



World Health
Organization



WHO MALAWI COUNTRY OFFICE

**Comprehensive Annual Report
Year 2022**



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Acronyms and Abbreviations

CBOs	Community-Based Organizations	MICS	Multiple Indicators Cluster Survey
CCS	Country Cooperation Strategy	MK	Malawian Kwacha
COVID-19	Coronavirus Disease-19	MoH	Ministry Of Health
DALYs	Disability Adjusted Life Years	MSTG	Malawi Standard Treatment Guidelines
DHIS	District Health Information System	NCDs	Non-Communicable Diseases
DHS	Demographic Health Survey	NDC	National Determined Contribution
DHSS	Director of Health and Social Services	NGOs	Non-Governmental Organizations
EPR	Emergency Preparedness and Response	NHA	National Health Accounts
EU	European Union	NSO	National Statistical Office
FCDO	Foreign and Commonwealth Development Organization	NTDs	Neglected Tropical Diseases
GAP	Global Action Plan	OHSP	One Health Surveillance Platform
GDP	Gross Domestic Product	RCO	Resident Coordinator's Office
GF	Global Fund	SDGs	Sustainable Development Goals
GoM	Government of Malawi	SERP	Socio-Economic Recovery Plan
GPW	General Program of Work	SRH	Sexual and Reproductive Health
HFs	Health Facilities	STIs	Sexually Transmitted Infections
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome	TB	Tuberculosis
HRH	Human Resources for Health	TWG	Technical Working Group
HSAs	Health Surveillance Assistants	UHC	Universal Health Coverage
HSSP	Health System Strategic Plan	UNCT	United Nations Country Team
IDSR	Integrated Disease Surveillance and Response	UNICEF	United Nations Children's Fund
IEC	Information, Education, and Communication	UNSDCF	United Nations Sustainable Development Cooperation Framework
IHR	International Health Regulations	USAID	United States Agency for International Development
JICA	Japan International Cooperation Agency	WaSH	Water, Sanitation, and Hygiene
KPIs	Key Performance Indicators	WCO	Who Country Office
M&E	Monitoring & Evaluation	WHO	World Health Organization
MDAs	Ministries, Departments and Agencies	WPV	Wild Poliovirus

Foreword

2022 was an eventful year for Malawi and for us as a country office. Within the framework of our General Programme of Work (GPW), we continued our efforts to support the Government of Malawi priorities to ensure improved access to quality essential health services; attainment of Universal Health Coverage (UHC) through strengthening of health systems and primary health care; promoting healthier populations through multisectoral actions and approaches, whilst responding to Multiple public health emergencies

Together with our partners and support from the regional and headquarters we rapidly responded to the Wild Polio Virus I (WVP1) outbreak, COVID-19 including ramping up vaccination coverage, Storm Anna and Cyclone Gombe and the Cholera.

Despite the immense burden on the health sector due to the multiple emergencies, significant achievements were recorded. The Health Sector Strategic Plan III 2023-2030 and the Health Financing strategy 2023-2030 were finalized providing the policy direction and the roadmap for attainment of Universal Health Coverage (UHC) in Malawi.

Other achievements include the generation of critical health data and evidence to inform policy interventions, progress in HIV and Malaria control and immunization catchup following reversal of progress due to COVID19, institutionalization of quality improvement and maternal newborn point of care QI initiatives

Significant Strides have been achieved in elimination of Neglected tropical diseases (NTDs), Malawi was validated as the first country in Sub-Saharan Africa to eliminate Trachoma as a public health problem. This milestone was celebrated in the presence of HRH Sophie Countess of Wessex, where WHO presented the elimination certificate to MoH. During the regional Lymphatic Filariasis Meeting hosted in Malawi, the country was celebrated for achieving Lymphatic Filariasis elimination in 2021.

These achievements were made possible with the support of the Regional Office and Headquarters who supported us throughout the year 2022. We are also grateful for the strong support from our partners



Dr Neema Rusibamayila Kimambo
WHO Country Representative for Malawi

and donors who continue to help us drive this health agenda. As I invite you to read this highlight of our achievements, I wish to use the opportunity to thank the Ministry of Health and Government of Malawi for the great collaboration and partnership. I sincerely appreciate and thank all WHO staff who dedicated their expertise and time to support their counterparts and closely worked with health development partners for better alignment and harmonization of programmes to promote the health of Malawians.



Advancing Universal Health Coverage through Health Systems Strengthening.

Malawi's UHC coverage index has improved over the years, and when compared against other Low-Income Countries¹. Whilst significant progress has been made with regards to improved access to essential packages

of health services, services disruptions between 2021 and 2022 due to Covid-19 pandemic led to reduction in uptake of some services significantly affecting the service coverage score (Table 1).

Table 1 Summary of UHC General Performance in Malawi

Domain	Unadjusted Score for Equity	Adjusted Score for Equity
Service Coverage	53.99	51.74
Financial Risk Protection	97.45	94.1
UHC	75.28	69.77

Source: Ministry of Health (2021)

To facilitate key improvement in the health system and improve health indicators, the Ministry of Health Malawi with support from WHO and other partners developed the third edition of the Health Systems Strengthening Plan² in the year under review. The HSSP III was designed to contribute to the sustainable development goals with focus on SDG3 and related goals defined for the period from 2015-2030. The plan is well aligned with the national Health Financing Strategy (HFS)³ and was developed under the theme; "Reforming for Universal Health Coverage". The plan seeks to reform the health system through the implementation of strategic reforms which cut across diverse health systems pillars. For service delivery, the country seeks to transition from vertical programming approaches to integrated platforms of care leveraging on the synergies, linkages and resource efficiency such approaches bring.

With regards to Health Workforce, the performance management system will be implemented together with the development of a harmonised in-service training system for human resources. Health Financing will also be enhanced to improve strategic purchasing in health financing. Following the development of the plan, WHO further supported the conducting of a prioritisation workshop to design a fit for purpose Health Benefits package within the available resources and delivered using integrated platforms of

care from the community level to primary, secondary, and tertiary levels of care.

Malawi was also supported by WHO and other partners to develop the Health Financing Strategy 2022-2030. The goal of the HFS 2022-2030 is to set a well-governed health financing architecture able to mobilise adequate resources, distribute the resources in an efficient and equitable way, and strategically purchase services based on a well-defined benefit package in pursuit of UHC Malawi launched the HSSP III and National Health Financing Strategy 2022-2032.

Key Results

HSSP III and Health Finance Strategy 2022-2023 developed to guide efforts towards UHC

Evidence based HR planning through Operationalization of Integrated Human Resource Information System and National Health Workers Account

Support for conduct of National Health Workers Account

¹ Tracking universal health coverage in the African region, WHO 202

² Malawi Health Systems Strengthening Plan, 2022-2027

³ Malawi National Health Financing Strategy 2023-20230



Enhanced Strategic Planning of the National Health Workforce and IHRIS Implementation of Roadmaps

Malawi has a huge Human resource for health deficit with only 52% the established HRH positions are filled. The filled positions are maldistributed across districts with low absorption rate, high attrition rate (MOH, 2018).

To improve strategic planning for HRH, WHO supported Health workforce strategic planning through provision of technical and financial support for the completion of the 2021 National Health Workers Account (NHWA) and formulation of the roadmap for the implementation of recommendations from the exercise.

WCO further supported the second National Health Workers Account (NHWA) data collation, analysis and reporting exercise conducted by MOH National Technical Committee with a focus on modules such as Labour, Education and Service Delivery. During this exercise, data was captured for staff employed under the Public Sector, Christian Health Association, and staff within academic institutions to complete the education component of NHWA. The findings are being used to inform implementation of the HSSP III and revision of the Human Resource strategic plan 2022-2030. Integration of the road maps on NHWA and the Health Labour Market Analysis will be key during the next part of the biennium.

Expanded Use of Human Resources Information System At National and District for Improved HRH Planning

In collaboration with key partners such as MoH, CDC and USAID and GIZ, WHO supported the operationalization of the Human Resources Information System at national and district level to provide comprehensive, timely, accurate, and up to date HRH data. Engagement meetings were conducted in four districts in the northern zone involving 50 district council members on integrated human resources information system (IHRIS). The expansion of IHRIS nationwide with cascaded interventions, will provide reliable annual data for the NHWA and assure visibility of HRH across all districts for informed strategic planning,

Enhanced Implementation of An Integrated Performance and Appraisal Management System

To improve efficiency and strengthen health workforce

performance especially at the subnational levels, WHO supported the MOH to integrate a Human Resources for Health performance management as part of district -led quality improvement initiative implementation. This system helped to implement performance appraisal mechanisms guided by clear work plans. It was similarly used to track staff absenteeism. Staff capacity building was also enhanced through provision of technical and financial support for the development of a virtual Continuous Professional Development platform for staff development. WHO will continue to support the roll-out of the platform to increase utilisation and improve usability and expand the range and scope of modules available on the platform to meet the varied training needs of the various health care available.

Completed 2018/19 National Health Accounts and Launched A Costed National Health Financing Strategy 2022-2030

The WCO supported the MOH to finalise the development of the 2018/2019 National Health Accounts report. In- country capacity building for key technical officers across the cross-cutting Ministries, Departments and Agencies was built for in -country development of the report on an annual basis. The training focused on systems for review of national accounts, data collection, analysis and writing of NHA reports and towards more cost efficient and effective NHA studies to achieve the UHC and SDG3 targets. The 2019/20,2020/21 and 2021/22 NHAs will jointly be conducted using these country-led systems. Integrated with National AIDS Assessment (NASA) and resource mapping exercises. The 2019 Covid-19 resource tracking report was disseminated during the five zonal review meetings held in May 2022. Costing of the national health financing strategy and road map on NHA institutionalisation with support from WHO AFRO and WCO was completed. The National Health Financing Strategy 2022-2030 was launched in January 2023 with the Health Sector Strategic plan 2022-2030.

Progressed Dialogues on Financing Malawi Health Sector Towards A Self-Sustaining Government Funded Health Sector

A high-level financing dialogue was held in the context of HSSP III with participation of all stakeholders. The health donors submitted a high-level Statements for Health Financing Dialogue in context of supporting the HSSP III and alignment to the Paris Declaration and Accra Agenda for Action on aid effectiveness principles. With recognized effort to shift to a more holistic view of health service provision that leverages



disease-specific funding towards strengthening the whole system in an integrated way, integrating lessons learnt from the Sector Wide approaches (SWAps) on donor coordination and alignment between 2010 and 2015.

The health donors take cognizant that the health sector is highly donor funded and donor dependent. Donors provided most resources in the health sector, at 54.5 percent of Total Health sector Expenditure (THE) which decreased from 58.6% in 2017/18 fiscal year (NHA report 2018/19). Public funds have also decreased during the period of the NHA study from 24.4 percent to 24.1 percent of the Health Sector funding. The government is expected to increase financial allocation to the health sector to meet the Abuja target of 15%, while annually reducing donor dependence on funding the health sector and out of pocket expenditure on health care (11.9%).

Quality of Care and Safety

By the end of 2022, Malawi had achieved a 20% reduction in Maternal Mortality from 439 to 349 per 100,000 live births through the implementation of various high impact, low-cost interventions that the Ministry of Health and its health partners including WHO provided. Neonatal mortality had also declined by 52.5% from 42 to 19 per 1000 live births whilst under-five mortality rate also declined by 33% from 63 to 42 per 1000 live births (NSO, MDHS (2016) (Figure 1). Despite the progress, Malawi's neonatal mortality rate (NMR) is among the highest in Sub-Saharan Africa. Birth asphyxia, prematurity, and infections account for most of the neonatal deaths in Malawi. Malawi is implementing its Every Newborn Action Plan (ENAP) which aims to reduce neonatal

mortality to reach the SDG3 targets with support from WHO.

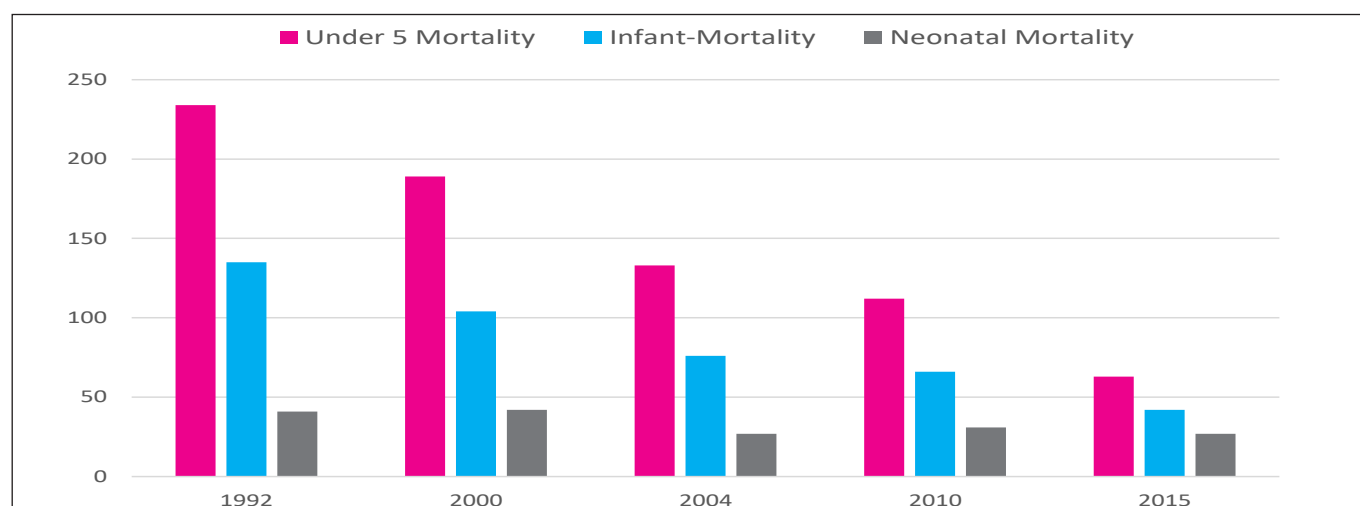
WHO continued to support the government's efforts to strengthen the health systems capacity for the provision of quality health services that are safe, effective and people centred. The national scale up plan on MNCH quality of health was developed and implemented, expanding coverage from none (9) to twenty-nine (29) districts ensuring integration of quality improvements in MNCH services.

Furthermore, through the implementation of a six-month mentorship programme, health worker skills to provide quality services was enhanced in nine districts resulting in a pool of district mentors thus empowering the districts to conduct district led mentorship. The mentors continue to facilitate implementation of quality improvement (QI) projects aimed at reducing maternal, neonatal and child mortality and improving experience of care for mothers and caregivers, applying a whole facility approach mentorship approach.

Quality improvement and its associated mechanisms enhances a culture of learning, sharing, and documentation of best practices. The need for continuous learning amongst health care workers is a key characteristic of a functional and effective health care service delivery system. WHO supported district based collaborative learning sessions that brought together QI teams from health facilities and provided an excellent opportunity for peer learning on QI.

Following the mentorship program, improved MNH outcomes have been observed in the districts. Below is an illustration of improvements from selected

Figure 1: Trends in early childhood mortality rates



Source: NSO, MDHS (2016)



learning sites of Thyolo, Kasungu and Zimba South district hospitals where reduction in both the numbers of maternal and neonatal deaths we observed.

Since the implementation of the online MNCH quality of health care CPD platform in April 2022, over 700 health workers have accessed the online CPD platform aims to bridge the knowledge and skills gaps in quality of healthcare and to reach most health workers with primary and refresher knowledge on self-assigned modules. Complementary e-learning platforms include the use of monthly zoom meetings and sharing using the WhatsApp platform.

