



Government of the Republic of Malawi Health Sector Strategic Plan III 2023-2030

Reforming for Universal Health Coverage

First Edition



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The MoH is committed to effectively providing its stewardship role in the implementation of the HSSP III to honour all the efforts and contributions that all the different stakeholders made in the development of this strategy.

A handwritten signature in black ink, appearing to be 'CMW', written over a light grey grid background.

Dr Charles Mwanambo
Secretary for Health
January 2022

Acronyms

AMR	Antimicrobial Resistance
ANC	Antenatal Care
ART	Antiretroviral Therapy
BEmONC	Basic Emergency Obstetric and Neonatal Care
CDR	Central Data Repository
CEA	Cost Effectiveness Analysis
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CH	Central Hospital
CHAM	Christian Health Association in of Malawi
iCHIS	Community Health Information System
CMED	Central Monitoring and Evaluation Department
CMR	Child Mortality Rate
CMST	Central Medical Stores Trust
CoM	College of Medicine
CPD	Continuous Professional Development
CSO	Civil Society Organization
DALY	Disability Adjusted Life Year
DC	District Commissioner
DEC	District Executive Committee
DFF	Direct Facility Financing
DHA	Department of HIV/AIDS
DHMT	District Health Management Team
DHRMD	Department of Human Resource Management and Development
DHO	District Health Office
DHIS	District Health Information System
DHS	Demographic and Health Survey
DIP	District Implementation Plan
DOTS	Directly Observed Treatment, Short Course (for Tuberculosis)
DPSM	Department of Public Sector Management
DPT	Diphtheria, Pertussis and Tetanus
EH	Environmental Health
eHIN	Electronic Health Information Network
EHP	Essential Health Package
EHRP	Emergency Human Resource Plan
EML	Essential Medicines List
EmONC	Emergency Obstetric and Neonatal Care
EMS	Essential Medicines and Supplies
ENAP	Every Newborn Action Plan
EPI	Expanded Programme on Immunization
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
HBP	Health Benefits Package
HCMC	Health Centre Management Committee
HDP	Health Development Partners

HDU	High Dependency Unit
HEU	Health Education Unit
HIS	Health Information System
HMIS	Health Management Information System
HPV	Human Papillomavirus
HRH	Human Resources for Health
HRMIS	Human Resources Management Information System
HSA	Health Surveillance Assistant
HSJF	Health Services Joint Fund
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group
ICT	Information and Communications Technology
ICU	Intensive Care Unit
IDSR	Integrated Disease Surveillance and Reporting
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPTp	Intermittent Preventive Treatment during Pregnancy
iHRS	Integrated Human Resource Information System
IRS	Indoor Residual Spraying
IUCD	Intrauterine Contraceptive Device
JAR	Joint Annual Review
LF	Lymphatic Filariasis
LLIN	Long Lasting Insecticidal Nets
LMIS	Logistics Management Information System
MCDA	Multicriteria Decision Analysis
M&E	Monitoring and Evaluation
MBTS	Malawi Blood Transfusion Service
MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rate
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
MoF	Ministry of Finance
MOH	Ministry of Health
MoLGRD	Ministry of Local Government and Rural Development
MoU	Memorandum of Understanding
MSTG	Malawi Standard Treatment Guidelines
MSCC	Minimum Standards for Clinical Services
MW2063	Malawi 2063
MIP-1	Malawi 2063 First 10-Year Implementation Plan
NAO	National Audit Office
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHSRC	National Health Sciences Research Committee
NLGFC	National Local Government Finance Committee
NMCP	National Malaria Control Programme
NMR	Neonatal Mortality Rate

NRIS	National Registration and Identification System
NSO	National Statistical Office
NTDs	Neglected Tropical Diseases
OPC	Office of the President and Cabinet
ORS	Oral Rehydration Solution
PFM	Public Financial Management
PHC	Primary Health Care
PHL	Public Health Laboratory
PLHIV	People Living with HIV
PMRA	Poisons Medicines Regulatory Authority
PMTCT	Prevention of Mother to Child Transmission of HIV
PoW	Program of Work
QA	Quality Assurance
QECH	Queen Elizabeth Central Hospital
QI	Quality Improvement
QM	Quality Management
QMD	Quality Management Directorate
RUM	Rational Use of Medicines
SDGs	Sustainable Development Goals
SLA	Service Level Agreement
SEL	Standard Equipment List
SMT	Senior Management
SOPs	Standard Operating Procedures
SRHR	Sexual and Reproductive Health Rights
STH	Soil Transmitted Helminths
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
THE	Total Health Expenditure
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
VHC	Village Health Committee
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
YFHS	Youth Friendly Health Services

Foreword

The Government of Malawi is committed to ensuring that people in Malawi attain the highest possible mental, physical, and social health and a high quality of life. The health sector contributes to this aspiration through the delivery of cost-effective, high quality, equitable and integrated health care within the available health financing. This is the path the HSSP III sets.

The HSSP III has placed communities at the heart of service provision through the reform on integrated platforms of care that will aim to achieve holistic, and client focussed care. The HSSP III also aims to empower communities to take charge of their health through the introduction of equitable and community led domestic health financing mechanisms. Strengthened community oversight of local health care delivery is also a strong component of the proposed governance mechanisms in the HSSP III.



The HSSP III has considered the effects of population growth, the structure of the Malawi population and urbanisation on health and the demand for health care in the design of health systems interventions such as infrastructure development. It has also accounted for other health determinants such as poverty, climate change, natural disasters and disease pandemics and defined priorities for multi-sectoral and inter-sectoral collaboration.

The HSSP III will build strong and holistic health systems. Hence, it places joint processes for planning, budgeting, and reporting and their governance mechanisms at its centre. The HSSP III will build a performance management system and has outlined strong implementation arrangements to ensure its successful implementation. For human resources for health, a review of the existing health workforce capabilities will be conducted in order to build a health workforce that is responsive to changes in the burden of disease and many other factors. Capacities of training institutions will have to be built in order to train new health workforce cadres and increase numbers of the existing cadres. This must be done collaboratively between Government and its Development partners. The Government of Malawi is committed to increasing the health workforce subject to the country's economic performance.

It is my sincere hope, therefore, that since we have jointly formulated this strategic document, it will be the single most important point of reference for implementation and design of service delivery initiatives as it embodies our dream for a better health care delivery system and improved health for the people of Malawi.

A handwritten signature in black ink, appearing to read 'Kandodo'.

Honourable Khumbize Kandodo Chiponda, MP
Minister of Health, Malawi
December 2022

Executive Summary

The Health Sector Strategic Plan III (HSSP III) outlines the objectives, strategies and activities needed to build upon progress during implementation of the Health Sector Strategic Plan II (HSSP II) and accelerate Malawi's progress in achieving Malawi's Universal Health Coverage (UHC) targets by 2030. The HSSP III is motivated by Malawi 2063's vision of self-reliance and outlines how the health sector will contribute to the human capital development and mindset-change pillars of the vision. In the spirit of inclusivity, the HSSP III development process was extensively consultative and participatory, ensuring that the prioritization of resources and outcomes in the plan reflect a shared vision.

Notwithstanding a very challenging environment characterized by up to four waves of the COVID-19 pandemic, the health sector registered notable progress across impact level performance measures. For example, maternal mortality ratio was at 349 deaths per 100,000 live births in 2019 against the HSSP II target of 350 deaths per 100,000 live births; under-5 mortality rate was 39 per 1,000 live births in 2020 against the HSSP II target of 48 deaths per 1,000 live births; infant mortality rate was 29 per 1,000 live births in 2020 against the HSSP II target of 34 deaths per 1,000 live births; and the neonatal mortality rate was 19 per 1,000 live births in 2020 against the HSSP II target of 22 deaths per 1,000 live births. In addition, the HSSP II HIV incidence target of 2 cases per 1,000 adult population aged 15-49 years was surpassed and was at 1.21 in 2020. Despite such progress, however, significant gaps in population health, service delivery and health systems building blocks remain, and require addressing in order to meet UHC goals by 2030.

The goal of the HSSP III, therefore, is to move towards UHC by improving health status, financial risk protection and client satisfaction. It is recognized, however, that resources for health care delivery are inadequate. The HSSP

III has therefore defined a Health Benefits Package (HBP) previously referred to as Essential Health Package (EHP) in previous HSSPs to maximize population health given the limited available resources.

The HSSP III has the following objectives across nine priority areas:

1. *Service Delivery*: Increase equitable access to and improve quality of health care services.
2. *Socio-Economic Determinants*: To improve overall health, environmental health and prevent disease through addressing social determinants of health and burden of disease.
3. *Infrastructure & Medical Equipment*: To improve the availability, accessibility and quality of health infrastructure and medical equipment at all levels of health care.
4. *Human Resources*: Improve the availability of competent and motivated human resources for health (HRH) for quality health service delivery that is effective, efficient, and equitable.
5. *Medical Products and Technology*: To improve the availability, quality, and rational utilization of medicines and related medical supplies, balancing among the 3 P's: patients, products, and personnel.
6. *Digital Health*: To develop a sustainable and harmonized country led digital health system that covers all areas of service provision and enables efficient delivery of health services at all levels of the health system.
7. *Research*: To promote and coordinate a health research agenda in order to generate high quality evidence required to inform the development of health and health care delivery.
8. *Leadership and Governance*: To enhance effectiveness of leadership and governance at all levels of the health sector.
9. *Health Financing*: To set a well-governed health financing architecture that is able to mobilize adequate resources, distribute the resources in an efficient and equitable way, and strategically purchase services based

on a well-defined benefit package in pursuit of UHC goals.

Eleven reforms that are deemed game-changing, have been identified, informed by high quality evidence as well as extensive consultations. These are: in *Service Delivery* - transitioning from vertical programming to integrated platforms of care for service delivery; in *Health Workforce* – 1) implementation of a performance management system, 2) development of a harmonized in-service training system for human resources for health linked to continuous professional development, and 3) evidence-based matching of health workforce supply and demand; in *Infrastructure and Medical Equipment* – 1) upgrading of urban health centres to community hospitals to improve city primary and secondary care, and 2) equipment inventory management to achieve procurement and utilization efficiency; in *Supply Chain* - effective management and coordination across parallel supply chains while working towards greater systems integration through CMST by 2030; in *Digital Health* - scaling up of digital health systems; in *governance* – 1) implementation of a “One Plan, One Budget, One M&E” system, and 2) increase provider autonomy; and in *Health Financing* - strategic purchasing in health financing.

The total cost of implementing the intervention matrix for all the eight years is estimated at US\$31.2 billion (MWK 32 trillion) representing the full resource need before the prioritization. For the 2023/24 FY, although the need was \$4 billion, it was estimated from resource mapping round seven that only approximately \$690 million (\$537.1 million fungible funding and \$153 million non-fungible Government and donor funding) would be available in total. Therefore, the 2023/24 needs were prioritised down for to fit within the \$537.1 million envelope estimated. Assuming conservatively that this level of funding persists, the HSSP III will realistically be implemented at \$4.7 billion, with an acceptable margin of error, over the eight years.

The implementation of the HSSP III will be based on an HSSP III operational plan that will draw from the HSSP III intervention matrix. The Health Sector Working Group (HSWG) will

steer the “One Plan, One Budget, One Report” process. The district stakeholder forum will provide overall multi-sectoral and partner coordination at the district level. The Secretary for Health will oversee overall coordination of the sector, while designated directors at the national level will provide overall leadership of their respective thematic areas. The Director of Health and Social Services at the District Council shall provide overall technical coordination in line with Council governance arrangements. Government, Donors and Implementing partners will be guided by MOUs and a Code of Conduct.

In order to effectively monitor the HSSP III, 1) the health information system will be decentralized to each decision-making entity at each level of the health system; 2) all partners in the health sector will align and harmonize their data systems to facilitate timely transmission of information to decision makers at all levels of the health system; 3) streamlined and interoperable digital health systems will be imperative; 4) All efforts shall be made toward digitalizing service delivery at the point of care and data shall be collected and extracted from these systems to support service delivery and timely and accurate reporting. HSSP III will be a living document and, in that spirit, MOH plans to publish digital versions of future editions of HSSP III on MOH website to ensure that latest evidence is translated into strategic priorities.



Photo: Doctor counselling a paediatric patient at a health centre.

Chapter 1: Introduction and Background

1.1 Introduction to the HSSP III

Malawi's population health and service delivery level outcomes have improved over the past decade albeit some gaps yet remain that require addressing. For instance, Life expectancy has increased from 55.6 years to 64.7 years between 2010 and 2020. This is mainly due to declines in the maternal mortality rate (MMR) from 444 deaths per 100,000 live births years in 2010 to 349 deaths per 100,000 live births in 2017; reductions in under-five mortality rate (U5MR) from 84.2 deaths per 1,000 live births years in 2010 to 38.6 deaths per 1,000 live births in 2020; reductions in infant mortality rate (IMR) from 52.4 deaths per 1,000 live births years in 2010 to 29 deaths per 1,000 live births in 2020 and reductions in neonatal

mortality rate (NMR) from 27.9 deaths per 1,000 live births years in 2010 to 19.1 deaths per 1,000 live births in 2020.

Malawi's Universal Health Coverage (UHC) index, which measures progress of Countries are making in achieving UHC, was estimated at 48% in 2019 which compares favourably with countries in the same per capita Gross Domestic Product (GDP) range¹. Potential drivers of this remarkable performance include a highly efficient HIV response and effective delivery of essential life-saving interventions. For HIV/AIDS, for example, the country's performance against the 95:95:95 targets stood at 93:97:93 in 2021 (UNAIDS). HIV related deaths have consequently declined from 6.25 deaths per 1,000 population in 2004 to 0.63 deaths per 1,000 population in 2020. Other service delivery improvements have come from progress in maternal, neonatal and child health (MNCH) services especially through sustained high rate of coverage of high impact preventive and curative health interventions including antenatal and delivery care, immunization, distribution of Long-Lasting Insecticidal Nets (LLINs) and treatment of common infectious diseases (UNICEF, 2018).²

Despite the notable progress in population health and service delivery outcomes,

¹ The World Bank. (2022, June 03). *World Bank Open Data*. Retrieved from The World Bank: <https://data.worldbank.org/>

² UNICEF. (2018). *Every Child Alive: The urgent need to end newborn deaths*. Retrieved from <https://data.unicef.org/resources/every-child-alive-urgent-need-end-newborn-deaths/>

significant gaps persist especially due to under investments across health system building blocks (MoH, 2001)³. This health sector strategic plan takes an investment approach by prioritizing health service delivery, implementing value generating health system interventions and undertaking a highly coordinated set of reforms for an efficient health system able to withstand public health emergencies and other shocks.

The Health Sector Strategic Plan III (2023-2030) is a pivotal document developed at an opportune time when Malawi recently launched a new vision, the Malawi 2063, and its initial corresponding ten-year implementation plan, the Malawi 2063 First 10-Year implementation plan (MIP-1), (2021-2030)⁴. The HSSP III has drawn on the Malawi 2063 principles of self-reliance and mindset change by specifying a reform package to set the health system towards these ambitions and ensure a health system that is fit for purpose. It also aligns to the multi-sectoral approach to human capital development laid out in the Vision.

While sustaining or simply refining many routine interventions from previous HSSPs, the HSSP III is different in its conceptualization and deep understanding of the rapidly changing local and international operating environment. A key highlight is its explicit recognition that the fiscal space situation is likely to be vulnerable, yet with dedication to a purposely designed and evidenced informed catalytic reform package, progress towards the 2030 Universal Health Coverage targets for Malawi is recoverable and sustainable. Another departure is the “systems and reforms” in the health systems building blocks approach underpinning its design in which the aim is to optimize functioning of each building block while sufficiently accounting for the intricate connectedness of the building blocks to achieve the service delivery and ultimate health goals. And finally, the HSSP III has taken practical steps to optimally decentralize service delivery and empowering communities to take full ownership of the system at service delivery level.

HSSP III timing is critical because it coincides with the last eight years of the Sustainable Development Goals (SDG) period. The Ministry of Health recognizes that to attain SDG targets in 2030, there must be fundamental reforms and restructuring of the health system. Malawi has made significant progress in service delivery and health indicators as is shown later but this has been in the context of a fragmented health care system, both in health care delivery and health financing. Therefore, to accelerate progress towards SDG targets fragmentation and other key bottlenecks must be addressed.

1.2 Methodology and conceptual framework for the HSSP III

1.2.1 Conceptual framework for the HSSP III

The WHO building blocks frameworks was used to inform the thematic areas of the HSSP III according to which the objectives have been defined. The World Bank Flagship Control Knob framework was used to guide a bottleneck analysis and development of strategies and activities to address the bottlenecks (Figure 1: Conceptual Framework for the HSSP III). The inception report developed for the HSSP III provides detailed methodology and key references for the approach (MOH 2021)⁵. Based on the World Bank framework, the goals of Universal Health Coverage (UHC) are to: 1) improve health status (both levels and distribution of health); 2) provide adequate financial risk protection, ensuring that the

³ MoH. (2001). *The Mid-Term Review of the Malawi Health Strategic Plan II*. Lilongwe

⁴ National Planning Commission. (2020). *Malawi 2063*. Lilongwe 3: National Planning Commission

⁵ MOH. (2021). HSSP III Development Inception Report

population do not get impoverished as a result of a weaker healthcare delivery system; and 3) ensure clients are satisfied with the health system (Maeda, et al., 2014).⁶ The framework suggests three intermediate performance measures through which the UHC goals will be achieved namely; 1) improved access to health services, 2) improved/enhanced quality of healthcare, and 3) efficiency in health service delivery.⁷

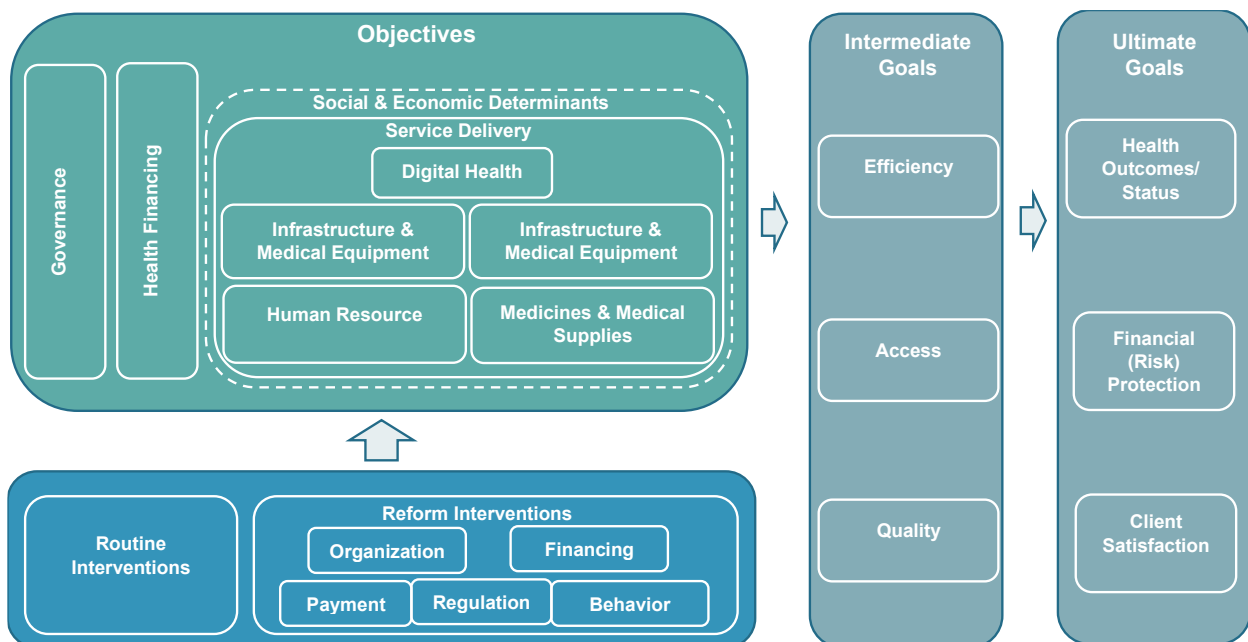
At the objective level, the WHO Building Blocks framework was utilized but the results were refined based on the results of the bottleneck analysis. It guided the choice of investment areas and identification of routine HSSP III strategies and activities. The control knobs framework on the other hand informed the bottleneck analysis and identification and prioritization of the reforms in each building block. Routine interventions are defined here as those needed to monitor or maintain a clinical/health service status quo for example daily provision of consultations by clinicians, daily lab tests, daily or scheduled provision of community interventions, provision of supervision and M&E services, ongoing

construction of infrastructure, ongoing procurement of equipment etc.⁸ Figure 1 distinguishes routine and reform interventions.

The logic of the conceptual framework in Figure 1 is as follows. Effective implementation of the routine and reform interventions (strategies and their activities) will lead to the achievement of the objectives (at the building block level). Improvements in the building blocks are then expected to lead to improvements in service delivery outcomes of health service access (including equity), quality and efficiency, and ultimately improving health outcomes, client satisfaction and financial risk protection. The agreed reform package on the hand will deliver the fundamental changes to the processes in policies and institutional arrangements of the health sector, led by the Government, to increase the likelihood of implementation.⁹

Inside each building block, to guide the bottleneck analyses and interventions prioritization, specific frameworks, for example, a supply chain cycle in supply chain, or the four functions of health financing in health financing, were used. This ensured that all relevant gaps

Figure 1: Conceptual Framework for the HSSP III



⁶ Akiko Maeda et al. (2014). *Goals of the Universal Health Coverage*. Washington DC: World Bank. Retrieved from https://elibrary.worldbank.org/doi/10.1596/978-1-4648-0297-3_ch1

⁷ Roberts, Marc. et. al. (2009). *Getting Health Reform Right: A Guide to Improving Performance and Equity*

⁸ Egen's Medical Dictionary. (2011). Retrieved September 19, 2022, from <https://medical-dictionary.thefreedictionary.com/routine+intervention>

⁹ https://apps.who.int/iris/bitstream/handle/10665/127574/WP_HlthSecReform_Final%20Version.pdf;sequence=1

across the system or functions of the building block are identified, and their solutions are thus considered during prioritization. Further, the control knob framework was used to check the extent to which the organizational, financing, payment, regulatory and behavioural issues significantly undermined performance inside a building block, and this process was the basis for identifying and prioritizing the reforms. Therefore, the HSSP III takes a “systems and reforms” in the health systems building blocks approach and attempting to optimize functioning of each building block while sufficiently accounting for the intricate connectedness of the building blocks.

1.2.2 Determining the Health Benefits Package and associated health system investment requirements

The health system exists to deliver quality and efficient health services. This is summarized at the intermediate goal level of the conceptual framework in Figure 1. Malawi’s health system is severely resource constrained and therefore must provide a highly prioritized set of interventions that have the greatest likelihood of achieving the maximum population health impact possible given existing constraints. Chapter 4 describes the methodology for the definition of the Health Benefit Package (HBP) which then informed prioritization of health systems investments of the HSSP III.

The costs of the HSSP III in Chapter 6 were estimated for the 2023/2024 financial year (FY) to 2030/2031 FY (three months into 2031). Initial costing estimated the financial requirements for a delivering the prioritized need. Next, these costs were compared to the projected financial resources in the health sector, and then iteratively prioritized downwards to ensure that the HSSP III fits within the available resource envelope. This re-prioritization was essential to direct limited financial resources towards strategic reform areas and priorities of the health sector for the next eight years. The HSSP III was costed using Microsoft Excel to improve costing

ownership, flexibility and transparency, a departure from the HSSP II which used the OneHealth tool.

The process of setting impact indicator targets for HSSP III was rigorous yet pragmatic. For indicators that had 2030 targets already, for example, those in the National Health Policy, these were adopted. For indicators that did not have targets projected up to 2030, these were estimated first by benchmarking against other African countries in the GDP per capita range up to USD1,036, the lower bound for classification into LMIC, which is MIP’s classification target of 2030. Using this, the achievement level of the best performing country in the GDP range was adopted. For some indicators, Malawi’s health outcomes were superior in this GDP range. As a result, these were based on programme targets and validated at stakeholder’s workshop. At the health system outcome and output level, the targets are based on results of prioritization scenarios for the HBP, human resources, reforms, and routine interventions.

1.3 Background

Malawi is a landlocked country with a surface area of 118,484 Km² of which 94,276 Km² is land mass. It has an estimated population of 19.4 million in 2022, 41% of which are under the age of 15 and 15% are under the ages 5 – 15¹⁰. At an average annual growth rate of 2.69% per annum, the population is estimated to grow to 23.1 million in 2030. 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 65.62 years, for both sexes, in 2022.¹¹ An estimated 81.5% of the population lives in the rural areas currently but Malawi is predicted to experience an average annual urban population growth rate of 4.2% from 2013 to 2030¹², which is expected to exert pressure on urban health care delivery system.

Malawi’s Gross Domestic Product (GDP) per capita in 2017 was estimated at USD513¹. Real GDP growth for Malawi was reported as 4% in 2017.² The economy is predominantly based in

¹⁰ National Statistical Office. Malawi Population and Housing Census Report - 2018. Zomba, Malawi; 2019.
¹¹ UNICEF 2015

¹² Annual Economic Report 2021

Table 1: Distribution of health facilities by type and ownership

Facility Type	Facility Owner					Total
	Govt	Private for profit	CHAM	Private non-profit	NGO	
Clinic	20	233	7	46	46	352
Dispensary	49	2	2	8	1	62
Health Centre	364	4	109	7	5	489
Health Post	89		5		1	95
Hospital	49	9	41	1		100
Grand Total	571	248	164	62	53	1098

Source: Malawi Harmonized Health Facility Assessment (2019)

agriculture, forestry and fishing contributing to 23.2% of GDP in 2021.³ The health sector contributed 5.4% of GDP and 3.4% of annual growth of the economy in the same year. Informal employment is higher than formal employment, estimated at 89% and 11% respectively¹³. The mean and median earnings per month for the total economically active population were estimated at USD 114 and USD 37, respectively. The economy is heavily dependent on foreign development aid – for example donor funding represented 58.6% of total health expenditures (THE) between 2015/16-2017/18 although the share declined to 55% in 2018/19¹⁴.

Literacy is higher among men (83%) than women (72%) but with significant strides in narrowing gender disparities in education¹⁵. The median number of schooling years completed has increased significantly over time: in 1992 it was estimated at 0.4 and 4.3 years for women and men respectively compared with 5.6 years for women and 6.6 years for men in 2016. 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.¹⁶

1.3.1 Organization of the Malawi Health Care System

Health service delivery system in Malawi is organized at three levels which are linked by a referral system: 1) Primary (community and facility), 2) Secondary, and 3) Tertiary. The services are delivered through a network of public, Non-Governmental Organizations (NGOs), Private-not-for-Profit, and Private-for-Profit providers. Table 1 shows the distribution of health facilities by type and ownership. Overall, Government owns the largest number of all health facility categories.

After the Government, privately owned health and CHAM facilities are the most numerous. CHAM compliments public facilities through a memorandum of understanding (MOU) with prioritization of Government support to CHAM facilities located outside a mandatory 8 Km radius of public facilities from one another. In 2016, there were a total of 5090 outreach clinics, 79% of which were owned by Government while CHAM owned 19% of these. Also, in the same year, there were 3542 village clinics, all of which were owned by Government.¹⁷

Based on its mandate as stipulated in the 1998 National Decentralization Policy, the Ministry of

¹³ The Malawi Labour Force Survey 2013

¹⁴ Ministry of Health, Malawi National Health Accounts Report for Fiscal Year 2018/19, Department of Planning and Policy Development, Lilongwe 3

¹⁵ Malawi Demographic and Health Survey 2015-2016

¹⁶ Malawi Demographic and Health Survey 2015-2016

¹⁷ MOH. (2016). *The Health Care System*. Retrieved June 22, 2022, from <https://www.health.gov.mw/index.php/2016-01-06-19-58-23/national-aids>

Health provides oversight to the health sector in Malawi. The Ministry of Health's specific functions include strategic planning, policy making, standards setting, technical support, monitoring and evaluation, quality assurance, resource mobilization, and international representation. The Ministry is also responsible for the oversight of tertiary hospitals namely: Queen Elizabeth Central Hospital (QECH) in Blantyre, Zomba CH in Zomba City, Zomba Mental Hospital in Zomba City, Kamuzu Central Hospital (KCH) in Lilongwe City, and Mzuzu CH in Mzuzu City. A proposal to fully decentralize the management of these hospitals to autonomous hospital boards was granted by Cabinet in 2018 though not fully implemented even now.

At the district level, in line with the decentralized architecture, District Councils oversee the management, planning, execution, and evaluation of the health District Health Services and budgets. The Council is comprised of ward councillors and other members like Traditional Authorities (Tas), MPs, representatives of special interest groups among others, led by a Council Chairperson elected from the members. The Council provides oversight to a Council Secretariat that is headed by a District Commissioner, with a number of directorates under him (e.g., Administration, Finance, Public Works, Health and Social Services, Planning and Development among others). The Council establishes Service Committees to facilitate its work in particular areas of work. These committees include a) Finance; b) Development; c) Education; d) Works; e) Health and environment; f) Human Resources; and g) Planning and Development.

1.3.2 Legal, Policy and Development frameworks

This section highlights the legal, policy and strategic frameworks, within the health sector and in other sectors that have a bearing in the effective implementation of this HSSP III. It also provides the international instruments that have informed the design of this HSSP III. While some will expire inside the HSSP III period, MOH will ensure effective representation and contribution to the formulation of their successors, so that they fully embody the

multisectoral collaboration framework assumed for successful achieve of the HSSP III goals.

1.3.2.1 Legal framework

The Constitution of Malawi

The Constitution provides that the State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving the goals of health and social determinants of health. It mandates the health sector "to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care."

Public Health Act (1948)

The Public Health Act consolidates the law regarding the preservation of public health in Malawi. It addresses issues regarding infectious diseases and creates institutions for responding to emerging public health challenges.

Medical Practitioners and Dentists Act (1987)

It provides for the establishment of the Medical Council of Malawi, the registration and disciplining of medical practitioners and dentists, the regulation of training within Malawi of medical personal and generally for the control and regulation of the medical profession and practice in Malawi.

Nurses and Midwives Act (1966)

It establishes a Nurses and Midwives Council with the purpose of administering the certification, licensing, and disciplining of nurses and midwives.

Pharmacy and Medicines Regulatory Authority Act, 2019

It provides for the establishment of the Pharmacy, Medicines and regulatory Authority which is mandated to regulate and control the manufacture, importation, exportation, distribution and sale of medicines and allied substances and veterinary products, establish a functional system for pre- and post-marketing surveillance of safety, quality, efficacy and effectiveness of medical products and to optimize the risk-benefit balance, establish, maintain and enforce standards for medicine

quality control laboratories, among others key functions.

HIV and AIDS (Prevention and Management) Act, 2017

This act stipulates directions for HIV prevention and management. It establishes the National AIDS Commission to implement, co-ordinate and facilitate the national HIV response; manage and co-ordinate the implementation of Government Policies on HIV and AIDS; and provide technical support to Government in the formulation and review of HIV and AIDS policies.

Local Government Act (1998)

The Local Government Act (1998) consolidates the law regarding local Government. It provides for health service delivery to be decentralized to district and city councils and empowers communities to be responsible for their own health and healthcare services. It also mandates the Ministry of Health to be responsive for health-related policies, trainings, and supervision.

Public Private Partnership Act (2011)

This act provides for partnerships between the public sector and private sector for the supply of infrastructure and delivery of services as means of contributing towards sustaining economic growth, social development, and infrastructure development; and provides for the development and implementation of public private partnership arrangements in Malawi for the delivery of infrastructure and services.

Public Financial Management (PFM) Act (2022)

It fosters and enhances effective and responsible economic and financial management by Government, including adherence to policy objectives. It also provides accompanying accountability arrangements and specifies consequences for compliance and non-compliance PFM rules. The Ministry of Health must, in compliance with this Act, ensure responsible economic and financial management of health sector resources and must be accountable for the same. Further, the Ministry must produce a national health sector budget for the areas under its responsibility.

Public Procurement Act (2003)

It provides for the principles and procedures to be applied in, and to regulate, the public procurement of goods, works and services in Malawi, including in the health sector.

1.3.2.2 Policy Framework

National Health Policy (2018)

The National Health Policy (2018-2030) provides the overall policy direction for the health sector. The second Health Sector Strategic Plan was developed as a first strategic plan for the National Health Policy. This HSSP III will be the second and final strategic vehicle towards the Malawi SDG and NHP goals for 2030.

National HIV and AIDS Policy (2022)

The National HIV and AIDS Policy aims at facilitating the evidence-based programming and strengthening of the National HIV and AIDS response while recognizing the emerging issues, gaps, challenges, and lessons learnt during the implementation of the first policy.

National Multisector Nutrition Policy (2018)

The National Nutrition Policy seeks to promote evidence-based programming and strengthening of the national nutrition response. The NHP promotes good sanitation and good hygiene practices and management of over-nutrition and non-communicable diseases.

National Decentralization Policy (1998)

The Decentralization Policy seeks to create a democratic environment and institutions for governance and development at the local level that facilitate grassroots participation in decision making. The Decentralization Policy supports the district health systems comprising of community, primary and secondary service delivery levels to accelerate the efforts of achieving of the health sector goals which include improving health status of Malawians, providing adequate financial risk protection, and improving client satisfaction.

National Education Sector Investment Plan (2020 – 2030)

The National Education Sector Investment Plan outlines the framework for implementation of school health, water and sanitation, and hygiene; HIV and AIDS; gender and investments in health training institutions.

National Gender Policy (2015)

The Gender Policy seeks to mainstream gender in the national development process to enhance participation of women and men, girls, boys at individual, household, and community levels for sustainable and equitable development.

National Health Promotion Policy (2013)

The National Health Promotion Policy was developed to give direction for programming of health promotion interventions.

Other relevant Policies

Health has strong linkages with other social and sectoral policies as a crossing-cutting issue. These policies among others include but are not limited to the National Population Policy; National Social Support Policy National Sports; and Youth Development Policy.

1.3.2.3 National Development framework

The Malawi 2063

The Malawi 2063 (MW2063) envisions an inclusively wealthy and self-reliant industrialized upper middle-income country. It is planned to be operationalized through the Malawi 2063 First 10-Year implementation plan (MIP-1), replaced the Malawi Growth and Development Strategy (MGDS) as the national development strategy which was operationalising the Vision 2020. Malawi 2063 focuses on three pillars: agricultural productivity & commercialization, industrialization, and urbanization. These pillars are supported by seven enablers: human capital development, mindset change, effective governance systems and institutions, enhanced public sector performance, private sector dynamism, economic infrastructure, and environmental sustainability. Health falls under the human capital development enabler.

1.3.2.4 International instruments

Sustainable Development Goals (2016-2030)

All United Nations (UN) member states including Malawi adopted the Sustainable Development Goals (SDGs) in 2015. Although all of them contribute to health, SDG 3 falls under the domain of the health sector. It aims to achieve healthy lives and well-being of all at all ages. The targets of SDG 3 include the following:

- 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 newborns and under five children.
- Target 3: By 2030, end the epidemics of AIDS, TB, Malaria and Neglected Tropical Diseases (NTDs), 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.
- Target 9: By 2030, substantially reduce the number of deaths and illness from hazardous

chemicals and air, water and
soil pollution and
contamination

Paris Declaration on Aid Effectiveness (2005)

The Paris Declaration encourages developing countries to set their own strategies for poverty reduction, improve institutions and tackle corruption. It outlines that donor countries are to align behind these objectives using local systems and coordinate with simplifying their procedures and sharing information to avoid duplication. Lastly, it stipulates that, developing countries and donors are to shift focus to development results and results get measured, and donors and partners to be accountable for development results. The Accra Agenda for Action (AAA) in 2008 reaffirmed the Paris Declaration emphasizing the need to untie aid and reduce fragmentation.

The Paris Declaration proposes four main areas for improvement which include 1) *Ownership* – Countries have more say over their development processes through wider participation in development policy formulation, stronger leadership on aid co-ordination and more use of country systems for aid delivery; 2) *Inclusive partnerships* – All partners, including donors in the OECD Development Assistance Committee and developing countries, as well as other donors, foundations and civil society, participate fully; 3) *Delivering results* – Aid is focused on real and measurable impact on development; and 4) *Capacity development* – to build the ability of countries to manage their own future also lies at the heart of the AAA.¹⁸

Astana Declaration on PHC

The Astana Declaration envisions: 1) Governments and societies that prioritize,

promote and protect people's health and well-being, at both population and individual levels, through strong health systems; 2) Primary health care (PHC) and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed; 3) Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being; and 4) Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.¹⁹

1.4 Organization of the HSSP III Document

The rest of the document is organized as follows. Chapter 2 summarises the health sector situation analysis report²⁰ that was produced to inform HSSP III priorities. Chapter 3 provides the goal, vision, mission, and objectives of the HSSP III and these derive from the National Health Policy (NHP) with slight modification informed by the bottleneck analysis. Chapter 4 presents the Health Benefits Package for the HSSP III. Chapter 5 presents the strategies for the HSSP III objectives based on results of the mid-term evaluation, the situation analysis that was conducted as part of the HSSP III process and a bottleneck analysis based on consultations with stakeholders. Chapter 6 presents HSSP III costing and financing arrangements. Chapter 7 presents the implementation arrangements while Chapter 8 presents monitoring and evaluation arrangements.

