Government of Malawi

Ministry of Health

HEALTH SECTOR ANNUAL PROGRESS REPORT

for the 2023-24 Fiscal Year

October 2024

Ministry of Health
P.O. Box 30377,
Capital City,
Lilongwe 3
Malawi

Table of Contents

Foreword

The 2023/24 FY health sector performance report is significant because it is the first annual report of the HSSP III (2023-2030). The Joint Annual Review (JAR) in which this report is presented is also significant in that it is the first all encompassing JAR in years, making a shift from multiple programmatic JARs to one health sector JAR. This year's theme**, *"Achieving Universal Health Coverage Through Integrated Health Care Models and Sustained Community Health Management in Malawi,"*** sums up the spirit of the HSSP III, which focuses on integrated health care delivery and integrated systems especially in primary health care.

The report highlights progress across all the pillars of the HSSP III. These include service delivery, social determinants of health, human resource for health, infrastructure and medical equipment, medical supplies and technologies, digital health, reseach and monitoring and evaluation, health financing and leadership and governance. Despite the progress, challenges persist across all the pilllars that mostly emanate from limited financial resources, structural or organizational and leadership and governance weaknesses. We are committed to addressing these challenges through advancing the HSSP III reforms, especially those that aim to address these three areas.

I wish to express my deepest gratitude to our health workers, development partners, and stakeholders, whose unwavering commitment has been instrumental in the progress we have made. Together, we will continue to build a resilient health system that ensures the well-being of every Malawian.

Dr. Samson Mndolo
SECRETARY FOR HEALTH

Executive Summary

Introduction

The 2023/24 FY health sector annual report marks a pivotal first year of reflection, as the HSSP III was launched in January 2023. This year's theme underscores the reform orientation of the HSSP III; integrated health care delivery is a core reform that is supported by and interconnected with the other game-changer reforms. This report will be discussed in a combined Joint Annual Review covering both HIV and the entire health sector for the first time in many years, an embodiment of this year's theme in action.

Methodology

The report adopts the logic of the HSSP III, where progress is reported by each HSSP III pillar. For each pillar, progress is report as follows:

i. How reforms in each pillar were implemented
ii. How the strategies for each pillar were implemented
iii. Challenges encountered their impact on sector performance
iv. Recommendations.

The report disaggregates performance by district, where possible, to highlight disparities in health outcomes and enable focused attention to underperforming districts for the next planning cycle. Besides tracking HSSP III implementation progress, the report intends to inform the one plan for the 2025/26 FY and any necessary policy adjustments.

Findings

Service delivery

For the service delivery integration reform, the Ministry finalized the development of the Health Service Packages (HSPs) for integrated platforms of care for all levels. The Ministry developed an integration blueprint with three integrated care pathways as follows:

i. Integrated screening
ii. Integrated maternal and child health clinic
iii. Integrated chronic care (HIV/NCD) clinic

The implementation of the integrated pathways commenced in Mangochi for community-based outreach clinics. The Ministry started preparations for the initial learning implementation of the integrated screening pathway in Rumphi and Nkhotakota districts in late 2024.

To promote quality and client safety in health service delivery, Malawi initiated the Stepwise National Quality Improvement Program in all districts. It is a certification program which uses Integrated Quality of Care Standards (QOC) to rate health facilities from star one to star five. In 2023, ~20% (138/800 health facilities) were enrolled in the program and baseline assessments were done. Of the 138 facilities, 71 primary facilities (all one star), 65 secondary facilities (53 facilities with one star, 6 facilities two stars, 5 facilities with 3 stars, and 1 facility five stars) and all five tertiary facilities (3 facilities with one star and 3 facilities with two stars) were assessed in 2023.

In terms of service utilization, OPD attendance per capita was estimated at 1.1 visits per person nationally in 2023. Utilization of health services depends on their availability which means that health facilities must have basic consumables, laboratory diagnostic items and medications available in addition to staffing, equipment and infrastructure to provide services. Within a sample of 1477 facilities in the Malawi Harmonized Health Facility Assessment (MHHFA) 2024, only 2.7% of facilities had all basic equipment traced (see Figure 10). There were higher proportions of facilities with blood pressure machine (88.8%), stethoscope (88.6%) and adult weighing scale (83.9%) but less with an examination light (34.1%) and ophthalmoscope (20.0%). For consumables, most facilities had disposable syringes (93.4%), intravenous cannulas (87.6%) and intravenous infusion sets (83.0%) but less than 5% had sutures.

The low proportion of facilities with essential consumables, medications and diagnostic tests in addition to difficult geography likely led to decreased utilization, and this in part may have led to elevated inpatient death rates in 2023. The overall inpatient mortality rate was 19.3 per 1000 admissions with the highest rates of 56, 43 and 42 in Kamuzu, Zomba and Queen Elizabeth Central Hospitals, respectively (see Figure14). However, there were five districts including Mchinji, Likoma, Karonga, Mwanza and Balaka that had inpatient mortality rates of over 20 per 1000 admissions.

The report highlights progress against selected indicators for reproductive, maternal, neonatal and child health (RMNCH), non-communicable diseases (NCDs) and communicable diseases. For RMNCH, of 1467 facilities surveyed in the MHHFA, most had family planning services (87.5%) but less with antenatal services (55.5%), delivery services (42.8%) and care for small and sick newborns (45.5%) with only 31.6% and 11.3% with basic and comprehensive emergency maternal and delivery services respectively. Sixteen percent of all pregnancies in Malawi were in adolescents aged 15-19 years old. The mean institutional delivery mortality ratio per 100,000 live births was 84 with a wide variation, minimum of 6.5 in Phalombe to a maximum of 491 at Kamuzu Central Hospital. The average

institutional fresh stillbirth rate was 17.7 deaths per 1,000 live births. Sixty-six percent of children under 1 were fully immunized.

For non-communicable diseases (NCDs), while most facilities had a blood pressure machine (88.8%), less than 20% had other basic diagnostic modalities such as a blood glucose test (17.3%), liver function tests (6.3%) or renal function tests (6.2%). Similarly for medications, about half of facilities had a type II diabetes medication (metformin 63.9%) and antihypertensives (54%) but only 11.2% had insulin for type I diabetes and 3.3% had fluoxetine for depression treatment. The overall accident and injury mortality rate for Malawi was estimated at 1 per 100,000 population. There were extremely high accident and injury mortality rates in Mzimba-South, Karonga and Thyolo at 6.8, 6.7 and 2.9 per 100,000 people with the rest of the districts having mortality rates less than 2 per 100,000 people. The variable mortality rates may be partly due to the limited availability of essential resources, with only 48.4% of facilities having 24-hour access to a functional vehicle with a driver for patient transport. Additionally, few facilities are equipped with haemoglobin testing (26.4%), blood transfusion capabilities (13.5%), splinting supplies (13.4%), or suture consumables (5.1%).

For communicable diseases, significant progress has been made in HIV management with 87%, 97%, and 93% of children, adult women, and adult men living with HIV (PLHIV), respectively, knowing their status, indicating high case finding rates. Similar to high rates of PLHIV who knew their status, ≥95% of adult PLHIV were on ART and virally suppressed, with children having the lowest values. Malawi has almost achieved the UNAIDS 95-95-95 targets for 2025 with only the diagnosed PLHIV being less than 95%. With the noted success in finding and treating PLHIV, the overall adult (15+) HIV prevalence was 7.6% with the highest prevalence in Zomba City and Blantyre city at 17% and 15% respectively and the lowest prevalence in Ntchisi District at 2.6%. Currently, there are only around 14,000 new infections in Malawi per year and only around 56,000 people living with HIV are still undiagnosed. The overall HIV prevalence is estimated to be 8.9%.

For TB, the notification rate was estimated at 89.7 cases per 100,000 population. Only 15.1% of facilities had diagnostic capacity with TB sputum microscopy or GeneXpert according to the MHHFA. The treatment success rate for TB was estimated at 90.7%. With its high incidence and mortality, malaria is an important communicable disease in Malawi. From the MHHFA 2024 survey, over 95% of facilities provided diagnosis or treatment of malaria with high availability of malaria rapid diagnostic tests (94.2%). Prevention efforts such as intermittent preventative treatment was available in about 50% of facilities with most pregnant women and children receiving nets in the high incidence areas. With these efforts,

the overall incidence of malaria has decreased from 407 cases per 1000 population in 2016 to 328 in 2023.

Social determinants of health

Factors outside of healthcare, such as housing, education, and access to clean water, have a more substantial impact on population health than the healthcare sector itself. Addressing these determinants is critical to achieving health equity and fostering overall well-being. A total of 814,800 out of 4,200,000 households were reached with information and communication on personal health (e.g., nutrition, disease prevention); environmental factors (e.g., water sanitation and hygiene, safe housing, occupational health); and community, social, and civic life (e.g., individual and community interactions, health policies, human rights). The ministry conducted an inspection of food and fortification monitoring. Ninety seven percent of the salt that was monitored was found with iodine, 96% was properly labelled and 94% was well packaged. During the same period, of the food stuffs that were inspected 99% were found to be fit for human consumption. Of the food premises that were audited only 59% were satisfactory and of the food handlers that went for medical examination only 54.7% were certified fit.

In March 2023, Malawi was hit by Tropical Cyclone Freddy which impacted numerous districts in the southern region of the country. It is estimated that over 2,267,458 individuals, representing 11 percent of the total population, were affected with more than 659,278 displaced and 679 reported deceased, along with 537 individuals missing and over 2,186 injured. Tropical Cyclone Freddy struck when Malawi was experiencing one of the worst cholera outbreaks in recorded history with 59,060 cases and 1,769 cholera – related deaths (CFR=3.0%) reported across all 29 districts by the end of October 2023. In a notable achievement for climate and health integration, Malawi secured climate financing worth $36 million from the Green Climate Fund (GCF). A national Multi-Hazard RCCE Strategy was developed as a comprehensive framework to improve risk communication and community engagement in times of crisis.

Infrastructure and medical equipment

The Ministry of Health started discussions and necessary planning work with district health offices and prospective funders to upgrade initial health centres to community hospitals in Blantyre, Lilongwe and Mzuzu in line with the reform to decongest central hospitals by strengthening primary and secondary care. This initial planning work will be integrated into the Capital Investment plan currently in development. The Ministry also procured specialised equipment to start the establishment of an ophthalmology centre of excellence at Kamuzu Central Hospital and allocated resources for the establishment of a cardiac

centre of excellence at Queen Elizabeth Central Hospital. Initial equipment were procured and HRH capacity building commenced for the cardiac centre of excellence. The establishment of the national cancer treatment centre progressed being at 95% completion.

The following projects were completed: Lilongwe Institute of Orthopaedic and Neurosurgery (LION) phase 1, Zomba Infectious Disease Unit, Nancholi Health Centre, area 23 Health Centre, Makina Health Centre, and MDR TB isolation wards in Karonga, Rumphi, Mzimba, Kasungu, Balaka, Zomba, QECH, KCH and Nsanje. The Ministry working with NLGFC completed wide ranging rehabilitations of health facilities in Chikwawa, Balaka, Kasungu, Dowa, Mzimba, and Chitipa.

The Ministry of Health started the development of standard health infrastructure guidelines to ensure consistency in the design and construction of health facilities across all levels of care. The guidelines will align with the Health Service Package (HSP).

Human resources for Health

The Ministry made progress in implementing HRH reforms. For the first HRH reform, the development and implementation of a robust performance management system, orientation was successfully conducted for all District Health Offices (4 people per district), Central Hospitals, the Ministry of Health (MoH) headquarters, and the Health Service Commission, establishing a foundation for consistent workforce accountability across the health sector. The implementation of PMS progressed well in districts such as Lilongwe, Dedza, Ntcheu, Mchinji, Zomba, Mangochi, Blantyre, and Phalombe. For the second HRH reform, evaluating and re-engineering health worker cadres to reflect the changing pattern of the burden of disease, the Ministry of Health commissioned a holistic health worker cadres review, and the report was nearly completed. For the third reform, in-service training integration, the Ministry of Health commissioned work to develop an integrated in-service curriculum and the report was almost completed. A CPD harmonisation taskforce was also established under the Quality management directorate to spearhead this work. An integrated CPD pilot, supported by GIZ, is underway in Ntcheu, focusing on standardizing in-service training for all health cadres. This pilot will serve as a model for scaling CPD nationally to enhance skills consistently across districts.

The total number of health workers increased from 34,287 in 2019 to 45,508 in 2023, representing a growth of approximately 32.7% over five years. The 2023/24 period saw a significant total of 6,830 new recruits. Nevertheless, high vacancy rates persisted. The Pharmacy Technicians cadre had the highest vacancy rate (48%), followed by the Nurse/Midwife Technician cadre at 42%, Laboratory Technicians (42%), and Medical

Officer/Specialist category (41%). Lower vacancy rates were seen in Nursing/Midwifery Officers (11%) and Clinical Officers/Technicians (16%).

Medical products and technologies

The Ministry of Health started the establishment of a Logistics Management Unit (LMU) to improve pharmaceutical and health product management in response to the reform for this pillar which aims to achieve supply chain integration. A Program Management Office was established in 2023 to develop an LMU blueprint. The Ministry also released the sixth edition of the Malawi Standard Treatment Guidelines (MSTG) and Essential Medicines List which were long overdue for review. One highlight from the review was the incorporation of the Access, Watch and Reserve (AWaRe) categorization for antibiotics. To strengthen the rational use of medicines and mitigate pilferage, the Ministry introduced dispensing guidelines. The national medicines quality control laboratory at PMRA received accreditation in February 2024 (ISO/IEC 17025;2017) which means medicines can now be tested locally. Another significant initiative that was implemented was the migration of the electronic health information network (eHIN) platform from a subscription-based model to an open-source system.

Digital health

The reform on electronic health record is being implemented through the MaHIS which is a comprehensive patient information system that will see all patients being managed under one integrated system. The MaHIS is aimed to reduce redundancy in patient systems and ensure a streamlined one system approach for all programs. Key progress include for the MaHIS includes the development of an emergency module which is being piloted at QECH Adult Emergency and Trauma Centre (AETC), the development of an OPD module and ongoing development of other modules such as antenatal, labour and postnatal, non-communicable diseases (NCDs), immunization registry and an in-patient module (IPD).

Use of the National ID is a key reform area that presents many opportunities including enhancing patient identification and health financing. The MOH joined other ministries in using the National ID. The primary use case is patient registration and identification at point of care. This is being tested in Karonga in five health facilities namely Chilumba Garrison, Chilumba Rural, Kaporo HC, Karonga District hospital and Nyungwe HC.

Health research and monitoring and evaluation

One of the key strategies under health research is to build health research capacity in public, private, research, and academic institutions. About 276 people were trained in different topics such as manuscript writing (2), policy brief (30), small grants writing (105), data

analysis using R (5), research methodology (127), evidence-based informed decision making (2), and financial management for donor-funded projects (5). The key initiatives under monitoring and evaluation included the DHIS2 mobile scale-up initiative which involved training of 1506 staff. The scale up allows health centres to directly enter data into the DHIS2 system, streamlining the data flow process. The Ministry also conducted data management training for newly recruited clerks and production of health information system data bulletin based on DHIS2 data (national & district Bulletins).

Leadership and governance

The reform under this pillar is the implementation of a One Plan, One Budget and One Report. The first One Plan was developed for the 2023/24 FY. For the One Budget, in the 2023/24 FY, the Senior Management of the Ministry decided to move towards a single Project Implementation Unit (PIU). Further, a consultancy was commissioned to explore the design of the single PIU. A study tour was also conducted to Ethiopia and Rwanda to learn about their single PIUs. Another major milestone was the introduction of a health facility planning tool which is intended to provide the foundation for a comprehensive "One Plan, One Budget, One Report" at the facility level.

Many TWGs performed well in terms of meetings while the health sector working group and leadership and governance TWG were among the weakest TWGs despite their critical importance. The infrastructure and medical equipment TWGs were also very weak.

The Ministry commenced a process to develop a health sector devolution plan to further deepen health sector decentralization. Stakeholder meetings were conducted to draft the plan.

Health financing

According to the 2023/24 One plan, between the Ministry of Health and external partners, financial contributions totalled to $565,320,484.46 for the 2023-2024 fiscal year. Over the years, Government expenditure on health has steadily increased from MK125 billion in 2017/18 to MK330 billion in 2023/24. However, as a ratio to the national budget, the proportion has remained below the Abuja Declaration target of 15%. The proportion dropped by 0.4 percentage points, from 9.4% in 2021/22 to 9.0% in 2022/23 and remained constant in 2023/24.

The Ministry engaged the Ministry of Finance and economic affairs and other government stakeholders on the possibility of establishing a health fund through ear-marked taxes. A joint Ministry of Finance and Ministry of Health taskforce was set up to drive agenda. The Ministry of Health also engaged the private sector to strengthen their involvement in

healthcare financing and delivery in the country. The Ministry successfully implemented a Direct Facility Financing (DFF) pilot in Rumphi. DFF is being scaled up to 13 more districts which are Blantyre, Ntchisi, Chitipa, Nsanje, Neno, Dedza, Salima, Balaka, Machinga, Chikwawa, Lilongwe, Nkhotakota and Kasungu.

Key recommendations

- Launch a targeted Quality of Care (QoC) improvement program for facilities currently rated with one or two stars.
- Accelerate investment in clean water, sanitation, and hygiene (WASH) infrastructure, focusing on regions prone to waterborne diseases.
- Implement targeted nutrition programs in high-need areas, particularly for vulnerable groups like children and pregnant women.
- Equip communities, especially in flood-prone areas, with training and resources for emergency preparedness and climate adaptation
- Leverage the Integrated Human Resource Information System (iHRIS) for data-informed decision-making on recruitment, deployment, and retention strategies.
- Train healthcare providers on best practices for medication use to reduce waste and ensure consistent availability for patients.
- Engage community leaders in health planning and decision-making to better align services with local needs and improve accountability.
- Provide targeted training for district health officers and facility managers on strategic planning, resource management, and operational oversight.

Focus spending on cost-effective, high-impact health services that address urgent needs and improve overall health outcomes.

List of Abbreviations

ADC	Area Development Committee
AEFI	Adverse Events Following Immunisation
AETC	Adult Emergency and Trauma
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ARI	Acute Respiratory Infections
ART	Antiretroviral therapy
BCG	Bacille Calmette-Guerin
BEmONC	Basic Emergency Obstetric and Newborn Care
bOPV	Bivalent oral polio vaccine
CAC	Comprehensive Abortion Care
CBMNC	Community based maternal and newborn care
CDD	Community Directed Distributors
CECAPO	Cervical Cancer Prevention and Control Program
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHAI	Clinton Health Access Initiative
CHAM	Christian Health Association of Malawi
CHISU	Country Health Information Systems for Data Use
CMED	Central Monitoring and Evaluation Division
COP	Conference of Parties
COPD	Chronic Obstructive Pulmonary Disease
COVID	Coronavirus Disease
CPD	Continuous Professional Development
CPR	Contraceptive Prevalence Rate
CT	Computed Tomography
CUR	Contraceptive Utilization Rate
DCCMS	Department of Climate Change and Meteorological Services
DDF	Direct facility financing
DDT	Dichloro-diphenyl-trichloroethane
DHA	Department of HIV/AIDS
DHD	Digital Health Division
DHIS	District Health Information Software
DHMT	District Health Management Team
DHO	District Health Office
DHRMT	Department of Human Resource Management and Development
DMPA-SC	Depot-medroxyprogesterone acetate self-injectable contraception

DPT	Diphtheria
DQM	Data quality management
DR	Drug Resistance
DST	Drug Susceptibility Testing
EC	Emergency Contraceptives
EHO	Environmental Health Officer
EHP	Essential Health Package
EHS	Environmental Health Services Section
eIDSR	Electronic Integrated Disease Surveillance and Response
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Programme on Immunization
ES	Environmental Surveillance
EWARS	Early Warning Alert and Response System
FP	Family Planning
FSB	Fresh stillbirth
GAVI	Global Alliance for Vaccines and Immunisation
GFC	Green Climate Fund
GIS	Geographical Information System
GIZ	The Deutsche Gesellschaft für Internationale Zusammenarbeit
HAT	Human African Trypanosomiasis
HCCCT	Health and Climate Change Core Team
HCWM	Health Care Waste Management
HCMC	Health Centre Management Committee
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HO	Hospital Ombudsman
HPV	Human Papilloma Virus vaccine
HR	Human Resource
HRH	Health Resource for Health
HSA	Health Surveillance Assistant
HSJF	Health Service Joint Fund
HSSP	Health Sector Strategic Plan
HTA	Health Technology Assessment
HTC	HIV Testing and Counselling
HTS	HIV Testing Services
ICCM	Integrated Community Case Management
iCHIS	Integrated Community Health Information System
IHAM	Islamic Health Association of Malawi

IHRIS	Integrated Human Resource Information System
IMCI	Integrated Management of Childhood Illness
IMMR	Institutional Maternal Mortality Rate
INMR	Institutional Neonatal Mortality Rate
IPC	Infection Prevention and Control
IPTp	Intermittent Preventive Treatment
IPV	Inactivated polio vaccine
IRS	Indoor Residual Spraying
ISS	Integrated Supportive Supervision
ITN	Insecticide Treated Net
IUD	Intrauterine device
KCH	Kamuzu Central Hospital
KUHES	Kamuzu University of Health Sciences
LA	Artemether Lumefantrine
LAPA	Local Authority Performance Assessment
LF	Lymphatic Filariasis
LLIN	Long lasting insecticide net
LSTM	Liverpool School of Tropical Medicine
M&E	Monitoring and Evaluation
MaHIS	Malawi Health Information System
MDA	Mass Drug Administration
MDAS	Ministries, Departments and Agencies
MDHS	Malawi Demographic and Health Survey
MDU	Mobile Diagnostic Units
MH	Mental Health
MHFR	Master Health Facility Registry
MIS	Malaria Indicator Survey
MMDP	Morbidity Management and Disability Prevention
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
MNH	Maternal Neonatal Health
MOEEAC	Malawi Onchocerciasis Elimination Expert Advisory Committee
MoH	Ministry of Health in Malawi
MOU	Memorandum of Understanding
MR	Measles Rubella
MSB	Macerated stillbirth
MSP	Malaria National Strategic Plan
MVA	Manual vacuum aspiration

NAC	National AIDS Commission
NCD	Non-Communicable Diseases
NCDI	Non-communicable Diseases and injuries
NGO	non-governmental organisation
NMCP	National Malaria Control Program
NND	Neonatal death
NSO	National Statistics Office
NTD	Neglected Tropical Diseases
NTLEP	National Tuberculosis and Leprosy Elimination Programme
ODF	Open Defaecation free
OPC	Office of the President and Cabinet
OPD	Outpatient department
ORS	Oral rehydration salt
ORT	Other Recurrent Transactions
PAC	Post abortion care
PCV	Pneumococcal Conjugate vaccines
PHC	Primary Health Care
PHIM	Public Health Institute of Malawi
PIU	Project Implementation Unit
PLWHA	People Living with HIV and AIDS
PMI	President's Malaria Initiative
PMS	Performance Management System
PMTCT	Prevention of Mother to Child Transmission
PS	Principal Secretary
QECH	Queen Elizabeth Central Hospital
QI	Quality Improvement
QIST	Quality Improvement Support Team
QIT	Quality Improvement Team
QMD	Quality Management Directorate
QOC	Quality of Care
RCCE	Risk communication and community engagement
RDT	Rapid diagnostic test
RHD	Reproductive Health Directorate
RLMF	Reaching the Last Mile Fund
RTA	Road traffic accident
SAC	school aged children
SADC	Southern African Development Community
SARA	Service Availability and Readiness Assessment

SATBHSSP	Southern African Tuberculosis and Health Systems Support Project
SCI	Save The Children International
SGBV	Sexual and gender-based violence
SHSA	Senior Health Surveillance Assistant
SIA	Supplementary Immunization Activities
SLA	Service Level Agreement
SOP	Standard operating procedures
SP	Sulfoxide-pyrimethamine
SRHR	Sexual and Reproductive Health and Rights
STH	Soil Transmitted Helminthes
STI	Sexually Transmitted Infections
TA	Traditional Authorities
TAS	Transmission Assessment Survey
TB	Tuberculosis
TBA	Traditional birth attendant
TCV	Typhoid Conjugated vaccine
Td	Tetanus diphtheria
TFR	Total fertility rate
TOR	Terms of Reference
TPT	Tuberculosis preventive therapy
TWG	Technical Working Group
UHC	Universal Health Coverage
UK	United Kingdom
UNCRPD	United Nations Convention on The Rights of Persons with Disabilities
UNDP	United Nations Development Fund
UNFCCC	United Nations Framework Conference on Climate Change
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
V &AA	Vulnerability and Adaptation Assessment
VHC	Village Health Committees
VIA	Visual inspection with acetic acid
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization
WIT	Work Improvement Teams
XDR	Extremely Drug Resistant
YCBDA	Youth Community distribution agent
YFHS	Youth Friendly Health Services

List of Figures

List of Tables

1. Introduction

The Health Sector Strategic Plan III (HSSP III) (2023 - 2030) is the guiding framework for health development in Malawi. Its goal is to improve the health status of all Malawians and increase client satisfaction and financial risk protection towards attainment of Universal Health Coverage. The HSSP III is aligned with Malawi 2063, the long-term country development strategy, that envisions an inclusively wealthy and self-reliant economy, with human capital as one of the critical enablers for sustainable development.

This 2023/24 FY health sector annual report marks a pivotal first year of reflection, as the HSSP III was launched in January 2023. This year's theme *"Achieving Universal Health Coverage through integrated health care models and sustained community health management in Malawi"* underscores the reform orientation of the HSSP III; integrated health care delivery is a core reform that is supported by and interconnected with the other game-changer reforms as follows:

1. Implementation of the “One Plan, One Budget and One report” at the national, tertiary and district levels to strengthen alignment and harmonization of donor and Government funds
2. Increased provider autonomy
3. Increased domestic resource mobilisation and strategic purchasing of health services
4. Development and implementation of a robust performance management system that is linked to implementation of strategic and operational plans at all levels
5. Holistic review of health worker cadres to reflect the changing pattern of the burden of disease
6. Development and implementation of an integrated in-service training curriculum that is linked to a coordinated Continuous Professional Development (CPD) system to generate efficiency savings, and enhance performance
7. Development and implementation of a real time equipment inventory management system
8. Supply chain integration
9. Development of a shared electronic health record (EHR) system to support efficient service delivery
10. Upgrading urban health centres to community hospitals, and community hospitals in the cities to full hospitals to deliver gate-keeping primary care and secondary care services, respectively.

This report adopts the logic of the HSSP III, where progress is reported by each HSSP III pillar. The HSSP III pillars are briefly described below:

1. **Service Delivery:** Expanding equitable access to essential health services, focusing on improving maternal and child health, combating HIV and tuberculosis, and addressing the rising burden of non-communicable diseases.
2. **Social Determinants of Health:** Addressing the broader social determinants that influence health outcomes, including access to clean water, sanitation, nutrition, and environmental health, while promoting wellness and a healthy living environment. This aligns with a vision of creating supportive conditions that enhance overall health and resilience at the community level.
3. **Infrastructure and Health Technologies:** Improving infrastructure and ensuring the availability of essential health technologies. This includes construction, rehabilitation, and maintenance of health facilities, and strategic investments in medical equipment to support quality health service delivery.
4. **Human Resources for Health (HRH):** Enhancing the availability, quality, and equitable distribution of health workers. This pillar focuses on recruitment, retention, and training.
5. **Medical Products and Technologies:** Ensuring availability and efficient use of essential medicines and health commodities including improving procurement processes, enhancing supply chain management, and strengthening rational use to reduce stockouts and wastage.
6. **Digital Health:** Integration of digital health solutions to increase efficiency and support evidence-based decision-making including developing a harmonized digital health system that enables real-time data use, enhances coordination, and improves the quality of healthcare delivery.
7. **Research, Monitoring, and Evaluation:** Strengthening health research as a foundation for evidence-based policymaking, advancing monitoring and evaluation mechanisms to track progress, ensure accountability, and continuously adapting interventions to meet emerging health needs.
8. **Leadership and Governance:** Improving accountability, transparency, and coordination across all levels of the health system
9. **Health Financing:** Strengthening the financial sustainability of the health sector by enhancing resource mobilization, including domestic financing, strategic purchasing and fostering partnerships with development partners.

Progress for each pillar is reported as follows: first, by detailing the implementation of strategies aligned with each objective or pillar; second, by assessing advancements made

in reforms within each pillar; third, by analysing challenges encountered and their impact on sector performance; and lastly, by providing recommendations for improvement. The report disaggregates performance by district, where possible, to highlight disparities in health outcomes and enable focused attention to underperforming districts in the next planning cycle. Besides tracking HSSP III implementation progress, the report intends to inform the one plan for the 2025/26 FY and any necessary policy adjustments.

2. Methodology

The methodology of this report involved collection, consolidation and analysis of thematic reports and data from MoH departments and programmes and districts.

2.1 Data Collection

The District Health Information System 2 (DHIS2) was the primary source of data. DHIS2 aggregates performance data across all districts and health facilities. In addition, supplementary data from programmatic reports, monitoring and evaluation assessments, and other sources were used.

2.2 Analytical Approach

The HSSP III M&E matrix was used to report progress. Since this matrix was not completed during HSSP III development and there is ongoing work to complete it, there was a process to develop indicators for where gaps existed, especially in indicators for reform implementation. For the selected indicators, the following analyses were conducted:

- District comparison to identify disparities in health outcomes and inputs and the need for targeted interventions.
- Trend Analysis: Where relevant, trends over time were examined to show progress or identify areas where additional efforts are required.

3. Pillar Performance

3.1. Pillar 1: Service Delivery

The objective of this pillar is to *"increase equitable access to and improve the quality of health care services"*. Changing health needs, more ambitious health goals and public expectations are raising the bar for health systems to produce better health outcomes and add great social value. As access to healthcare improves, there is a need for equitable distribution of health care measured on quality and competency that is centered on the client experience. Quality of care will become an even larger driver with increased health care utilization and the burden of disease is likely to shift to more complex conditions that require a knowledgeable and flexible workforce.

3.1.1. Implementation of service delivery strategies

Strategy 1: Design systems to create integrated platforms of care from primary to tertiary level

This strategy contains the service delivery reform which is stated as follows in the HSSP III: "*transitioning from vertical programming to integrated platforms of care for service delivery. This will involve developing and implementing a strategic plan for integrated service delivery which will define and deliver integrated platforms of care and maximize synergies across programmes. This will significantly reduce planning, execution and evaluation inefficiencies that come with fragmented service delivery"*. The Ministry of Health (MOH) finalized the development of the Health Service Packages (HSPs) for integrated platforms of care during the period under review. Four HSPs for Health Posts, Health Centres, Secondary Hospitals and Tertiary Hospitals were completed in 2024 and currently in use for guiding health sector essential and standard lists. The MOH also completed an analysis of Integration options and possibilities to inform service delivery integration design with a resulting integration blueprint of three integrated care pathways:

i. Integrated screening
ii. Integrated maternal and child health clinic
iii. Integrated NCD clinic.

A protocol, guidelines and data collection tools for integrated screening were developed while the same documents for integrated chronic care clinics and integrated MNCH clinics will be developed in either in the first half of 2025. The Ministry will start the initial learning implementation of integrated screening in Rumphi and Nkhotakota districts by the end of 2024, with the addition of the chronic and MNCH pathways in the same facilities in 2025.

Integrated outreach clinics have commenced as well in Mangochi under the Primary Impact Initiative supported by USAID. The expectation is that the integration implementation will be scaled to more districts gradually in future. Concurrently, the MOH is developing an operational report focused on the comprehensive review of HRH cadres, health service packages, and integration analysis that will lead to the development of an integrated service delivery strategic plan.

Strategy 2 – Promote quality and client safety in health service delivery across the continuum of care from community to tertiary levels

To promote quality and client safety in health service delivery, Malawi has recently initiated the Stepwise National Quality Improvement Program in selected facilities all districts. It is a certification program which uses Integrated Quality of Care Standards (QOC) to rate health facilities from one-star to five-star. In 2023, around 20% (138/800 health facilities) were enrolled in the program and baseline assessments were done. In 2023, assessments were conducted across 138 enrolled facilities, which included 71 primary facilities (all rated one star), 65 secondary facilities (comprising 53 one-star, 6 two-star, 5 three-star, and 1 five-star facility), and all five tertiary facilities (3 rated one star and 2 rated two stars).

Figure 1:Facilities Baseline Score in stepwise QOC assessment

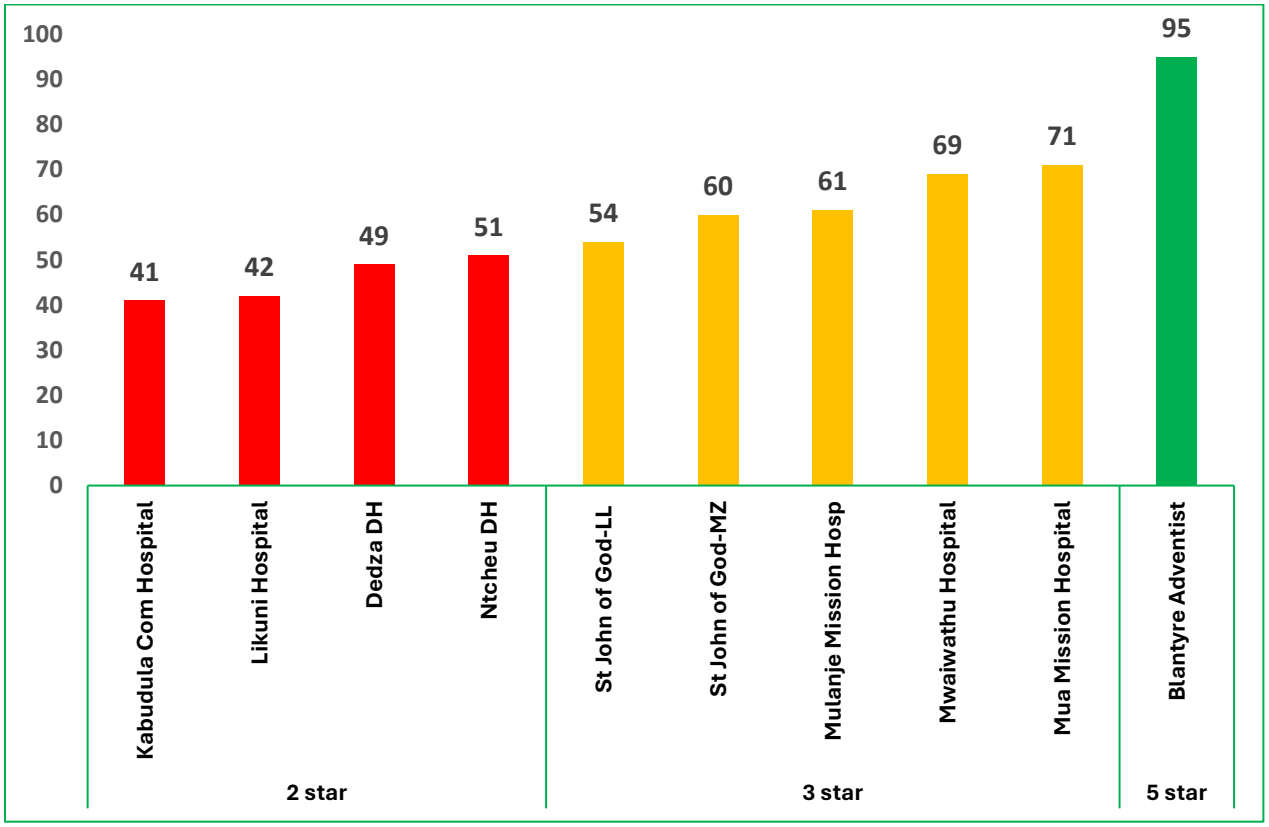
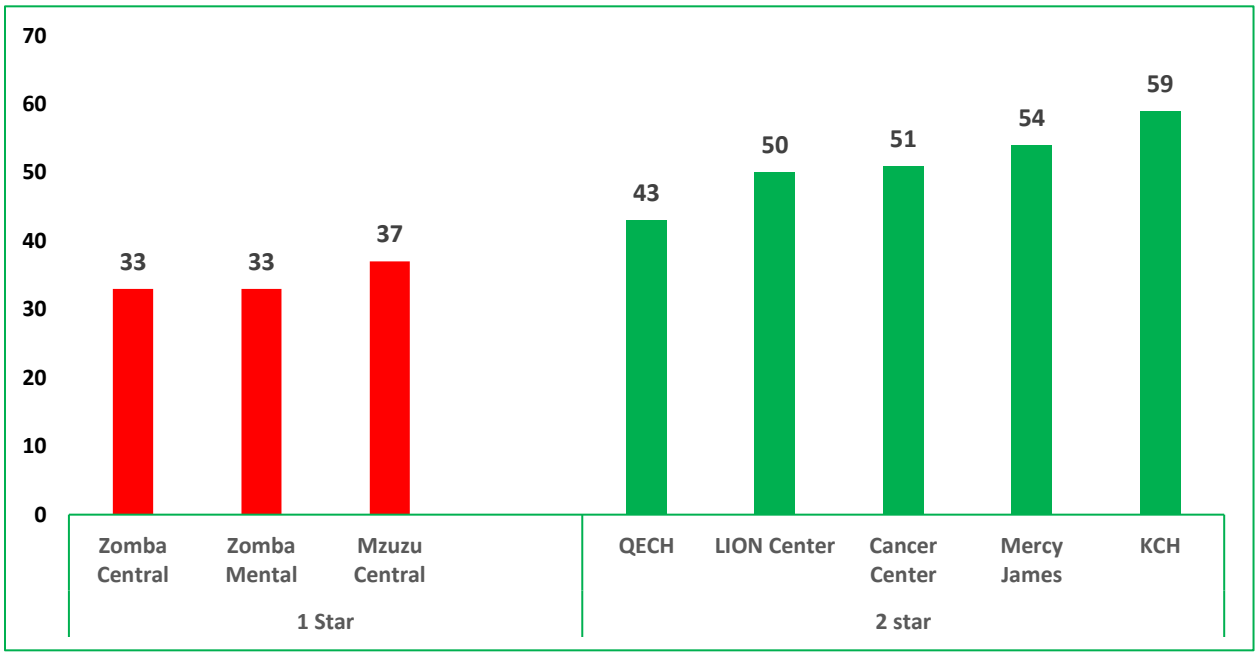


Figure 1 above shows the results of QOC assessments of primary health care facilities by proportion of quality indicators and rating using the stars system. It represents primary facilities in districts in the north, central and southern regions respectively. All primary facilities in Malawi assessed scored one star with proportion of quality indicators 0-40%. For the assessed secondary health facilities, only one private hospital – Blantyre Adventist Hospital scored five stars, which is the highest score in the country. Other secondary facilities including St John of God Mzuzu campus, Mua Mission, Nkhoma Mission and Mulanje Mission Hospitals scored three stars and Kabudula community Hospital, Likuni Mission Hospital, Dedza District, Ntcheu District and Machinga District Hospitals achieved two stars rating level.

