WHO
COUNTRY COOPERATION STRATEGY

MALAWI

2005-2009

CONTENTS

ABBREVIATIONS

ADB	African Development Bank
AFP	acute flaccid paralysis
AIDS	acquired immunodeficiency syndrome
ARI	acute respiratory infection
ART	antiretroviral treatment
BCG	Bacille-Calmette-Guérin
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention
CHAM	Christian Health Association of Malawi
CIDA	Canadian International Development Agency
CONGOMA	Council for Nongovernmental Organizations in Malawi
DANIDA	Danish International Development Agency
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
DPC	Disease Prevention and Control Officer of WHO Country Office
DPT	diphtheria-pertusis-tetanus
EHP	Essential Health Package
EPI	Expanded Programme on Immunization
EU	European Union
FAO	Food and Agriculture Organization
FHP	Family and Reproductive Health Officer of WHO Country Office
GC	gini coefficient
GDP	gross domestic product
GFATM	Gobal Fund to Fight AIDS, Tuberculosis and Malaria
GTZ	Gesellschaft fiir Technische Zusammenarbeit
HDR	Human Development Report
HIPC	highly-indebted poor country

HIV	human immunodeficiency virus
HQ	headquarters
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illness
IMR	infant mortality rate
JICA	Japanese International Cooperation Agency
MAP	Multisectoral AIDS Programme
MDG	millennium development goal
MK	Malawi kwacha
MMR	maternal mortality ratio
MOA	Ministry of Agriculture
MoH	Ministry of Health
MOLG	Ministry of Local Government
MPRS	Malawi Poverty Reduction Strategy
MPN	Management Processes Officer of WHO County Office
MTEF	medium-term expenditure framework
NEPAD	New Partnerships for Africa's Development
NGO	nongovernmental organization
NNT	neonatal tetanus
NPO	National Professional Officer (WHO Country Office)
OECD	Organisation for Economic Cooperation and Development
POW	Programme of Work
PSIP	Public Sector Investment Programme
SADC	Southern African Development Community
Sida	Sweden International Development Cooperation Agency
SWAp	sector-wide approach
TB	tuberculosis
U5MR	under-five mortality rate
UN	United Nations

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
UK	United Kingdom
WFP	World Food Programme
WHO	World Health Organization

FOREWORD

In the year 2000, the Executive Board of the World Health Organization (WHO) approved a Corporate Strategy to guide the work of the WHO Secretariat. This Corporate Strategy emphasized the central role of countries in the work of WHO; hence, the global strategy was revised and adapted to the needs of each country. These measures constitute the basis for the WHO Country Cooperation Strategy (CCS).

The Country Cooperation Strategy describes WHO strategic priorities for each country in order to obtain an integrated response from the three levels: country office, regional office and headquarters. The CCS is a clear expression of the WHO country focus: the strategic agenda will guide cooperation between WHO and Member States for the medium term. The CCS will serve as a reference for WHO workplans and resource allocations, whether those resources are from countries, region, HQ or other sources such as collaborating centres.

The WHO Cooperation Strategy was developed through an extensive consultative process involving the Organization at all levels, the Ministry of Health, other government agencies, private sector and civil society organizations, training and research institutions, development partners and other key stakeholders in health.

The process involved questioning, in-depth analysis of key health and development challenges of each country and consideration of the WHO comparative advantage.

I acknowledge the exhaustive process that has led to the formulation of this document, and I would like to thank the government and all stakeholders in health for their efforts and active participation. I have no doubt that the CCS process will help countries in their efforts to focus on priority health issues and coordinate the actions of different partners and stakeholders.

Our challenge now is to transform these strategies into concrete actions, with a view to improving WHO performance at country level as well as the health outcomes for populations in greatest need.

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1. INTRODUCTION

The mission of the World Health Organization (WHO) in Malawi is to promote "the attainment of the highest possible level of health by all the peoples of Malawi". The WHO Country Cooperation Strategy (CCS) for Malawi is an organization-wide framework of collaboration with the government and other partners in the health sector covering the period 2005-2009. It reflects a health programming cycle with measurable impacts.

The purpose of the CCS is to enhance the capacity of WHO in Malawi to support government efforts in achieving its priority national health objectives through provision of an optimum balance between the needs and expectations of the Government of Malawi on the one hand and the organization's response based on its comparative advantage on the other.

Through the CCS, WHO aims to be more selective, focused and responsive to the priority health needs of the people of Malawi while taking a measured shift from routine activities towards a more strategic role as adviser, broker and catalyst, maximizing synergies and promoting complementarities with relevant stakeholders, health agencies and development partners in the country.

The process of developing this CCS document involved extensive consultations with our key partner, the Ministry of Health, and 23 other agencies made up of relevant line ministries, national regulatory and registration councils, national health training institutions, bilateral and multilateral agencies, international organizations and nongovernmental organizations. The CCS drafting team led by the WHO Representative for Malawi consisted of senior policy-makers from the Ministry of Health and WHO staff from the three levels of the organization (WHO country office, WHO Regional Office for Africa and WHO headquarters).

In setting the medium-term strategic agenda, the CCS has been guided by the Malawi Ministry of Health Programme of Work (2003-2009), the Malawi Poverty Reduction Strategy (MPRS) 2002, the outcomes of the extensive consultations, the WHO Corporate Strategy that outlines global priorities for the period 2002-2005, the WHO African Region Strategic Framework 2002-2005 that defines priorities for the Regional Office for Africa for 2002-2005, the UN Common Country Assessment report (CCA) of 2001 and the UN Development Assistance Framework (UNDAF) for 2002-2006. It also takes into consideration the objectives of the United Nations Millennium Development Goals related to: child and maternal mortality; control of HIV/AIDS and

major diseases of poverty such as malaria and tuberculosis; development and poverty eradication; protection of the common environment; human rights; and protection of vulnerable groups to facilitate the achievement of the millennium development goals. The CCS document will be used as a common reference for country work throughout the Organization, influencing the programme budget and plans of action.

In full recognition of the ownership and leadership of the Ministry of Health and other national stakeholders in the implementation of the national health policy and plan, WHO will, in support of the Ministry of Health, offer strategic interventions in the following areas:

- Strengthening of national health systems development
- Disease prevention and control, including HIV/AIDS
- Family and reproductive health, including child survival
- Partnerships facilitation for health action.

2. WHO GLOBAL AND REGIONAL POLICY FRAMEWORK

WHO continuously changes the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges. The current organizational change process has the WHO CCS as its broad framework.

2.1 Goal and mission

The mission of WHO remains "the attainment by all peoples of the highest possible level of health" (Article 1 of the WHO Constitution). The Corporate Strategy and the Policy Framework for Technical Cooperation with Member Countries of the African Region outline key areas through which WHO intends to make the greatest possible contribution to health in the world, as well as in the African Region. The Organization aims at strengthening its technical, intellectual and policy leadership in health matters, as well as its managerial capacity to address the needs of Member States.

2.2 New emphases

The WHO Corporate Strategy emphasizes the following WHO responses to the changing global environment:

(a) Adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;

(b) Playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;

(c) Triggering more effective action to improve health and to reduce inequities in health outcomes by carefully negotiating partnerships and catalyzing action on the part of others;

(d) Creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

2.3 Strategic directions

On the basis of this new emphasis, WHO has set out four strategic directions for its contribution to building healthy populations and combating ill-health. These strategic directions, which are interrelated, provide a broad framework for the technical work of the Secretariat:

(a) Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;

(b) Promoting healthy lifestyles and reducing risk factors to populations;

(c) Developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands, and are financially fair;

(d) Developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

2.4 Core functions

The typology of WHO core functions, presented below, is based on the comparative advantage of the organization at all its levels:

(a) Articulating consistent, ethical and evidence-based policy and advocacy positions;

(b) Managing information, assessing trends and comparing performance of health systems; setting the agenda for stimulating research and development;

(c) Catalyzing change through technical and policy support in ways that stimulate action and help to build sustainable national capacity in the health sector;

(d) Negotiating and sustaining national and global partnerships;

(e) Setting, validating, monitoring and pursuing proper implementation of norms and standards;

(f) Stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health-care management and service delivery.

2.5 Global and regional priorities

In order to be more effective and efficient in its interventions, the organization has selected a limited number of global priorities on which to focus over the four-year period (2002-2005). The global priorities selected on the basis of those criteria are: malaria, HIV/AIDS and TB, noncommunicable diseases (cancer, cardiovascular diseases and diabetes), tobacco, maternal health, food safety, mental health, safe blood and health systems.

