

Malawi Global Health Initiative Strategy Document

I. U.S. Global Development Policy

The United States (U.S.) has launched a new global development policy. For Malawi, the policy objectives, operational model and architecture will be articulated in the Development Strategy of the U.S. Government (USG) Mission in Malawi, and implemented through three major initiatives globally: Feed the Future (FtF), the Global Health Initiative (GHI) and the Climate Change Initiative. The pillars of this new policy initiative are economic growth, innovation, public sector capacity, tailored strategies, and accountability. Execution of this policy hinges on the following elements: selectivity; country ownership and responsibility; division of labor; leverage of private investments; strengthened multilateral capabilities and analysis of impact. This document articulates a new multi-year strategy for support to the health and health-related sectors of Malawi to be implemented under GHI.

II. GHI Vision

Historically, the U.S. has funded health programs in Malawi that support specific disease or program efforts of the Government of Malawi (GOM). These include HIV/AIDS under the President's Emergency Plan for AIDS Relief (PEPFAR); malaria under the President's Malaria Initiative (PMI); and tuberculosis, family planning and reproductive health, maternal, neonatal and child health, and nutrition programs.

In partnership with the GOM, the U.S. Mission to Malawi will implement the health programs listed above under a single, coordinated health strategy called the Global Health Initiative (GHI) strategy. Its primary goal is **increasing access to quality health care to foster a healthier Malawian populace able to participate in the country's economic development**. Under GHI, the USG will support GOM to improve policy and governance, while investing in successful integration and coordination of vertical programs across the health spectrum. The USG will invest \$121,000,000 across the health sector in Malawi, and health will continue to be a priority within the foreign assistance provided by the USG.

In designing a strategy for GHI in Malawi, the USG has planned in concert with the GOM, taking its priorities and financial resource gaps into consideration. Along with the GOM, the USG also worked with civil society and other partners to analyze the most urgent health needs in Malawi. Finally, the team evaluated USG current investments and core competencies, to determine where new approaches could have the most impact. These considerations led to the following three areas of focus for GHI in Malawi: **1) the provision of quality care to reduce maternal, neonatal and child mortality and morbidity, 2) reduction of unintended pregnancies, and 3) the reduction of new HIV infections.**

To most strategically achieve these goals, USG will implement integrated and efficient programs that benefit the formal and informal health sector in ways that have a significant and sustainable impact. USG will make a concentrated effort on the cross-cutting areas of **human resources for health, infrastructure, and leadership, governance, management and accountability**, which are the most critical and most difficult problems in Malawi and which limit development significantly.

III. Critical Health Outcomes and Systems Issues in Malawi

Health Conditions and Statistics

Significant efforts by GOM and partners have improved the health status of Malawians in recent decades, particularly Malawian children, but many health challenges remain¹. With an estimated population of 13.6 million people and an annual growth rate of 3.2 percent, the population of Malawi is projected to more than triple in 30 years. While contraceptive use is well-established in the culture, total fertility remains high at six children per woman and access to family planning is limited for youth and rural communities. Ninety three% of women receive at least one antenatal visit although this is usually late in pregnancy. Nonetheless, women often struggle to access maternity services, inhibited by familial, community, and infrastructure burdens, including the distance to the health facility closest to them. Though approximately two-thirds of births take place in a health facility with a “skilled” attendant, representing a substantial increase in recent years², Malawi has one of the highest maternal mortality ratios in the world at 807/100,000.³ Although Malawi is on track to achieve Millennium Development Goal 4⁴, infant and under-five mortality rates remain unacceptably high at 72/1,000 and 122/1,000 live births respectively. Neonatal mortality (at 33/1,000 live births) accounts for one-third of infant deaths and one-fifth of deaths among children under-five years of age. Malaria is the leading cause of mortality and morbidity in Malawi with approximately six million episodes of malaria per year. Nutrition remains a serious health and development problem with nearly half of Malawi’s children stunted.

HIV

With an HIV prevalence of 12% that shows little evidence of decline, Malawi continues to face a severe HIV epidemic. Of the estimated 900,000 people infected with HIV, approximately 56% and 23% are women and children, respectively. It is anticipated that 90,000 new infections will continue to occur each year in the absence of stronger prevention efforts⁵, of which at least 23% will be as a result of mother-to-child transmission. The high HIV/AIDS prevalence has also had an impact on previous successes of the TB program. According to the World Health Organization (WHO), the estimated co-

¹ New DHS data will be available in early 2011 and many of these statistics will be revised

² Multiple Indicator Cluster Survey, 2006

³ Demographic and Health Survey 2004; Currently 3 different maternal rates for Malawi are in circulation including 510/100,000 and 1100/100,000. 807/100,000 is the approved figure used by the MOH.

⁴ Millennium Development Goal 4: Reduce child mortality.

⁵ HIV Sentinel Surveillance and Estimates and Projections, Ministry of Health, Malawi, 2007

infection rate for TB/HIV is about 70 percent. Finally, a majority of the population is at risk of exposure to one or more neglected tropical diseases (NTDs) including Lymphatic filariasis and Schistosomiasis.

Maternal Mortality

The maternal mortality ratio for Malawi has been reported to vary from 510/100,000 to 1100/100,000. The MOH currently uses 807/100,000. What is not in dispute is the unacceptably high mortality in the country. Malawi needs reliable data that accurately informs the current baseline, monitors progress, and provides opportunities for course-corrections where necessary. Amongst the experts, there is wide agreement that the single most significant cause of maternal mortality in Malawi is the lack of access to quality care in both the public and private sector. A commonly held view is that by promoting antenatal care and the delivery of more Malawian babies in the presence of “skilled birth attendants”, maternal mortality rates will improve. However despite impressive gains in the number of women delivering in health facilities, maternal death rates remain high.

While indicators reference "skilled" attendants, this description is largely a misnomer because too few nurses and clinical officers are sufficiently trained to respond to the medical crises that directly cause maternal mortality. This lack of training is exacerbated by severe staffing shortages, and inadequate facilities and technology. A lack of appropriate interventions in antenatal clinics (ANC) leads to higher risk in the labor setting, and poor referral systems for women at higher risk contributes to them not accessing appropriate levels of service in time. Inequitable distribution of health facilities adds to lack of access for women across the risk spectrum in many rural areas. This is all profoundly complicated by supply chain failures, which can ultimately derail life-saving interventions even when skilled staff are present.

Health System Challenges of Human Resources, Infrastructure and Management

Insufficient numbers of adequately trained health care workers remains one of the most significant challenges of the health sector in Malawi. Staff shortages across all professional cadres, inadequate incentives for staff, lack of professional development, transfers of qualified staff out of positions, poor morale, and low capacity of training institutions across the country all persist despite recent efforts by the MOH. The burden of health care delivery now rests on a cadre of workers called Disease Control Assistants (DCAs). DCAs were originally envisioned as community health workers, whose role was to bring very basic care to Malawi’s rural populations. However, DCAs have been so successful in implementing Malawi’s extensive shift in tasks to lower level workers, that they are either overworked, providing inadequate care, or are in such high demand that the facilities have absorbed them from the community. With decentralization of health system management, more funding and responsibilities have been devolved to districts, where there is often weak capacity to budget and manage funds effectively.

Health infrastructure in Malawi is in dire need of attention. Not only are there not enough facilities, but the standing facilities cannot cope with the high volume of clients they see, and often times do not have water or electricity, impeding quality health care provision. Facilities, where available, are often so

poorly designed that loss-to-follow-up and death arise as women move in search of the next referred service. Several facilities have critical equipment, but lack the service agreements necessary to maintain them. These infrastructure problems are exacerbated by drug stock-outs and inconsistent commodity supplies.

While the MOH has made critical progress in developing and embracing new policy positions and decisions, there remain significant challenges in its capacity. Oversight and accountability are not always optimal, resulting in limited priority-setting of interventions for the greatest public health impact and uneven application of best practices in policymaking and implementation. Evolving government policies, such as decentralization and frequent personnel transfers, along with inadequate funding for the health sector, present formidable external challenges to health care organizations. At the same time, MOH continues to face critical staff shortages, generally weak management systems, difficulty in sustaining high-quality services, and other internal challenges.

The Need for Quality Care

All of these challenges facing Malawi's health system ultimately impact the quality of care, and the USG team has made improving care one of the driving forces of the joint USG/GOM GHI strategy described below. Within the framework of the GHI strategy, the majority of interventions will focus on quality improvement, quality assurance, and performance-based financing for health workers. Quality of care data will serve to assist health care workers to improve their services, and will also be used as the foundation for performance-based financing. The team will actively involve civil society in the health care dialogue.

Given the team's specific goal of reducing maternal mortality, interventions to improve quality of care will focus on labor and delivery wards, and their staff. Specific interventions include strengthening the curricula for nurses, expanding basic Emergency Obstetrics Care (BeMOC), enhancing infrastructure, improving transportation systems, and resolving problems around commodity security and availability, particularly for oxytocin and misoprostol.

Integrating services for FP/RH, HIV, nutrition, malaria and MCH will improve access and availability of services and improve the quality of the services delivered to reduce unintended pregnancies. Our strategy recognizes that policy-informing tools such as the National Health Accounts (NHA) can improve health outcomes for pregnant women, as well as reduce rates of HIV transmission, through improving the quality of decisions on allocation of budgets, deployment of community nurses, placement of electronic data records, and provision of data for decision-making. Tools like the NHA have the potential to collectively ensure that provision of health care services to Malawi incorporate the best data possible into programming.

