MINISTRY OF HEALTH

MALAWI CHILD HEALTH STRATEGY II

2021 – 2026

'Pathway to Newborn, Infant , Child Survival and Health Development'

Ministry of Health
P.O. Box 30377
Lilongwe 3
Malawi

November 2021


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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS AND ACRONYMS

ACSD	Accelerated Child Survival and Development
AFP	Acute Flaccid Paralysis
AIP	Annual Implementation Plan
ANC	Antenatal Clinic
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
AU	African Union
BCI	Behavior Change Intervention
BEmOC	Basic Emergency Obstetric Care
CEMONC	Comprehensive Emergency Obstetric and Newborn Care
CBCC	Community Based Child Care Centres
CFR	Case Fatality Rate
CHAM	Christian Health Association of Malawi
CMAM	Community Management of Acute Malnutrition
CMST	Central Medical Stores Trust
COIN	Care of the Infant and Newborn
CPAP	Continuous Positive Airway Pressure
CPR	Contraceptive Prevalence Rate Community based
CSO	Civil Society Organisations
DDA	Deputy Director Administration
DEHO	District Environmental Health Officer
DFID	Department for International Development (UK)
DHMT	District Health Management Team
DHIS 2	District Health Information Software 2
DHS	Demographic and Health Survey
DHSS	Director of Health and Social Services
DOTS	Directly Observed Therapy, Short Course
DPT	Diphtheria, Pertussis and Tetanus
EHP	Essential Health Package
EMLS	Essential Medical Laboratory Services
EmOC	Emergency Obstetric Care
EMPIC	Enhanced Management of Pneumonia in the Community
ENAP	Every Newborn Action Plan
EPI	Expanded Program on Immunization
GAVI	Global Alliance Vaccine Initiative
HCMC	Health Centre Management Committees
HCT	HIV Counseling and Testing
HES	Health Education Services
HMIS	Health Management Information System
HSA	Health Surveillance Assistant
HSSP	Health Sector Strategic Plan
iCCM	Integrated Community Case Management
iCHIS	Integrated Community Health Information System
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication

IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPT	Intermittent Presumptive Treatment
ITN	Insecticide Treated Net
IYCF	Infant and Young Child Feeding
KMC	Kangaroo Mother Care
LF	Lymphatic filariasis
LMIS	Logistical Management Information Systems
MBTS	Malawi Blood Transfusion Service
MDHS	Malawi Demographic Health Survey
MDG	Millennium Development Goal
MGDS	Malawi Growth and Development Strategy III
MICS	Multiple Indicator cluster survey
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Rate
NMR	Neonatal Mortality Rate
NGO	Non-Governmental Organisations
NHP	National Health Plan
NLGFC	National Local Government Finance Committee
NMCP	National Malaria Control Program
NSO	National Statistical Office
OAU	Organisation of African Unity
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PHAST	Participatory Hygiene and Sanitation Transformation
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Care
REC	Reach Every Child
RHD	Reproductive Health Directorate
SBC	Social Behaviour Communication
SDG	Sustainable Development Goals
SLA	Service Level Agreements
SOP	Standard Operating Procedures
SP	Sulfadoxine-Pyrimethamine
SRHP	Sexual Reproductive Health Program
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
SWOT	Strengths Weaknesses Opportunities Threats
TB	Tuberculosis
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
TWG	Technical Working Group
UCL	Universal Childhood Immunisation
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's' Fund
VHC	Village Health Committee
WHO	World Health Organization
ZHSO	Zonal Health Support Offices

FOREWORD

Malawi achieved the target for under-five mortality reduction during the MDG era from 189/1000 live births (DHS, 2000) to 63/1000 live births (DHS, 2015/2016), but despite these substantial gains, it continues to experience deaths among under five children. Studies have pointed at the failure of satisfactory progress on newborn and infant mortality. The mortality trends over the period beyond MDGs have shown an unpredictable trajectory. In districts where services require multiple or integrated efforts, such as stunting and undernutrition, there can be significant mismatch between target and actual performance." A very good example where services require multiple or integrated efforts for improvement is the case of Mchinji district where under-five mortality from the 2016 DHS data showed high under-five mortality of 123/1000 live births. This is a result of the districts' unsatisfactory performance on a critical direct death-driven high impact intervention on stunting under nutrition which is at 44% while country level is 37%. This mismatch in performance is common in many districts.

Progress and lessons from the previous Child Health Strategy (2014 -2020) has formed the basis for the 2021-2026 Child Health Strategy. To reverse the under-five mortality rates, we have redesigned our thinking by focusing on intervention areas where the Ministry of Health (MoH) needs to perform better, and strengthening services that have proven to have impact and are implemented within the quality-of-care framework at all service delivery levels. To create a pathway for the survive, thrive and transform agenda, this 2021-2026 Child Health Strategy has also aligned relevant programmatic elements by recognising the contributions of other sectors on child health through identification of redesigned life-course interventions These priorities are contained in the Malawi Growth and Development Strategy (MGDS III) 2017-2022 and linked to the Malawi 2063 Agenda.

This Child Health Strategy covers children from birth up to 18 years, including interventions for children 6 to 10 years of age, who tend to be missed though still face health challenges. MoH will continue promoting linkages between and among programmes to facilitate continuum of care for children 0-18 year, such as the Sexual and Reproductive Health strategy which covers those 10-18 years of age.

In realising our dream towards improved child health indicators, I call upon implementers at all levels of health care to use this Child Health Strategy as a guiding tool towards standardised delivery of child care services in the country. I equally urge partners, stakeholders and donors to embrace and financially support the aspirations of MoH through their resource mobilisation efforts which are clearly laid out in this Child Health Strategy. The gains realised from implementation of this strategy will be celebrated by all. Malawi's future is dependent on children who survive, thrive and transform into productive citizens.

Honourable Khumbize Kandodo Chiponda, MP

MINISTER OF HEALTH

ACKNOWLEDGEMENTS

The Child Health Strategy 2021 to 2026 is a national living document. It gives direction and provides implementation arrangements for strengthening delivery of identified evidence proven child health interventions at all levels of health care service delivery.

The document has been developed through the engagement of locally assembled dedicated and patriotic Malawians who volunteered to form a writing team. The writing team was supported by a reference group comprising senior Ministry of Health members, Child Health Partners and Global Child Health experts.

This Strategy underwent different stages and processes for its development. Different individuals, partners and donors supported the processes of situation analysis, consolidation, validation and report writing. In this regard, the Ministry of Health appreciates the Integrated Management for Childhood Illnesses (IMCI) unit team for facilitating and leading the development processes. This team is comprised of Dr. Humphreys Nsona, Ernest Kaludzu, Haxson Twaibu, Clifford Dedza, Newton Temani, Tiwonge Mkandawire, Hilda Kafumba and Dominic Manthalu

For the numerous contributions and for working tirelessly on all the stages of the strategy development, the Ministry of Health is so thankful to the writing team that comprised of led by Willie Kachaka (Consultant, E4C) and comprised of Dr. Emmie Mbale (Paediatrician, QECH and KUHES), Dr. Pui-Ying Iroh Tam (Paediatrician Wellcome Trust.), Charles Mulilima (Malawi Principal College of Health Sciences) and Enoch Bonongwe (Deputy Director Social Welfare, Ministry of Gender Social Welfare and Community Development). The Ministry also appreciates the efforts of the reference group members comprising Dr. Queen Dube (Chief Health Services), Dr. Storn Kabuluzi (Director Preventive Health Services), Dr. Fannie Kachale(Director Reproductive Health), Dr. Gerald Manthalu (Deputy Director Planning), Wilkes Silema (Deputy Director Planning), Dr. Sethy Ghanasyan Chief of Health, UNICEF), Elimase Kamanga Gama (Technical Director ,ONSE-MSH) and Amos Misomali (ONSE-MSH, Dimagi). Global Health contributors were: Dr. Anne Detjan, Dr. Maureen Momanyi, Rory Nedft and Jennifer Barak, from UNICEF HQs and regional Office; Dr Teshome Desta Wodehanna from WHO regional Office and Dr. Dyness Kasungami-Matoba and Sita Strother of the Child Health task force secretariat. They worked tirelessly on almost all the development of the strategy

In addition, the Ministry appreciates the contribution from members who provided inputs throughout the strategy development process namely; Dr. Owen Musopole, George Banda, Lucy Mkutumula, Dr.Janet Guta, Jean Nyondo, Doreen Ali, Shanton Kacheche, Bowen Kaponda, Daniel Ntengula, Edward Soko, Beatrice Nindi, Martin Maulidi, Christina Mchoma, Dr. Susan Kambale (WHO), Texas Zamasiya (UNICEF), Kondwani Makwenda, Ricky Nyaleye and Deliwe Banda (FHI360), Martha Saidi (World Relief) and Wezi Kalumbu (ONSE-MSH), Gomezgani Jenda (Save the Children), Chifundo Kuyeli (USAID), Abigail Nyaka (LMH) and Florence Mshali (AMREF).

Costing of the National Health strategy has been facilitated by Dr Gerald Manthalu from the Planning Directorate in collaboration with Stephanie Heung and Ian Yoon from CHAI.

Finally, the Ministry is grateful for the commendable financial and technical support provided during the strategy development processes by the following partners: USAID–(ONSE-MSH, World Relief and FHI360), UNICEF, Save the children, World Health Organization, Malawi Liverpool Wellcome Trust, Last Mile Health and AMREF.

Dr. Charles Mwansambo
SECRETARY FOR HEALTH

EXECUTIVE SUMMARY

Improving health of children remains a priority of the Malawi Government. Significant reductions in infant and under-five mortality has been documented in the country since the previous strategy and the country remains on track to achieve the child health-related SDG targets. Child mortality in the country has declined in the past 10 years: between 2010 to 2020, under-five mortality declined from 112 to 63 deaths per 1,000 live births, while infant mortality reduced from 66 in 2010 to 42 deaths per 1,000 live births. It is imperative that Malawi maintains this progress. This may require a focus on newborn health, where indicators are poor with the current neonatal mortality rate being 27 deaths per 1,000 live births. The leading causes of child mortality includes malaria, HIV related causes, pneumonia, prematurity, asphyxia, diarrhoea, neonatal sepsis and malnutrition among others.

Building on previous Child Health Strategy (2014-2020), the government of Malawi has developed a five year Child Health Strategy for the period 2021-2026 in order to further reduce child mortality in the country and move towards the SDG targets. To increase access and coverage of quality child health interventions, the strategy presents a redesign of child health programming: to include the 6-18 years age group, in addition to the traditional approach that focused on children under five years of age only. Evidence indicates that children in the 6-10 and 11-18 age groups often experience inadequate health care, nutrition and the absence of protective environment. Among the challenges that hinder access to comprehensive quality health care services include negative social norms, cultural beliefs, gender socialisation and power dynamics at both household and community levels, compounded by inadequate skills among health workers. This Child Health Strategy recognises the importance of addressing these challenges, as well as NCDs and trauma, among others. It has at the center of its implementation, the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) approach and integrated Community Case Management (iCCM)/ Community Management of Malnutrition (CMAM) integration, as well as childhood tuberculosis and child protection.

The Malawi Government through this strategy targets reducing under-five mortality to 30 deaths per 1,000 live births and neonatal mortality to 15 deaths per 1,000 live births by 2026. This will be achieved through identification of key, high impact interventions. The strategy recognises the bottlenecks and barriers towards achieving these targets. These include: a wide provider-patient ratio, inadequate specialised health providers such as paediatricians; consistent unavailability of essentials medicines and supplies such as dispersible amoxicillin; inaccessible and inadequate infrastructure especially in rural areas; inadequate financing; and weak coordination and collaboration among child health players.

This strategy strives to address these challenges by: improving availability and readiness of quality neonatal and child health services at all levels; reducing provider workload at health facilities through increased recruitment of health workers and continue building capacity, improving availability of infrastructure to support service provision; strengthening health facility-based perinatal care; improving case management to ensure providers' ability to diagnose; treat and make appropriate referral of child health conditions; strengthening nutrition promotion; counselling and assessment as part of child health services delivery; improving coordination, governance and

management of partnerships and multi-sectoral approaches including nutrition, early stimulation and adolescent health; improving health promotion and social behavioural communication (SBC) strategies for child health uptake of services; strengthening the supply chain of essential commodities and equipment for child health and strengthening evidence–based programme management.

As a pathway for the survive, thrive and transform agenda, this Child Health Strategy has also aligned relevant programmatic elements while recognising the contributions of other sectors on child health through identification of priority redesigned life-course interventions for children, harmonised, mainstreamed and packaged by health programmes through experiences of child care at all levels. These priorities are contained globally in Every Child Counts strategy 2021 -2025, while locally they are part and parcel of the Malawi Growth and Development Strategy (MGDS III) 2017-2022 and linked to the Malawi 2063 agenda.

The formulation process of this strategy involved collaboration with stakeholders, other government departments and development partners contributing to the well-being of women, newborn, children and adolescents. This inclusive approach is necessary for collective ownership and shared commitment to the successful implementation of the plan. The Government of Malawi draws inspiration from its commitment to several global, regional, local instruments, protocols and declarations to which Malawi is a signatory.

This Child Health Strategy will continue the improvements in child health achieved under the ongoing Health Sector Strategic Plan II and will also inform HSSP III being developed. This strategy envisages continued reduction in child mortality in the course of its implementation and has been costed at a total of MWK163,678,667,848 equivalent to USD$204,585, 834 (for five years which includes MWK 16,685,055,509 (USD$61,375,750) expected as direct child health support and MWK 146,993,612,338 (USD$143 210, 084) as other Departments and Partner Support

CHAPTER 1.0: INTRODUCTION AND BACKGROUND

1.0 Introduction

The 2021-2026 National Child Health Strategy is a successor strategy to the 2014-2020 Malawi Child Health Strategy. The strategy proposes a new focus in package of services, implementation arrangement while embracing multisectoral and life-course approaches to child health. This strategy has at the centre of its implementation, the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) approach. This has been informed by lessons learnt in the implementation of the previous strategy, and aims to achieve child health targets through focused interventions for enhanced coordination and accountability of child health outcomes.

The strategy focuses on the life-course approach which places emphasis on health and well-being that are interconnected at every stage of life and across generations, from childhood through adolescence to adulthood. It involves interventions across core sectors in addressing socioeconomic determinants of health in IMNCI. This approach includes critical child health interventions within the health sector, while recognising the contribution of other sectors to child health outcomes. It also draws lessons learnt from, and aligns with, the Global Strategy for Women, Children and Adolescent Health where there has been a strategic shift from mere survival to survive, thrive and transform. For the purposes of this document, "survival" implies ending preventable deaths**,** **"**thrive" means **e**nsuring health and well-being, and "transform" entails expanding enabling environments**.**

This strategy represents a redesign of child health programming from the traditional approach that focused on children under-five years only, to including those aged 6-18 years. Children 6-10 years and those 11-18 years often experience inadequate health care, nutrition and the absence of a protective environment. Health challenges increase when children are also affected by HIV and AIDS as well as humanitarian disasters. Negative social norms, cultural beliefs, gender socialisation and power dynamics at the household level and community, compounded by inadequate skills in health workers, also hinder access to comprehensive quality health care services for children in these age groups (UNICEF Report, 2019). While many health programmes focus on children under-five years, children 6-10 years of age have been left out over time. On the other hand, reproductive health programmes address reproductive health issues for children aged 10 to 18, however other elements of health care are left out, including noncommunicable diseases (NCDs) and trauma, among others. The Child Health Strategy recognises the importance of meeting the needs of children in these age groups through the life-course approach that looks holistically through linkages with other sectors, both within and outside health.

Improving child health outcomes requires a holistic approach. Achieving child health goals, therefore, requires both intra and intersectoral collaboration and fostering of strategic partnerships. Key intervention areas in achieving child health outcomes include care during pregnancy and child birth, early childhood development, nutrition and adolescent girls and young women. The Strategy defines directions with priority conditions to be addressed, uses proven high-impact interventions, sets performance targets, and establishes a monitoring, evaluation and learning mechanism and coordination framework.

In line with the current strategic thinking, the 2021 – 2026 Child Health Strategy;

i. Presents the vision, mission, core values and desired outcomes, is supported by a theory of change, provides more detailed matrices of outputs and output targets that will assist in measuring outcomes, and a logical framework for monitoring and evaluating the achievements.

ii. Underpins the high priority placed on aligning the Child Health Strategic Plan with the Health Sector Strategic Plan (HSSP) II and the Global Strategy for Women, Children and Adolescent Health with an overall goal to ensure that all children reach their full potential.

iii. Promotes investments to improve access to and utilisation of quality health services.

iv. Signals how the Ministry intends to operationalise and achieve its Pathway to Agenda 2030 of the Sustainable Development Goal (SDG) 3 Progress for Malawi.

1.2 Background to the Child Health Strategy

The 2021-2026 Child Health Strategy builds on the gains made in the 2014-2020 strategy. It is formulated in the context of and is aligned to the long-term Malawi Agenda 2063. It is also aligned to the priorities in the Malawi Growth and Development Strategy (MGDS) III (2017-2022), the Essential Health Package (EHP), the HSSP-II (2017-2022) and the decentralisation policy (1998). The HSSP provides the policy direction for health in Malawi to address inequities so that all children, adolescents and women have access to quality health care and services necessary to fulfill their rights to survival, development, protection and participation.

1.3 Rationale for the Development of the Strategic Plan

The Child Health Strategy is an important tool for the provision of the integrated management of neonatal, child and adolescent health interventions within the health sector whilst recognising the contribution of other sectors to child health outcomes. The rationale for this strategy is to achieve the following:

i. Provide strategic direction for the Ministry's desired future operations in newborns, infants and child health development.
ii. Establish clear and specific, realistic, measurable goals, objectives, achievable outcomes and outcome targets, outputs and output targets, as desired results for improving child health outcomes.
iii. Create a common understanding of expected results among multisectoral stakeholders. MoH and other ministries.
iv. Align MoH members of staff to a common goal thereby enabling everyone to be working towards the achievement of that goal.
v. Set the basis for proper and realistic budgeting.
vi. Use the strategy as a resource mobilisation tool.
vii. Define specific action items and help establish an action plan for effective implementation.

1.4 The process of developing the Child Health Strategy

The 2021-2026 Child Health Strategy has been developed following the review of the previous strategy. The formulation process of this strategy involved collaboration with stakeholders, other government departments and development partners that contribute to the well-being of women, newborn, children and adolescents. This inclusive approach is necessary for collective ownership and shared commitment to the successful implementation of the plan.

1.4.1 The importance of evidence-based child health research

The National Child Health Strategy embraces a multisectoral and life-course approach to child health. Incorporating research throughout the implementation process of this strategy is critical to the development of lessons and formulation of more effective interventions. This strategy includes operational research as one of the underpinning pillars.

1.5 Linkages with National, Regional and International Development Policies

In developing this strategy, the Government of Malawi draws inspiration from its commitment to several global, regional and local instruments, protocols and declarations. Malawi is a signatory to the United Nations Convention on the Rights of the Child (1990); World Health Assembly Resolution on Universal Coverage of Maternal, Newborn and Child Health interventions; the Agenda 2030 of the Sustainable Development Goals,, Organization of African Unity (OAU), the African Charter on the Rights and Welfare of the Child; the Abuja Declaration (2005); the 2008 Ouagadougou Declaration on Primary Health Care (PHC) and Health Systems in Africa; the 2005 Paris Declaration on Aid Effectiveness; African Union (AU); Maputo Plan of Action on Sexual and Reproductive Health and Rights; and the 2015 Call to Action: A Promise Renewed.

Other international commitments includes the United Nations Global Strategy for Women's Children's and Adolescents' Health, the United Nations Commission on Life-Saving Commodities for Women and Children (UNCoLSC) and its associated RMNCH Trust Fund, the Global Action Plan for Pneumonia and Diarrhoea (GAPPD), the Global Newborn Action Plan (GNAP), the United Nations Commission on Information and Accountability (UNCoIA), the outcome of Rio + 20 conference in 2012, Every Woman Every Child and Global Vaccine Action Plan.

The strategic plan has been developed in line with Government priorities spelled out in the Malawi Growth and Development Strategy III, the Malawi Vision 2063, the Agenda 2030 of SDGs, the Agenda 2063 for Africa and the Government Reform Programme. Specifically, the plan has been developed in line with the following;

1.5.1 The Malawi Growth and Development Strategy (MGDS) III, 2017 – 2022

The Malawi Growth and Development Strategy (MGDS) III is the overarching five-year medium-term strategy for Malawi. The MGDS III provides the overall framework for socio-economic development agenda for Malawi and it is a reference document for planning by all institutions in the country. The MGDS III identifies health and population as a key priority area to sustainable socio-economic development. It further identifies key strategic interventions which should be implemented in order to achieve results which includes good health.

1.5.2 The National Health Policy 2018

The National Health Policy provides direction on key issues that are central to the development and function of the health system in Malawi. It promotes health specific interventions at the health facility and community levels, including the Universal Health Coverage which includes children.

1.5.3 The Health Sector Strategic Plan (HSSP II) 2017-2022

The HSSP II is the health sector's medium-term strategic plan outlining objectives and activities and guiding resources allocation over the period from 2017-2022. The HSSP II also serves as an investment case for Malawi health sector. Its goal is to provide Universal Health Coverage (UHC) of quality, equitable and affordable health care services with the aim of improving health status, financial risk protection and client satisfaction.

1.5.4 The Malawi Vision 2063

The Malawi Vision 2063 identifies good health and nutrition as enablers for human capital development. These are challenged by many factors such as poor nutrition, poor health services, poor access to quality education and skills mismatch. The goal is to attain universal health coverage with quality, equitable and affordable health care for all Malawians.

1.5.5 Sustainable Development Goals 2030

This Child Health Strategy takes cognizance of the SDGs, particularly goal number 3 which is good health and wellbeing. This goal impacts on several other goals. The improvement in the health of the population is expected to increase national output due to the increase in labour supply and labour productivity. The economic gains are stronger in the medium to long-term when the increase in resource allocation to the health sector is followed by corresponding increase in investment on maternal, neonatal, child and adolescent health as well as linkages to development of productive adolescent skills with other sectors.

1.5.6 AU Agenda 2063

The AU Agenda 2063 is a shared framework for inclusive growth and sustainable development which was agreed upon in 2013 by African leaders during the 50th Anniversary of the Organization of African Unity (OAU). The AU Agenda 2063 is anchored on a number of aspirations: aspiration one envisions "a prosperous Africa based on inclusive growth and sustainable development." To achieve this ambition, one of the key goals for Africa is to ensure that its citizens are healthy and well-nourished and adequate levels of investment are made to expand access to quality health care services for all people.

1.5.7 The National Multi-Sector Nutrition Policy 2018 – 2022

The National Multi-Sector Nutrition Policy 2018–2022 upholds the government's commitment to eliminate all forms of malnutrition. Its goal is to have a well-nourished Malawian population that effectively contributes to the economic growth and prosperity of the country. The policy is intended to prevent undernutrition with emphasis on children under-five, adolescents, school-going children, pregnant and lactating women, People Living with HIV (PLHIV) and other vulnerable groups.

1.5.8 Every Child Counts 2021 – 2025

The Child Task Force strategic plan (2021 to 2025) led by its Child Health Task Force Steering Committee and Secretariat aims to focus on child health more broadly, while emphasizing reducing preventable post-neonatal mortality in the countries that are off track (the unfinished child survival agenda) to achieving the SDG target of reducing under-5 mortality to at least as low as 25 per 1,000 live births. By advocating for increased strategic investments in primary health care as a key platform to deliver the life-saving interventions, accelerating action throughout the continuum of care and aligning global and national initiatives and programs, this multi-stakeholder (country and global) effort will also position health systems to deliver on the thrive targets through a multi-sectoral and life-course approach.

The Task Force strategy includes a focus on equity to reach all children who are underserved by current programs and initiatives. This is critical because, even in countries making significant progress towards the SDG mortality reduction target, pockets of underserved populations continue to face higher under-five mortality rates. Such underserved communities exist in Malawi, which is among the low income Countries where health outcomes are progressing slowly due to confounding factors like poverty, overcrowding, malnourishment, and wasting of children.

1.5.9 The Sexual Reproductive Health and Rights Policy, 2017 – 2022

The overall goal of the National Sexual Reproductive Health and Rights Policy is: “To enhance the reproductive health status of all Malawians by increasing equitable access to reproductive health services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs.”

Other regional protocols and international conventions are outlined in Table 1:

Table 1: Policies and Strategies governing the Child Health Strategy

Core Programmes		Policies and Strategies
1	Intergrated Management of Childhood Illnesses	IMCI policy 2016
2	National Malaria Control Programme	Malaria policy and Malaria Strategic plan 2017 -2022
3	Expanded Programme on Immunization (EPI)	EPI policy and EPI comprehensive multiyear plan 2017 - 2021
4	Integrated Community Case Management (ICCM)	iCCM RoadMap 2017 - 2022
5	Nutrition programme	National nutrition policy 2018
6	HIV and AIDS	National HIV and AIDS Policy 2021 - 2026
7	WASH	National Sanitation Policy 2008 Sanitation and Hygiene strategy 2018 - 2024
8	Reproductive Health Programme	Sexual Reproductive Health Reproductive SRHR Strategy 2017 – 2022 and Every Newborn Action Plan (ENAP)
9	Early Childhood Development Policy	National ECD Policy 2017–2022
10	Child Protection	National Children's Policy and National Plan of Action on Vulnerable Children 2015 - 2019
11	Community Health	National Community Health Strategy 2017 - 2022

CHAPTER 2.0: SITUATION OF MATERNAL, NEWBORN AND CHILD HEALTH IN MALAWI

Malawi has achieved significant reduction in infant and under-five mortality from 2000 levels, and remains on track to achieving the child health-related SDG targets. Data from the DHS (MDHS 2000, MDHS 2015/16) show that mortality has declined in the country over the past 10 years and that this decline is more pronounced over the last 5 years (MDHS2010, MDHS 2015/16). Under-five mortality is currently at 63 per 1,000 live births. Infant mortality has also declined from 66 in 2010 to 42 per 1,000 live births by 2015/16. Malawi is one of the low-income countries that made significant reduction in under-five mortality rates and achieved MDG4 target before the target year of 2015.

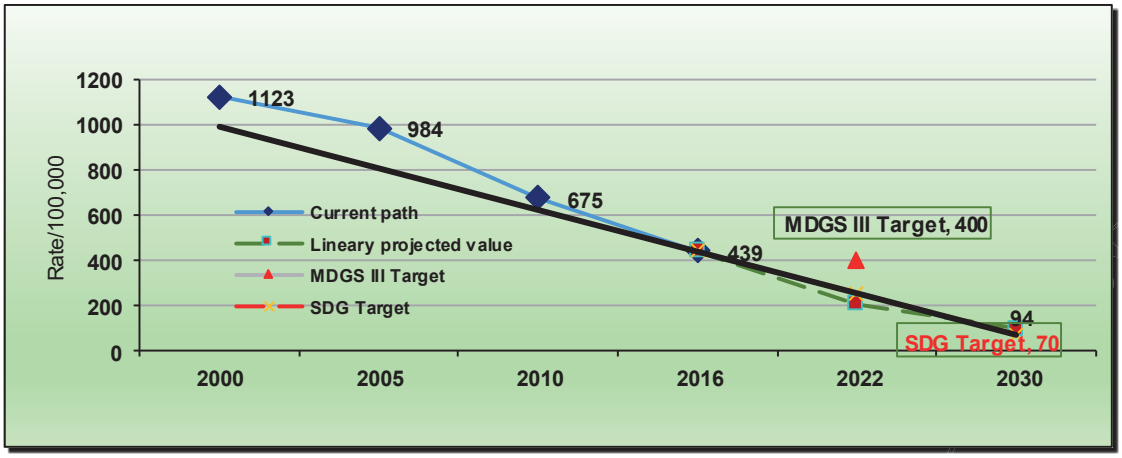
Sustaining these gains entails maintaining the annual rate of reduction in under-five mortality with a special focus on newborn health, where indicators are poor; the current neonatal mortality rate is 27 per 1,000 live births (DHS 2015/2016). The 2020 estimates by UNICEF show further decline in mortality, with under-five mortality at 42 per 1,000 live births, infant mortality at 31 per 1,000 live births and neonatal mortality at 20 per 1,000 live births. Malawi recognises that these figures are still too high. The status of maternal, newborn and child health is described further below.

