Government of the Republic of Malawi

Ministry of Health

NATIONAL COMMUNITY HEALTH FRAMEWORK

2023 – 2030

Integrating health services and engaging
Communities for the next generation

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FOREWORD

The Government of Malawi is committed towards achieving good health and well-being of all citizens. This commitment is in line with the right to life, which every human being is supposed to enjoy. Among all levels of health services delivery, community health holds considerable sway as it is often the common entry point for access to health services. Community health is an integral part of Universal Health Coverage. In view of this, the Government of Malawi will continue to offer health services at community level that are of high-quality standard, accessible, cost effective and achievable within the available health financing.

Successful implementation of the National Community Health Framework (NCHF) for the period of 2023-2030 hinges on robust community health systems and strong performance management framework. The NCHF (2023-2030) is a blueprint based on a strong conceptual foundation and places communities at the heart of service provision and financing. The NCHF is centred on principles of inclusion, equity, integration of services, transparency and accountability, gender equality, community leadership and learning. For the first time, the NCHF provides a clear community health financing architecture that among other things includes involvement of communities in resource mobilisation for infrastructure and using available resources efficiently.

The NCHF defines key community health interventions, focus, measurement metrics and associated costs for the period 2023-2030. It is a living document and has been developed as a joint effort by various partners and stakeholders in line with the Health Sector Strategic Plan (HSSP III) and other existing policies and instruments. I therefore enjoin everyone to embrace the document to improve the health status and livelihoods of people in Malawi.

Honourable Khumbidze Kandodo Chiponda, MP

Minister of Health

July 2023

ACKNOWLEDGEMENTS

The development of the NCHF (2023-2030) was necessitated by the expiry of the National Community Health Strategy (2017- 2022) and other prevailing circumstances in the health sector. The NCHF is premised on the vision of improving health status and wellbeing of more than 19 million people living in Malawi. The development of the framework was made possible by a cross-section of stakeholders brought together by the Ministry of Health's objective to ensure vital health services are within reach for all Malawians. The stakeholders provided valuable input, which has shaped the NCHF.

The Ministry of Health in collaboration with development partners, non-governmental organisations (NGOs), civil society organisations (CSOs), district councils, other relevant government departments, local leaders, community health workers, and community members developed the NCHF. The Ministry expresses gratitude to all who contributed to the development of the NCHF from its infancy stage to the time of completion. Special recognition should be given to all national programme managers and department heads for providing much needed input during development of the NCHF.

The Ministry of Health is indebted to the following officials: Dr. Storn Kabuluzi (Director of Preventive Health Services), Dr. Rose Nyirenda (Director of HIV, STI and Viral Hepatitis), Dr. James Mpunga (Director of National TB Programme). The Ministry recognizes contributions from Dr. Gerald Manthalu (Director of Planning and Policy Development) and others for continuous support and leadership towards development of the framework.

The Ministry is grateful to the Community Health Services Section team led by Doreen Namagetsi Ali (Deputy Director Preventive Health Services responsible for Community Health Service) and Mr. Precious Phiri (National PHC Coordinator) who spearheaded the whole process of developing this NCHF.

The Ministry further appreciates the impeccable role of the district council authorities such as District Health Management Teams (DHMTs), District Commissioners (DCs), Directors of Planning and Development (DPDs), Health Surveillance Assistants, local leaders, and Village Health Committee (VHC) members for their participation during consultations on the development of this framework.

The Ministry acknowledges and appreciates the Ministry of Agriculture, Irrigation and Water Development; Ministry of Education, Science and Technology, and the Ministry of Local Government, Unity, and Culture for providing their valuable input throughout the development of the NCHF.

The Ministry wishes to convey special thanks and appreciation to the following partners who supported the development of the NCHF financially: UNICEF, Save the Children, Malawi Redcross Society, Last Mile Health (LMH) and Amref Health Africa. Further, the Ministry recognizes USAID Malawi, Malawi Health Equity Network (MHEN), Malawi Network of AIDS Service Organizations (MANASO), mothers2mothers, University of Malawi, Federation of Disability Organizations in Malawi (FEDOMA), Partners in Health (PIH), Malawi Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (MANERELA+), Youth Net and Counselling (YONECO), Coalition of Women Living with HIV and AIDS (COWLHA) and other NGOs and OPDs for their technical support during the development of the NCHF.

The Ministry greatly appreciates Kamuzu University of Health Sciences (KUHES) through Prof. Phuka and Mrs. Beverly Laher for providing guidance and technical support during the development of the NCHF. The Ministry is also thankful to the Consultant Mr. Harry Madukani for providing strategic guidance and high-level facilitation throughout all stages of the development of the NCHF. The Ministry recognizes the Community Health Ambassador Mr. Maziko Matemba and all members of the core writing team and reviewers for all roles taken during the process of developing the Framework.

The Ministry appreciates the services of Mr. Moses Zuze, Mr. Francis Zhuwao and Mr. Gladstone Mchoma from the Directorate of Planning and Policy Development (DPPD) who facilitated the costing of the NCHF.

Finally, it must be emphasised that the NCHF went through meticulous development stages which involved consultations with various stakeholders. Therefore, this NCHF is a true reflection of the hopes and aspirations of citizens in terms of their needs and how community health system can address those. I therefore call upon all of us to own the document, implement and sustain it for the benefit of all recipients of care in rural and hard to reach areas.

Dr Samson Mndolo

Secretary for Health

July 2023

ACRONYMS

ABYM	Adolescent Boys and Young Men
ADC	Area Development Committee
AEDC	Agriculture Extension Development Coordinator
AEDO	Agriculture Extension Development Officer
AEHO	Assistant Environmental Health Officer
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
AIP	Annual Implementation Plan
ANC	Antenatal Care
ART	Antiretroviral Therapy
BCG	Bacille Calmette-Guérin
CAD	Community ART Distribution points
CAG	Community ART Groups
CBDAs	Community Based Distribution Agents
CBO	Community Based Organization
CDA	Community Development Assistant
CHAG	Community Health Action Group
CHN	Community Health Nurse
CHO	Community Health Officer
CHNP	Community based Health Nutrition Program
CHS	Community Health Services
CHT	Community Health Team
CHVs	Community Health Volunteer
CHW	Community Health Workers
CIP	Capital Investment Plan
CMA	Community Midwife Assistant
CMAM	Community based Management of Acute Malnutrition
COVID-19	Coronavirus Disease – 2019
CSO	Civil Society Organization
COWLHA	Coalition of Women Living with HIV and AIDS
DAIP	District Annual Implementation Plan
DCHS	District Community Health Section
DCSA	Disease Control Surveillance Assistants
DDP	District Development Plans
DEC	District Executive Committee
DHO	District Health Office
DHPO	District Health Promotion Officer
DHIS	District Health Information System
DHSS	Director of Health and Social Services
DIP	District Implementation Plans
DMYIP	District Multi-year Implementation Plans
DOT	Directly Observed Therapy
DPD	Director of Planning and Development
DSD	Differentiated Service Delivery
EHO	Environmental Health Officer
EHPs	Essential Health Packages
EMRS	Electronic Medical Record System
FEDOMA	Federation of Disability Organizations in Malawi
FGD	Focus Group Discussion
GDP	Gross Domestic Product

GMV	Growth Monitoring Volunteers
HAT	Human African Trypanosomiasis
GVH	Group Village Headman
HCAC	Health Centre Advisory Committee
HBPs	Health Benefits Packages
HCMC	Health Centre Management Committee
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papillomavirus
HR	Human Resource
HSA	Health Surveillance Assistant
HTS	HIV Testing Services
iCHIS	Integrated Community Health Information System
ICT	Information, Communication and Technology
IDD	Iodine Deficiency Disorder
IFA	Iron and Folic Acid
IMCI	Integrated Management of Childhood Illness
IPTp	Intermittent Preventive Treatment in pregnancy
IPV	Inactivated Polio Vaccine
ITN	Insecticide Treated Net
ISS	Integrated Systems Solutions
IYCF	Infant and Young Child Feeding
KMC	Kangaroo Mother Care
KUHES	Kamuzu University of Health Sciences
LBW	Low Birth Weight
LF	Lymphatic Filariasis
LGBQTI	Lesbian, Gay, Bisexual, Queer, and Intersex
LIMS	Laboratory Information Management System
LMH	Last Mile Health
MANASO	Malawi Network of AIDS Service Organizations
MANERELA+	Malawi Network of Religious Leaders Living with or personally affected by HIV
MDHS	Malawi Demographic Health Survey
MDR-TB	Multidrug Resistant TB
MHEN	Malawi Health Equity Network
MNCH	Maternal Newborn and Child Health
MoH	Ministry of Health
MP	Member of Parliament
MPHIA	Malawi Population-based HIV Impact Assessment
MTR	Mid-Term Review
NCD	Non-Communicable Diseases
NCHF	National Community Health Framework
NCHS	National Community Health Strategy
NGO	Non-Governmental Organisation
NMT	Nurse Midwife Technician
NTD	Neglected Tropical Diseases
OHSP	Occupation Health and Safety Policy
OPD	Organisation of Persons with Disabilities
ORT	Other Recurrent Transactions
OVP	Oral Polio Vaccine

PHC	Primary Health Care
PHI	Public Health Importance
PIH	Partners in Health
PIH	Partners in Hope
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
PPD	Planning and Policy Development
PPE	Personal Protective Equipment
PrEP	Pre-exposure prophylaxis.
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goal
SHSA	Senior Health Surveillance Assistant
SOP	Standard Operating Procedure
TA	Traditional Authority
TB	Tuberculosis
ToR	Terms of Reference
ToT	Trainer of Trainers
TWG	Technical Working Group
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USSV	Unstructured Supplementary Service Data
VDC	Village Development Committee
WHO	World Health Organization
WPV	Wild Polio Virus
YONECO	Youth Net and Counselling

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EXECUTIVE SUMMARY

Malawi provides health services at community, primary, secondary, and tertiary levels. All these levels are very crucial towards achieving improved health and well-being of citizens. However, health services offered at community level (community health) provide an entry point to health care.

Community health care is the provision of basic health services in rural and urban communities with the participation of people who live there and is essential to improving health and livelihoods in Malawi. The much touted "bringing services closer to the people" expression finds meaning in community health.

Sustainable Development Goals (SDG) particularly SDG 3 dwells on universal health coverage. As such, community health care forms an integral component of sustaining Malawi's development agenda. This is because community health activities have contributed to historical improvements in Malawi's health outcomes, especially for women and children, such as the decline in child mortality and malaria fatality rates.

Malawi's health sector faces a wide range of challenges. The challenges include limited access to health services by a section of the citizenry, inadequate financing of health services, high infant mortality and maternal mortality and high incidence of HIV and AIDS among other things. Challenges peculiar to the community health system include inadequate number of community health workers (CHWs) with the existing CHWs unevenly distributed across the country. Community health workers also face challenges related to lack of clarity on their roles and tasks, inadequate training and supervision and limited access to transport. Communities experience frequent stock-outs of medicines and lack sufficient infrastructure such as health delivery structures.

With the challenges mentioned above, the Ministry of Health (MoH) through the Community Health Services (CHS) Section developed the country's first ever National Community Health Strategy (NCHS) for the period of 2017-2022. This step was taken in recognition of the importance of community health and the opportunity to address these challenges.

A Mid-term Review (MTR) was commissioned to review progress towards implementation of milestones of the NCHS (2017-2022). The MTR focused on assessing the implementation process, lessons learned and progress towards objectives as of 2021. Findings of the MTR indicated that overall, 51 of the 122 activity targets in the NCHS road map were met as of November 2021 representing 41.8% of the targets; 20 (16.4%) activity targets were assessed to have been partially met. The MTR unearthed several challenges during the first phase of NCHS. Nevertheless, two main challenges were very conspicuous namely resource constraints and the advent of COVID-19 pandemic.

Findings of the MTR and other emerging issues informed the development of the NCHF[1] for the period 2023- 2030. The NCHF was developed in coordination with the Directorate for Planning and Policy Development (DPPD). The NCHF ties into the Health Sector Strategic Plan (HSSP III) blueprint. In developing this NCHF, consultations were done at local, district, zonal and national level. The consultations involved a cross-section of stakeholders across the health system,

[1] In line with "One Plan, One Budget and One Report Reform" of HSSP III, this document is now called National Health Community Framework and not National Community Health Strategy as was formerly called from 2017 to 2022.

local government and communities. The stakeholders helped to highlight strengths and challenges, identify, and prioritise key issues and activities, and develop the NCHF implementation plan.

The vision of the NCHF is to improve the livelihoods of all people in Malawi. The mission is to ensure quality, affordable, integrated community health services that are culturally acceptable, scientifically appropriate, and accessible to every household through community participation – to promote health and contribute to the socio-economic status of all people in Malawi. By 2030, the NCHF aims to contribute to achievement of health outcome targets aligned with the HSSP III as outlined in sections below.

The NCHF will be a springboard for delivery of the Health Benefits Package (HBP), as defined by HSSP III. CHWs will continue to deliver the services through an integrated approach. Integration will take place at the point of care, which helps to improve health system efficiencies, reduce fragmentation and increase access to care.

Coordination will also be central to the implementation of the NCHF. Other key features within the community health system include a team-based structure for CHWs, strengthened supervision, reinforced community structures such as Village Health Committees (VHC) and Community Health Action Groups (CHAG) and enhanced coordination led by the CHS Section and district-level Community Health Officers.

The NCHS (2017-2022) had six thematic areas for the community health system. One of the key recommendations of the MTR was to add a new thematic area pertaining to community health financing in response to one of the main challenges in implementing NCHS, which was resource constraints. Therefore, NCHF contains seven thematic areas for the community health system – each with an ambitious target and interventions to be implemented by 2030 as follows:

1. Health Services Delivery: Deliver the Health Benefits Package (HBP) at community level through integrated services provided by CHWs in Community Health Teams (CHTs). Key interventions to achieve this goal include scaling up integrated delivery of the HBP at community level and rolling out CHTs with clear job descriptions for all CHW cadres. The target for 2030 is that role clarity guidelines will be revised and disseminated among all CHWs, Community Health guidelines will be updated and disseminated, and community referral pathways will be developed and operationalized. The NCHF envisions that health services at community-level will be offered in an integrated fashion such as community health screening, community disease surveillance and response, community-based outreach clinics and community-based distribution of drugs. Integration will also extend to community health education sessions of various diseases and conditions, community health defaulter tracing of various diseases, community-based death audit, community-based counselling and psychosocial support and community based palliative care.

2. Human Resources: Build a sufficient, equitably distributed, well-trained community health workforce. Key interventions to achieve this goal include recruiting additional CHWs; promoting equitable geographical distribution of CHWs and providing high-quality, integrated pre-service and in-service training to all CHWs. The target for 2030 is that job descriptions and clarification of roles for all CHWs will be updated, HSA pre-service and in-service training curriculum will be revised and SHSAs will be trained using the curriculum for Community Health Assistants in phased fashion. Further, integrated refresher training for CHTs will be conducted, district CHS Section will be established with officers recruited, revised HR policy will be enforced and revised. Furthermore, additional CHWs will be recruited, a package of non-monetary and social incentives will be reviewed, a training module on integrated supervision for AEHOs, CHNs and CMAs will

be developed and Disease Control Surveillance Assistants will be trained based on the new curriculum.

3. Information and Communications Technology: Promote a harmonised community health information system with a multi-directional flow of data and knowledge. Key interventions to achieve this goal include harmonising data management practices; exploring integrated mHealth solutions for CHWs; training all CHWs in the CHT on ICT and data management and launching two-way feedback and data review systems between communities and the health system. The target for 2030 is that an inclusive and disaggregated database of CHWs will be developed, information platforms at community level will be created and supported and policies on ICT interventions at community level will be reviewed. In addition, ICT materials (mHealth) will be procured, distributed, and managed with all community health workers and data from birth and death registration at community level will be incorporated.

4. Supply Chain and Infrastructure: Provide sufficient supplies, transport, and infrastructure for CHWs in the CHT. Key interventions to achieve this goal include construction of health posts (Integrated Community Health Service Delivery Structures) and CHW housing units in hard-to-reach areas; procurement and distribution of durable, high-quality bicycles and motorcycles to CHWs; and scale-up of electronic supply and drug management to cover all of community health. The 2030 target is that community ICT equipment e.g., tablets, printers, computers and network accessories and materials to assist persons with disabilities will be procured. Integrated Standard Supply List for CHWs in collaboration with Physical Asset Management will be reviewed and disseminated, 900 health posts will be installed with solar power, 1200 access roads will be upgraded, 850 Wide Area Network will be installed, and transport guidelines will be revised to include CHWs. In terms of procurement, 6000 quality bicycles will be procured for HSAs, 11400 bicycles will be procured for VHCs/CHAGs, 850 motorcycles will be procured for SHSAs, 11,400 houses will be constructed for HSAs and 802 health posts will be constructed.

5. Community Engagement and Participation: Strengthen community engagement in and ownership of community health. Key interventions to achieve this include generating support for community health, building the capacity of prioritised community structures (e.g., VHCs, CHAGs, and HCACs) and rolling out enhanced social accountability mechanisms at community level (e.g., scorecards). Target for 2030 is that HCMCs will be formed and trained, community feedback mechanisms established and monitored in terms of its functionality and health service charters developed.

6. Leadership and Coordination: Ensure sufficient policy support and funding for community health and that community health activities are implemented and coordinated at all levels. Key interventions to achieve this goal include scaling up the coordinating function of the CHS Section at the national level; establishing Community Health Section at district level, strengthening community-level coordination through CHAGs and CHTs and hosting regular coordination meetings between stakeholders at all levels. The target for 2030 is that 30 national level coordination meetings and 30 national level CH TWG meetings will be conducted. Also, Terms of References (ToRs) for district community health committee meetings will be developed, 30 district-level community health coordination meetings will be conducted, CH virtual platform will be established, 30 community health coordination meetings for program managers will be conducted, 28 district community health offices will be established and NCHF will be disseminated to all CHTs.

7. Community Health Financing: Set a community health financing architecture that can mobilise adequate resources for implementation of interventions at community level. Key interventions to achieve the goal of community health financing are two namely mobilising adequate, sustainable, and predictable funds for community health to optimally deliver essential health packages services at community level and establish and strengthen community institutional arrangements and systems for effective community health financing. The target for 2030 is that institution capacity for CHSS will be built in community health financing, a resource mobilisation plan will be developed, private sector will be engaged in PPP initiatives and there will be increased community health funding from ORT budget via DIP.

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

Over the next eight years, implementation of the NCHF will require coordinated efforts from all actors working in the community health system. Implementation of NCHF will continue to strengthen systems that were put in place during implementation of NCHS and will also scale up activities that were spelt out in NCHS with an addition of new activities. M&E will take place at every stage of implementation.

The CHS Section of the MoH is responsible and accountable for the successful implementation of the NCHF – and must have sufficient resources to carry out this mandate. Specific roles of the CHS Section include coordination and planning across programmes; development of policies and guidelines; monitoring adherence to policies and guidelines; overarching management of CHTs and support for community structures (VHCs, CHAGs, HCACs, etc.). To fulfil these roles, the CHS Section will require predictable financial resources and additional human capacity, with the goal of recruiting additional staff to the current full-time employees. Apart from the 9 full time employees that were earmarked to be in place during the implementation of NCHS (2017 to 2022), there is a need to employ more officers like Resource Mobilisation Officer and full-time officers at district level as Community Health Officers.

The total cost of providing high-quality community health services to all people in Malawi from 2023 -2030 is estimated at MWK **580,581,831,222**. According to the estimated budget ceiling per year, 2028, 2029 and 2030 have the highest cost of about MWK **84 billion** each year. The highest cost is under Human Resources for Health amounting to MWK **414,798,081,020** followed by Supply Chain and Infrastructure (MWK **128,279,198,695**). Remuneration for community health workers makes the Human Resources for Health thematic area the highest cost driver (MWK **394,063,780,900**) whereas construction of community health posts make the Supply Chain and Infrastructure thematic area the second highest cost driver with a total cost of MWK **9.9 billion**. The lowest costed thematic area is Community Health Financing (MWK **3,440,842,773**) and the

lowest cost driver is the newspaper advert (MWK **4,000,000**). Financing the NCHF will require support from the government, donors, partners and the private sector.

The NCHF document is structured as follows: Chapter 1 introduces community health in Malawi and Chapter 2 summarises the process that took place to develop the NCHF. Chapter 3 presents the national community health strategy and includes the vision, mission, guiding principles, strategic objectives, and interventions by thematic area to achieve the objectives. Chapter 4 summarises the costing of the NCHF. Chapter 5 provides a detailed overview of the structure of the Malawi community health system, which is essential to achieving the strategic objectives. Chapter 6 summarises implementation arrangement and framework. Chapter 7 outlines program management and lastly chapter 8 lays out a provisional M&E plan. The annex provides additional details on the general implementation plan.

CHAPTER 1

INTRODUCTION

1.1 Background to NCHF

This NCHF covers an eight-year period (2023-2030) and is aligned with HSSP III which covers the same lifespan. As such, it has been developed in tandem with some of the building blocks/pillars of HSSP III namely health service delivery, human resources, health financing and information and communications technology. The alignment will ensure that gains realised from implementing the interventions of NCHF contribute to outcomes of HSSP III and ultimately the new vision of Malawi 2063 as HSSP III draws some principles from Malawi 2063. The NCHF is also aligned to WHO building blocks on primary health care.

The NCHF also contributes to Sustainable Development Goal number 3, which is about good health and well-being. The international community, through Goal 3, has committed itself to a global effort to eradicate disease, strengthen treatment and healthcare, and address new and emerging health issues. A holistic approach to better health will require ensuring universal access to healthcare (Universal Health Coverage) as spelt out in Sustainable Development Goal target 3.8. The foregoing statements typify community health, which NCHF serves. NCHF therefore comes in handy as it coincides with the last eight years of the Sustainable Development Goals (SDG) period and the Ministry of Health recognizes that to attain SDG targets in 2030, there must be fundamental reforms and restructuring of the health system.

As part of ensuring universal access to health care, WHO guideline on health policy and system support emphasises on addressing health workforce shortage, maldistribution, and performance challenges as these are essential for progress towards all health-related goals, including universal health coverage. Effective health workforce strategies include the education and deployment of a diverse and sustainable skills mix, harnessing in some contexts the potential of CHWs operating in interprofessional primary care teams. As such, there is a need to optimise community health worker programmes embedded within community health.

