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Title of thesis

Malawi's Maternal and Child Health Policies: Analysis, Lessons and Strategies for Addressing Gaps

By

Student Name: **Judith Ng'ombe Daire**
Student Number: **DRXJUD001**

University of Cape Town

THESIS SUBMITTED TO THE UNIVERSITY OF CAPE TOWN

In fulfilment of the requirements for the Degree of Doctor in Philosophy
Faculty of Health Sciences, Nursing Department

Supervisor: **Professor Doris Deedei Khalil**
University of Cape Town

Co-Supervisor: **Dr. Maureen Chirwa**
College of Medicine,
University of Malawi

Date of Submission: 15th August 2009

DECLARATION

I, Judith Ng'ombe Daire, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being or is to be submitted for another degree in this or any other university.

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Signature

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Date

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Dedication

This thesis is dedicated to my husband and friend, Arthur Daire who shares so much with me.

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First and foremost, I thank God for His unceasing love and blessings; He has given me the opportunity and capacity to reach this far in my academic and professional development.

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Abbreviations

ACSD	Accelerated Child Survival and Development
AIDS	Acquired Immunodeficiency Syndrome
ANC	antenatal care
BEmOC	Basic Emergency Obstetric Care
BLM	Banja La Mtsogolo
CEmOC	Comprehensive Emergency Obstetric Care
CHAM	Christian Health Association of Malawi
CHIP	Central Hospital Implementation Plan (s)
CHN	Community Health Nurse
CMS	Central Medical Stores
CNO	Chief Nursing Officer
CO	Clinical Officer
COM	College Of Medicine
CRC	Convention on the Rights of the Child
CSD	Early Survival and Development
DFID	Department for International Development
DHO	District Health Officer
DHMT	District Health Management Team(s)
DHS	Demographic and Health Survey
DIP	District Implementation Plan (s)
DNO	District Nursing Officer
ECD	Early Childhood Development
EHA	Environmental Health Assistant (s)
EHO	Environmental Health Officer (s)
EHP	Essential Health Package
ENM	Enrolled Nurse Midwife
EmOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunisation
ETR	End of Term Review
FA	Financial Assistance
FP	Family Planning

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FPAM	Family Planning Association of Malawi
FWCW	Fourth World Conference on Women
GAVI	Global Alliance for Vaccines and Immunizations
GBS	General Budget Support
GDP	Gross Domestic Product
GHIs	Global Health Initiatives
GNP	Gross National Product
GoM	Government of Malawi
HA	Health Assistance
HIMS	Health Information Management System
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HNO	Hospital Nursing Officer
HMIS	Health management Information system
HPFP	Health Policy Framework Paper
HR	Human Resource(s)
HSR	Health Sector Reforms
HW	Health Worker
ICPD	International Conference on Population and Development
IDA	International Development Assistance
IMCI	Integrated Management of Childhood Illnesses
INGO	International Non Governmental Organisations
IMF	International Monetary Fund
IMR	Infant Mortality Rate
JCE	Junior Certificate of Education
JHPIEGO	John Hopkins Programme for International Education in Gynaecology and Obstetrics
JPoW	Joint Programme of Work
JSI	John Snow Inc.
KCH	Kamuzu Central Hospital
KCN	Kamuzu College of Nursing
MA	Medical Assistant(s)
MCH	Maternal and Child Health
MDGs	Millennium Development Goals

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MDRI	Multilateral Debt Relief Initiative
MEDP	Ministry of Economic development and Planning
MGCWCS	Ministry of Gender, Child Welfare and Community Service
MGDS	Malawi Growth and Development Strategy
MGYCS	Ministry of Gender, Youth and Community Services
MICS	Multiple Indicator Cluster Survey
MLG	Malawi Local Government
MMC	Malawi Medical Council
MMR	Maternal Mortality Rate/Ratio
MO	Medical Officer
MoA	Ministry of Agriculture (Malawi)
MoE	Ministry of Education (Malawi)
MoF	Ministry of Finance (Malawi)
MoH	Ministry of Health (Malawi)
MoIWD	Ministry of Irrigation and Water Development (Malawi)
MSCE	Malawi School Certificate of Education
MSH	Management Sciences for Health
NAC	National AIDS Commission
NAF	National Action Framework
NEPAD	New Partnership for Africa's Development
NGO	Non Governmental Organization(s)
NHP	National Health Plan(s)
NMCM	Nurses and Midwives Council of Malawi
NMT	Nurse Midwife Technician
NO	Nursing Officer
NSF	National Strategic Framework
NSO	National Statistics Office (Malawi)
NT	Nurse Technician
OAU	Organisation of African Unity
PHC	Primary Health Care
PHD	Provincial Health Department
PMTCT	Prevention of Mother To Child Transmission
PNO	Principal Nursing Officer
PoA	Programme of Action

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PRA	Participatory Rapid Appraisal
PRSP	Poverty Reduction Strategy Paper
QECH	Queen Elizabeth Central Hospital
RH	Reproductive Health
RHMIS	Reproductive Health Management Information System
RHU	Reproductive Health Unit
RN	Registered Nurse
RNM	Registered Nurse Midwife
SADC	Southern Africa Development Community
SAPs	Structured Adjustment Programme
SBA	Skilled Birth Attendant(s)
SNO	Senior Nursing Officer
SMART	Acronym (Specific, Measurable, attainable, Relevant and Time bound)
SMI	Safe Motherhood Initiative
SMS	Senior Medical Superintendent
SRH	Sexual and Reproductive Health
SRN	State Registered Nurse
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approaches
SWOT	acronym (Strengths, Weaknesses, Opportunities and Threats)
TA	Traditional Authority
TB	Tuberculosis
TBA	Traditional Birth Attendant
TWGs	Technical Working Groups
TA	Technical Assistance
UCT	University of Cape Town
UNAIDS	United Nations Programme of HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations International Children Emergency Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
U5MR	Under-five Mortality Rate
VCT	Voluntary Counselling and Testing for HIV

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VHC	Village Health Committee
WHO	World Health Organization
WI	Ward In-charge
WVI	World Vision International
ZHSO	Zonal Health Support Office

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Operational definition of terms

Agenda setting	is about placing national issues on the policy-making agenda and determining priorities
Allocation of resources	refers to budgeting and allocation of resources for implementation of national policies
Bilateral donor	a country or organization from a country that gives financial assistance to another country
Evaluation	To judge, appraise, or assess the worth of a programme or project to determine outcomes and values of policy action
Evidence-based	Means being results-oriented
Feedback	refers to generating and submitting reports to relevant decision makers regarding the impact of the policy
Health	The state of complete well-being physically, mentally and socially and not just the absence of disease or infirmity
Gender inequality	Refers to unequal access to health services between the two sexes
Health policy	expressions of agreement on general purpose, decisions, practices, statements, purposive course of actions, regulations, and laws on national health issues to be addressed
Infant mortality	the probability of dying before one-year of age expressed per 1 000 live-births
Implementation	The carrying out and putting into action programmes and projects, or setting the policy decision into motion
Maternal death	Relates to death of a woman during pregnancy, or within forty-two days of termination or after giving birth.
Maternal health	Refers to the health and well-being of women during pregnancy, childbirth and the postpartum period
Maternal mortality	death of women during pregnant or within 42 days of delivery or termination of pregnancy from any causes except accidents
Maternal mortality rate	The number of maternal incapacitation relating to

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	childbearing divided by the number of live births (or by the number of live births plus foetal deaths) in any given year
Morbidity rates	The rates at which disease condition prevent a person from functioning at their optimum level
Mortality rates	Records of deaths in a given period within a given community or country; also sometimes referred to as the proportion of deaths within a given population
Operational policies	refer to the rules, regulations, guidelines, and circulars that translate national policy into service delivery
Policy agenda	National or organisational issues or health problems to be considered for policy discussions and decision-making
Policy content	what the policy document stipulates for example vision, goals, objectives and strategies
Policy context	refers to systemic or environmental factors, such as political, economic, social, both national and international influences that could affect policy decision-making
Policy process	refers to steps and phases in policy development, negotiations, implementation, monitoring and evaluation, and outcomes
Policy analysis	the process of studying established policies to determine processes utilised in their developments, including their contents, implementation, evaluation, impact, and key role-players
Policy initiation	Refers to the establishment of the necessity for a policy to be made and thereafter the development of a vision and formulation of general goals for the policy
Poverty	the state of poor, lack of the means of providing material needs and means of accessing services
Stakeholder	Target groups or individuals with vested interest in an issue or policy, in other words critical role-players in a given policy process
Under-five mortality	The rates at which children between die between the time of birth and up to the age five, usually expressed as per 1 000 live-births
Women's empowerment	refers to the ability of women to transform economically and socially to fully participate in the decisions that affect their lives

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Executive summary

Title: Malawi's Maternal and Child Health (MCH) Policies: Analysis, Lessons and Strategies for Addressing Gaps. The topic of MCH policies was chosen for the study because improving health of mothers and children seemed not to be making the progress it should, despite existing MCH policies and programmes since independence in Malawi. This was thought to be a significant topic because morbidity and mortality rates among mothers and children reflect the status of the nation's population and health system of the country as a whole. As such drawing policy makers' attention through evidence from research findings to improve MCH, the government indirectly improves the country's health status in general.

Aims and objectives: the primary aims were to analyze Maternal and Child Health policies in Malawi. Secondly, to explore lessons and strategies for addressing gaps in MCH policy development and implementation. To identify lessons and gaps, the study reviewed content of MCH policy documents in Malawi from 1964 to 2008, analyzed context of MCH policies in Malawi, analyzed MCH policy process in Malawi, and analyzed the influence of key MCH policy stakeholders in Malawi.

Methodology: Multiple qualitative research designs were employed to focus the study. The term multiple qualitative research designs refer to using two or more research designs in a study, for example this study used three qualitative research designs, namely, evaluative research, multiple case studies and grounded theory. Data were collected through official documents review, self-administered questionnaires, and interviews. In addition, field visits to health facilities were undertaken. **Data analysis**: data from each data source were analyzed separately and then triangulated to compare results from the three data sources. Quantitative data was analyzed using "STATISTICA 7" software to facilitate basic descriptive statistical analysis of responses to closed-ended questions. Content of qualitative data was analyzed with the aid of "NVivo 7" software, which facilitated coding and identification of categories and themes from data collected.

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Results: MCH policies in Malawi were largely influenced by international factors. In addition, the country's MCH policies did not stipulate plans for implementation, monitoring, supervision, review and evaluation. Further to that, policy goals were broad with no targets and policies were not results oriented and evidence-based. Further to that, private providers, implementers and beneficiaries were not involved in MCH policy development. Finally, contextual factors influencing MCH were consistent with the constraints encountered in implementing MCH policies.

Recommendations: Firstly, adoption of international MCH policies should address contextual factors in the health sector in addition to their focus on specific disease condition or a target population. Secondly, policy makers should develop policies that are specific and time bound. Thirdly, policy makers should develop MCH policies that are results-oriented and based on local evidence. Fourthly, MCH polices should include planned and budgeted strategies for monitoring, reviews, and evaluations. Finally, policy makers should provide opportunities for involving private providers, implementers and beneficiaries in policy development. **Outcomes of the study**: Recommendations outlined in this PhD thesis were submitted to the Malawian Ministry of Health as part of conditions for permission to conduct the study. In addition, a workshop was conducted to share findings with the senior management. Results of the study have also been presented at various international conferences with articles submitted for review in peer-reviewed journals.

This work has made notable contribution to knowledge in two key aspects. Firstly, it has produced a valuable Policy Analysis Instrument – an adapted version of Walt and Gilson Policy Analysis Framework and has demonstrated application of this instrument on Malawi's Maternal and Child Health Policies. Secondly, this work, in applying the Policy Analysis Framework, has carried out a case study that has produced specific findings regarding policy development and implementation in Maternal and Child Health sub-sector of Malawi's health sector. There is direct immediate contribution towards improving policy development and implementation as well as service delivery in Malawi's Maternal and Child Health.

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Chapter One

INTRODUCTION

This study was conducted in Malawi from March to December 2008. The focus of the study was analyzing Maternal and Child Health (MCH) policies in Malawi in terms of their content, process, context and stakeholders in order to identify lessons and strategies for addressing gaps. The study made recommendations as strategies for addressing the identified gaps in MCH policies as well as healthcare services for women and children in Malawi. This chapter provides background of the researcher and need for the study. It also provides overview of MCH policies in Malawi and describes progress of MCH in relation to Millennium Development Goals [MDGs]. In addition, the chapter outlines the problem statement and justification for the study. Finally, the chapter delineates the study aims and objectives as well as structure of the thesis.

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1.1. Background to the researcher

The author developed interest in MCH whilst undertaking a University Certificate in Midwifery at Kamuzu College of Nursing (KCN), University of Malawi. During clinical placements, she came to understand the unmet health needs of mothers and children in Malawi. After graduating, she worked at Mulanje Mission Hospital in Mulanje district of Malawi. As part of her managerial role, she chaired the Maternal Death Auditing Committee and was dismayed at some of the causes of death associated with pregnancy in the district. Her interest in the subject grew even more whilst studying for her Master's Degree at Leeds University in the United Kingdom and selected Reproductive Health (RH) as an elective module. She was also disturbed to discover that maternal mortality rate in Malawi was one of the highest worldwide.

On completing the Masters Degree from Leeds University in United Kingdom, she was appointed by CARE International in Malawi as Project Manager for Sexual and Reproductive Health (SRH) project. One of allocated projects was to investigate factors affecting accessibility to maternal and neonatal healthcare at community level.

Consequently, both her academic and work experiences became energizing factors for her to conduct this study on MCH in Malawi. She wanted to contribute in improving MCH in Malawi. Even though health needs of women and children in Malawi are exacerbated by numerous factors at individual, community, national, and international level, nevertheless national policies play major role in determining availability of health services for the population. Subsequently the researcher's interest and reasoning for examining MCH policies as one of the strategies for improving health of mothers and children in Malawi.

1.2. Introduction of the study

According to the World Health Organization [WHO] (2005a), the future of a healthy society depends on the health of its children today, and their mothers who are guardians of that future. WHO (2005a) maintained that despite much good work over the years, 10.6 million children and 529 000 mothers are still dying each year from mostly avoidable causes. Although for decades there has been global consensus that health of mothers and children is public priority, much still needs to be done (WHO 2005a). According to WHO (2005a), this is because progress has been made by countries that are already in a relatively good position in the early 1990s, whereas countries less favourably placed, such as those in Sub-Saharan Africa have been left behind. For instance, Maternal Mortality Ratios (MMR), range from 830 per 100 000 in Sub-Saharan African countries compared to 24 per 100 000 in European countries (WHO, 2005a). Of the 20 countries with the highest MMR worldwide, 19 are in the Sub-Saharan Africa (WHO 2005a). The slow progress in realising improved health for children and women in Sub-Saharan Africa is evident despite the existence and implementation of various MCH policies and programmes (WHO, 2005a). For example, MMR almost doubled in Malawi between 1992 and 2000 regardless of implementing Primary Health Care (PHC) as well as Safe Motherhood Initiatives (SMI).

Malawi has various health policies and programmes in its attempt to achieve "Health for all Malawians" (Baker, 1975). In addition, substantial financial resources have been invested in the health sector over the past three decades. Nevertheless, health

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indicators in Malawi remained poor, e.g., Maternal Mortality Rate (MMR) doubled from 620 to 1120 per 10000 from 1992 to 2000 (National Statistics Office [NSO] (2005). In 2004, MMR was estimated to be as high as 984 per 100000 (NSO, 2005). In addition to high MMR, there was slow progress in improving infant and child health. For example, during 1990-2005 estimates indicated that Under-Five Mortality Rate (U5MR) declined by 30 percent. In addition, Infant Mortality Rate (IMR) declined by 27 percent and neonatal mortality declined by 36 percent (NSO, 2005). The persistent poor MCH indicators in Malawi, clearly indicates the need for strategies to improve MCH in the country starting from policy development to implementation right through to evaluation.

1.3 Overview of MCH policies in Malawi

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Since independence, Malawi has a total of five, National Health Plans (NHP). Four of them are based on PHC strategies (MoH, 2004b). The remaining one is the most recent NHP (2004-2010), which is based on the Sector Wide Approach (SWAp) and the Essential Health Package [EHP] (MoH, 2004b). In all these health plans, MCH remained one of their health priorities. In addition to NHP, policies specifically related to health of women exist in Malawi. For example, in 1996, the SMI Programme was launched with the goal of drastically reducing MMR by the year 2004, i.e. from 620 to 310 per 100,000 live births (MoH, 1996). In 1999, the National RH Strategy for 1999-2004 was developed to support and provide focus to the RH component of the 1999-2004 NHP (MoH, 1999a). In 2000, National RH Service Delivery Guidelines were developed to assist all levels of service providers to deliver comprehensive RH services (MoH, 2000a). In 2000, there was a Maternal Mortality Reduction Conference in Mangochi - Malawi, which resulted in a Safe Motherhood Operational Plan and the development of an Obstetric Life Saving Skills trainers' and service providers' manuals (MoH, 2000b). In 2002, a Reproductive Health policy was developed to guide implementation of the RH Strategy (MoH, 2002a). In 2003, Malawi National Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) policy was developed with the aim of preventing the spread of HIV infections and reducing the population's vulnerability to the disease. One of the policy's objectives was to improve provision of treatment, care and support for people living with HIV/AIDS and to mitigate the socio-economic

impact of the disease on individuals, families, communities and the nation (National AIDS Commission [NAC], 2003).

The latest strategy developed is the ‘Road-Map for Accelerating the Reduction of Maternal and Newborn Mortality and Morbidity in Malawi 2006-2010’ (MoH, 2006b). The Road-Map specified that the key to reducing maternal mortality is to increase access to Skilled Birth Attendants (SBA) during delivery and an effective postnatal care. A crucial element of the Road-Map is provision of quality Basic Emergency Obstetric Care (BEmOC) and Comprehensive Emergency Obstetric Care (CEmOC). Along with the Road-Map is the National RH Strategy for 2006-2010, which is an update of the previous Reproductive Health Strategy for 1999-2004 (MoH, 2006a).

In addition, separate policies and programmes with specific focus on children’s health also exist in Malawi, e.g. Expanded Programme for Immunization (EPI) and Integrated Management of Childhood Illnesses (IMCI). EPI was initiated in 1976 as a pilot Program with support from the WHO and United Nations International Children’s Fund [UNCEF] (Wansi, Mtango, Maganga, Banda and Msiska 2000). The Programme became operational in 1979 with the goal of reducing child morbidity and mortality due to communicable diseases like Tuberculosis (TB), measles, polio etcetera (Wansi et al, 2000). According to Wansi et al (2001), Malawi had been implementing IMCI initiative since 1998. The IMCI initiative had three strategic approaches. The first approach was improving health workers skills in examining sick children. The second was to strengthen the country’s health system, and thirdly to improve household and community childcare practices (Wansi et al, 2001).

There are a number of policies that guide implementation of existing programmes related to child health. For example, Expanded Programme on Immunization in Malawi 2002 (MoH, 2002b) and Programme of Child Survival and Development 1988-1992 (Government of Malawi and UNICEF, 1988). Other policies on child health are Integrated Management for Child Illnesses Approach policy for Accelerated Child Survival and Development in Malawi, 2006 (MoH, 2006c) and Five year national strategic plan for Accelerated Child Survival and Development in Malawi, 2007 (MoH, 2007). Despite the existence and implementation of MCH

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policies, maternal, neonatal and child mortality rates remained significantly high. Until 2000, the MoH's MCH policies were developed around achieving goals of health for all as advocated by WHO. Since 2000, Malawi health policies have been developed around achieving MDGs (Malawi Government, 2003).

1.4 The progress of MCH in relation to MDGs in Malawi

The formulation of MDGs targets and indicators revealed that special priorities were given to the health of women, mothers and children (WHO, 2005). Malawi signed the Millennium Declaration adopted at the United National General Assembly in September 2000 (Malawi Government, 2003). Like many other countries that signed the Millennium Declaration, Malawi is committed to achieving MDGs and has oriented its health service activities around these goals through various ministries (International Monetory Fund [IMF], 2007). The MDGs are being implemented through the Malawi Growth and Development Strategy (MGDS), which is the overarching strategy that directs sectoral planning (IMF, 2007). The MDGs are the hallmark of MGDS in a bid to reduce poverty and expedite development (IMF, 2007).

According to the 2007 MDGs report of Malawi, progress to date on MCH related MDGs is mixed (Ministry of Economic Planning and Development [MEPD], 2008)). Malawi is making good progress towards reducing under-five mortality from 234 deaths per 1000 live births in 1992, to 133 in 2005 (MEPD, 2008). At this rate, it is anticipated that U5MR will decline to as low as 41 deaths per 1000 live births by the year 2015, surpassing MDGs target of 78 deaths per 1000. This implies that the country is likely to reduce U5MR by more than two thirds of the 1992 level (MEPD, 2008). In addition, IMR has been steadily declining in Malawi from a very high level of 134 during 1992 to 69 in 2006 (NSO, 2006a; 2005; 2001; 1992). At this rate of decline, Malawi is likely to achieve its MDGs target of 44 deaths per 1000 by 2015. However, the proportion of one-year-old children immunized against measles dropped from 86 percent in 1992 to 77 percent in 2006 (NSO, 2006a). The projection shows that by 2015, only about 71 percent of the one-year-old children will be immunized against measles and this percentage would be below the MDG target of 95 percent (MEPD, 2008).

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Therefore, while some progress has been made, Malawi still faces challenges in its efforts to reduce child mortality because of resource constraints within the public health sector (MEPD, 2008). The total expenditure on health in the country is equivalent to US$20 per capita that still falls short of the minimum expenditure of US$34 recommended by the World Health Commission (MEPD, 2008). The financial constraint has translated into host of problems, e.g. poor access to services by the population culminating in high incidences of preventable diseases. In addition to resource limitations, weak inter-sectoral collaboration has also constrained the health sector from dealing with other determinants of poor health in children such as safe water, good sanitation and good nutrition (MEDP, 2008). The HIV/AIDS pandemic also poses a challenge to the proposed accelerated reduction of child mortality (MEPD, 2008).

WHO, UNICEF and UNFPA, estimated in 2000 that Malawi is among countries with the highest MMR in the world (MEDP, 2008). The MMR in Malawi increased sharply from 620 to 1120 deaths per 100 000 live births in 2000. However, the death rate later declined to 984 deaths per 100 000 live births by 2004 (NSO, 1992; 2001; 2005). If this trend in reducing MMR is maintained, Malawi would have MMR of about 610 deaths per 100 000 births by the year 2015 (MEDP, 2008). According to MEDP (2008), Malawi is anticipating to have MMR of 155 deaths per 100 000 live births by the year 2015 (MEDP, 2008). Hence, unless additional measures are initiated, it is unlikely that the MDG targets would be met.

The proportion of births attended by skilled health personnel was 55 percent in 1992, 56 percent in 2000, and 62 percent in 2006 (NSO, 2005 and 2006b). According to MEDP (2008) projections, the proportion of births attended by skilled health personnel in 2015 will have increased to 67 percent. MEDP maintained that Malawi therefore is not on track to reach its target of 99 percent by 2015 (MEPD, 2008). The challenge that the country is facing in relation to high MMR is critical shortage of human resources. This has resulted in child-births being attended to by untrained health providers and attendants (MEDP, 2008). Another challenge is that access to Emergency Obstetric Care (EmOC) is poor due to inadequate and poorly equipped health facilities. Furthermore, the problem is exacerbated by cultural practices, which encourage early marriages, home deliveries, and discourage the use of modern

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contraceptive methods (MEDP, 2008). The debate of why so little has changed in MCH in Malawi and indeed in sub-Saharan Africa has been going on for a long time (MEDP, 2008).

1.5 Problem statement

Improving health of mothers and children seemed not to be making the progress it should, despite existing MCH policies and programmes since independence in Malawi. For example, MMR almost doubled as indicated earlier. In addition, between 1990 and 2005 infant and under-five mortality decreased at a slow rate (NSO, 2005). Malawi MMR still ranks high among its neighbouring countries according to WHO estimates for 2000 (DFID, 2007). Malawi's MMR was estimated at 1800 per 100 000 for the year 2000 while MMR for Mozambique, Tanzania and Zambia were estimated at 800, 1500, 1200 per 100 000 respectively (DFID, 2007)). Although the reasons for high MMR and IMR may be numerous and complex, the situation indicates that existing Malawi MCH policies seemed not to be influencing mothers and children's health as expected. Hence the need to analyze Malawi MCH policies to determine if the slow progress in improving health of mothers and children in Malawi lies in policy development or at the implementation levels.

Despite existence of MCH policies in Malawi since independence, institutional policy development and implementation framework had not been clear. The MOH planning unit is supposed to be the policy-developing department of the Ministry. Yet, policy development had been characterized by uncoordinated policy formulation and often under the influence of international donors (MoH, 1999b). Furthermore, although MCH policy processes existed in the country, stakeholders were not aware of the processes for any health policy (MoH, 1999b). Consequently, although there were numerous local and international stakeholders involved in health care delivery, their involvement in policy development was not clear.

Lastly, most programme evaluations in Malawi concentrated on service delivery only such that no explicit research had been conducted at the time of writing this thesis on health policy development and implementation in Malawi as means of improving healthcare services. Nevertheless, some efforts to analyze all government policies on

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commerce and industry were made by the Office of Vice President in 2000 (Malawi Government, 2000). To the author's knowledge no such efforts had been undertaken in the health sector, hence the need to analyze MCH polices in Malawi to understand health policy process as well as means to improve MCH services in Malawi.

1.6 Justifications for the study

The first justification for the study was that existing MCH policies in Malawi did not seem to be addressing health needs of mothers and children. As such, there could be potential gaps that need to be explored for MCH policy development processes and implementations, e.g. involving important stakeholders and beneficiaries.

The second justification was supported by the MDGs report (United Nations [UN], 2007) which indicated that progress against the goals at mid point was inadequate. Some of Malawi's key challenges included continued high MMR and slow progress in reducing child mortality and morbidity rates in the country (UN, 2007). Factors contributing to the slow progress were reported to be lack of investment in the country's weak health systems, insufficient and poorly coordinated donor sources, lack of agreement on effective technical strategies, and limited scaling-up of interventions that work (Gilson and Raphael, 2008:United Nations, 2007). Nevertheless, an area that received little attention but contributed to slow progress in achieving health related MDGs was the analysis of how and why national health policies achieved less than expected, perform differently from expected, or even failed (Buse, Dickinson and Gilson, 2007). Most MCH programme evaluations in Malawi had concentrated on service delivery, i.e. implementation aspect of policies.

The third justification was that high maternal and child mortality rates have indirect impact on socio-economic status within families and communities as well as the country itself. To elaborate on this issue, children are the future human resource pool for a country. Therefore, it is imperative that children born today should survive, grow, and develop to their fullest potential for a prosperous Malawi. Furthermore, mothers are custodians of the country's future and their health needs ought to be one of the country's priorities as well. Considering the value attached to children and women in African culture, Malawi cannot afford to continue loosing mothers and

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children through preventable deaths (WHO, 2005). On the other hand, healthy mothers play important social role in caring for children before and after birth. Mothers also care for those who are ill and the elderly. As such, improving their health should be a country's priority.

The fourth justification was to explore strategies for improving MCH policies in Malawi in view of the high morbidity and mortality rates for mothers and children. Wansi et al (2001) argued that high morbidity and mortality rates among mothers and children reflect the status of the nation's population and health system of the country as a whole. Therefore, by improving MCH, the government indirectly improves the country's health status in general. The fifth justification was supported by Merson, Black and Mills, 2006, they stipulated that many lessons had been learnt on strategies that worked in improving MCH from countries like Sri Lanka and Malaysia. Therefore, for such similar lessons to be effectively implemented in Malawi there was a need for country specific information on gaps and lessons in existing MCH policies.

1.7 Aims and specific objectives of the study

1.7.1 First aim:

To analyze MCH policies in Malawi from 1964 to 2008

Objectives:

- To review content of MCH policy documents in Malawi from 1964 to 2008
- To analyze context of MCH policies in Malawi
- To analyze MCH policy process in Malawi
- To identify and analyze the influence of key MCH policy stakeholders in Malawi

1.7.2 Second aim:

To explore lessons and gaps in MCH policy development process

Objectives:

- To explore experiences of MCH stakeholders in policy development
- To explore processes for involving stakeholders and target groups in MCH policy development in Malawi

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- Examine interaction processes between policy makers and implementers

1.7.3 Third aim:

To explore lessons and gaps in MCH policy implementation

Objectives:

- To explore experiences of stakeholders in implementing MCH policies in Malawi
- To determine types of constraints and problems encountered at government health facilities, private and NGOs in implementing MCH programmes in Malawi
- To examine the relationship between government resources, policies, and actual MCH implementation in Malawi

1.7.4 Fourth aim:

To explore strategies for improving maternal and child health in Malawi

Objectives:

- To review literature on strategies for improving MCH policies and services
- To make recommendation as strategies for addressing gaps in MCH policies and services in Malawi

1.8 Structure of the thesis

The thesis is divided into seven chapters. Chapter 1 introduces the researcher and need for the study. It also provides overview of MCH policies in Malawi and progress of MCH in relation to MDGs in Malawi. Further to that, the chapter describes the problem statement and justifications for the study. Finally, the chapter presents aims and objectives of the study as well as the layout of the thesis. Chapter 2 covers literature reviewed and describes the study context, factors affecting women's and children's health in Malawi. In addition, the chapter discusses models of public health policy analysis which underpinned the conceptual framework for the study. The chapter also presents and describes the adapted conceptual framework for the study.

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Chapter 3 sets out details of the multiple qualitative methodologies employed in conducting the study. In addition, the chapter presents justifications for selecting evaluative research design, multiple-case study approach, grounded theory as well as rationale for triangulation of the three research designs. The chapter describes methods and processes of data collection as well as validity and validity of data collection instruments. The chapter also describes study population and strategies utilized in selecting settings and respondents. Finally, the chapter outlines the process of data analysis, ethical considerations, and implications of the study.

Chapter 4 presents results obtained from data collected. Firstly, the chapter presents results obtained from documents reviewed, questionnaire as well as interview responses, and field visits. Secondly, it presents the outcomes of triangulation of data sources based on study aims and objectives. The chapter also outlines constraints during data collection and potential limitations of results obtained. Finally, the chapter discusses validity and reliability (trustworthiness) of results obtained.

Chapter 5 discusses the results obtained under the following headings, MCH policies in Malawi from 1964-2008, lessons and gaps in MCH policy development in Malawi, as well as lessons and gaps in MCH policy implementation in Malawi. Chapter 6 summarizes study results and reflects on whether the study met its stated aims and objectives in relation to study conceptual framework. Chapter 7 presents recommendations as suggested strategies for addressing gaps in MCH policies in Malawi. Finally, the chapter proposes areas for further research in order to improve MCH in Malawi based on results obtained.

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Chapter Two

LITERATURE REVIEW

2.1 Introduction

The previous chapter introduced the study background, aims and justification. This chapter presents literature reviewed from academic, government and international organisations' documents. It describes the study context from historical perspectives, provision of health services in Malawi and factors affecting MCH and Health Sector Reforms (HSR) in Malawi. The chapter also explains factors influencing MCH in Malawi. In addition, it presents and describes theoretical models that underpin the study and the adapted conceptual framework for the study.

2.2 Context of the study

Geographically, Malawi is a small land-locked country of the Sub-Saharan Africa, located in South East Africa (MoH, 2005). Malawi is bordered by Tanzania to the North and North East, by Mozambique to the East, South and South West, and Zambia to the West and North West [See Appendix A] (MoH, 2005). Lake Malawi, formerly known as Lake Nyasa, occupies most of the country's eastern border (MoH, 2005). According to NSO (2005), Malawi with a population growth rate of 1.7% has a total population of 11,937,934, of which 85% lives in the rural areas of the country (NSO, 2005). Females comprise 51% of the total population of whom 42.2% is said to be in the reproductive age of 15-49 years old. The country's fertility rate is estimated at 6.3 children per each childbearing woman (MOH, 2005).

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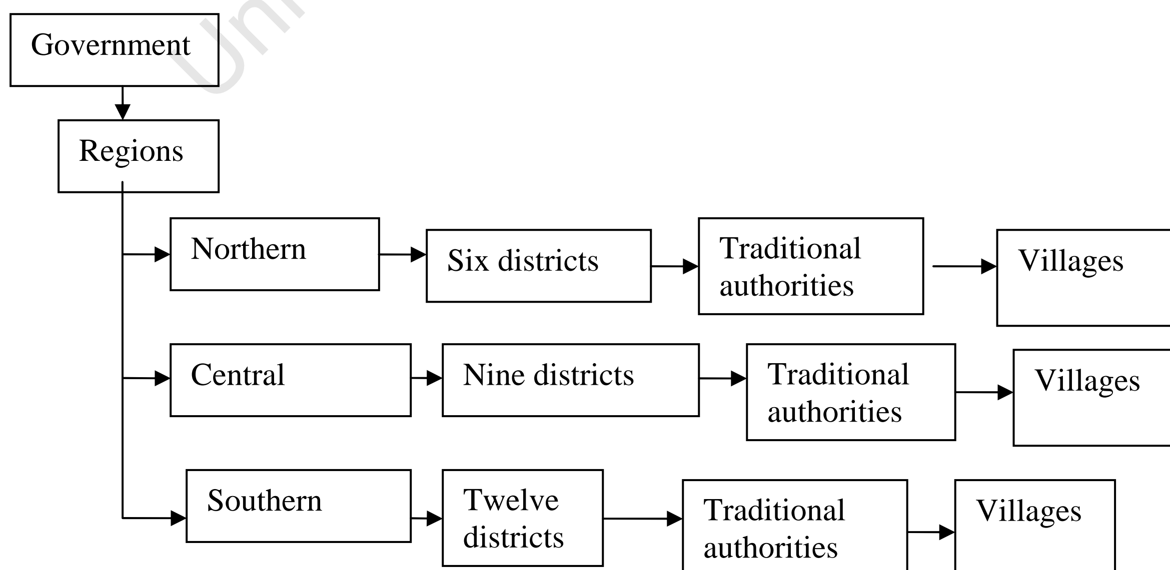
Historically, the country Malawi was named British Central Africa in 1891-1907, then Nyasaland from Lake Nyasa in 1907-1964 (NSO, 2005). Nyasaland was combined with the colonies of Northern and Southern Rhodesia (now Zambia and Zimbabwe respectively) to form a federation (Stevenson, 1964). The federation was known as Federal government of Rhodesia and Nyasaland between 1951 and 1963 (NSO, 2005:1). The federal government movement was protested by black Africans who

were wary of alignment with the ultra conservative white-minority rule in South Rhodesia (Lwanda, 2005). Nyasaland gained independence from Britain on July 6, 1964, and was renamed Malawi (NSO, 2005). Dr. Hastings K. Banda became Malawi's first prime minister (a title that was later changed to president), and ruled under one party government (NSO, 2005). Dr. Bakili Muluzi of the United Democratic Front won the country's first democratic elections in May 1994, ending Dr. Banda's 30-year rule (Lwanda, 2005). In 1999, Dr. Muluzi was re-elected and in May 2004, Dr. Bingu Wa-Mutharika became the second democratically elected president of the country (NAC, 2003).

Administratively, Malawi is divided into three regions i.e. Northern, Central, and Southern. The regions are sub-divided into districts. Northern region is divided up into six districts, Central region has nine and Southern region has twelve districts (see Appendix A). The districts are further sub-divided into Traditional Authorities (TA). Each TA is made up of groups of villages (MoH, 1999a). The village level is the smallest administrative unit in the country of which the village headman is the overall leader (MoH, 1999a). Number of TAs and villages depends on the sizes of districts. Figure 2.2 presents the administrative structure of Malawi. Health service provisions in Malawi including MCH are delivered along these administrative hierarchies (MoH, 1999a).

Figure 2.2: Administrative Structure in Malawi



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2.3 Health services provision in Malawi

2.3.1 Historical account of health services and MCH

The MoH in Malawi started as a medical services department under the federal government of Rhodesia and Nyasaland in 1900 (Baker, 1975). Organizationally, there was a principal medical officer-in-charge of eight medical officers and seven nursing sisters (Baker, 1975). The federal medical services were designed primarily to care for colonial government officials until the early 1920's when services were extended to the local population (Stevenson, 1964). Medical services expanded at unprecedented rate between the end of the World War 2 in 1945 and 1954 (Stevenson, 1964). The expansion was due to the introduction of free government medical services to the indigenous population particularly to soldiers and their families during the World Wars in addition to egalitarian trends in general world politics (Baker, 1975). On the termination of the federation in December 1963, health services provision responsibilities were transferred to individual territorial governments and in 1964 Malawi developed its first NHP (Baker, 1975).

Since independence, curative health services were the primary focus of health service delivery. However, records of specific MCH in Malawi can be accessed dating back to1974 when MCH programme was launched in the country (Levin, 1999). Levin maintained that since then, the government of Malawi had been providing maternal health services, including antenatal care and delivery, immunization against tetanus, prenatal and obstetric care (Levin, 1999). In addition, health and nutrition education was offered to mothers, including promotion of breast-feeding (Muula and Chanika, 2002). Although health services are delivered according to MoH directives, other public and private organisations also provide healthcare to the population.

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2.3.2 Health Services Providers in Malawi

The MoH is the major provider with other organisations such as,

- Ministry of Agriculture (MoA) is responsible for food production and security in the country to ensure healthy nutritional status of every Malawian.
- Ministry of Education (MoE) provides formal education including health education on nutrition, sexual and reproductive health through its formal curriculum. It provides special education programmes such as sexual and reproductive health for girls.
- The Ministry of Gender, Child Welfare and Community Service (GCWCS) is concerned with community development and social welfare. Social welfare activities include building of school blocks, clinics, housing for teachers, roads, bridges, water points and dams. It operates adult literacy classes and collaborates with the Department of Irrigation and Water Development as well as the MoH in the area of water and sanitation service provision. It provides health education on reduction of unplanned pregnancies, abortions and early marriages among the youth through community mobilization.
- Health professional regulatory bodies include the Nurses and Midwifes Council of Malawi (NMCM), and the Malawi Medical Council (MMC) register professionals to provide quality health care to the population
- Training institutions like the University of Malawi and Mzuzu University that train doctors and registered nurses. In addition the Malawi School of Health Sciences trained Clinical Officers (COs), Nurse Midwife Technicians (NMT), Pharmacy Assistants, Laboratory Assistants, Environmental Health Officers/Assistants and Medical assistants. On the other hand, Christian Health Association of Malawi CHAM group of institutions train NMT, COs, and other paramedical staff.

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2.3.3 Healthcare service providers in Malawi

Nearly all formal healthcare services in Malawi are provided by five agencies (MoH, 2006). MoH is the primary provider of healthcare; it provides 60% of all healthcare services in the country (MoH, 2006b). The MoH provides free services at points of delivery and contracts out some services to organisations such as CHAM (MoH, 1999a). The second major health care provider is CHAM that provides 37% health care services (MoH, 2006b). The third group of providers are private health care practitioners. The private sector provides services in varying levels through a vertical approach. Some private organisations provide out of pocket services except International Non Governmental Organizations (INGO), local Non Governmental Organizations (NGO), and faith-based organizations whose services are usually free (MoH, 1999a). NGOs, commercial companies, the Army and Police services provide 2% of healthcare in the country (MOH, 2006b). The fourth provider is the Ministry of Local Government (MLG) that is responsible for 1% of health service delivery (MoH, 2006b). The fifth group of providers are traditional healers and Traditional Birth Attendants (TBA) but their exact numbers and extent of their services are not known (MoH, 1999a).

2.3.4 Levels of healthcare services in Malawi

Healthcare services in Malawi are provided at three levels, i.e. primary, secondary, and tertiary (MoH 1999a). Primary health care services are delivered through rural hospitals, health centres, health posts, outreach clinics and community initiatives such as the revolving drug fund systems (MoH, 1999a). At TA and Village levels, primary health care services are provided by TBAs, traditional healers, mobile clinics, health posts, health centres and rural hospitals (MoH, 1999b). Secondary level healthcare is provided by public district and CHAM hospitals, whose main function is to back up activities of primary level health facilities (MoH, 1999a). Secondary healthcare facilities provide surgical back up services mostly for obstetric emergencies, general medicine and paediatric in-patient care for acute conditions (MoH, 1999a). In each district, a district hospital is located in urban area of that particular district, while mission hospitals are randomly situated reflecting colonial missionary settlements (MoH, 1999b). District and CHAM hospitals refer serious cases to tertiary hospitals

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within a region in which the district hospital is situated (MoH, 1999b). Tertiary level healthcare is provided by central hospitals (government or private). They provide services similar to those at secondary level, in addition to wide range of specialist surgical and medical interventions (MoH, 1999a). District, CHAM and tertiary hospitals also provide primary healthcare services to the population living near the hospitals (MoH, 1999b).

2.3.5 Strategies for delivering healthcare services in Malawi

The health sector's goal in Malawi is to improve health status of all Malawians through healthcare delivery system capable of promoting health, preventing and curing diseases, protecting life, increasing productivity, and reducing occurrence of premature deaths (MoH, 2004b). PHC remained the main healthcare delivery strategy until 2004 (MoH, 2004a). The focus of PHC was on cost-effective package of essential health services with communities as main stakeholders (MoH, 1999a; MoH, 2004a). At the time of writing this thesis, the overarching strategy for healthcare provision was based on SWAp for delivering EHP (MoH, 2004b). EHP focuses on the provision of basic cost-effective package of promotive, preventive and curative health services (MoH, 2004a; MoH, 1999a). EHP service delivery package is in line with Health Sector Reforms (HSR) currently being implemented in Malawi.

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2.4 Health sector reform in Malawi

These are major changes in the Malawian health sector which are being promoted by International organizations, such as the World Bank (Omar, 2002). HSR tend to be based on criticism of state dominated, inefficient and centralized public sector (Frenk, 1994; Bossert, 1998). However, the common prescriptions for change within the public health sector include greater involvement of the private sector, decentralization, separation of financing and provider functions, and the introduction of new financing mechanisms for health care (Walt and Gilson, 1994).

According to MoH (1999a), MoH in Malawi embarked on various reforms to improve the health sector. MOH (2004b) stipulated that decentralization for health provision in Malawi involved devolution of health service delivery to District Assemblies. In this

context, MoH retained stewardship for policy formulation, policy enforcement, and regulate health care (MoH, 2004b). In addition, MoH maintained its role in establishment and enforcement of healthcare standards, training and curriculum development, and international representation (MoH, 2004b). Another HSR underway in Malawi was implementation of SWAp (MoH, 2004b). According to Peters and Chao (1998), SWAp is when all significant funding for the sector supports a single sector policy and expenditure program, under government leadership. MoH adopted SWAp as the overarching strategy for implementing the Joint Programme of Work (JPoW) in 2004 (MoH, 2004b). JPoW is a six-year NHP for 2004-2010 that forms the sector wide programme for health in the country (MoH, 2004b). Six core areas targeted for reform include decentralization of health services management, human resource development, health financing, hospital autonomy, essential health package and districts' capacity building (MoH, 2004b).

The MoH services are financed entirely by the government and international donors (WHO, 2005b; MoH, 2006b). MoH (2006b) argues that health expenditure is inadequate, for example the cost of delivering cost effective basic healthcare like EHP was calculated at US$17.53 per capita per year in 2000 (NSO, 2001). At the time of writing, public health services in Malawi were free at the point of delivery (MoH, 2006). However, in line with health sector reforms, Malawi government was in the process of exploring mechanisms for cost sharing, whilst maintaining free services for vulnerable members of the population (WHO, 2005b). For example, optional fee paying facilities in all public hospitals for users with the ability to pay and health insurance for employees in the formal sector (WHO, 2005b). In addition to the reforms, there are other factors that influenced health as well as MCH in Malawi.

2.5 Factors Influencing MCH in Malawi

Several factors influence the health of mothers and children in Malawi. These include accessibility to health services, shortage of healthcare personnel, poverty, literacy and gender inequalities. Some of these factors directly or indirectly contribute to morbidity and mortality amongst mothers and children.

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2.5.1 Mortality rates

Maternal mortality

Maternal mortality rate almost doubled from 620/100 000 per live births in 1992 to 1120/100 000 live births. According to NSO (2005), Malawi's MMR was estimated in 2004 to be about 984 deaths per 100 000 live births. Mann, Bokosi and Sangala, (2006) stated that major determinants of this MMR rates were high fertility rate, low uptake of family planning services (14%), large percentage of high risk pregnancies, poor access to essential obstetric services and poor quality of obstetric services. An Emergency Obstetric Care (EmOC) Services Assessment in Malawi in 2005 showed that most deaths were due to direct factors relating to pregnancy, labour and postpartum (MoH, 2005). For example, thirty-nine percent of maternal death were due to ruptured uterus and obstructed labour whilst 19% were dues to postpartum sepsis; obstetric haemorrhages (14%), disorders of hypertension (8%) complications of abortion (5%); ectopic pregnancy (2%); and retained placenta accounted for 1% (MoH, 2005). On the other hand, indirect causes of maternal deaths contributed 15 percent of all deaths (MoH, 2005). It must be noted however that percentages given in brackets here are with reference to total from only facility-based data. According to Hoffman (2004), the numbers of maternal deaths occurring in communities are significantly high, although the exact figure is not known since they are not recorded. For example, community audit of maternal deaths undertaken by the Nankumba Safe Motherhood Project in Mangochi, reported that 44% of maternal deaths occurred at home, in transit to hospital, or at the TBA or at home (Hofman, 2004).

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Neonatal and child mortality

According to NSO (2005), neonatal mortality accounts for 40% of infant mortality in Malawi. The major causes of neonatal mortality are infections, complications during delivery (e.g. asphyxia and trauma), pre-maturity and delays in getting to health facilities as well as complications of pregnancy (MoH, 2005; WHO, 2005a). In 1992, the infant mortality rate (IMR) was 134 per 1000 live births and U5MR was 234 per 1000 live births (NSO, 1993). NSO (2001), indicated that IMR and U5MR improved to 104 and 189 per 1000 live births, respectively in 2000 (NSO, 2001). For the past 15 years, the estimates indicated that, Infant Mortality Rate (IMR) declined by 30 percent

(from 104 to 76 per 1,000 live births), and U5MR declined by 27 percent from 190 to 133 per 1,000 live births (NSO, 2005). According to MoH (1999b), under-five mortality is caused by malnutrition, anaemia, pneumonia and diarrhoeal diseases. In addition to high maternal and child mortality rates a variety of disease conditions also influenced of MCH in Malawi.

2.5.2 Disease conditions

Communicable diseases - HIV/AIDS/TB

Levels of HIV infection in the adult population of Malawi remained constant over the past decade at about 12%-17% (NSO, 2005). The total number of people infected with HIV was estimated to be about one million in 2003, including about 80 000 children under the age of 15 (NSO, 2005). Mann et al (2006) argued that one-third of those infected, live in urban areas and two-thirds in rural areas. He maintained that over 800 000 children under the age of 18 are orphans (Mann, 2006). NSO (2005) also stated that the downward trend of life expectancy in Malawi is attributed to the HIV/AIDS epidemic, for instance death rates for persons aged 15-49 tripled since 1990. In Malawi, HIV/AIDS is the leading cause of death amongst the reproductive age group. HIV/AIDS accounts for over 40 percent of all in-patient admissions and 70 percent of mortality in hospitals (MoH, 1999a). The proportion of maternal deaths due to AIDS is estimated to be 25 percent, and mother-to-child transmission accounts for 25 percent of all new HIV infections (Ratsma, 2003).

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In addition, HIV sero-positivity rate among women attending antenatal care in 1995 was more than 30 percent in urban areas and 12 percent of population age group was living with HIV/AIDS (UNAIDS, 1999). HIV/AIDS directly affects health of infected women, increases the risk of complications of pregnancy and childbirth (WHO 2005a). These complications include miscarriage, anaemia, postpartum, haemorrhage, puerperal sepsis and post-surgical complications (WHO, 2005a). HIV/AIDS is also a major indirect cause of maternal mortality through increased rates of malaria and opportunistic infections like tuberculosis (Mclntre, 2003). Children of HIV-positive mothers have high mortality rate than children of HIV-negative mothers (Monasch and Boerma, 2004). HIV infection in children is almost always acquired

through mother-to-child transmission and 60% of infected children die before their fifth birthday (Monasch and Boerma, 2004).

In Malawi, HIV/AIDS accounts for up to 10% of child deaths (Newell, Brahmbhatt and Gyhs, 2004). According to WHO, (2005a) HIV/AIDS puts additional strain on fragile health systems because it generates demand for new services. For example, prevention of mother-to-child transmission, HIV counselling and testing, and other complex diagnostic procedures (Tawfik and Kinoti, 2001). Such new services call for increased spending on infrastructure, technical and human resources. In developing countries that do not have adequate health funds, MCH services are affected (WHO, 2004).

NSO (2005), stated that tuberculosis (TB) cases doubled in the last 10 years, i.e. 14 322 cases were reported in 1991 and 27 000 cases in 2004 in Malawi. The increase of cases had been attributed to low immunity due to HIV infection (NSO 2005). Mortality rate among TB patients is still high, for instance 21% in smear positive patients and in smear negative patients mortality rate ranged from 30% to 50% (Nyirenda, 2006). Lack of facilities, shortage of personnel, and poor quality of services and high infection rate of HIV in TB patients may be the major contributing factors to the high mortality (Nyirenda, 2006). NAC (2003) stated that this is a cause of great concern. However, the cure rate improved from 65% in 1996 to 73% in 2003. In addition, the advent of ARVs provides some hope for the future (NAC, 2003).

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Malaria

Malaria was one of the most commonly reported causes of morbidity and mortality particularly amongst pregnant women and children. For example, about 40% of deaths of children below 2 years of age were reported to be related to malaria in 2000 (NSO, 2001). In addition, incidence of malaria in pregnant women in Malawi is 18.7 percent and is associated with pregnancy loss, low birth weight, and neonatal mortality (Dzinjalamala, 2006). Malaria is also one of major causes of anaemia in children and pregnant mothers (Dzinjalamala, 2006; Harrison, 1997). For instance,

about 56 percent of women attending antenatal care in Malawi have anaemia due to a combination of malaria and malnutrition (MoH, 1999a).

Non-communicable diseases

There is a growing awareness of the increase of non-communicable diseases such as hypertension, diabetes, cancer, asthma, mental health problems and oral health (WHO, 2005b; MOH, 1999b). On the other hand, there is insufficient information on non-communicable diseases on which to determine trends in magnitude and to monitor morbidity and mortality in Malawi (MoH, 2007). However, WHO (2005b) stated that indications from clinical settings reveal that cases of diabetes, hypertension and cancer are on the increase.

2.5.3 Other factors

Other factors influencing MCH in Malawi include inadequate access to health care facilities, severe shortage of health care personnel in the country, inadequate and inefficient allocation of financial resources, poverty resulting in malnutrition, and literacy amongst women in the country.

