Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 16-May-2022 | Report No: PIDA33460

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Malawi	P178095	Second Additional Financing for Malawi COVID-19 Emergency Response and Health Systems Preparedness Project	P173806
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Malawi COVID-19 Emergency Response and Health Systems Preparedness Project	Eastern and Southern Africa	04-May-2022	07-Jun-2022
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Republic of Malawi	Ministry of Health

Proposed Development Objective(s) Parent

To prevent, detect and respond to the threat posed by COVID-19 in Malawi and strengthen national systems for public health preparedness.

Components

Emergency COVID-19 Response
Supporting National and Sub-national, Prevention and Preparedness
Implementation Management and Monitoring and Evaluation
Contingent Emergency Response Component

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	60.00
Total Financing	60.00
of which IBRD/IDA	50.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	50.00
IDA Credit	25.50
IDA Grant	24.50

Non-World Bank Group Financing

Trust Funds	10.00
Global Financing Facility	10.00

Environmental and Social Risk Classification

Substantial

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Malawi is a landlocked country in south-eastern Africa and one of the poorest countries in the world**. Around 85 percent of Malawi's population is estimated to live in rural areas and rely on rainfed agriculture for employment. Malawi's real per-capita gross domestic product (GDP) has remained largely flat over the last two decades and now lags behind regional peers. Malawi has one of the lowest rates of total investment in Sub-Saharan Africa, averaging 14.9 percent of GDP since 2000 compared to neighboring Tanzania at 24.5 percent and Zambia at 34.7 percent. Growth and investment have historically been undermined by macroeconomic instability. From 2011 to 2016, Malawi saw its exchange rate depreciate rapidly and inflation rise above 20 percent, which led to some of the highest interest rates in the region, depressing investment and impeding structural transformation.

2. **Malawi's development challenges are significant.** Despite being among the 15 most agriculture-dependent countries in the world, Malawi's economy has been defined by an underproductive and predominantly rainfed agriculture sector. Malawi's natural assets are increasingly under pressure from population growth and climate shocks. Meanwhile, job creation is restricted by market distortions and unreliable access to information and communication technology (ICT), electricity, and finance. While Malawi has made impressive gains on the Human Capital Index (HCI), rising from 0.36 to 0.41 over the last 10 years, exponential population growth reinforces the exclusion of women from economic opportunities, outstrips job creation, strains rural land, and puts unsustainable pressure on classroom capacity and learning outcomes.

3. **Malawi's economy has been heavily impacted by the COVID-19 pandemic.** Malawi experienced a fourth wave of COVID-19 pandemic in December 2021, though overall it had less of an economic impact than in earlier waves. While economic growth is projected to pick up from 0.8 percent in 2020 to 2.4 percent in 2021, with a population growth rate of about 3.0 percent, this level of economic growth indicates a contraction in per capita output.[1] The COVID-19 crisis is increasing poverty, particularly in urban areas, where the services and industry sectors have been hit hard. The pandemic is also disproportionally affecting human capital investment in poor households, reducing future intergenerational income mobility.

Sectoral and Institutional Context

4. **Status of the COVID-19 situation:** Malawi's first confirmed COVID-19 case was registered on April 2, 2020, and the country has so far experienced four COVID-19 waves. As of May 3, 2022, the country has registered a total of 85,790 confirmed COVID-19 cases, including 2,634 deaths. The median age of all cases is 34 years (IQR =24 to 45 years) and 56.5 percent of the cases are male. The national case fatality rate is 3.1 percent. The median age of the COVID-19 deaths in Malawi is 61 years (IQR 49-72 years) and about 64 percent are men. However, the actual number of COVID-19 cases and deaths could be higher than reported due to limited testing and contact tracing capacities as well as weak surveillance system in the country. As one of the COVID-19 measures to mitigate severe disease burden and control transmission, Malawi rolled out a vaccination program on March 11, 2021. The program initially targeted frontline health workers, social workers, and high-risk population (Phase 1), but later extended (Phase 2) to everyone aged at least 18 years in April 2021 and 12 years and above in November 2021. The GoM's plan is to vaccinate 70 percent of the population (13.3 million people) by June 2023. As of May 3, 2022, the country has fully vaccinated (complete primary vaccine series) about 1.15 million people, which represents about 6 percent of the population. In addition, around 1.2 million and 4,500 people have received the first dose of the vaccines and booster vaccines, respectively.