The team acknowledges the challenge of directly correlating these kinds of systems-strengthening activities with changes in national-level health indicators. The intention of the strategy is to show plausible contributions by the priority approaches outlined in the document by using a strong monitoring system alongside the direct evaluation of systems-strengthening activities on health outcomes.

IV. Coordination of GOM, Development Partners and USG Health Strategies

Under the leadership of GOM, the MOH and development partners adopted a Sector Wide Approach (SWAp) to plan, finance, and monitor programs in the health sector in 2004. The joint Program of Work developed by the SWAp guides the investments and activities of all health partners in Malawi, and it prioritizes programs contributing to the successful implementation of the Essential Health Package (EHP) as part of the Malawi Poverty Reduction Strategy (MPRS). The SWAp uses a pooled or common funding approach, currently moving into its second phase, to provide a means for the government and international donors to better harmonize program implementation and reporting, and to more efficiently use available resources. The SWAp has also made provision for discrete funds to support the health sector programs. USG remains a discrete donor in Malawi; USAID is a signatory to the SWAp and both USAID and CDC, the latter through a cooperative agreement with the MOH, are active and valued partners in the inclusive planning and implementation of health programs fostered by GOM under the SWAp.

The strategy of the GOM has been to assemble five “Common Approach to Budget Support” (CABS) donors, which include: African Development Bank (AfDB), Department for International Development (DfID), European Union (EU), Norway and the World Bank. The CABS donors provide general budget support to the GOM and review progress against an agreed Performance Assessment Framework in the health sector. The health SWAp has created a Memorandum of Understanding (MOU) which governs the use and implementation of the pooled and discrete funds. . The major funders of the health pool are DfID, Norway, AfDB, with substantial support provided by the Global Fund (44% in 2008-2009) and the German Development Cooperation (GTZ+KFW, 3%)⁶. The largest discrete donor in Malawi is the USG (25%) with the UN Agencies, ICEIDA, Japan and Irish AID, also largely supporting the sector outside the pool. USG discrete inputs complement the cooperating partner’s budget and pooled support. This arrangement reduces USG risk and provides flexibility to respond to annual appropriations by Congress.

The MOH is currently finalizing its next strategic plan for the health sector. Called the Program of Work II (POW II, see Figure 1), this plan is structured around seven keys areas, or “Building Blocks”, which have been identified as essential to the successful implementation of a national health care program. These Building Blocks have a strong focus on increasing health access for the rural poor and vulnerable groups such as women and children, and they emphasize service delivery, service quality, and health systems strengthening.

Fig. 1. Malawi’s Program of Work II: Building Blocks of the National Health Care Program	
Building Block 1	Adequate and appropriately trained human resources
Building Block 2	Fit-for-purpose infrastructure, health care technology, and information systems
Building Block 3	A functional procurement and supply chain management system delivering high quality drugs and medical supplies at all levels
Building Block 4	A comprehensive approach to quality improvement at all levels, facilitating effective service delivery

⁶ Data Source – Malawi Aid Atlas Published January 2010, Ministry of Finance, Government of Malawi

Building Block 5	Disease prevention and health promotion strengthening and complementing effective service delivery
Building Block 6	Evidence-based decision-making through research, monitoring and evaluation
Building Block 7	MOH fulfils its core functions in a cost-effective manner and establishes a sustainable health financing system

The USG health portfolio under GHI is aligned with the POW II through its programs in maternal, neonatal and child health, reproductive health and family planning, HIV, malaria, tuberculosis, nutrition, NTDs and health systems strengthening (see Figure 2). In addition to financial resources, USG commits significant technical assistance in both its health and non-health programs in developing evidence-based policies and strategies that will strengthen health service delivery including the POW II, the HIV National Action Framework, Global Fund applications, and the National Agriculture Strategy as some examples.

The main tenet of the Program of Work (both POW I and POW II) is the implementation of the Essential Health Package (EHP) as part of the MPRS. USG support in the health sector addresses the major causes of morbidity and mortality that primarily affect the poor and the most vulnerable groups in society with particular focus on the following key priority areas (see also Figure 2):

- Prevention, care and support, and treatment for HIV/AIDS through PEPFAR;
- Prevention and treatment of malaria through PMI;
- Support for the national roadmap for accelerating reduction in maternal and neonatal morbidity and mortality through Child Survival and Health (CSH) funds ;
- Increased utilization of modern family planning methods through CSH funds;
- Scale-up of high impact interventions that contribute to the greatest reductions in child mortality for Malawi, including support for essential nutrition interventions through CSH funds and strengthening TB case detection and treatment through CSH and PEPFAR funds.

In the Malawi Growth and Development Strategy of 2006-2011, the GOM identifies “Health and Population” as an important sub-theme, and notes that a healthy population is “not only essential but also a prerequisite for economic growth and development.” Consistent with this perspective, USG has, as an example, provided support to the GOM to strengthen family planning services at national, facility and community levels. USG has supported improvements in the functioning of the health system through strengthened policies, laboratory services, human resources, procurement and supply chain management, leadership, supervision, fiscal responsibility and monitoring capacities of the MOH.

Fig.2. U.S. Global Health Initiative aligns with Malawi’s Health Plan, the Program of Work	
Malawi EHP Interventions	U.S. Global Health Initiative⁷
• Vaccine Preventable Diseases- EPI /IMCI ⁸	• Child Health
• Malaria	• Malaria

⁷ Current and proposed USG support aligns with the GHI priorities noted here.

⁸ Integrated Management of Childhood Illness (IMCI) Program

<ul style="list-style-type: none"> • Adverse Maternal and Neonatal Outcomes - Family Planning and Reproductive Health/Safe Motherhood 	<ul style="list-style-type: none"> • Maternal Health; Newborn Care; Family Planning and Reproductive Health
<ul style="list-style-type: none"> • Tuberculosis 	<ul style="list-style-type: none"> • Tuberculosis
<ul style="list-style-type: none"> • Acute Respiratory Infections 	<ul style="list-style-type: none"> • Child Health
<ul style="list-style-type: none"> • Acute Diarrheal Diseases- including Cholera Control 	<ul style="list-style-type: none"> • Child Health
<ul style="list-style-type: none"> • Sexually Transmitted Infections- including HIV/AIDS 	<ul style="list-style-type: none"> • Reproductive Health • HIV
<ul style="list-style-type: none"> • Schistosomiasis 	<ul style="list-style-type: none"> • NTDs
<ul style="list-style-type: none"> • Nutritional Deficiencies 	<ul style="list-style-type: none"> • Nutrition
<ul style="list-style-type: none"> • Eye, Ear and Skin Infections 	-
<ul style="list-style-type: none"> • Common Injuries & Emergencies 	-
<ul style="list-style-type: none"> • Essential Supporting Structures and Systems to enable effective delivery of the EHP 	<ul style="list-style-type: none"> • Health Systems Strengthening

V. Multi-sectoral Coordination

Internal

To operationalize GHI, the USG health team will prioritize close harmonization and communication internally across its agencies and disciplines, and externally with GOM and with partners, both local and international. The State Department will coordinate this effort among in-country agencies including USAID, HHS/CDC, DOD and Peace Corps, as well as other USG agencies with strong contributions to GHI but no in-country presence. Lessons learned from successful business models will improve efficiencies in coordination and implementation within USG, as well as with GOM and all partners. To ensure USG health programs are effectively aligned and coordinated with the priorities and efforts of Malawi’s national health strategies and reports on health targets, the team will strive to include Malawian leadership in the development and selection phase of various types of funding opportunities. USG will also ensure the women, girls and gender equality principle is consistently applied.

Seeking a coordinated “whole of government” approach, the health team will also more fully engage USG non-health initiatives including Feed the Future (FtF) and the Millennium Challenge Corporation (MCC) Compact program in the power and energy sector. The team will also intensify collaborations with USG sectors working in public affairs, gender, education, sustainable economic development, water and sanitation, agriculture, democracy and governance, and financial management, and will include Democracy, Conflict and Humanitarian Assistance (DCHA) and Economic Growth and Trade (EGAT) for humanitarian and economic growth partnerships. Both FtF and GHI teams recognize that reducing under-nutrition in Malawi is intertwined with changing how smallholders practice agriculture. Therefore GHI will work collaboratively with the Mission’s FtF team on all programming aimed at improving nutritional outcomes in Malawi, especially for women and children. This will entail forging new partnerships with FtF agriculture programs in order to leverage or create new points of entry to

strengthen community health programs that have nutritional benefits. GHI will also join FtF in mainstreaming inclusive gender perspectives as a cross-cutting priority in activity design and implementation. By coordinating FtF efforts with GHI, the same families and individuals targeted for a reliable source of quality food and sufficient resources to access and purchase food, can also be supported by efforts in the health sector. Similarly, the team will pursue avenues to link other interventions, for example climate change (cookstoves), neglected tropical diseases, water and sanitation, outbreak investigations and vaccine control.