The WHO African Region is facing enormous health challenges. The WHO Regional Office for Africa has decided to focus its attention on 12 priorities closely related to the 11 global priorities, but adapted to the regional context. These 12 priorities are: HIV/AIDS, tuberculosis, malaria, maternal health, child and adolescent health, strengthening of health systems, blood safety, humanitarian and emergency action, health promotion, noncommunicable diseases control including mental health, and poverty and health.

3. COUNTRY SITUATION ANALYSIS: HEALTH AND DEVELOPMENT

3.1 Country profile

Geography and population

Malawi is a small country with an area of 118 484 square kilometres of which 20% is water. It is landlocked and bordered by Mozambique in the south and east, Zambia to the west and Tanzania to the east and north. The country, with three regions and 27 districts (12 in the south, nine in the centre and six in the north) is 901 km long and ranges from 80 to 161 km in width. The country has a population of about 11.9 million and an annual growth rate of 1.9%. The population density is estimated at about 105 persons per square kilometre (range: 307 to 42 per district), which is the highest in sub-Saharan Africa.

Malawi has a relatively young population. The 1998 census indicates that the under-five age cohort accounts for 17% of the total population; 4% are under 1 year; 27% fall within the 5-14 year age bracket; 52% are 15-64 years; and 4% are aged 65 years or older. The median age is 18 years. It is estimated that life expectancy at birth has significantly dropped from 51 in 1992 to the present 39.3 years. Of the total population enumerated in 1998, 51% are females, implying a sex ratio of 96 males per 100 females. The normal course of demographic transition from high fertility/high mortality to high fertility/low mortality and then low fertility/low mortality has been jeopardized by the impact of the HIV/AIDS epidemic on mortality rates.

Socioeconomic overview

At independence in 1964, Malawi had three major economic and social policy objectives: to improve agricultural production, to diversify into manufacturing and industrial processing, and to eliminate ignorance, disease and poverty. Over the past 40 years, economic growth has been fluctuating from about 6% (1964-1979) down to about 0.6% (1990-1994). In 1995/96 the real economic growth rate rose to 13.8%, but has since been declining, to -1.5% in 2001/2. Malawi is among the 10 poorest countries of the world (World Bank Report, 1994). Currently, its GDP is around US$ 170 per capita. The major reasons for the decline have been a series of exogenous shocks such as high import prices and droughts. Policy weaknesses and slippages have also contributed to the decline in growth.

Agriculture is the mainstay of the economy. The agriculture sector is however highly vulnerable to adverse weather conditions. Nevertheless, agriculture accounts for about 35% of GDP and 93% of export earnings and provides more than 80% of employment. Tobacco is the main export earner, accounting for more than 70% of Malawi's agricultural exports. Manufacturing and other industry and services account for 65% of GDP.

Table 1 shows other selected economic indicators for 1994 to 2001. Domestic savings as a proportion of GDP has been on the increase particularly in 2000 and 2001.

Table 1: Selected economic performance indicators

Year	1994	1995	1996	1997	1998	1999	2000	2001
GDP growth rate (%)		13.8	10.4	7.0	2.2	3.6	2.0	-1.5
Current account deficit (MKmn)	-234 4.8	-269 3.7	-432 5.5	-611 5.7	-467 2.5	-127 51.2	-119 81.4	-104 82.9
CAD/GDP, excluding grants (%)	-22.8	-12.6	-12.2	-14.3	-8.6	-16.1	-11.5	-7.3
Aver. annual inflation (%)	34.7	83.1	37.7	9.1	29.7	44.9	29.6	27.2
Average exchange rate (MK:1US$)	8.7	15.3	15.3	16.4	31.1	44.1	59.5	72.2

Source: Malawi - Project for Economic Governance. http//www.malawipublicfunding.org

Malawi's macroeconomic performance was modest during the second half of the 1990s. Table 1 shows the trend in selected macroeconomic statistics. Between 1995 and 1997 there was remarkable growth in real gross domestic product owing largely to the provision of free farm inputs through the Starter pack and the Targeted input programmes. As both were highly donor dependent, since progress could not be sustained. It can therefore be seen from the table that between 1997 and 2001 the real GDP growth rate never went beyond the 5.5% that is required to reduce the

proportion of the population living below the poverty line and was in fact negative in 2001. Overall, per capita GDP growth averaged 1.5% for the entire period 1990-2001 (UNDP Development Report). The inflation rate was generally high over the period, above 27% with the exception of 1997 when it was 9.2%. This was mainly due to huge depreciations in the Malawi kwacha over the same period. Inflation in Malawi tends to be driven by movements in the exchange rate because of the country's heavy dependence on imported inputs. The current account deficit shows fluctuations that are attributable to fluctuations in tobacco export earning which, in turn, are susceptible to the vagaries of the weather. In order to finance the current account deficit, the government resorted to external borrowing, hence the huge increases in the external debt stock as a share of GDP from 90.8 % in 1997 to 150.3% in 2000 (World Bank, 2003).

Some 65.3% of Malawi's population are poor, living below US$ 0.33 per day. An analysis of indices of inequality in consumption showed that the poorest 20% of the population accounted for only 6.3% of total consumption of goods and services, while the richest 20% accounted for 46.8%. Poverty is more prevalent in rural areas. The gini coefficient (GC), a measure of distribution of wealth in a country (GC = 1 signifying most unequal distribution), is 0.40 (0.37 and 0.52 in rural and urban areas, respectively).

The major causes of poverty have been identified as low land productivity due to rapid environmental degradation and limited or inadequate access to land, low levels of education, poor health status with HIV/AIDS playing a very critical role, rapid population growth and gender inequalities (MPRS paper, April 2002). Furthermore, many people have no access to capital.

As a consequence, Malawi continues to lag behind in terms of human development. The Human Development Index, a composite index that measures deprivation in three basic dimensions of human development-a long and healthy life, knowledge and a decent standard of living-has been poor for Malawi. From 0.314 in 1975, the index increased steadily to 0.404 in 1995. However, this performance did not continue as the index fell to 0.387 in 2001.

3.2 Health status

The main health problems highlighted in the 1999-2004 National Health Plan include:

(a) High maternal mortality and morbidity

(b) High child mortality and morbidity

(c) High HIV seroprevalence and deaths due to HIV/AIDS related illnesses.

Malawi's health indicators are among the worst in the world. At the rate Malawi is currently moving, it will require much effort and resources to meet the demands of the MDGs. In the 1990s, the infant mortality rate (IMR) was 134 per 1000 live births and the under-five mortality rate (U5MR) was 234 per 1000 live births. During the same period, the maternal mortality ratio (MMR) was around 620 per 100 000 live births.

According to DHS 2000, IMR and U5MR improved to 104 and 189 per 1000 live births, respectively, while maternal mortality has worsened to 1120 per 100 000 live births. Life expectancy at birth for males and females has dropped substantially, from 51 and 52.4 years in 1992 to 37.5 and 38.2 by 2004, respectively (HDR 2004). The downward trend of life expectancy is no doubt due in large part to the HIV/AIDS epidemic. Table 2 shows some of the important health indicators in Malawi.

Table 2: Selected health indicators for Malawi

Indicator	**1999/2000**
Total population11.9 million	
Infant mortality rate per 1000 live births	104
Under-five mortality rate per 1000 live births	189
Total fertility rate	6.1
Life expectancy at birth	37.8 years
Crude birth rate per 1000 population	46
Population growth rate	1.9%
Maternal mortality ratio per 100 000 live births	1120
Antenatal care coverage (%)	91.4%
Attendance at birth by trained personnel	55%
Contraceptive prevalence rate (DHS 2000)	25%
% of low birth weight babies	13.1%
Children under 5 years chronically malnourished	49%
Children 12-23 months fully immunized (DHS 2000)	70%
Immunization BCG	89.2%
Immunization measles	64.2%
Population per physician	101,000
Public health expenditure (PP/US$) private/public	8%
National adult HIV seroprevalence (15 - 49)	14.4%

Source: DHS 2000 and HDR 2004

Maternal mortality and newborn health

Malawi's maternal mortality ratio is the highest in Africa. It is estimated at 1120 deaths per 100 000 live births, and only 50% of Malawian women deliver in health facilities. The Obstetric Quality Care Assessment conducted in 2003 shows that most deaths were due to direct factors of pregnancy, labour and postpartum. The main underlying cause of these deaths is the weak health system that fails to respond adequately to women's needs and which is characterized by poor quality of care, lack of essential medicines, equipment and supplies, shortage of skilled attendants and a poor referral system. The situation is further compounded by inappropriate policies and practice regulations that hinder the maximization of the use of existing skilled attendants.