5. **Government of Malawi (GoM) response:** In March 2020, the country developed in collaboration with technical partners a costed contingency plan focusing on critical priorities and immediately committed MWK 2.5 billion (US$3.4 million) towards the COVID-19 response. This plan was updated as the situation evolved, and more funding became available. The GoM gradually intensified its efforts, initially focusing on measures such as screening at airports and other points of entry (PoE). The measures were enhanced after the President declared a "State of Disaster" (March 20, 2020) including: (i) redeployment of health personnel to border and PoE; (ii) travel suspension; (iii) closing of all schools and colleges; (iv) restricting public gatherings to less than 100 people; and (v) banning travel of foreign nationals from countries highly affected by COVID-19. In response to the second wave, the President declared a second "State of Disaster" on January 12, 2021 and identified priority needs: (i) testing and contact tracing; (ii) recruitment of additional medical personnel; (iii) procurement of medical equipment (e.g. oxygen); and (iv) increasing hospital space or infrastructure as priority needs. As one of the COVID-19 measures to mitigate severe disease burden and control transmission, Malawi rolled out a vaccination program on March 11, 2021. The program initially targeted frontline health workers, social workers, and high-risk population (Phase 1), but later extended (Phase 2) to everyone aged at least 18 years in April 2021 and 12 years and above in November 2021. The GoM's plan is to vaccinate 70 percent of the population (~ 13.3 million people) by June 2023.

6. **Malawi has conducted a vaccine readiness assessment to identify gaps and options to address them,** as well as to estimate the cost of vaccine deployment. While there have been learnings from the first phase of deployment in 2021

[1] Malawi Economic Monitor, December 2021.

including the importance of collaboration and coordination within and across ministries, with districts and with partners, with the adoption of a two-prong approach to vaccine deployment (i.e., facility-based and campaign mode involving community outreach and house-to-house visits), key gaps remain in most aspects of the assessment. These gaps include: (i) updating of the COVID-19 National Deployment and Vaccination Plan (NDVP) to ensure improved planning and coordination of all stakeholders; (ii) mobilization of resources for procurement of vaccines, demand creation and deployment; (iii) disease surveillance system that ensures timely availability and use of COVID-19 related data to inform planning and decisions; (iv) sufficient and sustainable operating and maintenance of waste management measures and equipment along with capacity building in line with IPC guidelines to improve waste care management; (v) recruitment and training of additional staff for vaccination in the communities and training of existing staff on new types of vaccines and regulations to enable accelerated deployment and uptake; (vi) insufficient equipment and back-up power banks along with need for recruitment of additional data collectors to address the issue of backlog of data from communities, and to ensure data including grievances in relation to vaccine programs are collected in timely manner from multiple intake points, managed, reviewed and used; (vii) inadequate and insufficient vaccine infrastructure to accommodate and maintain vaccines that require ultra-cold chain (UCC) and to sustain power to ensure vaccine potency during power outage; and (viii) confidence, acceptance and demand for COVID-19 vaccines remain low in pockets of population affecting uptake, requiring appropriate messages and materials for public communication and advocacy, and community involvement. The proposed second additional financing (AF2) in coordination with other partners will support the GoM's efforts to address these gaps.

