World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2013

MALAWI

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ABBREVIATIONS

ACSD	:	Accelerated Child Survival and Development
ACT	:	Artemisinin Combination Therapy
ADB	:	African Development Bank
AFP	:	Acute Flaccid Paralysis
AFRO	:	World Health Organization Regional Office for Africa
AIDS	:	Acquired Immunodeficiency Syndrome
ARI	:	Acute Respiratory Tract Infections
ART	:	Antiretroviral Therapy
ARV	:	Antiretroviral drug
BEmOC	:	Basic Emergency Obstetric Care
BFHI	:	Baby Friendly Hospital Initiative
BLM	:	Banja La Mtsogolo
CCA	:	Common Country Assessment
CCS	:	Country Cooperation Strategy
CDC	:	Centers for Disease Control (USA)
CHAM	:	Christian Health Association of Malawi
CIDA	:	Canadian International Development Agency
DA	:	District Assembly
DAD	:	Debt and Aid Division
DALY	:	Disability Adjusted Life Year
DAS	:	Development Assistance Strategy
DFID	:	Department of International Development (UK)
DHS	:	Demographic and Health Survey
EHP	:	Essential Health Package
EmOC	:	Emergency Obstetric Care
ENA	:	Essential Nutrition Action
EPI	:	Expanded Programme on Immunization
EU	:	European Union
FDC	:	Fixed Dose Combination
GDF	:	Global Drug Facility
GDP	:	Gross Domestic Product
GOM	:	Government of Malawi
GPW	:	General Programme of Work
GTZ	:	German Technical Cooperation
HDI	:	Human Development Index

HIPC	:	Heavily Indebted Poor Countries
HIV	:	Human Immunodeficiency Virus
HMIS	:	Health Management Information System
HQ	:	Headquarters
HRH	:	Human Resource for Health
IDSR	:	Integrated Disease Surveillance and Response
IMCI	:	Integrated Management of Childhood Illnesses
IMF	:	International Monetary Fund
IST	:	Intercountry Support Team
ITN	:	Insecticide-Treated Nets
JCPR	:	Joint Country Programme Review
MDGs	:	Millennium Development Goals
MDHS	:	Malawi Demographic and Health Survey
MDR	:	Multidrug-Resistant
MGDS	:	Malawi Growth and Development Strategy
MNCH	:	Maternal, Newborn and Child Health
MNH	:	Maternal and Neonatal Health
MOH	:	Ministry of Health
MOLG	:	Ministry of Local Government
MTCT	:	Mother-to-Child Transmission
MTR	:	Mid-Term Review
MTSP	:	Medium-term Strategic Plan
NAC	:	National Aids Commission
NCD	:	Noncommunicable Disease
NEPAD	:	New Partnership for Africa's Development
NGO	:	Nongovernmental Organization
NPO	:	National Professional Officer
NSO	:	National Statistical Office
NTD	:	Neglected Tropical Disease
OPC	:	Office of the President and Cabinet
ORS	:	Oral Rehydration Salt
PD	:	Paris Declaration
POW	:	Programme of Work
PPP	:	Purchasing Power Parity
RED	:	Reaching Every District
SP	:	Sulfadoxine-Pyrimethamine
SWAp	:	Sectorwide Approach
TB	:	Tuberculosis
UN	:	United Nations

UNDAF	:	United Nations Development Assistance Framework
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children's Fund
USG	:	United States Government
WB	:	World Bank
WCO	:	World Health Organization Country Office
WHO	:	World Health Organization

EXECUTIVE SUMMARY

The Country Cooperation Strategy is a WHO reference document to guide country work in planning and resource allocation through alignment with national health priorities and harmonization with other development partners. It clarifies roles and functions of WHO in supporting the national strategic plan for health through the sectorwide approach and the Malawi Growth and Development Strategy. The Country Cooperation Strategy is based on a systematic assessment of the recent national achievements, emerging health needs, challenges, government policies and expectations. It therefore provides direction to the Organization for current and future biennial country workplans.

Malawi has a high disease burden characterized by high prevalence of communicable diseases, maternal and child health problems, and increasing burdens of noncommunicable and neglected tropical diseases. The adult HIV prevalence is estimated at 12% with an estimated 85 000 new infections occurring annually. Of the 28 000 tuberculosis cases reported annually, 70% of the patients also test positive for HIV. Malaria is the major cause of hospital visits in under-five children and adult deaths. The high maternal mortality ratio of 807 per 100 000 live births translates to 13 maternal deaths per day. Infant and under-five child mortality rates have shown a steady decline since 1985. However, there has not been a proportionate decrease in neonatal mortality rate. There is also anecdotal evidence that neglected tropical diseases such as soil-transmitted helminthiasis, schistosomiasis, lymphatic filariasis, onchocerciasis and trachoma are on the increase. Noncommunicable diseases are an increasing public health problem in Africa, including Malawi, and they account for about 12% of the total estimated DALYs.

There are several development partners operating in the health sector which include multilateral, bilateral and nongovernmental organizations. Official development assistance, which constituted 26.6% of the country's GDP in 1990, increased to 27.8% in 2005 (UNDP 2007). In the 2006-2007 financial year, about US$ 450 million was disbursed in aid, of which 20.8% was allocated to health. The government contributes about 40% of the total health expenditure. In a country where aid makes a significant contribution to the national income, it is essential to enhance aid effectiveness. To guide the process of aid mobilization, coordination and utilization based on the norms of the Paris Declaration, the Government drafted the Development Assistance Strategy which focuses on the need for development partners to respond to government reforms by increasing alignment to government systems and strategies and to harmonize practices to reduce transaction costs.

To ensure effective implementation of the priorities for 2008–2013, the implications of the CCS with respect to core competencies and knowledge management capacity requirements of the WHO Country Office are outlined. Monitoring and evaluation will include annual, mid-term and final reviews and an evaluation at the end of the new CCS which will be operationalized by means of biennial workplans.

The CCS focuses on three organization-wide priorities: national health security, strengthening health systems, and investing in health while tackling social determinants of health to reduce poverty.

Priority Area 1: Building Individual and National Health Security

Weaknesses exist in the management of epidemics and natural disasters, and these are compounded with persisting problems of high maternal and childhood deaths as well as high burdens of communicable and noncommunicable diseases. The strategic agenda is to strengthen institutional capacity for prevention and control of diseases, effective response to disasters and epidemics, and delivery of quality maternal and child health services.

Strategic Approaches

WHO will provide technical support in the development of policies and strategies to strengthen capacity of the Ministry of Health in its leadership roles in coordination, preparation and response to emergencies. Through the SWAp mechanism, support will be provided to government to strengthen coordination and planning processes for maternal, newborn, child and adolescent health interventions.

Priority Area 2: Strengthening the Health System

The current resource allocation follows methodologies that do not fully address equity issues. Health sector resources and investment are largely from external donors. The WCO strategic agenda will focus on strengthening health system capacity for equitable and efficient service delivery through improved stewardship, resource development, investment and better financing. The agenda will also attempt to promote evidence-based decision making at all levels of the health system through enhanced capacity to generate and utilize information.

Strategic Approaches

WHO will support the country to scale up production of health workers, identify effective retention measures and improve evidence-based decision-making in the area of HRH. Support will be provided to the MoH to develop a health financing policy and initiate prepayment schemes in line with the resolutions of the World Health Assembly. Furthermore, efforts will be intensified to institutionalize National Health Accounts.

Priority Area 3: Investing in Health and Tackling Social Determinants of Sealth to Reduce Poverty

Though the Malawi government and stakeholders have made considerable investments in health, poverty and other social factors continue to negate the gains made. The social determinants of health will be addressed through intersectoral and community participation. The strategic agenda will be to address social and environmental determinants of health through risk factor reduction and promotion of intersectoral action and community involvement for health, based on the principles of Primary Health Care.

