Scottish Government Health Partnership Programme

Malawi Scoping Report

April 2025

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List of acronyms

AMR	Antimicrobial resistance
ART	Anti-Retroviral Treatment
CHWs	Community Health Workers
CPD	Continuing Professional Development
CSO	Civil Society Organisation
CwPAMS	Commonwealth Partnerships for Antimicrobial Stewardship Scheme
DHIS	District Health Information System
DHO	District Health Office
DHMT	District Health Management Team
FCDO	Foreign and Commonwealth Development Office
FGD	Focus Group Discussions
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GESI	Gender Equity and Social Inclusion
GHP	Global Health Partnerships
GHWP	Global Health Workforce Programme
HCAC	Health Centre Advisory Committees
HCMC	Health Centre Management Committees
HIS	Health Information System
HMIS	Health Management Information System
HP	Health Partnership
HRH	Human Resources for Health
HRIS	Human Resource Information Systems
HS	Health System
HSA	Health Surveillance Assistants
HSS	Health System Strengthening
HSSP	Health Sector Strategic Plan
HWF	Health Workforce
IDI	In-Depth Interview
IHRIS	Integrated Human Resources Information System
IMCI	Integrated Management of Childhood Illness
INGO	International Non-Government Organisation
IMR	Infant Mortality Rate
IOM	International Organization for Migration
IPC	Infection Prevention Control
KIIs	Key Informant Interviews
KuHES	Kamuzu University of Health Sciences
LE	Life Expectancy
MACHA	Malawi Council for the Handicapped
MaSP	Malawi Scotland Partnership
MEHN	Malawi Equity Health Network
MMR	Maternal Mortality Rate

MoH	Ministry of Health
NHSP	National Health Strategic Plan
NCDs	Non-communicable diseases
NGO	Non-governmental organisation
NHS	National Health Service
NMR	Neonatal Mortality Rate
NOM	National Oversight Mechanism
OOP	Out of Pocket (Payments)
PHC	Primary Health Care
PSC	Programme Steering Committee
QI	Quality Improvement
SG	Scottish Government
SGHPP	Scottish Government Health Partnership Programme
SRH	Sexual and reproductive health
TB	Tuberculosis
THET	Tropical Health and Education Trust
ToR	Terms of Reference
UHC	Universal health coverage
UN	United Nations
U5MR	Under 5 Mortality Rate
WHO	World Health Organisation

Introduction to Scottish Government HP programme

Programme aim

The aim of the Scottish Government Health Partnership Programme (SGHPP)Programme is to support international Health Partnerships between health institutions in Malawi, Rwanda, Zambia and those in Scotland to develop the capacity of the health workforce and the health systems in which they work.

Programme outcome

The programme's long-term outcome is "Strengthened health systems mean that partner countries are supported in progress towards attainment of specified national health plan priorities, supporting improved health worker and health service performance for all, including marginalised populations in partner countries."

Purpose and objectives of the scoping assessment in Malawi

Aim and objectives

The scoping assessment in Malawi aimed to explore health systems (HS) and health workforce (HWF) issues, challenges and priorities, and identify and validate the HWF priorities that Health Partnerships (HPs) could potentially address. In Malawi, in-country scoping activities were undertaken from 14th-18th April 2025. Discussions explored how to promote innovative HPs aligned with, and supportive of national priorities and capacities, could contribute towards health systems strengthening (HSS) and universal health coverage (UHC). In accordance with the Scottish Government's (SG) International Development principles (The Scottish Government, 2021), the scoping assessment took a gender equity and social inclusion (GESI), anti-racist and feminist approach, exploring intersectionality inequalities, power dynamics and community participation, with a view to localisation and sustainability.

Global Health Partnerships (GHP – formally THET) consulted with identified and selected stakeholders in Malawi prior to the country visit to:

- Provide information and create awareness and support for the programme with individual stakeholders.
- Commence the stakeholder analysis to identify and map key actors, their interests, and power dynamics and the contexts within which they operate.
- Share information on the scoping assessment, outlining the purpose, objectives and expected outcomes.
- Explore HWF issues, challenges, and priorities and how the programme can contribute to these.
- Explore and identify appropriate and inclusive mechanisms and individuals to oversee the planning, review and monitoring of programme interventions.
- Gather information on any current or potential HS/HWF programmes and initiatives (including those funded by SG) and funding sources in Malawi.

While in-country, GHP built on preparatory activities, including information sharing and promoting broad stakeholder participation in co-creation and

decision making on programme design and prioritisation. The activities undertaken in country involved the following:

- Sharing information and building awareness on the SGHPP goals, the HP approach, and expected outcomes to foster broad support and collaboration.
- Validating HS/HWF priorities identified through stakeholder consultations held during the proposal development process and the desk review.
- Assessing the potential of the health partnership approach to address identified HS/HWF priorities.
- Understanding key GESI considerations and power imbalances from the perspectives of girls, women and marginalised groups to inform HP strategies and interventions that could level power imbalances and elevate vulnerable voices and their needs.
- Refine stakeholder analysis to map key actors, power dynamics, and governance mechanisms to inform and enhance programme coordination and oversight.
- Exploring contextually appropriate participatory approaches, and learning from past participatory efforts of what worked, what failed, and why.
- Promote the development of HPs in Malawi that are in line with national goals, and which reflect local context, ownership, and sustainability, drawing on the principles of the NHS Scotland Global Citizenship Framework (The Scottish Government, 2024).
- Identifying key stakeholders to be engaged in the programme generally, and more specifically in the programme governance mechanisms, including the National Oversight Mechanism (NOM) and Programme Steering Committee (PSC).

Stakeholder consultations

A multi-disciplinary, multi-sectoral stakeholder engagement approach was adopted to enable a rich, comprehensive examination and analysis of HWF/HSS priorities, and the identification of potential SGHPP interventions. Inclusive, multistakeholder engagement also aimed to foster national ownership, trust, and collaboration, and drawing on diverse lived experiences, knowledge and expertise helped shape the assessment outcomes, while promoting country ownership and commitment to the design and implementation of the programme.

GHP consulted with a range of national and sub-national stakeholders, identified and arranged in consultation with the Ministry of Health (MoH) and the GHP In-Country Representative, Dieckens Binali. This included stakeholders and institutions who have been or continue to be involved in Scottish Government (SG) funded partnerships programmes, as well as those who were new to the SG partnership approach.

Stakeholders were provided with information on GHP, the SGHPP model, and the purpose of the scoping assessment (Terms of Reference - Annex 2). The semi-structured topic guides (Annex 3) were used to identify national HS/HWF issues and challenges, to elicit stakeholders' views and perspective on HS/HWF priorities, and to gather information on other HWF/HSS programmes and initiatives in the country. The tools enabled the exploration of GESI and other equity considerations, assessment of localisation mechanisms and related policies and plans, and an examination of power relations and imbalances. In the identification of key HWF priorities, stakeholders were reminded to consider the appropriateness and

feasibility of the SGHPP model to address the priorities identified, as well as the funding envelope available for a typical SGHPP programme.

The aim of these consultations was to produce findings that would inform the design and delivery of equitable HPs that seek to level power imbalances and elevate vulnerable voices and their needs, that empower women and girls, that place communities at the centre of the co-creation process and promote mechanisms that empower and support local leaders and communities. The priorities identified, outlined below, were reviewed with a HP lens and further assessed against the relevance of the HP model to address the issues highlighted.