7. **The GoM developed the initial NDVP, which was approved February 18, 2021, based on the findings of the Vaccine Introduction Readiness Assessment (VIRAT) and gap analysis.** This was focused on the Phase 1 of vaccination program targeting 20 percent of the population comprising healthcare workers, social workers, and high-risk population, including people with co-morbidities, the elderly, disabled, refugees and internally displaced populations (IDPs). The plan was revised in June 2021 to include Phase 2 target groups with overall coverage target of 60 percent of the population. In November 2021, the GoM further adjusted the coverage target from 60 to 70 percent of the population by June 2023 to align with the WHO's Global COVID-19 Vaccination target. Consistent with WHO's guidance and on recommendation of the Malawi Immunization Technical Working Group (MAITAG), the GoM introduced COVID-19 booster vaccines in February 2022. The rationale for the booster included (i) waning protection against COVID-19 infection over time, (ii) emerging variants of concern that evade the immune system and (iii) the need to provide adequate protection to the population, especially the higher risk groups. The eligibility criteria for booster are the same as for the primary vaccine series, but priority is given to high-risk groups, e.g., the elderly. The GoM has also approved the use of Pfizer vaccine for children aged at least 12 years effective January 2022 based on the MAITAG's recommendation. The policy directive to make COVID-19 vaccine mandatory for all frontline workers was reversed amid public and selected civil society organizations backlash. The NDVP is due for revision to incorporate changes that the GoM has made since the last update, including (i) increase of coverage target, (ii) adjustment of the eligibility criteria, (iii) the approval of the booster vaccines and (iv) introduction of more types of COVID-19 vaccines in addition to AstraZeneca. The proposed AF2 will support updating of the NDVP, including costing.

C. Proposed Development Objective(s)

Original PDO

To prevent, detect and respond to the threat posed by COVID-19 in Malawi and strengthen national systems for public health preparedness.

Current PDO

The PDO remains the same with the second additional financing (AF2).

Key Results

8. To continue to measure overall progress in the coverage and deployment of the COVID- 19 vaccine, and the gender gaps the project aims to address, along with progress in the expanded scope of the project (namely aspects of system strengthening and maintaining essential health services (EHS), new indicators are added to the project Results Framework. In addition, some indicators from the parent project will be revised (Table 1). The project target for those fully vaccinated will be modified to reflect the increase in support under AF2 (inclusive of the contributions from the COVAX Facility and bilateral donations).

Table 1: Summary of changes to the PDO and Intermediate Results Indicators under AF2

Indicator	Level	Status	Rationale
Number of OPD Visits per 1000 population	PDO	New	This is a new indicator to monitor the change in outpatient consultations as part of the support on maintenance of essential health services.
Percentage of targeted population fully vaccinated based on the targets defined in national plan, disaggregated by sex (Percentage	PDO	Revise	This indicator's target was revised to reflect the increased support for vaccine procurement. The project vaccination target was increased from 28 percent to 30 percent.
Percentage of suspected cases of COVID-19 reported and investigated based on national guidelines (Percentage)	PDO	Delete	This indicator is proposed for deletion as it is difficult to define and collect in country.
Number of districts with the required climate-sensitive / energy efficient ultra-low-temperature freezer to store COVID-19 vaccines	IRI	New	This is a new indicator to monitor capacity to store COVID-19 vaccines requiring ultra-low temperatures.
Number of central hospitals rehabilitated for COVID-19 case management	IRI	New	This is a new indicator to monitor rehabilitation works of 4 central hospitals for COVID-19 case management
Number of incinerators that are functional	IRI	New	This is a new indicator to monitor adherence to waste management requirements
Percentage of users of modern contraceptive methods (Gender)	IRI	New	This is a new indicator to monitor uptake of modern contraceptive methods, as part of the support on maintenance of essential health services
Percentage of pregnant women who made their first ANC visit within the first three months of pregnancy (Gender)	IRI	New	This is a new indicator to monitor uptake of early ANC visits during the first trimester, as part of the support