Figure 2: Facility performance on stepwise QoC standards

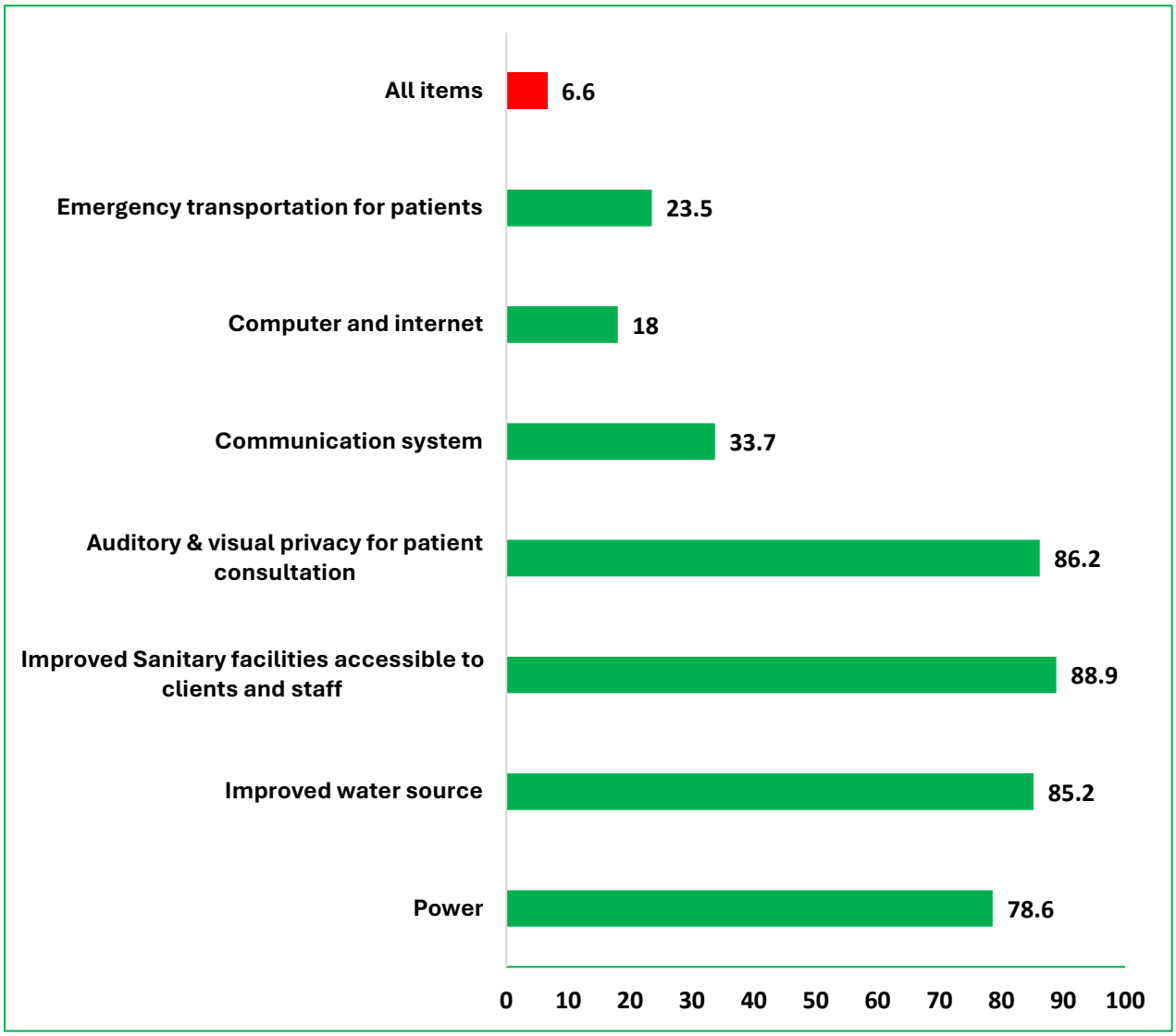


For tertiary health facilities (Figure 2), the two major central hospitals of Queen Elizabeth Central Hospital (QECH) including Mercy James and Kamuzu Central Hospital (KCH) including the Cancer Center and Lilongwe Institute of Orthopedics and Neurosurgery (LION) scored two stars, whereas Zomba, Zomba Mental and Mzuzu Central Hospitals were all assessed to be at the one-star level.

Within the Stepwise National Integrated QOC Standards, there are several tracked quality of care indicators that can enhance or constrain service delivery within Objective 1 and have been tracked in the Malawi Health Facility Assessment (MMHFA) completed in 2024. Common deficiencies in the health facilities assessments included unavailability of

policies, guidelines and standard operating procedures to guide care, inadequate medications and supplies, poor infrastructure and equipment, limited quality improvement initiatives, continuous professional development and governance to guide and improve care provision, unclean health facilities and poor documentation. This correlates directly to findings in the MHHFA 2024 that demonstrate a lack of basic diagnostics, equipment, consumables, medications and available ambulance transport that constrain quality service delivery. For example, while, most facilities had privacy (86.3%), improved sanitation facilities (88.9%), water (85.2%) and power source (78.6%), but less than 35% had communication systems (33.7%), computer and internet (18.8%) and emergency transportation for patients (23.5%). Only 6.6% of facilities had all items available (see Figure 3 below).

Figure 3: Availability of key facility resources



Strategy 3 - Strengthen client-centered care and patient trust at all levels of the healthcare system

Currently, the following structures in health facilities are already in place; the hospital ombudsman and health facility management committees, which are used to get healthcare feedback from patients and communities as part of strengthening client-centered care and patient trust. To better understand user and non-user voices on the health care system, the People's Voice Survey is scheduled be completed in 2025.

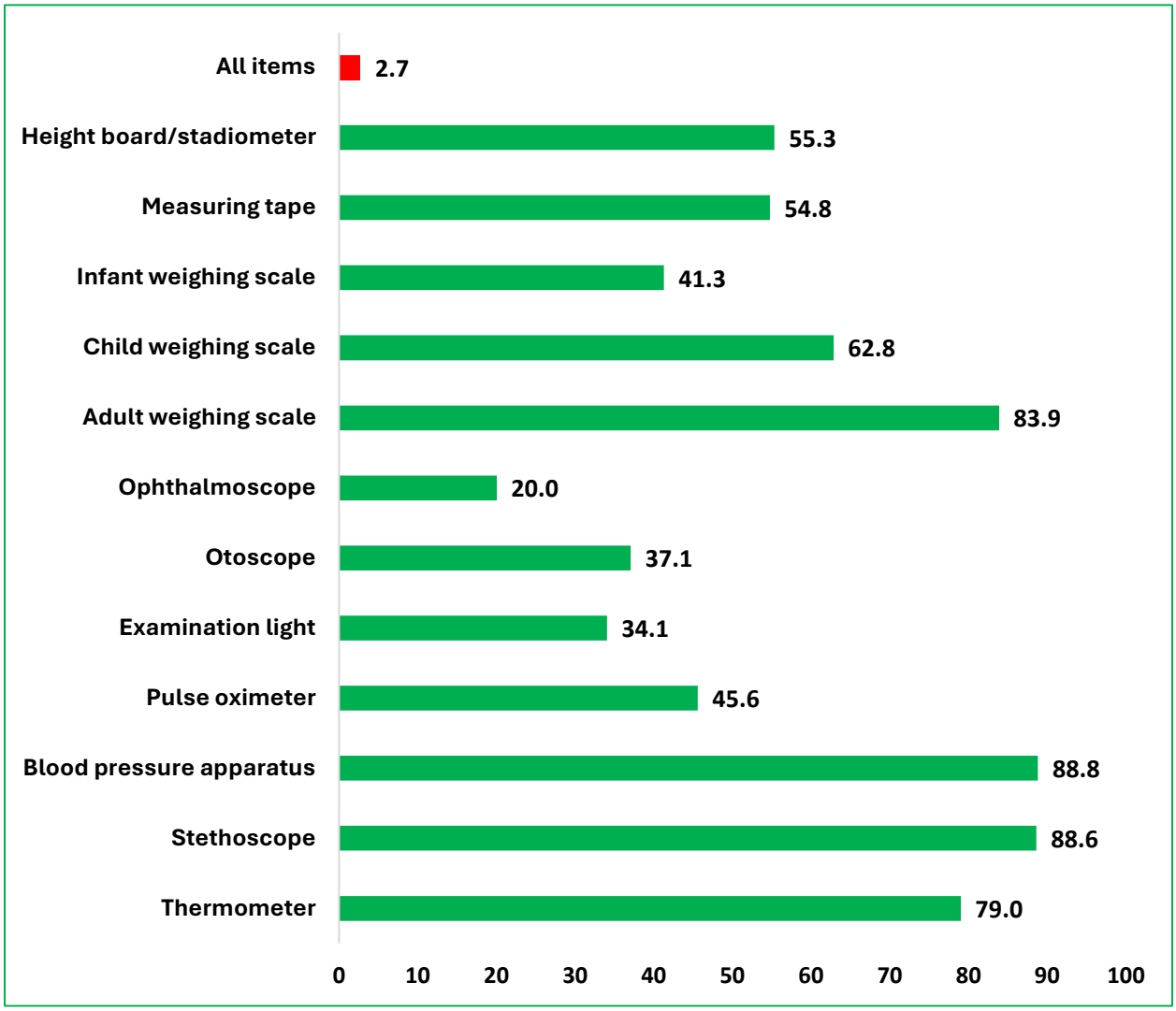
3.1.2. Progress on Health Service Delivery Indicators

In this section we will examine health service delivery indicators with focusing on utilization, resource inputs, direct outcomes by thematic areas and mortality to demonstrate the state of service delivery in Malawi. As we know, provision of care depends on resource inputs to the health sector including human resources for health, infrastructure, diagnostics and equipment, and medications and consumables. Without these inputs, especially in specific thematic areas such as non-communicable disease (NCDs) and reproductive, maternal, neonatal and child health (RMNCH) and community and primary care levels, close to the patient, the utilization of services, outcomes of patients and mortality will be constrained.

3.1.2.1. Health care resource inputs

Utilization and provision of care with resulting health outcomes depends on service availability implying that health facilities must have basic consumables, laboratory diagnostic items and medications available in addition to staffing, equipment and infrastructure to provide high-quality services. Within a sample of 1477 facilities in the MHHFA 2024 (Figure 4), only 2.7% of facilities had all basic equipment traced. There were higher proportions of facilities with a blood pressure machine (88.8%), a stethoscope (88.6%) and adult weighing scales (83.9%), fewer facilities had an examination light (34.1%) and an ophthalmoscope (20.0%).

Figure 4: Proportion of health facilities with basic equipment



Moving to diagnostics, in 2024, the mean availability of tracer items was 27.1% of facilities (Figure 5). Malaria rapid diagnostic test (RDT), HIV testing, urine dipstick for pregnancy and syphilis RDT were the most available all over 50%. However, chemistry and electrolyte testing including liver and kidney function, blood counts and microbiologic culture had <10% availability.

Comparing to 2018, only a few diagnostic tests—specifically haemoglobin, urine glucose, and urine protein tests—showed an upward trend in 2024, while the remaining tests saw a decline (Figure 6). The most commonly available diagnostic test among all facilities was the malaria diagnostic capacity, which was available at 75.5% and 88% of facilities in 2024 and 2018, respectively, followed by HIV diagnostic capacity (70.1% in 2024 and 78% in 2018), urine test for pregnancy (60.2% in 2024 and 57% in 2018), and syphilis rapid test (58% in

2024 and 60% in 2018). The least available diagnostic tests among all facilities in 2024 were the blood glucose and hemoglobin measurement which were only available in 17.3% & 17.7% of facilities.

Figure 5: Facilities with diagnostic capacity items available in 2024

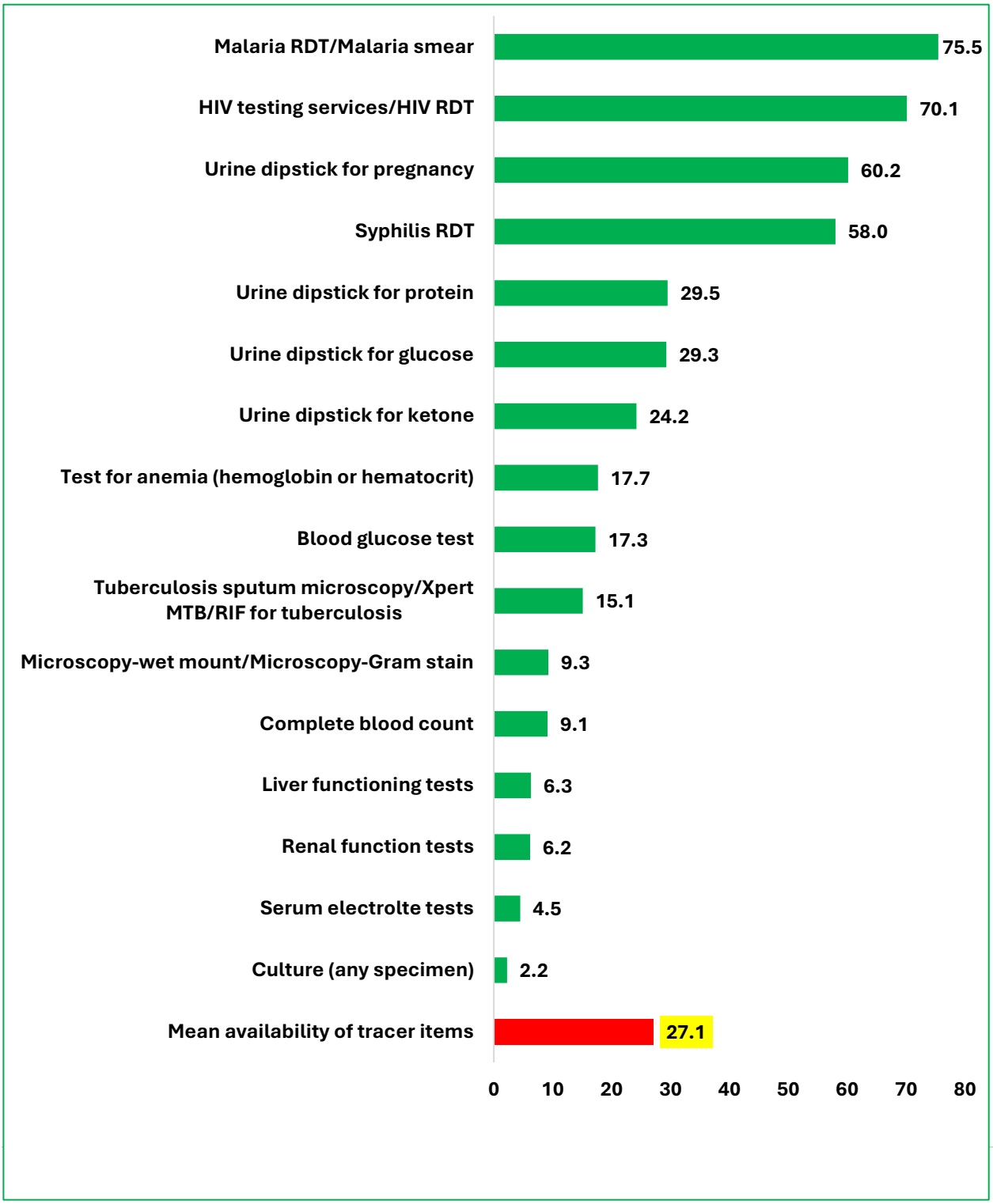
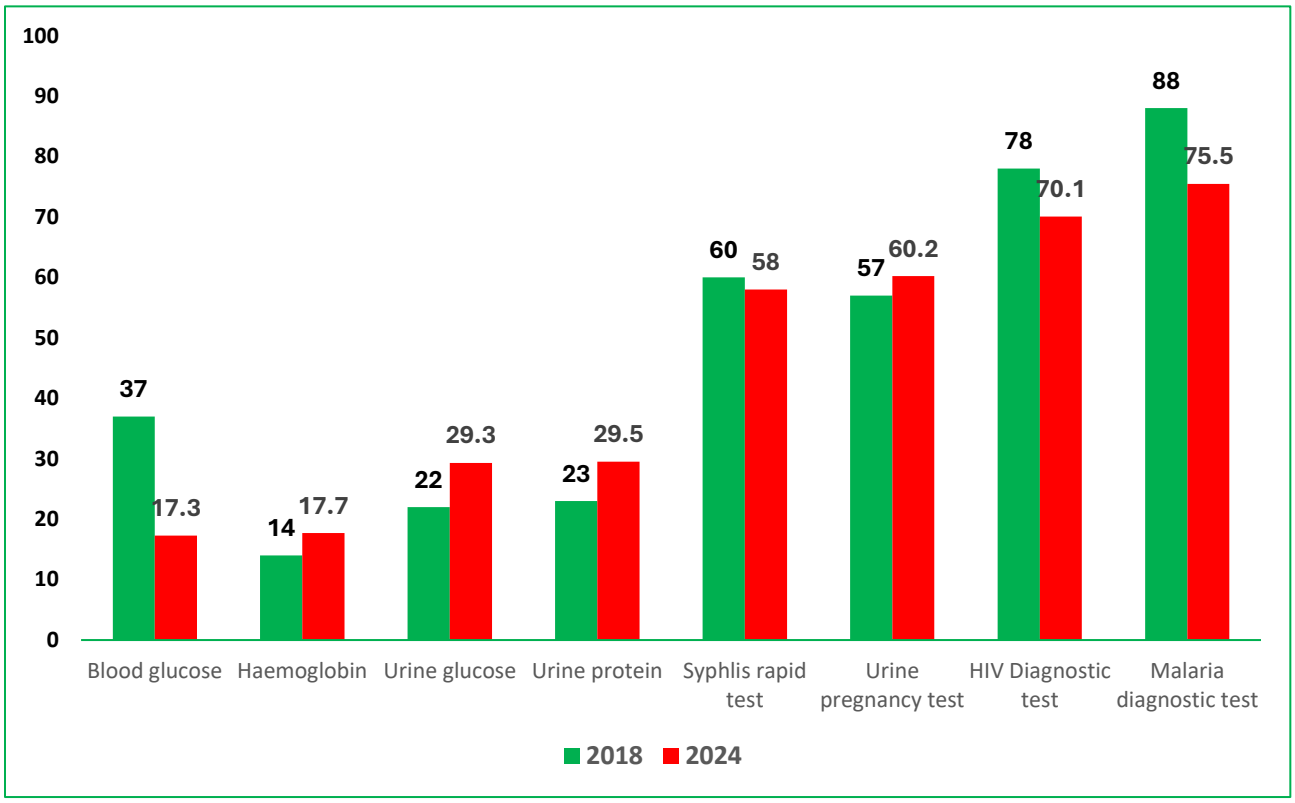
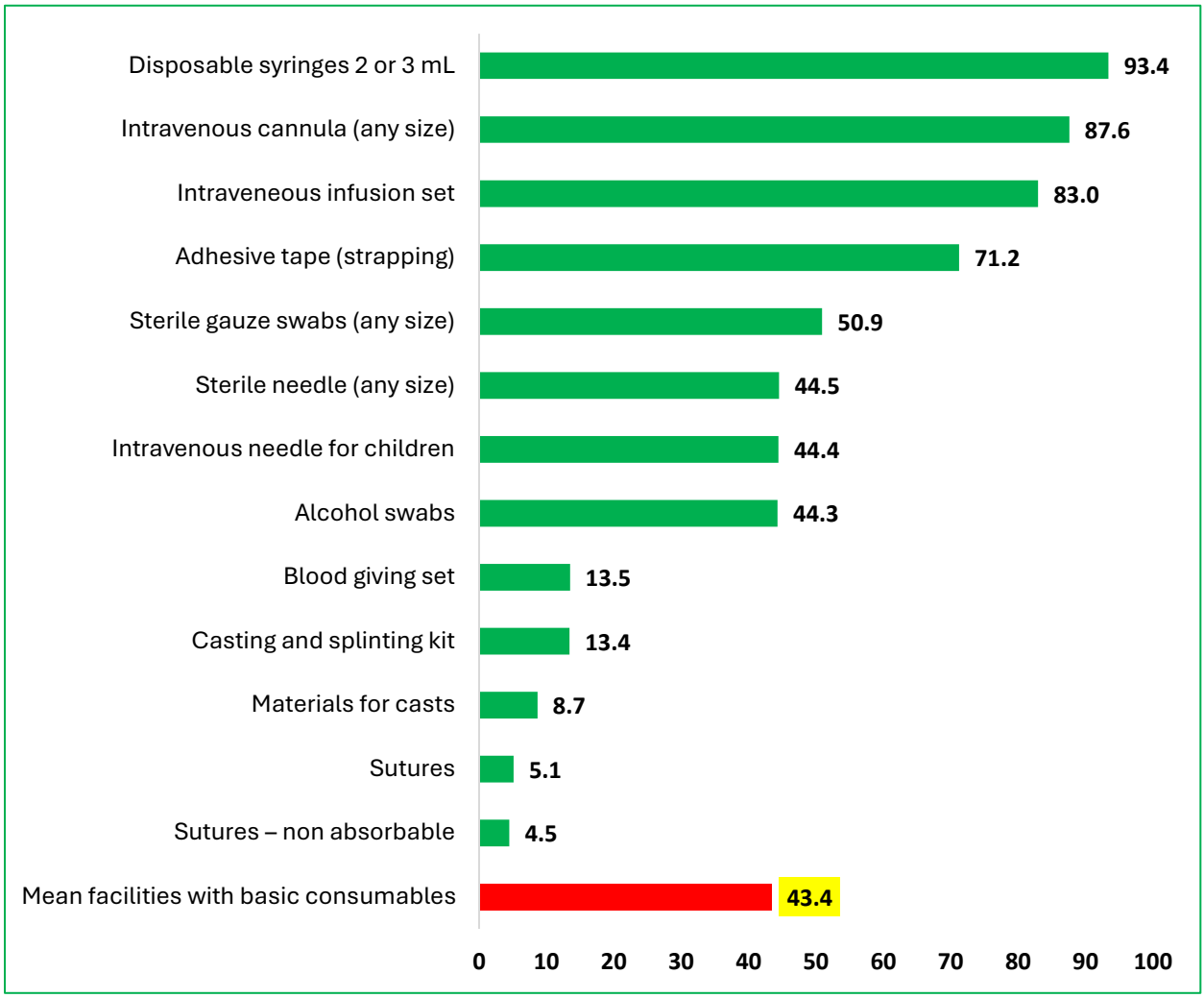


Figure 6: Facilities with diagnostic capacity items available in 2018/19 (n=1106) and 2024 (n=1477)



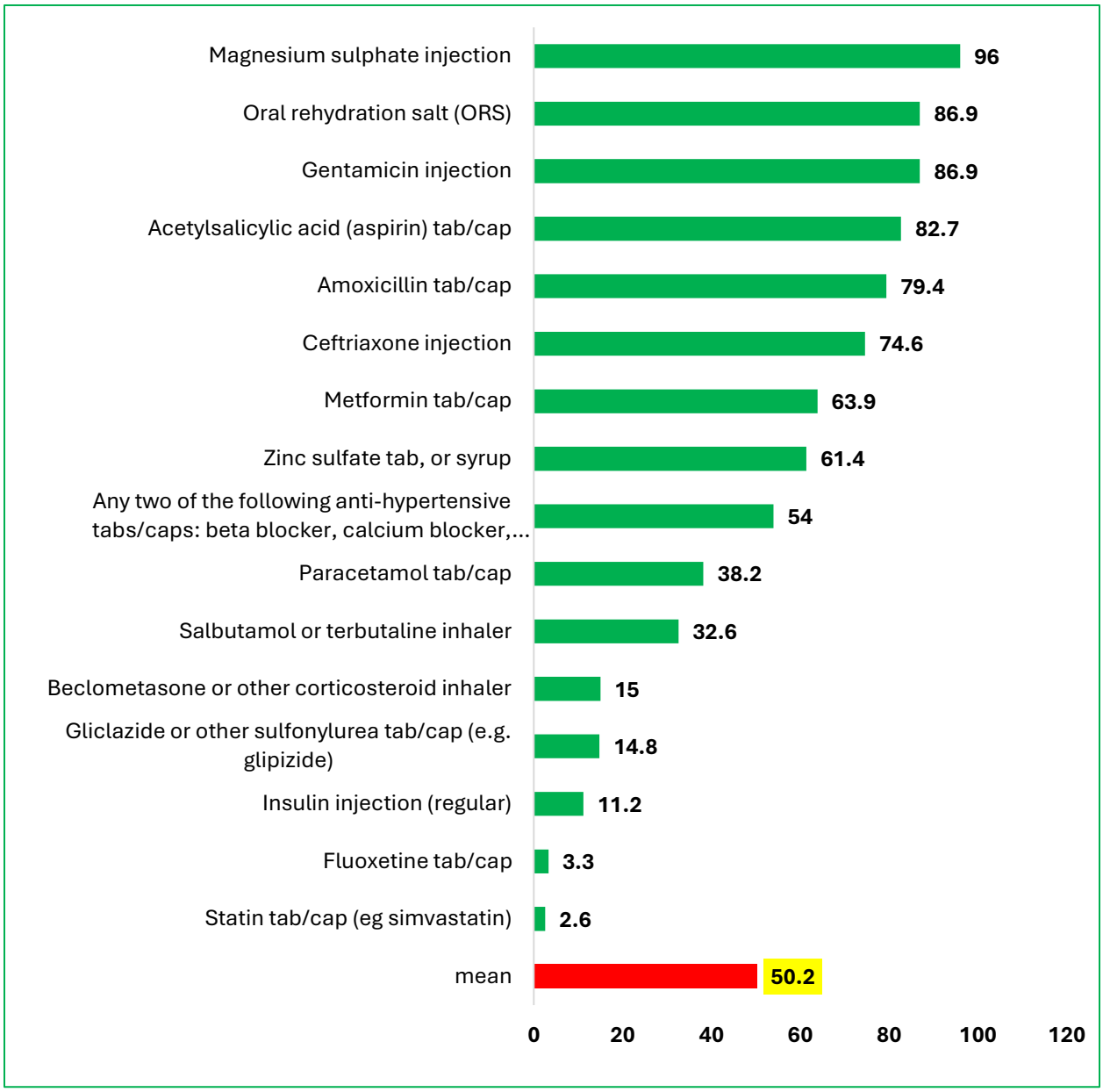
The trend for consumables is very similar. A mean of 43% were equipped with basic consumables tests (Figure 7). Most facilities had disposable syringes (93.4%), intravenous cannulas (87.6%) and intravenous infusion sets (83.0%), with few facilities (less than 20%) having consumables for emergencies such as blood transfusion, casting and sutures.

Figure 7:Proportion of health facilities with basic consumables



In terms of essential medications in 2024 on the MHHFA, on average, out of a total of 1403 facilities, each facility had between 9 and 10 essential medicine items out of a possible total of 16, representing an average of over 50% available items (Figure 8). No facility had all 16 essential medicines on-site on the day of the survey. The most commonly available essential medicines were magnesium sulphate injection (96%) and oral rehydration solution (87%). The least available were statin tablets for elevated cholesterol (2.6%) and fluoxetine tablets for depression and anxiety (3%). In comparison to the MHHFA survey in 2018, 12 of the 16 essential medicines were available at a greater percentage of facilities, including gentamicin injection and magnesium sulphate injection.

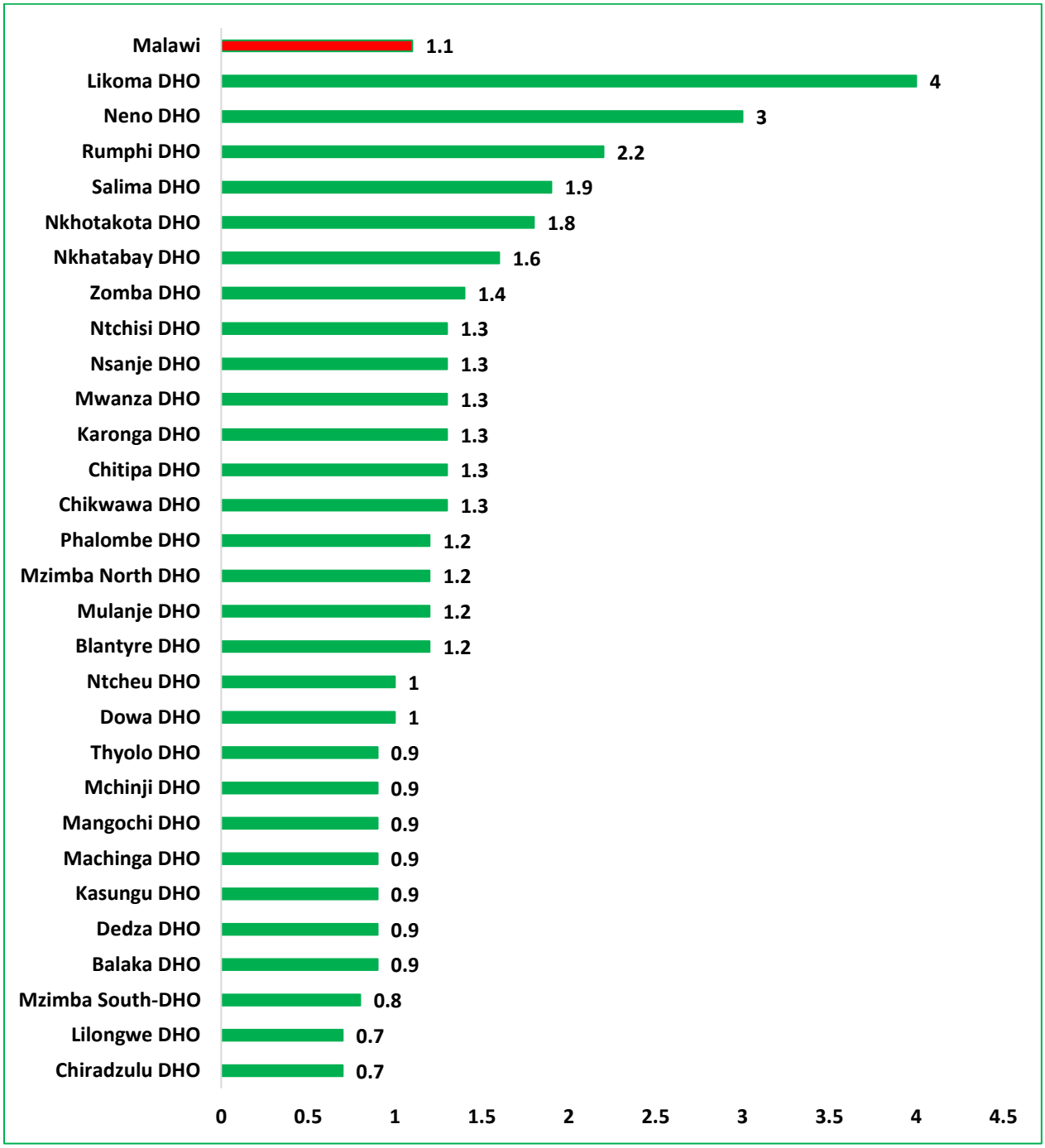
Figure 8: Facilities with essential medicine items available, 2024 (N=1403)



3.1.2.2. Health care utilization

OPD attendance per capita by district ranged from 0.6 visits per person in Lilongwe district to 4.0 visits per person in Likoma district with the overall utilization at 1.1 visits per person nationally in 2023 (Figure 9). This has increased from the Malawi Harmonized Health Facility Assessment (MHHFA) 2018/2019 there was 0.8 outpatient visits per person per year but only 20% of the way towards achieving the outpatient service utilization target of five outpatient visits per person per year.

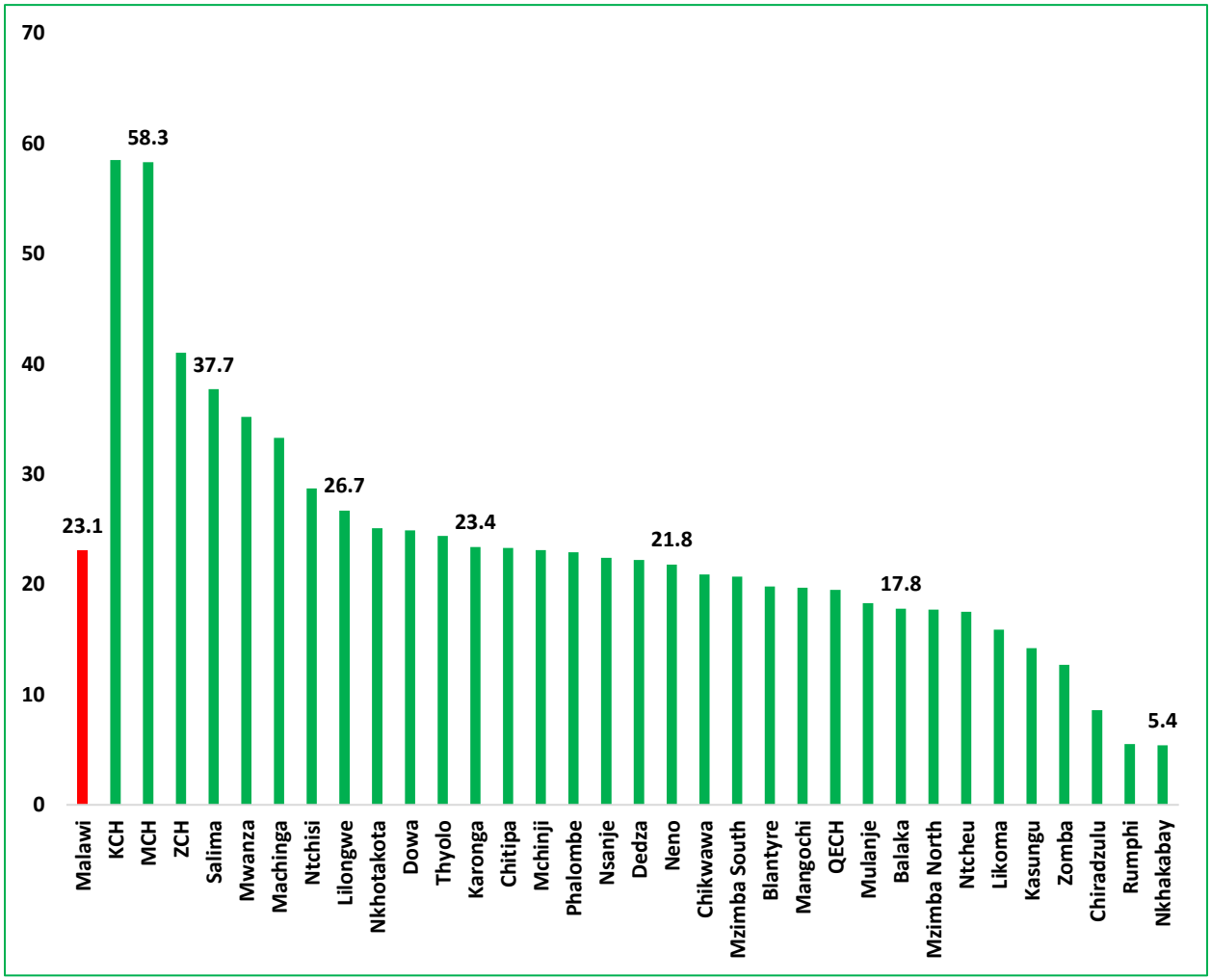
Figure 9:Outpatient department attendance/visits per capita



For inpatient utilization of health services, the bed occupancy rate for Malawi in FY2023/2024 was 23.1% (Figure 10), Tertiary hospitals have the highest bed occupancy rates, likely reflecting their resource inputs and ability to provide care. However, for the districts there is a broad range of bed occupancy rates with Salima, Mwanza and Machinga >30% to Chiradzulu, Rumphi and Nkhatabay <10%.