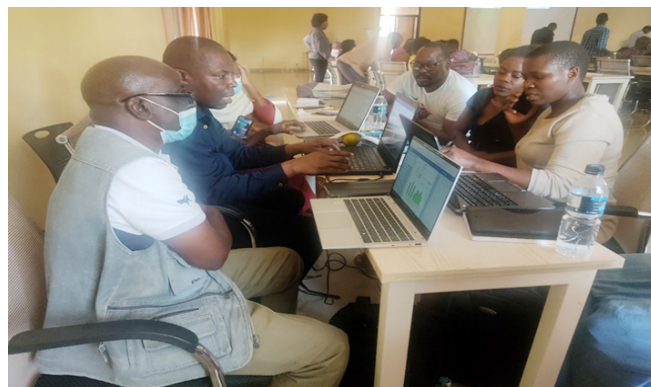
Use of Data for Action in Maternal and Newborn Health Interventions

To increase use of data for action and build district level capacity to use the Maturv platform and DHIS-2 to effectively monitor trends in maternal and neonatal deaths as part of maternal and perinatal death surveillance and response (MPDSR) process, the WHO supported a training workshop of 78 district safe motherhood coordinators and HMIS focal persons use of the two data platforms. MPDSR involves qualitative, in-depth investigations of the causes and circumstances surrounding maternal and perinatal deaths and is an integral part of quality-of-care improvement efforts to reduce maternal deaths, as well as preventable stillbirths and neonatal deaths. In addition, the workshop-built consensus on MPDSR monitoring and response activities at district and health facility level, reviewed selected MPDSR indicators for the fiscal years 2020/21 and 2021/22, produced the annual MPDSR progress report 2020/21 and 2021/22 with performance analysis on key indicators, experiences and recommendations including platform application on Maturv and DHIS-2 interoperability and reporting.

WHO also supported capacity building in MPDSR for health managers from the national level and conducted further advocacy towards strengthening maternal and newborn health interventions and institutional reporting towards better maternal and newborn care outcomes.



WHO and Ministry of Health led trainings



Participants during plenary and zonal break away sessions

Key Results

- 1 National Quality Strategy Launched
- 2 Digital innovation expanded access to training on Quality MNCH care for over 700 healthcare via online CPD platform
- 3 Quality of Midwifery training improved through curriculum review of 5 Midwifery colleges
- 4 Strengthened oversight and institutionalization of MPDSR through training of 78 Health Managers across 29 districts
- 5 Improved capacity in application of ICD 11

Capacity Building in the application of international Classification of Disease (ICD 11)

To support the operationalisation of the national Maternal and Perinatal Death Surveillance and Response Guidelines, Civil Registration and Vital Statistics interventions and other strategies to reduce maternal mortality and morbidity in the context of the achieving health sector outcomes outlined in the health sector strategic plan, the WHO supported trainings in ICD 11. The training targeted health managers, district safe motherhood coordinators, nurses, clinicians and HMIS staff.

The ICD is used to translate diagnoses of diseases, causes of deaths and health-related problems from words into codes making analysis of data easier. The training equipped participants with the necessary knowledge and skills required for mortality surveillance, birth and death registration and medical certification of death.



Harvesting Quality Improvement Lessons

In October 2022, the Country office supported the Ministry of Health to conduct the second national QoC under the theme **“Investing in Quality Health Care: A roadmap to Achieving Universal Health Coverage and Sustainable Development Goals”**. The conference was officially opened by the Minister of Health, Honourable Khumbize Kandodo Chiponda MP. The conference took stock of the quality improvement initiatives in the health sector since the launch of the MNCH QOC Network in 2017 in Malawi in the context of the Health Sector Strategic Plan II (HSSP II) implementation toward achieving UHC and SDG3 targets by 2030.

The documented achievements, challenges, best practices, and innovations will inform revision of the national quality management strategy and MNCH QOC roadmap 2023-2030. The conference demonstrated that there is valuable learning at community, facility and district level and drew the follow key recommendations:

Managers in the healthcare system should promote use of the launched quality of care standards at all levels

The MoH-QMD and partners should consider an integrated approach to QI and health systems strengthening in the next phase of implementation

All stakeholders in health care should prioritise people centred care as an integral part of capacity building.

All key principles about people centred care should be an integral part of capacity building for district health managers and health workers.

The office of the Ombudsman should empower health service users to be involved in their own health, to know and demand for quality health service.

Strategic guidance for sexual and reproductive health interventions in the context of the national health strategic plan

The WHO supported finalisation of the national Sexual Reproductive Health Delivery guidelines 2022-

and the National Cervical cancer strategic plan 2019-2029. WHO further supported the review of obstetric protocols and MNH guidelines to ensure they are in line with current WHO evidence-based technical guidance to achieve maximum outcomes. The WCO also supported the Ministry of Health to finalise the family planning (FP) 2030 cost implementation plan and the FP reference manual to be used by both family planning providers and FP trainers.

Every Newborn Action Plan was updated with guidance from WHO AFRO and support from other partners such as UNICEF. WHO also supported revision of the National Reproductive Health Service Delivery guidelines aligning with current WHO obstetric care guidelines that are based on the most current evidence. The revised national service delivery guidelines provide direction on the eight components of reproductive health and form a solid foundation from which service providers at all health facilities in both the public and private sectors, as well as non-governmental organisations, can provide comprehensive, high-quality and standardised reproductive health care.

Strengthened Midwifery Education for Universal Health Coverage

The WHO country office supported the analysis of the midwifery leadership profile to identify gaps and propose solutions. The analysis focused on leadership, capacity building and strengthening of collaboration with learning institutions under the Four Pillar for Nursing and Midwifery Leadership teams (QUAD and policy dialogue with the Ministry of Health, nursing and midwifery institutions and partners under the QUAD approach.

The role of QUAD is to create a cohesive force of nursing and midwifery leadership in Malawi to drive the implementation of the MOH five strategic national Nursing and Midwifery Policy direction under Education and research, Nursing and Midwifery Workforce, Regulations and service deliver, Professional associations, Leadership, governance and Partnerships to advance the UHC agenda with the nurses to facilitate the strengthening of midwifery interventions in Malawi.

WCO also supported the review of the Midwifery curriculum for 5 midwifery institutions namely Malamulo College of Health Sciences, Kamuzu University of Health Sciences, Catholic University, Mzuzu University and Ekwendeni college of Health sciences.

Malawi Embarks on the Process towards Validation



on the Path to Triple Elimination of Vertical Transmission of HIV, Syphilis and Hepatitis B

Malawi has made progress in the prevention of vertical transmission of HIV since the adoption of the Option B+ policy in 2011. Currently, the country has reduced the MTCT rate to 6% (2023) from 29% in 2010 and a total of 124,000 HIV Infections have been averted since 2010 due to PMTCT interventions. Prompt diagnosis of HIV, Syphilis, and Hepatitis B for infected women during pregnancy and breastfeeding, rapid ART initiation and syphilis treatment, as well as continuous VL suppression, remain the main pillars for the Triple Elimination of HIV, Syphilis, and Hepatitis.

Good progress with the preliminary processes for certification on the path to triple elimination of the three conditions was made in 2022. The WHO conducted an orientation session of the national validation committee on the validation process and trained the team on the estimation of congenital syphilis cases, one of the impact indicators required for the validation process. A self-assessment of the country programme performance was initiated.

Scaled up integrated Service Delivery for Child Health at Community Level

Since the Development of the Health Sector Strategic plan that promotes integration and harmonisation of services for better leveraging of resources, the IMCI and Nutrition Units of the MoH, have incorporated treatment of uncomplicated severe acute malnutrition protocols into ICCM. The integration considered key issues: community level protocol, supply chain management of Ready-to-use Therapeutic Food (RUTF), data management and community engagement.

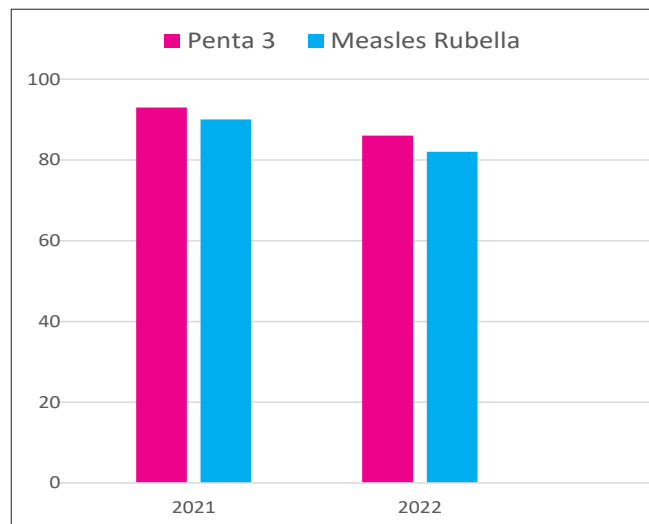
WCO supported this process by providing financial and technical support for the review of protocols, especially Sick Child Recording Form and reporting tools. This incorporation saw the capacity building through refresher training sessions of functional ICCM HSAs in 4 Districts of the Country with a coverage of around 850 HSAs to date, procurement of RUTF and respective commodity boxes.

In addition, WHO supported the revision of data tools and the DHIS2 reporting system of the MoH was configured to reflect the new development in all ICCM data elements. As 31st December 2022, the trained HSAs in the 4 implementing districts were managing ICCM plus CMAM cases.

Improving access to immunisation services

As of 31st December 2022, the national Pentavalent

Vaccine 3 coverage was 87%, which was above the recommended 80% coverage at National level. However, a declining trend was noted as compared to 2021. This decline was due to the huge impact of the multiple emergencies on the continuity of essential services.



To address this challenge, WHO through continuous review of data collaborated with MOH to implement key measures to address the declining routine immunisation coverages.

Health workers in low performing districts were supported with integrated supportive supervisions, 18 supervisors sent out to 240 HF in 12 districts, this built Health worker capacity in data management and service delivery.

WHO collaborated with UNICEF and other partners, supported the development of key national guidelines and strategies to provide the policy guidelines for recovery and improvement of immunisation systems. These included the National Zero-dose Strategy and the urban immunisation strategy. The guidelines have been disseminated and implementation commenced with a focus on reaching all zero-dosed, under immunised and missed children.

Another intervention implemented by WHO to address declining vaccination coverage was the support for the conduct of Periodic Intensification of Routine Immunisation (PIRI) activities in November 2022 which primarily focused on improving the HPV and MR 2 coverage. 21% (42,206) of the target population received the first dose and 14% (27,444) received the 2nd dose of HPV vaccine. MR 2 coverage 74% in 2021 compared to 60% in 2022 and HPV coverage 12% in 2021 compared to 14% in 2022.

Vaccine safety and pharmacovigilance; WHO



supported capacity building of 457 health workers on AEFI surveillance in 12 districts, this improved skills and knowledge on identification, notification, reporting, management, and investigation of AEFI. Reporting increased by 43% in the targeted districts, with a total of 254 cases reported nationwide.

Introduction of the Typhoid Conjugate Vaccine into routine immunisation

Typhoid fever is endemic in Malawi with a high disease burden in children under 15 years. WHO supported the country's new vaccine application process to introduce the Typhoid Conjugate Vaccine into the country in line with the WHO guidelines.

Following a successful application to GAVI for typhoid conjugate vaccine introduction, WHO supported national and subnational level preparation for TCV introduction in the country.

The country has planned to introduce TCV vaccine to children between the ages of 9-month-to 15 years in catch-up campaigns as part of an integrated campaign with Measles- Rubella vaccine, Oral Polio Vaccine and Vitamin A supplements to eligible children in Q2, 2023.

Vaccine Preventable Disease Surveillance

As part of the implementation of the AFP enhanced surveillance plan, WHO provided financial support to recruit and deploy 05 national polio epidemiologists and 02 international stop officers to high priority districts. The additional Human resource was essential for the strengthening of AFP surveillance at the subnational level and improving subnational capacity in vaccine preventable disease surveillance. A total of 179 AFP cases were reported in 2021 as compared to 486 cases reported in 2022 representing a 172% increase in AFP case reporting and 31% increase in the number of districts that met the minimum key AFP surveillance indicators.

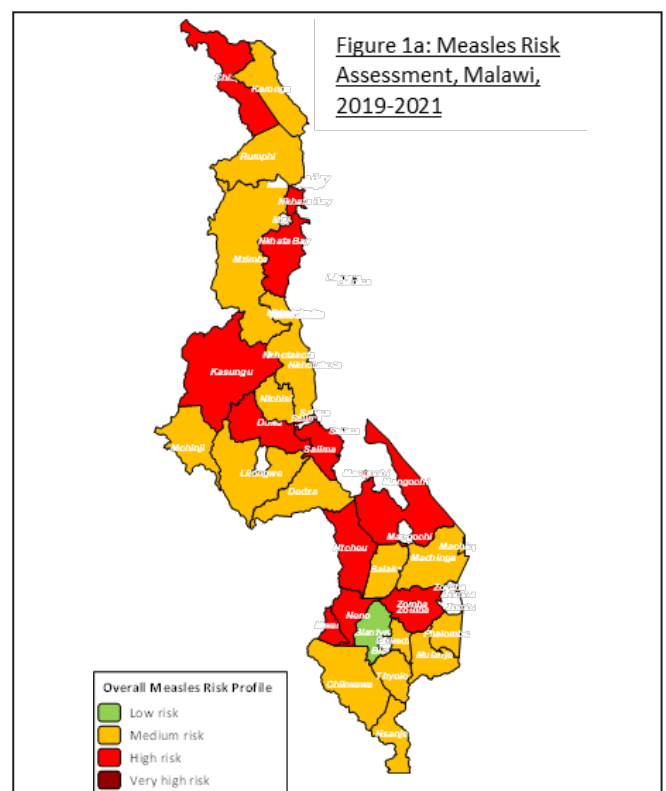
In addition, WHO supported the establishment of an Environmental surveillance system for Polio as part of the National AFP Enhanced Surveillance Plan. WCO provided financial and technical support for the establishment of 12 environmental sites across the country. In the 2nd biennial, no single site missed sample collection and over 80% of samples were collected using real-time data management tools such as the ODK application. 290 environmental samples collected and 04 were positive for WPV1 in July, August, and December.


With support from WHO, the AFP sample referral system was strengthened, and samples laboratory transfer was reduced from average over 10 days to 03



days to the National Public Health Reference laboratory in line with WHO recommendations.

WHO supported MOH to conduct a measles risk assessment using the WHO Measles Risk Assessment tool ahead of the planned Measles Rubella nationwide campaign. Following the assessment, the overall risk profile for Measles showed that 35.7% (10) of districts were at a high risk of Measles outbreak. 57% (16) of the districts were at a medium risk of Measles outbreaks. These findings also facilitated the development of measles contingency plans considering ongoing outbreaks in the region.





Communicable and Non-communicable Diseases



Progress towards achieving the UNIADS 95-95-95 targets

HIV

As of December 2022, the estimated number of people living with HIV in Malawi was 1,004,918 (Spectrum estimates). HIV prevalence among adults (15 years and over) is estimated at 8.9% (MPHIA 2020-2021) with annual incidence calculated at 0.21%, corresponding to approximately 20,000 new cases of HIV annually (MPHIA 2020-2021) among adults. There has been remarkable progress towards the 95-95-95 targets achieving 94-99-94 (MOH-HIV Dept Routine data).

There has been sustained multisectoral effort in supporting Government to implement WHO approved strategies to control the epidemic and these strategies include the rapid scale-up ART, the universal test and treat approach that started in 2016, scale up of lifelong ART (Option B+) for prevention of mother to child transmission of HIV, introduction of HIV self-testing in 2018, the transition to Dolutegravir-based regimens in 2019, and an increase voluntary male medical circumcision.

However, ART coverage is higher among adults compared to children at 74% in children and although the number of new infections is decreasing, the 20,000 new cases annually is still on the higher side if the epidemic is to be contained by 2030. The joint TB/HIV integrated supportive supervision reports have consistently flagged gaps in health worker knowledge and competencies on the updated HIV clinical management guidelines. The HIV response is largely dependent on external funding sources with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and PEPFAR as the biggest funders. Domestic funding is estimated at 14% and this is a cause for concern.