Strategic Approaches

WHO will support promotion and maintenance of national collaboration, partnerships and formation of networks. It will also support the MoH to strengthen capacity of health workers in mobilizing communities for active participation in planning, implementation and monitoring of health actions. Furthermore, WHO will strengthen the capacity of the MoH to develop a health promotion policy and operational plan.

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

SECTION 1

INTRODUCTION

The Country Cooperation Strategy (CCS) is the WHO tool for alignment with national health strategies and priorities as well as for harmonization with other UN agencies and development partners working in health and other sectors.

The second Country Cooperation Strategy for Malawi covers the period 2008-2013 and builds upon the CCS 2004-2007. It provides direction to the Organization for preparing the biennial country workplans. This CCS incorporates national, regional and global developments in health that have occurred since the first CCS was developed and is based on a systematic assessment of the country's health and development challenges.

The World Health Organization has defined a global health agenda in its Eleventh General Programme of Work (GPW), 2006-2013. To implement the Eleventh GPW, the organization has developed a Medium-Term Strategic plan (MTSP) 2008-2013 based on 13 strategic objectives. This provides a more strategic and flexible programme structure that better reflects the needs of countries while facilitating more effective collaboration across all levels of the Organization.

The WHO Regional Office for Africa has also identified the regional priorities for action in its document *Strategic Orientations for WHO Action in the Africa Region 2005-2009*. It underscores the fact that WHO priorities in Africa reflect country priorities and are in line with the GPW's global agenda and other regional and global initiatives.

At the national level, the Malawi Growth and Development Strategy (MGDS) 2006-2011 serves as a single reference document on socioeconomic growth and development priorities for the country. The government has also designed the Development Assistance Strategy (DAS) 2006-2011 aligned to the MGDS and emphasizing the importance of development partners and line ministries aligning to the priorities of the MGDS.

In the health sector, the SWAp was adopted in 2004 as a mechanism for coordinating the activities of all stakeholders in health under the government's leadership. A six-year strategic plan covering the period 2004-2010 has been formulated to guide the activities of partners involved in health development.

The programmatic response of the United Nations system in Malawi to the changing realities has been the development of the United Nations Development Assistance Framework (UNDAF) aligned to the MGDS and MDGs. The UNDAF covers the period 2008-2011. Its outcomes are based on the MGDS themes. In light of the above-mentioned developments, the need for developing a second generation CCS for Malawi cannot be overemphasized. The current CCS has been developed through consultations with the government and relevant partners.

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 SOCIODEMOGRAPHIC, ECONOMIC AND POLITICAL SITUATION

Malawi is a land-locked country in south central Africa with a land area of about 118 484 square kilometers. According to the 1998 Housing and Population Census, the population of Malawi was estimated at about 9.9 million, 85% of which lived in rural areas. In a recent housing and population census conducted in 2008 the preliminary results indicate that the population has gone up to 13 066 320, representing an increase of 32% from 1998 (NSO 2008). The average annual intercensal growth rate 1998-2008 is 2.8% (NSO 2008). Some of the salient sociodemographic features are presented in Table 1.

Table 1: Malawi sociodemographic indicators

Indicator	Value
Proportion of population <15 years of age (%)	46
Life expectancy at birth, 2005 (years) (male/female)	47/46
Healthy life expectancy at birth, 2002 (years) (male/female)	35/35
Infant mortality rate, 2006 (per 1000 live births)	69
Under-five mortality rate, 2006 (per 1000 live births)	118
Maternal mortality ratio (per 100 000 live births)	807
Total fertility rate	6.3
Adult literacy rate, 2006 (%) (male/female)	77/56
Net primary school enrollment ratio, 2004	95.0

Sources: Population Reference Bureau (2007), WHO (2007), NSO and ORC Macro (2005), NSO and UNICEF (2006), NSO (2006), UNDP (2007)

Malawi is a low-income country with an estimated gross domestic product (GDP) per capita of 667 (PPP[1] US$) in 2005. During the period 2000–2005, GDP per capita registered an average annual growth rate of 1.2% (World Bank 2008). In 2005, official development assistance constituted about 27.8% of the GDP (UNDP 2007). The country reached the completion point under the Enhanced Heavily-indebted Poor Countries (HIPC) Initiative and got approval of debt relief under the Multilateral Debt Relief Initiative in 2006 (IMF 2006). This implies that the country will save about US$ 110 million every year that was used to pay

[1] Purchasing Power Parity.

foreign debt (People's Daily Online 2006). About 52% of the population lives below a national poverty line of 16 165 Malawi kwacha per person per year (the equivalent of US$ 147 at that time, NSO 2005). The gini coefficient[2] for the period 2000-2005 was 0.39.

With a human development index (HDI) in 2005 of 0.437, the country is classified with the group of low human development countries, most of which are in sub-Saharan Africa. The country's HDI rank during the same period was 164 out of 177 countries. Trends in HDI indicate that, although there was a gradual increase in the HDI value from 0.330 in 1975 to 0.444 in 1995, a decline was observed during the period 1995–2005.

Malawi became an independent nation on 6 July 1964 and has been a multi-party democracy since 1994. The National Assembly has 193 seats, all directly elected to serve five-year terms. In 2006, women occupied 14% of the total seats in parliament. Under the 1995 constitution, the president is chosen through universal direct suffrage every five years. The members of the presidentially-appointed cabinet can be drawn from either within or outside of the legislature. The constitution provides for an independent judiciary which is made up of magisterial lower courts, the High Court and the Supreme Court of Appeal. There are 28 local authorities known as district assemblies. Within these district assemblies there are three cities and one municipality.

2.2 HEALTH STATUS AND HEALTH SECTOR CHALLENGES

Health Status

Malawi, like much of sub-Saharan Africa, faces a growing burden of disease. The epidemiological profile is characterized by a high prevalence of communicable diseases including HIV/AIDS, malaria and tuberculosis; high incidence of maternal and child health problems; an increasing burden of noncommunicable diseases; and resurgence of neglected tropical diseases. Figure 1 depicts an overview of the disease burden in Malawi.

HIV/AIDS, Tuberculosis and Malaria (ATM)

The national adult (15-49) HIV prevalence is estimated at 12% (MoH 2007a). Heterosexual contact is the principal mode of HIV transmission, while mother-to-child transmission (MTCT) accounts for about 25% of all new HIV infections (NAC 2004). Out of an estimated 250 000 adults and 23 000 children requiring ART, only 150 000 adults and about 10 000 children were on ART as at December 2007.

Malaria is also responsible for about 40% of all under-five hospitalizations and 40% of all hospital deaths (World Bank 2000). Treatment policy change from sulfadoxine-pyrimethamine (SP) to artemisinin-based combination therapy (ACT) was effected in 2007.

Annually, close to 28 000 cases of all forms of TB are notified countrywide, and about 70% of these cases are HIV positive. However, despite an increase in TB case notification rates, WHO estimates case detection rate of 42% for new smear positive cases against a global target of 70% (WHO Global Tuberculosis Report 2008). Multidrug-resistant tuberculosis (MDR-TB) is an emerging threat although a national survey to quantify its magnitude has not been conducted due to lack of capacity.

[2] The gini coefficient measures the extent to which the distribution of income among individuals or households deviates from a perfectly equal distribution. A gini coefficient of zero means perfect equality, while a coefficient of 1 implies perfect inequality. Countries with a gini coefficient of 0.50 and above are considered to have high levels of income inequality.