			on maintenance of essential health services
Percentage of surviving infants receiving the last (i.e., third) recommended dose of pentavalent vaccine at the national level	IRI	New	This is a new indicator to monitor uptake of Pentavalent 3 as part of the support to maintain essential health services.
Number of district where Event- Based Surveillance system is functional	IRI	New	This is a new indicator to monitor the support on EBS systems in all 29 districts
Percentage of health care facilities adhering to health care waste management as per the national IPC minimum standards	IRI	New	This is a new indicator to monitor health facilities adherence to waste management as per the national IPC minimum standards
Number of health staff trained in infection prevention and control per MOH-approved protocols	IRI	Revise	The indicator's target was revised to reflect the increased support for IPC trainings. The target was increased from 870 to 1448.
Number of districts conducting monthly community dialogues on COVID-19 vaccination and prevention measures	IRI	Revise	Original indicator name was "Civil Society Organization (CSO) representatives are active members of the National Task Force (NTF) responsible for monitoring and guiding the COVID-19 vaccine rollout". The indicator's name, definition, baseline, and target were revised to better align with the citizen engagement initiatives in country and feedback loop.
Percentage of targeted population who received at least one dose of a COVID-19 vaccine, by sex	IRI	Delete	This indicator and sub-indicator are proposed for deletion due to the evolving situation in country.
M&E system established to monitor COVID-19 preparedness and response plan	IRI	Delete	This indicator is proposed for deletion due to the evolving situation in country.

D. Project Description

9. The changes proposed for the AF2 entail expanding the scope of activities under the parent project (Malawi COVID-19 Emergency Response and Health System Preparedness Project – P173806), adjusting its overall design. As the proposed activities to be funded under the AF2 are aligned with the original PDO, the PDO would remain unchanged.

10. The content of the components and the Results Framework of the parent project are adjusted to reflect the expanded scope and new activities proposed under the AF. With further increase in financing through the proposed AF2, adjustments in institutional and implementation arrangement are proposed (see section E:

Implementation). The total project amount will be increased from US$37.0 million to US$97.0 million. The Closing Date would be extended from December 31, 2023 to December 31, 2025.

i. Proposed New Activities

11. The additional activities will be incorporated into the existing components of the parent project as described below.

Component 1: Emergency COVID-19 Response (parent project US$5.3 million equivalent; AF1 US$28.8 million; proposed AF2 US$44.5 million equivalent, IDA and US$10.0 million equivalent, GFF)

Subcomponent 1.1: Case Detection, Confirmation, Contact Tracing, Recording, Reporting (parent project US$4.1 million equivalent; AF1 US$1.0 million equivalent, proposed AF2 US$3.38 million equivalent, IDA)

12. **This sub-component would be scaled-up.** The AF2 plans to enhance case detection, confirmation, rapid response and reporting of COVID-19 cases building on the support provided under the parent project and the AF1. Building on the AF1 that supported strengthening diagnostic testing in Malawi, including optimization of existing RT-PCR platforms, the proposed AF2 will support (i) lab capacity strengthening activities for COVID-19 and for other diseases including climate sensitive diseases through procurement of diagnostic equipment, procurement of re-agents and supplies, and training of health care workers in use and maintenance of equipment; (ii) training of health care workers and rehabilitation officers on rehabilitation of post COVID-19 disorders, and in cardio-pulmonary management of COVID-19 patients respectively; and (iii) standardization of COVID-19 medical records and training of health care workers in management and use of standardized records; and (iv) strengthen mobility of district level rapid response teams to improve disease surveillance.

Subcomponent 1.2: Health System Strengthening (parent project US$1.2 million equivalent; AF1 US$1.8 million; proposed AF2 US$23.62 million equivalent, IDA)

13. **This sub-component would be scaled up to strengthen the health system's ability to detect and manage COVID-19 cases and include new activities.** Waves of surges in cases of COVID-19 has placed increased pressure on the health system. The AF2 will further strengthen oxygen supply systems and will support the health system through a phased approach to: (i) improved case detection of COVID-19 cases as well as other infectious disease detection and through procurement of digital health and diagnostic equipment (CT scanner, Magnetic Resonance Imaging (MRI), digital X-ray machines, ultra sound machines); (ii) improved management of COVID-19 cases through procurement and installation of oxygen supply systems at 12 district hospitals; (iii) improved skills of health care workers through (a) training in managing critically ill patients and dissemination of clinical guidelines including oxygen use and (b) in-country specialized training for nurse leaders in emergency critical care, and anesthetists; and (iv) improved infrastructure through (a) renovation of one PHC training center, expansion and renovation of health facilities and district labs as well as data centers, and (b) construction of an infectious disease isolation center at a central hospital. Renovations will take into account design measures to help facilities more effectively withstand climate shocks, such as flooding and high winds.