The neonatal mortality rate has been reported at 42 per 1000 live births, which is 35% higher than the expected rate for a developing country. Neonatal mortality also accounts for 40% of infant mortality in Malawi. The major causes of such mortality are infections, complications during delivery (e.g. asphyxia and trauma), pre-maturity and delays in getting to health facilities. This calls for more attention at delivery points.

HIV/AIDS

A technical working group organized by the National AIDS Commission analyzed the latest sentinel surveillance results for 2003 to estimate national HIV prevalence in Malawi. The analysis indicates that levels of HIV infection in the adult population of Malawi have remained constant for the last seven years at 12%-17%. The level of HIV infection among adults in urban areas is over 20%. HIV prevalence is about twice as high in the south as in the north and central regions. However, the stable prevalence at 12%-17% does not mean that the HIV/AIDS problem has been solved. Every year as many as 80 000 people die from AIDS and more than 80 000 new infections occur, at least half among young people aged 15-24.

There are some hopeful signs. The infection level among young women (15-24 years) attending antenatal clinics in Lilongwe has declined from about 26% in 1996 to 16% in 2004. For all adults (15-49) in Lilongwe the level of infection has declined from 26% in 1998 to 17% today. Unfortunately, the indications are not positive elsewhere. Infection levels are above 10% everywhere except some rural sites in the Central Region. HIV prevalence is very high, 20%-35%, in Blantyre, Mzuzu City and several semi-urban sites. The total number of people infected with HIV is estimated to be between 700 000 and one million in 2003, including 60 000 to 80 000 children under the age of 15. One-third of those infected live in urban areas and two-thirds in rural

areas. Over 800 000 children under the age of 18 are orphans. The death rate for adults aged 15-49 has tripled since 1990. The number of tuberculosis cases is three times higher than it would be without AIDS.

There are huge unmet needs for orphan care, antiretroviral drug therapy (with an estimated 160 000 people now eligible for treatment), access to voluntary testing and counselling and antenatal care including prevention of mother-to-child transmission.

Malaria

Malaria is the most commonly reported cause of morbidity and mortality both in adults (particularly in pregnant women) and children. There are more than 8 million episodes of malaria illness per year experienced by Malawi's entire population of about 11.9 million. About 40% of deaths of children under 2 years of age are related to malaria. In addition, malaria is a cause of pregnancy loss, low birth weight, and neonatal mortality. The public spends US$ 35 per annum per household on malaria treatment. The national malaria control strategy incorporates correct case management, provision of insecticide-treated bednets, and intermittent presumptive treatment during pregnancy.

Malnutrition

Malnutrition is endemic in Malawi, with 50% of under-five children chronically malnourished. Causes include household food insecurity due to poverty, poor weaning and feeding practices, and frequent infections. Micronutrient deficiencies are also common. About 56% of pregnant women attending antenatal clinics are anaemic. Malnutrition is highest among very young children (between 6 and 29 months). A large proportion of malnourished children are ill with HIV/AIDS.

Tuberculosis

Tuberculosis cases have doubled in the last 10 years. A total of 14 322 cases of all forms of TB were reported in 1991 and 27 000 cases by 2004, the increase due largely to HIV infection. Intensified IEC activities of the national programme probably also contributed to increased case reporting. The mortality rate is still high (21% in smear positive patients). The mortality rate in smear negative patients ranges from 30% to 50% and is a cause of great concern. However, the cure rate has improved from 65% in 1996/99 to 73% in 2003. Lack of facilities, shortage of personnel, poor quality of services and high infection rate of HIV in TB patients may be the major contributory factors to the high mortality. The advent of ARVs provides some hope for the future.

Diarrhoeal diseases and cholera

Diarrhoeal diseases, especially in children, and cholera epidemics are common in Malawi. According to DHS (2000), 18% of under-five children are reported to have experienced diarrhoea during the past two weeks preceding the survey. Malawi experienced a devastating food crisis in 2001/2002 which was compounded by the worst nationwide cholera epidemic which affected over 34 000 people and caused 958 deaths.

Other communicable diseases

Other communicable diseases contributing to total disease burden in Malawi are schistosomiasis, trypanosomiasis, onchocerciasis, leprosy and bacterial pneumonia. Vaccine-preventable diseases include tetanus (including neonatal tetanus), measles, pertussis, poliomyelitis, diphtheria and tuberculosis. High routine coverage for all childhood immunizations has been sustained since 1989. However, coverage for all antigens declined to less than 80% between 1999 and 2002 due to global shortage of vaccine supplies and decreased access to services. This is also suggested by a decline in the percentage of people possessing a vaccination card, from 86% to 81% during the same period. Malawi has maintained certification quality of AFP surveillance for the past five years. The last clinically confirmed polio case was in 1992. The country is currently applying to be certified polio free. Measles and NNT are in the elimination phase although several episodes of measles outbreaks were recently reported throughout the country. Active- based surveillance for AFP, NNT and measles is in place to ensure that all possible suspected cases are timely investigated and laboratory confirmed. In January 2002, a pentavalent vaccine was introduced in the country to extend protection of children to include Haemophilus influenzae and hepatitis B infections as well as DPT.

Noncommunicable diseases

The health sector previously focused its attention on communicable diseases. There is, however, a growing awareness of the increase of noncommunicable diseases such as hypertension, diabetes, cancer, asthma, mental health problems and oral health. Currently, there is insufficient information on noncommunicable diseases on which to determine trends in magnitude and to monitor morbidity and mortality. However, there are indications from clinical settings that cases of diabetes, hypertension and cancer are on the increase.

3.3 Major issues impacting on health

Human resources

The Government of Malawi in general and the Ministry of Health (MoH) in particular are challenged by an acute shortage of skilled personnel. Compounding the problem is the inequitable distribution of available human resources. The distribution of staff favours urban areas at the expense of rural areas where 87% of the population reside. This is due to the unattractive working environment in rural areas, i.e. lack of social and educational facilities and accommodation. According to the National Health Plan (1999-2004) the distribution of medical officers and registered nurses is in favour of tertiary care facilities with 68% of medical officers and 64% of registered nurses located in tertiary care services. Recently, the shortage of health personnel has been exacerbated by high turnover due to various factors including high mortality attributed to HIV/AIDS related illnesses, attrition as a consequence of retirement and resignations, and brain drain of skilled people who depart to industrialized countries, particularly the United Kingdom (of 108 nurses leaving Malawi in 2003, 90 went to the UK). The status of personnel establishment in MoH is summarized in Table 3.

There are approximately 29 nurses per 100 000 population in Malawi, compared to 472,129 and 85 per 100 000 in South Africa, Zimbabwe and Tanzania, respectively. Only 11 of 357 health centres meet MoH staffing standards, and district hospitals are equally under-staffed, with an average of 22 nurses per district hospital compared to 175 nurses required. Also, 10 of 27 districts have no physician (and are manned by a clinical officer), and four districts are without any physician in either the public or private sector. There is one physician per 100 000 population, compared with 56 in South Africa and seven in Zambia.

Table 3: Established posts and vacancies within MoH, 2004

Category	Established posts/required	Filled posts	Vacancy (%)
Nurses	6,084	2,178	64%
Clinical Officers	356	212	40%
Medical Assistants	692	327	53%
Physicians:			
Generalists	356	212	40%
Surgeons	115	17	85%
Ob-Gyn	126	11	91%
Medicine	65	3	95%
Paediatrics	60	5	92%
Anaesthetists	14	4	71%
Pathologists	22	0	100%
All categories[1]	7890	2969	62%

Sources: Human Resources in the Health Sector (draft), April 2004, MoH, and unpublished presentation, Office of Principal Secretary, MoH

This human resources for health situation has been recognized by the Ministry of Health and is identified as a priority issue. A six-year crisis response plan has been developed with the support of DFID, and the estimated funding of US$ 270 million for this plan is being sought. However, there is a need for a well-designed comprehensive medium- and long-term approach.

Food insecurity

Food insecurity, both chronic and acute, is a major manifestation of rural and urban poverty. At both the individual and household levels, food insecurity is characterized by the inability to acquire, through production, purchase or transfers, sufficient food for a healthy and active life. The key determinants of household food insecurity in rural Malawi are: constraints in food availability (low household food production); seasonal instability of food supplies; limited off-farm income and employment opportunities to ensure access to food; and inadequate safety nets resources. This has led to endemic malnutrition in Malawi. According to HDR 2004, 45% of under-five children are chronically malnourished and about 56% of pregnant women attending antenatal clinics are anaemic (DHS 2000).

