partners. Procurement for goods and services will sourced by be UNFPA. As part of HACT UNFPA has in place the implementing partner (IP) micro-assessment which provides an overall assessment of the Implementing Partner's programme, financial and operations management policies, procedures, systems and internal controls.	UNFPA/UN WOMEN/WHO	
Risk 2 Political demonstrations if the proposed lockdown is not accepted or election date is delayed delaying delivery of key essential procurement.	Political	2	3	3	Continued monitoring of the political situation will inform project decisions. Supply lines will be monitored to ensure secure passage of key materials and stocks. UN will engage with political actors to build a consensus around Corona-19 virus aid.	UNFPA/UN WOMEN/WHO	
Risk 3 Delays in disbursement of funds.	Operational	2	Select from above	Select from above	UNFPA procurement processes will coordinate and support the Ministry of Health and assist access supply chains via global purchasing network. Present scenario planning will be continuously updated.	UNFPA/UN WOMEN/WHO	

Budget by UNDG Categories

1. **UNFPA**
2. **UN Women**
3. **WHO**

Budget Lines	Fiscal Year	Description	UNFPA	UN WOMEN	WHO	Total USD
1. Staff and other personnel	2020	Cost sharing with existing staff and recruitment of consultants,	60,000	10,000	10,000	80,000
2. Supplies, Commodities, Materials	2020	Printing and distribution of guidelines and protocols for the service delivery points.			20,000	20,000
		Procurement of IT equipment for the provision of virtual training for the service providers (UNFPA, WHO) and establishment of the call-in center (UN Women).	20,000	80,000	20,000	120,000
		Procurement of protective wear and infection prevention materials for the provision of MNH care.	60,000			60,000
3. Equipment, Vehicles, and Furniture, incl. Depreciation	2020	Procurement of equipment and supplies for the provision of Basic and Comprehensive Emergency Obstetric Care services, including tents and refurbishments of facilities.	350,000		20,000	370,000
4. Contractual services	2020	Contracting NGOs for the provision of referral services of clients	40,000	20,000		60,000
		Service provision for the monitoring of refurbishment and other activities.	10,000			10,000
5. Travel	2020	Spot checks and monitoring on implementation of the services.	20,000	20,000		40,000
6. Transfers and Grants to Counterparts	2020	Transfer of grants to INGOs (UN Women) Salary support for midwife/nurses/community health workers (UNFPA)	80,000	60,000		140,000
7. General Operating and other Direct Costs	2020	Communication, logistics, transportation.	14,579	10,000	10,000	34,579
Sub Total Programme Costs			**654,579**	**200,000**	**80,000**	**934,579**
8. Indirect Support Costs ***** 7%			45,821	14,000	5.600	
Total			**700,400**	**214,000**	**85,600**	**1,000,000**

Signatures

E-Signature/validation through the system or email from the RC confirming submission

Annex 1. Detailed work plan

Expected Outputs	Planned activities	Year (2020-21)				Planned budget		
		Q2	Q3	Q4	Q1	Responsible party	Budget description	Amount USD
Output 1: Protocols and guidelines established to review guidelines and ensure compliance of facilities for the treatment of pregnant women during Covid-19.	Activity 1.1: Procure IT equipment for Covid-19 treatment centers to enable information exchange and monitoring.	x				Ministry of Health; WHO	Airtime; screens; laptops; tablets; installation; security.	20,000
	Activity 1.2: Establish tracking and monitoring systems for lifesaving drugs and commodity supplies for pregnant women.	X				Ministry of Health; WHO	DSA for spot checks to compile data.	10,000
	Activity 1.3: Conduct data collection on pregnant women treatment for tracking and monitoring.	X	X	X	X	Ministry of Health; WHO	DSA for spot checks to compile data.	10,000
	Activity 1.4: Produce, print and distribute 50,000 copies of guidelines for treatment of pregnant women during Covid-19.	X				Ministry of Health; WHO	Drafting; translation services; layout; printing and distribution.	20,000
	Activity 1.5: Conduct orientation of 5000 health professionals on care of pregnant women during Covid-19.	X				Ministry of Health; WHO	Airtime; material and consultant fees. DSA for field mentorship visits.	10,000
							Subtotal	70,000
Output 2: Strengthened continuity of maternal and new-born health services including provision of comprehensive obstetric care services operations during covid-19.	Activity 2.1: Procure and install 58 tents and renovation of maternity units for treatment of pregnant women (isolation units for affected and non-affected cases) in Covid-19 treatment centers in 28 districts.	X	X			Ministry of Health; UNFPA	58 tents and labour costs (30- Covid-19 centers, 8-central hospitals, 10- districts,10-health centers).	90,000
	Activity 2.2: Install 19 water tanks in 19 Covid-19 treatment centers.	X	X			Ministry of Health; UNFPA	Procurement of 19 water tanks and pipes; installation of water tanks.	100,000
	Activity 2.3: Recruit 290 additional staff to increase staffing in the Covid-19 centers for labour and	X	X	X	X	Ministry of Health; UNFPA	Temporary staff fees.	80,000