2.1 Status of Maternal Health

The World Health Organization (2017) estimates that globally, the Maternal Mortality Ratio (MMR) fell by nearly 38% between 2000 and 2017, from 342 to 211 maternal deaths per 100,000 live births. The average annual rate of reduction (ARR) in global MMR during the 2000–2017 period was 2.9%; this means that, on average, the global MMR declined by 2.9% every year between 2000 and 2017 (estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2018). Sub-Saharan Africa and South Asia accounted for 86% of global maternal deaths in 2017, with sub-Saharan Africa alone accounting for roughly 66% (WHO, 2018).

Similarly, Malawi has registered progress in major health outcomes during the implementation of the MDGs 2015 and the beginning of the SDG era. According to MDHS data, MMR has declined by 94 percent since 2000. MMR doubled from 620 in 1990 to 1123 maternal deaths per 100,000 live births in 2000. Since then, it has declined to 439/100,000 in 2016. UNICEF 2020 estimates estimate MMR at 349/100,000. The MGDS II target for 2022 is 400/100,000 and while the SDG target for 2030 is less than 70/100,000, the Malawi agreed target is 110/100,000. Malawi is making moderate progress and on track to achieve 94 maternal deaths per 100,000 live births by 2030. Figure 1. Shows trends in maternal mortality rates.

Figure 1: Current Status and Trends in Maternal Mortality Rates (MMR)



2.1.1 Causes of Maternal Deaths

Globally, the primary causes of maternal deaths are haemorrhage (22.9%), hypertensive disorders (18.5%), abortion complications (14.5%), infections (8.6%), obstructed labour (4.3%), hepatitis (12.5%), syphilis (6.2%) and other infectious conditions (12.5%) (WHO, UNICEF, UNFPA, World Bank and UN, 2014; Lozano, Naghavi, Foreman, et al., 2012). The Malawi EmONC survey reports show that post-partum haemorrhage (PPH) remains the highest direct cause of maternal mortality at 23% in 2015 and 34% in 2020. However, over this same period, obstructed labour declined from 4% to 1%. Other causes of maternal deaths are summarised in Table 2. Furthermore, both reports show that indirect causes contributed to 30% of maternal deaths, which include anaemia, malnutrition and NCDs. Note that at the time of producing this strategy, data for EmONC 2020 was still provisional estimates. Below is Table 2 comparing causes of maternal deaths between 2015 and 2020 EmONC assessments.

Table 2: Causes of Maternal Deaths Between 2015 And 2020 EmONC Assessments

CAUSES OF MATERNAL DEATH	EmONC 2015	EMONC 2020
PPH and Retained placenta	26%	34%
Pre-eclampsia/ Eclampsia	16%	19%
Sepsis	12%	16%
Ruptured Uterus	13%	9%
Abortion complications	7%	8%
APH	5%	5%
Obstructed labour	4%	1%
Ectopic Pregnancy	1%	1%
Others (Indirect causes)	9%	7%

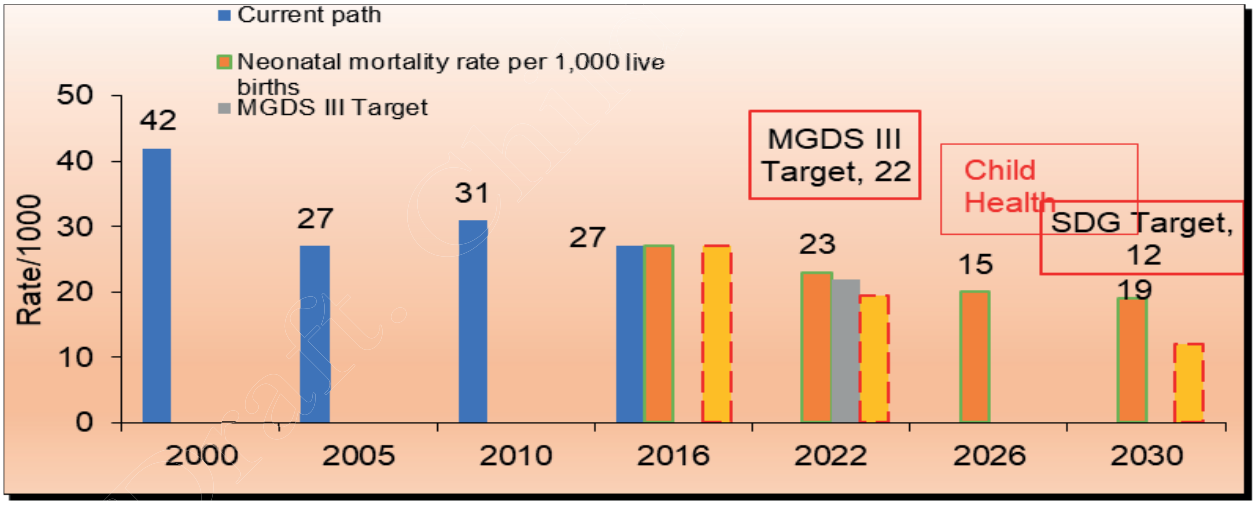
2.2 Status of Newborn Health

Globally, there has been a 52% decline in neonatal mortality rate between 1990 and 2019 from 36.6 to 17.5 per 1,000 live births (World Health Statistics 2021).

The Countdown to 2015 report estimates that neonatal mortality accounts for 31% of all child deaths in Malawi. Neonatal mortality rates (NMR) declined from 41 deaths per 1,000 births in 2000 to 27 deaths per 1,000 in 2016 (Refer Fig. 2). Mortality rates varied across districts, with some showing very high mortality rates of over 40 per 1,000 such as Mangochi and Thyolo; Zomba had the lowest of 12 per 1,000 live births (Refer Fig. 3).

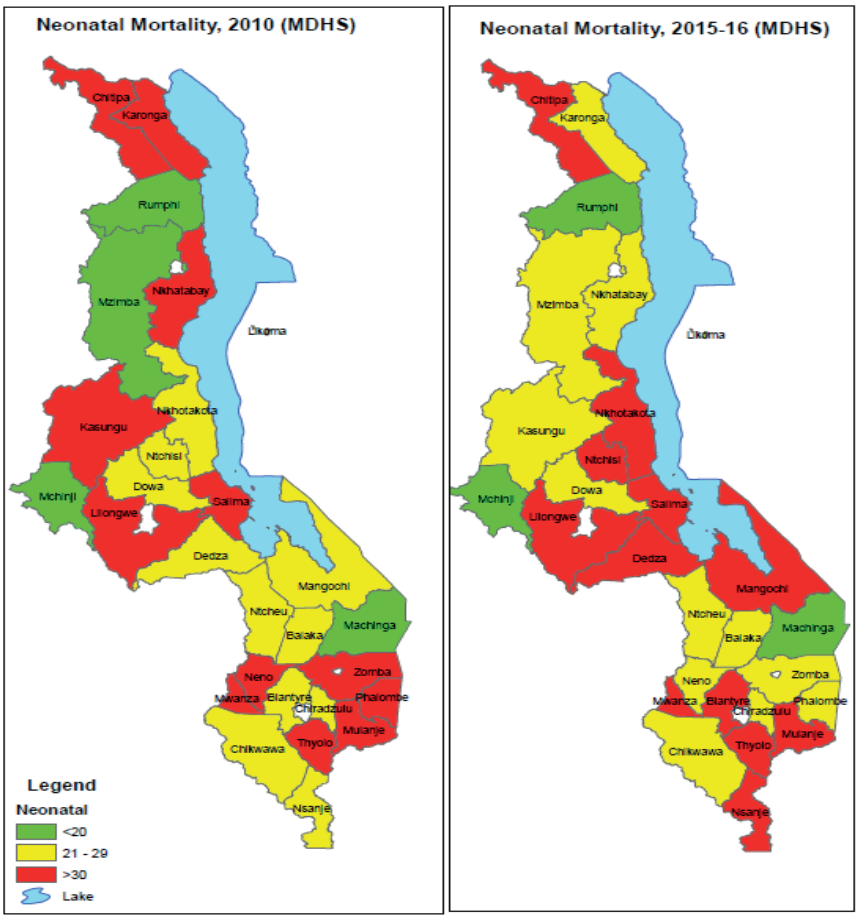
It is imperative to focus our energies on rapidly reducing NMR. Fortunately, cost-effective, feasible interventions exist to address the main causes of newborn deaths, but widespread coverage is lacking. Figure 3 below shows trends in NMR. The neonatal mortality target for 2030 is 12 deaths/1,000 live births. At the current rates of decline, the country is off track, but extra effort is required to meet the target.

Figure 2: Trends in Neonatal Mortality



Using real-time data from facility records, institutional NMR declined from 11.1 in 2014 to 8.3 in 2017 but increased again to 9 in 2020 (Ministry of Health and Population, DHIS2).

Figure 3: Map of Malawi showing Neonatal Mortality Rates by District, 2010-2015/16



2.2.1 Causes of Neonatal Deaths

The MDHS 2016 shows that neonatal deaths account for 30% of under-five deaths. The major causes of these deaths are birth asphyxia 48%, complications of preterm delivery 40%, and sepsis 5% among others. The chart below illustrates the percentage contribution of the major causes of deaths (MDHS 2016).

Malawi has one of the highest rates of prematurity in the world at 18-20%[1,2] and 12.9% neonates have low birth weight. However, 2018 estimates by UNICEF and WHO show the prematurity rate for Malawi to be 10.5%. Prematurity puts a significant pressure on the health system. The risk of

1 Kulmala T, Vaahtera M, Ndekha M, Koivisto AM, Cullinan T, Salin ML, Ashorn P. The importance of preterm births for peri- and neonatal mortality in rural Malawi. Paediatr Perinat Epidemiol. 2000 Jul;14(3):219-26. doi: 10.1046/j.1365-3016.2000.00270.x. PMID: 10949213.

2 Nynke van den Broek, Chikonde Ntonya, Edith Kayira, Sarah White, James P. Neilson, Preterm birth in rural Malawi: high incidence in ultrasound-dated population, Human Reproduction, Volume 20, Issue 11, November 2005, Pages 3235–3237, https://doi.org/10.1093/humrep/dei208

death whether in a facility or in the community is higher for a premature infant than a term infant. Prematurity is also associated with disability and poor health, even later in life. Maternal interventions are key in reducing mortality and morbidity related to prematurity and other causes. Malaria parasitaemia and anaemia are both associated with high risk for both premature birth and mortality. The Ministry has several interventions to reduce premature births like micronutrient supplementation in the form of iron and folic acid, Intermittent Presumptive Treatment (IPT), screening and testing for syphilis and HIV in pregnancy and use of antenatal corticosteroids to improve lung maturity.

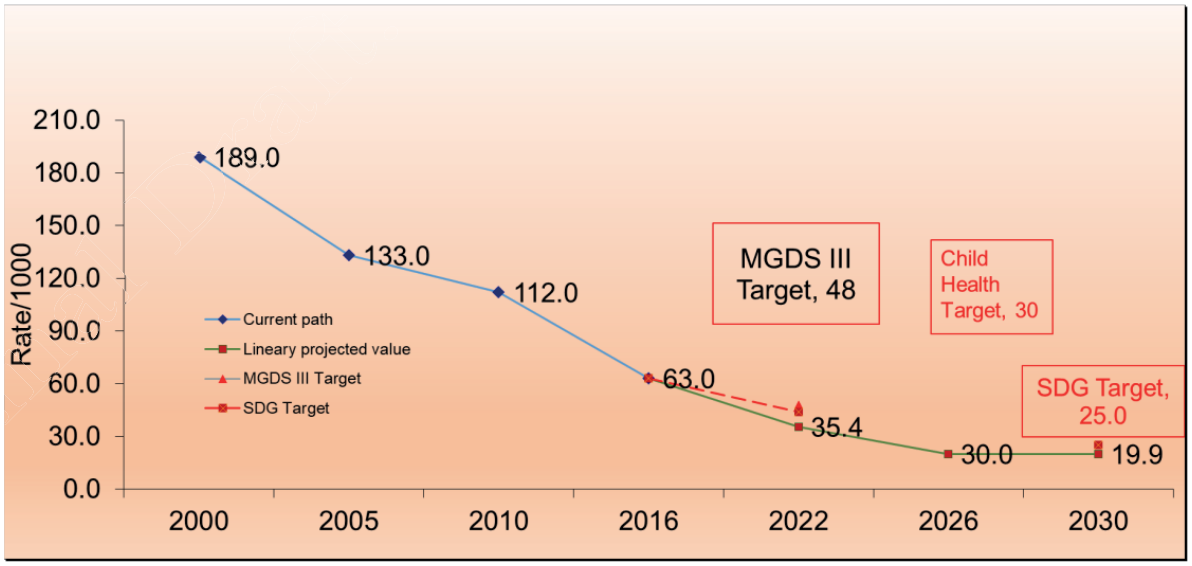
Birth asphyxia is a direct consequence of labour and delivery care. Strengthening the quality of obstetric services plus the provision of timely and appropriate resuscitation services can impact directly on birth asphyxia and its outcomes.

Neonatal sepsis and infections contribute to almost a quarter of neonatal deaths. Use of antibiotics for prolonged-labour rupture of membranes reduces the incidence of early onset of neonatal sepsis. Use of aseptic techniques and basic hygiene during delivery has been associated with a much lower rate on neonatal infections and improves outcomes.

2.3 Status of Under-Five Children

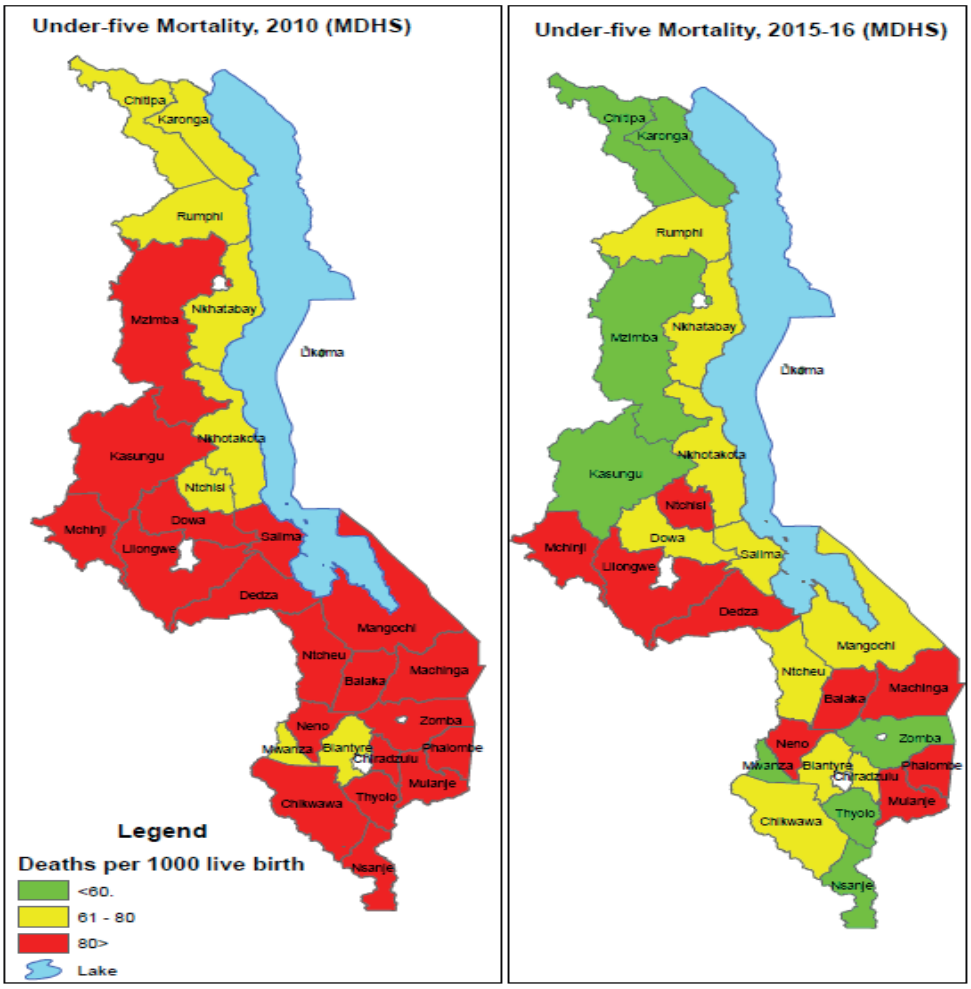
Over the past 20 years, Malawi's child mortality has declined. The DHS 2015/16 under-five mortality is at 63 per 1,000, down from 112 deaths per 1,000 live births in 2010. However, this still falls short of the proposed SDG target of 25 deaths per 1,000 live births by 2030. Figure 4 below shows trends in under-five mortality rate.

Figure 4: Trends in Under-Five Mortality Rate



Trends in under-five mortality at district level show a different pattern between MDHS 2010 and MDHS 2015/16. Unlike MDHS 2010, where four districts had mortality rate of over 140, there has been varying degrees of achievements by districts in 2016. Of the high mortality districts, only two have remained below the cut-off point of 140 per 1,000 live births. The rest of the districts achieved minimal reductions.

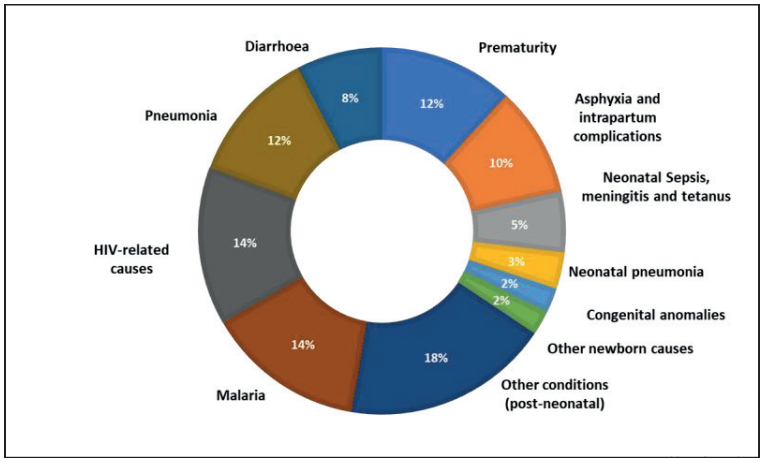
Figure 5: Map of Malawi Showing Under-five Mortality Rates by District, 2010-2015/16



2.3.1 Causes of Under-Five Deaths

According to the NSO 2015/16, neonatal mortality accounts for 30% and infant mortality accounts for 67% of under-five deaths. The under-five malaria incidence rate in 2018/19 was 460.8 per 1,000 under -five population, with a case fatality rate of 47.2%. The major causes of under-five death in Malawi are malaria (13%), HIV/AIDS (13%), pneumonia (11%), diarrhoea (7%) and other conditions (17%) (WHO/CHERG, 2012, based on DHS 2016). Figure 6 shows the causes of under-five deaths.

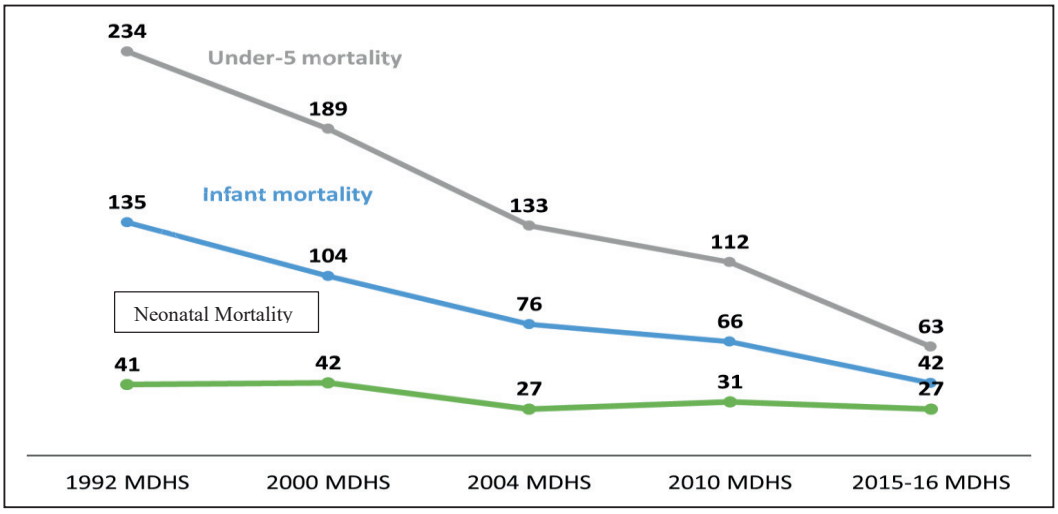
Figure 6: Causes of Under-Five Deaths, 2016



2.3.2 Summary Trends in Child Mortality in Malawi

Since 1991, there has been a steady decline in under-five mortality as well as infant mortality in Malawi. Under-five and infant mortality rates declined from 234 to 63/1,000 live births and 135 to 42 per 1,000 live births in 2016, respectively (MDHS 2016). Similar to the global trend, the decline has been disproportionate with an average annual reduction rate of 8.6% between 1 and 59 months but only 4.2% in neonates between 2000 and 2016.

Figure 7: Trends in Child Mortality in Malawi, 1992-2016



2.4 Health trends for children aged 5 to 18 years

Health care services for children 5-18 years have previously been omitted. This age group is mistakenly considered out of danger and does not experience the level of mortality that is seen in the under-five population. Data for this age group is not well captured in most documents. This population is, however, at a significant risk of many preventable and treatable conditions that can affect their capacity to achieve their full potential. Worldwide, adolescents (10-18 years) constitute 16% of the population but 23% in Sub Saharan Africa. In Malawi, 40% of the population is composed of children 5-19 years, and adolescents alone contributing to 25% of the overall population (NSO, Malawi 2018).[3] This strategy will highlight the issues surrounding lack of adequate care, and address them within the available approaches.

2.4.1 Children 5 to 10 years

Children 5-10 years need to be in optimal health to attend school regularly, achieve their best potential academically and optimise their long-term economic capacity. Pneumonia, malaria and diarrhoea is operationally a challenge on their management by service providers in the absence of appropriate guidelines. Anaemia, in children from Malawi's malaria endemicity, micronutrient deficiencies such as iodine, iron and Vitamin A deficiencies, poor access to WASH services and infection with soil-transmitted helminths can result in permanent impairment to intellectual capacity, chronic illness, and poor growth. These children are also prone to NCDs, trauma such as road traffic accidents and falls. Access to services needs to be timely and appropriate to avoid unnecessary deaths and long term morbidity. Interventions such as School Health Programmes address some of these issues and are an opportunity to identify children with additional health needs and risk factors.

2.4.2 Adolescents 10 to 18 years

Adolescents have challenges in accessing care that fit their needs. In particular, this is reproductive health services, but care is also needed to address both communicable and NCDs. Investing in this age group is described as having a "triple dividend"– improving health now, enhancing it throughout the life-course and contributing to the health of future generations,"[4] since habits established in this period are likely to be carried out through life.

In Malawi, 60% of 15-19 year olds have had sex by the age of 17, and only 15% of girls and 30% of boys have access to modern contraceptives.[5] Experience of adolescents' care with reproductive services show that stigma and attitudes of health workers are a deterrent to accessing information on prevention of sexually transmitted infections, reproductive rights, and a accessing services. There is also a lack of clear transitional plan for adolescents with chronic conditions into adulthood. All these, if properly addressed, can empower adolescent health and wellbeing in both the short and long-term.

[3] http://www.nsomalawi.mw/index.php?option=com_content&view=article&id=136%3Amalawi-table-30-population-by-age-and-sex&catid=8&Itemid=3
[4] Patton, GC, Sawyer, SM, Santelli, JS, Ross DA, et al. Our Future: the Lancet Commission on Adolescent Health and Wellbeing. Lancet 2016; 387: 2423–78.
[5] Adolescents in Malawi: Sexual and Reproductive Health

2.5 Progress in Service Provision in Maternal Health

Attendance by Skilled Personnel

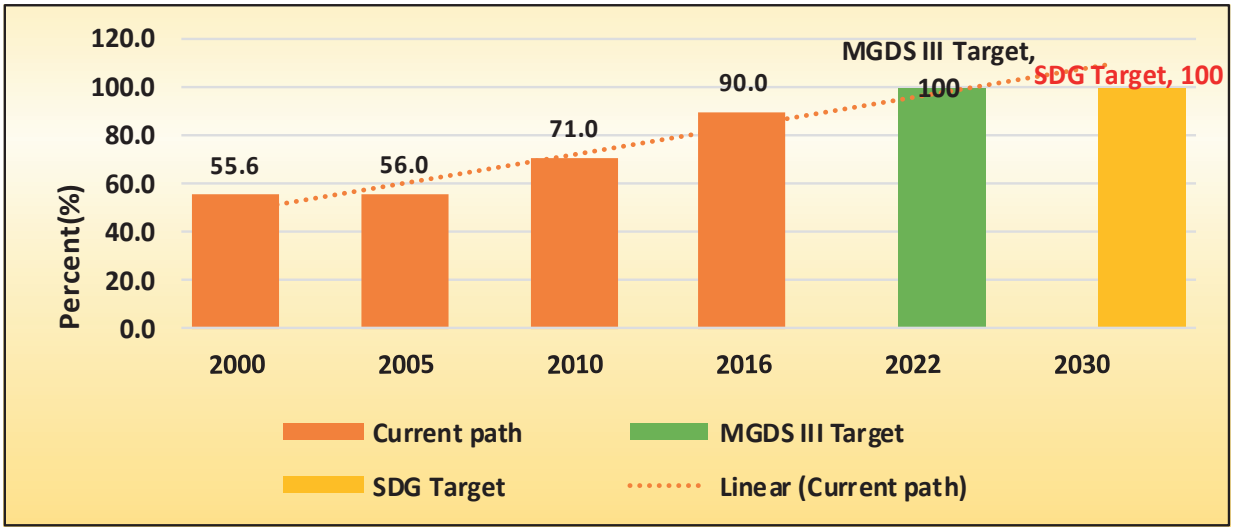
Progress has been made in the implementation of interventions in maternal health. The trends in the proportion of births attended by health personnel have increased globally. In Malawi, births attended by skilled health personnel have increased by almost 50 percent, from 56% in 2000 to 90% in 2016 (MDHS, 2016). The MGDS III and SDG targets that the country should reach by 2022 and 2030 respectively is reflected in Figure 2.

Antenatal Care (ANC) services coverage

According to the 2015-16 MDHS, around 95% of women attended at least one ANC visit during pregnancy; the percentage of women that attended the ANC at least 4 times has been declining from 62% in 1992 to 51% in 2016, and only 24% had attended ANC in the first trimester.

ANC attendance is essential for early identification, diagnosis and treatment of health problems that can adversely affect the health status of the pregnant woman, the baby and prevent complications during pregnancy labour and delivery. Some conditions which can be detected and treated during pregnancy are: anemia, pre-eclampsia and syphilis, which may lead to low birth weight babies, premature delivery and neonatal syphilis, to mention just a few.

Figure 8: Proportion of Births Attended by Skilled Personnel (%)



Source: MDHS Report, NSO and ICF (2017)

Post Natal Care (PNC) for Mothers and Newborns

Timely postnatal checks on the mother and baby in the first 48 hours helps in early identification and treatment of complications in the baby and postnatal woman. The Malawi National Sexual and Reproductive Health and Rights policy and strategy state that all women who deliver in health facility or at home should have a postnatal check at the nearest health facility within 72 hours after birth. The 2015-16 MDHS findings show that the proportion of mothers who received a postnatal check in the first 48 hours after delivery has held steady at 41% in 2010 and 42% in 2016, while the proportion of newborns that receive PNC within 48 hours is reported to be 60%. Women who deliver in a health facility are more likely to receive PNC within 48 hours of delivery as compared to those who delivered elsewhere.

2.5.1 Availability and Progress in Coverage of Key Interventions in Newborn Health

Intervention packages have been established and implemented in neonatal care in addition to those addressed by maternal interventions. The Newborn Steering Committee was established which incorporates MoH and all partners involved in neonatal care. This committee allows for strengthened and coordinated neonatal interventions and easy tracking of progress.

Since 2015, dedicated sick newborn units have been established in every district hospital in the country, apart from Phalombe where a hospital is being built and Likoma where the intervention is just being established. These units provide a platform for effective care and management of the sick newborn by dedicated staff allocated to that unit.

