

Malawi SDG Acceleration Fund Project Document

This template facilitates the development of relevant and catalytic projects, to be considered by the United Nations Malawi SDG Acceleration Fund. Every proposal shall include effective actions that support SDG acceleration in the country, based on strategic, thematical and/or sectorial priorities of the Government of Malawi. It must be aligned with the results and sectors prioritized by the Fund.

Implementing Organization(s) general information

Name of participant organization(s)	United Nations Children's Fund, United Nations Development Programme, World Food Programme, World Health Organization
Other implementing organization(s)	Government of Malawi, Ministry of Health College of Medicine, University of Malawi
Name of the legal representative of the organization(s)	Dr. Nonhlanhla Dlamini WHO Country Representative: Malawi
Name/Title/Organization of the person responsible of the project	<i>Dr Nonhlanhla Dlamini/ WHO Country Representative/ WHO Malawi</i> <i>Rudolf Schwenk/ UNICEF Country Representative/ UNICEF Malawi Country Office</i>
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PROJECT DOCUMENT

1. Project Name: Malawi National COVID-19 Vaccine Programme Support

2. Overview

2.1 General Information

Implementing Organizations:

The proposed project is a UN Joint Programme bringing together the comparative advantage of each of the four participating UN agencies in the Malawi country context to support the timely, efficient, and targeted deployment of the COVID-19 vaccine and implementation COVID-19 National Preparedness and Response plan to specific target groups for a one year period. UNICEF, brings to the partnership a strong background in humanitarian operations, immunization and social mobilisation in emergency situations and being the primary UN agency supporting the Expanded Programme on Immunization. WHO leads the health brief for the UN in the country and brings to this programme a history of human resource capacity support for vaccine deployment including the preparation of national guidelines and SOPs adapted from its global work. WHO is the lead UN partners in COVAX, the vaccine pillar of the Access to COVID-19 Accelerator (ACT-A). The UN World Food Programme in Malawi has supported logistics capacity in emergencies and especially in the COVID-19 response in Malawi over the course of 2020 as part of the National Logistics Cluster. World Food Programme (WFP) and UNICEF will collaborate on the supply chain component of the programme. UNDP has supported the Ministry of health to deploy a system to support inventory management and dispensing at health facilities as well as a National Registration Database with primary information on all Malawians above the age of 18. These systems can be used to target vulnerable persons from the database and ensure real time reporting of the usage, storage and possible wastage of vaccine doses at facility level.

Government Counterparts:

The leading government agency is the Ministry of Health and the specific programme the Expanded Programme on Immunization (EPI) and its organs the National Taskforce (NTF) for the COVID-19 vaccine rollout and the Malawi Immunization Technical Advisory Group (MAITAG). This will be the main focus of engagement at the national level. The Inter Cluster Coordination Group, Health Cluster and the Emergency Operations Unit for the COVID-19 response and the Presidential Taskforce on Coronavirus (PTF) will be secondary points of contact for national level activities. The delivery of health services is devolved and at district level the main implementing unit will be the District Executive Committee and through it the District Health Management Team and the District Taskforce (DTF) for the vaccine roll-out.

Project duration: 12 months

Starting date: April 15, 2021 **Ending Date:** April 14, 2022

Window of the Fund:

Population Management and Inclusive Human Development: COVID-19 Response

Geographic Scope:

This project will be implemented in all of Malawi's districts and municipal authorities.

Direct and indirect beneficiaries:

Direct beneficiaries are the 3.8 million priority recipients of COVID-19 vaccination including frontline health workers (377,969, out of which Female Health Workers -177,646), other health and social workers (491,360), populations with co-morbid conditions (1,814,250), the elderly aged above 60 years (944,922),

and persons in humanitarian camps (173,270) in phase 1 and phase 2 of the COVID-19 vaccine deployment.

Approaches for identification of the high-risk priority group for vaccination :

Target group identification is aimed at getting the eligible groups for COVID-19 vaccination in an equitable manner through prioritizing the recipient groups. This is in anticipation that the initial supply will not be adequate to reach the whole population. It is therefore important to prioritize groups to receive the initial vaccine supply from COVAX facility as well as subsequent vaccines that will be made available to the country. The identification and prioritization is based on COVID-19 morbidity and mortality data.

The microplanning will be done by adapting the existing micro planning tool for Supplementary Immunization Activities (SIA). The variables will include facility population and segregated priority groups. It will provide calculations for supply chain and logistics requirements which will facilitate the delivery of the vaccination. It will also include COVID-19 prevention items like a number of masks, handwashing facilities and sanitizers.

The frontline health care workers and the social workers will be identified using the Human Resource staff return being made available at the public Human resources offices. These target numbers will provide the basis for calculation of logistic and supply requirements for the delivery of the vaccines. There is likely not to face huge challenges with vaccination of the phase I priority groups because of a recent experience in rolling out Hepatitis B vaccines to all health workers.

The **Health Workers and Social Workers** shall be reached and vaccinated at their workplaces. At each health facility a COVID-19 vaccination point shall be available for the entire day to enable all health workers at the institution and social workers in that area access the service. This arrangement will enable health workers to get vaccinated whilst ensuring that services are not disrupted. Ministry of Health in consultation with the Human Resources Management offices identified the health and social workforce through staff return aggregates and physical counting of the employees. This data will facilitate supply chain and logistics including management of the delivery strategy so that each and every frontline worker is reached with information and the actual vaccine. The health workers will be registered on the day of actual immunization. A vaccine data card will be provided to each vaccinated individual so they can produce when they come back for their second dose and for their record.

Vaccine Rollout schedule with vaccination phase and target groups:

No	Target groups	Phase I (number)	Phase II (number)	Phase III (number)	Total
		Mar-June 2021	July -Nov 2021	Jan -May 22	
1	All health care workers	566,954	TBA	0	
2	Social workers including teachers, police, military, staff	302,375	TBA	0	

No	Target groups	Phase I (number)	Phase II (number)	Phase III (number)	Total
		Mar-June 2021	July -Nov 2021	Jan -May 22	
	from Malawi Revenue authority				
3	People with chronic illnesses	1,814,250	TBA	0	
4	Elderly people above 60	944,922	TBA	0	
5	Other categories like, refugees, Internally displaced population	173,270	TBA	0	
6	Young people between above 40 to 60 years old	0	1,980,000	0	
7	Social employment groups unable to social distance (commercial sex workers, vendors and individuals working at supermarkets, shops, financial institutions like banks) and travellers	0	TBA	0	
8	Age groups of high risk to transmit disease (18 to 40 years)	0	0	2,880,000	
	Total	3,779,688	4,679,376	2,880,000	11,339,064

Indirect beneficiaries are the about 5.7 million Malawian children enrolled in primary and secondary schools¹, who will be able to physically attend school in safer environments. Over 1.6 million Malawians who access health services at various facilities as more health workers, having received the vaccination will be available for work and Increased safety and security, for about 18 million Malawians, from the protection offered by the vaccine to the uniformed security forces in the country.

2.2 Budget

Total Budget: US\$ 2.1m

Name other Budget sources:

UN MPTF: \$2.1m

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http://www.nsomalawi.mw/images/stories/data_on_line/general/malawi_in_figures/2020_Malawi_in_Figures.pdf

SDG Acceleration Fund proposal will support the roll out of COVID-19 vaccination programme for the priority 20% population and UN MPTF Fund of USD 2.1 M will fit in the overall USD 4.8M national response plan as the planned supported activities are in line with NDVP. The SDG-AF funding will fill critical funding gaps in operational costs to enable implementation of strategic activities such as training of health workers, communication and social mobilization activities and strengthen cold chain capacity and waste management for a sustainable vaccine roll out.

The total estimates of funding requirements of the vaccine deployment for both phase 1 and phase 2 currently stands at \$ 4.8 million. Government of Malawi has allocated \$ 1,935,484 from domestic resources for operational costs for the vaccine roll out in all 29 districts as matching funds for this funding. In addition, USAID has provided over \$1.8 million for operational costs for such activities for trainings, cold chain and communication and social mobilization among others. Also, the government has leveraged \$30 million from the World Bank for procurement of vaccines and operational costs for an additional 10% of the population. The government continues to engage in bilateral and multilateral resource mobilization efforts to raise funding for the full deployment of the vaccine.

