Meeting of the Board
21 – 24 October 2024
Songdo, Incheon, Republic of Korea
Provisional agenda item 10

GCF/B.40/02/Add.06

30 September 2024

Consideration of funding proposals – Addendum VI

Funding proposal package for FP244

Summary

This addendum contains the following six parts:

a) A funding proposal titled "Climate Resilient Health and Well-Being for Rural Communities in southern Malawi (CHWBRC)";
b) No-objection letter issued by the national designated authority(ies) or focal point(s);
c) Secretariat's assessment;
d) Independent Technical Advisory Panel's assessment;
e) Response from the accredited entity to the independent Technical Advisory Panel's assessment; and
f) Gender documentation.

Table of Content

Funding Proposal

coProject/Programme title:	**Climate Resilient Health and Well-Being for Rural Communities in southern Malawi (CHWBRC)**
Country(ies):	**Malawi**
Accredited Entity:	Save the Children Australia
Date of first submission:	[2023/12/20]
Date of current submission	[2024/09/20]
Version number	[V.B.40]

GREEN CLIMATE FUND

Contents

Note to Accredited Entities on the use of the funding proposal template

- Accredited Entities should provide summary information in the proposal with cross-reference to annexes such as feasibility studies, gender action plan, term sheet, etc.
- Accredited Entities should ensure that annexes provided are consistent with the details provided in the funding proposal. Updates to the funding proposal and/or annexes must be reflected in all relevant documents. leader
- The total number of pages for the funding proposal (excluding annexes) **should not exceed 60**. Proposals exceeding the prescribed length will not be assessed within the usual service standard time.
- The recommended font is Arial, size 11.
- Under the GCF Information Disclosure Policy, project and programme funding proposals will be disclosed on the GCF website, simultaneous with the submission to the Board, subject to the redaction of any information that may not be disclosed pursuant to the IDP. Accredited Entities are asked to fill out information on disclosure in section G.4.

Please submit the completed proposal to:

fundingproposal@gcfund.org

Please use the following name convention for the file name:

"FP-[Accredited Entity Short Name]-[Country/Region]-[YYYY/MM/DD]"

ST OF ACRONYMS	
ACPC	Area Civil Protection Committees
AE	Accredited Entity
ARA	Adaptation Results Area
CACs	Community Action Cycles
CEFM	Child, Early and Forced Marriage
CHAGs	Community Health Action Groups
CHVs	Community Healthcare Volunteers
CHWBRC	Climate Resilient Health and Well-being for Rural Communities in southern Malawi
CN	Concept Note
CRECCOM	Creative Centre For Community Mobilisation
CSB	Corn Soy Blend
CSO	Civil Society Organisation
DCCMS	Department Of Climate Change And Meteorological Services
DEC	District Executive Committee
DHAP	District Health Adaptation Plan
EAD	Environmental Affairs Department
EE	Executing Entity
ESP	Environmental And Social Policy
ESS	Environmental and Social Safeguards
EWARS	Early Warning And Response System
EWS	Early Warning Systems
FMCA	Financial Management Capacity Assessment
FA	Fiscal Agent
FP	Funding Proposal
GBV	Gender-based Violence
GCM	Global Climate Model
GDP	Gross Domestic Product
GEF	Global Environment Facility
GFCS	Global Framework For Climate Services
GoM	Government Of Malawi
HCCCT	Health And Climate Change Core Team
HNAP	Health National Adaptation Plan
HSAs	Health Surveillance Assistants
HSJF	Health Sector Joint Fund
JNTCCCDRM	Joint National Technical Committee on Climate Change and Disaster Risk Management
MEAL	Monitoring, Evaluation, Accountability and Learning
MHPSS	Mental Health and Psychosocial Support
MNCH	Maternal, Newborn and Child Health
MoGCDSW	Ministry of Gender, Community Development and Social Welfare
MoH	Ministry of Health
NAPs	National Adaptation Plans
NCDs	Non-communicable Diseases
NDC	Nationally Determined Contribution

NGO	Non-governmental Organisation
NPF	National Planning Framework
PHC	Primary healthcare
PIU	Project Implementation Unit
PMU	Project Management Unit
PSC	Project Steering Committee
PWD	People With Disabilities
RCP	Representative Concentration Pathway
RRMP	Residual Risk Management Plan
SBC	Social Behaviour Change
SCA	Save The Children Australia
SCI MW	Save The Children International, Malawi Country Office
SCUK	Save The Children Fund (United Kingdom)
SDG	Sustainable Development Goals
SHSAs	Senior Health Surveillance Assistants
SRH	Sexual and Reproductive Health
TAG	Technical Advisory Group
TAs	Traditional Authorities
tCO2eq	Tons Of Carbon Dioxide Equivalent
ToC	Theory Of Change
TOR	Terms Of Reference
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
WASH	Water, Sanitation And Hygiene
WHO	World Health Organisation

A. PROJECT/PROGRAMME SUMMARY

A.1. Project or programme	Project	**A.2. Public or private sector**	Public
A.3. Request for Proposals (RFP)	*If the funding proposal is being submitted in response to a specific GCF Request for Proposals, indicate which RFP it is targeted for. Please note that there is a separate template for the Simplified Approval Process and REDD+.* Not applicable		

A.4. Result area(s)	*Check the applicable GCF result area(s) that the overall proposed project/programme targets below. For each checked result area(s), indicate the estimated percentage of **GCF and Co-financers' contribution** devoted to it. The total of the percentages when summed should be 100% for GCF and Co-financers' contribution respectively.*		
		GCF contribution	**Co-financers' contribution[1]**
	Mitigation total	Enter number %	Enter number %
	☐ Energy generation and access	Enter number %	Enter number %
	☐ Low-emission transport	Enter number %	Enter number %
	☐ Buildings, cities, industries and appliances	Enter number %	Enter number %
	☐ Forestry and land use	Enter number %	Enter number %
	Adaptation total	Enter number %	Enter number %
	☒ Most vulnerable people and communities	50 %	50 %
	☒ Health and well-being, and food and water security	50 %	50 %
	☐ Infrastructure and built environment	Enter number %	Enter number %
	☐ Ecosystems and ecosystem services	Enter number %	Enter number %

A.5. Expected mitigation outcome *(Core indicator 1: GHG emissions reduced, avoided or removed / sequestered)*	Not applicable	**A.6. Expected adaptation outcome** *(Core indicator 2: direct and indirect beneficiaries reached)*	Total: 4,157,812	
			Direct: 1,798,878	Indirect: 2,359,162
			9.4%	12.4%
A.7. Total financing (GCF + co-finance[2])	37,068,208 USD	**A.9. Project size**	Small (Upto USD 50 million)	
A.8. Total GCF funding requested	33,000,000 USD *For multi-country proposals, please fill out annex 17.*			
	Mark all that apply and provide total amounts. The sum of all total amounts should be consistent with A.8.			

[1] Co-financer's contribution means the financial resources required, whether Public Finance or Private Finance, in addition to the GCF contribution (i.e. GCF financial resources requested by the Accredited Entity) to implement the project or programme described in the funding proposal.

[2] Refer to the Policy of Co-financing of the GCF.

A.10. Financial instrument(s) requested for the GCF funding	☒ Grant 33,000,000 ☐ LoanEnter number ☐ GuaranteeEnter number	☐ Equity Enter number ☐ Results-based payment Enter number	
A.11. Implementation period	*60 months (5 years)*	**A.12. Total lifespan**	*120 months (10 years)*
A.13. Expected date of AE internal approval	*This is the date that the Accredited Entity obtained/will obtain its own approval to implement the project/ programme, if available.* *12/20/2023*	**A.14. ESS category**	*Refer to the AE's safeguard policy and GCF ESS Standards to assess your FP category.* C
A.15. Has this FP been submitted as a CN before?	Yes ☒ No ☐	**A.16. Has Readiness or PPF support been used to prepare this FP?**	Yes ☐ No ☒
A.17. Is this FP included in the entity work programme?	Yes ☒ No ☐	**A.18. Is this FP included in the country programme?**	Yes ☒ No ☐
A.19. Complementarity and coherence	*Does the project/programme complement other climate finance funding (e.g. GEF, AF, CIF, etc.)? If yes, please elaborate in section B.1.* Yes ☒ No ☐		
A.20. Executing Entity information	1. Save the Children International, Malawi Country Office (SCI MW). Registered in Malawi. International Non-Governmental Organisation. 2. Ministry of Health. Registered in Malawi. Governmental Organisation. 3. Save the Children Fund (SCUK[3]). Registered in the United Kingdom. International Non-Governmental Organisation. For further information, please refer to Implementation Arrangements below **(Section B.4)**		
A.21. Executive summary (max. 750 words, approximately 1.5 pages)			

[3] Save the Children UK or SCUK are trade names and abbreviations.

1. Malawi is exposed to increasing temperatures, changing rainfall patterns, and extreme events (e.g., droughts, floods and high/extreme temperature events) which result in a range of health-related impacts. The main project impacts will address climate-related increases in: malaria, diarrhoeal diseases (e.g., cholera), diseases/conditions related to high/extreme heat (e.g. heat strain/stress), food and nutrition insecurity, mental health conditions (e.g. depression and anxiety), and gender-related impacts (e.g., increases in gender-based violence). Other climate-related health impacts consist of the physical impacts that climate hazards have on WASH infrastructure (e.g. the destruction of boreholes and latrines) and on healthcare infrastructure.
2. Existing WASH and healthcare infrastructure is not well-equipped to withstand climate extremes, and healthcare staff are not well-equipped to provide climate-resilient healthcare. The lack of knowledge in the system is reflected in poor levels of awareness of climate risk at community level. Climate-related health impacts are compounded by numerous factors (e.g. high levels of poverty, gender inequality, persistent malnutrition, etc.).
3. The project takes a holistic health system and multi-pronged approach to develop a climate-resilient healthcare system that will reduce the adverse effects of climate change on health and well-being. This intent is aligned with the Guiding Principles for Financing Climate and Health Solutions developed at the 28th session of the Conference of Parties to the UNFCCC (COP28) in Dubai[4]; these principles establish a shared vision for financing that will protect people from the range of climate risks to health, and build resilient, environmentally sustainable health systems[5].
4. The project combines national-, district-, and community-level interventions to create sufficient conditions for scalability, and sufficient integration to catalyse the transition to a climate-resilient health system. Institutionally, the project will strengthen and spread a climate-informed health surveillance system and early warning system that functions at national level and is able to provide appropriate early warning for the occurrence of climate-sensitive diseases and conditions (Outcome 1), aimed at mitigating the risk of increases in malaria, diarrhoeal diseases, malnutrition and diseases/conditions linked to high/extreme heat. The damage to the healthcare system and WASH physical infrastructure from climate-related hazards will be reduced by strengthening the resilience of health centres, hospitals and WASH infrastructure in the south, and by developing and applying national standards and guidelines for climate-resilient facilities (Outcome 2). Healthcare staff will be capacitated to reduce a range of climate-related health risks through improved disease monitoring, health messaging, and disease treatment and prevention (Outcome 3); central to Outcome 3 is addressing the increased risks, under a changing climate, of malaria, diarrhoeal diseases, malnutrition, mental health impacts and gender-related impacts. Communities will be better prepared to manage a range of impacts of climate change on health (Outcome 4) through being empowered to identify and reduce climate risks to health, with a particular focus on marginalised groups (including pregnant women and households with children under two). Again, central to Outcome 4 is the reduction of the risks of malaria, diarrhoeal diseases, malnutrition, mental health impacts and gender-related impacts under a changing climate. The project will specifically target six climate vulnerable districts in the south of Malawi, namely Ntcheu, Balaka, Machinga, Mangochi, Phalombe and Zomba **(see Annex 2: Section 6.2: Target Areas and Beneficiaries)**.
5. Strengthening health systems under climate change is already within the ambition of the government of Malawi (National Health Strategic Plan pillar 2), but this ambition is challenged by the lack of structured guidance to support the operationalization of required actions. The focus of this project therefore includes the establishment of context-relevant climate change impacts on health that will support the determination of the necessary action plans to guard against climate-related impacts to the health system. The project will facilitate the development of climate-sensitive infrastructure standards and facilitate utilization of climate-sensitive health data through existing decision-making platforms (e.g. the human health and climate change coordination core team), which, as already institutionalized platforms, are therefore likely to remain functional beyond the project life span. As regards resources, the project will support government in the inclusion of health in the national climate adaptation funding mechanism, taking advantage of the growing impetus towards inclusion of health in climate change processes and plans.
6. The project's goal statement is: IF the health system in southern Malawi is strengthened in terms of governance, health and climate information systems, service delivery and community engagement, THEN the negative impacts of climate change on the health of women, children and men will be reduced, BECAUSE healthcare staff, facilities and communities will have stronger capacity to anticipate, plan and respond to climate-health risks.

[4] The GCF was an initiating party to the Guiding Principles for Financing Climate and Health Solutions, and these are endorsed by the Ministry of Health of Malawi and Save the Children. Please see: Green Climate Fund (2023) 41 funders, partners endorse new guiding

principles for financing climate and health solutions to protect health. GCF Press Release, 02 December. Available at: https://www.greenclimate.fund/news/41-funders-partners-endorse-new-guiding-principles-financing-climate-and-health-solutions.

[5] COP28 UAE (2023) Guiding principles for financing climate and health solutions. COP28 UAE. Available at: https://www.cop28.com/en/guiding-principles.

B. PROJECT/PROGRAMME INFORMATION

B.1. Climate context (max. 1000 words, approximately 2 pages)

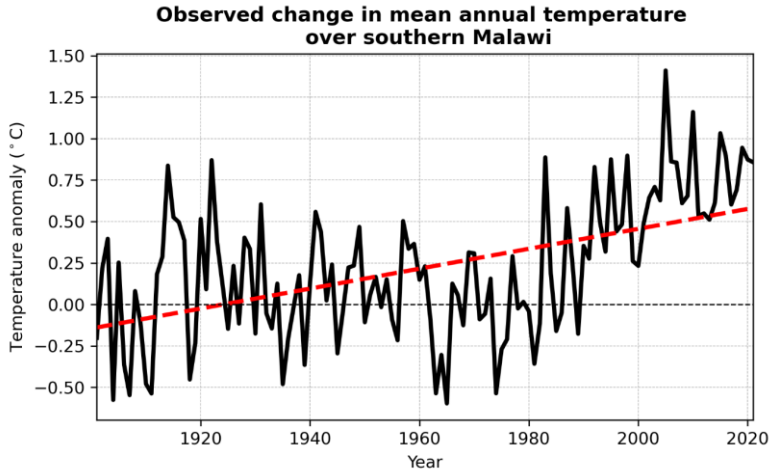
Context and current climate

7. Malawi is among the most climate-vulnerable countries in the world, ranking 161st out of 185 countries on the Notre Dame Global Adaptation Index in terms of its vulnerability to climate change and other global challenges in combination with its readiness to improve resilience[6]. The proposed project focuses largely on Malawi's Southern Region, as it is prioritised for climate adaptation in the National Adaptation Plan of Action (2006) and draft National Adaptation Plan (2016) due to its high exposure to climate risks and impacts, in combination with high vulnerability.

8. Observed temperature and precipitation is computed from temperature datasets from the Climate Research Unit[7]. Southern Malawi is largely characterised by low-lying areas with semi-arid conditions, and is the hottest part of the country, with temperature range between 12 and 35°C, and extremes of 40°C in semi-arid areas possible. Observed mean annual temperature has increased over time, relative to the 1961–1990 average **(Figure 1; refer to Annex 2, Section 3.1.1, for full details).**

9. Malawi has a unimodal (austral summer) rainfall pattern **(refer to Annex 2, Section 3.1.2)**. Mean annual rainfall ranges from 725 mm to 2500 mm depending on location. The warm-wet season occurs from November to April, during which period 95% of the annual rainfall is received. December to January is the wettest period and coincides with the period when most of the agricultural activities take place. Observed mean annual rainfall has decreased over time, relative to the 1961–1990 average (Figure 2).

10. Malawi is exposed to both floods and droughts, with events increasing in frequency, magnitude and scope over time **(Annex 2, Section 3.1.3)**. Heavy and/or persistent precipitation, together with changes in land use and land cover[8], has led to a considerable increase in flood risk across the Shire River basin in southern Malawi. Heavy precipitation is also caused by tropical cyclones making landfall, together with strong winds, flooding, landslides and mudslides. The impacts of flooding (often caused by tropical cyclones) have also been increasing in recent years in the project region. The frequency, duration and severity of droughts in southern Malawi has increased since the early 1980s, consistent with observed changes in temperature. While records for extreme temperatures and heatwaves were either not available, reliable or of sufficient duration to support an objective and robust historical analysis, a set of temperature-based extreme indices were examined in the climate projections **(refer to paragraph 12).** The clear signal in the projected trends in changes in temperature-based extremes support the notion that southern Malawi will be exposed also to heat-related hazards, particularly considering the region's current temperature range and extremes, and the increase in mean annual temperature over time **(paragraph 8).**



[6] Notre Dame Global Adaptation Index. Available at: https://gain.nd.edu/our-work/country-index/rankings/.

[7] Harris, I. *et al*. (2014) Updated high-resolution grids of monthly climatic observations - the CRU TS3.10 Dataset. International Journal of Climatology 34: 623-642. doi:10.1002/joc.3711.

[8] Nkhoma, L. et al. (2021) Evaluation of integrated impacts of climate and land use change on the river flow regime in Wamkurumadzi river, Shire Basin in Malawi. Journal of Water and Climate Change 12: 1674–1693. doi:10.2166/wcc.2020.138.

Figure 1. Observed mean annual temperature for southern Malawi presented as annual departures from the climatological mean. The red dashed line represents the trend in the observed change in temperature over southern Malawi.

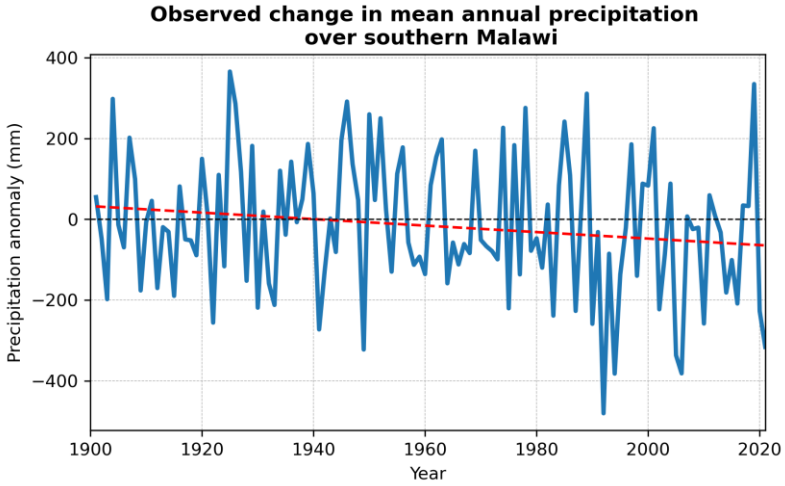


Figure 2. Observed change in mean annual precipitation over southern Malawi, presented as annual departures of the cumulative annual precipitation (mm/year) from the climatological mean. The red dashed line highlights the trend in the observed change in precipitation.

Climate change projections

11. Novel climate projections for southern Malawi were computed from bias-corrected outputs of Global Climate Models (GCMs) participating in the fifth phase of the Coupled Model Intercomparison Project (CMIP5)[9]. A bias-corrected archive of CMIP5 models has been made available through the AMMA2050 project[10]. The AMMA2050 archive provides a wide suite of global climate projections that have been bias-corrected for the African region and thus the AMMA2050 bias-corrected datasets provide a relatively high-resolution set of climate projections useful for development application and impact modelling; for this analysis, an ensemble of 16 CMIP5 GCMs were examined **(refer to Annex 2, Section 3.2 for full details).** In terms of temperature, projections clearly show further significant increases for Southern Malawi **(refer to Annex 2, section 3.2.1 for full details)**. By the mid-century, GCMs project a 1-2°C increase in under both the RCP4.5 and RCP8.5 scenarios, compared to the historical reference period (1976-2005). By the end of the century, temperatures are expected to rise by 2°under RCP4.5 and by more than 4°C under RCP8.5 (Figure 3). In terms of precipitation, while there are greater uncertainties with regards to the direction and magnitude of projected changes in precipitation as compared to temperature, models are relatively consistent in projecting a decrease across southern Malawi over the course of the 21st century, with the decrease becoming apparent from the middle of the century onwards, and with the degree of projected change being greater in RCP8.5 than RCP4.5 **(Figure 4; Annex 2, section 3.2.2).**

[9] Taylor, K.E. *et al*. (2012) An Overview of CMIP5 and experimental design. Bulletin of the American Meteorological Society 93: 485-498. https://doi.org/10.1175/BAMS-D-11-00094.1.

[10] Famien, A.M. *et al.* (2018) A bias-corrected CMIP5 dataset for Africa using the CDF-t method – a contribution to agricultural impact studies. Earth System Dynamics 9: 313–338. doi:10.5194/esd-9-313-2018.

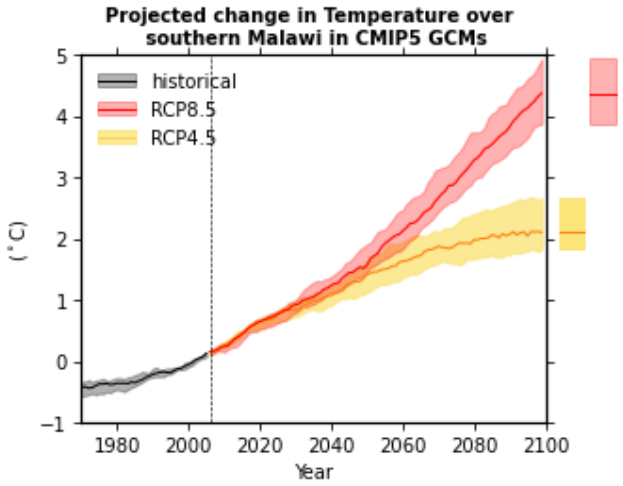


Figure 3. Projected changes in temperature presented as a year-on-year anomaly in the absolute value (10-year running mean) relative to the mean over the historical period (1976-2005). The solid line on graph is the multi-model ensemble median and shaded area represents interquartile spread (25th and 75th percentile) between individual projections.

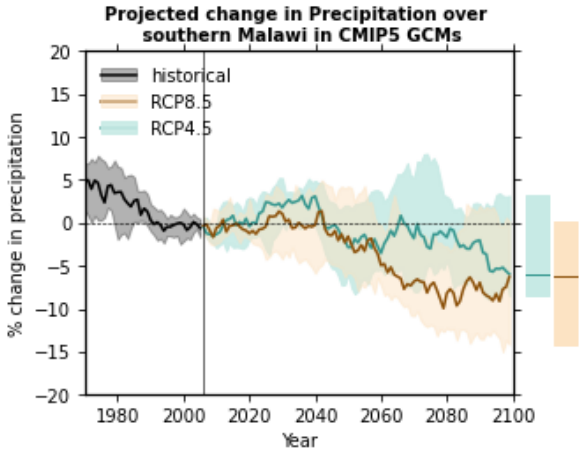


Figure 4. Projected changes in mean annual precipitation presented as year-on-year percent change in mean annual precipitation (10-year running mean) relative to the mean over the historical mean (historical period 1976-2005). Solid lines on the graph represent the multi-model ensemble median and shaded area represents the interquartile range (25th and 75th percentile) between individual models.

12. In terms of temperature-related extremes, it is likely that maximum temperature, minimum temperature, warm days, warm nights and warm spell duration will all increase over the course of the 21st century across southern Malawi for both RCP4.5 and RCP8.5 emission scenarios, with the increase being more pronounced under RCP8.5 **(refer to Annex 2, section 3.2.3.1** for full details; see Figure 5 for the projected changes in maximum and minimum temperatures, as an illustrative example). By contrast, cold nights, cold days and cold spell duration are all likely to decrease over the course of the 21st century for both emissions scenarios, with the decrease being more pronounced in RCP8.5 than RCP4.5.

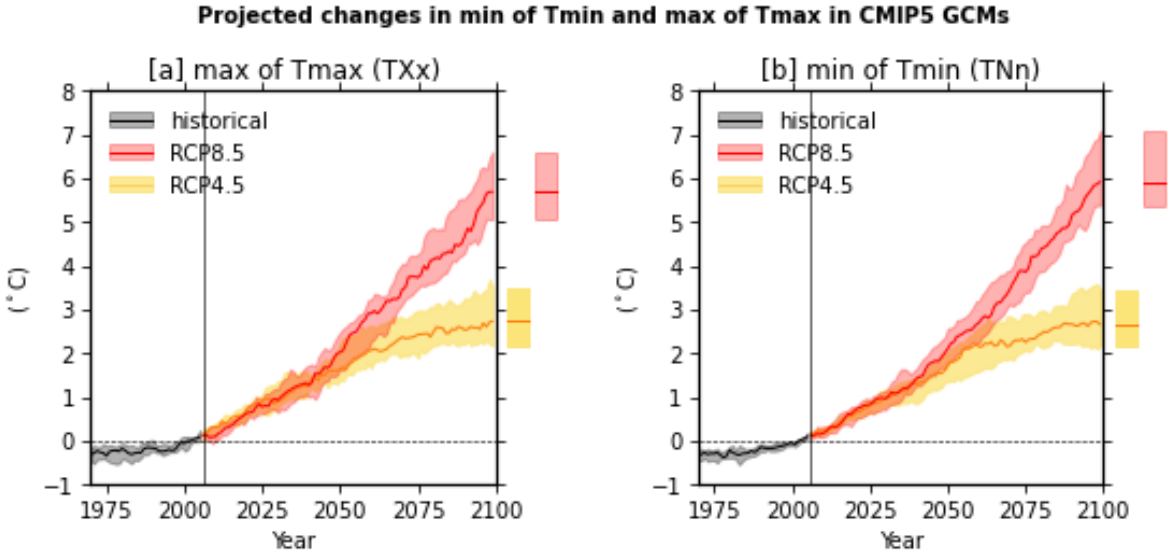
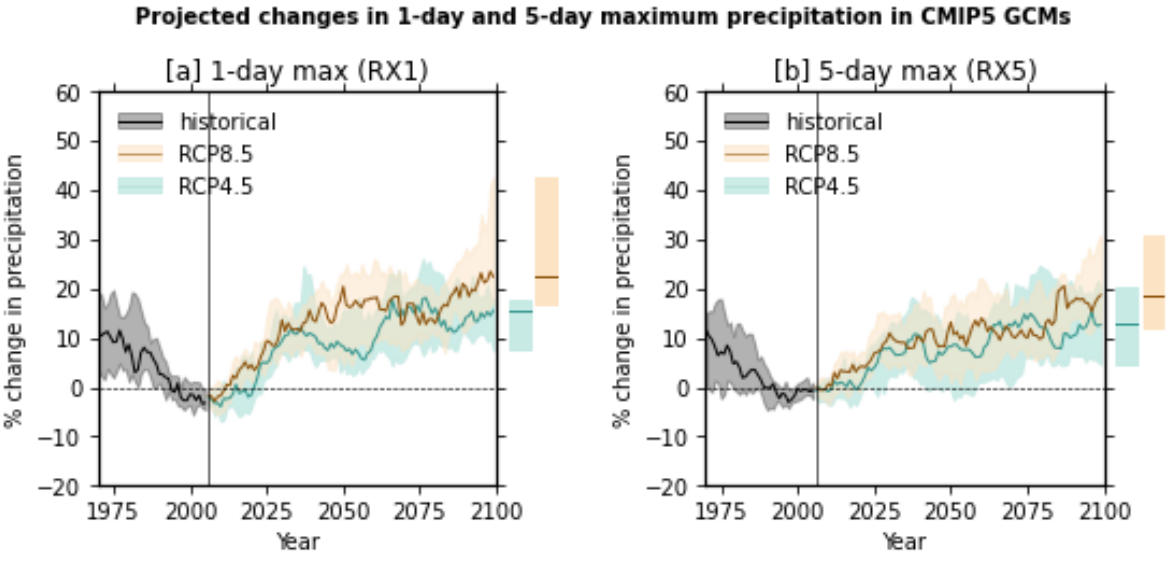


Figure 5. Projected changes in (a) maximum of maximum temperature (TXx) and (b) minimum of minimum temperature (TNn) over the course of the twenty-first century over southern Malawi for two emission scenarios. Projected changes are relative to the average over the 1976 – 2005 historical reference period and are presented as ensemble median (solid line). Shaded area is the interquartile range (25th and 75th percentile) between individual models.

13. With respect to precipitation-based extremes, 1-day and 5-day maximum precipitation, as well as total precipitation on very wet and extremely wet days, are all likely to increase over the course of the 21st century across southern Malawi under both RCP4.5 and RCP8.5, with increases generally more pronounced in RCP8.5 **(refer to Annex 2, section 3.2.3.2 for full details**; see Figure 6 for the projected changes in 1-day and 5-day maximum precipitation, as an illustrative example). Extreme rainfall can also be caused by tropical cyclones when they make landfall. While there is a projected decrease in the number of tropical cyclones making landfall in the region at 1°C, 2°C and 3°C of global warming, they are projected to become more intense, so when they do make landfall, the impacts are expected to be high[11].



[11] Niang, I., et al. (2014) Africa. In: Climate Change 2014: impacts, adaptation, and vulnerability. Part B: Regional aspects. Contribution of Working Group II to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change [Barros, V.R., et al. (eds.)]. Cambridge University Press, Cambridge, United Kingdom and New York, NY, USA, pp. 1199-1265. Available at: https://www.ipcc.ch/report/ar5/wg2/africa/.

Figure 6. Projected changes in (a) 1-day and (b) 5-day maximum precipitation over southern Malawi, relative to the average over the historical reference period (1976-2005) in bias-corrected CMIP5 GCMs. Solid lines are multi-model ensemble medias and shaded areas are the interquartile range (25th and 75th percentiles) between the individual models.

14. Finally, with respect to drought risk, consecutive dry day duration is likely to increase over the 21st century, and by the end of the century, the maximum number of consecutive dry days in a year increases by up to 30 days across parts of southern Malawi for the RCP8.5 emissions scenario, relative to the historical reference period. The projected change is less pronounced in the RCP4.5 emissions scenario (Figure 7; **refer to Annex 2, section 3.2.3.3** for full details).

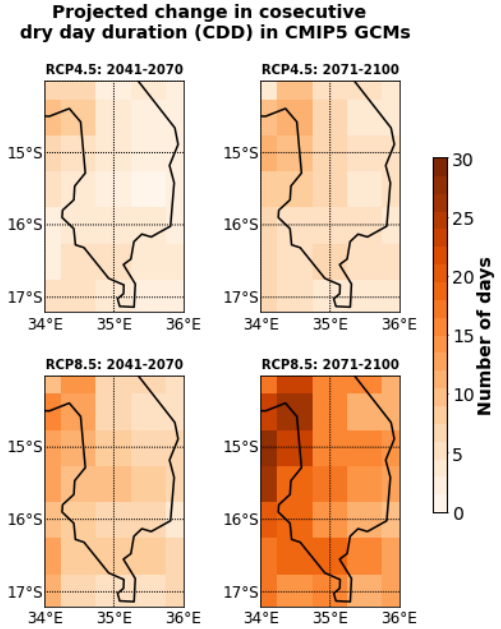


Figure 7. Projected changes in maximum consecutive dry day duration for the mid-century and end-of-century time slices over Southern Malawi for two different emission scenarios, relative to the historical reference period (1976-2005).

Anticipated impacts from climate change on health and well-being, and vulnerabilities in the target region

15. The projected changes in temperature, rainfall, and extremes that have been detailed above have numerous implications for health and well-being, and the availability, accessibility and quality of healthcare[12], if not addressed promptly. Given the major climatic drivers that southern Malawi faces the CHWBRC project seeks to respond to: increasing mean temperatures, decreasing mean precipitation, increases in precipitation-related extremes and increases in temperature-related extremes; the related climate hazards are increased flooding (as a result of an increase in precipitation-related extremes, to which tropical cyclones sometimes also contribute), increased high/extreme heat events, and increases in droughts. The increased disease burden from climatic changes will reduce well-being, likely increase poverty, and impede child development, and the impacts of climate change on health disproportionately affect women, children, and other marginalised groups. It is therefore the objective of this project to develop a climate-resilient healthcare system that will reduce the adverse effects of climate change on health and well-being through a multi-pronged approach, prior to the realisation of the numerous and extensive impacts of the above-mentioned climatic hazards on health and well-being, and on healthcare provision. The impacts of these climatic hazards are detailed below.

16. The main vulnerabilities in the target areas are related to the high levels of poverty and food insecurity, gender inequality, persistent malnutrition, environmental degradation and dependence on rain-fed agriculture, limited access to water and sanitation facilities, and high unemployment **(refer to Annex 2, Section 2.1).** The health implications of climate change are mediated through several direct and indirect pathways, all of which exhibit social and gendered differences. Climate change exacerbates existing inequalities, particularly gender inequalities[13], as will be illustrated further below. For

[12] USAID (2022) Climate change impacts on human health and the health sector. USAID. Available at: https://www.usaid.gov/sites/default/files/2022-05/Climate_Change_Impacts_on_Human_Health_and_the_Health_Sector_508_Tagged_Mar_2022.pdf.

[13] E.g. Paglialunga, E. *et al*. (2022) Climate change and within-country inequality: new evidence from a global perspective. World Development 159: 106030. https://doi.org/10.1016/j.worlddev.2022.106030; Huyer, S. *et al*. (2020) Can we turn the tide? Confronting gender inequality in climate policy. Gender & Development 28: 571-591. https://doi.org/10.1080/13552074.2020.1836817.

example, collecting water in times of scarcity places a heavy burden on women and girls who miss opportunities for study, work, and self-care as a result[14] **(Annex 2, Section 3.3.8).**

17. In terms of water and sanitation, declines in the water table, resulting from a combination of environmental degradation**,** decreasing rainfall, and increasing demands placed on water resources, have cost implications for the provision of safe water, sanitation, and health (WASH) in the Southern Region, due to increased demand for water pumping systems **(refer to Annex 2, Section 3.3.1).** In addition, extreme rainfall events and floods will exacerbate the damage to WASH infrastructure that has already been observed in recent extreme events, such as the destruction of boreholes, water taps, gravity-fed schemes, and latrines by tropical storm Ana in 2022[15]. The recent census shows that 75% of toilet facilities in the Southern Region are pit latrines and 65% of people are dependent on boreholes for drinking water[16], highlighting the vulnerability of WASH infrastructure in the Southern Region to climatic extremes.
18. The rain-fed nature of agriculture in Malawi[17] means that its productivity levels are highly dependent on the nature and change of rainfall. Thus, drying trends will negatively impact what is already a short growing season[18]; further, increases in temperature negatively affect crops **(refer to Annex 2, Section 3.3.2).** Thus, climate change is anticipated to negatively impact agricultural production in the target areas. For instance, maize is a staple crop, and yields decrease with higher temperatures, with sensitivity to heat intensified in drought conditions: by the 2050s, in parts of southern Malawi, one in every two or three years will have a failed agricultural season[19]. Climate change-induced decreases in agricultural productivity affect food security by reducing the quantity, quality, and diversity of foods available[20]; these factors will have a severe impact on malnutrition, exacerbating an already challenging situation where 39% of under-five children in rural areas are stunted, 3% are wasted, and 12% are underweight[21]. Poor food quality and diversity weakens immune systems, increasing susceptibility to diseases.
19. Changing temperature and rainfall patterns will influence the seasonality, intensity, and geographical prevalence of climate-sensitive infectious and vector-borne diseases **(refer to Annex 2, Section 3.3.3).** For one example, there is a strong relationship between increased temperatures and diarrhoeal diseases like cholera[22], which is the 5th biggest cause of mortality in Malawi[23], with the country experiencing regular cholera outbreaks. For children younger than five in low- and middle-income countries, diarrhoea is also responsible for exacerbating malnutrition. Floods have also typically increased exposure to water-borne diseases as a result of contamination. Diarrhoea incidence is expected to rise progressively to 2050 in the districts of Chikwawa, Lilongwe, and Zomba[24]. Beyond diarrhoea and cholera, there are strong concerns over malaria, for which temperature, along with rainfall and humidity, is a key driver of the rate of transmission[25]. Based on stakeholder engagement **(see Annex 7),** knowledge levels at district and community level on changing disease risk are variable, which impedes the capacity to anticipate and adapt.
20. Non-infectious climate-sensitive diseases and conditions are also highly likely to increase in the future **(refer to Annex 2, Section 3.3.3)**, with heat and heatwaves impacting many diseases and conditions. Extreme heat and heatwaves impact heat strain or stress, the risk of which is exacerbated by dehydration[26] (in turn aggravated by decreases in water

[14] Tomberge, V.M.J. et al. (2021) The physical burden of water carrying and women's psychosocial well-being: evidence from rural Nepal. International Journal of Environmental Research and Public Health 18:7908. Doi: 10.3390/ijerph18157908.

[15] Department of Disaster Management Affairs (2022) Emergency Response Plan: Tropical Cyclone Ana.

[16] NSO (2018) Malawi population and housing census. Government of Malawi, Zomba.

[17] Narain et al. (2022) Malawi - Country Climate and Development Report. World Bank Group, Washington DC. Available at: http://documents.worldbank.org/curated/en/099545010272237260/P1772201ced75ce9182e7142761bde013662bca4fe42.

[18] Ngongondo, C. et al. (2014) Growing season length and rainfall extremes analysis in Malawi. IAHS-AISH Proc. Reports 363, 361–366. Available at: https://iahs.info/uploads/dms/16616.65-361-366-363-65-Paper-53-Ngongondoetal.pdf.

[19] Verhage et al. (2018) Climate risk assessment and agricultural value chain prioritisation for Malawi and Zambia. CCAFS Working Paper no. 228. Wageningen, the Netherlands: CGIAR Research Program on Climate Change, Agriculture and Food Security (CCAFS). Available at: www.ccafs.cgiar.org.

[20] Owino et al. (2022) The impact of climate change on food systems, diet quality, nutrition, and health outcomes: a narrative review. Frontiers in Climate 4. https://www.frontiersin.org/articles/10.3389/fclim.2022.941842

[21] Doctor, H & Nkhana-Salimu, S. (2017) Trends and determinants of child growth indicators in Malawi and implications for the Sustainable Development Goals. AIMS Public Health 4: 590-614. Doi: 10.3934/publichealth.2017.6.590.

[22] Reyburn, R., Kim, D.R., Emch, M., Khatib, A., Von Seidlein, L. and Ali, M., 2011. Climate variability and the outbreaks of cholera in Zanzibar, East Africa: a time series analysis. The American Journal of Tropical Medicine and Hygiene 84: 862-869. DOI: 10.4269/ajtmh.2011.10-0277.

[23] Institute for Health Metrics and Evaluation (IHME) (2023) Malawi. Institute for Health Metrics and Evaluation, Seattle, USA. Available at: https://www.healthdata.org/malawi.

[24] Government of Malawi (2021) Draft Health National Adaptation Plan March 2021.

[25] E.g., Blanford, J. *et al*. (2013) Implications of temperature variation for malaria parasite development across Africa. Scientific Reports 3: 1300. https://doi.org/10.1038/srep01300.

[26] Gauer ,R. & Meyers BK (2019) Heat-related illnesses. American Family Physician 99: 482-489.

availability). Non-communicable diseases (NCDs) make up 25% of the total burden of disease in Malawi and 29% of the mortality[27]. Many NCDs are related to heat/temperature rise, including cardiovascular disease, stroke, renal disease, diabetes, and respiratory disease[28]. People with cardiopulmonary and other chronic diseases, and very young children are particularly vulnerable to the effects of heat. In Malawi, lower respiratory tract infections, stroke and ischemic heart disease are all leading causes of death[29]. In the Southern Region, a quarter of the population is made up of under-ten-year-old children[30]. Studies show a marked increase in the risk of death and hospitalisation from NCDs when patients are exposed to excessive heat[31], yet across the globe heat-related mortality and morbidity is poorly registered, which impedes adaptation.

21. Increased temperatures and heat-related extremes in Malawi will also affect people's health and well-being more broadly **(see Annex 2, Section 3.3.4).** These hazards are associated with increased mental health issues, multiple adverse pregnancy and birth outcomes[32], occupational health issues[33], and increased healthcare costs[34]. To consider the case of mental health, the prevalence of mental ill-health is on the rise in both the developed and developing world with mental and behavioural disorders contributing significantly to the global burden of disease[35], and multiple studies also demonstrate the relationship between maternal depression and subsequent malnutrition in their infants[36]. Climate change exacerbates many social, environmental and economic risk factors for problems in mental health and psychosocial wellbeing[37]. Mental health impacts of climate change in Malawi are still poorly quantified. However, a recent and as yet unpublished study conducted in 2022 found that 86% of women reported that their mental health has been affected by climate change[38]. In focus groups conducted in the project target districts, women, pregnant women and breastfeeding mothers noted the stress and anxiety that extreme events bring because of the uncertainty they create, which continues long after the actual extreme event is over.

22. Some of the ways in which the above-mentioned climatic changes are likely to exacerbate existing inequalities in health impacts, particularly gender inequalities in the target areas, are: climate-related impacts on food availability (e.g. droughts leading to decreased yields) causes particular stress and anxiety for women, because gendered roles dictate women's responsibility for household food security[39] **(Annex 2, Sections 3.3.4 and 3.3.8)**; water and sanitation scarcity make it more difficult for women and girls to manage menstrual hygiene which in turn limits their participation in school, workplace, and community[40] **(Annex 2, Section 3.3.8)**; disruption caused to WASH facilities (at schools) by extreme precipitation/flooding have caused more problems for girls than boys **(see Annex 8: Gender assessment)**; Gender-Based Violence (GBV) and child, early and forced marriages are known to increase following climate-related shocks and disasters[41] (e.g. droughts; for one example, the drying of Lake Chilwa has been associated with an increased

[27] Ministry of Health (2017) National Action Plan for the Prevention and Management of Non-Communicable Diseases in Malawi. Available at: https://www.iccp-portal.org/system/files/plans/MWI_B3_s21_Malawi%20NCD%20Strategy_2018.pdf.

[28] Global Heat Health Information Network (2023) Heat and Health. Available at https://ghhin.org/heat-and-health/.

[29] *Ibid*.

[30] Malawi Data Portal (2018) Population of Malawi by Region, Age, 2018. Malawi National Statistical Office, Zomba, Malawi. Available at: https://malawi.opendataforafrica.org/azfucgf/population-of-malawi-by-region-age-2018.

[31] Global Heat Health Information Network (2023) Heat and Health. Available at: https://ghhin.org/heat-and-health/.

[32] Chersich M.F. et al. (2023) Increasing global temperatures threaten gains in maternal and newborn health in Africa: A review of impacts and an adaptation framework. International Journal of Gynecology & Obstetrics 160: 421-429. doi: 10.1002/ijgo.14381.

[33] Kjellstrom, T. et al. (2009) Workplace heat stress, health and productivity–an increasing challenge for low and middle-income countries during climate change. Global Health Action 2: 2047-2052. doi: 10.3402/gha.v2i0.2047.

[34] Wondmagegn, BY, *et al*. (2019). What do we know about the healthcare costs of extreme heat exposure? A comprehensive literature review. Science of the Total Environment657: 608-618. doi: 10.1016/j.scitotenv.2018.11.479.

[35] WHO (World Health Organization) (2022) Mental disorders. World Health Organization, Geneva, Switzerland. Available at: https://www.who.int/news-room/fact-sheets/detail/mental-disorders

[36] E.g., Smith Fawzi et al. (2019) Lifetime economic impact of the burden of childhood stunting attributable to maternal psychosocial risk factors in 137 low/middle-income countries. BMJ Global Health 4:e001144. doi:10.1136/ bmjgh-2018-001144.

[37] WHO (2022) Mental health and climate change: policy brief. World Health Organization, Geneva, Switzerland. Available at: https://www.who.int/publications/i/item/9789240045125;

[38] GCU (Glasgow Caledonian University) (2022) Climate change makes violence against women in Malawi worse, study finds. Glasgow Caledonian University, Glasgow, Scotland. Available at: https://www.gcu.ac.uk/aboutgcu/universitynews/climate-change-makes-violence-against-women-in-malawi-worse,-study-finds#:~:text=More%20than%2086%25%20of%20the,to%20their%20marriage%20(10%25).

[39] GCU (Glasgow Caledonian University) (2022) Climate change makes violence against women in Malawi worse, study finds. Glasgow Caledonian University, Glasgow, Scotland. Available at: https://www.gcu.ac.uk/aboutgcu/universitynews/climate-change-makes-violence-against-women-in-malawi-worse,-study-finds#:~:text=More%20than%2086%25%20of%20the,to%20their%20marriage%20(10%25).

[40] Tomberge, V.M.J. et al. (2021) The physical burden of water carrying and women's psychosocial well-being: evidence from rural Nepal. International Journal of Environmental Research and Public Health 18:7908. Doi: 10.3390/ijerph18157908

[41] Women Deliver (2021) The link between climate change and sexual and reproductive health and rights: an evidence review. New York, USA. Available at: https://womendeliver.org/wp-content/uploads/2021/02/Climate-Change-Report.pdf.

number of early marriages in daughters[42]), and child and adolescent marriage and pregnancy rates are already high, particularly in rural areas[43] **(Annex 2, Sections 3.3.3 and 3.3.5)**; and the availability and accessibility of sexual and reproductive health services is negatively impacted by extreme events, particularly floods **(Annex 2, Section 3.3.5)**.These gendered impacts combine and intersect in multiple ways **(Annex 2, Section 3.3.8).** For instance, increases in GBV as a result of climate stresses (e.g., floods) means there is increased demand for GBV services at a time when they are likely to be less accessible (as floods can render healthcare centres inaccessible). Increased incidence of GBV together with loss of access to sexual reproductive health services lead to unwanted pregnancy and increased incidence of child, early, and forced marriage, which in turn lead to higher school dropout rates and poor health outcomes for girls and babies. For example, a study conducted in 2022 in both Nkhata Bay and the project district of Mangochi found that roads and bridges washed away by floods prevented access to sexual and reproductive health services by adolescent young men and women, leading to early and unwanted pregnancies and marriages, which disrupted education attainment for both boys and girls, with girls' individual health and wellbeing the most affected[44].

23. Repeated extreme events, particularly floods**,** cause physical damage to healthcare infrastructure and to transport infrastructure, which impedes the availability of and access to health care. Infrastructure includes buildings, WASH facilities, equipment and medical supplies. Infrastructure damage of health facility buildings and transport infrastructure has occurred across the project areas **(Annex 2, Sections 3.3.6 and 3.3.7).** An annual average of 100 education and health care facilities are already affected by 1-in-10 year floods, and 145 facilities in 1-in-50 year floods, with over 40% of the average annual loss accruing to the Southern Region[45]. This situation is compounded by the current deficits in the healthcare provision system, which relate both to the state and upkeep of facilities and the presence and capacity of staff to be able to provide sufficient services.

24. Climate-related health outcomes observed by communities within the target districts are outlined within **Annex 8**, under the section "Community Profiles: Gender and Social Inclusion Focus".

Related projects/interventions

25. Malawi has demonstrated commitment to addressing climate change through progress made on national climate change policies, the NAP and the Nationally Determined Contribution (NDC). The proposed project aligns closely with the NDC priority themes of "Healthy and protected people", "Effective and efficient Early Warning Systems" and "Climate proofed infrastructure, buildings and energy systems". Malawi has accessed GCF readiness funds and as part of this funding, in-country mechanisms are being established. "Advancing The NAP Process: Climate Resilience for Sustainable Development In Malawi" (UNEP-implemented) developed capacity and tools for the coordination and execution of future NAP processes. The resultant assessments, Malawi NAP Stocktaking Report (2016) and priorities informed the development of this project, and activities are fully aligned with identified priorities. As part of the draft NAP, Malawi's health sector is developing a Health National Adaptation Plan (HNAP). The proposed project will directly contribute to the draft HNAP objectives on i) community empowerment; ii) health adaptation by non-state actors; iii) preparedness for and management of climate change health effects; iv) climate-resilient health infrastructure and services; iv) capacity building for climate response and mobilisation of additional resources[46]. Malawi's NDA and other key national stakeholders are also benefiting from capacity strengthening for climate change programming thanks to GCF Readiness support[47].

26. The GCF-funded project, "Scaling Up the Use of Modernized Climate Information and Early Warning Systems" (FP002, 2017-2023); UNDP-implemented), aimed to save lives and minimise risks to livelihoods by enhancing hydro-meteorological capacity for early warning and forecasting, development and dissemination of tailored products for smallholder farmers and fishermen, and strengthened capacities of communities to respond to climate-related disasters (floods). The project installed weather stations, a lightning detection and thunder alert system, lake-based weather

[42] Alcayna, T. *et al*. (2021) Climate change impacts on health: Malawi assessment. Red Cross Red Crescent Climate Centre, The Hague, Netherlands. Available at: https://www.climatecentre.org/wp-content/uploads/RCRC_IFRC-Country-assessments-MALAWI-3.pdf.

[43] NSO (National Statistical Office) (2017) Malawi Demographic and Health Survey. National Statistical Office, Lilongwe, Malawi.

[44] Sibale, B. *et al*. (2022) Formative assessment to inform design of a gender transformative positive youth development (PYD) approach to improve family planning/reproductive health (FP/RH). Pact Malawi, Lilongwe, Malawi.

[45] These numbers will be even higher for extreme events like those of 2015 and 2022. World Bank GFDRR, 2019. Disaster risk profile: Malawi. Available at: https://www.gfdrr.org/en/publication/disaster-risk-profile-malawi-2019.

[46] Further details on the project's strong alignment with the HNAP are provided in Annex 2: Feasibility Study, Section 2.2.

[47] Readiness support to strengthen the Malawi NDA and key national stakeholders' capacities in climate change programming in Malawi. Available here.

buoys, automated hydrological water level stations, and a weather data visualisation and integration system[48]. As part of stakeholder consultation for the proposed project, a meeting was held with UNDP (May 2021) to identify synergies for scaling up access to climate information. Under Outcome 1, the proposed project will strengthen and integrate the existing health early warning with the improved climate information capacities built under FP002. This will include the installed weather stations which will be instrumental for the proposed establishment of sentinel sites (Activity 1.1.3). It will refer to lessons learned and best practices pertaining to communicating climate risks to community members and, where possible, use mechanisms and structures created through FP002. Coordination with the legacy of this UNDP-implemented project and maximising synergies and lessons learned, will take place through the executing entities for both projects (Department of Disaster Management Affairs and Ministry of Health) being represented on the Joint National Technical Committee on Climate Change and Disaster Risk Management (JNTCCCDRM)[49].

27. "Solar for Health" is a GCF funding proposal led by UNDP for a project covering Malawi, Zambia, Zimbabwe, Namibia, and Liberia. The total value is $219 Million of which $73 Million would be for Malawi. It is envisioned to be a 10-year project with Ministry of Health (MoH) as the Executing Entity, in partnership with WHO and Renewable Energy Association. This project is anticipated to start in 2024. It has three components: 1) Low carbon infrastructure focusing on solarisation of health facilities targeting 450 health facilities; 2) Climate informed health services to finalise the national level Early Warning and Response Systems (EWARS) with four sentinel sites (Chitipa, Salima, Zomba, and Chikwawa) to improve collection and integration of climate and health data. 3) Creating an Enabling Policy Environment and Community of Practice. The proposed MoH-Save the Children GCF project will continue to align with this MoH-UNDP proposal as both move towards approval by the GCF to ensure synergies and complementarity. During implementation, there will be close collaboration between the two projects via the MoH as Executing Entity for both projects, via the Health And Climate Change Core Team (HCCCT) and with UNDP (on solarisation) and WHO (on health surveillance and early warning systems). On a technical level this will also be ensured by WHO being represented on the Technical Advisory Group of the CHWBRC (See Implementation Arrangement below).
28. The CHWBRC will also build on a project financed by the Adaptation Fund – "Adapting to Climate Change Through Integrated Risk Management Strategies and Enhanced Market Opportunities for Resilient Food Security and Livelihoods" (approved 2019), implemented by the World Food Programme (WFP). This project seeks to promote access to integrated climate risk management strategies and structured market opportunities as a means of enhancing climate adaptation and food security, targeting 85,000 households (382,500 beneficiaries) in Balaka, Zomba, and Machinga districts in 22 Traditional Authorities (TAs), with a total of 23,600 farmers from the three districts with surplus production benefiting from access to market access opportunities including through farmer associations and cooperatives throughout the duration of the project. Given geographical complementarity in districts covered, the proposed project will utilise capacity developed through existing projects financed by the Adaptation Fund and focus on disseminating relevant information to inform decision-making and risk reduction in the health sector, targeting community health committees, school children, community health facilities, and district health departments. Under Outcome 4 the proposed project will focus on improving climate-resilient food and nutrition security with a particular focus on pregnant women and household with children under 2, that will complement activities implemented through the project financed by the Adaptation Fund and, where possible, scale-up and link beneficiaries with services offered under the AF project (e.g., financial services). Coordination with the Adaptation Fund-financed project, and maximising synergies and lessons learned, will take place through each implementing entity being represented on the JNTCCCDRM.
29. The CHWBRC is aligned with the strategic priorities of the GCF Strategic Plan 2024-2027, including in terms of improving early warnings and integrated risk management approaches and contributing to the aims of the Early Warnings for All Initiative[50], namely "Detection, observations, monitoring, analysis and forecasting of hazards", "Dissemination and communication", and "Preparedness and response".
30. Further details and other projects that the proposed GCF project will build on are presented in **Annex 2: Section 2.5.**

B.2 (a). Theory of change narrative and diagram (max. 1500 words, approximately 3 pages plus diagram)

31. The project's Theory of Change (ToC), outlined in Figure 8, details the causal links and pathways from activities to outputs and project-level outcomes. Together, these activities, outputs, and project-level outcomes are designed to generate measurable adaptation results for the health system and communities in Malawi.

[48] UNDP Annual Performance Report FP002, 2023

[49] The JNTCCCDRM is a multi-stakeholder technical committee, chaired by government, that coordinates climate change and disaster risk management activities and reports to the National Steering Committee on Climate Change

[50] https://public.wmo.int/en/media/press-release/early-warnings-all-initiative-scaled-action-ground

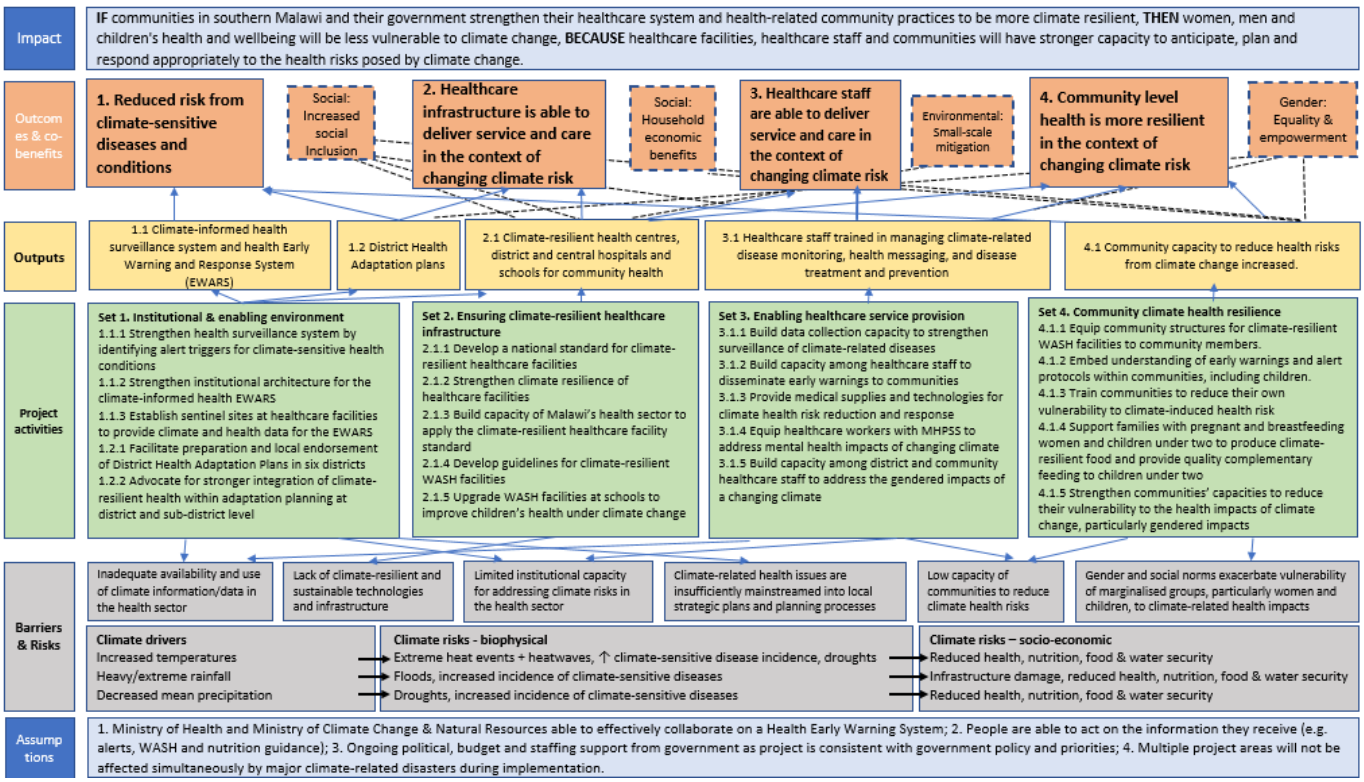


Figure 8. Theory of Change diagram for the Community Health and Well-being for Rural Communities in southern Malawi project

Barriers

The project will address the following barriers:

32. Barrier 1: *inadequate availability and use of climate information/data in the health sector*: integrated surveillance (disease surveillance and weather surveillance) systems are key for enhancing the capacity of health systems to prepare and adapt to climate-sensitive diseases and conditions. Climate-informed surveillance can enhance the preparedness of health systems via early warning systems, which anticipate risks and trigger early warning responses to avoid or reduce impact and prepare for effective response. In the context of a rapidly changing environment and risk landscape, early warning systems are a valuable tool for building the adaptive capacity and climate-resilience of health systems. However, the extent of Malawi-specific knowledge on the links between climate parameters and climate-sensitive diseases and conditions is underdeveloped, and largely linked with low-resolution studies that cover the region. The absence of country-specific information contributes to gaps in integrated risk monitoring, early warning and response; thus, there is a lack of an integrated surveillance and climate-informed health early warning system in Malawi.
33. Barrier 2: *lack of climate-resilient and sustainable technologies and infrastructure*: the lack of specific attention to climate change impacts on the health sector also means that healthcare infrastructure is poorly prepared to deal with the impacts of climate exposure. The recent occurrence of multiple extreme events in the south of the country has further exposed the extent of impacts that arise from direct damage to buildings and supplies. This damage impedes the capacity of the sector to deliver healthcare both immediately after the event and in the recovery period and acts as a barrier to the achievement of a healthy population in Malawi. For example, in early 2022, Tropical Storm Ana resulted in the destruction of 47 Community Health Facilities in the Southern Region in the form of infrastructural damage, power cuts, loss of medicines, damage to medical equipment, vaccines and other supplies[51].
34. Barrier 3: *limited institutional capacity for addressing climate risks in the health sector:* There is limited institutional capacity to anticipate, prepare for and respond to the health risks of climate change and this is a further barrier to adaptation. At a broader level, there is insufficient institutional coordination between the Ministry of Health and Department of Climate Change and Meteorological Services to enable the functioning of an integrated surveillance and climate-informed health early warning system in Malawi. Within the healthcare system, healthcare staff do not have

[51] Department of Disaster Management Affairs (2022) Emergency Response Plan: Tropical Cyclone Ana.

sufficient capacity to use climate-informed health surveillance and early warning and response systems; and are not aware of how climate change will affect health outcomes and how they need to alter their service delivery and messaging accordingly. They also lack sufficient resources (medical supplies and technologies) for climate health risk reduction and response. This means that health risks of climatic changes are overlooked and under-addressed, leading to poorer health outcomes, and an inability to sustain the healthcare improvements that have been attained over recent years.

35. Barrier 4: *climate-related health issues are insufficiently mainstreamed into local strategic plans and planning processes*: Whilst preliminary investigations of the links between health and climate have been undertaken, and a Health National Adaptation Plan (HNAP) drafted, these national-level efforts are not supported by strong institutional awareness or capacity at local level, and multi-sectoral collaboration on health and climate change is lacking at district and sub-district levels.
36. Barrier 5: *low capacity of communities to reduce climate health risks*: the lack of information and awareness around climate risks to health means that communities are not aware of the nature of a range of climate-related health risks. Without such knowledge, they are unable to take measures to reduce risk, which means that health burden from climate change will increase and undermine general health and well-being.
37. Barrier 6: *marginalised groups, particularly women and children, are more vulnerable to climate-related health impacts*: people have differential vulnerability to climate change and extremes. Marginalised groups are more likely to have lower adaptive capacity and higher sensitivity to the health impacts of climate change. Vulnerability to climate-sensitive diseases is often higher among women, children, the elderly, people with disabilities, and the poor[52]. This differential vulnerability often arises from socially-constructed gender and social norms that give rise to differential resource allocation, decision-making and political participation. For instance, gendered roles accord responsibility for food provision to women. If agricultural production decreases as a result of a variable climate, this can lead to food and nutrition insecurity **(Section 3.3.2, Annex 2).** The stress created by such circumstances has impacts particularly on the mental health of women **(Section 3.3.4, Annex 2).** Increases in food and nutrition insecurity can lead to coping strategies that further reinforce gender inequality, for example pulling girl children from school and encouraging early marriage **(Section 3.3.8, Annex 2).** Food and nutrition insecurity affect particularly children under five, and young children are also particularly vulnerable to a number of climate-sensitive diseases and conditions **(refer to Section D.4 for references).**

The theory of change

38. The theory of change hypothesises that:

IF the health system in southern Malawi is strengthened in terms of governance, health and climate information systems, service delivery and community engagement,
THEN the negative impacts of climate change on the health of women, children and men will be reduced,
BECAUSE healthcare staff, facilities and communities will have stronger capacity to anticipate, plan and respond to climate-health risks.