Neglected Tropical Diseases

Although the magnitude of neglected tropical diseases (NTDs) in Malawi is not known, there is anecdotal evidence from health facilities that these diseases are re-emerging or are on the increase. According to a lymphatic filariasis mapping survey done in 2003 the national prevalence of lymphatic filariasis is 9.2%, ranging from 0% in Chitipa district to 35.8% in Balaka district (Ngwira B et al 2007).

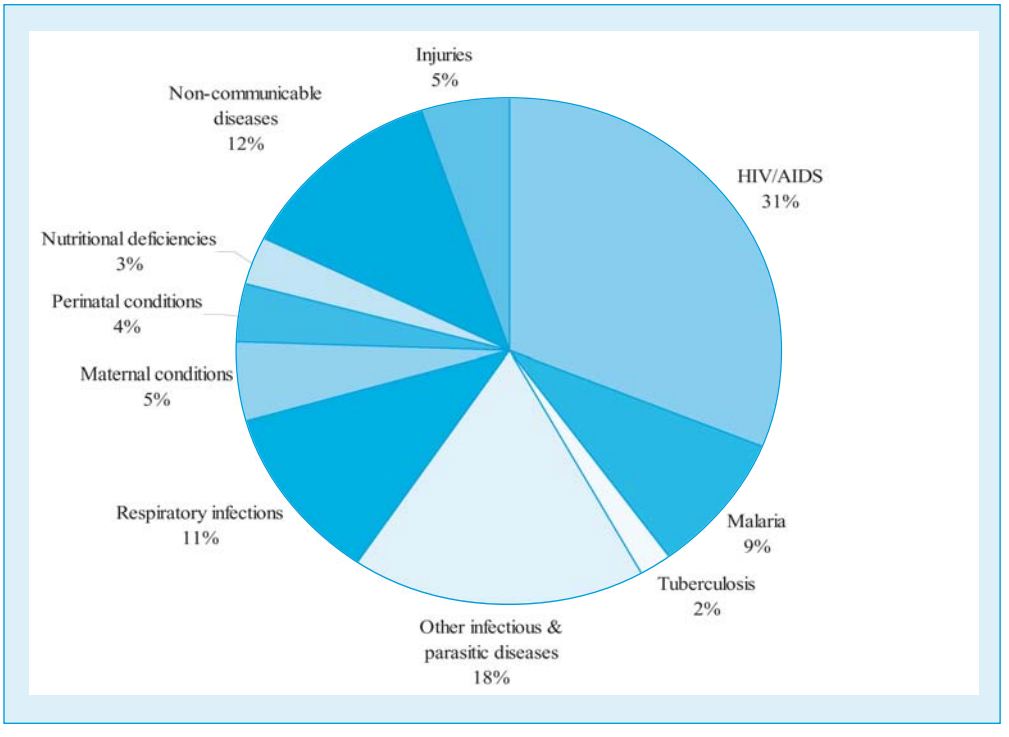
Noncommunicable Diseases

Noncommunicable diseases (NCDs) are also an increasing public health problem in Malawi. WHO estimates from the burden of disease study conducted in Member States show that cancers and other noncommunicable diseases contribute significantly to the causes of deaths in Malawi. In 2002, NCDs accounted for about 12% of the total DALYs[3] estimated (WHO 2004).

Maternal and Child Health

The maternal mortality ratio is high at 807 per 100 000 live births. Teenage motherhood is at 34% and accounts for 20% of maternal deaths. Low levels of literacy amongst women also indirectly contribute to high MMR. The total fertility rate ranges from 7.6 in the lowest wealth index quintile to 4.4 in the highest quintile and from 8.0 for mother with no education to 3.6 in mothers with secondary education and above (NSO and UNICEF Malawi 2008).

Figure 1: Malawi: Estimated total DALYs by cause, 2002



Source of data: WHO (2004)

[3] Disability adjusted life years. The DALY combines in one measure the time lived with disability and the time lost due to premature mortality. One DALY can be thought of as one lost year of healthy life.

The MDHS 2004 showed that only 57.1% of clients visited antenatal clinics four times and 47% of the pregnant women received the recommended two-dose malaria prophylaxis regimen with SP. It has also been observed that syphilis testing (a component of focused antenatal care in Malawi) is not done routinely in many facilities due to lack of reagents. The contraceptive prevalence rate is 38.4% (NSO and UNICEF Malawi 2008).

Although it is reported that 50% of deliveries are conducted by skilled health attendants, the quality of care remains a concern. In 2005 only 18.5% of women with obstetric complications were treated in emergency obstetric care (EmOC) facilities, with a case fatality rate of 3.4%. According to the assessment conducted in 48 health facilities by the MoH (2005), complications of abortion comprised 30% of direct obstetric complications presenting at the hospitals.

In its efforts to address the maternal and neonatal health situation, Malawi developed a Road Map in 2005 with a focus on:

(i) improving availability, access to and utilization of quality maternal and neonatal health (MNH) care,
(ii) strengthening human resources to provide quality skilled care,
(iii) strengthening the referral system and
(iv) strengthening national and district health planning and management of MNH care.

Infant and under-five child mortality rates are generally showing a steady decline since 1985. Despite the significant decline in child and infant mortality over the years, there has not been a proportionate decrease in neonatal mortality.

Malawi has maintained routine immunization coverage above 80% for most antigens since 1989; eliminated measles and neonatal tetanus; and reached polio certification level surveillance. However, there is need to increase routine coverage and maintain high quality AFP and measles surveillance.

The immediate and most common causes of infant and child mortality and morbidity are malaria, pneumonia, diarrhoea, neonatal causes and HIV/AIDS. Malnutrition is associated with over half of these childhood deaths. In 2005, a survey by NSO and ORC Macro found that about 19% of children under-five years of age were ill with cough and difficult breathing, 37% had fever, and 22% had diarrhea in the two weeks preceding the survey.

Uptake of cost-effective child survival interventions is still low. Only 20% of children with symptoms of ARI/fever and 36% with diarrhoea were taken to a health facility. About 61% of children with diarrhoea were treated with ORS, and 57% of children with fever were given an antimalarial drug. Reported antibiotic usage for suspected pneumonia was 29% (NSO and ORC Macro 2005).

While availability of a bednet in the household is estimated at 49%, the proportion of children sleeping under an ITN is still around 23%. Exclusive breastfeeding at 4 and 6 months are 71% and 56.4% respectively (NSO and ORC Macro 2005). Coverage of Vitamin A supplementation was 65% in 2004.

To improve the health of children, the country has implemented the Accelerated Child Survival and Development (ACSD) policy, the IMCI strategy, the EPI Reach Every District (RED) strategy, and recently the Essential Nutrition Action (ENA), a new strategy for implementing nutrition interventions at community level. A total of 20 out of 48 hospitals are now implementing the Baby Friendly Hospital Initiative (BFHI) in order to improve exclusive

breastfeeding and reduce infant and young child deaths. A five-year strategic plan 2004-2008 for the prevention and control of micronutrient deficiency has been developed.

Health Systems

The Ministry of Health retains stewardship role of policy formulation, regulation and enforcement, ensuring standards, training, curriculum development and international representation. MoH is also the largest provider of health services and accounts for 60% of health facilities. In 2004, the Government of Malawi started implementing a health sectorwide approach (SWAp) guided by a six-year joint programme of work (POW) 2004-2010 that was developed in collaboration with partners. The POW priorities revolve around the provision of the Essential Health Package (EHP) which focuses on interventions against 11 major conditions that predominantly affect the Malawian poor. Provision of the EHP is part of the Malawi Poverty Reduction Strategy.

Implementation of the POW is within the decentralization framework (GOM 1998) through the Local Government Act of 1999, with devolution of health service delivery to District Assemblies (DAs). Monitoring of the POW is based on biannual joint reviews with all the stakeholders.

