Scottish Executive International Development

Report of health sector visit to Malawi 18th - 22nd April 2005

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Summary and key points.

1. Scotland's relationship with Malawi stretches over 100 years. Existing connections should be encouraged and built upon, as new connections are forged.

2. The health of the Malawian people has suffered over the last number of years from a fragile economy, a devastating HIV/AIDS epidemic (adult prevalence 14.4%), a lack of front line health workers due to attrition, immigration and illness, and a lack of health resources. This has given rise to a human resource emergency in the health sector. There are also predictions of a severe impending food shortage due to lack of rains.

3. The Ministry of Health have developed, with external partners, an effective joint **Programme of Work** to implement an **Essential Health Package** – designed to deliver a prioritized package of services that focuses on the major causes of morbidity and mortality in Malawi and an **Emergency Human Resource Programme** aiming to double the number of nurses and triple the number of doctors in Malawi's public heath service.

Scottish engagement with the Malawi Health Service through the Ministry of Health and the Christian Health Association of Malawi (CHAM), must be coherent with this Programme of Work.

4. Maternal mortality has risen to above 1800 deaths per 100,000, making it the third highest in the world. Midwives, obstetricians and equipment are particularly needed.

5. A menu of action and suggestions are made about ways in which Scotland might support the whole Malawian health service through staff training, human resources, and equipment needs.

6. This menu has been developed in consultation with the Ministry of Health in Malawi.
Requests include:

- teaching and training for all cadres of health workers
- health promotion personnel and material for prevention and education for all diseases but in particular HIV/AIDS and sexual health.
- clinical support (after discussion with Malawian counterparts to ensure appropriateness and cultural sensitivity).
- clinical supplies and equipment (simple items such as gloves, surgical clamps are desperately needed).

7**. Nine priority areas are described for potential Scottish Malawian health co-operation**. These include:

- Maternal health*
- Support for the Emergency Human Resource programme, which highlights training of all cadres of health workers
- Support to develop training capacity at the College of Sciences
- Support for teaching at undergraduate and post graduate level at the College of Medicine
- Support for the Ministry of Health (MOH) Planning Directorate
- Support for the HIV/AIDS treatment and prevention programme
- Support for the Health Education Unit
- Physical assets management
- Health management information services

* Malawi is currently developing a 'Road Map' to improve maternal health. Specific support to maternal health could include:

- Human resources and training: curriculum development in evidenced-based obstetric practices, supporting the training institutions in this area; improving the profile of the midwife; supporting exchange visits for midwives, obstetricians etc
- Equipment: supporting PAM Unit (Physical Assets Management Unit) in developing standard equipment lists, procuring standard equipment not funded under the SWAP, supporting Bottom hospital directly, supporting maintenance of equipment with specialisation in obstetric equipment
- IEC (Information, education and exchange behaviour change): supporting materials production and development with a focus on maternal services, the role of the midwife, and harmful traditional practices
- Support ART (Antiretroviral Therapy) programmes in the area of Prevention of Mother to Child transmission

The nine priority areas identified are cognizant with a commitment to the internationally agreed agenda for development summarized in the Millennium Development Goals.
These goals are a set of measurable and time bound targets adopted at the UN Millennium summit in 2000.

Their focus is on:
Halving the proportion of people suffering from extreme hunger and poverty
Guaranteeing all children complete primary school
Ensuring girls have the same opportunities as boys
Reducing by two thirds a child's risk of dying before the age of five.
Reducing by three quarters a mothers risk of dying from pregnancy related causes
Halving the proportion of people without access to safe drinking water
Stopping and reversing the spread of HIV, Malaria and TB;
Protecting the world's ecosystems and biodiversity
Giving people greater access to essential medicines
Ensuring rich countries grant steeper debt relief, more foreign aid, and fairer opportunities to trade

The report of the visit 18th to 21st April 2005

Introduction:
The Scottish Executive International Division have commissioned a needs assessment of health care priorities in Malawi in order to inform the strategic direction of the International Development Strategy.
This report is the result of discussions with a number of health experts in Malawi including the Ministry of Health and DfID, the Colleges of Medicine, College of Nursing and College of Health Science and representatives from the Christian Health Association of Malawi (CHAM). We are aware that this report gives insufficient information on the work of all institutions and reflects a more central/southern Malawi bias. This was not intentional and the report needs to be read as a brief snap shot of engagement possibilities, aware that other themes may emerge. There are many institutions in the north of Malawi and support to these institutions should also be a priority.
We appreciate the time given by many excellent practitioners, policy advisers and planners who provide significant services in situations of tight resources, and inadequate staffing. We are ever mindful of the enormous achievements of individuals and appreciate that health staff in Malawi can teach us much about dedication, care, courage and determination. To cite Dan Berwick words, in a paper in the BMJ last year, "We will meet in developing countries a level of will, skill and constancy that may put ours to shame. We may well find ourselves not the teachers we thought we were but students of those who simply will not be stopped under circumstances that would have stopped us long ago". [1]

1. Malawi Background

The small landlocked country of Malawi borders Zambia, Tanzania and Mozambique. A third of Malawi is covered with lakes, the largest being Lake Malawi. It has five national parks and outstanding beautiful scenery.

President Bingu wa Mutharika was elected by popular vote for a five year term in May 2004 (next elections to be held May 2009). The president is both the Chief of State and Head of Government with a 46-member Cabinet named by the president Since the beginning of 2005 President Bingu wa Mutharika is moving ahead with the formation of a new political Democratic Peoples' Party following his resignation from (dissolution of) the United Democratic Front (UDF).

The population of Malawi is diverse in terms of language, religion and ethnicity. There are about nine indigenous ethnic groups, Chewa, Nyanja, Tumbuka, Yao, Lomwe, Sena, Tonga, Ngoni, Ngonde in addition to Asian and Caucasian groups.

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[1] Berwick D, Lessons from developing countries on improving health BMJ 2004; 328:1124-9.

Health and socio-economic facts

Malawi has among the lowest per capita income in Africa. Poverty is chronic and widespread. 6.5 million (65.3%) of the population live in poverty and a further 27% live in extreme poverty. Unemployment is estimated to be around 93%.

Life expectancy has fallen from 48 years in 1990 to 38 years in 2002. Preventable causes of morbidity and mortality constitute the major contributors to the disease burden in Malawi.

Almost half of the population of 11.8 million are aged 14 years and under.
0-14 years: 46.9%
15-64 years: 50.4%
65 years and over: 2.8%

Birth rate 43.95 births/1,000 population (2005 est.)
Death rate 23.39 deaths/1,000 population (2005 est.)
The total fertility rate (TFR) of 6.3% gives rise to a 2% pop increase annually.