Water and sanitation

A Multiple Indicator Survey published in 1995 revealed that only 36.8% of the Malawi population had access to safe drinking water within a distance of one kilometre. About 71.8% of the population had access to a pit latrine while only 5.5% had access to adequate sanitation. With more efforts in the promotion of sanitation, the Ministry of Health has reported that the percentage of people having access to adequate sanitation has increased from 5.5% to 15%. About 59% of people in Malawi now have access to safe water; i.e. 43% of the population use boreholes and 16% use piped water. Only 4% of the population regularly use hand-washing facilities.

Inadequate financial resources

The national expenditure of US$ 4.93 per capita for health sector severely restricts health services delivery. WHO report of the commission on macroeconomics and health (2001) recommends a minimum per capita investment on health of US$ 36. In addition the NEPAD members states agreed a minimum of 15% allocation to national health for a meaningful health development of which Malawi trails at 9% as of 2003/ 2004.

Poverty

Poverty is the underlying cause of many social and health problems in Malawi. It is both a developmental and health issue. It is estimated that 65% of the population is living below the poverty line. It is in line with this reality that the Government of Malawi in collaboration with other stakeholders developed the Malawi Poverty Reduction Strategy.

Literacy

Literacy in Malawi is low. About 51.3% of women and 24.5% of men are functionally illiterate or have not attended school (HDR 2004). Up to 80% of rural women can neither read nor write. Secondary school enrolment is only 4% overall. The quality of education is poor, primarily as a result of high teacher-to-pupil ratios (1:70 in 1994) and lack of basic teaching material (National Health Plan 1999-2004).

Disasters

Malawi experiences both natural and man-made disasters; these include floods, landslides, droughts, and epidemics. The most notable ones of recent times are the annual cholera epidemics, Phalombe floods (1999) droughts (1990-1994), Lower Shire

Floods (1998) and a combination of drought, floods and cholera pandemic (2001-2002). Other epidemics, that have affected Malawi recently are plague especially in Nsanje district and pneumonia in Ntchisi district (2003). Disasters have been associated with increased incidence of diarrhoeal diseases, malaria, and maternal mortality.

Accessibility to health services

Malawi has a good coverage of health facilities, 80% being within a 5-km radius. Unfortunately most Malawians have difficulty accessing these facilities due to several issues, such as poor road networks, especially in the rural communities, and poor communication systems.

Gender equality and women's empowerment

It has been increasingly realized that full and complete development requires the maximum participation of women on equal terms with men in all fields. Women constitute 51% of Malawi's population and have largely been discriminated against both in terms of participation in development efforts and benefiting from the outcome. The general observation is that women with their low educational levels and low status in society have limited access to information and resources. The findings from the emergency obstetric care assessment done in 2005 showed that women have little control on decisions made on their health for example the decision to go to a health facility by most expectant women was made by somebody else. There are still very few Malawian women in key decision making positions and women's representation in parliament stands at 14% which is less than half of the minimum 30% endorsed by SADC member states.

3.4 Health care delivery system

Nearly all formal health care services in Malawi are provided by the Ministry of Health (60% of the services), the Christian Health Association of Malawi (CHAM) (37%) and the Ministry of Local Government (1%). Other providers, namely private practitioners, commercial companies, army and police provide 2% of health services. There are also traditional healers and traditional birth attendants, whose exact number and extent of service provision is unknown.

Health services are provided at three levels:

- Primary level: services are delivered through rural hospitals, health centres, health posts, outreach clinics and community initiatives.

- Secondary level: includes district hospitals and CHAM hospitals. Some of these have limited specialist functions.
- Tertiary level: at present, tertiary level hospitals provide services similar to those at secondary level, along with a small range of specialist surgical and medical interventions.

Table 4 summarizes the ownership and type of health facilities in Malawi.

Table 4: Health facilities in Malawi, 1999

Facility type	MoH	CHAM	MoH/ LG	MoH/ MoA	Local Govt.	State House	Total
Central Hospitals	4	0	0	0	0	0	4
District Hospitals	22	0	0	0	0	0	22
Hospitals	1	22	0	0	0	0	23
Rural Hospitals	16	18	1	0	0	0	35
Mental Hospitals	1	1	0	0	0	0	2
Urban Health Centres	8	0	0	0	0	0	8
Health Centres (Maternity + Disp)	193	88	33	0	11	0	325
Maternity Units	0	4	0	0	12	0	16
Dispensaries	45	13	3	2	3	2	68
Closed	2	0	0	0	0	0	2
TOTAL	**291**	**146**	**37**	**2**	**26**	**2**	**504**

Source: Malawi Health Plan 1999-2004

3.5 Health sector development

The Ministry of Health has embarked on various reforms to improve the health sector. One of the reforms is the sector-wide approach (SWAp). Adoption of the SWAp follows from a realization that the piecemeal pursuit of separately financed projects, though successful at individual project level, has not led to any tangible sector-wide impact in improving health indicators in Malawi.

A six-year programme of work, jointly developed by the ministry and all development partners forms the sector wide programme for health for the next few years. Six core and over-riding areas targeted for reform include decentralization of the management of health services, human resource for health development, health financing, hospital autonomy, essential health package and managerial capacity building for districts.

A central component of the SWAp is the essential health package (EHP). The EHP focuses on promoting the provision of a basic cost-effective package of promotive, preventive and curative health services; determined both technically and through practical experience as those services that will have the most significant impact on the health status of the population.

The EHP has already been elaborated, and includes health interventions centered on eleven conditions. The interventions including all the required inputs have been defined and costed. It is estimated that implementation of the EHP, which will initially cover approximately 60% of the population due to resource constraints, will cost approximately US$ 18 per capita per annum. Implementation at district level will be through District Implementation Plans, which are developed according to MoH guidelines.

Malawi has also adopted the MDGs which set the following health targets to be achieved by the year 2015:

- Reduce by two thirds, between 1990 and 2015, the under five mortality rate
- Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
- Halt and begin to reverse the spread of HIV/AIDS by 2015
- Halt and begin to reverse the incidence of malaria and major diseases by 2015.

To monitor the achievements of the MDG targets, as well as the performance of the health sector reforms, there will be need for accurate data and efficient health information management system, which is currently very weak. The health information management system needs major improvement.

The main challenge in the health sector development is the successful implementation of the reforms, simultaneously with new financing mechanisms, decentralization, and provision of new services including anti-retroviral drug treatment of AIDS on a massive scale to an already stressed health care system.

3.6 Health financing

The Ministry of Health services are entirely financed by the government and donors. The national expenditure of US$ 4.93 per capita for health sector severely restricts good service delivery. Currently the Ministry of Health estimates that over two-thirds of the Ministry's financial resources are consumed by secondary and tertiary care services, which are themselves critical for the support and guidance of the lower structures in terms of supervision, training and patient referral.

In recent years, the proportion of government expenditure allocated to the health sector has varied from 7%-13% of the national budget. Government intends to maintain its expenditures on health to between 12% and 13%.

Table 5 shows health financing as a percentage of government budget over the past 12 years.

Table 5: Government share of expenditure 1993/94-2004/2005 (MK million)

Function	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	99/00	00/01	2001/02	2002/03	2003/04	2004/05
Defense	124.6 (5.6)	159.4 (4.1)	255.9 (4.1)	339.8 (4.5)	431.1 (3.6)	439.0 (3.5)	*	*	988.1 (2.1)	117.8 (0.3)	208.0 (0.37)	24.8 (0.03)
Justice	118.8 (5.3)	180.2 (4.7)	252.7 (4.1)	378.6 (5.0)	469.8 (4.0)	0	*	*	86.3 (0.18)	75.4 (0.17)	52.2 (0.09)	85.0 (0.09)
Educat-ion	248.5 (11.1)	351.8 (9.2)	884.0 (13.7)	1270.8 (16.8)	2092.3 (17.3)	1679.0 (13.3)	*	*	5864.1 (12.9)	6859.4 (15.2)	8835.0 (15.6)	10638.6 (11.8)
Health	150.1 (6.7)	228.5 (5.9)	381.8 (6.2)	616.0 (8.1)	818.4 (6.8)	762.0 (6.0)	*	*	5302.5 (11.6)	4472.3 (10.0)	5559.4 (9.8)	9139.0 (10.2)

Source: Ministry of Finance

** Information not available.*

Currently public health services in Malawi are free. The government, however, is in the process of exploring mechanisms for cost sharing, while maintaining free services for vulnerable citizens. The ministry intends to explore and where feasible, introduce alternative sources of health financing in Malawi. These will begin with the establishment of optional fee paying facilities in all public hospitals, for users with the ability to pay. Eventually introduction of health insurance for employees in the formal sector will be explored. Coupled with this, reforms will aim at improving the use of the financial resources, by improving both allocative and technical efficiency.