Subcomponent 1.3: Vaccine Procurement and Deployment (parent project US$0; AF1 US$26.0 million equivalent; proposed AF2 US$17.5 million equivalent, IDA)

14. This subcomponent would be scaled up, and finance procurement of additional eligible COVID-19 vaccines. The proposed AF2 will finance the procurement and delivery to the port of entry of one million vaccine doses and associated supplies such as syringes to cover 2.5 percent of the Malawi population.

15. The proposed AF2 will also expand support for deployment of vaccines and to further enhance immunization systems and service delivery capacity to the level required to sustain delivery of COVID-19 vaccines at scale. To this end, the proposed AF2 is geared to assist the GoM, working with the World Bank Group (WBG), WHO, UNICEF and other development partners, to overcome bottlenecks as identified in the most recent COVID-19 vaccine readiness assessment in the country. Most of the support under this subcomponent (US$12.5 million) will go towards sustaining and expanding complimentary support to deployment priorities identified in the NDVP and to address current gaps identified in the readiness assessment to accelerate deployment, increase uptake, and improve data reporting and use. Climate-sensitive vaccination planning and deployment will be taken into account. Accordingly, support includes the following: (i) update the NDVP document to ensure improved planning and coordination; (ii) recruitment and training of additional staff for vaccination in the communities and training of existing staff on new types of vaccines and regulations to enable accelerated deployment and uptake; (iii) strengthening of digital platforms linked to the One Health Surveillance Platform (OHSP) and the Health Management Information System (HMIS) including the e-Vaccination platform and open Logistic Management Information System (LMIS); (iv) enhance UCC storage capacity in all districts to support rollout of vaccines that require ultra-low temperature through purchase of low Global Warming Potential (GWP) ultra-low temperature cold chain equipment; (iv) procure and install solar panels to generate back-up power for the vaccines cold chain system at national, regional and district stores; (v) procure and repair solar panels to support vaccine cold chain at health facilities; (vi) enhance waste management capacity, including (a) support to operational costs of existing incinerators, and (b) procurement of biohazard bags; and (c) strengthen the logistics along the supply chain, including procurement of mobile van units, motorbikes and push bikes for periodic community-based vaccination campaigns to reach communities without contributing to greenhouse gas emissions (Express Vaccination Program).

16. Demand creation and Risk Communication and Community Engagement (RCCE) still faces challenges as reported in the recent vaccine readiness assessment. Therefore, the proposed AF2 will support: (i) periodic review of the communication campaigns to inform the design of effective community outreach strategies and messages; (ii) intensify and scale up dissemination of up-to-date messages through mass media, social media and community outreach to increase access and uptake in both urban and rural areas through the Express Vaccination Program; (iii) strengthen the community feedback system to track rumors to inform the design of correct messaging and effective community outreach strategies; (iv) strengthen policy advocacy to increase uptake of the COVID-19 vaccines; (v) improve institutional delivery of the RCCE activities through provision of technical assistance to develop/update RCCE materials, including rumor tracker system and communication strategies; and (vi) improve coordination with all RCCE partners through regular meetings and monitoring field visits to assess progress and impact. Communication campaigns will include sensitization messages on climate shock emergency preparedness and response.

Subcomponent 1.4: Monitoring and Maintaining Essential Health and Nutrition Services

(parent project US$0; AF1 US$0; proposed AF2 US$10.0 million equivalent, GFF)

17. **This is a new sub-component**. The proposed new sub-component will assist the GoM mitigate essential health services (EHS) disruptions as identified in the Malawi Ministry of Health Guidelines on the Continuation of Essential Health Services during COVID- 19 and MOH's monitoring of EHS during the COVID-19 period currently being undertaken with support from the GFF/ WB and other partners. Malawi experienced moderate disruptions during the pandemic (March 2020 – November 2021) considering pre-pandemic trends and seasonality.