39. The project aims to achieve impact through four interlinked outcomes (described in full in Section B.3): Outcome 1, reduced risk from climate-sensitive diseases and conditions; Outcome 2 Healthcare infrastructure is able to deliver service and care in the context of changing climate risk; Outcome 3 Healthcare staff are able to deliver service and care in the context of changing climate risk; Outcome 4, Community level health is more resilient in the context of changing climate risk. The potential for transformation comes from taking a multi-pronged approach that targets several pillars identified as the foundations of climate-resilient health systems – covering the institutional and enabling environment (Outcome 1), healthcare infrastructure (Outcome 2), enabling healthcare service provision, including through staff capacity (Outcome 3), and building community climate-health resilience (Outcome 4).
40. The potential for transformation comes from taking a multi-pronged approach that targets several pillars identified as the foundations of climate-resilient health systems – covering the institutional and enabling environment (Outcome 1), healthcare infrastructure (Outcome 2), enabling healthcare service provision, including through staff capacity (Outcome 3), and building community climate-health resilience (Outcome 4).
41. The project combines national, district, and local level interventions to create strong conditions for scalability, and strategic integration to catalyse the transition to a climate-resilient health system. By addressing the institutional and enabling environment at both national and district level, there is scope to establish critical mass among health staff in government and healthcare facilities so that districts not targeted directly by the project could take on board

[52] World Health Organization (2013) Protecting health from climate change: vulnerability and adaptation assessment. World Health Organization, Geneva, Switzerland. Available at: https://www.who.int/publications/i/item/protecting-health-from-climate-change-vulnerability-and-adaptation-assessment.

interventions, such as climate-resilient healthcare facility standards; whilst the health EWARS will be developed so that it can be used nationally and rolled out in target districts and health facilities. At district level, ownership by relevant staff at District Executive Council level will create sufficient momentum to increase the profile of climate in health planning. The comprehensive capacity strengthening of government health sector technical staff at national and district level, and healthcare staff and practitioners, recognises that a whole-of-system approach is necessary to gain the critical mass necessary to truly embed new practices. At community level, efforts will be tailored to the varied needs of different population groups, and Outcome 4 includes targeted support to the groups who are most physiologically vulnerable to food and nutrition insecurity from which so many other health problems typically stem.

42. The project is expected to achieve social, environmental and gender co-benefits, namely:

Co-benefit 1 – Social: Improved social inclusion for marginalized community members, through increased access to public health information, cooperative management of community assets, and increased involvement.

Co-benefit 2 – Social: Improved social outcomes for household economies based on using improved integrated homestead farming and nutrition practices due to reduced need to purchase diversified food for nutritionally vulnerable household members.

Co-benefit 3 – Environmental: Very small-scale mitigation co-benefits through solar installations at health facilities reducing reliance on diesel generators at facilities and on the national electrical grid.

Co-benefit 4 – Gender: Increased gender equality and empowerment, through improved knowledge of climate change impacts on gender issues, community-level training and engagement on gender roles and dynamics, women-focused training on nutrition, and increased women's participation and influence in decision-making.

Assumptions

43. Assumption 1: The Ministry of Health (as the custodian of the health EWARS) and the Ministry of Climate Change & Natural Resources (as the producer and custodian of weather and climate information) need to be able to effectively collaborate on a climate-informed health EWARS. The roles and responsibilities around provision of early warning information can vary, for example the Department of Climate Change and Meteorological Services (DCCMS) issues warnings of extreme weather but, if that were foreseen to lead to risks to human health (through extreme heat or potential disease outbreaks), then it is likely that Ministry of Health should issue that warning. Activities under Outcome 1 aim to strengthen the institutional relationship between the two bodies to enable this. Precedents exist for such institutional arrangements between different ministries, as river-related flood risk warnings are currently issued by the Ministry of Water and Sanitation, informed by weather information from DCCMS. However, achieving Output 1.1 (Climate-informed health surveillance system & Early Warning and Response System) assumes that these linkages will be able to be strengthened.
44. Assumption 2: The success of Output 4.1 (community capacity to reduce health risks from climate change increased) is contingent upon the assumption that people are able to act on the information they receive (e.g., alerts, WASH, and nutrition guidance) in order to reduce their risk. Outcome 4 focuses strongly on providing information to communities (enabled by Outcomes 1, 2 and 3 which ensure that the institutional, infrastructure and staff capacity are in place to generate and provide this information). Comprehensive efforts are made to build capacity and provide people with the tools to make climate-resilient health decisions, and the assumption is that people will be able to act on this. In order to support this action, especially in the context of Malawi being a very poor country, the project will adopt approaches that use limited land, rely on local and renewable inputs, and are easy to implement and sustain. The social differentiation of these capacities has been recognized within the Gender Action Plan **(Annex 8)** and within the broader targeting, together with specific, supporting interventions where these are required (for example provision of inputs to support stronger nutrition among pregnant and breastfeeding women and mothers of children under two under Outcome 4).
45. Assumption 3: The overall success and sustainability of the project is based on the assumption that there will be ongoing political, budget, and staffing support from government. Aligning the project with existing policy frameworks and ensuring that the outputs contribute to commitments in those policies, does what is within the sphere of control of the project, however, for the longer-term impact to be achieved, ongoing government support is required. Extraneous circumstances such as high-level political change can alter national development priorities and goals, and hence the assumption here is that current commitments remain.
46. Assumption 4: Multiple project areas will not be affected simultaneously by major climate-related disasters during implementation. Although the long-term aim is to build resilience of the health system, this resilience-building will be a scaffolded process over time and the occurrence of severe or repeated extreme events would run the risk of impeding progress, not least because the attention of the health sector, facilities, and staff would be diverted into emergency response.

Target geographies and beneficiaries

47. The CHWBRC project is designed to maximise impact by combining national-level and district-level activities that will improve the enabling environment for climate and health (Outcome 1, Outcome 3) with targeted investments at 79 health facilities in six target districts (Outcome 2), investments to equip healthcare staff to be better prepared to manage climate risks in six districts (Outcome 3) and community-level interventions in 500 villages across 25 TAs that are highly or extremely vulnerable to climate change (Outcome 4). The selected health facilities and communities are located in the six target districts of Ntcheu, Balaka, Machinga, Mangochi, Phalombe and Zomba.

48. The selection of the target districts and TAs was determined through a rigorous and consultative process that involved prioritisation in terms of adaptation needs by government and other stakeholders combined with a vulnerability assessment **(Annex 2, Section 6.2).** The vulnerability assessment used quantitative methods that have been adopted in previous vulnerability assessments focused on climate change and health[53], and was based on a range of indicators for sensitivity and adaptive capacity that were selected from among the range of indicators in climate vulnerability assessments, taking into account the availability of existing data at appropriate resolution[54]. The results of the health vulnerability assessment placed districts in categories from very high to very low vulnerability, with vulnerability being relatively higher in the southern parts of Malawi, compared to the north. Thus, the project selected six contiguous districts in the southern part of the country, these being the above-mentioned districts of Mangochi, Balaka, Machinga, Zomba, Phalombe and Ntcheu. Full details are presented in **Annex 2, Section 6.2.1**. Lack of high-resolution data availability at TA level impedes the creation of sensitivity and adaptive capacity indices as were done at district level. Instead, to determine which TAs should be targeted, available socio-economic and nutrition indicators were selected and compared against the Malawian national average. Overall, based on these indicators, the selected TAs have high levels of poverty and female-headed households **(see Annex 2, Section 6.2.2 for full details).** Within the TA population, proactive targeting will take place for women, particularly pregnant and breastfeeding women and mothers of children under two, the elderly, people with disabilities, and youth **(see Annex 2, Section 6.2.2 and Annex 8).**

49. The 79 healthcare facilities that will be targeted for physical upgrades to enhance climate resilience are based on the following criteria:

- All government-funded health centres within the six target districts will be selected (comprising 75 in total)
- In three traditional authorities (TAs), four additional health centres funded by the Christian Health Association of Malawi (CHAM) will be selected, because there are no government-funded health centres within those TAs. See **Annex 2, Section 2.4.1, and Section 6.2.3** for a further description of CHAM.
- One district or central hospital within each district is selected (five district hospitals, and one central hospital in Zomba district, all government-funded)

50. The focus is on health centres due to their unique status as the most common primary health facility within the relevant catchment areas, serving the most vulnerable and remote community members within the Traditional Authorities while being large enough to host a substantial group of Health Surveillance Assistants (HSAs) and undergo physical infrastructure modifications. The selected health centres are of different sizes and have a range of catchment populations, detailed in **Annex 2, Section 6.2.3**. For further information about the health system in Malawi and the different types of health facilities, please see **Annex 2, Section 2.4.1.**

51. Within the 25 TAs, 20 villages per TA will be selected for some of the Outcome 3 and 4 activities, to make up a total of 500 target villages. These villages will be selected in a consultation between the District Health Management Team (DHMT), Save the Children, the Implementing Partners **(Section B4),** and authorities within the TA and villages themselves. The communities will be selected based on a combination of the following factors:

    - Willingness to participate in the project intervention
    - Involvement in previous donor-funded projects (priority given to communities without prior projects)
    - Existence of ongoing donor-funded projects
    - Social vulnerability
    - Population size

[53] Berry, P. *et al*. (2018) Assessing Health Vulnerabilities and Adaptation to Climate Change: A Review of International Progress. International Journal of Environmental Research and Public Health 15: E2626.

Helldén, D. (2021) Climate change and child health: a scoping review and an expanded conceptual framework. The Lancet Planetary Health 5: e164–e175.

[54] Beccari, B. (2016) A Comparative Analysis of Disaster Risk, Vulnerability and Resilience Composite Indicators. PLoS Currents. 8, ecurrents.dis.453df025e34b682e9737f95070f9b970.

- Proximity to school

52. The project will reach 1,798,878 direct beneficiaries and 2,359,162 indirect beneficiaries. The direct beneficiaries consist of the total population of the target Traditional Authorities, whereas the indirect beneficiaries consist of the population of the target districts, less the populations within the target Traditional Authorities. Further details of beneficiary calculations are provided in **Annex 2, Section 6.2.3.**

B.2 (b). Outcome mapping to GCF results areas and co-benefit categorization

Fill in the GCF results area table below to map each project/programme outcome identified in section B.2(a) to the contributing GCF results area(s) by referring to the description of eight results areas provided in the guidance note.

Outcome number	GCF Mitigation Results Area (MRA 1-4)				GCF Adaptation Results Area (ARA 1-4)			
	MRA 1 Energy generation and access	**MRA 2** Low-emission transport	**MRA 3** Building, cities, industries, appliances	**MRA 4** Forestry and land use	**ARA 1** Most vulnerable people and communities	**ARA 2** Health, well-being, food and water security	**ARA 3** Infrastructure and built environment	**ARA 4** Ecosystems and ecosystem services
Outcome 1	☐	☐	☐	☐	☒	☒	☐	☐
Outcome 2	☐	☐	☐	☐	☐	☒	☒	☐
Outcome 3	☐	☐	☐	☐	☐	☒	☐	☐
Outcome 4	☐	☐	☐	☐	☒	☐	☐	☐

If any co-benefits have been identified in section B.2(a), fill in the Co-benefit table below to map each co-benefit to the corresponding category as defined in the FP guidance note.

Co-benefit number	Co-benefit					
	Environmental	**Social**	**Economic**	**Gender**	**Adaptation**	**Mitigation**
Co-benefit 1 (*social*)	☐	☒	☐	☐	☒	☐
Co-benefit 2 (*social*)	☐	☒	☐	☐	☒	☐
Co-benefit 3 (*environmental)*	☒	☐	☐	☐	☐	☒
Co-benefit 4 (*gender)*	☐	☐	☐	☒	☒	☐

B.3. Project/programme description (max. 2500 words, approximately 5 pages)

53. This comprehensive adaptation health system project focuses on enhancing climate resilience in healthcare and addressing risks and impacts from droughts, heat stress and floods and delivering against two GCF results areas. The CHWBRC combines interventions at national, district, and community levels, including early warning systems, healthcare facility standards, and capacity building. It aligns with the national agenda, Malawi's National Adaptation Plan, and exhibits transformative potential in addressing the climate-health nexus. CHWBRC will directly benefit 1,798,878 vulnerable people and will indirectly benefit a further 2,359,162 vulnerable people within 6 districts and 500 communities of southern Malawi.The project takes a holistic health system approach, as advocated by the WHO, to develop a climate-resilient healthcare system that will reduce the adverse effects of climate change on health and wellbeing. The project will achieve climate-resilient health and wellbeing through a multi-pronged approach as set out in the project ToC (**Figure 8**).

OUTCOME 1: Reduced risk from climate-sensitive diseases and conditions

54. The activities under this outcome will enable better surveillance of climate-related diseases and conditions; enhance the use of climate information in the health sector for effective health early warning; and build institutional and human capacity to increase community health adaptive capacity. These activities will address the barrier of inadequate availability and use of climate information/data in the health sector, the barrier of limited institutional capacity for addressing climate risks in the health sector and the barrier that climate-related health issues are insufficiently mainstreamed into local strategic plans and planning processes. The project will produce greater understanding of the associations between climate data and the incidence of the target diseases/conditions, as well as develop Malawi-specific thresholds and alert trigger levels through studies and validation for the target diseases/conditions. Full details of this Outcome are presented in **Annex 2 (Section 6.1.5).**

Output 1.1 Climate-informed health surveillance system and health Early Warning and Response System (EWARS)

Activity 1.1.1 Strengthen the health surveillance system by identifying alert triggers for key climate-sensitive health conditions

55. Malawi has a Health Management Information System (HMIS) that includes surveillance of disease outbreaks, but these are not analysed together with weather conditions. Therefore, additional evidence is needed to add resolution to the understanding of disease patterns in relation to weather variables in Malawi to inform the design of a climate-health EWARS. Concurrently, using this information and existing knowledge on the linkages between climate and different diseases/conditions, alert triggers need to be set that distinguish different potential threat levels for different diseases/conditions. These include diseases linked to high/extreme heat exposure, malaria, cholera and diarrhoea, and drought-linked malnutrition. The alert triggers will, in turn, inform the transmission of early warning information should the thresholds be reached through surveillance or anticipation. Triggers will be calculated based on a combination of threshold levels for climate-related indicators, with incidence of disease for the target diseases. There is ongoing work by the Ministry of Health, the Department of Climate Change and Meteorological Services (DCCMS), and several academics and technical consultants to develop a functioning health EWARS at national level, in four pilot districts for malaria, with some nascent work on understanding associations between climate data and cholera incidence. The work under the proposed project would build on existing research conducted by these institutions, and scale-up the rollout of the EWARS to five additional districts through *inter alia* the establishment of sentinel sites. The final datasets to be utilised will be determined as part of this project activity. The work of strengthening the health surveillance system by identifying alert triggers for key climate-sensitive health conditions will be a collaborative effort between: Save the Children; the Ministry of Health; the Met office through the (DCCMS); the Environmental Affairs Department (EAD); the Department of Disaster Management Affairs (DODMA); academics; and technical consultants – either individuals or a firm / specialist agency. The collaboration will be facilitated by establishing a committee at the start of the project, who will then meet regularly to oversee the work of the consultants, and the consultants will provide regular updates and present the ongoing work. With regards to the health surveillance system, Malawi has an integrated disease surveillance and response strategy, where 43 diseases/conditions are reported upon via one tool (which is an improvement from the past where each disease had its own surveillance system). For many diseases/conditions, such reporting is monthly or quarterly, but for epidemic-prone diseases – which includes malaria and cholera, two of the focus diseases for this project – reporting occurs on a weekly basis. With regard to acute malnutrition and diseases/conditions linked to high/extreme heat, there are no platforms for surveillance of either in place. For these diseases/conditions, the project currently aims to contribute towards a climate-informed EWARS that is not linked to disease surveillance (though during the implementation of the project activities, the potential to leverage current health services activities to conduct acute malnutrition surveillance will be explored).

56. This activity will: i) improve the existing health surveillance system to incorporate climate information; and ii) set alert triggers for the specific diseases and conditions listed above. Targeted studies and expert validation will be undertaken for each of the diseases/conditions, followed by validation by the HCCCT and relevant national and district-level stakeholders. Malawi-specific thresholds for these diseases/conditions will be determined via collaboration with relevant ongoing and planned efforts – particularly for malaria and cholera – of the MoH, Department of Climate Change and Meteorological Services (DCCMS), international organisations (e.g., WHO), and national/international research initiatives by universities and the private sector. Specific sub-activities under this activity (and under all other project activities, as relevant) are listed in **Section E6.**

Activity 1.1.2 Strengthen the institutional architecture for managing the ongoing operation of the climate-informed health Early Warning and Response System (EWARS)

57. Significant national efforts in Malawi have been made to improve the availability of weather and climate information and to disseminate it to different sectors, but this information has not yet been adequately utilised in the health sector.
58. The proposed project will improve the institutional architecture for effective communication of weather and climate information from the DCCMS to the MoH. At this stage, there are no well-established forums which meet regularly with a fully-functioning committee, terms of reference or similar administrative processes. The project will strengthen the forum between the two ministries that enables communication of weather and climate information, and interpretation of the significance of this information for particular diseases/conditions, in order to develop a climate-informed health EWARS. The intention of the proposed project is to establish a more concrete forum governed by a committee, which will meet at least on a quarterly basis for governing purposes, with clearly-defined processes for sharing data between the two organizations, including information about precisely which kind of data will be shared and the regularity. Outside of the quarterly governance meetings, there will be more regular communications (at least weekly) between technical and data colleagues regarding weather alerts and automated sharing of data, which links to the technical system already in development by WHO, MoH and DCCMS. For longer-term weather and climate information (e.g., seasonal forecasts), this forum should enable interpretation to inform annual planning; for short-term information (e.g., extreme event alerts) this forum should facilitate rapid communication across scales, from national through district down to the local (community) level. There is currently no structured, formal platform that combines met and health surveillance data, as such the objective is to ensure the linkage between the two: either ensuring that met data also includes epidemiological data (linking to the data generated from the health surveillance system in the sentinel sites), or having epidemiological data generated as part of the met data sets.
59. The resulting climate-informed health EWARS will be integrated with existing Common Alert Protocols and potentially integrated with early warning systems and surveillance focused on physical safety and livelihoods protection. The institutional architecture will enable communication from national level to district and local level through the MoH, in alignment with current communication channels. Training manuals and guides will be developed with and for all levels, building on the current modules and curricula used by the Malawi College of Health Sciences and in training of HSAs. The knowledge and skills of health and disaster management staff (at national level and at district level beyond the six target districts) regarding the existence and functioning of the climate-informed health EWARS will be enhanced. The project will build the capacity of relevant national-level technical staff for the long-term operation and sustainability of the system beyond donor-funded projects.
60. At community level, the project will assess the accessibility needs of target communities and develop inclusive communications that respond to context-specific barriers, are gender-responsive, and reach the most vulnerable and marginalised.

Activity 1.1.3. Establish sentinel sites at selected healthcare facilities to provide improved climate and health data for the health Early Warning and Response System (EWARS)

61. Selected healthcare facilities will be strategically designated as sentinel sites to provide better data for surveillance and prediction of (specifically) malaria and cholera. The sentinel sites will send health surveillance data to the District Health Information System and the national HMIS, and this data will then be combined with meteorological data to improve modelling, predictions and responses in the health EWARS. This activity will expand the current approach used by the MoH and the WHO for the existing malaria sentinel site at the Zomba central hospital, establishing additional sentinel sites in the other five project target districts. Healthcare staff and information technology staff at the sentinel sites will receive dedicated training under Activity 3.1.1 so that data can be appropriately collected. Where the new sentinel healthcare facilities lack essential information technology equipment (e.g., tablets, reliable internet connections), the project will invest in providing such equipment to the healthcare facilities where the MoH can guarantee funds for its long-term operation and maintenance. The sentinel site health facilities – typically hospitals – will also benefit from increased and better-quality data from surrounding health centres. Therefore, the project will also invest in providing essential data collection equipment to these surrounding health centres.

Output 1.2: District Health Adaptation plans

Activity 1.2.1 Facilitate preparation and local endorsement of District Health Adaptation Plans in six districts

62. District Health Adaptation Plans (DHAPs) will be developed in alignment with the priority actions of the Health National Adaptation Plan. Their development will include: analysis of the nature of district-specific climate risks to health, including differential vulnerabilities of the district population, together with gender-responsive and socially-inclusive actions; risk communication and prevention strategies; mechanisms to direct resources in case of new disease outbreaks/surge capacity (linked to the health EWARS); protocols and policies informed by current and predicted climatic conditions; and emergency management coordination measures to anticipate and respond to climate events affecting public health (linked to the health EWARS).
63. The process of DHAP generation will mirror the consultative nature of other district planning documentation, soliciting inputs from district staff in other sectors, non-government stakeholders, communities, including children and young people. The DHAP will be produced in alignment with other relevant district planning documents (e.g., the District Development Plan). Draft plans will be validated in multi-stakeholder forums prior to district-level endorsement. For effective implementation of the plans, awareness of climate change risk to health and the actions identified in the DHAP will be raised among district council members, and community health action groups, through a one-day training in the 25 target TAs. Community health action groups will be provided with a visual aid summarising the DHAP contents, and supported logistically to ensure they are able to cascade this inclusively to community level. Budget is also allocated for quarterly meetings at district level to monitor implementation and for course correction. It is understood that post-project, the Government will continue to hold such meetings as extensions of wider district council meetings. To ensure that this process of DHAP production and implementation can be replicated beyond the target TAs, a toolkit that outlines the process will be developed. Building capacity at district and subdistrict levels in the operationalization of the DHAPs (District Health Adaptation Plans) will facilitate generation of lessons learnt and best practices that will inform improvement of the NHAP (National Health Adaptation Plan) at the higher level. Human health and climate coordinators (from the MoH) at the district level will generate data (at the district and sub-district levels) and share it with the national-level human health and climate coordinators. The project will facilitate a robust monitoring and feedback system between the two levels of human health and climate coordinators, via existing platforms, for instance, the Human Health and Climate Change Coordination Team, that is chaired by the MoH through the national climate change and health manager. Conversely, the HNAP serves as an overarching document for health and climate work and therefore serves to provide strategic and implementation guidance to the DHAPs.
64. The DHAPs will be accompanied by an action plan with timeframes, costs and a definition of roles and responsibilities of different parties. A tool for district and traditional authority health climate risk assessment and adaptation planning will be developed in collaboration with the MOH and other relevant ministries, that will support planning efforts in districts not targeted through this project.

Activity 1.2.2. Advocate for stronger integration of climate-resilient health within adaptation planning at district and sub-district level

65. Holistically addressing climate-health risk requires mainstreaming of climate and health into broader district development planning activities. This activity will actively engage other parties that are involved in planning processes: the District Planning Director's office; the District Executive Committee offices that are responsible for disaster risk reduction, climate adaptation and other sectoral planning; and the area and village committees whose development plans feed into the district one. Broader development plans (District Social Economic Profile, District Development Plans and District Budgets on health, climate change and disaster) will be reviewed in the six target districts in order to establish their status and advocate for stronger inclusion and integration of climate-resilient health within them. The advocacy activities will take place at different levels, from national level coalition-building, to district-level engagements and development of action plans, to engagement of key population groups at community level (facilitated by the project working in collaboration with other civil society groups to build the advocacy agenda and conduct specific engagements with key decision makers).
66. At the district level, the project will use the existing governance structures, for instance, the District Executive Committees, that are responsible for overall development work at the district level.Working with key members of the District Executive Committees, such as the Director of Planning and Development, the project will facilitate high visibility and prioritisation of health and climate in the District Development Plans and District Profiles. Civil society actors that exist within the districts (which varies by district, for instance these could consist of international NGOs and/or local NGOs), youth groups, and key actors from across relevant sectors (e.g. health, education, climate change and natural resources) will be engaged.
67. Coalition-building meetings will be organised nationally, as well as in the six target districts, with other organisations/networks that work on climate adaptation, disaster risk reduction, and sectoral planning; and joint

advocacy strategies and action plans will be developed collaboratively with non-government groups. At national level, there are a number of platforms that can be used to facilitate the advocacy and coalition-building work, to build the climate change/health agenda and prioritise it. For example, there is a Civil Society Network on Climate Change (that has its own youth network as a separate entity); there are the Cabinet, Principal Secretary and Parliamentary Committees on Social Services; there is the Malawi Health Network and Coalition on Universal Health Coverage. There will also be a Project Steering Committee established under the project that can be used to facilitate advocacy and coalition-building given the set of actors that will be involved (see **section B.4**, paragraph 126). The representation and inclusion of marginalised voices (e.g., women and girls' organisations, children and young people) will be strengthened during the processes described here. In line with the UNCRC General Comment 26 on Environment with a special focus on climate change, which calls on governments to protect children from the adverse impacts of climate change, the project will facilitate children and young people's engagement in community, district and national level advocacy on issues of climate-resilient health.

OUTCOME 2: Healthcare infrastructure is able to deliver service and care in the context of changing climate risk

68. This outcome focuses on ensuring that healthcare system physical infrastructure (e.g., health centres, hospitals) is able to continue providing healthcare services in light of climate hazards (e.g., heat and floods), addressing the barrier of a lack of climate-resilient and sustainable technologies and infrastructure. This outcome's activities will provide guidelines for climate-resilient health infrastructure, improve the climate resilience of health facilities, and improve WASH facilities within schools, given the clear links between climate change, water-borne diseases, WASH security and overall health **(Annex 2, Section 3).** For full details of this Outcome, **refer to Annex 2 (Section 6.1.6).**

Output 2.1 Climate-resilient health centres, district and central hospitals and schools for community health

Activity 2.1.1 Develop a national standard for climate-resilient healthcare facilities

69. Extensive WHO guidance exists on how to best strengthen the climate resilience of physical infrastructure[55], but this guidance has not been tailored to Malawi. This activity will translate the WHO guidance to the Malawi context, taking into account aspects such as construction standards and design, sustainable energy supply (including for vaccine cold chains, lighting, water pumping), sustainable WASH (including water-use efficiency), ventilation/cooling and supply of technology to enable effective surveillance of climate-sensitive health conditions. It will also build upon Save the Children's existing knowledge on how to ensure gender-responsiveness and social inclusion when designing infrastructure and public facilities. This standard will be produced through a consultative process, and training on the national standard will be developed and delivered to health infrastructure planners in the public and private sector at national level. The MoH will be able to use the standard when commissioning/upgrading infrastructure throughout the country.

Activity 2.1.2 Strengthen climate resilience of healthcare facilities

70. This activity will apply the standards developed under Activity 2.1.1 to build the climate resilience of a range of health facilities in the six project districts. Physical interventions will be in line with Save the Children Australia's ESS Category C Accreditation. These interventions will include solar energy systems to improve energy supply in order to enhance climate resilience (i.e., solar energy for vaccine cold chains, lighting, water pumping and cooling fans), and improved WASH facilities (i.e., rainwater harvesting systems, water filters, hand-washing facilities).
71. As part of the installation of equipment, suitable health facility staff will be trained in basic operations and maintenance for the solar and WASH equipment; and local artisans who can conduct larger-scale repairs will be identified. Health facilities will also be linked to service providers and suppliers who can provide equipment replacement parts and complete maintenance tasks beyond the technical capacity of local artisans. Infrastructure maintenance staff within the MoH district offices will receive training to oversee the operations and maintenance of solar and WASH equipment at health facilities.
72. To maximise learning potential, a standalone tool will be produced, building on the guidance produced under Activity 2.1.1. This tool can be used by healthcare facilities in other districts and nationally to screen their current facilities

[55] WHO (n.d.) Healthy hospital, healthy planet, healthy people. Addressing climate change in health care settings. World Health Organization, Geneva, Switzerland. Available at: https://www.who.int/docs/default-source/climate-change/healthy-hospitals-healthy-planet-healthy-people.pdf?sfvrsn=8b337cee_1.

against climate risk, taking into account aspects such as construction standards and design, climate-resilient and sustainable energy supply, sustainable WASH, etc.

Activity 2.1.3 Build capacity of Malawi's health sector to apply the climate-resilient healthcare facility standard

73. The transformative potential of this project beyond the target districts will be augmented by providing training in the application of the climate-resilient healthcare facility standard and the screening tool developed respectively in Activity 2.1.1 and Activity 2.1.2. Training will take place through the MoH at national level and will include national MoH staff, staff from the six target project districts, and their counterparts from Malawi's other 22 districts. This capacity-building will also target the non-government healthcare sector (i.e., private not-for-profit institutions) which serve up to a quarter of Malawians in certain areas[56], as well as the small number of private for-profit institutions. Study visits for health infrastructure planners from national level and non-target districts to resilient healthcare facilities upgraded by the project will also be arranged.

Activity 2.1.4 Develop guidelines for climate-resilient WASH facilities

74. Beyond healthcare facilities, there are other public buildings where climate-resilient WASH is necessary, including government offices and schools. Therefore, guidelines will be created for developing climate-resilient WASH facilities and retrofitting existing facilities in public buildings, following a consultative process that will include marginalised groups (e.g., women, disabled people), to ensure consideration of the necessary gender and social inclusion elements. The guidelines will consider the most environmentally-appropriate and economically-efficient methods according to geographical location and climate conditions. The skills and knowledge of health and education sector staff at national level, and in six project districts, to apply the guidelines will be built. This activity will also advocate for the guidelines to be applied in the health, education and other sectors.

Activity 2.1.5. Upgrade WASH facilities at schools to improve children's health under climate change

75. Building on the guidelines developed under Activity 2.1.4, this activity will implement climate-resilient WASH solutions at public schools across the 25 target TAs, in selected villages. To enhance safe water supply (to build resilience to the health impacts of droughts, floods and heat), rainwater harvesting systems will be installed at schools, including the necessary filtration devices to provide safe drinking water. In addition, small-scale water treatment solutions for existing water points at schools, and hand-washing facilities, will be installed where appropriate. The provision of clean water is crucial to reduce the transmission of diseases such as cholera, and for sufficient hydration in the face of high/extreme temperatures. The improved WASH facilities at schools will benefit school children, teachers, parents and other people in the community, who use these facilities more frequently than healthcare facilities. A maintenance committee, responsible for the upkeep of the WASH facilities, will be established and/or strengthened at each school, and will consist of school staff and community authorities and members (including representatives from the youth, women/girls and disabled people). There will also be coordination at district level with the Ministry of Education (responsible for WASH at schools).

OUTCOME 3: Healthcare staff are able to deliver service and care in the context of changing climate risk

76. This outcome will build the capacity of healthcare staff to understand how climate risk will alter public health risks, how they can inform surveillance of conditions, how they can interpret and disseminate climate-informed EWARS messaging, and how they can better anticipate and manage physical and mental health needs in their communities. It addresses the barrier of inadequate availability and use of climate information/data in the health sector, and the barrier of limited institutional capacity for addressing climate risks in the health sector. For full details of this Outcome, **refer to Annex 2 (section 6.1.7).**

Output 3.1 Healthcare staff trained in managing climate-related disease monitoring, health messaging, and disease treatment and prevention

Activity 3.1.1. Build data collection capacity to strengthen surveillance of climate-related diseases

[56] WHO – Regional Office for Africa (n.d.) WHO Malawi Country Cooperation Strategic Agenda (2017–2022). World Health Organization – Regional Office for Africa, Brazzaville, Republic of Congo. Available at: https://www.afro.who.int/sites/default/files/2019-08/World%20Health%20Organization%20Malawi%20Country%20Cooperation%20Startegy%202017%20to%202022.pdf.

77. Data analysts and technicians working in healthcare facilities within the districts, and HSAs working in communities, will be empowered to understand what type of surveillance inputs are required to augment the existing District Health Information System and inform the EWARS. This activity comprises a needs assessment of these staff across the six project districts, to inform the design of a training course which will be delivered at national level to all relevant district data analysts and technicians. Subsequent district-level trainings will be undertaken in each district to cascade the training to the relevant HSAs.

Activity 3.1.2 Build knowledge and capacity among district and community healthcare staff on climate and health and use of EWARS alerts

78. This activity will train healthcare staff at district and community level on climate impacts on health, including how to understand and interpret the alert system developed for the target diseases/conditions, as it will be the primary responsibility of this staff to disseminate such information to the local (community) level. Since there are regularly new entrants to the primary health care provision system, it will be necessary to run such training frequently, and thus a cadre of national trainers will be established that can be deployed as necessary. This cadre of trainers is likely to be drawn from both government and non-government representatives in the health and/or climate spaces and should be gender representative. Trainings will then be run from healthcare facilities, covering resident staff and the HSAs that work under each facility. Healthcare 'staff' at community level includes community health volunteers (CHVs) and Community Health Action Groups (CHAGs), which are both essential and existing staff at the community level. Further information about the structure of the healthcare system is available in **Annex 2, section 2.3.**

79. There are already significant lessons that can be learned around the communication of climate information to different user groups, including from MCLIMES (FP002). This activity will include training on these communication methods (e.g., inclusive access to information for people with disabilities who may be unable to read or hear; or using personal contact to deliver information, for e.g., through people personally delivering messages in spaces that women frequent given gender roles such as around water points, churches or health centres).

Activity 3.1.3 Provide medical supplies and technologies for climate health risk reduction and response

80. Climate change creates additional needs for medical supplies and technologies to manage the impacts on disease burdens and health; this activity will support meeting the additional needs for medical supplies and technologies to manage the increasing risk of malaria, cholera/diarrhoea and malnutrition under a changing climate. This includes reviewing and modifying as necessary the processes for identifying and procuring the annual needs for treatment and prevention supplies, to ensure that forecasted climate conditions and risks inform current planning processes.

    The activity will support the additional prevention needs for managing malaria, including malaria prophylaxis via Long Lasting Insecticide Nets (LLINs) and Seasonal Malaria Chemoprevention (SMC), to be administered through health care facilities. This programme will target children in the TAs of two districts for implementation of SMC, benefiting the recipient children and strengthening the in-country evidence base to support policy discourse, as SMC is not yet adopted or mainstreamed in Malawi. However, it is recommended by WHO, and the National Malaria Strategic Plan (2023-2030) recognises the potential role of SMC and "embraces" efforts to explore and build the case for its integration[57]. LLINs have been a long-term feature of malaria control strategies in Malawi, but although nets are present and used in many households,[58] gaps in availability remain. LLINs will be procured and allocated to each of the 25 programme TAs (proportionate to population) during years 2, 3 and 4. Allocation will be targeted to pregnant and recently-delivered infants and their mothers. The AE and the Malawian Government acknowledges the importance and role of approaches that are integrated with up-stream vector control and larval source management. This is reflected in the national strategy and with activities previously funded by the Global Fund and President Malaria Initiative. Historically, they supported the implementation of IRS in four high-burden districts until 2022, including the project-focus district of Mangochi. However, currently the government has de-prioritised IRS and larval source management for the application of current funding mechanisms (including Global Fund and PMI) due to the overall and relative costs of these interventions, verses LLINs, which have been prioritised. Protective household behaviours in relation to effective use of LLINs are also focused on within programme community/group resilience activities (Outcome 4 – 4.1.3).

[57] Ministry of Health, Government of Malawi (2023) National Malaria Strategic Plan (2023-2030). National Malaria Control Programme, Ministry of Health, Lilongwe, Malawi.

[58] The average household size in Malawi is 4.4, according to the World Bank, with each medical treatment delivered at household level.

81. This activity will provide additional supplies of Oral Rehydration Solution and Zinc treatments through the health care facilities in all 25 target TAs, because while they are essential for supportive treatment during cholera and diarrhoea outbreaks, available supplies are inadequate and cannot meet the increased need that will result from climate-related events (**Annex 2, section 5.3**).
82. This activity will further deliver therapeutic feeding for treatment of acute childhood malnutrition (Ready to Use Therapeutic Food for Severe Acute Malnutrition, and Corn Soy Blend (CSB) and vegetable oil or CSB++ for Moderate Acute Malnutrition), which will be provided on the basis of screening and identification by HSAs using assessments based on Mid-Upper Arm Circumference tapes, to respond to the additional treatment needs that result from climatic changes (**Annex 2, sections 5.3 and 5.4**).

    The project will use existing platforms and coordination mechanisms for quantification, procurement, distribution, and delivery of supplies - the Health Technical Support Services (HTSS) - that USAID plays a significant role in, to maximise efficiency. All supplies, including LIINs, Oral Rehydration Solution and Zinc, and therapeutic feeding products when supported, use this mechanism. Districts Health Offices arrange distribution and collection of combined district-specific supplies directly from the Central Medical Stores.

Activity 3.1.4 Equip healthcare workers with MHPSS capacity to address mental health impacts of changing climate

83. Considering the growing evidence that climate risk poses additional threats to mental health, this activity aims to provide training to expand the capacity of district health, social work and disaster response staff, and Health Surveillance Assistants (HSAs) and Senior Health Surveillance Assistants (SHSAs), to identify and provide better Mental Health and Psychosocial Support (MHPSS) to communities. This includes the assessment of current practice norms relating to and impacting on MHPSS in existing maternal, newborn and child health, and primary health care (PHC), services in the target districts, including assessing the extent to which healthcare workers understand the links between a changing climate and mental health and well-being.
84. This assessment will inform the development of contextually-appropriate capacity-building materials, adapted from existing tried-and-tested Save the Children tools. These include packages for building and integrating practical skills of health workers in PHC and young child health, specifically addressing the intersection between MHPSS, maternal well-being and Infant and Young Child Feeding, that have been used with success internationally[59]. Additionally, training will focus on increasing the capacity of healthcare workers to respond appropriately to the increasing need for MHPSS for women, girls, men and boys impacted by GBV, Child, Early and Forced Marriages (CEFM) and loss of access to/availability of Sexual and Reproductive Health (SRH) services. Training materials will further address how healthcare workers can use short-term and longer-term weather and climate information to prepare for expected changes in different mental health and well-being conditions, based on what is currently known about the links between a changing climate and mental health and well-being.
85. These training materials will be complemented by a telephone-based clinical support mechanism for PHC and community-based health workers by connecting them to more experienced clinical advice at hospital level within the health system.
86. As with Activity 3.1.2, the regular entry of health care providers into the system will necessitate that training is run regularly, hence a cadre of national trainers that can be deployed as necessary will be trained. These trainers will be drawn from MoH staff with emphasis placed on retention of staff trained through the national cadre. Embedding these staff within the Ministry will allow them to be deployed for further training of staff as necessary.

Activity 3.1.5 Build capacity among district and community healthcare staff to address the gendered impacts of climate change

87. Reflecting the evidence that climate change impacts GBV, CEFM and Sexual and Reproductive Health and Rights (SRHR) **(Annex 2, Sections 3.3.4, 3.3.5 and 3.3.8),** this activity aims to expand the capacity of healthcare staff at district and community level to identify and provide appropriate support to communities (beyond increasing MHPSS

[59] It is used in Yemen (now adopted into Yemeni Ministry of Health national guidelines) and Palestine amongst others, and currently being introduced in Somalia and Nigeria.

capacity as per Activity 3.1.4). This involves the assessment of current practice norms relating to and impacting on GBV, CEFM and SRHR in the project target districts; the understanding of healthcare workers of the links between a changing climate and changes in GBV, CEFM and SRHR; and a review of existing protection mechanisms and services for GBV, CEFM and SRHR in the community and different government institutions (e.g., women's shelters).

88. This assessment will inform the development of a contextually-appropriate training module on climate and GBV, CEFM and SRHR, informed also by consultations with women and girls in the communities. Healthcare staff at district and community level will be trained (within the training occurring under Activity 3.1.2, to reduce training fatigue, using the national cadre of trainers employed within 3.1.2) on how to overcome barriers to addressing GBV, CEFM and SRHR, including familial reluctance and harmful social norms and beliefs, and how to provide GBV, CEFM and SRHR services. Training will need to address how healthcare workers can use short-term and longer-term weather and climate information to prepare for expected increases in GBV, CEFM and loss of access to/quality of SRH services, based on what is currently known about the links between these issues and a changing climate. It is not the intent that these associations will be quantified within the scope of this project. The intent is to train health care providers on how – based on available knowledge – they might anticipate spikes in gender-based impacts. For example, given it is known that droughts can lead to spikes in CEFM, health care providers will be made aware of this association so that when the EWARS and other sources of climate information suggest increases in drought, they are aware to prepare for the expected increase in gender-related impacts. Where GBV/CEFM/SRHR protection services and mechanisms exist in the community and/or other government institutions, healthcare staff will be trained on how to refer patients appropriately for further support.

89. Recognising that climate risk will increase the number of girls and women in need of treatment for GBV, CEFM and SRH and recognising further that available supplies are inadequate and cannot meet the increased need that will result from climate-related events (**Annex 2, section 5.3**), this activity will also review current processes for identifying annual needs for GBV, CEFM and SRH treatment supplies (e.g., post-exposure prophylaxis for HIV, emergency contraception) and propose modifications as necessary, based on climate information and expected risks. This activity will also provide some support to meeting additional needs for treatment supplies, targeting the areas of greatest need based on the assessment of the current state of practice relating to GBV, CEFM and SRHR, and on the consultations with women and girls in the communities.

OUTCOME 4: Community level health is more resilient in the context of changing climate risk

90. This outcome will address the need to increase community awareness, skills and competencies on climate risks to health, and strengthen the capacities of communities to better manage their risk through collective action. It addresses the barriers of low capacity of communities to reduce climate health risks, and of marginalised groups, particularly women and children, being more vulnerable to climate-related health impacts. Capacity strengthening, training and engagement activities will build on Save the Children's strong experience in participatory empowerment, engaging communities for collective action, social and behaviour change, and inclusive and participatory training methods. Capacity strengthening and training will be provided by qualified trainers in collaboration with relevant government departments and staff as well as Malawian academic institutions and international experts, as appropriate. For full details of this outcome, **refer to Annex 2, section 6.1.8.**

Output 4.1 Stronger community capacity to reduce health risks from climate change.

***Activity 4.1.1 Equip community structures to provide knowledge and skills for climate-resilient WASH facilities to community members*.**

91. Climate change poses risks to safe WASH and ensuring that communities know how to manage these risks is essential. Adopting the guidelines developed through Activity 2.1.4, this activity will train complementary groups of people in the six project districts through a cascade mechanism, whereby existing structures are engaged to apply new knowledge and skills with wider community members, teachers and leadership, who will share and disseminate content and messages onwards on the importance of and how to design feasible, safe, inclusive and appropriate community-level WASH facilities. These groups will consist of Area Civil Protection Committees (ACPC), Village Health Committees, and group village-level traditional leaders, and the training will be facilitated by district-level training-of-trainers from health and education departments (so that teachers and health facilities operations and maintenance staff are able to implement and manage climate-resilient WASH in their institutions and homes). The initial training will be provided by a cadre of trainers from the national level, and all trainings will seek to include women. A core component of the training will emphasise the gender and social differences in vulnerability to WASH-related issues, and the importance of ensuring that climate-resilient WASH is appropriately designed, clean, safe,

private, dignified and accessible to socially-marginalised groups. The training will also highlight the importance of including women, the elderly, youth, and people with disabilities in the cascade of training beyond ACPC, traditional leadership, district health and education officials. This activity will also support the formation of management, maintenance and monitoring groups to ensure that community-level WASH facilities remain safe, clean and accessible over time, with management, maintenance and monitoring groups for female facilities being led by appropriately-trained women.

Activity 4.1.2 Embed understanding of early warnings and alert protocols within communities, including children.

92. This activity focuses on sensitising communities to the meaning of health EWARS messages and appropriate responses to these messages. Sensitisation and community engagement will be conducted through multiple channels to maximise efficiency through the chances of repeated content from different and trusted sources. The first activity will be to conduct an up-to-date analysis of which stakeholders, involved in supporting early warnings of various types, are working in each district; this activity is a prerequisite for finalising sensitisation and engagement plans that are complementary to existing efforts. District-specific plans will then be developed (by the implementing partner in collaboration with government officers from all relevant sectors) and adapted throughout the project implementation period, containing a structured process of awareness-raising, training, and sustained community engagement to increase knowledge, skills and competencies of all members of the community to receive, understand, and be able to act on early warning alerts.
93. This activity will allow for the co-creation, pre-testing and provision of community-focused training materials and tools that can be distributed by health care staff as well as other community mechanisms (e.g., civil protection committees, local formal and non-formal leadership). These materials will be self-explanatory and typically visual materials appropriate to local context and literacy levels. They will be supplemented by other media, for example on community radio to remind of alert levels and action protocols. This activity will particularly target two groups: schools and the marginalised and vulnerable.
94. School children will be targeted for specific awareness-raising of early warning messages through materials that can be distributed through schools, and guidance on interactive activities for teachers on how to integrate this into the existing curriculum. This is partly because children need to understand early warning alerts for their own health and safety, but also because children have the potential to lead efforts as agents of change, influencing their peers, younger siblings and families passing crucial information to adults , considering low levels of literacy in some communities in Malawi.
95. Recognising the difficulty of “last mile” communication to vulnerable groups, dedicated attention will also be paid to ensuring that particularly marginalised and vulnerable groups - including out-of-school children, the elderly, and people/children with disabilities – receiving content in appropriate formats. These groups will be identified through the district youth and district social welfare officers, and appropriate format will include ‘theatre for development’ for out-of-school youth, and radio transmissions including targeting through community mapping with the district officers.

Activity 4.1.3 Train communities to reduce their own vulnerability to climate-induced health risk

96. Once healthcare staff have been trained (in Output 3.1), they will be able to partner in similar training that targets and engages community members to raise awareness of how to reduce vulnerability to a broad range of climate-induced health risks. This will include engagement with Traditional Healers, who remain influential health actors at the community level, particularly in rural areas.
97. The range of public health risk from climate change is variable and often socially-differentiated. This activity will develop a screening tool that considers multiple dimensions of vulnerability for use by individuals to identify the nature of climate risk to their health and that of their family members. This tool will complement a range of social and behaviour change efforts that will occur in the districts. Efforts could include public campaigning on climate and health risk through community events, including a mobile climate and health promotion unit that will travel through the six project districts distributing relevant information on early warning (using materials produced as part of Activity 4.1.2) as well as relevant content targeting a range of climate-related health impacts (malaria, cholera/diarrheal disease, malnutrition, mental health, GBV, SRHR and cardiovascular, respiratory and adverse pregnancy and birth outcomes). Linking with 4.1.2 and 4.1.5, events could include community theatre and discussion, to engage audiences in two-way communication around certain climate related health conditions leading to community household and collective action. To support the dedicated content, this activity will also identify and capitalise upon opportunities to integrate climate and health content into other fora and channels. This includes programmes and community training materials

that are being used in the health, water, agriculture and gender sectors. Particular focus in this activity will be placed on raising awareness of the socially-differentiated risk of climate-related health conditions.

98. Appropriate social and behaviour change assessments will be conducted, to ensure that social and behaviour change content, messages and interventions are created that are context-specific, appropriate, acceptable and feasible – and delivered in the appropriate formats and through the right channels. These considerations are particularly important when planning how to reach marginalised and vulnerable groups, including out-of-school children, the elderly, and people/children with disabilities.

Activity 4.1.4 Support families with pregnant and breastfeeding women and children under two to produce climate-resilient food and provide quality complementary feeding to children under two

99. Existing development and adaptation deficits mean that chronic food and nutrition insecurity exists in Malawi, and the first 1,000 days from when a child is conceived until their second birthday is a period of particular vulnerability to this food and nutrition insecurity[60]. Recognising the current deficits, this activity will target malnutrition-vulnerable groups, e.g., households with pregnant women, breastfeeding mothers, and/or children under 2, by supporting households to realise the food and nutrition security and dietary diversity on which they have been trained and make best use of available foods to support their and their young children's daily diets. As dictated by community needs, this activity may also include referral of children discharged from acute malnutrition treatment (for example under Activity 3.1.3).

100. This activity recognises the complex intersection of underlying causes of malnutrition and thus adopts coordinated agriculture-health-nutrition interventions. Programme approaches are built on Malawi's current integrated homestead farming (which includes integrating plants, trees and small livestock around the home, and soil health and water management) successes. The project will work with the National Agriculture Nutrition Technical working group to conduct a review of the integrated homestead farming manual and programme, modifying it to be stronger on climate-related nutrition. Target villages in project districts will be assessed to understand the propensity to implement integrated homestead farming, and based on the assessment, an intervention strategy will be created at village level in 500 villages. Proven health centre, community groups, and household approaches will be used to support integrated household farming (through own and provided agricultural inputs, health centre demonstrations, training, and peer-to-peer mentoring) of climate-resilient nutritious foods, cooking demonstrations and training on food preservation, processing, and storage to address seasonal food shortages. Improved seeds and varieties will be propagated from one season to the next as priority and sustainable inputs.

101. Health centres will role model the same climate and nutrition smart approaches that are taught to communities and provide a learning space for staff and communities, as well as a space to multiply and share local resources such as seeds. The intervention groups will be used as a contact point and platform for further discussions with families about the use of foods produced (plants, trees, and animals) and other available foods, for more effective complementary feeding and responsive care of infants, young children and the whole family.

Activity 4.1.5 Strengthen communities' capacities to reduce their vulnerability to the health impacts of climate change, particularly gendered impacts

102. Climate impacts affect men, women, children, youth and vulnerable populations differently. Community-led gender equality and social inclusion interventions are required so that girls, boys, women, men, the elderly and people with disabilities have equal access to the health care they need and are equally protected from the impacts of climate change.

103. To achieve greater gender equality and social inclusion in health outcomes, as well as supporting those most affected by climate change impacts to adapt and respond, the project will adopt a community-based adaptation approach, fostering a community-led process through which those most affected by and interested explore, set priorities and plan collectively for improved health. As such, the project will engage communities (men, boys, girls, women, parents, religious and community leaders, representatives from existing community structures, as well as representatives of health service providers, government and relevant civil society organizations) in discussions (a series of reflective sessions) for collective action to explore relevant issues, potential solutions and visions of what the future might look like. The sessions require participatory facilitation and being conducted with segregated groups who work separately (groups of men, boys, women, girls, etc.) and then come together to share action plans and prioritise

[60] WHO *et al*. (2018) Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. World Health Organization, Geneva, Switzerland. Available at: https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/child-health/nurturing-care.

actions. This activity will design and develop manuals and discussion guides for different engagement groups, train facilitators to facilitate participatory group discussions using adult learning principles, establish different engagement groups (including government and service providers, as appropriate), and hold facilitated discussions amongst the groups through an iterative process that culminates with all groups brought together to reach consensus on desired community actions and to determine who will be the lead implementer of each action. Training and support will then be provided to these parties to equip them with necessary skills to carry out community actions. By working through this approach, communities will identify the socio-cultural barriers/enablers, resources, risk factors, especially for those most marginalised, to access health services and begin to work towards positive change. They will also identify bottlenecks to accessing services - and will link with internal and external partners to address these barriers. This kind of engagement approach recognises that people do not change their behaviour based on information alone; it is a combination of having the information, discussing it through two-way communication at different levels of the community (including gatekeepers of decision making), as well as having the confidence and enabling environment to make positive choices, collectively and individually, while addressing underlying social norms that ultimately leads to changed behaviours. This kind of community mobilisation, with multiple partners at community, district and provincial levels, is an empowering approach to social change that can increase the community level decision-making required by decentralization and democratization.

104. Discussions will have a particular focus on gender-based violence prevention, gender norms, joint household decision making around child care, and positive masculinities. Using evidence-based approaches, the project will provide a safe space for men to work together to identify harmful attitudes, beliefs and practices and to develop alternative, positive ways of being. These skills, and the consequent transformation of social norms, are then promoted across the community, with the support of non-formal and formal leadership, which leads to reductions in climate-exacerbated GBV and CEFM, thus complementing Activity 3.1.5.
105. By targeting a range of harmful gender and social norms, these interventions have also been shown to lead to reductions in malnutrition and improvements in maternal and child health, thus complementing Activity 4.1.4. Men can be engaged together with wives and extended family members on nutrition and social norms, food practices and care for children and mothers, equitable control of money and resources in the family, food sharing and consumption, encouraging men's role in child-rearing, etc.
106. Finally, these interventions can also lead to improvements in mental health, thus complementing Activity 3.1.4, as men can be engaged together with women on the negative community stigmas and norms surrounding mental health, as well as improve couples' communication and relationships around the care of children. Stigma comprises a major barrier to help-seeking in people with mental health difficulties in developing countries, particularly among vulnerable members of the population including the poor and women[61].
107. This intervention will draw on Save the Children's work in Eastern and Southern Africa including Malawi, Mozambique, Kenya, Tanzania and DRC. Selected villages, out of those most vulnerable, will be supported with this intervention, the outcomes of which will be used for learning purposes.

B.4. Implementation arrangements (max. 1500 words, approximately 3 pages plus diagrams)

108. **Save the Children Australia (SCA)** is the Accredited Entity to the GCF that will undertake all key fiduciary and operational responsibilities for the delivery of the programme vis-à-vis the GCF. SCA's role is to ensure compliance with the GCF systems and procedures and to be the interface with the GCF Secretariat. SCA, as the AE, will enter into legally binding subsidiary agreements with the three Executing Entities (EE):

- the **Ministry of Health (MoH)** in Malawi, as the implementing executing entity
- **Save the Children International, Malawi Country Office(SCI MW)** as the channelling executing entity within Malawi and as implementing executing entity

[61] E.g., Mascayano, F. *et al.* (2015) Addressing stigma relating to mental illness in low- and middle-income countries. Frontiers in Psychiatry 6. https://doi.org/10.3389/fpsyt.2015.00038; Kohrt, B.A. *et al.* (2018) The role of communities in mental health care in low- and middle-income countries: a meta-review of components and competencies. International Journal of Environmental Research and Public Health 15: 1279. https://doi.org/10.3390/ijerph15061279; Javed, A. *et al.* (2021) Reducing the stigma of mental health disorders with a focus on low- and middle-income countries.

Asian Journal of Psychiatry 58: 102601. https://doi.org/10.1016/j.ajp.2021.102601.

- **The Save the Children Fund (Save the Children UK or SCUK are trade names and abbreviations)** as the executing entity responsible for channelling funds internationally**.**

109. SCA, as the AE, will enter into legally binding subsidiary agreements (subsidiary agreements) with the three Executing Entities (EE): the Ministry of Health (MoH) in Malawi, Save the Children International, Malawi Country Office (SCI MW) as both the national channelling executing entity in Malawi and as implementing executing entity, and the Save the Children Fund (SCUK) as the international channelling executing entity. SCI Malawi will enter into a delivery contract with Catholic Health Commission (CHC) and Creative Center For Community Mobilization (CRECCOM). All AMA and FAA requirements will be cascaded through the subcontracting arrangements.

Co-financing - The sources of co-financing (4 donors – FCDO, Foundation S, GSK and Moondance Foundation and 1 in-kind contribution from the Government of Malawi) will be managed by the three EE's, with SCI MW managing co-financing contributions from FCDO, and working closely with the Government of Malawi to manage their in-kind commitment. Co-financing from FCDO will be channelled through the MoH's Health Sector Joint Fund (HSJF) to SCI MW. SCI MW will sign an agreement with MoH for FCDO's co financing portion of funds. FCDO already have the overarching HSJF governance documents in place between FCDO and MoH. Co-financing from Foundation S, GSK and Moondance Foundation will be contracted through SCUK who, as the international channelling funds EE, will flow funds to SCI MW. No funds will be directly disbursed to communities in cash. Co-financing from the Government of Malawi will come in the form of in-kind contribution. Government of Malawi will enter into a subsidiary agreement with SCA and SCI MW which will include the terms of the in-kind contribution.

110. The Nationally Designated Authority for the Green Climate Fund in Malawi is the **Environmental Affairs Department (EAD)**, part of the Ministry of Natural Resources and Climate Change. The EAD will serve as an advisory body on the Project Steering Committee (described below), as well as maintaining a working relationship with the GCF through regular communications and meetings.

Executing Entities

111. **SCI MW** is registered as an international Non-Governmental Organisation under the Non-Governmental Organisations Regulatory Authority (NGORA) in Malawi and has legal status in the country since its initial registration under the NGO Act of 2012. SCI MW will oversee implementing partners to deliver community-level activities, as well as working in partnership with the MoH at national level to oversee the entire project through a Project Implementation Unit, which will be staffed by employees from both SCI MW and MoH. SCI MW has extensive and demonstrable experience delivering community-based health, education, and child protection programmes, as well as implementing gender transformative and child-centred approaches in its resilience programming. SCI MW can receive and reflow GCF funds through its SCI central office (headquartered in London). As per SCI financial policies and procedures, SCI central office holds donor income and funds that are transferred to SCI Malawi based on realized project expenditures on a monthly basis. **The Save the Children Fund (SCUK),** based in the United Kingdom, will act as the international channelling executing entity for the project and will provide account management support to SCI MW in accordance with the account management system employed by the Save the Children Association to ensure compliance and high-quality delivery of projects.

112. The **MoH** is a government department in Malawi and its mission is 'To provide strategic leadership for the delivery of a comprehensive range of quality, accessible, and efficient health services to all Malawians through the creation and sustenance of a strong health system'. For this GCF project – as mandated by the NDA – the lead implementing directorate within MoH will be 'Preventive Health Services'. In recent years, the Preventive Health Services Department has delivered several key climate-resilient health programmes including, for example, the GFCS 'Adaptation for Africa' project (**Section B3,** and **Annex 2, section 2.1.5**). Working through the preventive health directorate will ensure that governance processes for the project are coordinated, and that management of climate-related diseases is delivered in a cost-efficient manner, in-keeping with the overall Ministry of Health strategy and considering the views of technical experts in Malawi.

113. The Ministry of Health will lead and provide oversight for most of the coordination and capacity building activities at national and district level, especially building capacity of Government of Malawi staff – for example, on improving health EWARS (activity 1.1.1, as well as 3.1.1 and 3.1.2 at district level) and leading on the development of the District Health Adaptation Plans (activity 1.1.2). These activities make up almost all of Outcome 1, a majority of Outcome 3, and developing guidelines as part of Outcome 2 (2.1.1 and 2.1.4), as well as supporting the implementation of physical infrastructure improvements to health facilities (2.1.2).

114. In 2015 the MoH – supported by three bilateral donors[62] - established a project management structure called the **Health Sector Joint Fund (HSJF)**, to support the MoH's implementation of the Health Sector Strategic Plan (HSSP). It is a pooled funding mechanism designed to receive funding from multiple development partners, using elements of Government of Malawi's Public Financial Management (PFM) systems (i.e., planning, budgeting, procurement, monitoring & reporting), but maintaining a parallel funds flow (via commercial banks) with strong fiduciary and procurement oversight and controls. The fund allows the Government and the Development Partners to pool resources while maintaining earmarks for specific activities. In addition, it helps reduce bilateral engagements and improve coordination of development efforts in the health sector, as well as avoid lengthy and burdensome national financial procedures. The HSJF therefore affords the double benefit of using Government systems for planning, budgeting, procurement, and reporting purposes, while maintaining a speedy flow of funds and strong fiduciary and procurement controls. The principles operationalising the HSJF are set out in the Joint Declaration of Intent for the HSJF and the Common Fiduciary Oversight Arrangement (CFOA) between the Government of Malawi and the participating Development Partners of 1 December 2015. Within the fund, there is a **'fiscal agent (FA)'**, an independent financial organisation recruited jointly by the MoH and development partners. The FA is registered in Malawi with the Registrar of Companies and internationally as an American firm and its official name is DT-Global International Development. The FA is a separate legal entity from the MoH and development partners. They are a consultant providing fiduciary and procurement oversight for the Fund - HSJF. The FA was selected through a competitive tender process run by KfW (A Banking institution under German public law). Development partners have conducted due diligence on the FA before contracting it to manage the HSJF. The fiduciary risks in the HSJF flow of funds were reduced through the engagement of external oversight agents, which processes all payments made by the HSJF in accordance with agreed polices and procedures, and reviews procurement procedures prior to contract award and assist MoH procurement staff in the conduct of other health-related procurements funded by the Government. The funds that flow to MoH is managed by the FA as the purpose of the FA is to mitigate the fiduciary risks associated with funds channelled through the HSJF and to support improvements in the PFM arrangements in the health sector. The FA is a contracted external entity that manages Development Partner funds in accordance with agreed HSJF policies and procedures. It verifies payment requests and co-authorises payments for HSJF funded expenditure at the MoH. It rejects payments if agreed policies and procedures have not been complied with, manages the fund's holding and operating bank accounts, is responsible for accounting for transactions and financial reporting, and reviews and co-approves procurement processes for HSJF funded purchases. In addition, it provides oversight and technical assistance services to the Government. GCF proceeds will not be transferred to the FA but to the MoH. In addition, the FA supports the preparation of annual budgets and implementation of ex-ante and ex-post controls; responsible for the fund's accounting and reporting, and risk management arrangements; maintains the HSJF Fiscal Accountability Plan and data management system (accounting data archival system and on- and off-site data backup facilities), provides audit support, and capacity building and technical assistance to the MoH. Currently, all the HSJF Development Partners signed a Common Fiduciary Oversight agreement and there is a clause that allows a Partner to withdraw from the Fund. Where the FA has been liable, they have refunded to the Fund. In case of malpractice, FA is legally obliged to pay back any misused funds. Staff in the fiscal agent sit within the MoH office in Lilongwe to ensure cohesive and collaborative financial management. The fiscal agent manages the entire pooled funding, with responsibility for: i) verifying and co-signing payments for HSJF expenditures at central and decentral levels; ii) managing both holding and operating HSJF bank accounts; and iii) applying post-hoc control of eligible HSJF expenditures. SCI MW and MoH have agreed a hybrid approach to project management, so there will be dedicated finance staff recruited 100% for the GCF project into the Fiscal Agent Unit at MoH (as opposed to using 'pooled' staff already existing within the fund, who work across multiple projects), and the portion of funds that flows through the MoH will be managed by the FA (FA will not have legal title to the bank account), through a separate bank account opened solely for the GCF project[63]. GCF funds will not comingle with other funds in the HSJF since GCF is not part of the Common Fiduciary Agreement (as mentioned above). More information about financial flows is included in **paragraph 124 - 129 below**. Under the current setup, all MoH departments implementing HSJF funded activities do not operate separate accounts. Instead, the Fiscal Agent pays staff and suppliers, on behalf of the MoH, on an activity by activity basis following Malawian Public Finance Management policies and procedures. All HSJF bank accounts are operated on a three joint co-signatory arrangement with two signatories form the MoH and the third from the Fiscal Agent. All agreements between EE (SCI MW) and the Fiscal Agent will cascade down the requirements under the AMA and FAA, including ensuring that the funds are disbursed

[62] FCDO, UK; KFW, Germany; NORAD, Norway

[63] All HSJF bank accounts are held in the name of the MoH. Therefore, the Fiscal Agent will not have legal title to the bank account for the GCF project but will be responsible for operating the bank account including being one of the signatories to the account.

and utilized in accordance with the implementation plan. The Fiscal Agent has no discretion in the implementation of the funded activities and usage of GCF Proceeds.