GHP met with two established SG-funded projects in Malawi and one HP that is waiting to start working together, following contacts provided by SG. GHP's knowledge of the work of these stakeholders, in addition to the lessons learned from previous and existing GHP-supported HPs in Malawi under the Commonwealth Partnerships for Antimicrobial Stewardship Scheme (CwPAMS) and the Global Health Workforce Programme (GHWP) have informed the overall findings. GHP will continue to reach out to these and other SG-funded HPs on the priorities identified.

Partners	Initiative	Focus areas	Period
NHS Tayside & MoH	NHS Tayside Emergency Medicine	Emergency care QI, national trauma network	2010–present
Scottish psychiatrists & MoH	SMMHEP (Mental Health)	Training, governance, QI at Zomba Hospital	2006–present
Scottish Government & MoH	Global Goals Partnership	Health system strengthening, ICT, training	2018–present
KUHeS & MoH (*)	KUHeS Dental/Public Health	Dental school startup, quality oversight	2019–present
Serves as a link between Malawi & Scottish partners (*)	Malawi Scotland Partnership (MaSP)	Health, education, civic governance/human rights, and Sustainable economic development	2004-present

(*): visited institutions during scoping assessment

Approach and methodology

Desk review

GHP undertook a rapid desk review of country specific documents such as health sector and HWF policies, strategies and plans, available human resource information systems (HRIS) and/or health management information system (HMIS) data, and other relevant government, donor and/or development partner reports/analyses to construct an overview of HWF issues, challenges and priorities. Brief analyses of the Malawi HS and the HWF situation are provided below.

Data collection

Qualitative data collection tools such as semi structured topic and interview guides for key informant interviews (KIIs), in-depth interviews (IDIs) and focus group discussions (FGDs) were designed informed by the desk review, including key health sector and HWF policies and plans (e.g. Health Sector Strategic Plan III

(HSSP III) (2023-2030)), pre-award stakeholder consultations, the GHP Principles of Partnership and GESI tools, SG guidance and frameworks, and regional and global HWF guidance, among others. GHP conducted 12 KIIs and facilitated three FGDs with a range of stakeholders at national and sub-national levels (See list of stakeholders met - Annex 4).

In Malawi, the FGDs were undertaken with Health Centre Management Committee members and young women in a rural community setting. An in-depth interview was facilitated with the District Health Management Team (DHMT) in a peri-urban location, to ensure local-level perspectives informed programme design. Table 1 below provides further details of the numbers of interviews and FGDs and participants.

Table 1. Data collection

Method	Number		Type
	M	F	
Key Informant Interviews x12	6	6	Local CSOs, INGOs, current Scottish Partners, Government Officials, Education Institution, Health workers
In-depth interview	3	6	District Health Management Team
Focus Group Discussion 1	7	5	Members of the Health Centre Management
Focus Group Discussion 2	0	10	Young women involved on a voluntary basis in community-based health project

Health systems and health workforce analyses

Malawi's health system

Country health profile

Malawi is a landlocked country with an estimated population of 21.1 million in 2023, projected to reach 37.4 million by 2050. The annual Population Growth Rate is 2.6%, with an Age Distribution as follows: 0–14 years, 21.6%; 15–64 years, 74.9%; 65+ years, 3.5%. Life expectancy increased from 55.6 to 64.7 years between 2010 and 2020, with a reduced maternal mortality rate (MMR), under-five mortality rate (U5MR), infant mortality rate (IMR), and neonatal mortality rate (NMR). However, non-communicable disease and injury mortality has been on the increase over the last decade, now accounting for over 40% of mortality in Malawi (World Bank-2022). This changing disease burden requires a broader skills mix and innovative and integrated health care delivery models.

Health service provision levels

Healthcare services are provided at three levels:

1. Primary health care and community-based care is delivered through community-based outreach, urban health centres, and primary health centres such as rural or community clinics. At this level, the primary cadre is Health Surveillance Assistants (HSAs), who are responsible for treating

ailments such as diarrhoeal diseases and providing communities with knowledge, skills, and tools. They receive 12 weeks of training, but the Malawi Medical Council is working towards formally regulating and training HSAs.

2. Health service provision at the secondary Level is organised into 28 district levels. It is decentralised from the national level to District Councils through District Health Offices (DHOs). The district is responsible for the recruitment of selected lower-level staff, with higher-level health workers managed centrally. At the district level, there is a wide range of health services provided through a mix of health worker cadres.
3. The tertiary level includes specialised services provided by speciality doctors and specialist nurses at central hospitals. The Ministry of Health is responsible for the four central hospitals in Malawi.

As per Table 2 below, most of the health services are provided by the government which are generally free. However, most government hospitals lack supplies like essential medicine and equipment, which forces people to visit private facilities or pharmacies to procure medicine.

Table 2. Distribution of Health Services by type and ownership (HSSP III)

Facility Type	Facility Owner					Total
	Govt	Private for profit	CHAM	Private non-profit	NGO	
Clinic	20	233	7	46	46	**352**
Dispensary	49	2	2	8	1	**62**
Health Centre	364	4	109	7	5	**489**
Health Post	89		5		1	**95**
Hospital	49	9	41	1		**100**
Grand Total	**571**	**248**	**164**	**62**	**53**	**1098**

Disease burden in Malawi (2025)

The Integrated Management of Childhood Illnesses (IMCI) has been implemented in health facilities to improve care for newborns and children. Survey data show progress in treatment coverage, with 57% of children with diarrhoea receiving oral rehydration and continued feeding (2015–2016), and 55.6% of children with acute respiratory infections receiving antibiotics (2019–2020) (HSSP III). Immunization coverage also improved, with fully vaccinated children increasing from 81% in 2017 to 89% in 2019 during HSSP II. Between 2017 and 2020, the Expanded Programme on Immunization introduced new vaccines including IPV, HPV, and the malaria vaccine in 11 pilot districts, and transitioned from the Measles Conjugate Vaccine to the Measles Rubella Vaccine (HSSP III).

Adolescents make up about 24% of Malawi's population and face significant sexual and reproductive health challenges, including high rates of unintended pregnancies, sexually transmitted infections, and HIV. Notably, 30.8% of adolescent girls begin childbearing early, contributing to maternal complications that account for 20% of maternal deaths among girls aged 15–19 (HSSP III). Additionally, 14% of pregnancies in this age group end in abortion, reflecting inadequate access to youth-friendly reproductive health services. These issues also affect newborns, who face increased risks of illness and death when born to very young mothers. These

trends highlight the urgent need for comprehensive, adolescent-focused Sexual and Reproductive Health and Rights interventions in Malawi.

Malawi continues to face a significant disease burden from both communicable and non-communicable diseases. The following summarises the current situation:

Communicable diseases

Communicable diseases continue to pose significant public health challenges, with several conditions demanding sustained attention and response. HIV/AIDS remains a major concern, though expanded testing and treatment programmes have helped improve detection and care. Tuberculosis (TB) is still prevalent, but advancements in diagnostic capacity have enhanced the ability to identify and manage cases more effectively.

Malaria stands out as a leading cause of illness and death, particularly among children, underscoring the need for ongoing prevention and treatment efforts. Cholera experienced its deadliest outbreak between 2022 and 2023, resulting in over 59,000 reported cases and 1,770 deaths, highlighting vulnerabilities in water and sanitation systems.

Polio has seen a troubling resurgence since 2022, with both wild and vaccine-derived cases re-emerging in several regions. Meanwhile, the COVID-19 pandemic, though no longer at its peak, continues to be managed through robust vaccination campaigns and surveillance systems.