Malawi has made gains regarding health service delivery in the past years. Nevertheless, there are still grey areas and bottlenecks to be addressed if the gains are to be sustainable and if more gains are to be realised. Some of the grey areas that require attention include issues of coordination due to fragmented health care system, health financing and response to emergencies among other things. These are some of the issues being accentuated in the NCHF.

1.2 Methodology and Theory of Change for NCHF

To develop the NCHF, an integrated framework that uses the HSSP III building block frameworks to define the objectives of the health system was used. The inception report developed for NCHF provided detailed methodology and key references for the approach (Consultant Inception Report). HSSP III is based on the World Bank framework where NCHF also draws the goal of Universal Health Coverage (UHC) by emphasising on bringing services closer to the people.

The use of objectives for HSSP III building blocks framework in the NCHF will ensure that interventions that were already effective in the NCHS (2017-2022) are sustained in the NCHF

while accommodating reforms inside each building block that will increase impact of the rest of the routine community health system interventions. This approach will also allow reform interventions to be clearly identifiable and inform the implementation arrangements necessary for successful delivery of the NCHF.

Figure 1 summarises the logic of the NCHF. Effective implementation of the routine and reform interventions (strategies and their activities) will lead to the achievement of the objectives (at the building block level of HSSP III).

FIGURE 1: THEORY OF CHANGE FOR NCHF

Intervention	Intermediate Goal	Ultimate Goal (HSSP III)
-Fully integrate community health services at the point of care -Ensure complete alignment of the package of services delivered by CHWs to the community components of the HBP -Prioritize and strengthen supervision	Deliver HBP at community level through integrated services provided by CHWs in CHTs	Increase equitable access to and improve quality of health care services
-Enhance recruitment, selection, deployment and equitable distribution of human resources for community health -Improve staff development strategies, policies, procedures and practices for human resources for community health -Institute and provide for competitive remuneration, benefits, and working conditions for human resources for community health -Achieve policy recommendations for the ratios of CHWs to members of the population. -Ensure all members of the CHT – including CHNs and CMAs	Improve availability, development, performance, motivation and retention of human resources for community health for effective, sufficient, efficient and equitably distributed health services delivery at community level	Improve availability of competent and motivated human resources for health for quality health service delivery that is effective, efficient and equitable.
Harmonise data management processes. Provide sufficient training for HSAs, their supervisors, and CHVs on data and ICT. Create a data feedback loop for CHWs and communities.	Promote a harmonised community health information system with a multi-directional flow of data and knowledge	Develop a sustainable and harmonized country-led digital health system that covers all areas of service provision and enables efficient delivery of health services at all levels of the health system
Develop service delivery structures in hard-to-reach areas. Provide houses for CHWs – all SHSAs, all HSAs, and CHNs as needed – living in rural areas Provide durable transport options to HSAs and SHSAs Integrate the community health supply chain with the broader supply chain.	Provide sufficient supplies, transport, and infrastructure for CHWs in the CHT	Improve the availability and quality of health infrastructure and medical equipment
-Collaborate with prioritised community structures -Strengthen leadership and accountability at community level.	Strengthen community engagement in and ownership of community health	Enhance the effectiveness of leadership and governance at all levels of health sector
-Coordination at national level -Coordination at district level -Coordination at community level -Integrated referral pathway -Stakeholders and partners	Ensure sufficient policy support and funding for community health and that community health activities are implemented and coordinated at all levels	Enhance the effectiveness of leadership and governance at all levels of health sector
-Mobilize adequate, sustainable, and predictable funds for community health to optimally deliver essential health packages services at community level. -Establish and strengthen community institutional arrangements and systems for effective community health financing. -	Set a community health financing architecture that is able to mobilize adequate resources for implementation of interventions at community level	Set a well-governed health financing architecture that is able to mobilize adequate resources, distribute the resources in an efficient and equitable way, and strategically purchase services based on a well-defined benefit package in pursuit of UHC goals

1.3 Situation Analysis

Malawi spans over 118,484 km^2 (45,747 sq mi) and has an estimated population of 19,431,566 (as of January 2021)[2]. It is a landlocked country and boarders with Tanzania to the north, Lake Malawi to the east, Mozambique to the east and south, and Zambia to the west. Malawi's capital (and largest city) is Lilongwe. Its second largest city is Blantyre, its third largest is Mzuzu and its fourth largest is its former capital, Zomba. The country is divided into three regions and sub-divided into 28 local government and administrative districts. The districts are further divided into Traditional Authorities, then Group Village Heads with villages as the smallest administrative units. At an average annual growth rate of 2.69% per annum, the population is estimated to grow to 23.1 million in 2030. Malawi has a young population with 64% of the total population under the age of 15. Then 18% is under the age of 5, and only 3% above 65 years. Life expectancy is currently at 65.18, which is a 0.68% increase from 2021[3].

Malawi is predominantly agricultural, with about 81.5% of the population living in rural areas. However, Malawi is predicted to experience an average annual urban population growth rate of 4.2% from 2013 to 2030[4]. GDP averaged 2.83 USD Billion from 1960 until 2021, reaching an all-time high of 12.63 USD Billion in 2021 according to official data from the World Bank[5].

Malawi has registered notable gains as regards health outcomes over the past two decades. For instance, WHO reported 639 maternal deaths per 100,000 live births in 2015. In 2020, maternal mortality had reduced to 349 per 100,000 live births. The Malawi Demographic Health Survey (MDHS) of 2015-2026 shows that under five-child mortality in the period before the 2015-16, was at 67 per 1000 live births. The infant mortality rate in 2021 was 36.078 deaths per 1000 live births showing a sharp decline from the infant mortality of 2015 according to WHO.

The HIV prevalence rate was 8.9% according to MPHIA 2020/21 a drop from 10.6% according to MPHIA results of 2015/16. In addition, Malawi has reached an equilibrium in HIV between new infections and deaths.

Despite gains registered in the health sector as underscored in the paragraph above, there is still a heavy burden of disease evidenced by high levels of child and maternal mortality rates and high prevalence of diseases such as tuberculosis, malaria, HIV & AIDS and other tropical diseases in Malawi. While there have been significant achievements over the past two decades in Malawi's TB response, TB remains a major public health problem. Malawi has an estimated TB burden of 27,000 cases[6]. Malaria remains the leading cause of death and accounts for about 15% of admissions in hospitals and about 36% of all outpatient department cases[7].

The Malawi health sector operates under a decentralised system guided by the Local Government Act (1998). The decentralised system has four tiers of service delivery: community, primary, secondary, and tertiary. Community services include those delivered through community initiatives, village clinics/health posts and community health workers.

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[2] National Statistical Office. Malawi Population and Housing Census Report - 2018. Zomba, Malawi; 2019.

[3] Malawi Life Expectancy 1950-2022 | MacroTrends, https://www.macrotrends.net/countries/MWI/malawi/life-expectancy, accessed on 10th July, 2022.

[4] Annual Economic Report 2021.

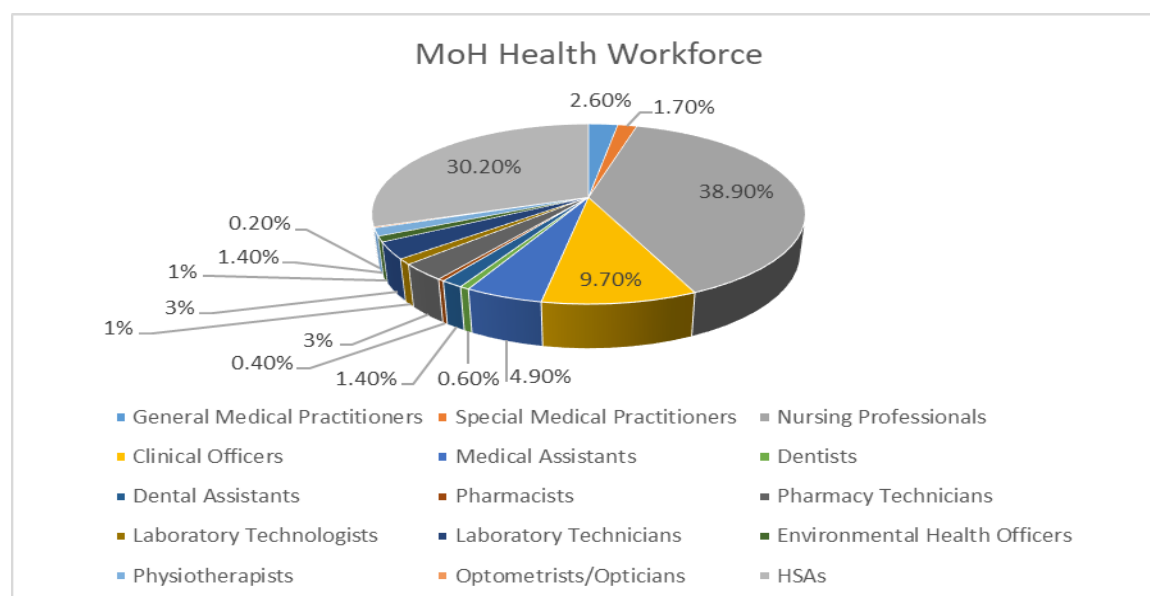
[5] https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=MW

[6] World Health Organization. Global Tuberculosis Report, 2021.

[7] U.S. President's Malaria Initiative.

Community health system was constituted during the implementation period of the NCHS (2017-2022) to ensure effective and efficient delivery of health service delivery at community level. The community health system comprises community health structure with a composition of CHTs. Members of CHTs are Community Health Volunteers (CHVs), Health Surveillance Assistants (HSAs), Senior Health Surveillance Assistants (SHSAs), Community Midwife Assistants (CMAs), Community Health Nurses (CHNs) and Assistant Environmental Health Officers (AEHOs). Today, Malawi has approximately 11,500 Health Surveillance Assistants (HSAs) deployed in communities across the country, comprising almost 30% of MoH's health workforce as depicted in figure 2. Community health therefore connects millions of people to the health system by providing primary health care services where people live.

FIGURE 2: ESTABLISHED PUBLIC HEALTH WORKFORCE FOR MINISTRY OF HEALTH



Source: National Health Workforce Account Report, 2023

At community level, CHTs are responsible for service delivery to their respective catchment populations. The CHTs are linked to the Health Centre Management Committees (HCMCs) that are in turn linked with the health centres. The community health structure is also linked with local government structure at community level in the sense that the Area Development Committee (ADC) oversees Health Centre Management Committees (HCMCs) within the jurisdiction of the ADC at TA level. The ADC is linked to the Council through the Councilors and Member of Parliament as well as the Traditional Authority, all of whom are members of the Council in some respect. At the GVH level, the Village Development Committee (VDC) oversees and coordinates community level DIP interventions through the VHC and CHAGs. These community level structures are supported by technicians who are linked to both the HCMC thereby ensuring linkage across the technical and political decision-making arms of the District Council and hence relevant mechanisms at the national level.

Community-based primary care is gaining prominence in Malawi and many other countries. Globally, community-based primary healthcare is critical to achieving the global health milestones put forward by the Sustainable Development Goals (SDGs). SDG 3 aims to ensure healthy lives

and promote well-being for all ages by 2030, including the target to achieve universal health coverage by 2030. Overall, the SDG targets related to health have a much broader scope than the health-related MDGs 4 and 5. Achievement of these goals therefore demands comprehensive approaches that focus on strengthening health delivery systems – including community health. CHWs help fight leading causes of morbidity and mortality, build capacity to handle the growing burden of both communicable and non-communicable diseases and help prepare for and respond to health emergencies. Many countries – including Ethiopia, Nepal, and Brazil – have seen transformative results from strengthening their community health systems. In Liberia, CHWs played a critical role in responding to the Ebola crisis. The success has resulted in an increase in the number of funders of and organisations working in community health. Recognizing this potential, many global efforts are underway to strengthen community health systems.

Malawi uses paper-based integrated community health registers (iCHRs) to collect data at community and household levels as one way of strengthening the community health systems. Personal registers are used to collect client-level data of individuals from various households. Reports are compiled and aggregated from the registers for decision-making purposes. However, having realised the need for continued development of a sustainable and harmonised country-led digital community health information system that covers all areas of service provision and enables efficient delivery of health services at community level, the health sector introduced the Health Management Information System (HMIS).

HMIS records, stores, retrieves, and improves health aggregate data to improve decision-making. Electronic Health Records (EHRs) are collected using various Electronic Medical Records at health facility levels. Other platforms such as One Health Surveillance Platform (OHSP), collect patient-level surveillance data but also at facility level. However, these platforms do not capture community patient-level data hence a gap regarding Health Information Digital System at community level. As such, the Ministry of Health through CHSS and DHD introduced the integrated Community Health Information System (iCHIS) that supports patient-level data collection, data analytics and reporting to yield informed decision-making. The iCHIS will ensure a strengthened and robust community health system that offers both routine community health services as well as much needed digitised service delivery at community level. It is now being used as a database for CHWs.

One of the crucial prerequisites for community-based primary care to succeed is the issue of financing. It is acknowledged that some activities in the NCHS were not implemented because setting up of community health systems took a significant portion of the implementation period. However, funding constraints also contributed towards failure to implement some of the activities of the NCHS hence the need to set a community health financing blueprint.

1.4 Rationale for the NCHF (2023-2030)

The National Community Health Framework (2023-2030) was conceived against a background of various reasons that necessitated its coming into being. The reasons are as follows:

i. Expiry of the NCHS (2017-2022): National Community Health Strategy outlived its lifespan hence it was subjected to revision which resulted into the development of this NCHF.
ii. Prevailing circumstances: From 2017 when NCHS came into existence up to the year 2022, several issues affecting community health have emerged. These include COVID-19 pandemic, change of policies in the health sector, natural disasters, financial constraints, and others.

iii. Development of HSSP III: The NCHS was fed into HSSP II. Since HSSP II outlived its lifespan which necessitated the development of HSSP III, it logically follows that the NCHS should also be revised as it is like the operation plan of HSSP III.

The NCHF aims to achieve Malawi's health and development goals by setting an eight-year agenda for community health in conformity with HSSP III. This includes laying out key actions necessary to sustain a more scientifically and culturally acceptable, integrated, and efficient community health system. Specifically, the NCHF seeks to:

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

CHAPTER 2

CONSULTATION PROCESS AND FINDINGS

2.1 Review Process of NCHS (2017-2030)

The review process of NCHS (2017-2022) was designed as a participatory process involving all key community health stakeholders. This extended to the participation of non-governmental organisations, development partners, other government ministries and the Ministry of Health at various levels of health provision and policy management. Key consultation processes and findings were as follows:

2.1.1 First CH-TWG Meeting to Present Concept Note and Roadmap of NCHF

During the CH-TWG meeting, a road map regarding the development of NCHF was presented. During the meeting, discussions ensued and suggestions pertaining to how best to develop NCHF for the period 2023-2030. Participants and attendees included representatives from the Government, development partners, non-governmental organisations, the private sector and civil society organisations.

2.1.2 National and Zonal Consultative Stakeholder Meetings

One national and two zonal consultative stakeholder meetings were conducted during the development of NCHF. The aim of the consultative stakeholder meetings was to solicit suggestions and recommendations for the content of NCHF considering MTR and other observations emanating from the implementation of NCHS. During the consultative meetings, results of MTR were presented coupled with an overview of the NCHS. Thereafter, participants were divided into seven groups according to the six thematic areas of the NCHF and an additional thematic area of community health financing as per recommendation of MTR. In the groups, participants reviewed activities of the NCHS in terms of progress or lack of it according to findings of MTR. Thereafter, participants were asked to populate a template with activities of NCHS that were to reflect again in NCHF and suggested new activities to go in NCHF based on findings of MTR and other prevailing conditions. Participants of the consultative stakeholder meetings included members of selected CSOs, faith-based organisations, CBOs, ward councillors, district councils especially members of DHOs and Ministry of Health especially Community Health Services Section.

2.1.3 Continuous Engagement with Directorate of Planning and Policy Development

The continuous engagement with the Directorate of Planning and Policy Development of the Ministry of Health served the purpose of aligning interventions of NCHF with HSSP III. Products of national and regional consultative stakeholder meetings up to validation meetings were shared with the Directorate. Input was solicited at various development stages of NCHF.

2.1.4 Regional Validation and National Consensus Stakeholder Workshops

Activities for the NCHF draft were finalised by a writing team of experts considering recommendations of MTR, emerging issues and stakeholder consultation meetings. After the NCHF draft was produced, it was subjected to critical review and analysis through a validation workshop comprising relevant stakeholders in the Northern Region and national consensus stakeholder workshop that took place in Lilongwe. Recommendations and input from the validation and national consensus stakeholder workshops formed the basis for the revision of the NCHF draft during the second writing session.

2.2 Key Findings of the Mid Term Review (MTR)

The National Community Health Strategy (NCHS) was Malawi's overarching first strategy for community health services in the country. The NCHS was implemented from 2017 to 2022. Implementation of the NCHS took a two phased approach. The first phase from 2017 to 2020 was designed to implement preliminary and foundational activities such as implementation of high impact activities, preparation of guidelines, reinforcement of structures, and establishment of Community Health Teams (CHTs) to strengthen the CHS. The second phase (2021-2022) would consolidate achievements in Phase I and would include expansion of the activities from Phase I. After implementation of the first phase of the strategy, a mid-term review of the NCHS was commissioned to gauge progress towards CHS objectives as well as learn from implementation experience towards the end of the first phase. It must be acknowledged that the MTR did not directly measure the NCHS outcomes and deductions made based on the chain of causation logic. Also, there was bias due to a small sample. To offset this, MTR consulted a wide range of stakeholders using different methods and triangulated results for validity.

2.2.1 Objectives

The overall objective of the MTR was to review progress towards implementation of the NCHS at mid-term, focusing on implementation process, lessons learned and progress towards objectives as of 2021.

Specific objectives of MTR were to:

- Review implementation processes across the 6 thematic areas and the 6 guiding principles and to which extent activities were achieved/implemented, effective, challenges faced, and lessons learned;
- Determine the extent to which the Government of Malawi and its partners have been able to mobilise the required resources for the implementation of the NCHS;
- Determine the progress towards NCHS objectives through quantification of indicator achievement at the mid-point, as well as qualitative assessments;
- Based on the MTR findings, prepare a summary of lessons learned, effective practices and practical recommendations on NCHS implementation improvement to inform strategic direction shifts of the current and next NCHF and HSSP III design.

2.2.2 Methodology

A qualitative design-involving community, district and national level consultations was used. The focus was on process evaluation-progress towards output targets at mid-term, challenges, lessons, emerging issues and not wholly on outcome indicators. Methods used included document review of CHSS administrative data, key informant interviews, FGDs with community members and HSAs, facility checklist on CHS-31 Health facilities, regional and national consultations, and a validation meeting.

2.2.3 MTR Key Findings per Thematic Area

Overall, 51 of the 122 activity targets in NCHS road map were met as of November 2021 representing 41.8% of the targets. Also, 20 (16.4%) activity targets were assessed to have been partially met.

TABLE 1: PROGRESS TOWARDS NCHS ROAD MAP ACTIVITY TARGETS

#	Thematic Area	Total Activity Targets	Activity targets met->95% achievement	Substantially met-75-94%	Partially met-50-69%	Not met-<50%	Unable to assess-no data/no target
1	Health Service Delivery	16	9	0	0	7	0
2	Human Resources	23	5	0	4	14	0
3	Information, communication & Technology	21	6	0	7	8	0
4	Supply Chain and infrastructure	21	8	0	7	6	0
5	Community Engagement	14	9	0	0	5	0
6	Leadership and coordination	15	9	0	0	6	0
7	Cross-cutting issues	12	5	0	2	5	0
	Totals	122	51	0	20	51	0

Key:

Target exceeded or met. 100%+ achievement	Substantially achieved. 75%-94% achievement	Partially met-50%-74% achievement	Target not met <50% achievement	Not rated (no targets or no data)

For each of the thematic areas, the following were the achievements:

i. Community Health Services Delivery

For health services delivery, over 82% of the 55 community EHP elements were delivered by HSAs, all guidelines were prepared and disseminated, role clarification and job descriptions were completed. There were efforts towards integrating health service delivery at point of care and supportive supervision was being carried out following an integrated approach.

ii. Human Resources for Community Health

Human resources for community health had four key achievements namely HSA positions established, 2040 HSAs recruited of 7,000 planned, HSA to population ratio as of 2020 was 1:1260 vs 1: 1,000 policy standard which was favourable when compared to NCHS target of 1:1,346, percentage of HSAs residing in their catchment areas was 47% versus 75% NCHS target. However, it must be noted that HSAs to population ratio showed improvement but hid cross-district and community differences.

iii. Information and Communications Technology

Information and communications technology registered achievements as an integrated community health village register was developed.

Integrated Community Health information System (ICHIS) is still under development. As of December 2022, Ministry of Health in collaboration with partners Last Mile Health (LMH), UNICEF, Wandikweza, and Save the Children have provided tablets and training on iCHIS to 1754 HSAs in Salima, Kasungu, Dowa, Balaka, Machinga, Blantyre, Thyolo. The iCHIS application is envisioned to have 12 modules centering on registers and Health Benefit Package (HBP) areas. Of these, 5 are developed.

iv. Supply Chain and Infrastructure

Supply chain and infrastructure had two notable achievements, and these were the procurement of 3,000 durable bicycles for HSAs and the commencement of field assessments for HSA houses construction.

v. Community Engagement and Participation

Community engagement thematic area recorded 9 activity targets that were fully or partially achieved of the 14 planned as of MTR. Key activities achieved included alignment of community level structures with the Ministry of Local Government and Rural Development (MoLGRD) on existing community structures, functions, and linkages, holding of a community health open day to raise awareness about the importance of community health in Malawi and wide dissemination of revised and clarified roles of community structures to DEC. Other achievements were implementation of quality assurance of community health service delivery, in keeping with existing guidelines on quality management, and by working with the Quality Management Directorate.

vi. Leadership and Coordination

As at MTR, notable achievements under leadership and coordination were a CHS TWG at the national level was in place to facilitate coordination, CHS TWGs were set up in all districts, a road map for NCHS activities was being followed and periodically reviewed by partners and CHS coordinators were identified in all districts.