In line with Office of the President and Cabinet (OPC) requirement of standard format for sector medium-term plans, the POW was converted into the Health Sector Strategic Plan (2007–2011) in 2007. The health care delivery system consists of primary, secondary and tertiary levels linked through a referral system. Primary Health Care is provided through community-based outreach programmes, dispensaries/health posts, health centres as well as community hospitals. Secondary level care is provided primarily through district hospitals (for the public sector) and CHAM hospitals. Finally, Central Hospitals provide tertiary level care. Table 2 shows the number of health facilities by type and ownership in the country.

Table 2: Facilities by type and ownership

	LEVEL OF CARE				
Ownership	**Primary**	**Secondary**	**Tertiary**	**Others**	**Total**
Government	493	53	5	24	575
CHAM	96	42	1	8	147
NGO	56	1	0	13	70
Private for profit	196	4	0	0	200
Statutory organization	13	0	0	7	20
Company	47	0	0	0	47
Total	**901**	**100**	**6**	**52**	**1059**

Source: MOH (2007)

One of the major challenges in the health system is the human resource crisis. Current staffing in Malawi is the lowest in the region with two physicians per 100 000 population and 59 nurses per 100 000 population (WHO 2006). Outputs at training institutions are currently too low to fill existing vacant posts. Retention of health workers is another challenge

as the public sector continues to lose skilled health workers to the private sector and the international market due mainly to low remuneration and poor working conditions. The HIV epidemic is also taking its toll on caregivers and administrators alike, exacerbating an already chronic shortage of appropriately trained personnel. The few available health workers are also not evenly distributed across the country.

Extensive efforts have been put in place to ensure attraction and retention of human resources. In 2001, MoH started training auxiliary nurses, and training of medical assistants resumed following its suspension in the early 1990s. These were some of the measures taken to bridge the staffing gap for nurses and clinicians. Since 2005, Malawi has also been implementing the emergency human resource programme which involves increasing training output, improving health worker remuneration and introducing retention incentives.

Access to health services is limited; only 46% of the population lives within 5 km of a health facility (EHP: Revised Content and Costs, MoH 2004). Although MoH services are free at point of delivery, there are indirect costs incurred by the rural population to get to these facilities. The EHP aims to improve this situation, for instance through standardization and expansion of community level services as well as protecting key resource inputs, such as transport for referrals and a secure budget for components such as drugs in the package.

The generation and use of information for decision-making is constrained by inadequate resources. Expenditure on health research constitutes less than 1% (MoH 2007b) of the national health expenditure which is less than the 2% recommended in 1990 by the Commission on Health Research for Development.

In order to ensure equitable access to quality, safe medicines and ensure rational use, the National Medicine Policy was revised in 2007. However, the Malawi Standard Treatment Guidelines and Malawi Essential Drug List are yet to be revised. A post marketing surveillance and pharmacovigilance system is also yet to be established. The Malawi National Drug Quality Control Laboratory has limited capacity to conduct quality control on new pharmaceutical products such as ARVs and ACTs. There are also frequent stock outs of the essential medicines and supplies in the public health system. The drug leakage study of 2006 has indicated the presence of some problems within the pharmaceutical sector, especially in the public health system (MoH 2006).

Health System Financing

The per capita total expenditure on health that stood at US$ 20 in 2004-2005 falls short of the US$ 34 recommended by the WHO Commission on Macroeconomics and Health to provide basic package of services in low-income countries. The Total Health Expenditure per capita is also not adequate to cover the Malawi EHP that is estimated to cost about US$ 17.5.[4] About 60% of the Total Health Expenditure is obtained from external sources. As at 2004-2005, government total expenditure on health as percentage of total government expenditure was about 9.3%; far below the Abuja target of 15%. Health expenditure incurred through private insurance continues to be low; marginally increasing from 2.3% in 2002/03 to 2.7% in 2004/05. Household or out-of-pocket payments on the other hand still comprise a significant proportion of the Total Health Expenditure; 12.1% in 2002-2003, 9.6% in 2003-2004 and 9.0% in 2004-2005.

[4] It has to be noted that the US$ 20 THE per capita includes interventions not included in the EHP and health administration costs.

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIPS FOR HEALTH

3.1 DEVELOPMENT ASSISTANCE

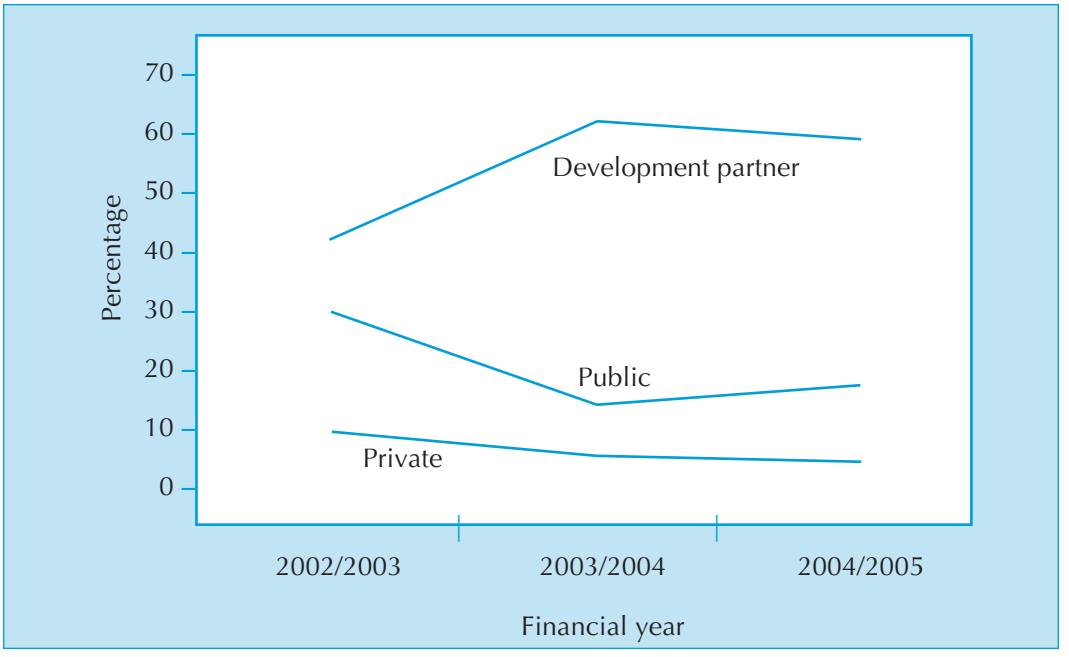
In Malawi, there are several development partners operating in the health sector which include multilateral, bilateral and nongovernmental organizations (NGOs). A mapping of the major health development partners is presented in Box 1.

Box 1: Mapping of development partners in health

Strategic focus development partners; Strengthening of national health systems; Human resources development decentralization; Organization of health services with emphasis on district health systems; Health information, evidence and research; Health action in crisis;	WB, ADB, UNDP, UNICEF, WHO, DFID, Norwegian Government, GTZ and JICA
Disease prevention and control including HIV/AIDS; Integrated disease surveillance and response; Disease control activities; Communicable diseases noncommunicable diseases;	WHO, UNICEF, DFID, WB, Norwegian Government, GTZ, USG and CIDA
Family and reproductive health; Maternal health; Child health;	EU, WHO, UNICEF, UNFPA, ADB, and Bill and Melinda Gates Foundation

Official development assistance, which constituted 26.6% of the country's GDP in 1990, increased to 27.8% in 2005 (UNDP 2007). In the 2006-2007 financial year, about US$ 450 million was disbursed in aid, of which 20.8% was allocated to health and about 7.6% to HIV/AIDS activities (DAD 2007). Health sector dependence on finances from development partners has been increasing over time, as can be seen in Figure 2.