Non-communicable diseases

Non-communicable diseases (NCDs) have emerged as a significant public health concern in Malawi, accounting for approximately 40% of all deaths nationwide. Among the most common conditions are cardiovascular diseases, diabetes, chronic respiratory illnesses, and various forms of cancer.

The growing burden of these diseases is closely linked to rapid urbanisation and lifestyle changes, including changes in diet, physical activity, and exposure to environmental risks. Compounding the issue is limited access to early diagnosis and effective treatment, which often results in late-stage presentation and poorer health outcomes. Addressing NCDs requires a comprehensive approach that includes prevention, early detection, and improved access to care.

Table 3. Key health Indicators in Malawi (2025)

Life Expectancy	~65 years, Infant Mortality Rate: ~35 deaths per 1,000 live births
Under-5 Mortality Rate	~50 deaths per 1,000 live births
Maternal Mortality Ratio	~349 deaths per 100,000 live births
Fertility Rate	~4.2 children per woman
Contraceptive Prevalence (modern methods)	~60% among married women
Skilled Birth Attendance	~90% of births
Diabetes Prevalence	7.66% of adults
Daily Smoking (Adults)	9.37% overall; 15.48% among men
Alcohol Consumption	3.22 litres per capita
Stunting (under-5 children)	~33%
Wasting (under-5 children)	~3%

Micronutrient Deficiencies	High prevalence, especially iron and vitamin A among women and children

Source: (WHO) – Global Health Observatory (2025)

Healthcare financing and coverage

In Malawi, international donors contributed approximately 55% of the total health expenditure in 2018/19, with government expenditure at 24% and individual out-of-pocket (OOP) expenditure at 12%, respectively (MoH, 2022). The services are delivered through a network of public, Non-Governmental Organisations (NGOs), Private-not-for-Profit, and Private-for-Profit providers.

Health workforce situation analysis

Achievements

During the HSSP II implementation period (2017-2022), Malawi made notable progress in strengthening human resources for health (HRH) systems. Key achievements included the rollout of a national performance management system, decentralisation of payroll to district councils, and the establishment of strategic leadership roles at district level. The MoH led the development of the HRH Strategic Plan and enhanced institutional capacity through functional reviews and increased support to the Health Service Commission.

Significant improvements were also made in workforce recruitment, retention, and training. Over 5,600 health workers were recruited in response to COVID-19, and housing, allowances, and professional development initiatives were introduced to improve retention, particularly in rural areas. Pre-service training was expanded through curriculum revisions and new degree programmes, while in-service training upgraded hundreds of health professionals to specialist roles, contributing to a reduction in vacancy rates and improved service delivery capacity

The available data on HWF stock and density (as at 2022) are presented in Table 4.

Table 4. Selected Health Worker Stock, Malawi, as at 2022

Cadre	Number	Density (per 10,000 pop)
Medical Doctors	1115	0.54
Nursing Personnel	9819	4.77
Midwifery Personnel	616	0.30
Dentists	101	0.05
Pharmacists	123	0.06
Total	**11,774**	**5.72**

Source: National Health Account Portal (Accessed 11.06.2025)

Health Workforce challenges

However, Malawi's health sector continues to face persistent HWF challenges, including high vacancy rates and limited absorption capacity. These issues are driven by inadequate alignment among inter-ministerial and intersectoral stakeholders in financing remuneration and benefits. Training institutions produce insufficient numbers of health workers, and there is a lack of coordination with

government bodies to align pre-service training outputs with national health sector targets. Additionally, Human Resources for Health policy development and planning remain weak, resulting in ineffective recruitment, deployment, and distribution of health workers. Additionally, Human Resources for Health (HRH) policy development and planning remain weak, resulting in ineffective recruitment, deployment, and distribution of health workers.

Further constraints include weak staff development and performance management systems. Health workers who complete upgrading programmes often face barriers to career progression, while limited incentives and poor working conditions contribute to high attrition, particularly in rural and hard-to-reach areas. The sector also struggles to retain health workers due to competition from private and international employers. Moreover, the limited adoption of digital innovations and underutilization of existing HR management platforms hinder efforts to improve efficiency and transparency in HWF management

Health Workforce priorities

Malawi's *National Health Policy (2018-2030)* and *Health Sector Strategic Plan III (2023-2030)* outline strategies to address these HWF challenges, including improving the quality of education and training to better meet HWF demands, population health needs and the availability and distribution of competent and motivated health workers.

Pillar 4 of the HSSP III covers the health workforce (see Annex 5). The objective of this pillar is "*to improve the availability of competent and motivated human resources for health for quality health service delivery that is effective, efficient and equitable*." The six strategies, and three reform areas outlined in Table 5 below point to the HWF priorities – related to recruitment and deployment, production and training, health workforce management (including performance management, remuneration and working conditions) and data for decision making.

Table 5. HWF Strategies and Reforms – HSSP III (2023)

Strategies	Reforms
4.1 Enhance recruitment, selection, deployment, and equitable distribution of human resources for health	Reform 4: Performance for Results Reform 5: Health Workforce Optimization Reform 6: Integration of In-service Training
4.2 Optimize production at training institutions and strengthen coordination between the institutions and health sector needs	
4.3 Improve staff development strategies, policies, procedures, and practices for human resources for health	
4.4 Strengthen and enforce performance management policies, procedures, and practices	
4.5 Institute and provide for competitive remuneration, benefits, and working conditions for human resources for health	
4.6 Generate reliable data and build capacity for evidence-based health workforce decision-making through digital innovations and technological platforms for human resource management	

Source: Health Sector Strategic Plan III (2023-2030) (pp. 55-57)

Health Workforce Reforms

The health workforce reforms provide insights into the focus of the Ministry of Health in Malawi. They include:

- **Reform 4: performance for results** aims to implement a robust performance management system that links staff incentives, promotions, and discipline to strategic and operational plan execution across all health system levels.
- **Reform 5: health workforce optimization** focuses on redesigning health worker cadres and training systems to align with evolving disease patterns and service delivery needs.
- **Reform 6: Integration of in-service training** will establish a coordinated in-service training and Continuous Professional Development (CPD) system to improve workforce competencies and service quality efficiently

Overview of gender policies & issues

Purpose of the Policy

The purpose of the National Gender Policy (2015) is to strengthen gender mainstreaming and women empowerment at all levels to facilitate attainment of gender equality and equity in Malawi. The policy has been instrumental in adopting robust measures like mandating **40–60% gender balance** in public service hiring, mandatory gender reporting by Ministries & Agencies, and Sexual Harassment Policies. Five laws have been amended, including the **Penal Code** (passed in 2022, assented in 2023), to strengthen protections for women and girls, redefine child age, and criminalise sexual offences. **UN Women (2022–2023)** reports increasing political representation: women now hold ~**23% of parliamentary seats**, and Malawi elected its **first female Speaker** alongside leadership roles in anti-corruption and legislative institutions among others (UN Women Transparency Portal, 2022).

The National Gender Policy tackles several challenges and emerging issues from the implementation of the 2000-2005 National Gender Policy such as: persistent unequal power relations between men and women, boys and girls due to strong patriarchal attitudes; increasing cases of gender-based violence; high HIV and AIDS infection rates especially among women and girls; limited male involvement in reproductive health, HIV and AIDS programmes; continued high dropout rates for girls from schools; high poverty levels particularly amongst women; limited participation and representation of women in decision-making processes at all levels; inadequate enforcement of laws; and huge disparities in access and control resources by most women.

Consultations with MoH representatives during the scoping assessment highlighted that an updated policy is being developed which will replace the 2015 policy, building on the previous gains of reducing gender inequality and enhancing meaningful participation with the following key outcomes:

- Reduce Gender Based Violence (GBV) and harmful practices including child marriages.
- Safeguard women rights and participation.

