Request for Health Systems Strengthening Support based on a jointly assessed National Health Strategy

Funding Request Template

Applicant Details

Country	MALAWI	
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Funding requested from GAVI only?	**Yes**
Funding requested from Global Fund only?	**No**
Funding requested from the Global Fund and GAVI (in this request form)?	**No**
Comments/remarks:	

Background

Duration of the National Health Strategy	
From (Month and year)	**To (Month and year)**
1st July 2011	30th June 2016
Planned Start and End dates for HSS support	
The duration of the funding request is determined by the duration of the current national health strategy. In the case where this is less than five (5) years, the Global Fund offers applicants the possibility to include a request for one (1) additional year of funding (please refer to section 3.3). Applicants can request a maximum of five years from the planned grant start date (including the remaining implementation of the strategy and the indicative year).	
From (Month and year)	**To (Month and year)**
Global Fund:	**Global Fund:**
GAVI: 1st January 2013	**GAVI:** 30th June 2016
Describe how the start and end dates above were selected. Also describe how they contribute to alignment with national financial and/or program review cycle/s.	
Response: In Malawi, the financial year runs from 1st July to 30th June of each year. On 1st July 2011 the Ministry of Health (MoH) and stakeholders in the health sector started implementing a 5 year Health Sector Strategic Plan (HSSP) to cover the period from 1st July 2011 until 30th June 2016. The comprehensive multi-year plan (cMYP) for immunisation has been revised to cover the period up to 2016 so that it is aligned with the HSSP. A three and a half year period for implementing proposed activities has been chosen in order to align with the remaining term for the HSSP, the cMYP and also the Malawi Growth and Development Strategy (2011-2016) which is the overall government development agenda for this period.	

Currency: 'Tick' (✓) which currency is used throughout this application.	USD

	Summary of HSS Funding Request				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Total**
Period	01/01/13 to 30/06/13	01/07/13 to 30/06/14	01/07/14 to 30/06/15	01/07/15 to 30/06/16	[redacted]
Funds requested from the Global Fund	0	0	0	0	0
Funds requested from GAVI	5,617,290	4,589,797	3,112,272	2,780,251	16,099,611
Total Funding Request					16,099,611

Eligibility

Global Fund eligibility – CCM eligibility and other requirements for requests to the Global Fund

Please fill out the separate eligibility document ''Section B – Eligibility and other Requirements section – HSS proposals/requests to the Global Fund", which is available here. Kindly note that applicants submitting a request to the Global Fund will also have to submit "Attachment C", the signed membership list as sign of request endorsement by all CCM members.

For more information on Global Fund eligibility, please refer to the Global Fund's Guidance Note: CCM Requirements.

If the JANS report identified weaknesses in Multi-Stakeholder Involvement (MSI) in the development of the national health strategy, please describe below how you intend to improve MSI in future development processes.

GAVI eligibility - Government endorsement and other requirements for requests to GAVI

Please note that this application will not be reviewed or approved by GAVI without the signatures of both the Minister of Health & Finance or their delegated authority.

[PLEASE NOTE THAT THE SIGNATURES HAVE BEEN SCANNED AND ARE IN ATTACHMENT 9]

Minister of Health:	**Minister of Finance**
Name:	Name:
Signature:	Signature:
Date: 28 August 2012	Date: 28 August 2012

Applicants to GAVI are also requested to fill out this eligibility section. For more information on GAVI eligibility, please refer to the following document.

Response: Malawi adopted Sector Wide Approach (SWAP) in 2004 as an overarching framework to guide the planning, financing, implementation and monitoring of delivery of health services. Through this approach, governance structures/committees comprising of representatives of all health sector players (Government departments; development partners, health training institutions, research institutes, health regulatory bodies, health professional associations, private sector, civil society, district assemblies, and faith based organisations) were formed to provide policy and technical guidance on all aspects of health service delivery. These committees included a health sector review group (HSRG) which brings together multiple health stakeholders in Malawi to act as a CCM for the health sector. The nongovernmental partners are represented at the HSRG by a subset of the civil society organizations operating in country.[1] Members include Ministry of Health, and selected representatives of the donors, research institutions, civil society, nongovernmental healthcare providers, training institutions, and professional societies. A number of technical working groups (TWGs) monitor progress and provide technical input into the implementation of different components of the HSSP, including human resources, financing, monitoring and evaluation, procurement, and the essential health package, and many others.

Stakeholders from these institutions participated in a series of meetings organized by the Ministry of Health to develop the HSSP. The development process started by an external evaluation of the 2004-2010 health sector`s Program of Work (POW). The evaluation report provided detailed information of success made through POW 1 implementation as well as health system challenges that needed to be areas of focus of the HSSP. The different TWGs provided input into specific health system issues to be addressed in the HSSP such as health financing, financial and procurement systems, high impact interventions to be included in the national essential health package, supply chain, development, recruitment and retention of health workers, etc.

Other data that informed the development of the HSSP was from the recommendations of Joint Annual Reviews held by health sector players during the life time of POW 1, disease/system specific reviews (malaria, EPI, HIV, HRH, financial audits etc) and WHO STEPS study (burden of disease study). Through FGDs conducted at community level and participation of Traditional Authorities, views of community members were also incorporated. Following inputs from TWGs and other sources, Planning Department of the Ministry of Health compiled the HSSP and circulated it to all health sector constituencies for their comments. Later, an internal and external JANS were conducted and recommendations from the JANS were used to finalize the HSSP. The files in Annex 1 contain detailed information about how each of the JANS findings were addressed in the revised HSSP, point by point.

The completed document was subjected to a three phase approval process that included review and approval by the senior management committee of the Ministry of Health including Secretary for Health, Directors, Deputy Directors and Program Managers. Second phase was submission of the HSSP document to members of the HSRG for their review and approval. The final approval was from the Honourable Minister of Health who is a member of the office of the President and cabinet responsible for providing the political

[1] CSOs represented at the HSRG include Health and Rights Education Programme (HREP), CARE International, Sight Savers International, SONISO, Africare, Ladder for Development, Youth Activist Organisation, Girl Leader Empowerment Organisation, Concern Universal, Every Child Organisation, Manet +, GTZ, CIDA Malawi, Catholic Relief Services, Save The Children (USA), Church and Society, FOCEDI, CAYO, InterAid, White Ribbon Alliance, Drug Fight Malawi, Hygiene Village, Health Consortium, Sue Ryder Foundation, Christian Health Association of Malawi (CHAM)

oversight for implementation of the health component of the Malawi Growth and development Strategy. Official launch of the HSSP was done by the Hon. Minister of Health during the Joint 2011/2012 Annual Review held in October 2012.

Development of the GAVI HSS proposal utilized the same structures and is seen as one mechanism for filling the resource gap identified in the HSSP. The TWGs were asked to evaluate the guidelines of the proposal and identify interventions to be considered for inclusion in the application. Considering the recommendations of all the stakeholders and TWGs, and taking into accounts the limits on available funding, the SWAp Secretariat finalized the proposed list of strategic interventions for inclusion and presented these to the HSRG, who then approved.

Note: In filling out the sections below please cross-reference as much as possible to the existing documentation of the National Health Strategy.

In the case of requests to both Global Fund and GAVI, please clearly delineate, both programmatically and in the budget and work plan, what is being requested from the Global Fund, and what is being requested from GAVI.

SECTION 1: EXECUTIVE SUMMARY

Applicants are strongly encouraged to complete the Executive Summary only after completing sections 2 to 7.

In this section, applicants are required to provide a concise summary of this application being presented to the Global Fund and/or GAVI. Details should be described in section 2.

The summary should provide an overview on the following points:

- For which elements of the National Health Strategy health systems strengthening (HSS) and/or community systems strengthening (CSS) support (for Global Fund) is requested, and why and how these elements were selected for the funding request.
- What is requested, and how the support requested is additional to, and complementary to existing support, as well as Global Fund and/or GAVI support.
- How this support will help achieve expected outcomes and impact as described in the National Health Strategy, including:
  - Improved outcomes in at least two of the three diseases (HIV/AIDS, Tuberculosis, Malaria) – for Global Fund support; and/or
  - Improved immunisation outcomes in the context of integrated service delivery – for GAVI support

EXECUTIVE SUMMARY

Background: The Ministry of Health (MOH) is the lead government agency with the mandate to safeguard health status of the people of Malawi. To ensure proper guidance on health service delivery, the MOH in consultation with other sector players develops a national health plan which outlines the country's health challenges and strategies to address bottlenecks in health service delivery as well as the health interventions that would lead to improvement in health indicators. Health system challenges identified during development of the HSSP include but are not limited to:

- Inadequate human resources to deliver the essential health package (p.30)
- Poor supply chain leading to frequent stock outs of essential medicines (p.30)
- Inadequate access and coverage of quality essential health services (pp.34-35)
- Poor quality of health information systems (pp.33-34)
- Inadequate financial and procurement systems (pp.32-33)

The goal of the HSSP is therefore to improve the quality of life of all the people of Malawi by reducing the risk of ill health and the occurrence of premature deaths, thereby contributing to the social and economic development of the country.

Context for this request: In 2007, GAVI approved HSS funding to the GoM which has helped address some of the health system challenges. This support resulted in high and sustained DPT-HebB-Hib3 coverage in 2009 (93%) and 2010 (93%), up from 91% in 2008, and other improvements in child health. The activities contained in this proposal are prioritized interventions from within the HSSP and the cMYP for which no funding has been

identified and which were selected through a consultative review process by technical working groups and the health sector review group. The selected interventions support immunization outcomes while contributing to overall systems strengthening.

The **goal** of this proposal is to reduce under-five child mortality through strengthening public health delivery. The **specific objectives** follow together with their service delivery areas (SDA).

Objective 1: Improve and sustain high immunisation coverage and support scale up of the essential healthcare package

This section links directly to Objective 2 in the HSSP, namely strengthened performance of the health system to support delivery of EHP services.

1.1 Human Resources for Health (HRH)
Activities under this SDA prioritize training new health care workers as well as improving the skills of existing health workers. This links to the HSSP objective: *To provide human resources that are adequate, properly trained and remunerated, well motivated and capable of effectively delivering the EHP to the Malawi population*. The key activities address the gaps in skilled personnel at community level through to zonal level. GAVI support will be supplemented by contributions by the Government of Malawi and other donors to achieve the human resource targets set in the HSSP.

1.2 Health Information System
Activities in this SDA contribute to the HSSP objective: *To provide reliable, complete, accessible, timely and consistent health-related information, and ensure that it is used for evidence-based decision making at all levels of the health system*. The specific activities proposed relate to significant gaps not provided for from other partners in the provision of supervision, the necessary tools for data collection, analysis and reporting and conducting routine validation of data and forms. GAVI-supported activities will align with other efforts to address problems with the quality and availability of data.

1.3 Programmatic reviews and planning
Periodic reviews of the immunization programs are essential to identifying gaps in capacity and service delivery. Activities in this area align with the HSSP strategy to ensure that surveillance and reviews are carried out on a regular basis at all levels and feed into the sector M&E framework. Additionally, support under this SDA will allow for realization of the HSSP outcome: *Develop national communication strategies that reflect integrated approaches to addressing EHP priorities at all levels*.

1.4 Transport
In line with the HSSP outcome: *Increase coverage by improving the health transport system*, this SDA will provide support to bicycle transport for health workers and utility vehicles for the health system to conduct supportive supervision and delivery of drugs, vaccines and supplies. GAVI support will contribute to achieving the targeted transport capacity across the health system.

Objective 2: Improve equity of service delivery to hard to reach population groups and unimmunized children through targeted interventions and involvement of communities and CSOs

This objective addresses inequities in access and improves the demand side of health services by reaching out to communities.

2.1 Interventions for reaching the hard to reach populations

Two strategies will be utilized to increase access to immunization and health services among hard to reach populations: RED strategy training, which will promote regular outreach services to hard to reach populations and local immunisation days to address gaps in coverage. GAVI support to these approaches will institutionalize a focus on equity in community service delivery.

2.2 Village Development Committees
This SDA is in line with outcome 3 in the HSSP and addresses the strategies and interventions that enable community empowerment and action through participation and representation. Current work with village development committees is fragmented and there are no available standards to guide implementation of health activities. This process will be strengthened though promotion of the inclusion of stakeholders, civil society and NGOs though local government structures and national committees at all levels. Priority will be given to VDCs from areas with high levels of child mortality. Support from GAVI will create strong community-based structures that can promote access to health services.

2.3 Civil Society Organization (CSO) immunisation forum
This is linked to outcomes 3 and 4 in the HSSP related to participation and to resource mapping. There is currently no support to enable CSOs to meet and discuss health issues. GAVI support will permit a national mapping of CSOs, 2 national conferences for CSOs on health systems and immunization services, and regular participation by CSO members in district, zonal and national meetings, creating structures for interaction aligned with the HSSP that will be sustained after the grant.

2.4 Infrastructure and transport for hard to reach areas
The proposed interventions include the construction of under-five shelters in hard to reach areas, the purchase of boats for lakeside districts and motorcycles for outreach services including training of engineers in their maintenance. Infrastructure limitations impact the delivery of health services in areas that are hard to reach; these sustainable investments will improve quality and consistency of MOH outreach to these areas.

Objective 3: Improve cold chain capacity and management at all levels of the health system

Proposal Objective 3 aims to strengthen cold chain capacity throughout Malawi in light of the current constraints faced due to introduction of pneumococcal and rotavirus vaccines and the ongoing need for repair and replacement of cold chain and transport equipment.