¹⁸ OECD. (2005). Paris Declaration and Accra Agenda for Action. Retrieved October 4th, 2022, from <https://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm>

¹⁹ WHO. (2018). Declaration of Astana. Retrieved from <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>

²⁰ MOH. (2022). HSSP III Situation Analysis Report



Photo: Patients waiting in a health facility.

Chapter 2: Situation Analysis

2.1 Overview of the Chapter

This chapter presents an overview of the situation of the health sector that informed HSSP III priorities. It also summarizes major program interventions during HSSP II implementation. Data for the situation analysis have come from the mid-term review report for the HSSP II, routine survey and research data, administrative sources including the health management information system (HMIS) and international databases. The full report on which this chapter was based is available (MOH, 2022).

2.2 Progress of Ultimate and Intermediate Health Impacts

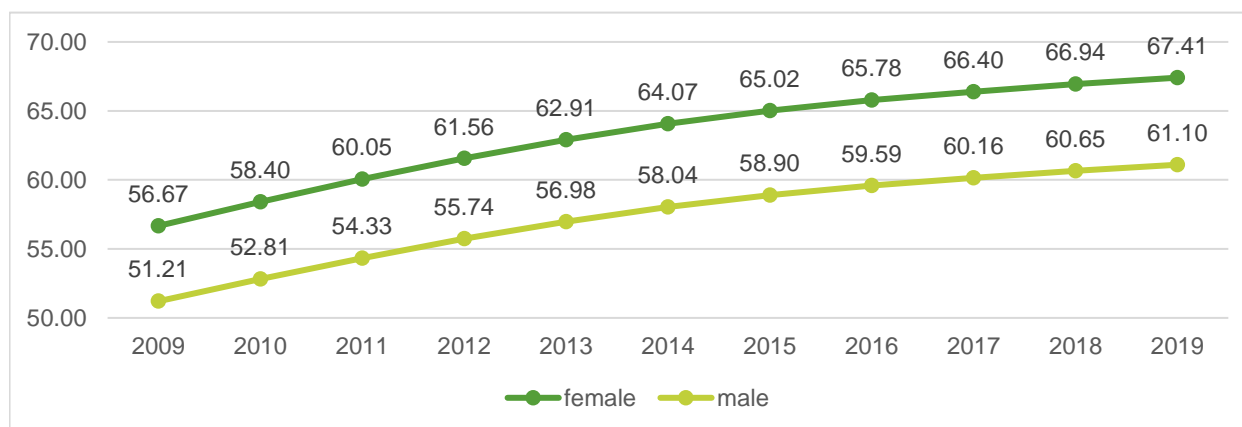
2.2.1 Trends in Health Impacts

2.2.1.1 Life Expectancy

Malawi has made significant progress in improving the health of its population. Average life expectancy has increased by 10 years over the last decade for both men and women (Figure 2). It is higher than the average life expectancy on the African continent of 62 years old in 2020 and on par with many SADC countries.²¹ This is attributed mainly to improvements in adult and childhood health because of robust implementation of HIV maternal and child health lifesaving interventions.

²¹ World Bank Data <https://data.worldbank.org/>

Figure 2: Trends in Life Expectancy (by Gender) in Malawi



Source: World Bank - Statista 2022

2.2.1.2 Trends in Mortality and Burden of Diseases

Mortality indicators have declined over the last decade. Based on the DHS (2015)²² and Multiple Indicators Cluster Survey (MICS) (2019)²³, maternal mortality ratio has declined from 439 per 100,000 live births in 2015 to 349 per 100,000 live births in 2019 marginally surpassing the HSSP II target of 350 per 100,000 live births. Under-5 mortality rate has declined from 63 per 1000 live births in 2015 to 39 per 1000 live births in 2020 surpassing the HSSP II target of 48 deaths per 1,000 live births. Infant mortality rate and neonatal mortality have had less of a decline but have trended down with 42 and 27 deaths per 1000 live births in 2015 to 29 and 19 deaths per 1000 in 2019 respectively surpassing the HSSP II targets of 34 deaths per 1,000 live births and 22 deaths per 1,000 live births, respectively.

Similarly, mortality from HIV has decreased by greater than 50% since 2010 with a stable TB death rate of 14 cases per 100,000 people in 2020.²⁴ However, non-communicable disease and injury mortality has been on an increase over the last decade now accounting for over 40% of mortality in Malawi.²⁵

Figure 3 shows the leading causes of burden of disease from 2010 to 2019 for Malawi. While communicable, maternal, and neonatal diseases continue to constitute a significant proportion of burden of disease, the burden of non-communicable diseases is increasing. Over the last 10 years, there has been major progress in reducing the burden due to HIV & AIDS, with the attributable burden declining by 12.35% from 2009 to 2019.²⁶ Despite a significant amount of programming around maternal and neonatal health and survival, this remains the highest burden of disease in Malawi.

2.2.2 Progress in Financial Risk Protection

Financial risk protection in health occurs when individuals receive the healthcare services they require, and do not suffer undue financial hardship as a result. Based on recent data (WHO, 2019), however, the financial risk protection index for Malawi is very high, at 97.45% (unadjusted for equity) and 94.1% (adjusted for equity).²⁷ Overall, Out-of-pocket

²² National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.

²³ NSO. (2021). Multiple Indicator Cluster Survey (MICS) 2019-20

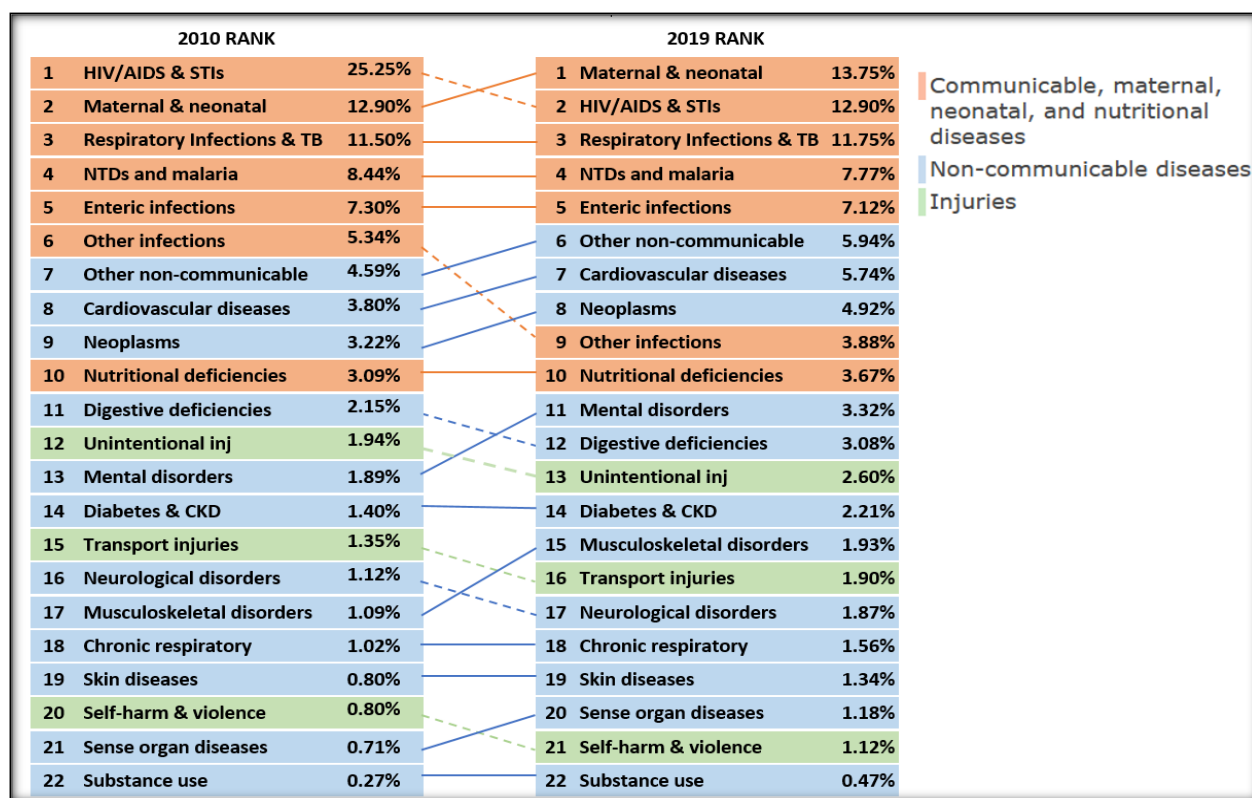
²⁴ World Bank Data <https://data.worldbank.org/>

²⁵ World Bank Data <https://data.worldbank.org/>

²⁶ Institute for Health Metrics and Evaluation (2022)

²⁷ This high financial protection index could also be due to the non-use of services by the poor. Given that the quality of care is poor in most public facilities due, inter alia, to lack of medicines, poor households may forego care from private facilities or even buying prescription medicines because they cannot afford it.

Figure 3: Leading causes of DALYs in Malawi in 2019



Source: Institute for Health Metrics and Evaluation

expenditure on health as % of THE was at 11.9% in 2018/19 (MOH, 2022)²⁸ however, this was before the onset of the COVID-19 pandemic and the global economic meltdown. The potential factors for this high performance on financial risk protection include 1) the current health financing design in which tax and donor funds are predominantly used to provide free access to essential health services at public and contracted non-state providers; 2) Public provision of health services to the majority of the population, 3) Subsidies and service level agreements with CHAM in geographical areas without a public facility. Major threats to sustained high performance in this indicator include limited growth of GDP per capita, rising costs of medical care, limited investment in the social protection sector, and limited coverage of Service Level Agreements (SLAs) with non-state providers of healthcare in areas without public health facilities.

2.2.3 Systems for Client feedback

Ensuring satisfied clients is one of the ultimate goals of service delivery. Until 2019, tracking of client satisfaction rates remained sporadic. From 2019 on, the MOH has pioneered the routinization of client satisfaction surveys across health facilities in the country. According to the Ombudsman data on overall client satisfaction, of the 3,987 users interviewed in 2020, approximately 83% indicated being satisfied with the services they received from their providers. In 2022, the percentage of clients satisfied with services increased to approximately 90%. The 2019 Harmonised Health Facility Assessment showed that client satisfaction²⁹ on treatment from health facility staff was 80%, on availability of staff was 81%, and on availability of medicines was 74%. Current limitations with tracking client satisfaction include: 1) lack of harmonization between routine data collection and periodic

²⁸ MoH (2022) Malawi National Health Accounts for Fiscal Year 2018/19. Lilongwe, Malawi: Ministry of Health, Department of Planning and Policy Development

²⁹ The client satisfaction score in HSSP II was aggregated; the figure was 85 percent. However, in surveys

conducted by ombudsmen, several additional dimensions have been introduced; we have indicated only a few of them.

national surveys; and 2) incomplete and under-reporting of data.

2.3 Health Service Delivery

2.3.1 Progress of Service Delivery

The HSSP II objective for health service delivery was “to increase equitable access to and improve quality of health care services.” This was to be achieved through the provision of free EHP at all levels of care. The interventions included in the revised EHP were as follows: Reproductive, Maternal, Neonatal and Child Health (RMNCH), vaccine preventable diseases, malaria, Integrated Management of Childhood Illnesses (IMCI), community health, neglected tropical diseases (NTDs), HIV/AIDS, nutrition, tuberculosis (TB), non-communicable diseases (NCDs) and oral health. Overall, Malawi’s UHC coverage has improved over the years (Figure 4a), and when compared against other Low-Income Countries, shows great performance (Figure 4b), pointing towards a very strong health

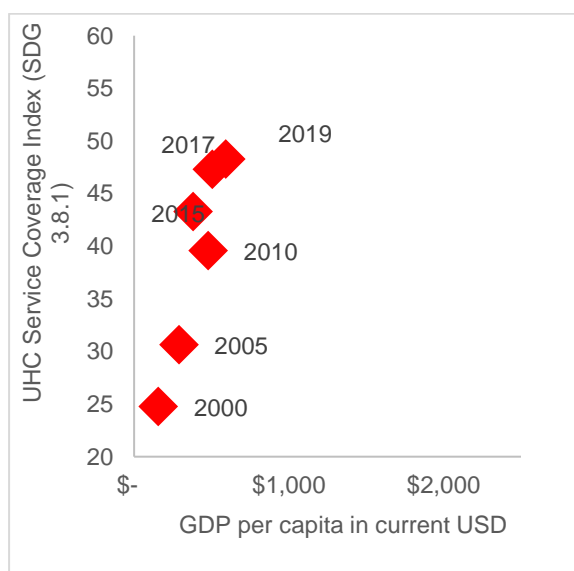
progress in service delivery was recorded across EHP programme areas as follows.

2.3.1.1 Reproductive, Maternal, Newborn, Child Health (RMNCH) services

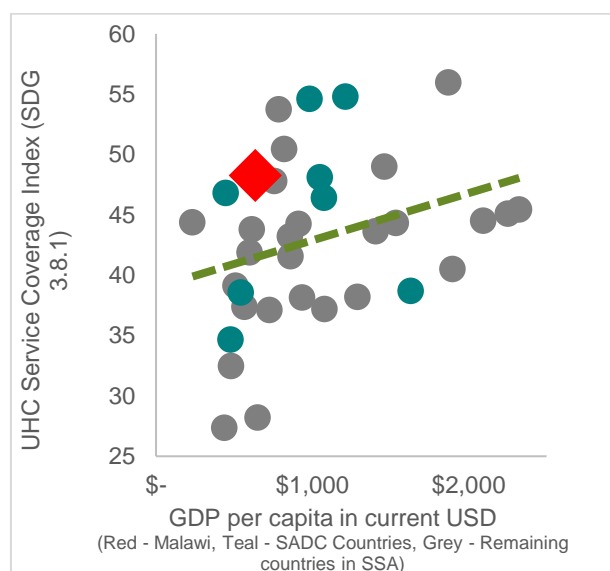
Adolescents constitute 24% of the total population and require a wide range of Sexual Reproductive Health Rights (SRHR) services such as treatment for unwanted pregnancies and sexually transmitted infections (STIs) including HIV (WHO, 2018). Approximately, 30.8% of adolescent females begin childbearing with a high number of complications. Complications from pregnancy and childbirth are among the leading causes of death among girls aged 15-19 years old, constituting 20% of maternal mortality in Malawi, with 14% of pregnancies in this age group ending in abortion (MOH, 2020)³⁰. Furthermore, neonates born to very young mothers are at greater risk of morbidity and mortality. A recent health facility assessment showed that Youth Friendly Health Services

Figure 4: Malawi’s Overall progress on Universal Health Coverage

Trends in Malawi’s UHC Coverage



Malawi’s UHC Coverage Compared with LMICs



Source: WHO and World Bank Data for Countries with annual per capital GDP not exceeding USD2500. Excludes countries with GDP per capita over \$2,500, small island countries, and Somalia as well as Eritrea (both due to missing data).

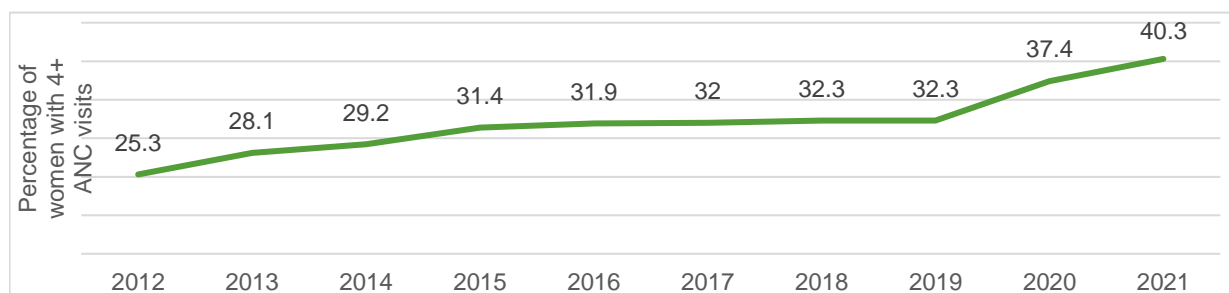
system organizationally. While the HSSP III period is not yet complete, the first two years point towards encouraging progress. The

(YFHS) remain under-utilized across a range of services likely due to poor service provision. For example, Intrauterine Contraceptive Device (IUCD) was only provided to 19% of youth with

³⁰ This is according to data presented in the report by the MoH on the Mid-term review of the HSSP II conducted

in 2020, presenting data most of which were up to the year 2019.

Figure 5: Trends in antenatal coverage (percentage of women that had 4+ ANC visits)



only 55% of adolescents receiving family planning services.³¹

The goal for RMNCH was to meet modern contraceptive prevalence rate (mCPR) of 60% by 2020 for all women of reproductive age.³² Significant progress has been made in increasing the mCPR in all women from 38.1% in 2012 to 48.3% in 2019 with married women at 78.4% and many adolescents continuing to lack access to contraception³³. Directly linked to achievements on mCPR are trends in the Total Fertility Rate (TFR). At the beginning of the implementation of the HSSP II, TFR was at 4.4 (NSO, 2017) and by 2018 it slightly dropped to 4.2 according to the 2018 Malawi Population and Housing Census (MPHC) (NSO, 2020).

At the start of HSSP II in 2017, only 24% of the pregnant women had their first antenatal visit during their first trimester, however, by 2019 it had increased to 27.6%.³⁴ The proportion of women completing at least four visits or more during the years between 2017 and 2021 has increased by 8.3 percentage points (Figure 5)³⁵.

To improve the delivery of interventions on maternal and neonatal health, the MOH is scaling up the delivery of comprehensive emergency obstetric and neonatal care (CEmONC) and basic emergency obstetric and new-born care (BEmONC) services to decrease maternal and neonatal complications and mortality. The proportion of institutional deliveries in 2021 was 96% which has returned

to the pre-COVID-19 pandemic baseline of >90% from 2017 to 2019 (DHIS2). Despite a high institutional delivery rate, the neonatal mortality rate has not declined, with most deaths occurring intrapartum or immediately postpartum. Improvements are needed in early neonatal care and immediate postnatal care including additional staff, infrastructure, equipment, and systems for high quality care.

The Integrated Management of Childhood Illnesses (IMCI) approach was utilized/implemented at health facilities to improve quality of care for new-borns and children. In the Demographic Health Survey in 2015-2016³⁶, 57% of children with diarrhoea received oral rehydration and continued feeding and in the most recent Multiple Indicator Cluster Survey 2019-2020³⁷, 55.6% of

³¹ Harmonized Health Facility Assessment 2018-19 Report

³² Reproductive Health Directorate, Ministry of Health. The Malawi Family Planning Costed Implementation Plan, 2016–2020. Government of Malawi.

³³ FP2030 Core Indicator Summary Sheet: 2018-2019 Annual Progress Report. https://fp2030.org/sites/default/files/Data-Hub/2019CI/Malawi_2019_CI_Handout.pdf

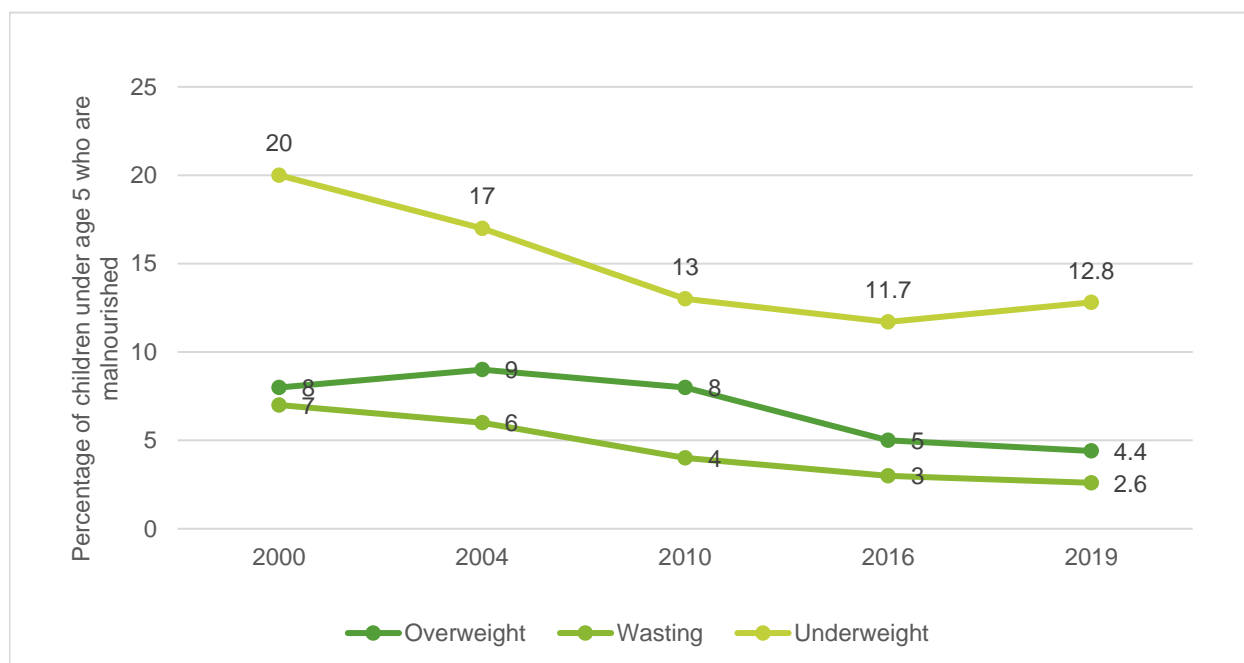
³⁴ NSO. (2021). Multiple Indicator Cluster Survey (MICS) 2019-20

³⁵ National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.

³⁶ National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.

³⁷ NSO. (2021). Multiple Indicator Cluster Survey (MICS) 2019-20

Figure 6: Trends in prevalence of overweight, wasting and underweight in children



Source: MDHS 2016, MICS 2020

children seeking care for acute respiratory infection received antibiotics.

The proportion of children who are fully vaccinated increased from 81% in 2017 to 89% in 2019³⁸ during HSSP II implementation (MTR 2021). Between 2017 and 2020 the Expanded Programme on Immunization (EPI) made a number of achievements including: (i) introduction of new vaccines namely Inactive Polio Vaccine (IPV) and Human Papillomavirus Vaccine (HPV); and (ii) switching from the Measles Conjugate Vaccine (MCV) to Measles Rubella Vaccine as recommended by WHO; and the introduction of malaria vaccine for children under 5 years old in 11 pilot implementation districts.

2.3.1.2 Nutrition

On nutrition, in the last 30 years, Malawi has reduced stunting (low height-for-age) to 35.35% in children under 5 years in 2020 which is by 20.65% points lower than in 1992 (NSO, 1995³⁹, NSO, 2008⁴⁰, NSO and ICF Macro,

2011⁴¹, NSO and ICF, 2017⁴², NSO and UNICEF, 2021⁴³). Similarly, the prevalence of wasting (low weight-for-height) has decreased from 3% in 2004 to 0.6% in 2019. Underweight status has decreased by almost half in the last 20 years from 26% in 2000 to 11.7% in 2020 (NSO and ICF, 2017, NSO and UNICEF, 2021). Key interventions for addressing malnutrition in children include growth monitoring and screening for malnutrition and prompt referral to malnutrition rehabilitation units for comprehensive care. Further, the Ministry strengthened community involvement through revamping care groups in over 60% of villages across the country.

³⁸ EPI programme data 2016-2019.

³⁹ NSO. (1995). Multiple Indicator Cluster Survey (MICS) 1995

⁴⁰ NSO. (2008). Multiple Indicator Cluster Survey (MICS) 2006

⁴¹ National Statistical Office (NSO) [Malawi] and ICF. 2011. Malawi Demographic and Health Survey 2010.

Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.

⁴² National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.

⁴³ NSO. (2021). Multiple Indicator Cluster Survey (MICS) 2019-20

2.3.1.3 Communicable Disease

2.3.1.3.1 HIV/AIDS

There has been sustained progress in managing HIV/AIDS in Malawi. The overall burden of HIV/AIDS has decreased with declining prevalence and incidence of HIV among adults aged 15-49 from 9.1% and 3.42% in 2017 to 8.1% and 2.16% in 2020 respectively (Figure 7). Consequently, the country has made significant progress on the 95:95:95 targets with attaining the 90:90:90 targets after 2019 and currently at 93:97:93 as of 2021 (UNAIDS 2021).

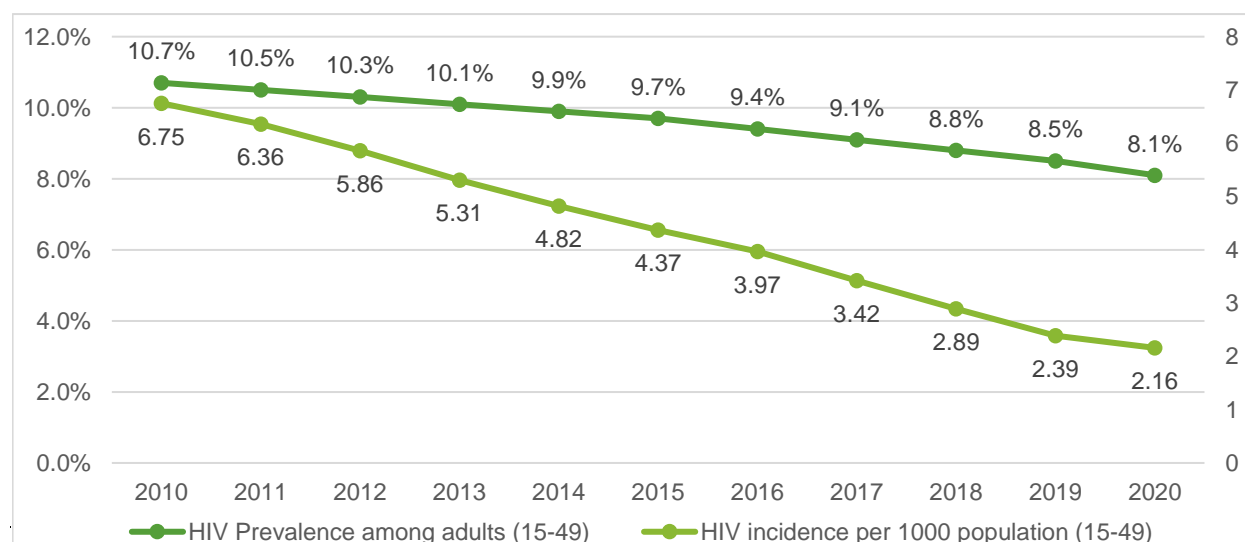
The HIV and AIDS national response plan has four main pillars, prevention, treatment and case management, impact mitigation, and program coordination. For prevention, the Department of HIV/AIDS (DHA) continued scaling up awareness and behavioural change campaigns targeting key populations, adolescent girls, and young women, youths, and traditional leaders. It also scaled-up the Voluntary Male Medical Circumcision (VMMC) and elimination of Mother to Child Transmission (e-MTCT) campaigns. For treatment and management, by 2019, 98% of pregnant women who tested HIV positive were initiated on antiretroviral therapy (ART) and by end of 2022, almost all populations were transitioned to the integrase inhibitor, dolutegravir for improved viral load suppression. To mitigate the adverse impacts of HIV, safety nets were

put in place, such as school bursaries for the affected children, social cash transfers and workplace HIV programs which provided monetary transfers to civil servants living with HIV. Programmatic coordination key successes included 1) the enactment of the HIV and AIDS Prevention and Management Act of 2018 which provided effective management and coordination of individuals with HIV 2) reform of the National AIDS Commission (NAC) from a public trust to a statutory cooperation improving the effectiveness, efficiency and relevant execution of this mandate and, 3) strengthening of the multi-sectoral and multi-disciplinary national, district, and community coordination structures resulting in an effective and sustainable response.

2.3.1.3.2 Tuberculosis

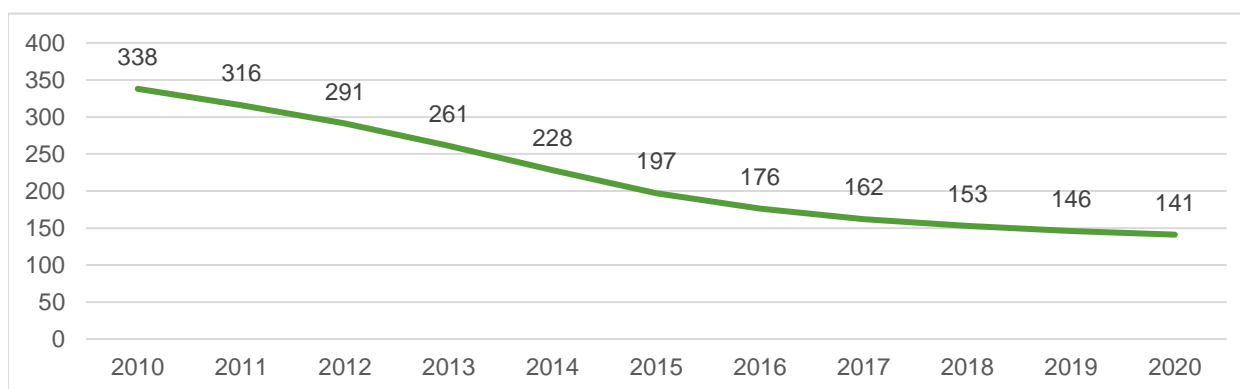
Tuberculosis incidence rate has declined from 162 per 100,000 population in 2017 to 141 per 100,000 population in 2020 (Figure 8). TB treatment success rate is reported at 86% (above the WHO target of 85%) with the TB death rate decreasing from 19% in 2005 to 8% in 2014. Despite this progress, with the COVID-19 pandemic there has been an overall decrease in service provision with a 3%-point drop in health facilities offering TB services and only 50% of facilities able to directly diagnose TB.⁴⁴

Figure 7: Trends in percentage HIV Prevalence among adults, 15-49 years of age and HIV incidence per 1000 population (15-49)



Source: UNAIDS 2020

Figure 8: Incidence of Tuberculosis per 100,000 population per year



Source: World Bank

On TB case management, the Ministry strengthened disease awareness campaigns through print materials and radio documentaries which proved vital especially with the disruption to outreach awareness campaigns during the COVID-19 pandemic. The awareness campaigns focused on promoting sanitation practices to prevent the spread of disease, addressing a risk factor of TB and multi-drug resistance TB. There was also an increase in Community Sputum Collection Points (CSCP) with 1603 collection points in 2020 across the country. This helped increase TB notification rates in the country. To improve patient management and notification rates, NTP has been implementing an E-health application for real time tracking of sample status and outcomes of diagnostic tests since 2017. By 2020, the system was functional in 33 sites including 7 mobile units.

2.3.1.3.3 Malaria

The key objective of the National Malaria Control Programme (NMCP) is to reduce the incidence of malaria by 50% with current incidence at 228.5 per 1,000 people at risk in 2021, which has increased from 205.9 per 1,000 people at risk in 2020.⁴⁵ Malaria requires a significant portion of health sector resources, with an estimated 6 million cases per year accounting for 30% of all outpatient visits and 34% of all hospitalizations (National Malaria Control Programme, 2019).

Mortality due to malaria has declined from 19.6 deaths per 100,000 population at the start of the HSSP II to 8.4 deaths per 100,000 population

in 2019, surpassing the HSSP II target of 12 deaths per 100,000 population in 2022. (National Malaria Control Programme, 2019). Key interventions to address malaria included:

- Piloting potential for a malaria vaccination program for children below 24 months of age in Karonga, Nkhata-Bay, Ntchisi, Mchinji, Lilongwe Rural, Balaka, Machinga, Mangochi, Phalombe, Chikwawa and Nsanje districts where over 80% of the targeted population have been reached.
- Sustaining provision of Intermittent Preventive Treatment (IPTp) services through which pregnant women receive three doses of SP and Long-Lasting Insecticidal Nets (LLINs).
- Implementing the Indoor Residual Spray (IRS) project in the malaria hotspots of Mangochi, Balaka, Nkhotakota and Nkhata-Bay districts.

2.3.1.4 International Health Regulations and Notifiable Infectious Diseases and other Public Health Events

2.3.1.4.1 COVID-19 Pandemic, its effects on the health system and interventions

The Malawi Government declared a state of national disaster due to COVID-19⁹ on 20th March 2020. As of 29 October 2022, the country had reported 88,073 confirmed COVID-19 cases, of which 2,683 has died with an overall case fatality ratio of 3.1%. To respond to

⁴⁵ World Bank Data <https://data.worldbank.org/>

the COVID-19 pandemic, the following key interventions were implemented with success. Surveillance, rapid response, and case investigation key activities included building the capacity of health care and other point of entry workers for case detection, specimen collection, contact tracing and reporting, and producing regular epidemiological reports. At all main points of entry in the country⁴⁶, personnel were trained to offer effective coronavirus and COVID-19 related port health services to arriving and departing travellers. Laboratory capacity for diagnosis of SARS-CoV-2 was enhanced, notably through 16 RT-PCR capable laboratories and 29 GeneXpert capable sites as of February 2022. The National Laboratory Network has since been capacitated for gene sequencing to detect SARS-CoV-2 variants prevalent in the country.

Case management has been a critical component of the COVID-19 response, especially as there were many cases during the initial phases of the pandemic with clinical disease that required specialized medical and nursing care. Units for care were established, and testing, treatment and care services were offered for free to all. In order to reduce mortality, quality of clinical treatment and care were enhanced through training and mentorship. Isolation units at central hospitals, and some district hospitals, were renovated and expanded to allow for more bed space in anticipation of further surges in cases.

COVID-19 vaccines were launched in March 2021 starting with high-risk populations such as front-line health care workers, social workers, individuals with comorbidities and elderly populations. Since January 2022, vaccination, and boosters, were extended to all aged 12 years and older. The national target is to achieve at least 70% vaccine coverage in the Malawi population by the end of 2022 at the latest. However, high levels of vaccine hesitancy have resulted in a low level of coverage since the launch. In February 2020, less than 10% of the population had been fully vaccinated.

Overall, these and other multi-sectoral interventions have been hugely successful. A Presidential Taskforce report⁴⁷ suggests that approximately 240,368 COVID-19 cases were averted by the preventive measures put in place during the first four waves as of 28 February 2022. The report also suggests that approximately 8,395 additional COVID-19 or COVID-19 related deaths were conceivably averted by preventive measures put in place across the four waves. Overall, the report shows that utilization of outpatient services did not show detectable negative impacts over the course of the first year of the Coronavirus pandemic, 2020/2021 (1,233 per 1,000 population), compared to the previous financial year, 2019/2020 (1,027 per 1000 population) suggesting that service utilization has resumed to pre-COVID -19 levels.

2.3.1.4.2 Other achievements in International Health Regulations and Notifiable Infectious Diseases

Malawi adopted the revised Integrated Disease Surveillance and Response (IDSR) strategy in 2022 to develop its national surveillance system in line with the International Health Regulation (IHR) requirements. IDSR monitors fifteen notifiable diseases through the Epidemiology Unit of the Public Health Institute of Malawi using the District Health Information System 2 (DHIS2) and ONE HEALTH Surveillance Platform (OHSP). An integrated approach is key with all notifiable diseases, as such, one platform would improve reporting and response.

For neglected tropical disease, Malawi achieved elimination of trachoma and lymphatic filariasis (LF) with significantly reduced onchocerciasis, which is close to elimination. There has been a reduction in schistosomiasis by an estimated 36% points and soil transmitted helminths (STH) by an estimated 20% points in the past decade.

2.3.1.5 Non-Communicable Diseases

Non-communicable diseases (NCDs) are the fastest growing cause of mortality and morbidity in Malawi with a growing share of the burden of

⁴⁶ Kamuzu International Airport in Lilongwe, Chileka Airport in Blantyre, Songwe in Karonga, Mbirima Border in Chitipa, Mwami Border in Mchinji, Biriwiri Border in Ntcheu, Dedza Border in Dedza, Mwanza Border in

Mwanza, Mlodza Border in Mulanje, Chiponde Border in Mangochi and Marka Border in Nsanje
⁴⁷ *Government Of Malawi (2022) The Coronavirus Pandemic in Malawi: Trailing the Waves*

disease.⁴⁸ As of 2018, NCDs are estimated to account for around a quarter of Disability-Adjusted Life Years (DALYs) (25.4%). NCDs are estimated to account for 32-40% of total deaths in Malawi, with 10% attributed to cardiovascular conditions, 10% to cancers, 2% to chronic respiratory diseases, 1% to diabetes, and 9% to other NCDs (WHO 2018).

More than 60% of NCD DALYs occur before the age of 40 and 62% are attributed to conditions not related to common behavioural and metabolic risk factors.⁴⁹ However, the health care system in Malawi is under-equipped to care for patients with NCDs. The Service Provision Assessment (SPA) 2013-2014 reported that less than 20% of facilities had equipment and medications required to treat NCDs, and less than 35% of staff were trained in care.⁵⁰

2.3.1.5.1 Cardiovascular Disease

Cardiovascular diseases include hypertension, stroke, ischemic heart disease, heart failure, rheumatic heart disease and more. These represent 15% of the total DALYs in Malawi.⁵¹ The estimate weighted age-standardized national hypertensive prevalence is 15.8%⁵², with a large proportion of patients uncontrolled.⁵³ Thus, there are increased complications of ischemic heart disease and stroke with the proportion of death due to these complications increasing between 2009 and 2019 with 23.1% of all deaths in Malawi due to

ischemic health disease and 21.4% due to stroke.⁵⁴

2.3.1.5.2 Diabetes

The contribution of diabetes has grown from 1.4% in 2010 to 2.21% in 2019.⁵⁵ An increase in overweight and obesity rates is a growing concern, as they are risk factors for type 2 diabetes. Malawi also has a persistently high proportion of patients with a low-body mass index with insulin dependent diabetes.⁵⁶ Screening and care provision remains low with only 4% of surveyed people reporting being screened and only 1.4% with elevated glucose on treatment.⁴⁶

2.3.1.5.3 Chronic Respiratory Disease

Chronic respiratory disease accounts for 5% of DALYs from NCDs in Malawi primarily stemming from asthma and chronic obstructive pulmonary disease.⁴⁶ A recent systematic review of literature demonstrated 10-12% of children in different settings exhibited wheezing and a high prevalence of abnormal spirometry.⁵⁷ Expanded training, recognition and available equipment and medications are needed for rapid diagnosis and treatment.