Objectives of the new policy will include:

- Improve gender equality and social inclusion so that girls can participate meaningfully in development.
- Reduce sexual and gender-based violence and strengthen mechanisms for reporting violence.
- Improve access and utilisation of Sexual Reproductive Health Rights (SRHR) services.

Revised policy statements will focus on:

- Women and girls' SRHR are improved through community mobilisation campaign, strengthening the existing community structures-mother groups etc, advocate for male engagement.
- HIV-Women and girls' exposure to HIV is reduced, promote community leaders' involvement, promote public awareness, advocate for male involvement on HIV/AIDS programming.

Findings

The scoping process focused on collaboratively identifying areas where HPs could meaningfully contribute—particularly in health systems improvements and health workforce development, while considering GESI, disparities and inequities in access to care in rural and remote areas, and the potential to enhance localisation and sustainability. All efforts were guided by principles of inclusion, ethics, and alignment with Malawi's national systems and context.

Stakeholder analysis

As engagement is shaped by which stakeholders are identified and invited to participate, as part of the scoping assessment, GHP undertook a stakeholder mapping and analysis in Malawi. The aim of this exercise was to identify a broad spectrum of national level stakeholders i.e. institutions, organisations and individuals within the health system and operating in the HWF space in Malawi who were familiar with the national health system and HWF issues, challenges and priorities, and have a role and interest in influencing health systems and HWF policy and development.

Effective stakeholder analysis requires going beyond visible, high-profile actors to uncover hidden relationships and include less prominent but more informed stakeholders about the contextual needs. This deeper, more inclusive approach broadens the analysis from national institutions to sub-national levels, from formal ministries to informal structures, and from traditionally accepted actors to those who may be less conventional but still legitimate and impactful. Such comprehensive mapping reveals both barriers and unconventional opportunities for policy engagement. It is also important to understand that the relevance and influence of stakeholders will vary by political context, sector characteristics, and stages of policymaking and implementation, underscoring the need for flexible, context-sensitive analysis to inform more effective and inclusive stakeholder engagement strategies (Moncrieffe and Luttrell, 2005).

GHP was conscious that identifying stakeholders and building relationships in Malawi would be continuous process, that individual stakeholders engaged during the scoping assessment might change over time and that important relationships

may only emerge as partnerships are formed and the programme progresses, and as specific priorities and objectives become clearer (Moncrieffe and Luttrell, 2005).

In Malawi, GHP consulted officials from various departments in the MoH, including the Principal Secretary, Directorate of Nursing and Midwifery, Policy and Planning and Human Resources Development. GHP met with the Child Welfare and Community Development department (within the Ministry of Gender) to understand GESI issues. Representatives from the World Health Organization (WHO), Foreign, Commonwealth and Development Office (FCDO) and UNICEF were also consulted. Furthermore, GHP met with health education and training institutions including Kamuzu University of Health Sciences. Engaging a wide range of stakeholders in Malawi's health sector during the GHP scoping assessment was essential for ensuring relevance, inclusivity, and impact. Key benefits include:

- Policy alignment and ownership through engagement with MoH leaders. The Ministry's endorsement adds legitimacy and increases the likelihood that findings will be acted upon.
- Fostering GESI by consulting the Ministry of Gender, Child Welfare and Community Development thereby ensuring that the assessment acknowledged vulnerabilities and inequities in access to health services and training opportunities, especially for women, people with disabilities, and marginalised groups.
- Engaging FCDO, WHO and UNICEF ensured global and regional perspectives, as well as technical expertise and funding alignment opportunities. They contributed insights on international best practices, ongoing health initiatives, and development partner coordination, ensuring the assessment aligns with existing donor-supported programmes.
- Engaging training institutions like Kamuzu University of Health Sciences was important for understanding the capacity, curricula, and challenges in training the future health workforce.

GHP consulted international NGOs with a strong interest in health workforce development including Village Reach, AMREF Health Africa, and Last Mile Health. Local civil society organisations like Malawi Equity Health Network (MEHN), a network of over 400 local organisations, were also consulted.

GHP furthermore visited a primary level health facility called Khombeza Health Centre where an FGD was conducted with the Health Center Management Committee. An in-depth interview was done with the District Health Management Team (DHMT) of a secondary level facility called Salima District Hospital. GHP went further to conduct FGDs with communities and service users (mother groups) to deepen their understanding of health workforce challenges at a lower level with a participatory approach to programming lenses. This broad consultation strengthened the assessment's context-specific recommendations and laid the foundation for sustainable implementation and impact. See Annex 6 for the Stakeholder Analysis Matrix.

GESI analysis

Different personal and social factors, such as gender, disability, age, race, ethnicity, religion, socioeconomic status and migration status, have an impact on people's

access to health services, health education, and health outcomes (UN Women, 2022). Individuals and groups can experience several of these factors at the same time. Intersectionality explains that inequalities are not a result of one distinct factor but instead, intersections of multiple social identities, structures, and power dynamics (International Organization for Migration (IOM), 2024). These factors can affect power dynamics between different groups of people, resulting in inequalities in decision-making as well as health services and health outcomes.

Overview of barriers & the impact of these on health aspects

Below provides an overview of the findings from the FGDs held with female community members, health workers, UN agency, as well as stakeholder meetings with local networks and NGOs who are focused on understanding and supporting marginalised groups.

Barriers to GESI have been explored during the scoping assessment using GHP's GESI Analysis Tool (Annex 7) in relation to: access to resources/services; beliefs and perceptions; roles and responsibilities; and institutions, laws and policies. The barriers have also been analysed in relation to their impact on access to health services, utilisation of services, health seeking behaviour, quality of care, and health outcomes. Power dynamics within the health system and different groups of people have been explored using existing frameworks – looking at what holds the power, what type of power, and what level the power dynamics are at play (e.g., household, local) (Oxfam, 2021; IOM, 2024).

Access to resources and health services

For people with disabilities, there is physical inaccessibility of facilities, lack of disability-sensitive design and services, and lack of trained health personnel who can provide sign language. For example, informants explained that people might have access to a wheelchair but there is often no ramp for wheelchairs or facilities that can accommodate wheelchairs. Patients requiring sign language might be reliant on family to help translate, which compromises patients' privacy and quality of care. These challenges are exacerbated for people with disabilities living in remote communities. **Rural communities** encounter long distances to reach health centres (including higher costs) and there is a lack of ambulances that serve rural communities, affecting timeliness of care. One FGD noted the challenges for women in rural communities who often must give birth in difficult conditions, for example only using the light of a mobile phone.

People with certain health status do not have the same access to health services. For example, antiretroviral therapy (ART) services are offered infrequently, and if missed, patients must wait until the next scheduled date to receive care. There is a lack of mental health support, especially for survivors of abuse. Patients with certain health conditions also experience negative treatment from health workers, for example, one FGD noted that health workers can shout at patients. Poor treatment by health workers towards women creates another barrier for women in accessing health services, with women noting that they are scared to be pregnant due to the poor quality of care they have received. Informants noted not feeling willing to seek care due to negative experiences with health services and the ability to accommodate patients' needs. **Migrant communities** experience reduced access to land and services, especially for women.

