UN Joint Programme on **Health System Strengthening for Equitable Health and Nutrition Outcomes**

Part of the Umoyo Wathu Programme

Proposal

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Contact:
Tedla Damte - Chief of Health
UNICEF Malawi
tdamte@unicef.org

This proposal was jointly developed by UNICEF, UNFPA and WHO for submission to FCDO to implement a joint UN Programme led by UNICEF, in partnership with UNFPA and WHO.

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Acronyms

ADC	Area Development Committee
ANC	Antenatal care
BEmONC	Basic emergency obstetric and new-born care
CEmONC	Comprehensive emergency obstetric and new-born care
CHAM	Christian Health Association of Malawi
CHSS	Community Health Service Section
CHIS	Community Health Information System
CHT	Community Health Teams
CMST	Central Medical Stores Trust
CHW	Community Health Worker
COVID-19	Coronavirus Disease of 2019
CSE	Comprehensive Sexuality Education
C4D	Communication for Development
DFID	Department for International Development
DHMT	District Health Management Team
DIP	District Implementation Plan
DoDMA	Department of Disaster Management Affairs
DPPD	Department for Planning and Policy Development
DTIU	Drug Theft Investigation Unit
EHP	Essential Health Package
FCDO	Foreign Common Wealth and Development Office
GOM	Government of Malawi
HCD	Human Centred Design
HCMC	Health Center Management Committee
HCIG	Health Center Improvement Grants
HSA	Health Surveillance Assistant
HSJF	Health Services Joint Fund
HSSP	Health Sector Strategic Plan
ICT	Information Communication Technology
IHAM	Islamic Health Association of Malawi
IPCHS	Integrated People Centred Health Services
LGAP	Local Government Accountability and Performance Project
MDA	Maternal Death Audit
MNH	Maternal and New-born Health
MoH	Ministry of Health
MPDSR	Maternal and Perinatal Death Surveillance and Response
NCHS	National Community Health Strategy
NLGFC	National Local Government Finance Committee
ONSE	Organized Network of Services for Everyone's Health
PHC	Primary Health Care
PSBI	Possible Serious Bacterial Infection
QMD	Quality Management Directorate
QIST	Quality Improvement Support Teams
QoC	Quality of Care
SADC	Southern African Development Community
SBCC	Social and Behaviour Change Communication
SCM	Supply Chain Management
SDG	Sustainable Development Goals
SLA	Service Level Agreement
SRHR	Sexual and Reproductive Health and Rights

RMNCH	Reproductive, Maternal, New-born, and Child Health
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VDC	Village Development Committee
VHC	Village Health Commitee
WASH	Water, Sanitation and Hygiene
WIT	Work Improvement Teams

Names and signatures of participant organizations

Participating Organizations
UNICEF *Name of representative* Tedla Damte OIC Representative *Signature:* Tedla Damte OIC Representative *Date* 16-Aug-2021
UNFPA *Name of representative* Won Young Hong *Signature:* Won Young Hong *Date* 19-Aug-2021
WHO *Name of representative* Nonhlanhla Dlamini *Signature:* Nonhlanhla Dlamini *Date* 19-Aug-2021

1. Introduction

The United Nations Resident Coordinator's Office (RCO) and the United Nations Children's Fund (UNICEF), in partnership with the United Nations Population Fund (UNFPA) and the World Health Organization (WHO), is pleased to submit this proposal to the UK Foreign Common Wealth and Development Office (FCDO) on Health Systems Strengthening (HSS) in the Republic of Malawi, as part of the Umoyo Wathu programme. The partner agencies, in support of the Government of Malawi (GoM), are in a unique position to implement a synergistic programme aimed to strengthen the Malawian Health System.

This proposal outlines a comprehensive package of system strengthening interventions in response to dialogue with FCDO Malawi and the GoM and is in alignment with the strategic health priorities of the country. Working through a Human-Centred Design (HCD) approach, the partner agencies have communicated with the GoM at different levels, safeguarding that national and district-specific needs and priorities are incorporated into the programme design. In alignment with agency mandates, the joint UN team's first priority is government ownership and will work to strengthen capacity and enable improved ways of working to become institutionalised and sustainable.

With a wealth of experience working in the Malawian context, the partner agencies bring a depth of technical and operational expertise in life-saving interventions and systems strengthening. Through leveraging this experience, existing programme interventions and strong partnerships throughout the GoM, the results achieved will be sustainable and long term. It also allows for access to key knowledge and information to inform practice, advocacy and policy across multiple sectors at community, sub-district, district and national levels. This bottom up approach begins with a first-hand understanding of challenges and opportunities on the ground and is at the core of this proposal's approach to supporting strong, resilient health systems.

All partner agencies pledge to the principles of "leaving no-one behind" and "endeavour to reach the furthest behind first." This is wholly in line with FCDO's priority to help the world's most vulnerable and is in line with the Astana Declaration on primary health care (PHC). The proposed programme aligns to this central priority, as well as FCDO Malawi's other priorities to strengthen governance, build resilience to crisis, as well as deliver value for money.[1]

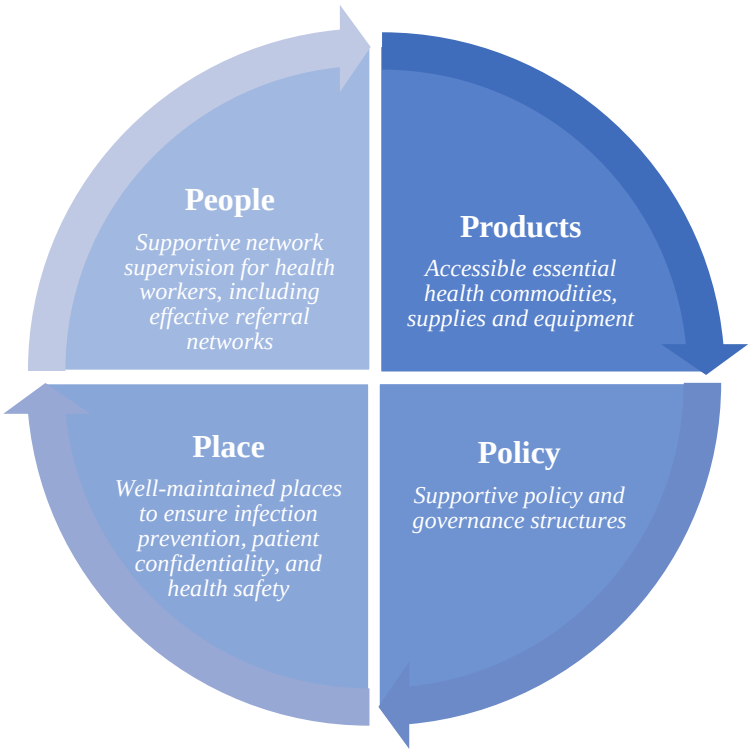
The proposed programme's Theory of Change (ToC) identifies a sub-set of services from the Malawi Essential Health Package (EHP) comprising essential sexual, reproductive, maternal, neonatal, adolescent and child primary health services. It holistically incorporates *quality* of care, *integration* of services and systems, system *resilience* and is underpinned by the strengthening of *governance*, supportive policies and accountability within Malawi's decentralised health structures. It is proposed that implementing tailored interventions within these four strategic areas will significantly contribute to having a responsive and resilient health system that facilitates the simultaneous availability of the "4 Ps" – namely, skilled *People*, accessible necessary *Products*, well-maintained *Places* of care, and supportive *Policies* and governance to provide quality, people-centric, integrated health services through a prioritized EHP.

[1] Headline Deliverables as outlined in the DFID Malawi Country Profile July 2018. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/723216/Malawi-July-2018.pdf>. Accessed 11 September 2019.

In this programme, the "4 Ps" have been precisely defined (see Figure 1), and will help tell the narrative underpinning this proposal:

- ***People***. Competent and motivated people – health service providers – are able to provide integrated quality health care, to being capable of supervision and mentorship, as well as of leading sub-national clusters. The core idea behind the *people* is the management and capacity building of available human resources for health.
- ***Products.*** This includes essential medical products, as well as any essential technical products or materials (such as tools, SOPs, guidelines, etc.) needed for integrated quality health care and to be developed, strengthened or operationalised during the programme.
- ***Place.*** Primarily interpreted as the *place* – facility or a community-level physical space – that also includes non-physical spaces, such as stakeholder consultation fora.
- ***Policy.*** Referring to supportive policies and governance structures.

Figure 1. *The "4 Ps" for Quality of Care*



This proposal is centred around supporting evidence based, life-saving key interventions and pertinent governance and policy changes aligned with the essential health package and the overall health care system in Malawi. These interventions were developed around the "4 Ps" and cut across the strategic output areas of quality, integration, resilience and governance. Together, the prioritized interventions will contribute to integrated quality sexual, reproductive, maternal, neo-natal, adolescent and child health services being available and accessible at primary health care and community levels. This, in turn, is an essential condition required for women, men, children and adolescents in Malawi to attain a state of good health by 2025. The complex and inter-dependent relationships

between these variables, as well as the logic sequence of programme outputs and outcomes, are outlined in the theory of change.

The prioritised package of interventions within the EHP is described in Table 1. These interventions will be further refined during the inception phase in consultation with Malawian Ministry of Health (MoH), FCDO and other key stakeholders (see PACK). The focus of the programme will be to support the public health facilities and CHAM as well as link with existing programmes to deliver the prioritized package of interventions.

Table. 1: *Prioritised package of sexual, reproductive, maternal, neo-natal, adolescent and child health interventions from the Malawi Essential Health Package (EHP)*

Prioritized EHP	**Programme intervention will focus on:**
Reduction of unmet need for family planning, including addressing the SRHR issues of adolescents to improve prevention and management of teen pregnancy	**Reduction of unmet need for family planning** requires ensuring the availability of a range of long-acting, reversible and short-acting contraceptive methods, including male and female condoms and emergency contraception (EC) at primary health care facilities to meet demand; Building capacity of Health Surveillance Assistants (HSAs), Community Midwives and Community Health Nurses and Community based Family Planning Distribution Agents to enable provision of quality family planning services in the community in accordance to cadre scope of practice and task shifting guidelines with the aim of reaching out to women and adolescents in hard to reach with modern contraceptives. Strengthen existing information, education, and communication materials, and contraceptive counselling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination; and ensure the community is aware of the availability of contraceptives for women, adolescents, and men. **Prevention of teen pregnancy and SRI/HIV among young people**, particularly pregnancy among unmarried girls by improving the provision of integrated SRHR information and services for adolescents. This integrated package of adolescent services will be developed and deployed by following the WHO's Global Standards, released in 2015, that has 8 specific standards to judge the quality of adolescent healthcare services.
Reduction of maternal and new-born morbidity and mortality	**Reducing maternal and new-born morbidity and mortality requires e**nsuring availability and accessibility of clean and safe delivery, essential new-born care, and lifesaving emergency obstetric and new-born care (EmONC) services. Through QoC interventions, methodologies will be put in place to measure adherence to clinical protocol pertaining to the prioritised EHP. *Referral hospital level*: ensure skilled medical staff and supplies for provision of comprehensive emergency obstetric and new-born care (CEmONC) including management of unwanted pregnancy, miscarriage and abortion complications/post-abortion care, post-partum and post-abortion family planning.

	Health facility level: Strengthen capacity of skilled birth attendants and ensure availability of supplies for vaginal births and provision of basic emergency obstetric and new-born care (BEmONC) including referral/management of unwanted pregnancy, miscarriage and abortion complications/post-abortion care and fistula, post-partum and post-abortion family planning. *Community level:* Develop or strengthen community based maternal, new-born care (CBMNC) in the 6 districts (Rumphi, M'bewa (Mzimba), Ntchisi, Kasungu, Nsanje and Chikwawa) including 24/48 hour postpartum and postnatal care, kangaroo mother care for LBW babies, EBF, postpartum family planning, postpartum depression, and overall information and education about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Ensure a functioning referral system is established 24 hours per day, 7 days per week to facilitate transport and communication from the community to the health centre and hospital.
Reduction of child morbidity and mortality	Ensuring the availability of the following full EHP intervention packages: • Essential vaccine package (including childhood illnesses, maternal tetanus and HPV for girls) • ARIs and Diarrhoeal Disease (IMCI) • Integrated Community Health Package, including child protection screening. The focus will be at primary health care facilities and community, including strengthening capacity of HSA, community midwives and the HCMCs. Linkages between community and facility will be strengthened linked with QOC and DIPs. Sub-district level supply chain systems will be strengthened.
Prevention of sexual violence and respond to the needs of survivors by strengthening supportive services	Preventative measures at community, local, and district levels, including health facilities, to protect affected populations, particularly women and girls, from sexual violence; making clinical care and referral to other supportive services (role of one-stop centres to be explored) available for survivors of sexual violence; and putting in place confidential and safe spaces within health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.
Strengthening preparedness and response of MISP (Minimal Initial Service Package) in humanitarian emergencies	Preparedness, essential supplies, response, community preparedness and communications, capacity building, recovery and surveillance to prevent and manage disease outbreaks; provision of quality MISP (Minimal Initial Service Package) as agreed by UN Inter-agency group; and, WHO and UNICEF recommended essential child health services for humanitarian emergencies. The Inter-agency group's definition of MISP includes: (a) comprehensive family planning services, including services manage unwanted pregnancies; (b) comprehensive maternal and neo-natal health services; (c) HIV and other STIs services; and, (d) prevention of SGBV and management of SGBV survivors.

2. Background

Malawi has committed itself to achieving the Sustainable Development Goals (SDGs), which place Universal Health Coverage (UHC), the reduction of maternal, new-born and child mortality, and the prevention and treatment of under-nutrition at the core of the global and national health agenda between 2015 and 2030. Over the last two decades Malawi's health system has focused on improving quality and coverage of essential health and nutrition services. The Malawian Ministry of Health (MoH) recognises that, in addition to having increased and sustained investments to ensure all Malawians use promotive, preventive, curative, rehabilitative and palliative health services, it is also important that such services are affordable and of sufficient quality to be effective. Malawi is the only country within the Southern African Development Community (SADC) region to offer free public health care.

The Umoyo Wathu (U-W) programme is designed to strengthened primary health care in Malawi for Universal Health Care which provides a responsive and resilient health system essential for adapting and responding to emergencies, such as the current pandemic, and ensure lifesaving interventions reach those in need. Building upon support provided by FCDO through a grant that was vital in ensuring the health system was immediately prepared to handle an influx of COVID-19 cases and prevent the spread of COVID-19, this proposal is aimed at ensuring the health system is well functioning and communities have continued access to life saving primary health care.

2.1 COVID-19 and initial response

The first recorded cases of the virus now known as Severe Acute Respiratory Coronavirus 2 (SARS-CoV-2) appeared in Wuhan, China in December 2019.[2] The virus causes the Coronavirus Disease of 2019 (COVID-19) which has since spread across the globe and been documented in more than 200 countries and territories.. . . As of the 21st of July 2021, Malawi has registered 45 465 cases and 1389 deaths. Of these cases, 2,547 are imported infections and 42,918 are locally transmitted. The current community transmission stands at 94% with each of the 29 administrative districts reporting at least a case per day. On COVID-19 vaccination, a total of 428,407 vaccine doses has been administered in the country so far, cumulatively 385,242 and 43,165 people have received the first dose and second dose respectively.

Malawi has developed a national contingency plan, which is being funded by UK Aid, World Bank (WB), International Monetary Fund (IMF), Global Fund (GF), Global Alliance for Vaccines and Immunization (GAVI), Government of Malawi (GoM),Health Sector Joint Fund (HSJF), and GiZ. FCDO began supporting the Republic of Malawi in COVID-19 preparedness and early response activities as of mid-March 2020, through UNICEF, as it was anticipated that the COVID-19 emergency would affect service continuity by putting a strain on existing health infrastructure, human resources, equipment and commodities, as well as suppress demand for health services due to fear of contracting the disease. With the evolution of the pandemic in Malawi, a costed extension of additional GBP 6 million was granted from FCDO and signed on 2nd June 2020 to scale up support to 12 districts[3] that were reporting high numbers of infections. This additional support covered more districts and provided relief to the existing health systems by provision of more human resources for health (HRH), strengthening surveillance,

[2] World Health Organization website: Coronavirus timeline

3 Rumphi, Ntchisi, Likoma, Neno, Nsanje, Mzimba, Chiradzulu, Thyolo, Phalombe, Chitipa, Kasungu, and Chikwawa

refining the C4D activities, expanding treatment units availability, ensuring continuity of Primary Health Care (PHC) services, and provision of PPE and other essential equipment in the coming months.

2.2 Current health sector reforms and policies

To accelerate progress towards UHC, the Government of Malawi is undertaking several inter-related health sector reforms aimed at (1) sustaining and further improving equitable access to essential health and nutrition services, (2) improving the efficiency of the health system, (3) enhancing quality of health and nutrition services at all levels of care for improving treatment outcomes and patient satisfaction, and (4) ensuring that the cost of using essential health services does not put people at risk of financial harm. The National Health Policy, the Malawi Health Sector Strategic Plan II (HSSP 2017-2022), The National Community Health Strategy and the National Nutrition Policy and Strategic Plan (2018-2023) provide an overarching framework for these reforms. Quality and equity of health care are squarely included in the mission of the HSSP II.

Health care financing

Despite the efforts of the MoH to increase its health budget each year, the MoH and the Treasury lack information on the level of costs incurred at district level (and at facility level) to deliver healthcare. This stems from the absence of proper financial reporting and feedback from the health facilities to the districts and from the districts to the central level. A further issue is linked to the lack of participation of the local level of government in the budget allocation process, which thwarts the capacity of the local level to inform the central level on the actual needs. Therefore, the budget allocation process is not grounded on the financing needs, but it is also not linked to any performance criteria as no performance measurement mechanisms is in place (or possible, given the scantiness of the financial reporting). Connected to this issue is the fact that Malawi could significantly reduce its health financing gap by making efficiency savings. One study shows that approximately 20% to 40% of health resources, for instance, are lost through various forms of wastage and leakages. The Global Financing Facility Task Team recently completed a costed investment case for RMNCAHN. It identified current gaps and bottlenecks, interventions to remove the bottlenecks and reduce system inefficiencies, all in order to improve maternal, adolescent and child health outcomes through expanding the quality coverage of quality EHP services. Amongst others, the key inefficiencies and bottlenecks identified in the health system are connected to insufficient human, technical and financial resources, inadequate planning and poor utilisation of the planned budgets, fragmented financing mechanisms, low absorption capacities, corruption, low staff morale, absenteeism and limited professional development of health staff.

Health Services Joint Fund

The Health Services Joint Fund (HSJF) was established between the Government of Malawi and key health sector donors (currently the United Kingdom, Germany and Norway) as a means of coordinating donor input and ensuring that funds are expended to meet jointly agreed priority health objectives of the MoH. Participation in the fund is open to all donors and the use of funds are fully integrated within the planning and budgeting cycles of the Ministry. The investments are specifically targeted to the meet the objectives of the Health Sector Strategic Plan II.

The Fund is governed by an Executive Committee which serves as the policy making body of HSJF. This is made up of one representative from each of the Fund Partners. A formal decision-making process is in place to ensure that decisions on the use of funds are consistent with Government of Malawi and development partner procedures

and regulations. One of the aims of HSJF is to improve the Public Financial Management (PFM), this is currently done through several positions that aim to identify potential risks in fund usage, ensure that procurement regulations and best procurement practices are followed and to conduct due diligence (compliance and accounting).

Health supply chain management system

The Government of Malawi and development partners are working together to strengthen the health supply chain management system to work through an integrated national supply chain. The multiple public systems currently operating in the health sector in Malawi were created out of necessity to ensure that donated commodities reach intended end users in a timely manner and at the right places. A Joint Strategy has been developed to integrate parallel supply chains into the national system. In 2017, an Integration Steering Committee was formed to oversee the implementation of a single integrated supply chain. Chemonics has been contracted to strengthen and support one national health commodities supply chain system.[4] However there is little attention currently on building the capacity for supply chain management, planning, monitoring and implementation at decentralized levels.

Primary health delivery system

Since 2017, Malawi has also been implementing a National Community Health Strategy to delivery basic health services (the Essential Health Package (EHP) as outlined in the HSSP II) through an integrated approach and with greater participation and ownership by communities. Christian Health Association of Malawi (CHAM) health facilities are supported by government through Service Level Agreements (SLAs) to ensure the EHP is accessed by ultra-poor in the rural hard to reach facilities. The strategy addresses ways to strengthen the primary health delivery system through six thematic areas, namely: health service delivery; human resources; information, communication and technology; supply chain and infrastructure; community engagement; and leadership and coordination. Existing challenges have been identified, such as:

- Health and nutrition financing, especially for PHC;
- The vision, design and implementation of financial protection mechanisms;
- Health and nutrition governance and management structures, particularly, at the sub-national level;
- Health research, monitoring and evaluation capacity, including the elimination or reduction of parallel reporting systems;
- The use of data for decision-making, particularly at the sub-national level;
- Mechanisms to support client and community safety and satisfaction;
- Cross-sectoral collaboration, especially with on-going governance reforms at the sub-national level and with the various departments and Ministries;
- Shortages of essential medical products and technologies;
- Supply chain management, particularly at the sub-national level;
- Irrational use of medicines, leakage and pilferage;
- Human resource capacity and shortage;
- Poor clinical practices.

[4] Malawi National Supply Chain Integration Project, Quarterly Report, September 2019.

The consequences of these challenges are reflected in the lack of readiness, harmonized policy environment and optimal functionality of primary health care facilities and community-based delivery channels providing quality essential health services, especially for SRMNCAH.

