Application Form for Country Proposals

Providing approximately two years of support for an HPV Demonstration Programme

Submitted by
The Government of Malawi

Date of submission: 31 October 2012

Deadline for submission: 31 October 2012

Please submit the Proposal using the form provided.

Enquiries to: proposals@gavialliance.org or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public. The Proposal and attachments must be submitted in English, French, Spanish, or Russian.

Note: Please ensure that the application has been received by the GAVI Secretariat on or before the day of the deadline.

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

Countries will be expected to sign and agree to the following GAVI Alliance terms and conditions in the application forms, which may also be included in a grant agreement to be agreed upon between GAVI and the country:

FUNDING USED SOLELY FOR APPROVED PROGRAMMES
The applicant country ("Country") confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THIS PROPOSAL
The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

RETURN OF FUNDS
The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION
The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION
The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS
The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY
The Country and the signatories for the government confirm that this application is accurate and correct and forms a legally binding obligation on the Country, under the Country's law, to perform the programmes described in this application.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in this application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in this application.

USE OF COMMERCIAL BANK ACCOUNTS

The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants. The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

1. Application Specification

Q1. Please specify for which type of GAVI support you would like to apply to.

Preferred vaccine (bilavent (GSK) or quadrivalent (Merck)) See *below* for more information	Month and year of first vaccination	Preferred second presentation[1]
Quadrivalent	September 2013	

For more information on vaccines:
http://www.who.int/immunization_standards/vaccine_quality/PQ_vaccine_list_en/en/index.html

[1] This "**Preferred second presentation**" will be used in case there is no supply available for the preferred presentation of the selected vaccine ("**Vaccine**" column). If left blank, it will be assumed that the country will prefer waiting until the selected vaccine becomes available.

2. Executive Summary

Q2. Please summarize the country's HPV Demonstration Programme plan.

Cancer is a leading cause of morbidity and mortality worldwide. In 2008, globally, there were 12.7 million new cancer cases and 7.6 million cancer deaths (around 13% of all deaths) with 56% of the new cases and 63% of the cancer deaths occurring in developing countries (WHO, 2007). According to Msyamboza et al (2012) of the 10,541 new cancer cases among females registered in Malawi between 2007 and 2010, cancer of the cervix was the commonest accounting for 45.4% of all cases followed by Kaposi sarcoma (21.1%), cancer of the oesophagus (8.2%), breast (4.6%) and others.[1]

Cervical cancer is the most frequent cancer among women in Malawi, and the 2nd most frequent cancer among women between 15 and 44 years of age.[2] According to WHO, Malawi has a population of 3.72 million women ages 15 years and older who are at risk of developing cervical cancer. Current estimates indicate that every year 2316 women are diagnosed with cervical cancer and 1621 die from the disease. Human papilloma virus (HPV) is a very common infection among the productive age groups and is greatly associated with cervical cancer. Data is not yet available on the HPV burden in the general population of Malawi. However, in Eastern Africa, the region Malawi belongs to, about 33.6% of women in the general population are estimated to harbour cervical HPV infection at a given time.

As a result of this burden, the country has developed a cervical cancer prevention and treatment strategy based on using a single visit approach with screening through Visual inspection with Acetic Acid and treatment/management through cryo-therapy and/or referral. However, one of the very important strategies for dealing with cervical cancer is through an early intervention with HPV vaccine. This vaccine is available on the global market and licensed for adolescent girls age 9-13. However, they are not normally targeted in routine immunisation. Therefore new strategies for effectively delivering the vaccine to this age group are warranted and need to be tested out before they are applied nationally.

[1] Msyamboza et al. "Burden of cancer in Malawi; common types, incidence and trends: National population-based cancer registry" BMC Research Notes 2012, 5:149. http://www.biomedcentral.com/1756-0500/5/149

[2] Ibid.

In view of this, the government of Malawi is submitting an application to GAVI to vaccinate a total of 10,931 girls in the districts of Zomba and Rumphi each year, based on current population projections held by the National Statistics Office. Preparations will begin in March 2013 for delivery of the first dose in September 2013. The demonstration programme aims at achieving coverage of 60% of the third dose of HPV vaccine among girls in the targeted year, through mainly a school delivery strategy where girls in Standard 4 will be targeted. Outreach targeting girls out of school who are aged 10 will also be conducted in cooperation with community stakeholders. During the second year, the HPV vaccine will be delivered along with a selected priority health intervention to adolescents of the same age group.

The country will draw on its experience with successful introductions of pentavalent vaccine in 2002, pneumococcal vaccine in 2011, and rotavirus vaccine in 2012. Existing cold chain capacity will be utilised and health workers, community leaders, community health volunteers, teachers, parents, and girls themselves will be reached with training and sensitization materials. The Ministry of Health will be the key implementer assisted by key development partners such as WHO, UNICEF, USAID, and CDC. Activities of the implementation will be guided by the National Taskforce on HPV Introduction, which serves as the Technical Advisory Group and is composed of members from the Ministry of Health Reproductive Health Unit, Expanded Programme on Immunisation, and Non-Communicable Diseases Unit as well as Ministry of Education, other relevant line ministries at national and district level, and key stakeholders.

After the first year of the demonstration project, the project will be evaluated with regard to coverage achieved, acceptability of the vaccine, feasibility and cost of delivering the vaccine as a national program. Additionally, the demonstration programme will determine the feasibility and effectiveness of delivering associated adolescent health interventions in conjunction with the HPV vaccination campaigns. This data will inform the national plan and proposal to GAVI for national introduction of the HPV vaccine in 2015, in line with national health strategies. It will also contribute to a revision of the national Cervical Cancer Control strategy to incorporate immunisation of girls age 9-13.

3. Immunisation Programme Data

Q3. Please provide national coverage estimates for DTP3 for the two most recent years from the WHO/UNICEF Joint Reporting Form in the table below. If other national surveys of DPT3 coverage have been conducted, these can also be provided in the table below.

Trends of national DTP3 coverage (percentage)				
Vaccine	**Reported***		**Survey****	
	2011	**2010**	**2011**	**2010**
DTP 3	**98%**	**102%**	**N/A**	**93%**

*Source: Reported: WHO/UNICEF JRF 2011

**Source: Survey: 2010 Malawi Demographic and Health Survey (2010 MDHS)

Q4. If survey data is included in the table above, please indicate the years the surveys were conducted, the full title, and if available the age groups the data refer to.

The survey data is extracted from the 2010 Malawi Demographic and Health Survey (2010 MDHS), National Statistical Office (NSO) and ICF Macro. 2011. 93% coverage of DPT3 refers to the percentage of children age 12-23 months who received pentavalent vaccine 3rd dose at any time before the survey.

Note: The IRC may review previous applications to GAVI for a general understanding of country's capacities and challenges.

4. HPV Demonstration Programme Plan

4.1 District(s) profile

Q5. Please describe which district or districts have been selected for the HPV Demonstration Programme, completing all components listed in the table below.

Component	District 1 Zomba	District 2 Rumphi
Topography (% urban, % semi-urban, % rural, % remote, etc.)	13% City, 87% rural Data source National Statistics Office (NSO) 2008	10% City, 90% rural Data source NSO 2008
Number and type of administrative subunits, e.g., counties, towns, wards, villages	14 wards (City), 7 Traditional Authorities (TA) (Rural) Data source NSO 2008	3 TAs, 6 Sub Chiefs and Rumphi, 1 Boma, 1 Game Reserve, 1 National Park; Data source NSO 2008
Total population	88,314 city, 579,638 rural, 667,952 total Data source NSO 2008	172,034 total Data source NSO 2008
Total female population (%)	49.4% city, 52.3% rural Data source NSO 2008	51% total Data source NSO 2008
Total female population aged 9-13 years (% of total female population)	43,389 (12.5% of total female population) Data source NSO 2008	11,265 (12.9% of total female population) Data source NSO 2008
Number and type of public health facilities	3 Hospitals 13 Health centres 6 Dispensaries Data source HMIS 2012	4 hospitals 8 health centres Data source HMIS 2012
Number and type of health workers in all district public health facilities	101 Nurses 658 Health Surveillance Assistants (HSAs) 21 Environmental Health Officers (EHOs) and Assistant Environmental Health Officers (AEHOs) 30 Clinical Officers / Medical Assistants Data source HMIS 2012	51 Nurse/Midwife 25 HSAs 13 EHOs and AEHOs 37 Clinical Officers / Medical Assistants 2 Medical Doctors Data source HMIS 2012
Number and type of private health facilities	2 Hospitals-Christian Health Association of Malawi (CHAM) 8 Health centres-CHAM 3 Dispensaries-CHAM 10 Private Dispensaries Data source HMIS 2012	6 CHAM 7 Private for profit Data source HMIS 2012
Number and type of health workers in private health facilities in the district	86 Nurses 6 Clinical Officers 7 EHO/AEHO Data source HMIS 2012	34 Nurse/Midwife 30 HSAs 20 Clinical Officers 2 Medical doctors Data source HMIS 2012
Number and type of public	Primary schools: 196 rural, 21	Primary schools: 174 total

and private primary and secondary schools	urban, 217 total Secondary schools: 26 rural, 21 urban Southeast region: 37% of primary and 48% of secondary schools run by government Data source EMIS 2011	Secondary schools: 39 total Northern region: 35% of primary and 77% of secondary schools run by government Data source EMIS 2011
Number of teachers in public and private primary and secondary schools	Primary teachers: 2,140 rural, 527 urban Secondary teachers: 299 rural, 410 urban Southeast region: 33% of primary and 52% of secondary teachers in government-run schools Data source EMIS 2011	Primary teachers: 1,134 Secondary teachers: 298 Northern region: 34% of primary and 70% of secondary teachers in government-run schools Data source EMIS 2011
Estimates of the number and percent of girls attending school for each of the following ages:* **9 year old girls** **10 year old girls** **11 year old girls** **12 year old girls** **13 year old girls**	9 year old girls: 6,934 (80%) 10 year old girls: 6,934 (80%) 11 year old girls: 6,934 (80%) 12 year old girls: 6,934 (80%) 13 year old girls: 6,934 (80%) Data source NSO 2008	9 year old girls: 1,858 (82%) 10 year old girls: 1,858 (82%) 11 year old girls: 1,858 (82%) 12 year old girls: 1,858 (82%) 13 year old girls: 1,858 (82%) Data source NSO 2008
Estimates of the number and percent of girls out of school for each of the following ages:* **9 year old girls** **10 year old girls** **11 year old girls** **12 year old girls** **13 year old girls**	9 year old girls: 1,744 (20%) 10 year old girls: 1,744 (20%) 11 year old girls: 1,744 (20%) 12 year old girls: 1,744 (20%) 13 year old girls: 1,744 (20%) Data source NSO 2008	9 year old girls: 395 (18%) 10 year old girls: 395 (18%) 11 year old girls: 395 (18%) 12 year old girls: 395 (18%) 13 year old girls: 395 (18%) Data source NSO 2008

*Malawi census data reports school enrolment status for 9-13 year old girls as a group, by district. It is likely that a higher proportion of girls are enrolled at age 9 than at age 13, due to drop out by year. It is also likely that the proportion of girls enrolled has increased since 2008, due to overall increasing enrolment in Malawi primary schools.