There is a decreasing relative inpatient beds per 10,000 population from the MHHFA in 2018-2019 - from 10.07 inpatient beds per 10,000 population in 2018-2019 to 6 in 2024. This is due, in part, to an increasing population without an increase in inpatient infrastructure. Currently, from the Malawi Harmonized Health Facility Assessment (MHHFA) 2024 initial report, there is 0.7 facility and 6 inpatient beds for every 10,000 of the population, achieving 24% of the inpatient bed density target of 25 inpatient beds per 10,000 population.

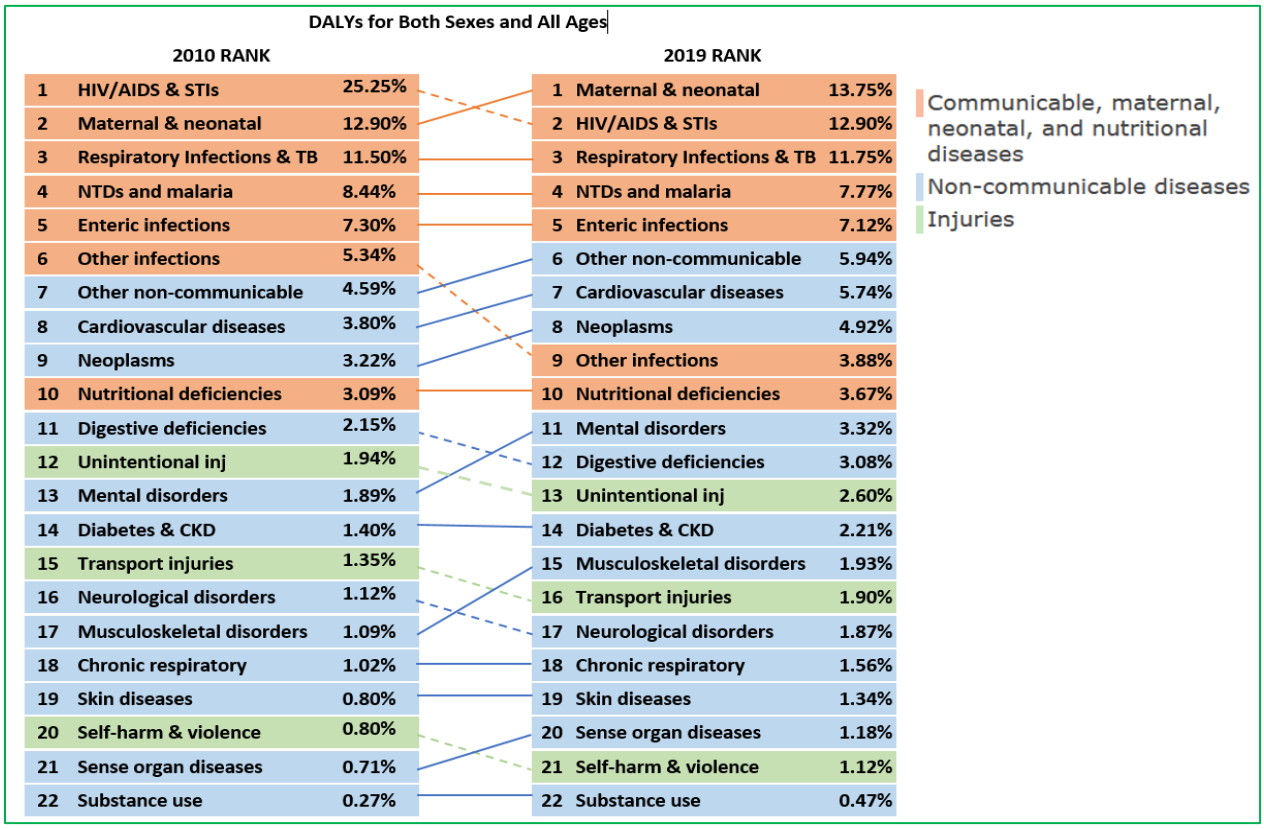
Figure 10: Bed occupancy rate by district



3.1.2.3. Health service delivery progress indicators by broad thematic areas

Health interventions under HSSP III, along with the subsequent health service packages, were prioritized based on the leading contributors to disease burden, measured in Disability Adjusted Life Years (DALYs) as of 2019 (see Figure 11). Compared to 2010, there was a slight increase in the DALYs burden from maternal and neonatal conditions in 2019, while the HIV/AIDS burden has nearly halved. In contrast, the burden from non-communicable diseases and injuries combined has risen by nearly 40%. Given this evolving and complex disease landscape, there is a need to update prioritized process, outcome, and impact indicators, which this section aims to address. We will review selected indicators for reproductive, maternal, neonatal and child health followed by non-communicable and communicable disease in the sections below.

Figure 11:Comparison of leading causes of DALYS in Malawi (2010 to 2019)

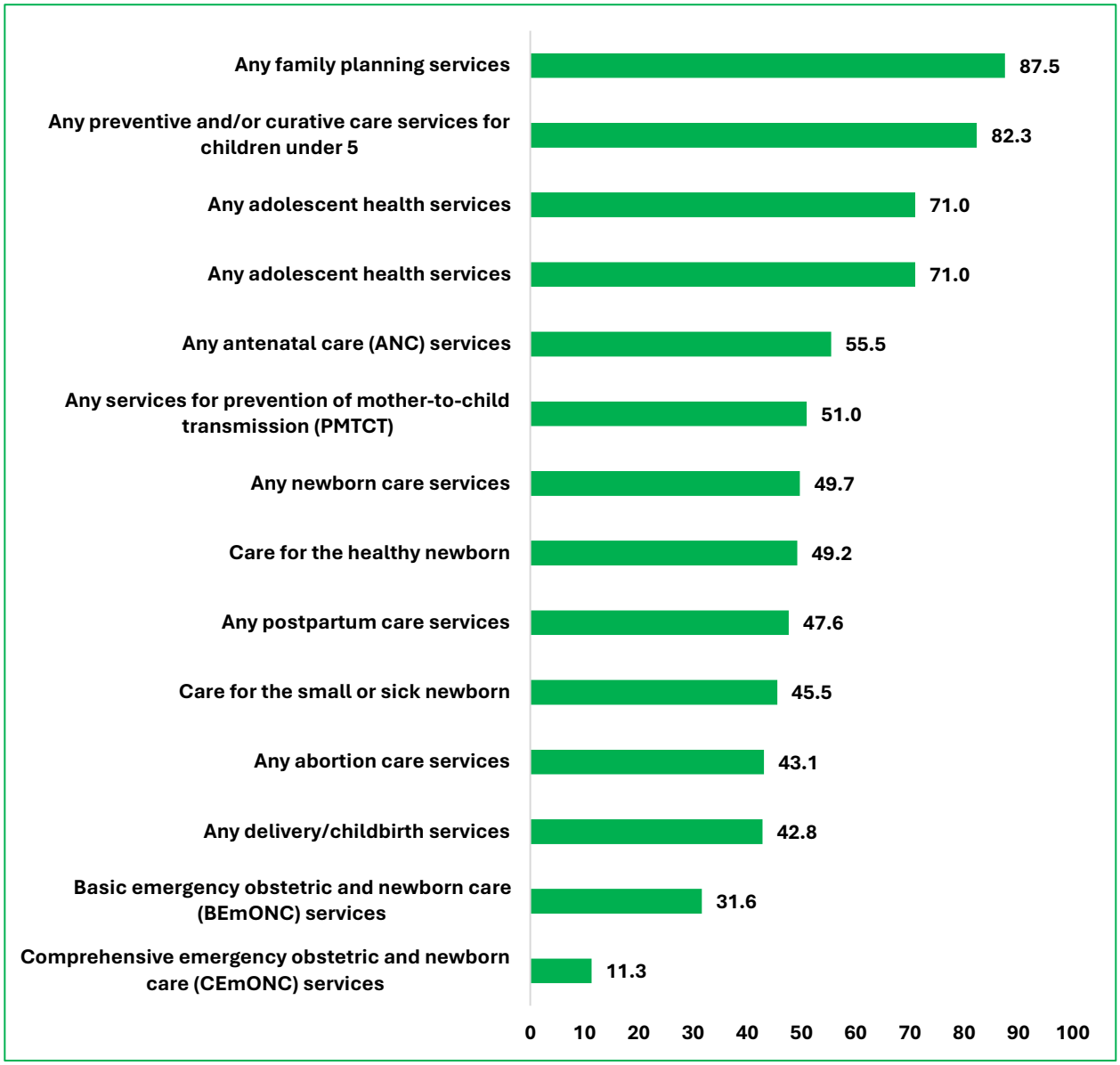


**Source: 2019 Diseases and Injuries Collaborators. Global burden of 369 diseases and injuries in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet (London, England). Oct 17, 2020;396(10258):1204-1222.*

3.1.2.3.1. Reproductive, Maternal, Neonatal and Child Health

For Reproductive, Maternal, Neonatal and Child Health (RMNCH) services, there is a care cascade from family planning to maternal care and delivery care to the neonate and child health that spans the beginning of the life course. In examination of availability of RMNCH services through the MHHFA survey in 2024, of 1467 facilities surveyed mostly had any family planning services (87.5%) but less with antenatal services (55.5%), delivery services (42.8%) and care for small and sick newborns (45.5%) with only 31.6% and 11.3% with basic and comprehensive emergency maternal and delivery services respectively (Figure 12).

Figure 12:Availability of maternal, neonatal, and child health services (N = 1467)



For reproductive health, the modern contraceptive prevalence rate overall in 2023 in Malawi is 38.5% with seven districts (Likoma, Mwanza, Mulanje, Nsanje, Chiradzulu, Phalombe and Neno) over 50% (Figure 13). Despite these increasing numbers, there is still an elevated unmet need for family planning, which may be due in part to the lack of availability of family planning services and commodities at health facilities as seen in Figure 14 from the MMHFA. While 82% of facilities offer family planning services, only 62% had injectable contraception and 30% had intrauterine contraception devices (IUCD). In the periods being compared, family planning services provision has remained constant, but there has been an increased availability of most contraception methods.

Figure 13:Modern contraceptive prevalence rate (mCPR)

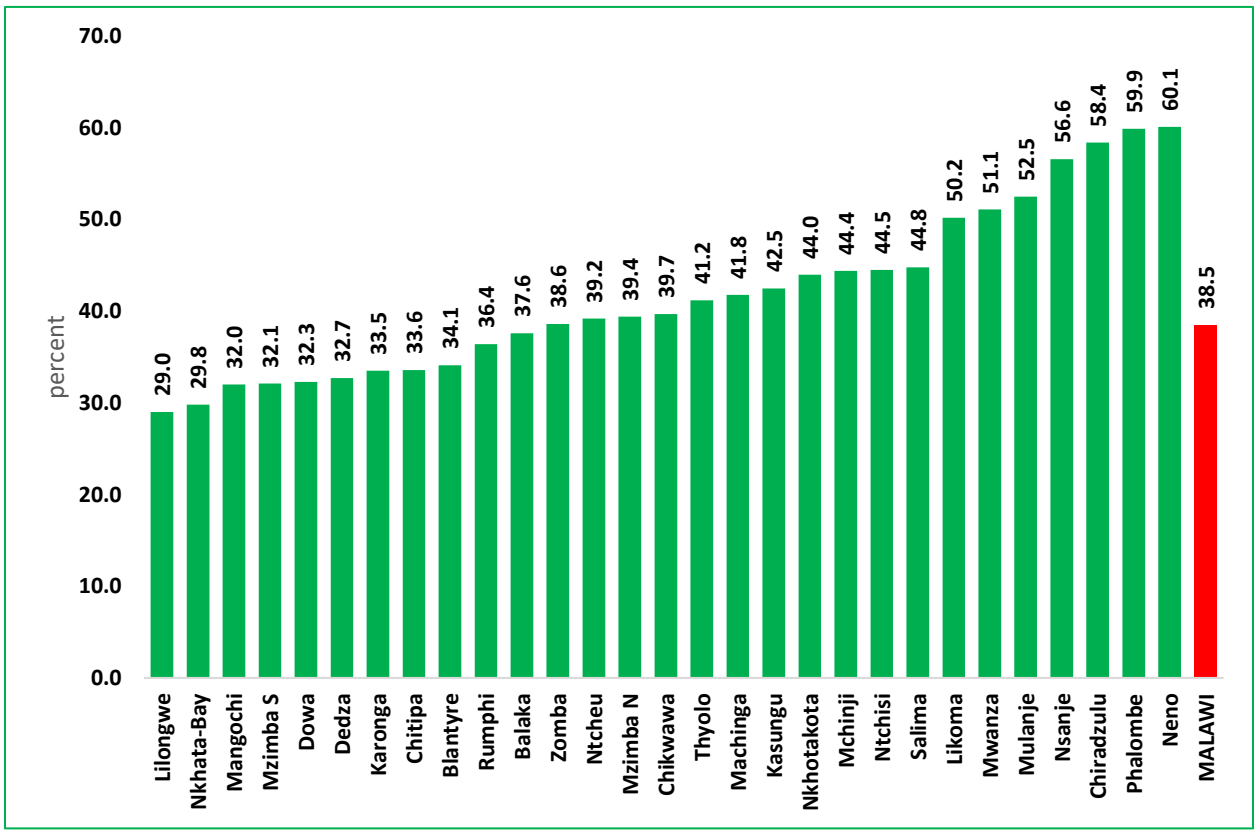
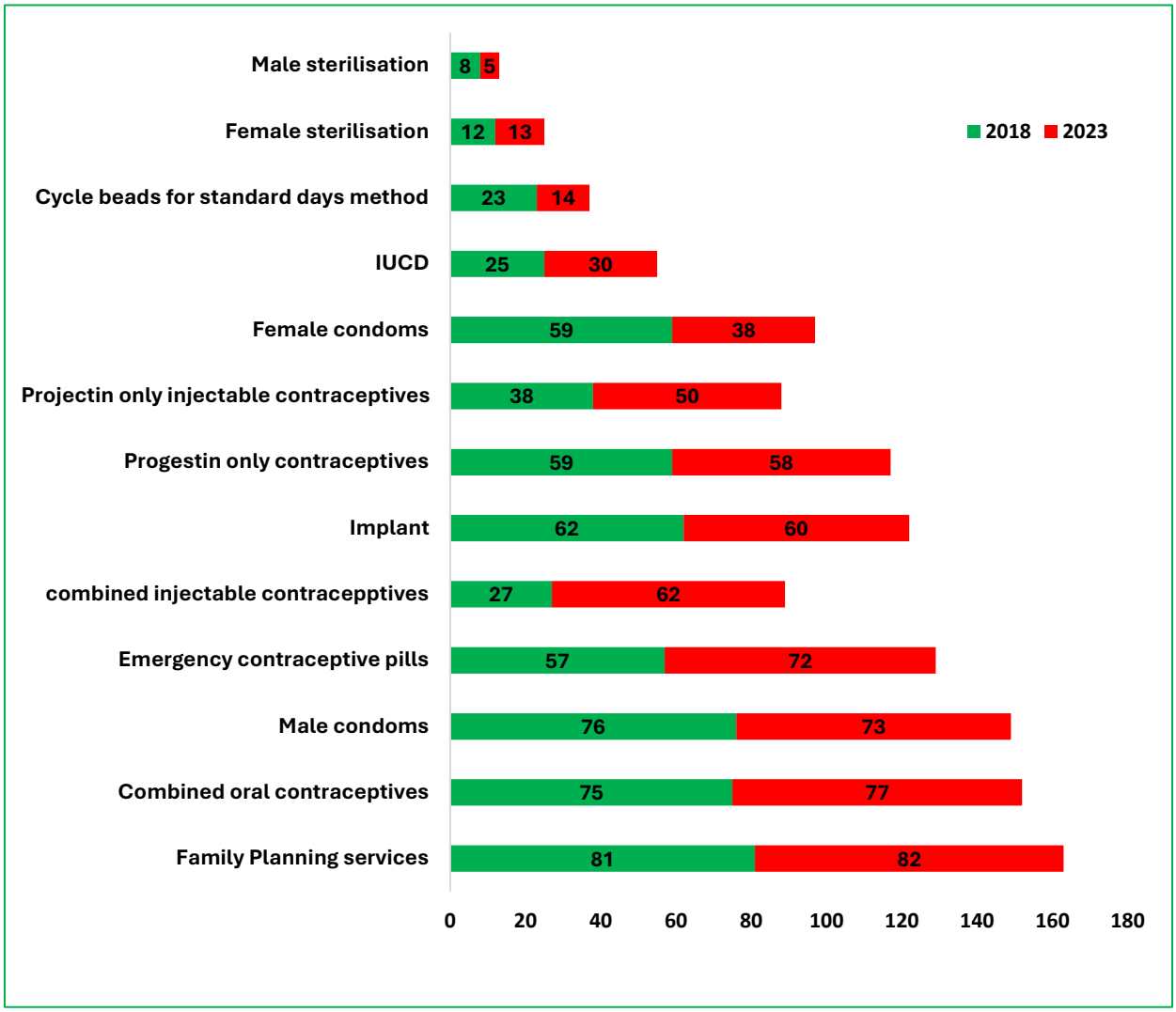
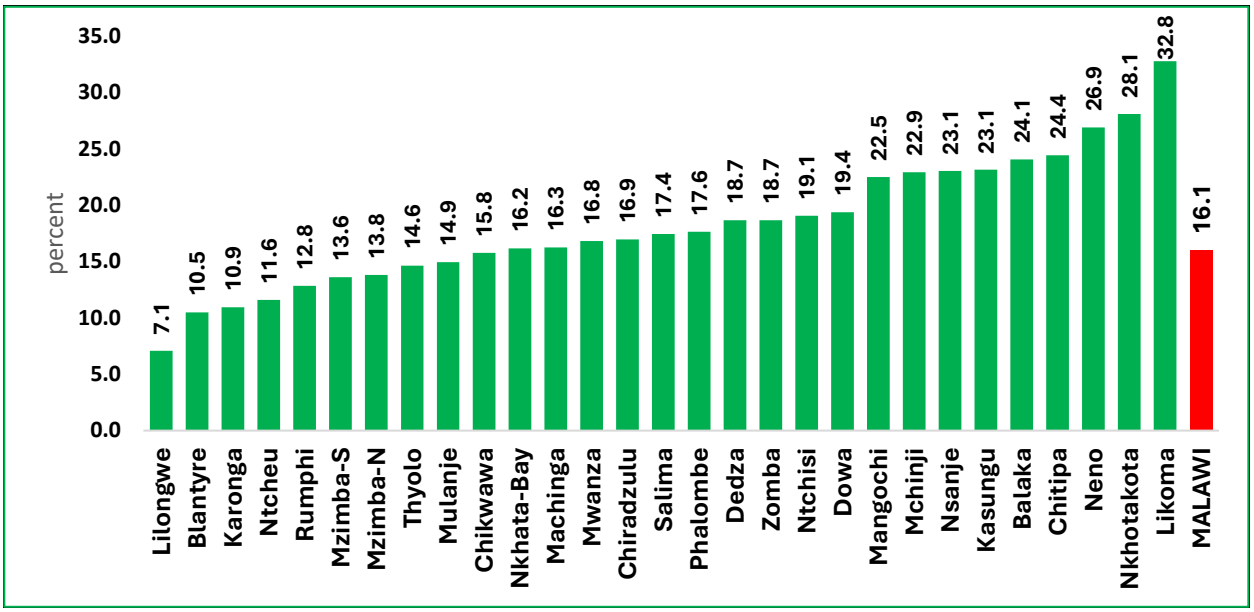


Figure 14:Comparison of 2013 SPA to 2018/2019 HHFA: Availability of family planning services



An analysis of the next step of the life course includes than on pregnancies. As observed in Figure 15, 16% of all pregnancies in Malawi are in adolescents aged 15-19 years old. The districts with the highest rates of adolescent pregnancy - greater than 25% of all pregnancies – include Likoma (32.8%), Nkhotakota (28.1%) and Neno (26.9%). Only one district, Lilongwe, has a <10% adolescent pregnancy rate with Blantyre and Karonga close behind at 10.5% and 10.9% respectively.

Figure 15:Teenage/Adolescent pregnancy rate (percentage of women aged 15- 19 who have given birth or are pregnant) by district



There is an overall low percentage of women with their first antenatal care (ANC) visit in the first trimester at 9.3% of all women. However, there are district outliers with Salima at 56.7% and Neno at 31.4% of women seeking ANC care in the first trimester (Figure16). The low ANC care numbers may be due, in part, to low ANC coverage and availability of full services at the facilities that offer ANC care along with the elevated adolescent pregnancy rate. For example, from the HHFA survey 2024 in Figure 17, only about 50% of facilities provide ANC care and only 50% of these have basic ANC requirements including iron supplementation, intermittent malaria prevention and monitoring for hypertensive disorders of pregnancy.

Figure 16:Early postnatal care coverage; first ANC visit in 1st trimester

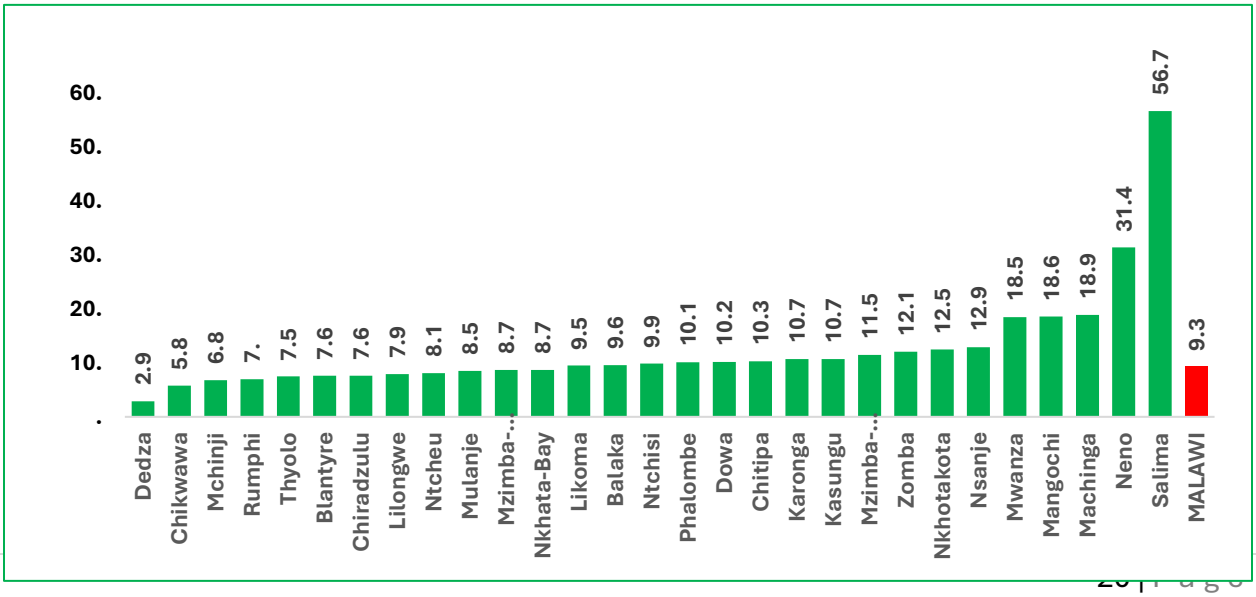
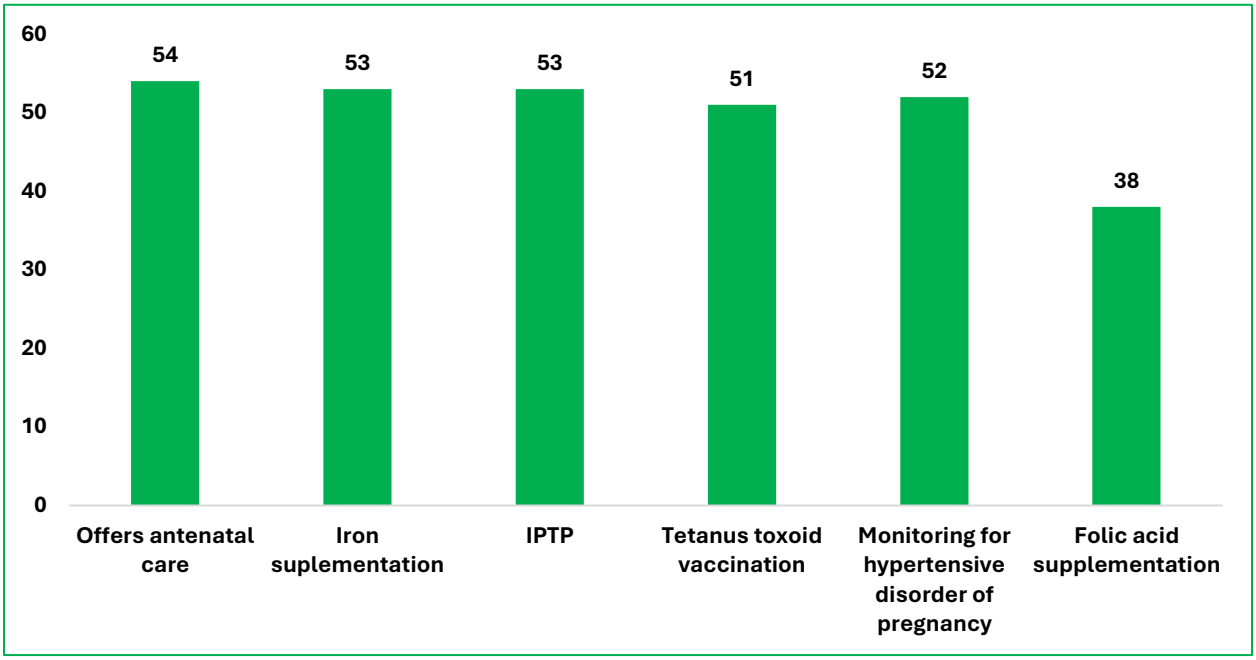
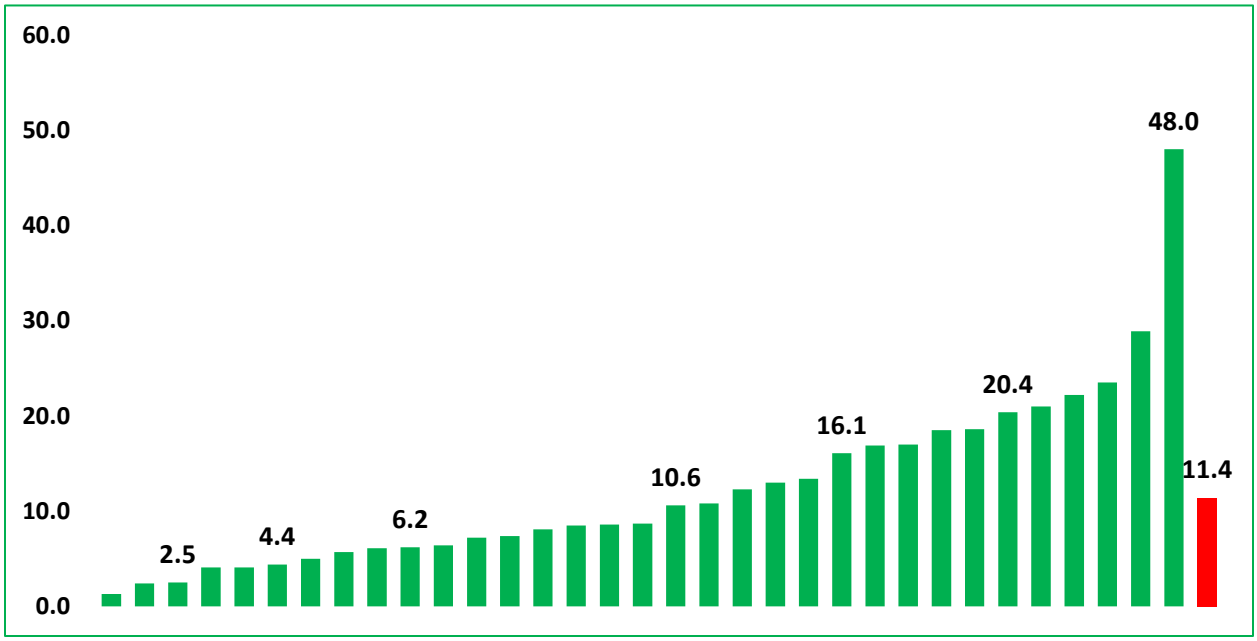


Figure 17: Health facilities that offer antenatal care services (N=1462), Malawi 2023/2024



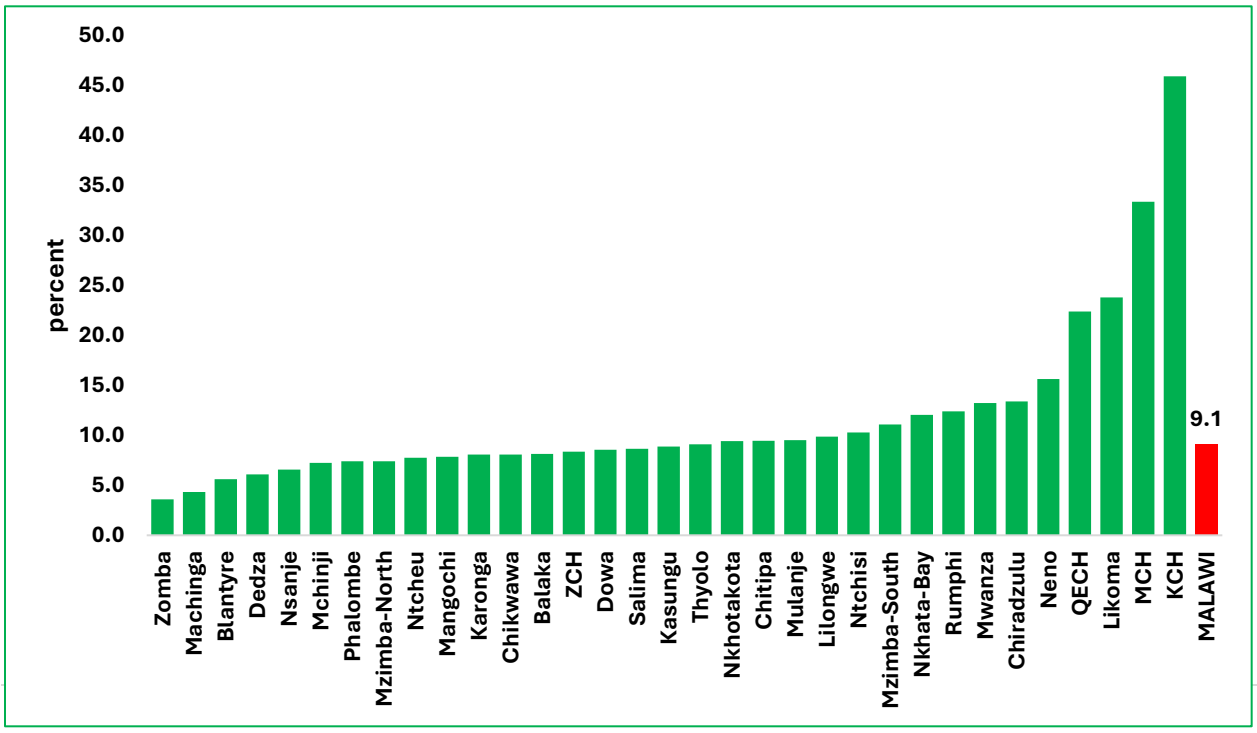
In examination of the quality of ANC care, availability of iron and folate tablets for women across districts in 2023 was tracked. In Figure 18, only 10.8% of women receive four months of the iron-folate tablets when they should receive at least 10 months of tablets with eighteen of the twenty-nine districts had less than 10% of pregnant women receiving at least 4 months of iron-folate tablets. Without this medication, there is risk of increased incidence of pregnancy-induced anemia which can lead to increased risk of preeclampsia, eclampsia, preterm birth, low birth weight and neonatal death and neural tube defects in newborns.[,]

Figure 18:Proportion of pregnant women receiving at least four months of iron folate tablets in 2023



In the next step on the life course, at delivery 9.1% of births are delivered by the caesarean section (Figure 19). All tertiary referral hospitals and Likoma district with its geography account for more than 20% of the births. This may be due in part to the low coverage of comprehensive emergency maternal and delivery services and unavailability of facilities and the resource inputs to provide services.

Figure 19: Caesarean section births by district/hospital



With less availability of ANC and emergency cesarian section services, there is a decreasing, but still elevated birth asphyxia and fresh stillbirth rates at 4.7% and 17.7% respectively (Figure 20 and 21). There is a broad range on these indicators by hospital and district with tertiary referral hospitals having the highest rates (more than 7% birth asphyxia and over 20% fresh still births) due to referrals for more serviced and resourced facilities. However, Mwanza, Nkhata Bay, Machinga and Chiradzulu have proportions of at least 6% birth asphyxia and Mwanza, Likoma and Mzimba-South have fresh stillbirth rates more than 20%.