3.7 Health and development challenges

The government faces huge challenges in addressing the socioeconomic development of the population. There are high levels of poverty, a poorly functioning economy, a largely rural population with high levels of illiteracy, and frequent external "shocks" such as disease outbreaks and natural disasters. Disease burden is increasing in many areas; malaria remains the biggest killer, and deaths from TB are increasing. The impact of HIV/AIDs accounts for a large part of the increase in adult mortality, and improving access to anti-retroviral therapy is now a major priority.

However, despite increases in pledges of external funds, health services are not significantly improving, as shown by worsening maternal mortality. The loss of health staff, and the inadequate resources for primary care are major problems for the government, which supplies most of the health services. The MoH aims to improve the situation through pooling efforts in a SWAp and by decentralizing its health services, but these reforms are still in their early stages.

4. DEVELOPMENT ASSISTANCE: AID FLOWS AND COORDINATION

4.1 Overall trends in development aid

Funding for health services comes from government consolidated funds, credit and donors as well as user charges. The total MoH budget for the current year 2004 is 3.654 billion Malawi kwacha (approximately, US$ 34.4 million). This total amount is roughly divided as follows: personnel 1.183 billion MK (US$ 11.14 million); drugs: 1.207 billion MK (US$ 11.37 million); other recurrent transactions 1.264 million MK (US$ 11.9 million). About 30% of the public health budget is supported by donors.

Reflecting government and donor commitment to integrated support to the health sector, there is a trend away from funding discrete projects and towards sector-wide and budgetary support, including financing the EHP. Of the estimated cost for EHP implementation of US$ 17.52 per person per year, only about US$ 12 is available at present, of which US$ 4 from government and approximately US$ 8 from donors. The Commission on Macroeconomics and Health states that the minimum a government must invest in the health of its citizens in order to promote development is US$ 36 per capita.

The integrated support under SWAp will increase transparency on the magnitude and allocations of donor assistance to health. Table 6 shows estimated donor assistance from 1994 to 2006.

Table 6: Estimated donor assistance to the health sector in Malawi

Period	No. of donors	Estimated annual commit (US$ million)
1994 - 97 Actual	13	66.5
1998 - 00 Actual	9	75.7
2003 - 04 Forecast	19	96.1
2004 - 05 Forecast	19	139.0
2005 - 06 Forecast	19	124.3

Source: 1994 - 97 from Picazo (2001), 1999 - 2000 from OECD website and 2003 -2006 from MoH (2003).

4.2 Major development agencies active in the health sector

There are about 17 donors operating in the health sector. These include multilateral, bilateral and nongovernmental organizations. The multilateral organizations include Global Fund, UNICEF, UNFPA, UNAIDS, WHO, WFP, UNDP, FAO, ADB and World Bank. The bilaterals are EU, DANIDA, JICA, DFID, GTZ, CIDA, Nordic Development Fund, Foreign Ministry of Norway, USAID, CDC and the Netherlands. Many NGOs are active in the health sector. They are coordinated through an umbrella organization, CONGOMA. The donor community and the government have recognized the tremendous contribution by NGOs and are therefore working more in partnership with them.

UN agencies support development activities in the health sector through UNDAF. Interventions include joint programming and single-agency activities. The MDGs, which specify targets to be reached by the year 2015, are monitored by the UN system.

The support to the health sector by partners comes in five forms. The figures and projections for 2003 to 2006 are summarized in Table 7. General budget support shows what goes in health and excludes funds for HIV. The drop in 2005/6 estimates is exaggerated due to lack of project finance figures.

Table 7: International Development Assistance, 2003-2006 (US$ million)

Category	2003/4	%	2004/5	%	2005/6	%
General Budget Support	10.17	12.55	2.93	2.9	2.93	4.58
SWAp basket funds	10.28	12.69	32.36	32.04	25.00	39.06
Project finance (reprogrammable)	19.50	24.07	33.00	32.67	25.40	45.94
Project finance (not reprogrammable)	28.50	35.18	26.90	26.63	11.00	17.19
Project finance (not reprogrammable and outside POW)	12.20	15.06	5.50	5.45	_*	_*
Total	**81**	**100.00**	**101**	**100.00**	**64**	**100.00**

Source: Modelling work done in support of POW finalization, based on PSIP database
** Indicates missing data*

The donor support to HIV/AIDS programmes over a five-year period amount to US$ 467 million that is over and above SWAp and EHP framework. The major donors in this area are DFID, USAID, Foreign Ministry of Norway, Sida, CIDA, EU, CDC, GTZ, GFATM, World Bank, WFP, UNICEF, UNDP, WHO, UNFPA, FAO and Government of Malawi. This large inflow of funds for HIV/AIDS control is relatively independent from integrated funding for the health sector and enters the sector via a different channel (the National AIDS Commission).

4.3 Mechanisms and tools for coordination

The government has instituted several mechanisms to monitor financing of development, including donor inputs. The medium-term expenditure framework (MTEF) is a three-year rolling plan developed with assistance from cooperating partners in 1995. MTEF is a strategic medium-term approach to budgeting, to focus on reallocation of expenditure to priority activities and on integrating recurrent and development expenditures. Phase one of the MTEF included the development of logical frameworks to assist in redefining of ministry goals, objectives and programmes and preparation of activity-based budgets to improve the accuracy of programme costing.

Cooperation between donors and government is assured at a multisectoral level through the Aid Coordination Group, which meets monthly under the chairmanship of the Ministry of Finance. At the level of the health sector, the Health and Population Sub-Group meets monthly and is co-chaired on a rotating basis by donor partners. WHO is also a member of other coordinating committees, e.g. Interagency Coordinating Committee for Malaria and the Malawi Global Fund Country Coordinating Mechanism.

The SWAp that the country has taken on since 2004 is another key mechanism that will coordinate donors despite the complexity of its implementation.

5. WHO COUNTRY PROGRAMME

5.1 Country office operations

The WHO office in Malawi was established in 1965. The mission of WHO in Malawi is to assist in "the attainment of the highest possible level of heath by .all the peoples of Malawi". To achieve the mission the office provides technical leadership in:

- Policy guidance
- Partnerships facilitation in health action
- Advocacy role in resource mobilization and allocation
- Health systems strengthening.

In the last ten years the country office has undergone considerable changes. From 1994/95 the Malawi country office had increased its technical staff from four to nine in 2004/5. Within the same period overall number of staff increased from 21 to 25. Similar increases have been noted in are as of work from 12 to 18, Regular budget from US$ 1 391 251 to US$ 2 541 000 and extrabudgetary support from US$ 1 000 000 to US$ 5 044 100. In 2004, extrabudgetary funding accounted for 70% of all funding through the country office.

Despite the increase in technical staff there is a large discrepancy between the staff and the number of areas of work. The nine national professional officers cover the following areas: FHP covers family and reproductive health, mental health, and child and adolescent heath. DPC covers disease prevention and control, communicable disease surveillance and response, and emergency and humanitarian action. The following areas have one officer for each: malaria, health information and promotion, tuberculosis, HIV/AIDS, IMCI, EPI and MPN.

In 2003/4 the country office maintained a balance of highly experienced national professional officers and international experts. The office also received consultants from the Regional Office and headquarters.

5.2 WHO areas of work

The 2004-2005 country programmes comprises 17 areas of work which reflect the priorities of the five-year Programme of Work of the Ministry of Health and of the WHO Regional Office for Africa. For 2006-2007 the areas of work have been reduced to 13 (see Annex 2). The WHO support to the country office is largest in four areas: EPI, HIV/AIDS, Making Pregnancy Safer, and Malaria. This is illustrated in Table 8.