External

USG Malawi has a long-standing, congenial relationship with GOM, and the Ministry of Health (MOH) in particular, and is highly engaged in developing plans and strategies in all areas of the health sector. USG works in collaboration with the Office of the President and Cabinet (Departments of Nutrition and HIV and AIDS; Public Service Management; Ministries of Finance, Development Planning and Corporation; Gender, Child and Community Development (MOGCCD); Local Government and Rural Development; Labor; Education; Defense (Malawi Defense Force), Agriculture and Food Security, and others).

Information sharing, identifying areas of current and potential collaboration and working across all sectors of government have been hallmarks of USG investments, to date. GHI provides an opportunity for smart and deliberate planning with the GOM around its national priorities and national plans. For example, by working upstream with Ministry of Finance and DHRMD to address human resource constraints in the MOH, effective programming of limited resources in line with International Monetary Fund (IMF) and World Bank negotiated settlements with the GOM are more likely.

USG maintains very strong ties with local civil society and international development partners, playing a leading role on key health and health-related coordinating bodies in Malawi including the Health Donor Group, and the Malawi Global Fund Coordinating Committee. This high level of coordination with bilateral and multilateral partners and with civil society has been fostered and led by GOM and ensures effective and informed decision making can occur by GOM.

Opportunities to partner with other development initiatives led by external agencies will be seized upon when appropriate, as will openings to incorporate GHI principles into the Malawi health portfolio through existing governance structures. USG will also expand its partnerships in GHI by working with public and private partners that are not traditionally engaged in the health sector but can contribute to raising the health status of Malawian citizens⁹.

Significant engagement with various stakeholders occurred in both the development of GHI goals and priorities in Malawi, and ensured mutual expectations in the resourcing and implementation of this new initiative. Engagement with the highest levels of GOM by USG in Geneva and Washington D.C. helped clarify the intent of the new U.S. development policy. Consistent U.S. interagency briefings by representatives from HHS/CDC, USAID, and the State Department with the Minister of Health and

⁹ Government and private partners may include the Malawi Water Board, Electricity Supply Corporation of Malawi (ESCOM, a public electricity provider), private communications companies, the Ministry of Land and Housing, Standard Bank, commercial farms and estates

Deputy, and other senior MOH officials promoted local understanding of GHI, particularly around financing of GHI. A team from U.S. headquarters visited Malawi to meet with government partners, civil society, academia and other health donors, and to work with the USG Malawi team in developing GHI priorities and direction. Through ongoing dialogues with the GOM, civil society, donors and other key stakeholders the USG is working to ensure that the GHI strategy is aligned with and contributes to the government's sector wide approach for health in a country-owned and sustainable manner.

VI. Priority areas of USG support under GHI

Under GHI, the USG health team will continue to support the implementation of the GOM's Program of Work for Health with intensified coordination and program integration among USG agencies and with partners¹⁰. Based on disease burden, agency core competencies, opportunities for integrated programming, current USG investments, and financial gaps, USG has elected to focus on assisting the GOM, civil society, and other partners to **reduce maternal, neonatal and child mortality and morbidity, decrease unintended pregnancies, and reduce new HIV infections** in Malawi.

The Malawi health system is extremely weak due to a massive human resource crisis, poor pharmaceutical management, unreliable information systems, limited financing, and a rapid devolution of authority over service delivery to the district level. It will be impossible to achieve the identified priority areas without greater and more effective investments in health systems and services. While continuing USG intentions to strengthen existing programs, three systems strengthening priority areas were selected by USG with GOM support for greater effort under GHI: **human resources for health, infrastructure, and leadership, governance, management and accountability**. The supporting Results Framework and Matrix articulate how the GHI strategy intends to support Malawi meet its health objectives by investing in these areas.

The areas selected represented opportunities where USG financial inputs and technical assistance could make the most significant and sustainable impact across all areas of the health sector while also strengthening country capacity and ownership, scaling-up integrated programs, complementing other funding sources, and encouraging evidence-based and transparent decision-making and resource allocation. A number of other health systems strengthening areas are critical to successful service delivery including strengthening the procurement and supply chain management system, financial transparency and accountability, organizational development, and the more efficient collection and use of data. However, USG determined that with real and sustainable changes in these three focus areas, other health systems challenges will also be addressed. For example, while USG invests substantial financial and technical resources into developing the capacity of the MOH to strengthen the procurement and supply chain system, the greatest stumbling blocks remain GOM leadership's commitment to reforming the systems and the human resource constraints to carry out the changes. Thus, these areas – selected with GOM support – represent the most critical and difficult problems facing Malawi's healthcare system. By addressing these we hope to achieve long-lasting impact.

¹⁰ For details on plan for coordination within USG, see accompanying briefer on governance structures for GHI in the field.

Priority Area 1

Human Resources for Health

Malawi faces enormous challenges in the area of human resources for health (HRH), with 70% vacancy rates in some health facilities. Both out-migration and migration from the public to the private sector have contributed to this situation, which is compounded by low output from training institutions and poor deployment and retention policies. A six-year Emergency Human Resources Plan (EHRP) implemented by GOM and partners that addressed the acute shortage of health workers in the public sector ended in 2009, with direct costs exceeding \$95 million. The evaluation completed at the end of the EHRP found that while the number of health workers in the public health sector did increase by 53%, only 4 of 11 cadres met or exceeded their targets. In addition, the evaluation found that the EHRP did elevate Malawi out of the staff emergency it faced in 2004, but “the gains are fragile due to the lack of a plan for sustainability, weak health systems, population growth and a continuing high burden of disease.”

In the next phase of planning to strengthen HRH, the GOM is moving away from an emergency approach to scaling-up and focusing on a sustainable growth approach. HRH priorities articulated by the GOM and partners that are relevant to this strategy include the following: 1) define the cadres most needed to implement the EHP and achieve the Millennium Development Goals, 2) implement a staff development strategy focusing on capacity building and management for training institutions, 3) establish human resource management at a senior level in the MOH and staff the department with a core of experienced HRH managers, 4) develop in-service programs to strengthen leadership and management at all levels of the MOH. GHI will prioritize USG support to these efforts.

Current USG and Partner Human Resources for Health support to GOM

Key GOM partners in HRH include the Ministries of Health; Labor; Finance; Gender, Children and Community Development; the DHRMD; and the Christian Health Association of Malawi (CHAM), which provides over 40% of public health services in Malawi. Key donor partners include the United Kingdom’s Department of international Development (DfID), the Government of Norway through the Norwegian Church Aid, WHO, the Global Fund for AIDS, TB and Malaria (GFATM) and the German Government through GTZ. Several approaches and activities in HRH currently receiving USG support can be found in the FY2010 Country Operational Plan (COP) for PEPFAR, the FY2011 Malaria Operational Plan (MOP) and the FY2010 F-Operational Plan (F-OP). Examples include support to both pre-service and in-service nurse education; placement and retention plans for health care workers and support to capacity-building for health-related NGOs to improve organizational management and service delivery.

Human Resources approaches enhanced by GHI

We will integrate our training support in HRH by requiring all USG implementing partners to coordinate their pre-service training across maternal and child health, malaria, nutrition, and HIV. We will partner with the GOM, as well as nurse and medical associations, around a common plan for improving nurse and medical education in Malawi. The USG and her implementing partners will support the GOM’s effort to better deploy staff in hard-to-reach areas and to utilize a robust Human Resource Information System

(HRIS) that facilitates the rational allocation of health staff. USG will encourage headquarter dialogue with the World Bank and IMF to ensure that efforts in the health sector are aligned to World Bank and IMF agreements with GOM.

Key Priority Activities for USG in Human Resources:

Improving the quality of care provided in Malawi across the health spectrum is the highest priority for the GHI strategy. USG will support the Ministry of Health to: provide sustained and sufficient human resources and the equitable distribution of these workers; increase access to community health services; produce highly motivated and skilled staff whose performance is improved; and develop and approve key government policies impacting salaries, resources, and task-shifting. The strategic deployment of better-trained staff across districts and increased incentives for provision of quality services, in combination with strengthened quality improvement mechanisms, will improve the community's confidence in the public health care system.

USG has prioritized the following new or expanded activities to implement the GHI strategy in Malawi:

- 1) Undertake an evaluation regarding the rationalization of HSA's. This evaluation will address the possible re-introduction of clinical assistants at the primary care level, which improve quality of care at facilities and within the community, as HSA's would be able to return full-time to their original scope of work.
- 2) Incentivize high-quality care provision through performance-based financing.
- 3) Provide financial and technical support for pre-service training and training coordination for multiple cadres.
- 4) Expand the implementation of clinical mentoring and supportive supervision visits.
- 5) Strengthen District Health Management Teams in the areas of program planning, financial management, supervision and reporting.

GOM Five year/MDG Targets

- Increased percentage of health centers with minimum staff norms – (TBD)
- Increased number of students graduating from health training institutions by category – (TBD)
- Decreased maternal mortality ratio from 807/100,000 to 155 per 100,000 live births
- Increase in the number of eligible adults and children provided with a minimum care service from 157,413 to 550,000
- Increase in the TB case detection rate from 39% to 62%

Priority Area 2

Infrastructure

The POW II identified infrastructure investment, including the increased use of technology, as critical to improving the health system. GOM includes 'bricks and mortar' as well as equipment, maintenance and information systems, as necessary components of infrastructure. GHI presents an opportunity to better coordinate multiple funding streams and include non-traditional health partners that contribute to strategic funding of infrastructure investments in planning. For example, the USG will work with the GOM to increase the engagement of the private sector in improving the country's health infrastructure.