Infant and child mortality rates are 135 per 1000 live births and 189 per 1000 births. Maternal Mortality is currently estimated at over 1800 per 100,000[2] (up from 1120 in 2000). Malawi has the third highest maternal mortality in the world, only Afghanistan and Sierra Leone have higher figures, reflecting their war torn status.

Gender relations in Malawi also have a great impact on who benefits from health care. Women in Malawi have less access to cash, fewer economic opportunities and limited control over household resources and decision-making. Women also provide a disproportionate share of informal health care provision in households and communities. Social roles and expectations, and norms and values of behavior mean that women are more vulnerable to ill health, yet have fewer resources and opportunities to protect their health or to seek care. (DfID)

HIV/AIDS.

National prevalence is 14.4% Prevalence is highest in the Southern region, where it is double the level in the Central belt and the north of Malawi. It is estimated that 900,000 are infected with HIV/AIDS with 86,000 deaths per annum. Highest infection rate is among young people (15-24 age range) with a 6-1 female-male ratio. An estimated 850,000 children are orphans.
In a sample of pregnant women attending antenatal clinics in urban Blantyre, HIV seroprevalence rose from 2.6% in 1986 to over 30% in 1998, decreasing to 28.5% in 2001. The Malawi Minister of Health indicated that less than 3% of adult Malawians currently know their HIV/AIDS serostatus.

At present 170,000 are estimated to need anti-retroviral therapy, of which approximately17, 600 are receiving treatment.

[2] World Health report projection 2005

Traditional beliefs and practices

Though gender inequity is a major factor in HIV spread some localized beliefs and customary practices related to certain ethnic groups are also responsible for increasing the risk of HIV infection. Among these are polygamy, extramarital sexual relations, marital rape, first aid to snakebite victims, ear piercing and tattooing (*mphini*), and traditional practices such as widow- and widower- inheritance (*chokolo*), death cleansing (*kupita kufa*), forced sex for young girls coming of age (*fisi*), newborn cleansing (*kutenga mwana*), circumcision (*jando* or *mdulidwe*), ablution of dead bodies, consensual adultery for childless couples, initiation of girls by village elder (*fisi*), wife and husband exchange (*chimwanamaye*) and temporary husband replacement (*mbulo*).

Traditional teaching around initiation ceremonies influence the way in which sex is discussed and viewed between men and women. Young men are taught to be physically strong and sexually active.

Economy

Landlocked Malawi ranks among the least developed countries in the world. The economy is predominately agricultural, with about 90% of the population living in rural areas. Agriculture accounted for nearly 40% of GDP and 88% of export revenues in 2001. 90% of the labor force of approximately 4.5 million work in agriculture - tobacco, (accounts for over 50% of exports), sugarcane, cotton, tea, corn, potatoes, cassava (tapioca), sorghum, pulses; groundnuts, macadamia nuts; cattle, goats. The traditional system of land inheritance and ownership does not encourage investment or sustainable production.

The economy depends on substantial inflows of economic assistance from the IMF, the World Bank, and individual donor nations. In late 2000, Malawi was approved for relief under the Heavily Indebted Poor Countries (HIPC) programme. In November 2002 the World Bank approved a $50 million drought recovery package, to be used for famine relief. In 2004 Malawi requested the International Monetary Fund (IMF) to put it on a staff-monitored programme, which aims to address macro-economic imbalances by containing government borrowing and holding down inflation.

An International Monetary Fund team (March 2005) has recently lauded the new Government of Malawi for its control on public spending and tackling corruption and said that its economy was turning around.

Hunger predictions

According to the office of the UN Resident Representative in Malawi, results from the latest crop assessment, released by the Ministry of Agriculture on 1 April 2005, pointed to "impending hunger". A further Malawi Vulnerability Analysis Committee (MVAC) survey from 29 March to 4 April showed that some areas were likely to experience food deficits of up to 15 percent during the April-June period, affecting an estimated 577,300 people. Maize production forecasts are down 24.6 percent from last year's final crop estimate, while prolonged drought conditions reduced the sweet potato harvest by 12.8 percent and tobacco by 12.5 percent. Last year's harvest was particularly poor in the country's south and central regions following a dry spell.

2. Health care in Malawi

The majority of Malawians rely on traditional healers and Traditional Birth Attendants (TBAs) for many of their health care needs.[3] Only 54% of the rural population has access to a health facility within 5km. Front-line health services suffer from lack of drugs, poor staff-client relations, and poor quality diagnosis and treatment and even a lack of lighting.

Healthcare is provided through Government, Church and private (for profit) institutions. The Christian Health Association of Malawi (CHAM) coordinates under one umbrella the work of different church denominations in the health field and serves as a liaison between the churches and government health authorities.

There are 152 health units affiliated to CHAM representing eighteen different churches and church organizations among which are 20 hospitals, 32 primary health centres, 83 health centres, 13 dispensaries, 1 mental health service centre, 1 mobile unit and 2 health posts. There are also twelve associate members - these are non church-related units. Together these units are responsible for more than 35% of the health services in the country, with a significant coverage of the rural areas.

The Central Church of Africa Presbyterian (CCAP) as a Presbyterian reformed protestant Church has close links with the Church of Scotland. The CCAP comprises three Synods in Malawi, Livingstonia Synod, Nkhoma Synod and Blantyre Synod and two Synods in Zambia and Zimbabwe. These five Synods are joined together in the mother Synod called the General Synod. The Malawi Synods have a total Christian population of 3 million, making CCAP the second largest Church in Malawi after the Roman Catholic Church. Each of the three Synods operate hospitals and clinics which are running various programmes such as voluntary Counseling and Testing, (VCT), Prevention of Mother to Child Transmission, (PMTCT) and Antiretroviral therapy, (ART) mostly funded from outside. In addition they are involved in Orphan Care Programmes, and home based care activities for the sick, the elderly and the poor. As well as HIV/AIDS programmes many other activities including maternal and child services, water and well provision, food security programmes are run by CHAM hospitals. CHAM also trains the majority of the Nurse Midwife Technicians in the country at nursing schools attached to 6 of their hospitals.

Public services are free-of-charge at the point of delivery, but out-of-pocket expenditure accounts for 26% of total health spending, with the poorest households spending up to 10% of their annual consumption on health care. The poor have the greatest burden of ill health and are the least likely to access health services. CHAM hospitals operate a system of charging for health care

Malawi is facing acute human resource crises. The single biggest constraint on health programmes has been the shortage of health professionals at all levels and locations, with the greatest impact on peripheral services. Positions filled are inequitably distributed with rural sites frequently disadvantaged. Malawi can currently fill less than 50% of established posts in key areas such as clinical officers and registered nurses.