Matching funds: US\$ 550,000 (Govt) *Indicate if the Project counts with matching funds, either from the Government and/or from the implementing organization(s).*

Leverage: US\$ 700,000 (UN) and US\$ 30 M (World Bank) for roll out of COVID-19 vaccination beyond 20% of priority population

Leverage is made up of resources that contribute to the sustainability of the initiative, but do not go into specific project activities, nor are they part of the operational budget.

2.3 Executive summary

The global COVID-19 pandemic has a profound impact on Malawi- the two waves of infection experience so far have caused significant morbidity and mortality, disrupted continuity and demand for health services, disrupted schooling with additional harm to children, and caused damage to livelihoods and the country's economy. Malawi is one of the global Access to COVID-19 Tools Accelerator (ACT-A) beneficiary countries and is a recipient of COVAX vaccines for priority groups amounting to 3.8m people or 20% of the population in a collaboration with this fund. It is also in the process of mobilising additional resources and partnerships to vaccinate a further 8.2m targeting to reach 80% of this number by August 2022.

This project aims to provide technical and logistical assistance and to support vaccine deployment and national COVID-19 response monitoring activities between April 2021 and April 2022. It does this by focusing on 4 key output areas- increasing demand and uptake, supporting human resource capacity, strengthening supply chain, infrastructure, equipment and consumables, and enhancing monitoring, evaluation, and learning. It also prioritises support for leadership and governance at the national, zonal, and district levels. Key success metrics will be the safe administration of the COVID-19 vaccine to >80% of the key target groups at the right place with complete documentation and minimal vaccine wastage. This will reduce incidence of COVID-19 related morbidity and mortality. This is expected to minimise the disruption of services in the health and education sectors and reduce negative knock on effects of the pandemic on livelihoods in Malawi which have disproportionately affected women and girls.

2.4 Project General Objective

The project seeks to support the national deployment of the COVID-19 vaccine in Malawi to directly lead to the vaccination of 3.8 million people from specific priority groups over the course of one year under the implementation of the COVID-19 National Preparedness and Response plan. It will do this by supporting the efforts of the government of Malawi and partners to improve demand and uptake of the vaccine, provide the human resources capacity required for the deployment, augmenting the cold-chain and general supply chain, and supporting monitoring, evaluation and learning during and after the vaccine deployment.

2.5 Names and signatures of participant organizations and counterparts

In case of approval, this document must be signed by the representatives of the recipient organizations, and by the incumbent national or districtal authorities. By signing this document, the parts assume full responsibility in the achievement of the results, the workplan and the budget established in this document.

Participating Organizations	Government Counterparts
<p>World Health Organization Dr Nonhlanhla Dlamini, WHO Representative Signature: [Redacted] Date and stamp 23/4/2021</p>	<p>Ministry of Health, Secretary for Health Dr Charles Mwansambo Signature: [Redacted] Date and stamp</p>
<p>UNICEF Rudolf Schwenk, Country Representative Signature: [Redacted] Date and stamp 21 April 2021</p>	
<p>WFP Benoit Thiry, Country Representative Signature: [Redacted] Date and stamp 21/04/2021</p>	
<p>UNDP Shigeki Komatsubara, Country Representative Signature: [Redacted] Date and stamp [Redacted]</p>	



3. Situation analysis (problem)

Malawi registered its first confirmed case of COVID-19 in April 2020². It has since had two waves of cases- between May and July of 2020 and the second wave from January to March 2020 currently tapering off. The country has so far had more than 32,000 cases as of 10 March 2021 with 1074 deaths and a calculated case fatality rate of 3.3%³. The challenges posed by COVID-19 to Malawi are fourfold: (i) direct morbidity and mortality, (ii) indirect morbidity and mortality due to disruption of health systems and influence of health seeking, (iii) micro- and macro-economic effects including damage to livelihoods from epidemic control restrictions and effects on commerce, (iv) disruption of education and effects on child safety.

Prevalence studies suggest that COVID-19 related morbidity and mortality may be understated in African countries and Malawi in particular due to limited testing, poor care seeking, and lack of post-mortem examinations^{4,5}. Malawi may therefore have had worse mortality than has been recorded. Health workers have also been disproportionately affected with 1622 confirmed cases (1008-Male and 614-Female) and 21 deaths (15-Male and 6-Female) as at 10 March 2021. Infected and exposed health workers have also had to go into isolation/quarantine causing acute shortages and disrupting provision of health services. Service disruptions and fear of contracting the virus are also thought to have reduced demand for key health services. Coverage rates for institutional delivery fell 8.8% between 2019 and 2020⁶. These may be indicative of other shrinkage in demand and utilisation across the health system. Studies of resulting morbidity and mortality have not been done. Furthermore, the analysis estimates that moderate movement and livelihood restrictions would generate a higher economic cost, which would lead to a loss of \$6.7 billion – the estimated present value of GDP loss over the next 30 years⁷. As a response to the pandemic, schools in Malawi were closed countrywide, disrupting learning in twice for a total period of over 6 months in 2020 and 2021. During this period, instances of child abuse, teenage pregnancy, and gender based violence rose.

Malawi has a teenage pregnancy problem with 29% of girls having begun childbearing by the age of 19.⁸ The households in the lowest wealth quintile, thus the least resilient in the economic disruption due to COVID-19 control related restrictions has the highest teenage pregnancy rate of 44%. It can be presumed that further disruptions to education in subsequent waves of the epidemic will expose the most vulnerable girls to teenage pregnancy and dropping out of school. A Ministry of Gender and Social Welfare rapid assessment report in 2020 established that closure of schools coupled with limited household economic resources during the covid-19 period contributed to over 13,000 cases of child marriages and over 40,000 cases of teenage pregnancies. GBV cases from Malawi Police Service shows a 68% increase in reported

² Malawi National COVID-19 Vaccine Deployment Plan, 2021

³ Public Health Institute of Malawi. Daily Situation Report of 9 March, 2021.

⁴ Chibwana, M. G. et al (2020). High SARS-CoV2 Seroprevalence in Health Care Workers But Relatively Low Numbers of Deaths in Urban Malawi. *NIH Preprint/MedRxiv*

⁵ Mwananyanda, L. et al (2021). COVID-19 Deaths in Africa: Prospective Systematic Postmortem Surveillance Study. *BMJ*.

⁶ DHIS2, June 2020.

⁷ UN Malawi. Discussion Paper- Socioeconomic Impact of COVID-19 in Malawi.

⁸ Malawi DHS 2015-16

cases of sexual and genderbased violence between 2019 and 2020 in the periods January to May (from 3424 to 5,067 reported cases).

The country has a low net enrollment ratio for children aged 14-17 years with only 18% of girls and 17% of boys in secondary school according to the MDHS 2015-16. Among the poorest households, this falls further to 4.5% in the lowest wealth quintile and 5.5% in the second. The country has already had two school closures corresponding to the local epidemic's first and second waves. The most vulnerable children dropping out of school is a great risk for child protection from sexual and labour exploitation and the entrenchment of poverty through unrealized human capital. NPC (2020) estimates that the social cost of closing schools for Malawi will be around \$5.2 billion over the next 50 years. One of the negative effects of the closure of schools cited by respondents (48%) is increased workload for those responsible for childcare, who are mostly women.

Malawi's crude birth rate is 32/1000 persons or 576,000 deliveries in a year. The country has made great progress in maternal health by attaining near-universal institutional delivery under the care of skilled birth attendants. Institutional deliveries dropped 8% in 2020. It is expected that restoring the health system function for maternal health will avert about 46,000 home deliveries with the attendant risks to mothers and newborns.