115. Overall, the Fiscal Agent will manage 4.9% of all budget funds (including co-financing), compared to 95.1% being managed by SCI. The relatively low amount included here is due to the Ministry of Health's own preference to not manage funds associated with procurement of goods, due to previous experience with procurement delays. A large portion of the budget for the CHWBRC is assigned to procuring large infrastructure items such as solar equipment and WASH infrastructure (primarily under component 2). GCF funds will not be used explicitly to pay for services of the FA. There is budget allocated to staffing and operations for the Ministry of Health (which will be managed by the fiscal agent), but this is for direct project activities as opposed to general servicing of the Fiscal Agent. In the event of non-cooperation by one or more of the 3 signatories, the issue will be raised promptly at an ad-hoc meeting with key members of the project steering committee, and the case will be presented to the permanent secretary or the minister for health who will manage the process and identify any potential barriers or blockages to signing the documents. The GCF/FA Account will have clear accountability mechanisms chaired by the Permanent Secretary for Health and the Country Director for Save the Children. If there is a case of primary signatories being unavailable, there are clear schemes of delegated authority which are written concretely into financial policies for each of the three agencies.

Other parties

116. In addition to the two Executing Entities, the project will be delivered by two procured parties, operating across the six target districts who have been determined by a rigorous assessment. The two parties are **Catholic Health Commission of Malawi (CHC),** and **Creative Centre for Community Mobilisation Malawi (CRECCOM),** both of which are registered NGOs in Malawi under NGORA. The two parties were identified through a comprehensive mapping exercise based on their capacity to deliver the intended project activities, track record of delivering successful interventions in partnership with SC and other donors, and experience working within the project districts. Several parties were assessed according to Save the Children's internal partnership assessment guidelines (the Partnership Assessment Tool – PAT), and the two parties were chosen due to their suitability for selected activities, combined with a stronger performance assessment than other entities. CHC and CRECCOM will follow the same list of activities, sub-activities and deliverables as the wider project. The budget for each implementing partner is clearly defined and there will not be discretion allowed on usage of funds. CHC and CRECCOM have no discretion in implementing the funded activities and selecting the final beneficiaries.
117. **CHC** is a faith-based organisation with a national headquarters in Lilongwe, operating through Diocesan commissions in 8 dioceses across Malawi, covering all districts in the country. They coordinate and implement health facility-based care as well as community-based programmes and are currently working with 91 health facilities across the country. The assessment found that they have a strong governance structure and adequate financial systems and controls in place. CHC will lead on community-based activities in Outcomes 3 and 4 particularly, leading on the rollout of additional treatment for climate-related diseases under Outcome 3 (3.1.3), and the training of community members in both climate-resilient WASH facilities (4.1.1), and the nutrition component for mothers of children under 2 years old (Activity 4.1.4).
118. **CRECCOM** is a registered NGO in Malawi under NGORA that specialises in community engagement, with some experience implementing public health projects. SCI MW has worked with CRECCOM previously and has observed their strengths in community mobilisation and working with schools. CRECCOM have their headquarters in the Southern district of Zomba (one of the target project districts) with offices in other districts across southern Malawi, including four of the project districts. CRECCOM will be leading on managing the mobile health unit under Outcome 4, as well as delivering training and distributing materials at community level for the improved Health Early Warning Systems (activity 4.1.2).
119. Both organisations will be present in all six districts. These two partners will act as implementing partners for SCI MW, who will have contracts in place with both organisations, with funds flowing directly from SCI MW to the two partners, based on the budget allocated to the activities they will lead. For more information, see **Annex 4: Detailed budget.**

Financial Management Capacity Assessment

120. A Financial Management Capacity Assessment (FMCA) of the Ministry of Health was undertaken in March 2023.[64] The overall results of the assessment were mixed, with some positive findings balanced by a number of strong caveats that could impact delivery of the project. Positive results of the assessment included:

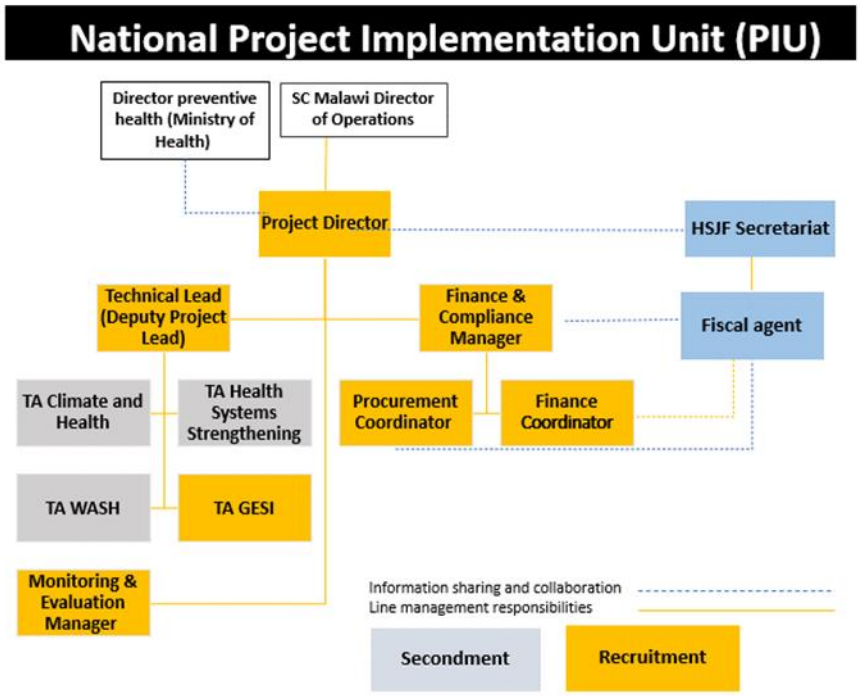
- a well-structured finance department, with adequate staffing in place and a clear organisational hierarchy in place, ensuring appropriate levels of sign-off and compliance.
- experience implementing a range of donor-funded projects, including with the World Bank, Global Fund, and USAID amongst others.
- functional internal audit systems which are operating regularly to provide regular checks on project and departmental finances, however, some limitations remain to the internal audit system.
- the existence of a dedicated internal financial compliance unit, providing additional checks to the audit department, and specifically focusing on budget development processes, examining expenditure transaction categorisation and holding accountability for underperforming finance staff.

121. However, the assessment also found several limitations in the MoH's overall financial management which are outlined in the FMCA report. These will be mitigated through the implementation arrangements which will support government capacity to manage future climate finance. One key issue uncovered by the assessment, as well as being mentioned by the Ministry, was procurement. Government procurement regulations combined with the capacity within the Ministry, meant that procurement was often delayed. To mitigate potential procurement challenges, the Ministry of Health and SCI Malawi have agreed that procurement within the project will use Save the Children's systems, with funds flowing through Save the Children for all large procurements including all goods and non-consulting services. This includes procured parties for infrastructure improvements to health facilities and schools. The Ministry of Health will retain oversight of smaller consultancy procurements (with an absolute maximum value of US$50,000 – most fall below US$20,000 and are mainly low-value consultancies for training delivery, for example), but dedicated PMU staff will work closely with existing Ministry officials to ensure all guidelines and rules are adhered to, and the Ministry will still use the thresholds and policies of Save the Children. Within outcome 1, activity 1.1.1, there are higher-value consultancies for establishing thresholds for disease burden related to EWARS. Procurement for this activity will be managed by Save the Children but the Ministry of Health will lead the activity and hold ownership of the results of the assessments. For more information about financial risks and mitigations see **Annex 20: First level AML CFT assessment.** Procurement detail is available in **Annex 10** and **section G3.**

Project Management and Staffing Structure

122. At the national level, the project will be managed by a Project Implementation Unit (PIU), which will consist of newly-hired project staff and Government staff on secondment to the PIU from Ministry of Health. The PIU will be hosted by MoH, and will consist of an overall Project Director (reporting to the Director of Operations of SCI MW, with a dotted (matrix) line to the Director of Preventive Health Services, MoH). Staff in the PIU will be contracted by Save the Children. The Project Director will directly manage a Technical Lead, an M&E Manager, and a Finance and Compliance Manager (with responsibility for compiling financial reports across the Executing Entities and partners, as well as working closely with the Fiscal Agent) for the project. A dedicated Procurement Coordinator will also sit at the national-level PIU. The Technical Lead for the project will oversee a team of technical specialists, some of whom will be government secondments. The technical team will include a Climate and Health Technical Advisor, a GESI Advisor, and a Technical Specialist for Solar and WASH to oversee the physical infrastructure improvements.

[64] This Financial Capacity Assessment has been prepared in accordance with Green Climate Fund (GCF)'s Financial Risk Management Framework, and Administrative Guidelines on procurement, along with Sierra Leone's Public Financial Management Act, (2016) and Regulation (2020), Finance Act (2022), National Public Procurement Act (2016), and Regulation (2020).



123. FA will provide financial services for the PIU acting on their instruction but ensuring financial compliance and oversight of all GCF funds that flow to the MoH for the implementation of this project, via a new dedicated project bank account that receives funds only from the GCF for the purpose of this project (as opposed to other donor funds). Save the Children will hire a Finance Coordinator into the Fiscal Agent unit to manage the GCF account. For the funds flowing from the AE to SCI MW, fiduciary management will be the responsibility of the dedicated Finance and Compliance Manager working on the GCF project, as well as supporting staff working for SCI MW. SCI MW will open a dedicated bank account for the management of the funds allocated to activities to be led by Save the Children. Finance and Compliance Manager will work closely with the Finance Coordinator hired into the Fiscal Agent unit to manage the GCF account and will provide oversight to the work of the FA for the project. Further detail has been shown in **Figure 9** below, marked through the pink line on Financial Flow (GCF). Project funds will flow from GCF and channelled internationally from SCA as AE to SCUK as the international channelling funds EE. SCUK will then flow funds to SCI MW as the national channelling funds EE, who will provide funding tranches to the MoH (where the Fiscal Agent will be responsible for managing the MoH GCF specific bank account) and to the implementing partners, following the endorsement of work plans and budgets by the Project Steering Committee. Financial performance reporting will be done by the Executing Entities, implementing partners and procured parties to the PIU which is managed by SCI MW. All goods and services will be procured by the EEs and implementing partners – no funds will be directly disbursed to communities in cash.
124. The Fiscal Agent will be responsible for opening the dedicated bank account for the project and managing all payments and transactions required for the activities led by the MoH, including funding district-level health offices for district activities. They will also be responsible for compiling financial reports for the MoH activities and will work closely with the dedicated PIU staff to provide monthly financial reporting for the Ministry's components. The Project Director will be a signatory on the bank account managed by the Fiscal Agent, as well as one MoH staff member and one staff member from the Fiscal Agent.
125. There will also be dedicated district-level PIUs in each of the six districts to ensure the coordination of project implementation. It will be staffed by employees from the District Health Office (DHO), Save the Children and the two implementing partners, operating out of a shared office space within the district councils. The district team will consist of an overall Project District Coordinator, who will be a government secondment in districts where there is adequate Government staffing capacity, as well as Field Officers working for the implementing partners with direct responsibility for community-level engagement and monitoring staff to cover several districts each to avoid overlap and inefficiencies. Given that many activities take place at the 'Traditional Authority' (TA)-level, there will be 'community mobiliser' staff

who are permanently based at the TA in all TAs and will not require dedicated office space. Financial stipends and services for these community-mobilisation staff will be coordinated through the district headquarter office. Working alongside the implementing partners to deliver community-health activities will be health surveillance assistants (HSAs), who are attached to individual health facilities and who each serve a population of ~1,000 people in their community catchment areas. HSAs are coordinated by the DHO and are employed by the Ministry of Health and will receive stipends to facilitate movement to the target communities as part of CHWBRC project.

126. For activities that MoH will lead on payments will be managed by the Fiscal Agent, whereas for Save the Children and partner-led activities, will be managed by SCI MW.

127. In addition to the national-level PIU, there will be a Project Steering Committee (PSC) comprising of Permanent Secretaries from several key ministries as agreed with the MoH and EAD, and a selected set of participants from NGOs, as well as SCI MW. Ministries represented on the PSC will include: Ministry of Health; Ministry of Natural Resources and Climate Change; Ministry of Agriculture; Ministry of Local Government; Ministry of Energy; Ministry of Gender, Community Development and Social Welfare and the Department of Disaster Management Affairs. In addition to the government agencies and SCI MW, the 'Civil Society Network for Climate Change Secretariat – CISONEC' will be represented. CISONEC is a group of professionals and civil society organisations working collaboratively on climate change, to provide policy positions to Government and other policy makers through advocacy, lobbying and facilitating discussions between key thought leaders. The PSC will be responsible for the project's strategic direction and will oversee activity implementation, including steering activities implemented by the Project Implementation Unit (PIU), which will manage day-to-day operations. The PSC will be co-chaired by two of the EEs being SCI MW and the MOH. The AE will ensure that decisions taken by the PSC are consistent with the AMA, FAA and FP by regularly holding meetings with the core project team, including the Chief of Party and the Country Director of SCI MW. This way, the AE will be updated on all key decision points, both during and ahead of time, so that they can inform the implementing partners of any risk of potential inconsistencies with AMA, FAA and FP. The AE will also run a learning and knowledge session during the project inception period on the AMA and the FAA so that all partners understand their responsibilities ahead of project implementation and understand what amendments may need prior to AE and / or donor approval. No financial flows will take place between SCI MW and the PSC; the working relationship will be solely based on reporting and consultation. The AE will review and sign off PSC agendas to ensure compliance with the FP, AMA and FAA.

128. Finally, there will be a **Technical Advisory Group (TAG),** which will meet more regularly – at least monthly – than the PSC and will comprise of technical leads from organisations with expertise in the project thematic area (HCCCT, CSO Health network, WHO), and co-financers (GSK, Foundation S). The role of the TAG will be to advise the PIU on project implementation, especially on technical aspects of EWARS, implementation of medical treatment and supplies, and health and nutrition interventions under Outcome 4.

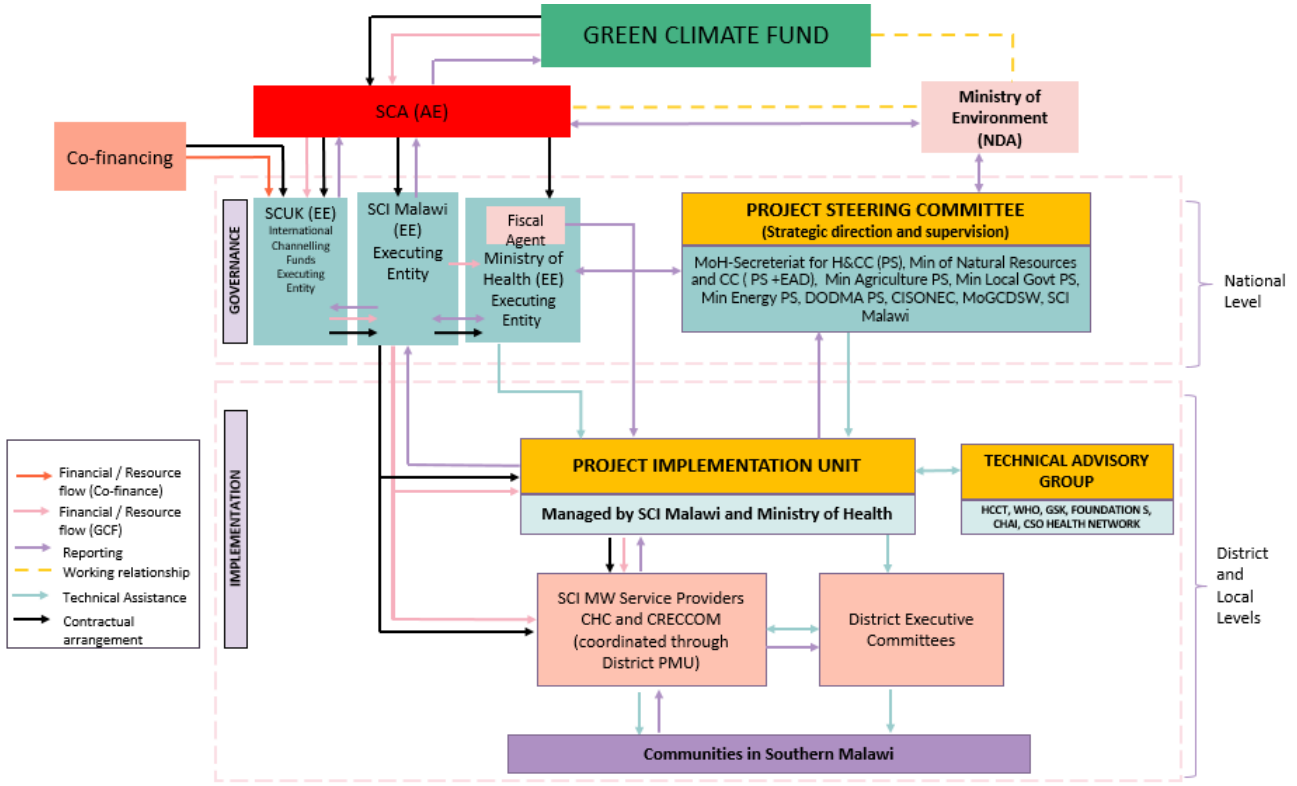


Figure 9 – Implementation Arrangements and Financial Flow Diagram

B.5. Justification for GCF funding request (max. 1000 words, approximately 2 pages)

129. Malawi has developed plans for adaptation financing and a National Climate Change Fund is currently under discussion. According to the NAP Framework[65] and Updated NDC[66], adaptation finance needs are estimated at USD4.5 billion through to 2040, with around one third in the current decade, and two thirds in the decade from 2031-40. The NAP framework estimated that only one quarter (24%) of the total requirement is to be funded domestically, with three quarters (76%) conditional on international support and that the bulk of the support is required over the coming decade. This reflects the current national budget situation, which is highly dependent on donor funding.
130. The projected costs for adaptation are also an order of magnitude of difference from current available financing, with less than 1% of the national budget made available for both environment and climate change activities. Current adaptation funding from international climate finance is also low and makes up just a small fraction of these projected costs. USD4.1million of GCF readiness funds have been allocated. There has been one dedicated adaptation project under GCF (Scaling up the use of modernised climate information and early warning systems, FP002) with a total value of USD18million (which is coming to an end); and Malawi is part of the multi-country Cooling Facility (FP177) which is cross-cutting. There is one Adaptation Fund project under implementation until 2025 implemented by WFP which is building the resilience of food systems (total value US$9.9 million). Under the Global Environmental Facility (GEF), various projects are implemented across the country, including four LDCF projects with a total value of USD19,110,100, and climate change focal area projects under implementation with a value of USD442,676, with further projects at the stage of concept approval. However, this total (USD51,552,776) is approximately 1.5% of the USD3.3billion (75% of USD4.5billion) that is anticipated to be needed to be met by international support under the NAP Framework and Updated NDC.
131. It also comes against a backdrop of increasing economic costs of climate change through extreme events. At the end of the last decade, Malawi was losing approximately 1.7% of GDP annually to the combined effects of droughts and

[65] Ministry of Natural Resources, Energy and Mining, 2020. Malawi's National Adaptation Plan Framework. Environmental Affairs Department March 2020. https://napglobalnetwork.org/wp-content/uploads/2020/03/napgn-en-2020-malawis-national-adaptation-plan-framework.pdf

[66] Republic of Malawi, 2021. Updated Nationally Determined Contribution. Lilongwe

floods – which was over 5 times higher than the average for Least Developed Countries of 0.3%[67]. Five of the last nine years have had national disasters declared due to extreme weather events, all of which led to extensive economic losses. In 2022 the country was hit by Tropical Storms Ana and Gombe (costing 0.5% of GDP); in 2019 there was Cyclone Idai (costing 0.13% of GDP); in 2016 a severe drought linked with El Nino caused a food and humanitarian crisis (costing 5.6% of GDP); and in 2015 there was a 1-in-500-year flood in January (costing 0.5% of GDP) [68]. In 2023 cyclone Freddy cost USD506.7million, while the total cost of recovery and reconstruction is $680.4 million[69]. Looking ahead, climate forecasts suggest increasing confidence in a strong El Niño by late 2023, and therefore poorly distributed rainfall during the 2023/24 production season is expected, with a likely surge in food assistance needs in 2024[70].Typically, the effect of such disasters leads to an increase in vulnerable people and a fall in GDP not only in the year of the event, but also in successive years due to the costs of recovery. However, the decreasing return period between disasters compounds these costs and reduces the likelihood of the economy bouncing back. This is shown in the effects on poverty levels. For every three Malawians that moved out of poverty between 2010-19, four fell back into it due to the impact of weather shocks[71]. As outlined in **section B1**, extreme event exposure is anticipated to continue to increase.

132. As part of the NAP development process, Malawi outlined a strategy for financing climate adaptation actions that include seeking funding from the GCF, mobilising the private sector, and integrating adaptation priorities in Ministry spending plans through district development plans. However, the private sector and market in Malawi are underdeveloped, and a macroeconomic crisis has been unfolding. Following a slight rebound in GDP in 2021 after the impacts of COVID-19 in 2020, there was a decrease again in 2022 as a result of the Russia-Ukraine war and a balance-of-payments crisis. This is against the backdrop of the increasingly regular occurrence of extreme events which have significant impacts on the economy through the reductions in agricultural outputs. The country continues to experience regular blackouts, and headline inflation reached 26.7% in October 2022 (highest since June 2013)[72].
133. These factors make both national government and private sector financing for adaptation largely unrealistic. Hence grant funding from GCF is needed to implement the proposed project to achieve the critical transformation of the health system that is needed for the country to be able to respond to current and future climate risk, where the ultimate beneficiaries of such transformation are communities in one of the poorest countries in the world, in particular the most vulnerable population groups **(refer to Section D.4.).** This GCF grant funding will be the anchor for co-financing from the Government of Malawi, demonstrating the government's strong support in the context of its constrained fiscal space, as well as leveraging significant co-financing from the private sector. Further justification for the proposed GCF grant is provided in **Annex 2: Feasibility Study, Sections 2-4 and in Annex 3: Economic analysis**.

B.6. Exit strategy (max. 500 words, approximately 1 page)

134. The project activities and strategies have been designed with a focus on long-term sustainability and replicability in order to ensure results and benefits continue beyond the implementation period. Throughout the lifespan of the project, institutional and service provider capacity will be sufficiently built in order to transform the health systems in Malawi. Key elements of the CHWBRC exit strategy include:
    - **Embedding the project within the Ministry through:**
        - **Capacity building** - The project is strongly supported by the extensive emphasis on building capacity, which underpins all four project outcomes. This capacity building takes place across levels (national to district to group village to village) and across sectors (taking into account government staff in and outside health, primary and secondary health care providers in the formal and traditional sectors, and those in charge of health care

[67] Pauw, K., J. Thurlow, M. Bachu and D. E. Van Seventer (2011) 'The Economic Costs of Extreme Weather Events: A Hydro-Meteorological CGE Analysis for Malawi', Environment and Development Economics, 16: 177–98.

[68] Malawi Government (2016) Malawi 2016 Drought Post Disaster Needs Assessment Report, 198p.
Malawi Government (2019) Malawi 2019 Flood Post Disaster Needs Assessment Report, 106p.
Government of Malawi. 2023. Malawi 2023 Tropical Cyclone Freddy Post-Disaster Needs Assessment. Lilongwe: Government of Malawi.

[69] Government of Malawi. 2023. Malawi 2023 Tropical Cyclone Freddy Post-Disaster Needs Assessment. Lilongwe: Government of Malawi.

[70] FEWS NET (2023) Crisis (IPC Phase 3) persists in south, but food assistance remains inadequate. Malawi – Food Security Outlook Update. Famine Early Warning Systems Network, Washington DC, USA. Available at: https://reliefweb.int/report/malawi/malawi-food-security-outlook-update-august-2023.

[71] Caruso, German Daniel; Cardona Sosa,Lina Marcela. Malawi Poverty Assessment : Poverty Persistence in Malawi - Climate Shocks, Low Agricultural Productivity, and Slow Structural Transformation (English). Washington, D.C.: World Bank Group. http://documents.worldbank.org/curated/en/099920006302215250/P174948072f3880690afb70c2097fe214d

[72] Engel,Jakob; Hirano,Yumeka; Nyirenda,Yalenga Loraine; Nur,Hayaan Diriye Abdi; Chilima,Efrem Zephnath; Thapa,Dipti; Botha,Blessings Nyanjagha; Eliste,Paavo. Malawi Economic Monitor : Planning Beyond the Next Harvest, Advancing Economic Stability and Agricultural Commercialization (English). Washington, D.C. : World Bank Group. http://documents.worldbank.org/curated/en/099945012012289449/P17952904c6c4603d0b0660c8a8483

facilities). The aim is to build a critical mass that enables system transformation and sustainability of the changes. Part-staffing the project with seconded staff from the Ministry of Health will ensure that they return to their positions at the end of the project and are able to integrate project practices into Ministry of Health's procedures and norms.

- **Long term ownership –** The project also builds on previous learning on building sustainable local capacity – which involves multi-level approaches and repetition of capacity building activities (in order to deal with potential high turnover of government staff, and to ensure a scaffolded approach that ultimately results in an overall strengthened health system, regardless of individual staff turnover), and also a commitment to leave a legacy of local capacity. This will be enabled by training local cadres of trainers (on early warning messages alongside other climate impacts – activity 3.1.2, on MHPSS-activity 3.1.4) who will be able to deliver training within the project, but also after the project – negating the need for an exit strategy that would be required if design relied on external trainers. The focus on advocacy (activity 1.2.2) also contributes to a greater critical mass of understanding of climate and health risk at national and local level, and within and outside government, to contribute to sustainability of project goals. The national standards developed for climate-resilient health facilities and public WASH facilities will further support continuity. Sustainability will also be supported by the evidence generated through the project interventions and its use to advocate for increased resource allocation within government budgets and by the private sector.

- **Community ownership and capacity building –** Sustainability has also been central to the design of the activities, ensuring that provision of infrastructure is embedded in a strong understanding of its importance and local ownership and investment in its continued functioning. Using people centred designs that actively engage communities in the planning and implementation of interventions complemented by community social accountability activities (community score cards) will be key approaches for facilitating ownership and creating a platform for continued feedback to the project. Engaging communities is also key for norm shifting, addressing engendered negative social norms and catalysing adoption of desired behaviours. This includes enhancing dialogue and reflections on power, and visioning to ensure the interventions remain locally-led and responsive to the needs of all. Overall, the project envisages that transforming the ways in which communities make decisions and manage their resources ensures sustainability.

- **Operations and Maintenance plan (to ensure long-term effectiveness of infrastructure investments) –** Provision of infrastructure (Activity 2.1.2) will support the strengthened climate resilience of health care facilities (e.g., provision of solar panels for sustainability of lighting and cold chain; and WASH facilities). Suppliers for these infrastructural changes have been identified on the basis of sustainability and longevity of the technology (for example durable ferrocement tanks for rainwater harvesting). In addition to supporting the capacity building of health care facility staff in screening for climate risk, the activity also involves establishment of a maintenance committee at facility level to ensure transfer of responsibility for management and sustained operations. To complement the system strengthening activities in the health sector, the project will strengthen resilience of schools in terms of WASH to support health, through building the capacity of Primary Education Advisors as key leads in implementation, monitoring of WASH interventions in schools. The project will equip a maintenance committee at school level, consisting of both school staff members and community members, who will take responsibility for the upkeep of equipment. There will also be coordination at district level with the Ministry of Education, which is responsible for WASH at schools.

- **Alignment with other projects/investments –** The EWARS will build on existing work on establishing a national EWARS system by WHO that will work towards consolidating and building interoperability of the existing meteorological early warning system and the health surveillance system to strengthen weather and climate sensitive health surveillance system. This will enable data documentation and analysis to inform the forecasting and fortify anticipatory action and evidence-based decision making whilst strengthening collaboration of the existing implementation and coordination structures across the disaster risk management and health structures from the national to district to sub district levels. Strengthening already existing and established platforms ensures ownership and sustained functionality of the EWARS. Key activities at community level will include establishing and strengthening functionality, and capacity building of community structures across the relevant sectors including Village Civil protection committees from disaster risk management; Area and Village Nutrition Coordination Committees from Nutrition; Community Health Action Groups (CHAGs) and village Health Committees to lead development and operationalisation of subdistrict health action adaptation plans and to serve as existing capacity to sustainably socialise communities on the heightened climate risk on health and encourage adoption of practices to minimise future risks. The project also aligns with and supports national policies, climate strategies and other projects/investments which is further detailed under **section D5 Country Ownership.**

- **Evidence generation and dissemination of knowledge nationally –** To ensure project benefits are captured and lessons learned, the CHWBRC includes a focus on monitoring, evaluation, and knowledge sharing of best

practices. The project will ensure a feedback loop among partners to continually assess any gaps, needs and opportunities in activity implementation for uptake into revised strategies. Knowledge sharing in Malawi and internationally will also be facilitated by Save the Children's networks.

C. FINANCING INFORMATION

C.1. Total financing

(D) Requested GCF funding + ii + iii + iv + v + vi + vii)	Total amount	Currency
	33,000,000	million USD ($)

GCF financial instrument	Amount	Tenor	Grace period	Pricing
(i) Senior loans	Enter amount	Enter years	Enter years	Enter %
(ii) Subordinated loans	Enter amount	Enter years	Enter years	Enter %
(iii) Equity	Enter amount			Enter % equity return
(iv) Guarantees	Enter amount	Enter years		
(v) Reimbursable grants	Enter amount			
(vi) Grants	33,000,000			
(vii) Results-based payments	Enter amount			

(b) Co-finan	Total amount	Currency
	4,068,208	million USD ($)

cing information						
Name of institution	**Financial instrument**	**Amount**	**Currency**	**Tenor & grace**	**Pricing**	**Seniority**
GlaxoSmithKline (GSK)	Grant	1,271,800	million USD ($)		Enter%	Options
Foundation S	Grant	1,064,272	million USD ($)		Enter%	Options
Government of Malawi	In kind	1,266,019	million USD ($)		Enter%	Options
Foreign, Commonwealth and Development Office (FCDO)	Grant	317,950	million USD ($)		Enter%	Options
Moondance Foundation	Grant	148,167	million USD ($)		Enter%	Options
(c)Total financing = (a)+(b)	**Amount**		**Currency**			
	37,068,208		million USD ($)			
(d) Other financing arrangements and contributions (max	135. The Government of Malawi (through the Ministry of Health) have committed a total of US$1,266,019 of in-kind co-financing, which comprises staff salaries for existing MoH staff working on the GCF project, and contributions through operational budgets which have been calculated as a representative proportion of the Ministry's overall budget, in line with the budget that the ministry will receive through this GCF project. Full details of Government of Malawi in-kind contributions are available in **Annex 4.** Staff salary contributions are calculated based on existing staff that will be working on discrete activities, for example: a proportion of the principal quantity surveyor's time has been allocated to Activities 2.1.2 and 2.1.5 (installing infrastructure at health centres and schools). 136. The United States Agency for International Development (USAID) have also committed to parallel financing for the CHWBRC project through their existing 'Momentum for Country Global Leadership (MCGL)' project in Malawi, which is working in four of the six project districts, with a broad focus including climate-resilient health at community level. USAID have					

. 250 words, approximately 0.5 page)	committed to parallel financing for the full value of their project during the implementation timetable of the CHWBRC project**,** totalling US$27,700,000. The Global Fund will commit to parallel financing by engaging with the Malawi MoH, the GCF and SCI MW to help facilitate coordination and alignment between the CHWBRC project and key Global Fund implementing partners including the National Malaria Control Program (NMCP) on Malaria-related interventions and the Public Health Institute of Malawi (PHIM) on surveillance. Green Climate Fund investments through the CHWBRC project will be complementary to those made by the Global Fund during its new Grant Cycle 7 (GC7) funding cycle (1 July 2024 to 30 June 2027). Global Fund will invest a total of US$ 585 million towards Malawi's national responses to HIV, Tuberculosis and Malaria and for strengthening the national health system both through its conventional grants and the COVID-19 Response Mechanism (C19RM) funding stream. Where appropriate, Global Fund will also explore alignment during implementation, such as in facilitating the sourcing of WHO approved health commodities in accordance with national standard specifications at preferential prices through potential access to Global Fund's Pooled Procurement Mechanism (PPM)." The Rockefeller Foundation have also confirmed parallel financing for the CHWBRC project through their support to SEED Global Health for 'Rapid Vulnerability and Adaptation Assessment (rVAA) - Toolkit Development and Malawi Pilot', which will be implemented across all districts.

C.2. Financing by component

Component	Output	Indicative cost Options	GCF financing		Co-financing		
			Amount Options	Financial Instrument	Amount Options	Financial Instrument	Name of Institutions
Component 1: Reduced risk from climate-sensitive diseases and conditions	Output 1.1	1,431,013	1,178,771	Grants	25,763 2,639 122,955 100,885	Grants Grants Grants In-Kind	GSK Foundation S FCDO GoM
	Output 1.2	987,328	826,043	Grants	10,761 1,270 22,460 126,794	Grants Grants Grants In-Kind	GSK Foundation S FCDO GoM
Component 2: Healthcare infrastructure is able to deliver service and care in the context of changing climate risk	Output 2.1	14,559,030	14,172,292	Grants	111,136 13,979 50,190 68,276 143,157	Grants Grants Grants In-kind Grants	GSK Foundation S FCDO GoM Moondance
Component 3: Healthcare staff are able to deliver service	Output 3.1	7,749,211	6,545,401	Grants	616,763 271,642	Grants Grants	GSK Foundation S

and care in the context of changing climate risk					74,960 240,445	Grants In-kind	FCDO GoM
Component 4: Community level health is more resilient in the context of changing climate risk	Output 4.1	7,887,050	7,117,711	Grants	427,565 262,940 39,847 38,987	Grants Grants Grants In-Kind	GSK Foundation S FCDO GoM
Monitoring, Evaluation, Accountability and Learning	Output 5.1	1,792,560	1,599,425	Grants	148,965 7,538 36,631	Grants Grants In-kind	Foundation S FCDO GoM
Project Management Cost	PMC	2,662,017	1,560,357	Grants	79,811 362,838 654,001 5,010	Grants Grants In-kind Grants	GSK Foundation S GoM Moondance
Indicative total cost (USD)		37,068,208	33,000,000		4,068,208		

This table should match the one presented in the term sheet and be consistent with information presented in other annexes including the detailed budget plan and implementation timetable.

case of a multi-country/region programme, specify indicative requested GCF funding amount for each country in annex 17, if available.

C.3 Capacity building and technology development/transfer (max. 250 words, approximately 0.5 page)

C.3.1 Does GCF funding finance capacity building activities?	Yes ☒ No ($2,325,880)
C.3.2. Does GCF funding finance technology development/transfer?	Yes ☒ No ☐ ($9,185,873)

137. The GCF funding will finance capacity building activities across the entire health system, from national level, through to community level with community health volunteers and community health action groups. The capacity building includes an overview of the impacts of climate change on health, as well as more detailed training to healthcare workers about specific aspects of climate change impacts on health, including:
    - Training on data collection and surveillance for specific diseases covered in the EWARS (district level staff)
    - Training on the climate change impacts on mental health (district and sub-district level staff)
    - Training on climate change impacts on gender-based violence, Child and Early Forced Marriage, and Sexual and Reproductive Health (district and sub-district level staff)
138. The project will also work to establish clear plans with district executive committees to ensure adaptation planning is built into Government planning protocols, which involves not only staff from the Ministry of Health and District Health office, but the broader district, with representatives from each department taking responsibility for setting up plans.
139. Technology development and transfer will also apply in several outputs of the project. At district level, district hospitals will be provided with modern computers, functioning internet and software needed to link to the

district-level EWARS dashboard and to the national level. At health centre-level, each facility will be provided with two modern tablets to enable dedicated staff members to aggregate health data collected by HSAs to feed into the district-level dashboard at the district hospital (sentinel site) The costs for technology for the health EWARS is included in Activity 1.1.3. Staff will be trained in data entry and submitting data up to the relevant level in the automation process (3.1.1 and 3.1.2).

140. As well as the EWARS, new technology in the form of solar improvements and WASH improvements will be implemented at health facilities (Activity 2.1.2 – solar and WASH), and schools (2.1.5 – WASH only). Solar improvements will include:

- Solar direct drive freezers and fridges
- Solar home systems, i.e., photovoltaic panels, batteries and associated equipment
- Solar lights
- Cold storage

141. Improvements to WASH will include:

- Rainwater harvesting systems
- Small-scale WASH solutions (clay filters, borehole improvements)
- Ecosan latrines

D. EXPECTED PERFORMANCE AGAINST INVESTMENT CRITERIA

This section refers to the performance of the project/programme against the investment criteria as set out in the GCF's Initial Investment Framework.

D.1. Impact potential (max. 500 words, approximately 1 page)

142. The project will contribute to the GCF's overarching adaptation impact – contributing to increased climate-resilient sustainable development – by directly increasing the climate resilience of the health system in Malawi, with direct benefits to an estimated 1,798,878 beneficiaries (899,439 women and 899,439 men) and indirect benefits to an estimated 2,359,162 beneficiaries (1,179,581 women and 1,179,581 men) in southern Malawi (10% of the country's total population), with a particular focus on women, children and other vulnerable groups. This will be achieved through gender-sensitivity and social inclusion in all activities, ensuring women, children and people with disabilities have equal opportunities to benefit. In practice this means recognition of differential vulnerability to climate-sensitive diseases and conditions, which is reflected in efforts to build the capacity of the healthcare system and staff to respond to these challenges (Outcome 3), and to enable people themselves to identify and reduce their own risk (Outcome 4). It also means expressly targeting pregnant women, breastfeeding mothers and children under 2 for tangible climate-resilient food and nutrition support (Outcome 4) to reduce vulnerability to drought. The number and disaggregation of direct beneficiaries will be determined based on activities.
143. The project will result in substantial reductions in the risk of loss of lives and wellbeing by focusing on diseases/conditions that are among leading causes of mortality and morbidity with the situation exacerbated by climatic changes: Malaria, diarrhoeal diseases, malnutrition, diseases linked to heat exposure, mental health and psychosocial problems, and the gendered health impacts of climate change. The project will help reduce climate-related morbidity and mortality through its focus on strengthening the capacity of the health system (including its workforce) and the capacity of local communities to anticipate and address health-related climate change impacts. Further, as most health facilities in Malawi currently do not have climate-resilient infrastructure, the project's focus on increasing the climate resilience of health and WASH facilities will help protect infrastructure from the impacts of extreme weather events (and thereby reduce the negative knock-on effects on health outcomes, for example, increasing the resilience of WASH facilities will help reduce the spread of cholera and diarrhoeal diseases). The project will also increase the number of households with year-round food security.
144. The project's focus is in alignment with the Guiding Principles for Financing Climate and Health Solutions developed at the 28th session of the Conference of Parties to the UNFCCC (COP28) in Dubai, to which the GCF was an initiating party and which are endorsed by both the Ministry of Health of Malawi and Save the Children[73]. These principles establish a shared vision for financing that will protect people from the range of climate risks to health, and build resilient, environmentally sustainable health systems, in recognition of the critical need to protect people from the harmful health impacts of climate change[74]. The current project is particularly well aligned with the following priority areas of the Guiding Principles for Financing Climate and Health Solutions: implementing proactive public health and adaptation measures to build healthy, resilient, adapted communities and protect people from the range of climate risks to health, with an emphasis on the most vulnerable and impacted communities; building stronger, resilient, and environmentally sustainable health systems, including by enhancing the sector's preparedness and adaptive capacity; elevating country ownership and leadership (see **section D.5**); and collaborating with countries to support resource mobilisation and leverage national and international finance for climate and health solutions, whilst enabling the human and other resources needed to ensure the long-term impact of investments in climate and health solutions.

D.2. Paradigm shift potential (max. 500 words, approximately 1 page)

[73] Green Climate Fund (2023) 41 funders, partners endorse new guiding principles for financing climate and health solutions to protect health. GCF Press Release, 02 December. Available at: https://www.greenclimate.fund/news/41-funders-partners-endorse-new-guiding-principles-financing-climate-and-health-solutions.

[74] COP28 UAE (2023) Guiding principles for financing climate and health solutions. COP28 UAE. Available at: https://www.cop28.com/en/guiding-principles.

145. **Potential for scaling up and replication.** The proposed project activities will remove the barriers to transformative change as described in the Theory of Change (Section B1), thereby enabling a step change in the climate resilience of Malawi's health system. This will be based on WHO's building blocks for climate-resilient health systems[75] as reflected in the GCF sectoral guidance on health and well-being[76]. It will be achieved by the demonstration of integrated approaches at district level to strengthening the resilience of infrastructure and health service provision and promoting climate-resilient health and well-being at community level. At the end of the project, each of the participating districts will have a DEC that understands the nature of climate risk to health; a District Health Adaptation Plan, capacity to integrate climate risk to health into development planning, including annual planning for medical supplies, access to early warnings from the EWARS (into which district surveillance is being fed), knowledge of how to build climate-resilient health care facilities and WASH. They will also have health care staff who are able to anticipate and respond to climate risk to health, including through treatments and MHPSS, and provide greater public health support to communities. Because of the focus on building systems (for example the EWARS at national level) and training (for example on how to screen infrastructure and WASH for climate resilience), these approaches can be replicated and scaled out to other districts, facilitated by the national institutional and enabling environment, thus catalysing impact beyond a one-off project investment.
146. **Potential for knowledge exchange and learning.** Knowledge sharing and evidence generation will be underpinned by a robust M&E plan and enabled through oversight of project implementation by the Health and Climate Change Core Team (HCCCT) of the multi-stakeholder Joint National Technical Committee on Climate Change and Disaster Risk Management JNTCCCDRM). The JNTCCCDRM will be the primary forum for knowledge sharing with government and non-government actors; whilst internationally Save the Children will leverage its international network to inform health sector adaptation in other countries, including through SADC climate change fora and the UNFCCC COPs (through the HCCCT). Support for advocacy in activity 1.2.2 builds stronger coalitions with knowledge on climate and health. A number of activities include particular knowledge products that promote sharing of knowledge (e.g. a toolkit on how to develop a DHAP under activity 1.2.1; a tool for applying the climate resilience screening guidelines for health care facilities under activity 2.1.2; exchange visits to demonstrate what climate-resilient healthcare facilities look like under activity 2.1.3; a guideline for climate-resilient WASH under 2.1.4; and a range of training materials targeting climate risk to public health through early warning, nutrition and WASH under Outcome 4).
147. **Contribution to the creation of an enabling environment**. In order to contribute to longer-term sustainability, the proposed project creates an institutional and enabling environment at national level (including the health early warning system in Activity 1.1.2, the standard for climate-resilient healthcare facilities in Activity 2.1.1 and the guideline for climate-resilient WASH facilities in Activity 2.1.4, all of which are accompanied by awareness-raising and training); and at district level by advocating for stronger integration of climate-resilient health within adaptation planning at district and sub-district level (Activity 1.2.2). These activities and the project's broader contribution to achieving the goals of key national policies (described below) will strengthen the enabling environment for climate resilient healthcare in Malawi.
148. **Contribution to the regulatory environment and policies.** The proposed project develops district health adaptation plans (Activity 1.2.1) and advocates for stronger integration of climate-resilient health within adaptation planning at district and sub-district level (Activity 1.2.2); and contributes to achieving the goals of the National Climate Change Management Policy (2016), the National Health Policy (2018) and National Environmental Health Policy (2018), the Updated NDC (2021) and the Health National Adaptation Plan **(see Annex 2).**
149. **Contribution to climate-resilient sustainable development pathways.** This project leverages Malawi's initial commitments to adaptation in the health sector through the Global Framework for Climate Services (GFCS) Adaptation for Africa project, and the draft Health National Adaptation Plan. Its integrated and holistic approach to health system climate resilience at multiple levels creates the enabling environment to enable easy scale up, and critical mass of demonstration of what health system climate resilience looks like at district level for ease of replication will provide sufficient nudge for a step-change into a climate-resilient sustainable development pathway, in line with national planning documents such as Vision 2063 and the Malawi Growth and Development Strategy III.

D.3. Sustainable development (max. 500 words, approximately 1 page)

[75] WHO, 2015. Operational framework for building climate resilient health systems. Geneva: WHO.

[76] GCF. 2022. Health and Wellbeing Sectoral Guide. Sectoral Guide Series. Yeonsu: Green Climate Fund.

150. The project is fully aligned to Malawi's sustainable development agenda, and commitments under the Sustainable Development Goals. It particularly contributes to SDG 1 (No Poverty), SDG 2 (Zero Hunger), SDG 3 (Good Health and Well-being), SDG 4 (Quality Education), SDG 5 (Gender Equality), SDG 6 (Clean Water and Sanitation) and SDG 13 (Climate Action) in the following ways:

- SDG 1: The suite of healthcare interventions, including equipping communities with improved health practices, will reduce the health costs borne by households and loss of income associated with poor health. Improved nutrition practices and integrated homestead farming will also contribute to reducing poverty.
- SDG 2: Empowering households to practice integrated homestead farming and to adopt other resilient nutrition practices will contribute to increased food security and improved nutrition. Malnutrition will be reduced by the strengthening of surveillance for malnutrition and early warnings for drought-linked malnutrition coupled with improved anticipatory procurement and provision of treatments for acute malnutrition.
- SDG 3: All the project interventions will work together to achieve good health and well-being at the community level through improved capacity to anticipate and respond to climate risk, infrastructure and supplies. This will enable better support for healthcare provision (including MHPSS) and will enable healthcare staff to deliver healthcare in the context of a changing climate. In addition, communities will have more knowledge of climate risks to their health and how they can adapt, including through sound nutritional practices and WASH.
- SDG 4: Quality and equitable education will be supported through improved WASH facilities at schools, awareness raising and training for school children specifically on the health EWARS and how they can reduce climate risks to their health, as well as improved nutrition boosting early childhood development.
- SDG 5: The project design is gender responsive and socially inclusive, aiming to ensure the full participation of women in capacity building and empowerment opportunities, and access to healthcare provision that reduces their risk.
- SDG 6: The development of guidelines on climate-resilient WASH facilities in public buildings, combined with training at national and district level on the guidelines (Activity 2.1.4) will contribute to this SDG. In addition, at district and sub-district level, knowledge on the installation and use of climate-resilient WASH facilities will be cascaded to community members through existing governance structures (Activity 4.1.1), enabling sustainability. The upgrading of WASH facilities at health facilities and schools will also contribute to this SDG.
- SDG 13: The entire scope of this project is in line with SDG 13, climate action, in taking urgent action to combat climate change and its impacts by enabling locally-led action based on climate risk evidence through health, nutrition and WASH.

The project will achieve a range of co-benefits, including:

151. *Co-benefit 1 Social*: Improved social inclusion for marginalized groups will result from improved dissemination of information on public health, particularly reaching hard to reach groups including out-of-school children, the elderly and people with disabilities (Activity 4.1.2), through the mobile health awareness units and other methods such as theatre for development for youth. Social inclusion will also be achieved through cooperative management of community assets (Activities 2.1.2, 2.1.5, 4.1.1), especially WASH facilities installed in communities, through inclusion of women, children and people with disabilities.

152. *Co-benefit 2 Social: Improved social outcomes for household economies* based on using improved integrated homestead farming and nutrition practices due to reduced need to purchase diversified food for nutritionally vulnerable household members.

153. *Co-benefit 3 Environmental: Very small-scale mitigation co-benefits through solar installations at health facilities reducing reliance on diesel generators at facilities and on the national electrical grid.*

154. *Co-benefit 4 Gender: Increased gender equality and empowerment* will result from the engagement of the whole community in conversations about power and gender dynamics (Activity 4.1.5). This community transformative approach raises the voices of women and girls as well as other most impacted people and also enables them to become activists in policy change (Activity 1.2.2). This will be complemented by better, more gender responsive health services (Activity 3.1.5) and the consideration of gender aspects in climate-resilient facilities, e.g., WASH guidelines and health facility standards, as well as inclusive provision of medical supplies and technologies. This will be underpinned by a gender-responsive and socially-inclusive approach that recognises the underlying structures and root causes that bring about gender inequality and social exclusion, and addresses them so that all individuals (including women, children and people with disabilities) have potential for equal benefits from the project, with targeted support to the most vulnerable groups (pregnant women, breastfeeding mothers).

D.4. Needs of recipient (max. 300 words, approximately 1 page)

155. **Vulnerability of the country and/or specific vulnerable groups, including gender aspects**. Malawi has high vulnerability to climate change. Among the most common climate hazards affecting Malawi are floods and droughts, and on average, Malawi loses c. 1.7% of GDP every year due to the combined effects of droughts and floods – which is more than 5 times higher than the average for least developed countries of 0.3%[77]. Changing climate and extreme events have impeded economic growth and progress against poverty indicators: for every three Malawians that moved out of poverty between 2010-19, four fell back into it due to the impact of weather shocks[78]. There is high reliance on natural resource-based livelihoods and on agriculture, a reliance that plays a major role in vulnerability to climate change. When the natural resource base and agricultural sectors are impacted by climatic changes, chronic and recurrent food insecurity result, with large-scale effects: currently 5.4 million people are facing moderate or severe food insecurity, and 4.4 million people are facing mild food insecurity (in total, this represents over half of the total population)[79]. Climate shocks are a major driver of poverty and food and nutrition insecurity and are undermining many of the progress and gains in development that have been made. Climate impacts are gendered and socially differentiated, affecting men, women, children, youth and vulnerable populations differently. Risk is worsened by differing aspects of vulnerability which are physiological, socio-economic, physical, ecological and environmental. For example, the socially-constructed gender and social norms that give rise to differential resource allocation, decision-making and political participation are reflected in differential vulnerability to climate change and extremes. Vulnerability to climate-sensitive diseases is often higher among pregnant and breastfeeding women, children, the elderly, people with disabilities, and the poor[80] . The impacts of food insecurity on malnutrition affect particularly children under five[81], and infants and young children also particularly vulnerable to the effects of heat[82], malaria[83], and diarrhoea[84]. The impacts of climate change are strongly gendered in a variety of ways (see **Annex 8: Gender and Social Inclusion Assessment, and Annex 2, Section 3.3).** The gender impacts of climate change severely affect the life chances of women and girls. For instance, child marriage strongly reduces the likelihood that girls will complete education[85]. As another example, women who experience loss of access to family planning and SRH services experience unwanted pregnancy, resulting in poor outcomes for children and increased poverty [86] . Beyond women, girls and children, the impacts of climatic changes and extremes often disproportionately affect other marginalised groups, such as people with disabilities **(refer to Annex 8 for full details)** and the elderly. For instance, Tropical Cyclone Freddy highlighted the increased vulnerability of many people with disabilities because of the limited access to public services, including specialised health services, and the loss of assistive services, often provided by relatives[87]. For another example, adults older than 65 years are

[77] Pauw, K. et al. (2011) The economic costs of extreme weather events: a hydro-meteorological analysis for Malawi. Environment and Development Economics 16: 177-98. doi:10.1017/S1355770X10000471.

[78] Caruso, G.D. & Cardona Sosa, L.M. (2022) Malawi poverty assessment: poverty persistence in Malawi - climate shocks, low agricultural productivity, and slow structural transformation. World Bank Group, Washington, D.C. Available at:

http://documents.worldbank.org/curated/en/099920006302215250/P174948072f3880690afb70c2097fe214d

[79] Integrated Food Security Phase Classification (IPC) (2022) IPC analysis report on the chronic food insecurity situation – Malawi. Integrated Food Security Phase Classification, Rome, Italy. Available at: https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Malawi_ChronicFoodInsec_2022May_report.pdf.

[80] World Health Organization (2013) Protecting health from climate change: vulnerability and adaptation assessment. World Health Organization, Geneva, Switzerland. Available at: https://www.who.int/publications/i/item/protecting-health-from-climate-change-vulnerability-and-adaptation-assessment.

[81] UNICEF (2023) Over half a million children at risk of malnutrition in Malawi. Available at: https://www.unicef.org/press-releases/over-half-million-children-risk-malnutrition-malawi.

[82] Chapman et al. (2022) Past and projected climate change impacts on heat-related child mortality in Africa. Environmental Research Letters 17: 074028. Available at: https://iopscience.iop.org/article/10.1088/1748-9326/ac7ac5/meta.

[83] World Health Organization (WHO) (2023) Malaria. WHO, Geneva, Switzerland. Available online at: https://www.who.int/news-room/fact-sheets/detail/malaria.

[84] World Health Organization (WHO) (2017) Diarrhoeal disease. WHO, Geneva, Switzerland. Available online at: https://www.who.int/news-room/fact-sheets/detail/diarrhoeal-disease.

[85] Wodon, Q., *et al*. (2017) Economic impacts of child marriage: global synthesis report. The World Bank and International Center for Research on Women, Washington, DC. Available at: https://documents.worldbank.org/en/publication/documents-reports/documentdetail/530891498511398503/economic-impacts-of-child-marriage-global-synthesis-report.

[86] Women Deliver (2021) The link between climate change and sexual and reproductive health and rights: an evidence review. New York, USA. Available at: https://womendeliver.org/wp-content/uploads/2021/02/Climate-Change-Report.pdf.

[87] Government of Malawi (2023) Malawi 2023 Tropical Cyclone Freddy Post-Disaster Needs Assessment. Government of Malawi, Lilongwe, Malawi. Available at: https://reliefweb.int/report/malawi/malawi-2023-tropical-cyclone-freddy-post-disaster-needs-assessment-april-2023.

often particularly vulnerable to the effects of heat; heatwaves in Malawi are projected to increase heat-related deaths in older people (65+ years) to 73 per 100,000 year by 2080, up from 3 per 100,000 between 1961-1990[88].

156. **Economic and social development level of the country and the affected population.** Malawi's Human Development Index value for 2021 is 0.512, putting the country in the low human development category position (i.e., 169 out of 180 countries and territories)[89]. Around half of the country (50.7%) was living in poverty in 2019-20. This proportion is higher in rural areas, and higher in the southern part of the country: poverty headcounts in the target districts range from 48.8% in Zomba to 63.7% in Phalombe[90].

157. Absence of alternative sources of financing. There is very limited fiscal space to support adaptation in Malawi (see **section B5).** Financial barriers to adaptation are becoming more evident as a result of COVID-19, the Russia-Ukraine war, inflation and a widening fiscal deficit. The project will address the financial barriers to action to build the capacity and knowledge of the health sector to better leverage its existing resources in a climate-resilient way.

158. Need for strengthening institutions and implementation capacity. Knowledge of climate and health in Malawi is limited. The Ministry of Health in Malawi has very limited capacity to address climate change, with only preliminary awareness raising and efforts made under one project which largely have not extended to district level. Likewise, the adaptation efforts spearheaded by the Environmental Affairs Department and the disaster risk reduction efforts spearheaded by the Department of Disaster Management Affairs are not currently sufficiently integrating health as a result of this lack of knowledge and poor institutional capacity. The project builds on these preliminary efforts to strengthen adaptation to climate change in the health sector, and the existing national level policies. In line with Malawi's Decentralisation Policy (2013), implementation will take place at the local level through District Executive Committees, ensuring the extension and furthering of national efforts to ensure that districts are also able to integrate climate risk into health planning, and to better implement national policies. In line also with community-based adaptation principles, the project's adaptation package provides a menu of actions (within Outcome 4) focused on supporting communities to improve their vulnerability to climate-related health impacts and build resilience to unavoidable impacts. This includes community-based and community-led processes to empower communities to address the social inequities that exacerbate climate vulnerability.

D.5. Country ownership (max. 500 words, approximately 1 page)

159. **Alignment to climate change strategies and policies -** This project is entirely aligned with the National Climate Change Management Policy, and implements priorities as outlined in the National Adaptation Plan framework[91], the updated Nationally Determined Contribution and the Health National Adaption Plan, which aims to "create a health sector that is resilient to climate change effects". It builds on and leverages the country's first health and adaptation project (GFCS Adaptation for Africa) by expanding knowledge on climate and health risks (e.g., on the links between disease burden and climate variables under Outcome 1), strengthening the institutional framework (in Outcomes 1 and 2) and staff capacity around health and climate change (in Outcomes 1 and 3). This project's design has also been informed by lessons from the GFCS Adaptation for Africa project, placing particular emphasis on: sustainably building local capacity (for example where cadres of national trainers will be produced to equip healthcare workers with the capacity to address the mental health and gendered impacts of a changing climate in Outcome 3, and to deliver training on the EWARS and interpretation of alerts arising from this system under Outcomes 3 and 4); developing local training materials (for activities under Outcomes 1-4); and ensuring all components start their activities at the same time to avoid delays. The project will also leverage the improved climate information enabled by MCLIMES (FP002).

160. **Alignment to gender action plans/policies -** The project has been designed through a bottom-up and inclusive process, based on extensive stakeholder consultation **(see Annex 7: Stakeholder engagement)** under the oversight of the HCCCT of the multi-stakeholder JNTCCDRM (Malawi's primary multi-stakeholder coordination body on climate change-related activities which is chaired by the Environmental Affairs Department as the NDA),

[88] WHO (2016) Climate and health country profile Malawi – 2015. World Health Organization, Geneva, Switzerland. Available at: https://climhealthafrica.org/wp-content/uploads/2017/06/Malawi-WHO-UNFCCC-Country-Profile.pdf.

[89] UNDP (2022) Human Development Report 2021/22. Uncertain times, unsettled live: shaping our future in a transforming world. Available at: https://hdr.undp.org/system/files/documents/global-report-document/hdr2021-22pdf_1.pdf?_gl=1%2A10jx22h%2A_ga%2AMTgwMDkwODA5NC4xNjg3MDk5NTIx%2A_ga_3W7LPK0WP1%2AMTY4NzA5OTUyMC4xLjEuMTY4NzA5OTU1OS4yMS4wLjA.

[90] NSO (2021) 2020 Malawi Poverty Report. Government of Malawi, Zomba.

[91] Ministry of Natural Resources, Energy and Mining (2020) Malawi's National Adaptation Plan Framework. Environmental Affairs Department, Lilongwe, Malawi. Available at: https://napglobalnetwork.org/wp-content/uploads/2020/03/napgn-en-2020-malawis-national-adaptation-plan-framework.pdf

which has overseen the entire process of project design through the nominated task team members. Both the HCCCT and JNTCCCDRM comprise representatives from government, academia, civil society and the private sector. In addition, extensive consultation was undertaken in all six target project districts with representatives of the district executive committees (particularly the district health office) and with men, women, children and people with disabilities. The project design takes particularly into account the needs that were expressed by women, which included to support them in the stress and anxiety that extreme events bring (through activity 3.1.4), to support their capacity to grow their own nutritious food to feed children (activity 4.1.4), and to ensure that climate-resilient nutrition and WASH-related information is cascaded through community leaders to ensure widespread dissemination (activities 4.1.1 and 4.1.4). It also includes needs expressed by children for climate-resilient WASH facilities in schools (activity 2.1.5) and by people with disabilities for mobile public health communications unit to disseminate public health information (activity 4.1.3).

161. **Alignment with other government departments -** The HCCCT endorsed the Ministry of Health as the Executing Entity, alongside SCI MW as the other Executing Entity. Implementation arrangements have been designed to ensure close engagement with both HCCCT and MoH, with oversight by the HCCCT, reporting to the JNTCCDRM, where lessons from ongoing implementation and evaluation will be shared with other relevant stakeholders. To ensure optimal and ongoing alignment with national health and climate agendas, the PMU will have staff seconded from the MoH so that their time is dedicated to project tasks (also a lesson learned from GFCS Adaptation for Africa – see **Annex 2, section 2.5.1** for more information).

Accredited Entity (AE) and Executing Entity (EE) experience

162. **AE's Comparative Advantage**. Save the Children has technical experts worldwide, including in climate change, natural resource and ecosystem management. The AE, SCA, has technical expertise in developing and implementing climate change adaptation projects, including for the GCF. SCA's Climate Change Division has supported the CHWBRC's development and will provide continued technical oversight to the EE's on GCF compliance throughout CHWBRC implementation. As per the implementation arrangements outlined in **Section B.4**, SCUK will work with SCA and SCI SL to support the CHWBRC implementation. SCUK has Climate Change Technical Advisors experienced in locally-led climate change adaptation and extensive experience of supporting SCI MW in-country teams throughout implementation.

163. **EE Suitability (SCI MW).** Save the Children (SC) has worked in Malawi over the past 40 years since 1983 implementing a wide range of activities in education, health, nutrition, child protection, resilience, livelihoods, social protection and has over the past 10 years increased in implementing climate sensitive activities mostly in agriculture. SCI MW has been instrumental in leading successful pilots of different programmes which has transitioned to multi-million dollar government funded projects including the current World Bank Funded Investing in Early Years Programme whose design was informed by Save the Children's Nutrition Embedded Evaluation Programme; the Interactive Radio Instruction education programme which the government is implementing through the Ministry of Education; the partnership for resilience programme which the government is being funded by IFAD and other multiple donors as FARMSE. SCI MW has a strong track record of leading policy changes and strategies which has informed programming of various government led programmes in Malawi including the Saving New Born Lives which informed the development of policies, strategies and protocols for new born and child health in Malawi. In the current 2022-2024 strategic plan, SCI MW is leading implementation of novel projects that will pave way for scale up by the government and partners including Nutrition Cash Plus Interventions, since 2022, SCI MW works on an annual average budget of USD 20 Million with a total budget of USD 50 Million for the 2022-2024 strategic period.