To ensure that policy and practice are based on current evidence, WHO provided technical support to the Department of HIV/AIDS and Viral Hepatitis in the Ministry of Health to update the HIV clinical management guidelines and the STI management guidelines in 2022.

In response to health worker skills and competency gaps on updated HIV Clinical Management guidelines, WHO also provided financial and technical support for orientation of 225 health workers from across the country May 2022. The aim of the orientation was to ensure that providers have the requisite knowledge and skills to deliver quality HIV/TB services.

Technical and financial support was also provided in the planning and implementation of the joint TB/HIV midterm programme review whose results were used to inform Global Fund Cycle7 request for funding.

Reducing Morbidity and Mortality from Tuberculosis

Tuberculosis

Much as Malawi is not a high TB burden country it is one of the countries with the highest dual burden of TB/HIV (WHO,2022). In 2021 the incidence of TB in 2021 was 32/100,000 population while mortality was at 39/100,000 population. Low case detection remains a common feature among the adult population with a detection gap of around 34%. The country has also not optimally rolled out the WHO recommended molecular rapid diagnostics.

On a yearly basis, WHO supports the National TB and Leprosy Elimination Programme (NTLEP) with technical guidance on programmatic management of drug resistant TB through the Regional Greenlight Committee (rGLC) monitoring missions. The 2022 rGLC mission took place in October 2022. WHO continues to engage MOH on uptake of WHO approved new molecular diagnostics.

Strengthening Viral Hepatitis Care

The prevalence of Hepatitis B (HBV) and Hepatitis C (HCV) in the general Malawi population is not well known and the mortality related to these infections is also not accurately established owing to limited availability of data. However, a systematic review of a few local studies done in 2018 places the pooled prevalence of HBV at 8.1%. HCV pooled prevalence from the same systematic review with RNA confirmation places the burden at 7.3%.

It is against this background that in 2022 WHO provided technical support to the Department of HIV/AIDS and Viral Hepatitis in the Ministry of Health to develop a Viral Hepatitis Strategic Plan and Clinical Management guidelines to govern implementation of VH activities.

Reducing morbidity and mortality from Malaria

Malawi has registered significant progress on reducing malaria-related mortality and morbidity during the implementation of the Malaria Strategic Plan (2017-2022). Malaria mortality declined by 61%, from 23/100,000 in 2016 to 9/100,000 in 2022 (MOH,2023). Malaria incidence also declined markedly during the same period, from 407/1,000 in



2016 to 220/1,000.

Malawi introduced the malaria vaccine (RTS/AS01) into its routine immunisation programme in April 2019. The phased introduction of the malaria vaccine was done in clusters in 11 districts across the country where it is integrated into routine immunisation.

However, the country is still experiencing fluctuating trends in malaria incidence rates. Other challenges include limited health worker capacity on novel or updated practices; poor adherence to guidelines, poor ANC service utilisation, long commodity procurement lead times, sub-optimal Social and Behavior Change (SBC) for Malaria, limited data use at all levels, and low fidelity of activity implementation.

In 2022, WHO provided technical support to MOH in strategic planning which included the malaria strategic plan end term review and used the report to inform the development of the successor strategic plan Global Fund Cycle7 request for funding.

Following encouraging results from the malaria vaccine pilot that Malawi undertook alongside Kenya and Ghana, WCO as an in-country coordination entity for the Malaria vaccine implementation programme (MVIP), continued to provide extensive technical

support to malaria vaccine introduction in routine immunisation.

As of quarter three 2022, malaria vaccine uptake was at 94% of eligible children who had received the first dose of the vaccine with coverage for the second, third and fourth doses at 80%,77% and 51% respectively. Based on these results, WCO supported the country in the development of the malaria vaccine expansion plan and the approval of its implementation by the GAVI and partners. This expansion will increase access to the vaccine within the implementation districts. As part of the implementation process, WHO supported MoH with development of training materials, guidelines, and the update of data management tools for monitoring the implementation.

WCO supported the training of trainers as well as health workers training. Over 6000 health workers acquired critical skills and knowledge required for malaria vaccine deployment. Further, WCO provided technical support in the Gavi application for the expansion of the malaria vaccine. The country received positive feedback for the application and the country is planning to expand the intervention to five additional districts.



In April 2019, Lusitana was the first child in the world to receive the first malaria vaccine through routine immunization as part of pilot introduction. Now age 4, Lusitana is fully vaccinated and healthy.

MVIP

Malaria Vaccine Implementation Programme

The Malaria Vaccine Implementation Programme is a collaboration of the Ministries of Health in Ghana, Kenya and Malawi, WHO, PATH, GSK, UNICEF and partners.



Malawi expands access to the malaria vaccine



First child to receive malaria vaccine in Malawi

RTS,S/AS01 (RTS,S) is the first vaccine recommended by WHO for use against a human parasitic disease of any kind. If introduced widely, it could save tens of thousands of lives each year. The Government of Malawi was the first to launch the vaccine in a landmark pilot programme in April 2019. The Malawi Ministry of Health launched the pilot implementation of the malaria vaccine in 11 districts in April 2019, followed by Ghana and then Kenya. To date, more than 400 000 children in Malawi have received at least one dose of the malaria vaccine; more than 1.2 million children have been reached with the malaria vaccine across the three pilot countries in Africa.

<https://www.afro.who.int/countries/malawi/news/malawi-expands-access-malaria-vaccine>

<https://www.afro.who.int/countries/malawi/news/innovation-work-reflections-malawi-worlds-first-malaria-vaccine-rtss-childhood-vaccination>

Boosting equity to malaria prevention in Malawi through vaccination

Clara Magalasi, who lives in a rural village near Lilongwe, the capital city of Malawi, woke up to a grey morning with a dull sky that was threatening rain. For Clara, the weather did not stop her from walking 4 kilometers to Chileka Health Centre. Her daughter Grace Butawo, who just turned 22 months, was due for her fourth and final dose of the RTS, S malaria vaccine. According to Clara, she was conscious about the dates to take her child for the final dose of the malaria vaccine as she understands its benefits.

“I understand that if my child gets all 4 doses, the vaccine will give her the most protection against malaria and severe malaria. Ever since Grace was born, she has never suffered from malaria, unlike my other children who experienced a lot of malaria episodes when they were the same age as Grace,” says Clara.

When added to currently recommended malaria control tools, the RTS, S malaria vaccine can reduce episodes of malaria in children by 40% and reduce life-threatening severe malaria by around 30%.

Malaria vaccine pilots mark second anniversary

As of this month, Grace is one of the estimated 220,000 children in Malawi who have received at least one dose of the RTS, S malaria vaccine through routine immunization as part of a landmark pilot implementation in sub-Saharan Africa - led by the

“

I understand that if my child gets all 4 doses, the vaccine will give her the most protection against malaria and severe malaria. Ever since Grace was born, she has never suffered from malaria, unlike my other children who experienced a lot of malaria episodes when they were the same age as Grace

”



Ministries of Health in Malawi, Ghana, and Kenya, coordinated by WHO, and supported by in-country and regional and global health partners.

Two years ago, Malawi became the first country in the world to introduce the malaria vaccine into its childhood immunization programme, followed by Ghana and then Kenya. The vaccine was introduced in a phased approach that targeted 11 districts in Malawi.

Globally, more than half of childhood deaths occur in Africa, and malaria is a major cause of death. In January 2016, the World Health Organization (WHO) recommended pilot implementation of the RTS, S malaria vaccine in children to use alongside other malaria control interventions in settings of moderate-to-high parasite transmission. The malaria vaccine is the first and, to date, the only vaccine that can significantly reduce malaria in children.

The power of immunization to increase health equity

“To reduce childhood deaths, we can look to the potential of interventions like the malaria vaccine to deliver added malaria prevention on the successful child vaccination or EPI platform that reaches about 80% of children in the country. The vaccine provides considerable added protection against malaria to children. It is an additional tool alongside insecticide-treated nets (or bed nets), and it is also an opportunity to reach children not yet using bed nets or other malaria prevention interventions - the malaria vaccine could increase equity in access to life-saving malaria interventions,” said Dr Nonhlanhla Dlamini, WHO Representative in Malawi.

The Malawi Ministry of Health has in place malaria control measures such as insecticide-treated nets (ITNs) and indoor residual spraying with insecticides (IRS). However, there are still households in hard-to-reach areas that do not yet benefit from such interventions.

As Seliya Lawrence, also from rural Lilongwe, says, her house never got IRS but her 10-month-old baby has so far received 3 doses of malaria vaccine.

“I know about IRS, but that programme did not come in our area. I am grateful that my child is getting malaria vaccine which can protect her from severe malaria,” said Seliya.

Other potential benefits: reduced hospital admissions, more preventive health care visits

Hospital visits and admissions due to malaria put a financial burden on the vulnerable. In Malawi almost 60% of childhood outpatient health facility visits are due to malaria. Data from Chileka Health Centre in Lilongwe indicates a decrease in hospital admissions for malaria illness among children under age five years since the vaccine was introduced. Health workers say this drop may be due to the malaria vaccine.

Madalitso Chadewa, a Senior Health Surveillance Assistant at Chileka Health Centre says. “Since the malaria vaccine was introduced, it may have managed to keep many children out of the hospital.”

Chidewa says the pilot has also improved the routine immunization uptake. Before the pilot, most mothers would quit under-five clinic visits when their children get their last jab of measles at 15 months. But malaria vaccine has extended the immunization period to 22 months of age.

“When children come at 22 months, aside from giving them the RTS, S fourth dose, we also do growth monitoring and general health checks. These health checks are essential because they help to detect preventable health threats in the under-five children,” she says.

Malaria vaccine pilot in the context of COVID-19

WHO has been supporting the Ministry of Health to ensure the continuity of essential immunization and malaria services during the pandemic, including malaria vaccination in pilot districts. The malaria vaccine pilot has continued without major disruptions.

“We understand how COVID-19 has put pressure on our health system. It is important for us to ensure that child vaccination services, including the malaria vaccine programme, continues during this time because immunizations reduce child illnesses, save lives, and help relieve the strain on the health system,” says Dr Randy Mungwira, the WHO technical officer for the malaria vaccine pilot programme in Malawi.

Next steps for the malaria vaccine pilot

Data and experience from the malaria vaccine in pilot implementation will inform on how best to reach children with the 4-dose vaccine regimen, the vaccine’s impact on severe malaria and on lives saved, and the vaccine’s safety in routine use. So far, accrued safety data are very reassuring.

<https://www.afro.who.int/news/boosting-equity-malaria-prevention-malawi-through-vaccination>



Eliminating Trachoma and Lymphatic Filariasis

Eight Neglected tropical Diseases (NTDs) are known to be endemic in Malawi and these include Schistosomiasis (bilharzia), Soil Transmitted Helminthiasis, Lymphatic Filariasis (Elephantiasis), Trachoma, Human African Trypanosomiasis (Sleeping sickness, Leprosy and Skin Diseases and Onchocerciasis (River Blindness).

Having achieved the lymphatic filariasis elimination status in 2021, WHO provided technical support to MOH on its path to elimination for trachoma in 2022. The support included dossier preparation at country level and dossier review by the expert committee at regional office level.

Malawi hosted the Integrated Onchocerciasis and Lymphatic Filariasis Regional Programme Review Meeting and one of the side events during the meeting was the presentation of an award of recognition to



Gathering stories from Trachoma survivors

WHO validates Malawi for eliminating trachoma, first country in Southern Africa

In September 2022, World Health Organization (WHO) validated Malawi as having eliminated trachoma as a public health problem- the first country in southern Africa and the fifth in Africa to achieve this significant milestone. Malawi has been known to be endemic for trachoma since the 1980s. Despite a considerable reduction in the prevalence of active trachoma over the years, reports from district health facilities continued to show that trachoma was a public health concern.

In 2011, the Malawi Government launched a trachoma elimination "SAFE" (Surgery, Antibiotic, Facial Cleanliness and Environmental improvement) strategy. In 2018, a survey was conducted in selected

Malawi as the third country to eliminate elephantiasis in Africa.

At a celebratory function of the trachoma elimination status achievement organised by the Ministry of Health in collaboration with Sight Savers, the WHO Representative, Dr Neema Kimambo, presented a WHO elimination status achievement certificate from the WHO Director General to the Minister of Health, Hon Khumbize Kandodo Chiponda in the presence of Her Royal Highness the Countess of Wessex, the Vice Patron of the Queen Elizabeth Diamond Jubilee Trust.

Non communicable Diseases

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

Following the adoption of a regional PEN-Plus strategy to address severe NCDs at first level referral health facilities in the region in August 2022 by Health Ministers at the 72nd WHO Regional Committee for Africa, WHO has remained engaged with MOH to adopt and implement this regional strategy which aims at addressing the burden of severe NCDs among rural and unreached populations through decentralised, integrated outpatient services in first-level referral health facilities.

districts with support from WHO Malawi Country Office and Sight Savers, a non-governmental organization confirmed endemicity in seventeen districts out of a total of twenty-eight districts.. In 2015, Malawi reported 7.6 million people were at risk of trachoma infection. Following the surveys, Malawi with support from WHO and partners stepped up efforts against trachoma. Implementation of safe strategy against trachoma. Implementation of safe strategy was funded by the Queen Elizabeth Diamond Jubilee Trust, with the goal of eliminating trachoma as a public health problem in Malawi by 2020.

Malawi established a national trachoma taskforce to lead in implementing a WHO-recommended SAFE strategy to control trachoma. WHO's mandate was to



provide technical leadership and coordination to the implementation of the strategy.

Building capacity of health workers to perform trachoma surgeries was one of the critical elements in Malawi’s trachoma control strategy. Trainings of a cadre of mid-level eye clinicians on surgery to treat the blinding stage of trachoma were based on WHO training guidelines and manual for trichiasis surgery for trachoma. The number of surgeons trained for eye care programme was based on the number of trachoma cases to be managed per district to achieve the elimination threshold. An estimated 6,500 trachomatous trichiasis surgeries were conducted to achieve elimination threshold in Malawi.

Mass drug administration (MDA) of azithromycin (Zithromax, Pfizer) was rolled out in all endemic districts. Dosing for the antibiotic followed WHO recommendations. WHO worked hand in hand with environmental health officers in districts, existing community health structures and partners to ensure minimum 80% coverage rate of the MDA campaigns.

Public awareness campaigns to promote facial cleanliness and personal hygiene was and remains central in trachoma prevention and control in Malawi. WHO support in this thematic area was ensuring that appropriate tools and messages that emphasized on general body hygiene and water and sanitation (WASH) were developed and delivered to intended audiences. By 2016, considerable progress was made with more than 80 % of endemic districts

having successfully completed the required SAFE interventions.

The Global Trachoma Mapping Project (GTMP) protocol, a tool developed by the World Health Organization, was used to conduct impact surveys. WHO was a key partner in conducting both impact and pre-validation surveillance surveys which indicated the level of trachoma being below the elimination threshold. With technical guidance from WHO Country Office, Malawi submitted a trachoma elimination dossier in July 2022 that was subjected to WHO sanctioned independent reviewers who validated that the country had indeed reached the elimination threshold after which WHO validated the country as having eliminated trachoma as a public health problem.

Efforts to eliminate trachoma as a public health problem was made possible due to strong multisectoral collaboration between WHO, government, donors, and partners. The collaboration ensured that each player has clearly defined roles for all the four thematic areas.

WHO will continue to assist Malawi’s health authorities in post elimination surveillance ensuring there is a rapid response to any resurgence of the disease.

<https://www.afro.who.int/countries/malawi/news/who-validates-malawi-eliminating-trachoma-first-country-southern-africa>



Her Royal Highness the Duchess of Edinburgh, Minister of Health-Malawi, Country Representative WHO Malawi holding the Trachoma elimination certificate



Preparing for and Responding to Health Emergencies



Overview

Malawi committed to strengthen health security as enshrined in the International Health Regulations (IHR) 2005 as well as building its capacities to prevent, prepare for, detect, and respond to health emergencies in accordance with the Regional Strategy for Health Security and Emergencies 2022-2030 and indicator 3.d.1 of the UN Sustainable Development Goals. Monitoring of these health emergency capacities utilized the IHR monitoring and evaluation framework (IHRMEF) and standard Member State Party Annual Report (SPAR). Baseline indicators showed that only 3 of 15 capacities met the required minimum 60 % score.