2.3.1.5.4 Cancer

Neoplasm represents the highest DALY burden for NCDs in Malawi at 16%. Oesophageal cancer is the highest DALY and cause of death, with non-Hodgkin's lymphoma and cervical cancer as the next largest contributors.⁵⁸ Recognition and screening are still low with just

⁴⁸ Malawi Ministry of Health. Malawi NCDI Poverty Commission. Malawi National NCDI Poverty Commission Report. 2018
<http://www.ncdipoverty.org/malawi-report>

⁴⁹ Malawi Ministry of Health. Malawi NCDI Poverty Commission. Malawi National NCDI Poverty Commission Report. 2018
<http://www.ncdipoverty.org/malawi-report>

⁵⁰ Malawi Ministry of Health. Service Provision Assessment (SPA). Lilongwe, Malawi

⁵¹ Global Burden of Disease, 2019.

⁵² Amberbir, A., Lin, S. H., Berman, J., Muula, A., Jacoby, D., Wroe, E., Maliwichi-Nyirenda, C., Mwapasa, V., Crampin, A., Makwero, M., Singogo, E., Phiri, S., Gordon, S., Tobe, S. W., Masiye, J., Newsome, B., Hosseinipour, M., Nyirenda, M. J., & van Oosterhout, J. J. (2019). Systematic Review of Hypertension and Diabetes Burden, Risk Factors, and Interventions for Prevention and Control in Malawi: The NCD BRITE Consortium. *Global heart, 14*(2), 109–118.
<https://doi.org/10.1016/j.gheart.2019.05.001>

⁵³ Hoffman, R. M., Chibwana, F., Kahn, D., Banda, B. A., Phiri, L., Chimombo, M., Kussen, C., Sigauke, H., Moses, A., van Oosterhout, J. J., Phiri, S., Currier, J. W., Currier, J. S., & Moucheraud, C. (2021). High Rates of

Uncontrolled Blood Pressure in Malawian Adults Living with HIV and Hypertension. *Global heart, 16*(1), 81.
<https://doi.org/10.5334/gh.1081>

⁵⁴ GBD 2019 Diseases and Injuries Collaborators. Global burden of 369 diseases and injuries in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019 [published correction appears in *Lancet*. 2020 Nov 14;396(10262):1562]. *Lancet*. 2020;396(10258):1204-1222. doi:10.1016/S0140-6736(20)30925-9

⁵⁵ Institute for Health Metrics and Evaluation

⁵⁶ Malawi National STEPwise Survey for Non-Communicable Diseases Risk Factors 2017 Report

⁵⁷ Nightingale R, Jary H, Meghji J, Rylance S, Masiye J, Chiumia H, Rylance J, Mortimer K, Lesosky M. Non-communicable respiratory disease in Malawi: a systematic review and meta-analysis. *Malawi Med J*. 2020 Jun;32(2):64-73. doi: 10.4314/mmj.v32i2.3. PMID: 35140842; PMCID: PMC8788589.

⁵⁸ Malawi Ministry of Health. Malawi NCDI Poverty Commission. Malawi National NCDI Poverty Commission Report. 2018
<http://www.ncdipoverty.org/malawi-report>

12% of women screened for cervical cancer and no screening for other types of cancer except Kaposi sarcoma in HIV clinics.

2.3.1.5.5 Neurological and Mental Health Disorders

Neurological disorders account for an estimated 4.5% of the NCD burden with migraines and epilepsy representing the highest contributions. Whereas first line treatment for epilepsy is found readily, safe, and effective long-term treatment is scarce in Malawi.

Mental health and substance use disorders account for 2.3% of total DALY burden in Malawi and 9.5% of NCD DALYs but have very little recognition and treatment due to staffing, knowledge, and lack of treatment. Major depressive disorder contributes to the highest DALY burden but has been found to rarely be diagnosed at primary health facilities.⁵⁹

2.3.1.5.6 Injuries and emergency response

Injuries represent 19% of all NCD burden of disease within Malawi with 12% of that burden from unintentional injuries and 4% from transport related injuries. Of unintentional injuries, falls are estimated to make up the largest burden of disease (2.1% of NCD DALY). Between 2009 and 2020, up to 10,733 accidents were reported at KCH alone, of these, 2531 resulted in admissions. Of the admissions, by mode of transport, 29%, 20%, 17%, 10%, 7%, 5%, 12% were due to pedestrian, bicycle, motorcycle, car, lorry, minibus, and other, respectively. A review of motorcycle accidents show that these have increased from 291 in 2017 to 1488 in 2020, but declined potentially due to travel restrictions, to 1268 in 2021⁶⁰.

In response to the increasing burden due to accidents and other emergencies, the MOH established the Emergency Response and Disaster Management Division to regulate and coordinate pre-hospital emergency medical services, hospital emergency services, and the management of health advisory call centre (Chipatala Cha Pa Phone). Under the Southern

Africa Trade and Facilitation Program, Trauma care centres were approved, and these will be used as emergency units in four districts of Dedza, Ntcheu, Balaka, and Neno while in Blantyre, this will involve renovations of the Accidents Emergency and Trauma Centre at QECH. Then completed, these will significantly reduce the mortality and morbidity due to accidents along the M1 road.

2.3.1.6 Antimicrobial Resistance

Antimicrobial resistance (AMR) is increasingly becoming a service deliver challenge. AMR occurs when microbes – bacteria, viruses, fungi, and parasites – evolve in ways that reduce medicine’s ability to fight them. Without effective medicines, the number of people with severe microbial infections will increase, as will the number of those who die from these infections. The main drivers of AMR include misuse and overuse of antimicrobials; lack of access to clean water and adequate sanitation for people and animals; poor infection preventions and control measures in healthcare facilities and farms; limited access to quality affordable medicines, vaccines, and diagnostics; and lack of awareness and knowledge about AMR. To address the AMR challenge, Malawi developed a national action plan (NAP) on AMR, the Antimicrobial Resistance Strategy 2017-2022 which adopts a One Health approach to AMR.

2.3.2 Progress in Quality Management

The evidence on service delivery shows that Malawi has increased access to health care services and yet the country is still experiencing poor outcomes in key indicators that are sensitive to quality of care. To address this, MOH institutionalized the Quality Management Directorate (QMD) to champion quality initiatives in the health sector. The Quality Management Policy (2016 to 2022) identified the following key priority areas, strengthening leadership governance and social accountability, improving clinical practice skills, and competencies, patient safety, people-centred care, research, monitoring and

⁵⁹ Udedi M. (2014). The prevalence of depression among patients and its detection by primary health care workers at Matawale Health Centre (Zomba). *Malawi medical*

journal: the journal of Medical Association of Malawi, 26(2), 34–3

⁶⁰ MOH (2022) Injuries Among motorcycle users – A policy brief prepared by Department of Planning, MOH

evaluation capacity. Below is the progress made during the implementation of HSSP II. To enhance leadership for quality management, tailored leadership and management manuals and trainings were created for central hospitals, District Health Management Teams (DHMT) and Health Facility Management Teams (HFMT). 150 DHMT members were trained across fifteen districts and 181 health facility in-charges were trained in 5 districts. On Health Facility Accreditation, implementation of safe care standards and Council for Health Service Accreditation of Southern Africa (COHSASA) standards was initiated with improved performance of health facilities implementing COHSASA standards after a year of implementation (See Figure 9).

The MOH developed national quality of care standards as a step towards international recognition. This will provide a unified performance measurement for health facilities on a rating scale of 1 to 5 stars. Based on adherence to these standards, the facilities with 5-star ratings will be designated as Centres of Excellence and will be used as a reference point in the rolling out of a countrywide programme covering public, private not-for-profit and private for-profit facilities. To improve quality of care, the MOH led harmonization of the quality improvement (QI) approach and in-service training by joining the MNCH QOC network with implementation in nine districts.

2.3.3 Bottlenecks in Health Service Delivery

The following challenges remain:

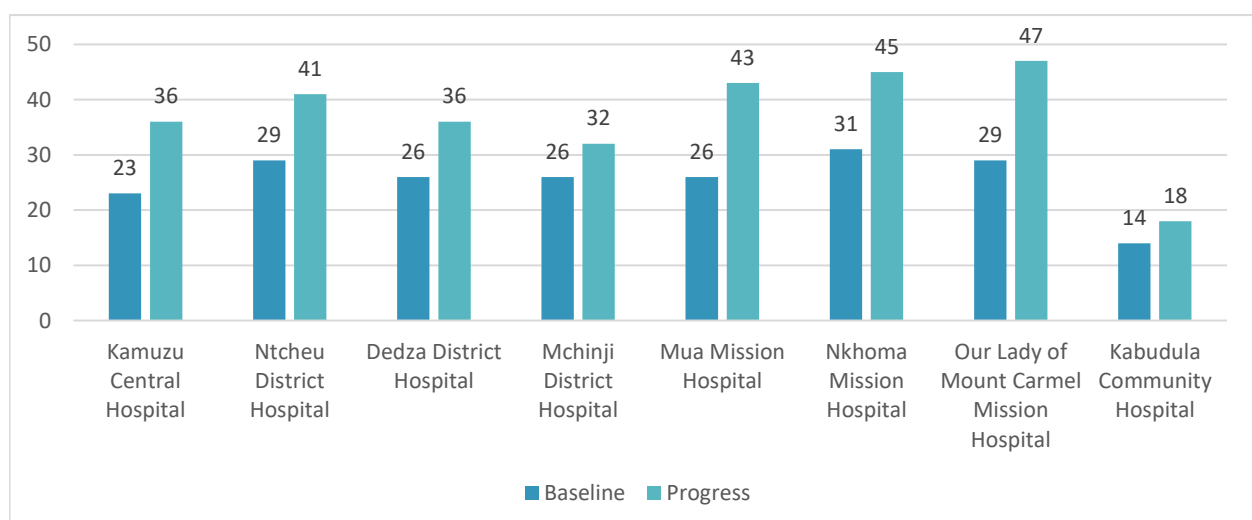
- Lack of well-defined integration and streamlining in primary, secondary and tertiary healthcare services.
- Lack of clear definition of what services belong at what level of care (i.e., primary, secondary, and tertiary).
- Lack of clearly defined interdisciplinary and multidisciplinary platforms for specialty and sub-specialty health service delivery.
- Weak referral systems across the levels of care.
- Lack of coordinated resources for health.
- Poor quality and lack of client safety in healthcare service delivery; and
- Weak client-centred and client trust in service delivery.

2.4 Social Determinants of Health

2.4.1 Achievements in Social determinants of Health

The Ministry of Health working in partnership with other ministries and stakeholders made some achievements in the implementation of the HSSP II. These hinged on policy frameworks, legal instruments, and service provision to provide oversight and direction to

Figure 9: Hospital performance in the implementation of COHSASA standards (in percent)



the implementation of interventions that aim to reduce the environmental and social risk factors to health.

The Ministry developed a number of policy documents that aim at harmonizing implementation arrangements by all stakeholders to avoid overlapping of mandates including the National Environmental Health Policy (2018), Household water treatment and storage policy (2017), National Food Safety and Hygiene (2021), National Health Care Waste Management Policy (2022), National Sanitation and Hygiene Strategy (2018), National Health Communication Strategy (2017), National Community Health Strategy (2017), National Water Policy (2021), Environmental Management policy (2017), National Road Map on Water Sanitation and Hygiene in health care facilities (2022).

The Ministry participated in the development and revision of legal instruments including, The Public Health Act of 1948 (now completed pending presentation to Parliament through Ministry of Justice and Constitutional Affairs) and Environmental Management Act (2017).

Using the above legal instruments and policy frameworks, the health sector implemented a variety of interventions. Sanitation and hygiene were promoted through participatory approaches. 53% of the total number of villages in Malawi attained Open Defecation Free (ODF) status, up from 3% in 2011. In addition, 44.7% of households have hand washing facilities, while 58% of the health care facilities meet the basic WASH services. Contributed to the in safe water supply coverage from 55% in 2016 to 67% in 2022. This resulted in reduced cases of diarrhoeal diseases including cholera. There was improvement in vector and vermin interventions leading to strengthened sustainable vector and vermin control measures i.e., indoor residual spraying (ISR) for Malaria control. General disease surveillance systems improved resulting in real time reporting of notifiable and emerging diseases such as COVID-19 and polio in both inland and entry points. In the core function of food safety and hygiene, the country managed to audit and inspect 56% of food premises from 30% in 2016. During the implementation of the HSSP II, there was improved delivery of port of

entry services because of the increased capacity in the domain.

2.4.2 Bottlenecks in Social Determinants of Health

The following challenges remain:

- High prevalence of preventable medical conditions.
- Weak financial capacity to access health.
- Weak education system to address health issues.
- Limited infrastructure and weak environmental conditions.
- Lack of inter-sectorial coordination in preventing and responding to violence, discrimination, accidents, and injuries.
- Food insecurity and poor nutrition services.
- Inhibitive societal institutions.
- Weak disaster risk management and climate change.
- Limited sectoral collaboration; and
- Weak port health.

2.5 Progress in the Implementation of Health Systems for Service Delivery

This section provides an overview of health system interventions that were implemented during the HSSP II period, organized by the thematic areas prioritized during the consultations for the HSSP III. These interventions are drawn from the program annual reports, Ministry of Health annual progress reports as well as the HSSP II MTR report. The bottlenecks encountered during the implementation of the programs are also highlighted under each thematic area.

2.5.1 Health Infrastructure and Medical Equipment

2.5.1.1 Achievements during HSSP II implementation

The Malawi National Health Policy seeks to reduce travel distance to the nearest health facility to within a 5km radius for every Malawian by 2030. The HSSP II target was to

have a health facility within 8km radius from households. To achieve this, the MOH continued with construction, rehabilitation and equipping of health facilities.

Key construction works during the period included construction of the Lilongwe neurosurgery by LIONS at KCH, completion of the 250 bed Phalombe District Hospital, construction of Domasi and Mponela Community Hospitals, and 8 new health centres of which 5 are operational. During the period, 25 health posts were constructed, and another 55 were under construction, in hard-to-reach areas. MOH also completed construction of radiotherapy and brachytherapy bunkers at the National Cancer Centre in Lilongwe. With regard to rehabilitation, 14 health centres in the northern region were rehabilitated, with new two-story maternity wing fully equipped at Mapale in Mzuzu. At QECH, 5 infectious disease wards and the Intensive Care Unit (ICU) were rehabilitated, thereby increasing the bed capacity from 6 to 16. Various district hospitals as well as other health centres were also rehabilitated during the period.

On medical equipment, industrial scale gas plants were procured for all central hospitals (except Zomba) and in district hospitals of Nkhatabay and Phalombe. At Mzuzu Central Hospital (MCH) the gas plant is not yet installed as it is being shipped. Three more plants are being procured and contracts have already been signed for Mangochi, Bwaila and Kasungu hospitals. These have improved therapy for patients in ICU, High Dependency Unit (HDU), and paediatric wards, especially for neonates born prematurely. In addition to lowering hospital costs, they have also significantly lowered costs for health centres as they are now able to refill their cylinders at their nearest central or district hospital.

To improve access to, efficiency and quality of digital radiography, MOH has embarked on a paradigm shift to migrate from analogue to digital radiography through the purchase of over 28 digital x-ray machines for all the central and district hospitals. At QECH, a state-of-the-art CT scanner capable of producing 128 slices in one rotation was procured and installed. A 16-slice CT scanner procured for MCH has reduced its expenditures on referrals to KCH.

For an efficient referral process, the Malawi health sector needed about 300 ambulances at the beginning of the HSSP II, against a stock of serviceable ambulances of only 124 in 2017/18. To address the gap, a total of 191 ambulances were procured between 2019 and 2022 using Government, World Bank and Global Fund funding.

To increase efficiency of laboratory sample and results transportation, essential and urgent drugs, blood products and other health commodities between hard-to-reach health centres and district hospitals, MOH with support from partners introduced medical drone technology in 8 districts of Nsanje, Chikwawa, Zomba, Mangochi, Balaka, Kasungu, Ntchisi and Salima. The drone technology is contributing tremendously to closing the gap on emergency deliveries of essential medicines and reduction of turn over time of lab samples and results from one week to just hours or two days at most.

2.5.1.2 Bottlenecks in Health Infrastructure and Medical Equipment

- Weak policies, guidelines and processes on acquisition, distribution, installation, maintenance, use and disposal of medical equipment.
- Inadequate budget for medical equipment.
- Frequent breakdowns and lack of quality assurance on the existing medical equipment with increased downtime of equipment in the facilities.
- Limited investment in technical support cadres with weak institutional capacity of health technical support services function.
- Under-decentralization of the health infrastructure and medical equipment budgets.
- Dilapidated and outdated infrastructure for medical equipment; and
- Insufficient medical equipment and health infrastructure management and capacity at all levels of service delivery.

2.5.2 Human Resources for Health

2.5.2.1 Achievements in Human Resources for Health

The HRH objective in the HSSP II was to improve availability, retention, performance, and motivation of health sector workers for effective, efficient and equitable health service delivery. The HRH interventions focused on improving the retention of health workers; improving recruitment, development, and performance management; enforcement of public service policies, regulations and procedures; improving quality and coordination of training; and strengthening HR planning process to incorporate evidence-based planning.

There has been significant progress towards improving the HRH situation. During the HSSP II period, to improve performance management and increase retention, government rolled out a performance management system, introduced performance contracts at senior HRH levels, and conducted annual salary reviews across the civil service. To continue the path towards decentralization, government also decentralized payroll management to district councils and restructured positions at district level, including introduction of the position of Director of Health and Social Services. To improve policy coordination, the MOH led the development and implementation of the HRH Strategic Plan, completed an approved functional review of central hospitals with many more functional reviews at the district level that are pending approval, and strengthened the Health Service Commission with new office space and increased funding. Lastly, to increase retention of health workers, the Ministry constructed new housing units especially in rural areas, supported in-service trainings and continuous professional development programs. The Ministry also provided allowances to healthcare workers for working outside of their contracted hours to meet the increased health workforce demand at the peak of COVID-19 pandemic.

On the production side, during the HSSP II period, output from across health training institutions production averaged 3000 per year. The result is a decrease in the overall vacancy rate of generalist cadres in public and CHAM

facilities that provide primary and secondary care, from 60% to 51%. Cadre-specific changes in vacancy rates are depicted in Figure 10 below – note that in addition to wide variances in vacancy rate by cadre, the vacancy rates by cadre displayed below are an aggregate nationwide. There is also wide variance within cadres, depending on the district and rural / urban / peri-urban status of the health facility.

While the decrease in vacancy rate is notable, and despite all the progress reported above at the policy and implementation level, the numbers are still lower than the projected need. For example, the population to health worker ratio which, in 2020, was at 2.85 health workers per 1,000 population against the WHO target of 4.45 per 1,000.

Between 2020 and 2022, in response to the COVID-19 pandemic, the Ministry of Health recruited 5,622 health workers of different cadres including 179 medical doctors, 325 nursing officers and 86 clinical officers and 233 laboratory personnel. However, the Ministry was unable to recruit key positions including senior anaesthetic clinical officers, oncology nurse specialists, Orthopaedic nurse specialists, theatre nursing officers, medical physicists, and nuclear medicine technologists for the Lilongwe Institute of Orthopaedic and Neurosurgery and Cancer Treatment Centre despite advertising the vacancies. Presumably from a lack of available and interested specialists in the national labour pool.

In pre-service training, key activities implemented included revision of training syllabi and curricula for certificate in midwifery, registered nursing and midwifery, clinical officer, and medical assistant levels. Introduction of the direct entry nursing degree programs in adult health, child health, mental health and psychiatric, community health and midwifery as well as accreditations of additional health training institutions were done during HSSP II implementation. Furthermore, joint monitoring and evaluation of nursing and midwifery training institutions, regional and national stakeholders' meetings (training colleges, teaching hospitals, professional associations, partners) were done to monitor and discuss issues affecting nursing and midwifery education as well possible solutions

to improve the quality of nursing and midwifery education.

Also, for in-service training, the Ministry facilitated upgrading of hundreds of healthcare workers, including nurse midwife technicians to registered nurses, nursing, and midwifery officers to nursing and midwifery specialists in reproductive health, maternal and child health and others; as well as Doctor of Philosophy in inter-professional development. Medical officers have also been upgraded to specialists in areas such as medical physics, radiation oncology, surgery, anaesthesia and accidents and emergencies. These efforts were on top of numerous other trainings that were undertaken at the district, facility, and community levels. These trainings have assisted health care professionals to have capacity skills to be able to manage programs at all levels of care.

2.5.2.2 Bottlenecks in Human Resources for Health

- High vacancy rates with poor absorption. This is partly due to challenges with aligning inter-ministerial and intersectoral partners on increasing financing of remuneration and benefits.
- Sub-optimal production at training institutions and lack of coordination between the institutions and government on matching supply and demand of pre-service training with health sector targets.
- Ineffective policy development and planning functions for human resources for health; ineffective and inequitable absorption, recruitment, selection, deployment, and distribution of HRH.
- Ineffective staff development strategies, policies, procedures, and practices including limited ability to appropriately promote workers who train in upgrade programs and return to the public health workforce.
- Ineffective performance management policies, procedures, and practices; limited incentives and capacity to retain the health workforce especially in rural and other hard-to-reach areas amidst high vacancy rates and resultant attrition rates to the private workforce and international workforce; and
- Limited digital innovations and use of existing technological platforms for HR management.

Figure 10. Vacancy Rates by Cadre, from 2017 to 2021, for Public Facilities and CHAM Facilities that Provide Primary Care and Secondary Care, as Compared to the Establishment

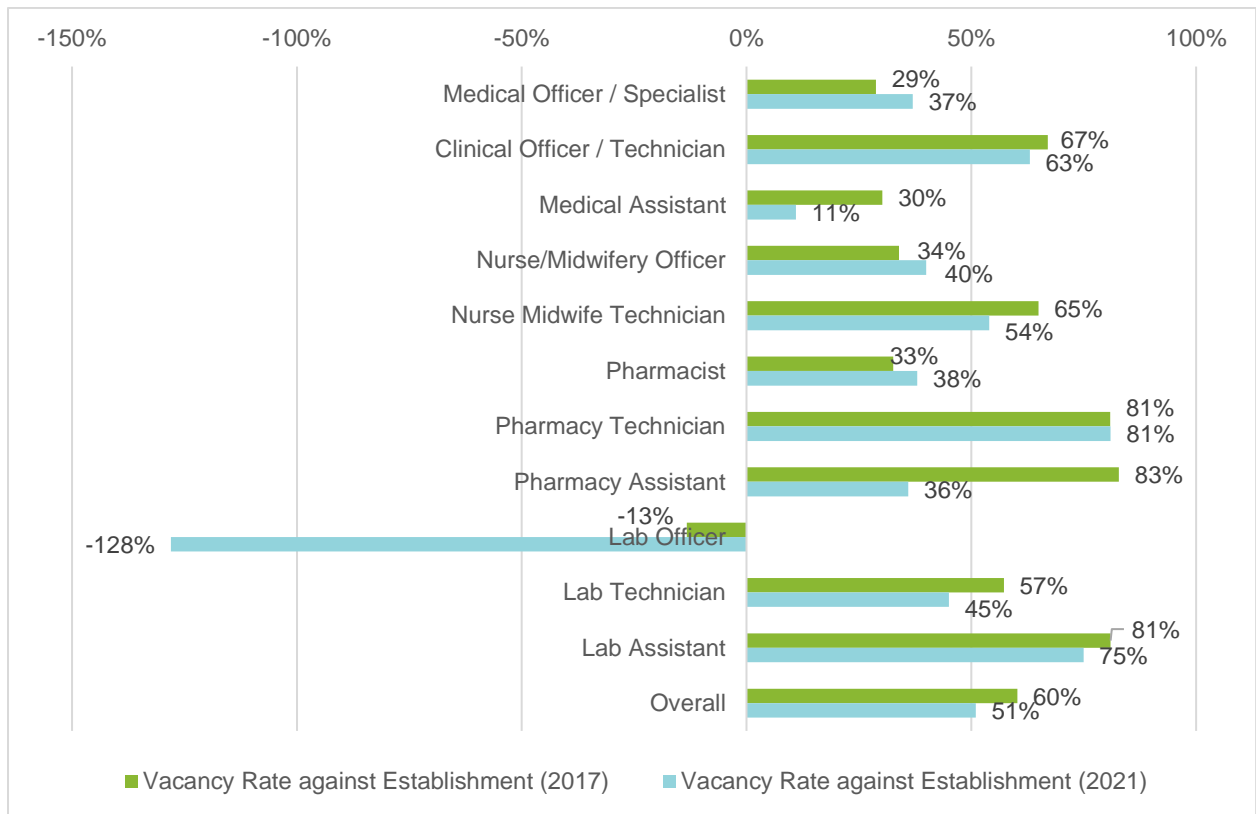
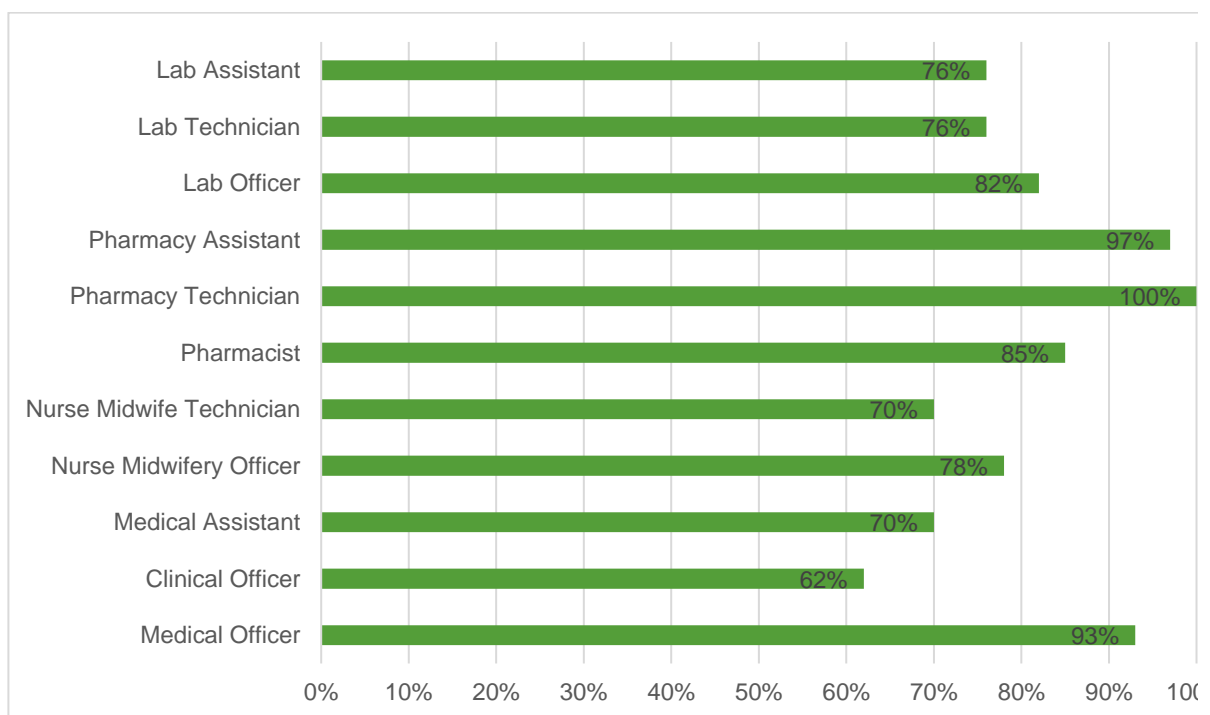


Figure 11: Absorption Rates for Licensed Graduates by Cadre, per Early 2020 Graduate Mapping Exercise



2.5.3 Medical Products and Technology

2.5.3.1 Achievements in Medical Products and Technology

To improve the overall coordination and functioning of the supply chain for medical products and technologies, the Ministry and stakeholders successfully reviewed the Malawi Standard Treatment Guidelines (MSTG) and essential medicines list which was awaiting approval from senior management. It also developed the Malawi Supply Chain Transformation Plan which will guide the supply chain integration agenda for the Ministry and address to a greater extent, existing bottlenecks in procurement, warehousing, transportation, storage at facility level, as well as support efficient medicine utilization at facility level.

During the period, the MOH continued to strengthen USAID supported Logistics Management Information System (OpenLMIS) and adopted the UNDP funded electronic Health Information Network (eHIN) in 2020 to facilitate real time End-to-End commodity tracking. The online OpenLMIS has improved ordering medicines from CMST as well as reporting of commodity usage by district hospitals and central hospitals. The eHIN on the other hand has improved tracking of the dispensing activities in the supply chain. These efforts are already addressing critical supply chain challenges of transparency, data visibility and accountability of health commodities in the supply chain

To enhance regulation of medicines and medical technologies, Government through the Poisons Medicines Regulatory Authority (PMRA) enacted the PMRA Act No. 9 of 2019. The PMRA was in the process of reviewing other related regulations in an effort to prevent conflicts hindering its regulatory role. A functional review of the PMRA had also already concluded in 2021 and was still awaiting Government approval. To enhance the visibility of its work, the PMRA implemented various initiatives including creating a website on the Medsafe 360 platform.

2.5.3.2 Challenges in Medical Products and Technology

- Shortage of essential medicines availability.
- Weak policy and regulatory framework for quality assurance of medicines and medical products.
- Sub-optimal decentralization of critical supply chain management functions.
- Weak short, medium, and long-term quantification, costing and budget execution for medicines and medical supplies.
- Inefficient procurement of health commodities.
- Inefficient warehousing and distribution of medicines and medical supplies.
- Sub-optimal distribution and use of medicines and medical technological services.
- Weak execution and monitoring of the medicines and medical supplies budget; and
- Inefficient and unsafe utilization of medicines and medical supplies at health facility level.

2.5.4 Digital Health

2.5.4.1 Achievements in Digital Health

MOH's digital health reform aims to enhance efficiency in health service delivery and precision in medicine. A major development in this area was the establishment of the Digital Health Division. Through the digital health strategy, this will provide digital health governance, coordination, and leadership in the country. During the period, digital health infrastructure substantially expanded, including the extension of the Government Wide Area Network (GWAN) from District Council offices to District Health offices and some other selected health facilities, as well as solar power backup systems to more than 100 facilities to support the use of digital health solutions. This will increase internet access to health facilities.

A milestone was the development and deployment of an Interoperability Architecture to support with interoperability of digital health systems. So far, software components under the interoperability architecture include Interoperability Layer, Master Health Facility

Registry, the Master Patient Index and Terminology Registry. The Interoperability Architecture is already currently facilitating the sharing of data between HMIS DHIS 2 and OpenLMIS (Drugs and Essential Medicines data platform), HMIS DHIS 2 and DHA MIS, HMIS DHIS 2 and Integrated Supportive Supervision System, among other systems.

During the period, MOH, through support various implementing partners and the Department of Computer Science at the University of Malawi is developing the integrated Community Health Information System (iCHIS), a digital system that combines software, hardware, people, and processes to support informed decision making and action taken by community health workers. This game-changing digital health intervention will also demonstrate the potential that exist when funder invest in in locally conceived and executed solutions in addressing local needs sustainably and cost-effectively.

Another milestone is the establishment of the Central Data Repository (CDR) for patient level data. The CDR working together with the Master Patient Index is a starting point for the Shared Health Record where a patient can move with their electronic health record from one health facility to another. On customization and deployment of electronic learning (eLearning) for Continuous Professional Development (CPD), the Ministry has made Reproductive Health and Digital Health modules available for online learning by healthcare workers.

2.5.4.2 Challenges in Digital Health

- Weak coordination of digital health investments in the health system.
- Lack of reliable Information and Communications Technology (ICT) infrastructure to enable utilization of digital health systems.
- Lack of capacity among communities and health workers to utilize digital health investments.
- Lack of continuity of care through shared health records; with ineffective alignment between monitoring and evaluation needs of health sector strategies and digital health solutions currently being deployed.

- Weak security of information and ICT systems; and
- Lack of interoperability among the country's digital health systems.

2.5.5 Health Research and M&E

2.5.5.1 Achievements in Health Research and M&E

Stronger monitoring and evaluation (M&E) are critical for providing the intelligence for evidence-based decision-making and performance monitoring. During the HSSP II implementation, the following interventions were implemented to strengthen health research and M&E. Over 250 statistical clerks were recruited and trained in data management, with particular focus on DHIS2. A mobile DHIS2 was introduced in 15 districts and MOH had secured over 2000 tablets as part of the roll out of the mobile DHIS2. In the area of health research, the Ministry through the Public Health Institute of Malawi strengthened the District Health Emergency Response Teams in all the districts in the country. The teams play acritical role on the response to COVID-19, cholera, and polio outbreak. The Ministry also collaborated with the Ministry of Agriculture on anthrax outbreak response in Balaka District.

2.5.5.2 Challenges in Health Research and M&E

- HMIS remains under-developed conceptually to support effective performance management.
- No effective system to track activity implementation and thus basis for assessing implementation progress limiting evaluation impact
- Extreme fragmented and vertical programming, thereby undermining a sector-led monitoring and evaluation platform.
- Poor data quality which is a barrier to effective use of evidence and decision making on service quality, availability, and continuity of healthcare; and
- Weak appetite by national and international funders to develop local capacities to conduct research (people, skills, funding) in part due to weak research-policy makers engagement mechanisms.

2.5.6 Leadership and Governance

2.5.6.1 Achievements in Leadership and Governance

On leadership and governance, the Ministry continued to use technical working groups (TWGs) as a platform for coordination and joint decision-making. TWGs, however, proliferated leading to duplication and poor coordination. The more than anticipated increase in the number of TWGs attributed to the multiplicity of donor. The vertical and horizontal feedback mechanism of the TWG system has mostly been weak; TWG reports have not fed into the HSWG and there has been only modest progress with decentralization. Functional reviews for districts were done for some districts, leading to more stability in district health leadership with minimal transfers and a district leadership training was rolled out in 15 out of the 29 district health offices. So far, over 200 health centre managers were trained in health management and there were 400 established hospital ombudsmen to promote health workers' accountability to the community. The Ministry, however, did not have a devolution plan partly owing to an outdated national decentralization policy.

2.5.6.2 Challenges in Leadership and Governance

- Leadership capacities to plan, execute and evaluate policies and plans remain weak at all levels of the health sector, a problem compounded by proliferation of national strategic plans, from a total of 19 at the collapse of the Health Pool Fund in 2013/13 to 56 in 2019/20⁶¹.
- Agenda setting suboptimal and laborious, with inconsistencies in policy direction, ineffective policy engagement arrangements.
- Weak implementation, enforcement and monitoring of health sector policy, legal and regulatory frameworks at national and sub-national levels.

- Weak accountability mechanisms and performance management at service provider level, particularly due to ineffective decentralization and autonomy of health service providers; and
- Ineffective stakeholder oversight and coordination health sector stakeholders, their activities, and resources at all levels.

2.5.7 Health Financing

2.5.7.1 Achievements in Health financing

In 2018/19 fiscal year, per capita THE was US\$39.9, marginally increasing from 39.5 in 2017/1862. In addition to being stagnant for the past decade, this is far below the WHO recommended US\$86 per capita expenditure on health for optimal implementation of Universal Health Coverage⁶³. A simulation of per capita THE forecasts that by 2030 it will be approximately US\$50, suggesting sustained and serious fiscal space constraints over the HSSP III period. The 2018/19 NHA showed that 58% of THE was donor funding and 42% was from domestic sources. Critically, compared with the SADC regional average per capita spending of US\$240.9 in 2019, the 2018/19 NHA also shows that Malawi's health investment was the lowest in the Southern African Development Community (SADC) region. Against this background, the HSSP II target was to implement health financing interventions for increasing domestic health financing as well as ensuring efficient use of available funding.

On revenue mobilization, the MOH scaled up optional paying services in central hospitals and piloted paying wards in two district hospitals (Nkhata-Bay and Nkhotakota). Government also developed health sector specific guidelines for Public Private Partnerships to increase domestic financing through private sector participation. Also, the proportion of health insurance expenditure rose from 5.2% in 2017/18 to 9.8% in 2018/19 indicating the increasing importance of health insurance in

⁶¹ Ministry of Health. 2022. Resource Mapping Studies Rounds 5, 6, & 7. Department of Planning and Policy Development, Lilongwe 3

⁶² Ministry of Health. 2022. Malawi National Health Accounts Report For Fiscal Year 2018/19, Department of Planning and Policy Development, Lilongwe 3

⁶³ World Health Organization (WHO). 2015. *Raising Revenues for Health in Support of UHC: Strategic Issues for Policy Makers*. Geneva: World Health Organization.

financing healthcare over time in Malawi. The introduction of a medical insurance scheme for civil servants in 2021 is likely to enhance the role of private health insurance schemes. Overall, the domestic share of private health financing schemes to the THE marginally increased from 42% in 2017/18 to 45% in 2018/19.