Kangaroo Mother Care (KMC) is a cost-effective intervention that can be used for the care of low birth weight and premature infants especially in low resource settings. KMC can be practiced in both facility and at community level and both are practiced in the country to various degrees. In the 2015 EmOC report, 62% of facilities provided ambulatory KMC services. Malawi also introduced Family-Led Care model, an approach that allows caregivers to become active participants of care provision for premature and low birth weight newborns.

The Care of the Young Infant and Sick Newborn (COIN) course was developed and has been used to equip health workers with skills for immediate newborn care, neonatal resuscitation, management of the small and sick newborn and also incorporates the use and basic maintenance of neonatal equipment.

MoH adopted the Community-Based Maternal and Newborn Care (CBMNC) package in 2007. The MoH also adopted Helping Babies Breathe (HBB), and introduced Newborn Essential Solutions and Technologies. The MoH introduced administration of antenatal corticosteroids to improve survival of the preterm newborns.

According to the 2018 harmonised health facility assessment report, other available services in all the health facilities includes: child vaccination, growth monitoring, curative and prevention of mother-to-child transmission (PMTCT).

2.5.2 Availability and Progress in Coverage of Key Interventions in Child Health

According to the 2015/16 MDHS, 70% of children received basic vaccinations by 12 months of age, and 76% of children 12-23 months received all basic vaccinations, compared to 81% in 2010 and 64% in 2004. The percentage of children under-five who were stunted was 37%, underweight was 12% wasted 3% and overweight at 5% in 2015/16. The percentage of children 6-59 months who were anaemic was 63%. In 2015/16, the prevalence of acute respiratory infection/pneumonia in under-five children was 5%, of which 78% seek advice or antibiotic treatment, compared to 7% and 70%, respectively, in 2010. The prevalence of diarrhoea was 22%, and 78% received oral rehydration therapy, 28% received Zinc while 13% received no treatment. Among under-five children, 29% had fever (symptom of malaria) and the prevalence peaked at 36% among children 12-23 months. Advice or treatment was sought for 61% and 24% of children under-five with fever received antibiotics. The vast majority (92%) that had fever received anti-malarial treatment.

2.5.3 Barriers to Accessing Newborn, Infant and Child Health Services

Deaths that occur among under-five children and neonates are due to a number of factors which include delay in making a decision to seek care, delay in reaching the health facility and delay in receiving care at the health facility. There are a number of barriers and bottlenecks associated with these delays **(**Bantie et al. 2019; Mgawadere et al., 2017, Liu et al., 2019; Lungu et al., 2016). Below is the diagrammatic presentation of the delays and the associated bottlenecks/barriers.

Table 3: Barriers and Bottlenecks Contributing to Delays in Accessing Health Care Services

Type of delay	Bottlenecks/ Barriers
Delay in deciding to seek care	• Low level of education • Religious and cultural practices • Perceived loss of work time • Perceived low quality of services
Delay in reaching the health facility	• Economic status of parents • Distance to the nearest health facility • Delay in identifying complications • Poor roads
Delay in receiving care at the health facility	• Long waiting time • Poor attitude of health workers • Lack of medical supplies • Inadequately trained health workers • Poor referral system • Inadequate knowledge on disease complications

2.6 Availability and Progress in Coverage of Key Interventions in Adolescents and Children 5-10 years

Currently, data is being collected using various instruments at service delivery levels of the health care system. However, these collected data are combined in registers and other instruments that also capture all other age groups. This has led to failure to produce reports through the DHIS2 platform for the MoH. Disaggregating data based on ages (children 5-9 years and 10-18 years) will assist in programmatic planning, tracking of progress and better management and coverage approaches that are proposed in the interventions through this Child Health Strategy. While interventions for girls 9 to 15 years are not well documented, the MoH introduced HP vaccine in 2019.

CHAPTER 3.0: SWOT ANALYSIS AND EXPERIENCE OF CARE

A SWOT analysis was conducted to understand both the internal and external environments in which the child health programme operates. The internal perspective looked at the strengths and weaknesses of the MoH whilst the external environment involved analyzing the opportunities and threats. The strengths highlight areas in which the MoH should continue to build and leverage on as it forges into the future, while the weaknesses highlight areas which the MoH needs to reduce or eliminate to effectively deliver on its mandate. The opportunities consist of factors prevailing in the market that the MoH can exploit to its advantage and the threats are those factors that can adversely affect its operations if not properly addressed. The SWOT for Child Health Programme thus set out in Table 4 which cuts across all the Key Result Areas.

Table 4: SWOT Analysis based on each Key Result Area

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
Community-based preventive and curative interventions	**Service delivery** - Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.	• Decentralised health care system. • Established Community Health Strategy. • Availability of community structures. • Established CMAM and Scaling Up Nutrition (SUN). • Availability of outreach services. • Availability of functional Village clinics. • Strong community-led WASH interventions. • Availability of Community-based maternal newborn care.	• Limited coverage of community-based newborn care. • Inadequate supplies. • Inadequate resources to support community health workers and supervision. • Lack of integration of services. • Weak ownership of some of the partner supported initiatives. • Shortage of personnel – high vacancy rates. • No established infrastructure for outreach services, affecting privacy for ANC, VCT, and PMTCT. • Low staff motivation • Weak community engagement on cultural beliefs affecting early care seeking behavior. Weak referral system.	• Availability of local partners or organisations. • Emerging trends in targeted donor resource support to implementation level.	• COVID-19 pandemic diverting already limited resources away from core priority programmes. • Changes in donor focus affecting sustainability of some initiatives. • Poor road conditions affecting mobility.
	Health workforce - A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes	• Availability of community health workers. • Revised HSAs training curriculum better aligned to needs and meets regulatory board minimum requirements.	• Insufficient staff for some cadres of community health workers, resulting in task. shifting to HSAs beyond their expected competence level. • Over-reliance on one community health cadre	• Availability of external partner resources to support recruitment and payroll needs for some cadres.	• Competition for health workers from other employers.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
	possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).		(HSAs) for majority aspects of community health programme delivery. • Misdeployment of community health nurses and community health midwives. • Limited availability and service provision due to some HSAs not residing in catchment areas. • Inadequate capacity building for health workers to competently deliver MNCH interventions. • Limited resources to support supervision, outreach clinics, and HSA bicycle/transport needs. • Limited career progression among community health workers.	• Strong global movement that supports UHT, including community health workers.	
	Health information systems - A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.	• Availability of one unified data platform (DHIS2 Tracker). • Data collection institutionalised as part of service delivery. • Availability of monitoring mechanisms and tools. • Clear agreed framework for community health information system (iCHIS).	• Poor data quality. • Inability of current health information system to measure, track, and report quality of care (QoC) and access to healthcare by sub-national groups for targeted improvement action. • Inadequate data utilisation at service delivery level. • Lack of integrity – data manufacturing.	• Strong global momentum to support digital health. • Global interest and commitment to support QoC improvement, including health systems that support QoC reporting.	• Connectivity challenges limiting data transmission and access. • Cyber security threats.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
			• Continued use of paper-based data collection tools for the community level. • Inadequate resources to implement the iCHIS.		
	Medicinal products and other supplies - A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.	• Availability of policy permitting provision of some essential medicines and supplies at community level. • Availability of accountable community structures / committees that monitor medicines and supplies stocks. • Availability of drug boxes for HSAs.	• Long procurement procedures. • Stock outs of essential medicines and supplies. • Irrational use of essential medicines, including antibiotics. • Failure to meet demand by CMST. • Mismanagement of medicines and supplies.	• Availability of additional partner resources that support procurement of medicines and supplies. • External research support on antibiotic prescribing practice and consumption to guide policies.	• Antimicrobial resistance, limiting effectiveness of available antibiotics.
	Health financing - A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.	• Government commitment in financing community health. • Community health workers fully incorporated in national budget.	• Chronic government under-funding to health sector.	• Availability of donor resource support. • Coordinated donor approach to health support.	• Donor priorities and policies impact. sustainability of health service provision. • Emergence of pandemics affecting donor priorities and resource allocation.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
	Leadership and governance - Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.	• Policies, strategies, and guidelines for community health developed and in place. • Availability of policy for child health with health sector focus. • Availability of Essential Health Package and Health Sector Joint Fund. • Availability of clear policy and strategic plan to increase of number of HSAs to a proportion of 1 per 1,000 population using government funds. • Existence of community structures through which multi-sector health interventions are implemented. These include the Health Centre Management Committees (HCMCs) including the Area and Village Health Committees. • Child health communication strategy developed to promote the high impact interventions.	• Leadership conflicts at community level affects team performance. • Weak governance system at facility level fueling corruption where patients pay for services otherwise meant for free.	Increased number of NGOs, CSOs, and development partners working at community level in health promotion. • Growing global recognition and commitment to support effective leadership and governance in health.	• Changes in donor priorities and policies impact sustainability of core health programmes, including leadership and governance support. • Emergence of pandemics affecting donor priorities and support to core programmes, such as leadership and governance strengthening at community level.
Facility-based services	**Service delivery** - Good health services are those which deliver effective, safe, quality, personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.	• MGDS III identifies nutrition as a priority under other development areas. • Availability of HSSP II 2017–2022. • Regular Child Health Campaigns. • Introduction of Reach Every Child (REC) approach for EPI. • Use of available community structures e.g. CBCCs for delivery	• Insufficient commodities for child health. • Limited service delivery due to the insufficient numbers of health staff. • Inadequate staff supervision. • Poor maintenance and replacement system for cold chain equipment and other essential equipment.	• Presence of implementing partners.	• Extreme weather conditions and disasters, e.g. floods. • Cultural and religious beliefs. • Pandemics.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
		of high impact interventions to children and pregnant women. • Availability of standards and guidelines such as in management of the sick child. • Availability of outreach services. • Availability of community-based health workers. • Existing infrastructure. • Presence of service-level agreements. • Birth registration system established. • Establishment of sick newborn care units.	• Lack of transport for integrated outreach. • Infrastructure quality not meeting requirements for new borns, isolation for infectious diseases (e.g. COVID-19), KMC, etc. • Corruption – some providers requiring patients to pay for free services. • Inadequate services for children with NCDIs at secondary and primary level. • Insufficient reviews and clinical audits on causes of maternal, neonatal, and child deaths. • Weak community engagement on cultural beliefs affecting early care seeking behavior. • Delay in care-seeking and referral for sick children and women. • Weak referral system. • Delayed identification and support for children with disability.		
	Health workforce - A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes	• Availability of trained and committed health workers. • Availability of regulatory bodies. • Career growth opportunities. • Availability of training institutions.	• Insufficient specialised providers. • Skills, diagnostic and treatment capacity to manage NCDIs not available.	• Donor support with specialised technical assistance personnel.	• Changes in donor priorities can affect budget and ability to support specialised technical assistants.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
	possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).	• Availability of salary top up allowance for health workers. • Availability of specialised providers.	• High vacancy rate-patient/ provider ratio is still high. • Lack of formally established feedback and appraisal systems. • Low remuneration in government facilities. • Attrition of trained staff. • Inadequate motivation.		
	Health information systems - A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status	• Availability of policies and guidelines for digital health. • Availability of one unified functional data platform (DHIS2 Aggregate). • Availability of electronic data systems for patient level data - Electronic Medical Records. • Data collection institutionalised as part of service delivery. • Availability of monitoring mechanism and tools. • Defined indicators and tools for M&E, e.g. registers, SOPs. • Functional departments focused on health information systems (Digital Health Division and Central Monitoring and Evaluation Division). • Availability of pre-service training in HIS. • Data quality audits (DQA) conducted every 2 years.	• Poor data quality. • Inadequate data utilisation at service delivery point. • Continued use of paper-based tools. • Lack of reliable power supply. • Weak cyber security systems. • Lack of adequately trained IT personnel. • Lack of regular data quality self –assessments. • Inadequate/poor IT infrastructure e.g. servers. • Fragmented electronic data systems. • Child health data not adequately captured in registers.	• Strong global commitment to support DHIS2 expansion to facility level. • Implementing partners direct support to HIS. • Government commitment through eGov to facilitate e-services in all line ministries.	• Connectivity challenges limiting data transmission and access. • High internet cost.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
	Medicinal product and equipment - A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.	• Availability of policies for regulating use of medicines. • Functional Central Medical Stores Trust (CMST) as supplier • Availability of efficient logistical management systems (Open LMIS,) • Availability of the Physical Assets management department • Availability of medicine stores in all facilities • Trained pharmacy assistants at health centre level.	• Weak supply chain system for essential drugs and supplies affecting availability at facility level. • Irrational use of essential medicines (including ACTs). • Poor stock management in some facilities. Overdependence on CMST as single supplier. • Lack of preventive maintenance of assets (servicing). • Inadequate essential equipment. • Poor management of equipment donated to the public facilities. • Inadequate supply of oxygen for critical care.	• Availability of partner support in procurement and distribution of medicines and direct equipment donations. Partner support to offices and storage facility (Prefabs)	• Antimicrobial resistance limiting effectiveness of available antibiotics. • Frequent regimen change affecting utilisation of the available ARV's stock. • Public health emergencies divert resources from regular programmes and affect medicine availability at facility level.
	Health financing - A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.	• Government budget commitment to support procurement and distribution of medicines. • Vibrant health financing unit in Planning and Policy Development Directorate.	• Chronic inadequate domestic funding, leading to overdependence on donors for health budget. • Weak internal controls leading to misappropriation of health funds. • Weak budget monitoring and reviews.	• Availability of increasing donor resource support (technical and budget). • Well-coordinated donor approach to health budget support.	• Changes in donor priorities and policies have major impact on sustainability of health service financing and delivery. • Emerging pandemics affecting donor priorities and financial support to core programmes.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
	Leadership and governance - Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.	• Policies, strategies, and guidelines well developed and disseminated to staff at facility levels. • Availability of child health policies and guidelines at facility level. • Availability of EHP and Joint Sector Fund. • Functional governance structures in place (Health Centre Management Committees, Area Committees). • Child Health Communication strategy developed to promote high impact interventions. • Leadership training materials for facility level in place. • Established SLAs with CHAM. • Newborn care integrated in IMCI guidelines. • Scale up plan for child health interventions in place.	• Unfavorable working conditions for workers in facilities. • Low staff motivation. • Weak maintenance plan for ambulances and other essential equipment. • Political interference in procurement of medicines affecting quality, quantity, and timeliness of medicine availability. • Leadership conflicts at facility level affecting team performance. • Weak governance systems at facility fueling corruption where patients pay for services that are meant to be provided free. • Loss of staff to other employers in health sector due to poor conditions relative to competition. • Inadequate support and follow up of action points on clinical audit findings.	• Growing donor support to strengthening health systems, including leadership and governance, • Most training institutions now include Leadership and governance modules in pre and post service trainings.	• Changes in donor priorities and policies impact sustainability of support to core health programmes including leadership and governance. • Emergence of pandemics affecting donor priorities and support to non-clinical programme areas such as leadership and governance.
Tertiary childcare services	**Service delivery**	• Guidelines and SOPs in place for most aspects of child health. • Availability of maternal and perinatal death surveillance and response (MPDSR) Guidelines. • Designated areas of childcare services.	• Rapid response systems not available in the district. • Lack of preventive maintenance of essential equipment. • Inadequate CEmONC services in the facilities eg	• Availability of donor support for tertiary level.	• Emergence of pandemics affecting donor priorities and support to regular programmes like child health, including for tertiary level.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
		• Integrated child health services. • Availability of essential technologies for diagnosis and management of newborn conditions (CPAP, Radiant warmers, pulse oximeters including bilirubinometers).	blood transfusions and administration of anticonvulsants. • Weak supervision system. • Limited awareness of patients' rights and respectful maternity care charter among patients and providers. • Lack of district hospitals in Lilongwe, Zomba, Mzuzu, and Blantyre causing congestion in the tertiary facilities. • Frequent and uncoordinated staff rotation negatively impacting quality of care. • Weak referral system. • Delayed identification and support for children with disability.		• Changes in donor priorities and policies impact sustainability of service provision even at tertiary levels.
	Health workforce	• Availability of more qualified and registered health workers. • Capacity building in case management provided to health workers.	• Inadequate numbers of specialised health care providers, affecting timely provision of care. • Insufficient human resources for other cadres. • Budget constraints to hire additional staff. • Inadequate mentorship and supportive supervision • Inappropriate deployment of trained and specialised health workers.	• Wide pool of well-trained healthcare resource on the market. • Growing numbers of specialised medical training institutions.	• Competition for health workers from other employers.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
			• Frequent and uncoordinated staff rotation.		
	Health information systems	• Digital health strategy in place. • Strong digital health coordination/ governance system. • Government commitment to deploy DHIS2 to tertiary level.	• System remains largely manual (timeliness of data, visibility, oversight implications) and having quality issues. • Limited budget allocation to digital health. • Lack of customised reports to support reviews and clinical audits on causes of maternal, neonatal, and child deaths from DHIS2. • Limited budget to procure monitoring tools including registers and reporting forms. • Lack of resources, e.g. computers. • Telemedicine facilities not functional. • Child health data not adequately captured in registers.	• Availability of donor support.	• Changes in donor priorities and policies may affect support to tertiary levels and lead to system failure.
	Medicinal product	• Policies, strategies, and guidelines in place. • Governance structures in place (Pharmacy and Medicine Regulatory Authority). • National quantification of medicines in place. • Some supply chain systems available (Open LMIS)	• Weak supply chain system for essential drugs and supplies affecting tertiary level. • Inadequate supply of blood and blood products in the banks. • Inadequate supply of oxygen in the tertiary facilities	• Donor support to tertiary level.	• Public health emergencies divert resources from regular programmes, including tertiary hospitals.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
		• Some central hospitals have oxygen plants • Autonomy to procure medicines and supplies from the market	• Inadequate supply of paediatric formulations of drugs and supplies • Weak supervision of drug stores in central hospitals.		
	Health financing	• Established Health Financing Division within Planning and Policy Development Department to oversee resourcing.	• Low government budget allocation relative to needs.	• External partner resource support (technical, budget support).	• Changes in donor priorities and policies may affect funding support to tertiary levels. • Pandemics affecting donor priorities and support to health sector, including tertiary level care.
	Leadership and governance	• Policy, strategy, and guidelines in place for most aspects of child health. • Established SLAs with CHAM. • Newborn care integrated in IMCI guidelines. • Scale-up plan for child health interventions in place.	• Insufficient maintenance of ambulances and medical equipment. • Insufficient reviews and clinical audits on causes of maternal and child deaths. • Insufficient supportive supervision. • Weak appraisal system.	• Partner support in health systems strengthening, which includes leadership and governance capacities.	• Variability in partner support across tertiary hospitals.
Level of Care	**Systems Framework**	**Strengths**	**Weaknesses**	**Opportunities**	**Threats**
Community-based preventive and curative interventions	**Service delivery** - Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.	• Decentralized health care system • Established Community Health Strategy • Availability of community structures • Established CMAM and Scaling Up Nutrition (SUN). • Availability of outreach services • Availability of functional Village clinics	• Limited coverage of community-based newborn care • Inadequate supplies • Inadequate resources to support community health workers and supervision. • Lack of integration of services	• Availability of local partners or organizations • Emerging trends in targeted donor resource support to implementation level.	• COVID-19 pandemic diverting already limited resources away from core priority programs. • Changes in donor focus affecting sustainability of some initiatives • Poor road conditions affecting mobility.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
		• Strong community led WASH interventions. • Availability of Community-based maternal newborn care	• Weak ownership of some of the partner supported initiatives. • Shortage of personnel – high vacancy rates • No established infrastructure for outreach services, affecting privacy for ANC, VCT, and PMTCT. • Low staff motivation • Weak community engagement on cultural beliefs affecting early care seeking behavior. Weak referral system		
	Health workforce - A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).	• Availability of community health workers • Revised HSAs training curriculum better aligned to needs and meets regulatory board minimum requirements.	• Insufficient staff for some cadres of community health workers, resulting in task shifting to HSAs beyond their expected competence level. • Over-reliance on one community health cadre (HSAs) for majority aspects of community health program delivery. • Misdeployment of community health nurses and community health midwives • Limited availability and service provision due to some HSAs not residing in catchment areas.	• Availability of external partner resources to support recruitment and payroll needs for some cadres. • Strong global movement that supports UHT, including community health workers.	• Competition for health workers from other employers.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
			• Inadequate capacity building for health workers to competently deliver MNCH interventions. • Limited resources to support supervision, outreach clinics, and HSA bicycle/transport needs. • Limited career progression among community health workers		
	Health information systems - A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.	• Availability of one unified data platform (DHIS2 Tracker) • Data collection institutionalized as part of service delivery. • Availability of monitoring mechanisms and tools. • Clear agreed framework for community health information system (iCHIS).	• Poor data quality • Inability of current health information system to measure, track, and report quality of care (QoC) and access to healthcare by sub-national groups for targeted improvement action. • Inadequate data utilization at service delivery level • Lack of integrity – data manufacturing • Continued use of paper-based data collection tools for the community level. • Inadequate resources to implement the iCHIS.	• Strong global momentum to support digital health • Global interest and commitment to support QoC improvement, including health systems that support QoC reporting.	• Connectivity challenges limiting data transmission and access. • Cyber security threats.
	Medicinal products and other supplies - A well-functioning health system ensures equitable access to essential medical products,	• Availability of policy permitting provision of some essential medicines and supplies at community level.	• Long procurement procedures • Stock outs of essential medicines and supplies	• Availability of additional partner resources that support procurement	• Antimicrobial resistance, limiting effectiveness of available antibiotics.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
	vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.	• Availability of accountable community structures / committees that monitor medicines and supplies stocks. • Availability of drug boxes for HSAs.	• Irrational use of essential medicines, including antibiotics. • Failure to meet demand by CMST. • Mismanagement of medicines and supplies.	of medicines and supplies. • External research support on antibiotic prescribing practice and consumption to guide policies.	
	Health financing - A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.	• Government commitment in financing community health. • Community health workers fully incorporated in national budget.	• Chronic government under-funding to health sector.	• Availability of donor resource support • Coordinated donor approach to health support.	• Donor priorities and policies impact sustainability of health service provision. • Emergence of pandemics affecting donor priorities and resource allocation
	Leadership and governance - Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.	• Policies, strategies, and guidelines for community health developed and in place. • Availability of policy for child health with health sector focus • Availability of Essential Health Package and Health Sector Joint Fund. • Availability of clear policy and strategic plan to increase of number of HSAs to a proportion	• Leadership conflicts at community level affects team performance • Weak governance system at facility level fueling corruption where patients pay for services otherwise meant for free.	Increased number of NGOs, CSOs, and development partners working at community level in health promotion. • Growing global recognition and commitment to support effective leadership and	• Changes in donor priorities and policies impact sustainability of core health programs, including leadership and governance support. • Emergence of pandemics affecting donor priorities and support to core programs, such as leadership and governance

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
		of 1 per 1000 population using government funds. • Existence of community structures through which multi-sector health interventions are implemented. These include the Health Centre Management Committees (HCMCs) including the Area and Village Health Committees. • Child health communication strategy developed to promote the high impact interventions		governance in health.	strengthening at community level.
Facility-based services	**Service delivery** Good health services are those which deliver effective, safe, quality, personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.	• MGDS III identifies nutrition as a priority under other development areas. • Availability of HSSP II 2017–2022. • Regular Child Health Campaigns • Introduction of Reach Every Child (REC) approach for EPI • Use of available community structures e.g. CBCCs for delivery of high impact interventions to children and pregnant women • Availability of standards and guidelines such as in management of the sick child • Availability of outreach services • Availability of Community based health workers • Existing infrastructure • Presence of service level agreements	• Insufficient commodities for child health. • Limited service delivery due to the insufficient numbers of health staff • Inadequate staff supervision • Poor maintenance and replacement system for cold chain equipment and other essential equipment • Lack of transport for integrated outreach • Infrastructure quality not meeting requirements for new borns, isolation for infectious diseases (e.g. covid-19), kangaroo mother care, etc • Corruption – some providers requiring patients to pay for free services.	• Presence of implementing partners	• Extreme weather conditions and disasters, e.g. floods • Cultural and religious beliefs • Pandemics

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
		• Birth registration system established. • Establishment of sick newborn care units.	• Inadequate services for children with NCDIs at secondary and primary level • Insufficient reviews and clinical audits on causes of maternal, neonatal, and child deaths. • Weak community engagement on cultural beliefs affecting early care seeking behavior. • Delay in care-seeking and referral for sick children and women • Weak referral system • Delayed identification and support for children with disability		
	Health workforce A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).	• Availability of trained and committed health workers • Availability of regulatory bodies • Career growth opportunities • Availability of training institutions • Availability of salary top up allowance for health workers. • Availability of specialized providers	• Insufficient specialized providers • Skills, diagnostic and treatment capacity to manage NCDIs not available. • High vacancy rate-patient/ provider ratio is still high. • Lack of formally established feedback and appraisal systems • Low remuneration in government facilities. • Attrition of trained staff. • Inadequate motivation.	• Donor support with specialized technical assistance personnel.	• Changes in donor priorities can affect budget and ability to support specialized Techical Assistants.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
	Health information systems A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status	• Availability of policies and guidelines for digital health. • Availability of one unified functional data platform (DHIS2 Aggregate). • Availability of electronic data systems for patient level data - Electronic Medical Records. • Data collection institutionalized as part of service delivery. • Availability of monitoring mechanism and tools • Defined indicators and tools for M&E, e.g. registers, SOPs • Functional departments focused on health information systems (Digital Health Division and Central Monitoring and Evaluation Division). • Availability of pre-service training in HIS • Data quality audits (DQA) conducted every 2 years.	• Poor data quality • Inadequate data utilization at service delivery point. • Continued use of paper-based tools. • Lack of reliable power supply • Weak cyber security systems • Lack of adequately trained IT personnel • Lack of regular data quality self –assessments • Inadequate/poor IT infrastructure e.g. servers • Fragmented electronic data systems. • Child health data not adequately captured in registers	• Strong global commitment to support DHIS2 expansion to facility level. • Implementing partners direct support to HIS • Government commitment through eGov to facilitate e-services in all line ministries.	• Connectivity challenges limiting data transmission and access. • High internet cost
	Medicinal product and equipment A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.	• Availability of policies for regulating use of medicines. • Functional Central Medical Stores Trust (CMST) as supplier • Availability of efficient logistical management systems (Open LMIS,) • Availability of the Physical Assets management department • Availability of medicine stores in all facilities	• Weak supply chain system for essential drugs and supplies affecting availability at facility level. • Irrational use of essential medicines (including ACTs). • Poor stock management in some facilities. Overdependence on CMST as single supplier.	• Availability of partner support in procurement and distribution of medicines and direct equipment donations. Partner support to offices and storage facility (Prefabs)	• Antimicrobial resistance limiting effectiveness of available antibiotics. • Frequent regimen change affecting utilization of the available ARV's stock. • Public health emergencies divert resources from regular programs and affect medicine availability at facility level.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
		• Trained Pharmacy Assistants at health centre level.	• Lack of preventive maintenance of assets (servicing). • Inadequate essential equipment • Poor management of equipment donated to the public facilities. • Inadequate supply of oxygen for critical care		
	Health financing A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.	• Government budget commitment to support procurement and distribution of medicines. • Vibrant health financing unit in Planning and Policy Development Directorate.	• Chronic inadequate domestic funding, leading to overdependence on donors for health budget. • Weak internal controls leading to misappropriation of health funds. • Weak budget monitoring and reviews.	• Availability of increasing donor resource support (technical and budget). • Well-coordinated donor approach to health budget support.	• Changes in donor priorities and policies have major impact on sustainability of health service financing and delivery. • Emerging pandemics affecting donor priorities and financial support to core programs.
	Leadership and governance Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.	• Policies, strategies, and guidelines well developed and disseminated to staff at facility levels. • Availability of child health policies and guidelines at facility level. • Availability of EHP and Joint Sector Fund. • Functional governance structures in place (Health Centre	• Unfavorable working conditions for workers in facilities. • Low staff motivation. • Weak maintenance plan for ambulances and other essential equipments. • Political interference in procurement of medicines affecting quality, quantity,	• Growing donor support to strengthening health systems, including leadership and governance, • Most training institutions now include Leadership and governance	• Changes in donor priorities and policies impact sustainability of support to core health programs including leadership and governance. • Emergence of pandemics affecting donor priorities and support to non-clinical program areas such as leadership and governance.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
		Management Committees, Area Committees). • Child Health Communication strategy developed to promote high impact interventions. • Leadership training materials for facility level in place. • Established SLAs with CHAM. • Newborn care integrated in IMCI guidelines. • Scale up plan for child health interventions in place.	and timeliness of medicine availability. • Leadership conflicts at facility level affecting team performance. • Weak governance systems at facility fueling corruption where patients pay for services that are meant to be provided free. • Loss of staff to other employers in health sector due to poor conditions relative to competition. • Inadequate support and follow up of action points on clinical audit findings.	modules in pre and post service trainings.	
Tertiary childcare services	**Service delivery**	• Guidelines and SOPs in place for most aspects of child health • Availability of maternal and perinatal death surveillance and response (MPDSR) Guidelines • Designated areas of childcare services. • Integrated child health services • Availability of essential technologies for diagnosis and management of newborn conditions (CPAP, Radiant warmers, pulse oximeters including bilirubinometers)	• Rapid response systems not available in the district • Lack of preventive maintenance of essential equipment • Inadequate CEmONC services in the facilities eg blood transfusions and administration of anticonvulsants • Weak supervision system. • Limited awareness of patients' rights and respectful maternity care charter among patients and providers. • Lack of district hospitals in Lilongwe, Zomba, Mzuzu,	• Availability of donor support for tertiary level	• Emergence of pandemics affecting donor priorities and support to regular programs like child health, including for tertiary level. • Changes in donor priorities and policies impact sustainability of service provision even at tertiary levels.