Achievements

Specific investments for preparedness and readiness focused on addressing prioritized tasks and functions. The key achievements realized during 2022 included:

- (1) Overall improvement to 5 capacities attaining the minimum 60 % SPAR score in crucial thematic areas of surveillance, laboratory, risk communication and community engagement (RCCE), emergency management and health service provision. A summary of results for all capacities is presented in Fig 2 below, accessible through [e-SPAR Public \(who.int\)](https://www.who.int/e-spar-public).
- (2) Strengthened multisectoral coordination and cross-border collaboration for health security, inclusive of cross border inter-

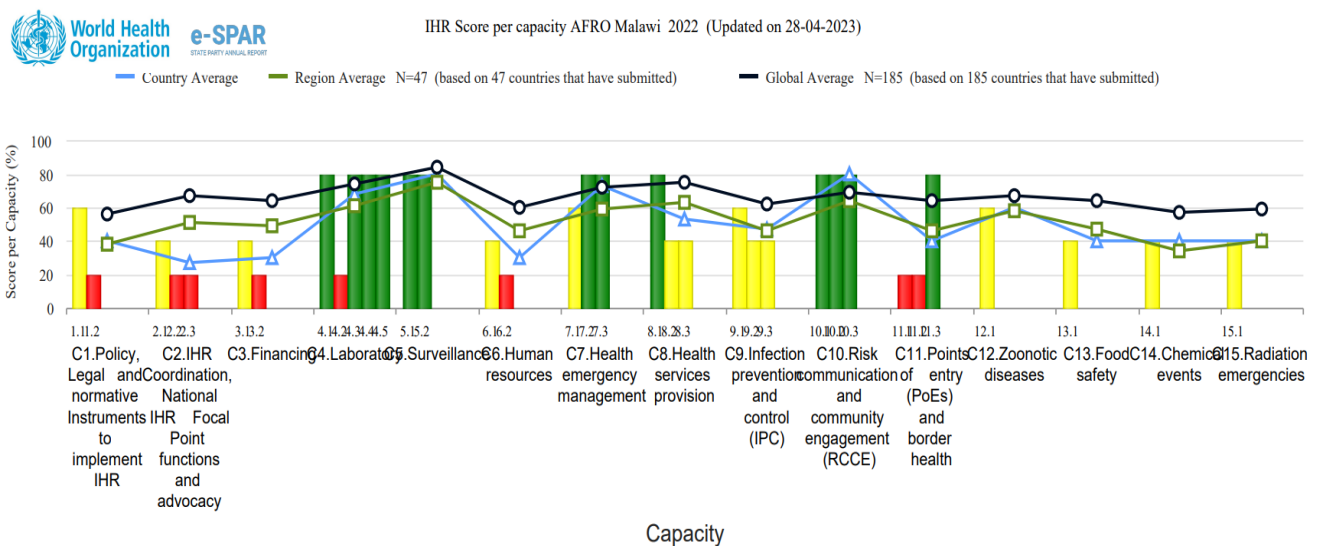
district collaboration between Malawi and Mozambique, that translated into establishment of 4 inter-district multidisciplinary committees with membership from human health, homeland security agents, immigration, port health, animal health, forestry, and district councils. This collaboration had positive impact in facilitating sharing of data, lessons and challenges during a protracted cholera emergency that affected the two countries during 2022.



Cross border activities

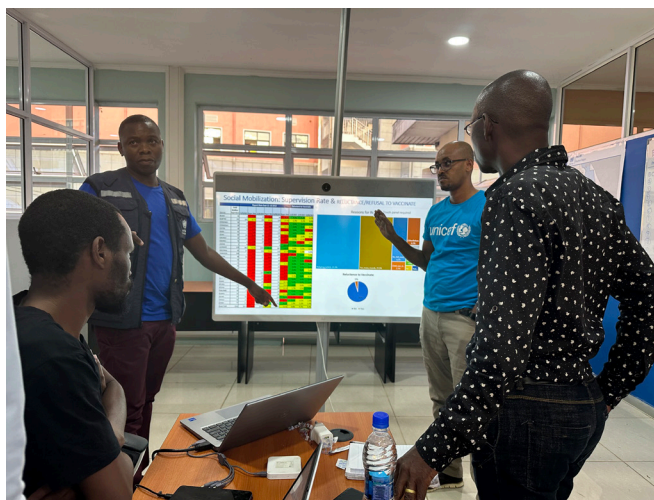
- (3) Supported the government Public Health Emergency Operations Centre (PHEOC) to be operational through technical support for development of a PHEOC handbook in collaboration with African CDC and many partners.

Figure 2: Summary of IHR Core capacities score





- (4) Conducted a regional simulation exercise on functionality of PHEOC to improve readiness for high-threat pathogens such as Ebola virus disease, thereby enabling convening of multisectoral partners under one roof for joint planning and decision making, providing a platform of collaboration among national and international partners and timely information sharing for potential public health emergencies that could be of national and international concern.



A WHO supported PHEOC for Polio Virus Outbreak Response

- (5) Facilitated conduct of intra-action reviews (IARs) for COVID-19 and cholera graded emergencies in collaboration with Africa CDC. The lessons learnt from these IARs provided qualitative assessments of the capacities leading to recommending priority strategic actions towards revisions of emergencies response plans for both cholera and COVID-19 in 2022.
- (6) Supported development of a Critical care strategy for improved standards and norms in clinical settings, through collaboration with the International Federation for Emergency Medicine (IFEM) to provide training and clinical mentorship in Basic Emergency Critical Care (BECC) and Advanced Emergency Critical Care (AECC). This resulted into creating a critical mass of 3 master trainers, 10 registered trainers, 34 provisional trainers, and an in-country pool of 89 BECC providers.



Basic Emergency Care Course Training in Liwonde

- (7) Supported development of a national health emergencies multi-hazard response and operational plan (NHEROP) following an all-hazards risk assessments using standards WHO Standard Tool on Assessing Risk, providing a risk calendar and geographical scope for climatic-related emergencies. This result guided prepositioning of cholera supplies to high-risk districts of Nsanje, Chikwawa, Mulanje, Phalombe and Balaka at least a month before the predicted calendar.

Areas of improvement



Strengthening of sub-national preparedness and readiness through broad dissemination of multi-hazards risk calendar, testing functionality of coordination mechanisms and sub-national prepositioning of supplies guided by the calendar.



Resource mobilization for investments in IHR (2005) capacities that are consistently below 60 % with timely periodic external evaluation of the IHR capacities.



Strengthen readiness for PHEOC and points of entry functionalities through varied types of simulation exercises



Conduct of a joint One-health assessments followed by joint operational planning.

**Lessons Learnt**

- Convening of multisectoral partners for preparedness and readiness facilitate standards for public health security.

Collaborating Partners.

Collaborating government institutions include ministries of Health, Agriculture, Water and Sanitation, Homeland Security, Climate Change, Justice, Local Government; as well as specific departments inclusive of Immigration, Port Health, Animal Health, Police, Livestock, Forestry, Disasters Affairs Management department (DODMA) and District Councils. Collaboration partners include Africa CDC, UNICEF, IOM, WFP, UNFPA, FAO, Malawi Red Cross Society, Save the Children, and academia.

Strengthening integrated disease surveillance and risk assessment

Malawi adopted the Integrated Disease Surveillance and Response (IDSR) approach to enhance early detection and facilitate rapid response to any public health emergencies. This to come out in the response.

WHO supported MOH to reactivate the production of IDSR Weekly Bulletin and strengthened capacity improvements towards surveillance early warning alert system inclusive of revisions of electronic tools for One Health Surveillance Platform (OHSP). Surveillance data management capacities were strengthened in all 29 districts by training over 180 health care workers including IDSR coordinators and HMIS Officers to enhance utilization of data for early detection of any health threats and facilitate rapid response. To improve the availability and quality of health events data, WHO supported data management activities including data review meetings for all 29 districts, supporting rolling out of electronic data capturing tools, capacity building of district and facility focal persons on data capturing and analysis to support decision making

Through these investments, Malawi has sustained disease surveillance reporting to AFRO HIR, sharing of disease surveillance information with other UN agencies and multisectoral partners. For example, in the current cholera response, WCO Surveillance

has been instrumental in supporting compilation of cholera daily data from all districts to national level for preparation of different information products to guide the response activities. The WCO surveillance team in collaboration with PHIM epidemiology team have managed to document and published 358 daily cholera reports and 46 weekly situation reports shared with all responders and stakeholders. Since engaging the surveillance officers at WCO in April 2022, the team has managed to publish 40 IDSR weekly bulletins for the same period (40 epidemiological weeks)

WHO strengthened laboratory capacity by procuring reagents, test kits and sample packaging materials for priority conditions such as COVID-19, Cholera, Polio and M-Pox. The reagents included media for bacteriology and M-Pox PCR reagents. This was to enhance capacity in the confirmation of suspected case patients.

WHO office recruited a team of public health emergency surveillance officers and data managers to support the response to multiple emergencies including COVID-19, Cholera, and natural disasters (Cyclone Anna and Tropical storm Gombe). The PHE surveillance officers were deployed to the most affected districts to strengthen diseases surveillance and response activities.

To strengthen cross border collaboration and reduce cross border transmission, WHO provided technical support during meetings between Malawi and Mozambique. The meetings brought together officers from national level and sub-national levels as part of a consultative process on how to rapidly detect and respond to cross border health threats using a One health approach.

Responding to health emergencies

In the year 2022, Malawi responded to multiple emergencies which ranged from COVID-19, Tropical Storm Anna (TSA) and Cyclone Gombe (CG), Cholera and Polio outbreaks. At the beginning of the year 2022, Malawi had 15066 active COVID 19 cases. From February 2022, the storm and cyclone affected 2.2 million people across 10 districts as well as causing substantial damage to health facilities, road networks and displacing populations inclusive of health care workers. After 30 years of no polio cases reported in Malawi, in February of 2022, Malawi government declares a polio outbreak after cases were reported. Towards the end of February, same year, the country recorded the first index case for Cholera



Responding to flooding emergency



A health center submerged in water in the southern region of Malawi

To contain the health impact of flooding, nearly US\$ 400 000 was released from WHO's contingency emergency fund (CFE) within 24 hours of request. With partners, WHO supported the Ministry of Health to assess 104 health facilities for functionality and safety; train 303 health workers in cholera management; procure lifesaving cholera emergency treatment and laboratory testing kits that reached 8,000 patients; and vaccinate nearly 800 000 children aged 1 to 14 against cholera. More than 43 000 displaced individuals benefited from mobile clinics, some of them boat-powered, across the five most affected districts in the south of the country.

Through the UN CERF funding, WHO supported the team for interagency assessment for the health cluster to come up with the report which contributed to the Response plan by all clusters. WHO also provided basic medical supplies to the affected districts. It also supported the Ministry of Health to apply for the OCV in anticipation of cholera. In total with CERF funding through WHO and its partners reached 5300 people with lifesaving treatment through the mobile clinics in camps. Over 20,236 contacts were traced through case findings. WHO procures Supplies like ORS, HTH and printed job aids which helped to teach

more than 300 health workers. Local team was supported by the surge team from AFRO in all the districts to respond to the impacts of the cyclone. The investments and intervention resulted into reduction of morbidities and mortalities in the affected districts by achieving <1 case fatality and attack rates of <1 % and transmission interruption fatality rate.

Responding to COVID-19 emergency

Following the global of COVID-19 as a public health emergency of international concern in 2020, Malawi registered its first case in April 2020, with continued registering of cases into 2022 averaging about 400 new cases per day.

WHO implemented a Hospitalization Surveillance System Project of acute and post Covid-19 conditions at 2 of the 4 busiest tertiary hospitals of Kamuzu Central Hospital and Queens Central Hospital whose results showed that 60% of the managed patients had no post illness while 10% had respiratory issue and another 10% had cardiovascular complications. These results informed clinical decision and update of guidelines and management protocols to improve clinical care and outcomes.



Further on, WHO contributed to the global COVID-19 clinical data platform for clinical characterization and management of hospitalized patients, enrolling 45 health facilities whose results informed modelling work and targeting of vaccination strategies.

To continually improve on capacity, over 750 health workers were trained in critical care management of COVID-19 patients and infection prevention and control in emergency treatment units (ETUs) in 20 districts of Malawi aimed at reducing hospital mortality and health care worker infections and promoting healthcare worker and patient safety.

WHO country office adapted IPC/WASH Partners Mapping Tool which was deployed to identify the scope of work in IPC/WASH for each partner and prevent the duplication of activities within the districts. The purpose of the exercise was to document all partners within Malawi with focus on names, geographical areas, the type of organization such as public, private, faith based, local, international, academic and the level including national, district or health facility, programmatic focus or pillars involved with, activities implemented or to be implemented, duration, donors, budge and challenges.

During the response period, it was noted that partners are not fairly distributed in all districts as in the Northern region all the partners are based in Mzimba

South and Rumphi, in the Central region more partners are centralized in Lilongwe and in the Southern region more partners are centralized in Blantyre district.

Despite many strides made in Infection Prevention and Control (IPC) in Malawi the emergence and re-emergence of communicable diseases such as COVID-19, polio, and cholera, leaves the country far from attaining minimum IPC standards.

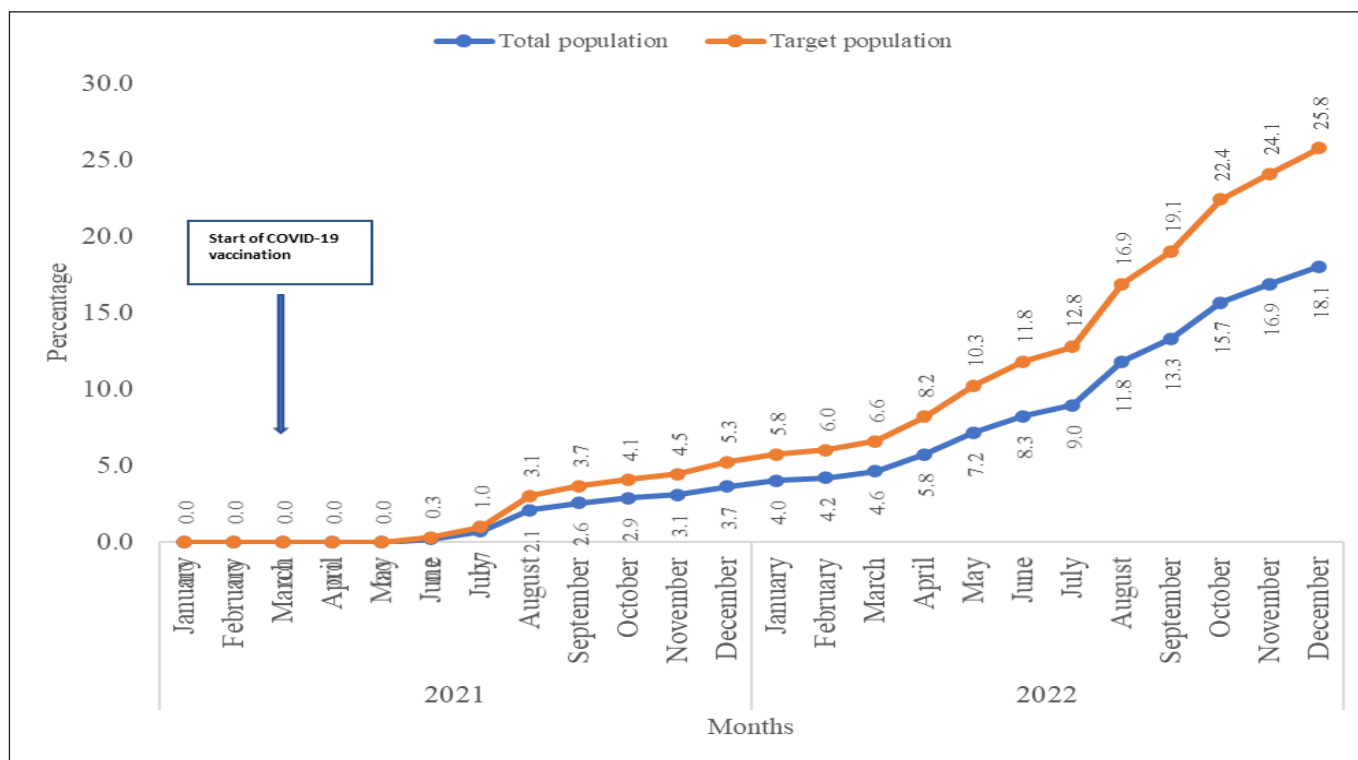
Natural disasters such as floods hinder the effective provision of safe Water, Sanitation and Hygiene (WASH) services further depriving the country of effective means for sustaining WASH practices in healthcare facilities (HCF).

