GOVERNMENT OF THE REPUBLIC OF MALAWI

Health Sector Strategic Plan II 2017-2022

Towards Universal Health Coverage

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Table of Contents

List of Tables

List of Figures

ACKNOWLEDGEMENTS

Developing the Health Sector Strategic Plan II (2017-2022) has been a huge task, which has been made possible by the enormous commitment and effort of all who have been involved in the process.

The Health Sector Strategic Plan II has been developed by the Ministry of Health jointly with Development Partners, Non-Governmental Organizations (NGOs), Civil Society Organizations (CSOs), District Councils and other government Ministries, Departments and Agencies (MDAs).

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Dr. Dan Namarika
Secretary for Health
July 2017

ACRONYMS

A&E	Accident and Emergency
ACT	Artemisinin-based Combination Therapy
ADC	Area Development Committee
AIP	Annual Implementation Plan
AJR	Annual Joint Review
ANC	Antenatal Care
ARI	Acute Respiratory Infections
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BoD	Burden of Disease
BP	Blood pressure
CBHBC	Community Based Home Based Care
CDC	Centre for Disease Control and Prevention
CDR	Case Detection Rate
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CH	Central Hospital
CHAM	Christian Health Association in of Malawi
CHSU	Community Health Sciences Unit
CHW	Community Health Worker
CMED	Central Monitoring and Evaluation Department
CMR	Child Mortality Rate
CMST	Central Medical Stores Trust
CoM	College of Medicine
CPR	Contraceptive Prevalence Rate
CRVS	Civil Registration and Vital Statistics
CSO	Civil Society Organisation
DALY	Disability Adjusted Life Year
DC	District Commissioners
DEC	District Executive Committee
DFID	Department for International Development
DHMT	District Health Management Team
DHRMD	Department of Human Resource Management and Development
DHO	District Health Officer
DHIS	District Health Information System
DHS	Demographic and Health Survey
DIP	District Implementation Plan
DoDMA	Department of Disaster Preparedness Management Affairs
DOTS	Directly Observed Treatment, Short Course (for Tuberculosis)
DPSM	Department of Public Sector Management
DPT	Diphtheria, Pertussis and Tetanus
EH	Environmental Health
EHP	Essential Health Package
EHRP	Emergency Human Resource Plan
EML	Essential Medicines List
EmOC	Emergency Obstetric Care

EmONC	Emergency Obstetric and Neonatal Care
EMS	Essential Medicines and Supplies
ENAP	Every Newborn Action Plan
FGD	Focus Group Discussion
GBV	Gender-based violence
GDP	Gross Domestic Product
GFATM	Global Fund for the Fight against AIDS, Tuberculosis and Malaria
GIZ	Gesellschaft für Internationale Zusammenarbeit
GoM	Government of Malawi
GVH	Group Village Headman
HAC	Health Advisory Committee
HCAC	Health Centre Advisory Committee
HCMC	Health Centre Management Committee
HCW	Health Care Worker
HDP	Health Development Partners
HEU	Health Education Unit
HIS	Health Information System
HMIS	Health Management Information System
HPV	Human Papillomavirus
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resources Management Information System
HSA	Health Surveillance Assistant
HSC	Health Services Commission
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group
HTC	HIV Testing and Counselling
ICT	Information and Communication Technology
IDSR	Integrated Disease Surveillance and Reporting
IEC	Information Education and Communication
IFMIS	Integrated Financial Management Information System
IHD	Ischaemic Heart Disease
IHP+	International Health Partnerships and other Initiatives
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPSAS	International Public Sector Accounting Standards
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
IT	Information Technology
ITN	Insecticide Treated Nets
JANS	Joint Assessment of National Strategic Plans
JAR	Joint Annual Review
KCN	Kamuzu College of Nursing
LF	Lymphatic filariasis
LLITN	Longer Lasting Insecticide Treated Net
LMIS	Logistics Management Information System
LRI	Lower Respiratory Infections

M&E	Monitoring and Evaluation
MBTS	Malawi Blood Transfusion Service
MCH	Maternal and Child Health
MDG(s)	Millennium Development Goal(s)
MDR	Multi Drug Resistant
MGDS	Malawi Growth and Development Strategy
MICS	Multiple Indicators Cluster Survey
MMR	Maternal Mortality Ratio/Rate
MoEST	Ministry of Education, Science and Technology
MoF	Ministry of Finance
MoH	Ministry of Health
MoLGRD	Ministry of Local Government and Rural Development
MoU	Memorandum of Understanding
MP	Member of Parliament
MTC	Mother To Child
MTEF	Medium Term Expenditure Framework
MTHUO	Malawi Traditional Healers Umbrella Organization
MTR	Medium Mid-Term Review
MYR	Mid-Year Review
NAO	National Audit Office
NCD	Non-Communicable Disease
NCST	National Commission for Science and Technology
NDP	National Drug Policy
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHSRC	National Health Sciences Research Committee
NLGFC	National Local Government Finance Committee
NMR	Neonatal Mortality Rate
NPHI	National Public Health Institute
NSO	National Statistical Office
NTDs	Neglected Tropical Diseases
ODPP	Office of the Director of Public Procurement
OI	Opportunistic Infection
OPC	Office of the President & Cabinet
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PAM	Physical Assets Management
PBM	Performance-Based Management
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PHAST	Participatory Sanitation And Hygiene Transformation
PHC	Primary Health Care
PHIM	Public Health Institute of Malawi
PHL	Public Health Laboratory
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PNC	Post Natal Care
PoW	Program of Work

PPP	Public Private Partnership
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
RH	Reproductive Health
RTA	Road Traffic Accidents
RUM	Rational Use of Medicines
SBCC	Social Behaviour Change Communication
SDGs	Sustainable Development Goals
SDP	Service Delivery Point
SHI	Social Health Insurance
SLA	Service Level Agreement
SMT	Senior Management
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STH	Soil Transmitted Helminths
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TA	Technical Assistance
TA	Traditional Authority
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
THE	Total Health Expenditure
TORS	Terms of Reference
TWG	Technical Working Group
U5MR	Under Five Mortality Rate
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
VH	Village Headman
VHC	Village Health Committee
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WHS	World Health Survey
ZHSO	Zonal Health Support Office

FOREWORD

The Government of Malawi is committed to ensuring that people in Malawi attain the highest possible level of health and quality of life. This will be achieved by addressing social risk factors and ensuring universal coverage of basic health care, which is the constitutional obligation of Government. Health is also an important area for investment by development partners, private institutions and other organisations due to its catalytic effect to the economic sector.

HSSP II development started at an opportune time when the Millennium Development Goals (MDGs) had just ended and the Sustainable Development Goals were launched. The HSSP II, therefore, incorporates the SDG agenda and builds on the attainment of MDGs 4 and 6, reducing child mortality and combating HIV and AIDS, Malaria and other diseases respectively; reduction in maternal mortality; and high coverage of certain key interventions such as skilled attendance at birth and immunisation. The HSSP II has used latest evidence and methods to revise the Essential Health Package that is more realistic than its predecessor packages and helps the public health sector to achieve higher total population health, increase financial risk protection and client satisfaction with health care.

It is well known that health care provision in Malawi is highly dependent on external financing. The HSSP II has, therefore, focussed on strengthening governance of the health sector in order to improve efficiency and get the maximum out of existing resources i.e. human, financial and material. The HSSP II has also put to the fore exploration of domestic financing mechanisms, although it is still envisaged that development aid to the health sector will be critical to sustain the gains made. We, therefore, look forward to continued support from our development partners.

As a strategic document that we have jointly formulated, it is my sincere hope that it will henceforth become the single most important point of reference for design of service delivery programmes, addressing social determinants, resource mobilization and health financing, as it embodies our dream for a better health care delivery system for all the people of Malawi.

Honourable Dr. Peter Kumpalume, MP
Minister of Health
July 2017

EXECUTIVE SUMMARY

The Health Sector Strategic Plan II (HSSP II) 2017-2022 is the health sector's medium term strategic plan outlining objectives, strategies and activities and guiding resources over the period 2017-2022. It succeeds the HSSP I (2011-2016). HSSP II builds on the successes achieved under the previous plan while addressing areas where targets were not met and progress was slow.

Under the HSSP I Malawi made substantial health gains. HSSP I targets for Under-5 mortality and infant mortality were surpassed, 63/1000 live births against a target of 78/1000 livebirths for the former and 42/1000 livebirths against a target of 45/1000 for the latter. There was also a steady decline in the maternal mortality ratio (MMR), which was estimated at 439/100,000 live births in 2016, down from 675/100,000 in 2010. Neonatal Mortality Rate was estimated at 27/1000 live births in 2016, down from 31/1000 live births in 2010. Despite the progress, Malawi's MMR and neonatal mortality rate (NMR) are among the highest in Sub-Saharan Africa. The HIV prevalence among women and men age 15-49 age decreased between 2010 and 2015-16 from 10.6% to 8.8%.

The gains in health outcomes could partially be attributed to increased utilisation of some key services such as skilled attendance at birth which was estimated at 90% in 2016 and the percentage of pregnant women making at least one ANC visit during pregnancy was 95%. On the other hand, only 24% of pregnant women had their first ANC visit in the first trimester; only 51% had four or more ANC visits and only 42% of women and 60% of new-borns received a postnatal check 48 hours of birth. Median coverage of basic vaccinations reached as high as 95% although there was a decline in the percentage of children aged 12-23 months were fully immunized from 81% in 2010 to 71.3% in 2016.

There was mixed progress with regard to development of health systems. The MoH promoted a total of 2,438 staff to more senior positions in the 2014/2015 fiscal year (FY), across many cadres. These promotions however did not extend to health staff working in CHAM facilities, which has created inequities across the workforce. There is still a vacancy rate of 45%, however. During the HSSP I period, a total of 12 new health facilities (1 district hospital and 11 health centres) were constructed. The proportion of the population living within 8 km radius of health facility, however, declined from 81% in 2011 to 76% in 2016. This indicates that there is still a significant proportion of the population that is underserved, especially those residing in the rural and hard to reach areas.

The health care system experienced shortages of essential medical products and technologies. This was due to many factors including inadequate funding, weak supply chain management and irrational use of medicines, leakage and pilferage. For health information systems, critical milestones were achieved at policy level including development of an eHealth strategy, an approved HIS Policy (October 2015), an updated handbook of national indicators and a HIS operational plan. Challenges still remain, the key one being the existence of parallel reporting systems which has created structural challenges and weakened the mainstream monitoring and evaluation system. There was mixed progress with respect to governance of the health sector over the past five years. Weak governance structures resulted in poor coordination.

Health care financing in Malawi remains a challenge. During the period 2012/13-2014/15, development partners' contributions accounted for an average 61.6% of total health expenditure (THE), Government accounted for an average of 25.5% and households 12.9% of the THE. In the HIV/AIDS subsector, donor contributions average 95% of total financing. Health care financing reforms were hence explored such as feasibility of a national health insurance scheme and establishment of a health fund.

Inequalities in health outcomes and health care access persisted during HSSP I; there were differences by wealth status, education, gender and geographical location. The 2016 MDHS shows, for example, that the prevalence of stunting in children under five years is 46% among children in the lowest wealth quintile, 37% among those in the middle wealth quintile and 24% for children in the highest wealth quintile.

The goal of the HSSP II is to move towards Universal Health Coverage (UHC) of quality, equitable and affordable quality health care with the aim of improving health status, financial risk protection and client satisfaction.

The HSSP II aims to further improve health outcomes through the provision of a revised essential health package (EHP) and health systems strengthening for efficient delivery of the EHP. Specifically, the HSSP II sets eight strategic objectives for Malawi's health sector – each with strategies and targets to implement by 2022:

1. Health Service Delivery: **Increase equitable access to and improve quality of health care services.** Objective 1 builds on the successes of the Essential Health Package (EHP), which has outlined the health care interventions available to all Malawians, free at the point of access, since 2004. The aim is to achieve universal free access to a quality revised Essential Health Package (EHP), irrespective of ability-to-pay, to all Malawians.

2. Socio-Economic Determinants: **Reduce environmental and social risk factors that have a direct impact on health.** Objective 2 focuses on strategies that address the environmental and social risk factors that impact on health care requirements and health outcomes. Specifically, the objective focuses on behaviours and life styles, water and sanitation, food and nutrition services, housing, living and working conditions. This objective will be largely implemented at the community level.

3. Infrastructure & Medical Equipment: **Improve the availability and quality of health infrastructure and medical equipment.** Objective 3 attempts to ensure existing health facilities are of sufficient quality and properly equipped to address their specified health care requirements and to increase the proportion of the population of Malawi living within 8km of a health facility.

4. Human Resources: **Improve availability, retention, performance and motivation of human resources for health for effective, efficient and equitable health service delivery.** Objective 4 focuses on improving the absorption and retention rate of health workers in the public health sector while also achieving an equitable distribution.

5. Medicines & Medical Supplies: **Improve the availability, quality and utilization of medicines and medical supplies.** Objective 5 focuses on improving the efficiency of the supply chain for medicines and medical supplies to ensure the availability of the EHP.

6. Health Information Systems: **Generate quality information and make it accessible to all intended users for evidence-based decision-making, through standardized and harmonized tools across all programmes.** Objective 6 focuses on improving and harmonising data collection and management at all levels of the health system, through improving ICT capacity, data protocols and linkages between levels.

7. Governance: **Improve leadership and governance across the health sector and at all levels of the health care system.** Objective 7 focuses on improving communication and strengthening

coordination in the health sector particularly with the goal of reducing duplication and fragmentation in the health sector.

8. Health Financing: **Increase health sector financial resources and improve efficiency in resource allocation and utilization.** Objective 8 focuses on attempts to increase the sustainable finances available to the health sector through both revenue raising and efficiency savings.

A primary concept of the HSSP II has been the rationalisation of the health sector's objectives and activities. The design of the HSSP II has been more realistic than ambitious to ensure all objectives are actually achieved. A number of strategic choices were made with the focus of the HSSP II being on strengthening health sector governance structures and linkages, increasing equitable access and quality of EHP services, focusing infrastructure investments on rehabilitations and increasing medical equipment investments and improving use of health information at all levels.

The five-year cost of the HSSP II is estimated to be USD2,613 million. Costs increase from USD504 million in 2017/18 fiscal year (FY) to USD540 million in 2021/22. The total cost per capita each year remains constant at about USD30.

The HSSP II will be implemented by DHOs, central hospitals, development partners, civil society organisations, Non-Governmental Organisations (NGOs) and other health stakeholders. It will be monitored and evaluated using a set of National Health Indicators. Routine and survey data will be used to measure progress through a harmonized country-led M&E framework.

The HSSP II is structured as follows: Chapter 1 introduces Malawi's health care system and outlines the HSSP II development process. Chapter 2 provides an in-depth situation analysis providing a synthesis of both the health status and health care system. Chapter 3 puts forward the HSSP II vision, mission and goal as well as outlining the objectives set to achieve these. Chapter 4 introduces the revised Essential Health Package (EHP) outlining its detail and objectives. Chapter 5 provides detail of the strategies in the HSSP II by objective. Chapter 6 provides information about the strategic choices made in the plan outlining the priorities and implementation arrangements while also presenting a risk analysis with mitigation strategies. Chapter 7 presents the cost of implementing the HSSP II and Chapter 8 outlines the M&E framework.

1

Introduction

1. Introduction

1.1. Context

Malawi is a landlocked country with a surface area of 118,484 km of which 94,276 km is land. Administratively, the country is divided into three regions, namely the northern, central and southern regions. The country has 28 districts, which are further divided into traditional authorities (TA) ruled by chiefs. The Traditional Authorities are sub-divided into villages, which form the smallest administrative units. Politically, each district is divided into constituencies that are represented by Members of Parliament (MPs) in the National Assembly and constituencies are divided into wards, which are represented by local councillors in District Councils.

The country has an estimated population of 17.4 million people in 2017[1] with an average annual growth rate of 2.7%, giving an estimated population of 20.4 million people by 2022. An estimated 84% of the population lives in the rural areas as compared to 16% in urban centres. Malawi is predicted to experience an average annual urban population growth rate of 4.2% from 2013 to 2030[2], which will result in an increase in urbanization. Malawi has a young population with 64% of the total population under the age of 15, 18% under the age of 5 and only 3% above 65 years. Life expectancy at birth is estimated at 63.9 for both sexes in 2017[3].

Malawi's Gross Domestic Product (GDP) per capita in 2015 was estimated at USD381.40[4]. Real GDP growth for Malawi was reported as 2.9% in 2016[5]. The economy is predominantly agro-based, with agriculture and forestry and fishing contributing to 28% of GDP[6]. Informal employment is higher than formal employment, estimated at 89% and 11% respectively[7]. The mean and median earnings per month for the total economically active population were estimated at USD114 and USD37, respectively. Development aid plays a key role in the economy and in the health sector it accounts for on average 62% of total funding[8]. In addition, diaspora remittances increasingly contribute to the country's economy, estimated at USD34 million in 2015[9].

Literacy is higher among men (83%) than women (72%)[10]. The median number of schooling years completed has increased significantly over time; in 1992 it was estimated at 0.4 years for women and 4.3 years for men compared with 5.6 years for women and 6.6 years for men. This shows that Malawi has also made significant strides in narrowing gender disparities in education. The 2015-16 Malawi Demographic and Health Survey has demonstrated increased women empowerment over time by various attributes. For example, the percentage of women involved in decisions about their health care increased from 55% in 2010 to 68% in 2015-16 and women's involvement in decisions about major household purchases increased from 30% to 55% over the same period.

[1] National Statistical Office in 2016 Population Projections
[2] Unicef 2015
[3] Human Development Report (2016)
[4] Audit Report - Global Fund Grants for Malawi - October 2016
[5] National Accounts and Balance of Payments Technical Committee, Ministry of Finance, Economic Planning and Development and National Statistics Office, Sept. 2016
[6] ibid
[7] The Malawi Labour Force Survey 2013
[8] National Health Accounts for 2012/13-2014/15
[9] World Development Indicators 2017
[10] Malawi Demograhic and Health Survey 2015-2016

1.2. The Malawi Health Care System

Health services in Malawi are provided by public, private for profit (PFP) and private not for profit (PNFP) sectors. The public sector includes all health facilities under the Ministry of Health (MOH), district, town and city councils, Ministry of Defence, Ministry of Internal Affairs and Public Security (Police and Prisons) and the Ministry of Natural Resources, Energy and Mining (Ministry of Health, 2008b). Public provision of health care is enshrined in the republican constitution which states that the State is obliged "*to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care*" (Ministry of Justice, 2006). Health services in the public sector are free-of-charge at the point of use. The PFP sector consists of private hospitals, clinics, laboratories and pharmacies. Traditional healers are also prominent and would be classified as PFP. The PNFP sector comprises of religious institutions, non-governmental organisations (NGOs), statutory corporations and companies. The major religious provider is the Christian Health Association of Malawi (CHAM) which provides approximately 29% of all health services in Malawi (MSPA 2014). Most private and private-not-for-profit providers charge user fees for their services. Table 1 shows the distribution of health facilities by type and ownership.

TABLE 1: HEALTH FACILITIES OFFERING FREE SERVICES IN MALAWI

Facility Type	CHAM	Government	NGO	Private	Total
Dispensary	4	49	4	30	87
Health Centre	107	413	4	18	542
Health Post	18	132	2		152
Hospital[11]	38	45	1	1	85
Outreach	968	4,008	43	71	5,090
Village Clinic		3,542			3,542
Total	**1,135**	**8,189**	**54**	**120**	**9,498**

Source: UNICEF Health Facility Mapping Report (2016)

Malawi's health system is organized at four levels namely: community, primary, secondary and tertiary. These different levels are linked to each other through an established referral system. Community, Primary and Secondary level care falls under district councils. The District Health Officer (DHO) is the head of the district health care system and reports to the District Commissioner (DC) who is the Controlling Officer of public institutions at district level.

1.2.1 Community Level

At community level, health services are provided by health surveillance assistants (HSAs), health posts, dispensaries, village clinics, and maternity clinics. Each HSA is meant to be responsible for a catchment area of 1,000 and there are currently 7,932 HSAs supported by 1,282 Senior HSAs in post[12]. HSAs mainly provide promotive and preventive health care through door-to-door visitations, village and outreach clinics and mobile clinics (Ministry of Health, 2011).

1.2.2 Primary Level

At primary level, health services are provided by health centres and community hospitals. Health centres offer outpatient and maternity services and are meant to serve a population of 10,000. Community hospitals are larger than health centres. They offer outpatient and inpatient services and conduct minor procedures. Their bed capacity can reach up to 250 beds (Ministry of Health, 2011).

[11] Includes Central and District Hospitals
[12] Malawi National Community Health Strategy (2017)

1.2.3 Secondary Level

The secondary level of care consists of district hospitals and CHAM hospitals of equivalent capacity. Based on Table 6, secondary level health care facilities account for 9.5% of all health care facilities. They provide referral services to health centres and community hospitals and also provide their surrounding populations with both outpatient and inpatient services.

1.2.4 Tertiary Level

The tertiary level consists of central hospitals. They ideally provide specialist health services at regional level and also provide referral services to district hospitals within their region. In practice, however, around 70% of the services they provide are either primary or secondary services due to lack of a gate-keeping system (Ministry of Health, 2011).

1.2.5 Ministry of Health Headquarters

The functions of the central level include policy making, standards setting, quality assurance, strategic planning, resource mobilization, technical support, monitoring and evaluation and international representation. Five Zonal Health Support Offices (ZHSOs) are an extension of the central level and provide technical support to districts.

1.2.6 District Health Offices

The functions of the district health offices (DHOs) include: managing all public health facilities at district level and directing provision of both primary and secondary level health services at district level. DHOs report to the District Commissioners who are under Ministry of Local Government. At technical level, DHOs receive technical backstopping from the Zonal Health Support Offices (ZHSOs) who are under the Ministry of Health.

1.3 HSSP II Development Process

The HSSP II development process involved a broad range of stakeholders and this was done through consultative workshops, technical working groups and visits to institutions, departments and programmes at Ministry of Health headquarters, District Health Offices, Central Hospitals, health regulatory bodies, other Ministries, Departments and Agencies (MDAs), the private sector, development partners and Civil Society Organizations (CSOs) were consulted. The Ministry of Health instituted a steering committee that was chaired by the Director of Planning and Policy Development (DPPD) in MoH and had representation from all key stakeholders in the health sector to guide and coordinate the development of the HSSP II. The Directorate of Planning and Policy Development then developed a concept paper, which outlined the framework for HSSP II development. The Steering Committee prepared a roadmap for developing the HSSP II detailing the key activities to be undertaken and the time frame for implementation. The HSSP draft document was then subjected to a Joint Assessment of National Strategies (JANS) process to strengthen its quality.

A Consultant undertook an initial review of HSSP (2011-2016). Then DPPD led a problem tree analysis to identify the root causes of poor health outcomes and health care system challenges. Health care system problem analysis was done with respect to access, efficiency and quality. The HSSP II process benefited from problem analysis that was undertaken as part of the development of the quality of health care strategy which coincided with the HSSP II development process. Consultants undertook more detailed analysis in the areas of drugs and medical supplies, human resources for health, and medical infrastructure and equipment. From these processes, a situation analysis of health and the health care system in Malawi was drafted. A workshop was then held with a wide range of health sector actors to agree on HSSP II priorities based on the situation analysis. The process of revising the essential health package (EHP) was undertaken simultaneously with a series of inclusive meetings and workshops.

1.4 Strategic Linkages with Relevant Policies and Strategies

The HSSP II, as the national health sector medium term strategy, contributes to the national development strategy. The Malawi Growth and Development Strategy (MGDS) II (2011-2016) expired and the next national development strategy (2017-2022) will be the final medium term strategy completing the Vision 2020. The national development strategy is the means of achieving the long-term goals outlined in the Vision 2020. The Vision 2020 states that:

"By the year 2020, Malawi as a God-fearing nation will be secure, democratically mature, environmentally sustainable, self-reliant with equal opportunities for and active participation by all, having social services, vibrant cultural and religious values and being a technologically driven middle-income economy.[13]"

In addition, the HSSP II strategically operationalizes the overall goal and specific objectives of the draft National Health Policy (NHP) which is to improve the health status, and increase client satisfaction and financial risk protection towards attainment of Universal Health Coverage and the 2030 Sustainable Development Goals (SDGs) agenda, thereby contributing to the above mentioned short and long term national development agenda. Malawi is also a signatory to a number of international conventions and the both the NHP and the HSSP II took cognizance of the country's international commitments. These include: the 2005 Abuja Declaration; the 2008 Ouagadougou Declaration on Primary Health Care (PHC); and the Paris Declaration on Aid Effectiveness, the Accra agenda for action and the Busan partnership for effective development cooperation which call for harmonisation and alignment of aid.

The Constitution of the Republic of Malawi states that the State is obliged "*to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care*" guaranteeing all Malawians adequate health care and ensures equality of access to health services.

[13] Vision 2020. http://www.sdnp.org.mw/malawi/vision-2020/index-org.htm

2

Situation Analysis

Situation Analysis

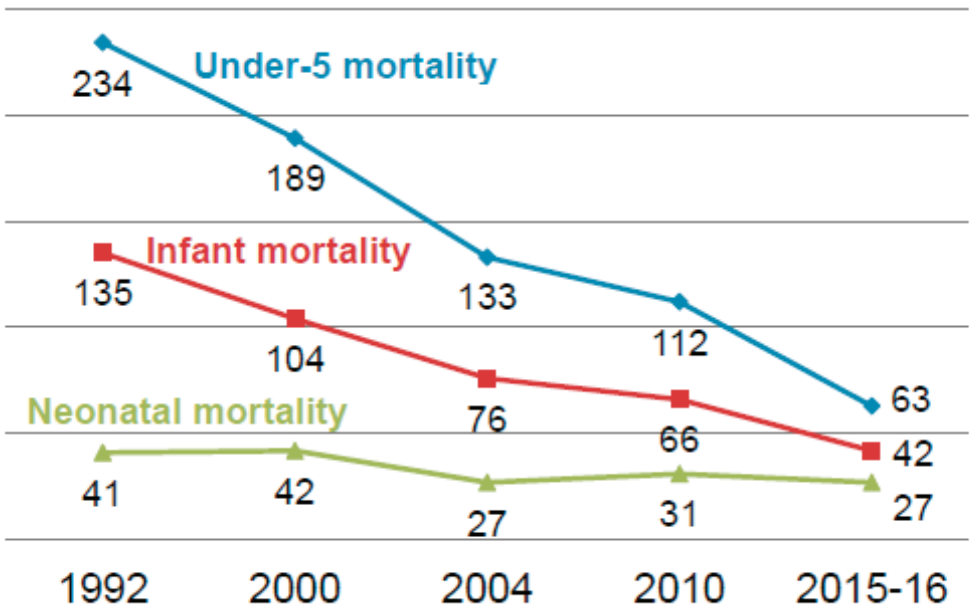
From 2011-2016, the HSSP I guided the Ministry of Health and all stakeholders. The goal of the HSSP I was '*to improve the quality of life of all the people of Malawi by reducing the risk of ill health and the occurrence of premature deaths, thereby contributing to the social and economic development of the country*'[14]. In achieving this, the HSSP would contribute to the attainment of the Malawi Growth and Development Strategy (MGDS II) and the Millennium Development Goals (MDGs). Substantial progress was made during the implementation of the plan over the last five years, while many challenges also remain. This chapter first looks at progress made with respect to health outcomes and then the health care system.

2.1 Health Status

2.1.1 Progress at impact level and attainment of MDGs

There have been improvements in health status indicators over the HSSP 1 period. Figure 1 shows a steady decline in child mortality estimates over time. HSSP I targets of 78/1000 for Under-5 mortality and 45/1000 for infant mortality were surpassed. There is a steady decline in the maternal mortality ratio (MMR), which was estimated at 439/100,000 live births in 2016, down from 675/100,000 in 2010. Despite the progress, Malawi's MMR and neonatal mortality rate (NMR) are among the highest in Sub-Saharan Africa.

FIGURE 1: TRENDS IN CHILD HEALTH INDICATORS



Source: MDHS 2016

Malawi achieved four out of eight Millennium Development Goals (MDGs). Two of the goals met were; reducing child mortality and combating HIV and AIDS, Malaria and other diseases. Table 2 shows progress against MDG targets that the health sector has influence over.

[14] Malawi Health Sector Strategic Plan 2011-2016

TABLE 2: STATUS OF MDG TARGETS IN MALAWI AT ENDLINE

GOAL	INDICATOR	BASELINE	MDG TARGET	ACHIEVEMENT	REMARK
Eradicate extreme poverty and hunger	Prevalence of Underweight children (%)	25.4	14	16.7	NOT MET
Reduce child mortality	Under five mortality rate (per 1000)	189	78	85	MET
	Infant mortality rate	103	44.7	53	MET
	Proportion of 1 year children immunised against measles	83.2	95.3	85	NOT MET
Improve maternal health	Maternal mortality ratio (per 100,000)	1120	155	439	NOT MET
	Proportion of births attended to by skilled health personnel	55.6	100	90	NOT MET
Combat HIV and AIDS, Malaria and other diseases	HIV prevalence among 15-24 year old pregnant women (%)	24.1	0	10.6	NOT MET
	Prevalence and death rates associated with Malaria (%)	3.6	0	3.3	NOT MET
	Access to Malaria treatment within 24h of onset of symptoms (%)	8	60	31	NOT MET
	Proportion of households with at least one ITN	31		71	MET
	Death rates associated with Tuberculosis	22		8	MET
	Proportion of TB cases under DOTS (%)	57	100	100	MET

Source: Malawi Millennium Development Goals Endline report 2016

Note: Malawi Demographic and Health Survey (2016) has latest estimates for some of the indicators in the table

Despite making progress over the period of the last HSSP, Malawi continues to hold a high burden of disease, including HIV/AIDS, respiratory infections, malaria, diarrhoeal diseases and perinatal conditions. Furthermore, while Malawi continues to struggle with reducing its communicable disease burden, it is now faced with growth in non-communicable diseases and its impact.