2.3 Prevailing health challenges

Maternal, new-born and child health

While Malawi has made great strides in improving maternal, new-born and child health outcomes over the past decade, maternal mortality and morbidity remain high. The ratio of 634 maternal deaths per 100,000 live births in 2015 is unacceptably high and appears inconsistent with the noteworthy progress made in 'skilled attendance at delivery' and 'facility-based deliveries,' which are reported to stand at over 90%.[5][6] This inconsistency could be partly attributed to the low quality of assisted and facility-based deliveries and inadequate pre- and post-delivery care. The recently concluded EmONC assessment in 2020 revealed that assisted vaginal delivery was performed at 28 % of facilities evaluated; manual removal of placenta and retained products of conception at 49% and 41% of facilities respectively. Failure to provide these basic services accounted for why many facilities did not meet the basic EmONC standard. Only 24% of pregnant women have their first ANC visit in the first trimester and only 51% have the recommended eight visits. Compliance with maternal iron folic acid supplementation use also remains a challenge. Also, postnatal coverage remains low, with only 42% of women receiving postnatal check-ups within two days of delivery and half within 14 days of delivery. It is estimated that 39% of babies are born to adolescent girls aged 15-19 years. The risk of maternal death for adolescents is five times higher than for women in their twenties, and babies of adolescent mothers are more likely to be pre-term and underweight.

Maternal nutrition

Malnutrition is a significant factor in the health of women, new-borns and children. Pregnant women who are poorly nourished are likely to deliver premature babies, and babies that are small for dates and quality of life for such new-borns is under jeopardy, as the latest DHIS2 data indicates with high levels of neonatal deaths. Thirty-five per cent of pregnant adolescent girls are anaemic and 13% are underweight, an important factor in their higher risk of death during pregnancy. The consumption of a diverse and minimum acceptable diet for lactating mothers is far from sufficient and 21% of women of reproductive age (including 35% of adolescent girls) are anaemic.

Water, sanitation and hygiene

Water, sanitation and hygiene (WASH) is an important component of quality health services. WASH in health facilities provides the foundation for infection prevention and control practices, decreases health care-associated infections and reduces antimicrobial resistance. A major challenge remaining is that WASH in health care facilities is not fully mainstreamed into health programming. As a result, approximately 21% of the health care facilities lack piped water on premises, 11% do not have improved sanitation, 27% are without soap and water for handwashing, 57% lack proper medical waste management services, and 10% do not even have any form of safe segregation of medical waste.[7]

[5] United Nations Maternal Mortality Estimation Inter-agency Group (WHO, UNICEF, UNFPA, United Nations Population Division and the World Bank).

[6] Malawi MDG Endline Survey 2014. Zomba, Malawi: National Statistical Office. 2015.

[7] Joint Monitoring Program (JMP) for Water Supply and Sanitation, 2019.

Reproductive health

Women in Malawi are faced with significant obstacles in realising their sexual and reproductive health and rights (SRHR). One fifth of all deaths among women of reproductive age are pregnancy related.[8] While the GoM is committed to reducing unwanted pregnancy for all women of reproductive age including reducing teenage pregnancy by 5% as committed through FP2020, constraints in access and use of modern family planning (FP) remain. as evidenced in the 2020 EmONC assessment out of the 482 facilities only 88% percent of the facilities provided family planning services. Post abortal care services were provided in 51 percent of facilities . The Malawi Population is growing at a fast rate of 2.8 annually, with projections that the current 17 million may increase to as much as 30 million by the year 2030.[9] In addition to the reproductive rights that need to be realised for all Malawian women, the UNDAF notes that a population growth of this scale will put enormous pressure on limited land resources, availability of public services, energy and other resources, and will make poverty reduction harder to achieve.

Adolescent health

Adolescent health is increasingly recognised as a critical issue in Malawi and the world over. Malawi has a young population, with a median age of 17.[10] While adolescent/youth friendly health services were provided in 90 percent of facilities in the 2020 EmONC assessment, a recent study conducted by UNICEF on harmful traditional practices in Malawi highlighted the need to prioritise adolescent health, with particular focus on reproductive health. Malawi has one of the highest rates of child marriage in the world with almost half of adolescent girls married before their eighteenth birthday.[11] Moreover, adolescent birth rate in the country is currently at 136/1000 live-births, whilst unmet need for family planning among this group compared with other age groups is high. The results of this are clearly described above and this important cross-cutting area works between health, protection, nutrition and educations.

Emergency preparedness and response

Malawi is a disaster-prone, landlocked country that faces humanitarian challenges, which constrain economic growth and sustainable development. Protracted natural disasters have left vulnerable communities without reliable food sources or viable livelihoods. Malawi has suffered from high rates of HIV infection and malaria, acute malnutrition, frequent outbreaks of cholera, and other water-borne diseases for decades, and continues to be at a significant risk of other highly communicable disease outbreaks in the country, such as Ebola and now COVD-19. The 2020 EmONC report highlighted that Covid-19 testing was available in only 9 % of facilities. Vulnerabilities are increased, particularly for pregnant women and young people, during disasters. A quarter of women between the ages of 15-49 have experienced a form of sexual violence and evidence shows that during times of emergency this may increase. In addition, women lack necessities for menstrual hygiene, pregnant women lack clean and safe delivery equipment and safe spaces should they go into labour. The Global Health Security under the ambit of International Health Regulation (IHR 2005) require strong local public health approach to be able to successfully detect and suppress the spread of an outbreak at Source. Lessons drawn from COVID-19, a novel pathogen against which neither a vaccine nor effective treatment exists can only be controlled by a strong and strategic public health response. Therefore, under Umoyo Wathu (UW) strengthening public health capacities, alongside the integration

[8] Country Assessment on the Cycle of Accountability for Sexual and Reproductive, Maternal, Neonatal and Child Health and Human Rights, 2016, United Nations Population Fund.

[9] 2017 Root Cause Analysis in The United Nations Development Assistance Framework - Malawi, 2019-2023.

[10] The United Nations Development Assistance Framework - Malawi, 2019-2023.

[11] 2015-16 MDHS.

of public health within the health sector and across the whole of government will be prioritized. These challenges require preparedness, early action and innovative solutions that can help revolutionise the way in which the humanitarian and development actors operate within the full resilience cycle – disaster preparedness, emergency response, capacity building and strengthening health systems and communities. Efforts will be made to strengthen national and subnational levels outbreak alert, verification and risk assessment, information sharing and communication; improved coordination and collaboration between national and local levels with different actors for early response; applying the precautionary principle in implementing travel-related measures for early detection against emerging pathogen with pandemic potential. It is important to ensure that Malawian communities are capacitated, well prepared and fully understand what mitigation plans have been put in place and what to do during disasters to prevent more losses of lives and property.

3. Programme overview

3.1. Context

The proposed programme has been conceptualised by taking into consideration the current socio-political and economy context in the country, as well as health financing, planning and the current health service delivery. Key health and development indicators remain unacceptably poor in Malawi.

Many communities, especially those in rural areas, still live too far away from health facilities to be able to receive consistent, timely, quality health care. The SDGs clearly emphasise achieving Universal Health Coverage with quality. UHC is conceived at the national level, but health services are delivered in communities. The greatest health and equity gains are often to be found through approaches targeting sub-district facilities and the community, with supportive management from the district level. In a 2010 study by UNICEF, it was found that such an approach—an equity-focused approach—can also be the most cost-effective to achieve key health outcomes.[12]

In 1998, Malawi initiated the process of decentralisation, devolving the responsibility for the provision of government services, including health, to its 28 district councils. Planning and budgeting for health at a district level is thus the responsibility of local health governance structures. While decentralisation is not a new reform, the Government of Malawi is now working to complete the implementation of the reform. Malawi is a signatory of the Astana Declaration and is fully engaged in global efforts around the quality provision of primary health care. This energy, coupled with the renewed emphasis and momentum to complete the decentralisation process, provides an important opportunity to support the MoH's efforts to strengthen the primary health care delivery system.

The last several months has brought lessons to light in terms of how well the health system is able to adapt and respond to COVID-19 challenges, as well as highlight areas to strengthen in general. A well-functioning health system is critical for a sustained response to public health emergencies and for ensuring that life-saving services continue to be available by those who need them. Such responses relies on the existing health system in terms of manpower, infrastructure, coordination and, to a certain extent, supplies and financing. The U-W programme will work towards strengthening this fundamental system and pay particular focus on ensuring a continuity of essential health services, especially focusing on most vulnerable groups-mothers, children and newborns. With the

[12] UNICEF. Narrowing the gaps to meet the goals, 2010

understanding that COVID-19 is here for an extended while, the programme will also contribute towards the establishment of the 'New Normal' for resilience and health systems strengthening and adapt to changing contexts and supporting communities and families to experience good health, even when faced with unexpected volatility and shocks. Through the interventions outlined in this proposal and increased coordination, the overall emergency-development nexus will be strengthened, and the systems prepared to respond to increased cases of COVID-19 or other emergencies that may arise.

This programme looks beyond tackling specific diseases and towards strengthening health systems, tailored for and together with people. It is focused on reducing inequities and supporting communities and families to be able to experience good health and well-being, even when faced with unexpected volatility and shocks.

3.2. Expected outcome, outputs and results

The overarching vision of the proposed programme has been defined as follows: **"Women, men, children and adolescents in Malawi attain a state of good health by 2025."**

Having implemented the set of actions in key intervention areas, the programme is expected to achieve the following outputs and significantly contribute to the following outcome:

Outcome

"A responsive and resilient health system that ensures the simultaneous availability of the "4 Ps" - People, Product, Place, Policy- for quality and integrated service delivery."

Outputs

1. **Quality:** Women, men, adolescents, children and new-borns have access to quality health services;
2. **Integration:** De-centralised health systems in target districts are able to deliver integrated life-saving interventions;
3. **Resilience**: Health systems in target districts can predict, prepare and respond to health emergencies in a timely manner;
4. **Governance:** Supportive policies, planning, implementation and coordination processes in target districts are implemented and strengthened with a functioning accountability

Expected results:

- 241 health centres (CHAM, IHAM and Public) targeted for Quality of Care (QoC);
- 5,637 health workers (1,353 midwives and 4,284 HSAs) from the 12 districts targeted towards workforce professionalization;
- 12 designated CEmONC facilities that are fully functional as CEmONC facilities;
- At least 57 BEmONC facilities functional in the 12 target districts;
- 80% of the health facilities targeted by the joint programme meet the Youth Friendly Health Services (YFHS) standards;
- 100% of health centres and health posts in the selected districts offer at least three modern family planning methods (including self-injectables);
- Post-partum family planning (PPFP) services offered in the 12 districts after UNJP interventions;
- 15 health facilities with water storage facilities;
- 15 health facilities with handwashing facilities at points of care;

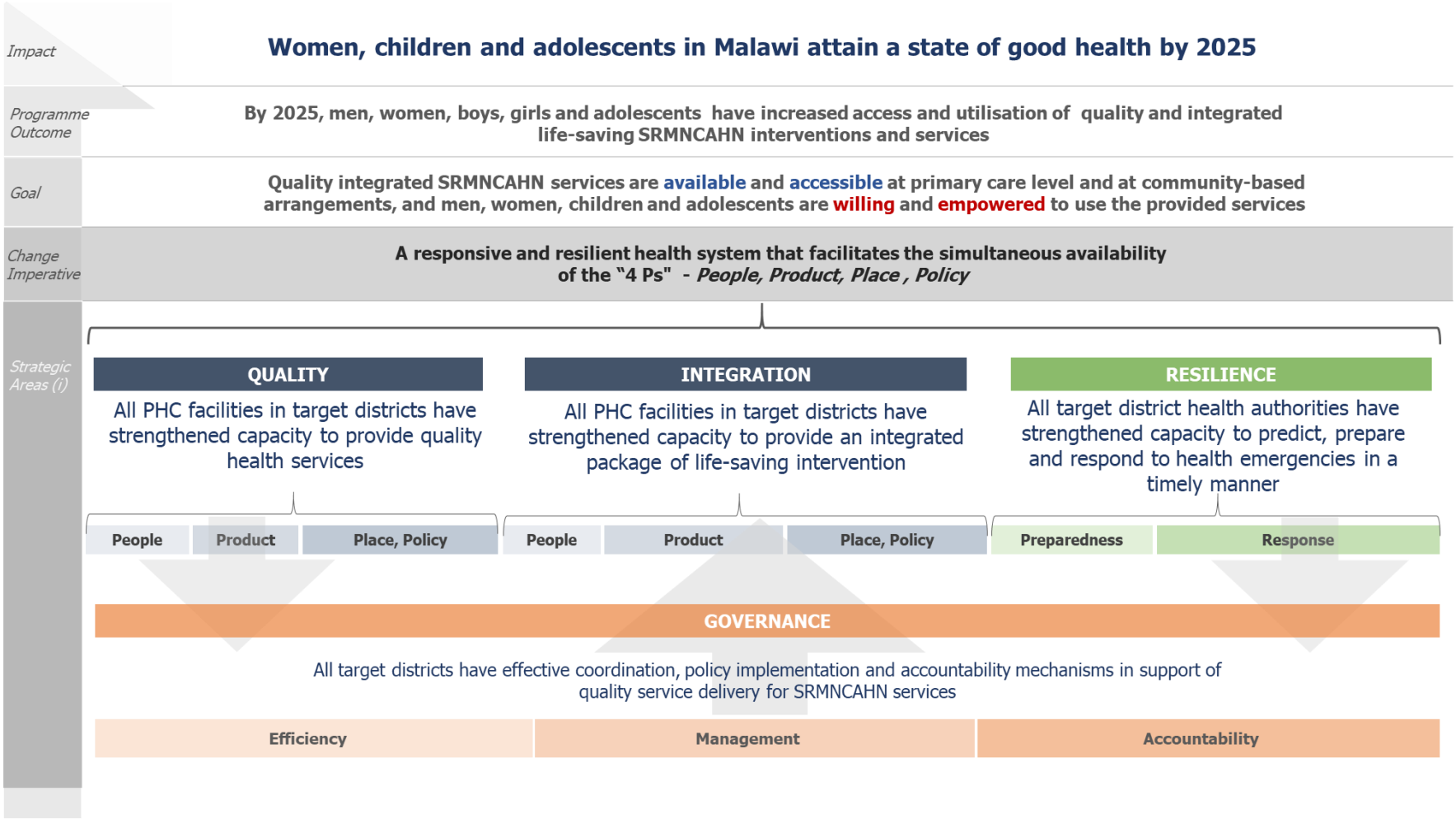
- 95% of HCMCs will have utilised and accounted for 100% of the HCIG 60 health centres in the 12 districts will manage their health centre grants.

4. Theory of change

The proposed programme's theory of change is built around the four strategic output areas of quality, integration, resilience and governance. It propounds that focused interventions within these four strategic output areas will significantly contribute to having a responsive and resilient health system that facilitates the simultaneous availability of the "4Ps" – that is, skilled people, essential products, well-maintained places and supportive policies. This, in turn, will contribute to quality integrated RMNCH (Reproductive, Maternal, Newborn and Child Health) services being available and accessible at primary care and community levels, leading to high coverage of such services which is a key condition for women, men and children to attain a state of good health by 2025. This Theory of Change continues to resonate well with UK's strategic priorities set out in the FCDO Business Planning process in early 2021 – ending preventable maternal, new-born and child deaths by 2030, and strengthening global health security and preventing future pandemics.

The Theory of Change Model is presented below, followed by a narrative that describes the conditions which bring about the desired changes.

Figure 2. *Theory of Change model visualisation*



4.1. Theory of Change model

4.1.1. Strategic output areas

a. Quality & Integration

People

- **If** there is an effective system in place for sustainable training and collaborative supervision, mentorship and skills-building in professional coaching of health workers at both primary and community-based arrangements for integrated care;
- **if** modalities, tools and integrated pathways are developed or strengthened to enhance functional, service and clinical integration at facility and community level services;
- **if** there is a comprehensive nation-wide health system staff deployment system in place, a network allowing for supported flexible human resource sharing, as well as task shifting within and between the service providers;
- ***assuming*** enough health workers are recruited at national level and offered decent working conditions, and that other projects in parallel are addressing awareness and empowerment of the health care service recipients;

Then, *there will be skilled and motivated health workers available at both primary health facilities and community-based arrangements capable of ensuring the provision of integrated health care service, even for young people and other hard to reach populations, including in the context of COVID-19.*

Product

- **If** there is a functioning integrated supply chain system, allowing optimisation in terms of quantification and procurement of commodities and supply process, as well as the application and use of technology for commodity tracking at district and sub-district level, especially stock-out at the last mile;
- **assuming** good quality necessary medical supplies are available in sufficient numbers across the country through the HSJF;
- **if** quality data and information in relation to medical supplies and related processes is collected and analysed and continuously shared across different levels of the health system, as well as between service providers;
- **if** there is a functioning community health system to provide quality modern contraception in the community, including to adolescents and young people and other hard to reach populations;

Then, *sufficient essential good-quality life-saving supplies will be available and accessible at primary health facilities and community-based arrangements.*

Place

- **If** QoC Improvement Plans are executed and established both at health system and health facility level as well as used for day-to-day performance and progress monitoring processes;
- **if** Centres of Excellence and fistula repair centres are functioning;
- **if** relevant data and information is shared between the service providers and analysed to inform decision making in operations; including maintenance of life-saving equipment and strong links to the HSJF;
- **if** effective advocacy and policy is implemented to increase budget allocation of essential health services;
- **assuming** sufficient funds are available;

Then, *primary health facilities and community-based arrangements will be equipped with adequate infrastructure and facility-level systems and processes, including accessible WASH facilities, to provide vital life-saving services.*

- **If** a referral system is activated to offer life-saving services, such as EmONC, and linkages and close working relationship between various levels of health care facilities are stimulated;
- **If** simultaneous availability of 4Ps (People, Product, Place and supportive Policies) with functional referral system supported by evidence-based policies for effective functional**,** service and clinical integration is established;

Then *delivery of people-centric, high quality integrated health services following a life-course approach will significantly improve.*

a. If *all of the above conditions are in place and effectively functioning,* ***then, de-centralised health systems in target districts will have strengthened capacities be able to deliver quality, integrated and accessible life-saving interventions for women, adolescents, children and new-borns.***

b. Resilience

Preparedness, response and recovery

- **If** the aforementioned collaborative mentorship and supervision working model is introduced at different health system levels and executed effectively;

Then, *constant capacity building and knowledge transfer will be facilitated among health workers, supported by capacity to carry out data analysis and invoke available information to inform timely emergency management decisions.*

- Also, **if** quality and real-time data is available, harmonised and digitalised through existing tools and analysed and invoked for surveillance and addressing SRMNCAH, including SGBV services, especially in an emergency context;
- **if** the aforementioned M&E system at key health system levels is in place, integration of separate supply chain systems and databases of medical supplies is implemented, and essential supplies are ready to be distributed in response to a crisis;
- **if** isolation areas and shelters, where people and patients can be moved during crisis, are pre-identified through constant emergency landscape monitoring;
- **if** community systems and plans are in place so as communities are well capacitated to function and bridge gaps when facility level work may be disrupted;
- **if** health workers and community members affected by COVID-19 are provided with psychosocial, protection and childcare support;
- **if** safeguarding policies are implemented, including prevention of Sexual Exploitation and Abuse (PSEA) within the health system;
- **if** health facilities are ready to respond to various health emergencies with business continuity plans and integrated packages of health services;

Then, *effective and timely coordination between the health network stakeholders will be in place as well as sufficient supply delivery; also,* ***then,*** *life-saving routine services will continue to be provided during emergencies without interruption.*

b. If *all the above conditions are in place and effectively functioning,* ***then, health systems in target districts have strengthened capacity to predict, prepare and respond to health emergencies in a timely manner.***

c. Governance

Efficiency & Management

- **if** a feedback loop of continuous and reliable financial information between the local and the central level is established;
- **if** the actual cost of delivering healthcare services at local level is calculated and modelled and the costing model is embraced by MoH and NLGFC;
- **if** a clear framework for allocating health funding within the districts is designed and applied;
- **if** management committees of health centres are capable of managing facilities, supply chain processes, and staff deployment structures effectively in terms of finances;
- **if** the aforementioned relevant data and information is shared within the health system network and used to inform decision making in terms of planning and budgeting;
- **if** management committees of health centers are capable to produce and interpret financial information;
- **if** the aforementioned established capacity building and knowledge transfer system is applied in daily work by health workers, as well as **if** capacity of health-related district committees to coordinate the entire health system is built through support with consistent coaching, professional training and technical help where needed;
- **if** national level coordination mechanisms are well functioning;
- **assuming** the aforementioned simultaneous availability of 4Ps with functional referral system supported by evidence-based policies for effective functional**,** service and clinical integration is established;

Then, *district and sub-district-level planning and budgeting processes will be evidence-based and plans and budgets effectively rolled-out across all health system levels; also,* ***then,*** *health-related district and sub-district committees will be functioning effectively and hence reinforce the overall coordination of the health system.*

Accountability

- **Assuming** health care providers and system managers at different levels – national, district, facility, and community, are managing existing facilities effectively and are able to ensure efficient allocation of human, material and financial resources across the system to sufficiently cover the needs of the service recipients, as aforementioned;
- **if** the office of the Ombudsman is supported in strengthening their compliance mechanisms, as well as in increasing their visibility and presence closer to the service user, especially in remote areas;
- **if** both formal and citizen-led accountability mechanisms for health spending are reinforced through comprehensive support either for the existing social accountability initiatives, or for scaling-up new initiatives;
- **if** community-level structures and citizen fora are inclusive, and people are able and willing to hold service providers and sub-district and district-level decision-makers accountable for quality health care service provision;

Then, *effective community-level accountability structures and related compliance processes will be in place.*

c. If *all the above conditions are in place and functioning properly,* ***then all target districts will have effective coordination, policy implementation and accountability mechanisms in support of quality service delivery for SRMNCAH services.***

4.1.2. Programme outcome

IF the activities under the four strategic output areas – ***Quality, Integration, Resilience, and Governance –*** fulfil the conditions outlined in Section 4.2.1., and ensure the following ***four outputs are produced****:*

1) women, men, adolescents, children and new-borns have access to quality health services;
2) de-centralised health systems in target districts will be able to deliver integrated and accessible life-saving interventions for women, adolescents, children and new-borns;
3) health systems in target districts will be prepared for and able to respond to health emergencies in a timely manner and without interruption; and
4) planning and implementation processes in target districts will be strengthened, with a functioning accountability system to enable the simultaneous availability of the '4Ps.'