In the recent 2018/19 NHA, the US\$39.9 came from 166 financing sources and was executed by 264 implementing partners. On a positive note, of the 166 financing sources, 10 organizations control 97% of the total health sector funding, providing an opportunity for greater aid effectiveness through coordination, such as effective joint planning, execution and M&E arrangements. Particularly with respect to enhancing efficiency at the service delivery level, results of Public Expenditure Reviews⁶⁴, health sector PFM assessments at national and subnational levels⁶⁵, and health budget process reviews⁶⁶ commissioned during the HSSP II period have underscored the need for:

- Strengthening the role of district management in PFM and re-engineering health community governance structures to provide effective PFM oversight across budget planning, execution, and evaluation;
- Enhancing autonomy of providers at health facility level by clarifying their functions vis-a-vis district management, recognizing health facilities as spending units, and instituting effective performance management measures to guarantee optimal access, quality, and efficiency of health care delivery;
- Making spending more flexible to allow managers to opportunistically respond and adjust to community needs;
- Unifying payment systems to encourage donors to align with government systems while ensuring

the new financial management information system is designed to cater to budget planning, execution and monitoring and evaluation needs at national, sub-national, and service provider levels; and

- Moving towards strategic purchasing by strengthening resource allocation frameworks and processes to allocate funds explicitly based on population, need, and the volume of services produced; and concurrently introducing effective provider payment mechanisms that increase effectiveness of resource allocation and PFM

Implementation of the above and other related recommendations was already underway. The Health Services Joint Fund (HSJF), a multi-donor fund pooling arrangement outside of the mainstream Government PFM system which was initiated towards the end of the HSSP I, was strengthened during the HSSP II period. Current Development Partners financing the health sector through the HSJF are the German Government through KfW, The Norwegian Government, and the United Kingdom. To access funding, implementing partners must demonstrate alignment to the HSSP II at the activity level – a key milestone towards the *One Plan, One Budget, and One M&E* agenda of the HSSP III. Notable achievements include implementing an organizational review, strengthening the joint Government, Donor and Implementing Agency oversight arrangement, enhanced fiduciary oversight, recruitment of full-time coordination staff, and initiating design and implementation of robust performance management systems for the Fund. As a result, this has seen increasing donor confidence, as evidenced by increased allocation to the HSJF, from US\$1.186 million in the 2015/16 Fiscal Year to US\$19.2 million in 2022. Additional donor financing coordination and alignment strengthening initiatives were also

⁶⁴ World Bank. 2020. *Malawi Public Expenditure Review 2020: Strengthening Expenditure for Human Capital*. World Bank, Washington, DC. © World Bank. <https://openknowledge.worldbank.org/handle/10986/35855> License: CC BY 3.0 IGO.

⁶⁵ World Bank. 2021. *Public Financial Management in the Health Sector in Malawi: Opportunities to Strengthen Service Delivery at the Local Level*. Health, Nutrition and Population Policy Brief. World Bank, Washington, DC. ©

World Bank. <https://openknowledge.worldbank.org/handle/10986/35865> License: CC BY 3.0 IGO.

⁶⁶ UNICEF Malawi. 2021. *Immunization and Nutrition Supplies Budget Process Mapping*. Available <https://www.unicef.org/esa/documents/unicef-malawi-immunization-and-nutrition-supplies-budget-process-mapping>

introduced during the HSSP II period. In 2022, through support from the Umoyo Wathu, a joint UN funded project by the FCDO programme, the MOH initiated implementation of direct facility financing (DFF) through which donor funds will be channelled directly to health facilities. In preparation for eventual transfer of funds to facilities, a pilot is being implemented in Rumphi where the District Council, the District Health Management Team, and Health Facility Management Committees are being trained on how to manage funds and oversee service provision. Concurrently an evaluation is being designed to be executed alongside the DFF implementation and will inform decisions on optimal designs for DFF scale-up. The work is being led by a multi-stakeholder DFF project implementation committee comprising MOH, Health Donor Group, Ministry of Finance, District Councils, National Local Government Finance Committee, and Ministry of Local Government and Rural Development.

A similar programme is being implemented under the US funded Government to Government (G2G) arrangement in which US funds are channelled directly to district councils in beneficiary districts. At the time of this report, the G2G pilot was underway in Zomba and Mangochi districts. Under the U.S. funded G2G, the U.S. has provided 5.3 million U.S. Dollars to the Ministry of Finance (MoF) to pay for 155 health, social welfare, and support staff in Zomba and Mangochi Districts. It has also provided US\$2.1 million and US\$3.04 million to the Zomba and Mangochi District Councils respectively to strengthen health systems that are vital to improving outcomes in MCH, nutrition, and HIV. The G2G approach is a milestone in that Government of Malawi systems are used, thereby building institutional capacity to promote self-reliance and long-term sustainability.

To better coordinate the health financing function, in 2021, Government created the Health Financing Division within the Department of Planning and Policy Development in the MOH. The Division has already facilitated the development of a national health financing strategy which will operationalize the financing strategies outlined in Chapter 5: of this HSSP III. Concurrently,

through the UK funded Thanzi la Onse project, Government facilitated the establishment of the Health Economics and Policy Unit at the Kamuzu University of Health Sciences. Sustained through an FCDO grant via the HSJF, this unit will increase the production and uptake of relevant and policy-oriented research and analysis, as well as local capacity building in health policy, planning, financing, and economics.

2.5.7.2 Challenges in Health Financing

- Weak capacity to mobilize adequate, sustainable, and predictable funds for the health sector to optimally deliver essential health services;
- Substantial inefficiency and inequity in pooling and management of resources for the health sector;
- Underdeveloped strategic purchasing measures across the healthcare service delivery continuum; and
- Weak institutional arrangements and systems for effective health financing at all levels of the health system

2.6 Conclusion

Overall, while Malawi's health sector has seen sustained progress across health systems, service delivery impacts, and ultimate health impacts, serious gaps exist and must be addressed in order to meet Malawi's Universal Health Coverage aspirations. While health financing remains a serious bottleneck to navigate during the HSSP III, important bottlenecks were observed across all health systems building blocks, causing avoidable inefficiencies, limitations in access, and gaps in quality of care. Given the serious fiscal space challenges for health situation for Malawi, forecast to manifest throughout the HSSP III period, addressing health systems bottlenecks will require a "business unusual" approach. To carry out "business unusual" the health sector must focus on value-for-money-informed implementation, performance management, and speedy execution of catalytic reforms across all priority areas, anchoring all efforts on effective and decisive leadership across all levels of the health system. The next chapters provide a framework through which these will be addressed in the HSSP period up to 2030.



Photo: Health worker leads a session.

Chapter 3: The Vision of the Health Sector Strategic Plan III

3.1 Overview of Chapter

This chapter provides an overview of the overall vision, mission, goal, guiding principles and objectives for the HSSP III. The vision, mission and goal were derived from the National Health Policy, while the objectives were derived from the HSSP II with modifications to accommodate emerging areas of digital health and research. Each HSSP III objective is assigned a pillar, and then mapped into the WHO Building Blocks that are outlined in Chapter 5.

3.2 Vision, Mission, and Goal

3.2.1 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.*

3.2.2 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.*

3.2.3 Goal

The goal of the HSSP III is to *improve the health status of all Malawians and increase client satisfaction and financial risk protection towards attainment of Universal Health Coverage.* Progress towards this goal will be measured through long-term impact on health status, client satisfaction and financial risk protection; as well as intermediate impacts (i.e., service delivery) dimensions of access, quality and efficiency as presented in Chapter 8: and in the monitoring and evaluation matrix in Annex 2 on HSSP III M&E Matrix.

3.3 Guiding Principles

The guiding principles of the HSSP III are taken from HSSP II⁶⁷, Malawi 2063⁶⁸ as well as the HSSP III Development Inception Report⁶⁹. They demonstrate Government's commitment towards attaining equitable, accessible, affordable, and sustainable high-quality evidence-based health care. The following are the guiding principles for the HSSP III:

- i. *Solidarity*: In the HSSP III, the solidarity principle means “every individual contributes to financing of health services based on their ability to pay, regardless of income or social standing, and has the same access to the services provided by public or contracted providers”⁷⁰. This is in keeping with the *Umunthu*⁷¹, an underpinning principle of the Malawian society.
- ii. *Community Empowerment*: The HSSP III design is based on enabling communities to gain greater control of their health outcomes. This includes decision-making for service delivery and the health systems that affect access, as well as quality and efficiency of the services provided. This stance is rooted in the democratic principle of *power to the people* and decentralized governance to enable realization of this principle.
- iii. *Decentralization*: Health service provision and management shall be in line with the Local Government Act 1998, which entails devolving health service delivery at all levels to community health governance structures and alignment with Local Government structures.
- iv. *Transparency and Accountability*: The HSSP III design creates effective internal and external accountability institutions and measures at service provider level and eliminates risk of diffusion of responsibility. All other accountability measures must build upon strong community governance and oversight.
- v. *Human Rights-Based Approach and Equity*: The HSSP III 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.

- vi. *Gender Sensitivity*: Gender mainstreaming shall be central in the planning and implementation of all health policies and programmes.
- vii. *Ethics*: The ethical models that promote shared values, confidentiality, fairness, safety, and efficacy in both the provision of health care and health care research shall be adhered to.
- viii. *Client Centeredness*: Service provision will be considerate of the peoples' personal circumstances, preferences, values, family situations and lifestyles.
- ix. *Efficiency and Effectiveness*: All stakeholders shall be expected to use available resources for health efficiently and effectively to maximize health gains.
- x. *Integration of Health Service Delivery*: This will be promoted to leverage efficiency and effectiveness in addressing health needs of the people of Malawi.
- xi. *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.
- xii. *Value for Money*: Demonstration of value for money shall be a routine requirement for Government and Donor funded programmes and projects under the HSSP III.
- xiii. *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.

⁶⁷ MoH (2017). Malawi Health Sector Strategic Plan I (2017 – 2022)

⁶⁸ National Planning Commission (2020). Malawi 2063

⁶⁹ MOH. (2021). *HSSP III Development Inception Report*

⁷⁰ Saltman Israel Journal of Health Policy Research 2015, 4:5 <http://www.ijhpr.org/content/4/1/5>

⁷¹ Kayange, G.M. (2018). Conceptual Analysis of Ubuntu/Umunthu and Meaning. In: Meaning and Truth in African Philosophy. Philosophical Studies Series, vol 135. Springer, Cham. https://doi.org/10.1007/978-3-030-01962-4_8

3.4 Objectives

The objectives of the HSSP III focus on two main aspects: 1) strengthening health systems inputs for the delivery of integrated platforms of care with financing through an enhanced health service package-based Health Benefits Package and 2) confronting social determinants of health that put communities at risk for disease. The HSSP III objectives are therefore to:

1. Increase equitable access to and improve the quality of health care services.
2. Improve overall health, environmental health, and disease prevention through addressing social determinants of health and burden of disease.
3. Improve the availability, accessibility and quality of health infrastructure and medical equipment at all levels of health care.
4. Improve availability of competent and motivated human resources for health for quality health service delivery that is effective, efficient, and equitable.
5. Improve the availability, quality and rational utilization of medicines and related medical supplies, balancing the 3 P's: patients, products, and personnel.
6. Develop a sustainable and harmonized country-led digital health system that covers all areas of service provision and enables efficient delivery of health services at all levels of the health system.
7. Promote and coordinate a health research agenda in order to generate high-quality evidence required to inform the development of health and health care delivery.
8. Enhance the effectiveness of leadership and governance at all levels of health sector.
9. Set a well-governed health financing architecture that is able to mobilize adequate resources, distribute the resources in an efficient and equitable way, and strategically purchase services based on a well-defined benefit package in pursuit of UHC goals.



Photo: Health workers attend to a mother and child.

Chapter 4: Health Benefits Package for HSSP III

4.1 Introduction & Background

Sustainable Development Goal target 3.8 is to 'Achieve Universal Health Coverage (UHC), including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality, and affordable essential medicines and vaccines for all' by 2030.⁷² However, the resources available for health service delivery are limited especially in Low- and Middle-Income Countries (LMICs), so not all services can be provided free of charge in public facilities. Health Benefits Packages (HBPs) – sometimes called Essential Health Packages (EHPs) - are an increasingly common way of explicitly defining which health services are provided free of charge or at a reduced cost as the basis of UHC.⁷³ In past

HSSPs, Malawi has defined the EHP, but it is important to clarify that the EHP is not a care delivery platform for describing “essential services”. Rather, it is a prioritization mechanism to maximize population health. Therefore, in the HSSP III it will be referred to as the HBP.

Despite defining HBPs over the past 20 years, implementation of the HBPs at the service delivery level has been difficult. A district health expenditure tracking study estimated that about 20% of resources were spent on non-HBP related conditions (Mwase, Bowie, Kaluwa, & Chirwa, 2010).⁷⁴ It was recognised during HSSP III development that the current list based HBP design is incompatible with the current health system configuration, inhibiting its success. This incompatibility arose because 1) Malawi provides health services free at the

⁷² United Nations Economic and Social Council. Progress towards the sustainable development goals. New York 2017

http://www.un.org/ga/search/view_doc.asp?symbol=E/2017/66&Lang=E

⁷³ The World Bank. Universal Health Coverage Study Series (UNICO). 2017

<http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series> (accessed 7 May 2022).

⁷⁴ Mwase, T., Bowie, C., Kaluwa, S., and Chirwa, M. (2010). District Health Expenditure Pattern. Lilongwe, Malawi: Ministry of Health

point of service; as such health systems resources have already spent by the time a client is diagnosed as either requiring HBP or non-HBP services. 2) The reimbursement for health systems inputs such as the health workforce is not linked to HBP delivery. 3) For co-morbid patients, treating only HBP-related conditions can lead to sub-optimal benefit if HBP-related and non HBP-related conditions are dependent and 4) some interventions by their nature must be delivered as a package to provide full health benefit.

For the HSSP III, the list-based approach is maintained as a transitory measure for defining integrated platforms of care. The integrated platforms of care will be defined for each level of the health system, health systems inputs required to deliver holistic, and client focussed care within resource constraints. New health financing mechanisms defined in Chapter 5 will take effect that are compatible with the integrated care approach.

This chapter presents the current HSSP III HBP for 2023 – 2030 formulated through an evidence-based and highly participatory approach incorporating dimensions of equity, feasibility, and financial risk protection to maximize population health with limited funding resources. The results of this chapter informed a broader analysis of the bottlenecks undermining service delivery and therefore UHC. The interventions chapter and the budget prioritization process were heavily informed by the HBP design. While the HBP design also took into account systems constraints, including financing and human resources.

4.2 HBP Definition process

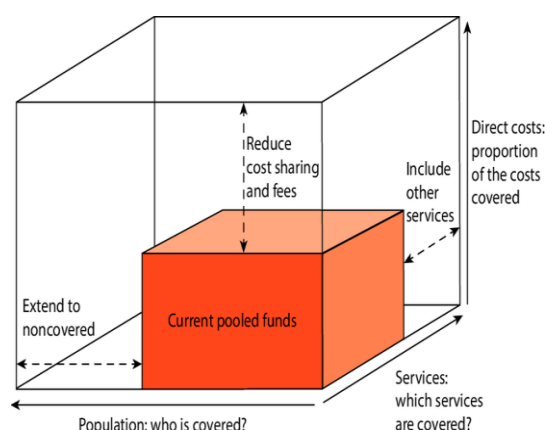
The development and prioritization of the HBP for the HSSP III was highly consultative with experts and health workers from all levels of the health system represented. Development of the primary and secondary HBP were done in consultation and collaboration with MOH programmes and departments, the Essential Health Package technical working group (EHP TWG), district health offices, central hospitals,

technical experts, Civil Society Organisations (CSOs), bilateral donors and implementing partners. All five tertiary hospitals were also visited.

4.2.1 Primary and Secondary Health Benefits Package

Primary and secondary HBP prioritized interventions were created through cost-effectiveness analysis (CEA) and multi-criteria decision analysis (MCDA). CEA assisted in prioritizing interventions that maximized population health within limited resources. MCDA was incorporated to i) develop a practicable and rigorous prioritization framework methodology based on a set of agreed upon criteria and ii) incorporate social and equity dimensions into decision-making⁷⁵. According to the UHC cube, there are trade-offs across the breadth of health services, population coverage, and proportion of costs that are covered (Figure 12)⁷⁶. Making sound choices requires a combination of technical judgements (e.g., CEA) and socio-political priorities. MCDA is a flexible decision framework for this.

Figure 12: UHC cost cube



A list of 305 potential interventions for the HBP at primary and secondary levels was compiled. A review of available literature for similar contexts identified cost-effectiveness data for 145 interventions. Medicines and medical supplies costs from Malawi, epidemiological

⁷⁵ What's in, what's out: designing benefits for universal health coverage / edited by Amanda Glassman, Ursula Giedion, and Peter C. Smith, (2017). <https://lccn.loc.gov/2017019856>

⁷⁶ Baltussen, R., Niessen, L. Priority setting of health interventions: the need for multi-criteria decision analysis. *Cost Eff Resour Alloc* 4, 14 (2006). <https://doi.org/10.1186/1478-7547-4-14>

data for the population in need, and demand constraints were utilized to estimate the total net health benefit of each intervention. Interventions with the greatest health-generating potential given estimated constraints were prioritized. Interventions were considered cost-effective if the estimated cost per DALY averted for an intervention was equal to or less than the cost-effectiveness threshold of \$65 per DALY averted.

Concurrently, a participatory MCDA process was conducted regardless of the availability of CEA data. Inclusion criteria for MCDA were severity of disease or potential disease, the effectiveness of the intervention, poverty reduction, vulnerable population, and level of care taken from the values and objectives of the HSSP III. The MCDA criteria were assigned weights. The proposed interventions for the HBP were scored against the inclusion criteria and a final weighted average was calculated.

Initial prioritization of the primary and secondary interventions was done using CEA results and validated by MCDA methods. Where CEA evidence was not available, only MCDA scores were used. After this, prioritization was iterative, adjusting coverage levels until the package was within the estimated resource envelope.

The final primary and secondary HBP includes 115 interventions (Annex 3: HBP data available

in digital edition on MOH website) with 71% having cost-effectiveness data that could avert over 31 million DALYs in 2023 with expected increases annually through 2030.

4.2.2 Tertiary Health Benefits Package

A tertiary HBP cannot be designed in the same way as the primary and secondary packages due to the complexity of tertiary care. In addition, tertiary care would rarely be cost-effective at the Malawi cost-effectiveness threshold of \$65 per DALY averted⁷⁷. The arguments against a list based HBP also apply more in the context of tertiary care. In addition, each tertiary hospital is unique and an HBP-specific HBP has to be defined for each tertiary hospital.

The definition of the hospital specific tertiary HBPs commenced with the collection of health systems inputs by specialty and central hospital to inform the development of tertiary platforms of care. The consultations focussed on current platforms of care, required inputs of staff, infrastructure, equipment, medicines, medical supplies, and envisioned future platforms of care. This process also generated interventions that were included in the HSSP III intervention matrix. The work to define tertiary platforms of care will be ongoing in the first years of the HSSP III.

⁷⁷ Woods, BS, Revill, P, Sculpher, MJ & Claxton, KP 2016, 'Country-level cost-effectiveness thresholds: initial

estimates and the need for further research' *Value in Health*, vol 19, no. 8, pp. 929–935.



Photo: A mother and child at a Health Facility.

Chapter 5: HSSP III Strategic Interventions

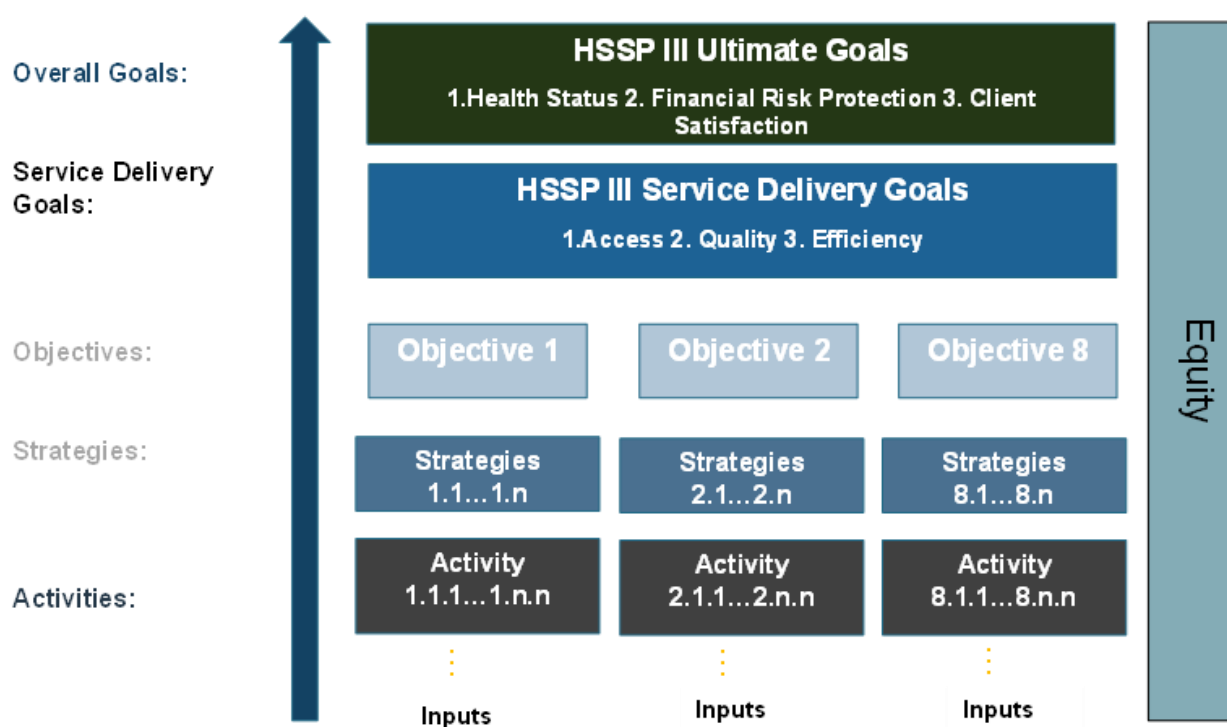
5.1 Overview of Chapter

The situation analysis chapter has demonstrated the progress and gaps in the health service delivery, which if well-funded and fully implemented can optimize the delivery of (Figure 13). Below shows the interventions logic underpinning the intervention matrix in Annex 1: Detailed annual intervention implementation Plan for HSSP III. The objectives and interventions are highly interrelated, and it is the optimization in each objective that is assumed to drive the service delivery and ultimate goals of the HSSP III.

This chapter presents the strategies under each objective (HSSP III Pillar) and, under each

the HBP package as prioritized by Government. These strategies are based on an analysis of the bottlenecks in delivery of HBP interventions prioritized analysis, informed by the situation analysis and a robust participatory process with stakeholders at all levels of the health system (strategy, the summary of activities to be implemented is presented in detail in Annex 1: Detailed annual intervention implementation Plan for HSSP III. Further details, below the activity level in the intervention logic (Figure 13), are contained in a costing matrix which has sub-activities, and associated costs. For programming based on the HSSP III, the costing matrix will be used to provide details on each activity.

Figure 13: HSSP III Interventions Logic



5.2 Strategic Interventions and Activities

Pillar 1: Service Delivery

The objective for this pillar is to “increase equitable access to and improve quality of health care services.” Changing health needs, ambitious health goals and public expectations are raising the bar for health systems to produce better health outcomes and greater social value. As access to health care improves, there is need for equitable distribution of health care measured on quality and competency that is centred on the client experience.⁷⁸ Quality of care will become an even larger driver as utilization of health systems increases and burden of disease shifts to more complex conditions that require knowledgeable and flexible workforce.

Strategy 1.1 Design systems to create integrated platforms of care for primary to tertiary level

Integrated, people-centred quality services cannot be organized around vertical disease

programs but require a comprehensive platform of care - from primary to tertiary care - that considers individuals’ needs holistically, placing the client and community at the centre of health services. The MOH will define platforms of care delivery in order to achieve this. A platform of care is defined as a configuration of health systems inputs and processes required to provide total care appropriately and cost-effectively at the different levels of the health care system e.g., primary, secondary and tertiary. At the tertiary level, this will include the establishment of centres of excellence in the areas where central hospitals have comparative advantage. This will include, but not be limited to ophthalmology, orthopaedics and neurosurgery, cardiology, and cardiothoracic surgery. Platforms of care will enhance coordination and increased efficiency and effectiveness to sustain high quality of care. A strategy on integrated service delivery will be developed guide implementation of pillar one.

Strategy 1.2 Promote quality and client safety in health care service

⁷⁸ Kruk ME, Gage AD, Arsenault C, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. *Lancet Glob Health*. 2018 Nov;6(11): e1196-e1252. doi: 10.1016/S2214-109X(18)30386-3.

delivery across the continuum of care from community to tertiary levels

Due to the focus on vertical disease programs, Malawi does not have a clearly defined harmonized standards of care with aligned corresponding inputs for each level of care. There have been efforts to identify standards of care through quality improvement on the path to accreditation but has not been unified throughout all aspects of care on a platform model. In this strategy through the development of unified standards of care for community, primary, secondary, and tertiary levels, we will emphasize a culture of quality and client safety through provider performance adhering to evidence-based standards with continuous improvement, enforcement of client safety mechanisms and decentralized performance-based financing mechanisms.

Strategy 1.3 Strengthen client-centered care and patient trust at all levels of the healthcare system

To improve access, health outcomes and confidence in the health care system, people-centred care must be at the centre of all intentions and work. This requires that there be promotion, empowerment and monitoring of client rights and trust but also the health care workforce from management to direct provision of care. Ensuring and enforcing service charters with client and community input is vital to meet the needs of communities, disease burden, and equitable access to high-quality, respectful care.

Reform 1: Integrated platforms of care

The reform will see transitioning from vertical programming to integrated platforms of care for service delivery. This will involve developing and implementing a strategic plan for integrated service delivery which will define and deliver integrated platforms of care and maximize synergies across programmes. This will significantly reduce planning, execution and evaluation inefficiencies that come with fragmented service delivery

Pillar 2: Social Determinants of Health

The objective of this pillar is “to improve overall health, environmental health and prevent disease through addressing social determinants of health and burden of disease.” Health is influenced by a multitude of non-medical and environmental factors. There is need for implementation of evidence-based effective preventative and environmental approach within the health care system to prevent disease, accident, and injury. This requires timely assessment and response to the growing burden of climate change effects, natural disaster, disease pandemics, and access to health and safe water and food. This work is multi-sectoral and inter-sectoral requiring collaboration amongst diverse areas and ministries including legal, medical, environmental, education, cultural, religion, policy, and politics. Strategies to improve overall health demand systems to be agile and adaptive to respond to people’s changing and diverse needs in a rapidly evolving environment.

Strategy 2.1 Drive wellness and healthy lifestyle practices in the community and health care system

Wellness is not just a physical convention but requires promotion of mental, preventative, and social community health including diet, physical exercise, and freedom to live without discrimination or stigma. To attain this goal, Malawi must integrate healthy practices through an inter-sectoral approach targeting special populations such as youth, vulnerable, and those living with chronic disease, not just within the health care system but in communities, workplaces, schools, religious and social organizations.

Strategy 2.2 Increase access to safe food, water sanitation and hygiene (WASH), housing and working environments

Significant disease burden is attributable to social determinants of health and requires improvements in educational attainment, housing, workspaces, piped water access, toilet, trade, and agricultural practices. It must include reducing illness and death due to hazardous chemicals and vectors of disease in

air, water and soil pollution and contamination. The Government in collaboration with partners and stakeholders in the water sector will implement interventions to improve access to sanitary facilities, and collaborate with players in the water, housing, and food sectors to implement interventions for increasing access to clean water, safe homes and workplaces, and ensure food safety.

Strategy 2.3 Strengthen occupational health

The Government and health sector will work to promote and maintain the highest degree of physical, mental, and social health in all workplaces. Working conditions and environment must be conducive to maximize safety and health of employees through effective managerial systems and personnel policies.

Strategy 2.4 Strengthen pandemic, disaster preparedness response and surveillance of eradicated diseases

Malawi has seen the severe effects of emerging pandemics (i.e., COVID-19, Monkeypox), re-emerging outbreaks (i.e., polio, cholera, typhoid) and disasters (i.e., Cyclones Ida, Ana and Gombe) in the past 5 years. These emergencies require a rapid, flexible, and multi-sectoral response with efficiently integrating inputs such as human resources with a background of continuous surveillance and preparation through sector wide health systems strengthening (HSS).

Strategy 2.5 Strengthen inter-sectoral prevention and response to violence, discrimination, accidents, and injury

Accidents and injury prevention and response have been proven to decrease mortality and morbidity through inter-sectoral programs that address road and community safety through preventative legislation, enforcement of laws and awareness and timely reaction and treatment. Violence and discrimination are often the result of power imbalances between people and groups, and is often seen due to disease, gender, wealth, religion, and politics. These power imbalances and injury and accident prevention must be addressed through sensitization, and intolerance of such

actions and community building. Additionally, prevention, treatment, and rehabilitation services for victims/survivors of violence and injuries must be strengthened.

Strategy 2.6 Address health and health delivery effects of climate change

Climate change effects are felt throughout the health system from changing transmission of disease to adding to food and water scarcity to affecting fragile health infrastructure. Significant collaborative research, evaluation, policy, and implementation processes are required to address climate change and environment including meteorology, environmental, education, agriculture, and infrastructure stakeholders and ministries. The health sector will contribute to improve monitoring systems and the capacity of healthcare providers to use data for priority setting at different levels.

Pillar 3: Infrastructure and Health Technologies

The objective of this pillar is “to improve the availability, accessibility and quality of health infrastructure and medical equipment at all levels of health care.” To effectively deliver high-quality health care, the health care system must have immediate access to adequate and functioning patient-centred infrastructure and medical equipment for diagnosis and treatment. In addition to filling the gap of these system inputs for platforms of care, development of measurement tools and efficient maintenance of infrastructure and equipment is critical. This objective will address infrastructure building block bottlenecks with an integrated capital investment plan providing the link between medical infrastructure, equipment, and human resources for health.

Strategy 3.1 Construct new health infrastructure to meet service delivery needs

The MOH will continue with construction of new health infrastructure to reduce travel distances including for referrals. This will include construction of new district hospitals in the cities of Lilongwe, Blantyre, Zomba, and Mzuzu to decongest central hospitals in these districts,

as well as new district hospitals in Rumphu, Dowa and Chikwawa to replace the current structures. Trauma management centres along the main M1 road will be established to manage road traffic injuries and prevent avoidable deaths. In line with the Capital Investment Plan prioritization, construction of new community hospitals, health centres, health posts, maternity units, laboratory and radiology units, specialized construction at central hospitals and staff houses will be prioritized.

Strategy 3.2 Rehabilitation, upgrading, maintenance and equipping of health infrastructure to meet service delivery needs

Based on the Capital Investment Plan, the activities under this strategy will include rehabilitating and maintaining health facilities with expanding existing health infrastructure to respond to increased demand. A focus will be ensuring maintenance of all facilities to maintain high-quality services. To reduce travel distances to referral facility, urban health and selected health centres will be upgraded to community hospitals, and health posts to health centres especially in hard-to-reach areas. All health facilities must be provided with access to reliable sources of power and water for functioning and expanding care delivery.

Strategy 3.3 Strengthen procurement, acquisition, distribution, and installation of equipment

Under this strategy, activities will aim to improve efficiency in the procurement, acquisition of infrastructure and medical equipment in line with the integrated standards of care per level, the Health Benefits Package, and the adjusted Standard Equipment Lists in line with standards. There is significant need to review procurement processes to ensure adequate user representation, streamline brands of medical equipment, minimize the number of service contracts, and optimize number and training for maintenance engineers and users for all equipment. Maximization of efficiency and timeliness of these activities are vital for timely care delivery and patient-centred care.

Strategy 3.4 Strengthen maintenance and use of equipment

Preventive maintenance is key to increasing the life and functionality of medical equipment to screen, diagnose and provide treatment for patients. In Malawi with the significant amount of donated equipment and lack of systematic equipment management and maintenance systems, there is a lack of maintenance of equipment leading to poor functioning and non-use. There must be improvement in these systems to deliver timely and excellent care with the understanding that maintenance is not just the actual planned work on medical equipment but also quality control measurement, ensuring functioning non-medical/administrative equipment to facilitate program management and ensuring RMUs have sufficient human resource capacity and equipment to perform their function.

Strategy 3.5 Strengthen transport and referral at all levels of healthcare delivery system

The re-engineering of platforms of care with the Health Benefits Package requires referral mechanisms to be redesigned and strengthened to ensure patients optimally reach the next level of care. Without efficient referral systems patients often cannot access lifesaving care and pay out of pocket for self-transport. Activities planned under this strategy include enhancing ambulance management and patient transport for effective and efficient services and, scaling up of the use of technologies for on-demand transportation, particularly drones. This will entail that all types of transport are readily available and increased community participation in the management of these important assets for effective referral. Digitalizing transport and referral processes at all levels of care will increase effectiveness and efficiency of the referral arrangements.

Strategy 3.6 Strengthen evidence-based management of infrastructure and medical equipment

The activities planned under this strategy include strengthening decentralization of infrastructure planning, and monitoring of implementation execution by district councils and community oversight entities. Coordination between the Directorate of Health Technical Support Services, the Directorate of Planning and Policy Development, and infrastructure

units at central hospital and district council level must be utilized to reduce diffusion of responsibility and duplication of investment. Guidelines on donation of infrastructure and medical equipment will be updated in line with integrated standards of care for platforms at primary, secondary and tertiary levels, and the Health Benefits Package. Investment decisions will be regularly informed by evidence from surveys and digital tracking tools on status of infrastructure and equipment functionality, as well as efficiency studies on medical equipment procurement and utilization.

Reform 2: Value for money in health technologies acquisition and utilization

This will involve developing and implementing real time equipment inventory management systems and ensuring systems for achieving efficiency and accountability in acquisition of health technologies, optimal distribution and efficient utilization of acquired technologies.

Reform 3: Efficiency of Gatekeeping for Centres of Excellence

This reform will involve upgrading of urban health centres to community hospitals, and community hospitals in the cities to full hospitals to deliver gate-keeping primary care and secondary care services, respectively. The goal will be to ensure these upgraded facilities deliver services at the level of or surpassing that currently delivered at central hospitals when clients in immediate catchment areas of central hospitals by-pass their nearest health facilities. By shifting primary care and the bulk of secondary care away from central hospitals, the reform will facilitate the establishment of centres of excellence as financial, human, and other health systems for central hospitals are refocused to improve on existing and potential capacity in tertiary services.

Pillar 4: Human Resources for Health

The objective for this pillar is “to improve the availability of competent and motivated human resources for health for quality health service delivery that is effective, efficient and equitable.” Delivering high-quality patient centred care, development, and sustainability of human resources for health is very critical in achieving universal health coverage. An examination of the disease burden, capacities required, and which cadres can perform which functions most efficiently and effectively is vital to provide the optimal platforms of care. To achieve this objective there is a critical need to link performance management of all cadres and levels within the health system with actualization of high-quality care. The underpinnings of performance management include national integrated strategic HRH plans, skill building, reinforcing capacities and talent management and competitive and fair compensation.

Strategy 4.1 Enhance recruitment, selection, deployment, and equitable distribution of human resources for health

HRH productivity in Malawi requires highly competent, motivated personnel and equally distributes human resources for health and high-quality care efficiently. Increasing production of the health workforce is one of the essential priorities in the health sector to deliver the primary, secondary and tertiary platforms of care. Employing best practices for staff recruitment and selection as well as decentralizing the recruitment to sub national levels is essential. This requires timely functional reviews aligned to standards of care, evidence on the demand for health services and burden of disease, cadres who can perform required services and quantification of need at each level of care including at the community level. Furthermore, rationalizing and ensuring equitable staff deployments as aligned to evidence on the demand for health services is vital.

Strategy 4.2 Optimize production at training institutions and strengthen coordination between the

institutions and health sector needs

It is imperative to ensure more effective and efficient use of resources with alignment to individual and community health needs. One example is pre-service production of prioritized training programs which are coordinated and meet quality standards that are in alignment with long-term HRH recruitment requirements from community to tertiary levels. This must be done through a holistic sector wide approach rather individual programs or strategic plans. The Ministry of Health in collaboration with Civil Service Commissions and employers must instil professional behaviour with regulatory bodies enforcing accreditation standards at training institutions and throughout the health sector.

Strategy 4.3 Improve staff development strategies, policies, procedures, and practices for human resources for health

Building capacity through staff development to improve human capital will increase productivity and performance. All newly recruited and redeployed health workers must be properly oriented to their role. Once placed, an intensified supervision/mentorship/coaching program must be instilled for cadres across all levels of care as linked to the CPD system, which in turn links to renewal of licensure. A harmonized CPD system must align to service delivery needs, and be inclusive of professional behaviour and client satisfaction, ensuring quality assurance and return on investment.