According to the latest burden of disease estimates in the Global Burden of Disease report (2013), communicable diseases remain the leading causes of Disability Adjusted Life Years (DALYs) in Malawi. Table 3 shows the top 10 causes of DALYs in Malawi in 2011.

TABLE 3: LEADING CAUSES OF DALYS IN MALAWI, 2011

	Condition	% total DALYS
1.	HIV/AIDS	34.9
2.	Lower Respiratory Tract Infections	9.1
3.	Malaria	7.7
4.	Diarrhoeal Diseases	6.4
5.	Conditions arising during perinatal period	3.3
6.	Tuberculosis	1.9
7.	Protein Energy Malnutrition	1.6
8.	Road Traffic Accidents	1.5
9.	Abortions	1.4
10.	Hypertensive Heart Diseases	1.2

2.2 Service Provision

2.2.1 Reproductive, Maternal, Neonatal, Child and Adolescent Health conditions

2.2.1.1 Reproductive and Adolescent Health

Adolescent health indicators remain poor while there was progress with respect to some key reproductive health indicators during the HSSP I period. The MDHS (2016) reported that median age at first sexual intercourse for women age 25-49 has not changed between 2000 and 2016, 16.8 years for both years. Nineteen percent of women age 25-49 had first sex before age 15[15]. Consequently, the proportion of teenage pregnancies is high; 29% of adolescents aged 15-19 years have begun child bearing[16]. Adolescent pregnancies account for 25% of all pregnancies annually[17]. Malawi thus has a high adolescent birth rate of 143/1,000 live birth[18]. The minimum legal age for marriage was increased from 16 to 18 years in the Marriage, Divorce and Family Relations Act of 2015 to address this problem.

The health burden resulting from adolescent pregnancies is significant. Adolescent pregnancies also account for 20% of maternal deaths while approximately 70,000 women have abortions every year of which 33,000 are treated for subsequent complications annually. Unsafe abortions cause 17% of maternal deaths in Malawi. 50% of women presenting for post-abortion care are under the age of 25 years.

[15] MDHS 2016
[16] MDHS 2016
[17] MDHS 2010
[18] MoH (2015) National Youth Friendly Health Services Strategy 2015-2020

Attempts have been made to offset early pregnancies and the subsequent high population growth rate. The contraceptive prevalence rate (CPR) has significantly increased, from 42% in 2010 to 58%[19] in 2016 (targeted 60% for 2016). This trend has contributed to the decline in Total Fertility Rate from 5.7 births per woman in 2010 to 4.4 births per woman in 2016[20]. There is, however, still significant unmet need for contraception, with 19% of women wanting to delay pregnancy or not wanting to have any more children. Unmet need for family planning among unmarried sexually active women, mainly adolescents and young people, is higher at 40% and the contraceptive prevalence rate is only 44%[21], leading to high fertility rates for this demographic group.

2.2.1.2 Maternal and Neonatal Health

Section 2.1.1 showed progress made in this area at the impact level. This is partially attributable to high skilled attendance at birth at 90% in 2016[22] and high percentage of pregnant women making at least one ANC visit during pregnancy, at 95%. On the other hand, only 24% of pregnant women had their first ANC visit in the first trimester and only 51% had four or more ANC visits. Only 42% of women and 60% of newborns received a postnatal check 48 hours of birth. There are plans to scale up legal birth registration to all facilities in 2017.

The number of health facilities that can provide a full package of comprehensive and basic emergency obstetric and neonatal care services are few. Only 45 (53%) hospitals and 29 (5%) health centres can provide a full package of comprehensive and basic emergency obstetric and neonatal care (CEmONC and BEmONC) services respectively and an additional 32% of hospitals and health centres provide partial CEmONC and BEmONC services respectively[23]. In addition to shortages of midwives and doctors to provide obstetric and neonatal services, there are also shortages of supplies and logistics in most health facilities and inadequate transport for referral of emergencies.

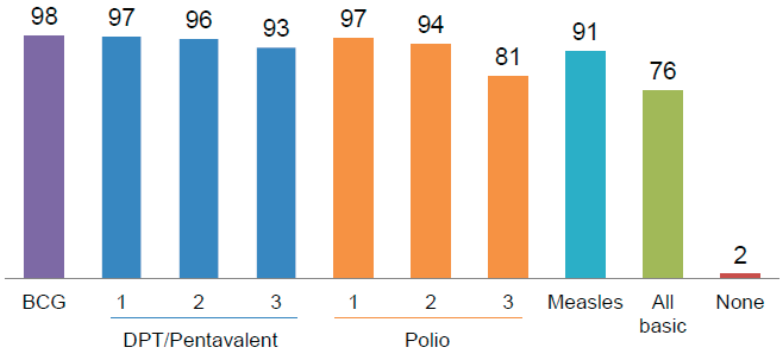
Malawi is implementing its Every Newborn Action Plan (ENAP) which aims to reduce neonatal mortality to 15 per 1,000 live births by 2035.

2.2.1.3 Child Health

Malawi adopted the Integrated Management of Childhood Illnesses (IMCI) approach for comprehensive and integrated management of common childhood illnesses. Nearly 70% of health facilities offer basic child health interventions using the IMCI approach. At community level, child hood illnesses are managed through the integrated community case management (iCCM) approach. The coverage of most childhood interventions has always been high and national immunization coverage of most antigens is over 85% as shown in Figure 2[24]. The 2010 MDHS report shows that 81% of children aged 12-23 months were fully immunized, but this has declined to 71.3% in 2016 (Figure 3). Therefore, a renewed push for full immunization coverage is required.

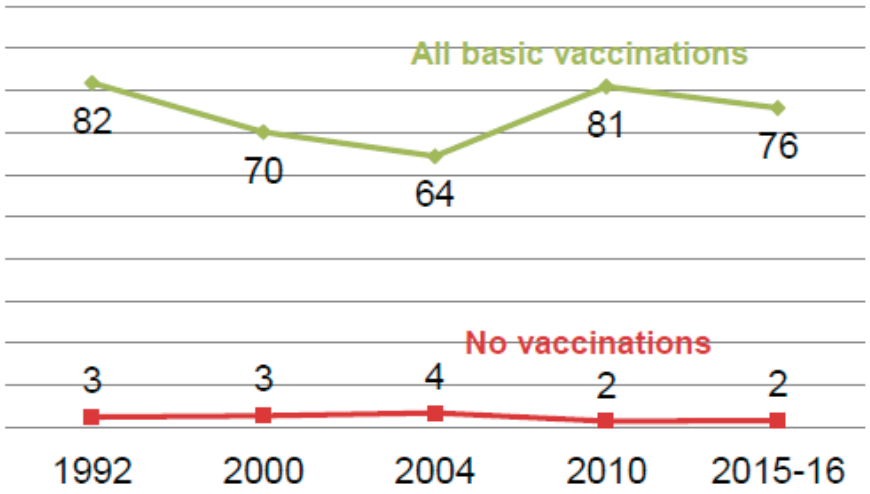
[19] MDHS 2016
[20] MDHS 2016
[21] MDHS 2016
[22] MDHS 2016
[23] Emergency Obstetric and New Born Care Needs Assessment – 2014 MoH
[24] EPI Comprehensive Multi-Year Plan, 2016-2020

FIGURE 2: COVERAGE OF BASIC VACCINATIONS AMONG CHILDREN AGE 12-23 MONTHS



Source: MDHS 2016

FIGURE 3: PERCENTAGE OF CHILDREN AGE 12-23 MONTHS WHO RECEIVED ALL BASIC VACCINATIONS



Source: MDHS 2016

Acute respiratory Infections (ARIs) are still significant causes of morbidity and mortality especially among children under five years. Overall, ARIs are the second leading cause of DALYs in Malawi and the leading cause of mortality. According to the MDHS 2016, mothers reported that 5% of children Under-5 had symptoms of ARI 2 weeks before the survey, 29% had fever and 22% had a diarrhoeal episode.

2.2.2 HIV/AIDS and Sexually Transmitted Infections (STIs)

Malawi continues to make progress in the fight against HIV and AIDS response. The HIV prevalence among women and men age 15-49 age has decreased between 2010 and 2015-16 from 10.6% to 8.8%[25]. The national HIV incidence for both women and men age 15-49 years is 0.32%. Malawi is a global pioneer of the 'Option B+' programme, which automatically puts HIV+ pregnant and breastfeeding women on life-long antiretroviral therapy (ART)[26]. Eighty percent of pregnant women infected with HIV were on ART by May

[25] MDHS 2016
[26] UNAIDS 2016. UNAIDS in Malawi. Shaping a fast track agenda to end AIDS: 2014-15 biennium report.

2015 through the Option B+ programme. Malawi aims to achieve the 90-90-90[27] targets and it is estimated in 2016 that 72.7% of people living with HIV and AIDS (PLHIV) age 15-64 know their status, 88.6% are on ART, while among those who are on ART, 90.8% are virally suppressed[28]. By end of 2015, more than half of the 1.1 million HIV positive people (795,144) had been initiated on ART, with a sustained reduction of the newly infected every year from 120,000 in 1999 to 33,000 in 2015. Approximately 80% of HIV infected TB patients were receiving ART. There is a gradual decline in AIDS deaths estimated at 31,000 in 2015 and projected to fall below 25,000 by 2020 with a gradual increase in the number of patients on ART.

MDHS (2016) reported that 15% of women and 10% of men age 15-49 who responded that they ever had sex, reported having an STI or symptoms of an STI 12 months before to the survey.

While there has been a clear success in the treatment of HIV and AIDS, there is unsatisfactory and inconsistent utilization of HIV preventive measures. Condom use at last sex with a non-marital, non-cohabiting partner was estimated at 54% among young women and 76% among young men. Misconceptions and lack of women's negotiating power have contributed to this low and inconsistent condom use. In addition to this, sexual violence is high; 20% of women have experienced sexual violence since the age of 15[29].

2.2.3 Tuberculosis

Malawi has registered significant progress in the prevention, control and management of TB over the last five years. Strategies put in place to strengthen TB/HIV collaboration are further enhancing efforts in the control and management of TB. The number of TB cases notified has decreased to just below 18,000 cases recorded in 2014. The death rate associated with TB has also decreased from 19% in 2005 to 8% in 2014. TB treatment success rate is reported at 86% (above the WHO target of 85%).. According to the 2011 Drug Resistance survey, the prevalence of drug resistant TB is 0.4% among the new smear positive patients and 4.8% among the retreatment patients. This prevalence is low compared to most SADC member states.

Results from the national TB Prevalence Survey conducted in 2014, however, indicate that there is still a high TB burden in Malawi with an estimated prevalence of 451/100,000 among the adult population with an adjusted prevalence for all age groups at 334/100,000. This is just more than twice the 2014 WHO case detection target of 140/100,000.

2.2.4 Malaria

Malaria is endemic throughout Malawi and continues to be a major public health problem with an estimated 6 million cases occurring annually. It is a leading cause of morbidity and mortality in children under five years and pregnant women. Malaria accounts for over 30% of outpatient visits[30] and is ranked 3rd on the list of conditions that result in Years Lost to Disability[31].

Malaria control efforts have focused on scaling up interventions for prevention and treatment of malaria. Long Lasting Insecticide Nets (LLINs) were distributed to pregnant women and children through routine channels and mass distribution campaigns to scale up vector control measures. There are mixed results with respect to coverage of malaria prevention interventions during the HSSP I period. The percentage of

[27] By 2020, 90 percent of all PLHIV will know their HIV status; 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART); and 90 percent of all people receiving ART will have viral suppression.
[28] Malawi Population-Based HIV Impact Assessment MPHIA 2015-2016
[29] MDHS 2016
[30] MoH, 2012 HMIS data
[31] Global Burden of Disease, 2013

pregnant women who received at least one dose of the recommended IPTp dosage during ANC visit increased from 60.4% in 2010 to 89% in 2016, however only 63% reported taking two or more doses[32]. The percentage of children under five years who slept under an ITN decreased from 55.4% in 2010 to 45% in 2016, while for pregnant women, it decreased from 50.8% to 47% in the same period[33]. The coverage of Indoor Residual Spraying (IRS) however is very low due to lack of financial resources and resistance to chemicals. Treatment of malaria cases has greatly improved with the rolling out of the use of rapid diagnostic tests (RDTs) to all facilities and ensuring that every suspected malaria case has to be confirmed before prescribing any antimalarial.

Mortality due to malaria has reduced, as demonstrated by a reduction of malaria case fatality rate (CFR) from 46% in 2011 to 24% in 2014, representing a reduction of 50%. However, a number of districts still record high incidence and case fatality rates, where focused approach to address high incidence and case fatality rates of malaria is required.

2.2.5 Non Communicable Diseases Prevention and Control

Non-Communicable Diseases (NCDs) are increasingly contributing to the burden of disease in Malawi. NCDs are the second leading cause of deaths in adults after HIV/AIDS in Malawi. They account for 16% of all deaths with 17% in males and 14% in females. Malawi has very high levels of hypertension at 32.9% in adults, which is much higher than many countries in the region. Malawi also has a very high burden of cervical cancer (age standardized incidence of 75.9 per 100,000[34]) which accounts for 9,000 DALYs per year in women.

TABLE 4:PREVALENCE OF COMMON NON-COMMUNICABLE DISEASES IN MALAWI

Disease/condition	Prevalence	Data source
Hypertension	32.9%	NCD STEPS Survey 2009
Cardiovascular Disease (using cholesterol as a marker)	8.9%	NCD STEPS Survey 2009 N=3910, age 25-64 years)
Injuries other than RTA	8.5%	WHS[35]Malawi 2003 (N=5297, age>=18years)
Diabetes	5.6%	NCD STEPS Survey 2009
Asthma	5.1%	WHS Malawi 2003 (N=5297, age >=18 years)
Road Traffic Accidents (RTA)	3.5%	WHS Malawi 2003 (N=5297, age >=18 years)

*WHS - World Health Survey, World Health Organization Report 2005

In Malawi there are many people with mental disorders, a majority of whom seek medical care at health facilities but are misdiagnosed with a physical diagnosis due to the presenting physical symptoms. Common disorders such as depression and anxiety whose prevalence is estimated at 10-20% are often missed or not treated[36]. A link between ART treatment and the development of psychosis has been noted. In addition to depression and anxiety, alcohol and substance use or abuse of cannabis and other substances are very common with practically no drug treatment centre at primary, secondary or tertiary levels.

[32] MDHS 2016
[33] MDHS 2016
[34]GLOBOCAN 2012
[35] World Health Survey, World Health Organization Report 2005
[36] National Action Plan for Prevention and Management of NCDs in Malawi - 2012-2016

Several initiatives are being implemented to address some of the NCDs in Malawi. These include: World Diabetes Foundation project to improve access, care and prevention of NCDs and scaling up of Human Papilloma Vaccine (HPV) project targeting 9-13 year girls to prevent cervical cancer. An Alcohol Policy was approved in 2017 which will help regulate alcohol distribution and sales as a measure of addressing alcohol consumption; a mental health policy is currently under review to include emerging issues.

A national Dental & Oral Health Survey conducted in 2014 showed that 50% of school going children (6-9 years) had tooth decay and the prevalence of tooth decay among 12-17 years old was about 78%. A national Oral Health Week that focuses on oral health preventive and control measures such as dental health education, screening and treatment and tooth fluoridation was instituted as an annual event for the past five years. Over 3 million school going pupils were educated, screened and fluoridated over the last five years.

Poor health seeking behaviour, unhealthy lifestyles among the population, inadequate human and financial resources, poor reporting on DHIS2 NCDs and Mental Health data by health facilities and poor infrastructure for chronic care clinics remain key challenges to the prevention, control and care of NCDs.

2.3 Social Determinants of Health

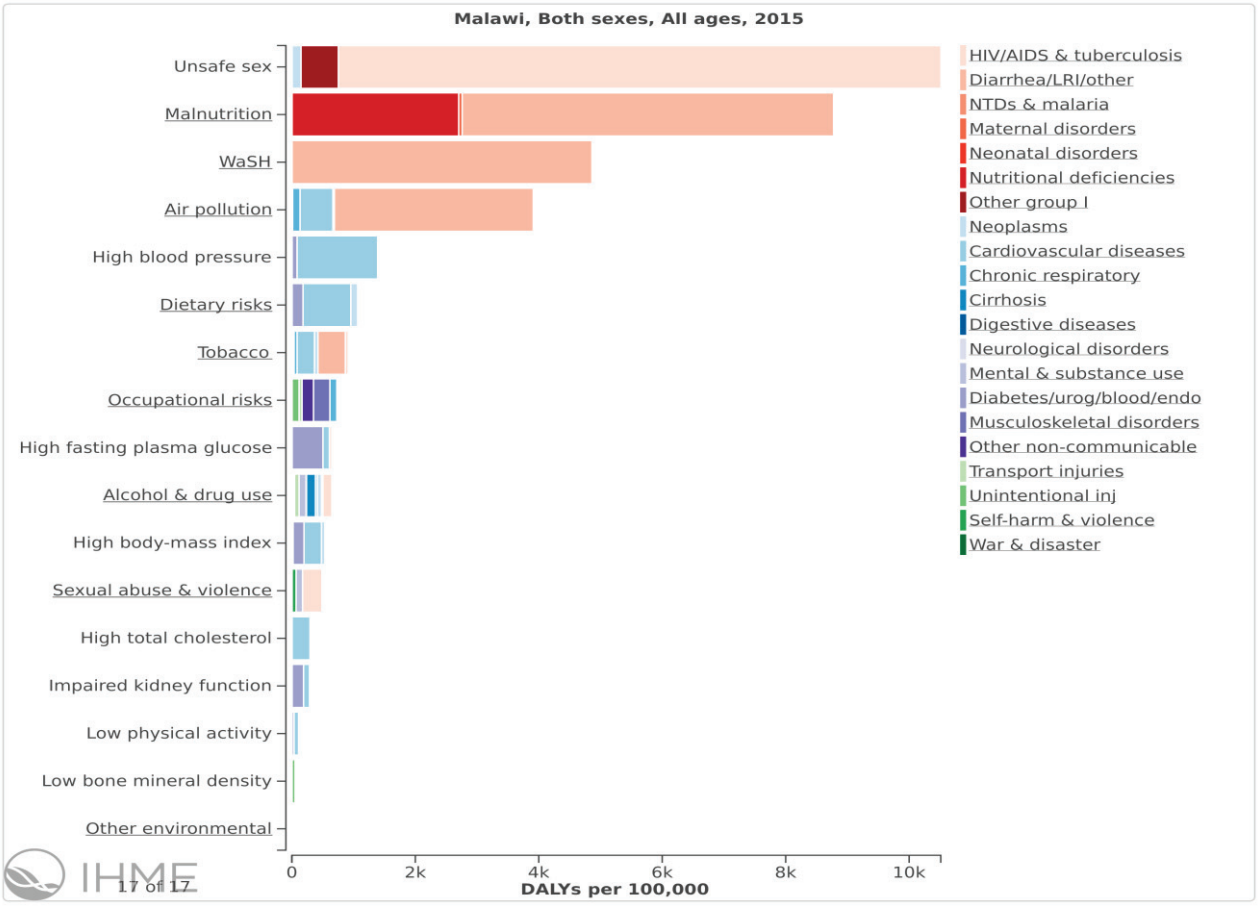
The high burden of disease responsible for the high premature loss of life arises largely because of the conditions in which people are born, grow, live, work and age[37]. A significant proportion of Malawi's population suffers from extreme and persistent poverty. 68.8% of the population lives below USD1.25 and 81.4% below USD2.00.[38] Household income is not only very low, then, but the distribution is also relatively flat with only a small proportion of households possessing significant spending power. A substantial proportion of Malawi's working population operates in the informal sector.

Figure 4 shows key risk factors and their contribution to the burden of disease based on 2015 burden of disease analysis for Malawi.

[37] 2008 Commission on Social Determinants of Health: *Closing the gap in a generation: Health equity through action on the social determinants of health*

[38] Integrated Household Survey 3 (2010/11)

FIGURE 4: MAJOR RISK FACTORS AND THEIR CONTRIBUTION TO BURDEN OF DISEASE



Source: Institute for Health Metrics and Evaluation. http://www.healthdata.org/malawi

One of the leading determinants of health is the level of education. Education influences almost all the risk factors in Figure 4. National surveys show that health indicators are worse among people who have no or little education than those who have received secondary education or higher. For example, the 2016 MDHS shows that more than 4 in 10 children born to mothers with no education (43%) are stunted compared with 38% of children born to mothers with primary education, 30% of children whose mothers have a secondary education and 12% of children born to mothers with more than a secondary education[39].

Living conditions is also another key determinant of health. The proportion of households who obtain drinking water from an improved source has increased from 80% in 2010 to 87% in 2016[40]. 52% of households usually use an improved and not shared toilet facility and proportion of households with no toilet facility at all has decreased from 13.5% in 2008 to 6% in 2016[41]. Household access to safe water and use of toilet are key in the control of water borne diseases. The majority of households in 2016 were using solid fuels (96%) which puts children at higher risk of respiratory infections if the rooms are not well ventilated.

[39] 2016 MDHS
[40] 2016 MDHS
[41] 2016 MDHS

Road traffic related injuries and death is becoming a big public health problem in Malawi. The total number of road traffic accidents increased by 11 percent from 7,390 in 2013/14 to 8,194 in 2015/16 and the number of people seriously injured and killed increased by 8% and 9% respectively[42]. Road traffic fatality rate in Malawi is 35 deaths per 100,000 population, which is above the African regional average of 26.6 deaths per 100,000 population, and twice the global average of 17.4 deaths per 100,000 population[43]. The majority of the road traffic accident (RTA) victims are pedestrians and cyclists due to mainly to poor visibility on roads and lack of use of reflector jackets.

2.4 Health Systems

2.4.1 Human Resources for Health

Persistent gaps in human resource capacity exist across all cadres, districts and health care levels within Malawi's public sector. The MoH has an estimated 23,188 personnel (out of a total of 42,309 positions that exist in the MoH staff establishment) working in the public health sector, a 45% vacancy rate (See Annex 1). For selected eight frontline categories of clinical staff only 17,298 positions are filled of 25,755 for both CHAM and MoH. Table 5 provides the summary.

TABLE 5: VACANCY RATE OF CLINICAL STAFF AGAINST ESTABLISHED POSITION FOR MOH AND CHAM

Cadre	Establishment[44]	Filled	Vacant	% Vacant
Medical Officer	398	284	114	29%
Clinical Officer	3,135	1,159	1,976	63%
Nursing Officer	3,275	1,098	2,177	66%
Nurse Midwife Technician	8,626	3,475	5,151	60%
Medical Assistant	1,506	1,199	307	20%
Pharmacy Technician	1,063	218	845	79%
Lab Technician	1,053	397	656	62%
Health Surveillance Assistants	6,699	9,468	(2,769)	-41%
Total	25,755	17,298	8,457	33%

Source: HRH Assessment Report, June 2016

There is a 100% vacancy rate for clinical psychologist and consultant psychiatrist positions. Although the GoM trains at least 20 psychiatric nurses and psychiatric clinical officers every year, the number of psychiatric staff actively doing mental health activities is very low due to general shortage of nurses in the health system. There are no mental health counsellors in public health system.

The MoH promoted a total of 2,438 staff to more senior positions in the 2014/2015 fiscal year (FY), including, Medical Specialists, Medical and Clinical Officers, Nurses, Allied Health Professionals, Administrative Officers and Medical Assistants. A number of HSAs were interviewed for promotion to Senior HSAs. These promotions however did not extend to health staff working in CHAM facilities, which has created inequities across the workforce.

Challenges in HRH include discrepancy between the establishment and need; for example, although HSAs have exceeded their establishment, the target of 1 HSA/1000 population requires about 16,000 HSAs and this is far from met; outdated and sometimes lack of job descriptions; mal-distribution of the available staff

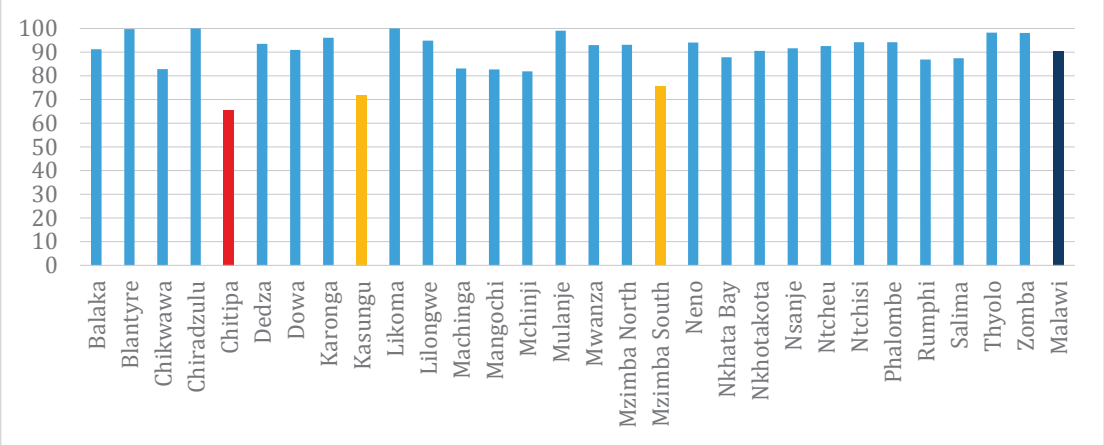
[42] Health Financing in Malawi: Fiscal Space Analysis and Prospects for Introducing Earmarked Taxes for Health – September 2016
[43] Health Financing in Malawi: Fiscal Space Analysis and Prospects for Introducing Earmarked Taxes for Health – September 2016
[44] Establishment figures from the Functional Review (2007)

across cadres, levels of care, districts and urban versus rural; no national guidelines for in-service training or continuous professional development (CPD) leading to uncoordinated in-service trainings within and across Government, donors and NGOs and exacerbating the existing staff shortages in facilities; declining government pre-service training budget over the last 3 years; limited quality of training in health training institutions particularly CHAM schools that have inadequate teaching staff and; poor quality of internship of health workers due to inadequate qualified supervisors.

2.4.2 Health Infrastructure and Equipment

During the HSSP I period, a total of 12 new health facilities (1 district hospital and 11 health centres) were constructed. MoH policy is that every Malawian should reside within an 8km radius of a health facility. The proportion of the population living within 8km radius of health facility (health centres and hospitals) stands at 90% in 2016, an increase from 81% in 2011[45]. This indicates that there is still a proportion of the population that is underserved; especially those residing in the rural and hard to reach areas and 56% of Malawian adult women still cite distance to health facility as a key barrier to health access when they are sick.[46] There are also shortages of transport and communication infrastructure. The Malawi Service Provision Assessment Survey (MSPA) 2014 showed that of the government facilities in Table 1, only 63% had regular electricity, 91% had an improved water source, 22% had a client latrine and 69% had communication equipment. CHAM facilities performed slightly better in all categories. Only 24% of health facilities have a functioning ambulance. The state of maintenance of most vehicles is poor, especially in remote areas with bad roads[47]. There is also a critical shortage of staff houses at almost all health facilities. Most of the health facility infrastructure across both Government and CHAM is dilapidated due to long periods of lack of maintenance.

FIGURE 5: PROPORTION OF POPULATION LIVING WITHIN 8KM OF A HEALTH CENTRE OR HOSPITAL



Source: UNICEF Health Facility Mapping (2016)

There are a number of challenges regarding medical equipment. The quantity and quality of equipment in Government and CHAM health facilities is low and 20-25% is out of service[48]. There are inadequate functional vehicles for both referral of patients and for general transport in the health sector. The status of medical equipment is not routinely tracked. Information was previously collected in the Planning and

[45] UNICEF Health Facility Mapping in Malawi, 2016
[46] National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.
[47] Service Provision Assessment – MoH, 2014e
[48] Inventories performed by PAM Q3/Q4 2016

Management of Assets in the Health Sector (PLAMAHS) software which has not been updated since 2007. Equipment donations, or procurement with donated funds, are not in line with national needs and standards, and rarely include budgets for maintenance, infrastructure needs or training. There are insufficient qualified technical staff at all levels (DHOs and Regional Maintenance Units (RMUs). The capital investment rate has been very low, at only 5.4 percent of total health expenditure (THE) and not in tandem with the increased level of health spending[49].

2.4.3 Medical Products and Technologies

The health care system in Malawi has experienced regular shortages of essential medical products and technologies. This situation is due to many factors including inadequate funding, high disease burden, high purchasing prices, weak supply chain management, lack of drug storage spaces, unreliable information systems, irrational use of medicines, leakage and pilferage (Ministry of Health, 2011; Mueller et al., 2011; WHO, 2007). In 2015/16 FY, an average of 24% of health facilities could maintain enough stocks to cover 1 to 3 months for the 23 HSSP I tracer medicines and medical supplies against a national target of 60%.

There are numerous parallel supply chains for health products in Malawi, managed by different stakeholders. CMST, the body responsible for the procurement of drugs in the public sector, has been implementing the recommendations of the 2012 joint supply chain integration strategy, which outlined 36 benchmarks[50]. Warehousing and storage of health products continue to pose significant challenges across all levels of the health system. A new pharmaceutical warehouse is in the final stages of construction. CMST is not adequately capitalised which prevents it from purchasing sufficient medicines for the country and operating a revolving fund to ensure sustainability.

