Malawi WHO country Office

ADL HOUSE
PO Box 30390
Lilongwe

2015 Annual Report

Table of Contents

Cover page pictures: (Top left; WR speaking to the media during World Health Day commemoration, top right; Participants of a big walk on World TB Day, middle; a young girl receiving Human Pailloma Virus vaccine dose and bottom; Honorable Minister, Dr Peter Kumpalume, MP and the UN/AIDS Country Director, Ms. Amakobe Sande both speaking to reporters on World AIDS Day)

Message from the Representative

Dr Eugene Nyarko WHO Representative

2015 was another a busy year for Malawi WHO country office (WCO) being the end of the biennium. Guided by the Country Cooperation Strategy (CCS) and the WHO General Programme of Work, the WCO successfully supported the Government of Malawi in collaboration with other UN agencies.

We supported the Malawi Government through provision of technical and financial support; provision of drugs, equipment and other materials. We also provided technical support on norms, standards and guidelines as well as evidence to inform policy decisions and direction on all the health issues. WHO facilitated strengthening the health systems through provision of technical support during the development of a number of policies and strategic plans. Some of these include: TB 5 Year development Plan 2012-2016, the National TB Manual, Child Health Strategy, Health Promotion policy, the National Alcohol Control policy, the Human Resources for Health Strategic Plan 2012-2016, Sexual and Reproductive Health Strategy and the district implementation planning guidelines.

During the year, we also provided technical support in the resource mobilization for the Ministry of Health through GAVI HSS applications as well as HIV and malaria Global fund applications. There was also significant financial support through the Partnerships for Maternal Newborn and Child Health (PMNCH) implemented in 10 out of 28 districts of the country. ONE UN Fund including the Joint UN Program on Adolescent Girls Program also contributed to WHO's efforts of addressing the country's health needs.

In my conclusion, let me take this opportunity to thank all members of staff of the Malawi Country Office for their dedication to duty throughout the year. It is pleasing to note that the relationship with our counterparts in Government, the UN family and other levels of the organization, as well as all partners in the Health Sector was cordial in 2013. It is my sincere hope that the collaboration with all stakeholders in health will continue in 2014.

Acronyms

ART	-	Antiretroviral Therapy
CDC	-	Centre for Disease Control
DFC	-	Direct Finance Cooperation
DHO	-	District Health Officer
EHP	-	Essential Health Package
EID	-	Early Infant Diagnosis
EPI	-	Expanded Programme on Immunization
ETAT	-	Emergency Triage Assessment and Treatment
GAVI	-	Global Alliance for Vaccines and Immunization
GSC	-	Global Service Center
GSM	-	Global Management System
HPR	-	Health Promotion
HPV	-	Human Papilloma Virus
HSS	-	Health System Strengthening
HTC	-	HIV Testing and Counseling
ICATT	-	IMCI Computerized Adaptation and Training Tool
IMCI	-	Integrated Management of Childhood Illness
IRS	-	Indoor Residual Spraying
KMC	-	Kangroo Mother Care
LLIN	-	Long Lasting Insecticide Treated Net
MDG	-	Millennium Development Goals
MDSR	-	Maternal Death Surveillance and Response
MIS	-	Malaria indicator Survey
MOH	-	Ministry of Health
NCD	-	Non-Communicable Diseases
NFM	-	New Funding Model
NHA	-	National Health Accounts
NTD	-	Neglected Tropical Diseases
OPV	-	Oral Polio Vaccine
PMNCH	-	Partnership for Maternal Newborn and Child health
PMTCT	-	Prevention of Mother to Child Transmission
TB	-	Tuberculosis
UN	-	United Nations
UNDAF	-	United Nations Development Assistance Framework
UNICEF	-	United Nations Children’s Fund
VIA	-	Visual Inspection with Acetic acid
VPD	-	Vaccine Preventable Diseases
WCO	-	WHO Country Office

WHO	-	World Health Organization
YFHS	-	Youth Friendly Health Services

Executive Summary

Like the previous year 2014, Ministry of Health continued to experience challenges in human resources shortage, weak health information systems and shrinking funding for district health service delivery. Shortage of essential drugs for the EHP conditions and irrational use of drugs, for example anti-malarials, were common thereby depriving the community their right to access treatment and care. In addition the country had to shift its strategies and mainstream Ebola Virus Disease prevention and control intervention such as creation of awareness and systems strengthening.

In all aspects and in line with 2011 – 2016 Health Sector Strategic Plan (HSSP), WHO continued to support the Malawi Government through: provision of technical and financial support; provision of drugs, equipment and other materials and provision of norms, standards and guidelines as well as evidence to inform policy decisions and direction on all the health issues highlighted.

Financial support was provided through the Partnerships for Maternal Newborn and Child Health (PMNCH) and ONE UN Fund addressing country's health needs in the areas of mother, Newborn and child health, and the Joint UN Program on Adolescent Girls Program.

HIV and AIDS, Malaria, tuberculosis were still the major public health problems in Malawi, while maternal mortality ratio at 574 per 100,000 live births (DHS2010) being one of the highest in the world. The MDG target is 155 per 1000 live birth. On the other hand Malawi has achieved MDG 5 on under-five mortality rate which is at 85 per 1,000 births by 2015. There is also evidence of the increasing burden of Non-Communicable Diseases such as cancer and oral health and their risk factors.

The main achievements in the areas of health system, HIV/AIDS, Tuberculosis and malaria (ATM), child health, maternal, newborn and adolescent health, Non-communicable disease and neglected tropical diseases including health promotion.

