Harnessing momentum:
Priority areas of intervention to further strengthen Malawi’s health sector

Key messages:

01 Malawi has made good progress towards tackling pressing health priorities, but it continues to carry a significant burden of communicable diseases, and high maternal mortality and stunting rates persist. Its current Health Sector Strategic Plan aims to progressively achieve universal health coverage of an essential health package.

02 This policy brief draws on the comprehensive 2018/19 Malawi Harmonised Health Facility Assessment to identify the barriers affecting service delivery and proposes interventions to make progress on the implementation of the essential health package over the coming years.

03 Significant barriers to effectively deliver this package of care include inequity in access to services; lack of critical inputs such as human resources, medical equipment and medicines; and suboptimal clinical quality of care. A concerted response is needed to fill the gaps in service availability and readiness nationwide to ensure that all Malawians can benefit.

04 Governance and health sector management should be strengthened to maximize the value for money from public financing to health and to maximize the delivery of critical health services by the private sector.
Malawians are healthier and live longer than they ever have. In 2000, life expectancy in Malawi was 45 years. It has now reached almost 64 years for both men and women. Vaccination coverage for children under 5 has also increased to nearly 95%, and the under-five mortality rate – a key marker of equity and access – has dropped substantially from 234 deaths per 1,000 live births in 1992 to 63 deaths per 1,000 live births in 2015-16. These significant improvements in health are in large part due to the Government of Malawi’s expansion of key maternal health, child health, and nutrition services across the country over the last 25 years. As a result of these important reforms, Malawi outperformed some targets set under both its own Health Sector Strategic Plan (HSSP I) for 2011–2016, and the Millennium Development Goals.

Despite these successes, health challenges in maternal and child health persist. For example, while the number of women who die during (or immediately after) childbirth has reduced over the last six years, the maternal mortality ratio remains stubbornly high at 439 deaths per 100,000 live births. This is despite the fact that assistance by a skilled birth attendant is high and nearly all births occur in health facilities.

Malawi Health Sector Strategic Plan II

The HSSP II aims to further improve health outcomes through the provision of an essential health package and health systems strengthening. It sets eight strategic objectives:

- **Health service delivery**: Increase equitable access to and improve quality of health care services*
- **Socio-economic determinants**: Reduce environmental and social risk factors that have direct impact on health
- **Infrastructure and medical equipment**: Improve the availability and quality of health infrastructure and medical equipment*
- **Human resources**: Improve availability, retention, performance, and motivation of human resources for health for effective, efficient and equitable health service delivery*
- **Medicines and medical supplies**: Improve the availability, quality and utilization of medicines and medical supplies*
- **Health information system**: Generate quality information and make it accessible to all intended users for evidence-based decision-making, through standardized and harmonized tools across all programs
- **Governance**: Improve leadership and governance (particularly setting direction and regulation) across the health sector and at all levels of health system*
- **Health financing**: Increase health sector financial resources and improve efficiency of their allocation and utilization

*Denotes areas assessed in the 2018/2019 Malawi Harmonised Health Facility Assessment
interventions, most maternal deaths are preventable. The high number of maternal deaths possibly reflects inequities in access to quality health services in Malawi. In addition, the country continues to carry a high burden of communicable diseases including malaria, HIV/AIDS, respiratory infections and diarrheal diseases.

Malnutrition also remains an ongoing challenge. Malawi’s stunting rates – while they have improved – still fall short of global targets and standards. The 2015-16 Demographic and Health Survey found that well over a third of children under five years were stunted, above the developing country average of 25%, although a much lower proportion suffer severe stunting or wasting[3]. Furthermore, about half of all deaths of children under five are associated with severe or moderate malnutrition, with no significant improvements to the contribution of malnutrition to child mortality since the early 1990s[4].