Figure 20: Births with birth asphyxia by district in 2023

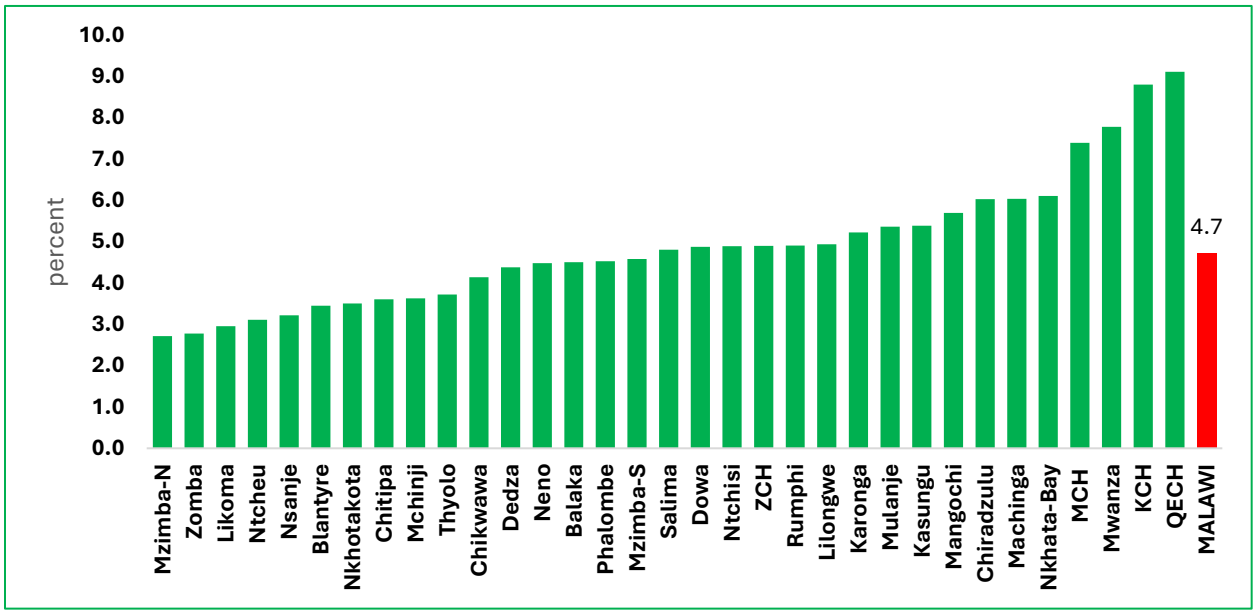
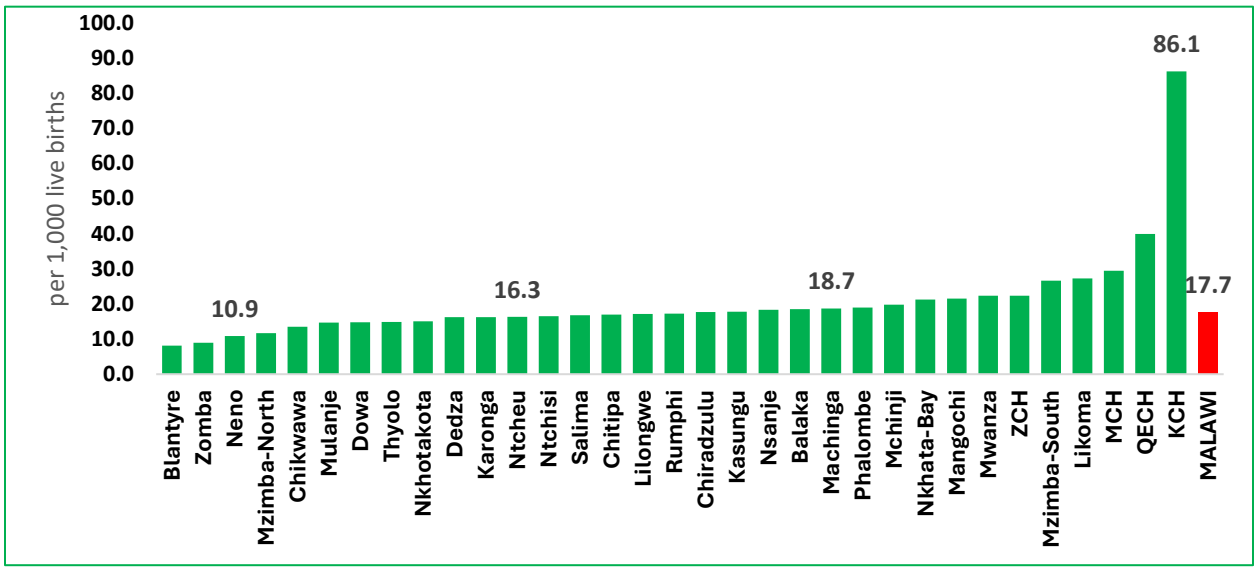
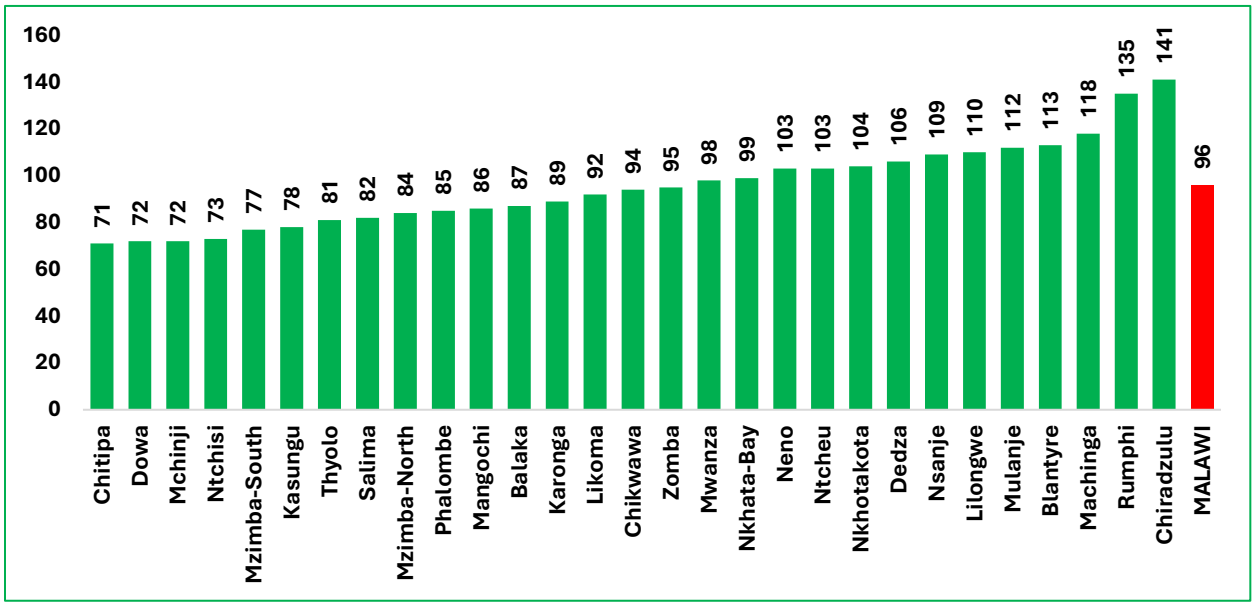


Figure 21: Institutional stillbirth rate per 1000 live births by district in 2023



Moving to childhood immunization services, overall, 96% of children under 1 are fully immunized in Malawi (Figure 22). While only six districts have less than 80% of children under 1 fully immunized, the eleven districts have >100% - showing some concerns in data quality and tracking.

Figure 22:Percentage of Under 1year children fully immunized, 2023 by district



Considering the limitations in the provision of reproductive, maternal, neonatal, and child health services, institutional maternal mortality rates (IMMR) per 100,000 live births vary significantly, ranging from 6.5 deaths in Phalombe to 491.7 deaths in Blantyre (Figure 23). Examining these rates by district and tertiary facilities, there is a pattern of elevated rates compared to the average in central tertiary referral hospitals which is expected for referred complicated cases. Similarly in institutional neonatal mortality rates (INMR) per 1000 live births, QECH and Zomba central hospitals have the highest INMRs (25.5 and 17.7 per 1000 live births respectively) with five districts with INMR greater than 10 per 1000 live births including Likoma, Karonga, Mangochi, Mwanza and Kasungu (Figures 24). Where some districts have higher IMMR or higher INMR, some districts have both. For example, Likoma – 328.4/100,000 and 14.8/1000 and Karonga – 138.5/100,000 and 13.4/1000 - districts are among the top five highest morality rates. In examining the RMNCH care cascade, there are challenges in availability of services and resource availability at facilities – especially contraception, ANC and emergency peripartum services. In part, this results from decreased utilization of services and poor service quality resulting in poor maternal, neonatal, infant and child outcomes and mortality.

Figure 23: Distribution of Institutional Maternal Mortality Rate (IMMR) (per 100,000 live births) by district, 2023

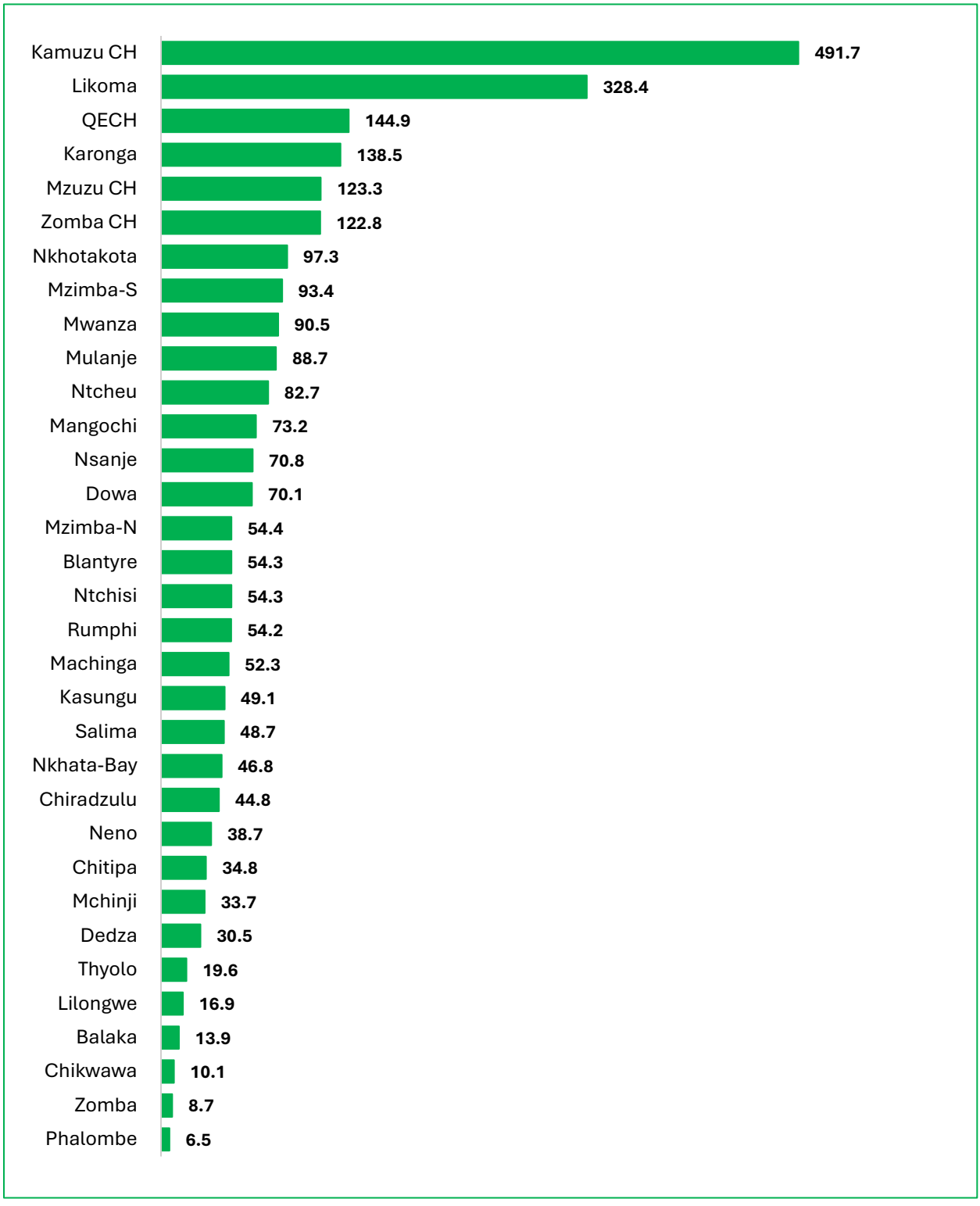
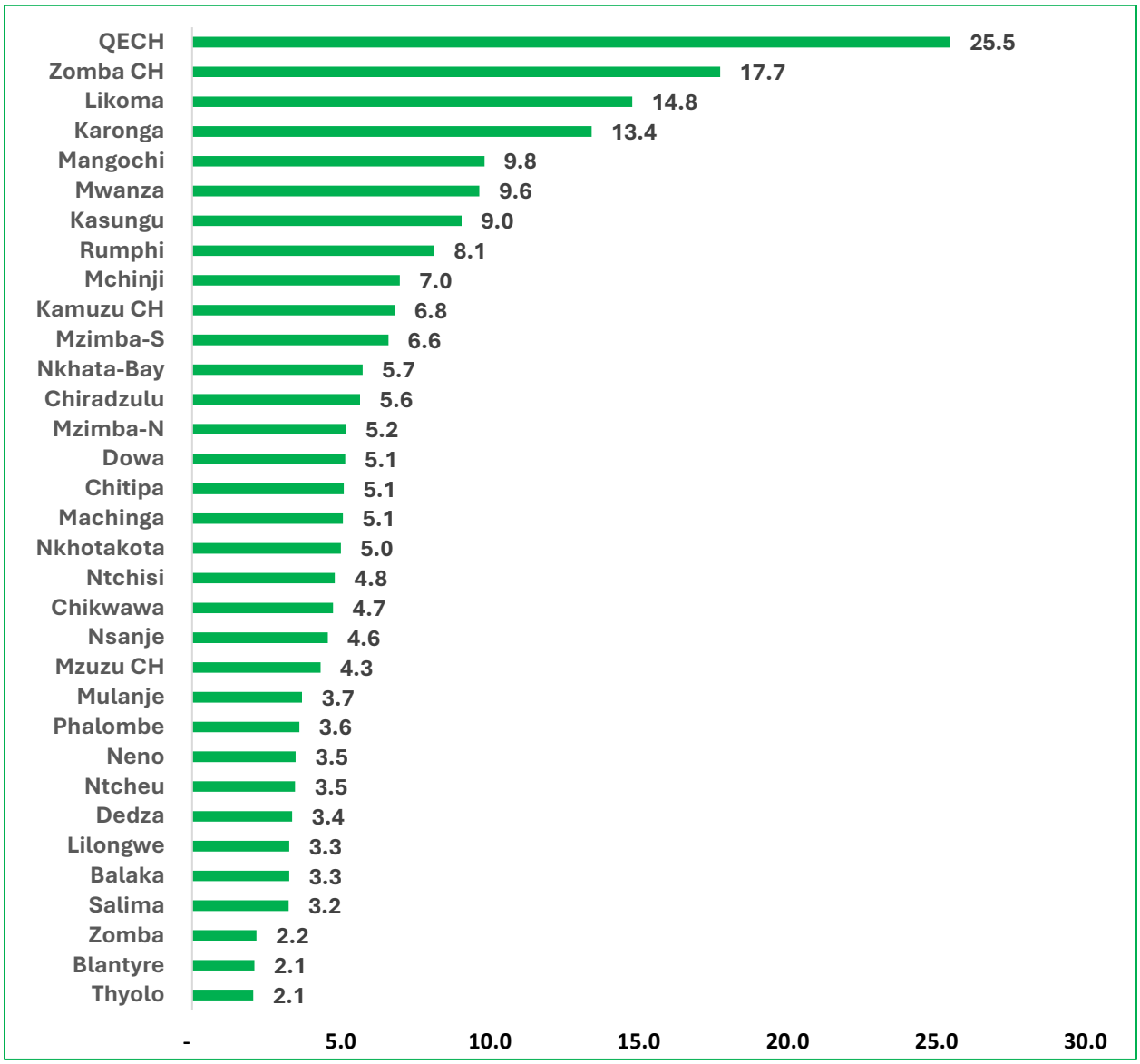


Figure 24: Distribution of Institutional Neonatal Morality Rate (INMR) (per 1000 live births) by district, 2023



3.1.2.3.2. Non-Communicable Diseases

For non-communicable diseases (NCDs), in review of resource inputs, while most facilities have a blood pressure machine (88.8%), less than 20% have other basic diagnostic modalities such as a blood glucose test (17.3%), liver function tests (6.3%) or renal function tests (6.2%). Similarly for medications, about half of facilities have a type II diabetes medication (metformin 63.9%) and antihypertensives (54%) but only 11.2% have insulin for type I diabetes and 3.3% have fluoxetine for depression treatment.

From these limitations in case finding, diagnostics and available treatment in Malawi, there are lower rates from routine facility data compared to NCD prevalence rates in population-level studies. Overall, for FY23/24, the prevalence of hypertension, diabetes, asthma/COPD and mental health are 7.9, 2.0, 1.5 and 1.0 per 1000 population respectively in Malawi (Figures 25-28). However, according to the literature, the estimated prevalence of hypertension, diabetes, asthma and mental health in Malawi is 15.8% from a local adult cohort study, 1.4% by the STeps study (had been 5.6% in 2010)[6], 10-12% for childhood asthma in a cohort study and ~19% of depression as the most common mental health condition. Furthermore, there are specific NCD capacity building and resource support in six districts (Neno, Salima, Karonga, Rumphi, Ntchisi, and Mangochi) through the expanded Pen-Plus Model which demonstrates increased case finding in these districts in routine data. This can be seen in the differences of prevalence between districts in the disaggregated prevalences (Figures 25-28) with other program influences such as the St. John of God mental health program in Mzimba.

Figure 25: Rate of Asthma/COPD per 1,000 population

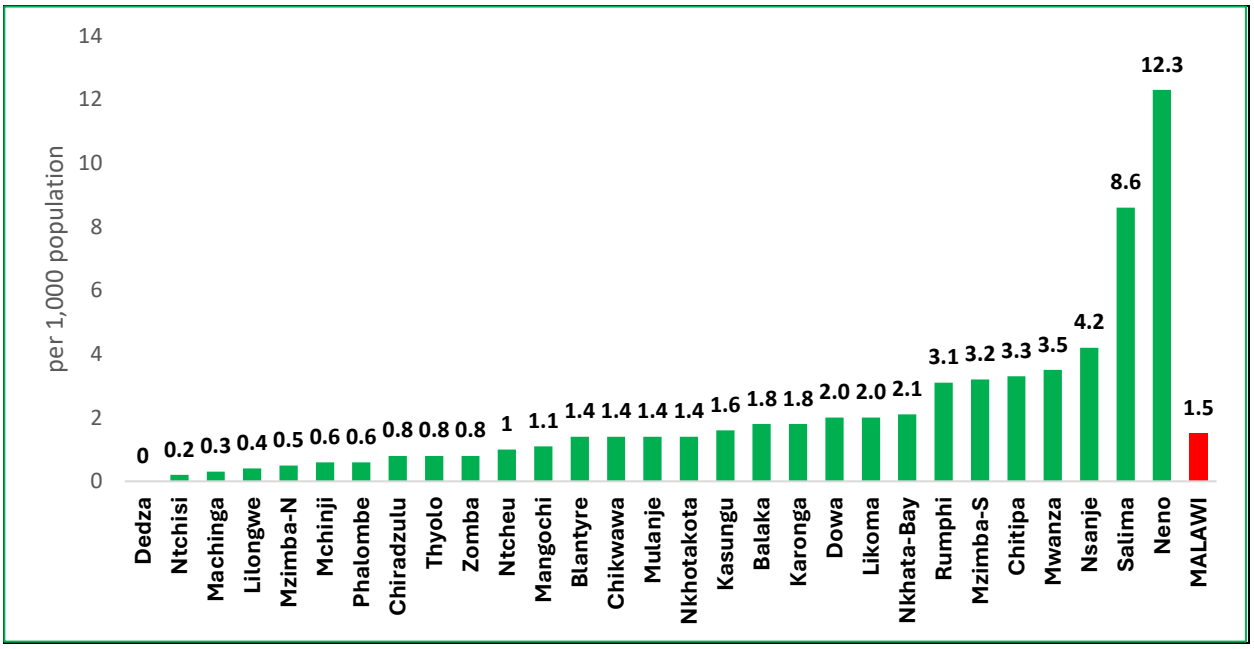


Figure 26: Rate of Hypertension per 1,000 population

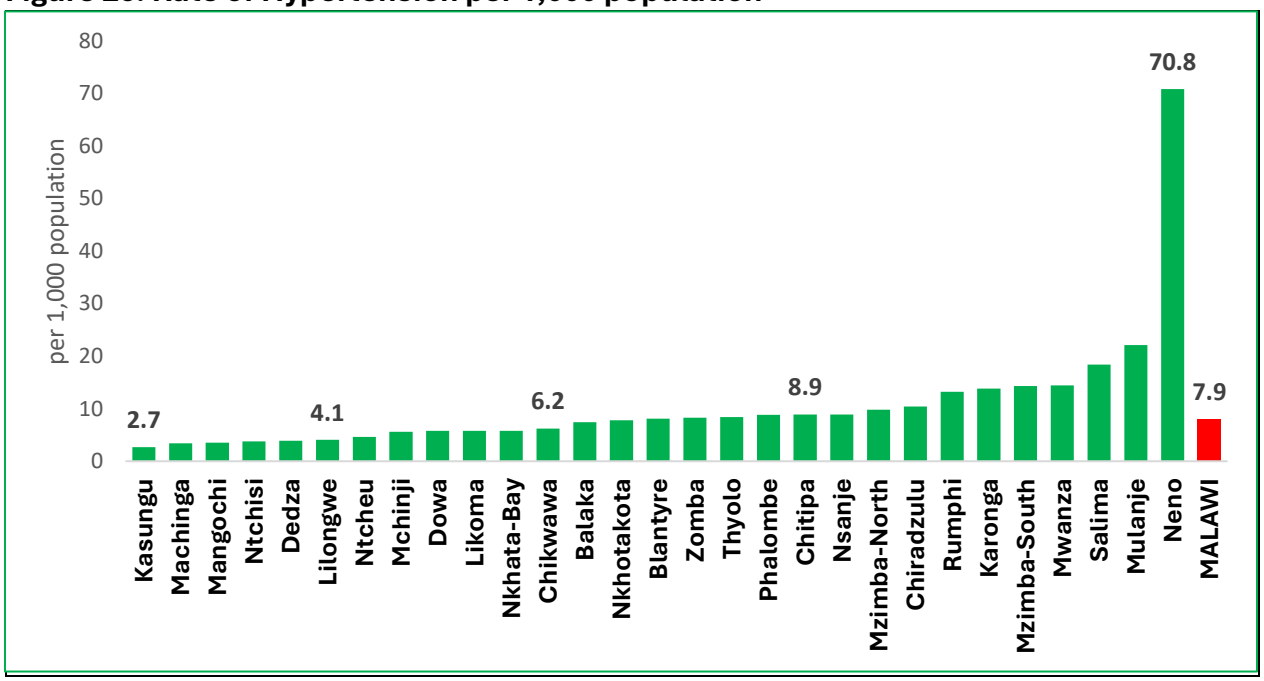


Figure 27: Rate of Diabetes cases per 1,000 population

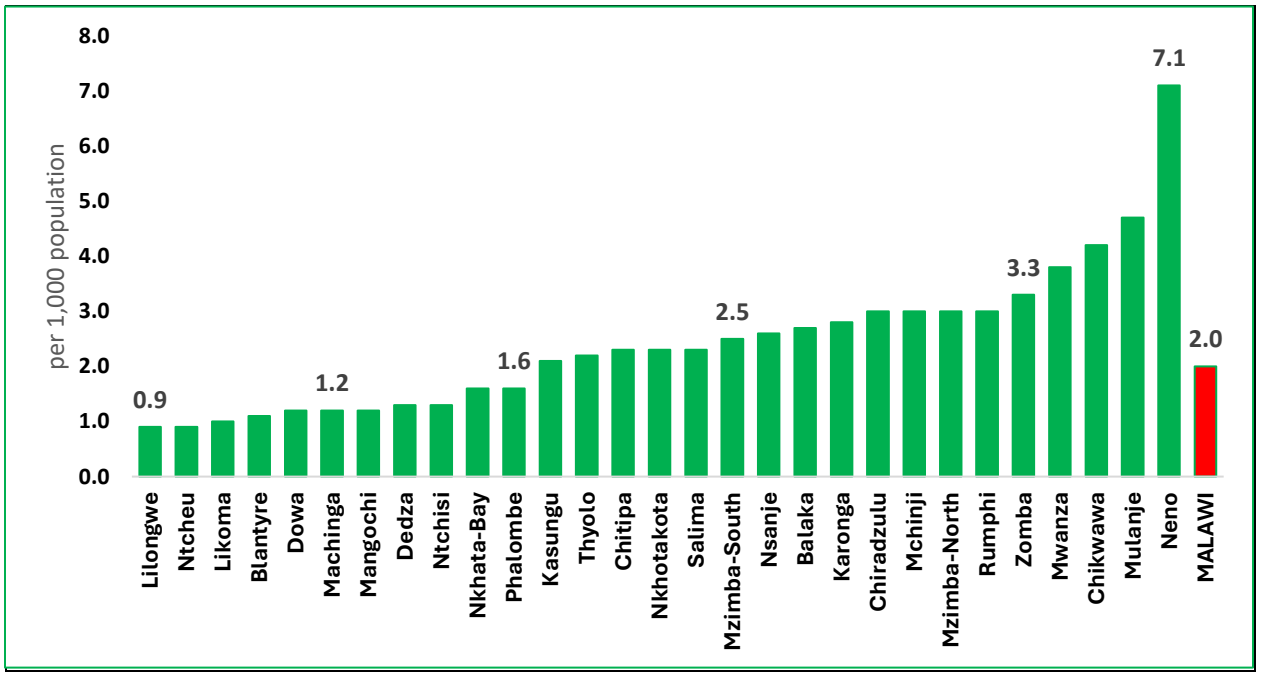
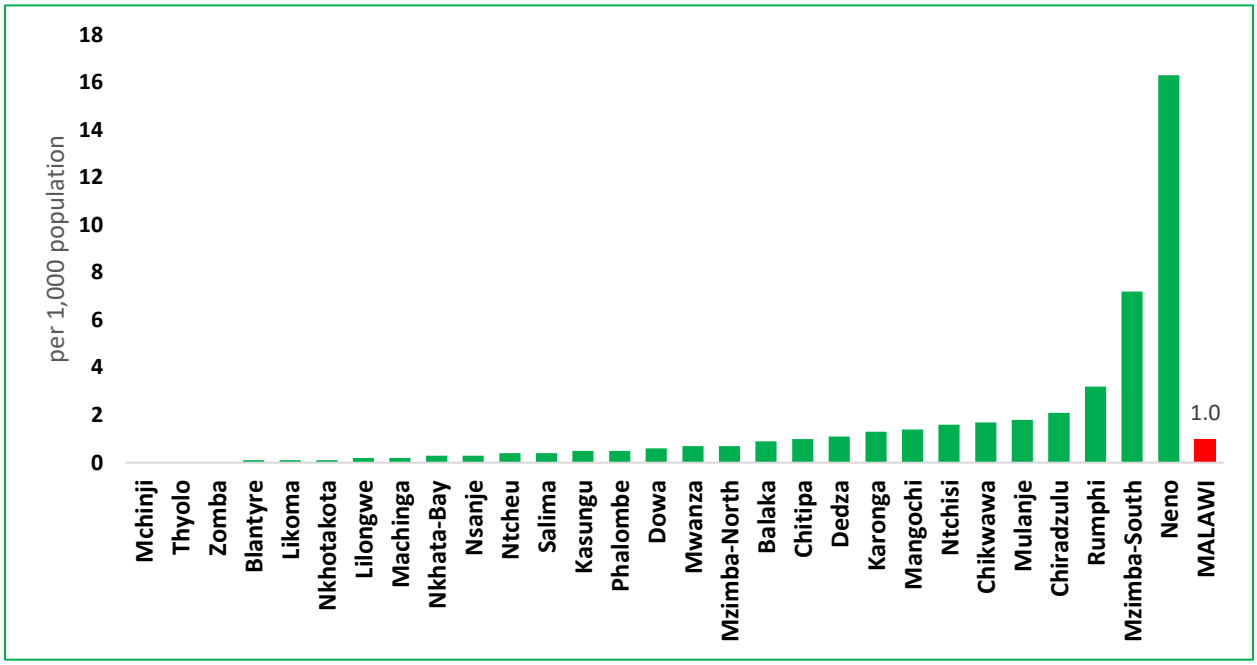


Figure 28: Rate of Mental Health cases per 1,000 population



Examining the causes of mortality, the accident and injury mortality rate overall in Malawi is 1.0 per 100,000 population (Figure 29). There are extremely high accident and injury mortality rates in Mzimba-South, Karonga and Thyolo at 6.8, 6.7 and 2.9 per 100,000 people with the remainder of districts with mortality rates under 2.0 per 100,000 people. However, these districts with high mortality rates have on average only 830 accidents per year while other districts such as Lilongwe and Blantyre have 2000+ accidents per year (Figure 30). The variable mortality rates may be due in part to only 48.4% facilities having 24-hour access to a functional vehicle and driver for transport with very few facilities with hemoglobin testing (26.4%), blood giving capabilities (13.5%), and splinting (13.4%) or suture consumables (5.1%) (MMHFA 2024)

Figure 29:Road traffic accident mortality numbers by district

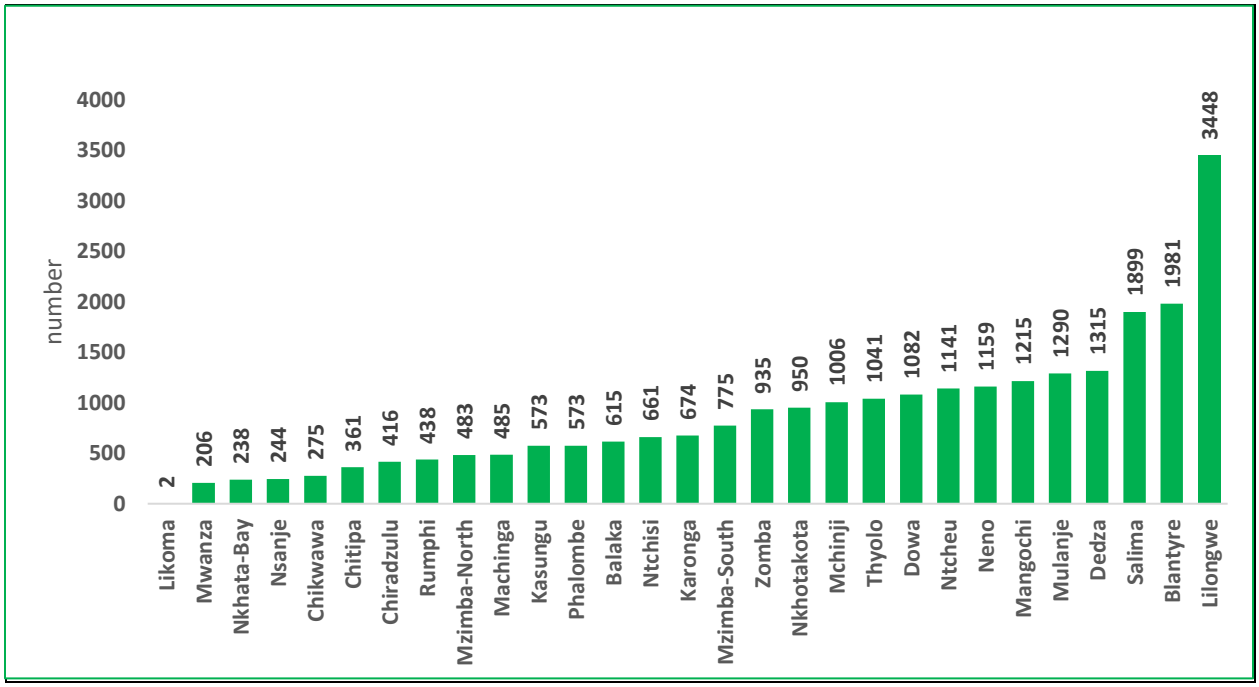
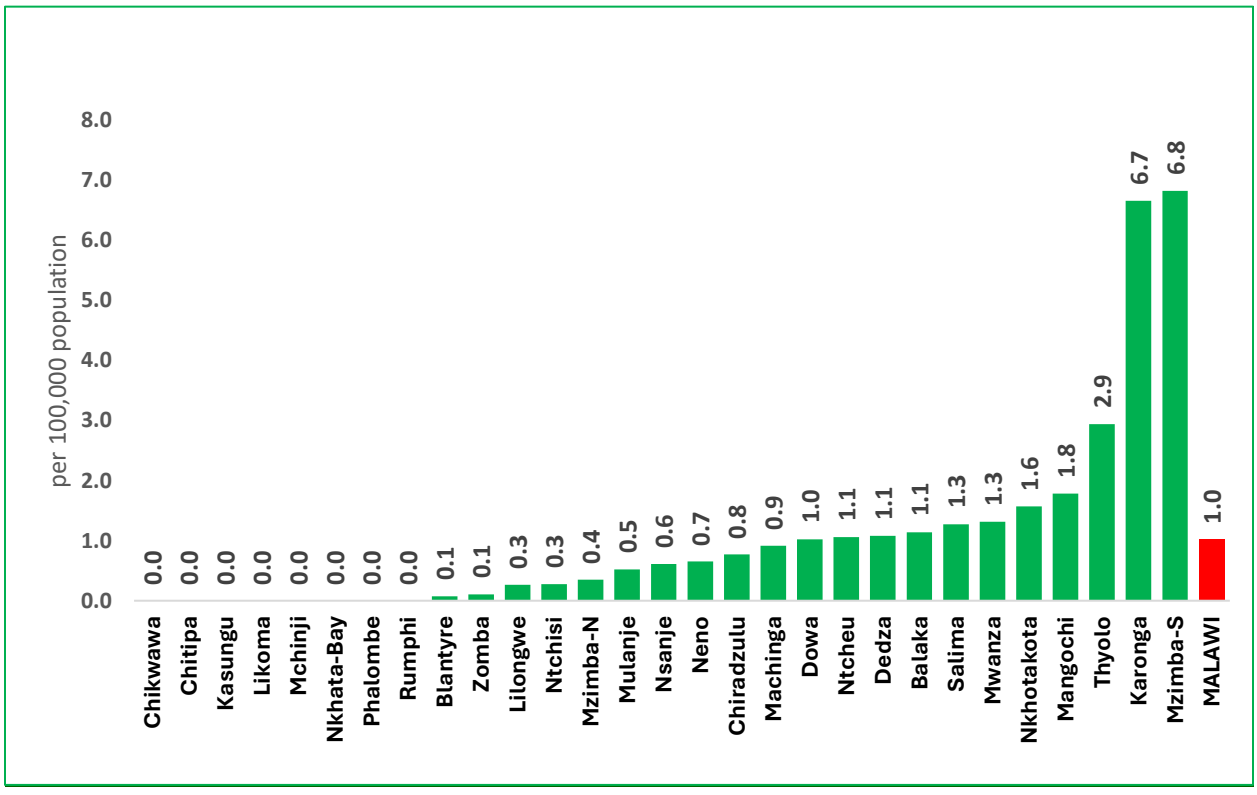


Figure 30: Accident/injury mortality rate 2023



3.1.3.4 Communicable Diseases

3.1.3.4.1 HIV

For HIV, there is a higher diagnostic (73% of facilities have onsite HIV testing) in part resulting in high rates of PLHIV knowing their status through testing. From the HIV treatment cascade (Figures 31), demonstrates 87%, 97% and 93% of PLHIV children, adult women and men who know their status respectively with high case finding. Similarly to high rates of PLHIV who know their status, there are rates ≥95% of adult PLHIV on ART and virally suppressed with children at the lowest at 83% and 84% respectively with a high availability of medication and patient follow up. Malawi has almost achieved the UNAIDS 95-95-95 targets for 2025 with only the diagnosed PLHIV <95%.

With the noted success in finding and treating PLHIV, the overall adult (15+) HIV prevalence is 7.6% with the highest prevalence in Zomba City and Blantyre city at 17.0% and 15.0% respectively and the lowest prevalence in Ntchisi District at 2.6% (Figure 32). Currently, there is only ~14,000 new infections in Malawi per year and only ~56,000 people living with HIV undiagnosed (Figure 33). The overall prevalence has decreased from the Malawi Population HIV Impact Assessment (MPHIA 2020-21) found to be 8.9%.