During the year, WHO facilitated strengthening the health systems through provision of technical support during the finalization of important policies and strategic plans. The WHO also provided technical support in the resource mobilization for the Ministry of Health through GAVI HSS applications as well as HIV and malaria Global fund applications.

Despite the achievements that have been mentioned above, there were some challenges that hampered the implementation of the activities. Some of these include: inadequate human, financial and material resources for delivery of equitable and efficient health services. There were also competing priorities in the implementation of programmes. This report has also drawn some lessons and specific recommendations to the programmes.

1.0 Introduction

This 2015 report outlines the programmatic areas where financial and technical support was provided to the Ministry of Health under WHO strategic objectives as stipulated in 2014 – 2015 Biennial Work Plan focusing on key issues, WHO's response, the main achievements, lessons learnt and recommendations.

The report describes the WHO strategic approach which mainly is leadership on health issues, providing norms and standards as well as policy guidance. The strategic approaches also include capacity building through training, provision of equipment and materials. The approach also entails commissioning of research to generate evidence to support advocacy for policy develoment.

2.0 WHO Country Office

The WHO is located in ADL house at City center in Lilongwe the capital of Malawi. The WHO representative is the head of the office support by 12 technical officers. The finance and administration is headed by the Operations Officer and supported by 14 general service staff. Administration and Finance provides logistical support across key programmatic areas.

The key programmatic areas include Expanded program on Immunization (EPI), HIV and AIDS, Tuberculosis and Malaria prevention and control, Disease Prevention and Control, Health Systems and Financing; Sexual and Reproductive Health; Maternal, Newborn Child and adolescent Health, Essential Medicines and Health Promotion.

3.0 Health status in Malawi

In 2015 the key issues for the WHO country office included health systems, health programmes, resources, and disaster and risk management.

3.1 Strengthening the health systems

3.1.1 Leadership & Governance

The Ministry of Health (MOH) retains stewardship role of policy formulation, regulation and enforcement, ensuring standards, training, curriculum development and international representation. MOH is also the major provider of health services and accounts for about 60% of health facilities.

Malawi is implementing the Health Sector Strategic Plan (HSSP) 2011-2016 which will soon be replaced with the new one under development. The HSSP priorities revolve around the provision

of the Essential Health Package (EHP) which focuses on interventions against 13 major conditions that predominantly affect the Malawian poor. Provision of the EHP is part of the Malawi Growth and Development Strategy (MGDS II). Implementation of the HSSP is within the decentralization framework (GOM 1998) through the Local Government Act of 1999, with efforts towards devolution of health service delivery to District Councils. Monitoring of the HSSP is based on biannual joint reviews with all the stakeholders. Three Regulatory Bodies are charged with regulatory oversight and enforcing key GoM Acts governing the health sector: Pharmacy, Medicines and Poisons Board, Medical Council of Malawi, and the Nurses and Midwives Council of Malawi.

3.1.2 Human Resources for Health

One of the major challenges in the health system is the human resource shortage. Current staffing in Malawi is the lowest in the region with 1.9 physicians per 100,000 population and 34.3 Nurses and midwives per 100,000 population (WHO 2009). Outputs at training institutions are currently too low to fill existing vacant posts. Retention of health workers is another challenge as the public sector keeps losing skilled health workers to the private sector and the international market due mainly to low remuneration and poor working conditions. The few available health workers are also not evenly distributed across the country. The HSSP acknowledges that there is critical shortage of HR, low motivation for health workers, weak HR planning and management, inequalities in the distribution of HCWs and that training institutions are not producing adequate numbers of graduates to meet Malawi's needs among other challenges. The present human resources for health strategy has weaknesses in that it only focuses on MOH, is not based on the supply and demand in its projections of future requirements and there is no clear retention strategies The Human resources management information system is not adequately functioning.

3.1.3 Service Delivery

The health care delivery system is organized into primary, secondary and tertiary levels linked through a referral system. Primary health care is provided through community based outreach programmes, dispensaries/health posts, health centers as well as community hospitals. Secondary level care is provided primarily through district hospitals (for the public sector) and CHAM hospitals. Finally, Central Hospitals provide tertiary level care. Although MOH services are free at point of delivery, there are indirect costs incurred by the rural population to get to these facilities. The EHP aims to improve this situation, for instance through standardisation and expansion of community level services as well as protecting key resource inputs, such as transport for referrals and a secure budget for components such as drugs in the package. Service Level Agreements (SLAs) between the Ministry of Health and Christian Health Association of Malawi(CHAM) facilities for the delivery of Maternal and Neonatal Health (MNH) services is one way of ensuring equity of access to health services. Health service delivery in Malawi is faced with numerous challenges including: poor quality of services; poor and unequal access; substantial health inefficiencies; an unresponsive health system with inadequate accountability mechanisms and structures especially at community and district level; and a poor referral system which all have strong implications for the accessibility, sustainability, quality, equity, effectiveness and efficiency of health service delivery.

3.1.4 Health Information System

The national Health Management Information System (HMIS) in Malawi is paper based at facility level but is computerised at district and national levels using the web based DHIS 2. Multiple systems for electronic patient management information systems (Baobab, Rainbow, CHAM hospitals) and other patient-based systems like open MRS are also being used in the country. Paper based data collection accounts for over 90% of data collection efforts and the overreliance on manual processes for data management poses a problem for the MoH as paper based data management makes it difficult to record, extract, share and use the data especially because of the acute shortage of personnel to support the processes at facility level. To date, almost 30% of all vertical programmes are submitting and accessing their data through HMIS. Challenges in recording and extracting data contribute to and result in poor data quality as most facilities are not able to submit the required data timely affecting data reliability and accuracy.