2.2.4 Implementation Challenges or Limitations

Overall, the biggest challenge was resource constraints, which crippled implementation of some activities. COVID-19 pandemic also undermined implementation schedules greatly. Other implementation challenges were as follows:

- The CHT concept was introduced but did not become fully operational.
- Integration was always difficult during supportive supervision- due to time constraint.
- Most HSAs did not reside in their catchment area.
- There was under-staffing of the CHS Section in MoH which affected efficient implementation of interventions.
- Inclusion of the vulnerable population in community health such as people with disabilities and the youth was still an issue.
- Not all HSAs were using mHealth for data and service delivery.
- ICHIS was not yet concluded, and the system was not launched thereby delaying training of HSAs in data management.
- Mobility for many HSAs was still a challenge as procured bicycles did not reach all HSAs.
- There was a prolonged period of stock-outs of some supplies like Amoxil for community management of illnesses.

- There was less than adequate community ownership and hence participation in the provision of housing for CHWs in some areas as the construction of CHW housing could not happen as compared to what happens with the education sector.
- Most CHAGS reported not to be fully functional (meetings were irregular).
- Bulk of CHAGs and HCACs were not oriented yet, hence, not fully aware of their roles.
- Limited application of community scorecards and sharing of results.
- In some districts, some partners did not work with DEC/DHSS when planning and implementing activities.
- There was no definitive mechanism to finance CHS at the health facility.
- There was still limited accountability to communities regarding service delivery.
- There was limited engagement and participation of the private sector in CHS. Private sector agencies such as business entities have so far played a limited role in CHS.

2.2.5 Conclusion and Recommendations

MTR noted that considerable efforts were made by the Government of Malawi through the Ministry of Health and its partners to implement NCHS. However, there was a generally slower than expected implementation pace occasioned by funding constraints and the COVID-19 pandemic. MTR suggested two major focus areas for NCHF. The first one was that in NCHF, there should be no drastic departure from current NCHS thematic areas given that a lot of energy was dedicated towards setting up systems during the lifespan of NCHS with limited implementation. Community health financing was also recommended to be an additional stand-alone thematic area besides the six thematic areas in NCHS. MTR further made the following recommendations:

- Monitoring effectiveness of guidelines is required.
- Training and orientation of HSAs and SHSAs as a continuing need.
- ICHIS needs to be concluded and launched.
- There is a need to operationalize community health team concept.
- There is a need to utilise supervision guidelines.
- There is a need to set up and implement a coherent CHW development programme to address community health human resources shortfalls.
- There is a need to address CHW accommodation issues.
- There is a need for greater involvement of communities in CHW recruitment.
- There is a need to harmonise information and data collection instruments as part of implementing the integrated community health management information system.
- There is a need to mobilise resources for constructing health posts.
- Efforts should be made to continue to mobilise resources to fund transportation for CHW-durable bicycles.
- Resource District Community Health Technical Working Group functioning across all districts.
- Improve partner reporting and coordination with District Councils.

CHAPTER 3

KEY INTERVENTIONS OF THE NCHF

3.1 Community Health in Malawi: Key Definitions

In Malawi, community health refers to a basic package of preventive, promotive, curative, rehabilitative and surveillance health services delivered in rural and urban communities with the participation of people who live there. This package of services consists of the community components of Health Benefits Packages (HBPs) according to HSSP III also known as Essential Health Packages (EHPs) in HSSP II.

Health Benefits Packages at community levels are defined as a set of subsidised packages of healthcare interventions that are essential to make progress towards the Sustainable Development Goal target 3.8 of Universal Health Coverage (UHC) in low-income and middle-income countries. HBPs are divided into three categories in the HSSP III, and these are primary, secondary and tertiary HBPs[8]. However, for the NCHF, the focus is on the primary category of the HBPs.

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

Community Health Workers are in three categories namely permanent salaried CHW such as HSAs and CHNs, temporarily salaried CHW such as health promoters and Community Health Volunteers (CHV) who are not salaried but are provided with incentive package. Incentive package includes bicycles, PPEs (raincoats, gumboots, umbrellas, heavy duty gloves), back pack, lunch allowances when the CHW works more than half a day, transport refund when the CHW works outside 8 km radius.

Platform for Community Health Programs: The NCHF will create a platform so that all community health programs are implemented efficiently and effectively.

3.2 Vision

The vision of the NCHF is to improve the livelihoods of all people in Malawi.

3.3 Mission

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

3.4 Strategic Goal

By 2030, the NCHF aims to contribute to the achievement of key HSSP III objectives that hinge on effective delivery of community health services as follows:

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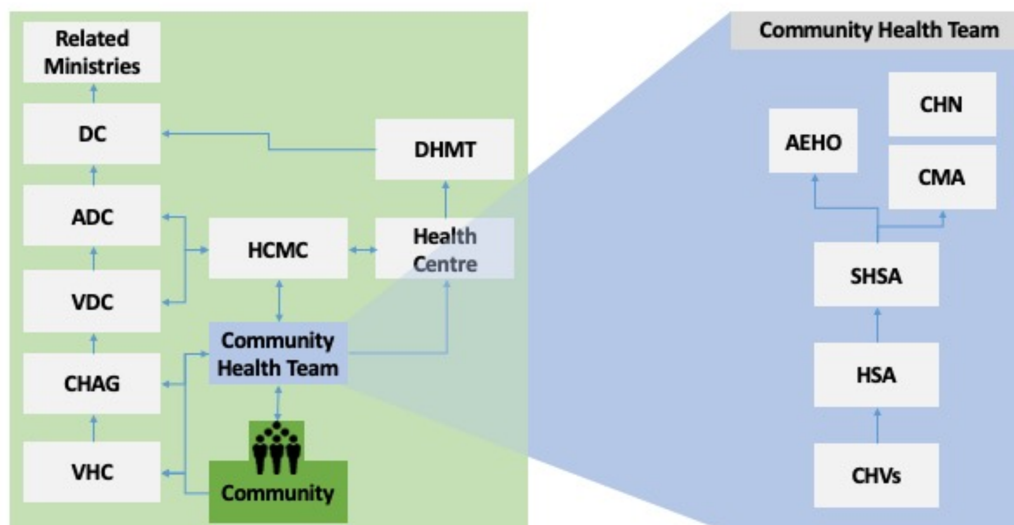
[8] The final primary and secondary HBP includes 99 interventions with 71% having cost-effectiveness data that could avert over 42 million DALYs in 2021 with expected increases annually through 2030 according to HSSP III.

- Increase equitable access to and improve the quality of health care services;
- Improve overall health, environmental health, and disease prevention through addressing social determinants of health and burden of disease;
- Improve the availability, accessibility and quality of health infrastructure and medical equipment at all levels of health care;
- Improve availability of competent and motivated human resources for health for quality health service delivery that is effective, efficient, and equitable;
- Improve the availability, quality and rational utilisation of medicines and related medical supplies, balancing the 3 P's: patients, products, and personnel;
- Develop a sustainable and harmonised country-led digital health system that covers all areas of service provision and enables efficient delivery of health services at all levels of the health system;
- Promote and coordinate a health research agenda to generate high-quality evidence required to inform the development of health and health care delivery;
- Enhance the effectiveness of leadership and governance at all levels of the health sector.
- Set a well-governed health financing architecture that can mobilise adequate resources, distribute the resources in an efficient and equitable way, and strategically purchase services based on a well-defined benefit package in pursuit of UHC goals.

Interventions of NCHF will be implemented through a community health system that was set up during the implementation of NCHS. The community health system will be community led and centred on and to incorporate, organise and motivate all participants including community members, volunteers, full time health workers, local governance, and community structures. Community health system will continue to be centred around the community and Community Health Team (CHT[9]) which will have linkages with community structures, local government, and the health system. This will ensure the achievement of the vision and mission of NCHF.

[9] CHTs are a team of CHWs meant to meet monthly with core team members and quarterly with extended team members. Core CHT members include 5 HSAs, 1 SHSA, and all CHVs in that area. The extended CHT also includes 1 AEHO and 1 CHN/CMA

FIGURE 3: COMMUNITY HEALTH SYSTEM STRUCTURE



3.5 Target

The framework will use life cycle approach[10] with inclusion as the underlying principle. However, there will be emphasis on the following groups as key target audience in the framework:

3.5.1 People with Disabilities

Implementation of NCHF shall continue to engage people with diverse disabilities in advancing their interests to make sure that nobody is left behind. Besides on-going engagement, interventions such as designing buildings so that they are disability friendly, promotion of sign language in points of care, use of braille and hearing aids and provision of albinism skin commodities at community level among others shall be promoted.

Integration of specific training on disability inclusion for community level health care workers will be explored targeting practising workers and those under active training. The training could extend to non-medical staff working at the community level with a focus on accessibility and respectful communication. Deliberate efforts will be made to include persons with disabilities and their representative organisations in the formal mechanisms (e.g. round tables, participatory dialogues, public hearings, online consultations) that take place when deciding packages of care or any other health-related matters in the community.

3.5.2 Key and Vulnerable Populations

Key and vulnerable populations shall be engaged in community health especially in service provision. These shall include people living with HIV, male and female sex workers and LGBTQI and uniformed forces.

[10] Life cycle approach is a concept that emphasises on prevention and early intervention at every stage of life – intrauterine period, early childhood, adolescence, youth, middle age and old age. Outcome at one point in the life cycle might be a determinant for health elsewhere further in the cycle.

3.5.3 Young People (AGYW and ABYM)

AGYW and ABYM are very crucial regarding advancing community health. If AGYW and ABYM are engaged meaningfully, health gains can be realised such as reduced HIV new infections, reduced teenage pregnancies, reduced maternal mortality and many more gains. NCHF shall engage young people in interventions such as SRHR outreach clinics, training them as Young Community Based Distribution Agents (YCBDAs) to promote commodities such as family planning and health education in general.

3.5.4 Pregnant Women and Children Under-Five

One of the ultimate goals of NCHF is to reduce maternal and child mortality. This goal shall be realised by engaging pregnant women and children under-five with community interventions in all points of care at community level. Pregnant women and children under-five shall be engaged in communities using points such as village clinics and community health posts with integrated services such as immunisation, family planning, ANC, HIV services, NCD chronic commodities and under-five clinics and other services like HTC, TB and cancer screening.

3.6 Guiding Principles

To achieve the vision and mission, NCHF will operate on six cross-cutting guiding principles. These principles lay the foundation for a strong, well-functioning community health system in Malawi:

i. **Integration:** Ensure that programmes and initiatives related to community health integrate seamlessly at community level through coordination of service delivery, supervision, training, supply chain, and M&E and promotion of clear referral pathways and lines of clinical responsibility between community, other primary, secondary, and tertiary health facilities. The integrated approach requires close partnership across communities, programmes, partners and sectors as well as efforts to fully leverage existing resources.

ii. **Community leadership:** Ensure the strategy listens to the needs and priorities of the Malawian people and that community members have ownership and remain accountable for the health of their communities. This includes recognizing the realities that CHWs face and designing a system that supports them appropriately.

iii. **Equity and Inclusion:** Ensure all people in Malawi – including women, people with disabilities, key and vulnerable populations, and residents of hard-to-reach areas – receive high-quality care at the community level.

iv. **Gender equality:** Ensure that the community health system in Malawi achieves gender equality at all levels, from leadership, to employment, to health service delivery. Gender distribution is key to determining access to services for women and children.

v. **Learning:** Promote continuous learning and course correction based on strengthened monitoring and evaluation efforts.

vi. **Transparency and Accountability:** Stakeholders shall discharge their respective mandates in a manner that is transparent and takes full responsibility for the decision they make.

3.7 Thematic Areas

Unlike NCHS (2017 – 2022) which had 6 thematic areas, NCHF has 7 thematic areas having taken into consideration one of the key recommendations from MTR to have an additional thematic area on community health financing.

3.7.1 Thematic Area 1: Community Health Services Delivery

Strategic Objective: To deliver integrated community health services as outlined in the HBP provided by Community Health Teams.

Strategic Recommendations

- Fully integrate community health services at service delivery point.
- Increase access to integrated health services through increased accessible service delivery points. This will ensure reduced distance to access health services – bringing services closer to people and reduced workload and pressure on delivery points.
- Align community health services delivered by CHWs to the community components of the HBP including prevention, promotion, community case management, surveillance, referral and rehabilitation.
- Strengthen supervision and mentorship of Community Health Teams;
- Strengthen Community Health Teams structures to ensure that CHWs are benefitting from peer learning and working collaboratively to deliver services.

Implementation of High Impact Interventions

High impact interventions shall be delivered as priority interventions under the HBP. These shall be delivered in an integrated and inclusive manner by CHWs. High impact interventions shall include:

HIV and AIDS

Malawi has made a lot of gains in identifying people living with HIV in the community and putting them on treatment. It is estimated that in 2025, the country will approximately have more than one million people alive on ART. The number of new HIV infections among adults and children continues to drop though still not at acceptable levels. Sustaining the gains and closing the gap of the new HIV infections will be a priority focus in this NCHF.

Delivery of comprehensive HIV preventions package at community level will include:

- Condom distribution.
- Demand creation of treatment packages.
- HIV self-testing.
- Modern contraceptives.
- Identifying and testing in the community.
- Follow up of treatment interrupters.
- Community ART Distribution.
- Community-led monitoring.

Treatment as prevention and viral load monitoring in the community remains a priority in this NCHF. The Framework will continue to strengthen community systems to sustain gains made in epidemic control with particular focus on identifying the new positive and linking them to care, adherence and retention to recipients of care and default to tracing. Special attention shall be on children, key populations, adolescents, young women/men, and breastfeeding women to reduce new HIV infections.

CHTs will implement activities according to updated role clarity guidelines and will prioritise and emphasise innovative community based Differentiated Service Delivery (DSD) models for both HIV prevention and treatment packages using maximising participation of community led structures. Community ART Distribution Points (CAD) and Community ART Groups and DSD

for testing will be strengthened at community level. Informal CHWs such as expert clients, mentor mothers and Community Based Distribution Agents (CBDAs) shall continue to trace treatment interrupters, trace loss to follow up of mothers and children in care. They will also assist in distribution of recommended essential health commodities at community level after proper orientation.

Malaria

Intervention package of malaria are diagnosis and testing, prevention, and treatment according to HBP as spelt out in HSSP III. Minimum level of care to the intervention package is:

- Primary and the care is outlined as rapid diagnosis tests.
- Mass ITN distribution.
- Indoor residual spraying.
- Uncomplicated first line malaria treatment including rectal treatment for <5 years old.
- Home treatment.
- Community case management.

These services shall be conducted at community level like in village clinics by CHTs such as HSAs. As part of community ownership, community volunteers shall be empowered to take part in indoor residual spraying.

TB

Intervention package of TB are preventive therapy treatment and psychosocial support according to HBP. Primary minimum level of care includes interventions such as 3HP preventative therapy for people living with HIV and also the following:

- Isoniazid Preventive Therapy for HIV+ pregnant women.
- Isoniazid Preventive Therapy for children in contact with pulmonary TB cases.
- DOT supports first line TB treatment.
- DR-TB treatment and case management.
- Nutritional support and counselling

Considering that Malawi is still using smear microscopy largely as the first entry point of TB diagnostic and testing, case detection at community level using community sputum collection points and house to house volunteers shall be strengthened as part of community health intervention in NCHF.

Vaccine Preventable Diseases

The vaccines that shall involve CHTs especially HSAs are BCG vaccine, Polio vaccine (OPV and IPV), Measles vaccine, Human Papillomavirus (HPV), rabies vaccine and COVID-19 vaccine among others. The vaccines shall be promoted through:

- Vaccination campaigns.
- Door to door campaigns.
- Community outreach.
- Support for community cold chains for vaccines.

Health Promotion, Prevention and Control

The intervention package of health promotion and prevention shall include surveillance, home care and promotion and prevention. Primary interventions in this area shall be:

- Home-based care for chronically ill patients.
- General health promotion & engagement.
- Disaster preparedness and response.
- Human health and climate change engagement and promotion.
- Promotion of hygiene and sanitation including water quality and food safety.
- Prevention of violence.
- Occupational health prevention such as prevention of accidents, injury, and trauma.

Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)

As countries grow due to increased global economic development, existing health care systems prove ill-equipped to deal with the new population increments. This challenge is exacerbated by resource constraints with limited facilities that may prove inaccessible to increasing segments of the population. RMNCAH continues as a persistent challenge particularly in rural areas. Improving RMNCAH requires successful community engagement, and the integration of community care subsystems into the primary care health system will have wide-ranging effects on the sustainability, effectiveness, and longevity of community health systems. In this Framework, CHT especially HSAs and community nurses will play a crucial role in RMNCAH by offering basic services such as:

- Cervical cancer screening at community level.
- Oral contraception, male and female condoms in family planning, injectables.
- Counselling and referral for long acting and permanent family planning methods
- Early detection of pregnancies, home visits during pregnancy and post-partum period.
- Detection of high-risk pregnancies including adolescent mothers.
- Community care for LBW/and Preterm babies including Kangaroo Mother Care (KMC)
- Community care for cerebral palsy babies.
- Deworming prophylaxis.
- Daily iron and folic acid supplementation.
- IPTp malaria[11]. Adolescent health, ASRH including family planning, development issues including involvement in committees and volunteer groups etc, counselling and referral for substance abuse.
- Verbal autopsies.
- Community dialogue/ awareness sessions and participatory appraisals on RMNCAH.

Nutrition

In community-based programs, workers—often volunteers and part-time workers—interact with households to protect their health and nutrition and to facilitate access to prevention and treatment of sickness and conditions. Mothers and children are the primary targets, but others in the household are also indirectly targeted. Community health interventions in this framework shall be characterised by CHWs gathering people at a central point (like village clinic) or visit them in their homes for growth monitoring and promotion and other nutrition sensitive and specific interventions. The existence, training, support, and supervision of the CHWs - based in the community or operating from a nearby health facility – shall characterise the interventions of Community-based Health and Nutrition Programs (CHNPs). Essential public function of nutrition includes among other areas, screening and prevention and treatment of malnutrition. CHTs especially HSAs and community nurses shall provide primary minimum level of care such as:

[11] IPTp entails administration of a curative dose of an effective antimalarial drug (currently sulfadoxine-pyrimethamine) to all pregnant women without testing whether they are infected with the malaria parasite.

- Growth monitoring and promotion.
- Mass community nutrition screening and referral.
- Micronutrient supplementation including Vitamin A Supplements (VAS) and Iron and Folic Acid (IFA) and deworming in infants and children 6-59 months.
- Nutrition care support and treatment for people living with HIV and AIDS including mothers and children, adolescents, and adults.
- Promotion of utilisation of iodised salt for prevention of Iodine Deficiency Disorder (IDD).
- Nutrition education and counselling.
- Promotion of dietary diversification.
- Community-based management of moderate and severe acute malnutrition.
- Distribution of micronutrient powders (*Ndisakanizeni*) for children 6 – 23 months.
- Promotion of appropriate Infant and Young Child Feeding (IYCF) practices including exclusive breastfeeding and appropriate complementary feeding after 6 months and support for continued breastfeeding up to 6 months and beyond.

Public Health Emergencies of National and International Concern

Essential public health functions, including health promotion, health protection, disease prevention, and surveillance and early warning mechanisms create a prepared system. This is vital to minimise exposure to health hazards and prevent health emergencies. In NCHF, the community shall play a role in emergencies of Public Health Importance (PHI). CHT shall systematically engage with communities to implement inclusive preparedness activities during the mitigation, response recovery phases of disaster at community level. Some of the areas that CHTs shall play a role will be:

High Impact Infectious Disease (for example, COVID-19 and Cholera)

- Preparedness training to screen, detect and manage.
- Epidemic investigation/ case report of suspicious conditions.
- Community integrated disease surveillance and response.

Natural Disasters like Floods/Cyclones

- Screening for all possible conditions.
- Digital data repository managers.
- Early warning systems

Neglected Tropical Diseases

The main objective of the NTDs Program is to make Malawi free from Neglected Tropical Diseases by 2030. The diseases of interest for Malawi are Onchocerciasis[12] (river blindness); Trypanosomiasis[13] (sleeping sickness); Soil-transmitted helminth infections (intestinal worms); Schistosoma (Bilharzia), Lymphatic filariasis (LF), Trachoma, Leprosy and other skin conditions including scabies. Other diseases not worked on are snake and vermin bites, rabies, and other diseases common in other countries but not mapped yet. All these diseases affect the poor people in the community and the most effective interventions include the following:

[12] The disease is called river blindness because the blackfly that transmits the infection lives and breeds near fast-flowing streams and rivers, mostly near remote rural villages. The infection can result in visual impairment and sometimes blindness.

[13] African Trypanosomiasis, also known as "sleeping sickness", is caused by microscopic parasites of the species Trypanosoma brucei. It is transmitted by the tsetse fly (Glossina species), which is found only in sub-Saharan Africa.

- Preventive chemotherapy through community mass drug administration.
- Community treatment of lymphoedema and hydrocele surgeries;
- Community vector control.
- Behaviour change and communication.
- Improved sanitation and hygiene practices.

Non-Communicable Diseases (NCDs)

The main types of NCD are cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma) and diabetes and mental health challenges. Essential public health functions in NCD include screening and diagnosis, prevention and NCD treatment. CHWs shall play a role in NCDs in offering primary care such as:

- Screening for hypertension, diabetes type I and obesity.
- Prevention of cardiovascular disease.
- Hypertension management and monitoring.
- Digital data repository manager.
- Linking people with NCDs to care.
- Counselling and psychosocial support.
- Community accidents like *Kabaza (l*ocal name for bicycle/motorcycle taxis) accidents and climate related accidents

In this regard, Community Health shall champion for community paramedics to respond to accidents in communities. These will provide first aid or life support care to injured patients prior to transporting them to health care facilities.

Palliative Care

Key palliative care interventions at community involves CHNs and other CHWs conducting home visits and outreach services to provide treatment, (including monitoring adherence to long-term treatments), care and support. The interventions include:

- Community nursing and medical care.
- Good symptom control.
- End of life care.
- Information, education, and counselling.
- Mentorship of caregivers.
- Good liaison across all partners/ stakeholders.
- Social care.
- Spiritual care.
- Provision of social and psychosocial support.

Activities for Community Health Services Delivery

3.7.1.1 Review role clarity guidelines to include emerging issues.
3.7.1.2 Disseminate role clarity guidelines to all community health workers.
3.7.1.3 Conduct physical audit/standards on the implementation of the NCHF.
3.7.1.4 Conduct review meetings at national, district and zonal level for joint work plan
3.7.1.5 Update the community health guidelines in line with emerging issues such as the HBP and emergencies of public health importance.
3.7.1.6 Disseminate the updated, integrated, and inclusive CH guidelines at all levels.