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
			and Blantyre causing congestion in the tertiary facilities • Frequent and uncoordinated staff rotation negatively impacting quality of care. • Weak referral system • Delayed identification and support for children with disability		
	Health workforce	• Availability of more qualified and registered health workers • Capacity building in case management provided to health workers	• Inadequate numbers of specialized health care providers, affecting timely provision of care. • Insufficient human resources for other cadres. • Budget constraints to hire additional staff. • Inadequate mentorship and supportive supervision • Inappropriate deployment of trained and specialized health workers. • Frequent and uncoordinated staff rotation.	• Wide pool of well-trained healthcare resource on the market. • Growing numbers of specialized medical training institutions	• Competition for health workers from other employers.
	Health information systems	• Digital health strategy in place • Strong digital health coordination/ governance system • Government commitment to deploy DHIS2 to tertiary level.	• System remains largely manual (timeliness of data, visibility, oversight implications) and having quality issues. • Limited budget allocation to digital health • Lack of customized reports to support reviews and clinical	• Availability of donor support	• Changes in donor priorities and policies may affect support to tertiary levels and lead to system failure

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
			audits on causes of maternal, neonatal, and child deaths from DHIS2. • Limited budget to procure monitoring tools including registers and reporting forms. • Lack of resources Eg. Computers • Telemedicine facilities not functional. • Child health data not adequately captured in registers		
	Medicinal product	• Policies, strategies, and guidelines in place • Governance structures in place (Pharmacy and Medicine Regulatory Authority). • National quantification of medicines in place. • Some supply chain systems available (Open LMIS) • Some central hospitals have oxygen plants • Autonomy to procure medicines and supplies from the market	• Weak supply chain system for essential drugs and supplies affecting tertiary level. • Inadequate supply of blood and blood products in the banks. • Inadequate supply of oxygen in the tertiary facilities • Inadequate supply of paediatric formulations of drugs and supplies • Weak supervision of drug stores in central hospitals.	• Donor support to tertiary level	• Public health emergencies divert resources from regular programs, including tertiary hospitals.
	Health financing	• Established Health Financing Division within Planning and Policy Development Department to oversee resourcing.	• Low government budget allocation relative to needs.	• External partner resource support (technical, budget support)	• Changes in donor priorities and policies may affect funding support to tertiary levels. • Pandemics affecting donor priorities and support to

Level of Care	Systems Framework	Strengths	Weaknesses	Opportunities	Threats
					health sector, including tertiary level care.
	Leadership and governance	• Policy, strategy, and guidelines in place for most aspects of child health. • Established SLAs with CHAM • Newborn care integrated in IMCI guidelines. • Scale-up plan for child health interventions in place	• Insufficient maintenance of ambulances and medical equipment • Insufficient reviews and clinical audits on causes of maternal and child deaths • Insufficient supportive supervision • Weak appraisal system	• Partner support in health systems strengthening, which includes leadership and governance capacities.	• Variability in partner support across tertiary hospitals.

EXPERIENCES OF CARE

This strategy focuses on delivering quality health care services in all its critical components including experiences of care by clients, patients and guardians in the course of accessing care. Experience of care encompasses aspects which can affect client satisfaction or dissatisfaction such as waiting times, provider attitudes, communication with clients, time for assessment, availability of medicines and services among others. Experience of care is an important variable that influences future client care-seeking behaviour. Table 5 below, summarises some of the gaps in service provision based on stakeholder consultations and observations from points of care as they affect client experience of care.

Table 5: EXPERIENCES OF CARE BY PERIOD OF INTERVENTION

Life Cycle Approach (Intervention Period)	Gaps in experience of care
Antenatal	• Encouraging male involvement but infrastructure and environment design not male friendly • Long waiting hours • Inadequate assessment of the pregnant women • Poor communication between HW and ANC clients • Fear of infections e.g. COVID • Cultural beliefs affecting attendance during 1st trimester • Feeling of not being assisted due to lack of weighing equipment • Sent back if do not bring spouses (husbands) so women use surrogate husbands e.g. bicycle taxi drivers • Clients know their health care workers by name • Woman are not treated with respect and dignity • Husbands do not want to sing health promotion songs • Nurturing care not considered a priority • Services not catering for needs of women with disability

Life Cycle Approach (Intervention Period)	Gaps in experience of care
Labour and Delivery	• WASH facilities not in good condition • Inadequate beds and space • Lack of privacy in delivery rooms • Waiting for referral/ambulances • No support from husband and family • Poor communication to labouring mothers, abuse from staff • Equipment not available for care of women in labour • Delays in accessing caesarian section • Not being monitored during labour • Self-deliveries • Use of torches or cellphone light when giving care • Guardians told to fetch water from wells or boreholes for their patients • Felt well cared by midwives especially male • Episiotomies not sutured • Early initiation of breastfeeding within 1hour and skin to skin after birth not followed • Birth companion not allowed • Porridge given by guardian, not provided by health facility • Discharged to Postnatal soon after delivery • Floor bed delivery • Services not catering for needs of women with disability
Postnatal / Neonates (≤6 weeks)	• Inadequate support and psycho-social support after loss of child, inadequate numbers of psychosocial providers • Emotional support for mothers with premature babies • Postnatal assessment not done • Congestion in the ward • Supplies not available • Pain management of the neonates • Infection control • Less provision of care for the new born, separation from mothers • Sex of baby and time of birth not informed • Asked to provide name of baby to be recorded in the birth registration form • Health care worker naming newborn baby • Early discharges • Baby received immunisations on discharge • Told to come for follow up after 1 week
Infants 6 weeks - <1 year	• Poor pain management • Congestion in the ward • Not prioritised for ambulance services

Life Cycle Approach (Intervention Period)	Gaps in experience of care
	• Delays in receiving care • Nurturing care not considered a priority • Caregiver buying essential drugs not available at the facility • Incomplete assessment due to long queues • Triaging assisting in timely provision of care to very sick infants • Caregivers not appropriately counseled on infant's condition and home care • Environment not usually child-friendly as it lacks play material to take away fear in children • Poor communication about a procedure creates anxiety in caregivers
Under-fives 1 - <5 years	• Poor pain management • Congestion in the ward • Not prioritised for ambulance services • Delays in receiving care • Lack of privacy during assessment and management • Nurturing care not considered a priority • Caregiver buying essential drugs not available at the facility • Treatment being prescribed without proper clinical examination or investigation • Health workers unpleasant behavior at health facilities • Triaging assisting in timely provision of care to very sick infants • Caregivers not appropriately counseled on infant's condition and home care • Poor communication about a procedure creates anxiety in caregivers • Environment not usually child-friendly as it lacks play material to take away fear in children • Under-five children being attended to in the same consultation room with adults especially at health centres • Stigma towards children with disability
5 - 10 years	• Denial of access for village clinic services • Lack of privacy • Morbidity data combined with all age groups at out patients departments of PHCs • No data for M and E and planning for age group at MoH • Poor assessment and management in cases of child abuse and defilement • Poor trauma management at facilities • Poor management of NCDs • Infrastructure not friendly to children with disability

Life Cycle Approach (Intervention Period)	Gaps in experience of care
	• Experience of care for infants and under-five children are also relevant to this age group
Adolescents (10 - 18 years)	• Disrespectful and judgmental providers • Lack of privacy during assessment • Lack of post abortion care • Adolescents not recognised as a distinct group, especially during clinical consultation • Inadequate family planning services due to cultural and religious barriers, • Sexual Exploitation and Abuse by health workers • Unavailability of life skills to avoid and manage exploitation and abuse • Poor communication about a health condition to the patient themselves • Lack of transitional care plan for children with chronic diseases, particularly NCDs. • Limited access to information on awareness, prevention, and care for substance abuse.

Coupled with the above analysis of bottlenecks, experiences of care and leveraging on existing threats and opportunities this Child Health Strategy will focus on the Goals, strategic direction followed by interventions are presented in Chapters 4 and 5 below.

CHAPTER 4.0: STRATEGIC DIRECTION

Vision: A Malawi where all new-borns, infants, children and adolescents survive, thrive and transform to their fullest potential.

Mission: To ensure survival, health, child development, and wellbeing of all newborns, children and adolescents in Malawi, through effective delivery of quality evidence-based, high impact, holistic and integrated interventions at all levels of the health care system.

Strategic Goal: To reduce under-five mortality to 30 deaths per 1,000 live births and neonatal mortality to 15 deaths per 1,000 live births by 2026. These goals will contribute to achieving a reduction in childhood morbidity and mortality in line with SDG targets for 2030.

4.1 Core Values and Principles

The formulation of this strategy is guided by the following values and principles:

i. ***Leadership and mutual accountability:*** All stakeholders shall discharge their respective mandates in a manner that takes full responsibility for the decisions made in the course of providing health care.

ii. ***Human Rights and Equity Based Approach:*** *This* principle ensures respect for human rights and fundamental freedoms including the right to life, human dignity, equality and freedom from any form of discrimination, and encompasses all provisions in the Convention on the Rights of the Child. Therefore, all the people of Malawi shall have access to health services without distinction of ethnicity, gender, age, disability, sexual orientation, mental and health status, religion, political belief, economic, socio-cultural condition or geographical location. The rights of health care users and their families, providers, and support staff shall be respected and protected.

iii. ***Gender Sensitivity:*** Gender inequality is a root cause of many barriers to sustainable development around the world and it continues to have a negative impact on a range of Reproductive Maternal, Newborn, Child and Adolescent health (RMNCAH) issues. Gender related power imbalances contribute to excess female mortality and morbidity across the lifecycle. Harmful gender norms affect men and boys by encouraging risk taking and by limiting their health seeking behaviour (Save the Children Gender Equality Programme Guidance & Toolkit,2014). This strategy therefore encompasses protection and promotion of human rights which will be essential in preventing maternal, newborn, child and adolescent mortality and morbidity in Malawi.

iv. ***Ethical Considerations:*** The ethical requirement of confidentiality, safety and efficacy in both the provision of health care and health care research shall be adhered to and respected for every Malawian citizen.

v. ***Efficiency and effectiveness****:* Efficiency and effectiveness will remain the hallmark in the use of available health care resources to ensure that consumers of health services are not deprived of their rights to health and maximise health outcomes.

vi. ***Community Participation*****:** Implementation of the 2021-2026 Child Health Strategy will be done at all levels of care including the community level. Implementation will take into consideration of the other existing strategies including the Community Health Strategy. Community contribution will be through the defined structures such as the Community Health Action Groups (CHAGs), care groups, support groups, CBOs, ADCs, community and religious leaders among others. Both curative and preventive services will be provided by community health workers such as HSAs, Community Health Nurses, Community Midwives Assistants. Services will be provided at household level, community level through home visits, outreach clinics, village clinics, and at health posts.

vii. ***Evidence-based decision making****:* Interventions shall be based on proven and cost-effective best practices. Lessons and evidence generated through research during implementation will be used to inform ongoing adjustments in service provision.

viii. ***Partnership and Multi-sectoral Collaboration****:* Public-Private Partnership (PPP) and multi-sectoral collaboration shall be encouraged and strengthened to address the determinants of health.

ix. ***Decentralisation***: Health services management and provision shall be in line with the Local Government Act of 1998 which entails devolving decision making around health service delivery to local assemblies.

x. ***Innovation****:* All health care providers shall use approved health care technologies that are appropriate, relevant and cost effective. Introduction of new innovations will be encouraged in line with the Digital Health Strategy.

xi. *Responsiveness:* The child health services shall be responsive to the needs of Malawians, including children and adolescents.

4.2 Strategic Interventions

This section describes intervention areas and activities designed to achieve each of the four strategic objectives defined in this Child Health Strategic Plan

Table 6: Strategic Objectives and Intervention Strategies Included in the Child Health and Development Strategic Plan

Objectives	Strategies
1. Improve availability and readiness of quality neonatal and child health services at community level	1.1 Promote good home health care practices and ensure access through HSAs, Community Health Nurses, Community Midwife Assistants and other community volunteers. 1.1.1 Conduct home visits by HSAs and Community Health nurses to assess and counsel on nurturing care for ECD, nutrition and growth monitoring, WASH, do postnatal checks and make appropriate referrals. 1.1 .2 Plan and conduct outreach clinic activities for immunisation, growth monitoring, ANC, PNC, FP 1.2 Support establishment of Village clinics for sick care management at PHC levels and Community level to improve supply and demand for health services. 1.3 Support Training, mentorship and supportive supervision of Village Health Committees, 1.4 Empower the committees to monitor medicines and supplies for village health clinics. 1.5 Support periodic mentorship and supportive supervision of HSAs and Community Health nurses, Community midwife Assistants and other community volunteers that provide services at community level. 1.6 Support the introduction and establishment of Enhanced management of Pneumonia in the Community (EMPIC) 1.7 Support the introduction and establishment of iCCM for children 5 to 10 years old 1.8 Support training of HSAs on Childhood TB, Child Protection and abuse as part of iCCM 1.9 Support training of HSAs on iCCM plus CBMNC
2. Reduce provider workload at facility level through increased capacity of health workers	2.1 Improve availability of Community healthcare workers 2.1.1 Establish and strengthen Technical Working group workforce at district level for MNCAH 2.1.2 Conduct risk assessment and refresher training of HSAs on Childhood TB/HIV, Child protection and CBMNC 2.1.3 Draw a redistribution plan to ensure community nurses, community midwifery assistants and HSAs are well distributed in the country 2.1.4 Lobby for recruitment and deployment of community nurses, community midwifery assistants and HSAs according to redistribution plan

Objectives	Strategies
	2.2 Support capacity building of at least 2 staff per health facility in essential competencies in skilled delivery, essential newborn care, Integrated Management of Newborn and Childhood Illnesses (IMNCI), Infant and young Child Feeding, ETAT, Nurturing care, lifesaving skills, and emergency obstetrics care, including management of 3rd stage of labour during deliveries. 2.3 Build capacity of community health workers in data management 2.4 Build capacity of medical and nursing lecturers as trainers of trainers in maternal, newborn and child care, including IMCI and nurturing care for ECD in order to improve in-service and pre-service training
3. Improve capacity of community health workers and availability of infrastructure to support service provision for adequate and appropriate delivery of basic health services.	3.1 Support training of facility level workers in IMNCI, Nurturing care for early childhood development, with emphasis on on-the-job mentoring and coaching for immediate application and quick gains. 3.2 Strengthen facility readiness for provision of quality of health care through availability of appropriate infrastructure, WASH facilities, equipment and furniture. 3.3 Maintain and rehabilitate the already existing infrastructures 3.4 Facilitate construction of infrastructure at community level to reduce radius access distance for 5km or below in communities 3.5 Promote pre-service and in-service training that focuses on mentoring, supportive supervision and monitoring the quality-of-service delivery for child health. 3.6 Support iCCM + CMAM trainings for HSAs 3.7 Support refresher training for facility and community health workers 3.8 Support mentorship review meetings 3.9 Support conduct of supervision quarterly at National level and district level 3.10 Support fuel to support SHSAs to conduct district level supervision for iCCMs HSAs
4. Strengthen health facility-based perinatal care	4.1 Equip health facilities properly with trained staff In EmONC skills 4.2 Strengthen use of obstetric guidelines and protocols in management of complications. 4.3 Increase the availability of equipment and supplies 4.4 Develop a structured induction system for the newly recruited staff 4.5 Institutionalise mentorship programme at facility level to support health facilities, 4.6 Develop preventive maintenance programme for essential equipment 4.7 Strengthen quality of antenatal care interventions through eight ANC contacts 4.8 Institutionalise postnatal care within 48 hours and initiation of breastfeeding within an hour of birth 4.9 Support HSAs training to provide follow up of PSBI cases and postnatal children 4.10 Support documentation of PSBI cases at PHC levels Support documentation and reporting of PSBI at PHC levels

Objectives	Strategies
5. Improve risk assessment in case management to ensure providers' ability to diagnose, treat and make appropriate referral of child health conditions	5.1 Establish IMNCI, and train service Providers to improve risk assessment classification and treatment of conditions while adhering to guidelines 5.2 Strengthen ETAT 5.3 Support the training of Health workers from Private clinics on IMNCI 5.4 Support pre-service training in Health Training Institutions 5.5 Equip PHCs for strengthened ETAT management 5.6 Strengthen care and management of HIV-exposed infant and HIV positive child and adolescents 5.7 Strengthen diagnosis, and management of NCDs in children and adolescents 5.8 Intensify supportive supervision and monitoring of the quality-of-service delivery for child health at all levels. 5.9 Improve quality of care through supervision of child health-related interventions 5.10 Promote availability of diagnostic equipment and essential medicines for children and adolescent conditions
	5.11 Strengthen mapping of households with pregnant women, newborns and under-five children using the village health register. 5.12 Support the conduct of case management review meetings 5.13 Support the conduct of death audits
6. Strengthen nutrition promotion, counselling and assessment as part of child health service delivery	6.1 Promote optimal maternal nutrition during pregnancy and lactation 6.2 Promote age-appropriate infant and young child feeding practices 6.3 Integrate nurturing care interventions with Nutrition services 6.4 Strengthen growth monitoring and case management of moderate and severe acute malnutrition among under-five children 6.5 Support integration of CMAM into broader iCCM services at community level 6.6 Provide micronutrient supplements, deworming tablets and dietary counselling. 6.7 Strengthen community mobilisation targeting influential community leaders and family members (grandparents, aunts, men) to promote exclusive breastfeeding. 6.8 Strengthen scaling up of nutrition interventions
7. Improve coordination, governance and management of partnerships and multi-sectoral approaches including nutrition, early stimulation and adolescent health	7.1 Strengthen partner mapping for child health services and coordination structures 7.2 Strengthen compliance of private health facilities with norms, standards and practices of management of childhood illnesses 7.3 Build capacity of health care governance structures e.g. Health Centre Management Committee (HCMC) drugs committees, CHAG, VHCs. 7.4 Facilitate integration of IMNCI, iCCM with DNCCs, CBCCs for early child stimulation 7.5 Strengthen referrals at PHC level such as Village clinic 7.6 Support review of iCCM road map 7.7 Strengthen maternal, neonatal, child case reviews (deaths and near misses) 7.8 Support planning, review and TWG meetings for child health 7.9 Support conduct of annual and quarterly review meetings at all levels 7.9.1 Support conduct of TWG meetings at national and district level

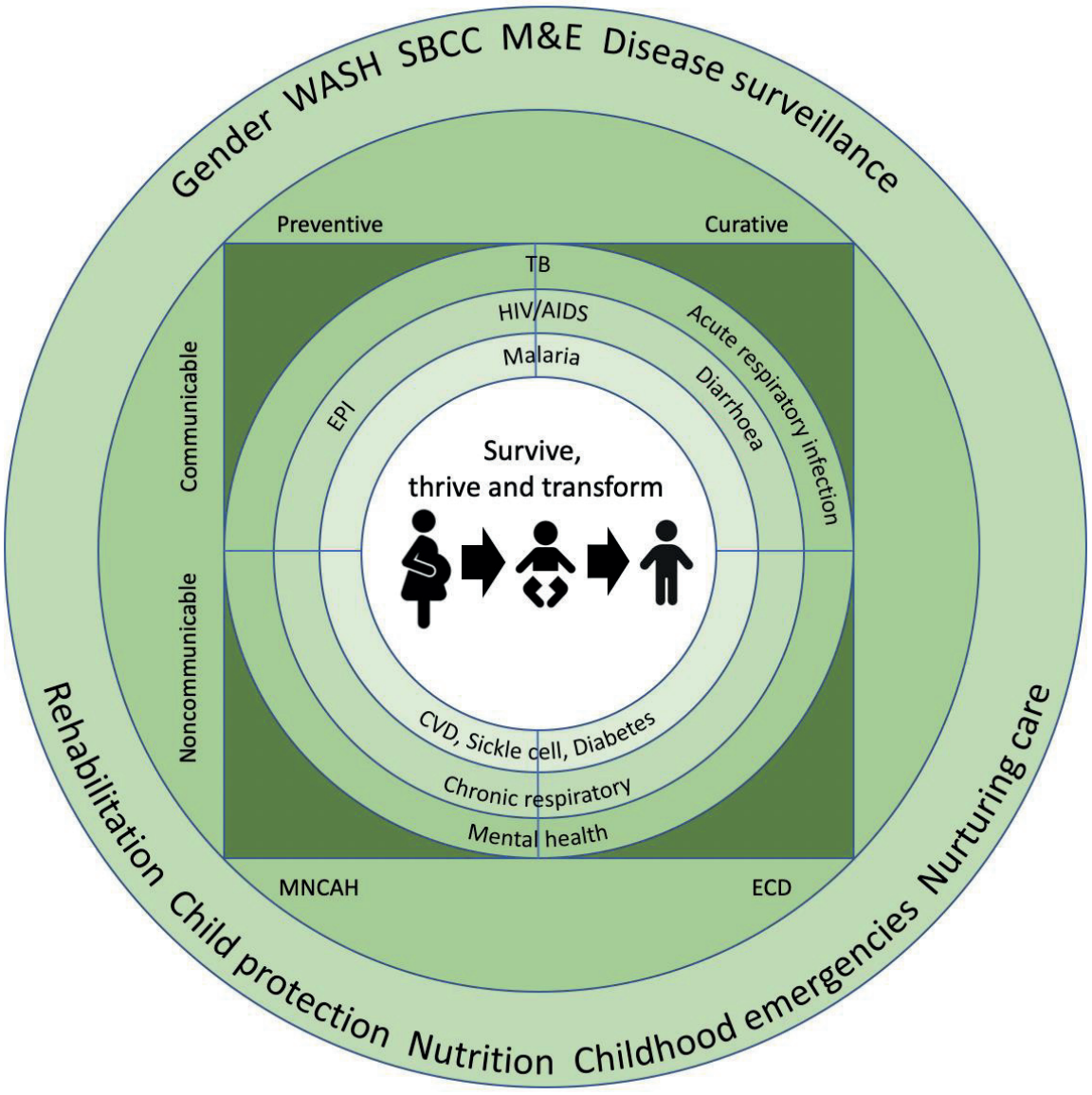
Objectives	Strategies
	7.9.2 Establish and support the Child Health Steering committee to strengthen partnership. 7.9.3 Motivate HSAs by establishing a commemoration of iCCM day (Village clinic day)
8. Improve health promotion and SBC strategies for increased uptake of child health services	8.1 Develop SBC/ IEC materials on neonatal and child health in collaboration with Health Education Service (HES). 8.2 Review SBC/IEC materials on MNCAH and IMNCI 8.3 Build capacity of district master trainers in SBCC on key care seeking barriers and approach to resolve them. 8.4 Build capacity of community gatekeepers, religious leaders, opinion leaders/champions and community volunteers to drive change that addresses misconceptions and negative cultural beliefs to increase care seeking. 8.5 Support the conduct of mass campaigns for child Health 8.6 Provide quarterly recognition to model communities that achieve meaningful improvement in postnatal, new-born, and child health care seeking behaviour.
9. Strengthen the supply chain of essential commodities and equipment for child health	9.1 Revamp cStock community supply chain system for local sustainability 9.2 Advocate for integration of cStock with iCHIS 9.3 Build capacity of HSAs, facility in-charges and SHSAs in the use of cStock information system 9.4 Support training and on-the-job mentorship/coaching of the extended district health management teams (DHMTs) to monitor community supply chain performance via cStock dashboard 9.5 Build capacity of MoH IT and council staff on technical management of cStock system and servers. 9.6 Participate in annual quantification of medicines and advocate for child health related medicines. 9.7 Support on-the-job refresher training for health facility teams on effective use of Open LMIS/supply chain data to strengthen timely requisition of medicines to avoid stock outs. 9.8 Support procurement of fingertip pulse oximeter, ARI timers, drug box, growth monitoring and nutritional assessment equipment 9.9 Support procurement bCPAP machines for selected PHC facilities 9.10 Improve supply of essential drugs and supplies by central medical stores trust (CMST) to health facilities with goal of no stock-out of any single supply for more than 2 weeks 9.11 Support IMCI Unit with supply and maintenance of transport for integrated child health supervision 9.12 Support distribution of equipment and emergency drugs during epidemics 9.13 Ensure availability of drugs and supplies for NCDs in children
10. Strengthen evidence–based programme management	10.1 Build capacity of child health managers on programme management at national and district levels. 10.2 Support research to develop evidence-based approaches to child health management. 10.3 Strengthen utilisation of child health real time data to inform ongoing programme improvement, including monthly meetings at service delivery points to review performance, discuss challenges, and mentor/coach staff.

Objectives	Strategies
	10.4 Support scale up of digital supervision tools for facility IMNCI and iCCM and use of data from supervision to address bottlenecks and improve performance. 10.5 Support periodic data quality audits and resolve weak areas at village clinic and facility levels. 10.6 Support review of monitoring tools for child health. 10.7 Support the review and printing of child health guidelines. 10.8 Support the development indicators from registers on children 5-10 years 10.9 Support data management review and data utilisation meetings at facility and Village clinic levels. 10.10 Support the production of under-five registers and 5-10 registers. 10.11 Support configuration of new data elements into DHIS2 10.12 Support conduct of training in form of mentorship and coaching of HMIS and focal persons at PHC levels in data management to address specific skill gaps observed from supportive supervision.

CHAPTER 5.0 PROGRAMMATIC APPROACH IN CHILD HEALTH

This Child Health Strategy constitutes programmatic building blocks within MoH and linkages with other line ministries. Its implementation requires integrating services across programmes as depicted in Figure 9 below.

Figure 9: Redesign of child health using life cycle approach



5.1 Delivery Platform for Child Health Programme Redesign

5.1.1 Integrated Management of Childhood Illnesses (IMCI)

With support from UNICEF, USAID, WHO and other partners, MoH has been implementing successful IMCI strategies since 1998 to deal with the high under-five morbidity and mortality. The IMCI, aims at providing holistic and integrated services for the survival, growth and health development of children under this age and effectively links with other departments within and outside MoH for children older than five years.

The IMCI strategy has three main objectives. It aims at improving health workers' skills through training in the integrated management of sick children and it endeavours to improve the availability of essential drugs and referral mechanism. It further aims at improving and promoting family and community childcare practices for child survival, growth and development.

It is coordinated by the IMCI unit which is mandated to ensure that all children suffering from common illnesses are managed holistically at out-patient and in-patient of health facilities and at home. It ensures that all health facilities have at least two IMCI trained health service providers. Similarly, since 2008 MoH established the integrated Community Case Management (CCM) in which HSAs are trained and deployed in hard-to-reach areas where access to health services is restricted by distance (more than 8km) and other geographical features. The HSAs are trained to open village clinics where they manage uncomplicated cases of malaria, pneumonia, diarrhea, newborn sepsis, malnutrition, red eye and refer the severe cases to the higher-level health facilities. To date iCCM is implemented in all the 29 districts with partners allocated to support specific districts. These services are supplied with all essential medicines and supplies. Adequate transportation and communication systems are available for effective management of common childhood illnesses and that 80% of health providers adhere to all the key care practices of IMCI and child care.