Table 8: WHO country office approved budget, planned costs and resource gaps, 2004-2005

Area of Work	Total Budget	%	Approved		Ressource Gap
			RB	OS	
Communicable disease surveillance	175,000	1.60%	109,000	16,000	50,000
Communicable disease prevention, eradication and control	436,000	3.98%	73,000	100,000	263,000
Malaria	720,000	6.58%	70,000	650,000	0
Tuberculosis	261,000	2.38%	61,000	100,000	100,000
Health Promotion	140,000	1.28%	140,000	0	0
Mental Health and substance abuse	38,000	0.35%	38,000	0	0
Child and Adolescent Health	483,000	4.41%	153,000	197,000	133,000
Making Pregnancy Safer	1,556,000	14.21%	78,000	1,478,000	0
HIV/AIDS	1,721,000	15.72%	69,000	1,605,000	47,000
Sustainable Development	83,000	0.76%	23,000	60,000	0
Nutrition	164,100	1.50%	41,000	123,100	0
Health and Environment	249,000	2.27%	59,000	0	190,000
Health Action in Crisis	313,000	2.86%	9,000	0	304,000

Essential Medicines: access, quality and rational use	38,000	0.35%	28,000	10,000	0
Immunization & Vaccine Development	2,529,600	23.11%	27,000	420,000	2,082,600
Research Policy and Promotion	58,000	0.53%	58,000	0	0
Organization of Health Services	821,588	7.50%	344,000	285,000	192,588
WHO's Presence in Countries	1,161,000	10.61%	1,161,000	0	0
Total	**10,947,288**		**2,541,000**	**5,044,100**	**3,362,188**

5.3 SWOT analysis

Table 9 gives the analysis of the strengths, weaknesses, opportunities, and threats of WHO in Malawi. In general, performance in specific disease control activities has been good, while less attention has been given to broader policy and systems issues.

Despite identified problems, WHO Office in Malawi has the potential to improve its operations. The office has ability to source technical and financial support from elsewhere. In addition its impartial position, good track record in utilisation of funds and demand from other partners for its leadership present new opportunities.

The potential for improvement faces some challenges. These include: occasional communication failure between MoH and WHO, insufficient technical capacity at policy and macro-economic level, its inadequate capacity to use large sums of funds, its bureaucratic bottlenecks to release of funds within WHO, the tendency of WHO HQ to work with country partners without informing WHO country office and office's inability to change its traditional support to vertical programmes.

Table 9: The SWOT analysis of WHO in Malawi

ISSUE	STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
Policy guidance for global norms and standards	1.Technical competence in Health 2.Availability of norms and standards	1.Insufficient technical capacity at policy and macro-economic level 2.Tendency to do more implementation than advice provision	1.Availability of technical back-up from HQ and RO 2. Availability of financial back-up from HQ and RO 3.Institutional respect by MoH and other partners in health. 4. Legitimacy and credibility gained with support of Member States in WHO 5.Ability to provide consultants 6.Wide demand for WHO policy	
Partnerships and facilitation in health action (roles include leading UN country team and ensuring partner compliance with country health priorities)	1.Mandate to organize and facilitate national health days for health action 2.Ability to broker health and its links to non-health issues 3.The recognition of WHO by MoH as a facilitator for health action	1.Limited interactions with other partners outside MoH 2.Insufficient influence on final version of UN documents e.g. UNDAF	1. Health environment that promotes collaboration and integration (reforms) 2.WHO impartiality 3.WHO credibility 4.WHO mandate in health	1.Occasional communication failure between MoH and WHO 2. Partners with strong financial resources pushing their agendas
Advocacy for resource mobilization and allocation	1.Structure is in place 2.Ability to analyse situations at local levels	1. Limited flexibility in allocation of funds 2. Most EB funds not easily accessible	1. Institutional respect from other partners 2. Ability to analyse situations at global, and regional levels	1. Bureaucratic bottlenecks to release funds within WHO

	3. Ability to mobilize funds and source technical assistance locally 4. Good track record in fund utilization	3. Weak financial base	3. Ability to mobilize resources/funds globally by HQ and regional level	3. Limited access to pledged funds
Health systems strengthening	1.Capacity for developing human resources for health 2.Availability of technical support to HIS, essential drugs, etc 3.Advocacy for compliance to norms and standards	1.Insufficient support to government on macro-policy including NHA 2.Inadequate monitoring and evaluation of health system performance	1.Overwhelming demand to technical assistance from WHO 2.Donor interest to fund health systems strengthening	1.Verticality of most programmes 2.Inadequate availability and utilization of data for decision-making 3.Attrition of trained staff due to HIV/AIDS and greener pastures

6. WHO STRATEGIC AGENDA

6.1 Introduction

The overall goal of WHO work in Malawi is to contribute to the improvement of the health of its people through supporting health sector development, advocating health promoting policies and providing technical leadership in collaboration with the government, donors and other actors in the health sector. WHO will work with all partners towards developing a more equitable and efficient health system.

In line with its new corporate policy and in cognisance of its comparative advantage, WHO will, over the next five years, take a more selective and strategic approach to its work in Malawi. The following priority components of the strategic agenda for WHO in Malawi have been identified:

- Strengthening of national health systems development
- Disease prevention and control, including HIV/AIDS
- Family and reproductive health, including child survival
- Partnership facilitation for health action.

However, the broader mandate of WHO will still be respected and applied when necessary and if requested by the national authorities; for example, in the areas of food safety, environmental health and sanitation, schistosomiasis, Buruli ulcer and disaster preparedness and response.

Recognizing that poverty is a major determinant of ill-health in Malawi, both as a cause and as an effect, WHO will make special efforts to assist the government to develop mechanisms to reach the poor and maximize the contribution of health to poverty reduction. It will therefore advocate for health services that are pro-poor. In addition, special efforts will be made to support those interventions that target diseases associated with poverty. Furthermore, WHO will assist in devising special measures to protect the poor from the impoverishing effects of health care expenditures and minimize the financial barriers to health care.

An overarching approach for achieving the objectives of the strategic agenda will be continued support for promotion of good health practices and healthy lifestyles, including strengthened collaboration with the education sector (e.g. school health).

6.2 Priority components

Strengthening of national health system development

WHO will support the strengthening of the health system in the following areas:

Human resource development and retention

WHO will:

- Collaborate with with MoH on continuing analysis and operational research on the factors leading to attrition in the health workforce and effectiveness of interventions
- Support the implementation of the current 6-year crisis response plan
- Advocate for a comprehensive medium and long term approach to human resource for health.
- Support strengthening of national health institutions, including nursing and medical schools.

Organization of health services (with emphasis on district health systems)

WHO will:

- Provide technical support in the development and review of policies and guidelines in implementation of district health systems
- Provide technical support for sectoral policy and planning such as will be required for implementing the SWAp
- Support monitoring performance of district health systems using existing tools, with special attention to performance gaps associated with decentralization and introduction of the SWAp
- Support monitoring MoH to maintain appropriate balance between centrally driven and decentralized public health services
- Support the government by appraising options to improve the quality of health services
- Facilitate the strengthening of drug management system
- Facilitate adaptation and dissemination of evidence-based health policies, norms and standards in collaboration with government and partners.

Health information evidence and research policy

WHO will:

- Facilitate development of health research policy and planning including targeted operational and basic research
- Facilitate the institutionalization of operational research in all levels of MoH for informed decision-making
- Increase support for operational research by reallocation of some resources from discrete training activities and workshops towards support for operational research designed to provide practical information for decision-makers
- Improve information processing and dissemination within the country office and the MoH, with a progressive shift from a paper-based library to an electronic and internet-based information management system.

Health Action in Crisis (HAC)

WHO will:

- Reinforce health interventions and systems that mitigate, prevent disasters and promote efficient response to emergencies;
- Streamline public, CHAM and private health services approach to disaster victims;
- Design or introduce effective and efficient protocols for managing the various kinds of emergencies that occur on a regular basis in Malawi.

Disease prevention and control, including HIV/AIDS

WHO role in this area will be in the following areas:

Strengthen Integrated Disease Surveillance and Response (IDSR)

WHO will:

- Strengthen capacity of the central Epidemiology Unit and Public Health Laboratory to collate, analyse and report on disease patterns
- Facilitate timeliness and completeness of flow of information from peripheral levels

- Facilitate continued improvement of community and district- level outbreak detection, investigation and control
- Improve mechanisms for flow of data from IDSR into the health management information system.

Scaling up technical support to disease-specific control activities

WHO will:

- Facilitate technical updating, and development and revision of technical documents (guidelines, training manuals etc.) to assure quality
- Provide selective support to control of "orphan diseases" (those with little donor support) such as trypanosomiasis, schistosomiasis, Buruli ulcer etc.
- Continue to provide support to disease programmes targeted for:
  - Elimination and eradication
  - Diseases of epidemic nature
  - Diseases of public importance.

HIV/AIDS control

WHO will:

- Continue technical support to HIV/AIDS policy development and development and updating of protocols and guidelines
- Support Global Fund implementation; and support scale-up of ART with the intermediate goal of having 45 000 people on treatment by end 2005
- Encourage and technically support optimum programme integration with the national tuberculosis control programme and the SWAp
- Monitor programme performance, quality assurance, and equity of access, selecting best options for Malawi.