Strategy 4.4 Strengthen and enforce performance management policies, procedures, and practices

Within the health sector of Malawi there is vital need to motivate and build out passion in health care workers. Therefore, there is need to enforce performance contracting, performance appraisals and consequence management across the entire health sector with linking performance appraisals to job description and work plans. Policies need to be put in place to review existing supervision lines with enforcing monitoring regulation of health worker training and practice as well as supportive supervision

and mentorship. Optimizing the health workforce through a fair and formalized employment package requires clear roles and expectations, guidelines with coordinated career pathways for growth and promotion through talent management, and retention strategies.

Strategy 4.5 Institute and provide for competitive remuneration, benefits, and working conditions for human resources for health

Within this strategy, innovative and competitive remuneration and benefiting interventions will be developed. Incentives to motivate and retain health workers in hard-to-reach areas will be designed and working conditions will be improved to increase staff retention within the health system. This is critical to ensure staff are motivated to provide high quality care to the communities they serve.

Strategy 4.6 Generate reliable data and build capacity for evidence-based health workforce decision-making through digital innovations and technological platforms for human resource management

Building the capacity of HR practitioners to conduct evidence-based decision-making is vital in health sector, including use of enterprise resource planning (ERP) systems, tools, and technologies such as the Integrated Human Resource Information System (iHRIS). iHRIS and Human Resources Management Information System (HRMIS) systems must be integrated with expansion of digital infrastructure to enable implementation of iHRIS and ensure regular data validation of all HRH databases.

Reform 4: Performance for Results

This reform will focus on development and implementation of a robust performance management system that is linked to implementation of strategic and operational plans at the national/district/facility levels and all Ministry of Health employee promotions, incentives, and disciplinary systems.

Reform 5: Health Workforce Optimization

This reform will entail evaluating and re-engineering health worker cadres to reflect the changing pattern of the burden of disease and numbers of patients. It will involve phasing out some cadres based on evidence, re-orienting other existing cadres into new roles and introducing new ones, as necessary. This will entail rethinking of the cadres and competencies needed to deliver the defined platforms of care. This will also entail rationalizing pre-service and in-service training to ensure it supports the training requirements of this workforce optimization reform while fully recognizing other objectives of health training institutions that are under the education sector.

Reform 6: Integration of In-service Training

This will focus on developing and implementing an integrated in-service training curriculum that is linked to a coordinated Continuing Professional Development (CPD) system to generate efficiency savings and enhance performance. It will also ensure that health workers have requisite competencies to deliver comprehensive care.

Pillar 5: Medical Products and Technology

The objective of this pillar is “to improve the availability, quality, and rational utilization of medicines and related medical supplies, balancing among the 3 P’s: patients, products, and personnel”. Care delivery platforms at all levels of care will require availability and access to high-quality essential medications and medical supplies to provide adequate care to address the changing burden of disease. Reforms to address shortages of essential medicines required to deliver care with the prioritized Health Benefits Package are critical to address quality of care throughout the life course of the HSSP III. The already developed “Master Supply Chain Transformation Plan (MSCTP) 2021-2026” acts as a guiding document for strategies and activities outlined

in HSSP III and below which also consider the 13 domains in supply chain management, using the logistics cycle as a framework.

Strategy 5.1 Procure sufficient medicines and commodities to deliver health services both within and beyond the Health Benefits Package

As outlined under implementation arrangements of Health Benefits Package, HSSP III will aim to align the HBP with the integrated standards of care, with the MSTG to guide diagnosis and treatment to ensure that all HBP interventions can be delivered. During implementation, it will be necessary to align the funding need for medicines required to deliver the HBP with the resources available to ensure there are no stock outs within the package. In addition, procurement of commodities to deliver the primary, secondary, and tertiary services outside of the HBP is necessary to ensure UHC alignment.

Strategy 5.2 Enhance the quantification and forecasting processes by improving the quality of data inputs used and building the capacity of key stakeholders to collect and utilize the data

Quantification and forecasting are critical in planning for timely and sufficient availability of supplies at point of care. Quantification requires robust and periodically available service delivery and stock data to ensure all variables are well considered when predicting the need for commodities especially for products that have a high degree of known seasonality to improve availability during high-demand periods. In addition, interoperability of data collection and analysis systems need to be improved to ensure robustness of data for forecasting.

Strategy 5.3 Improve procurement practices to ensure best-value, flexible procurement

Inefficient procurement of health commodities along with associated policies pose a major challenge for cost-effective procurement with limited financial resources. While key performance indicators for the procurement process within the country may help to identify and resolve bottlenecks, a multi-year planning

for commodities informed by robust quantification both at the national and subnational level is required. The value of “Buy Malawi” needs to be strengthened along with increasing flexibility to CMST for procurement to reduce capital tie ups in contractual obligations.

Strategy 5.4 Improve warehousing and distribution infrastructure, practices, and processes to maintain product quality and shelf life

Plugging gaps in warehousing and supply chain infrastructure, practices, and processes is critical to ensure timely and adequate distribution of essential medicines at all levels of care. Financing for warehousing distribution of both essential medicines required to deliver HBP and those outside of HBP are needed to be planned on an ongoing basis to ensure a well-functioning supply chain. This would also require quantification, in adequate detail, the cost of warehouse and distribution from port-to-client and identifying areas of cost efficiencies. Policies and processes will be updated through revision of the SOP for warehousing, distribution, and reporting, as well as aligning pharmaceutical waste management guidelines per the updated standards of care to minimize wastage. Potential for new *technologies, such as drone transportation, will be evaluated, and where proven cost-effective and feasible, implemented to ensure efficient and reliable distribution of products.*

Strategy 5.5 Increase rational drug use and deter/prevent pilferage at all levels

Regular updates to standards of care and the HBP necessitate a need to review and update the dispensing guidelines to support and monitor the rational use of medicines (RUM) and medical supplies. Pilferage is a commonly cited challenge for medicines at all levels of care and needs to be addressed through revisiting and reinforcing the role of the Drug Theft Investigation Unit (DTIU), while also assessing the value lost due to pilferage. This would also mean strengthening stock management and record keeping practices at the point of care and packaging labelling to deter pilferage.

Strategy 5.6 Improve medicine quality through increased Quality Assurance (QA) capacity including testing, auditing, and licensing

Weak policy and regulatory framework for quality assurance of medicines and medical products need to be redressed through improved pharmacovigilance mechanisms, while also building capacity of PMRA to carry out appropriate quality control functions at all levels. In addition, initiatives aiming at improving Malawi Blood Transfusion Services (MBTS) practices to ensure blood safety in blood transfusion centres, and all other centres utilizing blood components is needed to resolve challenges related to poor blood practices. Further, diagnostic capacity will be expanded in line with the service delivery integration reform, the redefined platforms of care, re-engineered human resource capacity and other service delivery considerations of the HSSP III.

Strategy 5.7 Harmonize and expand implementation of information systems to improve end-to-end (e2e) visibility in the pharmaceutical supply chain

Improving accessibility of quality information for evidence-based decision making remains a key challenge in Malawi based on the situational analysis. Expanding and creating an enabling digital ecosystem at all health facilities will help in strengthening timely data reporting and robust data quality. This would include rolling out installations of OpenLMIS software and eHIN to all health facilities, identifying appropriate data collection tools while building capacity of health facilities in reporting data. Inter-operability is necessary to avoid duplication and parallel systems while building mechanisms to build cross linkages between CMST and district pharmacy managers and hospitals.

Strategy 5.8 Improve capacity to oversee, supervise, and coordinate across all supply chains and stakeholders.

Policy and oversight over medicines and medical supplies budget, and implementation arrangement is important to understand the bottlenecks and challenges faced in supply

chain as well as coordination between stakeholders at all points of care. Creation of a Logistics Management Unit (LMU) will be considered to coordinate among parallel supply chains, including vaccines, likely within HTSS, under the assumption that donors will continue to fund those systems. It is proposed to lobby for inclusion of CSO representatives on CMST board to enhance transparency and accountability during the awards of “public contracts”. Clarity on responsibilities among Ministries of Health, Ministry of Finance, NLGFC, CMST, and District Councils over the supply chain management functions of medicines and related health products is needed to ensure effective and efficient execution of responsibilities.

Strategy 5.9 Develop procedures and establishment of temporary mechanisms that adapt to predict, detect, and respond to emergencies

COVID-19 pandemic and other emergencies have disrupted supply chains across the world⁷⁹ while creating additional demand pressures on existing overburdened supply chains systems. Building resilience based on the lessons learnt from the pandemic through linking supply chain efforts with the Public Health Institute of Malawi, building local manufacturing capabilities, planning for surge capacity requirement, and adaptive transportation technologies could be key for the future. Revising and implementing the Emergency Supply Chain Playbook processes during emergencies would be considered.

Reform 7: Supply Chain Transformation

This reform will aim to identify and address inefficiencies at the procurement, warehousing, distribution, and utilization stages of the supply chain system for medicines and medical products. This will involve generating the relevant evidence, and implementing the prioritized interventions including 1) harmonizing and digitalizing quantification and tracking system for medicines and consumables to

achieve a data-driven ordering and supply chain at all levels of decision making; 2) integrating planning, coordination, management and monitoring and evaluation activities of the supply chain; and, 3) working towards greater systems integration through CMST by 2030

Pillar 6: Digital Health

The objective of this pillar is “to develop a sustainable and harmonized country led digital health system that covers all areas of service provision and enables efficient delivery of health services at all levels of the health system.” The HSSP III focuses on sustainable and holistic development of digital health as a means of contributing to the SDG 3 goal of Universal Health Coverage. A holistic and integrated approach to digital health development is consistent with the integrated platforms of care approach and people-centred focus in Chapter 8. Information generation is then a resultant, nevertheless an integral part of such a digital health system. This objective hence includes strategies on development of health information systems, building a data use culture and HSSP III monitoring and evaluation.

Strategy 6.1 Improve coordination of digital health investments to increase efficiency.

This will require strengthening of leadership and governance structures for management of digital health interventions and creating an enabling environment for effective implementation of digital health solutions. It will also entail assessing new digital health needs against the capabilities of existing core systems, such as the DHIS2, to avoid unnecessary duplication and waste of resources. If it is deemed that new digital health solutions are required, then they must pass the sustainability criterion.

Strategy 6.2 Establish a reliable ICT infrastructure that enables utilization of digital health systems

⁷⁹ Javid Moosavi, Amir M. Fathollahi-Fard, Maxim A. Dulebenets; 1-2, Supply chain disruption during the COVID-19 pandemic: Recognizing potential disruption

management strategies; International Journal of Disaster Risk Reduction; 2022, <https://doi.org/10.1016/j.ijdrr.2022.102983>

ICT infrastructure and energy development needs of health facilities and health sector establishments will be drawn from an integrated health sector capital investment plan (CIP). This CIP will also define requirements for ICT devices such as computers, tablets, printers, and mobile phones that are required at all levels of the health system.

Strategy 6.3 Build the capacity of clients, communities, health care workers, and IT personnel to participate in and benefit from digital health interventions

To attain the full benefit of digital health, it is critical to increase the capacity of the health workforce to utilize digital health interventions. This will be achieved through innovative and cost-effective knowledge sharing mechanisms that would include regular integrated supervision, on-job coaching, and mentorship. For clients and communities, awareness raising activities will be implemented to achieve acceptability and build their capacity and confidence in the use of digital health interventions.

Strategy 6.4 Leverage technology to increase access to and quality of service delivery

The HSSP III aims to use innovative digital health technologies to increase access and quality of health care. This will be done through increasing coverage of existing digital health solutions and leveraging the use of predictive analytics and big data. All these digital health interventions must, however, be aligned with the comprehensive digital health architecture and to the platforms of care within service delivery.

Strategy 6.5 Improve security of information and ICT systems

This will entail the development and deployment of standardized security management processes in order to promote acceptable use of data and related tools and ensure that digital health information and users are protected from threats of any kind, malwares, breach of privacy, and misuse of information. Ethics in digital health delivery will be strengthened to promote privacy and security of clients' data. The MOH will also conduct a risk analysis and enforce

implementation of disaster recovery standard operating procedures.

Strategy 6.6 Promote continuity of care through the shared health record

The MOH will lead efforts to ensure that longitudinal and cross-sectional patient health records are accessible at the point of service delivery. The key activity will be to implement a comprehensive and integrated, user centred and secure Electronic Health Record (EHR) system. In addition, the MOH will strengthen the identification of clients and staff across the health system.

Reform 8: Fully decentralized and digitalized HMIS for each Decision-Making Unit

This reform, leveraging on present and future investments in digital health, will aim to deliver fully decentralized yet optimally integrated, fit for purpose, HMISs at the community, health facility, district, central hospital, HSSP III objective, and national levels. This will be based on fast-tracked delivery of user-driven Electronic Health Record (EHR) and decision-making needs of decision-making units at national, health facility, districts, and community levels. Through deployment and interoperability, a shared EHR across levels of care will allow for patient-level data to inform progress, in real-time, of service delivery. With each facility treated as an entity that has common as well as unique decision-making and information. Combined with resource use and other data, each decision-making unit will then have a custom, but integrated HMIS as detailed in Chapter 8.

Pillar 7: Research

The objective for this pillar is “to promote and coordinate the conduct of health research in order to generate high quality evidence required to inform the development of health and health care delivery” Research and its evaluations will build the evidence base to choose standards and platforms to achieve a high functioning health system with ability to

make decisions for maximizing population health.

Strategy 7.1 To build health research capacity in public, private, research and academic institutions

Health research leadership, management and governance are critical to achieve this strategy. This will entail strengthening relevant research ethics committees (RECs), strengthening adherence to National Health Sciences Research Committee (NHSRC), Standard Operating Procedures (SOPs), enforcing ethical standards on the conduct of health research and developing legislation and policy on Intellectual Property rights.

Strategy 7.2 To achieve the development of evidence-based policies in health through intensification of knowledge generation, translation, and utilization of research

The HSSP III will strengthen coordination of health research knowledge generation, research knowledge translation and knowledge sharing. Knowledge generation should include analysis of routinely collected and survey data, compilation, and analysis of disease & events surveillance data to support detection of outbreaks and implementation of International Health Regulations (IHR). Research transparency and accessibility of evidence generated from clinical trials and implementation science should be strengthened through mechanisms such as an open research repository and translation from implementation.

Strategy 7.3 To ensure that portals for research funding are accessed and that there are adequate funds to finance health research in Malawi

The HSSP III will aim to build capacity to write health research grant proposals and market them to prospective funders. This will help make research self-sustaining and build research careers thereby positioning the health sector to provide local solutions to health care challenges. A key intervention to stimulating of this local capacity building will be deliberate efforts by Government to channel domestic and

external funds to priority health research institutions and local think-tanks.

Strategy 7.4 Strengthen the sharing and accessibility of data across systems to enable use.

The MOH will lead efforts to ensure that longitudinal and cross-sectional patient health records are accessible at the point of service delivery. The key activity will be to implement a comprehensive and integrated, user centred and secure Electronic Health Record (EHR) system. In addition, the MOH will enforce linkage of EHR, HMIS and the National Registration and Identification System (NRIS) primarily through requiring that every Malawian present their national ID or birth registration as a requirement to access publicly funded healthcare.

Strategy 7.5 Effectively monitor and evaluate HSSP III implementation

To effectively monitor the HSSP III, its performance indicators and logical framework must be integrated into health information systems. Then all stakeholders including private health facilities must align and adhere to the HSSP III reporting requirements. Parallel data validation processes by MOH departments and partners must be integrated, and routine data collection and reporting tools and systems must be rationalized and harmonized. Systems for generating impact data such as national civil registration, the generation of vital statistics and national health-related surveys must be strengthened and aligned to key HSSP III evaluation cycles.

Pillar 8: Leadership and Governance

The objective of this pillar is “to enhance effectiveness of leadership and governance at all levels of the health sector.” Leadership development and governance are at the centre of production of high-quality care and achievement of UHC in Malawi. Political and individual level commitment to change through supportive behavioural architecture following real-time data and health outcomes is required. Commitment to continuous learning and quest for highest quality health systems within the resources available. For leadership and governance to work there is need to reinforce

the compliance with policies, laws, and regulations, strengthen the role of coordination with the private sector and other key stakeholders in the health sector, and strengthen management of decentralized health systems by district leaders.

Strategy 8.1 Develop and implement a “One Plan, One Budget and One M&E” system in order to strengthen alignment and harmonization of donor and government funds towards health sector priorities

The integration and coordination of the “One Plan, One Budget, One M&E” system is critical to the success of the HSSP III, and incremental steps need to be made for efficiency, efficacy and improved health outcomes with institutionalizing accountability to citizens and users. Annual HSSP III Operational Plans must be prioritized to consolidate selected activities from Government and partners (from the national, central hospital, and district levels), and enforce alignment and harmonization of Government and donor funding annually in line with the principles of aid effectiveness and development cooperation. Health sector MOUs must be to align to the HSSP III with transparent tools for monitoring and evaluating adherence. Conducting Joint Annual Reviews, zonal reviews, and district reviews as an integrated system with a common set of integrated indicators (e.g., tracking progress on DIP implementation and the National Health Indicators Handbook) is vital to monitor annual HSSP III implementation.

Strategy 8.2 Strengthen policies, guidelines, and frameworks including at the multi-sectoral level

Regularly updating legal frameworks, roles and responsibilities regarding all health services and community health programs is crucial. Following updates, compliance to these must be reinforced amongst all stakeholders. It is necessary to ensure that other national sectoral plans that are closely linked to health, including education, agriculture, gender, and WASH integrate social determinants of health during planning and implementation. These plans at a policy level must be developed from implementation and incorporate community

engagement fostering through a holistic integrated approach.

Strategy 8.3 Enhance financial management to strengthen accountability of funds

Despite adverse macro-fiscal conditions, fiduciary concerns, and donors shifting funding toward vertical disease program, there has been significant improvements in health service delivery over the past two decades in Malawi. Government financial management processes require ex-ante commitment control, with all spending routed through the financial management information system checked for appropriations and available budget. To enhance the accountability and financial prudence there must be routine audits to strengthen accountability and transparency of Government funds and routine financial management activities including the processing of salaries.

Strategy 8.4 Improve governance, including stakeholder oversight, coordination, and implementation at all levels of the health service delivery system

The Ministry of Health provides the oversight leadership and coordination to ensure that the health sector achieves its stated goals and objectives through its programs and institutions. The local Government ensures that the coordination, accountability, implementation, and management of health activities at a decentralized level in order to improve service delivery and coverage of health services, improved quality, and cost effectiveness. To effectively work together there must be enhancement of sector-wide governance structures with strengthening of oversight communities from leadership to community levels.

Reform 9: “One Plan, One Budget and One M&E”

HSSP III will enforce implementation of “One Plan, One Budget and One M&E” at the national, tertiary and district levels in order to strengthen alignment and harmonization of donor and Government funds. Under this reform, health systems development will domicile into the HSSP III alone, with a

maximum of one sub-strategy per HSSP III pillar; Exceptions will require endorsement of the Health Sector Working Group. Consequently, all programme and technical department functions will be planned in an integrated manner through operational plans with joint prioritization of activities. Joint planning is critical for systems-wide resource allocation and integrated health care delivery.

Reform 10: Community-led PFM Oversight

This reform will re-orient community oversight by establishing effective principle-agent arrangements between communities as owners of the health system on the one hand, and providers at tertiary, secondary and primary healthcare levels. It will entail establishing robust evidence on scalable and sustainable cost-effective community oversight arrangements including the organizational and capacity building options to get the best possible health decentralization, fiscal and service delivery results.

Pillar 9: Health Financing

The objective of this pillar is “to set a well-governed health financing architecture that is able to mobilize adequate resources, distribute the resources in an efficient and equitable way, and strategically purchase services based on a well-defined benefit package in pursuit of UHC goals.” The first three strategies under this objective aim to improve the performance of each of the four health financing functions of revenue mobilization, risk pooling, resource allocation, and provider payment, while the fourth strategy will aim to build institutional capacity for the health financing function. The following activities will be implemented under each strategy.

Strategy 9.1 Mobilize adequate, sustainable, and predictable funds for the health sector to optimally deliver essential health services

For the health benefit package, at the very minimum, the WHO recommended investing up to USD86 per capita per year. Malawi’s total health expenditure has been stuck approximately USD40 per capita per year over the past decade. This means that significant efforts will be required to achieve the UHC goal of this strategy. Further, the evidence that Malawi has a far more superior UHC index compared to countries with the same level of health financing and outperforms a large number of countries with higher per capita national incomes suggests current organization of the health system remains overall efficient, although evidence suggests scope for more efficiency gains exists. The MOH will therefore undertake and fast-track implementation of revenue mobilization activities across domestic and donor pools, as well as efficiency reforms across all the pillars of this strategic plan.

To mobilize more domestic revenue for health, the MOH and stakeholders will enhance advocacy for increased and sustained Government allocations from approximately 10% currently to the Abuja target of 15% of total Government budget as a demonstration of Government’s commitment to UHC. Within the health sector, paying services will be optimally developed and scaled at all levels of the health systems to tap from health financing currently spent as out-of-pocket and private health insurance. Consequently, the MOH will facilitate development of optional paying services at tertiary, secondary and qualifying urban health centres, to allow providers to deliver services complementary to the HBP with additional personal or insurance-based payment. Additional revenue will come from imposing fees on food handler certification, provision of fumigation services, and contracting with employers to provide medical fitness certification.

Additionally, MOH will promote, regulate, and scale up community-based resource mobilization and management arrangements. This HSSP III aims to devolve some of the revenue mobilization responsibilities to the clients of the health system. There will be establishment of community health funds based on individual contributions and corporate contributions to a

community managed account. The specific form of these community funds will differentiate based on community specific socioeconomic profiling with complete community ownership of their local health funds. At the national level, the Direct Facility Financing scheme under the Health Services Joint Fund as well as all results-based financing scheme will be designed to catalyse community ownership of these locally mobilized resources.

For the HSSP III period, donor financing will remain a critical source of health financing in Malawi. Maintaining donor expenditures on health even at pre-COVID-19 levels will require significant institutional changes in the MOH, particularly moving towards a more proactive mobilization of international funds as well as commitment to efficiency through increasing disbursements rates, ensuring high utilization rates, and guaranteeing value for money. The major focus will be to develop the capacity of the district health system to manage donor funds, empowering communities to proactively provide oversight of health funds; and strengthening the evidence base locally for responsive health economics and financing assessments.

Also, private health insurance will be encouraged, 1) as a source of financing for optional cover for taxpayers who may opt out of public healthcare consumption leaving the limited tax and donor funding to cover those living in poverty; and 2) to provide additional health cost coverage for services not in the HBP. The MOH will strengthen the regulatory framework for private insurance, such through the development of relevant legislation, establish a health insurance regulatory body, and develop inspectorate capacity within this new body.

In the programming of the HSSP III, it is recognized that the domestic economy and international aid may not grow at the pace enough to generate the funds with which to break the USD86 per capita barrier by 2039. Consequently, using observed trends in health expenditure for the past two decades, a target of USD50 by 2030 remains the most feasible ambition. To mitigate against this serious fiscal space constraints, the MOH and stakeholders will fast track implementation of efficiency

enhancing reforms to create efficiency savings with which to expand access and quality of care. This will be achieved notably through the provider management reforms highlighted later in this chapter, and through efficiency enhancing reforms and systems strengthening initiatives across the pillars of this HSSP III. These provider level efficiency reforms will cover domestic and international sources of health financing.

Strategy 9.2 Improve efficiency and equity in pooling and management of resources for the health sector

In line with the decentralization policy, MOH will coordinate with MoF, NLGFC, Malawi Local Government Association and other relevant entities in capacitating district councils and central hospital boards to manage public funds meant for service delivery. The implication of this is that district councils and central hospital boards will be responsible for budgets on operations, staffing, medicines, and infrastructure development, rehabilitation, and replacement for primary health facilities. For donor funding, fund holding arrangements will be based on balancing the accountability needs of the funding source, and the *One plan, One budget and One M&E* reform outlined in the implementation arrangements chapter. The pooling arrangements for donor funds will aim to increase coordination of Government and donor financing to ensure focus on health HSSP III priorities through efficient coordination in planning and implementation. MOH will work with relevant Government entities to strengthen PFM so that in future most donor financing can be channelled directly to primary level.

The Health Services Joint Fund (HSJF), a multi-donor fund established in 2015 to provide a shared funding mechanism for Malawi's health sector donors, will be strengthened through increased management capacity, increasing the funding levels, and attracting more donors. Over the HSSP III period, the goal of the fund will be to catalyse direct district and central hospital budget support as well as direct budget transfers to service providers. Further enhancements will include increased joint planning, execution, and evaluation arrangements with top ten discrete funding pools including the Global Fund to Fight

Tuberculosis, HIV/AIDS, and Malaria; GAVI, the Vaccine Alliance; US Government agencies and the World Bank.

MOH will also support and provide a conducive environment for **Government-to-Government Financing Arrangements as efficient mechanisms for** transfers from a foreign Government agency to a Malawi Government entity, thereby cutting unnecessary administrative costs that diminish resources made available to providers. The resources will be planned, executed, and evaluated using the principles of a decentralized budget, where resources will be allocated to and executed at the level where implementation of the funded activities take place.

For partners not able to join the HSJF and who can implement the Government-to-Government arrangement, the principle of *One plan, One budget and One M&E Plan* shall apply. Donors will be required to provide funding to activities that are prioritized in the District Implementation Plan or the HSSP III. In all cases, for non-Government funds, MoUs and associated codes of conduct will be enforced to ensuring that partners that have not pooled their funding are aligned to the “One Plan, One Budget, One M&E” philosophy.

Strategy 9.3 Develop and implement strategic purchasing measures across the healthcare service delivery continuum

Interventions under this strategy will strengthen resource allocation arrangements at national, tertiary hospital, district council levels, to achieve allocative efficiency and equity in the distribution of healthcare financing, thereby achieving the health service delivery and ultimate goals of the HSSP III. At the health sector level, resource allocation processes will apply to Government and donor funds. For Government health budget, MOH will agree with Treasury to reach the 15% Abuja target by 2026⁸⁰. For donor budgets, the MOU with each donor shall establish aggregate forecasting commitments, including any earmarking, in the next three years through the resource mapping process.

⁸⁰ United Nations. (2016). Abuja Declaration – Outcome Document of the Habitat III Africa Regional Meeting

Within the health sector, at the national level, a three-stage resource allocation process will be followed. First, the total budget from Government and donor pools will be established through aggregate resource mapping ahead of the annual budget preparation process. The second stage will involve allocating the budget across national, tertiary, and district levels. For tertiary hospitals, allocations will be based on the designated mandate, planned output and predetermined performance measures. The third stage will involve resource allocation to departments at the tertiary level; and across service delivery at the district level. To preserve the value of the health sector budget and guarantee the maintenance of volume and quality of services, budgets for service providers at each level will be increased each year by not less than 10% of the total health sector budget in the previous year.

As the projected annual per capita expenditures fall far short of the minimum required to deliver an optimally designed HBP, health benefits rationing mechanisms and criteria for accessing entitled services will be regularly reviewed and strengthened.

Several key principles will inform access to care in public health facilities: 1) feasibility of enforcing the HBP, 2) use of national identification cards for service provision, and 3) a unified beneficiary registry to determine which individuals are exempt from initial and additional pre-payments when accessing care. Table 2 shows the population groups and their entitlements under this HSSP III

Table 2: Populations groups and their entitlements

Population Group	Entitlement
Identified Poor and Vulnerable Groups	Clients identified as poor and vulnerable groups will qualify for free services, accessing the HBP free of charge at public health facilities. The identification of these clients will be based on producing a national ID and evidence from the Unified Beneficiary Registry.
Formal Sector	Malawian formal sector employees without any health

Population Group	Entitlement
Employees without health insurance cover	insurance will access the HBP free of charge at public facilities since they have already made their contributions through PAYE. Catchment populations whose only service provider is a Government contracted faith-based provider shall be exempt from paying the user fees on services covered in the HBP. Access to Government and CHAM facilities by this group will require production of a combination of national ID, employer ID and Taxpayer Identification Number to identify the user.
Formal Sector Employees on Private Health Insurance Scheme	The solidarity principal is based on risk pooling of the poor and non-poor, sick and health and young and older. The pooled funds will allow for a health benefit package consistent with the total pooled revenue. All formal sector employees on medical insurance schemes will only use health services in the public sector on production of a health insurance ID. For the insured services, providers shall claim from the insurance companies. For non-covered services, free access will be confined to the services in the HBP.
Non-Poor Informal Sector	To use a Government or contracted faith-based service provider, the non-poor in the informal sector will be required to contribute to the cost of care through an insurance scheme or pay the full cost of care at the point of access. These will require production of a national ID.
Non-nationals	All non-nationals with residency status for six months or more will access public or contracted facilities on production of 1) residence permit, 2) insurance cover, or 3) proof of exemption (for example, PAYE certification). Non-residents and those staying less than six months will require comprehensive health insurance cover to access health services in the public sector.

For the HSSP III, the following fund holding arrangements shall be introduced or strengthened. The general principle of fundholding arrangements under the strategic plan is that health funds should be allocated to and devolved into the service delivery level responsible, and directly accountable for implementation success and failure.

While there has been progress in fiscal decentralization, gaps remain across key areas namely: Procurement of biomedical equipment; Maintenance of biomedical equipment; Construction, expansion, and rehabilitation of health facilities; Supply chain management of drugs; and Recruitment and deployment of health personnel. MOH will work with relevant Ministries and departments to facilitate full decentralization of these budget lines, away from MOH and National Local Government Finance Committee (NLGFC) to central hospitals and district councils. At district councils, MOH will facilitate further decentralization of the health financing to health facilities including establishing and sustaining stronger accountability and oversight structures and mechanisms at each fundholding level including health facilities.

MOH will ensure a unified disbursement and fundholding arrangement for all donor initiatives that transfer funds directly to District Council, including a performance monitoring framework to ensure only cost-effective result-oriented initiatives are scaled up and sustained. During MOH will develop legal instruments for sound public financial management at the facility level including a performance framework for measuring PFM progress of each facility in real-time and proactively implementing responsive capacity building programmes. After five years, the DFF will be promoted as a mechanism through which health sector funds across Government and donor pools will be disbursed to service providers.

Strategy 9.4 Establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system

The health financing interventions for the HSSP III assume a very proactive rather than passive resource mobilization drive that had

characterized previous HSSPs. Toward this, MOH and stakeholders will sustain capacity strengthening of the Health Financing Division (HFD). This will focus on the HFD's capacity to coordinate, implement and monitor the HFS. It will also be responsible for increasing its capacity to coordinate health financing and planning capacity development at the building block level, central hospital, district council, and district level service provider level.

The HFD will also enhance collaboration mechanisms between key Ministries, Departments and Agencies (MDAs) for effective implementation of the health financing building block. These will include Ministry of Finance (MoF), Ministry of Local Government (MoLG), National Local Government Finance Committee (NLGFC), and the National Audit Office (NAO). It will further involve establishing new institutions such as a Health Technology Assessment, Private Public Partnerships, a health insurance regulation, etc., that are determined relevant for sound functioning of the health financing building block. This capacity will be supported through continued investment in evidence, particularly in health economics and financing analysis capacity, coordinated through the joint MOH-Kamuzu University of

Health Sciences Health Economics and Policy Unit, the Health Economics, Policy, and Ethics Thinktank, and the Annual Health Financing Summit. These health financing coordination efforts will be anchored in a sound health financing management information delivered as a module in the re-engineered Health Management Information Systems outlined in Chapter 8.

Reform 10: Expanding domestic resources and robust provider payment arrangements

This will involve introduction of contributions from non-poor informal sector and concurrent enforcement of the use of appropriate identification in order to identify those eligible for user fee exemptions. A strategic purchasing reform will be introduced and will focus on the creation of robust resource allocation frameworks and processes, and implementation of intelligence-based provider payment mechanisms to better align resource allocation, budget execution and the Health Benefit Package.



Photo: Medication and supplies.

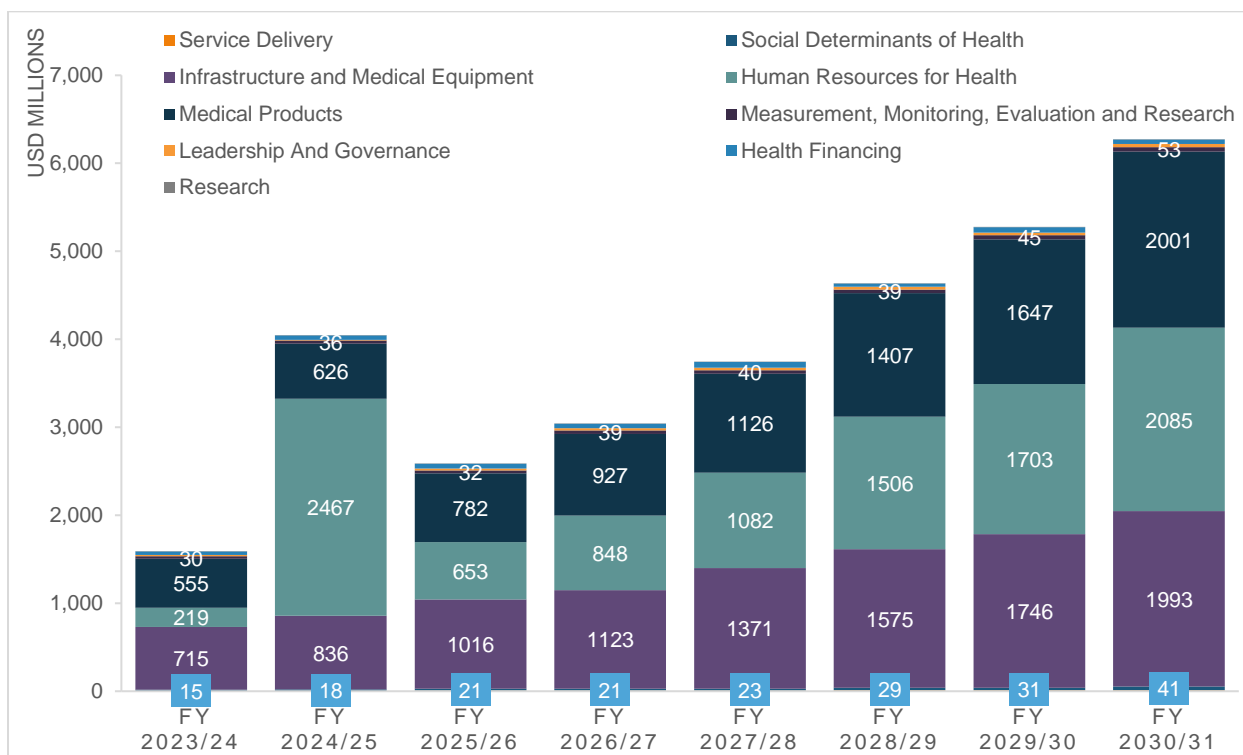
Chapter 6: HSSP III Costing and Prioritization

This chapter summarizes the costing and prioritization results for interventions in the HSSP III. Through this process, the costs to deliver the full set of HSSP III interventions from FY 2023/2024 to FY 2030/2031 were estimated. Next, these costs were compared against the projected financial resources available in the health sector, and then iteratively prioritized downwards through a consultative process between Government and health sector donors to ensure that the HSSP III fits within the available resource envelope. This prioritization is essential to direct limited financial resources towards strategic reform areas and priorities of the health sector for the

next eight years, in alignment with “One Plan, One Budget, One Report.” Costing and prioritization processes are covered in greater detail in Annex 4 available in digital edition on MOH website.

The total cost of implementing the intervention matrix for all the eight years is estimated at US\$31.2 billion (MWK 32 trillion) representing the full resource need before the prioritization process. The cost per capita in the first year is \$78.7, and \$172.12 on average over the eight years of HSSP III. Figure 14 shows detailed HSSP III costs by each objective.

Figure 14: Financial Resource Need by Objective of HSSP III



Next, a realistic estimate of resources available for allocation to health sector priorities were identified using the MOH’s Resource Mapping Round 7 data. Fungible resources (assumed to be available for re-allocation by the budget holder to priorities in HSSP III) were estimated at \$537.1 million for FY 2024/2025 out of a total of \$689.8 million health sector funding per Resource Mapping Round 7 for FY 2019/20; this excludes non-fungible resources such as the government’s current operational budgets and payroll, as well as donor program management and administrative costs.

Through multiple consultative stakeholder discussions, the HSSP III was prioritized for the implementation year of FY 2024/2025 in order to fit within the existing resource envelope and therefore more effectively enable resource allocation through the “One Plan, One Budget, One Report” approach. Overall, the total resource need of \$4.0 billion in FY 2024/2025 was highly prioritized downwards to match the resource envelope of \$537.1 million.