[3] HIV/AIDS National Policy Office of the President and Cabinet, National AIDS Commission, October 2003

Ten of Malawi's 29 districts have no government doctors, 4 districts have no doctor at all. Vacancy rates are significantly higher in rural areas.
Significant health care provision is provided by CHAM whose doctors and nursing staff have responsibility for much of the rural areas.
We were told of significant differences in capacity to deliver care between CHAM hospitals and Government hospital, CHAM hospitals on the whole being much better equipped with resources for service delivery.

Health staff per 100.000 population

Cadre	Botswana	South Africa	Ghana	Tanzania	Malawi
Physicians	28.7	25.1	9.0	4.1	1.6
Nurses	241.0	140.0	64.0	85.2	28.6

A List of Doctors in Government Hospitals

	Mzuzu	Lilongwe Central Hospital	Queen Elizabeth Central Hospital	Zomba Central	Districts	Total
Type of Doctor						
Surgeon		2	16	1		19
Dental Surgeon	1	2	1	1		5
Gynaecologist		3	6	1		10
Internal Medicine	1					1
Ophthamologist		2	1			3
Paediatrician	1	2	12	1		16
Cardiologist (TB Specialist)	2	1				3
Urologist	1					1
Anaesthetist	1					1
Medical Officer	3	17	23	2	20	65
Total	**10**	**29**	**59**	**6**	**20**	**124**

A complementary chart listing the doctors working in CHAM hospitals is missing.

3. The response to the Malawian crises in health care

A Joint Programme of Work (POW) has been developed through a consultative process with the central Ministry of Health (MOH) and various donor programmes contributing to a Sector-wide approach (SWAp). An **Essential Health Package will** be implemented over the next six years. This package has been costed at US$17 per head of population per year but currently funding for only $12 has been found (MOH will contribute $7 per capita with remainder from donors). The WHO's Macro-economics and health review suggests that a minimum package of health care should cost about $36 per person per year.

Summary of the Joint Programme of Work [2004 – 2010] for the Health Sector in Malawi
The priorities of the joint Programme of Work POW revolve around the provision of the Essential Health Package (EHP) as part of the Malawi Poverty Reduction Strategy. The broad objective of the POW is to raise the level of health status of all Malawians by reducing the incidence of illness and occurrence of premature deaths in the population. The sector wide programme will improve the health status of the population while reducing the geographical, socio-economic and gender inequalities in health. The programme will enhance the capacity of the Ministry of Health for stewardship and policy development, and strengthen the District Health Management systems for planning, budgeting and delivery of quality health services.

The programme will include the following components:
(i) Improving financial management systems; (ii) Improving health sector financing; (iii) Enhancing infrastructure and support services; (iv) Fostering partnerships for health; (v) Improving regulation; (vi) Reforming organizational arrangements; (vii) Developing human resources for health services; (viii) Strengthening priority health interventions including HIV/AIDS; (ix) Strengthening management information systems and performance monitoring and (x) Improving supply chain management systems including procurement.

Malawi's Poverty Reduction Strategy Plan (PRSP) sets out a strategy for achieving poverty reduction through sustainable and equitable growth.
The Malawi Country Plan aims to achieve a harmonised approach working in partnership with all the major bilateral and multilateral development agencies, including strategic use of current support to the Ministry within the framework of the National Sexual and Reproductive Health programme.

The role of DFID in Malawi[4]

DfiD recognize that improved health outcomes will not depend solely on health service provision. Major health gains will be achieved through inter-sectoral linkages. They anticipate that the Sector Wide Approach (SWAp) governance structure, and the involvement of civil society, may promote cross-linkages across sectors such as the

[4] Improving Health in Malawi A Sector Wide Approach including Essential Health Package and Emergency Human Resources Programm**e DFID Programme Memorandum November 2004**

provision of safe water and sanitation, better education, and promotion of gender equity. These will impact positively on the health of the poor, particularly women.

In December 2004, the Secretary of State agreed DFID support of £100 million sterling over six years within the action plan to support the Government of Malawi in improving the effectiveness, efficiency and equity of the essential health care delivery systems in the country through a Sector Wide Approach (SWAp). DFID will pool its funds with the World Bank and Norway/SIDA. Other donors in the sector such as USAID, JICA, GTZ and UN agencies support the POW and will contribute their support through project funding.
DfiD and other pool donor support will finance:

1) **Essential Health Package** – designed to deliver a prioritized package of services that focuses on the major causes of morbidity and mortality in Malawi. It will target Malawi's limited resources on **eleven public health interventions** [see table] that will be made accessible to everyone who has need of them. The interventions are organized in an integrated package, focusing on primary health services supported by effective referral to a district hospital. They aim to establish a minimum standard of health care for all, to be provided free of charge; They emphasise the need for expansion of community-level health services; and prioritising allocations to peripheral health services, poor geographical areas and areas with the greatest health needs.
2) **Emergency Human Resource Programme** – aims to double the number of nurses and triple the number of doctors in Malawi's public heath service. Programme will expand training capacity by over 50% on average, and more in key cadres, pay salaries supplements of 52% for 11 grades of health workers to help retain key workers, and pay for volunteer physicians and nurse tutors to fill vacant posts that are critical for training and health services.(Funding $ 205 million pledged by DfiD, The Global Fund for TB, HIV/AIDS and Malaria and the Malawian government)
3) **Capacity building in financial management, procurement, human resources, monitoring and evaluation, and health service planning and management** improving the effectiveness and efficiency of both the health system and the referral network to support delivery of the essential health package.

Priority Themes of the Essential Health Package:
1. To address child mortality: an effective extended programme of immunisation, basic nutritional interventions, widespread coverage of insecticide treated bed nets for the under fives, and appropriate and timely management of childhood fevers;
2. to reduce maternal mortality: skilled attendance at birth, promotion of wider birth spacing and prevention of unwanted pregnancies, and intermittent preventive therapy during pregnancy to reduce the burden of malaria;
3. to help reduce HIV infections: comprehensive behavioural change strategy, syndromic management of sexually transmitted infection and widespread provision of voluntary counselling and testing;
4. To treat AIDS: provision of antiretroviral therapy (ART) free of charge through the public health system;
5. To reduce tuberculosis: implementation of the 'DOTS' (Direct Observed Treatment Short course) strategy.

The Essential Health Package addresses many barriers to access by giving emphasis to access to peripheral health services in the 'Community Health Package'. Central to this package of basic public health interventions are the Health Surveillance Assistants (the community-based health workers). Only 10% of all health facilities have the capacity to deliver the Essential Health Package.