It is estimated that Malawi loses about 30% of the national drug budget to pilferage[51]. A health commodity leakage study[52] led to the establishment of the Drug Theft Investigation Unit (DTIU) and an 'Action Plan for Drug Availability and Security'. The DTIU is has demonstrated huge success in its inception period auditing, investigating and reaching a successful prosecution rate of 66%. The DTIU, however, faces the challenge of limited staff.

There is limited little quality control testing done to assess the safety and efficacy of medicines. The country receives a significant supply of donated drugs. Drug donation guidelines of 2008 are not enforced by the PMPB and this has resulted in proliferation of medicines, some short-dated and not aligned to the essential medicines list. The National Quality Control Laboratory is under-resourced in personnel and equipment[53]. As such, about thirty percent of medicines registered in Malawi are not assessed for full pharmacopoeia specification. The capacity of Drug and Therapeutic Committees (DTCs) in most health facilities is still weak.

2.4.4 Health Information System

The MoH continues to strengthen the collection and reporting of data through a harmonized Health Management Information System (HMIS), which includes the District Health Information Software (DHIS2). The DHIS2 is the central data repository, which aggregates routine health management information data emanating from health facilities. At the policy level critical milestones have been achieved in the area of health information systems (HIS), including an eHealth strategy, an approved HIS Policy (October 2015), an updated handbook of national indicators and a HIS operational plan with budget. The new handbook of

[49] National Health Accounts 2015
[50] Implementation of the 2012 Joint Strategy for Supply Chain Integration in Malawi - Evaluation Report: USAID. UKAID - March 2016.
[51] Nkhata, 2015
[52] Health Commodity Leakage in Malawi - Royal Norwegian Embassy - October 2013.
[53] Assessment Report of the Malawi Pharmacy, Medicines and Poisons Board – USAID - October 2015.

national indicators updates the 110 indicators of the health sector defined in 2003, aligned to the monitoring and evaluation (M&E) master plan developed by the Ministry of Finance, Economic Planning and Development (MoFEP&D).

The HIS, however, still has many weaknesses. The existence of parallel reporting systems has created structural challenges and weakened the mainstream monitoring and evaluation system. There are programme-specific M&E frameworks in addition to the HSSP M&E framework. Data quality is still poor due to challenges in recording, extracting and reporting data, with most facilities not able to collect and submit the required data on time. Another key weakness is limited use of data that can be linked to the poor quality of data. The MoH HIS relies on manual data collection and reporting processes, which makes it difficult to record, extract, share and use the data. Although some systems have been computerized there is no interoperability in their current state. There is inadequate human resource capacity and poor ICT infrastructure at all levels. While effort towards alignment has been made, some of the research activities undertaken in the country are commissioned, conducted and funded externally and do not align with national health priorities included in the HSSP. Although there are efforts to ensure research results are disseminated, gaps also exist in the management and sharing of research results at the local level, due to lack of a documentation system that supports the sharing of research reports and data in order to inform decision-making.

2.4.5 Leadership and Governance

2.4.5.1 National Level

There has been mixed progress with respect to governance of the health sector over the past five years. In 2015, the MoH revised the structure of technical working groups (TWGs) that are responsible for providing leadership and guidance on thematic health issues at the central level. The activity and quality of guidance provided by TWGs has varied considerably with some meeting monthly while others have been inactive.

The Office of the President and Cabinet (OPC) introduced Organisational Performance Agreements (OPAs) and Individual Performance Agreements (IPAs) in order to increase effectiveness and accountability in the civil service. The MoH has produced and signed contracts with the OPC since the 2015/16 FY. All Directorates in MoH are mandated to produce periodic reports in fulfilment of these contracts. The OPC is responsible for conducting an independent assessment of these contracts.

There is need for better coordination within the MoH. There are Departments or institutions that have overlapping responsibilities which creates inefficiency and there is little or no communication amongst them. There is also poor coordination between MoH and some partners and between partners themselves which contributes to duplication and inefficiency. There is lack of clarity over entry point of donors/NGOs with some going through MoH and others going through DHOs exacerbating accountability challenges.

The MoH, ZHSOs and District Health Offices (DHOs) are required to conduct quarterly Integrated Support Supervisions (ISS) to central hospitals, district hospitals and lower level facilities respectively. Since 2012, electronic checklists were developed and uploaded on smart phones, replacing the previous paper-based checklists. There have been challenges to conduct regular supervision that emanate from inadequate resources.

Financial management capacity needs improvement. A Financial Management Improvement Plan (FMIP) was formulated in 2012 with planned actions at various levels to strengthen financial management systems and build capacity. The MoH finance department, however, has inadequate capacity, in terms of numbers and skilled staff and ICT equipment. The Internal Audit Unit (IAU) conducts regular audits and prepares audit

reports that are followed up by the Independent Audit Committee for Health. It, however, receives insufficient Government funding to conduct field visits and has inadequate capacity in terms of numbers and skilled staff, transport and ICT equipment. MoH prepares procurement plans every year but the plans are rarely followed during implementation resulting in ad hoc procurements and accumulation of arrears. There is also limited capacity in procurement.

2.4.5.2 District Level

Districts have been decentralised since 1998. District Health Management Teams (DHMTs) are located within district hospitals but have dual responsibilities of managing both the district hospitals and wider district health services. The functional roles and responsibilities of DHMT members are not entirely clear and there is a lack of terms of reference (TORs) and job descriptions for individual positions. Further, turnover within DHMT members is high which limits continuity and institutional memory.

DHMTs produce District Implementation Plans (DIPs) to guide implementation at district level. Guidelines for DIPs were developed in 2013 and are due for revision due to developments happened during the HSSP 1 period. A number of local oversight institutions exist in order to ensure accountability and transparency of health facilities. These bodies rarely exist and when they do, they perform their roles ineffectively. Civil society organisations (CSOs) at district level have limited capacity to hold public servants accountable.

DHOs have instituted stakeholder coordination mechanisms to address lack of coherence and coordination of resources. These mechanisms work better in some districts than others. Some local partners have not subscribed to these mechanisms.

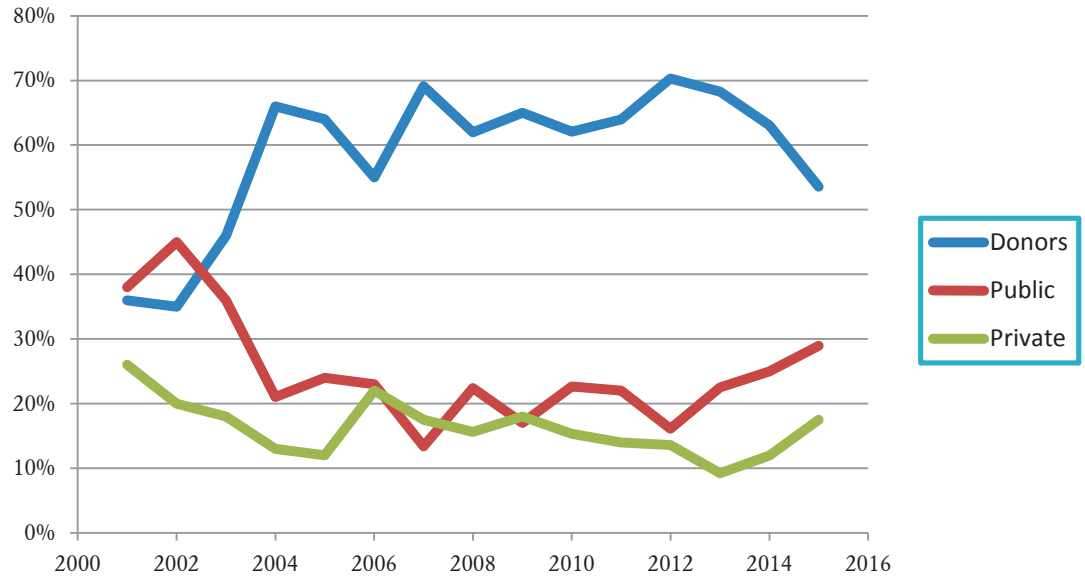
2.4.6 Health Financing & Payment

2.4.6.1 Health Financing

Malawi's health sector financing comprises general revenue, donor funding and household expenditures in terms of direct payments by patients and private health care insurance. Figure 5 shows that since the 2012/13 FY donor financing is declining while public and private expenditures are rising. During the period 2012/13-2014/15, development partners' contributions accounted for an average 61.6% of total health expenditure (THE), Government accounted for an average of 25.5% and households 12.9% of THE[54]. In the HIV/AIDS subsector, donor contributions average 95% of total financing. With such heavy donor reliance, the health financing system in Malawi is unsustainable and unpredictable. Furthermore, planning is made increasingly difficult due to the fragmented system of donor funds and lack of on-budget or pooled funds.

[54] The Malawi National Health Accounts Report 2012/13-2014/15

FIGURE 6: HEALTH CARE FINANCING TRENDS BY SOURCE



Source: National Health Accounts, 2002 -2015.

Total Health Expenditure (THE) during fiscal years 2012/13, 2013/14 and 2014/15 increased in nominal terms, but there was a fall in USD terms as shown in Table 16 below[55].

TABLE 6: SUMMARY OF HEALTH EXPENDITURES DURING FISCAL YEARS 2012/13-2014/15

Indicator	2012/13	2013/14	2014/15	Average
Total Health Expenditure (THE) (MWK billion)	235.2	253.0	302.7	263.6
Total Health Expenditure (USD million)	696.7	623.3	669.6	663.2
Per capita THE (USD)	43.5	37.6	39.2	40.1
Government THE as a % of total government expenditure	10.9%	9.5%	10.8%	10.4%
Household expenditure on health as a % of THE	6.8%	8.3%	10.9%	8.7%

Source*: NHA (2015)*

Malawi's average per capita spending on health over the period, USD40.1 per capita, was the lowest in the Southern Africa Development Community (SADC) region, compared to SADC region average of USD228.8 in 2014. Government THE as a percentage of total government expenditure increased from 6.5% (FY 2009/10) to an average of 10.4% between 2012/13-2014/15 showing a growing commitment from government to the health sector.

[55] The Malawi National Health Accounts (NHA) Report - 2012/13-2014/15

There is almost a middle split in total health sector resources between pooled and non-pooled resources. During the fiscal years 2012/13-2014/15, an average of 49.5% of the total health resources were pooled under central and local government schemes and 2.6% was pooled under voluntary health insurance schemes[56]. A significant proportion of the funds, almost 50%, were therefore not effectively pooled (39.8% of funds in the numerous and fragmented pools of Not for Profit Institutions Serving Households (NPISH/NGOs), 8.5% of out of pocket expenditures (OOPs) with no risk pooling and 2.6% with private pools).

A large proportion of health sector financing is programmatic donor financing and fragmented which calls for alignment and coordination. The MoH, UK DFID, Norway, Germany and Flanders set up a Health Services Joint Fund (HSJF) in December 2015 in order to pool and better coordinate donor resources with the ultimate goal of eventually moving back to on-budget funding.

Malawi has a large informal sector that does not contribute to the general revenue stream through direct taxation. There is therefore a horizontal equity problem as workers in the formal sector contribute to the financing of the health sector while their comparable counterparts in the informal sector do not, while still receiving the benefits. The lack of contribution from the informal sector may mean Malawi does not have the fiscal capacity to meet the desired levels of health expenditure in the health sector.

2.4.6.2 Health Care Payment

The allocation of health resources is a multilevel process. Resource allocation to districts is supposed to be guided by the Intergovernmental Fiscal Transfers Formulae (IGFTF) controlled by the National Local Government Finance Committee (NLGFC). The parameters for the Health Resource Allocation Formula were agreed in 2008. However, the formula is not actively used in district resource allocation decisions with historical allocation remaining the method used.

Payment for drugs is centralized and handled by the MoH for central hospitals and the National Local Government Finance Committee (NLGFC) for DHOs. Orders to CMST are placed at cost centre level with limited communication among the key stakeholders. This has created accountability and transparency challenges between CMST and central hospitals and DHOs.

District allocations are managed by DHOs. Health centres and clinics are not designated as cost centres and hence not explicitly allocated financial resources. They do not control or manage financial resources but order supplies from the DHOs. Government uses an input-based payment system which provides limited incentive to pay attention to health outcomes and patient satisfaction. This results in an attempt to provide every service when it is not possible to do that given the available resources. Performance Based Budgeting (PBB) is being rolled out but is still some way from being properly implemented.

The situation is different from the way DHOs pays CHAM facilities under Service Level Agreements (SLAs). MoH has signed 103 SLAs with CHAM in order to remove the financial barrier faced by populations in CHAM catchment areas since CHAM facilities charge user fees[57]. In the SLA arrangement, EHP interventions at CHAM health facilities are provided free at the point of access and MoH/District Health Offices reimburse CHAM the cost of services based on per case reimbursement rates agreed in the contract. Since the introduction of SLAs, there has been an increase in the number of people receiving health care in CHAM facilities[58].

[56] The Malawi National Health Accounts Report 2012/13-2014/15
[57] Number of signed SLAs as of 30th March 2017
[58] Manthalu et al. (2016). The effect of user fee exemption on the utilization of maternal health care at mission health facilities in Malawi

Besides the CHAM payment for results model, a number of pilots have been undertaken exploring results-based financing, notably the 'Results Based Financing for Maternal and Neonatal Health' and the 'Performance Based Financing' projects[59]. Experience from the 'Performance Based Incentive' pilot, implemented in 17 health facilities has shown that when facilities are given resources according to the needs and that resources are linked to performance, access to services has increased as health workers are motivated to work harder to improve performance to thus earn more resources for their facilities. The RBF4MNH pilot had 3 key components: Performance Agreements (PAs) with health facilities offering maternity services as well as DHMTs (the supply-side component); a conditional cash transfer (CCT) for women delivering at RBF facilities to contribute to the costs associated with delivery (the demand-side component); and investments in infrastructure and equipment. The experiences demonstrated that supply-side financing is indeed one of the strategic purchasing arrangements that can enhance performance as opposed to line budget and salary payments, while also indicating CCTs can improve demand for health care.

There have been challenges with the payment systems for SLAs. These have included late payment of bills, poor communication among stakeholders, inadequate human and material resources and lack of systems to monitor performance of SLAs[60]. For performance based financing schemes, there is no national guiding framework and they are not integrated within overall Government reforms on performance management.

2.4.7 Health Sector Reforms

The MoH made progress with respect to its reform agenda. Revision of the Public Private Partnerships with CHAM was completed and the memorandum of understanding between Government and CHAM was signed on 18 January 2016. In addition, MoH in collaboration with CHAM established a designated SLA Management unit within the CHAM Secretariat with HSJF funding. Central Hospital reform, which aims to increase efficiency through decentralising the management of central hospitals was presented to Cabinet. It will be presented to Cabinet again after addressing issues that Cabinet raised during the first presentation. With respect to decentralisation of the district health system, the MoH developed a Concept Note after background studies which will be presented to the MoH Senior Management for their endorsement before presenting to the MoLGRD for final approval[61]. Because Malawi's health financing is not sustainable, Government is exploring alternative financing mechanisms. These include establishment of a health fund and introduction of a national health care insurance scheme. Creation of the health fund awaits agreement among key stakeholders and approval by the Treasury. Assessment of the feasibility of a national health insurance scheme was completed and recommendations are being deliberated by relevant authorities.

2.4.8 Quality of Care and Safety

Given the improvements in many service delivery indicators over time, for example immunisation coverage and skilled birth attendance, the MoH realises that further improvements can only be made by strengthening the quality of health care. The MoH developed the first Quality Assurance Policy in 2005 with the aim of providing guidance on the establishment and implementation of Quality Assurance (QA) and Quality Improvement (QI) in all health care facilities, both public and private. The Policy was, however, limited both in scope and impact and did not adequately guide the HSSP I on issues of quality. The MoH has therefore established a Quality Management Department (QMD) to spearhead holistic quality improvement in the health sector. QMD is developing a policy and strategic plan to guide and coordinate all partners with a particular focus on health care quality improvement. These processes have happened in synchrony with

[59] "Ministry of Health/Support for Service Delivery Integration (MoH/SSDI) Performance Based Incentive" and "The Initiative for Result Based Financing for Maternal and Neonatal Health (RBF4MNH)" (MoH)
[60] Chirwa et al., 2013;
[61] Details of these reforms and their objectives can be accessed from the Malawi Health Sector Reforms Brief

HSSP II development and have fed into each other. QMD successfully facilitated the launch of a network to improve quality of care for mothers, new-borns and children involving nine countries including Malawi in February 2017[62].

Health care quality is hampered by the cross-cutting health care system inputs outlined in this section. Worth of mention, however, are factors such as weak leadership, inadequate human resources for health, uncoordinated and weak social accountability mechanisms, poor clinical practices, insufficient client safety systems as well as lack of patient feedback mechanisms on the quality of care received in both public and private facilities.

2.4.9 Blood Transfusion

Malawi Blood Transfusion Services (MBTS) has improved the processing and supply of quality and safe blood. 100% of blood donations are screened for at least HIV before transfusion. Annual collection of blood has increased from 50,000 units of blood in 2014/15 to an average of 57,000 units of whole blood in 2016 against an estimated annual demand of 80,000 units. 65% of the country's blood need is collected from voluntary non-remunerated blood donors.

There are still gaps in blood transfusion services. There is weak legislation, regulatory and supervisory environment and guidelines on the practice of blood transfusion need updating. 35% of blood units are collected from donors, who supply direct to hospitals to cover gaps, thereby compromising on safety and quality of blood. MBTS has inadequate capacity in terms of infrastructure, human resources, equipment and commodities to set up sentinel sites at all major hospitals as one way of decentralizing blood collection, screening and distribution. Maintaining an uninterrupted supply of essential reagents and supplies is a challenge.

2.4.10 Laboratory and Imaging Services

Besides challenges in cross cutting health systems requirements such as human resources, equipment and infrastructure, the delivery of laboratory and medical imaging services has been affected by weak quality assurance and accreditation systems and inadequate bio-safety and bio-security mechanisms for both laboratories and imaging services.

2.4.11 Emergency Medical Services and Referral Services

In Malawi, emergency medical services (EMS) and referral services are weak and not well streamlined. There are limited resources and logistics for referral of emergencies. Almost all DHOs and Central Hospitals face critical shortages of standardized ambulances for emergency referrals. There is a serious lack of capacity to deal with any pre-hospital care in terms of available paramedics and ambulances. Training for paramedics in EMS is currently not available. A dedicated emergency response phone number and a coordinated call centre to respond to emergency calls do not exist.

The Government of Malawi refers abroad cases for which specialist care is not available within the country. Referrals are primarily recommended for five main categories of care: cancer (radiotherapy), cardiac conditions, eye conditions (retinal detachment), renal transplant and orthopaedic conditions (knee replacement). The external referral programme is an interim measure with the long-term solution being developing capacity of central hospitals or courting investors to establish a national referral hospital. However, EMS in collaboration with World Bank is piloting to introduce responsive emergency care systems for responding to roadside traffic accident along the main transportation corridors in Malawi.

[62] http://www.who.int/maternal_child_adolescent/topics/quality-of-care/malawi-network/en/

2.4.12 Public Health Institute of Malawi

The Public Health Institute of Malawi (PHIM) was established as an entity under the MoH in 2012. PHIM is currently an entity within the MoH, but is in the process of being established as a semi-autonomous statutory body through a legislative bill. PHIM is structured in three units – the Epidemiology Unit, the Research Unit and the National Reference Laboratory and receives its core funding for its activities tasks through the annual budget of the MoH Malawi. Key activities that have taken place under the leadership of PHIM include:

- The first national assessment of status of the IHR (2005) core capacities in Malawi in 2015.
- The establishment and launch of the Frontline Field Epidemiology Training Program in 2016.
- Hiring of a legal consultant to draft a bill to establish the institute as a semi-autonomous body in 2016.

Prioritized activities for PHIM include developing the legislation for establishment of PHIM, revision of the institute's strategic plan, acquiring land from the Ministry of Lands for the construction of PHIM, implementation of the IHR action plan and implementation of the FETP among others.

In 2003, Malawi adopted the Integrated Disease Surveillance strategy, which is a multi-disease surveillance and response strategy. In 2009 Malawi started the process of revising the IDSR technical guidelines, which was finalized in 2014 but the new guidelines have not yet been disseminated or implemented. There has been no IDSR-specific training held since 2005. With the update of the guidelines, the MoH has prioritized the surveillance of 38 diseases, conditions and events.

Some of the current limitations of the IDSR strategy include lack of integration of vertical disease program data; limited capacity for data analysis, particularly at the sub-national levels; sub-optimal timeliness and completeness of reporting; and lack of capacity in outbreak detection and response.

The MoH, through PHIM, with support from CDC has started a Frontline Field Epidemiology Training Programme (FETP). This program is a 3-month in-service program focused on detecting and responding to diseases and events of public health importance or international concern. Participants learn and practice the fundamental skills used in front-line surveillance including use of case definitions, disease detection and reporting, investigation, outbreak investigation and response, surveillance monitoring and evaluation, and data analysis and interpretation for decision-making. The first cohort was scheduled for April 2016 with participants from the central level, following which the program will be rolled out at the district-level.

2.5 Conclusion

The analysis in the Chapter has demonstrated the progress that Malawi has made in improving health outcomes and health care delivery. For example, Malawi achieved MDGs on reducing child mortality and combating HIV and AIDs, Malaria and other diseases, skilled birth attendance is very high, maternal mortality declined, immunisation rates are improving; and HIV prevalence has declined. There are, however, inequalities in health outcomes and health care access by wealth status, education, gender and geographical location. The 2016 MDHS shows, for example, that the prevalence of stunting in children under five years is 46% among children in the lowest wealth quintile, 37% among those in the middle wealth quintile and 24% for children in the highest wealth quintile[63]. The ownership of ITNs increases by wealth quintile from 45% in the lowest quintile to 69% in the highest quintile. This chapter also showed that financing of health care is not sustainable in Malawi. The implications of these findings are that: to further improve health outcomes, there is need to focus more on quality of health care, there is need for action on social determinants like

[63] 2016 MDHS.

wealth and education hence the importance of the Sustainable Development Goals (SDG) agenda; there is need to further analyse and address inequalities and there is need to keep exploring sustainable health care financing mechanisms.

3

HSSP II Overarching Agenda

3 HSSP II Overarching Agenda

3.1 Vision

The Vision of the health sector is to achieve a state of health for all the people of Malawi that would enable them to lead a quality and productive life.

3.2 Mission

The Mission of the Ministry of health 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.

3.3 Goal

The goal of the HSSP II is to move towards Universal Health Coverage (UHC) of quality, equitable and affordable health care with the aim of improving health status, financial risk protection and client satisfaction.

UHC is defined as a situation where everyone – irrespective of their ability-to-pay – gets the health services they need in a timely fashion without suffering any undue financial hardship because of receiving the care. Malawi is moving towards UHC through implementation of the essential health package, which Government and its development partners will endeavour to make accessible to every Malawian free at the point of care.

3.4 The Sustainable Development Goals

The HSSP II is designed to contribute to the sustainable development goals through interventions in the essential health package and action on social determinants of health. The UN launched the SDGs that build upon MDGs in September 2015. Seventeen SDGs were agreed with SDG 3, "*Ensure healthy lives and promote well-being for all ages"* is directly relevant to health. The WHO also outlines how 16 of the 17 SDGs are indirectly related to health[64]. SDG 3, has the following targets:

Target 1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

Target 2: By 2030, end preventable deaths of new-borns and under five children.

Target 3: By 2030, end the epidemics of AIDS, TB, malaria and Neglected Tropical Diseases, and combat hepatitis, water-borne diseases and other communicable diseases.

Target 4: By 2030, reduce by one-third premature mortality from NCDs through prevention and treatment, and promote mental health and wellbeing.

Target 5: Strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

Target 6: By 2020, halve deaths and injuries from road traffic accidents.

Target 7: By 2030, achieve universal access to sexual and reproductive health care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Target 8: Achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

[64] Health in the SDG Era, World Health Organisation

Target 9: By 2030, substantially reduce the number of deaths and illness from hazardous chemicals and air, water and soil pollution and contamination

3.5 Objectives of HSSP II

The objectives of the HSSP II focus on two main aspects: strengthening health systems for the delivery of an essential health package and tackling social determinants of health. They are as follows:

1) Increase equitable access to and improve quality of health care services
2) Reduce environmental and social risk factors that have direct impact on health
3) Improve the availability and quality of health infrastructure and medical equipment
4) Improve availability, retention, performance and motivation of human resources for health for effective, efficient and equitable health service delivery
5) Improve the availability, quality and utilization of medicines and medical supplies
6) Generate quality information and make it accessible to all intended users for evidence-based decision-making, through standardized and harmonized tools across all programs
7) Improve leadership and governance (particularly setting direction and regulation) across the health sector and at all levels of health system
8) Increase health sector financial resources and improve efficiency of their allocation and utilization

3.6 Guiding Principles

The guiding principles demonstrate government's commitment towards attainment of equitable, accessible, affordable and sustainable high quality evidence-based health care. The following are the guiding principles for the HSSP II:

i. *National Ownership and Leadership:* In the interest of national development and self-reliance, all partners in the health sector shall respect national ownership and Government leadership will remain central in guiding the implementation of the HSSP II;

ii. *Primary Health Care:* Provision of health services shall be based on the principle of Primary Health Care (PHC) as a basic philosophy and strategy for national health development.

iii. *Human Rights-Based Approach and Equity*: The HSSP II has been developed to attempt to ensure all people in Malawi – including vulnerable population and residents of hard-to-reach areas – receive the same high quality health care regardless of geographic location or socio-economic factors.

iv. *Gender Sensitivity:* Gender mainstreaming shall be central in the planning and implementation of all health policies and programmes;

v. *Ethical Considerations:* The ethical requirement of confidentiality, safety and efficacy in both the provision of health care and health care research shall be adhered to;

vi. *Efficiency and Effectiveness*: All stakeholders shall be expected to use available resources for health efficiently and effectively to maximize health gains. Opportunities shall be created to

facilitate integration of health service delivery to leverage on efficiency and effectiveness in addressing health needs of the people of Malawi;

vii. *Transparency and Accountability:* Stakeholders shall discharge their respective mandates in a manner that is transparent and takes full responsibility for the decision they make;

viii. *Coordination and collaboration:* Developing the health system around the principle of 'one policy, one strategy, one M&E plan'. Additionally, promote coordination between partners operating within the health sector and across sectors addressing fragmentation and reducing duplication.

ix. *Community Participation:* Community participation shall be central in addressing health needs of the people of Malawi;

x. *Evidence-based decision-making:* Health sector strategies and activities are chosen and pursued to achieve the optimal possible 'outcome', based on value, effectiveness and quality, as informed by the best available evidence.

xi. *Decentralisation:* Health service provision and management shall be in line with the Local Government Act 1998, which entails devolving health service delivery to Local Government structures;

xii. *Appropriate Technology:* Health care providers shall use health care technologies that are safe, appropriate, relevant and cost-effective and beneficial to Malawi.

xiii. *Universal Health Coverage (UHC):* In making the transition towards UHC, three fundamental policy questions arise: what services should be available under UHC, to whom should they be made available, and what (if any) user chargers or other arrangements should be attached to services that are not considered priorities given current circumstances.

xiv. *Demonstrable Value for money:* Ensure efficiency and effectiveness of health care services and health care service delivery. This is not confined to health interventions but ideally extents to health systems inputs also to ensure Malawi maximises its health outcomes for its inputs.

xv. *Accountability for results and expenditures:* To ensure successful implementation of HSSP II activities performance measurement and accountability will be central to achieving health targets. This further links with value for money

xvi. *Sustainability:* A central requirement of any system of UHC is that the range of services made available to the population is consistent with the funds available to it. Realistic planning is essential to ensuring successful implementation of activities and achievement of targets.

4

The Essential Health Package (EHP)

4 The Essential Health Package (EHP)

4.1 Introduction

The drive for UHC has been endorsed by WHO, World Bank and the UN's SDGs and is now increasingly being pursued in country health sector strategies. In attempting to move towards UHC countries face difficult choices about how to prioritise health issues and expenditure such as which services to expand, whom to include and how to shift from out-of-pocket payments to prepayment.[65]

The WHO Consultative Group on Equity and UHC proposed a three-part strategy for "countries seeking a fair progressive realization of UHC":[66]

- Categorize services into priority classes using relevant criteria;
- First expand coverage for high-priority services to everyone;
- While doing so, ensure disadvantaged groups are not left behind. This will often include low-income groups and rural populations.

These principles explain the decisions taken regarding the definition of the Essential Health Package (EHP).

The Government of Malawi remains committed to the provision of free health care for all. The Constitution of the Republic of Malawi states that the State is obliged "*to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care*"[67]. The Constitution therefore guarantees all Malawians that they will be provided with health care and other social services of the highest quality within the limited resources available.

Since 2004 Malawi has implemented an EHP, containing cost effective interventions delivered free of charge at the point of use to Malawians. The aim of the EHP has been to address the burden of disease by delivering cost-effective interventions that target the top diseases and conditions in terms of burden of disease. Diseases and conditions were clustered under the categories of Reproductive, Maternal, Neonatal and Child Health conditions; Communicable Diseases and Non-Communicable Diseases.

4.2 Review of the EHP 2004-2016

While the EHP is supposed to guide free health care provision in an attempt to achieve universal health coverage (UHC)[68], there have been a number of related problems since its inception, which have hampered this objective.