Beliefs and perceptions

Cultural beliefs (e.g. gender roles, traditional medicine) perpetuate the exclusion of certain groups and discourage appropriate health-seeking behaviour. Certain traditions and cultural practices do not allow hospital access or health education and frequently traditional medicine is sought as the first choice. People with disabilities experience exclusion and are "usually shunned away", as one group of respondents noted. **Women and girls with disabilities** experience heightened invisibility, risk of abuse, and exclusion from services, both in the community and in health systems that do not accommodate their needs. Adolescent girls experience discrimination based on gender and age; informants noted that early marriage continues to be a cultural tradition which can impact adolescent girls' access to health education and services. Migrant communities experience increased vulnerability due to intersecting identities. Negative bias and perceptions by health workers towards women and girls, in particular, can result in denial of care (e.g. especially in family planning or adolescent health). Negative attitudes from providers discourage women and youth from returning to health facilities and therefore may not receive timely health services.

Roles and responsibilities

Gender norms expectations were the main barrier highlighted by all informants. Gender **expectations limit individual agency for both women (as caregivers) and men (norms around masculinity)** in Malawi. Women often delay seeking healthcare because they prioritise caregiving roles, with informants noting that women will prioritise household responsibilities and their family before focusing on their own health. Men tend to go to the health facilities much later than women, which may result in delayed care and poor health outcomes. However, as one informant noted that these expectations are not just from men but also women's own attitudes and expectations as well. **People with disabilities** are often excluded from formal and informal responsibilities due to assumptions about their capacity, particularly for women with disabilities who are striving for leadership roles.

Institutions, laws and policies

Malawi has made progress with updating the gender policy, but informants emphasised that more work is needed to socialise it amongst health professionals. **People with disabilities** face both physical and attitudinal barriers to services; policies often neglect them, especially those with intellectual or sensory impairments. Informants questioned whether people with disabilities were meaningfully involved in policy development – highlighting the lack of disability-friendly health facilities or consideration in planning – leading to inaccessible health services and policies that do not meet the needs of the community. There is limited focus on mental health, adolescent health, and respectful maternity care within institutional policies and health projects. Migrant communities and displaced people are often excluded from formal decision-making, with informants noting that they were not aware of any formal mechanisms for migrant communities to be represented in health governance or health policies, accentuating the exclusion of individuals.

Power analysis

Across the discussions, the dominant finding was that power imbalances - reinforced by gender, location, disability, and cultural expectations - are embedded in both informal norms and formal institutions. Intersectionality amplifies these

inequities, leaving some groups (e.g., girls with disabilities in rural areas) especially vulnerable and invisible in health services and health planning. Informants highlighted that men tend to hold the formal and informal decision-making power across all levels in Malawi (household, community, national).

At the household level, men are the dominant decision-makers in most households, particularly regarding financial and health-related decisions. Informants noted that irrespective of whether women are earning money, how the money is used is still decided by men. Women rely on informal support networks whereas men may have broader or more formal access to financial resources. This reflects significant informal power imbalance in household decision-making, affecting women's ability to access services independently.

At community-level, informants explained that women refuse to take leadership positions in structures where men are dominant, which is principally at the community-level where traditional leaders (chiefs) and health centre management committees hold the decision-making power, especially in rural communities. Male community members in one focus group reflected that their community group has representatives from both men and women, but other informants highlighted that there is a need to proactively support women to participate and lead within the community structures. Young people and people with disabilities have limited meaningful contribution and decisions are often made without inclusive consideration of these groups.

At district level, District Health Management Teams (DHMTs) control health planning and budgets. Service users, particularly women, are often excluded from national level decision-making spaces. Respondents noted that there is need to look at who is making the policies and laws and whether they are being made in a participatory manner with input from diverse perspectives.

At national and international level, donors, development partners (e.g., WHO, NGOs), and funding agencies significantly influence Malawi's health strategies and policy focus areas. Several informants noted that the scope and nature of health programmes are determined or influenced donors, which often do not reflect the needs of the community due to the donor's lack of local engagement or equitable approaches.

Possible GESI opportunities and approaches for Health Partnerships

Based on the barriers identified during the FGDs and stakeholder meetings, informants provided several opportunities for addressing GESI challenges through HP initiatives. These are outlined below and mapped against relevant Malawi National Gender Policy 2015 areas, as well as within the main scoping priorities in the next section.

1. **Promote inclusive community engagement and representation**

Across all discussions, there was a strong emphasis on intentional inclusion of women, people with disabilities, young people, and migrant communities, in discussions around health services and planning, leadership, and community structures.

Examples:

- Identify the community structures that provide entry points for engagement with different groups and individuals (E.g. District Councils). Engage these entry points at the start of the project and throughout. Deliberately support women to participate in existing decision-making forums – E.g., consider different times of day and locations to support inclusive engagement. (Objective 1, Priority Area 8)
- Include representation of marginalised voices in the project steering committee to ensure their perspectives are part of the project decision making. (Objective 3, Priority Area 2)
- Tailor communication to young people and people with disabilities to promote inclusive engagement in health awareness and services. E.g. young people often feel comfortable to express themselves in youth groups. Partnerships could facilitate opportunities for young people to participate in discussions about services that affect them, particularly related to mental health. Engage with local organisations already focusing on disabilities – E.g. Malawi Council for the Handicapped (MACOHA). (Objective 2, Priority Area 2 – but this mention is in relation to HIV/AIDS)
- Engage men and boys, as well as women and girls, in discussions around GESI barriers, as often men and boys are left out of these discussions. Use GESI and power analysis tools to prioritise specific gaps for the facility/community and co-tailor interventions as a partnership. (Objective 3, Priority Area 2)

2. **Work with traditional leaders to address norms that negatively impact accessibility to health care**

Traditional leaders have local influence in health services and are seen as powerful gatekeepers.

Examples:

- Find appropriate ways to engage with traditional leaders — working closely with them rather than in parallel or against them, as this is viewed by respondents as essential to shifting norms around gender, disability, and cultural beliefs – E.g., explore ways that traditional healers could help with referral practices. (Objective 1, Priority Area 2, Malawi National Gender Policy 2015)

3. **Train and support health workers to deliver respectful and inclusive health services**

Informants called for better training for health workers in respectful, gender-sensitive, and disability-inclusive care, and for improved staffing and working conditions (particularly focusing on wellbeing of health workers).

Examples:

- Provide capacity building to health workers on patient-centred care (including respective and responsive practices), disability competencies (e.g., sign language training), and gender and cultural norms awareness training – particularly in the delivery of health care. (Objective 3, Priority Area 2)

- Consider GESI improvements within the health facility environment and support better working conditions and wellbeing for health workers – E.g., safeguarding practices for health workers at work. (Objective 1, Priority Area 2)
- Engage wider local and national stakeholders in discussions around rooted cultural and gendered norms – E.g. facilitate opportunities where feasible to discuss GESI barriers together with decision-makers and service users. (Objective 1, Priority Area 2)

Limitations and continuing discussions

The findings of the scoping assessment do not necessarily represent the comprehensive picture due to contextual variation in relation to GESI at local, regional or national levels, as individuals' roles may vary depending on location, community, and wider changing socioeconomic factors. Due to the short length of time for the scoping assessment, the scope of the specific groups that were met with, and the frameworks used to explore the findings, there will undoubtably be limitations in the findings. Although steps were taken to consider power dynamics within the scoping process (e.g. who was in the room, who collected the data), dynamics will still be present and may have affected responses from stakeholders. The FGDs were facilitated in the local languages and notes taken and summarised to inform the analysis, potentially reducing the specificity of some findings. Through the SGHPP, GHP plans to continue to explore GESI barriers and opportunities with additional stakeholders, as well as explore aspects that require in-depth discussions – such as, the interests motivating actors and organisations for or against change.