These prioritized areas of investment include:

- The eleven "game-changer" reforms in the HS SP III

- Medicines, commodities, and supply chain costs for an access-constrained, realistic Health Benefits Package scenario
- Upgrading of health centres to be community hospitals, for decongesting central hospitals in urban areas
- Rehabilitation of central hospitals as per the Capital Investment Plan
- Prioritized equipment from the Standard Equipment List to deliver the Health Benefits Package at all levels of care
- A proportion of unfunded administration costs of central hospitals and District Health Offices
- A proportion of health workforce pre-service education and salaries for both facility- and community-based cadres, as described further in section 6.2 below
- A proportion of other prioritized activities from the HSSP III intervention matrix, as prioritized by stakeholders during the consultative workshops

Table 3: Overview of prioritized areas within the HSSP III

Description of Prioritized Area	Resource Allocation
Eleven “game-changer” reform activities	\$41,624,147
Drugs and commodities + 20% supply chain costs for a <u>realistic, access-constrained Health Benefits Package</u>	\$400,055,821
Capital Investment - Upgrade Health Centres to Community Hospitals from Capital Investment Plan	\$8,381,421
Capital Investment – Rehabilitation of Central Hospitals from Capital Investment Plan	\$7,640,047
Prioritized equipment costs from the Standard Equipment List in order to deliver the Health Benefits Package at all levels of care	\$6,626,768
Health Workforce – absorb existing graduates from training institutions; train, recruit, and equip HSAs and SHSAs to meet National Community Health Strategy targets of 1 HSA to 1000 population; pre-service education and salaries for Community Midwifery Assistants; a proportion of costs to provide high-quality pre-service education	\$59,652,839
11% of unfunded admin costs at DHOs and central hospitals, as estimated from the HSSP II Operational Plan	\$498,485
10% of other prioritized activities from the HSSP III intervention Matrix (activities whose prioritization score is >=150% of the expected average score)	\$12,566,688
Total Fungible Resources Prioritized	\$537,046,215
MOH Personal Emolument budget and other administrative overheads (estimated from RM 7, FY 2019/20) - considered non-fungible but available to overall health sector	\$60,10,0000
Donor budgets including program staff salaries, and administrative overheads (estimated from RM 7, FY 2019/20) - considered non-fungible but available to overall health sector	\$92,741,959
Total Health Sector Resources (estimated from RM7, FY 2019/20)	\$689,820,411

One limitation of the prioritization process is that it was primarily based on consultative discussions amongst health stakeholders as Malawi does not currently have robust data on the relative cost-effectiveness of different health systems pillars compared to one another, i.e., whether health workforce, governance, or supply chain are relatively more cost-effective investments compared to one other, and what the optimal mix of these health systems inputs would be. In addition, fungible resource estimates are based on historical budget data from the MOH Resource Mapping exercise; the actual available resources that can be re-allocated to HSSP III priorities may vary and will depend on self-reported estimates obtained from donors for each year of HSSP III implementation.

6.1 HBP Cost and Prioritization

The Health Benefit Package (HBP) provides cost of medicines and medical supplies required to deliver the prioritized interventions in Annex 3: HBP data available in digital edition on MOH website. To calculate the number of visits for each HBP intervention, we utilized the product of i) target population taken from the Malawi Census⁸¹ for the specific year, ii) population in need (PIN) of the intervention from available literature, program targets and prevalence and/or incidence data iii) demand constraint from available literature, DHS/MICS surveys for the proportion of patients seeking care for the intervention and iv) access constraint which was required due to limited funding. Access constraints were not added for non-fungible donor interventions, as this funding is tagged to specific interventions with

⁸¹ National Statistical Office. Population and Housing Report – 2018. Zomba, 2019.

full funding of drugs and consumables. However, interventions for which drugs and commodities are funded with GoM budgets and fungible donor funding (assumed) required access constraints to fit within the budget from Resource Mapping round 7 data. This means that only a proportion of the total calculated amount of drugs and consumables can be afforded and provided. The access constraint restricts drugs and consumable purchasing from 46% to 65% of the total need with prioritization done depending on maximising patient DALYs averted or MCDA score (Table 4)

Medicines and medical supplies were mapped and quantified per patient for each intervention. Costs for medicines and medical supplies were taken from the Central Medical Stores Trust

(CMST) cost list and supplemented from MOH recent procurements and the UNICEF drug cost database. The total cost of the drugs and consumables was multiplied by the total number of visits for each intervention and summed across all interventions for the total cost.

With the addition of the access constraint, about 80% of the expected visits will be covered with just 28% of fungible and GoM funded activities. Currently, costs for the 81 interventions utilizing drugs and consumables meet the annual resource allocation for drugs and consumables by the GoM and donors in 2022 (Table 5). However, in the immediate future, there is a need for alignment of the budget to increase access for GoM and fungible donor funded interventions.

Table 4: Criteria for Access Constraint of HBP Interventions

Access Constraint*	Number of interventions (total 115)	DALY criteria	MCDA criteria (out of a total score of 3)
46%	30	<30,000	<2.4
58%	17	>10,000 to <100,000	2.4-2.89
65%^	23	>100,000	>2.8
100%	45	Donor funding	Donor funding

* The proportion of the total drugs and consumables that can be purchased for the interventions due to resource envelope

^Additions of vaginal delivery, Caesarean section delivery and newborn sepsis despite not fitting in developed criteria

Table 5: HBP Cost per type of funding in relation to the Drug and Consumable Budget from 2021 Resource Mapping

Type of funding	Cost of activities within the type of funding (\$USD)	As a percentage of drug and consumable budget from Resource Mapping R7 (FY 2019/20)
Non-fungible donor-funded activities	173.6 million	101%
Fungible donor and Government of Malawi activities	117.1 million	99%
Total cost	290.7 million	101%

6.2 Prioritization of Health Workforce Costs

This section provides a deep dive on the prioritized package of health workforce investments, which was rigorously modelled and prioritized as they represent one of the largest cost drivers of the HSSP III.

Step 1: Iterative revisions of service delivery targets, and their corresponding health workforce targets, to fit health workforce

costs within the available resource envelope

For the HSSP III, as a part of the consultative process between Government and health sector donors to ensure that the HSSP III fits within the available resource envelope, a workforce target-setting model was run for several scenarios of varying levels of service coverage and quality, to determine the associated optimal health workforce targets. Targets were then fed into a pre-service pipeline model and intervention planning tool to

determine the associated pre-service education costs. Through continuous iterations between government and donors, the health workforce targets were gradually scaled down until the associated salary and pre-service costs required to meet the targets fit into the realistic resource envelope projections for the Malawi health sector. This envelope was determined to be \$59.7 million for the health workforce in FY2024/2025.

The following section describes how this amount was prioritized across various health workforce interventions. A detailed description of the data sources, approach, and results for each scenario that was run in the model are summarized in Annex 4 available in digital edition on MOH website and detailed in the accompanying document titled “*Detailed Annex for the Health Workforce Interventions of the Malawi Health Sector Strategic Plan (HSSP III) for 2023-2030*”.

Step 2: Prioritizing health workforce interventions for the access-constrained, status quo quality FY2024/2025 package

The \$59.7 million for health workforce interventions in FY2024/2025 was prioritized with a focus on value-for-money and strengthening the community health workforce.

First, absorption of graduates from pre-service training programs in FY2024/2025 was fully funded, as it is poor value-for-money to not absorb trainees that have already had pre-service capacity and scholarship costs invested in them.⁸² The projected number of graduates in FY2024/2025 was distributed across districts proportional to the service delivery need, and then multiplied by the inflated average gross annual pay for each cadre to arrive at the \$5.4M

cost of this prioritized intervention for FY2024/2025.

Next, maintaining baseline pre-service education enrolment in FY2024/2025 was prioritized and fully funded at \$6.7M. As operating costs of training institutions and salaries of current faculty are covered by the Ministry of Education, this only included scholarship costs. Scholarships included FY2024/2025 enrolment and all students currently in the pipeline regardless of their starting year,^{83,84} as the next best value-for-money is to complete the pipeline for students who are partway through their education and have already had costs invested in their pre-service education.

Then, HSA and SHSA scale-up to their respective targets (1 HSA to 1000 population, and 1 SHSA to 10 HSAs) was fully funded, as a strong community health workforce will not only strengthen equitable access to care, but also increase service provision of primary care. Given the significant resource constraints for the HSSP III, investments in the community health workforce also tend to be cost-effective relative to cadres at higher levels of the health system. Salaries, pre-service education, and supplies for HSAs were costed at a total of \$15.8M for FY2024/2025.

CMAs were also prioritized as a critical community health workforce cadre that increase access to care and service provision of primary care. The HSSP III prioritizes an intervention package of \$15.6M in CMAs in FY2024/2025, including salaries for the FY2024/2025 CMA graduating class, scholarships for all CMA trainees enrolled at baseline in FY2024/2025, and selected

⁸² Included in this calculation were FY2024/2025 graduates of generalist cadres and paediatric specialist cadres. Due to a lack of available, quality data at the time of publication, the calculation excludes other specialist cadres and the unabsorbed trainees currently in the labor market. Community-based cadres were excluded as those costs are addressed separately. No FY 2023/2024 graduates were included, as assumptions around the absorption rate are difficult to determine amidst insufficient clarity around availability of funding for salaries in that year. The calculation also assumed optimal licensing exam schedules and recruitment drive timing that would enable recent graduates to enter the workforce in the same fiscal year that they graduated in.

⁸³ For example, all students enrolled in a three-year program that started in FY2022/2023 and FY2023/24

were costed, but not students who enrolled in a two-year program in FY2022/2023 as those students will have graduated.

⁸⁴ FY2024/25 enrolment was assumed to be an average of enrolment in all years that the program has been operational since 2012. Students currently in the pipeline are extrapolated from a combination of available data and in recent years where data is not yet available, the average of previous years as described above. Included in this calculation were FY2024/25 graduates of generalist cadres and paediatric specialist cadres. However, due to a lack of available, quality data at the time of publication, the calculation excludes other specialist cadres and the unabsorbed trainees currently in the labor market. Community-based cadres were excluded as those costs are addressed separately.

investments to improve the quality of education for CMAs at baseline enrolment.

Finally, the remaining \$16.1M was allocated towards improving the quality of pre-service training at baseline enrolment. The domain with the most direct link to quality of education is faculty, as training institutions have indicated that infrastructure and equipment can be reconfigured to accommodate more students. The full faculty training and salary costs to reach the ideal student: faculty ratios for baseline enrolment were therefore prioritized for the intervention package. Additionally, selected infrastructure and skills lab equipment needs were also included, though given resource constraints, these are only a subset of the full suite of infrastructure and equipment investments needed to ensure high-quality pre-service education. These costs were also allocated across the various training programs for each health workforce cadre proportional to their need.

Despite a proposed \$60M additional investment in health workforce in FY2024/2025, staffing levels in 2030 will still be insufficient to deliver even the most highly prioritized scenario: an access-

constrained Health Benefits Package at status-quo quality of care. The capacity of Malawi’s health system to provide even the most basic of services will be greatly reduced, even at status quo levels of quality of care. Improving quality of care of Malawi will require substantial increases in investment in the health workforce.

As there is an over \$400M gap between the allocation for health workforce interventions in FY2024/2025 and what was needed to staff and deliver the targets in even the most highly prioritized, access-constrained Health Benefits Package scenario, there are no funds prioritized to scale-up pre-service training, as even provision of a high-quality education at baseline levels of enrolment is not possible. Even if all health workforce trainees are consistently and completely absorbed into the public health workforce each year until 2030, maintaining baseline enrolment is projected to result in staffing levels in 2030 that are still 20% below what is needed to provide care for the most highly prioritized, access-constrained scenario of the Health Benefits Package with status-quo quality of care. Gaps by cadre vary and can be seen below:

Table 6: Projected workforce and workforce gaps in 2030, if the prioritized health workforce investment package is funded as proposed

Cadre	Projected workforce in 2030 after prioritized, resource constrained HSSP III investments *	Workforce needed in 2030 to provide access-constrained Health Benefits Package at status quo quality of care	Projected Gap in 2030 (#)	Projected Gap in 2030 (%)
Medical Officer / Specialist	831	1817	986	54%
Clinical Officer / Technician	2710	2710	0	0%
Nursing/Midwifery Officer	3302	3302	0	0%
Nursing/Midwifery Technician	9318	11212	1894	17%
Pharmacist	190	131	0	0%
Pharmacy Technician	272	783	511	65%
Pharmacy Assistant	698	698	0	0%
Lab Officer	496	1144	648	57%
Lab Technician	743	1298	555	43%
Lab Assistant	238	238	0	0%

**Projected workforce if baseline is maintained and absorbed, or for cadres producing beyond their target, if enrolment is scaled down to target and absorbed*

If patterns of historic resource availability for health workforce interventions continue, it will greatly hamper Malawi’s ability to achieve

meaningful, system-wide improvement in quality of care. A first step is to align the existing resource envelope towards the prioritized

health workforce interventions in the HSSP III, per the “One Plan, One Budget, One Report” approach. Additionally, substantial increases in investment in health workforce – from both government and donors – will be required for expansion of health care access and quality

improvement in Malawi to become a reality. The financing and resource mobilization sections can be referred to for possible solutions to increase health sector funding to address these gaps.



Photo: Health workers conduct a meeting.

Chapter 7: Implementation Arrangements

7.1 Governance for “One Plan, One Budget, One M&E”

Implementation of the HSSP III will require strong leadership and governance with responsibility amongst all health sector stakeholders in Malawi. It will be implemented under the health sector partner alignment and coordination arrangement within an established decentralized health service delivery system. The system and structures established by the Government of Malawi at the national, central and district level system levels will be defined in this chapter with roles clearly stated for a standardized stakeholder engagement process. There will be a strict requirement for stakeholder alignment to the strategies and activities of the HSSP III, enforced by MOUs and a code of conduct agreed by all stakeholders. At the heart of the implementation arrangements in this chapter is the actualization of “*One Plan, One Budget and*

One M&E reform.” This is informed by the evidence on proliferation of health sector National Strategic Plans (NSPs) over the last 15 years, as well as evidence that just ten organizations fund over 90% of the health sector budget, which provides a strong opportunity for efficiency gains through aid harmonization⁸⁵.

To increase the Government’s necessary directive to set priorities across the health sector, guarantee partner alignment, and harmonize implementation procedures and information sharing, the HSSP III proposes that all health systems activities are jointly planned, prioritized, implemented, and monitored. Through the HSSP III development process, the MOH and Development Partners adopted the “One Plan, One Budget, One M&E Report” model, with a commitment to reduce to only necessary National Strategic Plans per HSSP III Pillar. This chapter sets out the governance structures and implementation arrangements necessary to deliver this key reform.

⁸⁵ Resource Mapping and Expenditure Tracking (Round7).

7.2 Annual operational planning, associated governance processes for “One Plan” and budgeting

While the HSSP III covers 8 years, it will be planned and operationalized annually. The HSSP III Implementation Plan will be implemented using the Annual HSSP III Operational Plan which has been detailed enough to guide execution and monitoring, thereby increasing Government ownership and effectiveness of Development Partner technical and financial assistance. The “One Plan” will include an integrated, transparent joint planning, implementation coordination, and monitoring, including through the national, zonal, and DIP review platforms that will enable ongoing refinement of the intervention and monitoring and evaluation matrices through the Annual HSSP III Operational Plan. They will further become vehicles for monitoring and evaluation efforts, complemented by performance management mechanisms to incentivize improved delivery of the HSSP III.

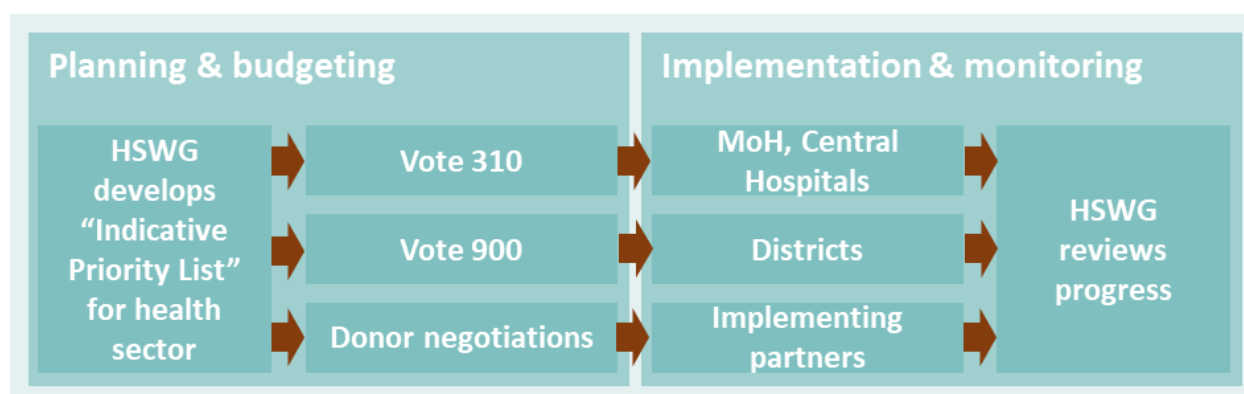
The priorities for the HSSP III are based on planning and costing for the full health system in harmonized platforms of care for primary, secondary, and tertiary levels, rather than through the lens of vertical disease programs. MOH directorates, disease programs, and districts (via District Implementation Plans) have integrated their priorities into the HSSP III and will iterate on these priorities through the annual HSSP III Operational Plans to ensure their evolving priorities are fully and accurately reflected in the “One Plan.”

The HSSP III is based on the best-available evidence to ensure reliability and accuracy in estimating resource needs and to achieve its ambitions. However, given the eight-year timeframe of the HSSP III, the planning and costing will be flexible and revised annually via the HSSP III Operational Plan, based on emerging technical evidence and priorities in relation to changing evidence, diagnostic capabilities, and quality improvement.

All planned activities and associated costs will be jointly prioritized as part of the annual HSSP III Operational Plan process across all departments, with defined and transparent prioritization criteria. The aim is to support Government and partner decision-making on the optimal areas of investment given limited health sector resources. For the latter, the Resource Mapping and National Health Accounts (NHA) results will provide estimates of the available funding envelope. Leveraging existing work on the MOH Resource Mapping exercise and partner mapping for the District Implementation Plans, a mechanism will be developed (in cooperation and agreement with key partners) that allows for partners to directly “sign up” to fund the Government’s priorities at both the national and district level.

Once the HSSP III has been signed off, the indicative outline of activities for the eight years will become the framework for the Annual HSSP III Operational Plan. At the beginning of each annual planning and budgeting cycle and based on the HSSP III activities for the respective year, the MOH Department for Planning and Policy Development (DPPD) will separate out activities by building block (Figure 15)

Figure 15: Flow from planning and budgeting to implementation and monitoring



Once completed, the repurposed HSWG will come together to develop an “Indicative Priority List” for the entire health sector. The HSWG, with Terms of References outlined in the Guidelines for Malawi 2063 Pillar and Enabler Coordination Groups, will be fit-for-purpose to steer the “One Plan, One Budget, One M&E Report” process. The HSWG is envisaged to include MoH Directors, with representatives from central hospitals, districts, Health Donors Group (HDG), implementing partners, and non-state actors including civil society. Critical TWGs will continue to cascade technical expertise and decision-making upwards into the HSWG.

The HSWG will jointly endorse and adopt the “Indicative Priority List,” which will become the unified list of priority activities for the whole of the health sector as the first step of the annual HSSP III Operational Plan. The “Indicative Priority List” will subsequently be used as the foundation for planning and budgeting processes and negotiations. Internally, this includes processes in advance and preparation of Vote 310 (Ministry of Health) and Vote 900 series (District Councils) budgets. Externally, this includes partner negotiations and the signing or re-confirming of memoranda of understanding (MOU) and the partner code of conducts (CoCs).

As new technologies, diagnostic and treatment capabilities, priorities, and financing mechanisms adjust, there will be need to adjust the HBP accordingly with standards of care. Additionally, it is expected that within the first 3-5 years of the HSSP III, the HBP will transition from a list-based model to platforms of care to align with health service delivery reforms.

The process to establish the Vote 310 component of the Operational Plan will be initiated with DPPD presenting relevant parts of the “Indicative Priority List” at the Strategic Hearing meeting with the Ministry of Finance. It will be fully established with the approval of the annual budget by Parliament. The processes to approve the Operational Plan will not change significantly from the status quo, but stakeholders who are not directly involved in the Vote 310 process, such as district representatives, will be informed on progress and receive the final Vote 310 component of the Operational Plan. The process and documents will be publicly shared with all stakeholders for transparency, alignment, and complementarity of activity planning.

When referring to the “Indicative Priority List,” the District Implementation Plans will consolidate three main components, which will be embedded into the planning tools themselves:

- i. Health centres: Suggest activities based on a review of health centre needs and gaps against the standards in the PHC platform of care, and inclusive of NGO, CSO, and community leader perspectives.
- ii. District hospitals: Suggest activities based on a review of district hospital needs and gaps against the standards in the secondary platform of care.
- iii. DHMT and program coordinators: Above-facility level activities from health centres and district hospitals, such as supervision and other district-level coordination and monitoring activities, based on the “Indicative

Priority List” and tailored to the individual district context and needs.

The process of preparing the Vote 900 component of the Operational Plan with information sharing and engagement between MOH HQ and districts requires improvement. To achieve alignment, DHMTs must hold formal zonal-level meetings, including central MOH/DPPD, to ensure national and district alignment around the “Indicative Priority List” and its relevance to the specific district context, as well as utilize data from integrated reviews such as the Joint Annual Review (JAR). Once District Councils have submitted cross-sector plans and budgets (including the DIP tool information in Vote 900 format) to Ministry of Local Government and Rural Development, the 29 Directors of Health and Social Services should share final DIP tools with MOH/DPPD.

During the process of negotiation with partners and resource allocation, the “Indicative Priority List” will be jointly endorsed by the HSWG, with all donors and partners filling out a partner entry checklist as part of joint planning of new funding entering the health sector. Subsequently partners should meet with technical focal persons, either the director for the respective building block or the Secretary to Health (SH) if multiple building blocks are involved. The director or the SH will introduce the agenda to the relevant TWGs⁸⁶ to review and recommend changes as needed. The review includes mapping of project funding against the

“Indicative Priority List” and DIPs to ensure alignment with national and local Government priorities.

Donor and partner proposals must be agreed upon by Senior Management (SMT) and then HSWG for adoption, with the subsequent partner MOU⁸⁷ signed with MOH and all involved District Councils. Lastly, the relevant Head of Mission should also sign against the partner code of conduct.

Once Vote 310, Vote 900 and partner negotiations have concluded, the DPPD will consolidate these three data sources to achieve one unified document, the annual Operational Plan.

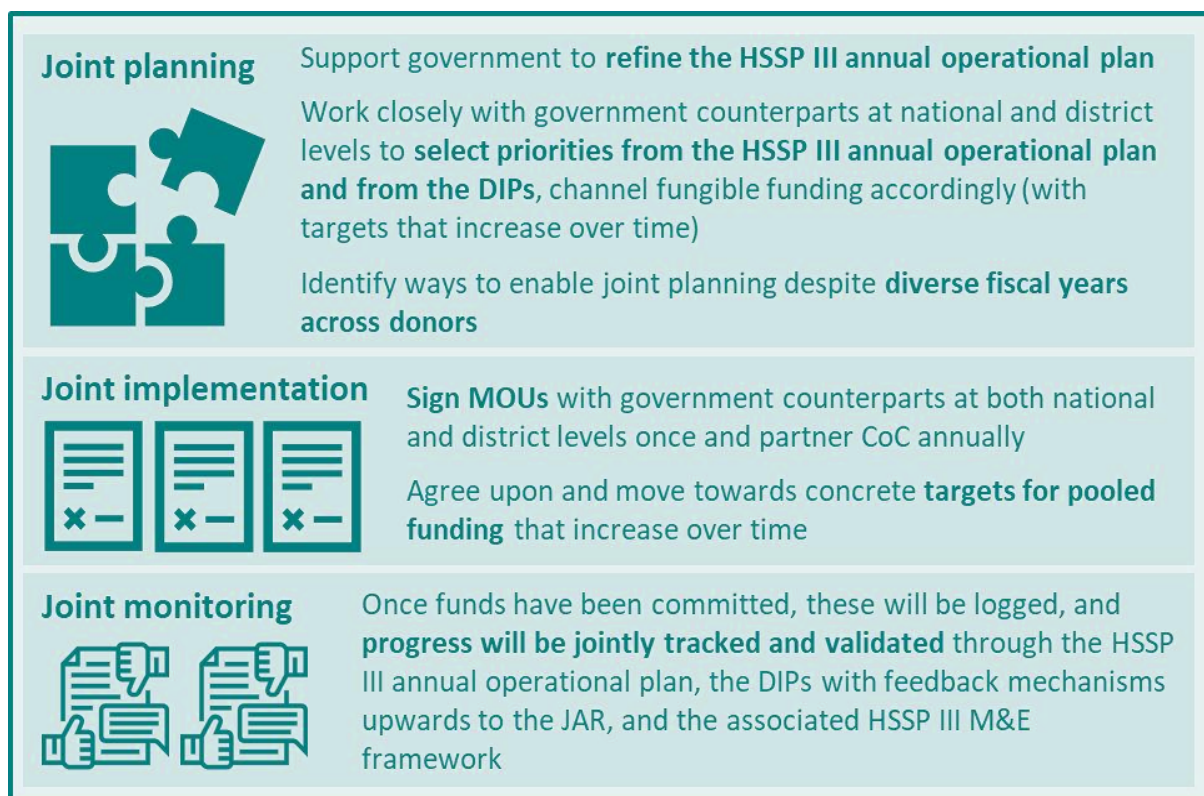
7.3 Implementation of Annual Operational Plan, and Code of Conduct

The Health Sector Working Group (HSWG) and the district stakeholder forum will provide continued multi-sectoral and multi partner coordination. At the national level, the Secretary to Health (SH) oversees implementation of the health system and is supported by directors. Directors will provide technical guidance for relevant areas and oversee budget execution, while TWG will provide technical guidance and coordinate with partners.

⁸⁶ While many TWGs exist already, the number and scope of TWGs is envisaged to be reformed to better align with the “One Plan, One Budget, One Report” model and associated health systems building blocks.

⁸⁷ MOU will only be signed once, while partner code of conduct is to be signed annually as part of the Operational Plan process.

Figure 16: Joint planning, joint implementation, and joint monitoring



Government budgets and funds will be executed using the Public Financial Management (PFM) system and against the Operational Plan. Process included in execution of the budgets are expected to largely follow established processes with service delivery devolved to District Councils and tertiary hospitals.

To achieve “One Plan, One Budget, One M&E Report,” Government expects all that partners, implementing partners, and other relevant actors in the health sector, will sign up to a code of conduct (CoC). The CoC outlines basic principles for engagement for operationalizing the HSSP III across planning, implementation and monitoring and evaluation cycle and will encompass the partner entry checklist described above.



Photo: Health workers convene at a meeting.

Chapter 8: Monitoring and Evaluation Arrangements

8.1 Introduction to the chapter

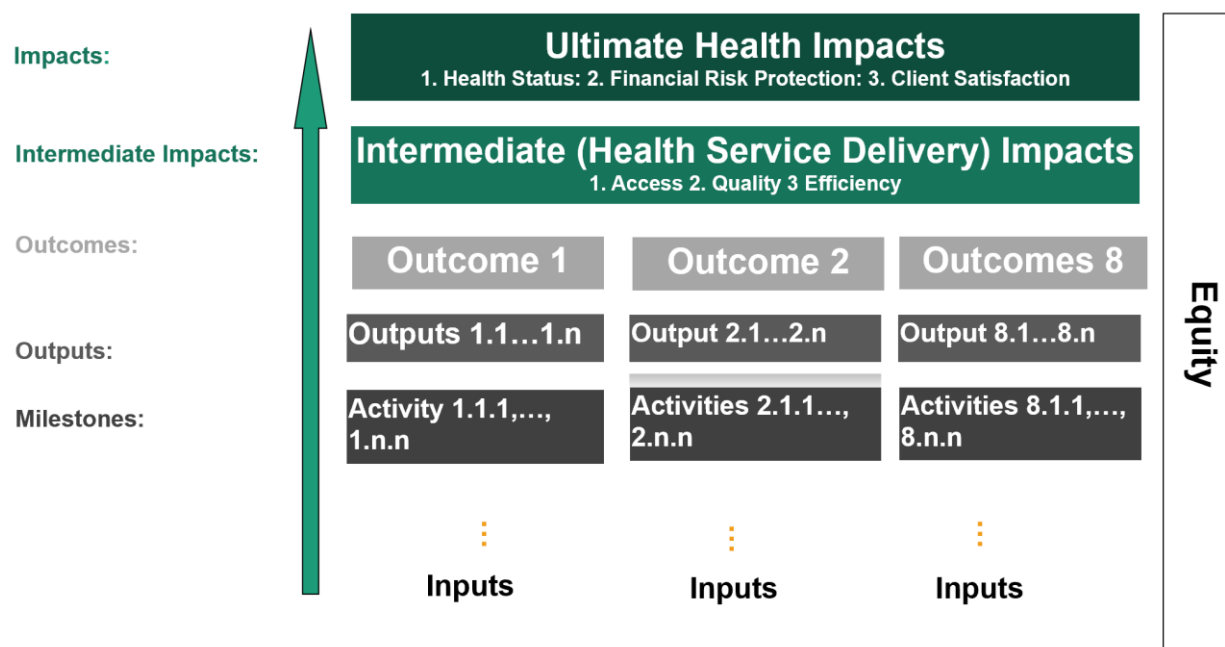
This chapter provides the Digital Health and Health Information System arrangements for optimal monitoring and evaluation of the HSSP III. It builds upon the heavy technical and financial investment already made in digital health and aligns this to the HSSP III results management framework to ensure timely and

robust evidence informed decision making at all levels of the health system.

8.2 Overview of the Results Framework for the HSSP III

In line with the intervention logic presented in Chapter 5, the basic structure for the M&E system for the HSSP III is presented in Figure 17 below.

Figure 17: HSSP III Results Logic



At the ultimate impact level, the framework will track progress towards the overall goal of the HSSP III. The health system exists to contribute to the attainment of population health, with UHC as the end goal. In order to contribute to these population level health impacts, the health system shall deliver desired high quality health services. That is, the goal of the health sector to deliver health services, which in turn, contributes to achievement of population health. At the health system level, therefore, progress will be tracked using intermediate (service delivery) data elements and impact indicators. The majority of the indicators to measure ultimate and intermediate impacts derive directly from the existing core indicators for the Malawi health system which in themselves are contextualized based on WHO guidance on SDG-aligned health system indicators.

Progress in each of the health systems pillars (building blocks) is important to achieve its respective service delivery goals of access, quality, and efficiency, and eventually the ultimate goals of improved health status,

financial risk protection and client satisfaction. The HSSP III specifies one broad deliverable, called outcome, at the objective (pillar) level. Achieving each outcome will require effective implementation of the strategies under each pillar. Each strategy, therefore, will be measured using a broad output. Therefore, there is one outcome for each objective; and for each strategy, there is one output. Activity targets are defined, and a set of activities targets/milestones will need to be achieved in order to achieve the output. The milestones for these activities are not fixed in the HSSP III. They will therefore be agreed upon annually, along with the inputs needed to achieve them. This will occur during the annual planning process at each level of service delivery, in alignment with the processes outlined in Chapter 7 on HSSP III implementation arrangements.

8.3 Health Sector Data

Table 7 below shows the sources from which the Ministry will get data for performance measurement of HSSP III interventions.

Table 7: Data Sources for performance management

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) from medical certification of cause of death (MCCoD), cause of death (COD) coding, verbal autopsy (VA) data for community deaths and birth registration data
Health Facility Survey	Service Availability and Readiness Assessment (SARA)/Service Provision Assessment (SPA)
	Provision Assessment (SPA)
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)

8.4 Structure of the Health Information System for the HSSP III

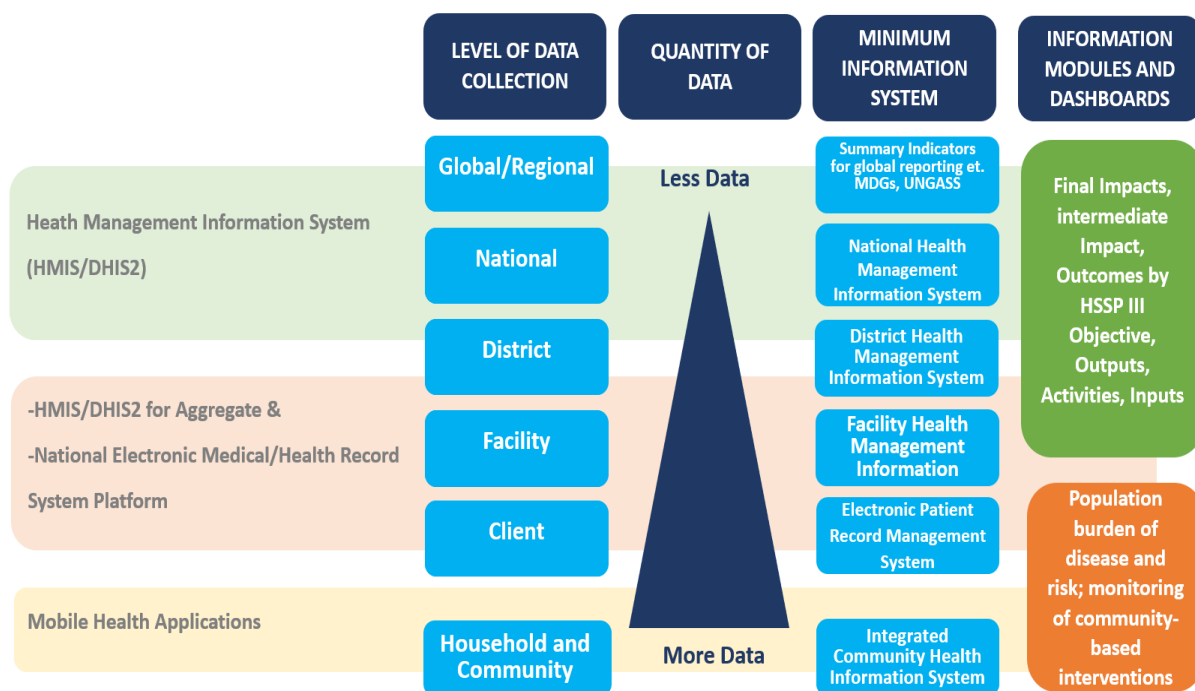
To facilitate information for effective monitoring and evaluation of the HSSP III, the MOH will sustain and fast track the implementation of the Health Information System Architecture of 2016 as modified and shown in Figure 18.⁸⁸ This is based on extensive work undertaken by CMED and Digital Health Division within the Ministry, with support from collaborating partners. It is also informed by the specific information needs of the HSSP III intervention logic and implementation arrangements which places responsibility of planning, implementation and monitoring and evaluation at management team of each institution at national, tertiary hospital, district council, secondary health facility, primary health facility and community levels. The structure provides for level specific MISs starting from community, facility, district, and national levels.

At the community level, the Integrated Community Health Information System (iCHIS) will be the primary digital health and Information

Management System for all stakeholders in the health sector. All applications for community level supporting and health service delivery should align to the iCHIS through the interoperability architecture implemented by the Digital Health Division, in close collaboration with the CHSS for the pillar domain knowledge. As community members are the clients of service providers, the iCHIS will be linked to the facility through the integrated hospital electronic health record system which will manage patient services at individual level. The integrated hospital electronic health record system will share individual level service delivery data with the patient level Central Data Repository (CDR)/the data lake as the Shared Health Record service provided by the Ministry.

⁸⁸ Based on Concepts agreed in 2016 and revised in 2020; modified in the HSSP III to suit the specific monitoring and evaluation requirements

Figure 18: Health Information System Structure for the HSSP III



The data from the CDR will be aggregated and shared with the District Health Management Information System which will be the system for monitoring the HSSP III results framework at the district and national levels. In keeping with the governance arrangements outlined in Chapter 7 as well as the results logic outlined above, from primary facility, secondary facility, District Council, Central Hospital, and National level, the programme specific management information system shall have modules and dashboards at the impact and intermediate impact levels. These dashboards will be integrated into a harmonized dashboard platform at HSSP III level and available to all other levels

The fundamental principal guiding the HIS and Digital Health solutions for HSSP III is that decision makers at each level will be serviced with their information requirements for optimized decision-making, before processing and submitting information requirements of upstream decision makers. The key implications for this are that 1) the health information system will be decentralized to each decision-making entity at each level of the

health system; 2) the Interoperability architecture for Malawi’s national health information systems will require aligning with the HSSP III monitoring and evaluation framework; 3) All partners in the health sector will align and harmonize their data systems, despite paper or digital, so facilitate timely transmission of information to decision makers at all levels of the health system. 4) All efforts shall be made toward digitalize service delivery at the point of care and data shall be collected and extracted from these systems to support with timely and accurate reporting. At minimum, a decentralized health management information system will be implemented at each decision-making entity at each level of the health system with the following modules in Table 8 below.

Table 8: HSSP III Health Management Information Systems Modules at National, Central Hospital, District Council, and District level secondary and primary health facility levels

HSSP Implementation Monitoring Modules	III Impact Monitoring Modules
<ul style="list-style-type: none"> Service Delivery Social Determinants of Health Human Resources 	<ul style="list-style-type: none"> Intermediate Impacts (Access, Quality and Efficiency)

<ul style="list-style-type: none"> • Infrastructure and Medical Equipment • Medical Products and Technology • Health Information System and Digital Health • Research • Leadership and Governance • Health Financing 	<ul style="list-style-type: none"> • Population (Health Status, Client Satisfaction, Financial Risk Protection)
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8.5 Determining the Information requirements for the HSSP III Monitoring and Evaluation Framework

The information for monitoring and evaluating of the HSSP III will be determined as follows. Evaluation questions will be developed across the results and decision-making chain. First, an assessment will be undertaken to determine which questions can be addressed based on data already being collected through the existing Health Information Systems, CRVS system and periodic surveys. For the evaluation questions not addressed through administrative information management systems or surveys, a determination will be made on which questions could be addressed by revising and adapting existing information systems and surveys. The relevant administrative data sources will then be adapted accordingly, and stakeholders for the relevant surveys will be engaged to determine feasibility of adapting the survey instruments, either paper or digital tools, as well as aligning the timeframes to the HSSP III needs. For any outstanding questions, data collection process and systems will be determined as appropriate. Within the first year of implementation, all baseline information will be established and will form the basis for performance contract and performance

monitoring with MOH Senior Management, Central Hospitals and District Councils, including forming the basis for assessing effectiveness of partner supports.