[65] UHC is the practical expression of the right to health. The right to health is defined in a way that acknowledges that it will impossible for governments to provide all forms of health care to all people at once. Therefore, the prioritization of services provided under UHC – which implies that some services will not be provided, is not necessarily a violation of the right to health.

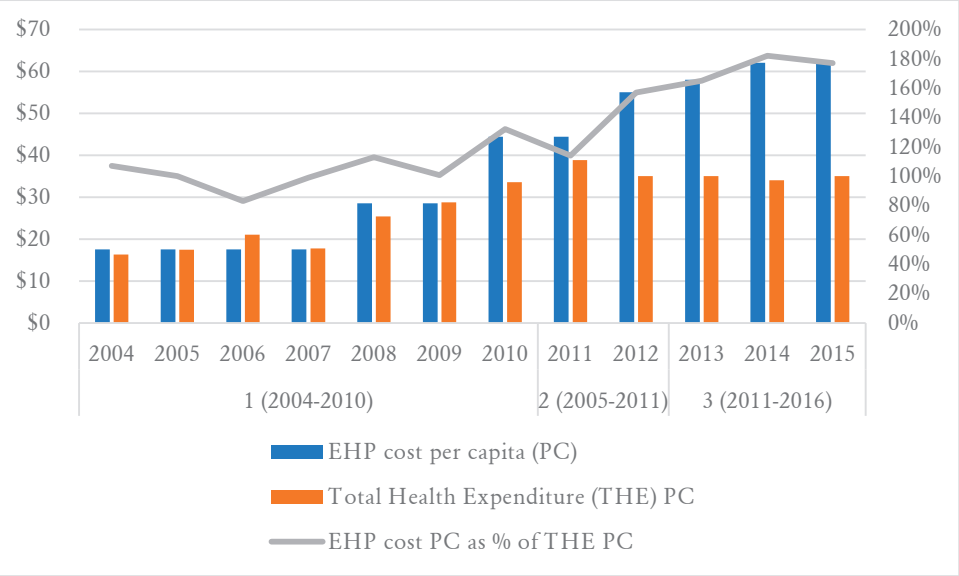
[66] WHO Consultative Group on Equity and Universal Health Coverage. Making fair choices on the path to universal health coverage: Final report of the WHO Consultative Group on Equity and Universal Health Coverage. Geneva: World Health Organization; 2014

[67] Section 13 (c) of the Constitution of the Republic of Malawi

[68] UHC is 'a situation where *everyone – irrespective of their ability-to-pay – gets the health services they need in a timely fashion without suffering any undue financial hardship as a result of receiving the care'* (World Bank, 2016)

First, the EHP has consistently been financially unobtainable and unsustainable as shown in Figure 6. EHP provision is also becoming more unachievable as more interventions have been added while the resources available have remained almost the same.

FIGURE 7: PER CAPITA EHP COST AND ACTUAL PER CAPITA HEALTH EXPENDITURE



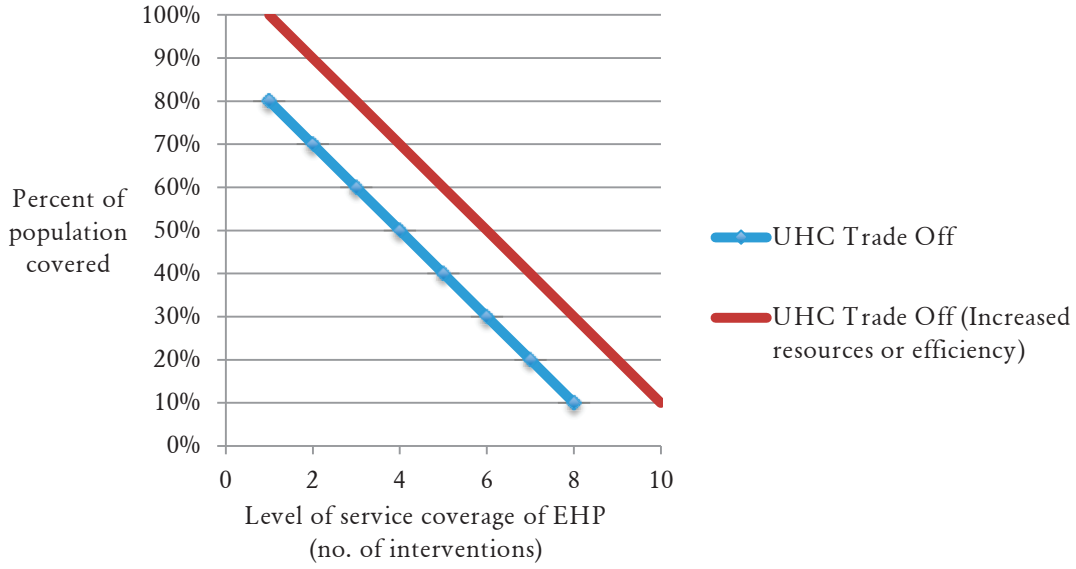
Note: EHP cost PC as % of THE PC is read off the secondary axis, on the right-hand side of the chart. The numbers 1 to 3 before the year categories represent revisions i.e. 1 (2004-2010) was the first EHP package.
Sources:

(a) A Joint Programme of Work for a Health Sector Wide Approach (SWAp) 2004-2010, Republic of Malawi
(b) Ministry of Health, Malawi
(c) WHO Global Health Expenditure database, downloaded 21 March 2016
(d) Health Sector Resource Mapping 2011-2015

Second, given that the broad objective of the EHP has been to provide an explicit set of interventions free at the point of access to the population of Malawi, EHP provision has been inequitable in practice because, failure to fully fund it has meant varying degrees of coverage for different interventions, by level of health care system and geographical location.

The above issues arose because previous EHPs did not take into account the inherent trade-off between population covered and interventions included. With a fixed budget there is an unavoidable trade-off that must be considered in the definition of any package. This is illustrated in Figure 7 where, for the blue line, if the EHP has two interventions about 70% of the population is covered and when the EHP has eight interventions only 10% is covered.

FIGURE 8: ILLUSTRATIVE TRADE-OFF BETWEEN COVERAGE OF PACKAGE & POPULATION COVERAGE



Third, using a burden of disease (BoD) cut-off point for diseases and conditions whose interventions would be included in the EHP meant cost-effective interventions for excluded lower burden diseases and conditions could not be part of the EHP. Instead cost-ineffective interventions for diseases and conditions that were above the BoD threshold were included in the EHP trading-off a potential significant quantity of health.

Fourth, the cost-effectiveness threshold that was used for determining whether an intervention would be included in the EHP did not reflect the opportunity cost of health spending in Malawi[69]. Interventions were deemed cost-effective if the cost was under USD1050/DALY[70]. Recent estimates of the cost-effectiveness threshold for Malawi put it between USD3-116/DALY[71], much lower than previously thought.

4.3 The Essential Health Package (EHP)

In revising the EHP, the intention was to address the above outlined issues as well as account for changes in disease patterns, available resources and new interventions that would have been introduced. The Senior Management of the MoH tasked the EHP TWG to revise the EHP. The EHP TWG in turn formed a taskforce to drive the process.

4.3.1 Process of EHP development

The first step in revising the health benefits package was to outline the process required as shown in Figure 9:

[69] For an in depth exploration of this issue see 'Toward the Development of an EHP for Malawi', Ochalek et al. (2016)

[70] WHO-CHOICE employs a cost-effectiveness threshold of 1-3x GDP per capita. $1050/DALY represents 3x GDP per capita for Malawi in 2011

[71] Ochalek (2016)

FIGURE 9: ESSENTIAL HEALTH PACKAGE REVISION PROCESS

Key Question	• What is the objective of the health benefits package? • What criteria should be used in defining the package? • Which stakeholders should have input on objective and criteria?	• What data exists to measure criteria? • How to collect & collate new and existing evidence? • How to ensure issues identified in review are addressed?	• How to compare evidence collected? • How to ensure package makes clinical sense?
Activities	• Review previous EHP & identify challenges • Engage Senior Management & EHP-TWG • Establish EHP Task Force	• Develop tool for data collection and analysis • Collect and quality check data • Appraise tool & data	• Undertake analysis using criteria • Validate clinical aspect with front line health worker input
Outputs	• Defined Objective & Criteria	• Cost-effectiveness tool developed & populated	• EHP defined

The Essential Health Care Package (EHP) will be used to guide current free service provision in the health sector. The EHP is primarily concerned with the purchasing and provision of health care to individuals. But additionally, the EHP will be used for resource mobilisation and pooling with shortfalls in coverage indicating where future funding should be directed.

4.3.2 Objective

The aim of the EHP is to ensure timely universal free access to a quality Essential Health Package, irrespective of ability-to-pay, to all the people in Malawi.

4.3.3 Criteria for Defining Package

The EHP task force assessed a number of criteria to guide intervention inclusion & exclusion decisions. The criteria used in defining the package were:

- Health Maximisation
  This criterion is consistent with the goal of the HSSP II in Section 3.3. In order to maximise health, cost-effectiveness analysis (CEA) is usually used. This enables the prioritization of interventions in a way that maximizes population health under a constrained budget.

A CEA Framework[72] was developed which ranks interventions by their cost-effectiveness in Malawi[73]. In assessing cost-effectiveness both the costs and clinical effects of interventions are considered. Interventions were deemed cost-effective if their Incremental Cost-Effectiveness Ratio (ICER) – which represents value for money – was below USD61. After considering cost-effectiveness, the CEA Framework also accounted for BoD by accounting for the case numbers in Malawi, then interventions were ranked by their impact on total population health (measured in DALYs averted). The framework also accounts for health system constraints that prevent interventions from full (100%) implementation. This informs the maximum investment that should be spent to improve an interventions implementation level.

- Equity
  Another consideration was whether an intervention targeted at risk or marginalised demographic groups. Interventions targeting women and children under-five were prioritised. Additionally, if an intervention was easily delivered at community level, thereby largely targeting rural populations this was also considered. Largely, equity considerations were considered informally as part of the process due to a lack of substantive and informative data on intervention equity implications.

- Continuum of Care
  The concept of the continuum of care was considered important. This is a concept involving a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. An example of where this played a role in inclusion/exclusion decisions was where it was deemed unreasonable to include screening or testing in the package if treatment was not also included. Conversely, it was considered that if the package included first-line treatment this did not always necessitate the inclusion of second-line treatment.

- Complementarities
  Whether complementarities exist between interventions was also considered due to the potential for efficiency savings. If an intervention was regularly delivered as part of a package of care, for example, vaccines and ANC, this was taken into consideration.

- Exceptional donor funded interventions
  Donor funding was not an explicit criterion for inclusion due to its unpredictability. Therefore, to avoid circumstances where an intervention was included in the revised EHP on the basis that donors financed it but this financing was withdrawn in future, only very exceptional cases were considered.

  The case of the Global Alliance GAVI funding essential vaccines and Global Fund financing ART were considered exceptions, as it was considered highly probable that donor financing of these interventions will remain largely stable in the medium term.

It is important to note that the CEA alone maximizes total health, while the incorporation of other considerations that change resource allocation decisions results in lower total health.

[72] For further insight into the CEA Framework see '*Supporting the Development of an Essential Health Package: Principles and Initial Assessment for Malawi*', CHE Research Paper 136, Ochalek et al., 2016.
[73] '*Cost Per DALY Averted Thresholds for Low- and Middle-Income Countries: Evidence From Cross Country Data*', CHE Research Paper 122, Ochalek et al., 2016.

4.3.4 EHP

The below table outlines the interventions included in the EHP:

TABLE 7: LIST OF INTERVENTIONS IN EHP

Category	Intervention Package	Intervention	Level of Care
RMNCH	ANC Package	Tetanus toxoid (pregnant women)	Community/Primary/Secondary
		Deworming (pregnant women)	Community/Primary/Secondary
		Daily iron and folic acid supplementation (pregnant women)	Community/Primary/Secondary
		Syphilis detection and treatment (pregnant women)	Community/Primary/Secondary
		IPT (pregnant women)	Community/Primary/Secondary
		ITN distribution to pregnant women	Community/Primary/Secondary
		Urinalysis (4 per pregnant woman)	Primary/Secondary
	Modern Family Planning	Injectable	Community/Primary/Secondary
		IUD	Primary/Secondary
		Implant	Primary/Secondary
		Pill	Community/Primary/Secondary
		Female sterilization	Secondary
		Male condom	Community/Primary/Secondary
	Delivery Package	Clean practices and immediate essential new-born care (in facility)	Primary/Secondary
		Active management of the 3rd stage of labour	Primary/Secondary
		Management of eclampsia/pre-eclampsia (Magnesium sulphate, Methyldopa, Nifedipine, Hydralazine)	Primary/Secondary
		Neonatal resuscitation (institutional)	Primary/Secondary
		Caesarean section with indication	Secondary
		Caesarean section with indication (with complication)	Secondary
		Vaginal delivery, skilled attendance (including complications)	Primary/Secondary
		Management of obstructed labour	Primary/Secondary
		Newborn sepsis - full supportive care	Primary/Secondary
		Newborn sepsis – injectable antibiotics	Primary/Secondary
		Antenatal corticosteroids for preterm labour	Primary/Secondary
		Maternal sepsis case management	Primary/Secondary
		Cord Care Using Chlorhexidine	Primary/Secondary
		Hysterectomy	Primary/Secondary
		Post-abortion case management	Secondary
		Treatment of antepartum haemorrhage	Primary/Secondary
		Treatment of postpartum haemorrhage	Secondary
		Antibiotics for pPRoM	Primary/Secondary

Category	Intervention Package	Intervention	Level of Care
Vaccine Preventable diseases	Essential Vaccines Package	Rotavirus vaccine	Community/Primary/Secondary
		Measles Rubella vaccine	Community/Primary/Secondary
		Pneumococcal vaccine	Community/Primary/Secondary
		BCG vaccine	Community/Primary/Secondary
		Polio vaccine	Community/Primary/Secondary
		DPT-Heb-Hib / Pentavalent vaccine	Community/Primary/Secondary
		HPV vaccine	Community/Primary/Secondary
Malaria	First Line uncomplicated Malaria treatment	Uncomplicated (adult, <36 kg)	Community/Primary/Secondary
		Uncomplicated (adult, >36 kg)	Community/Primary/Secondary
		Uncomplicated (children, <15 kg)	Community/Primary/Secondary
		Uncomplicated (children, >15 kg)	Community/Primary/Secondary
	Complicated Malaria treatment	Complicated (adults, injectable artesunate)	Primary/Secondary
		Complicated (children, injectable artesunate)	Primary/Secondary
	Malaria Diagnosis	RDTs	Community/Primary/Secondary
		Microscopy for Malaria	Primary/Secondary
Integrated management of childhood illnesses (IMCI)	ARIs	Pneumonia treatment (children)	Community/Primary/Secondary
		Treatment of severe pneumonia (Oxygen)	Primary/Secondary
	Diarrhoeal Disease	ORS	Community/Primary/Secondary
		Zinc	Community/Primary/Secondary
		Treatment of severe diarrhoea (IV Fluids)	Primary/Secondary
	Nutrition	Community management of nutrition in under-5 - Plumpy Peanut	Community/Primary
		Community management of nutrition in under-5 - micronutrient powder	Community/Primary
		Community management of nutrition in under-5 - vitamin A	Community/Primary
	Malaria Diagnosis	RDTs for under-5	Community/Primary
Community Health	Community Health Package	Growth Monitoring	Community/Primary
		Vermin and Vector Control & Promotion	Community/Primary
		Disease Surveillance	Community/Primary
		Community Health Promotion & Engagement	Community/Primary
		Village Inspections	Community/Primary
		Promotion of hygiene (hand washing with soap)	Community/Primary
		Promotion of Sanitation (latrine refuse, drop hole covers, solid waste disposal, hygienic disposal of children's stools)	Community/Primary
		Occupational Health Promotion	Community/Primary
		Household water quality testing and treatment	Community/Primary

Category	Intervention Package	Intervention	Level of Care
		Home-based care of chronically ill patients	Community/Primary
		Child Protection	Community/Primary
NTDs	Treatment and MDA	Schistosomiasis mass drug administration	Community/Primary
		Case finding and treatment of Trypanosomiasis	Primary
		Trachoma mass drug administration	Community/Primary
HIV/AIDS	HIV Prevention	Cotrimoxazole for children	Community/Primary/Secondary
		PMTCT	Community/Primary/Secondary
	HIV Testing	HIV Testing Services (HTS)	Community/Primary/Secondary
	HIV Treatment	HIV Treatment for all ages – ART & Viral Load	Community/Primary/Secondary
Nutrition		Vitamin A supplementation in pregnant women	Community/Primary/Secondary
		Management of severe malnutrition (children)	Community/Primary/Secondary
		Deworming (children)	Community/Primary/Secondary
		Vitamin A supplementation in infants and children 6-59 months	Community/Primary/Secondary
TB		Isonized Preventive Therapy for children in contact with TB patients	Primary/Secondary
		First line treatment for new TB Cases for adults	Primary/Secondary
		First line treatment for retreatment TB Cases for adults	Primary/Secondary
		First line treatment for new TB Cases for children	Community/Primary/Secondary
		First line treatment for retreatment TB Cases for children	Community/Primary/Secondary
		Case management of MDR cases	Primary/Secondary
	TB Testing	LED test	Primary/Secondary
		Xpert test	Primary/Secondary
		MGIT test	Primary/Secondary
		LJ test	Primary/Secondary
NCDs		Treatment of Injuries	Primary/Secondary
	Mental Health treatment	Basic psychosocial support, advice, and follow-up	Community/Primary/Secondary
		Anti-epileptic medication	Community/Primary/Secondary
		Treatment of depression (first line)	Community/Primary/Secondary
		Testing of pre-cancerous cells (vinegar)	Primary/Secondary
	Diabetes treatment	Diabetes Type I	Primary/Secondary
		Diabetes Type II	Primary/Secondary
		Hypertension	Primary/Secondary

Category	Intervention Package	Intervention	Level of Care
Oral Health	Tooth pain treatment	Management of severe tooth pain, tooth extraction	Primary/Secondary
		Management of mild tooth pain, tooth filling	Primary/Secondary

Although Malawi is currently undergoing an epidemiological transition in which the prevalence of non-communicable diseases is rising, the resource constraints prevent many curative interventions targeting non-communicable diseases from being included in the EHP. While in future additional curative interventions tackling the NCD disease burden can be included, for the most part the only feasible interventions for addressing them currently is health promotion and education to address their socio-economic determinants.

The resources available to Malawi for the provision of the drug, medical supplies and commodity inputs into the EHP totalled USD162M for the FY 2015/16[74]. If the package was provided to all of the population in need, the total drugs, medical supplies and commodities cost of providing the EHP is USD247M and averts a total of 41.5 million DALYs.

TABLE 8: COMPARISON OF EHP RESOURCES AND COSTS BY INTERVENTION CATEGORY[75][76]

Category	Total Resources USD (2015/2016 FY RM4)	Total Cost (Full Implementation)
RMNCH	14,595,601	62,374,566
Vaccine Preventive Diseases	18,412,835	5,142,930
Malaria	13,440,439	30,020,036
IMCI	141,990	2,602,061
NTDs	779,048	100,400
TB	3,744,100	85,620,190
NCDs (incl. MH)	223	3,713,605
Oral Health		10,533,672
HIV & STIs	81,670,857	46,251,124
Nutrition	9,081,015	683,999
Total	**141,866,109**	**247,042,586**

Source: Resource Mapping Round 4 & EHP Tool

Table 8 shows the resources provided for drugs and medical supplies by disease against the cost of fully implementing the EHP by disease category (i.e. 100% coverage). The table show how there is both an absolute shortfall in resources but also that there are disease category's with relatively larger shortfalls. The resources provided to HIV & STIs, for instance, are almost enough for 100% coverage of EHP interventions,

[74] Health Sector Resource Mapping Round 4, FY 2014/15 – 2018/19

[75] The total resources and costs differ slightly here due to mapping methodology with USD20M labeled 'cross-cutting' in the resource mapping. Similarly, due to unavailability of cost data on certain interventions calculations of the totals have been made assuming data availability is not correlated with cost

[76] Table 8 costs and resource requirements reflect only drug and supplies

while there is a large shortfall in Malaria. It is worth noting that some of the resources in the HIV & STI category may currently be going towards non-EHP interventions and would still require reprogramming.

Although the total cost of the package is larger than the current resources available for its provision, the cost of providing the revised EHP is 31% less than the cost of providing its predecessor package (USD362M). Additionally, if the resources were available to provide the previous EHP to the whole population in need it would have averted 45 million DALYs. Therefore, while implementing the previous package would have cost USD7.91 per DALY averted, with the revised EHP it only costs USD5.97 per DALY averted. This indicates that the revised EHP provides better value for money than the previous package.[77]

The above indicates that although further steps are required to ensure planning and allocation is undertaken within the resource envelope available, significant progress has been made in this area, with planning becoming more realistic and less aspirational.

4.3.5 Outstanding EHP Issues

While the re-definition of the EHP has attempted to address many of the issues that faced its predecessor package, there are many issues that remain outstanding and will need further attention to resolve.

- Inadequate resources

As shown above, despite the cost of the revised EHP being closer to the resources available for its provision than before, the cost continues to outstrip resources. The result of this is that, even assuming no health system constraints, it will not be possible to deliver the new EHP to the entire population in need. It is important that ongoing discourse around the EHP focuses on the budgets available for its provision.

- Lack of awareness about EHP among stakeholders

Only 33% of managers for health centres knew about existence of the EHP[78]. Clearly, there are many issues related to the provision of the package that this re-definition does not address. It is vitally important that the revision of the package is complemented with a wider EHP strategy encouraging its promotion and implementation.

- Lack of EHP policy enforcement

Relatedly, simple awareness of the policy is a necessary but not sufficient condition for its implementation. EHP policy has consistently lacked the enforcement necessary to translate the policy decisions into implementation. This constrains delivery of the EHP. Similarly, greater attention needs to be given to the health system constraints to delivering the EHP. Removal of these constraints should receive much priority.

Lastly, currently financing and payment is not explicitly linked to EHP interventions. This means that, in effect, EHP interventions are treated in the same way as non-EHP interventions. A system of financing and payment to providers that separates EHP interventions from non-EHP interventions must be developed for the package – and health care in general – to be delivered effectively.

- Inequalities in EHP utilization

While the EHP is theoretically available to all Malawians free at the point of access, there remain large variations in its utilization. Rural, uneducated and poor populations continue to underutilize health care

[77] The incremental cost-effectiveness ratio (ICER) of the revised EHP is USD26.86. Given that the estimated cost-effectiveness threshold is USD60 the revised EHP can be considered cost-effective.
[78] Mueller et al. (2011)

services. DHOs and partners must strengthen or introduce initiatives for increased access for the poor, rural and uneducated women in Malawi.

- Linking health systems inputs to EHP provision

To the extent possible, health systems inputs and standards should be explicitly linked to the EHP. The Malawi Standard Treatment Guidelines and the Essential Medicines List (EML) should also reflect the interventions included in the EHP.

4.3.6 EHP Operationalization

The EHP is a supply-side reform aimed at strengthening health service delivery. The EHP defines not just the interventions to be delivered but the level at which they will be provided. While long-term operationalization of the EHP will ideally rely on financial incentive structures, in the short-term its delivery will be guided by regulatory requirements. The operationalization of the EHP will therefore, in the immediate term, rely on organizing the inputs into delivering the package.

4.3.6.1 Short term Operationalization

Operationalizing the EHP, will therefore rely on the shaping of the Essential Medicines List, the Essential Equipment List and the Standard Treatment Guidelines around the EHP. As the Essential Medicines List (EML) dictates the drugs CMST can purchase, gearing the list around the EHP is an indirect form of strategic purchasing. The DHO will be responsible for the purchase of essential medicines from CMST. Although such regulations help prioritise EHP provision they do not ensure full prioritisation. Some drugs and medical supplies used for EHP interventions will also be used for non-EHP interventions and there is little preventing the use of the same inputs for use in non-EHP interventions. Communication of the EHP will, therefore, be key to ensuring health workers abide as fully as possible to prioritizing EHP interventions.

Further, more wide ranging reforms will be required to ensure the full prioritisation of EHP interventions. Before these take place, prioritised delivery of the EHP will rely on the above outlined regulation organization.

4.3.6.2 Long Term Operationalization

In the longer-term, to ensure appropriate EHP prioritisation it may be desirable to restructure the purchasing system to explicitly link to EHP interventions. Health care provision is currently funded through passive commissioning of health services. In order to ensure fully prioritisation of EHP interventions a move towards active purchasing will be required. Because of the current structure of budgeting and provider payment mechanism further reforms will need to be made if active purchasing is to take place.

Currently, there are two pilot studies looking at results-based financing (RBF) in Malawi, whose experience can be drawn from to assess the options around reforms to the purchasing mechanism. Further, the results of the evaluation of the National Health Insurance reform recommended directing efforts towards purchasing reforms. Therefore, a possibility for the long-term operationalization of the EHP is to ensure linkage to a national strategic purchasing framework developed.

Further, due to Development Partners funding a significant proportion of the health sector the Ministry of Health will engage in lobbying to ensure funding of EHP interventions is prioritised above other interventions. This will be crucial to ensuring the delivery of EHP services has sufficient economic support. In this sense, an MoH objective and measurable target will be to ensure as close to 100% implementation of EHP interventions as possible. This will be a central output target for the whole of the health sector.

4.3.6.3 Delivery of the EHP

The EHP health services will be delivered at different levels, namely community, primary, secondary and tertiary. These different levels are linked to each other through a comprehensive referral system that has been established within the health system. At the community level, health services are provided by community-based cadres such as HSAs, community-based distributing agents (CBDAs), Health Posts and other volunteers, mostly from NGOs. HSAs provide promotive and preventive health services including HIV testing and counselling (HTC) and provision of immunization services. Some HSAs have been trained and are involved in community case management of acute respiratory infections (ARIs), diarrhoea and pneumonia among children under five years of age. Services at this level are conducted through door-to-door visits, village clinics and mobile clinics. Community health nurses and other health cadres also provide health services through outreach programs. Village Health Committees (VHCs) promote PHC activities through community participation and they work with HSAs on preventive and promotive health services such as hygiene and sanitation. Health centres support HSAs. Each health centre has a Health Centre Advisory Committee helping communities to demand the quantity and quality of services that they expect by monitoring the performance of health centres in collaboration with VHCs. Health centres are responsible for providing both curative and preventive EHP services[79]. At a higher level there are community hospitals, which provide both primary and secondary care, and each has an admission capacity of 200 to 250 beds. Complicated EHP cases will be referred to the secondary and tertiary levels as necessary. CHAM facilities at both primary and secondary levels will continue to be part of the system that provides EHP. MoH will continue to implement the new MOU with CHAM to increase coverage of the EHP in catchment areas of CHAM facilities.

While the EHP outlines the health interventions that will be provided free at the point of access, the list focuses largely on interventions that require drug, medical supply and commodity inputs. This is because medical supplies are, by nature, the most rival and diminishable input into service delivery i.e. if one person uses them there is less supply for others. Interventions that do not require significant inputs beyond staff time will continue to be delivered i.e. advocacy on EPI, advocacy on breastfeeding, teaching mothers on the recognition of ARI etc.

3.8.7 Conclusion

The provision of an essential package of health care services is essential to achieving the targeted health gains in Malawi over the next five years. The revision of the EHP attempts to increase the fiscal space available to the provision of the EHP, by cutting lower-priority expenditures to make room for more desirable ones. This allows the scale up of interventions deemed higher priority. It is essential to continue to move towards a consistent, transparent and accountable process for both the development and delivery of the current and future packages. Key to the success of the EHP will be the enforcement and monitoring of its delivery to ensure the proper and full implementation of the prioritised interventions. The designing and adjustment of systems is still required to allow the package to be properly delivered and realize the full potential health gains i.e. linking health financing to the delivery of the package.

[79]MoH (2004) *Handbook and guide for health providers on the Essential Health Package in Malawi* Lilongwe: MoH

5

Strategies for the HSSP II

5 Strategies for the HSSP II

This chapter outlines strategies for the objectives listed in Section 3.5. These objectives focus on strengthening the health care system for the delivery of the EHP. They also tackle social determinants of health. The corresponding activities for each strategy are detailed in Annex 2.

5.1 Objective 1: Increase equitable access to and improve quality of health care services

The HSSP II will prioritize increasing equitable access to and quality of health service delivery through providing the essential health package free at the point of access to all who need it and ensuring defined quality standards are adhere to. While the Malawi health care system provides a wider range of services than the EHP, the focus of the public health care system will be to ensure universal coverage of the EHP. The HSSP II thus continues the tradition of the HSSP I (2011-2016) and Program of Work (PoW) (2004-2010) in which Malawi defined a package of interventions to be delivered free at the point of access. However, as previously noted, further health system reforms will be required to ensure the EHP is delivered as intended. The strategies are as follows:

5.1.1 To ensure timely universal free access to a quality Essential Health Package, irrespective of ability-to-pay, to all people in Malawi

5.1.2 Conduct communication campaign/training on EHP for all staff

5.1.3 Break EHP into levels of service provision

5.2 Objective 2: Reduce environmental and social risk factors that have a direct impact on health

The health sector will work with responsible Ministries, Departments and Agencies (MDAs), private sector, Civil Society Organizations (CSOs), Development Partners and the community to reduce environmental and social risk factors that have a direct impact on health. The health sector will strengthen community health education and promotion to enable people to make informed and healthy decisions, improve health seeking behaviours and adopt preventive measures. Well-implemented community health interventions will also assist in reducing demand for expensive curative care. The health sector will also aim at strengthening inter-sectoral collaboration and partnerships to address the key determinants of health. The following are the priority strategies that will be implemented in each of the focus areas to address the social determinants of health.