Priority infrastructure inputs of all GOM partners will be guided by the POW II. Within the POW II, the Service Provision Assessment (SPA) supported by USG will be critical to updating the Capital Investment Plan (CIP). The CIP will serve as the primary document to guide USG investments, which will focus on primary and secondary-level facilities. National priorities for GOM infrastructure activities have been defined in the current CIP and encompass: 1) constructing and renovating fit-for-purpose, environmentally friendly physical spaces (health facilities, laboratories, and health care workers housing), 2) ensuring the required utilities are in place to provide consistent water, electricity, sanitation and other services, 3) designing useful, standardized spaces that streamline services and reduce the time burdens on both patients and providers, 4) expand electronic data collection and other health management information systems (HMIS), and 5) provision of equipment such as basic furniture, scales, and tapes, and equipment maintenance and repair. GHI will continue to prioritize USG support to these efforts.

Current USG and Partner Infrastructure support to GOM

Key partners in infrastructure development and maintenance include GOM (Ministries of Health; Local Government and Rural Development; Lands, Housing and Urban Development; Gender, Children, and Community Development), CHAM, Malawi Water Board, and Electricity Supply Corporation of Malawi. Key donor partners include MCC, the Government of Japan's International Cooperation Agency, DfID, the European Union, GFATM, and private companies including communications companies. Several approaches and activities in infrastructure currently receiving USG support can be found in the FY2010 Country Operational Plan (COP) for PEPFAR, the FY2011 Malaria Operational Plan (MOP) and the FY2010 F-Operational Plan (F-OP). Examples include implementation of a housing scheme for health workers; rehabilitating primary health care service delivery points to provide additional space for integrated services such as family planning; and increasing safe water sources for health facilities, schools and communities.

Infrastructure approaches enhanced by GHI

USG will work with GOM to complete the Service Provision Assessments of all health facilities. The assessment will be used to guide upgrading of facilities, including Maternal/Child Health (MCH) sites, with goals of increasing patient load capacity and improving worker and patient flow within facilities to reduce wait times. Implementing partners will expand efforts in community mobilization and community demand creation for services in areas inaccessible to MOH services. New under GHI is the rural electrification program, support to the revision and implementation of the national CIP including the rational distribution of facilities, and consultation and waiting room layout assessments.

Key Priority Activities for USG in Infrastructure:

Under GHI's prioritized interventions, infrastructure improvements will enable training institutions to support more students in the health fields to receive a better education. Upgrades of facilities will make labor and delivery services more accessible in hard-to-reach communities and increase the accessibility of essential lab and other support services which are regularly maintained. Improved HMIS will allow clinics to better manage patient information and better layouts will ensure integrated services are available for women, children, men and families at all facilities. These efforts will be strengthened

through renovations and maintenance of both ANC and labor and delivery settings to improve patient experiences and outcomes. We expect these enhancements to improve attendance and retention in MCH services. Redesigned ANC clinics will also be more welcoming to male partners, allowing them to take part in their partner’s care during pregnancy, as well as be tested with her for HIV. These interventions will contribute to the reduction of new HIV infections in discordant long-term couples.

USG has prioritized the following new or expanded infrastructure activities to implement the GHI strategy in Malawi:

- 1) Design the infrastructure and equipment section of the second Program of Work.
- 2) Undertake a national Service Provision Assessment that will catalog facilities, equipment, and human resources by facility.
- 3) Update the Capital Investment Plan (CIP) to reflect the actual distribution and capacities of health facilities, as well as the desired five year strategy scenario for infrastructure, including design of facilities that maximize patient flow and minimize loss-to-follow up.
- 4) Create a community-building fund, which engages communities, traditional leaders and their district assemblies, in the joint implementation of infrastructure improvements.
- 5) Renovate facilities for comprehensive quality care, prioritizing those centered on women and children. Priority renovations will focus on labor and delivery, post-partum family planning, integrated ANC and ART service provision.
- 6) Expand electronic data systems through touch-screen technology and cell phone technology to assist in better patient care as well as enabling improvement to data quality and completeness.
- 7) Implement National Stock Status Database to accurately reflect commodities and medical supplies availability.

GOM Five year/MDG Targets

- Increased percentage of health facilities with functioning water, electricity and communication – (TBD)
- Increased percentage of the population living within 5 Km of a health facility – (TBD)
- Increase in the% of the population with access to clean water to 80%
- Increase percentage of children under age 5 who slept under an ITN from 59% to 90%
- Increase percentage of married women that use modern methods of contraception from 38% to 65%
- Increase in the percentage of births attended by a doctor, nurse or midwife from 54% to 90%
- Increase in the number of ART patients managed by Electronic Data Systems to 60,000

Priority Area 3

Leadership, Management, Governance and Accountability

Challenges in leadership, management, governance, and accountability from the national level to point-of-care settings pose one of the most serious threats to providing sustained high quality, equitable and cost-effective health care in Malawi. USG and GOM priorities in this area encompass the following: 1) strengthening leadership and management capacities at central, zonal and district level to improve program planning, financial management, human resource management and data management, 2) strengthening capacities in analysis and use of fiscal and program data to improve evidence-based

programming at all levels, 3) strengthen supervision skills and systems at zonal, district and facility levels, 4) strengthen the capacity of local governance structures to effectively implement and monitor health services within their districts, 5) strengthen involvement of civil society in health planning and accountability at all levels, and 6) strengthen capacity of the MOH to implement performance based management of health programs and human resources.

Current USG and Partner Support to GOM in Leadership, Management, Governance and Accountability

Key GOM partners in leadership, management, governance, and accountability include the Ministries of Health, Local Government and Rural Development, and Finance, as well as the National Assemblies and Local Councils. In addition to the USG, other donor partners include DfID, GFATM and GTZ. A wide range of local civil society organizations and USG implementing partners are also key partners in this area, including CHAM. USG Malawi currently supports central, zonal and district health management teams in program planning, financial management, supervision and reporting and supports the GOM to implement National Health Accounts surveys and the institutionalization of the surveys in MOH fiscal planning systems.

Leadership, Management, Governance and Accountability approaches enhanced by GHI

USG will expand its partnership with the GOM by reaching out to key line Ministries including Finance, Local Government, and Rural Development, as well as Parliament and other legislative and civil society bodies. USG will work in the area of legislative strengthening to increase engagement of the Parliamentary Committee on Health in the sector. The USG team will also work closely with both civil society and the media to increase their participation in health planning and accountability. By targeting local governance issues, USG also intends to ensure that management and financial skills are transferred and that there is a process for accountability and transparency within civil society. USG will advance country ownership through new leadership mentoring, supporting the private sector to health services, supporting health policy and guideline development; and promoting social mobilization and governance at community levels. Working at all levels of the system will allow the USG to link policy improvements to health outcomes, the latter of which is the goal of the GHI strategy.

Key Priority Activities for USG in Leadership, Management, Governance and Accountability:

To impact the burden of disease in Malawi, USG's GHI strategy addresses the cross-cutting health system challenges which will make the greatest and most sustained impact in both the short and long term. In this area, specific interventions will be identified to ensure demonstrable health leadership outcomes by the GOM, including: timely decision-making; improved accountability; enhanced use of evidence-based approaches in program development and resource allocation; and increased involvement of civil society.

A combination of interventions will be undertaken including performance-based financing, professional academic and mentor-based training, leadership and management training and technical support for organizational development in key government ministries. This multi-prong approach will improve the

health programs developed at the central level, and the quality of those programs implemented at district and facility levels both in services provided and commodities procured and distributed. This approach will also develop positive provider attitudes and behaviors, incentivizing them to perform at a higher standard. This in turn will improve patient experiences interacting with health care providers and the quality of services they receive, and increase the likelihood that patients will more openly communicate with their providers. We anticipate this better communication will allow providers to more definitively diagnose and treat illnesses, as well as promote preventive services including family planning, and HIV testing. Thus, a chain of improvements beginning at the national level will strengthen care at the clinical level, putting the nation on track to reduce maternal and neonatal morbidity and mortality, decrease unintended pregnancies, and reduce the number of new HIV infections.

USG has prioritized the following new or expanded activities to implement the GHI strategy in Malawi:

- 1) Undertake an assessment of all pertinent National Health Accounts;
- 2) Evaluate the attribution of funds from the district assembly budget to the purchasing of medication, disposables, and other commodities;
- 3) Work to enact measures in the health sector related to procurement processes and personnel policies to ensure greater transparency at all levels;
- 4) Collaborate with District Assemblies on their annual budget and their attribution of resources to the health sector;
- 5) Empower civil society organizations to better advocate for health care issues (i.e. funding, provision, anti-corruption).