Additionally, there are a limited number of trained IPC health workers, resulting in the insufficient capacity to implement activities.

Lessons Learnt

Strengthened IPC, improved quality of care and patient safety is essential in achieving universal health coverage and sustainable development goal 3.

The success of the IPC program is therefore vital as it is crosscutting and improves the effectiveness of the implementation of other programs such as AMR, Maternal and Child Health, HIV, etc.





COVID-19 vaccine deployment

As of 31 December 2022, 4,487,723 persons representing 23.4% of the total population had received at least a single dose of the COVID-19 vaccine and 1,746,229 persons (18.1%) had completed primary vaccination series in the total population. The most significant increase in COVID-19 coverage was in the 2nd Biennial. WCO supported the equitable deployment of COVID-19 vaccines to both genders amongst priority groups as well as in the general population.

In June 2022, Malawi received a High-Level Mission from the COVID-19 Vaccine Deployment Partnership (COVDP) who provided in-country support to accelerate COVID-19 vaccine uptake.

To ensure that pre COVID-19 campaign preparedness was effectively done through monitoring of the key performance indicators, WHO supported the rollout of the National COVID-19 vaccination Campaign Preparedness dashboard at the national and sub-national Level.

WCO- Malawi also supported the development and deployment of Electronic Monitoring Tools for COVID-19 Campaign supervision which was deployed in the campaigns by supervisors across all levels of the Health System. This system replaced the previous paper-based supervisory tool. The new system

ensured the availability of real-time data, populated on an easily accessible dashboard for prompt analysis of field findings.

Malawi also achieved a high health worker vaccination rate with 94% of health workers completing their primary series in 2022.

COVID-19 Surge staff and capacity building

WHO supported the deployment of 2260 data entry clerks across 29 districts for the November – December 2022 campaign. These clerks supported the digitization of 70% of the data generated during campaigns as of 31st December 2022.

WCO- Malawi further supported the Kamuzu University of Health Sciences to conduct a data backlog clearing exercise to clear 1million of the undigitized COVID-19 data into the National COVID-19 registry in DHIS 2. As of 31st December 2022, 43% of that data had been cleared with work still ongoing.

With support from the Africa Regional Office, WHO deployed 7 technical experts to accelerate COVID-19 vaccination in country with competence service delivery, planning and partner coordination, data management, risk communication and community engagement. This further enhanced in-country capacity in augmented COVID-19 vaccine deployment efforts.

Strengthening Health Workforce for Improved COVID-19 Clinical Care:

The Malawi Experience



COVID 19 case management training

The second wave of COVID-19 in Malawi resulted in an increasing number of patients with severe and critical illness and consequent mortality with a case fatality rate (CFR) of 3.29% as of early March 2021. Additional analysis of outcomes among hospitalized patients revealed an average mortality rate of 47.9% for patients admitted in the district and central hospitals. This situation stimulated the implementation of case management training for healthcare workers (HCWs) aimed at reducing the mortality in hospitalized patients with the severe and critical COVID-19 and the overall CFR.

The first step in the implementation of the case management training was a situational and learning needs analysis. This showed the strengths and weaknesses in the treatment of patients with severe and critical COVID-19. The analysis showed that the HCWs were motivated and committed to learning



and improving patient care. The key gaps identified were the poor acuity assessment and triaging and inadequate utilisation of early warning systems for assessment of severity and escalation of care. The prescription of oxygen and use of delivery devices was suboptimal and did not follow existing SOP on initiation and weaning of oxygen therapy. In addition, the utilisation of equipment for non-invasive ventilation such as high flow nasal cannula (HFNC) and continuous positive airway pressure (CPAP) devices where available was limited. There were gaps in the quality of care for coexisting comorbidities and complications.

In response to identified gaps from the learning needs analysis, training content was developed utilising the WHO training modules for SARI and COVID-19; other critical care resources and the Malawi COVID-19 case management guidelines. Key areas of focus in the training included acute assessment, triaging and emergency care in patients with severe and critical COVID-19; Use of early warning systems to identify early deterioration and promote an escalation of care; basic and advanced oxygen therapy for patients with severe and critical COVID-19; use of non-invasive ventilation (HFNC/CPAP) and respiratory rehabilitation (awake proning); management of special situations, comorbidities and complications; Contingency planning, efficient oxygen use and oxygen requirement assessment; difficult decision making for COVID-19 resurgence and mental health and psychosocial support.

The training was delivered through workshop format combining visual, auditory and kinaesthetic learning methods with group-based simulation exercises, case scenarios and follow up onsite mentorships.

Three hundred and two (302) HCWs in 3 regions and 9 districts including the 4 central (secondary to tertiary) hospitals were trained in the 6 workshops and four onsite sessions. Appropriate diversity in the composition of trainees was achieved with the inclusion of HCWs in public and private/mission hospitals. The trainees included 36 medical doctors, 180 nurses, 62 clinical officers, 13 physiotherapists, 8 anaesthetic technicians and 3 in other categories.

The training evaluation included quantitative and qualitative assessments. Average post-test scores were 84.6% compared to pre-test scores of 65.4%. The qualitative evaluation also showed a significant impact. The quoted statement from one of the participants “the outcomes would have been different if we had this training in January” echoes the impact of the training. A database of trainees was generated

with outstanding performers recommended for the upcoming National training of trainers (ToT). Follow up monitoring of hospital mortality in some facilities also shows significant improvement.

The next phase of activities includes a TOT aimed at building a team of in-country facilitators for sustainability. Additional integrated case management and IPC training will also be implemented. A set of the trained HCWs will also join a proposed support network to provide mentorship to district level COVID-19 treatment facilities.

Responding to cholera emergency



A Cholera Treatment Center during the 2022 Cholera outbreak

WHO supported training of 80 Training of Trainers for cholera outbreak response and case management. The TOT cascaded the cholera trainings to 1,107 Health workers countrywide serving a population of 1,880,000 million people at risk of cholera infection. The WHO team carried out mentorship visits to cholera treatment centers in the most affected districts of the Northern region to improve case management. The team consisting of a cholera case management specialist who supported the HCWs in the CTCs to improve treatment outcomes and reduce case fatality rates in cholera cases from 3.7% to less than 1%.

Donation of logistics for cholera response

WHO supported MOH with Cholera supplies that were distributed to all the affected districts actively reporting cases. These cholera kits supported approximately 4,600 cholera cases and have costed over 190,000 USD (MK 200 million). The Cholera kits were officially handed over to the Minister of Health on 25 October 2022.



On 12 December 2022, WHO donated a consignment of 1,324,400 Sodium Dichloroisocyanurate (NaDCC) for community water treatment, 562,900 ORS and 129,900 Zinc tablets for community oral rehydration points, expected to cater for an estimated 140,000 mild cholera cases (ORS and Zinc supplies) and cut further cholera infection transmission (water purification tablets).

Cholera Vaccine Deployment

WHO supported a successful application to ICG of 4.9 million oral cholera vaccines which was deployed to 21 of the 29 cholera affected districts with 85% of the target population covered with this essential vaccine. The vaccination campaigns were implemented in May – June 2022 and November to December 2022.

Cholera RCCE

WHO supported the distribution of the 150,000 assorted cholera IEC materials to all the districts across the country. The distribution was bundled up with the case management materials to improve management of cholera cases and reducing the case

fatality rate which has remained extremely high at 3% against the expected CFR of <1%.

WHO supported social mobilization for the upcoming reactive OCV campaign in all the targeted 13 districts to ensure high uptake of the vaccine during the campaign which started on 28 November 2022. The social mobilization orientation reached 510 District Executive Committee (DEC) members and 3,800 local leaders from the targeted areas of the 13 OCV campaign implementing districts.

IPC in Cholera

WHO supported the development of the WASH cluster response plan addressing waterborne diseases including cholera prevention and control. The response plan will assist with resource mobilization for WASH response in all the 29 districts for the year 2023. WHO further supported coordination and technical guidance during IPC and WASH meeting with all the 29 district coordinators to review the current response progress and identify gaps requiring urgent support from national level MOH and partners such as UNICEF, Malawi Red Cross Society.

Vaccines help battle cholera outbreak in Malawi

In late 2022 staff at Tukombo Health Centre, a stone's throw away from the shores of Lake Malawi, were stretched to the limit. The small facility in northern Malawi had been repurposed to serve as a cholera treatment centre to care for hundreds of patients as cases surged amid the country's worst outbreak.

At the peak of the infection wave, Tukombo area (in Nkhata Bay District) accounted for 60% of the 1500 cases recorded then in the whole of Malawi's Northern Region. "We had to work double shifts. It was a stressful situation," recalls Dyson Tchuwa, a health surveillance assistant at the health centre.

Now operations at Tukombo have almost returned to normal after several hectic weeks, thanks in part to a vaccination campaign in November 2022 that helped stem the tide of infections.

Since the onset of the cholera outbreak in Malawi in March 2022, World Health Organization has supported the country to access 4.9 million doses of oral cholera vaccines from the International Coordinating Group—the body that manages emergency supplies of vaccines—with funding from Gavi, the Vaccine Alliance. To date, vaccines have been deployed in 21 out of Malawi's 29 districts. In May and June



Oral Cholera Vaccination campaign

2022, 1.95 million doses were administered during a campaign in nine of the most affected districts, in the country's Southern region. A second batch of 2.9 million doses arrived in October and WHO together with UNICEF supported a vaccination campaign in 14 more districts. In Nkhata Bay District, the number of new cases decreased from 381 in October 2022 to only 43 in December 2022.

For both campaigns, only one dose was administered instead of two, due to the global shortage in oral



cholera vaccines.

“I know the dark side of cholera”

“I almost lost my life,” says Jones Chinula, a fisherman in Tukombo, as he shows his vaccination certificate. “I spent five days in hospital fighting for my life. I know the dark side of cholera, and this is why I am happy that the vaccine has been made available in my area.”

Since March 2022, Malawi has reported over 44 500 cases and nearly 1440 deaths. The first cholera cases were reported in the country’s south following floods. A total of 10 districts were affected as of July 2022. The disease then quickly spread to the north of the country and by the end of October 2022 all 29 districts were affected. The government declared the outbreak as a national public health emergency on 5 December 2022.

Cholera is an acute intestinal infection caused when someone consumes food or water contaminated with the bacterium *Vibrio cholerae*. Untreated, cholera can kill within hours. People living in places with poor sanitation and unsafe drinking water are most at risk.

“The trend of cholera changed significantly in the Southern region after the oral cholera vaccination campaign, and this helped the government to focus on other aspects of rebuilding the health system post-floods,” says Dr Charles Mwansambo, Secretary for Health in the Ministry of Health. In Nsanje, one of the most affected districts in the Southern region, cholera cases dropped from an average of 10 cases a day to less than three cases a day between May and December 2022. Despite the rainy season, which saw an upsurge of cases in a number of districts, Nsanje is still reporting low case numbers.

Cholera vaccination is crucial in outbreak control but should be complemented by measures to address the triggers of the disease. In Malawi, cases continue to increase in many districts, including some where cholera cases are usually not reported as the rainy season continues.

Multi-sectoral interventions

“Oral cholera vaccination should be used in conjunction with improvements in water and sanitation to control cholera outbreaks and for prevention in targeted areas known to be at high risk for cholera,” says Dr Neema Kimambo, WHO Representative in Malawi. “We will continue to engage with partners and donors to ensure that if a need for additional oral cholera doses arise, we are well prepared and support the Ministry of Health accordingly.”

A surge in cholera outbreaks globally has strained the supply of cholera vaccines, prompting the International Coordinating Group to temporarily suspend the standard two-dose vaccination regimen in cholera outbreak response campaigns, using instead a single-dose approach.

“Vaccine is an additional tool for the response, and in the absence of it, we are working with the Ministry of Health and partners to employ multi-sectoral interventions to effectively control cholera,” says Dr Kimambo.

In Tukombo, where health surveillance assistant Tchuwa and his colleagues expended huge efforts to vaccinate the population, the fight is not over. “Apart from the vaccination, we have intensified chlorine distribution in households for water purification and we are engaging fishing villages on water, hygiene and sanitation to ensure that we contain the cholera outbreak,” he says.

<https://www.afro.who.int/countries/malawi/news/vaccines-help-battle-cholera-outbreak-malawi?country=39&name=Malawi>

Polio Outbreak Response

On 17th February 2022, Malawi declared an outbreak of wild polio virus type 1 (WPV1) in a three-year-old female child following a history of paralysis and subsequent investigation. This was the first reported case in country since 1992 and in the African region since 2016. This triggered a nationwide response that focused on enhanced surveillance of AFP cases, strengthening routine immunization, and implementation of nationwide supplementary immunization campaigns (SIA) using bivalent oral poliovirus vaccine (bOPV) in Malawi.

Polio is a public health emergency of international concern (PHEIC) and WHO in collaboration GPEI provided full-scale technical and financial support to the response at the National and Sub-national levels. As of 31st December 2022, Malawi has conducted four rounds of nationwide Polio campaigns with improving SIA quality.

During the fourth round, 3.6 million under five children were vaccinated, 21 (72%) of the districts passed the lot quality assessment (LQAS). The progressive improvement in Polio SIA over the four rounds was critical in reaching all eligible children, zero-dosed and underserved populations to ensure rapid closure of immunity gaps across the country.



Over 33 million children vaccinated against wild poliovirus in southern Africa

A year since Malawi confirmed its first case of wild poliovirus type 1 in 30 years, more than 33 million children across five southern African countries have been vaccinated against the virus, with over 80 million vaccine doses administered over the past year.



Oral Polio Vaccine administration

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A total of nine wild poliovirus cases have been reported so far, with one in Malawi and eight in neighbouring Mozambique since the declaration of an outbreak on 17 February 2022 in Malawi. The last confirmed case to date was in August 2022 in Mozambique. The wild poliovirus in Malawi and Mozambique originated from Pakistan, one of the two last endemic countries.

Concerted emergency response launched following the outbreak in 2022 has helped increase protection among children through vaccines in Malawi, Mozambique, Zambia, Tanzania and Zimbabwe. The countries have also ramped up disease surveillance and community mobilisation to help find cases and halt the virus.

“Southern Africa countries have made huge efforts to bolster polio detection, curb the spread of the virus and ensure that children live without the risk of infection and lifelong paralysis,” said Dr Matshidiso Moeti, World Health Organization (WHO) Regional Director for Africa. “We continue to support the polio control efforts across the region so that every child receives the protection they need.”

To date, 19 vaccination rounds have been concluded

in the most at-risk areas and at least five more are planned for 2023 in the five countries.

Additionally, more than 10 new environmental surveillance sites have been set up over the past year in the affected countries with support from WHO. The fully operational sites are playing a critical role in the efforts to detect silent circulating poliovirus in wastewater.