Noncommunicable diseases

WHO will:

- assist government in assessing and monitoring the magnitude of the problem of noncommunicable diseases.

Family and reproductive health, including child survival

Technical support to MoH and partners on maternal mortality reduction including emergency obstetrics

WHO will:

- Provide technical support for a comprehensive multi-partner assessment of the problem
- Provide technical support to MoH in emergency essential obstetric care
- Facilitate strengthening of the referral system
- Facilitate availability of essential obstetric drugs and equipments at district leve
- Strengthen maternal death reporting and auditing
- Provide technical support to address the problem at an integrated and policy level, since high maternal mortality in Malawi is linked to dysfunctional health systems
- Provide technical support for the improvement of perinatal care
- Provide technical support in the promotion of adolescent friendly reproductive health services.

Child health

WHO will:

- Promote and ensure better integration of IMCI with related child survival and maternal health interventions
- Provide guidelines and assist in the adaptation of IMCI protocols to include the treatment of HIV infected children.

Partnership facilitation for health action

Donor collaboration

WHO will:

- Promote the government agenda such as SWAp, decentralization, improving hospital management amongst development partners

- Pursue active and consistent engagement with partners through Aid Coordination Group and Health and Population Donor Sub-group
- Facilitate rational and coordinated use of Global Fund funds for HIV/AIDS and malaria through WHO membership in the Malawi Global Fund Coordinating Mechanism.

Macroeconomics and poverty reduction

WHO will:

- Engage with International Monetary Fund, World Bank and Ministry of Finance in support of Ministry of Health on macro-policy issues (allocation for social sector through HIPC funds, structural adjustment credits, World Bank MAP funds etc), using concepts of the Commission on Macroeconomics and Health
- Work with all partners to translate the principles of the Malawi Poverty Reduction Strategy into concrete and implementable programmes in the health sector
- Work with MoH to promote intersectoral collaboration for health
- Promote government's active engagement in addressing social determinants to health through national policies and their implementation.

Working within the United Nations

WHO will:

- Ensure that joint UN initiatives are realistic, specific, and in line with national plan for health sector, including achievement of MDGs.

7. IMPLICATIONS OF THE STRATEGIC AGENDA FOR WHO

7.1 Country office

Implementation of the proposed strategic agenda will require more active engagement of the country office with health partners in policy guidance, partnerships, advocacy for health and strengthening of the health systems. This has implications for WHO at country, regional and headquarters levels. The strategic agenda envisages a fundamental shift in the organizational culture, and operations of the WHO Malawi country office.

The following changes are required in WHO country office:

- Reorganization of operations to incorporate stronger policy and strategic support to the country, while maintaining the technical competency in health.
- Reorganization of professional staff into two technical clusters, a cross-cutting group and a services support unit, reflecting the new WHO strategic areas (see Annex 1).
- Re-assignment of professional staff to match skills with strategic priorities;
- Employment of an international health sector advisor, an international medical officer to support The 3 by 5 Initiative, an international medical officer for malaria and a health economist.
- A shift in country office operations from discrete process or programme-based approaches to a broad sectoral results-based approach.

7.2 Regional Office

The WHO Regional Office for Africa will provide technical and administrative support to WHO country operations customized to national needs, based on the CCS. The Regional Office will examine delegation of authority to the WHO representative and country office to ensure that sufficient flexibility exists for country-level implementation. The procedures for channelling locally mobilized resources should also be reviewed in order to avoid delays in disbursement

7.3 WHO headquarters

In line with the principle of "One WHO", WHO headquarters will work with the Regional Office to provide technical support and mobilize resources for the implementation of the Malawi CCS, and to document lessons learned from the CCS process and its impact on WHO work. WHO headquarters will continue to provide up-to-date technical information to the Malawi office.

8. MONITORING AND EVALUATION

The CCS strategic agenda will be translated into the Programme Budget and biennial plans of action through WHO regular managerial process. The country office will develop adequate expected outputs, targets, milestones, baseline and performance indicators to monitor the progress of the Programme Budget and plans. The implementation of the biennial plan of action will be subjected to the six-monthly WHO monitoring process of semi-annual, mid-term and biennial reviews.

In addition, a CCS support network involving the three levels of the organization, MoH and selected key partners will evaluate and review the CCS for impact and adjustments as deemed necessary or at least 6 months before the end of the indicated year on the document.

9. CONCLUSION

The key orientation of the Malawi National Health Policy framework developed in 1995 was to raise the health status of all Malawians through the development of the health delivery system capable of promoting health, preventing, reducing and curing disease, protecting life and fostering the general well-being and increased productivity and reducing the occurrence of premature death. Translating this into implementable actions, the Malawi Ministry of Health Joint Programme of Work (2003-2009) identified some major priority health challenges such as drastic reduction in the unacceptably high: maternal mortality and morbidity; child mortality and morbidity; HIV seroprevalence and deaths due to HIV/AIDS related illnesses and other major poverty-related diseases; to be tackled through delivery of high quality essential health package within the context of a decentralized health system.

In addition, the Republic of Malawi, which has operated under a resource-constrained environment for most of the 40 years since independence, attracts many donors with various interests in the health sector. Currently, donor contributions account for a large proportion of the national health budget. However, much remains to be done to ensure that all investments in the health sector are harmonized and used for maximum impact. While new initiatives (SWAp, decentralization and hospital autonomy) are promising, and new resources are available (Global Fund, donor basket funds), managing institutional change and ensuring quality service delivery will require coordinated efforts of all partners in support of government.

WHO developed the Medium-Term Country Cooperation Strategy (2005-2009) to better focus and guide its work in Malawi with enhanced support to government in responding to identified health and development challenges. The CCS forms the basis of WHO work in and with Malawi and will be used as common reference for country level interactions throughout the organization influencing the Programme Budget and plans of action. The priority areas identified include: strengthening of national health systems development; prevention and control of major diseases; improving family and reproductive health and promotion of partnerships and facilitation for health action. Success in these areas will contribute to poverty reduction and achievement of the health MDGs in Malawi.

The process of developing the CCS allowed for several partners to be engaged, and provided, to the country office a tremendous learning opportunity, it is our utmost desire that its implementation will be under the same spirit of enhanced partnership and collaboration.