Q6. Please give a brief description of why this district (or districts) was (were) selected to participate in the HPV Demonstration Programme.

The districts were selected during the first HPV stakeholders' meeting on August 31, 2012 (minutes are included as Attachment 1). The diverse group decided to include two districts for the pilot to represent the different situations in different parts of the country, and to ensure results that are generalizable to most parts of the country. The group discussed criteria including:

- Identifying a district with a large urban population (Zomba)
- Including a district with a predominantly rural population (Rumphi)
- Including a district from the North region (Rumphi) to represent that region's unique geography and cultural makeup
- Including a district from South or Central region (Zomba) to represent both as these regions share many similarities
- Identifying districts with populations that are close to an average size, not too large or too small, without unique challenges to the EPI programme
- Avoiding districts with large populations of people crossing the country's border to access health services (i.e. some districts bordering Mozambique and Tanzania)

- Avoiding districts with relatively excellent EPI performance or relatively poor EPI performance.

Other criteria that were discussed, but that did not influence the final decision included:

- Political considerations around the home districts of the President and her husband or based on political party affiliations.
- Existence of research infrastructure for follow-on evaluations.

In both instances, it was agreed that the decision should be made without regard to these criteria.

Q7. Please describe the operations of the EPI programme in the district(s) selected for the HPV Demonstration Programme.

Component	District 1 Zomba	District 2 Rumphi
Number and type of administrative subunits (e.g. health facilities) used for routine vaccine delivery	34 facilities	24 facilities
Number and type of outreach sessions in a typical month used for routine vaccine delivery	# static sessions: 492 # outreach sessions: 202	# static sessions: 77 # outreach sessions: 145
DPT3 coverage*	111 %; year 2011	108%; year 2011
Polio3 coverage *	104%; year 2011	108%; year 2011
Measles first dose coverage*	117 %; year 2011	104%; year 2011
Pentavalent 3 coverage*	111 %; year 2011	108%; year 2011
TT2+ (pregnant women)*	99 %; year 2011	71%; year 2011

*Source of coverage data: EPI Routine Administrative data 2011. Please note that these performance levels are in the middle of the range of coverage among different districts in Malawi.

Q8. Please summarize the performance of the district EPI programme as reported in any recent evaluation, for example identifying resources available, management, successes, and challenges.

Supportive Supervision was conducted for EPI for all 28 districts in June 2012. 3 facilities were visited in each district, including the district hospital and 2 facilities that were less frequently visited. The supervision found overall good vaccine and waste management practices in line with the national EPI program standards and high rates of completion of scheduled clinics of 97% among visited facilities. The key recommendations of the supportive supervision included:

- More effective use of data for decision-making at facility level, such as displaying immunization monitoring charts.
- Strengthen the cold chain by
    - Improve temperature monitoring at facilities and improved responses to cases when the temperature goes outside of the acceptable range.
    - Establishing maintenance systems, including replacement and repair for malfunctioning refrigerators.
- Improve supply chain management at national, regional, and district level by preparing timely forecasts to avoid stock-outs across product lines.

Some findings specific to Zomba district:

- One of the health facilities visited did not have any stocks of 3 different antigens.
- There was variable cold chain knowledge and practices by health workers in the facilities visited—although all vaccines inspected were in good condition, knowledge on the shake test and VVM interpretation was weak, and not all facilities conducted twice daily temperature monitoring.
- Supervision was conducted by the national EPI within the last quarter.

Some findings specific to Rumphi district:

- Strong understanding of EPI population calculations and overall good display of data at facility level.
- Variable cold chain knowledge and practices—all vaccines found in good condition and temperature monitoring conducted effectively, but knowledge on shake test and VVM interpretation at facility level was weak.
- Good stock management practices and only one facility had a stock out of one antigen.
- Strong completion rate of scheduled immunization sessions and low dropout rates (<10%).

In July 2012, a Post-Implementation Evaluation (PIE) was conducted to examine the introduction of pneumococcal vaccine in Malawi, where 6 districts were selected for visiting. Rumphi was one of the selected districts. Some of the relevant district-level findings of the PIE were as follows:

Strengths:

- All facilities waited for training before beginning to administer the new vaccine
- Consistent usage of auto-disable syringes and safety boxes across all levels.
- Broad community acceptance and awareness of the new vaccine.

Weaknesses:

- High levels of facility-level stock-outs of the new vaccine.
- Low levels of health worker understanding on AEFIs and zero reporting despite the existence of a standard form and system for reporting.
- Inconsistent sources of denominator data for coverage calculations, and prevalent coverage reporting over 100%.

Rumphi and other districts were recommended to:

- Prepare social mobilization materials and train health workers for social mobilization activities well in advance of the targeted launch date.
- Ensure effective ordering and responsiveness to stock outs at facilities.
- Plan for high uptake of the vaccine by clients in the first year of introduction
- Regularly conduct district supportive supervision to facilities, particularly facilities that are facing challenges.
- Ensure twice daily monitoring of all refrigerators at all facilities.

Q9a. Please describe any current or past linkages the district EPI programme has had with the primary and/or secondary schools in the district, e.g., going to schools for health education, delivery of vaccinations, outreaches, etc.

The district EPI programmes sometimes use schools as venues to host outreach Under-5 clinics, as an alternative to health posts where health infrastructure is inadequate, or to increase community level access. Schools have also been used in the recent past to deliver tetanus vaccines targeted at female adolescents and during child health campaigns to administer insecticide treated bed nets, Vitamin A, anti-bilharzia and anti-helminth medications. Finally, there is a well-established School Health and Nutrition program (SHN) that operates in schools across the country.

In 2010/2011, during the measles outbreak, both districts' EPI programmes organized measles vaccination campaigns in schools in the district to supplement the district overall campaign. In Zomba, all primary schools are visited by health workers routinely to give them educational talks on different topics like cholera, measles, malaria etc.

Q9b. Please indicate if gender aspects relating to introduction of HPV vaccine are addressed in the demonstration programme?

HPV vaccination will be targeted to school girls in standard 4, 89% of who are aged 9-13 years old, with a plurality who are aged 9. But both girls and boys in the same grade will be provided with health education on the HPV vaccine. In the second year, there will be integration with other feasible services based on the assessment outcomes, which will target both boys and girls according to their identified needs. Social mobilisation materials will also address issues that may be raised due to targeting vaccine recipients by gender.

Q9c. Please describe any recent evidence of socio-economic and/or gender barriers to the immunisation programme through studies or surveys?

Socio-economic determinants of completion of the immunization schedule for children aged 12 to 23 months identified in the 2010 Malawi Demographic and Health Survey (DHS) included

- Area of residence, with higher rates of completion occurring in rural areas (84%) vs urban (76%)] and the Northern region (84%) vs Central (78%)],
- Mother's education, with mothers with secondary school education (84%) vs mothers with no education (75%) and
- Wealth quintile, with 82% for children in the fifth wealth quintile vs 78% in the lowest wealth quintile.

A qualitative Knowledge, Attitudes and Practices (KAP) study was conducted in Malawi in 2012 to inform the launch of rotavirus vaccine (Attachment 2). The KAP study found overall high acceptance of the immunisation program and broad understanding of the importance of timely vaccination and complete courses of vaccines. Socio-economic barriers identified included that farmers, particularly tenant farmers, were often not able to take their children for vaccination during the rainy season, and impoverished parents who did not have appropriate clothes to wear were deterred from going to the clinic as well.

As noted by Bowie et al[3], religion is a significant factor in access to immunisation in Malawi. There are certain faith groups such as Zion and New Apostolic Faith who do not allow their children to receive vaccination. This leads to regular micro-epidemics especially of measles that typically start in these groups. Some studies done in Malawi have indicated that there are some fears of side effect of the vaccine being offered, religious sects that do not allow their children to be vaccinated and negative attitude of some of the health workers. In a WHO study (2009), barriers to immunisation included, communication and information gaps, family characteristics, parental attitudes and knowledge[4].

Gender of the child did not have any effect on immunization coverage in the DHS, a finding which was also supported by a study conducted by the Swiss Tropical Health Institute. In terms of gender factors affecting parents' ability to access services for their children, the KAP revealed that 98% of people bringing their children for immunisation were mothers of the children, and that men played a role primarily in providing money or permission for women to take their children to access health services**.**

4.2 Objective 1: HPV vaccine delivery strategy

Q10. Please describe the HPV vaccine delivery strategy selected (school-based, facility-based, outreach, mixed, other, etc.) and the rationale for its selection.

Note: If the application proposes to use school as a venue for HPV vaccine delivery the minimal proportion of girls of the target vaccination cohort or target grade that is enrolled in school must be 75% nationwide (not only in the selected district).

[3] Bowie et al. "Poverty, Access and Immunization in Malawi: a descriptive study" Malawi Medical Journal Vol 18, issue 1, 2006 http://www.medcol.mw/commhealth/publications/national%20research/bowie%20poverty%20epi%20mmj%2006.pdf

[4] WHO 2009 - Epidemiology of the Unimmunized Child; Findings from the Grey Literature

The selected strategy is school based where the primary target will be school going girls in standard 4. The rationale for this selection is that 74% of girls 9-13 in Malawi are currently attending school as of 2008 (NSO) and 89% of girls in this education level are between 9 and 13 years old (EMIS 2011). However, since enrolment in Malawi primary schools has been increasing more than the population growth rate in the last 5 years, it is likely that the percentage of girls in the population now enrolled is higher. We expect that with this approach, the majority of girls will be vaccinated at schools. School going girls who miss a dose on the day of vaccination in their school will be vaccinated during the mop up campaigns in the following month, and those who miss both opportunities for their dose will be directed to the nearest health facility to get their HPV doses. Non-school going girls of age 10 will be targeted through health facility monthly outreaches conducted in the same month as the school doses or will be recruited to receive the vaccine at a nearby health facility or through Youth Friendly Health Services.