164. SC MW has a strong portfolio in resilience, education, child protection, child rights governance, health, nutrition programming implemented in almost 24 districts in Malawi with funding portfolio summarized as below:

Project	Project description	Value (Million USD)	Start Date	End Date
Maziko	Mother Child Cash Grant programme focusing on reducing prevalence of chronic malnutrition and enhance better ECD outcomes through provision of maternal and child grants complemented with plus interventions of food security,	11.60	November 2021	October 2026

	livelihoods, gender transformative programming.			
NORAD framework	All children especially the most vulnerable and marginalized enjoy their right to learning, survival and protection through enhancing interventions in numeracy and literacy, protection of child's rights, reduction of child marriages, teen age pregnancies and reduction of newborn and child mortality	13.55	January 2019	December 2023
Momentum	**To reduce maternal, child, and newborn mortality** by employing a multisectoral approach to scale up and increase access to quality health services in seven districts of Malawi with an intentional focus on youth and civil engagement.	2.86	October 2022	April 2027
Smart Climate	Contribute towards improved resilience of communities in central and northern regions of Malawi to unpredictable climate challenges and pandemic consequences.	0.87	September 2022	September 2025
Titukulane	Sustainable, Equitable and Resilient Food and Nutrition Security for Ultra-Poor and Chronically Vulnerable Households in Mangochi and Zomba	15.55	October 2019	September 2024
		44.43		

165. SC is a recognized Ministry of Health (MoH) partner in Malawi implementing facility and community-based reproductive, maternal, and newborn health interventions, including: voluntary family planning service delivery support; focused antenatal care; capacity building for delivery assistance by skilled birth attendants; early postnatal care for mothers and newborns; Kangaroo Mother Care (KMC) for preterm babies; and interventions targeting the management of birth asphyxia. All of our programs emphasize quality improvement to ensure proper care of pregnant women and neonates throughout pregnancy, childbirth, and the postpartum period. Our innovative capacity building approaches of ensuring minimal disruption to service delivery has been critical to the MOH's adoption of our implementation strategies.

166. **EE Suitability (Ministry of Health).** MoH is responsible for developing, reviewing and enforcing health and related policies for the health sector; spearheading sector reforms; developing and reviewing standards, norms and management protocols for service delivery. MoH provides strategic leadership for the delivery of a comprehensive range of quality, accessible, and efficient health services to all Malawians through the creation and sustenance of a strong health system. MoH has recent experience in delivering several large donor-funded programs from the World Bank and USAID.

D.6. Efficiency and effectiveness (max`. 500 words, approximately 1 page)

Concessionality

167. As outlined in **Section D.5**, building a climate-resilient health sector is a key component of Malawi's response to climate change. As also noted above **(Section B.5),** accessing finance to support adaptation measures – both within and outside of the health sector – at the scale required to create transformational change has been difficult for governments and civil society. Communities in Malawi are some of the least responsible for the emissions that are causing climate change, but they are among the first to suffer the impacts given Malawi's high vulnerability and because of their limited ability to adapt will feel these impacts more acutely than people in more developed countries. The Government of Malawi is clear that significant external financing will be required – including specifically referencing GCF funds in their NAP – if the country is to effectively manage the unavoidable impacts of

climate change. There is a clear argument for high co-finance and private sector engagement in mitigation action. The argument for poor countries to finance their own adaptation actions in response to a problem stemming from the unregulated use of the global commons, or to take out concessional loans to do so, is less clear. It is even less strong when the ultimate beneficiaries are communities in one of the poorest countries in the world, facing extreme weather events – not at all of their own making – with increasing regularity. Investing in health infrastructure to effectively adapt to such events pays dividends – for community members themselves through improved health outcomes, but also for the national economy. The financial argument for investing in resilience-building within the health sector is strong, and clear; for each extreme event and recovery period, there is an increasing cost associated, especially given the reduced turnaround for recovery periods highlighted in **Section B5**. The project will allow communities to recover and withstand such events far more effectively, and reduce the related cost associated with each extreme event.

168. The Government of Malawi struggles to find the resources to meet current development needs within communities, let alone proactively address anticipated future climate change impacts. The funding amount requested from the GCF for this project is commensurate with the scale of the problem and the Malawi Government's desire to take a nation-wide approach to addressing health adaptation needs.

Financial structure

169. The financial management structure for the project has also been designed with efficiency in mind, making the best use of the capacity of each organisation involved. Working through the Ministry of Health as an executing entity with responsibility for coordinating both within the ministry and across government, means that the connections and knowledge will already be in place to coordinate the project effectively, and provide strong governance. This is true both at a national level, with MoH staff seconded into the PMU, and at district level, with district health staff seconded onto the project – these staff will be retained by MoH post-project implementation period. However, noting the Ministry's challenges with procurement **(Section B4)** – especially of larger items – the infrastructure improvements as well as any higher-value consultancies will be procured using Save the Children's more efficient procurement systems.

170. Working through national partners at the community level also provides efficiencies for the project, because they are already well-established in most of these communities and will have full-time community mobilisation staff based in the relevant Traditional Authorities. This is an effective way of working not only because it will save on repeated travel from national, to district, to sub-district level to mobilise the target communities, but also because the partners already have relationships with said communities and understand how to operate effectively in those contexts.

Economic and Financial Analysis

171. An economic and financial analysis **(Annex 3)** undertaken as part of the project's design phase examined five specific adaptation measures that are broadly representative of the overall project's intervention strategy:

- Operational health Early Warning and Response System (EWARS)
- Strengthening the climate resilience of healthcare facilities through solar and WASH improvements
- Improved climate resilience of school WASH facilities to improve children's health
- Providing medical supplies and technologies for climate health risk reduction and response
- Reduced malnutrition through production of climate-resilient foods and quality complementary feeding for children under 2

172. The analysis showed that overall, all five of the adaptation measures analysed have either a very high or high economic internal rate of return and can be justified on economic grounds. Furthermore, the selected measures will have a significantly positive economic impact for the targeted communities over the life of the project and beyond.

173. The economic analysis also undertook assessment of the incremental adaptation benefits of the five selected measures in the context of the overall project budget. This analysis showed the project has an EIRR of 13%, which is greater than the discount rate of 9%. The level of the EIRR is due to the size of the non-investment flows required to enable and support the adaptation investments, to ensure their long-term sustainability and to catalyse a paradigm shift in resilience in Malawi. The analysis found that the project presents a strong investment for the GCF. While the types of benefits these activities generate are often non-monetary and have the characteristics of public goods (which are often challenging to quantify for any credible economic analysis), without these activities the

project's economically quantifiable adaptation investments would be significantly less impactful in the immediate term, would be less sustainable in the longer term and would fail to generate transformational change.

Efficiency and effectiveness

174. Considering only the GCF grant for the project, the cost per direct beneficiary of the intervention is $18.35, but when considering co-financing contributions, this increases to $20.6. When taking both direct and indirect beneficiaries, the total USD per beneficiary is $7.93 for the GCF grant only, and $8.91 for the total project cost. The co-financing percentage for the project is 10.97%.

E. LOGICAL FRAMEWORK

*This section refers to the project/programme's logical framework in accordance with the **GCF's Integrated Results Management Framework** to which the project/programme contributes as a whole, including in respect of any co-financing.*

E.1. Project/Programme Focus

Please indicate whether this proposal is for a mitigation or adaptation project/programme. For cross-cutting proposals, select both.

☐ Reduced emissions (mitigation)

☒ Increased resilience (adaptation)

E.2. GCF Impact level: Paradigm shift potential (max 600 words, approximately 1-2 pages)

This section of the logical framework is meant to help a project/programme monitor and assess how it contributes to the paradigm shift described in section D.2 above by applying three assessment dimensions - scale, replicability, and sustainability.

Accordingly, for each assessment dimension (see the definition per assessment in the accompanying guidance note), describe the current state (baseline) and the potential scenario (target) and rate the current state (baseline) by using the three-point-scale rating (low, medium, and high) provided in the guidance note. Also describe how the project/programme will contribute to that shift/ transformation under respective assessment dimensions (scale, replicability and sustainability). In doing so, please refer to section B.2(a) (theory of change).

Assessment Dimension	Current state (baseline)		Potential target scenario (Description)	How the project/programme will contribute (Description)
	Description	Rating		
Scale	Despite growing attention to adaptation in Malawi, the health sector has been overlooked relative to agriculture and natural resources. To date, there has only been one (now finished) project on health and adaptation, which has established some interest (which is driving the draft HNAP) and some structures (e.g., the HCCCT). Further developments are impeded by lack of knowledge on the specific nature of climate change on	Low	The project will directly benefit 1,798,878 people in Malawi, across six districts and 25 traditional authorities within those districts. This includes 79 health facilities receiving infrastructure improvements – namely solar and WASH installations – and improved technological capacity to deliver the Early Warning and Response System (EWARS). As part of the EWARS, the project will establish five new sentinel sites which will enable full cohesion between district health, climate and weather data in five new districts to inform targeted responses to upcoming	Scalability is enabled by establishing national level systems that can then easily be extended to 22 other districts in the country in addition to the 6 districts targeted directly by the project (Outcome 1). For the EWARS, the project will facilitate impact at scale by working at national level in terms of strengthening the knowledge base, national capacities, institutional arrangements and setting alert levels (Outcome 1), as well as in the 6 target districts in terms of district staff capacity and sentinel sites (Outcomes 1 and 3). In this way the EWARS can then be accessed, used and contributed to across the 22 non-target districts, and the project provides training to the 22

	disease burden and conditions, lack of institutional capacity in the Ministry of Health and among districts, and insufficient integrated (multilevel) efforts to enable transformation of the health system to be climate resilient.		climate-based disease outbreaks. In order to implement the EWARS, the project will establish new thresholds and alert triggers for at least four different climate-sensitive diseases/conditions, allowing more effective early warning messaging. At the community level, the project will work with community members directly in 500 villages across the 25 Traditional Authorities, installing WASH facilities at schools to improve community health, as well as working with vulnerable groups to improve nutrition outcomes for around 35,000 households. The project will also strengthen the Government of Malawi's annual planning exercise to procure medicines and treatments aligned with the impacts of climate change on health, and will bolster district health staff capacity to deliver additional treatments. This project will build a climate-resilient health system for the first time in Malawi, covering all six building blocks as outlined by WHO framework on climate-resilient healthcare.[92] SCI Malawi has a permanent	non-target districts on its functioning, enabling scaling to these districts. Another example of how the project will achieve impact at scale is the national-level activity to improve the MoH's annual forecasting and procurement for medical treatments considering anticipated climate change impacts (Activity 3.1.3). Support for advocacy and coalition-building also focuses at national level, enabling scaling of interventions. The integrated system-wide approach, covering all building blocks of a climate-resilient health system, also creates the system shift necessary for impact at scale.

[92] WHO: 'Operational framework for building climate resilient health systems', accessed 27/10/2023, available here.

			presence in Malawi and will continue to work with MoH post-implementation to capture the quantifiable results within and beyond the scope of the intervention to support further scaling.	
Replicability	Adaptation in the health sector is currently overlooked. There are institutional and capacity barriers, with the Ministry of Health having limited expertise on climate and health, and other national institutions having advanced adaptation in other sectors, but not health. This situation is exacerbated at district level, where limited knowledge on climate and health means that these issues are not considered in planning documents or practices. Thus, not much is currently in place that can be replicated and the baseline for replication is low.	Low	An integrated approach that targets multiple aspects of the health system at district level – namely the institutional environment (at district level), infrastructure, health care provision (through supplies and technologies and staff capacity) and public health awareness of climate risk – creates a climate-resilient district-level health system in the 6 target districts that can be replicated to other districts. The target scenario is built upon sustainable technical and institutional capacity among staff, as well as by creating tools, models, physical examples and a stronger evidence base. Interventions including the health early warning and response system model, the infrastructure improvements to health facilities, the WASH improvements to schools for community health and the community-level activities to promote gender equality and community health, will all be rolled out in the six target districts. As part of the project, national standards for infrastructure will be created which can be rolled out in non-	Replicability is enabled by Outcomes 1-4. Whilst DHAPs will be enabled in the target districts, a toolkit will be provided to district staff in non-target districts (Output 1.2), to detail the process so that the institutional framework can be replicated in other districts. Infrastructure will be made climate-resilient in the target districts (Activity 2.1.2), but the standard on climate-resilient health infrastructure and guideline on climate-resilient WASH (Activity 2.1.4) will enable replication in other districts, together with exchange visits to climate resilient-strengthened infrastructure (also under Activity 2.1.4). Training materials produced to build the capacity of healthcare staff to provide early warning information and health care that responds to climate risk (Activity 3.1.1 and 3.1.2) can be applied elsewhere (enabled by the fact that Ministry of Health endorsement will be sought for the training on climate change, and health early warnings). Public health awareness activities in Outcome 4 – including the school materials on early warning (4.1.2) and the self-administering tool for individuals to assess their own health risk of climate change – will also facilitate replication, given

			target districts, as well as the model for creating district health adaptation plans.	that the tools can easily be printed and distributed to individuals in non-target districts. With the activity targeting pregnant and breastfeeding mothers of children under 2 for climate-resilient nutrition practices (4.1.4), the demonstration effect of these practices will encourage replicability among other community members in the target TAs. The expectation is that any community members not included in the demonstrations will still benefit from the techniques as there will be a critical mass of knowledge within communities, and those receiving training and inputs initially will share knowledge with other community members.
Sustainability	Malawi makes extensive commitments to adaptation through its updated NDC and draft National Adaptation Plan (and draft Health National Adaptation Plan), as well as through the National Climate Change Management Policy. However, despite these documents having commitments to adaptation in the health sector, these commitments have not been translated into local-level plans from which implementation occurs. There are also significant institutional and knowledge barriers and technical capacity gaps that impede adaptation of the health system. Finally, behavioural norms – especially at community level –	Medium	The project addresses knowledge barriers and builds sustainable capacity to enable adaptation in the health system through targeting national and district technical staff in the Ministry of Health and DEC; health care facility staff; and primary and secondary healthcare providers. They will then be better able to ensure climate risk to health is implemented in district-level planning documents, in the planning and management of new health care facilities, and in the provision of climate-resilient healthcare. The district health adaptation planning also involves consultations with community members to understand adaptation priorities and seek inputs into district plans. All of the efforts at community level are focused on empowering individuals to assess the nature of climate risk to their	The project focuses on establishing the institutional and enabling environment and building sustainable capacity. This approach will be achieved through multi-pronged and repeated capacity-building among government staff, (Outcome 1) health facility staff and healthcare providers (Outcomes 2 and 3), in order to deal with turnover; as well as inclusion of traditional healers who are still the primary port of call for many Malawians seeking healthcare (Outcome 4). Sustainability of project results will also be increased by taking inclusive and community-based approaches (Outcome 4), including addressing barriers in terms of gender and social inclusion (Activity 3.1.5 and Outcome 4). The provision of training will be enabled through producing national cadres of training focusing on different elements (for example health early warning systems, MHPSS, gendered impacts of a changing climate – Outcome 3) to ensure that capacity to continue to provide such training lasts beyond the project lifespan. Where appropriate, Ministry of Health endorsement of training materials will be sought, to embed them within national practices going forwards.

	arise from both a lack of knowledge of climate impacts on health, and a lack of ability to address these impacts when faced with them due to levels of poverty, which mean that communities struggle to adapt to the increasingly severe impacts of climate change.		health and adopt appropriate practices to reduce risk. As a result of this approach, the project has a high likelihood of achieving sustained impact beyond the implementation period.	Significant amounts of training and awareness-raising materials will be produced (Activity 4.1.2) and knowledge management strategies will ensure they are well distributed, not only through national, district and health care structures, but also through the JNTCCCDRM. The general approach is to work through and strengthen existing structures, both through healthcare (for example CHAGs and healthcare groups) and traditional governance structures, for example group village headmen.

E.3. GCF Outcome level: Reduced emissions and increased resilience (IRMF core indicators 1-4, quantitative indicators)

Select appropriate IRMF core and supplementary indicators to monitor project/programme progress. More than one IRMF (core and or supplementary) indicators may be selected as applicable for each GCF results area and project/programme outcome (as defined in the table in section B.2(b)). If IRMF indicators are unable to measure any given project/programme outcomes, project/programme-specific indicators should be developed under section E.5 (project/programme specific indicators).

GCF Result Area	IRMF Indicator	Means of Verification (MoV)	Baseline	Target		Assumptions / Note
				Mid-term	Final[93]	
		Sources of information and methods used to collect and report data /information to measure progress against targets	*The starting point or current value of the indicators before the implementation of the project*	*The estimated value of the indicator at the mid-point of the implementation*	*The estimated value of the indicator at the completion of the implementation*	*Externalities and factors outside project management's control that may impact the outcomes* *Data sources and methodologies applied for estimating baseline and targets*
ARA1 Most vulnerable	Core 2: Direct and indirect beneficiaries reached	Government records (e.g., census; health	Direct 0 total 0 Women (W)	Direct 719,460 total 359,730 W	Direct 1,798,878 total 899,439 W	The direct reach is the population in the 25 target traditional authorities, and the indirect reach is the district population in the six

[93] The final target means the target at the end of project/programme implementation period. However, for core indicator 1 (GHG emission reduction), please also provide the target value at the end of the total lifespan period which is defined as the maximum number of years over which the impacts of the investment are expected to be effective.

people and communities		sector data such as DHIS) Project documentation, e.g. baseline, mid-term and endline evaluations; monitoring reports	0 Men (M) Indirect 0 total 0 W 0 M	359,730 M Indirect 943,665 total 471,832 W 471,832 M	899,439 M Indirect 2,359,162 total 1,179,581 W 1,179,581 M	target districts minus the direct beneficiaries. Direct and indirect beneficiaries will be counted via aggregated project reporting, which will include activity and sub-activity level attendance, as well as project M&E (i.e., surveys of uptake, and media/social media engagement) A subset of the beneficiaries under Core 2 are also covered by Supplementary 2.4.
ARA1 Most vulnerable people and communities	Supplementary 2.4: Beneficiaries (female/male) covered by new or improved early warning systems	Government records (e.g., census, health sector data, DODMA records) Project documentation, e.g. baseline, mid-term and endline evaluations; monitoring reports	Direct 0 total 0 Women (W) 0 Men (M) Indirect 0 total 0 W 0 M	Direct 719,460 total 359,730 W 359,730 M Indirect 943,665 total 471,832 W 471,832 M	Direct 1,798,887 total 899,439 W 899,439 M Indirect 2,359,162 total 1,179,581 W 1,179,581 M	Interventions are cascaded effectively via health system and people understand early warnings Direct and indirect beneficiaries will be counted via aggregated project reporting, which will include activity and sub-activity level attendance, as well as project M&E (i.e., surveys of uptake, and media/social media engagement) These beneficiaries covered by Supplementary 2.4 are a subset of the beneficiaries under Core 2.
ARA2 Health, well-being, food and water security	Core 2: Direct and indirect beneficiaries reached	Government records (e.g., census; health sector data such as DHIS which includes health facility data)	Direct 0 total 0 Women (W) 0 Men (M) Indirect	Direct 719,460 total 359,730 W 359,730 M Indirect	Direct 1,798,878 total 899,439 W 899,439 M Indirect	Assumes that interventions are cascaded effectively and the early warning and alert response systems are understood by community members

		Project documentation e.g. baseline, mid-term and endline evaluations; monitoring reports	0 total 0 W 0 M	943,665 total 471,832 W 471,832 M	2,359,162 total 1,179,581 W 1,179,581 M	Direct and indirect beneficiaries will be counted via aggregated project reporting, which will include activity and sub-activity level attendance, as well as project M&E (i.e., surveys of uptake, and media/social media engagement)
ARA2 Health, well-being, food and water security	Supplementary 2.5: Beneficiaries (female/male) adopting innovations that stregthen climate change resilience	Project documentation, e.g. baseline, mid-term and endline evaluations; monitoring reports. Equipment use trackers and service logs.	Direct 0 total 0 Women (W) 0 Men (M) Indirect 0 total 0 W 0 M	Direct 359,730 total 179,865 W 179,865 M Indirect 471,832 total 235,916 W 235,916 M By mid-term, 20% of the population in the target traditional authorities will be adopting innovations to strengthen climate change resilience	Direct 1,259,055 total 629,528 W 629,528 M Indirect 1,651,413 total 825,707 W 825,707 M By the end of the project, 70% of population in target Traditional Authorities will be adopting innovations to strengthen climate resilience	Communities want to adopt the promoted climate-resilient actions. We are counting ‘innovations’ as the following: • Improved climate resilience of healthcare facilities, including WASH infrastructure (rainwater harvesting, improved water filters, etc.) and solar power • Improved climate resilience at schools through targeted WASH interventions • Responsive and improved Health Early Warning Systems including the mobile health unit, and improved data collection systems through e.g. tablets and internet connectivity • Improved individual farming or kitchen garden approaches for vulnerable mothers and pregnant women (to improve ability to grow climate-resilient crops)

						The target of 70% is based on realistic assumptions of numbers of beneficiaries within the target communities who will benefit from these interventions, and aligns with the figures for separate indicators described in section E5 below, as well as the beneficiaries for particular interventions described in the Feasibility study, section 6.3. This indicator will be monitored using a combination of surveys, as well as service use trackers or logs for particular types of equipment.
ARA3 Intrastructure and built environment	Core 3: Value of physical assets made more resilient to the effects of climate change and/or more able to reduce GHG emissions	Ministry of Finance and Ministry of Health appraisals Project documentation e.g. baseline, mid-term and endline evaluations; monitoring reports	$0	$2,500,000	$8,600,000	Best estimates based on currently available data – during implementation will be adjusted based on assessment of each of the target health facilities, in coordination with Ministries of Health and Finance. Figure provided is the value of project budget towards climate-resilient infrastructure upgrades at 79 health facilities.

E.4. GCF Outcome level: Enabling environment (IRMF core indicators 5-8 as applicable)

Select at least two relevant IRMF core (enabling environment) indicators to monitor and elaborate the baseline context and project/programme's targeted outcome against the respective indicators. Rate the current state (baseline) vis-à-vis the target scenario and select the geographical scope of the outcome to be assessed. Describe how the project/programme will contribute towards the target scenario. Refer to a case example in the accompanying guidance to complete this section.

Core Indicator	Baseline context (description)	Rating for current state (baseline)	Target scenario (description)	How the project will contribute	Coverage
Core Indicator 5: Degree to which GCF investments contribute to strengthening institutional and regulatory frameworks for low emission climate-resilient development pathways in a country-driven manner	Limited integration of climate change into i) central health policies and management of health facilities and ii) community/health facility coordination at community level. Some horizontal cross-government coordination (e.g., JNTCCCDRM) to address climate change issues but limited in scope and not always working effectively Limited financial resources dedicated to defining and implementing health-related adaptation pathways (Health National Adaptation plan is still a 'draft' document)	low	Medium (11-14) Components of an institutional framework are in place that strengthen the integration of climate change in the health sector. A permanent climate-informed health surveillance and early warning system exists at national level, along with strengthened institutional capacity in place for its ongoing management. At district level, strengthened governance structures for the management of climate change risks and effects on health are in place, as is multi-sectoral collaboration on health and climate change via multi-stakeholder fora.	Project activities under Outcome 1 will strengthen institutional architecture and build capacity for climate-informed health surveillance system and health Early Warning and Response System. Project will work at district-level to develop and implement district health adaptation plans (DHAPs). The work embedded under Outcome 1 will cascade into supporting the other Outcomes, given the indicator's broader focus on supporting climate-resilient development pathways.	National level (one country)
Core Indicator 6: Degree to which GCF investments contribute to technology deployment, dissemination, development or transfer and innovation	Currently limited knowledge within health sector to use technologies addressing the climate change impacts on health.	low	Medium (11-14) Technology underpinning the health EWARS is being deployed sustainably,	Project activities under Outcome 2 will deploy solar energy for healthcare facilities and WASH solutions for healthcare facilities and schools.	Multiple sub-national areas within a country

	Limited financial resources dedicated to innovation relating to climate change challenges – especially in the health sector. Some examples of small-scale pilots to trial technology and innovation related to health EWARS (e.g., WHO pilot in four districts) but progress has stalled due to human and financial capacity limitations		supported by the necessary skills. In target healthcare facilities, solar energy solutions are installed and managed sustainably, and in target healthcare facilities and schools, WASH solutions are installed and managed sustainably.	Project activities under Outcomes 1 and 3 will deploy technology and innovation to contribute to the health EWARS, including: computers; tablets; improved internet connectivity; software to host the data dashboard at district level and the ability to link to the national-level dashboard. Health staff will also be provided with skills to work on innovation.	
Core indicator 8: Degree to which GCF investments contribute to effective knowledge generation and learning processes, and use of good practices, methodologies and standards	National and district level processes and practices to build climate health knowledge in health sector are limited or absent. No national standards for climate-resilient health facilities and climate resilient WASH facilities. Limited knowledge of target disease patterns in relation to weather variables in Malawi.	low	Medium (11-14) National and district level processes and good practices (e.g., cadres of trainers, mobile awareness units, community mobilisation approaches, etc.) exist to inform and guide the training, awareness-raising and engagement of health workers and communities across the country. Robust and validated guidelines and standards for climate-resilient health facilities and climate-resilient WASH facilities exist and can be applied across the country. Targeted knowledge exists on select disease patterns	Project activities under Outcome 3 will disseminate good practices for reducing climate-health risk via training of health workers, while Outcome 4 will do so via direct engagement with communities, through formative research to understand current barriers and inform message development relating to EWARS and climate and health more broadly. The project will also contribute to creating robust standards for both climate-resilient health facilities (Activity 2.1.1) which will be incorporated into the current health facility infrastructure standards, and by defining effective climate-resilient WASH standards and guidelines (activity 2.1.4). These guidelines and standards will subsequently be validated by national	Multiple sub-national areas within a country

			in relation to weather variables in Malawi. Where new regions/districts (and potentially other countries) adopt the processes, good practices, guidelines and standards, they directly apply knowledge and lessons (positive and negative) that have been generated and and shared by the project.	government and disseminated widely across multiple districts. Under Outcome 1, the project will contribute towards the creation of a body of knowledge on the relationship between select diseases and weather variables in Malawi.	

E.5. Project/programme specific indicators (project outcomes and outputs)

Project/programme results (outcomes/ outputs)	Project/programme specific Indicator	Means of Verification (MoV)	Baseline	Target		Assumptions / Note
				Mid-term	Final	
Outcome 1. Reduced risk from climate-sensitive diseases and conditions						
Output 1.1 Climate-informed health surveillance	Number of climate sensitive diseases/conditions for which thresholds are identified and validated	Report of studies on threshold setting,	0	4	4	Government officials willing to engage in the process and to validate the thresholds

system and health Early Warning Alert and Response System (EWARS)		records of meetings to validate and finalise				Existing pilot work on setting thresholds for diseases in Malawi is built upon successfully by project team and partners
	% of participating national and district officials with increased knowledge of health early warning systems and climate information services *Disaggregation: Gender, district*	Attendance records and evaluations of participants at training and dissemination events; annual health official knowledge and attitudes survey	0	60 %	95 %	Training delivered on EWARS is effective and successfully improves knowledge of government officials Government officials attend full training package for comprehensive knowledge and skills on health and climate
	Number of national and district government officials with access to improved dashboard of climate-informed health EWARS *Disaggregation: Gender, district*	Annual health official knowledge and attitudes survey	0	40	90	Improved server for EWARS is installed and functioning effectively by project mid-term (conditional on ongoing work by WHO in Malawi) Access to the server and associated IT systems is granted on an equitable basis

						The national level Health Early Warning and Response System (EWARS) has been sufficiently developed by WHO by Y2 of the CHWBRC project Assumes that all those who receive training (at both national and district level) will be provided with access credentials to the system and will use it regularly. Officials will receive training on dashboard use and then be provided with unique login. Based on a core group at national level (15) and 15 per district. Zomba is excluded as they already have a pilot sentinel site up and running and district officials are using the pilot dashboard.
	Number of sentinel sites established	Activity reports detailing sentinel installation; monthly reports detailing sentinel operation	0	1	5	Suitable sites are identified and agreed by government and the project team
Output 1.2 District Health Adaptation Plans	Number of District Health Adaptation Plans (DHAPs) developed and validated by District Executive Committee (DEC) *Disaggregation: district*	Drafts of DHAPs, minutes of DEC meetings where they are validated	0	6	6	Multi-sectoral buy-in to the DHAP process is successfully secured, and district government departments work together effectively District Executive Committees (DEC) are willing to engage in the DHAP process and to validate the plans.
	Number of District Development Plans that allocate budget to climate-resilient health interventions (based on DHAPs) *Disaggregation: district*	District Development Plans and District Annual Budgets	0	3	6	Multi-sectoral buy-in to the DHAP process is successfully secured, and district government departments work together effectively DEC staff promote the DHAPs to the wider district departments
Outcome 2: Healthcare infrastructure is able to deliver service and care in the context of changing climate risk						

Output 2.1 Climate-resilient health centres, district and central hospitals and schools for community health	Number of target health facilities with solar improvements implemented *Disaggregation: district*	Installation reports and signed acceptance of work records	0	20	79	Relevant staff at target facilities are willing to engage in the installation process. Complementary projects are willing to coordinate and share knowledge with the proposed project for implementation of solar equipment on health facilities Procured contractor leading on installation successfully procures solar panels and equipment for installation Community members around health facilities are willing to collaboratively work on security aspects to prevent theft of equipment Assessment of health centres will show that not all health centres require full solar improvements
	Number of target health facilities with improved WASH facilities installed *Disaggregation: district*	Installation reports and signed acceptance of work records	0	20	79	Relevant staff at target facilities are willing to engage in the installation process. Complementary projects are willing to coordinate and share knowledge with the proposed project for implementation of WASH equipment on health facilities Procured contractor leading on installation successfully procures equipment and materials for installation Community members around health facilities are willing to collaboratively work on security aspects to prevent theft of equipment Assessment of health centres will show that not all health centres require full WASH facility upgrades

	% of target health facilities adopting guidelines for climate-resilient WASH *Disaggregation: district*	Annual survey of healthcare facilities	0	30 %	90 %	Guidelines developed are effectively disseminated to health facilities across the project districts Health centre staff understand the new guidelines and are willing to work with project staff to ensure they are implemented in their facilities
	% of target health centres adopting national standards for climate resilience *Disaggregation: district*	Annual survey of healthcare facilities	0	30 %	90 %	Guidelines developed are effectively disseminated to health facilities across the project districts Relevant district and health facility staff support the adoption of the guidelines.
	# of schools with improved WASH facilities installed *Disaggregation: district*	Installation records and acceptance of work records	0	100	400	Staff and community members around schools are willing to engage with the installation process Contractor successfully procured and delivers installation of rainwater harvesting systems as per terms of reference
Outcome 3: Healthcare staff are able to deliver service and care in the context of changing climate risk						
Output 3.1: Healthcare staff trained in managing climate-related disease monitoring, health messaging, and disease treatment and prevention	# of additional households receiving treatment for cholera and diarrheal disease (ORS, Zinc) *Disaggregation: gender (household headship)*	Record of treatment distribution	0	3,000	8,000	HSAs continue to visit targeted households in their catchment areas in order for households to receive vital climate-related health treatments. Procurement of treatment is conducted without any delays Community members will make themselves available to receive treatment
	# of additional households receiving treatment or preventive measures[94] for malaria *Disaggregation: gender (household headship)*	Record of treatment distribution	0	5,000	15,000	Procurement of treatment is conducted without any delays HSAs continue to visit targeted households in their catchment areas in order for households to receive vital climate-related health treatments. Community members will make themselves available to receive treatment

[94] Long lasting insecticide nets, and seasonal malaria chemoprevention

	# of district and health facility staff trained on surveillance operation and data collection *Disaggregation: Gender, district*	Training Report and annual health knowledge and attitudes survey	0	25 (25 district-level staff)	115	District and health facility staff will be willing to undertake training to improve capacity for data collection to feed into EWARS
	# of health outreach staff (HSAs and SHSAs) and community healthcare volunteers (CHVs) trained on climate and health and utilization of new EWARS *Disaggregation: Gender, type of staff, district*	Training Reports and annual health knowledge and attitudes survey	0 HSAs 0 CHVs	200 HSAs and SHSAs 1,500 CHVs	650 HSAs and SHSAs 5,460 CHVs	District health staff and Community volunteers will be willing to undertake training to improve capacity for data collection to feed into EWARS
	% of target health facility staff that report to have conducted Mental Health and Psychosocial Support in Practice *Disaggregation: Gender, district*	Training record and annual health knowledge andattitudes survey	0%	30 %	85 %	Relevant trained staff in MHPSS deployed to provide MPHH
	% of district and community healthcare staff reporting to have conducted community engagement activities on climate change impacts on gender issues *Disaggregation: gender, district*	Annual health knowledge and attitudes survey	0%	30 %	75 %	Training on climate impacts on gender issues is effective in building the knowledge and skills of district and community health care staff to conduct community engagement activities on gendered impacts of climate change
Outcome 4: **Community level health is more resilient in the context of changing climate risk**						

Output 4.1: Stronger community capacity to reduce health risks from climate change	% households that demonstrate understanding of the design, implementation and management of climate-resilient WASH facilities *Disaggregation: gender (household headship)*	Community knowledge, attitudes and practices survey	0%	30 %	90 %	Trained district and community health level staff conduct community engagement activities to effectively impart knowledge to households on climate resilient WASH
	% of target villages reached by mobile health awareness units *Disaggregation: district*	Monthly project activity reports Vehicle log	0%	35 %	90 %	Mobile health awareness units are operational throughout the project lifecycle Multiple project areas are not simultaneously impacted by severe weather events that prevent access to villages
	# School and out of school children and young people engaged with new education/curricular materials about early warning and climate resilient health. *Disaggregation: Gender, age, district*	Community knowledge, attitudes and practices survey, Project records	0	10, 000	25, 000	Mobile health awareness units are able to visit all target communities Project staff target the most suitable community members and hard to reach children can be accessed as part of the project
	# Households with pregnant women, breastfeeding mothers and children under 2 that grow climate-resilient complementary nutritious food	Intervention evaluation records, Mid-term and endline survey	0	5,0 00	20, 000	Major impacts of climate change (e.g., floods, droughts) do not prevent participating mothers from successfully growing food

	% of children 6-23 months who received Minimum Dietary Diversity the previous day *Disaggregation: gender*	Mid-term and endline Survey	0% (to be updated at baseline)	20 %	50 %	Mothers will provide food grown under the training activity, to their children Food grown by mothers as a result of training and inputs will suffice to meet the minimum dietary diversity requirements for infants There are no extreme weather events that impact the ability to grow food
	% of pregnant and breastfeeding women who received Minimum Dietary Diversity the previous day	Mid-term and endline Survey	0% (to be updated at baseline)	20 %	50 %	Households will provide food grown under the training activity, to pregnant and breastfeeding women Food grown by households as a result of training and inputs will suffice to meet the minimum dietary diversity requirements for pregnant and breastfeeding women There are no extreme weather events that impact the ability to grow food
	% of target community members demonstrating increased understanding of how to address gender issues exacerbated due to climate change (GBV, SRH, CEFM) Disaggregation: *gender*	Community knowledge, attitudes and practices survey	0% (to be updated at baseline)	30 %	80 %	Community gender-focused groups are established successfully in communities Training delivered to community members about gender impacts on climate change is effective at imparting information
Project / programme co-benefit indicators						

Co-benefit 1 (*social)* Improved social inclusion for marginalized community members, through increased access to public health information, cooperative management of community assets, and increased involvement.	% of community members that believe their social group has equal opportunity to manage community assets *Disaggregation: gender, social groups*	Community knowledge, attitude and practices survey	0% (to be updated at baseline)	25 %	85 %	Maintenance committees for equipment installed at community level include representatives from marginalized groups in the community
	% of project participants from vulnerable groups (out of school children, elderly, people with disabilities) reporting improved access to information on public health *Disaggregation: gender, social groups*	Community knowledge, attitudes and practices survey	0%	65 %	90 %	Mobile health awareness units and other methods (theatre for development, improved materials) successfully deliver information to heard-to-reach groups

	% of women and girls and women and girls with disabilities reporting improved access to decision-making processes and agree that the government or other stakeholders includes their voices in decisions *Disaggregation: social groups*	Community knowledge, attitudes and practices survey	0%	65 %	90 %	Attempts made to ensure inclusion of women and girls and women and girls will disabilities in output 1.2 (district health adaptation plans) and output 4.1 (stronger community capacity to reduce health risks from climate change) are effective in including qualitative improvements in access to decision making power
Co-benefit 2 (*social)* Improved social outcomes for household economies based on using improved integrated homestead farming and nutrition practices due to reduced need to purchase diversified food for nutritionally vulnerable household members	% of target households participating in integrated homestead farming and nutrition practices that report reduced household expenditure on food groups they can produce at home *Disaggregation: gender, social groups*	Intervention evaluation records, Mid-term and endline survey	0%	20 %	70 %	Households participating in trainings are able to implement measures effectively There are adequate numbers of community health workers to undergo training
Co-benefit 3 *(environmental)* Targeted facilities have reduced emissions of greenhouse gases due to project-supported	# of target health facilities with reduced estimated GHG emissions due to installation of solar energy systems that reduce reliance on diesel generators and national grid electricity	Survey of healthcare facilities, installation records	0	20	60	Facilities targeted under project are currently using fossil energy sources Emission reductions are estimates based on assessment tools and not based on actual GHG emission measurements

small-scale infrastructure upgrades, especially solar improvements						
Co-benefit 4 (*gender)* Increased gender equality and empowerment through community training, knowledge of differential climate change impacts	% of target communities taking part in the gender transformative community mobilisation approach *Disaggregation: gender, social groups*	Intervention attendance records	0%	40 %	90 %	Communities understand the community mobilisation approach and both women and men are willing to engage
	% of project participants who report positive change in attitudes towards equitable gender norms or roles *Disaggregation: gender, social groups*	Community knowledge, attitudes and practices survey	0%	40 %	90 %	Activities regarding gender norms and gender dynamics lead to women's improved access to decision-making at household level Activities specifically focused on women (e.g., nutrition activities) lead to greater women's empowerment Gender-based activities equally lead to men understanding the differential power dynamics in communities

E.6. Project/programme activities and deliverables

Activities	Description	Sub-activities	Deliverables
Outcome 1: Reduced risk from climate-sensitive diseases and conditions			
Output 1.1 Climate-informed health surveillance system and Early Warning and Response System (EWARS)			
1.1.1 Strengthen the health surveillance system by identifying alert triggers for key climate-sensitive health conditions	Determine new thresholds and alert triggers for 4 specific climate-sensitive diseases and disseminate widely within the health sector as	1.1.1.1 Establish and support the functioning of 1 sub-task team of the HCCCT to convene process of identifying Malawi-specific thresholds and setting alert trigger levels through studies and validation 1.1.1.2 Determine Malawi-specific thresholds and warning levels for diseases linked to high / extreme heat exposure 1.1.1.3 Determine Malawi-specific thresholds and warning levels for malaria	4 reports detailing new thresholds and warning levels set for each of the climate-sensitive diseases/conditions- by Q2Y2

	well as climate and disaster risk management sectors at national level and across project and non-project districts	1.1.1.4 Determine Malawi-specific thresholds and warning levels for diarrhoeal disease/cholera 1.1.1.5 Determine Malawi-specific thresholds and warning levels for malnutrition linked to drought 1.1.1.6 Arrange 2 multi-stakeholder validation activities with national and district level representatives with HCCCT (each combining 2 of the 4 studies)	
1.1.2 Strengthen the institutional architecture for managing the ongoing operation of the climate-informed Early Warning and Response System (EWARS)	Work closely with government bodies across climate and health sectors to ensure a joined-up and collaborative approach to support the new Early Warning and Response System (EWARS)	1.1.2.1 Strengthen linkages between relevant parties (e.g., DCCMS, MoH) at national level through convening an appropriate coordination committee and defining TORs 1.1.2.2. Strengthen appropriate mechanisms for cascading information from the climate-informed EWARS from national to local level through MoH, and ensure that these mechanisms are functional to the 6 target districts 1.1.2.3 Support the convening of quarterly meetings of the national committee (1.1.2.1) for oversight and management (including monitoring and evaluation of alert dissemination and use) 1.1.2.4 Build skills and knowledge of the existence and functioning of the climate-informed EWARS among health staff at national level and in non-target districts (project district staff covered in 3.1.1 and 3.1.2) 1.1.2.5 Build skills and knowledge of the climate-informed EWARS among disaster management staff at national and district level, including through ensuring awareness raising in national disaster risk management coordination fora and annual multihazard contingency planning	New Data Software for EWARS designed and installed in 5 sentinel sites to link climate and health data and automatically generate warnings-by Q2Y2 Dissemination workshop on EWARS for 120 government officials-by Q4Y3 At least 60 government officials (national and district) trained in cascading EWARS from national to district and sub-district levels in the 6 target districts-by Q2Y2 75 officials in non-target districts trained on new EWARS system-by Q4Y3 1 National committee established to meet quarterly for monitoring and oversight-by Q1Y2

1.1.3. Establish sentinel sites at selected healthcare facilities to provide improved climate and health data for the health Early Warning and Response System (EWARS)	Work with Ministry of health officials to determine suitable sentinel sites, and distribute equipment for their effective operation	1.1.3.1 Select locations of sentinel site healthcare facilities 1.1.3.2 Put in place arrangements and essential equipment for the selected healthcare facilities to function as sentinel sites 1.1.3.3 Provide essential technological equipment for health data collection at health centres.	5 sentinel sites established and selected from target health facilities in project districts-by Q1Y3
Output 1.2 District Health Adaptation Plans			
1.2.1 Facilitate preparation and local endorsement of District Health Adaptation Plans in 6 project districts	Work with district councils to create and endorse district health adaptation plans, local versions of the health national adaptation plan	1.2.1.1 Assess the state of knowledge of climate change risks to health among district-level government staff (across sectors) in 6 project districts 1.2.1.2 Based on results of 1.2.1.1, build capacity to understand the dimensions of climate change risk to health to district level government staff (across sectors) in 6 project districts 1.2.1.3 Enable production of DHAPs in each of the 6 project districts (facilitating district inputs through consultation, drafting, validating and presenting for adoption) 1.2.1.4 Build capacity to implement the DHAPs across sectors at district level (district council) 1.2.1.5 Build skills and knowledge on the dimensions of climate change risk to health and implementation of the DHAPs to CHACs in the 25 target TAs across 6 districts 1.2.1.6 Support cascading of knowledge on dimensions of climate change risk to health and implementation of the DHAPs by CHACs to village members 1.2.1.7 Develop a toolkit for use in other (non-target) districts on how to develop and implement a DHAP at district, CHAC and community level	6 District Health Adaptation Plans produced and validated by the District Executive Committees (DEC)-by Q2Y3 150 district officials trained in implementing the DHAPs-by Q4Y2 1 toolkit for developing and implementing DHAPs produced and delivered in 22 non-target districts (600 copies)-by Q4Y3
1.2.2 Advocate for stronger integration of climate-resilient	Create effective collaborative groups to bring	1.2.2.1 Organize coalition-building meetings nationally and in the 6 target districts with other organizations/networks that work on climate adaptation, disaster risk reduction, and sectoral	6 coalition-building meetings held in target districts-by Q1Y3

health within adaptation planning at district and sub-district level	together key voices that can advocate for inclusion of climate-resilient health in adaptation planning at district-level	planning, in order to ensure integration of climate-resilient health planning, integration of health in adaptation and disaster risk reduction, and to leverage resources and increase impact. 1.2.2.2 Collaborate with other (non-government) groups to develop joint advocacy strategies and action plans. 1.2.2.3 Strengthen representation and inclusion of marginalised groups within coalitions (1.2.2.1) and policy consultations (1.2.2.2) to ensure evidence-informed policy. 1.2.2.4 Review plans in the 6 target districts (District Social Economic Profile, District Development Plans and District Budgets on health, climate change and disaster) in order to establish their status and strategic entry points for influencing. 1.2.2.5 Advocate for stronger inclusion and integration of climate-resilient health in district planning processes.	Review of 6 district plans-by Q1Y3 1 Advocacy strategy created and validated between multi-sectoral stakeholders-by Q1Y3
Outcome 2: Healthcare infrastructure is able to deliver service and care in the context of changing climate risk			
Output 2.1 Climate-resilient health centres, district and central hospitals and schools for community health			
2.1.1 Develop a national standard for climate-resilient healthcare facilities	Develop a standard with guidelines for creating climate-resilient healthcare facilities that can be applied nationally	2.1.1.1 Undertake a multi-level consultative process to develop and validate a national standard for climate-resilient healthcare facilities, incorporating gender-responsiveness and social inclusion in the standard. 2.1.1.2 Develop and deliver training on the national standard to health infrastructure planners in the public and private sector at national level.	1 National standard created and validated by multi-sectoral stakeholders-by Q2Y3 20 national-level officials trained on new national standard-byQ3Y2
2.1.2 Strengthen climate resilience of healthcare facilities	Install WASH and solar improvements to health facilities in the six project districts to improve climate-	2.1.2.1 Assess the extent of alignment of 79 healthcare facilities in the 6 project districts with the national standard developed under 2.1.1.1; and finalise the prioritisation of planned climate resilience strengthening activities. 2.1.2.2 Scope, undertake tender process and oversee service providers applying modifications to strengthen resilience of healthcare facilities.	Solar installations implemented in 79 health facilities by Q4Y4 Improved WASH facilities (e.g., Rainwater harvesting and solar

	resilience and equip maintenance committees to handle ongoing upkeep	2.1.2.3 Develop a standalone tool (building on 2.1.2.1) for use in determining climate resilience strengthening needs of health care facilities for use nationally and in other districts. 2.1.2.4 Establish maintenance committees at facility level with responsibility for protecting and maintaining equipment 2.1.2.5 Deliver training on equipment upkeep and establish links to nearby service providers and suppliers	pumps) installed in 79 healthcare facilities-byQ4Y4 New screening tool created and delivered to 22 non-target districts-by Q1Y3 Maintenance committees established and trained for all 79 facilities-by Q1Y3
2.1.3 Build capacity of Malawi's health sector to apply the climate-resilient healthcare facility standard	Train officials at national and district level outside of the six target districts to implement the climate-resilient healthcare facility standard	2.1.3.1 Design and deliver training on the climate-resilient healthcare facility standard (2.1.1) and the associated screening tool (2.1.2.3) to health infrastructure planners at national level and in non-target districts. 2.1.3.2 Organise study visits for health infrastructure planners from national level and non-target districts to resilient healthcare facilities upgraded by the project.	75 officials from non-target districts are trained on standard and take part in study visits to see model health facilities-by Q2Y5.
2.1.4 Develop guidelines for climate-resilient WASH facilities	Work with health sector and WASH sector officials to create guidelines on climate-resilient WASH facilities, to be applied across different sectoral areas	2.1.4.1 Undertake multi-level consultative process to develop and validate guidelines for climate-resilient WASH facilities. 2.1.4.2 Build skills and knowledge (based on guidelines developed in 2.1.4.1) of health and education sector staff at national level and in 6 project districts to design and manage climate-resilient WASH facilities. 2.1.4.3 Advocate for guidelines on climate-resilient WASH facilities to be applied in the health, education, social welfare and other sectors	Guideline for climate-resilient WASH developed and validated by key stakeholders-byQ3Y2 50 multi-sectoral officials trained on using new guideline-by Q1Y3
2.1.5 Upgrade WASH facilities at schools to improve children's	Install improved climate-resilient WASH facilities (including rainwater	2.1.5.1 Select schools in target communities, based on needs assessment of schools. 2.1.5.2 Scope, undertake tender process and oversee service providers to implement rainwater harvesting and other small-scale WASH solutions at schools.	Improved WASH facilities installed in 400 schools-by Q1Y5

health under climate change	harvesting, solar pumps, filters) in at least 400 schools across the six project districts	2.1.5.3 Establish and train maintenance committees on WASH technologies, including school authorities and community authorities and members	Maintenance committees established and trained at all 400 schools-by Q1Y5
Outcome 3: Healthcare staff are able to deliver service and care in the context of changing climate			
Output 3.1 Healthcare staff trained in managing climate-related disease monitoring, health messaging, and disease treatment and prevention			
3.1.1 Build data collection capacity to strengthen surveillance of climate-related diseases	Train healthcare staff on data collection and disease surveillance to equip them with skills to implement the EWARS	3.1.1.1 Assess state of knowledge of climate change impacts on health among healthcare staff in 79 facilities in 6 districts. 3.1.1.2 Design and deliver training on surveillance operation for HMIS staff	25 district staff (district health office) trained on surveillance operation and data entry-by Q1Y3 90 Health Surveillance Assistants (HSAs) and Senior HSAs trained on surveillance operations and data entry-by Q3Y3
3.1.2 Build capacity among district and community healthcare staff to disseminate early warnings to communities	Train district and community health staff or volunteers on communication and dissemination mechanisms to inform community members on early warning alerts	3.1.2.1 Design and obtain MoH endorsement of a training course on climate and health and the utilisation of early warning alerts from the climate-informed EWARS. 3.1.2.2 Establish and build capacity of a national cadre of trainers (considering gender representation) on climate and health and the utilisation of early warning alerts from the climate-informed EWARS. 3.1.2.3 Build the knowledge and skills of district staff and health facility staff in 79 facilities on climate and health awareness and how to use the surveillance system and warning alerts (using national cadre of trainers). 3.1.2.4 Assess state of knowledge of climate change impacts on health among community healthcare staff (HSAs and SHSAs) in 25 TAs in six project districts.	Training module on climate-informed EWARS designed and endorsed by MoH-by Q4Y2 National cadre of 25 trainers receive 'training of trainers' and are equipped to deliver training to staff at district and sub-district level-by Q2Y3 650 HSAs and SHSAs trained in total (by national cadre) on implementing the EWARS across the 6 project districts

		3.1.2.5 Build the knowledge and skills of community healthcare staff (HSAs and SHSAs) in 25 TAs in six project districts on climate and health awareness and how to use the alerts from the climate-informed EWARS (using national cadre of trainers and district staff). 3.1.2.6 Training of community healthcare volunteers (part of village health committees) by senior HSAs and HSA trainers trained in 3.1.2.5 for climate and health knowledge and the dissemination of warning alerts.	and 79 health facilities-by Q4Y3 5,200 Community Healthcare Volunteers (CHV) trained in new EWARS mechanism across the 25 TAs-by Q2Y5
3.1.3 Provide medical supplies and technologies for climate health risk reduction and response[95]	Improve government planning, budgeting and procurement process for medical supplies to account for additional needs as a result of climate health risk	3.1.3.1 Review the process of identifying annual needs for malaria prevention (LLINs and seasonal chemoprevention) and the supply of medication and propose modifications (e.g., to timing, quantities, targeting-building on 1.1.3.1) if necessary, when considering climate risk. 3.1.3.2 Review the process of identifying annual needs for supply of diarrhoea treatment and propose modifications (e.g., to timing, quantities, targeting-building on 1.1.4.1) if necessary when considering climate risk. 3.1.3.3 Review the process of identifying annual needs for supply of therapeutic and supplementary feeding and propose modifications (e.g., to timing, quantities, targeting-building on 1.1.5.1) if necessary, when considering climate risk. 3.1.3.4 Annually review results of 3.1.3.1-3.1.3.3 to allocate funding to needs. 3.1.3.5 Develop and document procurement process (including security of supply) for procuring supplies to meet needs identified in 3.1.3.1 for malaria prevention. 3.1.3.6 Develop and document procurement process (including security of supply) for procuring supplies to meet needs identified in 3.1.3.2 for diarrhoea treatment requirements exacerbated during cholera for children under 5 years.	1 new climate-sensitive procurement method developed and validated by MoH and Ministry of Finance-by Q1Y2 Treatment for severe or moderate acute malnutrition delivered to 35,000 total children, and pregnant and breastfeeding women-by Q1Y5 81,000 doses of cholera and diarrhoeal treatment delivered by HSAs-by Q1Y5 Malaria nets and seasonal chemoprevention delivered to at least 75,000 households-by Q1Y5

[95] Deliverables for this activity have been set at 80-90% of what is budgeted due to the likelihood of unforeseen circumstances negatively impacting the numbers of treatments delivered or households reached.

		3.1.3.7 Develop and document procurement process (including security of supply) for procuring supplies to meet needs identified in 3.1.3.3 for therapeutic and supplementary feeding. 3.1.3.8 Activate annual procurement processes, as appropriate reflecting decisions made in 3.1.3.4. 3.1.3.9 Support rollout of malaria prevention (LLINs and seasonal chemoprevention). 3.1.3.10 Support rollout of supplementary diarrhoea treatment (ORS + Zinc). 3.1.3.11 Support rollout of therapeutic and supplementary feeding for children under 5 years and pregnant and breastfeeding women.	
3.1.4 Equip healthcare workers with MHPSS capacity to address mental health impacts of changing climate	Train health staff to understand the impacts of climate change on mental health, and how to deal with patients experiencing associated issues	3.1.4.1 Review the state of inclusion of MHPSS aspects in existing MNCH and PHC services in 6 project districts, and outline process for the strengthening of climate risk-related MHPSS where appropriate 3.1.4.2 Identify and adapt existing tools and training +packages on climate-related MHPSS in MNCH and PHC services into a climate and MHPSS module for inclusion in the training provided under Activity 3.1.2, and obtain appropriate endorsement by MoH. 3.1.4.3 Build the knowledge and skills of district health, social work and disaster risk management staff, and HSAs and SHSAs, for climate risk-related MHPSS in existing MNCH and PHC services (using national cadre of trainers from 3.1.2.2. 3.1.4.4 Establish support mechanism for clinical support to health care staff identifying climate risk-related MHPSS needs through existing MCNH and PHC services.	Training manual on climate-related MHPSS developed and endorsed by MoH-by Q3Y2 1,000 HSAs and SHAs trained on climate-related MHPSS services-by Q4Y3
3.1.5 Build capacity among district and community healthcare staff to	Raise awareness and train district and community healthcare staff or	3.1.5.1 Assess the state of knowledge and practice regarding climate related GBV, CEFM and SRHR among district and community healthcare staff in the 6 project districts; further, identify and catalogue existing protection mechanisms and services for GBV, CEFM and SRHR in the community and different government institutions	1 Training module on climate impacts on gender issues created and validated by MoH-by Q3Y2

address the gendered impacts of a changing climate	volunteers on the different ways that climate change impacts gendered issues – especially Gender based violence, child marriage and sexual and reproductive health issues	3.1.5.2 Consult women and girls in the communities, including women and girl activists, to solicit their perspectives and inputs on climate-related GBV, CEFM and SRHR issues and needed support. 3.1.5.3 Based on the results of 3.1.5.1 and 3.1.5.2, design and obtain MoH endorsement of a training module on climate and GBV, CEFM and SRHR, adapting any Malawi-specific existing tools and training packages, for inclusion in the training provided under Activity 3.1.2. 3.1.5.4 Build the knowledge and skills of district and community healthcare staff in 6 districts on climate and GBV, CEFM and SRHR (using national cadre of trainers from 3.1.2.2), including designating and training specific providers with clear responsibilities related to the care of survivors. 3.1.5.5 Review the process of identifying annual needs for GBV, CEFM and SRH treatment supplies (e.g., family planning supplies, post-exposure prophylaxis for HIV, HIV treatment, emergency contraception, safe abortion services) and propose modifications (e.g., to timing, quantities) if necessary, based on expected climate risks; review the results annually to allocate funding to needs. 3.1.5.6 Review the results of 3.1.5.5 to allocate funding for procurement of selected GBV, CEFM and/or SHR treatment supplies (targeting the areas of greatest need) and support rollout/dispensation of treatment.	2,000 district and community-level staff trained on gendered impacts of climate change-by Q4Y3 Procurement method for GBV, SHRH and CEFM treatment supplies revised to incorporate climate impacts-by Q4Y3
Outcome 4: Communities better prepared to manage the impacts of climate change on health			
Output 4.1 Stronger community capacity to reduce health risks from climate change			
4.1.1 Equip community structures to provide knowledge and skills for climate-resilient WASH facilities to community members	Work with community members to ensure they understand how to maintain WASH facilities existing	4.1.1.1 Equip capacity of Area Civil Protection Committees (ACPC) and traditional leadership at group village level to understand and cascade knowledge on the design, implementation and management of climate-resilient WASH facilities (using cadre of trainers). 4.1.1.2 Train district and facility health and education staff on the design, implementation and management of climate-resilient WASH facilities.	375 members of ACPCs trained on effective use of climate-resilient WASH facilities-by Q2Y3 Women-led WASH monitoring groups established in at least

	in the communities, and ensure climate-resilience of said facilities	4.1.1.3 Train women and support the formation of management, maintenance and monitoring groups, and reporting mechanisms, to ensure that community-level, climate-resilient WASH facilities remain safe, clean, accessible and aligned with the performance standards to which they were designed.	400 target communities-by Q4Y3
4.1.2 Embed understanding of early warnings and alert protocols within communities, including children.	Working through mixed channels, ensure different sectors of the community are reached by early warning system alert messaging, and that the different community strands understand how to interpret the information	4.1.2.1 Design process for awareness raising, training, and sustained community engagement over the project lifespan to build capacity to receive, understand, and act on early warning alerts. 4.1.2.2 Develop and deliver community-focused training materials and tools on early warnings and alert protocols using multiple media and channels. 4.1.2.3 Develop and distribute training materials for primary and secondary schools on early warnings and alert protocols and climate-resilient health and well-being, and guidance for teachers on using these within existing curricula. 4.1.2.4 Develop and distribute appropriate training materials on early warnings and alert protocols and climate-resilient health and well-being for out-of-school children, the elderly, people/children with disabilities (as identified by the district youth officer and district social welfare officer)	Early warning training materials developed and delivered in 500 communities through mixed channels (e.g. leaflets, SMS, radio jingles)-by Q2Y4 At least 5,000 out of school children, elderly people and people with disabilities receive early warning materials across the 500 target communities via mixed channels (e.g., radio, leaflets)-by Q1Y5
4.1.3 Train communities to reduce their own vulnerability to climate-induced health risk	Design a new system of community messaging for public health, and distribute information on climate-induced health risks through mobile health units, ensuring traditional healers are engaged in the process	4.1.3.1 Develop and distribute screening tool to enable assessment of individual risk (e.g., occupational, physiological, gender vulnerability etc.) to climate change health impacts. 4.1.3.2 Conduct formative research among target communities to develop appropriate and targeted messages, to enhance the likelihood that communities will take actions to reduce and respond to health risks. 4.1.3.3. Scope the operation of programmes, the structures that are being used for delivery (e.g., group-based approaches) and who they are targeting in order to identify, and amend where necessary, entry points for integration of climate-informed public health messaging. 4.1.3.4 Assess the state of community-level materials (training, awareness-raising, SBC and key materials) produced through different ministries (health, water, agriculture, gender) to determine appropriateness for integrating climate-informed public health messaging.	New community-level public health messaging to reduce risk of climate-induced health impacts developed and validated by multi-sectoral stakeholders-by Q4Y2 2 mobile health awareness units equipped and visits conducted across 500 villages to promote messaging on climate-induced health risks-by Q2Y5

		4.1.3.5 Work through appropriate channels with programmes (4.1.3.2) and sectors (4.1.3.3) to integrate climate-informed public health messaging into existing relevant materials and opportunities. 4.1.3.6 Design, equip and enable a mobile climate and health promotion unit for a continuous campaign that inclusively builds capacity to manage individual and collective health risk from climate change. 4.1.3.7 Engagement of Traditional Healers to orientate them to the project, discuss information about the impact of climate and health, their perceptions of climate and health, and their role in helping community knowledge and adaptation.	3,375 traditional healers trained on climate-induced health risks-by Q2Y5
4.1.4 Support families with pregnant and breastfeeding women and children under two to produce climate-resilient foods and provide quality complementary food to children under two	Focus on pregnant women and breastfeeding mothers with children under 2 to deliver a nutrition intervention, designed to allow mothers to grow their own food which is resilient to climate change and sufficiently nutritious to feed infants	4.1.4.1 Review the integrated homestead farming module and modify to be stronger on climate-resilient nutrition. 4.1.4.2 Assess target villages in project districts to understand propensity to implement integrated homestead farming, including: functionality of care groups and Community Based Childcare Centres (CBCCs), existing integrated homestead farming and suitability; proportion of population who are vulnerable (households with young pregnant or breastfeeding mothers and/or children under 2). Based on assessment, create intervention strategy at village level in 500 villages. 4.1.4.3 Identify individual participants at village level - through sign-posting and referral via antenatal care, community activities of HSAs and SHSAs, and the CBCC - to convene groups of participants, who should be from households with the most vulnerable mothers, especially young and breastfeeding mothers. 4.1.4.4 Undertake procurement process for set-up, equipment and inputs for climate-resilient complementary nutritious food to be used by role models in health centre, staff, and community leader demonstration plots; and an additional 30 starter packs per village for the first 3 years. Saved seed and stock will be used and shared in pass-on programmes ever year and only used in the final year.	Integrated homestead farming starter kits delivered in 500 villages-byQ2Y5 Community Health Action Groups trained on nutritious feeding in 500 villages-by Q4Y4 Nutrition starter kits (including seeds, organic fertiliser) delivered to at least 35,000 mothers across 500 villages across project implementation period-by Q3Y2 35,000 households trained in homestead farming approach-by Q2Y5[96]

[96] Project budget provides for 45,000 homestead farming starter kits but deliverable set at 35,000 to account for potential of some community members opting not to complete training course.