“Response teams have worked intensely in the fight against polio not only in Malawi but in the rest of the neighbouring countries in a coordinated manner. We will not rest until we reach and vaccinate every child to stop polio transmission,” said Dr Emeka Agbo, acting Country Coordinator for the Global Polio Eradication Initiative in Malawi.

Reaching all households where eligible children live is critical to protect them against the risk of paralysis. The national health authorities, with support from the Global Polio Eradication Initiative, efforts are ongoing to map cross-border communities, migratory routes, border crossings and transit routes.

“Community health workers have been pivotal in the vaccination campaigns and will continue going door-to-door, bringing polio vaccines to children who might otherwise be missed,” said Dr Jamal Ahmed, WHO Polio Eradication Programme Manager.

Polio is highly infectious and affects unimmunized or under immunised children. In Malawi and Mozambique, it has paralysed children younger than 15 years. There is no cure for polio, and it can only be prevented by immunisation. Children across the world remain at risk of wild polio type 1 as long as the virus is not eradicated in the last remaining areas in which it is still circulating.

Despite the circulation of wild poliovirus type 1 and the variant polioviruses, incredible progress has been made. Since 1988, when the Global Polio Eradication Initiative was set up, polio cases have plummeted by 99% from an estimated annual total of 350 000.

Importation of any case must be treated as a serious concern and high-quality response efforts to reach every child with polio vaccine are critical to prevent further spread.



On 25 January 2023, the WHO Emergency Committee under the International Health Regulations concluded that the risk of international spread of poliovirus remains a public health emergency of international concern.

<https://www.afro.who.int/countries/malawi/news/over-33-million-children-vaccinated-against-wild-poliovirus-southern-africa?country=39&name=Malawi>

Malawi intensifies response after wild poliovirus detected

Polio emergency response teams in Malawi are ramping up disease surveillance and deepening investigations after the country detected a case of wild poliovirus—the first of its kind in Africa since 2016. Determining the extent of the risk and searching for any further cases are among the crucial steps for an effective response to halt the virus and protect children from its debilitating impact.

The African region was declared and certified as free of indigenous wild polio in August 2020 after eliminating all forms of wild poliovirus. Laboratory analysis linked the strain detected in Malawi to the one circulating in Pakistan’s Sindh Province in 2019.

In January 2022 soon after Malawi received preliminary results of poliovirus, the Ministry of Health, with support from World Health Organization (WHO), swiftly launched response measures, collecting additional stool samples from contacts of the index case, and shipping them for further analysis, as well as actively searching for possible new cases. The country declared an outbreak of wild polio on 17 February following confirmation of the virus type. This is the first case of wild poliovirus in Malawi since 1992.

Within days of the outbreak being declared, expert teams deployed to the country to support key response measures including setting up a fully functional environmental surveillance system to complement clinical acute flaccid paralysis surveillance for possible polio cases. This entails identifying suitable wastewater locations to serve as environmental surveillance sites and training responders at national and local levels to collect and package samples for shipping and analysis.

Environmental surveillance for polioviruses has now been established in six sites in two districts. These include Lilongwe District that encompasses the capital Lilongwe where the initial, and so far, the only case, was detected. Other sites are in Blantyre, Mzuzu and Zomba cities.

The polio response teams have also undertaken a risk assessment, which includes detailed disease investigation, epidemiological surveillance



Environmental surveillance at Kauma sewage site in Lilongwe

assessment as well as analysing factors that can hinder or ease response operations. Additionally, educating and informing the media and the public about polio is ongoing, so they can also report any suspected cases.

To support the country team, experts from the WHO Regional Office for Africa were deployed within days of Malawi declaring the outbreak. The surge team of six includes a coordinator, a technical and operations expert, surveillance experts and a data manager. The WHO team is part of a broader multi-partner Global Polio Eradication Initiative (GPEI) support to the country.

“We have all the necessary tools and all the necessary tactics to successfully stop this outbreak,” said Dr Janet Kayita, acting WHO Representative in Malawi. “Malawi has been polio-free before and can rapidly be so again. The key is to optimize operations and now ensure that every child is reached with the life-saving polio vaccine.”

Malawi has scheduled a mass supplemental polio vaccination response targeting under-five children, using the Bivalent Oral Polio Vaccine recommended by WHO and the GPEI partners for wild poliovirus (type 1). Four rounds of polio vaccination campaigns are planned. All the neighbouring countries – Mozambique, Tanzania and Zambia – have been alerted and are planning to conduct immunization



campaigns as well.

“The quality of the vaccination campaign is essential to interrupt transmission of poliovirus from child to child. Therefore, it is critical to ensure that the vaccination rounds reach every child,” said Deputy Minister of Health, Honourable Enock Phale. “We ask all our political leaders, religious leaders and community leaders to support the government in encouraging our communities to take part in the polio eradication activities by taking their children for the routine polio immunization.”

An immediate-response public awareness campaign has been launched by the Ministry of Health and partners to alert the public of the outbreak, describe the planned response and provide information about polio and the vaccine.

Malawians are treating the outbreak with due urgency.

“I am ready to do whatever it takes to protect my

children including getting the polio vaccine. We do not want to see polio paralysing children again as it was 30-plus years ago,” said a resident of Area 24 in Lilongwe, who wished to remain anonymous.

Polio is a highly infectious disease caused by a virus. It invades the nervous system and can cause total paralysis within hours, particularly among children under five. The virus is transmitted from person to person mainly through faecal matter or, less frequently, through contaminated water or food, and multiplies in the intestine. While there is no cure for polio, the disease can be prevented through administration of a safe, simple and effective vaccine.

“Malawi is now considered a polio-affected country. We are working tirelessly with the government and our GPEI partners to reverse this. The WHO African Region’s status as wild polio-free remains intact. However, our work now is to quickly prevent any in-country spread of wild poliovirus and keep children safe,” said Dr Christopher Kamugisha, the GPEI Coordinator.

Making a difference on health in Africa- Malawi polio vaccinator story

Macron Chauluka is a community health worker on the front lines of Malawi’s ongoing fight against the wild poliovirus.

After an outbreak of the virus, which can paralyse and even cause death, was declared in the country in February 2022, a total of around 2.9 million children, who are most at risk, were identified nationwide for vaccination across four rounds.

In often hard-to-reach rural areas, the dedication of local health workers like Macron, who works at Machinga District Hospital in Southern Malawi, is key to the success of such campaigns. “I am determined to reach every eligible child in my catchment area,” he says.

Despite being physically challenged, which makes his mobility limited, Macron walks at least 3kms every day to deliver the potentially life-saving oral polio vaccines door to door, as well as to health facilities and outreach sites.

“My motive for being a vaccinator is that I am contributing towards saving lives, especially children, from vaccine preventable diseases,” Macron says. “I am willing to cross rivers and defy any obstacle until all children are vaccinated against polio.”



Health Surveillance Assistant conducting door to door polio immunization

<https://www.afro.who.int/about-us/making-difference-health-africa/macron-chauluka-polio-vaccinator>



**Strategic Health Information,
Country Data Management and Analysis**



Capacity on Data Quality and Use Strengthened in Primary Health Care Facilities.

WCO supported data use capacity building initiatives started at district and health facility level in 14 districts in reference to the MNCH QOC indicators. Data visualisation charts were shared with over 100 health facilities and trends analysis on key indicators on provision and experience of care under maternal and newborn health were developed and displayed. Additionally, WCO provided Problem analysis and planning tools including journals, Quality Improvement (QI) projects documenting and assessing progress using the Plan Do Study Act (PDSA) cycle with a total of over 180 QI projects initiated using data. WCO further supported virtual capacity building workshops on data quality integrated desk DQA using the WHO DQA tool and the field-based data audits and data use were conducted for district HMIS officers and these trainings will be cascaded to other data officers at health facility, data for action sessions.

Health sector Strategic Plan II expired in 2022. A national roadmap on HMIS review was rolled out starting with a workshop to review the HSSP III M&E framework with inputs by MoH directorates with support from WHO. To further strengthen data collection, analysis, WCO facilitated a trainer of trainers' workshop on strengthening routine data collection, analysis and use of routine SRMNAH data to monitor progress towards SDGs in November 2022 in which countries developed roadmaps for strengthening their health information systems with focus on RMNCAH.

Aligned HSSP III M&E Framework to the country needs with inputs by MOH Directorates and Partners.

In June 2021, Malawi Ministry of Health launched its eighth-year Health Sector Strategic Plan (HSSP III) development, whose implementation period is aligned to the Universal Health Coverage roadmap and Sustainable Development Goals (SDGs) from year 2022 to 2030. Among the HSSP III strategies is to strengthen health information systems across the various health service delivery platforms to align with the programme and overall health sector information needs. Data was not disaggregated at all levels under monthly, quarterly, and annual health sector reporting. To respond to this need, A total of 50 M&E officers reviewed the national HMIS indicators and data tools to address age, gender, geographical and disability disaggregated data. The focus on national HMIS review was timely and had inputs from the national HMIS review workshop that also aimed at reviewing and updating the HMIS reporting tools, aligning them to the needs of the HSSP III M&E Framework and

incorporation of agreed disaggregation of data elements for all programs. The next steps involve finalisation of review of HMIS tools by departments and sharing the same with the secretariat, agreeing on timelines for having a final consensus workshop to endorse the changes made, plans for harmonising HMIS revised tools with DHIS2 on indicator definitions and disaggregation of data elements, and moving the revised tools into digital platform (DHIS2) and ensuring linkages/interoperability with other platforms. The indicators would then be included and monitored jointly nationally and with partners in the Malawi health observatory platform.

Institutionalised annual zonal and national performance reviews to assess and document achievement of National Health Sector Outcomes.

For the past two years 2021 and 2022, annual zonal reviews and Joint annual health sector reviews have been conducted with support by WHO. Annual Zonal reviews give the districts an opportunity to monitor and review their own progress on delivery of the essential health services against the HSSP III indicators and targets towards SDG3 targets and UHC. In 2022, the MoH conducted five annual zonal data performance reviews meetings targeting all the 29 districts in Malawi. The District Health Management Team (DHMT) reviewed their district performance against the HSSP III indicators including trends in service uptake during the Covid-19 pandemic from March 2020 to June 2022. The DHMT shared experiences, challenges, good and detailed best practices to improve service delivery at district, health facility and community level. All districts documented increasing teenage pregnancy rate, nationally from 10.9% in 2017 to 25.6% in 2021. As part of Covid-19 recovery plan including building resilient health systems towards quality health services, WCO will continue to support the need for training health workers in integrated quality of health care and institutionalisation of QI initiatives and measurement in all services to include Covid-19 response plan on adolescent health services at district, health facility and at community level. Overall institutional maternal Mortality Ratio per 100,000 live births increased from 56% in 2019 and to 65% in 2021 and the current institutional neonatal mortality rate is higher than the national average of 27 neonatal deaths per 1000 live births.

The digital Health Policy 2022-2027 For Malawi was drafted with participation of MOH and implementing partners.

Health care delivery systems incorporate digital health as an integral component to aid health services delivery and strengthen the Health System for the attainment of universal health coverage (UHC). However, the lack of a national digital health policy has resulted in



several challenges in the implementation of the current digital health technologies. For this reason, the WCO participated during the first and third digital health policy formulation task force workshop with participation of MoH task force members and representation of the Office of the President and Cabinet (OPC). WHO shared the key global and regional policies and guidelines on digital health and key progress in supporting Malawi digital health strategy implementation. The policy is intended to improve the effectiveness, efficiency, monitoring and evaluation of the health services in the country through the use of digital health platforms, provide a comprehensive high-level framework and direction for addressing the challenges in the utilisation of digital health solutions in the delivery of health services and overall strengthening of the Malawi health system in addition to serving as the basis for development of relevant digital health laws and regulations and align the management of digital health in the country with international best practices.

Digital Adaptation Kit Concept Adapted by MOH Integral with Client Care systems under Maternal Health.

The DAK are software-neutral, operational, and structured documentation based on WHO clinical, health system and data use recommendations to inform the design of digital systems more systematically and transparently. Use of the DAK to improve efficiency of health delivery systems and processes and interoperability with the existing electronic medical systems (EMR) is a new concept that required orientation of the national Task Force to oversee the implementation of the roadmap developed. To respond to this need, a national task force was oriented in the Digital Adaptation Kit for maternal health for ANC and FP modules to be piloted in two health facilities as part of operationalizing the digital health policy and strategy on use of ICT at point of care at primary health care levels.

As a follow up on strengthening of health information and digital health systems in its member countries, WHO supported the Ministry of Health as well as other implementing partners such as HISP Malawi supported to orient the Reproductive and sexual health Directorate officers in developing a roadmap on DAK for operationalization at country level in addition to customising the country SRHD guidelines and protocols on integrated service delivery during the DAK adaptation process. The project is led by Reproductive health directorate who are also the process owners, and whose involvement has increased both visibility as well as ownership of DAK adaptation Kit adoption in Malawi.

Thus far, these steps propelled DAK adaptation to ANC process cleaning stage. WHO will continue to support the next steps towards realisation of full DAK adaptation in

the country including the processes of DAK Adaptation, Software Integration, and implementation in two pilot health facilities and to facilitate scale within one year of implementation.

Functionalised Monitoring and Evaluation System of National Polio Outbreak Response.

In February 2022, Malawi Health Authorities declared a wild polio type 1 (WPV1) outbreak following detection of the virus in a three-year-old child residing in the city of Lilongwe. Following the declaration of the outbreak several activities were conducted including a national-wide polio Supplementary Immunisation Activity (SIA) campaign. In response to this outbreak, The WHO supported the M&E pillar under the national polio outbreak response to include the development of the data collection tools such as tally sheets, summary sheets, ODK forms, google sheets for administrative and preparedness data, development of Power BI dashboard for data visualisation for pre-campaign, intra-campaign, and post-campaign. WHO supported the training of HMIS officers, data clerks, vaccinators, and supervisors in all 29 districts on the use of various data collection tools. IQVIA provided technical support through engagement of a data officer who joined the team in training of officers, data analysis and development of data collection tools. This intervention aimed to ensure quality data was collected, analysed and visualised for use at national and subnational levels and consequently, improve the quality of the polio SIA campaign. Additionally, 116 LQAS surveyors and 504 independent monitors in all 29 districts were also trained to conduct LOT Quality Assurance Sampling (LQAS) survey for LQAS surveys and in-process and end-process monitoring for independent monitors during all the 4 rounds of the polio supplementary activities. The data analysis training capacitated the officers on weekly data entry of AFP cases and weekly data analysis which resulted 40 Malawi polio weekly bulletins, preparation of data analysis presentations for seven country calls, annual zonal review meetings after every round of polio SIA and during the weekly polio SIA meetings with national and field based WHO officers and Ministry of Health staff.

Increased number of knowledge products for Polio Response.

WHO supported the Ministry of Health with production of health information products under polio such as Poliovirus outbreak response bulletins. 40 weekly bulletins were produced and circulated. The bulletins were covering the following areas: coordination, supplementary activities (SIA), communication and social mobilisation, vaccine management and logistics, monitoring and evaluation, detailed case investigation, and improvement plans/next steps.



Ensuring Healthier Population



School filming initiative-Healthier populations

Overview

Globally, an estimated 24% of the burden of disease and 23% of all deaths can be attributed to environmental factors. In Malawi the main environmental risks affecting the communities are water and sanitation. Effects of climate change is also increasing the deterioration of water and sanitation, food insecurity, and food safety standards in communities.

Road Traffic Injuries continue to contribute to injuries, disability, and fatality in Malawi. According to the Global Status Report 2018, 31 people per 100000 population die because of Road Traffic Injuries. In addition, government financial commitment to implement interventions to address the modifiable non-communicable disease risk factors (alcohol abuse, tobacco smoking and substance abuse, unhealth diets, physical inactivity) using the existing legislative legislations is lacking. Financial support from WHO has never been adequate apart small resources to support generation global status reports.