3.1 Training in cold chain maintenance and repair
Due to the importance of the cold chain for vaccine efficacy, and the significant investment that has been made in cold chain equipment, it is important to ensure that there are sufficient skilled technicians to maintain these assets. This is related to the HSSP outcome: *Strengthen capacity of maintenance services*. Malawi has found it effective to provide this training to different levels, and GAVI support will train staff from national to facility level.

3.2 Assessment of cold chain capacity and management
These activities are aligned with the monitoring and evaluation section of the HSSP. Funding is being sought from GAVI to conduct a comprehensive cold chain assessment and an effective vaccine management assessment towards the end of the cMYP and the HSSP to assess progress and identify the investments required in the period 2016-2021.

3.3 Cold chain infrastructure and transport
Construction of both dry and cold stores at district level and zonal level along with trucks to deliver vaccines and other commodities in support of the EHP will ensure adequate space capacity to manage supplies for immunization and other EHP commodities.

3.4 Cold chain equipment
These procurements support achievement of the HSSP outcome: *Improving performance of the sector through support to essential medical devices.* This proposal requests support for the procurement of cold chain equipment including refrigerators and freezers with sufficient spare parts, cold chain tool kits, vaccine carriers, cold boxes, temperature monitoring devices and manual forklifts for use at the newly constructed cold stores.

3.5 Waste Management
Support is requested for the provision of incinerators at high volume zonal and national stores in support of the HSSP outcome relating to health care waste disposal.

A detailed narrative describing the activities under each service delivery area is included below. Attachments include a comprehensive logframe (Attachment 11) and budget (Attachment 10).

SECTION 2: PROGRAMMATIC INFORMATION

Please describe:

1) The nature of the support requested and linkages to the National Health Strategy, with reference to the National Health Strategy and any other relevant annual or sub-sector plans (for example, human resources or monitoring and evaluation plan). Explain how the support will address identified health system gaps, and why priority was given to these particular gaps, relative to other unfunded gaps. Summarize what support is requested from the Global Fund and/or what support is requested from GAVI. For the Global Fund, if this HSS request entails a request for funding that extends beyond the end of the Strategy (to a maximum of 12 months), please explain which interventions of the health sector plan will be continued (this also needs to be reflected in the logframe).[2]

2) How the support requested is additional to, and complementary to existing support, including Global Fund and/or GAVI support. Please reference the financial gap analaysis in section 3 below.

3) How funds requested are expected to contribute to expected outcomes and impact as described in the National Health Strategy, including:

    - Improved outcomes in at least two of the three diseases (HIV/AIDS, Malaria, Tuberculosis) – for Global Fund support; and/or
    - Improved immunisation outcomes in the context of integrated service delivery – for GAVI support

4) Please fill in the logframe (Attachment 1). The goals, objectives, service delivery areas (SDAs) and activities requested need to be provided here, and how they will be implemented. Please delineate what HSS support is requested from the Global Fund and what support is requested from GAVI.

Please see the guidance note entitled: ''Guidance Note for Developing Common Health System Strengthening Funding Requests Based on National Health Strategies'' that details what types of HSS support can be requested.

Note that for Global Fund, Community Systems Strengthening (CSS) activities can be included under HSS. Applicants can refer to the Global Fund Community Systems Strengthening Framework. The CSS framework is intended for use by all those who play a role in dealing with major health challenges and have a direct interest in community involvement and action to improve health outcomes, including governments, community actors, donors, partner organisations and other key stakeholders.

[2] Please see annex - Additional Global Fund Information about the Indicative Year.

Response:

National Health System Context

Health Sector: The Ministry of Health (MOH) is the lead government agency with the mandate to safeguard health status of the people of Malawi. To fulfil this mandate, the MOH is guided by the Public Health Act of 1948 and the National Health Policy that provide the legality of health service provision by different players in the country and guidance on what constitutes national health priorities. Health provision includes both the public and private sector comprising for profit and non profit, NGOs and civil society. The public sector provides care to 60% of the population while 39% is by the Christian Health Association of Malawi (CHAM) and the remaining 1% by private, NGO and CSO organizations. The public sector includes all facilities under the MoH and Ministry of Local Government and those of other ministries such as Education, the Police, the Prison Service and the Army. Public facilities provide services free of charge while the private and CHAM facilities charge user fees for some services, but not for selected public health interventions such as EPI. In accordance with the Decentralization Act (1997) the Ministry of Local Government and Rural Development is responsible for the delivery of health services at district and lower levels with technical guidance from the MoH. As alluded to, the MoH headquarters is mainly responsible for development of policies, standards and protocols and for providing technical support for supervision. It also manages the tertiary level healthcare system.

To improve access to the essential health package, health services are delivered at four levels by both the public, private, NGO, SCOs and faith based organisations The first level of care consists of community initiatives, health posts, dispensaries. At this level, health services are provided by community-based cadres such as the salaried Health Surveillance Assistants (HSAs), and volunteers such as community-based distributing agents (CBDAs), village health committees (VHCs) and volunteers from NGOs. HSAs provide promotive and preventive health services that include HIV counselling, immunization services and community case management of acute respiratory infections (ARIs), diarrhoea and pneumonia among under five children through provision of care at facilities, door-to-door visits, village clinics and mobile clinics. Community health nurses and other health cadres also provide health services through outreach programs. VHCs promote PHC activities through community participation; and they work with HSAs on preventive and promotive health services such as hygiene and sanitation. All community health initiatives are supervised by community health nurses and assistant environmental health officers (AEHOs) based at health centres.

The second level of care is at primary health centres. Each health centre has a Health Centre Advisory Committee (HCAC), which helps communities to demand the quantity and quality of services that they expect by monitoring the performance of health centres. Health centres are responsible for providing both curative and preventive EHP services, including maternal and child health services, and HSAs also provide selected preventive and promotive health services across the essential health package at this level.

At the third level, EHP services are provided by District and Community Hospitals that provide referral services for health centres. District hospitals have bed capacity ranging from 200 to 300 beds; and they deliver both general in-patient and out-patient services to the local town population. Faith based organizations and some private providers manage hospitals that offer services similar to those of a district hospital. The public district hospitals also provide technical backstopping through supportive supervision to health centres.

The fourth level of care is provided by tertiary or Central Hospitals (CHs) that provide referral health services for their respective regions. Central hospitals offer specialized services such as obstetrics and gynaecology. There are currently five CHs located in the three regions of the country. The CHs are responsible for professional training, conducting research and

providing support to districts.

Since the implementation of a six-year Emergency Human Resource Plan (EHRP) under the PoW, the human resource situation within the health sector has improved significantly. The total number of professional Health Care Workers (HCWs) increased by 53% from 5,453 in 2004 to 8,369 in 2010; the capacity of health training institutions increased across a range of programs and staff retention improved, among other things. However, only four of the 11 priority cadres (namely clinical officer, environmental health officers, radiology and laboratory technicians) met or exceeded their targets as set in the original EHRP design. An expanded staff establishment among priority HCW cadres (nurses, physicians, clinical officers, environmental health officers, laboratory and pharmacy technicians), has led to significant vacancies (see Attachment 2, Annex 2). The human resource challenges remain both acute and complex and HR projections show that accelerated training initiatives are needed to come anywhere near the numbers of health staff needed to provide minimum standards of service delivery.

National Health Sector Strategic Plan (HSSP) and approach to health bottlenecks: To ensure proper guidance on health service delivery, the MOH in consultation with other sector players develops a national health plan which outlines the country's health challenges and strategies that would address bottlenecks in health service delivery as well as the health interventions that would lead to improvement in health indicators. As discussed above, the HSSP is based on recommendations made during the external evaluation of the 2004 – 2010 (POW1) health program of work which outlined health system challenges affecting delivery of health services in the country, as well as input from many stakeholders in country. Health system challenges identified during development of the HSSP include but are not limited to:

- Inadequate human resources to deliver the essential health package (p.30)
- Poor supply chain leading to frequent stock outs of essential medicines (p.30)
- Inadequate access and coverage of quality essential health services (pp.34-35)
- Poor quality of health information systems (pp.33-34)
- Inadequate financial and procurement systems (pp.32-33)

Please refer to the page numbers above in the HSSP (Attachment 2) for a detailed discussion of these health system challenges that prevent achievement of improved health outcomes (HSSP chapter 2 section 2). .

The goal of the HSSP is therefore to improve the quality of life of all the people of Malawi by reducing the risk of ill health and the occurrence of premature deaths, thereby contributing to the social and economic development of the country. Its main objectives are to:

- Increase coverage of high quality EHP services
- Strengthen performance of the health system to support delivery of the EHP
- Reduce risk factors to health
- Improve equity and efficiency in the delivery of EHP services

Proposed strategies to achieve these outcomes were subjected to careful cost effectiveness analysis as outlined in the HSSP (Attachment 2, chapter 5) and the selected cost effective strategies are incorporated into this proposal.

Context for this request: In 2007, GAVI approved HSS funding to the GoM which has helped address some of the health system challenges. This support resulted in high and sustained DPT-HebB-Hib3 coverage in 2009 (93%) and 2010 (93%), up from 91% in 2008, and other improvements in child health. This was achieved through immunisation programme improvements in the following areas: increased access to outreach activities, supportive supervision, provision of EPI vaccines and supplies, cold chain expansion and

maintenance at all levels, and data management. However, due to currency fluctuations, the costs for some activities changed significantly between proposal drafting and implementation, This problem was further exacerbated by the de facto devaluation in May 2012, when the Malawi kwacha immediately lost 36% of its value[3], and therefore not all approved activities could be implemented.

This proposal seeks to address challenges that were not addressed as part of the 2007 grant, as well as addressing those approved activities whose funds were reprogrammed in the 2010 and the 2011 APR were reprogrammed. In addition to HSS support, Malawi is a beneficiary of GAVI new vaccines support for the introduction of pneumococcal vaccine in 2011 and rotavirus vaccine in 2012, initiatives which have created new requirements for transport and cold chain capacity in country. GoM is co-financing the purchase of the vaccines (cMYP – Attachment 3a). The activities contained in this proposal are prioritized interventions from within the HSSP and the cMYP for which no funding has been identified and which support immunization outcomes while contributing to overall systems strengthening. During the implementation of this grant, there will be an emphasis on mainstreaming gender in all of the interventions and ensuring equity in access to services.

Goal, Objectives, and Activities: The **goal** of this proposal is to reduce under-five child mortality through strengthening public health delivery.

The specific objectives and associated activities follow.

The objective and activity numbering employed throughout corresponds to the numbering on the logframe (Attachment 11). In the text below, some activities from the logframe have been grouped to simplify the narrative, and therefore a range of activities may be discussed at once.

Objective 1: Improve and sustain high immunisation coverage and support scale up of the essential healthcare package

This objective links directly to Objective 2 in the HSSP, namely strengthened performance of the health system to support delivery of EHP services. It addresses areas fundamental to the strengthening of the health system, including the EPI programme. Through strengthened delivery of immunization services and the other components of the essential healthcare package, under five child mortality will be reduced. Under this objective, there are four Service Delivery Areas (SDAs): Human resources for health, health information system, programmatic reviews and planning, and transport.

1.1 Human Resources for Health (HRH)

1.1.1 Conduct pre-service training for additional Assistant Environmental Health Officers (AEHOs): In the 2007 GAVI HSS grant for Malawi there was a provision for training of Health Assistants (HAs) as supervisors of HSAs. This position, however, has been abolished, creating a significant gap in HSAs' supervision which significantly affects vaccination as well as the provision of other services. GAVI HSS funds for HAs have been reprogrammed to train 70 AEHOs, the cadre now supervising HSAs. Currently there are 139 AEHOs in the MoH and 235 established posts which are vacant, for a total vacancy rate of 64%. The GoM currently trains 30 AEHOs per year, at this rate, considering attrition, it will

[3] "Malawi devalue Kwacha currency," Nyasa Times. 7 May 2012. http://www.nyasatimes.com/malawi/2012/05/07/malawi-devalue-kwacha-currency/

take in excess of 8 years to fill all the vacancies. Although there is additional capacity at training institutions, lack of financial resources prevents additional AEHOs from being trained. In this grant, support is being sought from GAVI to provide pre-service training for an additional 100 AEHOs in 3 years, starting in 2013. At this rate, the GAVI grant will support 100 AEHOs to be trained, decreasing the vacancy rate by 27 percent. Combined with the 90 AEHOs trained by Ministry of Health in 3 years, some of the vacancies will still remain unfilled. . The recruitment process will include new AEHOs and upgrading of HSAs who are already in the system. Gender considerations will be included to ensure an appropriate balance between men and women. This is in line with the Human Resource Plan. Once trained, they are expected to oversee community health initiatives aimed at addressing all of the disease conditions targeted in the essential health package as well as water and sanitation, AEHOs play a critical role in supervising these initiatives and ensuring they are carried out consistently at a high level of quality and effectiveness. Salaries for these positions will be provided by the Malawi government

1.1.2 Conduct pre-service training for HSAs: As previously mentioned, HSAs are salaried health employees based at community level and they provide the bulk of immunisation services at both outreach and static clinics. They also conduct growth monitoring, HIV testing and counselling, malaria prevention and treatment, TB prevention, water and sanitation, village health clinics, maternal health and family planning among other interventions. With Malawi's population estimated at 14 million, and based on the requirement of 1 HSA per 1,000 persons, Malawi requires 14,000 HSAs. Previous grants from the Global Fund HSS, HIV, and Malaria grants as well as UNICEF have supported GoM to recruit and train HSAs. Currently, 10,150 HSAs are employed against an establishment of 12,937. Of the 10,150 currently active, 5,500 received a 10-week pre-service training and 4,650 have not yet received it. This pre-service training prepares HSAs for health extension work focused on community health interventions, including immunisation. Support is therefore being requested from GAVI for training 2,200 HSAs. This level of output takes into consideration the capacity of public and private training institutions. Once they have been trained, the GoM will continue to fund them in their positions. In the selection for training, gender considerations will be included to ensure an appropriate balance between men and women in line with the Human Resource Plan.