In alignment with the Malawi school year, which starts in September, in Year 1 the schedule for conducting vaccinations will be as follows:

September 2013	Administer Dose 1
October 2013	Mop up sessions for Dose 1
November 2013	Administer Dose 2
December 2013	Mop up sessions for Dose 2
March 2014	Administer Dose 3
April 2014	Mop up sessions for Dose 3

Depending on lessons learned from the introduction, the Year 2 schedule is anticipated to be similar. Each facility will know the schools in their catchment areas and will create micro-plans for conducting outreach to ensure that all of the doses are delivered within the target month. Mop up sessions will provide opportunities to reach girls that missed previous doses and to target girls out of school.

All doses will be recorded in an updated woman's health passport that girls will receive free of charge and that will allow them to track HPV vaccination completion along with other important health information**.** Vaccination will be administered on a voluntary basis, with parents or children allowed to opt out of services if they prefer.

Q11. If schools are being used as a venue for HPV vaccine delivery, please state the percentage of girls in the target age group which are attending school in the district(s).

80% of girls age 9-13 in Zomba and 82% of girls age 9-13 in Rumphi are currently enrolled in school, according to data from the 2008 census. However, since enrolment in Malawi primary schools has been increasing more than the population growth rate in the last 5 years, it is likely that the percentage of girls in the population now enrolled is higher.

Q12. Please identify a single year of age (or single grade in school) target vaccination cohort within the target population of 9-13 year old girls. Describe the total number of girls included and the proportion of the adolescent (10-19 year old) and female (all ages) population they represent. Identify the data source for this information and state whether these data have been validated by other means.

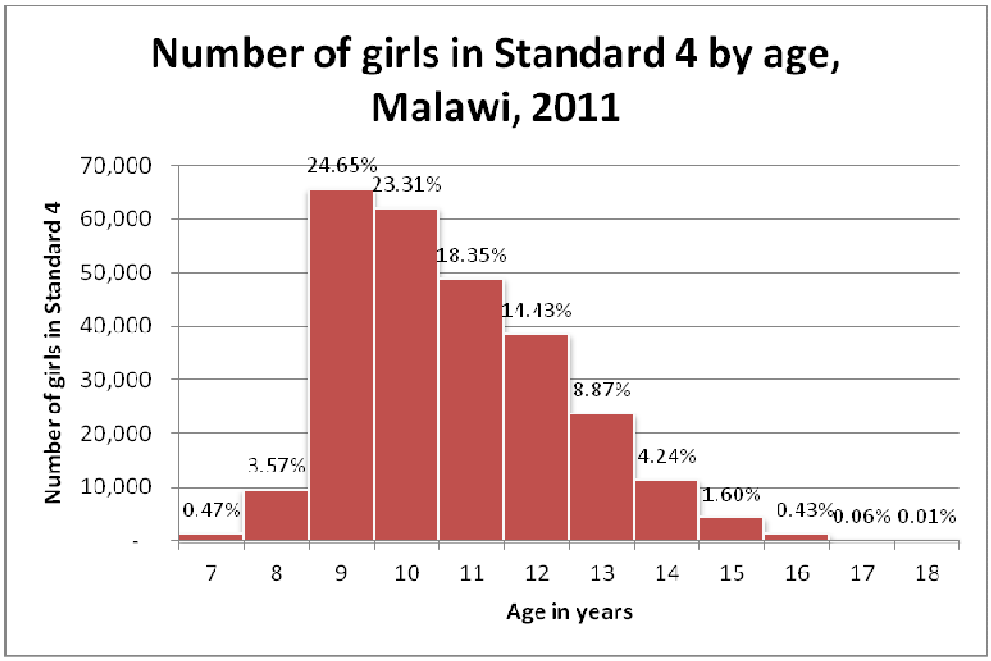
A single year cohort will be vaccinated which is girls in standard 4. For girls out of school, the target age is 10 year old girls. Despite this, however, during the immunisation process, tallying of the vaccinated girls will be done as per age of the girls, using the WHO tally sheets.

In the target districts, the total number of girls age 10 is 10,931 according to the 2008 census figures provided by the National Statistics Office. This represents approximately 12% of the population of girls age 10-19 and 2.5% of the total female population.

Q13. If the target population is a single grade in school, describe the percentage of girls in the target grade which are between the ages of 9 and 13 years and the data source.

Note: If the strategy selects eligible girls based on their grade in school, then at least 80% of the girls in the target age group should be between 9 and 13 years of age (the WHO recommended age group for HPV vaccine).

Based on 2011 Education Statistics from the Department of Education Planning in the Ministry of Education, Science and Technology (EMIS), 89.6% of girls enrolled in Standard 4 in Malawi are between the ages of 9 and 13, with nearly half aged 9 and 10.



The promotion rate for girls in Standard 4 in the two target districts is 75%, with a repetition rate of 16%. In the second year of vaccination during the demonstration programme, girls who have repeated Standard 4 will be screened out.

Q14. Please describe how eligible out-of-school girls will be identified and the mechanism for providing them an opportunity to receive HPV vaccine.

Malawi has a well-developed system of community based primary care interventions delivered by health surveillance assistants (HSAs). HSAs will identify, register and follow up the eligible non-school going girls, using village health registers where available. In addition, local village leaders and village health committees will assist in the identification of non-school going girls of the eligible age to be vaccinated during health facility outreach clinics, or supporting referrals to the nearest health facility for vaccination. Girls in school receiving the vaccinations will also be asked to refer their non-school going friends based in the community for the service. Youth friendly health services, where they exist, will also be leveraged to recruit girls age 10.

During the HPV demonstration project in Uganda, the age of out of school girls was very difficult to ascertain. In Malawi some historical events that took place 10 years ago will be used to estimate age of the non school going girls. In Year 1, the reference will be made to when the third president came to power.

Q15. Please describe the mechanism for reaching all the target girls with three doses who were missed on the main vaccination days, specifying plans for reaching hard-to-reach or marginalized girls.

We plan to vaccinate in a given school on a single day per dose. We however think that some girls may miss vaccination because they are not at school on the day of vaccination. We therefore planned for mop up sessions in the month immediately following the delivery of each dose in schools. At the same time, information will be given to teachers and community at large that girls who miss vaccination at schools will get their subsequent HPV vaccine dose from an outreach during mop up sessions at the school on a specific day in the following month or at their local health facility at any time. This information will also be included in the health worker training as well as through community sensitisation. All vaccinations will be recorded in the woman's health passport in order to verify vaccination status and to avoid administering more than 3 doses to any girl.

HSA's who work in the community will also be involved in following up any girls who may have been missed by working hand in hand with village leaders and village health committees in identifying the girls and referring them for vaccination. Where available, they will check in village registers for eligible girls within their community.

Q16. Please summarize ability to manage all the technical elements which are common to any new vaccine introduction, e.g. cold chain equipment and logistics, waste management, vehicles and transportation, adverse events following immunization (AEFIs), surveillance, and monitoring, noting past experience with new vaccine introductions (such as rotavirus, pneumococcal vaccine, or others).

The introduction of HPV in selected districts will be implemented smoothly based on past experiences on the introduction of new vaccines: DPT-HepB-Hib (2002), PCV13 (November, 2011) and rotavirus vaccine (October, 2012). The EPI also has ample experience with conducting vaccination outreaches both as part of routine immunization delivery and during Supplementary Immunization Activities. Logistically, the demonstration programme will be feasible to handle as the demonstration programme will be dealing with only two districts and with a small target population. All the necessary components required for the introduction of any new vaccine as mentioned above are in place and institutionalized, including waste management and logistics systems. Additionally, the EPI unit conducted a national Cold Chain Inventory in 2011 which provides facility-level data on cold chain capacity which can be used for planning and prepositioning of cold chain equipment. The new HPV vaccination outreaches should not interfere with delivery of routine immunizations through under-5 clinics at facilities and through outreach sessions.

As the supervision visits noted deficiencies in some cold chain management practices, refresher elements on temperature monitoring and other elements for ensuring consistent cold chain for the HPV vaccines will be incorporated into the training of health workers for HPV.

EPI monitoring tools will be reviewed and updated as part of the project roll out and health workers will be trained on the updated tools during the project training. Monitoring and Evaluation tools will also be updated for AEFIs prior to the introduction of HPV, and health workers will be informed of the HPV vaccine reportable events to be reported and managed or referred at the respective levels of the health system.

Q17. Please describe the cold chain status for the selected district and the data source(s) for this information. Information such as the number of cold storage facilities, function and working order of the facilities, storage capacity (and any excess capacity), distribution mechanism for routine delivery of vaccines, status of vaccine carriers and icepacks (e.g., supply shortages or excesses), and plan for HPV vaccine storage and distribution during the HPV Demonstration Programme.

In 2011, Malawi conducted a comprehensive inventory of all cold chain equipment in the country. The following data draws from the data collected at this time:

Component	District 1: Zomba	District 2: Rumphi

Number and type of cold storage facilities	41 facilities with cold storage	22 facilities with cold storage
Functioning and working order of the facilities	62 of 84 fridges working well (26% of fridges not working)	26 of 31 fridges working well (16% of fridges not working)
Storage capacity (any excess) HPV will be stored at +2 to +8 degrees Celsius. Assuming 1 dose vial of 10 vials/box whose storage volume is 15 cubic centimeters, the capacity should be enough at all levels.	4,338L of +2 to +8 total net internal storage volume (Per CCEM forecast tool, 39 facilities with >30% surplus positive storage space)	1,408L of +2 to +8 total net internal storage volume (Per CCEM forecast tool, 22 facilities with >30% surplus positive storage space)
Distribution mechanism **The distribution system is the same in all districts in the country. In exceptional cases, few facilities can collect vaccine at the district. Otherwise, districts are mandated to supply vaccine and other related supplies to health centres on monthly basis based on predicted consumption.**	5 facilities collect from DVS (12%). 36 facilities receive deliveries from DVS (88%).	16 facilities both collect or receive deliveries from DVS (73%). 4 collect from DVS (18%). 2 receive deliveries from DVS (9%).
Number and status of vaccine carriers **Vaccine carriers are adequate for routine immunization services in all districts. They may be inadequate in some facilities only during national immunization campaigns when more temporary vaccination sites are opened in order to reach more children in remote and populous urban areas.**	250 vaccine carriers and cold boxes working, 2 not working. 252 total.	109 working, 0 not working. 109 total.
Number and status of icepacks (any shortages or excess) **We have adequate number of ice packs although in some facilities, use of ice packs that are not in conformity with the vaccine carriers has been reported.**	46 x 0.3L icepacks 721 x 0.4L icepacks 270 x 0.6L icepacks 1,037 total icepacks	482 x 0.3L icepacks 92 x 0.4L icepacks 26 x 0.6L icepacks 600 total icepacks

Q18. Additional district cold chain information if necessary:

The Cold Chain Implementation Plan describes the need for replacement of equipment as well as distribution of the equipment to new health facilities. EPI will this year procure refrigerators for the health facilities using funding from a GAVI health systems strengthening grant. Two additional proposals have been submitted that will support additional cold chain procurements. In the HSFP proposal, procurement of additional cold chain equipment has been budgeted for 2013. A proposal to JICA also has a component of cold chain equipment. The introduction of HPV in those selected districts will NOT require any additional vaccine cold storage capacity.