Figure 31:SPECTUM HIV Treatment cascade (%)

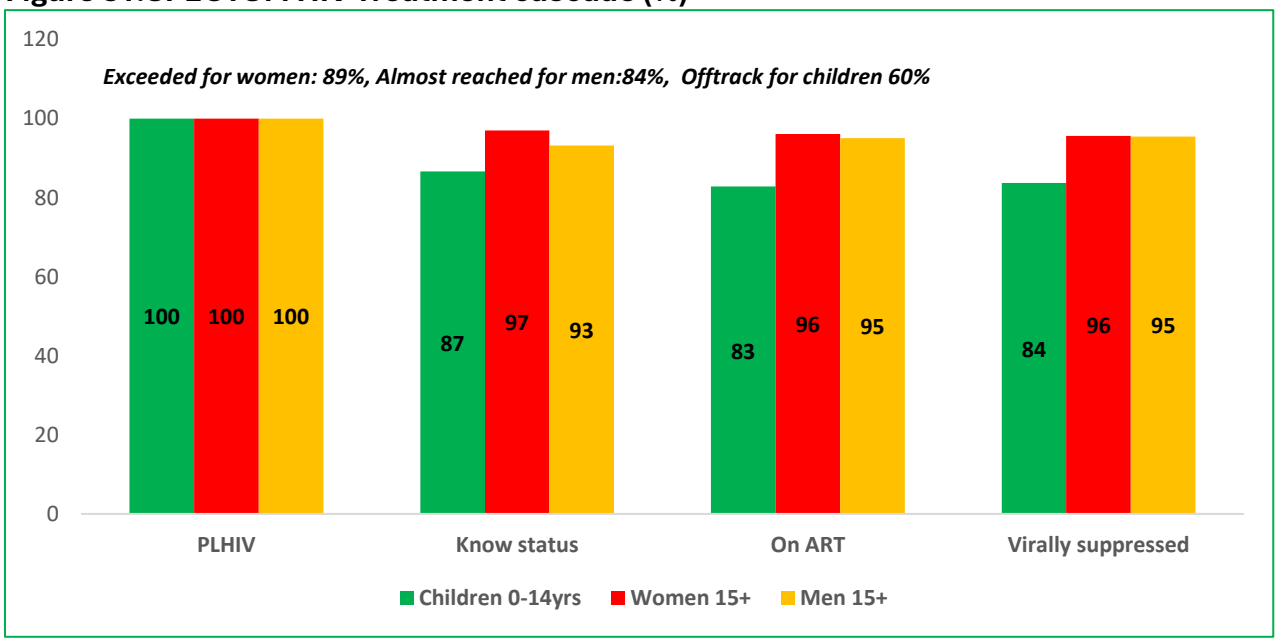


Figure 32: Prevalence HIV Adult (15+ years) by district

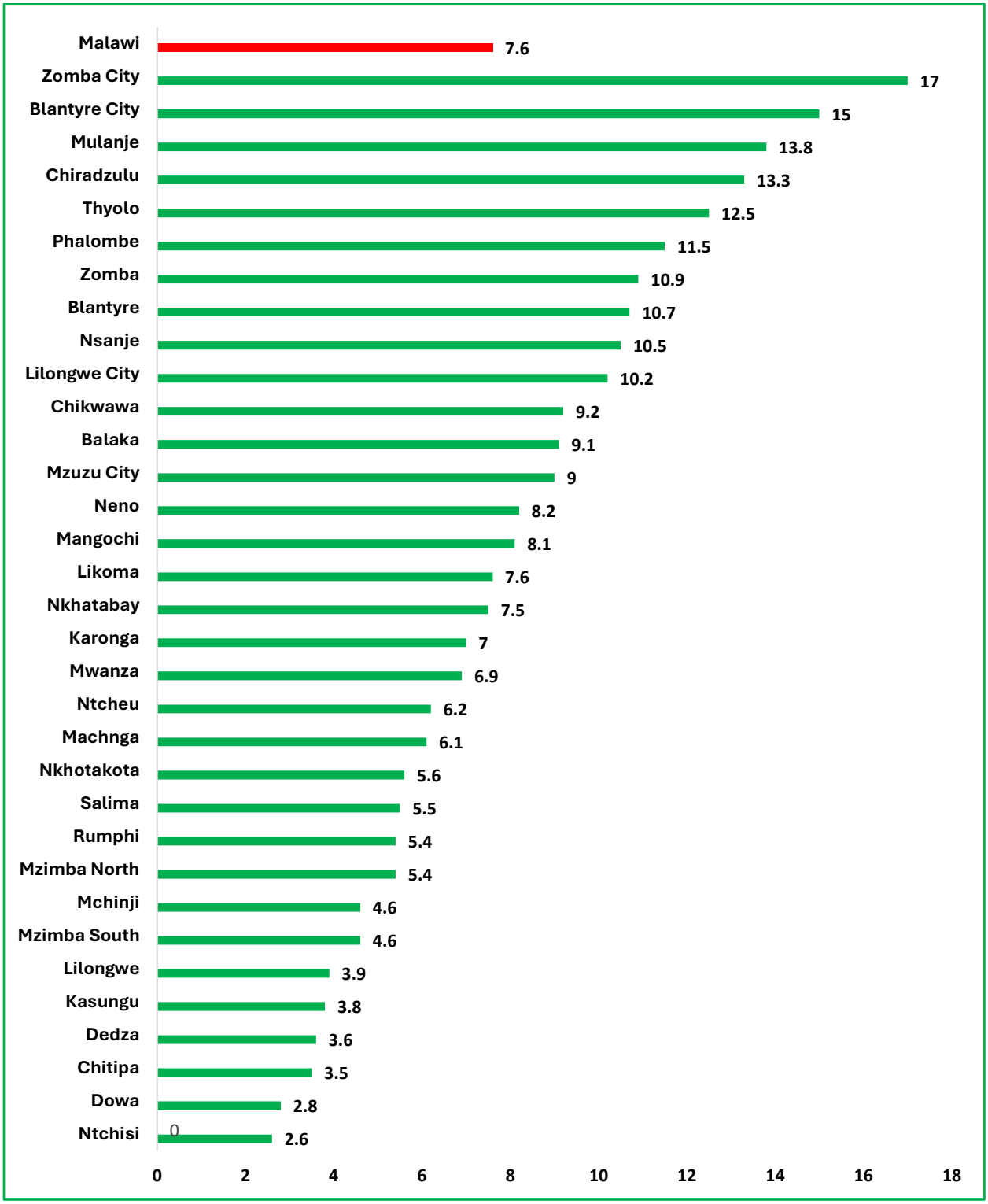
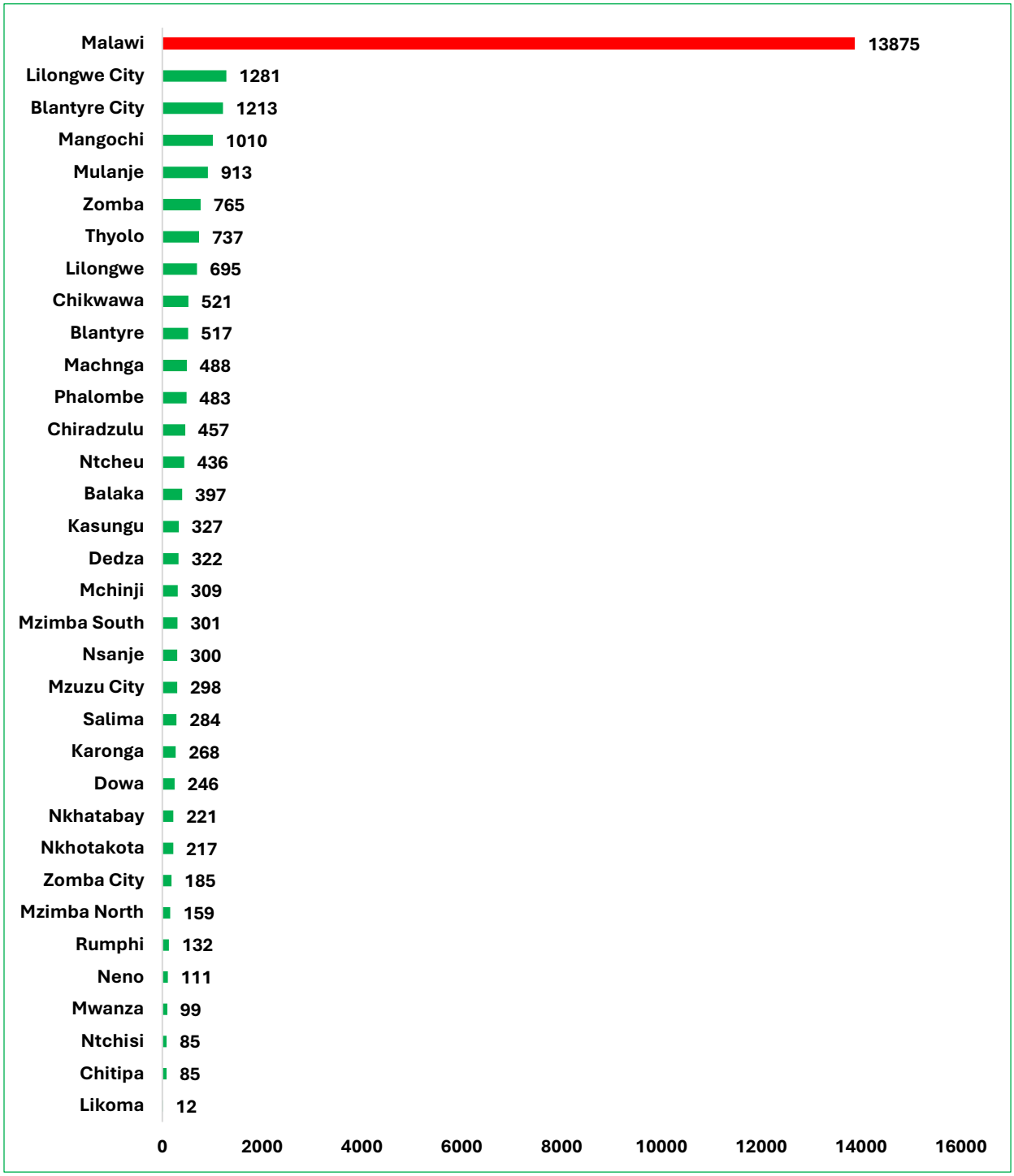


Figure 33:Annual HIV infections by district



3.1.4.1.2 Tuberculosis

For tuberculosis (TB), from the MHHFA 2024 survey, only 15.1% of facilities have diagnostic capacity with TB sputum microscopy or GeneXpert. With the low recognition and diagnostic capacity, there is an overall 89.7 per 100,000 of the population TB notification rates in Malawi (Figure 34). However, there is a large difference between the districts with lower TB notification rates with Nsanje, Mwanza, Blantyre and Neno Districts with >150 cases per 100,000 people but seven districts (Ntchisi, Mzimba-South, Kasungu, Zomba, Dowa, Machinga and Phalombe) with <50 cases per 100,000 people. Once the cases have been notified, overall, Malawi has a 90.7% TB treatment success with all but two districts (Karonga and Likoma) with over 80% of TB patients demonstrating treatment success (Figure 35).

Figure 34: TB case notification rate per 100,000 by district

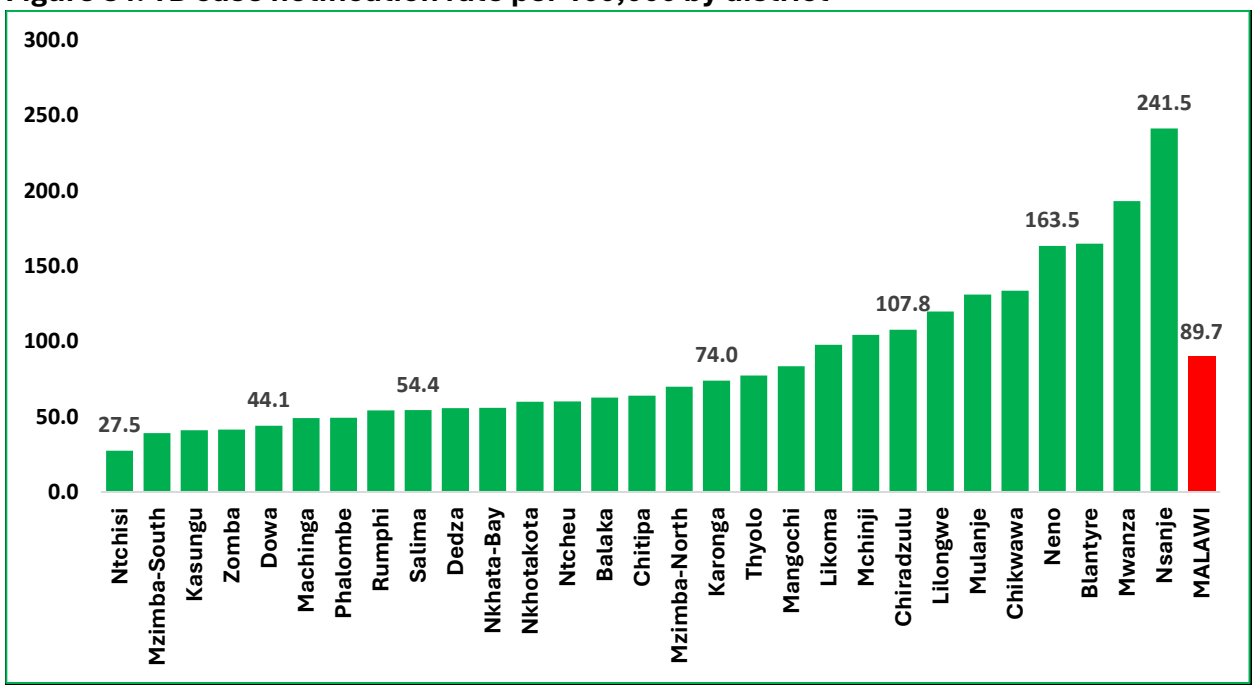
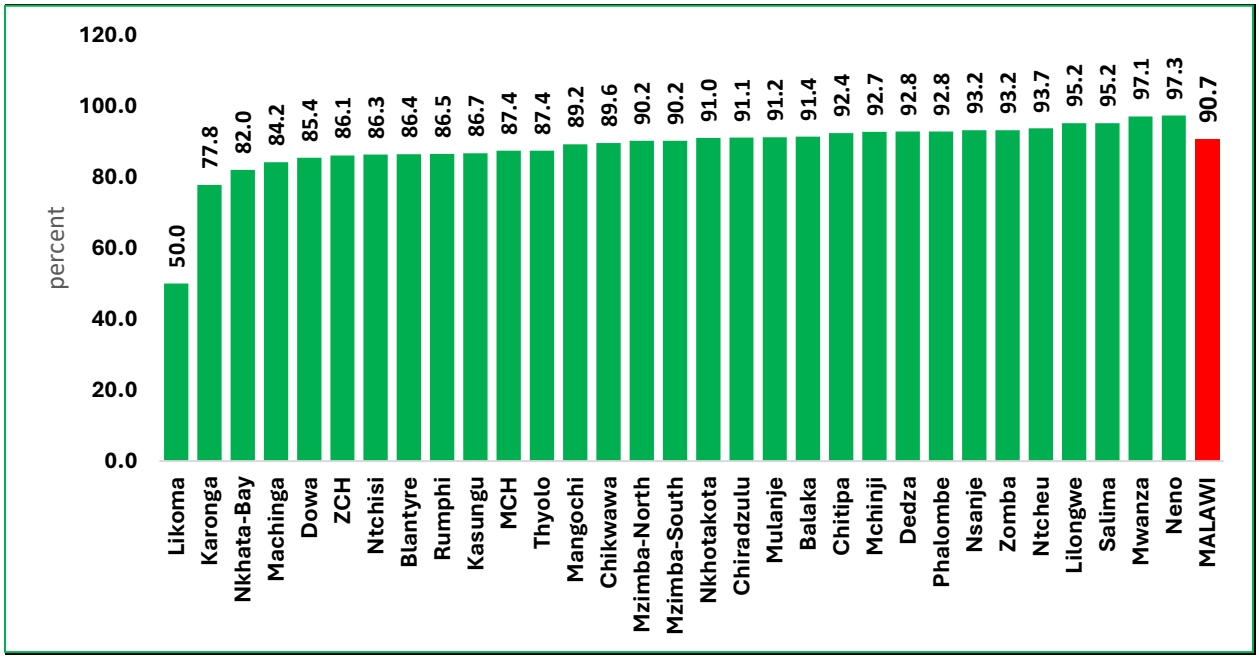


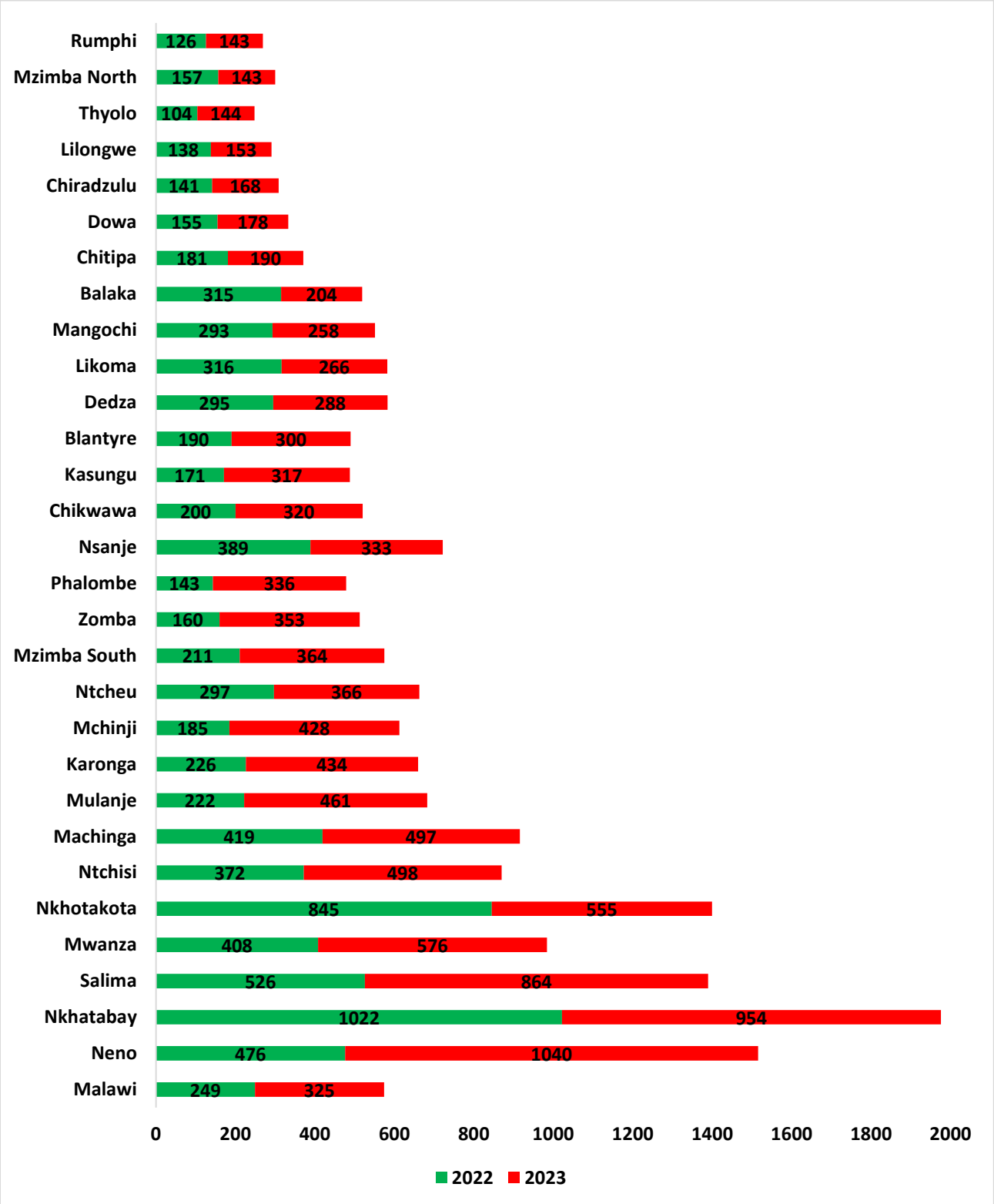
Figure 35: TB treatment success rate by district



3.1.4.1.3 Malaria and NTDs

With its high incidence and mortality, malaria is an important communicable disease in Malawi with subsequent high availability of prevention, diagnostics and medications. From the MHHFA 2024 survey, over 94.2% of facilities provide diagnosis or treatment of malaria with high availability of malaria rapid diagnostic tests. Prevention efforts such as intermittent preventative treatment are available in about 50% of facilities with most pregnant women and children receiving nets in the high incidence areas. With these efforts, the overall incidence of malaria has decreased from 407 cases per 1000 population in 2016 to 328 in 2023 (Figure 36). However, in the last year the malaria incidence has increased from 249 in 2022 to 325 in 2023. All districts have reported an increase in malaria cases except for Nkhotakota, Nsanje and Balaka and three districts (Neno, Nkhatabay and Salima) with >850 malaria cases per 1000 population.

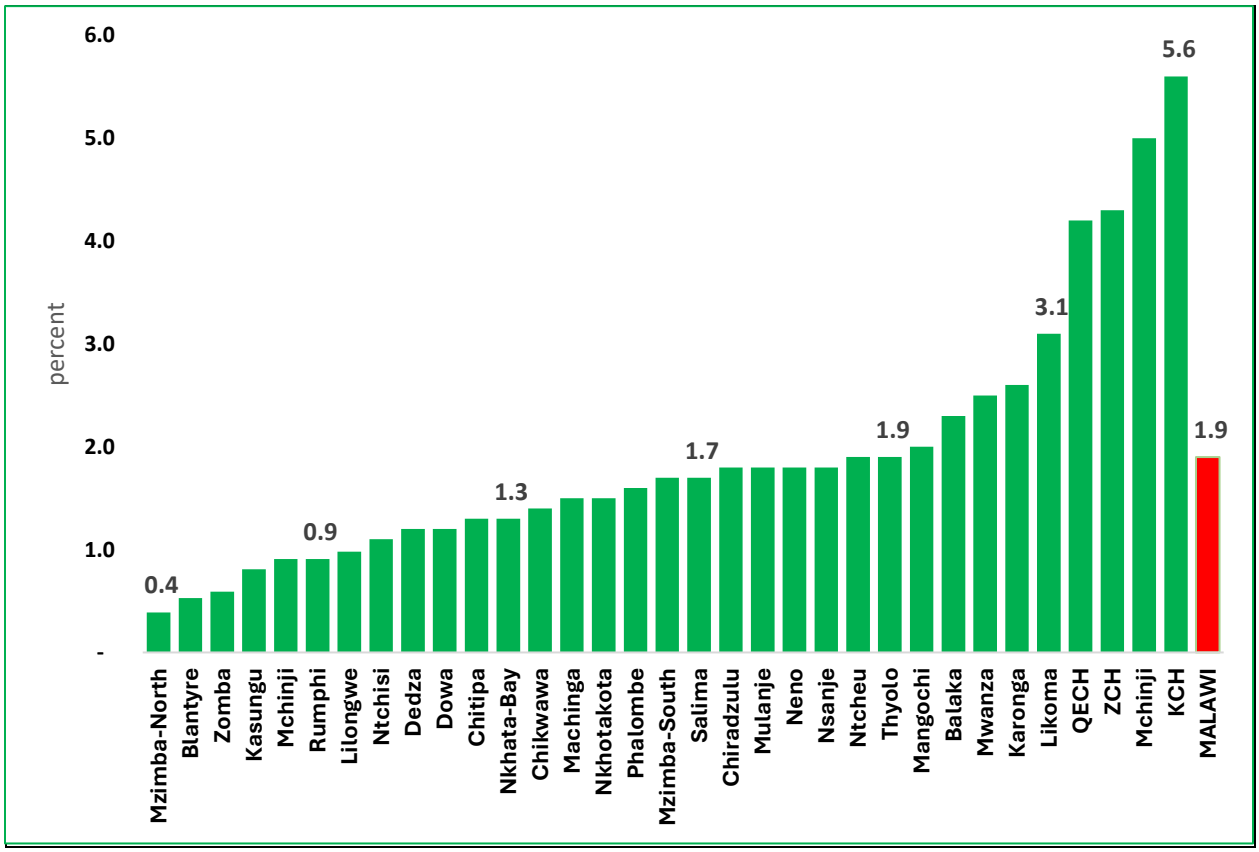
Figure 36: Malaria incidence rate per 1000 population by district



3.1.2.4. Overall mortality rates

The low number of facilities and essential consumables, medications and diagnostic tests in addition to difficult geography likely leads to decreased utilization with decreased inpatient bed occupancy rate, and this in part has led to elevated inpatient death rates in 2023 (Figure 37). The overall inpatient mortality rate was 19.3 per 1000 admissions with the highest rates of 56, 43 and 42 in Kamuzu, Zomba and Queens Central Hospitals respectively. However, there are five districts including Mchinji, Likoma, Karonga, Mwanza and Balaka who have inpatient morality rates of over 20 per 1000 admissions. Currently primary facility and community deaths cannot be tracked on a large scale to complete the total mortality rates' picture, and the peri-operative mortality rate is also not tracked effectively.

Figure 37:In-patient mortality rates by district



3.1.2 Challenges

Challenges in service delivery stem from lack of resource inputs leading to poor utilization, especially in NCDs and RMNCH and provision of care with subsequent poor outcomes. The root causes of lack of resource inputs included limitations in delays in funding, human resources for health both at national, district and health facility levels, adequate space, protracted procurement processes, delays in orders and funding resources for medications and consumables, and lack of equipment for diagnostics and treatment with little capacity for maintenance. These resource input challenges were compounded by inadequate or poor coverage of training and mentorship for enhancement of service delivery and high-quality data and evidence to make programmatic decisions.

3.1.3 Recommendations

In examination of the data review presented for the service delivery pillar, there remain gaps in basic resource inputs such as trained staff, medications, and equipment for prevention, screening, diagnosis, and treatment of high-burden conditions such as NCDs and MNCH. These gaps are evidenced throughout this chapter in the poor diagnostic, medication, consumable and equipment availability especially for NCD and MNCH from routine data monitoring and the Malawi Health Harmonized Facility Assessment (2024) that in part result in most primary and secondary facilities assessed for Quality of Care (QoC) receiving only one star or two stars. The continuum then leads to a lack of patients receiving care as seen with low outpatient and NCD care utilization and poor patient outcomes and continued elevated mortality especially in MNCH.

Without the resource inputs and adequate facilities, there is a resultant low outpatient utilization and bed occupancy rates that continues the cycle of lack of care delivery and high mortality and morbidity. The continuum is further exacerbated by a lack of well-resourced facilities in rural or hard to reach areas as seen in the district disaggregation. High-quality, adequate service delivery can only be achieved with improved resource inputs, accessible facilities with further acute and chronic care capacity at primary care level and refocusing on the high-burden diseases in Malawi with leveraging integrative patient-centered approaches.

3.2 SOCIAL DETERMINANTS OF HEALTH

The Social Determinants of Health (SDH) pillar within the Health Sector Strategic Plan III (HSSP III) focuses on non-medical factors that significantly influence health outcomes and contribute to health disparities. Research suggests that sectors outside of healthcare, such as housing, education, and access to clean water, have a more substantial impact on population health than the healthcare sector itself. Addressing these determinants is critical to achieving health equity and fostering overall well-being. In the reporting year, a Technical Working Group (TWG) on Social Determinants of Health was established, marking a step forward in collaboration across sectors to address these issues.

3.1.3. *Progress against strategies for addressing social determinants of health*

3.2.4.1 Drive wellness and healthy lifestyle practices in the community and healthcare system

A total of 814,800 out of 4,200,000 households were reached with information and communication on personal health (e.g., nutrition, disease prevention); environmental factors (e.g., water sanitation and hygiene, safe housing, occupational health); and community, social, and civic life (e.g., individual and community interactions, health policies, human rights). The following activities were conducted to reach the population:

- Procurement of Communication Equipment: 29 Public Address Systems and megaphones were distributed across all 29 District Councils, funded by GAVI, UNICEF, and the World Bank.
- Development of Communication Strategies: National strategies were developed for Non-Communicable Diseases (NCDs), Typhoid Conjugate Vaccine (TCV) for Malaria, and the Expanded Program on Immunization (EPI), financially supported by the Clinton Health Initiative (CHAI) and Palladium.
- Training for Health Promotion Officers: District Health Promotion Officers were trained in Social Learning, Interpersonal Communication, and Community Feedback Techniques with funding from UNICEF, enhancing skills for community engagement.
- World Health Day Observances: Health awareness days included World TB Day on March 24, World Health Day on April 7, World Malaria Day on April 25, DADC Malaria Week held in the second week of November, World AIDS Day on December 1, as well as events for World Handwashing Day, and awareness days for Diabetes and Cervical Cancer.

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

Efforts to enhance sanitary facilities and improve access to clean water, safe housing and secure workplaces face significant challenges due to cyclones and floods that can damage water infrastructure and sanitation systems were made. According to the Joint Monitoring Program (JMP), in 2020, 70 percent of the population in Malawi had at least basic access to improved water supply services, i.e. having an improved water source within a round trip of walking distance of 30 minutes. During the reporting year, it was established that up to 83 percent of households had access to clean water per national guidelines.

The ministry conducted an inspection of food and fortification monitoring. Ninety seven percent of the salt that was monitored was found with iodine, 96% was properly labelled and 94% was well packaged. During the same period, of the food stuffs that were inspected 99% were found to be fit for human consumption. Of the food premises that were audited only 59% were satisfactory and of the food handlers that went for medical examination only 54.7% were certified fit.

Sanitation and Hygiene Overview

In 2023, sanitation coverage in Malawi was impacted by cyclones, resulting in a significant decrease in overall sanitation metrics. Currently, 53% of villages and 49% of Traditional Authorities (TAs) have attained Open Defecation Free (ODF) status, a decrease from previous years due to storm-related damage. The situation in health facilities is equally challenging, with sanitation and hygiene coverage now at 37%**,** highlighting the strain on infrastructure and the urgency for recovery measures. The percentage of households with handwashing facilities is similarly limited, standing at 47%**,** underscoring the need for expanded sanitation resources and public health efforts.

To address these sanitation gaps and strengthen public health, the Ministry of Health reviewed and developed comprehensive monitoring tools at both national and district levels. These tools are designed to track and evaluate the performance of key public health themes, including food safety and hygiene, occupational health and safety, vector and vermin control, water sanitation and hygiene, health emergencies, and climate change resilience.

Progress in policy development also marked a key achievement for the Ministry. Two major policies were introduced: the Food Safety and Hygiene Policy and the Healthcare Waste Management Policy. The latter was approved in May 2024 alongside a 10-year roadmap for healthcare waste management. The Healthcare Waste Management Policy has been printed and is pending an official launch and distribution, while the Food Safety Policy awaits cabinet committee presentation. Additionally, the Ministry developed guidelines on Port Health and Healthcare Waste Management**,** both presented at the Social Determinants Technical Working Group and awaiting senior management review.

These developments indicate Malawi's ongoing commitment to enhancing sanitation, hygiene, and overall public health standards despite recent setbacks from climate-related events. The new policies and monitoring frameworks lay a foundation for improving hygiene, waste management, and health facility sanitation as the country continues to build resilience against future environmental and public health challenges.

3.1.1.2 Strengthen occupational health

Working conditions must prioritize the safety and health of all employees through the implementation of effective systems and policies. The Government and health sector are committed to promoting and maintaining the highest standards of physical, mental, and social health across all workplaces. Healthcare workers are particularly vulnerable to various occupational hazards including infectious diseases, hazardous chemicals, radiation, excessive heat and noise, violence, and harassment as well as inadequate access to safe water, sanitation, and hygiene.

Table 1:Progress on Occupational Safety and Health (OSH) Indicators and Target

Indicator	Baseline	Target	Progress by 2023
Number of new regulations, policies or guidelines developed	2	3	66.7%
Number of specialized OSH personnel trained	1	6	In progress
Number of personnel trained in OSH short courses	0	50	200%

Indicator	Baseline	Target	Progress by 2023
Number of OSH clinic monitoring and continuous improvement tools developed	0	3	33.3%
Number of OSH service centres established	0	8	163%
Number of miners and ex-miners screened for occupational lung diseases	0	1650	400%
Number of health care workers screened for occupational lung diseases	0	4000	75%
Number of OSH visibility and awareness programs	0	2	100%
Percentage of institutions adhering to minimum standards on occupational health			15

During the year, a total of 110 out of 735 health facilities, representing 15 percent, demonstrated adherence to minimum standards for occupational health. Figure 2 illustrates districts based on the health facilities that complied with these minimum standards.

3.1.1.3 Strengthen vector and vermin control, pandemic, disaster preparedness response and surveillance of diseases

Malawi has grappled with various emergencies during the reporting period including disease outbreaks such as Cholera and climate related disasters, notably Tropical Cyclone Freddy. The country is highly vulnerable to the impacts of disasters due to its geographical location along the Great African Rift Valley, rapid population growth, poor settlement patterns, weak infrastructure, and limited access to information and knowledge on climate change, among

other factors. Floods, cyclones and droughts are the most prevalent weather-related shocks affecting Malawi (JICA, 2022; PHIM, 2023).

In March 2023, Malawi was hit by Tropical Cyclone Freddy which impacted numerous districts in the southern region of the country. It is estimated that over 2,267,458 individuals, representing 11 percent of the total population, were affected with more than 659,278 displaced and 679 reported deceased, along with 537 individuals missing and over 2,186 injured. Of those affected, over 58 percent were women of reproductive age and four percent were pregnant women (Government of Malawi, 2023). The impact of Cyclone Freddy was significantly greater compared to Tropical Cyclone Ana which occurred in 2022. Notably, Tropical Cyclone Freddy struck when Malawi was experiencing one of the worst cholera outbreaks in recorded history with 59,060 cases and 1,769 cholera – related deaths (CFR=3.0%) reported across all 29 districts by the end of October 2023 (FEWSNET, 2023; WHO, 2024). Following a decline in the cases from August 2023, the Malawi Government declared that cholera was no longer a public health emergency during the same period.

Table 2: Impact Summary of Affected, Displaced, and Casualty Figures by Year

YEAR	People Affected	People Displaced	People Died	People Missing	People injured
2022	990,000	190,400	46	18	200
2023	2,267,458	659,278	679	537	2186
TOTAL	**3,257,458**	**849,678**	**725**	**555**	**2386**

Source: Cyclone Anna Flash Appeal 2022 and Cyclone Fredy PDNA Report 2023

The emergencies underscore the urgent need to enhance the country's emergency preparedness and response capabilities. However, currently, only 17 percent of the country's districts have established emergency preparedness and response plans.

3.1.1.4 Strengthen intersectoral prevention and response to violence, discrimination, accidents, and injury

In 2023, Malawi made significant strides in enhancing intersectoral prevention and response mechanisms to address issues of violence, discrimination, accidents and injuries. Firstly, a stakeholder mapping was conducted to map our partners and stakeholders to work together toward prevention and response to violence, discrimination, accidents, and injury. Besides, capacity building for grievance redress committees was conducted across all the facilities/districts. The Ministry also mobilized resources for accidents and injury prevention.

Through the Spotlight Initiative, a collaborative effort between the UN, the EU and the Malawi government, focused on eliminating violence against women and girls, the provision of services for survivors and the legal framework for gender equality have been improved as a way of addressing violence and discrimination against girls and women. The Ministry of Health ensured access to sexual and reproductive health rights (SRHR) and quality service delivery (Spotlight Initiative Malawi, 2023).

Collaborative efforts have been initiated to reduce violence stemming from ethnic and political intolerance through a project implemented in Mulanje and Mangochi districts by UNDP, UNFPA, UN Women, UNODC, IOM, the Ministry of Local Government, District Councils of Mulanje and Mangochi, Malawi Police Service and the Public Affairs Committee with funding from the Governments of Ireland and Iceland. Training programs have been implemented to equip community leaders and local structures with skills necessary to prevent conflicts from escalating into violence (UNDP, 2022).

3.1.1.5 Address health and health delivery effects of climate change

In a notable achievement for climate and health integration, Malawi secured climate financing worth $36 million from the Green Climate Fund (GCF). This funding represents a critical step towards enhancing climate resilience within the health sector. Of the total, $31 million will be allocated to Save the Children International (SCI), which will implement climate adaptation and mitigation interventions aimed at improving the healthcare infrastructure and community resilience to climate-related shocks. Meanwhile, $5 million is designated for the Ministry of Health (MoH) to integrate climate risk management into health systems, enabling better preparedness and response to climate-induced health risks. The final approval for this funding was granted in October 2023, signifying a significant

collaboration between international partners and the government to address climate-related health vulnerabilities (Green Climate Fund, 2021).

During the year, the Ministry of Health, through partnerships with the Rockefeller Foundation and Seed Global Health, successfully mobilized $350,000 to conduct critical vulnerability and adaptation assessments. These assessments aim to identify the most pressing health risks posed by climate change and develop strategic interventions to strengthen community and health facility resilience. The funding will support climate adaptation activities that are directly linked to enhancing the public health sector's capacity to cope with extreme weather events, such as floods and droughts. This initiative is a key part of the broader strategy to build a climate-resilient health system by understanding and addressing the vulnerabilities of communities most affected by climate impacts.

Malawi's National Multi-Hazard RCCE Strategy was developed as a comprehensive framework to improve risk communication and community engagement in times of crisis. The strategy focuses on building a more resilient population by enhancing public awareness and preparedness for multiple hazards, including climate-related disasters, disease outbreaks, and other emergencies. The RCCE strategy is aligned with Malawi's broader disaster risk management framework and health communication efforts, fostering better collaboration between government agencies, health workers, and local communities to manage risks and mitigate the impacts of various hazards.

3.1.4. *Challenges*

- Weak coordination and communication among various ministries, agencies, and sectors involved in health, disaster management, and agriculture hinder progress.
- Limited funding for outreach programs, particularly in rural and hard-to-reach areas, impacts the Ministry’s ability to provide education and services.
- Only 17% of districts have established emergency preparedness and response plans, despite recurring disasters like cyclones and floods.
- While 15% of facilities adhere to occupational health standards, a significant number still fall short, leaving workers exposed to various risks.
- There is insufficient awareness among community health workers on the impact of climate change on health, limiting their ability to address climate-related conditions.