1.1.3 Train MOH staff in Masters degree programs: Under the GAVI 2007 HSS grant, the GoM trained 4 staff at Masters Level, all of them still working at the Ministry of Health. Continued training of staff at Masters Level in the Ministry of Health will contribute towards the strengthening of Malawi's health system and provide MOH leaders with the knowledge and skills to better implement health systems activities and continually improve governance. Selection of the staff to be trained and the course to be followed will be by the Ministry of Health Training Committee, based on the available skills and identified gaps within the MOH. Priority will be placed on management needs in the EPI. Skills will be shared to other members in the ministry, generating a ripple effect of more highly skilled national leadership. Since some staff are still being trained, it is proposed that if this grant proposal is successful, 3 people from the MOH will be trained to obtain an MPH or other Masters degree relevant to management. This training program will be pursued at the University of Malawi or any country within the Southern Africa Development Community as it is less expensive.

Commented [EC1]: Need to update Logframe and budget with new activity title.

1.1.4 – 1.1.5 Training on facility based disease surveillance: Training in facility based EPI disease surveillance focuses on training health workers at the facility level in the case detection and management of three main diseases which are targeted for eradication/elimination, namely polio, measles and NNT. Case detection and reporting is done at community, health centre, district and central hospital levels and this is supported by supervisory visits, as well as active search and training at facility level. This is an ongoing activity, being supported by WHO; however, the In-Depth National Surveillance Review conducted in May 2012 found notable deficiencies. Of facilities visited, only 39% had been

trained in surveillance, and 30% of the health workers interviewed participated in the training. This is reflected in low levels of knowledge about key surveillance indicators, for example only 4% of health workers could describe core indicator calculations and investigation procedures for acute flaccid paralysis, and only 30% could describe the case definition for neonatal tetanus (In-Depth National Surveillance Review report May 2012, Attachment 6). Additionally, the revised operational standards for AFP case detection rates have recently been increased from 2/100,000 among persons aged less than 15 years to 4/100,000. Additional support from GAVI will help Malawi to reach this target by providing training to an additional 8,000 health workers over the duration of the project. This training will reach 67% of all health workers and will be targeted towards high and medium priority facilities, government, CHAM and private, identified based on WHO criteria of prioritization. This prioritization focuses on facilities where cases of AFP are most likely or likely to seek care. The effectiveness of the training initiative will be strengthened by surveillance follow up, also funded through this proposal. Performance will be assessed during future in-depth surveillance reviews, which will be funded by WHO.

1.1.6 Conduct in-service training for Mid Level Managers (MLM): This training provides MLMs (namely district coordinators, clinicians, nurses, environmental health officers as well as HSA trainers, lecturers and tutors) with technical knowledge about immunisation, including how to address challenges that impact negatively on the uptake, injection safety and waste management, and use of data for management. MLM training modules were developed by WHO and UNICEF. The trainings will contribute to increasing outreach to unimmunized children, improving vaccine management, increasing data utilization, and enhancing management capacity across health programs. Using the 2007 GAVI HSS grant, and supplemented by UNICEF, 81 MLMs were trained in 2011. Due to increases in training costs during the grant period, it was difficult to train more staff despite the need. In order to continue to improve the ability of immunization staff to overcome uptake challenges and reach the remaining unimmunised children, this proposal seeks financial support to train 290 mid-level managers (10 per district, over 2 sessions) in MLM at regional level. Training will be conducted by people within government training institutions who have been trained as trainers in the standard modules provided by WHO and UNICEF. Gender will be considered in recruiting participants to ensure fair representation. An additional day will be added to the MLM training to provide data management training in a cost effective manner, as it is targeted at the same cadre of staff. Follow on activities from the training will be funded by the districts where the managers are based.

1.1.7 Conduct in-service training on 'Immunisation in Practice': 'Immunisation in Practice' training has been developed by WHO and other partners. It is designed to train the providers of immunization services on a number of areas, including the planning, monitoring and utilisation of data in order to improve immunisation services. This is done at health facility level. Training of trainers will be conducted using funds from other sources. With GAVI funding, a total of 9,000 health workers, mainly HSAs, will be trained. No such training has previously taken place; it is a new intervention that is expected to improve service delivery quality and immunisation coverage. Follow on activities from the training will be funded by the facilities and districts where the health workers are based.

1.2 Health Information System

The HMIS is used to collect routine data on delivery of the essential health package in Malawi. While this system is functional, it faces a number of challenges such as inadequate funding, stock outs of HMIS forms and other supplies, inadequate support for ICT at all levels, untimely submission of HMIS data by districts including lower levels and low quality of data due to insufficient validation. These are global challenges which are outlined in the HSSP, but also affect the collection of data on immunisation; hence support is being requested in order to ensure high quality data for both the Central Monitoring and Evaluation

Division at MoH headquarters and EPI. This will be done through supportive supervision, printing of essential forms, and upgrading of IT equipment.

1.2.1 - 1.2.2 Conduct supportive supervision at district and zonal levels: Supportive supervision is essential for effective functioning of health programs including EPI, nutrition, IMCI, and others. In Malawi, integrated supervision targets multiple program areas. District supervisors include members of the district health management team and program-specific coordinators. National and zonal staff should conduct supervision visits to districts four times in a year, and districts should conduct supervision to facilities twelve times in a year. However, the PIE found that supervision is currently done less frequently at national and During the In-Depth Surveillance Review, irregular supervisory visits to health facilities were observed; 40% of health facilities had not been visited by district level in the last 12 months (Attachment 6) In order to ensure that supervision is done as scheduled, funding is being requested for two quarters per year for national and zonal supervision for 3 years, with the remaining two quarters funded by MoH, with support from in-country health donor partners such as WHO, UNICEF, CHAI, and MCHIP. At district level, funding will cover 2 rounds of visits per year to health facilities, with the remaining 10 visits to be covered out of district budgets and support from their local partners. Although this funding will not resolve all of the issues preventing supportive supervision, when combined with the increased transport capacity and decreased vacancy of AEHOs, the overall supervisory structure will be strengthened and supervision coverage will be closer to the required levels.

1.2.3 - 1.2.6 Print monitoring tools (EPI feedback bulletins, TT registers, Under 1 registers and child health passports): As has been mentioned, funding for the health sector is inadequate and departments within the MoH must work within budget ceilings. For EPI the highest priority is given to the purchase of vaccines and injection supplies, therefore when budget ceilings are implemented, there is little or no funding available for the production of bulletins and monitoring tools, which negatively impacts the program's ability to monitor, evaluate and improve EPI performance. Under-1 registers and child health passports are used across all health programs including EPI, HIV, malaria, nutrition, TB, and IMCI. They are produced by HMIS in coordination with the respective programs. Hence funding is being sought to ensure their continued availability and the resultant effective functioning of the HMIS. The review and printing of monitoring tools for rotavirus have been funded by UNICEF and funds for these will continue to be sourced internally. Future rounds of printing will be funded from GOM or other donor budgets.

1.2.7-1.2.9 Replacement of IT office equipment: The 2007 GAVI HSS grant provided for the purchase of IT office equipment for the district health offices, EPI staff at headquarters and other disease control programs. Based on a working life of 5 years, it is proposed that some of the office IT equipment purchased by the current GAVI HSS grant will need to be replaced after this period. This equipment is essential to collection, storage, and dissemination of information within the health system. The GoM has already made plans to replace some of the IT equipment at the EPI Unit, and other MoH offices. In order to complement GoM efforts in the replacement of office equipment, support is being requested from GAVI to replace 10 selected district desk top computers, 3 laptops for the EPI Unit at headquarters, 10 printers for the district level and 4 photocopiers for national and regional level. All purchased equipment will be loaded with appropriate software and the Government of Malawi will conduct maintenance and provide connectivity. Additionally, any training required on the new equipment and software will be provided by the Government of Malawi.

1.3 Programmatic reviews and planning

1.3.1 Support the development of the Health Promotion Strategic Plan: The MoH and partners have been developing the Health Promotion Policy in support of the HSSP's

renewed emphasis on health promotion. An accompanying strategic plan will be drafted and finalized to guide implementation of the health promotion activities. This Plan is in line with the HSSP which, for the first time, puts priority on health promotion and disease prevention, generating demand for services. Funding is therefore being requested in Year 1 to support the MoH and partners to develop this plan. Funding for finalization activities will be recruited from other partners as part of the annual implementation plans.

1.3.2 Support HMIS review meetings at zonal level: HMIS review meetings at zonal level provide a forum where data from multiple programs from the district and lower levels are reviewed and validated before being submitted to MoH headquarters to be compiled and presented at the national review meetings. At these meetings, districts' data management strengths and weaknesses are identified and an opportunity is provided for knowledge transfer. In previous meetings, lack of IT equipment has been raised repeatedly as a key challenge, which will be addressed by the purchase of equipment as described above. The HMIS review meetings are intended to be held quarterly, but are often cancelled due to inadequate funding. Funding is therefore being requested for two quarters per year over 3.5 years, for a total of 7 meetings per zone in order to ensure that these meetings are held regularly and as scheduled. The funding for the other two quarters will be sourced internally from GoM, UNICEF or WHO. This activity will ensure the availability of high quality data for decision-making in the health system, and the results of the review meetings lay the groundwork for the next Health System Strategic Plan.

1.3.3 Conduct a WHO 30 cluster survey: As part of monitoring and evaluation, EPI programs are supposed to conduct a WHO 30 cluster survey in order to monitor program performance and validate the administrative immunisation coverage data as required by international standards. The last WHO 30 cluster survey in Malawi was conducted in 2003. The In-Depth Surveillance Review in May 2012, noted that the next coverage survey was overdue and advised EPI to plan to conduct one (Attachment 6). Funding for this activity is not currently available from elsewhere, hence this request from GAVI for conducting a WHO 30 cluster survey in Years 1 and 3.

1.3.4 Conduct EPI comprehensive review: The last comprehensive EPI review was completed in 2003 and one is scheduled for 2012, for which funding will be sourced from in-country partners. Another comprehensive review will be required in 2015 to support the development of the 2016-2021 HSSP and cMYP. Funding is being requested for the 2015 comprehensive review. The revised HSSP and cMYP will provide the roadmap for following up the identified issues and challenge, as well as the resource needs and resource mobilization plan.

1.3.5 - 1.3.6 Conduct Data Quality Survey (DQS) (internal) and Data Quality Audit (DQA)(external): Malawi consistently reports high immunisation coverage based on routine immunisation coverage data, as well as surveys, such as the Demographic Health Surveys (DHS) and Multiple Indicator Cluster Survey (MICS). Having accurate immunization data is essential for the EPI managers to track and improve program performance and provides a basis for high level monitoring of outcomes. Having reliable, validated data also allows for Malawi to track progress against international benchmarks. The first DQS was conducted in August 2012, with support from MCHIP and CHAI in country. Recommendations from this review will be acted on, but will require further assessment to determine if data quality has improved. In order to ensure that routine data shared with HDPs and other stakeholders is of high quality, GoM is seeking support from GAVI to conduct a follow up DQS (internal) in 2013 and 2015 and DQA (external) in 2014 and 2016.

1.3.7 Review EPI monitoring tools: The EPI monitoring tools need to be reviewed periodically to include all required fields and capture necessary indicators. With the coming of new innovations and best practices in various health programs, some fields may need to

be updated, such as fields to capture new vaccines. Additionally, the results of reviews that have been conducted recently have identified shortcomings in the existing tools, that require revision, .Conducting a one time review also assists in maintaining standardization of tools and ensuring cross-linking of the different tools. The monitoring tools will be reviewed in Year 1 of the implementation period

1.4 Transport

1.4.1 Purchase of bicycles for HSAs: In order for HSAs to perform their responsibilities effectively, especially outreach clinics for immunization, there is a need for them to be provided with bicycles for transport so that they can reach all households within their catchment areas. As community-based health providers, HSAs use bicycles as an effective means of transportation to cover the areas with multiple health interventions, such as sanitation, ITN distribution, TB control, family planning, HIV testing, and immunization follow up. Bicycles also serve as an important retention and motivational tool for HSAs. The HSAs currently in post have been provided with bicycles by GoM, GAVI and Global Fund among other partners. In the 2011 Cold Chain Assessment, an inventory found that nationally, there were an average of 2 HSAs for every bicycle (Attachment 4). If funded, the MOH will purchase bicycles for 2,500 HSAs to account for new recruits and replace a portion of those which have fallen into disrepair. The cMYP 2012-2016 planned for the procurement of 8,000 bicycles overall, therefore the remaining bicycles will be sourced from the government and other partners. Gender will be taken into consideration when procuring and distributing bicycles. Health facility in-charges will be responsible for maintenance and supervision of the bicycles.

1.4.2 Purchase of utility vehicles: Utility vehicles are used for transportation of vaccines, supplies, drugs, ITNs, monitoring forms, equipment and are utilized by the districts during training and supportive supervision across program areas. Utility vehicles are required for delivering immunization services in hard to reach areas and other health outreach activities and campaigns. With support from GAVI, GoM purchased 12 utility vehicles for districts. Other HDPs such as the Global Fund have also purchased vehicles for the MoH. To date, not all districts have received a new vehicle through these procurements and continue to face transport problems. The 2012-2016 cMYP planned for the provision of 38 utility vehicles. Support is being requested from GAVI for the purchase of 17 of these vehicles in 2013/2014 to ensure that there is reliable and adequate transport for service provision. 3 vehicles will be used at the national level, 2 at zonal level, and 12 distributed to districts most in need of additional transport capacity, or nearly all of the districts that did not receive vehicles previously. The remaining vehicles will be sourced from the government and other partners. Maintenance and running costs will be provided by the Government of Malawi.