Under the ***ASSUMPTION*** that:

- *an effective de-centralisation process is in place, the Health Sector Joint Fund (HSJF) and the USAID-funded Local Government Accountability Project (LGAP) are well-functioning, and the UNJP is well linked in with other national and sub-national governance work underway*[13] *and*
- *awareness and service user empowerment are being addressed by other projects in parallel.*

THEN, the programme outcome will be achieved:

> ***A RESPONSIVE HEALTH SYSTEM THAT FACILITATES THE SIMULTANEOUS AVAILABILITY OF THE "4 Ps" – PEOPLE, PRODUCT, PLACE, POLICY***

5. Strategic Output Areas and Interventions

Many countries have identified PHC as an urgent priority, but they lack comprehensive data to pinpoint specific weaknesses, understand underlying causes, and strategically direct resources to address the causes. This proposal focuses on RMNCH (Reproductive, Maternal, Newborn and Child Health) as the pathfinder for health systems strengthening to improve service delivery. The HSS programme was originally due to be rolled-out in 12 target districts; however since programme inception this has had to be revised downwards due to FCDO funding constraints, discussed further in Section 6.2 . The inrtervention will currently

The programme addresses specific challenges within the health system's building blocks and subsequently strengthens the interaction between the building blocks to adapt, deliver and scale-up key components of the Essential Health Plan (EHP). The work will address the black box of service delivery by building on the MNH Quality of Care (QoC) framework and the accountability platform to understand the dynamics that are shaping Malawi's health system and how it impacts PHC and universal health coverage.

The SDGs set out to not only meet the needs of populations and communities but to reduce risk, vulnerability and overall level of need, providing a reference frame for humanitarian and development

[13] This assumption originally included the Local Government Accountability Project (LGAP) which was due to be a component of the broader Umoyo Wathu prgoramme, but this is no longer going ahead; therefore it is important that the UNJP is also well linked in with other governance work underway through MoH/other Development Partners. The programme comes to a closure in Aug 2021, but USAID is working on a follow up project, lthough the scope is not clear.

actors to contribute to the common vision of supporting the principles of "leaving no-one behind" and "endeavouring to reach the furthest behind first." The year 2020 ushered in a decade of ambitious actions for SDG, the Decade of Action calls for accelerating sustainable solutions to the world's biggest challenges which includes health. This grant is therefore timely to accelerate improvement of primary health in Malawi.

Given the current COVID-19 pandemic and Malawi's difficult geographic setting – being a disaster-prone landlocked country facing humanitarian challenges – the emergency interventions in this programme are largely focused on resilience i.e preparedness, prediction, prevention, and early and adequate action in times of emergency. Support and technical assistance will be provided to ensure that the public sector and community is equipped and able to respond in a timely manner. Availability and use of good quality real time data are central to this process. Through these interventions and increased coordination, the overall emergency-development nexus will be strengthened and will ensure that the health system in Malawi is prepared to respond to any emergency that may arise.

The below listed strategic output areas – *Quality, Integration, Resilience, and Governance*, already introduced in the ToC Model – present more detailed intervention areas necessary to achieve expected outputs. Note that while Integration and Quality are two distinct and important output areas, the intervention areas identified often work across both quality and integration even though they are presented as separate areas.

5.1 Quality

The Lancet Global Health Commission on High Quality Health Systems in the SDG Era states that 'The burden of mortality attributable to poor care is larger than that due to lack of access to care.'[14] The study shows that in low- and middle-income countries (LMIC) between 5.7 and 8.4 million deaths occur each year from poor quality of care, which means that quality defects cause 10% to 15% of the total deaths in these countries. This also means that inadequate quality of care contributed to more deaths than non-utilisation of services. Beyond the cost to human lives and disability, adverse events from unsafe care are also costly in terms of loss of trust in the health system. A recent call to action in a first of its kind joint publication from the WHO, World Bank and OECD reinforced the necessity for all governments to institutionalise quality of care within the overall national strategic directions on health.[15]

Furthermore, COVID-19 has made it painfully clear that the world cannot afford to have weak primary health care. Quality primary health care goes beyond having the front-line supplies such as masks and testing kits. It is having trusted health care providers, provide quality care when and where it is needed. It means confidence that the health centres are safe and ready with the right medicines and supplies, regardless of outbreaks.[16] It also means having the necessary supportive policies in place; hence it means have the 4Ps in place.

Quality and equity of health care are highlighted in the mission of the HSSP II and 2020 EmONC assessment recommendations in Malawi and this proposal supports the MoH in these efforts. In addition, the National Quality Policy and Strategy, approved in 2018, is currently being implemented. Malawi is

[14] Kruk ME, Pate M. The Lancet Global Health Commission on High Quality Health Systems 1 year on: progress on a global imperative. Lancet Glob Health. 2020. https://doi.org/10.1016/S2214-109X(19)30485-1

[15] World Health Organization, OECD, and International Bank for Reconstruction and Development/The World Bank. Delivering quality health services: a global imperative for universal health coverage, 2018

[16] Tritter B, Schwarz D. As COVID-19 Spreads, Its Time to Diagnose and Treat Our Broken PHC Systems. Primary Health Care Performance Initiative (PHCPI). Health Policy Watch, March 2020.

also part of the global Quality of Care network for MNCH. In support of these important national strategies, two key intervention areas proposed to achieve quality health services are: increasing data-use for evidence-based decision making and strengthening mentoring and supervision systems for improving quality of care. Furthermore, maintaining continuity of care will be an important addition to the quality strategy in the current COVID-19 context.

The Umoyo Wathu programme will build on some of the key recommendations from the UK's Independent Commission on Aid Impact (ICAI) report in 2018[17] specifically around the availability and accessibility of good quality and respectful care for women and their babies and investing in gathering data on targeting of services as well as the quality of services and on outcomes. This includes:

- Better understanding and tackling the barriers facing poor and young women in accessing health services, and effectively monitoring whether interventions are effectively reaching poor, young, marginalised and hard-to-reach women.
- better measuring the causes of maternal mortality and the adequacy of health services in order to support improved care, better targeting of interventions and greater accountability of service providers.
- A specific focus on improving the quality and integration of health services, including addressing environmental factors such as nutrition and access to water and sanitation, to make pregnancy and childbirth safer.
- focusing on the long-term development of health system infrastructure and institutions, and paying greater attention to sustainability.

Overarching recommendations from Independent Commission on AID Impact (ICAI):

- FCDO to develop a long-term approach to improving maternal health
- Clarify approach to HSS (position paper)
- Prioritize improvements in the availability & accessibility of good quality & respectful care for women and their babies
- FCDO to directly monitor impact of its SRMH programmes, targeting adolescents and poorest women
- Triangulate results when using models
- Invest in country efforts to gather data on quality services & outcomes

Data-use for evidence-based decision making

Interventions to improve the quality, analysis and use of data for evidence-based decision making is an important component for strengthening health systems. They can improve accountability at a district level and quality and efficiencies at the facility level.

Monitoring integrated PHC and the EHP at the facility level is an important component to ensure quality, integrated services are reaching all who need it. The Joint Programme will have focused work on how best to do this, building on existing tools, including the development of a digital dashboard which can be used at the district level through review meetings to enhance learning and data sharing on a quarterly basis. The USAID funded ONSE programme has supported MoH with a digital Integrated Supportive Supervision (ISS) platform which includes digital checklists/tools for DHMTs to easily monitor facility performance, identify critical bottlenecks affecting service delivery, and inform targeted management support to address bottlenecks. The Umoyo Wathu programme will adopt and adapt such existing digital tools or platforms and expand to the target districts.

[17] Independent Commission for Aid Impact. Assessing DFID's results in improving Maternal Health: An impact review. October 2018. https://icai.independent.gov.uk/html-version/maternal-health/

Advocacy needs to continue for strengthening the existing HMIS platform to ensure disaggregated data flow upstream from districts and includes both facility and community level data. At the community level, work is planned to expand an electronic community health information system (eCHIS) to further improve data collection, as well as analysis and visualization allowing for better feedback of key health indicators. Through work with Central Monitoring and Evaluation Division (CMED) and Quality Management Division (QMD), the addition of key missing indicators as well as integration of eCHIS data into the DHIS2 platform will be conducted.

Estimates suggest that mortality of mothers and new-borns is likely to increase during outbreaks, such as the current COVID-19 pandemic, due to reductions in the provision and utilisation of routine health services.[18] Service provision may be interrupted because of a reduction in the health workforce due to reassignment for the emergency response, staff infections and/or burn out. There may be supply chain disruptions related to interruptions in global traffic and other reasons. Certain interventions that are delivered through campaigns, such as immunisations, may be paused or scaled down. Service utitlisation may also be reduced due to movement restrictions, financial restrictions or a fear of contracting infections at a health facility.

To ensure service continuity, it is crucial to strengthen the surveillance and response. This can be done by actively monitoring the access to antenatal care, provision of safe facility-based delivery and emergency care, including access to timely caesarean section and hospital-based management of pregnancy complications whenever a maternal or perinatal death or near miss has occurred. Further efforts must be made to monitor hospital deliveries and any reports of home deliveries as reluctancies to visit facilities or a scale down in available of services may limit the mobility of pregnant women to seeking care at static health facilities.

Building on the monitoring of the availability of the 4Ps, there is a need to build a real time monitoring system to alert and address increases in MNCH complications and deaths. This will create a more resilient system with the ability to quickly respond to the indirect adverse effects on MNCH due to COVID-19 or any other outbreak or emergency. The intervention will therefore, in collaboration with the MoH, create a dashboard for real time reporting of maternal and neonatal deaths instead of waiting for monthly reports using existing platforms such as eIDSR. It will also allow for early follow-up with districts and facilities to find possible shortages of staff or supplies. The programme will explore the use of digital health technology to support real time monitoring. Potential indicators will include those that monitor trends in access to ANC, skilled birth attendance, emergency obstetric and neonatal care and key immunizations for children.

When a maternal or new-born death occurs, it must be investigated to understand what went wrong, how to correct the situation and, if possible, prevent any further deaths from preventable causes. The Maternal Perinatal Death Surveillance and Response (MPDSR) system exists and will be reinforced for both real time surveillance and better response. MPDSR will also lay emphasis on perinatal mortality and new-born care which will require strengthening the death registration system at community and health facility levels.

[18] Roberton T, Carter E, Chou V et al. Early estimates of the indirect effects of the coronavirus pandemic on maternal and child mortality in low- and middle-income countries. John Hopkins School of Public Health, Manuscript. 2020

Much of the effort in the past in relation to the MPDSR system has been on response, however the importance of being prepared for emergencies of any kind requires investments in innovative surveillance methods that will provide real-time surveillance data collection. There is currently no facility level electronic reporting system in use to support MPDSR teams. The proposed new real time monitoring tools will be introduced through training the safe motherhood coordinators, with the addition of COVID-19 surveillance and near miss reporting that will seek to replace paper based maternal and neonatal death reporting systems. The Umoyo Wathu programme will engage the ReproductiveReprodutive Health Directorate (RHD) in scaling up existing platforms such as MatSurv developed in collaborationcaollboration with Malawi Liverpool Wellcome Trust.

Work will also take place to reinforce the use of the MPDSR system to respond to deaths and near misses through implementation of response action plans, lessons learned and feedback to health care facilities and personnel to improve ownership and accountability.Linked with the QISTs, capacities will be built on MPDSR and verbal autopsy to address avoidable causes of both maternal and neonatal death at both the community and facility levels. This will be key to understand and respond to the barriers that exists to provide safe and quality health services for mothers and new-borns in the context of COVID-19 and beyond.

Strengthening mentoring and supervision systems for improving quality of care

Mentorship and professionalization of district-level stakeholders, health facility staff, community workers and support groups to implement key evidence-based interventions is central to this proposal. Looking beyond traditional training methods and focusing on output-based capacity building through the use of innovative quality improvement methods and techniques, including tools mentioned above, but also institutionalising quality improvement mechanisms at district and sub-district levels. As suspension of larger gatherings and in-person trainings is a fact in the context of COVID-19, digital solutions such as tele-medicine and online learning platforms for QoC video materials, recorded webinars, and case presentations of quality improvements are needed as part of the capacity building package.

Through the technical assistance modality of this programme (see section 6.2), consistent on-site coaching and mentoring will be provided. This will need to be in-person visits but also through digital platforms where recordings of online sessions can be used as a learning resource. This includes providing support to the Quality Management Directorate (QMD) to further build capacity among Quality Improvement Support Teams (QIST) and Work Improvement Teams (WIT) at district level on RMNCH, and a cascading of capacity building down to the facility level. Training packages, such as recorded webinars, trainings, guidelines and tools, exist and they will be rolled out and scaled up to the districts. Training components will be heavier in the first few years and work will begin to partner with a national training institute, or another appropriate area of the

WHO Academy has developed a new COVID-19 mobile learning app that is targeted specifically to health workers. The app provides mobile access to the WHO COVID-19 knowledge resources, including up-to-the-minute guidance, tools, training, and virtual workshops to support health workers in caring for patients infected by COVID-19 and protect themselves as they do their critical work. It provides detailed information and tools addressing key areas of concerns for health workers responding to the outbreak:

- Infection prevention control
- Case management
- Use of personal protective equipment
- Staff safety and health
- Risk communication & community engagement

It is available in the Apple App Store (https://apps.apple.com/us/app/who-academy/id1506019873?ls=1) and the Google Play Store (https://play.google.com/store/apps/details?id=org.who.WHOA).

national system, to ensure quality improvement becomes part of the training system and is sustained after the life of the programme.

Ensuring continuation of essential health services during health outbreaks

Within the context of emergency preparedeness, including public health emergencies such as COVID-19 in Malawi, the provision of essential health services is likely to be disrupted which will have a major impact on the ability to deliver comprehensive and safe maternal and neonatal care with quality. The high proportion of emergency care and surgery that is due to maternity related causes and the time critical nature of these interventions means that maternity care is likely to be an early and sensitive indicator of health systems dysfunction. It is therefore critical to develop specific guidelines for service continuity within various areas of the health system with an emphasis on maintaining quality of care. Health workers need to be oriented and trained on how to maintain essential maternal and new-born services during outbreaks. These orientations and trainings can be both in-person meetings but also through the use of digital platforms. Selected sites, including central and district hospitals must be refurbished to ensure separate spaces to provide comprehensive and basic EmONC services.

5.2 Integration

Evidence shows that fragmented approaches minimise the capacity of a health system to provide continuity of care, contributing to difficulties of timely access to care, delivery of poor-quality services, duplication of efforts and inefficient use of resources. These approaches further lead to low service-user satisfaction and cause gaps in care for patients with multi morbidities.[19,20,21,22,23] Sub-optimal functioning of integrated services at primary and secondary facilities, and community platforms, is linked to the lack of a functional integrated system.

Strengthen integrated service delivery at district and rural hospitals, primary and community health services

Integrated service delivery strengthening at sub-district health facilities (including health centres, health posts and in the community) requires strong and consistent health care cadres to provide care where the majority of the people live in Malawi. When community members come to a facility, having a system, tools and the capacity to provide several, integrated interventions at the same visit can increase the overall coverage of essential life-saving interventions. This proposal will work to develop and strengthen modalities and tools enhancing functional, service and clinical integration at facility and community levels.

[19] The World Health Report 2008: primary health care (now more than ever). Geneva: World Health Organization; 2008 (http://www.who.int/whr/2008/en/, accessed 15 October 2018).

[20] Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007. (https://www.who.int/healthsystems/ strategy/everybodys_business.pdf, accessed 15 October 2018).

[21] The World Health Report 2000. Health systems: improving performance. Geneva: World Health Organization; 2000 (http://www.who.int/whr/2000/en/whr00_en.pdf?ua=1, accessed 15 October 2018).

[22] Global strategy on people-centred and integrated health services. Interim report. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/handle/10665/155002/WHO_HIS_ SDS_2015.6_eng.pdf?sequence=1, accessed 15 October 2018).

[23] Integrated health service delivery networks: concepts, policy options and a road map for implementation in the Americas. Washington DC: Pan American Health Organization; 2011 (Renewing primary health care in the Americas No.4) (https://www.paho.org/hq/ dmdocuments/2011/PHC_IHSD-2011Serie4.pdf, accessed 15 October 2018).

This comprises of developing and putting in place integrated care pathway models for district and rural hospitals, primary health centres, health posts and at the community level. The facility based integrated care model will be based on the proven Practical Approach to Care Kit (PACK) approach which was initially developed by the Knowledge Translation Unit, University of Cape Town and British Medical Journal (BMJ). It will be adapted for the Malawian context and for prioritised EHP services, including nutrition. The UN Joint Programme not only will support development of this integrated care pathways model but also facilitate its effective implementation in partnership with DHMTs.

The Practical Approach to Care Kit (PACK) guide is a comprehensive, evidence-informed approach to clinical care that supports primary care improvement initiatives. It is comprised of clinical guidance, an implementation strategy, health systems strengthening and monitoring and evaluation components. Initially focused on lung health and tuberculosis primary care in South Africa, it has incrementally expanded to include HIV and sexually transmitted infections and then comprehensive adult care through cycles of development, refinement, evaluation and testing. A core component of this intervention is a clinical decision support tool, the PACK guide. Unusual among clinical practice guidelines, the PACK guide is commonly used by clinicians *during* a primary care consultation. PACK has survived as a go-to resource for primary care health workers throughout South Africa who describe it as 'A tool for every day for every patient'.

Cornick R, Picken S, Wattrus C, et al. The Practical Approach to Care Kit (PACK) guide: developing a clinical decision support tool to simplify, standardise and strengthen primary healthcare delivery. BMJ Global

Strengthen BEmONC and CEmONC services and networks

As women and new-borns are at high risk of morbidity and death during labour, delivery and the first week after birth, investing in improved access to and quality of care, especially EmONC is essential. Despite a high (91%) coverage of skilled birth attendance, associated declines in maternal and new-born morbidity and mortality have been modest, and for stillbirths virtually non-existent. One major reason is the lack of access to quality EmONC with only 4% of health facilities able to provide all the relevant basic signal functions.[24] Significant work therefore needs to be done to ensure the right people, products and equipment are in place at the right levels and that services are provided in line with WHO standards of care.

EmONC Facility Network

As part of the existing national EmONC/BEmONC programme, a facility network will work as a peer support group and mechanism to share knowledge, materials, equipment and staff. Through the EmONC assessments, functional facilities will be identified and linked. Systems of communication will be installed to develop functional links between facilities to share knowledge on particularly difficult cases, materials or equipment where there may be a temporary shortage or malfunction, of staff when there is particular need. Mentorship focused relationships will be facilitated and supported to ensure continuity of quality care and continuous mentorship.

In order to address these needs, the UN Joint Programme on HSS will focus on: (1) carrying out EmONC rapid assessments to assess the performance of the signal functions at the start and end of the programme; (2) develop district and facility specific EmONC improvement action plans through the QIST and WITS teams (see quality section) that address the gaps identified through the assessments regarding people, product and place-of-care; (3) facilitate integration of activities of the EmONC action plans into the District Implementation Plans (DIPs) as well as district response plans for COVID-19; (4) support to specific new-born health interventions such as strengthening immediate new-born care services, (5) support the implementation of the plans through the creation of a EmONC facility network and improve their functionality to be able to provide the relevant signal functions, (6) strengthen the human resource capacity and standards of care through the creation of a Centres of Excellence and (7) ensure the

[24] Ministry of Health and Population. EmONC Assessment Report, 2014.

EmONC referral systems and processes are in place and functional through a comprehensive assessment and development and support of a roadmap to address essential bottlenecks currently in the referral systems. Integration of other critical interventions and continuity of care amidst the COVID-19 crisis for EmONC services will be reinforced.

A Centre of Excellence[25] will initially be established in the southern region, since the programme will engage with College of Medicine (CoE) to act as the Centre of Excellence. Based on the progress with the approach, other CoE in Central (Lilongwe) and Northern (Mzuzu) will be considered in future years.The programme will explore existing networks within CoM to improve knowledge management beyond the selected UW districts. CoE will establish linkages with other networks in future years. Conceptualization of the network model will be initated in Y2. Nurses and midwives, as well as community health workers (CHWs) and care groups, are vital to for providing BEmONC, in particular in identifying complications during pregnancy or childbirth and referral services for EmONC and the Centre will build specific EmONC skills for inter-professional teams. Linkages will be established with the Ministry of Health's Human Resources Directorate to ensure deployment, motivation, retention, performance and business-continuation at the Centres of Excellence.

The EmONC Centre of Excellence has been identified during the inception phase and centre-specific rapid assessments will be undertaken to develop multi-year capacity development plans to enable it to serve as a Centre of Excellence for EmONC and obstetric fistula repair and management. These capacity development plans will be developed with the ToT planned in the Quality interventions. The Centre of Excellence will be responsible for overseeing readiness and functionality of EmONC and fistula repair and management in the targeted districts and beyond, including for women who test positive for COVID-19. The centre will ensure provision of safe spaces for COVID-19-positive women who also experience complications or have complicated cases and build capacity of district teams to follow better infection prevention control (IPC) measures for EmNOC services.