18. This new subcomponent will support the GoM in taking actions aligned to the NCPRSP to minimize disruption and maintain EHS during the period of surge in COVID-19 cases when health care workers providing EHS are mobilized to respond to COVID-19 cases, and also as they are mobilized for COVID-19 vaccine deployment at health facilities, communities and in schools. Key areas of support include: (i) strengthen human resources for health (HRH) through (a) temporary recruitment, training and deployment of community health workers and skilled birth attendants to ensure continued and expanded provision of quality routine services at community level, including antenatal, birth and postnatal services for pregnant adolescent girls, and (b) temporary hiring and training of Health Surveillance Assistants (HSAs) to deliver the package of EHS at the community level including family planning, children's routine vaccination, health promotion messages for women and children to seek EHS at health facilities, as well as transport for HSAs. While delivering the services during the funding period, the Ministry of Health will be engaging the Treasury to ensure that they are absorbed into the system after the funding period; (ii) procurement of essential medicines and supplies to mitigate stockouts and ensure continuity of EHS delivery (including family planning commodities, antenatal medicines and drugs for community management of childhood illnesses); (iii) IPC-WASH at health facilities through (a) review/finalization and dissemination of the national IPC policy and IPC training manual, (b) procurement of personal protective equipment (PPE) for frontline workers, and (c) undertaking health facility IPC WASH assessment; and (iv) strengthen the HMIS for timely data production and dissemination for evidence-based decision making through (a) the development of the Health Monitoring, Evaluation and Health Information Systems Strategy (2023-2030) and an operational plan, (b) revision and implementation of the HIS SOPs; (c) upgrading of the DHIS2 and training of users, and (d) strengthening of systematic monitoring, analysis, dissemination and use of quality EHS data both at national and sub-national levels of decision-making.

Component 2: Supporting National and Sub-national Prevention and Preparedness (parent project US$0.95 million equivalent; AF1 US$0 million equivalent; proposed AF2 US$2.5 million equivalent, IDA)

19. This sub-component would be scaled up to support strengthening of rapid response teams at the district level by enhancing their disease surveillance capacity and their mobility to respond to public health emergencies. Specifically, the AF2 will support: (i) development and dissemination of disease integrated diseases surveillance and response (IDSR) guidelines, including for climate sensitive diseases; (ii) training of trainers for community-based surveillance in 10 districts; (iii) training of frontline health workers on the third edition of the IDSR guidelines; (iv) roll-out event-based surveillance to all 29 districts; (v) One Health approach through enhanced media scanning and hotline to respond effectively to public health threats at the district level; (vi)

procurement of ambulances for emergency response and in support of surveillance activities; and (vii) financing for surveillance operations. Integration of climate emergency and response training and planning as part of emergency preparedness planning, training, and supervision will be undertaken. This component will also finance strengthening surveillance of climate-sensitive diseases.

Component 3: Implementation Management and Monitoring and Evaluation (parent project US$0.75 million equivalent; AF1 US$1.2 million equivalent; proposed AF2 US$3.0 million equivalent, IDA)

20. This component would be scaled up. The proposed AF2 plans to provide support towards: (i) strengthen monitoring and research activities, including clinical and epidemiological studies on COVID-19 and other infectious diseases, and vaccine hesitancy, and other studies to inform government's strategic direction with respect to health emergencies and climate related diseases; (ii) enhanced reporting of adverse occurrences such as elite capture through grievance redress mechanism (GRM) and through a dedicated hotline and amplified citizen engagement activities; (iii) improved implementation of the environmental and social commitment plan (ESCP) and ongoing supervision and management of safeguard requirements by the district teams beyond the life of the project; and (iv) procurement of vehicles at the central level to strengthen project coordination and supervision of the expanded project activities including close supervision of execution of civil works and supervision of sub-national level activities.