Health workforce priorities

Pre-award consultations

In July 2024 GHP undertook a scoping assessment in Malawi and consulted with a wide range of stakeholders to identify HS/HWF priorities, the results of which informed the design of the DHSC-funded Global Health Workforce programme (GHWP). Priorities identified included the need to: strengthen the regulation of health professional education and practice; improve the quality of HWF education; strengthen HWF management; and improve evidence generation to inform policy.

Based on further consultations with Malawi stakeholders during this scoping assessment (April 2025), these HS/HWF priorities were refined and again validated with the MoH and other key stakeholders. Stakeholders identified initial HWF and HS performance areas where the SGHPP could contribute, including addressing inequalities in HWF development, the need for broader skills mix, stronger planning, and access to quality care. The SGHPP will align with Malawi's commitments and ambitions related to primary health care (PHC) strengthening, UHC and the attainment of SDGs.

The SGHPP will build on achievements from past and ongoing SG projects in Malawi, e.g. engaging district and community groups such as Health Centre Management Committees (HCMC) in Malawi to expand delivery of essential services as well as supporting cross-country initiatives (e.g. the Quality Improvement for Health Partnerships Programme), and communities of practice.

In-country consultations and priorities identified

1. HWF education and training

i. *Lack of context-specific training materials and inadequate capacity building for health workers:* Consultations with informants identified a significant gap in the availability of context-specific training materials and structured capacity-building initiatives for health workers in Malawi. Existing training programmes are not adequately tailored to local disease burdens, resource limitations, or local languages. As a result, health workers at various levels frequently lack the practical skills and contextual understanding required to provide effective, responsive care. Moreover, limited opportunities for ongoing professional development, mentorship, and in-service training further constrain the ability of health workers to adapt to emerging health challenges.

ii. *Fragmented Continuing Professional Development (CPD) and lack of standardised Quality Improvement (QI) models:* The scoping assessment revealed a lack of harmonisation in CPD programmes for health care workers in Malawi, with fragmented approaches across cadres, institutions, and sectors. CPD initiatives are often implemented in isolation, without alignment to national standards or workforce competencies. This has led to uneven skill development, duplication of efforts, and limited impact on health care quality. Additionally, the absence of standardised and widely adopted QI models across health facilities has further weakened the systematic application of QI practices. Many facilities lack clear guidance, tools, and capacity to implement, monitor, and sustain QI initiatives. Addressing these gaps is essential to promote a coordinated, competency-based CPD system and to institutionalise effective QI models that support continuous improvement of health services in Malawi.

iii. *Inadequate patient safety and QI mechanisms in primary and secondary health facilities:* The scoping assessment revealed that patient safety remains insufficiently addressed across many primary and secondary health care facilities in Malawi. Despite ongoing national efforts to improve health care quality, there is limited institutionalisation of systematic QI practices, particularly at lower levels of care. Facilities lack tools, training, and dedicated personnel required to identify safety risks, monitor quality indicators, and implement corrective actions. Furthermore, infection prevention and control (IPC) measures, medication safety protocols, and incident reporting systems are inconsistently applied or poorly enforced. Addressing these challenges will require structured QI approaches, capacity building, and stronger accountability mechanisms to enhance patient safety across all levels of the health system.

iv. *Limited capacity of health workers to deliver patient-centred care:* While the national health policy emphasises the importance of respectful, responsive, and equitable service delivery, informants explained that many frontline providers in Malawi lack the necessary training and support to operationalise these principles in daily practice. Contributing factors include inadequate pre-service and in-service training on communication, empathy, shared decision-making, and cultural sensitivity. This gap has led to persistent reports of poor client-provider interactions, low levels of patient engagement —particularly among vulnerable groups such as adolescents, women, and persons with disabilities. Furthermore, mechanisms should be

strengthened to incorporate patient feedback into service delivery improvements, creating a feedback loop that promotes accountability and continuous quality improvement. This aligns with Malawi's health sector priorities and international commitments (e.g. WHO 2020 – Delivering Quality Health Services: A Global Imperative for Universal Health Coverage), including the UHC agenda and the Sustainable Development Goals

v. *Inadequate access to online learning for health workers in hard-to-reach areas:*
Online learning platforms for health workers in remote and hard-to-reach areas is critical in addressing disparities in training and professional development opportunities. Strengthening remote learning capacities is essential to support a competent and well-informed health workforce in Malawi, capable of delivering quality care across the country. By leveraging digital technologies, health workers will be empowered with up-to-date knowledge and skills necessary to deliver quality health services, ultimately improving health outcomes in remote communities which experience numerous challenges.

2. Health service delivery

i. *Limited youth health awareness activities and access to adolescent-friendly services:* The FGDs highlighted a gap in the availability and reach of youth-focused health awareness activities and adolescent-friendly health services in Malawi. Many young people, particularly in rural areas, lack access to accurate information on sexual and reproductive health, mental health, nutrition, and prevention of communicable and non-communicable diseases. Existing health promotion efforts are not tailored to the unique needs and communication preferences of adolescents and young people, especially those living with disabilities. Additionally, the limited number of health facilities offering youth-friendly services—combined with stigma, privacy concerns, and a lack of adequately trained providers—discourages young people from seeking care. This gap highlights the urgent need for coordinated, age-appropriate interventions that promote youth engagement and improve health outcomes.

ii. *Insufficient training of health workers to sustain ART service delivery:* The recent termination of support from the US government in Malawi has created a gap in capacity of health workers - particularly nurses and clinicians - to provide comprehensive antiretroviral therapy (ART) services. This reduction in external funding and training support was mentioned by informants in relation to the availability of adequately trained staff, threatening the continuity and quality of HIV treatment programmes. Addressing this gap will require targeted training initiatives to build and sustain the competencies of health workers.

3. Health workforce

i. *Inadequate support for the wellbeing of health workers:* Informants identified a gap in efforts to support the physical, mental, and emotional wellbeing of health workers in Malawi. There is currently no comprehensive national framework or coordinated approach to promote health worker wellbeing, including mental health services, stress management, occupational safety, and supportive supervision. Addressing this gap is essential for sustaining a motivated, resilient, and high-performing health workforce. Informants expressed there is a need to facilitate GESI

improvements within the health facility environment and support better working conditions and wellbeing for health workers.

ii. *Inadequate availability and accessibility of skilled health workers in rural areas*: The scoping assessment revealed a persistent gap in the deployment and retention of skilled health workers in rural and hard-to-reach areas of Malawi, directly undermining the objectives of the Health Sector Strategic Plan III (HSSP III), which prioritises equitable access to essential health services and strengthening of primary health care. Despite policy recognition of the need for a balanced health workforce, rural facilities continue to experience chronic shortages of critical cadres such as nurses, midwives, and clinical officers. Contributing factors include weak implementation of rural retention strategies, inadequate incentives, poor infrastructure, and limited opportunities for professional development. These conditions lead to high turnover, service delivery disruptions, and reduced quality of care for underserved populations. Addressing this gap is essential to supporting HSSP III's vision of a resilient, responsive, and people-centred health system capable of delivering UHC. Targeted deployment strategies, rural-focused training programmes, and incentive packages are essential to attract and retain skilled personnel in underserved areas, thereby improving health outcomes and advancing equity in healthcare access.

