Government of the Republic of Malawi

Ministry of Health

NATIONAL COMMUNITY HEALTH STRATEGY 2017 - 2022

Integrating health services and engaging communities for the next generation

July 2017

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Printed by Design Printers Ltd

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Foreword

The Government of Malawi is committed to improving health and livelihoods in Malawi through community health – the provision of basic health services in rural and urban communities with the participation of people who live there. Historically, Community Health has significantly contributed to improvements in Malawi's health outcomes in particular attainment of MDG4. However, the community health system faces resource constraints and inconsistencies around quality of service – which negatively affect health outcomes.

Recognising the importance of community health and the opportunity to address these challenges, the Ministry of Health (MoH) has developed the country's first National Community Health Strategy (NCHS) for the period of 2017-2022. This strategy has been developed in collaboration of all partners and stakeholders in line with existing policies and the Health Sector Strategic Plan (HSSP II).

This NCHS is intended to play an expansive role in ensuring that health services are accessible and patient-centred to achieve significant impact not just over the course of the next five years, but for a generation. Several consultations with various stakeholders, partners, civil society, and organizations across the health system, local government, other government departments, and communities highlighted community health's issues, priorities and interventions.

The core business of the NCHS is to ensure quality, integrated community health services which are affordable, culturally acceptable, scientifically appropriate, and accessible to every household through community participation. This strategy focuses on multiple areas such as integration of health services; community engagement; sufficient and equitable distribution of well-trained community health workforce; sufficient supplies, transport, and infrastructure, and more. This will contribute effectively to the attainment of national and international goals in particular Sustainable Development Goals (SDGs) 3 of Universal health coverage.

The NCHS is more than a strategy. With a stronger community health system, we can all contribute to improved livelihoods for all people in Malawi. I, therefore, call upon all programme managers, donors, development partners, and implementing partners to take this strategy as the core document of reference for planning, implementing and evaluating community health services and for mobilizing resources and health financing, as it reflects the MoH's aspiration for attainment of national and international health goals by improving the lives for all the people of Malawi.

Honourable Dr. Peter Kumpalume, MP
Minister for Health
July 2017

Acknowledgement

Developing Malawi's first ever National Community Health Strategy has been a monumental undertaking with the vision of improving the livelihoods of the more than 17 million people living in our country. This task has required the input, collaboration, and support from an array of stakeholders brought together by the Ministry of Health's objective to ensure vital health services are within reach for all Malawians.

The National Community Health Strategy has been developed by the Ministry of Health jointly with development partners, non-governmental organizations (NGOs), civil society organizations (CSOs), district councils, other government departments, local leaders and communities.

The Ministry is thankful for and recognizes the contributions of all National Programme Managers and Department heads for providing valuable inputs to the development of the strategy. In addition, the Ministry is thankful to senior ministry officials including Dr. Charles Mwansambo, Chief of Health Services; Dr. Storn Kabuluzi, Director of Preventive Health Services; Ms. Rose Phiri, Director of Administration; Ms. Tulipoka Soko, Director of Nursing and Midwifery Service; Mr. Hilary Chimota, Director of Human Resource and Development; Ms. Emma Mabvumbe, Director of Planning and Policy Development; Dr. Chithope Mwale, Director of Clinical Services and others for continuous support towards development of this strategy.

Furthermore, the Ministry is grateful to the Community Health Services Section team including Doreen Namagetsi Ali, Deputy Director Preventive Health Services responsible for Community Health Service; Mr. Precious Phiri, National PHC Coordinator; Ms. Elizabeth Chingayipe, Supply Chain and Infrastructure Officer; Mr. Samuel Gamah, ICT and M&E Officer, and Mr. Matthew Ramirez, AMP Health Management Partner for providing vision, leadership, and unwavering commitment into the creation of this strategy.

In addition, the Ministry is very grateful to council authorities such as DHMTs, DCs, DPDs; legislators (MPs, and councillors); Health Surveillance Assistants, local Leaders (TAs) and village health committee members; and other ministries such as Ministry of Agriculture, Local Government, Education and others for providing their valuable inputs throughout the development of this strategy.

The Ministry wishes to convey special thanks and appreciation to the following partners: USAID Center for Accelerating Impact and Innovation in USA, UNICEF, Save the children-Malawi, ONSE (MSH), USAID Malawi, National AIDS Commission (NAC), World Bank, WHO, GIZ, all NGOs and Aspen Management Partnership for Health for their financial and technical support to the development of this strategy.

The Ministry is also greatly indebted to the Dalberg Consulting Team for providing strategic guidance and high-level facilitation throughout all stages of the strategy's development.

We would also like to thank all members of the core writing team and reviewers for spearheading the process. This team included MoH colleagues Ms. Catherine Chiwaula (Community Nursing), Mr. Allone Ganizani (Environmental Health), Mr. Humphreys Nsona (IMCI), Mr. Newton Temani (IMCI), Mr. Kondwani Mamba (Mangochi DEHO), Ms. Lonie Mkwepere (Mangochi DNO); as well as partners Mr. Reuben Ligowe (USAID Malawi), Ms. Nikki Tyler (USAID CII DC), Mr. Gomezgani Jenda (Save the Children), Ms. Anna Chinombo (Save the Children), Ms. Hellen Mwale (ONSE), Mr. Texas Zamasiya (UNICEF), Ms. Corey Farrell (UNICEF), Ms. Wina Sangala (MHSP), Ms. Anokhi Parikh (Dalberg), Ms. Sylvia Warren (Dalberg), Mr. Manpreet Singh (Dalberg), and Ms. Erin Barringer (Dalberg).

Finally, the National Community Health Strategy is the product of a remarkable process which involved consultations with various stakeholders and represents the understanding of our citizens, what they need, and what our health system must become to support them. It is now the responsibility of all of us to own, support, and implement for the benefit of us all.

Dr. Dan Namarika
Secretary for Health
July 2017

Acronyms

ADC	Area Development Committee
AEHO	Assistant Environmental Health Officer
AIDS	Acquired Immune Deficiency Syndrome
CAC	Community Action Cycle
CAG	Community Action Group
CBD	Community-based Distributors
CBDA	Community-based Distribution Agent
CBO	Community-based Organisation
CCM	Community Case Management
CH	Community Health
CHAG	Community Health Action Group
CHN	Community Health Nurse
CHO	Community Health Officer
CHS	Community Health Services
CHT	Community Health Team
CHV	Community Health Volunteer
CHW	Community Health Worker
CMA	Community Midwife Assistant
CMED	Central Monitoring & Evaluation Division
cPHC	Community-based Primary Health Care
CRVS	Civil Registration and Vital Statistics
DC	District Council
DEC	District Executive Committee
DEHO	District Environmental Health Officer
DFI	Development Finance Institution
DHA	District Health Administrator
DHIS	District Health Information System
DHMT	District Health Management Team
DHO	District Health Office
DHPO	District Health Promotion Officer
DIP	District Implementation Plan
DMO	District Medical Officer
DNO	District Nursing Officer
DPPD	Department of Planning and Policy Development
EHO	Environmental Health Officer
EHP	Essential Health Package
EPI	Expanded Programme on Immunisation
GDP	Gross Domestic Product
GMVs	Growth Monitoring Visitors
GVH	Group Village Headman
HAC	Hospital Advisory Committee
HCAC	Health Centre Advisory Committee
HCMC	Health Centre Management Committee
HEC	Health and Environmental Committee

HEU	Health Education Unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Post
HRH	Human Resources for Health
HSA	Health Surveillance Assistant
HSSP	Health Sector Strategic Plan
HTSS	Health Technical Support Services
iCCM	Integrated Community Case Management
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MGDSIII	Malawi Growth and Development Strategy III
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MoLGRD	Ministry of Local Government and Rural Development
MOU	Memorandum of Understanding
MP	Members of Parliament
NCD	Non-communicable Diseases
NCHS	National Community Health Strategy
NGO	Non-Governmental Organisation
NMR	Neonatal Mortality Rate
NMT	Nurse Midwife Technician
NTD	Neglected Tropical Disease
PE	Peer educators
PHC	Primary Health Care
RHU	Reproductive Health Unit
SDG	Sustainable Development Goal
SHSA	Senior Health Surveillance Assistant
SOP	Standard Operating Procedure
TA	Traditional Authority
TB	Tuberculosis
TBA	Traditional Birth Attendants
TOR	Terms of Reference
TWG	Technical Working Group
U5MR	Under-Five Mortality Rate
VC	Village Clinic
VDC	Village Development Committee
VHC	Village Health Committee
WHO	World Health Organisation
ZHSO	Zonal Health Support Offices

Executive summary

Community health –the provision of basic health services in rural and urban communities with the participation of people who live there – is essential to improving health and livelihoods in Malawi. Community health activities have contributed to historical improvements in Malawi's health outcomes, especially for women and children, such as the decline in child mortality and malaria fatality rates. Going forward, community health will help Malawi to achieve its commitment to the Sustainable Development Goals (SDG); in particular, SDG 3 on universal health coverage. Therefore, building a strong community health system is core to Malawi's development agenda.

Malawi's community health system faces resource constraints and inconsistencies around quality of service – which negatively affect health outcomes. Malawi has a shortage of at least 7,000 community health workers (CHWs), and existing CHWs are unevenly distributed across the country. Community health workers also face challenges related to lack of clarity on their roles and tasks, inadequate training and supervision, and limited access to transport. Communities experience frequent stock-outs of medicines and lack sufficient infrastructure (e.g., health delivery structures). Moreover, planning and implementation gaps are common due to ongoing challenges with decentralisation; inadequate institutional coordination, especially between government and partners; fragmented data collection; and lack of sustained community engagement. These challenges contribute to adverse health outcomes across the country; for example, life expectancy remains low at 61 years and the maternal mortality rate is high at 439 per 100,000 live births.

Recognising the importance of community health and the opportunity to address these challenges, the Ministry of Health (MoH) has developed the country's first National Community Health Strategy (NCHS) for the period of 2017-2022. The Community Health Services (CHS) Section has led this work in coordination with the Department for Planning and Policy Development (DPPD). The NCHS ties into the Health Sector Strategic Plan (HSSP II), which underscores primary health care and community participation as core principles. Extensive consultation guided the development of the NCHS: over 500 stakeholders across the health system, local government, and communities helped to highlight strengths and challenges, identify and prioritise key issues and activities, and develop the implementation plan.

The vision of the NCHS is to improve the livelihoods of <u>all people</u> in Malawi. The mission is to ensure quality, integrated community health services are affordable, culturally acceptable, scientifically appropriate, and accessible to <u>every household</u> through community participation – in order to promote health and contribute to the socio-economic status of all people in Malawi. By 2022, the NCHS aims to contribute to achievement of two health outcome targets aligned with the HSSP II: a 25% decrease in the under-five mortality rate (U5MR)from 64 to 48 per 1,000live births and a 20% reduction in the maternal mortality ratio (MMR) from 439 to 350 per 100,000live births.

To achieve these goals, the NCHS defines a new community health system for Malawi. Within this system, community health refers to a package of basic preventive, promotive, curative, rehabilitative, and surveillance health services delivered at the community level with the participation and ownership of rural and urban communities. This package consists of the community components of the Essential Health Package (EHP), as defined by HSSP II, and CHWs will deliver these services through an integrated approach. For the NCHS, integration is defined as the coordinated delivery of multiple health interventions as well as interventions from other sectors that improve health outcomes. Integration will take place at the point of care, which helps to improve health system efficiencies, reduce fragmentation, and increase access to care. Other key features within the community health system include a team-based structure for CHWs, strengthened supervision, reinforced community structures (e.g., Village Health Committee, Community Health Action Group), and enhanced coordination led by the CHS Section and district-level Community Health Officers. Overall, the NCHS outlines the aspirations for how the community health system should function and puts in place processes and activities to achieve these goals.

The NCHS also sets six strategic objectives for the community health system – each with an ambitious target and interventions to implement by 2022:

1. Health services delivery: ***Deliver the Essential Health Package at community level through integrated services provided by CHWs in Community Health Teams****(CHTs)*. Key interventions to achieve this goal include scaling up integrated delivery of the EHP at community level and rolling out CHTs with clear job descriptions for all CHW cadres. The target for 2022 is that 75% of HSAs deliver the majority of the community components of the EHP.
2. Human resources: ***Build a sufficient, equitably distributed, well-trained community health workforce***. Key interventions to achieve this goal include recruiting additional CHWs; promoting equitable geographical distribution of CHWs; and providing high-quality, integrated pre-service and in-service training to all CHWs. The target for 2022 is that Malawi reaches 74% of its policy recommendation for the ratio of trained HSAs to members of the population(~15K HSAs and ~1.5K SHSAs) and that 75% of HSAs and SHSAs are residing in their catchment areas.
3. Information, communication, and technology: ***Promote a harmonised community health information system with a multi-directional flow of data and knowledge***. Key interventions to achieve this goal include harmonising data management practices; exploring integrated mHealth solutions for CHWs; training all CHWs in the CHT on ICT and data management; and launching two-way feedback and data review systems between communities and the health system. The target for 2022 is that 75% of HSAs are reporting using the standardized village health register and that 50% of CHTs are using mHealth for integrated service delivery, data collection, and supervision.
4. Supply chain and infrastructure: ***Provide sufficient supplies, transport, and infrastructure for CHWs in the CHT***. Key interventions to achieve this goal include construction of Health Posts (Integrated Community Health Service Delivery Structures) and CHW housing units in hard-to-reach areas; procurement and distribution of durable, high-quality bicycles and motorcycles to CHWs; and scale-up of electronic supply and drug management to cover all

of community health. The 2022 target is that 95% of HSAs have a high quality, durable bicycle and that 900 Health Posts are operational and supporting integrated community health service delivery in hard to reach areas.

5. Community engagement: ***Strengthen community engagement in and ownership of community health***. Key interventions to achieve this include generating support for community health (e.g., launching national community health day); building the capacity of prioritised community structures (e.g., VHCs, CHAGs, and HCACs), and rolling out enhanced social accountability mechanisms at community level (e.g., scorecards).The 2022 target is that 70% of Village Health Committees (VHCs) are meeting regularly on a monthly basis to support community health activities and that 70% of CHAGs and HCACs are active.
6. Leadership and coordination: ***Ensure sufficient policy support and funding for community health and that community health activities are implemented and coordinated at all levels.*** Key interventions to achieve this goal include scaling up the coordinating function of the CHS Section at the national level; recruiting a Community Health Officer for each district; strengthening community-level coordination through CHAGs and CHTs; and hosting regular coordination meetings between stakeholders at all levels. The target for 2022 is that community health actors will have completed 80% of all agreed-upon coordination activities and milestones.

The five-year implementation plan provides in-depth information on all recommended activities.

In addition, six cross-cutting guiding principles – integration, community leadership, equity, gender quality, learning, and transparency and accountability – will underpin the success of the NCHS. The first two principles help ensure that existing programmes and initiatives related to community health leverage partnerships and integrate seamlessly across sectors, and that community members have ownership and remain accountable for the health of their populations. The principles of equity and equality demand that *all* Malawians receive high-quality care from a community health system that promotes gender equality. The NCHS promotes continuous learning and course correction based on strengthened monitoring and evaluation efforts. While transparency and accountability are vital to maintaining the trust and commitment of all stakeholders. These principles are relevant across the full community health system and all NCHS strategic objectives.

Over the next five years, implementation of the NCHS will require coordinated efforts from all actors working in the community health system. Implementation will take place across two phases that recognise the necessity of strengthening the foundational elements of the community health system before launching and scaling activities. Phase 1 will focus on setting the community health system up for success by clarifying guidelines and reinforcing structures. In parallel, implementation of high-impact activities, including procuring transport for CHWs, rolling out CHTs, recruiting CHWs, and setting up coordination mechanisms at all levels, will commence. Phase 2 will focus on scaling activities from Phase 1 and implementing additional activities, including: training CHWs on integrated service delivery, ensuring full rollout of the EHP and access to supplies, and constructing CHW housing units, among others. M&E will take place at every stage of implementation.

The CHS Section of the MoH is responsible and accountable for the successful implementation of the NCHS – and must have sufficient resources to carry out this mandate. Specific roles of the CHS Section include coordination and planning across programmes; development of policies and guidelines; monitoring adherence to policies and guidelines; overarching management of CHTs, and support for community structures (VHCs, CHAGs, HCACs, etc.). To fulfil these roles, the CHS Section will require predictable financial resources and additional human capacity, with the goal of reaching nine full-time employees (FTE) by the end of the five-year strategy. Effective programme management also hinges on dedicated coordination efforts from *all* actors in order to ensure efficient use of resources and consistency across the community health system.

The total cost of providing high-quality community health services to all people in Malawi from 2017-2022 is estimated at $407 million, or about $3.9 in recurrent costs per Malawian each year by year 5. Annual costs will increase each year as Malawi scales up the number of CHWs and CHTs and associated supervision and training. CHW salaries, EHP commodities and supplies, and infrastructure account for the majority of costs – 30%, 20%, and 20%, respectively. Start-up costs (e.g., construction of Community Health Service Delivery Structures) total $117 million (29%), whereas year-by-year recurrent costs reach $79 million by year 5. Financing the NCHS will require support from government, donors, partners, and the private sector.

Overall, the NCHS will transform the community health system and create enormous returns for Malawi: the NCHS can save over 9,000 child lives each year, generate at least a 5:1 economic return on investment, empower communities and women, and prevent and mitigate global health security crises.

The NCHS document is structured as follows: Chapter 1 introduces community health in Malawi and Chapter 2 summarises the process to develop the NCHS. Chapter 3 presents the national community health strategy and includes the vision, mission, guiding principles, strategic objectives, and interventions by thematic area to reach these objectives. Chapter 4 provides a detailed overview of the structure of the new Malawi community health system which is essential to achieving the strategic objectives. Chapter 5 summarises the five-year implementation plan and resource requirements. Chapter 6 describes NCHS programme management – including how the CHS Section will collaborate with stakeholders. Lastly, Chapter 7 lays out a provisional M&E plan and targets. The annexes provide additional detail on the implementation plan, costing, and an overview of the findings from the NCHS Situation Assessment and stakeholder consultations.

The NCHS is more than a strategy: with a stronger community health system, we can all contribute to improved livelihoods for all people in Malawi.

Chapter 1: Introduction

1.1 Background

Malawi is a landlocked country with a population of nearly 17 million people – which is estimated to surpass 20 million in the next five years[1]. Malawi has 28 administrative districts, which are further divided into traditional authorities (TA) and villages, the smallest administrative unit**.** Malawi's economy has expanded over the past 30 years, with real GDP growth estimated at 2.9% in 2016. It remains predominantly an agricultural country, with agriculture, forestry, and fishing contributing 28% of GDP. Currently, GDP per capita is approximately $380, and given that inflation and population growth currently outpace economic growth, average living standards are falling. In 2010-11, 29% of households lived under the international poverty line of $2 per day. Poverty remains particularly prevalent in rural areas, where over 14 million people –more than 80% of the population – live.

Despite recent achievements, Malawi has not yet achieved optimal health outcomes. Life expectancy remains low at 61 years. Over half of the country's total disability-adjusted life years are a result of the top four leading causes– HIV/AIDS, lower respiratory infections, malaria, and diarrheal diseases. Malawi has reduced its child mortality rate, leading to achievement of Millennium Development Goal (MDG) 4. However, other indicators remain stagnant or even face declines. For example, the percentage of facilities able to deliver Malawi's essential health package (EHP) fell from 74% in 2011 to 52% in 2015. Therefore, fewer people are accessing critical health services.

The Malawi health sector operates under a decentralised system guided by the Local Government Act (1998). The Act delegates authority and funding from central government ministries to district assemblies, who guide health sector planning, budgeting, procurement, and service delivery at district and community levels. At central level, the Ministry of Health (MoH) sets strategic direction and formulates sector-wide governing policies. 29 district health offices oversee services provided in and outside of the district hospital. Five Zonal Health Support Offices (ZHSOs) provide technical support to districts in planning, delivery, supervision, and monitoring of health services. In total, the percent of government expenditure going toward public health averaged 10.4% from 2012-13 to 2014-15, well below the Abuja target of 15%. Therefore, donors have contributed the majority of resources for the health sector in recent years.

The decentralised system has four tiers of service delivery: community, primary, secondary, and tertiary. Community services include those delivered through community initiatives, village clinics/health posts, and community health workers. Primary includes dispensaries, maternity facilities, health centres, and community and rural hospitals. District hospitals deliver secondary-level inpatient and outpatient services and serve as referral facilities for the primary level of care. At tertiary level, central hospitals serve as referral facilities for the

[1]All information in this section comes from the HSSP II, the NCHS Situation Assessment, and the Malawi Demographic Health Survey; please refer to these documents for sources.

district hospitals and provide additional services in their regions. Central hospitals also have the mandate to offer professional training, conduct research, and provide support to the districts. While the Ministry of Local Government and Rural Development (MoLGRD) is responsible for health care service delivery at community, primary and secondary levels, the MoH remains responsible at tertiary level.