The number of suicide deaths continue to rise annually and are higher among youths compared to other age groups. This is against a background of limited access to mental health services with mental health services being provided mostly in private sector making it not affordable to many people. About 14% of pregnancies in Malawi occur among girls aged 15-19 years old. Babies of adolescent mothers face higher risks of low birth weight and preterm birth.

In 2022, with Malawi responding to multiple emergencies, the Ministry of Health had challenges in coordination of Risk Communication and Community

Engagement (RCCE) Activities. Another challenge was inadequate resources to implement interventions to address rumors and misconceptions about the COVID-19, Polio and Cholera outbreak and the moderate tropical storms.

2022 Achievements

Strengthened Nation Food Safety and Quality Control Systems

Malawi is implementing the CODEX Alimentarius Trust Fund Project and in 2022, in collaboration with the Food and Agriculture Organization, Ministry of Agriculture, the Ministry of Trade and the private sector finalized the National Food Safety Policy 2022. The policy is a milestone towards enhancement of food borne disease control and surveillance mechanism. In addition, the policy is a legislative guide to establishment of the national food safety and quality control systems in Malawi.

In 2022, the Ministry of Health validated the procedures to be used by the National CODEX Committee (NCC) and the CODEX Contact Point (CCP) to manage CODEX work in Malawi. The CODEX management procedures were disseminated to relevant government and private sectors.

Strengthened the school health setting

Since the COVID-19 was declared a pandemic of international concern in 2019, the Ministries of Education and Health did not conduct school health and nutrition technical working groups.

According to the national school health and nutrition



strategic plan for the year 2018-2022 plan, the school health technical working groups (TWG) should conduct the meetings on quarterly basis and the National SHN Technical Committee to meet biannually.

In December 2022, the WHO provided technical and financial support to conduct the first School Health technical working group meeting since 2019. The two sectors agreed on a general communication from the Ministry of Education permitting school health interventions such as immunization and mass drug administration interventions to take with the support of the school management and the community.

Health behaviors promoted for emergency preparedness and response

In response to the multiple emergencies, the WHO supported the review of communication strategies and messages for all the emergencies. In particular, the WHO supported the printing and distribution information, education, and communication materials to 27 districts that were affected by cholera outbreak. The print materials consisted of 100,000 water, sanitation, and hygiene promotion booklets and 91,000 leaflets for literate communities, 28,200 posters.

In addition, the WHO supported media engagement activities and provided regular message updates to MOH and partners and continued producing and distributing information education and communication materials. The presence of print materials, distributed by health workers in communities contributed to the reduction in spread of rumors and misconceptions. The media disseminated accurate messages which also addressed spread of rumors and misconception of the emergencies.

Strengthened and raised the national climate change and health profile at Conference of Parties 27

In the frames of the Conference of Parties 27 WHO AFRO supported participation of Ministry of Health Delegates, aiming to raise the national health profile and co-organized a series of side events at the WHO's Health Pavilion as well as other Pavilions.

The main outcome of the conference was that strategic multilateral meetings and contacts were conducted and established between WHO AFRO/HQ and Malawi. Health conversation in the context of mitigation, adaptation and climate financing was explored and elevated, supporting the COP 26 Health commitments that Malawi government signed. An

opportunity to come together and demonstrate the political will to take on the climate challenge through concerted, collaborative and impractical action. WHO and MoH specifically provided support in a series of side events and round table discussions.

National Health and Climate Change Core Team (HCCT) meeting

Health and Climate Change Core Team (HCCT) convened meeting with support from WCO. A team of 30 members from different government, academia, and media sectors. In the frame of raising momentum to achieve COP 26 health initiative commitment, the core team held quarterly meetings to align health and climate interventions through application of funds from Green Climate Funds (GCF) as well as strengthen collaboration among the stake holders implementing climate change thereby improving climate resilient and sustainable low carbon emission health system.

UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water Survey

WCO through WHO/HQ supported Ministry of Water and Sanitation conducting UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) survey. The purpose of the survey was to update the WASH systems, including policy frameworks, institutional arrangements, monitoring systems, regulation, human resources, and finance. The key findings identified several gaps linked to availability of human and financial resources, as these have been identified as common barriers to progress in the WASH sector. These are likely to reflect broader gaps in WASH institutional mandates, capacity, planning and resources in "acceleration needed" countries. Therefore, to bridge these gaps would need to address strengthening the broader WASH system if Malawi are to be able to accelerate progress towards their national targets.

Maintained focus of health issues on national health agenda through commemoration days

In 2022 the WHO continued to support the Ministry of Health on bringing pertinent global health issues on the national agenda. In the year, the WHO support technically and financially to commemorate World Health Day through panel discussion on the theme our planet our health, World TB Day, World AIDS Day, World Breastfeeding Week and the first Community Health Day commemoration in Mangochi. The key messages for the commemoration days were disseminated through national newspapers, radio and TV, Facebook, Twitter and WhatsApp channels.



Key Results

- ❖ Strengthened Nation Food Safety and Quality Control Systems
- ❖ Strengthened the school health setting.
- ❖ Health behaviours promoted for emergency preparedness and response
- ❖ Strengthened and raised the national climate change and health profile at Conference of Parties 27
- ❖ National Health and Climate Change Core Team (HCCT) meeting.
- ❖ UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water Survey
- ❖ Maintained focus of health issues on national health agenda through commemoration days

Enhanced local health services saving lives in Malawi

PEN-Plus Scale-up - The Case of Malawi

According to the World Health Organization (WHO) Noncommunicable Disease Progress Monitor 2022, NCDs are responsible for almost 40% of deaths in Malawi.

In Malawi, chronic care services for severe and complex NCD conditions are often only available at referral hospitals in urban areas. To address this care delivery gap for severe and complex chronic conditions, WHO recommends an expanded integrated care delivery strategy at first-level hospitals called PEN-Plus. which has been successfully piloted in Neno district.

WHO's Package of Essential Noncommunicable Disease Interventions, commonly called WHO PEN, puts forward a primary care model for NCDs in low- and middle- income countries. PEN focuses mainly on chronic conditions that are part of the 4x4 model and can be managed well with basic interventions at the primary level for such conditions as type 2 diabetes, hypertension, and asthma. PEN-Plus builds on this model of care, putting forward the staffing, training, interventions, and commodities needed at first level (district) hospitals. Put simply, PEN-Plus is a model of decentralised care for first-level hospitals for severe chronic NCDs. It means an integrated and specialised team of mid-level providers; clinical officers and nurses working at every district and community hospital to care for patients



PEN-Plus services at a primary healthcare in Neno

with diseases such as type 1 diabetes and rheumatic heart disease

Introduction of PEN-Plus in Malawi was a result of a WHO regional consultation meeting convened in Kigali, Rwanda in 2019, where the gap in chronic care for more severe, complex NCDs, particularly in rural areas was flagged and a draft regional strategy was reviewed to address this gap through decentralised, integrated outpatient services at first-level hospitals (PEN-Plus).

Prior to this meeting, Malawi's MOH in collaboration



with the NGO, Partners In Health–Abwenzi Pa Za Umoyo (PIH – APZU) had successfully developed and implemented a Malawian model for a PEN-Plus Clinic in Neno District. Neno District has a population of about 140,000 people and is in the Southwest Health Zone and one of the poorest and most rural districts in Malawi. The first two outpatient clinics for integrated care of complex NCDs opened at Neno District Hospital and Lisungwi Community Hospital late in 2017. The two PEN-Plus clinics are staffed by an integrated care team consisting of clinical officers, nurses, and clerks, who are overseen by an internal medicine physician and a nurse mentor.

All staff received specialised training for complex NCDs prior to the launch of the clinic, with regular refresher training thereafter. The training was paired with onsite clinical mentorship. The clinics rapidly enrolled patients with complex NCDs, including type 1 diabetes and rheumatic heart disease, who had previously been seen in the district's outreach program that provided integrated HIV-NCD care at the two hospitals and 12 health centres in their catchment areas. Over the first year of operations, approximately 260 patients were enrolled into the two PEN-Plus clinics.

In 2019 the PEN-Plus staff launched a mentorship program for the primary care clinics to improve diagnosis, linkage to care, and retention in care for patients with severe NCDs. An expert Stakeholder Consultation Group was established by the Malawi Ministry of Health in 2019 to consider and plan for implementation of this PEN-Plus strategy. The Stakeholder Consultation Group comprises WHO and experts representing a broad range of clinical specialties and organisations, spanning government departments, academic institutions, implementing organisations, NGOs, and civil society.

In 2021, the Ministry of Health launched the PEN-Plus Operational Plan to guide scale-up and identify practical ways to implement PEN-Plus across the country. The plan draws from a large volume of stakeholder consultation across the Ministry, clinical management implementing partners, civil society, and other technical partners, building on the work of the NCDI Poverty Commission.

Mentorship and training of health workers have been key in the rollout and scaling up of PEN and PEN-Plus services across Malawi. Using adapted WHO curriculum on NCD care and management, the Ministry of Health with technical guidance from WHO trained and continues to train mid-level providers such as nurses and clinical officers in the skills needed to provide integrated chronic care services for

NCDs, including diagnosis, symptom management, psychosocial support, and palliative care. Since 2019, at least 444 clinicians and nurses have received this formal training in noncommunicable diseases to strengthen the implementation of PEN and PEN-Plus services in primary health care facilities.

WHO technical guidance has gone a long way in building requisite health worker capacities at the six secondary-level health facilities in the country, including two in Neno district, now providing PEN-Plus care. This has already spared more than 300 patients in Neno alone from having to travel to referral hospitals, like Kamuzu Central Hospital in the capital Lilongwe, which in turn also helps to decongest central facilities.

Implementing PEN-Plus locally has also helped to reduce catastrophic costs for Malawian families in the course of seeking care. In addition to reducing significant transport costs, the services provided through the PEN-Plus programme are free of charge. By contrast, a 2018 report by the Malawi National Noncommunicable Diseases and Injuries Poverty Commission showed that out-of-pocket spending on such services accounted for 14.7% of monthly per capita household expenditure in 2015.

To optimise efficiency, the Ministry of Health has endorsed Neno district hospital as a centre of excellence for complex chronic NCDs care. Using WHO curriculum, the district hospital has since developed health workers training manuals and NCD care guidelines which will be used as training tools for healthcare workers in other five soon to be established pilot districts.

In August 2022, Health Ministers at the 72nd WHO Regional Committee for Africa adopted a [regional PEN-Plus strategy to address severe NCDs at first-level referral health facilities in the region](#). Malawi has made a commitment to adopt and implement this regional strategy which aims to address the burden of severe NCDs among rural and unreached populations through decentralised, integrated outpatient services in first-level referral health facilities.

Over the next five years, the Ministry of Health in Malawi aims to scale up the PEN-Plus initiative to incorporate at least 26 district and community hospitals across three regions of the country, with support from World Diabetes Foundation (WDF), Partners in Health and the United Nations Children's Fund (UNICEF).

<https://www.afro.who.int/about-us/making-africa-healthier/enhanced-local-health-services-saving-lives>



Improving quality of health care services to advance maternal new-born and child health outcomes in Malawi



A nurse caring for preterm twins

Malawi is among the pathfinder countries under the World Health Organization (WHO) coordinated Maternal and New-born Quality of Care Network. The goal of the network is to halve maternal and new-born deaths and stillbirths and improve the experience of care in health facilities in participating countries by the year 2022. To realise the objectives of the network, the Malawi Ministry of Health integrated the nine maternal and new-born health quality of care standards in health facilities as provided for by the national quality of health care policy and strategy. Through its collaborative leadership, WHO has led efforts to better align maternal and new-born health quality of health care support under the United Nations Joint Programme (UNJP) Umoyo Wathu Health Systems Strengthening (UW-HSS). The UNJP Umoyo Wathu is a six-year programme (2019-2025) supported by the Foreign, Commonwealth and Development Office (FCDO) as part of the intergovernmental cooperation between the Government of Malawi (GoM) and the United Kingdom. WHO's focus under the UN Joint Project (Umoyo Wathu) is on Quality of Health Care and Resilience. WHO's focus under the UN Joint Project (Umoyo Wathu) is on Quality of Health Care and Resilience.

WHO has facilitated the formation of Quality Improvement structures in 280 health facilities across the country. These structures have been initiating quality improvement projects to improve quality of care and health outcomes. Over 300 MNCH QI projects under antenatal care, maternity/labour ward and post-natal care are underway in 280 health facilities. Additionally, WHO is strengthening the ability of Quality Improvement Support Teams

(QISTs)/Work Improvement Teams (WITs) at primary healthcare level to adhere to standards of Maternal, Neonatal, Child Health (MNCH) Quality of Care. These are done through quarterly district led mentorships, refresher training and online continuous professional development.

To improve efficiency, WHO has been supporting the building capacity of health workers to implement quality of care initiatives. WHO introduced an online continuous professional development (CPD) learning platform for MNCH Quality of care with video materials, recorded webinars, and case presentations. To date, a total of over 1034 healthcare providers have attended various modules through self-directed learning.

WHO supported over 60 targeted health facilities with data visualisation charts with the aim to promote use of data to inform evidence-based quality improvement initiatives. Healthcare providers are using the data charts to track performance of health outcomes and to identify areas for improvement.

In most targeted primary healthcare facilities, WHO and partners are promoting collaboration between communities and healthcare providers to carry out quality improvement projects. This strategy has helped hospitals to reorient care around the needs and preference of users and challenged the hospital to maintain good standards.

The overall impact of the project has been an increased provision and uptake of quality cost effective life-saving primary healthcare services. There is evidence of integration of quality improvement initiatives in various departments within health facilities which is strengthening the overall health system. Most of the health facilities are also institutionalising quality improvements in various departments and by designating focal points to be overseers of quality improvements projects and interventions.

During the Covid-19 pandemic in 2020 and 2021 the quality of the health services including uptake were disrupted leading the increased maternal and neonatal mortality, reduction in uptake of EPI under vaccine preventable diseases and increased teenage pregnancy rates. Overall institutional maternal Mortality Ratio per 100,000 live births increased from 56% in 2019 and to 65% in 2021 and the national average of 27 neonatal deaths per 1000 live births. All districts documented increasing teenage pregnancy



rate, nationally from 10.9% in 2017 to 25.6% in 2021. Malawi has one of the highest *maternal mortality* ratios globally, currently estimated at 439 *maternal deaths* per 100,000 live births (MDHS 2015-16). Major causes of maternal death are: severe bleeding, infections, unsafe abortions, eclampsia and obstructed labour. The MNCH QI projects implemented aim to address the major causes of maternal mortality and morbidity. Neonatal mortality, often caused by birth asphyxia, premature birth, and infection, is estimated at 29 per 1,000 live births.

Implementation of the programme has been highly affected by multiple emergencies that Malawi is facing including COVID-19, polio, and cholera outbreak, creating challenges in service continuity. Collaboration of the UN agencies UNICEF, UNFPA and WHO has brought multiple support systems towards quality health care includes integration on experience in working in humanitarian settings to address the multiple emergencies and to minimise disruptions in essential services delivery. There are major gaps in infrastructure and supplies in most health facilities, a

key factor weakening the health system.

WHO and partners have put up strategies to ensure period assessment of implementation of the project including quality improvement initiatives. Each individual district is being supported to make their own quarterly quality assessment to identify needs and areas that need support with focus on quality of healthcare integral in health systems building blocks. This approach will enable WHO and partners to align their support based on unique needs of the district and health facilities.

Tracking of key impact indicators is jointly conducted with the Ministry of Health with focus on institutional maternal and neonatal mortality and morbidity and teenage pregnancy rates with mixed picture on progress considering services destructions due to COVID-19 pandemic. The Malawi Demographic survey is anticipated in 2022 on the current trends in maternal and neonatal mortality and impact of various services.

Improving maternal and new-born care in Malawi

In 2020, Yewo Kamanga of Mzimba, a district in northern Malawi, had a high-risk pregnancy. At 20 weeks, she was diagnosed with pre-eclampsia. She was scared. "I knew that there is a high chance of undesirable outcomes for both me and my unborn child."