Inadequate access to health services

Various factors contributed to inadequate accessibility of healthcare services in Malawi. Distance from health facility, poor road networks, limited financial capacity especially in areas served by private health facilities, and cost of transport act as a disincentive in the decision to seek health care (Thaddeus and Maine, 1994; MoH, 1999b; WHO, 2005b). Only 46% of the population live within 5km of orthodox healthcare facility in Malawi (MOH, 2002b). MoH, (1999b) argued that limited financial capacity often discourages the poor from seeking healthcare because of their inability to pay for such services. Mann et al (2006) stipulated that another factor contributing to inadequate accessibility of healthcare services is the status of availability of the services. Inadequate facilities, lack of drugs, supplies, human resource and equipment have resulted in unavailability and poor quality of services.

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For example, only 42% of facilities had required human resource during the day, while 13% of facilities provided 24 hour services in 2005 (MOH, 2007). In addition, Malawi had only 2% of the recommended minimum number of Basic Emergency Obstetric Care (BEmOC) facilities required (MoH, 2007).

Shortage of health care personnel

Malawi Government, MoH in particular is challenged by acute shortage of skilled personnel (WHO, 2005b). Compounding the problem is inequitable distribution of available qualified health care personnel in the country (MoH, 1999b). Distribution of staff still favours urban areas whereas 87% of the population live in the rural areas of the country (WHO, 2005b). This is due to unattractive working environment in rural areas, i.e. lack of social and educational facilities including accommodation (MoH, 1999b). According to MoH (1999b), 68% of medical officers and 64% of registered nurses work in tertiary healthcare facilities. Shortage of health personnel is also exacerbated by various factors like HIV/AIDS related illnesses (MoH, 1999b). Malawi, experiences high staff attrition rates due to retirement, resignations, and exodus to industrialized countries e.g. of 108 nurses who left Malawi in 2003, ninety were reported to be working in United Kingdom (WHO, 2005b).

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There were approximately twenty-nine nurses per 100 000 population in Malawi, compared to 85 nurses per 100 000 in South Africa, Zimbabwe and Tanzania, respectively in 2004 (WHO, 2005b). Similarly, Malawi had one physician per 100 000 population, compared to 56 in South Africa and seven in Zambia (WHO, 2005b). Furthermore, 11 health centres out of 357 met MoH staffing standards with district hospitals under-staffed with about 22 nurses per district hospital compared to the 175 nurses required (WHO, 2005b; MoH, 2004b). In addition, ten of the twenty-seven districts health facilities including some within the private sector are manned by clinical officers instead of medical officers, (MEDP, 2008).

Inadequate and inefficient financial resource allocation

According to MoH (2006), Malawi's health system was financially under-resourced, for instance, the country's per capita expenditure on health care was about U$20, severely restricting health services delivery (MEDP, 2008; MoH, 2007). According to MoH (2007), WHO recommends minimum per capita investment on health of US$34. In addition, New Partnership for Development (NEPAD) member states agreed on a minimum of 15% of the national budget allocation for meaningful health development of which Malawi trails at 9% during 2003/2004 (MoH, 2006; WHO, 2005b). Consequently, Malawi experiences persistent shortage of drugs, medical supplies, and equipment (MOH, 1999b). Inadequate and inefficient financial allocation is also compounded by high population growth, and increasing disease burden such as HIV/AIDS/TB (GAVI, 2005; MoH, 1999b). Despite population increase, available health services are not expanding (Jamison et al, 2006; MoH, 1999b).

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Poverty

Poverty is the state of being poor; lacking the means of providing material needs and means of accessing services (Nelson, 1990). In terms of Gross National Product (GNP) per capita, Malawi with GNP per capita of PPP US$ 605 in 2003 is one of the poorest countries in the World (Graham et al, 2004). It is estimated that over 65 percent of Malawians live on less than one US$ per day. Bowie (2006) argued that poverty is the underlying cause of many social and health problems as well in Malawi. However, Bowie (2006) reported that not everyone in Malawi is poor. For instance, the richest 10% of the population had per capita income that was eight times higher than the poorest 10%. For example, in 1998, the least poor 20% of the population consumed almost 7.5 times as much as the population's poorest 20% (NSO, 1999). In addition, Bowie (2006) elaborated that there are significant inequalities in resource consumption and that the population's top 10% consumed over twelve times as much as the bottom 10%.

The inequality in resource consumption also underpins accessibility and utilization of health services. According to Mann et al (2006) the poorest 10% of women are twice as likely to give birth at home with the aid of a TBA. He argued that consequently the

poorer and rural women are less likely to be delivered by skilled attendants, e.g. nurse-midwives, clinical officers or doctors (Mann et al, 2006). Furthermore, maternal deaths among poor and rural women are higher and less likely to be reported (Mann et al, 2006). According to Jamison et al (2006), poverty also directly influences nutritional status and well-being of mothers and children in Malawi.

Malnutrition

According to the MoH, (1999a), malnutrition is endemic in Malawi, with 50% of under-five children chronically malnourished. Malnutrition is reported to have increased vulnerability of children to common infectious diseases and anaemia (MoH, 1999a) and is attributed to poverty, poor weaning and feeding practices, and frequent infections (Wansi et al, 2001). In addition, pregnant women who become pregnant in a state of nutritional deficit were unprepared to cope with the extra physiological demands of pregnancy (Jamison et al, 2006).

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Literacy rates amongst women

Literacy in Malawi is estimated to be about 51.3% of women while 24.5% of men were functionally illiterate (NSO, 2005). NSO (2005) also stated that up to 80% of rural women can neither read nor write with secondary school enrolment at 4%. According to Mann et al (2006), level of education has a strong correlation with health service utilization. For instance, it is reported that with education, women are less likely to engage in harmful practices and beliefs in supernatural causes of illness or death (Ghebrehiwot 2004; Harrison, 1997). Mann et al (2006) stipulated that use of traditional healers and Traditional Birth Attendants (TBAs) is associated with delays in seeking care from health facilities, complications of morbidity and mortality. However, for maximum impact on health care utilisation, Mann et al (2006) argued that education up to secondary level is necessary but this also partially reflects the fact that majority of educated women live in urban areas with greater access to health facilities.

Gender inequalities and women's empowerment

Gender inequality, in my definition, is the unequal access to health services between the two sexes. While women's empowerment refers to the ability of women to transform economically and socially to fully participate in the decisions that affect their lives. WHO (2005a) suggested that a country's full and complete development requires the maximum participation of women on equal terms with men in all fields. Women in Malawi, constitute 51% of the population (NSO, 2005), but have been discriminated against both in terms of participation in development efforts and benefiting from services (IMF, 2007). The IMF (2007) also reported that there are still very few Malawian women in key decision-making positions and their representation in parliament (14%) is still far less than the stipulated number (30%) specified by Southern African Development Community (SADC) member states. At community level, women have little control over decisions made relating to their health. For instance, MOH (2005) elaborated that decisions to attend antenatal care are usually made by husbands and the women's uncle. IMF (2007) argued that education is a key factor for women empowerment. However, women tended to have lower education levels than men leading to their lower participation in many areas of development.

2.6 Health policy process in Malawi

The term policy broadly refers to expressions of general purpose, decisions, practices, statements, purposive course of actions, regulations and laws (Barker, 1996; Hogwood and Gunn, 1984). The definition implies that health policy involves decisions by actors involved and/or related to healthcare and extends beyond health services and includes environmental and socio-economic effects on health (Collins, 2005). In this paper, MCH policy referred to expressions of agreement on general purpose, decisions, practices, statements, purposive course of actions, regulations and laws on the MCH issues. According to Parsons (1995) and Hogwood and Gunn (1984), policy process includes issue search and agenda setting, issue definition, setting objectives and priorities, and analysis of the policy options and selection of the best options. In addition, policy process includes policy implementation, monitoring and evaluation, policy review, and policy maintenance, succession and termination.

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Walt (1994) further argued that policy process approach could either be bottom-up or top-bottom.

Policy-making in Southern African countries shared some common features (Gaidzanwa, 2001). Gaidzanwa (2001) argued that there was very little capacity development and participatory abilities of the colonized people of Southern Africa (Gaidzanwa, 2001). Thus, at independence there was lack of capacity in policy formulation, analysis, and implementation within the newly independent countries (Gaidzanwa, 2001). This problem was compounded as the new leaders' favoured patrimonial relationships with the people and used authoritarian leadership styles of colonialism (Hossain and Myllyla, 1998). The situation resulted in centralized, hierarchical, and bureaucratic forms of public administration leading to predominantly top-down policy approaches (Hossain and Myllyla, 1998). The public administrative structures also provided very little room for policy players from outside the civil service to participate in a meaningful policy-making (Gaidzanwa, 2001).

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Health policy process in Malawi is similar to that of Mozambique, Zambia and South Africa where the approach is mainly top-down. Mozambique Ministry of Health (MMoH) defines sectoral policies and objectives for several years basing on reports from Provincial Health Departments [PHD] (MMoH, 2001). MMoH analyze reports from PHD and develop sectoral policies in consultations with PHD. PHD formulated their plans and programmes in order to implement and monitor government policies formulated by ministry of health (MMoH, 2001). In Zambia, Ministry of Health (ZMoH, 2005) formulates policies and mobilizes resources for implementation which are then passed to central board of health (ZMoH, 2005). The central board of health is responsible for commissioning health services, interpretation of policies and legislation into technical guidelines, monitoring policy implementation and evaluation (ZMoH, 2005). Information for policy is provided through health statistical bulletins and epidemic reports as well as district performance assessments and policy reviews (ZMoH, 2004). The policy formulation process followed at national level in South Africa involves development of draft policy by a particular programme/directorate within the national department of health (Shung-King, 2006). The draft policy is

developed through a consultative process with various stakeholders and circulated for comments to other directorates, national departments and other stakeholders. Comments are considered and final policy document is compiled and presented to Provincial Health Restructuring Committee (PHRC). Upon acceptance by PHRC, the policy is approved by Ministers and members of Executive Council (Shung-King, 2006).

In Malawi, the predominant approach for policy process is that of top-down approach. In top-down approach the coordinating body, e.g. Reproductive Health Unit (RHU) or MoH planning department initiates needs assessment based on international trend or influenced by donors but in consultations with health organizations, individual health experts, health regulatory bodies, training institutions and implementers through workshops (MoH, 2002). An example is formulation of the Road-Map and RH policy following needs assessment RHU or MoH planning department drafted and circulated a policy document.

Although several MCH policies did exist in Malawi, at the time of writing, no research on health policy analysis had been done. However, the Office of Vice President made efforts to analyze policies in 2000 (Malawi Government, 2000). The office of presidency analyzed Commence and Industry sector policies to explore trends and develop policy framework for the economic sector (Malawi Government, 2000). Some of their findings included that economic policies in Malawi are donor-driven and influenced by international policies. This was found to be because Malawi is a donor dependent country. In addition, formulation of economic policies in Malawi was supported by external donors both financially and technically due to the external influence as well as limited human capacity in the country. At the time of the study, no such analysis had been undertaken in the health sector of Malawi, hence the need for this study. For this reason the study used theoretical models for health policy analysis from literature.

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2.7 Theoretical models of public health policy

Policy scientists have used numerous strategies to approach public policy analysis (Fox, Bayat and Ferreira, 2006). Hanekom, (1987) identified and described two main forms of policy models, i.e. prescriptive (normative) and descriptive models.

2.7.1 Prescriptive models

The models forming the prescriptive approaches are founded in decision-making. However, they have become applied to policy analysis in an attempt to reveal constraints in public policy process (Fox et al, 2006). They are carried out to inform formulation of a policy e.g. formative evaluation, or anticipate ways that a policy might fare if introduced e.g. responses of other stakeholders to the proposed changes (Buse, Mays and Walt, 2005).

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Green (2007) described three models forming prescriptive approaches for public policy as the rational-comprehensive, incremental and mixed-scanning models. The rational-comprehensive model implies that the policy maker has a full range of options from which to choose (Fox et al 2006). Policy analysis therefore is concerned with how these options are selected. According to Hanekom (1987), the incremental model to policy making is usually associated with Charles Lindblom, who used the term in his criticism of the rational-comprehensive decision-making model. The incremental model postulates that a limited number of alternatives, differing marginally from the status quo and from which the policy maker has to make a selection is available. In the incremental model, public policy is regarded as the continuation of existing government activities, with only small (incremental) adaptations to provide for changes that may occur (Hanekom, 1987). Mixed-scanning policymaking integrates the good qualities of the rational-comprehensive model with those of the incremental, first by reviewing the overall situation or policy and second, by concentrating on the deviation, i.e. the specific need, or negative policy result or impact (Hanekom, 1987).

2.7.2 Descriptive approaches

The second category of policy analysis approaches is the analysis of policy itself, which turns out to be retrospective and descriptive (Buse et al, 2005). It looks back at why or how a policy made its way to the agenda, its content, and whether or not and why it has achieved its goals e.g. formative evaluation. Descriptive models can be traced to decision-making models, which were adapted for or applied to policy making and can be successfully applied to policy analysis (Hanekom, 1987).

According to Fox et al (2006), the descriptive models include the functional process, elite/mass, group, systems, and institutional models. The functional process model looks at the "whom and how" of policymaking, representing actions and processes involved in policymaking and management (Fox et al, 2006). The elite/mass model represents policy formulation by small elite in the cabinet or by the government. This group governs a large, passive, and ill-informed public (the masses) Fox et al, 2006. Policy made by the elite flows downwards to the masses and is implemented by public officials and government institutions specially chosen for this purpose (Hanekom, 1987). The group model represents public policy, which is derived from interest groups that are able to influence policy by continuously interacting with policy makers and acting as links between such policy makers and individuals (Fox et al, 2006). For public policy making, the group model is ideal in that it can concentrate on the role of interest groups in the process at the initiating or adaptation of policy or both (Hanekom, 1987).

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According to Hanekom (1987), the systems model of policy making is regarded as response by the political system to the demands, wants, needs, problems and goals of interest groups or individuals. As a model for public policy, the systems model can provide information on such aspects as effectiveness of the feedback process and the degree to which feedback information is incorporated in existing or new polices (Hanekom, 1987). The institutional model is based on the premise that public policy is the product of public institutions responsible for its implementation. As public policy is legitimised by government, they have important bearing on policy results (Fox et al, 2006). Consequently, relationship between structure and policy should

always be taken into account in policy analysis (Hanekom, 1992). Fox, Schwella and Wissink (1991) introduced contingency model for policy development derived from public management. They argued that contingency model perceives policy process as situational bound that could change as needs of the particular environment fluctuate (Fox et al, 1991).

Buse et al (2005), categorized both prescriptive and descriptive approaches to public policy as types of policy analysis. This study adopted the descriptive approach to public health policy analysis. This was because the study examined Malawian health policies from 1964 to 2008 (previous and current MCH policies). Walt and Gilson, (1994) suggested that for both prescriptive and descriptive, the policy content, process, context and stakeholders, are essential analytical aspects for a conceptual framework for analyzing health policies. Therefore, Walt and Gilson's framework for health policy analysis formed the basis for the study's conceptual framework.

2.8 Conceptual framework for the study

Conceptual framework for analyzing MCH policies in Malawi was adapted from Walt and Gilson (1994) framework. Walt & Gilson (1994) introduced a model for health policy analysis that examines four areas of health policy, i.e. content, context, process, and actors.

2.8.1 Analysis of health policy content

Analysis of policy content focuses on what policy documents state. According to Shung-King, (2006), there are no guidelines as to what constitute policy documents. On the other hand, content of policy documents depends on a number of factors. Green and Collins (2006) suggested that one of those factors is the purpose, which can vary significantly. Nevertheless, Hardee, Feranil, Boezwinke and Clark (2004), suggested that written policy documents should include the following components,

- Rational - including a statement of the programme and justification for the policy
- Goals and objectives - what the policy is expected to achieve and specific time frame for achievement

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- Programme measures – outlined broad categories of activities
- Implementation and institutional arrangements - including organizations and ministries involved
- Funding and other resources - levels and sources required including human resources
- Plans for monitoring and evaluation

2.8.2 Analysis of Context of health policy

Analysis of policy context focuses on the environment in which the policy statements were made (Walt, 1994). Context refers to systemic factors, e.g. political, economic and social, both national and international, that may have effect on health policy (Buse et al, 2005). There are many ways of categorizing such factors but Leichter (1979) provides one useful way. He categorized contextual factors as situational, structural, cultural, and international or exogenous factors. Situational factors are transient, impermanent or extraordinary conditions, which can have an impact on policy, e.g. wars or droughts or the HIV/AIDS epidemic. Structural factors are relatively unchanged elements of society, e.g. the political system, type of economy, employment base, demographic features or technological advance. Cultural factors may also affect health policy, e.g. male family members making healthcare decisions for their women folks. International or exogenous factors are leading to greater inter-dependence between states, influencing sovereignty or cooperation in health. Although, national governments deal with many health problems, some need cooperation between national, regional or multilateral organizations. To understand how health policies change or not, means being able to analyze the context in which they are made.

2.8.3 Analysis of health policy process

Analysis of policy process examines steps involved in developing a policy. Process refers to way that policies are initiated, formulated, negotiated, communicated, implemented and evaluated. The most common approach to understanding policy process is to use “stages heuristic” (Sabatier and Jenkins-Smith, 1993). Stages heuristic is breaking the policy process into series of stages but acknowledging that this is a theoretical model and does not necessarily represent exactly what happens in

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the real world (Sabatier and Jenkins-Smith, 1993). According to Sabatier and Jenkins-Smith, 1993, the first series of stages is *Problem identification and issue identification* that explores how issues get onto policy agenda and why some issues do not. The second series of stages is *Policy formulation* that explores people involved in formulating policy, how polices are arrived or agreed upon and communicated. The third series of stages is *Policy implementation*, which explores how policy was executed to ascertain whether, reasons for policy failure. The fourth series of stages is Policy evaluation, which identifies what, happens once a policy is put into effect, monitored, or achieved its objectives. This may be the stage at which polices are changed or terminated or new policies introduced.

2.8.4 Analysis of actors/stakeholders

According to Walt (1994), actors and stakeholders may be used to denote individuals, e.g. a Minister, organizations, e.g. WHO, or companies, e.g. pharmaceutical companies. Actors may influence policy process at the local, national, regional or international levels. The extent to which actors are able to influence policy will depend on their perceived or actual power. Power may be characterized by mixture of individual wealth, personality, level or access to knowledge or authority. Nevertheless, power is inherent within the organization and structures that individual actors work and lives. The relationship of these four areas is presented diagrammatically in Figure: 2.8a. Figure 2.8b presents an adapted conceptual framework for the study.

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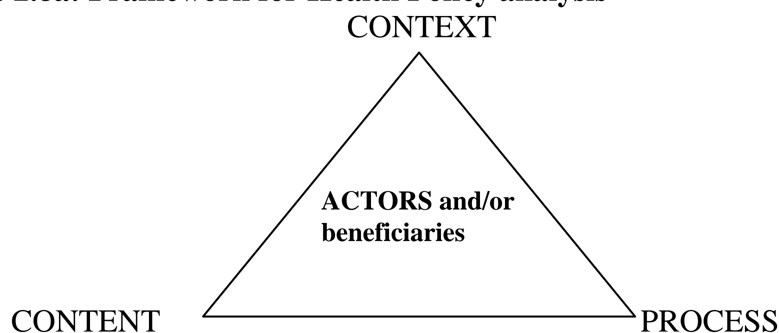
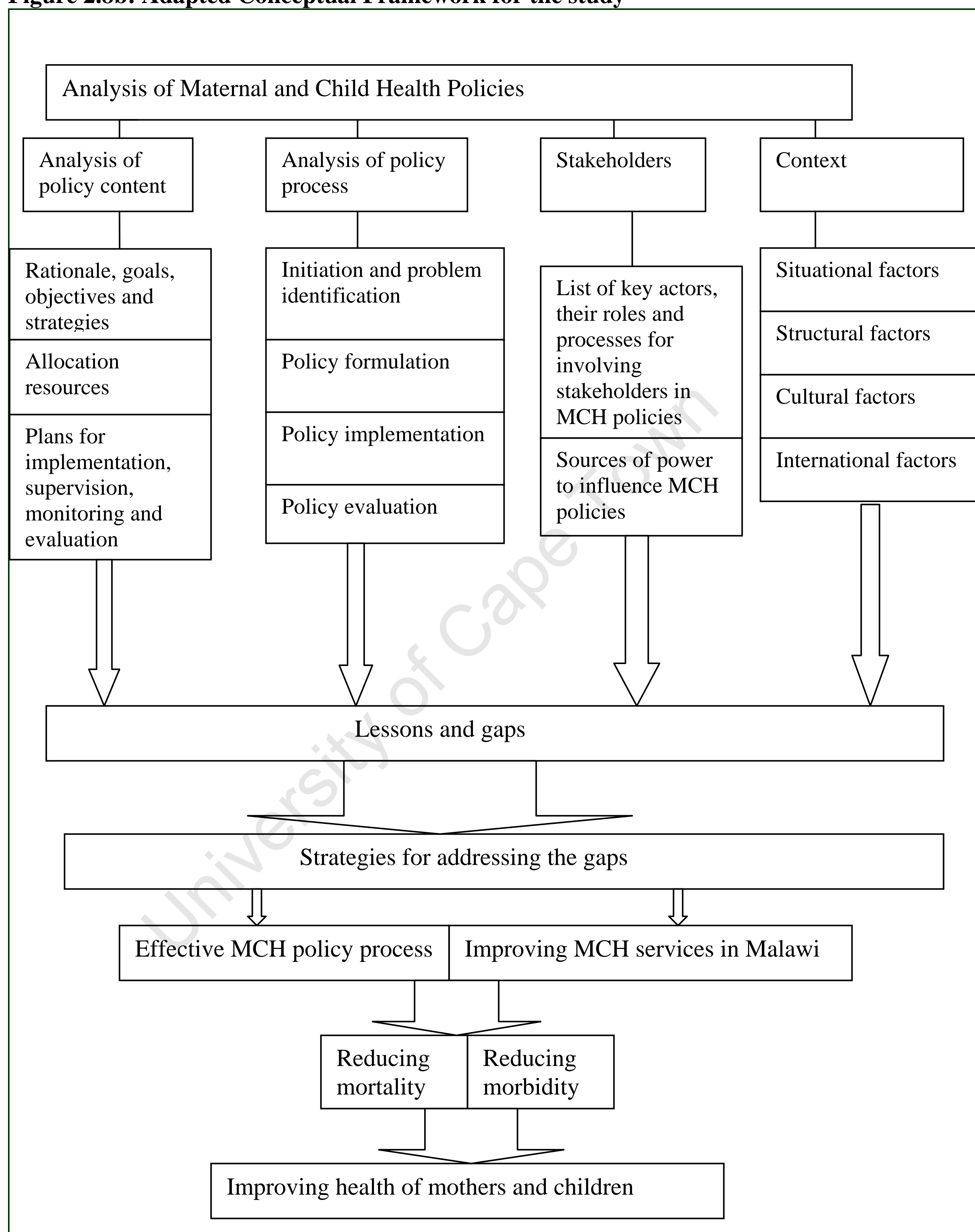
Figure 2.8a: Framework for Health Policy analysis



Source: Walt and Gilson (1994)

Figure 2.8b: Adapted Conceptual Framework for the study



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Source: Adapted from Walt and Gilson (1994)

The conceptual framework outlines information, which was collected under each analytical concept of MCH policies in Malawi based on adapted framework from Walt and Gilson (1994). The information collected was analyzed to identify lessons as well as gaps in Malawian MCH policies. Following that, recommendations for improving MCH policies were proposed as strategies for addressing identified gaps. Ultimately, if the recommended strategies will be accepted and implemented in Malawi, the health of mothers and children is anticipated to be improved by reducing morbidity and mortality. Nevertheless, the conceptual model does not stipulate how this information for the study was collected. The next chapter will outline the study methodology, research designs and methods for data collection as well as analysis.

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Chapter Three

METHODOLOGY

3.1 Introduction

Chapter two described the study context and adapted conceptual framework for the study. Chapter 3 presents methodology employed in this study. The chapter describes qualitative research methodology and rationale for its selection for the study. In addition, the chapter presents the three qualitative research designs employed for the study, i.e. evaluative research, multiple case studies and grounded theory. The chapter delineates methods and processes of data collection including study population and criteria for selections of samples. Finally, the chapter outlines process of data analysis, ethical considerations, and implications of the study.

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3.2 Qualitative methodology

For the purpose of this study, qualitative research methodology was selected because qualitative research studies naturally occurring events (Bowling, 1997). In addition, the richness of qualitative data has strong potential to reveal complexities of processes, relationships and interactions (Bowling, 1997). This study explored processes and context of policy development and implementation, as well as interaction of actors for MCH policies in Malawi. Three qualitative research designs were selected and triangulated, i.e. evaluative research, multiple case studies, and grounded theory. It was anticipated that by using multiple research approaches, the strengths of each approach would complement and minimize any biases introduced by the others (Patton, 2002).

3.2.1 Evaluative research

In its widest context, evaluation is concerned with systematic collection of information to explore effectiveness and characteristics of programmes in order to improve their outcomes (Ross and Freeman, 1993). Ovretveit (1998), described different types of evaluation techniques, e.g. process evaluation and pluralistic

evaluation. Process evaluation uses qualitative strategies though not exclusively, to assess progress, gain insight into how the programme or intervention was organised and worked. Lazenbatt (2002), suggested that pluralistic evaluation examines stakeholders' perspectives of programme success or failure. Holloway (2005) argued that within evaluation traditions, differences of opinions exist about the role that qualitative evaluations play in the wider policy-making context. It could be argued that qualitative evaluation, whatever its philosophical framework provides an account of what is going on from the perspectives of those involved in implementation of policies/programmes (Holloway, 2005). This design guided the study to obtain information about MCH policies in Malawi from various stakeholders. The design also enabled the researcher to review MCH policy documents to identify lessons and gaps in MCH policies in Malawi.

3.2.2 Multiple case studies

Creswell (2007) and Hancock (2002), defined multiple case studies as a qualitative approach in which the investigator explores issues through multiple bounded systems over time. The main reason for selecting multiple case studies for this study was that questions about MCH policies and practices involve local and national health politics. According to Pope and Mays (2000), many health policies and interventions depend on the involvement of several stakeholders for their success. Each stakeholder may have a legitimate but different interpretation of events. Capturing those different views is best achieved through interviews and other qualitative data collection strategies within case-study. The strength of multiple case study designs is that each case provides insights and explanation into complex real world developments with each case (Pope and Mays, 2000). In this study, the MoH national headquarters, tertiary and district hospitals, and health centres were selected as multiple healthcare settings for the study. As such, multiple case study research design guided the researcher in selecting research participants and key informants from each of the settings.

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3.2.3 Grounded Theory

Strauss and Corbin (1990:3-4) defined grounded theory as a "*theory that" is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis and theory stand in reciprocal relationship with each other"*. They argued that grounded theory seeks to develop theory that is grounded in data systematically gathered and analyzed (Strauss and Corbin, 1998). Strauss and Corbin, (1998) further elaborated that a key feature of grounded theory is the constant comparative method of analysis in which data collection and analysis are simultaneous and interactive processes. The selection of Grounded theory as one of the research designs in this study was to guide data collection and analysis. Data was collected through documents review, self-administered questionnaires, interviews and field visits. Simultaneous data collection and analysis process was utilized during data collection to compare previous collected data with new data in order to enrich data collected.

On the other hand, Glaser and Strauss (1967) defined grounded theory as the inductive process of coding and identifying analytical categories as they emerge from the data. For example, developing hypotheses from the ground or research field upwards rather than defining them prior. Pope and Mays (2000) argued that analytical categories may be derived inductively, obtained gradually from the data or used deductively, at either the beginning or half way through the analysis as a way of approaching the data. They argued that though less commonly associated with qualitative research, various deductive forms of analysis have been utilised increasingly in applied qualitative research (Pope and Mays, 2000). Pope and Mays, (2000) continued that framework approach appeared to have been developed specifically for applied or policy relevant qualitative research in which the objectives of the investigation are typically set in advance. Although the framework approach is heavily based in the original accounts and observations of the people studied (that is grounded and inductive), it starts deductively from the aims and objectives already set for the study (Pope and Mays, 2000). Data collected for this study was analyzed utilizing content analysis principles from grounded theory based on the framework

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approach. In this approach patterns of data were categorized according to study objectives and conceptual framework. Study results were also presented according to aims and objectives of the study.

3.3 Process of data collection

Based on literature review, initial self-administered questionnaire, interview guide, and field visit guide were constructed. After construction of the data collection tools, ethical clearance and permission to collect data in Malawi was sought from the Health Research Council of Malawi, (see Appendix B). In addition, clearance to proceed with the study was also sought from the Health Sciences Faculty Human Ethics Committee of the University of Cape Town [UCT] (see Appendix C). Once permission and ethical approvals to conduct the study had been granted, data collection tools were piloted.

Letters were sent to participants for the pilot requesting their permission to participate in the study (see Appendix D). Results from the pilot were analysed and findings were utilized to refine final data collection tools, i.e. the self-administered questionnaire, the interview guide, and field visit guide. Permission to gain access to health facilities was sought from MoH national headquarters (see Appendix E). In addition, copies of brief outline of the research proposal were sent to each of the participating institutions (see Appendix F). Health facilities, and individuals involved in pilot study were excluded from the final data collection process.

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3.4 Methods for data collection

The study utilized three main data collection strategies, i.e. official documents review, self-administered questionnaires, and interviews. To support the three main methods of data collection, field visits were undertaken to observe MCH services in selected government funded health facilities. Information obtained from the three data sources was triangulated. Justification for the multiple sources of data was that no single source of information could be trusted to provide comprehensive perspectives of situations or phenomena understudy (Patton, 2002). Patton (2002) argued that combination of document review, questionnaires, and interviews tend to increase validity and strengthen the study approach.

3.4.1 Official documents review

Permission to access MCH official documents in Malawi was obtained from MoH (see Appendix G). Government MCH documents were reviewed. Official documents reviewed in this study provided information on policy content, context, process and stakeholders. Consequently, documents reviewed addressed the first aim of the study. All policy documents from 1964-2008 and concerned with MCH in Malawi were analyzed. The following were documents reviewed:

- National Health Plan (NHP) 1965-1969, 1973-1988, 1986-1995, 1999-2004
- Health Policy Framework Paper (HPFP) 1995
- The Joint Programme of Work for a health Sector Wide Approach (SWAp) 2004 to 2010, 2004
- Programme of Child Survival and Development (CSD), plan of operations and plans of action 1988-1992
- Reproductive Health (RH) policy, 2002
- National RH Strategy, 2007-2011
- National policy on Early Childhood and Development (ECD), 2001
- Road map for accelerating the reduction of maternal and child health and neonatal mortality and morbidity in Malawi (The Roadmap), 2006 and 2007 (revised version)
- IMCI approach policy for Accelerated Child Survival and Development (ACSD) in Malawi, 2006
- Five year national strategic plan for Accelerated Child Survival and Development (ACSD) in Malawi, 2007

In addition, other critical documents were reviewed and made reference to, to support information obtained from the above list of policy documents:

- Report of the joint programme review, maternal and child health, expanded programmes on immunizations and other elements of primary health care, 1984 (MoH, 1884)
- Handbook and guide for health providers on the essential health package (EHP) in Malawi, 2004 (MoH, 2004a)

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- Emergency Obstetric care services in Malawi: Report of a national wide assessment, 2005 (MoH, 2005)
- Malawi Poverty Reduction Strategy Paper (PRSP) (Government of Malawi, 2002)
- Malawi Growth and Development Strategy (MGDS) [Government of Malawi, 2005)
- Millennium Development Goals reports, 2003,2005, 2007 (MEDP, 2003, 2005 and 2007)
- District Implementation Plans (DIPs)
- Demographic Health Surveys, 1992, 1996, 2000, 2005 (NSO, 1992, 1996, 2001 and 2005)

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3.4.2 Self administered questionnaires

Construction of primary questions for self-administered questionnaire was based on literature reviewed and information from documents reviewed. The questionnaire contained close-ended questions with a list of response options for participants to choose from. The results from pilot study informed the final questionnaire, which was distributed to the study participants (See Appendix H). Self-administered questionnaire in this study was used to pursue issues from documents reviewed. The questionnaire responses provided information on MCH policy process and stakeholders' involvement in policy development. In addition, questionnaire responses provided information on respondents' experiences of MCH policy development and implementation. Each questionnaire was transcribed into text and sent back to respondents to verify information and consent inclusion of information in the final report.

3.4.3 Interviews

The initial interview guide was formulated basing on literature reviewed. The final interview guide was informed by results from pilot study and information from documents reviewed as well as questionnaire responses (see Appendix J). Semi-structured interview with open ended questions were used to focus the interview and allow participants to give as much information as possible as they felt comfortable

with. The interviews were conducted in English and audio-taped with permission obtained from each participant in order to capture responses accurately. The recorded interviews were transcribed at the end of each interview session and submitted to each interviewee for verification of information provided and their consent were sought for inclusion of their views in the final report. Interviews were used to collect data and verify information from documents reviewed and questionnaire responses. Interview responses provided information on MCH policy process and stakeholders. In addition, interview responses provided information about participants' and key informants' experiences in MCH policy development and implementation in Malawi.

3.4.4 Field visits (additional source of data collection)

Field visits were conducted to observe selected health facilities for purposes of reality checking of MCH policy implementation. Information collected from field visits was intended to validate and support data from reviewed official documents and responses from questionnaires as well as interviews. A general guide for field visit for the study was developed basing on literature reviewed as well as information obtained through documents review, questionnaires and interviews (see Appendix K). Table 3.4 summarizes methods of data collection for the study and information they provided basing on study objectives.

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Table 3.4: Objectives and sources of data

Aims	Objectives	Data sources	Information to be collected
To analyze MCH Policies in Malawi from 1964 to 2007	• To review content of MCH policy documents in Malawi from 1964 to 2007 • To analyse context of MCH polices in Malawi • To analyse MCH policy process • To identify and analyse the influence of key MCH policy stakeholders in Malawi	• Official document review • Questionnaires • Interviews • Field visits	• Content of MCH polices • Process of policy development • Context of MCH policies • Stakeholders and their influence
To explore lessons and gaps in MCH policy development process	• To explore experiences of MCH stakeholders in policy development • To explore processes for involving stakeholders and target groups in MCH policy development in Malawi • Examine interaction processes between policy makers and implementers	• Self-administered questionnaires • Interviews • Field visits	• Experiences of MCH stakeholders in policy development • Processes for involving stakeholders in MCH policy development in Malawi • Interaction processes between policy makers and implementers
To explore lessons and gaps in MCH policy implementation	• To explore experiences of MCH stakeholders in policy implementation • To determine types of constraints and problems encountered at government health facilities, private and NGOs in implementing MCH programmes in Malawi • To examine the relationship between government resources, policies, and actual MCH implementation in Malawi	• Self-administered questionnaires • Interviews • Field visits	• Types of constraints and problem encountered at public health facilities, NGOs and private health facilities implementing MCH services • Relationship between government resources and actual MCH policy implementation
To explore strategies for improving MCH in Malawi	• To review literature on strategies for improving MCH policies and services • To recommend strategies for improving MCH in Malawi	• Literature review	• Strategies for improving MCH

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3.5 Validity and reliability of data collection methods

According to Brink (2006), validity and reliability addresses the issue of whether instrument used to collect data yielded data that reflects the truth. Therefore, validity and reliability is discussed in regard to data collection methods' trustworthiness, face validity, content validity, construct validity and internal consistency.

Trustworthiness

In line with this study being trustworthy, the researcher described in detail how data was collected (Brink, 2006). In addition, categories of data were developed through continuous review of documents, questionnaire and interview transcripts as well as field notes (Hansen, 2006). Further to that, data from three data sources was compared and contrasted for similarities and differences in order to validate the results from each data source. Furthermore, two academic supervisors also reviewed the raw data and verified categories from data analysis to serve as validity check. Considering that some participants were the researcher's colleagues since the researcher had worked in the same system before, the primary supervisor who came from a different country (Ghana), who conducted and completed health policy analysis study of a sub-Saharan African country, provided a check on the research process. Additionally, aspects of the paper were presented at international conferences to obtain feedback from conference delegates (See Appendix S). The thesis research proposal was presented to academic staff in the School of Health and Rehabilitation in Faculty of Health Sciences at UCT.

Face validity,

Face validity means that the instrument appears to measure what it is supposed to measure (Brink, 2006). Questionnaire and interview guide as well as field visit guide were reviewed by a panel of researchers in the Nursing Department, School of Health and Rehabilitation Sciences Faculty of Health Sciences at UCT. In addition all data collection tools were reviewed by two research supervisors from UCT and University of Malawi. Both the panel of researchers and study supervisors checked if the tools would generate required information in relation to study aims and objectives. Further to that, formulation of data collection tools was based on conceptual framework for health policy analysis which specified kind of information to be collected for each analytical concepts of the framework.

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Content validity,

Content validity is an assessment of how well the instrument represents all components of the variables to be measured (Brink, 2006). Golafshani (2003) argued that this type of validity is used in the development of questionnaires, interview schedules or guides. Construction of data collection instruments for this study was based on reviewed literature of health policy analysis and MCH official policy documents. The literature revealed essential aspects of MCH policies to be investigated and therefore guided formulation of questionnaires, interview guide and field visit guide. Literature also guided decisions of what information needed to be obtained through each data collection tool. The instruments were then presented to panel of experts in health policy research (academic staff from School of Health and Rehabilitation Sciences in the Faculty of Health Sciences at UCT) for evaluation of content validity of the instruments. Formulation of data collection tools was also done under supervision of two research supervisors who checked content and what data was to be collected by each data collection tool. The experts evaluated each item on the instruments with regard to the degree to which aspects of MCH policies analyzed were represented, as well as the instruments' overall suitability for use (Brink, 2006). In addition the study adapted a conceptual framework for analyzing health policies by Walt and Gilson (1994) which also guided the content of data collection tools. Documents reviewed in the study could be accepted as valid sources of information, as they were able to provide information on policy content, process, context and stakeholders involved (Bowling, 1997). Therefore, document review formed the basis for further data collection and analysis. The interviews generated large volume of data some of which had to be discarded as they did not address the focus of the study. However, the use of the adapted framework and objectives for the study guided the researcher to extract relevant information for the study (Hansen, 2006).

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Construct validity

According to Wainer and Braun (1988), construct validity is concerned with what construct is the instrument actually measuring. It measures the relationship between the instrument and the related theory. For example, the sequences in which questions were arranged in the questionnaire and interview guide (Appendix H and J), enabled participants and key informants to provide the required information. That is questions were categorized according to policy process as well as objectives for the study i.e. problem identification, situation analysis, policy formulation, policy implementation, monitoring and evaluation.

Internal consistency

Internal consistency addresses the extent to which all items on an instrument measure the same variable (Brink, 2006). In this regard, issues which could not be clarified by data from documents were further explored through questionnaires and interviews. For example in the questionnaire (See appendix H), one of the questions asked participants to list factors affecting MCH policies in Malawi. In interviews again (See Appendix J), the same question was asked to participants and key informants "what factors influence MCH policies in Malawi?" In addition same components on MCH policies were examined through documents review, questionnaires and interviews i.e. policy content, context, process, stakeholders and lessons as well as lessons and gaps in MCH policy development and implementation. Data from reviewed documents and responses from questionnaires as well as interviews was compared for consistency. Therefore, triangulation of data from data sources revealed internal consistency for the required data across all the three instruments.

3.6 Gaining access to study population and health facilities

Once ethical approval and permission to conduct the study in Malawi had been granted, permission to access public health facilities was sought as stated earlier. In addition, letters requesting recommended health centres for field visits were sent to each District Health Management Team (DHMT) (see Appendix L). Individual study participants and key informants were approached and letters inviting them to participate in the study were handed to them to either participate in completing the questionnaires (see Appendix M) or to be interviewed (see Appendix N). In addition, an informed consent was obtained from participants and key informants before completing self-administered questionnaires or being interviewed (see Appendix P). At the end of data collection phase, thank-you letters were sent to participants and key informants for participating in the study (see Appendices Q and R).

3.7 Samples and sampling

The data collection was undertaken in Malawi in all the three regions, i.e. Northern, Central and Southern regions. Public tertiary hospitals, district hospitals and health centres were selected as study cases. The study population included all MCH policy makers and implementers in Malawi. Study participants were drawn from MoH National Headquarters, tertiary hospitals, district hospitals and health centres. Key informants were drawn from,

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CHAM National Headquarters, the private sector including INGOs, local NGOs, private-for-profit hospitals, public and private clinics including those managed by CHAM.

3.7.1 Health facilities and criteria for selection

Health facilities and criteria for selection

Non probability purposive sampling (Hansen, 2006) was used to select public tertiary hospitals, district hospitals and health centres. Probability sampling technique however was used to select specific district hospitals to be included in the study.

Tertiary hospitals

Three tertiary hospitals were chosen to be study cases because they are the highest level of MCH service delivery. In addition, tertiary hospitals participate in MCH policy developments at different stages including formulation and implementation. There are four tertiary hospitals in Malawi. One tertiary hospital is situated in each region of Central and Northern regions, i.e. Kamuzu (KCH) and Mzuzu Central Hospitals respectively. The remaining two tertiary hospitals are located in the Southern region, i.e. Queen Elizabeth Central Hospital (QECH) and Zomba Central Hospital. QECH is the oldest tertiary hospital compared to Zomba Central Hospital, which was upgraded in 2006 from secondary to tertiary level hospital. The oldest tertiary hospital (QECH) was selected in southern region because of its established systems of policy and service delivery as a tertiary hospital. Therefore, Mzuzu, Lilongwe and Queen Elizabeth Central Hospitals were selected for the study.

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District hospitals

District hospitals were selected as study cases because they are also involved in policy formulation as well as implementation with settings and systems different from tertiary hospitals. Two public district hospitals from Northern region, three from Central and four from southern region were selected for the study. The numbers of district hospitals per region were selected by dividing the number of districts per region with a common denominator of three (Khalil, 2000). In Malawi, there were 27 districts in total, 6 in northern, 9 in central and 12 in central region (See Appendix A). Taking 3 as a common denominator, 2, 3 and 4 district hospitals were included in this study from northern, central and southern region respectively. Random sampling technique was applied to select the specific District Hospitals to be included in the study. District Hospitals selected were Mzimba and Rumphi

from Northern region, and Ntcheu, Ntchisi and Mchinji from Central region. Mulanje, Thyolo, Chirazdulu and Machinga were district hospitals selected in the southern region.

Health centres

Health centres were also selected as study cases because they are primary level delivery facilitates for MCH services and they participate in implementation of MCH policies. Only two health centres from each selected district were included in the study due to time constraint as indicated earlier. The selection of specific health centres for the study was based on recommendations of DHMT through the DHO of the selected District Hospitals (see Appendix M). However, the criteria for selecting the two health centres from each district was that one should be nearest and another should be farthest from the District Hospital.

3.7.2 Study Participants and criteria for selection

Non probability purposive sampling technique was utilised in the selection of participants from participating health facilities (Verkevisser, Pathmanathan, and Brownlee, 2003). Participants were selected strategically so that their in-depth knowledge would give optimal insight in gaps and strategies for improving MCH in Malawi. Criteria for selecting participants were based on level of the healthcare facility, position within the organisation, involvement in MCH policies and specific information required. Tables 3.7.2 and 3.7.2 Cont. 1 provide detailed information on criteria for selecting participants.

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Table 3.7.2: Criteria for selecting participants

Institution	Key informant	Involvement in MCH policies	Expected information
MoH Headquarters	Directors	-Participate in policy formulation	-Policy development process. -MCH policy stakeholders and their influence in MCH policy. -Experiences in MCH policy Development. -Processes for stakeholder involvement -Interaction processes between policy makers and implementers -Constraints in implementing MCH policies. -Relationship between government resources and actual implementation of MCH policies
Tertiary hospitals	Directors and head of departments Principal Nursing Officer and	-Participate in formulation of policies -Communicate policies to implementers Supervise implementation	-Policy development process MCH policy stakeholders and their influence in MCH policy -Experiences in MCH policy development. -Processes for stakeholder involvement -Interaction processes between policy makers and implementers -Constraints in implementing MCH policies. -Relationship between government resources and actual implementation of MCH policies
ZHSO	Central East Zone Officer Central West Zone Officer	-Supervise health facilities	-Policy development and implementation processes Lessons and gaps in MCH policy development and implementation
Tertiary Hospitals	Departmental Nursing Officer	-Participate in policy formulation -Translate and Communicate policies to staff members	-Policy process -MCH policy stakeholders and their influence in MCH policy -Experiences in MCH policy development -Processes for stakeholder involvement -Interaction processes between policy makers and implementers -Constraints in implementing MCH policies -Relationship between government resources and actual implementation of MCH policies
	MCH coordinators and Ward in charges for maternity and paediatric wards	**Sup**ervise and monitor implementation	-Policy process -MCH policy stakeholders and their influence in MCH policy -Experiences in MCH policy development -Processes for stakeholder involvement -Interaction processes between policy makers and implementers -Constraints in implementing MCH policies -Relationship between government resources and actual implementation of MCH policies

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Table 3.7.2 Cont. 1

Healthcare facility	Position of the participant	Involvement in MCH policies	Expected information
District hospitals	DHOs DNOs HNOs	-Participate in policy formulation -Communicate polices to district and health centre staff -Supervise delivery of healthcare services at facility level	-Policy process -MCH policy stakeholders and their influence in MCH policy -Experiences in MCH policy development -Processes for stakeholder involvement -Interaction processes between policy makers and implementers -Constraints in implementing MCH policies -Relationship between government resources and actual implementation of MCH policies
	Ward In-charges MCH coordinators	-Supervise staff at departmental level in healthcare facilities -Implement MCH services	-Policy process -MCH policy stakeholders and their influence in MCH policy -Experiences in MCH policy development -Processes for stakeholder involvement -Interaction processes between policy makers and implementers -Constraints in implementing MCH policies -Relationship between government resources and actual implementation of MCH policies
Health centres	Health centre in – charge and in-charge for maternity unit	-Supervise and implement MCH services	-Interaction processes between policy makers and implementers -Constraints in implementing MCH policies -Relationship between government resources and actual implementation of MCH policies

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3.7.3 Key informants and Criteria for Selection

Key informants were also strategically selected, thus non probability purposive sampling technique was applied. The criteria for selecting informants was based on institution, position within the organisation, involvement in MCH policies and specific information expected to be provided as presented in table 3.7.3 below:

Table 3.7.3: Criteria for selecting key informants

Institution	**Key informant**	**Involvement in MCH policies**	**Expected information**
Central Medical Stores (CMS)	-Procurement officer -Distribution officer Regional officer	Procure and distribute medical supplies and equipment	-Stakeholders' involvement in policy development and implementation -Relationship between government resources and actual implementation of MCH policies -Constraints in implementing MCH policies
International NGOs (WHO, UNICEF, UNFPA)	Directors	-Advocate for MCH policies Participate in policy formulation -Fund policy formulation and implementation	-Policy development and implementation process -MCH policy stakeholders and their influence in MCH policy -Experiences in MCH policy development. -Processes for stakeholder involvement -Interaction processes between policy makers and implementers -Constraints in implementing MCH policies. -Relationship between government resources and actual implementation of MCH policies
Local NGOs (Banja La Mtsogolo)	Directors	Implementation of MCH services	-Interaction processes between policy makers and implementers -Constraints in implementing MCH policies. -Relationship between government resources and actual implementation of MCH policies
CHAM	CHAM secretariat Coordinator Hospital directors	-Participate in policy formulation -Communicate polices to CHAM hospitals -Supervises staff in CHAM hospitals -Mobilizes resources for CHAM hospitals	-Policy development and implementation process -MCH policy stakeholders and their influence in MCH policy -Experiences in MCH policy development -Processes for stakeholder involvement -Interaction processes between policy makers and implementers -Constraints in implementing MCH policies -Relationship between government resources and actual implementation of MCH policies
Private for profit hospitals and clinics	Directors	Provide MCH services	-Roles and influence of private for profit health practice in MCH policies -Communication channels

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3.8 Process of data analysis

Preliminary data analysis was undertaken simultaneously with data collection, i.e. constant comparative data analysis (Glaser and Strauss, 1967). Constant comparative analysis was conducted by comparing information from documents reviewed with information from questionnaire and interview responses (Patton, 2002). Information from documents reviewed informed on data that was collected through questionnaires (Bowling, 1997). Similarly, information from documents reviewed and questionnaire responses informed on data that was collected through interviews. On the other hand new information collected was compared with information previously collected. For example, filled questionnaires were transcribed and compared with previous collected data. In the same way, audio-recorded interviews were transcribed on completion of each interview session and compared with previously collected data (Patton, 2002). These processes enabled the researcher to compare new information with that which was previously provided, especially information on areas that required more focus and further investigation.

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The preliminary data analysis was followed by more detailed data analysis at completion of the data collection phase (Patton, 2002). Data documents reviewed, responses from questionnaires and interviews responses were analyzed separately (Maree, 2007). Then findings from the three data sources were triangulated to crosscheck and validate findings (Patton, 2002). Quantitative data was analyzed using computer software called "STATISTICA 7". This helped to conduct basic descriptive statistical analysis responses to closed-ended question, e.g. frequency distribution.

Qualitative data collected was analysed using computer software called "NVivo 7". It enabled content analysis by searching text for categories, themes, and recurring words (Strauss and Corbin, 1998). Outlined below were the steps utilised for analysis of data collected (Strauss and Corbin):

- Data from official documents reviewed were written in a narrative form (text) and data from questionnaires and interviews was transcribed into text
- Statements and phrases that pertained to MCH policy process, content, context, MCH policy stakeholders, lessons, gaps and strategies for addressing gaps were extracted and coded as patterns, categories and themes basing on the study aims and objectives

- Meanings were formulated from the identified and coded patterns, categories and themes
- The meanings formulated from coded themes were used as descriptions of the research findings
- For validity, the researcher presented preliminary results to study participants and key informants (original data sources) for them to validate the results.

Process of data triangulation involved identification of common themes from the three data sources, identification of similarities and differences in the identified themes, and identification of themes only available in one data source (Bowling, 1997). In addition triangulation of data identified divergence and convergence of information in the three data sources and evidence of information provided in one data source without corroboration in the other two sources

The data from three sources was compared as follows,

- Document review with questionnaire responses
- Document review with interview responses
- Questionnaire responses with interview responses
- Questionnaire responses with document review

3.9 Ethical considerations

Since the study utilized human subjects, participants and key informants in the study had to be protected as specified in the Helsinki Declaration and the Constitution of the republic of South Africa (World Medical Association, 2008 and Republic of South Africa, 1996). Consequently, ethical approval was sought from the Health Sciences Research Committee under the Malawian Ministry of Health and Faculty Of Health Human Ethics Committee at UCT in South Africa. In addition to obtaining study ethical approvals, ethical considerations relating to informed consent, participant-researcher relationship, and gaining access to research area and participants were observed in the study.