		4.1.4.5 Support Integrated Homestead Farming role models (at health centres, care group leaders, lead farmers, traditional healers, etc.) in each target village along with agricultural extension workers, working with care group members in the village to provide initial shared understanding of homestead farming and how that can improve family and infant and young child nutrition and health. 4.1.4.6 Deliver training (by extension workers and lead farmers) on demonstration plots to households with vulnerable mothers, including modules on: using household waste; climate-resilient indigenous seeds and stock; hermetic bags; cooking demonstrations and training on food preservation, processing and storage; and distribute start-up kit to households. 4.1.4.7 Facilitate ongoing monitoring of vulnerable households by care group leaders and lead farmers in the implementation of integrated homestead farming.	
4.1.5 Strengthen communities' capacities to reduce their vulnerability to the health impacts of climate change, particularly gendered impacts	Building on 3.1.5, train community members on gendered impacts of climate change, through the community mobilisation approach	4.1.5.1 Design and develop manual and discussion guides for different levels of engagement / engagement groups (men, women, girls and boys, religious leaders, etc.) 4.1.5.2 Identify and train facilitators to facilitate the group discussions at different levels of engagement / within different engagement groups 4.1.5.3 Establish different engagement groups (including government and service providers, as appropriate) and hold facilitated discussions amongst the groups through an iterative process that culminates with all groups brought together to reach consensus 4.1.5.4 Set priorities for actions to address the issues that groups agreed on, determine who will be the lead implementer of each action, and provide training and support to these parties to equip them with necessary skills 4.1.5.5 On a regular basis re-convene the engagement groups to listen, problem-solve, gain insights and update the outputs of 4.1.5.4 as necessary	GESI-focused community groups established or strengthened in 200 villages-by Q4Y2 Clear action plan created for each of 200 groups-by Q1Y3 10,000 women, girls, men and boys trained on gendered impacts of climate change-by Q4Y4

E.7. Monitoring, reporting and evaluation arrangements (max. 500 words, approximately 1 page)

The project has a monitoring, evaluation, accountability and learning (MEAL) framework, designed to measure two main areas:

- progress towards project objectives in line with the NDCs for Malawi, and
- contributions to key GCF Investment Criteria and the Adaptation Performance Measurement Framework.

175. Project-level monitoring and evaluation will be undertaken in compliance with Save the Children's MEL systems and processes as well as aligned to the Malawi Government National Planning Framework (NPF) to ensure complementarity with existing government systems and reporting processes. The M&E Plan will emphasise monitoring and evaluation within the broader 2063 National Planning framework, clarifying the role and responsibilities of government ministries and aid coordination.

The PIU's MEAL manager/adviser will be responsible for designing a study to established baseline, mid-line and final data for:

- Fund-level core indicators and outcomes
- Project level results and indicators Monitoring

176. Setting up the monitoring system of the project will involve different steps. The primary responsibility for day-to-day project monitoring and implementation rests with the Project Manager. The Project Manager in consultation with key stakeholders will develop annual work plans to ensure the efficient implementation of the project. A project inception workshop, involving the SCA, SCUK, the Executing Entities (MoH and SCI MW) and other key stakeholders will be held within the first six months of the project. The overarching objective of the inception workshop is to: a) assist the Project team and stakeholders to understand and take ownership of the project strategy, objectives and outcomes and discuss any changes in the overall context that influence project implementation; b) discuss the roles, support services and complementary responsibilities of the project team and the national government ministries including reporting and communication lines and conflict resolution mechanisms (the PIU, implementing entities and outsourced consultants will undertake all data collection and analysis as per the processes and templates finalised during this process); c) review the results framework, re-assess baselines as needed, and discuss reporting, monitoring and evaluation roles and responsibilities and finalise the M&E plan.

177. The Project team will ensure that the indicators included in the project results framework are monitored and reported on annually and will objectively report progress. Project components will be monitored separately as well as in relation to the achievement of higher-level projects results and overall GCF goals.

178. The Project M&E will each cover two levels of performance: GCF-level performance (expected performance against investment criteria) and project-level performance. Details of MEAL implementation will be negotiated and included in the agreements between the AE, the Executing Entities – the MoH and SCI MW. Annual reviews will be led by the PMU with the participation of district council staff and other government ministries involved in the project.

Evaluation

The project's mid-term evaluation process will include an internal impact evaluation and an independent process evaluation. An independent final impact evaluation will take place no later than three months prior to operational closure of the project. Evaluation data will be collected by the PIU, implementing entities and outsourced consultants using designs agreed by the steering committee).

179. The evaluations will rely on key evaluation questions (to be developed during inception planning) to respond to the performance and impact of the project's completed activities and will include assessment against OECD-DAC and GCF evaluation criteria. These may include the following: relevance; effectiveness of the project and processes; the efficiency of processes; sustained impact and coherence in climate finance delivery; gender equity and inclusiveness; innovation and potential for paradigm shift; country ownership; coherence of climate finance; and potential for building scale and unexpected results (positive and negative). Overall, the evaluation will contribute to accountability and learning by reviewing emerging evidence on the performance and the impact and/or likelihood of the project and disseminating that evidence to project implementors, beneficiaries and stakeholders (including donors) to support evidence-based decision-making. The midterm evaluation will be instrumental in contributing – through operational and strategic recommendations – to improve implementation, setting out any necessary corrective measures for the remaining period of the project. The final evaluation will assess the relevance of the intervention, its overall performance, as well as sustainability and scalability of results, differential impacts and lessons learned.

The evaluation will also assess the extent to which the intervention has contributed to the Fund's higher-level goal of achieving a paradigm shift in adaptation to climate change in Malawi.

180. The full MEAL plan is available in **Annex 11.**

F. RISK ASSESSMENT AND MANAGEMENT

F.1. Risk factors and mitigations measures (max. 3 pages)

The top 5 risks for the project are provided below with further details on all potential risks (including low risks) in **Annex 2.**

Selected Risk Factor 1 - Limited Technical Capacity

Category	Probability	Impact
Technical and operational	High	Medium

Description

Lack of technical capacity and oversight for government and partner organisations, affects implementation, resulting in delays

Mitigation Measure(s)

The project will mitigate this risk by ensuring National PIU and District PMU staffing include technical specialists on infrastructural elements (solar and WASH) to work with relevant government counterparts and supervise the work of the contractors. Division of labour between the EE's on supervisory responsibilities will be clarified to avoid delays in communication. The project will also provide direct technical assistance to Government departments and other delivery partners and supported through Save the Children's systems and national footprint. The breadth of the project will also help ensure community capacity is not overwhelmed. Working across all six provinces will enable the project to spread the investment across space and time. A slow and considered development of in-country, local and ongoing technical capacity and ownership supported by national and international expertise will help ensure sustainable engagement across government and the building of government skills and technical capacity throughout the life of the project.

Strong partnerships between the AE, EEs and IEs is critical. During the design process, EEs worked closely with all partners throughout to ensure that all perspectives were taken into account. This will continue throughout implementation, including via the project's management structure and the stakeholder engagement plan **(Annex 7 of the Funding Proposal Package)** to ensure all partners work cooperatively towards agreed goals via agreed methods. The project will ensure adequate staffing for the partner organisations. Setting up of District PIU at DC offices, with strong District Leads to provide support and supervision, alongside government focal points, ensuring continuous visibility and coordination with relevant members of the District Technical and Executive Staff, will be critical for the visibility, ability leverage further resources and synergies with ongoing priorities, and sustainability of the project's work. Implementation table will ensure careful phasing of the work, close collaboration between 2 partners, spot checks by Programme Director and Technical Leads and specialists. The project governance structure promotes the inclusion of governmental IEs into the decision-making processes in an open and transparent manner further promoting shared ownership and trust.

Selected Risk Factor 2 – Project Safety and Sustainability

Category	Probability	Impact
Technical and operational	High	Medium

Description

Lack of financial capacity for the government to continue, causes project activities ceasing, exposes key project infrastructure such as solar installations in health facilities to theft and damage.

Mitigation Measure(s)

The project will mitigate this by embedding sustainable approaches to changing the governance framework and empowering government ministries to increasingly lead implementation of project activities. This will help ensure the knowledge, experience, skills and staff positions supported by the project remain after the project ends. Project will ensure that the contractors identified make adequate budget provisions for security of the items installed. The project will also incorporate learnings from previous experiences from MoH and other donors. We will work with community structures to develop community norms and policing to ensure resources for sustainability and that training and guidelines are available for healthcare staff for upkeeping minor damages and repairs.

Selected Risk Factor 3 – Lack of Community Ownership		
Category	**Probability**	**Impact**
Technical and operational	High	Medium
Description		
Communities are not engaged resulting in a lack of community ownership of the project hampering project sustainability and results.		
Mitigation Measure(s)		
SCI MW will partner with CRECCOM, a CSO well known for its strength in community mobilisation approaches to engage intensively with communities across the project cycle especially around activities in outcome 4. This will ensure community buy in and strengthen project ownership. In addition, Save the Children has a 40-year history of working in Malawi and has strong experience in ensuring that local communities are fully engaged in projects. Stakeholder engagement at the community level has proven this to be the case, with all community members consulted across a range of targeted areas expressing a desire to be involved in the project		
Selected Risk Factor 4 – Financial Management		
Category	**Probability**	**Impact**
ML/FT	High	Medium
Description		
Limited capacity in the financial management systems, causing external fraud and corruption, resulting in misuse or theft of project funds		
Mitigation Measure(s)		
The fiduciary management procedures that will be utilised for the project under the Malawi Government will reduce the overall risk. This includes conducting annual audits, requesting regular financial reports, managing procurement through Save the Children, providing training on fraud policy and procedure. The MoH and SCI MW have agreed that most procurement within the project will use Save the Children's systems (further explained below in **paragraph 200**), with funds flowing through Save the Children for all large procurements including all goods and non-consulting services. This includes procured parties for infrastructure improvements to health facilities and schools. There will be a dedicated procurement officer within the PIU, who will work closely with ministry officials on any low-value procurement they are responsible for. In addition, the AE has established and effective corporate policies regarding financial management that further mitigate this risk. There are no intentions to distribute or disburse to beneficiaries, either directly or indirectly, cash, vouchers, commodities or other items of value.		
Selected Risk Factor 5 - **Climate Induced Disasters**		
Category	**Probability**	**Impact**
Other	High	Medium
Description		
High exposure to climate hazards in Malawi, including increasing temperatures, changing rainfall patterns, causing extreme events such as floods and droughts, destroying project sites and investments.		
Mitigation Measure(s)		
To mitigate this risk project workplans and activity schedules will consider seasonal risks such as flooding and droughts in collaboration with MoH to determine best course of action and use of resources. In addition, the project will start implementing emergency health interventions identified during the inception phase of the project. The project will also leverage SC's and donor humanitarian resources to respond to any disasters. Project activities also embed understanding of early warnings and alert protocols within communities to reduce vulnerability to climate-induced risks.		
Selected Risk Factor 6 - **Insufficient Climate and Health Data Integration**		

Category	Probability	Impact
Technical and operational	High	Medium
Description		
The project's success, particularly in establishing disease surveillance systems and developing early warning systems (e.g., Activity 1.1.2) may rely on accurate and timely integration of climate and health data. Lack of integrated data can hinder early warning system development, leading to increased disease burden, reduced health system resilience, and undermining the project's overall goal of enhancing climate resilience in the health sector.		
Mitigation Measure(s)		
The MoH have advised that an MoU for the sharing of data between the Meteorological department and the Ministry of Health has already been signed during 2024. Additionally, the Project Steering Committee which includes representatives from the relevant departments, will ensure facilitation for efficient operation of the MoU and information sharing.		
Selected Risk Factor 7 - **Data Availability and Quality**		
Category	**Probability**	**Impact**
Technical and operational	High	Medium
Description		
Insufficient high-resolution data can hinder the accurate targeting of interventions, potentially affecting activities that rely on data collection, analysis, and application in intervention planning, such as those potentially linked to Activity 1.1.2.		
Mitigation Measure(s)		
The most recent available social and spatial data sets at district level and below are the 2018 Census and 2017 Integrated Household Survey, although districts produce socio-economic profiles that also capture local level data. The proposal development stage has already created access to additional relevant information, for example through the Ministry of Health on the latest distribution and classification of health care facilities. In addition many non-government actors are also collecting relevant data (including as part of monitoring and evaluation of complementary interventions). Having physical presence of project staff in districts through the district PIUs will enable easier access to available data. In addition the results of the various project M&E tools, notably the baseline survey, will inform intervention activity. The district PIUs and project MEAL officer will be tasked with ensuring that any data that is obtained throughout the project lifespan is categorised and metadata made available to the project team for further access, in accordance with the relevant data owners' requirements.		
Selected Risk Factor 8 - **Limited Institutional Capacity and Coordination**		
Category	**Probability**	**Impact**
Technical and operational	High	Medium
Description		
Limited institutional capacity, and lack of coordination between health and climate agencies, can impede project execution and delivery of project activities; lack of coordination is most likely to affect project activities related to inter-agency collaboration, training, and capacity-building initiatives.		
Mitigation Measure(s)		
The project will leverage the Project Steering Committee and the national-level Project Implementation Unit to enhance communication and collaboration between health and climate agencies and enhance smooth project execution and achievement of desired project outcomes.		

G. GCF POLICIES AND STANDARDS

G.1. Environmental and social risk assessment (max. 750 words, approximately 1.5 pages)

181. The CHWBRC project confirms the assessment of Category C (low risk) as a result of the Environmental and Social Screening composed of a project development discussion, stakeholder meetings, a desktop study of similar projects in the region as well as a review of potential options. The proposed project has minimal or no adverse environmental or social risks or impacts. Furthermore, any minimal identified risks or impacts can be easily avoided through the application of simple management measures. In accordance with the GCF Revised Environmental and Social Policy (the ESP) (B.BM-2021/18), an environmental and social assessment was required to adequately screen and assess potential environmental and social impacts.
182. In undertaking this screening, the potential risks and impacts have been considered that include direct and indirect, induced, long-term and cumulative impacts and have taken into account the proposed activities area of influence. SEAH provisions have been included in the project risk screening and its Environmental and Social Assessment and Residual Risk Management Plan (RRMP) **Annex 6**, to prevent and respond effectively to SEAH in a survivor-centered and gender-responsive way in accordance with the GCF Revised ESP (B.BM-2021/18).
183. As per guidelines, the screening has been carried out at the pre-mitigation stage to enable the most serious potential impacts of the activities to be considered. While there are several categories of sub-projects proposed under CHWBRC, as per GCF requirements, the risk category of the highest risk activity is applied to the entire project.
184. The SCA PESSMS has been expanded and tailored for the proposed project and is used to screen the project activities described in the project Log frame **(Section E: Logical Framework).** The SCA PESSMS Screening Tool consists of two parts – Part 1 determines the appropriate extent and type of environmental and social assessment required for the design phase and Part 2 is a Risk Categorisation Checklist which takes into consideration any potential environmental and social risks including requirements based on specific ESS standards.
185. The full Environmental and Social Safeguards Assessment and Residual Risk Management Plan (ESARRMP) is available in **Annex 6.**

G.2. Gender assessment and action plan (max. 500 words, approximately 1 page)

186. Climate change disproportionately affects marginalised groups who face inequality and barriers in daily life[97]. The project aims to transform practices, institutional and human capacity to improve the health and wellbeing of 1,798,878 direct beneficiaries (899,439 women) in Malawi, with a particular focus on women, children/youth and people with disabilities. Gender and social norms reflect structural drivers of differential vulnerability which need to be recognised and understood in order to enable equitable benefits from project participation, and support gender transformation post-project. A full gender equality and social inclusion (GESI) assessment has been conducted (based on a literature review, key informant interviews and focus groups in target communities from across the six project districts), accompanied by a Gender Action Plan (GAP) that outlines indicators, targets, responsible roles and budget that will ensure equitable benefits from project participation and how the project contributes to overall GESI transformation. The full GESI assessment and action plan is available at **Annex 8** and is summarised in the paragraphs below.
187. Climate change exacerbates the existing gender and social inequalities and marginalisation in Malawi: differential vulnerability for women, children/youth, and people with disabilities to climate change and extremes arises from socially constructed norms that give rise to differential resource allocation, decision-making and political participation. Despite a comprehensive array of policies and laws related to gender equality and social inclusion issues, Malawi suffers from considerable gaps in implementation[98]. Political participation by women, people with disabilities and children/youth is limited across all levels, from the national to the local. A deeply-entrenched

[97] The Office of the High Commissioner for Human Rights (2022) The impacts of climate change on the human rights of people in vulnerable situations. Report of the Secretary-General. Office of the United Nations High Commissioner for Human Rights, Geneva, Switzerland. Available at: https://www.ohchr.org/en/documents/thematic-reports/ahrc5057-impacts-climate-change-human-rights-people-vulnerable.

[98] E.g., Asfaw, S. & Maggio, G. (2018) Gender, weather shocks and welfare: evidence from Malawi. The Journal of Development Studies 54: 271-291. Doi: 10.1080/00220388.2017.1283016.

patriarchal culture constrains the opportunities that are available to women and girls[99]; people with disabilities are typically viewed through the charity model of providing assistance rather than being supported to play active roles in society[100]; and firmly-entrenched harmful social norms and beliefs (e.g. violence against children) are one of the critical obstacles to realizing children's rights in the country[101]. Access to healthcare is affected by gender and social exclusion issues; for instance, maternal mortality rates are still high, at 439 per 100,000 live births in 2015-16[102]. Healthcare is even less accessible for people (particularly women) with disabilities, who are not targeted for special service provision[103]. Malawi does not invest sufficiently to counter the extensive deprivations endured by its children, owing to the small size of its budget and revenue; funding for a number of social sectors that are crucial to the wellbeing of children are highly dependent on donor support, raising sustainability concerns[104].

188. The differential resource allocation, decision-making and political participation highlighted above contribute to limited adaptive capacity to climate change, in terms of systems, services, information and assets, of women, children/youth and people with disabilities. Together with generally higher sensitivity, marginalised groups are thus more vulnerable to climate-related impacts. Women face multiple barriers and vulnerabilities in the context of climate change in Malawi[105]. For instance, poverty and limited access to education contribute to their vulnerability, as they are often economically dependent on men and lack the resources to adapt to climate-related challenges[106]. Women are often disproportionately affected by disasters, both in the short- and longer-term. For instance, after tropical cyclone Idai and the associated floods in 2019 in Malawi, a disproportionate number of women were counted among the internally displaced people, with 63% of those in shelters in Machinga, Mangochi, Balaka and Zomba being women[107]. The sexual and reproductive health and rights of women are particularly affected in times of climate disasters. For instance, incidents of gender-based violence have been shown to increase after disasters in Malawi[108]. Beyond the effects on gender inequality, in 2023 tropical cyclone Freddy aggravated social exclusion in several Southern Malawi districts, including Phalombe[109]. Malawi is among the top 40 countries ranked as having

[99] Lovell (2021) Gender equality, social inclusion and resilience in Malawi. BRACC discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf

[100] Molloy E. (2020) PROSPER Gender Equality and Social Inclusion Analysis Report. BRACC report. Overseas Development Institute, London, UK.

[101] UNICEF (2023) For every child: child-friendly, inclusive, resilient communities. UNICEF Brief. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/8646/file/For%20every%20child%20Child-friendly,%20Inclusive,%20Resilient%20Communities%20-%20UNICEF%20Malawi%20Pillar%203%20Brief.pdf.

[102] NSO (2017) Fourth Integrated Household Survey: household characteristics. National Statistical Office, Zomba, Malawi. Available at: http://nsomalawi.mw/index.php?option=com_content&view=article&id=225&Itemid=111.

[103] Lorenzo, T. *et al*. (2015) Determining the competences of community-based workers for disability-inclusive development in rural areas of South Africa, Botswana and Malawi. Rural Remote Health 15: 2919. PMID: 26048267. Available at: https://pubmed.ncbi.nlm.nih.gov/26048267/.

[104] UNICEF (2023) For every child: child-friendly, inclusive, resilient communities. UNICEF Brief. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/8646/file/For%20every%20child%20Child-friendly,%20Inclusive,%20Resilient%20Communities%20-%20UNICEF%20Malawi%20Pillar%203%20Brief.pdf.

[105] Lovell (2021) Gender equality, social inclusion and resilience in Malawi. BRACC discussion paper. Overseas Development Institute, London, UK. Available at:

https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf

[106] Fruterro, A. *et al*. (2023) Gendered impacts of climate change: evidence from weather shocks. Policy Research Working Papers 10442. The World Bank, Washington DC, USA. Available at: https://openknowledge.worldbank.org/handle/10986/39813; Dessy, S.,L. *et al.* (2023) The gender education gap in developing countries: roles of income shocks and culture. Journal of Comparative Economics 51: 160-180. Available at: https://doi.org/10.1016/j.jce.2022.11.002.

[107] Government of Malawi (2019) Malawi 2019 Floods Post Disaster Needs Assessment (PDNA). Government of Malawi, Lilongwe, Malawi. Available at: https://reliefweb.int/report/malawi/malawi-2019-floods-post-disaster-needs-assessment-report.

[108] Desaia, B. & Mandal, M. (2021) Role of climate change in exacerbating sexual and gender-based violence against women: a new challenge for international law. Environmental Policy and Law 51:137-157. Doi: 10.3233/EPL-210055.

[109] Government of Malawi (2023) Malawi 2023 Tropical Cyclone Freddy Post-Disaster Needs Assessment. Government of Malawi, Lilongwe, Malawi. Available at: https://reliefweb.int/report/malawi/malawi-2023-tropical-cyclone-freddy-post-disaster-needs-assessment-april-2023.

a high climate risk for children, with climate-induced water scarcity the main factor[110]. Climate shocks are frequently occurring and with increased intensity, threatening the health, nutrition, education, development and the survival of children.

189. Consultations were held with communities to understand the impacts of climate change on community members. Focus group discussions were held with men, women, children/youth and people with disability separately to understand the key impacts of climate change. At a broad level, the community consultations confirmed the negative impacts of climatic changes on health, with diverse impacts mentioned: heat exhaustion exacerbated by dehydration (as a result of increased temperatures and decreasing rainfall), nutritional insecurity (from climate-induced decreases in agricultural production), malaria (from changes in climatic parameters), and cholera and diarrhoea (from climate-related destruction of WASH facilities). Community consultations also confirmed the gendered and socially-differentiated nature of vulnerability to the health impacts of climatic hazards. The health impacts of poor food and nutritional security were recognised as a particular risk for women (particularly pregnant and breastfeeding women) and children. Flooding damage to infrastructure impedes the capacity of women to access antenatal, sexual and reproductive health services, and other health care, with increases in unplanned pregnancies and pregnancy complications. Displacement is a particular problem in the wake of extreme events for marginalised groups; and women, pregnant women and breastfeeding mothers also particularly noted the stress and anxiety that extreme events bring, both during the event and a long time after. People with disabilities face particular barriers in accessing relevant health-related information and in accessing healthcare, as well as facing particular mobility challenges during extreme weather events. Women, people with disabilities and children/youth all remain marginalised within community-level institutional structures and decision-making fora.
190. The GESI Action Plan notes that the project interventions will be targeted in ways that support women, girls, youth and children, and people (men, women, children) with disabilities, including by: increasing the capacity of district and community healthcare staff to address the gendered and socially-differentiated impacts of a changing climate; ensuring gender-responsiveness and social inclusion considerations are embedded within physical infrastructure improvements designed to withstand climate; and by engaging, supporting and empowering communities themselves to mobilise to reduce their own vulnerability to the gendered and socially-differentiated health impacts of climate change, including through addressing underlying social norms and behaviours. The project will prioritise the impact on climate change on the health of the most vulnerable and marginalized people: women, girls, youth and children, and people (men, women, children) with disabilities. The project will take a holistic approach to tackling climate-related health impacts on the most vulnerable (including impacts related to sexual and reproductive health, gender-based violence, malnutrition and diarrheal diseases).
191. Under the project, all stakeholder engagement will have issues of gender and social inclusion and equity at their core. The project will mainstream gender equality and inclusion by addressing the power relationships at the root of inequality with the aim of ensuring that all the interventions are conducted with the full and meaningful participation of those whose voices are less often heard: women, girls, youth and people with disabilities. The GESI Action Plan will use an approach which starts with reflections on how power is wielded, how decisions are made and who controls resources.
192. The GESI Action Plan sets out a range of actions and targets to ensure that the implementation of activities is inclusive and reflects the lived experience of vulnerable and excluded people. Targets are specifically disaggregated to account specifically for the inclusion/participation of women, youth, and men and women with disabilities. In this way, the project will be creating a healthier, more equitable, more successful and resilient community. One example of a GESI action is, all training materials and all materials used in awareness-raising activities must include modules or specific information on the differential needs of vulnerable groups (women, youth and people with disabilities), and training materials must be accessible to men and women with disabilities. Another example of a GESI target is that at least 50% of those receiving training must be women, and at least 10% youth, and among the training participants there must be at least one man and one woman with a disability.
193. Implementation arrangements will engage partners with a track record of successfully implementing GESI-sensitive approaches with communities in the project thematic area (health) in each project district. Support for GESI will be provided through the Project Management Unit and Save the Children to raise institutional awareness of the importance of commitment to gender equality and social inclusion in internal and external management

[110] UNICEF (2021) The climate crisis is a child rights crisis: introducing the children's climate risk index. United Nations Children's Fund, New York, USA. Available at: https://www.unicef.org/media/105376/file/UNICEF-climate-crisis-child-rights-crisis.pdf.

practices. A gender role within the Project Implementation Unit will be employed to support implementation of GESI-appropriate measures. A regular (minimum annual) dedicated review of the GESI strategy and Action Plan will be undertaken, and adaptations made to the GAP and project implementation as needed. GESI implications will also be consistently discussed and brought up as a standing point to meetings, both internally and with stakeholders.

G.3. Financial management and procurement (max. 500 words, approximately 1 page)

194. The project's financial management and procurement approach follows SCA's approved processes to which they were accredited and hold the Accreditation Master Agreement with GCF. SCA was accredited to the GCF small size, category C ESS, basic fiduciary standards and project management standards. The approach is further guided by assessments of the executing entities' financial systems and consultations with the MoH in Malawi carried out during the design. A summary of the due diligence completed for the EEs and associated mitigations can be found in **Annex 20 – Know Your Customer Due Diligence Assessment.**
195. Fiduciary arrangements will follow a decentralised model, that involves SCUK, as the international channelling funds executing entity, flowing funding from the Accredited Entity (AE) to the national channelling and implementing executing entity, SCI MW, who will provide direct funding tranches to the MoH, as the other national Executing Entity, following endorsement of work plans and budgets by the Project Steering Committee and the NAB.
196. The portion of the project that is allocated to the Ministry of Health, will be transferred into a new bank account opened for the purposes of this GCF project, and would be opened by the 'Fiscal Agent', which is a function within the Health Services Joint Fund under the MoH. For more information about the Fiscal Agent, please see **section B4.** Funds will be managed by the FA, who will have responsibility for day-to-day spending, cash transfers, payment vouchers, purchase orders, and will compile financial reports to be submitted to the PMU for the Government portion of the project.
197. Implementing partners and contractors will be used in the project, and the portion of the overall budget that is allocated to procured parties will flow from SCI MW directly, as per the terms of reference and contracts for each supplier or partner. Funds used for district-level implementation will be transferred from SCI MW, via the PMU, to the relevant district offices operating under the project. This is in line with Save the Children's operating structure and is the project management mechanism used to ensure efficient and effective project implementation. Save the Children and partner district offices receive funds from the national office, and provide financial reporting including receipts, vouchers and other documentation to the national level PIU, who will compile the overall financial reporting for the project.

Performance management and audit

198. SCI MW will manage project implementation and financial reporting in line with our established project management systems and in conformity with the FAA and Subsidiary Agreements (SA) (when developed and agreed), cascading down all compliance requirements and project management requirements. As a channelling funds EE, SCUK will provide account management support to SCI MW in accordance with the account management system employed by the wider Save the Children movement to ensure compliance and high-quality delivery of the project and financial management and reporting **(section B4)**. In this role, SCUK will also be responsible for conducting project audits, reviewing financial reports submitted by the PMU in Malawi, and conducting spot checks on project documentation to ensure rigorous compliance before submitting to the AE and the GCF. Each implementing partner's financial acquittals will be required prior to further disbursements to ensure spending and delivery is on track as per the budget and implementation plan. These arrangements will contribute to ensuring project funds are effectively managed and SCA's fiduciary standards are adhered to, which are compliant with all GCF requirements.

Procurement

200. As per the request of the MoH, all major procurement for the project will go through the Save the Children systems. By Save the Children's systems, we mean Save the Children will be the lead EE and budget holder for that particular procurement, and the procurement will be fully managed by PIU staff employed by Save the Children in partnership with SCI MW's existing procurement team, who have extensive experience procuring both goods and services in Malawi. We confirm that the AE's procurements rules can be applied for all procurements under the project, however the Government of Malawi will adhere to their own public procurement rules, which are stricter than AE procurement and still fall within the AE's rules. Furthermore, Save the Children has established software systems used for procurement, namely 'Agresso', a financial management system, and 'prosave', which is the system we use to raise all procurement requests. For items listed as 'going through Save the Children's systems', we will use our well-established software which ensures fully compliant procurement in line with the AMA and global Save the

Children procurement rules. The AE will monitor and engage in oversight of the procurement process, in line with its normal procedures clarified in the subsidiary agreement. These systems are automated and ensure efficient procurement. The MoH will retain control of selected smaller procurements of consultancy services only (no procurement of goods and non-consulting services) with an absolute maximum value of USD50,000. However, most of the Government-led procurement is valued at less than USD20,000 and is primarily for low-value consultancies, for example for development of training materials and facilitation. This is due to a long and burdensome process with government procurement systems, and historic delays in procurement leading to overall delays in project implementation. The MoH will adhere to public procurement guidelines as is mandatory for all government departments in Malawi. However, there is no contradiction between Government of Malawi thresholds and procurement guidelines under the AMA, since the thresholds and guidelines dictated by the Government of Malawi fall within those set out in the AMA. All government entities will be applying public procurement guidelines as per standard procedure. Procurement thresholds will be in line with thresholds dictated by the SCI MW (**Annex 10**), and procurement will be initiated by the Chief of Party. However, the terms of references for services and goods, as well as the selection committee, will involve both PMU staff and staff from relevant departments within the Ministry of Health. For example, in selecting consultancies to set thresholds for vector-borne diseases, key technical staff from preventive health would be involved in the shortlisting and final selection. The portion of funds allocated to the Ministry includes some small areas procurement, and for these discrete pieces, Save the Children will lead on the initiation of procurement and the procedures to move from the tender process to the selection and contracting of consultants.

G.4. Disclosure of funding proposal

Note: The Information Disclosure Policy (IDP) provides that the GCF will apply a presumption in favour of disclosure for all information and documents relating to the GCF and its funding activities. Under the IDP, project and programme funding proposals will be disclosed on the GCF website, simultaneous with the submission to the Board, subject to the redaction of any information that may not be disclosed pursuant to the IDP. Information provided in confidence is one of the exceptions, but this exception should not be applied broadly to an entire document if the document contains specific, segregable portions that can be disclosed without prejudice or harm.

Indicate below whether or not the funding proposal includes confidential information.

☐ No confidential information: The accredited entity confirms that the funding proposal, including its annexes, may be disclosed in full by the GCF, as no information is being provided in confidence.

☒ With confidential information: The accredited entity declares that the funding proposal, including its annexes, may not be disclosed in full by the GCF, as certain information is being provided in confidence. Accordingly, the accredited entity is providing to the Secretariat the following two copies of the funding proposal, including all annexes:

- full copy for internal use of the GCF in which the confidential portions are marked accordingly, together with an explanatory note regarding the said portions and the corresponding reason for confidentiality under the accredited entity's disclosure policy, and
- redacted copy for disclosure on the GCF website.

The funding proposal can only be processed upon receipt of the two copies above, if containing confidential information.

H. ANNEXES

H.1. Mandatory annexes

☒	Annex 1	NDA no-objection letter(s) (template provided)
☒	Annex 2	Feasibility study - and a market study, if applicable
☒	Annex 3a	Economic and/or financial analyses
☒	Annex 3b	Economic and/or financial analyses in spreadsheet format
☒	Annex 4	Detailed budget plan (template provided)
☒	Annex 5	Implementation timetable including key project/programme milestones (template provided)
☒	Annex 6a	Environmental and Social Safeguards Assessment and Residual Risk Management Pla (ESARRMP)
☒	Annex 6b	Appendix 2 Safeguarding Risk Assessment
☒	Annex 7	Summary of consultations and stakeholder engagement plan
☒	Annex 8	Gender assessment and project/programme-level action plan (template provided)
☒	Annex 9	Legal due diligence (regulation, taxation and insurance)
☒	Annex 10	Procurement plan (template provided)
☒	Annex 11	Monitoring and evaluation plan (template provided)
☒	Annex 12	AE fee request (template provided)
☒	Annex 13	Co-financing commitment letters, if applicable (template provided)
☒	Annex 14	Term Sheet

Other annexes as applicable

☒	Annex 15	Evidence of internal approval (template provided)
☐	Annex 16	Map(s) indicating the location of proposed interventions
☐	Annex 17	Multi-country project/programme information (template provided)
☐	Annex 18	Appraisal, due diligence or evaluation report for proposals based on up-scaling or replicating a pilo project
☐	Annex 19	Procedures for controlling procurement by third parties or executing entities undertaking projects financed by the entity
☒	Annex 20	First level AML/CFT (KYC) assessment
☒	Annex 21	Operations manual (Operations and maintenance)
☐	Annex 22	Assessment of GHG emission reductions and their monitoring and reporting (for mitigation and cross cutting-projects)[111]
☒	Annex 23	Disease Control Programmes in Malawi

[111] Annex 22 is mandatory for mitigation and cross-cutting projects.

** Please note that a funding proposal will be considered complete only upon receipt of all the applicable supporting documents.*

No-objection letter issued by the national designated authority(ies) or focal point(s)

Telephone: +265 1 771111
Tele fax No: +265 1 773379

Our Reference No: EAD/99/07/26A
Your Reference No: ....

All communications should be addressed to:
Director of Environmental Affairs

ENVIRONMENTAL AFFAIRS DEPARTMENT
PRIVATE BAG 394
LILONGWE 3
MALAWI

Malawi, 1 November 2023

To: The Green Climate Fund ("GCF")
The Executive Director
Green Climate Fund
SO DO Business District
175, Art Centre Dacro
Republic of Korea

Dear Madam/Sir,

Re: Funding proposal for the GCF for Save The Children - Climate Resilient Health and Well-being for Rural Communities in Southern Africa Malawi

We refer to the project titled ***Climate Resilient Health and Well-being for Rural Communities in Southern Africa, Malawi*** as included in the funding proposal submitted by **Save The Children** to us on 1 November 2023.

The undersigned is the duly authorized representative of the Environmental Affairs Department, the National Designated Authority of Malawi.

Pursuant to GCF decision B.08/10, the content of which we acknowledge to have reviewed, we hereby communicate our no-objection to the project as included in the funding proposal.

By communicating our no-objection, it is implied that:

(a) The Government of Malawi has no-objection to the project as included in the funding proposal;
(b) The project as included in the funding proposal is in conformity with the national priorities, strategies and plans of Malawi;
(c) In accordance with the GCF's environmental and social safeguards, the project as included in the funding proposal is in conformity with relevant national laws and regulations.

We also confirm that our national process for ascertaining no-objection to the project as included in the funding proposal has been duly followed.

We acknowledge that this letter will be made publicly available on the GCF website.

Kind regards,

Tawonga Mbale-Luka (Ms)
Director of Environmental Affairs
GCF Nationally Designated Authority
Malawi

Secretariat's Assessment of FP244

Proposal name:	Climate Resilient Health and Well-Being for Rural Communities in southern Malawi (CHWBRC)
Accredited entity:	Save the Children Australia
Country:	Malawi
Project:	Small

I. Overall assessment of the Secretariat

1. The funding proposal is presented to the Board for consideration with the following remarks:

Strengths	Points of caution
The project targets the most climate-vulnerable districts in Malawi, a least developed country, by employing a holistic climate-informed, health system-strengthening approach to reduce the adverse effects of climate change on health and well-being.	The upcoming 2025 general election in Malawi presents a risk to project stability and continuity due to potential political shifts and uncertainties that could affect governance and regulatory environments
Proposed project activities will remove barriers to transformative change and enable a step change in the climate resilience of Malawi's health system by demonstrating integrated approaches at the district level to strengthen the resilience of infrastructure and health service provision and promoting climate-resilient health and well-being at the community level.	
This is only the third of GCF's health-specific climate action proposals, following the approval of health sector funding proposals for the Lao People's Democratic Republic (approved at the thirty-seventh meeting of the Board (B.37)) and the Cook Islands (B.38).	

2. The Board may wish to consider approving this funding proposal in accordance with the term sheet agreed between the Secretariat and the accredited entity (AE), and, if considered appropriate, subject to the conditions set out in annex II of document GCF/B.40/02.

II. Summary of the Secretariat's assessment

2.1 Project background

3. The objective of this project is to strengthen the climate resilience of the health system in Malawi, with direct adaptation benefits in Malawi's five southern districts of Ntcheu, Balaka, Machinga, Mangochi and Phalombe, as well as in the Zomba district, which is centrally located. The five southern districts are classified as very highly vulnerable to climate impacts mediated by increasing temperatures, changing rainfall patterns, and extreme events, including droughts and floods. These climate impacts are compounded by low adaptive capacities and vulnerability resulting from high levels of poverty, food insecurity, gender inequality, persistent malnutrition, environmental degradation, dependence on rain-fed agriculture, limited access to water and sanitation facilities, and high unemployment.

4. The project will directly benefit 1,798,878 vulnerable people (9.4 per cent of Malawi's population) and indirectly benefit a further 2,359,162 vulnerable people (12.4 per cent of Malawi's population) within 6 districts and 500 communities of southern Malawi. The project adopts a holistic health system-strengthening approach, as advocated by the World Health Organization, to develop a climate-resilient health care system by combining national, district and community-level interventions to create sufficient conditions for scalability, and sufficient integration to catalyse the transition to a climate-resilient health system.

5. The main project impacts will address climate-related increases in malaria, diarrhoeal diseases (e.g. cholera), diseases/conditions related to high/extreme heat (e.g. heat strain/stress), food and nutrition insecurity, mental health conditions (e.g. depression and anxiety) and gender-related impacts (e.g. increases in gender-based violence). Other climate-related health impacts that will be addressed include the physical impacts that climate hazards have on health care infrastructure and water, sanitation and hygiene (WASH) facilities.

6. The AE has identified the following barriers to health system climate resilience in Malawi:

(a) Inadequate availability and use of climate information/data in the health sector;

(b) Lack of climate-resilient and sustainable technologies and infrastructure;

(c) Limited institutional capacity for addressing climate risks in the health sector;

(d) Climate-related health issues are insufficiently mainstreamed into local strategic plans and planning processes;

(e) Low capacity of communities to reduce climate health risks; and

(f) Marginalized groups, particularly women and children, have lower adaptive capacity and higher sensitivity to climate-related health impacts.

7. The project design elaborates four components that are aligned to the priorities of the updated Strategic Plan for the GCF 2024–2027 (USP-2), namely:

(a) Institutionally, the project will strengthen and spread a climate-informed health surveillance system and health early warning system that functions at the national level and is able to track and provide appropriate early warning for the occurrence of climate-sensitive diseases and conditions (outcome 1);

(b) Physical health care infrastructure will be retrofitted and adapted to withstand climate risk by strengthening the resilience of health centres and hospitals in the south, and by developing and applying national standards and guidelines for climate-resilient facilities (outcome 2);

(c) Health care staff will be equipped to reduce climate health risk through improved disease monitoring, health messaging, and disease treatment and prevention (outcome 3);

(d) Communities will be better prepared to manage the impacts of climate change on health (outcome 4) as a result of a more resilient health care system and empowerment to

identify and reduce climate risks to health, with a particular focus on marginalized groups (including pregnant women and households with children under two) who require particular targeted interventions to address physiological vulnerability to climate change.

8. The proposal builds on the GCF Readiness and Preparatory Support Programme funds that have supported various climate policies, strategies and the necessary institutional capacities to sustain and drive Malawi's climate agenda. These include: (i) "Advancing The NAP Process: Climate Resilience for Sustainable Development In Malawi" implemented by United Nations Environment Programme, which developed capacity and tools for the coordination and execution of future national adaptation plan (NAP) processes; and (ii) the GCF-funded project, "Scaling Up the Use of Modernized Climate Information and Early Warning Systems" (FP002, implemented by United Nations Development Programme), which aimed to save lives and minimize risks to livelihoods by enhancing hydrometeorological capacity for early warning and forecasting, develop and disseminate tailored products for smallholder farmers and fishermen, and strengthen capacities of communities to respond to climate-related disasters such as floods.

9. Additionally, the project builds on the Adaptation Fund's "Adapting to Climate Change Through Integrated Risk Management Strategies and Enhanced Market Opportunities for Resilient Food Security and Livelihoods" (approved in 2019).

10. This environmental and social safeguards category C project responds to the following USP-2 targets: (a) T3: Climate information and early warning systems (CIEWS); (b) T7: Clean energy; and (c) T9: Adaptation and locally led action.

11. The project requests GCF funding of USD 33 million in the form of grants with co-financing of USD 4,068,208, comprising of USD 1,271,800 from GSK; USD 1,064,272 from Foundation S; USD 317,950 from the Foreign, Commonwealth and Development Office (FCDO) of the Government of the United Kingdom of Great Britain and Northern Ireland; USD 148,167 from the Moondance Foundation; and USD 1,266,019 in in-kind co-financing from the Government of Malawi.

12. Save the Children Australia (SCA) is the GCF AE that will undertake all key fiduciary and operational responsibilities for the delivery of the project. SCA, as the AE, will enter into legally binding subsidiary agreements with three executing entities (EE):

(a) The Ministry of Health (MoH) of Malawi, as the implementing EE;

(b) Save the Children International – Malawi Country Office (SCI MW), as the funds-channelling EE within Malawi and as implementing EE; and

(c) Save the Children Fund (Save the Children United Kingdom (SCUK) is the trade name and abbreviation), as the EE responsible for channelling funds internationally.

13. The project's exit strategy is crucial for sustaining the project's impacts beyond its lifetime. It emphasizes local planning (e.g. the establishment of district and subdistrict health adaptation plans), institutional strengthening, community engagement via Community Health Action Groups and the engagement of Community Healthcare Volunteers in community-level planning and activity implementation, policy advocacy, knowledge-sharing and robust monitoring and evaluation. This will ensure that project initiatives are deeply integrated into local and national frameworks, empowering communities and institutions to continue practices and support essential services and extension support that bolster climate resilience.

14. The project's risk assessment identifies political factors such as collaboration challenges between government stakeholders and changes in the government's development priorities as significant risks, categorized as having medium probability and impact. Specific concerns include limited cooperation between partners (i.e. different ministries and departments, which could hinder effective implementation and knowledge-sharing regarding climate-resilient

practices). To mitigate these, the project involves key governmental actors in committees to ensure cohesive work across agencies. Another political risk arises from potential shifts in government focus, which may affect commitment to health system adaptation strategies. This is mitigated by the project's strong alignment with Malawi's current complementary policies. High-level government officials are also included in decision-making processes to address policy changes proactively. Additional exogenous risks like extreme weather events and health crises like the coronavirus disease 2019 (COVID-19) pandemic are also noted, with plans to enhance health system services that support resilient health service provision and adjust project management practices to ensure continuity despite these challenges.

2.2 Component-by-component analysis

Component 1: Reduced risk from climate-sensitive diseases and conditions (total cost: USD 2.42 million; GCF cost: USD 2.00 million)

15. The activities under this component will strengthen the capacity to manage climate-informed health early warning and response systems (EWARS), make it accessible at selected health care facilities, and enhance the overall health surveillance system. These activities will address the following barriers: (1) inadequate availability and use of climate information/data in the health sector; (2) limited institutional capacity for addressing climate risks in the health sector; and (3) climate-related health issues are insufficiently mainstreamed into local strategic plans and planning processes. These activities will raise awareness of and provide training to address the associations between climate data and the incidence of the target diseases/conditions and develop Malawi-specific thresholds and alert trigger levels through studies and validation for the target diseases/conditions. Specific activities include:

16. Output 1.1: Climate-informed health surveillance system and health EWARS:

(a) Activity 1.1.1: Strengthen the health surveillance system by identifying alert triggers for key climate-sensitive health conditions;

(b) Activity 1.1.2: Strengthen the institutional architecture for managing the ongoing operation of the climate-informed health EWARS;

(c) Activity 1.1.3: Establish sentinel sites at selected health care facilities to provide improved climate and health data for the health EWARS.

17. Output 1.2: District health adaptation plans:

(a) Activity 1.2.1: Facilitate preparation and local endorsement of district health adaptation plans in six districts;

(b) Activity 1.2.2: Advocate for stronger integration of climate-resilient health within adaptation planning at district and subdistrict level.

Component 2: Health care infrastructure is able to deliver service and care in the context of changing climate risk (total cost: USD 14.56 million; GCF cost: USD 14.17 million)

18. This component focuses on ensuring that the physical health care system infrastructure (e.g. health centres, hospitals) is able to continue providing health care services in light of climate hazards (e.g. heat and floods), thus addressing the barrier of a lack of climate-resilient technologies and infrastructure. This component's activities will provide guidelines for climate-resilient health infrastructure, improve the climate resilience of health facilities, and improve WASH facilities within schools, given the clear links between climate change, waterborne diseases, WASH security and overall health. Specific activities include:

19. Output 2.1: Climate-resilient health centres, district and central hospitals, and schools for community health:

(a) Activity 2.1.1: Develop a national standard for climate-resilient health care facilities;

(b) Activity 2.1.2: Strengthen climate resilience of health care facilities;

(c) Activity 2.1.3: Build capacity of Malawi's health sector to apply the climate-resilient health care facility standard;

(d) Activity 2.1.4: Develop guidelines for climate-resilient WASH facilities;

(e) Activity 2.1.5: Upgrade WASH facilities at schools to improve children's health under climate change.

Component 3: Health care staff are able to deliver service and care in the context of changing climate risk (total cost: USD 7.76 million; GCF cost: USD 6.55 million)

20. This outcome will build the capacity of health care staff to understand how climate risk will alter public health risks, how they can inform surveillance of conditions, how they can interpret and disseminate climate-informed EWARS messaging, and how they can better anticipate and manage physical and mental health needs in their communities. It addresses the barrier of inadequate availability and use of climate information/data in the health sector, and the barrier of limited institutional capacity for addressing climate risks in the health sector. Specific activities include:

21. Output 3.1: Health care staff trained in managing climate-related disease monitoring, health messaging, and disease treatment and prevention:

(a) Activity 3.1.1: Build data collection capacity to strengthen surveillance of climate-related diseases;

(b) Activity 3.1.2: Build knowledge and capacity among district and community health care staff on climate and health and use of EWARS alerts;

(c) Activity 3.1.3: Provide medical supplies and technologies for climate health risk reduction and response;

(d) Activity 3.1.4: Equip health care workers with Mental Health and Psychosocial Support (MHPSS) capacity to address mental health impacts of a changing climate;

(e) Activity 3.1.5: Build capacity among district and community health care staff to address the gendered impacts of climate change.

Component 4: Community-level health is more resilient in the context of changing climate risk (total cost: USD 7.89 million; GCF cost: USD 7.12 million)

22. This outcome will address the need to increase community awareness of and skills and competencies in climate risks to health and strengthen the capacities of communities to better manage their risk through collective action. It addresses the barriers of low capacity of communities to reduce climate health risks and of marginalized groups, particularly women and children, being more vulnerable to climate-related health impacts. Capacity strengthening, training and engagement activities will build on SCA's strong experience in participatory empowerment by engaging communities for collective action, social and behavioural change, and inclusive and participatory training methods. Specific activities include:

23. Output 4.1 Stronger community capacity to reduce health risks from climate change:

(a) Activity 4.1.1: Equip community structures to provide knowledge and skills for climate-resilient WASH facilities to community members;

(b) Activity 4.1.2: Embed understanding of early warnings and alert protocols within communities, including children;

(c) Activity 4.1.3: Train communities to reduce their own vulnerability to climate-induced health risks;

(d) Activity 4.1.4: Support families with pregnant and breastfeeding women and children under two to produce climate-resilient foods and provide quality complementary feeding to children under two;

(e) Activity 4.1.5: Strengthen communities' capacities to reduce their vulnerability to the health impacts of climate change, particularly gendered impacts.

24. Monitoring and evaluation components total cost: USD 1.79 million; GCF cost: USD 1.59 million)

25. This cost will cover the relevant activities required to monitor and evaluate the project's progress towards the targets set out in the project's logical framework, particularly at the GCF outcome and project level, and with respect to co-benefits. The cost is about 4.8 per cent of the total project cost and is aligned with the Evaluation Policy for the GCF.

26. Project management (total cost: USD 2.66 million; GCF cost: USD 1.56 million)

27. The total project management cost, including the co-financing portion, is 7.2 per cent of the total project budget. In compliance with the general principles and indicative list of eligible costs covered under GCF fees and project management costs mentioned in decision B.19/09, paragraph (b), the AE has provided a detailed breakdown of the project management costs for both the GCF portion and the co-financing portion.

III. Assessment of performance against investment criteria

3.1 Impact potential *Scale: N/A*

28. The project will directly benefit an estimated 1,798,878 beneficiaries (899,439 women and 899,439 men) and indirectly benefit an estimated 2,359,162 beneficiaries (1,179,581 women and 1,179,581 men) in southern Malawi (21 per cent of the country's total population), with a particular focus on women, children and other vulnerable groups.

29. Adaptation benefits are a result of (i) the increased climate resilience in infrastructure and the built environment of 79 health facilities, which will sustain health services in 500 communities of southern Malawi; (ii) increased access to health services and facilities even in the event of climate-driven extreme weather events; (iii) increased training for government staff of Malawi in the utilization of the health information system and early warning system; and (iv) communities benefiting from awareness-raising sessions (communication tools) and adaptation solutions in food security and treatment and prevention of climate-sensitive health outcomes, including malaria, diarrhoeal diseases, heat-related illnesses, undernutrition and climate-driven mental health conditions.

30. Mitigation co-benefits are captured in the number of target health facilities with reduced estimated GHG emissions due to installation of solar energy systems that reduce reliance on diesel generators and national grid electricity and in the number of installations of solar photovoltaic arrays on roof tops with battery storage and hot water systems during upgrades of health facilities. The total monetary value of physical assets and equipment protected will be captured as a final target.

3.2 Paradigm shift potential *Scale: N/A*

31. Proposed project activities will remove barriers to transformative change and enable a step change in the climate resilience of Malawi's health system through the demonstration of integrated, district-level approaches to strengthening the resilience of infrastructure and health service provision and promoting climate-resilient health and well-being at community level.

32. At the end of the project, each of the participating districts will have a district executive committee that understands the nature of climate risk to health; a district health adaptation plan; and capacity to integrate climate risk to health into development planning, including annual planning for medical supplies, access to early warnings from the EWARS, and knowledge on how to build climate-resilient health care facilities and WASH facilities. They will also have health care staff who are able to anticipate and respond to climate risks to health, including through treatment for and prevention of climate-driven morbidity, and provide greater public health support to communities. Because of the focus on building systems (for example, EWARS at national level) and training (for example on how to screen infrastructure and WASH for climate resilience), these approaches can be replicated and scaled out to other districts, facilitated by the national institutional and enabling environment, thus catalysing impact beyond the one-off project investment.

33. Knowledge-sharing and evidence generation will be underpinned by a robust monitoring and evaluation plan and enabled through oversight of project implementation by the Health and Climate Change Core Team of the multi-stakeholder Joint National Technical Committee on Climate Change and Disaster Risk Management.

34. The proposed project creates an institutional and enabling environment at national level, including for EWARS, the standard for climate-resilient health care facilities, and the guideline for climate-resilient WASH facilities, all of which are accompanied by awareness-raising and training.

35. Additionally, the project contributes to the regulatory environment and policies by developing district health adaptation plans (activity 1.2.1); advocates for stronger integration of climate-resilient health within adaptation planning at district and subdistrict level (activity 1.2.2); and contributes to achieving the goals of the National Climate Change Management Policy (2016), the National Health Policy (2018), the National Environmental Health Policy (2018), the Updated Nationally Determined Contributions (2021) and the Health National Adaptation Plan (HNAP).

36. The project leverages Malawi's initial commitments to adaptation in the health sector through the Global Framework for Climate Services Adaptation for Africa project and the draft HNAP. Its integrated and holistic approach to health system climate resilience at multiple levels creates the enabling environment for easy scale up and critical mass of demonstration of what health system climate resilience looks like at the district level. This allows for ease of replication and will provide sufficient impetus for a step change into a climate-resilient sustainable development pathway for Malawi, in line with national planning documents such as Vision 2063 and the Malawi Growth and Development Strategy.

3.3 Sustainable development potential *Scale: N/A*

37. The project is fully aligned to Malawi's sustainable development agenda and its commitments under the Sustainable Development Goals (SDGs). It contributes particularly to SDG 1 (No poverty), SDG 2 (Zero hunger), SDG 3 (Good health and well-being), SDG 4 (Quality education), SDG 5 (Gender equality), SDG 6 (Clean water and sanitation) and SDG 13 (Climate action).

38. The project incorporates a number of co-benefits, including:

(a) Social co-benefits: Improved social inclusion for marginalized groups will result from improved dissemination of information on public health, particularly reaching hard-to-reach groups, including out-of-school children, the elderly and people with disabilities. Moreover, improved social outcomes for household economies will derive from using improved integrated homestead farming and nutrition practices due to reduced need to purchase diversified food for nutritionally vulnerable household members;

(b) Environmental co-benefits: Very small-scale mitigation co-benefits through solar installations at health facilities, thereby reducing reliance on diesel generators at facilities and on the national electrical grid;

(c) Gender co-benefits: Increased gender equality and empowerment will result from the engagement of the whole community in conversations about power and gender dynamics.

3.4 Needs of the recipient *Scale: N/A*

39. Malawi's Human Development Index value for 2021 is 0.512, putting the country in the low human development category position (i.e. 169 out of 180 countries and territories). Around half of the country (50.7 per cent) was living in poverty in 2019–2020. This proportion is higher in rural areas and higher in the southern part of the country: poverty headcounts in the target districts range from 48.8 per cent in Zomba to 63.7 per cent in Phalombe.

40. Malawi has high vulnerability to climate change. Among the most common climate hazards affecting Malawi are floods and droughts, and on average, Malawi loses 1.7 per cent of gross domestic product every year due to the combined effects of droughts and floods, which is more than five times higher than the average for least developed countries (0.3 per cent). A changing climate and extreme events have impeded economic growth and progress against poverty indicators: for every three Malawians that moved out of poverty between 2010–2019, four fell back into it due to the impact of weather shocks.

41. There is very limited fiscal space to support adaptation in Malawi. Financial barriers to adaptation are becoming more evident as a result of COVID-19, the Russian Federation–Ukraine conflict, inflation and a widening fiscal deficit. GCF grant funding will address the financial barriers to health and climate action and build the capacity and knowledge of the health sector to better leverage its existing resources in a climate-resilient way.

42. Knowledge of climate and health in Malawi is limited. The MoH in Malawi has very limited capacity to address climate change, with only preliminary awareness-raising and efforts made under one project, which largely have not extended to the district level. Likewise, adaptation efforts spearheaded by the Environmental Affairs Department and the disaster risk reduction efforts spearheaded by the Department of Disaster Management Affairs are not currently sufficiently integrating health as a result of this lack of knowledge and poor institutional capacity.

43. The project builds on these preliminary efforts to strengthen adaptation to climate change in the health sector and in existing national-level policies. In line with the Malawi Decentralization Policy (2013), implementation will take place at the local level through District Executive Committees, allowing the extension and furthering of national efforts to ensure that districts are also able to integrate climate risk into health planning and better implement national policies.

3.5 Country ownership *Scale: N/A*

44. This project is entirely aligned with the National Climate Change Management Policy and the priorities outlined in the NAP framework, the updated NDC and the HNAP, which aims to "create a health sector that is resilient to climate change effects". It builds on and leverages the country's first health and adaptation project (Global Framework for Climate Services Adaptation for Africa) by expanding knowledge on climate and health risks, placing particular emphasis on: sustainably building local capacity, developing local training materials and ensuring all components start their activities at the same time to avoid delays.

45. The proposal is well aligned with Malawi NDC priority themes of "Healthy and protected people", "Effective and efficient early warning systems" and "Climate-proofed infrastructure, buildings and energy systems". The adaptation component of the updated NDC (2021) identifies 10 strategic options relating to institutional framework, knowledge, technology and financing, and resilience for the most vulnerable. This proposal contributes towards building the resilience of the most vulnerable by adopting multi-pronged approaches in developing a climate-resilient health care system that will reduce the adverse effects of climate change on health and well-being.

46. The proposal also responds to various areas referenced in Malawi's Health Sector Strategic Plan 2023–2030 as well as priorities highlighted in the Malawi NAP Stocktaking Report (2016). Malawi's health sector is currently developing a HNAP, and the proposed project will directly contribute to the draft HNAP objectives on (i) community empowerment; (ii) health adaptation by non-state actors; (iii) preparedness for and management of climate change health effects; (iv) climate-resilient health infrastructure and services; and (iv) capacity-building for climate response and mobilization of additional resources.

47. This proposal is highly prioritized by the Government of Malawi and addresses key areas that were highlighted during a GCF interdivisional mission to the country (13–17, February 2023), where health and education were mentioned as part of Malawi's top three important areas to be prioritized for programming with GCF. The interventions outlined in this proposal build on some conceptual ideas that had initially been drafted by the Malawi NDA and national health actors.

48. This proposal has undergone extensive and detailed consultations with key national and subnational actors in the country (Annex 7 – Stakeholder engagement plan and summary of stakeholder consultations). Furthermore, GCF has also supported the co-creation of the proposal through various engagements and consultations with the NDA and other actors in-country.

3.6 Efficiency and effectiveness *Scale: N/A*

49. The proposal demonstrates efficiency and effectiveness of the project by presenting a high quality and robust economic analysis with clear and thoroughly referenced and calculated data and assumptions. The economic analysis evaluates the economic viability of five measures that have been identified as able to be valued and monetized, and that are broadly representative of the overall project's interventions.

50. Economic viability in the long run is demonstrated through the results against economic indicators in the five selected measures. Valuation of economic benefits has been conducted using various methods, including climate change-attributable disability-adjusted life years, avoided costs regarding morbidity and mortality, and value of statistical life in Malawi. In all five models, the project scenarios generate moderate or high returns above a social discount rate of 9 per cent. The overall project-level economic net present value is USD 5.14 million, with an economic internal rate of return of 13 per cent, demonstrating that the project is economically viable.

51. The financial viability and profitability of the project interventions are not demonstrated, as the financial analysis was not submitted. The proposal justifies this omission by stating that the project interventions are public in nature, and the beneficiaries are largely subsistence-based, with no expected financial returns or revenues through this project. Consequently, the project requests the highest level of concessionality, seeking full grants from the GCF to ensure economic viability. The financial adequacy and appropriateness of such concessionality are justified by the macroeconomic context and fiscal constraints of Malawi, with its fiscal deficit and public debt rising in recent years.

52. The project's adaptation cost is USD 7.9 per beneficiary and USD 18.3 per direct beneficiary, which are on the lower end of the GCF portfolio for health and adaptation projects. The co-financing ratio is 0.12. The proposal references the application of best practices in the project and highlights its great potential for scaling up and replication, given the AE's expertise and experience in delivering climate-resilient health interventions in the field.

IV. Assessment of consistency with GCF safeguards and policies

4.1 Environmental and social safeguards

53. The proposed project is categorized as C for environmental and social impacts, in accordance with GCF's Revised Environmental and Social Policy and the AE's accreditation level. Minimal environmental and social risks and impacts are expected from small-scale infrastructure works related to upgrading of health and school facilities (i.e. rainwater harvesting systems, handwashing stations and other WASH facilities, solar power installations, etc.). The AE has developed an environmental and social assessment and residual risk management plan (ESARRMP) that provides for the screening of proposed activities and management of the potential minimal environmental and social residual risks and impacts. The plan also has an exclusion list and would screen out activities that would result in a medium or high environmental or social risk categorization. The exclusion list will avoid activities that will involve disturbance to any existing asbestos-containing materials, among other things.

54. The Project Implementation Unit (PIU) will be established to implement safeguards measures on a day-to-day basis. Stakeholder engagement will continue during implementation and a grievance redress mechanism (GRM) will be put in place to channel and address any issues and complaints from communities and other stakeholders.

55. **GCF Indigenous Peoples Policy and ESS7 (Indigenous Peoples).** Consistent with its categorization, the funding proposal activities have low risk for non-compliance with the Indigenous Peoples Policy.

56. **Sexual exploitation, abuse and harassment (SEAH).** The AE adopts a zero-tolerance policy for SEAH committed by representatives against adults or children in the communities where the project will be implemented. Based on the results from the AE's Safeguarding Risk Assessment Tool, the project may have low SEAH risks associated with the presence of project staff/representatives, consultants, volunteers, partners and suppliers spending time in communities and from survivors and/or communities potentially being unable to identify or report instances of SEAH, despite rigorous prevention efforts and reporting channels that are in place. Specific SEAH measures are incorporated in the ESARRMP, such as the provision of training on SEAH, awareness-raising on reporting procedures (GRM), and provision of referral services for victims and survivors. The PIU, through the Safeguarding Specialist, will be responsible for monitoring SEAH measures during implementation.

4.2 Gender policy

57. The AE provided a gender assessment and action plan with the funding proposal and therefore complies with the requirements of the GCF Updated Gender Policy. The gender assessment is based on primary and secondary sources. These included secondary data in the form of literature review of policy documents and published research; focus group discussions with women, men, and people with disabilities across the six targeted districts; and lastly, key informant interviews for key district-level personnel.