3.1.5 Health system financing

At present, the health sector does not have an approved Health Financing Strategy: the 2014 draft National Health Financing Strategy is yet to be finalized and approved. The country would like to achieve universal health coverage through a number of reformed proposed for implementation. These reform areas which include establishing a Health Fund, reviewing the MoH/CHAM Memorandum of Understanding (MOU), Introduction of a National Health Insurance Scheme, and decentralization of the Health System.

According to the latest National Health Accounts (NHA) report that covers the fiscal years 2009/10, 2010/11 and 2011/12 the per capita total expenditure on health stood at US$40 in 2011/12. A major proportion of the Total Health Expenditure (THE) is from external sources with the figure standing at 65.4% in 2011/2012 (MOH 2014). The government total expenditure on health (as percentage of total government expenditure) continued to decrease from the 9.3% in 2004/2005 reaching 6.2% in 2011/12. These figures are far below the Abuja target of 15%. Out of pocket per capita expenditure on health ranged from 3.8% in 2009/10 to 4.0% in 2011/12 averaging at 3.8% (MOH, 2014). The average out of pocket expenditure on health as a percentage of private expenditure on health was 70.7% between 2009/10 and 2011/12. The Government per capita expenditure on health in 2012 was US$6.3.

3.1.6 Responses from Other Sectors

Addressing social determinants of health is a major priority in the HSSP and the MOH is making efforts to work with other stakeholders in order to address this. Some of these stakeholders include those in the water sector, education, finance, agriculture, gender and the information sectors. An assessment of the inclusion of health in all policies has been completed and this will help in addressing the gaps and direct key focus areas.

3.2 HIV/AIDS, tuberculosis and malaria:

Malawi is among the countries worst affected by the HIV epidemic, with 10.6% prevalence in the 15-49 year old population[1]. The most recent epidemic modeling estimates 10.3% prevalence, indicating a slight reduction since 2010. SPECTRUM modeling also estimated 26,000-34,000 new infections in 2014[2].

Projections suggest that in the absence of significant programmatic shifts, HIV prevalence will continue with a slow decline to about 9.3% in 2016. Declines in prevalence may be the result of decreased incidence or continued mortality among unidentified or untreated PLHIV, though people are now living longer with HIV and AIDS due to the successful ART programme. Current estimates put the number of people living with HIV and AIDS (PLHIV) at about 1,000,000 and it is anticipated that this number will increase to about 1,040,000 in 2016, largely as a result of increased survival as a result of the scaled up and integrated ART and PMTCT programme.

According to the WHO Global TB Report 2014, TB incidence and case notifications in Malawi have both declined over the past decades. However, TB incidence estimates are likely to be adjusted upwards in the light of the TB prevalence survey results indicating a prevalence of 286/100,000 in the general population (all ages).[3] The prevalence rate however is higher at 451/100.000 among adults. According to the same survey, up to 39% of bacteriologically confirmed cases would have been missed if X-ray screening was not applied, implying that symptom screening alone in high risk groups could potentially miss a significant proportion of TB cases.

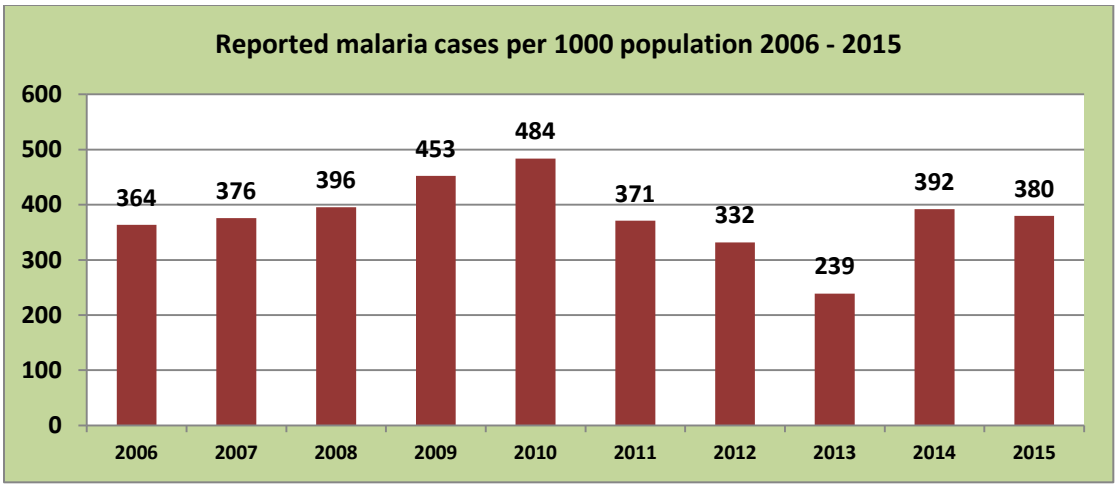
Although HIV co-infection rate among TB patients has declined from 77% in 2000 to the current 56%, it still remains one of the highest in the sub-region.

Malaria is endemic in Malawi and transmission is higher in areas with high temperatures and low altitude particularly along the lakeshore and lowland areas of the lower Shire Valley. Transmission is high during Malawi's rainy season (October through April). According to DHIS II report in 2015, malaria incidence was at 380 cases per 1000 population representing a 21% decline between 2010 and 2015. Malaria parasite prevalence in under-five children also registered a decline from 43% in 2010 to 33 percent in 2014 (MIS 2014).