3.1.5. *Recommendations*

- Strengthen collaboration between ministries and sectors, ensuring smoother communication and shared responsibilities in addressing social determinants of health.
- Allocate additional resources to expand outreach programs, especially targeting rural and marginalized areas, to increase coverage of health education and services.
- Prioritize the development and implementation of emergency preparedness and response plans in districts highly vulnerable to natural disasters.
- Increase efforts to ensure all health facilities comply with minimum occupational health standards, improving the safety of healthcare workers.
- Integrate climate risk management into the training of community health workers, ensuring they can address climate-related health impacts effectively.

3.3 INFRASTRUCTURE AND HEALTH TECHNOLOGIES

The infrastructure and health technologies pillar of HSSP III is pivotal to enhancing the availability, accessibility, and quality of health infrastructure and medical equipment across Malawi. The progress within the Infrastructure and Health Technologies pillar is driven by the following key strategies:

3.1.6. *Progress against reform*

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

The Ministry of Health started discussions and necessary planning work with district health offices and prospective funders to upgrade initial health centres to community hospitals in Blantyre, Lilongwe and Mzuzu. This initial planning work will be integrated into the Capital Investment plan currently in development. The Ministry also procured specialised equipment to start the establishment of an ophthalmology centre of excellence at Kamuzu Central Hospital and allocated resources for the establishment of a cardiac centre of

excellence at Queen Elizabeth Central Hospital. Initial equipment was procured and HRH capacity building commenced for the cardiac centre of excellence.

3.1.7. *Progress against strategies*

1. **Construction of new Health Infrastructure**: The expansion of the health network by constructing new facilities in underserved areas is fundamental to ensuring equitable healthcare access.

Table 3: Progress Overview of Health Infrastructure Projects by Funders

Funder	Project	Contract value ($)	Expenditure to date ($)	% progress to date
GoM, OFID and IAEA	**National Cancer Centre**	**USD7,709,477 .36**	**USD 6,309,510.99**	95% complete. The contractor is finalizing the civil works. Installation of equipment is in progress.
GoM	**Domasi Community Hospital**	**MWK6,994,01 1 ,641.44**	**MWK5,121,013, 024.20**	The overall progress is 95%, with the contractor working on fittings, paintings, and other finishing touches. Priority was given to completing the Outpatient Department (OPD), Administration Block, ten staff houses, and

Funder	Project	Contract value ($)	Expenditure to date ($)	% progress to date
				essential external works.
GoM	**Mponela Community Hospital**	**MWK7,953,522,080.13**	**MWK5,870,941,168.77**	The overall progress is at over 40%. Phase 1 is at 85%. It includes an administration block, Outpatient Department block (OPD), Maternal and Child Health (MCH), X-Ray, and Mortuary. The Contractor has finalized painting and installing electrical and sanitary fittings. On external works, the contractor has done the road layout. Phase 2 is at 55% - It includes, Theatre, male, female, paediatric wards, maternity wing, nutrition block, kitchen, laundry. The

Funder	Project	Contract value ($)	Expenditure to date ($)	% progress to date
				contractor has finalized roofing, plastering, and applying undercoat to the interior walls of the 4 blocks, namely, the nutrition block, paediatric ward as well as male and female wards. Phase 3 is at 0%. This includes the construction of staff houses
GoM and the Global Fund (**55 Health Posts/ Improved Access to Primary Health Care**)	**25 Health posts under Global Fund**	**MWK4,617,189,889.20**	Mwanza Neno- **1,603,349,916** Thyolo & Phalombe - **1,034,188,804** Dedza- **566,887,478** Ntchisi- **514,622,681** Mzimba North- **721,355,708**	The overall progress is 85%. The contractors are currently focusing on the finishing touches.

Funder	Project	Contract value ($)	Expenditure to date ($)	% progress to date
	30 Health Posts under MoG	**MWK 2,000,000,000.00**		At the contract award stage. Other health posts are being supported by other partners and councils themselves. So far 75 health posts have been completed.
the Global Fund	**Mzuzu Central Hospital gas plant**	**MWK 93,327,567.50**	**74,132,710**	Two machines out of the three were installed but not yet commissioned. Currently fixing the electrical works. Expected commissioning end November 2024
the Global Fund	**Mzuzu Infectious Disease unit**	**MWK1,793,117,579.84**	**1,454,253,987**	The contractor is roofing the structures. Expected completion March 2025
GAVI	**Construction and**	**MWK470,000,000.00**	**MWK329,000,000.00**	Mangochi; the contractor has

Funder	Project	Contract value ($)	Expenditure to date ($)	% progress to date
	installation of Incinerators in Mzuzu and Mangochi			finalized the slab ready to install the mechanical incinerator. Mzuzu; the contractor has commenced the civil works.
GAVI	**Construction of vaccine stores**	**MWK2,356,035,320.25**	**MWK1,040,260,904.06**	Mzimba District Hospital, the contractor is working on finishes, windows, and sanitary fittings among others. Central Medical Stores, the contractor is working on the roof. Mangochi, the superstructure walls were erected, and the contractor is about to start the ring-beam. Domasi, the contractor is

Funder	Project	Contract value ($)	Expenditure to date ($)	% progress to date
				working on the superstructure walls, at the window level
the Global Fund	**Construction and installation of the Kasungu incinerator**	**MWK453,035,442.35**	**MWK215,022,897.00**	The contractor has finalized all civil works, installed the machinery, and is ready to be commissioned.
World Bank	**QECH infectious diseases unit**	**15,000,000,000**		Contract awarded, mobilization in progress.

Completed new infrastructure

These include the Lilongwe Institute of Orthopaedic and Neurosurgery (LION) phase 1, Zomba Infectious Disease Unit, Nancholi Health Centre, area 23 Health Centre, Makina Health Centre, and MDR TB isolation wards in Karonga, Rumphi, Mzimba, Kasungu, Balaka, Zomba, QECH, KCH and Nsanje.

Stalled new infrastructure

These include Lilongwe Health Sciences blocks, Central Hospital flats, 10 health centres, and TB block at CHSU.

2. **Rehabilitation, Upgrading, and Maintenance of Existing Health Infrastructure**: Modernizing existing facilities to meet the increasing health demands remains a crucial focus. Rehabilitation helps decongest central hospitals by improving the capacity and functionality of lower-level facilities.

Table 4: Health Infrastructure Rehabilitation and Construction Projects

Funder	Project	Contract value ($)	Expenditure to date ($)	% progress to date
the Global Fund	**Rehabilitation of laboratories (Mulanje DHO, Kakoma in Chikwawa, Malomo in Ntchisi and Jenda)**	**MWK712,357,250.94**	Mulanje-**111,711,556** Kakoma-**123,560,573** Malomo-**112,461,041** Jenda-**48,244,388**	Chikwawa, the contractor is working on floor finishes and external works. overall progress is at 85% Mulanje, overall progress is at 75%. The contractor has installed the ceiling, aluminium windows, and door frames, remaining with sanitary fitting. QECH, the overall progress is at 85%. The contractor has installed ceiling boards, painting has been done remaining with the last coat, windows installed, remaining with vinyl sheeting and electrical fittings.

Funder	Project	Contract value ($)	Expenditure to date ($)	% progress to date
				Jenda, the contractor finalized the painting and joinery fittings, remaining with finalizing floor finishes (vinyl sheeting) Ntchisi, finalized painting finishes and joinery fittings, remaining with the installation of air conditioning and sluice
The World Bank	**Central hospitals rehabilitation**	**MWK8,500,000,000**		Contracts awarded
The World Bank	**Minor rehabilitation (OHC, Labs and X-ray rooms)**	**4,979,592,640.90**		Contracts awarded and on-site

Completed rehabilitation

The Ministry working with NLGFC under this project. The sites for the rehabilitations include Chikwawa, Balaka, Kasungu, Dowa, Mzimba, and Chitipa. Furthermore, the NLGFC has commenced rehabilitation work in the remaining 23 districts.

Stalled rehabilitation work

These include the results-based Financing of Maternal and Newborn Health project (Balaka, Ntcheu, Dedza, and Mchinji) and Balaka isolation ward.

Pipeline Projects:
These include.

- Upgrading of Health Centres into Urban and Rural Community Hospitals
- Improvement of primary health facilities (health centre's) programme
- Establishment of Centres of Excellence at the Central Hospitals
- Upgrading of Health Centres into Urban and Rural Community Hospitals
- Construction of 200 Health posts
- Establishment of a mental facility at Kamuzu Central

The effective execution of these projects is however subject to the availability of funding.

Infrastructure Guidelines

The Ministry of Health is developing Standardized Health Infrastructure Guidelines to ensure consistency in the design and construction of health facilities across all levels of care. These guidelines will align with the Health Service Package (HSP) and provide standardized specifications for health infrastructure, including facility designs and staff accommodations. This initiative aims to enhance the quality and uniformity of healthcare delivery by establishing clear infrastructure standards for all health facilities.

Capital Investment Plan (CIP)

The Ministry is developing the Capital Investment Plan (CIP) which will prioritize capital investments for the HSSP III. The CIP will guide capital investments by all stakeholders and form the basis of an infrastructure management system.

3. **Strengthening Evidence-Based Management of Infrastructure and Medical Equipment**: This strategy emphasizes the need for efficient resource management, aiming to ensure that health facilities are well-equipped, and infrastructure is maintained to meet long-term health needs. In the year under review, the Ministry commenced the development of an equipment tracking system with the support of the Health Services Joint Fund.

3.1.8. *Challenges*

- Funding shortfalls have been a major impediment to completing infrastructure projects on schedule.
- Price fluctuations due to inflation and devaluation.
- Delays in the release of government funding have hindered project momentum.

3.1.9. *Recommendations*

1. Advocate for improved processes for the timely release of funds, possibly through a fast-track disbursement mechanism
2. Implement more robust financial monitoring systems to track budget performance against inflation and currency exchange rates
3. Alignment of projects towards one plan, one budget, and one PIU to enhance efficiency and quick decision-making.

3.4 HUMAN RESOURCES FOR HEALTH

The Human Resources for Health (HRH) pillar of the HSSP III is pivotal to ensuring the availability of competent and motivated human resources for health for quality health service delivery that is effective, efficient and equitable. This pillar aims to improve the recruitment, deployment, development, and retention of healthcare professionals, thereby contributing to the achievement of Universal Health Coverage (UHC) by 2030.

3.1.10. *Progress against HRH reforms*

Performance Management System (PMS)

The first HRH reform is stated as the "development and implementation of a robust performance management system that is linked to implementation of strategic and operational plans at the national/district/facility levels and all Ministry of Health employee promotions, incentives, and disciplinary systems". The performance management system reform includes capacity building for managers in performance management systems (PMS) and aligning performance appraisals with job descriptions and work plans.

Performance Management System (PMS) orientation was successfully conducted for all District Health Offices (4 people per district), Central Hospitals, the Ministry of Health (MoH) headquarters, and the Health Service Commission, establishing a foundation for consistent workforce accountability across the health sector. The implementation of PMS has progressed significantly in districts such as Lilongwe, Dedza, Ntcheu, Mchinji, Zomba, Mangochi, Blantyre, and Phalombe. This progress paves the way for more structured performance appraisals and improved alignment of staff goals with institutional objectives.

Re-engineering health workforce cadres

The second HRH reform entails evaluating and re-engineering health worker cadres to reflect the changing pattern of the burden of disease and numbers of patients. It will involve phasing out some cadres based on evidence, re-orienting other existing cadres into new roles and introducing new ones as necessary. It will also entail rationalizing pre-service and in-service training to ensure it supports the training requirements of this workforce optimization reform while fully recognizing other objectives of health training institutions that are under the education sector. The Ministry of Health with the financial support of USAID commissioned a holistic health worker cadres review in the 2023/24 FY and the report is nearly complete.

Inservice training integration

The third HRH reform focuses on developing and implementing an integrated in-service training curriculum that is linked to a coordinated Continuing Professional Development (CPD) system to generate efficiency savings and enhance performance. It will also ensure that health workers have requisite competencies to deliver comprehensive care. The Ministry of Health commissioned work to develop an integrated in-service curriculum and the report is almost complete. A CPD harmonisation taskforce was established under the Quality management directorate to spearhead this work. An integrated CPD pilot, supported by GIZ, is underway in Ntcheu, focusing on standardizing in-service training for all health cadres. This pilot will serve as a model for scaling CPD nationally to enhance skills consistently across districts.

3.1.11. *Progress against Strategies*

The progress within the HRH pillar is driven by the following key strategies:

1. Recruitment, Selection, Deployment, and Equitable Distribution of Health Workers

The focus here is on increasing the number of health workers and ensuring their equitable deployment, particularly in hard-to-reach areas.

Table 5: Health Worker Distribution by Zone

Zone	2019	2020	2021	2022	2023
Northern	5371	6114	6,885	7271	7,583
Central East	3985	4854	5,241	5543	5,691
Central West	9113	11847	12,421	12551	13,261
Southeast	7642	8551	8,707	8903	9,112
Southwest	8176	8954	9,195	9432	9,861
Malawi	**34,287**	**40,320**	**42,449**	**43,700**	**45,508**

The total number of health workers increased from 34,287 in 2019 to 45,508 in 2023, representing a growth of approximately 32.7% over five years. This indicates a steady increase in workforce capacity across the health sector, which is critical for improving healthcare service delivery.

Table 6:Health worker distribution by district & cadre (2023)

Zone	Doctors	clinical off	Clinical Tech	Med Assist	Nursing Off	Nurse Tech	CMA	Lab	Comm..	Pharmacy
North	123	167	223	410	463	807	51	104	1118	81
Central East	58	206	231	391	453	1012	78	89	2456	89
Central West	326	228	412	588	808	1548	124	331	3687	186
Southwest	330	299	488	612	732	1877	133	346	4113	217
Southeast	79	146	301	479	567	941	86	187	2644	144
Total	**916**	**1046**	**1655**	**2480**	**3023**	**6185**	**472**	**1057**	**14018**	**720**

Public Health sector/CHAM facility vacancy rates by cadres

The table below examines vacancy rates across key health cadres in Malawi's public sector health facilities. Vacancy rates reflect staffing gaps that can have significant impacts on service delivery, particularly for critical positions like medical officers, nurses, and laboratory technicians. in critical roles such as medical officers, nurses, and lab technicians etc

Table 7: Healthcare Workforce Distribution and Vacancy Rates by Sub-Cadre

Sub- Cadre	Authorized Posts	Filled Posts	Vacancies	Vacancy Rate (%)
Medical Officer/Specialist	1547	916	531	41
Clinical officer/Technician	3218	2701	517	16
Medical Assistant	3444	2480	964	28
Nursing/Midwifery Officer	3381	3023	358	11
Nurse/Midwife Technician	10612	6184	4428	42
Laboratory Technician	963	554	409	42
Pharmacist	228	149	79	35
Pharmacy Technician	812	419	393	48
Pharmacy Assistant	243	152	91	37
Laboratory Assistant	717	501	216	30

The Nurse/Midwife Technician role has the highest vacancy rate at 42% with 4,428 unfilled positions out of 10,612 authorized posts, followed closely by Laboratory Technicians (42%) and Pharmacy Technicians (48%). The Medical Officer/Specialist category also shows a high vacancy rate of 41%, with 531 vacancies. Lower vacancy rates are seen in Nursing/Midwifery Officers (11%) and Clinical Officers/Technicians (16%), indicating relatively better staffing in these roles.

Table 8: Recruitment numbers by funders (government and partners)

Year	Total recruited	Gov funded	Global fund	PEPFAR	DAI / G to G / GSED
2019/20	2283	1582	484	119	221
2020/21	11416	2188	9126	102	
2021/22	2118	416	1620		82
2022/23	1820	844	976		
2023/24	6830	1691	5139		

For the period 2019/20 FY to 2023/24 FY, 2020/21FY marked the highest recruitment at 11,416, mainly due to Global Fund support (9,126 hires). The 2023/24 period also saw a

significant total of 6,830 recruits, with the Global Fund again as a primary contributor. Government funding remained steady across years, peaking in 2019/20 with 1,582 recruits and showing consistent support alongside variations in external funding. PEPFAR and DAI/G to G/GSED had smaller, fluctuating roles, emphasizing their targeted funding approach compared to the broader contributions of the Global Fund and government.

Optimization of Training Institutions and Coordination with Health Sector Needs

Table 9: Health Training Colleges Output

CADRE	2019	2020	2021	2022	2023	TOTAL
Physician (Medical Doctors)	51	48	66	71	67	**303**
Laboratory Technologists	33	41	39	51	38	**202**
Pharmacists	28	31	47	44	33	**183**
Physiotherapists	17	28	41	28	47	**161**
Nurse / Midwife Technician	518	812	701	811	1233	**4075**
Clinical Officer	18	37	41	32	28	**156**
Registered Nurses	52	79	112	88	91	**422**
Medical Assistant*	132	118	176	210	177	**813**
Radiography Technician	11	8	24	17	27	**87**
Dental Therapist	18	21	19	14	26	**98**
Environmental Health Officer	67	71	88	112	96	**434**
Laboratory Technician	117	127	141	166	154	**705**
Pharmacy Technician	55	71	48	51	77	**302**
Community Midwife Assistant	244	213	206	231	278	**1172**
Pharmacy Assistant	58	66	91	87	101	**403**
Laboratory Assistants	66	44	51	33	47	**241**
Total	**1485**	**1815**	**1891**	**2046**	**2520**	**9757**

The data highlights the staffing trends across various healthcare cadres from 2019 to 2023, showcasing significant increases in some cadres. The Nurse/Midwife Technician category stands out with a steep rise, totaling 4,075 over five years and peaking in 2023 with 1,233—the highest annual count in any cadre, signaling a major focus on bolstering nursing and midwifery staff.

- Another noteworthy increase is seen in the Community Midwife Assistant cadre, totaling 1,172, showing steady growth each year, likely in response to rising demand for community-based maternal and child health services.
- The Laboratory Technician role also saw growth, totaling 705, with consistent recruitment over the years to support diagnostic services. The Medical Assistant cadre followed suit, reaching a total of 813, and peaking at 210 in 2022.
- Other clinical roles like Registered Nurses (totaling 422) and Environmental Health Officers (totaling 434) reflect a commitment to expanding essential healthcare services, although growth in these areas has been more moderate.
- Physician numbers remain relatively lower in total at 303, though they show consistent growth, emphasizing the challenges and gradual expansion in securing higher-level medical expertise.

Provision of Competitive Remuneration, Benefits, and Working Conditions

Table 11 provides an overview of employee retention and attrition within the health sector across all health cadres for the 2023/24 fiscal year. At the start of this period, there were 47,555 employees, but by the end of the fiscal year, this number had decreased to 45,508, reflecting an overall attrition rate of 4.5%. Throughout the year, 2,047 employees left the health workforce, marking a significant turnover. The data also shows that the average tenure for employees in this sector is approximately seven years, highlighting a moderate level of job stability within health cadres.

Table 10: Staff attrition rate

Health cadre	*Employees at the beginning of 2023/24 fiscal year*	*Employees who left (2023/ 24 fiscal year)*	*Employees at the closure of 2023/24 fiscal year*	*Attrition rate (%)*	*Average years of service*
All Health Cadres	47,555	2,047	45,508	4.5	7

Data Generation and Capacity Building for Evidence-Based HRH Decision-Making

Currently, 21 out of 30 facilities, including central hospitals and the Ministry of Health Headquarters, have access to the Integrated Human Resource Information System (iHRIS), representing 70% coverage; however, only 14 of these are effectively utilizing the system for

workforce management, resulting in an effective usage rate of 46.7%. While iHRIS access is widespread, there are significant gaps in its use, particularly in districts like Lilongwe, Blantyre, Zomba, Mangochi, and others where access exists, but usage is not yet optimized. Additionally, 9 facilities, including Mwanza, Neno, and Balaka, lack iHRIS access altogether.

Table 11: Districts with a functioning iHRIS

S/N	DHO/CENTRAL HOSPITAL	ACCESS	USE
1	Mzimba North	Yes	Yes
2	Mzimba South	Yes	Yes
3	Lilongwe	Yes	No
4	Blantyre	Yes	No
5	Zomba	Yes	No
6	Mangochi	Yes	No
7	Mulanje	Yes	No
8	Thyolo	Yes	No
9	Chikwawa	Yes	No
10	Kasungu	Yes	No
11	Dowa	Yes	No
12	Central Hospitals	No	No
13	Chitipa	Yes	Yes
14	Karonga	Yes	Yes
15	Rumphi	Yes	Yes
16	Likoma	Yes	Yes
17	Mchinji	Yes	Yes
18	Salima	Yes	Yes
19	Nkhotakota	Yes	Yes
20	Mwanza	No	No
21	Neno	No	No
22	Chiradzulu	No	No
23	Ntcheu	Yes	Yes
24	Dedza	Yes	Yes
25	Balaka	No	No
26	Machinga	No	No
27	Phalombe	No	No
28	Nsanje	No	No
29	Nkhatabay	Yes	Yes
30	MoH HQ	Yes	Yes

3.1.12. *Challenges:*

- Limited funding prevents the Ministry from meeting its recruitment targets, causing workforce shortages, especially in underserved areas.
- Budget cuts have reduced pre-service and in-service training opportunities, hindering workforce development.
- Strict establishment rules prevent timely adjustments in staffing levels, delaying recruitment and deployment.
- Delayed promotions have led to dissatisfied health workers, resulting in legal disputes and reduced morale.
- Training programs are not adequately aligned with the needs set out in the establishment, leading to inefficient use of resources in the instances where the trained health workforce cannot be absorbed due to their cadre not being included in the establishment.
- Poor data sharing within the Ministry hampers effective workforce planning and coordination.
- Lack of access to private sector HRH data limits comprehensive workforce planning and integration efforts.
- The limited use of performance appraisal results, especially for staff promotions, creates a barrier to their effectiveness, as health workers do not recognize the importance of these evaluations.

3.1.13. *Recommendations*

- Continue to lobby for increased funding from MoF, DHRM&D, donors, Local Governments and other HRH stakeholders to increase the amount of sustainable funding for staff recruitment to meet the HR needs of the system.
- Matching pre-service education across Training Institutions to health workforce needs on the ground, and with the establishment to guarantee higher absorption, and cost-effective use of limited resources.
- Enhance the use of iHRIS by ensuring that all DHOs, Central Hospitals, and Ministry departments fully adopt the system for data entry and sharing.
- Update the iHRIS to the latest version to ensure better interoperability with HMIS to ensure simpler data entry.
- The Ministry of Health and key stakeholders such as the Local Government Service Commission should enforce the use of performance appraisals in key decisions like promotions, rewards and sanctions to increase staff engagement and ensure appraisals are meaningful and drive accountability.

3.5 MEDICAL PRODUCTS AND TECHNOLOGIES

The Medical Products and Technology Pillar of the HSSP III aims to ensure the availability, accessibility and rational use of essential medicine and health commodities in Malawi. This Pillar is integral to achieving Universal Health Coverage (UHC) in Malawi by 2030, as uninterrupted access to quality medical products directly influences health outcomes and the whole efficiency of the healthcare system.

A well-functioning supply chain will ensure the timely delivery of health commodities and strengthen the capacity of the health system to respond efficiently to the health needs of the population. The Ministry of Health is hence implementing the Malawi National Supply Chain Transformation Plan (MNSCTP), a comprehensive strategic framework designed to reform the supply chain in alignment with the goals outlined in the HSSP III. The MNSCTP focuses on ten key areas: procurement, warehousing, distribution, waste management, information systems, financing, human resources, policy and regulation, quantification, and monitoring and evaluation. By addressing these critical areas, the MNSCTP aims to create resilient supply chains that can adapt to the dynamic nature of healthcare, including emergency responses necessitated by recent natural disasters and public health crises.

3.5.8 Progress against reform

The reform under this pillar is to identify and address inefficiencies at the procurement, warehousing, distribution and utilization stages of the supply chain system for medicines and medical products. This will involve generating the relevant evidence and implementing the prioritized interventions including 1) harmonizing and digitalizing quantification and tracking system for medicines and consumables to achieve a data-driven ordering and supply chain at all levels of decision making; 2) integrating planning, coordination, management and monitoring and evaluation activities of the supply chain; and, 3) working towards greater systems integration through CMST by 2030. The reform falls under the strategy of improving capacity to oversee, supervise, and coordinate across all supply chains and stakeholders.

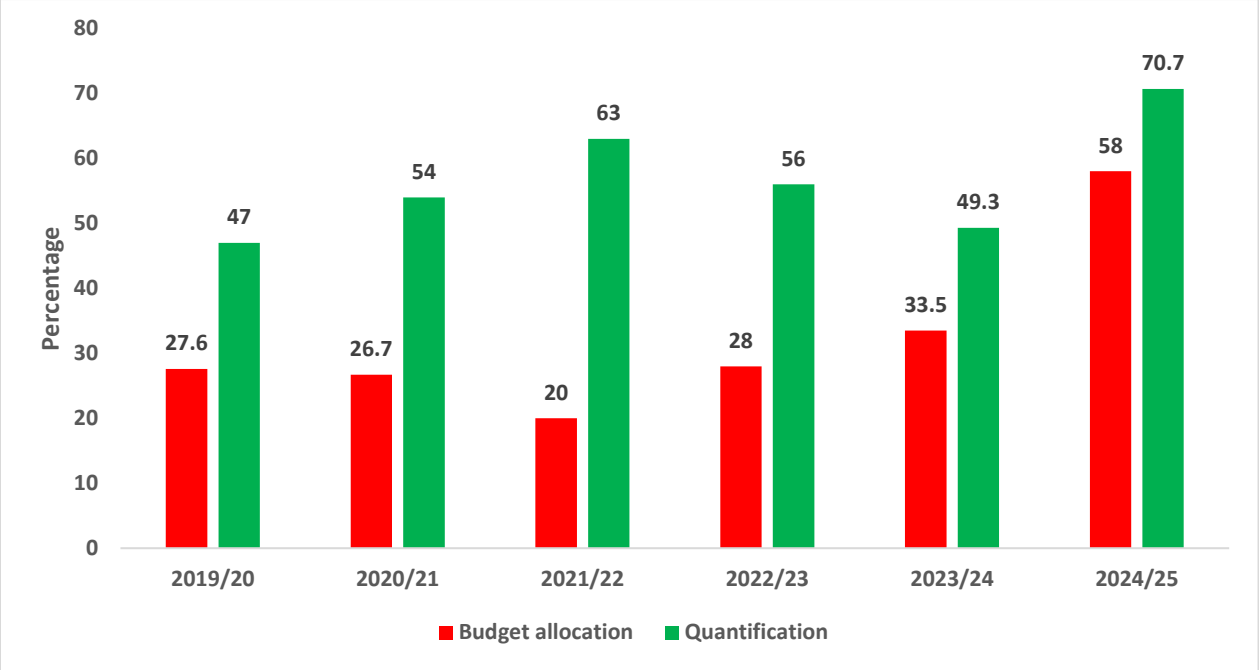
The Ministry of Health is establishing a Logistics Management Unit (LMU) to improve pharmaceutical and health product management in Malawi. The LMU will lead and integrate supply chain systems for health commodities, aiming to reduce stockouts and wastage and support universal health coverage by 2030. Designed as a coordination platform, the LMU will streamline logistics activities across public health programs to maximize efficiency and minimize waste. Supported by the Global Fund, a Program Management Office was established in 2023 to develop an LMU blueprint, endorsed by the Drugs and Medical Supplies TWG. Despite progress, resource mobilization challenges remain, but a phased approach will ensure the LMU's sustainable implementation.

3.1.14. *Progress against strategies*

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

To achieve this strategy in the 2023/24 financial year, the Ministry invested significantly in estimating health needs and optimizing supply planning and resource allocation to the central hospitals, district councils and the Central Medical Stores Trust (CMST). The challenge in implementing this strategy, however, was the inadequate financing of the commodities procured through Government funding via CMST. The allocation of resources was inadequate to meet the country’s healthcare demands, as illustrated by the disparity between the total quantified needs and the allocated drug budget (Figure 1). The CMST average order fill rate to district councils was 43%.

Figure 38:Quantification vs drug budget allocation



In the 2024/2025 financial year, although central hospitals have been allocated funding according to the quantification report, district councils remain significantly underfunded by the National Local Government Finance Committee (NLGFC). This underfunding is further highlighted by health facilities overshooting their respective drug budgets while CMST delivers on average less than 50% of ordered supplies. As of October 2024, district councils have consumed 57% of the Drug budget in 5 months with a high likelihood of depleting their reserves before the end of the 12-month period.

Table 12: District Hospital Budget Drawdowns

Budget Draw Downs for March 2024				
Facility	**Budget Allocation**	**YTD draw downs**	**% Draw Down**	**% Expected Draw Down**
	MK'000	**MK'000**		
Balaka DHO	622,368	984,327	158.16	100.00
Blantyre DHO	1,770,880	1,779,957	100.51	100.00
Chikwawa DHO	802,265	802,625	100.04	100.00
Chiradzulu DHO	604,062	771,557	127.73	100.00
Machinga DHO	797,649	805,144	100.94	100.00
Mangochi DHO	1,306,141	1,833,431	140.37	100.00
Mulanje DHO	651,187	892,459	137.05	100.00
Mwanza DHO	567,332	585,186	103.15	100.00

Neno DHO	396,795	659,162	166.12	100.00
Nsanje DHO	512,772	614,712	119.88	100.00
Phalombe DHO	612,277	832,954	136.04	100.00
Thyolo DHO	1,021,470	1,164,878	114.04	100.00
Zomba DHO	1,144,131	1,144,549	100.04	100.00
Sub-Total	**10,809,329**	**12,870,940**	**119.07**	**100.00**
Dedza DHO	1,106,541	1,203,530	108.77	100.00
Dowa DHO	1,037,197	1,058,214	102.03	100.00
Kasungu DHO	1,301,299	1,794,281	137.88	100.00
Lilongwe DHO	3,748,036	4,585,898	122.35	100.00
Mchinji DHO	838,292	924,564	110.29	100.00
Nkhotakota DHO	747,259	956,402	127.99	100.00
Ntcheu DHO	865,803	918,905	106.13	100.00
Ntchisi DHO	557,269	646,629	116.04	100.00
Salima DHO	716,911	960,642	134.00	100.00
Sub-Total	**10,918,608**	**13,049,064**	**119.51**	**100.00**
Chitipa DHO	435,566	435,847	100.06	100.00
Karonga DHO	550,212	842,291	153.09	100.00
Likoma DHO	97,475	111,389	114.27	100.00
Mzimba North DHO	743,932	804,644	108.16	100.00
Mzimba South DHO	847,401	1,033,476	121.96	100.00
Nkhatabay DHO	457,806	550,414	120.23	100.00
Rumphi DHO	472,913	605,281	127.99	100.00
Sub-Total	**3,605,304**	**4,383,343**	**121.58**	**100.00**
TOTAL DHOs	**25,333,240**	**30,303,346**	**120.06**	**100.00**

Moreover, delays in the disbursement of funds from the Treasury to CMST and private suppliers exacerbate the situation, resulting in prolonged creditor days and increased prices for government facilities. As of October 2024, CMST is owed more than 30 billion by the NLGFC and Treasury for sales made to district councils and central hospitals. This scenario diminishes the purchasing power of the already constrained resources, complicating the Ministry's ability to effectively procure essential medicines.

Historically, all health facilities relied solely on CMST for their procurement needs. To improve availability in health facilities, recent policy changes now allow central hospitals to utilize 40% of their drug budget and district hospitals to use 10% to procure from private suppliers. However, due to delays in funding disbursements from the Ministry of Finance, these facilities faced some challenges in sourcing from private suppliers, who were often hesitant to engage with government facilities and frequently charged much higher prices. This situation further complicated the procurement landscape, creating additional barriers to access for essential medicines.

To mitigate against these financial challenges, the Ministry continued to lobby for adequate and efficient financing of the health supply chain. A landmark midyear budget review of an additional 10 billion Kwacha was achieved in the 2023/2024 financial year through the support of the parliamentary health committee.

Additionally, the Ministry diversified its funding sources for the essential health program by securing support from donors such as the World Bank, USAID and the Health Sector Joint Fund to supplement where there were shortfalls. Commodities worth over 15 million Dollars from the multiple grants were procured with some items still in the pipeline.

Additionally, the Ministry secured funding for the recapitalization of CMST from the World Bank. 13 million dollars in foreign currency was made available to CMST. This grant had the dual effect of increasing the capital for restocking but also overcoming the challenge of Forex which was a significant bottleneck in the previous year.

Enhance data driven quantification and forecasting processes to inform best-value and flexible procurement of medicines and commodities to deliver health services both within and beyond the Health Benefits Package.

The Ministry of Health recognizes the critical role that effective quantification plays in enhancing the efficiency and effectiveness of health supply chains, particularly in the context of achieving Universal Health Coverage (UHC).

In the 2023/24 year, The Ministry of Health coordinated the quantification process for health commodities in Malawi. This included facilitating the collaboration of key stakeholders and mobilizing the resources to ensure that health facilities are adequately prepared to assess and project their needs for medicines and health commodities. Preparation for the quantification exercise began in September 2024 and the national quantification exercise was conducted in November 2023. District and central hospital personnel underwent training in data cleaning in excel and the Quantification Analytics Tool (QAT), which has been adopted as the standard quantification tool for Malawi.

3.1.15. *Challenges*

Funding Allocation: One significant challenge noted was that funding allocations do not always align with quantification outputs. Historically, this misalignment was partially attributed to the timing of the national quantification exercise, which traditionally took place in January, after the Ministry of Finance had already engaged with the National Local Government Finance Committee (NLGFC) and the Ministry of Health. In 2023, the Ministry

of Health through HTSS successfully adjusted the quantification date to November to align with the budget calendar. Additionally, personnel from the Treasury and NLGFC were invited to participate in the quantification exercise, fostering collaboration and ensuring that financial planning is more closely aligned with health commodity needs.

- Data Quality and Completeness from the oLMIS data from selected facilities posed a challenge and required additional verification from their facilities.

3.1.16. *Recommendations*

- Enhance Resource Mobilization: Explore innovative funding mechanisms to support training and capacity-building initiatives to strengthen data collection.
- Streamline Preparation Processes: Maintain the adjusted November timeline for quantification to ensure alignment with the budgeting process.
- Strengthen Data Quality Initiatives: Invest in ongoing training and support for data management to ensure high-quality data collection and reporting.

Improve procurement practices to ensure best-value, flexible procurement

In the 2023/2024 FY, The Ministry of Health focused on addressing procurement bottlenecks within CMST and the general procurement regulatory environment to allow for faster processing times. Through the Operational Excellence Technical Assistance Team (OPE) for CMST from Kaizen Institute with sponsorship from the Global Fund, a holistic approach was taken to optimize CMST business processes. With regards to procurement, the project aimed to support CMST to improve their procurement processes and mechanisms with focus on areas such as long-term framework supply contracts and contract management.

As of the end of the project, significant progress has been made in moving all of the manual processes into the ERP. At the beginning of the project, there was no contract management in Navision, and the control of purchase orders in the system was sporadic. This resulted in the operations department having no visibility of future orders or deliveries, which manifested as duplicated procurement requests resulting in potential overstocks and mismanagement of stocks. As at the close of the project, all contracts were managed in Navision, with all resultant purchase orders (call orders), also being managed in Navision. Therefore, the pipeline data in Navision, can now be considered as accurate, which should lead to improved quantification, supplier management and pipeline analysis.

Outside of the internal CMST procedures, delays have been experienced in the procurement of health commodities due to the processes at PPDA. In the 2025/24 year, timelines and

thresholds for medicines and medical supplies were revised and therefore the review of procurement dossiers by PPDA is more efficient and an increased number of staff at PPDA also contributed to the quickening of the process. Additionally, CMST has been earmarked by PPDA to be introduced on the e-procurement platform.

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

Effective warehousing management and inventory management is a crucial component of the health supply chain, directly impacting the quality, availability and distribution of essential health commodities. In 2023/24, efforts were directed towards optimizing operations at the central warehouse and the health facilities through digitization were possible and standardized procedures.

At CMST, the OPE aimed to implement good inventory management and warehouse management practices and set up centralized inventory and order management. At the end of the implementation of the project, the biggest improvement was seen around warehousing. The OPE worked with CMST to align the operational processes to the ERP, with the ambition that key performance indicators and management of essential transactions would be monitored daily to ensure that all physical transactions were recorded in the ERP accurately and in a timely manner. This is a remarkable achievement as, at the beginning of the project, CMST warehousing was routinely running parallel processes to the ERP, with transactions being recorded manually outside the system, resulting in large variances between the ERP and the reality captured by stock takes and other audit functions.

The alignment of the operational processes to the ERP was also foundational work in preparation for the transition from Navision to Microsoft Dynamics which has a component of a warehouse management system. Furthermore, preparations are also underway to link bar code scanning equipment to the ERP.