Community-based primary care is gaining prominence in Malawi and many other countries. Globally, community-based primary healthcare is critical to achieving the global health milestones put forward by the Sustainable Development Goals (SDGs). SDG 3 aims to ensure healthy lives and promote well-being for all ages by 2030, including the target to achieve universal health coverage by 2030. Other SDGs focused on poverty, hunger, education, gender equality, and water and sanitation also imply ambitious goals for the health sector[2]. Overall, the SDG targets related to health have a much broader scope than the health-related MDGs 4 and 5. Achievement of these goals therefore demands comprehensive approaches that focus on strengthening health delivery systems – including community health. CHWs help fight the top killers of mothers and children**;** build capacity to handle the growing burden of non-communicable diseases; and help prepare for and respond to health emergencies[3]. Many countries – including Ethiopia, Nepal, and Brazil – have seen transformative results from strengthening their community health systems. In Liberia, CHWs played a critical role in responding to the Ebola crisis. This success has resulted in an increase in number of funders of and organisations working in community health. Recognising this potential, many global efforts are underway to strengthen community health systems. These include the One Million Community Health Workers Campaign and the Financing Alliance for Health.

1.2 Community Health in Malawi

In Malawi, community health refers to the provision of basic health services in rural and urban communities with the participation of people who live there. Formal community health workers (CHWs) have existed in Malawi since the 1970s**,** when Malawi established Cholera Assistants following an outbreak of cholera**.** The MoH later changed the cadre of Cholera Assistants to Health Surveillance Assistants (HSAs), with their job description focusing more on prevention and promotion services than curative services. However, the MoH has relied heavily on task shifting to HSAs as one way of addressing human resource gaps and promoting equity in access to health services**.** Therefore, many HSAs have taken on more tasks and curative services without adequate supportive supervision**.** Today there are several cadres of CHWs employed by the government, including: HSAs, Senior HSAs (SHSAs), Community Health Nurses (CHNs), Community Midwife Assistants (CMA), and Assistant Environmental Health Officers (AEHOs). HSAs and SHSAs alone make up over half of the MoH's+17,000 health workers and continue to play a fundamental role in extending access to

[2]These include Goal 1 on poverty; Goal 2 on hunger, food security, nutrition, and sustainable agriculture; Goal 4 on quality education; Goal 5 on gender equality; and Goal 6 on water and sanitation

[3] Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing Recommendations, 2016

healthcare to all people in Malawi. Malawi also has an active network of Community Health Volunteers (CHVs) [4].

Community health is essential in improving health and livelihoods. 84% of the population lives in rural areas, 24% do not live within five kilometres of a health facility, and only 4% of rural households have access to electricity. Fifty six percent (56%) of Malawian adult women cite distance to health facility as a key barrier to health access when they are sick[5]. Community health therefore connects millions of people to the health system. Moreover, community-level interventions are critical in fighting the top four leading causes of illness – HIV/AIDS, lower respiratory infections, malaria, and diarrheal diseases – which together account for over half of the country's disability-adjusted life years (DALYs) [6]. For example, integrated community case management (iCCM) programmes in Malawi rely exclusively on HSAs; HSAs often conduct immunisations; and HSAs can test for HIV. Going forward, CHNs will be able to distribute ARVs and actively monitor HIV patients. Community health also saves money: one study in Malawi found that community-based management of acute malnutrition is more cost-effective than facility care[7]. Overall, delivery of many life-saving health services would not be possible without Malawi's strong network of CHWs.

Although community health activities have underpinned many historical improvements in Malawi's health outcomes, further progress is needed. Despite recent improvements in infant and under five mortality, household sanitation practices, and malaria case fatality rates, many community health challenges remain. For example, the maternal mortality rate of 439 deaths per 100,000 live births[8] is significantly higher than the SDG goal of 70 per 100,000 live births; immunisation rates for children aged 12-23 declined from 81% to 76% between 2010 and 2015; and only 43% of children sleep under insecticide-treated mosquito nets[9]. Moreover, the community health system continues to face significant resource constraints and inconsistencies around quality of services. Notably, Malawi needs 7000+ more HSAs to meet the Malawi policy recommendation of 1 HSA per 1000 people, and only 51% of current HSAs reside in their catchment areas[10]. Improving health in Malawi hinges on addressing these challenges.

Looking forward, a strengthened community health system will advance the strategies of the Health Sector Strategic Plan (HSSP) II, decentralisation, and other national programmes. These efforts include health promotion, water and sanitation, nutrition, disease surveillance, community-based family planning, IMCI, childhood tuberculosis, HIV/AIDS, and EPI – all of

[4] Per the Guidelines for Management of Community Health Volunteers in the Health Sector in Malawi, CHVs are "individuals who willingly offer their time, skills and knowledge to work with the communities to improve the health status of the communities they reside in without expecting financial remuneration."
[5] National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.
[6] Institute for Health Metrics and Evaluation, Global Burden of Disease Study: GBD Results Tool, 2015
[7] Health Policy and Planning, "Cost-effectiveness of community-based management of acute malnutrition in Malawi," 2011
[8] Estimate is from the past seven years; Malawi Demographic and Demographic and Health Survey Health Survey, 2015-2016
[9] National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.
[10] National Integrated Community Case Management, Malawi Micro-planning report, 2015

which rely on the community health system and CHWs for delivery of life-saving interventions. The HSSP II underscores community-based primary health care and community participation as core principles across the eight HSSP II strategic objectives – and defines the package of services to be delivered at community level. Community health will in turn impact progress within the broader frameworks of the National Health Policy (2017-2030) and the Malawi Growth and Development Strategy III (MGDSIII).

1.3 Rationale for the NCHS

Against this backdrop, the National Community Health Strategy (NCHS) aims to achieve Malawi's health and development goals by setting a five-year agenda for community health. This includes laying out key actions necessary to create a more scientifically and culturally acceptable, sustainable, integrated, and efficient community health system. Specifically, the NCHS seeks to:

- **Build consensus** on integrated community health to unite stakeholders from multiple sectors around a unified plan. This consensus includes the vision and mission of community health, the priority issues, the solutions and activities, and its role as part of the HSSP II.
- **Identify gaps in support** for community health so that the MoH and partners can target where further resources and support are needed. This includes examining existing guidelines and policies, knowledge and skills in the community health system, and other resources (e.g., human, materials, and infrastructure).
- **Establish standards** to ensure consistency and quality of all aspects of community health – including processes and coordination, communication, and implementation.
- **Develop an integrated implementation plan** in order to translate consensus, resources, and ideas into action that will lead to improved community health outcomes. The integrated implementation plan, as detailed in Chapter 5, spans five years and aligns with the HSSP II. It maps key activities by responsible stakeholders and timeline to ensure ease of use for stakeholders at all levels of the health system.
- **Build partnerships for effective implementation** in order to foster high-quality services and performance improvements; continuous leveraging of resources; and minimal duplication.

Chapter 2: Consultation process and findings

2.1 Process to develop the NCHS

Extensive consultation guided the development of the NCHS. This included an in-depth Situation Assessment, five Zonal Workshops, two National Workshops, two writing retreats, and additional one-on-one interviews and consultations throughout the process. Over the course of this process, 500+ stakeholders were consulted. Participants included select national programme representatives, Zonal Managers, DHMTs, NGOs, civil society, other government departments (e.g., education, agriculture, irrigation, and water development, gender, and media), District Commissioners, councillors, Members of Parliament (MP), local leaders, community members, pharmacists, HMIS officers, and HSAs.

Collectively, consultations supported to:

- Develop an initial assessment of the Malawi community health system by identifying strengths and challenges (Situation Assessment)
- Identify and prioritise key issues related to community health (Zonal and National Workshops)
- Identify and prioritise activities to address key issues (Zonal Workshops)
- Make recommendations related to key issues emerging from workshops (National Workshops)
- Make decisions about core components of the NCHS (Writing retreats)
- Develop a five-year implementation plan (Writing retreats and National Workshop)

Figure 18in Annex C summarises the participants, objectives, and approach for each consultation activity, and the section below summarises the key findings.

2.2 Key findings from consultations

2.2.1 Situation Assessment

The Situation Assessment found that the community health system is functioning and playing an integral role across promotion, prevention, and curative services across the country. Key strengths include the existence of several policies and guidelines specific to community health – as well as the long-standing existence of the HSA cadre; the recent filling of the SHSA cadre; the licensed CHN and CMA cadres; and the AEHO cadre. Malawi also has an active Community Health Technical Working Group (CH TWG) to coordinate stakeholders, and long-term community health planning efforts are underway through the HSSP II and the NCHS. On the ground, several programmes (e.g., IMCI and EPI) are using community health data to review and improve performance, and partners contribute supplies and transport for CHWs. Most importantly, recognition of the value of community health is increasing across the MoH and partners.

Despite numerous strengths, many systemic challenges remain. Firstly, the community health system remains fragmented across different programmes and partners, creating problems with coordination and integration. Secondly, resources are insufficient to meet the existing health needs and disease burden, especially considering the extent of the population that is rural and/or hard-to-reach[11]. In total, the Situation Assessment identified +100 issues of varying importance that affect community health service delivery in Malawi. For additional detail, please see Annex C

2.2.2 Zonal and National Workshops

Building on the Situation Assessment, zonal and national workshops provided a forum where many important issues and proposed interventions related to community health were discussed and prioritised across six thematic areas. The six Thematic Areas of the Community Health Framework are based on the HSSP II Framework and the WHO Health Systems Framework. The six Thematic Areas are: (i) health services delivery; (ii) human resources; (iii) information, communication, and technology; (iv) supply chain and infrastructure; (v) community engagement; and (vi) leadership and coordination. The paragraphs below summarise key challenges under each Thematic Area.

FIGURE 1: COMMUNITY HEALTH FRAMEWORK THEMATIC AREAS

1. Health services delivery*:* High-quality service delivery is the cornerstone of a strong community health system. Two broad challenges with respect to health service delivery were prioritised: (i) limited integration of community health services at the point of care, and (ii) lack of clarity on roles and functions of different actors within the community health system[12].

There is inadequate clarity on which health services should be delivered at the community level and how they should be integrated. Vertically-based health programmes (e.g., iCCM, HIV/AIDs, nutrition, malaria, and immunisations); ineffective implementation of the health sector devolution plan; and the lack of an overarching policy at the national, district, and community levels to coordinate community health further exacerbate this challenge.

There is also lack of clarity on how CHW cadres and relevant supporting structures (e.g., AEHO, VHCs) currently work together as a system, how referral works, and who is responsible

[11] For iCCM, hard-to-reach is defined as further than 8km from a health facility. There is discussion about changing 8km to 5km to align with global standards.
[12] Workshop participants also prioritised lack of community engagement on matters affecting their health as a key issue, but this is considered in Section 4.7: Community engagement

for what tasks. In particular, HSAs are overburdened and have inconsistent and unclear responsibilities. While guidelines on the management of task shifting to HSAs exist, task shifting sometimes takes place with little oversight. For example, implementing partners sometimes add tasks to HSA workloads without coordinating with the district government. In addition, the linkages between HSAs and other cadres of CHWs – including community health nurses (CHNs) and volunteers – are weak.

2. Human resources*:* Four key human resources challenges were highlighted:(i) a shortage of CHWs, particularly HSAs; (ii) uneven distribution of CHWs across Malawi; (iii) sub-optimal performance of CHWs due to inadequate training; and (iv) lack of incentives and clear career paths for CHWs.

Malawi does not currently meet the recommended benchmark of 1 HSA per 1000 people. In addition to this shortage, HSAs are unevenly distributed across districts, and half of HSAs do not reside in their catchment area. While there are currently enough SHSAs to meet the recommended 1 SHSA to 10 HSAs ratio, they are unevenly distributed – resulting in a severe lack of supervision in certain districts. There are a number of underlying causes of this uneven distribution, including limited accommodations for HSAs in hard-to-reach areas, ease of transfer between districts, poor incentives to stay in hard-to-reach areas, and a lack of enforcement of guidelines on recruitment and deployment for HSAs.

Several underlying factors reduce the effectiveness of CHW performance, including insufficient training and poor incentives. Given the expanded scope of work for many HSAs, the initial 12-week pre-service HSA training does not adequately equip HSAs with the skills they need. SHSAs, on the other hand, have received no dedicated pre-service training. Further, training is not equally distributed across CHWs, and follow-up trainings for HSAs are inconsistent – many of these supplementary trainings come from partners and programmes, and there is limited national coordination of how non-state actors are building HSA capacity. Finally, the lack of significant non-salary incentives across multiple CHW cadres – such as housing, transport, performance-based incentives, and limited career paths – sometimes results in demotivation.

3. ICT*:* Communication and information management is critical in assessing health outcomes and health coverage, managing the workforce, tracking the quality of care delivered, and ensuring effective integration of service. NCHS consultation activities prioritised two overarching information and communication challenges: (i) a lack of integrated data collection tools and systems, and (ii) inaccessibility of data at the community level.

Lack of integrated data collection tools results in duplicated data collection efforts from HSAs and therefore creates substantial workload burden. At present, HSAs are assigned over 50 data collection forms and processes, 40 of which are expected to be completed at least monthly. While the Central Monitoring and Evaluation Division (CMED) has developed an essential indicators list, implementing partners – who have their own monitoring requirements – often extend this list. Poor partner coordination has resulted in duplication of

data systems and reporting. Therefore, many opportunities exist to reduce data collection time and improve integration. The MoH, through CMED, is revising the indicators and working to integrate information systems, including DHIS 2, iHRIS, and cStock. Further, many partners across Malawi are experimenting with mHealth solutions for data collection, stock management, and service delivery to address some of the data management challenges.

Related to data management, there is limited flow of information between actors in the community health system. During consultations, HSAs and VHCs noted they do not receive feedback or readouts about the data they collect and share. As a result, they do not feel ownership and/or see value in the elaborate data collection requirements placed on them. Further, given the absence of data, community stakeholders are unable to utilise data to plan, implement, or improve community health services.

4. Supply chain and infrastructure*:* Effective community health systems require basic infrastructure at the community level and well-functioning supply chains. Based on consultations, priority challenges include (i) insufficient infrastructure, particularly clinic shelters and HSA housing; (ii) inadequate and low-quality transport for CHWs, and (iii) supply shortages due to poor supply chain management. These challenges are particularly acute in hard-to-reach areas and have implications for the quality of care communities receive.

At present 41% of EPI outreaches are conducted under a tree, and the lack of housing contributes to SHSAs and HSAs residing outside of their catchment area. Similarly, limited transport options for CHWs impacts their ability to access communities. Some HSAs have bicycles, but these bicycles are not of high-enough quality and there are no clear plans for their maintenance and replacement.

Numerous challenges with supply chains at the community level lead to shortages of key supplies. Community health workers experience regular stock-outs of critical medicines due to poor stock management and insufficient funds at the national level. There is a lack of security and storage options for drugs at the community level, and drug mismanagement is a serious system-wide challenge. Finally, community supply chains are not well-integrated into national supply chains; for example, there is no standard supply list for HSAs – making supply management at the community level difficult.

5. Community engagement: Strong community structures and community-level engagement are critical in ensuring successful community health programmes. Many of the current externally-driven, top-down processes of health policy development do not promote community participation in and ownership of community health. Key issues prioritised during consultations include: (i) insufficient community-level engagement, participation, and ownership of community health and (ii) lack of strong community-level structures and insufficient clarity on their roles and responsibilities.

The community health system, as it stands, is not sufficiently accountable to the community in terms of monitoring, prioritisation of key health issues, and deployment and performance

of CHWs. For example, the community is seldom actively involved in setting health priorities. Vertical health programming, ineffective devolution of health to the district and community level, and the lack of an overarching policy at the national, district, and community level to coordinate community health further exacerbates this challenge. Moreover, communities are also not aware of the benefits of community health programmes. The lack of awareness means that communities do not access community health as their first point of care, instead going straight to hospitals.

While numerous community structures exist to support community health – e.g., VHCs, HCACs, HACs, Health and Environment Committees (HECs) – there are considerable gaps and areas for improvement. Firstly, many of these structures are not functioning as they should. For example, many VHCs and HCACs are not operational. Secondly, some stakeholders noted there are no clear guidelines on the functions and reporting structures of different health committees (i.e., HAC, HEC, VHC) and capacity building is needed. In addition, their roles relative to each other; to the community health system; and to other non-health community organising structures remain unclear. Thirdly, many members of these structures are not sufficiently aware of and/or do not have sufficient training to implement their responsibilities, as per existing guidelines.

6. Leadership and coordination: Strong leadership, institutional support, and coordination underpin a well-functioning community health system – and will determine the success of the implementation of the NCHS. Through consultations, stakeholders noted two key challenges in this Thematic Area: (i) inadequate coordination of planning and implementation at the community, district, national level and (ii) insufficient linkages across national, district, and community level stakeholders.

Uncoordinated planning and implementation of activities is common across the MoH, DHOs, and partners. For instance, at the national level, donor funding does not always align with MoH priorities, and alignment with district and community priorities is even less common. At the district level, DHOs do not have sufficient oversight over the partners active in their jurisdiction, which results in poor coordination (and associated duplication and gaps) of programmes. Many implementing partners often bypass district governments and set up their programmes directly in communities, further exacerbating coordination problems. The absence of a CH-focused technical working group at district level and a weak capacity to coordinate further exacerbates coordination problems. Lastly, the lack of clear guidelines on devolution means that oversight roles of governance structures across the system remain weak.

Chapter 3: The national community health strategy

3.1 Community health in Malawi: Key definitions

In Malawi, **community health** refers to a basic package of preventive, promotive, curative, rehabilitative, and surveillance health services delivered in rural and urban communities with the participation of people who live there. This **package of services** consists of the community components of the Essential Health Package (EHP), as defined by HSSP II[13].

FIGURE 2: COMMUNITY HEALTH DEFINITION

> ***Community health*** *refers to basic preventive, promotive, curative, and rehabilitative health services delivered at the community level with participation and ownership of rural and urban communities. This package of services consists of the community components of Malawi's Essential Health Package.*

CHWs within the CHT will deliver the package of community health services through **integration at the point of care**. Integration is defined as the coordinated delivery of multiple health interventions as well as interventions from other sectors that improve health outcomes. This integrated approach helps to improve health system efficiencies, reduce health care fragmentation, and increase access to care. The level of integration will vary based on the point of care. Data management, supply chains, CHW supervision, and programme planning will also be integrated where possible.

3.2 NCHS vision and mission for a new community health system

The vision of the NCHS is to improve the livelihoods of all people in Malawi. The mission is to ensure quality, integrated community health services are affordable, culturally acceptable, scientifically appropriate, and accessible to every household through community participation – in order to promote health and contribute to the socio-economic status of all people in Malawi.

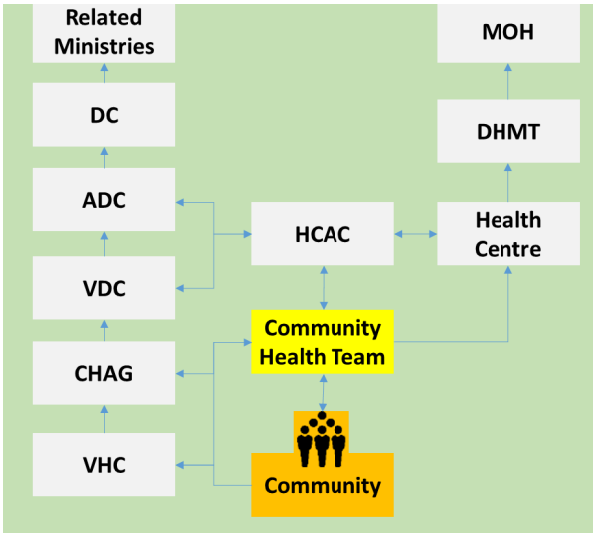
By 2022, the NCHS aims to contribute to the achievement of key HSSP II health outcome targets that hinge on effective delivery of community health services:

- Child mortality: A 25% decrease in the under-five mortality rate (U5MR) from 64 to 48 per 1,000live births by scaling up iCCM, immunisations, and other community-level interventions that save the lives of children
- Maternal mortality: 20% reduction in the maternal mortality ratio (MMR) from 439 to 350 per 100,000 live births by promoting ANC facility visits, educating mothers and spouses on dangerous signs during pregnancy, educating women on correct use of Misoprostol after delivery in the community, and other health promotion efforts that save the lives of mothers

[13] Please see the Annex C for a full list of EHP interventions.