GOM Five year/MDG Targets

- Increased percentage of GOM budget allocated to the health sector (TBD)
- Decreased infant mortality rate from 81/1000 to 45 per 1000 live births
- Decrease in the percentage of children who are stunted from 46% to 25%
- Increase in the number of HIV positive pregnant women who received ARVs to reduce the risk of MTCT from 16,817 to 45,000
- Increase in the% of the population at risk provided with ivermectin/albendazole - TBD
- Decrease in the neonatal mortality rate from 37/1000 to 25/1000

USG Integration under GHI

Across all our activities, USG will intensely pursue smart integration with the goal of breaking down siloed delivery of care to Malawian clients. Integration is being driven by strategic coordination across USG partners funded by various agencies. USAID and CDC partners focused on service delivery will scale-up new modules in electronic data systems to expand beyond HIV clinics to include TB/HIV services, MCH, FP, STI and out-patient services in high patient-burden hospitals. USAID partners delivering voluntary medical male circumcision (MC) services will provide technical assistance through training to DOD and CDC partners, including the MOH. A new flagship USAID procurement – “integrated support for

service delivery” – will bundle services for HIV, Malaria, FP/RH, MNCH, Nutrition and TB, offering one-stop shopping across five zones and 15 districts and will reach over 8 million Malawians.

Across program areas, PEPFAR and PMI will work together to expand services for 500 village health clinics in hard-to-reach areas where young children access anti-malaria drugs and treatment for other common childhood illnesses. The health country team will continue its partnership with the education team to provide scholarships to vulnerable girls, as a lack of education is a primary risk factor for early acquisition of HIV. The education program provides scholarships for vulnerable school-age girls to attend primary school at which point PEPFAR continues scholarships into secondary school.

PEPFAR has formed partnerships with the new MCC compact developers that leverage the private energy sector to make health investments in infrastructure deliver. Feeder roads developed under Feed the Future, households supported by Food for Peace, health policies strengthened under Democracy and Governance, and high efficiency cookstoves purchased with U.S dollars, are all merging under common coordination to improve all health outcomes.

VII. GHI Principles

While USG Malawi recognizes the challenge of implementing the GHI principles, the GHI principles already serve as foundations of the USG health programs in Malawi. Moving forward, USG will more fully realize its core competencies, actively implement the guidance for each principle, and document successes and lessons learned in these areas.

Implementation modalities for GHI principles will be fully articulated in FY2012 plans; a brief synopsis is provided here:

A. GHI Principle - Implement a Women, Girls and Gender Equality Approach

- **Key Issues and Needs:** Implementing a women, girls and gender equality approach is critical to sustaining the gains made in delivering the Malawi EHP and for GHI success. The GOM has prioritized mainstreaming of gender issues across all sectors; the GHI guidance provides assistance for USG implementers to ensure a focus on issues such as equitable access, empowerment and inclusion of women and girls, and engagement of men and boys.
- **Priority Actions:** 1) Gender analysis in all USG project design, and 2) Dissemination meeting with stakeholders on the GHI supplemental guidance on women, girls and gender equality principle.
- **Examples of Implementation:** ETAT, Emergency triage mechanisms introduced at the point of initial care at a referral hospital, outpatient or under 5 clinic for children; Scale-up of new WHO ART/Prevention of Mother-to-Child Transmission (PMTCT) and infant feeding programs by GOM; Expanding women’s access to income and productive resources by linking PMTCT services to Title II Food for Peace program; Advancing the integration of HIV services with antenatal care (ANC) and Family Planning (FP)/Reproductive health (RH) services; Strengthening Gender-Based Violence screening in HIV testing and counseling (HTC) sessions and client referrals to Victim

Support Units and post-exposure prophylaxis services at community and district level; Active participation of men and boys in uptake of contraception; Strengthening integration of FP/RH services with other EHP services; Increasing access to FP commodities and quality FP counseling for young women through youth friendly health services; Prioritizing work on harmful gender-based norms and practices in social and behavior change interventions; Improving the quality and increasing early uptake of ANC; Strengthening referrals and linkages to ensure mother and infant pair follow-up; Reducing maternal and neonatal mortality through improvements to infrastructure and to quality of care.

B. GHI Principle - Increase impact through strategic coordination and integration

- **Key Issues and Needs:** Strong central level coordination exists between the GOM, development partners in the health sector, and local and international implementing partners. USG has a recognized history of good interagency collaboration and communication, while at the same time utilizing the flexibility of different operational and funding mechanisms across agencies to increase our impact. The GHI framework will provide further opportunities for USG to engage government and development partners as one USG.
- **Priority Actions:** Coordination with non-health partners; Coordination among implementing partners; Decentralization to the districts where integration is implemented. Facilitate coordination between targeted partners, e.g. linking partners with complementary services, as well as targeting geographic areas to link partners' activities with each other and under GOM and civil society supervision. GHI/FtF working group has been established with priority deliverables set and plans for a USG multi-sectoral working group have been made.
- **Examples of Implementation:** Support provision of community-based integrated FP and HTC services; Support further integration of maternal and child health programs with HIV services; Expand community integrated management of childhood illness; Facilitate implementation of the national laboratory strategic plan across health sectors; Integrate MCH and nutrition programs through linking with FtF, and as part of HIV activities that provide care and support for women and under-fives, including orphans and vulnerable children; Use a family-centered approach for PMTCT and HIV/AIDS care, support and treatment as a platform for other essential components of MCH services.

C. GHI Principle - Leverage key multilateral organizations, global health partnerships, and private sector engagement

- **Key Issues and Needs:** USG actively communicates with key multilateral organizations and coordinates efforts with partners and GOM on the health sector priorities and activities, including the Health Donors Group and the Global Fund Country Coordinating Mechanism. The USG will continue to be actively engaged with the GOM and the donor network in the development and implementation of the next SWAp.
- **Priority Actions:** Under GHI, USG will continue to strengthen its direct technical engagement in relevant national level for a and will promote greater private sector involvement in improving health outcomes in Malawi. USG will also work with other priority GHI-compatible initiatives of

non-USG institutions including the International Association of National Public Health Institutes and the WHO H4 initiative.

- **Examples of Implementation:** Work with OXFAM to improve civil society's advocacy role in the health sector and support more citizen watchdogs in country for better health and governance outcomes in Malawi; Collaboration with USAID's Democracy and Governance team on civil society, legislature strengthening, and improved allocation of the GOM's health resources; Continue collaboration with WHO, UNICEF, the Gates Foundation through USG Maternal Child Health funding to support the MOH's Integrated Management of Childhood Illness (IMCI) Program; Work towards an independent Global Fund Country Coordinating Mechanism Secretariat; Continue to identify opportunities to increase the contribution of the private sector in the health sector and in relevant aspects of the learning agenda.

D. GHI Principle - Encourage country ownership and invest in country led plans

- **Key Issues and Needs:** USG Malawi's model for developing the HIV/AIDS Partnership Framework and the Partnership Framework Implementation Plan (PFIP) provides a solid example of USG's existing commitment to encourage country ownership and invest in country led plans. The Partnership Framework and PFIP were based on the country's National Action Framework and were developed with significant collaboration with the Malawian government. The PMI approach to planning buys into the strategic plans of various programs as well as the Program of Work and is also a best practice in promoting country ownership in Malawi. GHI involves the same players in GOM and new partners to health under the global development directive.
- **Priority Actions:** Under GHI, USG will continue with this model by planning its primary focus and activities around the Malawian government's POW II Building Blocks. The USG has strategically aligned its planning to address Malawi's health and development goals in an integrated manner through participation in the design of the POW II and through support of the POW II implementation. Further, USG will capitalize on its strengths in providing strategic technical assistance to improve local capacity and to contribute to the sustainability of GOM's plans and systems.
- **Examples of Implementation:** HIV/AIDS Partnership Framework and the PFIP; CIP development; National Lab Strategy development; National Strategy Application to the Global Fund; Global Fund OIG report recommendation acted upon.

E. GHI Principle - Build sustainability through health systems strengthening

- **Key Issues and Needs:** Efficient and synergistic improvements across the health sector will be targeted through efforts to: train and retain health care workers; build capacity of Central Medical Stores to reliably supply health commodities; foster forecasting for rationale use of drugs and improve quantity procurement; increase use of affordable and locally sustainable technologies; expand health information systems and link these systems across health programs; and, provide broad-based support to the national laboratory system. USG will also support the development of leadership and management systems at the Ministry and district

levels, including systems for human resources, monitoring and evaluation, and finance management.

- **Priority Actions:** Multi-sectoral Health Systems Strengthening working group will be formed within USG to build on valuable information sharing during the GHI strategy development
- **Examples of Implementation:** The USG will support continued expansion of the electronic data system in the country and across the disease areas; The USG will support a performance based strategy to improve the country's health supply chain system.

F. GHI Principle - Improve metrics, monitoring, and evaluation

- **Key Issues and Needs:** USG will support national government efforts to coordinate the collection and use of health information across health areas, and will promote efforts to collect reliable data that is useful for action and for analytically evaluating interventions. The learning and research agenda described below reflects GOM and USG identified areas for evidence based programming.
- **Priority Actions:** Improving the utility of the HRIS; technical assistance for and support to the development of electronic data systems that can be linked across health areas including primary health care centers.
- **Examples of Implementation:** Development of data registers used at health facilities, including efforts to simplify these registers and integrate them across health services; Central Data Repository of the MOH and web-based Health Management Information System, designed to streamline data aggregation and improve data quality.