4.3 Objective 1: HPV vaccine delivery training and community sensitisation & mobilisation plans

Q19. Please describe initial plans for training of health workers and others who will be involved in the HPV Demonstration Programme.

Malawi will draw on experiences with introduction of new vaccines to implement best practices in training and roll out. At the national level, a subcommittee of the National Taskforce on HPV Introduction will be identified who will develop training materials and a training plan. These new materials will utilize existing resources such as the EPI field guide, WHO templates and will also draw on training materials from other countries that have already introduced HPV vaccine. The training subcommittee will also be responsible for modifying the existing EPI tools for use in the pilot district only. Training on use of the new tools will be incorporated with the other training modules. Training topics for health workers will include:

- Cervical cancer epidemiology and its prevention
- Link between HPV and cervical cancer
- Role of vaccination in preventing cervical cancer
- Vaccine handling and management
- Record keeping and reporting
- AEFI reporting and management
- Vaccination tools and materials and how they are used.
- How to mobilise and sensitise communities
- Dealing with rumours

Training will be conducted using a two-step cascade. Members of the subcommittee who developed the materials will train district and zonal officers as trainers, including zonal EPI officers, district health officers, district EPI coordinators, primary education advisors, district school health focal points, and other relevant officers. These teams of trainers will then train health workers in the lower level health facilities. All of the health surveillance assistants, all of the nurses, and a selection of clinicians in the district will be trained to provide the vaccine, deliver health information about it, record doses administered, and conduct microplanning to achieve high coverage in the target population. The trained district staff and the health workers will then be responsible for conducting community sensitization and training of teachers in the district, with a focus on head teachers and the school health teacher in each school.

Q20. Please describe initial communication plans for sensitizing and mobilizing communities for the HPV Demonstration Programme.

The University of Malawi, College of Medicine has completed research on health systems readiness for HPV vaccination (supported by PATH), in which key information pertaining to communication and sensitisation strategies has been collected (Attachment 3). They have clearly defined the information gaps and issues that need to be handled before commencement of the HPV vaccination. These results will guide the communication and sensitisation strategy. The RHU and EPI will work with Health Education Unit at the Ministry of Health to finalise information, education and communication materials (IEC) that will be used to sensitise and mobilise the community for HPV vaccination. We also note that there is a pool of existing materials from other countries such as Uganda where they have done a demonstration project, and they already have generic materials that we shall adapt and make use of here in Malawi.

Based on the findings of the readiness study, sensitisation and mobilisation will include both electronic materials such as radio where applicable and newspapers, posters and flyers for girls, their teachers and their parents. Also meetings will be held to inform key opinion leaders and stakeholders in the community about the pilot e.g. chiefs, religious leaders, nongovernmental organisations.

A community-based communication strategy will target all of these groups to allay misgivings or misinformation prior to delivery of the first dose in the community. The KAP study conducted in advance of the launch of rotavirus vaccine indicated that health workers are the most trusted source of the information about health and immunizations (Attachment 2). During the training, the health workers will be sensitised on the IEC materials and asked to make use of them. Plans for community outreach sessions prior to vaccination delivery will be incorporated into the micro-planning by district, and local partners will be involved including CHAM, churches, and local NGOs as they can assist with mobilization through their existing structures.

Q21. Briefly describe any initial thinking about potential barriers or risks to community acceptance and the process or communication plan that might be used to address this. Consider briefly describing any positive leverage points that might be beneficial for programme implementation to promote acceptability.

The readiness study conducted by the College of Medicine and the Centre for Social Research, assessed Malawi's readiness for HPV vaccine introduction through a community survey (Attachment 3). The study identified a number of potential barriers, including most notably:

- Beliefs that HPV vaccination will promote sexual initiation and promiscuity amongst the vaccinated girls
- Questions why only girls in a select age range are to be vaccinated and why are boys not included in the vaccination programme
- Beliefs that HPV vaccination is a form of sterilisation for the girls
- Certain religious beliefs and practices

The same survey asked respondents to suggest solutions to the identified challenges. Their recommendation was that there should be adequate community awareness campaign using multiple media channels such as radio, TV, posters and print. Additional mass campaigns should also be run by the Health Education Unit using their well established structures from national level to the community level. More importantly there will be need to include campaign messages that target men and boys. We feel that as with any other new vaccine, there are sometimes negative rumours in the community, but the plan to mitigate them is to ensure effective communication about the vaccine. For example, the formative research has indicated the community might be concerned about fertility. Communication will therefore put a lot of emphasis in addressing this issue, and the other issues that were identified as potential misperceptions that could impact uptake.

Given that few districts will be participating in the demonstration project, the other potential barrier is that the demonstration programme might be confused with a vaccine trial. There might be questions from the selected districts asking why and how they were selected to participate in the demonstration project. We plan to sensitize the communities and policy makers about the entire HPV vaccine introduction process in Malawi, in that while these two districts will go first in introducing the vaccine, everyone will finally be reached with HPV vaccine when it is introduced nationally in the near future.

4.4 Objective 1: HPV vaccine delivery evaluation plan

Q22. Indicate the agency/person who will lead the evaluation required for the "Learn by Doing" objective.

The evaluation will be led by the Centre for Reproductive Health (CRH) based at the College of Medicine. The principal Investigator will be Dr Bagrey Ngwira, a clinical epidemiologist with extensive research experience in field based epidemiological studies as well vaccine trials. The Co-investigators will be Dr Frank Taulo, Director for the CRH and a Specialist Obstetrician with special interest in cervical cancer and Dr Alister Munthali, Associate Professor and Director of the Centre for Social Research at Chancellor College, University of Malawi with an interest in understanding determinants of public confidence in immunisations. This is the same team that has just completed a study on Assessment of Malawi's Health System in readiness for HPV vaccine introduction (Attachment 3). Technical support in conducting this evaluation will be sought from development partners such as PATH, UNICEF, MCHIP, CDC, WHO and the Clinton Health Access Initiative (CHAI) on an as-needed basis.

Program implementation oversight at national level will be provided through the EHP technical working group (TWG) sub-group for the Expanded Programme on Immunizations (EPI) and the Sexual and Reproductive Health sub-TWG. This task force may include Ministry of Health and Ministry of Education officials from the pilot districts and other relevant stakeholders as appropriate. The TWG will also have the overall responsibility to endorse the implementation plan and the adaptation of existing M and E tools to include indicators for HPV vaccination and monitoring of

vaccination related adverse effects. A task force will be established within the TWG to determine the feasibility of integration into routine service delivery which includes a needs assessment. In addition, information systems will be reviewed, revised and evaluated to monitor implementation including logistics, supply chain management and QC functions such as cold chain procedures.

Evaluations of coverage and access to adolescent health interventions will be conducted post-introduction. Programmatic assessments will be conducted with the guidance of task force members to monitor progress towards objectives. An evaluation of coverage will determine the mean age of the target group that actually received HPV vaccination and the coverage in specific populations. This will also guide the need for catch-up vaccination campaigns. The direct impact of the HPV vaccine introduction long term will require the development of a national surveillance system for HPV- associated cervical dysplasia. This will require the enumeration of sources currently conducting and reporting cervical cancer screening and the establishment of a national monitoring and evaluation system for these indicators. Ministry of Health will determine their capacity to conduct the specific assessments proposed or if there is need to out-source this activity.

4.5 Objective 2: Assessment of adolescent health interventions

Q23. Please summarize the anticipated activities for the assessment of adolescent health interventions, such as planning milestones, stakeholder meetings, methodology for the assessment, process for identifying a lead for this activity, and the process to involve the TAG in this work.

The Reproductive Health Unit in the Ministry of Health will identify priority interventions that could be packaged with HPV vaccination through consultations with stakeholders supporting adolescent health strategies. Attention will also be paid to health interventions in the Health Sector Strategic Plan 2012-2016, which identifies a list of priority health interventions to be addressed through an Essential Health Package (EHP) for Malawi. Opportunities for integration with HPV vaccination include combining HPV vaccination with the delivery of other EPI vaccines such as tetanus toxoid vaccine or other health interventions like youth friendly health services, nutrition, water and sanitation education, HIV counselling services, interventions on gender based violence, etc.

Once the intervention or interventions have been identified, the national task force will be responsible for identifying the lead to conduct the assessment of the adolescent health integration. The timeline will involve revision of the evaluation plan from June to July in 2014, data collection during the period of Year 2 implementation from September 2014 to March 2015, with the aim of providing the final report containing recommendations for the national scale up of the vaccine by June 2015.

4.6 Objective 3: Development or revision of cancer control or cervical cancer prevention and control strategy

Q24. Please summarize the planned activities for the development or revisions of a national cervical cancer prevention and control strategy, such as planning milestones, stakeholder meetings, methodology for developing the strategy, process for identifying a lead for this activity, and the process to involve the TAG in this work.

We plan to form a technical advisory committee that will develop and guide the implementation of a comprehensive prevention strategy. This committee will be composed of technical experts from immunisations, reproductive health, cancer control, and other professional bodies like the association of obstetrics and gynaecology, paediatricians, etc.

About 5 years ago, WHO implemented a study to assess the acceptability and feasibility of implementing a cervical cancer prevention program with “see and treat” approach based on VIA and cryotherapy, and Malawi was one of the countries selected to participate in this. Malawi subsequently developed a national cervical cancer control strategy based on this approach

(Attachment 4). The HPV demonstration project will therefore be an additional opportunity to strengthen the comprehensive cervical cancer prevention strategy in Malawi. It is also notable that the HPV vaccine has been included in the Malawi Health Sector Strategic Plan 2011-2016 (HSSP) (Attachment 5) for introduction in 2015, so it has already been incorporated into national strategy documents and planning.