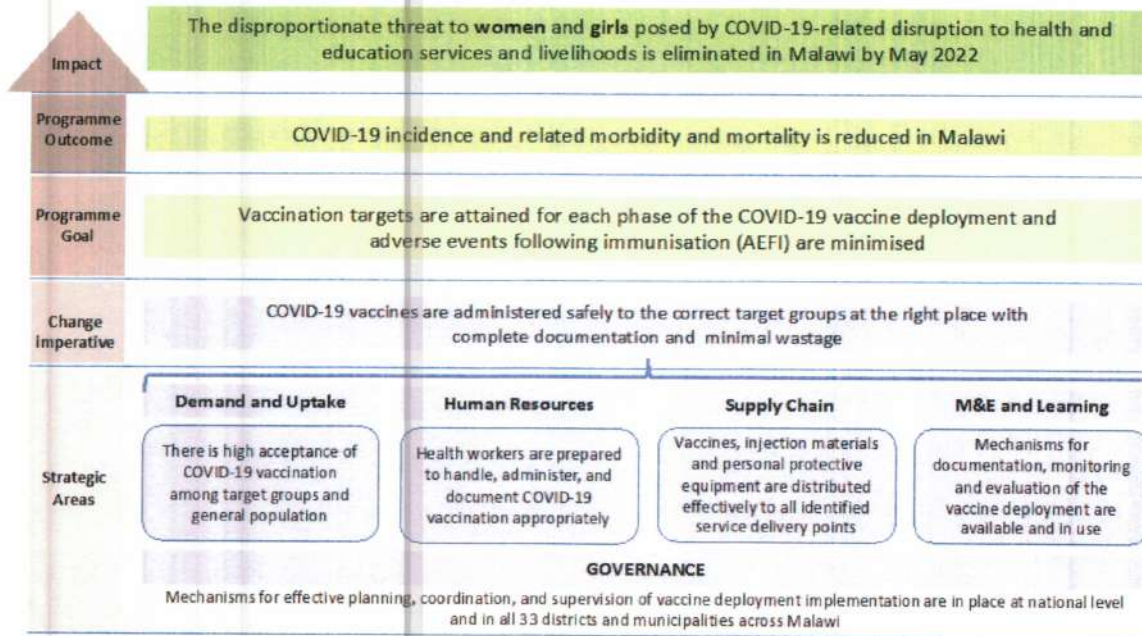
GAVI findings regarding the importance of addressing GE during COVID-19: Since the beginning of the coronavirus pandemic COVID-19 appears to discriminate against gender as it affect men worse than women and in Malawi , [men are 70% more likely to die](#) from the virus following diagnosis than women. The social, economic and long-term health consequences are in fact disproportionately impacting the lives of women and girls, in ways that could continue to exacerbate divides and inequalities within societies and impact the most marginalised, including migrant, disabled, HIV, and lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) communities.

ECONOMIC RAMIFICATIONS: The economic ramifications of COVID-19 are substantial and could exacerbate already present financial inequalities. Women represent a massive proportion of the [unprotected informal economy](#), livelihoods that include agriculture, markets and domestic workers and women globally perform [three times](#) as much unpaid care labour than men, and with families working from home during widespread lockdowns, the pressures on women as both full-time workers and carers can be immense. Economic insecurity also underlies [increases in domestic violence](#).

4. Theory of Change

The overall objective of this project is to complement the current efforts in the prevention, detection, and treatment of COVID-19 under the Malawi National Preparedness and Response Plan mitigate the effects of related disruption on the population especially on the health and education of women and girls. The operational aim is the successful deployment of a vaccine on a national scale. The 4 key strategic areas are Demand and Uptake, Human Resources, Supply Chain, and M&E and Learning. These are undergirded by Governance and jointly expected to result in equitable and safe service provision with minimal wastage.

Figure 1: *Theory of Change Model Visualisation*



Demand and uptake:

- If there is effective communication of the correct information to the population about the COVID-19 vaccines;
- If there is engagement of national, community, and religious leaders, community volunteers, and civil society organisations;
- And if there is participatory planning within communities for the vaccination programme;

Then, there will be a high acceptance of COVID-19 vaccination among target groups and the general population;

Because- there will a high level of knowledge of the vaccine’s benefits, risks, and priority target groups; and there will be positive attitudes towards the vaccine and confidence to received vaccination.

Human Resources:

- If there are adequate numbers of health care workers appointed as vaccinators;
- If the vaccinators are effectively trained on the procedures and information for safe administration and patient counselling for the vaccine;
- If adequate tools, guidelines, and job aids are made available at every prospective vaccination point of service;
- If there are proportionate incentives for vaccinators carrying out extraneous tasks;

- And if there is adequate mentorship and supportive supervision of vaccinators and immediate supervisors;

Then, the health workers will be prepared to handle, administer, and document COVID-19 vaccination appropriately;

Because- they will be the knowledge, skills, and motivation required.

Supply chain:

- If there is correct mapping of expected vaccine recipients;
- If there is adequate quantification and preparation of distribution plans for vaccines, injection materials, and personal protective equipment (PPE);
- If there is sufficient cold chain storage and transport capacity to handle the required vaccines at national and regional storage sites and health facilities;
- And if there is a mechanism for tracking distribution of these commodities across the supply chain up to the recipient;

Then, the vaccines, injection materials, and PPE will be effectively distributed to all identified service delivery points;

Because- they distribution plans with match supply to need and be effectively implemented in a timely way.

Monitoring, Evaluation, and Learning:

- If data tools are designed, produced and provided at each level of the vaccine deployment;
- If digital systems are leveraged for data handling and rapid turnaround in supply chain management, listing of eligible persons, vaccine administration and documentation, vaccine surveillance, and post-introduction evaluation;
- If there is sufficient mentorship and supervision for adherence to required documentation and reporting;
- And if a learning agenda is formulated and implemented;

Then, mechanisms for documentation, monitoring, and evaluation of the vaccine deployment will be available and in use;

Because- the availability of tools and effective supervision will lead to a high level of accountability and adherence to documentation and data recommendations.

IF: All these are in place across the districts and municipal authorities,

Governance:

AND: Mechanisms for effective planning, coordination, and supervision of vaccine deployment are in place at national level and across all 33 districts and municipal authorities in Malawi;

THEN: COVID-19 vaccine will be administered safely to the correct target groups with complete documentation and minimal wastage.

The goal of the programme is to attain vaccination targets for each target group based on projections and to minimise preventable adverse events after immunisation (AEFI). The targetting of key groups at high risk of getting infected and/or at high risk of getting severe illness will lead to reduced morbidity and mortality. As more people get vaccinated, it is expected that there will be disruption in transmission as the proportion of immune individuals approaches the numbers required for herd immunity. Ultimately, this should reduce the disruptive effects of COVID-19 and its mitigation measures and the threat this currently poses to health, education, and livelihoods in Malawi and improve availability and utilisation of safe delivery for women and reduce dropout, teenage pregnancy and early marriage among adolescent girls..

Key assumptions are that:

- There will be an adequate human resources pool from which to mobilise vaccinators and the vaccination drive will not compromise provision of other services;
- The available vaccines will continue to be safe and effective for prevention of infection, morbidity, and mortality even in the face of new virus variants;
- There will be adequate funding for operational costs for the current rollout of the vaccines;
- There will be additional funding for vaccines and deployment beyond the current 20% population coverage guaranteed under the COVAX facility.

5. Participating and implementing organizations

Organization	Role	Added Value	Capacities and experience
WHO	Lead agency for human resource capacity component and co-lead for the project and for monitoring, evaluation and learning	Supporting MoH in development of training materials, implementation of training and deployment of human resources; guiding development of clinical guidelines	Internal expertise in human resources for health, guidelines and standards
UNICEF	Co-lead agency for supply chain management support (procurement and warehousing); co-lead for the project and for monitoring, evaluation and learning	Supporting the procurement of equipment and consumables, warehousing and preparation of distribution plans. Convening agencies for the programme and coordinating M&E and learning.	Specific experience in providing support in Malawi for cold-chain and vaccine deployment including introduction of new vaccines. It has international medical procurement capacity through its Supply Division and warehousing capacity in country. It has technical expertise in supply chain as well as in knowledge management
WFP	Co-lead agency for supply chain (in country logistics and distribution)	Considering its leading role in humanitarian logistics and co-lead status under the national transport and logistics cluster, WFP brings the relevant operational expertise for the seamless delivery of this project	Expertise in humanitarian logistics and emergency response operations and active role in the COVID-19 Response in providing supply chain support to the Government and humanitarian partners.