The facility component of IMCI was scaled up to all districts in 2006. Strategic Planning focusing on the 15 high impact interventions was initially based on the Accelerated Child Survival and Development Strategy (ACSD) 2008 -2012, which is succeeded by the Road Map for Sustainable iCCM services in Malawi (2017-2021).

The main constraints and challenges are inadequate financial resources to implement the package as a whole in all districts; acute shortage of staff at health facility level; inadequate referral and communication systems; frequent stock-outs of essential medicines and supplies; and inadequate coordination and inequitable allocation of resources resulting from lack of interest by partners.

In order to address these challenges, in the children health redesign all IMCI partners are encouraged to support efforts to scaling up and maintain universal coverage of a standardised minimum package of maternal, newborn and child high impact interventions using the IMCI approach through a managed partnership approach.

5.1.2 Acute Respiratory Infections (ARI) Programme

ARI is one of the most significant causes of morbidity and mortality amongst children worldwide. In Malawi, from 2004 to 2010 to 2015/16 the proportion of children with ARIs taken to a health facility for treatment increased from 19.6% to 70.3% to 78%.

The ARI programme aims at contributing in the reduction of under-five deaths through reducing pneumonia deaths and other related childhood lung diseases. Programme activities, including the Emergency Triage Assessment and Treatment (ETAT) and Paediatric Hospital Improvement Initiative (PHI), are integrated packages that aim to bring different childhood interventions together, and to establish well-functioning emergency rooms and emergency areas that will respond to the needs of sick children, as well as equip holding room with basic emergency equipment so that children can receive adequate treatment when referral is difficult.

Challenges faced by ARI programme include lack of relevant medicines, lack of adequate resources to scale up implementation of interventions to satisfactory levels, inadequate availability of emergency equipment and inadequately trained health workers in the use of emergency equipment.

With its increasing scope of activities, the ARI programme is in the process of developing a detailed operation plan for paediatric care in the country. This plan will cover all factors that negatively affect paediatric care such as the health education system, service delivery that include equipment sourcing and management, information management and use and operational research. The plan will be finalised in line with the Health Sector Strategic plan (HSSP) II and the current Child Health strategy.

5.1.3 Expanded Programme of Immunisation (EPI)

The Expanded Programme on Immunisation (EPI) was established to contribute in the reduction of infant morbidity and mortality rates due to vaccine preventable diseases by providing quality immunisation services. The EPI programme is therefore to keep Malawian children free from vaccine preventable diseases through facilitation to increase access to immunisation services, provision of effective and potent vaccines and increase demand for the services in order to reduce infant morbidity and mortality rates due to childhood vaccine-preventable diseases.

MoH is mandated to fully immunise infants against childhood vaccine-preventable diseases before attaining the age of 12 months. MoH is also mandated to vaccinate all pregnant women and women of childbearing with at least two doses of tetanus toxoid vaccine (TTV). It also aims at sustaining high community awareness on the importance of completing the immunisation schedule for acute flaccid paralysis, measles and neonatal tetanus.

Malawi achieved Universal Childhood Immunisation (UCI) in 1989 and high coverage has been sustained (Ministry of Health, 2007). Malawi received a shield in December 2012 from GAVI alliance as symbol of recognition for maintaining high levels of immunisation coverage. Malawi has had a robust and enviable immunisation programme for many years and recent high coverage is confirmed in the 2015/16 DHS report which shows that 76% of children aged 12-23 months were fully immunised. Currently 70% of one-year olds are fully immunised (DHS 2015/16). Despite this dip, the percentage of children 12-23 months who have received no vaccinations remained low at 2%.

5.1.4 National Malaria Control Programme

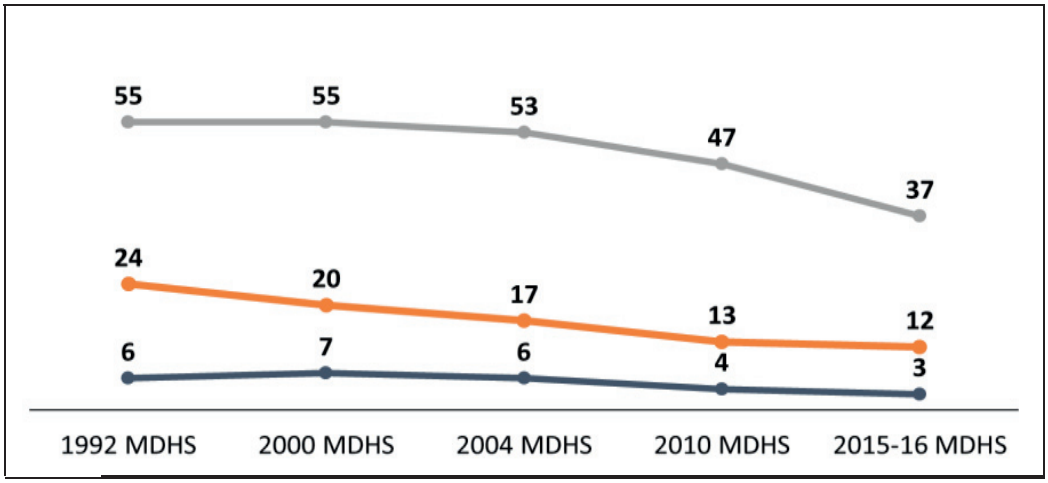
Malaria is endemic throughout Malawi and continues to be a major public health problem with an estimated caseload of 3 million in 2018/19. It is a leading cause of morbidity and mortality in children under five years of age with a case fatality rate of 47.2% (NSO 2020). The primary control strategy includes the ownership and use of both treated and untreated mosquito nets. In 2005 the Malawi Ministry of Health adopted the distribution of insecticide-treated nets (ITNs) as one of the major malaria control interventions. This formed part of the 2011-2015 National Malaria Strategic Plan, which was to achieve universal coverage with ITNs (1 net for every 2 individuals in household) and target of at least 90% net ownership and net usage among pregnant women and children under age 5 by 2016.

Overall, there has been considerable progress in scaling up interventions and controlling malaria. There has been a decline in malaria prevalence from 33% in 2014 to 24% in 2017. Insecticide-treated net (ITN) ownership has increased from 70% in 2014 to 82% in 2017 (2017 Malawi Malaria Indicator Survey (MMIS). The results of the 2017 MMIS also show improvement on use of intermittent preventive treatment during pregnancy (IPTp) by pregnant women age 15-49. Coverage has increased from 64% for two or more doses in 2014 to 77% in 2017. The percentage of women who took three or more doses of SP/Fansidar for prevention of malaria in pregnancy increased from 13% in 2014 to 43% in 2017. In addition, numbers of children receiving a parasitological test and artemisinin-based combination therapy continue to increase. The programme is also conducting Indoor Residual Spraying (IRS), and 5% of household in 2015/16 reported receiving IRS in the 12 months before the survey (DHS).

5.1.5 Nutrition

Over the past two decades, Malawi has reported a decline in the rates of undernutrition, an indication that the increased investments in nutrition is paying off. Between 2004 and 2010, the Malawi Demographic and Health Survey (MDHS) showed an 8-percentage point reduction in stunting (53 percent to 47 percent), and the MDHS conducted in 2015-16 reported 37.1% stunting in children under-five, of which 11.0% were severely stunted. Similar trends were reported for underweight (low weight- for-age), which declined from 17% (MDHS 2004) to 11.7% (MDHS 2015-16), and wasting (low weight-for-height) from 6% (MDHS 2004) to 2.7% (MDHS 2015-16). See Figure 10 below. Even with the noted decline in undernutrition, continued efforts are needed to address the high rates of stunting.

Figure 10: Trends in Nutritional Status in Children



*Based on the 2006 WHO Child Growth Standards

According to MDHS 2015-16, the prevalence of anaemia among under-five children dropped from 73% in 1992 to 63% in 2010, and the prevalence has remained at 63% in 2015-16. Among women, anaemia dropped from 44% in 2004 to 29% in 2010, and by 2015-16 the prevalence increased to 33% (Figure 3). During the same period, the Malawi Micronutrient Strategy 2015-16 indicated a prevalence of 25% in preschool children, 21% in school-aged children, 21% in women, and 6% in men.

Causes of undernutrition in Malawi are manifold. Repeated infections (including acute respiratory infections, diarrhoea, and malaria) and suboptimal breastfeeding and IYCF practices that result in inadequate dietary intake are immediate causes of malnutrition, but underlying causes include poor hygiene practices and lack of safe water and sanitation; food insecurity; high fertility; gender inequality; and poverty.

Through the health sector Essential Health Package (EHP), various policies, strategies, and interventions are implemented to improve maternal, neonatal, and child health.

5.1.5.6 Interventions and activities for Prevention of malnutrition

- Promotion of early initiation of breastfeeding and exclusive breastfeeding;
    - Building health workers skills and knowledge to support mothers to successfully breastfeed
    - Scale up the Baby Friendly Hospital Initiative (BFHI).
    - Educate all mothers about importance of early initiation (this could be during ANC, labour, postnatal care or any other opportunity
    - Support all mothers to initiate breastfeeding within 30 minutes of life.
    - Implementing of KMC especially for SGA infants;
    - Discouraging use of breast milk substitute as early onset feeds.
- Educate all mothers during ANC and PNC about importance of exclusive breastfeeding (EBF) in first six months and continued breastfeeding up to two years and beyond, appropriate maternal and child position and attachment, increased frequency during illness and after illness.
- Integrate Nurturing care with nutrition services

- Scaling up IYCF structures for delivery of IYCN by creating, mother groups in every village integrate with other community childcare activities such as iCCM activities.
- Vitamin A supplementation and deworming for women within 8 weeks of delivery and children from 6-59 months.
- Iron-folic acid supplementation for adolescent girls, pregnant and lactating women.
- Advocate for the use of iodised salt.
- CMAM activities and nutrition commodities for managing malnutrition like RUTF, multiple micronutrient powders to children 6-24 months.
- Treatment of moderate and severe acute malnutrition (NRU, OTP and SFP) -advocate for funding and CSB, food safety for all.
- Nutrition interventions during emergencies.

5.1.6. Noncommunicable diseases (NCDs) in children

The incidence of noncommunicable diseases and Injuries (NCDIs) is increasing globally. In 2017, NCDs were estimated to have caused 174 million years of disability and contributed to a million deaths in those less than 20 years of age. It is estimated that up to 70% of NCDs in adulthood have their origins in childhood or adolescence; therefore, interventions in childhood to minimise morbidity and reduce demand on the health system is essential.

The 2018 Malawi NCDI Poverty Commission report revealed that a third of the burden of premature mortality and disability in the country is caused by NCDIs, and 69% of these deaths are caused by conditions outside of cardiovascular disease, cancer, chronic respiratory disease, mental disorders and diabetes. These five conditions with their five corresponding risk factors were the initial focus of NCD interventions. The report further revealed that a quarter of disability-adjusted life years (25.4%) and an even larger share of deaths (29%) in Malawi can be attributed to NCDIs. More than 60% of NCD DALYs in Malawi occur before the age of 40, and 62% are attributed to conditions that are not related to common behavioral and metabolic risk factors.

In children the highest burden of NCDIs are cardiovascular disease (including congenital and acquired heart disease with Rheumatic Heart Disease being most common), childhood cancers, chronic respiratory disorders such as asthma, mental health disorders (such as epilepsy, neurodevelopmental disorders), type I diabetes, injuries -accidental and non-accidental, hematological disorders (sickle cell anaemia) and renal disorders (Table 4 outlines NCDIs services for children in the country).

Services for patients with NCDIs have been focused mainly in central hospitals and some district hospitals. The Malawi Service Provision Assessment (SPA) 2013-14 revealed that with the exception of acute epilepsy, equipment and medications required to treat this limited set of NCDs were available at less than 20% of facilities both at lower levels of the health system (health centers and clinics) and at all facilities in rural areas. The Package of Essential Noncommunicable Disease Intervention – Plus (PEN Plus) is a model of care for management of NCDIs that the MOH is rolling out to improve the quality and access for the management of NCDIs at district and even rural hospitals. This initiative includes investment in human resource through training and mentorship, improving monitoring and evaluation, improving drugs and supplies for management and strengthening referral pathways for affected patients. These interventions unfortunately focus

mainly on adults and gaps remain for provision of quality services for children with NCDIs as this is a unique population with unique needs and management approaches. The country does not have national guidelines for management of NCDIs in children and data for NCDIs in children is not captured in the health facility registers or in DHIS II. If children make it into adulthood, there is also no process for transitioning adolescents with NCDIs into adulthood. In order to expand interventions for children with NCDIs alongside those adults to address the specific needs of the paediatric population. The outputs for the Child will work towards achieving this.

Table 7: Outline of NCDs in children, services provided and challenges

NCDs	Services	Challenge
Cardiovascular disease - congenital and acquired. Most common acquired is rheumatic heart disease, which can be prevented by early treatment of upper respiratory tract infections and management of acute rheumatic fever	-Diagnosis is done in central hospitals by a paediatric cardiologist or few trained personnel, prior to initiation of care. Follow up care is provided in the district hospital -Many children require referral for surgery.	Specific training is required to scan children's hearts and few have these skills. Referral for surgery is often delayed and options are limited. Drug stock outs are frequent Drug formulations and strengths are not tailored to doses for neonate and infants
Childhood cancer	Childhood cancer is managed in tertiary hospitals; outcomes are hampered by late diagnosis and limited treatment options. Childhood cancer register in place.	Late presentation and late referral Limited palliative care services Lack of harmonised cancer registries among main referral facilities
Chronic respiratory disorders include asthma, chronic lung disease (seen commonly in children with HIV infection)	Children are primarily managed in secondary and tertiary level facilities	Availability of inhalers which are the mainstay of asthma; treatment from CMST especially at district hospital level
Mental health problems	These include anxiety, depression which often co-exist with other conditions such as epilepsy, physical and mental disability. Rehabilitation services are available in district hospitals.	Limited mental health and social services for affected children and their families.
Injury - includes all forms of physical harm, both accidental (falls, road traffic accidents, poisoning, and drowning) and non-accidental (defilement)	Emergency management is required, which is addressed in ETAT One stop centres established in some districts and central hospitals	Limited access to child specific care
Haematological disorders including Sickle cell anaemia	Patients managed in secondary and tertiary level facilities Treatment is lifelong but requires monthly injections and other interventions.	Skills and knowledge are limited at secondary levels facilities Diagnostic services are limited and the most common rapid sickle cell test is not reliable. Lack of standardised guidelines for managing sickle cell

NCDs	Services	Challenge
Diabetes	Patients managed in secondary and tertiary level facilities Mainly type I/insulin-dependent diabetes in children Control is generally poor.	Access to supplies, glucose monitoring, insulin and insulin syringes is erratic and require strengthening.
Renal disease – nephrotic syndrome, acute and chronic renal failure	Provided at central and some district hospitals.	Almost no services for management of renal failure in children.

5.1.7 Nurturing Care for Early Childhood Development and Protection

Over the past 25 years, Malawi has made progress in increasing the coverage for key maternal, Child health, nutrition, education, water, and sanitation interventions, leading to improvements in early childhood development (ECD) outcomes. Child health and wellbeing is not only the absence of disease but also responsive care, opportunity for early learning, play and communication (stimulation), nutrition and protection from abuse and violence. These help in reaching developmental milestones faster and early identification of disabilities. Nutrition, for example, has a huge impact on child health outcomes. From preconception to the first 1,000 days, any nutritional deficiency has a negative implication on overall child health (Aiseh, et al, 2018). Male engagement is also crucial for emotional support of pregnant and lactating women as well as in the process of providing care to children in the first 3 years of a child's life (Zvara, et al, 2013).

From years of research, it is established that investing in early childhood development is cost effective in that for every $1 spent on early childhood development interventions, the return on investment can be between 6 and 17 USD. Children who do not have the benefit of nurturing care in their earliest years are more likely to encounter learning difficulties in school, in turn reducing their future earnings and impacting the wellbeing and prosperity of their families and societies (WHO, UNICEF and World Bank Group, 2018). The ECD is, therefore, good for everyone – governments, businesses, communities, parents and caregivers, and most of all, babies and young children.

It is further established that the period from pregnancy to age 3 is the most critical, when the brain grows faster than at any other time as 80% of a baby's brain is formed by this age. For healthy brain development in these years, children need good health, responsive care, opportunities for early learning and a safe, secure and loving environment, with adequate nutrition and stimulation from their parents or caregivers. This is a window of opportunity to lay a foundation of health and wellbeing whose benefits last a lifetime and carry into the next generation (WHO, UNICEF and World Bank Group, 2018). Caregivers require capacity building to provide a stimulating, safe and supportive environment and enabling policies for children to survive and thrive. The implementation of the nurturing care framework for ECD requires a multisectoral approach and should be integrated into existing policies, strategies, guidelines and services.

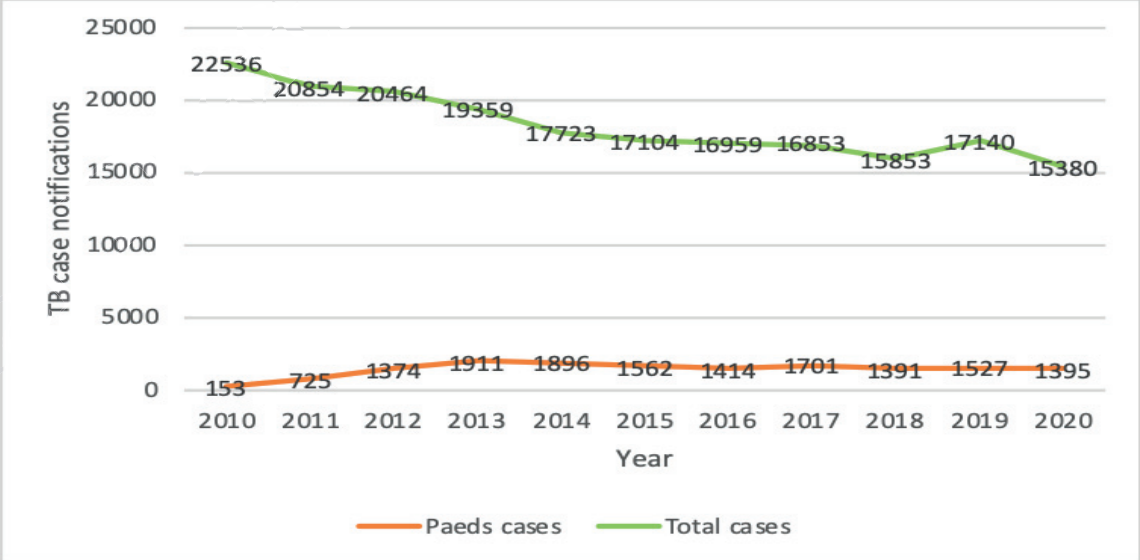
This Strategy strives to establish a child protection system that prevents and responds to all forms of violence, abuse, exploitation and neglect of children in Malawi. It also aims to increase access for child protection services. For instances, through the IMCI Programme, over 3,000 HSAs in 20 districts have been oriented to assess potential child abuse and refer them to appropriate departments such health facilities and one stop centres. The Strategy also promotes linkages with the Ministry of Gender, Women and Social Welfare and well media outlets in preventing and managing child abuse.

5.1.7 National TB Control Programme

The Malawi National Tuberculosis Control Programme (NTP) was established in 1964 under the Ministry of Heath to coordinate the national response in the fight against TB in the country. In Malawi, childhood TB contributes about 9% of all new and relapse TB cases. Confirmed Pediatric TB cases increased from 0.6% in 2010 to 9% in 2020, reflecting improved active case finding and reporting (Ministry of Health and Population, National Tuberculosis & Leprosy Strategic Plan: 2021-2025).

To reach underserved populations and increase early detection of child TB cases, the National TB Control Programme extended the IMCI scope to include childhood TB from 2016. With funding support from the World Bank, USAID and other partners over 3,000 Health Surveillance Assistants (HSAs) in 20 districts have been trained in identifying and referring under-five contacts to TB patients for further investigation. The Programme plans to expand coverage of contact tracing and referral for childhood TB from the current 3,000 HSAs in 20 districts to nearly 4,000 HSAs across all districts. Figure below shows trends in TB case notifications for total and pediatric figures.

Figure 11: Total notified TB cases for Malawi from 2010 - 2020



5.1.8 HIV and AIDS

Malawi has one of the highest HIV prevalence and fertility rates in the world. In 2019, HIV prevalence was at 8.9% while fertility rate averaged 4.1 (UNAIDS, 2020). This duality makes controlling mother-to-child transmission both a key priority and a major challenge.

The Government of Malawi, with donor support, has made remarkable progress in the fight against HIV and AIDS pandemic in the last 10 years. HIV prevalence decreased from 10.6% in 2010 to 8.9% in 2019. As of 2019, there were 1.1 million people living with HIV in Malawi, of whom 79% were receiving ART.

With the introduction of the Option B+ in the management of the HIV and AIDS in 2011, ART access increased over 7-fold and infant infection rates decreased by 66% within three years. New HIV pediatric infections declined from 15,000 in 2010 to 2,500 in 2019 (UNAIDS,2020) and coverage of Prevention of Mother to Child Transmission (PMTCT) through Option B+ increased from 44% in 2010 to 72% in 2014 (UNAIDS data, 2020). Through PMTCT programme, an estimated 9 300 new HIV infections among children were averted in 2019, with transmission rates from mother-to-child reduced to 8.8% at 12 months after birth. The Malawi government will continue to intensify testing and treatment to reduce new infections among children and adults including adolescents.

5.1.9 Water and Sanitation

This Child Health Strategy promotes working with the environmental departments at all levels to ensure access to safe drinking water and good basic sanitation. According to DHS 2016, 80 per cent of households use an improved source of water. Lack of access to safe drinking water and proper sanitation are the main cause of diarrhoea diseases. The prevalence of diarrhoea in Malawi is estimated at 17.5 % with 38 % in children aged 6-12 months and 22% for under-five children. In 60% of cases treatment of diarrhoea was sought from a formal health provider, and 24.2% of children under six months and 13% under-five years of age reportedly did not receive any treatment at all. On the other hand, 78% of under-five children with diarrhea received oral rehydration therapy (DHS 2015-16). The MoH will also continue to increase access for treatment of diarrheal diseases through its established facilities, outreach clinics and village clinics among others.

Malawi adopted the Community Led Total Sanitation (CLTS) in 2008 to make the country Open Defecation Free (ODF) by promoting sanitation in the communities. The proportion of households without toilet facility is at 11%. By 2020 only 4 (4%) districts, 141 out of 279 (TAs 47%) and 16,794 (43%) villages had attained the ODF status (MoHP, 2021).

The presence of a handwashing facility with soap and water on premises has been identified as the priority indicator for global monitoring of hygiene under the SDGs. Households that have a handwashing facility with soap and water available on premises will meet the criteria for a basic hygiene facility (SDG 6.1.4 and 6.1.2). About 10% of households have a basic handwashing facility (JMP 2017).

5.1.10 Health Promotion and Social Behaviour Communication (SBC)

The goal of the SBC activities in this strategy is to advance the objective of improving ***health seeking practices"*** for pregnant and lactating mothers and as care givers of neonatal and under-five children. The SBC activities will use evidence-based interventions targeting specific audiences and determinants of behaviors. The activities will build on the successful implementation of other SBC interventions such as *Moyo ndi Mpamba* National Health Communication Campaign.

The SBC activities will address priority behaviors using visual and trigger print materials, targeted interpersonal communication (IPC) and community mobilisation activities, as well as targeted radio, video, and social media engagements to amplify the frequency and reach of SBCC messages on key priority and "gateway" behaviors; including early attendance of ANC, immunisation, FP for adolescents and young couples, attendance of PNC, and care-seeking within 24 hours of the onset of any signs and symptoms.

The SBC activities will maintain the life stage approach as a framework for integrating complementary behaviors into packages designed to integrate priority behaviors and appropriate channels for each of the priority life stage audiences – mothers of neonatal and their male partners, caretakers of children under-five, and adolescents (ages 10-14 and 15-19).

Addressing societal and cultural barriers that influence behaviors, including social norms, may require application of more than one behavior change theory. Therefore, the SBC activities *will use* a Social Ecological Model (McKee et al 2000), that combines individual, interpersonal, and community-level theories to analyze determinants of behavior change across the individual, interpersonal, community, and enabling environment domains. The SBC activities will examine cross-cutting determinants of behavior – information/knowledge, motivation, ability-to-act, and social norms – at each level of the Social Ecological Model to identify barriers and facilitators to social and behavior change.

5.1.11 Child Health Emergencies and COVID-19

Child health emergencies form a part of the national strategy. Emergencies can range from natural disasters to infectious disease epidemics, and these events impact child health at some level. One example are floods, which can lead to an increase in diarrhoeal cases affecting children. Similarly, COVID-19 pandemic has brought challenges to child health: from an increase in child abuse, leading to a need for child protection interventions; to an increase in teenage pregnancies during the school closure period; and an impact on adult health, many of whom are caregivers of children. Therefore, even though COVID-19 pandemic has been more of a threat for adults, children also are vulnerable. In conclusion, there is need for a focused and coordinated national response for emergencies, which this strategy will contribute to addressing the needs.

5.2 Theory of Change

These Child Health Redesign interventions are reinforced by the Theory of Change (ToC) as adapted from the Commonwealth of independent states (2014) that hypothesises that if:

1. Health facilities are adequately staffed with the right skilled personnel of health workers;
2. Community health workers are capacitated to deliver quality maternal and Newborn Health services;
3. Health staff at the EmONC health facilities have improved knowledge and skills to provide essential perinatal services;
4. Health facilities are adequately refurbished, equipped, and supplied with necessary and adequate commodities and supported with strong supply chain systems (including innovative technology systems), adequate and competent health workforce to provide essential MNCAH and Emergency Obstetric and Newborn Care (EmONC) services;
5. Adequate resources are made available to support health systems in a sustainable way; AND
6. Quality Improvement mechanisms are in place for integrated life-course approaches to MNCAH services including improved supply chain management of essential MNCAH medicines and commodities

THEN Mothers, newborns and children will survive, thrive and transform from:

1. Improved availability and readiness of quality Maternal, Neonatal and Child Health Services including emergency obstetric and newborn care;
2. Increased utilisation of Maternal, Newborn and Child Health services;
3. Improved community awareness and demand for quality of care for Maternal, Newborn and Child Health services;
4. Quality Improvement teams in place for integrated life-course MNCH services including improved management of essential MNCH medicines and commodities;
5. Reduced barriers of the access for pregnant and post-partum women's and their newborns' visits to health facilities for MNH services including EmONC;
6. Reduced barriers of access for MNCH services and
7. Increased SBCC awareness programme at the community level in place

Ultimately the Goal of improved care seeking behaviour and reduction in mortalities and morbidities for mothers, newborns children and adolescents will be attained. *(Figure 12)*.

Figure 12: Theory of Change

CONTEXT

Main Challenges

- Lack of progress in NMR reduction
- Low availability of newborn care
- Delays and poor care seeking practices for mothers and sick children
- Low uptake of mothers/newborns received a postnatal visit within the first 2 days (MDHS, 2016).

Key National Policies and Strategies

- Policy guidance and coordination supported by the National Health Policy 2010
- Malawi Growth and Development Strategy (MGDS III)
- Health Sector Strategic Plan (III) 2021/2026.

BOTTLENECKS

Health Systems

- Low government budget allocation relative to needs. – not meeting the declaration that was signed
- Insufficient Health workforce
- Poor supply chain system for **essential drugs and supplies**

Facility Based Care

- Inadequate Health workforce, patient/ provider ratio is still high
- Inconsistent availability of essential drugs
- Inadequate essential equipment
- Inadequate Infrastructure

Community & Household

- Community-based newborn care not yet brought to scale
- Lack of integration of services
- Problems in drug management resulting in insufficient availability of essential drugs at primary healthcare (PHC)/Community level
- Concerns about Quality and Experiences of care
- Delays in care seeking practices for sick children and women
- Cultural Practices and Beliefs

PRIORITIES

O.1: Improved availability and readiness of quality neonatal child health services at community level.
O.2: Strengthened health facility-based perinatal care
O.3: Improved case management to ensure providers' ability to diagnose, treat and make appropriate referral of child health conditions.
O. 4: Strengthened the supply chain of essential commodities and equipment for child health

O.5: Reduced provider caseload at facility level through increase in capacity of community health care workers
O.6: Improved capacity of community health workers and infrastructure availability to support service provision
O.7: Strengthened nutrition promotion, counselling and assessment as part of child health services delivery.