3.9.1 Informed consent and right to withdraw

Informed consent is grounded in the ethical principle of autonomy that encompasses the notion of being a self-governing person with decision-making capacity (Polit and Hungler, 1999). Polit, Beck and Hungler, (2001) defined informed consent as participants having

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adequate information regarding the research, being capable of comprehending the information. They continued that informed consent is also having the power of free choice enabling them to consent voluntarily to participate in a research or decline participation. Consequently, voluntary informed consent was obtained from both study participants and key informants. As suggested by Marvasti (2004), the informed consent process for the study included the following steps;

- The researcher explained the study as well as provided the potential study participants and key informants with an information sheet describing the study (See Appendix F). The information sheet consisted of general description of the study; the participants' right to accept, decline or withdraw his/her participation; emphasis that participation is voluntary and withdraw was possible at any time without penalty; explanation about how their confidentiality and anonymity was to be protected; and what would happen with the data during and after the study. This information was also repeated in letter requesting participants and key informants to participate in the study (see Appendix M and N).
- When they agreed to participate by either filling a self-administered questionnaire or being interviewed, participants and key informants as well as the researcher signed the consent form (See Appendix P)
- Participation was voluntary, without coercion or inducement
- Withdrawal of participation in the study was permitted at any time without any punishment (World Medical Association, 2008 and Republic of South Africa, 1996). However, none of the participants and key informants withdrew from the study.

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3.9.2 Confidentiality and anonymity

A further ethical consideration relates to the researcher's responsibility to give assurances of confidentiality and anonymity (Polit et al, 2001). According to Hansen (2006), confidentiality is the obligation of persons to whom information has been given not to use such information for any other purposes other than that for which it was given. She maintained that confidentiality also refers to participant anonymity, i.e. participants' identity should not be revealed in published results of a study (Hansen, 2006). Polit et al (2001), argued that a promise of confidentiality to participants is a guarantee that any information provided would not be made accessible to a third party. Consequently, raw data collected for the study was only accessible to the researcher and her two supervisors. Measures to ensure confidentiality of personal information also included secured storage of data and the use of a

system of coding to protect the individual's identity during the process of data analysis and in the publication of research results. Participants were also given written assurance that audio tapes would be destroyed on completion of the study. Polit et al (2001) argued that anonymity occurs when even the researcher cannot link a participant with data from that person. However, qualitative data collection methods such as field visits and interviews made it impossible to maintain anonymity at all stages (Behi and Nolan, 1995). According to Robley (1995), small sample size and thick descriptions provided in the presentations of findings could present problems in maintaining confidentiality. For this reason, the transcribed data from questionnaires and interviews as indicated earlier was returned to the respondents for verification, clarifications, and permission to use information provided in the final document of the thesis. Furthermore, names of participants were not utilised during data collection, analysis and presentation of results. Numbers were used to identify each questionnaire, interview transcripts, and a separate sheet of paper had a list of the numbers with corresponding names for the participants, so as to enable the researcher to identify a respondent in case further clarification or information would be required. Finally, study findings were presented in a manner that protected identities of participants and key informants. For example, names of individuals were not used. In addition to that, positions and names of institutions as well as places were used in a manner that identity of participants and key informants would not be known i.e., “Senior Official, UNICEF” and “Director, Central Hospital 1.”

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3.9.3 Authenticity of data

Authenticity of data is another ethical consideration. According to Munhall (1998), describing the experiences of others in the most honest way possible is the most critical ethical obligation of the qualitative researcher. An important strategy in meeting this responsibility in qualitative research is the notion of 'bracketing'. The aim of bracketing is to suspend or set aside one's beliefs about the phenomenon being studied in order to avoid influencing both the collection and interpretation of data (Orb, Eisenhauer and Wynaden, 2001). They also suggested that the process of publication may also result in a breach of confidentiality or anonymity (Orb et al, 2001). Therefore, all the direct quotes were put in brackets and permission to use direct quotes was obtained from the respondents. In addition, the researcher made sure that examples of raw data do not reveal the participants’ identity in terms of names and positions in their work places. This entails that within the process of gaining consent, participants knew how the results were to be presented.

3.9.4 Researcher-participant relationship

Speziale and Carpenter (2003), state that data collection methods of qualitative research such as interviews and field visits entail a researcher-participant relationship. They argued that the nature of this relationship raises distinct ethical issues concerning trust for researchers using qualitative methods (Speziale and Carpenter, 2003). According to Seale, Gobo, Gubrium and Silverman (2004), trust refers to the relationship between the researcher and participants, and the researcher's responsibility not to spoil the field for others in the sense that potential research participants become reluctant to participate in future research activities. Trust also applies to the report defining the standards for presenting both the researcher and the study as trustworthy (Seale et al, 2004)). The researcher used appropriate communication channels to get access to health facilities, participants and key informants. In addition, the researcher introduced herself and explained study aims as well as process to both participants and key informants on initial meetings (See Appendices M, N and P). Further to that, study participants and key informants were assured of their privacy and confidentiality throughout the study (See Appendix P). Furthermore, the researcher sent transcribed questionnaires and interviews to participants and key informants as a way of being transparent of what is to be included in the final report. Last but not least, the researchers contact details were made available to participants and key informants for continuous communication (See Appendix M and N). Finally, the primary research supervisor came from Ghana. She therefore provided a check on the research process.

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3.10 Implications of the study

This work has made notable contribution to knowledge in two key aspects. Firstly, it has produced a valuable Policy Analysis Instrument – an adapted version of Walt and Gilson Policy Analysis Framework and has demonstrated application of this instrument on Malawi's Maternal and Child Health Policies. Secondly, this work, in applying the Policy Analysis Framework, has carried out a case study that has produced specific findings regarding policy development and implementation in Maternal and Child Health sub-sector of Malawi's health sector. There is direct immediate contribution towards improving policy development and implementation as well as service delivery in Malawi's Maternal and Child Health.

The study is also envisaged to contribute to improvement of health services specifically those of women and children in Malawi in a number of ways. Firstly, the study will recommend strategies for addressing gaps in MCH policies. Secondly, it is anticipated that study findings will inform policy-makers in Malawi on identified lessons learnt in MCH policies and services which could be replicated in the country. Thirdly, the study will highlight gaps in MCH policies in Malawi and how priorities of reducing maternal and child mortality had been missed in policy context. In so doing, the study will draw the attention of policy makers and implementers to the urgency of need to reduce maternal and child mortality significantly. The study will therefore help policy makers to re-focus priorities of MCH policies. Fourthly, the study is anticipated to contribute to the achievement of health-related MDGs, which is both worldwide and nationwide agenda. Finally, the study's findings will add to the body of knowledge on health policy analysis, specifically MCH in Malawi. Such policy analysis had not been explicitly documented in Malawi (Malawi, Government, 2000).

The study's findings were presented to senior management of Malawian MoH to share results obtained during the RH research dissemination meeting in June 2009 (See Appendix V for the programme). In addition, to provide a feedback on preliminary study results to key stakeholders and informants, a workshop was also conducted in June 2009. To share findings with international audience, some aspects of results obtained had been presented at international conferences (See Appendix S). Furthermore, articles basing on study results were submitted for review in peer-reviewed journals (See Appendix T).

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Chapter four

RESULTS

4.1 Introduction

The previous chapter focused on the research methodology, data collection methods and process of data analysis. This chapter presents the results from data collected. The study results are presented as themes based on the study's aims and objectives in relation to the conceptual framework. Firstly, the chapter presents results from each of the data collection sources, i.e. documents review, self-administered questionnaires, and interviews as well as field visits. Secondly, it presents triangulation of results from the three main data sources. The chapter also describes some aspects of validity and reliability of the results obtained. Finally, the chapter outlines constraints during data collection and possible limitations of results obtained.

4.2 Results from documents reviewed

Malawi government MCH official documents from 1964 to 2008 were reviewed. The results are presented in table format according to the study aims and objectives. The tables are arranged in regard to categories of documents reviewed. Documents were categorized into National Health Plans (NHPs); other MoH planning documents; Reproductive and Maternal Health Policies; Child Health Policies; and other policies affecting MCH in Malawi. Table 4.2 summarizes how the reviewed documents were categorized during data analysis.

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Table 4.2: Categories and names of documents reviewed for the study

Category of documents	Name of documents
National Health Plans (NHPs)	National Health Plan 1965-1969 (MoH, 1965) National Health Plan 1973-1988 (MoH, 1971) National Health Plan 1986-1995 (MoH, 1986) National Health Plan1999-2004 (MoH, 1999a)
Other MoH planning documents	Health Policy Framework Paper (HPFP) 1995 (MoH, 1995) To the year 2020: A Vision for the health sector in Malawi (Vision 2020), (MoH, 1999b) A joint Programme of Work for a health Sector Wide Approach (SWAp) 2004 to 2010, 2004 (JPoW), (MoH, 2004b)
Reproductive and Maternal Health Policies	Reproductive Health (RH) Policy, 2002 (MoH, 2002a) The Roadmap for accelerating the reduction of Maternal and Neonatal Mortality and Morbidity in Malawi (The Roadmap) – 2006 (MoH, 2006b) National Reproductive Health (RH) Strategy - 2006-2010 (MoH, 2006a)
Child Health Policies	Expanded Programme on Immunization in Malawi (EPI), 2002 (MoH, 2002b) A Programme of Child Survival and Development (CSD): plan of operations and plans of action (a programme of CSD), 1988-1992 (Government of Malawi and UNICEF, 1988) Integrated Management for Child Illnesses (IMCI) Approach policy for Accelerated Child Survival and Development (ACSD) in Malawi, 2006 (MoH, 2006c) Five year national strategic plan for Accelerated Child Survival and Development (ACSD) in Malawi, 2007 (MoH, 2007)
Other policies impacting on MCH in Malawi	National policy on Early Childhood Development (ECD), 2001 (MGYCS 2001) HIV/AIDS policy, 2003 (NAC, 2003) HIV/AIDS national Action Framework (NAF), 2005-2009 (NAC, 2005a)

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4.2.1 Content of MCH policies in Malawi from 1964 to 2007

Results about content of MCH policies in Malawi are presented under the following headings; rationale for MCH policies; goals, objectives and strategies for MCH policies; resources for MCH policies; plan for implementation; plan for monitoring and supervision; and plan for review and evaluation (See Tables 4.2.1a to 4.2.1e).

Rationale for MCH policies in Malawi

Some of reviewed documents did not outline rationale for MCH in the country, e.g. all the NHPs, HPFP, the RH policy, the RH National Strategy, EPI manual and Programme of CSD, HIV/AIDS action framework (MoH, 1965; MoH, 1971; MoH, 1986; MoH, 1995; MoH, 1999a; MoH, 2002a; MoH, 2002b; MoH, 2006a; NAC 2003; and NAC, 2005 respectively). On the other hand, documents that provided detailed rationale were Vision 2020, the JPoW, the Roadmap, IMCI Approach Policy, Five-year National Strategy for ACSD, National policy on ECD, the HIV/AIDS policy and action framework (MoH, 1999b; MGYCS, 2001; NAC, 2003; MoH, 2004b; NAC, 2005a; MoH, 2006b; MoH, 2006c; MoH, 2007 respectively) [See Tables 4.2.1a to 4.2.1e].

Priorities, goals, objectives and strategies for MCH policies in Malawi

All official documents reviewed had their priorities, goals, objectives and strategies specified (Tables 4.2.1a to 4.2.1e), however these were broad objectives and strategies (GoM and UNICEF, 1988; MGYCS, 2001; MoH, 1965; MoH, 1971; MoH, 1986; MoH, 1995; 1999a; MoH, 1999b: MoH, 2002a; MoH, 2002b; MoH, 2004b; MoH, 2006a: MoH, 2006b: MoH, 2006c; MoH, 2007; NAC, 2003; NAC, 2005a). Priorities for NHPs were set but the objectives and strategies were also broad meaning that they had no specific targets outlined and were not time bound (Table 4.2.1a). Similarly, objectives and strategies for HPFP and JPoW were broad and not specific. HPFP outlined priority areas for HSR in Malawi (Table 4.2.1b). The table also shows that even though JPoW had a matrix indicator that outlined baseline data and target indicators, there were some missing information (Table 4.2.1b). Reproductive and Maternal Health Policies had broad objectives and strategies (Table 4.2.1c). In addition, even though the National RH Policy had log frame, there were missing information on baseline data and targets indicators (Table 4.2.1c). EPI manual had specific objectives and strategies, whilst Programme of CSD, IMCI approach policy, and the five-year strategic plan for CSD had broad objectives and strategies outlined (Table 4.2.1d).

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Similarly, objectives and strategies for Other Health Policies influencing MCH in Malawi were broad. In addition, although HIV/AIDS NAF outlined its log-frame, there was missing information on baseline data and targets (NAC, 2005a) [See Table 4.2.1e].

Tables 4.2.1c and 4.2.1d also showed that priorities for Maternal and Reproductive Health policies, and Child Health policies were based on international and/or regional agreements. For example, priorities for RH policy were presented as RH components and were based on the ICPD (MoH, 2002a). Goals for the Roadmap were based on MDG4 whilst strategic directions for the National RH Strategy were based on ICPD. Goals, objectives and strategies of EPI manual were based on EPI disease targets developed by UNICEF and WHO (MoH, 2002b). Project priorities for the Programme of CSD were based on UNICEF programme design framework (Government of Malawi and UNICEF, 1988). Goals for IMCI approach policy and five-year strategic plan for ACSD were based on MDG5 (MoH, 2006c). In addition, strategies for Five-year Strategic Plan for CSD were based on high impact interventions published in the Lancet Journal series (MoH, 2007). National Policy on ECD, National HIV/AIDS Policy and HIV/AIDS NAF (MGYCS, 2001; NAC, 2003 and NAC, 2005a) did not clearly state that their objectives and strategies were based on international and regional agreements [See Table 4.2.1e].

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Resources for MCH policies in Malawi

All the NHPs outlined estimated financial resources required for their implementation but NHP 1965-1969 and 1973-1988 did not indicate sources of funding (MoH, 1965; MoH, 1971; MoH, 1986; MoH, 1999a respectively). In addition to financial resources, NHP 1999-2004 outlined health facilities, physical assets and human resources required (MoH, 1999a). Financial resources for NHP 1986-1995 and 1999-2004 were to be funded by both donors and the Government of Malawi (MoH, 1986; MoH, 1999a). However, donors funded large proportion of financial resources required. For example, for both NHP 1986-1995 and 1999-2004 (MoH, 1986; MoH, 2004b), 71% of the total financial resources were to come from donors and 29% from government (Table 4.2.1a). Resources for HPFP and Vision 2020 were not outlined in the documents (MoH, 1995; MoH, 1999b). Estimated financial resources for JPoW were outlined, i.e. 29% and 71% of the funding were to come from domestic public finances and International Development (IDA) respectively (Table 4.2.1b). Resources for RH Policy and National RH Strategy were not outlined but it was specified that financial resources would be mobilized, however it was not mentioned how this would

be achieved (MoH, 2002a; MoH, 2006a). Financial resources for the Roadmap and national RH strategy were to be allocated through JPoW because the Roadmap and national RH strategy were to be implemented as part of EHP within the context of SWAp (Table 4.2.1c). Although resources for EPI were not outlined, the document mentioned that financial resources would be funded by donors, whilst financial resources for Programme of CSD were outlined in the document and it would be funded by both government and donors (MoH, 20002b; GoM and UNICEF, 1988). Resources for IMCI Approach Policy were not outlined whilst resources for Five Year Strategic Plan for CSD were outlined as 50% from donors, 30% from government and 20 % from private sources (MoH, 2006c; MoH, 20070 [See Table 4.2.1d]. Resources for National Policy on ECD and HIV/AIDS Policy were not clearly stated, whilst resources for HIV/AIDS NAF were outlined but still it did not indicate source of funding (MGYCS, 2001; MoH, 2006c; MoH, 2007) [See Table 4.2.1e].

Plan for implementation

The NHPs documents (MoH, 1971; MoH, 1986; MoH, 1999a) outlined implementation structure except the NHP for 1965-1969, however they had no plans for implementation (Table 4.2.1a). HPFP did not outline both its implementation structure and plan (MoH, 1995). The Vision 2020 and JPoW documents outlined implementation structures but did not have implementation plans (MoH, 1999b). However, the JPoW (MoH, 2004b) mentioned that it was to be implemented through annual rolling work plans based on District Implementation Plans (DIP), work plans for MoH national headquarters and central hospitals (Table 4.2.1b). Reproductive and Maternal Health Policies were to be implemented within the delivery of EHP through SWAP but had no implementation plans (MoH, 2002a; MoH, 2006b; MoH, 2006b) [See Table 4.2.1c]. EPI manual, IMCI Approach Policy and Five-year National Strategic Plan for CSD documents outlined implementation structures but they also had no plans for implementation. Programme for CSD document outlined implementation plans and structures (MoH, 2002b; MoH, 2006c; MoH, 2007) [See Table 4.2.1d). The National policy on ECD and HIV/AIDS policy had no plans for implementation but outlined responsibilities of various government ministries (Government of Malawi and UNICEF, 1988; NAC, 2003). Similarly, HIV/AIDS NAF (NAC, 2005a) document did not outline implementation plans but outlined implementation structures (Table 4.2.1e).

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Plan for monitoring and supervision

The NHP documents (MoH, 1965; MoH, 1971; MoH, 1999a) had no plan for monitoring and supervision, however, monitoring for the 1999-2004 NHP was to be conducted through Health Management Information System (HMIS) data (Table 4.2.1a). HPFP, Vision 2020, and JPoW (MoH, 1995; 1999b; MoH, 2004b) had no plans for monitoring and supervision outlined. HPFP did not mention how it was to be monitored and supervised. JPoW was to be monitored through HMIS data and annual joint reviews (Table 4.2.1b). Reproductive and Maternal Health Policies had no plans for monitoring and supervision (MoH, 2002a; MoH, 2006b; MoH, 2006a). Reproductive and Maternal Health policies were to be monitored through monthly reports from and quarterly reports from Reproductive Health management Information System (RHMIS) and HMIS (Table 4.2.1c). Child Health Policies had no plans for monitoring and supervision (GoM and UNICEF, 1988; MoH, 2002b; MoH, 2006c; MoH, 2007). However, EPI, Programme of CSD and Five-year National Strategic Plan for CSD were to be monitored through HMIS and monthly, quarterly and financial reports (Table 4.2.1d). National policy on ECD and HIV/AIDS Policy had no plans for monitoring and supervision (MGYCS, 2001; NAC, 2003). Whilst HIV/AIDS NAF had plans for monitoring in a separate document, however supervision was not included in the plan (NAC, 2005a). HIV/AIDS policy and HIV/AIDS NAF (NAC, 2003; NAC, 2005a) were to be monitored through routine data collection and analysis and sentinel surveillance (Table 4.2.1e).

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Plan for review and evaluation

NHP documents (MoH, 1971; MoH, 1986; MoH, 1999a) had no evidence of plans for review and evaluation (Table 4.2.1a). HPFP, Vision 2020 and JPoW (MoH, 1995; MoH, 1999b; MoH, 2004b) had no plans for review and evaluation (Table 4.2.1b). RH Policy stated that evaluations were to be conducted using baseline and periodic surveys whilst the Roadmap stated that it would be evaluated through periodic analysis of HMIS data, however they both had no plans for review and evaluation (MoH, 2002a; MoH, 2006b). National RH strategy had no plans for review and evaluation and it was not evident how it would be evaluated (Table 4.2.1c). Plans for review or evaluation for Child Health Policies were not outlined but MoH (2006c) mentioned that IMCI policy was to be reviewed every five years. Five-year National Strategic Plan for CSD was to be evaluated through DHS, MICS and surveys (MoH, 2002b; Government of Malawi and UNICEF, 1988; MoH, 2006c; MoH, 2007) [See Table 4.2.1d]. National Policy on ECD and HIV/AIDS Policy had no plans for

review and evaluation (MGYCS, 2001; NAC, 2003). HIV/AIDS policy was to be reviewed every five years and HIV/AIDS NAF was to be evaluated through biannual and annual reviews. HIV/AIDS NAF document had detailed plan for evaluation but had no plan for review (NAC, 2005a; NAC, 2005b) [See Table 4.2.1e].

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Table 4.2.1a: Malawi National Health Plan documents

Content	1965-1969	1973-1988	1986-1995	1999-2004
Rationale for the policy	No evidence found	No evidence found	No evidence found	Not evident in the document
Priorities, goals, objectives and strategies	Priority areas were outlined but objectives are broad (MoH, 1965:8)	Main objective and priorities were set but they were not time bound. Objectives and activities were broad i.e. "establishment of basic health services (MoH, 1971:106)	Priorities are set but the objectives are broad with no targets. Objectives and strategies were broad i.e. "strengthen the hospital system," (MoH, 1986:5-3)	Priority areas were outlined Objectives have targets but not specific and time bound i.e. "to provide quality health care in all health facilities," (MoH, 1999a:21)
Resources for policies	Estimated financial resources were outlined. However it was not evident in the document about the funding sources (MoH, 1965:23)	Estimated financial resources were allocated for each priority area for 15 years. However it was not evident in the document about funding sources (MoH, 1971:157-164)	Estimated financial resources were outlined, totalling MK96.6 million. (MoH, 1986:7-14). It was documented that a large proportion of MoH development budget was financed by international donors. Recurrent budget for MoH was to be financed by government treasury (MoH, 1986:3-27)	Outlined health facilities, physical assets and human resources (MoH, 1999:51-67).Estimated financial costs for implementing the plan were outlined totalling to US$504.45 million. 70.9% of the financial cost was to come from international donors (MoH, 1999a:67-68)
Plan for implementation	No implementation structure and plans outlined (MoH, 1965)	Outlines implementation structure i.e. outlines MoH organizational structure and responsibilities of each office and health facilities No implementation plans outlined (MoH,1971:106-109)	Outlines implementation structure i.e. outlines MoH organizational structure and responsibilities of each office and health facilities No implementation plan outlined (MoH,1986:8-2 to 8-16) .	Implementation to base on district five-year plan to be translated into annual implementation plans (MoH, 1999:71). Outlines implantation structure i.e. states responsibilities health facilities, MoH headquarters and other providers (MoH, 1999a:71-73). No implementation plans outlined
Plan for monitoring and supervision	No plans for monitoring or supervision outlined (MoH, 1965)	No plans for monitoring or supervision specified (MoH, 1971)	No plans for monitoring and supervision outlined	Monitoring to be done through HMIS data (MoH, 1999a:74-76) No plans for monitoring or supervision outlined (MoH, 1999a:74)
Plan for policy review and evaluation	No mentioning of review or evaluation	No mentioning of review or evaluation evident in the document (MoH, 1971)	Did not mention anything on review or evaluation (MoH, 1986)	No plans for review or evaluation evident in the document (MoH, 1999a:74)

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Table 4.2.1b: Other MoH Planning Documents

Content	Health policy framework paper 1995	Vision 2020, 1999	The Joint Programme of Work, 2004-2010
Rationale for the policy	Not evident in the document	Portrays the vision of MoH for reform of the health sector and outlines the reforms SWAp healthcare financing, decentralization, hospital autonomy (MoH, 1999b:11)	Outlines vision and mission for the health sector (MoH, 2004b:5)
Goals, objectives and strategies	Outlines health reform measures (MoH, 1995:1). Objectives were broad (no targets and not time bound), i.e. ' improve the quality and coverage of healthcare for rural and peri-urban population" (MoH, 1995:32). Broad strategies i.e. "decongest central hospitals and upgrade peri-urban health centres" (MoH, 1995:34)	Goals and objectives were not stated. Outlines priority areas for improvement as part of health sector reform i.e. human resource development and management health facilities development and physical assets management, healthcare financing, financial management and EHP (MoH, 1999b:51-65	Objectives were broad i.e. "*to increase the overall availability of resources in the health sector and to allocate and utilize them equitably and efficiently, respectively"* (MoH, 2004b:15). Broad strategies i.e. "provide adequate supplies of essential drugs, medical supplies and laboratory consumables" (MoH, 2004b:16). However the document had an indicator matrix as an annex, but there is missing information on baseline data and target indicators (MoH, 2004b:113-117)
Resources for policies	No evidence of financial or human resources allocated	No evidence of financial or human resources allocated	Estimated financial resources allocated for each strategy i.e. total programme cost for human resource component was US$ 6.7 million (MoH, 2004b:23). Large proportion of financial resources was to come from IDA (71%). The remaining 29% was to come from domestic public finance (MoH, 2004b:39). Private sources of finance (regulatory functions of MoH and health insurance are still underdeveloped (MoH, 2004b:39)
Plan for implementation	No implementation structure or plans outlined (MoH, 1995)	Outlines implementation structure. For example it outlines the responsibilities of MoH headquarters, central hospitals, regional health offices and district health offices (MoH, 1999b:91-96). No implementation plans outlined	Implementation to base on annual rolling work plans based on District Implementation Plans and work plans for MoH headquarters and central hospitals (MoH, 2004b:16). Outlines implementation structure i.e. routine operations and district and central hospitals (MoH, 2004b:73). No implementation structure or plans outlined.
Plan for monitoring and supervision	No plans for monitoring or supervision outlined (MoH, 1995). Did not mention means for monitoring and supervision	No plans for monitoring and supervision outlined (MoH, 1999b). Did not mention means for monitoring and supervision	To be monitored through HMIS data and annual joint reviews (MoH, 2004b:35). No plans for monitoring and supervision outlined (MoH, 2004b)
Plan for review and evaluation	No plans for review or evaluation specified (MoH, 1995)	No plans for review or evaluation outlined (MoH, 1999)	No plans for review or evaluation outlined (MoH, 2004b)

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Table 4.2.1c: Malawi Reproductive and Maternal Health Policy documents

Content	RH Policy, 2002	The Roadmap 2006	National reproductive health strategy 2006-2010
Rationale for policy	Not evident in the document	Malawi government made a renewed commitment to address maternal mortality crisis in response to Global and African Union call to formulate country specific roadmap and Conformity to attain MDGs (MoH, 2006b:viii, 3-5)	Not evident in the document
Goals, objectives and strategies	Outlines components of reproductive services in Malawi basing them on ICPD (MoH, 2002a:2). Outlines broad policy statements under each RH component i.e. "all RH services shall be provided in an integrated manner" (MoH, 2002a:5) . Has broad objectives i.e. ensure quality and standardization of services (MoH, 2002a:4). No strategies outlined (MoH, 2002a)	Goal is based on MDG4 and 5 i.e. "to accelerate the reduction of maternal and neonatal morbidity and mortality towards the achievement of MDGs" (MoH, 2006b:6). Objectives are broad i.e. "to increase availability, accessibility, utilization and quality of skilled obstetric care during pregnancy, childbirth and postnatal period at all levels of healthcare delivery system (MoH, 2006b:6). Strategies are broad i.e. "strengthen the referral system (MoH, 2006b:7). Interventions are broad i.e. establish/strengthen communication system between health centre and referral hospital" (MoH, 2006b:7)	Outlines strategic directions basing on ICPD as priorities i.e. "family planning" (MoH, 2006a:14,16,17) . No evidence on objectives found (MoH, 2006a) . Strategies are broad i.e. "strengthen availability, accessibility and utilization of FP services at health facility and community level" (MoH, 2006a:17). Activities are broad i.e. "expand CBD services to all communities (MoH, 2006a:18). Missing data in the Log frame baseline and target indicators (MoH,2006a:18,21,22,23,25,29, 30, 31, 33, 35)
Resources	No evidence of financial or human resources allocated. Resources were to be mobilized. It was not evident how the financial resources were to be mobilized (MoH, 2002a)	To be implemented in the context SWAp, estimated total cost was US276 million. 94% of financial and human resources were budgeted in POW and there was a funding gap of 6% (MoH, 2006b:25-33). The document did not state how the remaining funding was to be mobilized. No information on sources of funding	No evidence of financial and human resources. However it was to be implemented as EHP in the context of SWAp and resources were t be allocated through JPoW (MoH, 2006a:10). No information on sources of funding
Plan for implementation	To be implemented through EHP and SWAP, no plans for implementation (MoH, 2002a:13)	To be implemented within SWAP through EHP. There is no evidence of plans for implementation (MoH, 2006b:xi)	Implementation within EHP and SWAp. No evidence of plans for implementation (MoH, 2006a:12,13)
Plan for monitoring and supervision	No plans for monitoring and supervision Monthly reports through RHIS Quarterly RHMIS and HMIS reports from HIMU (MoH, 2002a:17)	No plan for monitoring and supervision Monitoring to be done through HMIS (MoH, 2006b:9-11)	No information on plans for monitoring and supervision. The document did not mention means for monitoring (MoH, 2006a)
Plan for review and evaluation	Evaluation to be done through base-line and periodic surveys, but no detailed plans for evaluation and review (MoH, 2002a:17)	No plan for review. Evaluation to be done through periodic analysis of HMIS data MDHS (MoH, 2006b:9-11). However there is no detailed plan for evaluation.	No information on plans for review and evaluation. No mention of how it was to be evaluated (MoH, 2006a)

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Table 4.2.1d: Malawi Child Health Policy documents

Content	EPI manual, 2002	Programme of child survival and development, 1988	IMCI approach policy, 2006	Five year national strategic plan for ACSD, 2007 - 2011
Rationale for policy	Not evident in the document	Not evident in the document	Outlined its rational (MoH, 2006c:9)	Outlines vision and mission for the policy (MoH, 2007:27)
Priority setting	Goals, objectives and strategies are based on EPI target diseases developed by UNICEF and WHO (MoH, 2002b:5). Had specific objectives, with targets and time frame (MoH, 2002b:5).	Project priority areas were based on programme design conceptual approach developed by UNICEF (GoM and UNICEF, 1988:12-13). Broad objectives and strategies i.e. "to train all peripheral heath staff.." "to organize training courses….(GoM and UNICEF, 1988:20)	Goal was based on MDG5 (MoH, 2006c:10). Objectives and strategies are broad i.e. "all children suffering from common illnesses managed holistically at out-patient of health facilities" (MoH 2006c:10)	Goal was adopted from MGD5 (MoH, 2007:29). Objectives are broad i.e. "achieve universal coverage of selected high-impact interventions….by 2011" (MoH, 2007:29). Priority areas are based on adopted high impact interventions for newborn and child survival published in (MoH, 2007:30-32).
Resources	Resources were not outlined. However it was documented that resources were to come from donors (MoH, 2002b:3)	No information on human and physical resources. Estimated financial resources were outlined, i.e total cost for health sector was US$3 475 000. Financial resources for the programme were to come from UNICEF (GoM and UNICEF, 1988:14-18)	Resources not outlined Financial resources for the policies were to be mobilized from government and donors (MoH, 2006c:18)	No information on human and physical resources. Financial resources were outlined of which 50% was to come from donors, 30% from government t and 20 % from private sources (MoH:2007:62,70)
Plan for implementat ion	Outlines implementation structure i.e. organogram (MoH, 2002b:2). No detailed implementation plans	Detailed implementation plans and structure for each project priority area(GoM and UNICEF, 1988:43,49,54,64)	Outlines implementation framework. No implementation plans (MoH, 2006c:14-18).	Outlines implementation structure i.e. framework for implementation (MoH, 2007:53-56). No implementation plans
Plan for monitoring and supervision	Monitoring through monthly reports and HIMS. No plans for monitoring and supervision(MoH, 2002b:92,96)	Monitoring to be done through monthly reports. No detailed plans for monitoring and supervision (GoM and UNICEF, 1988:58)	No information on plans for monitoring and supervision (MoH, 2006c)	Monitoring through monthly, quarterly and financial programme reports. No detailed plans for monitoring and supervision (MoH, 2007:58)
Plan for review and Evaluation	No evidence on plans for review and evaluation (MoH, 2002b)	No detailed plans for review and evaluation (GoM and UNICEF, 1988)	To be reviewed every 5years. No plans for review and evaluation (MoH, 2006c:19)	Evaluation to be done through DHS, MICS and surveys. No plans for review and evaluation (MoH, 2007:57)

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Table 4.2.1e: Other Health Policies impacting on MCH in Malawi

Content	National policy on ECD, 2001	HIV/AIDS policy	HIV/AIDS National Action Framework
Rationale for policy	Outlines purpose, rational and justification for the policy (MGYCS, 2001:3-4)	Outlines rational for the policy (NAC2003:8)	Not evident in the document
Goals, objectives and	Broad objectives i.e. " to provide the best start for the children's life." Broad strategies i.e. "encourage timely introduction of complimentary foods (MGYCS, 2001:11)	Broad objectives i.e. "to reduce individual and societal vulnerability to HIV/AIDS by creating enabling environment," Outlines guiding principles i.e. "public health approach," (NAC, 2003:4,6).	Outlines priority area i.e. 'treatment, care and support," objectives i.e. "to increase access to high quality community home-based care," strategies i.e. develop retentions of volunteers. Although outlines log frame, there is missing data on baseline and targets in the log frame (NAC, 2005a:16,26,50)
Resources for policies	No information on financial and human resources outlined (MGYCS, 2001)	No information on financial and human resources outlined (NAC, 2003)	No information on human and physical resources. Estimated financial resources were allocated for each priority area i.e. total finances for treatment, care and support was US$ 205 285 840 (NAC, 2005a:56)
Plan for implementation	No implementation plans, however outlines roles and responsibilities of different ministries (MGYCS, 2005:14-19).	No implementation plans Does not define implementation structure	No detailed implementation plan. Outlines implementation structure i.e. institutional framework and responsibilities for stakeholders (NAC, 2005a:8-11)
Plan for monitoring and supervision	No plans for monitoring and supervision	Monitoring to be done through routine data collection and analysis, and sentinel surveillance. No information on plans for monitoring and supervision (NAC, 2003:39,40)	Detailed M and E plan is in a separate document but supervision is not mentioned. Monitoring to be done through routine data collection and analysis, and sentinel surveillance. (NAC, 2007; 2005a; 2005b)
Plan for review and evaluation	No plans for review and evaluation	To be reviewed every five years. However no plans for review and evaluation	Biannual and annual reviews to support monitoring but no plan for review. Detailed M&E plan with resources allocated and responsible personnel indicated (NAC, 2007; NAC, 2005a and NAC, 2005b)

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4.2.2 Context of MCH policies in Malawi

MCH policies in Malawi were influenced by various factors which make up the context of the policies. Results for the context of MCH policies in Malawi are presented in four categories, which are situational, structural, cultural and international factors. Situational factors that occurred between 1964 and 2008 in Malawi included, transfer of government from colonial to one party government in 1964, political transformation from one party system to multi-party democracy in 1994, droughts in 1991/1992 and 1993/1994, and HIV/AIDS pandemic which was first diagnosed in 1985 in Malawi (Tables 4.2.2a to 4.2.2e).

The structural factors that influenced MCH policies in Malawi included high population growth rate, high fertility rate, predominantly agro-based economy, and high inflation rate. Additional factors identified from reviewed documents were inadequate infrastructure, inadequate human resource in the health sector, and inadequate government budget allocation to the health sector. Other factors that influenced MCH policies in Malawi include low employment base, increasing levels of poverty, food insecurity, illiteracy, gender imbalance, high disease burden, high and mortality rates (Table 4.2.2a to 4.2.2e).

According to official documents reviewed, various cultural factors also affected MCH policies in Malawi, e.g. cultural beliefs and practices (Table 4.2.2a to 4.2.2e). In addition, international factors also influenced MCH policies in Malawi i.e. some policies were developed in response to, based on, or to fulfil international trends and agreements. For example, NHP 1986-1995 was based on the Alma Ata Declaration (MoH, 1986). NHP 1999-2004 was developed in response to the World Bank call for decentralization and the WHO SWAp guidelines (MoH, 1999a) [See Table 4.2.2a). HPFP was developed in response to the World Bank call for Health Policy Framework Papers (MoH, 1995). Vision 2020 was developed in response to the World Bank's call for long-range health plans based on PRSP (MoH, 1999b). JPoW was developed because of MoH's need for international donor partners to finance the sector through SWAp (MoH, 2004b) [See Table 4.2.2b]. RH Policy was developed in response to ICPD and FWCW as Malawi adopted ICPD PoA (MoH, 2002a).

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Similarly, the Roadmap was developed based on development of MDGs and in response to African Union's call for country specific roadmaps to reduce maternal and neonatal morbidity/mortality (MoH, 2006b). National RH strategy was developed as government's commitment to SMI, ICPD, FWCW and MDGs (MoH, 2006a) [See Table 4.2.2c]. Malawi adopted EPI in 1979 (MoH, 2002b) and programme of CSD was based on a programme framework developed by UNICEF (GoM and UNICEF, 1988). IMCI Approach policy was based on IMCI strategy developed by WHO and UNICEF and adopted in Malawi in 1998 (MoH, 2006c). In addition, IMCI approach policy was developed as the government's commitment to UN Declarations on MDGs. Furthermore, IMCI approach policy was developed in the context of MDGS, Human Rights Based Approach to Programming, EHP and SWAp. Strategic plan for CSD was formulated as a government's commitment to international and regional declarations on CSD (MoH, 2007) [See Table 4.2.2d]. Policy on ECD was developed in response to Convention on the Rights of a Child to which Malawi was a signatory in 1987 and Convention of Elimination of all forms of Discrimination against Women in 1991 (MGYCS: 2001. HIV/AIDS policy and NAF (NAC, 2003; NAC, 2005a) were developed in response to HIV/AIDS pandemic as well as government's commitment to regional and international declarations i.e. MDGs, UNGASS, Abuja declaration (Table 4.2.2e).

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Table 4.2.2a: National Health Plan documents

Policy documents	Situational factors	Structural factors	Cultural factors	International factors
NHP 1964-1965	Transfer of government from colonial to independence under one party rule (MoH, 1965)	Inadequate resources i.e. shortage of staff, inadequate infrastructure (MoH, 1965:3)	Not evident in the document	Not evident in the document
NHP 1973-1988	Not evident in the document	Population largely rural i.e. 90% of the population stayed in small villages (p7-9) High fertility rate, 8.2, densely populated (MoH, 1971:7-9). Agricultural based economy leading to limited resources (MoH, 1971:13) . Shortage of professional staff resulting in difficulties in implementing policies (MoH, 1971:23)	Not evident in the document	Not evident in the document
NHP 1986-1995		High mortality rates i.e. child and infant mortality 151 and 149 deaths per 1000 live births respectively. High fertility rate, 7.6 (MoH, 1986:2-2) Limited financial resources and donor dependence (MoH, 1986:4-5) Lack of staff both at management and service delivery level (MoH, 1986:4-6) Lack of access to health services greatest in rural areas (MoH, 1986:4-7)	Not evident in the document	Global agreement to use PHC as service delivery strategy (MoH, 1986:3-3) In 1978 Malawi government endorsed the PHC approach as a healthcare delivery system (MoH, 1986:3-3)
NHP 1999-2004	Two major droughts in 1991/1992 and 1993/1994 (p3) HIV/AIDS epidemic (MoH, 1999:4)	Agricultural based economy (MoH, 1999:3). Small formal employment sector (MoH, 1999a:3). Growing population, population was 9.8 million with TFR of 6.7 and growth rate of 3.2% (MoH, 1999a:3). Young population i.e. almost half of the population is under 15 years of age (MoH, 1999a:3). Low literacy i.e. 48% of women and 30% of men were functionally illiterate (MoH, 1999a:3). Low life expectancy, 44 years at birth (MoH, 1999a:4). High mortality i.e. MMR of 620/100000, IMR of 54, U5MR of 234, MMR (p4). High disease burden i.e. diarrhoeal, acute respiratory infections, HIV/AIDS, STDs, TB, malnutrition was epidemic (MoH, 1999a:4-5). Limited access to healthcare services i.e. low geographical access (MoH, 1999a:17). Inadequate resources (human, finances, drugs, equipment) (MoH, 1999a:17) . Unavailability of information for decision making i.e. HMIS information is neither systematized nor easily accessible for proactive planning (MoH, 1999a:74). Weak inter-sectoral linkages in health service delivery (MoH, 1999a:18)	Not evident in the document	Developed in line with the World Bank call for HSR like decentralization and SWAp for healthcare financing (Mohindra, 2007:166; Green, 2007:80; World Bank, 1993). Adoption of Government policy on national decentralization (MoH, 1999a:10).

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Table: 4.2.2b Other MoH planning documents

Policy documents	Situational factors	Structural factors	Cultural factors	International factors
HPFP	Political transformation from single party political system to multi-party democracy in 1994 (MoH: 5). The country was hit by droughts in 1992 to 1994 (MoH: 1995) HIV/AIDS prevalence rate of 11.7% of the population (MoH: 1995:25).	High population growth rate and fertility rate, 6.7 and 3.6% respectively (p4) Agricultural based economy (MoH, 1995:5). High inflation rate,(MoH, 1995:10) High mortality i.e. MMR of 620/100000, U5MR of 234/1000, IMR of 134/1000 (MoH, 1995:4 and 25). Inadequate resources i.e. under funding of the health sector and uncertainty in budgetary allocations, drug shortages, staff shortages (MoH, 1995:10) . Centralized health system and slow progress in decentralization (MoH, 1995:28). Weak inter-sectoral collaboration (MoH, 1995:30) . Lack of community empowerment (MoH, 1995:27-30)	Not indicated	Response to the World Bank call for Health Policy Framework Papers Suspension of development aid by western donors (MoH, 1995:5)
Vision 2020	Droughts in 1991/1992 and 1993/1994	Poverty i.e. with per capita GNP of US$170 and 60% of Malawians live below poverty line, huge fiscal deficit rapid inflation, fluctuating GDP (MoH, 1999b:11, 22). Low life expectancy i.e. 44 years (MoH, 1999b:11). Increased disease burden, High mortality rate i.e. MMR of 620/100000, IMR of 134/1000, U5MR of 234/1000 (MoH, 1999b:11). Inadequate resources i.e. financial, human, drugs and poor infrastructure (MoH, 1999b:18-19). High population growth rate i.e. growth rate was 3.2% annually, TFR was 6.7 (MoH, 1999b:19). High illiteracy and Poverty (MoH, 1999b:19-20). Poor HMIS (MoH, 1999b:20). Weak managerial structures and systems (MoH, 1999b:20-21).	Not indicated	Response to the World bank call for health sector long range plans. Was based on PRSP (MoH, 1999b:ii)
POW	Not evident in the documents	Low life expectancy i.e. 39 year (MoH, 2004b:6). Poverty, 65.3% of the population below poverty line (MoH, 2004b:6) High mortality i.e. MMR of 1120/100000, IMR of 104/1000, U5MR of 189/1000 (MoH, 2004b:6) High disease burden i.e. diarrhoeal diseases, ARIs, STIs, HIV/AIDS, TB (p7) Inadequate resources i.e. critical shortage human resources, drugs and essential supplies, poor infrastructure (MoH, 2004b:6,13)	Not indicated	Health sector reforms Malawi adopted SWAPs as financing strategy for the health sector by international donor partners (MoH, 2004b:i). HIV/AIDS epidemic (MoH,

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		Inadequate community involvement and participation (MoH, 2004b:14)		2004b:6)

Table 4.2.2c: Malawi Reproductive Health Policies

Policy documents	Situational factors	Structural factors	Cultural factors	International factors
Reproductive health policy	Not evident in the document	High fertility rate of 6.3 and teenage pregnancies (MoH, 2002a:2). High mortality i.e. MMR of 1120/100000, IMR of 104/1000, U5MR of 189/1000 (MoH, 2002a:2) Low rate of skilled attendance at delivery i.e. 56% (MoH, 2002a:2) Unmet need for family planning at 30% (MoH, 2002a:2)	Home deliveries by untrained TBAs and family members. SRH harmful practices. Domestic and sexual violence. No male involvement maternal and child health issues (MoH:2002a:12)	Developed in response to ICPD in 1994 and the FWCW in 1995 (MoH, 2002a:1). Malawi adopted ICPD Programme of Action (MoH, 2002a:ii,1)
The Roadmap	Not evident in the document	Agricultural based economy (MoH, 2006b:1) Poverty i.e. GDP of US$170, 65% of the population is below poverty line (MoH, 2006b:1) High MMR of 1120/100 000 (MoH, 2006b: 1) Weak community participation and involvement (MoH, 2006b:5) Shortage of staff, drugs, inadequate infrastructure (MoH, 2006b:5) Inadequate coordination mechanisms among partners and stakeholders (MoH, 2006b:5)	Harmful social and cultural beliefs and no male involvement (MoH, 2006b:5)	Based on MDGs related to maternal and child health. Was developed in response to African Union call for country specific roadmaps (MoH, 2006b:viii,3-4).
RH strategic plan	Not evident in the document	Poverty i.e. GDP per capita of US$170, poverty headcount and extreme poverty headcount was at 52.4% and 22.4% respectively (MoH, 2006a:11) Rural based population i.e. 85% of the population (MoH, 2006a:11) Growing population i.e. growth rate of 2.1 with TFr of 6.0 High mortality i.e. low life expectancy of 40 year at birth, MMR of 984 deaths /100 000 (MoH, 2006a:11) Increasing urban-rural migration (MoH, 2006a:11) Inadequate resources i.e. per capita health expenditure of $12, high, high vacancy rates i.e. 67.6% vacancies rate for nurses, inadequate and poor infrastructure (MoH, 2006a:12) Low accessibility of health services i.e. 46% of the population has access to health services to formal healthcare facility within a 5km radius, 20 % of the population lives within 25km of a hospital (MoH, 2006a:12)	Harmful practices and no male involvement (MoH, 2006a:27,31)	Safe Motherhood Initiative, ICPD and FWCW, MDGs (MoH, 2006a:5,10,13). Adoption of ICPD Programme of Action and MDGs (MoH, 2006a:5,10, 12)

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Table 4.2.2d Child Health Policy documents

Policies	Situational factors	Structural factors	Cultural factors	International factors
EPI manual	Not evident in the document	Child mortality due to preventable diseases (MoH, 2002b:3). External donor dependence i.e. EPI is heavily indebted to external donors (MoH, 2002b:3). Poor procurement and distribution logistics for medical supplies i.e. untimely delivery of supplies (MoH, 2002b:3). Inadequate human resource and infrastructure (MoH, 2002b:2). Insufficient supervision (MoH, 2002b:2)	Cultural believes and practices in child ailments and treatments (MoH, 2002b:3)	WHO established EPI, 1974 (MoH, 2002b:1) Malawi launched of EPI in 1979 (MoH, 2002b;1)
Programme of CSD	Not evident in the document	High child mortality i.e. IMR rate ranged from 137 to 233/1000, U5MR was 320 deaths/1000 live births (GoM and UNICEF, 1988:6). Poverty due to low-off-farm income of women which has serious problems of food and basic economic security (GoM and UNICEF, 1988:7). Food insecurity contributing to malnutrition among women and children GoM and UNICEF, 1988:8). Disease burden i.e. malaria, respiratory diseases and diarrhoeal diseases MoH, 1988:8). High illiteracy rate among women (GoM and UNICEF, 1988:11).	Home deliveries Cultural believes and practices on pregnancy, delivery and child care (GoM and UNICEF, 1988:8)	Was based on a programme framework developed by UNICEF on the situation of women and children and nutrition situation (GoM and UNICEF, 1988:2)
IMCI approach policy	Not evident in the documented	Young population i.e. 17% children under the age of five of the population (MoH, 2006c:8). Predominantly agro-based economy (MoH, 2006:8). Poverty i.e. per capita income of US$177, 65% of the population live below poverty line (MoH, 2006c:8) . Disease burden i.e. malaria, diarrheal, malnutrition, HIV/AIDS (MoH, 2006c:8). Mortality i.e. low life expectancy of 37 years, MMR of 984/100 000, IMR of 76/1000, U5MRof 189/1000 (MoH, 2006c:8)	Traditional beliefs and practices in child illness and treatment, child feeding, pregnancy and delivery (MoH, 2006c:8)	WHO and UNICEF developed IMCI approach. (MoH, 2006c:3, 7). Malawi adopted IMCI approach in 1998 (MoH, 2006c:3, 7). As a commitment to UN Declaration on MDGs in 2000. Malawi was a signatory to UN declaration on MDGs in 2000. IMCI policy was developed in the context of MDGS, Human Rights Based Approach to Programming (HRAP), EHP and SWAp MoH, 2006c:3, 7).
Strategic plan for ACSD		Growing population with growth rate of 3.3 and TFR of 6.3 (2007:6 and 8). Young population, 22% of the population is under five years of age (MoH, 2007:6). Poverty, 86% of Malawians live rural areas on agro based economy; the country's GDP is estimated at US$157.5 (MoH, 2006:8). Mortality i.e. MMR of 984/1000 and NMR of 31, IMR 0f 69, U5MR of 118 per 1000 respectively. Inadequate resources i.e. shortage of funding due to shifting donor priorities (per capita expenditure on health of US5), shortage of skilled human resource, frequent drug stock outs, inadequate physical infrastructure (MoH,	Not evident in the document	Malawi adopted IMCI which in 1998 was developed by WHO and UNICEF. Response to government commitment to international and regional declarations on ACSD MDGs, Abuja declaration, CRC, Dakar declaration, African Union call (MoH, 2007:viii,30-32). Adoption of high impact interventions, IMCI approach and government's commitment to international/regional agreements/declaration on acceleration of CSD

		2007:20). Poor quality of HMIS data (MoH, 2007:22).		development (MoH, 2007:viii, 30-32)

Table 4.2.2e: Other Health policies impacting on MCH in Malawi

Policy documents	Situational factors	Structural factors	Cultural factors	International factors
Policy on ECD		Agricultural based economy (MGYCS, 2001:1) Poverty i.e. 65% of the population live below poverty line, line 9MGYCS, 2001:1 and 4). Young population i.e. more than 50% of the population is below the age of 18 (MGYCS, 2001:1) High mortality i.e. child mortality of 189/1000, IMR of 104/1000 and MMR of 1120/100000 (MGYCS, 2001:1,4) High child disease burden i.e. malaria, diarrhoeal diseases, respiratory infections and malnutrition are leading causes of child mortality and HI/AIDS (MoH, 2001:1,4) Illiteracy and gender based violence towards women (MGYCS, 2001:1) Child abuse i.e. sexual, emotional, physical and child labour (MGYCS, 2001:1). Poor access to health services especially in rural areas Food insecurity (MGYCS, 2001:5) Poor sanitation and accessibility to safe water are worse in rural than urban areas (MGYCS, 2001:7)	Not evident in the document	Was developed in response to Convention on the Rights of a Child to which Malawi is a signatory in 1987 and Convention of Elimination of all forms of Discrimination Against Women in 1991(MGYCS, 2001:ii,7). Adoption of the Conventions of on the Rights of the Child [CRC] and Convention of Elimination of all forms of Discrimination Against Women (MGYCS, 2001:ii,7)
HIV/AIDS policy	HIV/AIDS epidemic i..e. HIV/AIDS first case in 1985 (NAC, 2003:vii	Poverty i.e. 65% of the rural and 55% of the urban population living in poverty (NAC, 2003:1) Young population i.e. 45% of the population below age if 15 resulting in high dependence ratio (NAC, 2003:1) HIV/AIDS infection and death i.e. HIV prevalence among 15-49 years old at 15% (NAC, 2003:1)	Cultural/traditional and religious practices and beliefs i.e. polygamy, chokolo and gender imbalance in accessing public services like education and health (NAC, 2003:1)	HIV/AIDS pandemic (NAC, 2003:1) Commitment to regional and international declarations i.e. MDGs, UNGASS, Abuja declaration (NAC, 2003;2-3)
HIV/AIDS action framework	HIV/AIDS epidemic i..e. HIV/AIDS first case in 1985 (NAC, 2005a:4)	HIV prevalence of 14-33% in 2004 (NAC, 2005:4), poverty i.e. 65.3% of the population were poor in 1998 (NAC, 2005a:2), food insecurity	Cultural beliefs and practices; Gender imbalance; Child inheritance; and Child cleansing (MoH, 2007:5)	MDGs, UNGASS declaration (NAC, 2005a:1; NAC, 2007:2)

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4.2.3 Process of MCH policy development in Malawi

Initiation and problem identification

No evidence was found in official documents reviewed on how NHPs from 1965 to 1995 (MoH, 1965, 1971 and 1986) were initiated. NHP for 1999-2004 resulted from agreement between MoH and its donor partners on how HSR was to be implemented in Malawi (MoH, 1999a) [See Table 4.2.3a]. The commencement of HPFP and Vision 2020 policy development was based on the governments' response to the World Bank call to develop HPFP and long-range plans (MoH, 1995; MoH, 1999b). Similarly, launch of JPoW resulted from agreement between MoH and its international donors on SWAp for health sector financing (MoH, 2004b) [See Table 4.2.3b]. In addition, the introduction of Reproductive and Maternal Health Policies (MoH, 2002a, 2006b and 2006a), child Health Policies (Government of Malawi and UNICEF, 1988; MoH, 2002b, 2006c and 2007) and other Health Policies influencing MCH in Malawi (MGYCS, 2001; NAC, 2003 and 2005a) were the result of national governments' response to international and regional agreements and other health trends (Tables 4.2.3c to 4.2.3e).