58. Malawi's constitution enshrines gender equality and disability. Malawi is a signatory to regional, continental, and international equality agreements, and gender is a cross-cutting issue across all policies, including those on climate change. Malawi has put in place the Gender Equality Act (passed in 2013), with the aim of promoting gender equality and equal integration, influence, empowerment, dignity and opportunities, and the National Disability Mainstreaming Strategy and Implementation Plan, which aims to bridge the gap between policy and practice. Additionally, the country has the National Climate Change Management Policy 2016 in place, which addresses gender, population dynamics, and HIV and AIDS as cross-cutting issues and commits to mainstreaming gender and issues affecting disadvantaged groups into all climate change strategies, plans and programmes.

59. Policy implementation remains weak due to the dominance of sociocultural and pervasive gender norms, which affect equality and inclusion, and inadequate resourcing to the relevant stakeholders and duty bearers. Women and girls with disabilities continue to face discrimination and heightened gender-based violence. Generalized material deprivation in the country exacerbates gender inequalities. Women are progressively gaining access and control over some resources and greater decision-making power. However, the gender norms are still limiting. Malawi has low political representation of women at national and other levels, and land ownership favours men. Despite the Land Act 2017 being in place to increase women's access to and control and ownership of land, gender norms still favour male ownership. Gender-based violence is rife, and 41 per cent of women have experienced gender-based violence at least once in their lifetime.

60. Climate-resilient health and well-being for rural communities in the southern Malawi gender action plan has been designed to make intentional actions towards gender equality and social justice and address root causes of gender inequality in the project focus area. The gender action plan not only prioritizes activities to support women but also includes girls, boys, youth and men facing vulnerabilities. The activities include identifying triggers for climate-sensitive health conditions by enhancing health surveillance mechanisms. Specifically, the AE will determine threshold levels for the different diseases so that specific consideration is given to differences in thresholds for women, children, men and women with disabilities. To embed more sustainability, the AE will enhance the existing climate-informed health early warning systems by strengthening management processes and ensuring women and other groups facing vulnerabilities are consulted and participate actively in committees. Women and people with disabilities will be consulted to determine whether there are considerations to be taken into account when building infrastructure.

61. The AE will hold reflective workshops on gender, power, inequality, and decision-making to identify where the impacts of climate change are likely to occur and plan accordingly. The project will support families with pregnant women, breastfeeding mothers and children under two to ensure appropriate infant feeding and produce climate-resilient, complementary nutritious food. Additionally, community-level staff overseeing the homestead farming will receive training on community engagement. Furthermore, the AE will conduct a full gender and power analysis as part of the baseline study, explicitly examining how gender inequality and other social inequalities, including disability, shape access to power and resources and subsequently develop a gender equality and social inclusion (GESI) strategy. The AE has included project activities, key indicators and targets (for women, men, boys and girls), timelines, indications of who is responsible for what roles, and budgetary costs against each activity. The project will put in place a publicized GRM that is responsive to different populations, and the GESI assessment findings will be disseminated to all actors. The AE will engage a GESI specialist who is part of the PIU to ensure a gender lens is applied across all activities. The GESI specialist will be an integral part of this project, working closely with the project staff and largely with three key government secondments.

62. The Secretariat recommends that the AE ensure that some of the stereotypes presented in the gender assessment report are revisited to ensure that the project does not indirectly cement these gender biases. The aim is to ensure that we also achieve gender co-benefits through the project.

4.3 Risks

4.3.1. Overall project assessment (low risk)

63. The aim of the project is to achieve climate-resilient health and well-being in Malawi through a comprehensive approach. This approach integrates actions across national, district, and community levels to build a robust health care system capable of adapting to climate challenges. Its purpose is to enhance and synchronize efforts to strengthen early warning systems, reinforce health care infrastructure, improve health care staff capacity, and empower communities to manage climate-related health risks. The project will achieve climate-resilient health and well-being through a multi-pronged strategy classified into four outcomes: outcome 1: Reduced risk from climate-sensitive diseases and conditions; outcome 2: Health care infrastructure is able to deliver service and care amidst changing climate risks; outcome 3: Health care staff are equipped to provide service and care in the face of changing climate risks; and outcome 4: Community-level health is more resilient in the context of evolving climate risks. The total project financing is USD 37,068,208, which will be funded through USD 33,000,000 from GCF as a grant, with additional co-financing totalling USD 4,068,208 from FCDO, Foundation S, GSK and a Moondance Foundation grant and one in-kind contribution from the Government of Malawi, resulting in a co-financing ratio of 1:0.12.

4.3.2. Accredited entity/executing entity capability to execute the current project (low risk)

64. The AE for the project is SCA, which will manage all fiduciary and operational aspects. The EEs include SCI MW and the MoH in Malawi. SCI MW has been operating in Malawi since 2012 and has a strong track record in delivering community-based health, education, and child protection programmes, with proven expertise in gender-transformative and child-centred approaches. The MoH has successfully led key climate-resilient health programmes and established the Health Sector Joint Fund in 2015 with the support of FCDO of the Government of the United Kingdom of Great Britain and Northern Ireland; KfW, Germany and the Norwegian Agency for Development Cooperation, Norway, demonstrating the significant experience of MoH in managing donor-funded projects and improving health infrastructure. The AE has six approved projects with GCF under implementation, namely SAP042, SAP036, SAP030, SAP027 and FP184.

4.3.3. Project-specific execution risks (low risk)

65. **Inflation pressure**: We recognize the key challenge of inflationary risks currently impacting Malawi, as highlighted in the funding proposal, which may affect project execution by influencing costs and financial stability. To mitigate this risk, the project will utilize United States dollars (USD) for all transactions. The inflationary environment may necessitate ongoing budget adjustments, potentially causing delays or requiring additional funding. The AE will hold funds and transact in USD, with budget allocations for activities subcontracted to EEs, inclusive of cost and schedule overrun assessments to account for contingencies.

66. **Insufficient climate and health data integration**: The project's success in establishing effective disease surveillance and early warning systems relies significantly on the timely integration of climate and health data. Without a formalized approach to data integration, there

is a risk of delayed or inaccurate information, which can undermine the development of early warning systems and hinder the project's objective of improving climate resilience in the health sector. The AE acknowledges this risk and has implemented mitigation measures, including signing a memorandum of understanding (MOU) for data-sharing between the MoH and the Meteorological Department. Additionally, the Project Steering Committee, which includes representatives from the relevant departments, will ensure efficient operation of the MOU and facilitate information-sharing.

67. **Project viability (and concessionality)**: The use of grants (i.e. 100 per cent concessionality) is considered appropriate. As highlighted in the funding proposal, Malawi is facing a significant funding shortfall for climate adaptation, with only 1.5 per cent of the required USD 3.3 billion secured through international support. The funding proposal also notes that the country is incurring increasing economic losses from extreme weather events, such as Cyclone Freddy, which caused damages amounting to USD 506.7 million in 2023, further straining recovery efforts. GCF grant funding, as outlined in the funding proposal, is therefore essential to support the transformation of the health system, build resilience for the most vulnerable communities, and attract additional co-financing.

4.3.4. Compliance risk (low risk)

68. The proposed project activities – health care staff and institutional capacity-building, strengthening health care physical infrastructure, and training/awareness-building for local communities –present relatively reduced risks of money-laundering/terrorist financing (ML/TF). In addition, the AE has also highlighted risks of other prohibited practices in its baseline assessment and has incorporated control measures into the project design to mitigate the overall integrity risk exposure, including systems for identification, review and monitoring throughout the project cycle.

69. In addition, the implementation arrangements in which the AE, SCA, will undertake all key fiduciary and operational responsibilities for project delivery (with its Malawi country office (SCI MW) serving as the as Malawi domestic funds-channelling EE/implementing EE and its United Kingdom counterpart (SCUK) serving as the international funds-channelling EE) further mitigate ML/TF risks. More broadly, SCI MW has a long history of programming across Malawi, and the AE has provided assurance that SCI MW has sufficiently strong systems, capacity and experience to implement the scope of work outlined in the funding proposal. In addition, compliance risk mitigation is further strengthened by the use of a dedicated, independent fiscal agent under the other implementing EE, MoH, whose role is to ensure that funds are disbursed and utilized in accordance with the implementation plan.

70. Based on the inherent ML/TF and other integrity risks associated with the project's proposed activities, as well as the corresponding mitigation measures, the overall compliance risk is deemed to be low.

4.3.5. GCF portfolio concentration risk (low risk)

71. In case of approval, the impact of this proposal on the GCF portfolio concentration in terms of result area and single proposal is immaterial.

4.3.6. Recommendation

72. It is recommended that the Board consider the above factors in its decision.

Summary risk assessment		Rationale
Overall project	Low	

Accredited entity/executing entity capability	Low	The funding proposal has an overall risk assessment of low based on the issues highlighted. It is recommended that the Board consider the above factors in its decision.
Project-specific execution	Low	
GCF portfolio concentration	Low	
Compliance	Low	

4.4 Fiduciary

73. The project's financial management strategy aligns with GCF-accredited processes overseen by SCA, in line with small size, category C environmental and social standards, basic fiduciary standards, and project management standards. Funds flow through a decentralized model: SCUK acts as the international funds-channelling EE, directing resources to SCI MW, which channels funds to the MoH upon approval by the Project Steering Committee and National Approval Body. MoH manages project funds through a dedicated fiscal agent within the Health Services Joint Fund, overseeing daily expenditures, cash transfers and financial reporting to the Project Management Unit. Implementation partners receive funds directly from SCI MW for procurement and district-level activities, ensuring alignment with SCA's operational structure. Financial reporting, including receipts and vouchers, is consolidated at the national level by the PIU, ensuring transparency and accountability throughout the project lifecycle.

4.5 Results monitoring and reporting

74. The project "Climate Resilient Health and Well-Being for Rural Communities in Southern Malawi" includes a robust monitoring and evaluation plan aligned with GCF objectives that focuses on baseline indicators and accountability through stakeholder roles. Detailed monitoring and evaluation arrangements are provided in Sections B.3 and E.7 of the funding proposal and specify reporting frameworks, indicators and timelines. A structured learning framework includes biannual workshops and a knowledge-sharing platform to capture and disseminate lessons learned. The strong causal linkages in the Theory of Change and logical framework support effective monitoring, data collection and verification.

75. The project's outcomes aim to reduce climate-sensitive disease risks, enhance health infrastructure, improve health care staff capacity, and prepare communities for climate impacts. Key outputs include better disease surveillance, climate information integration, upgraded health facilities, and community training. Results in this regard will be tracked by constituting a community-level planning, monitoring, and evaluation involving Community Health Action Groups and Community Healthcare Volunteers to ensure local participation. The project also establishes community-based early warning systems and health surveillance mechanisms, and trains members for data collection and reporting.

4.6 Legal assessment

76. The accreditation master agreement (AMA) was signed with the AE on 20 December 2019 and became effective on 20 May 2020.

77. The AE has provided a legal opinion confirming that it has obtained all internal approvals and it has the capacity and authority to implement the project.

78. The proposed project will be implemented in the Republic of Malawi, a country in which GCF is not provided with privileges and immunities (P&I). This means that, amongst other

things, GCF is not protected against litigation or expropriation in this country, which risks need to be further assessed. The GCF Secretariat provided a draft agreement on P&I and a background note to the Government of Malawi on 30 September 2015. The latest communication was during the country mission to Malawi from 13 to 17 February 2023, in which the Government of Malawi indicated that it would restart negotiations on the P&I agreement with GCF.

79. The Heads of the Independent Redress Mechanism (IRM) and Independent Integrity Unit (IIU) have both expressed that it would not be legally feasible to undertake their redress activities and/or investigations, as appropriate, in countries where the GCF is not provided with relevant privileges and immunities. Therefore, it is recommended that disbursements by the GCF are made only after the GCF has obtained satisfactory protection against litigation and expropriation in the country, or has been provided with appropriate privileges and immunities.

80. To address the matters raised in this section, it is recommended that any approval by the Board is made subject to the following conditions:

(a) Signature of the funded activity agreement in a form and substance satisfactory to the GCF Secretariat within 180 days from the date of Board approval; and

(b) Completion of the legal due diligence to the satisfaction of the GCF Secretariat.

Independent Technical Advisory Panel's assessment of FP244

Proposal name:	Climate Resilient Health and Well-Being for Rural Communities in southern Malawi (CHWBRC)
Accredited entity:	Save the Children Australia
Country:	Malawi
Project:	Small

I. Assessment of the independent Technical Advisory Panel

1.1 Overview

1. Malawi is among the most climate-vulnerable countries in the world. The proposed project focuses largely on Malawi's southern region, as it is prioritized for climate adaptation in the national adaptation plans due to its high exposure to climate risks and impacts, in combination with high vulnerability. Malawi is exposed to increasing temperatures, changing rainfall patterns, and extreme events which result in a range of health-related impacts.

2. The project intends to strengthen resilience to climate change in the health-care sector of southern Malawi. The project combines interventions at the national, district, and community levels. It intends to strengthen a climate-informed health surveillance system and early warning system to provide appropriate early warning for the occurrence of climate-sensitive diseases and conditions (outcome 1). This aims to mitigate the risk of increases in the occurrences of malaria, diarrhoeal diseases, malnutrition, and diseases/conditions linked to high/extreme heat. The resilience to climate hazards of health centres, hospitals, and water, sanitation and hygiene (WASH) infrastructure shall be strengthened and national standards and guidelines for climate-resilient facilities shall be developed. Seventy-nine health-care facilities will be targeted for physical upgrades to enhance climate resilience (outcome 2). Training of health-care staff in improved disease monitoring, health messaging, and disease treatment and prevention is planned (outcome 3). Communities shall be empowered to identify and reduce climate risks to health (outcome 4).

3. The project targets 500 villages selected in a consultation between the District Health Management Team, Save the Children, and the implementing partners. The project will reach around 1.8 million direct beneficiaries and 2.36 million indirect beneficiaries.

4. The project is executed by the Save the Children International Malawi Country Office, as the channelling executing entity within Malawi and as an implementing executing entity; the Save the Children Fund, as the executing entity responsible for channelling funds internationally; and the Malawi Ministry of Health, as an implementing executing entity.

5. The sources of finance for the USD 37 million project are (i) USD 33 million in grant finance from GCF; (ii) USD 2.8 million in grant finance from foundations, the Government of the United Kingdom of Great Britain and Northern Ireland, and the private sector; and (iii) USD 1.3 million in-kind from the Government of Malawi. The project implementation period is five years. Save the Children Australia has already had a similar project approved by GCF for the health sector of the Lao People's Democratic Republic (SAP 030 approved at the thirty-seventh meeting of the Board).

1.2 Impact potential *Scale: Medium-High*

6. The project has an adaptation impact related to the areas of "most vulnerable people and communities" (50 per cent of finance), and "health and well-being, and food and water security" (50 per cent of finance). It also has a minor mitigation impact through the provision of solar photovoltaic systems on health posts, an impact which has not, however, been quantified by project proponents.

7. The expected adaptation outcome has 4.16 million direct and indirect beneficiaries of which 1.80 million are considered direct beneficiaries, representing 9 per cent of the total population, and 2.36 million indirect beneficiaries, representing 12 per cent of the total population. The beneficiaries are located within 6 districts and 500 communities of southern Malawi. The project will target 79 health-care facilities (including five district hospitals and the central hospital in Zomba) in the target districts and target traditional authorities for climate-resilient infrastructure improvements.

8. The adaptation outcome was calculated by including as direct beneficiaries the entire population of the 25 targeted traditional authorities which is commensurate with all people living in the catchment area of the supported health facilities. While the people in the catchment area are targeted, the intensity level (level of support provided per person) is considered low to medium, and only direct clients of the health facilities could be considered high intensity.[1] The direct and indirect beneficiaries represent the entire population of the six target districts. The district population will benefit from improved policies under the district health adaptation plans, an improved health early warning and response system that will cover the entire district – improved data collection capacity, and new sentinel sites established in five out of the six project districts (Zomba – the sixth district – has already had a site established as a pilot by the World Health Organization (WHO)).

9. Climate change will increase the diffusion and severity of the core identified diseases linked to climate change (malaria, diarrhoeal disease, food and nutrition insecurity). The projected changes in temperature, rainfall, and extremes have numerous implications for health and well-being, and the availability, accessibility, and quality of health care. The increased disease burden from climatic changes will reduce well-being disproportionately affecting women, children, and other marginalized groups. At the same time, the identified diseases are well-known, their cause–effect relationship is established, and treatment and prevention methods are clear. Climate change causes an amplification of the impacts of existing diseases which creates additional stress on the health system.

10. The project takes a holistic health system approach, as advocated by WHO, to develop a climate-resilient health-care system that will reduce the adverse effects of climate change on health and well-being. The project addresses climate-induced stress by preventing a deterioration within the health system. This is addressed through interventions at the institutional level (strengthening of institutional capacities), at the health system staff level (improving the capacity of health staff), at the community level (empowering people and improving the population's knowledge), and at the physical infrastructure level (upgrading of health-care centres).

11. The project aims to make the health system more effective at detecting, treating, and preventing these climate-induced diseases. Early detection and access to efficient medical care lowers the fatality rates caused by disease. Activity 1 under output 1 thus strengthens the health surveillance system by identifying triggers for key climate-sensitive conditions and a health early warning and response system, while other activities under this output strengthen the

[1] See, for example, the methodological approach of the Adaptation Fund (2014), *Methodologies for Reporting Adaptation Fund Core Impact Indicators*. Available at www.adaptation-fund.org/document/methodologies-for-reporting-adaptation-fund-core-impact-indicators-march-2014/

institutional architecture for the climate-informed health early warning and response system and establish sentinel sites at selected health-care facilities to improve climate and health data. District health adaptation plans shall be locally endorsed in six districts aligned with the priority actions of the national adaptation plan in health. The project aims to strengthen the integration of climate-resilient health within adaptation planning at district and sub-district levels. The knowledge and capacity among district and community health-care staff on climate and health shall be improved. In addition, the risk of exposure can be reduced by improving the population's knowledge, attitudes, and practices with regard to these diseases, and implementing routine sustainable vector control activities in the community. The upgrading of health facilities shall increase their resilience towards climate change. Upgrades proposed by the project are only partially directly related to climate-change impacts, but serve, however, to improve rural health services. Typical interventions are solar energy systems to improve energy supply and improved WASH facilities.[2] A national standard for climate-resilient health-care facilities shall also be developed.

12. A critical aspect is the sustainability of services and improvements to health facilities. The project works on establishing national guidelines for climate-resilient health centres linked with practical showcases in 79 facilities where this will be implemented. However, to adopt these changes on a national scale will require substantial additional national and/or international finance. The sustainability of services provided is on the one hand entrenched in improved capacity of staff and empowerment of people. However, maintaining the project service levels will require long-term finance to reduce the likelihood of one-off interventions and limited impacts.

13. The project involves significant outreach, will reach numerous beneficiaries, and can contribute towards reducing the impact of climate-related diffusion of critical diseases. The project interventions tackle a critical health problem that is being aggravated by climate change and can have a significant impact on the health situation of the people affected. However, interventions are currently not linked to a stable and sustainable funding source which might result in future discontinuation. Overall, the independent Technical Advisory Panel (iTAP) rates the project impact potential as medium to high.

1.3 Paradigm shift potential *Scale: Medium*

14. Increasing access to and the usability of climate and early warning information, and strengthening health workforce and community capacity to address climate-change impacts shall result in a paradigm shift. The paradigm shift shall be achieved by the demonstration of integrated approaches at the district level. A combination of climate-responsive health plans, guidelines for climate-resilient health-care facilities, and trained staff shall ensure the continuity and spread of measures.

15. Knowledge-sharing and evidence generation shall be enabled through oversight of project implementation by the Health and Climate Change Core Team of the multi-stakeholder Joint National Technical Committee on Climate Change and Disaster Risk Management, which will be the primary forum for knowledge-sharing with government and non-government actors.

16. The project aims to help in creating an institutional and enabling environment at the national level through the health early warning system, the standard for climate-resilient health-care facilities, and the guideline for climate-resilient WASH facilities. At the district level,

[2] The term "WASH facilities" here refers to the provision of water, sanitation, health-care waste management, hygiene and environmental cleaning infrastructure and services across all parts of a facility. See: https://www.who.int/teams/environment-climate-change-and-health/water-sanitation-and-health-(wash)/health-care-facilities/wash-in-health-care-facilities

the enabling environment is improved by advocating for stronger integration of climate-resilient health within adaptation planning at district and sub-district levels.

17. Structural problems of the Malawi health system, such as the lack of finance and lack of fund commitment by the government for the health sector, are not directly tackled by the project. Per capita health-care spending (in USD) as well as health-care spending as a percentage of the gross domestic product has decreased in the period from 2012 to 2018 in Malawi.[3] Malawi has consistently missed the Abuja Declaration on health financing target for African States to allocate 15 per cent of their total budgets to the health sector.[4] The National Health Accounts of 2022 indicate that donors contribute an average of 55 per cent to health sector funding. The newly introduced Health Financing Strategy for 2023–2030 strategic approach to health-care financing is expected to reduce the country's reliance on external funding gradually, as it seeks to strengthen domestic resource mobilization and improve the efficiency of health-care spending.

18. To ensure replication and expansion to other districts and a continuation of service levels within the targeted districts, the project relies on tapping external funding sources as well as increased domestic funding. The continued reliance on external funding is considered critical in terms of the sustainability of project operations. The iTAP notes and appreciates the in-kind financing provided by the Government of Malawi. A financial strategy, including an increasing share of finance provided by the national and local governments would reduce the concerns related to the sustainability of the project and the actual potential for a paradigm shift.

19. Overall, the project is not considered to result in a notable paradigm shift as it expands and amplifies existing approaches without making a structural change to the health system. Without tackling the funding problem, the paradigm shift potential is deemed to be limited, with interventions remaining at the project level with the expectation or hope of replication. Guidelines and plans are important elements in achieving a paradigm shift, but, if not linked with finance sources, their impact is deemed to be limited. Overall, the iTAP rates the potential for the project to affect a paradigm shift as a medium.

1.4 Sustainable development potential *Scale: Medium to high*

20. The project is aligned primarily with Sustainable Development Goal (SDG) 3 (Good health and well-being), SDG 6 (Clean water and sanitation), and SDG 13 (Climate action). It also contributes towards SDG 1 (No poverty), SDG 2 (Zero hunger), SDG 4 (Quality education), and SDG 5 (Gender equality). The main emphasis is therefore on good health and well-being through improved awareness, information, and capabilities to react to and prevent the diffusion and severity of climate-related diseases, and improving the infrastructure of health centres.

21. The project shall also achieve co-benefits, including enhanced social inclusion for marginalized groups as a result of improved dissemination of information on public health, better social outcomes for households due to improved integrated homestead farming and nutrition practices, small-scale environmental benefits from solar installations replacing diesel generators at health facilities, and increased gender equality and empowerment through engagement of the whole community.

22. The project interventions shall achieve good health and well-being at the community level through improved capacity to anticipate and respond to climate risk, infrastructure, and supplies. An improved health-care system has a highly positive social and economic impact with reduced morbidity and mortality levels and improved quality of life. Investments in the area of improved health-care have, in general, a high economic rate of return.

[3] Data sourced from Malawi's National Health Accounts, 2022.
[4] The 2023/2024 health sector budget is worth 8.7 per cent of the total government budget.

23. While the sustainable development impact is important and considered to be high during project implementation, the sustainability of efforts is questioned as no structure is in place to ensure continuous financial support once the project implementation period is over. Overall, the iTAP rates the potential for sustainable development of the project as medium to high.

1.5 Needs of the recipient *Scale: High*

24. Malawi has high vulnerability to climate change resulting in high gross domestic product losses and reducing the progress on reducing poverty. The gender impacts of climate change severely affect the life chances of women and girls and often disproportionately affect other marginalized groups, such as people with disabilities. The proposed project focuses largely on Malawi's southern region, as it is prioritized in the national adaptation plans. Malawi is exposed to both floods and droughts, with such events increasing in frequency, magnitude, and scope over time. Projected trends indicate that southern Malawi will be exposed increasingly to heat-related hazards. Climatic changes will reduce well-being affecting women, children, and other marginalized groups disproportionately.

25. Malawi's Human Development Index value for 2021 is 0.51, putting the country in the low human development category position. Around half of the country was living in poverty in 2019–2020 with higher poverty levels in the southern part of the country.

26. According to Malawi's national adaptation plan framework, adaptation finance needs are estimated at USD 4.5 billion through to 2040 with three-quarters expected to be financed through international support. This reflects the current national budget situation, which is highly dependent on international funding.

27. Malawi has a very limited fiscal space to support adaptation action. Public expenditure available for climate change adaptation is insufficient to meet the needs across all sectors. The project builds on preliminary efforts to strengthen adaptation to climate change in the health sector, and the existing national-level policies.

28. Overall, the iTAP rates the needs of the recipient as high.

1.6 Country ownership *Scale: High*

29. The no-objection letter of Malawi has been provided.

30. The project is aligned with the National Climate Change Management Policy, the national adaptation plan framework, the updated nationally determined contribution, and the health national adaption plan.

31. The project is also aligned with Malawi's health sector strategic plan 2023–2030. Malawi's health sector is currently developing a health national adaptation plan. The Health and Climate Change Core Team of the Government of Malawi (HCCCT) endorsed the Ministry of Health as the executing entity, alongside Save the Children as the other executing entity. Implementation arrangements have been designed to ensure close engagement with both HCCCT and the Ministry of Health, with oversight by the HCCCT.

32. The project has carried out a broad and intensive process of stakeholder engagement.

33. Save the Children has worked in Malawi over the past 40 years implementing a wide range of activities in education, health, nutrition, child protection, resilience, livelihoods, and social protection, and has over the past 10 years increased its implementation of climate-sensitive activities, mostly in agriculture. Save the Children is a recognized Ministry of Health

partner in Malawi implementing facility and community-based reproductive, maternal, and newborn health interventions.

34. The Ministry of Health is responsible for developing, reviewing, and implementing health and related policies for the health sector; spearheading sector reforms; and developing and reviewing standards, norms, and management protocols for service delivery. The ministry has also experience in delivering large donor-funded programmes.

35. Save the Children has broad experience in monitoring and evaluation (M&E) of traditional development projects and their outputs and outcomes, including in the health sector. Experience with M&E in climate resilience is less evident due the accredited entity Save the Children (AE) having less experience in this specific sector. The approach and methodology to assess the expected outcomes and outputs in climate-resilience improvement and the monitoring of impacts on direct and indirect beneficiaries are not clear from the M&E plan presented. In the question-and answer session, the AE mentioned that this shall be realized as a first step during project inception – however, it would have been useful and could also have provided more clarity on the budget, if this had been done beforehand.

36. The iTAP considers the alignment of the project with the priorities of the host country government to be high and assesses the track record of the executing entities involved as high. Overall, the iTAP rates country ownership of the funding proposal as high.

1.7 Efficiency and effectiveness *Scale: Medium*

37. The total investment amount is USD 37 million with USD 33 million from GCF with a co-financing ratio of 11 per cent. This is considered a low co-finance ratio for an activity that requires continuous (government) funding to be sustainable.

38. A valuation of economic benefits has been conducted using aspects such as avoided costs on morbidity and mortality. The project scenarios generate consistently moderate or high returns with an economic internal rate of return of on average 13 per cent, which is above the social discount rate of 9 per cent. The financial viability of the project is not calculated as project interventions are considered public in nature, and the beneficiaries are largely subsistence-based, with no expected financial returns or revenues through this project.

39. Overall, the iTAP rates the efficiency and effectiveness of the funding proposal as medium.

II. Overall remarks from the independent Technical Advisory Panel

40. Overall, the funding proposal is comprehensive, and although there are various risks and weaknesses (as highlighted above), it shows a credible pathway to achieving notable impacts.

41. The iTAP recommends that the Board approve this funding proposal.

42. It is recommended that, together with the Ministry of Health, the project develops a feasible financial strategy with increasing financial participation of national and local governments and clear annual targets of increased health expenditure in the districts involved, including also the development of feasible, realistic plans to roll out the climate-resilient health facility infrastructure approach in additional facilities. This is considered critical for ensuring the sustainability of efforts and to achieve a sustained impact.

43. It is recommended that the AE prepare a monitoring and evaluation system that explains how the monitoring and evaluation system will be used to assess the outcomes of adaptation activities and the quantification of the adaptation beneficiaries.

Response from the accredited entity to the independent Technical Advisory Panel's assessment (FP244)

Proposal name:	Climate Resilient Health and Well-Being for Rural Communities in southern Malawi (CHWBRC)
Accredited entity:	Save the Children Australia
Country:	Malawi
Project:	Small

Impact potential
Thank you for your positive comments and the medium-high rating for the impact potential. We acknowledge the feedback that interventions are not linked to a stable funding source. While some activities will have a national impact (such as climate resilient health facilities) and support the Ministry of Health, we recognize there is still a need to extend infrastructure work to more climate-vulnerable healthcare facilities and districts. The project aims to support the government's efforts to attract or allocated more resources to the health sector over the coming years.
Paradigm shift potential
Thank you for your comments. We acknowledge the gap regarding reliance on external funding. Malawi is the world's 8th poorest country, facing severe public financing challenges. Government revenue is largely spent on staff salaries and debt servicing. Reliance on development partners is high, especially in the health sector. Economic challenges (44% devaluation in 2023), compounded by climate events, have been severe. Significant efforts are needed to improve public financing for health. The project will focus on quality implementation and showcasing impact to build momentum for progress in the financing and delivery of climate resilient health services in climate-vulnerable districts.
Sustainable development potential
Thank you for the medium-high rating and positive comments on the project's contribution to the SDGs and its social, environmental, and gender co-benefits. The AE acknowledges concerns about sustainability due to the lack of continuous financial support post-implementation. However, we believe there is enough political momentum and recognition from the MoH regarding the need for investment in this area. With the projects engagement, support, and advocacy, leveraging the Project Steering Committee and Technical Advisory group, it will support the MoH in developing a financing plan and commitment for continued investments in climate-resilient health systems.
Needs of the recipient
Thank you for the high rating. We agree that Malawi has high vulnerability to climate change and high need for adaptation finance. We believe the design of the CHWBRC project responds well to these needs through its aim of strengthening adaptation to climate change in the health sector.

Country ownership
Thank you for the high rating along with positive feedback on the alignment of the CHWBRC with relevant national climate change and health priorities, policies and plans, in addition to the positive comments on the broad and intensive stakeholder consultations, and on the significant experience of Save the Children and of the Ministry of Health. Responses to comments on the M&E plan are presented in the Overall Remarks section below.
Efficiency and effectiveness
Thank you for the medium rating. Despite the 11% co-financing ratio being deemed low by iTAP, we believe private sector co-financing is significant because: • the private sector grants represent some of the largest in the climate and health projects. Our co-financers remain highly engaged and interested and we recently hosted the President of Global Health GSK in Malawi, who considered the project one of their most important globally. • co-financing has brought in strategic partnerships enhancing the project's credibility and reach. This includes parallel financing from Rockefeller Foundation, Global Fund and exploring private sector partnerships with the Clinton Health Access Initiative.
Overall remarks from the independent Technical Advisory Panel: We are pleased that iTAP has endorsed our project to the Board and address the following comments: • We acknowledge the recommendation to develop a sustainable financial strategy with the MoH. Malawi aims for self-reliance by 2063, with each sector, including health, striving for increased public financing. Climate events have cost the economy an average of 1.7% of GDP annually over the past 3-5 years. Therefore, significant increases in public health financing are unlikely in the next 5-10 years. The project will focus on high-quality, impactful implementation with the MoH, mobilising resources to expand the work in climate-vulnerable districts. It will support the Health Strategy Financing Roadmap to support boosting funding for a climate-resilient healthcare system. • The project's M&E plan will be further developed during project inception to comprehensively assess outcomes and outputs on climate resilience.

Save the Children

Climate Resilient Health and Well-Being for Rural Communities in southern Malawi (CHWBRC)

Annex 8: Gender Assessment and Project Level Action Plan

Accredited Entity: Save the Children Australia

Version: Final B.40 - 20 September 2024

LIST OF ACRONYMS	
APDM	Association for People with Disabilities in Malawi
CPRD	Convention on the Rights of Persons with Disabilities
CRC	Convention on the Rights of the Child
DCCMS	Department of Climate Change and Meteorological Services
DDF	District Disability Fora
DHAP	District Health Adaptation Plan
EWARS	Early Warning, Alert and Response System
FEDOMA	Federation of Disability Organisations in Malawi
GBV	Gender-Based Violence
GESI	Gender Equality and Social Inclusion
ILO	International Labour Organisation
IPV	Intimate partner violence
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MEAL	Monitoring, evaluation, accountability, and learning
MGDS	Malawi Growth and Development Strategy
MHPSS	Mental Health & Psychosocial Support Network
MK	Malawian kwacha
MoH	Ministry of Health
MoGCDSW	Ministry of Gender, Community Development and Social Welfare
MP	Member of Parliament
MPHIA	Malawi Population-Based HIV Impact Assessment
MUAC	Mid-upper arm circumference
NGO	Non-Governmental Organisation
NPV	Non-partner violence
OECD	The Organisation for Economic Co-operation and Development
PHC	Primary Healthcare
TA	Traditional Authority
TVET	Technical and Vocational Education and Training
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WASH	Water sanitation and hygiene

Table of Contents

Gender equality and Social Inclusion Assessment

Introduction

1. Malawi is exposed to climatic changes, and the country's Southern Region is prioritised for climate adaptation in the National Adaptation Plan of Action (2006) and draft National Adaptation Plan (2016) due to its high exposure to climate risks and impacts, in combination with high vulnerability. The major climatic drivers that southern Malawi faces and that this project seeks to address are: increasing mean temperatures, decreasing mean precipitation, increases in precipitation-related extremes and increases in temperature-related extremes; the related climate hazards are increased flooding, increased high/extreme heat events, and increases in droughts (as detailed in Annex 2, sections 3.1 and 3.2). The increased health-related impacts from climatic changes (e.g. increased disease burdens) will reduce human well-being and likely increase poverty, and the impacts of climate change on health disproportionately affect women, children, and other marginalised groups who face inequality and barriers in daily life[1]. For instance, during climate-related disasters (e.g., floods), disparities put women and those with disabilities at higher risk of injury and death, hindering their access to relief and perpetuating vulnerability[2]. Women and girls also become more vulnerable to gender-based violence, including sexual harassment, sexual exploitation, including transactional sex, being trafficked , intimate partner violence and child marriage[3]. As another example, studies have also shown that climate change hazards negatively impact women's mental health and well-being[4]. As a final example, 82% of Malawi's population lives in rural areas, and women account for 65% of smallholder farmers[5], making them particularly exposed to food insecurity resulting from climatic changes and their impacts on agriculture. As many women are dependent on natural resources, and most earn a living in the informal sector, this leaves them less able to withstand economic and environmental shocks.[6] Women in Malawi are particularly sensitive to climate-driven food insecurity due to increased nutritional needs during menstruation and childbirth[7].

2. The Climate Resilient Health and Well-being for Rural Communities in southern Malawi (CHWBRC) project aims to transform practices, institutional and human capacity to improve the health and wellbeing of 1,798,650 people (out of which 899,325 are women), with a particular focus on women, children and people with disabilities. Gender and social norms reflect structural drivers of differential vulnerability which need to be recognised and understood in order to enable equitable benefits from project participation, and support gender and social inclusion transformation .
3. This document sets out a gender equality and social inclusion (GESI) assessment for Malawi and the project area, and then outlines how GESI-sensitive approaches are embedded across all project activities to reduce differential vulnerability to climate change.

   The domains of analysis are:

   - Law, policy and institutions.
   - Social norms and beliefs.
   - Roles, responsibilities and resources.

[1] The Office of the High Commissioner for Human Rights (2022) *The impacts of climate change on the human rights of people in vulnerable situations*. Report of the Secretary-General. Office of the United Nations High Commissioner for Human Rights, Geneva, Switzerland. Available at: https://www.ohchr.org/en/documents/thematic-reports/ahrc5057-impacts-climate-change-human-rights-people-vulnerable.

[2] Fruterro, A. *et al*. (2023) *Gendered impacts of climate change: evidence from weather shocks*. Policy Research Working Papers 10442. The World Bank, Washington DC, USA. Available at: https://openknowledge.worldbank.org/handle/10986/39813.

[3] Matekaire, T, and Carey, T., (2023, April 24) *Climate Change In Malawi Is Putting Women And Girls At Greater Risk Of Sexual And Gender-Based Violence*. Equality Now. https://www.equalitynow.org/news_and_insights/climate-change-in-malawi-is-putting-women-and-girls-at-greater-risk-of-sexual-and-gender-based-violence/ and Carey, T., (2023, June 12*) Cyclone Freddy Has Put Women & Girls In Malawi At Greater Risk Of Sexual Abuse & Exploitation.* Equality Now. https://www.equalitynow.org/news_and_insights/malawi-cyclone-freddy-has-put-women-girls-in-malawi-at-greater-risk-of-sexual-abuse-exploitation/

[4] Dahnoun, Y. (2022, August 18), *Bearing the Brunt.* The Ecologist. https://theecologist.org/2022/aug/18/bearing-brunt.

[5] World Bank Indicators (2022) Rural population (% of total population) | Data (worldbank.org)

[6] Danish Trade Union Development Agency (2022) Malawi Labour Market Profile. https://www.ulandssekretariatet.dk/wp-content/uploads/2022/03/LMP-Malawi-2022-Final1.pdf

[7] Watts *et al*. (2018) The 2018 report of The Lancet, *Countdown on health and climate change: shaping the health of nations for centuries to come*. The Lancet 392: 2479-2514. Doi: 10.1016/S0140-6736(18)32594-7.

- Decision making, leadership and participation.
- Differential vulnerability to climate change and extremes.
- Access to and control of resources; and
- Gender-based violence.

4. The analysis is based on a literature review, key informant interviews and focus groups with women in target communities from across the six target districts. The action plan then outlines, in alignment with the MEAL plan, indicators, targets and budget that will ensure equitable benefits from project participation and how the project contributes to overall GESI transformation.

5. Gender equality refers to the absence of discrimination on the basis of sex. For Save the Children, gender equality is when one sex is not routinely privileged or prioritized over the other, and all people are recognized, respected and valued for their capacities and potential as individuals and members of society. Further, gender equality is when girls, boys, women, and men have equal rights, obligations and opportunities to: security and good health; a viable livelihood and dignified work; participate in the care of home and dependent family members; take active part in public and political life; learn and participate in relevant education; and live a life free from violence. This means that rights, responsibilities, and opportunities will not depend on the gender society attributes to each person[8].Social Inclusion refers to the inclusion of those who are excluded from political, economic and societal processes, which prevents their full participation in society. In Malawian contexts, social identities such as socio-economic status, rurality, HIV status and (dis)ability, both explicitly and tacitly exclude people from services, participation, and opportunities. Moreover, having multiple and intersecting identities in addition to gender, often leads to greater marginalisation and disadvantage[9].

Methodology

6. The team used a combination of primary and secondary methods:
    - Literature review of policy documents, project reports and published research.
    - Focus group discussions with men, women, pregnant and breastfeeding women, and people with disabilities in selected locations from across the six target districts, using standard question guides and in local languages.
    - Key informant interviews were conducted with key district level staff and representatives of disability NGOs.

Focus groups with women, and pregnant and breastfeeding women

7. Focus group discussion guides for women, and pregnant and breastfeeding women, covered the same topics as highlighted above under the section on the men's focus groups.

Focus groups with children

8. Focus groups was conducted with three boys and three girls aged 14 and 15. The focus group discussion guide for children included the following broad topics, to elicit information on the specific impacts of climate change on children:
    - Their perception and understanding of climate change.
    - Their experience of any climate change effects, with some examples, including whether climate change affected livelihoods.
    - The existence and condition of WASH facilities in their schools.
    - Their views on priority climate adaptations areas.

Focus group discussions with Men

9. Focus group discussion guides for men covered a range of topics, prompted both by the initial project design and by the need to elicit information on the gendered impacts of climate change (to inform the GESI action plan). The views of men on the following broad topics (which were used as departure points for discussion) were solicited:
    - Their experiences and perceptions of climate hazards affecting their community.

[8] Save the Children (n.d.) *Principles for Gender Equality.* Save the Children Canada, Toronto, Canada. Available at: https://resourcecentre.savethechildren.net/pdf/principles_for_gender_equality.pdf/.
[9] UN Department of Economic and Social Affairs (2010) *Analysing and measuring social inclusion in a global context*. United Nations, New York, USA. Available at: https://www.un.org/esa/socdev/publications/measuring-social-inclusion.pdf.

- Their perceptions and experiences of the manner in which climate change affects health, and of the most common climate change-induced diseases; particular attention was paid to how the health of children, pregnant and breastfeeding mothers may be affected by climate change.
- Their knowledge level on nutrition-related issues (complimentary supplementary foods, the six food groups, etc.) and the existence of any partners supporting the provision of complementary foods.
- Their perceptions of access to antenatal care during disasters and post-disaster periods.
- Their views on activities that could be implemented for children, pregnant women and breastfeeding mothers to improve the latter's health and nutrition so as to minimise the impacts of climate change.
- Their perceptions regarding the inclusion of women in village-level decision-making structures.
- Their views on priority climate adaptations areas for their community.

Focus groups and key informant interviews with people with disabilities

10. The focus group discussion and key informant interview guides for people with disabilities included the following broad topics: the main institutions existing in the district that deal with issues of disability, and their roles (including in decision-making on key areas e.g., health, nutrition) and types of projects; what are the barriers that people and children with disabilities face; what are the barriers that people with disabilities face in accessing health care services, particularly during climate crises; and what is the representation of people with disabilities in village-level structures.

Key Findings

11. Malawi's gender inequality is pronounced, as indicated by the international gender indices (Table 1), which show high levels of inequality.

12. National gender and disability policies and legislation exists, and Malawi is signatory to regional, continental and international equality agreements. Gender and, to a lesser extent disability, is represented as a cross-cutting issue in national policies on climate change, disaster risk reduction, health and agriculture.
13. Policy implementation is weak, with few strategies and actions plans to operationalise policies, and little public evidence of monitoring and evaluating plans, strategies or policies. These challenges are compounded by an ongoing – but still incomplete – process of policy decentralisation that muddies the lines of accountability and reporting vertically (between line ministries at national and district level) and horizontally (across sectors at national level and local level). This has particular implications for the (lack of) implementation of gender and social inclusion as cross-cutting issues in sectoral policies.
14. There has been effort to integrate women in formal decision-making structures at national government, in districts, and in decision making fora at community level While there has been some shift in gender norms around women's participation, women remain under-represented in household, community and political decision-making processes[10].
15. Negative gender norms lead to differential access to resources and assets in multiple[11,12,13] domains, and at multiple levels (including down to the intra-household level). Although some parts of Malawi are matrilineal, this creates inheritance lines to and from husbands and sons of the women, and the society is still strongly patriarchal. Under customary law, women's access to land is also typically mediated through male family members.

[10] AfDB – African Development Bank. Republic of Malawi, Country Gender Profile, Current state of Gender Equality and Women Empowerment. Abidjan, Côte d'Ivoire: African Development Bank Group; 2020. p. 14, 46, 12, 24, 70, 28, 29. (https://www.afdb.org/en/documents/malawi-country-gender-profile-2020).

[11] Chirwa, E. W. (2008). Land tenure, farm investments and food production in Malawi. Research Paper No. 18. Future Agricultures Consortium.

[12] Peters, P. E. (2010). "Our daughters inherit our land, but our sons use their wives' fields": Matrilineal-matrilocal land tenure and the New Land Policy in Malawi. Journal of Eastern African Studies, 4(1), 179-199.

[13] Takane, T. (2008). Customary Land Tenure, Inheritance Rules, and Smallholder Farmers in Malawi. IFPRI Discussion Paper 00758. International Food Policy Research Institute

16. Gender-based violence remains a significant problem, including in post-disaster settings[14,15,16] and girl children continue to have fewer opportunities than boy children, reinforcing situations of gender inequality.
17. Women and girls with disabilities are at greater risk of gender-based violence (including non-partner violence (NPV) and intimate partner violence (IPV) than women and girls without disabilities[17,18,19]. Women and girls with disabilities face a complex set of risk factors that compound their challenges including a combination of gender inequality, stigma, and discrimination against people with disabilities.
18. Both men and women with disabilities continue to face stigma that prevent them from equal access to opportunities and active participation in society, and this is particularly true for women and girls with disabilities[20,21,22] and males and females with psychosocial and intellectual disabilities.

Table 1. Summary of Malawi's position in different global gender indices

Index	**Rank/Score**	**Notes**
Global Gender Gap Index (World Economic Forum)[23]	0.632, ranks 122 out of 146 (2022)	Scores well in health and survival; average in economic participation and opportunity; and below average in political empowerment and educational attainment.
Gender Inequality Index (UNDP)**[24]**	0.565, ranks 142 out of 161 (2019)	Small gender gap in labour force participation, population with at least some secondary education; large gender gap in share of seats in parliament.
Social Institutions and Gender Index (OECD)**[25]**	41%, high level of discrimination	High inequality in restricted civil liberties; medium inequality in restricted access to productive and financial resources and discrimination in the family; less inequality in restricted physical integrity (physical integrity which comprised of violence against women and female genital mutilation)

Key Data[26]

- The population in Malawi at last count in 2018 was 17,563,749, of which 49% (8,521,456) are men and 51% (9,042,293) are women.

[14] UN Women. (2015). The Effect of Gender Inequality on Disaster Recovery: Gender Inequality and Violence in Disaster Settings. UN Women. Retrieved from UN Women
[15] Government of Malawi & UNICEF. (2017). Situation Analysis of Children and Women in Malawi. Lilongwe: UNICEF Malawi. Retrieved from UNICEF Malawi
[16] Human Rights Watch. (2014). "I've Never Experienced Happiness": Child Marriage in Malawi. Retrieved from Human Rights Watch
[17] World Health Organization. (2011). World Report on Disability. World Health Organization. Retrieved from World Health Organization
[18] Human Rights Watch. (2018). "As Long as They Let Us Stay in Class": Barriers to Education for Persons with Disabilities in China. Human Rights Watch. Retrieved from Human Rights Watch
[19] United Nations. (2018). Disability and Development Report - Realizing the Sustainable Development Goals by, for and with persons with disabilities. United Nations. Retrieved from United Nations
[20] Ibid.
[21] World Health Organization. (2011). World Report on Disability. World Health Organization. Retrieved from World Health Organization
[22] Committee on the Rights of Persons with Disabilities. (2016). General comment No. 3 (2016) on women and girls with disabilities. United Nations. Retrieved from OHCHR
[23] World Economic Forum (2022) Global gender gap report. World Economic Forum, Geneva, Switzerland. Available at: https://www3.weforum.org/docs/WEF_GGGR_2022.pdf.
[24] United Nations Development Programme (2023) Gender inequality index. United Nations Development Programme, New York, USA. Available at: https://hdr.undp.org/data-center/thematic-composite-indices/gender-inequality-index#/indicies/GII.
[25] OECD (2019) Social Institutions and Gender. OECD, Paris, France. Available at: https://data.oecd.org/inequality/social-institutions-and-gender.htm.
[26] NSO (2017) Malawi demographic and health survey. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=222&Itemid=108; AFDB *et al*. (2020) Republic of Malawi, Country Gender Profile. African Development Bank, Abidjan, Côte d'Ivoire. Available at: https://www.afdb.org/en/documents/malawi-country-gender-profile-2020. Government of Malawi (2018) . Census 2018 - Malawi Data Portal (opendataforafrica.org)

• Population growth rate is high, with an increase of 35% since 2008.
• The population is youthful: 3% of the population are under the age of one, 14.5% (7.3% female and 7.2% male) are under five years old, 15% are aged 5-9 (7.6% female and 7.4%male), 14.4% are aged 10-14 (7.3 female and 7.1 male), 11.6% are aged 15-19 (5.9% female and 5.7% male). and 44.5% of the population were 20 or over, and 4% of the population were 65 years or older. The median age is 17.
• Ethnically Malawi comprises several tribes: 6.0 million people (34.4%) are Chewa, 3.3 million people (18.9%) are Lomwe, 2.3 million people (13.3%) are Yao, 1.8 million people (10.4%) were Ngoni, and 1.6 million people (9.2%) are Tumbuka. • The population is largely rural (84%), with only 16% living in cities (mostly in the four major cities of Blantyre, Lilongwe, Mzuzu and Zomba). The proportion of the population living in urban areas only increased by 0.7 percentage points between 2008 and 2018. • 44% of the population lives in the Southern Region, 43% lived in the Central Region and 13% lived in the Northern Region. • Informal employment predominates, comprising 89% of employed persons. Informal employment is more prevalent in rural than urban areas, and more prevalent among women than men. • Labour force participation rate is lower for women (73%) than men (82%) and unemployment is higher among women (26%) than men (14%). Women are far less likely than men to be paid for their labour (59% of women reporting not being paid for work compared to 26% of men). • In terms of poverty, 57% of female-headed households are poor compared to 43% of male-headed households, due to their engagement in low-income activities and unpaid care, limited ability to engage in decision-making, limited access to resources and assets, higher illiteracy rates, and inadequate access to systems and services including education and healthcare[27]. • Seven out of ten women report encountering at least one obstacle to accessing health care. The most commonly reported problems included “distance to the health facility (56%) … obtaining money to pay for treatment (53%) … not wanting to go alone (30%) or needing to obtain permission to go for treatment (16%)”. Women have poor control over reproductive control and remain highly vulnerable to HIV transmission. • Child nutrition is poor, with 37% of children under age 5 stunted (short for their age); 3% wasted (thin for their height); 12% underweight (thin for their age) and 5% overweight (heavy for their height). Feeding practices of only 8% of children aged 6–23 months meet the minimum acceptable dietary standards. • The Malawi Population-Based HIV Impact Assessment (MPHIA) carried out by the Malawi Ministry of Health in 2015-2016 found HIV prevalence among adult women (aged 15-64) to be 12.8%, compared with 8.2% among adult men. In 2018, 4.3% of young women were living with HIV, compared to 2% of young men. • Disability prevalence rates for Malawians aged 5 or older with at least one disability is 10.4% (men 10% and women 11%)[28]. In 2015/16, 29% of children aged 2–9 were reported to have at least one functioning problem or disability[29], while Albinism prevalence is at 0.8%[30]. • Despite improvements over the years, there are gender differences in education access, particularly at secondary level, where girls have poorer educational outcomes than boys, and women have higher rates of illiteracy than men.

Laws, Policy and Institutional Arrangements

19. Gender equality is enshrined in the Constitution of Malawi, which prohibits any discrimination on the basis of “race, colour, sex, language, religion, political or other opinion, nationality, ethnic or social

[27] NSO (2017) Malawi demographic and health survey. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=222&Itemid=108; AFDB *et al*. (2020) Republic of Malawi, Country Gender Profile. African Development Bank, Abidjan, Côte d’Ivoire. Available at: https://www.afdb.org/en/documents/malawi-country-gender-profile-2020.
[28] NSO (2019) 2018 Malawi population and housing census. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=226&Itemid=6.
[29] NSO (2017) Malawi demographic and health survey. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=222&Itemid=108.
[30] NSO (2019) 2018 Malawi population and housing census. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=226&Itemid=6.

origin, disability, property, birth or other status"[31] (section 24). Specifically, gender equality is one of the fundamental principles (section 13a) which aims "To obtain equality for women through (a) full participation in all spheres of Malawian society on the basis of equality; (b) the implementation of the principles of non-discrimination and such other measures as may be required; and (c) the implementation of policies to address social issues such as domestic violence, security of the person, lack of maternity benefits, economic exploitation, and rights to property'.

20. Malawi is a signatory to major international commitments to achieving gender equality, including the Convention on the Elimination of Discrimination Against Women, the Beijing Declaration and Platform for Action, and the Southern African Development Community Protocol on Gender and Development.

21. The Gender Equality Act was passed in 2013[32], with the aim to "promote gender equality, equal integration, influence, empowerment, dignity and opportunities, for men and women in all functions of society, to prohibit and provide redress for sex discrimination, harmful practices and sexual harassment, to provide for public awareness on promotion of gender equality and to provide for connected matters". The National Gender Policy 2015[33] aims to reduce gender inequality and enhance "participation of women, men, girls and boys in socio economic and political development". It also includes goals to advocate for increased access to, retention and completion of quality education for girls and boys; to ensure the sexual and reproductive health rights of women, men, boys and girls, and to improve the status of HIV and AIDS; to strengthen gender mainstreaming in all sectors of the economy; to reduce poverty among women and other vulnerable groups (orphans, widows, people living with HIV and AIDS, persons with disabilities, the elderly) through economic empowerment; to promote women's participation in decision-making positions in both politics and public life; to reduce gender-based violence; and to strengthen the capacity of the National Gender Machinery[34].

22. With regard to disability, Malawi ratified the Convention on the Rights of Persons with Disabilities (CRPD), which provides the international policy framework on disability, in 2009. The Government also developed several laws and policies to promote, fulfil and protect rights of people with disabilities. The Disability Act was passed in 2012[35], with the aim "to make provision for the equalisation of opportunities for persons with disabilities through the promotion and protection of their rights; to provide for the establishment of a Disability Trust Fund; and to provide for matters connected with or incidental to the foregoing". The National Policy on Equalisation of Opportunities for Persons with Disabilities 2006[36] aims to ensure that concrete steps are taken for people with disabilities to access the same fundamental rights and responsibilities as any other Malawian citizen. This has been supplemented in 2018 by a National Disability Mainstreaming Strategy and Implementation Plan[37] which aims to bridge the gap between policy and practice. Additional policies include for Child Care, Protection and Justice Ac (2010), National Youth Policy and the National Sports Policy. The Disability Act (2012) incorporates provisions of the Convention on the Rights of the Child (CRC) and the CRPD. There is also a draft Persons with Disabilities Bill 2019 which seeks to build on the shortfalls in the current Disability Act to fully domesticate the UN CRPD and to strengthen national response mechanisms on disability[38]. Despite availability of all the above policy commitments, children and adults with disabilities

[31] Constitution of the Republic of Malawi (1994) Available at: https://www.malawi.gov.mw/index.php/resources/documents/constitution-of-the-republic-of-malawi?download=44:constitution-of-malawi.

[32] Malawi Government (2013) Gender Equality Act (No. 3 of 2013) Government of Malawi, Lilongwe, Malawi. Available at: https://www.gender.gov.mw/index.php/documents/policies?download=12:gender-equality-act-no-3.

[33] The Republic of Malawi (2015) National Gender Policy: second edition. Ministry for Gender, Children, Disability and Social Welfare. Government of Malawi, Lilongwe, Malawi. Available at: https://cepa.rmportal.net/Library/government-publications/National%20Gender%20Policy%202015.pdf.

[34] The so-called "national gender machinery" is established to coordinate government interventions to promote gender equality, and consists of a network of national institutions, mechanisms and processes coordinated by a central policy coordination body (https://www.cmi.no/publications/5880-the-gender-machinery-women-in-malawis-central).

[35] Malawi Government (2012) Disability Act (No. 8 of 2012). Malawi Government, Lilongwe, Malawi. Available at: https://afri-can.org/wp-content/uploads/2019/08/Governement_of_Malawi_Disability_Act_2012.pdf.

[36] Republic of Malawi (2006) National Policy on Equalisation of Opportunities for People with Disabilities. Ministry of Persons with Disability and the Elderly, Lilongwe, Malawi. Available at: https://www.malawi.gov.mw/index.php/proud/thuwala/candis?download=42:malawi-national-policy-on-equalisation-of-opportunities-for-persons-with-disabilities.

[37] Malawi Government (2018) National Disability Mainstreaming Strategy and Implementation Plan 2018–2023. Government of Malawi, Lilongwe, Malawi. Available at: http://rodra.co.za/images/countries/malawi/policies/National%20Disability%20Mainstreaming%20Strategy_FINAL%20AND%20PRINTED-2.pdf.

[38] Chikasamba, H. (2019) Malawi: revised country report. Centre for Human Rights, University of Pretoria, Pretoria, South Africa. Available at: http://rodra.co.za/country-reports-malawi/22-countries/malawi/62-malawi-updated-country-report.

continue to experience significant barriers to sanitation, education, health and protection[39]. A range of other policies, plans, strategies and international agreements make reference to gender and disability (Table 2**Error! Not a valid bookmark self-reference.**).

23. In Malawi, individuals with albinism[40] are recognized as having a disability and are especially vulnerable. The Government of the Republic of Malawi has implemented legislative and institutional measures, for example, the National Action Plan on Persons with Albinism (2018), a multi-sectoral National Technical Committee on Abuse of Persons with Albinism and training of police prosecutors and magistrates across the country in prosecuting cases of attacks against persons with albinism, among other measures. The Malawi judiciary has introduced specialised High Court divisions; was working towards the re-introduction of a functional e-case management system; had developed the capacity of judicial officers, increased the number of judges, and revamped and scaled up the use of mobile court[41].

24. Several policies and mechanisms have been put in place to improve the situation of youth[42] in Malawi[43]: national development frameworks and sectoral policies are concerned with youth development issues, particularly employment. In addition, recent institutional mechanisms have been set up to facilitate youth participation and representation in policy processes. Malawian youth are entitled to the rights enshrined in international conventions, such as the Universal Declaration of Human Rights (UDHR, 1948), ILO Minimum Age Convention (1973), Convention on the Rights of the Child (CRC, 1989) and African Youth Charter (2006). Malawi has enacted a number of laws featuring youth. Central among them is the National Youth Council Act (1996), which includes provisions for the "promotion, coordination and implementation of youth development programmes in Malawi; the establishment of the National Youth Council of Malawi (NYCOM); and to further provide for matters incidental thereto or connected there within"[44]. At the legislative and policy level, the following acts and policy plans are also worth mentioning: the Childcare, Protection and Justice Act (2010), the HIV/AIDS Prevention Management Act (2018), the National Children's Commission Act (2019), the National Action Plan on Trafficking in Persons (2017-2022), the National Strategy on Adolescent Girls and Young women (2018-2022), the National Strategy on Ending Child Marriages (2018-2022) and the National Action Plan on Child Labour (2019-2025). The National Youth Policy (2013) aims at providing an enabling environment for the youth to develop their full potential based on seven policy priorities. The overall objective of the National Youth Policy (2013) is to provide a framework that guides youth development and the implementation of all youth programmes that contribute to improving the welfare of Malawian youth. The policy is a revised version of the 1996 National Youth Policy and was adopted to address the new challenges and emerging issues currently facing Malawian youth. It identifies seven policy priority areas for action: i) youth participation and leadership; ii) youth economic empowerment; iii) national youth service; iv) education for youth; v) youth and science, technology and environment; vi) youth health and nutrition; and vii) social services, sports, recreation and culture[45]. Whilst these measures demonstrate the government of Malawi's intent to implement the rights of children and youth, challenges exist in the implementation of these measures[46].

[39] Ebuenyi, I.D. *et al.* (2021) Exploring equity and inclusion in Malawi's National Disability Mainstreaming Strategy and Implementation Plan. International Journal for Equity in Health volume 20: 18. https://doi.org/10.1186/s12939-020-01378-.

[40] Albinism is a relatively rare, non-contagious, genetically inherited condition resulting in little to no pigmentation in the skin, hair and eyes. The condition affects people worldwide regardless of ethnicity or gender. Persons with albinism are highly vulnerable to skin cancer and often have disabilities, mainly as a result of vision impairment and skin impairment.

[41] The Office of the High Commissioner for Human Rights (2023) Experts of the Committee on the Rights of Persons with Disabilities acknowledge Malawi's efforts to implement the convention, ask questions on persons with disabilities' involvement in disaster management and measures to promote sign language. Office of the United Nations High Commissioner for Human Rights, Geneva, Switzerland. Available at: https://www.ohchr.org/en/news/2023/08/experts-committee-rights-persons-disabilities-acknowledge-malawis-efforts-implement.

[42] Following the Malawi revised National Youth Policy (2022) [not publicly available], youth is defined as 10-29 years of age (children therefore fall below age 10).

[43] OECD Development Centre (2018) Youth Well-being Policy Review of Malawi. EU-OECD Youth Inclusion Project, Paris. Available at: https://www.oecd.org/countries/malawi/Youth-well-being-policy-review-Malawi.pdf.

[44] Government of Malawi (1996) National Youth Council of Malawi Act. Available at: https://malawilii.org/akn/mw/act/1996/22/eng%402014-12-31.

[45] Republic of Malawi (2013) National Youth Policy. Ministry of Youth and Sports, Lilongwe, Malawi. Available at: https://www.npc.mw/wp-content/uploads/2020/07/National_Youth_Policy.pdf.

[46] OECD Development Centre (2018) Youth Well-being Policy Review of Malawi. EU-OECD Youth Inclusion Project, Paris. Available at: https://www.oecd.org/countries/malawi/Youth-well-being-policy-review-Malawi.pdf; Humanium (2021) Children of Malawi: realizing children's rights in Malawi. Humanium, Tannay, Switzerland. Available at: https://www.humanium.org/en/malawi/.