The programme will also ensure the EmONC referral systems and processes are in place and functional. Simple digital technology-driven approaches to enhance referral and feedback loops will be tested and replicated. For example, simple systems need to be put in place to facilitate communication when a woman (and baby) is/are being referred from one facility to another, ensuring timely life-saving care is awaiting that women when she arrives. This will include strengthening of the ambulance management system, including support to the maintenance department in the districts to ensure roadworthy patient vehicles/ambulances. As part of strengthening referral pathways for COVID-19 mothers, it will ensure the screening and isolation of COVID-19 mothers and the provision of transportation to avert this second delay. To avert the third delay, a clear referral pathway to a known place of delivery must be identified and ensure that facility is equipped with the proper infection control protocol and materials. This will be integrated and built upon the existing district health system, including CHAM facilities. A comprehensive assessment will be done to thoroughly examine the referral systems from the community level to the facility level providing EmONC including the feedback mechanisms. Some of the bottlenecks are known, but not all, proven interventions will be developed and put in place in the first year to remove the essential bottlenecks currently in the referral systems, including how to effectively and efficiently repair ambulances and equipment need for referrals. Work will begin in 1 or 2 districts to pilot the best way forward in creating a functioning referral system.

Technical assistance at the primary and community health services level

[25] Elrod.J K, Fortenberry Jr. Jl. BMC Health Services Research, 2017; 17 (suppl):425

In addition to decreasing the fragmentation of services and increasing the efficiency of facilities, a review will be carried out to identify the key needs to ensure there are strong cadres of health workers at the sub-district level. We will build on the functional review conducted by MoH for Y2. For Y3 District level functional review especially for the DHSS (Director Health and Social Services) will be supported. Related to the known human resources for health shortage in the country, there is currently an over-reliance on community health workers, especially the HSAs. HSAs alone constitute more than fifty per cent of the MoH workforce and remain largely unregulated. A task shifting policy exists providing written clarity of their roles, however they are often doing more and in a fragmented way. In the first year, a review will be completed to identify how to support and further professionalize this core cadre of health care worker to improve the quality of integrated service delivery at primary and community health services.

National, district and community level support will be provided to the MoH for integrated forecasting and quantification for commodities, including capacity building of health care workers at district and sub-district levels. The National forecasting and quantification of health commodities in Malawi is led by the Pharmaceutical Unit of the Directorate of Health Technical Support Services (HTSS) of the Ministry of Health (MOH). The exercise is supported technically and financially by the joint UNICEF/ USAID Global Health Supply Chain program— Procurement and Supply Management (GHSC-PSM). Improving the availability of commodities at the community level involves working at various levels. Frequent stock outs at the community level arise despite having commodities available at the district health facility level. The current challenges exist primarily between the community level and its resupply point, thus solving supply constraints at the community level would yield significant improvements in care, such as integrated Community Case Management (iCCM) program effectiveness, coverage, and scale.

There is also a need to improve the availability of quality supply chain data for decision making at facility level and reduce vertical layers of procurement so that an integrated cross-sectoral commodity procurement is possible within the supply chain. Support to District Pharmacy Teams will strengthen inventory management skillsets and support to facilities will improve quantification, forecasting, reporting, supportive supervision and distribution. Districts will be supported with the development and implementation of an application to assist with supportive supervision to reduce contact as a COVID-19 prevention measure. UNICEF has technical expertise in health commodities forecasting and quantification and will work with the MOH and other partners to provide national, district and community level support for an integrated forecasting and quantification for commodities, including capacity building of health care workers at district and sub-district levels.

With the advent of COVID-19, the integration of WASH/ Infection Prevention Control (IPC) becomes paramount in preventing and curtailing transmission of COVID-19 in health facilities, at the personal and community level, and immediate assessments are needed. The interventions will cover the following aspects: availability of water and chlorine, handwashing systems (water/soap, alcohol rub /hand-sanitizers or chlorine water), treated water, toilets cleanliness and thorough disinfection (separated from suspected/confirmed cases and other persons), faecal sludge management where required, medical and solid waste regular disposal and safe elimination.

5.3 Resilience

Malawi is a country prone to natural disasters such as drought, flooding and intense winds. These and similar threats not only cause public health emergencies such as disease outbreaks, including cholera and typhoid, but can also impact health system infrastructure and even disrupt regular health services. To complicate matters, the COVID-19 pandemic started when Malawi was unprepared to handle an influx of cases of COVID-19. As measures are being taken to limit the spread of the virus, health and social systems are likely to struggle to cope with restrictions in movement and added economic strain. The health system is in a fragile state to respond to an outbreak in addition to any sustained community transmission of COVID-19, given that we are now in the third wave, and it's likely that we will have subsequent waves over the next few years.

Despite improvements over the past decade, the Post Disaster Needs Assessment (PDNA) following Cyclone Idai and spearheaded by the Government of Malawi revealed that response preparedness and resilience-building activities remain shallow and inconsistent in the Republic of Malawi.[26,27,28] On the Global Health SecuritySecutiy Index, Malawi's overall rating is at 28.0 which classifies it in the the group of least prepared countries with a ranking of 154/195. Within Africa it is ranked 36/54 countries. A Joint External Evaluation was conducted in Malawi in 2019 which outlined key recommendations for the country in order to adhere to IHR (International Health Regulations). Buidling on these recommendations the UNJP programe will foster collaboration in key areas such as the One Healht platform, strengthen PoE and establishment of EOC (Emergency Operations Centre) and scaling up of IDSR guidelines.

Recommendations from JEE (Joint external Evaluation):

- Legislation to support authorities to meet IHR obligations. Address gaps in legislation in areas of biosafety and biosecurity
- Foster collaboration in key areas such as One Health platform
- Formalize an institute to serve as IHR focal point. Address gaps in co-ordination among programmes and ministries
- Formalize processes related to IHR implementation (Policy, SOPs, Guidelines), communication & coordination
- National public health risk assessment
- Establishment of PHEOC, strengthen PoE
- IDSR guidelines - > operational scaling up
- Develop national action plan for health security

Without intensifying investment in resilience building in the health sector, the current situation would lead to an even greater disruption of the public health system, potentially endangering the lives of women, including pregnant and lactating mothers, young people, men and children across the country. Umoyo Wathu will build the ability of households, communities and the health systems to anticipate, manage and overcome the cumulative stresses that may arise. The Umoyo Wathu programme will take

[26] Malawi National Cholera Prevention and Control Plan, 2017.

[27] UNICEF 2018, Nutrition Statistics in Malawi. Available from <https://www.unicef.org/malawi/sites/unicef.org.malawi/files/2018-09/UNICEF_Nutrition_Factsheet_2018.pdf>. Accessed on 17 SEP 2019

[28] Malawi 2019 floods Post Disaster Needs Assessment Report. Available from <http://www.dodma.gov.mw/index.php/downloads?download=18:malawi-2019-floods-post-disaster-needs-assessment-report>. Accessed on 17 SEP 2019.

forward some of the key recommendations from the JEE framework, especially around digital health innovations and strengthening emergency preparedness. While manyof the interventions in the UNJP's resilience strategy are lead by UNICEF, close collaboration and engagement with WHO will be crucial for strategizing and implementing as per JEE recommendations.

The Malawi national Emergency Contingency plan, developed by intercluster coordination led by DoDMA, outlines how the national response to emergencies are triggered and the country is prepared for future epidemics. However, mitigating the impacts of these public health emergencies needs development of a resilient health system to ensure that the growing population in the targeted districts maintains a state of good health. Effective preparedness and timely response activities are key components of impact mitigation and they rely on the existence and functionality of the health system. Malawi has a National Resilience strategy which will be linked to interventions of Umoyo Wathu to further strengthen community resilience.

The proposed People, Product, Place of Care and Policy strategy asserts that a simultaneous presence and interaction of the "4 Ps" is of paramount importance to a resilient health system. In addition, in view of the situation of COVID-19, additional mitigation measures aimed at prevention and containment of the outbreak have been implemented.

First of the four pillars is the People who are capable of ensuring effective emergency alertness and rapid response. Historically, when an outbreak or public health emergency has been encountered where there are limited or unavailable human resources, districts have pulled out staff from hospitals and health centres to respond to the emergency, causing significant disruption to routine programmes in the health units. Capacity of service providers will be strengthened on a rapid response to perceived threats, including outbreaks of cholera, COVID-19 and related infection prevention and control (IPC), the delivery of the SRHR Minimum Initial Service Package (MISP), including gender-based violence, and the prevention and management of Sexual Exploitation and Abuse (PSEA) in an emergency response.

The second pillar is the availability and delivery of products such as medical supplies, accurate data and equipment. Poor information sharing amongst partners, as well as between district and national levels, can lead to uncoordinated supply delivery, often resulting in no last-mile delivery of supplies to beneficiaries.[29] Also limitations in data management, for instance the use of paper-based data collection methods and limited surveillance at a district level before, during and after emergencies, can further contribute to poor decision-making, lack of preparedness and, eventually, an inequitable response.

Furthermore, the Place of Care must be adaptable during the time of a disaster with critical functions maintained through Business Continuity Plans (BCPs), requiring adequate capacity and infrastructure amongst communities in order to deal with the eventualities that may occur. Work through the UNJP to build resilience to disasters and maintain Business Continuity will be linked with Malawi's Climate Vulnerability Assessment of the health system's vulnerability to climate change. Work on climate resilient health systems will be initiated in Y3. Safe spaces will be set up for pregnant women to enhance clean and safe deliveries and referral systems strengthened for obstetric emergencies both basic and comprehensive.

[29] Malawi 2019 Floods Post Disaster Needs Assessment Report. Available from <http://www.dodma.gov.mw/index.php/downloads?download=18:malawi-2019-floods-post-disaster-needs-assessment-report>. Accessed on 17 SEP 2019.

Finally, as the Policy component, development and application of integrated Standard Operating Procedures (SOPs) for disaster response and preparedness that bring together the people, products and place at the national, district, health facility and community levels and are supported by strengthened governance structures must serve as the foundation for effective emergency preparedness, particularly at the district level in Malawi's decentralised structure.

Based on the strategy above, the Umoyo Wathu programme will contribute and complement the ongoing COVID-19 response in the country, both supporting the existing response and contributing towards establishment of the 'New Normal' for resilience and health systems strengthening. The programme will complement the capacity building efforts of MoH in surveillance activities, , supporting the health workforce in maintaining primary health care services for all women of child bearing age including pregnant women and children, greater engagement of communities in awareness generation and empowering to protect themselves against COVID-19, strengthening planning and coordination mechanisms especially at the sub-national level and supporting the continuity of essential health services.

As COVID-19 is expected to change the way we operate in the coming few years, several innovative interventions need to be introduced to ensure that the health systems remain resilient and COVID-19 and other infectious diesease outbreaks are controlled in such a way that they do not pose threat to existing health systems. The Ministry of Health has overseen the development of digital applications for COVID19 response including, WhatsApp chatbot, USSD, SMS (RapidPro based). At the core of all of the applications is the One Health Surveillance Platform (OHSP). OHSP is a convergence platform that host all COVID-19 PoE, Case-Based Surveillance (CBS) data (including suspected and confirmed case), lab results, contact tracing, rumour log (all WhatsApp ChatBot, RapidPro SMS, USSD self-reporting) data. Among the system is an interoperability layer that facilitates the data exchange across the applications into and from the OHSP. The data in OHSP has been used to facilitate data analytics and is projected on the EOC dashboards, as well as feeding into the dynamic epidemiological data model. MoH has been able to develop this with the support of various partners. This programme will further contribute to innovative ways of surveillance, contact tracing, and mathematical statistical modelling customized to the Malawi context (both at health facility and community level). The programme will pilot and test the improved models, with integrated data sources and improved visualizations which will be made openly available to MoH and stakeholders to support their programmatic efforts. In addition, the programme will support capacity building activities and introduce mechanisms to strengthen the Ministry and other key stakeholder's ability to use and generate insights from the models for more accurate, timely decision support.

The resilience interventions supported under the UN Joint Programme on HSS will also ensure prevention and management of Sexual and Gender-based Violence (SGBV) during emergencies and humanitarian situations. Specific activities will include, but not limited to: support to the Malawi Prevention of Sexual Exploitation and Abuse (PSEA) network through trainings of all staff and contractors; capacity building of Rapid Response Team on SGBV; Mental Health Psychosocial Support (MHPSS). A multisectoral MHPSS Task Team has been established and have created a MHPSS referral pathway which constitutes a flowchart of the referral processes and the contacts of the MHPSS service points across the country. The referral pathway is unique in that it provides a list of providers that have diverse skill sets to be able to respond to both MHPSS and GBV. Priorities for MHPSS now include ToT and cascading of psychological first aid (PFA) training from district level to facilities and the community to ensure that the issue is well understood. For COVID-19 response specifically, social workers or someone trained in PFA should be part of contact tracing teams. The key activities under MHPSS will include assessment of families, communities and people affected with COVID-19 for

psychological distress, provision of mental health and psychosocial interventions within the affected community, including people in isolation and building capacity of health care providers, social workers and para-social workers that offer psychosocial support. Trained/ deployed government and volunteers in each district can also work as psychosocial support teams. People from that team will also support the surveillance team for COVID-19.

A roadmap for enhancing preventive measures at community, local, and district levels, including health facilities, to protect affected populations, particularly women and girls, from sexual violence will be developed and key interventions will be implemented through the UNJP. Some of the interventions will include putting in place confidential and safe spaces within health facilities to receive and provide appropriate clinical care, strengthening the current clinical care, including areas such as counselling and intake, and referral mechanisms to supportive services for survivors of sexual violence including and Mental Health Psychosocial Support (MHPSS) and access to the justice system. There will be need for awareness building and demand creation activities in the first year for empowering of people. Links will also be made with work on GBV in emergencies work planned in the resilience section of this proposal.

In addition, an Emergency Drone Response Unit will be established at the National level to improve the situational awareness of the humanitarian response team in case of a natural disaster. It will provide timely visual information of the most affected areas including the hardest-to-reach areas. This Unit will also be essential for emergency response as it can assist with search and rescue activities. Furthermore, work to better map malaria breeding sites, for transporting medical samples and other commodities will be completed and a study on breeding fish that feed on mosquito larvae.

While the interventions and activities have the four Ps interwoven throughout as described here, the workplan includes a completed list of activities and is organized across the following intervention areas:

- Preparedness: strengthening district level emergency preparedness;
- Strengthen outbreak alert, verification and risk assessment, information sharing and communication by capacititating the RRTs.
- Improved coordination and collaboration between national and local levels with different actors for early response
- Implementing precautionary principle in implementing travel-related measures for early detection against emerging pathogen with pandemic potential.
-Community preparedness and communications—develop communication plans and adoption of key health messages;
- Capacity building of rapid response teams, training on PSEA, establishing a HR roster and sustainable CB initiatives;
- Surveillance. Real-time data collection, harmonisation and digitalisation, screening at point of entries.

Prevention and management of sexual exploitation and abuse (PSEA)

The need for reinforced action to protect beneficiaries of humanitarian assistance from sexual exploitation and abuse arose from reports confirming that humanitarian workers had been responsible for acts of sexual exploitation and abuse. PSEA policies and practices aim to end sexual exploitation and sexual abuse by humanitarian workers, including UN personnel and contractors.

PSEA training is available and mandatory for all UN Funds and Programmes Personnel including volunteers and contractors. PSEA seeks to three key outcomes: 1) safe and accessible reporting for survivors, 2) quality assistance for the survivors of sexual exploitation and abuse (SEA), and 3) enhanced accountability, including investigations.

FCDO has introduced Safeguarding against Sexual Exploitation and Abuse and Sexual Harassment (SEAH) across FCDO programmes during Covid 19 Pandemic, which is closely in line with PSEA safeguards.

A key step towards developing an agile and highly responsive health system is to have communities and health facilities at the forefront delivering

good quality information. A good starting point for this would be linking up the OHSP and eIDSR platforms with DHIS-2.

5.4 Governance

There are a number of important and well-formulated policies and strategies at the national level, including the constitution which guarantees all Malawians the provision of health care and other social services, the National Health Policy, the HSSPII and most recently the National Community Health Strategy. Implementation of these policies and strategies is operationalised through a decentralised health system. While gaining momentum, the decentralization process faces numerous governance challenges, ranging from administrative hurdles to policy-implementation challenges, inadequate funding, weak supply chain management, and irrational use of medicines, leakages and drug pilferage. These challenges, or inefficiencies within the health system, can be summarised by 1) inadequate planning and budgeting, especially at the district and sub-district level, 2) poor coordination structures and management processes, and 3) lack of accountability within the different levels of the health system. The new HSSP-III currently under development will focus on health system enablers rather than disease areas, including strengthening health financing, governance, accountability and performance management.
The health sector is largely dependent on donor funding, accounting for nearly 76%. Since 2016 the Health Sector Joint fund has been a mechanism of providing direct budget support to MoH while safeguarding against the fiduciary risk. One of the key challenges of this mechanism has been the low absorption rate.A 2019 rapid review of the HSJF made a few recommendations including, among others, the MoH nesting the HSJF budget within the sector-wide annual investment plan and allocating more funds in support of district level interventions. However, this requires detailed work on procedural design and risk assessment.
Meanwhile, low absorption rates is not an attribute of HSJF alone. Funds from other development partners also have low absorption rates such as Gavi (34%), GFATM (30%). Looking beyond HSJF, from a sector perspective strengthening government systems and capacity in planning and budgeting, procurement and financial management is needed. A key area of governance interventions at the national level will include proving support to MoH at the national level to align HSSP with the HSJF, building district leadership and management capacity as well as capacity building of districts in evidence based planning and budgeting.

In order to achieve the defined outputs, key *governance* interventions in this proposal are focused around (1) strengthening health sector planning, budgeting, coordination and implementation at the sub-national level and (2) improving accountability for improved health outcomes, at health facility level.

With limited fiscal space in Malawi's health sector, planning and budgeting plays a crucial role in ensuring the efficient use of available yet scarce resources. However, the process of planning and budgeting for health at the local level faces several challenges. Firstly, despite the extensive number of services devolved to the local level, there is little information on the actual costs incurred by the local level to deliver such services, nor on the minimum level of allocations needed by the local level and health centres to function effectively. Together with a cumbersome fiscal transfer system currently under reform, this contributes to allocations that are not adapted to the sectoral and local needs. Furthermore, not only are the allocations too low, they are not disbursed timely, heightening the pressure on the health care facilities and not encouraging proper cash management and budgeting practices. This in turn reverberates on the incapacity of the local level to keep proper accounting information and to feed it

back to the central level which is needed for a healthy accountability loop and better, more attuned allocative decisions.

Low overall financing to districts hamper discretionary spending capacity, yet even when allowed to discretionary allocate resources, health is hardly prioritized. In one budget analysis for a 2016/2017 financial year for a particular district, it was established that 90% of the total funds allocated in the district were allocated for infrastructural development under other sectors, such as education, agriculture and roads, despite the health sector facing numerous challenges in the district. A multi-sectoral district level framework for fund allocation is thus needed. Health centres should become cost centres and report consolidated financial information to provide the districts and the councillors on their capacities to deliver services in effective and efficient ways. Improved coordination and capacity strengthening of local health governance structures is needed to spearhead the prioritization of funding for health. Planning and coordination among various local governance structures such as VDC (Village Development Committee), ADC (Area Development Committee), HCMC (Health Centre Management Committee) and VHC (Village Health Committees), remains an essential duty, however there is no coordination or linkages between the structures. Also, at a district level, there is a general thinking and assumption among councillors (contrary to the notion of de-centralization) that health financing is the sole responsibility of MoH.

Despite the existence of local health governance structures, there is also lack of effective participation and community voice in health planning and budgeting. One of the factors contributing to this is non-functionality of those structures themselves, coupled with limited capacity for participation among the citizenry. In emergencies, coordination between central and local government structures is key in achievement of results at both district and community level. Central level structures such as clusters provide a national level direction on addressing emergencies such as disease outbreaks. It is, however, the local government system that implements and localise these decisions. At district level, the secretariat is then expected to closely collaborate with community level structures at village, group and traditional authority level.

Strengthening health sector planning, budgeting & implementation

At the national level, this will include setting up a Secretariat for Joint Annual Review (to be included in Y2 phase). The costing of service delivery at local level will be carried out through a modelling exercise. This will inform the MoH, National Local Government Finance Committee (NLGFC) and the Treasury on the minimum level of allocations to be provided to the districts, allowing them to deliver healthcare services according to the devolutions plans. The programme will support implementation of the Health Sector aid harmonisation manual at local (district and sub-district) and national levels and support for the HSJF(TA). It will provide support to the Department for Planning and Policy Development (DPPD) in improving health financing including strategy review, and support to conduct annual resource mapping and dissemination of the analysis at district levels. This will build on and complement the current work being undertaken by MoH along with key development partners. The programme will support the production of an options paper on the establishment of a framework for resource allocations at district level, within sectors and in the health sector between facilities. The options paper will be based on the ongoing efforts of reform of the fiscal transfer system and will include the set up of performance-based grant system to finance discretionary development expenditures and strengthen the financial management and planning capacity at sub-district level. Furthermore, the programme will support improvements in transparency of public expenditure on health by strengthening the reporting structures between the local and central level and through the regular production and dissemination of budget briefs to key stakeholders. The Task Shifting Policy will be reviewed and advocacy with MoH will be carried out to encourage and support task shifting to differentiate and gap-

fill service delivery. Policy, guidelines, and operational plans will be updated to support implementation at sub-district level. The development of the SOP on waste management will also be supported.