Within this period, CMST has made significant progress in the agenda of building a warehouse to increase storage capacity. This is a priority for the Ministry of Health as funds are currently being spent to outsource storage for government and donor procured commodities which can be repurposed towards further strengthening Malawi's public health supply chain. The drawings were finalised, and the documents were submitted to the public sector investment program to assist with mobilization of resources.

In the downstream supply chain, efforts to optimize inventory management practices focused on the revision of the Malawi Health Commodities Logistics Management Information Systems to guide practices in the public health facilities. The revision included

the addition of guidance on new areas such as reverse logistics, donation guidelines, handling of expired commodities, monitoring and evaluation and dispensing guidelines. The game changer with regards to the updated guidelines is the revision of the stock card to include batch number and expiry date which will strengthen the traceability of commodities. The new stock card and SOPs were finalized but are not yet in use.

Challenges

- The revision of the SOPs is to be accompanied by training; however, the Ministry is yet to identify funding for the activity.
- Funding for the CMST warehouse is yet to be identified.
- Funding for the upgrading of CMST ERP has been identified through the supply chain digitization project, however the project is yet to commence although it has a fixed end date of December 2025
- Many health facilities have inadequate storage space despite the addition of the prefabricated storage units (SIABs). Furthermore, many of the SIABs have maintenance needs which the district councils and central hospitals are not able to maintain. There is funding available through the Global Fund to maintain several units however the funding will not suffice for all damaged SIABs.

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

In addition to the availability of essential health commodities, the rational use of these medicines is a cornerstone of effective healthcare delivery and plays a crucial role in Malawi's health supply chain, particularly as the country strives to achieve Universal Health Coverage (UHC). Ensuring that medicines are prescribed, dispensed, and consumed appropriately not only maximizes therapeutic outcomes but also minimizes the risks of adverse effects and medication misuse. Promoting the rational use of medicine not only improves patient outcomes but also serves as a critical strategy for mitigating pilferage in the health supply chain.

In 2023/24 The Ministry implemented several interventions to strengthen the rational use of medicines and mitigate pilferage. The introduction of the dispensing guidelines in the SOP is a significant milestone as this has been an area that has been overlooked which puts the patient at risk with untrained personnel dispensing medication to patients. The point of dispensing is the last point of contact between the patient and the health facility in most cases, and it is essential that the patient leaves the facility with the right medication and complete information on how to utilize the medicine to promote their safety and health outcome.

In 2023, the Ministry of Health also released the sixth edition of the Malawi Standard Treatment Guidelines (MSTG) and Essential Medicines List which were long overdue for review. One highlight from the review is the incorporation of the Access, Watch and Reserve (AWaRe) categorization on antibiotics. This is a stewardship mechanism developed by the WHO to guide the selection of first line and second line antibiotics according to the likelihood of the development of resistance. This addresses a key aspect of rational medicine use which is Antimicrobial Stewardship (AMS).

To promote transparency and accountability of medicines use, the Ministry continued to implement the eHIN system at the point of dispensing as it requires health workers to account for each item that is either dispensed or administered to a patient. Additionally, the eHIN system tracks health commodities by batch number as well as keeping log health workers performing each transaction. This feature has been useful on several occasions to track irregular transactions in facilities that have good uptake of the system. In the 2023/24 year, the Drug theft investigation unit also continued to conduct audits and raids as part of routine audits but also responses to anonymous tips or police cases where health workers were suspected of theft.

Challenges

- Poor utilization of the eHIN system in most facilities by health workers resulting in low reporting rates in the system. There is no enforcement by the district and central hospital management on use of the system and it appears to be optional and not mandatory.
- DTIU operations are expensive to run and there are often times when the unit has no resources to conduct its work in the facilities.
- Dispensing guidelines are yet to be implemented, funding for the trainings is yet to be identified.

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

Under this strategy, the Ministry aims to promote quality at every stage of the supply chain which is crucial for building confidence among patients and health workers alike. In the 2023/24 FY, significant efforts were directed towards capacitating the national medicines quality control laboratory at PMRA. The lab received accreditation in February 2024 (ISO/IEC 17025;2017) which marks a significant milestone for the country. This means it is now recognized as a lab that gives precise results allowing the lab to also test samples from Global fund and other partners in the approved scope of tests. This also increases the

Ministry's confidence in test results from the lab on commodities procured via CMST and those manufactured locally.

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

In the 2023/24, significant strides were made in enhancing Malawi's health supply chain, through multiple initiatives aimed at digital transformation. These efforts are crucial for improving interoperability, data visibility, and overall efficiency within the health system.

National Product Catalogue

The National Product Catalogue (NPC) is nearing completion and is set to standardize the naming of health commodities across various systems across the supply chain. This standardization is a key enabler for interoperability, facilitating seamless communication and data exchange among different platforms. An orientation workshop for key stakeholders is planned to ensure effective utilization of the NPC upon its finalization.

Supply Chain Digitization Project

The Ministry of Health has successfully secured $4 million in funding from USAID through the Global Fund for a comprehensive supply chain digitization project. This project aims to transition Malawi's existing supply chain architecture to a prescribed model featuring a functional interoperability layer. Key objectives and actions include:

- Enhanced Data Sharing: The new architecture will allow systems to freely share data, improving visibility across the entire supply chain.
- Infrastructure Improvements: Funding will bolster storage infrastructure within the Ministry and upgrade the ERP system at the Central Medical Stores Trust (CMST) to incorporate a warehousing management system.

Migration of the eHIN Platform

Another significant initiative successfully implemented is the migration of the electronic Health Information Network (eHIN) platform from a subscription-based model to an open-source system. This transition is providing is a more cost-effective arrangement than the former subscription-based system which required a few for each user thus accommodating a larger number of users and allowing for easier modifications to meet the specific needs of the Malawian health system. The eHIN system will continue to capture critical data at the point of dispensing, further supporting the rational use of medicines.

Data Visualization Initiatives

For many years, while actionable supply chain data has been generated through the Open Logistics Management Information System (LMIS) in the health sector, it has not been effectively utilized for decision-making. The Ministry of Health put concerted effort in 2023/24 to enhance data visualization to make this information more accessible and actionable. Several interactive dashboards have been developed to present supply chain data in a user-friendly format, enabling stakeholders to analyse trends and make informed choices.

To support these initiatives, a monthly decision-making meeting with key stakeholders is held to review the data displayed in the dashboards. These meetings have proven beneficial in identifying data quality issues, correcting errors, and addressing other challenges within the data management process. The platform facilitates real-time monitoring, ensuring that decision-makers have access to accurate and relevant supply chain information, thereby promoting the effective use of data in improving health outcomes

Challenges

- The digitization project has a fixed end date, which creates pressure to complete all phases of implementation within a limited timeframe. Delays in the project's start could compromise the overall implementation and effectiveness of the system.
- Some data quality issues persist, including inaccuracies and inconsistencies, which can undermine the reliability of the information generated through the systems.
- Despite the migration to an open-source model, the eHIN system has not been fully utilized in many health facilities.

3.6 DIGITAL HEALTH

The Digital Health Pillar of the HSSP III is critical for transforming healthcare delivery through development and integration of digital technologies across Malawi. This pillar aims to enhance access, efficiency, and quality of health services by leveraging digital solutions such as electronic health records (EHRs), health information systems, mobile health (mHealth), and telemedicine, ultimately contributing to the achievement of Universal Health Coverage (UHC) by 2030.

3.1.17. *Progress against Reforms*

3.1.1.6 Malawi Healthcare Information System (MaHIS)

The MaHIS as described above is a comprehensive patient information system that will see all patients being managed under one integrated system. The MaHIS is aimed to reduce redundancy in patient systems and ensure a streamlined one system approach for all programs. The scope of MaHIS is as follows, Outpatient, Inpatient, Emergency health care services across all levels of the healthcare spectrum. Healthcare Technical Support Services such as Laboratory testing, Radiology, Pharmacy services, Physiotherapy, Medical and clinical support services Health care Logistics, Admin and Management support: such as Human Resource Management, finance, inventory management, maintenance, transportation, logistical support. Key progress include.

Development of the Emergency module: An emergency module has been developed and is being piloted at QECH Adult Emergency and Trauma Center (AETC). The module covers patient registration, triage, primary and secondary assessments. The AETC module, also referred to, is expected to reduce redundancy in data collection, efficiently categorize patients using the triage algorithm, and provide quality decisions on patient care.

Development of the OPD module: The OPD module is a general use case for patients in all health facilities. The module covers registration, vital monitoring, consultation, diagnosis and prescription. The module is integrated with dispensation, lab test and ordering functionality. This is a breakthrough in transitioning patient data at the outpatient department as the country has no reliable and functional OPD system.

Expansion to other core modules: Other core modules under development in MaHIS include Antenatal, Labour and Postnatal (MNH), Non-Communicable diseases (NCD), Immunization Registry and In-patient module (IPD)

Integration with other systems: There is a planned integration between MaHIS, iCHIS and Malawi HMIS. The integration between iCHIS and MaHIS will facilitate community referral of patients and follow-up. For Malawi HMIS and MaHIS, the integration will be the streamlined reporting of aggregate data.

3.1.1.7 Integrated community Health information System (iCHIS)

The Integrated Community Health Information System (iCHIS) is a digital toolkit aimed to improve the health of the communities by digitizing services provided by community health workers. The integration in iCHIS was made possible by delinking all parallel community health systems and utilizing one system for community health services approach. The iCHIS collects data of persons, villages and communities also known as village register, water

points, latrines and all environment health related data. It also collects data on RMNCH, IMCI, Malaria, eIDSR and NCDs. The services are mostly aimed to improve the lives of under-five children, pregnant mothers and the community at large. In 2023, iCHIS was rolled out to three districts namely Chitipa, Salima and Mchinji where at least 700 health workers were trained to use the platform.

3.1.1.8 Use of National IDs in healthcare

Use of National IDs is a key reform area in enhancing patient identification in health facilities. The MOH has joined other ministries in using National IDs. The primary use case is patient registration and identification at point of care. This use case is being tested in Karonga targeting five health facilities namely Chilumba Garrison, Chilumba Rural, Kaporo HC, Karonga District hospital and Nyungwe HC. Awareness messages have been sent notifying the public of the use case. At present, National IDs are not mandatory for patients but there is evidence of accelerated care due to reduced traffic at point of registration.

3.1.18. *Progress against strategies*

Table 13: Key Performance Indicators for Digital Health Implementation

Indicator	%	Numerator	Denominator
Percentage of digital health investments coordinated through national governance frameworks	100	44	44
Percentage of health facilities with functional ICT infrastructure	38.07	276	725
Percentage of health workers trained on digital health interventions	7.68	1000	13000
Percentage of facilities using digital health technologies for service delivery	41.38	300	725
Percentage of facilities using OpenLMIS for reporting	55.17	400	725

Improving Coordination of Digital Health Investments

Malawi is among most developing countries that are enhancing the ICT infrastructure to improve health service delivery. Through the digital health division, the country consolidated

and registered all health-related systems on the digital health atlas (DHA). The DHA is a WHO global technology registry platform aiming to strengthen the value and impact of digital health investments, improve coordination, and facilitate institutionalization and scale. The DHA is reviewed annually to ensure up-to-date information on digital investments. Apart from this the digital health has a TWG and Sub-TWGs to monitor performance of investments based on the One Digital Health Plan. To ensure good coordination and governance, the digital health has managed to develop two guiding documents - the digital health policy and product development and request procedure. The digital health policy aims to enforce standards for the digital health investments in the country. The product development and request procedure aim to align stakeholders and partner's requests for system development and also ensure that there is progress tracking of all investments under development.

Establishing Reliable ICT Infrastructure

Lack of adequate ICT equipment remains a challenge in the health sector. Over time the equipment has been managed in silos by all stakeholders and partners responsible for purchase and deployment. Functional ICT equipment is defined as all healthcare equipment - desktops, laptops, tablets, smartphones, server and networking equipment that are actively being used and meet minimum performance requirements. The digital health is developing an equipment registry that will aid tracking of all health equipment served through the digital health or in silos and this will enable visibility of all ICT investments in the country. The equipment registry will ensure unbiased distribution of devices across all health facilities, thus ensuring use of digital health investments across all health facilities. Currently the country has at least 38.07% of health facilities having functional ICT infrastructure. Digital health is also procuring data center equipment through the World Bank COVID-19 emergency preparedness fund that will address challenges related to systems hosting. In addition to this the digital health has included budget lines for procurement of additional tablets and desktops in donors and one plan budget. While issues of parallel management of ICT equipment are still vast in the country, digital health is working with CMED to consolidate the list of all equipment distributed in health facilities and this will be the baseline of the equipment registry.

Building Capacity for Digital Health Participation

This strategy covers training of health personnel on digital health systems. Training of users, also included in system deployment is a useful step to data use. System trainings were on iCHIS, DHIS2 (HMIS) and OHSP in 2023 that targeted at least 1000 system users. The iCHIS training was conducted in Mchinji, Chitipa and Salima as first implementation districts. The training covered areas related to environmental health, IMCI and RMNCH. The DHIS2 (HMIS)

training was conducted as an enhanced package following the upgrade of the system. It targeted all data clerks and district coordinators. Finally, the OHSP was conducted targeting HSAs and data clerks to orient users on IDSR reporting including event-based surveillance.

Leveraging Technology to Increase Service Delivery Quality

Under this strategy, the country's focus is on the shared health record by building comprehensive health systems. This responds to the challenge of parallel systems in the health sector. Digital health is developing a healthcare information system that will cover all service delivery points shortly referred to as MaHIS. The MaHIS is leveraging OpenMRS design and will scale up existing technology mostly supported by PEPFAR IPs and other donors. The MaHIS will function at patient level by capturing patient records at entry and exit, including follow-up at community level using iCHIS. At aggregate level, there are integration plans to ensure data is being transmitted centrally to the Malawi HMIS, an aggregate repository of data. On aggregate, 41% of health facilities are using digital health technologies for service delivery. This demonstrates a moderate level of adoption but suggests that more targeted efforts are needed to ensure the uptake of digital solutions across all facilities

Harmonizing and Expanding Information Systems

The use of OpenLMIS for reporting stands at 55.17%, indicating that over half of the health facilities have adopted the logistics management information system. This shows good progress toward achieving an integrated approach to health logistics, which is part of HSSP III's broader strategy to harmonize digital health solutions. However, efforts must continue to further increase the adoption rate to ensure seamless management of health commodities and improve supply chain visibility.

3.1.1.9 One Health Surveillance Platform for Pandemic Preparedness

The One Health Surveillance Platform (OHSP) was developed during the COVID-19 pandemic with the first use case as COVID-19 surveillance. Having successfully implemented, the OHSP has adapted IDSR for weekly and monthly reporting. The system has included data points that will aid in identification of potential outbreak sites, through a centralized database and help decision makers to prepare for outbreaks.

3.1.1.10 Digitalization of the Service Level Agreement at point of care

The Service Level Agreement (SLA) has faced challenges across the levels of the health system in processing claims and refunds. Some of the challenges include errors in documentation, costs associated with a paper-based system, including printing, toner, and

physical transportation, lack of real-time data and reliance on manual data entry, difficulties in generating comprehensive reports and planning the overall budget, lengthy process with a 2-to-3-month turnaround time and inadequate transparency in payment status and outstanding claims. As such the digital health is working with the SLA unit to develop a digital SLA system that will manage claims and invoices. The system is expected to reduce the challenges associated with claims and refunds and thus help the end beneficiaries (patients) to benefit from non-interrupted SLA benefits.

3.1.19. *Challenges*

- SOPs for coordinating digital health investments have not been fully disseminated.
- Significant ICT infrastructure gaps remain at the national, district, and facility levels, requiring an assessment to identify needs.
- Funding limitations restrict the scaling of digital health systems and training programs.
- Inadequate server infrastructure and frequent downtimes negatively affect the reliability of digital health systems.
- Delays in hiring systems security personnel hinder progress in establishing a fully functional security department.
- Challenges remain in fully integrating health facilities with the shared health record system, requiring additional support for alignment.

3.1.20. *Recommendations*

- Expedite the dissemination and training on Standard Operating Procedures (SOPs) to ensure consistency in the implementation of digital health investments nationwide.
- Conduct a comprehensive ICT needs assessment for all health facilities and data centers, followed by strategic expansion of ICT infrastructure to meet digital health requirements.
- Lobby for increased funding from governmental and partner organizations to scale up digital health training programs and enhance server infrastructure reliability.
- Accelerate the recruitment of systems security personnel to quickly establish a fully operational security technical department for safeguarding digital health systems.
- Provide technical assistance to integrate all health facilities into the MaHIS system for a unified patient record

3.7 HEALTH RESEARCH AND MONITORING & EVALUATION

Health research and Monitoring & Evaluation (M&E) are critical for providing the evidence base needed for informed decision-making, policy development, and effective program implementation. In the context of the HSSP III, these elements are essential for tracking

progress toward achieving Universal Health Coverage (UHC) and improving health outcomes across Malawi.

3.1.21. *Progress against Strategies*

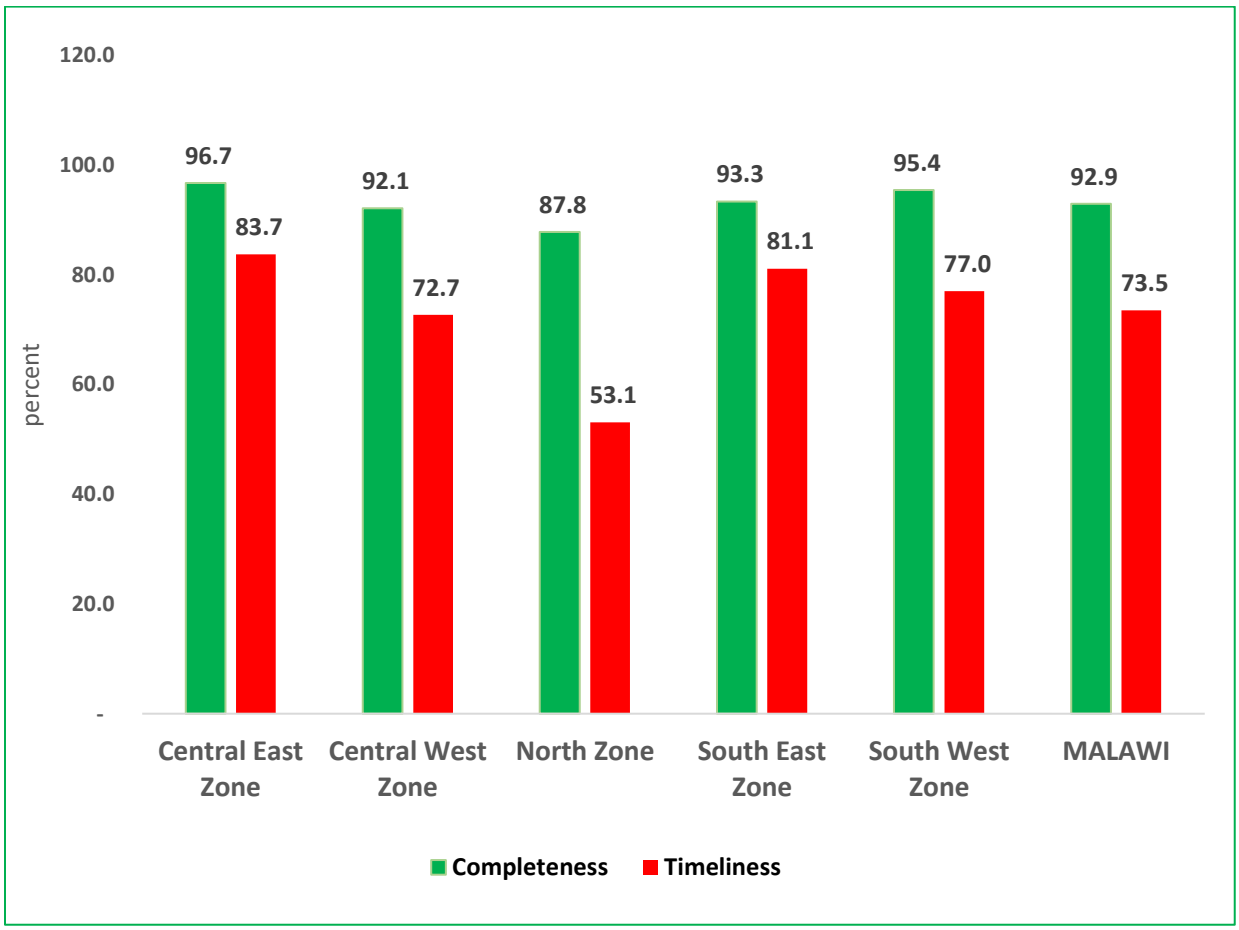
Strategy1: Build health research capacity in public, private, research, and academic institutions.

Capacity building is a newly established section of the research division. As such training has not been tracked. However, several training sessions have been conducted so far with support from other donors. The training conducted included participants from PHIM and district hospitals. About 276 people were trained in different topics such as manuscript writing (2), policy brief (30), small grants writing (105), data analysis using R (5), research methodology (127), evidence-based informed decision making (2), and financial management for donor-funded projects (5)

Table 14:Summary of Capacity-Building Activities and Training Participation

Activity	Total number	Participants	National Total
Staff trained in manuscript writing	2	PHIM	2
Staff trained in policy brief writing	30	MOH, PHIM (ACDC)	30
Staff trained on small grant writing	105	PHIM, MOH staff	105
Staff trained on data analysis using R	5	PHIM	5
Staff trained on research methodology	127	MOH	127
Staff trained in evidence-based informed decision-making	2	PHIM	2
Staff trained in financial management for donor-funded projects	5	PHIM	5
Total staff trained	276		276

Figure 39: HMIS 15 Reporting Status by Zone - 2023

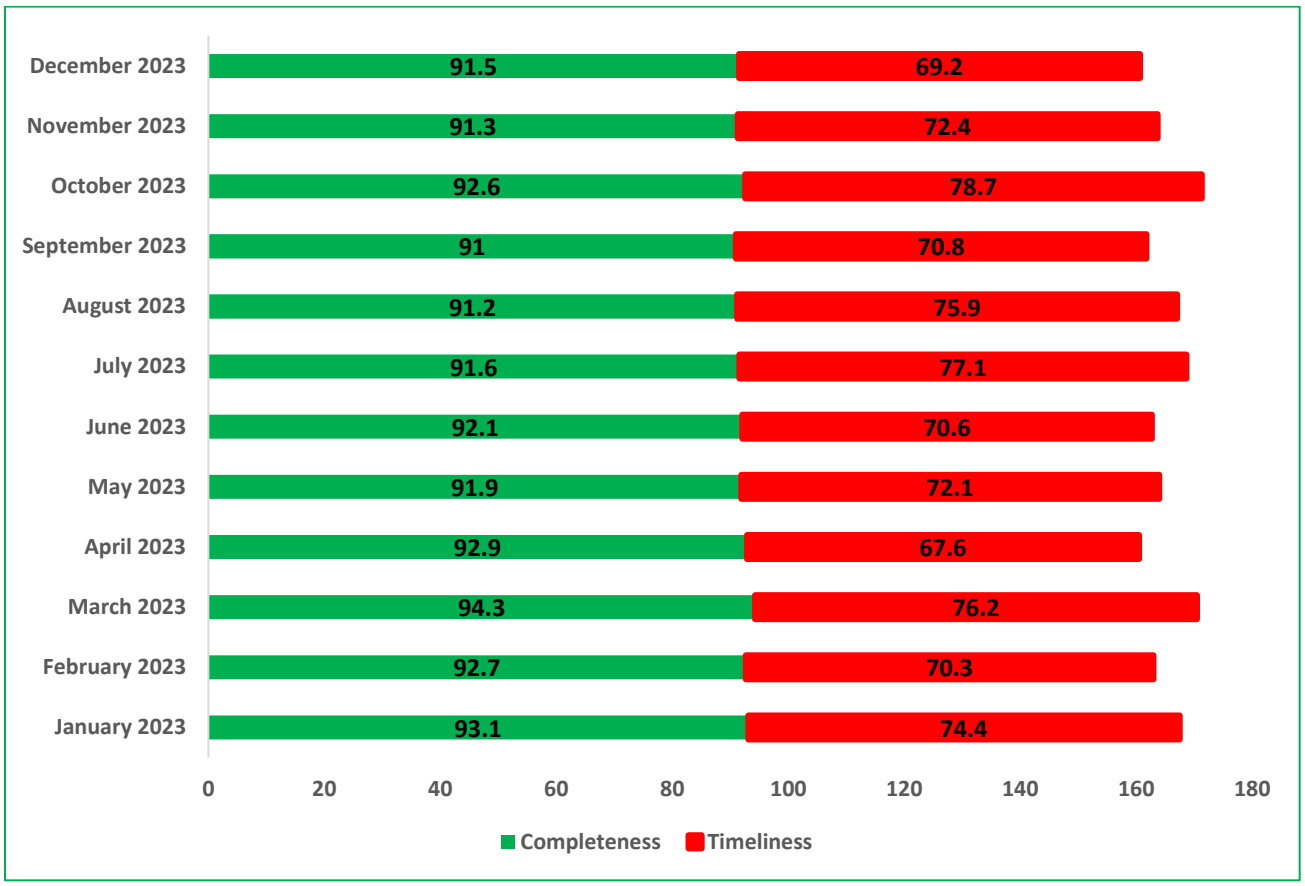


The chart above illustrates the reporting rates for completeness and timeliness across five health zones in Malawi for 2023, with Malawi's national average shown as an aggregate.

- Completeness rates are consistently high in all zones, with Malawi averaging 92.9%. The Southwest Zone leads with 95.4%, while the North Zone shows the lowest completeness at 87.8%.
- Timeliness of reporting, however, is notably lower across the board, with a national average of 73.5%. The Central East Zone performs best with 83.7%, while the North Zone struggles with the lowest timeliness rate of 53.1%.

While most data is submitted, delays in reporting are widespread, particularly in the North Zone.

Figure 40: HMIS Reporting Status by month

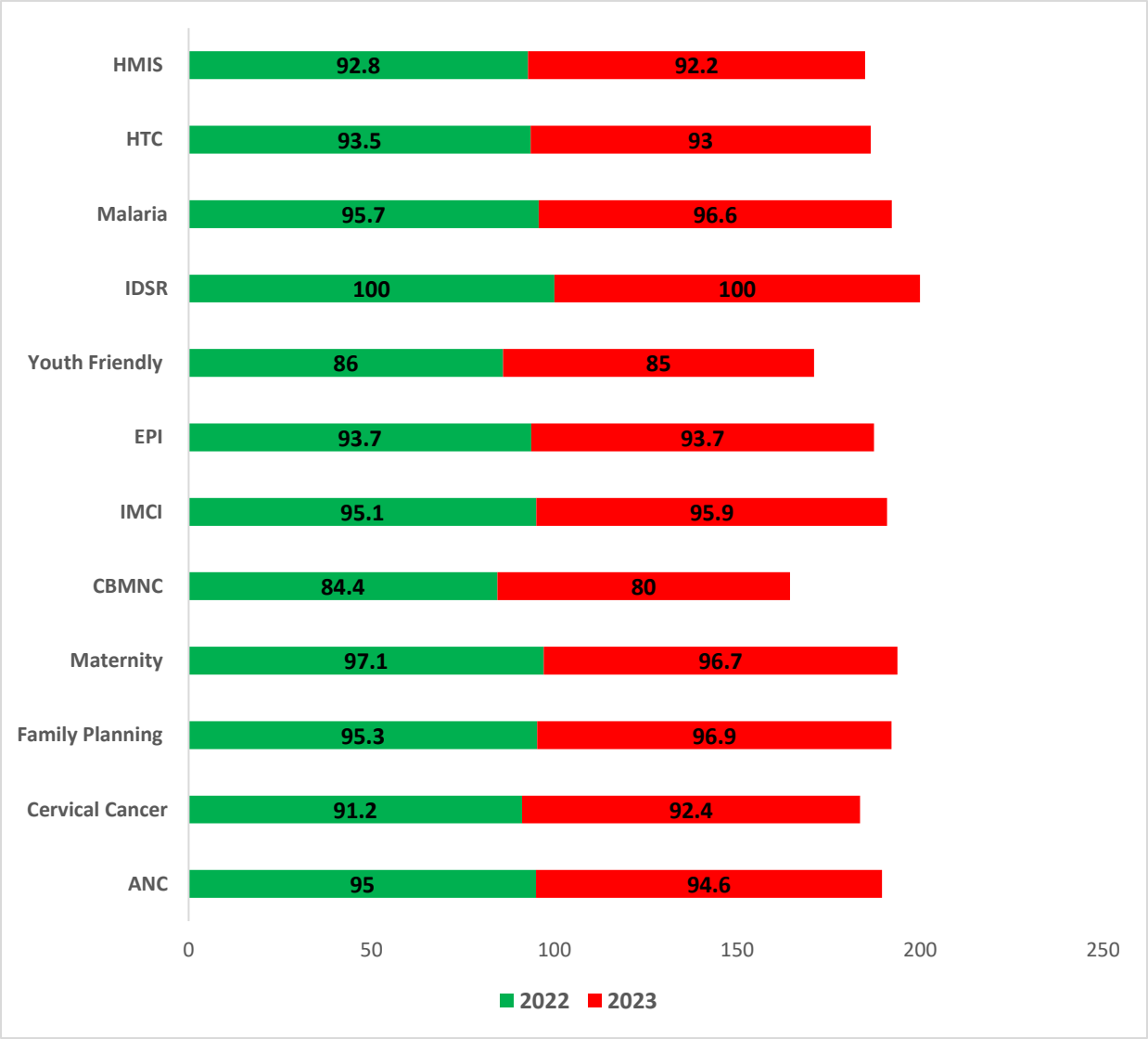


The graph above tracks completeness and timeliness of health data reporting from January to December 2023.

- Completeness remains consistently high throughout the year, hovering around 90-95%. This indicates that health facilities have consistently submitted their reports, ensuring that data is available for decision-making.
- Timeliness, on the other hand, fluctuates between 70-80%, with noticeable dips in May and September. This suggests that while reports are being completed, delays in submission are frequent, particularly during certain months, potentially due to system issues or operational challenges.

  The difference between completeness and timeliness highlights the need for improved systems and processes to ensure that health data is not only complete but also submitted on time, enabling timely interventions and policy decisions. In the DHIS2 system, dataset completeness specifically refers to the percentage of health facilities that submit all required reports on time, providing a full picture of service delivery across Malawi.

Figure 41: Dataset completeness - 2022 and 2023



The chart above is comparing dataset completeness between 2022 and 2023 across various health programs

- ANC (Antenatal Care) showed a slight decrease in completeness from 95% in 2022 to 94.6% in 2023, indicating consistent performance in data submission but with a slight decline that may warrant attention.
- Cervical Cancer program completeness improved from 91.2% to 92.4%, signalling better reporting in 2023.
- Family Planning and Maternity datasets demonstrated strong performance, with slight improvements in completeness. Family Planning increased from 92.4% to 95.3%, while Maternity increased from 95.3% to 95.9%, reflecting stable reporting across health facilities.

- Community-Based Maternal and Newborn Care (CBMNC) saw an increase from 97.1% to 97.6%
- IMCI (Integrated Management of Childhood Illness) completeness dropped from 84.4% in 2022 to 80% in 2023, which may indicate issues such as resource or operational challenges in reporting, requiring targeted intervention.
- Youth Friendly Services experienced a slight decline from 86% in 2022 to 85% in 2023, while IDSR (Integrated Disease Surveillance and Response) maintained perfect reporting rates at 100% for both years, highlighting its prioritization and strong adherence to reporting requirements.
- Malaria, HTC (HIV Testing and Counselling), and HMIS datasets all saw stable reporting with marginal changes, maintaining high completeness rates in 2023 (Malaria at 96.6%, HTC at 96.6%, and HMIS at 92.2%).

Training in DHIS2 mobile by district and cadre

Part of Malawi's recent scale-up initiative, which allows health centre's to directly enter data into the DHIS2 system, streamlining the data flow process. Previously, health centres would send data to district offices for entry, but this shift signifies a major improvement in real-time data reporting and management.

Table 15:DHIS2 Mobile Training summary by cadre, 2023

Role/Designation	Total Trained
Data/Ward/Statistical Clerk	939
Nurse/Clinician/Facility In-Charge	365
HAS	145
Environmental Health Officer	6
HMIS Officer	8
Auxiliary staff (HA)	19
Program Coordinator	14
Other staff	10
Grand Total	**1506**

- A total of 939 Data/Ward/Statistical Clerks across districts received DHIS2 mobile training, highlighting a strong focus on empowering those responsible for health data entry.

- 365 Nurses/Clinicians/Facility In-Charges also received training, ensuring that frontline health workers are equipped to handle data input responsibilities at the facility level, directly into the DHIS2 system.

Table 16: Summary of Key M&E Activities and Outcomes for Health Data Management in 2023

Activity Description	Coverage	M&E indicator	Outcome
DHIS2 Mobile expansion: Scaled up deployment per district in the 24 remaining districts	1560 clerks trained	Number of clerks trained in DHIS2 Mobile	Achieved real-time data entry at the facility level across all districts.
Supportive supervision to monitor functionality (DHIS2 mobile expansion) and provided ongoing staff mentorship on system usage.	Supervisions conducted in all Zones	Number of supervisions conducted	Improved system functionality and data accuracy through mentorship.
workshop on production of HIS data bulletin based on DHIS2 data (National & District Bulletins).	All districts produced data bulletins	Number of data bulletins produced	Increased use of data for decision-making at the district level.
Data Management Training for Newly Recruited Clerks.	186 clerks trained	Number of newly recruited clerks trained in data management	Strengthened data entry capacity at health facilities through proper training.
integrated zonal level data and performance review meetings.	5 Zonal review meetings (1 per zone)	Number of zonal review meetings held	Zonal performance tracking and improvements.
Facility level Data Review/Feedback Meetings with Health Facility Staff	Review meetings conducted for all facilities countrywide	Number of facilities review meetings conducted	Improved performance at the facility level through regular feedback.

In office data quality assessments (DHIS2)	Sampled facilities/districts/datasets	Routinely	Improved data accuracy, completeness, and timeliness of health facility reports in DHIS2.

- Significant progress was made in capacity-building efforts, with 1,560 clerks trained in DHIS2 Mobile and 186 newly recruited data clerks trained in data management, strengthening data entry capacity across health facilities. Additionally, training extended to health facility in-charges, ensuring that frontline staff are well-equipped to manage data accurately and efficiently.
- The production of health information bulletins by all districts marks a significant advancement in the use of data for informed decision-making.
- The expansion of DHIS2 Mobile to 24 districts enabled full coverage across the country, allowing direct data entry by all health centres in the DHIS2.

3.1.22. *Challenges*

- Many health centres, particularly in remote areas, suffer from unreliable internet connectivity, and some facilities lack access to power altogether. This severely limits their ability to perform timely data entry into DHIS2 Mobile, contributing to significant delays in data submission
- Inadequate On-the-Ground Technical Support: While initial training was provided, many facilities lack ongoing technical support to troubleshoot technical issues with tablets as well as DHIS2

3.1.23. *Recommendations*

- To address the timeliness issues, efforts should focus on improving internet connectivity and infrastructure in remote areas.
- Provide continuous on-the-job training and mentorship for all cadres involved in data handling

3.8 LEADERSHIP & GOVERNANCE

The Leadership and Governance pillar of the HSSP III focuses on establishing strong, effective leadership and governance structures at all levels to guide the health system towards achieving Universal Health Coverage (UHC). This pillar ensures that the health sector operates with transparency, accountability, and effectiveness, facilitating policy implementation and strategic decision-making.