Following the Year 1 evaluation, and depending on the results, MOH staff in the departments of Reproductive Health and Non-Communicable Diseases will propose revised text to the cervical cancer control strategy that incorporates HPV vaccination for 9-13 year old girls. These changes will be presented to and approved by the RHU sub-TWG, which will finalize the new strategy.

4.7 Technical advisory group

Q25. Please identify the membership and terms of reference for the multi-disciplinary technical advisory group established that will develop and guide implementation of the HPV Demonstration Programme and list the representatives (at least positions, and ideally names of individuals) and their agencies.

- **Countries are encouraged to use their ICC or a subset of the ICC as the multi-disciplinary TAG.**
- **The TAG must at least have representatives from the national EPI programme, cancer control, education, and the ICC (if separate from the ICC), and adolescent and/or school health (if they are represented within the Ministry of Health).**

In keeping with the nomenclature for working bodies in Malawi, the Technical Advisory Group for this activity will be referred to as the National Taskforce on HPV Vaccine Introduction (NTF). Please note that the make-up and function of the group is still as indicated in the proposal guidelines.

Enter the family name in capital letters.

Agency/Organisation	Name/Title	Area of Representation[1]
Ministry of Health, Noncommunicable Diseases (NCD)	Dr. Beatrice MWAGOMBA, Program Manager	Non-communicable disease
Ministry of Health, Health Education Unit (HEU)	Hector KAMKWAMBA, Principal Health Education Officer	Health communications
College of Medicine (COM)	Dr. Bagrey NGWIRA, Lecturer/Senior Research Fellow	Evaluation, Epidemiology, Vaccinology
Ministry of Education, School Health and Nutrition (SHN)	Charles MAZINGA, Deputy Director	School health
Ministry of Health, Reproductive Health Unit (RHU)	Twambilire PHIRI, Principle Reproductive Health Officer	Reproductive health
Ministry of Health, Expanded Programme on Immunisation (EPI)	Geoffrey CHIRWA, Deputy Programme Manager	Immunisation
Clinton Health Access Initiative (CHAI)	Emily CHURCHMAN, Vaccines Programme Manager	Cold chain logistics and programme planning
Maternal and Child Health Integrated Program (MCHIP)	Hannah HAUSI, Immunisation Technical Advisor	Immunisation
Centers for Disease Control and Prevention (CDC)	Dr. Alice MAIDA, Medical Officer	Non-communicable diseases, reproductive health, maternal, neonatal and child health

United Nations Children's Fund (UNICEF)	Grace MLAVA, Health Specialist	Reproductive and adolescent health
World Health Organization (WHO)	Dr. Kelias MSYAMBOZA, Disease Prevention and Control Officer	Non-communicable diseases
National Statistics Office (NSO)	Deric ZANERA, Chief Statistician	Population and demography

[1]Area of representation includes cancer control, noncommunicable disease, immunisation, adolescent health, school health, reproductive health, maternal or women's health, cervical cancer prevention, nursing association, physicians, health communications, midwives, civil society group, education, etc.

Q26. If known, please indicate who will act as the chair of the technical advisory group.

Enter the family name in capital letters.

	Name/Title	**Agency/Organisation**	**Area of Representation**
Chair of Technical Advisory Group	Dr. Beatrice MWAGOMBA, NCD Program Manager	Ministry of Health, NCD	Non-communicable Diseases

4.8 Project manager/coordinator

Q27. List the contact details, position, and agency of the person who has been designated to provide overall coordination for the day-to-day activities of the two-year HPV Demonstration Programme, taking note that a technical officer/lead/manager from EPI might be most suitable as a part of their current role and responsibilities.

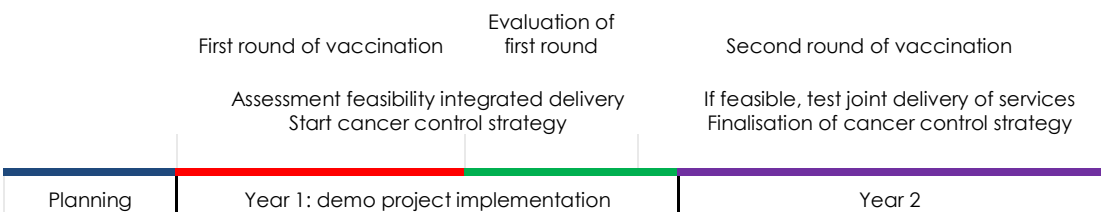
Enter family name in capital letters.

Name	Mr. Moussa VALLE	**Title**	Logistics Officer, EPI
Tel no	+265 999 935 457 or +265 1 725 637		
Fax no		**Agency**	EPI
Email	vallemjm@yahoo.co.uk	**Address**	EPI Unit Private Bag 30377 Lilongwe 3 Malawi

5. Timeline

The HPV Demonstration Programme will include immunization of the cohort of girls in two consecutive years (Figure I). Countries are required to begin vaccinating in the demonstration district within two years of the application.

Figure I. HPV Demonstration Programme timeline



Q28. Please modify as necessary and complete the timeline below for the main activities for HPV vaccination, assessment of adolescent health interventions, and development/revision of a national cervical cancer prevention and control strategy planned for the HPV Demonstration Programme. Applicants may want to complete this in MS Excel.

Please see Attachment 6 for the complete timeline.

6. Budget

Q29. Please provide a draft budget for year 1 and year 2, identifying activities to be funded with GAVI's programmatic grant as well as costs to be covered by the country and/or other partner's resources.

Note: If there are multiple funding sources for a specific cost category, each source must be identified and their contribution distinguished in the budget.

Cost category	Funding source	Estimated costs per annum in US$	
		Year 1	Year 2
TAG meetings	GAVI	525	263
Programme management and coordination	MOH	17,000	8,000
Cold chain equipment	GAVI		-
Other capital equipment (describe)	GAVI	-	-
Personnel, including salary supplements and/or per diems	GAVI	10,552	10,552
	Partners	24,000	24,000
Transport	GAVI	8,060	8,060
Training	GAVI	4,443	1,443
	Partners	6,000	9,000
Community sensitization and mobilization	GAVI	2,323	1,130
	Partners	7,000	3,000
Waste disposal	GAVI		
AEFI monitoring	GAVI		
Monitoring and supportive supervision	GAVI	9,450	4,725
Evaluation of vaccine delivery	GAVI	93,000	
Assessment of feasibility of integrating ADH with HPV vaccines	GAVI		25,000
Drafting national cervical cancer prevention and control strategy	GAVI	2,000	
Technical assistance from local experts	Partners (In kind)	15,000	15,000
Subtotal for which GAVI funds are being requested		**136,352**	**60,172**
Subtotal from other funding sources		**63,000**	**50,000**
TOTAL		**199,352**	**110,172**

Assumptions and Narrative:

Programme management and coordination: Including staff time, administrative supplies, fuel for supervision, vehicle maintenance costs, and communication costs. These costs will be covered from Ministry of Health budgets.
Personnel, including salary supplements and/or per diems: 3,750MK (US$12.93) per day for vaccinators, supervisors, drivers, and support staff for three campaigns per year, including initial rounds and mop up rounds. Also including allowances during data analysis workshops. Funding will be sourced from partners to support these costs in part each year.
Transport: Costs for distribution of vaccines to facilities ahead of the campaigns, as well as transport costs during the campaigns.
Training: Rounds of training of all relevant health workers in Year 1 and Year 2 in advance of the campaigns. Year 1 costs also include costs of developing and printing training guides. Funding will be sourced from partners to support these costs in part each year.
Community sensitization and mobilization: Rounds of social mobilization prior to vaccine introduction and prior to each round of immunization. Year 1 costs also include development of social mobilization materials. Partners will contribute to the costs of materials development and production.
Monitoring and supportive supervision: Supporting rounds of national level supervision of the demonstration districts.
Evaluation of vaccine delivery and assessment of feasibility of integrating ADH with HPV vaccines: Estimated costs to the Ministry of conducting these reviews. In Year 1, the designated amount will support the Centre for Reproductive Health (CRH) based at the College of Medicine to conduct the coverage survey. In year 2, the funds will go to an agent to be determined for the ADH feasibility assessment and year 2 coverage assessment.
Drafting national cervical cancer prevention and control strategy: Costs of updating the cervical cancer control strategy in Year 1.
Technical assistance from local experts: In both rounds, partners will provide in-kind technical assistance, possibly to include cold chain forecasting, materials development, assistance with program design and coordination, literature searches, etc.

7. Procurement of HPV vaccine

HPV vaccines must be procured through UNICEF. Auto-disable syringes and disposal boxes will be provided.

Q30. Using the estimated total for the target population in the district and adding a 25% buffer stock contingency, please describe the estimated supplies needed for HPV vaccine delivery in each year in the table below.

Required supply item	Number required per year	Year 1	Year 2
Number of vaccine doses	36,072	$ 180,361.50	$ 180,361.50
Number of AD syringes	36,400	$ 2,293.21	$ 2,293.21
Number of disposable safety boxes	328	$ 308.25	$ 308.25
TOTAL		**$ 182,962.97**	**$ 182,962.97**

Quantification Assumptions:
Target population: 10,931 girls
Number of doses per girl: 3
Vaccine buffer: 10% (per updated guidance from WHO)
AD Syringe buffer: 11% (per guidance from EPI)
Safety boxes calculation: 1 box/100 syringes (per guidance from EPI)
Safety boxes buffer: 11% (per guidance from EPI)

Cost Assumptions

Vaccine: US$5.00 (per GAVI HPV Demonstration Programme Application Guidelines)
AD Syringes: US$0.063 per unit including freight cost (per guidance from EPI)
Safety boxes: US$0.94 including freight cost (per guidance from EPI)

Q31. Please indicate how funds for operational costs requested in your budget in section 6 should be transferred by the GAVI Alliance (if applicable).

All financial transactions will be guided by the Aide Memoire Governing the Financial Management of GAVI Health Systems Strengthening (HSS) and Immunisation Services Support (ISS) Cash Grants in Malawi (Attachment 7). Per this document:

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1. The GAVI Alliance Secretariat will, when this Aide Memoire has been signed, disburse the next tranche of GoM's HSS and ISS grants to the following accounts:

Bank Name:	Reserve Bank of Malawi
Bank Address:	Lilongwe 3, Malawi
Account Holder:	Ministry of Finance
Account No:	300616-2087-01
Swift Code:	RBMA MW MW
Corresponding Bank Name:	CITIBank N.A. New York, USA
Swift Code:	CITIUS33

2. The disbursement of any further instalment shall be subject to the GoM demonstrating that it has complied with all of the measures detailed in this Aide Memoire and the submission of Annual Progress Reports acceptable to the Independent Review Committee of the GAVI Alliance.