Problems for MCH policies in Malawi were identified through various methods; nevertheless review of national and international documents was the most cited method. Problem identification for NHPs (MoH, 1965; MoH, 1986; MoH, 1999a) was based on review of national and international policy documents except for NHP 1973-1988 (MoH, 1971). Policy problems for NHP 1973-1988 were identified through baseline assessment of health services in Malawi (Table 4.2.3a). Problem identification for HPFP (MoH, 1995), vision 2020 (MoH, 1999b) and JPoW (MoH, 2004b) was based on review of previous national policies and international documents (Table 4.3.2b). Problems for RH Policy (MoH, 2002a) were identified through needs assessment workshop. Problems for Roadmap (MoH, 2006b) were identified through a national EmOC assessment workshop. Situation analysis of National RH Strategy (MoH, 2006a) based on review of previous strategy and other documents which fed into (Strengths, Weaknesses, opportunities and Threats) SWOT analysis (Table 4.2.3c). Problems identified in the programme for CSD were based on programme design framework from UNICEF (GoM and UNICEF, 1988). Problem identification

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for IMCI approach policy was conducted through baseline study (MoH, 2006c). Problem identification of five-year national strategic plan for ACSD (MoH, 2007) and EPI manual (MoH, 2002b) were based on review of national and international documents (Table 4.2.3d). Problem identification for policy in the ECD policy document was based on review of national and international policies (MGYCS, 2001). Problem identification of HIV/AIDS policy (NAC, 2003) was based on review of HIV/AIDS control programmes and national wide assessments undertaken by consultants appointed by the Malawian government. Problem identification for the HIV/ADS national action framework (MoH, 2005a) was based on end of term review of National Strategic Framework (NSF) for 2000 - 2004 (Table 4.2.3e).

Policy formulation

External consultants formulated NHPs for 1965-1969 and 1973-1988 (MoH, 1965; MoH, 1971). NHP 1986-1988 (MoH, 1986) was formulated by MoH with assistance from international technical specialists, other government ministries and departments with the World Bank and MSH providing additional technical and financial assistance (MoH, 1986). MoH planning unit with financial and technical assistance from the World Bank, USAID and DFID facilitated formulation of NHP for 1999-2004 (MoH, 1999a). In addition, formulation of NHP for 1999-2004 was based on DIPs and developed through consultative workshop and series of consultations (MoH, 1999a) [See Table 4.2.3a].

There was no information on how HPFP was formulated (MoH, 1995). On the other hand, a core team comprising of MoH managers and international donors formulated Vision 2020 with donors providing financial and technical assistance (MoH, 1999b:15-16). JPoW was formulated by consolidating work plans from various departments and MoH planning unit coordinated formulation process (MoH, 2004b:i and 3). Technical and Financial assistance was provided by WHO and other MoH donor partners (Table 4.2.3b). Formulation of Reproductive and Maternal Health Policies was through technical and financial assistance from donors (MoH, 2002a; MoH, 2006a; MoH, 2006b) [See Table 4.2.3c]. MoH and TWG formulated Child Health Policies with financial and technical assistance from donors (GoM and UNICEF, 1988; MoH, 2002b, MoH, 2006c; MoH, 2007) [See Table 4.2.3d]. Policy on ECD did not document how it was formulated (MGYCS, 2001). Teams and

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committees formulated the HIV/AIDS Policy and HIV/AIDS NAF with technical and financial assistance from donors (NAC, 2003; NAC, 2005a) [See Table 4.2.3e). It was not evident how policy decisions were arrived at from reviewed documents (Tables 4.2.3a to 4.2.3e).

Policy implementation

While NHP 1965-1969 (MoH, 1965) did not document how it was to be implemented, NHPs for 1973-1985 and 1986-1995 (MoH, 1971; MoH, 1986) described the implementation structure but did not outline implementation plans. Implementation of NHP 1999-2004 (MoH, 1999a) was to base on districts' five-year plans, which were translated to budgeted annual plans (Table 4.2.3a). HPFP (MoH, 1995) did not state how it was going to be implemented, whilst Vision 2020 (MoH, 1999b) described its implementation structure but did not outline implementation plan (MoH, 1999b:91-96). Implementation of JPoW (MoH, 2004b) was to be guided by annual work plans (Table 4.2.3b). Reproductive and Maternal Health policies (MoH, 2002a, MoH 2006a; MoH, 2006b) were to be implemented as part of EHP through JPoW (Table 4.2.3c). Programme of CSD (GoM and UNICEF, 1988) was to be implemented through various ministries. Implementation of IMCI approach Policy (MoH, 2006c) was to involve both private and public partners and various ministries. The Five-year National Strategic Plan for ACSD (MoH, 2007) was to be implemented through various ministries. However it was not evident in the document if the document was translated into work plans at implementation level (Table 4.2.3d). Programme of ECD (MGYCS, 2001) was to be implemented through various stakeholders. HIV/AIDS policy (NAC, 2003), and HIV/AIDS NAF (NAC, 2005a) had no information on how they were to be implemented (Table 4.2.3e). Finally, it was not evident in all documents reviewed on how the policies were to be communicated to implementers (Tables 4.2.3a to 4.2.3e).

Monitoring and supervision

All NHPs (MoH, 1965, MoH, 1971, MoH, 1986; MoH, 1999a) were to be monitored through HMIS data but there was no information on supervision (Table 4.2.3a). It was not evident in the documents how HPFP and Vision 2020 (MoH, 1995; MoH, 1999b) were going to be monitored and their implementation supervised. JPoW (MoH,

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2004b) was to be monitored through HIMS and annual joint reviews mid-term review but there was no information on supervision (Table 4.2.3b). Reproductive and Maternal Health Policies (MoH, 2002a; MoH, 2006a; MoH, 2006b) were to be monitored through HMIS routine data collection and analysis. However it was not evident how their implementation was to be supervised (Table 4.2.3c).

Programme of CSD (GoM and UNICEF, 1988) was to be monitored through implementation reviews. Supervision and monitoring were to be the responsibility of implementing partners by providing regular reports. Supervision for five-year strategic plan for ACSD (MoH, 2007) and IMCI (MoH, 2006c) was to be done by IMCI coordinators and monitoring was to be done through reports and bi-annual reviews (Table 4.2.3d). Supervision and monitoring for policy on ECD (MGYCS, 2001) was the responsibility of the implementing partners. Implementing stakeholders were to be responsible for providing regular reports to MGYCS (MGYCS, 2001:19-20). MGYCS was going to carry out review of implementation as part of the normal performance review circle. There was no information on supervision. HIV/AIDS policy (NAC, 2003) was to be monitored through sentinel surveys and routine HIMS data but there was no information on supervision. HIV/AIDS NAF (NAC, 2005a) was to be monitored through routine data collection analysis, and sentinel surveillances. There was no information on supervision (Table 4.2.3e).

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Policy review and evaluation

It was not evident in documents if MCH policies were evaluated, however some were reviewed. All NHPs (MoH, 1965; MoH, 1971; MoH, 1986; MoH, 1999a) were reviewed prior to developing the next plans (Table 4.2.3a). There was no information to indicate if HPFP (MoH, 1995) and vision 2020 (MoH, 1999b) were reviewed or evaluated. JPoW (MoH, 2004b) was still being implemented at the time of study, however MoH and donors conducted bi-annual and annual reviews as means of tracking implementation progress (MoH, 2004b:35) [Table 4.2.3b]. There was no information to indicate if RH Policy (MoH, 2002a) and the Roadmap (MoH, 2006b) were reviewed or evaluated. National RH Strategy (MoH, 2006a) was still being implemented (Table 4.2.3c).

There was no information to indicate that Programme of CSD (GoM and UNICEF, 1988) was reviewed or evaluated. IMCI Approach Policy (MoH, 2006c), Five-year Strategic Plan for CSD (MoH, 2007) and EPI (MoH, 2002b) were still being implemented at the time of the study; however, the previous EPI manual was revised not evaluated (Table 4.2.3d). There was no information to indicate that Programme for ECD (MGYCS, 2001) and HIV/AIDS Policy (NAC, 2003) were reviewed or evaluated. NAC conducted End of Term Review (ETR) of National Strategic Framework whose results fed into HIV/AIDS NAF, in addition HIV/AIDS NAF (NAC, 2005a) was evaluated every year as evident by yearly reports (NAC, 2005b) [See Table 4.2.3e].

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Table 4.2.3a National Health Plans

Policy documents	Initiation and problem identification	Policy formulation	Policy implementation	Policy evaluation
NHP 1965-1969	No evidence on initiation Based on review of national and international documents (MoH, 1965:ii). Not evident on how policies were arrived at or communicated t implementers	WHO consultant conducted baseline study and developed the plan (MoH, 1965:1) It is not clear how policies were arrived at It is not known how it was communicated to implementers	Did not document how it was to be implemented in terms of who was to do what and when	Was reviewed when developing the next plan (MoH, 1971:ii; MoH, 1986:3-2 to 3-4). Not evident if evaluation was done
NHP 1973 - 1988	No evidence on initiation An assessment of health services in Malawi by external consultants. Review of journals, national and international documents (MoH, 1971:1-6).	WHO team of consultants conducted an assessment of healthcare services in Malawi and draw up the plan. Consultants were reporting to a planning committee in MoH which was to see through the implementation of the plan (MoH, 1971:1-6) It was not documented how policies were arrived at and how it was communicated to implementers	Implementation was to be overseen by MoH planning committee (WHO, 1965:2) Has implementation structure but does not outline who was to do what and when in terms of implementing activities of the plan to achieve its objectives (MoH, 1971)	Was reviewed when developing the next plans (MoH, 1986:3-2 to 3-4) Not evident if evaluation was done
NHP 1986-1995	No evidence on initiation Based on review of previous national policies and strategies, and international documents (MoH, 1986:3)	MoH with assistance from external technical specialists and other government ministries and departments undertook comprehensive review of health sector in Malawi (MoH, 1986:1). The plan resulted from this review through a documented planning process (MoH, 1986:2). A consultant coordinated technical assistance from World Bank and MSH were involved in preparatory work for the plan (MoH, 1986:1)	Describes how proposed recommendations should be implemented. Outlines organizational structure but does not outline who was to do what and when in terms of implementing activities of the plan to achieve its objectives (MoH, 1986:8-2 to 10-4). No information of how implementation was to be monitored or supervised.	Reviewed when developing the next plan, HPFP and vision 2020 (MoH, 1995;1,2,16-20; 1999a:9,15-90; 1999b:1)
NHP 1999-2004	Agreement between MoH and its donor partners on HRS (MoH, 1999a:1). Focus group discussions at TAs at district level lead to community needs assessment. TWGs reviewed previous policies identified six priorities (MoH, 1999a:1).	Two week consultative workshop to draft district planning guidelines which underwent extensive review through series of consultations with DHOs, RHOs, SMS, CHAM, planners from other ministries and donor agencies. Series of consultations resulted in finalized 5-year district plans whose integration resulted in 1999-2004 NHP. The plan was drafted by MoH technical teams under leadership of planning unit (MoH, 1999a:15-16). TA and FA was provided by WB, USAID and DFID (MoH, 1999a:1)	Implementation at district level to base on each district 5 year plans, in congruence with national 5 year plan, which will be translated into budgeted implementation plan (MoH, 1999b;71). Outlines implementation structure but no plans for implementation (MoH, 1999b:71-73). Monitoring was to be done through HMIS. (MoH, 1999b:74-75). Did not mention if supervision was to be done.	Reviewed when developing the next plan (MoH, 2004b:4-5)

Table 4.2.3b Other MoH planning documents

Policy documents	Initiation and problem identification	Policy formulation	Policy implementation	Policy evaluation
HPFP	Response to WB call for HPFPs. Based on review of previous health plans (MoH, 1995:16-30)	Not evident in the document	No information on how it was going to be implemented, by who and when. No information on how it was going to be communicated to implementers No information on how it was to be monitored and supervised	Reviewed when developing next plans (MoH, 1999a:15; 1999b:1). No evidence if it was evaluated or not.
Vision 2020	Response to WB calls for long range plan. Based on review of previous plans and assessment of inherited problems lead to identification of priorities (MoH, 1999b:9,15-90)	Core team comprising of MoH managers and donors was formed. Under which various committees to explore identified priorities were formed (MoH, 1999b:15). Two week consultative workshop to draft district planning guidelines and a revised long range plan. Both guidelines and long range plan underwent extensive review through series of consultations with DHOs, RHOs, Senior Medical superintendents, CHAM, planners from other ministries and donor agencies. Series of consultations resulted in 5-year district plans, fourth NHP and Vision 2020 (MoH, 1999b:15-16). WB and USAID provided external consultation to MoH. WB, USAID and DFID provided FA (MoH, 1999b:15).	Describes implementation structure but no plans as to what is going to implemented by who and when (MoH, 1999b:91-96). Not evident on how the plan was to be communicated to implementers. No information on how it was to be monitored and supervised (MoH, 1999b)	Not evident if the document was reviewed or evaluated (MoH, 1999b)
POW	Agreement between MoH and donor agencies for joint plan of work. Based review of various document sources to facilitate prioritization process (MoH, 2004b:I, 12-14)	Developed through consultative and consolidation of work programmes from various programmes and central MoH departments (MoH, 2004b: i). TA and FA were provided by WHO and other partners (MoH, 2004b:3). Directors, programme managers and DHMT through DHOs submitted plans as a basis for PoW. Planning Unit coordinated formulation process (MoH, 2004b:3)	Implementation on based on SWAp guided and governed by code of conduct and MOU amongst stakeholders in joint POW (MoH, 2004b: ii). Implementation guided by annual work plans based on activities outlined in DIPs and annual work plans of central MoH (MoH, 2004b:ii,35 and 37). Monitoring through HIMS, annual joint reviews mid-term review (MoH, 2004b: ii and 35). Did not mention how it was to supervised	Still being implemented , however MoH and donors conduct bi-annual and annual reviews as means of tracking implementation progress (MoH, 2007:9; 2004b:35)

Table 4.2.3c: Reproductive health and maternal health

Policy documents	Initiation and problem identification	Policy formulation	Policy implementation	Policy evaluation
RH Policy	Following ICPD recommendations and Global Safe Motherhood Initiative (MoH, 2002a:1,7). Bases on needs assessment workshop (MoH, 2002a:ii)	Technical and financial assistance from USAID and DFID. Needs assessment workshop where stakeholders agreed to develop a policy. Drafting and finalization (MoH, 2002a:ii-iii). No detailed information on formulation process (MoH, 2002a)	Outlines implementation structure but no plans in terms of what activities were to be implemented by who, where and when (MoH, 2002a:14). RH services to be integrated with other services through EHP and to be implemented through JPoW. To be monitored through RHMIS (MoH, 2002a:17). No information on supervision	No information on whether it was reviewed or evaluated
The Roadmap	MMR crisis in the country, response to global and African call and conformity to attain MDGs (MoH, 2006b:viii,3,5). National wide EmOC assessment to identify capacity of healthcare delivery system to reduce maternal and neonatal mortality and to propose action oriented plan (M0H, 2006b:v)	Technical and financial support from WHO, UNFPA and UNICEF (MoH, 2006b:v, vii). Formulated through stakeholders' consultation meeting which resulted into a draft. A small TWG finalized the document (MoH, 2006b:vi-vii)	To be implemented through SWAp, EHP and JPoW, however no plans on how it was to be implemented (MoH, 2006b: xi). No information on how it was to be communicated to implementers. No information o how it was to be monitored and supervised	It has no time frame and there is no information on whether it was reviewed or evaluated
RH Strategic Plan	ICPD recommendations and commitment to attain MDGs (MoH, 2006a:5, 13). Based on review of previous reproductive health strategy 1999-2004 and other documents which fed into SWOT analysis for each strategy (MoH, 2006a:5,17,19-20,22-23,25,26,28,29,30,31,32,34)	Technical and financial assistance was provided by USAID and JHPIEGO (MoH, 2002; 6). The process started with defining the current status of RH programme with its achievements, and in-depth analysis of strengths, weaknesses, opportunities and threats. The SWOT analysis formed the basis of suggested strategic direction for plan. (MoH, 2006a:10)	To be implemented through SWAP and EHP based on priorities set in joint POW (MoH, 2006a:10). No information on how it was to be communicated to implementers (MoH, 2006a). No information on how it was to be monitored and supervised	Still being implemented, however it was not evident in document whether it was to be reviewed or evaluated

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Table 4.2.3d: Child Health Policies

Documents	Initiation and problem identification	Policy formulation	Policy implementation	Policy evaluation
Programme for CSD	Study of the Situation of children and women in Malawi basing on the programme design framework by UNICEF (GoM and UNICEF, 1988:2-8)	Formulation process not evident in the document, however, the programme was designed following analysis of the situation of children and women in Malawi. This was followed by funding by UNICEF. (GoM and UNICEF, 1988:11). Financial and technical assistance from UNICEF and WHO	To be implemented through various ministries i.e. education, health, agriculture etc and implementation plan was outlined (GoM and UNICEF, 1988:13, 20-32). Monitoring through monthly implementation reviews and reports (GoM, 1988; 65) . No information on how it was communicated to implementers and on supervision	Process evaluation and end of programme evaluation were to be conducted but there were no plans for both evaluations and evidence to confirm if these were done or not (GoM and UNICEF, 1988:58,65)
IMCI approach policy	In response to global child mortality and morbidity, UNICEF and WHO developed IMCI strategy. .Malawi adopted IMCI approach in 1998 and implementation started in 1999. Baseline study in 2000followed by survey of community IMCI in 2004. Also based on review of existing policies, plans and household survey results (MoH, 2006c:7 and 9)	Formulation process involved development of a preliminary draft by TWG which underwent review through consultative and consensus building meetings with stakeholders. Finally the policy was endorsed by relevant ministries i.e. health, education, agriculture, women and child development etc. TA provided by WHO and UNICEF, FA by UNICEF, WHO and MSH (MoH, 2006c:4, 5,7).	Outlines implementation structure i.e. institutional framework which outlines stakeholders and their roles, no implementation plans . Each stakeholder was responsible communicating the policy to implementing structures (MoH, 2006c; 12-18). Not evident on how it was communicated to implementers and monitored or supervised.	To be reviewed every 5 year but no plans for review and evaluation outlined.
Strategic plan for ACSD	Malawi is committed to various international and regional declaration to reduce child mortality and morbidity i.e. MDGs, the African Union 5th Ordinary Session of the Assembly, Dakar Declaration, etc (MoH, 2007: viii,2). Based on review of national and international documents (MoH, 2007:6-26,30)	No detailed information on formulation process. The documents stated that it resulted from a multi-sectoral efforts coordinated by MoH and MoWCD. UNICEF, WHO and MSH provided technical and financial support. National steering committee and TWG drafted and reviewed the plan (MoH, 2007:x)	To implement through various ministries. Monthly, two-monthly and quarterly supervision of HSAs, health facilities and DHMT. But did not specify who was to carry out the supervision. Monitoring through monthly and quarterly programme activity reports, financial management reports, and bi-annual review meetings (MoH, 2007:,50,58)	Outlines structure for monitoring and evaluation but no plans outlined (MoH, 2007:59-61). The policy was still being implemented and it was not reviewed or evaluated yet
EPI manual, 2002	WHO established EPI in response to global childhood illnesses in 1974. Malawi adopted EPI in 1979. EPI manual 1982, 1994. National EPI review in 1999. WHO new guidelines and Zambia EPI (MoH, 2002b:1)	WHO and UNICEF provided technical and financial support. Hired consultant updated the document and made a draft which was reviewed by stakeholders. WHO and UNICEF did final editing. No information on dissemination (MoH, 2002b: iii).	Outlines the implementation structure Monitoring through EPI registers, coverage charts and routine HMIS monitoring (MoH, 2002b:1and 92-99). No information on supervision	The previous EPI have been revised and not evaluated. The 2002 one was still being implemented, however it did not have time frame (MoH, 2002:1)

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Table 4.2.3e Other Health Policies influencing MCH in Malawi

Policy documents	Initiation and problem identification	Policy formulation	Policy implementation	Policy evaluation
Policy on ECD	In response to conventions on Rights. Malawi is a signatory to Conventions on the Rights of the Child (CRC), OAU Charter, CEDAU, and Dakar Declaration (MGRCS, 2001:ii-iii). Based on review of national and internal policies (MGYCS, 2001:4-9)	Formulation process not evident in the document	To be implemented through various stakeholders. Supervision and monitoring is the responsibility of the implementing partners. Stakeholders will be responsible for providing regular reports to MGYD MGYCS will carry out review of implementation as part of the normal performance review circle (MGYCS, 2001:19-20	No information whether the document was reviewed or evaluated. No plans for review or evaluation
HIV/AIDS Policy	Malawi commitment to fight against HIV/AIDS at regional and international declarations i.e. UNGASS convention and MDGs. Based on review of national and international documents, and national wide assessment HIV/AIDS control programme done by consultants (NAC, 2003:3)	No information on formulation process. Stakeholders at consensus building committee included HIV/AIDS drafting team, Policy and Advocacy Steering committee, and team of consultants, TWG, Board of Commissioners and Cabinet Committee. Financial and technical support from USAID, UNDP and UNAIDS (NAC, 2003:xi)	No information on how it is going to be communicated to implementers and implemented Monitoring to be done through sentinel surveys and routine HIMS data. No information on supervision (NAC, 2003:39,40)	No information if it was reviewed or evaluated
HIV/AIDS national action framework	Malawi government's commitment to international and regional agreements i.e. Malawi aimed to implement NAF based on three indicators stipulated in UNGASS convention (NAC, 2005:1). Expiry and end of term review of NSF for 2000 - 2004 (NAC, 2005a:i-ii,1).	A multi-disciplinary Steering Committee was formed to guide NAF development process. A team of consultants was recruited. A two-day national workshop NSF ETR and subsequent NAF development. Participants included stakeholders at district and national level. Following the workshop, consultants developed tools and undertook consultations at national, district and community level. Another stakeholders meeting to disseminate findings of consultation to inform NAF (NAC, 2005:1-2). UNAIDS and UNDP provided financial and technical support (NAC, 2005a:iii)	No information how it is going to be communicated to implementers and implemented. To be monitored through routine data collection analysis, and sentinel surveillances. No information on supervision 9NAC 2005:37)	NAC conducted ETR of the national strategic framework which fed into the HIV/AIDS action framework NAC produces M and E reports every year i.e. Malawi HIV and AIDS Monitoring and Evaluation Report 2005-2006 (NAC, 2005b)

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4.2.4 Stakeholders

Most of the reviewed documents indicated that stakeholders were involved in MCH policy development through different teams like TWGs, task force and Technical Core Team (Table 4.2.4a). For example, NHP 1973-1985, NHP 1999-2004, Vision 2020, JPoW, IMCI Approach Policy, Five-year national Strategic plan for ACSD, RH policy, Roadmap, RH national strategy, HIV/AIDS policy and HIV/AIDS NAF were formulated through teams of stakeholders (MoH, 1971; MoH, 1999a; MoH, 1999b; MoH, 2004b; MoH, 2006c; MoH, 2007; MoH, 2002a; MoH, 2006b; MoH, 2006a, NAC, 2003; NAC, 2005a). The stakeholders included MoH, CHAM, academic institutions, multilateral organization, bilateral organization and national organizations (Table 4.2.4a). Table 4.2.4b, shows that MoH and international donors had high level of influence on MCH policies in Malawi whilst implementing partners and CHAM had medium level of influence. The Table also shows that local NGOs, private-for-profit, regulatory bodies, health workers and training institution had low level of influence on MCH policies. Lastly, the Table shows that beneficiary had very low-level influence on MCH policies in Malawi (Table 4.2.4b).

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Table 4.2.4a: Processes for involving stakeholders in MCH policy in Malawi

Policy	Processes for involving stakeholders	Stakeholders affiliations
NHP 1965-1969	No teams	Not applicable
NHP 1973-1988	Planning committee to which consultants gave feedback (MoH, 1971:1-3)	MoH permanent secretary, MoF, division of economic planning, WHO consultants (MoH, 1971:1-3)
NHP 1986-1995	No teams	Technical specialists from WHO, MoH officials (MoH, 1986:2)
NHP 1999-2004	Planning Unit Technical Support Teams TWGs (MoH, 1999a:1)	MoH, CHAM, MMC, NMCM, NGOs, health donor community and government departments (MoH, 1999a:1)
Vision 2020	Core Team (MoH, 1999b:15-16)	Principal secretary, senior-level MoH managers and donors (MoH, 1999b:15-16)
HPFP	No information (MoH, 199b)	No information (MoH, 1999b)
JPoW	Joint implementation Subcommittee for SWAp/EHP (MoH, 2004b:4)	MoH, collaborating partners and civil society organizations (MoH, 2004b;4)
Programme for CSD	No teams	UNICEF and MoH (GoM and UNICEF, 1988:2)
IMCI approach policy	Policy formulation team IMCI TWG (MoH, 2006c:5)	MoH, UNICEF, MoWCD, WHO MoH, MSF, WVI, WHO, UNICEF, MoWCG, MoAFS, MoE, MoIWD (MoH, 2006c:5)
Strategic plan for ACSD	National Steering Committee and TWG (MoH, 2007:viii-ix)	MoH, MoWCD, MoAFS, MoIWD, UNICEF, WHO, Africare, MSH, World Relief, WVI (MoH, 2007:viii-ix)
RH policy	Task force (MoH, 2002a:ii-v)	KCN, Umoyo Network, RHU-MoH, SM Project, BLM, MOGYCS-Department of youth, NMCM, NYCM, JSI/FPLM, USAID, JHPIEGO, MMC, RAC (MoH, 2002a:ii-v)
The Roadmap	Task force TWG (MoH, 2006b:vi-vii)	USAID, CHAM, DNO-Dowa, KCH-OBGY, UNFPA, RHU-MoH, UNICEF, COM, WHO, DHO-Dowa, GTZ, QECH-OBGY MoH, UNFPA, UNICEF (MoH, 2006b:vi-vii)
RH strategic plan	Stakeholders TWG (MoH, 2006a:6)	RHU-MoH, USAID, CHAM, COM-CRH, JHPIEGO, UNICEF, KCN, LATH, MCHS, MCM, HEU-MoH, planning-MoH, FPAM, BLM, NMCM, HMIS (MoH, 2006a:6) JHPIEGO, KCN, MoH (MoH, 2006a:6)
HIV/AIDS Policy	HIV/AIDS policy drafting team, Policy and Advocacy Steering committee, TWG, Board of Commissioners, cabinet Committee (NAC, 2003:xi)	Not specified
HIV/AIDS NAF	National Steering Committee, Technical Core Team (NAC, 2005a:iii)	MoF, Save the Children Federation, Umoyo Network, NAC, UNDP, UNAIDS (NAC, 2005a:iii)
EPI manual	Team of reviewers (MoH, 2002b:iii)	UNICEF, DFID, EPI-MoH, WHO (MoH, 2002b:iii)
Policy on ECD	No teams involved, it was formulated by MOGYCS (MGYCS, 2001:1)	MOGYCS, MoH, MoEST, MoA, religious institutions (MGYCS, 2001:1)

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Table 4.2.4b: List of stakeholders, their involvement in MCH policies, level of power/influence and their sources of power

Stakeholders	Involvement in MCH policies	Level of influence/ power	Source of power
MOH	Formulates MCH policies	High	- The mandate to provide health services in Malawi - Infrastructure, equipment and human resource
Donors	- Align international priorities with the national priorities - Provide technical assistance - Fund policy formulation, implementation of programmes	High	- Financial resources - Technical expertise - Access to new information
Implementing partners	- Implement MCH programmes - Provide technical assistance	Medium	- Access to financial resources - Technical expertise
Local NGOs	- Implement MCH vertical projects	Low	- No access to resources and information - No capacity
CHAM	- Implements MCH programmes	Medium	- Access to resources - Has infrastructure, equipment and human resource
Private for profit	- Implement MCH services for profit	Low	Technical expertise
Private not for profit	- Implement MCH services	Low	Access to resources
Regulatory bodies	- Supervise health professionals and health facilities-regulate health services	Low	Authority- licence health professional and facilities
Health workers	- Implement government MCH policies and services	Low	Technical expertise
Training institution	- Train health professionals - Conduct research	Low	Technical expertise
Beneficiaries	- MCH services recipients	Very low	None

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4.2.5 Lessons and gaps in MCH policy development

Lessons

In all official documents reviewed it was not evident that lessons had been learnt from previous MCH policy development in Malawi (Table 4.2.5) with the exception of Vision 2020 (MoH, 1999b), which outlined lesson for policy makers as "the potential overall impact for EHP is beyond the scope of any single sector and will require inter-sectoral collaboration at many levels," (MoH, 1999: 68).

Gaps

There was no documented evidence in the NHP 1965-1969 (MoH, 1965) on gaps in MCH policy development. The NHP 1973-1988 and 1986-1995 documents specified lack of skilled personnel at national level to plan and develop policies as potential gap for policy development in the country. On the other hand, the NHP 1999-2004 document (MoH, 1999a) indicated a number of gaps in policy development. Gaps identified were uncoordinated planning and priority setting with interventions being planned and implemented independent of each other resulting in duplication and overburdening of district level implementation. Other lessons were that there was no clear institutional framework for policy formulation and implementation, and policy formulation was uncoordinated and often at the influence of donors (MoH, 1999a). Weak inter-sectoral collaboration in policy development was a also gap in policy development identified in HPFP as well as lack of community empowerment (MoH, 1995). Vision 2020 listed weak managerial structures and systems with most departments and hospitals operating without goals or objectives, and poor HMIS i.e. current information systems have failed to produce on time required information for managerial decision making as a gap in policy development (MoH, 1999b). There was no documented evidence of gaps in MCH policy development in JPoW (MoH, 2004b); Maternal and Reproductive Health policies (MoH, 2002a; MoH, 2006a; MoH, 2006b); Child Health Policies (MoH, 2002b; GoM and UNICEF, 1988; MoH, 2006c; MoH, 2007) and other policies impacting on MCH in Malawi (MGYCS, 2001; NAC, 2003; NAC, 2005a) [See Table 4.2.5].

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Table 4.2.5 lessons and gaps in MCH policy development

Policy documents	Lessons	Gaps
NHP 1965-1969	Not evident in the document	Not evident in the document
NHP 1973-1988	Not evident in the document	No skilled personnel at national level to plan and develop policies (MoH, 1971:23-24)
NHP 1986-1995	Not evident in the document	Lack of experienced staff in planning and to develop policies (MoH, 1986:4)
NHP 1999-2004	Not evident in the document	Uncoordinated planning and priority setting with interventions being planned and implemented independent of each other resulting in duplication and overburdening of district level implementation No clear institutional framework for policy formulation and implementation Planning unit is supposed to be the policy clearing house of the MoH, but current practice has been characterised by uncoordinated policy formulation initiatives often at the influence of donors (MoH, 1999a:3-5)
HPFP	Not evident in the document	Weak inter-sectoral collaboration in policy development Lack of community empowerment (MoH, 1995:30)
Vision 2020	The potential overall impact f EHP is beyond the scope of any single sector and will require inter-sectoral collaboration at many levels (MoH, 1999b:68)	Weak managerial structures and systems i.e. most departments and hospitals operated without goals o objectives Poor health information management systems i.e. current information systems have failed to timely produce the required information for managerial decision making (MoH, 1999b:21)
JPoW	Not evident in the document	Not evident in the document
RH policy	Not evident in the document	Not evident in the document
The roadmap	Not evident in the document	Not evident in the document
RH national strategy	Not evident in the document	Not evident in the document
EPI	Not evident in the document	Not evident in the document
Programme of CSD	Not evident in the document	Not evident in the document
IMCI policy	Not evident in the document	Not evident in the document
Five year strategy for ACSD	Not evident in the document	Not evident in the document
National policy on ECD	Not evident in the document	Not evident in the document
HIV/AIDS policy	Not evident in the document	Not evident in the document
HIV/AIDS national framework	Not evident in the document	Not evident in the document

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4.2.6 Lessons and gaps in MCH policy implementation

There was no documented information on lessons learnt in MCH policy implementation. On the other hand, information on constraints in implementing MCH policies was regarded as gaps in MCH policy implementation (Tables 4.2.6a to 4.2.6e). Reviewed documents showed that public health facilities encountered a number of constraints in implementing MCH policies (Tables 4.2.6a to 4.2.6e). Information on constraints in MCH policy implementation was not evident in NHP 1965-1969 (MoH, 1965). NHP 1973-1988 indicated shortage of professional staff at MoH national office and lack of supervision of most of the district health services as constraints (MoH, 1971). NHP 1986-1995 specified list of constraints as follows inadequate financial resources and lack of enough experienced staff in national planning, day-to-day management and financial planning; budgeting and control, day-to-day management of health facilities (i.e. Drug management, and information systems at central, regional, district and health centre levels; inadequate manpower). Other lessons were lack of knowledge in the general population due to low levels of education (MoH, 1986). NHP 1999-2004 (MoH, 1999a) also listed various constraints including limited access to quality and effective healthcare due to low geographical access and services that targeted population at risk only. Other lessons listed were shortage and inadequate distribution of trained health personnel, shortage of essential drugs, medical supplies and equipment; and weak regulatory infrastructure (MoH, 1999a:17-18) [See Table 4.2.6a].

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Some of the constraints outlined in the HPFP document (MoH, 1995) included uncertainty in budgetary allocations, slow progress of decentralization, inadequate and poorly distributed health staff. Other lessons were drug shortages in health facilities; and weak inter-sectoral collaboration on health issues; and inadequate support for community structures (MoH, 1995). Vision 2020 (MoH, 1999b) indicated some of the following constraints, inadequate funding, scarcity of trained human resources, and inadequate and poor physical facilities. Vision 2020 also listed persistent shortage of drugs and medical supplies as a result of inadequate financial allocations as a constraint to policy implementation. Other constraints listed were high population growth, high illiteracy and poverty, high burden of diseases, weak managerial structures and systems, as well as poor health and information

management systems (MoH, 1999b). Constraints listed in JPoW (MoH, 2004b) included inadequate capacity to formulate policy, coordinate implementation, monitor progress and adequately support district health services. High burden of disease, poor access to healthcare, critical shortage of staff, and inadequate managerial skills at national and district level were also listed as constraint in policy implementation. Other constraints were inadequate involvement and participation of villages, inadequate financial management systems and accountability within the sector, and inadequate attention to evidence based decision making (Table 4.2.6b).

No information was evident in RH policy document on constraints in MCH policy implementation (MoH, 2002a). However, the Roadmap (MoH, 2006b) identified amongst others, shortage of staff, weak human resource management, and limited availability and utilization of maternal healthcare services. Low quality maternal healthcare services, weak procurement and logistics systems for drugs, supplies and medical equipment; problems of infrastructure, and weak referral systems were also listed as constraints for implementing policies. Other constraints were weak monitoring, supervision and evaluation, inadequate coordination mechanisms among partners and stakeholders, weak community participation and involvement, and; harmful socio-cultural beliefs and practices (MoH, 2006b). National RH strategic plan (MoH, 2006a) indicated inadequate human resources, limited financial resources, and poor and inadequate infrastructures as constraints in policy implementation (MoH, 2006a) [See Table 4.2.6c].

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Some of the constraints outlined in the EPI policy document included the following; insufficient financial resources; untimely and insufficient delivery of supplies; insufficient management and supervision (MoH, 2002b:3). There was no information evident in Programme of CSD (GoM and UNICEF) and IMCI Approach Policy (MoH, 2006c) on constraints in MCH policy implementation. In addition, the Five-year National Strategic plan for ACSD (MoH, 2007) identified constraints included shortage of funding, critical shortage of drugs and basic medical diagnostics equipment; serious shortage of skilled human resources; inadequate and poor healthcare facilities and; no evidence based decision making (MoH, 2007:20-22) [See Table 4.2.6d). There was no information evident in the other health policies documents that impact on MCH policies in Malawi (MGYCS, 2001; NAC, 2003;

NAC, 2003) [See Table 4.2.6e]. On the other hand, evidence was not documented on constraints encountered by NGOs and private sector.

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Table 4.2.6a: Constraints in MCH policy implementation: National Health Plans

Policy documents	Public facilities	NGOs	Private not for profit	Private for profit
NHP 1964-1965	Not evident in the document	Not evident in the document	Not evident in the document	Not evident in the document
NHP 1973-1988	Shortage of professional staff at MoH Lack of supervision of most district health services (WHO, 1971:93-94)	Not evident in the document	Not evident in the document	Not evident in the document
NHP 1986-1995	Inadequate financial resources i.e. 99% of development budget was financed by external donors. Lack of enough experienced staff in national planning and day to day management; financial planning; budgeting and control; day to day management of health facilities; drug management; and information systems at central, regional, district and health centre levels. Inadequate manpower; vacant post rates were high for a number of categories of workers especially medical officers, MA, pharmacists, radiographers, dental technicians, and health inspectors. Lack of knowledge in the general population due to low levels of education (MoH, 1986:4-5 to 4-7)	Not evident in the document	Not evident in the document	Not evident in the document
NHP 1999-2004	Limited access to quality and effective healthcare due to low geographical access with 46% of the population living within 5km radius of a health facility; most services targeted at the population at risk only. Shortage and misdistribution of trained health personnel. Shortage of essential drugs, medical supplies and equipment. Inadequate and inefficient/inequitable resource allocation i.e. at less than US4 dollars per capita, the health sector was very limited. Weak inter-sectoral linkages i.e. project and vertical programme approach resulted in uncoordinated planning, duplication of services and overburdening of district level implementation. Weak policy and regulatory infrastructure as a result regulation of health services has been problematic (MoH, 1999a:17-18)	Not evident in the document	Not evident in the document	Not evident in the document

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Table: 4.2.6b: Constraints in MCH policy implementation: Other MoH planning documents

Policy documents	Public facilities	NGOs	Private not for profit	Private for profit
Health policy framework paper	Uncertainty in budgetary allocations an i.e. due to severe financial constraint, government was operating on monthly cash budgets since December, 19994. Slow progress of decentralization Inadequate and poorly distributed health staff. Drug shortages in health facilities Weak inter-sectoral collaboration on health issues Lack of community empowerment to identify health problems and to implement activities. Inadequate support for community structures such as VHC to ensure sustainability of community based PHC activities (MoH, 1995:27-30)	Not evident in the document	Not evident in the document	Not evident in the document
Vision 2020	Inadequate funding Scarcity of trained human resources Inadequate and poor physical facilities. Persistent shortage of drugs and medical supplies as a result of inadequate financial allocations High population growth High illiteracy and poverty High burden of diseases Weak managerial structures and systems Poor health and management information systems (MoH, 1999b:18-20)	Not evident in the document	Not evident in the document	Not evident in the document
JPoW	Inadequate capacity to formulate policy, coordinate implementation, monitor progress and adequately support district health services High burden of disease Poor access to healthcare due to geographical and economic factors Critical shortage of staff, poor deployment and management policies and practices for human resources Weak capacity to plan and budget for the efficient delivery of EHP services at district level Inadequate involvement and participation of villages, Area Development Committee structures and Civil Society Organizations in health planning and decision making processes Inadequate financial management systems and accountability within the sector	Not evident in the document	Not evident in the document	Not evident in the document

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	Inadequate attention to evidence based decision making. (MoH, 2004:13-14)			

Table 4.2.6c: Constraints in MCH policy implementation: Malawi Reproductive Health Policies

Policy documents	Public facilities	NGOs	Private not for profit	Private for profit
Reproductive health policy	Not evident in the document	Not evident in the document	Not evident in the document	Not evident in the document
The Roadmap	Shortage of staff and weak human resource management Limited availability and utilization of maternal healthcare services Low quality maternal healthcare services Weak procurement and logistics systems for drugs, supplies and medical equipment Problems of infrastructure Weak referral systems Weak monitoring, supervision and evaluation Inadequate coordination mechanisms among partners and stakeholders Weak community participation and involvement Harmful social and cultural beliefs and practices (MoH, 2006b:5)	Not evident in the document	Not evident in the document	Not evident in the document
RH strategic plan	Inadequate human resources Limited financial resources Poor and inadequate infrastructures (MoH, 2006a:12)	Not evident in the document	Not evident in the document	Not evident in the document

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Table 4.2.6d Constraints in MCH policy implementation: Child Health Policies

Policy documents	Public facilities	NGOs	Private not for profit	Private not for profit
EPI manual	Due to insufficient financial resources some outreach clinics either stopped functioning or frequently got cancelled Untimely and insufficient delivery of supplies Insufficient management and supervision among EPI Officers at all levels. (MoH, 2002b:3)	Not evident in the document	Not evident in the document	Not evident in the document
Programme of child survival and development	Not evident in the document	Not evident in the document	Not evident in the document	Not evident in the document
IMCI approach policy	Not evident in the document	Not evident in the document	Not evident in the document	Not evident in the document
Strategic plan for child survival and development	Funding shortage Critical shortage of drugs, basic medical diagnostics equipment and related supplies impede delivery of High Impact Interventions Serious shortage of skilled human resources for stewardship, management of health programmes and provision of clinical services. For example only 42% of facilities have the required human resource during the day, whilst only 13% of the facilities provided 24-hour services Inadequate and poor healthcare facilities Decision making not evidence based (MoH, 2007:20-22)	Not evident in the document	Not evident in the document	Not evident in the document

Table 4.2.6e Constraints in MCH policy implementation: Other Health policies impacting on MCH in Malawi

Policy documents	**Public facilities**	**NGOs**	**Private not for profit**	**Private for profit**
Policy on ECD	Not evident in the document	Not evident in the document	Not evident in the document	Not evident in the document
HIV/AIDS policy	Not evident in the document	Not evident in the document	Not evident in the document	Not evident in the document

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HIV/AIDS action framework	Not evident in the document	Not evident in the document	Not evident in the document	Not evident in the document

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4.3 Results from questionnaire responses

4.3.1 General information

Table 4.3.1a: Respondents' profession, level of education, position and responsibilities in MCH programmes

Profession	Frequency	Level of education	Position	Responsibility in MCH programmes
MO	6	First degree	DHO	Represent district in policy forums Supervise implementation
CO	5	Diploma	1 DHO 2 deputy DHO 1 ward in charge 1 not in position	Represent districts Supervise clinical services Manage ward activities
MA	12	Certificate	11 Health centre in-charge 1 not in position	Manage health centres activities
RN	10	First degree	6 ward in-charges 1 HNO 1 DNO	Manage ward activities Manage nursing services Manage nursing services
RNM	25	15 First degree 10 Diploma	12 ward in-charges 7 HNO 3 DNO 2 Departmental NO 1 SNO	Manage ward activities Manage nursing activities Manage nursing activities Manage depart activities Manage nursing activities
NT	1	Certificate		Provide services to patients
NMT	6	Diploma	1 health centre in-charge 5 not in position	Manage health centre Provide services to patients
ENM	15	Certificate	1 health centre in-charge 1 ward in-charge	Manage health centre Provide services to patients
Others Midwife HA 1 EHO 4 EHA CHN 1	 3 1 4 1 1	 Certificate MSCE Diploma JCE JCE	MCH coordinator	Provide services to patients Provide vaccinations to U5 Manage MCH services Provide vaccinations Provide services to patients

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Ninety questionnaires (90) were distributed of which eighty-eight (88) were completed and returned, two were not returned because the participants were away at a workshop. From the 88 questionnaires returned, 54 questionnaires were fully complete and 34 were partially complete. Table 4.3.1a presents a breakdown of respondents' position and role in MCH programmes in the selected health facilities. The completed questionnaires were mostly from central hospitals and district hospitals, only two were from health centres. Respondents of the questionnaire included six Medical Officers (MOs) who were also District Health Officers (DHOs), five Clinical Officers (COs) of which one was a DHO and two were deputy DHOs. One of the remaining two COs was a Ward In-charge. Other respondents were 12 Medical Assistants (MAs) of which eleven were in-charge of health centres. The questionnaire respondents also included Registered Nurses (RNs) and Registered Nurse Midwives (RNMs) who were also in-charge of wards, Hospital Nursing Officers (HNOs), District Nursing Officers (DNOs), Principal Nursing Officers (PNOs), Senior Nursing Officers (SNOs) and Departmental Nursing Officers (Departmental NOs). Other categories of nurses that responded to the questionnaires, included Nurse Technicians (NTs), Nurse Midwife Technicians (NMTs) and Enrolled Nurse Midwives (ENMs). Other professions like Health Assistants (HAs), Environmental Health Officers (EHOs), Environmental Health Assistants (EHAs) and Community Health Nurse (CHN) also participated in the study. Results from questionnaire responses are presented in frequency distribution Tables below (Tables 4.3.2a to 4.3.4q).

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4.3.2 Content of MCH policies in Malawi

Table 4.3.2a: Rationale for MCH policies in Malawi

Response options	Frequency
Yes	11
No	20
Others; justification	7
Mission	4
Goals	6
Policy statements	10
Did not know	30

Participants (n=58, 66%) provided responses of which 30 indicated that they did not know the rationale for MCH policies in the country. More participants indicated that MCH policies did not have rationale (Table 4.3.2a).

Table 4.3.2b: Goals and objectives for MCH policies in Malawi

Response options	Frequency	Comments
Yes	68	Goals and objectives are not evidence based Goals and objectives are not results oriented Goals and objectives have no targets
No	7	

Participants (n=75, 85%), provided information on goals and objectives of MCH policies in the country. Out of this number, 68 participants confirmed that MCH policies in the country had goals and objectives. However, participants' comments show that goals and objectives were not evidence based and results oriented (Table 4.3.2b).

Table 4.3.2c: Allocation of resources for policy implementation in MCH policies

Response options	Frequency
Financial resources	28
Human resources	13
Physical resources	9
All of the above	13

Participants (n=63, 72%) provided responses on types of resources allocated for the implementation of MCH policies. From the number of responses, 28 participants indicated that MCH policies had financial resources allocated, 13 indicated that MCH policies had human resources allocated, whilst 9 indicated that MCH policies had physical resources allocated and 13 indicated that MCH policies had all resources allocated (Table 4.3.2c).

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Table 4.3.2d: Views on the adequacy of resources allocated for implementing MCH policies

Response options	Frequency	Additional comments
No	76	Inadequate health personnel Poor infrastructure Inadequate equipment Frequent shortage of essential drugs Limited funding against so many priorities
Yes	2	When resources are there they are adequate. The government has increased funding for hospitals.
Yes/no	10	Erratic supply/resources are not continuously supplied Other resources are donations, therefore are not sustainable

All the participants (n=88, 100%) provided views on the extent that resources allocated were adequate or otherwise. Of the 88 respondents, 76 indicated that resources are not adequate, 2 maintained that resources are adequate and 10 participants said yes and no with explanations (Table 4.3.3c).

Table 4.3.2e: Plan for policy implementation

Response options	Frequency
Yes	15
No	41

Participants (n=56, 64%) provided responses, the Table shows that 41 participants indicated that MCH policies in Malawi did not have plan for implementation (Table 4.3.2e).

Table 4.3.2f: Plan for policy monitoring and supervision

Response options	Frequency
Yes	15
No	48

Participants (n=63, 72%), 48 indicated that MCH policies did not have plan for monitoring and supervision (Table 4.3.2f).

Table 4.3.2g: Plan for policy review and evaluation

Response options	Frequency
Yes	9
No	51

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Participants (n=60, 68%) provided views on plans for policy review and evaluation with 51 indicating that MCH policies in Malawi did not have plan for review and evaluation (Table 4.3.2g).

4.3.3 Context of MCH policies in Malawi

Table 4.3.3a: Factors affecting MCH policies in Malawi

Profession of participants	Contextual factors affecting MCH policies in Malawi
MO and CO	- Poverty both at community and national level - High disease burden - HIV/AIDS - Inadequate resources - High illiteracy rate - Poor infrastructure (roads, hospitals, communication system) - Traditional beliefs and cultural practices
RNM and RN	- High population - Poverty both at community and national level - High disease burden - Inadequate resources - High illiteracy rate - Poor infrastructure (roads, hospitals, communication system) - Traditional beliefs and cultural practices
MA, NT, NMT,ENM and others	- Lack of resources - High illiteracy rate - Cultural beliefs - Lack of knowledge among communities on issues relating to MCH - Gender imbalance in decision making on health issues at community level

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Table 4.3.3a shows list of factors affecting MCH policies in Malawi as indicated by participants according to their profession. MO, CO, RNM and RN indicated that poverty, high population, high disease burden illiteracy, inadequate resources, poor infrastructure and traditional believes were factors affecting MCH policies in Malawi. MA, NT, NMT, ENM and other professions indicated factors affecting MCH policies in Malawi as the following; lack of resources, illiteracy, cultural beliefs, lack of knowledge among communities on issues relating to MCH and gender imbalance in decision making on health issues at community level.