Better coordination and management will be achieved through strengthening the district health system in planning and implementation of their District Implementation Plans (DIP) and budgets in the districts covered by the UNJP. Better management of health services in hard-to-reach areas is key for improving equity and long term, impactful development. This work will build upon on current interventions using a bottleneck analysis approach/UNICEF model to improve evidence-based planning and performance and scale it up to the target districts. In this COVID-19 environment it will be important to use all available and possible means for strengthening the district capacity in planning DIPs and budgets, improving equity. Meetings and consultation sessions will be a combination of face to face (whilst adhering to the COVID-19 prevention measures) and remote sessions with the available information and communication technology (ICT) methods. Utilisation of web-based platforms will be crucial in the provision of key trainings, consultations, and decision-making meetings. There will also be need for the monitoring and evaluation of the interventions and programmes. In addition, it will be important to continuously assess and monitor ongoing delivery of essential health services to identify gaps and be able to address these as COVID-19 evolves.

In order to better share data and evidence of what works, or does not work, an annual PHC forum will be initiated and held each year by the Community Health Unit. This is a national forum that will bring together best practices across the country allowing districts to share and cross-learn from each other. This builds on Quality Improvement principles of "All teach, All learn"' fostering a culture of evidence sharing and empowering PHC communities. This can also lead to the organic spread of ideas and innovations beyond the geographic scope of the programme districts or areas of work. It will be an important annual moment of reflection to present data and share success stories from the field. Learning from the past months of the COVID-19 pandemic, innovative ways of gathering people virtually, as well as in person, will be sufficiently thought through.

Health Centre Management Committees (HCMC) work to bridge the gap between the community and the health centre, acting as the voice of the community and playing an oversight role. Building from the successful MHSP project, the HCMCs will provide a platform for community engagement with health facility operations to enhance community health. Effective HCMCs are expected to identify suitable approaches to solve conflicts and challenges faced by both the community and the service providers. This can mean mobilising local resources, or lobbying stakeholders or local government for higher level solutions, and then keeping track and informing the community of the progress made in improving services. The HCMCs will be further capacitated in the management of small grants (Health Centre Improvement Grants (HCIG)). The grants will provide the committees with an autonomy to remove key management bottlenecks at the facility level, as well as an opportunity to build in a performance system to further increase the quality of management and thus the care provided.

In Malawi, uneven distribution of health facilities has led to geographic inequities in population coverage and financial protection. The evidence, linking geographic access to health services and women's use of facility delivery, is very strong. In order to better serve the population, especially in the hard to reach areas, the MoH has Service Level Agreements (SLAs) with Christian Health Association of Malawi (CHAM) and Islamic Health Association of Malawi (IHAM). CHAM and IHAM facilities are often located in the remote, hard-to-reach rural areas. Additionally, the SLAs eliminate any financial barriers and do not charge user fees. These facilities will also receive the technical support through this programme working to improve quality integrated services they provide. One option is to incorporate the same health centre management committees and management of small grants in these facilities with

a clear performance system for these facilities. This will need greater clarity and be discussed further with the FCDO team, especially as FCDO fund the CHAM (and from 2021/22, IHAM) SLAs through the HSJF.

6. Changes to Programme Scope

Further to reductions in budget by FCDO as a result of UK ODA reductions, the team has had to revisit and re-design the proposal to match the available funding. The funding challenges notwithstanding, the programme continues to respond to the original programme objectives, of maintaining a focus on quality, ending preventable deaths, and strengthening global health security to improve the response to C19 and future epidemics/pandemics. The proposal tries as much to retain the intervention scope of the programme while necessitating significant reductions to the geographic scope. Ths is further expailned in the section below:

- While the programme will continue to support the QIST and WITS as well as maternal and perinatal death surveillance and response, MNH QoC **cascade training** at the national and district level is not included in the current set of interventions.
- While support to quarterly supervision to health facilities and improving the ability of QISTs (QI Support Teams) and WITs (Work Improvement Teams) to adhere to the adopted 9 standards for QoC will continue, establishment of a functioning **mentoring system** through inter-facility collaborative learning sessions and QoC monitoring will not be covered under the revised proposal.
- All activities related to MPDSR interventions will continue to be implemented under the programe but will essentially focus on improving the intervention where such systems already exist (but perhaps not fully functional) but will not invest in the **establishment of MPDSR mechanisms** in districts and health facilities where it does not already exist.
- Interventions related to maintaining the continuity of care in the context of COVID-19 such as adaptation of service continuity guidelines and demand creating initiatives for ANC/PNC using innovative approaches such as open days have been excluded in the current proposal.
- Capacity of community health structures on the implementation of integrated **self-care** health package
- District-level consultation with **communities** and local stakeholders to strengthen district level emergency preparedness and planning
- **Procurement** of essential supplies for staging initial response to disease conditions and outbreaks
- Strengthening **voice and accountability** for improved heatlh outcomes, at district and sub-district level

Further to any budgetary improvements in the forthcoming years, the programme would like to re-consider some of these interventions.

Meanwhile, as stated earlier, the programme has had to significantly reduce the geographic scope of the programme. Two major changes in this regard include the reduction of districts to six from the original proposal of 12 districts and by-passing the zonal/satellite structures within the MoH (this is an intermediary level between the central MoH and district health system).

The changes to the programme scope also has had implications for staffing under consideration in the Umoyo Wathu programme. The level of effort for most UNJP staff associated with this programme has been reduced.Furthermore, since the programme will not be focussing at the intermediate (zonal) level, Zonal co-ordinators (n=4) and M&E staff (n=4) associated with this level have been exclude in the revised budget.

7. Programme implementation

7.1. Technical assistance delivery modality

Technical assistance and capacity building of the national health system is central to this UN Joint Programme and thus developing the appropriate technical assistance delivery modality is fundamental. The below modality was established to ensure that adequate capacity exists to implement the programme, taking into account the complementary capacities among agencies at central, district and sub-district level.

Furthermore, this programme will leverage on and collaborate with existing interventions in the target districts, supported by FCDO and other donors, including FCDO-supported PROSPER/BRACC, AFIKEPO, KFW, BMZ, and ONSE. UNICEF has a current investment of more than $40 million looking at community health systems strengthening, this proposal is designed to build on and synergisewith those ongoing investments.

Leadership and coordination structures are key and form an anchor of the technical assistance delivery modality. As the partner agencies are headquartered in Lilongwe, UNFPA and UNICEF will support three district and sub-district levels of the health system each, working in line with the national decentralisation process. Support will thus be provided at national and district levels.

At the National level, three international technical specialists will be engaged at each of the UN agencies. They will provide specific technical guidance and support on one of the output areas (Quality, Integration, Resilience and Governance). In each District there will be two Technical Support Officers working directly with the DHMT. One technical officer will have the primary role to ensure that all key interventions are integrated as a central part of district planning processes—creating a linkage for policy action at the district level, and to support the district teams in the quality implementation of those interventions and second technical officer will have the key responsibility of coaching and mentoring clinical staff on MNH Quality of Care.

This modality allows for strong engagement at the district and sub-district level, yet mechanisms for strong coordination between the three agencies and the Government.

Given that this programme is largely centred around providing technical support to the MoH, a majority of the activities in Year-2 are focussed on training and supervision of the various structures within different levels of the health system. Current models of capacity building within MoH place an over emphasis on training which is likely to have little effect on health care provider performance and is associated with a significant risk, since a substantial chunk of the resources allocated under ‘training’ interventions go towards daily subsistence allowances (DSAs) for the trainees. Work to develop a new model for sustainable capacity building that can be embedded within the health system in Malawi will be carried out starting in Year 2 to inform the apoproach in subsequent years of the programme, in and details of the approach to this strategic shift are provided in the section on Year-2 workplan (Section 7).. Strategies such as linking training registration/attendance with National ID card will also be explored. Meanwhile for the current year, we will continue with third party utilization and monitoring of funds (such as the CIT-Cash in transit mechanisms).

7.2. Implementation scope: target districts

The programme is expected to reach up to 3 million beneficiaries in six target districts. These districts have been selected based on the level of support they currently receive from development partners and other equity considerations such as mortality rates, per capita investments, population: HCP (Health Care Provider) ratio and poverty index.

As a result of a reduction of available funding from FCDO following the Business Planning process in early 2021 and a reduction in Overseas Development Assistance (ODA) from 0.7% to 0.5%, theThisgeographic scope of the programme has been halved half, since there were 12 districts covered in the original proposal, which were designed to complement the Organised Network of Services for Everyone's Health (ONSE) programme of SRMNCAH services currently being implementated in 16 of the 28 Districts (due to end in 2021/22, with planning for a successor programme underway).. Furthermore, unlike as was initially envisaged in the programme, the engagement of health zones (satellites) will not be part of the implementation process. The original proposal was that proposed the zones would be the hub through which knowledge transfer from the UW districts to the other districts would occur. This change will impact on the organic uptake and spread of the interventions and lessons learned intervention among other non-Umoyo Wathu districts. The programme will explore innovations in digital learning to facilitate knowledge management beyond the UW district as well as explore other UNJP platforms such as MNH QoC framework, the Cente of Excellence pleatform, the Health Data Collaborative and UHC partnership platforms.

Detailed orientation and planning will take place with the six target districts. It will be a time to finalise how to specifically to operationalise all the interventions throughout the six districts, including finalising the detailed workplan and budget for year two (Apr'21-Mar'22). During this phase, recruitment of key human resources will begin, as well as engagement of partnerships, including any implementing partners that will be used. A full management approach and programme governance and coordination structure will be finalised, with job descriptions and terms of references finalised and recruitment underway.

Table 2. *Intervention district population and key indicators*

Northern Zone
Chitipa
Karonga
Nkhata Bay
Rumphi
Mzimba
Mzimba
Likoma Island

South Eastern Zone
Mangochi
Machinga
Balaka
Zomba
Mulanje
Phalombe

Central Eastern Zone
Kasungu
Nkhotakota
Ntchisi
Dowa
Salima

South Western Zone
Chiradzulu
Blnatyre
Mwanza
Thyolo
Chikwawa
Nsanje
Neno

Central Western Zone
Lilongwe
Mchinji
Dedza
Ntcheu

Districts approved by MoH
Districts Selected

Beyond the reduction in implementation districts, an overview of the key changes in programme scope are given above in Section 6.

TARGET ZONES	TARGET DISTRICTS	Population (Census data)	HCPper 100,00 popln	Health budget per capita	Neonatal Mortality Rate (NMR)
NORTH	Rumphi	229,161	19.4	47	29.7
	Mzimba So	940,184	8.31	25	43.2
CENTRAL	Ntchisi	317,069	11.75	30	27.9
	Kasungu	842,953	8.16	21	39.5
SOUTH	Nsanje	299,168	10.92	41	48.1
	Chikwawa	564,684	8.18	43	44.6

TOTAL POPULATION: **3,193,219**

7.3. Coordination and collaboration with parallel projects

The success of the proposed programme depends on two core working processes:

1. Partnership between each of the programme-district government health entities, and
2. Close collaboration with implementing partners and other FCDO/other donor projects operating in these geographical and thematic spheres in Malawi.

Leveraging existing projects already in operation will enable the programme to make gains through synergy and avoidance of duplication, and to build on the efforts already made to date. This programme thus aims to complement parallel ongoing programmes and work with and within national structures, rather than as a stand-alone intervention, and will place district engagement at the very centre of intervention efforts.

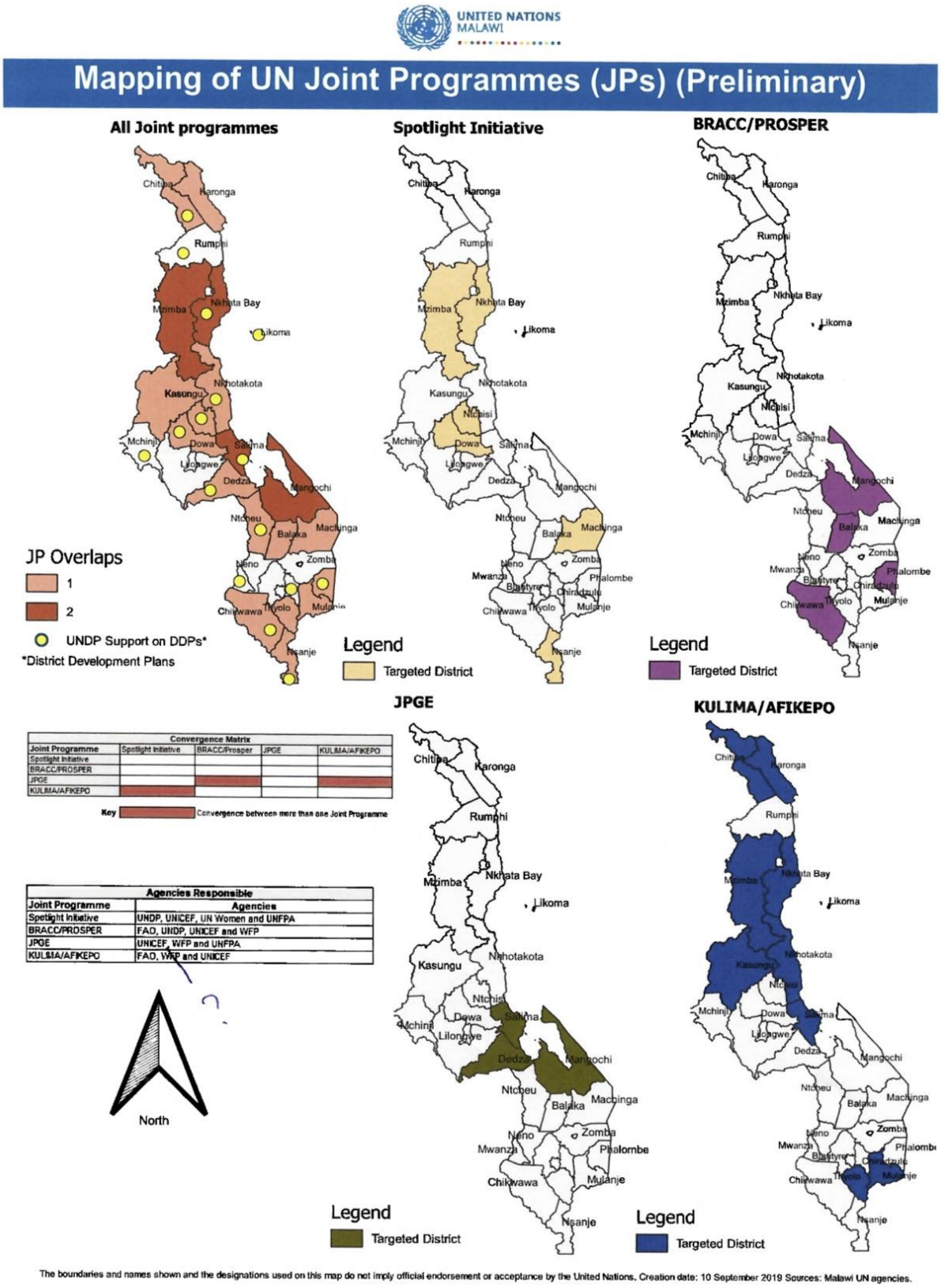
It is essential to mention that the proposed interventions will closely build on and work with the Local Government, Accountability and Performance (LGAP) project, funded by USAID. LGAP aims to support local government to effectively, efficiently and democratically fulfil its mandate to provide public services and represent citizen interests. The proposed HSS programme fits squarely within this objective and will complement the work by adding a sectoral focus on health, while building on systems and structures put in place by LGAP.

Furthermore, integration and coordination with already existing FCDO-supported initiatives is key to implementation. Close coordination, therefore, with FCDO-supported PROSPER, which is a consortium of UN agencies and NGOs that support the Government of Malawi in systems strengthening and resilience building, will be ensured. Through Tsogolo Langa FCDO supported SRHR program, modern family planning contraceptives and commodities will be made available to targeted facilities in Chikwawa district, to enable access to family planning services. Family Planning services will also be made available to eligible sexually active adolescent girls in the targeted districts. This includes the CHAM facilities and catchment areas through collaboration with PSI and WISH programs (in areas of convergence). Specific emphasis will be placed on building synergies between the proposed HSS interventions and PROSPER's work on social protection, data management and climate-sensitive agriculture.

Additionally, the proposed programme will work with "Afikepo" - a five-year (2017-2022) EU-supported nutrition programme being implemented jointly by UNICEF and FAO which aims to increase and diversify dietary intake of safe and nutritious foods to achieve optimal nutrition for women of child-bearing age, adolescent girls, infants and children.

Figure 4 is a map of current Joint Programmes showing the large coverage of existing programmes by the partner agencies. During the inception phase, the agencies will further map each district covered in this proposal with all other joint programmes, as well as those listed above to ensure collaboration and aligned work.

Figure 4. *Existing UN Joint Programmes in Malawi*



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Creation date: 10 September 2019 Sources: Malawi UN agencies.

Building on the convening capacity of the UN within country, the programme will embark on building an alliance among health donors and partners to develop a holistic approach to health systems strengthening.

7.4 Digital innovations in programme implementation

To strengthen the use of data, improve efficiencies and ensure sustainability of the planned interventions, the UNJP UW-HSS programme will leverage digital health innovations under several outputs. The targeted interventions will utilize innovations such as SMS, dashboards, rapid assessment data, visualization and more. Interventions which will be supported include but are not limited to Maternal & Perinatal Death Surveillance and Response (MPDSR) data management systems, data systems for monitoring PHC and EHP, electronic community health information systems (eCHIS), community and facility level referrals and emergency preparedness and response. In Year-2, a total of GBP 226,591 will be marked for the various digital programmes mentioned below.

- Strengthen Maternal & Perinatal Death Surveillance and Response (MPDSR) data management systems through software development and capacity building. The resources from FCDO will be used to leverage previous investments by Malawi Liverpool Wellcome Trust (MLW) (MatSurv tool) by conducting field testing of this tool in select districts and facilitating scale up in the UW districts.
- Strengthen data systems for monitoring PHC and EHP through the development/enhancement of a digital dashboard to allow for incoming data on key MNCH health service indicators from routine HMIS and rapid assessment data. This will be visualized alongside COVID-19 case and casualty data to identify trends, clusters and hotspots of fluctuations of health service disruptions. This a national activitiy that will benefit both the UNJP UW-HSS target districts as well as non-target districts. WHO will be leading mobilisation of additional resources needed to complete this activity.
- Scale up of the intelligent community health information systems (iCHIS) for improved data collection, analysis and visualisation, and provision of feedback of comunity level data. This will continue from the initial design developed during the inception phase
- Strengthen referral at community and facility level through establishing a referral system (including feedback mechanism) at both levels. The UNJP UW-USS district based team will conduct a bottleneck analysis of the referral system and identify areas where technical capacity of health workers need to be strengthened. Skills development will be supported through mentoring and a virtual learning network. This may include digital health solutions in line with International Conference on Population Development (ICPD) 2019 GoM commitment).
- Preparedness – Continuation of the production of innovative preparedness and response strategies using drones for malaria and emergency response and predicitve flood modelling which was initiated during the inception phase. This was completed in the inception phase.
- Strengthen an enhanced disease surveillance system through capacity building of Infectious Disease Surveillance and Response (IDSR) focal points and health workers, integration of the electronic IDSR (eIDSR) platform with DHIS2 and establishing an SMS central server connectivity for the MoH One Health Surveillance Platform (OHSP) and integrate with the eIDSR to support SMS reporting.
- Development and rollout of mQuarantine management system
- Ensure 24/7 connectivity of Health Unit eIDSR apparatus, district hubs, and national eIDSR platforms.

8. Year Two Workplan

As the full proposal explains, the Umoyo Wathu (U-W) programme was designed to strengthen primary health care in Malawi for Universal Health Care which provides a responsive and resilient health system essential for adapting and responding to the pandemic context. A well-organized health system that has skilled people, accessible products, well-maintained places of care and supportive policies—or the simultaneous availability of the "4 Ps"—will be able to maintain equitable, quality services even during an epidemic. Given the current COVID-19 pandemic situation, the strategic support of UW will

contribute towards establishment of the 'New Normal' for resilience and health systems strengthening in the following years. The programme will pay particular focus on ensuring a continuity of essential health services and adapting to changing contexts, strengthening the resilience of the health system and supporting communities and families to experience good health, even when faced with unexpected volatility and shocks. In developing the Year-2 plan particular attention is paid to the recommendations from the ICAI report on quality of care in FCDO MNCH programming as well as recommendations from the JEE (Joint External Evaluation) on IHR.

For the remaining second quarter (Jul-Sep'21) of Year-2, the programme will finalise the workplan and interventions and ensure alignment with the revised theory of change and results framework, orient MoH leadership and engage districts in developing a detailed district workplan and budget. Subject to budget approval, recruitment processes will be initiated. The programme will also roll out key interventions during this period. For implementation purposes, interventions can be broadly categorized into support and scale-up of existing interventions and establishment of new interventions. Current interventions suchs as training and integrated supportive supervision of health facilities, support to QIST and WITs, capacity building of RRTs in rapid response, training CHWs in supply chain management and DHMTs on leadership and management will be ongoing and initiated within $Q2Q_2$ of Year-2. During the course of the year, Umoyo Wathu staff will provide necessary support to MoH in implementing these activities while at the same time being participant observants of the process and identifying key health systems bottlenecks in the implementation of these interventions. Meticulous reports will be develop through the year which will then feed into the strategic support for these interventions in Year-3 of the programme.The level and approach to technical support and capacity building under the UW programme in Year-3 and beyond, will consider a strategic shift away from a DSA-heavy one off training-focused approach, towards, using human centred design and systems thinking approaches to re-define capacity building. We will adopt a systems view of health workforce professionalization, linking capacity building with performance and career growth not just for individuals (working with human resources deptt in MoH to implement performance appraisal systems) but also for organizations (for eg setting up accreditation mechanisms etc). There is also national level action needed complemented by district level actions and will involve engagement of professional associations and regulatory bodies.