	Essential Health Package Component **Eleven public health interventions**
1	Prevention and treatment of vaccine preventable diseases.
2	Malaria prevention and treatment
3	Reproductive and neonatal health interventions (including reproductive health, family planning, safe motherhood and PMTCT)
4	Prevention, control and treatment of Tuberculosis.
5	Management of Acute Respiratory Infections.
6	Prevention, treatment and care for Acute Diarrhoeal Diseases (including cholera)
7	Prevention and treatment of sexually transmitted infections (HIV/AIDS, ARVT and VCT)
8	Prevention and treatment of Shistosomiasis and related complications
9	Prevention and management of Malnutrition, Nutrition deficiencies, and related complications
10	Management of eye, ear and skin infections.
11	Treatment for common injuries.
	Support services
	• Essential laboratory services.
	• Drug procurement, distribution and management.
	• Information, Education and Communication.
	• Pre- and in-service training.
	• Planning, budgeting and management systems.
	• Monitoring and evaluation.

Emergency Human Resource Programme

The Programme covers ten professional and technical health staff cadres working for the Ministry of Health and Christian Health Association of Malawi (CHAM).
The 3 objectives are:

1) To re-employ trained Malawian nurses and clinical officers as well as retaining staff already in the service.

It is estimated that 800 or more registered nurses who have left the profession are potentially available in Malawi for re-recruitment.
Part of the strategy for recruitment and retention involves supplementing current salaries – at present by approx. 50% increase.
Enforced retention policies for trainees have been put in place and a redeployment strategy will relocate staff to priority, difficult-to-fill locations by offering a 'hardship incentive'.

2) To increase training capacity for all cadres of staff by over 50% on average, and more in key cadres: trebling the numbers in physician training and doubling nurse training.

This requires an investment in the infrastructure and teaching staff of existing medical schools. There is a risk that the education system may be unable to produce enough adequately educated people to be trained as health workers.

Most do not require higher-level entry qualifications and the College of Medicine have introduced pre-med courses for medical students. Support to the curriculum development and delivery within the Colleges is required.

3) To recruit overseas physicians and nurse tutors through volunteer organizations on two-year contracts. The Government plans to recruit 50 additional physicians and nurse tutors per year for three years through volunteer organizations such as VSO and UN volunteers

Health positions – targets and vacancies:				
Cadre	**Ministry of Health target cadre for Malawi**	**Required for, HIV and AIDS programmes**	**Current number in post**	**Current vacancies**
Physicians	433	10	139	**294**
Nurses	8440	3401	4717	**3723**
Clinical Officers	1405	689	942	**463**
Medical Assistants	1500	500	718	**782**
Laboratory Technicians	507	386	251	**256**
Pharmacists	285	344	93	**192**
Environmental Health Officers	1662	10	304	**1358**

The role of VSO in Malawi[5]

VSO Malawi works in eight focus districts in Malawi – Chitipa, Rumphi, Ntchisi, Ntcheu, Zomba, Mwanza, Nsanje and Thyolo, districts chosen because of their rural setting/ high poverty levels, (four are the poorest districts in Malawi) high prevalence of HIV/AIDS, and low involvement of other NGOs. Their policy is dictated by a concern to promote the inclusion of all people to exercise their rights to essential services. A specific focus is on work with people who are usually excluded from decision making processes and from essential services, especially people with disabilities, female headed households, and children and young people, particularly orphans and out of school youth.. The cross cutting themes of all VSO Malawi work are gender and disability. There is scope within the VSO strategic plan to develop partnerships and placements outside the focus districts, where the work will have a national impact.

VSO has three Programme Area Strategies, food security, right to quality education, and HIV/AIDS. The health services component of the HIV/AIDS strategy is supporting the Ministry of Health in its objective "to develop a health delivery system that is proactively responsive to the prevailing needs and problems – a health care delivery system that addresses current and foreseeable health, disease and health care management problems by focusing on the provision of a minimum package of

[5] Information from Jill Healey VSO Malawi Country Director, VSO Malawi Country Strategic Plan

essential health services to the people of Malawi with the emphasis on the poor, women and children." (VSO Country Strategic Plan 2004-9) VSO's primary role is in the provision of health care professionals, particularly nurse training professionals and doctors.

4. Potential engagement between Scotland and Malawian health sector

Current links

There are already important established links with Scotland and it is suggested that these should be nourished and where possible expanded.

Examples of these links are:

(a) Prior to the establishment of the College of Medicine in Blantyre, Malawi medical students received first three years of medical school at St Andrews University. Continuing links between University medical schools and the College of Medicine should be explored.
(b) The College of Medicine, Blantyre has established links with Royal College of Surgeons Edinburgh, and Royal College of Surgeons in Glasgow
(c) The Malawi-Scotland Partnership – a recently established umbrella organization seeking to bring together, in a supportive environment, the various organizations and individuals working and linking with Malawi.

i. Malawi Scotland Partnership the Malawi Millennium Project Links with Strathclyde University and Bell College with the Malawi Polytechnic in Blantyre, the University of Malawi, and the Kamuzu College of Nursing . The Livingstone clinic based at Kamuzu Central Hospital is supported by the Strathclyde partnership Millennium Project.
ii CCAP is a sister partner church with Church of Scotland. There are a significant number of established links between church organizations in Scotland and churches and health care facilities in Malawi.
iii. The Raven Trust links with Strathclyde University (John Challis) in road engineering and sending containers of equipment to Malawi
iv Scottish Malawi Network – organization of Scottish and Malawian people living in Scotland who have longstanding links with Malawi - produce regular bulletin, the Malawi Update.

(d) ALSO (Advanced Life Support in Obstetrics) instructors from Scottish hospitals are providing ALSO courses to Bottom Hospital, Lilongwe. .

The magnitude and multitude of the various links provide an indication of the depth of relationship between Scotland and Malawi. This report stresses that all engagement within the Health Sector of Malawi should be coherent with the Joint Programme of Work supporting the Essential Health Package –and the Emergency Human Resource Programme.

Mechanisms to ensure this coherence are:

- Ensuring that short training courses are developed and implemented with MOH and training institutions so that materials and teaching skills are passed on and become part of the national health care worker training curriculum
- Ensuring that any additional basic equipment is selected from MOH standardised equipment lists, and its procurement is included on the MOH consolidated procurement plan (reflecting discrete donor support from Scotland)
- Improvement in procedures is documented and institutionalized within MOH as part of a Quality Assurance programme
- Proposed new services outside the Essential Health Package are explored for feasibility and financial sustainability within Malawi's resource envelope

Area One: Maternal support and care [6]

Preliminary results from recent surveys indicate that maternal mortality has increased from 1200 to over 1800 per 100,000. It appears that the Safe Motherhood Programme running in Malawi for five years has been unable to halt the downward spiral of service provision, and the inadequate access to care for the majority of woman who need 2nd level support for delivery. This is particularly the case in the southern areas. CHAM staff in the north (Ekwendeni), working on the Safe Motherhood programme have successfully achieved "baby friendly status" training nurses, nurse students, and Traditional birth attendants in all aspects of safe motherhood. However the majority of Government health facilities outside the four central hospital facilities at Queen Elizabeth Blantyre, Kamuzu Central Hospital, Lilongwe, Muzuzu (north) and Zomba, struggle to provide second level care – blood transfusions, Caesarean Section, or assisted breach delivery. There is no functioning ventuse extractor in the Government hospitals.