4.3.4 Process of MCH policies

Table 4.3.4a: Ways through which policy makers became aware of MCH problems

Response options	Frequency
Meetings with health workers	30
Through pressure groups	4
International trends	10
Research findings	22
MCH records	15
MCH reports	54
Reports from community leaders	20
Reports from parliamentarians	5
Did not know	11

Participants (n=78, 89%) provided responses. 11 indicated that they did not know. The Table shows that more responses indicated that policy makers know about MCH problems through MCH reports, meetings with health workers, research findings and reports from community leaders (Table 4.3.4a).

Table 4.3.4b: Situation when a problem becomes an issue for MCH policy agenda

Response options	Frequency
When it is a national priority	11
When it becomes a crisis in the nation	23
When it affects political power	11
When it is an international priority issue	22
Did not know	7

Relatively more than half (n=49, 56%) of the respondents were aware of when problems become issues of MCH policy agenda. 7 participants indicated that they did not know. The Table shows that more responses indicated that a problem became an issue for MCH agenda when it became a crisis in the nation and when it is an international priority (Table 4.3.4b).

Table 4.3.4c: Factors that influence MCH issues onto policy agenda in Malawi

Response options	Frequency
Donor requirements	31
Needs of the population	33
Availability of funding	30
Political influence	16
International trends	13
Did not know	

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More than half of respondents n=49, 56%) were aware of the factors that influence MCH issues to get to policy agenda, 9 indicated that they did not know. The rest indicated that factors included needs of the population, donor requirements and availability of funding (Table 4.3.4c).

Table 4.3.4d: Processes for selecting MCH policy priorities in Malawi

Response options	Frequency
Voting	1
Consensus	37
Debate	14
Imposed	8
Did not know	4

More than half of the participants (n=52, 59%) provided responses on processes for selecting MCH priorities in Malawi. The Table shows that 37 responses indicated that process of selecting MCH priorities was consensus, followed by debate, which had 14 responses, 4 indicated that they did not know (Table 4.3.4d).

Table 4.3.4e: Means for communicating MCH policies to implementers

Response options	Frequency
In-service training	33
Policy briefing through staff meetings	16
Distribution of policy documents	41
Policy campaigns	4
Stakeholders policy dissemination meetings	38
Did not know	13

Participants (n=75, 85%) provided responses on strategies for communicating MCH policies to implementers in the country. The Table shows that more responses indicated that policies were communicated through distribution of policy documents, stakeholders' policy dissemination meetings and in-service training, but 13 did not responses to the question (Table 4.3.4e).

Table 4.3.4f: Monitoring of MCH policies in Malawi

Response options	Frequency
Yes	68
No	7
Did not know	7

Participants (n=74, 84%) indicated views on their knowledge of MCH monitoring in the country. 68 (92%) participants indicated that policies in Malawi were monitored,

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7 (8%) indicated that polices are not monitored, and another 7 did not know (Table 4.3.4f).

Table 4.3.4g: Ways for monitoring MCH policies in Malawi

Response options	Frequency	Additional comments
Supervision	46	- DHO supervision is erratic (ENM) - Supervision is inconsistent - They do not supervise (MA) - Almost a year has passed without being supervised (MA) - It is supposed to be quarterly but they came once last year and this year they have not come yet (NMT)
Midterm evaluation	14	
Keeping of records	11	
HMIS data	41	
Annual reviews	25	
Did not know	3	

Participants (n=70, 80%) provided responses on ways that MCH policies were monitored, 46 responses indicate that MCH policies were monitored through supervision, 41 responses indicated through HMIS, 25 responses indicated through annual reviews, and 3 indicated that they did not know (Table 4.3.4g).

Table 4.3.4h: Use of monitoring information in Malawi

Response options	Frequency
For changing policy goals	10
For making corrections or supplementing policies	7
For improving implementation of policies	41
For tracking implementation progress	34
Do not know	6

Participants (n=59, 67%) provided responses, 41 indicated that information from monitoring was used to improve implementation of policies, 34 indicated that information is used for tracking implementation process, and 6 did not know (Table 4.3.4h).

Table 4.3.4j: Review of MCH polices in Malawi

response options	Frequency
Yes	46
No	2
Did not know	11
None response	29

More than half of the participants (n=48, 55%) provided responses, 46 participants indicated that MCH policies were reviewed, only 2 said no whilst 11 indicated that they did not know and 29 did not provide answers (Table 4.3.4j).

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Table 4.3.4k: Purposes for reviewing MCH policies in Malawi

Response options	Frequency
For revising or evaluating a policy	35
For making corrections or supplementing polices	17
For developing new policies	15
For tracking implementation progress	58
Do not know	2

Participants (n=71, 81%) provided on purposes for reviewing MCH policies, 2 indicated that they did not know. The Table shows that 58 respondents indicated that the purpose for reviewing MCH policies was to track implementation progress and 35 responses indicated for revising or evaluation of policy (Table 4.3.4k).

Table 4.3.4m: Frequency of MCH policies review

Response options	Frequency
In the middle of implementation	13
When developing a new policy	44
At the end of implementation	38
Do not know	10

Participants (n=60, 68%) provided responses, 44 and 38 respondents indicated that MCH policies were reviewed when developing a new policy and at the end of implementation respectively, and 10 indicated that they did not know (Table 4.3.4m).

Table 4.3.4n: Opinions on evaluation of MCH policies in Malawi

Response options	Frequency
At the end of implementation	16
MCH policies are not evaluated	38
Do not know	3

Participants (n=54, 61%) provided information on their opinions of evaluation of MCH policies in Malawi, 3 indicated that they did not know. 38 respondents indicated that MCH polices are not evaluated whilst 16 indicated that MCH policies are evaluated at the end of implementation (Table 4.3.4n).

Table 4.3.4p: Sources of information for developing MCH policies in Malawi

Response options	Frequency
DHS	45
Research specifically initiated for MCH policies	20
General research	17
Information from international organizations and donors	19
Reports on best practices from other countries	32
Other sources of information: HMIS reports	23
Do not know	2

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Participants (n=56, 64%) provided information on their knowledge of sources of information for developing MCH policies in Malawi. Respondents indicated that sources of information for developing MCH policies in Malawi included DHS followed by reports on best practices from other countries and HMIS reports, and 2 indicated that they did not know (Table 4.3.4p).

4.3.5 Stakeholders

Table 4.3.5a: Groups of people involved in developing MCH policies in Malawi

Response options	Frequency
TWGs	36
International donors	33
MoH	31
DHO	19
Beneficiaries	3
Community leaders	5
Health workers	6
Do not know	3

Participants (n=54, 61%) provided information on various groups of people involved in MCH policy development in Malawi. Most respondents indicated that TWGs, international donors, MoH and DHOs were groups of people involved in MCH policies, and 3 did not know (Table 4.3.5a).

Table 4.3.5b: Means of involving beneficiaries in MCH policies in Malawi

Response options	Frequency
Representation in policy development forums	12
Policy monitoring through VHC	9
Surveys	15
Beneficiaries are not involved	36
Non response	16

Participants (n=72, 82%) indicated means of involving beneficiaries in MCH policy development. Table shows that 36 responses indicated that beneficiaries were not involved in MCH policy development, whilst the remaining respondents indicated process such as surveys, and representation in policy development forums and 16 did not provide information (Table 4.3.5a).

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Table 4.3.5c Stakeholders involved in identifying of MCH issues as problems

Response options	Frequency
Politicians (members of parliament)	18
Minister of Health (staff)	11
Principal secretary for health	11
Health workers (trained)	60
Community leaders	25
Community members	32
Civil society organizations	22
Director of planning	15
Non response	12
Did not know	9

Participants (n=67, 76%) provided responses on stakeholders involved in the identification of MCH issues as problem areas to be addressed. Table 4.3.5b shows that, most respondents indicated that health workers including community members were involved in identifying MCH issues as problems. 12 did not respond and 9 did not know.

Table 4.3.5d: Stakeholders that formulate policy goals and objectives

Response options	frequency
Technical working groups	32
Minister of Health	8
Director of reproductive health	8
Principal secretary for health	3
Director of planning	3
District health officers	8
Do not know	7

Slightly more than half of respondents (n=48, 55%) answered the question, 7 indicated that they did not know the stakeholders involved in the formulation of policy goals and objectives. On the other hand, 32 respondents indicated that Technical Working Groups (TWGs) were involved in formulating policy goals and objectives (Table 4.3.5c).

Table 4.3.5e: Stakeholders responsible for monitoring MCH policies in Malawi

response options	Frequency
DHO	18
DHMT	33
Special monitoring task force	11
External monitors	11
Programme coordinators	6
ZHSO	22

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Participants (n=79, 90%) provided information on the different types of stakeholders responsible for monitoring of MCH policies in Malawi. Stakeholders identified included DHMT, ZHSO and DHOs (Table 4.3.5d).

Table 4.3.5f: Stakeholders involved in MCH policy review

Response options	Frequency
DHO	14
Director of planning	17
Director of RHU	16
Director of preventive health services	8
TWGs	22
Civil society organizations	9
Principal secretary for health	3
Director of clinical services	2
Health workers	10
Community leaders	2
Others	0
Do not know	1

Participants (n=59, 67%) listed groups of stakeholders involved in MCH policy review. Table 4.3.5e indicated that stakeholders involved in reviewing MCH policies in Malawi include TWGs, DHOs, Director of RHU, Director of planning and Health Workers.

4.3.6 Lessons and gaps in MCH policy

Table 4.3.6a: Lessons in policy development and implementation

Profession	Institution	Lessons in policy development	Lessons in policy implementation
MO and Cos	District Hospital	-Beneficiaries and implementers should be involved in MCH policy development -Policies should be results oriented and evidence based -Evaluation should be done before developing a new policy	- Policies without resources will never be implemented and will never achieve the intended results - Cultural beliefs and practices play a greater role in policy implementation - For policies to be implemented, they need proper and timely communication to implementer
RNM and RN	District Hospital	-Policy makers should involve implementers in policy development	- Policies require adequate resources - Cultural beliefs and practices also need to be addressed by policies
MA, NT, NMT,ENM and others	Health centres	-Implementers should be involved in policy development	- Policy makers should communicate policies to implementers

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Table 4.3.6a presents information obtained from questionnaire responses on lessons in policy development and implementation. MOs, COs, RNM and RN from District Hospitals indicated lessons in policy development as follows; beneficiaries and implementers should be involved in MCH policy development; policies should be results oriented and evidence based; and evaluation should be done after implementing a policy and before developing another one. Whilst MA, NT, NMT,ENM and others from Health centres indicated lessons in policy development as implementers should be involved in policy development.

The table also presents information obtained from questionnaire responses on lessons in MCH policy implementation. MO, Cos, RNM and RN from District Hospitals indicated lessons in MCH policy implementation as follows; policies without resources will never be implemented and will never achieve the intended results, cultural beliefs and practices play a greater role in policy implementation, for policies to be implemented they need proper and timely communication to implementers. Whilst MA, NT, NMT,ENM and others from Health Centres indicated "policy makers should communicate policies to implementers" as lesson for policy implementation.

Table 4.3.6b: Gaps in policy development and implementation

Profession	Gaps in policy development	Constraints in policy implementation
MO and Cos	-Policy implementers and beneficiaries were not involved in MCH policy development -There was no interaction between policy makers and implementers -Policies were not communicated to grassroots implementers	- Inconsistent availability of medical supplies and equipment - Inadequate human resource - Lack of equipment - Unsustainable funding when donors pull out - Inadequate and poor infrastructure - High disease burden and new diseases
RNM and RN	Implementers are not involved in MCH policy development	- Inconsistent supply of medical supplies and equipment - Long distances between health facilities - Poor referral system (telecommunication, vehicles for referring patients and poor road network)
MA, NT, NMT,ENM and others	Implementers are not involved in MCH policy development	- Inconsistent supervision -Inconsistent and delayed supply of drugs and medical supplies -High illiteracy rate -Cultural beliefs -Lack of knowledge among communities on issues relating to MCH -Gender imbalance in decision making on health issues at community level

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Table 4.3.6b summarizes comments from questionnaire responses on gaps in policy development and implementation. MOs, Cos, RNM and RN from District Hospitals indicated that gaps in policy development included that implementers and beneficiaries were not involved in MCH policy development and that there was no interaction between policy makers and implementers. In addition they indicated that policies were not communicated to implementers. MA, NT, NMT, ENM and other professions from health centres indicated that implementers were not involved in MCH policy development" as a gap in policy development. On the other hand, MOs, Cos, RNM and RNM form District Hospitals listed the following as constraints to policy implementation; inadequate resources, inconsistent supply of medical supplies, high disease burden and new diseases. MA, NT, NMT, ENM and others from Health Centres listed the following as constraints to policy implementation; inconsistent supervision; high illiteracy rate; cultural beliefs and gender imbalance.

4.4 Results of interviews

4.4.1 General information

A total of thirty-nine participants and key informants were interviewed. Participants in study meant people who participated in the study either through filling in self-administered questionnaire or being interviewed working within MoH from national headquarters, hospitals and health centres funded by government. While key informants, refer to people who were interviewed in this study but work as stakeholders or partners of MoH. Table 4.4.1a outlines institutions from which interviewed participants and key informants were drawn and their involvement in MCH policies.

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Table 4.4.1: Summary of people interviewed

Institution	people interviewed	Status	Involvement in MCH policies
MoH headquarters	Directors Planning unit Clinical services Nursing service Preventive health RHU NAC	Participants	Participate in policy formulation Oversee implementation
Central Hospitals	Directors • QECH • KCH • Mzuzu CNO • QECH • KCH • Mzuzu Pharmacy manager • KCH • QECH • Mzuzu	Participants	Oversee implementation of MCH services in at tertiary level Participate in policy development forums Manage drugs and medical supplies at health facility level
ZHSO	Central East Zone Officer Central West Zone Officer	Participants	Supervise health facilities
Central Medical Stores	• Procurement officer • Distribution officer • Regional officer	Stakeholders	Procure, and distribute drugs and medical supplies
Health professional regulatory bodies	MMC NMCM	Stakeholders	Set standards for health facilities and regulate health professionals
Academic institutions	COM KCN	Stakeholders	Participate in policy formulation and implementation
CHAM	CHAM secretariat – health services Coordinator Hospital directors • Korean hospital • Mulanje, • Madise • St. Johns	Stakeholders	Participate in policy formulation at level Communicate polices to CHAM hospitals Supervises staff in CHAM hospitals Mobilizes resources for CHAM hospitals
Private for profit hospitals and clinics	Mwaiwathu Napery Private	Stakeholders	Provide MCH services
Inter donors	WHO, UNFPA, UNICEF, USAID, SAVE US, MSH	Stakeholders	Provide technical and financial assistance
Nation NGOs	BLM FPAM	Stakeholders	Implementation of MCH services

4.4.2 MCH policies in Malawi

Results from interview responses are presented as themes and categories in Tables 4.4.2a to 4.4.4b. Elaborate on this, because of the variety of information provided selected and consistent comments relevant to the themes and categories have been presented.

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Content of MCH policies

Interview responses indicated that rationale for MCH policy depended on stakeholders formulating the policy and there was no standard on what a policy should contain (Director 1, MoH National Headquarters and Senior Official, JHPIEGO). In addition, MCH policies were not results oriented or evidence based and policy goals as well as objectives were broad (Senior Official, UNICEF). Both participants and key informants said that priorities for MCH policies were adopted from international policy priorities (Director 1, MoH National Headquarters and Senior Official, UNICEF). Only estimated financial costs were documented and most MCH programmes were donor dependent, nonetheless resources were still inadequate (PNO, Central Hospital 2; Director 4, MoH National Headquarters). Interview responses showed that National policies had no implementation plans (Director 2, MoH National Headquarters). However, Senior Official for UNFPA said that implementation plans were to be developed at implementation level. Interview responses also indicated that District and Central Hospitals did not have strategic plans and DIPs were used as a budgetary tool instead of a tool for policy implementation and monitoring (DHO, District Hospital 7). Furthermore, responses from interviews revealed that MH policies did not have plans for monitoring, supervision, review and evaluation (Director 4 and 5, MoH National Headquarters) [See Table 4.4.2a and 4.4.2a Cont. 1].

Context of MCH policies

Interview responses revealed that situational factors that affected MCH policies in Malawi were political transformation from colonial to democratic multiparty Government system: droughts and HIV/AIDS (Director, CHAM Hospital 3; Director, CHAM hospital 4; Senior Official, CHAM National Headquarters; Director 6, MoH National Headquarters). Cultural beliefs and practices were the cultural factors that affected MCH policies (Director 5, MoH National Headquarters; MA Health Centre in-charge at Mchinji District; Midwife, Health Centre in Mulanje district). Finally international factors also affected MCH policies in Malawi, for example, factors that influenced MCH issues to get to policy agenda included advocacy from international donors as well as donor requirements (Director 1 and 4, MoH National Headquarters;

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Director, CHAM Hospital 2; Senior Official, UNFPA) [See Tables 4.4.2b and 4.4.2b Cont. 1].

Process for MCH policies

Initiation and problem identification

According to interview responses, factors that influenced initiation of MCH policies were advocacy from international donors, poor indicators in MIS reports, donor requirements and availability of funding (Director 3, MoH National Headquarters). Even though MCH concerns existed in Malawi they were not reflected in policy formulation until donor influence came into play (Director 5, MoH National Headquarters). Policy makers knew about problems concerning MCH through research findings, HMIS reports, DHS reports, international meetings and surveys (Senior Officials, SAVE the Children USA) [See Table 4.4,2c].

Situation analysis

Interview responses revealed that problems for MCH policies were identified through stakeholders' meetings where stakeholders reviewed national and international policy documents (Senior Official, JHPIEGO). Responses from interviews also revealed that, TWGs, Ministers of Health, Government officials, donors and Directors of MoH were the stakeholders involved in identifying MCH problems as policy issues (Director 1, MoH National Headquarters) [See Table 4.4.2c).

Policy formulation

From interview responses, MCH policies were formulated by TWGs and or task force with financial and technical support from international donors (Director, MoH National Headquarters). MCH policies were formulated through series of stakeholder consultations (Senior Officials, UNFPA and JHPIEGO; Director 1 and 5, MoH National Headquarters). Depending on content and type of policy, the policy was endorsed by both Director and Principal Secretary for Health or approved by cabinet of ministers or parliament (Director 2, MoH National Headquarters). Decisions about MCH policies were arrived at through consultations with stakeholders, consensus between donors and MoH, and adaptation from international and regional policies

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(Director 3, MoH National Headquarters; Senior Officials, USAID and BLM). Stakeholders involved in formulation of MCH policies included MoH officials, TWGs, donors and health workers (Director 4, MoH National Headquarters). Health workers were represented by DHOs, hospital directors, DNOs and PNOs (Director 4, MoH National Headquarters). MCH policies were communicated through stakeholders' policy dissemination meetings, distribution of policy documents, orientation meetings and in-service training (Senior Consultant in Obstetrics and Gynaecology, QECH; Senior Official, MSH) [See Tables 4.4.2c Cont.1 to 3]

Policy implementation

Results from interviews showed that NHP were translated to annual implementation plans since the formulation of NHP 1999-2004. In addition, implementation of NHP 1999-2004 was based on five year district strategic plans (Director 3, MoH National Headquarters). Central and District Hospitals were supposed to develop five-year strategic plans to be translated to annual implementation plans (Director 2, MoH National Headquarters). Although District Hospitals developed Five Year plans alongside NHP 1999-2004, they were not used (DHO, District Hospital 11). Even though annual implementation plans were meant to be used for implementing and monitoring policies, they were instead being used as budgeting tool (DHO, District Hospitals 5, 6 and 7). District and Central Hospitals used DIPs and CHIP respectively. MCH policies were implemented as part of EHP (Director 5, MoH National Headquarters) [See Table 4.4.2c Cont. 4].

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Monitoring and supervision

MCH policies were monitored through supervision, routine HMIS data, and quarterly reports (Table 4.4.2c Cont. 5). For example, ZHSO supervised public and CHAM health facilities in their zones while DHOs supervised public and CHAM health facilities in their districts (Directors, CHAM Hospital 3 and 4; Director 6, MoH National Headquarters). MoH programme coordinators supervised project based services in health facilities. In addition health facilities sent quarterly reports to MoH (Director, Hospital 1). On the other hand, private health facilities were not supervised (Private Practitioner, Blantyre District; Director 6, MoH National Headquarters) [See Table 4.4.2c Cont. 5].

Policy review and evaluation

Interview responses revealed that MCH policies were not evaluated but reviewed when developing new policies or revising policies (Director 1, MoH National Headquarters; Senior Official, BLM; Senior Official, UNFPA) [See Table 4.4.2c Cont. 5].

Stakeholders in MCH policies

Stakeholders' involved in MCH policies in Malawi

Stakeholders who identify MCH issues as problems for policy agenda included TWGs, donors, Ministers of Health, and Directors of MoH (Director 4, 3 and 1, MoH National Headquarters). Stakeholders who influenced MCH issues to get to policy agenda were donors, MoH Directors and programme coordinators (Director 2, MoH National Headquarter; Senior Official, UNFPA). Stakeholders involved in selecting priorities in MCH policies included MoH officials, TWGs, donors and health workers (Director 1, MoH National Headquarters). Beneficiaries and communities were not involved in decision making in MCH policies (Director2, MoH National Headquarters). Stakeholders were involved in MCH policy development through various teams like TWGs and Sub donor groups (Director, Central Hospital 1; Senior Official, CHAM Headquarters) [See Table 4.4.2d].

Stakeholder's sources of power to influence MCH policies in Malawi

Donors and MoH had more influence on MCH policies. Donors had financial resources, expertise and access to information (Senior Official, JHPIEGO; Senior Official, UNFPA; Senior Official, WHO). MoH has the mandate and resources i.e. human resources and infrastructure for providing health services (Director 6, MoH National Headquarters). Beneficiaries were regarded as recipients of services (Director 6, MoH National Headquarters) [See Table 4.4.2d Cont. 1].

4.4.3 Lessons and gaps in MCH policy development

Lessons

Interview responses indicated a number of lessons for MCH policy development (Table 4.4.3a). According to Senior Official (CHAM Headquarters) there was non-

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implementation of policies due to overlap of policies and that adoption of international policies should consider the Malawian context. Senior Officials (MMC and NMCM) indicated that lessons in MCH policy development included that policy development needed to involve implementers, policies without resources would not succeed, and that policy development required inter-sectoral coordination. Senior Officials from UNICEF and MSH indicated the following as lessons; if monitoring and evaluation were not planned and budgeted for such activities were not carried out, policies should be results oriented and evidence-based and that policies should focus on strengthening the health system. Senior Official (WHO) indicated that human resource crisis requires concerted effort as a lesson in MCH policy development. Other lessons indicated were that opportunities for involving implementers and target groups do existed but they were not utilized and that making communication of policies to implementers a performance issue for DHOs could improve interaction between implementers and policy makers (DHO, District Hospital 12 and Senior Official, CHAM Headquarters) [See Tables 4.4.3a and 4.4.3a Cont. 1].

Gaps

Responses from interviews indicated that there were gaps in MCH policy development. According to a Private Practitioners in Lilongwe and Blantyre Districts, private providers were not involved in policy development and policies were not communicated to private providers. ZHSO (Central East Zone) indicated that DHOs, DNOs, Hospital Directors and PNOs did not communicate policies to staff members at health facility level. In addition responses from interviews indicated that there was a breakdown of communication between policy makers and implementers (Senior Consultant of Obstetrics and Gynaecology) and that implementers were not directly involved in MCH policy development (Senior Official, JHPIEGO). Further to that health facility managers and supervisors did not get feedback from and communicate policies to implementers (Senior Official, WHO; Senior Consultant of Obstetrics and Gynaecology, KCH) and there was no accountability in Government facilities (Senior Official, CHAM Headquarters) [See Table 4.4.3b].

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4.4.4 Lessons and gaps in MCH policy implementation

Lessons

A number of lessons in MCH policy implementation were identified from interview responses (Table 4.4.4a). Senior Official (CHAM Headquarters), indicated that multiple responsibilities made MoH inefficient and that broad policy statements were difficult to implement. Director (Central Hospital 3) indicated that Central and District Hospitals needed to develop strategic plans. According to Senior Officials (CMS and MMC), planning and prioritizing medical supplies should be part of performance issue for DHOs, and if the available human resources were not retained the problem of HR would remain forever. Similarly, Pharmacy Manger (Central Hospital 2) indicated that successful policy implementation required adequate resources. Senior Official (UNICEF and UNFPA), indicated that objectives without targets could not be measured and that there was a need to disseminate and implement policies as well as that policy development and implementation ought to be evidence based and results oriented. Other lessons in MCH policy development included that evaluation to be considered part of the policy process (Director 6, MoH National Headquarters); and Monitoring to include linking of supervision with performance management (Senior Official, SAVE the Children USA) [See Table 4.4.4a].

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Gaps

Information on constraints was regarded as gaps in MCH policy implementation in Malawi. Interview responses indicated gaps as constraints for implementing MCH policies (Table 4.4.4b). Constraints encountered at public health facilities included inadequate human resources, inadequate and poor infrastructure, inconsistent supply of drugs and medical supplies and inadequate financial resources. Other constraints were; no continued funding for project based programmes when NGOs pull out and inadequate or non functioning equipment (Director, Central Hospital 1). Shortage of human resource was the only constraint encountered by private for profit facilities (Private Practitioner, Blantyre District). Senior Official (WHO) indicated the following as constraints encountered at NGO facilities; shortage of human resource, high poverty and illiteracy level, luck of resources for Government to sustain programmes initiated by NGOs and abuse of resources in Government (Table 4.4.4b).

Table 4.4.2a: Content of MCH policies

Themes	Categories	Comments
Rationale for MCH policies	Rationale for policy depended on stakeholders formulating the policy	*"It is not always that a policy would have its rationale documented; it really depends on the stakeholders formulating the policy" (Director 1, MoH National Headquarters).*
	There was no standard on what a policy should contain	*"Policies are written differently and sometimes instead of documenting rationale for policy, other polices have justification or overall objective. Some policies may have a mission, vision, it really depends on who is formulating the policy." (Senior Official, JHPIEGO).*
Goals, objectives and strategies	MCH policies were not results oriented and evidence based	*"Most of these policies are not results oriented as you may have noted that some have no targets and others have no time frame. Where would one go with policies without target and time frames? How do you measure progress and how will one know if objectives have been achieved or not?......" (Senior Official, UNICEF).*
	The goals and objectives were broad	*"Policies which are not evidence based, without targets cannot measure achievement and they take us nowhere in terms of improving MCH," (Senior Official, UNICEF).*
	Priorities for MCH policies were adopted from international policy priorities	*"Most of these MCH priority issues are advocated for at international and regional meetings where countries agree to develop policies around them," (Director 1, MoH National Headquarters).*
Resources for implementation	Only estimated financial costs were documented and MCH programmes were donor dependent	*"What you will find in policy documents is mostly an estimated financial cost to implement a policy. If you talk of human and physical resources required to implement policies other than what is already in existence, they are budgeted and included in the budge and estimated financial cost. The existing human and physical resources are part of the background and situation analysis of the policy; you do not include them again in the budget" (Director 4, MoH National Headquarters).*
	Resources are inadequate	*"MCH programmes are mostly donor dependent and the resources are inadequate Reproductive health, obstetric services, family planning, child health, HIV/AIDS, TB, Malaria and many programmes for mothers and children including health programmes for youths are funded by external donors (PNO, Central Hospital 2).* *"……normally what happens is that the department would ask so much amount of money in our budget and the Government would say that is too much. They give us what they call ceiling. The difference between ceiling and budget is the gap that is not funded. And then for most of programmes in the department we have a lot of external donor support from WHO, UNICEF, Global Fund and Bush Malaria Initiative. However the resources are still inadequate." (Director 4, MoH National Headquarters).*

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Table 4.4.2a Cont. 1: Content of MCH Policies in Malawi

Themes	Categories	Comments
Plan for implementation	National policies had no implementation plans.	*"National policies are implemented at different levels and facilities; it is at these facilities that implementation plans are developed, not at National level," (Director 2, MoH National Headquarters).*
	Plans for implementation were developed at implementation level	*"Implementation plans for National policies are supposed to be developed at district and central level. Other than that various departments also develop their work plans for implementing the policies. Therefore, you will not find implementation plans in the policies, (Senior Official, UNFPA).*
	District and Central Hospitals did not have strategic plans	*"At the moment, the hospital does not have strategic plans. We are working towards having and developing business plan. Central Hospitals have never had their strategic plans. All of us are utilizing JPoW for the Ministry," (Director, Central Hospital 3).*
	DIPs were used more as a budgetary tool and not for implementation and monitoring policies	*"The annual district implementation plans are used as a budgeting tool for requesting funding from MoH for delivering services as District Hospitals. When the parliament is about to open, were asked to submit our DIPs to MoH National Headquarters where all the DIPs and CHIPs and work plans from departments are put together to form the National MoH budget. It is the National MoH budget that is presented in parliament for getting Government financial allocation the whole health sector," (DHO, District Hospital 7).*
Plan for monitoring and supervision	National policies do not have detailed plans for monitoring and supervision	*"National Policies are guiding documents; they do not have detailed information on implementation plans, supervision, monitoring and evaluation. It is up to the hospital mangers to develop those details," (Director 4, MoH National Headquarters).*
Plan for policy review and evaluation	MCH policies did not have plans for evaluation	*"yes I understand your question, it is true that we do not plan for evaluation, the policies however do mention how they are to be evaluated but they do not have detailed plan and budget for evaluation, may be that is why most of our National plans have not been evaluated comprehensively" (Director 5, MoH National Headquarters).*

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Table 4.4.2b: Context of MCH policies in Malawi

Themes	Categories	Comments
Situational factors	Political transformation from colonial system	*"It all goes back to economic development, the country is poor. So even though we became independent politically, we could not function on our own for obvious reasons that we did not have skilled staff in everything on top of financial constraints. Therefore until today we still depend on external financial and technical support for developing and implementing policies and various health and non health programmes," (Director, CHAM hospital 3).*
	Democratic multiparty Government system was associated with mismanagement of Government financial resources which resulted in loss of donor confidence. This reduced funding to the health sector	*"You and I know very well that multiparty democracy although it was applauded internationally, it brought us many problems. There was mismanagement of Government financial resources and a lot of corruption. As a result, the Government lost its donor confidence and for your information, there was a time that that even donors suspended their financial development assistance. This led to numerous problems, it reduced financial allocation for the health sector and there was inconsistent financial allocation for more than two years in mid and late 1990's," (Director, CHAM hospital 4).* *"Multiparty democracy was associated with corruption and mismanagement of Government resources. It is also the time that we experienced inadequate funding for the ministry which lead to serious shortages in human resources and medical supplies as well as deterioration of infrastructures and quality for health services in general. The Government then, did not regard health as a National priority," (Senior Official, CHAM National Headquarters).*
	Droughts affected the nation's economy negatively, deepened poverty as well as food insecurity at individual and community level	*"It is pathetic when this country is hit by a drought; the majority of people have no food and no source of income because most of them are subsistent farmers. And it is not only the people but also the Government, Malawi's economy is agro-based, so a drought means reduced exports and income for the country," (Director 6, MoH National Headquarters).*
	HIV/AIDS has increased the disease burden and demand for healthcare services	*"We were doing well before the scourge of HIV/AIDS in terms of maternal and child heath, but HIV/AIDS has increased the disease burden in general. For example, opportunistic infections for HIV/AIDS like TB, pneumonia, meningitis are on the increase. In addition to that, knew programmes like PMTCT and VCT as well as treatment for increasing opportunistic infections have increased the demand for health care. This implies that there is an increase in work overload and a further stretch of*

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		the inadequate resources for healthcare," (Director 6, MoH National Headquarters).

Table 4.4.2b Cont. 1: Context of MCH policies in Malawi

Themes	Categories	Comments
Structural factors	There was no information obtained	The question formulated to obtain information on context of MCH policies asked for factors affecting MCH policies in Malawi in general. Therefore, the question did not address categories of the contextual factors affecting MCH policies in Malawi.
Cultural factors	Cultural beliefs and practices and practices prevent people from utilizing available healthcare services utilization healthcare services	*"People in this country still believe in traditional medicine to the extent that it is so difficult to convince them to come to hospitals. The DHS showed that almost 50% of the communities especially in rural areas do not go to the hospital when they are ill. This is a great concern to us because even if you build hospitals, recruit health workers as a Government these people are not coming to you, they will still die and increase the morbidity and mortality rate for the country," (Director 5, MoH National Headquarters).* *"People culturally define which diseases need treatment from healthcare facility or traditional healers and they also decide which advise from health workers to listen to'" (MA. Health Centre in-charge at Mchinji District).* *"Cultural believes and traditional practices make our work very difficult, because more especially pregnant women take dangerous traditional medicine during pregnancy and labour and sometimes they come with complications like ruptured uterus," (Midwife, Health Centre in Mulanje district).*
International factors	Factors that influenced MCH issues to get to policy agenda included advocacy from international donors as well as donor requirements	*"Most of these MCH priority issues are advocated for at international and regional meetings where countries agree to develop policies around MCH issues," (Director 1, MoH National Headquarters).* *"When the indicators in HMIS reports are poor, departments usually pick this up to discussion" (Director 4, MoH National Headquarters).* *"Donors may have funding for specific priority programme areas and they require MoH to develop policies on how the programmes will be implemented in a specific country," (Director, CHAM Hospital 2)* *"Donors develop international policies and work with MoH directors and programme coordinators to*

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		develop policies at National level," (Senior Official, UNFPA).

Table 4.4.2c: Process of MCH policies in Malawi

Themes	Categories	Comments
Initiation and problem identification	Factors that influenced MCH policies were advocacy from international donors, poor indicators in MIS reports, donor requirements and availability of funding	*"Most of these issues are advocated for at international and regional meetings where countries agree to develop policies around them," (Director 3, MoH National Headquarters).*
	Even though MCH concerns existed in Malawi they were not reflected in policy formulation until donor influence came into play	*"When the indicators in HMIS reports are poor, departments usually pick this up to discussion tables with our donor partners," (Director 5, MoH National Headquarters).*
	Policy makers knew about problems concerning MCH through research findings, HMIS reports, DHS reports, international meetings and surveys	*"Donors may have funding for specific programmes and they require MoH to develop policies on how the programmes will be implemented in a specific country," (Senior Official, SAVE the Children USA).*
Situation analysis	Problems for MCH policies were identified through a stakeholders meeting where stakeholders reviewed reference documents.	"*identification of problems for MCH policies is carried out by conducting a situational analysis is done at the same time with developing or revising policies, it a very cumbersome process, to start with, we have a one week stakeholders meeting……….and in this meeting that is where you take I do not know how many reference materials not only from Malawi but international documents especially the evidence based documents, international policies on reproductive health, child health, HIV/AIDS, family planning and any necessary document……Most of these documents come from WHO and other INGOs that take a lead in SRH and MCH issues. From Malawi you talk of MDHS reports, previous policies, HMIS reports what have you…...,"* (Senior Official, JHPIEGO).
	TWGs, Ministers of Health, Government officials, donors and Directors of MoH were the stakeholders involved in identifying MCH problems as policy issues	*"Information from health workers does not directly inform policy; they fill patient records and prepare monthly reports. The reports from hospitals and health centres are sent to the National HMIS for compilation and producing of HMIS reports. When we are then developing policies we review various documents and reports, this implies that health workers inform policies by sending information to central level. However HMIS data does not lead to formulation of MCH policies because HMIS data is not available and not adequate for decision making, if it is available the data is inaccurate and outdated," (Director 1, MoH National Headquarters).*

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Table 4.4.2c Cont. 1: Process for MCH policies in Malawi

Themes	Categories	Comments
Policy formulation	MCH policies were formulated by TWGs and or task force with financial and technical support from international donors	*"Various stakeholders are involved in policy formulation through different TWGs and task force teams. Usually the MoH planning unit facilitates formulating of National health plans for example, backed by external consultants of course. …………………International donors are also members of various TWGs, they can be consultants or hire external consultants and they also provide financial assistance for developing policies for example USAID, WHO. UNICEF and JHPIEGO provides technical and financial support for developing reproductive health policies," (Director 3, MoH National Headquarters).*
	Formulation of MCH policies involved identification of and a series of stakeholder consultations.	*"There are various ways of developing a policy; you can have a consultant as we are doing now for the review of RH policy. Sometimes like for the previous policies we did not have a consultant. It was spearheaded by the RHU. It involved inviting all the stakeholders to say this is the policy let us review it and we develop the policy together. When we invite the consultant it means it is the duty of the consultant to go to various stakeholders to review the documents and when s/he has a draft will have to call all stakeholders together and then everybody will be putting their inputs,"(Senior Official, UNFPA).* *"It is a very cumbersome process, to start with we have a one week stakeholder' meeting. It involves the RHU selecting key people from various institutions, in other words all the UN bodies, all the training colleges and service providers. So these people would meet to review document in question. It is mostly to do with group work and in this meeting that is where you take I do not know how many reference materials not only from Malawi but international especially evidence based documents from WHO and other INGO that take lead in all this, so they review documents for may be a week and develop a zero draft. After that zero draft, a small group of people have to meet to put more meat to that zero draft to make it first draft. And then another stakeholders meeting is held to thoroughly go into details of the document. It is then circulated and a gain a third stakeholders' meeting is held for more input into the document. Other people are also asked for information if they were not part of the stakeholders' meeting. Finally the document is sent in bunches to the director of RHU for his comments then it is finalized. We do some editorial work and then it goes to the Principal Secretary for MoH for approval" (Senior Official, JHPIEGO).*

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Table 4.4.2c Cont. 2: Process of MCH policies in Malawi

Themes	Categories	Comments
Policy formulation	Formulation of MCH policies involved identification of and a series of stakeholder consultations.	*"It is not very structured; of course there is some kind of process stages that you go through. We do some consultations with the districts and so on. You know these are the word nowadays stakeholders involvement, yes we do some consultations. Talking about consultations, it should be mentioned that we are coming from a situation where our system was very centralize when all decisions were made here on behalf of district and Central Hospitals. Even that time when we started opening up for consultations, we still do not see a lot of contributions from districts. So in terms of process yes we try to make consultations but it is like things are already decided here with donors of course," (Director 1, MoH National Headquarters).* *"What we do is to* review *documents because we have documents that we have hard in the past i.e. National assessment reports and previous policies and then we have documents and policies from other countries. So we had to put up a task force responsible for developing the policy which was multi-sectoral bringing in various stakeholders and that was backed by consultants some from health, others from human rights, institutional development and what have you. So it was a multi-disciplinary team of consultants that reviewed the various documents including HIV/AIDS policies from other countries. We were able to access financial and technical support from UNAIDS. So out of that there were issues that were coming out and we went into stakeholder consultations through regional meetings, district meetings, community dialogues and focus group discussion to pull out the issues and the we had the first draft," (Director 5, MoH National Headquarters).*
	Depending on content of policy the policy was approved by cabinet of ministers or parliament	*"It depends on what type of policy, department responsible for that policy does communicate. Once a policy is being formulated a particular department is going to come up with a suggestion to come up with policy basing on identified issues. Then they get people with technical knowhow it is usually WHO and other experts to draft then circulate to members of management. In fact it has to be presented formally for people to comment then it is presented to the PS then Cabinet of ministers so that ministers know what is going on. Depending on contents, it may end at cabinet of ministers' level or parliament," (Director 2, MoH National Headquarters)*

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Table 4.4.2c Cont. 3: Process for MCH policies in Malawi

Themes	Categories	Comments
Policy formulation	Decisions about MCH policies were arrived at through consultations with stakeholders; consensus between donors and MoH; and adaptation from international and regional policies	*"We try to make some consultations with stakeholders through meetings or workshops......," (Director 3, MoH National Headquarters).* *"Decisions about most policies were reached through consensus between the ministry or Government representatives with donor. There are circumstances of course when we just adapt international or regional policies for example the formulation of the roadmap. For the policies which we adapt, what happens is that may be the ministry and Government is already a signatory to those policies and in that sense we are just doing our part to make sure that the policies which we are a signatory to are implemented at National level ......" (Senior official, USAID).* *Donors develop international policies and work with MoH directors and programme coordinators to develop policies at National level (Senior Official, BLM).*
	Stakeholders involved in formulation of MCH policies included MoH officials, TWGs, donors and health workers Health workers were represented by DHOs, hospital directors, DNOs and PNOs	*"All the stakeholders are involved in selecting priorities for MCH policies. You talk of MoH officials, TWG, donors and health workers. Of course not everyone but their representatives depending on the type of policy being developed. For example all health workers are represented by DHOs, Hospital Directors, PNOs and DNOs," (Director 4, MoH National Headquarters)*
	MCH policies were communicated through stakeholders' policy dissemination meetings, distribution of policy documents, orientation meetings and in-service training	*"We are usually called for a policy dissemination meetings or workshops. Sometimes the ministry just send documents," (Senior Consultant in Obstetrics and Gynaecology, QECH).* *"If the policy is introducing a new programme for example IMCI or essential obstetric care, we conduct orientation meetings and in-service trainings as part of communicating as well as implementing policies," (Senior Official, MSH).*

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Table 4.4.2c Cont. 4: Process for MCH policies in Malawi

Themes	Categories	Comments
Policy implementation	NHP were translated to annual implementation plans since NHP 1999-2004	*"What I can say for certain is that District Hospitals and Central Hospitals develop annual implementation plans along with the National health plan since the fourth National health plan for 1999-2004. These are a translation of National health plans to operational plans at hospital level," (Director 3, Central Hospital).*
	Implementation of NHP 1999-200 was to base on five year District and central Hospital strategic plans	*"When we developed NHP 1999-2004, district and Central Hospitals were told t develop their own five year strategic plans which were to be translated to annual implementation plans for implementing the NHP and monitoring progress," (Director 2, MoH National Headquarters).*
	Districts developed Five year strategic plans, however they were not used for policy implementation and monitoring	*"The ministry tells us what we need to do when they have developed a National health plan. Like, during the National health plan for 1999-2004 we were asked to develop district five-year strategic plan and annual implementation plans but they were not used," (DHO, District Hospital 11).*
	Annual implementation plans were used as a budgeting tool	*"The annual implementation plans were used as a budgeting tool and for requesting funding from the central level," (DHO, District Hospital 6).* *"DIP is only used for asking money from MoH, it is emphasized when parliamentary budgeting is approaching," (DHO, District 7)* *"We use implementation plans a lot for coming up with a budget for the District Hospital including health centres," (DHO, district 5).*
	District and Central Hospitals used DIPs and CHIP respectively	*"DIPs are meant to be translation of National strategies; they started when we developed our fourth NHP. At that time, the districts were told to do a district plan, it was a five years plan and then after that we started the DIPs which are like annually. Central Hospitals also do develop their CHIP every year," (Director 5, MoH National Headquarters).*

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Table 4.4.2c Cont. 5: Process for MCH policies in Malawi

Themes	Categories	Comments
Monitoring and supervision	ZHSO supervise all health facilities in their zones	*"Now there are ZHSO who are supposed to supervise DHOs then they report to the office of DCS….. (Director 3, CHAM Hospital)*
	DHOs supervise health both public and CHAM facilities in their districts	*"Supervision comes through programmes and projects. Programme coordinators at district level when they go round to district and health centres they also supervise CHAM health facilities," (Director, CHAM Hospital 4)* *"DHO is responsible for supervising all health facilities in his/her district," (Director 6, MoH National Headquarters)*
	MoH programme coordinators supervise project based services in health facilities.	*"Supervision comes through programmes and projects….We have regular visits from MoH they come and see what we do…," (Director, CHAM Hospital 1).*
	Health facilities send quarterly reports to MoH	*"..and again we send reports to MoH on quarterly basis as part of HIMS (Hospital Director, CHAM Hospital 1)*
	Private hospitals and clinics are not supervised	*"we are not supervised by MoH, NMCM and MMC come occasionally to check if our nurses and doctors are licensed, (Private Practitioner, Blantyre District)* *"DHOs are responsible for supervise private hospitals and clinics quarterly in their designated districts, were ware that they are not doing it because ministry has not reinforced it, (Director 6, MoH National Headquarters)*
Policy review and evaluation	MCH policies were not evaluated but reviewed	*-"I wouldn't directly say which policy has been evaluated, may be what I have noted is that policies have overlapped without actually assessing to say how best have we implemented this policy," Senior Official, CHAM).* *-National Headquarters). "May be they are reviewed at least as far as I know, there has not been any formal evaluation," (Director 1, MoH National Headquarters).* *-"….. we have had review meetings and that is when we have conducted evaluation of such polices, I cannot recall that we have hard formal evaluations" (Senior Official, BLM).*
	MCH policies were reviewed when developing new policies or revising policies	*"To my knowledge I have not seen any policy being evaluated but what happens is that when a policy has expired, then you start a process of developing a new one but the process includes review of the previous policy to assess, where did we do well, where did we do wrong, what are the new emerging issues that have just come in. so it is not like you have an evaluation in the way you evaluate programmes but during the process*

		developing a new policy is that process of review and develop a new one," (Senior Official, UNFPA).

Table 4.4.2d: Stakeholders for MCH policies in Malawi

Themes	Categories	Comments
Stakeholders involved in MCH policies in Malawi	Stakeholders who identify MCH issues as problems for policy agenda included TWGs, donors , Ministers of Health, and Directors of MoH	*"TWG review previous policies and other documents to analyze MCH Situational, then they identify problems and make a plan basing on the identified problems." (Director 4, MoH National Headquarters).* *"MCH problems that Malawi is facing are not unique. So ministers and Government officials discuss issues and identify these problems at international level with donors," (Director 1, MoH nation headquarters).*
	Stakeholders who influenced MCH issues to get to policy agenda were donors, MoH Directors and programme coordinators	*"Directors of particular department come up with a suggestion to develop policy basing on identified issues," (Director 2, MoH National Headquarters).* *"Donors develop international policies and work with MoH directors and programme coordinators to develop policies at National level," (Senior Official, UNFPA).*
	Stakeholders were involved in MCH policy development through teams	*"I am involved in policy development as a member of IMCI TWG," (Director, Central Hospital 1).* *"...As CHAM secretariat, we have members who participate in policy development through all TWGs and Donor Sub groups,' (Senior Official, CHAM Headquarters).*
	Stakeholders involved in selecting priorities in MCH policies included MoH officials, TWGs, donors and health workers	*"All the stakeholders are involved in selecting priorities for MCH policies. You talk of MoH officials, TWG, donors and health workers. Of course not everyone but their representatives depending on the type of policy being developed" (Director 1, MoH National Headquarters)*
	Beneficiaries and communities were not involved in decision making in	*"Policies are kind of a science, at that level beneficiaries should not be involved, it sounds good to involve them but it just does not work,"*

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	MCH policies	*(Director 2, MoH National Headquarters).*

Table 4.4.2d Cont.1: Stakeholders for MCH policies in Malawi

Themes	Categories	Comments
Stakeholders sources of power to influence MCH policies in Malawi	MoH has the mandate and resources i.e. human resources and infrastructure for providing health services	*"We are responsible for the National population's health; it is our mandate to provide health services........ The Ministry has been mandated by parliament to ensure the health and well-being all citizens and people living in Malawi. We have doctors and nurses who tirelessly work day and night to provide healthcare to every citizen.....," (Director 6, MoH National Headquarters).*
	Donors had financial resources, expertise and access to information	*"We provide technical and financial support for the area of maternal and neonatal health, that we provide financial resources, medical supplies, trainings, develop policy documents and technical expertise," (Senior Official, JHPIEGO).* *"This is an INGO that is responsible for RH, population and development and gender...., we are in the country to support the Government of Malawi. We work with RHU, BLM, FPAM and other NGOs. We provide both technical and financial assistance," (Senior Official, UNFPA).* *"In the areas of maternal and neonatal health WHO has been in the fore front to try and assist Government to develop policies that are in line with Government agenda. We provide direction to Government on how to manage maternal issues and provide evidence based information which can assist Government to develop and implement programmes," (Senior Official, WHO).*
	Beneficiaries were regarded as recipients of services	*".... Beneficiaries and communities are at the receiving end, therefore they are involved at implementation level by utilizing the services," (Director 6, MoH National Headquarters).*

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Table 4.4.3a: Lessons in MCH policy development in Malawi

Lessons in MCH policy development	Comments
Non implementation of policies due to overlap of policies	*"Most of the policies developed go by international trends and we are overtaken by events such that other polices are not fully implemented," (Senior Official, CHAM Headquarters).*
Adoption of international policies should consider the Malawi context	*"Do not just adopt policies because we are being pushed but look at the problems in the country," (Senior Official, CHARM Headquarters).*
Policy development should involve implementers	*"They need to involve implementers more because they are they are the ones who implement and know exactly what needs to be done because policy makers do not know what is happening on the ground," (Senior Official, MMC).*
Policies without resources will not succeed	*"Policies on their own are insufficient, they need to be accompanied by the required resources," (Senior Official, MMC).* *"Whatever policies they going to develop without personnel everything is going to fail," (Senior Official, NMCM).*
If monitoring and evaluation are not planned and budgeted in policies they are not done	*"Monitoring and evaluation basing on routine data of HMIS is not enough. Evaluating implementation processes and evaluation of outcomes is important but they need to be clearly budgeted and planned for without which they will never be robust or done consistently," (Senior Official, UNICEF).*
Policies should be results oriented and evidence-based	*"Policies which are not evidence based, not results oriented and without targets. Without targets we cannot measure achievement and they take us nowhere in terms of improving MCH," (Senior Official, UNICEF).*
Every plan should include system strengthening	*"With weak health system every plan should include system strengthening for MCH programmes to be sustained," (Senior Official, MSH).*
Policies should focus on strengthening health system	*"We know what needs to be done, let's get the basics in place, we not gotten the systems right in most health facilities, we need to concentrate on strengthening health system basing on single coherent policy," (Director, CHAM Hospital 4).*

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Table 4.4.3a Cont. 1: Lessons in MCH policy development in Malawi

Lessons in MCH policy development	Comments
Policy development requires inter-sectoral coordination	*"We know what needs to be done, let's get the basics in place, we not gotten the systems right in most health facilities, we need to concentrate on strengthening health system basing on single coherent policy," (Director, CHAM Hospital 4).*
Human resource crisis requires concerted effort	*"MCH is beyond health sector, improve literacy, food security and deal with cultural believes," (Senior Official, NMCM).*
Opportunities for involving implementers and target groups do exist but they are not utilized	*"Human resource crisis cannot be solved by Government alone, it is wide and global and requires concerted efforts from all stakeholder," (Senior Official, WHO).* "...we *have decision making community structures like village health committees and safe motherhood task force but they are not functional and therefore not involved I decision making," (DHO, District Hospital 12).*
Making communication of policies to implementers a performance issue can improve interaction between implementers and policy makers	*"There a number of ways through which the ministry can involve the community e.g. through evaluation of policies ……," (Senior Official, USAID).* *"…..DHOs and hospital directors should be made accountable for communicating policies to staff making it a performance issue," (Senior Official, CHAM Headquarters).*

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Table 4.4.3b: Gaps in MCH development process

Categories	Comments
Private providers they are not involved in policy development	*"The MoH does not seem to invite people from the private sector to give any contribution not at all," (Private Practitioner, Lilongwe District).*
Policies are not communicated to private providers	*"We have access to the documents only via third or fourth parties when we do hear that there is a document from ministry on HIV/AIDS or maternal and child health," (Private Practitioner, Blantyre District).* *"You have to make it your own initiative to go and get the document," (Private practitioner, Lilongwe District).*
DHOs, DNOs, hospital directors and PNOs do not communicate policies to staff members at health facilities	*DHMTs and the supervisors do not communicate to the lower level that is where the problem is," (ZHSO, Central East Zone).*
There is a breakdown of communication between policy makers and implementers	*"I see nothing on communication from policy developers to us the technical people on the ground to see how the situation is, to see how we think the situation can be improved," (Senior Consultant of Obstetrics and Gynaecology, LCH).*
Implementers are not directly involved in MCH policy development	*"....to start with we have a stakeholders meeting, it involves key people from various institutions mostly TWG and other teams. Implementers are represented by their managers in policy development i.e. DHOs, DNOs, PNOs and Hospital Directors," (Senior Official, JHPIEGO).*
Health facility managers and supervisors do not get feedback from and communicate policies to implementers	*"DHMTs and the supervisors do not communicate to the lower level that is where the problem is," (Senior Official, WHO).* *"....they go from one meeting to another but they do not get information from us or communicate back to us...," (Senior Consultant of Obstetrics and Gynaecology, LCH).*
There is no accountability in Government facilities	*"..... it is difficult because in realities no one is accountable to any one in Government, both managers and staff are not supervised, their performance is not assessed and rewards are not based on performance. So it does not really matter if someone communicates policies to implementers or not, whether someone performs very well or not," (Senior Official, CHAM Headquarters).*

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Table 4.4.4a: Lessons in MCH policy implementation

Categories	Comments
Multiple responsibilities make MoH inefficient	*"Multiple responsibilities of MoH as policy maker, service provider, health services financer and stewardship make it not effectively manage and control implementation,"* (Senior Official, CHAM Headquarters).
Hospitals need to develop strategic plans	*"Implementation basing on annual implementation plan is not sufficient because Central Hospitals cannot be able to plan for the future, there is need for strategic plans for central and District Hospitals,"* (Director, Central Hospital 3).
Planning and prioritizing medical supplies should be part of performance DHOs	"*Planning in advance and prioritizing medical supplies should be part of performance issues in health facility management by DHOs,"* (Senior Official, CMS).
Successful policy implementation requires adequate resources	*"Effective implementation requires adequate resources where, when and how they are required,"* (Pharmacy Manager, Central Hospital 2).
If the available human resources are not retained the problem of HR will remain for ever	*"More health professional can be trained but there are no retention strategies in place, the problem will remain forever,"* (Senior Official, MMC).
Broad policy statements are difficult to implement	*"Policy statements are too broad sometimes, if they do not come with specified strategy of implementation it does not materialize,"* (Senior Official, CHAM Headquarters).
Objectives without targets cannot be measured	*"Most policies have broad objectives with no targets, how can one measure then or know that objectives are achieved?"* (Senior Official, UNICEF).
Disseminate and implement policies	*"Policies are there but are not being disseminated and we should not stop at developing policies we should implement,"* (Senior Official, UNFPA).
Evidence based policy development and implementation	"*Policies need a lot of evidence based information throughout its process from development, implementation and evaluation,"* (Senior Official, UNICEF).
Evaluation should be considered part of the policy process	*"Most policies are not evaluated as such exact achievements and failures of previous policies are missed, it will be helpful if evaluation is considered as part of planning circle,"* (Director 6, MoH National Headquarters).
Monitoring should include linking of supervision with performance	*"Monitoring needs to go beyond HIMS routine data and supervising health facilities and staff, achievement of policy objectives should be linked with performance management,"* (Senior Official,

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management	SAVE the Children USA).