Achieving this vision and mission will require a revised community health system, designed to be community led and centred and to incorporate, organize, and motivate all participants including community members, volunteers, full-time health workers, local governance and community structures. This system will be built around the community and the Community Health Team (CHT) and their linkages with community structures, local government, and the health system. CHTs are a team of CHWs meant to meet monthly with core team members and quarterly with extended team members. Core CHT includes ~5 HSAs, 1 SHSA, and all CHVs in that area. The extended CHT also includes 1 AEHO and 1 CHN/CMA. A summary of this system is in Figure 3 while details on the new community health system and roles of all stakeholders can be found in Chapter 4.

FIGURE 3: NEW COMMUNITY HEALTH SYSTEM STRUCTURE



3.3 Guiding principles and strategic objectives of the NCHS

To achieve the vision and mission, the NCHS has outlined six cross-cutting guiding principles that lay the foundation for a strong, well-functioning community health system in Malawi:

1. **Integration**: Ensure that programmes and initiatives related to community health integrate seamlessly at community level through coordination of service delivery, supervision, training, supply chain, and M&E and promotion of clear referral pathways and lines of clinical responsibility between community, other primary, secondary, and tertiary health facilities. This integrated approach requires close partnership across communities, programmes, partners and sectors as well as efforts to fully leverage existing resources.
2. **Community leadership**: Ensure the strategy listens to the needs and priorities of the Malawian people and that community members have ownership and remain accountable for the health of their communities. This includes recognising the realities that CHWs face and designing a system that supports them appropriately.
3. **Equity**: Ensure all people in Malawi – including women, vulnerable populations, and residents of hard-to-reach areas – receive high-quality care at the community level.
4. **Gender equality**: Ensure that the community health system in Malawi achieves gender equality at all levels, from leadership, to employment, to health service delivery
5. **Learning**: Promote continuous learning and course correction based on strengthened monitoring and evaluation efforts.
6. **Transparency and Accountability**: Stakeholders shall discharge their respective mandates in a manner that is transparent and takes full responsibility for the decision they make

The six cross-cutting guiding principles underpin all six NCHS strategic objectives shown below. The six strategic objectives each map to a Thematic Areas of the Community Health Framework and are aligned with the WHO framework as well as HSSP II strategic objectives.

1. **Health services delivery**: Deliver the Essential Health Package at community level through integrated services provided by CHWs in Community Health Teams.

   Target: By 2022, 75% of HSAs will deliver the majority of the community components of the EHP[14]

2. **Human resources**: Build a sufficient, equitably distributed, well-trained community health workforce.

   Target: By 2022, Malawi reaches 74% of its policy recommendation for the ratio of trained HSAs to members of the population (~15K HSAs and ~1.5K SHSAs) and that 75% of HSAs and SHSAs are residing in their catchment areas.

3. **Information, communication, and technology**: Promote a harmonised community health information system with a multi-directional flow of data and knowledge.

   Target: By 2022, 75% of HSAs are reporting using the standardized village health register and that 50% of CHTs are using mHealth for integrated service delivery, data collection, and supervision.

4. **Supply chain and infrastructure**: Provide sufficient supplies, transport, and infrastructure for CHWs in the CHT.

   Target: By 2022, 95% of HSAs have a high quality, durable bicycle and that 900 Health Posts are operational and supporting integrated community health service delivery in hard to reach areas.

5. **Community engagement**: Strengthen community engagement in and ownership of community health.

   Target: By 2022, 70% of Village Health Committees (VHCs) are meeting regularly on a monthly basis to support community health activities and that 70% of CHAGs and HCACs are active.

6. **Leadership and coordination**: Ensure sufficient policy support and funding for community health and that community health activities are implemented and coordinated at all levels.

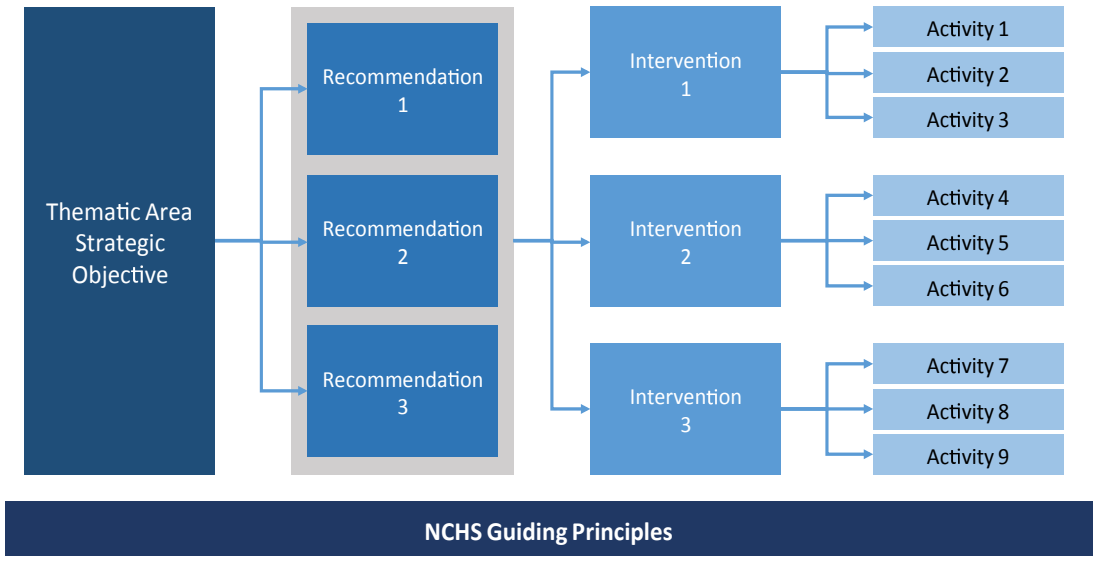
   Target: By 2022, that community health actors will have completed 80% of all agreed-upon coordination activities and milestones.

The NCHS strategic objectives form the framework for recommendations, interventions, and activities that are the roadmap to achieving the vision, mission, and objectives of the NCHS – as summarised in Figure 4 below. These strategic objectives and their targets stem from extensive consultations, outlined in Section 2, and guide the recommendations in

[14] The CHS Section and CMED will provide a detailed definition for each indicator and how to measure it.

Sections 3.4 to 3.9 below. The detailed implementation plan in Annex A contains additional information on each NCHS activity.

FIGURE 4: RELATIONSHIPS BETWEEN NCHS STRATEGIC OBJECTIVES, RECOMMENDATIONS, INTERVENTIONS, AND ACTIVITIES



3.4 Thematic Area 1: Health service delivery

***Strategic objective*: Deliver the Essential Health Package at community level through integrated services provided by CHWs in Community Health Teams.**

Strategic recommendations:

- **Fully integrate community health services at the point of care**. Integrated service delivery improves efficiency within the community health system and expands access to a wider array of life-saving interventions. Integration of community health at the point of care will require changes to training, supervision, M&E, and the community health supply chain, as discussed in Intervention 1.1 below and Section 4.6.
- **Ensure complete alignment of the package of services delivered by CHWs to the community components of the EHP.** These core community health services include prevention, promotion, community case management, surveillance, referral, and rehabilitative. Clear definition of the package and alignment with EHP helps to standardise CHW training and ensure more consistent, high-quality delivery of services across the country. Interventions 1.1 and 1.2 are required to promote integration of the package and clarify which CHWs are responsible for delivering which interventions.
- **Prioritise and strengthen supervision.** Supervision must be integrated with clearly defined roles and responsibilities. It should include three components: clinical mentoring, performance management and appraisal, and supportive supervision. This

comprehensive approach ensures that CHWs are well-supported with clinical tasks (e.g., service delivery) and other parts of their roles (e.g., data collection) and are held accountable for performance. The roll out of integrated supervision requires specific guidelines and resources (e.g., integrated supervision checklist), as discussed in Interventions 1.1 and 1.2 below.

- **Build Community Health Teams.** Community health workers will work within Community Health Teams (CHTs) that include CHVs, HSAs, a SHSA, an AEHO, and a CHN and/or other clinical member such as CMA. Team structures ensure that CHWs are benefitting from peer learning and working collaboratively to deliver services – rather than operating within cadre-based siloes. Team structures also strengthen referral mechanisms and reinforce regular clinical mentoring, performance management, and supportive supervision. Intervention 1.2 includes activities to institute formal CHTs across Malawi.

Interventions and activities:

To strengthen integrated health services delivery, the NCHS recommends two strategic interventions. Detailed activities for each intervention are outlined in Annex A.

1.1 Increase integration of community health services at the point of care. Key activities relate to scaling up integrated delivery of the community components of the EHP – guided by integrated health service delivery guidelines and tools (e.g., integrated supervision checklist and integrated referral form). The NCHS will also standardise and scale-up an integrated referral system across all programmes and levels of care for improved linkages with facilities.

1.2 Roll out Community Health Teams with clear job descriptions for all CHW cadres. This includes clarifying roles and updating job descriptions for all CHWs; launching formal CHTs and workplans to ensure CHWs spend the appropriate amount of time on assigned responsibilities; and developing and rolling out standard operating procedures (SOPs) on monthly integrated supervision (including clinical mentoring, performance management, and supportive supervision). As needed, the CHS Section will revise existing community health guidelines to mainstream quality improvement.

3.5 Thematic Area 2: Human resources

Strategic objective: Build a sufficient, equitably distributed, well-trained community health workforce.

Strategic recommendations:

- **Achieve policy recommendations for the ratios of CHWs to members of the population.** In order to ensure sufficient coverage of the population, the NCHS will work towards increasing the number of CHWs over the next five years – as captured in intervention 2.1 below – to meet global and national policy recommendations:
    - 1 HSA per 1,000 people
    - 1 SHSA per 10 HSAs
    - 1 AEHO per health facility
    - 2 CHNs per health centre

  - 1 CMA per Community Health Delivery Structure
- **Ensure all members of the Community Health Team – including CHNs and CMAs – spend sufficient time in the community**. To promote quality community health services, clinical members of the CHT must spend the majority of their time in the community, rather than at health facilities. This includes CHNs and CMAs who are based at health facilities and centres.
- **Allow district ownership of CHW deployment strategies.** Given varying levels of health care access and need across districts, different geographies can have unique CHW deployment strategies. Districts should work towards the average target ratio of 1 HSA per 1,000 people and 1 SHSA per 10 HSAs, but they have the discretion to decide how to deploy HSAs across the district. Given wide variability in the current deployment of CHWs, Intervention 2.2 includes activities necessary to promote a more equitable distribution of HSAs and SHSAs across the country.
- **Develop and roll out an integrated, government-led training programme for all CHWs in the CHT**. This training programme should include pre-service, in-service, and on-the-job training to ensure that CHWs can deliver the full integrated package of community services, as described in Section 4.3. More standardised, consistent training is also required to reduce inconsistencies in service delivery and sub-optimal CHW performance. To ensure equitable distribution of training, partners should coordinate any additional training programmes with District Health Offices and should not reach out to CHWs directly.
- **Define and launch a more standardised package of financial, non-financial and social incentives for CHWs in the CHT**. Standardised incentives are critical to retaining CHWs and promoting strong performance across the country. Therefore, the government will develop a package of financial, non-financial, social incentives, and performance-based incentives for CHW cadres in partnership with implementing partners, as discussed in intervention 2.4 below.

Intervention and activities:

To improve the quantity, quality, and distribution of CHWs in Malawi, the NCHS recommends four strategic interventions. It is worth noting that Intervention 2.4 on incentives closely relates to Interventions 2.1, 2.2, and 2.3 on recruitment, distribution, and training, respectively. Detailed activities for each intervention are outlined in Annex A.

2.1 Recruit additional CHWs from their communities to ensure sufficient capacity across the community health system. *This includes conducting a gap analysis to guide the recruitment decisions for all CHT members: HSAs, SHSAs, AEHOs, CMAs, and CHNs.*

2.2 Achieve a more equitable distribution of HSAs and SHSAs. Key activities include revision, dissemination, and roll out of the updated CHW Human Resource Policy and provision of hardship allowances to non-volunteer members of the CHT working in hard-to-reach areas.

2.3 Provide high-quality, integrated pre-service and in-service training to all CHWs**.** This includes the revision and roll out of the HSA pre-service training to increase its duration and scope and the launch of three new integrated training packages: SHSA pre-service

training, supervisor training (for AEHOs, CHNs, and CMAs), and CHT in-service training. The NCHS will also strengthen on-the-job training by implementing the CHT structure.

2.4 Provide incentives to all CHWs in the CHT to improve performance, retention, and time spent in community. Key activities relate to rolling out a package of non-monetary and social incentives for CHT members – such as performance-based incentives, housing, transport, ID cards, supplies, exchange visits, recognition of good performance, certificates, and celebrations.

3.6 Thematic Area 3: Information, communications, and technology

Strategic objective: Promote a harmonised community health information system with a multi-directional flow of data and knowledge.

Strategic recommendations:

- **Harmonise data management processes**. In order to reduce the burden of data collection on HSAs and other CHWs, government programmes (e.g. civil registration and vital statistics, National ID, and others) and partners should standardise and harmonise data collection methods. Integrated electronic data management solutions should also be harmonised with the National eHealth Strategy and consider leveraging existing mHealth/digital tools, as discussed in Interventions 3.1 and 3.2 below.
- **Provide sufficient training for HSAs, their supervisors, and CHVs on data and ICT.** All HSAs must receive training on data management, analysis and technologies to improve the quality of data collected and their ability to use the data productively. Intervention 3.2 below includes activities to integrate these skills into existing CHW trainings.
- **Create a data feedback loop for CHWs and communities**. Appropriate feedback loops are essential in ensuring CHWs in the CHT understand the value of the data they have the responsibility to collect. Activities that promote regular feedback, as outlined in Intervention 3.3, help CHWs in the CHT and communities use data to inform their decisions, thereby promoting higher quality care across the community health system.

Interventions and activities:

To strengthen information and communication systems related to community health, the NCHS recommends three strategic interventions. Detailed activities for each intervention are outlined in Annex A.

3.1 Harmonise existing community health data management systems. A sampling of activities includes rolling out a more streamlined, integrated Village Health Register which would include both integrated community health information and civil registration and vital statistics (CRVS) in line with national IDs. Activities would also include maintaining a comprehensive CHW database with information on employment status, training received, supplies received, and location for non-volunteer members of the CHT.

3.2 Explore an integrated mHealth solution for CHWs. Activities relate to exploring the launch of an integrated, electronic community health platform that improves data quality and verification; reduces data collection burden and duplication; improves real-time analysis and performance management; improves service delivery (e.g., via electronic job

aids); strengthens supply management (e.g., cStock or a similar interface), and allows for integration of community data with the DHIS II.

3.3 Build CHW and community capacity in data management. This includes training CHWs in the CHT on ICT, data management and analysis for performance and decision making by developing and integrating a new training module into CHW pre-service and in-service trainings.

3.4 Launch two-way feedback and data review systems. Key activities relate to conducting quarterly meetings for two-way sharing between CHTs, VHCs, CHAGs, HCACs and communities on their health metrics and performance – as well as monthly data validation review meetings at the health facility to ensure quality and consistency of data before sharing with the district. The NCHS will also create and roll out SOPs for community involvement in data collection, management, and dissemination – ensuring involvement of chiefs and local leadership.

3.7 Thematic Area 4: Supply chain and infrastructure

Strategic objective: Provide sufficient supplies, transport, and infrastructure for CHWs in the CHT.

Strategic recommendations:

- **Develop service delivery structures in hard-to-reach areas.** Over five years, the NCHS should target constructing Health Posts (integrated community health service delivery structures which are physical buildings staffed by HSAs and members of CHT that serves 3-5 catchment areas) in all hard-to-reach areas in order to increase access to comprehensive care for millions of people who do not currently live within 8km of a health facility. These Health Posts should be built with local materials, where possible, to promote sustainability and community contributions of materials and labour. The structures should also follow standardised guidelines, as detailed in Intervention 4.1 below, to ensure quality and consistency
- **Provide houses for CHWs – all SHSAs, all HSAs, and CHNs as needed – living in rural areas.** Available housing is critical to increasing both the percentage of HSAs who live in their catchment areas and CHW retention rates. To ensure privacy for CHWs, housing units should be separate from the Community Health Service Delivery Structures – as detailed in Intervention 4.1 below.
- **Provide durable transport options to HSAs and SHSAs.** HSAs require durable bicycles to fully cover their catchment areas, and SHSAs require motorcycles to perform supervision activities across approximately 10 catchment areas. SHSAs working in hard-to-reach areas should receive first priority for motorcycles, followed by SHSAs supervising over 10 HSAs. After achieving full bicycle coverage for HSAs, each VHC should also receive a bicycle to increase the mobility of CHVs. All transport options must have a clear maintenance plan to ensure sustainability over multi-year periods, as discussed in Intervention 4.2 below. To ensure flexibility, DHOs and partners should decide on how to support fuel and maintenance costs for transport options (e.g., motorcycles).

- **Integrate the community health supply chain with the broader supply chain.** Better coordination with existing supply chains is needed to ensure CHWs in the CHT have the supplies they need to deliver integrated services, as discussed in Section 4.5.

Interventions and activities:
To improve supply chain management and existing infrastructure, the NCHS recommends three strategic interventions. Detailed activities for each intervention are outlined in Annex A.

4.1 Rehabilitate and construct community health infrastructure. This includes construction of Health Posts in hard-to-reach areas and housing units for CHWs (HSAs, SHSAs, and CHNs as needed) in rural areas, as well as the rehabilitation of the three primary health care training centres. Although not feasible in the next five years, the next community health strategic plan will aim to increase the number of PHC training centres by two.

4.2 Provide reliable transport to SHSAs, HSAs, and CHV groups. Key activities relate to procurement and distribution of durable, high-quality bicycles and motorcycles to CHWs in the CHT, per the strategic recommendation above. The NCHS also recommends revision and roll out of transport guidelines to include CHW transport, maintenance, and monitoring.

4.3 Improve supply chain management at the community level. Key activities include the launch of a Standard Supply List for HSAs; training for CHWs on supply management and logistics and for community structures on drug monitoring; and expansion of electronic supply and drug management to cover all of community health – building on lessons learned from the existing cStock system.

3.8 Thematic Area 5: Community engagement

Strategic objective: Strengthen community engagement in and ownership of community health.

Strategic recommendations:
- **Collaborate with prioritised community structures.** To avoid fragmentation, government partners and programmes should build the capacity of prioritised community structures -- including the VHC, CHAG, VDC, HCAC and ADC – rather than creating additional ones. This relates to intervention 5.2 below.
- **Strengthen leadership and accountability at community level.** Social accountability not only strengthens quality of care, but also promotes the NCHS guiding principle of community leadership. This relates to interventions 5.1 and 5.3 below.

Interventions and activities:
To address the above-mentioned challenges, the NCHS recommends three strategic interventions. Detailed activities for each intervention are outlined in Annex A.

5.1 Strengthen community-level ownership of and engagement in programmes and interventions. This includes electing CHVs to manage some of the responsibilities of the CHT, rolling out official consultations with communities and CHTs to inform DIPs; holding

national community health day to raise awareness and buy-in; and development of community engagement guidelines. Throughout implementation of the NCHS, the CHAG will also regularly present to the VDC on community health issues and monitor progress.

5.2 Build the capacity of prioritised community structures involved in community health. This includes training community structures on their updated roles (i.e., VHC, CHAG, VDC, HCAC, ADC) and orienting the DEC, communities, and partners on these roles. Throughout implementation of the NCHS, the CHT will also support, monitor, and supervise the prioritised community structures.

5.3 Establish social accountability mechanisms within the community health system. Key activities include community monitoring and evaluation through two-way follow up and feedback mechanisms (e.g., scorecards, Community Action cycle (CAC), performance appraisals, assessments, and quarterly meetings to share information) and semi-annual meetings with local leaders and chiefs to improve accountability for implementation of the integrated district-level community health action plan and Village Action Plans.

3.9 Thematic Area 6: Leadership and coordination

Strategic objective: Ensure sufficient policy support and funding for community health and that community health activities are implemented and coordinated at all levels.

Strategic recommendations:

- **Coordinate at national level through the CHS Section and the CH TWG**. The CHS Section should be accountable for the successful implementation of the NCHS, which requires strengthened national coordination to ensure all stakeholders are working together toward common goals. Intervention 6.1 details specific national-level coordination activities for the CHS Section to implement.
- **Coordinate at district level through the Community Health Officer and the district CH TWG**. The Community Health Officer should be accountable for the successful implementation of the NCHS within each district. To ensure strong linkages with national community health efforts and the broader health system, the Community Health Officer should report regularly to the CHS Section and the DHMT. The Community Health Officer should also oversee specific coordination activities within each district, as detailed in Intervention 6.2.
- **Ensure national programme and partner coordination**. To reduce fragmentation across the community health system, all partners must work with the CHS Section and district-level Community Health Officer(s) to plan and implement community health related programmes and activities. Interventions 6.1, 6.2, and 6.3 all contain coordination activities relevant to actors working in community health.