Objective 2: Improve equity of service delivery to hard to reach population groups and unimmunized children through targeted interventions and involvement of communities and CSOs

Outcome 3 of the HSSP addresses the reduction of risks to health through a number of interventions aimed at promoting equitable delivery of health services and promotion activities through coordinated actions, including all partners involved in health, namely CSOs, Government and the private sector. It is recognised that in order to address the cultural, economic, social and gender factors that impact on the health of children and populations there is a need to address the settings within which they live (refer to the HSSP for a discussion on the healthy settings approach - Attachment 2). The HSSP also notes that “Investments in child survival interventions such as vaccines for various diseases, effective treatment of pneumonia at community level, and effective prevention and treatment of

malaria and diarrhoeal diseases have contributed significantly to the remarkable decline in infant and under five mortality rates"[4] in Malawi to date. Therefore, to achieve the target of reduced child mortality from 112 per 1000 live births in 2010 to 78 per 1000 in 2016, focus needs to be given to delivering this effective package of services to children who are not currently being reached effectively.

In order to reach children and mothers who are not presently being reached effectively by the health sector, the activities under this objective are aimed at developing strategies to reach people in the communities where they live as well as sensitizing communities to increase demand for basic healthcare services. This strategy will first be targeted in areas that presently have low immunisation coverage or other health challenges such as cholera. Through working with VDCs, DECs, and CSOs, targeting will be based on local understanding, as well as a grasp of the factors causing inequitable access to care and prevention.

Although national and district level immunisation coverage indicators in Malawi indicate high levels of reach of the healthcare system, some communities within each district are less likely to access healthcare services and are in need of targeted interventions. Among the areas with the lowest immunization coverage in the country include communities located next to the lake, where some people can only be reached by boat. In addition, there are mountainous areas, where outreach clinics are more difficult to conduct, and population is more scattered. In other places, large rivers create a natural barrier and prevent access to services. There are also some areas with relatively large populations of people whose religion encourages them not to use healthcare services, and rather to use prayer. Even in higher-performing districts, there are sub-populations of people who are less likely to access health services, for example tenant farmers who work on commercial tobacco estates or children with a mother who has no education. 2010 DHS data does not indicate any difference in vaccination rates between male and female children and only a small difference in coverage between children in the lowest wealth quintile when compared with children in the highest wealth quintile.[5]

It is understood that one of the major impediments to children not being fully immunised is related to women's access and utilisation of health services. Therefore, the efforts under this objective will be focused on reaching men and women in order to increase mothers' and their children's utilisation of basic healthcare services, including immunisation. Demand-side interventions begin in the community and will improve access not just to immunization, but to the full package of services provided at clinics and during outreach. This also includes a focus on nutrition-related interventions, as childhood stunting is one of the priority challenges facing Malawi. As stated in the HSSP: "Although there has been some reduction, malnutrition remains high, with 47% of children under five stunted and 20% severely stunted. The prevalence of diarrhoea and disease outbreaks such as measles have a significant influence on nutritional status, particularly acute malnutrition."[6] Therefore interventions that impact on nutrition, including measles vaccination, diarrhoea prevention and management, deworming, growth monitoring, and vitamin A supplementation are included in the delivery of services.

Through the HSSP, GoM uses a strategy to strengthen community actions through concrete and effective community participation in setting priorities, making decisions, planning strategies and implementing them to achieve improved health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and

[4] Page 21.

[5] 2010 DHS found that 78.3% of children age 12-23 months in the lowest wealth quintile had received all basic vaccinations, compared to 82.0% in the highest wealth quintile.

[6] Page 20.

destinies. The two relevant interventions that have been highlighted in the HSSP with regard to strengthening community systems are: (i) support the implementation of community action interventions to address EHP health priorities using the health promotion in multi-sectoral settings at all levels; (ii) train and support community structures to plan, implement and monitor interventions aimed at improving health. This includes government action as well as active participation by civil society organizations who carry local knowledge about challenges faced and have a strong role to play in supporting community health promotion. As active members of District Executive Committees and Village Development Committees, they will engage with the Ministry of Health activities and advocate for community priorities at village, district, zonal, and national levels. Based on the experience gained during the implementation of this objective, the lessons learnt will be used across the country.

Cost-effectiveness of the interventions delivered has been well-established during the development of the HSSP (Attachment 2)[7]. However, less is known about the cost-effectiveness of varying delivery strategies for reaching communities and the MOH will identify resources to undertake cost-effectiveness studies of delivery during the period of the grant to inform the next HSSP and the strategy for ensuring equity in access to care.

2.1 Interventions for reaching the hard to reach populations

2.1.1 – 2.1.2 Conduct TOT and in-service training for the Reach Every District (RED) strategy: The RED strategy explores innovative strategies to improve delivery of immunisation services at district and community level, with a focus on reaching unimmunised children and targeting service delivery to areas of low access. The strategy promotes regular outreach services for hard to reach areas and encourages the conduct of supportive supervision. Under the RED strategy, each facility makes a microplan for targeting hard to reach or never-reached children with immunization in their catchment area. Once reached with immunization, these children will also be able to access the full essential health package. Donors, such as UNICEF and GAVI, have previously supported Malawi to conduct training in the RED approach, most recently in 2012. This round of training reached about 1,390health workers, or about 15% of the total. There is, a need to continuously train health workers on the RED strategy, to account for new staff, staff not yet trained, and ensure implementation of the revision of training modules. The GAVI support will support a ToT for the coordinators at zonal level for a total of 116 health workers (4 per district) in the first year, who will then train 6,000 HSAs over a period of three years. Gender will be considered in recruitment of participants. During the period of the grant, funds will be sought to support training after the grant has finished.

2.1.3 – 2.1.4 Conduct local immunisation days and follow-up: Although immunisation coverage in Malawi is high at 90% or above for all vaccines, there are still some geographical areas in Malawi that have low immunization coverage of below 80%, as identified by DHOs through HMIS and EPI administrative data. Support is therefore being sought from GAVI to conduct local immunization days in each of the 29 districts[8] as this will help Malawi to reach the unimmunized children, and ensure that communities have equitable access to care. During such days, health workers use village health registers to track all of the children who have not been immunized and provide immunization services in identified low coverage catchment areas. This has proven to be an effective way of ensuring that unreached children are immunized. These LIDs will also serve as a platform for other cost effective interventions such as deworming (under $85/DALY), Vitamin A supplementation (under $80/DALY), ITN distribution (under $15/DALY), growth monitoring (under $85/DALY), screening for illnesses and health promotion. They will also provide tetanus toxoid to mothers. This outreach strategy is an essential part of health service delivery in Malawi as

[7] Page 45.
[8] Mzimba South and Mzimba North are treated as separate districts due to their size.

there are populations of people who cannot or do not access health care at the facilities. The RED approach will be utilized to assist each health facility to identify areas most in need. The support from GAVI will provide 2 rounds of LIDs in every district per year for three years. During the period of the grant, funds will be sought to support LIDs after the grant has finished.

2.2 Village Development Committees

2.2.1-2.2.2 Develop and print a training manual for Village Development Committees (VDCs) in healthy village settings: VDCs oversee a group of villages in a district and are responsible for identifying needs and facilitating planning and development at community level. They are comprised of citizens, village leaders, and CSOs working in the area. On average, there are 300-500 VDCs per district. VDCs have received some training in community development and action planning conducted by the Ministry of Local Government and Rural Development (MoLGRD). However, there is currently no manual for training of VDC members on health related topics, i.e. the development and the process of District Implementation Plans (DIPs) for health. Since the MoLGRD already has a manual for training VDCs, there is a need for thorough review of the training manual currently being used by MoLGRD and the incorporation of health issues, including immunisation and all elements of the revised essential health package. Funding is being requested to review and revise the training manual for VDCs. The revised manual will include village profiling (complementing the village health register which collects household information on births and immunisations), environmental, economic and social factors affecting health status, training in participatory methodologies, how to prepare a DIP and the role they can play in improving access to immunisation, child nutrition, and access to other health services. Participants in the development of the manual will include Government (MoH, Ministry of Local Government and Rural Development), CSOs and the private sector (including CHAM). GAVI is also being requested to fund the printing of 1000 VDC training manuals. An e-copy will be available and partners will print their own additional copies. The training of VDCs using this manual will be implemented by MoH and other players at community level including CSOs and CHAM. Since women are the major health carers in the home, during the training of VDCs the participation of women will be encouraged, and at least 50% of the committee members should be women and some should be youth as well. This manual will serve as a permanent resource for VDCs in developing and implementing DIPs related to health, and the e-copy will be reproducible by partners who have additional funding in the future. CSOs working at community level will also use the manual to train VDCs in their catchment areas.

2.2.3 Sensitisation of the members of the District Executive Committee: The training of VDC members in health and immunisation is a new initiative and as the DEC is an important decision making body at district level, it will be necessary to orient the members so that they are aware of the existence of the manual for training VDCs. A one day orientation seminar will be organised for DEC members, one in each district. At this seminar, profiles of the district will be presented and DEC members asked to analyse which areas (based on HMIS data) have low access to health services and poor health indicators, including for immunisation services. Priority will then be given to training VDCs in these targeted areas with low access. These meetings will also encourage support by the DEC to the VDCs, increasing their sustainability and follow-through.

2.2.4 ToT in healthy village settings: The objective of the training workshop will be to prepare key partners, namely MoH, MoLGRD, other GoM ministries and departments, HDPs, the private sector and CSOs to train in the healthy settings approach and use the available training manual for VDCs. The training manual will not only be for use by the MoH but also for CSOs, other GoM ministries and departments and other stakeholders. 725 trainers will be trained in the first year of the grant, averaging 25 trainers per district. The

District Health Management Teams (DHMTs) which are under MoLGRD will coordinate the training of VDCs at district level and will involve CSOs in the training. It is expected that each district will develop their own plans for training and the DHMTs will closely monitor this activity. These trainers will then be available for future trainings in healthy village settings, and will be available to other programs who wish to conduct trainings using the manual with outside funding.

2.2.5 - 2.2.6 Training and transport for VDC initiative: Training of VDC members shall be done by MoH (Environmental Health Officers and AEHOs), as well as other stakeholders, including MoLGRD and CSOs. The expected outputs from the training at VDC level will be action plans based on village profiling and identification of priority areas for intervention to improve access, including a profile of immunisation coverage at village level. The VDCs will then have the responsibility of sensitising community members about the need for immunisation and other health topics and helping HSAs conduct outreach clinics and other interventions to improve community health and access to services. Funding is therefore being requested for conducting the initial trainings for VDCs and in each district, targeting hard to reach and under-served communities. The VDCs to be trained will be selected based on areas with high levels of child mortality. GAVI support will allow for the training of 580 VDCs, with an average of 25 members each. Once trained, the VDCs will be better able to implement the healthy village settings approach, and will be stronger contributors to the development and implementation of DIPs. Once the training of VDCs has been institutionalised, the District Health Management Teams (DHMTs) will be encouraged to put this activity in their District Implementation Plans (DIPs). In order to effectively train VDCs and monitor their progress, there will be a need for transport for EPI staff and staff from Environmental Health Department to visit the districts and some community level VDC initiatives. This vehicle will be designated for support of the VDC initiative and civil society initiatives and will be supervised, fuelled, and maintained by the Ministry of Health Planning department for use by the CSO coordinating committee.

2.3 CSO immunisation forum

The HSSP calls for the mapping of partners involved in the delivery of health services at all levels of health care in order to determine districts and areas which are underserved. This is in line with the Paris Declaration on Harmonisation and Aid Effectiveness to ensure better use of existing resources. The MoH began resource mapping of donors and NGOs in November 2011, with support from the Clinton Health Access Initiative (CHAI). Additionally, some ad hoc initiatives have attempted to collect information about active CSOs in Malawi, such as zonal consultations in the South East zone. However, the involvement of CSOs in immunisation activities and general health promotion is not yet well known or described. There is anecdotal evidence that some local and international CSOs have played major roles in terms of promotion, transportation, and mobilisation of resources for immunisation services.

CSOs have the potential to advocate for the increased uptake of immunisation and other EHP services at community level, while at the national level they can advocate for more funding from GoM, national stakeholders and health development partners. Bearing in mind that Malawi has high immunisation coverage, in this proposal GoM wants to reach the remaining unimmunised children by actively involving CSOs in terms of advocacy and empowerment of local communities to demand immunisation services where demand is weak. This will be done through a multi-pronged approach including mapping of CSOs, hosting a national immunisation conference for CSOs to come together, supporting zonal meetings of CSOs, and supporting CSO representatives to participate in national meetings. There is currently no support to enable CSOs to meet and discuss health issues but the Ministry of Health has a structure where local CSOs are supposed to be represented at all levels from district, health zones and national which currently is not utilised much hence this

request to strengthen its membership and active participation in HSSP

2.3.1 Conduct a mapping of CSOs: Currently, while MOH recognises the potential of CSOs, there is no national forum where CSOs can work together and promote immunisation and other health services. In order to initiate CSOs' effective participation in promoting healthcare services, this proposal requests funding for teams of 2 people to spend 4 days in each district conducting a mapping exercise for CSOs to determine to what extent they are involved in activities relating to health. So far the involvement of CSOs in immunisation services has been limited and the mapping of CSOs will make the MoH aware of their existence and the interventions they are implementing. It will provide a foundation for multiple future collaborative activities and will facilitate the inclusion of CSOs in national decision-making bodies.