Emphasis on the third quarter will be on initiating the 'new' interventions. These include setting up the the EmONC Centre of Excellence and Network and Referral System, establishing linkage mechanisms between the UW programmeporgramme and the HSJF, conceptualising the institutionalization of accountability mechanisms ata the facility level through the implementation of the Health Sector Improvement Grants and the like. This will involve series of engagement with stakeholders and co-creating the models and concepts along with MoH. The fourth quarter will essentially focus on consolidating the interventions and learning from year-2 and re-strategizing the development of year-3 plans taking into consideration the context of COVID and the available budget for Year-3.

QUALITY

The programme will conduct a series of **rapid health facility assessments** to monitor the evolving capacity to provide essential health services, assess disruptions, workforce capacity, availability of commodities, identify where the existing integrated primary health care system has functioning linkages around the levels of care and where the linkages must be strengthened. This will include reorienting referral pathways including between community and facility, community strategies (see INTEGRATION below) and using available technologies to support essential health service delivery.

Quality of Care

Work will focus on optimising service delivery settings, through support to quarterly integrated supportive supervision to health facilties and strengthen ability of QISTs (QI Support Teams) and WITs (Work Improvement Teams) to adhere to the adopted 9 standards for QoC, using a phased and tailored approach based on facility's needs[30].

We will explore the potential of a digital platform, such as a website or digital messaging portal, will be developed to support essential health service delivery. This would include tele-consultations, e-prescriptions and automated stock tracking to maintain the availability of essential medications and supplies. A rapid in-service training will take place of the platform and digital literacy for community health workers will be developed which will support linkages between facility and community health.

The programme will review the recommendations from the NCCEMD (National Commission on Confidential EnquiryConfidetnial Enqiury into Maternal Deaths) to improve MPDSR (Maternal and Perinatal Death Surveillance and Response). Key recommendations include improving the surveillance mechanism and to this effect, UNJP has been in consultation with MLW (Malawi Liverpool Wellcome) Trust to understand and explore the potential for scale-up of the MatSurv app developed by researchers at MLW in collaboration with MoH. Other key activities include capacity building of HSAs in MPDSR and providing technical support to the review meetings.

Three key activities will be initiated for improving decision making within the health system. Firstly, district level support through District Pharmacy Teams for integrated forecasting and quantification of commodities, by strengthening facilities with quantification, forecasting, and distribution. Secondly, the programme will faciliate the enhancement of a digital dashboard to allow for incoming data on key MNCH health service indicators from routine HMIS and rapid assessment data to be visualized alongside COVID-19 case and casualty data to visualize trends, clusters and hotspots of fluctuations of health service disruptions. Thirdly, the programme will also scale up the rollout of the electronic community health information systems (eCHIS) for improved data collection, analysis and visualisation, and provision of feedback.

INTEGRATION

Strengthen integrated service delivery from the community up to district hospitals

U-W will strengthen the integrated care pathways for district and rural hospitals, primary health centres, health posts and at the community level helping to secure the continuity of care. This will help to limit the number of visits by integrating services as much as possible and increase use of outreach activities. Integration aims to addressing the persisting fragmentation in the services provided at community level, improving efficiency around community health workers workload and time use, and harnessing the synergies that can be gained from the integration of services on the community platform. So, it is the convergence of a variety of services from the Essential Health Package on different service delivery platforms. It includes Integration at different points of care within the community health platform and the interactions between community health worker cadres, community structures and committees, schools and early childhood development centres, and households.

The programme will build on the 8 Guiding Principles for Integrated Community Health Services Delivery:

- Comprehensiveness: Each point of care should have a comprehensive integrated community health services and interventions in order to be inclusive, exhaustive with at least a complete solution to the needs of client.
- Teamwork: At each point of care, the community health team should foster on teamwork for integration to work in a coordinated manner to all health services in the stipulated packages.

[30] National Quality Policy and Strategy, Quality Management Directorate, MoH

- Capacity building: The community health team should be trained on the full set of services of the integrated community health services and interventions to enable them to deliver efficiently and effectively.
- Collaboration: The community health team should work in partnership with other sectors to deliver a comprehensive community health services beyond the health system
- Supervision: The community health team must receive necessary integrated supportive supervision and required mentorship.
- Supply Chain integration: Integrated and strengthened supply chain to ensure continuity of all services and prevent fragmentation of services due to stockouts on essential supplies for provision of some services.
- Community-driven: The management of integrated community health services should be based on equitable-approach, population-centered, with consideration for human-rights and gender dimensions of health. This demands that communities are sufficiently engaged.
- Equity: Ensure all people in Malawi including men, women, boys and girls and vulnerable groups, and the hard-to-reach areas receive high quality care at the community level.

MOH with support of UNICEF has developed the national guideline for Integrated Community Health Services Delivery in Malawi and now, Govt of Malawi has received Global Funds to scale up this initiatives in 10 additional districts (yet to be finalised by MoH). This will be complemented further by UW interventions. The final package of interventions will be developed in consultation with MoH so as to avoid duplication of effort.

A full WASH in Health Care Facilities assessment will be conducted in targeted health facilities to ensure all facilities are brought to the same level of WASH basic services**.**
Linked with the current Task Shifting Policy and governance work to streamline the responsibilities of HSAs, the programme will provide TA to support the professionalisation of HSA and Senior HSAs at sub-district level. This would include working with the DHMT and HR & Environmental Health Agency on the roll-out and formalising structures in line with Community Health Strategy, and support the workload redistribution through review process and field monitoring execution.

Strengthen B/CEmOC
During the second and third quarter of this year, an, EmONC Centre of Excellence will be identified, and centre-specific rapid assessments will be undertaken. The Centre will be responsible to overseeing readiness and functionality of EmONC and management in the targeted districts and beyond. They will build capacity of district teams to follow better infection prevention control (IPC) measures for EmNOC services. Furthermore, the creation of an EmONC facility network will be initiated to improve their functionality to be able to provide the relevant signal function. The programme will also initiate preliminary work on improving the referral system.

With the advent of COVID-19, the integration of WASH/ Infection Prevention Control (IPC) becomes paramount in preventing and curtailing transmission of COVID-19 in health facilities, at the personal and community level, and immediate assessments are needed. IPC/WASH interventions in Year-2 will cover the following aspects: support central level and district level to conduct regular onspot supervision and mentorship for IPC/WASH in UNJP districts, raise awareness of IPC / WASH at community level with high incidence of Covid 19, Print and Distribute relevant IPC/WASH messages within and around ETU; Promote Hand Hygiene at points of Care (soap +HWF). This is also an opportunity to promote WASH/IPC on diseases other than COVID e.g. on childhood viral respiratory infections, on diarrheal disease, etc and the programme will gradually transition to this messaging in subsequent years.

RESILIENCE

The current health system is in a fragile state to respond to an outbreak of sustained community transmission of COVID-19. Without intensifying investment in resilience building in the health sector, the current situation would lead to an even greater disruption of the public health system, potentially endangering the lives of women, including pregnant and lactating mothers, young people, men and children across the country.The Umoyo Wathu programme will contribute to and complement the ongoing COVID-19 response in the country. The programme will build the ability of households, communities and the health systems to anticipate, manage and overcome the cumulative stresses that may arise.

In Inception Phase, training of the RRT teams that was conducted during COVID -19 preparedness and response in twelve districts of Rumphi, Ntchisi, Likoma, Neno, Nsanje, Mzimba, Chiradzulu, Thyolo, Phalombe, Chitipa, Kasungu, and Chikwawa. However, only one team was trained per districts, rather than two as per original plan. With UW funding additional teams were trained in the districts of Kasungu & Mzimba South, Ntchisi and Nsanje. Secondly under COVID-19 preparedness and during the inception phase of UW, the development and updating RCCE messages was supported. IPC training was implemented during COVID-19 preparedness in twelve districts of Rumphi, Ntchisi, Likoma, Neno, Nsanje, Mzimba, Chiradzulu, Thyolo, Phalombe, Chitipa, Kasungu, and Chikwawa as well as during the inception phase in Kasungu & Mzimba South, Ntchisi and Nsanje, the focus was mentorship and waste management beyond C-19.

Capacity building: In year two the capacity of service providers will be strengthened on a rapid response to perceived threats, including COVID-19 and related infection prevention and control (IPC) at both the facilities and in the community. The rapid response teams, or surge capacities, will be deployed to health facilities in affected districts to ring fence primary health care services. Malawi Health Units' institutional capacity will be developed to produce and distribute oxygen in country for all ETUs and health units. Capacity building will focus on maintenance of equipment so that there is access to high flow oxygen in the targeted districts. While the UNJP will support distribution and human capacity development, other partners i.e. WB, GF, GIZ etc are working on oxygen generation through establishment of PSA (Pressure Swing Absorption), LMO (Liquid Medical Oxygen) and installation of mobile plants. A roster of health personnel from all districts to enable non-affected districts to support affected districts with HR in times of emergency will be developed.

Surveillance: The MOH will be supported to undertake various surveillance activities, including border screening and isolations and follow up of contacts, people in isolation areas, home self-quarantine and point of entries.

Poor information sharing between district and national levels, as well as amongst partners, can lead to uncoordinated supply delivery which often results in no last-mile delivery of supplies to beneficiaries.[31] Also limitations in data management, such as the use of paper-based data collection methods and limited surveillance at a district level before, during and after emergencies, can further contribute to poor decision-making, lack of preparedness and, eventually, an inequitable response. Real-time data collection, harmonization and digitalization will be prioritized in the first year. Support will be provided to the IDSR-OHSP (One Health Surveillance Platform) focal points and health workers through

[31] Malawi 2019 Floods Post Disaster Needs Assessment Report. Available from <http://www.dodma.gov.mw/index.php/downloads?download=18:malawi-2019-floods-post-disaster-needs-assessment-report>. Accessed on 17 SEP 2019.

trainings and basic troubleshooting, including the establishment of a SMS central server connectivity for the OHSP team and integrated the eIDSR.

As COVID-19 is expected to change the way we operate in the coming few years, several innovative interventions will be introduced to ensure that the health system remains resilient and outbreaks are controlled. Innovative ways of surveillance, contact tracing, and mathematical statistical modelling customized to the Malawi context (both at health facility and community level) will be introduced and/or continue to operate in this period to ensure the threat of COVID-19 is consistently under check and balance.

Although there are no emergency supplies outlined under the current proramme, there was a significant procurement of COVID-19 related items through the Umoyo Wathu programme in 2020, and this remains a viable option if further central funds for the COVID-19 response are identified

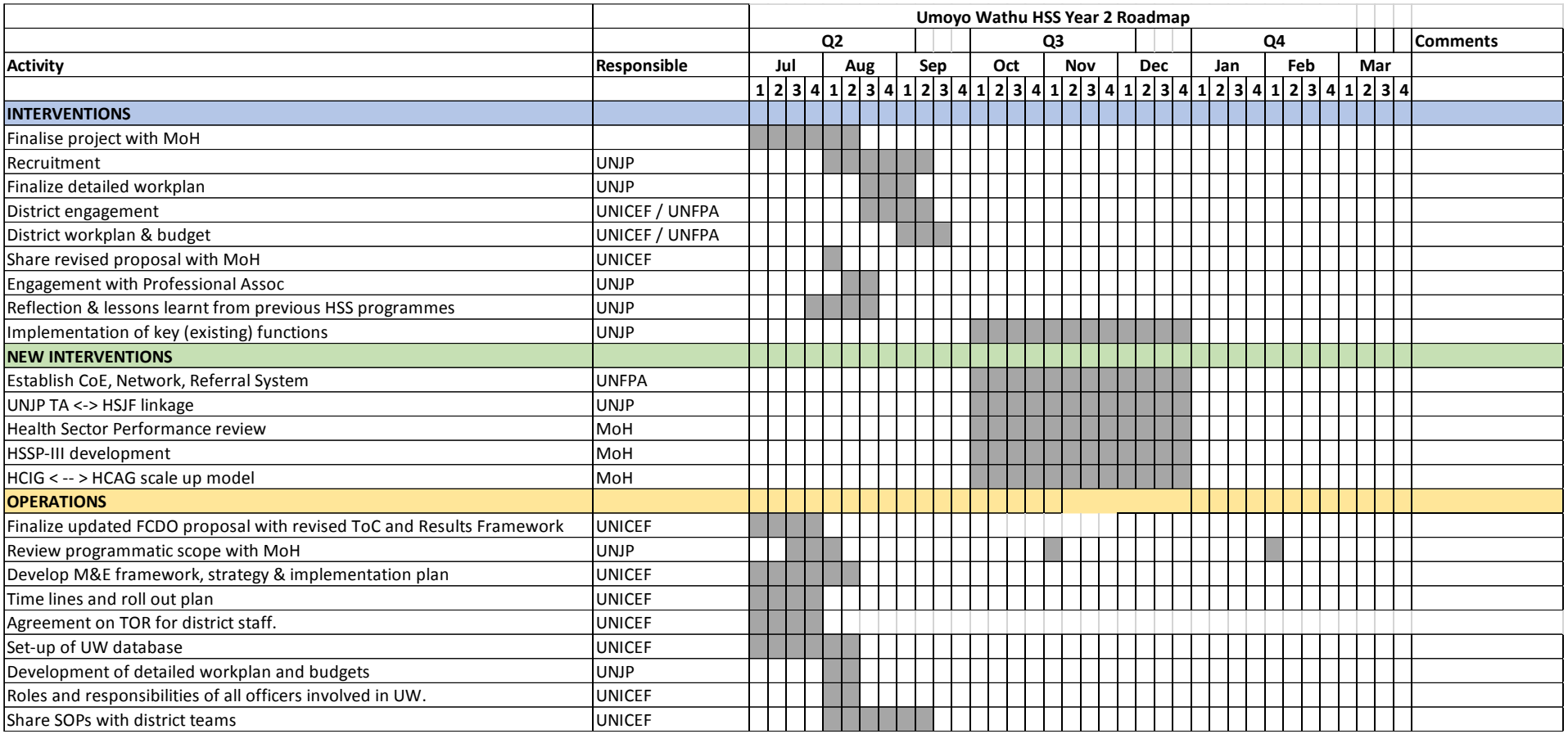
GOVERNANCE

Year-2 programme of work will continue and grow at the national level. Key activities include supporting governance and financing mechanisms in MoH through, resource harmonization, donor mapping, better linkage with HSJF, supporting fiscal decentraliszation process Support will be provided to DPPD on the national Health Financing strategy and overall aid-harmonization including technical engagement with the Health Sector Joint Fund.

While the national level direction in the COVID-19 response is vital, it is the local government system that implements and localise these decisions. At district level, the capacity of District Health Management Teams (**DHMTs**) is important. Support will be provided to DHMTs in evidence-based planning and budgeting (including stakeholder coordination, financial management, HR planning and forecasting), including on monthly reviews on how COVID -19 is affecting continuity of services and on how to address the emerging gaps. We will ensure service continuity is a continuous agenda item of the DIP Task Force which responsible for conducting these monthly review meetings. District level planning and budgeting will be complemented with coaching and mentoring of the district leadership.

Enhancing the capacity of Health Centre Management/Advisory Committees (**HCMC/HCAC**) is important to bridge the gap between the community and the health centre, acting as the voice of the community and playing an oversight role. The HCMCs will provide a platform for community engagement with health facility operations to enhance community health. The programme of work will involve working closely with the newly established Health Financing department in the MoH Planing Department towards establishing robust institutional arrangements for enhancing the role of HCAC (Health Centre Advisory Committees), initiate capacity building activities for national and district level stakeholders including non-MoH actors such as the National Local Governance Financial Commision ((NLGFC) as well as Health Centre Advisoy Committee (HCAC) members, review mechanisms for public financial management oversight at the facility level.
Figure below provides a summary of the roadmap for implementation of Year-2 activities.

Figure 1: Roadmap for Year-2 activities



		Umoyo Wathu HSS Year 2 Roadmap																																									
		Q2												Q3												Q4																Comments
Activity	Responsible	Jul				Aug				Sep				Oct				Nov				Dec				Jan				Feb				Mar									
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4						
INTERVENTIONS																																											
Finalise project with MoH																																										
Recruitment	UNJP																																									
Finalize detailed workplan	UNJP																																									
District engagement	UNICEF / UNFPA																																									
District workplan & budget	UNICEF / UNFPA																																									
Share revised proposal with MoH	UNICEF																																									
Engagement with Professional Assoc	UNJP																																									
Reflection & lessons learnt from previous HSS programmes	UNJP																																									
Implementation of key (existing) functions	UNJP																																									
NEW INTERVENTIONS																																										
Establish CoE, Network, Referral System	UNFPA																																									
UNJP TA <-> HSJF linkage	UNJP																																									
Health Sector Performance review	MoH																																									
HSSP-III development	MoH																																									
HCIG < -- > HCAG scale up model	MoH																																									
OPERATIONS																																										
Finalize updated FCDO proposal with revised ToC and Results Framework	UNICEF																																									
Review programmatic scope with MoH	UNJP																																									
Develop M&E framework, strategy & implementation plan	UNICEF																																									
Time lines and roll out plan	UNICEF																																									
Agreement on TOR for district staff.	UNICEF																																									
Set-up of UW database	UNICEF																																									
Development of detailed workplan and budgets	UNJP																																									
Roles and responsibilities of all officers involved in UW.	UNICEF																																									
Share SOPs with district teams	UNICEF																																									

		Umoyo Wathu HSS Year 2 Roadmap																																					
		Q2												Q3												Q4													
Activity	**Responsible**	**Jul**				**Aug**				**Sep**				**Oct**				**Nov**				**Dec**				**Jan**				**Feb**				**Mar**			
		1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
OPERATIONS																																							
Meetings with district teams	UNICEF / UNFPA																																						
Integrated supportive supervision	UNJP																																						
MPDSR recommendations	UNFPA /WHO																																						
EmONC assessment recommendations	UNJP																																						
Surveillance	UNJP																																						
C4D/RCCE plan	UNICEF																																						
QRM with FCDO	UNICEF																																						
PSC meeting	UNJP																																						
District Staff meeting	UNJP																																						
M&E system in place	UNJP																																						
Review implementation strategy for Y3	District teams																																						
Management meetings, membership, frequency, organiser (UNICEF)	UNICEF																																						
Technical meetings, membership, frequency, organiser	UNICEF																																						
District teams to present PEA/Situational analysis of districts	UNJP																																						
Meetings with different MoH departments & clarify UW programme	UNJP																																						

9. Value for Money statement

The UN agencies subscribe to a value for money approach which means maximising the impact of each pound spent and providing overall cost-effectiveness. They are committed to reviewing and developing measurement for the value for money of the programme as data becomes available, and to making adjustments in order to continue to competitively offer good value for money.

Efficiency

The programme has been conceptualised with efficiency at the very centre of its operations. The programme largely has a technical assistance remit, which means it is designed around government implementation of the interventions. Working *within* the existing decentralised government structures not only brings huge financial efficiencies but also many other benefits such as ownership of the interventions, knowledge building, etc. Operationally, the programme staff members will sit within government offices in each district, rather than setting up a separate office. Vehicles purchased by the programme will be shared with government staff within the districts, and government vehicles will also be used for programme activities (the programme will financially support with fuel and maintenance for the usage of these vehicles). Other programme costs such as materials will also be shared with government, where possible. Key costs such as salaries for implementing staff are largely avoided due to the nature of the programme operating through the government structures and existing government staffing whose capacities also need to be built to ensure sustainability. Additionally, key interventions such as operationalising the task shifting policy works to maximise the efficiency of the resources available in Malawi.

Efficiency will be further enhanced by working at and with different levels of the health system. For instance, as the programme works towards improving accountability and efficiency at the health facility level through structures such as the Health Centre Advisory Committees and the Health Centre Improvement Grants, there will also be concerted efforts at the national level to coordinate and institutationalise the HCIG approach within the health system. The programm will facilitate close co-ordination between MoH and MoLSG (Ministry of Local Self Glocal self overnment) in this process. Here the collective capacity of UN agencies will play a useful role in understanding and linking the local governance mechanism with the health systems governance mechanisms. UNICEF for instance supports a body of work around decentralization and local governance structures.

Another important VfM strategy adopted by the programme in light of significant budget reduction has been to re-organize the intervention budget into fixed (district) and tangible (intervention) costs that will give some flexibility to tailor funds to district specific needs, as no one size will fit all the districts. Each district will have funds of up to GBP 120,000 per annum earmarked that will support two technical support staff to be based at the district level and some support for district running costs (as outlined above). The modality by which districts will be able to utilize these funds is still under consideratios, since funds cannot be directly transferred to government entities as per FCDO guidelines.

Effectiveness

In the most holistic way, incorporating both service delivery and health system strengthening elements to have the greatest impact on saving lives within the focal districts. The focus on capacity building at the sub-national and sub-district level, as well as the support that will be provided to the government to deliver the programme, will ensure sustainability of results. The log frame and annual review of results will enable us to understand whether the project is delivering the expected results and help to ensure the

programme is having its intended effect, allowing for course correction throughout the life of the programme. A strong M&E component (to be developed in Year-2), which will include assessing value for money, as well as evidence generated by the project, will drive performance management.

Economy

The UN agencies have been operating in Malawi for over 50 years and have built strong best-practice systems around procurement, suppliers and a network of implementing partners with whom they implement interventions. Due to economies of scale and expertise, the agencies can ensure a good value is achieved on programme inputs. For instance, WHO and UNICEF will be working at the central level to support governance and financing mechanisms in MoH through, resource harmonization, donor mapping, establishing better linkage with HSJF and supporting fiscal decentralization process. Meanwhile at the district and sub-district level UNICEF and UNFPA have very good working relationship with district teams and stakeholders through their other service delivery programmes (immunization, IMCI, SRH services etc) and will leverage on these relationships to establish accountability mechanisms at the health facility level using the HCAC and HC improvement grant mechanisms (as described above). Thus a comprehensive package using top-down and bottom-up approaches will be developed, combining the collective capacity of UN partners. The net effect will be greater than the sum of the actions of individual agencies.