A number of reasons have been given for the increase in maternal mortality figures:

1. Impact of HIV
2. Delay in decision to seek services – (lack of knowledge re complications, limited antenatal care
3. Delay in accessing services (cultural issues – in many areas a woman has to seek permission, and funds, from head of household to leave family compound. Distance from health services and transport difficulties exacerbate this delay.

[6] *Information from Dr Grace Chiudzu, Senior Obstetrician and Gynecologist, Bottom Hospital and Dr Bailah Leigh (Technical Advisor, Reproductive Health Unit) and Matron at Bottom Hospital*

4. Delay in receiving services – only limited number of health services can perform surgery. Frequently long queues for admission to labour suite, (waiting for a free bed). Once reached there may not be sufficient staff on duty to offer immediate care.
5. Majority of births are at home. Traditional Birth Attendants (TBAs) require substantial training to improve quality of their service.
6. Variety of cultural beliefs which have serious consequences on health of mother e.g. a prolonged labour indicates a woman has been unfaithful (need for her to confess to speed labour up).
7. A lack of knowledge within the community. There is a major need to sensitize community on danger signs and complications of pregnancy

Maternity services in Lilongwe:
Bottom Hospital, Lilongwe provides the maternity services within Kamuzu Central Hospital, the major tertiary referral centre for the capital Lilongwe, and the 9 districts of the central region of Malawi. During 2004 10,115 women delivered

The site of Bottom Hospital is located five kilometres from Kamuzu Central Hospital site. There is no neo-natal intensive care unit at Bottom Hospital
Gynecology services are situated (5 kilometres away) at Kamuzu Central hospital site

Staffing levels – 5 specialists provide obstetric and gynecological support plus 6 clinical officers 18-20 midwives. On call service is shared between the two sites by one specialist and one Clinical Officer. The site distance and the nature of work frequently means that emergency work at one site is left unattended if staff are attending emergencies at the other site.
Equipment and resources – a shortage of numerous items – gloves, clamps, was reported by the Director, the matron and the Senior Obstetrician and Gynecologist. Bottom Hospital has 2 ultrasound scanners but need more, plus some training.
Retention of staff is a major problem. Poor pay, limited support, few resources, broken equipment and the huge staff shortage at all levels have a negative impact on job satisfaction. A number of midwives are still in Malawi but no longer working in health sector. (Some are in small business – selling at roadside stalls etc)

Needs Identified by service providers at Bottom Hospital:

- To increase in number of midwives
- To develop the specialization of midwifery – with support, accreditation and honour attached to the post.
- To adequately equip the facility to a standard coherent with the work load requirements.
- To provide on-going in house continuing education to staff on Obstetric Emergencies,

Possible Menu of Action for Obstetric and Gynaecology support within Malawi maternity units.

1. Continue and expand the links between midwives and pediatricians from Scottish maternity units to provide ALSO (Advanced Life Support in Obstetrics) course for staff at Bottom Hospital[7], and training trainers on site in the other major hospitals in the north and south of Malawi to deliver the course to others. Replicate training in other maternity units, and provide support to Colleges of Nursing, and College of Health Sciences in Malawi.
2. Supply of basic equipment: request for essentials surgical instruments such as clamps for abdominal surgery, a ventuse extractor, forceps, gloves, swabs. Also needed, a laparoscope and training on its use
3. On site update on procedures such as hysterectomy, vaginal fistulas,
4. Equipment and instruments for gynaecological procedures
5. Cancer support services need to be developed as a priority but the funding, and the qualified staff are not available (Cancer of the cervix is common – but there is no radiotherapy in whole of Malawi). .

Area Two : VSO support for the Health Service and related sectors through staff training.

In line with the Emergency Human Resource Programme it is suggested that Scotland can play a small role through VSO, supporting 10 NHS staff to apply for 2 year VSO placements. Planning for this requires discussion with VSO Country Director, Jill Healey.

The following VSO placements have been identified by VSO Malawi:

- Nurse tutors/ midwife tutors and clinical instructors for teaching at various sites. Midwives are essential
- 5 HIV/AIDS physicians – or physicians with a working knowledge of HIV/AIDS to be placed in KCV and QEH

Alongside nursing and clinical expertise the Ministry of Health in Malawi have suggested the potential scope of work for VSO volunteers skilled in:

- Medical engineering (maintenance and repair)
- Health Promotion
- Graphic Design, photography, radio and literature production skills for Health Education Unit
- Health Managers and Health Economists – support to Ministry and support to developing Health Management Diploma/Degree in Community Health Department at The College of Medicine at Blantyre.

[7] ALSO is an international charity established in America to provide in-depth training on obstetric emergencies. Its UK base is in Newcastle. (0191 276 5738 Miriam Abdullah – UK coordinator

Support around Staff retention[8]

Factors affecting retention include both 'push' factors such as:

1) Disillusionment and frustration with ill equipped, ill resourced services where little can be done to change health outcomes.
2) Low salaries
3) Weak promotions and postings procedures

And pull factors:

4) Attraction of overseas posts with higher salaries and better living conditions
5) Ongoing poaching from NGOs within Malawi (better pay and conditions)
6) Better pay and conditions for non health related jobs outside the health sector

Measures to address staff attrition

Alongside the important increase in salary of Front line workers (DfID initiative – raising salaries approximately 50%) there are active engagement techniques that Scotland can participate in to support retention:

1) Innovative ways of supporting staff on the ground – external links created through partnering with units in Scottish hospitals, mentoring and buddying systems.
2) Raising the kudos of certain strategic professions – e.g. midwifery – through support to the formation of an Association of Professional midwife of Scotland and Malawi. Making midwifery an emotionally and socially attractive occupation. Other professions would also benefit from this level of engagement – dieticians, ophthalmologists,
3) Supply of Equipment and resources support to facilitate possibilities of better outputs, (coordinated with Ministry of Health)
4) Develop a Scotland Specific Code of Practice on recruitment supporting the Department of Health Code of practice for the NHS not to actively advertise or encourage Malawian health staff to Scottish Health posts. (There are a number of trained and registered Malawian nurses working in Care homes in Scotland)

Area 3: Support to increase training capacity of Health Colleges (Government and CHAM) in Malawi.
Support to College of Health Sciences [9]

To enable an increase in the number of front line health workers a concerted effort is being made to train up new staff at all health care levels. There are a small number of colleges in Malawi offering training, some of these are Government run institutions and others are supported by the Christian Health Association of Malawi.
The Ministry of Health and the Director of Nursing both described huge need for teachers and clinical instructors on wards to support the increase in students in all health care worker training sites.