5.2.1 Promote healthy behaviours and lifestyles

5.2.2 Adopt and enforce protective health policies

5.2.3 Promote use of safe water and good sanitation practices

5.2.4 Improve food safety and hygiene and nutrition services

5.2.5 Promote planned and safe housing and urbanization practices

5.2.6 Promote safe working and living environments

5.2.7 Participate in road safety campaigns

5.2.8 Strengthen vector and vermin control services at community and in public institutions

5.2.9 Strengthen epidemic preparedness and response

5.2.10 Strengthen partnership and collaboration with other sectors and key stakeholders

5.3 Objective 3: Improve the availability and quality of health infrastructure and medical equipment

Health infrastructure comprises buildings (both medical and non-medical); equipment (medical equipment, furniture and hospital plant); communications (ICT equipment); and transport systems (ambulances, pickups, vans, trucks, motorcycles, bicycles etc. as required for healthcare at different levels). Priority will be given to the completion of unfinished projects and rehabilitation and upgrading of existing facilities in terms of additional staff housing, utilities, theatres, storage space among others. The following are the priority strategies.

5.3.1 Ensure availability of quality infrastructure
5.3.2 Ensure Essential Equipment List is aligned to EHP
5.3.3 Ensure availability of quality, safe and functional medical equipment
5.3.4 Explore options of leasing high cost medical equipment and using Public Private Partnerships for operating and managing high cost medical equipment in major hospitals
5.3.5 Strengthen transport system at all levels
5.3.6 Strengthen communication systems

5.4 Objective 4: Improve availability, retention, performance and motivation of human resources for health for effective, efficient and equitable health service delivery

Although some progress was made under the HSSP (2011-2016) in training, recruiting, retaining and motivating human resources for health, the country still faces critical shortages of key health technical cadres. The HSSP II will therefore continue to address HR management, development and planning; create more posts in the critical cadres and; improve the distribution and strengthen the motivation of health workers. A functional review of the MoH establishment will be conducted at the beginning of the HSSP II to rationalise HRH across levels of care in light of devolution of payroll to DHOs. The following are the priority strategies for Human Resources for Health.

5.4.1 Improve retention of properly deployed and motivated health workforce
5.4.2 Improve recruitment capacity
5.4.3 Enforce implementation of performance based management
5.4.4 Enforce public service policies, regulations and procedures
5.4.5 Improve quality and coordination of training
5.4.6 Strengthen the human resource planning process to incorporate evidence-based planning

5.5 Objective 5: Improve the availability, quality and utilization of medicines and medical supplies

Over the period of the HSSP (2011-2016) significant progress has been made to ensure that essential medicines and supplies (EMS) are made available in all health facilities. However, numerous challenges remain: there is inadequate financing, inadequate storage space; pilferage is still a major problem and the supply chain management is weak. Over the period of the HSSP II, the MoH will strive to ensure the availability of adequate quantities of high quality safe and affordable EMS for effective delivery of the EHP to all Malawians. The following are the priority strategies:

5.5.1 Review and strengthen policy and regulatory framework for quality assurance of medicines and medical products
5.5.2 Strengthen post-marketing surveillance and pharmacovigilance for medicines and medical products
5.5.3 Promote an uninterrupted supply of quality essential medicines and medical supplies to end-users
5.5.4 Improve the infrastructure for storage at national, district and facility levels
5.5.5 Improve the national Logistics Management Information System
5.5.6 Strengthen systems for medicines and medical products distribution
5.5.7 Monitor and support adherence to treatment and dispensing guidelines
5.5.8 Regularly update treatment (MSTG) and dispensing guidelines and essential medicines list
5.5.9 Ensure alignment of medicine lists with EHP
5.5.10 Strengthen Medicines and Therapeutic Committees (MTCs) in hospitals

5.6 Objective 6: Generate quality information and make it accessible to all intended users for evidence-based decision-making, through standardized and harmonized tools across all programmes

The MoH aims to establish a strong base of high quality, routinely available data for use in decision making by technicians and policy makers in the health sector. To achieve this a comprehensive knowledge management approach is needed in the health sector. The health sector will continue building a harmonized and coordinated national health information system with the Central Monitoring and Evaluation Department (CMED) as the national custodian. The following are the priority strategies. The MoH will also support capacity building for relevant and interested local researchers and collaboration between international and local researchers. The National Health Research Agenda will be reviewed and updated to ensure its alignment with HSSP II and a monitoring tool for its implementation will be developed.

5.6.1 Strengthen national capacity for planning, coordination and implementation of health information systems
5.6.2 Improve alignment of fragmented programmatic M&E approaches and data sources around a single country-led monitoring and evaluation platform
5.6.3 Improving data quality at all levels
5.6.4 Harmonize routine data systems
5.6.5 Enhance adoption of ICT systems and promote innovations in the use of paper-based tools for routine data management (data collection, data analysis, dissemination and use)
5.6.6 Strengthen monitoring and evaluation of HSSP II implementation
5.6.7 Strengthen expenditure analysis at national and subnational levels to monitor effective allocation of resources
5.6.8 Enhance local capacities to conduct and use research (people, skills, funding) for evidence-informed policy and practise
5.6.9 Enhance routine data and research reporting and utilization at all levels

5.7 Objective 7: Improve leadership and governance across the health sector and at all levels of the health care system

Given limited resources in the health sector and prevailing inefficiencies, good governance will be central over the HSSP II period to ensuring effective delivery of the EHP. It is envisaged that improved leadership and governance will generate additional fiscal space specifically through reduced leakage of essential medicines and medical supplies, increased availability of health workers at their duty stations, reduced duplication of efforts at both national and implementation levels, more efficient and transparent procurement processes and strengthened financial management capacity at all levels. The following are the priority strategies.

5.7.1 Strengthen leadership and management functions and structures at national, district and community levels

5.7.2 Enhance capacities in leadership and management and evidence-informed decision making

5.7.3 Strengthen accountability mechanisms and performance management across the system

5.7.4 Enhance pro-active risk assessment and management especially in finance and procurement

5.7.5 Strengthen the functionality of country-led joint HSSP planning and implementation at central and district levels

5.7.6 Establish systems and procedures for aligning and approving all partner inputs into the HSSP II priorities

5.7.7 Enhance opportunities for, and strengthen efficiency and effectiveness of, Public Private Partnerships

5.7.8 Strengthen implementation and monitoring of financial management improvement plans

5.7.9 Establish the means for improving central and district financial management and audit (infrastructure, equipment, personnel and connectivity)

5.7.10 Strengthen adherence and compliance to Public Procurement Act and health sector procurement plans

5.7.11 Strengthen health sector policy, legal and regulatory frameworks

5.7.12 Support effective decentralization of health care delivery

5.7.13 Enhance implementation of hospital autonomy

5.8 Objective 8: Increase health sector financial resources and improve efficiency in resource allocation and utilization

While attempts must be made to increase the resources available to the health sector, recent evaluations showed the biggest benefits are likely to derive from efficiency gains. This will require transparency and accountability in the use of resources in addition to

The health sector will therefore strive to mobilize sufficient financial resources to fund the health sector while ensuring efficiency, equity, transparency and mutual accountability in their use. The following are the

priority strategies for health financing. must be made, it is also clear that the resources currently available, even if used completely efficiently are not sufficient.

6

Strategic Choices and Effective Implementation

6 Strategic Choices and Effective Implementation

6.1 Introduction

This Chapter summarises the content of foregoing chapters and highlights the core HSSP II, activities that should be implemented. It also indicates how the HSSP II will be effectively implemented at all levels. The intended use of HSSP II is threefold:

- By implementers at all levels to guide activities and align to health sector direction;
- By Ministry of Health to provide strategic leadership and direction of the sector;
- By Development Partners to select and follow own and pooled investments, and align to national priorities.

6.2 Strategic Choices

In specifying objectives and strategies and defining the EHP, the HSSP II infers a number of strategic choices. These strategic choices are outlined here under their relevant sub-headings.

6.2.1 Financing

The assessment of the feasibility of health financing reforms such as the National Health Insurance Scheme and Health Fund have made clear that, in the medium term, the capacity and scope for domestic revenue raising is limited. Likewise, given the global climate it is highly unlikely that Development Partners funding will increase in the medium term, on the contrary, there is a possibility it may decrease.

It was seen in the previous medium term strategic plan, the HSSP, that the cost of implementing the plan far exceeded the resources available for its implementation. A consequence of this is that many of the activities planned under the previous strategy never took place. Therefore, a strategic choice of the HSSP II has been to pursue efficiency savings within the health sector. The Ministry of Health will continue with financing reforms aimed at increasing revenue nevertheless.

Efficiency savings will be pursued through various means. A number of strategies and activities are aimed at reducing leakage and pilferage while the feasibility of a number of reforms looking at where efficiency gains can be made will be assessed. Improvements in audit and financial oversight, both at central and decentralised level, will be crucial to ensuring health sector resources are used efficiently and wastage reduced. This is particularly important in the face of on-going decentralization. Over the course of the HSSP II, the health sector will be fully assessed for possible efficiency gains. Assessments of the provider payment system and improvements in strategic purchasing are possible areas to start.

6.2.2 EHP Strategic Choices

The revision of the EHP was based on the premise of universal health coverage (UHC) that ensures “that everyone – irrespective of their ability-to-pay – gets the health services they need; and that nobody suffers undue financial hardship as a result of receiving care.” Ultimately the revised EHP attempts to rationalize the previous EHP to ensure that all Malawians are able to access the services included in the package.

While the previous EHP professed to ensure all Malawians had access to the services in the package the reality was different. This is seen by the low implementation levels observed for services included in the EHP. Supply-side issues, stemming from the financial unaffordability of the previous EHP, primarily cause these low implementation levels. The Ministry of Health has therefore made the strategic choice of focussing on an affordable package of interventions which prioritizes prevention and promotion more than the previous package. While over 57% of the previous EHP interventions were curative in nature, only 41%

of the revised EHP interventions are. Both health promotion and prevention interventions constitute a larger proportion of the package than before. A related strategic choice is to focus on community level interventions and strengthening the community level health care system. Therefore, the scaling up of EHP coverage will take place through four key strategies:

- Rationalizing the EHP – forming a package closer to the resource available
- Scaling up services provided through community health care workers i.e. HSAs
- Expanding health infrastructure in hard-to-reach areas
- Continuing with the policy of contracting private providers to supply free services

It is hoped these, largely, pro-poor supply-side reforms will ensure greater horizontal equity in the provision of the EHP by extending coverage to areas previously not reached.

The HSSP II also focuses on the quality of health care services. The National Health Policy (2017) stresses the importance of raising the quality of health care delivery in Malawi, ensuring clinical effectiveness and client satisfaction are maintained to maximize treatment outcomes. A Quality Management Directorate has been established to that effect.

6.2.3 Health Systems Strengthening

The Ministry of Health makes the strategic decision that health systems strengthening will prioritise systems that support the delivery of the EHP. For human resources this implies greater priority will go towards training and filling vacancies that deliver the EHP. Table 9 demonstrates this strategic choice.

TABLE 9: HSSP II HRH TARGETS [80]

Cadre	2016-17 (current)	2017-18	2018-19	2019-20	2020-21	2021-22
Medical Officer	358	447	536	625	714	804
Clinical Officer	1,425	1,506	1,587	1,668	1,749	1,831
Nursing Officer	1,163	1,544	1,759	1,974	2,189	2,404
Nurse Midwife Technician	4,812	6,015	6,928	7,840	8,753	9,666
Medical Assistant	1,315	1,378	1,441	1,504	1,567	1,630
Pharmacy Technician	504	699	814	929	1,044	1,159
Laboratory Technician	475	528	561	595	628	662
Health Surveillance Assistants[81]	9,214	10,125	11,233	12,592	14,276	16,401
Total	**19,266**	**22,242**	**24,859**	**27,727**	**30,920**	**34,557**

Source: Ministry of Health HRH Analysis (2017)

[80] This table gives different figures to table 5 which reflects recent health worker recruitment financed by Global Fund in addition to a lack of a standardized mapping of job titles to cadres

[81] Health Surveillance Assistants (HSAs) do not have regular training output as the other cadres represented do. As such HSA recommendations taken from the National Community Health Strategy (2017)

For infrastructure development, the HSSP II will focus on completing ongoing projects and maintaining, rehabilitating and upgrading the existing stock of infrastructure rather than new infrastructure developments. However, there is the pre-planned construction of District Hospitals in Lilongwe, Blantyre, Zomba and Mzuzu to provide primary and secondary health care services in areas where Central Hospitals are currently providing these services. In addition, there are plans to develop 900 new Health Posts in hard-to-reach areas for integrated provision of community services. Each health post will serve 3 to 5 hard-to-reach catchment areas. Table 10 presents a summary of the priority infrastructure needs and their cost estimates. The Capital Investment Plan (CIP) report outlines the detailed infrastructure and medical equipment priorities over the next 5-years.

TABLE 10: CAPITAL INVESTMENT OVER HSSP II PERIOD (MAINTENANCE AND REHABILITATION - USD)

	Year					
Type	**1**	**2**	**3**	**4**	**5**	**Total**
Central Hospital	23,636,111	4,400,000	9,275,982	7,320,648	7,249,315	51,882,056
Dispensary	206,999	140,333	138,000	1,085,297	719,665	2,290,295
District Hospital	14,103,673	27,682,001	5,306,999	-	3,634,000	50,726,673
Health Centre	10,564,918	4,313,425	5,972,492	9,941,583	9,661,723	40,454,140
Health Post	149,332	19,709,049	19,904,181	20,076,250	20,351,998	80,190,810
Maternity Clinic	100,333	-	-	-	73,666	173,999
Mental Hospital	-	-	-	-	3,424,658	3,424,658
Urban Health Centre	73,666	406,665	-	-	-	480,331
Community Hospital	7,870,027	2,805,999	1,557,332	1,943,666	-	14,177,025
Outreach clinic	-	-	-	-	55,666	55,666
PHC Training Centre	150,000	-	-	-	-	150,000
Transport	585,421	2,906,380	3,075,948	3,774,067	4,793,011	15,134,827
Total	**57,440,482**	**62,363,851**	**45,230,934**	**44,141,511**	**49,963,702**	**259,140,478**

Source: Ministry of Health, Draft Capital Investment Plan (2017)

The strategic direction in relation to governance is to revitalize the national and district level governance bodies. While some operate successfully others have ceased to function. As such meeting dates for all TWGs, HSWG and all other relevant bodies will be set at the start of every Fiscal Year throughout the HSSP II period. These dates will be agreed with all Directors and Partners and replace the current ad hoc meeting structure, with extraordinary meetings called as and when required. This will help with effective steering of the sector and will be a first step towards ensuring effective joint implementation of the HSSP II. The Ministry of Health also prioritises strengthening existing coordination mechanisms to maximize sector harmonisation. To that effect, the Aid Coordination Unit (ACU) was established to ensure partner alignment to HSSP II objectives and strategies while minimizing duplication of financing and activities.

The HSSP II also prioritises strengthening accountability mechanisms at district level. The use of MoUs by implementers, standardised reporting requirements and annual planning process will be strengthened at district level. Resource Mapping and other data will be collected, analysed and presented to guide priority setting and entry and coordination of NGOs at district and national levels.

For health information systems, the situation analysis highlights the current challenges in health information which include poor quality of data, lack of harmonization between health information systems, heavy reliance on manual collection of data and inadequate data utilization to support decision processes. The HSSP II therefore focuses on strengthening planning, coordination and implementation of health information systems. This is particularly important considering the changing landscape in the roles between the central Ministry and the subnational levels including Central Hospitals, Zones and Districts. Governance tools such as standard operating procedures, HIS Policy, HIS strategy, e-Health Strategy, Indicator Handbook will help to standardize processes and strengthen HIS leadership in the wake of decentralization.

The next HIS strategic choice is to strengthen the quality of data to support evidence based decision making. As of 2016, only 5 reports out of the 80 available in the DHIS 2 (6%) had reached a reporting rate of 80% while only 8 (10%) had timeliness above 50%. Ordinarily, attention would be on improving data collection and reporting processes to ensure that data generation is of good quality, as was the case during HSSP I. While this will continue, focus within the HSSP II has been shifted to strengthening data use. Broader evidence including experiences from the HSSP I have shown that improving data use has a transitive effect on data quality. Additionally, promoting the use of data is expected to help identify gaps in data and consequently help promote harmonization of parallel systems and other HIS sub systems into the national evidence platform.

As highlighted above, one way to improve data quality is to improve the processes for data collection, collation and reporting. These processes are currently heavily reliant on manual tools with the already few health personnel spending huge amounts of time organizing and collating data. Within the HSSP II health information focus will be on strengthening and shifting to digital health information systems. The Ministry of Health will take advantage of the roll-out of the National ID, which in conjunction with birth and death registration, may be leveraged for several purposes within the health sector, such as patient tracking, patient billing (e.g. billing non-Malawians) and embedding the eHealth Passport. Furthermore, civil registration will provide routine data on birth and death rates, in both facilities and communities, as well as comprehensive cause of death information according to WHO standards for all facility-based deaths, expanding capacity for health planning and prioritization. Additionally, efforts to conduct expenditure analysis at national and subnational levels are expected to help monitor effective allocation of resources.

6.2.4 Social Determinants of Health

The HSSP II places great weight on health promotion and prevention activities, attempting to address social risk factors before they impact on individual and population health. Community health is a large priority in the HSSP II with a heavy focus on integrating and reinforcing community level health care and substantially increasing the number of HSAs over the HSSP II period. Effective implementation of the community health strategy is hence a high priority for the Ministry of Health.

While the EHP primarily focuses on health care interventions it is acknowledged that focusing on the EHP alone will not be adequate to maximize improvements in health outcomes, and that a multi-sectorial approach to addressing the social determinants of health will need to be implemented to compliment efforts in the area of health care delivery.

This multi-sectorial effort will focus on the structural factors that impact on population health such as poverty, education, inequality, transport, housing and stigma among other upstream factors that have health impacts. This approach will require the establishment of formal mechanisms to interact with other sectors in addition to data on the health impact of interventions outside the traditional health sector. More of a focus must be put on clarifying the structures in place, particularly regarding decentralization.

Regulation remains essential to operationalize and guide the decentralized model; a comprehensive stance on decentralization in the health sector has yet to be fully developed.

6.3 Effective Implementation

Successful implementation of the HSSP II will be the responsibility of all health sector stakeholders in Malawi. It will be implemented under the health sector partner alignment and coordination arrangement and the decentralized system. The system and structures established by the Government of Malawi and those created under the partnership alignment and coordination and the decentralized system will play their defined roles and responsibilities during the implementation of the HSSP II. The Ministry of Health will provide its overall stewardship role of the sector and provision of policy and technical support to implementing partners, especially the decentralized levels. This section discusses the Implementation Arrangements for the HSSP II, including role and responsibilities of various stakeholders.

The decentralization of the health sector in Malawi has meant the movement of some – but not all – governance functions of the health system to move from national to sub-national level. These decentralised functions include the allocation of funds and recruitment of human resources for health. Authority for some functions – such as capital investment and drug budgets – remain centralised at national level.

There remain many obstacles to complete and successful decentralization in the health sector. Effective governance is a requirement of achieving this. There is still not full clarity on the decentralized governance model design with clearly defined roles, linkages and reporting requirements between structures. Additionally, no district system of accountability has been developed. Different degrees of functionality of decentralization – in terms of the active status of local governance structures (e.g. drug management committees) – mean that different Districts essentially operate under different systems. Ensuring that the health sectors decentralized governance and financing model design is clear and adhered to will be central to ensuring successful implementation of the HSSP II.

6.3.1 National Level

The Ministry of Health will develop Annual Implementation Plans (AIP) outlining the activities to take place over the next Fiscal Year. The Department of Planning and Policy Development will be responsible for developing the AIP with input from Ministry of Health Departments and Partners. Senior Management will be responsible for approving the AIP. The Health Sector Working Group (HSWG) will be responsible for monitoring the overall implementation of the AIP for the current Fiscal Year with Technical Working Groups (TWG) providing oversight on the relevant thematic areas.

Departments within Ministry of Health will provide technical support in planning, delivery, supervision, and monitoring of health care provision but will not engage in actual health service implementation. The role of Departments is multi-faceted and includes:

- Coordination and planning across programs and stakeholders;
- Development of policies, guidelines, strategies;
- Monitoring adherence to guidelines and policies;
- Monitoring and evaluating health systems;
- Internal and external communication on matters related to the health sector.

The Ministry of Health is not responsible for direct implementation, but rather coordinates with implementing partners. HSSP II will be operationalized in specific areas through the development of Programmatic National Strategies, such as the National Community Health Strategy 2017-2022.

6.3.2 District Level

Districts will develop their District Implementation Plans (DIP) operationalizing the AIP for the HSSP II at subnational level. It will be the responsibility of the Ministry of Health to ensure the DIP aligns with the AIP. The District Health Office, run by the DHMT, should monitor implementation of health care service delivery, specifically the EHP. The DHMT is responsible for ensuring health facilities, through their Health Centre Management Committee (HCMC) and Health Centre Advisory Committee (HCAC), know their health service provision requirements. Further, it should highlight any constraints preventing service delivery to the Health and Environmental Committee and Central Level.

It will be the responsibility of the Ministry of Health, the DHMT and the Health and Environmental Committee to communicate the needs of the health sector to the District Executive Committee and District Council.

6.3.3 Communities

Community participation is crucial to ensuring quality health care provision occurs. Generating awareness and demand for health services; knowing their rights and entitlements; helping to improve services (e.g. via feedback mechanisms); and demanding that health service delivery meets the standards expected of it.

Community based organizations such as, NGOs, patient groups, CSOs and FBOs, among others play an important role in supporting communities in demanding and monitoring health care delivery in districts.

6.4 Risk Analysis

Failure to attain the objectives set out can be attributable to one or both of two broad causes:

- Failure to achieve the health objectives set, despite the provision of the required and planned inputs.
- Failure to achieve the health objective set, because the provision of the required and planned inputs was not met.

The risk analysis should analyse both potential situations, but the former is the true implementation failure while the latter is failure at the planning stage. Table 11 shows the risk management framework.

TABLE 11: HSSP II RISK MANAGEMENT MATRIX

RISK IDENTIFICATION	ANALYSIS OF RISK			RISK MITIGATION STRATEGY
	LIKELIHOOD	IMPACT/CONSEQUENCE	OVERALL RISK	
1.0 Health Service Delivery and Performance Risks	**3**	**3.5**	**H**	**Implement comprehensive risk management plan for the health sector;**
1.1 Inadequate delivery of quality Essential Health Package at all levels of care	3	4	H	• Roll out EHP Guidelines and HSSP operational plan; • Implement Citizens charter and performance contracts; • Improve compliance to standards and guidelines on health service provision.

1. Increasing number of environmental and climatic related health hazards	3	3	H	• Implement National Community Health Strategy; • Improve multi-sectoral integrated preparedness and timely response to environmental and health hazards.
2.0 Health Systems and Financing Related Risks	**4**	**3.6**	**H**	**Advocate for implementation of health financing strategy for the Health Sector**
2.1 Inadequate number of well-trained human resources for health at all levels of care	4	3	H	• Institute measures to enhance compliance to minimum standard norms and accountability measures for HRH in health facilities.
2.2 Increasing fiscal gap to finance HSSP delivery	4	4	H	• Develop and implement health financing reforms for increased funding for health; • Advocate for government adherence to Abuja declaration on government financing for health.
2.3 Shortages of essential medicines, infrastructure and medical equipment in public health facilities.	5	4	VH	• Institute measures to enhance compliance to minimum standard norms for HSSP tracer drugs, medical infrastructure and equipment at all levels.
2.5 Inefficiencies in supply chain management for medical supplies.	3	2	M	• Implement CMST and drug management reforms
2.6 Continued overreliance on external financing for health.	4	4	H	• Develop and implement health financing reforms for increased domestic financing for health.
3.0 Fiduciary and financial management for resources for health Risks	**4**	**3**	**H**	• Roll out government reforms on financial and procurement to enhance transparency and accountability in the health sector.
3.1 Mismanagement of Financial resources	4	4	H	• Roll out government reforms on financial management accountability and fiscal discipline in the health sector; • Strengthen audit functions in the Ministry and local councils.

3.2 Pilferage of drugs and medical supplies in public health facilities	4	3	H	• Develop and implement reforms to prevent drug mismanagement and institute corrective measures against non- complying officers; • Scale up Drug Theft Investigations Unit operations at all levels; • Revamp and engage Health Advisory Committees (HACs) to enhance social accountability for resources for health.
3.3 Non-compliance to procurement standards and systems by stakeholders leading to loss of funding and inefficiencies.	3	3	H	• Conduct regular procurement audits; • Implement reforms on improving procurement systems in the health sector.
3.4 Fiduciary risk assessments and Public Expenditure Analysis (PEFA) are often not undertaken.	2	2	L	• Conduct regular joint FRA and PEFAs
4.0 Governance, Planning, Coordination and Management Risks	**4.3**	**3**	**H**	**Develop and implement a harmonized strategy towards having one plan, one budget and one report for the Health sector**
4.1 Fragmentation in Planning, Budgeting and ME systems and tools in the Health sector	5	4	VH	• Develop timely operational plans, reports and reviews in a harmonized fashion at all levels; • Strengthening Aid Coordination functions in the Health Sector.
4.2 Decentralization risks resulting from limitations in technical capacity at local level.	3	2	M	• Develop and execute a roadmap to support local councils in devolution and decentralization processes.
4.3 Most resources remain off- budget or off-plan	5	3	H	• Develop guidelines for increased harmonization of planning and budgeting processes in the Sector; and, • Advocate and enforce local and international financial and procurement requirements among all players in the sector.

RISK MATRIX CALCULATOR

	CONSEQUENCES/IMPACT				
LIKELIHOOD	**Negligible-1**	**Minor-2**	**Moderate-3**	**Major- 4**	**Severe- 5**
Almost Certain -5	M	H	H	VH	VH
Likely- 4	M	M	H	H	VH
Possible- 3	L	M	H	H	H
Unlikely- 2	L	L	M	M	H
Rare- 2	L	L	M	M	H

VH= Very high risk- Requires close executive attention and detailed action/plan

H= High risk- Requires close management attention

M= Medium risk- specify management responsibility and monitor conditions closely

L= Manage by routine procedures.

6.5 Conclusion

As can be seen, although the HSSP II attempts to plan more realistically than its predecessor strategy, there are still large resource gaps and optimistic targets in all areas of the health system, most notably in the delivery of the revised EHP.

An annual implementation plan (AIP) will be developed for each year (the first year's work plan is in Annex 5). This first year AIP identifies the first steps within each objective necessary for the successful implementation of the EHP.

Essentially, the EHP revision attempted to rationalize planned service provision in Malawi while ensuring resources were used as efficiently as possible. The follow up exercises, and what will be the focus over the course of HSSPII implementation is that health system standards are based on this revised EHP.

7

HSSP II Financing

7 HSSP II Financing

Estimates of the financial resources required and available in the health sector are needed to guide implementation of the HSSP II. This section presents estimated costs and fiscal space from 2017/18 to 2021/22.

7.1 Methodology

The Ministry of Health selected the One Health Tool, a model for medium- to long-term strategic planning in the health sector, to estimate the costs of the HSSP II. The tool estimates the costs of health programmes, comprising of commodity costs needed for BHP service delivery and programme support costs, such as program-specific training, supervision, and M&E. The tool also estimates the resource needs of health system components, including infrastructure, human resources for health, logistics, health information systems, health financing, and governance. The costing team used Excel for activity-based costing of specific strategies in the HSSP II. All costs were mapped to the HSSP II objectives. MOH program staff, clinicians, and development partners provided all cost assumptions. Data from individual strategic plans, DHIS2, demographic and health surveys, and other health and disease-burden studies informed the development of assumptions. HSSP II cost results are compared to Round 4 Resource Mapping results to estimate the HSSP II funding gap.

7.2 Total Resource Needs

The five-year cost of the HSSP II is estimated to be USD $2,613 million. Costs increase from $504 million in 2017/18 to $540 million in 2021/22. The total cost per capita each year remains constant at about $30. HSSP II costs by objective are shown in Table 1 below.

TABLE 12: HSSP II RESOURCE NEEDS BY OBJECTIVE [82]

		Cost (USD) per year						
Objective		2017/18	2018/19	2019/20	2020/21	2021/22	Total in US $	% Total
1	**Increase equitable access to and improve quality of health services**	**294,352,308**	**297,448,601**	**305,397,705**	**308,073,133**	**306,074,548**	**1,511,346,295**	**58%**
	Commodity costs for BHP service delivery (includes wastage)	*175,108,337*	*193,518,515*	*201,619,389*	*198,183,217*	*201,358,299*	*969,787,757*	*37%*
	Program management costs	*119,243,971*	*103,930,086*	*103,778,316*	*109,889,916*	*104,716,249*	*541,558,538*	*21%*
2	**Reduce environmental and social risk factors that have a direct impact on health**	**13,513,103**	**14,913,209**	**16,344,148**	**17,864,933**	**19,391,192**	**82,026,585**	**3%**
3	**Improve the availability and quality of health infrastructure and medical equipment**	**58,028,263**	**62,932,476**	**45,587,308**	**44,497,885**	**50,280,432**	**261,326,364**	**10%**
4	**Improve the availability, retention, performance and motivation of human resources for health by 2022 for effective, efficient and equitable health service delivery**	**115,118,437**	**124,189,837**	**131,690,679**	**139,674,718**	**148,298,405**	**658,972,076**	**25%**
5	**Improve the availability, quality and utilization of medicines and medical supplies**	**5,667,415**	**5,305,178**	**5,108,467**	**2,995,237**	**646,396**	**19,722,693**	**1%**
6	**Generate quality information and make them accessible to all intended users for evidence-based decision-making, through standardized and harmonized tools that avoids duplication across all programmes**	**15,361,160**	**14,947,813**	**14,714,759**	**14,573,791**	**14,595,332**	**74,192,855**	**3%**

[82] The costing assumes a constant exchange rate of 714 MWK to 1 USD. Inflation is not accounted for in the cost results. The costing assumes a 20% commodity wastage rate annually.