8. Financial Management Arrangements Data Sheet

<table>
<tr><th colspan="2">Information to be provided by the recipient organization/country</th></tr>
<tr><td>1. Name and contact information of the recipient organization(s)</td><td>Ministry of Health, Malawi</td></tr>
<tr><td>2. Experiences of the recipient organization with GAVI, World Bank, WHO, UNICEF, GFATM or other donors-financed operations (e.g. receipt of previous grants)</td><td>Yes or No?

Yes

If YES, please state the name of the grant, years and grant amount:

<u>GAVI</u>

<table>
<tr><th>Name of grant</th><th>Years</th><th>Grant amount</th></tr>
<tr><td>Pentavalent Vaccine Introduction</td><td>2002</td><td>$100,000</td></tr>
<tr><td>Injection Safety Grant</td><td>2005-2009</td><td>$722,509</td></tr>
<tr><td>GAVI Routine New Vaccines Support (pentavalent, pneumococcal, rotavirus)</td><td>2002 - 2012</td><td>$99,100,219</td></tr>
<tr><td>GAVI Immunisation Services Support,</td><td>2006 - 2010</td><td>$1,986,000</td></tr>
<tr><td>PCV Introduction Grant</td><td>2011</td><td>$223,000</td></tr>
<tr><td>Rota Introduction Grant</td><td>2012</td><td>$611,500</td></tr>
</table>
</td></tr>
</table>

Health Systems Strengthening	2008 – 2012	$11,343,000

The Ministry of Health of Malawi has also received funds from the GFATM, CDC, USAID, UNICEF, JICA, FICA, and many other donors.

and provide the following:

For completed Grants:

- What are the main conclusions with regard to use of funds?

EPI has submitted APR and received additional funding as a result, through satisfactory finalization of the reports. An external audit conducted in 2008 by GAVI found satisfactory financial management.

For on-going Grants:

- Most recent financial management (FM) and procurement performance rating?

- Financial management (FM) and procurement implementation issues?

As part of the Sector Wide Approach, an independent audit is commissioned each year to assess the results and state of affairs of the MOH's accounts. The most recent audit covered the fiscal year ending in June 2011 and the findings were as follows:

Audit opinion

In our opinion:-

a) The consolidated statement of cash receipts and payments fairly reflects in all material respects, the transactions of the Ministry of Health – Sector Wide Approach (SWAp) programme for the year ended 30 June 2011 and of the results of the operations for the year then ended and is in accordance with International Public Sector Accounting Standard ("IPSAS") Financial Reporting under the Cash Basis of Accounting and comply with the provisions of the Public Finance Management Act.

b) Government funds have been provided and used in accordance with the provisions of Malawi Government rules and procedures and Memorandum of Understanding, with due attention to economy and efficiency and only for the purposes for which they were provided;

c) Donor (pooled and discrete) funds have been used in accordance with the conditions of the financing agreement and Memorandum of Understanding between the Ministry and development partners, with due attention to economy and efficiency and only for the purposes for which the financing was provided;

d) Goods and services have been procured in accordance with the Public Procurement Act (No 8 of 2003), and in accordance with the Memorandum of Understanding;

e) Necessary supporting documents, records and accounts have been kept in respect of Ministry's activities and in accordance with the Public Finance Management Act (2003). Clear linkages exist between the books of account and the Consolidated statement of cash receipts and payments presented to the donors;

3. Amount of the proposed GAVI HPV Demo grant (US Dollars)	US$196,542

4. Information about financial management (FM) arrangements for the GAVI HPV Demo Programme:	
• Will the GAVI Demo Programme resources be managed through the government standard expenditure procedures channel?	Yes. Per the Aide Memoire: The MoH shall enhance controls over programmes supported by GAVI cash grants with the following measures: • Copies of all MoH Internal Audit Unit reports on GAVI activities shall be forwarded to the Auditor General within three months of completion; • The MoH shall immediately institute a system for regular backups of all GAVI related data and have it stored in a separate and secured location; and • The MoH shall set up an asset register for GAVI funded assets. The details in the register shall 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. In addition to the conditions in the Aide Memoire, the Ministry of Health is currently undergoing a 2-year Financial Management Improvement Plan (FMIP), which goes from July 2011 to June 2013. Its purpose is to set out a plan of activity for the finance section of the MoH, Health Service Commission and Central Hospitals. It is guided by two key principles: first that it is better to devote time, effort and resources to getting existing systems, processes and practices working better (often there is a sound system in place but for various reasons, it is not working properly); and second that, the FMIP should represent another step on the way to developing a strong finance section in MoH that is self-reliant, with well-qualified committed staff and only occasional need for Technical Assistance. Regular updates on the status of this plan are compiled to monitor progress.
• Does the recipient organization have an FM or Operating Manual that describes the internal control system and FM operational procedures?	The Ministry of Health has an Operational Manual, which describes how resources are to be spent and measures that are to be followed to ensure that resources are utilized according to the stipulations in the award.
• What is the budgeting process?	To develop the annual MOH budget, a stakeholder meeting is called to identify key areas of intervention for specific departments and programmes. Following this meeting, departments develop their own workplans and budgets based on tentative ceilings developed by the Department of Planning and Policy Development. Then the Department of Planning communicates to the departments and programmes the final ceilings from the Treasury, so that they can do a final consolidation of their workplans. The workplans are then submitted for final consolidation across the departments and programmes. The final draft consolidated budget and workplan is presented to MOH management for approval. After approval, the full budget is submitted to Treasury. Treasury consolidates with other Ministry budgets and presents to Parliament. After Parliament approval, then Treasury prints the budget books that the various ministries can use for implementation of their workplans.
• What accounting system is used or will be used for the	Per the Aide Memoire:

GAVI HPV Demo Programme including whether it is a computerized accounting system or a manual accounting system?	**Accounting** Effective January 2011, all GAVI cash support grants to the GoM shall be administered through the Integrated Financial Management Information System (IFMIS) and accounted for in the Accountant General's accounts to Parliament.
• What is the staffing arrangement of the organization in accounting, auditing, and reporting? Does the implementing entity have a qualified accountant on its staff assigned to the GAVI HPV Demo Programme?	Yes, a specific finance officer has been assigned to GAVI grants who is a trained accountant.
• What is the bank arrangement? Provide details of the bank account at the Central Bank or at a commercial bank proposed to receive GAVI HPV funds and the list of authorized signatories. Include titles.	Bank Name: Reserve Bank of Malawi Bank Address: Lilongwe 3, Malawi Account Holder: Ministry of Finance Account No: 300616-2087-01 Swift Code: RBMA MW MW Corresponding Bank Name:CITIBank N.A. New York, USA Swift Code: CITIUS33 **Signatories:** 1. Mrs D.M. Banda - Accountant General 2. Mrs C.C. Banda - Assistant Accountant General 3. Mr. A. Kazombo Mwale - Director of Asset Management 4. Mrs Kauye - Principal Accountant
• In the implementation of the HPV Demonstration Programme, do you plan to transfer funds from central to decentralized levels (provinces, districts etc.)? If yes, how will this funds transfer be executed and controlled?	Yes, some of the funds will be transferred from the national MOH to the two implementing districts for the purposes of conducting the initial trainings as well as to support the outreach clinics. In collaboration with EPI, the District Health Officer (DHO) will create a budget for the activity and submit a request to MOH for the funds. The funds will be transferred to the DHO's office and all local disbursements will be handled by the DHO accountant. At t he end of the activity, funds will be liquidated with documentation by the DHO accountant to the MOH using a standard form.
• Does the implementing entity keep adequate records of financial transactions, including funds received and paid, and of the balances of funds held?	Yes, this is done through the Finance Department of the Ministry of Health. An officer has been assigned to keep records of all financial transactions as regards to funds received, paid, and funds held for GAVI grants.
• How often does the implementing entity produce interim financial reports?	Expenditure reports are produced on a monthly basis, and the full financial management report is shared on a quarterly basis.
• Are the annual financial statements audited by an external audit firm or Government audit institution (e.g. Auditor	Per the Aide Memoire: **Internal Audit** The MoH shall fill all the remaining vacant positions in the Internal Audit Unit within the MoH. Further, the terms of reference of the Internal Audit Unit shall be extended to

General Department…)?	include the audit of all GAVI related activities including procurement. Reports of all audit on GAVI related activities shall be forwarded to the GAVI Secretariat within six months of publishing the report and to the office of the Auditor General. **External audit** The MoH shall ensure that funds provided by GAVI are audited annually by independent external auditors and the audit report together with MoH response to the issues highlighted shall be submitted to the GAVI Alliance Secretariat within six months after the year end.
5. Information about procurement management arrangements for the GAVI HPV Demo Programme:	
• What procurement system is used or will be used for the GAVI HPV Demo Programme?	UNICEF SD will be utilized in line with all other EPI procurements.
• Does the recipient organization have a procurement plan or a procurement plan will be prepared for this HPV Demo Programme?	A procurement plan will be prepared. HPV vaccine has also been included in the annual product forecast submitted to UNICEF.
• Is there a functioning complaint mechanism?	Yes through the UNICEF country office.
• What is the staffing arrangement of the organization in procurement? Does the implementing entity have an experienced procurement specialist on its staff?	The Ministry has a Deputy Director for Procurement and a Chief Procurement Officer. As the Deputy Director position is currently vacant, the Chief Procurement Officer at the moment does the work of the Deputy Director. There is also a Principal Procurement Officer and at least five Procurement Officers. The Officers have undergone trainings in procurement and the majority have more than 10 years of experience.
• Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	UNICEF SD is responsible for quality assurance of vaccines and cold chain equipment prior to shipment. Once arrived in Malawi, currently the EPI conducts visual inspections of products received. There are plans for the Pharmacy Medicines and Poisons Board (PMPB) to develop a more thorough investigation of biologicals received and an external mission will be coming to Malawi to assess the PMPB Institutional Development Plan and setting up of regulatory systems in the next year.

9. Signatures

9.1 Government

The Government of Malawi acknowledges that this Programme is intended to assist the government to determine if and how it could implement HPV vaccine nationwide. If the Demonstration Programme finds HPV vaccination is feasible (i.e. greater than 50% coverage of targeted girls) and acceptable, GAVI will encourage and entertain a national application during the second year of the Programme. Application forms and guidelines for national applications are available at www.gavialliance.org. The data from the Demonstration Programme and timing of a national application are intended to allow uninterrupted provision of vaccine in the demonstration district and nation-wide scale-up.