25. Currently gender, children and disability fall under the remit of the same ministry, the Ministry of Gender, Community Development and Social Welfare (MoGCDSW) [47], which is mandated to promote gender equality and protect the welfare of Malawian women, men, girls and boys to become self-reliant and active participants and beneficiaries of the national development agenda. Strategic objectives for the Ministry include reduced gender inequalities among men, women, boys and girls; enhanced effective and sustainable socio-economic development; a conducive environment for the survival, growth and development of all children; resilience and self-reliance among vulnerable groups of people; and improved lives of persons with disabilities and elderly people.
26. Gender equality and social inclusion is actively considered in Malawi's long and medium-term development plans. Vision 2063[48] states that gender inequalities shall "be addressed to improve the socio-economic status of people in Malawi by accelerating the pace of inclusive wealth creation. Fundamentally, gender equality will be advanced at all levels through multi-sectoral approaches and the in-depth multi-disciplinary analysis of issues at the household, community and national level […] Way before 2063, Malawi shall have eliminated all gender-based discrimination and harmful practices, including gender-based violence and child marriages". In the enabler 5 on human capital development, gender transformative approaches are promoted as part of approaches to better target different groups, and the importance of implementing the Gender Equality Act is reinforced. Vision 2063 also recognises the existence of compounded and recurring shocks, including those from climate and health hazards, and that there needs to be shock sensitivity of the social protection system. The Malawi Growth and Development Strategy (MGDS) III[49] (2017-22) aims to move Malawi to a "productive, competitive and resilient nation". Cross-cutting themes for successful implementation include "gender balance; youth development; empowerment of persons with disability" as well as disaster risk reduction and resilience building. In particular two of the goals in MGDS III are to "[r]educe vulnerability and enhance the resilience of the population to disasters and socio-economic shocks' and "[t]o build an equitable society where opportunity is not defined by sex, age, disability and other vulnerabilities". Intended outcomes from MGDS III include "[g]ender mainstreamed in all sector plans, policies, programmes and development frameworks" and "[i]ncreased women and youth representation in all decisions", amongst others.

27. Key policies relating to resilience, climate change and disaster risk reduction also pay due attention to the importance of gender equality and social inclusion. The National Resilience Strategy[50] has four key pillars as part of its commitment to breaking the cycle of food insecurity, with gender and strengthening women's empowerment as a cross-cutting issue. The National Resilience Strategy also recognises the reality of different starting points by distinguishing different pathways for three different wealth categories: hanging in, stepping up and stepping out, with different interventions and trajectories for each. The strategy also includes a section on "equity and inclusiveness" which states that implementation of the National Resilience Strategy "shall ensure that all people, irrespective of their geographic location, sex, age, religion, political or other opinion, ethnicity or social origin, disability or other status are resilient to economic and environmental shocks that affect their lives and livelihoods. To be effective, resilience interventions will address age and gender specific needs, vulnerabilities and deprivations, and socio-economic inequities of affected people, and be reflected in their design, implementation, monitoring and reporting. The National Resilience Strategy will promote gender equality, including through targeted agricultural interventions for women and vulnerable groups".

28. The National Climate Change Management Policy 2016[51] also includes gender, population dynamics and HIV and AIDS as cross-cutting issues of the policy, committing to mainstream gender and issues affecting the disadvantaged groups into all climate change strategies, plans and programmes. And committing to integrate population issues into climate change management in the development agenda

[47] http://www.gender.gov.mw/

[48] NPC (2020) Malawi's Vision 2063: an inclusively wealthy and self-reliant nation. National Planning Commission, Government of Malawi, Lilongwe, Malawi. Available at: https://malawi.un.org/en/108390-malawi-vision-2063-inclusively-wealthy-and-self-reliant-nation.

[49] Malawi Government (2017) The Malawi Growth and Development Strategy (MGDS) III: building a productive, competitive and resilient nation. Malawi Government, Lilongwe, Malawi. Available at: https://malawi.un.org/en/42159-malawi-growth-and-development-strategy-mgds-iii-2017-2022.

[50] Government of Malawi (2019) Malawi National Resilience Strategy (NRS) (2018–2030): breaking the cycle of food insecurity duration. Office of the President and Cabinet Department of Disaster Management Affairs, Government of Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/reports/national-resilience-strategy.

[51] Government of Malawi (2016) National Climate Change Management Policy. Environmental Affairs Department, Ministry of Natural Resources, Energy and Mining, Lilongwe, Malawi. Available at: http://www.reforms.gov.mw/psrmu/national-climate-change-management-policy-2016.

through an integrated approach which would reduce poverty, protect natural resources and reduce inequality and incorporate HIV and AIDS as well as gender considerations in all climate change interventions including adaptation, mitigation, capacity building and technology development and transfer. The accompanying Implementation, Monitoring and Evaluation Strategy[52] for the National Climate Change Management Policy outlines a number of priority areas for promoting cross-cutting issues around gender and disadvantaged groups, alongside who is responsible for implementing different objectives and the timeframes for doing so.

29. The Disaster Risk Management Policy 2015[53] and its accompanying Implementation, Monitoring and Evaluation Plan [54] recognises alignment with the National Gender Policy. However, despite commitments to a people-centred early warning system and strengthening capacity to prepare for and respond to disasters, the policy itself makes minimal reference to gender. A new Disaster Management Bill was approved in April 2023 (Bill no 9 of 2023) and is awaiting operationalisation. It includes reference to the Gender Equality Act, but no reference to disability issues.

Table 2. Summary of acts, policies, plans, strategies and international agreements with relevance to gender equality and social inclusion (source: Lovell, 2021[55])

ACTS	POLICIES	PLANS AND STRATEGIES	INTERNATIONAL AGREEMENTS
▶ HIV and AIDS (Prevention and Management) Act (2018) ▶ Land Act (2016) ▶ Marriage, Divorce and Family Relations Act (2015) ▶ Trafficking in Persons Act (2015) ▶ Gender Equality Act (2013) ▶ Disability Act (2012) ▶ Deceased Estates (Wills, Inheritance and Protection) Act (2011) ▶ Child Care, Protection and Justice Act (2010) ▶ Prevention of Domestic Violence Act (2006) ▶ Chapter XV of the Penal Code: Offences Against Morality (1930) ▶ Witchcraft Act (1911)	▶ National Social Welfare Policy Promoting Social Inclusion and Human Dignity (2018) ▶ National Sexual and Reproductive Health and Rights Policy (2017–2022) ▶ National Education Policy (2016) ▶ National Policy for Older Persons (2016) ▶ National Gender Policy (2015) ▶ National Plan of Action for Vulnerable Children in Malawi (2015) ▶ National Cultural Policy (2015) ▶ National Action Plan to prevent Gender-based Violence (2014–2020) ▶ National Youth Policy (2013) ▶ National Population Policy (2013) ▶ National Policy on Equalisation of Opportunities for Persons with Disabilities (2006) ▶ National Policy on Orphans and Other Vulnerable Children (2003) ▶ National HIV/AIDS Policy (2003)	▶ Malawi National Social Support Programme II (MNSSP II) (2018–2023) ▶ National Strategy on Ending Child Marriages (2018–2023) ▶ Malawi Growth and Development Strategy (MGDS) III (2017–2022) ▶ National Action Plan for Women Economic Empowerment (2016–2021) ▶ National Plan of Action to Combat Gender- Based Violence in Malawi (2014–2020) ▶ Gender, Children, Youth and Sports Sector Working Group Joint Sector Strategic Plan (JSSP) (2013–2017)	▶ The Southern African Development Community (SADC) protocol on Gender and Development (2008) ▶ The African Youth Charter (2006) ▶ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2005) ▶ Maputo protocol (2003) ▶ Beijing Declaration and Platform for Action (1995) ▶ UN Convention on the Rights of the Child (1989) ▶ UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979)

30. In order to mainstream gender in all policies and promote gender equality and equity in the national development system, there is a Cabinet Committee on Community and Social Affairs (advised by a Gender Advisory Committee), a Parliamentary Committee on Social and Community Affairs and a Parliamentary Women's Caucus. At technical level, there are specific Technical Working Groups on 1) Gender, Culture, HIV and AIDS and Human Rights; 2) Gender-Based Violence; and 3) Political

[52] Government of Malawi (2016) Implementation, Monitoring and Evaluation Strategy for National Climate Change Management Policy. Environmental Affairs Department, Ministry of Natural Resources, Energy and Mining, Lilongwe, Malawi. Available at: https://cepa.rmportal.net/Library/government-publications/implementation-monitoring-and-evaluation-strategy-for-national-climate-change-management-policy/at_download/file.

[53] Government of Malawi (2015) National Disaster Risk Management Policy. Department of Disaster Management Affairs, Lilongwe, Malawi. Available at: https://reliefweb.int/report/malawi/malawi-national-disaster-risk-management-policy-2015.

[54] Government of Malawi (2015) National Disaster Risk Management Policy Implementation, Monitoring and Evaluation Strategy. Department of Disaster Management Affairs, Lilongwe, Malawi.

[55] Lovell (2021), *Gender equality, social inclusion and resilience in Malawi*. BRACC discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf

Empowerment of Women[56]. The UN system has a Gender and Human Rights Technical Working Group that coordinates UN action on gender and human rights; and there is also a donor's group on Gender and Human Rights.

31. Despite a comprehensive array of policies and laws around gender equality and equal rights regardless of ability, Malawi suffers from considerable gaps in implementation[57]. This gap was particularly recognised in MGDS III, which recognised that the gender equality goals from the previous MGDS I and II were not achieved. Likewise, the National Disability Mainstreaming Strategy and Implementation Plan was introduced recognising that policies has not adequately translated into practice.
32. The gaps in implementing gender or social inclusion policies within adaptation and resilience policy and programming can be attributed to several factors. These include the persistence of discriminatory socio-cultural beliefs and practices hindering GESI progress at all levels, insufficient involvement of women and disadvantaged groups in decision-making and community planning, the absence of disaggregated data and systematic monitoring and evaluation, a lack of well-defined roles, responsibilities, and coordination mechanisms across the Ministries, Departments and Agencies, limited gender-sensitive or socially inclusive budgeting, and the failure to integrate GESI considerations into resilience policies and programmes[58].

33. While gender focal points have been designated in Ministries, Departments, and Agencies within the public sector to oversee the integration of gender considerations in their respective sectors, they often face limitations in terms of technical capacity, gender budget allocation, and opportunities to influence policies. Additionally, policies tend to assign responsibilities to other ministries without clearly defining the necessary actions to fulfil those responsibilities. Consequently, these ministries typically do not incorporate these duties into their strategic planning, budgeting processes, or implementation efforts, and mechanisms for accountability remain largely absent[59].

34. In terms of disability issues, the Government of Malawi recognizes the valuable contributions of people with disabilities to political, social, and economic development, there is still a notable gap between policy intentions and on-the-ground implementation. A clear indication of this gap is the absence of specific disability-related targets and budget allocations within the program-based budgets of many government ministries and departments. Various barriers hinder effective disability mainstreaming in different sectors, including financial and capacity limitations, insufficient expertise in disability matters, and a lack of timely and comprehensive data. Additionally, development and implementation of policies needs full participation of the disability community itself. In Malawi, processes of policies and implementation strategies/plans are not always inclusive and lack input and voice from rural persons with disabilities. Government interventions end up focusing on social protection payments, with very little resources left for mainstreaming disability across programmes and providing much-needed assistive devices and disability-friendly infrastructures[60].

35. For people with albinism, additional concerns also persist regarding the documentation, management of protection, and judicial systems, as well as on the reporting of abductions, attacks, and killings of adults and children with albinism. There are still considerate gaps around: holding all involved perpetrators accountable, expediting investigations, improving security and school enrolment for children with albinism, ensuring access to assistive devices and healthcare materials, fostering cross-border cooperation, providing psychosocial support for survivors and those living in fear of attacks, and involving adults and children with albinism in matters that affect them. There are also identified gaps in resource allocation, coordination, awareness-raising efforts, and capacity-building programmes[61].

[56] World Bank (2022), Malawi gender assessment. World Bank, Washington, DC. Available at: https://documents1.worldbank.org/curated/en/099315004212212759/pdf/P176395040da430500beb7042a0d5846ee6.pdf
[57] E.g., Asfaw, S. & Maggio, G. (2018*) Gender, weather shocks and welfare: evidence from Malawi.* The Journal of Development Studies 54: 271-291. Doi: 10.1080/00220388.2017.1283016.
[58] AFDB *et al*. (2020) Republic of Malawi, Country Gender Profile. African Development Bank, Abidjan, Côte d'Ivoire. Available at: https://www.afdb.org/en/documents/malawi-country-gender-profile-2020.
[59] *Ibid*.
[60] UNICEF (2019) 2018/19 *Disability Budget Brief. Leaving no one behind: ensuring children with disabilities in Malawi have an equal chance in life.* UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/esa/media/3841/file/UNICEF-Malawi-2018-2019-Disability-Budget-Brief.pdf.
[61] Chikasamba, H. (2019) Malawi: revised country report. Centre for Human Rights, University of Pretoria, Pretoria, South Africa. Available at: http://rodra.co.za/country-reports-malawi/22-countries/malawi/62-malawi-updated-country-report.

Social Norms and Beliefs

36. Malawi is a highly patriarchal society and gender inequalities are deeply entrenched[62]; women are expected to be submissive to their husbands and male family members, and poor knowledge by women of their social and economic rights impedes their capacity to enable change, whilst patriarchal culture constrains the opportunities that are available to women and girls. Women typically have less access to resources, including healthcare, education and natural resources, different consumption patterns, access to information and participation in decision-making[63].
37. The 2015-16 Afrobarometer survey showed that a majority of Malawians said that men and women have an equal chance of getting a paid job, earning and income and owning or inheriting land[64]. However, there are misconceptions, based on traditional gender norms, that women can only gain resources through sexual relationships with men. This means that women engaged in businesses may be assumed to be promiscuous, and if a woman earns more than her husband she is seen to emasculate him. This creates barriers to women's involvement in economic activities[65].
38. Polygamy is common in some cultures in Malawi, particularly in rural areas, and can feed gender-based and sexual violence, including through threats of divorce and abandonment that force women into accepting submissive positions within their families and communities[66].
39. Traditional gendered approaches that target women run the risk of disadvantaging polygamous households, particularly second and subsequent wives, who are viewed as being part of male-headed households even though they receive little tangible support from their husbands[67].
40. Malawi has both matrilineal and patrilineal descent systems, with matrilineal systems common in much of the Southern and Central regions. However, this descent occurs within the context of a patriarchal society, meaning that even if women own land under matrilineal systems, they do not necessarily control decisions about it use (which falls to their husband or male extended family members)[68].
41. With regard to disability issues, people with disabilities are typically viewed through the charity model of providing assistance rather than being supported to play active roles in society[69]. In most Malawian societies, the birth of a child with disability is considered a tragedy[70], or seen as a punishment from God[71]. Persons with disabilities are seen as ill or different and consequently they are often excluded from even basic and essential services, and have difficulties accessing fundamental social, political and economic rights[72]. Those with psychosocial or intellectual disabilities are sometimes treated differently from persons with other disabilities. This is particularly the case for women and girls with psychosocial or intellectual disabilities, where the effects of negative social attitudes and perceptions combine with sexism and misogyny and women with these disabilities are disproportionally subject to gender-based

[62] Lovell (2021) *Gender equality, social inclusion and resilience in Malawi*. BRACC discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf

[63] World Bank (2021) *Unlocking Malawi's economic growth by bridging the widening gender gaps in the labor workforce*. World Bank, Washington DC, USA. Available at: https://www.worldbank.org/en/country/malawi/publication/unlocking-malawi-s-economic-growth-by-bridging-the-widening-gender-gaps-in-the-labour-workforce.

[64] Kayuni, H.M. (2017) *In Malawi, gender gaps persist despite popular support for equal opportunity*. Afrobarometer Dispatch 152, 15 June. Afrobarometer, Accra, Ghaha. Available at: https://www.afrobarometer.org/wp-content/uploads/2022/02/ab_r6_dispatchno152_malawi_gender.pdf.

[65] Lovell (2021) *Gender equality, social inclusion and resilience in Malawi*. BRACC discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf

[66] Mkandawire-Valhmu, L. *et al*. (2020) *Rural Malawian women's resistance to systematic oppression, violence, and abuse by their husbands*. Journal of Interpersonal Violence 35: 268-293. Doi: 10.1177/0886260516682518.

[67] Molloy E. (2020) PROSPER *Gender Equality and Social Inclusion Analysis Report*. BRACC report. Overseas Development Institute, London, UK.

[68] Berge, L. *et al*. (2014) *Lineage and land reforms in Malawi: do matrilineal and patrilineal landholding systems represent a problem for land reforms in Malawi?* Land Use Policy 41: 61-69. https://doi.org/10.1016/j.landusepol.2014.05.003.

[69] Molloy E. (2020) PROSPER Gender Equality and Social Inclusion Analysis Report. BRACC report. Overseas Development Institute, London, UK.

[70] Chilemba, E.M. (2014) The right to primary education of children with disabilities in Malawi: a diagnosis of the conceptual approach and implementation (Chapter 1). The African Disability Rights Yearbook, Southern African Legal Information Institute, Department of Public Law, University of Cape Town, Cape Town, South Africa. Available at: https://www.saflii.org/za/journals/ADRY/2013/1.html.

[71] Chimwaza, E.S. (2015) Challenges in the implementation of inclusive education in Malawi: a case study of Montfort Special Needs Education College and selected primary schools in Blantyre. Masters Thesis, Diakonhjemmet University College, Oslo, Norway. Available at: https://vid.brage.unit.no/vid-xmlui/bitstream/handle/11250/2385760/Masteroppgave2015ChimwazaEmmanuelBlessings.pdf?sequence=1.

[72] Chilemba, E.M. (2014) *The right to primary education of children with disabilities in Malawi: a diagnosis of the conceptual approach and implementation (Chapter 1).* The African Disability Rights Yearbook, Southern African Legal Information Institute, Department of Public Law, University of Cape Town, Cape Town, South Africa. Available at: https://www.saflii.org/za/journals/ADRY/2013/1.html.

violence[73]. High levels of stigma towards especially women persons with psychosocial and intellectual disabilities is even reflected through derogatory terminology used in Malawian legislation and judgments to refer to people with psychosocial and intellectual disabilities[74].

42. Children and adults with disabilities, especially girls and women, are particularly vulnerable to social and economic exclusion and discrimination. This extends across multiple facets of Malawian society, encompassing public and political engagement, healthcare, access to justice, employment, and other areas. This is all closely connected, i.e., health care access for people with disabilities in rural Malawi is hindered by closely interconnected financial, practical and social barriers[75]. Despite significant efforts in recent years to enhance educational access for all, both children and youth still face systematic exclusion at various levels of the education system, spanning from early childhood development to primary, secondary and tertiary education[76]. A UNICEF study[77] directly links barriers to education access to stigma and discrimination towards children with disabilities by peers, schools and teachers. Additionally, people with disabilities, particularly women, struggle to access skill development and employment opportunities, which has long-lasting impacts on their survival, protection, and overall development.[78]

43. Persons with albinism continue to face brutal attacks and killings due to societal misconceptions that body parts of persons with albinism contain magical powers for wealth generation. In some cases, perpetrators of the attacks and/or killings are close family members or other trusted members of the public; in one high profile case, a member of the clergy, a government health worker and a police officer are among the key suspects answering murder charges involving a person with albinism[79]. Additionally, children with albinism are often perceived as not being real people, and are excluded from development programmes, and services. This leads to a variety of problems, the most common of which are financial constraints, health complications due to a lack of adequate medical care, a lack of community support leading to stigma and discrimination, and superstitious beliefs. For example, there are beliefs that if an HIV positive person has sex with someone with albinism they will be cured. It is not only children with albinism who experience stigma and discrimination but their mothers as well: husbands often accuse mothers of children with albinism of infidelity, and rates of spousal abandonment are high[80].

44. Cultural and traditional practices are strong in Malawi, and often impede progress towards equality and social inclusion. Initiation ceremonies for girls are both sexual and non-sexual oriented. Examples of cultural practices outlined in the UNICEF report on traditional practices include:
    a. Fisi: the hiring of a fisi ("hyena" or hired man) to have sex with a woman or girl, usually practiced after initiation, when a husband and wife fail to conceive, or after the death of a husband.
    b. Kusasa fumbi: "shaking off of dust", a practice in which a girl or boy who has just gone through initiation is coerced into having sex to finalise the process.

---

[73] Meer, T. & Combrinck, H. (2015*) Invisible intersections: understanding the complex stigmatisation of women with intellectual disabilities in their vulnerability to gender-based violence*. Agenda 29:14-23. https://doi.org/10.1080/10130950.2015.1039307.

[74] Southern Africa Litigation Centre (2017) *Prosecuting sexual violence against women and girls with disabilities in Malawi: a preliminary analysis of the attrition of sexual offence cases in the criminal justice system*. Southern Africa Litigation Centre, Johannesburg, South Africa. Available at: https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/Sexual-violence-against-women-with-disabilities-in-Malawi.pdf.

[75]Lorenzo, T. *et al*. (2015) *Determining the competences of community-based workers for disability-inclusive development in rural areas of South Africa, Botswana and Malawi.* Rural Remote Health 15: 2919. PMID: 26048267. Available at: https://pubmed.ncbi.nlm.nih.gov/26048267/.

[76] Government of the Republic of Malawi (2019) Malawi education sector analysis. Ministry of Education, Science, and Technology, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/4581/file/Malawi%20Education%20Sector%20Analysis.pdf.

[77] UNICEF (2020) *A situation analysis of children with disabilities in Malawi*. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/4606/file/A%20Situation%20Analysis%20of%20Children%20with%20Disabilities%20in%20Malawi%20.pdf.

[78] UNICEF (2019) 2018/19 *Disability Budget Brief. Leaving no one behind: ensuring children with disabilities in Malawi have an equal chance in life*. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/esa/media/3841/file/UNICEF-Malawi-2018-2019-Disability-Budget-Brief.pdf.

[78] The Office of the High Commissioner for Human Rights (2023) *Experts of the Committee on the Rights of Persons with Disabilities acknowledge Malawi's efforts to implement the convention, ask questions on persons with disabilities' involvement in disaster management and measures to promote sign language*. Office of the United Nations High Commissioner for Human Rights, Geneva, Switzerland. Available at: https://www.ohchr.org/en/news/2023/08/experts-committee-rights-persons-disabilities-acknowledge-malawis-efforts-implement.

[79] Amnesty International. (2016). "We Are Not Animals to Be Hunted or Sold": Violence and Discrimination Against People with Albinism in Malawi. Retrieved from Amnesty Internation

[80] Under the Same Sun (2015), *Discrimination against women and girls with albinism in Malawi*. Under the Same Sun, Surrey BC, Canada. Available at: https://www.ecoi.net/en/file/local/1047320/1930_1447407590_int-cedaw-ngo-mwi-22043-e.pdf.

c. Lobola: the paying of dowry, which incentivises early marriage; and
d. Land-grabbing: a practice in which a widow is stripped of her belongings and cast out of the family home by her in-laws.

45. Traditional beliefs around witchcraft and vampires are also very strong and can lead to victimisation and targeting of children and older women, resulting in ostracization, violence and even death[81]. Pervasive views on witchcraft can intersect with disability. There have been reports of witchcraft rituals based on the belief that a person would get rich if they raped a woman or girl with a disability[82]. For example, 0.8% of the population have albinism[83] and experience discrimination driven by the belief that their bones contain magic or gold[84].
46. Focusing on the situation for children, firmly entrenched harmful social norms and beliefs are one of the critical obstacles to realizing children's rights in the country: particularly affecting girls, these include gender discrimination, violence against children, child marriages, killing and maiming children living with albinism and witchcraft persecution, all of which violate human rights and slow down social and economic development[85]. Violence is a daily reality in the lives of children: 82% of children experience violent discipline at home, with 17% of these cases being severe; corporal punishment is common in schools, childcare institutions and police detention; in 2019, violence against children resulted in the loss of MK234 billion, equivalent to 4.13% of GDP[86]. Further, child trafficking with a labour-oriented purpose takes place internally in Malawi[87]: boys from the southern parts of the country are particularly at risk and often forced to go work in tobacco farms in the country's northern parts. Traffickers exploit teenage boys in forced labour on farms, and young girls in sexual exploitation in clubs or bars. Child trafficking also takes place from Malawi to other African (e.g., Tanzania, Zambia, Mozambique) or Middle Eastern countries[88]. In 2017, 38% of children aged 5-17 were involved in child labour, and almost 70% of those children worked in agriculture[89].

Roles, Responsibilities and Resources

47. Access to healthcare is gendered in Malawi, which creates risks for pregnant women. Maternal mortality rates are still high, at 439 per 100,000 live births in 2015-16; around a quarter of women seek antenatal care in the first trimester of pregnancy, and by the time of birth only half of mothers have had access to four antenatal care visits[90]. Poorly-developed healthcare facilities, particularly in rural areas, contribute to both inadequate antenatal care and limited sexual reproductive health and rights services[91]. This is particularly a problem for people with disabilities, who are not targeted for special service provision[92].
48. Rates of adolescent pregnancy are high, with many women having their first pregnancy between the ages of 15-19; although the contraceptive prevalence rate has increased, there are still significant

[81] UNICEF (2018) Traditional practices in Malawi survey report. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/1546/file/Traditional%20Practices%20in%20Malawi:%20Survey%20Report.pdf.
[82] FEDOMA *et al.* (2004) *Living conditions among people with activity limitations in Malawi: a national representative study*. SINTEF, Oslo, Norway. Available online at: https://sintef.brage.unit.no/sintef-xmlui/handle/11250/2461628.
[83] NSO (2019) 2018 Malawi population and housing census. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=226&Itemid=6.
[84] Chikasamba, H. (2019) Malawi: revised country report. Centre for Human Rights, University of Pretoria, Pretoria, South Africa. Available at: http://rodra.co.za/country-reports-malawi/22-countries/malawi/62-malawi-updated-country-report.
[85] UNICEF (2023*) For every child: child-friendly, inclusive, resilient communities*. UNICEF Brief. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/8646/file/For%20every%20child%20Child-friendly,%20Inclusive,%20Resilient%20Communities%20-%20UNICEF%20Malawi%20Pillar%203%20Brief.pdf.
[86] *Ibid*.
[87] Humanium (2021) *Children of Malawi: realizing children's rights in Malawi*. Humanium, Tannay, Switzerland. Available at: https://www.humanium.org/en/malawi/.
[88] Department of State (2020) Trafficking in persons report. United States Department of State, Washington D.C., U.S.A. Available at: http://gvnet.com/humantrafficking/HT-2020-TIP-Report.pdf.
[89] Humanium (2021) *Children of Malawi: realizing children's rights in Malawi*. Humanium, Tannay, Switzerland. Available at: https://www.humanium.org/en/malawi/.
[90] NSO (2017) Fourth Integrated Household Survey: household characteristics. National Statistical Office, Zomba, Malawi. Available at: http://nsomalawi.mw/index.php?option=com_content&view=article&id=225&Itemid=111.
[91] Ministry of Health (2017) National Sexual and Reproductive Health and Rights (SRHR) Policy 2017-2022. Government of Malawi, Lilongwe, Malawi. Available at: https://malawi.unfpa.org/en/resources/national-sexual-and-reproductive-health-and-rights-srhr-policy-2017-2022.
[92] Lorenzo, T. *et al*. (2015) *Determining the competences of community-based workers for disability-inclusive development in rural areas of South Africa, Botswana and Malawi.* Rural Remote Health 15: 2919. PMID: 26048267. Available at: https://pubmed.ncbi.nlm.nih.gov/26048267/.

unmet needs for contraception, with 19% of women wanting to delay pregnancy or not have any more children[93].

49. Healthcare is even less accessible for women with disabilities, where medical professionals are likely to view disability as an illness, and frequently promote a medicalised model of disability[94]. There is also limited data on health care and disaggregated data on disability. In interviews with people with disabilities, they cited cost as a significant barrier to healthcare[95]. Not only are people with disabilities likely to be living in poverty but are also likely to face higher costs due to greater additional needs for access (such as transport and carers) and specialised treatment, and increased frequency of use. This is as a result, both directly and indirectly of the disability[96]. Not only do women with disabilities have less access to health and sexual and reproductive health services, women with severe functional disabilities access sexual and reproductive health services less often than those with less severe disabilities[97]. There is also real stigma against women with albinism, and they are often taken to traditional healers instead of to health clinics[98].

50. There are also heightened risks of women and men with disabilities in contracting HIV, compared to non-disabled people due to their vulnerability to sexual violence, lack of access of information, prevention, treatment and care services. Additionally, people living with HIV are likely to experience temporary and/or chronic impairments at different phases which can prevent their full and equal participation in society[99].

51. Gendered differences are embedded from a young age in Malawi. Literacy and education attainment differs: in the 2018 census, 71.6% of men reported being literate compared with 65.9% of women[100]. Although primary education rates have improved significantly among girls, attrition rates through secondary school are high, and 12% of women have never been to school, compared with only 5% of men. Increasing enrolment rates, whilst positive for gender equality, puts pressure on limited education facilities and teachers and can give rise to a decline in quality of teaching.

52. Social background is a strong driver of educational attainment. Children of educated mothers are far more likely to complete school than those whose mothers were not well educated. Despite both primary and secondary education being tuition-free since 2018 (intended to facilitate access to education), only 41% of Malawian children attend school, and only 20% of children aged 14-17 years old were attending secondary education in 2018[101]. Economic barriers are major barriers affecting a child's ability to attend school: some parents cannot pay school-related expenses (books, uniforms) while others are pulling children out of school to perform domestic work[102]. There are limited opportunities for school leavers, as the labour force struggles to productively absorb graduates, leading to unemployment and underemployment[103].

53. Children with disabilities, particularly girls, face additional barriers to attending and achieving in school. Only 3.35% of primary children have disabilities, and only 2.3% in secondary schools[104]. Nice percent of children with disabilities surveyed said that they had been refused admission to primary school. Barriers to education for children with disabilities include being refused entry, bullying, abuse or

[93] AFDB *et al*. (2020) Republic of Malawi, Country Gender Profile. African Development Bank, Abidjan, Côte d'Ivoire. Available at: https://www.afdb.org/en/documents/malawi-country-gender-profile-2020.
[94] Grugel, J. *et al*. (2022) *The human right to health, inclusion and essential health care packages in low-income countries: 'health for all' in Malawi*. International Journal of Human Rights in Healthcare. Doi: 10.1108/IJHRH-09-2021-0178.
[95] Harrison, J.A.K. *et al.* (2020) *Access to health care for people with disabilities in rural Malawi: what are the barriers?* BMC Public Health 20: 833. Available at: https://doi.org/10.1186/s12889-020-08691-9.
[96] *Ibid*.
[97] Jamali, M. Z. (2020*) Disability measurement and uptake of sexual and reproductive health services in Malawi.* Doctoral Thesis, University of Southampton, Southampton, UK. Available at: https://eprints.soton.ac.uk/444758/.
[98] Grugel, J. et al. (2022) *The human right to health, inclusion and essential health care packages in low-income countries: 'health for all' in Malawi*. International Journal of Human Rights in Healthcare. Doi: 10.1108/IJHRH-09-2021-0178.
[99] De Beaudrap, P*. et al*. (2014) *Disability and HIV: a systematic review and a meta-analysis of the risk of HIV infection among adults with disabilities in Sub-Saharan Africa*. AIDS Care 26: 1467-1476. Doi: 10.1080/09540121.2014.936820.
[100] AFDB *et al*. (2020) Republic of Malawi, Country Gender Profile. African Development Bank, Abidjan, Côte d'Ivoire. Available at: https://www.afdb.org/en/documents/malawi-country-gender-profile-2020.
[101] NSO (2019) 2018 Malawi Population and Housing Census. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=226&Itemid=6.
[102] Humanium (2021) *Children of Malawi: realizing children's rights in Malawi*. Humanium, Tannay, Switzerland. Available at: https://www.humanium.org/en/malawi/.
[103] Ministry of Education, Science and Technology (2017) Education management information system. Government of Malawi, Lilongwe, Malawi.
[104] Ministry of Education, Science and Technology (2019) Malawi education sector analysis. Government of Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/4581/file/Malawi%20Education%20Sector%20Analysis.pdf.

harassment from peers and/or teachers, difficulties in transport, inaccessible infrastructure, and non-inclusive teaching pedagogy. Girls with disabilities face increased stigma and discrimination, as well as school related gender-based violence[105]. Additionally, there is low participation of people with disabilities in tertiary, TVET or adult literacy classes, due to barriers including appropriate infrastructure and learning materials, and encouragement for their participation[106]. Due to significant safety and security issues many children with albinism do not go to school[107].

54. Malawi does not invest sufficiently to counter the extensive deprivations endured by its children, owing to the small size of its budget and the limited capacity of its economy to produce the required revenue. Funding for a number of social sectors that are crucial to the wellbeing of children are highly dependent on donor support, raising sustainability concerns: social protection, early childhood development, nutrition and WASH remain highly dependent on donor support (over 90%)[108]. Child protection remains a particularly neglected sector, with barely US$0.08 allocated per child per year, and social protection in general is overwhelmingly donor dependent[109].

55. Within the household, roles are strongly gendered[110]. Men typically dominate within the household due to socially constructed gender norms. Men have control over decisions relating to economic livelihoods, for example what crops to grow or whether or not to migrate for work. This has persisted overtime, even though there has been some change in women reporting participation in other decisions. Women have responsibility (sole or joint) for decisions relating to their own healthcare, to caring for children or elderly or infirm household members[111], and for decision relating to household maintenance, for example what to cook for dinner, when to visit their own family members. Findings from a recent project showed that the earner of income typically had control over that income, but the earner was more often than not the man in the household[112].

56. Over time, there have been increases in the capacity of women to have a say in decisions, particularly around their own health (an increase from 55% in 2010 to 68% in 2015-16) and in major household purchases (from 30% in 2010 to 55% in 2015-16), although this is typically thought to be due to an increase in joint decision-making, rather than women specifically becoming more empowered. In general, decision-making capacity is linked to age, education, and employment status[113].

57. There is some flexibility among gender roles in female-headed households, where women may have control of resources and greater decision-making power. However, perceived contravention of gender norms can cause challenges in the wider family and community. For instance, in the Building Resilience and Adapting to Climate Change programme[114] one woman noted that, after her husband died, she started to make decisions about her children's education and paid school fees without consulting her husband's family, who retaliated by denying her access to land and cutting off familial support. Where women in male-headed households had been able to earn their own money, for example through

[105] UNICEF (2020) A situation analysis of children with disabilities in Malawi. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/4606/file/A%20Situation%20Analysis%20of%20Children%20with%20Disabilities%20in%20Malawi%20.pdf.

[106] Ministry of Education, Science and Technology (2019) Malawi education sector analysis. Government of Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/4581/file/Malawi%20Education%20Sector%20Analysis.pdf.

[107] Lund, P. *et al*. (2015) *Barriers to access: factors limiting full participation of children with albinism at school in northern Malawi: Part 2. Field Report*, Coventry University, Coventry, UK. Available at: https://pure.coventry.ac.uk/ws/portalfiles/portal/3933649/Field+report+on+children+with+albinism+in+Malawi+Part+2.pdf.

[108] UNICEF (2023) For every child: child-friendly, inclusive, resilient communities. UNICEF Brief. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/8646/file/For%20every%20child%20Child-friendly,%20Inclusive,%20Resilient%20Communities%20-%20UNICEF%20Malawi%20Pillar%203%20Brief.pdf.

[109] *Ibid*.

[110] Lovell (2021) Gender equality, social inclusion and resilience in Malawi. BRACC discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf

[111] NSO (2017) Fourth Integrated Household Survey: household characteristics. National Statistical Office, Zomba, Malawi. Available at: http://nsomalawi.mw/index.php?option=com_content&view=article&id=225&Itemid=111.

[112] Vincent, K. *et al*. (2022) Gender equality and social inclusion in PROSPER: Intervention design and impacts. BRACC brief. Overseas Development Institute, London, UK. Available at: https://bracc.kulima.com/sites/default/files/2022-03/GESI%20brief.pdf.

[113] NSO (2017) Fourth Integrated Household Survey: household characteristics. National Statistical Office, Zomba, Malawi. Available at: http://nsomalawi.mw/index.php?option=com_content&view=article&id=225&Itemid=111.

[114] The five-year (2018-2023) "Building Resilience and Adapting to Climate Change" programme had a long-term impact to contribute to a reduction in extreme poverty and to ending the recurrent cycle of hunger and humanitarian assistance in Malawi (https://odi.org/en/about/our-work/building-resilience-and-adapting-to-climate-change-in-malawi-bracc-knowledge-and-policy-hub/).

participation in programme interventions, retaliation by men was reported, for example men confiscating their wives' IDs.

Decision-making, leadership and participation

58. Decision-making in the public sphere in Malawi remains male-dominated. Despite having recently had a female president (Joyce Banda from April 2012 to May 2014), women's representation in parliament remains low, and below the 40-60% target set by the 2013 Gender Equality Act. Scores and ranks in the political participation index of the Global Gender Gap Index are particularly low (Table 1). In the 2019 election, 22.9% of seats were held by women.[115] Also in the 2019 election, Malawi elected the first ever female speaker of parliament[116].
59. Low levels of political representation at national level are mirrored in political participation by women at community level. The 2019-20 Afrobarometer survey found that Malawian women are less likely than men to discuss politics (39% of women compared with 56% of men do so at least "occasionally"), join others to raise an issue (23% vs 28%), attend a campaign rally (49% vs 63%) and contact an MP (5% vs 15%)[117].
60. The Afrobarometer survey shows increasing support for women's equal participation in politics relative to men, and that rural residents were more likely to express support for women's political leadership than urban residents. However, this sits at odds with strongly patriarchal societies. When considering leadership roles at community level, often both men and women deemed women to be less suitable for leadership.
61. Among traditional leadership, although the numbers of women in leadership positions has increased, most traditional leaders are still men. This is underpinned by patriarchal and social norms, which gender equality legislation has struggled to overcome despite attempts to increase women's representation[118]. Decision-making fora remain more accessible to men than to women, and notable exceptions (where a woman is found in a position of influence) can be viewed as sufficient, thereby excluding other women from participating[119].
62. In local formal governance structures, for example at district, group village, area and village level, increasing efforts are made for gender-equal representation, as well as for participation by people with disabilities and youth. These efforts are particularly supported by externally-funded projects, for example those undertaken by UN agencies and NGOs.
63. People with disability report isolation and stigma, as well lack of accessibility, as barriers that prevent participation in community events and committees. There is almost no presence of women with disabilities in decision making positions at the national level. Even though the Local Government Act stipulates representation for five special interest groups in local councils, it does not explicitly include provisions for the representation of persons with disabilities, including women with disabilities. Consequently, women with disabilities, particularly in rural areas are even more invisible within the decision-making landscape. This is largely due to negative attitudes towards people with disabilities in general, but specifically women and girls with disabilities, low self-esteem and confidence levels amongst women and girls with disabilities, limited levels of education amongst women and girls with disabilities and absence of information or communication in accessible formats for campaigns, political and decision-making processes at all levels.
64. Child participation provides the opportunity for involvement, design and access to information, decision-making and capacity-building for children, such that children can feel empowered in society. The Malawi government recognizes that the level of child participation in Malawi, however, is only at the level of consultation, and involves minimal participation[120]. Further, even though children's views may be sought through consultations, they are not necessarily put into practice, and very often younger children

[115] IPU Parline (2023) Malawi National Assembly, data on women. Inter-Parliamentary Union, Geneva, Switzerland. Available at: https://data.ipu.org/node/102/data-on-women?chamber_id=13456.
[116] Phiri, M.M. (2019) Malawi parliament elects first-ever female speaker. AA, 19 June. Available at: https://www.aa.com.tr/en/africa/malawi-parliament-elects-first-ever-female-speaker/1510414.
[117] Kayuni, H.M. (2017) In Malawi, gender gaps persist despite popular support for equal opportunity. Afrobarometer Dispatch 152, 15 June. Afrobarometer, Accra, Ghaha. Available at: https://www.afrobarometer.org/wp-content/uploads/2022/02/ab_r6_dispatchno152_malawi_gender.pdf.
[118] Lovell (2021) Gender equality, social inclusion and resilience in Malawi. BRACC discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf
[119] Molloy E. (2020) PROSPER Gender Equality and Social Inclusion Analysis Report. BRACC report. Overseas Development Institute, London, UK.
[120] Ministry of Gender, Community Development & Social Welfare (2023) Child participation. Ministry of Gender, Community Development & Social Welfare, Lilongwe, Malawi. Available at: https://www.gender.gov.mw/index.php/14-sample-data-article/portfolio/apps/29-6.

are not given the opportunity to participate in consultations. Children are conspicuously missing from most spaces where plans and decisions for development are made, particularly at national and local authority levels, despite the fact that the perspectives of children over issues that affect them differ from those of adults; as a result, children's issues, including budgetary allocation for child-related services and programmes, are marginally catered for[121].

65. Socio-cultural norms have been found to be one of the major factors limiting child participation as children are viewed as being unable to make sound decisions, but multiple barriers exist to child participation in a range of settings, including family (where for example ineffective parenting skills can be a barrier), community (where for e.g., knowledge gap on child rights-related legal instruments and policy frameworks can be a barrier), council (where for e.g., inadequate resources can be a barrier) and national (where lack of government financing can be a barrier)[122]. Inadequate engagement spaces and pro-child participation aggravates the vulnerability of children to rights violations and poverty, and has resulted in some children being subjected to child marriages, teenage pregnancies, child labour, child prostitution, child begging and child trafficking, among others[123].

Access to and Control of Resources

66. Land ownership in Malawi is highly unequal. Recognising the importance of land as a productive asset, the Land Act was reviewed in 2017 to increase women's access, control and ownership of land. However patriarchal norms and traditional and cultural beliefs typically override the law and disadvantage women in both inheritance and land ownership rights [124]. Youth are similarly disadvantaged. Whilst the population of Malawi is dominated by the youth, this cohort has poor access to productive resources and assets, key amongst these land ownership[125]; for example, one study found that only 22.16% of the youth in the Central region of Malawi have access to farming land[126].
67. Limited access to land, labour, inputs and credit makes women more likely to engage in low-productivity subsistence agriculture and income-generating activities with low returns [127]: within agricultural livelihoods, women are likely to grow less valuable crops, such as maize, for subsistence purposes, whilst men tend to grow cash and export-oriented crops. Whilst women and men may work together to grow crops, men have better access to inputs and typically control the proceeds. Barriers to women's access to markets are both physical (for example lack of access to a bicycle or capacity to afford transport) and cultural (for example caring responsibilities and facing community disapproval). However, women in Malawi produce up to 80% of the country's food.

68. Recognising the gender gap in agriculture, a number of climate-smart agriculture programmes have actively targeted women, accompanied by programmes to address land ownership and access to resources [128]. Positive changes in the gender gap in agriculture is anticipated to improve intergenerational nutrition, education and health outcomes and lift people out of poverty[129].
69. Whilst access to formal credit remains low among women, rotating savings and credit associations and village savings and loans initiatives have grown in popularity and are widely seen to be the domain of women who are typically the registered members. However, when income is generated through such

[121] Malawi Government (n.d.) National child participation guidelines. NORAD and Save the Children, Lilongwe, Malawi. Available at: https://malawi.savethechildren.net/sites/malawi.savethechildren.net/files/library/National_Child_Participation_Guidelines.pdf.
[122] *Ibid*.
[123] *Ibid.*
[124] Lovell (2021) *Gender equality, social inclusion and resilience in Malawi. BRACC* discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf
[125] Mgomezulu, W.R. *et al*. (2019) Determinants of access to and ownership of farming land among rural youths in Central Region of Malawi. Journal of Economics and Sustainable Development 10: 142-148. Doi: 10.7176/JESD/10-12-15; Lindsjö, K. *et al*. (2021) Generational dynamics of agricultural intensification in Malawi: challenges for the youth and elderly smallholder farmers. International Journal of Agricultural Sustainability 19: 423-436. Doi: 10.1080/14735903.2020.1721237.
[126] Mgomezulu, W.R. et al. (2019) Determinants of access to and ownership of farming land among rural youths in Central Region of Malawi. Journal of Economics and Sustainable Development 10: 142-148. Doi: 10.7176/JESD/10-12-15.
[127] Lovell (2021) Gender equality, social inclusion and resilience in Malawi. BRACC discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf
[128] For some example see: https://africa.unwomen.org/en/news-and-events/stories/2020/10/malawi-adopts-climate-smart-groundnut-farming; https://www.nepad.org/news/update-gender-climate-change-and-agriculture-support-programme-focus-malawi; https://www.unwomen.org/en/news-stories/feature-story/2022/02/weather-forecasts-shift-climate-change-impact-for-women-farmers-in-malawi.
[129] UN Women, *et al*. (2015) The cost of the gender gap in agricultural productivity in Malawi, Tanzania, and Uganda. World Bank Group, Washington DC, USA. Available at: http://hdl.handle.net/10986/22770.

initiatives and finds its way to the household, it may be subject to the predominant decision-making patterns which see men as having control over it[130].

70. Women with disabilities in Malawi, face similar gender-based barriers as other women, but then face compounded challenges to employment including limited or inadequate access to transport, work or training spaces or tools, access to credit or other financial services, job opportunities, especially in rural areas, work-based learning programs, and skill and professional development offerings. High levels of economic stigma meant that access to capital or credit was very difficult. Trainings were often irrelevant and more based on a charity model than a social model of disability[131].
71. People, particularly women, with disabilities in Malawi are more likely to have never attended school and are less likely to be employed compared to their non-disabled counterparts. Consequently, their socio-economic prospects are disadvantaged, and women and men with disabilities in Malawi are at a higher risk of chronic poverty and extreme deprivation[132].
72. The employment rate for people with disabilities in Malawi remains low. Depending on the definition used, they constitute either 12% (including, for example, albinism and epilepsy and other invisible disabilities) or just 0.9% of the employed labour force (using Washington Questions Short Set)[133]. Data was not available that was disaggregated by sex, or by formal/informal economy.

Gender-Based Violence

73. Gender-Based Violence (GBV) is a "serious, prevalent, and deeply entrenched problem in Malawi" with 41% of all women reporting that they have experienced some form of GBV "at least once in their lives"[134]. The 2015-16 Demographic and Health Survey found that 34% of Malawian women (aged 15 and over) have experienced physical violence and 20% have experienced sexual violence[135]. There appears to be high tolerance for GBV, with 16% of men and 13% of women believing that a husband is justified in beating his wife for at least one of five specified circumstances, including burning the food, arguing, going out without telling him, neglecting the children and refusing sexual intercourse[136].
74. In recognition of the extent of GBV in society, determined key laws and strategies expressly commit to addressing the problem, including the Constitution, Vision 2063, and the Gender Equality Act. In addition, there is the Prevention of Domestic Violence Act (2006) and the National Action Plan to Prevent Gender-Based Violence 2014-20.
75. Sexual violence is criminalised by law under the penal code. However, rape is widespread in practice. Marital rape is not specified in the penal code so, although women can seek justice under the Prevention of Domestic Violence Act (2006), or the Marriage, Divorce and Family Relation Law 2015, in practice this rarely happens.
76. In general, progress in addressing gender-based and sexual violence is impeded by limited knowledge of the laws, weak enforcement capacity, disempowerment of women and poor access to justice for survivors of GBV[137].
77. Gender-based violence among adolescents is unacceptably high, as one in five girls and one in seven boys have experienced at least one incident of sexual abuse before 18. For girls between 13 and 17, most perpetrators are peers[138].
78. Child marriage rates are high, and in 2015 Malawi had the highest rate of child marriage in the world. The 2015 Marriage, Divorce and Family Relations Law increased the minimum age of marriage from

[130] Lovell (2021) *Gender equality, social inclusion and resilience in Malawi*. BRACC discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf

[131] Remnant, J., Wånggren, L., Huque, S., Sang, K., Kachali, L., & Richards, J. (2022). Disability inclusive employment in urban Malawi: A multi-perspective interview study. *Journal of International Development*, 34(5), 1002–1017. https://doi.org/10.1002/jid.3678

[132] UNICEF (2020) A situation analysis of children with disabilities in Malawi. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/4606/file/A%20Situation%20Analysis%20of%20Children%20with%20Disabilities%20in%20Malawi%20.pdf.

[133] NSO (2019) 2018 Malawi population and housing census. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=226&Itemid=6.

[134] Molloy E. (2020) PROSPER Gender Equality and Social Inclusion Analysis Report. BRACC report. Overseas Development Institute, London, UK.

[135] NSO (2017) Malawi demographic and health survey. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=222&Itemid=108.

[136] *Ibid.*

[137] AFDB *et al*. (2020) Republic of Malawi, Country Gender Profile. African Development Bank, Abidjan, Côte d'Ivoire. Available at: https://www.afdb.org/en/documents/malawi-country-gender-profile-2020.

[138] UNICEF (2023) *For every child: child-friendly, inclusive, resilient communities*. UNICEF Brief. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/8646/file/For%20every%20child%20Child-friendly,%20Inclusive,%20Resilient%20Communities%20-%20UNICEF%20Malawi%20Pillar%203%20Brief.pdf.

15 to 18, but the Constitution allows children as young as 15 to marry with parental consent[139]. The average age of marriage for women is 18 (compared with 23 for men), but 47% of women marry before the age of 18[140]. A significant concern is marriage before age 15: 8% of girls in rural areas and 4% of girls in urban areas marry before they turn 15[141]. The need to address the issue of child marriages has been recognised by the National Strategy on Ending Child Marriages 2018-23.

79. Adolescent pregnancy is persistently high, particularly in rural areas, with nearly a third of women aged 15-19 beginning childbearing in 2015-16[142], and is a major driver of young women of school-going age dropping out of school[143].
80. There is a notable lack of data concerning the nature and scope of sexual violence targeting women and girls with disabilities in Malawi. Women and girls with disabilities experience many of the same forms of violence all women and girls experience. However, international evidence shows that women and girls with disabilities are three times as likely to be raped and twice as likely to experience intimate partner violence and other forms of GBV as women who do not have a disability. They are often treated as asexual and not in need of sexual health education or health-care - and often excluded discussions and trainings around relationships or sexual and reproductive health[144]. This is based on social norms and biases that intersect across gender and disability which means that females of all ages with disabilities are often dehumanised or infantilised, excluded, and isolated. Sexual and gender-based violence also has the consequence of contributing to the incidence of disability among women. Girls and women with disabilities are less likely to report sexual violence or abuse or harassment, and when they do, they face challenges, including legal and accessibility barriers, when they seek to access justice in Malawi[145].

Differential vulnerability to climate change and extremes

81. The socially-constructed gender and social norms that give rise to differential resource allocation, decision-making and political participation are reflected in differential vulnerability to climate change and extremes[146]. Marginalised groups are more likely to find themselves in areas highly vulnerable to climate and health hazard exposure, and with limited adaptive capacity in terms of systems, services, information and assets.
82. The gendered health impacts of climate change are described in the Feasibility Study (Annex 2, Section 3.3); the following paragraphs summarize and provide examples of the differential vulnerability of women and girls to climate change and extremes. Women face multiple barriers and vulnerabilities in the context of climate change in Malawi[147]. Poverty and limited access to education contribute to their vulnerability, as they are often economically dependent on men and lack the resources to adapt to climate-related challenges[148]. Moreover, women have limited power and decision-making authority,

[139] Makwemba, M. *et al*. (2019) *Survey report: traditional practices in Malawi*. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/1546/file/Traditional%20Practices%20in%20Malawi:%20Survey%20Report.pdf.

[140] NSO (2017) Malawi demographic and health survey. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=222&Itemid=108.

[141] UNICEF (2023) *For every child: child-friendly, inclusive, resilient communities.* UNICEF Brief. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/8646/file/For%20every%20child%20Child-friendly,%20Inclusive,%20Resilient%20Communities%20-%20UNICEF%20Malawi%20Pillar%203%20Brief.pdf.

[142] NSO (2017) Malawi demographic and health survey. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=222&Itemid=108.

[143] UNICEF (2023) *For every child: quality learning and protection.* UNICEF Brief. UNICEF Malawi, Lilongwe, Malawi. Available at: https://www.unicef.org/malawi/media/8651/file/For%20every%20child%20Quality%20Learning%20and%20Protection%20-%20UNICEF%20Malawi%20-%20Pillar%202%20Brief.pdf.

[144] Kvam, M. H., & Braathen, S. H. (2006) *Violence and abuse against women with disabilities in Malawi.* SINTEF, Oslo, Norway. Available at: https://sintef.brage.unit.no/sintef-xmlui/handle/11250/2443387; Kvam, M. H., & Braathen, S. H. (2008) "I thought . . . maybe this is my chance": Sexual Abuse Against Girls and Women with Disabilities in Malawi. Sexual Abuse 20: 5-24. Available at: https://doi.org/10.1177/1079063208314817.

[145] Southern Africa Litigation Centre (2017) *Prosecuting sexual violence against women and girls with disabilities in Malawi: a preliminary analysis of the attrition of sexual offence cases in the criminal justice system*. Southern Africa Litigation Centre, Johannesburg, South Africa. Available at: https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/Sexual-violence-against-women-with-disabilities-in-Malawi.pdf.

[146] Sultana, F. (2014). Gendering climate change: Geographical insights. The Professional Geographer, 66(3), 372-381. DOI: 10.1080/00330124.2013.821730

[147] Lovell (2021) *Gender equality, social inclusion and resilience in Malawi.* BRACC discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf

[148] Fruterro, A. *et al*. (2023) *Gendered impacts of climate change: evidence from weather shocks*. Policy Research Working Papers 10442. The World Bank, Washington DC, USA. Available at: https://openknowledge.worldbank.org/handle/10986/39813;

both in their households and in their communities in Malawi. They lack control over finances and assets, and their representation in community politics is often inadequate[149]. This lack of influence hampers their ability to participate in climate adaptation strategies and policies[150].

83. Childbearing and traditional caregiving roles also increase women's vulnerability, as they are responsible for securing water, food, and fuel for their households; climate change exacerbates these responsibilities by forcing women and girls to travel farther to collect resources, leading to increased time and energy demands[151]. For instance, gendered roles mean that women typically have responsibility for fetching water, so if water availability declines under future climate, it will have implications for women and girls in terms of time taken to collect water, as well as potentially exposing them to gender-based violence, because of the increased risk of sexual and physical violence for women who walked long distances to access water[152]. In addition, collecting water in times of scarcity places a heavy burden on women and girls who miss opportunities for study, work, and self-care as a result[153]. Gendered roles also dictate women's responsibility for household food security, which causes stress and anxiety for women. A recent and as yet unpublished study for Malawi, conducted in 2022, found that 86% of women reported that their mental health has been affected by climate change[154]. The biggest concern cited by the women in the study was their inability to provide sufficient food for their children, an inability which they recognised led to hunger and malnutrition in their children, with knock-on detrimental effects on their children's health, education and general development. At the same time, there is also research evidence from Malawi that increased anxiety and mental health problems experienced by caregivers impedes their capacity for adaptation and to take the behaviour changes needed to mitigate the challenges they face and to provide optimal care for themselves and their children[155].
84. Women are often disproportionately affected by disasters, both in the short- and longer-term. For instance, after tropical cyclone Idai and the associated floods in 2019 in Malawi, a disproportionate number of women were counted among the internally displaced people, with 63% of those in shelters in Machinga, Mangochi, Balaka and Zomba being women[156]. There were reports of sexual transactions used as coping strategy, and concerns about increased pregnancy as a result. In the longer term, the floods had impacts on livelihoods. After the disaster, women were less likely to be able to engage in income-generating activities due to lack of opportunities and loss of livelihoods assets. Similarly, in 2023, tropical cyclone Freddy aggravated gender inequality in several Southern Malawi districts, including Phalombe[157]. Women were the most affected, because of their high representation in sectors that were most affected by the disaster[158], for example agriculture and microenterprises. The cyclone also caused much displacement, and many women in the affected districts were stripped of their dignity in temporary housing camps due to the lack of provision of gender-sensitive WASH facilities.

Dessy, S.,L. *et al.* (2023) The gender education gap in developing countries: roles of income shocks and culture. Journal of Comparative Economics 51: 160-180. Available at: https://doi.org/10.1016/j.jce.2022.11.002.

[149] Lovell (2021) *Gender equality, social inclusion and resilience in Malawi*. BRACC discussion paper. Overseas Development Institute, London, UK. Available at: https://cdn.odi.org/media/documents/ODI_Gender_equality_social_inclusion_and_resilience_in_Malawi_2021.pdf

[150] Global Gender and Climate Change Alliance (2016) *Gender and climate change: a closer look at existing evidence*. Women's Environment & Development Organization, New York, USA. Available at: https://wedo.org/wp-content/uploads/2016/11/GGCA-RP-FINAL.pdf.

[151] UN Women. (2018). Turning Promises into Action: Gender Equality in the 2030 Agenda for Sustainable Development. Retrieved from https://www.unwomen.org/en/digital-library/publications/2018/2/gender-equality-in-the-2030-agenda-for-sustainable-development-2018

[152] Tallman, P.S. *et al.* (2023*) Water insecurity and gender-based violence: a global review of the evidence*. WIREs Water 10: e1619. Available at: https://doi.org/10.1002/wat2.1619.

[153] UNICEF (2016) UNICEF: *Collecting water is often a colossal waste of time for women and girls*. UNICEF, New York, USA. Available at: https://www.unicef.org/press-releases/unicef-collecting-water-often-colossal-waste-time-women-and-girls; Tomberge, V.M.J. *et al.* (2021) The physical burden of water carrying and women's psychosocial well-being: evidence from rural Nepal. International Journal of Environmental Research and Public Health 18:7908. Doi: 10.3390/ijerph18157908.

[154] GCU (Glasgow Caledonian University) (2022*) Climate change makes violence against women in Malawi worse, study finds.* Glasgow Caledonian University, Glasgow, Scotland. Available at: https://www.gcu.ac.uk/aboutgcu/universitynews/climate-change-makes-violence-against-women-in-malawi-worse,-study-finds#:~:text=More%20than%2086%25%20of%20the,to%20their%20marriage%20(10%25).

[155] Slekiene J. *et al.* (2022) *Does poor mental health impair the effectiveness of complementary food hygiene behavior change intervention in rural Malawi*? International Journal of Environmental Research and Public Health 19:10589. doi: 10.3390/ijerph191710589.

[156] Government of Malawi (2019) Malawi 2019 Floods Post Disaster Needs Assessment (PDNA). Government of Malawi, Lilongwe, Malawi. Available at: https://reliefweb.int/report/malawi/malawi-2019-floods-post-disaster-needs-assessment-report.

[157] Government of Malawi (2023) Malawi 2023 Tropical Cyclone Freddy Post-Disaster Needs Assessment. Government of Malawi, Lilongwe, Malawi. Available at: https://reliefweb.int/report/malawi/malawi-2023-tropical-cyclone-freddy-post-disaster-needs-assessment-april-2023.

[158] CARE International. (2019). Cyclone Idai: Gender analysis. Retrieved from https://reliefweb.int/report/mozambique/cyclone-idai-gender-analysis-april-2019.

85. The sexual and reproductive health and rights of women are particularly affected in times of natural disasters. . Women are disproportionately affected by chronic malnutrition and are more vulnerable to climate-induced food and nutrition insecurity, particularly during pregnancy and breastfeeding. Maternal malnutrition exacerbates the impact of infectious diseases on maternal, foetal, and child health159. This has been highlighted as a significant risk in Malawi160.
86. Incidents of gender-based violence have been shown to increase after disasters in Malawi[161]. Among the long-term effects of disasters, child marriages are known to increase following shocks and disasters, because it can reduce the number of mouths to feed and raise income through the payment of dowries. For instance, after Covid-19, a helpline reporting child marriage saw an 83% increase in calls, whilst teen pregnancy also increased[162]. A study conducted in 2022 in both Nkhata Bay and the project district of Mangochi found that roads and bridges washed away by floods prevented access to sexual and reproductive health services by adolescent young men and women, leading to early and unwanted pregnancies and marriages, which disrupted education attainment for both boys and girls, with girls' individual health and wellbeing the most affected[163]. In particular, the drying of Lake Chilwa is associated with an increased number of early marriages in daughters[164]. These effects occur against a backdrop of already high child and adolescent marriage and pregnancy rates, particularly in rural areas, with nearly a third of women aged 15-19 beginning childbearing in 2015-16[165]. In Malawi, it is estimated that 1.5 million girls are at risk of becoming child brides due to the impacts of extreme weather events caused by climate change, which make it harder for families to afford to feed and house their own children[166].
87. The fact that early childbearing and high fertility rates can worsen women's health and limit their educational and economic opportunities makes it harder for women to adapt to climate change. However, reproductive health and family planning are often overlooked in climate adaptation strategies, along with efforts to address rapid population growth resulting from unintended pregnancies and unmet family planning needs[167].
88. Malawi is among the top 40 countries ranked as having a high climate risk for children, with climate-induced water scarcity the main factor[168]. Climate shocks are frequently occurring and with increased intensity, threatening the health, nutrition, education, development and the survival of children. For example, the first year of the devastating drought in 2015-2017, for instance, left 6.5 million people food-insecure, including 3.5 million children[169]. As another example, in 2022 tropical storms Ana and Gombe devastated the Southern Region of Malawi, causing severe damage to key infrastructures including roads, schools, and health facilities and damaging crops, affecting over 995,000 people,

[159] Grace, Kathryn et al. "Linking climate change and health outcomes: Examining the relationship between temperature, precipitation and birth weight in Africa." *Global Environmental Change-human and Policy Dimensions* 35 (2015): 125-137.
[160] USAID (2017) Climate Risk Profile: Malawi | Global Climate Change (climatelinks.org)
[161] Desaia, B. & Mandal, M. (2021) Role of climate change in exacerbating sexual and gender-based violence against women: a new challenge for international law. Environmental Policy and Law 51:137-157. Doi: 10.3233/EPL-210055.
[162] Rigby, J. (2020) Child marriages skyrocket in Malawi as Covid-19 closes schools, figures show. The Telegraph, 14 August, Available at: https://www.telegraph.co.uk/global-health/women-and-girls/child-marriages-skyrocket-malawi-covid-19-closes-schools-figures/.
[163] Sibale, B. *et al*. (2022) Formative assessment to inform design of a gender transformative positive youth development (PYD) approach to improve family planning/reproductive health (FP/RH). Pact Malawi, Lilongwe, Malawi. Available at: https://www.researchgate.net/publication/373555913_Formative_assessment_to_inform_design_of_a_gender_transformative_positive_youth_development_PYD_approach_to_improve_family_planningreproductive_health_FPRH.
[164] Alcayna, T. *et al*. (2021) Climate change impacts on health: Malawi assessment. Red Cross Red Crescent Climate Centre, The Hague, Netherlands. Available at: https://www.climatecentre.org/wp-content/uploads/RCRC_IFRC-Country-assessments-MALAWI-3.pdf.
[165] NSO (2017) Malawi demographic and health survey. National Statistical Office, Zomba, Malawi. Available at: http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=222&Itemid=108.
[166] Chamberlain, G. (2017) Why climate change is creating a new generation of child brides. The Guardian, 26 November. Available at: https://www.theguardian.com/society/2017/nov/26/climate-change-creating-generation-of-child-brides-in-africa#:~:text=%E2%80%9CGiven%20that%20there%20are%20about,That%20is%20a%20huge%20number.%E2%80%9D.
[167] Pullanikkatil, D. *et al*. (2013) *Linkages between population, reproductive health, gender and climate change adaptation in Malawi: case study from Lake Chilwa basin.* LEAD SEA Publications, Zomba, Malawi. Available at: https://www.researchgate.net/publication/282333556_Linkages_between_Population_Reproductive_Health_Gender_and_Climate_Change_Adaptation_in_Malawi_Case_study_from_Lake_Chilwa_Basin.
[168] UNICEF (2021) *The climate crisis is a child rights crisis: introducing the children's climate risk index*. United Nations Children's Fund, New York, USA. Available at: https://www.unicef.org/media/105376/file/UNICEF-climate-crisis-child-rights-crisis.pdf.
[169] WBG, UN & EU (2016) *Malawi Drought 2015-2016: Post-Disaster Needs Assessment*. World Bank Group, United Nations, and European Union, Washington DC, USA. Available at: http://hdl.handle.net/10986/25781.