[8] DFID Programme Memorandum

[9] *Information from Dr TG Masache, the Director of the College of Health Sciences, Lilongwe and Dr Ann Phoya, Director of Nursing*

The Director of the College of Health Sciences T.G Masache identified specific tutor support to enable the College to achieve the outputs planned through the Emergency Human Resource Programme

The College of Health Sciences which is part of a consortium with Kamuza College of Nursing, Zomba Nursing School and Blantyre Medical Assistant Training School and is based on three campuses – Lilongwe, Blantyre and Zomba. It is controlled by a Board of Governors with representatives from

- ❖ Nursing and Midwives Council of Malawi
- ❖ Medical Council of Malawi
- ❖ Pharmacy and poisons board
- ❖ University of Malawi College of Medicine

Its remit is to train mid level heath person. The Malawian Government pays for every student – students bonded for length of training. The rapid increase in numbers of students has not been met with an increase in staff nor in equipment. There are 10,000 applications for approx 600 places each year in the 3 campuses.

Training at the College
Lilongwe campus

(a) Clinical officers (3 year training plus 1 year internship). Numbers trained increased from 30 to 90 over last two years 50 trained at Lilongwe campus and 40 trained at Blantyre. (80 men and 10 women) – It was suggested that the gender disparity was linked to the requirement of sciences for entry to College, though girls do seem to be achieving good marks in science in some geographical areas. This is a potential area of support through Education links with Scotland.
(b) 20 pharmacy students
(c) 20 lab technicians increased to 40
(d) 20 radiography students
(e) 20 public health students
(f) 10 dental therapists
(g) 100 medical assistants (50 l and 50 B)

Zomba Nursing School
Campus offers Nurse Midwife training plus psychiatric nurse qualification for those who have primary Nurse training.

Blantyre Medical Assistant Training School
Campus offers
Enrolled nurse upgrade
Community health nursing and Nurse Technicians

Identified Needs:

- Consistent Clinical tutoring in all disciplines in colleges and on hospital wards to facilitate the extra student numbers. .
- Training staff in each institution
- Support for library – journals
- IT support and IT training for students

Specific requests

- 2 Lecturers in Medical Surgical Nursing or Midwifery with a BSc in Nursing
- 3 Lecturers in Clinical Medicine to teach either Paediatrics, Medicine, Surgery Obstetrics/Gynaecology or Psychiatry. The Lecturers should have a Medical, or Senior Nursing Degree
- Lecturers in Radiography, Dentistry, Pharmacy and Medical Laboratory we will welcome the assistance.

Possible Scottish Engagement

- Tutor Support to the College of Health Sciences
- Linkages with other Scottish Health Training Colleges
- Linkages to Pharmacy, and Laboratory Technical staff
- Basic equipment support to enable facilitate increased teaching load – for labs, computer suites.

There are a range of other training institutions - such as the nurse technician training school at Ekwendeni Hospital in the north of Malawi. The report was unable to visit all the training institutions but recognition of their need for support is registered.

Area Four: Support for the College of Medicine, Blantyre,[10] and for ongoing training and support of medical staff in all major hospitals throughout Malawi. .

The College of Medicine based at Queen Elizabeth Hospital, Blantyre is the only medical school in Malawi. As part of the Emergency Human Resources Programme the College has, over the past two intakes, increased its numbers of medical students to 50 per annum. The impact of this will emerge after preclinical training when there is insufficient clinical staff on wards to support the new number of students.

College of Medicine requires support with both undergraduate and post graduate teaching. This includes:

1) Preclinical teaching support: in basic sciences, anatomy, biochemistry and physiology; pathology division; clinical chemistry, microbiology and pathology, bacteriology and Haematology

2) MMed specialist training programme in Paediatrics, Surgery, Anaesthetics, Obstetrics and Gynecology and Medicine has been approved. The MMed requires

[10] Information from Dr Robin Broadhead, Principal of College of Medicine., Dr Neil French, Dr Stephen Gram (senior lecturers) Dr Eric Borgstein, and Professor Cam Bowie,
Email contact with Dr John Chizu Undergraduatate Dean.

support in all the clinical departments: teaching support for theory modules in anaesthesia, medicine, O&G, Paediatrics and surgery is required.

3) Department of Anaesthesia urgently requires consultant or senior registrar support, as the only consultant anesthetist will leave in September

4) A UK recognized training post based at some of the major hospitals in Malawi – e.g. Queen Elizabeth Hospital, Blantyre, Kamuzu Central Hospital, Lilongwe, Ekwendeni Hospital, in the north, as part of a SPR rotation would provide excellent continuity and consolidate linkages. The College of Medicine has links with a number of Royal Colleges which would facilitate this possibility of Scottish training being continued n Malawi under supervision from accredited trainers. The Royal College of Surgeons Edinburgh supports the Regional College of Surgeons of Central, Southern and Eastern Africa (COSCECA) through training places for Malawian surgeons. Royal College of Surgeons Glasgow support Post Graduate Training Initiative through the Malawi Millennium Project

5) Support from all Royal Colleges in Scotland to run courses for College of Medicine trainees

6) Support to send future trainers of trainers to Scotland for higher training in Surgery.

7) School of Pharmacy. At the invitation of the National AIDS Commission of Malawi (NAC) a proposal to develop a College of Pharmacy has been developed and accepted by the College of Medicine. Planning for the School is underway – key academic staff, and support with curriculum development is needed. Anticipated that initial intake of 10-15 students will take place January 2006

8) Equipment needs – shortages across the board from basics such as gloves and swabs to sutures, catheters, nasogastric tubes, chest drains, linen (reusable) drapes and theatre gowns.

9) **Masters or diploma qualification in Health Management.**
Community Health Department, Professor Cam Bowie.
At present a Masters in Public Health is very successfully run from Community Health Department using visiting lecturers from Liverpool and South Africa for some of the modular teaching. It is a three year part time course – cumulative number of students enrolled is 64. They come from a range of health disciplines
The Community Health Department recognize the need to establish a Masters qualification or at very least a diploma in Health Management.
Health service management and human resource development is a fundamental problem – junior doctors are taken into District management roles with no capacity or training. Staff requirements to run the course include staff with expertise in health finance, Human Resource Administration Management Health policy, procurement and supply chains. Staff do not need to be medically trained but to have significant management in health skills

Area 5. Support for Ministry of Health Planning Directorate

The Director of Planning, Mr Kalanje described in detail the various components within the Ministry of Health Programme of Work and identified that in all areas there were human resource crises, equipment crises and management crises. Working alongside DFID, support was very welcome.