The Government of Malawi would like to expand the existing partnership with the GAVI Alliance for the improvement the health of adolescent girls in the country, and hereby requests for GAVI support for an HPV Demonstration Programme.

The Government of Malawi commits itself to improving immunisation services on a sustainable basis. The Government requests that the GAVI Alliance and its partners contribute financial and technical assistance to support immunisation of targeted adolescent girls with HPV vaccine as outlined in this application.

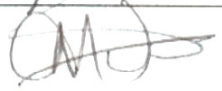
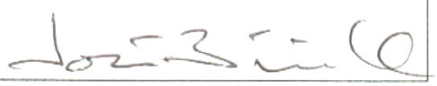
The Government of Malawi acknowledges that some activities anticipated in the demonstration programme could be considered research requiring approval by local ethics committees (e.g., collecting data from a random sample of parents of eligible girls for the HPV vaccine coverage survey). We acknowledge we are responsible for consulting and obtaining approval from appropriate local ethics committees (e.g., human subject protection committee or Institutional Review Boards) in our country, as required. By signing this application, the Government of Malawi and the TAG members acknowledge that such approval may be necessary and that it will obtain such approval as appropriate.

The table in Section 6 of this application shows the amount of support requested from the GAVI Alliance as well as the Government of Malawi's financial commitment for the HPV Demonstration Programme.

Please note that this application will not be reviewed by GAVI's Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Education or their delegated authority.

Q33. Please provide appropriate signatures below.

Enter family name in capital letters.

Minister of Health (or delegated authority)		**Minister of Education** (if social mobilization, vaccination or other activities will occur through schools) (or delegated authority)	
Name	Dr. Charles MWANSAMBO Principal Secretary for Health	Name	JOHN BISIKA Secretary for Education, Science and Technology
Date	31/10/12	Date	31/10/12
Signature		Signature	

Q34. This application has been compiled by:

Enter the family name in capital letters.

Full Name	Position	Telephone	Email
Dr. Beatrice MWAGOMBA	Program Manager, Ministry of Health, Noncommunicable Diseases (NCD)	+265 888 894 827	mwagombabeatrice@yahoo.com
Hector KAMKWAMBA	Principal Health Education Officer, Ministry of Health, Health Education Unit (HEU)	+265 881 334 004	hkamkwamba@yahoo.com
Dr. Bagrey NGWIRA	Lecturer/Senior Research Fellow, College of Medicine (COM)	+265 999 554 003	Bagrey.ngwira@lshtm.ac.uk
Charles MAZINGA	Deputy Director, Ministry of Education, School Health and Nutrition (SHN)	+265 888 347 760	charlesmazinga@yahoo.com
Twambilire PHIRI	Principle Reproductive Health Officer, Ministry of Health, Reproductive Health Unit (RHU)	+265 999 953 309	Twambilire2007@yahoo.co.uk
Geoffrey CHIRWA	Deputy Programme Manager, Ministry of Health, Expanded Programme on Immunisation (EPI)	+265 999 269 949	gzchirwa@yahoo.com
Emily CHURCHMAN	Vaccines Programme Manager, Clinton Health Access Initiative (CHAI)	+265 884 765 471	echurchman@clintonhealthaccess.org
Hannah HAUSI	Immunisation Technical Advisor, Maternal and Child Health Integrated Program (MCHIP)	+265 888 876 150	Hhausi2000@yahoo.co.uk
Dr. Alice MAIDA	Medical Officer, Centers for Disease Control and Prevention (CDC)	+265	amaida@mw.cdc.gov
Grace MLAVA	Health Specialist, United Nations Children's Fund (UNICEF)	+265 999 228 967	gfmlava@unicef.org
Dr. Kelias MSYAMBOZA	Disease Prevention and Control Officer, World Health Organization (WHO)	+265 888 301 305	msyambozak@mw.afro.who.int

Deric ZANERA	Chief Statistician, National Statistics Office (NSO)	+265 888 554 160	Dericzanera@gmail.com

9.2 National Coordinating Body – Inter-Agency Coordinating Committee (ICC) for Immunisation

Q35. We, the members of the Health Sector Review Group (HSRG) (HSCC equivalent in Malawi) met on October 30, 2012 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

We have also noted that the proposal has been reviewed through the sub-Technical Working Groups on EPI, SRH, and Reproductive Health Commodity Security and the MOH Senior Management Meeting, as well as by the Ministry of Education's Cross-cutting Technical Working Group.

The endorsed minutes of this meeting are attached as Attachment 8.

Enter the family name in capital letters.

Name/Title	Agency/Organisation	Signature
DR SAM PHIRI	LIGHTHOUSE	
Juwan CLAPHAM	DFID	
Wilfred Mumba	MEDICAL COUNCIL	
Trish Arara	MOH	
HSRG Members not in attendance, but endorsing the proposal:		
MARTIN MONDIWA	Nurse Council	
Mazuko Mafomba	HIREP Malawi	
Gift Kamanga	UNC project (representing Research Institutions)	

Q36. In case the GAVI Secretariat has queries on this submission, please contact:

Enter family name in capital letters.

Name	Mr. Moussa VALLE	**Title**	Logistics Officer, EPI
Tel no	+265 999 935 457 or +265 1 725 637		
Fax no		**Address**	EPI Unit Private Bag 30377 Lilongwe 3 Malawi
Email	vallemjm@yahoo.co.uk		

10. Optional supplementary information

Q37. (***Optional***) If available, countries may provide additional detail in the table below on training content, role, and framework.

Who will be trained	**Role in vaccine delivery** *(e.g., sensitization, mobilization, immunization, supervision, monitoring, etc.)*	**Training content** *(e.g., basics on cervical cancer, HPV, HPV vaccine, IEC messages, safe injections, AEFI monitoring, etc.)*	**Who will provide the training?**
Health workers	• Sensitizing communities • Delivering the HPV vaccine • Records keeping for vaccines and vaccinated girls • Ensure supply of all materials and tools for vaccination eg vaccine register, vaccination cards, tally sheets, etc. • Reporting AEFI • Dealing with rumours • Identification of eligible out of school girls using village health registers	• Cervical cancer epidemiology and its prevention • Link between HPV and cervical cancer • Role of vaccination in preventing cervical cancer • Vaccine handling and management • Record keeping and reporting • AEFI and their reporting and management • Vaccination tools and materials and how they are used. • How to mobilise and sensitise communities • Dealing with rumours	National level trainers District level trainers
Teachers	• Mobilising girls for vaccination • Registering eligible girls • Organising a vaccination site at school • Ensure orderliness at vaccination post • Reporting AEFI	• Cervical cancer and its prevention • Role of vaccination in preventing cacx Vaccination tools and materials	District trainers
School officials	• Ensuring the school is aware about the program	• Cervical cancer and its prevention • Role of vaccination in preventing cacx	Health workers
District leaders	• Mobilisation of communities	• Cervical cancer and its prevention • Role of vaccination in preventing cacx	National trainers
Community leaders	• Registering and	• Cervical cancer	Health

	following up out of school girls	and its prevention • Role of vaccination in preventing cacx	workers
Community volunteers	• Mobilisation and sensitisation of community	• Cervical cancer and its prevention • Role of vaccination in preventing cacx	Health workers
Parents	• Permission and support to their daughters to get vaccinated and complete all the 3 doses	• Cervical cancer and its prevention • Role of vaccination in preventing cacx	Health workers
Girls aged 9-13	• Choosing to receive vaccine	• Importance of getting vaccinated including completion of all the 3 doses	Teachers , parents and health workers

Q38. (***Optional***) If available, countries may provide additional detail in the table below on the types of information and/or materials that may be used/disseminated, to which audience, by which mechanism, and the frequency of each.

Types of information or materials *(e.g., leaflet, poster, banner, handbook, radio announcement, etc.)*	**Audience receiving material** *(girls, parents, teachers, health workers, district officials, community groups, etc.)*	**Method of delivery** *(e.g., parent meetings, radio, info session at school, house visit, etc.)*	**Who delivers** *(e.g., teachers, health workers, district official, etc.)*	**Frequency & Timing** *(e.g., daily, weekly, twice before programme starts, etc.; day of vaccination, two weeks before programme begins, etc.;)*
Leaflet	Girls, parents, teachers	Distribution to schools, youth clubs	teachers, girls, PTA members, parents	Day of vaccination
Poster	Girls, parents, teachers	Distribution to schools, youth clubs	teachers, girls, PTA members, parents	Once
Banners	Girls, boys parents, teachers, health workers, district officials, community members	Hoisted along main street in the targeted districts	Ministry officials	Once
Radio jingles	Girls, boys parents, teachers, health workers, district officials, community members	Electronic media In all radios, public, private , faith based, community radios	Comedians	Weekly for duration of the project
Letter to community	Girls, boys parents, teachers, health workers, district	Churches, prayer house , mosques	Through the District Commissioners Office	Twice a year

	officials, community members			
Campaign	Health workers , community based workers , volunteers	Face to face in the target districts		Once

Q39. (***Optional***) Technical partners (e.g. local WHO staff) are required to participate in planning and conducting the evaluation of HPV vaccine delivery. Please specify if such (an) expert(s) already exist on the country team (name, title, organization). Alternatively, or in addition, an international participant can be requested through technical partners if additional expertise is thought necessary.

Experts in evaluation are included in the Technical Advisory Group: Dr. Bagrey Ngwira of the College of Medicine and Dr. Kelias Msyamboza of WHO. Additional local expertise may be recruited from the Centre for Social Research, who were integral to the feasibility assessment. In addition, Dr. Emmanuel Mugisha of PATH has been involved in the demonstration programme application development and may also be available to assist as an international resource for evaluation.

Q40. (***Optional***) In the table below, countries can provide a brief summary of the current adolescent health services or interventions and health education activities and implementing agencies in the district selected to implement the HPV Demonstration Programme.

Please add additional tables if necessary.

	intervention	**intervention**	**intervention**	**intervention**
Description of intervention				
Agency and provider delivering the intervention				
Target population by age, grade, and sex				
Number and types of facilities implementing				
Geographic location(s) of the intervention (where in the country)				
Timing of the intervention (when)				
Frequency of the intervention (how often)				
Coverage of the target population (recent year)				
Coordinating agency				
Collaborating partners				
Implementation costs of the intervention, if known				
Funding source, if known				
Data source(s) for the information on each intervention				

Q41. (***Optional***) Provide a brief summary of the current cervical cancer prevention and treatment services and implementing agencies in the district selected to implement the HPV Demonstration Programme. If available, countries can include information on target populations, delivery structure, and funding sources.