UNDP	Co-lead agency for demand and uptake component and facility level inventory management.	Supporting the design and delivery of risk communication and community engagement; Identifying vulnerable groups for preregistration and supporting facility level inventory management	Experience in the Malawi context in resilience building to shocks and crises in communities and poverty eradication
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6. Coordination and Management

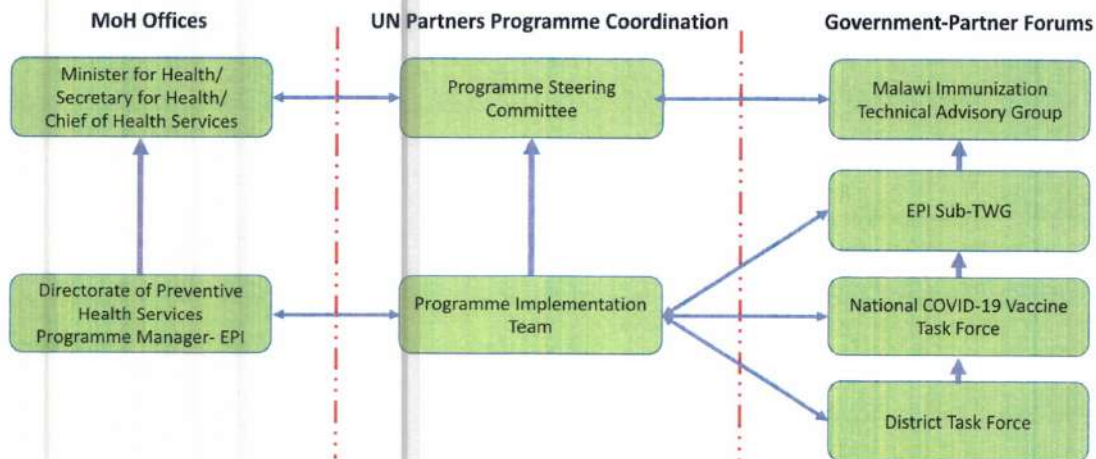
This programme is envisaged as a UN Joint Programme for Malawi under the “delivering as one” resolution of the UN. The delivery of the COVID-19 NVDP is planned and coordinated by the national Expanded Programme on Immunization (EPI). Under this is the EPI sub-technical working group which brings together the Ministry of Health, other sectors of government, implementing and civil society partners. Other government forums are the Malawi Immunization Technical Advisory Group (MAITAG) and the National Task Force (NTF) planning and monitoring the actual vaccine deployment. At district level, there will be District Task Forces (DTF) to coordinate and guide the implementation of district level activities.

The participating UN organisations (WHO and UNICEF) have representation in the EPI TWG and MAITAG. It is proposed that the UNJP partners form a steering committee led by senior managers of the various agencies that will meet every month to assess progress with the vaccine deployment. Each agency shall then nominate specific specialists and officers to constitute the Programme Implementation Team and coordinate with the MoH and other government partners as well as oversee on a day to day basis the activities of implementing partners, consultants, and contractors and liaison with stakeholders.

WHO will be the lead agency and the WHO Representative the overall programme contact.

The SDG AF proposal will build on existing coordination mechanisms and efforts at the national and subnational levels. At the National level, the National Task Force (NTF) which comprises of all key immunization partners and other stakeholders such as CSOs shall serve as the platform for coordinating efforts and tracking continuation of progress beyond the expiry of the SGD-AF funding. The NTF is already engaged in planning for an enhanced NDVP to target populations beyond the 20% covered through COVAX facility. The NTF will therefore continue to lead and coordinate COVID-19 vaccination roll out beyond the current eligible population ensuring sustainability of interventions supported under this funding. At the district level, District Councils will provide leadership and direction in the implementation bringing together government line ministries, NGOs, political leaders, community leaders and all relevant players to coordinate efforts and resources in the vaccine roll out.

In addition, using SDG AF funds, we are building the capacity of health workers and programme managers for COVID 19 vaccination for initial 20% priority population and the same health workers/programme managers will support and implement the overall roll out of COVID-19 vaccination beyond the initial 20% population. Similar, the strategic activities/initiatives that are being implemented using SDG AF funds for strengthening for Cold Chain & Vaccine Management, Waste Management, Social Mobilization and demand generation will support the overall vaccination plan of Govt of Malawi.

Figure 2: Chart of Programme Coordination Structures

7. Project logic of intervention

The project's operational objective is to ensure the availability, acceptability, and service delivery of COVID-19 vaccination to the correct priority groups in a phased manner in Malawi in line with the National Deployment and Vaccination Plan (NDVP) and the National COVID-19 Preparedness and Response plan. It does this by working in the 4 key areas of "Demand and Uptake", "Human Resources", "Supply Chain", and "Monitoring, Evaluation, and Learning" and by tying these areas through "Governance" at every level.

Demand and Uptake:

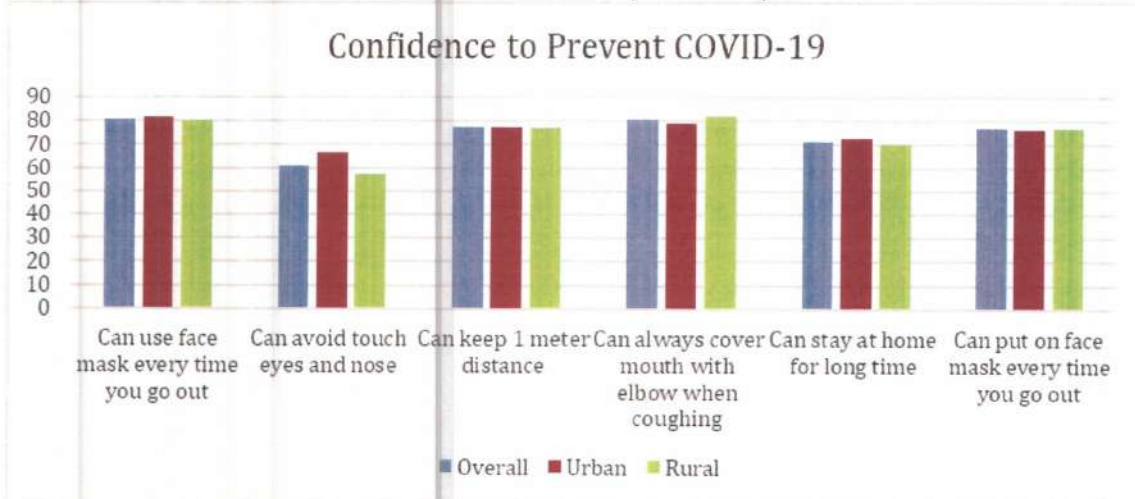
Since the COVID-19 outbreak, an "infodemic" of related information including misinformation and disinformation has spread alongside the pandemic. Malawi has not been left out and the national response to the local epidemic has faced resistance and even incidents of violence towards contact tracers and other health workers. Since early 2020, there has been general hesitancy around COVID-19 vaccine on social media and the overall tone of immunization content was trending negative in the region, including Malawi. Around 40% of content had a negative tone, with only 8% of articles and posts displaying positive content. Examples included posts encouraging vaccine refusal and conspiracy claims that Bill Gates is using the COVID-19 vaccine rollout to control people.

The following narratives were tracked in relation to the COVID-19 vaccines:

- Religious fears: Fears that it is work of the devil
- Effectiveness of the vaccine: Short period of manufacturing and new variants
- Safety concerns and misinformation: Specific adverse effects and infertility claims

- **Pandemic Fatigue:** Pandemic fatigue is increasing while risk perception remains low at around 40%.

The table below illustrates confidence levels for some preventive practices:



IOGT HEALTH WORKERS COVAX SURVEY : Key findings of the first round results on the health workers COVAX survey done in March 2021. It is from the online platform (Internet of Good Things (IoGT), which is a free platform) and the link for the survey : <https://datastudio.google.com/u/0/reporting/f5425ee4-9e5e-4a92-abf2-c1f9db4ee238/page/7j9yB>

1. More than half of the respondents (56.3%) say it is very easy to get vaccine services for themselves.
2. 70% say if the vaccine was recommended for them they would get it. 77.5% say they would also recommend it to eligible clients once it becomes available.
3. However, there seems to be trust issues with the vaccine. Only 37% of the respondents say they trust the vaccine very much, 23% say they don't trust it at all, 22% say they have little trust while 18% say they trust it moderately.
4. Even among themselves, 41.3% of the health workers say they are not sure if the people they work with will get the vaccine when it is made available for them.
5. While 21.3 of respondents don't have any concern with the vaccine, 38.8% say their biggest worry is the safety and side effects of the vaccines. 21.3% say they are concerned with the speed the vaccine was developed. 7.5% say they have been sick already and recovered from COVID-19.