2.3.2 National conference on experiences of CSOs in immunisation services: Many CSOs in Malawi are very focused in limited geographical areas and there are limited opportunities to share experiences and learn from a community of practice. The mapping of CSOs will help to identify CSOs especially those working at community level and their health related activities. Then a conference will be organised by the MoH early in the period of the grant, and CSOs will be required to present their experiences and lessons that can be learnt relating to health, both at national and community levels. This conference will also explore how CSOs can best be involved in the provision and promotion of immunisation services at all levels. During this conference, CSOs will develop a work plan for activities to encourage demand for immunization and other health services in the community in line with the HSSP. Funding for the conference for CSOs in 2 years of the project period is being sought from GAVI, but later the resources for such conferences will be sourced internally by the MoH or the CSOs themselves.

2.3.3 Hold zonal meetings for CSOs: Over the period of the previous programme of work (2004-2010), CSOs did not have their own forum for ensuring their full engagement and participation in health policy matters. Their participation in the HSRG was therefore less than optimal and an opportunity was missed to hear from this important constituency representing underserved communities. The major issue was lack of resources for CSOs to engage with each other and discuss and advocate for issues relating to health. In this proposal funds are being sought to support CSO zonal meetings in Year 1 and 3 where they can, together with MoH and MoLGRD, discuss health issues including immunization and understand and share the results of the joint annual reviews and how they can assist in implementation of recommendations. An outcome report will be prepared for each zonal meeting, with recommendations to CSOs and government partners on best practices and action items. Once these meetings are institutionalized, the MoH and CSOs can find alternative sources of funding to conduct the Year 2 zonal meetings and continue such meetings after the period of the grant. Discussions with other potential donors, CSOs and the MOH to fund this activity have already begun.

2.3.4 Support the attendance of CSOs at national sector review meetings: In order to catalyse the participation of CSOs in activities such as immunization, leading CSOs shall be supported to participate in national reviews and they will be given an opportunity to share their experiences. National sector review meetings take place biannually and bring together stakeholders across the health system to assess progress in meeting health challenges. The CSOs will send one representative from each zone and one national coordinator, for a total of 6 attendees to the national review meeting. Support is being requested for this participation in the biannual meetings for the entire 3.5 year period, for a total of 7 meetings supported. Participation in annual reviews will be based on co-funding with the CSOs themselves. At a later stage, CSOs will be encouraged to source their own funding for participation. The MoH will work with CSOs and link them with other sources of funding for

CSOs and funding will further be sourced from within the country for web hosting of CSOs in immunisation services. Following these meetings, CSO representatives will prepare outcome reports for sharing to CSOs not in attendance at the meeting.

2.3.5 CSO Project Management and Administration: The involvement of CSOs in immunisation services has been very minimal. There is a need for funds to catalyse the involvement of CSOs in immunisation services. In addition to the activities above, GoM is seeking support from GAVI to fund one national CSO that will be responsible for coordinating CSOs' activities in relation to the advocacy, provision and utilisation of health services. This national CSO will be critical to sustain the participation and knowledge of CSOs after the period of the grant and the seed money will catalyse the participation of CSOs in immunisation and related services at national level. The support will be for 3.5 years of project management and administration activities as outlined in the costing template.

2.4 Infrastructure and transport for hard to reach areas

2.4.1 Construction of under-five shelters: The HSSP (Attachment 2) promotes the participation of communities in the delivery of health services, and the EPI unit relies heavily on outreach services to provide immunization and health services in hard to reach areas. Currently, communities and their leadership work with HSAs to identify local structures (such as churches and schools) where services such as immunisation can be provided. However, in areas where no shelter is available, usually in the most disadvantaged communities, immunisation services are being provided and other health activities conducted in an open space or under a tree where during the dry season the safety and efficacy of vaccines is not guaranteed, and in the rainy season (November-April) outreach services are often cancelled due to lack of shelter. Support is therefore being requested from GAVI to construct 50 under-five shelters in hard to reach areas that are under-performing, as identified by DHOs. This will cover outreach services provided by the MoH and CHAM. The under-five shelters have a waiting area and room to conduct an under-5 clinic underneath a metal roof. In addition to immunization services, these shelters will support delivery of other interventions such as deworming, Vitamin A supplementation, ITN distribution, growth monitoring, screening for illnesses and health promotion. Village health meetings will also be conducted in the under 5 shelters. The shelters are very durable and will be used long after the period of the grant has finished.

2.4.2 Purchase of boats: Currently Malawi does not have boats for use by the health sector and they are hired when needed, sometimes including dugout canoes. In the 2007 GAVI HSS proposal, a provision was made for the purchase boats to transport vaccines, and supplies to districts in Malawi that are islands or along water bodies and difficult to reach by road. In addition to transporting EHP supplies, these boats were intended to be used for supportive supervision, outreach immunization services and for referral services. The proposal was to purchase 5 boats, unfortunately the UNICEF procurement price used for budgeting proved insufficient to procure even one boat. Therefore, this proposal requests support to purchase boats for the same 5 areas: Likoma Island, Zomba, Rumphi, Nkhata Bay and Nsanje. Boats will also be purchased for 2 additional areas—namely Machinga and Phalombe—that have water-side communities affected by the Lake Chilwa cholera outbreak. In these communities, frequent outreach is needed to provide water purification supplies, treatment supplies, and to transport patients to hospitals. In addition to vaccination and cholera activities, the boats will be used to support other disease control interventions, transportation of drugs, hospital supplies, food supplements for nutrition. Boat size and specifications will be determined by the work to be performed with them, the needs of the body of water they will traverse, and durability. Once purchased, the GoM will be responsible for the personnel manning the boats, their emoluments, servicing the boats, as well as ensuring that there is adequate fuel for running the boats.

2.4.3 Purchase of motorcycles for facilities: Motorcycles are for staff based at the facility and they are used for outreach as well as distribution of vaccines and other supplies to hard to reach areas. They are also used across the health sector for staff transport and supervision. The Cold Chain Assessment (Attachment 3) recommended that the procurement of motorcycles be prioritized for facilities serving hard to reach areas. In this proposal support is being requested to provide 40 motorcycles for districts, which will be allocated by the DHO to the facilities most in need. These will allow targeted facilities to reach areas that may be difficult to reach on bicycles or in a motor vehicle. Once purchased, the MOH will be responsible for training staff in safe motorcycle operation, and for providing maintenance, fuel, and safety equipment

2.4.4 Training of Physical Assets Management (PAM) engineers in motorcycle maintenance: Motorcycles have been purchased for the health sector by the Global Fund, GAVI and other donors. The motorcycles are important, among other things, for supervision by AEHOs. It was determined during the 2011 Cold Chain Assessment (Attachment 3) that 31% of motorcycles were not in working order; hence the need for training the PAM engineers so that they can repair the motorcycles without long delays. The trained engineers will use the skills acquired to maintain other motor cycles for other programmes such as Malaria, National TB and Reproductive Health Unit such that other programmes will not bother to conduct a similar training, hence reducing the Ministry`s overall resources for training the engineers in motorcycle maintenance. By building this skills base within the Ministry, the assets available for transportation will last longer and will be available for health services outreach more days out of the year, addressing a significant constraint within the health system. 10 people will be trained per year, over 3.5 years, for a total of 40 engineers trained.

Objective 3: Improve cold chain capacity and management at all levels of the health system

Proposal Objective 3 aims to strengthen cold chain capacity throughout Malawi in light of the current constraints faced due to introduction of pneumococcal and rotavirus vaccines and the ongoing need for repair and replacement of cold chain and transport equipment. The cold chain is essential to delivery of safe and effective vaccines, which are an important contributor to declining childhood mortality, particularly with the incorporation of vaccines against pneumonia and rotavirus, two major causes of under 5 mortality. The proposal focuses on increasing the capacity of Ministry of Health staff to ensure effective maintenance and repair of equipment stocks, conducting periodic reviews to assess the performance of the cold chain system, strengthening of cold chain and transport infrastructure, and procurement of cold chain and waste management equipment, including fridge and freeze tags for temperature monitoring to ensure vaccine efficacy. The proposed activities and items for procurement draw from assessments conducted in recent years, including the 2011 Cold Chain Assessment (Attachment 4).

3.1 Training in cold chain maintenance and repair

Due to the importance of maintaining the cold chain for vaccine efficacy, and the significant investment that has been made in cold chain equipment, it is important to ensure that there are sufficient skilled technicians to maintain these assets. During the 2011 Cold Chain Assessment (Attachment 4), it was found that 16% of refrigerators and freezers were in need of repairs. Moreover, due to the difficulty of having technicians travel between facilities, and the variation in skill required for different types of repairs, Malawi has found it effective to provide this training to different cadres at the zonal level and below.

3.1.1 Train PAM engineers in advanced cold chain repair: PAM engineers are

responsible for making all significant repairs to electrical equipment for all hospitals at all levels; however, they have not received any specific training for cold chain equipment. Moreover, the purchase of solar equipment will require specialized training. Major repairs are currently outsourced to private contractors incurring significant expense. In order to reduce costs in the long run, and continue to build PAM capacity for more specialised repairs, funding is being requested from GAVI to provide a 30 day training course in refrigeration for 10 staff (2 engineers in each zone). The PAM engineers that will be trained in cold chain repair will impart the knowledge and skills acquired to the rest of the chain maintenance technicians at DHO and Health Centre.

3.1.2 Train PAM Artisans in general cold chain maintenance and repair: PAM artisans are responsible for making general electrical repairs at the district level and can promptly respond to the needs of health facilities when cold chain equipment breaks down**.** Providing 2 artisans per district with a 15 day training course in cold chain repair will increase facilities' access to timely and cost effective repairs, and will ensure a broader skills base for these repairs within PAM.

3.1.3 Train cold chain technicians (CCT): To date, 67 cold chain technicians have been trained with support from the 2007 GAVI HSS Grant. This proposal will support refresher trainings for these staff members. During these 7 day district level training courses, CCTs will receive refresher training on existing equipment and be briefed in new equipment repair. They will also be given protective clothing and appropriate tools and instructed in their use. The proposal is to train a total 65 CCTs twice, in a two year interval. This will cover all of the CCTs currently working at district, zonal, and national levels. These staff will be able to maintain equipment in good repair, increasing the durability and availability of cold chain equipment.

3.1.4 Train HSAs in basic cold chain maintenance and repair: During the 2011 CCA (Attachment 4) it was noted that equipment often falls into disrepair due to a lack of knowledge on the effective use and maintenance of cold chain equipment. In order to reduce the need for repairs, and reduce the cost of simple repairs, it is proposed that over the next 3 years, 2 health workers in all GoM and CHAM facilities, a total of 1,588 HSAs, be provided with a 3 day training on use and maintenance of cold chain equipment. This will ensure on-site basic maintenance and care for the refrigerators, as well as cold chain basics such as temperature adjustment. As the daily users of the majority of refrigerators in Malawi, HSAs are crucial to upkeep and monitoring and building their skills will increase the functionality and effectiveness of the existing cold chain stock and ensure longevity of the newly procured items.

3.2 Assessment of cold chain capacity and management

3.2.1 Conduct a Cold Chain Assessment (CCA): A CCA was completed in 2011. This inventory collected data on all of the available cold chain equipment in Malawi and has been the basis for the development of the rehabilitation plan for the cold chain in Malawi for the next 5 years. There are plans to update key portions of the CCA annually. Funding is being sought from GAVI to conduct another comprehensive CCA in 2015 towards the end of the cMYP and the HSSP to inform the investments required in the period 2016-2021. This will also be a critical time due to new vaccine introductions in 2011 and 2012, and potential new introductions in the following years that will have impacted on the total availability of cold chain space. Although current figures include projections for the new vaccines, the 2015 CCA will verify the projections as well as the data gathered in the annual updates. No funding for the 2015 CCA has been identified from any other sources, however the HSSP that will begin in 2016 will suggest a resource mobilization strategy for future CCAs.

3.2.2 Conduct effective vaccine management (EVM) assessment: The EVM is essential

for assessment of the system used to ensure that vaccines are stored at appropriate temperatures and managed to avoid stock-outs. The last Effective Vaccine Management (EVM) assessment was carried out in 2009 and given the recent introduction of new costly vaccines, another EVM will be required in 2012. This will be funded by UNICEF. Again in 2015, the EVM will be required in order to ensure continued effective management of vaccines, and funding is being sought from GAVI for this EVM..The EPI unit will be responsible for following up recommendations and action items from the EVM and incorporating changes to suboptimal practices.