O.8: Improved coordination, governance and multi-sectoral collaboration at all levels
O.9: Improved SBCC strategies for child health uptake of services
O.10: Strengthened evidence–based program management

OUTCOMES

Enhanced provision and Quality of Care for MNCH services

Reduced Barriers to utilization of MNCH

Improved Care Seeking Behaviour for mothers and sick children

IMPACT

Reduced under-five mortality from 63 to 30 deaths per 1000 live births and neonatal mortality from 27 to 15 deaths per 1000 live births by 2026.

Universal Health Package

ASSUMPTION

A1: The political will and technical capacity within MOH and Child Health Stakeholders to ensure continued collaboration
A2: Adequate resources and coordination among stakeholders to work together
A3: Other Health stakeholders will tackle bottlenecks not addressed by GOM.
A4. Donors and Development partners support capacity development and Child Health Service delivery.

RISK

- Major disasters and emergencies including Covid 19 Pandemic
- Competition for health workers from other employers leading to high levels of attrition rates at national, district and school level
- Inherent bureaucratic challenges may result in programme implementation delays

CHAPTER 6.0 INSTITUTIONAL ARRANGEMENT &ACCOUNTABILITY FRAMEWORK

6.1 Institutional Coordination

The Child Health Strategy will be interactive at all levels and will be implemented by various stakeholders from the community level to the MoH senior management team. To implement this framework, the backbone for implementation will be the Senior Management, the Child Health Unit, tertiary hospitals, district hospitals, health centres and the community. The Senior Management level will be responsible for overall decision making and high-level linkages with other key line ministries. The Management will be supported by the Directors and the steering committee who will be making recommendations as well as technical direction to the management and vice versa. TWG will also act on and advisory role to the SH and the Unit for better coordination on resource mobilisation and other technical support.

The Child Health Unit will house the strategy and will provide overall coordination in the implementation of the strategy. To fulfil this function, the Unit will work closely with the regulatory bodies, academic institutions and government statutory corporations and also Development Partners, NGOs, the UN family, Civil Society, etc.

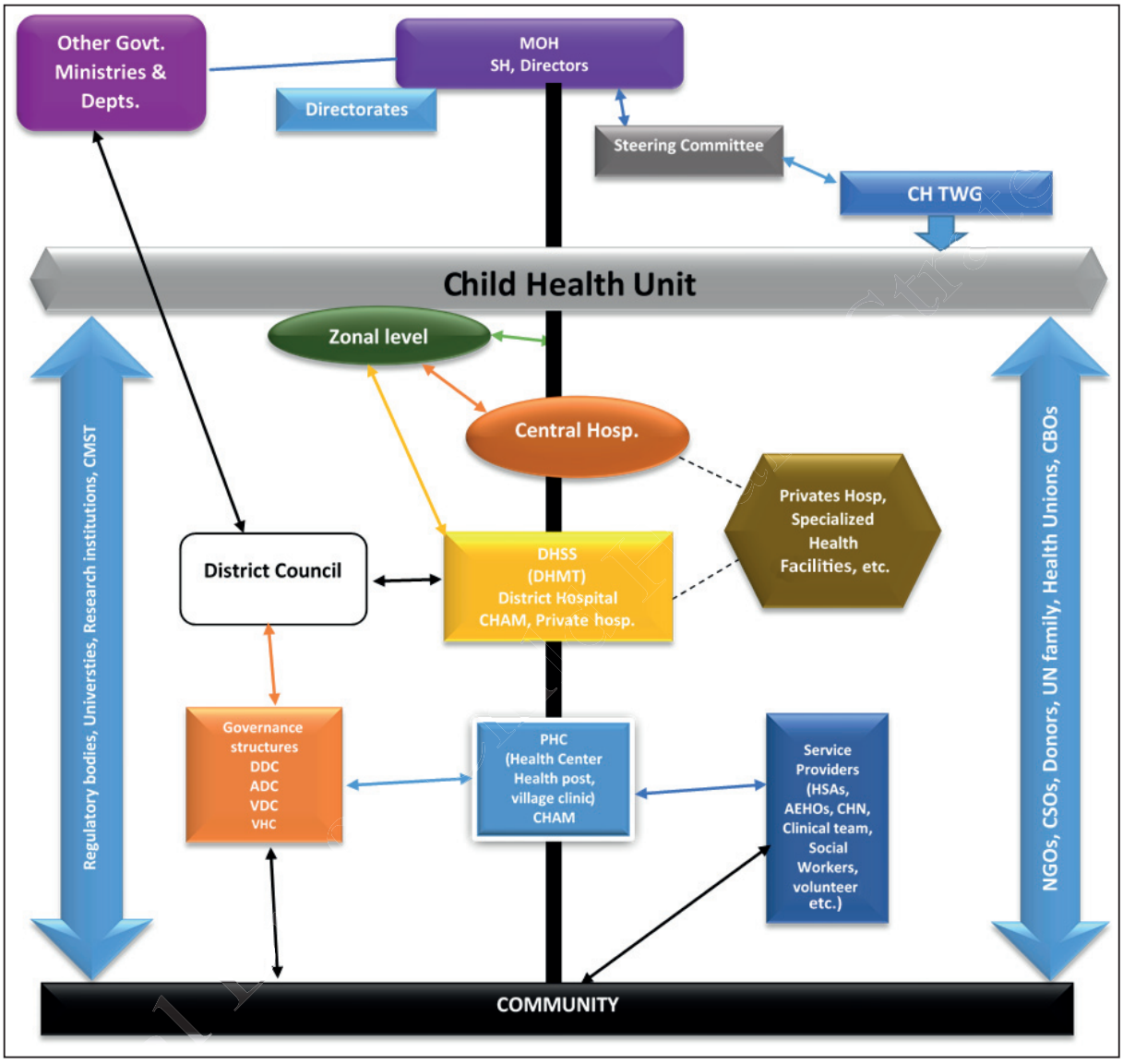
Tertiary hospitals will work directly with the district hospitals and closely coordinate with other specialist institutions, private hospitals and the partners coordinated through the Child Health Unit. While operating within the decentralised structure under the Ministry of Local Government.

District Hospitals will work directly with primary health facilities, CHAM and private hospitals and coordinate with partners through the Child Health Unit to implement the strategy. Primary health facilities will work directly with the community and the district hospitals while at the same time engaging with the governance structures and the partners as coordinated by the DHO and the Child Health Unit.

The Zonal Quality Management Offices will be critical to ensure that key policies and strategies are available and facilities are implementing in accordance too the policies and guidelines. The Zones will also be instrumental in providing supportive supervision, review of programmes at zonal level and providing feedback to both central level and district level stakeholders as required

At the community level, working within the Community Health Strategy as an overarching strategy, Community Health Workers including HSAs supported by the community structures and coordinating with partners through the DHSS and the Child Health Unit will do the implementation. The diagrammatic representation of the institutional framework is illustrated in Figure 13 below.

FIGURE 13: INSTITUTIONAL ARRANGEMENT AND ACCOUNTABILITY FRAMEWORK



6.2 Monitoring and Evaluation

This section defines the monitoring and evaluation (M&E) mechanism and structures that will be used in implementation of the Child Health Strategy. The complex nature of child health calls for harmonisation and integration of packages for monitoring so that the framework for monitoring and evaluation regularly allows for timely collection of data on maternal, newborn and child health; epidemiology, including morbidity; mortality and their causes; and programme performance indicators. The Child Health results framework outcome indicators and Output indicators and their targets are presented in Annex Tables 4 and Table 5 respectively.

6.2.1 Basis for Monitoring and Evaluation

Regular monitoring of a standard set of indicators on progress and outcome results remains necessary timely, accurate and comparable data at all levels, in order to understand the scale and outcomes of implementation; and how such information can be used for evidence-based decisions.

The purpose for this section is to guide in developing and strengthening the M&E system and inform how data and information will be gathered and used in monitoring and evaluating implementation of the Strategic Plan. Monitoring and evaluation will be done at three levels:

i). Community or local level monitoring to improve community case and supply chain services' management.
ii). Monitoring coverage of impact indicators to strengthen child health and overall health systems.
iii). Real time monitoring and national evaluation platform for implementation strength through DHIS2.

The plan institutes a mechanism for harmonising program data with DHIS2/HMIS and proposes a mechanism for monitoring at community, district and national levels.

Real-time monitoring is required to reinforce availability of essential commodities, accessibility, initial utilisation, continuous utilisation and effective coverage of the high-impact interventions for maternal, newborn, child health and NCDIs. This M&E has been developed to guide the collection, analysis, use and provision of information that enables tracking of progress made in child health, in order to make informed decisions, including mid-stream adjustments in strategies and resources use/mobilisation. The specific objectives for the Child Health M&E framework are:

iv). To strengthen M&E capacity of all levels and programmes involved in implementation and coordination of this strategic plan in timely and quality collection, analysis, utilisation and reporting, including dissemination of data on child survival.

v). To guide the development/strengthening of a national data base on neonatal, infant, child survival and accurate tracking of the same in a structured and coordinated flow of routinely collected data/information among players at all levels.

vi). To facilitate and enhance efficient and appropriate use of resources at all levels of implementation of the Strategic Plan, by tracking resource disbursements and utilisation at all levels to ensure results-oriented performance and best use of resources.

vii). To enhance the national, regional and international data collection and reporting requirements on child survival and health development (e.g. SDGs, Every Child Counts).

6.2.2 Mechanisms for M&E

Effective monitoring and evaluation is important in the strategy, to ensure progress towards achieving the SDGs by 2030 through increased coverage of identified high impact interventions. A set of high-priority indicators and operational targets is proposed that will be objectively measured and used for monitoring and evaluation purposes. This framework provides indicators to measure inputs, outputs, outcomes and impact of implementing the high-impact, low-cost interventions for child survival and health development. The inputs, processes and outputs will be assessed as part of performance M&E (using reports from sectors/departments and services statistics); while outcomes and impact will be assessed in terms of effectiveness M&E and by use of population level surveys such as DHS, and incidence studies.

Monitoring of the implementation of child health programmes will be done through:

- ***Monthly programme activity reports*** by departments, NGOs and sector organisations working on child health. The information will be collected using existing data capture tools and reporting mechanisms at each level.
- ***Quarterly programme reports*** by health facilities providing details on services provided and outputs of programmes specific to child survival. They will be collected using a routine system and processed through the DHIS2'Health Management Information System.
- ***Financial Management Report*** will be provided by implementers of the various programmes to assist in compiling reports on financial monitoring and to provide a link to programme activity reports.

To accelerate child health, the coverage of a selected set of high impact interventions will be monitored per locality at operational level through:

- Availability of essential commodities.
- Access to services, with special attention to vulnerable, marginalised or under-served populations.
- Initial and continued utilisation of services and defaulters tracing.
- Quality of service being provided.

Evaluation of the programme on child survival will be achieved through:

i. Malawi Demographic and Health Survey (DHS), population level surveys conducted by the Statistical office and other research instituted partners.
ii. Multiple Indicator Cluster Surveys (MICS), also to be done by the Statistical office.
iii. Malawi Malaria Indicator Survey (MMIS)
iv. Special surveys and studies to be conducted by implementers and other partners as operations research to address areas of interest in implementation of the Plan.

6.2.3 Structure for M&E

At the national level, there will be a central repository (database) located at the Child Health Secretariat linked to the HMIS. This will be linked to M&E subsystems in different Departments within the Ministry of Health, in child-focused units and organisations through routine reporting mechanisms. All partners involved in the implementation of the Strategic Plan shall report on progress in their specific areas within existing reporting lines and coordination frameworks created to oversee implementation of the Strategic Plan. Capacities for monitoring and evaluation will be strengthened at all levels.

The Technical Working Group for child health will work closely with the HMIS to:

i). Strengthen M&E functions for the Strategic Plan, with a particular focus on data collection at the community level through the village health register and at facility level.
ii). Develop an M&E implementation plan and an Operational Manual for the Strategic Plan, and ensure evidence-based planning with M&E information for district implementation plans and district development plans.
iii). Build capacities of the sub-systems.
iv). Mobilise resources to support the M&E functions.
v). Analyse and prepare appropriately packaged national M&E reports.
vi). Utilise the M&E and related research reports to guide decision making.
vii). Ensure quality control in M&E.

6.2.4 Role of partners

Partner institutions, development partners, CSOs and private sectors who are implementing, funding or coordinating child health interventions will report through relevant monitoring systems on their activities and outputs. They will:

- Monitor and evaluate their activities.
- Use, and where appropriate, build capacities of existing system for M&E.
- Utilise data collected for own decision making.
- Submit reports to the coordinating entity.

6.2.5 Coordination of M&E in a decentralised context

The basis for M&E at all levels is to use the data/information for programming, planning, resources mobilisation/allocation and advocacy.

Community Level

Some interventions will be implemented at the community level. Therefore, MoH and partners must collect data and use it to monitor trends in supply of inputs, routine activities and progress made to make regular adjustments in the programme. The HSAs will collect and collate data from services provided and use it for reporting, decision-making and priority setting.

District Level

Each District will receive reports from their TA, and will convene bi-annual District Joint Review Meetings to analyse district performance and progress in implementing the Strategic Plan with guidance from District Commissioner and led by DHSSs. Districts will submit their bi-annual joint review meeting reports to the national level.

National Level

At the national level, the Ministry of Health will convene review meetings of key national level partners and selected representatives from the District The steering committee shall convene to guide implementation. The purpose of these meetings is to identify early enough any problems in implementation and take appropriate and timely remedial actions, and to disseminate best practices to be adopted in areas that are not performing well. Annual Joint Review Meetings for all stakeholders in child health will be convened. These meetings will also act as a peer review forum for assessing progress in achieving targets set in child survival and development, as well as identifying barriers and making proposals for remedy.

The Technical Working Group on Child Health will develop a research agenda in collaboration with district health offices and training and research institutions, especially as they relate to coverage, quality, utilisation and compliance with the high impact interventions. The operations research agenda will be based on analysis of monitoring, supervision and evaluations, taking advantage of the district databanks, wherever they exist.

The Child Health Unit and partners will be supported to assess and document their experiences and use the lessons during re-planning and for advocacy purpose. The Child Health Unit shall prepare routine progress reports on a quarterly and bi-annual basis.

Each level may conduct:1) community-based participatory assessment and analysis; 2) population-based monitoring to assess progress and constraints; and 3) facility-based monitoring including use of Child Health audits. Support for action-oriented research will be important to fill any gap. There is a need to link effective coverage, quality of care and impact results to achievement of national targets, SDGs and other reporting obligations for accountability at all levels.

CHAPTER 7.0 COSTING AND FINANCING

7.1 Costing

The national child health strategy was costed based on the activities outlined within each strategic objectives and was guided by the Planning and Policy Development Directorate. Major costs have been estimated using the CHAI costing tool. Some of the costing line items were identified using the 2021 ICCM gap analysis. Recognizing that different programmes contribute to child health outcomes, costing was done in such a manner that duplication was avoided. In this regard, the cost for each strategic objective was split between what is considered direct child health program support and those that are contributed by other related departments and partners. The total strategy is costed at MK163,678,667,848.

7.2 Financing

This strategy will be financed by government, donor agencies and development partners. These resources will be managed prudently using recognized accountability and transparency mechanisms by both government and agencies. Table 8, below summarizes costs under each of the ten strategic objectives. The total cost for five years is MWK163,678,667,848 distributed as follows: Year 1 is MWK27,332,299,279; Year 2 is MWK 44,320,020,775 Year 3 is MWK15,860,226,342; Year 4 is MWK 16,500,067,420 and Year 5 is MWK59,666,054,030. For detailed costs by activity refer to Annex 6.

Table 8: Summary Cost by Strategic Objective (MWK).

No	Strategic objective	Direct Child Health support	Other Departments and Partner Support	Total
1	Improve availability and readiness of quality neonatal and child health services at community level	2,547,366,223	5,943,854,521	8,491,220,744
2	Reduce provider workload at health facilities through increased capacity of health care workers	1,006,363,365	2,348,181,185	3,354,544,550
3	Improve capacity of community health workers and availability of infrastructure to support service provision for adequate and appropriate delivery of basic health services.	3,093,091,183	7,217,212,760	10,310,303,944
4	Strengthen health facility-based perinatal care	1,866,526,213	103,127,994,727	104,994,520,940
5	Improve risk assessment in case management to ensure providers' ability to diagnose, treat and make appropriate referral of child health conditions	2,759,759,100	6,439,437,899	9,199,196,998
6	Strengthen nutrition promotion, counselling and assessment as part of child health services delivery	1,122,358,105	2,618,835,579	3,741,193,685
7	Improve coordination, governance and management of partnerships and multi-sectoral approaches including nutrition, early stimulation and adolescent health	1,795,203,081	4,188,807,189	5,984,010,269
8	Improve health promotion and SBCC strategies for child health uptake of services	171,822,820	400,919,914	572,742,734
9	Strengthen the supply chain of essential commodities and equipment for child health	112,419,604	9,398,743,932	9,511,163,536
10	Strengthen evidence–based program management	2,210,145,815	5,309,624,633	7,519,770,448
	Grand Total	**16,685,055,509**	**146,993,612,338**	**163,678,667,848**

CHAPTER 8.0 CONCLUSION

In conclusion, the Child Health Strategy redesign seeks to further consolidate the gains that the country has registered in child health and be inclusive to ensure that no one is left behind. This inclusiveness will be achieved through deliberate efforts that have included 6–18-year-olds for specific interventions within the lifecycle approach.

To achieve this ambitious goal, there is need for strengthened cooperation, coordination, coherence in implementation, and managed partnership that respects accountability to the common goal of improving child health and clearly defined roles and responsibilities.

In this regard, the successful implementation and attainment of the desired goal of this strategy will require commitment and leadership from the Ministry of Health and other relevant ministries, strong health systems, and donor and development partners' support, among other areas.

9.0 ANNEXES

ANNEX 1: MATERNAL AND CHILD HEALTH INTERVENTIONS

	Pre-conception and pregnancy	Labor and delivery	Postnatal and neonatal period	Post-neonatal and early childhood (1-59 months)
Referral Hospitals	• Provision of post abortion care	• Antibiotics for preterm prelabour rupture of membranes • Corticosteroids to prevent respiratory distress syndrome in newborns • Induction of labour to manage prelabour rupture of membranes at term • Skilled obstetric care and immediate newborn care and resuscitation • Preventing Parent to Child Transmission (PPTCT) of HIV • Postpartum sterilization • Prophylactic uterotonics to prevent postpartum hemorrhage • Manage postpartum hemorrhage using uterine massage and uterotonics • Magnesium sulphate for eclampsia • Active management of third stage of labour to prevent postpartum hemorrhage • Caesarean section for maternal/fetal indication • Prophylactic antibiotics for caesarean section • Neonatal resuscitation	• Essential newborn care • Care of sick newborn • Initiation of early breastfeeding • Exclusive breastfeeding • Hygienic cord and skin care and mask (by professional health workers for babies who do not breathe at birth) • Kangaroo mother care for preterm and low-birth-weight babies • Extra support for feeding small and preterm babies • Management of newborns with jaundice ("yellow" newborns) • Initiate prophylactic antiretroviral therapy for babies exposed to HIV • Presumptive antibiotic therapy for newborns at risk of bacterial infection • Use of surfactant (respiratory medication) to prevent respiratory distress syndrome in preterm babies • Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome • Case management of neonatal sepsis, meningitis and pneumonia • Family planning • Prevent and treat maternal anemia • Detect and manage postpartum sepsis	• Emergency triage Assessment and treatment • Pediatric Hospital Initiative • Screening for malnutrition at every contact with a child • Care of children with severe acute malnutrition • Vitamin A supplementation for 6-59 month olds • Routine immunization (including *Hib*, PCV and rotavirus vaccines) • Management of severe and complicated malaria • Case management of severe pneumonia • Case management of diarrhea including dysentery and persistent diarrhea • Diagnosis and management of common childhood illness • Provision of rehabilitative services for children with disability

	Pre-conception and pregnancy	Labor and delivery	Postnatal and neonatal period	Post-neonatal and early childhood (1-59 months)
Primary level facilities	• Management of unintended pregnancy • Availability and provision of safe abortion care when indicated • Provision of post abortion care • ***Appropriate antenatal care package:*** - Screening for anemia - Screening for maternal illnesses - Screening for hypertensive disorders of pregnancy - Iron and folic acid to prevent maternal anemia - Intermittent Preventive treatment for malaria - Counseling on family planning, birth and emergency preparedness - Smoking cessation - Tetanus vaccination - Prevention and management of sexually transmitted infections and HIV, including with antiretroviral medicines	• Antibiotics for preterm prelabour rupture of membranes • Corticosteroids to prevent respiratory distress syndrome in newborns • Induction of labour to manage prelabour rupture of membranes at term • Skilled obstetric care and immediate newborn care and resuscitation • Preventing Parent to Child Transmission (PPTCT) of HIV • Postpartum sterilization • Prophylactic uterotonics to prevent postpartum hemorrhage • Manage postpartum hemorrhage using uterine massage and uterotonics • Magnesium sulphate for eclampsia • Active management of third stage of labour to prevent postpartum hemorrhage • Neonatal resuscitation	• Essential newborn ca-re • Care of sick newborn • Immediate thermal care • Initiation of early breastfeeding • Exclusive breastfeeding • Hygienic cord and skin care and mask (by professional health workers for babies who do not breathe at birth) • Kangaroo mother care for preterm and low-birth-weight babies • Extra support for feeding small and preterm babies • Initiate prophylactic antiretroviral therapy for babies exposed to HIV • Presumptive antibiotic therapy for newborns at risk of bacterial infection • Family planning • Prevent and treat maternal anemia	• Facility-based care of childhood illnesses (IMCI) • Emergency triage Assessment and treatment • Pediatric Hospital Initiative • Care of children with severe acute malnutrition • Exclusive breastfeeding for 6 months • Continued breastfeeding and complementary feeding from 6 months • Vitamin A supplementation for 6-59 month olds • Routine Immunisation (including *Hib*, PCV and rotavirus vaccines) • Case management of uncomplicated malaria and severe malaria • Case management of uncomplicated pneumonia • Case management of simple diarrhea • Diagnosis and management of common childhood illness
Family and Community	• Interventions to delay first pregnancy and promote birth spacing • Antenatal home visits by CHWs • Iron and folic acid supplementation (pre-pregnancy) • Prevention of malaria with insecticide treated nets	• Social support during childbirth • Prophylactic uterotonics to prevent postpartum hemorrhage • Misoprostol to prevent hemorrhage	• Postnatal home visits by CHWs (Day 1, 3 and 7) • Immediate thermal care • Initiation of early breastfeeding • Exclusive breastfeeding • Hygienic cord and skin care • Kangaroo mother care for preterm and low-birth-weight babies • Case management of neonatal sepsis	• Routine immunisation (including *Hib*, PCV and rotavirus vaccines) • Prevention malaria using insecticide treated bed nets • Case management of uncomplicated malaria • Pre-referral treatment of suspected severe malaria • Case management of uncomplicated pneumonia

	Pre-conception and pregnancy	Labor and delivery	Postnatal and neonatal period	Post-neonatal and early childhood (1-59 months)
	• Counseling on family planning, birth and emergency preparedness • Prevention, detection and treatment of communicable and non-communicable disease and sexually transmitted and reproductive tract infections including HIV, TB and syphilis • Prevention of and response to sexual and other forms of gender-based violence • Pre-pregnancy detection and management of risk factors (nutrition, drugs, tobacco, alcohol, mental health, environmental toxins)		• Family planning • Prevent and treat maternal anemia • Detect and manage postpartum sepsis	• Case management of simple diarrhea • Screening and referral of children with severe acute malnutrition • Exclusive breastfeeding for 6 months • Continued breastfeeding and • complementary feeding from 6 months • Vitamin A supplementation for 6-59 month olds

ANNEX 2: SUMMARY OF MATERNAL, NEO-NATAL, CHILD HEALTH, NUTRITION, AND ADOLESCENT HEALTH COVERAGE INDICATORS

	2016/2017	2017/2018	2018/2019	2019/2020
Antenatal Services				
Total ANC clients registered	606360	676179	651919	663065
Focused Antenatal care (4 visits)	162138	168450	175270	191522
Antenatal visits in first trimester 12 weeks	78345	90606	82069	93838
Labor and Delivery				
Total deliveries	511746	551911	541901	557666
Number of functional EmONC facilities				
Live births	496172	535971	525953	538539
Pre-term births	17243	17230	16169	22670
Newborns with weight below 2.5kg (low	25132	37213	28770	34540
Fresh Still births	32	132	235	183
Macerated still births	44	238	200	204
Maternal				
Maternal deaths (Total)	519	397	355	392
Nursery/ Sick Newborn Care Units				
Number of neonates admitted	-	-	-	22670
Causes of admission				
Sepsis	-	-	-	1725
Asphyxia	20894	21821	24251	27416
Prematurity	17243	17230	16169	22670
Other	-	-	-	1640
RDS	-	-	-	131
Pneumonia	-	-	-	4770
Neonatal Deaths (Total)				
By Causes of death				
Sepsis	-	-	-	98
Asphyxia	*1466*	1736	2394	2328
Prematurity	-	-	-	273
RDS	-	-	-	131
Pneumonia	-	-	-	23
Other including congenital	-	-	-	-
# of fully immunized children under one	459603	565011	575222	568193
Antibiotic treatment for pneumonia (# of children aged 0–59 months with suspected	510922			

ANNEX 3: M&E RESULTS FRAMEWORK -SELECTED OUTCOME INDICATORS

Goal: To reduce under-five mortality from 63 to 30 deaths per 1000 live births and neonatal mortality from 27 to 15 deaths per 1000 live births by 2026. This goal will contribute to achieving a reduction in childhood morbidity and mortality in line with SDG targets for 2030.

Indicator Category	Indicator definition	Baseline Value	Reference Year	CHS Target (2026/27)	SDG 2030 Target	Data Source
Mortality	Maternal mortality rate (deaths per 100,00 live births)	439	2016	94	70	DHS 2021/22, 2026/27
	Under-five mortality rate (deaths per 1,000 live births)	56	2016	26	25	DHS 2021/22, 2026/27
	Infant mortality rate (deaths per 1,000 live births)	63	2016	30	25	DHS 2021/22, 2026/27
	Neonatal mortality rate(deaths per 1,000 live births)	27	2019	15	12	DHS
	Overall child mortality rate(deaths per 1,000 births)	63	2016	30	25	DHS 2021/22, 2026/27
Maternal Health	Antenatal care (ANC) first trimester (0-12wks)	9.5%	2019	36.5%	100%	MOH/RHD/DHIS2
	ANC Coverage (4+Visit)	27.3%	2019	45%	100%	MOH/RHD/DHIS2
	Facility Based Deliveries	91%	2016	100%	100%	MOH/RHD/DHIS2
	Skilled Birth Attendants (SBA)	90%	2016	100%	100%	MOH/RHD/DHIS2
	Postnatal Care (PNC) Mother within 48 hours	42%	2016	80%	80%	MOH/RHD/DHIS2
	Postnatal Care (PNC) Newborn within 48 hours	60%	2016	80%	80%	MOH/RHD/DHIS2
	Provide folic acid to pre-pregnant women	90%	2020	100%	100%	DHIS2/RHD
	Provide pregnancy testing and counselling	92%	2019	100%	100%	MOH/RHD
	Number of facilities with EmONC services (per 500,000) (Basic)	31	2020	141	141	MOH/EmONC Report
	Number of facilities with EmONC services (per 500,000) (Compressive)	46	2020	37	37	
	Number of facilities with EmONC services (per 500,000) (Basic + Compressive)	77	2020	184	184	MOH/EmONC Report
Child Health	Percent of children under 5 years with symptoms of pneumonia taken to appropriate health provider	78%	2016	100%	100%	DHS
	Percent of children under 5 years with diarrhoea treated ORS	65%	2016	100%	100%	DHS
	Percent of children under 5 years with diarrhoea treated ORS +Zinc	34%	2016	100%	100%	DHS
Malaria	Malaria diagnostics in children under-five	52%	2016	100%	100%	DHS/Malaria Program

Goal: To reduce under-five mortality from 63 to 30 deaths per 1000 live births and neonatal mortality from 27 to 15 deaths per 1000 live births by 2026. This goal will contribute to achieving a reduction in childhood morbidity and mortality in line with SDG targets for 2030.