3.7.1.7 Conduct community health team monthly meetings at health facility level, cluster level and at district level.
3.7.1.8 Conduct quarterly integrated supportive supervision to all CHWs and CHT.
3.7.1.9 Conduct bi-annual multi-sectoral district coordination meetings to track implementation of the NCHF.
3.7.1.10 Conduct community health orientation meetings for DHMT, HSAs, CDAs, CHNs, CMA, AEDC, and AEDOs to advocate for multi-sectoral, integrated, and inclusive services in the district.

Summary of Integrated Community High Impact Intervention Activities

3.7.1.11 Conduct integrated community health screening for all conditions and diseases at point of delivery including cancer, hypertensions, diabetes, asthma, malnutrition, vaccination, and others.
3.7.1.12 Conduct integrated refresher training on disease/condition prevention and control measures including preparedness, screening, and detection.
3.7.1.13 Conduct integrated community disease surveillance and response activities (e.g., investigations) at community level.
3.7.1.14 Conduct integrated community growth monitoring of target groups including under-five children and pregnant women.
3.7.1.15 Conduct integrated community-based outreach clinics focusing on various target groups including children, pregnant and postnatal women and adolescents.
3.7.1.16 Conduct integrated community-based distribution of drugs and other health commodity supplies (micronutrient powder, ARVs, deworming drugs, obstetric drugs, BP/HTN drugs and family planning supplies).
3.7.1.17 Conduct integrated community health education sessions of various diseases and conditions.
3.7.1.18 Conduct integrated community health defaulter tracing of various diseases and conditions.
3.7.1.19 Conduct integrated community health follow-ups of various diseases and conditions.
3.7.1.20 Conduct integrated community-based death audits including maternal deaths.
3.7.1.21 Conduct integrated community-based counselling and psychosocial support sessions of various diseases and conditions.
3.7.1.22 Conduct integrated community-based palliative care visits of various diseases and conditions in the community.
3.7.1.23 Conduct integrated community mass distribution of various drugs and other health commodity supplies in the communities including MDA, vitamin A supplementation, Iron and Folic Acid (IFA).

Note that implementation of the foregoing interventions shall be carried out with intentional consideration for inclusivity by various **health cadres according to revised role clarity guidelines.**

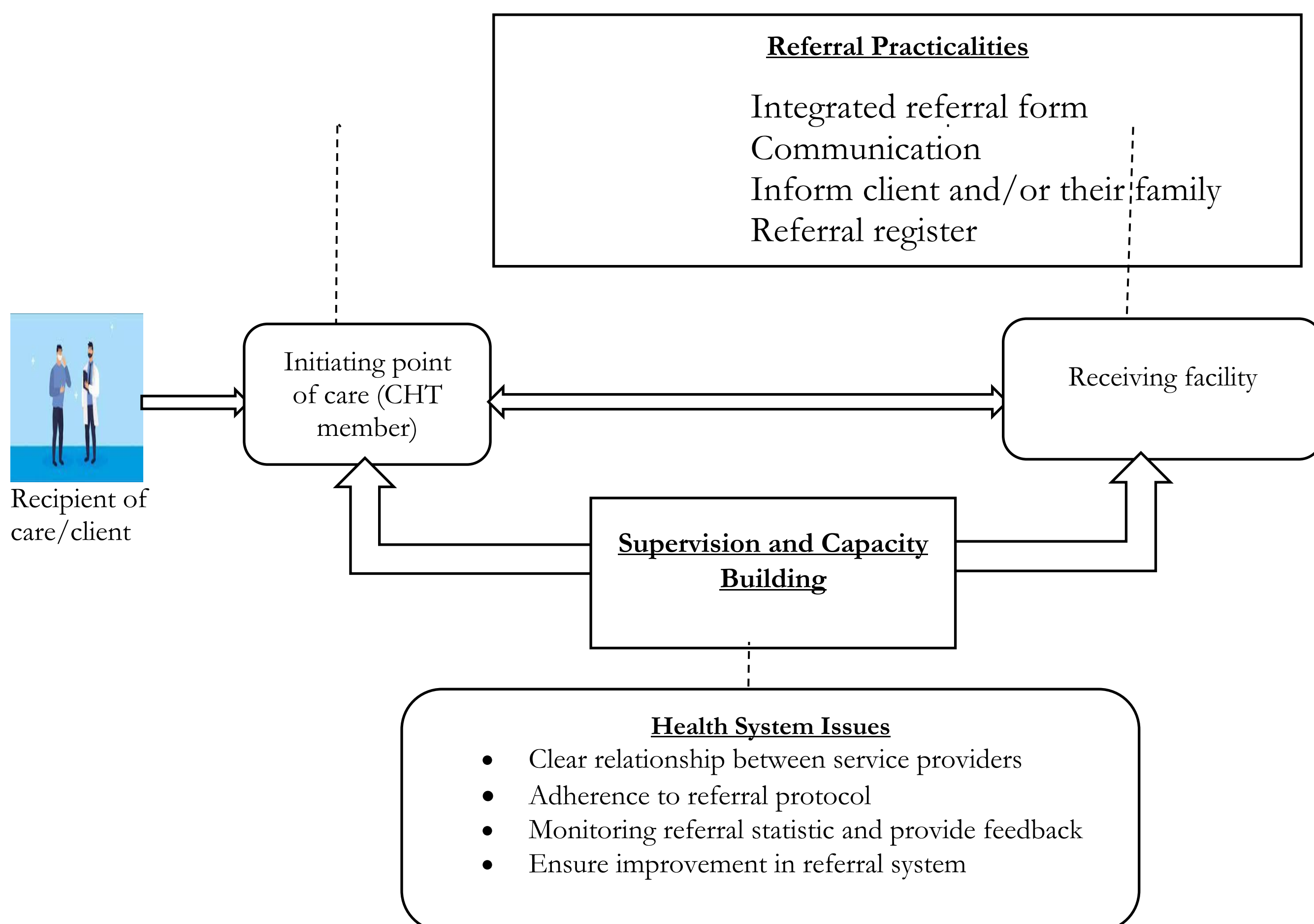
Community Referral Pathway: Community referral system will enhance coordination of services at community level. The community referral system will harmonise various services sought by recipients of care at various points of care. The community referral system shall work as follows:

- Recipients of care shall consult CHT members as first entry point of care.
- All possible conditions that can be presented before the CHT member shall be listed and designed into the integrated referral slip.

- The CHT member shall tick all conditions that require referral as presented by the recipient of care or indicate **"other"** if the condition is not on the list.
- On arrival at the health facility, there will be a desk officer to handle the referral cases.
- The desk officer will document the case and direct the recipient of care to the relevant provider without queuing.
- The provider who attends to the referred recipient of care shall scribble treatment feedback on the integrated referral slip, which will be recorded by the desk officer before the recipient of care goes back to the CHT member in the community to report back. The feedback will help the CHT member to follow up on the recipient of care in the community in terms of adherence to the prescribed treatment.

Key to the community referral pathway will be issues of confidentiality to curb stigma and discrimination.

FIGURE 4: COMMUNITY REFERRAL PATHWAY



3.7.2 Thematic Area 2: Human Resources

Strategic objective: To improve availability, development, performance, motivation, and retention of human resources for community health for effective, sufficient, efficient, and equitably distributed health services delivery at community level.

Strategic Recommendations:

- Enhance recruitment, selection, deployment, and equitable distribution of human resources for community health.
- Improve staff development strategies, responsive policies to support gender equity, procedures, and practices for human resources for community health.
- Institute and provide competitive remuneration, benefits, and working conditions for human resources for community health.
- Achieve policy recommendations for the ratios of CHWs to the population. To ensure sufficient coverage of the population, the NCHF will work towards increasing the number of CHWs with gender balance over the next eight years to meet national policy recommendations:
    - ✓ 1 HSA per 1,000 people.
    - ✓ 1 SHSA per 10 HSAs.
    - ✓ 1 AEHO per health facility.
    - ✓ 1 CHN per health facility.
    - ✓ 1 CHN per 5000 people.
    - ✓ 1 CMA per Community Health Delivery Structure.
    - ✓ 1 CMA per Community Health Delivery Structure.
    - ✓ 1 CMA per 2500 people.
    - ✓ 1 EHO per community/rural hospital.
- District councils shall facilitate recruitment and deployment of CHWs according to establishment, geography and population density given the varying levels of health care access and need across districts.
- Community rather than the health facility to promote quality community health services.

Activities

3.7.2.1 Update job descriptions and clarify roles for all CHWs (CHVs, HSAs, SHSAs, CHNs, CMAs and AEHOs).

3.7.2.2 Revise HSA pre-service and in-service training curriculum.

3.7.2.3 Provide high-quality, integrated pre-service training to all CHWs including HSAs in the revised training curriculum.

3.7.2.4 Train SHSA using the curriculum for Community Health Assistants in phased fashion.

3.7.2.5 Conduct integrated refresher training for CHTs.

3.7.2.6 Conduct harmonised district functional review of CH services.

3.7.2.7 Advocate for CHS Section establishment within the districts with DHRMD/Local Government Service Commission.

3.7.2.8 Recruit District CHS Section personnel in all districts.

3.7.2.9 Disseminate and enforce the revised HR policy in formats accessible to persons with disabilities.

3.7.2.10 Recruit and retain additional CHWs (AEHOs/CHNs/ HSAs/CMAs/CHVs) with gender balance and based on Malawi policy recommendation.

3.7.2.11 Review package of non-monetary and social incentives and implement it to improve motivation and quality of services provided by the CHTs.

3.7.2.12 Promote all CHW based on performance (performance appraisal) and merit (interview) in line with Malawi policy recommendations.

3.7.2.13 Develop a training module on integrated supervision for AEHOs, CHNs, CMAs, and other members of the integrated supervisory team.

3.7.2.14 Train AEHOs, CHNs, CMAs and other members on inclusive and integrated CHT supervision module.

3.7.2.15 Implement and integrated supervision of CHWs/services.
3.7.2.16 Train CHN/CMA/HSA on CBNMH.
3.7.2.17 Conduct induction of CHTs by focusing on CHTs updated roles, the package of community-level services and the community health system.
3.7.2.18 Implement remuneration package for CHWs.

3.7.3 Information and Communications Technology

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

Strategic Recommendations

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

Activities

3.7.3.1 Conduct national-level comprehensive training for iCHIS decision makers and managers/coordinators.
3.7.3.2 Conduct district level comprehensive training for iCHIS Users.
3.7.3.3 Conduct community level comprehensive training for iCHIS Users.
3.7.3.4 Integrate the community health workers database into iCHIS.
3.7.3.5 Develop community scorecards into the iCHIS.
3.7.3.6 Integrate iCHIS with external systems including HMIS, C-Stock, ISS, RapidPro, USSD, OHSP, LIMS, EMRs etc.
3.7.3.7 Review ICT policies on community level interventions.
3.7.3.8 Conduct iCHIS server administration and system maintenance.
3.7.3.9 Monitor usage and impact of the iCHIS system on community health through impact evaluation.
3.7.3.10 Conduct quarterly data review meetings for iCHIS at the district level.
3.7.3.11 Implement reverse billing or zero-rated billing to improve reporting.
3.7.3.12 Conduct iCHIS end-user training (scale up).
3.7.3.13 Conduct routine monitoring and maintenance of community health infrastructure and equipment to ensure sustainability (operation and maintenance).
3.7.3.14 Conduct monthly data validation review meetings at health facility level to ensure quality and consistency before sharing data with the districts.
3.7.3.15 Incorporate data from birth and death registration at community level.

3.7.4 Supply Chain and Infrastructure

Strategic Objective: Provide sufficient supplies, transport, and infrastructure[14] for CHWs in the CHT.

Strategic Recommendations:

- Develop service delivery structures in hard-to-reach areas.[15] Over the next eight years, the NCHF will target to construct health posts[16] in all hard-to-reach areas to increase access to comprehensive care for millions of people who do not currently live within 8 km of a health facility. The delivery structure should also include ICT infrastructure e.g., ICT equipment, connectivity, and power. These health posts should be built with locally available resources - where possible - to promote sustainability and community contributions of materials and labour. The structures should also be disability friendly and follow standardised guidelines to ensure accessibility, quality, and consistency.
- Provide houses for CHWs – SHSAs, HSAs, CMAs and CHNs as needed – living in rural areas as availability of housing is critical to increasing both the percentage of HSAs who live in their catchment areas and CHW retention rates.
- Provide durable transport options to HSAs and SHSAs. HSAs require durable bicycles to fully cover their catchment areas, and SHSAs require motorcycles to perform supervision activities across approximately 10 catchment areas. SHSAs working in hard-to-reach areas should receive priority for motorcycles, followed by SHSAs supervising over 10 HSAs. After achieving full bicycle coverage for HSAs, each VHC should also receive a bicycle to increase the mobility of CHVs. All transport options must have a clear maintenance plan to ensure sustainability over multi-year periods. To ensure flexibility, DHOs and partners should decide on how to support fuel and maintenance costs for transport options (e.g., motorcycles).
- Integrate the community health supply chain with the broader supply chain. Better coordination with existing supply chains is needed to ensure CHWs in the CHT have the supplies they need to deliver integrated services.

Activities

3.7.4.1 Review/assess the asset tracking system for community health service posts.
3.7.4.2 Procure and distribute materials to assist persons with disabilities at community level.
3.7.4.3 Review and disseminate integrated Standard Supply List for CHWs in collaboration with Physical Asset Management.
3.7.4.4 Monitor implementation of the developed guidelines for Health Posts and housing units for HSAs, SHSAs, and CHNs (as needed) in hard-to-reach areas.
3.7.4.5 Purchase solar equipment suited for health posts.
3.7.4.6 Install solar power equipment to already constructed health posts and outreach clinics.
3.7.4.7 Maintain solar power to already constructed health posts and outreach clinics.
3.7.4.8 Review existing supply chain systems in relation to commodities to be used at community level i.e., village clinics and health posts.
3.7.4.9 Update or extend the existing supply chain systems to include commodities used at community level.
3.7.4.10 Lobby for upgrading of access roads to hard-to-reach area health facilities and health posts to ease access to the primary centres of care.

[14] Infrastructure includes buildings, access, and ICT equipment.

[15] Hard-to-reach areas means a rural area where motor vehicle ambulance services are not easily accessible. Hard-to-reach areas are also those areas with physical barriers such as hill tracts, rivers islands, lakes etc.

[16] Health posts are basic and integrated community health service delivery structures which are physical buildings staffed by HSAs and members of CHT that serve 3 to 5 catchment areas at local level.

3.7.4.11 Purchase Wide Area Network equipment for Community HC.
3.7.4.12 Install Wide Area Network to community health facilities.
3.7.4.13 Maintain Wide Area Network to community health facilities.
3.7.4.14 Revise transport guidelines to include CHWs.
3.7.4.15 Conduct workshops to integrate village action plans, health delivery structures and housing units into council investment plans and DIPs to open health delivery structures to other funding possibilities.
3.7.4.16 Conduct routine monitoring and maintenance of community infrastructure and equipment to ensure sustainability (operation and maintenance) of community infrastructure and equipment.
3.7.4.17 Train CHTs in supply chain management and logistics.
3.7.4.18 Conduct refresher training in supply chain management and logistics.
3.7.4.19 Review the existing supply and drug management system.
3.7.4.20 Update the existing supply and drug management system to include community health.
3.7.4.21 Train VHCs, HACs, HCMC and medicine sub-committees on monitoring and managing drugs.
3.7.4.22 Conduct refresher training for VHCs, HACs, HCMC and medicine sub-committees on monitoring and managing drugs.
3.7.4.23 Procure supplies and consumables for CHW based on the recommended standards.
3.7.4.24 Procure high-quality and durable bicycles to ease mobility of HSAs.
3.7.4.25 Procure high-quality and durable bicycles for each VHC/CHAG with one group bicycle after all HSAs have received bicycles.
3.7.4.26 Procure motorcycles for supervisors of community health workers with priority to those working in hard-to-reach areas. Also, train the SHSAs on use and maintenance of the motorcycles.
3.7.4.27 Procure motorcycles for supervisors of community health workers with priority to those working in hard-to-reach areas. Also, train the CHNs and CMAs on the use and maintenance of the motorcycles.
3.7.4.28 Procure high quality tablets and accessories for CHWs based on the recommended standards.
3.7.4.29 Procure high quality laptops and accessories for supervisors based on the recommended standards.
3.7.4.30 Construct 209 HSA housing units, with the goal of reaching a third of rural areas by 2030 - prioritising the furthest and hardest to reach hard-to-reach areas and then working inwards.
3.7.4.31 Construct and equip 802 health posts with the goal of reaching 100% of hard-to-reach areas by 2030.

3.7.5 Community Engagement and Participation

Strategic Objective: Strengthen community engagement and participation for improved community ownership of community health.

Strategic Recommendations:

- Collaborate with prioritised community structures. To avoid fragmentation, government partners and programmes should build the capacity of prioritised community structures -- including the VHC, CHAG, VDC, HCMC, CHV, CBOs and ADC – rather than creating additional ones.
- Strengthen leadership and accountability at community level. Social accountability not only strengthens quality of care, but also promotes the NCHF guiding principle of community leadership.

Activities

3.7.5.1 Orient community structures (VDCs, ADCs CHAGs) on social accountability tools such as a scorecard.

3.7.5.2 Conduct engagement meetings with gatekeepers on emerging issues such as disease outbreak e.g. COVID-19 and others and mainstream issues like climate change, disability, and gender.

3.7.5.3 Conduct consultations of gatekeepers on periodic reviews of policies and strategies to ensure that policies are responsive to real issues on the ground.

3.7.5.4 Disseminate developed guidelines and policies at community level through VDCs, ADCs, CHAGs, HCMCs, HMCs and VHCs.

3.7.5.5 Sensitise stakeholders to reinforce utilisation and linkages of already existing community structures such as VHCs and VDCs in order to avoid fragmentation and duplication of efforts.

3.7.5.6 Orient VHCs and CHAGs and clarify their roles to reduce overlapping of roles and conflicts between the two structures.

3.7.5.7 Form and train HCMCs.

3.7.5.8 Conduct national level partner coordination meetings quarterly to plan, discuss and review community health activities.

3.7.5.9 Conduct Community Health Team monthly meetings at health facility level, cluster level and even at district level.

3.7.5.10 Disseminate developed guidelines and policies at community level through VDCs, ADCs, CHAGs, HCMC, HMC and VHC.

3.7.5.11 Develop health service charters.

3.7.5.12 Conduct community health open day.

3.7.5.13 Conduct bi-annual meetings with local leaders and chiefs to improve accountability for implementation of district-level integrated community health action plan.

3.7.5.14 Conduct community and CHT consultations on district implementation plans (DIPs).

3.7.5.15 Conduct inclusive community needs assessment, set community health priorities and participate in programme implementation.

3.7.5.16 Conduct community monitoring and evaluation through two-way follow up and feedback mechanism.

3.7.5.17 Support, monitor, and supervise the community structures (CHTs to support an on-going/monthly basis, and Community Health Officer to support on a quarterly basis).

3.7.5.18 Conduct inclusive awareness on community health programmes that enhance participation and demand for quality services through mass media campaigns, IEC materials community meetings.

3.7.5.19 Conduct quality assurance of community health service delivery, in keeping with existing guidelines on quality management and by working with the Quality Assurance Directorate.

3.7.6 Leadership and Coordination

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

Strategic Recommendations:

A. Coordination

- **Coordination at National Level:** To reduce fragmentation across the community health system, all partners must work with the CHS Section at national level. Coordination will be done through the CHS Section and the CH TWG. The CHS Section should be accountable for the successful implementation of the NCHF which requires strengthened

national coordination to ensure all stakeholders are working together towards common goals.

- **Coordination at District Level**: At district level, coordination shall be spearheaded by the Community Health Officer (CHO) and the district Community Health Coordination Committee (CHCC) responsible for coordination and technical issues. The CHO is accountable for the successful implementation of the NCHF within each district. The Community Health Officer will be reporting regularly to DHMT while updating CHSS to ensure strong linkages with national community health efforts and the broader health system.
- **Coordination at Community Level**: CHTs led by the AEHO will be responsible for coordination of activities at community level. All partners at community level should work with CHTs to plan and implement community health related programmes and activities.

B. **Leadership**

(a) **The National Community Health Services will provide leadership in resource mobilisation, policy, and guidelines development, monitoring and coordination, at district level.**

(b) At District level, the DHMT leadership will mobilise, oversee, and allocate resources, manage human resources, and coordinate district stakeholders.

(c) At community level, the CHT leadership will deliver services, engage community structures, provide on-going supervision, and mobilise community resources.

The Implementation of NCHF will involve a wide range of stakeholders. Some of the stakeholders are already mentioned in foregoing sections such as CHTs, ADCs, VDCs etc. However, the following stakeholders have been singled out as key allies in implementing the framework considering their influence within constituents and jurisdiction:

- **Members of Parliament (MPs):** Members of Parliament are crucial in the implementation of the strategy as they hold a considerable authority on issues of resources such as Constituency Development Fund.
- **Councillors:** Just like MPs, councillors can influence the resource mobilisation drive for community health especially on infrastructure, as they are part of decentralised development structure.
- **Civil Society and Coalitions:** There are many activities implemented at community level related to community health by CSOs (Community Health Impact Coalition). Some of the partners fund community health activities at community level including infrastructure such as community health posts.
- **CBOs:** Collaborations between health systems and community-based organisations are increasingly common mechanisms to address the unmet health-related social needs of high-risk populations. CBOs are therefore important health system stakeholders as they provide numerous, often highly valued programs and services to the members of their community.
- **Faith Based Organizations:** Faith-based organisations (FBOs) provide a significant amount of healthcare in Malawi. They contribute to the country's health services in the areas of family planning, immunisation, nutrition, and WASH, as well as overall health systems strengthening.
- **Community leaders such as Traditional and Religious Leaders:** Traditional and religious leaders play a pivotal role in Malawi in implementing community health interventions such as maternal, newborn and child health and mobilisation for services such as vaccinations. Traditional and religious leaders will therefore play a crucial role towards realisation of outcomes of NCHF.

- **Senior government officials.** They are key towards supporting community health in areas like resource mobilisation and advocacy.
- **Community Health Ambassador:** NCHF will continue to engage Community Health Ambassador to advance various interests of CHS Section.
- **Government Agencies:** Ministry of Education, Ministry of Gender, Children, Disability and Social Welfare, Ministry of Local Government, Ministry of Agriculture and Ministry of Water and Sanitation **etc.** Government agencies play a pivotal role in advancing community health, for instance, vaccinations in schools.
- **Private Sector:** Private sector contributes immensely to health services in Malawi through operation of clinics and other community health interventions. Through corporate social responsibility, the private sector can be engaged to take part in community health interventions like the building of community health posts.
- **Youth structures:** these include youth clubs that play a crucial role in mobilising young people towards uptake of SRHR services. Some young people are trained as Community Based Distribution Agents (CBDAs) and bring commodities to fellow youths in the communities such as family planning methods that can be handled by unlicensed cadres like condoms.
- **Auxiliary Bodies:** These are bodies established by national laws to complement efforts of public authorities in serving humanities. Such bodies include the Red Cross and Red Crescent.