Approach/methodology for Demand and Uptakes:

This key area of work aims to counter the effects of misinformation about the vaccine and improve acceptance of the vaccine by targeted populations.

- Community engagement activities including- development, printing, and distribution of operational guide for community engagement and required orientation; briefing of local leaders

- Development and implementation of media strategy for vaccine roll-out to increase public awareness and increase acceptance
- Interpersonal communication activities with specific target groups
- Formulation and implementation of a risk communication plan including a vaccine crisis management plan
- Development, printing and distribution of vaccination campaign materials§

1. Participant groups/target audience

Priority audiences addressed in this strategy are based on data from WHO guidelines, national guidelines and studies which identified the priority and key populations for COVID-19 Vaccination. The target audiences are the target population for the vaccination and their influencers.

The primary audience: Health workers in private and public health care facilities, older people aged 60 and above, people that have chronic conditions and social workers who interact with many people on daily basis like teachers, security institutions i.e. Police, Prisons and immigration staff among others.

The secondary audience: The leadership of association of medical doctors, nurses, environmental health, pharmacy, laboratory and other allied health association, associations on PLHIV, cancer, diabetics and others. The nurses’ council and medical council of Malawi, Teachers Association of Malawi. The leadership of elderly people in Malawi, pensioniers’ association of Malawi, religious groupings, Malawi interfaith association, Pentecostal churches of Malawi, traditional leaders, youth groups, disability organizations and community-based volunteers’ e.g. CHAGs.

The tertiary audience: Members of parliament, health right activists, Malawi healthy equity, MISA Malawi, media fraternity

2. Participants Audiences and Channels of Communication:

Primary target audience	Audience description	Proposed Approaches and Channels
COVID-19 Vaccine Communication		

Primary target audience	Audience description	Proposed Approaches and Channels
Health workers	All people engaged in actions whose primary intent is to enhance health in private and government facilities. Health workers infected with COVID-19 may contribute to health care-associated infection transmission of infection to their patients and people they care for, including those at high risk for developing severe COVID-19 disease and complications.	Interpersonal Communication: Face to Face Orientation, Focus Group discussions, digital media e.g. WhatsApp groups, power-point slide decks. Mass media: Radio/TV programs & spots.
Elderly	People aged 60 years and above due to their age-related lowered immunity exposing them to higher risk of many infections including COVID-19	Interpersonal Communication: community dialogues Community Mobilisation: Door to Door, Mobile van announcements, influential leaders, religious leaders, community-based volunteers' e.g. CHAGs. Mass Media: radio and TV spots/programs. Print media: Posters, flyers, leaflets, stickers.
Persons with underlying health conditions	People of all ages that are diabetic, living with HIV, have high blood pressure, asthma and other chronic conditions who are at significantly higher risk of severe disease or death due to COVID-19.	Interpersonal Communication: community dialogues. Community Mobilisation: Door to Door, Mobile van announcements, influential leaders, religious leaders, community-based volunteers' e.g. CHAGs. Mass Media: radio and TV spots/programs. Print media: Posters, flyers, leaflets, stickers.
COVID-19 Preventive Behaviours		

Primary target audience	Audience description	Proposed Approaches and Channels
Teachers, security staff, immigration staff, MRA staff, drivers, sex workers, hospitality staff	Due to the nature of their job, these workers interact with a lot of people and most of the time it can become difficult to adhere to preventive measures.	<p>Interpersonal Communication: Face to Face Orientation, digital media e.g. WhatsApp groups, power-point slide decks.</p> <p>Mass media: radio/TV programs & spots.</p>
People around borders/POEs (general populations)	They are at high risk of getting infected with COVID-19 as they may get exposed to travellers.	<p>Mass communication: leaflets, banners, radio programs/spots.</p> <p>Community Mobilisation: community dialogues, meetings, Door to Door, Mobile van announcements, influential leaders, religious leaders, community-based volunteers' e.g. CHAGs.</p>
Travellers	They are highly exposed to COVID-19 during travel.	<p>Mass communication: leaflets, banners.</p>
General population	They may have low risk perception due to misconceptions and myths.	<p>Interpersonal Communication: Community dialogues.</p> <p>Interpersonal Communication (for children and youth): Creativity Competitions (art, story, theatre, video) on themes that promote vaccine uptake (from T/A-level).</p> <p>Community Mobilisation: Door to Door, Mobile van announcements, influential leaders, religious leaders, community-based volunteers' e.g. CHAGs.</p> <p>Mass Media: radio and TV spots/programs.</p> <p>Print media: Posters, flyers, leaflets, stickers.</p>

Primary target audience	Audience description	Proposed Approaches and Channels
Children & Young People	<p>Children are particularly vulnerable to the socio-economic impacts and, in some cases, by pandemic mitigation measures e.g. school closures. They may not be able to access appropriate information or understand the recommended behaviours and also suffer from the psychosocial impacts of the pandemic. There may also be disruptions in care due to the socio-economic impacts.</p> <p>On the other hand, children and young people may be great spreaders of the word to their families and communities.</p>	<p>Interpersonal Communication: interactive guides, sensitization at school by School Health Committees or teachers.</p> <p>Mass Media: comic books, animations.</p> <p>Community Mobilisation: Door to Door, Mobile van announcements, influential leaders, religious leaders, community-based volunteers' e.g. CHAGs.</p>
The homeless	<p>They may live isolated from society and not have a network of family and friends to share information.</p> <p>They may be more focused on surviving and obtaining food than accessing official public health information and may be suspicious or fearful of government services while being at high-risk of getting severe COVID-19.</p>	<p>Interpersonal Communication: Guides for child protection frontline workers.</p>
GBV Survivors	<p>Gender-based violence (GBV) increases during every type of emergency, including disease outbreaks. Care and support for GBV survivors may be disrupted, including safety, security and justice services.</p>	<p>Interpersonal Communication: Victim support materials (integrated with COVID-19 messages).</p> <p>Print media: Posters, flyers, leaflets, stickers.</p>

Primary target audience	Audience description	Proposed Approaches and Channels
Persons with disabilities.	Even under normal circumstances, people with disabilities are less likely to access health care, education and employment and to participate in the community. They are more likely to live in poverty, experience higher rates of violence, neglect and abuse, and are among the most marginalized in any crisis-affected community. They are often excluded from decision-making spaces and have unequal access to information on outbreaks and availability of services, especially those who have specific communication needs.	Interpersonal Communication: Special materials for PwDs e.g Braille, sign language. Print media: Posters, flyers, leaflets, stickers.
Youth	15 to 30 year olds, especially school graduates living at home, and people already volunteering in community initiatives, currently unemployed.	Interpersonal Communication: Creativity Competitions (art, story, theatre, video) on themes that promote vaccine uptake (from T/A-level). Multi-media: WhatsApp groups, U-Report, Radio.

Human Resources:

The vaccination effort is a time-bound process due to vaccine shelf-life and viability and the urgency of protecting the priority populations and Malawians at large. It will therefore require a large deployment of human resources for mobilisation of communities and target persons, provision of vaccination, and assistance at the vaccination sites. The mobilisers, vaccinators, and volunteers will all require training, transportation to sites of activities and other logistical arrangements, and compensation for their effort and time.

- Cascade training of trainers, vaccinators, mobilisers, volunteers and supervisors
- Development and printing of training guides (field, operational, training deck, and SOPs)
- Briefing of supervisors, district executive committee members, vaccinators, and volunteers

Availability of human resources is critical in the introduction of the COVID-19 vaccine. The EPI Programme is under the directorate of Preventive Health services in the Ministry of Health. At National level, the programme is managed by the EPI Programme manager and assisted by his deputy. In addition, there are officers responsible for Routine immunization, cold chain, supply chain, surveillance for both diseases, and AEFI and Monitoring and Evaluation.

The country has five zones and in all the zones there are Routine immunization officers responsible for the zone. In two zones where there are cold-rooms and Zonal Immunization Supply Officers managing the cold rooms and supplies. There are 29 District EPI Coordinators managing EPI services in districts and these are assisted by their deputies and district Cold Chain Technicians.