Indicator Category	Indicator definition	Baseline Value	Reference Year	CHS Target (2026/27)	SDG 2030 Target	Data Source
	Malaria prevention in children under-five -sleeping under ITNs	43%	2016	100%	100%	DHS/Malaria Program
	ITN coverage	24%	2016	70%	100%	DHS/Malaria Program
	IRS coverage	5%	2016	37%	70%	DHS/Malaria Program
	Malaria diagnosis (RDT)	10021825	2019	5010913	n/a	DHIS2
	Malaria treatment 25m-59m	3072024	2019	1536012	n/a	DHIS2
Immunisation	Measles immunization coverage	92%	2019	95%	100%	EPI/DHIS2
	DPT3 immunization coverage	90%	2019	100%	100%	EPI/DHIS2
	Hib3 immunization coverage	90%	2019	100%	100%	EPI/DHSI2
	Rota Virus	92%	2019	100%	100%	EPI/DHSI2
	Penta 1 coverage	97 %	2019	100%	100%	EPI
	Penta 3 coverage	95%	2019	100%	100%	EPI
	Measles Rubella	75%	2019	100%	100%	EPI/DHS2
	Vitamin A coverage	9.2%	2019	100%	100%	DHIS2
	Pneumococcus Immunization	100%	2019	100%	100%	EPI/DHIS2
	Polio Immunization	90%	2019	100%	100%	EPI/DHIS2
	BCG Vaccine	91%	2019	100%	100%	EPI
Nutrition	Under-weight prevalence	12%	2016	7%	0	DHIS2
	Stunting	37%	2016	22%	0	DHS
	wasting	3%	2016	1%	0	DHS
	Low-birth weight	13.5%	2016	2.5%	0	DHS
	Exclusive breast feeding under 6 months	61%	2016	100%	100%	DHS
	Prevalence of anemia in women aged 15-49	34%	2016	25%	0	DHS
	CMAM prevalence rate	37%	2016	20%	0	DHS
	Percentage of children born with Low birth weight (LWB) babies	13.0	2016	9%	0	DHS
	Percentage women of reproductive age 15–49 years who are undernourished (thin BMI <18.5cms)	9.0	2016	5%	0	DHS
WASH	% of Population with access to safe drinking water	88%	2020	100%	100%	IHS
	% of Households with improved latrine	37.5 %	2020	100%	100%	IHS
	% of Households Practicing ODF	11%	2018	54%	100%	Census
	% of population with handwashing with soap	10%	2018	50%	100%	Census
	% of children 0-5 enrolled in ECD/ preschool	83%	2020	100%	100%	Ministry of Gender

Goal: To reduce under-five mortality from 63 to 30 deaths per 1000 live births and neonatal mortality from 27 to 15 deaths per 1000 live births by 2026. This goal will contribute to achieving a reduction in childhood morbidity and mortality in line with SDG targets for 2030.

Indicator Category	Indicator definition	Baseline Value	Reference Year	CHS Target (2026/27)	SDG 2030 Target	Data Source
Early Childhood Development (ECD) and Child Protection	% of children with birth registrations	6.4	2018	100	TBA	NRB
Youths and Adolescents	Proportion of women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months	42.2	2016	0	0	DHS
	Physical Violence	34.0	2016	25.9	25.9	DHS
	Sexual Violence	20.6	2016	19.2	19.2	DHS
	Emotional Violence	29.5	2016	29.5	29.5	DHS
	Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months	28.2	2016	0	0	DHS
	Proportion of women aged 15–24 years who were married or in a union before age 15	12.5	2016	0	0	DHS
	Proportion of women aged 15–24 years who were married or in a union before age 18	42.1	2016	0	0	DHS
	Percentage of women aged 15-19 who have given birth or are pregnant with their first child (teenage child bearing/ pregnancies)	29	2016	0	0	DHS

ANNEX 4: ANNUAL IMPLEMENTATION PLAN AND TARGETS

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
1.1 Conduct home visits by Community health workers (HSAs and Community Health nurses and community midwife assistants) to assess and counsel on nutrition and growth monitoring, WASH, do postnatal checks and make appropriate referrals.	Proportion of monthly designated integrated outreach clinics conducted	45%	50%	55%	60%	65%	IMCI report
	Proportion of first home visits to mothers/newborns within 3 days of delivery conducted by Community health workers (SOURCE - HSA register/village health register)	30%	35%	40%	45%	50%	IMCI report
	Proportion of newborns with one or more danger signs referred to health facility (CMNBC register)	40%	45%	50%	55%	60%	IMCI report
1.2 Conduct outreach clinic activities for immunization, growth monitoring, ANC, PNC and FP	Proportion of monthly integrated outreach clinic conducted	50%	55%	60%	65%	70%	IMCI report
1.3 Establish Village clinics for management of sick children at Community level to improve supply and demand for health services	Number of village clinics established and functional	3,631	3,813	4,003	4,203	4,413	IMCI report
1.4 Train, mentor and supervise Village Clinic Health committees	Proportion of village clinic Health committees trained, monitoring drugs and supplies meeting regularly (monthly)	65%	70%	75%	80%	85%	IMCI report
1.5 Support periodic mentorship and supportive supervision of HSAs and Community Health Nurses and CMAs and other community volunteers that provide services at Community level	Number of iCCM providers (Community health workers) who have been supervised quarterly	1,614	1,695	1,780	1,868	2,060	IMCI report
1.6 Empower the Committees to monitor medicines and supplies for VHCs	Proportion of committees trained to monitor commodities at Village Clinics	0	10%	20%	30%	40%	CHS

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
1.7 Support the introduction and establishment of Enhanced management of pneumonia in the Community (EMPIC)	Proportion of Districts implementing EMPIC Proportion of HSAs trained on EMPIC	0	10%	20%	30%	40%	IMCI Report
1.8 Support the introduction and establishment of ICCM for older Children 5 to 10 years old	Proportion of Districts implementing ICCM for older Children Proportion of HSAs trained on ICCM for older Children	0	10%	20%	30%	40%	IMCI Report
1.9 Support the establishment and training of HSAs on Childhood TB/HIV, Child protection and abuse as part of ICCM	Proportion of Districts implementing ICCM on Childhood TB/HIV Child protection and abuse Proportion of HSAs trained on Childhood TB/HIV, Child protection and abuse as part of ICCM	10%	20%	30%	40%	50%	IMCI Report
1.10 Support training of ICCM HSAs on CBMNC	Proportion of HSAs trained on ICCM plus CMBNC	20%	30%	40%	50%	60%	RHD Report
2.1 Establish TWG workforce for MNCAH	National workforce account in place for Community nurses, Community Midwifery assistants and HSAs	0%	10%	20%	30%	40%	HRH Strategy
2.2 Assess hard to reach areas to determine 5km radius for establishing village clinics	Proportion of hard to reach areas assessed for establishment of village clinics	50%	60%	68%	75%	80%	IMCI DHIS report
2.3 Draw a redistribution plan to ensure Community nurses, Community Midwifery assistants and HSAs are well distributed in the country	Redistribution plan in place	0	1	1	1	1	HRH Strategy

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
2.4 Lobby for recruitment and deployment of Community nurses, Community Midwifery assistants and HSAs according to redistribution plan	Proportion of Community nurses, Community Midwifery assistants and HSAs recruited and deployed	10%	30%	40%	50%	60%	Community Health Strategy
2.5 Support training of at least 2 staff per health facility in Integrated Management of Newborn and Childhood Illnesses (IMNCI) and iCCM + CMAM and nurturing care for ECD, EOC, ETAT	Proportion of health facilities with that least 2 health workers trained in IMNCI,	22%	30%	50%	64%	75%	IMCI report
	Proportion of health facilities with at least 2 health workers trained in ICCM + CMAM, EOC, ETAT	0	20%	40%	50%	60%	IMCI report
2.6 Build capacity of Community health workers in case management, data entry and record keeping	Proportion of community health workers trained in case management, data entry and record keeping	50%	60%	68%	75%	80%	IMCI report
2.7 Build capacity of HSAs in ICCM for Older Children	Proportion of ICCM HSAs trained in case management for ICCM	0	10%	20%	30%	40%	50%
2.6 Build capacity of medical and nursing lecturers as trainers of trainers in maternal, newborn and child care, including IMCI in order to improve in-service and pre-service training	Proportion of medical and nursing lecturers trained as trainers in maternal, newborn and child care, including IMNCI	10%	20%	32%	40%	50%	IMCI report
3.1 Support training of facility level workers in IMNCI with emphasis on-job mentoring and coaching for immediate application and quick gains	Proportion of facility level workers trained in IMNCI	0	20	40	60	80	IMCI Report
3.2 Strengthen facility readiness for provision of quality of health care through availability of appropriate infrastructure, WASH facilities, equipment and furniture.	Proportion of facilities with appropriate infrastructure, WASH facilities, equipment and furniture to provide quality health care	20%	40	50	65	75	IMCI Report
3.3 Maintain and rehabilitate the already existing infrastructures	Proportion of existing infrastructures maintained and rehabilitated	N/A					

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
3.4 Support the construction of health care facilities for provision of basic health care services.	Number of health care facilities constructed to provide basic health care services	N/A					
3.5 Facilitate construction of infrastructure at community level to reduce radius access distance for 5km or below in communities	Number of infrastructure constructed at community level	N/A					
3.6 Conduct pre-service and in-service training that focuses on mentoring, supportive supervision and monitoring the quality-of-service delivery for child health.	Number of pre-service and in-service trainings conducted on mentorship, supportive supervision and monitoring the quality-of-service delivery for child health	17	34	51	60	70	IMCI Report
3.7 Support iCCM + CMAM trainings for HSAs	Number of iCCM + CMAM trainings conducted for HSAs	0	2000	2160	3600	4160	IMCI Report
3.8 Support refresher training for facility and community health workers	Number of refresher trainings conducted for facility and community health workers	2	2	2	2	2	IMCI Report
3.9 Support mentorship and review meetings	Number of review meetings to discuss performance improvement	2	4	4	4	4	IMCI Report
3.10 Support conduct of quarterly supervision at national and district level	Number of supervisory visits to districts Number of service providers supervised for performance improvement	2	4	4	4	4	IMCI Report
3.11 Support with fuel to support SHSAs to conduct district level ICCM supervision	Proportion of Districts supported with fuel to support supervision	0	20%	30%	40%	50%	IMCI Report
3.12 Support procurement of Motorbikes for SHSAs to supervise hardest to reach areas	Proportion of Districts whose SHSAs have motorbikes to supervise hardest to reach clinics	0	20%	30%	40%	50%	IMCI Report
4.1. Equip health facilities properly with trained staff in EmONC skills	Proportion of health facilities with at least two providers trained in EmONC	64%	70%	75%	80%	85%	SRH Strategy

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
4.2. Strengthen use of obstetric guidelines and protocols in management of complications.	Proportion of health facilities with updated obstetric guidelines and protocols for management of obstetric complications	60%	65%	70%	75%	80%	SRH Strategy
4.3. Increase the availability of equipment and supplies	Proportion of health facilities that are providing all EmONC signal functions	66%	70%	75%	80%	85%	SRH Strategy
4.4 Conducted induction system for the newly recruited staff	Proportion of newly recruited staff oriented on EmONC	60%	65%	70%	75%	80%	SRH Strategy
4.5. Increase the availability of obstetric drugs	Proportion of EmONC sites with essential obstetric medicines	50%	55%	60%	65%	70%	SRH Strategy
4.6. Institutionalise mentorship program at facility level to support health facilities	Proportion of health providers mentored in MNCH at a facility level in a quarter	30%	35%	40%	45%	50%	SRH Strategy
4.7. Develop preventive maintenance program for essential equipment	Proportion of health facilities with active preventive maintenance program for essential equipment in place	15%	20%	25%	30%	35%	SRH Strategy
4.8. Strengthen quality of antenatal care interventions through eight ANC contacts	Proportion of women receiving attending 4+ ANC visits	50%	55%	60%	65%	70%	SRH Strategy
4.9. Institutionalize postnatal care within 48 hours for mothers	Proportion of mothers with postnatal care checks within 48 hours	43%	48%	53%	58%	63%	SRH Strategy
4.10. Institutionalize postnatal care within 48 hours for newborns	Proportion of newborns with postnatal care checks within 48 hours	60%	65%	70%	75%	80%	SRH Strategy
4.11 Provide resuscitation for all sick babies	Proportion of Babies born in health facilities with birth asphyxia received resuscitation	70%	75%	80%	85%	90%	SRH Strategy
	Proportion of skilled birth attendant trained COIN	40%	45%	50%	55%	60%	SRH Strategy
4.12 Improve outcomes for small and sick new born	Proportion of Newborn with low birth weight / Prematurity managed With KMC at facility	60%	65%	70%	75%	80%	SRH Strategy
	Proportion of district hospitals with functional special care newborn units	93%	100%	100%	100%	100%	SRH Strategy

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
	Proportion of women with preterm labour (< 34 weeks gestation) receiving at least one dose of antenatal corticosteroids	45%	50%	55%	60%	65%	SRH Strategy
4.13 Institutionalise perinatal deaths audits in all district hospitals	Proportion of district hospitals conducting perinatal death audits	0%	10%	15%	20%	25%	SRH Strategy
4.14 Support HSAs training to provide Follow up of PSBI cases and Postnatal children	Proportion of of Districts implementing follow up of PSBI cases Proportion of of HSAs trained to follow up PSBI cases	10%	20%	30%	40%	50%	IMCI Report
4.15 Support documentation and reporting of PSBI cases at PHC levels	Proportion of of Districts reporting PSBI cases	10%	20%	30%	40%	50%	IMCI Report
5.1. Strengthen IMNCI, NCDIs and train service providers to improve risk assessment, classification and treatment of conditions while adhering to guidelines	Proportion of health care providers trained in IMNCI and NCDIs risk assessment	30%	50%	60%	70%	80%	IMCI report
5.2. Strengthen ETAT	Proportion of facility-based health care providers trained in ETAT	30%	50%	60%	70%	80%	ARI program report
5.3 Support the training of Health workers from Private clinics in IMNCI	Proportion of Health Workers from Private Clinics trained in IMNCI	10%	20%	30%	40%	80%	IMCI report
5.4 Support pre-service training in Health Training Institutions	Proportion of Health Training Institutions teaching IMNCI in Curriculum	10%	20%	30%	40%	80%	IMCI report
5.5 Equip PHCs for strengthened ETAT management	Proportion of facilities with equipment for ETAT implementation	20%	30%	40%	50%	80%	ARI program report
	Proportion of HIV infected children on ART	78%	80%	85%	90%	95%	HIV UNIT

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
5.6. Strengthen care and management of HIV-exposed infant and HIV positive child and adolescents	Proportion of HIV infected adolescents on ART	73%	80%	85%	90%	95%	HIV UNIT
5.5. Strengthen diagnosis, and management of NCDs in children and adolescents	Percentage of children in active care for NCDIs (0-18 years)	0	10%	25%	35%	50%	NCD Unit
	Guidelines and training package for management of NCDIs in children developed	0	1	0	0	0	NCD Unit
	Number of health workers trained in diagnosis and management of NCDIs in children	0	60	120	180	240	NCD Unit
	Number of district hospitals providing Package of Essential Noncommunicable Disease Intervention (PEN-Plus) service for NCDIs in children	2	7	16	22	29	NCD Unit
	Number of hospitals reporting disaggregated data for children with NCDIs	0	14	19	23	29	NCD Unit
	Number of hospitals with diagnostic services and treatment for NCDIs in children	TBD	14	19	23	29	NCD Unit
5.6. Intensify supportive supervision and monitoring of the quality-of-service delivery for child health at all levels.	Proportion of of health facility reporting to have received quarterly supportive supervisions visits	30%	50%	60%	70%	75%	QMD
	Proportion of of health facility using the iSS tool	40%	55%	65%	70%	75%	QMD
5.7. Improve quality of care through supervision of child health related interventions	Proportion of of health facilities that have functional work improvement teams (WITs)	10%	30%	45%	60%	70%	QMD
	Proportion of of districts with functional quality improvement teams (QISTs)	50%	60%	70%	75%	80%	QMD
5.8.Promote availability of diagnostic equipment and essential medicines for children and adolescent conditions	Proportion of of health facilities with standard functional diagnostic equipment	15%	30%	45%	60%	70%	HTSS

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
	Proportion of of health facilities with adequate stocks of essential medicines for children and adolescent conditions	30%	50%	60%	70%	80%	LMIS report
5.9. Strengthen mapping of households with pregnant women, newborns and under-five children using the village health register.	Proportion of of HSAs with updated information on pregnant women, newborns and under-five children	15%	30%	40%	50%	60%	SRH Strategy
5.10 Support the conduct of death audits	Proportion of Districts conducting Death audits Proportion of death audit sessions per district	20%	30%	40%	50%	60%	SRH Strategy
5.11 Support the conduct of case management review meetings	Number of Districts conducting Quarterly review meetings Number of quarterly review meeting conducted	0	4	4	4	4	QMD SRH Strategy
Output 6: Strengthened nutrition promotion, counselling and assessment as part of child health services delivery.							
6.1. Promote optimal maternal nutrition during pregnancy and lactation	Number of HSA trained/oriented in management of malnutrition (iCCM+CMAM)	850	935	1,029	1,232	1,245	Community Health Report
	Number of Health Workers trained/oriented in management of malnutrition (IMNCI+ CMAM)	300	330	363	399	440	DHNA
	Number of health workers trained in Care for child development	N/A					
6.2. Conduct supportive supervision, monitoring, mentorship and collaborative learning sessions to improve malnutrition management.	Number of HSA supervised and mentored in management of malnutrition (iCCM+CMAM) last 3 months supervised and mentored.	2,080	2,288	2,517	2,769	3,046	Nutrition Unit IMCI Report

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
	Number of Health facilities supervised and mentored in management of malnutrition (IMNCI+ CMAM last 3 months	312	624	624	624	624	Nutrition Unit IMCI Report
6.3. Promote age-appropriate infant and young child feeding practices and growth monittoring	Number of households reached with counselling on IYCF practices	250,000	500,000	500,000	500,000	500,000	Nutrition Unit
6.4 Provide standard supplies/equipment necessary for the assessment and management of malnutrition.	# of facilities conducting routine MUAC check-up for under-five children.	624	624	624	624	624	Nutrition Unit
	# of under-five children who have their MUAC recorded for every visit	557,000	568,140	579,503	591,093	602,915	Nutrition Unit
6.5 Strengthen growth monitoring and case management of moderate and severe acute malnutrition among under-five children	Number of health worker trained in management of moderate and severe acute malnutrition (MAM and SAM)	1,320	1,320	1,320	1,320	1,320	Nutrition Unit
6.6 Support integration of CMAM into broader iCCM services at community level	Number of village clinics providing iCCM+CMAM	2,080	2,280	2,517	2,769	3,046	Nutrition Unit IMCI Report
6.7 Provide micronutrient supplements, deworming tablets and dietary counselling.	Number of health facilities with adequate stocks of micronutrient supplements, deworming tablets	624	624	624	624	624	Nutrition Unit IMCI Report
	# of school aged children reached with Vitamin A and iron supplementation	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	Nutrition Unit
6.8 Strengthen community mobilisation targeting influential community leaders and family members (grandparents, aunts, men) to promote exclusive breastfeeding.	Number of EBF community mobilization sessions conducted	50,000	50,000	50,000	50,000	50,000	Nutrition Unit
6.9 Conduct nutrition education and counselling for adolescent girls and women	# of adolescent girls and women reached	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	Nutrition Unit
Output 7: Improved coordination, governance and multi-sectoral collaboration at all levels							
7.1 Conduct partner mapping for child health services and coordination structures	Number of partners implementing child health services	n/a					

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
7.2 Strengthen compliance of private health facilities with norms, standards and practices of management of childhood illnesses	Number of compliant private health facilities out of the total number supervised in the last three months.	n/a					
7.3 Build capacity of health care governance structures e.g. Health Centre Management Committee (HCMC) drugs committees, CHAG, VHCs.	Number of functional Health Centre Management Committee (HCMC) ,drugs committees, CHAG, VHCs trained	624	624	624	624	624	DPPD
7.4 Facilitate integration of IMNCI, ICCM with DNCCs, CBCCs for early child stimulation	Number of district coordination meetings conducted in the previous quarter	28	28	28	28	28	CHS
7.5 Strengthen referrals at PHC level such as Village clinic	Number of health facilities supervised last 3 months	624	624	624	624	624	IMCI
7.6 Support review of ICCM road map	Road Map Developed	1	1	1	1	1	IMCI
7.7 Strengthen maternal, neonatal, child case reviews (deaths and near misses)	Number of health facilities visited for maternal, neonatal, child case reviews (deaths and near misses) last 3 months	624	624	624	624	624	IMCI Report SRH Strategy
7.8 Support planning, review and TWG meetings for national and District levels for Child Health	Number of TWG meetings conducted at National and District level	3	4	4	4	4	IMCI Report DPPD
7.9 Support conduct of annual and quarterly review meetings at all levels 7.9.1 Establish and support the Child Health steering committee to strengthen partnership 7.9.2 Motivate HSAs by establishing commemoration of ICCM day (Village clinic day)	Number of annual review meetings conducted Number of steering committee meetings conducted Number	1	1	1	1	1	DPPD CHS IMCI Report

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
Output 8: Improved SBCC strategies for child health uptake of services							
8.1 Facilitate development of child health specific SBC/ IEC operational plan in alignment with Child Health Strategy Re-design.	# of child health specific SBC plans developed and disseminated	1	1	1	1	1	HES
8.2 Develop SBC/ IEC materials on neonatal and child health in collaboration with Health Education Services (HES).	# of SBC materials developed and disseminated	15,000	15,000	15,000	15,000	15,000	HES
8.3 Review SBC/IEC materials on MNCAH and IMNCI	Number of SBC intervention areas reviewed	0	1	1	1	1	HES
8.3 Build capacity of district master trainers in SBCC on key care seeking barriers and approach to resolve them.	Number of district master trainers trained by HES in SBC	600	600	600	600	600	HES
8.4 Build capacity of community gatekeepers, religious leaders, opinion leaders/champions and community volunteers to drive change that addresses misconceptions and negative cultural beliefs to increase care seeking.	Number of SBC awareness meetings/ sessions conducted by VHC in their catchment	21,560	21,560	21,560	21,560	21,560	HES CHS IMCI
8.5 Provide quarterly recognition to model communities that achieve meaningful improvement in postnatal, new-born, and child health.	Number of communities recognized as model villages in postnatal, new-born, and child health.	4160	4160	4160	4160	4160	SRH Strategy CHS IMCI
8.6 Support The conduct of mass campaigns for child Health	Number of campaigns conducted at national level	1	1	1	1	1	IMCI HES
Output 9: Strengthened the supply chain of essential commodities and equipment for child health							

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
9.1 Revive cStock community supply chain system for local sustainability	# of iCCM HSAs trained/oriented in cStock	1664	4160	4576	5034	5537	IMCI
9.2 Strengthen use of cStock by HSAs managing village clinics	% of HSAs reporting through cStock	90%	90%	90%	90%	90%	IMCI
9.3 Build capacity of HSAs, facility in-charges and SHSAs in the use of cStock information system	Number of facility staff trained/oriented in cStock.	2413	3318	4223	5128	6033	IMCI
9.4 Conduct training of district teams to monitor community supply chain performance via cStock dashboard	Number of District Health workers trained in community supply chain performance via cStock dashboard	56	143	231	318	406	IMCI
9.5 Build capacity of MoH IT and council staff on technical management of cStock system and servers.	Number of council staff trained in cStock trouble shooting and user support.	16	25	25	25	25	IMCI
	Number of MoH IT trained in technical management of cStock system	5	5	5	5	5	IMCI
9.6 Participate in annual quantification of medicines and advocate for availability of child health related medicines.	Number of annual quantification meetings attended.	1	1	1	1	1	IMCI HTSS
	% of tracer child health medicines procured compared to quantification	95%	95%	95%	95%	95%	IMCI HTSS
9.7 Conduct refresher training for health facility teams on effective use of Open LMIS/supply chain data to strengthen timely requisition of medicines to avoid stock outs.	No Health facility team members trained in effective use of Open LMIS/supply chain	12	17	17	17	18	IMCI HTSS
9.8 Support procurement of fingertip pulse oximeter, ARI timers, drug box, growth monitoring and nutritional assessment equipment	Number of fingertip pulse oximeter procured	1099	2198	3297	4396	5495	PAM IMCI
	Number of ARI timers procured	1099	2198	3297	4396	5495	PAM IMCI

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
	Number of growth monitoring and nutrition assessment equipment procured	1099	2198	3297	4396	5495	Nutrition Unit
	Number of drug box procured	1099	2198	3297	4396	5495	IMCI
9.9 Support procurement of bCPAP machines for selected PHC facilities.	Number of bCPAP machines for selected PHC facilities	29	58	87	116	145	ARI IMCI
9.10 Improve availability of essential drugs and supplies at health facilities	% of facilities without stock out of tracer drugs in the last 3 months.	70%	80%	90%	90%	90%	IMCI HTSS
9.11 Support IMCI unit with supply and maintenance of transport for integrated child health supervision and program management	Number of Program management areas supported	1	1	1	1	1	QMD IMCI
9.12 Support distribution of equipment and emergency drugs during epidemics	Number of emergency relief packages procured and distributed	1	1	1	1	1	EH IMCI
9.13 Ensure availability of medicines and supplies for NCDs in children	Number of Hospitals with no stock outs for NCDs medicines	1	1	1	1	1	NCD HTSS IMCI
Output 10: Strengthened evidence–based program management							
10.1 Engage the NHSRC and College of Medicine Research and Ethics Committee to coordinate and guide on child health research.	# of child health research engagement meetings	1	1	1	1	1	NHSRC IMCI
10.2 Promote the review of current practices and development of evidence-based research in child health management.	National Child Health Research Agenda in place	1	1	1	1	1	DPPD IMCI NHSRC
		1	1	1	1	1	NHSRC

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
10.3 Advocate for local researchers to generate information for child health programming	# of child health research conferences conducted						IMCI
	# of child health research activities conducted	2	2	2	2	2	IMCI
10.4 Strengthen utilisation of child health real time data to inform ongoing programme improvement including at service delivery points	Number of facilities with timely reporting per MoH reporting guidelines.	624	624	624	624	624	IMCI
10.5 Support scale up of digital supervision tools for facility IMNCI and ICCM and use of data to address bottlenecks and improve performance	Number of facilities with reporting supervision using tools for facility IMNCI and iCCM	624	624	624	624	624	DPPD IMCI
10.6 Conduct periodic data quality assessment and audit and resolve weak areas at village clinic and facility levels	Number of data quality audits conducted with follow up actions implemented.	2	2	2	2	2	DPPD IMCI
10.7 Build capacity of child Health managers on program management at national and district levels	Number of staff trained	1	1	1	1	1	DPPD IMCI
10.8 Support research to develop evidence based approaches to child Health management	Number of partnerships established with research institutions	1	1	1	1	1	NHSRC IMCI
10.9 Strengthen utilization of child health real-time data for program improvements including monthly meetings at service delivery points to review performance, discuss challenges and mentor/coach staff	Number of Research areas on IR implemented	1	1	1	1	1	NHSRC IMCI
10.10 Support review of monitoring tools for child health	Number of monitoring tools reviewed periodically	1	1	1	1	1	IMCI
10.11 Support the review and printing of child health guidelines	Number of guidelines printed	1	1	1	1	1	IMCI