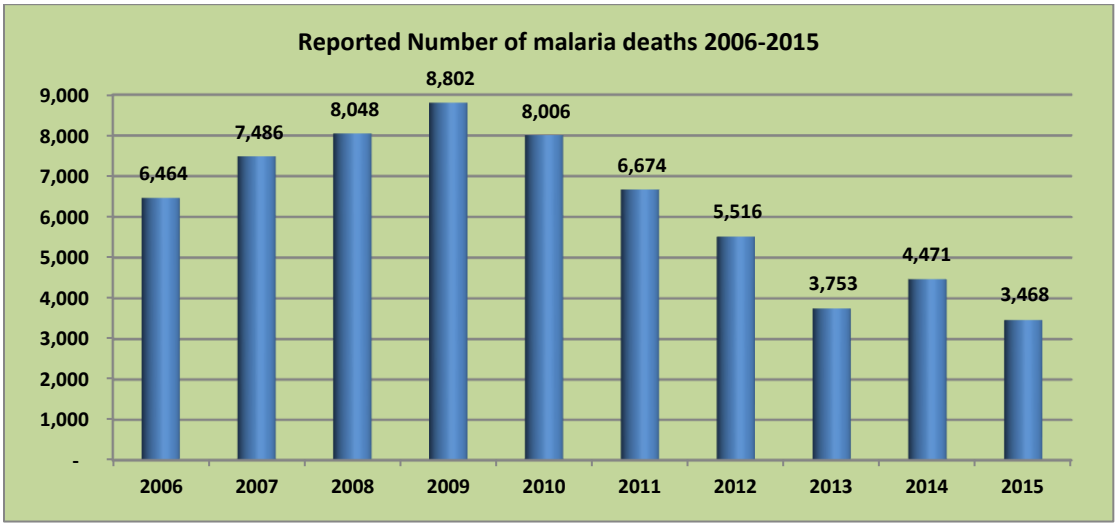
[1] National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro

[2] Joint United Nations Program on HIV/AIDS (UNAIDS) Malawi, May 2014 HIV estimates.

[3] Malawi Nationwide Tuberculosis Prevalence Survey Provisional Results. November 1, 2014. Presentation World Lung Health Conference, Barcelona, Spain Banda.R.P..



There is notable decline of 59% on malaria death from 8,006 deaths in 2010 to 3,468 deaths in 2015. The 2015 deaths indicate that there are almost 9 deaths due to malaria every day.



The main strategies for malaria control include use of Long Lasting Insecticide treated mosquito Nets (LLINs) and Indoor Residual Spraying (IRS); Prompt diagnosis and treatment of suspected cases and Intermittent Preventive Treatment for pregnant women. These strategies are supported by cross cutting approaches such as surveillance, monitoring and evaluation and operations research, behavioural change communication and programme management.

3.3 Child Health

In May 2012 all WHO Members states during the World Health Assembly, endorsed the Global Vaccine Action Plan (GVAP) 2011- 2020.The GVAP has six strategic objectives, and strategic objective number one of the GVAP asks all countries to commit to immunisation as a priority. The presence of an independent immunisation technical advisory committee indicates the commitment by a country towards the GVAP goals. The Ministry of Health in Malawi initiated the establishment of a National Immunisation Technical Advisory Groups (NITAG) in 2012. However key activities to establish the committee, however, could not be implemented due to funding constraints.

A Health Surveillance Assistant vaccinating a child during the 2015 World Health Day commemoration when the measles second dose was launched

A missed opportunity for vaccination (MOV) is defined as an occasion when a child, who is eligible for vaccination, and with no valid contraindication, visits a health service facility and does NOT receive all recommended vaccines. In Malawi MOV do occur however there has not been a formal study and documentation of factors causing MOV and how wide spread the problem is in the country.

In May 2015, all WHO Member States endorsed World Health Assembly resolution 68.3 on the full implementation of the Polio Eradication and Endgame Strategic Plan 2013-2018 (the Endgame Plan) and with it, the third Global Action Plan to minimize poliovirus facility-associated risk (GAPIII). The Endgame Plan set the goal of eradicating wild (WPV) and vaccine-derived polioviruses (VDPV). Achieving this goal requires: 1) detection of circulating polioviruses and interruption of transmission; 2) sequential cessation of the use of oral polio vaccine (OPV) to eliminate the risks for vaccine-associated paralytic poliomyelitis (VAPP) and outbreaks of circulating VDPV (cVDPV); and 3) implementation of measures for the safe handling and containment of polioviruses to minimize the risks for facility-associated reintroduction of poliovirus into polio-free communities, a prerequisite for final documentation of polio free status

The first step toward OPV cessation will be the withdrawal, in April 2016, of OPV type 2 (OPV2). OPV2 withdrawal will be accomplished by replacing trivalent OPV (tOPV) with bivalent OPV (bOPV, types 1 and 3) in all countries using OPV for immunization, facilitated by the introduction of at least 1 dose of inactivated poliovirus vaccine (IPV), composed of all three virus types.

Countries are required to complete Phase I and preparing for Phase II poliovirus containment activities of GAPIII, which includes the need to:

- Identify WPV2 and OPV2/Sabin 2 infectious and potentially infectious materials;
- Destroy, transfer, or contain WPV2 infectious or potentially infectious materials (including VDPV2) by end-2015;
- Destroy, transfer, or contain OPV2/Sabin 2 infectious or potentially infectious materials by end-July 2016.

3.4 Maternal Newborn and adolescent health

The key issues in maternal, new-born and adolescent health (MNH) are staff turnover, inadequate MNH equipment and supplies and high rates of premature deliveries. The staff turnover leads to inadequate health service providers in hard to reach emergency obstetric care facilities. The inadequate MNH equipment and supplies in health facilities and emergency obstetric care sites hinders the delivery of quality services. The high rate of premature deliveries contributes significantly to the high child mortality.