Particular Support needs identified:

- Each District needs support in developing and costing work plans
- Planning Unit would value an experienced person in Health Economics to work in ministry.

Summary of work programme areas.
Human resources
Recruitment/ filling of vacancies, retention, in service training

Pharmaceutical and Medical Supplies
Procurement (pharmaceuticals and lab supplies), delivery, storage, stock management at District level of drugs and supplies

Essential Basic equipment
Procurement of equipment and related services, maintenance of equipment and related services, and sourcing of equipment

Infrastructure – Facilities Development
Upgrading of existing facilities, construction of new facilities, and maintenance of existing infrastructure. Provision of safety equipment and services

Essential Health Package Service Delivery
Service delivery support

Central Operations Policy and Systems Development
At training institutions through the Central Administration (Ministry of Health)

Area 6. Support for HIV/AIDS treatment and prevention in Malawi

Dr Heatherwick Ntaba, Minister of Health, identified the priority health service needs in relation to HIV/AIDS

1) Research: address qualitative as well as quantitative research gap with particular emphasis on the needs assessment and situational analysis of particular target groups – Commercial sex workers, teenage children, pregnant women, men (30-45 yr group) Base interventions on donor policies or external plans.
2) Behaviour Change – very few people in Malawi know their status – the numbers need to increased, therefore substantial support is needed for the IEC Health Information unit of MOH – developing radio / other mechanisms to share messages, inform and encourage and enable engagement with the health service.

3) Prevention of Mother to child Transmission (PMTCT) 10% of infection spread is mother to child. How can this vertical transmission be curbed – problems are significant and it seems that the PMTCT programmes are not working.
4) Support to carers and people living with AIDS – increasing the quality of living of both these groups is essential and constitute a significant part of the Malawian population. – Reducing Carer fatigue – being aware of the gender discrimination within the carer population. Ensuring that PLWA are aware of risks – opportunitisic infections are treated.
5) ART delivery scale up is in place – human resource capacity impinging on more rapid scale-up. Still concerns that children are receiving very little attention – yet children are the countries' future. Numerous research issues within ART delivery – particular concerns around resistance emergence and equitable access.
6) Orphans and vulnerable children (OVCs) – significant and constantly growing problem. How can appropriate care be delivered, social, economic, emotional, physical support and mentoring essential. Serious concerns about the level of abuse among OVCs.
7) Sexual ethics, culture ad faith issues. Malawi still has many traditional exploitative relationships, non consensual relationships are firing the epidemic, but are not being adequately addressed at village level where there is acceptance. Come cultural traditions exacerbate transmission – these need t be targeted. Faith organisations are at grass roots level and must lay a role in exposing these, in informing and in guiding people from unhealthy to healthy traditions. Commercial sex activity is common – this high risk group of women are pawns in the hands of a huge high risk group of men.
8) Partnerships – networking NGOs, Faith based organisations and civil society organisations (CBOs). The National AIDS Commission is channeling resources to local CBOs but there is a need for more strong and integrated partnership at local as well as national level s that there is geographical spread, equity of access, and so that replication of services is not taking place in some areas. Also there needs to be stricter monitoring and evaluation.

The Malawi National Scale up Programme for ART delivery
Finance for antiretroviral drugs comes from the Global Fund. Malawi has no PEPFAR[11] funding. Combination generic drugs are currently being used

- 59 hospitals selected to deliver ARV.
- 1st line ART drug regimen only. The drugs are free to patients.
- Malawi is making good progress in equity of access to ART between rural and urban, male and female, rich and poor.
- Eligibility for ART - Post test or WHO clinical stage 3 or CD4 count under 200 if count available. Lack of CD 4 count does not prohibit start of treatment.
- Those eligible for ART undergo two stage counseling (a) group counseling session, (b) an individual counseling session one week later
- The ART programme registering and reporting system is based on the model of the National TB programme, and Zonal level TB officers collect both TB and ART data.

[11] The President's Emergency Fund for AIDS Relief

- A patient master card provides clinic with details – this MasterCard is updated every three months onto clinic records for cohort analysis. Finger printing identification is used in a few areas initiated by Taiwanese Government support.

Staff have been trained using a two stage approach modeled on, though significantly less labour or cost intensive than, the Botswana ACHEP programme– 5.5 day classroom training plus 2 week on site attachment 744 staff trained (Drs, nurses, CO, and 194 staff completed attachment training.
155 staff from 62 private hospitals trained.

December 2002 – 1200 patients at 3 sites
December 2003 4000 9 sites
December 2004 13,183 at 24 sites
March 2005 17, 600 patients were on ART at 24 sites.

In the absence of easy or equitable access to CD4 count the majority of patients have been started on ART because of being in WHO Stage 111

Treatment options The majority of hospitals (24) using the recommended first line regimen Stavudine + Lamivudine + Nevirapine i.e. Triomune) 11 have used alternative first line regimes Zidovudine based or Efavirenz based purchased from their on funds, for managing patients with side effects.
Of patients who have ever started on ARV therapy 84% are still alive, 8% are dead and 8% are lost to follow-up. Of those alive and on ART 98% are ambulatory, 85% fit to work, 10% have one or more major side effect and 96%, based on pill counts, show 95% or more adherence to therapy.
Women on ART outnumber men
A total of 656 children have ever been started on therapy

Largest proportions of deaths occur in the firth three months of treatment. In some areas this has caused an unfortunate association between ART usage and death,

Malawi has agreed an **Equitable Scaling-up Policy**
The cornerstones of which are

a) free drugs
b) heavily subsidized drugs in the private sector
c) first come first served basis but
d) health promotion targeted at those with priority needs

The scaling up of the ART Programme and identified areas of work:

1) Urgent need for increased Human Resources in health sector
2) Ensure all capacity in all health facilities is being is properly used.
3) Simplify treatment schedules
4) Urgently address the issue of paediatrics solutions of ART
5) Continue with free ART access for all
6) Further develop monitoring system
7) Increase rollout while simultaneously encouraging prevention

Potential areas of Engagement between Scotland and Malawi in the field of HIV/AIDS

1) Additional Staff, supporting Global Fund funded Malawian supervisors, providing on site support traveling around Malawi to ART delivery centres

2) On-going cohort analysis to monitor adherence and identify potential problem areas before crises levels. Main burden of work in cohort analysis relates to collecting outcome indicators for side effects and pill counts, checking each master card every three months. Additional staff to support Malawian colleagues in collecting, and analysing data.