Activities:

3.7.6.1 Conduct national level partner coordination meetings quarterly to plan, discuss and review community health activities.

3.7.6.2 Conduct national level TWGs quarterly to develop SOPs, checklists, validate training materials, share best practices, and enforce standards.

3.7.6.3 Develop ToRs for district community health committee meetings.

3.7.6.4 Convene district-level community health coordination meetings on a quarterly basis to bring together partners and representatives from other sectors and share work plans across partners.

3.7.6.5 Establish digital CH virtual platform for communication, networking and sharing of information.

3.7.6.6 Conduct quarterly community health coordination meetings for program managers at the national level (including CHS Section, MoH HR, Nursing Section, Environmental Health Team, Planning etc.).

3.7.6.7 Map, register and update partners list annually to identify opportunities for support and coordination.

3.7.6.8 Equip the Community Health Office at district level with supplies.

3.7.6.9 Disseminate NCHF to CHTs and all stakeholders.

3.7.6.10 Develop/review community health action plans that feed into the DIP.

3.7.6.11 Consolidate community health action plans to feed into the DIP.

3.7.6.12 Hold interface meetings between district CH section with local government and partner to lobby for support/funding for community health activities within the DIP.

3.7.7 Community Health Financing

Community Health Financing is aligned with objectives, strategies, and activities of HSSP III. As such, community health financing activities are an operationalization of objective 8 of HSSP III at community level. The activities are focusing on mobilising and pulling resources for effective implementation of NCHF. Community health financing will be implemented under core principles of collection, pooling, purchasing, distribution (equity), sustainability and efficiency.

Strategic Objective:
To set a community health financing architecture that can mobilise adequate resources for implementation of interventions at community level.

Strategic Recommendations

- Strengthen and build capacity of CHSS to raise resources, generate evidence and influence utilisation at system level.
- Mobilise adequate, sustainable, and predictable funds for community health to optimally deliver HBP services at community level.
- Establish and strengthen community institutional arrangements and systems for effective community health financing.
- Introduce financing mechanisms such as out of pocket and levies to support the community health financing.
- Improve and enhance equity in distribution, efficiency through optimal allocation and use of available resources in a constrained environment.

Activities

3.7.7.1 Conduct engagement meetings with communities in financing of community health services.

3.7.7.2 Train CHSS, DPPD and partners in community health financing to effectively implement the community health financing initiatives and accountability mechanisms.

3.7.7.3 Develop a resource mobilisation plan as a blueprint for all fundraising activities.

3.7.7.4 Train district teams to generate, understand and use resource mapping and budget and expenditure analyses when making allocation decisions towards various sections, including community health.

3.7.7.5 Develop guidelines for stakeholder integration (joint implementation), co-planning, colocation, and cost-sharing/pooling to reduce duplication and enhance efficiency in the delivery of community health services.

3.7.7.6 Promote CSO participation by encouraging formation of alliances and coalitions for mobilising resources and contributions from diversified sources as well as enhancing accountability.

3.7.7.7 Conduct regional private sector engagement for increased contribution towards community health.

3.7.7.8 Conduct advocacy meetings to lobby for increased community health funding from ORT budget via DIP.

3.7.7.9 Conduct advocacy meetings for community health via local government structures and partners.

3.7.7.10 Conduct advocacy campaigns at community level for increased community contribution towards community health.

3.7.7.11 Conduct engagement meetings with partners or donors for financing of NCHF such as lobbying for partners in supply chain management.

3.7.7.12 Conduct advocacy meetings for incorporation of social responsibility in line with community health activities like building of health posts.

3.7.7.13 Conduct advocacy meetings to lobby for ring fencing and protected minimum percentage towards community health from donor interventions, CDF and from local revenues (district councils)

3.7.7.14 Conduct participatory audit meetings with stakeholders as part of monitoring community projects using score cards.
3.7.7.15 Conduct advocacy campaigns at district level for increased community contribution towards community health.
3.7.7.16 Review the community health financing advocacy framework in line with the National Community Health Financing Operational Plan priorities.
3.7.7.17 Conduct advocacy meetings with partners on the adoption of HSSP III One Plan, One Budget, and One M&E.
3.7.7.18 Conduct quarterly community health funding gap analysis at subnational level.
3.7.7.19 Conduct annual funding gap analysis at national level.
3.7.7.20 Conduct community health financing coordination meetings at subnational level.
3.7.7.21 Conduct capacity and needs assessments to map where community health funding should be channelled.
3.7.7.22 Conduct cost-effectiveness assessment to estimate DALY's saved because of preventive health services compared to curative services–to build a case for more budgetary allocation towards community health and prevention.
3.7.7.23 Establish mechanisms for enhancing community accountability and action.

CHAPTER 4

COSTING SUMMARY

The NCHF was costed through a series of workshops. The workshops included alignment to the HSSP III and the MIP-1, micro-planning, and the actual costing. The Directorate of Planning and Policy Development facilitated costing with guidance from the custodians of the NCHF, the Community Health Section. Other stakeholders that supported the costing exercise included all technical directorates under the Ministry of Health, the Digital Health Unit and the Human Resource Department.

4.1 Costing Assumptions

The following assumptions were taken into consideration during costing:

- The implementation of the NCHF is in line with the reforms in the HSSP III (e.g., integrated platforms of care, integrated Capital Investment Plan (CIP), One Plan, One Budget and One M&E, human resource for health and health financing). As such, there is:
    i. No disease costing.
    ii. Infrastructure will be captured in the integrated CIP although it has been costed under NCHF.
- The NCHF has been costed in both Malawian Kwacha and United States Dollar. Costs in the NCHF will be adjusted with present inflation in the years being implemented.

4.2 Cost Summaries

Upon finalisation of the costing exercise, the following results were obtained from the cost sheets:

4.2.1 Cost per Year

As shown in table 4 below, the total cost for the NCHF is MWK **580,581,831,222** for the 8 years of implementation. Of these years, 2028, 2029 and 2030 have the highest cost. The year 2030 has the highest cost because although the assumption is that most of the interventions will have been implemented prior to 2030, yet salary increment – which is the highest cost item in the Framework – will be the highest in 2030.

TABLE 2: COST PER YEAR

Year	Cost (MWK)	Cost (USD)
2023	57,543,243,365	55,543,671
2024	62,689,652,648	60,511,248
2025	65,219,517,708	62,953,202
2026	70,449,542,709	68,001,489
2027	73,182,626,172	70,639,600
2028	78,326,844,870	75,605,062
2029	83,932,701,732	81,016,121
2030	89,237,702,018	86,136,778
Total	**580,581,831,222**	**560,407,173**

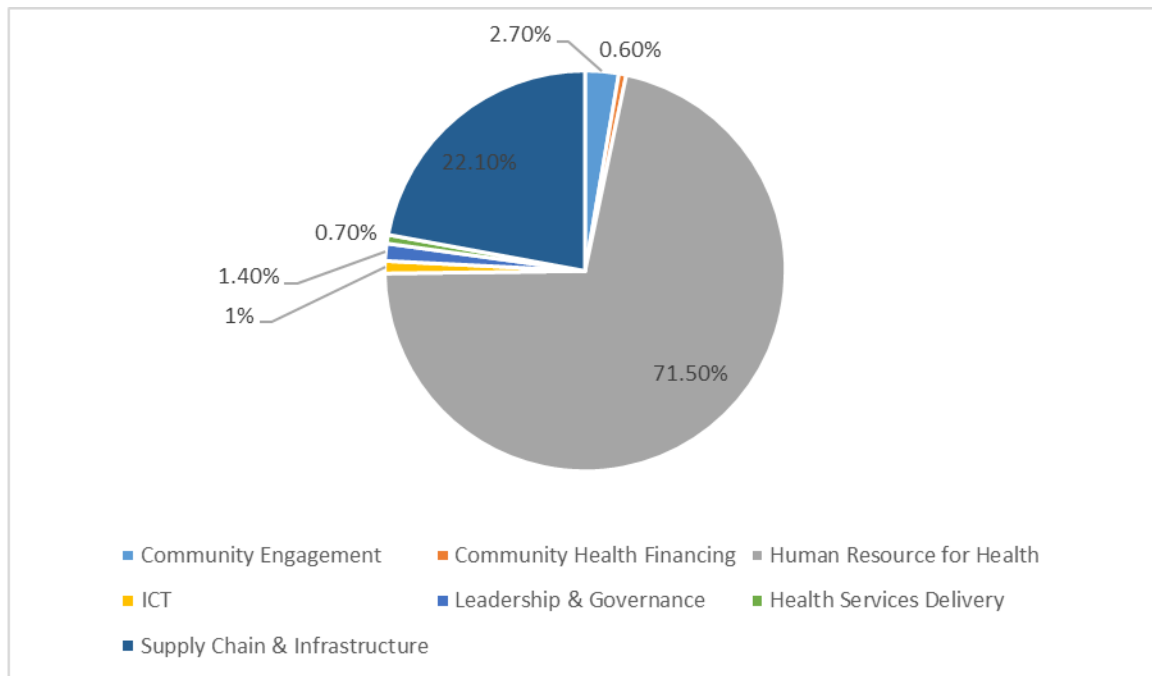
4.2.2 Cost per NCHF Thematic Areas

The NCHF has 7 thematic areas aligned to the HSSP III. As shown in table 6 below, Human Resource for Health has the highest cost of MWK 414,798,081,020 followed by Supply Chain and Infrastructure (MWK 128,279,198,695). Human Resource for Health has the highest cost because of the remuneration package for community health workers whereas Supply Chain and Infrastructure has the second highest cost thematic area because of construction of health posts. The least costed thematic area is Community Health Financing with MWK 3,321,277.

TABLE 3: COST PER NCHF THEMATIC AREAS

NCHF Thematic Area	Total Cost (MWK)	Total Cost (USD)
Community Engagement	15,886,304,541	15,334,270
Community Health Financing	3,440,842,773	3,321,277
Human Resource for Health	414,798,081,020	400,384,248
ICT	5,946,247,993	5,739,622
Leadership & Governance	8,053,747,600	7,773,888
Community Health Service Delivery	4,177,408,600	4,032,248
Supply Chain & Infrastructure	128,279,198,695	123,821,620
Grand Total	**580,581,831,222**	**560,407,173**

FIGURE 5: COST PERCENTAGE PER THEMATIC AREA



CHAPTER 5

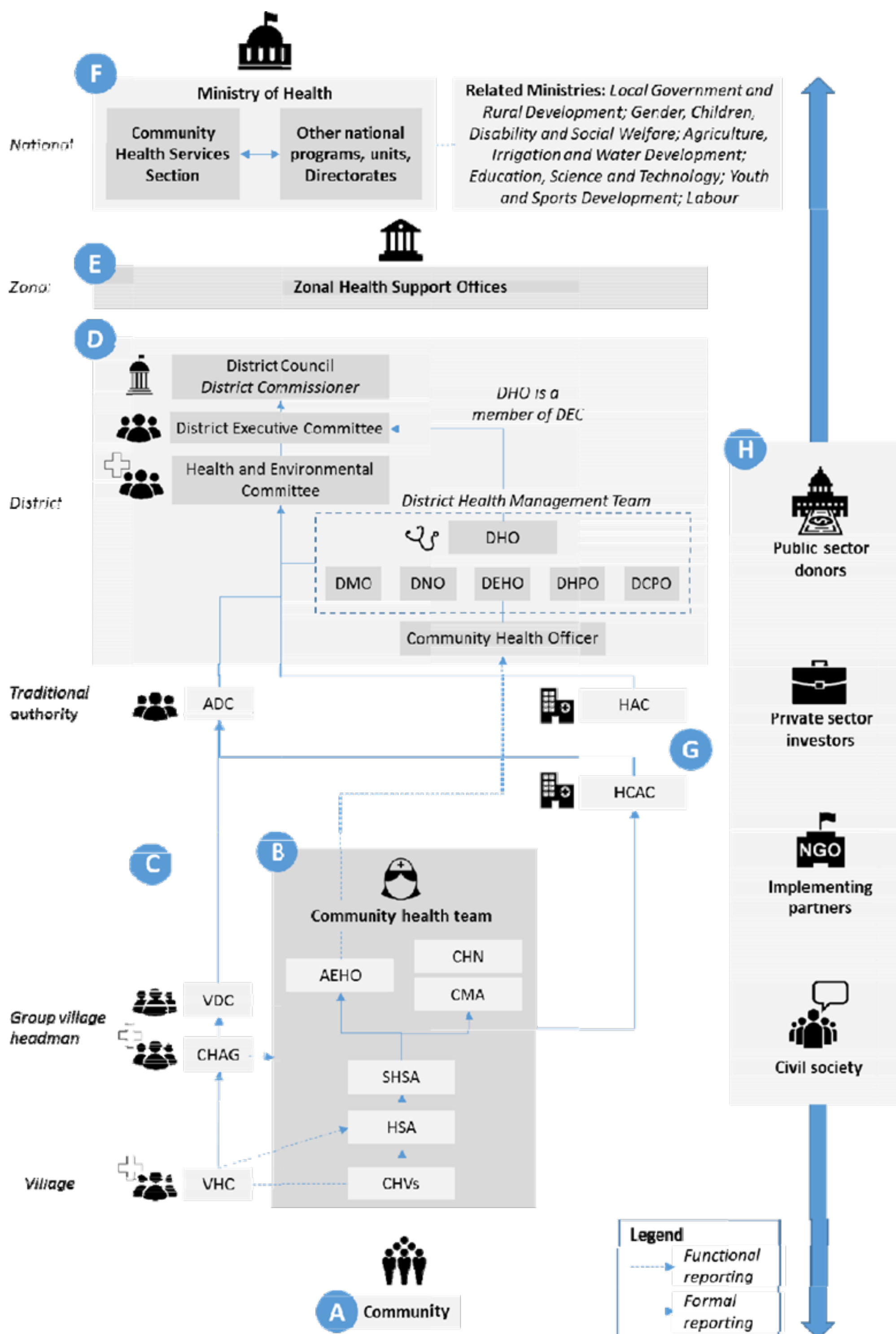
COMMUNITY HEALTH SYSTEM

Malawi's community health system spans a wide array of government departments and partners across sectors at the national, zonal, district, and community levels. A strong community health system requires clear roles for each stakeholder, as well as guidelines and norms on how stakeholders are expected to work together. Key stakeholders include the community, CHWs, health facilities, government, partners, financiers, and civil society – as depicted in Figure 6 below.

The sections below outline the aspirations for how the community health system should function. This includes the roles, responsibilities, and ways of working that all stakeholders should aim to follow throughout the implementation of the NCHF. This builds on the existing system but includes new and modified features to strengthen the system – based on workshop recommendations, decisions made during the writing retreats, and lessons learned from Malawi and other countries. The section lettering (e.g., A, B, C) indicates where each stakeholder group sits within Figure 6.

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

FIGURE 6: OVERVIEW OF THE COMMUNITY HEALTH SYSTEM



5.1 Communities

Communities have primary ownership of the community health system. They have three overarching roles: to use, provide, and monitor community health services. Community engagement is the process of working collaboratively with community members to fulfil all three of these roles – which involves generating awareness of and demand for services; planning for community health; helping to improve services (e.g., via feedback mechanisms); and supporting the enabling environment for community health. The latter includes advocating for inclusion of

community health priorities in Village Action Plans and contributing community resources, where possible (e.g., materials and labour for construction of Community Health Service Delivery structures and CHW housing units. Community participation, engagement, and ownership form the essential foundation for a strong community health system, an integral part of the health system.

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

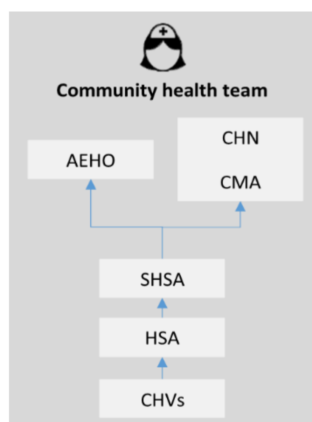
5.2 CHW

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

- **HSA**: HSAs form the backbone of the CHT. HSAs live in their catchment areas and are members of the communities they serve. They provide community health services and supervise CHVs. Malawi aims to have 1 HSA per 1,000 people, to align with national policy and the global benchmark. Each CHT should include approximately 5 HSAs.
- **SHSA**: Senior HSAs spend most of their time supervising HSAs. Each SHSA provides performance management and supportive supervision to 10 HSAs. Each CHT should include 1 SHSA, who is a member of two CHTs. The target ratio of SHSAs to HSAs is 1:10.
- **AEHO**: AEHOs directly supervise SHSAs. They provide performance management and supportive supervision. In addition, AEHOs oversee official performance appraisal for all SHSAs and HSAs. Each CHT should include one AEHO, who is a member of multiple CHTs. AEHOs receive performance management and appraisal and supportive supervision from Environmental Health Officers (EHOs).
- **CHN:** CHNs play an integral role in delivering community health services and ensuring quality. CHNs provide clinical mentoring to all SHSAs and HSAs, and they also deliver services that HSAs and SHSAs cannot provide. For example, the HIV program has proposed that CHNs distribute ARVs and closely monitor HIV patients going forward. Each CHT should include 1 CHN. Given nursing shortages, a CMA or another clinical officer can fill this role if a CHN is not available. CHNs will receive clinical mentoring, performance management and appraisal, and supportive supervision from registered nurses.
- **CMA:** CMAs are midwives who are licensed to practise by the Nurses and Midwives Council of Malawi. They provide critical midwifery services at community level. CMAs receive clinical mentoring and supportive supervision from Nurse Midwife Technicians (NMTs) and performance management and appraisal from NMTs, CHNs, registered nurses, or registered midwives. Each CHT should include 1 CHN or CMA.
- **CHV:** Community Health Volunteers are from the community and elected by the VHC. There should be at least 4 skilled CHVs per HSA. There are many types of skilled CHVs at the community level including Community Based Distribution Agents (CBDAs), Growth Monitoring Volunteers (GMVs) and Peer educators (PE), to name a few. They are active in health promotion, prevention, monitoring, surveillance, response, and

referrals. CHVs are part of the CHT and receive supervision from the HSA in their catchment area.

FIGURE 7: COMMUNITY HEALTH TEAM STRUCTURE



5.3 Local Government Structure

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

5.3.1 Village, group village, and traditional authority levels

VHC: HSAs are responsible for establishing VHCs in their village(s) and remain accountable to VHC members, who represent the community. Village health committees promote primary health care activities through recruitment of CHVs, overseeing work in the village according to their action plan, ensuring they hold regular meetings with their community to disseminate information and give feedback, and by working together with the HSA. HSAs support supervision and training of VHCs to assure quality. Each VHC should have approximately 10 members as described in the VHC manual.

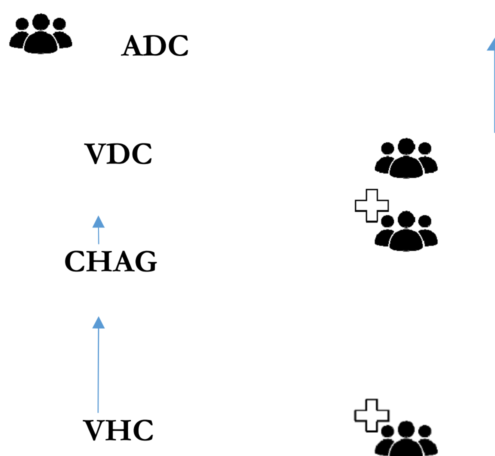
VDC: The VDC is responsible for identifying development issues at the Group Village Headman (GVH) level and taking them through the ADC to the DEC. This includes issues related to community health. Moreover, community health links to other sectors – such as nutrition – through the VDC.

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

ADC: The ADC is responsible for identifying development issues at the TA level and taking them through the council to the DEC. This includes issues related to community health.

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

FIGURE 8: PRIORITISED COMMUNITY STRUCTURES

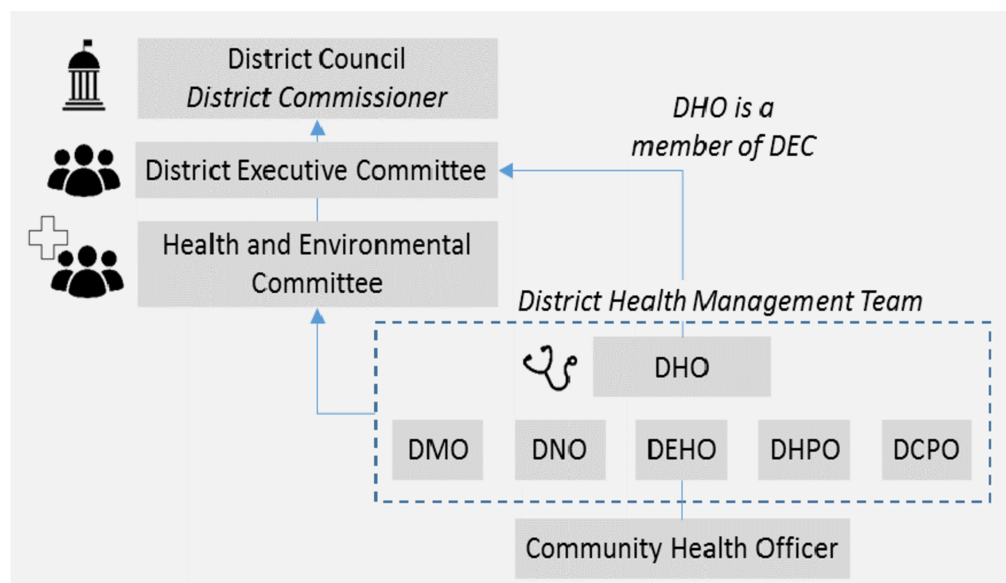


5.4 District Level

- **District Health Office:** The District Health Office oversees coordination, planning, supervision, and monitoring the implementation of the health agenda. The District Health Office includes the Director of Health and Social Services (DHO), District Medical Officer (DMO), District Nursing Officer (DNO), District Environmental Health Officer (DEHO), District Health Promotion Officer (DHPO), District Health Services Administrator and other supporting positions.
- **Community Health Officer**: Each District Health Office should have a designated Community Health Officer. The community health officer oversees coordination, planning, supervision, and monitoring of all activities related to community health in the district and reports to the DHMT and to the CHS Section.
- **District Health Management Team**: The DHMT promotes effective coordination between all health-related players in the districts. It is responsible for planning, organising, monitoring, and evaluating services in the district, including community health. Today, the DHMT includes the DHO, DMO, DNO, DEHO, DHPO, DHA, and District Accountant.
- **Health and Environmental Committee**: The sub-committee of the DEC that interacts with the DEC members and responds to health needs for the district.
- **District Executive Committee:** The DEC is responsible for the overall development of the district policy, including for the health sector and approval of all expenditures, as well as approving all partners working in the district. It is chaired by the District Commissioner, and the DHO is a member of this committee. It is critical the DEC takes community health needs into account when determining policies and approving budgets.
- **District Council:** As the overall administrator of public institutions at district level, the District Council must understand the importance of community health and incorporate

priorities into DIPs and other planning processes. In doing so, the DC helps ensure that community health efforts are part of a multi-sector approach.