4. Leadership and governance

i. *Limited leadership capacity among nurses and midwives at secondary-level health facilities:* Informants identified a gap in leadership and managerial capacity among nurses and midwives working in secondary-level health facilities across Malawi. Despite being the backbone of service delivery in these settings, many nurses and midwives are placed in supervisory or administrative roles without adequate training in leadership, health systems management, or strategic decision-making. This gap affects the efficiency, accountability, and quality of service delivery at the facility level and limits the ability of mid-level facilities to respond effectively to operational challenges, workforce coordination, and quality improvement initiatives. Strengthening the leadership capacity of nurses and midwives is essential to improving facility-level governance and advancing the goals of the Health Sector Strategic Plan III (2023–2030), which emphasises professional development and decentralised health system management.

ii. *Limited capacity of lower-level governance structures to effectively oversee health service delivery:* Discussions with stakeholders revealed that many lower-level governance structures—such as Health Centre Advisory Committees (HCACs), District Health Management Teams (DHMTs), and local councils—lack the capacity, resources, and authority needed to effectively oversee and support health service delivery. These structures face challenges including inadequate training, unclear roles and responsibilities, limited access to timely data, and weak coordination with higher-level governance systems, reducing the responsiveness and efficiency of local health systems. Empowering lower-level structures would improve responsiveness to local health needs, foster transparency, and strengthen the link between communities and the formal health system.

5. Community engagement

i. *Insufficient community engagement in QI initiatives:* The scoping assessment highlighted a gap in effective engagement with communities in QI efforts in Malawi. While policy frameworks like the HSSP III and the National Community Health Strategy (2017–2022) underscore the role of community participation, implementation at the facility level remains under resourced. Most health facilities lack institutionalised structures—such as functional health centre advisory committees—that facilitate regular community involvement in planning, performance monitoring, and feedback. This deficiency undermines accountability, weakens trust, and limits the potential for services to respond to local needs. Addressing this gap is important to support the people-centred care approach, improve equity and responsiveness, and advance Malawi's strategic objectives for participatory and quality health systems under HSSP III.

ii. *Low male involvement in GESI discussions:* Informants explained that men and boys are left out of discussions around GESI, limiting the understanding and shared responsibility of health outcomes. Engaging men and boys as active partners in understanding barriers is crucial to promoting informed decision-making and improving service utilisation.

6. Health information

i. *Strengthening health informatics and facility-level data use aligned with DHIS2:* Despite widespread implementation of the District Health Information System 2 (DHIS2) in Malawi, many health facilities continue to face challenges in effectively analysing and using the data they collect for local decision-making. While data reporting into DHIS2 has improved, its use for real-time service delivery planning, performance monitoring, and quality improvement at the facility level remains limited. This priority area will focus on building the capacity of health workers and facility managers to interpret and apply DHIS2 data for their own planning and operational decisions. This includes targeted training on data analysis, visualisation tools within DHIS2, and integrating data use into routine management practices. Enhancing facility-level data use will reinforce Malawi's broader goals of a data-driven health system and align with the Ministry of Health's commitment to evidence-based planning under the Health Sector Strategic Plan III (2023–2030).

7. Policy and regulation

i. *Absence of a comprehensive National Policy Framework on antimicrobial resistance (AMR):* Informants highlighted a critical policy gap in Malawi's response to AMR as the country lacks a comprehensive national policy to coordinate, guide, and institutionalise multisectoral efforts. The absence of a unified AMR policy hinders progress in areas such as surveillance, antimicrobial stewardship, IPC, and public awareness. This gap significantly undermines Malawi's capacity to implement its National Action Plan on AMR and limits alignment with global and regional AMR frameworks. HPs can provide evidence-based findings and interventions that can inform a national AMR policy, which is needed to establish governance structures, mobilise domestic resources, and ensure long-term sustainability of AMR containment efforts.

Summary of priorities

The table below provides a summary of the scoping priorities above and mapped against the Health Sector Strategic Plan III.

Table 6. Summary table of priorities

Area	**Priorities**	**HSSP III – HRH strategies under Pillar 4**	**HSSP III - HRH Reforms number**
Service delivery	- Youth health services (with focus on mental health) - Sustain ART service delivery		
Health workforce	Education and training - Develop context-specific training materials - Harmonisation of CPD and development of quality improvement models - Patient safety through quality improvement in primary and secondary health facilities - Patience-centred care, disability competencies, GESI training	Strategy area 4.2, 4.3, 4.4	Reform 4-Performance for results Reform 6-Integration of in-service training
	Health workforce management - Wellbeing and safety for health workforce - Strengthen the capacity of lower-level governance structure such as DHMTs and village health committees - Qualified health workers in rural areas to improve provision of primary healthcare	Strategy 4.1, 4.3 and 4.5	5-Health workforce optimisation
Leadership and Governance	- Leadership capacity of nurses and midwives at secondary-level health facilities.	Strategy 4.1, 4.3 and 4.5	5-Health workforce optimisation
Health information	- Strengthen health informatics and facility-level data use aligned with DHIS2		
Community engagement	- Strengthen community engagement in quality-of-care initiatives - Bridge gaps in service users' knowledge, skills, and awareness of healthcare rights		
Policy and regulation	- Providing evidence-based findings and advocacy to information a national AMR policy		

Cross cutting and emerging themes identified with stakeholders

Several themes were identified that can be considered by all HPs as part of the SGHPP, regardless of the specific focus area of the projects. The four main areas for consideration are below.

1. Transformative health worker education and training interventions
    - Adopt strategic and innovative approaches to the design and delivery of quality HWF education and training across clinical, public health and management areas that advance national HWF development ambitions and meet population health needs.
    - Promote equitable access and GESI-responsive practices to training, mentorship, leadership development and career advancement, especially for those in hard-to-reach areas and neglected areas (as defined by the Ministry of Health), advancing health equity and gender equality and social inclusion.
    - Utilise HPs to integrate community feedback and leadership into health planning to enhance HWF competencies and retain skilled HWs in these areas as well as strengthening PHC and community-based services.
2. Complementary, harmonised and flexible approaches
    - Promote alignment across HWF strengthening programmes and interventions, and with the Government of Malawi's "One Plan, One Budget, One Report" approach, enhancing complementarity and synergies across domestic and externally funded initiatives.
    - Foster flexible, adaptive and resourceful approaches that respond innovatively to circumstances to enhance health systems' resilience and sustainability, that support PHC strengthening and advance the national UHC agenda.
3. Participatory and GESI responsive approaches
    - Guided by the SG's Feminist approach to foreign policy (The Scottish Government, 2023), level power imbalances and elevate vulnerable voices and their needs, empower women and girls, place communities at the centre of co-creation processes, and promote mechanisms that empower and support local leaders and communities.
    - Adopt participatory and equitable governance mechanisms and programme management processes that facilitate transparency and accountability to local stakeholders.
    - Facilitate co-creation of localisation and decolonialisation strategies that engage diverse stakeholders, promoting country driven decision-making on interventions that are relevant, acceptable and address specific local health issues. Promoting reciprocity and mutual benefit is a key component of the HP approach and provides opportunities bidirectional learning.
4. Evidence generation and learning
    - Stimulate increased access and use of available HWF data for effective planning, implementation, monitoring and evaluation of HWF and health systems activities.
    - Promote innovative methods to generate evidence and learning of what works for HWF strengthening in Malawi, particularly in hard-to-reach and neglected areas (as defined by the Ministry of Health).

- Stimulate bi-directional learning that embraces and leverages new technologies and working practices to co-create solutions to identified challenges.
- Support the co-development and documentation of learning and evidence generated to inform national and global HWF policy and practice, and to facilitate bidirectional learning.
- Enhance the dissemination of evidence and learning to national, regional and international audiences through a range of learning products e.g., policy/evidence briefs, case studies, blogs, abstracts and publications, and platforms (e.g. conferences, Communities of Practice).