About 80% of vaccinations in Malawi are done by the cadre of Health Surveillance Assistants (HSA), some nurses mainly Community Health Nurses (CHN) and clinicians also provide immunization services. During vaccination sessions, the vaccinators are assisted by volunteers who support with crowd control, and other integrated interventions e.g. growth monitoring. Therefore, there will be a need to identify an adequate number of vaccinators among the available health workers to implement the COVID-19 vaccination.

The COVID-19 vaccination will be handled by Health surveillance Assistants as usual who will be supervised by the Community Health nurses, Public Health Officers at district including other cadres who will be designated to undertake the supervisory role depending on training and availability. At the health facility level, Nurses will be expected to vaccinate all the health and social workers at their health facilities.

Training of district/health facility AEFI team members and ensuring drugs and trained medical staff available to manage serious adverse events following immunization e.g. anaphylactic shocks on site

Supply chain:

The commodities required for delivery of safe vaccination services include vaccines, injection materials such as syringes, needles, swabs, and sharps containers, and infection prevention and control (IPC) and water, sanitation, and hygiene (WASH) equipment and consumables such as handwashing stations, soap, dispensers. Personnel also require personal protective equipment (PPE) such as gowns, face masks, face shields and gloves. These materials need to be available in adequate quantities and in good condition across the country and to be documented and replenished as necessary. Vaccine storage will use existing cold chain equipment of the national EPI programme which have been augmented under COVAX support to strengthen capacity for COVID-19 vaccine deployment.

- Vaccine procurement and importation support to the Ministry of Health for vaccines outside of the COVAX facility
- Development of standard operating procedures (SOPs)
- Further strengthening cold chain capacity down the supply chain
- Logistics resilience building – port health and health facility augmentation (including transportation and light engineering)
- Preparation of distribution plans for vaccines, injection materials, PPE, and auxiliary consumables
- Distribution of vaccines and other consumables to districts and health facilities

- Provision of waste management and reverse logistics services to the vaccination points
- Support for facility level inventory management and dispensing of doses to recipients

Monitoring, Evaluation and Learning:

Monitoring tools will be adapted from the COVID-19 vaccination monitoring framework and be utilized for data collection at national, district and community levels.

- Development of data monitoring tools
- Mapping of vaccine-eligible persons and confirmation of eligibility
- Effective vaccine management assessment (EVMA)
- Post-introduction evaluation (PIE) for COVID-19 vaccine
- Vaccine safety monitoring and documentation- surveillance for adverse events following immunization (AEFIs) and adverse events of special interest (AESIs).
- Developing, printing and distribution of data collection forms for community, district, and national levels
- Developing an online national and district dashboard and other digital modules such as for U-report, Chipatala cha pa Foni (CCPF)

Governance:

National level structures involved in the deployment of the vaccine include the Ministry of Health leadership, the EPI programme, EPI sub-TWG, the Malawi Immunization Technical Advisory Group (MAITAG) and the National Task Force (NTF). These structures are responsible for national level policy and strategy, guidance to and supervision of the districts, coordinating procurement and distribution of materials, and overall national monitoring and evaluation. District Task Forces (DTF) will be formed at district level to oversee activities at the district, health facility, and community levels.

- National level resource mobilisation and advocacy
- Preparation and distribution of guidance documents including guidelines, job aids, SOPs, and reporting formats
- Coordination of collaborative activities including information management and dissemination, mentorship and supervision, and communication
- Microplanning – development of tools and monitoring of implementation
- Supervision by NTF and DTFs

8. Results Sustainability

8.1 Project entry strategy

The Government of Malawi plans is implementing COVID-19 vaccination response to the COVID-19 pandemic since mid March 2021 aiming to reach at least 20% and 80% of the target population by August 2021 and May 2022 respectively. This UN joint project will support operationalization of the (NDVP), a one country plan which guides the acquisition, distribution and actual vaccination of the eligible population. The NDVP is a resource mobilization support tool and it is part and parcel of the National Covid-19 response

strategy. It is a must requirement for vaccine allocation by the COVAX facility. COVID-19 vaccine introduction has been planned and continues to be coordinated through existing immunization structures of the EPI program including the EPI Sub Technical Working Group (EPI TWG) and NTF where the participating UN agencies are represented and continue to provide technical guidance and support. Another key structure is the MAITAG that has received support from the UN to convene and provide policy recommendations on priority populations for COVID-19 vaccinations and choice of vaccine for the country basing on the epidemiological context and UN technical guidance tools and frameworks. At subnational level, a replica structure of the NTF called the District Task Force (DTF) will coordinate and guide implementation of district level activities. This NDVP was developed in line with the guidelines provided by WHO and MAITAG.

COVID-19 vaccination will be delivered using existing immunisation delivery platforms with a few modifications where necessary to accommodate the unique characteristics/needs of some of the targeted population groups. The same processes, monitoring tools, reporting structures and human resources for the routine vaccination will be utilised. The existing tools have been adapted to incorporate key COVID-19 vaccine related information. The UN support in capacity building of health workers on COVID-19 vaccine delivery which covered all key EPI programmatic components and the support for cold chain installation/expansion will help to strengthen the immunisation system even beyond COVID-19 vaccine introduction/roll out.

8.2 Project exit strategy

The UN joint Project will support the Malawi Government to roll out the COVID-19 vaccination in the specified timelines as outlined in the national deployment and vaccination plan to reach 80% of the targeted population with vaccination by May 2022. The vaccination will be coordinated by the Expanded Programme of Immunization using routine immunization structures. Thus UN agencies will have to support the vaccination programme with technical and financial support to ensure there is adequate capacity to handle the extra effort that will come with the COVID-19 vaccine.

The UN joint Project will contribute to the training of health care workers, development of monitoring and evaluation tools (vaccination cards, immunization registers, tally books and vaccine safety surveillance forms), and shipment of COVID-19 vaccines and immunization supplies from manufacture up to facilities. All these activities will be documented through periodic implementation reports from the responsible UN agencies supporting particular activities. The UN joint Project will continue evaluating the need of continuity of support including building capacity of the routine immunization as there is possibility of the vaccination becoming a regular activity depending on COVID-19 epidemiology.

9. Geographic Scope

The project will be implemented across all of Malawi's districts and local municipal authorities.

10. Beneficiaries

Direct beneficiaries are the 3.8 million priority recipients of COVID-19 vaccination including frontline health workers (377,969, out of which Female Health Workers are 177,646), other health and social workers (491,360), populations with co-morbid conditions (1,814,250), the elderly aged above 60 years (944,922), and persons in humanitarian camps (173,270) in phase 1 and phase 2 of the COVID-19 vaccine deployment.

Indirect beneficiaries are the subsequent recipients of the voluntary vaccination after phase 2 who will benefit from the seminal and catalytic effects of this programme and the 18m citizens and residents of Malawi and incoming travellers who will be at reduced risk of contracting COVID-19. 5.7 million Malawian children enrolled in primary and secondary schools⁹, will be able to physically attend school in safer environments. Over 1.6 million Malawians who access health services at various facilities as more health workers, having received the vaccination will be available for work. In particular 46,000 women will access safer delivery services as availability and demand of maternal health services which fell in 2020 is restored. There will be increased safety and security for about 18 million Malawians from the protection offered by the vaccine to the uniformed security forces in the country.

11. Results Framework and Budget

The Results Framework must contain a hierarchy of the effects of the fund, indicators, baselines and goals. The indicators must be SMART (specific, measurable, achievable, relevant, in a time frame and with a deadline). This hierarchy must be reflected in the following table.

Indicate to which indicator(s) of the UNSDCF the initiative aims. Likewise, propose the indicators and goals that allow their measurement according to the project activities. Secondary indicators should be outcome or impact. As much as possible the indicators demonstrate the change that the project is seeking to address. Choose indicators that you can measure and from which you can report AGGREGATED progress quarterly. Note that at least one gender indicator should be included.