Improving health outcomes in Malawi requires understanding the key health interventions being implemented and the potential barriers that affect service delivery. Malawi’s HSSP II (2017-2022) identifies a set of interventions necessary to further improve health outcomes, and to ensure the delivery of quality, equitable, affordable and patient-centred health care services. Malawi’s 2018/19 Harmonised Health Facility Assessment (HHFA), conducted by the Government of Malawi with support from international health and development agencies, provides a comprehensive diagnostic of the supply-side barriers that affect service delivery at health facilities. The 2018/19 HHFA survey instrument was comprised of a standard Service Availability and Readiness Assessment* and Service Delivery Indicators†. These were combined into a single tool with five modules: facility inventory; health worker roster; clinical vignettes; facility finances and governance; and client exit interviews. Data was collected from all health facilities in the country (1,106 health facilities) including government, faith-based, CHAM (Christian Health Association of Malawi) and private for-profit facilities between November 2018 and March 2019. The 2018/19 HHFA should be used to inform and guide the operationalization of Malawi’s current set of health sector reforms. This policy brief draws from this assessment, as well other research, identifying the most important policy interventions needed to achieve key health targets over the coming years.

**Box 1: What is included in Malawi’s essential health package?**

The EHP covers reproductive, maternal, neonatal and child health conditions (RMNCH), communicable diseases and non-communicable diseases. It includes:

- **Antenatal care** (e.g. tetanus toxoid, syphilis detection, etc.)
- **Family planning** (various options including IUD and pill)
- **Delivery and postnatal care** (including management of complications)
- **Essential vaccine package**
- **Malaria diagnosis and treatment**
- **Integrated management of childhood diseases** (e.g. acute respiratory infections, diarrheal disease, nutrition, etc.)
- **Community health package** (e.g. disease surveillance, hygiene promotion, etc.)
- **Neglected tropical disease treatment** (e.g. schistosomiasis, etc.)
- **Nutrition** (e.g. vitamin A supplements for pregnant women, deworming and management of severe malnutrition in children, etc.)
- **TB treatment** (including testing and first line treatments)
- **Non-communicable disease care** (e.g. diabetes management, mental health treatment, etc.)
- **Oral health**
1. Inequitable access to health services

Achieving universal health coverage in a sustainable and equitable way is the main goal of Malawi’s health sector reform plan, and an essential health package (EHP) – free at the point of use – is the government’s primary tool to achieve this. The aim is to expand coverage of a standard set of services to everyone (see Box 1), with a particular focus on targeting disadvantaged population groups. However, a similar EHP has existed in the country since 2004 and has faced a number of implementation challenges. Among them is inequality in utilization with rural, uneducated and poor populations facing severe constraints to accessing health care services in many cases.[5]

There are numerous supply- and demand-side issues that affect the use of services, but ensuring the availability of basic infrastructure and inputs is paramount and a gap that the 2018/19 HHFA highlighted as a major issue. For example, it revealed that Malawi had a very limited number of health facilities – only 0.6 health facilities per 10,000 population, which is substantially lower than the World Health Organization’s target of two health facilities per 10,000 population. This made access to health care services a problem in most of the country’s 29 districts. Although there was geographical variation in the density of health facilities, only one district (Likoma) met the global target (see Figure 1).

While the lack of health infrastructure should not be downplayed, Malawi benefits from a strong community-based service delivery model, with several cadres of community health workers employed by the government.
In fact, health surveillance assistants alone make up over half of the Ministry of Health’s 17,000 health workers and continue to play a fundamental role in extending access to healthcare⁰. In addition, Malawi has an active network of community health volunteers. In a context of limited resources, further leveraging this approach may be a more sustainable way to strengthen the health system. However, more support in terms of supportive supervision and overall coordination would be needed to make this work to deliver quality services.

In addition to having sufficient health facilities where people can seek care, facilities also need to be able to offer the services that form part of the EHP. The 2018/19 HHFA looked at the extent to which health facilities could do this through a service availability assessment⁴. On average, facilities offered about 70% of EHP services. However, there were considerable variations in the range of services available. In Blantyre, a lower performing district, facilities offered just half of the services they should, while in higher performing districts like Ntchisi and Neno up to 90% of services were available (see Figure 2). This suggests that the inequitable distribution of health services across the country is a major barrier to ensuring access to the EHP for all Malawians.

### 2. Lack of critical inputs such as human resources, medical equipment and medicines

Delivering quality primary health services requires a set of critical inputs – namely, staff, medical equipment and drugs. Having these in place makes a facility ‘ready’ to provide services. The 2018/19 HHFA explored facility readiness by measuring the extent to which health facilities could deliver EHP services. It assessed whether facilities had a range of medicines, commodities and diagnostic equipment, as well as the level of trained staff and guidelines in place⁶.