130,000 of whom were children under the age of five[170]. The storms also kept 100,000 more children and youth out of school.

89. With tropical Cyclone Freddy at least 2.3 million people have been affected (including 51 per cent female and 56 per cent children), of whom 659,278 have been displaced. Cholera has spread to all 29 districts, affecting 4.85 million people. Since the start of the outbreak, over 58,000 cumulative cases and 1,740 deaths have been reported. There is a risk of malnutrition due to acute food insecurity, affecting 3.8 million people in 21 districts. An estimated 573,800 children under five, and 228,000 pregnant and breastfeeding women are at risk of malnutrition. 171 At least 67 health facilities were damaged, and access to health services has been hampered due to damaged road infrastructure. The Protection Cluster estimates that 6.5 million children and their communities are in need of protection services, and the Education Cluster estimates that 5.3 million children will need education support172.
90. Beyond women and girls, the impacts of climatic changes and extremes often disproportionately affect other vulnerable groups, such as children and adults with disabilities. For instance, beyond the effects on gender inequality, in 2023 tropical cyclone Freddy aggravated social exclusion in several Southern Malawi districts, including Phalombe[173]. The districts that were affected are home to 1.1 million people with disabilities, or which approximately 10% were affected by the cyclone (132,837 women and 127,628 men). A total of 47,424 people with disabilities were displaced, of which 24,186 were women. Cyclone exposure increased vulnerability of many people with disabilities because of the limited access to public services, including specialised health services, and the loss of assistive services, often provided by relatives.
91. People with disabilities, particularly women and girls, face an elevated risk from the consequences of climate change due to various social and economic factors. Poverty, discrimination, and stigma constitute critical elements that influence how persons with disabilities are exposed to the effects of climate change[174]. Additionally, intersecting factors such as gender, age, ethnicity, geographic location, migration status, religion, and sex can further increase the vulnerability of certain individuals with disabilities to the adverse impacts of climate change. These impacts encompass various aspects of their lives, including health, education, food security, housing, access to clean water and sanitation, livelihoods, and mobility[175].
92. Focusing on children, Malawi is among the top 40 countries ranked as having a high climate risk for children, with climate-induced water scarcity the main factor[176]. Climate shocks are frequently occurring and with increased intensity, threatening the health, nutrition, education, development and the survival of children. For example, the first year of the devastating drought in 2015-2017, for instance, left 6.5 million people food-insecure, including 3.5 million children[177]. As another example, in 2022 tropical storms Ana and Gombe devastated the Southern Region of Malawi, causing severe damage to key infrastructures including roads, schools, and health facilities and damaging crops, affecting over 995,000 people, 130,000 of whom were children under the age of five[178]. The storms also kept 100,000 more children and youth out of school.

---

[170] UNICEF (2022) *Malawi commits to putting children's rights and voices at the forefront of climate action.* United Nations Children's Fund, Geneva, Switzerland. Available at: https://www.unicef.org/malawi/press-releases/malawi-commits-putting-childrens-rights-and-voices-forefront-climate-action.

171 UNICEF (2023) *Humanitarian Action for Children, April 2023 revised appeal. https://www.unicef.org/media/140356/file/2023-HAC-Malawi-rev-April.pdf*

172 *Ibid.*

[173] Government of Malawi (2023) *Malawi 2023 Tropical Cyclone Freddy Post-Disaster Needs Assessment.* Government of Malawi, Lilongwe, Malawi. Available at: https://reliefweb.int/report/malawi/malawi-2023-tropical-cyclone-freddy-post-disaster-needs-assessment-april-2023.

[174] UNFPA. (2021). The impact of climate change on persons with disabilities: A call for action. Retrieved from https://www.unfpa.org/resources/impact-climate-change-persons-disabilities-call-action.

[175] The Office of the High Commissioner for Human Rights (2022) *Analytical study on the promotion and protection of the rights of persons with disabilities in the context of climate change.* Report of the Office of the United Nations High Commissioner for Human Rights. Office of the United Nations High Commissioner for Human Rights, Geneva, Switzerland. Available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G20/097/56/PDF/G2009756.pdf?OpenElement.

[176] UNICEF (2021) *The climate crisis is a child rights crisis: introducing the children's climate risk index*. United Nations Children's Fund, New York, USA. Available at: https://www.unicef.org/media/105376/file/UNICEF-climate-crisis-child-rights-crisis.pdf.

[177] WBG, UN & EU (2016) Malawi Drought 2015-2016: Post-Disaster Needs Assessment. World Bank Group, United Nations, and European Union, Washington DC, USA. Available at: http://hdl.handle.net/10986/25781.

[178] UNICEF (2022) *Malawi commits to putting children's rights and voices at the forefront of climate action*. United Nations Children's Fund, Geneva, Switzerland. Available at: https://www.unicef.org/malawi/press-releases/malawi-commits-putting-childrens-rights-and-voices-forefront-climate-action.

Community Profiles: Gender and Social Inclusion Focus

93. Profiles of issues represented by communities across all six districts are presented here, based on gender-disaggregated focus group discussions with men (one in each district), women (one in each district), pregnant and breastfeeding women (one each in two districts) and children (one each in four of the six districts) (Table 3). In addition, people with disabilities were represented through focus groups and key informant interviews in each district with representatives of disability fora, people with disabilities, and parents of children with disabilities. This allows some consideration of intersecting identities, including among people with disabilities and women who are pregnant/breastfeeding and not. Further details of the consultations and methodology can be found in **Annex 7 – Stakeholder engagement plan and summary of consultations, Appendix C.**

Table 3. Summaries of community-level consultations.

Focus Group Discussions (number of participants)						**Key Informant Interviews**	**Total**
District	**Men**	**Women**	**Children**	**People with Disabilities**	**Pregnant & Breastfeeding mothers**	**People with disabilities**	
Balaka	✓ (4)	✓ (6)	✓ (8)	✓ (4)			22
Machinga	✓ (8)	✓ (5)	✓ (6)			✓ (1)	20
Zomba	✓ (4)	✓ (6)				✓ (1)	11
Mangochi	✓ (10)	✓ (10)	✓ (6)	✓ (3)	✓ (8)		37
Phalombe	✓ (8)	✓ (8)	✓ (8)	✓ (12)	✓ (10)		46
Ntcheu	✓ (10)	✓ (10)		✓ (10)			30
Total participants	***44***	***45***	***28***	***29***	***18***	***2***	***166***

The sections below outline the major findings from the focus group discussions.

Focus groups with women, and pregnant and breastfeeding women

The sections below outline the major findings from the focus group discussions.

94. Climate hazards to which women and pregnant women and breastfeeding mothers reported being exposed to in Mangochi and Ntcheu consisted of floods, droughts, heavy rains and heavy winds. Floods, droughts and unpredictable rainfall cause crop losses and variable production levels, while also leading to outbreaks of diarrhea as people do not have proper WASH facilities to use and are forced to resort to open defecation practices. They are also often forced to eat contaminated food. The lack of food production over the following season also causes food and nutrition security. In Ntcheu, flooding of the Bwanje river leads to farmland being submerged, meaning it cannot be cultivated. When maize is not available, people are forced to gather wild food such as mango, which limits dietary diversity and nutritional intake, and is a particular risk for children.
95. Major floods in January and February 2022 were particularly problematic. Stagnant water after the floods led to increases in malaria due to there being more breeding grounds for mosquitoes. Heavy rains and heavy winds caused damage to houses and schools, causing homelessness and the need to hold school classes under trees: Bwanje primary school in Ntcheu was damaged in early 2022. When food is stored in houses, flooding can cause it to spoil – as was reported for maize in Ntcheu. The women recognised that poor land cover due to deforestation increases vulnerability to damage from heavy winds. When losing houses, people are often moved to camps which encourages the spread of diseases.
96. Displacement is a particular problem in the wake of extreme events, including after the summer 2022 floods. The women remarked that the elderly are particularly vulnerable as they have limited capacity to obtain food and rebuild their houses. Promised post-flood support did not materialise, and many

women were forced to seek shelter in school blocks after damage to their houses. Women, pregnant women and lactating mothers also particularly noted the stress and anxiety that extreme events bring because of the uncertainty it creates, which continues long after the actual extreme event is over.

97. Flooding also impedes access to healthcare, which is a particular challenge to pregnant women and breastfeeding mothers. The women noted some extremely remote locations (e.g., villages in TA Mponda) where pregnant women are not able to access facilities, or have to wait a long time on arrival due to the increased healthcare needs caused by the extreme event. Many even end up giving birth in the community or en route, which increases the risk of complications. They particularly noted that, in the case of babies born to HIV-positive women, the lack of medical support creates risks for the baby. Pregnant and breastfeeding women and children are especially at risk of malnutrition. Health surveillance assistants have provided training on the six food groups and the importance of these for children, and how to use backyard gardens to grow a diversity of foods, including pumpkins, rape, vegetables, sweet potato, Chinese vegetables, okra, Amaranthus and maize.
98. The examples that women gave were about how porridge prepared in the morning should be augmented by ground nut flour or cooking oil – or avocado pears which can more easily be obtained if cost is a barrier to the former. Mid-upper arm circumference tapes can identify malnutrition risk, but if the flooded land does not permit growing or obtaining nutritious food, then there are no solutions that can be implemented. Disaster response support tends to focus on the immediate housing needs and overlooks the longer-term agricultural needs, hence highlighting the need for a longer-term adaptation approach.
99. A variety of actions have been taken to adapt to these circumstances, often with external support. In Mangochi, backyard gardens have been established, with pumpkins, sweet potatoes and black jacks, informed by nutritional needs, with training provided by the World Food Programme, Concern Worldwide and Emmanuel International. Small livestock have also been provided to support protein needs. The existence of care groups in the community was previously supported by UNICEF, USAID, Story Workshop and the Government of Malawi, but since early training in January 2022, the continuing support for implementation has been largely lacking, meaning that only a small number of the groups that were developed are now continuing. In particular, the functioning of care groups is impeded following extreme events such as floods and heavy rains because of the impacts on mobility. However, in Ntcheu there are care groups which, among other things, have encouraged households to have WASH facilities and cultivate yellow sweet potato.
100. Women reported in Mangochi that they do participate in the decision-making structures, including the development committees. This participation often follows traditional gender norms, for example they particularly mentioned a group that oversees issues for children under 5 and pregnant women. Women have also been trained to provide mid-upper arm circumference (MUAC) services to identify malnutrition risk in order to identify when hospital treatment is required.
101. Future adaptation priorities include provision of seedlings so that women can grow their own food in their gardens rather than waiting for emergency food to be provided. In Mangochi, women tended to mention planting of trees along watercourses (e.g., Acacia, bluegum, Tangatanga, Nkongomwa, M'bawa and Msangu) to reduce vulnerability to floods, heavy rain and heavy winds, and in Ntcheu women noted that bamboos and vetiver planted around farmland could reduce the vulnerability of crops.
102. Nutrition and WASH-related training to group leaders is also necessary so that they can cascade this information throughout the community. This training should include what robust household-level WASH facilities should look like so people can install them in their own homes to reduce disease transmission; and community-level water access. There is also a need to train more care group leaders, to increase the sustainability of care groups. Pregnant women and breastfeeding mothers need mosquito nets to reduce malaria transmission, and training and support on how to ensure climate-resilient health and nutrition, including through being able to access the six food groups.

Focus groups with children

The sections below outline the major findings from the focus group discussions.

103. The children understood climate change to be changes in the weather, linked to temperature and rainfall. They identified that climate change affected health through floods, droughts and extreme heat that may cause discomfort and increase risk of skin cancer. They identified that they are already experiencing climate change hazards, with a particular focus on floods. The children reported that floods caused damage to houses and rendered people homeless, and caused erosion of plants and animals and crops in farms. These effects were reported to have consequences for people's livelihoods – the children noted that reduced harvests lead to reductions in food intake. In Mangochi, where people

are dependent on businesses and markets, heavy rainfall and floods impede access to market. Heavy rain also makes it more difficult for people to fish on the lake. Personally, the children's lives had been directly affected. They noted that, in cases of flooding, they were not able to access school because of disrupted transport routes.

104. The limitations of the education facilities increase the vulnerability to climate change. When temperatures are high, it can make learning conditions uncomfortable because the school building is already oversubscribed with more than 400 students. The number of classrooms is insufficient, so some students learn outside, which is impractical in the rainy season. To manage this situation, the classes are divided into four groups and the groups rotate the use of the classroom – although this still means that when it rains, 75% of each class is not able to learn. There are seven toilets for boys and six for girls, and many (particularly boys) practice open defecation which increases risk of disease. There is a borehole, but it regularly needs maintenance and is not always functioning, which limits handwashing.

The children's main adaptation priorities include reliable water supply and basins for use in washing hands, and soap, as well as more classrooms and desks.

Focus groups with men

The sections below outline the major findings from the focus group discussions.

105. Climate hazards to which men reported being exposed to included heat waves, floods and heavy winds. Heat waves affect human health by leading to heat exhaustion and dehydration and, in some cases, skin diseases. Heat also has implications for agricultural production and, through implications for water availability, leads to crops dying off in gardens, farms and, in the worst cases, even in *dambo* (shallow wetlands) where water availability is typically better. These effects on agricultural production and water availability, in turn, have implications for food and nutrition security, and poor food and nutritional security in turn negatively impact health, which was recognized to be a particular risk for women and children. Children were reported to be at risk of being afflicted by scabies. Communities also reported increasing unpredictability of rainfall patterns, particularly with regard to the onset of the rainy season, which used to occur in October but was reported to now occur as late as January. Rainfall variability affects agricultural production even outside of extreme events, and can lead to insufficient harvests, with implications again for food and nutrition security.
106. Floods were reported in Mangochi, with particular mention of the January-February 2023 floods, when houses, livestock and other property was destroyed. Likewise in Ntcheu, communities with particular proximity to the Bwanje and Msanza rivers were particularly affected by flooding. Floods destroy crops in the fields, and in Ntcheu men highlighted the consequent risk of malnutrition for children and pregnant women, noting that many had their food intake reduced to one meal per day. Floods also impact on food and nutrition security in the longer term by washing away the nutrient-rich top soil and creating gullies and deposition of sand. In Mangochi, in order to compensate for these impacts, fertilizer has to be applied in the planting season following the floods, but the use of fertiliser is expensive and not accessible to everyone.
107. Damage to infrastructure, such as bridges, also impedes the accessibility to market and the ability to procure food there, for example in Mponda it was mentioned that the bridge close to Makawa trading centre was washed away. Men in Mangochi and Ntcheu also recognized that flooding damage to infrastructure impedes the capacity of women to access antenatal and other health care. In Mangochi they noted this was particularly prevalent in their community as they are situated far from the nearest health centre (in Koche). Men in Ntcheu also reported that floods impeded access to health care because their local Phanga clinic was closed; and the Bwanje health centre was inaccessible due to the bridge being impassable. Among other things, they noted that difficulties for women in accessing contraception led to increases in unplanned pregnancy. In Ntcheu the men also recognized that the damage to infrastructure impeded the capacity of the Health Surveillance Assistants to move around and provide their typical healthcare support. They also noted many deliveries taking place in the community with lack of attending staff, and an increase in pregnancy complications. Heavy winds also cause damage to buildings and shops and have led to loss of maize in the past in both Mangochi and Ntcheu.
108. Male community members reported direct experience with malaria, cholera, and diarrhea. Malaria is largely a seasonal disease, with high cases in the rainy summer season due to the quantity of stagnant water present. Men in Mangochi reported the existence of indoor residual spraying but still said that many cases of malaria occurred. Cholera is a particular risk during incidences of flooding as most households do not have toilets, which means that flood waters can easily spread waste from the uplands to the lakeside in Mangochi. In Mangochi many lakeside communihties drink water from the

lake due to groundwater being saline, thus exposing themselves to the risk of cholera/diarrheal diseases. Even where toilets are present, men in Ntcheu noted that floods wash toilets away, leading to open defecation and thus contamination. In Ntcheu drinking water is also contaminated by the deposition of waste in wells. The communities also recognised a link between climate change and cholera because the timing at which it occurs is now expanded to beyond only the start of the rainy season.

109. In both Mangochi and Ntcheu the community reported knowledge on improved nutrition and complementary and supplementary foods. In Mangochi, a past project by Concern Universal had encouraged growth of vegetables such as mpiru, rape and tomatoes in backyard gardens. Plan Malawi had also supported care groups, through which women were trained on how to prepare well-balanced meals using local resources, as well as being encouraged to breast feed children and give them complementary foods as soon as they reached six months of age. In Ntcheu communities recognized the training they have received from agriculture officials in meeting the needs of the six food groups and how "our body needs carbohydrates and fats that provide us with energy, protein for growth, vitamins to fight off sickness, minerals for strong bones and water for easy digestion and body cooling". They also recognized that community care groups encourage breastfeeding mothers to start giving 6-month-old infants complementary food to discourage stunting. They reported that mothers are encouraged to give infants food that are rich in iron and pureed, for example, porridge made of maize, groundnuts and soya floor, fish, vegetables, a range of fruits and plain water. However, breast feeding is encouraged up to the child being 2 years old.
110. Small livestock such as chicken and goats are kept in the area, but crop agriculture is now rare because many people have sold their land. In the past, prior to this happening, people used to grow orange fresh sweet potatoes. In Mangochi the lake is now the main source of livelihood through fishing. For people who do still have capacity to farm, even on a small scale, there are several NGO projects in operation that provide support, for example Plan International Malawi provides sweet potato vines and cassava cuttings; Concern Worldwide provides sweet potato vines and carrot seed; and World Relief provides vegetable seeds and pesticides. Churches Action for Relief and Development (CARD) and United Purpose provide goats through a pass-on programme. In Ntcheu the International Potato Centre (CIP) has distributed sweet potato vines in partnership with the nutrition department (under agriculture) to improve carotene uptake "to improve vitamin A in the body that is crucial to healthy immune system, eyesight and blood sugar levels". World Vision and the Department of Nutrition are also involved in the formation of care groups that are championing food cooking demonstrations to create awareness in mothers to boost confidence in their cooking techniques and utilization of available nutritious food.
111. Men reported that women are included in major committees in the community. However, the examples they gave were closely aligned to traditional gender norms, with women playing roles in cooking demonstration, village nutrition committees and care groups.
112. Three priority climate adaptations areas for the community were identified. The first consisted of healthcare priorities, which include the need for improved WASH through toilets and boreholes; better access to healthcare was also highlighted, because the nearest health facility at Koche is a mission hospital and only provides free support to cholera cases and delivery of children to pregnant women. The second priority consisted of the promotion of improved land cover through the provision of tree seedlings, because lowland lakeside communities in Mangochi are particularly vulnerable to flooding. And the third priority consisted of support for food security through promotion of drought-resistant and early maturing crops that grow well in a shorter and more unpredictable rainy season.

Focus groups and key informant interviews with people with disabilities

The sections below outline the major findings from the focus group discussions.

113. There are a number of disability-focused organisations operating in the six project districts. All districts have a District Disability Fora (DDF). These are multi-stakeholder bodies established by the Federation of Disability Organisations in Malawi (FEDOMA) that include representation from all sectors. The role of the District Disability Fora is to advocate for the rights of people with disabilities and provide relevant support, for example through the provision of wheelchairs and hearing aids. However, despite some involvement, these structures make little tangible difference in informing health, nutrition and disaster risk reduction activities.
114. In Ntcheu, for example, there is the Association for People with Disabilities in Malawi (APDM), FEDOMA, Sightsavers, and other NGOs and government sectors that are supporting people with

disabilities. Save the Children has a project on disability inclusion which involves youth empowerment, child protection, sexual and reproductive health, education, and economic empowerment. Hunger is implementing a project on nutrition and food security and economic empowerment, which involves distributing small livestock (pigs and goats) and other farm inputs (including fertiliser, soya and maize) to the households of people with disabilities, as well as establishing food banks around the communities. Sightsavers focuses on early childhood development centres where they provide caregivers with training and also screen children to identify disabilities. The CSO network advocates for disability rights by tracking performance of other stakeholders. The ADPM was established with the support of FEDOMA to advocate for inclusion of people with disabilities in community-level development activities. They promote resource mobilisation and run group farms growing maize for food and soya as a cash crop.

115. Despite the institutional framework being in place, and the targeted support provided by these NGOs, there remain substantial barriers to people with disabilities for obtaining equal rights and opportunities. This situation has implications for the health and wellbeing of people with disabilities in the face of climate change. The representative of ADPM in Ntcheu who is, himself, blind, explained that he has to rely on friends and family to share information because he cannot read it himself, and it is never disseminated in braille. Lack of sign language skills similarly prevents deaf people from accessing relevant information, which is a particular obstacle in the communication of disaster early warning information. To overcome these challenges, one recommendation is a mobile van that can disseminate information that properly consider issues of accessibility, for example, visually stimulating information for those with hearing impairments; or the distribution of radios among households with people with disabilities (other than hearing disabilities).
116. The ADPM representative in Ntcheu also provided examples of challenges that people with disabilities face in accessing healthcare. Relative to his home in Ntcheu, the nearest health care facilities (Dzunje and Mphepo zinayi) are approximately 15km away. Neither is fully set up to be inclusive of the needs of people with disabilities, and he reported that there are cases where people visit one health care facility and are told to travel to the other one. To avoid these challenges, many people with disabilities are forced to access community private dispensaries, which carries financial implications. If the costs of community private dispensaries are not affordable, some people are forced to take out loans, which increases the financial pressure they face. The other option for people with disabilities is to wait for a church-supported mobile clinic that visits only twice a month. People with mobility impairments experience particular obstacles after extreme events such as floods.
117. Challenges are magnified for children with disabilities. In Mangochi, the mother of a child with Down's syndrome expressed her fears for him walking around in summer, because of the heightened risk of flooding, even though he is expected to perform exercise to maintain his health status. Many disabled children do not attend school for the same reason, as heavy rains and flash flooding are a significant risk to their mobility. The school in the Ntcheu area does have three teachers trained in disability-focused education, however these teachers reflected that some parents still do not send their children to school, possibly due to fear of stigma. Parents of children with disabilities reflected on the increased costs of securing food and nutrition for their children, particularly in the lean season when harvests have gone down. Particular mention was made regarding the increased costs of fruit and how this leads to reduced dietary diversity.
118. Institutionally, despite the presence of the District Disability Fora at district level, people with disabilities are often marginalised at community level. They are poorly represented on village, group village and area village institutions, which reinforces the prevailing blindness to their needs. The ADMP representative provided the example of sexual and reproductive health services for women with disabilities not being prioritised, and how there have been cases of rape. He also mentioned that people with disabilities tend not to be visible when communities or local institutions are identifying target beneficiaries for (government and non-government) support interventions. The parents of children with disabilities in Mangochi also reflected that disability representation in decision-making structures is extremely poor there, with no disability-focused institutions in operation.

Project-specific conclusions and recommendations

Project-specific conclusions and recommendations

119. In light of the existing gender discrimination and social inclusion issues throughout Malawi and in the target areas of the project that have been highlighted, a list of project-specific conclusions and

recommendations follows for improving the rights and access to opportunities for women, children and people with disabilities. Overarching recommendations are presented, followed by specific national-level, district/area level, community level and project operations level.

Overarching Project Recommendations:

Recommendation 1: Promote leadership and participation of women, youth and people (women, men, youth) with disabilities in any community-level decision-making structures. Work will be done with women and men on women's and disability rights, gender norms, the importance and benefits of women's participation, pressures/norms for men, value of working together, communication, and non-violent, respectful relationships etc. Male and female champions will be identified to promote and reinforce women's participation.

Recommendation 2: Facilitate and promote consultation procedures across all aspects of the project that are inclusive, with proactive efforts made to ensure inclusion of women and youth and those who are from marginalised or excluded groups including women and men with disabilities, HIV and AIDs, etc. This includes developing safe venues for all participants to voice their priorities, opinions and concerns about climate risks and adaptation strategies while avoiding the potential influence of hierarchical and patriarchal structures impacting participation and input. When engaging community members in adaptation and resilience activities, the project can ensure that male, female and youth facilitators facilitate meaningful community participation.

Recommendation 3: Take opportunities to raise awareness and train stakeholders on the importance of inclusive approaches that contribute to gender equality and social inclusion.

Recommendation 4: Address gender norms through working with both men and women, boys and girls, promoting role models and champions to promote women's participation and leadership. Interventions should be designed to change negative attitudes about the role of women and girls and promote the value of participation and leadership from women, youth, and people with disabilities in the community to address climate-related risks to households and communities.

Recommendation 5: Meaningfully collaborate with partners and organisations of particular groups (e.g., child or youth-led groups, feminist and women's organisations, organisations of people with disabilities, etc.) at community, sub-national, national and regional levels

Recommendation 6: Promote fair access to essential services and support in accordance with individuals' needs, free from any obstacles such as discrimination, violence, or exploitation. This includes facilitating the involvement of individuals and groups who face heightened vulnerability or exclusion, aiding in the cultivation of self-protection skills, and enabling active participation in decision-making processes.

Recommendation 7: All training and information is presented in a GESI sensitive manner and tailored to the context and needs of particular groups of participants including women, youth, people with disabilities, children and those who are illiterate. This includes being translated into local languages, and how it is communicated (using different media, for example, word of mouth, written materials including in braille, radio broadcasts, social media, SMS and visual materials). Visual materials should challenge social and gender norms, and promote the inclusion of women, girls and men and women with disabilities. This also includes ensuring that relevant information and appropriate mechanisms to measure effectiveness, as well as safeguarding and complaint mechanisms, address vulnerability and accessibility concerns for all participants.

National level approaches

At the national level, the following approaches will be prioritised:

120. Consultation and close coordination with the MoGCDSW in their developing capacity-building programs for wider government Ministries, Departments and Agencies (MDAs) and government gender focal points that have been established in relevant MDAs to mainstream gender across the respective sectors.
121. Facilitate training on GESI and climate resilience for interested and engaged government stakeholders, ensuring that all training done, and materials generated, are done in a GESI-sensitive

manner, highlighting the importance of the GESI dimensions of climate and health vulnerability and adaptations.

122. Ensure that the health early warning system considers gender and social differences in vulnerability to disease when setting alert levels, and gender and social group-specific actions.
123. When implementing climate-related capacity strengthening and infrastructure standards and climate-resilient infrastructural interventions, include women, youth and people with disabilities (including women and girls with disabilities) in the design and implementation of trainings and health facility upgrades to ensure their priorities and needs are met. Climate-resilient infrastructure needs to include reference of good practice design standards to ensure accessibility for all.
124. Mainstream GESI across all climate-resilient WASH guidelines and standards.
125. Ensure that provision of new training materials for MHPSS and PHC services highlight the vulnerabilities of women and people with disabilities (including women and girls with disabilities), and what can be done to proactively target their needs to ensure equitable vulnerability reduction.

District/area level approaches

At the district/area level, the following approaches should be prioritised:

126. Promote advocacy actions and coalition-building activities that are informed by gender and social differences in vulnerability to climate-related health impacts, and that inclusion in policy documents and planning reflects these needs in order to be gender-responsive and socially-inclusive.
127. Strengthen capacity for data collection for the health early warning system to include sex, age and disability disaggregation of data.
128. Facilitate training on the health early warning system for health care facility staff which highlights the importance of proactively targeting women and people with disabilities with disease-specific alerts, reflecting their vulnerabilities.
129. Work with existing structures and planning processes to ensure that the rollout of malaria, cholera, diarrhoea and nutrition support interventions proactively targets women, pregnant and breastfeeding mothers, children, and people with disabilities (including women and girls with disabilities) to provide equitable vulnerability reduction.
130. Ensure Area Civil Protection Committees are sensitised to the need for inclusive representation within their structures and recognise the need to proactively target messages in a GESI-sensitive manner to different population groups.
131. Actively include gender and disability-focused district-council staff (for example the district social welfare officer) at district level in district and community level activities as a way of supporting the strengthening of gender and disability mainstreaming across sectors at local level.

Community level approaches

At the household and community level the following approaches should be prioritised:

132. Support community level health care staff to maintain up-to-date registers of marginalised groups, including boys and girls, pregnant and breastfeeding women, the elderly and women and men with disabilities in order to ensure their inclusion in health care messaging.
133. Ensure that men in the community are meaningfully engaged and sensitised to the nature of health vulnerability of pregnant and breastfeeding women and children, including through observation of homestead farming approaches.
134. Ensure that the mobile health unit and events proactively target marginalised social groups, both through its routes and positioning (e.g. locating outside health care centres, schools, churches, mosques); and through the active targeting of health content and interventions (delivered through written materials, including in braille, visual arts (theatre), two-way dialogue in small groups with participatory facilitators, loudspeaker, visual materials that have been co-created , and targeted approaches by staff tailored to the needs of different genders and social groups)
135. Ensure that the mobile health unit and community level health staff (e.g., health surveillance assistants) work with community leaders representing different social groups to expand public health care messaging.
136. Ensure that community level health care staff are sensitised to the need to collect sex, age and disability-disaggregated data.

137. Where meetings are called, ensure that venues are easily accessible, childcare is provided, the timings are sensitive to gender roles and daily time budgets, and appropriate support is available for people with disabilities.

Project operations

138. It is important to promote gender equality and social inclusion as core to project equity and effectiveness. Failing to ensure equitable access and benefits runs the risk of reinforcing existing gender and social inequalities. Instead, the differential starting points need to be integral in the planning of all activities to ensure that everyone can contribute and benefit. This ethos should underpin the entirety of the project leadership, including through the project management unit.
139. A full gender and power analysis should be conducted during the inception period, as part of the baseline study, explicitly examining how gender inequality and other social inequalities including disability shape access to power and resources across climate change and resilience. A regular review of the GESI strategy and Action Plan should be undertaken, and adaptations made as needed.
140. Implementation arrangements will engage partners with a track record of successfully implementing GESI-sensitive approaches with communities in the project thematic area (health) in each district. Support for GESI can be provided through the PMU and Save the Children to raise institutional awareness of the importance of commitment to gender equality and social inclusion in internal and external management practices.
141. Mainstreaming targets should be set across the project operations to drive accountability, including:
    - Fifty percent female staff.
    - Targets for women in leadership positions
    - Targets for recruitment, training and promotion of women and men with disability.
    - All project staff should be trained in gender equality and social inclusion, including on working with women and men with disabilities.
    - Findings from this report should be disseminated to Save the Children staff and partners.
    - Position descriptions for technical staff should include their ability to understand and address the needs of diverse groups.
    - Employ a position within the Project Implementation Unit to support implementation of GESI-appropriate measures and ensure that the Monitoring, Evaluation and Learning officer is aware of the importance of, and ensuring the collection of, sex, age and gender disaggregated data collection, analysis and reporting (already represented in the project logframe).
    - GESI implications are consistently discussed and brought up as a standing point to meetings, both internally and with stakeholders.

Gender equality and social inclusion action plan

142. Drawing on the rich information from the GESI assessment, this project is designed to take an intentional approach to gender equality and social justice. It will mainstream gender equality and inclusion by addressing the power relationships at the root of inequality with the aim of ensuring that all the interventions are conducted with the full and meaningful participation of those whose voices are less often heard: women, girls, youth, people with disabilities, etc.

143. The GESI Action Plan will use an approach which starts with reflections on how power is wielded, how decisions are made and who controls resources and then identifies positive changes that can be made in order that the implementation of activities is inclusive and reflects the lived experience of vulnerable and excluded people. In this way, the project will creating a healthier, more equitable, more successful and resilient community.

144. The project will prioritise the impact on climate change on the health of the most vulnerable and marginalized people: women, girls, youth and children, and people (men, women, children) with disabilities. The burden of responding to health shocks often falls disproportionately on women, since they usually act as primary caregivers in households, and as a result are responsible for managing the health of children and other family members. By using the information gathered in the GESI Analysis,

it will guide the community engagement in finding solutions to these problems that are equitable and sustainable.

145. To do this, the project will use a GESI and intersectionality lens, looking at different people's vulnerabilities and taking their capacities into account in the design and implementation of the project. This means preventing and minimising maladaptation of the interventions which could increase people's vulnerability to climate change, physical and psychosocial risks such as sexual and gender-based violence or perpetuate inequality.

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
Outcome 1: Reduced risk from climate-sensitive diseases and conditions				
Output 1.1: Climate-informed health surveillance system and Health Early Warning System				
Activity 1.1.1: Strengthen the health surveillance system by identifying alert triggers for key climate-sensitive health conditions	(GESI action) When determining threshold levels for the different diseases, ensure that specific consideration is given to differences in thresholds for women, children and men and women with disabilities, and that this is written into the new threshold documents. Targets: • Data disaggregated by gender, age and disability status in 100% of the new threshold-level plans. • Women comprise at least 40%, of the participants in multi-stakeholder workshops[179], • Youth comprise at least 5% (50% girls, 50% boys) of the participants in multi-stakeholder workshops. • At least 12 PWD (6 women and 6 men) are represented in the dissemination workshop (1 woman and 1 man per district).	Y1-Y2	Lead: GESI specialist Support: Climate adviser, DCCMS	$ 20,560 USD
Activity 1.1.2 Strengthen the institutional architecture for managing the ongoing operation of the climate-informed Health Early Warning System (HEWS)	(GESI action) Identify potential women for inclusion in the coordination committee for the health Early Warning and Response System (EWARS) and provide training and support for women to develop the skills and confidence to participate fully in the committee and be influential. (GESI action) When forming the coordination committee for the health EWARS, ensure that women's voices are represented in the process, and at least one man and one woman with a disability is	Y1-Y2 Y2 onwards	Lead: GESI specialist Support: DCCMS, MoH	$18,286 USD

[179] The formulation of this target reflects a potential reality, on the ground, of an insufficient pool of women in the relevant institutions, from which to draw members for the workshops

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	consulted when developing the Terms of Reference for the committee. (GESI action) The tools developed to strengthen skills and knowledge of the health EWARS among national and district staff must be co-created in consultation with at least one man and one woman with a disability, as well as with representatives from different social and economic groups, and the tools themselves must consider accessibility requirements so they can be used by all. (GESI Action) The training materials and all materials used in awareness-raising activities must include modules or specific information on the differential needs of vulnerable groups (women, youth and people with disabilities) in terms of early warning systems. Training materials must be accessible to men and women with disabilities. Targets: • At least 40% of the committee members must be women[180] • At least 50% of those receiving training must be women • At least 10% (50% boys and 50% girls) of those receiving training must be youth. • Among all the government officials participating in the training there must be at least one man and one woman with a disability	Y2-Y3 Y3 onwards		
Activity 1.1.3 Establish sentinel sites at selected healthcare facilities to provide improved climate and health data for the health Early Warning and Response System (EWARS)	(GESI action) As part of the initial meetings and consultations to finalize the location, women and people with disabilities must be adequately consulted to determine whether there are particular considerations in setting up sites that would impact their use.	Y1-Y2	Lead: GESI specialist Support; Chief technical advisor; climate change advisor, MoH	$20,823 USD
Output 1.2 District Health Adaptation Plans				
Activity 1.2.1: Facilitate preparation and local endorsement of District	(GESI action) Reflective workshop on gender, power, inequality and decision-making to identify where the impacts of	Y2-Y5	Lead: GESI specialist	$40,863 USD

[180] The formulation of this target reflects a potential reality, on the ground, of an insufficient pool of women in the relevant institutions, from which to draw members for the coordination committee

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
Health Adaptation Plans in six districts	climate change will hit and agree consensus on priorities. (GESI action) DHAPs will be developed using gender-sensitive, participatory approaches that explicitly consider the different needs of men and women, and should include clear recommendations to achieve gender equality and social inclusion, including for women and men with disabilities. (GESI action) In all training for district government staff, ensure that the differential impacts of climate change risk – especially by gender, disability status and age – are clearly highlighted. Trainings will be accessible for those men and women with disabilities. (GESI action) Ensure that throughout the consultation process, women, youth, and men, women and youth with disabilities, as well as women's rights and disability-focused organisations/networks, are targeted and included in the consultation, with their views represented and highlighted clearly. (GESI action) In cascading knowledge on climate change links to health, explicitly target the most marginalised people at community level – the Community Health Action Groups will identify these community members and ensure they are prioritised in any knowledge dissemination. This will be done in a way that avoids further stigmatisation or other do no harm risks. (GESI action) The toolkit produced for implementation of the DHAPs in the 22 non-target districts must be accessible to women and men with impairments, and explicitly consider the different communication requirements for marginalised groups – especially women and youth with disabilities. Images used in materials should represent a diverse range of people, showcasing the different actors involved in responding to climate-induced risks.	Y2-Y5 Y3-Y5 Y4-Y5 Y3 onwards Y4 onwards	Support: District officers, MoH	

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	Targets: • At least 50% of district government staff participating in the design and validation of the DHAPs are women, and at least 10% (50% boys, 50% girls) youth. • In each district, at least one woman and one man with disabilities are consulted in the design of the DHAPs. • For community-level training by community health action groups, at least 50% of the participants must be women, and at least 30% (50% girls, 50% boys) must be youth. Trainings will be accessible for women and men with disabilities.			
Activity 1.2.2: Advocate for stronger integration of climate-resilient health within adaptation planning at district and sub-district level	(GESI action) The networks and groups included in the coalition for integrating climate-resilient health into district plans, must include a disability-focused organisation or network, and a women's or girls' rights organisation or network. (GESI action) The joint advocacy strategy that is designed must include communications material showcasing the differential impacts of climate change on women, men and marginalised groups. (GESI action) As part of the advocacy strategy, voices of the most marginalised groups must be central and should be included in presentations delivered as part of the strategy – especially those of young women and women with disabilities. Targets • At least 50% of participants in the coalition must be women, and at least 15% (50% girls; 50% boys) must be youth. • At least one woman and man with disabilities will be included in the coalition per district.	Y2 onwards Y3 onwards Y3 onwards	Lead: GESI specialist Support: District manager Project officers Advocacy support function, MoH	$23,711 $USD
Outcome 2: Healthcare infrastructure is able to deliver service and care in the context of changing climate risk				
Output 2.1 Climate-resilient health centres, district hospitals and central hospitals				

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
Activity 2.1.1: Develop a national standard for climate-resilient healthcare facilities	(GESI action) The consultative process to develop the national standard for climate-resilient facilities must include a range of voices, with explicit consideration and focus given to female users of facilities, youth and children, and women and men with disabilities. (GESI action) The national standard developed must explicitly include guidelines on how healthcare facilities should consider the needs of women, youth and children, and those with disabilities. (GESI action) Training delivered on the national standard must include female trainers, preferably including women with disabilities, and be accessible for women and men with disabilities. Targets: • At least one woman and one man with disabilities per district must be included in the consultation process. • At least 25% (50% girls and 50% boys) of people included in the consultation process must be youth. • At least 50% of training participants must be female,and at least 10% (50% girls and 50% boys) youth.	Y1-Y2 Y2-Y3 Y2-Y5	Lead: GESI specialist / Health and nutrition specialist Support M&E manager Safeguarding specialist, MoH	$ 2,004 USD
Activity 2.1.2: Strengthen climate resilience of healthcare facilities	(GESI action) The initial assessment of the 79 health facilities to review alignment to national standard must include tools to determine suitability of climate-resilient features for women, youth and children, and women and men with disabilities. (GESI action) The Terms of Reference for the procurement and installation of physical improvements to health facilities must include clear deliverables about how the infrastructure would be adapted to consider the needs of women, youth and children, and men and women with disabilities. (GESI action) In the installation of physical improvements to healthcare facilities, consideration must be given to the differing needs (for example, for water use and access to electricity) of women, youth and	Year 2 Y2-Y4 Y3 Year 2	Lead: Procured party Support: GESI specialist Health and nutrition specialist Project director, MoH, DCCMS	$ 61,004 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	children, and men and women with disabilities. (GESI action) The tool developed to assess the climate-resilience of healthcare facilities must include assessment questions that specifically reference marginalised groups and how they access physical infrastructure in health facilities, as well as the separate risks they face. Targets: • In the initial assessment of health facilities, at least 50% of respondents must be women , and at least 15% (50% girls and 50% boys) must be youth. • In the initial assessment of health facilities, at least one man and one woman with a disability must be consulted per health facility. • Across the 79 health centres, at least 40% of those responsible for infrastructure maintenance (on the committees) must be women and at least 5% (50% girls and 50% boys) must be youth.			
Activity 2.1.3: Build capacity of Malawi's health sector to apply the climate-resilient healthcare facility standard	(GESI action) The training materials must be developed to ensure they are accessible to men and women with disabilities, with a range of access requirements considered, and developed in consultation with men and women with disabilities. (GESI action) Priority should be given to female health infrastructure planners going on study visits, to ensure that they are represented in the learning and planning process. Where necessary, the project will work with women to reduce gender barriers for them (childcare, etc.) as well as addressing barriers to those with disabilities. Targets: • At least 50% of training participants are women, at least 10% (50% girls, 50% boys) are youth, and out of all the participants across districts there is at least one female and one male participant with a disability.	Y4 Y4-Y5	Lead: GESI specialist Support: District coordinators, MoH	$4,235 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	• At least 50% of those participating in study visits are women and at least 10% (50% girls, 50% boys) are youth.			
Activity 2.1.4: Develop guidelines for climate-resilient WASH facilities	(GESI action) The consultative process to develop the guidelines for WASH facilities must include equally the voices of the most marginalised, especially women, youth and children, and men and women with disabilities. (GESI action) The guidelines must consider how women, youth and children, including those with disabilities, use WASH facilities, especially considering safe spaces for women and children and accessibility for those with disabilities. The guidelines must explicitly describe how the proposed new facilities will address these issues. The guidelines must also be accessible for all individuals with disabilities and be translated into local languages. (GESI action) Training delivered on WASH guidelines must be delivered in a way that includes the voices of women, youth and children, including those with disabilities, and any training materials developed must showcase the range of users of WASH facilities. Targets: • At least 50% of those involved in consultation and validation processes for the guideline must be women, at least 30% (50% girls, 50% boys) must be youth and at least 10% (50% girls, 50% boys) must be children. • At least 3 people with disabilities (ensuring both women and men with disabilities) are consulted to develop the guideline. • At least 50% of training participants must be women, and at least 30% (50% girls, 50% boys) must be youth. • At least one woman and one man with disabilities must be included in	Y1-Y2 Y2 Y3 onwards	Lead: WASH specialist Support: GESI specialist, Ministry of Water and Sanitation	$31,684 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	the training sessions in each of the 6 project districts.			
Activity 2.1.5: Upgrade WASH facilities at schools to improve children's health under climate change	(GESI action) As part of the initial assessment to inspect existing WASH facilities at schools, consult with women and girls to understand particular challenges they face, as well as representatives from people with disabilities (men, women, children) – especially any existing forums – to understand access requirements that can be built into the design and location of the WASH facilities. (GESI action) As part of the initial assessment, also ensure that school children themselves are consulted on the design and location of WASH facilities, to understand particular issues impacting their use and access to facilities. (GESI action) Include in ToRs for contractors explicit language about designing new WASH equipment with gender and marginalized people in mind, and use this as a selection criterion. Make sure that the inception period with the contractor for WASH also includes orientation by the project GESI specialist in inclusion of specific requirements for women and other marginalized groups. (GESI action) When forming maintenance committees for the equipment, make sure that the committee draws from a range of community members or school authorities (including women and children, and where possible, at least one person with a disability, which should be a woman in the first instance) so that upkeep and access requirements consider all necessary views. Targets: • At least 10% of respondents consulted in initial assessments are people with disabilities (of which minimum half are women), • Minimum 50% of respondents are women	Y1 Y1-Y2 Y2 Y3-Y5	Lead: WASH specialist Support: GESI specialist; community mobilization officers; district WASH officer, Ministry of Water and Sanitation	$121,732 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	• Minimum 50% (50% girls, 50% boys) are youth (of which minimum half are women) • Minimum 30% (50% girls, 50% boys) are children. • Gender, disability and other access requirements included in design for 100% of WASH facilities. • Maintenance committee members are at least 50% women across the entire project intervention, and at least 50% (50% girls, 50% boys) youth. • At least 40% of maintenance committees include at least one man and one woman with a disability. • There is a children's representative for the WASH maintenance committees in 100% of all target schools			
Outcome 3: Healthcare staff are able to deliver service and care in the context of changing climate risk				
Output 3.1 **Healthcare staff trained in managing climate-related disease monitoring, health messaging, and disease treatment and prevention**				
Activity 3.1.1: Build data collection capacity to strengthen surveillance of climate-related diseases	(GESI action) In conducting the initial assessment of healthcare staff, ensure that the assessment tool includes questions relating to the differential impacts of climate change on vulnerable groups, including the impact on GBV and SRH. (GESI action) Ensure that the questionnaire contains suitable demographic questions so that the data can be disaggregated by gender, age and disability status. (GESI action) Design training materials in a participatory and inclusive manner, with women and youth - including those with disabilities - consulted on the training content so that it is suitable for their differing needs. (GESI action) When delivering data entry training, ensure that there are equal numbers of female facilitators as men, and that they are trained in communicating most effectively those with differing needs	Y1–Y2 Y1–Y2 Y2 Y2-Y3	Lead: GESI specialist Support: M&E Manager Project officers, DCCMS	$6,438 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	(including for women and men with disabilities). Targets • At least 50% of respondents to the initial assessment are women, and 10% (50% girls, 50% boys) are youth. • In each district, at least two people with disabilities (one woman and one man) are included in the initial assessment. • At least 50% of training participants are women and 10% (50% girls, 50% boys) are youth. • In each district, at least one woman and one man with a disability is included in the capacity-building training. • At least 40% of training facilitators are women and at least 5% (50% girls, 50% boys) are youth.			
Activity 3.1.2: Build knowledge and capacity among district and community healthcare staff on climate and health and use of EWARS	(GESI action) When seeking endorsement from the MoH staff for the training course, women from the ministry should be consulted on the training materials and the materials should include specific reference to acute impacts of climate change on health for women, youth and children, including those with disabilities, including GBV and child marriage and reduced access to SRH. A specific conversation on this should take place with MoH officials in promoting the training. Training materials will be accessible for women and men with disabilities, and be produced in local languages. (GESI action) In the capacity building for district and community healthcare staff, ensure that there is a specific module on the differential impacts of climate change – especially natural disasters such as floods – on vulnerable group. The module should include GBV and child marriage prevention, including monitoring systems and referral and response, and SRHR, including for adolescents. (GESI action) In the capacity building for district and community healthcare staff,	Year 2 Y2-Y3 Y2-Y4 Y3 onwards	Lead: GESI specialist Support: Climate and health technical advisor M&E Manager, DCCMS	$84,517 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	ensure that there is a specific module on the differential impacts of climate change on vulnerable groups, particularly for males and females (of all ages) with disabilities. An intersectional lens must be used. (GESI action) When Senior Health Surveillance Assistants (SHSAs) and HSAs deliver the training to community volunteers, provide a separate space for women and men so that there is a safe space to discuss any traditional gender norms which may prevent women from either accessing early warning systems effectively, or that would cause them to bear the brunt of natural disasters more severely. It is crucial that the community volunteers are aware of the community dynamics in a disaster setting. Targets: • At least 3 people with disabilities (including 2 women with disabilities) are consulted in designing the training materials. • At least 40% of the members of the national cadre of trainers are women and at least 5% (50% boys, 50% girls) are youth. • At least 60% of training participants at district and health facility-level are women and at least 20% (50% girls, 50% boys) are youth. • In each district, at least one woman and one man with disabilities are included in the training for district and health facility staff. • At least 40% of respondents to needs assessment of community healthcare staff are women and at least 10% (50% girls, 50%boys) are youth. • At least 50% of the community healthcare volunteers receiving training are women and at least 15% (50% girls, 50% boys) are youth.			
Activity 3.1.3: Provide medical supplies and technologies for climate health risk reduction and response	(GESI action) When reviewing existing practices for determining threshold levels for specific illnesses or conditions, review with a GESI lens to assess whether the current practice considers the different needs of	Y1-Y2	Lead: Health and nutrition specialist Support: GESI specialist;	$81,172 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	women, youth and children, including those with disabilities, and other vulnerable groups. This should include any data collection tools used in the annual needs assessment tools, ensuring that the threshold data can be disaggregated effectively. (GESI action) In supporting distribution of treatments, HSAs should receive training on the differing needs of women, youth and children, including those with disabilities, and other vulnerable groups, in terms of disease burden, and when rolling out to communities, they should prioritise the most vulnerable groups. Targets: • At least 10% of those receiving treatments are people with disabilities (of which min. half are women). • At least 60% of those receiving treatment are women. • At healthcare facility level for facilitation of therapeutic and supplementary feeding, at least 60% of staff delivering the intervention are women, and at least 10% (50% girls, 50% boys) are youth.	Y2-Y3	procurement officer, MoH	
Activity 3.1.4: Equip healthcare workers with MHPSS capacity to address mental health impacts of a changing climate	(GESI action) In adapting existing tools and training packages on climate-relating MHPSS to the Malawi context, consult with women, men and youth – including those with disabilities - separately to understand how climate change impacts their mental health, and incorporate their views into training materials. This includes the mental health impacts of GBV caused by climate stresses. Ensure that all training materials are accessible for women and men with disabilities, and are translated into local languages. (GESI action) When building the national cadre of trainers, give space for women to lead the process – for example, by encouraging them to lead or facilitate group	Y1-Y2 Y3 Y4-Y5	Lead: GESI specialist Support: M&E Manager District leads Technical advisors, MoH	$29,380 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	discussions – and ensure that their voices are heard in the initial training process, giving them confidence to improve their skills. Ensure that women and men with disabilities are also included where possible, and given space to lead the process and have their voices heard. (GESI action) The training of community health workers by the national cadre of staff should include explicit instructions on how to target the most marginalised community members for MHPSS services, including training on recognition of people who would be unlikely to come forwards by themselves. Targets: • At least 60% of the national cadre of trainers should be female, and at least 5% (50% girls, 50% boys) youth. • At least one person in the national cadre of trainers should have a disability, with a woman with disability prioritised (this target assumes that people with disabilities are present in the pool of potential trainers, failing which, this target cannot be met). • In the review and consultative process, at least 5 people with disabilities should be included (of which 3 should be women). • At least 50% of the district and community health workers trained should be women, and at least 5% (50% girls, 50% boys) youth.			
Activity 3.1.5 **Build capacity among district and community healthcare staff to address the gendered impacts of climate change**	(GESI action) In developing a training module on climate and GBV, CEFM and SRHR , consult with women, men, children and youth – including those with disabilities - separately to solicit their perspectives and inputs on climate-related GBV, CEFM and SRHR issues and needed support. Ensure that all training materials are accessible for women and men with disabilities, and are translated into local languages.	Y2-Y5 Y2-Y4 Y2-Y4	Lead: GESI specialist, procured parties Support: Community mobilization officers; district officers, MoH	$18,952 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	(GESI action) When seeking endorsement from the MoH staff for the training course, women from the ministry should be consulted on the training materials and the materials should include specific reference to acute impacts of climate change on GBV, CEFM and SRH related issues for women, youth and children, including those with disabilities. Training materials will be accessible for women and men with disabilities, and be produced in local languages. (GESI action) The training of health workers by the national cadre of staff should include explicit instructions on how to target the most marginalised community members for GBV/CEFM/SRHR-related services, including training on recognition of people who would be unlikely to come forwards by themselves. (GESI action) In supporting distribution of treatments, health staff should receive training on the differing needs of women, youth and children, including those with disabilities, and when rolling out to communities, they should prioritise the most vulnerable groups. Targets: • In the review and consultative process, at least 80% of people consulted should be women, at least 50% (50% girls, 50% boys) should be youth, and at least at least 6 people with disabilities should be included (of which at least 4 should be women and girls). • At least 50% of the district and community health workers trained should be women, and at least 5% (50% girls, 50% boys) youth. • At least 10% of those receiving treatments are women with disabilities. • At least 80% of those receiving treatment are women and girls.	Y2-Y4		
Outcome 4: Community level health is more resilient in the context of changing climate risk				

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
Output 4.1: Stronger community capacity to reduce health risks from climate change.				
Activity 4.1.1: Equip community structures to provide knowledge and skills for climate-resilient WASH facilities to community members.	(GESI action) Ensure training on WASH facilities includes the particular requirements of women, youth and children, and people (men, women, children) with disabilities. These groups use WASH facilities differently and this must be reflected in the training. (GESI action) Identify women and girls – including those with disabilities - for inclusion in the management, maintenance and monitoring groups for community WASH facilities, and provide training and support for these women and girls to develop the necessary skills and confidence to lead these groups. (GESI action) In training district and facility health and education staff, ensure the needs of children in particular are highlighted, with techniques explained on ensuring children can access water effectively and safely. Targets: ● At least 40% of those trained at ACPC and Traditional leadership level are women[181], ● At least 1 person of those trained at ACPC and Traditional leadership level are youth in each TA ● At least 50% of those trained at district education and health facility level in each of the 6 target district are women, and at least 10% (50% girls, 50% boys) youth. ● At least one woman and one man with disabilities are trained at district education or health facility level in each of the 6 target districts. ● At least 50% of the cadre of trainers will be women, and at least 5% (50% girls, 50% boys) youth. ● 100% of those trained to lead the management, maintenance and monitoring groups for community WASH facilities are women, of which min. 20% (50% girls, 50% boys) are youth, and minimum 1	Y3-Y5 Y3-Y5 Y2-Y3	Lead: GESI specialist Support: Technical specialist, district leads, Ministry of Water and Sanitation	$ 1,967 USD

[181] The formulation of this target reflects a potential reality, on the ground, of an insufficient pool of women in the relevant institutions

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	should be a woman or girl with disability.			
Activity 4.1.2: Embed understanding of early warnings and alert protocols within communities, including children	(GESI action) Community-focused training materials developed at the national level should include co-creation with girls and boys, including those with disabilities, to determine the most effective way of reaching children at community-level. This could include a short workshop to identify understanding, needs, and receptivity to different media by girls and boys. (GESI action) Training materials developed for community engagement should also be co-created and pre-tested in consultation with disability action groups and women's and girls' rights organisations – and validated by these groups on completion of design. (GESI action) Staff operating at community level to deliver the training will receive additional training from the GESI specialist on community engagement for the most marginalised groups, ensuring that they are included in the actions. (GESI action) When delivering training for teachers and school pupils, community-level staff will include modules on the different roles of boys and girls, and separate spaces for girls will be provided to ensure they understand what is meant by early warnings and alert protocols. Targets: • At least 50% of individuals from marginalised groups (out-of-school children, the elderly, men and women and children with disabilities) taking part in training are women. • In each of the target villages, at least 20 individuals from marginalised groups take part in training (with a balance between out-of-school children, the elderly, men and women and children with disabilities).	Y1-Y2 Y1-Y2 Y2-Y5 Y2-Y5	Lead: GESI specialist Support: District leads, technical lead, technical advisors, DCCMS	$ 123,157 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	• At least 30% (50% girls, 50% boys) of community members taking part in training are youth. • At school level, at least 50% of pupils receiving training or information are girls. • At school level, at least 3 children with disabilities (2 girls, 1 boy) take part in training in each target village.			
Activity 4.1.3: Train communities to reduce their own vulnerability to climate-induced health risk	(GESI action) The screening tool will be developed to include specific questions for people with disabilities (men, women, children), women, and youth and children, to ensure the results can be disaggregated effectively, and the differential impacts of individual risk to climate change among marginalised groups can be calculated. (GESI action) The health content, interventions and messages that are delivered at a community level will be co-created and developed with women, youth, and men and women with disabilities to ensure they include information on the specific climate change risks to these marginalised groups, and are acceptable, feasible and appropriate to the context. Targets: • At least 50% of those receiving promotional materials or awareness-raising materials from mobile health units are women, at least 50% (50% girls, 50% boys) are youth, at least 20% are elderly and at least 5% are people with disabilities (with minimum half of these being women, and minimum half youth). • 100% of officers hired as SBC-specific officers to deliver materials as part of this activity are trained on access requirements for women and other marginalised groups, especially on early warning systems. • At least 50% of officers hired as SBC-specific officers are women,	Y1-Y2 Y2-Y4	Lead: GESI specialist, MoH	$117,160 USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	and at least 10% (50% girls, 50% boys) are youth.			
Activity 4.1.4: Support families with pregnant women, breastfeeding mothers and children under 2 to provide appropriate infant feeding and produce climate-resilient complementary nutritious food	(GESI action) Community-level staff overseeing the homestead farming module will receive training on community engagement with pregnant women and breastfeeding mothers, to identify the most vulnerable members of this group and ensure they are included in the training. This group is likely to include women with disabilities, so consultation, training and information needs to be accessible. Targets: • At least 5% of mothers included in the farming modules will be women with disabilities. • At least 30% of lead farmers across the target villages will be women[182]	Y1 Y2	Lead: Health and nutrition specialist Support: GESI specialist, agricultural extension officers, Technical advisors, Ministry of Gender, Community Development and Social Welfare	$ 235,670 USD
Activity 4.1.5 Strengthen communities' capacities to reduce their vulnerability to the health impacts of climate change, particularly gendered impacts	(GESI action) Facilitators proposed to conduct initial community outreach sessions must be assessed to ensure they have the suitable skills and attitudes to deliver initial training on gender and social inclusion issues, and have participatory facilitation skills. (GESI action) As part of the initial community engagement, select men and boys who will act as male champions within their communities and within district officers to promote the project impacts and champion the community- and district-level discussions among other men and boys. (GESI action) The consultant procured to deliver this activity (individual or organisation) must have experience of working specifically on women's and girl's issues in Malawi before, with a strong preference for an organisation who has worked on the intersection of gender and climate change, and who has experience working with other marginalised groups such as men and women with disabilities and with women's rights and disability-focused organisations/networks.	Y1 Y2-Y5	Lead: GESI specialist Support: District social welfare officers; Community mobilisation officers, Ministry of Gender, Community Development and Social Welfare	$143,986 USD

[182] The formulation of this target reflects a potential reality, on the ground, of an insufficient pool of women among the lead farmers

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	(GESI action) Ensure the training specifically targets men and boys, women and girls separately, to address power dynamics and gender norms faced within workplaces, communities and homes. Skilled facilitators who meet set criteria will be able to facilitate in a participatory manner, using adult learning principles, and mediate and manage power dynamics to ensure the voices of the most vulnerable are heard, and actions are decided on by democratic consensus. Targets: • Men and boys will be engaged to develop male champions in at least 25% of households targeted by the intervention. • At least 40% of facilitators are women, at least 10% (50% girls, 50% boys) are youth. • At least 50% of community members taking part in the intervention will be men, at least 5% will be people with disabilities (of which minimum half must be women), at least 30% (50% girls, 50% boys) will be youth and at least 10% (50% girls, 50% boys) will be children.			
Project Operations: Mainstream gender and social inclusion across project operations				
Project Operations: Mainstream gender and social inclusion across project operations	Throughout project: • (GESI action) Conduct a full gender and power analysis as part of the baseline study, explicitly examining how gender inequality and other social inequalities including disability, shape access to power and resources across climate change and resilience. • (GESI action) Develop a GESI strategy. • (GESI action) All Community Health and Well-being for Rural Communities Executing Entity and Implementing Partner staff receive training in gender equality and	Y1 – Y5	Lead: GESI specialist Support: Chief of Party, Partnerships manager, project officers, Ministry of Gender, Community Development and Social Welfare	$ USD

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	social inclusion annually throughout project implementation. • (GESI action) Position descriptions for Technical Staff include their ability to understand and address the needs of women, people with disability and youth throughout project implementation. • (GESI action) Full time GESI Specialist in the Project Management Unit throughout project implementation. • (GESI action) GESI Specialist to train and coach staff in MoH on mainstreaming GESI into plans, budgets and monitoring in Year 1. • (GESI action) Funding to enable GESI Specialist to travel with MoH and district authority staff adaptation activity implementation and monitoring on gender and social inclusion throughout implementation. • (GESI action) Findings of this GESI assessment be disseminated to project staff, government and non-government partners in Year 1 of implementation. • (GESI action) Project M&E and communications represent women, youth and people with disability in positive, empowered roles and use appropriate language and deliver in accessible formats. • (GESI action) Ensure the perspectives of women, men, girls, boys and people with disability are equally represented in project monitoring processes • (GESI action) Ensure progress on GESI action plan is included in all project reports • (GESI action) The project will publicise the grievance redress mechanism through means that ensure the process is accessible to women, men, girls, boys and people with disabilities. Targets:			

Project Activities	GESI Actions, Indicators and Targets	Timeline	Responsibilities	Costs
	• 50% of project staff are women. Baseline: 0% - to be updated once project team recruited. • 5% of project staff are people with disability (of which minimum half women with disability). Baseline: 0% - to be updated once project team recruited. • 50% of project leadership positions are held by women. Baseline: 0% - to be updated once project team recruited.			