⁹

http://www.nsomalawi.mw/images/stories/data_on_line/general/malawi_in_figures/2020_Malawi_in_Figures.pdf

Results Framework

Window: Population Management and Inclusive Human Development: COVID-19 Response: Proposal Outcome					Outcome Total Budget USD
	1 IMPACT: 1. Restoration and continuity of health and educational services and non-disruption of livelihood activities and mitigation of disproportionate effects on women and girls.				USD
	1.1 COVID-19 incidence and related morbidity and mortality is reduced in Malawi				
		Baseline	Target	Means of verification	Responsible Org
Impact Indicator	1a Percentage points improvement in institutional delivery rate from 2020 1b Retention rate of boy and girls in secondary school	Baseline (83%) Basekine XXX (UNDP to provide data)	91 % (8% improvement) TargetXXX (UNDP to provide data)	DHIS	WHO/UNICEF/UNDP/WFP
Outcome Indicator	1.1a Proportion of total confirmed cases per 1M population • Among health workers over 6 months • In general population over 6 months	TBD	>100% reduction (health workers, 53% Male and 47% Female)	MoH (Public Health Institute of Malawi epidemic situation reports)	WHO/UNICEF/UNDP/WFP

			>30% reduction (population)		
	1.1b Proportion of total deaths per 1M population <ul style="list-style-type: none"> • Among health workers over 6 months • In general population over 6 months 	TBD	>100% reduction (health workers) >30% reduction (population)	MoH (Public Health Institute of Malawi epidemic situation reports)	WHO/UNICEF/UNDP/WFP
Proposal Outputs	1.1.1 There is a high acceptance of COVID-19 vaccination among target groups and general population in Malawi				
	1.2.1 Health workers are prepared to handle, administer, and document COVID-19 vaccination appropriately				
	1.3.1 Vaccines, injection materials and personal protective equipment are distributed effectively to all identified service delivery points				
	1.4.1 Mechanisms for documentation, monitoring, and evaluation of the vaccine deployment are available and in use				
Proposal Output Indicators	1.1.1a % of fully immunized persons for each target group category disaggregated by sex and age	0%	100%	DHIS2/ COVID-19 vaccine registers	WHO/UNICEF/UNDP/WFP
	1.1.1b % of beneficiaries and/or their parents who are willing to be vaccinated (or given consent)	TBD (survey)	100%	DHIS2/ COVID-19 vaccine registers	WHO/UNICEF/UNDP/WFP
	1.1.1c % of individuals who believe that all eligible persons should take the COVID-19 vaccine	TBD (survey)	100%	Survey data	WHO/UNICEF/UNDP/WFP
	1.2.1a				WHO/UNICEF/UNDP/WFP

	% of major of immunised persons with major Adverse Effect Following Immunization (AEFI)	N/A	<1%	COVID-19 vaccination report	
	1.2.1b % of health facilities with no vaccine wastage	TBD (survey)	100%	Facility vaccine registers	WHO/UNICEF/UNDP/WFP
	1.2.1c % of target number of health workers and mobilizers trained	0%	100%	Activity reports	WHO/UNICEF/UNDP/WFP
	1.3.1a % of Health Facilities with functioning cold chain equipment	100%	100%	Readiness assessment data	WHO/UNICEF/UNDP/WFP
	1.3.1b % of health facilities with zero stock out of vaccine during month	0%	100%	Intra-activity review (IAR) data	WHO/UNICEF/UNDP/WFP
	1.4.1a % of health facilities with up-to-date COVID-19 vaccination data during the month	0%	100%	DHIS2/IAR data	WHO/UNICEF/UNDP/WFP

SDG Targets and Indicators

Sustainable Development Goals (SDGs) [select max 3 goals]			
<input type="checkbox"/>	SDG 1 (No poverty)	<input type="checkbox"/>	SDG 9 (Industry, Innovation and Infrastructure)
<input type="checkbox"/>	SDG 2 (Zero hunger)	<input type="checkbox"/>	SDG 10 (Reduced Inequalities)
<input checked="" type="checkbox"/>	SDG 3 (Good health & well-being)	<input type="checkbox"/>	SDG 11 (Sustainable Cities & Communities)
<input type="checkbox"/>	SDG 4 (Quality education)	<input type="checkbox"/>	SDG 12 (Responsible Consumption & Production)

<input type="checkbox"/>	SDG 5 (Gender equality)	<input type="checkbox"/>	SDG 13 (Climate action)
<input type="checkbox"/>	SDG 6 (Clean water and sanitation)	<input type="checkbox"/>	SDG 14 (Life below water)
<input type="checkbox"/>	SDG 7 (Sustainable energy)	<input type="checkbox"/>	SDG 15 (Life on land)
<input type="checkbox"/>	SDG 8 (Decent work & Economic Growth)	<input type="checkbox"/>	SDG 16 (Peace, justice & strong institutions)
<input checked="" type="checkbox"/>	SDG 17 (Partnerships for the Goals)		

Relevant SDG Targets and Indicators

[Depending on the selected SDG please indicate the relevant target and indicators.]

Target	Indicator # and Description	Estimated % Budget allocated
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	<p>1.1a Proportion of total confirmed cases per 1M population</p> <ul style="list-style-type: none"> • Among health workers over 6 months • In general population over 6 months <p>These are measures of incidence of COVID-19 in the general population and among health workers (as a proxy for target groups for this vaccine roll-out).</p> <p>Indicator description= (# confirmed cases/# of target population) x 1,000,000</p>	100%
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	<p>1.1.1a % of fully immunized persons for each target group category disaggregated by sex and age Indicator description= (# of persons receiving full dosing for COVID-19 vaccine/# of target persons) X 100%</p>	100%
3.d Strengthen the capacity of all countries, in particular developing	<p>1.1.1a % of fully immunized persons for each target group category disaggregated by sex and age</p>	100%

countries, for early warning, risk reduction and management of national and global health risks.	Indicator description= (# of persons receiving full dosing for COVID-19 vaccine/# of target persons) X 100%	
5.c: Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels	5.c.1: Proportion of health facilities to track and make public allocations for gender equality and women's empowerment	100%

OVERALL BUDGET

BUDGET SUMMARY ^{*10}					
CATEGORIES	WHO	UNICEF	WFP	UNDP	TOTAL
	A	B	C	D	A+B+C+D
1. Staff and other personnel	\$0.00	\$95,000.00	\$76,803.00	\$57,750.00	\$229,553.00
2. Supplies, commodities, materials	\$50,000.00	\$110,000.00	\$250,000.00	0	\$410,000.00
3. Equipment, vehicles, and furniture, incl. depreciation	\$0.00	0	\$0.00	\$124,844.00	\$124,844.00

¹⁰ This table is part of the Project document. It can't be presented as an annex.

4. Contractual Services	\$0.00	\$0.00	\$100,000.00	0	\$100,000.00
5. Travel	\$50,000.00	\$45,925.00	\$0.00	0	\$95,925.00
6. Transfers and grants to counterparts	\$365,185.00	\$215,000.00	\$0.00	\$260,000.00	\$840,185.00
7. General operating costs and other direct costs	\$50,000.00	\$53,000.00	\$40,696.00	\$19,250.00	\$162,946.00
Sub-total Programme costs	\$515,185.00	\$518,925.00	\$467,499.00	\$461,844.00	\$1,963,453.00
8. Indirect Support costs *6.5%	\$35,815.00	\$36,075.00	\$32,500.00	\$32,106.00	\$136,496.00
TOTAL	\$551,000.00	\$555,000.00	\$499,999.00	\$493,950.00	\$2,099,949.00

15 Crosscutting approaches

The programme has been necessitated by both direct suffering from the morbidity and mortality associated with the COVID-19 pandemic but also the indirect effects of the local epidemic on continuity of schooling and child nutrition and protection in school environments, continuity of health services and disruption of key maternal and child health services, and effects on livelihoods and the deepening of poverty in income-vulnerable households. The programme prioritises teachers and health workers, among other social workers, for protection against COVID-19. By protecting teachers, the programme ensures that children can continue with schooling and that this will have the direct effect of mitigating the risk to children in out-of-school settings such as teenage pregnancies and child labour and improve the welfare of children in terms of both education and protection. These effects have been disproportionately faced by girls in Malawi, especially the risk of early marriage.

Some of the key services for which demand and uptake has fallen in the course of the COVID-19 pandemic have been maternal health services, including institutional delivery which is critical for reducing maternal complications and mortality. Protecting health workers will ensure continuity of availability of key services due to lower incidence of COVID-19 among health workers and reduced need for isolation and quarantine. The vaccine deployment is entirely voluntary for target persons in compliance with a rights-based approach to preventive care services. The demand and uptake component of the programme will seek to provide information, correct misconceptions, and cause more people to volunteer to receive the vaccines. The targeting of groups for priority vaccination is also based on epidemiological realities that merge risk of contracting the disease and the likelihood of a poor clinical outcome. Health and social workers are targeted because of their increased risk of coming into contact with infected persons in the course of their work- this is a matter of justice. Persons with key conditions associated with severe COVID-19 disease are targeted due to this increased vulnerability.