3.5 NCDs and NTD

3.5.1 Neglected Tropical Diseases

In Malawi, there are eight (8) neglected tropical diseases (NTDs) that are endemic. These are Schistosomiasis (Schisto), Soil transmitted helminthes (STH), Lymphatic filariasis (LF), Onchocerciasis (Oncho), Trachoma, Leprosy, Human African Trypanosomiasis (HAT) and Rabies. The country has successfully eliminated or controlled LF, Oncho, STH and Trachoma. Schisto has been targeted as the next NTD to be eliminated by the year 2020. To achieve this goal, there was need to sustain high (>75%) mass drug administration (MDA) geographical and therapeutic coverage in school age children and the whole population including adults in hot spot areas.

3.5.2 Non-Communicable Diseases

In Malawi, Cervical cancer is the commonest cancer in women accounting for 45% of all cancer cases and the trend is increasing. It is estimated that every year; 2,316 women develop cervical cancer and 1,621 die from the disease.

In accordance with WHOs' recommended cost-effective strategies for cervical cancer prevention and control for resource-poor countries, Malawi is implementing cervical cancer screening programme using visual inspection with acetic acid (VIA) and is piloting Human Papilloma Virus (HPV) Vaccination in Zomba and Rumphi.

3.5.3 Emergencies: The flood disaster

On 13 January 2015 The President of the Republic of Malawi declared a state of disaster following severe floods that affected 15 (54%) out of 28 districts in Malawi. Over 638,000 people were affected, 230,000 were displaced and 100 people died. Nsanje, Chikwawa, Phalombe were the hardest hit districts.

3.5.4 Epidemic preparedness and response: Reactive Oral Cholera Vaccination Campaign

Despite some improvement in the provision of safe drinking water, proper sanitation and hygiene, cholera still remains a major public health problem in Malawi with outbreaks occurring almost every year since 1998. In 2015, a total of 693 cases and 11 deaths (CFR 1.6%, attack rate 0.013%) were reported from eight districts. Nsanje and Chikwawa were the most affected districts. In addition to improving water, sanitation and hygiene; oral cholera vaccine (OCV) was administered in Nsanje for the first time in Malawi.

Everyone one year old received the Oral Cholera Vaccine in selected cholera hotspot areas in Chikwawa and Nsanje during the flood emergency situation in 2015

3.6 Health Promotion

The Ministry of Health, in 2015 in collaboration with the World Health Organization and partners and launched the Health Promotion (HPR) policy which is an instrument to build the capacity of the ministry to deliver health services using the health promotion approaches. Prior to this launch Malawi health promotion was mainly focusing on IEC and production of materials and messages. Health promotion strategies such as the settings approaches were not used to address risk factors for communicable and non-communicable diseases.

The current policy emphasizes on strengthening multi-sectoral collaboration and a) advocacy for health based on human rights and solidarity, investing in sustainable policies, actions and infrastructure to address social determinants of health; b) build capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy; c) regulate and legislate policies to ensure a high level of protection from harm and enable opportunity for health and well-being for all people; d) partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions

3.7 Finance and administration

In finance and administration, WCO like other countries has been implementing Global Management System (GSM) since 2012. The system aimed at simplifying the monitoring of financial transactions. However, the system was still under development with some teething problems. For instance WHO Malawi office had mismatches in the budgets at the end of biennium. The Global Service Centre (GSC) direct payment to suppliers posed a challenge in reconciling debts with vendors for lack of immediate proof that WHO has honored bills.

4 Major Achievements

4.1 Strengthening the health systems

World Health Organization in 2015 supported capacity building for the district health information systems to improve the quality of routine data generated at the facility level. In addition it initiated of policy dialogue in a number of areas including universal health coverage

4.2 HIV/AIDS, tuberculosis and malaria:

By the end of March 2015, 551,566 patients (55% of the estimated 1 million HIV positive population) were alive and on ART; 48% (47,962 / 101,000) for children (<15 years) and 65% (503,604 /779,000) for adults.

Following adoption of life long ART for HIV positive pregnant and lactating women in 2011, Malawi continued to make strides in increasing ART uptake among this group and by the end of 2015 the coverage had increased to 73% from 64% in 2014 against a national target of 95%.

Within its normative role WHO provided technical support to the Ministry of Health informing the update of the National HIV Strategic Plan, HIV Clinical Management Guidelines, HIV Testing Services Guidelines and STI Management Guidelines.

Adolescents carry placards during World TB Day commemoration

WHO was also part of the Global Fund writing teams for the joint TB/HIV and Malaria Concept Notes to mobilize resources for the HIV response and Control and Prevention of Tuberculosis as well as Malaria. The two concept notes have since been signed into grants are expected to become operational during the first quarter of 2016.

Malawi is one of the countries whose New Funding Model concept note for malaria was approved and the grant has since been signed. World Health Organization provided technical support during the entire process of NFM concept note development. The malaria proposal has been approved and the grant of US$28million for the 2016-2017 has been signed.

On vector control, Malawi conducted vector resistance mapping in 8 districts to supplement the available information on resistance to the commonly used pyrethroides insecticides. The country has successfully procured 9.0million Long Lasting Insecticides Treated Nets (LLINs) in readiness for distribution campaign that was to take place in December 2015, however it was postpone to first quarter of 2016. Unfortunately due to some delays this will take place in first quarter of 2016 however registration of beneficiaries was completed in December 2015. Indoor Residual spraying was done in two districts of Karonga and Mchinji with coverage of over 85%.

A team of filed assistants collecting larva for vector resistance mapping in Mwanza district

In terms of case management, the country has been faced with overconsumption of ACTs compared to the number of reported malaria cases. In this regard, the country has developed a commodity security plan in collaboration with malaria

partners including WHO. Some of the actions have already started being implemented such as malaria data reviews at zonal and district levels.