3) At present the estimated 10% of patients with side effects may reflect recording bias – need to explore this further as there is significant variation from facility to facility) Recording requires to be strengthened and monitored

4) Pill counting for adherence is varied – on site education needs to be given to each facility

Potential support for HIV/AIDS research :

- National ARV research agenda – stretched staffing levels means that little operational research is being carried out on what lies behind ART uptake, hindrances to PMTCT uptake, and resistance and drop-out, second level treatment options
- What is the best management of the "hanging tablets" (tablets left over after clinic and visit count)? What happens to pills when patient dies?
- What are the reasons for gender disparity in ART uptake?
- What are the most equitable and efficient ways to decentralize treatment and monitoring from hospital sites?
- What are the pathways to getting ART?

Other areas of HIV/AIDS support

1. Exchange visits - with Clinical Officers from HIV/AIDS TB programme coming for a brief (I month) term to Scotland to work with HIV and STI experts on best practice, and to share experiences and engage in under and post grad teaching of Scottish medical and nursing students

2.Training of trainers programme - to be commenced with a fact-finding work visit from Scottish HIV/AIDS/STI Trainers on site in Malawi to familiarize with situation.

These Trainers could then return to Scotland and provide in-depth training in Scottish units to those who plan to work in Malawi for longer periods, or to those who come for short expert teaching sessions.

3) Journal support and best practice notes – steady information stream cross continent ensuring that personnel are up to date with important steps in HIV/AIDS.

Area 7: Support for Health Education Unit Ministry of Health[12]

The Unit has responsibility to plan, coordinate, produce, distribute all Health Education materials for all areas of Health throughout Malawi for the Ministry of Health.
With the introduction of the Essential Health Package the unit is rethinking strategy. IEC (Information, Education and Communication) officers have been placed in every district. They will require skills development. The unit is particularly keen to launch more into radio, and video to meet a market. Radio/video equipment has been gifted some time ago but shortages of staff mean they cannot make best use of it.

Areas of work:
Reproductive Health education:
a) Supporting female condom distribution
b) Promoting male condom for dual protection (fertility control and infection prevention)– attempt to shift its singular association as an HIV/AIDS tool.
c) Emergency contraception - for sexual assault, young people, contraceptive failure.
d) STI information delivery – focus on partner notification, condom use, encouraging early access to treatment

Reduction of High Risk Cultural Practices through information giving
Working with Salvation Army to train community leaders using a training package manual (developed by the Ministry of Health and Salvation Army based on Salvation Army's experience) to modify
a) High risk post initiation practices
b) high risk cleansing rituals
c) post menstruation practices involving sex
d) fisi practices
The manual explores how to deliver alternative acceptable practices, making specific use of traditional medicine
Literature (and visual aids) has been developed and pre-tested.
Problem unit faces is funds to process, and produce materials in quantities they are required. Skilled staff who could train on production of materials in house would assist service delivery.

Health Education Unit is coordinating the national communication for scale up of all HIV/AIDS related materials including scale up of ART
The unit has produced an interactive booklet with focus on **adherence,** offering appropriate explanations and reasons based in daily life context for safe and positive living

Prevention of Mother To Child Transmission draft booklet on birthing complications has been prepared and is awaiting production. "Do you have a safe plan for your baby's safe arrival and good health".

[12] This information came from coordinators Jonathon Nkomah and Beth Deutch (08841016 bethdeutch@africa-online.net)

Voluntary Counselling and Testing draft booklet developed "What to expect from VCT" plus 6 posters about providing VCT
One for counselors, young people, those showing signs of infection,
Also produced a booklet for couples modeled on local couple who had come through VCT on **Information on discordance**
As part of the Ministry of Health equity Policy for **key vulnerable groups** HEU have a remit to make appropriate messages available in appropriate media.
Drama – 5 regional training have been held for all district drama groups on message delivery and follow-up.

Greatest barriers the unit faces –

a) Printing – have no printing machine at HEU – cannot contract out without order through MofH procurement unit. (some materials have been waiting six months – some 9 months) HEU is a production unit without the facility to produce.
b) Limited staff capacity
Director – who is also the HIV/AIDS coordinator and communications officer for the ministry.
4 senior staff with responsibility for all RHU materials, 4 weekly radio programmes produced alongside Malawian broadcasting Corporation, TB information, supporting IMCH messages, cholera,
The production unit needs to be realistically staffed to meet demands.
Artists and video technical support person have died. Publication sector did produce quarterly newsletter and monthly letters to support all the IEC district officers. Now there is no support to IEC officers on field.
c) The unit has significant radio equipment (donated last year but not yet installed as no person or money available to do so. Also need training in use of this high-tech equipment, and staff capacity to run programmes.
d) Extensive work load is frequently interrupted by requests form Ministries to respond to variety of national commemoration days
e) development of material in languages other than English and Chichewa – there is a need for available information in Chitumbuka and Chiyao.

Identified needs

- External consultancy to evaluate unit's inputs and outputs and a realistic work plan developed.
- Support to strengthen design, photography of materials.
- Basic production skills related to video, print and radio

Would value support from Scottish colleagues – especially a VSO input, on

- Material Design and production work,
- Radio support, - have radio equipment but not staff trained to run this
- Photographic support –
- particularly how to read and manage new software
- A person with skills in production, design, photography etc who could commit for two years to work alongside local staff providing ongoing technical assistance and training was requested. VSO

Area 8. Medical Maintenance Support - Physical Assets Management Unit (PAM Unit) [13]

The EU and GTZ fund a technical support project to the Ministry of Health and have established a Physical Assets Management PAM Unit whose remit is to develop standard equipment lists, train hospital maintenance teams to support standard equipment and to improve skills of MOH in establishing maintenance contracts particularly for specialized equipment. The unit has a Regional Referral Maintenance Unit which provides support to each district.

District maintenance programme.
Only 5 of the 27 districts have District officers whose role is to supervise building, electrical, plumbing, carpentry, mechanical activity and skills development in health facilities.
Needs identified:

- Senior Engineer based in Regional Unit
- Medical equipment Biomedical Engineer.
- VSO District officers with electrical, engineering, mechanical skill base.

John Osborne from Scotland has previously spent time working with PAM as a Biomedical Engineer.

Area 9. Health Management Information Service (HMIS) within Ministry of Health Director Chris Moyo.

Though one of the Millennium Goals, the strengthening of the HMIS has received little attention. The weak HMIS is contributing to poor logistical control over service provision, poor projections, and inequitable services. Japanese Aid (JICA) has just placed a Monitoring and Evaluation (M&E) Technical Assistant in the HMIS unit and the SWAp is supporting the recruitment of a further Technical Assistant on M & E for the unit. Technical Assistance, coherent with services and plans already developed on Monitoring and Evaluation would be welcomed within the HMIS unit, along side IT input to facilitate open email communication for support. .

[13] Information from Dieter Horneber 01 788340/ 08 828491

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