Interventions and activities:

To address coordination challenges, the NCHS recommends three strategic interventions. Detailed activities for each intervention are outlined in Annex A

6.1 Scale up and enhance coordination mechanisms at the national level. Key activities relate to widely disseminating the NCHS at all levels and briefing stakeholders on community health-related roles and responsibilities of governance structures; singing Memoranda of Understanding (MOUs) with partners working in community health; leading regular coordination meetings; and developing a National Community Health Policy to set clear principles, norms, and guidelines.

6.2 Scale up and enhance coordination mechanisms at the district level. A sampling of key activities includes recruiting or appointing a designated Community Health Officer in each district; launching district-level CH TWGs that bring together partners and representatives from other sectors; and developing and implementing district-level community health plans that feeds into DIPs. Districts will also register and map partners to identify opportunities for support.

6.3 Strengthen coordination linkages across national, district, and community levels. Key activities related to establishing strong communication and reporting lines between the national CHS Section, district-level Community Health Officers, CHTs/CHAGs, HCACs and partners.

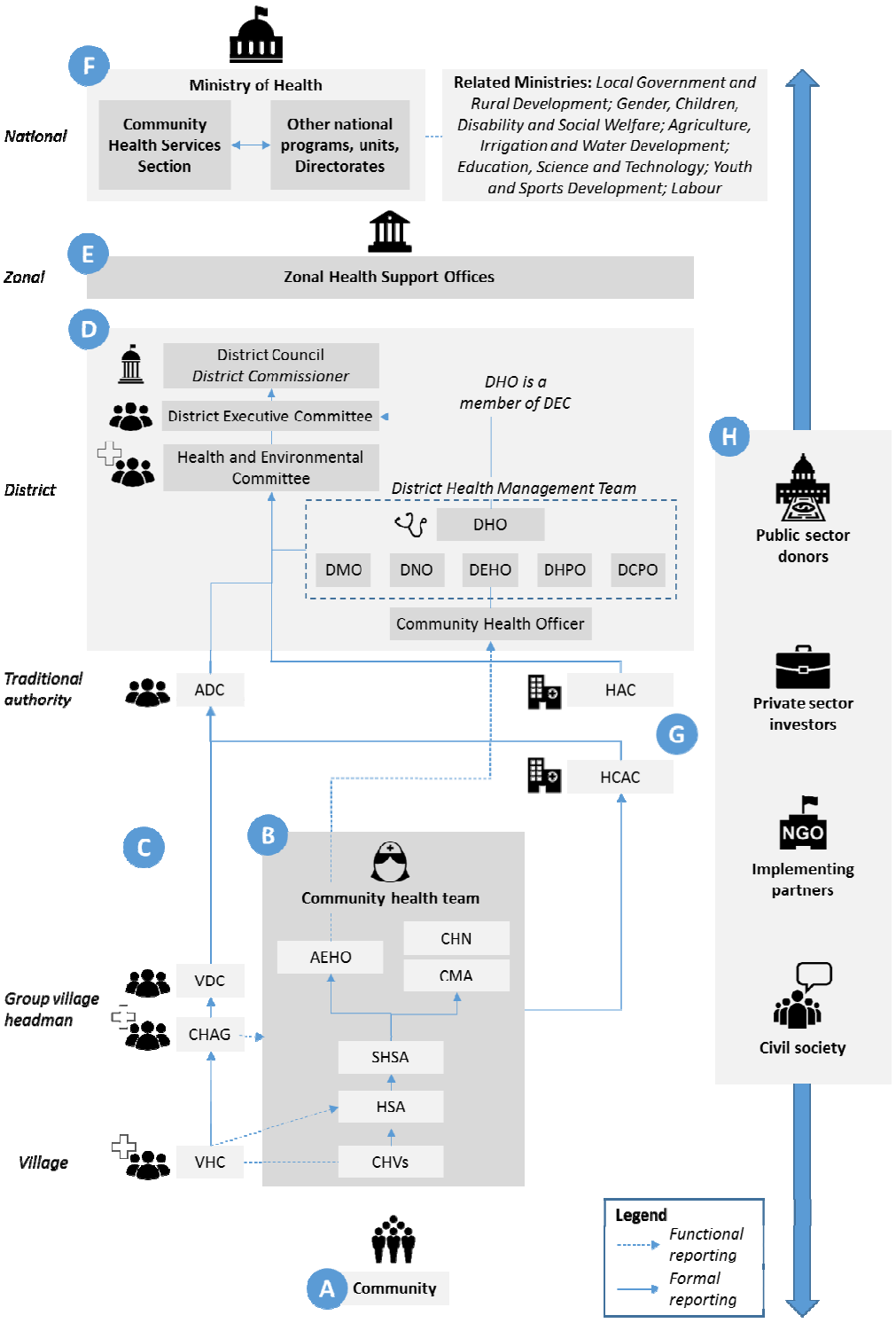
Chapter 4: The new community health system

Malawi's community health system spans a wide array of government departments and partners across sectors at the national, zonal, district, and community levels. A strong community health system requires clear roles for each stakeholder, as well as guidelines and norms on how stakeholders are expected to work together. Key stakeholders include the community, CHWs, health facilities, government, partners, financiers, and civil society – as depicted in Figure 5 below.

The sections below outline the aspirations for how the community health system should function. This includes the roles, responsibilities, and ways of working that all stakeholders should aim to follow throughout the implementation of the NCHS. This builds on the existing system, but includes new and modified features to strengthen the system – based on workshop recommendations, decisions made during the writing retreats, and lessons learned from Malawi and other countries. The section lettering (e.g., A, B, C) indicates where each stakeholder group sits within Figure 5.

Some of these roles may continue to evolve as the MoH revises its guidelines on health sector decentralisation. Going forward, the CHS Section will align the community health system structure with the forthcoming MoH decentralisation guidelines and the updated district- and community-level structures, roles, and responsibilities proposed.

FIGURE 5: OVERVIEW OF THE COMMUNITY HEALTH SYSTEM



4.1 Communities

A. Communities

Communities have primary ownership of the community health system. They have three overarching roles: to use, provide, and monitor community health services. Community engagement is the process of working collaboratively with community members to fulfil all three of these roles – which involves generating awareness of and demand for services; planning for community health; helping to improve services (e.g., via feedback mechanisms); and supporting the enabling environment for community health. The latter includes advocating for inclusion of community health priorities in Village Action Plans and contributing community resources, where possible (e.g., materials and labour for construction of Community Health Service Delivery structures and CHW housing units; see Section 4.6 for details). Community participation, engagement, and ownership form the essential foundation for a strong community health system, an integral part of the health system.

Community based organisations – such as NGOs, social and professional groups, civil society groups, and faith based organisations, amongst others – play an important role in supporting communities in demanding, planning, implementing, and monitoring community health services as well as promoting social accountability on community health.

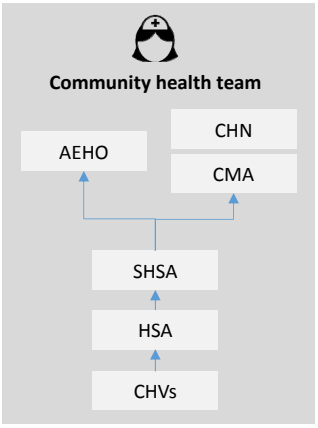
4.2 CHWs

B. CHWs

Community health workers serve as the first point of contact between communities and the health system. In many cases, CHWs are members of the communities they serve. Malawi has several cadres of CHWs, all of whom should work together in a well-defined Community Health Team (CHT) that exists at Group Village Headman (GVH) level. Each CHT should work plan together and meet monthly (with core team) and quarterly (with AEHOs and CHNs). In doing so, CHTs ensure high-quality supervision and peer learning – which ultimately strengthen the quality of community health services delivery. Each CHT should include:

- HSA: HSAs form the backbone of the CHT. HSAs live in their catchment areas and are members of the communities they serve. They provide community health services and supervise CHVs. Malawi aims to have 1 HSA per 1,000 people, to align with national policy and the global benchmark. Each CHT should include approximately 5 HSAs.
- SHSA: Senior HSAs spend the majority of their time supervising HSAs. Each SHSA provides performance management and supportive supervision to 10 HSAs. Each CHT should include 1 SHSA, who is a member of two CHTs. The target ratio of SHSAs to HSAs is 1:10.
- AEHO: AEHOs directly supervise SHSAs. They provide performance management and supportive supervision. In

FIGURE 6: COMMUNITY HEALTH TEAM STRUCTURE



addition, AEHOs oversee official performance appraisal for all SHSAs and HSAs. Each CHT should include one AEHO, who is a member of multiple CHTs. AEHOs receive performance management and appraisal and supportive supervision from Environmental Health Officers (EHOs).

- CHN: CHNs play an integral role in delivering community health services and ensuring quality. CHNs provide clinical mentoring to all SHSAs and HSAs, and they also deliver services that HSAs and SHSAs cannot provide. For example, the HIV program has proposed that CHNs distribute ARVs and closely monitor HIV patients going forward. Each CHT should include 1 CHN. Given nursing shortages, a CMA or another clinical officer can fill this role if a CHN is not available. CHNs will receive clinical mentoring, performance management and appraisal, and supportive supervision from registered nurses.
- CMA: CMAs are midwives who are licensed to practice by the Nurses and Midwives Council of Malawi. They provide critical midwifery services at community level. CMAs receive clinical mentoring and supportive supervision from Nurse Midwife Technicians (NMTs) and performance management and appraisal from NMTs, CHNs, registered nurses, or registered midwives. Each CHT should include 1 CHN or CMA.
- CHV: CHVs are from the community and elected by the VHC. There should be at least 4 skilled CHVs per HSA. There are many types of skilled CHVs at the community level including Community based Distribution Agents (CBDAs), Growth Monitoring Volunteers(GMVs) and Peer educators (PE), to name a few. They are active in health promotion, prevention, monitoring, surveillance, response, and referrals. CHVs are part of the CHT and receive supervision from the HSA in their catchment area.

4.3 Local government and Community Structures

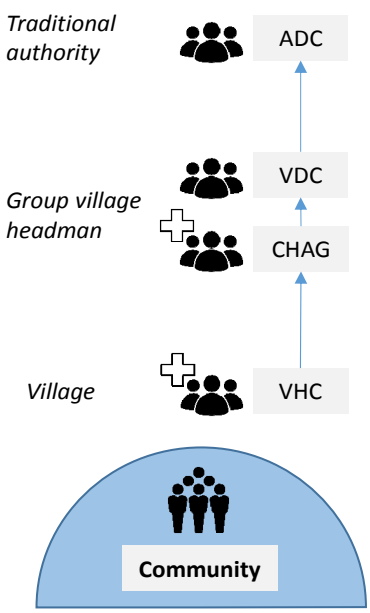
Local government oversees the day-to-day implementation of community health activities. It is very important that health-specific structures (e.g., VHC, DHO) have strong linkages to other local government structures (e.g., VDC, District Council). Local government consists of local authorities and district health officials:

C. Village, group village, and traditional authority levels

- VHC: HSAs are responsible for establishing VHCs in their village(s) and remain accountable to VHC members, who represent the community. Village health committees promote primary health care activities through recruitment of CHVs, overseeing work in the village according to their action plan, ensuring they hold regular meetings with their community to disseminate information and give feedback, and by working hand-in-hand with the HSA. HSAs support supervision and training ofVHCs to assure quality. Each VHC should have approximately 10 members as described in the VHC manual.
- VDC: The VDC is responsible for identifying development issues at the Group Village Headman (GVH) level and taking them through the ADC to the DEC. This includes issues related to community health. Moreover, community health links to other sectors – such as nutrition – through the VDC.

- CHAG: The Community Health Action Group – a structure proposed by the NCHS based on the existing Community Action Group model – is an arm of the VDC at GVH level and is responsible for linking several VHCs to one VDC. It serves as the collective voice on community health issues for both the VDC and individual village heads – which complements the technical-oriented CHT. The CHAG reports to the VDC. The CHAG also supports its designated VHCs, helping to ensure the committees are operational and functioning effectively. For technical guidance, the CHAG also coordinates closely with the CHT and the HCAC. To ensure strong representation, each village is part of one CHAG, and one person per village serves as a member. These village members account for ~60% of CHAG members, and VDC members account for the remaining ~40%. Given this 60% majority, all CHAG decisions apply to all villages.
- ADC: The ADC is responsible for identifying development issues at the TA level and taking them through the council to the DEC. This includes issues related to community health.

FIGURE 7: PRIORITISED COMMUNITY STRUCTURES



- HCAC: The Health Centre Advisory Committee (HCAC)is a committee of volunteers representing community members, the CHT and service providers which bridges the community and the health centre. Every health centre should have a HCAC that links with VHCs, ADCs, CHTs, CHAGs and DHMTs. HCAC members support management of health services including community health services.

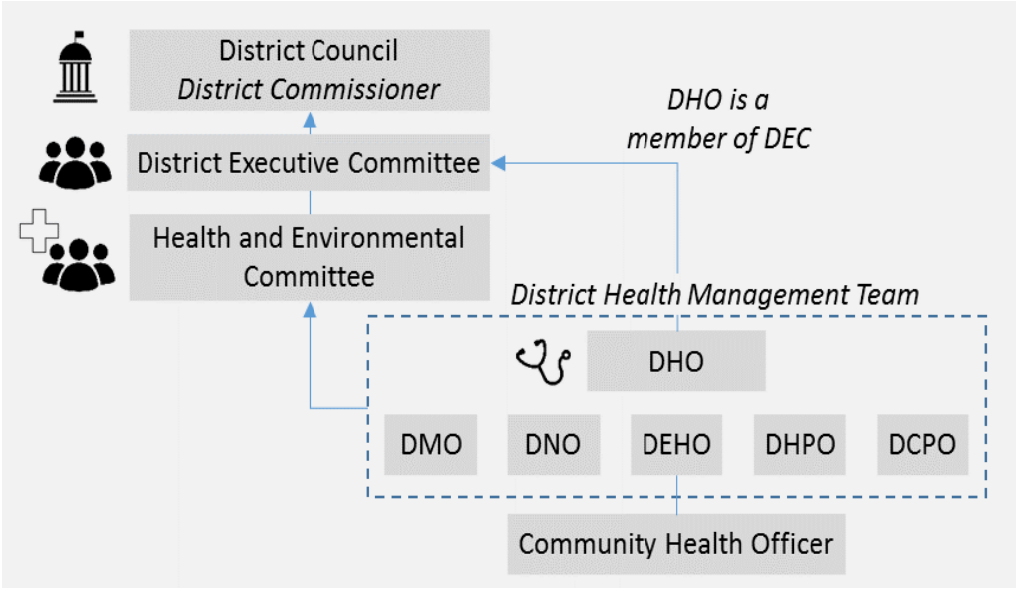
D. District level

- District Health Office: The District Health Office oversees coordination, planning, supervision, and monitoring the implementation of the health agenda. The District Health Office includes the District Health Officer (DHO), District Medical Officer (DMO), District Nursing Officer (DNO), District Environmental Health Officer (DEHO), District Health Promotion Officer (DHPO), District Health Services Administrator and other supporting positions.
- Community Health Officer: Each District Health Office should have a designated Community Health Officer. The community health officer oversees coordination, planning, supervision, and monitoring of all activities related to community health in the district and reports to the DHMT and to the CHS Section.
- District Health Management Team: The DHMT promotes effective coordination between all health-related players in the districts. It is responsible for planning, organising, monitoring, and evaluating of services in the district, including community health. Today, the DHMT includes the DHO, DMO, DNO, DEHO, DHPO, DHA, and District Accountant.

Preliminary decentralisation guidelines have been proposed and if finalised the structure presented here will be amended.

- Health and Environmental Committee: The sub-committee of the DEC that interacts with the DEC members and responds to health needs for the district.
- District Executive Committee: The DEC is responsible for the overall development of the district policy, including for the health sector and approval of all expenditures, as well as approving all partners working in the district. It is chaired by the District Commissioner, and the DHO is a member of this committee. It is critical the DEC takes community health needs into account when determining policies and approving budgets.
- District Council: As the overall administrator of public institutions at district level, the District Council must understand the importance of community health and incorporate priorities into DIPs and other planning processes. In doing so, the DC helps ensure that community health efforts are part of a multi-sector approach.

FIGURE 8: COMMUNITY HEALTH AT DISTRICT LEVEL



4.4 Zonal and National level

E. Zonal level

At the zonal level, the five ZHSOs support national coordination and district-level community health activities. ZHSOs play a critical role in ensuring dissemination of community health policies and guidelines across all 29 districts. They also provide technical support to districts in planning, implementing, supervising, and monitoring community-level health services. Zonal coordination meetings focused on community health must take place twice per year.

F. National level

At the national level the MoH sets strategic direction for the health sector and formulates governing policies. Central responsibilities include oversight of policy making, standard setting, quality assurance, planning and mobilising resources, guidance on implementation priorities, provision of technical support and supervision, research, and monitoring and evaluation.

Within the MoH, the CHS Section serves as the overall community health coordinator for Malawi. The CHS Section sits within the Preventive Directorate of the Ministry of Health and has the following roles:

- Coordination and planning across programmes and stakeholders
- Development of policies, guidelines, strategies
- Monitoring adherence to guidelines and policies
- Overarching management of CHWs within the CHT – including support with recruitment, capacity building, and national supervision
- Mobilisation of shared resources for the community health system
- Guidance on implementation priorities and technical support on community health to other programmes
- Monitoring and evaluation the community health systems
- Internal and external communication on matters related to community health

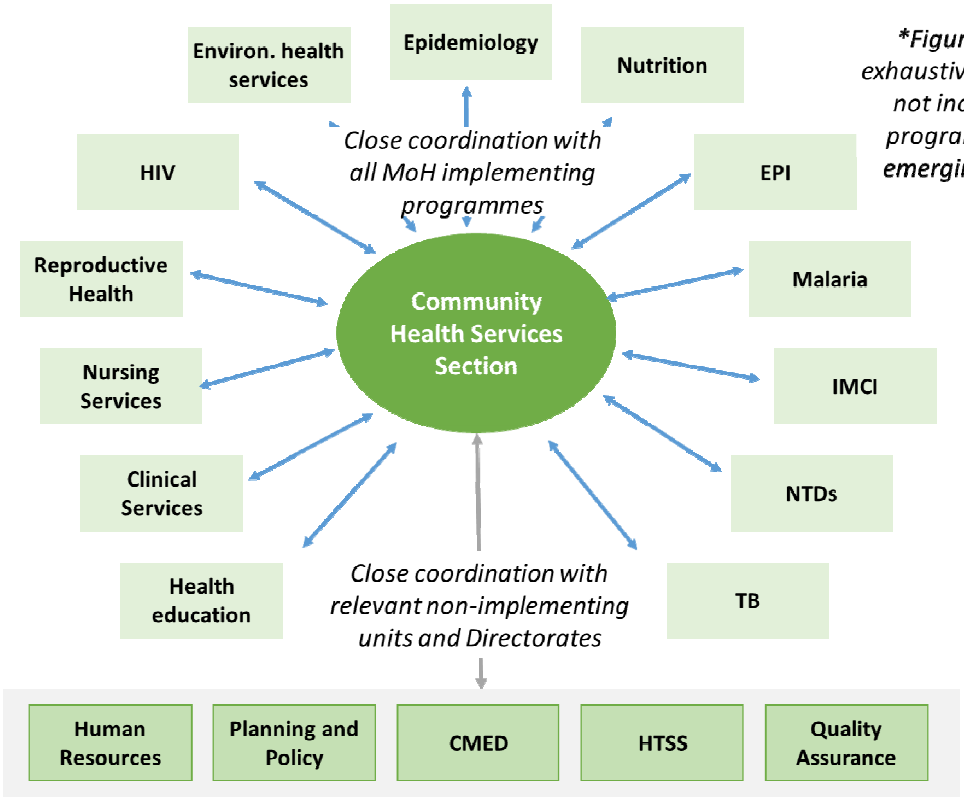
Given its mandate, the CHS Section plays the leading role in addressing community health challenges across the country.

Carrying out this mandate necessitates dedicated coordination efforts from all actors working in the community health system, both governmental and non-governmental.