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**Figure 2:**
Service availability index by district

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Service availability score

- **50% - 60%**
- **60% - 70%**
- **70% - 80%**
- **80% - 90%**
- **Lakes**

Source: 2018/19 Harmonised Health Facility Assessment, 2019
On average, facilities had just over 60% of the critical inputs needed to deliver quality essential services. While there was some variability in facility readiness by district (lowest 51%, highest 73%), no district had more than three-quarters of the critical inputs required for delivery of EHP services. Service readiness also varied greatly by facility type, with hospitals having around 80% of the critical inputs required compared to clinics and health posts, which had less than 50% (see Figure 3). The fact that lower levels of the health care system face considerable shortages of the critical health system inputs that are necessary for providers to deliver high-quality health services is particularly problematic because these facilities are the first point of contact for primary health care, serving the majority of the population.

**Figure 3:**
Facility readiness to deliver EHP services (%) by facility type

Source: 2018/19 Harmonised Health Facility Assessment, 2019

**3. Limited health workers with appropriate training**

The 2018/19 HHFA found that there were about 10 health workers for every 10,000 people in Malawi. The recommended global target is more than double this amount. Geographical disparity existed in the density of health workers, but as a general rule there were staff shortages virtually everywhere. At around 40 patients per provider per day, Malawi’s outpatient caseload was also substantially higher than that of other countries in Africa such as Kenya, Tanzania and Sierra Leone (13, 10 and 8 patients per day, respectively). Contexts where there is an insufficient number of health workers over an extended period tend to achieve relatively poor population health outcomes[6].

There was also a major issue with the performance of health workers. The Lancet Global Commission on High Quality Health Systems emphasizes that the availability
of inputs alone will not translate into better health outcomes unless providers also have the knowledge, skills and competencies to clinically care for patients\(^7\). Using patient vignettes, the 2018/19 HHFA provides the first assessment of the clinical knowledge of providers in Malawi. Overall, most health workers showed a good ability to both diagnose and treat major health conditions such as tuberculosis (88%), diabetes (78%), and pneumonia (75%). However, only three out of 10 were able to identify the correct diagnosis and treatment for diarrhoea and 54% for malaria, both of which are quite prominent diseases in the country (see Figure 4). When accounting for nutrition-related co-morbidities in these two clinical scenarios (i.e. malaria with anaemia and diarrhoea with severe dehydration), only a quarter of providers were able to state both a correct diagnosis and treatment. There was also significant room for improvement when it came to the ability of staff to assess and counsel on nutrition for sick children with only one in three able to do so adequately. Malawi’s performance in nutrition related-indicators may, in part, be explained by these findings.

**Figure 4:** Proportion of providers able to correctly diagnose and correctly treat common childhood and adult health conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Proportion of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary tuberculosis</td>
<td>88%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>78%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>75%</td>
</tr>
<tr>
<td>Malaria with anaemia</td>
<td>25%</td>
</tr>
<tr>
<td>Malaria</td>
<td>54%</td>
</tr>
<tr>
<td>Diarrhoea with severe dehydration</td>
<td>23%</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>30%</td>
</tr>
<tr>
<td>Anaemia in pregnancy</td>
<td>54%</td>
</tr>
</tbody>
</table>

The six conditions include: diarrhoea with severe dehydration, malaria with anaemia, pneumonia, anaemia in pregnancy, diabetes and pulmonary tuberculosis

Source: 2018/19 Harmonised Health Facility Assessment, 2019
4. Limited governance and leadership to ensure effective delivery of health services

Facility management is an important contributor to the performance of hospitals and clinics. The quality of health care delivered, as well as patient outcomes, is dependent not only on the availability of critical inputs and competent providers, but also on how well resources are managed.

The unreliability of providers’ presence at health facilities in Malawi poses a significant barrier to providing timely and quality health services for patients. An interesting finding from the 2018/19 HHFA was that one in five providers were absent in an unannounced visit, yet the majority of these absences were sanctioned (95%). The absenteeism rate was highest among doctors (27%) and mainly affected public health facilities. There seems to be considerable scope to improve the governance of public hospitals, especially in matters related to human resource management. In addition, only about half of the providers were paid on time in government hospitals, as compared to about 80% or higher in other facility types. This may have an impact on motivation.