On part of capacity building in the just ended year, over 8,000 health workers were trained in order to equip them with knowledge and skills following revision of malaria treatment guidelines that included use of Injectable Artesunate as a preferred treatment for severe malaria. Malawi also sent two members of staff for malariology course in Ethiopia whose main aim to equip them with knowledge and skills in malaria control. On malaria in Pregnancy, the country adopted the new WHO recommendations such that health workers are being trained on the revised policy.

On cross cutting activities, the country has finalized the communication strategy that will facilitate positive behaviour change towards malaria control interventions. Research dissemination was also done during the year whereby the results of 2014 malaria indicator survey and drug efficacy study were disseminated.

Some of the main challenges during the year included, delays in flow of funding especially those for LLINs campaign that has resulted in the delay in conducting the campaign. With the current parallel supply chain systems for malaria commodities, it posed a challenge of coordination during the year. The discrepancy between the ACT consumed and number of malaria cases reported still hampered delivery of case management services during the year.

4.2 Child Health

The minister of health made an official statement that the last wild polio viruses case was seen in Malawi in 1992. This official ministerial declaration of the eradication of Type 2 poliovirus was submitted to the WHO Regional Director and subsequently contributed to the official Global declaration of WPV 2 type. The National Certification Committee finalized the Phase 1 containment report and submitted the final report to WHO Regional Office.

An orientation workshop for the newly established NITAG was conducted. The participants were four core NITAG members and eight technical officers from the National EPI programme, which is the NITAG secretariat. Malawi became one of the few countries in the East and Southern African sub-region that has a National Immunization Technical advisory Group.

The Ministry of Health developed a trivalent OPV-Bivalent OPV national switch plan. Implementation of activities in the plan is underway and the country is planning to switch from trivalent OPV to bivalent OPV in April 2016, according to the global switch date.

4.4 Maternal Newborn adolescent and child health

WCO also provided technical and financial support for Maternal, Newborn, Child and Adolescent Health, training of health workers in the various aspects of reproductive health like long term Family planning methods, integrated management of maternal and newborn health, community based maternal and newborn care, ETAT and ICATT.

With technical support from WHO, Maternal Death Surveillance and Response guidelines and training materials, as well as the first national report of the Committee on Confidential Enquiry into Maternal Deaths was done. Trainings of health workers on MDSR was supported technically and financially by WHO.

WHO collaborated with partners to support government to conduct a follow up EmONC Assessment. The draft report is ready for dissemination.
The 2014 MDG endline survey findings showed a downward trend of keys indicators and an increase in contraceptive prevalence rate (CPR) as follows:

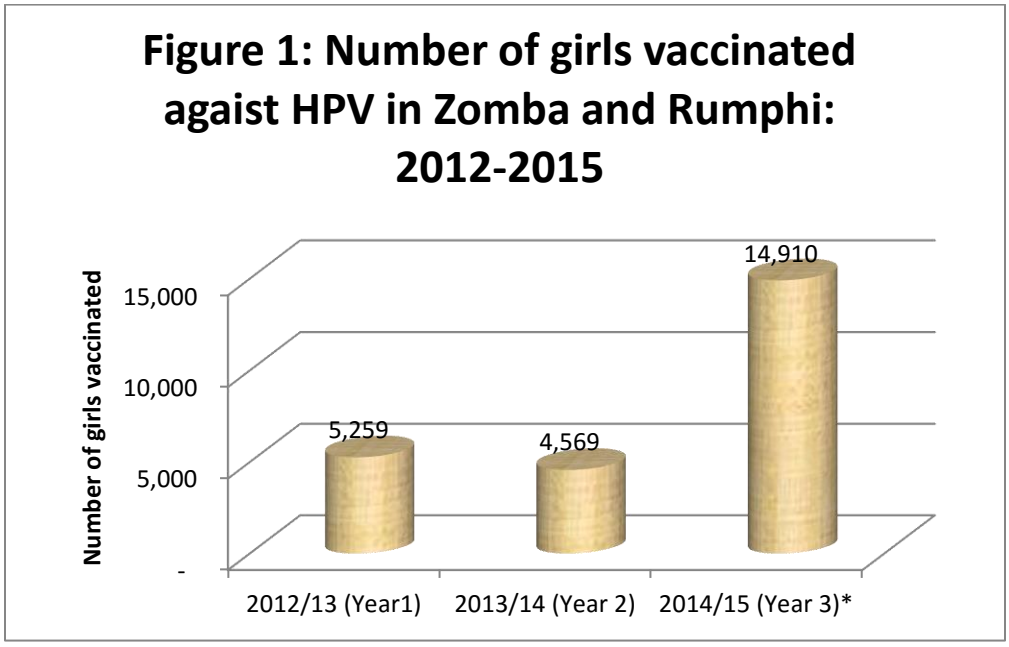
- Reduction of Maternal Mortality Ratio- 574/100000
- Births attended by skilled attendants – 87.4% (88% Institutional births)
- Total Fertility rate at 5.0
- Adolescent birth rate – 143/1000 Women of child bearing age (WCBA)
- Unmet need for Family planning – 19.4%
- CPR- 58.6%

UNFPA has been supporting training of more midwives to increase number of service provider and has been lobbying the government on equitable deployment of staff – to bring about rural – urban balance. To address this issue, a new born action plan has been developed which has been promoting use of antenatal

corticosteroids to reduce prematurity (although the most recent lancet report showed that use of corti-steroid had adverse effects of the baby.