3.3 Cold chain infrastructure and transport

3.3.1 - 3.3.2 Construct vaccine stores and dry storage for zonal and district offices: As noted in the 2007 GAVI HSS application, and reiterated in the recent CCA report, there is currently inadequate space for storing vaccines and other EPI supplies at all levels, and this is expected to be exacerbated by the planned addition of new vaccines in the coming years. As part of the 2007 GAVI grant, funding was approved for construction of national, regional and district EPI stores with high volumes. While the construction of regional stores is underway, due to underestimation of construction costs and inflation since grant inception, funds for district level stores have been reprogrammed to finish construction of the national vaccine store in Lilongwe as well as the Southern Regional vaccine store in Blantyre. Similarly, funds were not sufficient to build a new cold store in Mzuzu for the northern region, and the program decided instead to renovate the existing space to accommodate additional refrigerators as a temporary measure, Dry storage is currently being provided in sheltered containers, which are fine for an interim solution, but not as ideal for a long-term solution. Funding is therefore being requested for construction of both dry and cold stores in Mzuzu for the northern region and Zomba for the South East Zone covering 6 high population districts. Once the Zomba cold room is constructed, the regional cold room in Blantyre will serve the 7 districts in the South West Zone. Additionally, Lilongwe is a high volume district which is currently unable to collect their full vaccine allocation due to space constraints and both dry and cold stores will be constructed for Lilongwe. The vaccine stores will be constructed with adequate space to accommodate additional cold rooms that may be procured in the future, and the cold rooms will be a more durable solution for high volume sites than the current use of multiple refrigerators at these sites. Repair and maintenance will be provided by the higher level cadres listed above.

3.3.3 – 3.3.4 Purchase of 10 tonne and 3 tonne trucks for transportation of vaccines and other EPI supplies: 10-tonne and 3-tonne trucks are used by the Ministry of Health to transport vaccines, injection materials, ITNs, drugs, nutrition supplements, and many other essential health commodities. In 2010 the EPI Unit procured five 10-tonne trucks with support from GAVI for national and regional levels. As per GoM policy, these vehicles need to be replaced after 5 years in 2015. Support is being requested from GAVI for the replacement of three of these trucks to provide each region with one new truck. There are also 5 large districts in Malawi namely Lilongwe, Mangochi, Blantyre, Mzimba and Zomba which serve large populations and currently face challenges distributing their allocation of vaccines and other supplies. Support is being requested to purchase one 3-tonne trucks for each of these 5 large districts. Maintenance, drivers, and fuel for these vehicles will be provided by the Ministry of Health.

3.4 Cold chain equipment

3.4.1 - 3.4.14 Purchase of cold chain equipment and associated supplies: In 2011 a Cold Chain Assessment (CCA; Attachment 4) was conducted to inform the development of a 5 year cold chain rehabilitation plan. The assessment established current capacity at all levels of the system and compared this to the current and anticipated requirements (the pneumococcal vaccine was introduced in November 2011, and the introduction of rotavirus

is planned for October 2012). Other new vaccines will also be considered for introduction and cold chain capacity will be a key constraint. The results of the assessment, considering investments already made by GAVI in 330 refrigerators in 2010 with an additional 70 in the procurement process in 2012, as well as the 148 refrigerators purchased by WHO and UNICEF in 2011, suggest that additional capacity is still required over the next 5 years. The original forecast developed was for the period 2011-2015 and allowed for the introduction of PCV and rotavirus vaccines only. In anticipation of the introduction of other new vaccines, a second forecast was generated for the period 2012-2016 and included PCV, rotavirus, measles second dose, HPV and rubella vaccines (see Annex 8 of the CCA Report – Attachment 4). This forecast identified a need for an additional 800 refrigerators. This proposal requests support for the procurement of 223 refrigerators, 23 ice pack freezers, \\ and sufficient spare parts. The remaining refrigerators will be sourced from government and other development partners. The forecasts were carried out using the Cold Chain Equipment Manager tool that generates costs according to a preset database and these figures were used within the cMYP 2012-2016. However, the actual expected costs of procuring the equipment within Malawi are greater than those reflected in the Cold Chain Assessment report due to the inclusion of duty (Value Added Tax). These higher costs have been reflected in the HSS budget and will be reflected in next revision of the cMYP.

In addition to refrigerators, this proposal requests funding for 33 cold chain tool kits, 3,070 vaccine carriers, 500 cold boxes and 3,000 fridge and 24,000 freezer tags. One thousand five hundred fridge tags (enough for every refrigerator in Malawi, replaced after 2 years) will be procured in Year 1, and 3. Investment in this complementary cold chain equipment is an extremely cost effective way of ensuring the efficacy of expensive vaccine commodities and keeping the wastage rate at a low level. For example, there are currently only 200 fridge tags for approximately 1,500 working fridges in Malawi. The CCA found that 21% of working fridges had experienced a temperature excursion in the 30 days before the cold chain assessment. [Refer to the 2011 Cold Chain Assessment for Malawi (Attachment 4) and the cMYP (Attachment 3a)]. Other partners will assist with training and other implementation costs to ensure effective deployment of fridge and freezer tags.

3.4.15 Purchase of manual forklifts for EPI stores: Currently there are no manual forklifts at the national or regional EPI stores. Everything is being lifted by employees, which is inefficient and potentially dangerous to staff. Additionally, the newly constructed cold stores are much larger than the previous stores and additional equipment would improve commodity management and decrease transit time for vaccines, decreasing risk of damages. The purchase of these forklifts is especially important because the new vaccines are bulky and the forklifts will ensure that people manage higher volumes more effectively. Manual forklifts are easy to operate and greatly assist in moving boxes from place to place. Up to now, no source of funding for such equipment has been identified. The funding that is being requested from GAVI will allow Malawi to procure 1 fork lift for the national store and one for each of the 3 zonal stores. They will be supervised and maintained by managers at each of the cold stores.

3.5 Waste Management

3.5.1 Construction of incinerators at regional and national stores: There is currently no equipment for disposal of expired or otherwise faulty vaccines at national or regional stores and construction of incinerators is required to meet this need. Incinerators would be essential both to safely disposing of non-usable vaccines and diluents, but also of minimizing accumulation of waste during burn and bury or other methods of disposal. The program therefore seeks support from GAVI to construct one incinerator at national level, which can also be used by central region, and 3 incinerators at Mzuzu, Blantyre, and Zomba to be used by the zonal stores. They will be supervised and maintained by managers at each of the stores.

Management of GAVI HSS support: One percent of the GAVI HSS budget has been set aside for the management of the support to provide a contribution towards the total management costs. This includes costs of monitoring and evaluation and production of the Annual Performance Report, procurement costs of conducting tenders, contracting costs associated with developing infrastructure, and stationery used at MOH in support of the planning and implementation of the specified projects.

A comprehensive logistical framework showing all the proposed activities is shown in Attachment 11.

SECTION 3: FINANCIAL GAP ANALYSIS, WORKPLAN and BUDGET

3.1 Financial Gap Analysis at the Health Sector Level

Please provide an updated financial gap analysis at the level of the health sector, with an estimation of current and expected domestic and external funding.

For the purposes of the Global Fund, applicants are requested to provide this information by filling in a template (Attachment 2 – sheet "Table 1 H.Sector & CFinancing"). This includes required information on counterpart financing. Guidelines and instructions on how to fill the financial gap analysis and the counterpart financing tables can be found in additional sheets in the budget template file.

For requests to GAVI, applicants can either use the template (Attachment 2 – sheet "Table 1 H.Sector & CFinancing") or provide the financial gap analysis in an existing national format.

The financial gap analysis should be based on existing documents (for example resource mapping materials, medium term expenditure framework) and refer to the health financing section in the National Health Strategic Plan.

Describe how contributions from various sources of funds were estimated, and assumptions made, including reference to:

a. any changes in contributions anticipated over the period of support and the reason for any identified reductions over time; and
b. Any current delays in accessing the funding that should be explained, including the reason for the delay, and plans to resolve the issue(s).

At an aggregate level, show how the current and forthcoming government budget and other funding sources contribute to financing the national health strategy in the near term. For Global Fund applicants, the above questions should be answered in the separate document entitled "Eligibility and other Requirements section – HSS proposals/requests to the Global Fund".

Response:

The ideal total cost of implementing the HSSP is estimated at US$3.2 billion over five years, while the plan based on projected resources costs is US$2.3 billion, with an estimated gap over the five years of the HSSP of over US$900 million (Attachment 2). Part of this funding gap is a shortfall in funding for the cMYP. The GAVI HSS funding request is primarily focused on addressing the HSS funding gap in the cMYP (US$31,752,707; Attachment 3a). Attachment 10 is a resource mapping for immunisation services over the period of the HSSP.

The GoM through the HSSP is committed to funding the procurement of traditional EPI vaccines and the co-financing of the GAVI supported vaccines. The Malawi Ministry of Health has been commended for its commitment to co-financing, and Malawi has been consistently increasing its per capita expenditure on health from $25 in 1995 to $65 in 2010 in purchasing-power parity adjusted dollars.[9] However, there is a shortfall in the budget for cold chain equipment, transport equipment, operational costs, surveillance, social mobilization and monitoring and evaluation as outlined below. Over the 5 years of the HSSP,

[9] Global Health Expenditure Database. Malawi Report 1995-2010. WHO. http://apps.who.int/nha/database/StandardReport.aspx?ID=REP_WEB_MINI_TEMPLATE_WEB_VERSION&COUNTRYKEY=84694

the total budget for implementing EPI activities (including HSS) is US$383,000,385 and 39% of this will be used for the purchase of vaccines and injection supplies. The GoM will contribute about US$8,805,570 for traditional vaccines and their injection supplies and US$5,561,235 for co-financing new vaccines (DPT-HepB-Hib, PCV and rotavirus). GoM will therefore contribute US$14,366,805 for vaccines and injection materials. Table 3.1 below shows costs broken down by categories:

Table 3.1: Costs for cMYP components, 2012 – 2016

		Costs	Future Cost Projections					
cMYP Component		2011	2012	2013	2014	2015	2016	Total 2012 - 2016
		US$	US$	US$	US$	US$	US$	US$
	Vaccine Supply and Logistics	$9,639,090	$21,966,753	$29,992,283	$31,762,697	$34,610,473	$38,322,000	$156,654,205
	Service Delivery	$14,333,694	$16,064,172	$17,806,649	$19,726,010	$21,815,648	$23,906,804	$99,319,284
	Advocacy and Communication	$323,743	$360,884	$402,327	$448,572	$500,180	$557,727	$2,269,690
	Monitoring and Disease Surveillance	$647,485	$721,769	$804,653	$897,143	$1,000,361	$1,115,454	$4,539,380
	Programme Management	$970,076	$1,401,310	$1,100,207	$1,296,248	$1,799,266	$1,518,502	$7,115,533
	Supplemental Immunization Activities			$4,261,589			$5,055,454	$9,317,043
	Shared Health Systems Costs	$15,534,330	$17,066,110	$18,744,118	$20,581,992	$22,594,622	$24,798,259	$103,785,100
GRAND TOTAL		$41,448,417	$57,580,999	$73,111,826	$74,712,661	$82,320,550	$95,274,200	$383,000,235

The major sources of financing for EPI activities will be GoM, GAVI, UNICEF, WHO, CHAI and USAID (through the MCHIP program). Information on the amounts that partners will contribute was obtained from the partners themselves as the cMYP was being finalised. GoM will be the major financier of these activities at 62% followed by GAVI at 32% through the procurement of new vaccines and injection materials. The cMYP shows that out of US$383,300,385 required over the next 5 years, US$351,247,528 has been secured from different sources including GoM and GAVI; hence there is a funding gap of US$31,752,707. The major financing gaps are in 2013 and 2016 when Malawi plans to conduct supplementary immunisation campaigns. These campaigns have not been included in this proposal. Other items with significant funding gaps include logistics (vehicles, cold chain and other equipment) and activities and other recurrent costs and it is these important areas that have been prioritised in this proposal.

Over the first few years of the HSSP (2011-2016) the GoM will continue requesting for funding from multiple health development partners. During the development of the HSSP a decision was made to develop a sustainable financing policy and strategic plan for Malawi's health sector in order to address the prevailing inadequate funding for the sector. The policy and plan are currently in the process of being developed and will be ready by the second year of the HSSP. Most of the strategies being developed include mobilising resources within the country for example through the introduction of social health insurance, introduction of vice taxes on products such as tobacco, exploring replacement of some fuel levies with health and strengthening public private partnership (see Attachment 2).

The initial GAVI HSS grant contributed a great deal to systems strengthening in Malawi, including in some of the same areas as the current HSFP submission. The achievements and procurements of this first grant have been taken into consideration in budgeting for the HSFP. The funds from the first HSS grant will be completely spent by December 2012. A financial report to this effect will be provided to GAVI by the end of September, 2012. .

3.2 Financial Gap Analysis at the level of the Health Systems Component[10] (optional)

[10] For a definition of the health system components please refer to the document ''Guidance for Monitoring and Evaluation of National Health Strategies including HSS efforts'' http://www.who.int/healthinfo/HSS_MandE_framework_Oct_2010.pdf as well as the 'Monitoring and Evaluation Toolkit for Health and Community System Strengthening''

In order to provide further information on the financial context of the request, applicants can optionally attach a detailed financial gap analyses for requested HSS components (e.g. health information systems or human resources). This could be either in a national format or by completing the template provided in Attachment 2 – sheet "Table 2 HSS Gap Analysis – 1". Information at this level should be available if a country has a specific strategy for a health systems component that includes financial estimates for strategy implementation. Instructions on how to fill in the tables are included in the budget template.

3.3 Budget

Applicants are required to submit a budget that reflects the areas of the National Health Strategy for which funding is requested. As such, this budget should represent a part of the National Health Strategy budget. Applicants are given the choice to either submit their National Health Strategy budget by indicating the specific parts for which funding is requested, or submit the budget by filling in the template provided by GAVI and the Global Fund (Attachment 2).

Applicants who choose to submit their national budget and workplan need to ensure that it contains the relevant information as described in the guidance on the use of the GAVI and Global Fund budget template, which will be made available to applicants together with this request template.

Please explain how the amounts requested were calculated. Please also explain links, as appropriate, to previous financial gap analyses and annual plans.