Figure 2: Distribution of total health expenditure by financing source, 2002-2003 and 2004-2005



Source of data: MoH (2007)

As can be observed, the share of development partner input into the Total Health Expenditure increased from 45.9% in 2002-2003 to 60% in 2004-2005 while the government share decreased from 35.4% to 25.4%.

3.2 PARTNERSHIPS AND COORDINATION OF DEVELOPMENT ASSISTANCE

In a country where aid makes a significant contribution to the national income, it is essential to enhance aid effectiveness. To this end and in line with the Paris Declaration (PD) on Aid Effectiveness, there is a trend away from funding discrete projects towards other forms of aid modality such as sector and general budget support. Furthermore, to guide the process of aid mobilization, coordination and utilization based on the norms of the PD (ownership, alignment, harmonization, managing for results and mutual accountability), the Government of Malawi has drafted the Development Assistance Strategy (DAS). The DAS focuses on the need for development partners to respond to government reforms by increasing alignment to government systems and strategies and by harmonizing practices to reduce transaction costs.

The 2006 Survey on monitoring the Paris Declaration describes the challenges and priority actions in Malawi as indicated in Box 2.

Box 2: Overview of challenges and priority actions on enhancing aid effectiveness in Malawi

Dimensions	Baseline	Challenges	Priority actions
Ownership	Moderate	Human resources & institutional capacity constraints affect planning & implementation	Address capacity issues & staff shortages in the Ministry of Economic Planning & Development & Ministry of Finance
Alignment	Low	Weak public financial management, procurement & aid reporting system	Implement the Public Financial Management Action Plan reforms
Harmonization	Moderate	Lack of mechanism or strategy for ensuring enhanced harmonization	Implement the new Development Assistance Strategy & monitor the targets set on harmonization, including the establishment of new aid coordination dialogue fora.
Managing for results	Moderate	Need to ensure robustness of monitoring and evaluation systems	Ensure that the Joint Country Programme Review & Malawi Growth & Development Strategy (JCPR/MGDS) Annual Review meets the monitoring & evaluation needs of stakeholders
Mutual accountability	Low	No well-established mechanism for mutual assessment of progress against aid effectiveness commitments	Implement framework & indicators for mutual assessment set out in the Development Assistance Strategy, through the JCPR/MGDS Annual Review

Source: OECD (2007)

In the health sector, the sectorwide approach (SWAp) was adopted in 2004 as a mechanism for coordinating health development activities. SWAps strengthen government ownership and leadership of the health development agenda in the country. All development partners are expected to support a common plan and expenditure framework (the six-year strategic plan 2004–2010) that ultimately contributes to the Malawi Growth and Development Strategy 2006–2011 and the Millennium Development Goals. The financing modalities of the SWAp consist of pool and discrete funding. Pool funders are those that contribute to the common financing account (basket fund), while the discrete ones do not contribute to the basket. WHO financing modality falls in the group of discrete funding. From the UN system, UNFPA and UNICEF use the pool and discrete funding.

The UN system in Malawi has developed the United Nations Development Assistance Framework (UNDAF) covering the period 2008-2011. UNDAF is a programmatic response of the UN system to the development needs and priorities of the country; it is based on the MGDS and hence is compliant with the Paris Declaration on Aid Effectiveness. The UNDAF resource requirement is estimated at US$ 265 million over the four-year period of its implementation.

In the context of a changing aid environment WHO has a role to play in:

- Ensuring that health priorities are reflected in broader national development plans;
- Supporting the MoH to engage with existing or new aid modalities;

- Enhancing coordination mechanisms for health;
- Reinforcing systematic use of national systems;
- Supporting the monitoring and evaluation of MGDS and SWAps;
- Monitoring aid effectiveness in health.

3.2.1 Summary of Health and Development Challenges

The health and development challenges discussed in the above paragraphs can be summarized as follows:

Health Challenges

- High disease burden such as HIV/AIDS, malaria and tuberculosis;
- Re-emerging or increased incidence of neglected tropical diseases;
- Increasing noncommunicable diseases;
- High maternal mortality ratio at 807 per 100 000 live births;
- Low deliveries (50%) attended by skilled attendants;
- Maintenance of high immunization coverage;
- Low uptake of cost-effective child survival interventions;
- Usage of ITNs very low for both under-five children and pregnant women;
- Low outputs at training institutions to fill vacant posts within the health system;
- Weak retention mechanisms for health workers;
- Limited access to health services due to geographical and socioeconomic barriers;
- Inadequate utilization of information for decision-making;
- Stock outs of essential medicines and medical supplies in the public health system;
- Inadequate health expenditure per capita to cover the EHP;
- A vulnerable health sector that largely depends on external funding;
- A weak health system with inadequate capital and human resource investment.

Development Challenges

- A fragile economy that largely depends on external budgetary support;
- Weak public financial management, procurement and aid reporting systems;
- Absence of robust systems to monitor and evaluate aid effectiveness;
- Undeveloped mechanism for mutual assessment of progress against commitments and aid effectiveness.

SECTION 4

WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been and is still undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges, and the achievement of the health-related MDGs. This organizational change process has, as its broad frame, the WHO Corporate Strategy.[5]

4.1 GOAL AND MISSION

The mission of WHO remains "the attainment by all peoples, of the highest possible level of health" (Article 1 of WHO Constitution). The corporate strategy, the Eleventh General Programme of Work 2006–2015[6] and the document *Strategic orientations for WHO action in the African Region 2005–2009*[7] outline key features through which WHO intends to make the greatest possible contributions to health. The Organization aims at strengthening its technical and policy leadership in health matters as well as its management capacity to address the needs of Member States, including the Millennium Development Goals (MDGs).

4.2 CORE FUNCTIONS

The work of the WHO is guided by its core functions, which are based on its comparative advantage,[8] these are:

- Providing leadership in matters critical to health and engaging in partnership where joint action is needed;
- Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;
- Setting norms and standards, and promoting and monitoring their implementation;
- Articulating ethical and evidence-based policy options;
- Providing technical support, catalysing change, and building sustainable institutional capacity;
- Monitoring the health situation and assessing health trends.

[5] WHO EB 105/3, A corporate strategy for the WHO Secretariat.
[6] Eleventh General Programme of Work 2006-2015. A Global Health Agenda.
[7] Strategic orientations for WHO action in the African Region 2005–2009.
[8] Eleventh General Programme of Work 2006-2015. A Global Health Agenda.

4.3 GLOBAL HEALTH AGENDA

In order to address health related policy gaps in social justice, responsibility, implementation and knowledge, the global health agenda identifies seven priority areas; these include:

- Investing in health to reduce poverty;
- Building individual and global health security;
- Promoting universal coverage, gender equality and health-related human rights;
- Tackling the determinants of health;
- Strengthening health systems and equitable access;
- Harnessing knowledge, science and technology;
- Strengthening governance, leadership and accountability.

In addition, the Director-General of WHO has proposed a six-point agenda focussing on health development, health security, health systems, evidence for strategies, partnerships and improving the performance of WHO. In addition, the success of the Organization shall be measured in terms of results in women's health and the health of African people.