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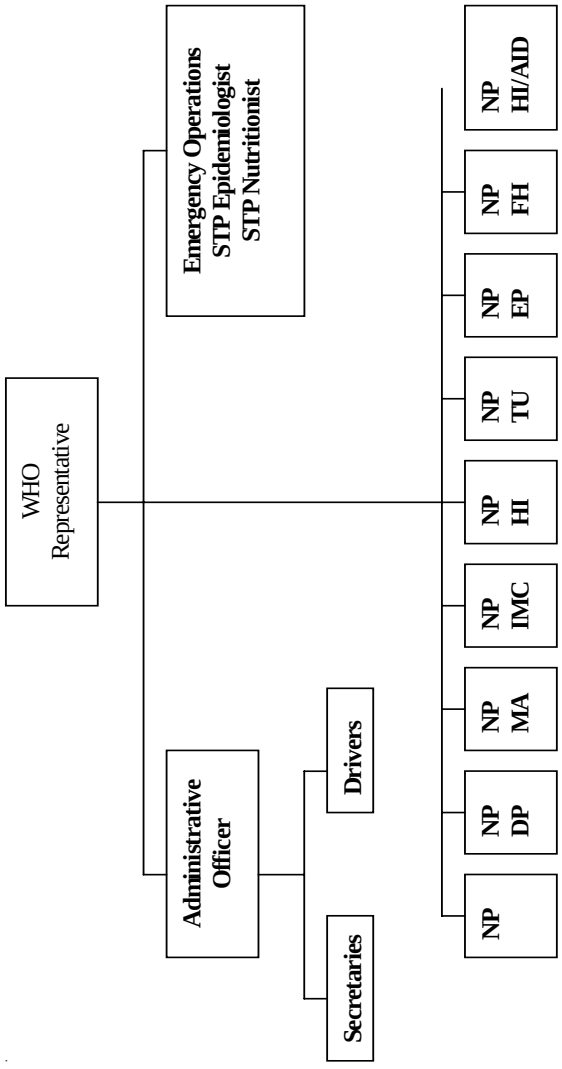
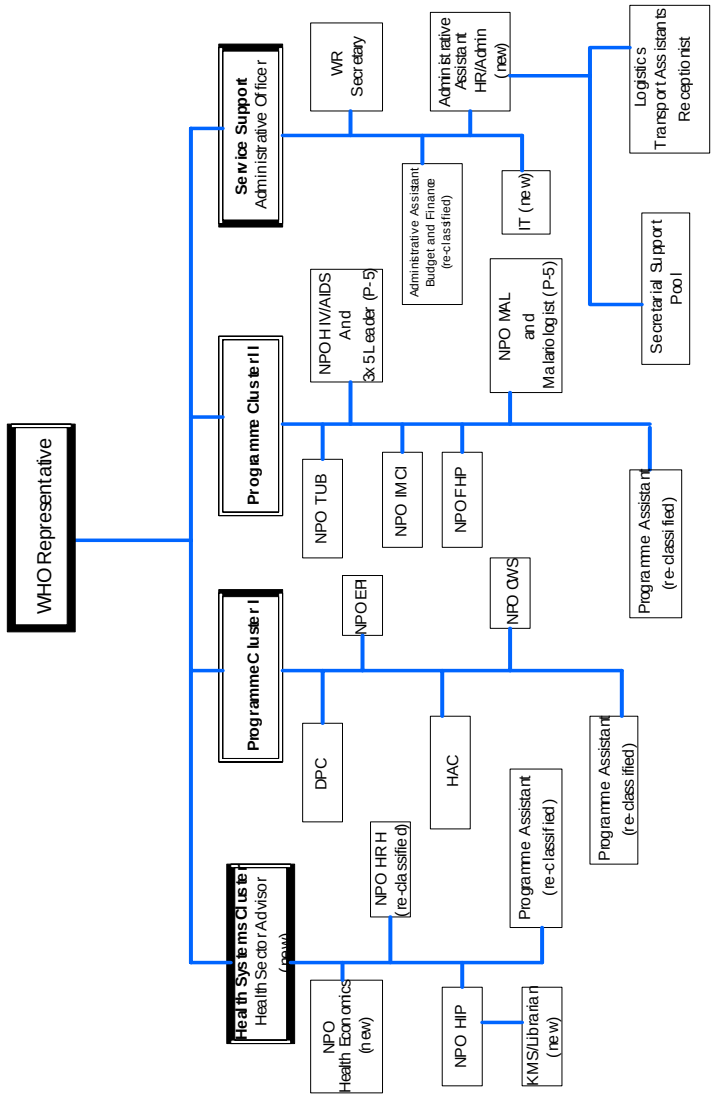
ANNEX 1: PRESENT AND PROPOSED ORGANIZATIONAL CHARTS

Presend Organizational chart



Proposed Organizational chart



ANNEX 2: 2006-2007 BIENNIUM SUMMARY OF AREAS OF WORK*

Area of work	Abbreviations
Communicable Disease Prevention and Control	CPC
Epidemic Alert and Response	CSR
Malaria	MAL
Tuberculosis	TUB
HIV/AIDS	HIV/AIDS (HIV)
Health Promotion	HPR
Health and Environment	PHE
Making Pregnancy Safer	MPS
Child and Adolescent Health	CAH
Immunization and Vaccine Development	IVD
Organization and Management of Health Services	OSD
Emergency Preparedness and Response	EHA
WHO's Presence in Countries	SCC

**AoWs not continued:*

Mental Heath and Substance Abuse (selected activities will be undertaken under Child and Adolescent health)

Sustainable Development (selected activities will be continued under Health and Environment)

Nutrition (selected activities will be continued under Emergency Preparedness and Response and Child and Adolescent Health)

Research Policy and Promotion (selected activities will be continued under any area of work as operational research)

ANNEX 3: PROCESS OF ELABORATING THE CCS IN MALAWI

The process of developing this CCS document involved extensive consultations during the first mission which took place from 23 February to 2 March 2004 with the national authorities in the MoH, line ministries (education, local government, finance, economic planning, agriculture and irrigation), development partners and NGOs. The team also consulted with the leadership of CONGOMA and CHAM, heads of training institutions (principals of the Malawi College of Health Sciences, Malawi College of Medicine, Kamuzu College of Nursing of the University of Malawi and the Registrar of the Nurses and Midwives Council), heads of UN agencies, World Bank and other development partners (DFID, USAID and CARE International).

The second CCS mission took place from 12 to 28 July 2004 principally to fine tune the strategic agenda and undertake the stakeholders meeting to review the draft CCS document. The CCS team was made up of senior policy-makers from the MoH and representatives from the three levels of WHO. The 11-member CCS core team was made up of Dr W Aldis, Mr Ben Chandiyamba, Mr Henry Damison, Mrs Theresa G Mwale, Dr Thomas Nyirenda, Mr Nelson Kalanje, Mr Edward Kataika, Dr Andrew Kosia, Dr Chris Mwikisa, Dr Funke Bogunjoko and Dr Bob Fryatt.

In total, 23 organizations were consulted during the two CCS missions and 47 people participated in the stakeholders review meeting.

ANNEX 4: PEOPLE ATTENDING THE TWO CCS MISSIONS

1	Dr H. Ntaba	Honourable Minister	Health
2.	Dr R Pendame	Principal Secretary	Health
3.	Dr H Somanje	Director Preventive health services	Health
4.	Dr R Mpazanje	Director Clinical Services	Health
5.	Tina Kines	-	WB
6.	Mrs L Setshwaelo	Res Represntative	FAO
7.	Dr E Morah	Country Director	UNAIDS
8.	Ms Zahra Nuru	Res Coordinator	UNDP
9.	Ms Ida Girma	Res Representative	UNICEF
10.	Mr Roger Wilson	-	DFID
11.	Mr M Nyirongo	-	USAID
12.	Principal Secretary	Agriculture	
13	Principal Secretary	Local Government	
14	Principal Secretary	Economic Planning	
15	Principal Secretary	Education	
16	Principal Secretary	Foreign Affairs	
17	Principal Secretary	Finance	
18	Principal Secretary	Information	
19	Mr Nick Osborne	Care International	
20	Executive Director	CHAM	
21	Executive Director	Youth Council	
22	Dr Magombo	Head of Health	Lilongwe City
23	Michael Tawanda	-	Norwegian Embassy
24	Mr Namagonya	Director	Social Welfare
25	Mr Kilembe	Director	Community Services

ANNEX 5: STAKEHOLDERS MEETING, 28 JULY 2004

Name	Designation
1. Dr W. L. Aldis	WHO Representative
2. Dr H. Somanje	Director of Preventive Health Services
3. Dr R. Chatora	DSD
4. Dr D. Makuto	Director FCN
5. Dr F. Bogunjoko	TCC/CAS
6. Dr B. Fryatt	CCO
7. P. Gwazayani	Reporter
8. A. Kachipeya	TV Journalist
9. Mrs F.E. Nkhata	MPN
10. Mrs C. Chihana	Principal
11. Mrs T.G. Mwale	FHP
12.Dr S. Mothebesoane-Anoh	Regional Advisor, Maternity Health & SM
13. H. Heirman	Coodinator, PRP
14. Ms. A. Singh	MDGS health + Development Policy
15. C. Bailey	Knowledge Management Advisor
16. Mrs N. Valentine	Equity in Health Economist
17. A. Liwanda	Journalist
18. D. Chatate	Technical Advisor
19. Mrs D. Ngoma	Vice Principal
20. C. Inani	Chief Education Officers
21. P.G.Z. Moyo	Registrar of Teachers' Schools
22. F. Gondwe	Deputy Executive Director
23. B.B. Chandiyamba	DPC
24. Dr S. Kambale	IMCI
25. B.T.Tauzie	Ag. CEHO
26. Dr A. Mawaya	Regional Advisor

27. Dr T. Okorosobo	Health Economist
28. Mrs E. Kalyati	UN Gender Coordinato
29. P Pennanen-Rebeiro	Assistant UN Res. Coordinator
30. Andy O'Connell	-
31. A. Eidhammer	Ambassador
32. E. Kataika	Deputy Director of Planning
33. Ms. J. Kayuni	Student
34. Mrs J. Nyondo	Project Officer
35. Ms. L.B. Maliro	Lecturer
36. Harvey Mwanza	Asst. Representative
37. P. Msakambewa	Asst. Registrar (F & A)
38. Alemayehu G.M.	Administrator
39. Ms. E. Kainula	National HIV AIDS Coordinator
40. Ms. L. Hawken	
41. Mrs J. Nyoni	Regional Advisor
42. G. Gedik	HRH/EIP
43. P. Mkandawire	Journalist
44. W.G. Bomba	HIP
45. Dr H. Getahum Gebre	STB
46. E.C. Nkhata	Nurse Educator
47. H. Damisoni	HIV/AIDS/NPO