The process of identification of eligible persons for priority vaccination is intended to be open and fair and the provision of required information to reach the populace as effectively as possible. This is to ensure that all willing eligible persons receive the vaccine and there is no significant misdirection of vaccine resources to undeserving persons.

15.1 Gender Equality

Gender equality is not only a fundamental human right, but a necessary foundation for a peaceful, prosperous and sustainable world. Therefore, all projects supported by the Fund must include actions that favor the closing of gender gaps and inequalities. For this purpose, any project must meet a Gender Marker of 2a or 2b. Mark with an X if it meets the following premises:

- The situation analysis includes a differential approach, identifying the different ways in which the problem affects women and girls differentially.
- The theory of change includes and promotes gender equality.
- The logic of intervention addresses gender inequalities in its results and expected impact.
- The indicators measure the differential impact between women, men, girls and boys.
- The Budget includes specific provisions for gender equality activities (at least 30% of the budget).

The strategic objective of the programme is to advance towards gender equality.

Autoevaluate the programme gender marker, as:

0

1

2a

2b

Indication:

- If you ticked between 0 and 1 to the previous premises, the gender marker will be 0: The gender dimension is insufficiently reflected in the project.
- If you ticked between 2 and 4 premises, the marker is 1: The Project contributes in a limited way to gender equality.
- If you ticked 5 premises the marker is 2a: The Project contributes significantly to gender equality.
- If you answered positively to all the premises and if the general strategic objective is to advance towards gender equality, the gender marker will be 2b.

The project must dedicate a total of 30% of its resources to activities that promote gender equality. Describe them below indicating specific amounts per activity:

Total USD \$650,000 (31.0%)

The project seeks to provide COVID-19 vaccination equitably to both genders among the persons targeted for priority vaccination and to track results by gender so as to address any skewing. In addition to the direct benefit to the individuals vaccinated, the project targets continuity in the provision of services in the health and educational sectors the disruption of which have disproportionately disadvantaged women and girls.

<u>Activity and its relation to the results framework (to which product/result it corresponds)</u>	<u>Effect in gender equality</u>	<u>Amount</u>
Provision of vaccination to frontline health providers	Ensuring continuity of key maternal health services that have fallen during the COVID-19 pandemic	US\$ 450,000
Provision of vaccination to teachers and social workers in uniform	Preventing disruption of schooling that has been linked to an increase in teen pregnancies and early marriage among adolescent girls, child labour among boys, and school dropout for both boys and girls.	US\$ 200,000

15.2 : Environment: Vaccine Waste Management

Vaccination campaigns are known to generate wastes. Types of wastes include sharps, infectious non-sharp wastes and IPC materials wastes e.g. gloves, masks, used syringes, and other injection materials that have negative effects on communities and the health workers. The risk from wastes generated during campaigns increases when temporary sites are opened in communities. The idea behind waste management is to ensure that we do not pose any risk to both humans and the environment while vaccinating the people. It is important that wastes are properly and categorically managed. The EPI through the supply chain coordination team will facilitate collection of different wastes from the vaccination sites to the designated incineration and disposal sites.

The National Vaccine Store (NVS) generates significant quantities of wastes from secondary packaging and packs that help maintain the right conditions during transportation of vaccine and injection materials. These wastes are shipped to pharma grade environmentally friendly incinerators located at Kamuzu Central Hospital (KCH) in the central region and Queen Elizabeth Central Hospital in the south where they are properly incinerated and disposed of. In addition, all waste generated at service delivery points including used syringes and vials are largely disposed of by incineration at the district hospital level. We are planning to use the same structures to dispose of waste that will be generated during the management of COVID-19 vaccine.

The EPI program-MOH will be responsible for ensuring that all vaccines and vaccine devices which have been used are recalled back to the National Vaccine stores. These will be reallocated or should they show signs of not being potent, then disposal will be planned with nearest incineration facility. A budget has been set aside to support this process and it is a common practice even during supplementary immunization activities SIA.

16 Monitoring and Evaluation

16.2 Monitoring

Programme monitoring contributes to ensuring accountability, learning and informing timely decision-making at the level of implementation. In addition to close tracking of inputs, activities and their contribution to outputs, it also serves as an input to managing for results and evaluation. More specifically, monitoring helps to (i) assure progress towards achievement of planned results, including attention to pace of implementation and use of resources;(ii) to identify implementation bottlenecks and barriers; and most importantly (iii) to trigger timely solutions, corrective actions as well as programme adjustments in response to the perspectives of children, women and their families, especially those from most vulnerable groups.

The project's results and measurement framework has 2 outcome indicators, each with two components, and 9 output indicators across 4 major output areas. Data collection will primarily be from the vaccination registers and DHIS2 for data relating to service provision; periodic surveys for assessment of population

knowledge, attitudes, and practices relating to the vaccine and COVID-19 prevention and for assessment of system functioning; and logistics management information system data for commodity distribution. Service indicators (vaccinations and vaccine surveillance), indicators related to commodity management and activity indicators such as trainings will be collated on a monthly basis at district, zonal, and national levels. Cross sectional surveys of system functioning (such as cold chain status) and of community attitudes and receptivity will be done quarterly. Outcome data will be collected as part of routine data for the Public Health Institute of Malawi and calculations made quarterly. Qualitative implementation data will be collected continually during mentorship and supervision visits. Monthly reviews of implementation will be carried out at district level and quarterly reviews at national level.

16.3 Evaluation

UN Joint Programmes follow the United Nations Evaluation Group (UNEG) standards for quality and independence. OECD evaluation criteria shall be used to address both learning and accountability and to make use of the best available evidence to:

- inform programme revisions,
- improving implementation,
- enhance system strengthening for evaluation and research through capacity-building,
- make use of lessons learned for evidence-based policymaking and advocacy, and
- to ensure accountability toward the donor and programme beneficiaries.

Baseline and Continual Evaluative Processes: The Malawi government undertook an assessment prior to the introduction the COVID-19 vaccine using WHO’s Vaccine Introduction Readiness Assessment Tool (VIRAT) with the support of the participating UN agencies.

The data from this will be used as a baseline to determine the starting point for some of the monitoring indicators and to support the evaluation. Continual knowledge management work will also be undertaken by the joint UN team using standard checklists to assess intervention progress based on the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework.

Knowledge products out of the evidence generated will be used to reach out to various key stakeholders with tailor-made learning briefs, infograms and documentaries.

Endline Evaluation: Post-Introduction Evaluation (PIE) will be done using the WHO PIE tool and this will serve as the evaluation mechanism for the project.

17 Risks Matrix

In this section use the contextual analysis carried out in the description of the problem to list the risks that, if materialized, will affect the implementation of the project.

Risk	Associated to the Result #	Classification			How will the risk be mitigated?
		Impact	Likelihood	Risk degree	

1. Withdrawal/recall of key candidate vaccine during roll-out	Supply, demand and uptake				Crisis communication; coordination of procurement of alternative vaccine candidates
2. Substantial rejection of vaccine by key influence groups e.g. religious, professional societies	Demand and uptake				Risk communication and community engagement; engagement of specific influential groups
3. Emergence of vaccine-resistant variants of SARS-CoV-2 in Malawi	Reduction of morbidity and mortality				Maintenance of COVID-19 surveillance and monitoring of travellers and points of entry
4. Emergence of counterfeit vaccines in communities	Demand and uptake				Designation and branding of vaccination centres for COVID-19; public communication, community engagement
5. Cold chain failures and loss of vaccine viability	Supply, efficacy for morbidity and mortality				Cold chain monitoring and supervision
6. Political instability may cause insecurities and adversely affect or delay implementation of the	Supply, demand and Uptake				The risk is largely beyond the control of the programme. However, the impact on programme performance will be minimized by developing and maintaining positive relationship; monitoring security situations and taking necessary adjustment to speed up implementation.
7. Serious Adverse Events Following Immunization (AEFI) e.g Anaphylactic Shock and other side effects	Demand and Uptake				Training of district/health facility AEFI team members and ensuring drugs and trained medical staff available to manage anaphylactic shocks on site