Component 4: Contingent Emergency Response Component (US$0.0 million)

21. The CERC is included to allow for rapid reallocation of project proceeds in the event of a future natural or man-made disaster or crisis that has caused or is likely to imminently cause a major adverse economic and/or social impact during the life of the project. This component will have no funding allocation initially. In the event of a future emergency, this component would allow the Government to request the World Bank to recategorize and reallocate financing from other project components to cover emergency response and recovery costs, if approved by the World Bank.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

E. Implementation

Institutional and Implementation Arrangements

22. **Stewardship and oversight**. There is no change in stewardship and oversight arrangements including the oversight provided by the Presidential Task Force (PTF), aided by the National Disaster Preparedness and Relief Committee (NDPRC) providing policy guidance and leadership in implementation of the COVID-19 response, DODMA which facilitate appropriate coordination arrangements and communication between Government, UN, and NGOs in responding to emergencies and during preparedness and response planning process and Health Cluster Committee. The MOH is the technical lead institution for implementing COVID-19 preparedness and response activities and provides all the necessary technical support and expertise through the Health Cluster Committee chaired by the Chief of Health Services.

23. **Implementation and monitoring arrangements.** The modifications to the implementation and monitoring arrangements that were made during the preparation of the first AF to reflect the expanded scope of the project (i.e., to include vaccination) will be further enhanced for AF2. The Public Health Institute of Malawi (PHIM), with support of the PIU, will continue to coordinate implementation and monitoring of the project. The Expanded Program for Immunization under the Directorate of Preventive Health Services (PHS) is responsible for implementation of vaccine-related activities and the MOH appointed a focal person from the EPI program to interface between the EPI program and the PHIM (PIU). The Clinical Directorate and Directorate of Policy Planning and Development are responsible for implementing oxygen-related activities under Subcomponent 1.2 and has designated an officer to interface with the PHIM. The same officer under the Clinical Directorate will also be responsible for implementation of the EHS under the new sub-component 1.4. The Health Technical Support Services (HTSS) Directorate is responsible for implementing the activities under Subcomponent 1.1 and part of subcomponent 1.2 and an officer from the directorate was appointed to interface with the PHIM. The designated officials have been/will be expected to actively participate in the regular project implementation meetings and missions. The EPI structures remain part of the project since the COVID-19 vaccine deployment is leveraging the existing structures. The approach to assign focal point persons from respective specialist from Departments in MOH to coordinate implementation of the activities under their mandate will guarantee continuity of implementation beyond the life of the project; further, this will ensure the capacity built is retained in MOH, contributing to sustainability of implementation capacity for the Government.

24. **Project management.** Project management structure has been adjusted to improve coordination. The GoM and the World Bank agreed during parent project preparation to situate the project in the existing PIU of the Southern Africa Tuberculosis and Health Systems Support Project (SATBHSSP) (P155658). The rationale was for the new project to benefit from the implementation experience gained in fiduciary management, M&E and Environment and Social Safeguards. However, due to the reported increased workload of handling two projects, whose scopes have significantly expanded over time through AF, a new independent PIU for the COVID-19 project will be established through a phased approach under the overall coordination of the PHIM Director. To augment numbers, skills and competences for implementation, positions of Infection Control and Medical Waste Specialist, Monitoring and Evaluation Assistant, Assistant Procurement Specialist and Accountant (Assigned from MoH) have been filled at PHIM and are working collaboratively with counterparts at SATBHSSP. However, because the COVID-19 Emergency Project has grown substantially in scope and financing, in addition to establishing an independent PIU at PHIM, it has been agreed to i) have a full time Project Coordinator who will be recruited and financed by the project and will report

directly to the PHIM Director and ii) recruit at Specialist level staff for Monitoring and Evaluation, Procurement and Financial Management. All environmental and social safeguards documents will be updated and redisclosed as required.

25. **In addition, a project implementation committee, chaired by the Chief of Health Services, will be established to provide implementation oversight.** The committee will comprise representatives of all implementing MOH departments and will meet monthly to receive monitoring reports and assess progress for all components of the project. The Directorate of Planning will be its Secretariat. The Office of the Secretary for Health will provide overall direction for the project.

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