3.1.24. *Progress against reform*

The reform under this pillar is the implementation of a One Plan, One Budget and One Report. This reform is a strategy under this pillar. This reform aims to streamline planning, budgeting, and monitoring processes for health sector activities at both the national and subnational levels, in order to align donor and domestic funding with government priorities, thereby improving the efficiency of resource allocation and promoting joint accountability across the health sector. Progress against the One Plan, One Budget and One Report in the 2023/24 FY was as follows:

- "One Plan" process: As part of the first year of implementing the "One Plan" under the HSSP III, MOH Directorates were supported in identifying their core HSSP III priorities for FY 2023-2024, which were consolidated and shared with the top ten health sector donors for the mapping of their funding and where possible reallocation and alignment of their funding to the priorities. The information was compiled into the FY2023-2024 "One Plan" and was disseminated with stakeholders through the HSSP III Technical Committee, health donors group, and technical working groups.
- One Budget: in the 2023/24 FY, the Senior Management of the Ministry made a decision to move towards a single Project Implementation Unit (PiU). The Honourable Minister of Health then communicated this decision to Heads of Missions and Cooperation that fund the health sector. Further, a consultancy was commissioned with FCDO support to explore the design of the single PiU. A study tour was also conducted to Ethiopia and Rwanda to learn about their single PiUs.
- One Report: With the support of UNICEF, a consultant was recruited currently drafting a comprehensive "One Report" results framework, which will support the harmonization of monitoring and evaluation processes at all health system levels. This will build on earlier work of developing a unified set of HSSP III indicators, which was presented for initial review by partners at the end of FY2023-2024 and formed the basis of this JAR report.
- Revisions of the DIP tool and launch of facility planning aligned with the HSSP III: To strengthen alignment with HSSP III strategies and reforms, the MOH began revising the DIP tool and developing a facility planning tool in FY2023-2024. Rolled out across Malawi in FY2024-2025, the facility planning tool is designed to support bottom-up

planning and budgeting against the Health Service Packages and facilitate progress towards service delivery integration. Facility plans will be incorporated into DIPs, providing the foundation for a comprehensive "One Plan, One Budget, One Report" at all levels.

Figure 42:Funding sources aligned to Government priorities in the 2023/24 FY

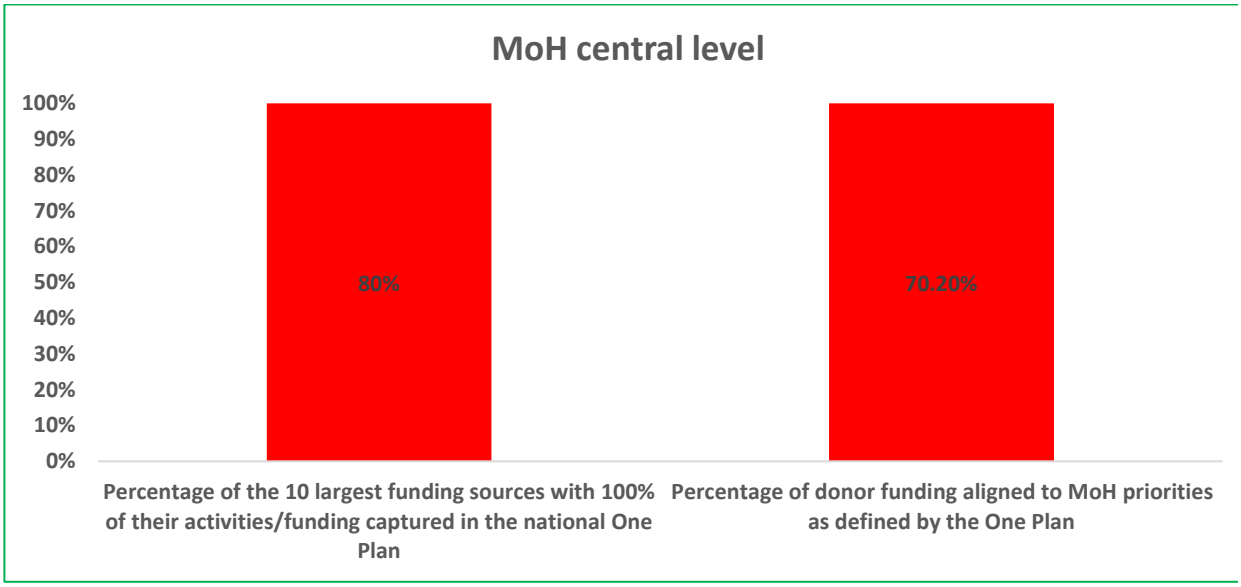
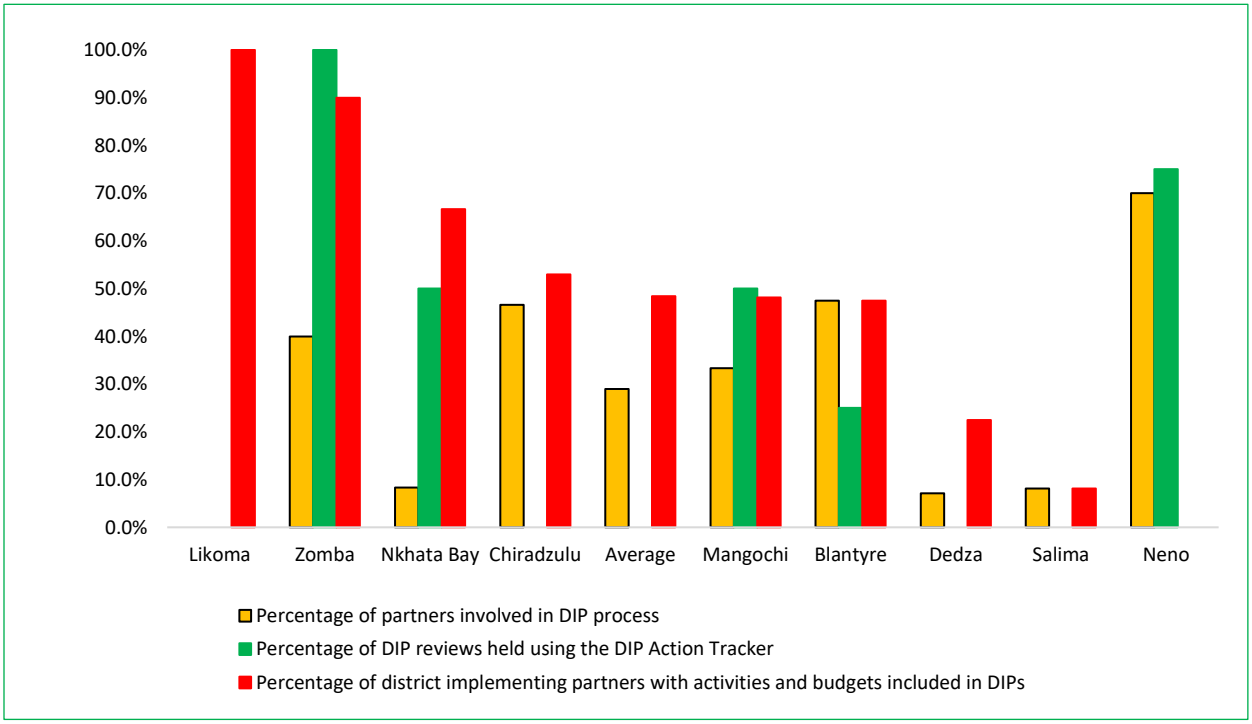
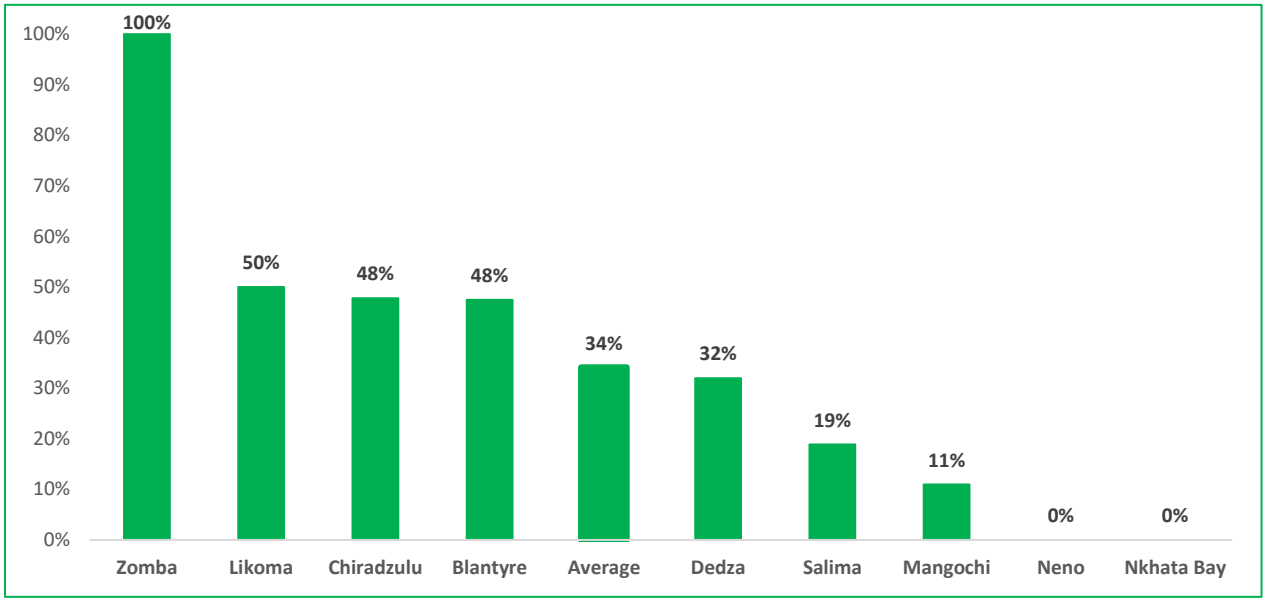


Figure 43:District partners involved in DIP processes and mapping their activities and funding



One Plan, One Budget and One M&E" system strictly requires stakeholder alignment to the strategies and activities of the HSSP III, enforced by MOUs and a code of conduct agreed by all stakeholders

Figure 44:Implementing partners that have MOUs with District Councils



Challenges that have been faced in implementing "One plan, One Budget and One Report"

- Delays in the consolidation of the FY2023-2024 "One Plan": Due to delays in launching the "One Plan" process and adaptations to the process for effective resource mapping, the FY2023-2024 "One Plan" was not finalized until September 2023, impeding the effective dissemination of the document and its utilization for joint planning and implementation.
- Difficulties in costing and prioritizing "One Plan" activities: Stemming from these delays, "One Plan" activities were not costed or prioritized by relevant MOH Directorates through a standardized process, potentially resulting in the inclusion of a higher number of priorities beyond available funding.
- Continued proliferation of parallel National Strategic Plans (NSPs): There are currently at least 19 NSPs, policies, or operational frameworks that extend beyond the HSSP III nine's pillars, potentially resulting in duplication and inefficiencies in health sector programming.
- Fragmentation across Project Implementation Units: Currently, there are four Project Implementation Units for GFATM and Gavi; the Health Services Joint Fund; the U.S.

Centres for Disease Control; and the World Bank (Investing in Early Years for Growth and Productivity Project and the "COVID-19 Emergency Response and Health Systems Preparedness Project). While ultimately under the authority of the Ministry's Secretary for Health, these PIUs report to different departments and are subject to disparate grant management procedures, contributing to inefficiencies and impeding harmonized implementation of health sector programming.

- Limited partner coordination with districts: Partner coordination and aid alignment remain weak at the subnational level, with only 34.1% of partners, on average, at district level having MOUs with the District Council. Partner involvement in DIP processes similarly remains low, at an average 29.0%, with only 48.4%, on average, of partner funding and activities reportedly captured in DIPs. Since many implementing partners are funded by central-level donors, they may not feel able to reallocate funding towards district/facility priorities, or implementing partner staff posted at the subnational level mat not have the authority to make these decisions.
- Insufficient partner support for subnational planning and monitoring activities: Although certain districts receive support for developing DIPs, other districts lack these resources, impeding their timely completion. Multiple districts also cited a lack of funding as the reason for low number of DIP reviews held during the year, potentially impacting DIP implementation and oversight.

Strengthening policies, guidelines, and frameworks including at the multisectoral level

The MOH has participated in the development of the national One Health Policy, which is still at its initial stages. Focused on taking a holistic, harmonized approach to supporting the health of people, animals and ecosystems, this policy will be key to strengthening the resilience of Malawi's health system.

The Ministry also fostered linkage of facility planning and Village Action Plans as part of the facility planning process. Health facilities were instructed to review and incorporate challenges and solutions identified in their village action plans for improved multi-sectoral planning and service delivery.

Challenges in strengthening multi-sectoral policies, guidelines, and frameworks

There is weak representation of health priorities in District Development Plans. There is also lack of visibility into village action plans: Facilities have reported lacking access to village action plans, impeding coordinated and holistic planning.

Enhancing financial management to strengthen accountability of funds

This strategy aims to improve financial accountability and transparency throughout the health sector by building capacity, strengthening and streamlining audit functions, and undertaking robust financial management activities at all levels. While indicators for this strategy are still being defined as part of the "One Report" process, the following progress has been made and challenges encountered in operationalizing this important strategy in FY2023-2024. Different financial and performance audits of government and donor funds were conducted, and to oversee routine financial management activities, including salary processing.

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

This strategy emphasizes on building a strong, well-coordinated system of governance, with active participation from all stakeholders, ensuring that policies are not only developed but also effectively implemented at every level of healthcare service delivery. Effective coordination structures and demonstrable leadership capacity are critical factors under this strategy.

For coordination structures, Table 17 shows how often national level TWGs met in the 2023/24 FY. The health sector working group and leadership and governance TWGs were among the weakest TWGs despite their critical importance. The infrastructure and medical equipment TWGs also very weak. Table 18 shows how sub TWGs met. The quality management and NCDs and mental health sub TWGs performed well while the medical rehabilitation sub TWG performed poorly. The list of sub TWGs in this table was not exhaustive.

Table 17: Technical working group meetings in the 2023/24 financial year

Sector or Technical working group	Required Number of Meetings/year	Number of Meetings conducted
Health Sector working group (HSWG)	4	0
Service Delivery	4	3
Social Determinants	4	4
Infrastructure and Equipment	4	1
Health Financing	4	4
Leadership and Governance	4	1
M&E TWG	4	3
Digital Health TWG	4	3
Human Resource for Health	4	
Research TWG	4	
Supply Chain/Diagnostics	4	

Table 18:Sub-technical working group meetings in the 2023/24 FY

Name of Sub-TWG	Expected Number of Meetings per year	Number of Meetings conducted
Quality Management	4	3
NCD & Mental Health	4	3
Medical Rehabilitation	4	1
INMCH		
IMCI Child Health		

The Ministry trained 150 District Health Management Team (DHMT) members in 18 DHMTs in leadership and management.

TWG rationalization

Due to an unstructured proliferation of TWGs and sub TWGs, the MoH commenced the process of TWG rationalization in order to streamline them and ensure they are fit for purpose to drive HSSP III implementation. The Ministry also rationalised its Senior Management Team and its TOR to focus on HSSP III delivery.

Decentralization

The Ministry commenced a process to develop a devolution plan to further deepen health sector decentralization. Stakeholder meetings were conducted to draft the devolution plan. It is expected that wider consultations will be conducted to validate the plan.

Challenges in leadership and governance

- TWG agenda setting is suboptimal
- There are inconsistencies in policy direction from different players (MoH and donor)
- Ineffective policy engagement arrangements
- Weak implementation, monitoring and enforcement of health sector policy, legal and regulatory frameworks at national and sub-national levels.
- Low sensitisation of governance arrangements amongst health stakeholders

3.1.25. *Recommendations*

- Strengthen annual "One Plan" processes to integrate HSSP III priorities and reduce parallel health plans.
- Use frameworks, TWGs, and reform task forces to support costing, prioritization, and monitoring.
- Align stakeholder workshops and quarterly reviews with HSSP III priorities.
- Operationalize and enforce the MOH circular on the "One Plan, One Budget, One Report" to reinforce aid alignment, joint planning, implementation, and monitoring at all levels. Similarly Implementing partners must have active MOUs and participate in DIP and facility planning.
- Increase awareness of governance arrangements, processes and procedures among health stakeholders

3.9 HEALTH FINANCING

The Health Financing Pillar of HSSP III focuses on ensuring that the health system in Malawi is sustainably financed to provide equitable and quality healthcare for all citizens. This pillar aims to strengthen revenue generation, improve resource allocation, and enhance efficiency in the use of health funds. By ensuring effective health financing, the Ministry of Health aims to achieve Universal Health Coverage (UHC) by 2030, where everyone has access to essential healthcare services without financial hardship.

Health sector funding and expenditures

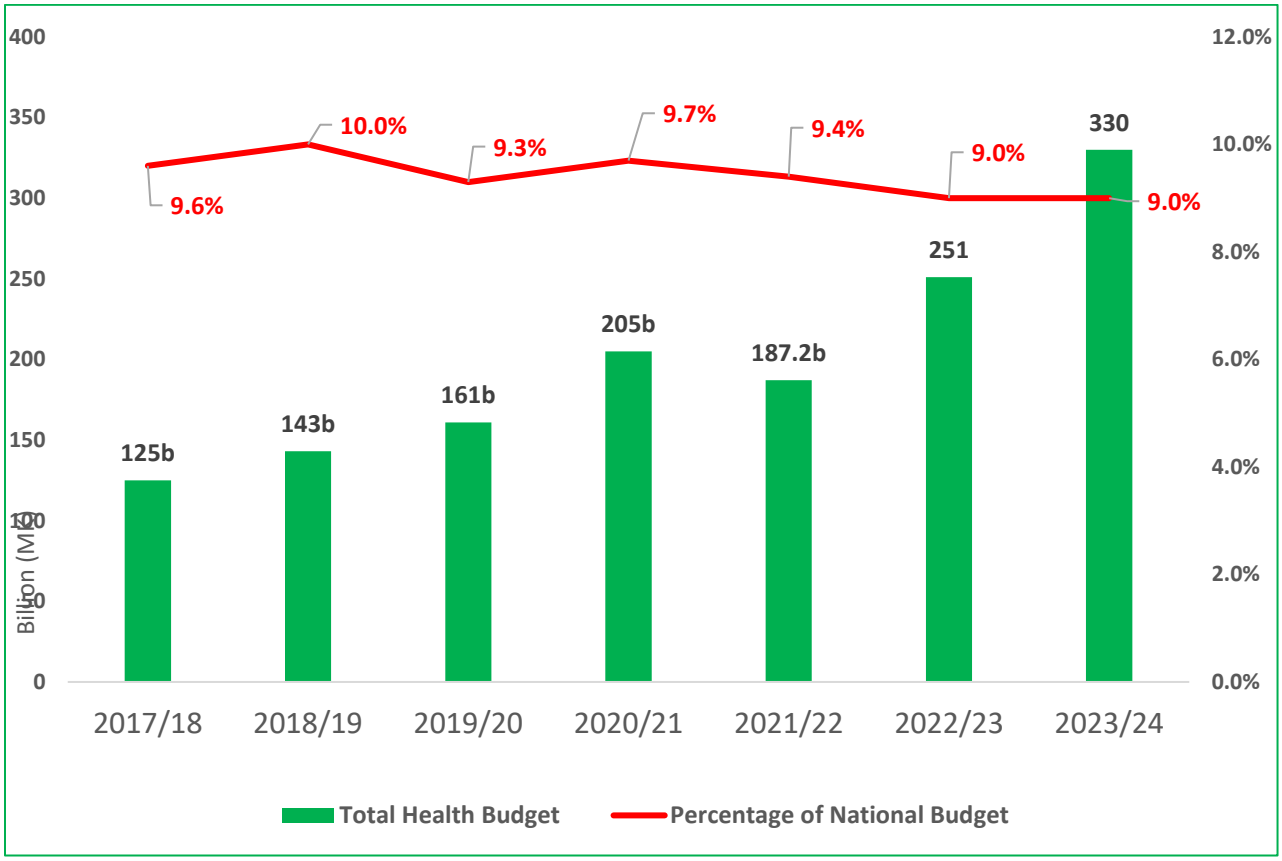
According to the 2023/24 One plan process, between the Ministry of Health and external partners, financial contributions for the fiscal year totalled $545,250,973.46 across these 15 donors and implementing partners. The table below shows the allocation of these contributions towards the nine HSSP III pillars.[1]

Table 19:Health sector funding and expenditures

Pillar	2023/24 Funding amount ($)	Major financing sources and partners
Service delivery	$116,462,505.69	Ministry of Health, CDC, FCDO, GFATM, GIZ, CHAI, HSJF, USAID, and UNICEF
Social determinants of health	$22,280,922.09	Ministry of Health, CDC, GIZ, UNICEF, CHAI, HSJF, and USAID
Infrastructure and health technologies	$30,778,644.42	Ministry of Health, CDC, GIZ, GAVI, HSJF, USAID, UNICEF, CHAI, and World Bank
Human resources for health	$105,824,146.41	Ministry of Health, CDC, CHAI, GIZ, GFATM, FCDO, WHO, and USAID
Medical products and technology	$240,059,079.16	Ministry of Health, CDC, GFATM, GIZ, HSJF, UNICEF, CHAI, WFP, and USAID
Digital health	$11,090,696.63	Ministry of Health, BMGF, CDC, GIZ, UNICEF, and USAID
Research	$7,322,195.32	Ministry of Health, CDC, FCDO, CHAI, HSJF, and USAID
Leadership and governance	$9,582,746.24	Ministry of Health, FCDO, GFATM, UNICEF, CHAI, and USAID
Health financing	$1,850,037.50	FCDO, GIZ, HSJF, KUHES, USAID, CHAI, GFATM, and WHO
Total	**$545,250,973.46**	

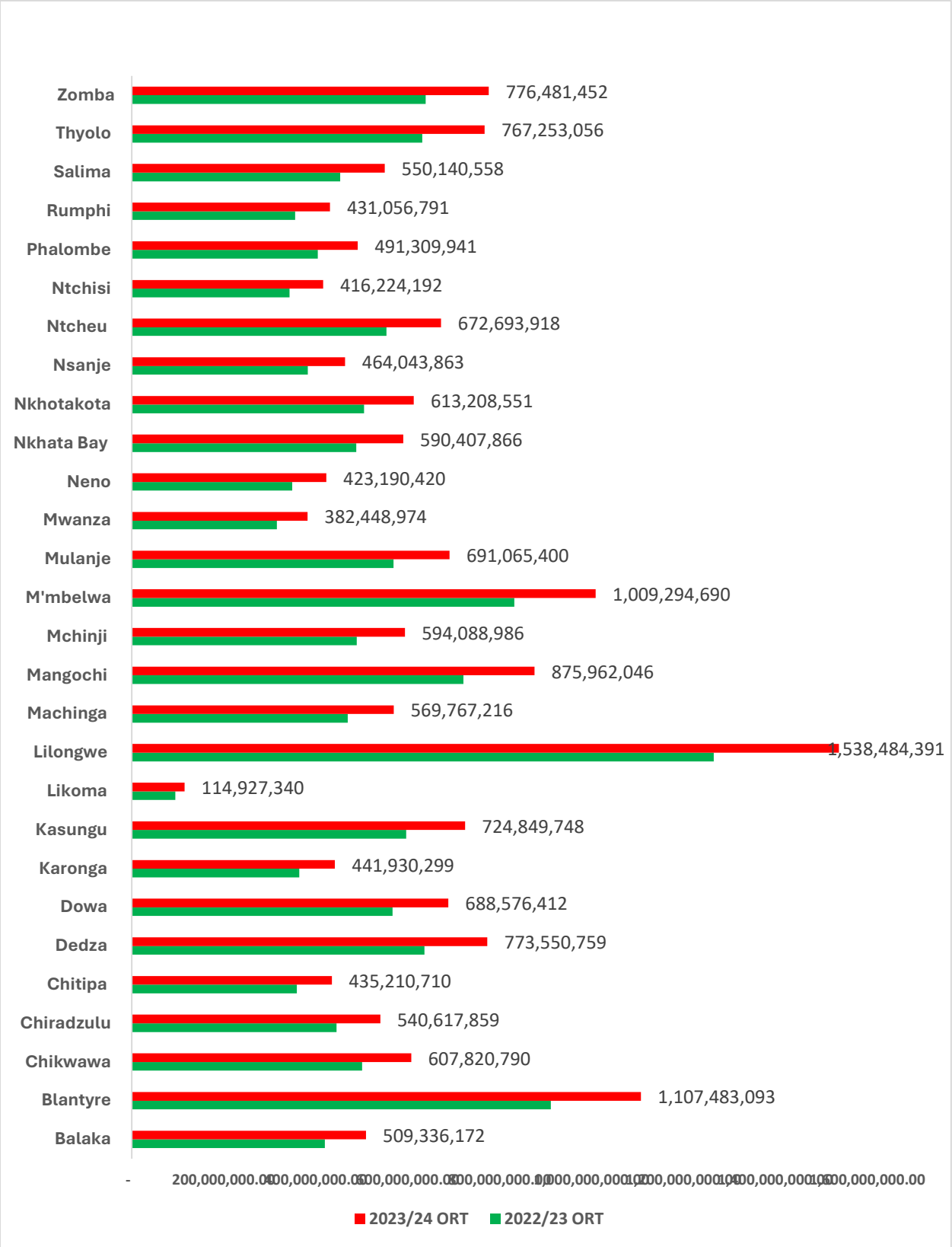
[1] In addition to this funding across pillars, an additional $20,069,511.00 was reported in project management staff salaries and overheads from external partners.

Figure 45:Total Government expenditure on health and as a percentage of national budget



Over the years, Government expenditure on health has steadily increased from MK125 billion in 2017/18 to MK330 billion in 2023/24. However, as ratio to the national budget, the proportion has remained below the Abuja Declaration target of 15%. In the two years under review, the proportion dropped by 0.4 percentage points, from 9.4% in 2021/22 to 9.0% in 2022/23 and remained constant in 2023/24.

Figure 46:District ORT Budget for 2022/23 & 2023/24



Between 2022/23 and 2023/24 Government increased ORT budgets for the local councils by 21%, from MK14.67 billion to MK17.8 billion. Lilongwe had the largest increase by MK272.74 million while Likoma had the least at MK20.23 million. In the two years under review, Government disbursed all the resources planned in the budget and utilisation rate was above 98% in both years. However, there continues a mismatch between the budget commitments and actual expenditures for development partner budgets. In the table below, expenditure rate for the six selected partners in the two years under review has been below 80%.

Table 20: Donor Budgets and Expenditures in 2022/23 and 2023/24 Fiscal Years

2022/23 - 2023/24 Donor Health Budgets and Expenditures				
Financing source	**FY 2022/2023 Budget (USD million)**	**FY 2022/2023 Expenditure (USD million**	**FY 2023/2024 Budget (USD million)**	**FY 2023/2024 Expenditure (USD million**
USAID	$141,614,439.00	$128,072,609.53	145,401,609	156,409,486
HSJF (FCDO, KfW, RNE)	$44,679,231.49	$25,351,743.74	$30,218,370.00	$11,610,003.00
GFATM	$217,406,569.00	$153,141,904.00	$198,945,506.00	$105,764,894.00
CDC	$86,048,589.00	$80,933,273	$89,039,456	$81,790,531
World Bank (Covid)	$22,916.00	$10,263.00	$44,393.00	$23,348.00
GAVI	6,025,322.20	$5,152,272.15	$11,510,773.50	$7,878,019.00
Total	**$495,774,150.69**	**$392,662,065.42**	**$475,115,714.50**	**$363,476,281.00**

3.1.26. *Key Strategies and indicators*

Strategy 1: Mobilize Adequate, Sustainable, and Predictable Funds for the Health Sector

This strategy seeks to increase per capita expenditure on health and the share of domestic contribution to the health expenditure in the country. During the period under review, the following activities were undertaken.

- The Ministry of Health engaged a consultant to work on health service integration to enhance health system efficiency in healthcare delivery.
- The Ministry also engaged Treasury and other government stakeholders on the possibility of establishing a health fund through ear-marked taxes. A joint Ministry of Finance and Ministry of Health taskforce was set up to drive agenda.
- The Ministry of Health engaged the private sector to strengthen their involvement in healthcare financing and delivery in the country. The Ministry of Health and the private sector jointly developed a dossier of investment opportunities in which the two could collaborate on through public private partnerships. So far the Ministry of Health is working with the Public Private Partnership Commission on conducting feasibility studies for the following projects;
  i. Establishment Renal Dialysis Centres
  ii. Establishment of Medical Diagnostic Centres
  iii. Establishment of Optional Paying Services at Central and District Hospitals.

  Karonga and Rumphi districts introduced optional paying services

Strategy 2: Improve efficiency and equity in pooling and managing resources for the health sector

As reported earlier, the Ministry started working towards a single PiU, rationalising in-service training, supportive supervisions and monitoring and evaluation activities across all health stakeholders in order to promote efficiency. The Ministry of Health also revised its internal budget guidelines that aim to promote robust resource allocation and effective implementation of the Ministry's budget.

3.1.1.11 Health Services Joint Fund

The Health Services Joint Fund (HSJF) is the only multi-donor project implementation unit in the Ministry. The Norwegian Embassy, KfW and FCDO have been pooling resources together through the fund to support the implementation of HSSP interventions. In the year under review, the Scottish Government expressed interest to join the fund.

Strategy 3: Develop and implement strategic purchasing measures across the healthcare service delivery continuum

The HSSP III developed the health benefit package which guides health service delivery in the country. The Ministry intends to pay service providers basing on the volumes and the quality of the services in the package that they deliver.

The Ministry implemented a Direct Facility Financing (DFF) pilot in Rumphi. DFF is being scaled up to 13 more districts which are Blantyre, Ntchisi, Chitipa, Nsanje, Neno, Dedza, Salima, Balaka, Machinga, Chikwawa, Lilongwe, Nkhotakota and Kasungu. The Government has committed MK200 million towards the scale-up. The Ministry of Health developed an intra-district resource allocation formula that would be used to devolve the district health office budget to all facilities in a district and support DFF. Implementation of this formula would be conditional on raising adequate resources for both secondary and primary health facilities. The Ministry also worked with the National Local Government Financing Committee to revise the district health resource allocation formula.

3.9.1.2 Service Level Agreements

Government continued to use CHAM and IHAM facilities to provide free maternal and child health services at the point of access in areas without public health facilities. Since inception, there has been a steady increase in service utilisation in these facilities. The number of facilities with Service Level Agreement (SLA) increased from 32 in 2007 to 175 in the 2023/24 FY. From April 2023 to March 2024, a total of 1,618,711 service interventions were delivered, excluding cross cutting services in lab, admissions, and OPD. SLA claims amounted to MK 5.9 billion, with maternal and neonatal Health (MNH) accounting for 34.7%, Paediatrics Under 5 for 17.7%, Admissions for 23.5%, and Laboratory for 13.2% of the costs. Notably, most cases were seen in MNH and Paediatrics Under 5, while Laboratory services, being crosscutting, accounted for 73% of all cases. Government pays these service providers through fee for service basis.

Table 21: Utilisation and costs under SLAs 2023

SLA Intervention Package	Total cases seen	Diagnostic cost
MNH	852,020	2,061,664,005.02
Paediatrics Under five	606,527	1,053,459,236.41
Paediatrics 6-12	52,148	58,051,359.37
Adult	95,853	192,638,373.58
Surgical	1,612	19,516,501.56

Laboratory	884,650	785,499,527.22
Other	10,551	59,758,121.10
Referrals	8,392	238,416,009.49
Admissions	168,548	1,395,544,946.49
OPD	1,835,586	71,350,851.22
Total	**4,515,887**	**5,935,898,931.46**

Strategy 4: Establish and strengthen institutional arrangements and systems for effective health financing at all levels of the health system.

The strategy seeks to enhance stewardship that ensures health funding is directed towards achieving health outcomes. Under this strategy, the following were achieved in the period under review.

- The Health Economics Policy Unit under the Kamuzu University of Health Sciences developed a syllabus on health management targeting district and health facility managers
- Ministry of Health officers were trained in health resource tracking to institutionalise resource tracking
- Civil Society developed a health financing advocacy strategy to support the implementation of the Health Financing Strategy and the HSSP III.

3.1.27. *Challenges:*

- **Delayed Operational Guidelines for Earmarked Taxes**: Finalization of guidelines for taxation on fuel, alcohol, and other sources has been slow, hindering implementation of the domestic resource mobilization reform.
- **Insufficient Funds for DFF Expansion**: The pilot of DFF in Rumphi has been successful, but current financial resources are insufficient for nationwide rollout.
- **Complex Donor Coordination**: The establishment of a unified multi-donor funding pool is facing challenges due to the complexity of donor integration and the need for clear operational guidelines.
- **Leadership Capacity**: Health facility management teams lack the capacity to manage and implement health financing reforms, especially in primary care settings.

3.1.28. *Recommendations*

- **Finalize Earmarked Taxation Guidelines**: Expedite the development and approval of guidelines for implementing earmarked taxes to boost domestic resource mobilization.

- **Increase Funding for DFF**: Lobby for additional funds to scale up DFF nationally and integrate it into public financial management systems to ensure sustainability.
- **Strengthen Donor Coordination**: Simplify the donor pooling process by establishing clear operational guidelines for integrating multiple donors into the "One Plan, One Budget" framework.
- **Improve Leadership Capacity**: Implement targeted leadership and governance training for health facility management teams to improve their ability to manage resources and implement reforms.
- **Fast-Track HTA and SLA Reforms**: Accelerate the completion of the HTA framework and SLA revisions to enhance strategic purchasing and cost-effective service delivery.

4 CONCLUSION

The 2023 Annual Health Sector Performance Report highlights significant progress in Malawi's healthcare system under the Health Sector Strategic Plan III (HSSP III) towards achieving Universal Health Coverage (UHC) by 2030. The integrated focus across service delivery, social determinants, infrastructure, human resources, medical products, digital health, M&E, governance, and financing has driven improvements in key areas, including maternal and child health, disease prevention, and health systems strengthening. Enhanced access to digital health tools, expanded service delivery models, and the Direct Facility Financing (DFF) model have contributed to a more effective health system framework that responds to both rural and urban needs.

Despite these advancements, the report identifies persistent challenges that require sustained efforts, particularly in infrastructure, human resources, and access to essential medical products and technologies. Barriers such as limited health facilities in remote areas, supply chain inefficiencies, and workforce distribution issues have created disparities in service accessibility and quality. Financial sustainability remains a challenge, with significant reliance on donor funding. Social determinants of health, including water and sanitation, nutrition, and community-based emergency preparedness, also require further attention to strengthen resilience and reduce health inequities.

The HSSP III framework provides a solid foundation for continued progress; however, further targeted interventions are necessary to address these challenges and ensure the delivery of equitable, quality healthcare across Malawi.

5 RECOMMENDATIONS

Service Delivery

- Establish a nationwide initiative to close resource gaps in NCD and MNCH services by equipping primary and secondary facilities with essential medications, diagnostic tools, and trained staff.
- Launch a targeted Quality of Care (QoC) improvement program for facilities currently rated with one or two stars.
- Develop infrastructure and service delivery upgrades in rural and hard-to-reach areas to establish fully operational facilities with acute and chronic care capacity.

Social Determinants of Health

- Accelerate investment in clean water, sanitation, and hygiene (WASH) infrastructure, focusing on regions prone to waterborne diseases.
- Implement targeted nutrition programs in high-need areas, particularly for vulnerable groups like children and pregnant women.
- Equip communities, especially in flood-prone areas, with training and resources for emergency preparedness and climate adaptation

Infrastructure and Health Technologies

- Prioritize new facility construction in regions with the greatest population needs to bridge the healthcare access gap in rural and remote areas.
- Upgrade facilities to include essential diagnostic tools, targeting district hospitals and high-traffic health centers to reduce unnecessary referrals.
- Allocate specific budgets for ongoing maintenance and repair of health facilities and equipment to ensure reliable service delivery and safe infrastructure.

Human Resources for Health (HRH)

- Schedule regular, structured training cycles in key clinical areas like maternal and child health and NCD management to keep healthcare workers updated on best practices.
- Leverage the Integrated Human Resource Information System (iHRIS) for data-informed decision-making on recruitment, deployment, and retention strategies.

Medical Products and Technologies

- Use electronic systems to track inventory in real-time and minimize stockouts, focusing on critical drugs and consumables.
- Invest in cold chain storage solutions, particularly in rural areas, to support the safe storage and distribution of vaccines and other temperature-sensitive medicines.
- Train healthcare providers on best practices for medication use to reduce waste and ensure consistent availability for patients.

Digital Health

- Improve internet and digital infrastructure in health facilities, ensuring connectivity in all Health facilities.
- Regularly train staff in using digital health tools like DHIS2 and OpenLMIS for accurate data collection, analysis, and reporting.

Research, Monitoring, and Evaluation (M&E)

- Fully operationalize the "One Report" policy to streamline data collection and reporting across health programs
- Collaborate with universities and research institutions to support evidence-based policymaking, particularly in high-burden areas like maternal health, infectious diseases, and health equity.

Leadership and Governance

- Implement regular audits and facility reviews and promote transparency in fund usage and service quality.
- Engage community leaders in health planning and decision-making to better align services with local needs and improve accountability.
- Provide targeted training for district health officers and facility managers on strategic planning, resource management, and operational oversight.

Health Financing

- Scale up DFF to allow more facilities to manage funds locally, enabling timely resource allocation to meet patient needs.
- Focus spending on cost-effective, high-impact health services that address urgent needs and improve overall health outcomes.