FIGURE 9: COMMUNITY HEALTH AT DISTRICT LEVEL



5.5 Zonal Level

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

5.6 National Level

At the national level the MoH sets strategic direction for the health sector and formulates governing policies. Central responsibilities include oversight of policy making, standard setting, quality assurance, planning and mobilising resources, guidance on implementation priorities, provision of technical support and supervision, research, and monitoring and evaluation. Within the MoH, the CHS Section serves as the overall community health coordinator for Malawi. The CHS Section sits within the Preventive Directorate of the Ministry of Health and has the following roles:

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

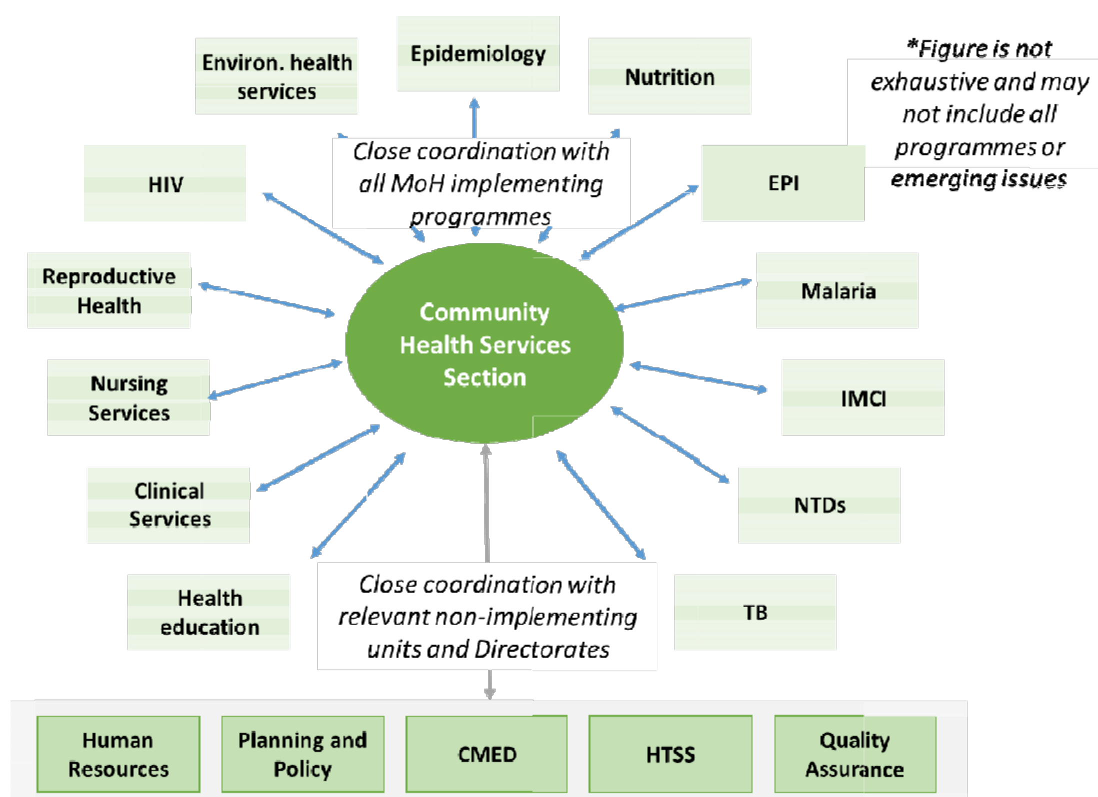
- Internal and external communication on matters related to community health.

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

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

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

FIGURE 10: FUNCTIONAL ROLE OF THE CHS SECTION WITHIN THE MOH



5.7 Health Centres

Health centres at community level integrate CHWs into other parts of the primary healthcare system. Facilities provide drugs and supplies to HSAs, and some HSA and SHSA supervisors (e.g., AEHOs and CHNs) are facility-based. Moreover, community health is a part of the continuum of care; therefore, CHWs refer patients with certain conditions to health centres and facilities15. It is therefore critical that facilities have a strong understanding of the community health system, including the role of facilities in providing supplies, drugs, and clinical mentoring and supporting standardised referral processes. Each health centre has an Advisory Committee (HCAC), which should include health workers, a representative from the CHT, and members of the community. The community members of the HCAC play a fundamental role in linking the community to the facility and vice versa, through monitoring, information sharing, awareness raising and resource mobilisation. It is important that health facilities at the community level are closely integrated with other parts of the community health care system.

5.8 Development Partners and Civil Society

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

- Ensure ongoing partner programmes and activities align to and coordinate with the NCHF, at the national, district, and community levels.
- Provide direct support for activities within the NCHF, including: supporting integrated pre-service and in-service training for all CHWs; helping districts provide CHW supplies, CHW transport, and CH infrastructure; and developing and scaling innovative ICT

solutions, revitalising and capacity building of VHCs, CHAGs, HCACs and other prioritised community health structures;
- Support broader capacity building and governance activities at the national, district, and community levels (e.g., supporting the operations of the CHS Section or helping to build the capacity of prioritised community-level structures).

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

At the national level, it is critical that partners collaborate with the CHS Section and districts to ensure efficient use of resources and consistency across the community health system. Firstly, coordination is essential in ensuring efficient use of resources by minimising duplication and directing resources to areas with the greatest need. Therefore, it is important that partners keep the CHS Section appraised of all activities related to community health. Partners can do so through a.) participation in coordination mechanisms (national CH TWG, partner coordination meetings) and b.) quarterly reporting to the CHS Section. Similarly, at the district level, it is important that partners coordinate all community health activities with the DC/DEC and the District Health Office – and specifically, the designated Community Health Officer within it. Second, coordination is essential to ensure a consistent system for delivering community health services – thereby eliminating the confusion that exists today from village to village given the many different terms, structures, and processes that programmes use.

Therefore, it is critical that partners commit to support the delivery of the integrated package of community health services (i.e., the community components of the HBP) rather than defining additional services and processes. Moreover, partners should only work with paid members of the CHT (e.g., HSAs, SHSAs, CHNs) if the DHO approves and oversees the activities; this includes any in-service and refresher training. Like all stakeholders, partners are expected to respect the scope of work of all CHW cadres – which only the Community Health TWG has the authority to change. Partners are ultimately accountable to the communities they serve. Therefore, partners should collaborate with existing community structures, including the VHC, CHAG, HCAC, and VDC.

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

5.9 Coordination Mechanisms

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

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

mobilising resources to support effective implementation of community service delivery at community level. The CH TWG meets every quarter.

Each district now has a dedicated CH TWG, led by the Community Health Officer. The CH TWG however should be made to be functional in NCHF implementation as it has been dormant due to funding constraints. The responsibility of CH TWG at district level mirrors that of the national CH TWG: providing technical support, advocating, and mobilising resources to support effective implementation at district level. Ensuring effective implementation is particularly important given districts oversee all day-to-day community health activities.

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

CHAPTER 6

IMPLEMENTATION ARRANGEMENT

Implementation arrangement of NCHF will be done with cross-reference to HSSP III.

Overview

Implementation of NCHF calls for strong leadership and collaboration. As such, the framework will be implemented with strong coordination links with decentralised health service delivery systems. The system and structures established by the Government of Malawi through the local councils with decentralised system levels will be utilised. With the implementation arrangements of HSSP III which emphasises on the actualization of "One Plan, One Budget and One Report", strategies and activities of NCHF will be aligned with strategies and activities of the HSSP III. Activities will take place across national, district, and community levels, with designated stakeholder(s) responsible for each. The implementation plan aligns with current guidelines to strengthen health services decentralisation, promoting the ownership of planning and implementation at district and community levels.

The implementation of NCHF will take place across two phases as highlighted in the foregoing chapter. However, there will be annual post-mortem reflection of activities and where necessary, adjustments will be made in alignment with the operational work plan of HSSP III. NCHF will be continually assessed throughout the implementation plan to ensure tracking of programme effectiveness. System assessment will include mid-term review after 4 years of implementation in 2026. The mid-term review will be conducted in order to determine implementation progress against set targets and possibly revise implementation trajectory to address identified bottlenecks. A final assessment will incorporate the ongoing performance monitoring of the NCHF M&E framework.

6.1 Annual Implementation Plans (AIPs)

CHSS will develop and implement Annual Implementation Plans and these will be linked with The HSSP III at the activity level. Similarly, CHSS will align its monitoring and evaluation system to the HSSP III M&E matrix at the output and outcome level. This comes against the backdrop that HSSP III is now a single overarching strategic planning document for all stakeholders in the health sector hence the establishment of **One Plan One Budget One Report.** .

6.2 Implementation Arrangement at National Level

At national level, implementation of NCHF shall be coordinated by CHSS of the Ministry of Health. The section shall be responsible in setting up standards such as development of relevant policies pertaining to community health, tools, guidelines and implementation of the same. The CHSS shall not be responsible for direct implementation but rather coordinating implementation of MoH programs at community level.

6.3 Implementation Arrangement at District Level

Implementation arrangement at district level will take cognizance of implementation arrangement of HSSP III which stipulates that at the district council level, the District Commissioner will provide implementation oversight of the HSSP III through the Director of Health and Social Services. Within the Directorate of Health and Social Services, relevant heads of departments shall lead implementation of assigned activities within the relevant HSSP III theme. At the District level,

District Multi-year Implementation Plans (DMYIP) will be developed every three years and will be the basis for joint stakeholder planning, execution and monitoring of District Annual Implementation Plans (DAIPs).

The DMYIP and DAIPs will inform the health sector sections of the District Development Plans (DDPs) ensuring perfect alignment of the DDPs to the HSSP III. As such, CHSS will participate in formulation of DAIPs so that NCHF interventions can be reflected in the DPPs. The reflection of NCHF activities into DDPs will also ensure that CHSS activities are considered in the district annual budget process as well through the aid alignment tools for development partners. At the district level, the Community Health Section will be under the District Health Office (DHO) where the District Community Health Officer will continue to report.

6.4 Implementation Arrangement at Community Level

At community level, CHTs will be responsible for service delivery to their respective catchment populations. Focal persons shall be responsible for engaging with community structures that are relevant for successful delivery of interventions in this NCHF. In line with recommendations from HSSP III, the Area Development Committee (ADC), shall oversee Health Centre Management Committees (HCMCs) within the jurisdiction of the ADC at TA level. The ADC is linked to the Council through the Councilors and Member of Parliament as well the Traditional Authority, all of whom are members of the Council in some respect.

At the GVH level, the Village Development Committee (VDC) shall oversee and coordinate community level DIP interventions through the VHC and CHAGs. These community level structures are supported by technicians who are linked to both the HCMC thereby ensuring linkage across the technical and political decision-making arms of the district council and hence relevant mechanisms at the national level.

6.5 Financing

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

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

Other stakeholders including donors, implementing partners, and the private sector will be looked on to fill critical gaps in NCHF financing requirements. Development partners, including multilateral donors, bilateral donors, foundations, development finance institutions and NGOs are crucial for financing the successful implementation of NCHF. As much as possible and

while working in an integrated fashion across programmes, partners' support will be needed across activities including delivering community HBP interventions, CHW training, supplies, transport, infrastructure, ICT, and more. NCHF will also look to mobilise private sector resources and develop public private partnerships (PPPs) to ensure sustainable implementation and financing sources. Recognized opportunities to work with the private sector include ICT, infrastructure, transport, and CHW supplies.

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

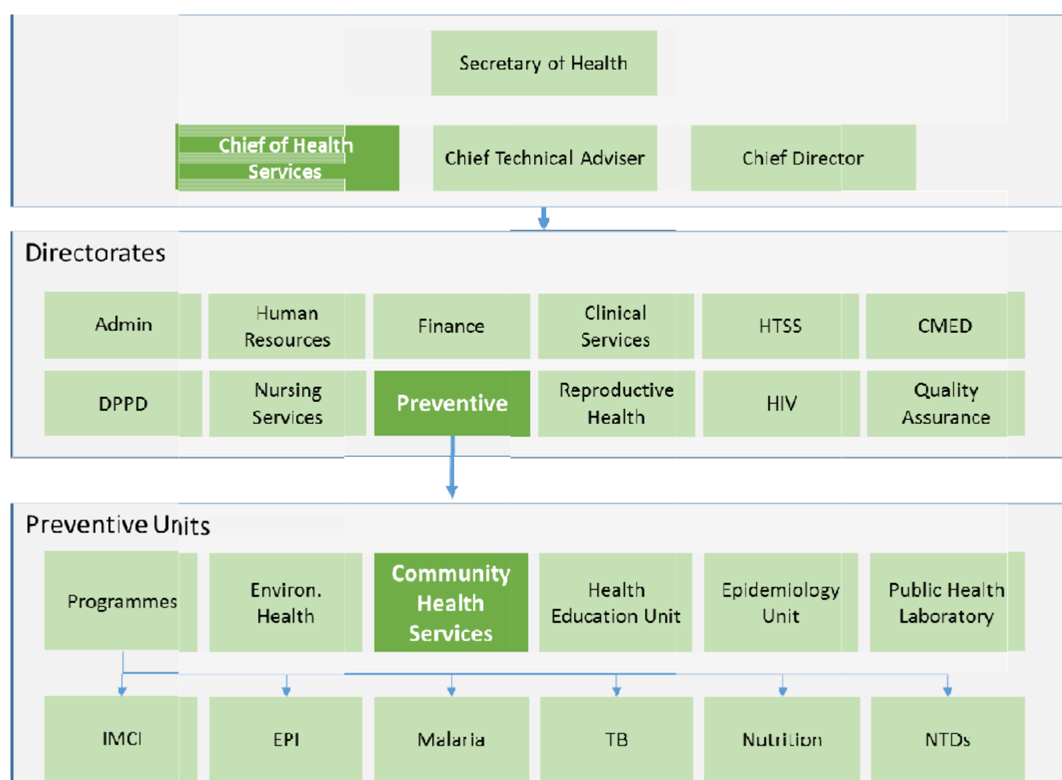
CHAPTER 7

PROGRAM MANAGEMENT

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

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

FIGURE 11: CHS SECTION WITHIN THE MINISTRY OF HEALTH



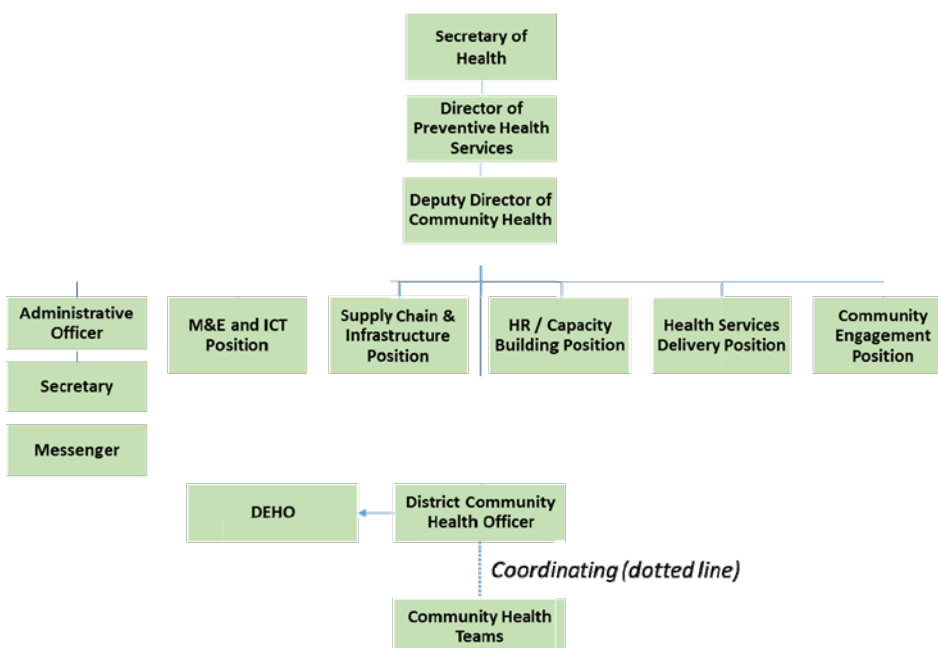
NCHF programme management hinges on mutual accountability and active coordination between the CHS Section and all actors working in the community health system – including national government programmes, district health offices, other local government authorities, partners, and communities themselves.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

TABLE 4: COORDINATION WITHIN THE CHS SECTION

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

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

FIGURE 12: CHS TEAM STRUCTURE



CHAPTER 8

MONITORING AND EVALUATION

Monitoring and evaluation will be a critical component of NCHF. It will ensure that there is regular review of the progress made on the planned interventions and will allow for modification or interventions based on lessons learnt during implementation and emerging evidence in community health issues. Apart from regular and periodic monitoring, rapid assessments will be conducted as part of action research after every three years of implementation.

NCHF will be monitored periodically by focusing on activity milestones, output and outcome indicators to measure progress and ensure that implementation bottlenecks are identified, and grey areas are attended to in time. A theory of change has been developed and has been aligned with the theory of change of the HSSP III as shown **in figure 1** in foregoing sections. The alignment means that the logic of the results chain of NCHF will be contributing to HSSP III theory of change.

8.1 Monitoring and Evaluation System and Process

At the national level, the Deputy Director of Preventive Health Services has the overall responsibility for ensuring that sound M&E arrangements are in place for successful delivery of the outputs and outcomes of the NCHF. There will be linkages with HSSP III monitoring framework in the spirit of **One Plan** where joint monitoring, zonal reviews and DIP reviews will be conducted. The head of CMED will coordinate systems and mechanisms for collection, management and use of information relevant for tracking progress on higher level *Monitoring and Evaluation Plan.* CHS Section bears primary responsibility for M&E of the NCHF. However, the M&E plan will be integrated into existing M&E systems of HSSP III to harmonise reporting at high outcome level. Collecting and reviewing community health information will require close coordination between MoH, district governments, development partners and communities. Within this M&E system, stakeholders will be responsible for different tasks.

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

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

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

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

Data analysis– Data analysis can be continuous or periodic, depending on the type of data being collected. The synthesis of findings will allow for evaluation of the

programme and its constituent's activities.

Research - Initiate and strengthen community health focused research activities to inform evidence-based implementation practices that work to achieve high impact.

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

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

Social accountability tools - Monitoring will take place at community, health facility, district, and national level of various systems. At community level, as part of community accountability, CHS will use **community scorecards** as a social accountability tool for monitoring purposes. Nevertheless, partners are provided with a leeway to use other social accountability tools that are duly approved such as Community Led Monitoring (CLM) at community level. There will be monitoring of utilisation of the integrated referral system and forms across levels of care and programmes as well.

8.2 Results Framework

By 2030, NCHF aims to contribute to achievements of HSSP III targets that focus on effective delivery of community health services:

1. Increased life expectancy at birth from 64 years in 2016 to 74 years.
2. Maternal mortality reduced from 439 deaths per 100,000 live births in 2016 to 70 per 100,000 live births.
3. Under-five mortalities reduced from 64 deaths per 1000 live births in 2016 to 25 deaths per 1000 live births.
4. Epidemics of malaria, tuberculosis, HIV/AIDS and NTDs reduced, and hepatitis, water-borne diseases and other communicable diseases combated.
5. Premature mortality from non-communicable diseases reduced by one third through prevention and treatment, and mental health well-being promoted.