Maternal and neonatal rates in Malawi are high. Malawi Demographic Health Survey (DHS) estimates

maternal mortality ratio at 439/100,000 live births and neonatal mortality rate (NMR) at 22 deaths per 1,000 live births.

At 28 weeks, Yewo went into preterm labour and delivered a baby girl with a birth weight of 800 grams. "She was so little. I had no faith that she was going to survive," says Kamanga.



Preterm babies need special care

Loveness Banda, senior nurse at the nursery unit in Mzimba District Hospital says the birth of Yewo's baby was the litmus test of a quality improvement project launched in the nursery ward.

Kamanga's baby—one of the youngest the hospital had ever cared for— was fortunate. The nursery had already adopted quality improvement strategies in managing premature neonates. After 55 days in hospital, she was discharged weighing 1500 grams.

When, Mzimba District Hospital recorded an increase in neonatal mortality rate in 2019, a neonatal death audit was conducted to analyse the leading cause and find lasting solutions for them.



“Our strategy was to ensure that our nursery unit is complying with Malawi Quality of Care framework and standards for improving quality of maternal and new-born care,” says Banda.

These initiatives improved staff performance, quality of health service delivery and overall health outcomes. Within six months of implementing the quality improvement project, neonatal deaths at the Mzimba district hospital were down by 40%.

Mzimba District Hospital is one of the 37 facilities in Malawi that are part of the Network for Improving Quality of Care for Maternal, New-born and Child Health (Quality of Care Network).

Quality of Care

In 2017, Malawi joined the Quality-of-Care Network (QoC), a broad-based partnership of committed governments led by the World Health Organization (WHO). The network aims at improving the quality of maternal and new-born health thereby reducing the institutional maternal and neonatal population by 50% by the year 2022. It provides a platform for countries to ensure that quality of care becomes an integral part of health care delivery. It also facilitates intercountry learning, knowledge sharing, and generation of local evidence and best practices.

WHO has been supporting the Ministry of Health in the implementation of national strategies for quality of care in the health sector using the Leadership, Action, Learning and Accountability strategies in

“One of the greatest lessons is that we can create continuous improvement within our health system by adopting facility-based approaches. The progress in the learning sites have proven that small ongoing positive changes in health facilities can reap significant improvements in the overall health system in Malawi.”

selected health facilities.

Malawi is using the Maternal Neonatal and Child Health (MNCH) programme as a learning platform by implementing WHO’s quality of care standards of care in six learning districts (Mzimba South, Kasungu, Lilongwe, Thyolo, Mangochi and Zomba).

Impact of Quality-of-Care Network

Malawi’s 37 learning health facilities have quality management structures that support rapid improvement of specific care processes and health outcomes. With support from WHO, all the learning sites use data to monitor implementation of their quality improvement initiatives. This has enabled the government to apply evidence-based decision making across all health programs.

According to the Ministry of Health’s Quality Improvement Officer, Alinafe Mangulenje, “Capacity building for health workers has shaped their competencies and performance, and ultimately the improved performance and motivation of human resources for health has resulted in effective, efficient and equitable health service delivery.”

The QoC initiative has further improved availability, quality and utilisation of medicines and medical supplies in the learning sites.

The improvements have also allowed more women to seek antenatal care, compared with previous years. Additionally, the number of births by skilled birth attendants has gone up in most of the learning districts by 60%.

Acting WHO Representative in Malawi Dr Janet Kayita is encouraged by the positive impact of the Quality-of-Care Network in Malawi. “One of the greatest lessons is that we can create continuous improvement within our health system by adopting facility-based approaches. The progress in the learning sites have proven that small ongoing positive changes in health facilities can reap significant improvements in the overall health system in Malawi.”

Quality of Care amid COVID 19

Amid the COVID 19 pandemic, health workers in the Quality-of-Care learning facilities have continued to provide quality of care improvements for mothers and new-borns. Dr Kayita points out that. “it is for this reason that WHO is calling on support and action to ensure that our health and care workforces are supported, protected, motivated and equipped to deliver safe health care at all times.”



**Corporate Services and
Who Country Office Enabling Functions**



Staff Retreat

The World Health Organization Country Office (WCO) in Malawi has over the years conducted staff retreats to review the WCO performance in the conduct of its mandate in- country and to re-strategize on the best approaches to effectively achieve its critical goal of promoting health, safety, and protection for the vulnerable.

Over the last five years, the WCO has however not been able to organise a Staff Retreat. The onset of the COVID-19 pandemic with the subsequent disruption of routine service delivery, repurposing of staff as well as ban on group gatherings led to a further postponement of the Staff retreat.

The 2022 WCO- Malawi Staff retreat was organised in the Lakeshore district of Mangochi from the 10th -15th September 2022. Sixty-five (65) staff members National and Sub- national levels participated in the four-and-a-half-day retreat.

The retreat was a success in boosting overall staff productivity through learning concepts such as their time management, setting priorities and gaining more focus on the key areas of their work. It also motivated change at collective and individual level to ensure that the Country Office is well positioned to deliver results through best utilisation and optimization of the country office resources including during periods of emergencies. The retreat was also a platform to enhance staff teamwork by providing an enhanced enabling environment and strengthening collaborations in all spheres of service delivery in support of the Member State.

MOH Priority Setting Workshop

On the 2nd of August 2022 WCO conducted a Priority Setting 2024-2025 consultation workshop with the Ministry of Health in Lilongwe. The main purpose of the review process was to revisit the priorities set at the beginning of the GPW13 considering the implications of the COVID19 pandemic, the analysis on the trajectory towards the achievement of targets and health outcomes, and other emerging priorities of the Organization. The consultative process represents a commitment of the three levels of the organisation in supporting Member States to achieve GPW 13 results through an evidence-driven approach.

The result of the review process is intended to be used for budget and financing decisions ensuring that the Organization is sharply focused on achieving the key areas of focus set together with Member States. The review process was an opportunity to realign

our priorities and leverage innovation whilst fulfilling Member States requirements for engagement in the planning and budgeting process.



The desired outcomes of the workshop included the following.

- (1) Analysis of output achievement and country priorities
- (2) Gaps Analysis in outcome and SDG achievement
- (3) Review of the alignment with national priorities
- (4) Overall recommendations on way forward selecting the outputs and outcomes for PB24-25

Human Resources

The Malawi WCO had 39 staff positions in their HR work plan for the 2022-23 biennium, 11 being vacant posts and 28 occupied positions. Of the 39 existent positions, 19 are General Service Positions, 16 are National Professional Officer (NPO) posts, and the other 4 are IPO posts. Constituting the 28 occupied positions are 13 General Service Posts, and 11 National Professional Officer (NPO), and 4 IPO posts.

There is an equal distribution of the GS staff to technical staff amongst male staff and likewise an almost equal distribution of the GS to Technical staff amongst female staff as well.

Due to multiple emergencies, the WCO had a significant hidden workforce in the form of SSAs and consultants in 2022. The WCO only has several consultants who are engaged in surveillance activities under the Polio and EPR teams. The WCO conducted a Functional Review in 2019 and by the end of 2022 the number of positions that were filled include the following EPI (Surveillance), IDSR (Surveillance), District Health Systems, Human Resources Assistant, RMNCAN officer.

Strategic Communication

Effective, integrated and coordinated communication is critical to ensuring that the World Health Organization's (WHO) achieves its Transformation Agenda's GPW13 Targets. As a fundamental component of this reform programme, consistent



and clear communication helps to inform WHO's stakeholders about public health and plays a crucial role in WHO's work in Malawi.

The overall desired impact is the achievement of GPW13 triple billion targets including the outcomes and outputs as measured by indicators. With the WHO Representative's leadership, everyone in the country office as a team contributes to support Member States in meeting their commitments to the Triple Billion targets and Sustainable Development Goals.

During the year under review, produced 60 stories for the country office website on human interest stories, including highlighting donor funding impact on beneficiaries in 2022. The office collaborated with AFRO to produce 45 web stories and 3 videos to publish on regional platforms showcasing the work of WHO in the country and its impact (annual). The office published 25 press releases on key announcements, milestones in collaboration with AFRO.

The office posted 3 tweets and 2 Facebook posts on WCO accounts weekly. The Communications team organised 3 briefings on Polio, Covid 19 and Cholera with the media health association/ journalists in 2022. The Communication team organised 3 media interviews with the Head of Office and the Emergency Team lead on multiple emergencies in Malawi.

The communication team continued to build a social media community to amplify WHO messages and visibility of its work. In the reporting year, the communication team used social media to show first-hand experience of WHO work in the field. The two WCO social media platforms gained 3000 followers and engagements as per the twitter analytics. This is attributed to the team's effort in creating content that is timely and relevant to the public. Cholera and Polio updates were the most popular and most engaged posts in both of our platforms.

Human Program Budget and Financial Management

The year 2022 was the beginning year of the 2022/2023 biennium and the initial allocated budget was US\$ 19 263 286 with a planned cost of US\$ 14 997 002 and the year ended with a financing rate at 95% for all programmes, 47% of the allocated budget of US\$ 9 061 251 was made available and the total utilisation of US\$ 4 158 640 was achieved at the rate of 46 % utilisation of the available funds for all work plans by the close of the year 2022. The proportion of total funds utilisation for all activities was US\$ 3 618

016 constituting 87% of all expenditures and staff costs were US\$ 540 623 constituting 13% of the total funds available.

Transparency, Accountability and Risk Management

The local compliance and risk management committee [LCRMC] was appointed by the WR and the committee met every three months to review the internal controls and risk register to ensure the country office operations are not at risk. Besides the LCRMC kept working at improving on the key recommendation emanating from the AFRO Administrative compliance review conducted in November of 2021. This has further created staff awareness on issues of transparency, internal controls, and accountabilities at all levels of responsibilities and routine tasks. So much information is available, all staff members completed the mandatory ilearn course on risk management

Procurement and Fleet Management

During the year 2022, Malawi was faced with multiple emergencies - Post Flood Recovery, COVID-19, Polio and Cholera outbreaks. This necessitated an increase in WCO operations especially in the areas of procurement and fleet management. The country office had to support the Government through the Ministry of Health with the response and in so doing the number of human resources increased which demanded an increase in fleet. As such, a number of procurements were done by the country office in support of the emergencies.

Introduction Direct Electronic Payments

On 16 February 2022, Malawi received confirmation of Wild Poliovirus Type 1 (WPV1) from an acute flaccid paralysis (AFP) case in Lilongwe. The response plan included at least 4 rounds of nationwide supplementary immunisation campaigns (SIA) using bivalent oral poliovirus vaccine (bOPV) in Malawi. The first response round was conducted from 21 to 26 March 2022 and second response round from 25 to 28 April 2022. Synchronised R3 campaign dates were conducted on 11th - 14th August 2022.

With the increase in campaigns, a decision was made to change from cash payments to digital payments. The implementation and use of digital payments for health workers payments facilitated efficiency and accountability in payments and provided the opportunity to increase scope for other payments.



Compliance and Control Framework

The Compliance Review Mission was undertaken by the AFRO Compliance Team with a field visit between 01st to 10th August 2022. The compliance review covered the transactions and operations of WHO Country Office in Malawi for the period 01 January 2021 to 30 June 2022 which include review on key management controls and risk management on selected areas. The general review processes evaluated the process and procedure through the following.

1. Updated understanding of WHO CO Malawi operations, its critical processes and information flow.
2. Evaluated the adequacy and effectiveness of financial and management controls, including compliance with WHO prescribed policies and procedures.
3. Evaluated operating effectiveness of existing controls by performing tests of controls using selected samples.
4. Performed test of transactions.

Key Challenges

During 2022, greater achievement was hindered by several impediments. The main challenges identified were:

1. Multiple emergencies negatively impacted work plans with many programmatic activities suspended, postponed, or repurposing of resources. The emergencies caused significant disruption in the country's health systems, affecting the provision of essential health services, and causing global shortage in some essential medicines and supplies.
2. Limited capacities to address increasing demand for support in areas such as: Health financing, Environmental Health, Infection Prevention and Control (IPC), epidemiology, surveillance, microbiology, nutrition, data management, NCD and communication.
3. High turnover and limited capacities at especially at subnational level, creating difficulties in the implementation of work plans mainly in the area surveillance, epidemiology, data analysis, preparedness, risk assessment and laboratory.

DFT set out to achieve three main objectives in implementing mobile money in Malawi

Objective

Sub-objectives

1

Advocacy and scoping

- Obtain buy-in of stakeholders (WHO country office, MoH and MNOs)
- Align on scope of implementation with WCO and MOH
- Sign contracts with local mobile money providers i.e. Airtel Money and TNM Mpamba to offer a bulk payments solution

2

Payment of campaign workers

- Engage a CIT/CBI company to complement
- Support WCO with the development of a hybrid strategy to support payments nationwide during the emergency outbreak.
- Work with MOH to obtain a list of all campaign workers both at National and District Level
- Work with the MNOs to conduct KYC validation on files of campaign workers submitted by the MOH
- Work with the CIT company on a distribution plan
- Make payment of campaign workers using a hybrid approach of mobile money and cash transfers

3

Conduct post-campaign research

- Provide list of paid beneficiaries in pilot districts to the digital research facility for research
- Support the digital research facility to conduct post campaign survey and research



4. Insufficient and unpredictable programmatic funding to fill vacant positions and implement key government priorities.

Key Lessons Learned

1. Enhancing real-time data collection, analysis and sharing through early warning disease surveillance systems in countries contributes to timely prevention and containment of public health threats.
2. Rapid risk assessment of acute public health events facilitates immediate grading of the event, creation of an incident management structure, resource mobilisation and follow-through of events.
3. Multi-sectoral actions and interagency collaboration and coordination is powerful to better coordinate supports, improve effectiveness and sustainability of the interventions, properly manage pandemic crises and achieve good results in the health sector.
4. Building capacities of WHO staff and national health personnel ensures optimal support for work plan implementation and the achievement of good results at country level. Specific learning needs were identified in the areas of preparedness, surveillance, response, prevention, quality essential health services and data management.
5. Strengthening resource mobilisation is essential to effectively address the major health system challenges in countries through ensuring availability of adequate human resources and sufficient equipment.
6. Regular monitoring and evaluation of the implementation of activities and FAT (Full, appropriate, and timely utilisation of funds) is crucial to improve achievement of good results.
7. Reprogramming is essential to address emerging needs, reallocate funds, improve the implementation of work plans and achieve planned results.
8. Advocacy for High level political commitment is critical in solving major public health issues.

Summary of key recommendations for better implementation and achievements of results in future

The main recommendations are as follows:

1. Ensure mobilisation of sufficient predictable and sustainable financing to fill vacant positions and better support activities to achieve targeted results.
2. Identify appropriate, efficient, and innovative approaches to ensure continuity in work plan implementation during health crisis particularly multiple emergencies
3. Ensure full implementation of Functional Review recommendations to ensure achievement of GPW13 and SDG targets.
4. Conduct regular capacity building to ensure availability of adequate capacities to address increasing demand for support from government mainly in the areas of: Health financing, Environmental Health, Infection Prevention and Control (IPC), Epidemiology, Surveillance, Emergency preparedness and responses, Data management and analysis and Management of NCDs.
6. Conduct advocacy with national authorities to share routine and survey data to better assess national health situation for appropriate responses and monitor the achievement of targets.
7. Conduct high-level advocacy with national authorities to increase investment in the health sector, which will ensure adequate human resources, medical products, equipment, infrastructures, and good level for IHR core capacities for more efficient and resilient health systems.

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- European Union
- France
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- Government of Canada
- Government of Germany
- Government of Norway
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- Norwegian Agency for Development Cooperation (Norad)
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- Rotary International
- Sanofi-Aventis
- Sasakawa Health Foundation
- Southern African Development Community Secretariat (SADC)
- Spain
- Susan Thompson Buffett Foundation
- Sweden
- Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
- UN Multi-Partner Trust Fund (MPTF)
- United Kingdom of Great Britain and Northern Ireland
- World Bank