- National government implementing programmes: The CHS Section is not responsible for direct implementation, but rather coordinates with MoH implementing programmes (see figure below) to strengthen the community health system. These programmes – including EPI, IMCI, Environmental Health, HIV/AIDs, TB, RHU, Nutrition, Malaria, and others– play a critical role in planning, implementing, and monitoring activities related to community health. Therefore, all national programmes implementing at community level should work closely with the CHS Section and follow guidelines for community health reporting and coordination. This includes participation in community health coordination meetings for all national programme managers that take place every quarter in addition to the quarterly Community Health TWG.
- Other national government: The CHS Section works closely with non-implementing units and Directorates, including: Department of Planning and Policy Development to set the strategic direction for community health; Human Resources to effectively manage CHWs within the CHT; HTSS to ensure adequate supplies are available at community level; and Health Education to ensure strong health promotion efforts within communities.
- Partners: Similar to national programmes, partners implementing at community level should work closely with the CHS Section and follow guidelines for community health

reporting and coordination. Partner coordination meetings focused on community health must take place every quarter.

FIGURE 9: FUNCTIONAL ROLE OF THE CHS SECTION WITHIN THE MOH



G. Heath centres

Health centres at community level integrate CHWs into other parts of the primary healthcare system. Facilities provide drugs and supplies to HSAs, and some HSA and SHSA supervisors (e.g., AEHOs and CHNs) are facility-based. Moreover, community health is a part of the continuum of care; therefore, CHWs refer patients with certain conditions to health centres and facilities[15]. It is therefore critical that facilities have a strong understanding of the community health system, including the role of facilities in providing supplies, drugs, and clinical mentoring and supporting standardised referral processes. Each health centre has a Health Centre Advisory Committee (HCAC), which should include health workers, a representative from the CHT, and members of the community. The community members of the HCAC play a fundamental role in linking the community to the facility and vice versa, through monitoring, information sharing, awareness raising and resource mobilisation. It is

[15] See Section 4.3 and the implementation plan for more detail on the referral system – which the NCHS aims to standardise and scale up.

important that health facilities at the community level are closely integrated with other parts of the community health care system.

H. Development partners and civil society

Development partners support critical community health activities in collaboration with the government and communities themselves. Key partners include donors, development finance institutions (DFIs), implementing partners, and private sector investors. Specific opportunities to support the community health system include:

- Ensure ongoing partner programmes and activities align to and coordinate with the NCHS, at the national, district, and community levels
- Provide direct support for activities within the NCHS, including: supporting integrated pre-service and in-service training for all CHWs; helping districts provide CHW supplies, CHW transport, and CH infrastructure; and developing and scaling innovative ICT solutions, revitalising and capacity building of VHCs, CHAGs, HCACs and other prioritised community health structures
- Support broader capacity building and governance activities at the national, district, and community levels (e.g., supporting the operations of the CHS Section or helping to build the capacity of prioritised community-level structures)

Given donors provided the majority of resources to the Malawi health sector in recent years, supporting government actors and supplementing their budgets will be critical.

At the national level, it is critical that partners collaborate with the CHS Section and districts to ensure efficient use of resources and consistency across the community health system. Firstly, coordination is essential in ensuring efficient use of resources by minimising duplication and directing resources to areas with the greatest need. Therefore, it is important that partners keep the CHS Section appraised of all activities related to community health. Partners can do so through a.) participation in coordination mechanisms (national CH TWG, partner coordination meetings) and b.) quarterly reporting to the CHS Section. Similarly, at the district level, it is important that partners coordinate all community health activities with the DC/DEC and the District Health Office – and specifically, the designated Community Health Officer within it. Second, coordination is essential to ensure a consistent system for delivering community health services – thereby eliminating the confusion that exists today from village to village given the many different terms, structures, and processes that programmes use. Therefore, it is critical that partners commit to support the delivery of the integrated package of community health services (i.e., the community components of the EHP) rather than defining additional services and processes. Moreover, partners should only work with paid members of the CHT (e.g., HSAs, SHSAs, CHNs) if the DHO approves and oversees the activities; this includes any in-service and refresher trainings. **Like all stakeholders, partners are expected to respect the scope of work of all CHW cadres – which only the Community Health TWG has the authority to change.** Partners are ultimately accountable to the communities they serve. Therefore, partners should collaborate with existing community structures, including the VHC, CHAG, HCAC, and VDC.

Civil society lobbies for community health priorities and the resources required to deliver high-quality services. Throughout consultation, stakeholders raised several priorities for the community health system, including: lobbying for resources to improve connectivity; lobbying the MoH to increase the drug budget and CMS to stock all essential medicines; and lobbying partners to support CHW supplies, equipment, and transport. Civil society also plays a critical role in third-party oversight and accountability of the health system.

4.5 Coordination mechanisms (not depicted in Figure 5)

The NCHS defines coordination as efforts to ensure that programme activities are implemented in a consistent, integrated, and resource-efficient manner. This is achieved through consistent communication, joint planning, implementation and monitoring of activities.

The Community Health Technical Working Group (CH TWG) serves at the primary forum for coordination at the national level – supported by the CHS Section. Members include the CHS Section, representatives from all other national programmes, all partners working in community health, and representatives from other sectors. The overall aim of the CH TWG is to support the integration of community health services – in order to provide appropriate, coordinated, effective, and efficient care – by assessing feasibility, providing strategic direction, and overseeing transition planning. Specifically, it is responsible for (i) providing technical support in planning, monitoring and evaluation of community service implementation at community level and (ii) advocating and mobilising resources to support effective implementation of community service delivery at community level. The CH TWG meets every quarter.

Each district should also have a dedicated CH TWG, led by the Community Health Officer. These are new structures recommended by the NCHS, and their responsibilities mirror those of the national CH TWG: providing technical support, advocating, and mobilising resources to support effective implementation at district level. Ensuring effective implementation is particularly important given districts oversee all day-to-day community health activities.

At community-level, the CHT and CHAG work together to coordinate activities within each group of villages (GVH level). The CHT provides technical leadership, while the CHAG is the primary vehicle for community leadership and participation/engagement. The CHT and the CHAG should meet each quarter to ensure strong coordination, both upwards with the VDC and ADC and downwards with the VHCs and community members.

Chapter 5: Implementation plan

5.1 Five-year action plan

Successful implementation of the NCHS will require coordinated efforts from all actors working in the community health system, including central and local government, partners, CHWs, and communities themselves. Activities will take place across national, district, and community levels, with designated stakeholder(s) responsible for each. The implementation plan aligns with current guidelines to strengthen health services decentralisation, promoting the ownership of planning and implementation at district and community levels.

The implementation of the NCHS will take place across two phases that recognise the necessity of strengthening the foundational elements of the community health system before scaling activities. The appropriate sequencing of certain activities ensures there is a community health system in place capable of supporting the vision and mission of the NCHS. At the same time, community health activities that are already taking place – such as the delivery of the EHP – will continue. This is to ensure that ongoing activities proceed without interruption as processes take due course. Finally, the NCHS will be continually assessed throughout the implementation plan to ensure tracking of programme effectiveness. System assessment will include a baseline, mid-term, and final assessment and will also incorporate the ongoing performance monitoring of the NCHS M&E framework.

Phase 1 *(years 1 and 2)***:** Phase 1 focuses on setting the community health system up for success by clarifying guidelines and reinforcing structures for the community health system and, in parallel, implementing a few high-impact activities. Critical early activities include clarifying roles and teams for CHWs, establishing district CH-TWGs, recruiting district Community Health Officers, establishing standard supply lists, rolling out revised CHW human resource and residency guidelines, and establishing and implementing a core set of integrated community health indicators.

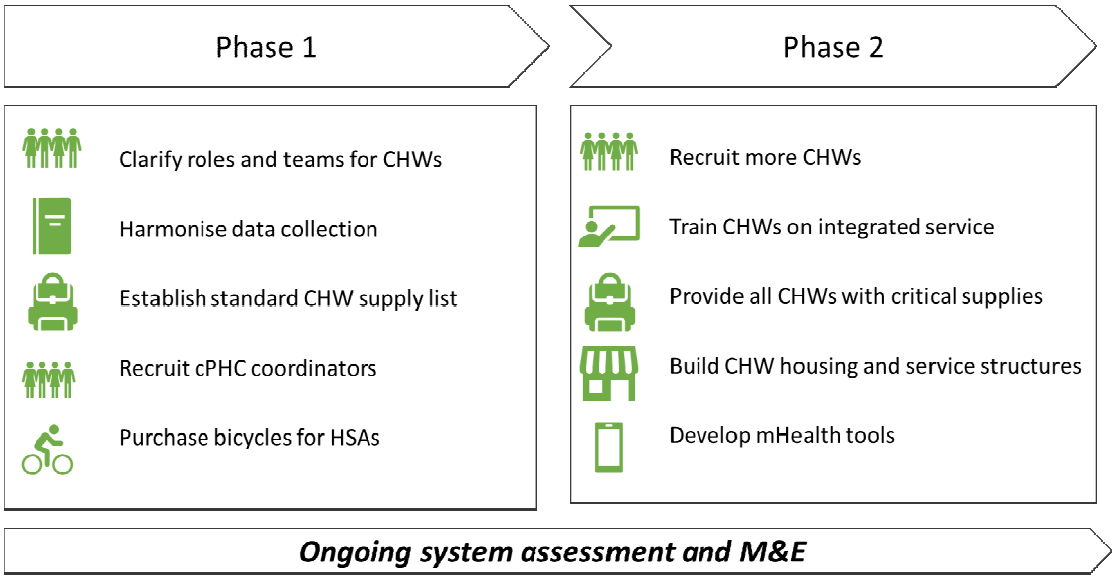
In parallel, implementation of some high-impact activities will commence to ensure continued momentum and rapid improvement of the quality of community health services being delivered. Activities include procurement of bicycles for HSAs, recruitment of more CHWs, setting up CHTs, harmonising data collection, and rolling out community engagement mechanisms. The implementation activities started in Phase 1 will continue through the entire period of the NCHS. Phase 1 will also include a baseline assessment of the community health system, against which the progress of the NCHS shall be tracked.

Phase 2 *(years 2-5)*:During Phase 2, in addition to scaling activities that have commenced in Phase 1, several new activities will be implemented. This includes developing and rolling out integrated training curriculums for both pre-service and in-service training of CHWs, implementing the standardised referral system, providing all CHWs in the CHT with critical supplies, constructing CHW housing units, and deepening community engagement and social accountability processes, amongst others. The latter half of Phase 2 will focus on scaling all

activities implemented in the first three years. Finally, this phase will include mid-term and final assessment of the NCHS.

Figure 10 presents a high-level summary of the five-year action plan, and Annex A provides a detailed action plan with a comprehensive list of activities to implement over five years. The detailed action plan, which is organised by Thematic Area, includes the level at which the activity takes place (national, district, community), responsible stakeholder(s) and timeline for each activity.

FIGURE 10: OVERVIEW OF FIVE-YEAR ACTION PLAN



5.2 Resource planning

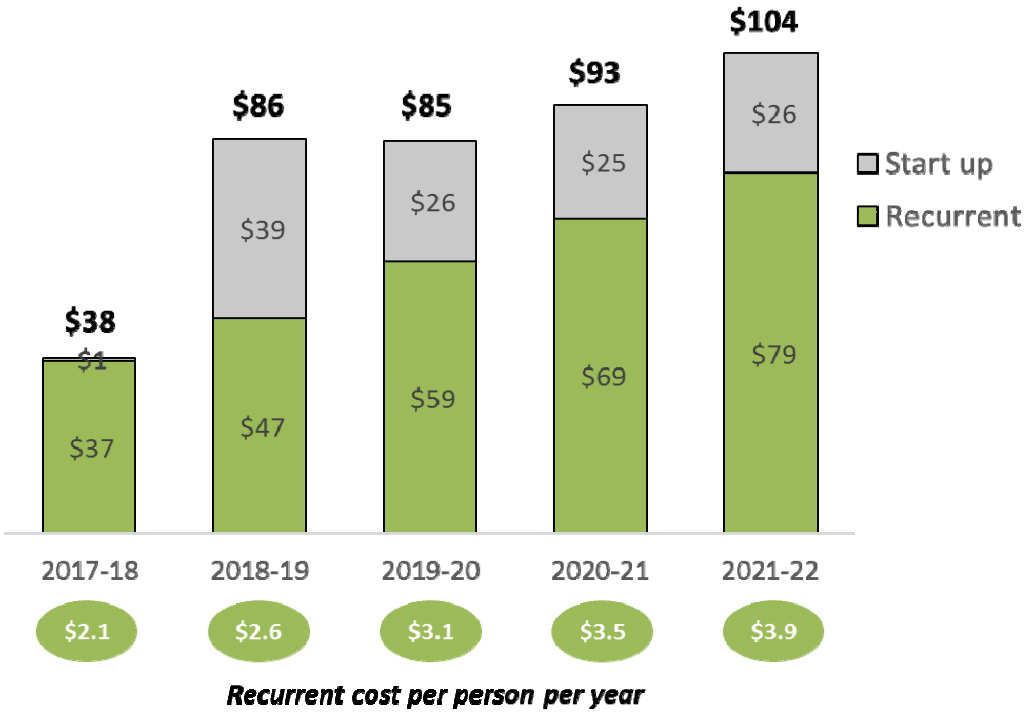
5.2.1 Costing

The total cost of implementing the NCHS over a five-year period is estimated at $407 million, or $81 million each year, on average, to provide high-quality community health services to all people in Malawi. Figure11 summarises the year-by-year costs, which increase each year as Malawi scales up the size of the formal CHW cadres – working toward targets of 1 HSA per 1,000 people; 1 SHSA per 10 HSAs; and sufficient AEHOs, CHNs, and CMAs to staff various health facilities, centres, and structures by 2021-22. Start-up costs total $117 million (29% of total) over the five years, whereas year-by-year recurrent costs are approximately $79 million by year 5.

Overall, the NCHS will cost approximately $3.9 per person per year, based on year 5 recurrent costs. This translates to $1,268 in recurrent costs per CHW – including CHVs, HSAs, SHSAs, and AEHOs – by year 5. This is in line with the costs of community health programmes

in other countries, for example: approximately $2.5 per person per year in Liberia and over $4 per person per year in Ethiopia[16]. Many community health programmes in other countries invest $1000-3000 per CHW[17]. What is not captured in these cross-country community health comparisons is the difference in scope for each setting. Malawi's population is over 80% rural with over four million people living in hard to reach areas. Recognizing this, the MoH employs multiple cadres supporting community health service delivery that have been fully costed in this strategy including HSAs, SHSAs, AEHOs, CHNs, CMAs, and District Community Health Officers. With the MoH's investment in these cadres, the scope of services offered at community level in Malawi are extensive and include iCCM, family planning, immunizations, WASH, HIV testing services, and more. In addition, the costs of infrastructure, supervision, transport, and ongoing training have been captured to ensure these services are provided consistently and with quality. Thus, the Malawi NCHS is intended to play an expansive role in ensuring health services are accessible and patient centred to achieve significant impact not just over the course this five year strategy, but for a generation.

FIGURE 11: COST TO IMPLEMENT THE NCHS, BY YEAR (USD MILLIONS)

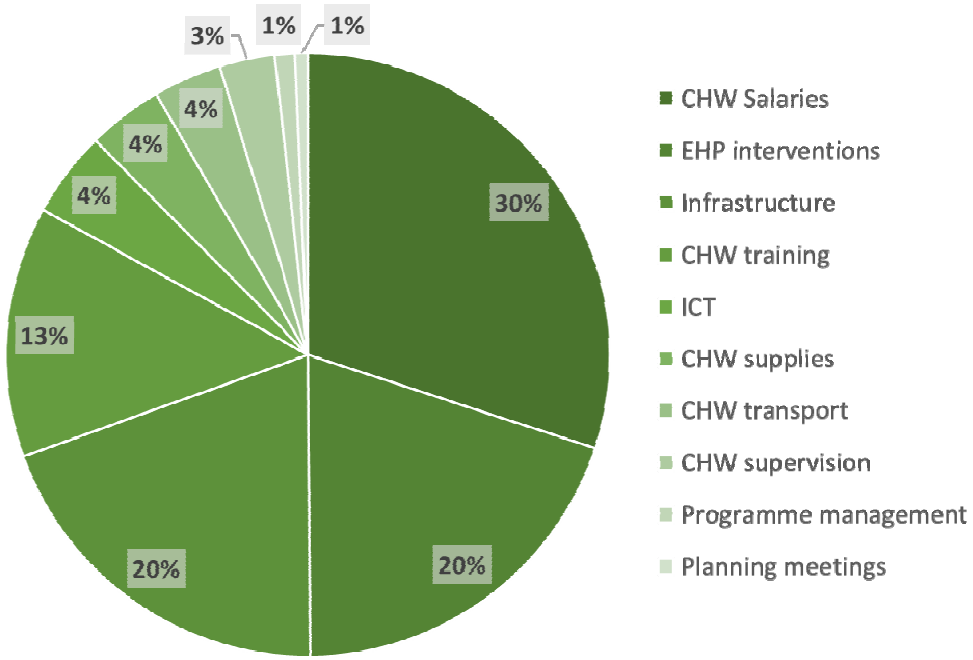


[16]"Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing Recommendations," 2015

[17]"Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing Recommendations," 2015

CHW salaries, delivery of community-level interventions within the Essential Health Package (EHP), and infrastructure account for the majority of costs –30%, 20%, and 20% respectively. Other large cost drivers include CHW training, supplies, and CHW transport.[18]The figure below summarises these inputs to the community health system and their relative contribution to total costs over the five-year strategy.

FIGURE 12: BREAKDOWN OF TOTAL COSTS TO IMPLEMENT THE NCHS, BY TYPE OF INPUT (%)



All NCHS costing estimates derive from a quantitative model (Malawi NCHS Costing Model) and align with the HSSP II costing estimates. Annex A contains detailed activity costs for all inputs to the community health system. Each activity was costed independently based on the scope, targets, and nature of the activity. All estimates are dependent on the activities and targets included in the NCHS; going forward, costs may be revised throughout implementation as activities change and new information comes in, based on lessons learned. All inquiries for further costing detail and methodology should be directed to the CHS section or DPPD.

5.2.2 Financing

Implementation of the NCHS will require financing from national and district government, donors, and the private sector. Only with the support of all stakeholders will the country be able to achieve its vision to improve the livelihoods of all people in Malawi.

[18] Please note that costs of training supervisors and paying their salaries are included in the CHW training and CHW salaries categories, respectively – rather than the CHW supervision category.

Central and district governments will be the first source for NCHS financing. The central government will continue to contribute significant resources towards procurement of commodities and supplies to implement the EHP at the community level including matching funds to development partners. In addition, the central government will lead programme management costs such as the CHS section's operational costs and policy and guideline development which will support broader mobilization of resources both domestically and internationally. The district governments will play a critical role especially with the continued transition to a decentralized system. District governments will be the primary source for CHW salaries and CHW supervision while it is also expected that districts will provide significant support towards transport and infrastructure including Health Posts and CHW housing. Communities also will be expected to participate and contribute through work as volunteers, community groups such as VHCs, and support in infrastructure especially with supplying materials and labour for the construction and maintenance of Health Posts and CHW homes.

Other stakeholders including donors, implementing partners, and the private sector will be looked on to fill critical gaps in NCHS financing requirements. Development partners, including multilateral donors, bilateral donors, foundations, development finance institutions, and NGOs are crucial for financing the successful implementation of the NCHS. As possible and while working in an integrated fashion across programmes, partners' support will be needed across activities including delivering community EHP interventions, CHW training, supplies, transport, infrastructure, ICT, and more. The NCHS will also look to mobilize private sector resources and develop public private partnerships (PPPs) to ensure sustainable implementation and financing sources. Recognized opportunities to work with private sector include ICT, infrastructure, transport, and CHW supplies.

The CHS Section will track financing commitments and progress toward established targets throughout the implementation of the strategy. To do so, the CHS Section will develop a funding database with the Aid Coordination Unit of the MoH to allow CHS active management of funding for community health. To promote transparency and accountability, the Section will share updates with all stakeholders through quarterly and annual meetings at the national, zonal, and district levels. The CHS Section will also be responsible for adjusting targets, supporting resource mobilisation, and prioritising resources – as necessary – based on year-to-year progress.