7	**Improve leadership and governance (particularly setting direction and regulation) across the health sector and at all levels of the health system**	**2,220,287**	**1,307,180**	**644,491**	**644,491**	**638,870**	**1,927,852**	**0%**
8	**Increase health sector financial resources and improve efficiency in resource allocation and utilization**	**44,822**	**18,198**	**10,198**	**10,198**	**10,198**	**93,614**	**0%**
	Total	**504,305,794**	**521,062,492**	**519,497,755**	**528,334,386**	**539,935,372**	**2,613,608,334**	**100%**

Objective 1 represents the largest proportion of HSSP II costs, with BHP service provision accounting for approximately 58% of the total HSSP IV financing requirement. Objective 1 costs include commodity costs (64% of Objective 1 costs) and programme management costs (36%).

Commodity cost requirements increase from $175 million in 2017/18 to $198 million in 2021/22, driven by increases in coverage of BHP interventions. HIV has the highest commodity resource requirements; across all five years of the HSSP II, HIV commodities represent 62% of total commodity costs. Provision of antiretroviral treatment accounts for $394 million of the $508 million needed for HIV commodities from 2017/18 to 2021/22 (excluding wastage). The second highest-cost programme area for commodities is reproductive, maternal, neonatal, and child health (RMNCH), which represents 17% of the total HSSP II commodity costs. The programme areas with the largest growth in commodity resource needs from 2017 to 2022 are oral health (111% increase in cost from 2017/18 to 2021/22), mental health (79%), and TB (20%). Commodity costs for some programme areas, such as immunization and malaria, are estimated to decline from 2017/18 to 2021/22. This is a result of anticipated declines in the need for these types of interventions, either through reductions in disease prevalence or incidence in the case of malaria or through changing demographics as the modern contraceptive prevalence rate increases over time, as in the case for immunization.

Programme management costs are highest in 2017/18, reflecting investments in program-specific training, supervision, M&E, and other activities at the onset of the HSSP II. The highest-cost programmes in terms of programme management are HIV ($238 million from 2017/18 to 2021/22), TB ($71 million), and RMNCH ($61 million).

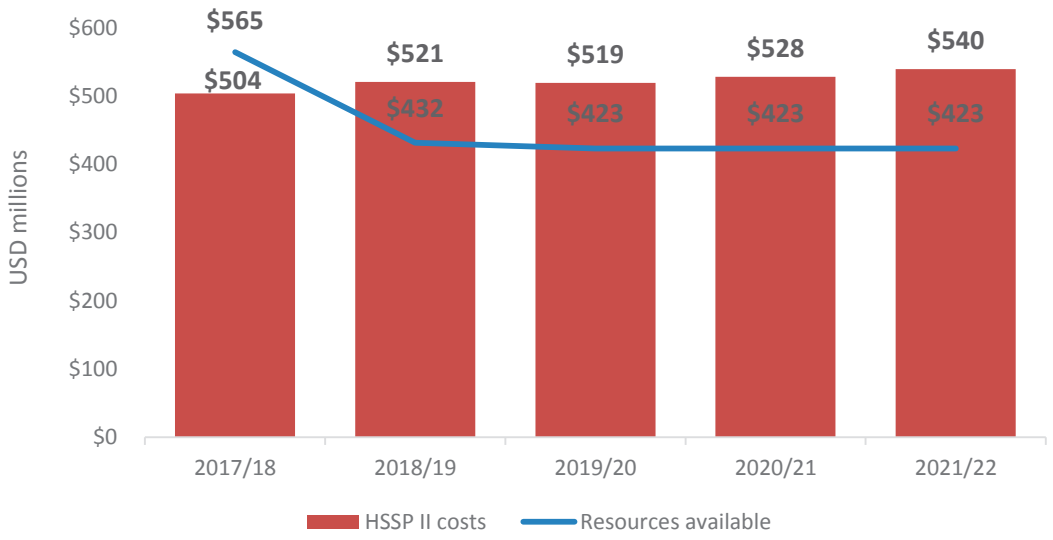
Objective 3 represents 10% of the HSSP II resource requirements. This is mostly due to the costs of constructing and renovating facilities and procuring medical equipment under the Capital Investment Plan (CIP). The priority investments under the CIP implementation period include $94 million for new construction of facilities, $80 million for rehabilitation, and $85 million for equipment. Objective 3 also includes investments in community health transport and infrastructure.

A quarter of the HSSP II costs are for Objective 4, which are costs related to human resources for health (HRH). HRH costs increase from $115 to $148 million from 2017/18 to 2021/22. Approximately 64% of HRH costs are for salaries and 7% is for pre-service training.

7.3 Fiscal Space

According to the latest Resource Mapping exercise, the Government of Malawi and donors have committed allocations of approximately $607 million to the health sector in fiscal year 2016/17. Commitments to the sector are lower for subsequent years ($565 million in 2017/18, $432 million in 2018/19, and $423 million in 2019/20). Based on these projections and the HSSP II cost estimates, the HSSP II has a funding gap ranging from about $89 million in 2018/19 to $117 million in 2021/22 (figure 10).

FIGURE 10: HSSP II COSTS VS. FISCAL SPACE

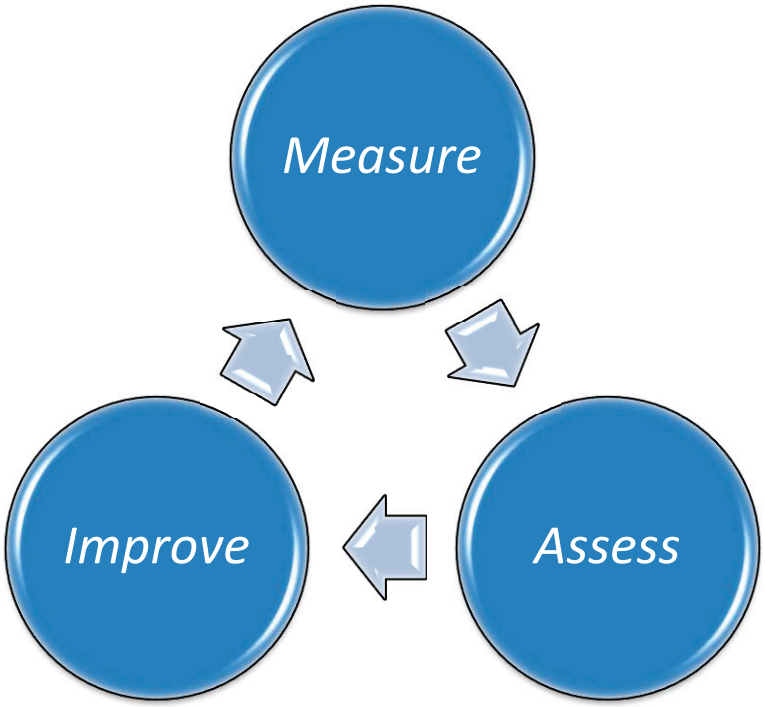


7.4 Health Expenditure Targets

The cost of implementing the HSSP II on an annual basis is estimated at USD30 per capita. According to the NHA, THE per capita was USD39.2 in 2014/15, with 10.9% of that being household expenditure on health. The THE targets for the HSSP II are set as USD43 (2018), USD45 (2020), USD47 (2022). However, simply achieving these targets alone is not enough to indicate success in the THE indicator. Further analysis will need to be undertaken to ensure that the HSSP II activities have been sufficiently financed (USD31 per capita), any financing over and above the HSSP II is aligned with Government vision, mission, goal and objectives within the health sector and that the proportion of household expenditure (and more specifically OOP payments) is not increasing.

8

Monitoring and Evaluation HSSP II



8 Monitoring and Evaluation of HSSP II

8.1 M&E System for HSSP II

The HSSP II monitoring and evaluation (M&E) national framework will measure progress of the implementation of HSSP II strategies at all levels. The HSSP II provides an overview of the M&E framework with a detailed M&E plan being developed in the first six months of HSSP II implementation. M&E will take place at every stage of implementation and will allow the MoH to continuously improve current and future programme planning, implementation, and decision-making. M&E related to HSSP II will take place under the Malawi National HIS Policy (2015) with a HIS Strategy (2017-2022) being currently developed to replace the expired HIS Strategy (2011-2016).

CMED will be the primary stakeholder responsibility for M&E of the HSSP II, the M&E plan will be integrated into existing MoH M&E systems where possible to avoid duplication of efforts.

TABLE 13: M&E FOR HSSP II RESPONSIBILITIES

Stakeholder	Responsibility
DPPD/CMED	• Primarily responsible for M&E of the HSSP II • Sets M&E guidelines, including indicators and cadence of data collection • Collates data nationally • Conducts data analysis • Sets M&E guidelines, including indicators and cadence of data collection • Conducts data analysis at national level • Conducts annual review of the HSSP II • Conducts Mid Term evaluation of HSSP II • Conducts End Term evaluation of HSSP II • Coordinates M&E efforts with MoH and partners • Disseminate findings to all levels
DHOs	• Collects, collates, and analyses district-level data • Submits high-quality data to MoH
Partners	• Assist in M&E activities as requested

HSSP II M&E will be undertaken on a continuous basis throughout its implementation via quarterly performance assessments. Additionally, more in depth assessments will take place during annual reviews and mid- and end-term evaluations.

TABLE 14: PERFORMANCE REVIEW METHODS

Methodology	Frequency	Output	Focus	Level of Monitoring and Review
Performance Assessment	Quarterly	Quarterly progress reports made available to stakeholders and senior management	To involve a review of progress against targets and planned activities. To be done through the HIS/M&E TWG and the Sector Wide TWG	Inputs, process, output and outcome (indicator trends in coverage) levels
Joint Annual Review and Planning	Semi-annual, Annual	Annual/semi-annual progress reports submitted to key stakeholders through the MoH Senior Management. To include league tables focused at various levels of reporting.	To involve a review of progress against targets and outcomes. To be done through the HIS/M&E TWG and the Sector Wide TWG	Input, process, output, and outcome levels
Mid Term Review	Midway through HSSP II implementation	Mid-term analysis report	Done through sector review process against target impact guided by HIS/M&E TWG and the Sector Wide TWG.	Input, process, output, outcome and impact levels
End Term Review	At end of HSSP II	End term analysis report	Independent review of progress, against planned impact.	Input, output, outcome and impact levels.

It should be noted that the HSSP II contributes but does not solely own the health outcome targets. While the public health sector is largely responsible for the input and output targets, health outcomes are aggregations of numerous factors outside the control of the health sector.

8.2 Health Sector Data

The MoH collects health sector data from numerous sources. For HSSP II indicators, Table 11 summarizes the data sources for performance measurement.

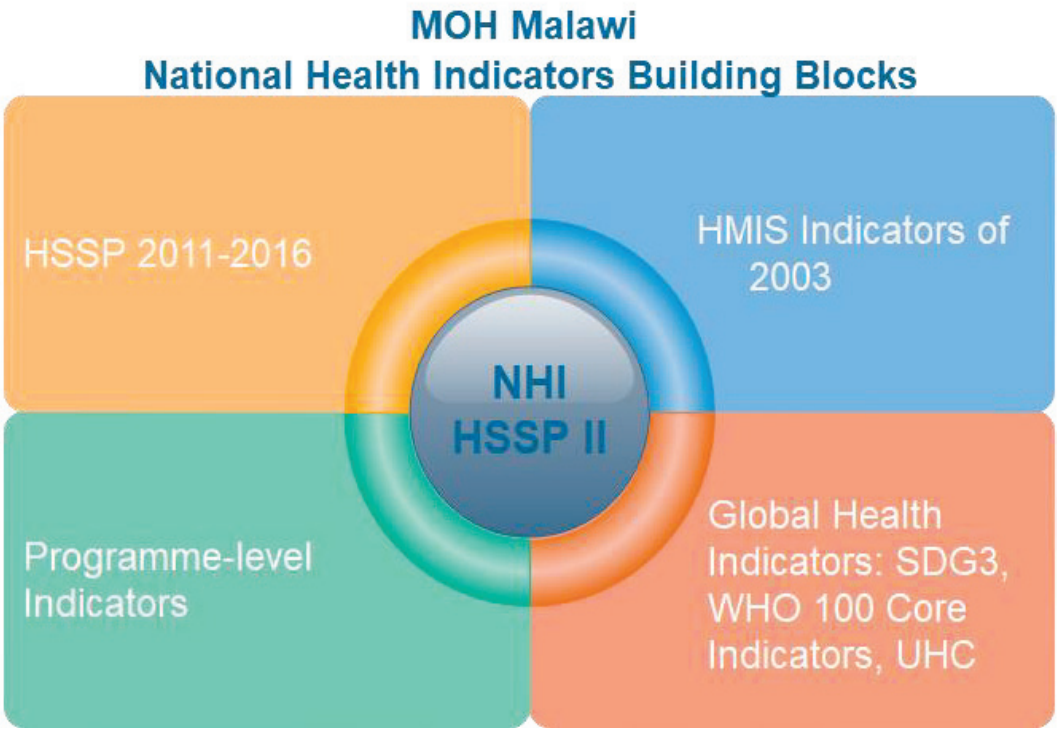
TABLE 15: DATA SOURCES REQUIRED TO REPORT ON INDICATORS

Data Source Type	Data Source
Routine Data	Health Management Information System (HMIS)
	Human Resource Information System (HRIS)
	Integrated Disease Surveillance and Response (IDSR)
	Logistics Management Information System (LMIS)
	Laboratory Information Management System (LIMS)
	Civil Registration and Vital Statistics (CRVS)
Health Facility Survey	Service Availability and Readiness Assessment (SARA)/Service Provision Assessment (SPA)
	National Health Accounts (NHA)
Household Survey	Malawi Demographic Health Survey (MDHS)
	Multiple Indicator Cluster Survey (MICS)
	Malaria Indicator Survey
	Population-based HIV Impact Assessments (PHIA)
	Welfare Monitoring Survey (WMS)

The MoH, in collaboration with sector partners, has developed a set of health indicators deriving largely from the data sources above in order to measure the performance of the health sector and HSSP II implementation. The health indicators are split into National Health Indicators and Programmatic Health Indicators. The National Health Indicators were developed accounting for programmatic preferences and national and global reporting requirements to ensure alignment with other reporting obligations. The indicators developed were compared against the list of core indicators in the HSSP I, the Malawi Handbook of Health Indicators (2003), the WHO list of 100 global health indicators and the SDG list of health indicators. Figure 10 depicts the sources of data that were used to come up with a list of indicators for measuring the performance of the HSSP II.

After consultations with programs and departments, the indicators were presented to the M&E TWG for improvement and ratification. In doing this, the MoH managed to come up with a list of indicators that are relevant for all levels of the health care system.

FIGURE 11: MALAWI NATIONAL HEALTH INDICATORS DATA SOURCES



The National Health Indicators will be the primary indicators used to measure the success of HSSP II implementation (Annex 3). These have been thoroughly documented in an updated handbook, the Malawi Handbook of Health Indicators (2017), due to be released after the HSSP II, and additional program-level indicators are in the process of being documented. Baselines and targets have been established for each indicator.

8.4 Operational Planning Tool

MoH will also be using an Operational Planning Tool to track funding commitments towards HSSP II implementation. This tool will map funding committed – both amount and source – to HSSP II strategies against the cost of implementing the strategies. Disbursement of funds will be tracked on an annual basis throughout HSSP II implementation, to help identify funding gaps in specific programmatic areas of the plan. The objective of the Operational Planning Tool is to mitigate the effects of implementation bottlenecks specifically related to financing. The tool will increase Government, donor and recipient accountability for their commitments, behaviour and results. Additionally, the Tool will increase financing predictability and improve harmonization. The Operational Planning Tool will be developed as part of Resource Mapping Round 5 (2017).

8.5 Performance Contracting

As part of the Performance Appraisal System (PAS) instituted through the Office of the President and Cabinet (OPC), MoH signs an annual Performance Contract with OPC and is expected to report on performance measures to OPC. Organisational Performance Contracts are signed on a yearly basis holding the Minister accountable to the President for the performance of MoH. Indicators are established for the next Fiscal Year immediately after budgets have been approved, allowing Departments to set realistic targets.

Annex 1: Objectives, Strategies and Key Activities of the HSSP II

Programme Area	Strategy	Activities
OBJECTIVE 1: Increase equitable access to and improve quality of health care services		
Service Provision	To ensure timely universal free access to a quality Essential Health Package, irrespective of ability-to-pay, to all the people in Malawi	Provide timely universal free access to a quality Essential Health Package, irrespective of ability-to-pay, to all the people in Malawi
		Develop a Central Hospital health care package
	Conduct communication campaign/trainings on EHP for all staff	Disseminate the revised EHP to all DHMTs
	Break EHP into levels of service provision	Revise guidelines on aspects of EHP available at each level of care
OBJECTIVE 2: Reduce environmental and social risk factors that have an impact on health		
Behaviours and life styles	Promote healthy behaviours and lifestyles	Support and build capacity of Health Surveillance Assistant (HSAs) to implement the Community Health programmes
		Promote exclusive breastfeeding and healthy eating habits
		Promote physical exercise at all levels in collaboration with the Ministry of Youth and Sports and the Ministry of Education
		Train service providers in the management of GBV cases in collaboration with other sectors
		Conduct advocacy and communication for behaviour change aimed at injury prevention, eliminating discrimination and disparities that negatively impact public health and development.
		Provide psychosocial interventions to people affected by violence, conflict and disasters
		Promote mental wellbeing to reduce alcohol consumption, tobacco consumption, and drug abuse
	Increase universal access to health (PHC) and social service coverage	Develop and implement a strategy of integrated community-based health programs
		Expand and strengthen coverage of health services using modern technology (e.g. telemedicine)
	Adoption and enforcement of protective health policies	Facilitate ratification of the Tobacco Control Framework
		Advocate for the Tobacco Control Framework activities
		Initiate development of Tobacco Policy by 2020

Programme Area	Strategy	Activities
Safe water and environmental health and sanitation	Promote use of safe water and good sanitation practices	Continuous health promotion on use of safe water and sanitation and hygiene facilities at all levels
		Facilitate establishment of safe water facilities with the Ministry of Water and other partners
		Repair damaged boreholes, pumps and other sanitation and hygiene infrastructure to appropriate functional standard
		Continuous water quality monitoring
		Promote construction of improved toilets and use of sanitation facilities by households
		Collaborate with city councils and other institutions to improve waste management systems
		Promote hygiene behavioural change interventions
		Train extension workers on Community-led total sanitation (CLTS)
		Trigger follow up and certify ODF communities
Food and Nutrition Services	Improve food safety and hygiene and nutrition services	Finalize the food safety guidelines and monitor implementation
		Continuous inspections, certifications, and audits of food establishments
		Monitoring of food fortification (per the Food Fortification Act) - Iodine in salt at household & commercial level, Vitamin A in flour, cooking oil, and sugar, Iron in flour
		Continuous health promotion on food handling and hygiene practices at all levels and conduct medical examination of food handlers
		Create awareness at community level on the right foods to eat for good nutrition status and promote their production
		Screen for malnutrition in all age groups and ensure appropriate care and rehabilitation for the identified individuals
		Support growth promotion and monitoring in the first two years of life at community level
Housing and Urbanization	Promote planned and safe housing and urbanization practices	Promote construction of properly ventilated dwelling houses and kitchens
		Facilitate formulation of bylaws that restrict construction of inadequately ventilated dwelling houses and enforce standards on housing

Programme Area	Strategy	Activities
		Continuous promotion of safe housing practices through all relevant structures (e.g. good housing construction, proper livestock management, good cooking practices, etc.)
		Develop urban health programmes targeting slums and public places
Environmental and living/working conditions	Promote safe working/living and road environment/conditions	Establish reporting system to gather data on occupation safety and injuries by 2022 in consultation with the Ministry of Labour
		Collaborate with the Ministry of Labour to revise the Occupational Safety, Health, and Welfare Act of 1997
		Conduct occupational safety surveys in some workplaces
		Conduct sensitization activities on adherence to safety measures at workplaces
		Created awareness on indoor air pollution prevention, proper liquid, solid and gaseous waste management
	Participate in road safety campaigns	Active involvement in road safety campaigns and interventions
Vector and vermin control	Strengthen vector and vermin control services at community and in public institutions	Conduct vector resistance research studies and create management plans
		Conduct community education on sanitation and hygiene to increase vector and vermin control
Epidemic preparedness and response	Strengthen epidemic preparedness and response	Establish emergency operations centers (EOCs) and designate and train technical (e.g. physicians, veterinarians, epidemiologists, microbiologists) and support staff to manage it
		Collaborate with the Ministry of Agriculture's Animal Health Department on surveillance and response of zoonotic diseases
		Carry out a joint external evaluation of IHR core capacities
		Monitor antimicrobial resistance
		Establish and train rapid response teams (RRTs) at the district- and central- level and Epidemic Management Committees (EMC), including village health committees
		Train Port Health Officers in carrying out disease screening activities at all ports of entry

Programme Area	Strategy	Activities
		Train health workers in Integrated Disease Surveillance and Response (IDSR), field epidemiology training program (FETP), and infection prevention and control
		Conduct trainings and simulation exercises on selected IHR core capacities or Global Health Security Agenda Action Packages
		Establish networks to share resources, scientific data, and best practices and to enhance the country's ability to fulfil relevant IHR core capacities
		Establish One Health Committees with legislative support and cooperation between Ministries of Health and Agriculture
		Develop and field test distance learning tools to train staff on public health emergency management response.
		Construct Treatment Isolation Centres for infectious diseases
		Implement syndrome and or event based surveillance systems through the IDSR framework and guidelines.
		Develop standardized electronic surveillance system to transmit surveillance data at all levels.
Partnerships and Collaboration	Strengthen partnership and collaboration with other sectors and key stakeholders for action socio-economic determinants of health (SDH)	Develop a policy/guidelines on multi-sectorial collaboration and allocation of resources on SDH
		Hold multi-sectorial review meetings biannually at all levels
OBJECTIVE 3: Improve the availability and quality of health infrastructure and medical equipment		
Health Infrastructure development and rehabilitation	Ensure availability of quality infrastructure	Complete construction of unfinished health facilities including provision of associated utility services
		Complete construction of unfinished staff houses (Umoyo and flats for HWs) and provision of associated utility services
		Renovate/rehabilitate/maintain existing health infrastructure including provision of associated utility services
		Undertake construction of Community Health Village Clinics
		Develop and upgrade health infrastructure including staff housing based on need to promote equitable access to quality health care

Programme Area	Strategy	Activities
Medical Equipment	Ensure Essential Equipment List is aligned to EHP	Finalize/revise standard equipment list for health facilities at different levels (central hospitals, district hospitals, community hospitals and health centres) with acknowledgement of EHP
	Ensure availability of green, quality, safe and functional medical equipment	Procure medical equipment
		Develop equipment replacement plan
		Conduct regular planned preventive maintenance (PPM) and corrective maintenance
		Ensure functionality of PLAMAHS or similar system for medical equipment
		Improve skills for Biomedical Engineers/Technicians, Medical Physicists and Equipment Users
		Promote linkages with training institutions and professional associations
	Explore options for PPPs in medical equipment acquisition and management	Pilot leasing of high cost medical equipment at major hospitals
		Pilot using PPPs in operating and managing high cost medical equipment at central hospitals
Transports Logistics	Strengthen transport system at all levels	Procure and distribute additional ambulances to match prescribed population ratio and other means of transport to maintain appropriate means of transport at all levels based on need
		Equip all Ambulances with proper referral equipment
Communication Systems	Strengthen the communication linkages	Develop policy on communication devices for health facilities
		Provide reliable form of communication systems/facilities e.g. cell phone
		Provide Information Technology (IT) infrastructure (computers and internet access) to health facilities
OBJECTIVE 4: Improve the availability, retention, performance and motivation of human resources for health for effective, efficient and equitable health service delivery		
Human resources management	Improve retention of properly deployed and motivated health workforce	Conduct induction for all newly recruited and promoted health workers
		Undertake in-service training
		Conduct annual Performance Appraisals for 100% of health workers
		Institute performance based incentives linked to appraisals for top 20% health workers

Programme Area	Strategy	Activities
		Develop retention policy & strategy (supervision, housing, water, solar for health workers in hard to reach areas)
	Improve recruitment capacity	Conduct functional review of MoH structures in relation to decentralization
		Review staff establishment for all cadres
		Recruit staff to meet at least 75% of staff establishment
		Deploy according to establishment
	Enforce implementation of performance based management	Undertake integrated supervisions at all levels
		Conduct quarterly Review Meetings
		Conduct performance appraisals for staff
		Orient staff at all levels on performance appraisal process
	Enforce public service policies, regulations and procedures	Produce government personnel regulations and procedures
		Induct all health workers through orientation and in-service training
		Implement relevant disciplinary action to constant abuse of policies, regulations and procedures
Expand Training and Education opportunities including CPD	Improve quality and coordination of training	Engage regulatory bodies to assess training accreditation standards
		Enforce existing accreditation standards
		Update records of registration status of its employees
		Incorporate professional behaviour and patient satisfaction into both pre- & in-service training curriculum
		Train tutors and other health worker educators teaching methodology
Human resource planning	Strengthen the human resource planning process to incorporate evidence based planning	Revise and update Human Resource in Health Strategy for Malawi
		Revise the criteria for setting population health worker ratio
		Move away from fixed facility staffing towards more appropriate evidence-based planning
		Ensure appropriate systems exist for HR planning in face of decentralisation
		Introduce and train HRMD in HRH projection models
		Facilitate the functionality & use of iHRIS at all levels
		Allocate human resources based on iHRIS data
		Conduct on-going training for HRMO

Programme Area	Strategy	Activities
OBJECTIVE 5: Improve the availability, quality and utilization of medicines and medical supplies		
Regulation and quality assurance of health products	Review and strengthen policy and regulatory framework for quality assurance of medicines and medical products	Undertake revision of legislation of 1988 Act on medicines and update other existing laws and regulation on medicines
		Enforce the policy on donation of medicines and medical supplies
	Strengthen post-marketing surveillance and pharmacovigilance for medicines and medical products	Develop technical competence in PMPB to support inspection and licensing of pharmaceutical facilities
		Procure laboratory equipment for PMPB National Quality Control Laboratory for testing quality of drugs
		Build capacity of personnel (numbers and skills) at PMPB to effectively measure efficacy and quality of medicines
Procurement	Promote an uninterrupted supply of quality essential medicines and medical supplies to end-users	Conduct drug quantification and forecasting exercises
		Train/employ logistics and supply chain managers in the public sector
	Procure sufficient quantities of medicines and medical products including laboratory commodities	Recapitalize CMST to ensure adequate and sustainable financing for medicines and medical supplies and provide clarity on recapitalization proceedures
Warehousing and distribution	Improve infrastructure for storage at national, district and facility levels	Strengthen the security and expand the capacity of the existing storage infrastructure at all levels
	Improve the national Logistics Management and Information System	Roll out the electronic data system for Logistics Management Information Systems (LMIS) to all health facilities
	Strengthen systems for distribution	Complete CMST reforms for joint integration of supplies chains
Rational Use of Medicines	Monitor and support adherence to treatment and dispensing guidelines	Build capacity of health workers on Rational Use of Medicines
		Introduce and enforce use of prescription forms at all levels of health system
		Conduct regular Rational Use of Medicines surveys
	Regularly update treatment (MSTG) and dispensing guidelines and essential medicines list	Revise and update treatment and dispensing guidelines in line with the EHP
		Update the 'Must Have List' for medicines and medical supplies
	Ensure alignment of medicine lists with EHP	Revise the Essential Medicines List in line with EHP
	Strengthen Medicines and Therapeutic Committees (MTCs) in hospitals	Build capacity of Medicines and Therapeutic Committees

Programme Area	Strategy	Activities
OBJECTIVE 6: Generate quality information and make it accessible to all intended users for evidence-based decision-making through standardized and harmonized tools across all programmes		
Routine data management (HMIS/DHIS-2, CRVS, etc)	Strengthen national capacity for planning, coordination and implementation of health information systems	Scale up DHIS2 System to cover all health facilities using M-Health technologies
		Supervise and monitor the implementation of HIS governance tools
		Finalise development and implement guidelines and standard operating procedures for HIS
		Sustain inter-sectoral forums including the M&E/HIS TWG and the sub TWGs of Data Collaborative Taskforce, mHealth and National Data Standards
		Institute effective monitoring and reporting mechanisms for the reform process and the HSSP II Implementation
		Scale up Civil and Vital Registration Systems
	Improve alignment of fragmented programmatic M&E approaches and data sources around a single country-led monitoring and evaluation platform	Harmonize data collection and reporting tools to remove duplications
		Expand the implementation of modern data collection and reporting tools to cover more facilities and functionality
		Identify community Health Information Systems for national scale up
		Finalise development of a harmonised National M&E Plan for the Health sector
		Ensure harmonization between health facility and community Health Information Systems
		Facilitate harmonization of performance reviews
		Conduct a Service Availability and Readiness Assessment (SARA)
		Participate in the design and implementation of key surveys including DHS, Integrated House Hold Survey, MIS, etc.
		Work towards the development of a routine client satisfaction survey
	Improve data quality at all levels	Conduct regular supervision and on-job training
		Conduct regular data validation exercise for reporting facilities
		Supply reporting facilities with adequate data collection and reporting tools