Governance mechanisms

In line with the guidance provided for the governance of the SGHPP and the Terms of Reference for the proposed National Oversight Mechanism (NOM) and Programme Steering Committee (PSC), GHP engaged senior MoH leadership and other relevant stakeholders to discuss and agree appropriate mechanisms and composition. Governance mechanisms between Malawi and other partner countries aim to enhance country ownership, oversight and coordination of the planning, design and implementation of the SGHPP in each country, ensuring that HP interventions are inclusive, coherent and aligned with national health systems and HWF policies and priorities.

Stakeholder debriefing and validation of identified priorities

GHP facilitated a debriefing for key MoH officials in the HWF and Policy and Planning department to present and validate the HS/HWF priorities identified through the scoping assessment. These officials agreed with the broad priorities identified, in particular, the proposed focus on capacitating and engaging sub-national governance mechanisms such as District Health Management Committees and Health Centre Management Committees to improve service quality, accountability, and community trust, a key aspect for a resilient and responsive health system. Development partners like WHO observed that coordinated online CPD platform in Malawi remains a priority as it improves access, equity, quality, and efficiency of professional development for health workers thereby strengthening the health system and supporting better health outcomes for all. This engagement also laid the groundwork for establishing the NOM and the Programme SC to ensure that implementation is country-owned and led and coordinated.

The validated priorities will inform the design of the grant calls and overall SGHPP management and monitoring, evaluation and learning MEL processes, to ensure partnerships are aligned with, and supportive of national priorities and capacities, promote sustainability and scalability, and innovative approaches to addressing HWF priorities.

Annexes

Annex 1. References

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Annex 2. Terms of Reference for scoping assessment *(separate document)*

Annex 3. Data collection tools *(separate documents)*

Annex 4. Stakeholders met during scoping assessment

No.	**Role**	**Institution**
1.	Director of Planning and Development	Ministry of Health
2.	Minister of Health	
3.	Principle Secretary	
4.	Director of Nursing	
5.	Human Resources	
6.	Country Representative	WHO
7.	Technical Officer-UCN	
8.	NPO-Health Systems	
9.	Service Delivery Systems Officer	
10.	EPR Team Lead	
11.	Surveillance Officer-EPR	
12.	HSS Coordinator	
13.	RMNCAH	
14.	M&E Officer	
15.	Training Officer	
16.	Country Manager	Amref
17.	Head of Programs	
18.	FP Advisor	
19.	CEO	Malawi Scotland Partnership
20.	Finance Officer	
21.	Intern	Salima District Hospital
22.	Env Health Officer	
23.	DMO	
24.	DNMO	Salima District Hospital
25.	PNNO	
26.	Deputy Director	MoH-QMD
27.	Associate Professor	KUHeS
28.	Director	Ministry of Gender, Child Welfare & Community Development
29.	Deputy Director	
30.	Executive Director	Malawi Equity Health Network
31	Program Manager	
32	Finance Manager	
33	Project Officer	
34	Country Director	Village Reach
35	Gender Officer	

Annex 5. HSSP III HRH Priorities

Pillar 4: Human Resources for Health Strategies and Reforms, extracted from the Malawi Ministry of Health and Population (2022), Health Sector Strategic Plan III 2023- 2030 (pp. 55-57).

Objective: To improve the availability of competent and motivated human resources for health for quality health service delivery that is effective, efficient and equitable.

Strategies

4.1 Enhance recruitment, selection, deployment, and equitable distribution of human resources for health	4.1.1 Recruit sufficient health workers to deliver the primary and secondary platform of care, as estimated by the workforce optimization model and specialist planning for the tertiary level
	4.1.2 Staff emergency operations centers (EOCs) with physicians, veterinarians, epidemiologists, and microbiologists
	4.1.3 Conduct regular functional reviews aligned to evidence on the demand for health services, such as the workforce optimization model and estimates of health workforce needed to deliver the tertiary platform of care, and including review of appropriate cadres to deliver each level of care (e.g., phase-out of the Medical Assistant cadre and replacement with Clinical Officers/Technicians)
	4.1.4 Rationalize and ensure equitable staff deployments as aligned to evidence on the demand for health services, such as the workforce optimization model and estimates of health workforce needed to deliver the tertiary platform of care
	4.1.5 Employ best practices for staff recruitment and selection
	4.1.6 Decentralize recruitment to sub national levels
4.2 Optimize production at training institutions and strengthen coordination between the institutions and health sector needs	4.2.1 Increase pre-service volumes for prioritized training programmes in alignment with the long-term HRH recruitment requirements, as estimated by the workforce optimization model for primary/secondary care and specialist planning for the tertiary level
	4.2.2 Develop and roll out interventions to strengthen coordination and quality assurance monitoring for pre-service training programs
	4.2.3 Embed professional behaviour and customer service teaching in training programmes
	4.2.4 Enforce accreditation standards for training institutions (by regulatory bodies)
4.3 Improve staff development strategies, policies, procedures, and practices for human resources for health	4.3.1 Conduct a role set analysis for all cadres and accordingly induct/orient newly recruited, promoted or redeployed human resource for health
	4.3.2 Develop and implement a harmonized continuous professional development (CPD) system linked to renewal of licensure
	4.3.3 Develop and implement the harmonized in-service training curriculum for all cadres of the health workforce, as

	embedded within the CPD system, aligned to service delivery needs, and inclusive of professional behaviour and client satisfaction
	4.3.4 Monitor the CPD system, inclusive of harmonized in-service training, for quality assurance and return on investment
	4.3.5 Intensify supervision/mentorship/coaching programs for cadres across all levels of care as linked to the CPD system
	4.3.6 Design and implement internships, fellowships, and residency programs for human resources for health
4.4 Strengthen and enforce performance management policies, procedures, and practices	4.4.1 Develop and implement a robust performance management system that is linked to implementation of strategic and operational plans at the national/district/facility levels and linked to health worker promotions, incentives, and disciplinary systems
	4.4.2 Conduct regular reviews of existing supervision lines to enable implementation of performance management
	4.4.3 Enforce robust regulation of health workers, their training and practice, including development, review, and enforcement of health service regulations and disciplinary procedures
	4.4.4 Re-structure clear and coordinated career pathways for career growth
	4.4.5 Develop and implement talent management and retention strategies and policies
4.5 Institute and provide for competitive remuneration, benefits, and working conditions for human resources for health	4.5.1 Develop innovative and competitive remuneration and benefits interventions
	4.5.2 Design and implement incentives to motivate and retain health workers in hard-to-reach areas
	4.5.3 Improve working conditions to improve staff retention
4.6 Generate reliable data and build capacity for evidence-based health workforce decision-making through digital innovations and technological platforms for human resource management	4.6.1 Build the capacity of HR practitioners to conduct evidence-based decision-making, including use of enterprise resource planning (ERP) systems, tools and technologies such as iHRIS at all levels
	4.6.2 Integrate iHRIS and HRMIS systems
	4.6.3 Procure IT infrastructure to enable HRH digital innovations such as iHRIS
	4.6.4 Conduct regular data validation of all HRH databases, including iHRIS, personnel records, payroll audits, among others

Source: Health Sector Strategic Plan III 2023- 2030 (pp. 55-57).

HRH Reforms

	Performance for Results

Reform 4	
Reform 5	Health Workforce Optimization
Reform 6:	Integration of In-service Training

Source: Health Sector Strategic Plan III 2023- 2030 (pp. 56 -57).

Annex 6. Stakeholder Analysis Matrix *(separate document)*

Annex 7. GESI Analysis Matrix *(separate document)*