Also worth noting is that the programme includes very limited direct procurement and the ones planned will fit within the existing stringent procurement processes of the UN agencies. For example, the vehicles which are intended to be purchased will come through the UN procurement system and economies will be made through vehicle-sharing. Additionally, the UN agencies will make use of existing staffing and central offices in Lilongwe and avoid setting up new structures and limit capital expenditure.

Equity

All partner agencies pledge to the principles of "leaving no-one behind" and "endeavour to reach the furthest behind first." The agencies understand that value for money is not just about the work outweighing the costs but having an impact on poor people's lives and going the last mile to reach those who are marginalised or left furthest behind. The programme focuses primarily on the community and facility levels in order to reach those who most need access to quality, free PHC. In addition to the this core focus of the programme, which itself aims to deliver more equitable services across the target districts, specific interventions have been shaped around reaching those with disability, such as those living with obstetric fistula, and reaching those in the hardest to reach areas, such as the EmONC Network which looks at population spread and corresponding access to facilities. The programme is entirely designed to reach the target populations – those in predominantly rural, poor communities – with both services and strengthened governance structures (through social accountability activities) for a more equitable health system.

Programme Assets

Programme assets specifically identified to be procured under the terms of this grant will be operated and controlled by the UN agencies for the duration of the programme. The UN agencies will be accountable to FCDO for the appropriate use of these assets, in line with project objectives. Ultimate ownership of programme assets will be decided in writing by all participants.

Assets have been procured under this programme during the inception phase. No assets have been budgeted under Y2 programme. The assests available include:

- 4 Vehicle (Toyota LC Hard Top,4WD,Diesel,LWB 13seat)
- Laptops and computers

- Printer, scanners
- Furniture (standard desk, swivel chairs, filing cabinet)
- Emergency materials under WASH (Waste bin, Gloves, Goggles, Helmet, Gum boots, Aprons, Slasher, shovesl, hand fork etc)

UN partners will use and maintain asset registers and conduct spot checks on assets etc. The programme will use end user monitoring system to monitor abuse of programme assets and supplies by partners; Supplies monitoring elements will be embedded into regular PMVs (Programme Monitoring Visits)

10.Communication and Visibility

Donor visibility and communication activities will be an integral part of this intervention. UNICEF, UNFPA and WHO ensure that all supplies will be marked with donor logo. All C4D publication, Web publications, health declaration forms, will all have donor logo. Some activities include; TV and radio programme featuring experts, frontline workers, parents, teachers and hopefully children to discuss prevention, experiences, impact mitigation and provide other useful information on COVID-19. In addition, human interest stories, professional photos, photo essays, video clips, infographics, interviews showcasing COVID-19 and other health responses in the field would make up parts of communication and visibility strategies

UN partners led by the Convening Agency will ensure that communications materials, products procured under UK support and assets will be appropriately branded to ensure ease of tracking assets and identification of support. It is expected that the "UK Aid — from the British People" logo will accompany the relevant UNICEF, UNFPA, WHO and Ministry of Health/Government of Malawi branding on all publicity materials, general communication on the project and labelled assets and facilities as appropriate. For Uk financing: The partner may use the UK aid logo in conjunction with other donor logos, and where the number of donors supporting activities is such as to make co-branding impractical, acknowledgement of funding from FCDO should be equal to that of other co-donors making contributions of equivalent amounts.

For UK financing: Intellectual property developed in all material (including, but not limited to, reports, data and designs, whether or not electronically stored) produced by the PUNOs or their personal, members or representatives in the course of this project ("the Material") will be the property of the Government. The joint programme hereby grants to FCDO a worldwide, non-exclusive irrevocable and royalty-free licence to use all the Material, where "use" shall mean, without limitation, the reproduction, publication and sub-licence of all the Material and the intellectual property therein, including the reproduction and sale of the Material and products incorporating the same, for use by any person or for sale or other dealing anywhere in the world.

11.Monitoring and Evaluation

Health Systems Strengthening programme will place a strong emphasis on monitoring and learning to generate robust evidence on what works, to inform programme implementation. Separately UK financing will be support an independent monitoring component (outside of this joint programme). RCO and all UN parties will support the continual monitoring of the programme by:

- Allowing the independent monitor to undergo a review of the programme biannually as a minimum;
- Facilitating field visits to programme sites;

- Allowing impromptu spot checks by FCDO to assess programme performance
- Assessing monitoring, evaluation and learning as part of the programme's Annual Review

The UNJP log frame and results matrix has identified impact, outcome and output level indicators that will be used to monitor and measure achievement. These will be monitored through a combination of routine monitoring indicators, additional assessments and surveys to be conducted as part of programme, as well as population-based surveys such as upcoming MICS and DHS. Output and outcome level indicators will reply on data from DHIS 2 as much as possible.

Data collection will be carefully considered given the current operating COVID-19 environment that may result in restricted movements as well as the need to practice social distancing. In addition to the regular monitoring activities, special consideration will be given to use of innovative remote monitoring approaches in order to ensure effective measurement and reporting on project achievements and bottlenecks as needed.

Baselines for a few of the indicators will need to be finalised once the selection of project districts are finalised. Furthermore, a detailed M&E plan will be developed early in year one of implementation. This will define the data collection process for some of the output indicators which measure progress on the sub-national programmes to be developed.

UNICEF as Convening Agency (CA)[32] shall prepare and submit quarterly interim implementation reports and uncertified financial report each quarter by the second Friday of the month following the end of each quarter. The first report which is the Inception report, will however, be submitted on the last Friday of the month of April 2021.

The Convening Agency and Participating UN agencies (PUNOs) will meet with FCDO quarterly to discuss financial and technical progress of the project. Agenda topics will be agreed beforehand to ensure the right participants are available for the meeting.

The CA will conduct quarterly Technical Programme review meeting with FCDO to discuss programme progress and required adjustments.

The CA and PUNOs will ensure that an updated Delivery Chain map/ funds flow and a Delivery Chain Risk Map is shared with FCDO at the beginning of the programme and whenever delivery plans have changed. The CA will ensure that a Risk Matrix is shared with FCDO at the beginning of the programme and an updated version is shared as part of the written narrative reporting. Any significant changes in risk will be communicated witrh FCDO immediately.

Evaluative Evidence Generation

UNICEF global Evaluation Policy advises all UNICEF programmes and projects to undertake high quality, robust evalautions for following UNEG standards and stringet evaluation criteria. MCO adheres to the same and thus a comprehensive evaluative evidence generatation plan will be developed for UNJP as well. Costs associated with reviews and evaluations will be shared by all participating agencies through the allocations to the managing partner.

A standard evaluation process will be followed for this programme which adheres to the United Nations Evaluation Group (UNEG) standards of quality and independence. The UNEG/UNICEF evaluation standards and process will be applied rigorously to this programme. Evaluations in this programme will be used for both learning and accountability.

[32] See Program Partners and Coordination Section below

A rigorous evaluation plan will be employed to make use of the best available evidence for 1) informing programme revisions, 2) improving implementation 3) system strengthening for evaluation and research through capacity-building, 4) making use of lessons learned for evidence-based policymaking and advocacy and 5) additionally, evaluations will also be used to help strengthen accountability toward the donor and programme beneficiaries. The following plan is proposed which can be further refined and strengthened during the inception phase of the programme in consultation with all partners and donor:

Evaluability Assessment (EA)

As per the OECD-DAC definition, the EA is the extent to which 'an activity or programme can be evaluated in a credible and reliable fashion.' When executed at the outset of a programme, the EA can be very beneficial for enhancing both programme measurability and potential to achieve results. It is therefore proposed to undertake the evaluability assessment exercise during the inception phase of the project to ascertain the availability of the relevant data, precision of indicators and capacity of management systems. This exercise can also contribute to the development of a robust value for money framework and measures.

Mid-term Evaluation

A mid-term, formative and utilization focused evaluation will be conducted at the mid-point of the programme implementation. It will serve for course corrections and aim to improve the effectiveness and quality of programme outputs and draw lessons to be used for any changes or transformations required as applicable.

End of Programme Evaluation

A summative, end-of-programme evaluation for the UNJP will be conducted to review the achievements of programme vis-à-vis its outputs and outcomes. This will determine which activities were successful and/or unsuccessful and their contribution to results. Gains, issues, and challenges around programme implementation will also be assessed through this summative evaluation to elicit lessons for future programmes. The evaluation will provide all participating agencies, relevant government departments and other key stakeholders with actionable recommendations for future programming.

To support the evalatuive evidence generation, research studies, reviews and other complementary evidence generation and knowledge management activities will be employed for availability of robust and user-friendly evidence throughout the programme.

Reporting

In addition to annual reporting by the MPTFO and MPTFO Secretariat. For UK financing, the Conveneing Agency shall prepare and submit quarterly interim implementation reports. Uncertified financial report each quarter will be shared through the RCO (Resident Coordinator Office).

The Convening Agency and Participants will meet with FCDO regularly to discuss financial and technical progress of the project. Agenda topics will be agreed beforehand to ensure the right participants are available for the meeting. The Technical Steering Committee will meet FCDO every quarter to discuss programme progress. Agenda will be agreed beforehand.

In addition to annual reporting by the MPTFO and MPTFO Secretariat. For UK financing, the Conveneing Agency shall prepare and submit an inception period report and uncertified financial reportwhich covers the period of end November 2020 to end March 2021 (4 months), by no later than April 30th 2021.

The Convening Agent will ensure that an updated Delivery Chain map/ funds flow and a Delivery Chain Risk Map is shared with FCDO at the beginning of the programme and whenever delivery route has changed. The Convening Agent will ensure that a Risk Matrix is shared with FCDO at the beginning of the programme and an updated version shared as part of written narrative reporting. Any changes in risk are communicated immediately to FCDO in between times.

12.Programme partners and coordination

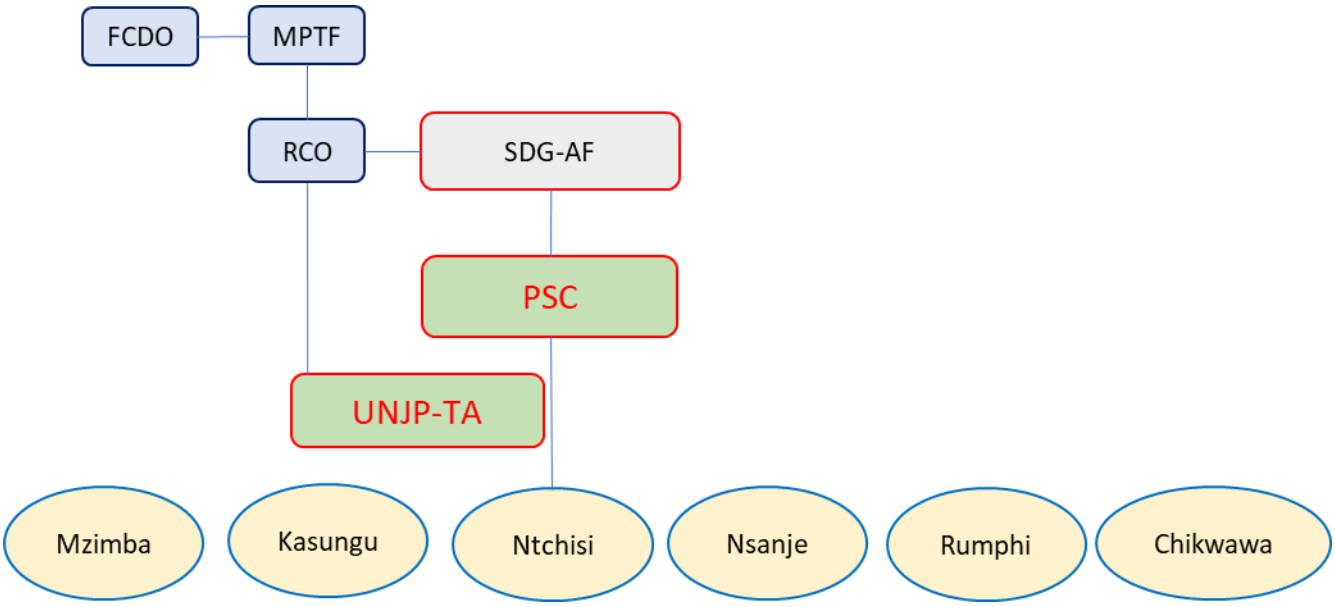
Programme Governance Structure:

The establishment of the UN Joint Programme on "Health System Strengthening for Equitable Health and Outcomes" is driven by the country situation and context. Early key programme priorities were identified in 2018 through joint consultations between Malawi's Government, the Ministry of Health and Populations, the Foreign, Commonwealth and Development Office (FCDO) and the United Nations Children Fund (UNICEF) and aligned to national development priorities as reflected in the Malawi Growth and Development Strategy 2017-2022 (MGDS). The involvement of the national government from the early stages of the Joint Programme formulation was critical to foster national ownership, sustainability, and impact of Health System Strengthening Programme. In recognizing the overarching goal of the Joint Programme in Strengthening the Health System of Malawi, the World Health Organization (WHO) and the United Nations Populations Fund (UNFPA) were jointly identified as critical partners in the Programme implementation based on their technical expertise, comparative advantage and capacity to deliver on common results considered to be essential for the successful implementation of the Programme and for producing the sought joint results of a Joint UN Programme.

Comprising three UN agencies and delivering on joint United Nations Sustainable Development Cooperation Framework (UNSDCF) for Malawi results, the Joint Programme is implemented under the overarching and strategic leadership of the UN Resident Coordinator Office in Malawi. It is governed by a Steering Committee co-chaired by the UN Resident Coordinator and FCDO. The financial administration of the Joint Programme is ensured by the United Nations' Development Program Multi Partner Trust Fund Office (UNDP/MPTFO). The overall coordination of the Joint Programme is ensured by the United Nations Children's Fund (UNICEF) in its role as a Convening Agent. The Programme is jointly implemented by UNICEF, the World Health Programme (WHO) and the United Nations Population Fund (UNFPA) as Participating UN Organizations (PUNOs). The Joint Programme Governance structure draws from and is based on the United Nations' Development Group guidance on Joint Programmes (2014) implemented through a Pass through modality and is presented under Fig 1. with respective roles and responsibilities of the governance structure outlined below.

The donor, national governmental partners, implementing partners, and each participating UN organization in the Joint Programme will be duly recognized in key external joint communication products used to publicize the initiative for the duration of the Joint Programme.

Fig.1. – Joint Programme governance system



Steering Committee

The Steering Committee is the overarching governing body of the Joint Programme. It provides strategic direction and oversight of the UN Joint Programme and has decision-making authority.

Composition

- The Steering Committee is Co-Chaired by the Foreign, Commonwealth and Development Office [name and title], herein referred to as "the donor", and the UN Resident Coordinator in Malawi.
- Members of the Steering Committee are the Heads of the Participating UN Agencies signatories of the Joint Programme Document:
    - The Country Representative of the United Nation's Children Fund (UNICEF);
    - The Country Representative of the World Health Organization (WHO);
    - The Country Representative of the United Nation's Populations Fund (UNFPA).
- By common agreement or on ad hock basis the SC may also include other members in observer capacity, such as government counterparts or civil society organizations.
- The Resident Coordinator's Office acts as Secretariat to the Steering Committee.

Roles and responsibilities

- The Streeting Committee (SC) has decision-making authority in regard to the implementation of the Joint Programme.
- The SC is the highest body for strategic guidance, fiduciary oversight, management oversight and coordination of the Joint Programme.
- The SC facilitates the collaboration between the Participating UN organizations (PUNOs) and host government for the implementation of the Joint Programme;
- The SC provides strategic direction and oversight for the Joint Programme Implementation.
- The SC reviews and approves the Joint Programme Document and annual work plans
- The SC approves allocation of resources and ensures those are in conformity with the detailed budget of the Joint Programme as reflected in the Programme Document (ProDoc);
- The SC reviews the Joint Programme implementation progress and addresses problems as an if such arise.
- The SC reviews and approves Joint Programme progress reports, budget revisions or reallocations, evaluation reports, notes audit reports (published in accordance with each PUNOs' disclosure policy), and initiates investigations (if needed).

Quorum

- The SC meets twice in a calendar year.
- In the eventuality of an urgent and strategic decision, ad-hock meeting can be convened.
- Each member of the SC (including the Co-chairs) bear on vote, for a total of five votes.
- The required quorum for decision making is of four votes (the two co-chairs and at least two Participating UN agencies)

Project Technical Steering Committee

The project Technical Steering Committee will consist of **CA, PUNOs, RCO and FCDO**. The Technical Committee will meet quarterly.

Roles and responsibilities

- Provides technical oversight of project implementation
- Discusses latest quarterly reports and proides feedback.
- Discusses latest uncertified financial reports and provides feedback
- Discusses possible programmed adaptions and changes
- Discusses financial/budgetary allocation changes from within pre-existing envelopes, which will be communicated to the Steering Committee through the SC Secretariat.

Administrative agent

The UN administrative agent for the Joint UN will be the MPTF Office based in UNDP headquarters, with the RCO and Convening Agency in Malawi providing regular backstop support. Support will be through the existing SDG Acceleration Fund Malawi and budgetary allocations managed through a 'pass through' funding modality. Programmatic and financial accountability rests with each PUNO for the proportion of funds received, which will manage their respective components of the Health System Strengthening for Equitable Health and Nutrition Outcomes Programme. The Joint UN Programme is envisaged as a joint programme made possible by co-finance contributions from development partners.

The Administrative Agent (AA) is responsible for the effective and impartial fiduciary management and financial reporting on the Joint Programme.

The Participating UN Organizations have selected jointly based on merit through a comparative review conducted by all participating UN organizations the United Nations Development Programme (UNDP) through the Multi-Partner Trust Fund Office (MPTFO) to perform the role of an Administrative Agent for the Joint Programme.

The UNDP/MPTFO is not a Participating UN Organization responsible for the Joint Programme implementation and thus provides only fiduciary administrative service to the Joint Programme.

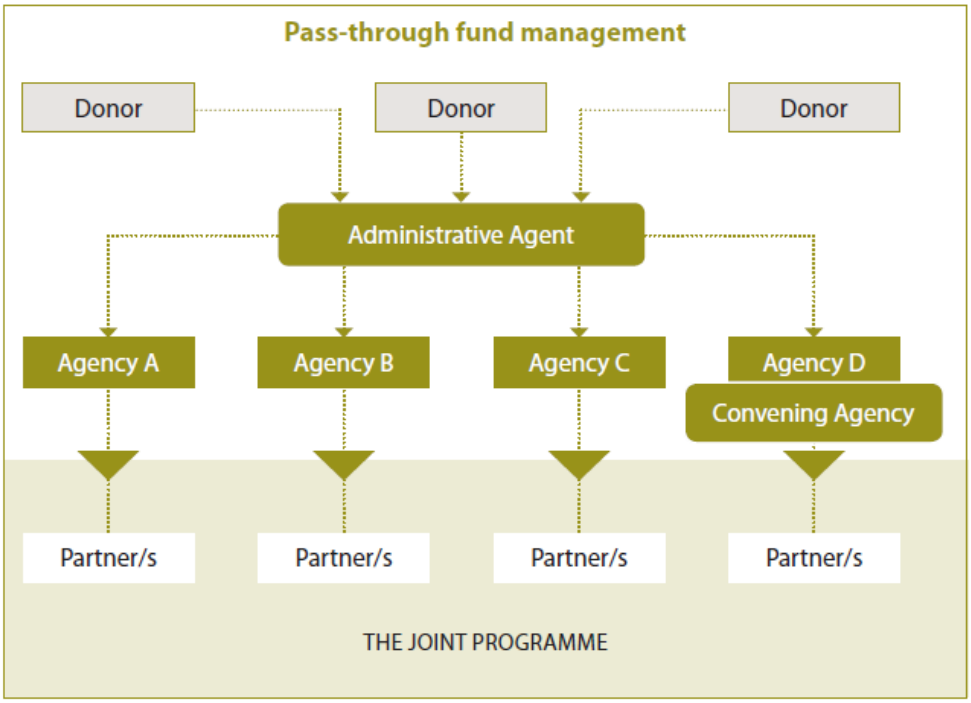
Roles and responsibilities

- The AA is accountable for effective and impartial fiduciary management and financial reporting to the donor on behalf of the PUNOs.
- The AA serves as the administrative interface between donors and the Participating UN Organizations for the purposes of fiduciary management and financial reporting only. To that end the AA will establishes a separate ledger account, referred to as the "Programme Account" under its financial regulations and rules for the receipt and administration of the funds received from donor providing financial support to the Programme through the Administrative Agent

- The AA:
  - receives donor contributions;
  - disburses funds to Participating UN Organizations based on Steering Committee instructions;
  - consolidates periodic financial reports and final financial report as per schedules agreed with the donor.
- The AA is involved in day-to-day administration and financial management of the Joint Programme.
- The Administrative Agent will be entitled to allocate an administrative fee of one percent (1%) of the Contribution by the Donor, to cover the Administrative Agent's costs of performing the Administrative Agent's functions

The modality of the financial management is presented under Fig.2 below

Fig. 2. Pass through fund management



Convening Agent

The Convening Agent (CA) is responsible for coordinating the programmatic aspects of the Joint Programme among the Participating UN Organizations

The Participating UN Organizations have selected jointly based on technical expertise and merit and through a comparative review by all participating UN organizations the United Nations' Children Fund (UNICEF) to perform the role of a Convening Agent for the Joint Programme. The following elements were taken into consideration: i) UN organization with country presence; ii) Thematic and functional area of expertise in the area covered by the programme; iii) Convening capacity to interface between Steering Committee and participating UN organizations.