Table 4.4.4b: Gaps in MCH policy implementation

Themes	Categories	Comments
Constraints encountered at Government facilities	Inadequate human resources Inadequate and poor infrastructure Inconsistent supply of drugs and medical supplies Inadequate financial resources No continued funding for project based programmes No equipment, inadequate or non functioning	*"Major constraints are inadequate human resources and financial, major equipment, we fail to implement certain policies effectively because equipment is not there, not working properly or we need to procure," (Director, Central Hospital 1).*
Constraints encountered at private for profit health facilities	Shortage of human resource	*"Human resource issue or capacity issues in general affects across the board be it in the public sector, private sector, civil society......... Malawi has a human resource capacity constraint," (Private Practitioner, Blantyre District).*
Constraints encountered at NGOs implementing MCH policies	Shortage of human resource due to high turnover High poverty level High illiteracy rate	*"We are experiencing high turnover of health professional, people come here and disappear within a year. You pump in a lot of resources, you train the person and then the next thing you see is a resignation letter," (Senior Official, FPAM).*
	Lack of resources for Government to sustain programmes initiated by NGOs Abuse of resources in Government	*"Human resource crisis leading to workload, financial resources are not enough. Low literacy levels-difficult to convince use of health services…. Even if communities are mobilized they don't find drugs, staff, and services so we are afraid to create demand. Ownership of programmes, donor dependence and sustainability plans in place. Although NGOs are trying to provide resources, where Government is a sole implementer resources are abused they don't go to grassroots,"*

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		(Senior Official, WHO)

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4.5 Field visits

Field visits were conducted from 5th May to 27th June 2008. The researcher spent one day at each Central and District Hospital and one day at two health centres in each District. In total 3 central hospitals, 12 District Hospitals and 24 Health Centres were visited in all the three regions (Table 4.5). It was observed that Mzuzu and Kamuzu Central Hospitals had inadequate and non functional equipment, whilst QECH was very clean and with relatively better equipment than the two Central Hospitals. Rumphi and Mzimba District Hospitals in Nothern Region were relatively small and old. Ntchisi and Mchinji District Hospitals in Central Region were relatively new whilst Ntcheu District Hospital in the same Region was relatively old. Chiradzulu, Machinga, Thyolo and Mulanje District Hospitals in Southern Regions were all relatively new (Table 4.5 and 4.5 Cont. 1).

Information obtained from visits to Health centres was similar with a few exceptions. All the roads going to health centres were seasonal roads and on average distances varied from 25 to 158 km from district hospitals. However in Rumphi district the farthest Health Centre was 350km away from District Hospital. Most Health Centres were manned by 1 MA and 1 NMT except Mzuzu (Nothern Region), Tembwe (Central Region) and Chonde (Southern Region). In addition most Health Centres had run out of medical supplies. For example Bolero did not have oxytocin for three months and there were no anti malarial drugs at Chonde in Mulanje District, Southern Region. Two of the 24 health centres visited had no utilities i.e. Bilira in Ntcheu District, Central Region had no electricity nor paraffin for lamps and Mtaja in Machinga District, Southern Region had no electricity and water (Table 4.5 and 4.5 Cont. 1).

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Table 4.5: Summary of field visits

Region	Central Hospital	Districts	Health centres	Information and observation
Northern region	Mzuzu	Rumphi Mzimba	Bwengu, Mzokoto Mzuzu, Bolero	• Luck of equipment at central hospital e.g. they did not have adequate delivery sets, they had no baby cord clamps (nurses observed improvising) • Both District Hospitals were relatively small and old i.e. ceiling falling out • There was one MA and NMT at Bwengu, Bolero and Mzokoto • Mzuzu Health centre had 1 RN, 3 COs and 6NMTs because it in urban area • Very small rooms for ANC, FP, maternity, U5 clinics • Very scattered health facilities and bad roads due to topography, 350km • Renovating paediatric ward and maternity at District Hospital • No oxytocin for three months at Bolero
Central region	KCH	Ntchisi Mchinji Ntcheu	Chinguluwe, Nthondo Tembwe, Mikundi Nsiyaludzu, Bilira	• At LCH there were no enough beds in labour wards and beds were very old, no surgical gloves, non functioning equipment i.e. oxygen concentrator • Ntchisi and Mchinji were relatively new whilst Ntcheu was relatively old • Seasonal roads to all health centres visited • No electricity and no paraffin for lamps i.e. Bilira H/centre • Too small and very old (Bilira and Nsiyaludzu • One MA and NMT in all health centres except Tembwe • New health centre (Tembwe)

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Table 4.5 Cont. 1: Summary of field visits

Region	Central Hospital	Districts	Health centres	Information and observation
Southern region	QECH	Chiradzulu Machinga Thyolo Mulanje	Namadzi, Mbulumbudzi Mtaja, Mlomba Mangunda, Nkhonjeni Chonde, Mulanje	• QECH was very clean, relatively better equipment than other central hospitals • District hospitals were new, they were bigger than other hospitals and relatively more functioning equipment than other District Hospitals • No anti-malarial drugs, patient advised to buy (Chonde) • Maternity was being renovated (Nkhonjeni) • No electricity, no water at Mtaja • All health centres had 1 MA and 1 NMT except Chonde which had 5 NMT and 2 MAs

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4.6 Triangulation of the data sources

Results from the three main data sources were triangulated to validate data from each data source. Results from documents reviewed were compared with responses from questionnaires and interviews as clearly outlined in sub section 3.8 in chapter 3. The triangulation of information from data sources showed that some information was obtained was from one data source only. In addition, some data was obtained from two data sources whilst most of the information was obtained from all three sources. Results from triangulation of data sources are presented in Tables 4.6.1 to 4.6.6b Cont. 1.

4.6.1 Content of MCH policies in Malawi

Information about rationale of MCH policies was obtained from all three sources of data (Table 4.6.1). Some documents indicated their rationales whilst others did not e.g. all the NHP, (MoH, 1965; MoH, 1971; MoH, 1986; MoH, 1999a) indicated their rationales and Vision 2020 and JPoW (MoH, 1999b; MoH 2004) did not indicate rationales (Tables 4.2.1a to 4.2.1e). Results from questionnaires indicated that MCH policies did not have rationales (Table 4.3.2a). However interview responses revealed that there was no standard on what a policy should contain. Depending on stakeholders formulating a particular policy, the policy could have rationale, purpose, mission, vision or overall goal (Director 1, MoH National Headquarters; Senior Official, JHPIEGO in Table 4.4.2a) [See Table 6.6.1].

All reviewed documents had priorities in terms of goals, objectives and strategies except Vision 2020, however, they were broad in the sense that they had no time-frame and targets (Tables 4.2.1a to 4.2.1e). Questionnaire responses indicated that MCH policies had goals and objectives (Table 4.3.2b). However, participants' comments showed that goals and objectives were not evidence-based or results oriented. On the other hand, interview responses confirmed information collated from documents and questionnaire responses. They indicated that MCH policies were not evidence based and results oriented in the sense that they had no targets. In addition to that goals and objectives were broad (Table 4.4.2a) [See Table 4.6.1].

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Although documents reviewed showed that resources for implementing MCH polices were outlined in MCH policies and that large proportion came from donors, questionnaires responses indicated that allocated resources were inadequate (Table 4.3.2d). Similarly, interview responses showed that estimated financial costs were outlined in policy documents. In addition responses from interviews revealed that MCH programmes were mostly donor dependent and resources were inadequate (Director 4, MoH National Headquarters; PNO, Central Hospital 4 in table 4.4.2a) [See Table 4.6.1).

It was evident from all three data sources that MCH policies in Malawi did not have implementation plans (Table 4.2.1a to table 4.2.1e; Table 4.3.2e; Table 4.4.2a Cont. 1). Interview responses further revealed that plans for policy implementation were supposed to be developed at implementation level (Table 4.4.2a Cont. 1). Documents reviewed also showed that MCH policies were not translated into operational plans (Table 4.2.1a to table 4.2.1e). All three data sources confirmed that MCH Policies did not have plans for monitoring, supervision, review and evaluation (Table 4.6.1).

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4.6.2 Context of MCH policies

Both documents reviewed and interviews showed that one of the situational factors for MCH policies was political Government transformation from colonial to independent Government under one party rule and transformation from one party Government system to multiparty democracy. Other situational factors were drought in 1991/1992 and 1993/1994 farming seasons and HIV/AIDS pandemic (Table 4.2.2a to 4.2.2e and 4.4.2b). Questionnaire responses only indicated HIV/AIDS as one of the factors that affected MCH policies (Table 4.3.3a). While there was no information obtained from interviews on structural factors that influenced MCH policies in Malawi, documents reviewed and questionnaires responses provided information on various structural factors (Tables 4.2.2a to 4.2.2e and 4.3.3a). These included High population growth, high fertility rate, predominantly agro-based economy, high inflation rate, inadequate resources, poverty, illiteracy, gender imbalance and high disease burden. All three data sources consistently showed that MCH policies in Malawi were also influenced by cultural and international factors (See Table 4.6.2).

4.6.3 Process of MCH policies in Malawi

Reviewed documents showed that initiation and problem identification for MCH policies were influenced by international factors like international declarations and health trends (Table 4.2.3b to table 4.2.3e). Questionnaire responses indicated that MCH problem became issues for policy agenda when they became national crisis and international priorities. In addition, questionnaire responses indicated that factors that influenced MCH issues to get to policy agenda include needs of the population, donor requirements and availability of funding (Tables 4.3.4b and c). On the other hand, interview responses revealed that factors that influence MCH issues to get to policy agenda included advocacy from international donors, poor indicators in HMIS reports, availability of funding and donor requirements. Further to that, donors, MoH directors and programme directors influenced MCH issues to get to policy agenda (Table 4.4.2c) [See Table 4.6.3].

According to documents reviewed, problem identification was based on some form of assessment i.e. SWOT analysis, review of previous policy documents and National as well as international documents, baseline studies, pilot studies and ETRs. Nevertheless, review of national and international documents was the most cited means for identifying MCH problems for MCH policies (Tables 4.2.3a to 4.2.3e). Questionnaire responses on the other hand indicated that policy makers became aware of MCH problems through MCH reports, meetings with health workers and reports from community leaders (4.3.4a). Interview responses indicated that Policy makers knew about problems concerning MCH through research findings, HIMS reports, DHS report, international meetings and surveys. In addition, source of information for MCH policy development included National and international documents, DHS reports, HIMS reports. MCH situation was analyzed through stakeholders meetings where stakeholders reviewed documents (Senior Officials, JHPIEGO and SAVE the Children USA; Director 1, MoH National Headquarters in table 4.4.2c) [See Table 4.6.3].

Documents reviewed showed that formulation of MCH policies was shifting from purely being formulated by external consultants to being formulated by government officials in consultations with a wide range of stakeholders. In addition to that, MCH

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policies were formulated with financial and technical assistance from international donors. Furthermore, MCH policies were formulated through consultative workshops and series of consultations with various stakeholders and institutions. It was not evident however, how policies were arrived at and communicated to implementers (Table 4.2.3a to 4.2.3e). Responses from questionnaires indicated that MCH policies were formulated by TWGs, international donors, MoH and DHO (Table 4.3.5a). Questionnaire responses also indicated that MCH policies were arrived at through consensus and debate (Table 4.3.4d). Additionally, MCH policies were communicated to implementers through distribution of policy documents, stakeholders' policy dissemination meetings and in-service trainings (Table 4.3.4e).

Interview responses supported findings from both documents and questionnaire responses. They indicated that MCH policies were formulated by TWGs and or task force with financial and technical assistance from international donors. MCH policies were developed through stakeholder consultation meetings. MCH policies were arrived at through consultations with stakeholders; consensus between donors and MoH officials; and adaptation from international and regional policies. MCH policies were communicated through stakeholders' dissemination meetings; distribution of policy documents; staff orientation meetings and in-service trainings (Tables 4.4.2c Cont. 1, 2 and 3) [See Table 4.6.3].

According to documents reviewed, only NHP 1999-2004 (MoH, 1999a) was translated into five-year district strategic plan and IPs, and JPoW was translated to IPs. The other reviewed documents were not translated to operational policies (Table 4.2.3a to 4.2.3e). No information was obtained from questionnaire responses because no question was formulated on translation of MCH policies. Responses from interviews supported results from documents reviewed. They indicated that NHP were translated to annual IPs since the formulation of NHP 1999-2004. In addition, implementation of NHP 1999-2004 was based on five year district strategic plans. Central and District Hospitals were supposed to develop five-year strategic plans to be translated to annual implementation plans. Although District Hospitals developed Five Year plans alongside NHP 1999-2004, they were not used. In addition, even though annual IPs were meant to be used for implementing and monitoring policies, they were instead being used as a budgeting tool. District and Central Hospitals used

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DIPs and CHIP respectively. Further to that MCH policies were implemented as part of EHP (Table 4.4.2c Cont. 4) [See Table 4.6.3 Cont. 1].

All three data sources showed that MCH policies were monitored through routine HIMS data collection and analysis, supervision, monthly reports, quarterly reports and sentinel surveys. In addition to that questionnaire and interview responses indicated that supervision was done by DHMT, ZHSO and DHOs (Table 4.6.3 Cont.1). It was evident in the documents that MCH policies were to be evaluated through periodic analysis of HMIS, baseline and periodic survey, DHS, MICS and reviews bi-annually and annually. However it was not evident in the documents if MCH policies were evaluated except for HIV/AIDS NAF. Questionnaire responses also indicated that MCH policies were not evaluated. Further to that, interview responses revealed MCH policies MCH policies were not evaluated but reviewed when developing a new policy or revising a policy (Table 4.6.3 Cont. 1)

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4.6.4 Stakeholders for MCH policies

Results from all three data sources showed that stakeholders for MCH policies in Malawi included MoH, CHAM, academic institutions, multilateral organization, bilateral organizations and National organizations, beneficiaries. In addition the results revealed that beneficiaries were not involved in policy development (Table 4.6.4). Documents review indicated that Stakeholders were involved in MCH policies development through different teams like TWGs, task force and Technical core team (Table 4.2.4a). No information was obtained from questionnaires because no question was formulated to obtain information on processes for involving stakeholders in policy development. Interview responses confirmed results from documents reviewed, they indicated that stakeholders were involved in MCH policy development through various teams (Table 4.4.2d) [See Table 4.6.4).

Documents reviewed and interview responses also indicated that MoH and international donors had high level of influence on MCH policies in Malawi. Implementing partners and CHAM have medium level of influence. Local NGOs, private for profit, regulatory bodies, health workers, training institutions and beneficiaries had low level of influence on MCH policies in Malawi (Table 4.2.4b).

No information was obtained from questionnaires because no question was formulated (Table 4.6.4). Both documents review and interview responses showed that MoH had more influence because it had the mandate to provide health services in Malawi and had resources i.e. infrastructure, equipment and human resources. Donors had influence because they had financial resources, technical expertise and access to new information. Beneficiaries did not have influence because they had no resources or expertise. There was no information obtained from questionnaires on sources of power for stakeholders to influence MCH policies because no question was formulated (Table 4.6.4).

4.6.5 Lessons and gaps in MCH policies development

More information on lessons in MCH policy development was obtained from interviews as compared to information obtained from documents reviewed and questionnaires (Table 4.6.5a). One lesson was identified from documents reviewed from Vision 2020 (MoH, 1999b) which stated that EHP required inter-sectoral collaboration. Responses from questionnaires indicated lessons for MCH development as follows; beneficiaries and implementers should be involved in MCH policy development, policies should be results oriented and evidence based, and that evaluation should be done before developing a new policy (Table 4.3.6a). Interview responses also identified a number of lessons in MCH policy development. For example, policies without resources will not succeed, every plan should include system strengthening, and human resource crisis requires concerted effort. Other lessons identified from interview responses were; there was non implementation of policies due to overlap of policies, adoption of international policies should consider the Malawi context, policy development should involve implementers, policies without resources will not succeed, and that if monitoring and evaluation were not planned and budgeted for in policies such activities were not carried out. Interview responses also identified the following as lessons in MCH policy development; policies ought to evidence-based and results oriented, every plan should include system strengthening in order to achieve MCH objectives, policies should focus on strengthening health system, policy development required inter-sectoral coordination and that human resource crisis required concerted effort (Table 4.4.3a and 4.4.3a Cont. 1) [See Table 4.6.5a].

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All three methods provided varied information on gaps in MCH Policy development. Some of the gaps identified from documents reviewed were that, there were no skilled personnel at national level to plan and develop policies, uncoordinated planning and priority setting, and weak inter-sectoral collaboration in policy development (Table 4.6.5b). Other gaps identified from documents reviewed included, unclear framework for policy formulation, weak managerial structures and implementation, and poor health information management system, as well as that, policy implementers and beneficiaries were not involved in MCH policy development. Questionnaire responses indicated the following as gaps in MCH policy development, policy implementers and beneficiaries were not involved in MCH policy development, there was no interaction between policy makers and implementers, and that policies were not communicated to grassroots implementers (Table 4.3.6b). Interview responses indicated the following as gaps in MCH policy development, private providers were not involved in policy development, policies were not communicated to private providers, and that DHOs, DNOs, hospital directors and PNOs did not communicate policies to staff members at health facilities. Other lessons identified from interview responses indicated that DHOs, DNOs, hospital directors, and PNOs did not communicate policies to other health providers in their designated districts, and that there was breakdown of communication between policy makers and implementers (Table 4.4.3b) [See Table 4.6.5b).

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4.6.6 Lessons and gaps in MCH policy implementation

No information was evident from documents on lessons in MCH policy implementation (Table 4.6.6a). Questionnaire responses indicated the following as lessons from MCH policy implementation, policies without resources did not achieve intended results. Questionnaire responses also indicated the following as lessons for MCH policy development; that cultural beliefs and practices played a great role in policy implementation, and that for policies to be implemented, they needed proper and timely communication to implementers (Table 4.3.6a). Interview responses indicated the following as lessons for MCH policy implementation; multiple responsibilities made MoH inefficient, hospitals needed to develop strategic plans,

and that planning and prioritizing medical supplies should be part of performance issues in HRM. Interview responses also indicated that successful policy implementation required adequate resources, if the available human resources were not retained the problem of HR would remain forever, and that broad policy statements were difficult to implement as lessons in MCH policy implementation. Other lessons included that objectives without targets could not be measured, policy development and implementation needed to be evidence-based and results oriented, evaluation should be part of the policy process, and that monitoring should include linking of supervision with performance review (4.4.4a) [See table 4.6.6a].

All three data sources indicated public health facilities in Malawi encountered several constraints in implementing MCH policies. However some information was provided by one or two data sources. All three sources of data confirmed that one of constraints encountered by public health facilities in MCH policy implementation was inadequate resources (financial, human, infrastructure and, medical equipment and supplies). Reviewed documents and questionnaire responses indicated that public health facilities also encountered the following constraints; high illiteracy, cultural beliefs and harmful practices, and problems in supervision (Table 4.6.6b).

Information on constraints encountered by public health facilities obtained from reviewed documents only included the following; weak community participation and involvement; weak procurement and logistics systems for drugs, supplies and medical equipment; weak managerial structures and systems; poor health information management system; and inadequate capacity to formulate, co-ordinate and implementation policy. The other information obtained only from reviewed documents included weak monitoring, supervision and evaluation; weak inter-sectoral linkages; weak regulatory infrastructure, and slow progress in decentralization. Finally, documents reviewed also identified weak inter-sectoral collaboration on health issues, lack of community empowerment; and lack of support for community structures as constraints encountered by public health facilities (Table 4.6.6b).

Information obtained from questionnaire responses only indicated the following constraints in implementing MCH policies in Malawi encountered in public health facilities; emerging new diseases, long distances between health facilities, poor

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referral system (poor telecommunication, vehicles for referring patients and poor road network). Other constraints indicated by questionnaire responses included lack of knowledge among communities on issues relating to MCH, and gender imbalance in decision making on health issues at community level. Unsustainable funding when donors pull out was the only information provided by both questionnaire and interview responses on constraints encountered by public health facilities.

No evidence was found in reviewed documents on constraints encountered by private and NGO public facilities. Questionnaire responses too did not provide this information. Therefore information on constraints encountered in implementing MCH policies by private and NGO health facilities was obtained from interview responses. Shortage of human resources was the only constraint encountered by private health facilities identified form interview responses. Responses from interviews indicated that NGOs encountered the following constraints; shortage of human resource due o high turnover, high poverty level, high illiteracy rate, no resources for government to sustain programmes initiated by NGOs and abuse of resources by government (Table 4.6.6b Cont. 1).

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Triangulation of data sources - Table 4.6.1: content of MCH policies in Malawi

Themes	Documents	Questionnaires	Interviews
Rationale for MCH policies	Some documents indicated their rationales whilst others did not e.g. all the NHP, (MoH, 1965; MoH, 1971; MoH, 1986; MoH, 1999a) indicated their rationales and Vision 2020 and JPoW (MoH, 1999b; MoH 2004) did not indicate rationales (Tables 4.2.1a to 4.2.1e)	MCH policies did not have rationale (Table 4.3.2a)	There was no standard on what a policy should contain. The policy can have rationale, purpose, mission, vision or overall goal (Director 1, MoH National Headquarters; Deputy Chief of Party, JHPIEGO in Table 4.4.2a)
Goals, objectives and strategies	All reviewed documents had priorities stated in terms of goals, objectives and strategies except Vision 2020 (MoH, 1999b). However, the goals, objectives and strategies were broad - they had no time frame and targets. In addition policy priorities were based on priorities for international policies (Table 4.2.1a to table 4.2.1e)	Participants indicated that MCH policies had goals and objectives. However, participants' comments show that goals and objectives were not evidence based and results oriented (Table 4.3.2b)	Policies were not results oriented and the objectives were broad (National Professional Health Officer, UNICEF). In addition, priorities for MCH policies were adopted from international policies (Director 1, MoH National Headquarters) [Table 4.4.2a]
Resources for policy implementation	Allocation of resources was outlined in some documents and not outlined in other documents For documents that outlined resources, only financial resources were outlined Large proportion of funding for MCH policies came from international donors (Table 4.2.1a to table 4.2.1e)	Allocated resources were inadequate (Table 4.3.2d)	Only estimated financial costs were documented in policies. MCH programmes are mostly donor dependent and resources were inadequate (Director 4, MoH National Headquarters; PNO, Central Hospital 4 in table 4.4.2a)
Plan for policy implementation	MCH policies did not have a plan for their implementation. MCH policies were not translated into operational plan (Table 4.2.1a to table 4.2.1e)	MCH policies had no plans for implementation (table 4.3.2e)	National level policies had no implementation plans. Plans for policy implementation were to be developed at implementation level (Director 2, MoH National Headquarters; Senior Official, UNFPA in table 4.4.2a Cont. 1)
Plan for policy monitoring and supervision	MCH policies had no plans for monitoring (table 4.2.1a to table 4.2.1e)	MCH policies did not have plans for monitoring and supervision (table 4.3.3f)	MCH did not have plans for monitoring (Director 4, MoH National Headquarters in table 4.4.2a Cont. 1)
Plan for policy review and evaluation	MCH policies had no plans for review and evaluation (Table 4.2.1a to table 4.2.1b)	MCH policies did not have plans for review and evaluation (Table 4.3.2g)	MCH policies did not have plans for review and evaluation (Director 5, National Headquarters in table 4.4.2a Cont. 1)

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Triangulation of data sources - Table 4.6.2: Context of MCH policies in Malawi

Themes	Documents	Questionnaires	Interviews
Situational factors	-Political Government transformation from colonial to independent Government. -Transformation from one part Government system to multiparty democracy -Drought in 1991/1992 and 1993/1994 farming seasons -HIV/AIDS pandemic (Table 4.2.2a to table 4.2.2e)	No information on political transformation and drought as factors affecting MCH in Malawi (table 4.3.3.a) HIV/AIDS was indicated as one of the factors affecting MCH in Malawi (table 4.3.3a)	Transformation from colonial Government system left the country dependent on external financial and technical support Multiparty Government system was associated with mismanagement of Government financial resources which resulted in loss of donor confidence and suspension of ODA Drought affected the nation's economy negatively and deepen poverty and food insecurity at individual and community level HIV/AIDS increased disease burden and demand for healthcare services (Director, CHAM Hospital 3 and 4; Senior Official, CHAM Headquarters; Director 6, MoH National Headquarters in Table 4.4.2b)
Structural factors	High population growth and high fertility rate Predominantly agro-based economy High inflation rate Inadequate human resource in the health sector Inadequate Government financial allocation to the health sector Inadequate and poor infrastructure Low employment base Increased levels of poverty Food insecurity; Illiteracy; Gender imbalance High disease burden (Table 4..2.2a to 4.2.2e))	High population Poverty both at community and National level; High disease burden HIV/AIDS; Inadequate resources High illiteracy rate Poor infrastructure (roads, hospitals, communication system) Gender inequality Lack of knowledge among communities on issues relating to MCH (Table 4.3.3a)	There was no information obtained from interview responses (Table 4.4.2b Cont. 1)
Cultural factors	Cultural believes and practices (Table 4.2.2a to 4.2.2e)	Cultural believes and practices (Table 4.3.3a)	Cultural beliefs and practices (Director 5, MoH National Headquarters; MA, Health Centre in-charge at Mchinji District Hospital; Midwife, Mulanje District Hospital in table 4.4.2b Cont. 1)
International factors	MCH polices were developed in response to international health trends and international as well as regional agreements (Table 4.2.2a to table 4.2.2e)	In addition to needs of the population and availability of funding, donor requirements influenced MCH issues to get to policy agenda (4.3.4c)	Factors that influenced MCH polices to get policy agenda included advocacy from international donors and donor requirements (Director 1 and 4, MoH National Headquarters; Director, CHAM Hospital 2; Senior Official, UNFPA in table 4.4.2b Cont.

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Triangulation of data sources - Table: 4.6.3: Process for MCH policies

Themes	Documents	Questionnaires	Interviews
Initiation and problem identification	MCH policies were influenced by international factors like international and regional declarations and health trends e.g. The commencement of HPFP and Vision 2020 policy development was based on the governments' response to the World Bank call to develop HPFP and long-range plans (MoH, 1995:16-30; MoH, 1999b:9, 15, 90) [Table 4.2.3b to table 4.2.3e)	MCH problems became issue for policy agenda when they became National crisis and an international priority. Factors that influence MCH issues to get to policy agenda include needs of the population, donor requirements and availability of funding (Tables 4.3.4b and c)	Factors that influence MCH issues to get to policy agenda included advocacy from international donors, poor indicators in HIMS reports, availability of funding and donor requirements. Donors, MoH directors and programme directors influenced MCH issues to get to policy agenda (Director 3 and 5, MoH National Headquarters; Senior Official, SAVE the Children USA in table 4.4.2c)
Situation analysis	Problem identification based on some form of assessment i.e. SWOT analysis, review of previous policy documents and National as well as international documents, baseline studies, pilot studies and ETRs (Table 4.2.3a to table 4.2.3e)	Policy makers became aware of MCH problems through MCH reports, meetings with health workers, research findings and reports from community leaders (Table 4.3.4a).	Policy makers knew about problems concerning MCH through research findings, HIMS reports, DHS report, international meetings and surveys. Source of information for MCH policy development included National and international documents, DHS reports, HIMS reports. It was done through stakeholders meeting where stakeholders reviewed documents (Deputy Chief of Party, JHPIEGO; Director 1, MoH National Headquarters in table 4.4.2c)
Policy formulation	Formulation of MCH policies was shifting from purely being formulated by external consultants to being formulated by Government official in consultation with a wide range of stakeholders. MCH policies were formulated with financial and technical assistance from international donors. MCH policies were formulated through consultative workshops and series of consultations with various stakeholders and institutions. No information on how policies were arrived at and communicated (Table 4.2.3a to 4.2.3e)	MCH policies were formulated by TWGs, international donors, MoH and DHO (Table 4.3.5a) MCH policies were arrived at through consensus and debate (Table 4.3.4d) MCH policies were communicated to implementers through distribution of policy documents; stakeholders policy dissemination meetings and in-service trainings (Table 4.3.4e)	MCH policies were formulated by TWGs and or task force with financial and technical assistance from international donors. MCH policies were developed through stakeholder consultation meetings. MCH policies were arrived at through consultations with stakeholders; consensus between donors and MoH officials; and adaptation from international and regional policies. MCH policies were communicated through stakeholders' dissemination meetings; distribution of policy documents; staff orientation meetings and in-service trainings (Tables 4.4.2c Cont. 1 and 2)

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Triangulation of data sources - Table: 4.6.3 Cont. 1: Process for MCH policies

Themes	Documents	Questionnaires	Interviews
Implementation	Only NHP 1999-2004 (MoH, 1999a) was translated into five-year district strategic plan and IPs, and JPoW was translated to IPs. The other reviewed documents were not translated to operational policies (Table 4.2.3a to 4.2.3e)	No information was obtained	National policies were translated into annual budgeted implementation plans. NHP 1999-2004 was translated to district five year strategic plans and annual IPs. Central Hospitals also developed IPs. IPs were not used for monitoring and implementation of policies IPs were more of a budgetary tool (Table 4.4.2c Cont.4)
Monitoring and supervision	MCH policies were monitored through routine HIMS data collection and analysis, supervision, monthly reports, quarterly reports and sentinel surveys	MCH policies were monitored through supervision, HIMS and annual reviews. Information from monitoring is used for improving implementation of policies and tracking progress. Supervision was done by DHMT, ZHSO and DHOs (Table 4.3.4g)	Supervision of MCH policy implementation was done by ZHSO, DHOs and MoH programme coordinators. Monitoring of MCH policies is done through supervision , routine HMIS data and quarterly reports (Table 4.4.2c Cont.5)
Review and evaluation	It was evident in the documents that MCH policies were to be evaluated through periodic analysis of HMIS, baseline and periodic survey, DHS, MICS and reviews (bi-annual and annual). However it was not evident in the documents if MCH policies were evaluated except for HIV/AIDS NAF (NAC, 2005a) which was evaluated every year (NAC, 2005b) [Tables 4.2.3a to 4.2.3e)	MCH policies were not evaluated (Table 4.3.4n)	MCH policies were not evaluated but reviewed when developing a new policy or revising a policy (Director 1, MoH National Headquarters; Senior Official, BLM; Senior Official, UNFPA in Table 4.4.2c Cont. 5)

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Triangulation of data sources - Table 4.6.4: Stakeholders for MCH policies in Malawi and their influence

Themes	Documents	Questionnaires	Interviews
Stakeholders for MCH policies in Malawi	The stakeholders include MoH, CHAM, academic institutions, multilateral organization, bilateral organizations and National organizations, beneficiaries Beneficiaries were not involved in policy development (Table 4.2.4a)	Stakeholders who identify MCH issues included health workers and community members (4.3.5c). Stakeholders who formulate policy goals were TWGs (Table 4.3.5d). Stakeholders responsible for monitoring of MCH policies were DHMT members, ZHSO and DHOs (Table 4.3.5e) Stakeholders involved in review of MCH policies were TWGs, DHOs, Director of RHU, Director of Planning and Health workers (Table 4.3.5f). Beneficiaries were not involved in policy development (4.3.5b)	Stakeholders who identified MCH problems as policy issues were TWGs, Minister of Health, Government officials and donors. Stakeholders involved in selecting priorities for MCH policies included MoH officials, TWGs, donors and health workers Donors, MoH directors and programme directors were stakeholders who influenced MCH issues to get to policy agenda Beneficiaries were not involved in policy development (Table 4.4.2d)
Processes of involving stakeholders in MCH policies	Stakeholders were involved in MCH policies development through different teams like TWGs, task force and Technical core team (Table 4.2.4a)	No question was formulated to obtain information on process of involving stakeholders	Stakeholders were involved in MCH policy development through various teams (Table, 4.4.2d)
Level of influence of stakeholders on MCH policies	MoH and international donors have high level of influence on MCH policies in Malawi. Implementing partners and CHAM have medium level of influence. Local NGOs, private for profit, regulatory bodies, health workers, training institutions and beneficiaries had low level of influence on MCH policies in Malawi (Table 4.2.4b)	No question was formulated to obtain information on influence of stakeholders on MCH policies	No information was obtained because no question was formulated
Sources of power for influencing MCH policies in Malawi	MoH had more influence because it has the mandate to provide health services in Malawi and had resources i.e. infrastructure, equipment and human resources. Donors had influence because they had financial resources, technical expertise and access to new information Beneficiaries did not have influence because they had no resources or expertise (Table 4.2.4b)	No question was formulated to obtain information on sources of power for influencing MCH policies in Malawi	MoH has the mandate and resources i.e. human resources and infrastructure for providing health services. Donors had financial resources, expertise and access to information. Beneficiaries were regarded as recipients of services (Table 4.4.2d Cont. 1)

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Triangulation - Table 4.6.5a: Lessons in MH policy development

Documents	Questionnaires	Interviews
One lessons identified form documents: The potential overall impact of EHP is beyond the scope of any single sector and will require inter-sectoral collaboration at many levels ((MoH, 1999b:68 in table 4.2.5)	Three lessons identified from questionnaires; -Beneficiaries and implementers should be involved in MCH policy development -Policies should be results and evidence based -Evaluation should be done before developing a new policy (Table 4.3.6a)	Several lessons identified; -Non implementation of policies due to overlap of policies -Adoption of international policies should consider the Malawi context -Policy development should involve implementers -Policies without resources will not succeed -If monitoring and evaluation are not planned and budgeted in policies they are not done -Policies should be based on evidence and have targets -Every plan should include system strengthening -Policies should focus on strengthening health system -Policy development requires inter-sectoral coordination -Human resource crisis requires concerted effort (Table 4.4.3a and 4.4.3a Cont. 1)

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Triangulation - Table 4.6.5b: gaps in MCH policy development

Documents	Questionnaires	Interviews
No skilled personnel at National level to plan and develop policies Uncoordinated planning and priority setting with interventions being planned and implemented independent of each other resulting in duplication and overburdening of district level implementation No clear institutional framework for policy formulation and implementation Planning unit is supposed to be the policy clearing house on MoH, but the practice has been characterized by uncoordinated policy formulation initiatives often at the influence of donors Weak inter-sectoral collaboration in policy development Weak managerial structures and systems i.e. most departments and hospitals operated without goals and objectives Poor health information management system i.e. current information systems have failed to timely produce the required information for managerial decision making. (Table 4.2.5)	Policy implementers and beneficiaries were not involved in MCH policy development There was no interaction between policy makers and implementers Policies were not communicated to grassroots implementers (Table 4.3.6b)	Private providers they are not involved in policy development Policies are not communicated to private providers DHOs, DNOs, hospital directors and PNOs do not communicate policies to staff members at health facilities DHOs, DNOs, hospital directors and PNOs do not communicate policies to other health providers in their designated districts. There is a breakdown of communication between policy makers and implementers (Table 4.4.3b)

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Triangulation - Table 4.6.6a: Lessons in MCH policy implementation

Documents	Questionnaires	Interviews
No information was evident in the documents on lessons on MCH policy implementation (Subsection 4.2.6)	Policies without resources will never be implemented and will never achieve the intended results Cultural beliefs and practices play a great role in policy implementation For policies to be implemented, they need proper and timely communication to implementers (Table 4.3.6a)	Multiple responsibilities make MoH inefficient Hospitals need to develop strategic plans Planning and prioritizing medical supplies should be part of performance issues in HRM Successful policy implementation requires adequate resources If the available human resources are not retained the problem of HR will remain for ever Broad policy statements are difficult to implement Objectives without targets cannot be measured Implement policies Evidence based policy development and implementation Evaluation is also part of the policy process Monitoring should include linking of supervision with performance management (Table 4.4.4a)

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Triangulation - Table 4.6.6b: Constraints in MCH policy implementation

Themes	Documents	Questionnaires	Interviews
Constraints encountered at Government health facilities in implementing MCH policies	High population growth, high illiteracy and poverty High disease burden, and harmful social and cultural beliefs and practice Weak community participation and involvement weak procurement and logistics systems for drugs, supplies and medical equipment Weak managerial structures and systems; poor health information management system; and inadequate capacity to formulate policy, to co-ordinate implementation, to monitor progress and adequately support district health services. Weak monitoring, supervision and evaluation Inadequate professional health workers; inadequate and poor infrastructure, shortage of drugs and inadequate medical supplies; inadequate financial resources Lack of experienced staff in planning and of day to day management of health facilities; weak inter-sectoral linkages; weak regulatory infrastructure; and slow progress in decentralization. Weak inter-sectoral collaboration on health issues; lack of community empowerment; and lack of support for community structures (See Table 4.2.6a to table 4.2.6e)	Inconsistent availability of medical supplies and equipment Inadequate human resource Lack of equipment Unsustainable funding when donors pull out Inadequate and poor infrastructure High disease burden and new diseases Long distances between health facilities Poor referral system (telecommunication, vehicles for referring patients and poor road network Inconsistent supervision Inconsistent and delayed supply of drugs and medical supplies High illiteracy rate Cultural beliefs (See Table 4.3.6b)	Inadequate human resources Inadequate and poor infrastructure Inconsistent supply of drugs and medical supplies Inadequate financial resources No continued funding for project based programmes No equipment, inadequate or non functioning (Director, Central Hospital 1 in Table 4.4.2g)

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Triangulation - Table 4.6.6b Cont. 1: constraints in MCH policy implementation

Themes	Documents	Questionnaires	Interviews
Constraints encountered at Government health facilities in implementing MCH policies		Lack of knowledge among communities on issues relating to MCH Gender imbalance in decision making on health issues at community level (see Table 4.3.6b)	
Constraints encountered at private facilities in implementing MCH policies	No information provided	No information provided because question on constraints did not ask respondents to categorize the constraints	Shortage of human resource (Private Practitioner, Blantyre District)
Constraints encountered by NGOs in implementing MCH policies	No information provided	No information provided because question on constraints did not ask respondents to categorize the constraints	Shortage of human resource due to high turnover High poverty level High illiteracy rate No resources for Government to sustain programmes initiated by NGOs Abuse of resources in Government (Senior Official, FPAM; Senior Official, WHO)

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4.7 Constraints and limitations of the study

Documents review

The first constraint with official documents was that some documents were not available, e.g. family planning policy and safe motherhood programme reports. Although permission to access relevant documents for this study was sought from the Malawian Principle Secretary for MOH, the ministry did not communicate the request to directors and programme coordinators. The experience support Polit and Hungler (1999) observations that sometimes institutions are reluctant to allow researchers to have access to official documents or responsible officials may not be willing to release documents. Despite the situation, MoH directors and other programme coordinators willingly provided the requested government documents, once the focus of the study and situation was explained to them.

The second constraint was that it was difficult to find some critical documents in the MoH library because documents were not systematically arranged, specifically NHP for 1965-1969, 1973-1986 and 1985-1999 as well as the HPFP. In addition, particular documents that were not being used were regarded as outdated. Further to that, the Librarian Assistant at MoH was busy with other duties during the data collection visits in Malawi. The researcher had to go through all stocked documents and it took longer than expected to find the required documents. Finally, the documents were collected in Malawi, copied and transported to South Africa for content analysis and because they were many, they posed tremendous travelling challenges.

The limitation for documents review was that certain aspects of information were not documented in some of the policies that were reviewed as argued by Patton (2002). He argued that some aspects of a programme are not documented in official documents. For example, NHP for 1965-1969, 1973-1988 and 1986-1995 did not document how they were initiated. In addition, documents were highly variable in quality, with detail in some cases and virtually nothing in other programmatic components (Marshall and Rossman, 1997). Further to that documents did not provide all the information that was required for the study because they were written for different purposes. For this reason, the study used other methods for data collection to complement data from official documents and official documents reviewed formed a basis for

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those methods. One the other methods used for data collection was self-administered questionnaire. Although self-administered questionnaires complemented information from documents review, they also had their limitations.

Self-administered questionnaires

The researcher personally distributed and collected the questionnaires to minimise postal delay and ensure safe return of the questionnaires. This required the researcher to travel to participants' places of work to hand-in the questionnaires. The challenge was that sometimes participants were not present at their work places for various reasons. Alternative arrangements were made to ensure that those participants received the questionnaires and that filled questionnaires were collected. Therefore extra visits were made to collect the completed and uncompleted questionnaires. Despite these elaborate arrangements, two questionnaires were not returned because the participants were attending three concurrent workshops.

The main limitation associated with the questionnaires was that although there was a good questionnaire return rate, 34 out of 88 questionnaires were not completely filled. The incomplete questionnaires comprised of three from District Hospitals and 31 from health centres. The participants from health centres said that they were not aware of policy process. In addition, questionnaires did not provide a chance for probing for more information. To counteract disadvantages of questionnaires, interviews were conducted to pursue issues from questionnaire responses.

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Interviews

Although valuable information was collected from participants and key informants, it is was difficult to gain access to them because they were usually busy people working under severe time constraints just as stipulated by Marshall and Rossman (1999). It was so difficult to arrange interview meetings with participants and key informants, e.g. senior public servants such that some meetings were rescheduled on several occasions. In addition, some key informants were specifying time limit for interviews. However, the issues for discussion determined the length of interview but the amount of data collected was not affected by their strict time limits.

Another limitation with regards to the interviews was that some key informants wanted to say the ideal situation and some senior MoH staff did not want to provide answers that would reflect negatively on the ministry with the fear of consequences if discovered. However both participants and key informants were re-assured of confidentiality of the information they provided and that their names would not be used in the final report. In addition, they were assured that positions and name of institutions and places would be used in a manner that their identity will not be known.

Field visits

Although this study draws cases from all the three regions, only two health centres were selected from each district due to lack of funding. In addition, the researcher did not have an appropriate vehicle that could cope with the poor state of the road in some of the districts. As a result, health centres that were visited were those that were reachable by a small car. This limited the study from including information of health facilities from the remotest health centres from District Hospitals. Not all the health centres that were visited in the southern and northern regions were informed by DHOs that the researcher was to visit them. As a result, reception to the study and data collection varied considerably. For example, at one health centre, the MA and the ENM did not want to talk to the researcher but accepted to complete the questionnaires after a long negotiation, numerous telephone calls to the DHOs and requesting verification of the researcher's identity card.

Another limitation identified during field visits was that observations were limited, e.g. information on process, context could not be observed. Therefore, there was limited information that was collected through field visits. In order to overcome this limitation, the researcher used other methods of data collection. Finally, field visits like the other three methods of data collection raised ethical issues of gaining access to field sites and research participants. The researcher sought approval for the study and permission to access field sites and participants.

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4.8 Validity and Reliability of the study results

Reliability of results for this study was enhanced by presenting quotations from interviews along with themes and categories identified during data analysis (Hamberg et al, 1994: Beck, 1993). In addition transcriptions of questionnaires and interviews were sent to respondents to verify accuracy of information they provided. Further to that, preliminary findings were presented to senior managers of MoH and key stakeholders who were study participants as well as key informants to verify the results. Furthermore, the study made reference to the documents from which the information was extracted. Reliability of the study results was also enhanced though data analysis. In addition to the researcher two academic researchers, one of whom was not from Malawi (she came from Ghana), verified categories and themes from raw data by looking at a copy of raw data and preliminary findings. Furthermore, data was collected from wide range of study participants and key informants. The study also triangulated information from the three data sources to validate study results (Strydon, Fouche and Delport, 2007).

The results obtained from the study are unique to Malawi; however it is possible to apply the results and research methodology to other developing countries in Sub-Saharan African countries. It must be stated however that the responsibility of applying results or part of the results of this study to other contexts rests on the readers (Lincoln and Guba, 1995). Nonetheless, to enhance transferability of the study results in Sub-Saharan Africa, the study context has been described in chapter one and two. In addition, the theoretical framework for study was based on concepts and models for public and health policy development and analysis (Walt and Gilson, 1994). The framework for the study guided data collection and analysis. By describing theoretical framework, the researcher stated the theoretical parameters within which the study could be applied. Collecting data from wide range of multiple participants and informants and triangulation of data sources strengthened the study's replication in other settings (Strydon, Fouche and Delport, 2007).

Hansen (2006) suggested that the researcher should give an account of the research process, allowing the reader to judge dependability of the research. Dependability was achieved by

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describing the criteria for selecting study participants and key informants as well as health facilities for field visits (Rice and Fizzy, 1999). In addition, summary of raw data and preliminary findings were presented to the primary supervisor who verified the results. Further to that, field notes provided detail about data collection processes. The study described the research method and designs. The description included rationale for selecting qualitative research method and designs. The processes and methods of data collection and analysis for the study were also described in chapter two. Finally, to achieve dependability of study results, an audit trail of the research process through memos and field notes was constructed. The notes could allow another researcher to trace the course of the research step by step via the decisions made and procedures described. In addition, large amounts of data have been presented in this final report. This allows other researchers to judge findings and conclusions reached (Hamberg, et al, 1994).

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Chapter Five

ANALYSIS OF RESULTS AND DISCUSSION

5.1 Introduction

Chapter 4 presented results of the study from the data collected. This chapter discusses the study results basing on aims and objectives of the study. Firstly, the chapter discusses MCH policies in Malawi from 1964 to 2008 in terms of their content, context, processes and stakeholders involvement in each of the policies. Secondly, the chapter discusses lessons and gaps contained in documents and as indentified from views of participants and key informants in MCH policy development and implementation in Malawi.

5.2 MCH policies in Malawi from 1964-2008

As presented in chapter four, a number of MCH policies existed in Malawi from 1964 to 2008. MCH policies in Malawi have been discussed in terms of their content, context, process and stakeholders.

5.2.1 Content of MCH policies in Malawi

Rationale for MCH policies in Malawi

Results from documents reviewed (subsection 4.2.1) indicated that some documents outlined rationales whilst other documents did not. Questionnaire responses indicated that MCH policies did not have rationales (subsection 4.3.2). Results from interviews indicated that rationale and purpose for MCH policies depended on stakeholders formulating the policy in Malawi (subsection 4.4.2). In addition, interview responses revealed that there was no standard on information contained in policy documents in Malawi. Comments from study participants and key informants (Table 4.4.2a);

> *"It is not always that a policy would have its rationale documented. It really depends on stakeholders formulating the policy" (Director 1, MoH National Headquarters)*

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"Policies are written differently and sometimes instead of documenting rationale for each policy, previous polices have justification or presented the overall objective. Some policies may have a mission and vision statements but it really depends on who is formulating the policy," (Senior Official, JHPIEGO).

The three data sources therefore, revealed that it was not standard for MCH policies in Malawi to have rationales outlined but instead, stakeholders formulating a particular policy may document purpose, overall objective, justification, vision and or mission for the policy (subsection 4.6.1 and Table 4.6.1). This finding is in conflict with Hardee et al (2004) suggestion that written policy documents should include rationale and justification.