Note that GAVI and the Global Fund seek to ensure that any proposed financing of salaries, per diems, other compensation, volunteer stipends and top-ups is consistent with current HR compensation in the health sector, specifically national salary or interagency frameworks.[11] Please explain how compensation issues in the health sector have been analyzed and what steps have been taken to ensure Global Fund and GAVI supported salaries are consistent with national salary or interagency frameworks, and include relevant documentation.

For the Global Fund, in cases where the remaining timeframe of the national strategy is less than five years (as measured from the expected time of grant signing), the Global Fund will accept HSS requests for funding for the remaining duration of the national strategy plus a maximum of 12 months of additional funding based on an indicative budget and description of the program – on condition that the total funding request does not exceed five years.[12]

[11] If they are not consistent, this could lead to diversion of staff from existing programs to new programs financed by GAVI and/or the Global Fund, which is something the Global Fund and GAVI want to avoid. If some or all of your salary costs are not consistent with existing compensation policies, provide a solid justification for this. Relevant documentation must be attached, even if the documentation is only in draft form. If no such documentation is available, provide a clear description of current practices as well as efforts to elaborate and document in-country compensation policies. For more information please see the relevant Global Fund policies.

[12] Please see annex - Additional Global Fund Information about the Indicative Year.

If this HSS request entails such a request for up to 12 month of additional funding, please explain:

- how the corresponding budget and indicators/targets were developed
- what the underlying assumptions of the financial request for the additional year are
- how these interventions and the budget link with the national strategy (it is assumed that the funding requested is for continuation of interventions and that these are consistent with the previous years of the strategy).

Response:

Attachment 10 is the detailed budget for the proposed HSS activities prioritized for GAVI HSS funding.

Note that reference should be made to the cMYP, the HSSP and the budget in excel on how the costs were calculated, including detail on the unit costs and activity-level assumptions. A prevailing market exchange rate from US dollars to Malawi Kwacha (MK) was utilized. Depending on the currency to be used for procurement, some costs were estimated in MK then converted, and others were estimated in dollars then converted.

49% of the budget contributes to Objective 1: To improve and sustain high immunisation coverage and support scale up of the essential healthcare package. Most costs are based on estimates as detailed in the HSSP, for example the cost of training AEHOs and HSAs. Costs of reviews draw from the experience of EPI in conducting similar exercises, and the transport estimated costs utilize prevailing prices for goods to be procured and imported to Malawi.

25% of the budget contributes to Objective 2: Improved access to immunisation services for hard to reach population groups and unimmunized children through targeted interventions and the involvement of communities and CSOs. Most of the budget estimates in this section were developed with the input of CSO partners, and draw on the costs of the activities in the HSSP. Infrastructure and transport costs utilize market prices.

25% of the budget contributes to Objective 3: Improved cold chain capacity and management at all levels of the health system. Training and assessment costs were based on the costs of similar activities when conducted in Malawi previously. Construction costs for the new cold rooms similarly mirror the costs of recently constructed cold rooms in Blantyre and Lilongwe. In order to estimate cold chain requirements for Malawi, the cold chain assessment conducted in 2011 was the basis and these were adjusted upwards to include equipment that was not captured by the forecasting tool namely the vaccine carriers, cold boxes and fridge/freezer tags, as well as reflecting the additional requirement associated with the potential introduction of new vaccines in the future such as HPV, rubella and measles second dose. Recent procurements of cold chain equipment using GAVI funds and UNICEF funds were also taken into consideration.

Finally, 1% of the total grant amount was set aside for management of the grant. This includes costs associated with data collection and reporting on the grant, procurement and the tendering process, and other related management costs.

3.4 Workplan

Please attach the current annual or biennual workplan of the areas of the National Health Strategy for which funding is requested. Countries can either submit their existing national workplans or use the Global Fund/GAVI budget template by providing further information on the timing of planned activities. If the annual budget breakdown is contained in a separate document from the operational plan, please submit the relevant documentation together with the operational plan. For requests to GAVI, in addition, please attach the latest approved cMYP, preferably costed, that covers the duration of the requested HSS support.

Response:

A comprehensive current annual operational plan relevant to areas for which support is being requested has been attached and this constitutes part of the HSSP (Attachment 2; Attachment 3a)

SECTION 4: FINANCIAL MANAGEMENT ARRANGEMENTS

Outline the financing channel to be used and specific financial management arrangements. Requested support should be "on-budget''. Please include a description of the budgeting, payment, reporting and audit arrangements. Reference should be made to any relevant financial management assessments (FMAs) and if appropriate, to the relevant sections of the JANS report. Use of existing financial management arrangements is encouraged. For the Global Fund, if this includes a pooling of contributions, please refer to the Global Fund policy on common funding mechanisms[13] or contact the Secretariat at proposals@theglobalfund.org.

It is expected that successful applications will report annually on the execution of the national health budget together with reporting programmatically on national targets. This will require gathering of information and reporting mechanisms from different sources to ensure the reporting is accurate. Please detail any relevant actions which will be taken to ensure that sufficient capacity exists for financial management, including financial risk management, of the requested funds.

Response:

The financial management arrangements for the HSS grant will remain the same as contained in the aide memoir signed by the Government of Malawi and GAVI for the 2007 HSS Grant to Malawi. GAVI will disburse HSS funds as proposed in this document to the MoH which will be responsible for management of these funds. The funds from GAVI shall be sent to the Reserve Bank of Malawi which in turn will transfer the funds to the Ministry of Finance (Accountant General's Office). The payment system in Malawi has been centralised and the Accountant General shall be responsible for all payments upon advice from the MoH. In terms of accounting GoM has introduced the Integrated Financial Management Information System (IFMIS) and all funds from GAVI shall be administered though this

[13] See "*Operational Guide – The Key to Global Fund Policies and Processes*" available at http://www.theglobalfund.org/en/library/documents/

system and accounted for by the Accountant General's report to Parliament.

Each year, as required by GoM, the MoH shall prepare annual implementation plans which shall include activities as contained in this GAVI HSS funding request. Annual Progress reports will be submitted to GAVI as part of the overall annual reporting for the health sector. The Department of Planning and Policy Development will provide explanations for any variations in the implementation of planned activities and costs. The MoH shall prepare monthly IFMIS budget reports as well as quarterly income and expenditure accounts. The details in the income and expenditure accounts shall include as a minimum, the opening and closing balances of GAVI cash grants, total expenditure for the quarter analysed as per categories indicated in this HSS proposal document. The MoH will prepare annual financial statements. These will be submitted to the GAVI Secretariat, the ICC and HSRG.

In terms of control, the MoH will send copies of all internal audits on GAVI activities to the Auditor General within three months of completion; institute a system for regular backups of all GAVI related data and have it stored in a separate and secured location; and set up an asset register for GAVI funded assets. The details in the register will include: asset type, asset serial number, date of purchase, supplier details, cost of the asset, location and condition of asset and the person responsible for the asset. Internal audit of GAVI funds will follow the existing guidelines in the GoM and copies of the reports will be sent to GAVI Secretariat and the Auditor General. GAVI funds shall be audited externally by independent auditors and the report and the MoH responses shall be sent to GAVI within 6 months after the financial year ends.

All funds will be kept in foreign exchange and then changed to Malawi Kwacha as needed.

For further details, see the Aide Memoire signed between Government of Malawi and GAVI (Attachment 8)

SECTION 5: IMPLEMENTATION ARRANGEMENTS

Briefly explain the implementation arrangements for the National Health Strategy, and how these arrangements will be used to implement this funding request and/or how implementer(s) will coordinate with existing arrangements.

Please describe the implementing institution(s) with responsibility for ensuring that the activities are successfully implemented and performance is monitored. Include for each implementer details of past experience, technical, managerial, procurement and/or financial arrangements and capacities, and any relevant actions that will be taken to ensure necessary capacity. If these actions are included in already existing technical assistance plans, please attach these plans to this request.

If there are multiple lead implementers, describe how co-ordination will occur between these lead implementers to ensure timely and transparent performance updates and disbursement requests, on separate and joint reporting.

The Global Fund recommends applicants to nominate at least one government sector and one non-government sector Lead Implementer (dual track financing). Applicants may find out more in the information note about dual track financing.[14]

For requests to the Global Fund, please provide the same information for sub-implementers with responsibility for implementing activities. In addition, describe how they were selected, and which activities they will conduct.

Response:

The day to day implementation of the GAVI support will be coordinated by the Director of Planning and Policy Development in close collaboration with the relevant heads of departments in the Ministry of Health (MoH). The HSS Core Group is responsible for the quarterly monitoring of the implementation of the GAVI HSS support and is chaired by the SWAp secretariat.

The Department of Human Resource will be responsible for all HR and related issues, but will consult the training institutions in country on the provision of pre-service training for HSAs and AEHOs as this is their responsibility. In-service training sessions will be included in the implementation plans at different levels and the Department of Human Resource will coordinate all training efforts under this request for GAVI HSS support.

Printing of Health Information System monitoring materials will be coordinated and supervised by Department of Health Management Information Systems.

The Department of Planning and Policy Development in the MoH will work with the Department of Buildings in the Ministry of Transport and Public Works during the construction of under-five shelters, cold and dry stores, and incinerators following the GoM procurement guidelines.

The procurement of all major items such as computers, printers, photocopiers, cold chain equipment, vehicles, motorcycles, bicycles and boats will be done at central level by the Procurement Unit of the Ministry of Health. The EPI Unit shall submit to the Procurement Unit the list of items that will need to be purchased annually and the Unit shall ensure that these are included in their annual procurement plans. All procurement will be done in line with the procurement guidelines issued by the Office of the Director of Public Procurement.

The Department of Administration will be responsible for the distribution of the trucks, utility vehicles, motorcycles, bicycles and boats based on the distribution list drawn up by the EPI Programme Manager.

The activities that are implemented at the district or lower levels will be captured in the District Implementation Plans.

The implementation of the community-based activities, including the involvement of CSOs, will be coordinated by the relevant District Health Management Teams who will work very closely with other stakeholders in the district. The EPI Unit and the Department of Environmental Health will work with the Ministry of Local Government and Rural Development to sensitise DECs on the training of VDCs.

The national efforts to effectively catalyse the participation of CSOs in health activities, such as immunisation, will be coordinated by the Department of Planning and Policy Development of the MoH, in close collaboration with the CSOs.

The 1% of the budget proposal designated for management will support the efforts of the various departments of the Ministry of Health to conduct the activities of the proposal.

[14] http://www.theglobalfund.org/en/application/infonotes/

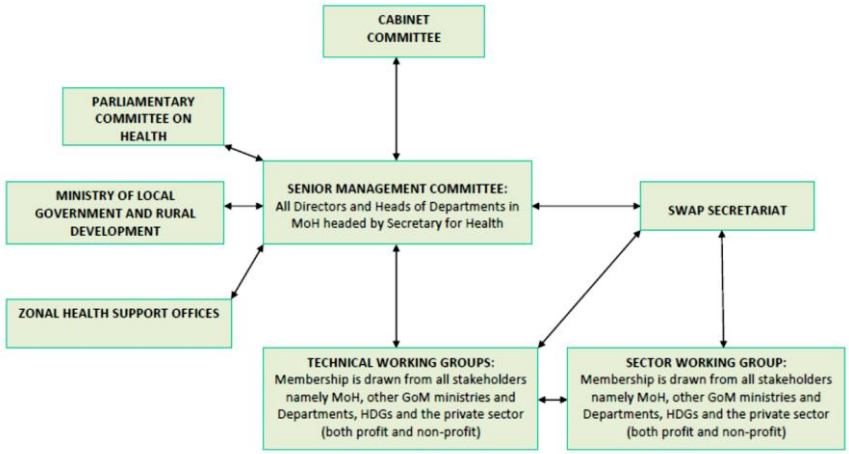
SECTION 6: GOVERNANCE AND OVERSIGHT ARRANGEMENTS

Describe the governance body (CCM for Global Fund requests and/or the relevant Health Sector Co-ordinating Committee for GAVI requests) that will have the responsibility for oversight (including financial oversight) of Global Fund and/or GAVI supported activities.

If the funding request is to both Global Fund and GAVI, please outline how the respective governance bodies will coordinate to perform this oversight function, including monitoring implementation and budgets. Also, describe how these bodies will coordinate with other relevant stakeholders.

Response:

The Health Sector Review Group (HSRG) is the governance body that will be responsible for oversight of the GAVI supported activities. The HSRG is co-chaired by the Secretary for Health and the Chairperson of the Health Donor Group (HDG) and the Director of SWAp serves as its secretary. Other members of the HSRG are drawn from representatives of discrete development partners, civil society, health professional associations, health regulatory authorities, local government, private practitioners, Christian Hospital Association of Malawi (CHAM), health research institutions, and health training colleges. The HSRG will review and endorse annual plans and budgets, and follow up on progress reports. Figure 1 below (also as Annex 10 in the HSSP) shows how the HSRG is related to other committees within the health sector in Malawi:



NB: Senior Management committee reports to the Cabinet Committee through the Honourable Minister of Health.

The HSRG, which is a multi-stakeholder committee, under the Ministry of Health, is the

governing body that will be responsible for governing the implementation of the grant. The HSS Core Group is responsible for the day to day monitoring of the implementation of the GAVI HSS support and is chaired by the SWAp secretariat. Technical issues related to the GAVI support will be addressed through a number of Technical Working Groups (TWGs), including the Essential Health Package TWG and the EPI sub-TWG **(**See the HSSP - attachment 2; also see attachment 5a, 5b, and 5c for minutes of the HSRG meetings and the EPI sub-TWG meeting that approved the proposal resubmission).