Setting baselines and target for HSSPs including this one has consistently met the challenge of unavailability of NSO survey data at the time of developing the strategies. To improve on this, MOH Statistics Unit will be capacitated to take leadership of all surveys that are important for health sector programming and align them to planning timeframes.

8.6 M&E Coordination Structure

At the national level, the CMED will coordinate implementation of monitoring and evaluation system while Digital Health Division will oversee digital health solutions servicing both the M&E needs as well as digital requirements for sound implementation of strategies and activities in each of the HSSP III pillars. As the Service Delivery Building Block is complex, Quality Management will coordinate technical and clinical processes related to both digital health and determination of the M&E requirements of programmes and departments falling within the health service delivery building block. Data quality assurance for the service delivery, human resources, infrastructure and medical equipment building blocks will be coordinated by the Quality Management Division.

For purposes of the HSSP III, the integrated Community Health Information System (iCHIS) will be the anchor system for all theme-specific modules implied in the theory of change of the HSSP III and linked with health facility integrated hospital electronic health records system and with other systems of relevance. To the extent possible, where similar indicators exist, opportunities shall be explored for mainstreaming health information for joint data collection and processing at minimum.

Table 9 below shows the levels of coordination, the office that has ultimate responsibility for performance, the office tasked with coordination responsibilities and the point for validating data into the health information system.

Table 9: Coordination responsibilities for Health Information System at all levels

Coordination Level	Performance Contract Holder	Coordinating Position	Validation Point
Overall Coordination of M&E	DPPD	DPPD	M&E TWG, AJSR, HSWG
Coordination of HIS	DD-CMED	Chief Economist	M&E TWG, AJSR, HSWG
Technical Advisor on Service Delivery Pillar Information	QMD/ Clinical/ Nursing/ Preventive	M&E Coordinators at Deputy Director level	TWGs by Pillar
Coordination of Digital Health	DPPD	Deputy Director - DHD	Digital Health TWG plus TWGs in Pillar
Coordination of the Health Statistical System	DD-CMED	Chief Statistician	HSWG, M&E TWG, NSO
HSSP III Pillar	Directors	M&E Focal Persons at Chief Officer Level	M&E TWG and other relevant TWGs for Pillars
Programme level	Programme Directors/ Managers	M&E Focal Persons at Officer Level	Service Delivery TWG and any relevant TWG
Central Hospital level	Directors	Chief Hospital Administrator	Hospital Boards and TWGs, Zonal and National Reviews
District Council	DHSS	M&E Officer - Health	District Council, District Stakeholder Forum, Zonal and National Reviews
District Hospital	Facility Manager	M&E Coordinator	Facility Management Committee, District Council, District Stakeholder Forum, Zonal and National Reviews
Community Hospital	Facility Management Team	Senior M&E Assistant (Upgraded HMIS data Clerks)	Community Hospital Management Committee, District Council, District Stakeholder Forum
Health Centre	Facility Management Team	M&E Assistant (Upgraded HMIS Data Clerks)	Health Centre Management Committee, Extended DHMT
Community Level	Facility Management Team	HSA	Facility Management Team, Health Facility Management Committee

8.7 General Digital Health and HIS Guiding Standards

The health information system and relevant digital health solutions will be based on the following standards:

- Requirements of the Health Sector Strategic Plan
- National Health Information Systems Policy of MOH
- National Digital Health Policy of MOH

- Strategies outlined in the Digital Health Strategy of MOH
- Strategies stipulated in the HIS and M&E Strategy of MOH
- Integrated Quality of Care standards
- Any HIS Standard Operating Procedures (SOP) that apply to the proposed solution
- Public Services ICT Standards of 2004
- Principles of Digital Development – www.digitalprinciples.org

-
- Principles of Donor Alignment for Digital Health – www.digitalinvestmentprinciples.org
 - Stipulations in the 5-Point Call to Action for Health Measurement and Accountability Post-2015

Any existing standards and guidelines endorsed by MOH for Digital Health systems.

Annexes

Annex 1: Detailed annual intervention implementation Plan for HSSP III

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
Objective 1: To improve equitable access to quality health care services		
1.1 Design systems to create integrated platforms of care for primary to tertiary level	1.1.1 Re-define services for integrated primary to tertiary level platform of care	1,2,5,8
1.1 Design systems to create integrated platforms of care for primary to tertiary level	1.1.2 Develop document/system to integrate and streamline standards and guidelines such as Standard Treatment Guidelines, Essential Medicines List, Minimum Standards for Clinical Care, Standard Equipment List, and health workforce planning	1,2,3,4,6
1.1 Design systems to create integrated platforms of care for primary to tertiary level	1.1.3 Identify specialty and sub-specialty service delivery platforms	1,2,3,4
1.1 Design systems to create integrated platforms of care for primary to tertiary level	1.1.4 Ensure interdisciplinary and multidisciplinary approach to platforms of specialty and sub-specialty care	1,2,3,4,5,6,7,8
1.1 Design systems to create integrated platforms of care for primary to tertiary level	1.1.5 Review and reinforce clear referral systems across the levels of care	1,2,3,4,5,6,7,8
1.2 Promote quality and client safety in health care service delivery across the continuum of care from community to tertiary levels	1.2.1 Develop, distribute, and reinforce implementation of integrated SOPs, protocols and guidelines to all facilities	1,2,3,4,5,6,7,8
1.2 Promote quality and client safety in health care service delivery across the continuum of care from community to tertiary levels	1.2.2 Develop and implement guidelines in delegation and task-shifting, taking into account scope of practice	1,2,3,4,5,6,7,8
1.2 Promote quality and client safety in health care service delivery across the continuum of care from community to tertiary levels	1.2.3 Reinforce QI initiatives at all levels of patient care.	1,2,3,4,5,6,7,8
1.2 Promote quality and client safety in health care service delivery across the continuum of care from community to tertiary levels	1.2.4 Establish and implement health facility standards of care and accreditation system	1,2,3,4,5,6,7,8
1.2 Promote quality and client safety in health care service delivery across the continuum of care from community to tertiary levels	1.2.5 Review and enforce standard documentation of all client encounters across the levels of care	1,2,3,4,5,6,7,8
1.2 Promote quality and client safety in health care service delivery across the continuum of care from community to tertiary levels	1.2.6 Create and enforce patient safety mechanisms across levels and platforms of care	1,2

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
1.2 Promote quality and client safety in health care service delivery across the continuum of care from community to tertiary levels	1.2.7 Design and implement screening services across all levels of care for amenable illness/disease	1,2,3
1.3 Strengthen client-centred care and patient trust at all levels of the healthcare system	1.3.1 Promote, empower, and monitor provider/client rights and responsibilities at all levels	1,2,3,4,5,6,7,8
1.3 Strengthen client-centred care and patient trust at all levels of the healthcare system	1.3.2 Ensure and enforce service charters are in place for each facility	2,3
Objective 2: To strengthen preventive health services and capacity to address social determinants of health to reduce the burden on health care system		
2.1 Drive wellness and healthy lifestyle practices in the community and health care system	2.1.1 Develop, pre-test, and regulate Information Education and Communication (IEC) materials	1,2,3,4,5,6,7,8
2.1 Drive wellness and healthy lifestyle practices in the community and health care system	2.1.2 Conduct research on cultural beliefs and practices negatively affecting health and on innovative approaches to address these beliefs	1,2,3,5,8
2.1 Drive wellness and healthy lifestyle practices in the community and health care system	2.1.3 Conduct community dialogue sessions and engagement/advocacy meetings on cultural beliefs and practices negatively affecting health and to empower the community to own and promote their health	1,2,3,4,5,6,7,8
2.1 Drive wellness and healthy lifestyle practices in the community and health care system	2.1.4 Conduct community sensitization through various channels of communication, integrated across disease areas including prevention and management of disease stratified for age, economic and workplace with broad range of information modes with focus on emerging high burden diseases such as NCDs and mental health	1,2,3,4,5,6,7,8
2.1 Drive wellness and healthy lifestyle practices in the community and health care system	2.1.5 Review health education and promotion packages with stakeholders, civic organizations, schools, health system workplaces, churches and more to ensure incorporation of health prevention and management strategies with appropriate access platforms	1,2,3,4,5,6,7,8
2.1 Drive wellness and healthy lifestyle practices in the community and health care system	2.1.6 Employ social media platform via a multisectoral approach to ensure youth are engaged and empowered on issues that affect them including SRHR, recreational drug use, mental health, violence, and abuse	1,2,3,4,5,6,7,8
2.1 Drive wellness and healthy lifestyle practices in the community and health care system	2.1.7 Engage Ministry of Education to incorporate and strengthen health education, social and life skill empowerment programs in schools on emerging health issues including NCDs, recreational drug abuse, violence, SRHR and more	1,2,3,4,5,6,7,8
2.1 Drive wellness and healthy lifestyle practices in the community and health care system	2.1.8 Integration of health education programs for NCDs and mental health into pre-existing delivery platforms of communicable diseases in the community and at all levels of the health system	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
2.2 Increase access to safe food, water sanitation and hygiene (WASH), housing and working environments	2.2.1 Ensure high quality food safety and processes	1,2,3,4,5,6,7,8
2.2 Increase access to safe food, water sanitation and hygiene (WASH), housing and working environments	2.2.2 Inspect, redesign, and improve work and living environments on health, safety, occupational, and environmental standards	1,2,3,4,5,6,7,8
2.2 Increase access to safe food, water sanitation and hygiene (WASH), housing and working environments	2.2.3 Ensure safe water and sanitation facilities in all communities	1,2,3,4,5,6,7,8
2.2 Increase access to safe food, water sanitation and hygiene (WASH), housing and working environments	2.2.4 Conduct multi-sectoral meetings to approve, monitor, and evaluate housing and structural designs from design up construction	1,2,3,4,5,6,7,8
2.3 Strengthen occupational health	2.3.1 Develop OHS standards at every level	1,2,3,4,5,6,7,8
2.3 Strengthen occupational health	2.3.2 Enforce occupational health and safety standards at all levels	1,2,3,4,5,6,7,8
2.3 Strengthen occupational health	2.3.3 Conduct investigations of OHS incidences and conditions	1,2,3,4,5,6,7,8
2.4 Strengthen vector and vermin control, pandemic, disaster preparedness response and surveillance of diseases	2.4.1 Develop and implement an integrated, intersectoral approach for vector and vermin control including needs assessment	1,2,3,5,7
2.4 Strengthen vector and vermin control, pandemic, disaster preparedness response and surveillance of diseases	2.4.2 Conduct operational research on entomology including establishing entomological laboratories for evidence-based vector and vermin control measures	
2.4 Strengthen vector and vermin control, pandemic, disaster preparedness response and surveillance of diseases	2.4.3 Develop a standard, coordinated intersectoral plan, assessment and M&E tools for pandemic or disaster response	1,2,3,4,5,6,7,8
2.4 Strengthen vector and vermin control, pandemic, disaster preparedness response and surveillance of diseases	2.4.4 Conduct coordination and surveillance meetings with the Ministry of Agriculture's Animal Health Department on surveillance and response of zoonotic diseases	1,2,3,4,5,6,7,8
2.4 Strengthen vector and vermin control, pandemic, disaster preparedness response and surveillance of diseases	2.4.5 Conduct outbreaks/epidemic/pandemic investigations	1,2,3,4,5,6,7,8
2.5 Strengthen intersectoral prevention and response to violence, discrimination, accidents, and injury	2.5.1 Facilitate establishment of traffic accidents coordination structures and response at all levels	1,2,3,4,5,6,7,8
2.5 Strengthen intersectoral prevention and response to violence, discrimination, accidents, and injury	2.5.2 Enact policy and laws to limit traffic accidents through intersectoral collaboration	1,2,3,4,5,6,7,8
2.5 Strengthen intersectoral prevention and response to violence, discrimination, accidents, and injury	2.5.3 Creation of legal and educational tools to prevent common non-traffic accidents	1,2,3,4,5,6,7,8
2.5 Strengthen intersectoral prevention and response to violence, discrimination, accidents, and injury	2.5.4 Promote policies and laws that equalize gender discrimination, place according consequences on SGBV including minors and respond to physical, economic and emotional abuse	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
2.6 Address health and health delivery effects of climate change	2.6.1 Complete intersectoral assessment of current and projected climate change effects on health in Malawi	1,2,3,4
2.6 Address health and health delivery effects of climate change	2.6.2 Participate in development of mitigation plan with emphasis on health and health delivery response	2,3,4,5,6
2.6 Address health and health delivery effects of climate change	2.6.3 Create policies, operational plans and laws such as limiting deforestation to mitigate health and health system effects	1,2,3,4,5
Objective 3: Improve the availability, accessibility and quality of health infrastructure and medical equipment at all levels of health care		
3.1 Strengthen evidence-based management and construction new health infrastructure to meet burden of disease and service delivery needs	3.1.1 Construct new health infrastructure, including new district hospitals, new community hospitals, new health centres, new health posts, new maternity units, new staff houses, construction of laboratories, construction of ultrasound rooms, x-ray room construction, and other new specialized construction at central hospitals, including speeding up construction of stalled projects	1,2,3,4,5,6,7,8
3.1 Strengthen evidence-based management and construction new health infrastructure to meet burden of disease and service delivery needs	3.1.2 Establish Trauma Management Centres in the hospitals along the M1 road to manage road traffic injuries	1,2,3,4,5,6,7,8
3.1 Strengthen evidence-based management and construction new health infrastructure to meet burden of disease and service delivery needs	3.1.3 Promote joint planning, consultations, and monitoring for equipment and infrastructure between the Directorate of Health Technical Support Services, the Directorate of Planning and Policy Development, and infrastructure units at District Council	1,2,3,4,5,6,7,8
3.1 Strengthen evidence-based management and construction new health infrastructure to meet burden of disease and service delivery needs	3.1.4 Publish and distribute standard designs for new infrastructure at all levels of care	1,2,7,8
3.2 Upgrade, rehabilitate and maintain health infrastructure to meet burden of disease and service delivery needs	3.2.1 Rehabilitate and maintain health facilities, including general rehabilitation, maternity unit rehabilitation, expansion of the health facility, expansion of wards, staff house rehabilitation, and water/power for health facilities, taking into account the cost of infrastructure maintenance at 2% of asset value stipulated in the PAM policy of 2002 and to accommodate requirements of modern equipment	1,2,3,4,5,6,7,8
3.2 Upgrade, rehabilitate and maintain health infrastructure to meet burden of disease and service delivery needs	3.2.2 Upgrade some health posts to health centres to decongest district hospitals	2,3,4,5,6,7,8
3.2 Upgrade, rehabilitate and maintain health infrastructure to meet burden of disease and service delivery needs	3.2.3 Upgrade all urban health centres to community hospitals in order to decongest central hospitals	1,3,4,5,6,7,8
3.2 Upgrade, rehabilitate and maintain health infrastructure to meet burden of disease and service delivery needs	3.2.4 Ensure health facilities have access to reliable sources of power and water, including fuel for generators, installation of water pumps and water tanks, and connection to the electricity grid	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
3.3 Strengthen procurement, acquisition, distribution, and installation of equipment	3.3.1 Procure medical equipment for primary health facilities according to the Standard Equipment List	1,2,3,4,5,6,7,8
3.3 Strengthen procurement, acquisition, distribution, and installation of equipment	3.3.2 Procure medical equipment for secondary health facilities according to the Standard Equipment List	1,2,3,4,5,6,7,8
3.3 Strengthen procurement, acquisition, distribution, and installation of equipment	3.3.3 Procure medical equipment for tertiary health facilities according to the Standard Equipment List and for advanced care based on tertiary hospital consultations	1,2,3,4,5,6,7,8
3.3 Strengthen procurement, acquisition, distribution, and installation of equipment	3.3.4 Procure plant and non-medical/administrative equipment to facilitate program management for delivery of the HSSP III based on the standard equipment list and gap analysis (e.g., office furniture in the District Health Office or in health facilities)	2,3,4,5
3.3 Strengthen procurement, acquisition, distribution, and installation of equipment	3.3.5 Develop and implement policy on procurement and disposal of medical equipment based on review of procurement processes and including representation of HTSS in procurement processes	1,2,3,4,5,6,7,8
3.3 Strengthen procurement, acquisition, distribution, and installation of equipment	3.3.6 Develop and implement policy on procurement and disposal of radioactive equipment and material	
3.4 Strengthen evidence-based management, maintenance and use of all equipment	3.4.1 Maintain medical equipment and plant in primary health care facilities, including quality control checks and planned preventative maintenance, taking into account the cost of equipment maintenance at 5% of asset value stipulated in PAM policy of 2002	1,2,3,4,5,6,7,8
3.4 Strengthen evidence-based management, maintenance and use of all equipment	3.4.2 Maintain medical equipment in secondary health care facilities, including quality control checks and planned preventative maintenance, taking into account the cost of equipment maintenance at 5% of asset value stipulated in PAM policy of 2002	1,2,3,4,5,6,7,8
3.4 Strengthen evidence-based management, maintenance and use of all equipment	3.4.3 Maintain medical equipment in tertiary health care facilities, including quality control checks and planned preventative maintenance, taking into account the cost of equipment maintenance at 5% of asset value stipulated in PAM policy of 2002	1,2,3,4,5,6,7,8
3.4 Strengthen evidence-based management, maintenance and use of all equipment	3.4.5 Ensure RMUs have sufficient human resource capacity and equipment to perform their function	
3.4 Strengthen evidence-based management, maintenance and use of all equipment	3.4.6 Review and publish Standard Equipment List for primary, secondary, and tertiary health facilities and ensure alignment with other guidelines such as the Health Benefits Package and Standard Treatment Guidelines	1,2,3,4,5,6,7,8
3.4 Strengthen evidence-based management, maintenance and use of all equipment	3.4.7 Track equipment functionality and developing equipment purchasing/maintenance plans, accordingly, including a survey for medical equipment and plant in all primary, secondary, and tertiary health facilities once every 3 years and an up-to-date inventory of medical equipment at each point of care	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
3.4 Strengthen evidence-based management, maintenance, and use of all equipment	3.4.8 Initiate the formulation of the legal instruments to aid the enforcement of equipment donation policy and guidelines	
3.5 Strengthen transport and referral at all levels of healthcare delivery system	3.5.1 Enhance ambulance management and patient transport for effective and efficient services, including availability of utility vehicles, boats, and fuel	1,2,3,4,5,6,7,8
3.5 Strengthen transport and referral at all levels of healthcare delivery system	3.5.2 Procure transport facilities (vehicles, bicycles, and motorcycles) for community health services	1,2,3,4,5,6,7,8
Objective 4: Improve the availability of competent and motivated human resources for health for quality health service delivery that is effective, efficient, and equitable		
4.1 Enhance recruitment, selection, deployment, and equitable distribution of human resources for health	4.1.1 Recruit sufficient health workers to deliver the primary and secondary platform of care, as estimated by the workforce optimization model and specialist planning for the tertiary level	1,2,3,4,5,6,7,8
4.1 Enhance recruitment, selection, deployment, and equitable distribution of human resources for health	4.1.2 Staff emergency operations centers (EOCs) with physicians, veterinarians, epidemiologists, and microbiologists	1,2,3,4,5,6,7,8
4.1 Enhance recruitment, selection, deployment, and equitable distribution of human resources for health	4.1.3 Conduct regular functional reviews aligned to evidence on the demand for health services, such as the workforce optimization model and estimates of health workforce needed to deliver the tertiary platform of care, and including review of appropriate cadres to deliver each level of care (e.g., phase-out of the Medical Assistant cadre and replacement with Clinical Officers/Technicians)	
4.1 Enhance recruitment, selection, deployment, and equitable distribution of human resources for health	4.1.4 Rationalize and ensure equitable staff deployments as aligned to evidence on the demand for health services, such as the workforce optimization model and estimates of health workforce needed to deliver the tertiary platform of care	1,2
4.1 Enhance recruitment, selection, deployment, and equitable distribution of human resources for health	4.1.5 Employ best practices for staff recruitment and selection	1,2,3,4,5,6,7,8
4.1 Enhance recruitment, selection, deployment, and equitable distribution of human resources for health	4.1.6 Decentralize recruitment to sub national levels	1,2,3,4,5,6,7,8
4.2 Optimize production at training institutions and strengthen coordination between the institutions and health sector needs	4.2.1 Increase pre-service volumes for prioritized training programmes in alignment with the long-term HRH recruitment requirements, as estimated by the workforce optimization model for primary/secondary care and specialist planning for the tertiary level	1,2,3,4,5,6,7,8
4.2 Optimize production at training institutions and strengthen coordination between the institutions and health sector needs	4.2.2 Develop and roll out interventions to strengthen coordination and quality assurance monitoring for pre-service training programs	1,2,3,4,5,6,7,8
4.2 Optimize production at training institutions and strengthen coordination between the institutions and health sector needs	4.2.3 Embed professional behaviour and customer service teaching in training programmes	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
4.2 Optimize production at training institutions and strengthen coordination between the institutions and health sector needs	4.2.4 Enforce accreditation standards for training institutions (by regulatory bodies)	1,2,3,4,5,6,7,8
4.3 Improve staff development strategies, policies, procedures, and practices for human resources for health	4.3.1 Conduct a role set analysis for all cadres and accordingly induct/orient newly recruited, promoted or redeployed human resource for health	1,2,3,4,5,6,7,8
4.3 Improve staff development strategies, policies, procedures, and practices for human resources for health	4.3.2 Develop and implement a harmonized continuous professional development (CPD) system linked to renewal of licensure	1,2,3,4,5,6,7,8
4.3 Improve staff development strategies, policies, procedures, and practices for human resources for health	4.3.3 Develop and implement the harmonized in-service training curriculum for all cadres of the health workforce, as embedded within the CPD system, aligned to service delivery needs, and inclusive of professional behaviour and client satisfaction	1,2,3,4,5,6,7,8
4.3 Improve staff development strategies, policies, procedures, and practices for human resources for health	4.3.4 Monitor the CPD system, inclusive of harmonized in-service training, for quality assurance and return on investment	1,2,3,4,5,6,7,8
4.3 Improve staff development strategies, policies, procedures, and practices for human resources for health	4.3.5 Intensify supervision/mentorship/coaching programs for cadres across all levels of care as linked to the CPD system	1,2,3,4,5,6,7,8
4.3 Improve staff development strategies, policies, procedures, and practices for human resources for health	4.3.6 Design and implement internships, fellowships, and residency programs for human resources for health	1,2,3,4,5,6,7,8
4.4 Strengthen and enforce performance management policies, procedures, and practices	4.4.1 Develop and implement a robust performance management system that is linked to implementation of strategic and operational plans at the national/district/facility levels and linked to health worker promotions, incentives, and disciplinary systems	2,3,4,5,6,7,8
4.4 Strengthen and enforce performance management policies, procedures and practices	4.4.2 Conduct regular reviews of existing supervision lines to enable implementation of performance management	3
4.4 Strengthen and enforce performance management policies, procedures and practices	4.4.3 Enforce robust regulation of health workers, their training and practice, including development, review, and enforcement of health service regulations and disciplinary procedures	1,2,3,4,5,6,7,8
4.4 Strengthen and enforce performance management policies, procedures and practices	4.4.4 Re-structure clear and coordinated career pathways for career growth	2,3,4
4.4 Strengthen and enforce performance management policies, procedures and practices	4.4.5 Develop and implement talent management and retention strategies and policies	1,2,3
4.5 Institute and provide for competitive remuneration, benefits, and working conditions for human resources for health	4.5.1 Develop innovative and competitive remuneration and benefits interventions	1,2,3
4.5 Institute and provide for competitive remuneration, benefits, and working conditions for human resources for health	4.5.2 Design and implement incentives to motivate and retain health workers in hard-to-reach areas	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
4.5 Institute and provide for competitive remuneration, benefits, and working conditions for human resources for health	4.5.3 Improve working conditions to improve staff retention	1,2,3,4,5,6,7,8
4.6 Generate reliable data and build capacity for evidence-based health workforce decision-making through digital innovations and technological platforms for human resource management	4.6.1 Build the capacity of HR practitioners to conduct evidence-based decision-making, including use of enterprise resource planning (ERP) systems, tools and technologies such as iHRIS at all levels	1,2,3,4,5,6,7,8
4.6 Generate reliable data and build capacity for evidence-based health workforce decision-making through digital innovations and technological platforms for human resource management	4.6.2 Integrate iHRIS and HRMIS systems	1,2,3,4,5,6,7,8
4.6 Generate reliable data and build capacity for evidence-based health workforce decision-making through digital innovations and technological platforms for human resource management	4.6.3 Procure IT infrastructure to enable HRH digital innovations such as iHRIS	1,2,3,4,5,6,7,8
4.6 Generate reliable data and build capacity for evidence-based health workforce decision-making through digital innovations and technological platforms for human resource management	4.6.4 Conduct regular data validation of all HRH databases, including iHRIS, personnel records, payroll audits, among others	1,2,3,4,5,6,7,8
Objective 5: To improve the availability, quality, and rational utilization of medicines and related medical supplies, balancing among the 3 P's: patients, products, and personnel.		
5.1 Enhance data driven quantification and forecasting processes to inform best-value and flexible procurement of medicines and commodities to deliver health services both within and beyond the Health Benefits Package	5.1.1 Procure sufficient commodities and supplies (inclusive of freight/clearance/tendering costs) to deliver the primary, secondary, and tertiary HBP, which will be provided free to charge to the end user	1,2,3,4,5,6,7,8
5.1 Enhance data driven quantification and forecasting processes to inform best-value and flexible procurement of medicines and commodities to deliver health services both within and beyond the Health Benefits Package	5.1.2 Adopt innovative methods to conduct supply chain and procurement processes for central hospitals and specialty centres to reflect patients' needs.	1,2,3,4,5,6,7,8
5.1 Enhance data driven quantification and forecasting processes to inform best-value and flexible procurement of medicines and commodities to deliver health services both within and beyond the Health Benefits Package	5.1.3 Ensure availability of quality and timely data for forecasting, especially for products that have a high degree of known seasonality to improve availability during high-demand periods	1,2,3,4
5.1 Enhance data driven quantification and forecasting processes to inform best-value and flexible procurement of medicines and commodities to deliver health services both within and beyond the Health Benefits Package	5.1.4 Enhance the functionality of the interoperability layer to assimilate various data collection systems	1
5.1 Enhance data driven quantification and forecasting processes to inform best-value and flexible procurement of medicines and commodities	5.1.5 Develop and implement key performance indicators (KPIs) of the procurement process to identify and resolve bottlenecks	1

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
to deliver health services both within and beyond the Health Benefits Package		
5.1 Enhance data driven quantification and forecasting processes to inform best-value and flexible procurement of medicines and commodities to deliver health services both within and beyond the Health Benefits Package	5.1.6 Introduce and conduct multi-year planning for commodities at national and sub-national levels	1,2,3,4,5,6,7,8
5.1 Enhance data driven quantification and forecasting processes to inform best-value and flexible procurement of medicines and commodities to deliver health services both within and beyond the Health Benefits Package	5.1.7 Increase use of “framework contracts” that provide flexibility to CMST in procurement, reducing capital tied to fixed contracts (e.g., contract for a ceiling of 1,000 units, committing to only 500, but willingness to pay an increased price for the balance)	1
5.1 Enhance data driven quantification and forecasting processes to inform best-value and flexible procurement of medicines and commodities to deliver health services both within and beyond the Health Benefits Package	5.1.8 Set standard for prequalification of vendors to central and district hospitals in light of decentralization	1,2,3,4,5,6,7,8
5.1 Enhance data driven quantification and forecasting processes to inform best-value and flexible procurement of medicines and commodities to deliver health services both within and beyond the Health Benefits Package	5.1.9 Review and disseminate the PMRA drug donations guidelines and develop clear mechanisms for improving CMST accountability for expired products including processes for channelling donations directly to districts	1
5.2 Improve warehousing and distribution infrastructure, practices, and processes to maintain product quality and shelf life	5.2.1 Fully fund costs of warehousing and distribution for commodities and supplies to deliver the primary, secondary, and tertiary HBP	1,2,3,4,5,6,7,8
5.2 Improve warehousing and distribution infrastructure, practices, and processes to maintain product quality and shelf life	5.2.2 Fully fund costs of warehousing and distribution for commodities and supplies to deliver the primary, secondary, and tertiary services outside of the HBP	
5.2 Improve warehousing and distribution infrastructure, practices, and processes to maintain product quality and shelf life	5.2.3 Continue to promote creation of community distribution	1,2,3,4,5,6,7,8
5.2 Improve warehousing and distribution infrastructure, practices, and processes to maintain product quality and shelf life	5.2.4 Update the current SOP manual for warehousing, distribution, and reporting	
5.2 Improve warehousing and distribution infrastructure, practices, and processes to maintain product quality and shelf life	5.2.5 Develop and implement measures aimed at reducing and eliminating waste, using the pharmaceutical waste management guidelines	1,2,3,4,5,6,7,8
5.2 Improve warehousing and distribution infrastructure, practices, and processes to maintain product quality and shelf life	5.2.6 Inspect shelf life of medicines both at procurement level and at service delivery point level	1,2,3,4,5,6,7,8
5.2 Improve warehousing and distribution infrastructure, practices, and processes to maintain product quality and shelf life	5.2.7 Distribute commodities across health facilities based on accurate, timely and complete logistics data for each facility	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
5.3 Increase rational drug use and deter/prevent pilferage at all levels	5.3.1 Review dispensing practices to support and monitor the rational use of medicines and medical supplies	1,2,3,4,5,6,7,8
5.3 Increase rational drug use and deter/prevent pilferage at all levels	5.3.2 Revisit and reinforce the role of the Drug Theft Investigation Unit (DTIU) to institute and sustain mechanisms that deter individuals from misuse of drugs, and clearly sanctions those charged with theft of drugs	1,2,3,4,5,6,7,8
5.3 Increase rational drug use and deter/prevent pilferage at all levels	5.3.3 Re-assess the volume/value of reported theft and determine reasonable measures to address leakages	1,2,3,4,5,6,7,8
5.3 Increase rational drug use and deter/prevent pilferage at all levels	5.3.4 Consider requiring package labelling (e.g., "Property of MOH") to reduce pilferage/arbitrage	
5.4 Improve medicine quality through increased QA capacity including testing, auditing, and licensing	5.4.1 Improve pharmaco-vigilance efforts overall, including post-market surveillance (PMS)	1,3,5,7
5.4 Improve medicine quality through increased QA capacity including testing, auditing, and licensing	5.4.2 Build technical capacity in PMRA to support auditing and licensing of pharmaceutical facilities	1,3,5,7
5.4 Improve medicine quality through increased QA capacity including testing, auditing, and licensing	5.4.3 Improve capacity of PMRA National Quality Control Laboratory for testing quality of drugs and other health commodities (e.g., condoms)	1,3,5,7
5.4 Improve medicine quality through increased QA capacity including testing, auditing, and licensing	5.4.4 Review possible barriers to registration of medicines to encourage more suppliers	1
5.4 Improve medicine quality through increased QA capacity including testing, auditing, and licensing	5.4.5 Incorporate traditional medicine policy into QA activities	
5.4 Improve medicine quality through increased QA capacity including testing, auditing, and licensing	5.4.6 Support initiatives aiming at improving Malawi Blood Transfusion Services (MBTS) practices to ensure blood safety in blood transfusion centres and all other centres utilizing blood components	1,3,4,5,6,7,8
5.5 Harmonize and expand implementation of information systems to improve end-to-end (e2e) visibility in the pharmaceutical supply chain	5.5.1 Continue the roll-out of installations of OpenLMIS software and eHIN in all health centres (all data is captured, but some facilities use paper forms which are entered into the system at other sites)	1,2,3,4,5,6,7,8
5.5 Harmonize and expand implementation of information systems to improve end-to-end (e2e) visibility in the pharmaceutical supply chain	5.5.2 Assess the value of each electronic data collection tool (e.g., eHIN, C-stock, OpenLMIS, WMS, ERP) and work towards greater integration in support of the Digital Supply Chain Strategy and Architecture (DSCS&A) of 2021	1,2,3,4,5,6,7,8
5.5 Harmonize and expand implementation of information systems to improve end-to-end (e2e) visibility in the pharmaceutical supply chain	5.5.3 Create master data mechanisms like traceability (in support of GS1) and interoperability to avoid duplication in medicines and locations as approved by the MOH in 2020	1,2,3

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
5.5 Harmonize and expand implementation of information systems to improve end-to-end (e2e) visibility in the pharmaceutical supply chain	5.5.4 Considering the cost-benefit of extending the MIS beyond the pharmacy level to departments and wards, e.g., prescription forms at facility levels, which would require electronic medical records or patient management system	1,2,3,4,5,6,7,8
5.5 Harmonize and expand implementation of information systems to improve end-to-end (e2e) visibility in the pharmaceutical supply chain	5.5.5 Integrate into existing systems, tools that allows generation of streamlined information on purchased and donated stock	
5.5 Harmonize and expand implementation of information systems to improve end-to-end (e2e) visibility in the pharmaceutical supply chain	5.5.6 Support coordination and information sharing between CMST and district pharmacy managers and hospitals	1
5.5 Harmonize and expand implementation of information systems to improve end-to-end (e2e) visibility in the pharmaceutical supply chain	5.5.7 Provide more rights at service provider level to know stock levels within the LMIS system	1,2,3,4,5,6,7,8
5.5 Harmonize and expand implementation of information systems to improve end-to-end (e2e) visibility in the pharmaceutical supply chain	5.5.8 Support initiatives aimed at strengthening M&E and data management systems within HTSS	1
5.5 Harmonize and expand implementation of information systems to improve end-to-end (e2e) visibility in the pharmaceutical supply chain	5.5.9 Support full development of the system for collecting and analysing of laboratory data	1,2,3,4,5,6,7,8
5.6 Improve capacity to oversee, supervise, and coordinate across all supply chains and stakeholders.	5.6.1 Consider creation of a logistics management unit (LMU) to coordinate among parallel supply chains including vaccines, likely within HTSS, under the assumption that donors will continue to fund those systems	1,2
5.6 Improve capacity to oversee, supervise, and coordinate across all supply chains and stakeholders.	5.6.2 Lobby to include representation of CSOs within the CMST board to enhance transparency and accountability during the awards of "public contracts"	
5.6 Improve capacity to oversee, supervise, and coordinate across all supply chains and stakeholders.	5.6.3 Rationalize responsibilities among Ministries of Health, Finance, NLGFC, CMST, and District Councils over the supply chain management functions of medicines and related health products	1,2,3
5.6 Improve capacity to oversee, supervise, and coordinate across all supply chains and stakeholders.	5.6.4 Support and enhance district-level capacity to conduct supply chain management functions in light of the decentralization of these services, including Drug and Therapeutic Committees among others	1,3,7
5.6 Improve capacity to oversee, supervise, and coordinate across all supply chains and stakeholders.	5.6.5 Enhance supportive supervision and training for supply chain management personnel at all levels of the healthcare levels	1,2,4
5.6 Improve capacity to oversee, supervise, and coordinate across all supply chains and stakeholders.	5.6.6 Support strengthening of administrative and technical management functioning of the medical diagnostics and public health laboratory (PHL) services	1,2,3,4,5,6,7,8
5.6 Improve capacity to oversee, supervise, and coordinate across all supply chains and stakeholders.	5.6.7 Include CHAM and its MOU across all areas and explore options for MOUs with additional partners	1,2