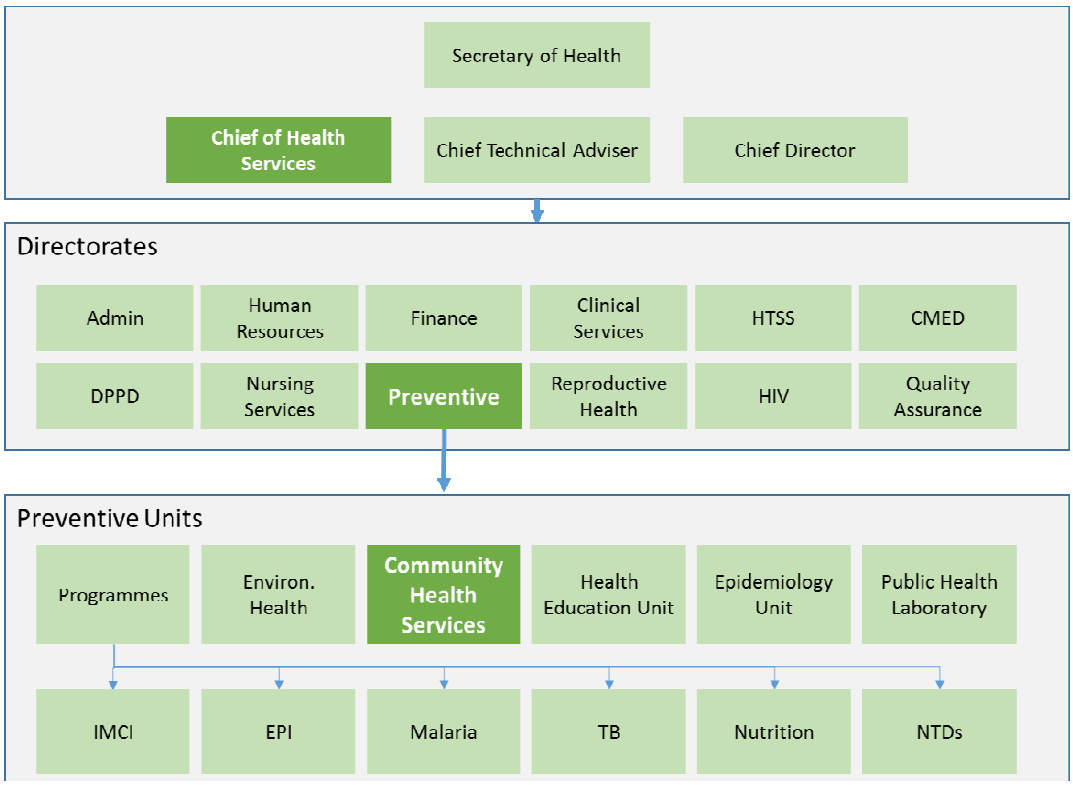
Overall, collective efforts to finance the NCHS will transform the community health system and create enormous returns for Malawi: Based on a conservative analysis, the NCHS can save over 9,000 child lives each year, generate at least a 5:1 economic return on investment, empower communities and women, and prevent and mitigate global and domestic health security crises. For additional detail on financing and investment opportunities, please see the NCHS Advocacy Tool.

Chapter 6: Programme management

The Community Health Services (CHS) Section of the Ministry of Health is responsible and accountable for the successful implementation of the NCHS. Community Health Service section takes the lead on addressing community health challenges through its mandate as the overall community health coordinator for Malawi. The section is also responsible in setting standards through the development and monitoring of policy and guidelines as well as leading strategic development. The CHS section also oversees management of CHWs through recruitment and capacity development through training.

As discussed in Section 4.4, the CHS Section is not responsible for direct implementation, but rather coordinates with MoH implementing programmes (e.g., HIV, malaria, nutrition, etc.), other parts of the national and local government, and non-governmental partners to strengthen the community health system. The CHS Section sits within the Preventive Directorate of the Ministry of Health, as detailed in the figure below.

FIGURE 13: CHS SECTION WITHIN THE MINISTRY OF HEALTH



NCHS programme management hinges on mutual accountability and active coordination between the CHS Section and all actors working in the community health system – including national government programmes, district health offices, other local government authorities, partners, and communities themselves. Each actor isresponsible for proactively collaborating with the CHS Section, as detailed in the table below. In addition, the CHS Section is responsible for sharing back community health information to these actors – via coordination meetings, annual reviews, bulletins, and other relevant channels.

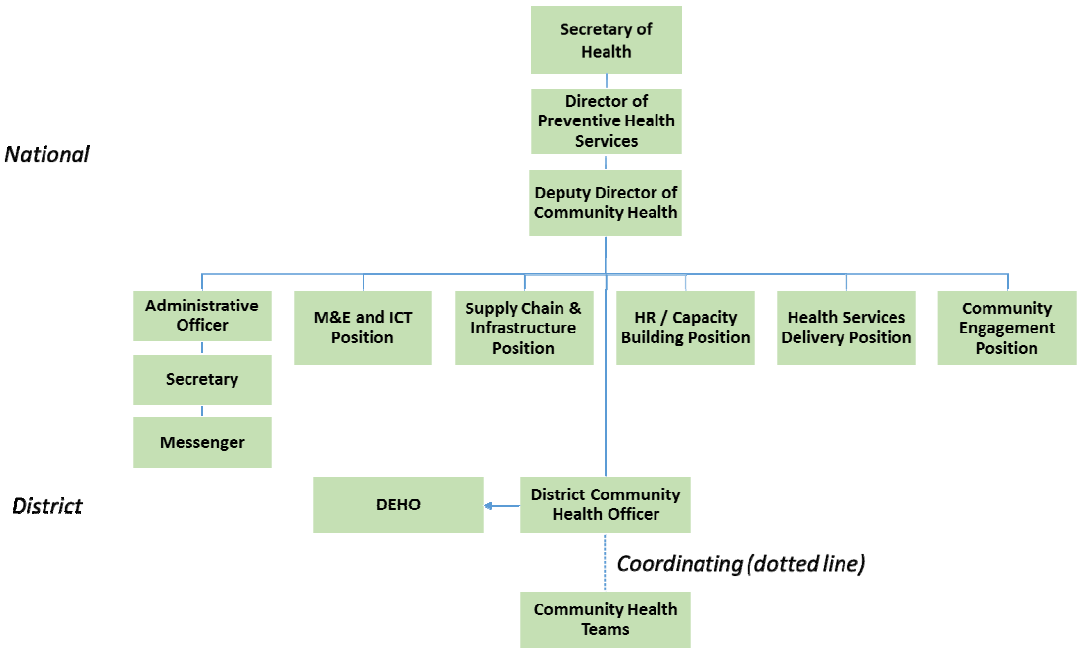
FIGURE 14: COORDINATION WITH THE CHS SECTION

Category	Actors included	Coordination with CHS Section
National MoH implementing programmes	• Directorates: Clinical Services, Nursing Services, Reproductive Health, HIV • Preventive Directorate Units: Environmental Health Services, Epidemiology, HEU • Programmes: Malaria, EPI, NTDs, Nutrition, IMCI, TB	• Help deliver integrated package of community services • Report each quarter on community activities to the CHS Section • Participate in every CHTWG meeting as well as quarterly CH national programmatic coordination meetings • Seek approval of CHTWG for all activities taking place at community level
National MoH non-implementing Directorates and Units with a clear link to CH	• Directorates: Human Resources, HTSS, Planning and Policy, CMED	• Account for all community health needs within planning and policy development processes • Coordinate CHWs in a way that promotes sufficient recruitment; strong performance and retention; and equitable distribution • Ensure strong health promotion efforts at community level • Include CHS section in relevant TWGs
District Health Offices	• All 29 districts, led by the District Community Health Officer	• Report each quarter on community activities to the CHS Section • Oversee delivery of integrated package of community services
Partners	• Donors supporting community health • Implementing partners working in community health	• Help deliver integrated package of community services • Report each quarter on community activities to the CHS Section • Seek approval of CHTWG for all

		activities taking place at community level • Secure approval of DHO before launching community health activities within the district, including any work with HSAs and other CHWs • Support for capacity enhancement and production of ToRs and training materials for community health structures

Lastly, effective programme management will require sufficient human and financial resources for the CHS Section. Firstly, the CHS Section requires additional human resources, including MoH staff members and shorter-term technical advisors, to successfully implement the NCHS. The figure below shows the proposed CHS team structure, which includes 9 full-time employees (FTE) – 6 programmatic FTEs and 3 administrative FTEs – by the end of scale-up. CHS Section staff members will also require short-term and long-term courses for continued learning as well as short-term and long-term technical assistance for managing the workload until the team is fully staffed. Secondly, the Section will require sufficient and predictable financial resources, as detailed in Section 5.2 on resource planning, to support operations. Thirdly, the CHS Section will require supplies and office space. All of these resources are critical to the success of the strategy over the next five years.

FIGURE 15: PROPOSED CHS TEAM STRUCTURE



Chapter 7: Monitoring and evaluation

7.1 Monitoring and evaluation system and process

The NCHS monitoring and evaluation (M&E) plan will provide a national framework to measure and track progress of the implementation of the strategy at all levels. The NCHS provides an overview of the M&E framework and a detailed M&E plan will be developed in the first phase of NCHS implementation. M&E will take place at every stage of implementation and will allow the CHS Section to continuously improve current and future programme planning, implementation, and decision-making.

M&E is a continuous process and consists of five key activities:

(i) *Alignment on indicators* - The indicators presented within the results framework in Section 6.2 below will be the minimum data collected for monitoring purposes. Additional indicators will need to be developed in conjunction with MoH staff, partners, and M&E experts to ensure that they are meaningful to all. The choice of indicators will need to be streamlined to ensure minimal data-collection burden on CHWs.

(ii) *Data collection* – Data collection is a continuous process and will be undertaken by a number of different stakeholders, including DHOs through CHWs, community structures (such as VHCs, CHAGs, and HCACs), and communities.

(iii) *Data analysis*– Data analysis can be continuous or periodic, depending on the type of data being collection. The synthesis of findings will allow for evaluation of the programme and its constituent's activities.

(iv) *Data dissemination* – It is important that the findings from M&E activities are disseminated widely, including to communities and CHWs. Such feedback loops support improved operations and performance. To address the existing challenge of limited flow of information between actors in the community health system, data will be reported back to CHWs and communities through quarterly meetings.

(v) *Refinement of programmes / Data utilization* – The process of M&E is iterative and the findings should ultimately result in a refinement and improvement of existing programmes, where necessary. The CHS Section will review the findings from the evaluation on an annual basis.

In addition to reporting on key output and outcome indicators, operational research will be a core component of the NCHS M&E plan. Such operational research will allow the CHS Section to learn about the effectiveness of certain interventions in addressing specific community health challenges in Malawi. Illustrative research questions that could be explored include: What are the most cost-effective interventions for driving community demand, improving retention of CHWs in their catchment area, and strengthening community structures? Does the implementation of a community information system result in improved accountability? What are effective ways to manage parallel community volunteers? And does the implementation of an integrated supervision tool improve quality

of service delivery and care? A research agenda, identifying the precise questions and responsible stakeholders, will be determined in the first year of NCHS implementation.

Although the CHS Section bears primary responsibility for M&E of the NCHS, the M&E plan will be integrated into existing MoH M&E systems where possible to avoid duplication of efforts. Collecting and reviewing community health information will require close coordination between MoH, district governments, development partners, and communities. Within this M&E system, stakeholders will be responsible for different tasks, as summarised in the figure below.

7.2 Results framework

Health outcome indicators and targets

By 2022, the NCHS aims to contribute to the achievement of two HSSP II health impact targets that hinge on effective delivery of community health services:

- Child Under-5 mortality: A 25% decrease in the under-five mortality rate (U5MR) from 64 to 48 per 1,000 live births by scaling up iCCM, immunisations, and other community-level interventions that save the lives of children
- Maternal mortality: A 20% reduction in the maternal mortality ratio (MMR) from 439to 350 per 100,000live births by promoting ANC facility visits, educating mothers and spouses on dangerous signs during pregnancy, educating women on correct use of Misoprostol after delivery in the community, and other health promotion efforts that save the lives of mothers.

Strategic objective indicators and targets, by Thematic Areas

The indicators for the M&E plan cut across the six strategic objectives as well as cross-cutting objectives, such as programme management and resource planning. The CHS Section and CMED will provide a detailed definition for each indicator and guidance on how to measure it.

FIGURE 16: PRELIMINARY LIST OF OUTCOME AND OUTPUT INDICATORS, BY THEMATIC AREA

Thematic Area	Outcome indicator	2022 target	Output indicators
Health services delivery	*% of HSAs delivering the majority of the community components of the EHP*	*75%*	• Package of services delivered at community level established and agreed upon by stakeholders • Updated CHW job descriptions and/or role clarity guidelines completed and disseminated • Updated supervision guidelines developed and disseminated to districts and partners • Percentage of CHTs that meet every month
Human resources	*% progress toward Malawi policy recommendation for the ratio of trained HSAs to members of the population (1 to 1,000)* *% of HSAs and SHSAs residing in their catchment area*	*74% (~15K HSAs, ~1.5K SHSAs)* *75%*	• Percentage of desired HSA positions established • Percentage of desired HSA positions filled • CHW attrition rate, by district • Percentage of SHSAs trained on integrated supportive supervision • Percentage of CHW Supervisor positions filled (AEHOs, CHNs, CMAs)
ICT	*% HSAs updating the standardised Village Health Register* *% of CHTs using mHealth for integrated service delivery, data collection, & supervision*	*75%* *50%*	• Percentage of quarterly community report back meetings conducted • Integrated village Health register developed • Percentage of CHWs trained in data management • Percentage of monthly data validation review meetings conducted at health facility level • Community health information system developed

Thematic Area	Outcome indicator	2022 target	Output indicators
Supply chain and infrastructure	*% HSAs with quality, durable pushbikes* *# of Health Posts operating &supporting integrated community health service delivery*	*95%* *900*	• Percentage of hard-to-reach catchment areas with Health Posts • Percentage of rural catchment areas with CHW housing units • Percentage of SHSAs with motorcycles • Percentage of VHCs with bicycles • Percentage of VHCs and HACs trained in drug and supplies monitoring • Percentage of health posts equipped and maintaining supplies
Community engagement	*% of VHCs that meet regularly* % of CHAGs and HCACs that are active	*70%* *70%*	• Revised roles of community structures involved in community health (VHC, CHAG, HCAC, ADC) clarified and disseminated • Percentage of VHCs that have received training • Percentage of CHAGs and HCACs that have been oriented and formed
Leadership and coordination	*% of all agreed-upon coordination activities and milestones completed*	*80%*	• National community health policy developed and disseminated • Percentage of CH-TWG meetings held with documented action agendas and attendance • Percentage of districts that report on coordination indicators • Percentage of CH TWGs established in all districts • Percentage of DHOs with Community Health Officers
Cross-cutting	NA	NA	• Proportion of CHS section positions filled • Proportion of required funds raised

Annexes

Annex A: Detailed costed implementation plan

The tables below provide the comprehensive five-year action plan by Thematic Area, which includes the level at which the activity takes place, responsible stakeholder(s), the activity code which links with the strategic intervention within the thematic area that the activity maps to (first two digits), a timeline for each activity, and the costs for that activity. The year(s) in which the activity takes place is shaded green while the annual costs associated with that activity shown in USD (thousands). The last two columns on the right show the total cost of the activity in USD (thousands) and MWK (millions). Activities that do not have a cost associated with them may either be covered by other activities that they are integrated with or be part of what existing resources will cover. **This implementation plan represents the total costs of the community health system each year and not just new or incremental activity.** For example, activities related to recruiting CHWs cost both the CHWs already employed as well as the newly recruited CHWs. This applies to HSAs, SHSAs, CHNs, CMAs, and AEHOs in which those already employed are costed within each year in addition to those newly recruited in each year. Costs were calculated using a quantitative community health system costing model (NCHS Costing Model).Additional details on costing, activities, assumptions and methodology can be found in the NCHS costing model with inquiries directed to the CHS section or DPPD.

FIGURE 17: DETAILED COSTED IMPLEMENTATION PLAN (USD THOUSANDS AND MWK MILLIONS)

Thematic Area 1: Health Service Delivery

Level	Responsible stakeholder	Activity Code	Activity	2017-18: Year 1	2018-19: Year 2	2019-20: Year 3	2020-21: Year 4	2021-22: Year 5	Total USD (K)	Total MWK (M)
National	CHS Section	**1.2.1**	Clarify roles and update job descriptions for all CHWs (CHVs, HSAs, SHSAs, CHNs, CMAs, AEHOs) to align on roles and scope of work, with the goal of addressing workload issues (e.g., via task shifting) and clarifying supervision responsibilities	$32	$0	$0	$0	$0	**$32**	**MWK 23**
National	CHS Section	**1.2.2**	Develop working guidelines on the structure and function of Community Health Teams and all CHWs within	$1	$0	$0	$0	$0	**$1**	**MWK 1**
National	CHS Section	**1.1.1**	Revise integrated health service delivery guidelines and tools and referral guidelines – including integrated supervision checklist and integrated referral form and system	$3	$0	$0	$0	$0	**$3**	**MWK 2**

National	CHS Section	**1.1.5**	Standardize the referral system across levels of care and programmes, and develop an integrated referral form	$4	$0	$0	$0	$0	**$4**	**MWK 3**
National	CHS Section	**1.2.8**	Revise key community health guidelines to mainstream quality improvement, including: Guidelines for the Management of Task Shifting to HSAs; Guidelines for the Management of CHVs; Guidelines for Community Participation in Primary Health Care; and Guidelines for Integrated Community EHP Interventions to reflect principles and recommendations of the NCHS and the HSSP II	$0	$0	$3	$0	$0	**$3**	**MWK 2**
National	CHS Section	**1.1.7**	Review integrated Basic Health Package to ensure alignment for next NCHS	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section	**1.0.0**	Deliver the EHP	$13,515	$14,759	$16,088	$17,503	$19,005	**$80,871**	**MWK 58,631**
District	DHO	**1.1.2**	Conduct awareness induction for Community Health Teams on their updated roles, the package of community-	$0	$0	$0	$0	$0	**$0**	**MWK 0**

			level services, and the community health system							
District	DHO, CHS Section	**1.1.3**	Conduct awareness meetings at district and community level for all sectors to advocate for integrated services in the district	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	DHO	**1.1.4**	Disseminate and implement integrated health delivery guidelines and tools – including integrated supervision checklist and integrated referral form and system	$56	$0	$0	$0	$0	**$56**	**MWK 41**
District	DHO	**1.1.6**	Implement and scale-up the standardized referral system	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Community	CHS Section, DHO	**1.2.5**	Develop procedures (SOPs) on monthly integrated supervision – including clinical mentoring, performance management, and supportive supervision – for both HSAs and SHSAs	$33	$0	$0	$0	$0	**$33**	**MWK 24**

Community	DHO	**1.2.6**	Institute CHW workplans that are integrated and mainstreamed into existing district-level workplans to ensure CHWs spend the appropriate amount of time on assigned responsibilities, in line with updated job descriptions	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Community	DHO	**1.2.3**	Conduct HSA supportive supervision visits	$288	$370	$472	$600	$750	**$2,480**	**MWK 1,798**
Community	DHO	**1.2.4**	Conduct SHSA supportive supervision visits	$63	$73	$85	$99	$114	**$433**	**MWK 314**
Community	DHO, CHS Section,	**1.2.7**	Form and standardize Community Health Teams at community level and start conducting monthly and quarterly meetings that are integrated and mainstreamed into existing health system meetings (e.g., performance review or HMIS meetings)	$1,208	$1,467	$1,764	$2,116	$2,545	**$9,100**	**MWK 6,597**
Grand Total				**$15,204**	**$16,669**	**$18,411**	**$20,317**	**$22,413**	**$93,015**	**MWK 67,436**

Thematic Area 2: Human Resources

Level	Responsible stakeholder	Activity Code	Activity	2017-18: Year 1	2018-19: Year 2	2019-20: Year 3	2020-21: Year 4	2021-22: Year 5	Total USD (K)	Total MWK (M)
National	CHS Section	**2.1.1**	Conduct a gap analysis to develop a policy document on recruitment of the Community Health Team, including specific hiring targets, timelines, and a review of establishment numbers per cadre	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section	**2.1.3**	Orient/on-board district Community Health Officer	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section	**2.4.1**	Review the package of non-monetary and social incentives to improve motivation and quality of services provided by the CHT – such as performance-based incentives, housing, transport, ID cards, supplies, exchange visits, recognition of good performance, certificates, and celebrations	$0	$0	$0	$0	$0	**$0**	**MWK 0**