Expected Outputs	Planned activities	Year (2020-21)				Planned budget		
		Q2	Q3	Q4	Q1	Responsible party	Budget description	Amount USD
	delivery (174 clinical staff; 116 support staff).							
	Activity 2.4: Procure and deliver equipment for the delivery units with delivery kits and supplies.	X	X			Ministry of Health; UNFPA	Delivery kits; delivery beds; miscellaneous disposables.	60,000
	Activity 2.5: Refurbish separate space to conduct routine and emergency caesarean sections for those women diagnosed with Covid-19 in the 4 central hospitals and selected 4 Covid treatment centers.	X	X			Ministry of Health; UNFPA	Equipment for provision of Comprehensive EmONC services. Refurbishment of space for surgical procedures.	370,000
	Activity 2.6: Install 29 waste management system for 29 maternal and new born units.	X	X			Ministry of Health; UNFPA	Procurement of 29 waste management units/equipment and labour costs.	10,000
							Subtotal	730,000
Output 3: Increased access to information, support and referral systems.	Activity 3.1: Procure Equipment and airtime for front-line workers for continuous virtual communication and training and PPE.					Ministry of Health; UN WOMEN	Airtime credit, TV monitor; Internet subscription, laptops.	20,000
	Activity 3.2: Establish Helpline services to link pregnant women and care providers to avoid home deliveries and provide referral for GBV services.					Ministry of Health; UNWOMEN; civil society organizations	Start-up costs of hotline number, cell-phone handsets; airtime; basic expenses for volunteers.	30,000
	Activity 3.3: Support mobilization of men and boys through HeForShe in supporting SRHR and sharing the burden of unpaid care in covid-19 context					NGO; UN WOMEN	Services, transport, communication and DSA	50,000
	Activity 3.4: Print and distribute COVID-19 messages targeting SRHR issues.					NGO; UN WOMEN	Cost of printing and distribution	20,000
	Activity 3.5: Provide airtime for					Ministry of Health;	Radio airtime;	50,000

Expected Outputs	Planned activities	Year (2020-21)				Planned budget		
		Q2	Q3	Q4	Q1	Responsible party	Budget description	Amount USD
	community radio stations for phone in programmes on discussion information and prevention of Covid-19 discussion and on the impact on pregnant women and encourage pregnant women to continue to seek antenatal services and deliver at clinics.					UNWOMEN	production costs.	
	Activity 3.6 Strengthen referral pathways for pregnant women from home to health facilities and GBV services.					Ministry of Health; UNWOMEN	Transport; communication.	10,000
	Activity 3.7: Strengthen Transport network for pregnant women to access health centers.					Ministry of Health; UNFPA/UNWOMEN	Transport costs. Ambulances/utility vehicles for 1 each in 10 plus in all 4 central hospitals. Standby transport in 28 districts.	20,000
	Activity 3.8: Support general operating costs including indirect costs.					UNFPA; UN WOMEN; WHO.	Direct and indirect costs	100,000
							Subtotal	200,000
							Total 1+2+3	***1,00,000.00***