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
5.7 Develop procedures and establishment of temporary mechanisms that adapt to predict, detect, and respond to emergencies	5.7.1 Link supply chain efforts with the Public Health Institute of Malawi to assist in responding to emergencies	3
5.7 Develop procedures and establishment of temporary mechanisms that adapt to predict, detect, and respond to emergencies	5.7.2 Consider the value of onshoring local manufacturing of some essential commodities, e.g., PPE	1,2
5.7 Develop procedures and establishment of temporary mechanisms that adapt to predict, detect, and respond to emergencies	5.7.3 Develop plan for ensuring excess/surge spacing in warehousing and distribution	1
5.7 Develop procedures and establishment of temporary mechanisms that adapt to predict, detect, and respond to emergencies	5.7.4 Implement the Emergency Supply Chain Playbook process	1,2,3,4,5
5.7 Develop procedures and establishment of temporary mechanisms that adapt to predict, detect, and respond to emergencies	5.7.5 Identify the major institutions involved in the supply chain response, including district-level public health emergency committees	1
Objective 6: To develop a sustainable and harmonized country led digital health system that covers all areas of service provision and enables efficient delivery of health services at all levels of the health system		
6.1 Improve coordination of digital health investments to increase efficiency	6.1.1 Strengthen leadership and governance structures for management of digital health interventions	1,2,3,4,5,6,7,8
6.1 Improve coordination of digital health investments to increase efficiency	6.1.2 Create an enabling environment for effective implementation of digital health solutions through appropriate legislation, policies and compliance mechanism	1,2,3,4,5,6,7,8
6.1 Improve coordination of digital health investments to increase efficiency	6.1.3 Strengthen Sustainability mechanism for digital health solutions	1,2,3,4,5,6,7,8
6.2 Establish a reliable ICT infrastructure that enables utilization of digital health systems	6.2.1 Improve capability of connectivity in poorly covered areas (i.e., areas with no or intermittent connectivity)	2,3
6.2 Establish a reliable ICT infrastructure that enables utilization of digital health systems	6.2.2 Extend coverage of renewable and hybrid power solutions	2,3,4,5,8
6.2 Establish a reliable ICT infrastructure that enables utilization of digital health systems	6.2.3 Improve availability of computing infrastructure and devices	1,2,3,4,5,6,7,8
6.3 Build the capacity of clients, communities, health care workers, and IT personnel to participate in and benefit from digital health interventions	6.3.1 Increase capacity of health workforce and IT personnel to implement and utilize digital health interventions	1,2,3,4,5,6,7,8
6.3 Build the capacity of clients, communities, health care workers, and IT personnel to participate in and benefit from digital health interventions	6.3.2 Increase awareness and capacity of clients and communities to utilize digital health interventions	1,2,3,4,5,6,7,8
6.4 Leverage technology to increase access to and quality of service delivery	6.4.1 Use innovative digital health technologies to increase access and quality of health (Also refer to MEHIS Activity 3.6)	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
6.4 Leverage technology to increase access to and quality of service delivery	6.4.2 Leverage use of predictive analytics and big data to improve health service delivery	1,2,3,4,5,6,7,8
6.4 Leverage technology to increase access to and quality of service delivery	6.4.3 Align digital health interventions with comprehensive digital health architecture	1,2,3,4,5,6,7,8
6.5 Improve security of information and ICT Systems	6.5.1 Ensure continuity of service delivery in all service delivery points in cases of disasters and loss of property	1,2,3,4,5,6,7,8
6.5 Improve security of information and ICT Systems	6.5.2 Develop and deploy standardized security management process in health sector to promote acceptable use of data and related tools, including hardware and software	1,2,3,4,5,6,7,8
6.5 Improve security of information and ICT Systems	6.5.3 Address ethical issues in digital health in order to promote privacy and security of clients' data	1
6.5 Improve security of information and ICT Systems	6.5.4 Ensure that digital health information and users are protected from undesirable threats including physical threats (fraud and theft), malwares, breach of privacy, misuse of information	1,2,3,4,5,6,7,8
6.6 Promote continuity of care through the shared health record	6.6.1 Lead efforts to ensure that longitudinal and cross-sectional patient health records are accessible at the point of service delivery	1,2,3,4,5,6,7,8
6.6 Promote continuity of care through the shared health record	6.6.2 Strengthen the identification of clients and staff across the health system	1,2,3,4,5,6,7,8
6.7 Strengthen the sharing and accessibility of data across systems to enable use.	6.7.1 Implement a standard framework as a national standard for interoperability	1,2,3
6.7 Strengthen the sharing and accessibility of data across systems to enable use.	6.7.2 Implement interoperability among priority systems	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.1 Rationalize and harmonize routine data collection and reporting systems	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.2 Finalize configuration and expand functionality of DHIS2 (GIS, climate change, DHIS 2 tracker and CRVS)	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.3 Strengthen implementation of a national civil registration system and the generation of vital statistics	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.4 Strengthen the implementation of key health related surveys	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.5 Strengthen disease surveillance through identification and reporting of notifiable diseases	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.6 Ensure timely tracking of priority HSSP3 Indicators	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.7 Implement coordinated approach to routine data validation	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.8 Promote the use of data for decision-making at health facility level	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.9 Institutionalize the systematic use of data in regular review meetings at all levels	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.10 Build capacity of actors across all levels on data analysis, interpretation, and use	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.11 Strengthen process monitoring of HSSP3 implementation and annual implementation plans	1,2,3,4,5,6,7,8
6.8 Effectively monitor and evaluate HSSP III implementation	6.8.12 Ensure alignment of partner activities to the MoH HIS/M&E strategies and annual implementation plans	1,2,3,4,5,6,7,8
Objective 7 To promote and coordinate the conduct of health research in order to generate high quality evidence required to inform the development of health and health care delivery		
7.1 To build health research capacity in public, private, research and academic institutions	7.1.1 Improve health research leadership, management and governance capacity	1,2,3,4,5
7.1 To build health research capacity in public, private, research and academic institutions	7.1.2 Enhance health research coordination mechanisms by strengthening relevant research ethics committees (RECs)	1,2,3,4,5,6,7,8
7.1 To build health research capacity in public, private, research and academic institutions	7.1.3 Enhance health research coordination mechanisms through increasing monitoring and inspection of adherence to National Health Sciences Research Committee (NHSRC) Standard Operating Procedures (SOPs)	1,2,3,4,5,6,7,8
7.1 To build health research capacity in public, private, research and academic institutions	7.1.4 Enhance health research coordination mechanisms through developing and implementing guidelines for enforcing ethical standards on the conduct of health research	1,3,5,7
7.1 To build health research capacity in public, private, research and academic institutions	7.1.5 Enhance health research coordination mechanisms through legislation and policy on intellectual property rights	1,2,3,4,5,6,7,8
7.1 To build health research capacity in public, private, research and academic institutions	7.1.6 Enhance Institutional Capacity of health and related researchers to enhance organizational efficiency and effectiveness	1,2,3,4,5,6,7,8
7.2 To achieve the development of evidence-based policies in health through intensification of knowledge generation, translation and utilization of research	7.2.1 Strengthen coordination of health research knowledge generation, research knowledge translation, knowledge sharing and knowledge utilization	1,2,3,4,5,6,7,8
7.2 To achieve the development of evidence-based policies in health through intensification of knowledge generation, translation and utilization of research	7.2.2 Include analysis of routinely collected and survey data, compilation and analysis of disease & events surveillance data to support detection of outbreaks and implementation of international health regulations (IHR) as part of knowledge generation	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
7.2 To achieve the development of evidence-based policies in health through intensification of knowledge generation, translation and utilization of research	7.2.3 Strengthen research transparency and accessibility of evidence generated from clinical trials and implementation science through mechanisms such as an open research repository	1,2,3,4,5,6,7,8
7.3 To ensure that portals for research funding are accessed and that there are adequate funds to finance health research in Malawi	7.3.1 Build capacity to write health research grant proposals and market them to prospective funders to help make research self-sustaining and build research careers thereby positioning the health sector to provide local solutions to health care challenges	1,2,3,4,5,6,7,8
Objective 8: To enhance effectiveness of leadership and governance at all levels of the health sector		
8.1 Develop and implement a “One Plan, One Budget and One M&E” system in order to strengthen alignment and harmonization of donor and Government funds towards health sector priorities	8.1.1 Develop annual HSSP III Operational Plans that consolidate prioritized activities from Government and partners and from the national, central hospital, and district levels	1,2,3,4,5,6,7,8
8.1 Develop and implement a “One Plan, One Budget and One M&E” system in order to strengthen alignment and harmonization of donor and Government funds towards health sector priorities	8.1.2 Enforce alignment and harmonization of Government and donor funding towards priorities in the annual HSSP III Operational Plan, in line with the principles of aid effectiveness and development cooperation	1,2,3,4,5,6,7,8
8.1 Develop and implement a “One Plan, One Budget and One M&E” system in order to strengthen alignment and harmonization of donor and Government funds towards health sector priorities	8.1.3 Conduct Joint Annual Reviews, zonal reviews, and district reviews as an integrated system with a common set of integrated indicators (e.g., tracking progress on DIP implementation and the National Health Indicators Handbook) in order to monitor annual HSSP III implementation	1,2,3,4,5,6,7,8
8.2 Strengthen policies, guidelines, and frameworks including at the multi-sectoral level	8.2.1 Ensure health sector representation in the development, implementation, and monitoring of other national sectoral plans that are closely linked to health, including education, agriculture, gender, WASH, etc.	
8.2 Strengthen policies, guidelines, and frameworks including at the multi-sectoral level	8.2.2 Facilitate development and inclusion of social determinants of health during the formulation of District Development Plans, Village Action Plans, and other multi-sectoral planning at the district and community levels	1,2,3,4,5,6,7,8
8.2 Strengthen policies, guidelines, and frameworks including at the multi-sectoral level	8.2.3 Update and review regulatory laws and guidelines every five years	1,2,3,4,5,6,7,8
8.2 Strengthen policies, guidelines, and frameworks including at the multi-sectoral level	8.2.4 Strengthen policy think tanks and policy engagement	2
8.3 Enhance financial management to strengthen accountability of funds	8.3.1 Conduct routine audits to strengthen accountability and transparency of Government funds	1,2,3
8.3 Enhance financial management to strengthen accountability of funds	8.3.2 Build financial management capacity across the health system	1,2,3,4,5,6,7,8
8.3 Enhance financial management to strengthen accountability of funds	8.3.3 Conduct routine financial management activities	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
8.4 Improve governance, including stakeholder oversight, coordination and implementation at all levels of the health service delivery system	8.4.1 Enhance functionality of sector-wide governance structures such as the Health Sector Working Group and TWGs	1,2,3,4,5,6,7,8
8.4 Improve governance, including stakeholder oversight, coordination and implementation at all levels of the health service delivery system	8.4.2 Increase provider autonomy and fiscal decentralization across primary, secondary, and tertiary levels	1,2,3,4,5,6,7,8
8.4 Improve governance, including stakeholder oversight, coordination and implementation at all levels of the health service delivery system	8.4.3 Update the functional review of the MOH in alignment with integrated planning for the health system	
8.4 Improve governance, including stakeholder oversight, coordination and implementation at all levels of the health service delivery system	8.4.4 Strengthen oversight of central and district hospitals, including building capacity of the hospital ombudsman, finalizing guidelines for Boards of Trustees for central hospitals, and other oversight mechanisms	1,2,3,4,5,6,7,8
8.4 Improve governance, including stakeholder oversight, coordination and implementation at all levels of the health service delivery system	8.4.5 Build oversight capacity of the members of the Health and Environmental Committees	1,2,3,4,5,6,7,8
8.4 Improve governance, including stakeholder oversight, coordination and implementation at all levels of the health service delivery system	8.4.6 Strengthen community oversight structures across planning, execution and evaluation of the health sector, including forming, training, performance contracting, and supervising HCMCs, CHAGS and VHCs, and strengthening linkages among community health structures	1,2,3,4,5,6,7,8
Objective 9: To set a health financing architecture that is able to mobilize adequate resources, distribute the resources in an efficient and equitable way, and strategically purchase services based on a well-defined benefit package in pursuit of UHC goals		
9.1 To mobilize adequate, sustainable, and predictable funds for the health sector to optimally delivery essential health services	9.1.1 Improve efficiency across all health system functions at all levels of the healthcare delivery system	1,2,3,4,5,6,7,8
9.1 To mobilize adequate, sustainable, and predictable funds for the health sector to optimally delivery essential health services	9.1.2 Enhance participation of communities in financing of public health services	1,2,3,4,5,6,7,8
9.1 To mobilize adequate, sustainable, and predictable funds for the health sector to optimally delivery essential health services	9.1.3 Improve and scale up optional paying services in public facilities	1,2,3,4,5,6,7,8
9.1 To mobilize adequate, sustainable, and predictable funds for the health sector to optimally delivery essential health services	9.1.4 Increase external funding to the health sector ²	2,3,4,5,6,7,8
9.1 To mobilize adequate, sustainable, and predictable funds for the health sector to optimally delivery essential health services	9.1.5 Improve financing of family planning using domestic resources	1,2,3,4,5,6,7,8
9.1 To mobilize adequate, sustainable, and predictable funds for the health sector to optimally delivery essential health services	9.1.6 Introduce innovative health financing mechanisms	1,2,3,4,5,6,7,8
9.2 Improvement of efficiency and equity in pooling and management of resources for the health sector	9.2.1 Reduce fragmentation of health sector funding	1,2,3,4,5,6,7,8

STRATEGY DESCRIPTION	ACTIVITY DESCRIPTION	IMPLEMENTATION YEARS
9.2 Improvement of efficiency and equity in pooling and management of resources for the health sector	9.2.2 Strengthen leadership, governance, and accountability mechanisms to ensure harmonization of health financing decision-making across all levels of the health system	1,2,3,5,6,7,8
9.2 Improvement of efficiency and equity in pooling and management of resources for the health sector	9.2.3 Improve management and accountability of Government and donor funds	1,2,3,4,5,6,7,8
9.3 Development and implementation of strategic purchasing measures across the healthcare service delivery continuum	9.3.1 Define and implement benefit packages for all levels of care	1,2,4,5,6,8
9.3 Development and implementation of strategic purchasing measures across the healthcare service delivery continuum	9.3.2 Develop and implement effective strategic resource allocation and use measures across the healthcare delivery	1,2,3,4,5,6,7,8
9.3 Development and implementation of strategic purchasing measures across the healthcare service delivery continuum	9.3.3 Develop and implement effective provider payment mechanisms	1,2,3,4,5,6,7,8
9.4 To establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system	9.4.1 Strengthen institutional capacity in health financing and PFM to effectively implement the Health Financing Strategy	1,2,3,4,5,6,7,8
9.4 To establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system	9.4.2 Strengthen generation and use of evidence in health financing decision making at all levels	1,2,3,4,5,6,7,8
9.4 To establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system	9.4.3 Strengthen the advocacy capacity for the Health Financing Strategy	1,2,3,4,5,6,7,8
9.4 To establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system	9.4.4 Strengthen the legal, regulatory and policy frameworks for health financing	1,2,3,4,5,6,7,8

Annex 2: HSSP III M&E Matrix

Ultimate Impacts									
1. Health Status: 2. Financial Risk Protection: 3. Client Satisfaction (and Equity by socioeconomic status, gender, geographical location)									
Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
HSSP III Impact: Improved health status, financial risk protection and client satisfaction.									
Mortality by age and sex									
Life expectancy at birth	64.7 (World Bank, 2020)	67	68	70	Annual projections (NSO)	National/TA	Age, Sex, SES, District		Health Status
Adult mortality rate between 15 and 60 years of age	18 per 1000 (World Bank 2021)	14	8	3	Annual (NSO)2wASzx	National/TA	Age, Sex, SES, District		Health Status
Under-five mortality rate	56/1000 live birth (MICS,2019/2020)	50	35	15	NSO	District/TA	Age, Sex, SES, District	RHD	Health Status
Infant mortality rate	40 per 1000 live births (2019/2020, MICS)	20	13	7	DHS & MICS	District	Age, Sex, SES, District	RHD	Health Status
Neonatal mortality rate	26 per 1,000 live birth (MICS, 2020)	19	18	17	DHS & MICS	District	Age, Sex, SES, District	RHD	Health Status
Perinatal Mortality	35 deaths per 1,000 (MDHS 2016)	30	25	20	Annual	District	Gestation age, Type of SB	RHD	Health Status
Mortality by cause									
Maternal mortality ratio	349 per 100,000 live births (World Bank, 2017)	304	258	213	DHS & MICS	District	Age, Sex, SES, District	RHD	Health Status

Ultimate Impacts

1. Health Status: 2. Financial Risk Protection: 3. Client Satisfaction (and Equity by socioeconomic status, gender, geographical location)

Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
		AIDS related mortality rate	70.3 per 1,000 population (MoH, 2020)	49					
Mortality rate from CV diseases, Diabetes, cancer, chronic respiratory diseases between ages 30 and 70	22.6% (World Bank, 2019)	21	19	17	Annual (DHIS 2)	Facility	Sex	NCD	Health Status
Malaria mortality rate	37.45 deaths per 100,000 population (WHO, 2020)	33	29	24	Annual (DHIS2)	Facility	Sex	NMCP	Health Status
Suicide mortality rate	5.4 per 100,000 population (World Bank, 2019)	5	4	4	Annual (DHIS 2)	Facility	Sex	Police	Health Status
Road traffic accident mortality rate	33.4 per 100,000 population (World Bank, 2019)	29	25	20	Annual (DHIS 2)	Facility	Sex	Traffic Police	Health Status
Fertility									
Adolescent fertility rate (age-specific fertility rate for women aged 10-14 and 15-19)	136 births per woman aged 15-19 (MICS,2020)	100	69	38	Monitored through DHS and MICS	National/District	Sex	RHD	Health Status
Total Fertility Rate	4.2 births per woman (MICS,2020)	4	3	3	Monitored through DHS and MICS	National/District	Age	RHD	Health Status

Ultimate Impacts

1. Health Status: 2. Financial Risk Protection: 3. Client Satisfaction (and Equity by socioeconomic status, gender, geographical location)

Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
Morbidity									
HIV prevalence rate (15+yrs) (%)	8.7% (MoH 2020)	7.8	7.2	7	Annual	District	Sex	HIV	Health Status
HIV incidence rate (15-49 yrs) (%)	0.22 per 1,000 HIV negative population (MoH, 2020)	0	0	0	Annual	District	Sex	HIV	Health Status
TB incidence rate	141 per 100,000 people (World Bank, 2020)	106	71	36	Annual	District	Sex	NTCP	Health Status
Transmission rate of HIV from mother to child	6.3 per 100 HIV infected mothers (Malawi Spectrum file)	5.7	5.5	5.3	Annual	National	None	HIV	Health Status
TB Incidence (notification) rate	141 per 100,000 (WHO 2020)	TBD	TBD	36	Annual	District	sex	NTbCP	Health Status

Ultimate Impacts

1. Health Status: 2. Financial Risk Protection: 3. Client Satisfaction (and Equity by socioeconomic status, gender, geographical location)

Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
Percentage of households making catastrophic payments for healthcare using the 10% of total consumption basket spent on healthcare	4.4 % WHO (2017)	TBD	TBD	0.1	Annual	District	Sex	DPPD (NHA)	Financial Risk protection
Proportion of households with catastrophic Out of Pocket expenditure exceeding 40% of non-food expenditure	TBD	TBD	TBD	TBD	Annual	District	Sex	DPPD (NHA)	Financial Risk protection
Medical Impoverishment rate	TBD	TBD	TBD	TBD	Annual	District	Sex	DPPD (NHA)	Financial Risk protection

Ultimate Impacts

1. Health Status: 2. Financial Risk Protection: 3. Client Satisfaction (and Equity by socioeconomic status, gender, geographical location)

Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
		Inequality adjusted Financial Risk Protection score	TBD	TBD					
Percentage of Client satisfied with the health service delivery	TBD	TBD	TBD	98	Annual	District	Sex	DPPD (NHA)	Client Satisfaction

Intermediate (Health Service Delivery) Impacts									
1. Access 2. Quality 3 Efficiency (and Equity by socioeconomic status, gender, geographical location)									
Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
HSSP III Intermediate Impact: Improved access to, quality and efficiency of health services									
ART coverage among known HIV-infected pregnant women	98%	99%	99%	99%	Annual	District	Sex	HIV	Access
Antiretroviral Therapy (ART) coverage	86%	88%	90%	92%	Annual	District	Sex	HIV	Access
HIV-positive TB patients on ART during TB treatment	99%	100%	100%	100%	Annual	District	Sex	HIV	Access
% of births attended by skilled health personnel	96.4% (2020, MICS)	98%	99%	100%	5 years (MICS)	District	Sex	RHD	Access
Demand for family planning satisfied with modern methods (all women)	79.9% (MICS,2020 currently Married)	TBD	TBD	83.3% FP2030 for All women	5 years (MICS)	District	Sex	RHD	Access
Intermittent preventive therapy for malaria during pregnancy (IPTp) Penta III coverage	36.22%	44%	52%	60%	Annual	District	Sex	NMCP	Access

Intermediate (Health Service Delivery) Impacts									
1. Access 2. Quality 3 Efficiency (and Equity by socioeconomic status, gender, geographical location)									
Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
HSSP III Intermediate Impact: Improved access to, quality and efficiency of health services									
Percentage of women with (5) or more doses of IPTp	TBD	TBD	TBD	TBD	Annual	District	Sex	RHD	Access
% of 1-year-old children immunized against measles	70% (MICS, 2020)	TBD	TBD	TBD	5 years (MICS)	District	Sex	RHD	Access
% of 1-year-old children fully immunized (survey based)	72.6% (MICS, 2020)	TBD	TBD	TBD	5 years (MICS)	District	Sex	RHD	Access
Use of Insecticide treated nets (ITN)	76.8% (MICS, 2020)	TBD	TBD	91	5 years (MICS)	District	Sex	NMCP	Access
Antenatal care coverage – at least four visits (%)	51% (MICS, 2020)	TBD	TBD	TBD	5 years (MICS)	District	Sex	RHD	Access
Postpartum care coverage	TBD	TBD	TBD	TBD	Annual	District	Sex	RHD	Access
Modern contraceptive prevalence rate (all women)	TBD	TBD	TBD	54.8% FP2030)	Annual	District	Sex	RHD	Access

Intermediate (Health Service Delivery) Impacts									
1. Access 2. Quality 3 Efficiency (and Equity by socioeconomic status, gender, geographical location)									
Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
HSSP III Intermediate Impact: Improved access to, quality and efficiency of health services									
Children with diarrhea receiving oral rehydration solution (ORS)	TBD	TBD	TBD	TBD	Annual	District	Sex	RHD	Access
Vitamin A supplementation coverage (6-59 months)	TBD	TBD	TBD	TBD	Annual	District	Sex	RHD	Access
Cervical cancer screening	61% facilities are providing Cervical cancer screening (EmONC, 2020)	TBD	TBD	TBD	Annual	District	Sex	NCD	Access
Percentage of CHAM catchment population not covered by SLAs	TBD	TBD	TBD	TBD	Annual	District	Sex		Access

Intermediate (Health Service Delivery) Impacts									
1. Access 2. Quality 3 Efficiency (and Equity by socioeconomic status, gender, geographical location)									
Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
HSSP III Intermediate Impact: Improved access to, quality and efficiency of health services									
Percentage of health facilities providing EmONC signal functions 3 months prior to assessment (disagg: BEmONC, CEmONC) OR: Availability of BEmONC and CEmON C services per 500,000 population	22%	TBD	TBD	TBD	Annual	District	Sex	RHD	Quality
Percentage of Health facilities with full infrastructure requirements in line with respective level of care/% health facilities meeting minimum infrastructure norms	TBD	TBD	TBD	TBD	Annual	District	Sex	QMD	Quality

Intermediate (Health Service Delivery) Impacts									
1. Access 2. Quality 3 Efficiency (and Equity by socioeconomic status, gender, geographical location)									
Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
HSSP III Intermediate Impact: Improved access to, quality and efficiency of health services									
Health worker density and distribution	TBD	TBD	TBD	TBD	Annual	District	Sex	HRH	Quality
Health worker density and distribution (adjusted for workload)	TBD	TBD	TBD	TBD	Annual	District	Sex	HRH	Efficiency
Current expenditure on health by government as a % of total expenditure on health	32.59% (World Bank, 2019)	36.20%	39.90%	43.50%	Annual	District	Sex	DPPD	Efficiency
Disbursement rates for Government and Donor Fund	TBD	TBD	TBD	TBD	Annual	District	Sex	DPPD	Efficiency
Clean audit rates for Government and Donor Funds	TBD	TBD	TBD	TBD	Annual	District	Sex	DPPD	Efficiency
Share of budget Devolved to facility level	TBD	TBD	TBD	TBD	Annual	District	Sex	DPPD	Efficiency

Intermediate (Health Service Delivery) Impacts									
1. Access 2. Quality 3 Efficiency (and Equity by socioeconomic status, gender, geographical location)									
Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
		2024	2027	2030					
HSSP III Intermediate Impact: Improved access to, quality and efficiency of health services									
Percent of donor funds and projects not fully aligned to HSSP III	TBD	TBD	TBD	TBD	Annual	District	Sex	DPPD	Efficiency

OUTCOMES AND OUTPUTS										
Impacts	Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
			2024	2027	2030					
Outcome 1: improved access to and equity of quality health services	Percentage of health facilities providing essential health services that meets minimum quality of care standards	39 (Annual report for MoH under the quality Directorate with reference to COHSASA introduced in 2019)	45	60	75	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Service Delivery
Output 1.1: Integrated health care systems developed	Percentage of services that are integrated at service delivery level	TBD	25	45	65	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Service Delivery
Output 1.2: Improved quality of health care standards	Percentage of health facilities meeting minimum	8	22	40	55	Health care reports, Meeting	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Service Delivery

OUTCOMES AND OUTPUTS

Impacts	Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
			2024	2027	2030					
	quality of health care standards					minutes, Bi-annually				
Output 1.3: Improved client-centered care at all levels of the healthcare system	Percentage of facilities with functional system on client-centered care	TBD	61	72	80	Suggestion Boxes, Facility Advisory Meeting minutes	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Service Delivery
Outcome 2: Improved capacity in preventive, promotion, and rehabilitative health service in addressing social determinants of health	Percentage of entities at all levels of care that have functional multi-sectoral stakeholder committees on social determinants of health	TBD	15	65	100	Annual Reports	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Social Determinants for health
Output 2.1: Increased awareness of positive health behavior in the community	Percentage of target population reached with priority health behavior change messages	TBD	30	85	100	Annual Reports	DISTRICT	Central Hospitals, District Hospitals, Zones & National	Preventive Health	Social Determinants for health
Output 2.2: Increased awareness on water sanitation and hygiene (WASH), safe housing and working environments	Percentage of target households reached with information and communication on water sanitation and hygiene (WASH), safe housing and working environments	TBD	25	75	100	Annual	District	Disaggregated by WASH, housing and working environments	WASH	Social Determinants for health
Output 2.3: Improved working environments	Percentage of institutions adhering to minimum standards on occupational health	TBD	35	75	100	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Social Determinants for health

OUTCOMES AND OUTPUTS

Impacts	Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
			2024	2027	2030					
Output 2.4 Enhanced capacity in vector and vermin control, pandemic, disaster preparedness response and surveillance of diseases	Percentage of target households reached with priority interventions on vector and vermin control, pandemic, disaster preparedness response and surveillance of diseases	TBD	30	65	100	Annual Reports	DISTRICT	Central Hospitals, District Hospitals, Zones & National	Preventive Health	Social Determinants for health
Output 2.5: Enhanced multi-sectoral capacity on prevention and response to violence, discrimination, accidents, and injury	Percentage of service provision points with capacity in preventions and response to violence, discrimination, accidents, and injuries	TBD	25	75	100	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Social Determinants for health
Output 2.6: Improved response capacity in the management of the effects of the climate and climate change at levels of service delivery	Percentage of entities with capacity in the management of the effects of the climate and climate change	TBD	25	65	100	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Social Determinants for health
Outcome 3: Improved availability of health infrastructure and medical equipment at all levels of health care	Percentage of population within 5km-radius of a public or contracted health facility meeting the minimum infrastructure and medical equipment requirements	TBD	10	50	100	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Infrastructure and medical equipment
Output 3.1 Increased number of health facilities constructed following the Capital Investment Plan (CIP)	Percentage of planned health infrastructure in the CIP constructed	TBD	10	60	100	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Infrastructure and medical equipment

OUTCOMES AND OUTPUTS

Impacts	Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
			2024	2027	2030					
Output 3.2 Increased number of health facilities upgraded or rehabilitated or maintained based on CIP	Percent health infrastructure, upgraded or rehabilitated or maintained based on CIP	TBD	10	65	100	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Infrastructure and medical equipment
Output 3.3 Increased number of health facilities with essential equipment	Percent of health facilities equipped to minimum requirements	TBD	10	65	100	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Infrastructure and medical equipment
Output 3.4: Improved equipment management systems at all levels	Percentage of health facilities with functional Asset Management Unit (AMU)	TBD	25	60	100	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Infrastructure and medical equipment
Output 3.5: Enhanced transport and communication systems based on CIP	Percentage of health facilities with functioning transport and communication systems	TBD	25	75	100	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Infrastructure and medical equipment
Output 3.6: Improved infrastructure and medical equipment	Percentage of institutions adhering to minimum infrastructure management guidelines	TBD	25	75	100	Health care reports, Meeting minutes, Bi-annually	DISTRICT	Central Hospitals, District Hospitals, Zones & National	QMD	Infrastructure and medical equipment
Outcome 4: Increased number of service delivery points with the required competent and motivated staff	Percentage of health facilities meeting the minimum staffing norms	TBD	TBD	TBD	100	Annual	District, National	Sex	DHR	Human resources for health

OUTCOMES AND OUTPUTS

Impacts	Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
			2024	2027	2030					
Output 4.1: Reduced vacancies at all levels of health system	Percentage of vacant positions filled	TBD	20	60	100	Annual	District, National	Sex	DHR	Human resources for health
Output 4.2: Increased number cadres that are produced at training institutions in line with the requirements of the HSSP III	Percentage of health cadres produced in line with the HSSP III needs	TBD	35	75	100	Annual	District, National	Sex	DHR	Human resources for health
Output 4.3: Increased number of service delivery point with standard human resources Management norms	Percentage of staff that enroll for staff development opportunities	TBD	25	75	100	Annual	District, National	Cadre	DHR	Human resources for health
Output 4.4: Increased number of service delivery points creating a conducive working environment for effective career progression	Percentage of functional service delivery points with functional performance management policies and systems	TBD	25	75	100	Annual	District, National	Sex	DHR	Human resources for health
Output 4.5: Increased staff morale and performance in the delivery of health care services	Percentage of staff rewarded based on performance criteria	TBD	25	65	100	Annual	District, National	sex	DHR	Human resources for health
Output 4.6: Increased access to quality data for decision-making	Percentage of service delivery utilizing own data for decision-making	TBD	25	75	100	Annual	District, National	sex	DHR	Human resources for health

OUTCOMES AND OUTPUTS

Impacts	Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
			2024	2027	2030					
Outcome 5: Increased quality, availability and rational utilization of medicines related and medical supplies	Percentage of health facilities without stock-outs of tracer medicines and related medical supplies.	TBD	15	60	100	Monthly, Annual	District	Central Hospitals, District Hospitals, Zones & National	HTSS	Medicines and medical supplies
Output 5.1 Increased capacity in quantification and forecasting to deliver health services	Percentage of service delivery points accurately quantifying and forecasting medicines and commodities	TBD	25	60	100	Monthly, Annual	District	Central Hospitals, District Hospitals, Zones & National	HTSS	Medicines and medical supplies
Output 5.2 : Increased capacity in logistics and storage management in maintaining product quality	Percentage of health facilities adhering to approved logistical cycle management	TBD	20	65	100	Monthly, Annual	District	Central Hospitals, District Hospitals, Zones & National	HTSS	Medicines and medical supplies
Output 5.3: Increased availability of medication for patient treatment	Percentage of prescriptions done according to standard treatment guidelines	TBD	15	60	100	Monthly, Annual	District	Central Hospitals, District Hospitals, Zones & National	Clinical Services	Medicines and medical supplies
Output 5.4: Increased medicine quality through improved capacity in Quality Assessment.	Percentage of targeted medicine quality assessments completed	TBD	10	60	100	Monthly, Annual	District	Central Hospitals, District Hospitals, Zones & National	QMD	Medicines and medical supplies
Output 5.5: Increased capacity in the supervisory and coordination of supply chains and stakeholders	Percentage of health personnel with capacity to conduct quality assessment including testing, auditing, and licensing.	TBD	TBD	TBD	100	Annual	District	Central Hospitals, District Hospitals, Zones & National	DHR	Medicines and medical supplies
Output 5.6: Increased capacity in Emergency preparedness and response	Percentage of institutions implementing a documented Emergency preparedness and response plan.	TBD	25	65	100	Annual	District	Central Hospitals, District Hospitals, Zones & National	DHR	Medicines and medical supplies

OUTCOMES AND OUTPUTS

Impacts	Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
			2024	2027	2030					
Outcome 6: Improved information and data management and sharing through digital health system	Percentage of health facilities with a functional facility wide management system	TBD	25	65	100	Annual	District	Disaggregate by HSSP III pillars, EHP priority areas and decision-making unit	Digital Health	Digital health
Output 6.1: Increased coordination and investment in digital health in line with CIP	Percentage of resources available for in digital health investments in line with the CIP	TBD	15	50	100	Annual	District	Central Hospitals, District Hospitals, Zones & National	Digital Health	Digital health
Output 6.2: Increased investment in ICT infrastructure supporting digital health systems	Percentage of health facilities with minimum required ICT infrastructure for digital health systems	TBD	20	65	100	Annual	District	Central Hospitals, District Hospitals, Zones & National	Digital Health	Digital health
Output 6.3: Increased staff capacity in digital health systems	Percentage of targeted users trained in digital health services	TBD	25	70	100	Annual	District	Sex	Digital Health	Digital health
Output 6.4: Increased health services delivered on digital health platform	Number of clients receiving services through tele health	TBD	25	65	100	Annual	District	Sex	Digital Health	Digital health
Output 6.5: Improved security of information and ICT Systems	Proportion of staff trained in information and ICT systems security	TBD	15	60	100	Annual	District	Sex	Digital Health	Digital health
Output 6.6: Increased integration and interoperability of health systems at all service delivery levels	Proportion of digital health sub systems integrated through interoperability for sharing of health data across platforms	TBD	20	65	100	Annual	District	Sex	Digital Health	Digital health

OUTCOMES AND OUTPUTS

Impacts	Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
			2024	2027	2030					
Outcome 7: Increased knowledge generation and management for health	Completion rate for research projects	TBD	25	65	100	Annual	District	Central Hospitals, District Hospitals, Zones & National	DPPD	Health research
Output 7.1: Increased health research capacity across public, private, research and academic entities	Percentage of health research conducted by MoH and CHAM staff	TBD	25	60	100	Annual	District	Central Hospitals, District Hospitals, Zones & National	DPPD	Health research
Output 7.2: Increased capacity in knowledge management and utilization for evidence based decision making by policy makers	Percentage of health policies informed by research evidence	TBD	15	50	100	Annual	District	Central Hospitals, District Hospitals, Zones & National	DPPD	Health research
Output 7.3: Increased financing in health research	Percentage health expenditure spent on research	TBD	4	8	10	Annual	District	Central Hospitals, District Hospitals, Zones & National	DPPD	Health research
Output 7.4: Increased sharing and utilization of data for decision-making	Proportion of service delivery points with information management systems that are integrated for data sharing	TBD	25	60	100	Annual	District	Central Hospitals, District Hospitals, Zones & National	DPPD	Health research
Output 7.5: Increased HSSP III implementation performance monitoring and evaluation	Percentage of targeted M&E activities completed	TBD	25	70	100	Annual	District	Central Hospitals, District Hospitals, Zones & National	DPPD	Health research
Outcome 8: Increased transparency and	Percentage of service delivery points meeting minimum standards of	TBD	30	50	70	Quarterly	Facility	By levels of service delivery	QMD	Leadership and governance

OUTCOMES AND OUTPUTS

Impacts	Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
			2024	2027	2030					
accountability in the health sector	transparency and accountability									
Output 8.1: Increased harmonization and alignment of donor and government funds towards health sector priorities	Percentage of health institutions adhering to the “One plan, One Budget and One M&E” system	TBD	25	60	100	annual	District	By health zones	Planning Department	Leadership and governance
Output 8.2: Increased coordination of policies, guidelines, and frameworks at the multi-sectoral level	Percentage of targeted activities implemented through multisectoral coordination completed	TBD	15	65	100	annual	District	By Program	Planning Department	Leadership and governance
Output 8.3: Increased accountability of budget utilization	Percentage of service delivery points meeting minimum accountability requirements	TBD	15	55	100	Quarterly	District	By facility, District Zone, National	Planning Department	Leadership and governance
Output 8.4 : Increased performance in health emanating from functional governance structures	Percentage of service delivery points with functional oversight or governance structures	TBD	15	60	100	Quarterly	District	By facility, District Zone, National, HAC, ADC	QMD	Leadership and governance
Outcome 9: Increased effectiveness of the health financial management system	Percentage of service delivery points with minimum health financial management systems requirements	TBD	15	45	100	Quarterly, Bi-annual, Annual	District	Central hospitals, District Public facilities, Faith-based Health facilities, Health Zone	DPPD	Health financing
Output 9.1: Increased financial sustainability in	Percentage of health service delivery points with	TBD	15	50	100	Quarterly, Bi-annual,	District	Central hospitals, District Public	DPPD	Health financing

OUTCOMES AND OUTPUTS

Impacts	Indicators	Baseline	Targets			Period of reporting and Means of Verification	Smallest geographic area	Disaggregation	Responsible programme	Domain
			2024	2027	2030					
the delivery of essential health services	sustainable financial mobilization strategies					Annual Financial Reports		facilities, Faith-based Health facilities, Health Zone		
Output 9.2: Increased efficiency and equity in management of pooled health resources	Percentage of service delivery points achieving minimum efficiency and equity requirements in financial management	TBD	15	65	100	Quarterly, Bi-annual, Annual Financial Reports	District	Central hospitals, District Public facilities, Faith-based Health facilities, Health Zone	DPPD	Health financing
Output 9.3: Increased efficiency in procurement in health	Percentage of service delivery points meeting minimum requirements for strategic purchasing	TBD	20	65	100	Quarterly, Bi-annual, Annual, LMIS	District	Central hospitals, District Public facilities, Faith-based Health facilities, Health Zone	HTSS	Health financing
Output 9.4: Improved health financing at all levels of health system	Percentage of health service delivery points adhering to health minimum financing requirements	TBD	20	60	100	Quarterly, Bi-annual, Annual Financial Reports	Facility	Central hospitals, District Public facilities, Faith-based Health facilities, Health Zone	DPPD	Health financing