G. GHI Principle - Promote research and innovation

- **Key Issues and Needs:** Providing assistance in the development of national health research agendas, supporting research at referral sites and training institutions to improve the quality of services, sharing model interventions and toolkits among partners, and further aligning USG and GOM's research priorities.
- **Priority Actions:** There is currently a unique opportunity to evaluate the implementation and cost-effectiveness of the new WHO ART/PMTCT and infant feeding guidelines. Other promising research opportunities of innovative interventions include studying: FP/RH delivery and outcomes under integrated and comprehensive HIV programs; the effectiveness of door-to-door combined HIV testing and FP services; health care worker retention and quality of care under an integrated training approach and task shifting; and, the impact of increased linkages with community organizations on early identification of HIV infected infants.
- **Examples of Implementation:** USG will continue to reinforce an evidence-based approach to program design and implementation, as well as systems to share best practices learned among stakeholders and implementers.

VIII. Learning Agenda

Each GHI strategy priority area presents an opportunity to expand investments in game-changing innovation by promoting research and development. Through applied science, operations research and implementation science, these projects can address important questions that are both globally relevant to GHI and locally relevant to Malawi. USG will work with the GOM and its partners to provide additional financial resources to support GOM learning opportunities/studies that would make joint investments more strategic, targeted and effective¹¹. At headquarters, such opportunities may include studying what are effective or useful metrics for health systems strengthening and capacity building or what are the benchmarks of country ownership. These particular studies will contribute to strengthening the health system, institutional and financial sustainability of the health system, integration of services, a focus on women and girls, and intensifying partnerships with national governments and other key stakeholders in country.

Maternal Mortality Studies

The learning agenda for improving maternal mortality builds on the GOM and USG's field experience and specific interventions being planned across the health sector, and integrates and focuses these with the addition of new interventions which can bring even greater impact to maternal outcomes. This strategy starts with the Service Provision Assessment (SPA), which will generate crucial data to form a comprehensive overview of health services in Malawi and their capacity to provide quality care, including those which factor in maternal outcomes. These assessments will document gaps in access to critical services, and help to guide next steps in program innovation, evaluation and operational research. The learning strategy will concurrently assess multiple ongoing interventions, including Malawi's push to integrate HIV services and extend ART to all HIV+ pregnant women, and integrated programs under the USG's Best Practices at Scale in the Home, Communities and Facilities (BEST) combined MCH program initiative. Given that interventions to strengthen health systems broadly are also expected to "lift the boat" of maternal health, it will be crucial to quantify the impact of these efforts on maternal mortality. The program evaluation and research agenda under BEST will be augmented and expanded through integration with the WHO-led H4+1 program, which is a broader partnership to advance implementation science focused on reducing maternal and child mortality. USG will support the GOM in shepherding H4+1 in Malawi. Finally, we will invest to strengthen capacity for data collection and analysis within the GOM, particularly within the MOH and its Reproductive Health Unit, to support better program decision-making and the integration of successful program interventions to scale-up and sustain better maternal outcomes. Supporting the development of Malawi's ability to capture and use reliable data to improve the quality of care and reduce maternal deaths is an essential element of the learning agenda strategy.

Proposed learning agenda studies for all priority areas:

¹¹ All learning agenda activities will begin with a comprehensive desk review

Study 1 (Human Resources for Health)

Given human resource shortages, what is the most cost effective staffing structure for primary healthcare workers? Can we demonstrate that such a structure improves health outcomes? To what level can tasks be shifted before an impact on quality is observed? What is the impact on health outcomes when community workers (nurses and DCAs) are utilized in facilities and not in the community? What data must be generated to inform quality of care issues impacting health outcomes? The study will involve testing different types of training, health packages delivered, and community health interventions. Resources will be required for program support in order for the research agenda to not impede service delivery.

Specific activities will be geared to strengthening coordination mechanisms with GOM and other development partners; operations research carried out, and programs monitored.

Short Term Potential Studies (1-2 years):	Long Term Potential Studies (3-5 years):
<ul style="list-style-type: none">• Desk review• Program Design• Policy Formulation• Update Capital Investment Plan	<ul style="list-style-type: none">• Project evaluation and related outcome monitoring• Identification of promising practices• Potential Impact evaluation• Program scale up

Study 2 (Infrastructure)

What is the impact of infrastructure investments on service delivery, patient flow, and loss-to-follow-up? How do newly built facilities impact service delivery and health outcomes? How does the design of facilities impact the quality of care provided? What is the impact of infrastructure grants provided to the community on services? How can facilities be both user-friendly and provider-friendly in the context of human resource shortages? What data must be generated to inform quality of care issues impacting health outcomes?

Specific activities will be geared to building community ownership; Strengthening coordination mechanisms with GOM and other Development Partners. Implementation will be phased in, operations research carried out, and programs monitored.

Short Term Potential Studies (1-2 years):	Long Term Potential Studies (3-5 years):
<ul style="list-style-type: none">• Service Provision Assessment• Update Capital Investment Plan	<ul style="list-style-type: none">• Project evaluation and related outcome monitoring• Identification of promising practices• Potential Impact evaluation• Program scale up

Study 3 (Human Resources and Governance)

What is the impact of performance-based financing (PBF) on raising the standard of service provision and health management? How does comprehensive PBF affect the provision of quality care in order to improve health outcomes? What is the role of performance-based management and leadership as an incentive?

Specific activities will be geared to strengthening coordination mechanisms with GOM and other development partners. Implementation will be phased in, operations research carried out, and programs monitored.

Short Term Potential Studies (1-2 years):	Long Term Potential Studies (3-5 years):
<ul style="list-style-type: none">• Formative assessment• Program design• Policy Formulation	<ul style="list-style-type: none">• Project evaluation and related outcome monitoring• Identification of promising practices• Potential Impact evaluation• Program scale up

Study 4 (Human Resources and Governance)

How do Service Level Agreements (SLAs) affect perceived and actual quality of care in Christian Health Association of Malawi (CHAM) facilities? What impact do SLAs negotiated between MOH and CHAM have on infrastructure needs for CHAM facilities? To what extent does the influx of clients in the not-for-fee category impact level of care of fee-paying clients?

IX. Monitoring and Evaluation

A new Results Framework has been developed to guide monitoring and evaluation (M&E) efforts in the implementation of the GHI strategy and measurement of key outcomes¹². Existing M&E systems across USG agencies and programs will serve as the foundation for establishing a comprehensive plan that informs progress made under GHI. It will be necessary to harmonize current M&E systems to ensure critical information is collected, analyzed and used in a coordinated and non-duplicative manner.

Higher level health outcomes and impacts will be measured using national population-based surveys such as the Malawi Demographic and Health Survey (MDHS) conducted every 5 years with U.S. support. In addition to routine program reports, HMIS data and surveys, special studies will be an integral part of the M&E effort in order to address the topics prioritized in the learning agenda. Currently, the M&E systems for tracking and evaluating health systems strengthening activities including HRH, infrastructure, leadership and governance are not adequate. USG Malawi will work closely with USG headquarters and the GOM to identify and operationalize innovative indicators to monitor and evaluate

¹² This is addressed in the attached Results Framework

our efforts under GHI. In addition to the often used quantitative indicators, important qualitative indicators and composite indices will be identified to broaden the scope and type of information collected and in particular monitor the quality of programs.

Additionally, indicators to measure the implementation of the GHI principles will be identified and become part of the M&E system. The Learning Agenda will be instrumental in demonstrating the relationship between the various outcomes identified in the results framework.

In line with the spirit of the “three ones”, and whenever feasible, GOM mandated indicators will be prioritized. Similarly, in addition to direct USG program targets, national targets identified in various GOM strategic documents will serve as benchmarks for GHI implementation in Malawi. For most outcome level indicators¹³, the results of the 2010 MDHS are expected to serve as a baseline.

Illustrative Indicators by Health Outcomes and Cross-cutting Areas

Health Outcomes	
Infant mortality rate; Maternal mortality ratio; Contraceptive prevalence rate; HIV incidence; TB treatment success rate; Malaria parasitemia rates; U5 mortality; Number of households with 1 or more LLIN; Rates of stunting and under-weight; Institutional delivery; Proportions of multiple partnerships; PMTCT coverage	
Human Resources for Health	Health care worker (doctor, nurse, HSA) to population ratio (Data source: CABS Indicator – SWAP); % of health centers with minimum staff norms (Data source: HMIS – CMERD); Number of students graduating from health training institutions by category (Data source: HR M&E db)
Infrastructure	Percent of health facilities with functioning water, electricity, and communication (Data source: PAMIS/HMIS); % districts reporting timely data (Data source: HMIS); % of population living within 5 km of a health facility (Data source: National Census data combined with MOH health facility geo-referencing data)
Leadership, Management, Governance and Accountability	Number of days of stock per month of tracer drugs (Data source: LMIS); % of supervision visits made to health facilities and written feedback provided (Data source: HMIS); % of GOM budget allocated to health sector (Data source: Ministry of Finance); % of recurrent budget funded and utilized annually (Data source: MOH); per capita allocation of health budget (Data source: Ministry of Finance)

Illustrative Indicators by GHI principle

¹³ For Malaria-related indicators, the 2010 Malaria Indicator Survey could serve as the source for baseline data.