UNICEF is also a Participating UN Organization responsible for the Joint Programme implementation.

Roles and responsibilities

- The CA is responsible for coordinating all the Joint Programme partners and reports back to the Steering Committee.
- The CA is responsible for the operational and programmatic coordination, including:
    - coordinates all the Joint Programme partners;
    - coordinates and compiles annual work plans and narrative reports;
    - coordinates monitoring of annual targets
- The CA coordinates and convenes various stakeholders, including:
    - convenes and reports on Steering Committee meetings;
    - coordinates the preparation of work plans,
    - facilitates audits (as required);
    - commissions mid-term and final evaluation; and
    - leads other planning of joint processes.
- Accountable for coordination of programmatic activities and narrative reporting and reports back to the Steering Committee;
- The CA may be involved in resource mobilization.
- The CA is involved in day-to-day coordination but does not hold any financial or programmatic accountability outside of its own financial and programmatic accountabilities as participating UN agency responsible for the Programme implementation.
- The CA work with the donor on a day to day implementation and agrees with the donor technical aspects of the programme implementation.
- The CA will conduct quarterly Technical Programme review meeting with FCDO to discuss programme progress and required adjustments.

Participating UN Agencies (PUNOs)

The Participating UN Agencies (PUNOs) are UN organizations that participate in the Joint Programme implementation, which may include UN funds, programmes and/or specialized agencies.

The United Nations' Children Fund (UNICEF), the World Health Organization (WHO) and the United Nations Populations Fund (UNFPA) are the Participating UN agencies for this Joint Programme. They were jointly identified together with the donor as critical partners in the Programme implementation based on their technical expertise, comparative advantage and capacity to deliver on common results considered to be essential for the successful implementation of the Joint Programme, including for producing the sought joint results.

The PUNOs have agreed to adopt a coordinated approach to collaboration with the donor and have developed a Joint Programme Document outlining key expected results from the Joint Programme. The PUNOS have further agreed to offer to the donor the opportunity to contribute to the Joint Programme and receive reports on the Joint Programme through a single channel – the UNDP/MPTF. For additional information, the UNJP Results Matrix details which PUNO is responsible for which activities and how they are linked to the key logframe outcomes.

Roles and responsibilities

- All PUNOs are jointly responsible for achieving Joint Programme goal.
- Each PUNO has a programmatic and financial responsibility for the funds disbursed to it as outlined in the Joint Programme Document (ProDoc).

- The PUNOs carry out the activities for which they are responsible in line with the budget contained in the ProDoc. Any modifications to the scope of the Joint Programme Document, including as to its nature, content, sequencing or the duration thereof by the concerned Participating UN Organization(s), will be subject to the approval of the Steering Committee.
- The PUNOs should promptly notify the Administrative Agent through the Steering Committee of any change in the budget as set out in the Joint Programme Document.
- The implementation of the programmatic activities are the responsibility of the PUNOs and will be carried out by each PUNO in accordance with its own applicable regulations, rules, policies and procedures including those relating to procurement as well as the selection and assessment of implementing partners.
- Each PUNO will establish appropriate programmatic safeguard measures in the design and implementation of its Programme activities, thereby promoting the shared values, norms and standards of the United Nations system. These measures may include, as applicable, the respect of international conventions on the environment, on children's rights, and internationally agreed core labour standards.
- Each PUNO assumes full programmatic and financial accountability for funds disbursed to them by the AA.
- Each PUNO will establish a separate ledger account under its financial regulations and rules for the receipt and administration of the funds disbursed to it from the Programme Account. That separate ledger account will be administered by each PUNO in accordance with its own regulations, rules, policies and procedures, including those relating to interest.
- Each PUNOs prepares narrative and certified financial reports annually for their components of the Joint Programmes. These reports are forwarded to the AA and CA for consolidation and submission to the donor.

11.3. Programme partners focus areas and responsibilities

Each of the participating agencies will lead on one or two of the output areas; WHO will be the lead agency on Quality, UNFPA to lead on Integration and UNICEF on Resilience and Governance.

As WHO's institutional capacity and mandate is focused at the national level, they will focus on providing support on health financing, specialised inputs for improving quality of care (including standards, guidelines, training packages, reporting tools) and on overall monitoring and evaluation of how the UN Joint Programme is contributing to UHC and the health SDGs. Through the technical assistance modality developed (see section 6.1), strong engagement at the district and sub-district level with UNICEF and UNFPA support will be embedded—creating a linkage for policy action these lower levels.

UNICEF and UNFPA will each support a number of districts but will work through an agreement upon common framework with set mechanisms in place for strong coordination between the three agencies and the Government. For certain interventions, such as EmONC Centres of Excellence or Health Centre Management Committees, for example, one agency will technically lead the intervention across the six districts while the day-to-day implementation of the programme and co-ordination of that intervention will be the responsibility of the UN agency allocated to that particular district (For eg: UNICEF-Mzimba and Kasungu and UNFPA-Ntchisi and Nsanje) . Programme partners' capability statements, along with their role and responsibilities in this programme summarised in Table 3.

Table 3. *Summary of programme partners focus areas and responsibilities*

Programme Partners	Core focus areas and responsibilities
UNICEF	*Areas of focus:* UNICEF will lead on improving the functionality of community-based care and district planning processes, much of which is focused under the Governance output. UNICEF will be the principal partner on all of the Resilience output's interventions.
UNFPA	*Areas of focus:* UNFPA will be the principal partner on all of the Integration output interventions. UNFPA will focus on developing and scaling-up an integrated care pathway for primary and secondary health care facilities and on improving the quality of contraception, pregnancy, delivery, including emergency obstetric and new-born care, services. It will ensure the availability of the seven and nine signal functions in basic and comprehensive EmONC facilities respectively, including improved referral services. It will ensure maternal and perinatal death surveillance and response (MPDSR) systems are responsive and response plans are being implemented by districts in a timely manner. It will also lead on assessment and scale-up of adolescent SRHR interventions.
WHO	*Areas of focus:* WHO will focus on providing national level support on Health Financing, specialized inputs for improving Quality of Care (including standards, guidelines, training packages, reporting tools) and on overall monitoring and evaluation of how the UN Joint Programme is contributing to UHC and the health SDGs. The quality of care and the monitoring and evaluation work will focus on, but not be limited to, the prioritised EHP intervention packages.
United Nation Resident Coordinator's Office (RCO)	*Role:* The Resident Coordinator co-chairs the Programme Steering Committee along with FCDO. The RCO also acts as Secretariat to the Steering Committee. Consolidation of the annual narrative reports submitted by the Participating Organizations/joint programmes in the fund is the responsibility of the MPTF secretariat. Locally the MPTF secretariat maintains and complements CA discussion with donor and GOM, where necessary on the project implementation and guarantees joint approach and coordination. In addition to the above, the RCO will support coordination and ensure strategic cohesion across all other joint programmes within the MPTF Fund.
Multi Partner Trust Fund (MPTF)	*Role:* MPTF, as the Administrative Agent, is responsible for financial management of the programme. MPTF's responsibility is to consolidate financial reports submitted by the UN Participating Organizations HQ Finance departments.

Table 4. ***Agency roles and responsibilities***

Agency	HQ Overheads	% Local Admin Costs	Role	Responsibilities	Accountability Lines
MPTFO	1%	0%	Administrative Agent (Fund Management)	Accountable for effective and impartial fiduciary management and financial reporting to the donor on behalf of the PUNOs. Administrative interface between donors and the Participating UN Organizations for the purposes of fiduciary management and financial reporting only. Receives donor contributions. Disburses funds to Participating UN Organizations based on agreed budget allocation across the 3 PUNOs Subject to the availability of funds, the Administrative Agent (AA) shall normally make each disbursement to the PUNO within three to five business days after receipt of the Fund Transfer Request. In addition, the MPTF Office through its GATEWAY (http://mptf.undp.org/) offers a web-based service portal, which provides real-time financial data generated directly from its accounting system. It provides all partners and the general public with the ability to track information on contributions, transfers and expenditures Consolidates periodic financial reports and final financial report as per schedules agreed with the donor. The AA will be entitled to allocate an administrative fee of one percent (1%) of the Contribution by the	SAA Signatory and accountable to FCDO for all programme funds

				Donor, to cover the AA's costs of performing the AA's functions	
RCO	0%	0%	Governance Function/Local Admin Support	Co-Chair Steering Committee. The TORs are flexible. Co-signatory with MPTFO/RC/FCDO. Consolidates annual reports (for all other MPTF donors) Ensures coordination on cross cutting issues in Malawi. Resolve any cross-agency disputes/discrepancies. Alternative point of contact for FCDO, regarding MPTFO – (other than for anything technical or operational – where FCDO will communicate directly with UNICEF). Linkages and complementarities to other joint programming within fund. To note separate UK HQ CMP through UNCD supporting RCO to have 5 people in every country.	SAA co-signatory and accountable to FCDO for programme funding and deliverables.

UNICEF	7%	GBP 1,250,000	Convening Agency	Responsible for consolidating narrative reporting and submitting to the RCO. Responsible for operational and programmatic coordination: coordinates all the PUNOs, coordinates and prepares annual work plans and narrative reports, coordinates monitoring of annual targets, calls and reports on Steering Committee meetings, commissions mid-term and final reviews/evaluations, facilitates audits, reports back to the Steering Committee, and other planning of joint processes Provides technical oversight of project implementation, discusses latest quarterly reports and provides feedback, discusses latest uncertified financial reports and provides feedback Discusses possible programmed adaptions and changes Prepares annual and final consolidated narrative progress reports based on the reports submitted by each participating UN Organisation, and shall provide those consolidated reports to the Administrative Agent for further submission to each donor that has contributed to the Joint Programme, in accordance with the timetable. The narrative reports should describe in a coherent manner what is being done jointly at outcome and output level. The generic annual and final programme narrative progress report template shall be used (http://mdtf.undp.org/document/download/5390). Coordinates the joint audit conducted either by one Internal Audit Services (IAS) on behalf of all, a group of IASs of participating UN organisations, or an	Accountable to RCO and FCDO for any funding to or through UNICEF, and for coordination, impact and coherence among PUNOs, including at district level. Note FCDO is a member of the Steering Committee, and UNICEF is the lead on operational and programmatic coordination. UNICEF is also lead focal point on all technical matters as conveneing agency.

				outside audit provider on behalf of all Internal Audit Services (IAS) involved Directly engaged in day-to-day coordination. Communicates directly with FCDO on technical and programmatic issues, including responding to day to day technical support and information requests. Responsible for development of terms of reference for the Joint Coordination Unit, for endorsement by all PUNOs Implementation: Output 1 UNFPA/UNICEF: Activities to reinforce the use of the MPDSR and associated feedback and improvement mechanisms Output 2: UNICEF: training of healthcare workers, technical assistance for forecasting and quantification of health commodities. UNFPA/UNICEF: (in collaboration with MoH and relevant government agencies) development and implementation of roadmap for the protection and girls and women from sexual and gender-based violence Output 3: UNICEF: Facilitation of consultative processes for emergency preparedness and planning; establishment of package and alternative sites for health services in emergencies; stockpiling of key essential supplies; capacity-building for district and health staff; development of modelling and risk forecasting system; staff safety and welfare related to COVID-19 response. Output 4: WHO/UNICEF: support for national level coordination mechanismsUNICEF: establishment of	

				PHC forum; support for DIP planning and implementation; establishment and training of HCMCs; community engagement and social accountability platforms and processes.	

UNFPA	7%	GBP 196,000	Participating UN Organization (PUNO)	Implementation: Output 1 UNFPA/UNICEF: Activities to reinforce the use of the MPDSR and associated feedback and improvement mechanisms Output 2: UNFPA: (working with MoH and UNJP partners) EMONC and YFHS status assessment, collaborative development of care pathway model, assessments and development of improvement plans and implementation plans; creation of EMONC facility network, 3 EMONC CoEs; development and piloting of self-care guidelines and services. UNFPA/UNICEF: (in collaboration with MoH and relevant government agencies) development and implementation of roadmap for the protection and girls and women from sexual and gender-based violence	Accountable to UNICEF as CA for technical matters, reporting etc. Accountable to RCO for funding related issues and overall support
WHO	7%	GBP 9,420	Participating UN Organization (PUNO)	Will lead on Quality Interventions; and Monitoring and Evaluation of how the programme is contributing to UHC and the health SDGs-Implementation: Output 1: WHO: Implementation of quality activities: collaboration with MoH and partners in institutionalisation of quality improvement mechanisms, measurement of adherence to clinical protocols, monitoring of EHP packages at facility level, tracking of availability of 3Ps, and supporting policy advocacy. Output 4: WHO/UNICEF: support for national level coordination mechanisms	Accountable to UNICEF as CA for technical matters, reporting etc. Accountable to RCO for funding related issues and overall support

All PUNOs	AsAbove	GBP 603,416 (This is included under the UNICEF budget)		Jointly responsible for achieving Joint Programme goal. Jointly feed into work plans. Programmatic and financial responsibility for the funds disbursed to it as outlined in the Joint Programme Document (ProDoc). Carrying out the activities for which they are responsible in line with the budget contained in the ProDoc. Any modifications to the scope of the Joint Programme Document, including as to its nature, content, sequencing or the duration thereof by the concerned Participating UN Organization(s), will be subject to the approval of the Steering Committee. Promptly notifying the Administrative Agent through the Steering Committee of any change in the budget as set out in the Joint Programme Document. Implementing programmatic activities in accordance with its own applicable regulations, rules, policies and procedures including those relating to procurement as well as the selection and assessment of implementing partners. Establishing appropriate programmatic safeguard measures in the design and implementation of its Programme activities including international conventions on the environment, on children's rights, and internationally agreed core labour standards and Prevention of Sexual Abuse and Harassment.	Accountable to UNICEF as CA for technical matters, reporting etc. Also accountable within their own institutional governance structures. Accountable to RCO for funding related issues and overall support

				Each PUNO assumes full programmatic and financial accountability for funds disbursed to them by the AA. Establish and manage a separate ledger account under its financial regulations and rules for the receipt and administration of the funds disbursed to it from the Programme Account. Preparation of narrative and certified financial reports annually for their components of the Joint Programmes. These reports are forwarded to the AA and CA for consolidation and submission to the donor.	

8.3.1 UNICEF Capability statement

UNICEF is mandated through the Basic Cooperation Agreement to work with GoM and has been operating in the country since 1964. Through its multi-sectoral work with national partners and its strong alignment with national priorities, UNICEF Malawi plays a key role in supporting the Government to meet the needs of children and the most vulnerable. The support includes strategic planning and policy design, inter-sectoral coordination and collaboration, technical assistance, knowledge generation and transfer, data collection and analysis, communication for development, community mobilisation, procurement of essential food and non-food items, specialised training and hands-on supervision, and end-user monitoring.

The current UNICEF/Government of Malawi Country Programme of Cooperation (2019 – 2023) aims to support national efforts to progressively realise the rights of children through an integrated life-cycle approach that systematically addresses the holistic needs of children from conception, through early childhood and into adolescence. To do so, the office operates through multi-sectoral teams, organised around (1) early childhood, (2) school-aged children, including adolescents, and (3) child-friendly and resilient communities.

Human-centred design principles form an integral part of UNICEF Malawi's ways of working, primarily focusing its work on the child, as well as on key frontline workers that are critical for the realisation of child rights, such as health workers. This enables effective, efficient and people-centred integrated programming, and places UNICEF Malawi in a unique position to lead on integrated health system strengthening. The current Country Programme builds on many years of successful collaboration with the Government of Malawi, including health and nutrition-related issues. For instance, UNICEF has supported the MoH to develop the Maternal and New-born Health Quality of Care Roadmap, as well as an Implementation Guide and, in collaboration with WHO and UNFPA, supported a baseline assessment of quality of care, which will inform the HSS programme's starting point. Furthermore, UNICEF's RMNCH programme supported the capacity building of CEmONC and BEmONC facilities and the establishment of Sick New-born Care Units in district health facilities.

Since 2012, UNICEF has also supported health systems strengthening, especially at the district level. Initially through the District Health Performance Initiative (DHPI) and more recently through the District Health Systems Strengthening Initiative (DHSSi) which is funded by the Bill and Melinda Gates Foundation. UNICEF's tools and methods, such as the "bottleneck analysis" and EQUIST analysis, have been widely adopted by the MoH and have recently been incorporated into the national planning guidelines for the health system. UNICEF has also been working with communities and has been strongly advocating for the Quality of Care Framework to be extended to the community level. At national, regional and global levels, UNICEF has a dedicated team working on MNH QoC and contributes to the national and global learning process, in addition to addressing the priorities of MNH at a beneficiary level. In recent years, UNICEF has also piloted the concept of social accountability in select communities – the success of this intervention, in fact, has laid the foundation for a nationwide social accountability framework (further information is available at https://www.unicef.org/malawi/what-we-do).

UNICEF is supporting the implementation of a joint UN capacity development strategy that aims to build workforce professionalisation in Malawi, including of the health workforce. To complement these efforts, UNICEF Malawi has established a dedicated multi-sectoral Task Team on professionalisation of the health workforce, operational since June 2019, which specifically aims to move beyond training workshops towards a comprehensive strategy for capacity building and professionalisation.

UNICEF Malawi is also the technical lead for the UN Network for Scaling-Up Nutrition in Malawi. UNICEF has supported the Department of Nutrition HIV/AIDS (DNHA) to ensure that Malawi continues to have a coherent and cohesive policy environment for nutrition. UNICEF has supported the MoH to scale-up management of nutrition in over 15 districts, building nutrition resilience and implementing nutrition specific and sensitive interventions. UNICEF has also played a leading role in reviewing existing nutrition-related policies and their implementation and has generated evidence to advocate for domestic resources for nutrition.

Lastly, UNICEF has a strong understanding of the sub-national context and has access to gather often difficult to obtain data. The office currently has 146 staff, including 41 international professional staff, and an annual budget of over US$ 50 million. Global and regional technical experts on health, nutrition, child protection and other core areas of UNICEF's mission closely support and provide technical backstop to the Malawi Country Office to ensure the highest and continuous technical quality of work.

8.3.2 UNFPA Capability statement

UNFPA has been in operation in Malawi since 1979, building national capacity on policy, programming and data management. Specifically, UNFPA has supported the MoPH to institutionalise maternal death and response systems to improve the quality of care at national and district levels to address avoidable causes of maternal death. UNFPA has local, regional and global expertise in strengthening basic and comprehensive emergency obstetric care functionality at facility level, while ensuring robust district data systems at the same time. As a data-driven agency, UNFPA has regionally and globally facilitated GIS mapping and EmONC facility network systems to improve access to EmONC services using census data. The EmONC Network facility has improved quality of care and access to EmONC services, as well as served as a platform for information sharing and collaborative learning. UNFPA continues to support the GoM to remain evidence-based through support to EmONC assessments, Demographic Health Surveys and Country Programme Evaluations, including strengthening of the district-level health information systems. In addition, UNFPA has been strengthening the Government's reproductive health commodity and security, and supply chain systems to ensure availability of these commodities in Malawi, particularly, in basic and comprehensive EmONC facilities. The global commodity-security initiative ensures the availability of life saving commodities for pregnant women and new-borns in Malawi, as well as tracking capabilities including last mile assurance.

UNFPA staff at country, regional and global levels support country programmes in applying innovations and lessons learnt from previous programmes, and the scaling-up of good practices. Presently, the Country Office in Malawi consists of a core of international and national programme personnel with vast experience in sexual and reproductive health and adolescent sexuality. The country office also receives technical support from the UNFPA East and Southern African Regional Office (ESARO), which has world class expertise on Reproductive Health and Youth Programming. These teams, both in-country and at the regional level, will support the delivery of the HSS programme.

8.3.3 WHO Capability statement

The WHO has had country presence in Malawi since its independence, with long-standing effective collaboration with MoH and partners in the area of health system strengthening. The agency has technical capacities with country office across clusters, namely, health systems and family reproductive health services, and several collaborating centres within Malawi, as well as technical support at sub-regional, regional and global levels.

13.BUDGET

Project Budget			ESTIMATED UTILIZATION OF RESOURCES (US$)		
Category	**Total (USD)**	**Total (GBP)**	***UNICEF***	***UNFPA***	***WHO***
Staff and other personnel costs	11,541,498	8,673,905	7,547,038	2,416,971	1,577,489
supplies, commodities and materials	-				
Equipment, Vehicles and Furniture including Depreciation	830,914	624,466	555,351	188,112	87,450
Contractual Services	380,053	285,625	380,053		
Travel	-				
Transfer and Grants to counterparts	23,337,240	17,538,885	14,481,505	5,862,687	2,993,048
General operating and other costs	1,900,110	1,428,010	1,634,043	253,533	12,534
Total programmable cost	**37,989,816**	**28,550,891**	**24,597,991**	**8,721,303**	**4,670,520**
Indirect costs (6.5%)	2,659,287	1,998,562	1,721,859	610,491	326,936
Total pass through Amount ($)	**40,649,102**	**30,549,453**			
MPTF (1%)	406,492	305,495			
Total Contribution	41,055,594	30,854,948			
Exchange rate used	1.330600001				
November 20 Exchange rate USD 1 = GBP 0,773					
https://treasury.un.org/operationalrates/OperationalRates.php					

14.Contact persons

UNICEF (Lead Partner)
Dr. Tedla Damte
Chief, Health & HIV
UNICEF, Malawi
tdamte@unicef.org

UNFPA
Dr. Jyoti Tewari
Regional Advisor-HSS,
UNFPA, South Africa
jtewari@unfpa.org

WHO
Dr. Solome Nampewo
Health Systems Specialist
WHO, Malawi
nampewos@who.int