4.4 GLOBAL PRIORITY AREAS

Global priority areas have been outlined in the Eleventh General Programme of Work.[9] They include:

- Providing support to countries in moving to universal coverage with effective public health interventions;
- Strengthening global health security;
- Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
- Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;
- Strengthening WHO leadership at global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

The regional priorities have taken into account the global documents and resolutions of WHO governing bodies, the health Millennium Development Goals and the NEPAD health strategy, resolutions on health adopted by heads of state of the African Union and the organizational strategic objectives which are outlined in the Medium-Term Strategic Plan (MTSP) 2008–2013.[10] These regional priorities have been expressed in *Strategic orientations for WHO action in the Africa Region 2005–2009*. They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health,

[9] Eleventh General Programme of Work 2006-2015. A Global Health Agenda.
[10] Medium Term Strategic Plan 2008-2013. Strategic Directions 2008–2013, p. 4, paragraph 28.

emergency and humanitarian action, health promotion, and policy-making for health in development and other determinants of health. Other objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructure.

In addition to the priorities mentioned above, the Region is committed to supporting countries to attain the health MDGs, and assisting in tackling the human resource challenges. In collaboration with other agencies, assisting countries to source financing for their national goals will be done with the leadership of countries. To meet these added challenges, one of the important priorities of the Region is that of decentralization and the installation of Intercountry Support Teams to further support countries in their own decentralization process so that communities may benefit maximally from the technical support availed to them.

To effectively address the priorities, the Region is guided by the following strategic orientations:

- Strengthening the WHO Country Offices;
- Improving and expanding partnerships for health;
- Supporting the planning and management of district health systems;
- Promoting the scaling up of essential health interventions related to priority health problems;
- Enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the WHO corporate strategy at country level will vary from country to country depending on country-specific contexts and health challenges. By building on the WHO mandate and its comparative advantage, the six core functions of the Organization, as outlined in Section 4.2, may be adjusted to suit individual country needs.

SECTION 5

CURRENT WHO COOPERATION

5.1 FIRST GENERATION COUNTRY COOPERATION STRATEGIES

The WHO Country Cooperation Strategy 2005–2007 was developed with the aim of providing a framework for collaboration with the government and partners in the health sector. Its development was guided by the Malawi Poverty Reduction Strategy (MPRS) 2002, the UN Common Country Assessment (CCA) report of 2001 and the UN Development Assistance Framework (UNDAF) for 2002–2006. However, the development of the current CCS had no input from the Medium-Term Strategic Plan (MTSP) 2008–2013 since it was not available then. The biennial workplans covering the period 2005–2007 were based on the current CCS and office-specific expected results were in line with the objectives of the MoH Programme of Work. There was linkage with the education sector through the school health programme; water and sanitation sector through the health cities initiative; and the youth sector through youth friendly health services.

5.2 KEY AREAS OF WHO SUPPORT

In line with its new corporate policy and in cognizance of its comparative advantage, WHO took a more selective and strategic approach to the implementation of the 2005–2007 CCS as shown in Box 3.

Box 3: Strategic agenda for CCS 2005–2007

Health systems strengthening;
Disease prevention and control, including HIV/AIDS;
Family and reproductive health, including child survival;
Partnerships and facilitation for health action.

WHO also continued to provide support in other areas of need such as food safety, environmental health and sanitation, schistosomiasis, Buruli ulcer, and disaster preparedness and response.

National health systems strengthening

The World Health Organization provided support in human resource development and retention through supplementation of lecturers' salaries at the College of Medicine and the award of fellowships in various advanced public health fields. WHO through the UN system provided technical support in recruiting UNV doctors that were posted at different levels of the health delivery system. With technical support from WHO, the 1991 National Drug

Policy was revised. WHO strengthened its capacity by recruiting additional personnel such as a health systems advisor who continues to provide technical assistance to the Ministry of Health in monitoring performance of district health services, giving special attention to performance gaps associated with decentralization and the introduction of SWAps.

Disease prevention and Control, Including HIV/AIDS

WHO provided technical support in consolidating and institutionalizing Integrated Disease Surveillance and Response in Malawi. Specifically support was provided towards the improvement of performance of the central Epidemiology Unit and Public Health Laboratory; assuring timeliness and completeness of flow of information from peripheral levels to district and central levels; continued improvement of community- and district-level outbreak detection, investigation and control; and integration of IDSR into the national Health Management Information System. WHO also provided support in the provision of funds, personnel, transport and communication systems to facilitate investigation of cases, monitoring and supervision at all levels. WHO maintained its support to noncommunicable diseases as well as neglected tropical diseases such as trypanosomiasis, schistosomiasis, onchocerciasis and leprosy.

In addition, WHO facilitated the development of a five-year plan of action for the Integrated Neglected Tropical Diseases Control Programme that focuses on elimination of lymphatic filariasis as well as control of onchocerciasis, schistosomiasis and soil-transmitted helminthiasis.

WHO facilitated three major achievements in tuberculosis control. Through WHO advocacy, the country migrated from single drug formulation treatment to more efficacious and patient friendly fixed dose combinations (FDCs). With WHO support Malawi secured a three-year grant for anti-TB drugs from the Global Drug Facility (GDF) at a time when the National Tuberculosis Programme (NTP) was transiting from vertical donor support to integrated SWAp support. Lastly, within its greater mandate of resource mobilization, WHO supported the successful Round 7 TB Global Fund application. WHO further supported the adaptation of the public health approach to the management of people with advanced HIV infection using ART, while advocating for increased HIV testing and counselling for all-sexually active Malawians, including pregnant women, TB and STI patients, and children. A national road map for the implementation of interventions necessary to achieve as close as possible universal access to prevention, treatment, care and support services was also developed with WHO support. WHO also supported implementation of the WHO/CDC generic protocol for monitoring emergence of HIV drug resistance.

WHO also supported the country in the malaria treatment policy change from mono-therapy (SP) to artemisinin-based combination therapy (ACT) that came into effect in November 2007. During the same time, the Ministry of Health, through WHO and other partner support, successfully secured financial assistance from the Global Fund for rounds 2 and 7.

Family and Reproductive Health, Including Child Survival

WHO supported the implementation of the Road Map for the reduction of maternal and newborn deaths. In-service training for health workers to provide skilled birth attendance was strengthened. Pre-service training for midwives was supported with training materials manikins etc to encourage competence based training. Policy change for management of mothers and development of standards were supported. Tools for monitoring maternal health (MDR and verbal autopsy tools) were developed. These tools assist in improving community awareness for prompt referral of emergencies and reporting maternal deaths to central level.

WHO provided technical, financial and equipment support for the implementation of basic emergency obstetric care (BEmOC). WHO also provided technical support in adolescent health activities and to the Reproductive Health Unit of the MoH through the development of national policy and strategic frameworks, standards and guidelines for young people, and training materials for Youth Friendly Health Services.

WHO further provided support to Integrated Management of Childhood Illness (IMCI) through integration of the strategy into the curriculum of state registered nurses, and through building capacities in some priority districts. In addition, WHO supported inclusion of newborn care and HIV/AIDS in the IMCI case management protocols. In EPI, WHO provided technical and financial support that has contributed to maintenance of national coverage of immunization against preventable childhood diseases above 80% for all antigens.

Partnerships and Facilitation for Health Action

WHO supported the government with the necessary technical and financial assistance from all levels of the organization—HQ, Regional Office and Country Office, necessary for strengthening partnerships between Government, other development partners and WHO. WHO participated in various health forums, including the Health and Population Donor Subgroup and SWAp technical working groups. Within the UN system, WHO provided leadership through the UNDAF social services cluster (UNDAF Outcome 3). WHO is the co-convener of this cluster as well as team leader of the health subgroup.

5.3 WHO PERFORMANCE

WHO encountered challenges during the implementation of the first generation CCS. These included shortage of human resources in the health sector, inequitable access to health services and limited resources to deal with the increasing burdens of communicable and noncommunicable diseases.