<u>Implement a Women, Girls and Gender Equality Approach</u>	Number of health facilities providing Gender-Based Violence counseling and referral; Rate of teenage pregnancy; Ratio of men and women living with HIV; Percentage of women who received 2+ IPTp during their most recent pregnancy; Percentage of pregnant women with moderate to severe malnutrition
<u>Increase impact through strategic coordination and integration</u>	Number of people counseled and tested for HIV (or referred for HTC) at a family planning clinic; Percentage of HIV positive TB patients that are started on ART; Number of eligible patients who received supplementary or therapeutic feeding; Availability of stakeholder coordination mechanism
<u>Leverage key multilateral organizations, global health partnerships, and private sector engagement</u>	Formal, sustained effort by USG to increase coordination with key stakeholders (including GOM and GFATM)
<u>Encourage country ownership and invest in country led plans</u>	Alignment of USG plans and strategies with national priorities; Percentage of GOM contribution to the national per capita health expenditure; Percentage of ART clients who receive their treatment at private settings; Percentage of USG funding that goes directly to indigenous organizations
<u>Build sustainability through health systems strengthening</u>	Budget expenditure rate; Stock out of essential commodities; Number of healthcare workers graduated from pre-service training institution; Percentage of health facilities with integrated electronic information systems
<u>Improve metrics, monitoring, and evaluation</u>	Percentage of health facilities with integrated electronic information systems; Implementation of data quality audits; Availability of complete and timely HMIS reports; Evidence of data use for decision making at national/district level
<u>Promote research and innovation</u>	Availability of a national health research agenda

NEXT STEPS:

- Because Malawi operates a SWAp in health where GOM, civil society and partners work around a common national plan, the next steps for the Malawi Health Country Team, an interagency workgroup for the entire sector, will be to engage with stakeholders to further develop the learning agenda areas and decide on priority studies.

- The Health Country Team has the adequate resources and staffing to conduct the priority activities identified in this strategy. The team will define a process to jointly develop an implementation plan that will make this strategy operational. The discussions will demonstrate precisely how the activities will be implemented, benchmarks monitored, annual progress and successes and challenges shared, in an inclusive and mutually beneficial manner for all agencies.

Acronyms:

ANC: Antenatal care
CHAM: Christian Health Association of Malawi
CIP: Capital Investment Plan
CSH: Child Survival and Health
DfID: Department of international Development
DHMTs: District Health Management Teams
DHS; Demographic and Health Survey
EHP: Essential Health Package
EHRP: Emergency Human Resources Plan
FtF: Feed the Future
FP: Family Planning
GFATM: Global Fund for AIDS, TB and Malaria
GHI: Global Health Initiative
GOM: Government of Malawi
HRH: Human Resources for Health
HRIS: Human Resource Information System
DCAs: Disease Control Assistants
HMIS: Health Management Information Systems
HTC: HIV Testing and Counseling
IMCI: Integrated Management of Childhood Illness
IMF: International Monetary Fund
MCC: Millennium Challenge Corporation
MCH: Maternal and Child Health
MDHS: Malawi Demographic and Health Survey
M&E: Monitoring and Evaluation
MOGCCD: Ministry of Gender, Child and Community Development
MOH: Ministry of Health
MPRS: Malawi Poverty Reduction Strategy
NTD: Neglected Tropical Diseases
PBF: Performance-Based Financing
PEPFAR: President's Emergency Plan for AIDS Relief
PFIP: Partnership Framework Implementation Plan
PMI: President's Malaria Initiative
PMTCT: Prevention of Mother-to-Child Transmission
POW II: Program of Work II
RP: Reproductive Health
SLAs: Service Level Agreements
SWAp: Sector Wide Approach
U.S.: United States
USG: U.S. Government
WHO: World Health Organization

Area	Relevant Key National/Priorities/Initiatives	Key Priority Actions Likely to Have Largest Impact	Key GHI Principles	Key Partners	MONITORING AND EVALUATION		
					Indicators	Data Source	National GOM Targets /Target Time Frame
1. Child Health Reduce under five mortality rates by 35% across assisted countries	Accelerated Child Survival and Development (ACSD) approach and Integrated Management of Neonatal and Childhood Illnesses (IMNCI)	Water and sanitation ORS IMCI/ACSD Immunization PHI/ETAT CCM, EID/Rx	Strategic coordination/integration, Health System Strengthening, Monitoring & Evaluation	MOH, BASICS, TBD/SSD	Under-five mortality rate	MDHS	78 per 1000 live births (MDG)
					Infant mortality rate	MDHS	45 per 1000 live births (MDG)
					Percentage of under 1 children who receive 3 doses of pentavalent vaccine	HMIS MDHS	85% (ACSD strategy, 2012)
					Percentage of population with access to clean water	MDHS	80% ACSD strategy, 2012)