Programme Area	Strategy	Activities
		Conduct regular facility data reviews at all levels
		Conduct bi-annual data quality assessments
	Expand effective use of information technology to improve the quality, availability and continuity of healthcare	Scale up use of electronic systems and provision of computer hardware and other equipment
		Develop ICT infrastructure to enable access to key electronic Health Information Systems
		Connect facilities to broadband internet
		Train more staff in ICTs for Health
		Build capacity of computer programmers to support HMIS Data systems at the District level
Monitoring and Evaluation	Strengthen monitoring and evaluation of HSSP II implementation	Develop UHC index to evaluate EHP implementation
		Conduct regular annual Implementation plan reviews
		Develop functional M&E framework for HSSP II
		Conduct mid-term and final review of HSSP II
Research	Enhance local capacities to conduct research (people, skills, funding)	Prepare research projects
		Conduct continuous capacity building for relevant and interested local researchers
		Review and update the National Health Research Agenda and ensure its alignment with HSSP II
		Enforce policy on collaboration between international and local researchers
		Develop monitoring tool for the research agenda
Reporting and utilization	Enhance routine data and research reporting at all levels	Establish a forum for dissemination of research within the health sector
		Document and disseminate best practices (knowledge management)
		Provide access to research conducted in the sector within the MoH web page and update it frequently
		Increase the capacity of CMED to present health information in user friendly formats
OBJECTIVE 7: Improve leadership and governance (particularly setting direction and regulation) across the health sector and at all levels of the health system		
Organization and Management	Strengthen leadership and management functions and structures at national, district and community levels	Finalize the National Health Policy to lead country health policy up to 2030
		Develop document explicitly outlining district governance structures providing clarity on roles, membership and linkages including developing and disseminating TORs for decentralised governance structures
		Conduct functional review of MoH structures in relation to decentralization

Programme Area	Strategy	Activities
		Establish a forum for the Minister to meet regularly with senior Directors
		Review, consult on, approve and make operational the proposed District Health Management structure at local councils
		Finalise, consult on and approve the proposal to establish Health Facility Management committees
		Conduct review of the functionality and effectiveness of TWGs
	Enhance capacities in leadership and management	Conduct a feasibility study into developing a health management curriculum at pre-service, master's and doctorate levels
		Re-vitalise, resource and implement the MIM public sector management induction for all newly qualified staff
		Conduct a feasibility of introducing the WHO mid-level management training course for DHMTs in Malawi
		Develop capacity of District Health and Environment committees
		Pilot and roll out training and mentoring for hospital and health facility management committees
	Strengthen accountability mechanisms and performance management across the system	Institutionalise performance contracts across the health sector
		Develop and implement a leadership succession plan across the health sector
		Develop and institute incentive mechanisms for good management practice at all levels
		Establish mechanisms for health facility management committees to feed into District HECs, and for community issues to be raised to national level
		Develop templates for and roll out citizens charters at HQ, District, health centre, hospital levels and with regulatory bodies
	Enhance pro-active risk-assessment and management especially in finance and procurement	Develop a joint risk management strategy (inclusive of government and DPs)
		Establish a regular annual cycle of joint risk assessment and review of the health sector

Programme Area	Strategy	Activities
Partnership coordination and alignment	Strengthen functionality of country-led joint HSSP planning and implementation at central and district levels	Ensure regular and proper functioning of all health sector governance bodies (HSWG, TWGs, HDG etc.)
		Undertake a stakeholder analysis of all partners active in health in Districts
		Establish and maintain a health partner database at National and District level
		Develop Health Sector aid Harmonization Manual
		Undertake joint annual operational planning on HSSP II implementation and annual meeting planning
		Establish bi-annual reviews of partner activities through a joint stakeholder meeting at District level
	Establish systems and procedures for aligning ALL partner inputs into the HSSP II priorities	Assess the interest and feasibility for Malawi to join the International Health Partnership Plus (IHP+)
		Develop a new MoU between government and development partners on aligning with and supporting the HSSP II
		Produce all necessary guidelines for programmatic, HRH, M&E, health financing etc. strategies
		Develop agreed standards for planning and reporting across government and partners
		Develop guidelines on how partners enter into Districts (including new standardized MOU template)
		Ensure that all health partners have signed an MoU in the Districts where they are active
Public Private Partnerships	Enhance opportunities for, and strengthen efficiency and effectiveness of Public Private Partnerships	Review and update the draft 2014 PPP Strategy, based on existing partnerships and more current information, informed by value for money considerations at national and District levels
		Disseminate and operationalise the PPP Strategy
		Produce an electronic tool for analysing the value for money of PPPs
		Undertake an annual review of PPPs in the health sector
Financial Management and Audit	Strengthen implementation and monitoring of financial management improvement plans	Maintain annual development of financial management improvement plans, focusing on bank reconciliations and other priority areas
		Undertake quarterly financial management monitoring and supervisory checks and produce monthly, quarterly and annual progress reports
		Develop, resource and implement an improved financial record keeping system

Programme Area	Strategy	Activities
		Develop and implement a financial management capacity building plan to strengthen staff performance for both financial and non-financial managers
		Identify and fulfill resource needs (i.e. Equipment, supplies, etc.) to improve financial management performance
		Maintain the conduct of quarterly FM Task Force
		Clarify roles and responsibilities between Central HQ and Districts as regards planning, financial reporting and audit
	Establish the means for improving central and district financial management and audit (infrastructure, equipment, personnel and connectivity)	Identify needs and mobilise resources for strengthening national and district audit capacity. Explore innovative initiatives for increasing the 'reach' of internal audit
		Build capacity of finance department to respond to and follow up on audit queries
		Maintain schedule of doing internal audits on a monthly (payroll), quarterly and annual basis, plus spot checks as necessary at HQ and District levels
		Maintain resources for the Drug Theft Investigation Unit (DTIU)
Procurement	Strengthen adherence and compliance to Public Procurement Act and health sector procurement plans	Review, revise and monitor the Procurement Improvement Plan on an annual basis
		Build capacity in contracting and procurement in Procurement Unit, across national and District level managers
		Roll out and implement procurement related performance contracts for managing public procurement within HQ, Districts and across associated institutions (CMST, MBTS, etc.)
		Conduct assessment of CMST purchasing and procurement mechanisms
		Expand whistle-blowing mechanisms to cover other types of procurement
		Disseminate the anti-corruption policy for the health sector
Regulation	Strengthen health sector policy, legal and regulatory frameworks	Initiate reviews, facilitate revisions and finalisation of regulatory acts: e.g. PMPB, Medical and Dental Act, Allied Health Professionals Act, Mental Health Act, Public Health Act etc.

Programme Area	Strategy	Activities
		Revise and update all key programme strategy documents to reflect the revised EHP priorities and alignment with the HSSP II
		Mobilise resources for regulatory bodies to perform their functions
		Initiate performance contracting and performance management initiatives to monitor regulatory performance across the public and private sectors
Organization Management Reforms	Enable effective decentralization	Decentralise human resource management functions to local councils
		Develop transparent process for communicating annual budgets for each health centre and hospital
		Implement guidelines for community oversight in all Districts
		Mobilise resources to support health management of decentralised structures and processes
	Enhance implementation of hospital autonomy	Set up the health facility management committees at Central Hospitals
		Implement performance contracts with health facility management committees. Develop guidelines and performance contracts for committees and develop capacity of committee members
		Initiate the process for enactment of health facility management committees
OBJECTIVE 8: Increase health sector financial resources and improve efficiency in resource allocation and utilization		
Resource Mobilization	Raise additional resources from existing funding sources	Finalize and approve Malawi Health Financing Strategy document
		Commission studies to consolidate and collect data to evaluate gaps in EHP delivery and implications of increased funding on population health, economic growth and demographic changes
		Use evidence base to lobby government and development partners for increased funding for the health sector
		Undertake annual Resource Mapping and National Health Accounts
	Introduce domestic financing mechanisms for health	Evaluate domestic funding mechanisms including legal implications

Programme Area	Strategy	Activities
Resource Pooling	Design options for pooling health financial resources and implement sustainable and risk-based financing schemes	Evaluate options for pooling resources to minimize risks including but not limited to medical insurance scheme e.g. HSJF
		Institutionalize Performance Based Financing e.g. pilot a Purchaser-Provider Split within the health sector
		Explore options for community savings for health financing
Strategic Purchasing/Resource Allocation	Strategic Purchasing for EHP Provision	Finalize designing of and operationalize Programme Based Budgeting (PBB)
		Design and implement performance based financing options e.g. Result Based Financing
		Explore making peripheral health facilities (e.g. community hospitals, health centres, dispensaries) cost centers and provide them with direct funding allocation
		Introduce formula for allocation of funds
		Review payment/reimbursement mechanism for EHP services
	Improving efficiency in resource allocation and utilization	Review the resource allocation criteria and formula to ensure rational and equitable resource distribution across districts

Annex 1: HSSP II M&E Framework

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
	Goal of the HSSP II:												
1	Impact	Health status	Services	Maternal mortality ratio	Survey: 574 per 100,000 live births (MICS 2014); 439 per 100,000 live births (DHS 2015-16); HMIS: 311 per 100,000 live births (Maternity, 2015)	439 per 100,000 live births	400 per 100,000 live births	350 per 100,000 live births	Survey: 3-5 years (DHS & MICS) HMIS: Annual	Survey: National HMIS: District	Survey: None HMIS: Primary complicatio n	RHD	HSSP I, SDG, MCHS, 100LCI, MLHI
2	Impact	Health status	Services	Neonatal mortality rate	Survey: 27 per 1,000 live births (DHS 2015-16); 29 per 1,000 live births (2014 MDG Endline/MICS) HMIS: 12.3/1000 (Maternity, 2015)	26 per 1,000 live births	24 per 1,000 live births	22 per 1,000 live births	Survey: 3-5 years (DHS & MICS) HMIS: Annual	District	Survey: Sex, Age (≤7 days, >7 days) HMIS: none	RHD/IMCI	HSSP I, SDG, 100LCI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
3	Impact	Health status	Services	Infant mortality rate (IMR)	42 per 1,000 live births (DHS 2015-16) 53 per 1,000 live births (2014 MDG Endline/MICS)	40 per 1,000 live births	37 per 1,000 live births	34 per 1,000 live births	3-5 years (DHS & MICS)	District	Sex, Age (neonatal, postneonatal)	RHD/IMCI	HSSP I, SDG, 100LCI, MLHI
4	Impact	Health status	Services	Under-5 mortality rate (U5MR)	64 per 1,000 live births (DHS 2015-16) 85 per 1,000 live births (2014 MDG Endline/MICS)	64 per 1,000 live births	55 per 1,000 live births	48 per 1,000 live births	3-5 years (DHS & MICS)	District	Sex, Age (0-11 months, 1-4 years)	IMCI	HSSP I, SDG, 100LCI
5	Impact	Health status	Services	HIV Incidence	4.1/1000 person-years among adults (15–49) (2014/15 Annual Review Report for the Health Sector)	2.6 per 1,000 person years	2.2 per 1,000 person years	2.0 per 1,000 person years (2020)	Every 2 years (Spectrum)	National	Sex	HIV	SDG, 100LCI
6	Impact	Health status	Services	TB case notification rate	121 per 100,000 (Tb National Strategic Plan 2015-2020)	191 per 100,000	196 per 100,000	196 per 100,000	Annual	District	TB diagnosis type; Type of TB; New/ relapsed; Age; Sex	TB	TB SP, 100LCI, NHLI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
7	Impact	Health status	Services	Malaria incidence rate (presumed and confirmed)	304 per 1,000 (DHIS2, 2015)	300 per 1000	260 per 1000	200 per 1000	Annual	District	Sex, Age (<5; 5+); Diagnosis type	Malaria	SDG, 100 LCI
8	Impact	Health status	Services	Malaria parasite prevalence among children aged 6–59 months	33% (Malaria Indicator Survey (MIS), 2014)	28%	24%	20%	Every 2 years (MIS)	National	Sex, Age	Malaria	100 CLI
9	Impact	Health status	Services	Mortality rate from CV diseases, cancer, diabetes, chronic respiratory diseases	19% (WHO NCD Profile)	15.2%	11.4%	7.6%	Depending on the frequency of global estimates	National	None	NCD	SDG
10	Impact	Health status	Services	Suicide mortality rate	Global estimate: 16 per 100,000 (WHO, 2012) HMIS: 0.3 per 100,000 (NCD, 2015)	14 per 100,000	12 per 100,000	10 per 100,000	Annual	District	Sex	NCD	SDG, 100 LCI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
11	Impact	Health status	Services	Road traffic accident mortality rate	Global estimate: 5.7 per 100,000 (WHO, 2013) HMIS: 1.1 per 100,000 (HMIS 15, 2015)	5.4 per 100,000	4.9 per 100,000	4.1 per 100,000	Annual	District	None	NCD	100 LCI
12	Impact	Health status	Services	Adolescent fertility rate (age-specific fertility rate for women aged 10-14 and 15-19)	15 – 19 year olds: 136 per 1,000 women (DHS 2015-2016); 143 per 1,000 (2014 MDG Endline/MICS)	15-19 year olds: 125 per 1000	15-19 year olds: 115 per 1000	15-19 year olds: 100 per 1000	3-5 years (DHS & MICS)	District	Age: (10 - 14; 15- 19)	RHD	SDG, 100LCI, MLHI
13	Impact	Financial risk	Health financing	Out-of-pocket payment for health	10.9 (NHA, 2015)	10.9%	9.5%	7%	Annual	National	None	DPPD	100CLI, MLHI
14	Impact	Health Status	Services	Total Fertility Rate	4.4 (DHS 2015-16); 5.0 (2014 MDG Endline 2014)	4.4 children per woman	3.5 children per woman	3.0 children per woman	3-5 years (DHS & MICS); 10 years (Census)	National	Rural/Urban ;	RHD	100CLI,MLHI
	Specific objectives												

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
15	Outcome	Coverage of interventions	Services	ART coverage among known HIV-infected pregnant women	85% (Malawi Integrated HIV Program Report 2016 Q4)	83%	85%	85% (2020)	Annual	District	None	HIV	HSSP I, 100 LCI
16	Outcome	Coverage of interventions	Services	Antiretroviral Therapy (ART) coverage	69% (679,056) (Malawi Integrated HIV Program Report 2016 Q4)	68%	78%	90% (2020)	Annual	National	None	HIV	100 LCI
17	Outcome	Coverage of interventions	Services	HIV-positive TB patients on ART during TB treatment	92.6 % (Tb Control Programme National Strategic Plan 2015 – 2020)	95%	95%	95%	Annual	District	Age; Sex; New, relapsed	TB	TB SP, 100 CLI
18	Outcome	Coverage of interventions	Services	Second line treatment coverage among MDR-TB cases	100% (Central Reference Lab Report, 2014)	100%	100%	100%	Annual	District	New, Relapsed	TB	MHLI, 100CLI, TB SP

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
19	Outcome	Coverage of interventions	Services	% of births attended by skilled health personnel	Survey: 89.8% (DHS 2015-16); 87.4% (2014 MDG Endline/MICS) HMIS: 57.9% (Maternity, 2015)	91	93	95	Survey: 3-5 years (DHS & MICS) HMIS: Annual	Survey: Region HMIS: District	Survey: Age; Type of provider; HMIS: None	RHD	HSSP I, 100CLI, MLHI
20	Outcome	Coverage of interventions	Services	Demand for family planning satisfied with modern methods (all women)	Married: 74.6% (DHS 2015-16), 75.1% (2014 MDG Endline/MICS); Sexually active, unmarried: 51.3% (DHS 2015-16)	Married: 80%; Un-married: 54%	Married: 82%; Un-married: 57%	Married: 84%; Un-married: 60%	3-5 years (DHS & MICS)	Region	Marital status; Age; urban/rural; Wealth quantile	RHD	SDG, 100 LCI
21	Outcome	Coverage of interventions	Services	Intermittent preventive therapy for malaria during pregnancy (IPTp)	Survey: 30% (DHS, 2015) 19.3 (2014 MDG Endline/MICS) HMIS: 66% (ANC, 2015; IPT2)	40%	50%	60%	Survey: 2-5 years (MIS, DHS, & MICS) HMIS: Annual	Survey: National HMIS: District	None	Malaria	HSSP I, 100CLI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
22	Outcome	Coverage of interventions	Services	Penta III coverage	Survey: 93% (DHS 2015-16); 90.5% (2014 MDG Endline/MICS) HMIS: 66.3% (HMIS 15, 2015)	95%	97%	99%	Survey: 3-5 years (DHS & MICS) HMIS: Annual	District	Survey: Sex HMIS: None	EPI	HSSP I, 100CLI
23	Outcome	Coverage of interventions	Services	% of 1-year-old children immunized against measles	Survey: 91.2% (DHS 2015-16), 85.1% (2014 MDG Endline/MICS) HMIS: 64% (HMIS 15, 2015)	92%	93%	94%	Survey: 3-5 years (DHS & MICS) HMIS: Annual	District	Survey: Sex HMIS: None	EPI	HSSP I, 100CLI
24	Outcome	Coverage of interventions	Services	% of 1-year-old children fully immunized	Survey: 71.3% (DHS 2015 – 2016) 38.5% (2014 MDG Endline/MICS) HMIS: 63.9% (HMIS 15, 2015)	88%	90%	92%	Survey: 3-5 years (DHS & MICS) HMIS: Annual	District	Survey: Vaccine type HMIS: None	EPI	HSSP I, 100CLI, SDG

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
25	Outcome	Coverage of interventions	Services	Use of Insecticide treated nets (ITN)	MIS 2014: 67% (Under 5), 62% (Pregnant women), 53% (All); DHS 2015-16: 44.7% (Under 5), 46.7% (Pregnant Women)	75% of total pop	80% of total pop	85% of total pop	2-5 years (MIS, DHS, & MICS)	National	Age (<5, 5+); Urban/Rural); Pregnant women	Malaria	HSSP I, 100 LCI, SDG
26	Outcome	Coverage of interventions	Services	Antenatal care coverage – at least four visits (%)	Survey: 50.6% (DHS 2015-16); 45% (MDG Endline Survey/MICS) HMIS: 28.7% (2015 ANC)	55%	60%	65%	Survey: 3-5 years (DHS & MICS) HMIS: Annual	Survey: Region HMIS: District	Survey: Birth order; Urban/ Rural; mother's education; wealth quintile HMIS: None	RHD	HSSP I, 100CLI, MLHI
27	Outcome	Coverage of interventions	Services	Postpartum care coverage	39.2% mother (DHS, 2015-16) 75% mother (2014 MDG Endline/MICS)	84%	87%	90%	3-5 years (DHS & MICS)	District	None	RHD	HSSP I, 100CLI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
28	Outcome	Coverage of interventions	Services	Modern contraceptive prevalence rate (all women)	Married women: 58% (DHS 2015-16), 57% (2014 MDG Endline/MICS); 45% (FPET, Track 20) Sexually active unmarried women: 44% (DHS 2015-16)	Married: 61% Un-married: 50% All women: 54%	Married: 67% Un-married: 54% All women: 58%	Married: 73% Un-married: 58% All women: 62%	3-5 years (DHS & MICS)	Region	Marital status; Age; Method	RHD	HSSP I, 100CLI, MCHS, MLHI
29	Outcome	Coverage of interventions	Services	Children with diarrhoea receiving oral rehydration solution (ORS)	64.7% (DHS 2015-16) 63.5% (2014 MDG Endline/MICS)	70%	79%	85% (2020)	3-5 years (DHS & MICS)	District	None	IMCI	100CLI, MCHS, MLHI
30	Outcome	Coverage of interventions	Services	Vitamin A supplementation coverage (6-59 months)	Survey: 64.1% DHS 2015 HMIS: 29.3 (HMIS 15, 2015)	99%	99%	99%	Survey: 5 years (DHS) HMIS: 6 months	District	Survey: Age (6-11 months, 1 - 4 years) HMIS: campaign v. routine	Nutrition	100 LCI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
31	Outcome	Coverage of interventions	Services	Cervical cancer screening	Not available)	TBD	TBD	TBD	Annual	National	Age	RHD	100LCI, SDG
	Health systems and risk factors												
32	Output	Quality and safety	Services	TB treatment success rate	84% (Tb National Strategic Plan 2015-2020)	88%	89%	90%	Annual	Facility	Age, Sex; TB diagnosis type	TB	TB SP, 100CLI, MHLI
33	Output	Quality and safety	Services	ART retention rate (12 months)	80% (2016 Q3 Integrated HIV Program Report)	80%	80%	80%	Annual	National	None	HIV	100 CLI, SDG
34	Output	Quality and safety	Services	EHP Coverage	73.3% (Programmes' reports 2017)	75%	77%	80%	Annual	District	Facility type; Ownership (MOH, CHAM, private)	Clinical Services/ DPPD?	HSSP I
35	Output	Access	Services	Outpatient service utilization (OPD visits per 1,000 population)	1,046 visits / 1,000 population.	>= 1,100	>= 1,100	>= 1,100	Annual	District	Age (<5, ≥5 years)	Clinical Services	HSSP I, 100CLI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
36	Output	Access	Medicine and medical supplies	% of health facilities with stock-outs of tracer medicines	20% (National Pharmaceutical strategic plan)	5%	5%	5%	3 years	N/A	None	HTSS Pharma	HSSP I, 100LCI
37	Outcome	Health workforce	Human resource for health	Health worker density and distribution	Government Doctor: 0.2(358) per 10,000; Nurses/midwives: 3.6(5979) per 10,000; Clinical Officers (CO): 0.8 (1425) per 10,000; Medical Assistant (MA): 0.8 (1315) per 10,000; (IHRIS, 2017)	Govt only – Doctor 0.2 (447); CO 0.86 (1,506); Nurses 4.2 (7,559); MA 0.77 (1,378)	Govt only – Doctor 0.3 (625); CO 0.87 (1,668); Nurses 5.1 (9,814); MA 0.79 (1,504)	Govt only – Doctor 0.4 (804); CO 0.90 (1,831) Nurses 5.9 (12,070) ; MA 0.80 (1,630)	Public sector: Annual Private and NGO sectors: per HR census schedule	District	Cadre; Ownership (MOH, CHAM, private)	HR	100LCI, SDG
38	Input	Health infra-structure	Infrastructure and equipment	Percentage of population living within 8 km of a health facility	81% (2011, HSSP I)	81%	85%	90%	Annual	District	Facility type; Ownership (MOH, CHAM, private)	PPPAME	100LCI, MLI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
39	Input	Health information	Health information system	Completeness of reporting by facilities	94.5% (HMIS 2015)	99%	99%	99%	Annual (monthly)	Health facility	Facility type; Ownership (MOH, CHAM, private)	CMED	100LCI
40	Input	Health financing	Health financing	% of GOM budget allocated to health sector	6% NHA (SoWC 2015 report) (expenditure is 10.4%)	9%	12%	15%	Annual	National	None	DPPD	HSSP I, MLHI
41	Output	Health security	Services	International Health Regulations (IHR) core capacity index	50% - IHR self-monitoring questionnaire (2014), National IHR core capacity assessment (2015)	60%	80%	100%	Annual (self-monitoring) 2-3 years (core capacity assessment)	Core capacity/ hazard areas	None	PHIM/ Epid Unit	SDG, 100LCI
42	Outcome	Risk factors	Risk factors	Heavy episodic drinking	19% men, 2.3% women (2009, STEPS survey)	Men 18.8%; Women 2.8%	Men 18.4%; Women 2.7%	Men 17.9%; Women 2.6%	5 years (STEPS survey)	National	Sex	NCD	SDG, 100LCI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
43	Outcome	Risk factors	Risk factors	Tobacco use among persons aged 18+ years	14%, (2009, STEPS survey)	14%	12%	10%	5 years (STEPS survey)	National	Sex	NCD	SDG, 100LCI
44	Outcome	Risk factors	Risk factors	Stunting prevalence (under-five)	42.4% (2014 MDG Endline/MICS); 37% (DHS 2015-16)	35%	33%	31%	3-5 years (DHS & MICS)	District	Sex, Age (0-5, 6-11, 12-23, 24-59 months); Severity	Nutrition	HSSP I, 100LCI, SDG
45	Outcome	Risk factors	Risk factors	Wasting prevalence (under-five)	3.8% (2014 MDG Endline/MICS); 2.7% (DHS 2015-16)	2.2%	1.7%	1%	3-5 years (DHS & MICS)	District	Sex, Age (0-5, 6-11, 12-23, 24-59 months); Severity	Nutrition	HSSP I, 100LCI, SDG,
46	Outcome	Risk factors	Risk factors	% of households with access to improved sanitation	Survey: 51.8% (DHS 2015-16) 40.6% (2014 MDG Endline/MICS) HMIS: 13.9% (Enviromental 2015)	65%	75%	85%	Survey: 3-5 years (DHS & MICS) HMIS: Annual	District	Survey: Urban/Rural; HMIS: Urban/Rural; Improved latrine type	Environmental health	HSSP I, 100LCI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
47	Outcome	Risk factors	Risk factors	Percentage of households with access to improved water source	Survey: 87% (DHS 2015-16); 86.2% (2014 MDG Endline/MICS) HMIS: 58% (HMIS 15)	87%	91%	95%	Survey: 3-5 years (DHS & MICS) HMIS: Annual	District	Rural, Urban	Environmental health	HSSP I, 100LCI
48	Process	Risk factors	Risk factors	Minimum acceptable diet for children 6-23 months	7.8% (DHS 2015-2016); 15% (breastfed), 5.2% (not-breastfed) (2014 MDG Endline/ MICS)	13%	18%	23%	3-5 years (DHS & MICS)	District	Breastfeeding status	Nutrition	100LCI
49	Outcome	Risk factors	Risk factors	Overweight prevalence (under-five)	5.1% (2014 MDG Endline/MICS); 4.5% (DHS 2015-16)	3.7%	3.3%	2.7%	3-5 years (DHS & MICS)	District	Sex, Age (0-5, 6-11, 12-23, 24-59); Severity	Nutrition	HSSP I, 100LCI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
50	Outcome	Risk factors	Risk factors	Percentage of low birth weight babies	Survey: 12.9% (2014 MDG Endline/ MICS); 12.3% (DHS 2015-16) HMIS: 4.2% (maternity, 2015)	11.0%	9.5%	8%	Survey: 3-5 years (DHS & MICS) HMIS: Annual	District	None	Nutrition	100LCI
51	Outcome	Risk factors	Risk factors	Percentage of children 6-59 months with anaemia	63% (DHS 2015-16)	61%	59%	58%	5 years (DHS)	District	Severity	Nutrition	100LCI
52	Output	Quality and Safety	Services	Client satisfaction with health services	Not available	70%	75%	80%	TBD	Region	TBD	DPPD	HSSP I; 100CLI
53	Impact	Coverage of interventions	Services	Inpatient malaria deaths per year per 100,000 population	23 per 100,000 (HMIS 15 and HMIS17, 2015)	20 per 100,000	17 per 100,000	14 per 100,000	Annual	District	Age (<5, 5+); Diagnosis type	Malaria	100 LCI

No.	Results chain	Domain	HSSP Thematic Area	Indicator	Baseline / recent estimates (source, year)	Target 2018	Target 2020	Target 2022	Period of reporting	Smallest geographic area	Dis-aggregation	Responsible programme	Alignment
54	Input	Health Systems	Health financing	Total health expenditure per capita (at average US $ exchange rate)	$39.2 (NHA, 2014-2015)	$43	$45	$47	Annual	National	None	DPPD	MLHI HSSP I
55	Input	Health Systems	HRH	Percentage of health centres meeting the minimum staff norms	Not available	TBD	TBD	TBD	Annual	District	Ownership	Human Resource	MLHI, HSSP I
56	Outcome	Coverage of interventions	Services	Universal health coverage index	Not available	TBD	TBD	TBD	Annual	National	None	DPPD	MLHI

Annex 2: EHP Data

				Target Population	Population in Need		Coverage Targets		Case Loads (Scale Up)		Case Loads (Full Implementation)	Unit Cost	Total Cost (Scale Up)		Total Cost (Full Implementation)	Total DALYS Averted	
Category	Intervention Package	Intervention	Target Population Label	2017-2018	2017-2018	2021-2022	2017-2018	2021 - 2022	2017-2018	2021-2022	2017-2018	USD (2017)	2017-2018	2021-2022	2017-2018	2017-2018 (Scale Up)	2017-2018 (Full Implementation)
RMNCH	ANC Package	Tetanus toxoid (pregnant women)	Pregnant women	812,079	100	100	91.8	98.36667	745,759	688,729	812,079	0.06	42,706	39,440	46,503	84,123	91,604
		Deworming (pregnant women)	Pregnant women	812,079	29	29	100.0	100	235,503	199,731	235,503	0.03	5,955	5,051	5,955		
		Daily iron and folic acid supplementation (pregnant women)	Pregnant women	812,079	32	28	77.7	86	201,829	165,846	259,865	0.67	135,225	111,117	174,110	38,347	49,374
		Syphilis detection and treatment (pregnant women)	Pregnant women	812,079	100	100	100.0	100	812,079	688,729	812,079	0.24	191,985	162,823	191,985	812,079	812,079
		IPT (pregnant women)	Pregnant women	812,079	100	100	38.3	80	310,620	550,983	812,079	0.18	55,087	97,714	144,018	42	110
		ITN distribution to pregnant women	Pregnant women	812,079	100.0	100	54.8	#N/A	444,613	654,292	812,079	0.93	413,490	608,492	755,233	15,019	27,431
		Urinalysis (4 per pregnant woman)	Pregnant women	812,079	100.0	100	53.0	#N/A	430,402	447,674	812,079	3.52	1,514,239	1,575,005	2,857,055		
	Modern Family Planning	IUD	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Implant	Women 15-49	656,400	100	100	49.2	60	322,949	724,250	656,400	1.12	361,702	811,160	735,168		
		Injectable	Women 15-49	4,676,848	100	100	49.2	60	2,301,009	2,308,548	4,676,848	0.50	1,146,673	1,150,430	2,330,637		