With the increasing number of players in the health sector, the advent of SWAp governance structures and the UNDAF cluster system, WHO is required to be more strategic in order to exercise its leadership and coordination role in the health sector. It was imperative that the Country Office focus on its comparative advantages while building on its existing strengths. The Country Office maintained its visibility by:

(i) remaining neutral and impartial in the provision of technical assistance;

(ii) playing a key role in disease prevention and control;

(iii) advocating for development and implementation of evidence-based policies within the health sector;

(iv) mobilizing technical expertise and financial resources from the IST, Regional Office and HQ; and

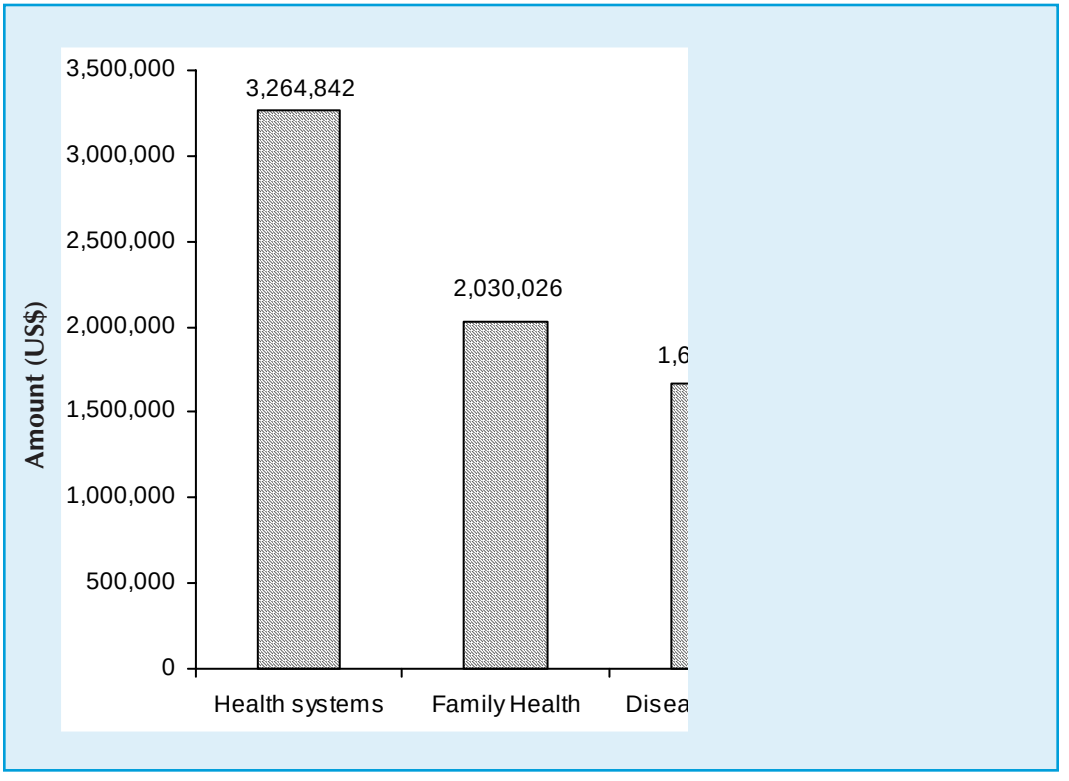
(v) by emphasizing the shift from direct implementation to executing its normative role.

5.4 FINANCIAL CONTRIBUTION

During the period of the first generation CCS, WHO provided financial support to the Government towards the strategic agenda through regular and voluntary funds as shown in

Figure 4. Additional financial support was sourced from voluntary funds from donors and partners, for example, through the Health Action in Crisis Appeal that was launched by the UN in response to the 2001-2002 humanitarian crisis and from the EU for supporting family health interventions in Making Pregnancy Safer.

Figure 3: WHO financial contribution by strategic agenda, 2004–2007



Source: WHO end of biennium financial reports 2005, 2007

5.5 HUMAN RESOURCES IN THE COUNTRY OFFICE

The WHO Country Office has a total of 29 staff members disaggregated as follows: 13 technical officers and 16 support staff. It is headed by a Country Representative who is supported by both international and local staff. There are three international staff, (health systems advisor, HIV/AIDS officer, and administrative officer), ten national professional officers (Malaria and Essential drugs, Health Promotion, Family and Reproductive Health, Managerial Process, Health and Environment, HIV/AIDS, Child and Adolescent Health, Expanded Programme on Immunisation, Tuberculosis, and Information, Technology and Communication Officer), three administrative assistants (Finance, Human Resources and Child and Adolescent Health), three programme assistants (for WR, Health Systems cluster and Disease Control cluster), one office cleaner, and six transport officers.

5.6 OFFICE LOCATION AND CONDITIONS

The office is located in Lilongwe which is the capital of Malawi. The offices are spacious and well furnished. Telephone communication is both by direct line and GPN. Electronic mail and internet services are available, supported by a network server. The office complies with the minimum operating security standards. In general, the working environment is conducive.

5.7 SUPPORT FROM THE REGIONAL OFFICE AND WHO HEADQUARTERS

With leadership of the Country Office based on expressed national needs, support was requested from the newly established IST office, the Regional Office and WHO/HQ; this support was availed for country operations.

SECTION 6

STRATEGIC AGENDA: PRIORITIES

COOPERATION

6.1 MISSION STATEMENT

The mission of WHO in Malawi, in accordance with the WHO Constitution remains "the attainment by the people of Malawi, of the highest possible level of health" in the context of sustainable national development and the Millennium Development Goals through:

- provision of technical leadership in health;
- effective collaboration with government and development partners;
- strengthened health security;
- improved coverage and equity of effective public health interventions and health system capacities.

6.2 PRIORITY AREAS, STRATEGIC AGENDA AND STRATEGIC APPROACHES

Based on analysis of the issues and challenges in Section 2, the first generation CCS, the Eleventh General Programme of Work and *Strategic orientations for WHO action in the African Region 2005–2009*, MTSP, UNDAF, MGDS and SWAp programme of work, the WHO Country Office will focus on the priority areas and strategic agenda as outlined in the paragraphs below. Some of the areas have been identified as weak and such areas include institutional capacity for the prevention and control of noncommunicable diseases; alertness and preparedness for emergencies and disease epidemics; delivery of maternal and child health services; equity and efficiency of the health delivery system; health systems research and its application; social and environmental determinants of health; and intersectoral collaboration and community involvement. These are the areas which will be supported during the implementation of the current CCS.

Access to health services is also limited by geographical and financial factors as well the lack of adequate health personnel to provide quality health services. The referral system and both national and district health planning are also weak. Financing of the health sector is presenting another challenge whereby the Total Health Expenditure per capita is also not adequate to cover even the Malawi EHP that is estimated at US$ 17.5. About 60% of the Total Health Expenditure in the country is obtained from external sources.

Priority Area 1: Building individual and national health security

Analysis of the previous CCS showed weaknesses in the management of epidemics like cholera as well as the handling of natural disasters. These challenges have added to the already existing problems of communicable and noncommunicable diseases as well as high maternal and childhood mortality rates, most of which are attributable to preventable causes.