4.3 NCDs and NTDs

In collaboration with Uganda Cancer Institute (UCI), WHO provided technical and financial to the adaptation of the new (2014) WHO Cervical Cancer Guidelines and Training materials, train 10 national trainers and 15 new cervical cancer providers. WHO also supported the administration HPV Vaccination Project in Zomba and Rumphi and the 2015 annual review for the National Cervical Cancer Control Programme. WHO is the only partners that has been supporting Cervical Cancer Programme consistently for the past three years. The two programmes were successfully implemented in 2015 based on the trends shown in figures 1, 2 and table 1 below.



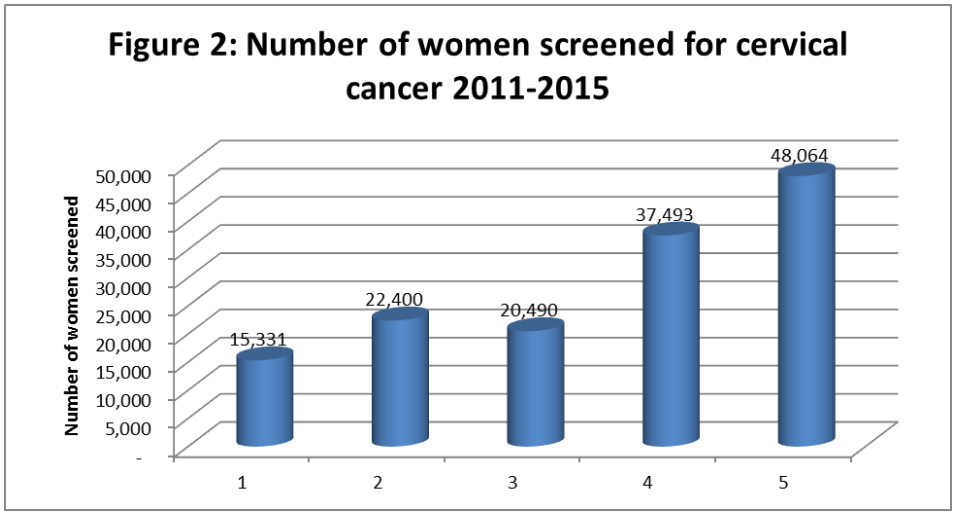


Figure 2: Number of women screened for cervical cancer 2011-2015
Number of women screened
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
15,331
22,400
20,490
37,493
48,064
1
2
3
4
5

Year	Number of women screened	Number of women with VIA positive	Number of women with VIA positive treated	Number of women with advance cancer
2011	15,331	894	388	798
2012	22,400	1,069	400	1,098
2013	20,490	1,447	528	1,294
2014	37,493	1,628	655	1,434
2015	48,064	2,177	896	1,625
	143,778	**7,215**	**2,867**	**6,249**

All sexually active women are encouraged to go for cervical screening once every 5 years. In the past 5 years, a total of 143,778 women were screened. Of these, 7,215 (5%) were positive and 6,249 (4%) and advanced cancer. Of the women who were VIA positive and were eligible for treatment, only 40% were treated. Lack of cryotherapy machine, gas or faulty machine were the main reasons for failure to treat eligible VIA positive women.

A young girl receiving an Human Papilloma Virus vaccine against cervical cancer

WHO provided financial support for the operation of in each of the three most affected districts of Nsanje, Chikwawa and Phalombe. The mobile clinic teams were providing basic health services and continuum of care to people on HIV, TB, diabetes and hypertension treatment living in 103 camps (22 in Nsanje, 19 in Chikwawa, 62 in Phalombe). A total of 15,266 people were treated for different diseases or conditions, at least 812 pregnant women received antenatal care, 338 people were receiving their HIV drugs and children were immunized.

Essential drugs and supplies for mobile clinics to last for three months (March to May 2015) were procured and distributed to the three districts.
To enhance disease surveillance and outbreak response, a total of 2,352 (Nsanje 370, Chikwawa 300, Phalombe 411, Blantyre 687 and Zomba 584) health workers were on cholera surveillance, treatment, prevention and control and 68 bicycles were procured for Health Surveillance Assistants (HSAs).

During the first round of the OCV campaign, a total of 156,592 (97.6%) people out of 160,482 target population received OCV. During the second round, a total of 137,629 (85.8%) people received OCV. Of these, 108,247 (67.6%) received their second dose while 29,382 (18.3%) were their first dose.

4.4 Health Promotion

The Health Promotion policy and its strategic plan, was successfully launched in mid-2015 by the Ministry of Health and partners. Since 2005 all the levels of the World Health Organization provided technical assistance to the development of this policy and the strategic plan. WHO supported the Ministry of Health to assess the extent to which "health" is addressed in sectoral policies in Malawi. This was the first step to generate evidence of existing policy and legislative gaps in social determinants of health and health promotion in Malawi and a report is available for dissemination in 2016. In addition the WHO supported the Ministry of Health in conducting the national food safety and quality situation analysis and produced a report titled Food Safety and Quality Control Situation Analysis for Malawi 2014. This is a platform for strengthening food safety and quality control systems in control. Using the Health Promotion framework that is in national Health Promotion policy a multi-sectoral mechanism will be established to spearhead the implementation of the report recommendation

The national alcohol policy and its strategic plan was also finalised and submitted to parliament for cabinet and parliament endorsement before a judicial review and enactment. WHO evidence based strategies is the pillar of this policy and strategic framework. The risk factors that the strategies aim to

address are alcohol related harm, road safety child and youth violence. The WHO in 2015 also introduced the Urban Health Equity Assessment and Response Tool (HEART) in Kasungu Municipal Council. A total of 18 health indicators were selected for an assessment using the tool in the municipality and a report and a plan is available for resource mobilization and implementation.