SECTION 7: MONITORING AND EVALUATION

Explain how impact and performance of the funded activities will be measured, including what indicators will be tracked and reported, and what data sources will be used. Please use the relevant sections of the national M&E plan, the national health strategy and/or the national health management information system (HMIS) and the programme specific monitoring plan. If there aren't adequate details on indicators, including baselines and targets for all indicators related to the funding request in the M&E plan or national health strategy, please submit this information using the attached template (Attachment 3). For Global Fund, if an indicative year is included, please explain how impact and performance will be evaluated and monitored.

Describe how existing monitoring activities -- e.g. joint annual reviews, surveillance by the HMIS -- will be used to monitor the program. Also describe how gender and other equity issues will be monitored.

List relevant actions that will be taken to ensure that the capacity exists to collect and analyse the necessary information. If these actions are included in already existing technical assistance plans, please attach these plans to this request.

Please refer to the document 'WHO compendium of core indicators and data sources for monitoring health sector strategic plans''[15] as well as the ''Monitoring and Evaluation Toolkit for Health and Community System Strengthening.''[16]

For GAVI, HSS funding supports Strategic Goal 2 of the GAVI Alliance Business Plan – Contribute to strengthening the capacity of integrated health systems to deliver immunisation.[17] Country performance monitoring should demonstrate how HSS funding will achieve immunisation outcomes in the context of integrated service delivery. Relevant indicators include:

1. Drop-out rate – Drop out between DTP1 and DTP3 coverage
2. DTP3 coverage - % of surviving infants receiving 3 doses of DTP-containing vaccine
3. Equity in immunisation coverage - % of GAVI supported countries where DTP3 coverage in the lowest wealth quintile is +/- 20% points of the coverage in the highest wealth quintile.

Requested HSS support to strengthen health systems needs to contribute to improved health outcomes in relation to immunisation and the three diseases, HIV/AIDS, tuberculosis and malaria. In listing relevant health systems input/process and output indicators related to the requested HSS support, applicants therefore should demonstrate to which corresponding immunisation/disease

[15] http://www.who.int/healthinfo/HSS_MandE_framework_Oct_2010.pdf
[16] Monitoring and Evaluation Toolkit for Health and Community System Strengthening
[17] http://www.gavialliance.org/library/gavi-documents/strategy/gavi-strategy-2011-2015---table/

outcome and impact indicators these will contribute. Please refer to the document “Monitoring and Evaluation Toolkit for Health and Community System Strengthening".

Response:

The **goal** of this proposal is to reduce under-five child mortality through strengthening public health delivery. This goal aligns with the HSSP health impact performance indicator to reduce under-five child mortality from 112 per 1000 live births in 2010 to 78 per 1000 live births in 2016. The National M&E plan forms part of the HSSP (Attachment 2, Annex 12). There are 38 performance targets in the HSSP which are utilised at a strategic level. These indicators will be monitored regularly by senior MoH management and through the Mid-Year Reviews and the Annual Joint Review Meetings. These goals will be monitored every four years through the Demographic Health Surveys and also through the Multiple Indicator Cluster Surveys. This national M&E plan, combined with the indicators detailed below and in the logistical framework, provides the performance framework for this proposal.

The three objectives of the proposal will be monitored through five **outcome indicators** drawn from the cMYP, HSSP, and Cold Chain Assessment. These will be used to monitor the results of the proposed investment and are as follows:

1. National DPT-HebB-Hib 3 coverage sustained above 90% each year (cMYP, HSSP)_
2. Drop out rate for DPT-HepB-Hib is less than 10% for all districts each year (cMYP)
3. Percentage of facilities able to deliver EHP services increased from 74% in 2010 to 90% in 2016 (HSSP)
4. 100% of districts achieve DPT-HebB-Hib 3 coverage above 80% each year (cMYP)
5. Percentage of facilities requiring additional cold chain capacity reduced from 10% in 2011 to 5% in 2016 (Cold Chain Assessment)

Outcome indicators 1, 2, and 4 align to indicators contained in the cMYP (Attachment 3a), and indicator 1 is also in the HSSP (Attachment 2, Annex 12). They are key measures of the performance of the immunization program, as well as indicators of the overall performance of the health system. These outcome indicators will be tracked through the annual Joint Reporting Form submission and monitored through routine EPI reports on a quarterly basis. The DPT-HebB-Hib 3 coverage data will also be monitored through the Multiple Indicators Cluster Survey, the Demographic Health Survey, and the coverage survey which will all take place during the period of the HSSP. The available data will be presented to the HSS Core Group and the EPI sub-TWG as soon as it is available.

Outcome indicator 3 is a core performance indicator for coverage of health services overall and is drawn from the HSSP. It is monitored using HMIS data at the Annual Joint Review meetings.

Outcome indicator 5 draws on the national experience with the cold chain assessment in 2011, and utilizes data collected from the assessment as well as a projection of cold chain capacity need by facility. The indicator will be monitored during the annual cold chain assessment update exercise and verified in the next national cold chain assessment. The EPI unit intends to include this indicator for routine monitoring in the next revision of the cMYP.

The baseline and target information for the five outcome indicators is as follows:

#	Outcome indicator	Baseline		Target		
		Value	Year	Value	Year	Source
1	DPT-HebB-Hib 3 coverage	93%	2010	>90%	Annual	HSSP Indicator, cMYP Official Estimates in the Joint Reporting Form
2	Drop out rate for DPT-HepB-Hib	6%	2010	<10% all districts	Annual	cMYP Official Estimates in the Joint Reporting Form
3	Percentage of facilities able to deliver EHP services	74%	2010	90%	2016	HSSP Indicator Official Estimates in the Joint Reporting Form
4	Number of districts with DPT-HebB-Hib 3 coverage above 80%	28 / 28 (100%)	2010	28 / 28 (100%)	Annual	cMYP District Coverage in Joint Reporting Form
5	Percent of facilities requiring additional cold chain capacity	82 / 826 (10%)	2011	41 / 826 (5%)	2016	Cold Chain Assessment Report

In the logframe for the GAVI HSS request for funding, one or more **output indicator** for each of the 13 Service Delivery Areas (SDAs) has been identified and these are presented in the table below.

SDA	Output indicator	Baseline		Target		
		Value	Year	Value	Year	Source
1.1	Assistant environmental health officers vacancy rate decreased	64%	2011	37%	2016	Department of Human Resource Development data
	% of HSAs who have not received pre-service training reduced	46%	2012	14%	2016	Primary Health Care Unit data
	% of health workers reporting training on disease surveillance during surveillance reviews increased	30%	2012	45%	2016	Surveillance Reviews reports
1.2	# visits conducted by the national team to each district for supervision per year.	3	2012	4 per year	2013 - 2016	Activity reports
	Child health passports in stock in all districts at each joint review meeting.	n/a	n/a	28/28 districts with passports in stock	Annual	Joint review meetings
1.3	Number of reviews	n/a	n/a	1 EPI Comprehensive review, 2 DQS,	2016	Activity reports

				2 DQA, 2 30 cluster survey		
1.4	% of districts receiving new vehicles by 2014	n/a	n/a	52%	2014	Distribution report
	# of bicycles per HSA increased	0.5	2011	0.75	2016	Cold Chain Assessment report
2.1	% of facilities utilizing an immunization monitoring chart increased	21%	2012	75%	2016	Supportive supervision reports
2.2	% of VDCs in Malawi with training in healthy village settings increased	0%	2012	29%	2016	Activity reports, MoLGRD
2.3	Number of planned zonal meetings carried out for CSOs each year	0	2012	10 per year	Annual	CSO reports
2.4	% of districts with infrastructure improvements (Under-5 shelters or new motorcycles) in their hard to reach areas by 2016	n/a	n/a	100%	2016	Activity reports
3.1	% of facilities with at least 1 staff trained in cold chain management	5% estimate	2011	95%	2016	Cold Chain Assessment report
3.2	# of assessments conducted	n/a		1 CCA, 1 EVM	2016	Activity reports
3.3	Cold room storage volume (in cubic litres) at zonal level increased	0 cubic litres	2012	49,000 cubic litres	2016	Cold Chain Assessment report
3.4	Number of functioning refrigerators at facilities increased	905 refrigera tors	2011	1,400 refrigera tors	2016	Cold Chain Assessment report
3.5	% of regional and zonal stores with access to an incinerator on site by 2016	0%	2012	100%	2016	Infrastructure Unit Update

Target values have taken into consideration staff attrition, contributions from other donors and programs, as well as the need for some items to be retired over time.

The output indicators will be monitored with data from a variety of sources and reported in the Annual Progress Report to GAVI. EPI will hold the primary responsibility for assembling data for the report, with assistance from HMIS, Department of Human Resource, and overseen by the HSS Core Group. During the joint review meetings activity reports will be

presented, and data from various ministry sectors will be shared according to the timing of activities outlined in the proposal and budget. The cold chain assessment report will also provide data for monitoring capacity of the cold chain at the end of the project. Data will be disaggregated by gender where relevant. The costs for managing and reporting the data will be supported by the 1% of the overall budget designated for grant management.

APPLICATION ANNEXES

LIST OF ATTACHMENTS

Countries are encouraged to submit requested information using existing country documentation and formats. The following attachments provide templates that can be used in cases where applicants choose to not submit requested information in national formats. Please note that in the cases of Attachment 1 and 2, the use of the templates is required (as noted below).

Document
Attachment 1: Logframe (use of template required by both GAVI and the Global Fund)
Attachment 2, "Table 1 H.Sector & CFinancing" sheet: Financial Gap Analysis (Excel worksheet) (use of template is optional for GAVI and required by the Global Fund)
Attachment 2, Detailed Budget of Funding Request (Excel worksheet) (use of template optional for both GAVI and the Global Fund)
Attachment 3: National M&E plan or Performance Framework (use of template optional for both GAVI and the Global Fund)
For Global Fund applicants: Section B: Eligibility and other Requirements section – HSS proposals/requests to the Global Fund

LIST OF SUPPORTING DOCUMENTS

A number of supporting documents need to be annexed to this application (see the table below). Additional documents which applicants believe are essential for the review of the request should be included in this table (add rows as needed and clearly name and number annexes).

Description	File Name	No
Required		
Report of the Joint Assessment of the national health strategy (including an assessment how feedback received during the JANS has been reflected in the final national health strategy)	Yes	1
Report of the Joint Assessment of the national disease strategy if the country has also recently conducted a joint assessment of one of the national disease strategies	N/a	N/a
Final National Health Strategy	Yes	2
National M&E plan (if not already part of the national health strategy document)	Included as part of HSSP	2
Current annual operational plan (and budget) relevant to areas for which support is requested	Included as part of cMYP	3a
Supporting documents covering components for which funding is requested (for e.g. human resources plan)	Yes – Cold Chain Assessment Report	4
Minutes of relevant meetings (eg. CCM, HSCC)	Yes -- HSRG minutes —initial proposal approval HSRG minutes — resubmission approval EPI sub-TWG	5a 5b 5c
For requests to GAVI: cMYP	Yes	3a (cMYP Report) 3b (Forecasting Tool)

		3c (Costing Tool)
Recommended		
National women's health or gender and health strategy (if it exists) OR National gender or women's equality/development policy or strategy	N/a	N/a
Reports/studies related to equitable access to health care	N/a	N/a
Other relevant supporting documents (for e.g. MTEF, disease strategy documents including recent implementation review reports, technical assistance plans)	Yes In-depth Surveillance Review report Response to the IRC Comments	 6 7
Aide Memoire signed between Government of Malawi and GAVI	Yes	8
Signatures (scanned copy)	Yes	9
Budget	Yes	10
Logframe	Yes	11
Resource Mapping	Yes	12

Annex – Additional Global Fund Information about the Indicative Year

For the Global Fund, in cases where the remaining timeframe of the national strategy is less than five years (as measured from the expected time of grant signing), the Global Fund will accept HSS requests for funding for the remaining duration of the national strategy plus a maximum of 12 months of additional funding based on an indicative budget and description of the program – on condition that the total funding request does not exceed five years.

Applicants are reminded that the additional request will be reviewed by the Technical Review Panel as part and in the context of the HSS request, which is based on the national strategy. The additional 12 months of funding request will also have to comply with the Guidelines for Budgeting in Global Fund grants.[18] The (maximum) 12 months of additional funding is a special provision intended to allow the timing of a new HSS funding request (based on the next national strategy) to be fully aligned with the country's national strategy cycle and to reduce the possibility of a funding gap during the steps needed to apply for funding of the next strategy. Applicants may optionally take advantage of this provision to request funding for up to 12 months beyond the end of the underlying national strategy or, alternatively, they may limit their funding request to the duration of the national strategy.

If using this provision, applicants are reminded that the additional period of funding should be reflected throughout all HSS request documents, including:

- The request template
- Budget: If the country submits a budget in their own format, an extra sheet covering the additional months of funding needs to be inserted with the same level of detail as the main part of the budget; if the Global Fund template is used, details need to be provided for the entire duration including the strategy duration plus the additional months.
- Work plan: If the country submits a work plan in their own format, an extra sheet covering the additional months of funding needs to be inserted with the same level of detail as the main part of the work plan; if the Global Fund template is used, details need to be provided for the entire duration including the strategy duration plus the additional months.
- Log frame: This should cover the strategy duration and additional months.
- M&E plan (or Performance Framework Template): If the national M&E plan is submitted, an extra sheet covering the targets for the additional months needs to be inserted with the same level of detail as the main part of the M&E plan. If the Performance Framework template is used, details need to be provided for the entire duration of the request (i.e. the strategy duration plus the additional months).

[18] Guidelines for Budgeting in Global Fund grants