National	CHS Section, Human Resources	**2.2.1**	Review and revise the existing Human Resource Policy. Ensure the policy addresses all issues related to desired CHW ratios, recruitment, deployment, residency, career path, hardship incentives, transfers, bonding mechanisms, and incentives	$5	$4	$0	$0	$0	**$9**	**MWK 6**
National	CHS Section	**2.3.1**	Revise HSA pre-service and in-service training curriculum (including training manual and job aids) to increase the duration and scope – ensuring the content covers all roles and responsibilities within the updated HSA job description – and obtain accreditation from the appropriate regulatory body	$0	$121	$0	$0	$0	**$121**	**MWK 88**
National	CHS Section	**2.3.4**	Create an SHSA in-service training programme, ensuring the content covers all roles and responsibilities within the updated SHSA job	$0	$79	$0	$0	$0	**$79**	**MWK 57**

			description and a new SHSA training programme							
National	CHS Section	**2.3.5**	Develop an annual, integrated refresher training package for CHTs	$0	$5	$0	$0	$0	**$5**	**MWK 4**
National	CHS Section	**2.3.6**	Develop training module on integrated supervision for AEHOs, CHNs, CMAs, and other members of the integrated supervisory team	$0	$21	$0	$0	$0	**$21**	**MWK 15**
District	CHS Section, Human Resources	**2.2.2**	Disseminate and enforce the revised HR policy	$0	$56	$0	$0	$0	**$56**	**MWK 41**
District	CHS Section, Human Resources	**2.2.3**	Explore the feasibility and sustainability of providing a hardship allowance to CHT members, excluding volunteers, working in hard-to-reach areas to support transport and/or relocation costs	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	CHS Section	**2.3.8**	Implement revised/new HSA and SHSA pre-service trainings	$0	$16,270	$3,219	$3,879	$4,770	**$28,137**	**MWK 20,399**

District	DHO	**2.1.2**	Ensure district Community Health Officer is in place	$315	$315	$315	$315	$315	**$1,575**	**MWK 1,142**
District	DHO	**2.1.4**	Recruit additional CHNs, where possible, working towards the ratio of 2 CHNs per health centre	$1,268	$1,437	$1,605	$1,774	$1,943	**$8,027**	**MWK 5,820**
District	DHO	**2.1.5**	Recruit additional CMAs from their catchment areas, where possible, working towards the ratio of 1 CMA per community health structure	$426	$513	$604	$699	$798	**$3,041**	**MWK 2,205**
District	DHO, communities	**2.4.2**	Implement the agreed package of non-monetary and social incentives to CHTs	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	DHO, partners	**2.3.2**	Coordinate all additional partner-led trainings through the designated Community Health Officer at the District Health Office, with the goal of minimizing duplication and the time CHWs spend away from their catchment areas	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	HR	**2.1.6**	Recruit additional AEHOs, working towards the Malawi policy recommendation of 1	$896	$992	$1,088	$1,184	$1,280	**$5,440**	**MWK 3,944**

			AEHO per health facility							
District	DHO	**2.1.8**	Recruit additional HSAs from their catchment areas, working toward the Malawi policy recommendation of 1 HSA per 1,000 people	$14,263	$16,024	$18,149	$20,757	$24,027	**$93,221**	**MWK 67,585**
District	DHO	**2.1.9**	Promote HSAs to SHSAs, as needed, working toward the Malawi policy recommendation of 1 SHSA per 10 HSAs	$2,341	$2,371	$2,443	$2,564	$2,741	**$12,460**	**MWK 9,034**
District	DHO	**2.3.7**	Implement training module on integrated supervision for AEHOs, CHNs, CMAs, and other members of the integrated supervisory team	$0	$244	$275	$307	$339	**$1,166**	**MWK 845**
District	DHO	**2.3.9**	Implement the annual, integrated refresher training package for CHTs	$0	$0	$5,429	$6,155	$7,072	**$18,656**	**MWK 13,526**
Community	DHO, CHTs	**2.3.3**	Increase on-the-job training for CHWs via Community Health Teams, including traditional, gap-based, and peer-to-peer	$0	$0	$0	$0	$0	**$0**	**MWK 0**

Community	DHO, community leaders	**2.1.7**	Select additional CHVs at the discretion of districts and communities	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Grand Total				**$19,515**	**$38,452**	**$33,128**	**$37,634**	**$43,285**	**$172,014**	**MWK 124,710**

Thematic Area 3: ICT

Level	Responsible stakeholder	Activity Code	Activity	2017-18: Year 1	2018-19: Year 2	2019-20: Year 3	2020-21: Year 4	2021-22: Year 5	Total USD (K)	Total MWK (M)
National	CHS Section, CMED	3.1.1	Complete data mapping to identify duplications in data collection across partners and programmes	$36	$0	$0	$0	$0	**$36**	**MWK 26**
National	CHS Section, DHO, Human Resources	3.1.3	Develop a database of CHW data, including information on employment status, training received, supplies received, and location for each non-volunteer CHW (e.g., HSAs, SHSAs)	$53	$0	$0	$0	$0	**$53**	**MWK 39**
National	CHS Section, CMED	3.1.5	Revise and streamline integrated Village Health Register based on findings from the data mapping exercise	$123	$0	$0	$0	$0	**$123**	**MWK 89**
National	CHS Section, CMED	3.1.6	Develop a comprehensive and harmonised community health information system	$3	$0	$0	$0	$0	**$3**	**MWK 2**

National	CHS Section, CMED	3.1.8	Create and support an information platform at the community level to strengthen community engagement and accountability (e.g. posters or charts in the community that allow community members to track progress)	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section, CMED	3.2.1	Develop training module on ICT and data management, including materials for supervisors, to integrate into CHW pre-service and in-service trainings	$0	$11	$0	$0	$0	**$11**	**MWK 8**
National	CHS Section, CMED	3.1.9	Integrate community-level data with DHIS II	$0	$11	$0	$0	$0	**$11**	**MWK 8**
National	CMED, HTSS/Pharmacy, CHS Section	3.1.4	Advocate for and ensure the expansion of c-stock (or any similar interface), integrated with LMIS and DHIS II, beyond the facility to the community	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section, DHO, Human Resources	3.1.7	Maintain the database of CHW data	$0	$0	$0	$0	$0	**$0**	**MWK 0**

National	CHS Section, CMED,	3.1.10	Integrate applications based on the findings of the ICT mapping to reduce the burden on CHWs and identify the opportunities for integration/interoperability	$0	$1,945	$3,234	$5,179	$6,467	**$16,825**	**MWK 12,198**
National	CHS Section, CMED	3.1.13	Implement a comprehensive and harmonised community health information system	$0	$25	$25	$25	$25	**$100**	**MWK 73**
District	CHS Section, CMED	3.3.2	Disseminate the harmonised Village Health Register and train CHTs to use it	$0	$168	$0	$0	$0	**$168**	**MWK 122**
District	CHS Section, CMED	3.1.11	Based on mapping, identify and explore mHealth solutions to improve data quality; reduce data collection burden and duplication; and improve real-time analysis	$0	$500	$0	$0	$0	**$500**	**MWK 363**
District	CMED, HTSS, CHS Section	3.1.12	Based on mapping, identify and explore mHealth solutions to improve service delivery, SBCC, and other health interventions at the	$0	$0	$0	$0	$0	**$0**	**MWK 0**

			community level							
District	DHO, CMED	3.2.2	Increase supervision of programme coordinators to increase use of ICT and improve data management	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Community	CHS Section, CMED, DHO	3.1.2	Complete mapping of ICT interventions at community level to identify duplications and opportunities for integration	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Community	CHS Section, CMED	3.3.3	Create SOPs for community involvement in data collection, management, and dissemination – ensuring involvement of chiefs and local leadership	$0	$56	$0	$0	$0	**$56**	**MWK 41**
Community	CHTs, facilities	3.3.1	Conduct monthly data validation review meetings at the health facility to ensure quality and consistency before sharing data with the district	$0	$0	$0	$0	$0	**$0**	**MWK 0**

Community	CHT, CMED, CH coordinator	3.3.4	Conduct quarterly meetings for two-way sharing of data on health and performance metrics between CHTs, VHCs, CHAG, and communities	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Grand Total				**$214**	**$2,716**	**$3,259**	**$5,204**	**$6,492**	**$17,885**	**MWK 12,967**

Thematic Area 4: Supply Chain and Infrastructure

Level	Responsible stakeholder	Activity Code	Activity	2017-18: Year 1	2018-19: Year 2	2019-20: Year 3	2020-21: Year 4	2021-22: Year 5	Total USD (K)	Total MWK (M)
National	CHS Section, HTSS, PAM	4.3.1	Develop an integrated Standard Supply List for CHWs, in collaboration with PAM	$1	$0	$0	$0	$0	**$1**	**MWK 1**
National	CHS Section, DPPD	4.1.1	Develop guidelines for Health Posts and housing units for HSAs, SHSAs, and CHNs (as needed) in hard-to-reach areas	$24	$0	$0	$0	$0	**$24**	**MWK 17**
National	CHS Section	4.2.1	Revise transport guidelines to include CHWs, including issues related to receipt of transport (e.g., bicycle and motorcycle), maintenance of transport, fuel, and monitoring of transport	$1	$0	$0	$0	$0	**$1**	**MWK 1**
National	CHS Section, HTSS	4.3.6	Create a plan to integrate community supply chains to existing supply chains	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	DCs, communities	4.1.2	Mainstream the plan for constructing and equipping Community Health Delivery Structures and housing units into DIPs, council investment plans, and Village Action Plans	$0	$0	$0	$0	$0	**$0**	**MWK 0**

National	DPPD	4.1.3	Rehabilitate, expand, and equip three primary health care training centres	$150	$0	$0	$0	$0	**$150**	**MWK 109**
National	HTSS, DHO	4.3.7	Train CHTs in supply management and logistics	$0	$0	$2,172	$366	$452	**$2,989**	**MWK 2,167**
National	CHS Section, CSOs	4.2.3	Advocate for community transport to each health centre for emergencies (e.g., motorbike ambulance and other options), especially in hard-to-reach areas	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	IMCI, DHO, HTSS, partners	4.3.2	Expand electronic supply and drug management to cover all of community health, building on lessons learned from the existing cStock system	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	DHO	4.3.8	Train VHCs, HACs, and medicine sub-committees on drug monitoring	$0	$0	$875	$73	$73	**$1,021**	**MWK 740**
District	DHO, partners	4.3.3	Procure HSA supplies based on Standard Supply List for CHWs	$1,042	$1,239	$2,056	$2,253	$3,069	**$9,659**	**MWK 7,003**
District	DHO, partners	4.3.4	Procure SHSA supplies based on Standard Supply List for CHWs	$92	$102	$176	$186	$259	**$814**	**MWK 590**
District	DHO, partners	4.2.2	Procure a durable, high-quality bicycle to every HSA, with priority given to those who work in rural and hard-to-reach areas	$556	$610	$664	$1,220	$1,274	**$4,325**	**MWK 3,136**

District	DHO, partners	4.2.4	Distribute and maintain durable, high-quality bicycle to every HSA, with priority given to those who work in rural and hard-to-reach areas	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	DHO, partners	4.2.5	Procure a durable, high-quality bicycle to each VHC/CHAG with one group bicycle, after all HSAs have received bicycles	$0	$941	$1,032	$1,124	$2,064	**$5,161**	**MWK 3,742**
District	DEHO, partners	4.2.7	Procure a motorcycle for SHSAs - with priority given first to those who work in hard-to-reach areas and then to those who supervise more than 10 HSAs	$0	$1,323	$1,345	$1,366	$1,387	**$5,421**	**MWK 3,930**
Community	CHS Section, Community, partners, DHO	4.1.4	Construct HSA housing units, with the goal of reaching a third of rural areas by 2022 - prioritizing the furthest and hardest to reach hard-to-reach areas and then working inwards	$0	$11,832	$11,832	$11,832	$11,832	**$47,328**	**MWK 34,313**
Community	CHS Section, Community, partners, DHO	4.1.5	Construct and equip Health Posts, with the goal of reaching 80% of hard-to-reach areas by 2022	$0	$7,877	$8,045	$8,218	$8,421	**$32,561**	**MWK 23,607**

Community	DHO, partners	4.3.5	Procure CHV supplies based on Standard Supply List for CHWs	$0	$1,107	$1,107	$1,886	$1,886	**$5,985**	**MWK 4,339**
Community	DHO, partners	4.2.6	Distribute and maintain a durable, high-quality bicycle to each VHC/CHAG with one group bicycle, after all HSAs have received bicycles	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Community	DEHO, partners	4.2.8	Distribute and maintain motorcycles to SHSAs - with priority given first to those who work in hard-to-reach areas and then to those who supervise more than 10 HSAs	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Grand Total				**$1,867**	**$25,031**	**$29,303**	**$28,523**	**$30,717**	**$115,441**	**MWK 83,695**

Thematic Area 5: Community Engagement

Level	Responsible stakeholder	Activity Code	Activity	2017-18: Year 1	2018-19: Year 2	2019-20: Year 3	2020-21: Year 4	2021-22: Year 5	Total USD (K)	Total MWK (M)
National	CHS Section, MoLGRD	5.2.1	Align with MoLGRD on (i) existing community structures, functions, and linkages (i.e., VHC, CHAG, ADC), (ii) proposals to add new sub-committees or community structures (e.g., CHAG), and (iii) implementation of these revisions	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section, DHO	5.1.2	Develop comprehensive community engagement guidelines, which includes building awareness at the community level; involving communities and other extension workers in planning, setting health priorities, and programme implementation; and strengthening community M&E.	$31	$0	$0	$0	$0	**$31**	**MWK 22**
National	CHS Section, DHO	5.1.5	Hold community health open day to raise awareness about the importance of community health in Malawi and	$0	$0	$279	$279	$279	**$837**	**MWK 607**

			express appreciation for CHWs and other actors across the CH system							
District	CHS Section, DHO	5.2.2	Widely disseminate revised and clarified roles of community structures to DEC, communities, and partners	$56	$0	$0	$0	$0	**$56**	**MWK 41**
District	DHO	5.2.3	Orient and train community structures on revised roles and responsibilities and build their capacity to deliver (includes VHC, CHAG, and HCAC)	$0	$2,344	$182	$182	$182	**$2,891**	**MWK 2,096**
District	DC, VDCs	5.3.2	Conduct semi-annual meetings with local leaders and chiefs to improve accountability for implementation of district-level integrated community health action plan and Village Action Plans	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	DC, DHO	5.1.6	Conduct community and CHT consultations on district implementation plans (DIPs)	$0	$0	$0	$0	$0	**$0**	**MWK 0**

Community	CHS Section, DHO	5.1.7	Disseminate and implement comprehensive community engagement guidelines	$0	$56	$0	$0	$0	**$56**	**MWK 41**
Community	DHO, communities, partners	5.1.1	Assess community needs, set community health priorities, and participate in programme implementation	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Community	DHO, VHCS, partners	5.3.1	Implement community monitoring and evaluation through two-way follow up and feedback mechanisms, e.g., scorecards, performance appraisals, assessments, and quarterly meetings to share information	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Community	CHS Section, HEU, DHO, communities, partners	5.1.3	Implement programmes that generate awareness of, participation in, and demand for community health through media campaigns (community radios), IEC materials, and community meetings	$0	$44	$44	$44	$44	**$177**	**MWK 128**
Community	DHO, CHAG	5.1.4	Present community health issues to VDC and monitor progress	$0	$0	$0	$0	$0	**$0**	**MWK 0**

Community	CHS Section, Quality Management Department	5.3.3	Implement quality assurance of community health service delivery, in keeping with existing guidelines on quality management and by working with the Quality Assurance Directorate.	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Community	DHO, CHTs	5.2.4	Support, monitor, and supervise the community structures (CHTs to support an on-going/monthly basis, and Community Health Officer to support on a quarterly basis)	$0	$0	$0	$0	$0	**$0**	**MWK 0**
Grand Total				**$87**	**$2,445**	**$506**	**$506**	**$506**	**$4,048**	**MWK 2,935**

Thematic Area 6: Leadership and Coordination

Level	Responsible stakeholder	Activity Code	Activity	2017-18: Year 1	2018-19: Year 2	2019-20: Year 3	2020-21: Year 4	2021-22: Year 5	Total USD (K)	Total MWK (M)
National	CHS Section	6.3.1	Disseminate NCHS at all levels and brief stakeholders on the community health-related roles and responsibilities of governance structures at all levels	$56	$0	$0	$0	$0	**$56**	**MWK 41**
National	CHS Section, CMED	6.3.4	Develop and introduce indicators to measure coordination across the community health system	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section	6.2.5	Develop National Community Health Policy to set clear principles, norms, and guidelines for community health in Malawi; this should include clarification of process for government programs and partners to work with HSAs and/or change their roles	$0	$47	$0	$0	$0	**$47**	**MWK 34**
National	CHS Section	6.2.1	Conduct National CH TWG by using the TORs to encourage attendance; requiring presentations to the TWG for any programs that involve	$10	$10	$10	$10	$10	**$52**	**MWK 38**

			community health; and developing stronger accountability mechanisms for government programs and partners to support CHWs							
National	CHS Section	6.2.2	Conduct national level partner coordination meetings quarterly to plan, discuss, and review community health activities	$5	$5	$5	$5	$5	**$26**	**MWK 19**
National	CHS Section	6.2.3	Conduct quarterly community health coordination meetings for program managers at the national level (includes CHS Section, MoH HR, Nursing Section, Environmental Health Team, etc.)	$5	$5	$5	$5	$5	**$26**	**MWK 19**
National	CHS Section	6.3.2	Conduct annual and bi-annual coordination and review meetings at national, district, and zonal levels; meetings should involve sharing workplans to ensure joint work planning, implementation, and M&E across partners and the government	$0	$17	$17	$17	$17	**$69**	**MWK 50**

District	DHO, CHS Section	6.1.1	Recruit/assign Community Health Officer at district level	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	DHO	6.1.2	Create a district-level community health TWG to bring together partners and representatives from other sectors	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	DC, partners	6.1.4	Register and map partners at district level to identify opportunities for support	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	CH coordinator within DHO	6.1.7	Develop a district-level community health plan that feeds into the DIP	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	DHO	6.2.4	Develop an integrated approach for local government and partners to fund community health activities within the DIP	$0	$0	$0	$0	$0	**$0**	**MWK 0**
District	DHO	6.1.3	Convene district-level community health TWGs on a quarterly basis to bring together partners and representatives from other sectors	$182	$182	$182	$182	$182	**$909**	**MWK 659**
District	DC, partners	6.1.5	Sign MOUs between DCs and partners, after the district mapping	$0	$0	$0	$0	$0	**$0**	**MWK 0**

District	DHO	6.1.6	Host semi-annual health stakeholder meetings at district level and share workplans across partners to ensure joint work planning, implementation, and M&E	$0	$91	$91	$91	$91	**$364**	**MWK 264**
Grand Total				**$259**	**$358**	**$311**	**$311**	**$311**	**$1,550**	**MWK 1,123**

Cross Cutting Activities

Level	Responsible stakeholder	Activity Code	Activity	2017-18: Year 1	2018-19: Year 2	2019-20: Year 3	2020-21: Year 4	2021-22: Year 5	Total USD (K)	Total MWK (M)
National	CHS Section	7.1.1	Recruit additional staff for the CHS Section	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section	7.1.2	Mobilise resources for the NCHS	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section	7.1.3	Launch the NCHS through a public event	$37	$0	$0	$0	$0	**$37**	**MWK 27**
National	CHS Section	7.1.5	Develop a research agenda for community health	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section	7.1.6	Develop detailed NCHS M&E plan with CMED, aligned with HSSP II	$0	$0	$0	$0	$0	**$0**	**MWK 0**
National	CHS Section	7.1.11	Conduct mid-term evaluation of the NCHS	$0	$0	$16	$0	$0	**$16**	**MWK 11**
National	CHS Section	7.1.12	Conduct final evaluation of the NCHS	$0	$0	$0	$0	$27	**$27**	**MWK 20**
National	CHS Section	7.1.13	Develop NCHS II	$0	$0	$0	$0	$162	**$162**	**MWK 117**
National	CHS Section	7.1.4	Secure on-going operational resources and equipment for the CHS Section (including national supervision)	$96	$29	$29	$33	$29	**$217**	**MWK 157**
National	CHS Section	7.1.8	Conduct operational research on priority topics	$200	$200	$200	$200	$200	**$1,000**	**MWK 725**
National	CHS Section	7.1.10	Develop annual community health bulletin	$0	$5	$5	$5	$5	**$20**	**MWK 15**

District	CHS Section	7.1.7	Purchase on-going operational supplies and equipment for the district Community Health Officer	$681	$352	$352	$384	$352	**$2,121**	**MWK 1,538**
Grand Total				**$1,014**	**$586**	**$602**	**$622**	**$775**	**$3,599**	**MWK 2,609**

Annex B: Summary of findings from the Situation Assessment, zonal and national workshops

Situation Assessment Summary

Overall, the community health system is found to be functioning and playing an integral role across promotion, prevention, and curative services. Community health is predominately delivered through HSAs who are the main connection between the formal health system and communities, delivering a wide range of services and are the main implementers of EHP. A majority of HSAs have received the basic 12-week HSA training while many have also received supplementary training. The +9,000 HSAs also make them the largest cadre of the MoH. In 2015, over 1,200 HSAs were promoted to Senior HSAs meaning there is now an improved opportunity for supervision and management of HSAs. Successful programs in community health such as immunizations, iCCM, environmental health and more have contributed to Malawi's significant declines in infant/under 5 mortality, malaria fatality rates, and improved sanitation and hygiene among others.