4.5 Finance and administration:

WHO Malawi office as a budget center cleaned up the mismatches through the expenditure batches in order to properly align expenditure against funded activities. Over 95% of data was successfully cleaned up.

5.0 Challenges

The health system in Malawi continues to experience many challenges some of which are human resources shortage, weak health information systems and shrinking funding to district from central level for supporting health service delivery. Shortage of essential drugs for the EHP conditions and irrational use of drugs were common thereby depriving the community their right to access treatment and care

During the year, WHO used the Direct Finance Cooperation (DFC) mechanism to disburse funds to the ministry of health and districts to facilitate implementation of activities for the measles campaign. There was also late disbursement of funds from district assemblies to the DHO due to bottlenecks in the current government policy whereby funds from partners and donors are supposed to be channelled through the district assembly bank accounts.

In TB the survey showed that symptom screening alone would have missed 39% of bacteriologically-confirmed cases. Still 52% of smear-positive cases would have been detected by symptom screening alone. In the year, 35% of bacteriologically-confirmed cases did not seek care for their symptoms. Of those that did, approximately 66% visited a public health facility. A final survey report and

dissemination are expected during the first quarter of 2015. However, provisional survey results have since informed the revised NTP NSP 2015-2020.

The WHO country office was also faced with delays in release of funds for implementation of activities which resulted into delayed implementation of activities. In general terms, there were limited financial resources to scale up and implement planned activities.

The WHO could not continue providing financial to MOH support to the MOH to ensure a successful implementation of the HPV vaccine demonstration project and its evaluation to inform the roll out provision to the other districts. The ball was thrown to government to allocate resources to the roll out which is not possible due to its financial problems.

Overall there were competing priorities for MOH officials which made it difficult to stick to the agreed times and in some cases some activities were no done at all.
Opportunities/ Constraints
A number of other partners; Banja La Mtsogolo (BLM), Livingstonia Synod, Nkhoma Synod, Baylor College of Medicine and SSDI came forward to support National Cancer Control Programme by training providers in their facilities. Frequent stock outs of acetic acid (vinegar) and inadequate number of cryotherapy machines were some of the main challenges.

5 Lesson Learnt and recommendations

1. The process of transferring funds to districts using the Direct Finance Cooperation (DFC) mechanism which WHO uses requires to start in good time in order to have time to respond to failed transfers.
2. WHO should continue providing support to the MOH to ensure a successful implementation of the HPV vaccine demonstration project and its evaluation which will inform the roll out provision to the other districts.
3. WHO should continue advocating for evidence based decisions in order to improve health outcomes.

4. WHO should continue providing technical support in production of the NHA in future due to ongoing changes in the methodology and the tools used.
5. WHO should continue collaborating with other partners in implementation of programme activities to enhance health and development.

7.0 Conclusion and Way forward

The Government stewardship played a critical role in ensuring significantly positive outcomes of the country cooperation strategy. Major efforts for WHO in the coming year 2016, will be focusing in maintaining the gains achieved in 2015 in in all programmes while leveraging resources to address health needs of the country. Linkages with all levels WHO and with other health partners will be maintained and enhanced in line with new challenges and other emerging health nee

Staff Movement

Mr Humphreys Masuku joined the WHO Malawi country office on 2 January 2015 as National Professional Officer / Environmental Health

NO	MISSION MEMBER	PURPOSE	PROPOSED DATES	FOCAL PERSON
1	Dr Nigel Rollins	Special supervision visit to Integrating and Scaling-up PMTCT through Implementation Research (INSPIRE) project	11-17 January 2015	Ms E Thom
2	Dr N Ganda Prof. Bokye Mr Bolo Tole Dr H Opata Ms A Pannell	Flood Disaster Response	27-Jan	Dr K Mayamboza
3	Dr Lorenzo Pezzoli	Cholera Risk Assessment	25-Feb	Dr K Mayamboza
4	Dr Andre Griekspoor	PDNA Analysis and Report Writing	4-Mar	Dr K Mayamboza
5	Mr Sanzan Diarra	Logistics	08 March - 10 April	
6	Dr Samuel Ogiri Dr Chawangwa Modondo	GLC Mission	15-25 March	Mr I Nyasulu
7	Mr Sifiso Phakathi	PMTCT Mission Site visit	22-28 March	Ms E Thom
8	Ms Amanda Gatto Mr Kamal Ait-Ikhlef Mr Israel	Technical support for floods	26 March - 05 April	
9	Dr Josephine Namboze Mr K Gausi			Mr W Dodoli
10	Ms Nitta Bellare	INSPIRE Project		Ms E Thom
11	Dr Lucien Manga Dr Graig Hampton	Malawi and Mozambique Flood Grade 2 Emergency Response After-Action-Review	10-15 May	Dr K Mayamboza
12	Dr Christine Horwood Mr Sifiso Phakati	INSPIRE Project special support visit to Mangochi		
13	Dr Maurice Bucagu Dr Nancy Kidula	Quality of Care Assessment	25 Jul - 07 Aug	Dr L Mgalula and Dr S Kambale
13	Dr Daniel Murokora Dr Prebo Barango	ToT and Adaptation of New WHO Cervical Cancer	16-29 August	Dr K Mayamboza
14	Dr Craig Dr Senga	National Capacity Bulding Risk Management Training	07 - 23 September	
15	Dr Jethro M Chakauya Dr Muhamad Gedi Mrs Z Machekanyanga Mrs Selloane Maepe	EPI Review Mission	16-29 September	Dr Kwame Chiwaya
16	Dr Peter Gaturuku Mr Eugene Mahlehla	Field test IDSR Community Based Surveillance Training Modules	19-23 October	Dr K Mayamboza