ANNEXES

Annex 1: Detailed Costed Implementation Plan

TABLE 5: DETAILED COSTED IMPLEMENTATION PLAN (2023 – 2030)

Activity	Activity code	Responsible Stakeholder	Level	2023 Year 1 MWK	2024 Year 2 MWK	2025 Year 3 MWK	2026 Year 4 MWK	2027 Year 5 MWK	2028 Year 6 MWK	2029 Year 7 MWK	2030 Year 8 MWK	Total (USD)	Total (MWK)
Thematic Area 1: Community Health Services Delivery													
Review role clarity guidelines to include emerging issues	3.7.1.1	CHSS	National	0	97,260,000	0	0	0	0	97,260,000	0	**187,761**	**194,520,000**
Disseminate role clarity guidelines to all CHWs	3.7.1.2	CHSS DHO, Zonal officer	District	0	143,030,400	0	0	0	0	143,030,400	0	**276,120**	**286,060,800**
Conduct physical audit/standards on the implementation of the NCHF	3.7.1.3	CHSS DHO, Zonal officer	District	648,000	864,000	864,000	864,000	864,000	864,000	864,000	864,000	**6,463**	**6,696,000**
Conduct review meetings for joint work plan	3.7.1.4	CHSS DHO, Zonal officer	District & National	127,280,400	127,280,400	127,280,400	127,280,400	127,280,400	127,280,400	127,280,400	127,280,400	**982,860**	**1,018,243,200**
Update the community health guidelines in line with emerging issues such as the HBP and emergencies of public health importance	3.7.1.5	CHSS	National	32,420,000	32,420,000	32,420,000	32,420,000	32,420,000	32,420,000	32,420,000	32,420,000	**250,347**	**259,360,000**
Disseminate the updated, integrated and inclusive CH guidelines at all levels	3.7.1.6	CHSS DHO, Zonal officer	National, District	0	143,030,400	0	0	0	0	143,030,400	0	**276,120**	**286,060,800**
Conduct CHT monthly meetings	3.7.1.7	CHSS	Health facility, Cluster	14,304,000	14,304,000	14,304,000	14,304,000	14,304,000	14,304,000	14,304,000	14,304,000	**110,455**	**114,432,000**

		DHO, Zonal officers, QMD	District										
Conduct quarterly integrated supportive supervision to all CHWs and CHTs	3.7.1.8	CHSS,DHO, Zonal officers, QMD	District Community	12,093,000	12,093,000	12,093,000	12,093,000	12,093,000	12,093,000	7,293,000	7,293,000	**84,087**	**87,114,000**
Conduct bi-annual multi-sectoral district coordination meetings to track implementation of the NCHF	3.7.1.9	DHO, CHSS	District	12,732,000	25,464,000	25,464,000	25,464,000	25,464,000	25,464,000	25,464,000	25,464,000	**184,344**	**190,980,000**
Conduct CH orientation meetings for DHMT, HSAs, CDAs, CHNs, CMA, AEDC, and AEDOs to advocate for multi-sectoral, integrated and inclusive services in the district	3.7.1.10	DHO, CHSS	District	7,714,000	7,714,000	7,714,000	7,714,000	7,714,000	7,714,000	7,714,000	7,714,000	**59,568**	**61,712,000**
Conduct integrated community health screening for all conditions and diseases at point of delivery	3.7.1.11	DHO, CHSS	Community	1,920,000	4,920,000	4,920,000	4,920,000	4,920,000	4,920,000	4,920,000	4,920,000	**35,097**	**36,360,000**
Conduct integrated refresher training on disease/condition prevention and control measures	3.7.1.12	DHO, CHSS	District	25,010,000	25,010,000	25,010,000	25,010,000	25,010,000	25,010,000	25,010,000	25,010,000	**193,127**	**200,080,000**
Conduct integrated community disease surveillance and response activities	3.7.1.13	DHO, CHSS	Community	9,840,000	9,840,000	9,840,000	9,840,000	9,840,000	9,840,000	9,840,000	9,840,000	**75,984**	**78,720,000**
Conduct integrated community growth monitoring of target groups	3.7.1.14	DHO, CHSS	Community	7,920,000	7,920,000	7,920,000	7,920,000	7,920,000	7,920,000	7,920,000	7,920,000	**61,158**	**63,360,000**

Conduct integrated community-based outreach clinics	3.7.1.15	DHO, CHSS	Community	7,920,000	7,920,000	7,920,000	7,920,000	7,920,000	7,920,000	7,920,000	7,920,000	**61,158**	**63,360.000**
Conduct integrated community-based distribution of drugs and other health commodity supplies	3.7.1.16	DHO, CHSS	Community	27,440,000	18,000,000	18,000,000	18,000,000	18,000,000	18,000,000	18,000,000	18,000,000	**148,108**	**153,440,000**
Conduct integrated community health education sessions of various diseases and conditions	3.7.1.17	DHO, CHSS	Community	1,920,000	26,000,000	26,000,000	26,000,000	26,000,000	26,000,000	26,000,000	26,000,000	**177,529**	**183,920,000**
Conduct integrated community health defaulter tracing of various diseases and conditions	3.7.1.18	DHO, CHSS	Community	16,100,000	16,100,000	16,100,000	16,100,000	16,100,000	16,100,000	16,100,000	16,100,000	**124,324**	**128,800,000**
Conduct integrated community health follow-ups of various diseases and conditions	3.7.1.19	DHO, CHSS	Community	19,680,000	19,680,000	19,680,000	19,680,000	19,680,000	19,680,000	19,680,000	19,680,000	**151,969**	**157,440,000**
Conduct integrated community-based death audit including maternal deaths	3.7.1.20	DHO, CHSS	Community	19,680,000	19,680,000	19,680,000	19,680,000	19,680,000	19,680,000	19,680,000	19,680,000	**151,969**	**157,440,000**
Conduct integrated community-based counselling and psychosocial support sessions of various diseases and conditions	3.7.1.21	DHO, CHSS	Community	33,680,000	33,680,000	33,680,000	33,680,000	33,680,000	33,680,000	33,680,000	33,680,000	**260,077**	**269,440,000**
Conduct integrated community-based palliative care visits of various diseases and conditions in the community	3.7.1.22	DHO, CHWs	Community	5,200,000	5,200,000	5,200,000	5,200,000	5,200,000	5,200,000	5,200,000	5,200,000	**40,154**	**41,600,000**
Conduct integrated community mass distribution of	3.7.1.23	DHO, CHWs	Community	16,680,000	16,680,000	16,680,000	16,680,000	16,680,000	16,680,000	16,680,000	16,680,000	**128,803**	**133,440,000**

various drugs and other health commodities supplies													
Sub Total				**400,181,400**	**814,090,000**	**430,769,400**	**430,769,400**	**430,769,400**	**430,769,400**	**809,290,200**	**430,769,400**	**4,032,248**	**4,177,408,600**
Thematic Area 2: Human Resources													
Update job descriptions and clarify roles for all CHWs (CHVs, HSAs, SHSAs, CHNs, CMAs, AEHOs)	3.7.2.1	HR MoH (Lead), CHSS, LGSC	National	28,350,000	0	0	0	0	0	0	0	**27,365**	**28,350,000**
Revise HSA pre-service and in-service training curriculum	3.7.2.2	HR MoH(Lead), MoLG, CHSS, Partners, Training institutions	National	0	30,600,000	0	3,840,000	3,360,000	0	0	0	**36,486**	**37,800,000**
Provide high-quality, integrated pre-service training to all CHWs in the revised training curriculum.	3.7.2.3	CHS Section, Partners, Training institutions	District	72,680,000	72,680,000	72,680,000	0	0	0	0	0	**210,463**	**218,040,000**
Train SHSA using the curriculum for Community Health Assistants in phased fashion	3.7.2.4	HR MoH (Lead), CHSS, MoLG, LGSC, Training Institutions, Medical Council of Malawi	District	65,040,000	237,120,000	237,120,000	229,440,000	229,440,000	0	0	0	**963,475**	**998,160,000**
Conduct integrated refresher training for CHTs	3.7.2.5	HR MoH (Lead), CHSS, MoLG, LGSC, Training	District	54,680,000	54,680,000	54,680,000	54,680,000	54,680,000	54,680,000	54,680,000	54,680,000	**422,239**	**437,440,000**

		Institutions, Medical Council of Malawi & Nurses and Midwife Council											
Conduct harmonised district functional review of CH services	3.7.2.6	HR MoH (Lead), CHSS, LGSC	District	83,123,200	18,480,000	0	0	0	0	0	0	**98,072**	**101,603,200**
Advocate for CHS Section establishment within the districts with DHRMD/Local Govt Service Commission	3.7.2.7	HR MoH(lead), MoLG, Parliamentary committee on Health, DHMD, development partners, DPD	National , District	48,680,000	3,360,000	0	26,020,000	0	0	0	0	**75,347**	**78,060,000**
Recruit district CHS Section personnel in all districts	3.7.2.8	HR MoH(lead) CHSS, MoLG, Local Government Service Commission	District	944,100,360	1,888,200,7 20	1,888,200,72 0	1,888,200,7 20	MWK 1,888,200,7 20	1,888,200,7 20	1,888,200,7 20	1,888,200,7 20	**13,749,03 4**	**14,161,505,40 0**
Disseminate and enforce the revised HR policy	3.7.2.9	HRMOH(Le ad) CHSS, GHSC, MoLG	National , District	69,600,000	0	0	0	0	0	0	0	**67,181**	**69,600,000**
Recruit and retain additional CHWs (AEHOs/CHNsHS As/CMAs/CHVs) with gender balance and based on Malawi policy recommendation	3.7.2.10	HR MoH(lead) CHSS, MoLG, Local Government Service Commission	District	0	0	0	0	0	0	0	0	**0**	**0**
Review the package of non-monetary and social incentives and implement it to	3.7.2.11	HRMOH(Le ad), CHSS ,GHSC, MoLG	National	69,704,000	0	0	0	0	0	0	0	**67,282**	**69,704,000**

improve motivation and quality of services provided by the CHT													
Promote HSAs and SHSAs based on performance (performance appraisal) and merit (interview) in line with Malawi policy recommendations	3.7.2.12	HRMOH(Lead),GHSC, MoLG, DHIRMD,	District	0	84,688,000	84,688,000	84,688,000	84,688,000	84,688,000	84,688,000	84,688,000	**572,216**	**592,816,000**
Develop training module on integrated supervision for AEHOs, CHNs, CMAs, and other members of the integrated supervisory team	3.7.2.13	HRMOH(Lead),development partners, CHSS, Government print	National	16,874,000	0	0	0	0	0	0	0	**16,288**	**16,874,000**
Train AEHOs, CHNs, CMAs and other members on inclusive and integrated CHT supervision module	3.7.2.14	HRMOH(Lead),development partners, CHSS, Government Print	District	174,560,000	174,560,000	174,560,000	174,560,000	0	0	0	0	**673,977**	**698,240,000**
Implement integrated supervision of CHWs/services	3.7.2.15	HRMOH(Lead),development partners, CHSS Government print, MoLG	Community	78,360,000	78,360,000	78,360,000	78,360,000	78,360,000	78,360,000	78,360,000	78,360,000	**605,096**	**626,880,000**
Train CHN/CMA/HSA on CBNMH	3.7.2.16	HRMOH(Lead),development partners, CHSS, MoLG	District	158,446,880	158,446,880	158,446,880	158,446,880	0	0	0	0	**615,328**	**611,764,015**
Conduct induction of CHTs by focusing on CHTs updated roles, the package of community-level	3.7.2.17	HRMOH(Lead),development partners, CHSS, MoLG	Community	245,680,000	245,680,000	245,680,000	245,680,000	245,680,000	245,680,000	245,680,000	245,680,000	**1,897,143**	**1,965,440,000**

services and the community health system													
Implement remuneration package for CHWs	3.7.2.18	HRMOH	National	34,500,000,000	37,900,000,000	41,690,000,000	45,859,000,000	50,444,900,000	55,489,390,000	61,038,329,000	67,142,161,900	**380,370,445**	**394,063,780,900**
Sub-Total				**36,609,878,440**	**40,946,855,600**	**44,684,415,600**	**48,802,915,600**	**53,029,308,720**	**57,840,998,729**	**63,389,937,720**	**69,493,770,620**	**400,384,248**	**414,798,081,020**
Thematic Area 3: Information, Communications and Technology													
Conduct national-level comprehensive training for iCHIS decision makers and managers/coordinators	3.7.3.1	CHSS, CMED, DHD (Including UNIMA), DPPD/PDU & implementing Partners	National	17,096,000	0	17,096,000	0	17,096,000	0	17,096,000	0	**66,008**	**68,384,000**
Conduct district level comprehensive training for iCHIS Users	3.7.3.2	CHSS, DHD (Including UNIMA) & CMED	District	80,320,000	150,600,000	0	0	0	0	0	0	**222,896**	**230,920,000**
Conduct community level comprehensive training for iCHIS users	3.7.3.3	CHSS, CMED, DHD (Including UNIMA), DPPD/PDU & implementing Partners	Community	1,034,182,000	136,800,000	0	0	0	0	0	0	**1,130,292**	**1,170,982,000**
Integrate the CHW database into iCHIS	3.7.3.4	CHSS, CMED, DHD, ICT & Partners	National	0	57,474,000	0	57,474,000	0	0	0	0	**110,954**	**114,948,000**
Develop community scorecards into the iCHIS	3.7.3.5	CHSS, CMED, DHD, ICT & Partners	National	0	0	75,630,000	75,630,000	0	0	0	0	**146,004**	**151,260,000**
Integrate iCHIS with external systems including HMIS	3.7.3.6	CHSS, CMED,	National	0	0	75,630,000	75,630,000	0	0	0	0	**146,004**	**151,260,000**

(DHIS2), C-Stock, ISS, RapidPro, USSD, OHSP, LIMS,EMRs etc		DHD, ICT & Partners											
Review ICT policies on community level interventions	3.7.3.7	CHSS, DHD,CMED, ICT & Partners	National	0	0	31,906,571	0	0	31,906,571	0	31,906,571	**92,394**	**95,719,713**
Conduct iCHIS server administration and system maintenance	3.7.3.8	CHSS, DHD, ICT	National	0	32,000,000	32,000,000	32,000,000	32,000,000	32,000,000	30,000,000	32,000,000	**214,285**	**222,000,000**
Monitor usage and impact of the iCHIS system to community health through impact evaluation	3.7.3.9	CHSS, CMED, DHD, ICT & Partners	Community	0	0	0	38,170,000	0	0	0	38,170,000	**73,687**	**76,340,000**
Conduct quarterly data review meetings for iCHIS at the district level	3.7.3.10	CHSS, CMED, DHD, District supportive supervision teams & Partners	District	20,272,000	20,272,000	20,272,000	20,272,000	20,272,000	20,272,000	10,136,000	20,272,000	**146,757**	**152,040,000**
Implement reverse billing or zero-rated billing to improve reporting	3.7.3.11	CHSS, DPPD, NLG & Partners	National	276,000,000	276,000,000	276,000,000	276,000,000	276,000,000	276,000,000	276,000,000	276,000,000	**2,131,274**	**2,208,000,000**
Conduct iCHIS end-user training (scale-up)	3.7.3.12	CHSS, CMED, DHD, ICT & Partners	Community	119,430,000	119,430,000	119,430,000	119,430,000	119,430,000	119,430,000	119,430,000	119,430,000	**922,239**	**955,440,000**
Conduct routine monitoring and maintenance of community health infrastructure and equipment to ensure sustainability (operation and maintenance)	3.7.3.13	CHSS, DPPD, Administration Division/Maintenance, DHD & Partners	Community	6,694,285	6,694,285	6,694,285	6,694,285	6,694,285	6,694,285	6,694,285	6,694,285	**51,693**	**53,554,280**

Conduct monthly data validation review meetings at health facility level to ensure quality and consistency before sharing data with the district	3.7.3.14	iCHIS district user support teams	Community	0	20,000,000	20,000,000	20,000,000	20,000,000	20,000,000	20,000,000	20,000,000	**135,135**	**140,000,000**
Incorporate data from birth and death registration at community level	3.7.3.15	CHSS, DHD,CMED, ICT & Partners	Community	0	155,400,000	0	0	0	0	0	0	**150,000**	**155,400,000**
Sub Total				**1,553,994,285**	**974,670,285**	**674,658,856**	**721,300,285**	**491,492,285**	**506,302,856**	**479,356,285**	**544,472,856**	**5,739,622**	**5,946,247,993**
Thematic Area 4: Supply Chain and Infrastructure													
Review/assess the asset tracking system for community health service posts	3.7.4.1	CHSS, DHD, Administration Department & other Partners	National	6,409,000	0	0	0	0	0	0	0	**6,186**	**6,409,000**
Procure and distribute materials to assist persons with disabilities at community level	3.7.4.2	CHSS, DPPD/PDU, Administration Division/Maintenance, DHD & Partners, HTSS,	Community	1,400,000	0	0	0	0	0	0	0	**1,351**	**1,400,000**
Review and disseminate integrated Standard Supply List for CHWs in collaboration with Physical Asset Management	3.7.4.3	CHSS, DPPD/PDU/PHAM, Administration Division/Maintenance, DHD & Partners, HTSS,	National	82,312,000	0	0	0	0	82,312,000	0	0	**158,903**	**164,624,000**

Monitor implementation of the developed guidelines for Health Posts and housing units for HSAs, SHSAs, and CHNs (as needed) in hard-to-reach areas	3.7.4.4	CHSS, DPPD, DHD & Partners	Community	18,648,000	18,648,000	18,648,000	18,648,000	18,648,000	18,648,000	18,648,000	18,648,000	**144,000**	**149,184,000**
Purchase solar equipment suited for particular health posts	3.7.4.5	CHSS, DPPD, Administration Division/Maintenance, DHD & Partners	National	103,670,857	53,622,857	71,497,142	107,245,714	0	107,245,714	107,245,714	71,497,142	**600,410**	**622,025,142**
Install solar power equipment to already constructed health posts and outreach clinics	3.7.4.6	CHSS, DPPD, Administration Division/Maintenance, DHD & Partners	Community	38,872,428	20,106,428	26,808,571	40,212,857	0	40,212,857	40,212,857	26,808,571	**225,130**	**233,234,571**
Maintain solar power to already constructed health posts and outreach clinics	3.7.4.7	CHSS, DPPD, Administration Division/Maintenance, DHD & Partners	Community	3,505,714.29	3,505,714.29	3,505,714.29	3,505,714.29	3,505,714.29	3,505,714.29	3,505,714.29	3,505,714.29	**27,071**	**28,045,714.32**
Review existing supply chain systems in relation to commodities to be used at community level i.e. village clinics and health posts	3.7.4.8	CHSS, Administration Division & Partners	National	51,588,000	0	51,588,000	0	0	51,588,000	0	0	**149,386**	**154,764,000**
Update or extend the existing supply chain systems to	3.7.4.9	CHSS, DPPD & Partners	National	25,800,000	25,800,000	25,800,000	25,800,000	0	25,800,000	25,800,000	0	**149,420**	**154,800,000**

include commodities used at community level													
Lobby for upgrading of access roads to hard-to-reach area health facilities and health posts to ease access to the primary centres of care	3.7.4.10	CHSS, DPPD/PDU, Administration Division/Maintenance, HTSS, DHD & Partners	District/ Community	40,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	**174**	**180,000**
Purchase Wide Area Network equipment for Community HC	3.7.4.11	CHSS, DPPD, Administration Division/Maintenance, DHD & Partners	National	4,232,000	4,232,000	4,232,000	4,232,000	4,232,000	4,232,000	4,232,000	4,232,000	**32,680**	**33,856,000**
Install Wide Area Network to community health facilities	3.7.4.12	CHSS, DPPD, Administration Division/Maintenance, DHD & Partners,	Community	6,496,857	6,496,857	6,496,857	6,496,857	6,496,857	6,496,857	6,496,857	6,496,857	**50,169**	**51,974,856**
Maintain Wide Area Network to community health facilities.	3.7.4.13	CHSS, Administration Division & Partners	Community	2,496,857	2,496,857	2,496,857	2,496,857	2,496,857	2,496,857	2,496,857	2,496,857	**19,281**	**19,974,856**
Revise transport guidelines to include CHWs	3.7.4.14	CHSS, DPPD/PDU/PHAM, Administration Division/Maintenance, DHD & Partners, HTSS	National	25,840,000	0	0	0	51,680,000	0	0	0	**74,826**	**77,520,000**
Conduct workshop to integrate village	3.7.4.15	CHSS, DPPD/PDU	District	0	64,000,000	64,000,000	64,000,000	64,000,000	64,000,000	64,000,000	64,000,000	**432,432**	**448,000,000**

action plans, health delivery structures and housing units into council investment plans and DIPs to open health delivery structures to other funding possibilities		/PHAM, Administration Division/Maintenance, DHD & Partners, HTSS											
Conduct routine monitoring and maintenance of community infrastructure and equipment to ensure sustainability (operation and maintenance) of community infrastructure and equipment	3.7.4.16	CHSS, DPPD, DHD & Partners	Community	0	19,260,000	19,260,000	19,260,000	19,260,000	19,260,000	19,260,000	19,260,000	**130,135**	**134,820,000**
Train CHTs in supply chain management and logistics	3.7.4.17	CHSS, DPPD, Administration Division, Council & Partners	Community	381,653,714	0	190,826,857	0	381,653,714	381,653,714	381,653,714	381,653,714	**2,026,154**	**2,099,095,428**
Conduct refresher training in supply chain management and logistics	3.7.4.18	CHSS, DHD, PMRA, CMS & Partners	Community	313,803,714	313,803,714	313,803,714	0	0	313,803,714	313,803,714	156,901,857	**1,665,946**	**1,725,920,428**
Review the existing supply and drug management system	3.7.4.19	CHSS, DHD, PMRA, CMS & Partners	National	0	0	0	42,140,000	0	0	13,500,000	0	**53,706**	**55,640,000**
Update the existing supply and drug management system to include community health	3.7.4.20	CHSS, DHD, PMRA, CMS & Partners	National	24,680,000	24,680,000	24,680,000	24,680,000	24,680,000	24,680,000	24,680,000	24,680,000	**190,579**	**197,440,000**
Train VHCs, HACs, HCMC and medicine sub-committees on	3.7.4.21	CHSS, DHD, PMRA, CMS & Partners	Community	526,924,836	1,053,849,673	1,053,849,673	526,924,836	526,924,836	0	0	0	**3,560,303**	**3,688,473,857**

monitoring and managing drugs													
Conduct refresher training for VHCs, HACs, HCMC and medicine sub-committees on monitoring and managing drugs	3.7.4.22	CHSS, Procurement Division & Partners	Community	0	0	526,904,122	1,053,808,244	1,053,808,244	526,904,122	526,904,122	0	**3,560,163**	**3,688,328,857**
Procure supplies and consumables for CHW based on the recommended standards	3.7.4.23	CHSS, Procurement Division & Partners	National	910,000,000	310,000,000	310,000,000	910,000,000	310,000,000	310,000,000	910,000,000	310,000,000	**4,131,274**	**4,280,000,000**
Procure high-quality and durable bicycles to ease mobility of HSAs	3.7.4.24	CHSS, Procurement Division & Partners	National	225,000,000	225,000,000	225,000,000	225,000,000	225,000,000	225,000,000	225,000,000	225,000,000	**1,737,452**	**1,800,000,000**
Procure high-quality and durable bicycles for each VHC/CHAG with one group bicycle after all HSAs have received bicycles	3.7.4.25	CHSS, Procurement Division & Partners	National	75,000,000	75,000,000	75,000,000	75,000,000	75,000,000	75,000,000	75,000,000	75,000,000	**579,150**	**600,000,000**
Procure motorcycles for supervisors of community health workers with priority to those working in hard-to-reach areas. Also, train the SHSAs on use and maintenance of the motorcycles	3.7.4.26	CHSS, Procurement Division & Partners	National	480,000,000	480,000,000	480,000,000	480,000,000	480,000,000	480,000,000	480,000,000	480,000,000	**3,706,564**	**3,840,000,000**
Procure motorcycles for supervisors of community health workers with priority to those working in hard-to-reach areas. Also, train the CHNs and CMAs on use and	3.7.4.27	CHSS, Procurement Division & Partners	National	300,000,000	300,000,000	300,000,000	300,000,000	300,000,000	300,000,000	300,000,000	300,000,000	**2,316,602**	**2,400,000,000**

maintenance of the motorcycles													
Procure high quality tablets and accessories for CHWs based on the recommended standards	3.7.4.28	DHD (Lead), CHSS, CMED & Partners	National	0	100,000,000	100,000,000	100,000,000	100,000,000	100,000,000	100,000,000	0	**579,151**	**600,000,000**
Procure high quality laptops and accessories for supervisors based on the recommended standards	3.7.4.29	DHD (Lead), CHSS, CMED & Partners	National	0	45,000,000	15,000,000	15,000,000	15,000,000	0	15,000,000	15,000,000	**115,830**	**120,000,000**
Construct 209 HSA housing units, with the goal of reaching a third of rural areas by 2030 - prioritising the furthest and hardest to reach hard-to-reach areas and then working inwards	3.7.4.30	CHSS, DPPD, NLG & Partners	Community	601,100,000	680,600,000	680,600,000	605,600,000	605,600,000	605,600,000	605,600,000	601,100,000	**4,812,548**	**4,985,800,000**
Construct and equip 802 health posts with the goal of reaching 100% of hard-to-reach areas by 2030	3.7.4.31	CHSS and Partners	Community	12,000,000,000	12,000,000,000	12,000,000,000	12,000,000,000	12,000,000,000	12,000,000,000	12,000,000,000	12,000,000,000	**92,664,092**	**96,000,000,000**
Sub-Total				**16,209,473,997**	**15,826,122,100**	**16,590,017,507**	**16,650,071,079**	**16,268,006,222**	**15,686,147,549**	**16,263,059,549**	**14,786,300,712**	**123,821,620**	**128,279,198,695**
Thematic Area 5: Community Engagement and Participation													
Orient community structures (VDCs, ADCs CHAGs) on social accountability tools such as scorecard	3.7.5.1	CHSS and partners	Community	31,205,160	31,205,160	31,205,160	31,205,160	31,205,160	31,205,160	31,205,160	31,205,160	**242,370**	**249,641,280**
Conduct engagement meetings with gatekeepers on	3.7.5.2	CHSS and partners	Community	1,120,214,572	1,120,214,572	1,120,214,572	1,120,214,572	1,120,214,572	1,120,214,572	1,120,214,572	1,120,214,572	**8,650,305**	**8,961,716,568**

emerging issues such as disease outbreak e.g COVID-19 and others and also mainstream issues like climate change, disability and gender													
Conduct consultations of gatekeepers on periodic reviews of policies and strategies to ensure that policies are responsive to real issues on the ground	3.7.5.3	CHSS and partners	District	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	**227,768**	**235,968,000**
Disseminate developed guidelines and policies at community level through VDCs, ADCs, CHAGs, HCMCs, HMCs and VHCs	3.7.5.4	CHSS and partners	Commu nity	0	43,810,200	0	0	0	0	0	0	**42,288**	**43,810,200**
Sensitise stakeholders to reinforce utilisation and linkages of already existing community structures such as VHCs and VDCs in order to avoid fragmentation and duplication of efforts	3.7.5.5	CHSS and partners	Commu nity	0	28,290,000	0	0	0	28,290,000	0	0	**54,614**	**56,580,000**
Orient VHCs and CHAGs and clarify their roles to reduce overlapping of roles and conflicts between the two structures	3.7.5.6	CHSS and partners	Commu nity	308,614,285	0	0	0	0	0	0	0	**297,890**	**308,614,285**