<p>2. Tuberculosis Save approximately 1.3 million lives by treating a minimum of 2.6 million new TB cases and 57,200 multi-drug resistant (MDR) cases of TB; contributing to a 50% reduction in TB deaths and disease burden.</p>	<p>DOTS Capacity building for HRH (lab & clinical staff) TB/HIV integration Intensified case finding Improving surveillance and treatment of MDR TB</p>	<p>DOTS, Strengthening TB/HIV integration, Lab strengthening, Decentralizing services to health centers Expansion of Community sputum collection centers Strengthening M&E system including TB prevalence survey Infection control Expanding TB services integrated with HIV services Strengthening National TB Program through management and technical support</p>	<p>Integration of Tuberculosis and HIV services HSS (lab, information system and supply chain) critical for the success of the TB program</p>	<p>MOH, CHAM, Lighthouse, College of Medicine Lab Consortium (COM), Howard University, Baobab, Partners in Hope, Dignitas, TB Cares II</p>	<p>TB Mortality TB Prevalence TB Cure Rate (new smear positives) Case detection rate</p>	<p>NTP WHO HMIS, NTP NTP</p>	<p>8% (NTP, 2011) 85% (NTP, 2011) 62% (NTP, 2011)</p>
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<p>3. Family Planning and Reproductive Health</p> <p>Prevent 54 million unintended pregnancies</p> <p>Reach a modern contraceptive prevalence rate of 35% across assisted countries, reflecting an average 2 percentage point annual increases by 2014:</p> <p>Reduce from 24 to 20% the proportion of women aged 18-24 who have their first birth before age 18</p>	<p>To reduce unmet need for family planning services through provision of voluntary comprehensive family planning services at all levels to all men, women and young people of reproductive age.</p>	<p>Improve contraceptive security; Provide a wide range of contraceptive methods; Strengthen communication s, outreach and services in communities with special emphasis on long acting and permanent methods; Create a unified evidence based social behavior change Communication strategy</p>	<p>Integration - FP services to women attending primary health care; advocate for investments that keep girls in school; work with local communities to change social and behavioral norms in support of FP; Base decisions on evidence. Research, monitoring, and evaluation yield important information to guide decision-making; Coordinate; Offer client-centered care. Honoring client preferences; Partnerships between public- and private-sector services to encourage fee for service; Strong leadership to help programs navigate change; Good management to solve operational problems. Address a wider range of health needs; variety of delivery points by integrating services where appropriate.</p>	<p>Abt Associates; Academy for Educational Development; Central Contraceptive Procurement (CCP); JHPIEGO/MCHIP ; JSI – DELIVER; Management Sciences for Health; TBD/behavior Change Communication (BCC); TBD/DHS/SPA; TBD/HPSS; Abt Associates/SHOPS/Private Sector; TBD/(SCM); TBD/Support for Service Delivery (SSD); World Learning INC.(FORECAST); World Learning (AHS)</p>	<p>Total Fertility Rate</p> <p>Percentage of married women that use modern method of contraception</p> <p>Percentage of women age 15-19 who are mothers or pregnant with their first child</p>	<p>M-DHS</p> <p>M-DHS, MICS</p> <p>M-DHS</p>	<p>5.7 (MGDS, 2011)</p> <p>65% (by 2015)</p>
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<p>4. HIV/AIDS: Support the prevention of more than 12 million new infections; Provide direct support for more than 4 million people on treatment; Support care for more than 12 million people, including 5 million orphans and vulnerable children.</p>	<p>Integrated ARV and PMTCT using the new WHO rapid guidelines Combination prevention targeting most at risk population (NPS) expand access to quality Voluntary medial male circumcision Strengthen capacity of communities to respond to HIV Strengthen health systems including labs, info. systems and HRH</p>	<p>Medical Circumcision Integrated ART/PMTCT Targeted combination prevention interventions Impact mitigation for OVC, PLHIV and families</p> <p>Continuum of care and treatment for PLHIV including integration of ART, PMTCT, Pre-ART, Mother-infant pair follow up</p> <p>Integration of services including with FP/RH, TB, and Nutrition</p>	<p>The integrated ART/PMTCT approach will improve HIV positive women's access to ART.</p> <p>USG support in these key priority areas complements GOM resources through the Global Fund.</p> <p>Combination prevention interventions will address damaging gender norms and practices that increase vulnerability and strengthen community ownership and linkages to services</p>	<p>Project Concern International, Baobab Health Trust, Christian Health Association of Malawi (CHAM), Howard University, Lighthouse Trust Malawi AIDS Counseling Resource Organization, Malawi Blood Transfusion Services Ministry of Health, Malawi, National AIDS Commission (NAC), University of Malawi College of Medicine, University of Malawi, College of Medicine Lab Consortium, Columbia University, University of Washington (ITECH), Abt Associates Academy for Educational Development; African Palliative Care Association, Baylor College of Medicine Children's Foundation Malawi Catholic Relief Services, Creative Associates, Dignitas International, Feed the Children Global AIDS Interfaith Alliance (GAIA); Johns Hopkins Bloomberg School of Public Health Center for Communications Program; Lilongwe Medical Relief Trust Fund (LMRTF); MACRO</p>	<p>1. Number of pregnant women who were tested for HIV and know their results</p> <p>2. Number of HIV positive pregnant women who received ARVs to reduce the risk of MTCT</p> <p>3. % of adults and children with advanced HIV infection receiving ART</p> <p>4. Number of eligible adults and children provided with a minimum of one care service; <18; 18+</p>	<p>MOH Quarterly Reports</p> <p>MOH Quarterly Reports</p> <p>MOH Quarterly Report</p>	<p>480,000 (ext NAF, 2012)</p> <p>45,000 (PFIP, 2014)</p> <p>360,000 (ext NAF, 2012)</p> <p>550,000 (PFIP, 2014)</p>
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<p>5. Malaria:</p> <p>Reduce the burden of malaria in at-risk populations by 70% by 2015</p>	<p>Strengthen malaria diagnostics and early case management of malaria including treatment at community level; Increase ownership and utilization of LLIN; Improving IPTp use; Increasing IRS coverage; Capacity building to National Malaria Control Program to plan and coordinate large scale malaria prevention and treatment programs</p>	<p>Combination treatment (ACTs) including treatment at community levels; Prevention interventions including indoor residual spraying (IRS) and long-lasting insecticide-treated bed nets (LLINs); Intermittent presumptive treatment (IPTp); Increased behavior change communication activities</p>	<p>Intermittent preventive treatment of malaria in pregnancy targets women during their increased period of vulnerability to malaria and its complications.</p> <p>Strengthening Malawi's supply chain management system is important component of the program. This will ensure consistent supply of malaria drugs and medical supplies.</p> <p>Strengthened malaria diagnostics will be crucial as it will be used to monitor the trends in malaria episodes and facilitate rational use of malaria drugs.</p>	<p>Abt Associates; Chemonics; EMCAB; JHPIEGO/MCHIP; JSI – DELIVER; QED Group; Swiss Tropical Institute; TBD - ITN Distribution; TBD - Supply Chain Management (SCM); The Partnership for Child Health Care, Inc. (PCHC/Basics); HHS/CDC</p>	<p>Prevalence of severe anemia among children 6-59 months</p> <p>Percentage of households that have at least one ITN</p> <p>Percentage of children under age 5 who slept under an ITN</p> <p>Percentage of pregnant women who received 2 doses of IPTp during last pregnancy</p>	<p>DHS, MIS</p> <p>DHS, MIS</p> <p>DHS, MIS</p> <p>MDHS, MIS</p>	<p>80% (ACSD, 2012)</p> <p>90% (ACSD, 2012)</p>
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<p>6. Maternal Health:</p> <p>Reduce maternal mortality by 30% across assisted countries</p>	<p>Improving the availability of and access to quality maternal and neonatal health care, including family planning and PMTCT; Strengthening human resources to provide quality skilled care; Strengthening the referral system; Strengthen national and district health planning; Empowering communities to ensure a continuum of care</p>	<p>Implement Performance Quality Improvement in MNCH and RH to ensure infection prevention; Increase coverage of BeMONC; Increase health facilities ability to cover the increase in facility-based births; Community-based distribution of modern family planning methods; Utilization of HSA's to promote early and often ANC as well as facility-based birth needs</p>	<p>Maternal Health program primarily addresses the health needs of pregnant women.</p>	<p>Abt Associates; Catholic Relief Services PPP - OVC – CRS; JHPIEGO/MCHIP; Partnership for Child HealthCare Inc. (BASICS); TBD - BEHAVIOR CHANGE COMMUNICATION (BCC); TBD - Capacity Building Health Finance Governance; TBD - HEALTH POLICY SYSTEMS STRENGTHENING (HPSS); TBD - MEASURE DHS SPA; TBD/SHOPS/Private Sector; TBD - SUPPLY CHAIN MANAGEMENT (SCM); TBD - Support for Service Delivery (SSD); US Peace Corps; World Learning Inc. - FORECAST</p>	<p>Maternal Mortality Ratio</p> <p>Percentage of births attended by a doctor, nurse or midwife</p> <p>C-section rate</p> <p>% of women with at least 4 ANC visits</p>	<p>MDHS, MICS</p> <p>MDHS, MICS</p> <p>MDHS, HMIS</p> <p>MDHS, MICS</p>	<p>155 per 100,000 live births (MDG)</p> <p>90% (Roadmap, 2014)</p> <p>10% (Roadmap, 2014)</p> <p>90% (Roadmap, 2014)</p>
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<p>7. Nutrition:</p> <p>Reduce child under nutrition by 30% across assisted food insecure countries in conjunction with the President's Feed the Future Initiative</p>	<p>Prevention and control of under nutrition with a focus on pregnant and lactating women, children under two years, under five children, school aged children, PLHIV, people in emergency situations and other vulnerable groups</p> <p>Promotion of access to quality nutrition and health services to facilitate effective management of under nutrition among various population groups</p> <p>Creation of an enabling environment that adequately provides for the delivery of nutrition services and implementation of nutrition programs and interventions</p>	<p>Essential Nutrition Actions with emphasis on complementary feeding; Community nutrition education; Strengthen linkage between nutrition and food security programs</p>	<p>Program focuses on vulnerable groups especially children and women</p> <p>Nutrition programs leverage food security interventions through Feed the Future</p>	<p>Abt Associates- HS20/20; CRS - WALA; CRS(USCCB)-Wellness and Agriculture for Life Advancement (WALA) Supplemental Nutrition-Individual Prevent Programs; TB/Medium Term Nutrition Capacity Building; TBD/HPSS Nutrition Enabling Environment and Capacity; TBD/Strengthening Agricultural Value Chains and Enterprises (SAVE); TBD/Support for Service Delivery Nutrition; TBD- (PATH) Infant and Young Child Nutrition- Population Based Nutrition-SD;TBD/Behavior Change Communication; TBD-(PATH) Infant and Young Child Nutrition; The Partnership for Child Health Care, Inc. (PCHC/Basics) ; UNICEF- Population-based Nutrition Service Delivery; US Peace Corps; World Learning Forecast</p>	<p>Percentage of children under five who are underweight</p> <p>Percentage of children under five who are stunted</p>	<p>MDHS, MICS</p> <p>MDHS, MICS</p>	<p>13% (MDG)</p> <p>25% (MDG)</p>
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<p>8. NTDs:</p> <p>Reduce the prevalence of 7 NTDs by 50% among 70% of the affected population contributing to</p> <p>1. the elimination of onchocerciasis in Latin America by 2016</p> <p>2. the elimination of lymphatic filariasis globally by 2020, and</p> <p>3. the elimination of leprosy</p>	<p>Mass drug administration vector control treatment of cases</p>	<p>Mass Drug Administration for Onchocerciasis and Lymphatic Filariasis; school-based MDA for Schistosomiasis treatment of leprosy and active case finding; No bilateral resources.</p>	<p>The surveillance of NTDs in Malawi needs strengthening. Opportunities for coordination with GOM and WHO;</p>	<p>MOH, WHO</p>	<p>Number (percent) of population at risk provided with Ivermectin/Albendazole</p>	<p>MOH Report</p>	<p>Mass drug administration for population at risk (LF and Oncho) School-based MDA for Schistosomiasis treatment and case finding for leprosy</p>
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<p>9. Health System Strengthening</p> <p>Address critical barriers that impede GHI health impact.</p>	<p>Emergency Human Resource Plan (EHRP) to meet the critical shortage of healthcare workers</p> <p>National data standards taskforce working on establishing standards for the national health information system</p> <p>Changing the Central Medical Store (CMS) into a Trust</p>	<p>Increase intake of healthcare worker training institutions through bursaries, training of faculty, supporting curricula reform</p>	<p>HSS Metrics/monitoring and evaluation</p>	<p>ALL Partners above</p>	<p>Number of ART patients managed by EDS</p> <p>Number of testing facilities (laboratories) that are accredited according to national or international standards</p> <p>HCW (doctor, nurse, HSA) to population ratio (Data source: CABS Indicator – SWAP)</p> <p>% of health centers with minimum staff norms (Data source: HMIS – CMERD)</p> <p># of students graduating from health training institutions by category (Data source: HR M&E db)</p>	<p>SWAP review</p> <p>SWAP review</p> <p>SWAP review</p>	<p>60,000 (PFIP, 2014)</p> <p>15 (PFIP, 2014)</p> <p>1 doctor to 31,000 population; 1 nurse to 1,700 population; 1 HAS to 1,000 population (2011, SWAP)</p> <p>clinician (25%); nurses (55%) (2011, SWAP)</p> <p>Doctors: 64 Nurses: 670</p> <p>All categories.: 1534 (2011, SWAP)</p>
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