Malawi adopted a strategy to introduce a national cervical cancer prevention (CECAP) program, using a single visit approach (SVA) with screening through Visual inspection with Acetic Acid (VIA) and treatment/management through cryo-therapy and/or referral. There are three CECAP strategies and these are:

- Strengthening awareness on reproductive cancers and service delivery.
- Strengthening human resources to provide cervical cancer services and
- Strengthening monitoring, evaluation and research.

Strengthening awareness is achieved through outreach and education with Information, Education and Communication (IEC) materials for the cervical cancer program and use of existing staff members in the health facilities to disseminate information about cervical cancer screening program.

Strengthening human resources to provide CECAP services through Visual Inspection using Acetic Acid (VIA) is offered by enrolled nurse midwives, registered nurse midwives and clinicians within family planning clinics as an integral service. Everyone who is providing FP and STI services is targeted for service provision with at least two (2) providers per facility. VIA/cryo-therapy is provided in the following facilities: Family planning clinics, sexually transmitted infections clinics, gynecologic clinics and ART clinics. Service provision follows a mixed service provision model where there are specific days dedicated to VIA/cryotherapy and some days where VIA/cryotherapy is provided concurrently with other services. Finally, Infection Prevention (IP) is a very important aspect of the VIA/cryotherapy program that is emphasized through an IP update included in the initial VIA/cryotherapy training and Supervision in IP.

There are gynecology clinics in all the central hospitals, where there is strong program support by the ob/gyns that form the backbone of referral services. Mechanism for client follow-up is through IEC stress on male involvement so that cryotherapy postponements are minimized. During a scheduled or problem visit, the provider checks in the client's health passport to verify if the client actually went to where she was referred and clients go back to the laboratory to get their results and bring them back to the gynecologist or provider in various districts. The training program and materials are well established by RHU/MoH in collaboration with the DHOs.

On the job skills supervision is done by RH coordinators once trained as VIA/cryotherapy supervisors. Most supplies are locally available and DHOs have a functional procurement system. Equipment and supplies are sourced locally and elsewhere they have been identified and distribution is done prior to initiating services.

Strengthening monitoring, evaluation and research is implemented through information management that is done through data collection in order to capture the key performance indicators which are as follows:

- Total number of providers trained in VIA and cryotherapy,
- Percentage of trained providers actively performing VIA and cryotherapy and
- Percentage of trained providers at target facilities who perform CCP services to standard.

In VIA-Based service the following statistics are collected;

- Total number of eligible women receiving VIA-based cervical cancer prevention services.
- Percentage of eligible women receiving VIA-based cervical cancer prevention services (coverage)
- Total number of women receiving VIA-based CCP services who are outside of the target age group (<30 and/or >45)
- Percentage of eligible women screened with VIA who test positive.

Similar data is collected on cryotherapy treatment, referral, and one year follow-up. Finally, the following data collection tools are used: logbook register, monthly summaries and quarterly reports and health passport books.

Q42. (*Optional*) Describe the plan for securing Ministry of Health approval of the draft national cervical cancer prevention and control strategy and any activities for dissemination to national, sub-national, and/or local partners and stakeholders.

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. 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 health sector strategies, including human resources, financing, monitoring and evaluation, procurement, and the essential health package, and many others.

Ministry of Health approval of the revised national cervical cancer control strategy will come from the Reproductive Health Unit sub-Technical Working Group (TWG), which falls under the Essential Health Package TWG. The RHU sub-TWG are the holders of the current strategy, and are mandated to assess technical proposals and strategies like this one**.**

Q43. (***Optional***) If known, please indicate the representatives of the TAG that will be involved in the assessment of the feasibility of integrating selected adolescent health interventions with delivery of HPV vaccine.

Enter the family name in capital letters.

	Name/Title	**Agency/Organisation**	**Area of Representation**
TAG member involved in assessment of ADH interventions	Ministry of Education, School Health and Nutrition (SHN), Deputy Director	Charles MAZINGA,	School health
TAG member involved in assessment of ADH interventions	College of Medicine, Lecturer/Senior Research Fellow	Dr. Bagrey NGWIRA	Evaluation, Epidemiology, Vaccinology
TAG member involved in assessment of ADH interventions	United Nations Children's Fund (UNICEF), Health Specialist	Grace MLAVA, Health Specialist	Reproductive and adolescent health
TAG member involved in assessment of ADH interventions	World Health Organization (WHO), Disease Prevention and Control Officer	Dr. Kelias MSYAMBOZA	Non-communicable diseases
TAG member involved in assessment of ADH interventions			

Q44. (***Optional***) If known, please indicate the representatives of the TAG that will be involved in the development or revision of a draft national cervical cancer prevention and control strategy.

Enter the family name in capital letters.

	Name/Title	**Agency/Organisation**	**Area of Representation**
TAG member involved in cervical cancer strategy	Ministry of Health, Reproductive Health Unit (RHU), Principle Reproductive Health Officer	Twambilire PHIRI	Reproductive health
TAG member involved in cervical cancer strategy	Ministry of Health, Noncommunicable Diseases (NCD), Program Manager	Dr. Beatrice MWAGOMBA	Noncommunicable disease
TAG member involved in cervical cancer strategy	United Nations Children's Fund (UNICEF), Health Specialist	Grace MLAVA	Reproductive and adolescent health
TAG member involved in cervical cancer strategy			

Q45. (***Optional***) If present, please describe the distribution of de-worming medication (anti-helminths) in the district(s).

Distribution of the de-worming medication is done every six months, organized by a national coordinating body in the Community Health Services Unit (CHSU).

Component	**District 1** Zomba	**District 2** Rumphi
Organization of the de-worming programme	Zomba DHO	Rumphi DHO
Lead agency	Zomba DHO	MOH, WHO and CHSU
Implementing agency and partners	Zomba DHO World Vision International City Assembly Millennium Villages Project Malawi Red Cross	Rumphi DHO Ministry of Education CHAM
Funding source(s)	MOH/DHO Other Recurrent Transactions (ORT)	MOH/DHO Other Recurrent Transactions (ORT)
Frequency and timing of implementation, e.g. twice yearly in March and October	The activity is done biannually and recently was done in July 2012	The activity is done biannually and recently was done in June 2012
Number in target population by age group and sex	School going children of both sexes	In general the target population was 57584 (Ref. District Education Office)
De-worming coverage by age group and sex	Coverage of school going children (both males and females) Albendazole 79% Praziquantel 68% July 2012 monitoring data	Coverage of school going children (both males and females) Albendazole 84%. Rumphi district hospital records

Q46. (***Optional***) If present and relevant, please describe any organized semi-annual health days (e.g., Child Health Days) that are currently implemented in the district(s).

Component	**District 1** Zomba	**District 2** Rumphi
Organization of the semi-annual health days	Health Surveillance assistant are trained and distribute the supplies to all under five children in their villages or	Child health days are done twice a year, particularly in May and November organised by Nutrition Unit of the MoH

	arranged clinics twice a year	
Lead agency	Zomba DHO	UNICEF (supplies drugs)
Implementing agency and partners	Zomba DHO CHAM City assembly World Vision International Malawi Red Cross Millennium Villages Project Emmanuel International Wala Project	MoH (at national level) Rumphi DHO CHAM World Vision International.
Funding source(s)	Zomba DHO	Currently, Rumphi DHO (previously UNICEF)
Frequency and timing of implementation, e.g. twice yearly in March and October	Twice a year	Twice a year, usually May and November.
Services delivered	Vitamin A supplementation, de-worming and sometimes net dipping	Information education and communication, vitamin A supplementation, and de-worming.
Number in target population by age group and sex	Vitamin A supplementation (5-59 months): 116,206 children De-worming (12-59 months): 94,419 children Data Source Child Health Days Activity Report June 2012	Vitamin A supplementation (6-59 months): 35,386 children De-worming (12-59 months): 30,770 children Data Source NSO 2011-2012 population projections
Coverage of the different services delivered by age group and sex	Vitamin A 90.6% De-worming 85% Data Source Child Health days Activity Report June 2012	Vitamin A 69.6%, De-worming 79.8%. Data Source NSO 2011-2012 population projections

Q47. (**Optional**) If present, please describe any organized health education programmes implemented at schools and/or in the community that are currently implemented in the district(s).

In Zomba, Health Surveillance Assistants organize health education session in all schools in their catchments areas on different topics. The school health programme is also operating in all primary schools where school going children are given IEC messages, physical examination, screening, environmental sanitation inspections and treatment of minor illnesses and referral.

In Rumphi, the health education programme is organised by the DHO through the Health Education Officer and School Health Coordinator in collaboration with other programme coordinators as health education is a cross cutting programme. At the district hospital, it is organised in all the departments. School health talks are done using multidisciplinary collaboration, in communities dialogues are done by community health nurses and health surveillance assistants. Drama is part and parcel of health education programme.

Component	**District 1** Zomba	**District 2** Rumphi
Organization of the health education programme	Done by School Health Programme Coordinator	Health Education Officer and School Health Coordinator
Lead agency	Zomba DHO	Rumphi DHO
Implementing agency and partners	Zomba DHO Save the Children Zomba Nursing School students	Rumphi DHO Ministry of Education Private Clinics YONECO CHAM.
Funding source(s)	Zomba DHO	Rumphi DHO
Frequency of services, e.g. once a month, weekly, etc.	Once a month	Three times a week at varying schools

Services delivered	These are done to children in Standard 1 and 2 and children and all those who have health problems: Physical examination Screening of minor illnesses Treatment Dental Environmental Inspection Health Education	Health assessment, health talks, treatment of minor health ailments and referrals
Location(s) of service delivery	Whole district	Communities, hospitals and clinics, primary and secondary schools.
Number in target population by age group and sex	250,000 school going children–both sexes Data Source School health 2012 Report	Open to every member of the community.
Coverage of the different services delivered by age group and sex	Per visit to Standard 1 and 2 children is 100% Overall visits is 25%	Not known.

Attachments:

1. Notes from first stakeholders meeting on HPV demonstration programme
2. Report of the KAP study on immunisation and diarrhoea
3. Preliminary report from the Malawi HPV readiness survey
4. National cervical cancer prevention programme strategy
5. Malawi Health Sector Strategic Plan 2011 - 2016
6. Timeline for Malawi HPV Demonstration Programme
7. Aide Memoire Governing the Financial Management of GAVI Health Systems Strengthening (HSS) and Immunisation Services Support (ISS) Cash Grants in Malawi
8. HSRG minutes of October 30, 2012 (to serve as HSCC review)