Form and train HCMCs	3.7.5.7	CHSS and partners	Community	11,420,000	11,420,000	11,420,000	11,420,000	11,420,000	11,420,000	11,420,000	11,420,000	**88,185**	**91,360,000**
Conduct national level partner coordination meetings quarterly to plan, discuss and review community health activities	3.7.5.8	CHSS (Lead), All Directorates in the MoH, Development Partners, Program Managers,DHSS	National	116,160,000	116,160,000	116,160,000	116,160,000	116,160,000	116,160,000	116,160,000	116,160,000	**896,988**	**929,280,000**
Conduct Community Health Team monthly meetings at health facility level, cluster level and even at district level	3.7.5.9	CHSS and partners	Community	254,100,000	254,100,000	254,100,000	254,100,000	254,100,000	254,100,000	254,100,000	254,100,000	**1,962,162**	**2,032,800,000**
Disseminate developed guidelines and policies at community level through VDCs, ADCs, CHAGs, HCMC, HMC and VHC	3.7.5.10	CHSS and Partners	Community	0	43,810,200	0	0	0	0	0	0	**42,288**	**43,810,200**
Develop health service charters	3.7.5.11	CHSS and partners	Community	24,780,000	0	0	0	0	0	0	0	**23,919,000**	**24,780,000**
Conduct community health open day	3.7.5.12	CHSS and Partners	National and Community	155,400,000	165,760,000	176,120,000	186,480,000	196,840,000	207,200,000	217,560,000	227,920,000	**1,480,000**	**1,533,280,000**
Conduct bi-annual meetings with local leaders and chiefs to improve accountability for implementation of district-level integrated community health action plan	3.7.5.13	CHSS and Partners	Community	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	**227,768**	**235,968,000**
Conduct community and CHT	3.7.5.14	CHSS and Partners	Community	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	29,496,000	**227,768**	**235,968,000**

consultations on district implementation plans (DIPs)													
Conduct inclusive community needs assessment, set community health priorities and participate in programme implementation	3.7.5.16	CHSS and Partners	Community	29,496,000	0	0	0	29,496,000	0	0	0	**56,942**	**58,992,000**
Conduct community monitoring and evaluation through two-way follow up and feedback mechanism	3.7.5.15	CHSS and Partners	Community	38,170,000	38,170,000	38,170,000	38,170,000	38,170,000	38,170,000	38,170,000	38,170,000	**294,749**	**305,360,000**
Support, monitor, and supervise the community structures (CHTs to support an on-going/monthly basis, and Community Health Officer to support on a quarterly basis)	3.7.5.16	CHSS and Partners	Community	38,170,000	38,170,000	38,170,000	38,170,000	38,170,000	38,170,000	38,170,000	38,170,000	**294,749**	**305,360,000**
Conduct inclusive awareness on community health programmes that enhance participation and demand for quality services through mass media campaign, IEC materials community meetings	3.7.5.17	CHSS and Partners	Community	28,290,000	28,290,000	28,290,000	28,290,000	28,290,000	28,290,000	28,290,000	28,290,000	**218,456**	**226,320,000**
Conduct quality assurance of community health service delivery, in	3.7.5.18	CHSS and Partners	Community	648,000	864,000	864,000	864,000	864,000	864,000	864,000	864,000	**6,463**	**6,696,000**

keeping with existing guidelines on quality management and by working with the Quality Assurance Directorate												
Sub Total				**2,245,156,017**	**2,008,752,132**	**1,903,201,732**	**1,913,561,732**	**1,953,417,732**	**1,962,571,732**	**1,944,641,732**	**1,955,001,732**	**15,334,270**	**15,886,304,541**
Thematic Area 6: Leadership and Coordination													
Conduct national level partner coordination meetings quarterly to plan, discuss, and review community health activities	3.7.6.1	CHSS	National	1,960,000	1,960,000	1,960,000	1,960,000	1,960,000	1,960,000	1,960,000	1,960,000	**15,135**	**15,680,000**
Conduct national level TWGs quarterly meetings to develop SOPs, checklists, validate training materials, share best practices and enforce standards	3.7.6.2	CHSS	National	1,960,000	1,960,000	1,960,000	1,960,000	1,960,000	1,960,000	1,960,000	1,960,000	**15,135**	**15,680,000**
Develop/Review ToRs for District Community Health committee meetings	3.7.6.3	CHSS	National	24,780,000	24,780,000	24,780,000	24,780,000	24,780,000	24,780,000	24,780,000	24,780,000	**191,351**	**198,240,000**
Convene district-level community health coordination meetings on a quarterly basis	3.7.6.4	District CHSS	District	90,000,000	90,000,000	90,000,000	90,000,000	90,000,000	90,000,000	90,000,000	90,000,000	**694,980**	**720,000,000**
Establish digital CH platform	3.7.6.5	CHSS	National	4,418,000	0	0	0	0	0	0	0	**4,264**	**4,418,000**
Conduct quarterly community health coordination meetings for program managers	3.7.6.6	CHSS	National	0	392,800,000	392,800,000	392,800,000	392,800,000	392,800,000	392,800,000	392,800,000	**2,654,054**	**2,749,600,000**

Map, register and update national partners and stakeholders	3.7.6.7	CHSS	National	0	0	0	0	0	0	0	0	**0**	**0**
Map, register and update district partners and stakeholders	3.7.6.8	CHSS District	District	0	0	0	0	0	0	0	0	**0**	**0**
Equip Community Health Office at district level with supplies	3.7.6.9	CHSS	National	0	900,000,000	0	900,000,00 0	0	900,000,00 0	0	900,000,00 0	**3,474,903**	**3,600,000,00 0**
Disseminate NCHF to CHTs and all stakeholders	3.7.6.10	CHSS	District	18,858,000	0	0	0	0	0	0	0	**18,203**	**18,858,000**
Develop/review community health action plans that feed into the DIP	3.7.6.11	CHSS District	District	0	75,624,000	0	0	75,624,000	0	75,624,000	0	**218,988**	**226,872,000**
Consolidate community health action plans to feed into the DIP	3.7.6.12	CHSS District	District	0	82,843,200	0	0	82,843,200	0	82,843,200	0	**239,893**	**248,529,600**
Hold interface meetings between district CH section with local government and partner to lobby for support/funding for community health activities within the DIP	3.7.6.13	CHSS	National	0	0	85,290,000	0	0	85,290,000	0	85,290,000	**246,979**	**255,870,000**
Sub Total				**141,976,000**	**1,569,967,2 00**	**596,790,000**	**1,411,500,0 00**	**669,967,20 0**	**1,496,790,0 00**	**669,967,20 0**	**1,496,790,0 00**	**7,773,888**	**8,053,747,60 0**
Thematic Area 7: Community Health Financing													
Conduct engagement meetings with communities in financing of community health services	3.7.7.1	CHSS and other partners	District, community	1,536,800	1,536,800	1,536,800	1,536,800	1,536,800	1,536,800	1,536,800	1,536,800	**11,867**	**12,294,400**

Train CHSS, DPPD and partners in community health financing to effectively implement the community health financing initiatives and accountability mechanisms	3.7.7.2	CHSS, Partners	National	0	11,172,085	0	0	0	0	11,172,085	11,172,085	**32,352**	**33,516,257**
Develop a resource mobilisation plan	3.7.7.3	CHSS and other partners	National	5,132,348	0	0	0	0	0	0	0	**4,954**	**5,132,348**
Train district teams to generate, understand and use resource mapping and budget and expenditure analyses when making allocation decisions towards various sections, including community health	3.7.7.4	CHSS and other partners	District	0	63,600,000	0	63,600,000	0	63,600,000	0	63,600,000	**245,560**	**254,400,000**
Develop guidelines for stakeholder integration (joint implementation), co-planning, colocation and cost-sharing/pooling to reduce duplication and enhance efficiency in the delivery of community health services	3.7.7.5	DPPD, CHSS, DHOs	National	13,570,514	0	0	116,160,000	0	0	0	116,160,000	**224,247**	**232,320,000**
Promote CSO participation by encouraging formation of alliances and coalitions for mobilising resources	3.7.7.6	CHSS and partners	National, district	36,960,000	0	0	0	0	0	0	0	**35,676**	**36,960,000**

and contributions from diversified sources as well as enhancing accountability													
Conduct regional private sector engagement on for increased contribution towards community health	3.7.7.7	CHSS and other partners	National District	1,536,800.00	1,536,800.00	1,536,800.00	1,536,800.00	1,536,800.00	1,536,800.00	1,536,800.00	1,536,800.00	**11,867**	**12,294,400**
Conduct advocacy meetings to lobby for increased community health funding from ORT budget via DIP	3.7.7.8	CHSS	National	1,844,000	1,844,000	1,844,000	1,844,000	1,844,000	1,844,000	1,844,000	1,844,000	**14,239**	**14,752,000**
Conduct advocacy meetings for community health via local government structures and partners	3.7.7.9	CHSS and Planning Department	National	33,820,000.00	57,640,000.00	57,640,000.00	57,640,000.00	57,640,000.00	57,640,000.00	57,640,000.00	57,640,000.00	**422,104**	**437,300,000**
Conduct advocacy campaigns at community level for increased community contribution towards community health	3.7.7.10	CHSS and other partners	Community	37,656,000	37,656,000	37,656,000	37,656,000	37,656,000	37,656,000	37,656,000	37,656,000	**290,780**	**301,248,000**
Conduct engagement meetings with partners or donors for new NCHF such as lobbying for partners in supply chain management	3.7.7.11	CHSS	National	18,946,285	0	0	0	0	0	0	0	**18,288**	**18,946,285**
Conduct advocacy meeting for incorporation of	3.7.7.12	CHSS	National District	15,560,000	15,560,000	15,560,000	15,560,000	15,560,000	15,560,000	15,560,000	15,560,000	**120,154**	**124,480,000**

social responsibility in line with community health activities like building of health posts													
Conduct advocacy meetings to lobby for ring fencing and protected minimum percentage towards community health from donor interventions, CDF and from local revenues (district councils)	3.7.7.13	District Council	District	2,859,600	2,859,600	2,859,600	2,859,600	2,859,600	2,859,600	2,859,600	2,859,600	**22,081**	**22,876,800**
Conduct participatory audit meetings with stakeholders as part of monitoring community projects through the use of score card	3.7.7.14	District CHSS	District	1,536,800	1,536,800.00	1,536,800.00	1,536,800.00	1,536,800.00	1,536,800.00	MWK 1,536,800.00	1,536,800.00	**11,867**	**12,294,400**
Conduct advocacy campaigns at district level for increased community contribution towards community health	3.7.7.15	CHSS, District Partners	District	173,101,000	173,101,000	173,101,000	173,101,000	173,101,000	173,101,000	173,101,000	173,101,000	**1,336,687**	**1 384,808,000**
Review the community health financing advocacy framework in line with the National Community Health Financing Operational Plan priorities	3.7.7.16	CHSS, Partners	National	0	5,612,348	0	0	0	0	5,612,348	0	**10,835**	**11,224,697**

Conduct advocacy meetings with partners on the adoption of HSSP III One Plan, One Budget and One M&E	3.7.7.17	CHSS, Partners	National	0	18,946,285	0	0	0	0	0	0	**18,288**	**18,946,285**
Conduct quarterly community health funding gap analysis at subnational level	3.7.7.18	CHSS, Partners	National	38,523,099.43	38,523,099.43	38,523,099.43	38,523,099.43	38,523,099.43	38,523,099.43	38,523,099.43	38,523,099.43	**297,476**	**308,184,795**
Conduct annual funding gap analysis at national level	3.7.7.19	CHSS, Partners	National	0	7,870,514.29	7,870,514.29	7,870,514.29	7,870,514.29	7,870,514.29	7,870,514.29	7,870,514.29	**53,179.15**	**55,093,600**
Conduct community health financing coordination meetings at subnational level	3.7.7.20	CHSS, District	National, District	0	4,034,000	0	0	0	0	0	0	**3,894**	**4,034,000**
Conduct capacity and needs assessments to map where community health funding should be channelled	3.7.7.21	CHSS, District	National	0	13,566,000	0	0	0	0	0	0	**13,095**	**13,566,000**
Conduct cost-effectiveness assessment to estimate DALY's saved as a result of preventive health services compared to curative services– to build a case for more budgetary allocation towards community health and prevention	3.7.7.22	CHSS	National	0	20,000,000	0	0	0	0	20,000,000	0	**38,610**	**40,000,000**
Establish mechanisms for	3.7.7.23	CHSS	National	0	72, 600,000	0	0	0	0	0	0	**70,077**	**72,600,000**

enhancing community accountability and action													
Sub-Total				**382,583,246**	**549,195,331**	**339,664,613**	**519,424,613**	**339,664,613**	**403,264,613**	**376,449,046**	**530,596,698**	**3,321,277**	**3,440,842,773**
GRAND TOTAL				**57,543,243,365**	**62,689,652,648**	**65,219,517,708**	**70,449,542,709**	**73,182,626,172**	**78,326,844,870**	**83,932,701,732**	**89,237,702,018**	**560,407,173**	**580,581,831,222**

Annex 2: Strategic Objective Indicators and Targets by Thematic Areas

The indicators for the M&E Plan cut across the seven thematic areas of the NCHF and speak to the M&E Matrix of the HSSP III as well in **"One Plan, One Budget, One Report"** spirit. The CHS Section and CMED will provide guidance on how to measure each indicator in terms of frequency and those tasked with responsibility of data collection.

TABLE 6 PRELIMINARY LIST OF OUTCOME AND OUTPUT INDICATORS, TARGETS AND BASELINE DATA BY THEMATIC AREAS

Thematic Area	Output Indicator	Baseline	Outcome Indicator	2030 Target
Health Services Delivery	• Number of CHTs that meet every month. • Number of review meetings at national, district and zonal level for joint work plan conducted. • Number of quarterly integrated supportive supervision conducted to all CHWs and CHTs. • Number of bi-annual multi-sectoral district coordination meetings conducted to track implementation of the NCHF. • Community health orientation meetings conducted for DHMT, HSAs, CDAs, CHNs, CMA, AEDC and AEDOs to advocate for multi-sectoral, integrated, and inclusive services in the district.	TBD	% of CHWs delivering most of the community components of the HBP	90%
	• Package of HBP services delivered at community level established and agreed upon by stakeholders. • Role clarity guidelines reviewed according to emerging issues. • Reviewed role clarity guidelines disseminated at community level. • Community health guidelines updated in line with emerging issues such as the HBP and emergencies of public health importance.	0	% progress towards developing health service delivery documents	100%

	• Number of integrated community health screenings for all conditions and diseases at point of delivery. • Number of integrated community-based outreach clinics focusing on various target groups including children, pregnant and postnatal women and adolescents. • Number of integrated community health education sessions of various diseases and conditions	TBD	% increase to integrated health services through increased accessible service delivery points	75%
Human Resources	• Number of HSAs undergoing pre-service training. • Number of HSAs undergoing in-service training	11,500 9600	# of CHWs with increased capacity building in delivering various services at community level	20,600 will have undergone pre-service training.
	• Number of HSAs recruited • Number of CHNs recruited • Number of CMAs recruited • Number of AEHOs recruited • Number of EHOs recruited	1 HSA per 1800 people 1 AEHO per two facilities 1 CHN per 87,000 people	% progress towards Malawi policy recommendation for the ratio of trained CHWs against the general population	1 HSA per 1,000 people; 1 AEHO per health facility; 1 CHNs per health facility; 1 CHN per 5000 people; 1 CMA per Community Health Delivery Structure;

				1 CMA per 2500 people 1 EHO per community/rural hospital.
	• Number of HSAs recruited; • Number of CHNs recruited; • Number of CMAs recruited; • Number of AEHOs recruited; • Number of EHOs recruited;	11,500 HAS 240 CHNs 600 CMAs 293 AEHOs 118 EHOs	# of CHWs per cadre	24,850 HSAs 4000 CHNs 8000 CMAs
ICT	• Number of CHWs trained in iCHIS. • Number of iCHIS supportive supervisions conducted;	1253 TBD	% of HSAs collecting data and uploading into the iCHIS	100%
	• Number of data validation review meetings conducted at a health facility level;	TBD	% of CHTs using mHealth for integrated service delivery, data collection and supervision	60%
Supply Chain and Infrastructure	• Number of community health posts to be constructed in hard-to-reach areas. • Number of CHWs housing units constructed in rural catchment areas.	96 209	# of health posts operating and supporting community integrated health service delivery	802
	• Number of HSAs with bicycles; • Number of SHSAs with motorcycles; • Number of CHWs with computers • Number of CHW with tablets.	TBD	% of CHWs provided with equipment for their work	98%

	• Transport guidelines revised to include CHWs; • Number of health facilities installed with Wide Area Network; • Number of community health posts installed with solar power; • Integrated and inclusive Standard Supply List for CHWs, in collaboration with Physical Asset Management reviewed and disseminated;	0 TBD 0	% progress towards developing service delivery structures in hard to reach areas	70%
Community Engagement and Participation	• # of community structures such as VDCs, ADCs, CHAGs VHC, HMCH, CMC and others oriented on social accountability tools to improve quality of health service delivery. • # of HCMCs and HMCs formed and trained to ensure ownership of the health services by the community through the HCMC;	TBD TBD	% progress of building capacity of community structures	90%
	• Number of VHCs that meet regularly. • Number of CHAs and HCMCs that are active. • Number of CHTs conducting monthly meetings.	TBD	% progress towards strengthening leadership and accountability at community level	80%
Leadership and Coordination	• ToRs for District Community health committee meetings developed; • Digital CH platform for communication, networking and sharing of information established; • Community Health Office under the Preventive Health Section at district level established;	0 None	% of all agreed-upon coordination activities and milestones completed	95%

	• Community health action plans developed for CHAGs, VHCs, VDCs and ADCs.	0		
	Number of quarterly community health coordination meetings for program managers at national level conducted.	0	# of meetings conducted	24
Community Health Financing	• Number of engagement meetings conducted with communities to finance community health services. • Resource mobilisation plan developed as a blueprint for all fundraising activities. • Guidelines developed for stakeholder integration (joint implementation), co-planning, colocation and cost-sharing/pooling to reduce duplication and enhance efficiency in the delivery of community health services	0 0 0	% progress towards mobilising resources for implementation of interventions at community level	75%
	• Number of staff trained in community health financing to effectively implement the community health financing and for transparency and accountability purposes.	0	# of community health staff with increased knowledge and skills in resource mobilisation and actively involved in raising funding for community health interventions	5

Annex 3: Monitoring and Evaluation Responsibilities

TABLE 7: M & E RESPONSIBILITIES OF VARIOUS STAKEHOLDERS

Stakeholder	Responsibility
CHSS	• Primarily responsible for M&E of the NCHF.

	• Sets M&E guidelines, including cadence of data collection. • Conducts data analysis at national level. • Emphasises data utilisation at all levels for decision making. • Conducts annual review of the NCHF and leads midterm/final NCHF evaluation. • Coordinates M&E efforts with MoH and partners • Sets the research agenda for community health along with partner
HMIS	• Collates data nationally. • Conducts data analysis
CHWs	• Collect data for core CH indicators through iCHIS at community level. • Upload the data. • Conduct basic analysis of data. • Disseminate findings to communities
DHO	• Collects, collates, and analyses district-level data. • Submits high-quality data to MoH. • Data utilisation for programming and decision making
Communities	• Collect data using community accountability tools such as scorecard
Partners	• Collect and analyse data. • Conduct independent research and evaluation. • Synthesise findings and disseminate findings to all levels