		Pill	Women 15-49	492,300	100	100	49.2	60	242,211	316,860	492,300	1.05	254,682	333,173	517,646		
		Female sterilization	Women 15-49	1,723,049	100	100	49.2	60	847,740	769,516	1,723,049	19.53	16,554,868	15,027,288	33,648,105		
		Male condom	Women 15-53	574,350	100	100	49.2	60	282,580	407,391	574,350	3.08	871,435	1,256,332	1,771,208		-
	Delivery Package	Clean practices and immediate essential newborn care (in facility)	Births	576,363	100	#N/A		#N/A	#N/A	#N/A	576,363	#N/A					
		Active management of the 3rd stage of labour	Pregnant women	812,079	100	100	60.3	95	489,407	654,292	812,079	0.06	31,734	42,425	52,656	3,572,672	5,928,174
		Management of pre-eclampsia (Magnesium sulphate, Methyldopa, Nifedipine, Hydralazine)	Pregnant women	812,079	2.18	2.18	84.1667	100	14,900	15,014	17,703	4.77	71,074	71,618	84,445	397,937	472,796
		Management of eclampsia (Magnesium sulphate, Methyldopa, Nifedipine, Hydralazine)	Pregnant women	812,079	1.8	1.8	84.2	100.0	12,303	12,397	14,617	6.67	82,008	82,635	97,435	89,689	106,561
		Neonatal resuscitation (institutional)	Births	576,363	1	1	100.0	100	5,764	4,533	5,764	8.13	46,863	36,854	46,863	573,732	573,732
		Management of Obstructed Labour	Pregnant women	812,079	10	10	100	100	81,208	68,873	81,208	30	2,436,236	2,066,186	2,436,236	2,207,943	2,207,943
		Cesearian section with indication	Pregnant women	812,079	0.5	0.5	88.4	95.0	3,661	3,337	4,142	21.05	77,075	70,246	87,186	35,282	39,910
		Cesearian section with indication (with complication)	Pregnant women	812,079	0.1	0.1	88.4	95.0	646	589	731	49.44	31,945	29,114	36,136	17,567	19,871
		Vaginal delivery, skilled attendance	Pregnant women	812,079	84.49	84	88.4	95	606,554	552,811	686,125	4.28	2,597,796	2,367,624	2,938,591	44,142	49,933
		New-born sepsis – injectable antibiotics	Births	576,363	9.0	9.0	84.2	100	43,660	40,793	51,873	0.74	32,092	29,986	38,130		

		New-born sepsis - full supportive care	Births	576,363	12	12	84.2	100	58,213	54,391	69,164	10.04	584,382	546,019	694,315	43,460	51,636
		Antenatal corticosteroids for preterm labour	Pregnant women	812,079	18	18	50.0	50	73,087	61,986	146,174	6.58	480,636	407,630	961,271	20,807	41,614
		Maternal sepsis case management	Pregnant women	812,079	7	7	79.6	90	45,240	43,390	56,846	48.21	2,180,915	2,091,747	2,740,417	14,110	17,730
		Cord Care Using Chlorhexidine	Births	576,363	100.0	100.0	70.0	100.0	403,454	453,260	576,363	0.07	30,063	33,774	42,947	476,076	680,109
		Hysterectomy	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	31.71					
		Treatment of antepartum hemorrhage	Pregnant women	812,079	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Treatment of postpartum haemorrhage	Pregnant women	812,079	3.9	4	60.0	80	19,003	21,488	31,671	17.77	337,659	381,827	562,765		
		Post-abortion case management	Abortions	130,145	47.1	47.1	100.0	100.0	61,350	68,793	61,350	12.42	761,699	854,105	761,699	3,068	3,068
		Antibiotics for pPRoM	Pregnant women	812,079	7	7	81.0	81	46,045	39,051	56,846	7.74	356,414	302,277	440,018	21,134	26,091
Vaccine Preventable diseases	Essential Vaccines Package	Rotavirus vaccine	Children < 1	562,969	100	100	92.7	99	521,685	439,979	562,969	2.19	1,140,222	961,640	1,230,455	70,860	76,467
		Measles Rubella vaccine	Children < 1	562,969	100.0	100.0	94.0	98.0	529,191	435,534	562,969	0.66	348,895	287,147	371,165	81,556	86,762
		Pneumococcal vaccine	Children < 1	562,969	100	100	90.8	99	511,364	439,979	562,969	2.97	1,518,829	1,306,804	1,672,105	787,500	866,973
		BCG vaccine	Children < 1	562,969	100	100	98.0	100	551,710	444,423	562,969	0.19	102,365	82,459	104,454	11,034	11,259
		Polio vaccine	Children < 1	562,969	100	100	84.2	99	473,833	439,979	562,969	0.11	54,033	50,173	64,198	9,477	11,259
		DPT-Heb-Hib / Pentavalent vaccine	Children < 1	562,969	100.0	100.0	94.0	99.0	529,191	439,979	562,969	1.83	969,272	805,870	1,031,141		
		HPV vaccine	Females 9-13 years	943,164	100	100	65.0	75	613,056	982,616	943,164	0.71	435,118	697,413	669,412		
Malaria	First Line uncomplicated Malaria treatment	Uncomplicated (adult, <36 kg)	People 5+	13,980,833	17.744	10	33.0	33	818,650	536,877	2,480,759	1.75	1,431,549	938,820	4,338,026	11,088	33,599
		Uncomplicated (adult, >36 kg)	People 5+	13,980,833	17.744	10	67.0	67	1,662,109	1,090,023	2,480,759	2.00	3,332,251	2,185,314	4,973,509	22,511	33,599
		Uncomplicated (children, <15 kg)	Children 0-4 years	2,974,515	10	15	59.0	59	175,496	201,666	297,452	22.41	3,932,719	4,519,154	6,665,625	2,377	4,029
		Uncomplicated (children, >15 kg)	Children 0-4 years	2,974,515	10	15	41.0	41	121,955	140,141	297,452	23.24	2,833,837	3,256,411	6,911,799	1,652	4,029
	Complicated Malaria	Complicated (adults, injectable	People 5+	13,980,833	3.18	3	100.0	100	444,590	439,263	444,590	2.49	1,106,188	1,092,932	1,106,188		

	treatment	artesunate)															
		Complicated (children, injectable artesunate)	Children 0-4 years	2,974,515	0.68	0	100.0	100	20,227	4,557	20,227	1.03	20,882	4,705	20,882		
	Malaria Diagnosis	RDTs	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Microscopy for Malaria	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
Integrated management of childhood illnesses (IMCI)	Respiratory Infections	Pneumonia treatment (children)	Children 1-59 months	2,927,601	2.786718	3	73.9	90	60,304	56,043	81,584	0.17	10,534	9,789	14,251	284,033	384,261
		Treatment of severe pneumonia (Oxygen)	Children 1-59 months	2,927,599	0.1	0.1	73.9	90.0	1,508	1,401	2,040	5.64	8,505	7,904	11,506		
	Diarrheal Disease	ORS	Children 0-59 months	2,974,515	223.434522	214	67.3	81	4,475,037	3,930,069	6,646,094	0.05	222,307	195,235	330,160	76,036	112,925
		Zinc	Children 1-59 months	3,789,689	223.4	214	36.8	81	3,118,853	5,102,891	8,467,474	0.18	551,770	902,776	1,498,019		
		Treatment of severe diarrhoea (IV Fluids)	Children 1-59 months	2,927,601	2.4	2.4	100.0	100.0	70,262	53,800	70,262	0.45	31,616	24,208	31,616		
		Community management of nutrition in under-5 - Plumpy Peanut	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Community management of nutrition in under-5 - micronutrient powder	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Community management of nutrition in under-5 - vitamin A	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
Community Health	Community Health Package	RDTs for under-5	Children 1-59 months	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Growth Monitoring	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	0	0	0	0		
		Vermin and Vector Control & Promotion	Total population	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	0	0	0	0		
		Disease Surveillance	Total population	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	0	0	0	0		
		Community Health Promotion	Total population	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	0	0	0	0		

		& Engagement														
		Village Inspections	Total population	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	0	0	0	0		
		Promotion of hygiene (hand washing with soap)	Total population	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Promotion of Sanitation (latrine refuse, drop hole covers, solid waste disposal, hygienic disposal of children's stools)	Total population	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	5.29					
		Occupational Health Promotion	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Household water quality testing and treatment	Total population	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Home-based care of chronically ill patients	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Child Protection	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
NTDs	Treatment and MDA	Schistosomiasis mass drug administration	Direct entry	6,217,151	100	100	100.0	100	6,217,151	6,217,151	6,217,151	0.01	60,482	60,482	60,482	379,936	379,936
		Case finding and treatment of Trypanosomiasis	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Trachoma mass drug administration	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
HIV/AIDS	HIV Prevention	Cotrimoxazole for children	Direct entry	110,142	100	100	100.0	100	110,142	95,000	110,142	5.15	567,545	489,521	567,545	275	275
		PMTCT	Women in need of PMTCT	47,882	100	100	83.0	87	39,742	46,578	47,882	11.35	450,934	528,499	543,294	118,248	142,468
	HIV Testing	HIV Testing Services (HTS)	Direct entry	2,641,390	100.0	100.0	100.0	100.0	2,641,390	4,428,512	2,641,390	4.73	12,504,331	20,964,561	12,504,331	54,962	54,962
	HIV Treatment	ART (all ages)	Direct entry	724,545	100	100	100.0	100	724,545	797,323	724,545	95.82	69,422,661	76,395,923	69,422,661	2,195,591	2,195,591
		Viral Load	Direct entry	338,867	100	100	100.0	100	338,867	357,680	338,867	7.62	2,582,359	2,725,725	2,582,359		

Nutrition		Vitamin A supplementation in pregnant women	Pregnant women	812,079	13.5	14	65.8	70	72,173	65,085	109,631	2.31	166,420	150,075	252,790	19,454	29,550
		Management of severe malnutrition (children)	Children 1-59 months	2,927,601	1.15	1	69.2	90	23,287	23,201	33,667	61.19	1,424,800	1,419,582	2,059,952	91,161	131,799
		Deworming (children)	Children 0-14 years	7,318,650	100	100	70.7	79	5,171,846	6,078,454	7,318,650	0.17	878,175	1,032,116	1,242,700		
		Vitamin A supplementation in infants and children 6-59 months	Children 6-59 months	2,693,031	62	58	87.7	96	1,463,752	1,145,059	1,669,679	0.09	138,657	108,468	158,164	-	-
TB		Isonized Preventive Therapy for children in contact with TB patients	#N/A	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A						
		First line treatment for new TB Cases for adults	Total population	16,955,348	0.227	0	79.0	79	30,406	33,262	38,489	20.02	608,830	666,008	770,671	2,197,081	2,781,115
		First line treatment for retreatment TB Cases for adults	Total population	16,955,348	0.227	0	12.0	12	4,619	5,052	38,489	86.15	397,888	435,255	3,315,732	333,734	2,781,115
		First line treatment for new TB Cases for children	Total population	16,955,348	0.227	0	9.0	9	3,464	3,789	38,489	33.88	117,362	128,384	1,304,026	250,300	2,781,115
		First line treatment for retreatment TB Cases for children	Total population	16,955,348	0.227	0	0.5	1	192	211	38,489	75.32	14,494	15,855	2,898,780	13,906	2,781,115
		Case management of MDR cases	Direct entry	86	100	100	100.0	100	86	103	86	858.82	73,858	88,458	73,858	6,367	6,367
	TB Testing	LED test	Direct entry	225,444	100	100	100.0	100	225,444	325,191	225,444	0.24	54,905	79,198	54,905		
		Xpert test	Direct entry	101,455	100	100	100.0	100	101,455	115,817	101,455	9.83	997,585	1,138,806	997,585		
		MGIT test	Direct entry	5,022	100	100	100.0	100	5,022	8,137	5,022	31.75	159,469	258,402	159,469		
		LGA test	Direct entry	5,022	100	100	100.0	100	5,022	8,137	5,022	0.21	1,039	1,684	1,039		
NCDs		Treatment of Injuries (Blunt	Total population	16,955,348	0.04	0.04	100.0	100	6,782	7,419	6,782	9.81	66,512	72,759	66,512		

		Trauma - Soft Tissue Injury)														
		Treatment of injuries (Fracture and dislocation)	Total population	16,955,348	0.08	0.08	100.0	100	13,564	14,838	13,564	51.97	704,951	771,156	704,951		
	Mental Health treatment	Basic psychosocial support, advice, and follow-up	Total population	16,955,348	2.8	2.8	3.0	3.0	14,242	15,580	474,750	0	-	-	-		
		Anti-epileptic medication	Total population	16,955,348	2.8	2.8	3.0	3.0	14,242	15,580	474,750	7.06	100,552	109,995	3,351,733	6,486	216,201
		Treatment of depression (first line)	Total population	16,955,348	5.0	5.0	1.3	3.0	11,304	27,822	847,767	26.87	303,683	747,458	22,776,238	8	577
		Testing of pre-cancerous cells (vinegar)	Pregnant women	#N/A	#N/A	#N/A		#N/A	#N/A	#N/A	#N/A	#N/A					
		Diabetes, Type I	Adults 40+	2,622,468	0.9	0.9	21.7	55.0	5,114	15,020	23,602	56.47	288,777	848,204	1,332,817	5	25
		Diabetes, Type II	Adults 40+	2,622,468	5.6	5.6	21.7	55.0	31,819	93,460	146,858	21.90	696,842	2,046,785	3,216,195	34	158
		Hypertension	Adults 40+	2,622,468	32.9	32.9	17.5	55.0	150,989	549,080	862,792	7.49	1,130,905	4,112,612	6,462,312	7,944	45,396
Oral Health	Tooth pain treatment	Management of severe tooth pain, tooth extraction	People 4+	14,570,162	3.9	6.0	100.0	100.0	568,236	1,006,405	568,236	0.30	172,894	306,214	172,894		
		Management of mild tooth pain, tooth filling	People 4+	14,570,162	1.5	3.5	100.0	100.0	218,552	587,069	218,552	2.34	511,105	1,372,915	511,105		

Annex 3: Detailed 1st Year Implementation Plan

Programme Area	Objective & Strategy (Obj.Strat)	Activity	Responsible stakeholder	Level	Q1	Q2	Q3	Q4
Services Delivery	1.1	Provide timely universal free access to a quality Essential Health Package, irrespective of ability-to-pay, for all the people in Malawi	MoH; District Health Offices; Facilities	All				
Services Delivery	1.3	Disseminate the revised EHP and all relevant documentation to DHMTs	MoH; DHOs; Facilities	District				
Services Delivery	1.4	Revise guidelines on aspects of the EHP available at each level of care	MoH, Planning & Policy Dept.	National				
Service Delivery	1.5	Develop a Central Hospital health care package	Central Hospitals; MoH, DPPD	National				
Behaviours and life styles	2.1	Support and build capacity of Health Surveillance Assistant (HSAs) to implement the Community Health programmes	MoH, Community Health Services Section (CHSS)	Community				
Behaviours and life styles	2.1	Promote exclusive breastfeeding and healthy eating habits	MoH, Nutrition	All				
Behaviours and life styles	2.1	Promote physical exercise at all levels in collaboration with the Ministry of Youth and Sports and the Ministry of Education	MoH, Clinical (NCDs)	All				
Behaviours and life styles	2.1	Train service providers in the management of GBV cases in collaboration with other sectors	MoH, RHD/Clinical	Central Hospitals, District				
Behaviours and life styles	2.1	Conduct advocacy and communication for behaviour change aimed at injury prevention, eliminating discrimination and disparities that negatively impact public health and development	MoH RHD/HEU	All				

Behaviours and life styles	2.1	Provide psychosocial interventions to people affected by violence, conflict and disasters	MoH, RHD, Clinical, HEU	District				
Behaviours and life styles	2.1	Promote mental wellbeing to reduce alcohol consumption, tobacco consumption, and drug abuse	MoH, Clinical	District				
Behaviours and life styles	2.2	Develop and implement a strategy of integrated community-based health programs	MoH, CHSS	National				
Behaviours and life styles	2.2	Expand and strengthen coverage of health services using modern technology (e.g. telemedicine)	MoH, Clinical, CMED	Central & District Hospitals				
Behaviours and life styles	2.3	Facilitate ratification of the Tobacco Control Framework	MoH, Clinical	National				
Behaviours and life styles	2.3	Advocate for the Tobacco Control Framework activities	MoH, Clinical	National				
Safe water and environmental health and sanitation	2.4	Continuous health promotion on use of safe water and sanitation and hygiene facilities at all levels	MoH, Preventive, HEU	District				
Safe water and environmental health and sanitation	2.4	Facilitate establishment of safe water facilities with the Ministry of Water and other partners	MoH, Preventive	National; District				
Safe water and environmental health and sanitation	2.4	Repair damaged boreholes, pumps and other sanitation and hygiene infrastructure to appropriate functional standard	MoH, Preventive (Environmental)	District				
Safe water and environmental health and sanitation	2.4	Continuous water quality monitoring	MoH, Preventive (Environmental)	District				
Safe water and environmental health and sanitation	2.4	Promote construction of improved toilets and use of sanitation facilities by households	MoH, Preventive (Environmental)	District				

Safe water and environmental health and sanitation	2.4	Collaborate with city councils and other institutions to improve waste management systems	MoH, Preventive (Environmental)	District				
Safe water and environmental health and sanitation	2.4	Promote hygiene behavioural change interventions	MoH, Preventive (Environmental), HEU	District				
Safe water and environmental health and sanitation	2.4	Trigger follow up and certify ODF communities	MoH, Preventive (Environmental)	National; District				
Food and Nutrition Services	2.5	Continuous inspections, certifications, and audits of food establishments	MoH, Preventive (Environmental)	District				
Food and Nutrition Services	2.5	Monitoring of food fortification (per the Food Fortification Act) - Iodine in salt at household & commercial level, Vitamin A in flour, cooking oil, and sugar, Iron in flour	MoH, Preventive (Environmental), Public Health Labs	District				
Food and Nutrition Services	2.5	Continuous health promotion on food handling and hygiene practices at all levels and conduct medical examination of food handlers	MoH, Preventive (Environmental), Public Health Labs	District				
Food and Nutrition Services	2.5	Create awareness at community level on the right foods to eat for good nutrition status and promote their production	MoH, Preventive (Environmental, CHSS), Clinical (Nutrition)	Community				
Food and Nutrition Services	2.5	Screen for malnutrition in all age groups and ensure appropriate care and rehabilitation for the identified individuals	MoH, Preventive (Environmental, CHSS, Nutrition)	Central Hospitals; District				
Food and Nutrition Services	2.5	Support growth promotion and monitoring in the first two years of life at community level	MoH, Clinical (Nutrition)	District				
Housing and Urbanization	2.6	Promote construction of properly ventilated dwelling houses and kitchens	MoH, Preventive (Environmental)	District				

Housing and Urbanization	2.6	Facilitate formulation of bylaws that restrict construction of inadequately ventilated dwelling houses and enforce standards on housing	MoH, DPPD; DEHO	District				
Housing and Urbanization	2.6	Continuous promotion of safe housing practices through all relevant structures (e.g. good housing construction, proper livestock management, good cooking practices, etc.)	MoH, Preventive (Environmental)	District				
Environmental and living/working conditions	2.7	Conduct occupational safety surveys in some workplaces	MoH, Preventive (Environmental), Administration	District				
Environmental and living/working conditions	2.7	Created awareness on indoor air pollution prevention, proper liquid, solid and gaseous waste management	MoH, Preventive (Environmental)	District				
Environmental and living/working conditions	2.8	Active involvement in road safety campaigns and interventions	MoH, Clinical	All				
Vector and vermin control	2.9	Conduct vector resistance research studies and create management plans	MoH, Preventive	National				
Vector and vermin control	2.9	Conduct community education on sanitation and hygiene to increase vector and vermin control	MoH, Preventive, HEU	Community				
Epidemic preparedness and response	2.10	Collaborate with the Ministry of Agriculture's Animal Health Department on surveillance and response of zoonotic diseases	MoH, Preventive (Epidemiology)	National; District				
Epidemic preparedness and response	2.10	Monitor antimicrobial resistance	MoH, Preventive (Epidemiology), Public Health Labs	National				
Epidemic preparedness and response	2.10	Establish and train rapid response teams (RRTs) at the district- and central- level and Epidemic Management Committees (EMC), including village health committees	MoH, Preventive (Epidemiology), Public Health Labs	National; District				
Epidemic preparedness and response	2.10	Train Port Health Officers in carrying out disease screening activities at all ports of entry	MoH, Preventive (Environmental)	District				

Epidemic preparedness and response	2.10	Train health workers in Integrated Disease Surveillance and Response (IDSR), field epidemiology training program (FETP), and infection prevention and control	MoH, Preventive (Epidemiology), PHIM	National; District				
Epidemic preparedness and response	2.10	Conduct trainings and simulation exercises on selected IHR core capacities or Global Health Security Agenda Action Packages	MoH, Preventive (Epidemiology), PHIM	National				
Epidemic preparedness and response	2.10	Establish networks to share resources, scientific data, and best practices and to enhance the country's ability to fulfil relevant IHR core capacities	MoH, Preventive (Epidemiology), PHIM	National; District				
Partnerships and Collaboration	2.11	Develop a policy/guidelines on multi-sectorial collaboration and allocation of resources on SDH	MoH, Preventive (Epidemiology), PHIM	National				
Health Infrastructure development and rehabilitation	3.1	Complete construction of unfinished health facilities including provision of associated utility services	MoH, Infrastructure Unit	District				
Health Infrastructure development and rehabilitation	3.1	Complete construction of unfinished staff houses (Umoyo and flats for HWs) and provision of associated utility services	MoH, Infrastructure Unit	District				
Health Infrastructure development and rehabilitation	3.1	Renovate/rehabilitate/maintain existing health infrastructure including provision of associated utility services	MoH, Infrastructure Unit	District				
Medical Equipment	3.2	Finalize/revise standard equipment list for health facilities at different levels (central hospitals, district hospitals, community hospitals and health centres) with acknowledgement of EHP	MoH, Physical Assets Management (PAM)	National				
Medical Equipment	3.3	Procure medical equipment	MoH, PAM; DHOs	National / District				
Medical Equipment	3.3	Develop equipment replacement plan	MoH, PAM; MoH, DPPD	National				
Medical Equipment	3.3	Conduct regular planned preventive maintenance (PPM) and corrective maintenance	MoH, PAM; DHOs	District				

Transport Logistics	3.5	Equip all Ambulances with proper referral equipment	MoH	District			■	■
Communication Systems	3.6	Develop policy on communication devices for health facilities	MoH, DPPD; MoH, PAM	National		■		
Human resources management	4.1	Develop retention policy & strategy (supervision, housing, water, solar for health workers in hard to reach areas)	MoH, HR	National		■	■	
Human resources management	4.2	Conduct functional review of MoH structures in relation to decentralization	MoH, HR; OPC	National	■			
Expand Training and Education opportunities including CPD	4.5	Engage regulatory bodies to assess training accreditation standards	MoH, HR	National				■
Human resource planning	4.6	Develop Human Resource in Health Strategy for Malawi	MoH, HR; MoH, DPPD	National	■	■		
Human resource planning	4.6	Facilitate the functionality & use of iHRIS at all levels	MoH, HR; MoH, CMED; DHOs	National / District / Facility				■
Rational Use of Medicines	5.10	Revise the Essential Medicines List in line with the EHP	MoH, Pharmaceuticals; MoH, DPPD	National	■			
Rational Use of Medicines	5.9	Revise and update treatment and dispensing guidelines in line with the EHP	MoH, Pharmaceuticals; MoH, DPPD	National	■			
Procurement	5.3	Conduct drug quantification and forecasting exercises	MoH, Pharmaceuticals;	National			■	
Procurement	5.4	Recapitalize CMST to ensure adequate and sustainable financing for medicines and medical supplies	MoH, DPPD; MoF	National	■			
Routine data management (HMIS/DHIS-2, CVRS, etc)	6.1	Finalise development and implement guidelines and standard operating procedures for HIS	MoH, CMED	National	■	■		

Routine data management (HMIS/DHIS-2, CVRS, etc)	6.2	Finalise development of a harmonised National M&E Plan for the Health sector	MoH, CMED	National				
Routine data management (HMIS/DHIS-2, CVRS, etc)	6.3	Conduct bi-annual data quality assessments	MoH, CMED	National				
Routine data management (HMIS/DHIS-2, CVRS, etc)	6.1	Scale up DHIS2 System to cover all health facilities using M-Health technologies	MoH, CMED	District				
Routine data management (HMIS/DHIS-2, CVRS, etc)	6.2	Conduct a Service Availability and Readiness Assessment (SARA)	MoH, CMED; MoH Infrastructure; MoH, HTSS; DHOs	District / Facility				
Routine data management (HMIS/DHIS-2, CVRS, etc)	6.4	Build capacity of Computer programmers to support HMIS Data systems at the District level	MoH, CMED; MoH, DPPD	District / Facility				
Routine data management (HMIS/DHIS-2, CVRS, etc)	6.2	Work towards the development of a routine client satisfaction survey	MoH, DPPD; CMED	National				
Routine data management (HMIS/DHIS-2, CVRS, etc)	6.1	Institute effective monitoring and reporting mechanisms for the reform process and the HSSP II Implementation	MoH, CMED	National				
Routine data management (HMIS/DHIS-2, CVRS, etc)	6.1	Scale up Civil and Vital Registration Systems	MoH, CMED; MoH, DPPD	National				
Organization and Management	7.1	Finalize the National Health Policy to lead country health policy up to 2030	MoH, DPPD	National				

Organization and Management	7.1	Develop document explicitly outlining district governance structures providing clarity on roles, membership and linkages including developing and disseminating TORs for decentralised governance structures	MoH, DPPD	National; District				
Organization and Management	7.1	Conduct functional review of MoH structures in relation to decentralization	MoH, DPPD	National				
Organization and Management	7.1	Establish a forum for the Minister to meet regularly with senior Directors	MoH, Senior Management	National				
Organization and Management	7.1	Conduct review of the functionality and effectiveness of TWGs	MoH, DPPD	National				
Regulation	7.2	Revise and update all key programme strategy documents to reflect the revised EHP priorities and alignment with the HSSP II	MoH	National				
Organization and Management	7.3	Develop templates for and roll out citizens charters at HQ, District, health centre, hospital levels and with regulatory bodies	MoH, DPPD; QMD	National				
Partnership coordination and alignment	7.5	Establish and maintain a health partner database at National and District level	MoH, Aid Coordination Unit (ACU)	District				
Partnership coordination and alignment	7.5	Undertake joint annual operational planning on HSSP II implementation and annual meeting planning	MoH, DPPD; SMT	National				
Partnership coordination and alignment	7.6	Develop a new MoU between government and development partners on aligning with and supporting the HSSP II	MoH, DPPD	National				
Partnership coordination and alignment	7.6	Produce all necessary guidelines for programmatic, HRH, M&E, health financing etc. strategies	MoH, DPPD	National				
Partnership coordination and alignment	7.6	Develop guidelines on how partners enter into Districts (including new standardized MOU template)	MoH, ACU	National				

Partnership coordination and alignment	7.6	Develop Health Sector aid Harmonization Manual	MoH, ACU	National				
Financial Management and Audit	7.8	Develop, resource and implement an improved financial record keeping system	MoH, Finance; MoH DPPD	National				
Financial Management and Audit	7.8	Maintain annual development of financial management improvement plans, focusing on bank reconciliations and other priority areas	MoH, Finance	National				
Financial Management and Audit	7.8	Undertake quarterly financial management monitoring and supervisory checks and produce monthly, quarterly and annual progress reports	MoH, Finance	National				
Financial Management and Audit	7.9	Identify needs and mobilise resources for strengthening national and district audit capacity. Explore innovative initiatives for increasing the 'reach' of internal audit	MoH, Finance; MoH DPPD	National / District				
Procurement	7.10	Conduct assessment of CMST purchasing and procurement mechanisms	MoH, DPPD	National				
Resource Mobilization	8.1	Finalize and approve Malawi Health Financing Strategy document	MoH, DPPD	National				
Resource Mobilization	8.1	Commission studies to consolidate and collect data to evaluate gaps in EHP delivery and implications of increased funding on population health, economic growth and demographic changes	MoH, DPPD	National				
Resource Mobilization	8.1	Undertake annual Resource Mapping and National Health Accounts						
Strategic Purchasing/Resource Allocation	8.4	Finalize designing of and operationalize Programme Based Budgeting (PBB)	MoH, DPPD					
Strategic Purchasing/Resource Allocation	8.4	Review payment/reimbursement mechanism for EHP services	MoH, DPPD					


NKHATA-BAY DISTRICT HOSPITAL