Goals, objectives and strategies

Results obtained from reviewed documents revealed that all the reviewed documents had priorities in terms of goals, objectives and strategies except Vision 2020 (Table 4.2.1b). However, goals, objectives and strategies were broad in the sense that they had no time-frame and targets. For documents whose goals, objectives and strategies had timeframe and targets outlined in their logic frames, there was missing information on either baseline data or targets (Table 4.2.1b). Questionnaire responses indicated that MCH policies had goals and objectives. However, participants' comments showed that goals and objectives were not evidence-based or results oriented (Table 4.3.2b). Interview responses confirmed information collated from reviewed documents and questionnaire responses. A key informant indicated that MCH policies were not evidence-based and results oriented in the sense that they had no targets and that goals and objectives were broad (Table 4.4.2a). Comments from interview responses included;

"Most of these policies are not results oriented as you may have noted that some have no targets and others have no time frame. Where would one go with policies without target and time frames? How do you measure progress and how will one know if objectives have been achieved or not?......" (Senior Official, UNICEF).

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There were consistence from the three data sources that goals, objectives and strategies for MCH policies in Malawi were broad and not results oriented as well as evidence based (Table 4.6.1). According to Hardee et al (2004), Fox et al, (2006), Green (2007), goals, objectives and strategies for health policies should be specific and results oriented as well as evidence based.

Results from documents reviewed also showed MCH policy priority areas in Malawi were influenced by international policy priority areas (Tables 4.2.1c to 4.2.1e). For example, priorities for RH policy were based on ICPD recommendations and priorities for the roadmap were based on MDG 4 and 5 (Table 4.2.1c). Questionnaire responses did not provide information on the basis for priorities of MCH policies in Malawi because no question was formulated. Interview responses supported results from documents review. They indicated that priorities for MCH policies were adopted from international policy priorities (Table 4.4.2a).

> *"Most of these MCH priority issues are advocated for at international and regional meetings where countries agree to develop policies around them," (Director 1, MoH National Headquarters)*

> *"Donors may have funding for specific priority programme areas and they require MoH to develop policies on how the programmes will be implemented in a specific country," (Director, CHAM Hospital 2)*

> *"The direction that the MoH takes is probably largely directed by INGOs, they developed MDGs, so INGOs are keen and focussing on that they come in with their interests. So somehow, they direct MoH on what to be the priority areas. Therefore, I think the INGO have a big impact in terms of directing MoH to pick up priorities. I do not know how far they have an impact on development of policies as such but I think it might be quite extensive. I come from an NGO myself and I know that they have international priorities have a big stamp on policy priorities at National level," (Director, CHAM Hospital 1).*

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Content evidence from three data sources confirmed that priorities for MCH policies in Malawi were based on priorities for international policies (subsection 4.6.1 and Table 4.6.1). in support of the finding, Akukwe (2006) argued that most priorities for MCH in Africa reflect widely held priorities on plight of women and children worldwide because of the extensive external donor support. He therefore, proposed that National policies should reflect National priorities (Akukwe, 2006).

Resources for implementation

Documents reviewed showed that resources for implementing policies were outlined in some documents and not in others (Table 4.2.1a to 4.2.1e). For instance, resources for NHPs, JPoW Five Year Strategic Plan for CSD and HIV/AIDS NAF (MoH, 1965; MoH, 1971; MoH, 1986; MoH 1999a, MoH, 2004b, MoH, 2007 and NAC, 2005a) were outlined. Whereas, resources for HPFP, Visio 2020, RH Policy, National RH Strategy, EPI, IMCI Approach Policy, National Policy on ECD and HIV/AIDS Policy, were not outlined in the documents (MoH, 1995; MoH, 1999b; MoH 2002a; MoH, 2006a; MoH 2002b). Resources for the Roadmap (MoH, 2006b), RH policy (MoH, 2002a) and RH National strategy (MoH, 2006a) resources were to be allocated through JPoW (MoH, 2004b) because they were to be implemented as part of EHP and in the context of SWAp. For the documents that had resources allocated, only the estimated financial resources were outlined in the documents (Subsection 4.2.1). Human and physical resources were not included in policies that were reviewed except for NHP 1999-2004 (MoH, 1999a) [See Table 4.2.1a).

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Questionnaire responses indicated that allocated resources for MCH policies were inadequate (Table 4.3.2d). Interview responses confirmed results from documents reviewed and questionnaire responses. They indicated that estimated financial resources for MCH policies were documented in documents, however they were inadequate. Interview responses also indicated that only estimated financial costs were documented and other resources like human and material were not documented (Table 4.4.2a). Comments from interview responses;

> *"What you will find in policy documents is mostly an estimated financial cost to implement a policy. If you talk of human and physical resources required to*

implement policies other than what is already in existence, they are identified and included in the budget. The existing human and physical resources are part of the background and situation analysis of the policy which you do not include again in the budget" (Director 4, MoH National Headquarters).

There was consistent evidence in the three data sources that only estimated financial resources were outlined in some MCH policy documents of Malawi. In addition, although resources were allocated in MCH policies, they were inadequate (Table 4.6.1). Yet according to Hardee et al (2004), resources refer to the financial, physical and human resources that are needed to implement policies. Fox et al (2006) argued that a budget should contain more than financial details. They suggested that a budget should cover all of the resources (human, physical and technological) needed to plan, implement and control a policy. Fox et al (2006) further suggested that policy development should be completed by adequate required resources to ensure implementation to achieve set goals and objectives.

On the other hand, some documents reviewed indicated that large proportion of funding for MCH programmes came from international donors (Table 4.2.1a to 4.2.1e). For example, external donors funded 70% of total estimated financial resources for JPoW and NHP 1999-2004 (MoH, 2004b and 1999a respectively). No information was provided by questionnaire responses because no question was formulated. Interview responses supported results from documents review. Results from interview responses indicated that external donors funded MCH programmes (Table 4.61). Comments from interview responses;

"Most of MCH programmes are funded by external donors and when donors pull out, the programmes that were funded by that donor suffer financially and usually die off" (DHO, district 7).

"MCH programmes are mostly donor dependent, usually reproductive health, obstetric services, family planning, child health, HIV/AIDS, TB, Malaria and many programmes for mothers and children including health programmes for youths are funded by external donors" (PNO, Central Hospital 2).

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"……normally what happens is that the department would ask so much amount of money in our budget and the Government would say that is too much. They give us what they call ceiling. The difference between ceiling and budget is the gap that is not funded. And then for most of programmes in the department we have a lot of external donor support from WHO, UNICEF, Global Fund and Bush Malaria Initiative" (Director 4, MoH National Headquarters).

There was general agreement in the three data sources that both the Government and external donors provided funding for MCH programmes in Malawi (Table 4.6.1). Despite this evidence, it was clear that external donors provided large proportion of financial resources for MCH in Malawi (table 4.6.1). The findings supported Akukwe's (2007) view that healthcare delivery systems of many African countries depend heavily on external financial support. He proposed that, external donor partners should provide long-term support and when external donor support is finished, National Government should have deployed alternative funding mechanisms.

Plan for implementation

Documents reviewed showed that most MCH policies in Malawi did not have a plan for their implementation. Although some documents outlined implementation structures, almost all documents had no implementation plans (Table 4.2.1a to 4.2.1e). Questionnaires responses indicated that MCH policies had no implementation plans (Table 4.3.2e). Interview responses supported results from documents and questionnaires. They indicated that National level policies had no implementation plans. However, interview responses indicated that plans for implementation were to be developed at implementation level (Table 4.4.2a Cont. 1).

"National policies are implemented at different levels and facilities; it is at these facilities that implementation plans are developed, not at National level," (Director 2, MoH National Headquarters).

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"Implementation plans for National policies are supposed to be developed at district and central level. Other than that various departments also develop their work plans for implementing the policies. Therefore, you will not find implementation plans in the policies, (senior official, UNFPA).

All the three data sources confirmed that MCH policies in Malawi did not have implementation plans (Table 4.6.1). The finding was not in support of Green's (2007). He suggested that policies should have implementation plans incorporated in the documents or long term policies should be translated into operational plans. He continued that these should also have short and annual operational implementation plans that are linked into national annual budget allocations.

Reviewed documents revealed that National MCH policies were not translated into operational plans at implementation level (Table 4.2.1a to 4.2.1e). For example, in most documents reviewed were not translated into operation plans at implementation level except the NHP for 1999-2004 and JPoW (MoH, 1999a; MoH, 2004b). The NHP for 1999-2004 (MoH, 1999a) indicated that it was to be translated to five-year district strategic plan and district implementation plans. In addition, the JPoW (MoH, 2004b) also indicated that it was to be translated into work plans at District and Central Hospitals as well as departmental level within the MoH. Comments from interview responses indicated that implementation plans based on NHP 1999-2004 (MoH, 1999a) and JPoW (MoH, 2004b) were developed separately at district and Central Hospital levels (Table 4.4.2a Cont. 1).

"DIP is meant to be a translation of National strategies. It started when we developed our fourth National health plan. At the time that we were doing the fourth NHP, the districts were told to do a district plan, it was a five year plan and then after that we started the DIPs which are like annually and then at some point they did a three year plan but it was a capital, it was very much focusing on infrastructure. Those are still there although in some cases we have noted that the plans are nowhere to be seen because of the turnover, may be the handovers were not done properly. For the JPoW District Hospitals develop budgets for annual implementation plans, the same with Central

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Hospitals and departments in MoH," (Director 3, National MoH Headquarters).

"At the moment, hospital does not have strategic plans. We are working towards having and developing business plan. Central Hospitals have never had their strategic plans. All of us are utilizing JPoW for the Ministry. Recently MoH is just finalizing its strategic plan which all of us now have to use in developing our own business plans as Central Hospitals. Therefore, we are going to buy in from the National strategic plan. What we have now, we only develop annual implementation plans which in themselves are not sufficient because you cannot be able to plan for the future," (Director, Central Hospital 3).

Even though the Director for Central Hospital 3 said that no Central Hospital had business plan, interview responses from DNO and Deputy Director for Central Hospitals 1 and 2 revealed that two Central Hospitals had business plans (Table 4.4.2). The business plans were part of the process for granting semi-autonomy to the two hospitals that was not approved in parliament.

"We developed the business plan together with our partners who were assisting us on issues of autonomy but then after their contract was over they had to pull out but we are still using the information. The issue of hospital autonomy went up to drafting of the bill to be presented in parliament but the bill was not passed in parliament. Now they are considering issues of creating a trust for the hospital rather than autonomy. The MoH and its partners are still discussing and the process is too slow," (DNO for Central Hospital 1).

Although the Deputy Director for Central Hospital 2 could not locate their business plan, access was granted to examine that of Central Hospital 1. Nevertheless, responses from interviews revealed that implementation plans for District and Central Hospitals including departments within the National MoH Headquarters were utilised as budgetary tool for requesting funding instead of a policy implementation tool (Table 4.4.2a Cont. 1)

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"The annual district implementation plans are used as a budgeting tool for requesting funding from MoH for delivering services as District Hospitals. When the parliament is about to open, were asked to submit our DIPs to MoH National Headquarters where all the DIPs and CHIPs and work plans from departments are put together to form the National MoH budget. It is the National MoH budget that is presented in parliament for getting Government financial allocation the whole health sector," (DHO, District Hospital 7).

There was consistent evidence in all the three data sources that National MCH policies were not translated into operational plans at implementation level to achieve results (Table 4.6.1). Only the NHP 1999-2004 and JPoW were translated into implementation plans at district and Central Hospital level. However, the implementation plans were utilized as tools for requesting funding for the health sector. Green (2007) argued that one of the reasons for failure to implement National policies is that National level policies are usually not translated into operational policies at implementation level.

Plan for monitoring and supervision

Documents reviewed showed that MCH policies had no plans outlining who was to monitor and supervise MCH polices in Malawi, when and how (Tables 4.2.1a to 4.2.1e). Questionnaire responses indicated that MCH policies had no plans for monitoring and supervision (Table 4.3.2e). Interview responses confirmed findings from document reviewed and questionnaires. Interview responses indicated that MCH policies did not have detailed plans for monitoring and supervision (Table 4.4.2a Cont. 1). Participants' comments indicated that MCH policies had no detailed plans because they were guiding documents.

"National Policies are guiding documents; they do not have detailed information on implementation plans, supervision, monitoring and evaluation. It is up to the hospital mangers to develop those details," (Director 4, MoH National Headquarters)

".Policy documents may not have detailed plan for monitoring and supervision, but they have indicators and they mention how they are to be monitored. It is up to the DHOs and ZHSOs to make sure that they use the

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indicators for monitoring and supervision. In addition the HIMS database has data on all the indicators I most of these policies," (Director 4, MoH National Headquarters).

All the three data sources provided consistent information that MCH policies in Malawi did not have plans for monitoring and supervision. Nevertheless, all three data sources indicated how MCH policies were to be monitored and supervised (Table 4.6.1). Fox et al (2006) did not support the finding by arguing that the first step in monitoring and supervision must establish what is to be monitored, by whom, when and how. They therefore suggested that policies should have detailed plans and resources for monitoring and supervision.

Plan for policy review and evaluation

Reviewed documents revealed that MCH policies in Malawi had no plans for review and evaluation (Tables 4.2.1a to 4.2.1e). Although documents mentioned that evaluation was to be conducted, they did not outline budget for evaluation, responsible personnel to conduct the evaluation, how and when. Questionnaire responses confirmed that MCH policies did not have plans for review and evaluation (Table 4.3.2f)). Interview responses indicated that even though policy documents mentioned how they were to be evaluated they had no plans outlined for evaluation (Table 4.4.2a Cont. 1). One respondent indicated that,

"yes I understand your question, it is true that we do not plan for evaluation, the policies however do mention how they are to be evaluated but they do not have detailed plan and budget for evaluation, may be that is why most of our National plans have not been evaluated comprehensively" (Director 5, MoH National Headquarters)

The three data sources concurred that although MCH policies in Malawi mentioned how they were to be evaluated, they did not have plans for review and evaluation (Table 4.6.1). This finding was not in support of Cloete and Wissink's (2000) view that evaluation should be planned, budgeted for, and incorporated into the policy design. They argued that such actions would ensure the availability of sufficient

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financial resources to conduct the evaluation, as these will form part of the approved budget for the policy or project or programme (Cloete and Wissink, 2000).

5.2.2 Context of MCH policies in Malawi

Different writers use different concepts to describe context of policy but for the purpose of this study, policy context was discussed under four broad headings, e.g. situational, structural, cultural and international factors as stipulated by Buse et al (2005).

Situational factors

According to documents reviewed, situational factors that occurred from 1964 to 2008 included the political Government transformation from a colonial system to independence under one party system then a democratic multiparty system (Tables 4.2.2a to 4.2.2e). However, documents did not show how political transformation affected MCH policy development and implementation. Interviews responses confirmed findings form documents reviewed. They indicated political transformation as one of the situational factors that affected MCH policies in Malawi (Table 4.4.2b).

> *"It all goes back to economic development, the country is poor. So even though we became independent politically, we could not function on our own for obvious reasons that we did not have skilled staff in everything on top of financial constraints. Therefore until today we still depend on external financial and technical support for developing and implementing policies and various health and non health programmes," (Director, CHAM Hospital 3).*

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Interview responses also showed that democratic multiparty system was associated with mismanagement of Government financial resources and corruption that resulted in loss of donor confidence and reduced funding to the health sector (Table 4.4.2b).

> *"You and I know very well that multiparty democracy although it was applauded internally, it brought us many problems. There was mismanagement of Government financial resources and a lot of corruption. As a result, the Government lost its donor confidence and for your information, there was a time that that even donors suspended their financial development*

assistance. This led to numerous problems, it reduced financial allocation for the health sector and there was inconsistent financial allocation for more than two years in mid and late 1990's," (Director 4, CHAM hospital).

"Multiparty democracy was associated with corruption and mismanagement of Government resources. It is also the time that we experienced inadequate funding for the ministry lead to serious shortages in human resources and medical supplies as well as deterioration of infrastructures and quality for health services in general. The Government then did not regard health as a National priority," (Senior Official, CHAM National Headquarters)

Interviews were the only data source that provided information on democratic multiparty system being associated with mismanagement of Government financial resources and corruption (Table 4.6.2). UNDP, 2005 supported this finding, it stated that, multiparty democracy in the 90s was characterized by corruption, financial mismanagement, and moral erosion which resulted in loss of donor confidence.

Another situational factor affecting MCH policies in Malawi was drought that occurred during 1991/1992 and 1993/1994 farming seasons (Tables 4.2.2a to 4.2.2e). Interview responses confirmed findings from documents reviewed (Table 4.4.2b). They indicated that droughts affected the nation's economy negatively and deepen poverty as well as food insecurity at individual and community level.

"It is pathetic when this country is hit by a drought; the majority of people have no food and no source of income because most of them are subsistent farmers. And it is not only the people but also the Government, Malawi's economy is agro-based, so a drought means reduced exports and income for the country," (Director 6, MoH National Headquarters).

The finding supports UNDP's (2005) view that the droughts grossly affected the Malawi's economic performance, exacerbated poverty and food insecurity in the country.

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Reviewed documents and questionnaire responses also indicated that HIV/AIDS was another situational factor that affected MCH policies in Malawi. Interview responses confirmed findings from documents and questionnaire responses. They showed that HIV/AIDS increased disease burden and demand for healthcare services (See Table 4.6.2);

> *"We were doing well before the scourge of HIV/AIDS in terms of maternal and child heath, but HIV/AIDS has increased the disease burden in general. For example, opportunistic infections for HIV/AIDS like TB, pneumonia, meningitis are on the increase. In addition to that, knew programmes like PMTCT and VCT as well as treatment for increasing opportunistic infections have increased the demand for health care. This implies that there is an increase in work overload and a further stretch of the inadequate resources for healthcare," (Director 6, MoH National Headquarters).*

Evidence from three data sources was consistent that HIV/AIDS was one of the situational factors that affected MCH policies in Malawi (Table 4.6.2). The finding supports WHO (2005b) stance that HIV/AIDS is both direct and indirect cause of death among women and children, and increases disease burden as well as demand for new services that further requires spending on infrastructure, equipment, drugs and human resources. In so doing HIV/AIDS further stretches already limited resources for the health sector.

Structural factors

Documents reviewed showed that structural factors that influenced MCH policies in Malawi from 1964-2008 included high population growth rate, high fertility rate, predominantly agro-based economy and high inflation rate (Tables 4.2.2a to 4.2.2e). In addition, inadequate human resource, inadequate Government financial allocation to the health sector and inadequate infrastructure were also identified as structural factors that influenced MCH policies in Malawi. Other factors were low employment base, increasing levels of poverty, food insecurity, illiteracy, gender imbalance and high disease burden. Questionnaires responses confirmed findings from documents reviewed. There was no information obtained from interview responses (Table 4.6.2). The results were in support of literature on factors influencing MCH in Malawi in subsection 2.5, chapter 2. According to reviewed literature various factors (i.e. high

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mortality, disease conditions, and shortage of healthcare personnel, inadequate financial resources, and inadequate access to health services, poverty, illiteracy and gender inequality) influenced MCH in Malawi.

Cultural factors

Reviewed document showed that cultural factors that affected MCH policies in Malawi were cultural beliefs and practices (Table 4.2.2a to 4.2.2e). Questionnaire and interview responses indicated that cultural beliefs and practices prevented people from utilizing available healthcare services in Malawi (Table 4.3.3a and table 4.4.2b Cont.1). For example comments from questionnaire response highlighted these issues,

> *"People culturally define which diseases need treatment from healthcare facility or traditional healers and they also decide which advise from health workers to listen to. So what happens is that they come with serious sick children after they have visited several traditional healers. Even if they come to the health centre and they receive treatment, they continue to give traditional medicine to the child or they may not follow our advice if it conflicts with their traditional beliefs. For example, here in the central region it is still common to give babies dirty water in which adults have washed their hands to drink. They believe that the dirty water will strengthen the baby's immunity. So you can see that although we provide health services, traditional practices counteract everything that we are doing," (MA, health centre in-charge at Mchinji District).*

> *"Cultural believes and traditional practices make our work very difficult, because more especially pregnant women take dangerous traditional medicine during pregnancy and labour and sometimes they come with complications like ruptured uterus," (Midwife, health centre in Mulanje district).*

Views outlined in questionnaire responses were also supported during interviews,

> *"People in this country still believe in traditional medicine to the extent that it is so difficult to convince them to come to hospitals. The DHS showed that almost 50% of the communities especially in rural areas do not go to the hospital when they are ill. This is a great concern to us because even if you*

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build hospitals, recruit health workers as a Government these people are not coming to you, they will still die and increase the morbidity and mortality rate for the country," (Director 5, MoH National Headquarters).

All three data sources confirmed that cultural factors affected utilization of healthcare services in Malawi (Table 4.6.2). The finding agreed with Khama et al (2006), views that harmful traditional practices and religious beliefs adversely affected health of women and children. According to the authors, a plethora of harmful beliefs and practices around pregnancy and childbirth affect health-seeking behaviour. In support of that view, Ghebrehiwot (2004) further elaborated that the disproportionately low use of health facilities in Malawi was a testimony to the strength of these cultural beliefs and practices. According to MEDP (2008), cultural practices encourage early marriages, home deliveries, and discourage the use of modern contraceptive methods in Malawi. MEDP advocated for health policies to have strategies for addressing cultural factors influencing health negatively.

International factors

Documents revealed that MCH policies in Malawi were developed in response to international health trends and agreements including international and regional agreements (Tables 4.2.2a to 4.2.2b). Questionnaire and interview responses confirmed that MCH policies were influenced by international factors (Table 4.6.2). Questionnaire responses indicated that in addition to needs of the population and availability of funding, donor requirements influenced how MCH issues get onto policy agenda in Malawi (Table 4.3.4c). Results from interview responses indicated that factors that influenced MCH issues to get to policy agenda included advocacy from international donors as well as donor requirements (Table 4.4.2b Cont. 1).

"Most of these MCH priority issues are advocated for at international and regional meetings where countries agree to develop policies around them," (Director 1, MoH National Headquarters).

"When the indicators in HMIS reports are poor, departments usually pick this up to discussion" (Director 4, MoH National Headquarters)

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"Donors may have funding for specific priority programme areas and they require MoH to develop policies on how the programmes will be implemented in a specific country," (Director, CHAM Hospital 2)

"Donors develop international policies and work with MoH directors and programme coordinators to develop policies at National level," (Senior Official, UNFPA).

All the three data sources corroborated that MCH policies in Malawi were influenced by international factors like international and regional agreements as well as health trends (Table 4.6.2). The finding supports Wolfe and Behague (2008) who argued that donor requirements for policies are imposed on recipient countries as a pre-requisite for continued funding. Mwabu, Wang'ombe, Okello and Munishi (2004), stance also supports the findings in arguing that health policies in many African countries are influenced by international factors to a greater extent because the countries are dependent on external financial and technical support. On the other hand, Buse et al (2005) stipulated that with globalization, international factors like transnational corporations, global health threats, policy conditions and pressure from global social movements, national health policies are greatly influenced by international factors.

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5.2.3 Process of MCH policies

Initiation and Problem identification

Documents revealed that since independence, the initiation of MCH policies in Malawi had largely been influenced by international factors, (Tables 4.2.3a to 4.2.3e). Questionnaires responses showed that MCH concerns became important issues when these became National crisis as well as international priorities (Table 4.3.4c). Interview responses also revealed that even though MCH concerns existed in Malawi, they were not reflected in policy formulation until international donor influence came into play (Table 4.4.2c). Some of the comments from interviews were;

Most of these issues are advocated for at international and regional meetings where countries agree to develop policies around them (Director 3, MoH National Headquarters).

When the indicators in HMIS reports are poor, departments usually pick this up to discussion with our donor partners (Director 5, MoH National Headquarters).

Donors may have funding for specific programmes and they require MoH to develop policies on how the programmes will be implemented in a specific country (Senior Official, SAVE the Children USA).

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All three data sources confirmed that initiation for MCH policies was largely influenced by international factors (4.6.3). Shiffman (2007) views supported the finding; he stipulated that once issues become international policy concern then they are advocated for at National level. He argued that international actors such as aid agencies and multilateral organizations first put maternal mortality reduction on the global agenda in order to promote and generate interest of national health officials. Shiffman (2007) further maintained that international donors provide financial and technical resources to address the problems at various National levels.

Situational analysis

Official documents showed that situational analysis for MCH policies in Malawi was based on some form of assessment i.e. SWOT analysis (Tables 4.2.3a to 4.2.3e). Other forms of assessments included baseline studies, pilot studies and End of Term Reviews (ETRs). At times these were undertaken at donors' request or were donor driven. For instance, WHO consultant conducted the situational analysis of NHP 1973-1988 whilst situational analysis for the Programme of CSD was based on UNICEF programme frame-work (MoH, 1971; MoH, 1988 respectively).

Questionnaire responses indicated that policy makers became aware of MCH problems through MCH reports, meetings with health workers, research findings and reports from community leaders (Table 4.3.4a). Interview responses showed that

policy makers knew about problems concerning MCH through research findings, HMIS reports, DHS reports, including international meetings and surveys (4.4.2c). In addition, interview responses revealed that problems for MCH policies were identified through stakeholders' meetings. For example, one key informant said that,

> "*Identification of problems for MCH policies is carried out by conducting a situational analysis. It is undertaken at the same time with developing or revising policies. It a very cumbersome process and to start with, we have one week stakeholders meeting I do not know how many reference materials not only from Malawi but international documents including evidence based documents, international policies on reproductive health, child health, HIV/AIDS, family planning and any necessary documents. Most of these documents come from WHO and other INGOs that take a lead in SRH and MCH issues. From Malawi you talk of MDHS reports, previous policies, HMIS reports what have you……,"* Deputy Chief of Party (INGO).

All three data sources confirmed that situation analysis for problems for MCH policies in Malawi was conducted by reviewing national and international documents during stakeholders meetings. In addition other methods were used to identify MCH problems in Malawi (Table 4.6.3). The finding support Green (2007) who suggested that varied techniques for identifying problems for MCH policies should be employed when developing policies.

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Policy formulation

Chronologically, the first health policy document that included MCH in Malawi was the first NHP in 1965 (MoH, 1965). The first NHP formed a basis on which the subsequent NHPs were formulated and this was strengthened with the international agenda of "health for all through PHC." Parallel to NHPs other MCH policy documents were formulated, for instance RH policy, national RH strategy, IMCI approach policy and the Road-map. These specific MCH policies were formulated to global influence to address specific MCH problems through vertical programmes and funding. Although NHPs remained dominant recurring policies, specific policies complemented or overridden MCH objectives and strategies in NHPs depending on

international community's and donor agencies' policy prescriptions as well as expectations.

Documents reviewed showed that formulation of MCH policies in Malawi was shifting from purely being formulated by external consultants to being formulated by government officials in consultation with a wide range of stakeholders. In addition MCH policies were formulated with technical and financial assistance from donor agencies. Questionnaire responses indicated that MCH policies were formulated by TWGs, international donors, MoH and DHO. Interview responses indicated that MCH policies were formulated by TWGs and other task force with financial and technical assistance from international donors (Table 4.6.3),

> *"Various stakeholders are involved in policy formulation through different TWGs and task force teams. Usually the MoH planning unit facilitates formulating of National health plans for example, backed by external consultants of course international donors are also members of various TWGs. they can be consultants or hire external consultants and they also provide financial assistance for developing policies for example, USAID, WHO, UNICEF and JHPIEGO provide technical and financial support for developing reproductive health policies," (Director 3, MoH National Headquarters).*

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It was evident in all three data that MCH policies were formulated by teams of stakeholders like TWGs with financial and technical assistance from external donor. The finding supports Whitefold and Manderson's (2000) view that most developing countries in Africa rely on financial and technical support in policy development from external donors. Buse et al (2005) also supported study results by arguing that often stakeholders become parts of networks, sometimes described as partners and teams to consult and decide on policy.

Documents reviewed showed that policies were formulated through stakeholder consultation workshops where stakeholders reviewed international and National documents to analyze the situation and set priorities as well as draft a policy in

question at the same time (Table 4.2.3a to 4.2.3e). In addition, stakeholders through a series of consultations further reviewed the draft policy. Depending on the type of policy, once it was finalized, the Director of MoH department under whom the policy in question fell endorsed it. Policies also required approval from parliament depending on content of the policy. Interview responses supported findings from documents and also indicated that process for developing MCH policies involved problem identification and a series of stakeholder consultations and endorsement by Director and Principal Secretary for MoH as well as parliament depending type and content of policy (Table 4.4.2c Cont. 1 and 2). Comments from participants and key informants;

"There are various ways of developing a policy. You can have a consultant as we are doing now for the review of RH policy. Sometimes like for the previous policies we did not have a consultant. It was spearheaded by the RHU. It involved inviting all the stakeholders to say this is the policy let us review it and we develop the policy together. When we invite the consultant it means it is the duty of the consultant to go to various stakeholders to review the documents and when s/he has a draft will have to call all stakeholders together and then everybody will be putting their inputs,"(Senior Official, UNFPA).

"It is a very cumbersome process, to start with we have a one week stakeholder' meeting. It involves the RHU selecting key people from various institutions, in other words all the UN bodies, all the training colleges and service providers. Therefore, these people would meet to review document in question. It is mostly to do with group work and in this meeting that is where you take I do not know how many reference materials not only from Malawi but international especially evidence based documents from WHO and other INGO that take lead in all this, so they review documents for may be a week and develop a zero draft. After that zero draft, a small group of people have to meet to put more meat to that zero draft to make it first draft. And then another stakeholders meeting is held to thoroughly go into details of the document. It is then circulated and a gain a third stakeholders' meeting is held for more input into the document. Other people are also asked for information

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if they were not part of the stakeholders' meeting. Finally the document is sent in bunches to the director of RHU for his comments then it is finalized. We do some editorial work and then it goes to the Principal Secretary for MoH for approval" (Senior Official, JHPIEGO).

"It is not very structured. Of course there is some kind of process stages that you go through. We do some consultations with the districts and so on. You know these are the word nowadays stakeholders involvement, yes we do some consultations. Talking about consultations, it should be mentioned that we are coming from a situation where our system was very centralize when all decisions were made here on behalf of district and Central Hospitals. Even that time when we started opening up for consultations, we still do not see lot of contributions from districts. So in terms of process yes we try to make consultations but it is like things are already decided here with donors of course," (Director 1, MoH National Headquarters).

"What we do is to review documents because we have documents that we have hard in the past i.e. National assessment reports and previous policies and then we have documents and policies from other countries. So we had to put up a task force responsible for developing the policy which was multi-sectoral bringing in various stakeholders and that was backed by consultants some from health, others from human rights, institutional development and what have you. Therefore a multi-disciplinary team of consultants reviewed various documents including HIV/AIDS policies from other countries. We were able to access financial and technical support from UNAIDS. So out of that there were issues that were coming out and we went into stakeholder consultations through regional meetings, district meetings, community dialogues and focus group discussion to pull out the issues and the we had the first draft," (Director 5, MoH National Headquarters).

"It depends on what type of policy, department responsible for that policy does communicate. Once a policy is being formulated a particular department is going to come up with a suggestion to come up with policy basing on identified issues. Then they get people with technical knowhow it is usually

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WHO and other experts to draft then circulate to members of management. In fact it has to be presented formally for people to comment then it is presented to the PS then Cabinet of ministers so that ministers know what is going on. Depending on contents, it may end at cabinet of ministers' level or parliament," (Director 2, MoH National Headquarters)

Data from reviewed documents and interviews confirmed that MCH policies in Malawi were formulated through series of stakeholder consultations. Depending on the type of policy, once it was finalized, the Director of MoH department under whom the policy in question fell endorsed it. Policies also required approval from parliament depending on type and content of the policy. The results were in support of literature on process of policy formulation. For instance, process of MCH policy formulation in Malawi was similar with that of Mozambique, Zambia and South Africa (MMoH, 2001; ZMoH, 2005 and 2004; Shumg-King, 2006). According to Gaidzanwa (2001) Policy-making in Southern African countries shared some common features.

Documents reviewed did not provide information on how decisions about MCH policies were reached at in Malawi (Tables 4.2.3a to 4.2.3e). Questionnaire responses indicated that MCH policies were made through consensus and debate. Interview responses indicated that MCH policies in Malawi were developed through a series of consultations with various stakeholders (Table 4.4.2c Cont. 2 and 3).

"We try to make some consultations with stakeholders through meetings or workshops......," (Director 3, MoH National Headquarters).

Donors develop international policies and work with MoH directors and programme coordinators to develop policies at National level (Senior Official, BLM)

"Decisions about most policies were reached through consensus between the ministry or Government representatives with donor. There are circumstances of course when we just adapt international or regional policies for example the formulation of the roadmap. For the policies which we adapt, what

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happens is that may be the ministry and Government is already a signatory to those policies and in that sense we are just doing our part to make sure that the policies which we are a signatory to are implemented at National level ......," (Senior official, USAID).

Comparing data from questionnaire and interview responses revealed that decisions about MCH policies were arrived at through consultations and consensus between Government officials, other stakeholders and donor agencies (Table 4.6.3). Buse et al (2005) supported this finding. They argued that policy makers often consult various stakeholders to see what they think about issues and obtain information.

Documents did not provide information on how MCH policies were communicated to policy implementers (Tables 4.2.3a to 4.2.3e). Questionnaire responses indicated that MCH policies were communicated through distribution of policy documents, stakeholders' policy dissemination meetings and in-service training programmes (Table 4.3.4e). Interview responses also showed that MCH policies were communicated through stakeholders' policy dissemination meetings, distribution of policy documents, orientation meetings and in-service training (Table 4.4.2c Cont. 3).

"We are usually called for a policy dissemination meetings or workshops. Sometimes the ministry just send documents," (Senior Consultant in Obstetrics and Gynaecology, QECH).

"If the policy is introducing a new programme for example IMCI or essential obstetric care, we conduct orientation meetings and in-service trainings as part of communicating as well as implementing policies," (Senior Official, MSH).

Therefore, results obtained from comparing data from questionnaire and interview responses showed that MCH policies in Malawi were communicated through stakeholders' policy dissemination meetings, distribution of policy documents, orientation meetings and in-service training (Table 4.6.3). The results supported the view of Hardee et al (2004). They stipulated that communication of policies to implementers through various ways is important. However, they argued that communication includes more than disseminating information, it should include

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networking and capacity development as well as stronger links between policy makers and implementers.

Policy implementation

Results from documents reviewed indicated that NHP for 1999 to 2004 (MoH, 1999a) was translated into five-year district strategic plans and annual Implementation Plans (IPs). JPoW (MoH, 2004b) was also only translated into IPs at district and Central Hospitals as well departments at MoH National Headquarters. It was not evident from the documents if the other MCH policies were translated into operational policies at implementation level (Tables 4.2 3a to 4.2.3e). Responses from questionnaires did not provide information on translation of National policies to operational policies. Interview responses showed that NHP 1999 (MoH, 1999a) and JPoW (MoH, 2004b) were translated to annual implementation plans and the other policies were not (Table 4.4.2c Cont. 4).

> *"What I can say for certain is that District Hospitals and Central Hospitals develop annual implementation plans along with the National health plan since the fourth National health plan for 1999-2004. These are a translation of National health plans to operational plans at hospital level," (Director 3, Central Hospital).*

> *"When we developed NHP 1999-2004, district and Central Hospitals were told to develop their own five year strategic plans which were to be translated to budgeted annual implementation plans for implementing the NHP and monitoring progress," (Director 2, MoH National Headquarters).*

Interview responses also indicated that although District and Central Hospitals developed IPs, they were not used for implementation and monitoring instead they were used as budgetary tools for requesting funding form MoH National Headquarters (Table 4.4.2c Cont. 4);

> *"The annual implementation plans were used as a budgeting tool and for requesting funding from the central level," (DHO, District Hospital).*

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"We use implementation plans a lot for coming up with a budget for the District Hospital including health centres," further elaborated the DHO, district 5.

"DIP is only used for asking money from MoH, it is emphasized when parliamentary budgeting is approaching," (DHO, District 7)

"The ministry tell us what we need to do when they have developed a National health plan. Like, during the National health plan for 1999-2004 we were asked to develop district five-year strategic plan and annual implementation plans but they were not used (DHO, District Hospital 11).

"DIPs are meant to be translation of National strategies; they started when we developed our fourth NHP. At that time, the districts were told to do a district plan, it was a five years plan and then after that we started the DIPs which are like annually. Central Hospitals also do develop their CHIP every year," (Director 5, MoH National Headquarters).

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Results from comparing documents and interview responses confirmed that NHP 1999-2004 and JPoW were translated to IPs at District and Central Hospitals (Table 4.6.3 Cont. 1). However the results also revealed that the other National MCH policies were not translated to operational plans at implementation level. Further to that even though NHP and JPoW were translated into implementation plans, the IPs were not used as a tool for implementing MCH policies, instead they were used as a budgeting tool for requesting funding from MoH National Headquarters. Green (2007) did not support this finding. He stipulated that national policies should be translated to operational plans. He further argued that if policies are not translated to operational plans at implementation level, they are more likely not to be implemented.

Monitoring and supervision

Documents showed that monitoring for MCH policies in Malawi was carried out through routine collection and analysis of HMIS data, supervision, monthly reports, quarterly reports and surveys (Tables 4.2.3a to 4.2.3e). Questionnaire responses

indicated that MCH policies were monitored through supervision, HMIS data, annual implementation reviews and midterm evaluations (Table 4.3.4g). Responses from interviews indicated that MCH policies were monitored through supervision, routine HMIS data and quarterly reports (4.4.2c Cont. 5).

Comments from interview responses

> *"Now there are ZHSO who are supposed to supervise DHOs then they report to the office of DCS.....," (Hospital Director, CHAM).*
>
> *Supervision comes through programmes and projects. Programme coordinators at district level when they go round to district and health centres, they also supervise CHAM health facilities," (Director 4, CHAM Hospital).*
> *"DHO is responsible for supervising all health facilities in his/her district," (Director 6, MoH)*
>
> *"Supervision comes through programmes and projects....We have regular visits from MoH they come and see what we do.....and again we send to MoH on quarterly basis as part of HIMS," (Hospital Director, CHAM 1).*

All three data sources showed that supervision for MCH policies was conducted by ZHSO who supervised health facilities in their designated zones (Table 4.6.3 Cont. 1). Although it was evident from documents reviewed that MCH policies did not have indicators for monitoring, findings from interview responses revealed that ZHSO used integrated supervisory checklist for all the services provided at tertiary, district and health centre healthcare facility level (Table 4.4.2c Cont.4). However, questionnaire and interview responses indicated that supervision was inadequate (Tables 4.3.4g; 4.4.2c Cont. 5). For example, the Director 4, National Headquarters said that supervision was scheduled on quarterly basis but on average, the ZHSO supervised District Hospitals in their designated zones three times a year. He attributed the inadequate supervision to a critical shortage of staff.

> *"There is s schedule for supervision on a quarterly basis, we provide supervision at zone level quarterly and zone level provides supervision at district level on quarterly basis. The study that was done showed that in the*

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previous 12 months instead of having four visits, the average was three, we are one short. Our main problem is shortage of staff and that is in the whole country we have a human resource crisis. Both RHU and zonal office and the district supervision team and the whole ministry there is a critical shortage of staff," (Director 4, MoH National Headquarters).

"It is supposed to be quarterly basis but I feel it is a bit delayed but at least on regular basis they do come to see that we are adhering to policies, whether protocols are displayed or data is collected in the right manner," (Director, CHAM hospital 1).

There was consistent evidence from three data sources that MCH policies were monitored through routine HIMS data collection and analysis, supervision, monthly reports, quarterly reports and sentinel surveys (Table 4.6.3 Cont. 1). However, supervision was inadequate and inconsistent (Table 4.6.3 Cont. 5). In support of study results, Cloete and Wissink (2000) pointed out that even though policy makers are aware of the importance, supervision and monitoring is inconsistent, inadequate and not properly planned for.

Policy review and evaluation

Results from documents reviewed showed that MCH policies were reviewed when developing new policies or revising the policies as a basis for situation analysis (Tables 4.2.3a to 4.2.3e). Responses from questionnaires indicated that MCH policies were reviewed to track implementation progress and revising as well as evaluating a policy (Table 4.3.4n). Interview responses indicated that MCH policies were reviewed when developing new policies or revising policies (Table 4.4.2c Cont. 5). On the other hand, results from documents review showed that MCH policies in Malawi were not evaluated. Questionnaire and interview responses confirmed results from reviewed documents (Table 4.3.4m and 4.4.2c Cont. 4) [See Table 4.6.3 Cont. 1).

"I wouldn't directly say which policy has been evaluated, may be what I have noted is that policies have overlapped without actually assessing to say how

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best have we implemented this policy," (Senior Official, CHAM National Headquarters).

"May be they are reviewed at least as far as I know, there has not been any formal evaluation," (Director 1, MoH National Headquarters).

"Usually what I have seen for some policies is we have had review meetings that are the times when we have conducted evaluation of such polices," (Senior Official, BLM).

"To my knowledge I have not seen any policy being evaluated, What happens is that when a policy has expired, then you start a process of developing a new one. the process includes review of the previous policy to assess, (a) where did we do well, (b) where did we do wrong, and (c) what are the new emerging issues that have just come in. So, it is not like you have an evaluation in the way you evaluate programmes but during the process of developing a new policy which is also the process of review, " (Senior Official, UNFPA).

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There was consistent evidence that although documents mentioned how they were to be evaluated, MCH policies in Malawi were not evaluated (able 4.6.3 Cont. 1). However, they were reviewed when developing a new policy or revising a policy. MoH (1999:6) supported the study results; it stated that, "*since independence no comprehensive evaluations of previous NHPs have been done*." Shung-King further supported study results, he elaborated that although evaluation is a critical part of policy process; it is seldom thought through at the outset and not always conducted. On the other hand Fox et al (2006) argued that one of the reasons why policies fail to have desired impact is that they are not adequately monitored, evaluated and controlled. They suggested that first step however is to establish what is to be measured, method of measurement and setting benchmark for measurement.

5.2.4 Stakeholders for MCH policies in Malawi

Documents showed that various stakeholders were involved in policy formulation through teams, for instance TWGs, steering committees and task force teams (Tables

4.2.3a to 4.2.3e). Questionnaire responses indicated that TWG were the stakeholders who developed MCH policies (Table 4.3.5d). Interview responses indicated that stakeholders who were involved in MCH policy formulation were MoH officials, TWGs, donors and health workers (Table 4.4.2d).

> *"All the stakeholders are involved in selecting priorities for MCH policies. You talk of MoH officials, TWG, donors and health workers. Of course not everyone but their representatives depending on the type of policy being developed," (Director 4, MoH National Headquarters)*

Three data sources confirmed that stakeholders were involved in MCH policy formulation through teams and members of those teams included MoH officials, donors and health workers (Table 4.6.4). The finding was supported by Green's view (2007). He suggested that involvement of stakeholders is important for two reasons: to ensure inclusion of their views and as a preliminary step in garnering their support for the eventual policy. Buse et al (2005) further agreed with the results, they stipulated that stakeholders often become parts of networks and groups to consult and decide on policies.

Documents also showed that MoH and donors had more influence on MCH policies in Malawi (Table 4.2.4b). MoH had high level of influence on MCH policies in Malawi because it had the legal mandate to provide health services, infrastructure, equipment and human resource. Whilst donors had high level of influence on MCH policies because they had financial resources, access to new information and technical expertise. As such almost all the MCH policies in Malawi were formulated with both financial and technical assistance from international donors (Tables 4.2.3a to 4.2.3e). On the other hand, beneficiaries had very low level of influence because they were recipients and had no access to resources or expertise. Interview responses confirmed results from documents review. They indicated that donors had financial resources, expertise and access to information for policy development and implementation (Table 4.4.2d Cont. 1). In addition, interview responses indicated that beneficiaries had no influence in policy development and implementation.

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"We provide support for the area of maternal and neonatal health financial, medical supplies, training, we develop policy documents and technical expertise as well," (Senior Official, JHPIEGO).

"This is an INGO that is responsible for RH, population and development and gender. We don' provide any service, we are in the country to support the Government f Malawi. Whatever we do we support whatever has been planned by the Government. In terms of RH we work with RHU and on the side of NGOs, we work with BLM and FPAM. We provide both financial and technical support," (Senior Official, UNFPA).

"We provide programme foreign assistance which is both financial and technical assistance for maternal health issues," (Senior Official, USAID).

Documents reviewed and interview responses provided consistent information that MoH and donors had more influence on MCH policies in Malawi, whilst beneficiaries had very low influence (Table 4.6.4). In support of study results, DFID (2008) stated that in many resource-poor countries, donors have more influence on health policies because they have financial and technical capacity as well as access to information.

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5.3 Lessons and gaps in MCH policy development in Malawi

5.3.1 Lessons

Results from documents reviewed showed that lessons for MCH policies in Malawi were not being documented in the policies. Only Vision 2020 had one lesson evident in the document; the potential overall impact for EHP is beyond the scope of any single sector and will require inter-sectoral collaboration at many levels. Whilst in all the remaining reviewed documents for the study, lessons were not evident in the documents (Table 4.2.5). On comparison of data from questionnaires and interviews the following were lessons in MCH policy development and analysis (Table 4.6.5a);

The first lesson was that policy makers should involve beneficiaries and implementers in MCH policy development.

"Grassroots need to be involved as they are actors in implementing policies and the ones who accept policies," (MA, health centre in Rumphi district).

"Community involvement is very important if policies are to serve communities," (ENM, health centre in Mzimba District).

"Involve people who will implement policies to put in their views because they are the ones who meet challenges at implementation stage," (Ward in-charge, paediatric ward at Central Hospital 2).

"They need to involve implementers more because they are they are the ones who implement and know exactly what needs to be done because policy makers do not know what is happening on the ground," (Senior Official, MMC).

The second lesson was that MCH policies should be results oriented, evidence based.

"Policies should be based on accurate data/information and focus on specified results," (HNO, District Hospital 3).

Policy makers have to learn to know if targets set are met or not before developing another policy," (Ward in-charge, maternity ward for Central Hospital 3).

"Policies which are not evidence based, not results oriented and without targets. Without targets we cannot measure achievement and they take us nowhere in terms of improving MCH," (Senior Official, UNICEF).," .

The third lesson was that adoption of international policies should consider the context.

"Do not just adopt policies because we are being pushed but look at the problems in the country," (Senior Official, CHAM National Headquarters).

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The fourth lesson was that if monitoring and evaluation were not planned and budgeted for in policy documents, such activities are not carried out.

> *"Monitoring and evaluation basing on routine data of HMIS is not enough. Evaluating implementation processes and evaluation of outcomes is important but they need to be clearly budgeted and planned for without which they will never be robust or done consistently,"(Senior Official, UNICEF).*

The fifth lesson was that MCH policies should also focus on strengthening health system for objectives of MCH to be achieved.

> *"With weak health system, every plan should include system strengthening for MCH programmes to be sustained," (Senior Official, MSH).*
> *"We know what needs to be done, let's get the basics in place, we have not gotten the systems right in most health facilities, we need to concentrate on strengthening health system basing on single coherent policy starting form development of policies. Each policy should also focus on health system strengthening for example training health workers, building or renovating health facilities, complementing Governments efforts in supplying drugs and medical equipment……," (Director, CHAM hospital 4).*

The sixth lesson was that policy development required inter-sectoral coordination.

> *"MCH is beyond health sector i.e., there is need to improve literacy, food security and deal with cultural believes, therefore there is a greater need for inter-sectoral coordination," (Senior Official, NMCM)*

The seventh lesson was that human resource crisis required concerted effort from the policy development level.

> *"Policies on their own are insufficient; they need to be accompanied by the required resources. Whatever policies they going to develop without personnel everything is going to fail," (NMCM)*

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".......We have a critical human resource shortage in hospitals and health centres and the nation at large. Government alone cannot solve this huge problem, we therefore need concerted effort from donor community, NGOs and the private sector to train health personnel....," (Director 6, MoH National Headquarters)

5.3.2 Gaps

Each data source provided different information on gaps in MCH policy development (Table 4.6.5b). The following were gaps identified from the documents reviewed;

- No skilled personnel at National level to plan and develop policies
- Uncoordinated planning and priority setting with interventions being planned and implemented independent of each other resulting in duplication and overburdening of district level implementation
- No clear institutional framework for policy formulation and implementation
- Planning unit is supposed to be the policy clearing house on MoH, but the practice has been characterized by uncoordinated policy formulation initiatives often at the influence of donors
- Weak inter-sectoral collaboration in policy development
- Weak managerial structures and systems i.e. most departments and hospitals operated without goals and objectives
- Poor health information management system i.e. current information systems have failed to timely produce the required information for managerial decision- making.

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Gaps indicated from questionnaire responses were that policy implementers and beneficiaries were not involved in MCH policy development and that policies were not communicated to the grassroots. In addition, there was no interaction between policy makers and implementers.

Interview responses highlighted the following gaps in MCH policy development in Malawi; Firstly, private providers were not involved in MCH policy development in Malawi neither were policies communicated to private practitioners. Stakeholders and participants maintained that DHOs represented private practitioners in addition to

representing public and CHAM health facilities from their designated districts at national policy development forums. However when they get back they never communicate policies to the people they represent. Some of their comments to support views expressed were,

> *"The MoH does not seem to invite people from the private sector to give any contribution not at all," (Private Practitioner, Lilongwe district).*

> *"We have access to the documents only via third or fourth parties when we do hear that there is a document from ministry on HIV/AIDS or maternal and child health. You have to make it your own initiative to go and get the document," (Private practitioner, Blantyre district).*

Secondly, there was no direct interaction between policy makers and implementers. DHOs were supposed to collate and report on situations that exist in all health facilities of their respective district to policy makers and give feedback on decisions made to staff in those health facilities. Subsequently, this created a communication breakdown between policy makers and implementers within public and private health facilities,

> *"DHMTs and the supervisors do not communicate to the lower level that is where the problem is," (ZHSO, Central West Zone).*

> *"I see nothing on communication from policy developers to us the technical people on the ground to see how the situation is, to see how we think the situation can be improved,"(Senior Consultant of Obstetrics and Gynaecology, KCH).*

Information obtained from the three data sources on gaps in MCH policy development was not consistent. Despite the inconsistencies, each data source showed that a number of gaps in MCH policy development existed; each data sources identified different information on gaps (Table 4.6.5b).

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5.4 Lessons and gaps in MCH policy implementation in Malawi

5.4.1 Lessons

There was no information evident from documents reviewed on lessons learnt in MCH policy implementation. Questionnaire and interview responses indicated lessons that policy makers and implementers should learn from MCH policies (Table 4.6.6a)). The first lesson was that policies without resources will never be implemented and achieve intended results.