In terms of governance structures and regulation in Malawi, the 2018/19 HHFA highlighted a big difference between how public facilities were run compared to private ones. For example, while about 70% of public hospitals had a Health Advisory Committee, which plays an important role as a feedback mechanism from facility to district policies and planning, this was not a requirement for private for-profit hospitals within the current district governance structure. Timely supervisory support to private health facilities was also particularly low in private compared to public facilities, with public hospitals receiving around five visits per year compared to just two for private hospitals. What is more, the quality of supervision was better for public facilities and there appeared to be no system for routine data quality reviews at private hospitals either. In short, there seemed to be a significant lack of governance structures and regulation for private health facilities – paramount for ensuring that the private sector aligns with the goals of the country’s health system and provides the same minimum quality of services.

The 2018/19 HHFA also brought to light the fact that the overwhelming majority of hospitals – regardless of whether they were managed by the government, CHAM or private for-profit companies – had a mechanism in place to ensure health sector responsiveness to clients. For example, each had developed a way of obtaining patients’ opinions on how health services were delivered and for feeding this information back to hospital staff. Patient responsiveness is one of the key goals of the HSSP II so the fact that there are systems in place to support this is encouraging.
Delivering the EHP equitably across the country should be the top implementation priority for the Government of Malawi. In practice, this means ensuring that critical health system inputs such as essential drugs, diagnostics and equipment are consistently available at health facilities. To achieve this, the government will need to take on a stronger role managing on- and off-budget support allocations, and using available data more effectively to make evidence-based decisions. Training for staff and better guidelines to enhance the readiness of facilities is needed as well. Inputs are important as they allow providers to assess and treat patients, but are not sufficient to ensure high-quality health service delivery. Given the gaps in service availability and readiness of facilities to deliver, the focus should first be on ensuring that all EHP services are fully available nationwide.

Health workers should be empowered to adequately diagnose and treat child health conditions. One way to do this is to include nutrition assessment and counselling as part of any child health visit. The capacity of health workers in Malawi to deliver quality clinical care was satisfactory for adult clinical conditions, but not for common under-five conditions related to malaria, diarrhoea and pneumonia. In particular, providers demonstrated challenges in diagnosis and treatment of co-morbidities, full adherence to clinical guidelines and conducting nutrition-relevant assessment and counselling for sick children. Quality improvement
strategies could include both pre-service and in-service training and should focus on supportive supervision and monitoring the quality of clinical service delivery. This should be complemented with capacity building of training institutions and increased regulation of health professionals.

**Task shifting patient consultations to nurses should be explored as a potential way to reduce the caseload of providers at health facilities.** The low density of health workers and their high workload highlights critical shortages in the health workforce. Increasing the number of skilled health providers may be a long-term solution, but in the short term engaging nurses to provide more patient consultations should be explored as a cost-effective strategy to reduce caseload. The 2018/19 HHFA showed that only 31% of nurses provided patient consultations so there is certainly scope to expand task shifting models further.

**Strengthening governance and management of human resources at public health facilities, while also introducing appropriate regulation and norms of private health facilities, should be urgently addressed.** Public health facilities showed significantly higher absenteeism rates compared to private health facilities, and they also faced issues when it came to the payment of salaries, which can negatively affect performance. One way to tackle absenteeism could be to train facility managers to ensure there is a minimum level of staff present to provide services. What is more, private facilities were not subject to the same norms and practices applied to public health facilities. While public and private facilities are bound to operate differently, the norms and standards they follow should not be quite so divergent.
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**Endnotes**

* The Service Availability and Readiness Assessment is a health facility assessment tool designed to assess and monitor the service availability and readiness of the health sector and to generate evidence to support the planning and managing of a health system. It is designed as a systematic survey to generate a set of tracer indicators of service availability and readiness.

† The Service Delivery Indicators are sets of health and education indicators that examine health workers’ and teachers’ effort and ability, as well as the availability of key inputs and resources that contribute to the functioning of a health facility or school.

‡ Service availability was defined as the average number of health services offered at health facilities; services included in this calculation are as follows: family planning; antenatal care; delivery; child preventative and curative care; malnutrition diagnosis and treatment; malaria; tuberculosis; and HIV. This was to align with what was collected in this survey and EHP.

§ Service readiness was defined as the average facility readiness score across EHP health services. Services that are not offered at a facility were excluded from the service readiness score for that facility. Individual items required to be ‘ready’ for a service were defined by the WHO Service Availability and Readiness Assessment Indicators and refined based on country guidelines.

**References**


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