Outputs and key Activities	INDICATOR	ANNUAL TARGETS					Source
		(Base Year) 2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	
10.12 Support the development of indicators from registers on children 5 to 10 years old	Number of meetings Number of registers developed	1	1	1	1	1	DPPD IMCI
10.13 Support data management review and data utilization meetings at facility levels	Number of review meetings conducted	4	4	4	4	4	DPPD IMCI
10.14 Support the development and production of under-five and for over 5 to 10 years registers	Number of registers developed and distributed	1	1	1	1	1	DPPD IMCI
10.15 Support configuration of new data elements into DHIS2	Number of reporting tools configured into DHIS2	1	1	1	1	1	DPPD IMCI
10.16 Support training in form of mentorship and coaching of HMIS officers and focal persons at PHC levels in data management to address specific skill gaps observed from supportive supervision	Proportion of Focal persons and HMIS officers trainer on child health data utilization	0	20%	35%	45%	60%	DPPD IMCI
10.17 Conduct quarterly Child Health taskforce M&E coordination meetings	# of Child Health Task force Coordination Meetings	4	4	4	4	4	QMD IMCI

ANNEX 5: COST AND FINANCING

No	Objective and Activity	Y1 Total cost MWK	Y2 Total cost MWK	Y3 Total cost MWK	Y4 Total cost MWK	Y5 Total cost MWK	Y1-Y5 Total cost MWK	Financing	
								Direct Child Health Support	Other Departments and Partner Support
1.0	**Improve availability and readiness of quality neonatal and child health services at community level**	**1,215,106,994**	**1,336,617,694**	**1,945,463,306**	**1,925,345,957**	**2,068,686,793**	**8,491,220,744**	**2,547,366,223**	**5,943,854,521**
1.1	Conduct home health visits	-	-	-	-	-	-	-	-
1.2	Conduct integrated outreach clinic activities	1,361,920	1,498,112	1,647,923	1,812,716	1,993,987	8,314,658	2,494,397	5,820,260
1.3	Establish Village Health Clinics	214,441,920	235,886,112	259,474,723	285,422,196	313,964,415	1,309,189,366	392,756,810	916,432,556
1.4	Conduct training of at least two staff at each health facility in IMNCI	147,768,754	162,545,630	178,800,193	196,680,212	216,348,233	902,143,022	270,642,907	631,500,115
1.5	Conduct mentorship and supervision visits	33,976,320	37,373,952	41,111,347	45,222,482	49,744,730	207,428,831	62,228,649	145,200,182
1.6	Train VHCs in management of medicines and supplies	81,784,320	89,962,752	98,959,027	108,854,930	119,740,423	499,301,452	149,790,436	349,511,016
1.7	Training of HSAs on EMPIC	-	-	475,183,843	308,038,548	293,865,250	1,077,087,641	323,126,292	753,961,349
1.8	Conduct Reresher training of HSAs on Childhood TB/HIV, Child protection and CBMNC	245,257,920	269,783,712	296,762,083	326,438,292	359,082,121	1,497,324,127	449,197,238	1,048,126,889
1.9	Conduct training on introduction and establishment of ICCM for older Children 5 to 10 years old	245,257,920	269,783,712	296,762,083	326,438,292	354,865,513	1,493,107,519	447,932,256	1,045,175,264
1.10	Conduct training of ICCM HSAs on CBMNC	245,257,920	269,783,712	296,762,083	326,438,292	359,082,121	1,497,324,127	449,197,238	1,048,126,889
2	**Reduce provider workload at health facilities through increased capacity of health care workers**	**516,723,488**	**566,833,837**	**623,517,220**	**685,868,943**	**961,601,062**	**3,354,544,550**	**1,006,363,365**	**2,348,181,185**
2.1	Support establishment national workforce for Community nurses, Community Midwifery assistants and HSAs	900,000	990,000	1,089,000	1,197,900	1,317,690	5,494,590	1,648,377	3,846,213
2.2	Develop Capacity at District level for NCDs for children	1,520,000	110,000	121,000	133,100	2,225,432	4,109,532	1,232,860	2,876,672

No	Objective and Activity	Y1 Total cost MWK	Y2 Total cost MWK	Y3 Total cost MWK	Y4 Total cost MWK	Y5 Total cost MWK	Y1-Y5 Total cost MWK	Financing	
								Direct Child Health Support	Other Departments and Partner Support
2.3	Draw a redistribution plan to ensure Community nurses, Community Midwifery assistants and HSAs are well distributed in the country	900,000	990,000	1,089,000	1,197,900	1,317,690	5,494,590	1,648,377	3,846,213
2.4	Lobby for recruitment and deployment of Community nurses, Community Midwifery assistants and HSAs according to redistribution plan	870,000	957,000	1,052,700	1,157,970	1,273,767	5,311,437	1,593,431	3,718,006
2.5	Support training of at least 2 staff per health facility in (IMNCI), NCDis and nurturing care for ECD, EOC, ETAT	-	-	-	-	205,675,362	205,675,362	61,702,609	143,972,754
2.6	Build capacity of Community health workers in data management	245,673,984	270,241,382	297,265,521	326,992,073	359,082,121	1,499,255,080	449,776,524	1,049,478,556
2.7	Build capacity of iCCM HSAs to manage Children over 5 years	245,257,920	269,783,712	296,762,083	326,438,292	359,082,121	1,497,324,127	449,197,238	1,048,126,889
2.8	Build capacity of medical and nursing lecturers as trainers of trainers in maternal, newborn and child care, including IMCI in order to improve in-service and pre-service training	21,601,584	23,761,742	26,137,917	28,751,708	31,626,879	131,879,830	39,563,949	92,315,881
3	**Improve capacity of community health workers and availability of infrastructure to support service provision for adequate and appropriate delivery of basic health services.**	**1,427,892,939**	**1,737,428,886**	**2,701,729,770**	**2,115,834,451**	**2,327,417,896**	**10,310,303,944**	**3,093,091,183**	**7,217,212,760**
3.1	Conduct training of facility level workers in IMNCI with emphasis on-job mentoring and coaching for immediate application and quick gains	411,995,040	455,834,544	501,417,998	551,559,798	606,715,778	2,527,523,159	758,256,948	1,769,266,211
3.1	Conduct of quarterly supervision at national and district level	161,433,600	177,576,960	195,334,656	214,868,122	236,354,934	985,568,271	295,670,481	689,897,790
3.1	Procurement of Motorbikes for SHSAs to supervise hardest to reach areas	-	-	902,703,875	211,954,829	233,150,312	1,347,809,015	404,342,705	943,466,311
3.2	Provision of appropriate infrastructure, WASH facilities, equipment and furniture.	-	163,974,653	-	-	-	163,974,653	49,192,396	114,782,257

No	Objective and Activity	Y1 Total cost MWK	Y2 Total cost MWK	Y3 Total cost MWK	Y4 Total cost MWK	Y5 Total cost MWK	Y1-Y5 Total cost MWK	Financing	
								Direct Child Health Support	Other Departments and Partner Support
3.3	Maintain and rehabilitate the already existing infrastructures	-	-	68,226,239	-	-	68,226,239	20,467,872	47,758,367
3.6	Conduct pre-service and in-service training that focuses on mentoring, supportive supervision and monitoring the quality-of-service delivery for child health.	21,601,584	23,761,742	26,137,917	28,751,708	31,626,879	131,879,830	39,563,949	92,315,881
3.7	Conduct Trainings for HSAs in iCCM + CMAM	452,233,920	497,457,312	547,203,043	601,923,348	662,115,682	2,760,933,305	828,279,991	1,932,653,313
3.8	Conduct Refresher training for facility and community health workers	161,700,754	178,002,830	195,803,113	215,383,424	236,921,766	987,811,887	296,343,566	691,468,321
3.9	Conduct review meetings	57,494,441	63,243,885	69,568,274	76,525,101	84,177,611	351,009,313	105,302,794	245,706,519
3.10	Conduct district level ICCM mentorship and supervision	161,433,600	177,576,960	195,334,656	214,868,122	236,354,934	985,568,271	295,670,481	689,897,790
4	**Strengthen health facility-based perinatal care**	**18,029,649,159**	**34,111,556,959**	**3,546,456,505**	**3,906,102,156**	**45,400,756,161**	**104,994,520,940**	**1,866,526,213**	**103,127,994,727**
4.1	Conduct HSAs training to provide Follow up of PSBI cases and Postnatal children	239,377,920	263,315,712	289,647,283	318,612,012	350,473,213	1,461,426,139	438,427,842	1,022,998,298
4.2	Conduct mentorship program at facility level to support health facilities	50,340,754	66,858,830	60,912,313	67,003,544	88,989,102	334,104,543	100,231,363	233,873,180
4.3	Conduct induction system for the newly recruited staff	7,809,627,429	-	1,181,206	1,299,327	1,429,259	7,813,537,221	-	7,813,537,221
4.4	Conduct outreach to Institutionalise quality of antenatal care interventions through eight ANC contacts	1,361,920	1,498,112	1,647,923	1,812,716	1,993,987	8,314,658	2,494,397	5,820,260
4.5	Conduct outreach to Institutionalize postnatal care within 48 hours for mothers	913,920	1,005,312	1,105,843	1,216,428	1,338,070	5,579,573	1,673,872	3,905,701
4.6	Conduct outreach to Institutionalize postnatal care within 48 hours for newborns	1,809,920	1,990,912	2,190,003	2,409,004	2,649,904	11,049,743	3,314,923	7,734,820
4.7	Conduct Training on provision of resuscitation for all sick babies	536,593,920	590,253,312	649,278,643	714,206,508	785,627,158	3,275,959,541	655,191,908	2,620,767,633
4.8	Conduct Training to Improve outcomes for small and sick new born care	536,593,920	590,253,312	649,278,643	714,206,508	785,627,158	3,275,959,541	655,191,908	2,620,767,633

No	Objective and Activity	Y1 Total cost MWK	Y2 Total cost MWK	Y3 Total cost MWK	Y4 Total cost MWK	Y5 Total cost MWK	Y1-Y5 Total cost MWK	Financing	
								Direct Child Health Support	Other Departments and Partner Support
4.9	Conduct Training to Institutionalise perinatal deaths audits in all district hospitals	538,553,920	592,409,312	651,650,243	716,815,268	788,496,794	3,287,925,537	-	3,287,925,537
4.10	Maintenance program for essential equipment	-	30,872,095,414	-	-	41,090,758,996	71,962,854,411	-	71,962,854,411
4.11	Procure equipment and supplies	8,208,145,586	1,012,543,079	1,113,797,387	1,225,177,126	1,347,694,839	12,907,358,018	-	12,907,358,018
4.12	Procurement of obstetric drugs	2,393,950	4,051	4,456	4,902	3,504,982	5,912,342	-	5,912,342
4.13	Strengthen use of obstetric guidelines and protocols in management of complications.	103,936,000	114,329,600	125,762,560	138,338,816	152,172,698	634,539,674	-	634,539,674
4.14	Develop and Deploy Integrated Paediatric Guidelines App		5,000,000	-	5,000,000	-	10,000,000	10,000,000	-
5	**Improve risk assessment in case management to ensure providers' ability to diagnose, treat and make appropriate referral of child health conditions**	**1,624,800,624**	**1,626,933,638**	**1,647,331,002**	**1,968,589,702**	**2,331,542,033**	**9,199,196,998**	**2,759,759,100**	**6,439,437,899**
5.1	Train service providers to strengthen IMNCI and NCDIs to improve risk assessment, classification and treatment of conditions for children and adolescents	160,760,754	176,836,830	194,520,513	213,972,564	235,369,820	981,460,481	294,438,144	687,022,337
5.2	Training to PHC workers to strengthen management of childhood illnesses for those over 5 years and adolescents	147,768,754	162,545,630	178,800,193	196,680,212	216,348,233	902,143,022	270,642,907	631,500,115
5.3	Conduct pre-service training in Health Training Institutions	160,760,754	176,836,830	194,520,513	213,972,564	235,369,820	981,460,481	294,438,144	687,022,337
5.4	Conduct training and follow up of Health workers from Private clinics in IMNCI and risk asessment	160,760,754	176,836,830	194,520,513	213,972,564	235,369,820	981,460,481	294,438,144	687,022,337
5.5	Procure Equipment for PHCs for strengthened NCDis, IMNCI, ETAT management	231,400,000	391,600	430,760	473,836	338,792,740	571,488,936	171,446,681	400,042,255
5.6	Conduct Training to strengthen ETAT	147,768,754	162,545,630	178,800,193	196,680,212	216,348,233	902,143,022	270,642,907	631,500,115

No	Objective and Activity	Y1 Total cost MWK	Y2 Total cost MWK	Y3 Total cost MWK	Y4 Total cost MWK	Y5 Total cost MWK	Y1-Y5 Total cost MWK	Financing	
								Direct Child Health Support	Other Departments and Partner Support
5.7	Procure equipment for diagnosis, and management of NCDs in children and adolescents	14,809,344	145,650,278	17,919,306	176,236,837	21,682,361	376,298,126	112,889,438	263,408,688
5.8	Intensify supportive supervision and monitoring of the quality-of-service delivery for child health at all levels.	190,758,034	209,833,838	230,817,221	253,898,944	279,288,838	1,164,596,875	349,379,063	815,217,813
5.9	Conduct supervision of child health related interventions	210,918,034	232,009,838	255,210,821	280,731,904	308,805,094	1,287,675,691	386,302,707	901,372,984
5.10	Procurement of diagnostic equipment and essential medicines for children and adolescent conditions	356,000	391,600	430,760	473,836	521,220	2,173,416	652,025	1,521,391
5.11	Conduct mapping of households with pregnant women, newborns and under-five children using the village health register.	10,980,480	34,795	38,275	42,102	46,312	11,141,965	3,342,589	7,799,375
5.12	Conduct of death audits	89,380,480	86,274,795	94,902,275	104,392,502	114,831,752	489,781,805	146,934,541	342,847,263
5.13	Conduct case management review meetings and follow up	98,378,480	96,745,145	106,419,660	117,061,626	128,767,788	547,372,699	164,211,810	383,160,889
6.0	**Strengthen nutrition promotion, counselling and assessment as part of child health services delivery**	**690,020,305**	**657,438,780**	**723,182,658**	**795,500,924**	**875,051,017**	**3,741,193,685**	**1,122,358,105**	**2,618,835,579**
6.1	Train community and facility health workers in management of malnutrition (iCCM+IMNCI+NCDIs)	147,768,754	162,545,630	178,800,193	196,680,212	216,348,233	902,143,022	270,642,907	631,500,115
6.2	Train community health workers in provision of integrated iCCM + CMAM	147,768,754	162,545,630	178,800,193	196,680,212	216,348,233	902,143,022	270,642,907	631,500,115
6.3	Support introduction and roll out of Developmental Growth milestones wall charts	27,263,040	29,989,344	32,988,278	36,287,106	39,915,817	166,443,586	49,933,076	116,510,510
6.4	Conduct household campaigns to promote IYCF practices	4,499,424	4,949,366	5,444,303	5,988,733	6,587,607	27,469,433	8,240,830	19,228,603
6.5	Procure and distribute standard equipment and supplies to facilities and village clinics for nutrition assessment	189,008,000	107,258,800	117,984,680	129,783,148	142,761,463	686,796,091	206,038,827	480,757,264
6.6	Train health workers in management of malnutrition	147,768,754	162,545,630	178,800,193	196,680,212	216,348,233	902,143,022	270,642,907	631,500,115

No	Objective and Activity	Y1 Total cost MWK	Y2 Total cost MWK	Y3 Total cost MWK	Y4 Total cost MWK	Y5 Total cost MWK	Y1-Y5 Total cost MWK	Financing	
								Direct Child Health Support	Other Departments and Partner Support
6.7	Advocate for availability of adequate micronutrient supplements and deworming tablets in all facilities	25,213,498	26,801,293	29,481,422	32,429,564	35,672,521	149,598,298	44,879,489	104,718,809
6.8	Conduct community sensitization on EBF targeting community influencers	365,040	401,544	441,698	485,868	534,455	2,228,606	668,582	1,560,024
6.9	Conduct community nutrition sensitization meetings targeting women and girls to increase awareness and promote good nutrition practices	365,040	401,544	441,698	485,868	534,455	2,228,606	668,582	1,560,024
7.0	**Improve coordination, governance and management of partnerships and multi-sectoral approaches including nutrition, early stimulation and adolescent health**	**1,006,311,097**	**1,072,548,841**	**1,179,803,725**	**1,297,784,098**	**1,427,562,508**	**5,984,010,269**	**1,795,203,081**	**4,188,807,189**
7.1	Conduct partner mapping to identify partners implementing child health by district	29,389,040	32,327,944	35,560,738	39,116,812	43,028,493	179,423,028	53,826,908	125,596,120
7.2	Provide mentorship to strengthen facility and provider adherence to childhood illness management norms, standards and practices	67,195,040	73,914,544	81,305,998	89,436,598	98,380,258	410,232,439	123,069,732	287,162,707
7.3	Train community healthcare governance structures to improve their oversight roles	147,768,754	162,545,630	178,800,193	196,680,212	216,348,233	902,143,022	270,642,907	631,500,115
7.4	Train district teams and CBCCs on integrated IMNCI, iCCM	147,768,754	162,545,630	178,800,193	196,680,212	216,348,233	902,143,022	270,642,907	631,500,115
7.5	Train facility staff in maternal, neonatal, and child case review, risk assessment and improvement	147,768,754	162,545,630	178,800,193	196,680,212	216,348,233	902,143,022	270,642,907	631,500,115
7.6	Conduct child health annual reviews for all levels	98,378,480	96,745,145	106,419,660	117,061,626	128,767,788	547,372,699	164,211,810	383,160,889
7.7	Train/orient HSAs in case referrals and follow up and perform NCDIs specialist visits	147,768,754	162,545,630	178,800,193	196,680,212	216,348,233	902,143,022	270,642,907	631,500,115
7.8	Conduct TWG at district level to review child health progress	121,895,040	122,633,544	134,896,898	148,386,588	163,225,247	691,037,318	207,311,195	483,726,122

No	Objective and Activity	Y1 Total cost MWK	Y2 Total cost MWK	Y3 Total cost MWK	Y4 Total cost MWK	Y5 Total cost MWK	Y1-Y5 Total cost MWK	Financing	
								Direct Child Health Support	Other Departments and Partner Support
7.9	Conduct meetings to review and revise iCCM Roadmap	98,378,480	96,745,145	106,419,660	117,061,626	128,767,788	547,372,699	164,211,810	383,160,889
8.0	**Improve health promotion and SBCC strategies for child health uptake of services**	**94,890,240**	**102,393,865**	**112,633,252**	**123,896,577**	**138,928,800**	**572,742,734**	**171,822,820**	**400,919,914**
8.1	Develop child health and NCDIs SBC materials and plans	1,295,040	170,544	187,598	206,358	1,896,068	3,755,609	1,126,683	2,628,926
8.2	Disseminate child health and NCDI SBC messages to remove barriers and promote care seeking practices	695,040	33,145	36,460	40,106	1,017,608	1,822,359	546,708	1,275,651
8.3	Train district master trainers in barriers to child health care seeking and SBCC on changing behaviours	43,295,040	47,624,544	52,386,998	57,625,698	63,388,268	264,320,549	79,296,165	185,024,384
8.4	Support VHC conduct SBCC awareness campaigns in their communities	24,215,040	26,636,544	29,300,198	32,230,218	35,453,240	147,835,241	44,350,572	103,484,668
8.5	Assess performance of communities in postnatal, newborn and child health and identify model communities	2,615,040	2,876,544	3,164,198	3,480,618	3,828,680	15,965,081	4,789,524	11,175,556
8.6	Support mass child health campaigns at national level	22,775,040	25,052,544	27,557,798	30,313,578	33,344,936	139,043,897	41,713,169	97,330,728
9.0	**Strengthen the supply chain of essential commodities and equipment for child health**	**1,488,271,760**	**1,710,330,336**	**1,881,363,370**	**2,069,499,707**	**2,361,698,364**	**9,511,163,536**	**112,419,604**	**9,398,743,932**
9.1	Attend annual quantification and advocate for adequate child health products	28,000	30,800	33,880	37,268	40,995	170,943	51,283	119,660
9.2	Procure and distribute bCPAP machines for selected PHC facilities	1,175,040	1,292,544	1,421,798	1,563,978	1,720,376	7,173,737	-	7,173,737
9.3	Procure and distribute child health /ARI supplies, by category	1,175,040	1,292,544	1,421,798	1,563,978	1,720,376	7,173,737	2,152,121	5,021,616
9.4	Procure and distribute emergency relief packages	1,175,040	1,292,544	1,421,798	1,563,978	1,720,376	7,173,737	2,152,121	5,021,616
9.5	Provide mentorship to pharmacy personnel at facility level to strengthen documentation, timely requisitioning, and stock management	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366

No	Objective and Activity	Y1 Total cost MWK	Y2 Total cost MWK	Y3 Total cost MWK	Y4 Total cost MWK	Y5 Total cost MWK	Y1-Y5 Total cost MWK	Financing	
								Direct Child Health Support	Other Departments and Partner Support
9.6	Provide supportive supervision on NCDIs and IMCI medicines utilisation	34,687,040	38,155,744	41,971,318	46,168,450	50,785,295	211,767,848	63,530,354	148,237,494
9.7	Support cStock refresher/re-orientation sessions	224,297,920	246,727,712	271,400,483	298,540,532	328,394,585	1,369,361,231	-	1,369,361,231
9.8	Support cStock running costs	8,160,000	8,976,000	9,873,600	10,860,960	11,947,056	49,817,616	-	49,817,616
9.9	Support cStock system strengthening	691,609,680	696,722,048	766,394,253	843,033,678	1,012,585,732	4,010,345,391	-	4,010,345,391
9.10	Support quantification to promote availability of NCDs and medicines for children	28,000	30,800	33,880	37,268	40,995	170,943	51,283	119,660
9.11	Train district council IT staff in cStock troubleshooting and user support	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	-	148,274,808
9.12	Train district teams in the use of cStock data for performance monitoring and improvement	6,793,920	7,473,312	8,220,643	9,042,708	9,946,978	41,477,561	-	41,477,561
9.13	Train health facility teams on use of OpenLMIS data to support product availability	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	-	148,274,808
9.14	Train HSAc, SHSAc, and MAc an use of cStock community supply chain data in monthly meetings	429,312,000	472,243,200	519,467,520	571,414,272	628,555,699	2,620,992,691	-	2,620,992,691
9.15	Train HSAs, SHSAs, and MAs in cStock community supply chain reporting	73,920	137,361,312	151,097,443	166,207,188	182,827,906	637,567,769	-	637,567,769
9.16	Train pharmacy and extended DHMT in use of cStock community supply chain data in monthly meetings	16,895,040	18,584,544	20,442,998	22,487,298	24,736,028	103,145,909	-	103,145,909
10	**Strengthen evidence–based program management**	**1,238,632,672**	**1,397,937,939**	**1,498,745,533**	**1,611,644,906**	**1,772,809,397**	**7,519,770,448**	**2,210,145,815**	**5,309,624,633**
10.1	Build capacity of program personnel	4,813,200	5,294,520	5,823,972	6,406,369	7,047,006	29,385,067	8,815,520	20,569,547
10.2	Conduct child health research engagement meetings	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.3	Conduct Data Quality assessment	112,895,040	124,184,544	136,602,998	150,263,298	165,289,628	689,235,509	206,770,653	482,464,856
10.4	Conduct Data review meetings	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.5	Conduct of annual and quarterly review meetings at all levels	15,251,008	16,776,109	18,453,720	20,299,092	22,329,001	93,108,929	27,932,679	65,176,250

No	Objective and Activity	Y1 Total cost MWK	Y2 Total cost MWK	Y3 Total cost MWK	Y4 Total cost MWK	Y5 Total cost MWK	Y1-Y5 Total cost MWK	Financing	
								Direct Child Health Support	Other Departments and Partner Support
10.6	Conduct Quality of Care assessment	112,895,040	124,184,544	136,602,998	150,263,298	165,289,628	689,235,509	206,770,653	482,464,856
10.7	Facilitate meetings to develop the national child health research agenda	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.8	Internet connectivity	2,340,000	2,574,000	2,831,400	3,114,540	3,425,994	14,285,934	4,285,780	10,000,154
10.9	Organize and host child health research conferences	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.10	Orientation of ICCM HSAs and facility workers during emergencies	4,813,200	5,294,520	5,823,972	6,406,369	7,047,006	29,385,067	8,815,520	20,569,547
10.11	Print and distribute PSBI/IMNCI registers	24,128,000	26,540,800	29,194,880	32,114,368	35,325,805	147,303,853	44,191,156	103,112,697
10.12	Print and distribute under 5 and children over 5 registers (OPD)	41,023,040	45,125,344	49,637,878	54,601,666	60,061,833	250,449,762	75,134,928	175,314,833
10.13	Printing of job aides and reporting tools for ICCM and NCDIs	24,128,000	26,540,800	29,194,880	32,114,368	35,325,805	147,303,853	44,191,156	103,112,697
10.14	Printing of training materials and guidelines	24,128,000	26,540,800	29,194,880	32,114,368	35,325,805	147,303,853	44,191,156	103,112,697
10.15	Procure Vehicles for Coordination	-	66,000,000	-	-	-	66,000,000	19,800,000	46,200,000
10.16	Procurement of RUTF	24,998,400	27,498,240	30,248,064	33,272,870	36,600,157	152,617,732	-	152,617,732
10.17	Promote IMNCI and ICCM e-learning and digitization	15,251,008	16,776,109	18,453,720	20,299,092	22,329,001	93,108,929	27,932,679	65,176,250
10.18	Refresher training for Facility Level Health workers on IMNCI	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.19	Replacement training for ICCM HSAs	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.20	Replacement training of Health workers on IMNCI	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.21	Support conduct of biannual program review meetings with focal persons	15,251,008	16,776,109	18,453,720	20,299,092	22,329,001	93,108,929	27,932,679	65,176,250
10.22	Support distribution of ORT equipment and emergency drugs during epidemics	8,979,008	9,876,909	10,864,600	11,951,060	13,146,166	54,817,742	16,445,323	38,372,419
10.23	Support fuel for Local running	4,752,000	5,227,200	5,749,920	6,324,912	6,957,403	29,011,435	8,703,431	20,308,005
10.24	Support international participation of meetings	7,625,504	8,388,054	9,226,860	10,149,546	11,164,500	46,554,464	13,966,339	32,588,125

No	Objective and Activity	Y1 Total cost MWK	Y2 Total cost MWK	Y3 Total cost MWK	Y4 Total cost MWK	Y5 Total cost MWK	Y1-Y5 Total cost MWK	Financing	
								Direct Child Health Support	Other Departments and Partner Support
10.25	Support joint conduct of supervision for bed-fellow programs ie IMCI + RHD, CHS + EPI e.t.c	13,087,040	14,395,744	15,835,318	17,418,850	19,160,735	79,897,688	23,969,306	55,928,382
10.26	Support mentorship of mentors and risk assessment	13,087,040	14,395,744	15,835,318	17,418,850	19,160,735	79,897,688	23,969,306	55,928,382
10.27	Support monitoring activities during emergencies	3,945,600	4,340,160	4,774,176	5,251,594	5,776,753	24,088,283	7,226,485	16,861,798
10.28	Support procurement of PPEs and WASH facilities for HSAs clinics	396,000,000	435,600,000	479,160,000	527,076,000	579,783,600	2,417,619,600	725,285,880	1,692,333,720
10.29	Support review of the ICCM road Map and NCDIs Brief	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.30	Support scale-up of digital Supervision tools for facility IMCI and ICCM to more districts within an integrated arrangement	15,251,008	16,776,109	18,453,720	20,299,092	22,329,001	93,108,929	27,932,679	65,176,250
10.31	Support supervision of supervisors	34,687,040	38,155,744	41,971,318	46,168,450	50,785,295	211,767,848	63,530,354	148,237,494
10.32	Support the capacitation of team for digital health and e-learning	27,935,040	170,544	33,801,398	206,358	226,994	62,340,335	18,702,100	43,638,234
10.33	Support the conduct of IMCI sub-TWG meetings	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.34	Support training of Trainers on IMNCI and ICCM focal persons	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.35	Train facilities on data use to improve management of NCDIs	24,287,040	26,715,744	29,387,318	32,326,050	35,558,655	148,274,808	44,482,442	103,792,366
10.36	Train facilities on data use to improve IMNCI and iCCM	24,211,008	26,632,109	29,295,320	32,224,852	35,447,337	147,810,625	44,343,187	103,467,437
	Grand Total	**27,332,299,279**	**44,320,020,775**	**15,860,226,342**	**16,500,067,420**	**59,666,054,030**	**163,678,667,848**	**49,103,600,354**	**114,575,067,493**

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