Table 3: Strategic agenda and approaches for priority area 1

Domain/ priority area	Strategic Agenda	Strategic Approaches
Priority 1: Health Security	1.1: Strengthen institutional capacity for prevention and control for communicable and noncommunicable diseases	• Technical support in the development of policies, strategies and plans in the various programme areas. • Support the country to address health systems barriers that impact on routine immunisation. • Strengthen Ministry of Health's capacity in the prevention and control of communicable and NCDs including NTDs. • Support government to conduct baseline survey for NTDs. • Support in training, and defining research agenda.
	1.2: Enhance early warning system for preparedness detection and response to emergencies and disease epidemics	• Support strengthening of capacity of the Ministry of Health in its leadership roles in coordination, preparation and response to emergencies. • Support the development of national emergency health guidelines.
	1.3: Improve capacity for the delivery of maternal and child health services	• Support in setting, validating, monitoring and pursuing the proper implementation of norms and standards for maternal, newborn, child and adolescent health. • Support government to strengthen coordination and planning processes for maternal, newborn, child and adolescent health. • Strengthen capacity of health workers, and referral system for maternal, newborn, child and adolescent health. • Support Government and partners to assess, test and scale up interventions for the reduction of abortion related morbidity and mortality as part of sexual and reproductive health. • Supported the strengthening of monitoring systems for maternal, newborn child and adolescent health.

Priority Area 2: Strengthening the health system

The resource base for the country is narrow; allocation of resources has followed methodologies that ignored equity. The bigger share of resources and investment in the health sector has largely been from donors as was discussed in Section 2. The above issues will be addressed through strengthening of the health system so that information is available and used for informed policy development and decision-making.

Table 4: Strategic agenda and approaches for priority area 2

Domain/priority area	Strategic Agenda	Strategic Approaches
Priority 2: Strengthening Health Systems	2.1: Strengthen the health system capacity for equitable and efficient service delivery	• Support the country in scaling up the production and retention of health workers. • Support evidence-based decision making in the area of HRH • Support will be provided to the MoH to develop a health financing policy/strategy and initiate prepayment schemes in line with the resolutions of the World Health Assembly and the Regional Committee. • Support MoH to institutionalize National Health Accounts. • Support the diagnosis of health system constraints and strengthening of the policy and planning processes. • Strengthen capacity to monitor the quality, safety, and efficacy and cost effectiveness of medical products.
	2.2: Promote evidence-based decision making at all levels of the health system	• Advocate for the mobilization of more resources for health research. • Support the MoH to play the leadership role in coordinating studies (including clinical trials). • Support the MoH to strengthen research capacity through training in health research and supporting operational studies that address priority problems.

Priority Area 3: Investing in health and tackling social determinants of health to reduce poverty

A lot has been invested in health in Malawi by the Government and other players in health, in areas like human resources and infrastructure. Poverty and the other social factors discussed in Section 2 are still the driving forces which negate any achievements resulting from the investments made. Intersectoral participation and involvement of the communities (who are the ultimate beneficiaries) in planning, implementation and monitoring of health actions would address the social determinants that impact on health.

Table 5: Strategic agenda and approaches for priority area 3

Domain/priority area	Strategic Agenda	Strategic Approaches
Priority 3: Investing in health and tackling social determinants of health to reduce poverty	3.1: Address social and environmental determinants of health	• Provide technical support to enhance health system capacity for the management, prevention and control of priority health problems at all levels. • Support the commemoration of world health days. • Support and strengthen the capacity of the Ministry of Health to develop the Health promotion policy and an operational plan.
	3.2: Promote intersectoral action and community involvement for health based on the principles of Primary Health Care	• Advocate for operational research in social and environmental determinants • Support the promotion and maintenance of national collaboration, partnerships and networking. • Advocate for active participation of civil society in health matters. • Support MoH to strengthen capacity of health workers in mobilizing community for active participation in planning, implementation and monitoring of health actions.

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

The previous section articulated the strategic direction, approaches and priority areas for WHO collaborative work in Malawi for the period 2008–2013. In order to implement the CCS effectively, this section outlines the implications for WHO Country Office in Malawi (WCO), for the Regional Office (RO) as well as for WHO Headquarters (HQ) in Geneva.

7.1 IMPLICATIONS FOR THE COUNTRY OFFICE

As the basis for developing a "One WHO country strategy, plan and budget" the WHO Country Office in Malawi will utilize the CCS as a central document in all planning and budgeting processes. The CCS will be the basis for the WCO biennial and annual workplans, translating strategic objectives into country-specific expected results, and it will also be used to foster dialogue with all stakeholders. The CCS will be revised as required after consultation with the Government of Malawi and other key stakeholders.

For effective implementation of priority area 1 (building individual and national health security), it will be necessary not only to retain the human capacity recently recruited in this area to the WCO but also ensure that the responsible officer continues to sharpen personal core competencies in knowledge management and specifically in prevention and control of communicable diseases and noncommunicable diseases, including neglected tropical diseases, as well as early warning systems for preparedness and response to emergencies and disease epidemics. The Bill and Melinda Gates grant for Maternal, Newborn and Child Health (MNCH) gives the WHO Country Office responsibility for managing a partnership between Government, UNFPA, UNICEF and WHO. It provides a unique opportunity to demonstrate results in the area of maternal, newborn and child health.

A functional cluster system which allows programme officers to work within and across strategic objectives when need arises to strengthen workplan implementation will need to be strengthened. A deliberate effort will be made to allocate more financial resources to support NCD and NTD programme interventions.

To promote the country's health system performance, the WHO Country Office needs to strengthen its technical support in health systems by recruiting/maintaining multi-skilled professionals. These include critical areas such as HRH, health financing, health policy and planning, health information and research, and health economics.

The WCO should develop its skills base for intersectoral action and community mobilization in order to address the social determinants of health and mobilize more resources for programme implementation. Moreover, it is necessary to strengthen negotiation, advocacy and convening skills so as to play the lead role in the health sector.

7.2 IMPLICATIONS FOR THE REGIONAL OFFICE

The WHO Regional Office for Africa (including the IST) will ensure that the Country Office has the managerial and technical capacity required for implementation of the strategic agenda by providing technical and administrative support to WHO country operations customized to national needs in a responsive manner, based on the CCS and biennial plans. The Regional Office will examine delegation of authority to the WR and Country Office to ensure that sufficient flexibility exists for country-level implementation. The procedures for channeling locally and externally mobilized resources should also be reviewed in order to avoid delays in disbursement.

7.3 IMPLICATIONS FOR WHO HEADQUARTERS

WHO Headquarters, in keeping with its mandate, will continue to provide the regional and country offices with global policy advice, directives on health development, and guidance on global norms and standards. In line with the principle of "One WHO", WHO Headquarters will work with the Regional Office to provide technical support and mobilize resources for the implementation of the Malawi CCS, and to document lessons learned from the CCS process and its impact on WHO work. WHO Headquarters will continue providing up-to-date technical information to WCO Malawi.

SECTION 8

MONITORING AND EVALUATION

Monitoring and evaluation of the Country Cooperation Strategy will include annual reviews of the CCS, a mid term review (MTR) to be conducted halfway in the period 2008-2013 and a summative evaluation at the end of the life span of the CCS in 2013.

The CCS will be operationalized by means of the biennial workplans which include those for 2008-2009, 2010-2011 and 2012-2013. Apart from the focused CCS annual reviews, reports from the semi-annual monitoring, MTR and end-of-biennium reports will be used as inputs in monitoring and evaluating the CCS. Moreover, as the CCS will be implemented in a changing aid environment and enhanced UN reform process with a focus on donor alignment and harmonization, monitoring and evaluation reports from UNDAF 2008-2011, government reports (including MDGs progress reports, MGDS monitoring and evaluation reports, SWAp reviews) and similar reports of other development partners will contribute to the CCS monitoring and evaluation process.

The indicators of progress described for each strategic objective will be assessed in terms of aggregate improvements in those indicators. However, since aggregate improvements do not tell the whole story, issues of equity and efficiency (technical and allocative) will also be monitored and evaluated.

A comprehensive and in-depth study will be conducted on a thematic area selected in collaboration with all levels of WHO, the Ministry of Health and other partners. The case study will provide detailed information on the achievements of the CCS and highlight the problems encountered and lessons of experience for future any CCS.

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