However, community health continues to be fragmented across different programmes and partners creating problems with coordination and integration. Resources are also insufficient to meet the need and disease burden especially with the high portion of the population that is rural or hard-to-reach. As part of this situation assessment well over 100 unique issues were identified. A review of key issues and assessment by thematic area follows below:

Health Service Delivery

Malawi has many guidelines and policies recently developed meant to shape community health including guidelines on task shifting to HSAs, integration, and community participation. However, these guidelines have varying degrees of dissemination and have struggled to see implementation. Basic HSA training has grown from a 6-week to a 12-week course covering +20 topics. As of 2017 all practicing HSAs will have completed the basic 12-week course with support from the Global Fund. This course does not cover additional trainings that have been offered to HSAs further expanding their roles and responsibilities to include programmes such as iCCM, nutrition, HTS, and more. These additional trainings, predominately partner-led and funded, have resulted in rapid expansion of responsibilities and inconsistency in roles and service quality for HSAs in addition to frequently taking HSAs away from their catchment areas. Recent analysis has shown at least **340 unique tasks** that have been assigned to HSAs which increases to **550** when different service points are also considered. Community groups such as VHCs and other CHVs *are* supposed to support in many of these activities, but there is a lack of clarity for which tasks can be managed by CHVs and most community groups have not been trained to do so. CHVs are also not ubiquitous across the country and vary depending on implementing partners in those areas while others may or may not be active. Meanwhile, staffing levels of other community health workers such as CHNs and CMAs have not allowed for a strong focus on community services.

The role of HSA supervision has traditionally been with the Environmental health unit, specifically AEHOs and EHOs. Programme specific supervision may also occur (e.g. HIV partners supervising HTC.) Supervision visits may be conducted by members of the MOH,

district officials, and donors/NGOs. An additional layer of supervisors was established when the MoH filled the cadre of Senior HSAs in 2015 by promoting over **1,200 HSAs to Senior HSAs** to provide increased support and supervision to HSAs. Unfortunately, Senior HSAs have not been trained in supervision or provided more specific role clarity. An assessment from 2015 showed that on average across districts HSAs were only receiving about **3 support and supervision visits annually** out of expected 12.Supervisors may or may not be trained in all areas in which they are supervising. For example, AEHO's have not received training in iCCM or HIV.

Human Resources

Malawi has devoted significant investment towards community health as the **9,214 HSAs** are full-time MoH employees and make up over half the MoH's clinical staff. However, the # of HSAs remains **over 7,000** short of meeting policy recommendation of 1 HSA to 1,000 population. Bottlenecks for filling vacancies from HSAs that have retired, transferred, or died also exist due to a lack of a process of filling vacancies especially amid the ongoing decentralization process. There is also a shortage of other community-level workers such as community nurses who are being used to fill gaps at health facilities and spending less time on community work.

Of the 9,214 total HSAs, **1,282 are Senior HSAs**. Unfortunately, the distribution of Senior HSAs across districts is not equitable relative to population size and # of HSAs. This means some districts have more Senior HSAs than HSAs while others have as many as **22 HSAs for every Senior HSA**. There is also limited documentation on supervision and not a protocol for dealing with HSAs not performing up to standard.

Accessibility of workforce is also a major challenge as **51%** of HSAs practicing iCCM are not residing in their catchment areas due to such factors as recruiting from outside catchment areas and districts, inadequate housing in hard to reach areas, and personal reasons such as following spouses to other locations. Weak HR accountability and incentive structures for HSAs have also contributed to this challenge. Career trajectory and paths are especially unclear for community health workers and HSAs noted **static salaries** regardless of years of service or number of tasks practiced or trainings passed. Career progression pathways, key skills needed, and performance based management and incentives are not established resulting in both motivation and commitment challenges affecting service delivery and turnover.

Information, Communication, and Technology

There is significant data collection through various methods and implementers of community health. HSA's are technically assigned to complete **over 40 M&E forms and processes** while there are currently **15 different types of data** used in community health. The amount of data collection creates a burden for implementers around consistency and quality of data that is weakened by insufficient quality assessments and training for data collection.

Individual programmes often have their own indicator lists, many that overlap with other areas, and greatly expand the burden of data collection on implementers such as HSAs. In

addition, CMED and many programmes do not use indicators that specify community level, meaning attribution to community health services is difficult. Multiple processes for data collection also raises questions around data quality given the amount of time needed to devote to multiple M&E processes as well as limited **trainings** and **supervision**. Integrated supervision tools have been a challenge as evidenced by attempts by SSDI and Save the Children in which both the format and time burden of the supervision tool inhibited more widespread use.

For accessing data and information, certain programmes use their vertically collected information well. However, wider audiences or units working across programmes face difficulty accessing information. For example, health systems such as **DHIS II**, HR systems such as **iHRIS**, and supply chain systems such as **cStock** all contain information relevant to community health. However, these sources have different user groups that do not share information regularly. There is an ongoing project to change this as DHIS II becomes the interface for multiple databases including HR. There is also no available database containing active programmes, partners, and activities in relation to health broadly and community health in particular. The newly formed Aid Coordination Unit is working on this though.

In Malawi, there are multiple projects being used by NGO's for appointment reminders and treatment compliance for HIV/AIDS care. For community health, D-Tree supports both CBMNH and iCCM through decision algorithms, supervisory checklist, and a tech support line. The NGO Village Reach has health center by phone and utilizes electronic data collection systems (ODK) while Baobab uses mHealth for EMRS, Vital Stats, and others. Finally, directly in community health iCCM with JSI are using cStock for management of drug tracking and orders.

Supply Chain and Infrastructure

In consultations with districts, housing for HSAs in catchment areas, structures for village clinics, and inadequate transport for HSAs and supervision were the top 3 issues prioritized representing **5 of the top 6 prioritized issues**.

For supplies and materials, there are multiple examples of successfully providing HSAs and communities with supplies including IMCI and EPI that manage extensive supply chains for community level activity. However, drugs and supplies face formidable obstacles in community health. Firstly, there is an overall shortage of many critical supplies in Malawi. Secondly, resources that are available are not distributed equally across geographies or need but are often influenced by the implementing partner for that area. Thirdly, due to a lack of an integrated system there are coordination challenges with complementary programmes. Fourth, insufficient prioritization for community-related drugs and supplies means districts and health centers often do not allocate sufficient resources for community health (including drugs and fuel). This has meant that community-level materials especially around drug commodities have depended on partner support such as Save the Children, UNICEF, PSI, and others to ensure HSAs have adequate supplies to practice and perform their responsibilities.

Also, community level supplies and materials have historically not been incorporated into the MoH Physical Assets Management plans. There are efforts underway currently to include at least iCCM and community health more broadly in their planning, sourcing, and allocation processes. These factors have led to large gaps for community level materials. For iCCM alone it was identified that nearly **3,000 bicycles**, over **2,000 drug boxes**, **20,000 uniforms**, **1,800 MUAC tapes**, and **2,000 cell phones** would be needed to fill the gap.

For infrastructure, the challenges are just as prevalent. Malawi's population is **84% rural** while **24% is not within 5km** of a health facility. In addition, **51% of iCCM HSAs are residing outside catchment areas** while **41% of EPI outreaches are conducted under a tree.** Many HSAs are also providing iCCM village clinic services out of their homes because they do not have access to a place specifically set aside to deliver services. Not having a structure to practice from, people are less likely to use services delivered under a tree, especially during the rainy season. Also, where structures do exist, they are often specified for a specific program (such as iCCM or family planning) instead of an integrated community health structure that delivers services across programs. Additionally, in hard-to-reach areas where adequate housing may be difficult to find, it is less likely for an HSA to reside in their catchment area. In fact, the issues of inadequate housing for HSAs in their catchment area was highlighted as the **number one priority to address for 13 districts**. Training facilities are also a consideration. There are currently 3 PHC Training sites which is positive, but not sufficient for large scale training activities and they also require renovation.

For supervision and management, transport and communication infrastructure represent key bottlenecks. Supervision and coordination are critical to achieving quality, consistent community health services but without functioning vehicles or internet at national and district levels the health system is held back. Due transport shortages, SHSA's and AEHO's do not visit all HSA catchment areas on a regular basis and only conduct a subset of required supervision at the facility. Guidelines recommend monthly supervision of HSAs, but reports show **3-4 time are year** is the average. It was noted in interviews that most supervision and all mentoring was done at the health facility.

Community Health Prioritization (Community Engagement)

Malawi has an extensive history of working with community members to support community health services. Each health center has a Health Center Advisory Committee which works to ensure communities receive the service they expect and who work closely with Village Health Committees. Village Health Committees provide promotion outreach services in the community by working closely with HSAs. Their work complements the preventative and curative services of the HSA and other CHWs. VHCs and other community involvement from local leaders such as chiefs and TAs as well as local governance structures have even played a role in mobilizing resources towards constructing community health structures and transport resources to collect drugs and supplies from health centers. Unfortunately, these examples are more the exception than the norm and broad, consistent expectations of communities are unclear. CHWs such as HSAs are often not directly accountable to their communities, while groups such as VHCs or CHAGs have not all been trained or oriented to their roles. Also,

there are examples of partners and programs starting new community groups thereby weakening existing CHVs and community groups instead of reinforcing them. Weak community systems then struggle with lower community awareness for services that are available.

A significant gap in all of this is data. Although specific examples exist there is a lack of a holistic view of how many CHVs and functional groups there are supporting community health that would allow a more proactive and focused effort. Without information on existing groups it will be difficult to formalize community roles in owning and managing community health.

Leadership and Coordination

To manage the health system appropriately there must be long-term goals and alignment towards common objectives. Unfortunately, Malawi has never had a National Community Health Strategy or Policy before and so it has been left to specific programmes to implement their long-term plans without fully coordinating around implementation and roles at the community level. This has led to inconsistent or unclear objectives, targets, and prioritization of tasks. It is also a large contributing factor to seeing HSA workload and tasks expanded so rapidly without cross-cutting oversight or guidance on the role of community level workers. Guidelines have been developed, but without the stronger coordinating mechanism of a strategy or policy or widespread stakeholder engagement, they have been difficult to implement. However, the initiative to develop a National Community Health Strategy and the development of the HSSP II have started to provide platforms to address these challenges. Partners are also supporting an increased coordinating structure for community health to move towards more integrated service delivery and a more integrated system overall.

Integration is thus a major priority for community health that will depend on improved coordination to succeed. The recently formed Community Health sub-TWG which first began in 2016 is a step in this direction which provides a forum for the MoH to call together programs and partners working at a community level to disseminate information and review new initiatives. *Table 18* provides a sample of different activities happening concurrently in Malawi relating to community health. However, significant hurdles still remain. Funding is uneven across programs while competing interests and meetings from development partners further prevent coordination. This means proposal processes or activity planning may not always include relevant stakeholders both because there is not enough time to do so and because priorities across teams and partners may be conflicting. The lack of coordination extends beyond the immediate health system and includes insufficient inclusion of community members, civil society organizations, and other sectors such agriculture or education working within the communities. Integration and a movement towards a more holistic and efficient use of resources will not be possible without changes both in the way implementing programs approach community health and in the way that the MoH tries to manage it.

Management processes and quality are another area which came up during consultations. Core management practices such as team planning and alignment, meeting coordination, assigning responsibilities and roles, and establishing communication standards and protocols all were identified as being barriers to effective leadership and coordination within the community health system. Tools such as a key contact list or a shared team calendar are either not in use or easily accessible. While overall, management practices receive significantly less attention than technical knowledge even though the primary challenges preventing coordination and integration are management related.

Consultative Workshops for NCHS Development

The figure below summarises the participants, objectives, and approach for each consultation activity, and the section below summarises the key findings from each activity.

FIGURE 18: CONSULTATION PROCESS TO DEVELOP THE NCHS

Activity	Participants	Objectives	Approach
Situation Assessment Aug 2016 – Jan 2017	• +30 MOH officials, +100 District officers, and +10 development partners • +20 sources and reports	• Develop a common view of the CH system • Identify strengths and issues (+100) • Support key planning processes (HSSP II)	Interviews, meetings, literature review
Five Zonal Stakeholder Workshops 7 – 16 February 2017	• +350 participants • DHMT, DCs, TAs, HSAs, VHCs • National & district technical officers • NGOs and other sectors	• Promote district-level ownership and communication • Prioritise key issues (+60) • Identify and prioritise key activities to address issues (+200)	Five one-day consultative workshops with group work
National Stakeholder Workshop 2 March 2017	• ~100 participants • National MoH officials and other sectors • National NGOs & development partners	• Promote national-level CH prioritisation • Promote national-level CH prioritisation • Promote national-level CH prioritisation •	One-day consultative workshop with group work
Writing retreat 6-10 March 2017	• CHS section • Key MoH national officials • Key partners, NCHS consultants	• Review learnings from activities • Identify and make key decisions • Align on core components of NCHS • Outline implementation plan	Five-day interactive workshop
National Stakeholder Workshop	• ~100 participants • National MoH officials and other	• Solicit input on the draft NCHS	One-day consultative workshop

5 April 2017	sectors • National NGOs & development partners		
Writing retreat April 2017	• CHS section • Key MoH national officials • Key partners, NCHS consultants	• Finalise NCHS decisions, based on input from the national workshop • Review and sequence activities within the implementation plan	Interactive workshop

FIGURE 19: ISSUES AND ACTIVITIES PRIORITISED BY WORKSHOP PARTICIPANTS, BY THEMATIC AREA

Thematic Area	Issues prioritised by participants	Activities prioritised by participants
Health services delivery *Definition: Alignment on services meant to be delivered at community level, clarity of roles in the health system, proper and coordinated training, and systems and guidelines to ensure sufficient and consistent quality of services.*	• Lack of clarity on roles and functions of different actors within the community health system • Lack of community engagement on matters affecting their health • Limited integration of health services at the point of care	• Providing clarity on CHW roles • Building capacity of structures and systems at the community level • Improving partner and departmental integration of health services at the point of care through awareness and district implementation plans
Human resources *Definition: Workforce that is sufficient, equitably distributed, supervised, accountable, and properly incentivised to community health workforce to thrive and fulfil their roles.*	• Shortage of community health workers, particularly HSAs • Uneven distribution of community health workers across Malawi • Sub-optimal performance of community health workers due to inadequate training and poor supervision	• Increasing the number of CHWs in the system • Distributing HSAs more evenly across the country by encouraging them to remain in their catchment areas and enforcing the existing HSA deployment policy • Improving incentives, training, and supervision for all CHWs
Information, communication, technology *Definition:* Critical to managing a large, decentralised CH workforce, assessing health outcomes, and coordinating across programmes and geographies with technology enabling more effective information and communication.	• Lack of integrated data collection tools and systems • Uneven data quality • Inaccessibility of data at the community level	• Harmonising data systems and collection mechanisms • Improving data collection quality through CHW training and supervision • Creating regular feedback loops between the community and the health facility through monthly data validation meetings and quarterly meetings for districts to report back to village health committees

Thematic Area	Issues prioritised by participants	Activities prioritised by participants
Supply chain and infrastructure *Definition: Effective community health requires a functioning supply chain and infrastructure that can support even hard to reach areas with equipment, vaccines, drugs, and other supplies needed.*	• Supplies shortages due to poor supply chain management and funding gaps • Insufficient infrastructure, particularly clinic shelters and HSA housing • Inadequate and low-quality transport	• Improving supply chain management through training and improved systems • Lobbying for additional resources from the MoH and partners • Constructing additional infrastructure such as clinics and housings for HSAs • Providing adequate and durable transport, such as high-quality bicycles and sufficient fuel
Community engagement *Definition: Community health is an essential part of Malawi's health system but in order to be successful it requires both community ownership and policy level attention in order to secure community, government, and external resources.*	• Insufficient community-level engagement, participation, and ownership of community health • Lack of strong community-level structures and insufficient clarity on their roles and responsibilities • Inadequate policy-level attention and support for community health	• Improving community-level ownership by engaging in joint planning • Providing clarity on and building community level structures • Prioritising community health at the national policy level
Leadership and coordination *Definition: Having effective and institutionalised planning and management practices, enables resources to be used in an efficient, actionable way and coordinated across different stakeholders.*	• Insufficient coordination between national, district, and community levels of health system • Inadequate coordination of planning and implementation of activities at the district level • Limited devolution of the health sector and health activities	• Improving coordination between all levels of government by developing a community health strategy and creating more fora for coordination • Improving coordination of partners and activities at the district level through stakeholder mapping and joint work planning • Facilitating devolution of the health sector by briefing stakeholders on governance structures and enforcing existing policies

Annex C: Full list of community interventions within the Essential Health Package (EHP)

Figure 20 lists all EHP interventions that are provided at the community level. Interventions that have a yellow box with an "x" are those only performed by CHNs or CMAs and are not provided by other CHWs such as CHVs, HSAs, SHSAs, or others.

FIGURE 20: LIST OF EHP INTERVENTIONS IMPLEMENTED AT COMMUNITY LEVEL

Category	Intervention	Only Done by CHNs/CMAs
RMNCH	Tetanus toxoid (pregnant women)	
	Deworming (pregnant women)	X
	Daily iron and folic acid supplementation (pregnant women)	X
	Syphilis detection and treatment (pregnant women)	X
	IPT (pregnant women)	X
	ITN distribution to pregnant women	
	Injectable	
	Pill	
	Male condom	
	Child Protection	
Vaccine Preventable Diseases	Rotavirus vaccine	
	Measles Rubella vaccine	
	Pneumococcal vaccine	
	BCG vaccine	
	Polio vaccine	
	DPT-Heb-Hib / Pentavalent vaccine	
	HPV vaccine	
Malaria	Uncomplicated (adult, <36 kg)	X
	Uncomplicated (adult, >36 kg)	X
	Uncomplicated (children, <15 kg)	
	Uncomplicated (children, >15 kg)	
	RDTs	X
iCCM	Pneumonia treatment (children)	
	ORS	
	Zinc	
	Community management of nutrition in under-5 - Plumpy Peanut	
	Community management of nutrition in under-5 - micronutrient powder	
	Community management of nutrition in under-5 - vitamin A	

	RDTs for under-5	
	Growth Monitoring	
Environmental	Vermin and Vector Control & Promotion	
	Disease Surveillance	
	Community Health Promotion & Engagement	
	Village Inspections (including emergencies, health and safety)	
	Promotion of hygiene (including hand washing with soap and food safety)	
	Promotion of Sanitation (latrine refuse, drop hole covers, solid waste disposal, hygienic disposal of children's stools)	
	Occupational Health Promotion (including climate change and health)	
	Household water quality testing and treatment	
	Home-based care of chronically ill patients	
NTDs	Schistosomiasis mass drug administration	
	Trachoma mass drug administration	
HIV/AIDS	Cotrimoxazole for children	X
	PMTCT	X
	HIV Testing Services (HTS)	
	ART (all ages)	X
	Viral Load (collection of samples only)	
Nutrition	Vitamin A supplementation in pregnant women	
	Management of severe malnutrition (children)	
	Deworming (children)	
	Vitamin A supplementation in infants and children 6-59 months	
TB	First line treatment for new TB Cases for children	
	First line treatment for retreatment TB Cases for children	
NCDs	Basic psychosocial support, advice, and follow-up	
	Anti-epileptic medication	X
	Treatment of depression (first line)	X

Annex D: Monitoring & Evaluation Responsibilities

FIGURE 21: M&E RESPONSIBILITIES OF VARIOUS STAKEHOLDERS

Stakeholder	*Responsibility*
CHS Section	• Primarily responsible for M&E of the NCHS • Sets M&E guidelines, including indicators and cadence of data collection • Conducts data analysis at national level • Emphasizes data utilization at all levels for decision making • Conducts annual review of the NCHS and leads midterm/final NCHS evaluation • Coordinates M&E efforts with MoH and partners • Sets the research agenda for community health along with partners
HMIS	• Collates data nationally • Conducts data analysis
DHOs	• Collects, collates, and analyses district-level data • Submits high-quality data to MoH • Data utilization for programming and decision making
CHWs	• Collect data for core CH indicators • Conduct basic analysis of data • Disseminate findings to communities
Communities	• Collect data
Partners	• Collect and analyse data • Conduct independent research and evaluation • Synthesise findings and disseminate findings to all levels