> *"Implementation of policies requires resources," (DHO, District Hospital 1).*

> *"For policies to be implemented, they need proper communication to grassroots and also timely resources for effective implementation," (DNO, District Hospital 7).*

> *"There can be a good policy on paper but without the availability of personnel, medical supplies, equipment as support structures, implementation cannot be as good with poor outcome," (HNO, District Hospital 3).*

> *"For policies to be successfully implemented, necessary equipment and supplies are needed," (NMT, health centre in District 7)*

> *"Effective implementation requires adequate resources where, when and how they are required," (Senior Consultant in paediatrics, Central Hospital 1)*

> *"Without human resources whatever policy is going to be put in place, it is going to fail," (Director, CHAM hospital 3).*

The second lesson is that cultural beliefs and practices play a great role in policy implementation.

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"Cultural beliefs categorise conditions that require modern treatment and those that need traditional treatment, so patients do not change despite health education or health talks. They end up coming very late to the hospital when they have developed complications more especially when a child is sick and during pregnancy. Sometimes they do not follow our advice," (Medical Assistant, Health centre in Mulanje district).

The third lesson is that for MCH policies to be implemented there is need for proper and timely communication to implementers.

> *"Mostly there is slow or delay in passing information down to health centres," (NMT, Health centre in Machinga district).*

> *"Policies are not disseminated in time to most of the implementers at grass root level and follow up supervision takes time or is never done," (NMT, health centre in Rumphi district).*

> *"Policies when they are sent to districts they just stay in office without being disseminated to health centres," (Medical Assistant, health centre in Ntcheu District).*

The fourth lesson is that the ability to communicate MCH policies to implementers should form integral part of performance review of DHOs and Central Hospital directors.

> *"Planning in advance and prioritizing medical supplies should be part of performance issues in health facility management (Senior Official, CMS).*

The fifth lesson identified is that multiple responsibilities of the Health Ministry tend to organisation to appear to be inefficient,

> *"Multiple responsibilities of MoH as policy maker, service provider, health services financer and stewardship make it not effectively manage and control implementation," (Senior Official, CHAM National Headquarters).*

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Sixth lesson is that all hospitals in the country ought to develop their individual strategic plans based on health needs of their communities,

"Implementation basing on annual implementation plan is not sufficient because Central Hospitals cannot be able to plan for the future, there is need for strategic plans for Central and District Hospitals," (Director, Central Hospital 3).

Seventh lesson is that if existing human resources are not retained the problem of shortage of qualified health professionals will never be resolved.

"More health professional can be trained but there are no retention strategies in place, the problem will remain forever," (Senior Official, MMC).

The eighth lesson is that broad MCH policy statements are difficult to implement**,**

"Policy statements are too broad sometimes, if they do not come with specified strategy of implementation it does not materialize," (Senior Official, CHAM National Headquarters).

The ninth lesson is that MCH objectives without clearly specified targets are difficult to measure,

"Most policies have broad objectives with no targets, how can one measure then or know that objectives are achieved?" (Senior Official, UNICEF).

The tenth lesson is that approved MCH policies need to be implemented**,**

"Policies are there but are not being disseminated therefore not being implemented, we are saying implement the policies," (Senior Official, MMC).

"We should not stop at developing policies we should implement," (Senior Official, MSH).

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The eleventh lesson is that development and implementation of MCH policies ought to be evidence-based,

> *"Policies need a lot of evidence based information throughout its process from development, implementation and evaluation," (Senior Official, USAID).*

The twelfth lesson was that evaluation ought to be part of the policy process.

> *"Most policies are not evaluated as such exact achievements and failures of previous policies are missed, it will be helpful if evaluation is considered as part of planning circle," (Director 6, MoH National Headquarters).*

The thirteenth lesson was that monitoring should include linking of supervision with performance management.

> *"Monitoring needs to go beyond HIMS routine data and supervising health facilities and staff, achievement of policy objectives should be linked with performance management," (Senior Official, SAVE the children US).*

The three data sources showed that there were a number of lessons that policy makers needed to learn from implementation of the previous MCH policies in Malawi (Table 4.6.6a).

5.4.2 Gaps

Information on constraints and in implementing MCH policies was regarded as gaps in MCH policy implementation during data analysis process. All three data sources confirmed that there were a number of constraints for implementing MCH policies encountered in public health facilities in comparison to constraints encountered at NGO and private facilities (Table 4.6.6b). The following were constraints encountered at public facilities with the implementation of MCH policies;

- high population growth, illiteracy and poverty
- high disease burden and emerging new diseases
- harmful social and cultural beliefs and practices

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- poor health information management system
- weak monitoring, supervision and evaluation
- inconsistent supply and inadequate resources (financial, infrastructure, human resource capacity and skills, drugs medical supplies)
- poor referral system (telecommunication, vehicles for referring patients and poor road network)
- weak managerial, regulatory and weak inter-sectoral collaboration systems
- lack of community involvement and empowerment
- inadequate and inconsistent supervision
- cultural beliefs and lack of knowledge among communities on issues relating to MCH
- gender imbalance in decision making on health issues at community level

Some of the above listed documented constraints were supported in questionnaire and interview responses,

> *"There is a critical shortage of drugs, medical supplies and equipment. Most of the times we improvise where we can and sometimes we do not provide the required patient care simply because there are no items to be used. For example if we have run out of "Neverapine" for PMTCT mothers transmit HIV to the newborn babies. It is pathetic to talk about this but it is real, that is what is happening on the ground," (DHO, District Hospital 9).*

> *"Inadequate resources, both human and materials, there is one nurse and one MA at health centre," (MA, Health centre in Rumphi District Hospital).*

> *Inaccessibility of health centres by communities and staff due to long distances and bad roads," (NMT, health centre in Machinga District Hospital).*

> *"Cultural believes categorize conditions for hospital and traditional treatment," (MA, health centre, Ntcheu District Hospital).*

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"There is lack of supervision from top official," (ENM, health centre, Thyolo District Hospital).

"High illiteracy levels, traditional beliefs and traditional practices in relation to pregnancy, birth and child care among communities," (Paediatric Ward in-charge, District Hospital 3).

Major constraints are inadequate human resources and financial, major equipment, we fail to implement certain policies effectively because equipment is not there, not working properly or we need to procure (Director, Central Hospital 1)

There was no documented evidence of constraints in implementing MCH policies encountered by NGO and private health facilities in Malawi. Questionnaire responses also did not provide information on constraints encountered in NGO and private. However, responses from interviews confirmed that shortage of human resource was the main constraint encountered by private health facilities. In addition, interview responses revealed that NGOs implementing MCH policies faced specific challenges such as shortage of human resource due to high turnover, high poverty level, high illiteracy rate, no resources for Government to sustain programmes initiated by NGOs; and abuse of resources in Government (Table 4.6.6b Cont. 1).

"Major constraints are inadequate human resources and financial, major equipment, we fail to implement certain policies effectively because equipment is not there, not working properly or we need to procure," (Director, Central Hospital 1).

"Human resource issue or capacity issues in general affects across the board be it in the public sector, private sector, civil society......... Malawi has a human resource capacity constraint," (Private Practitioner, Blantyre District)

"We are experiencing high turnover of health professional, people come here and disappear within a year. You pump in a lot of resources, you train the

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person and then the next thing you see is a resignation letter," (Senior Official, FPAM).

"Human resource crisis leading to workload, financial resources are not enough. Low literacy levels-difficult to convince use of health services…. Even if communities are mobilized they don't find drugs, staff, and services so we are afraid to create demand. Ownership of programmes, donor dependence and sustainability plans in place. Although NGOs are trying to provide resources, where Government is a sole implementer resources are abused they don't go to grassroots," (Senior Official, WHO).

In support of the various constraints identified in this study, Fox et al (2006) stipulated that implementing any policy faces a range of constraints resulting in either non implementation or poor/delayed implementation. Green (2007) summarized the constraints as none or poor planning for implementation, inadequate resources, lack of appropriate systems and lack of managerial and technical skills

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Chapter 6

SUMMARY AND CONCLUSIONS

6.1 Introduction

The chapter presents summaries of major findings and conclusions organised to address aims and objectives of the study. The chapter then reflects on whether the study had met its stated objectives in relation to the conceptual framework.

6.2 First Aim: to analyze MCH policies in Malawi from 1964 to 2008

The first aim of the study was achieved by analyzing MCH policies in Malawi over a forty-four year period. Under this aim, the objectives were to review content of MCH policies in Malawi; analyze context of MCH policies in Malawi; analyze MCH policy process in Malawi; and identify and analyze the influence of key MCH policy stakeholders in Malawi. The first aim and objectives are illustrated in the horizontal segment of the conceptual framework as illustrated in figure below (Figure 6.2a).

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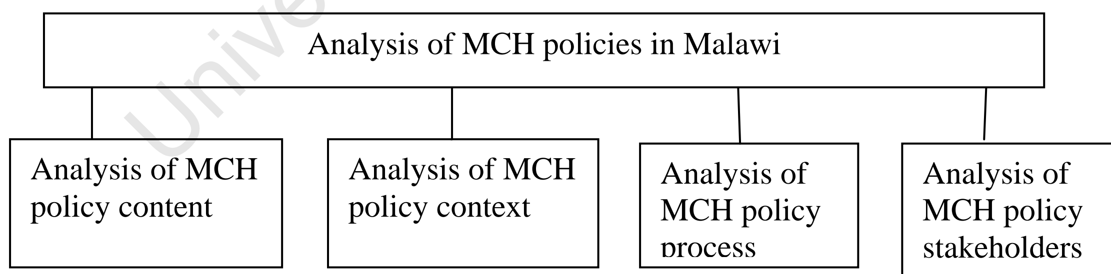
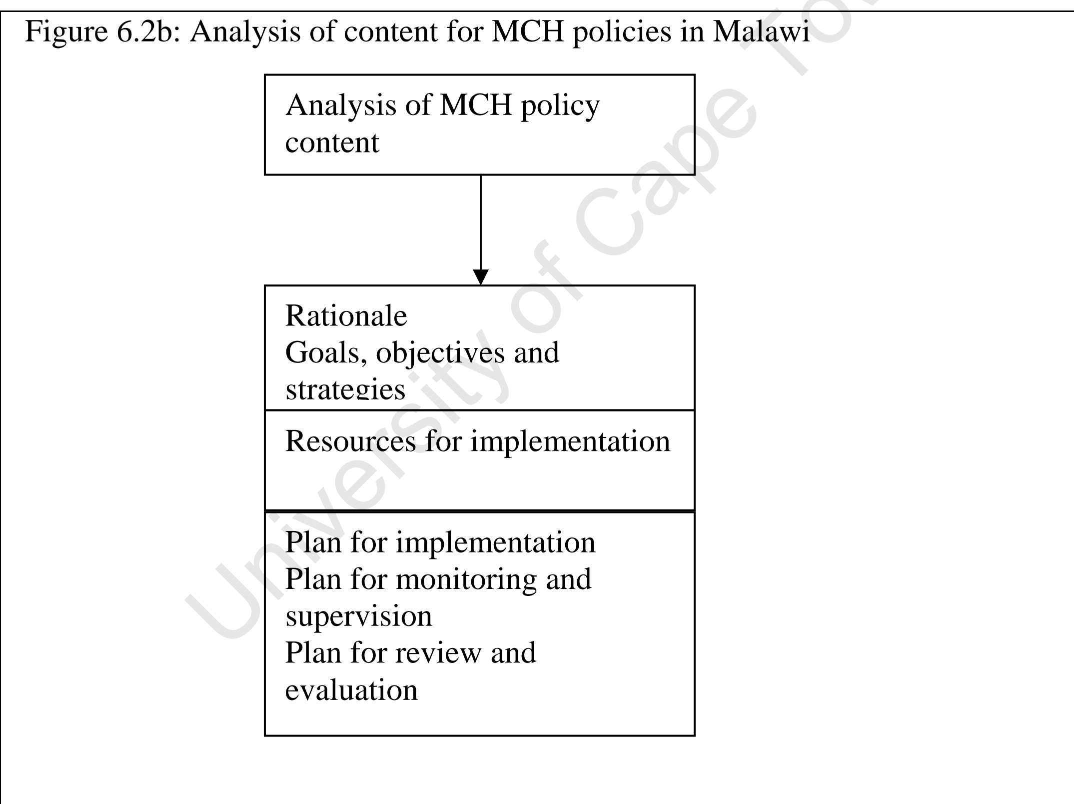
Figure 6.2a



6.2.1 Objective one: to analyze content of MCH policies in Malawi

Objective one was achieved through reviewing content of MCH policies in Malawi. According to the conceptual framework, the study reviewed policy documents to assess if they contained rationale, goals, objectives and strategies. The study also reviewed policy documents to analyze resources for implementation, plan for implementation, plan for monitoring and supervision, and plan for review and evaluation (see Figure 6.2b below). In addition, information about content of MCH policies in Malawi was also obtained through self-administered questionnaires and interviews (subsection 4.2.1; tables 4.2.1a to 4.2.1e; subsections 4.3.2, 4.4.2 and 5.2.1).

Figure 6.2b: Analysis of content for MCH policies in Malawi



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Conclusions were drawn from results and discussion in subsection 4.2.1 and 5.2.1 respectively. The three data sources revealed that it was not standardized for MCH policies in Malawi to have rationales outlined but instead, stakeholders formulating a particular policy may document purpose, overall objective, justification, vision and or mission for the policy (subsection 4.6.1 and Table 4.6.1). This finding was in conflict with Hardee et al (2004) suggestion that written policy documents should include

rationale and justification. In addition, there were consistencies in each of the three data sources that goals, objectives and strategies for MCH policies in Malawi were broad and not results oriented as well as evidence based (Table 4.6.1). According to Hardee et al (2004), Fox et al, (2006), Green (2007), goals, objectives and strategies for health policies should be specific and results oriented as well as evidence based. Furthermore, evidence from three data sources was consistence that priorities for MCH policies in Malawi were influenced or based on priorities for international policies (subsection 4.6.1 and Table 4.6.1). Akukwe (2006), argued that most priorities for MCH in Africa reflect widely held priorities on plight of women and children worldwide because of the extensive external donor support. He however proposed that National policies should reflect National priorities (Akukwe, 2006).

Study results also showed that allocation of resources for the reviewed documents were outlined in some documents and not outlined in other documents. Nevertheless, consistent evidence showed that only estimated financial resources were outlined in some MCH policies and that resources for MCH policies were inadequate (Table 4.6.1). Yet according to Hardee et al (2004), resources refer to the financial, physical and human resources that are needed to implement policies. Fox et al (2006) argued that a budget should contain more than financial details. They suggested that a budget should cover all of the resources (human, physical and technological) needed to plan, implement and control a policy. Fox et al (2006) further suggested that policy development should be completed by adequate required resources to ensure implementation to achieve set goals and objectives. In addition, there was general agreement in the three data source that both the Government and external donors provided funding for MCH programmes in Malawi (Table 4.7.1a). Despite this evidence, it was clear that external donors provided large proportion of financial resources for MCH in Malawi (table 4.6.1). The findings supported Akukwe's (2007), view that healthcare delivery systems of many African countries depend heavily on external financial support. He proposed that, external donor partners should provide long-term support and when external donor support is finished, National Government should have deployed alternative funding mechanisms.

Even though some MCH policies in Malawi outlined implementation structure, all the three data sources confirmed that MCH policies in Malawi did not have

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implementation plans (Table 4.6.1). The finding was not in support of Green (2007) view that policies should have plans for implementations. In addition, there was consistent evidence in all the three data sources that National MCH policies were not translated into operational plans at implementation level (Table 4.6.1). Only the NHP 1999-2004 and JPoW were translated into implementation plans at district and Central Hospital level. However, the implementation plans were utilized as tools for requesting funding for the health sector. Green (2007) argued that one of the reasons for failure to implement national policies is that national level policies are usually not translated into operational policies and implementation plans at implementation level. He suggested that national health policies should be translated to operational plans at implementation level for them to be appropriately implemented.

Furthermore, all the three data sources provided consistent information that MCH policies in Malawi did not have plans for monitoring and supervision. Nevertheless, all three data sources indicated how MCH policies were to be monitored and supervised (Table 4.6.1). Fox et al (2006) did not support the finding. They argued that the first step in monitoring and supervision must establish what is to be monitored, by whom, when and how. They therefore suggested that policies should have detailed plans and resources for monitoring and supervision as well as evaluation.

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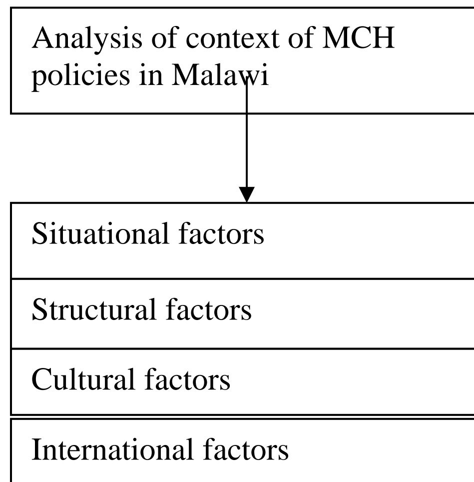
6.2.2 Objective 2: to analyze context of MCH policies in Malawi

Objective one was achieved through analyzing factors affecting MCH in Malawi. Even though the policy context was categorized into situational, structural cultural and international factors, the information obtained from all the three data sources was on factors affecting MCH in general (Subsections 4.2.2, 4.3.3, 4.4.2 and 5.2.2). The researcher arranged the factors according to the categories of the context as presented in the conceptual framework for the study (see figure 6.2c.below). Therefore, although all the information was obtained, it was the researcher's responsibility to categorize the data.

Figure 6.2c: Categories of the context for MCH policies



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Results on context of MCH policies in Malawi were presented and discussed as situational, structural, cultural and international factors affecting MCH in Malawi (subsection 4.2.2 and 5.2.2). Political transformation, droughts and HIV/AIDS were identified as situational factors affecting MCH policies in Malawi. in addition, the results revealed that political transformation from colonial Government to independence left the Government dependent to external financial and technical support for policy development as well as implementation (Table 4.6.2). In support of study results, UNDP (2005) elaborated that, political transformation from one party Government to democratic multiparty system was associated with corruption and mismanagement of Government resources. In addition droughts in Malawi affected the country's economic growth negatively and deepen people's poverty as well as food insecurity (UNDP, 2005). According to WHO (2005b), HIV/AIDS affected MCH by increasing the disease burden and therefore further stretching the inadequate resources for healthcare.

Results also showed that structural factors that influenced MCH policies in Malawi from 1964-2008 included high population growth rate, high fertility rate, predominantly agro-based economy and high inflation rate. In addition, inadequate human resource in the health sector, inadequate Government financial allocation to

the health sector as well as inadequate infrastructure were also identified as structural factors that influenced MCH policies in Malawi. Further to that, the other factors were low employment base, increasing levels of poverty, food insecurity, illiteracy and gender imbalance as well as high disease burden. The study found out that structural factors were the same factors identified as constraints for implementing MCH policies in Malawi (Table 4.6.2). this implies that structural factors posed as constraints for implementing MCH policies in Malawi.

Cultural factors like beliefs and practices also influence MCH policies in Malawi. All three data sources confirmed that cultural factors affected utilization of healthcare services in Malawi (Table 4.6.2). The finding agreed with Khama et al (2006), views that harmful traditional practices and religious beliefs adversely affected health of women and children. All the three data sources also confirmed that MCH policies in Malawi were influenced by international factors like international and regional agreements as well as health trends (Table 4.6.2). Mwabu, Wang'ombe, Okello and Munishi (2004), supported this finding in arguing that health policies in many African countries were influenced by international factors to a greater extent because the countries are dependent on external financial and technical support.

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6.2.3 Objective 3: to analyze the process of MCH policies in Malawi

Objective three was achieved by analyzing the stages and steps involved from policy formulation to implementation and evaluation. According to the conceptual framework the process included initiation and problem identification, policy formulation, policy implementation, monitoring and supervision, and review and evaluation (Figure 6.2d). Information on process of MCH policies in Malawi was obtained from all the three data sources (Subsection 4.6.3).

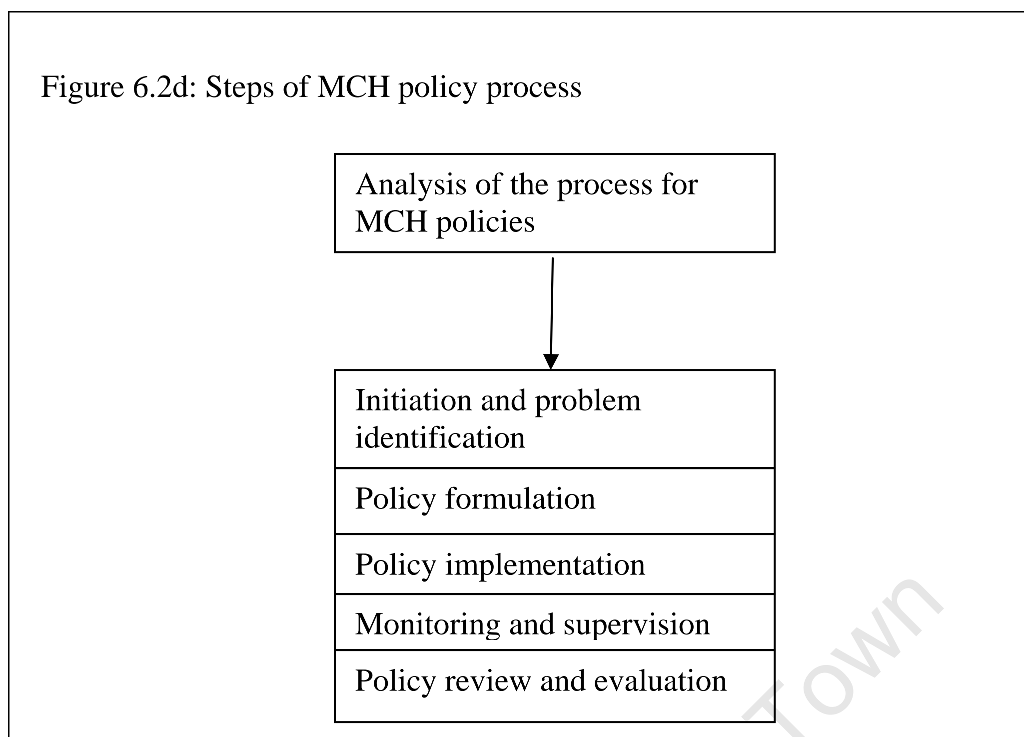

Figure 6.2d: Steps of MCH policy process

Drawing conclusions from study results and discussion in subsection 4.2.3 and 5.2.3 respectively, initiation for MCH policies was largely influenced by international factors. All three data sources confirmed that initiation for MCH policies was largely influenced by international factors (4.6.3). Shiffman (2007) view supported the finding, he argued that international actors such as aid agencies and multilateral organizations first put maternal mortality reduction on the global agenda in order to promote and generate interest of National health officials. In addition, all three data sources confirmed that situation analysis for problems for MCH policies in Malawi was conducted by reviewing national and international documents during stakeholders meetings. In addition other methods were used to identify MCH problems in Malawi (Table 4.6.3). The finding support Green (2007) suggestions that varied techniques for identifying problems for MCH policies should be employed when developing policies.

Data from reviewed documents and interviews confirmed that MCH policies in Malawi were formulated through series of stakeholder consultations. Depending on the type of policy, once it was finalized, the Director of MoH department under whom the policy in question fell endorsed it. Policies also required approval from parliament depending on type and content of the policy. The results were in support of

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literature on process of policy formulation. For instance, process of MCH policy formulation in Malawi was similar with that of Mozambique, Zambia and South Africa (MMoH, 2001; ZMoH, 2005 and 2004; Shumg-King, 2006). According to Gaidzanwa (2001) Policy-making in Southern African countries shared some common features.

Results obtained from comparing data from questionnaire and interview responses revealed that decisions about MCH policies were arrived at through consultations and consensus between Government officials, other stakeholders and donor agencies (Table 4.6.3). Buse et al (2005) supported this finding. They argued that policy makers often consult external groups to see what they think about issues and obtain information. On the other hand, three data sources confirmed that stakeholders were involved in MCH policy formulation through teams and members of those teams included MoH officials, donors and health workers (Table 4.6.3). The finding was supported by Green's view (2007). He suggested that involvement of stakeholders is important for two reasons: to ensure inclusion of their views and as a preliminary step in garnering their support for the eventual policy.

Data from questionnaire and interview responses confirmed that MCH policies in Malawi were communicated through stakeholders' policy dissemination meetings, distribution of policy documents, orientation meetings and in-service training (Table 4.6.3). The results supported the view of Hardee et al (2004). They stipulated that communication of policies to implementers through various ways is important. However, they argued that communication includes more than disseminating information, it should include networking and capacity development as well as stronger link between policy makers and implementers.

Results from comparing documents and interview responses confirmed that NHP 1999-2004 and JPoW were translated to IPs at District and Central Hospitals (Table 4.6.3 Cont. 1). However the results revealed that the other National MCH policies were not translated to operational plans at implementation level. Further to that even though NHP and JPoW were translated into implementation plans, the IPs were not used as a tool for implementing MCH policies, instead they were used as a budgeting tool for requesting funding from MoH National Headquarters. Green (2007)

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supported this finding; he stipulated that if policies are not translated to operational plans at implementation level, they are more likely not to be implemented.

There was consistent evidence from three data sources that MCH policies were monitored through routine HIMS data collection and analysis, supervision, monthly reports, quarterly reports and sentinel surveys (Table 4.6.3 Cont. 1). Supervision of health facilities was conducted by ZHSO who were supposed to supervise health facilities on quarterly basis. However, supervision was inadequate and inconsistent (Table 4.6.3 Cont. 1). In support of study results, Cloete and Wissink (2000) pointed out that even though policy makers are aware of the importance, supervision and monitoring is inconsistent, inadequate and not properly planned for.

It was evident from the three data sources that although documents mentioned how they were to be evaluated, MCH policies in Malawi were not evaluated. However, they were reviewed when developing a new policy or revising a policy (Table 4.6.3 Cont. 1). MoH (1999:6) supported the study results; it stated that, "*since independence no comprehensive evaluations of previous NHPs have been done*." In Shung-King further supported study results, he elaborated that evaluation is a critical part of policy process, but is seldom thought through at the outset and not always conducted. On the other hand Fox et al (2006) argued that one of the reasons why policies fail to have desired impact is that they are not adequately monitored, evaluated and controlled. They suggested that the first step however is to establish what is to be measured method of measurement and setting benchmark for measurement.

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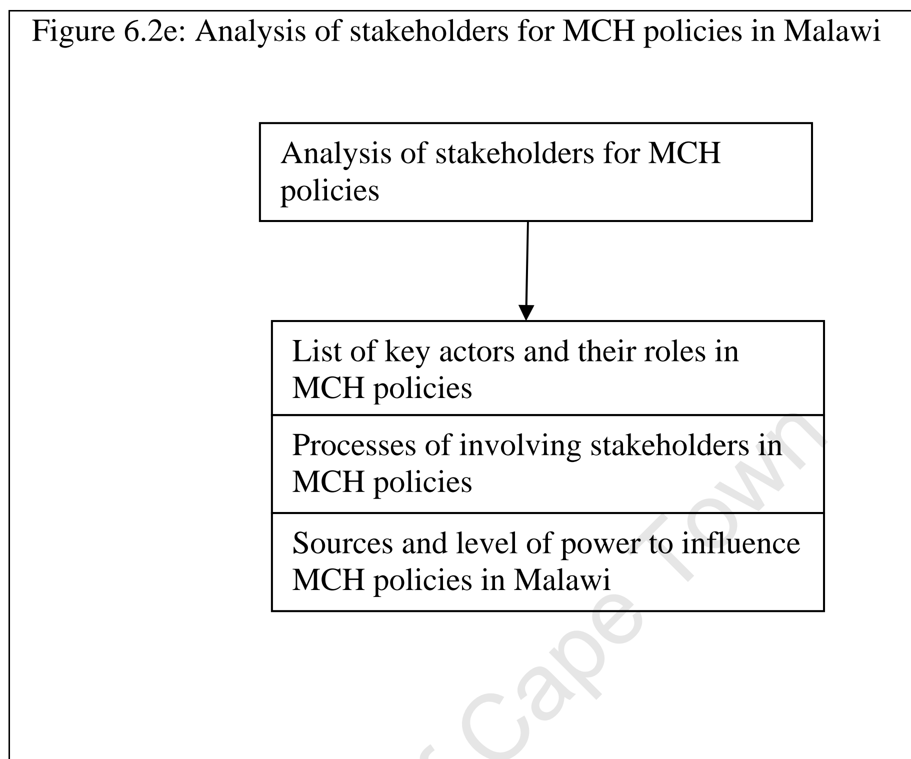
6.2.4 Objective 4: to identify and analyze stakeholders for MCH policies

The fourth objective was to identify and analyze stakeholders for MCH policies in Malawi. In relation to the conceptual framework, the objective was achieved by identifying and listing key actors and their roles in MCH policies. In addition, the objective was achieved by examining processes of involving stakeholders in MCH policies as well as sources and level of power to influence MCH policies as illustrated in figure 6.2e. All the three data sources provided information on the stakeholders for

MCH policies in Malawi (subsection 4.2.4, tables 4.2.4a to 4.2.4, subsection 4.3.5 and 4.4.2d).

Figure 6.2e: Analysis of stakeholders for MCH policies in Malawi



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In summary, three data sources confirmed that stakeholders were involved in MCH policy formulation through teams and members of those teams included MoH officials, donors and health workers (Table 4.6.4). The finding was supported by Green's view (2007). He suggested that involvement of stakeholders is important for two reasons: to ensure inclusion of their views and as a preliminary step in garnering their support for the eventual policy. Buse et al (2005) further agreed with the results, they stipulated that stakeholders often become parts of networks and groups to consult and decide on policies.

Documents reviewed and interview responses provided consistent information that MoH and donors had more influence on MCH policies in Malawi, whilst beneficiaries had very low influence (Table 4.6.4). In support of study results, DFID (2008), stated that in may resource-poor countries, donors have more influence on health policies because they have financial and technical capacity as well as access to information.

6.3 Second Aim: to explore lessons and gaps in MCH policy development

The second aim of the study was to explore lessons and gaps on MCH policy development. This aim was achieved through exploring experiences of MCH stakeholders in policy development; processes for involving stakeholders and target groups in MCH policy development in Malawi; and examining interaction processes between policy makers and implementers. Information on lessons for MCH policy development was mostly obtained from questionnaires and interviews because no information on lessons for MCH policy development was evident in the reviewed documents except in one document. Information on gaps in MCH policy development was obtained from all the three data sources. Information on lessons and gaps in MCH policy development was a consolidation of study results from policy content, context, process and stakeholders (see Figure 6.5).

Summarising study results and discussion from experiences of MCH stakeholders in policy development, processes for involving stakeholders and target groups in MCH policy development, and interaction processes between policy makers and implementers, the study identified lessons and gaps in MCH policy development in Malawi. The three data sources confirmed that that are various lessons to be drawn from previous MCH policy development (Table 4.6.5a). Some of those lessons included; MCH policies require inter sectoral collaboration, policy development should involve implementers and beneficiaries, and development should be results oriented as well as evidence based. Other lessons included that; development of MCH policies need to consider contextual factors when adopting international policies, health system strengthening and plan for evaluation to be in built in the policy documents.

Further to that evidence from three data sources on gaps in MCH policy development was not consistent; each data sources identified different information. However, the three data sources showed that a number of gaps in MCH policy development do exist (Table 4.6.5b). Several gaps were identified from documents reviewed for example, no skilled personnel at National level to plan and develop policies, no clear institutional framework for policy formulation and implementation and weak inter-

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sectoral collaboration in policy development. Gaps indicated from questionnaire responses were that policy implementers and beneficiaries were not involved in MCH policy development and that policies were not communicated to the grassroots. In addition, there was no interaction between policy makers and implementers. Interview responses highlighted a couple of gaps in MCH policy development in Malawi; Firstly, private providers were not involved in MCH policy development in Malawi neither were policies communicated to private practitioners. Secondly, there was no direct interaction between policy makers and implementers which created a communication breakdown between policy makers and implementers within public and private health facilities.

6.4 Third Aim: to explore lessons and gaps in MCH policy implementation

The third aim of the study was to explore lessons and gaps in MCH policy implementation. The aim was achieved through exploring experiences of stakeholders in implementing MCH policies in Malawi. In addition, the aim was achieved through investigating types of constraints and problems encountered at Government health facilities, private and NGOs in implementing MCH programmes in Malawi. Further to that the study examined the relationship between Government resources, policies, and actual MCH implementation in Malawi. Information of lessons and gaps in MCH policy implementation was a consolidation of information from policy content, context, process and stakeholders (see figure 6.5).

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The three data sources showed that a number of lessons need to be learnt from implementation of the previous MCH policies (Table 4.6.6a). Some of those lessons included that development of MCH policies should be followed by making resources required for their implementation available cultural beliefs and practices played a great role in policy implementation and that planning and prioritizing medical supplies should be part of performance DHOs for DHOs. Other lessons from MCH policy development were that multiple responsibilities made MoH inefficient, hospitals needed to develop strategic plans and successful policy implementation required adequate resources. Further to that lessons for MCH policy implementation

were that if the available human resources were not retained the problem of HR would remain forever, broad policy statements were difficult to implement and that objectives without targets could not be measured. Lastly lessons for MCH policy implemented also included that formulated policies needed to be implemented, policy development and implementation ought to be evidence-based as well as results oriented and monitoring ought to link supervision with performance review.

Information on constraints in MCH policy implementation from all three data sources was regarded as gaps for MCH policy implementation. Consistent evidence showed that there were more constraints encountered by public health facilities than constraints encountered by private and NGO health facilities (Table 4.6.6b and 4.6.6b Cont. 1). Shortage of human resource was a constraint in implementing MCH policies in Malawi across all providers of health services. In addition shortage of human resources was the only constraint encountered by private health facilities. Constraints encountered at public health facilities included inadequate resources that are human, infrastructure, medical supplies, medical equipment and financial resources. In addition, the constraints encountered in MCH policy implementation were similar to the results identified under the context of MCH policies in Malawi. In support of study results, Fox et al (2006) stipulated that implementing any policy faces a range of constraints resulting in either non implementation or poor/delayed implementation.

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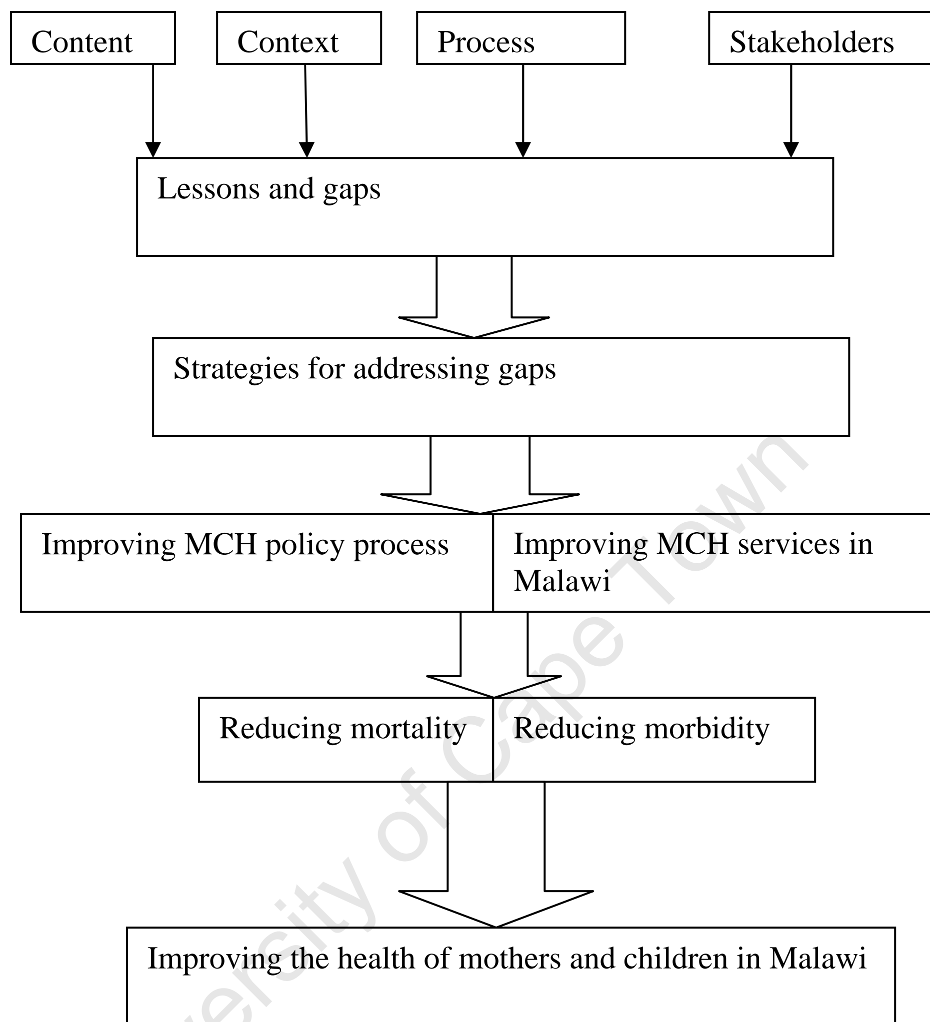
6.5 Fourth Aim: to explore strategies for addressing gaps

Strategies for addressing gaps in MCH policies were presented as recommendations for the study and proposed areas for further research in chapter 7. According to the conceptual framework, if the study recommendations will be implemented by MoH and its donor partners it is anticipated that there is going to be an improvement in the MCH policies as well as MCH services in Malawi. Consequently, reducing maternal and child mortality and morbidity in so doing improving the health of mothers and children in Malawi (see Figure 6.5). The study results were discussed in line with literature on MCH and health policy which either supported or disagreed with the study results in chapter five and 6. Basing on discussions and literature reviewed, chapter 7 proposes recommendations as strategies for addressing gaps in MCH policies in Malawi.

Figure 6.5: Lessons and gaps in MCH policy process and strategies for addressing gaps



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Chapter 7

RECOMMENDATIONS AND PERSONAL REFLECTION

7.1 Introduction

The final aim of the study was achieved through recommending strategies for addressing identified gaps in MCH policies in Malawi. This chapter therefore makes recommendations on strategies for improving MCH in Malawi in line with study results under each aim. Secondly, the chapter proposes areas for further research whose results will help to improve MCH policies as well as services in Malawi. Finally, the chapter presents the researcher's personal reflection of the study process.

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7.2 MCH policies in Malawi from 1964 to 2008

Recommendations: content of MCH policies in Malawi

(a) Policy makers in Malawi should develop MCH policies that are evidence-based and results oriented if improvement of the health of mothers and children in Malawi is to be achieved. This includes developing policy objectives that are specific, measurable, realistic, and affordable as well as time bound.

(b) Allocation of resources for implementing MCH policies should also include physical and human resources in addition to financial resources. This will help to ensure that where human resources are inadequate, strategies to address that problem should be included in MCH policies. In the same way, where there is medical equipment supply or infrastructure problems, strategies to address such problems should be included in the concerned MCH policy.

(c) MCH policies in Malawi should have implementation plans stipulating what activities are to be implemented by who, where, how and when. In addition, National level MCH policies in Malawi should be translated into operational policies and plans at implementation level i.e. tertiary and District Hospitals. The development of five year strategic plan should be re-instated at district and Central

Hospital level in addition to the departments at MoH National Headquarters. The five-year strategic plans should be translated to yearly work plans which will specify which activities are to be implemented by whom, when and how.

(d) MCH policies in Malawi should also have plans for monitoring, supervision, review and evaluation. The plan should specify indicators for monitoring and evaluation, who is to carry out monitoring and evaluation. In addition, resources and budget for monitoring and evaluation should be included in MCH policies. Supervision of MCH policies should be integrated in the health system and linked to achievement of goals and objectives stipulated in MCH policies. Finally, there should be a commitment to monitor implementation progress and measure success or failure of MCH policies in Malawi and learn for future improvement.

Recommendation: context of MCH policies in Malawi

(a) For successful implementation of MCH policies in Malawi, policies should also address cultural factors of the MCH policy context.

(b) Adoption of international and regional MCH policies should address contextual factors in Malawi in addition to their focus on disease and/ or population specific programmes like IMCI, reproductive health, and maternal health.

Recommendation: process of MCH policies in Malawi

(a) Although MCH policies are influenced by international factors, the priorities and specific objectives should address MCH problems encountered in Malawi. MoH and its donor partners should utilize other techniques for analyzing the health situation in Malawi in addition to review of documents. For example, health needs assessment which refers to techniques used to collect information about health needs using a variety of epidemiological methods. Another way to conduct a situation analysis is Participatory Rapid Appraisal (PRA) techniques which are used to obtain information from communities in a practical and participatory approach. These methods can help to generate new information for setting specific objectives and targets as well as priorities and objectives that will address MCH

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problems in Malawi. Further to that, generation of information for policy development should be part of the process for policy formulation.

(b) MoH should make deliberate effort to involve health workers and communities as well as beneficiaries in formulation MCH policies in Malawi. Involvement of these groups is important because it ensures inclusion of their views and as a preliminary step in gathering their support and commitment to implementing the eventual policy.

(c) MoH and donor partners should ensure that the utilization of technical assistance should aim to strengthen the capacity of national MoH officials to develop MCH policies.

(d) Long term policies should be linked to short term policies, for instance vision 2020 should have been linked to National health plan 1999-2004 and JPoW. In addition both the short term plans should have detailed implementation plan which should also be translated to annual work plans which are linked to annual budgets.

(e) National level policies should be translated to operational policies at implementation level that is Central and District Hospitals to ensure their implementation.

(f) Supervision of health facilities should be strengthened and involve private practitioners as well as NGOs. Policy makers should outline plans for implementation, stipulating who is to supervise where, when, how often and resources including human resources for supervision. In addition, supervision should be made a performance issue for DHOs and ZHSO. Further to that checklist for supervising health facilities should be linked to MCH policies goals as well as staff support during implementation.

(g) MCH policies should be evaluated at the end of implementation as an assessment of the extent to which plans have been implemented and it should also form the starting point for the next policy cycle. In addition to that policy review and or

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midterm evaluation should be undertaken as a means for monitoring specific aspects of implementation. However, evaluation and policy review should be planned and budgeted for and incorporated into the policy design. This will ensure the availability of sufficient resources to conduct the policy review and evaluation. In addition, plans and budget for policy review and evaluation ensures commitment to conducting the review and evaluation.

Recommendation: stakeholders for MCH policies in Malawi

a) MoH should make deliberate efforts to create opportunity for involving stakeholders from other sectors outside MoH. In addition, MoH should foster multi-sector coordination both at National policy level and policy implementation level. Multi-sectoral coordination ensures that services to addresses health determinants which cannot be provided by MoH are provided by relevant sectors like Ministry of Agriculture, MLG, and Ministry of Education. MoH and health facility managers should advocate for and/ or lobby for services that promote health of women and children.

b) Policy makers should involve beneficiaries, health workers and other sectors during situational analysis and evaluation as well as review of MCH policies. Their involvement can be achieved through providing their view to development of a policy and assessing its achievements or failures.

c) MoH in collaboration with Ministry of Local Government should revitalize functioning of community decision making structures. The community decision making structures can be used for involving beneficiaries and community members in MCH policies in Malawi.

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7.3 recommendation: lessons and gaps in MCH policy development in Malawi

a) Policy makers should involve implementers and beneficiaries when developing MCH policies in Malawi

b) Policy makers need to results oriented policies which are based on evidence

c) RHU should ensure that MCH policies in Malawi should address problems posed by contextual factors in Malawi in addition to addressing problems specific to the health of women and children.

d) RHU and planning Unit in MoH must ensure that MCH policies should also focus on strengthening the health system in Malawi. For example develop strategies for addressing the human resource shortage; shortage of drugs and medical supplies; and the poor and inadequate infrastructure.

e) Directors in MoH should make sure that monitoring and evaluation for MCH policies are built in both policy documents and policy process cycle.

f) MCH policies should be communicated to private practitioners as well as other stakeholders in policy implementation. Communication of policies to private practitioners as well as other policy implementer should be regarded as performance issue for DHOs, ZHSO and Directors of MoH.

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7.4 recommendations: lessons and gaps in MCH policy implementation in Malawi

a) The similarities in contextual factors affecting MCH policies in Malawi and constraint in implementing the policies implies that strategies for improving MCH services in Malawi need to go beyond the remit of RHU and MoH. The study also found out that, challenges of MCH policy implementation were based on inadequate resources (financial, human, health facilities, drugs

medical supplies). This study therefore recommends that as health systems are going through a transformation (health sector reforms) in a bid to improve health systems' effectiveness and quality of healthcare delivery, the basics in strengthening the health system should not be forgotten. Such basics include renovating old and building new health facilities to match the growing population. In addition, training of more health workers and ensuring adequate and timely supply of medical equipment and supplies.

7.5 Proposed areas for further research

In addition to the recommendations on strategies for improving MCH policies as well as services, the study proposes areas for further researcher that will also contribute to improving the health of women and children in Malawi. Concluding from the study results, discussion and summary of study results, the study proposes three areas for further research. One of the gaps in MCH policy development was that MCH policies were not communicated to private practitioners. It comes out clearly that public and private sectors provide health services independent of each other resulting in uncoordinated MCH services and therefore having little impact on population being served. Frenck (1993) suggests that Government should work out mechanisms of incorporating private sector in public health services, calling for a mix of public and private service provision for greatest efficiency.

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(a) A potential study should be conducted on a title such as: "*the contribution and impact of private sector in MCH service provision in Malawi: exploration of the current trends and strategies for their involvement in MCH policy process*". The first step, however, would be to understand private sector health service provision, by conducting a research. Firstly, the aim of such a study should be to find out the contribution of private health sector in MCH service provision in Malawi. Secondly, the study should draw Government's attention to work together with private sector in MCH starting from policy development to implementation and evaluation. The specific objectives should be to explore the contribution of private sector in MCH services in Malawi; explore current processes for involving private sector in MCH policy process; identify gaps in involvement of private sector in MCH policies; and recommend strategies for involving private sector in MCH policy process.

(b) The second proposed research study should be "*Coordination of MCH policy development and implementation with other sectors: exploration of the current trends and recommendations for improvement*". The rationale for proposing this study is that identified gaps in MCH policy development and implementation indicated that there is limited coordination between health sector and other sectors in MCH policy development and implementation. According to WHO (2000), it is also widely accepted that improving the health status of the population entails influencing the broader environment as some major determinants of health fall outside what is regarded the realms of the health sector. Having appreciated that determinants of health transcend the realms of the health sector, it is important that Malawi as a country ensures effective coordination of MCH policies and other sector policies in order to achieve sustained improved health for women and children. This study therefore recommends that a research should be done aiming at exploring the trend of coordination between health policy and other key sector policies. To achieve the study aim, the following specific objectives should be pursued; firstly, explore the health policy development process in Malawi; secondly, determine at what point in the MCH policy development process is coordination with other sector policies considered; thirdly, identify facilitating and restraining factors for coordination of MCH and other sector policies in Malawi; and recommend other means for inter-sectoral coordination in MCH policy development and implementation.

(c) The third research study should be conducted on "*strengthening management systems and capacity in the public health sector*". The justification for suggesting this topic is because; the lack of managerial capacity at all levels of the health system was identified as one of the gaps in MCH policy development and implementation in this study. Weaknesses in managerial capacity in health, especially at implementation levels, have been widely cited as a constraint to scaling up health services and achieving the Millennium Development Goals (MDGs). Therefore, the need to strengthen management systems and capacity for MCH policy development need not to re-emphasized. The proposed study should analyse the current managerial capacity at all levels in the health system; identify gaps; and make recommendations for improvement.

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7.6 Personal reflection on the research process

Introduction

I have acquired a lot of knowledge and skills so far which cannot be fully presented in this subsection. However, to encapsulate all my learning experiences, this personal reflection on the research process gives a brief summary of my learning experiences through reflecting within the study topic, aims and objectives of the study, methodology, results and dissemination of results.

General learning experience

On the general perspective, I have widened my knowledge and skills quite extensively in qualitative research methods. This was my first qualitative study in which I used three qualitative research designs, four data collection methods and had comprehensive interviews. The experience was both exciting because I was learning new knowledge as I went through different stages in the research process of the study. At the same time challenging as I had to learn new knowledge and skills as fast as I could and conduct the study within a specified timeframe. Interviews gave me an opportunity to understand how MoH officials and stakeholders view the health system in Malawi and MCH issues.

Study topic and problem identification

Areas of my research interest include health policies, health systems, health management, reproductive health, maternal health and child health. I struggled so much to define a research area because I wanted everything to do with all areas of my research interest. As a result I developed five research conceptual papers at the very initial stage but finally I ended up doing this study. In the process of conducting the study, reviewing literature, reviewing policy documents, doing interviews and conducting field visits, I discovered that the study revolved around almost all areas of my research interest.

Aims, objectives and methodology

This part of the research process has been of great value to my personal development in the field of research. I went through a process of matching aims, objectives and how to achieve those objectives as well as specific information to be obtained for each aim and objective. Following that I came up with how to collect the data for each objective. For instance table 3.4 on page 43 shows the link of aims, objectives,

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sources of data and data to be collected. Identifying research designs was another exciting and challenging aspect of the study; it involved a lot of reading. In choosing a research strategy I have learnt that different strategies exist depending on the nature of the research problem. Equally, I have learnt that problems can be solved using different strategies depending on the nature of problem.

Under Sampling, Data Collection and Data Analysis This topic helped me to understand that different sampling techniques exist depending on research questions and objectives. In addition, I have experienced that not all data is information as such data analysis is vital and important. Therefore I have started to appreciate that there is need to make sure that data collection in organization has to be succeeded with analysis to get information which can be used for decision making.

Writing and Presenting Research Findings

Through the process of results dissemination through a workshop with MoH official and stakeholders, I learnt that the government official do not easily accept negative study results, while stakeholders take that as evidence to support their perspectives of government systems. For example during research dissemination workshop in Malawi, there was a prolonged discussion to validate the research findings. In the discussion, government officials were opposing some of the findings like communication of policies to implementers, monitoring and evaluation. On the other hand stakeholders support the entire study results accusing government official on concentrating on policy development and not implementation, monitoring and evaluation.

Presentation of different aspects of the study at international conferences was the most exciting event because of travelling to countries I had not gone to yet especially Thailand. Travelling also provided a break to meet other searchers from the routine time table of academic work. Most importantly was the benefit of being recognized internally as a researcher as well as getting constructive feedback from other experts which complimented the guidance from my supervisors. Submitting article to be reviewed to be considered for publication in journal was strenuous. Different journals have different writing styles and expectations from authors.

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Conclusion

In conclusion, I feel I have been exposed to a lot of new knowledge and skills in health policy analysis and research methods. Reflecting on these new experiences has deepen my learning process, helped me to assess my progress in my academic work and strengthen my plan for the future. All in all my learning process in research has strengthened my professional competence and personal development.

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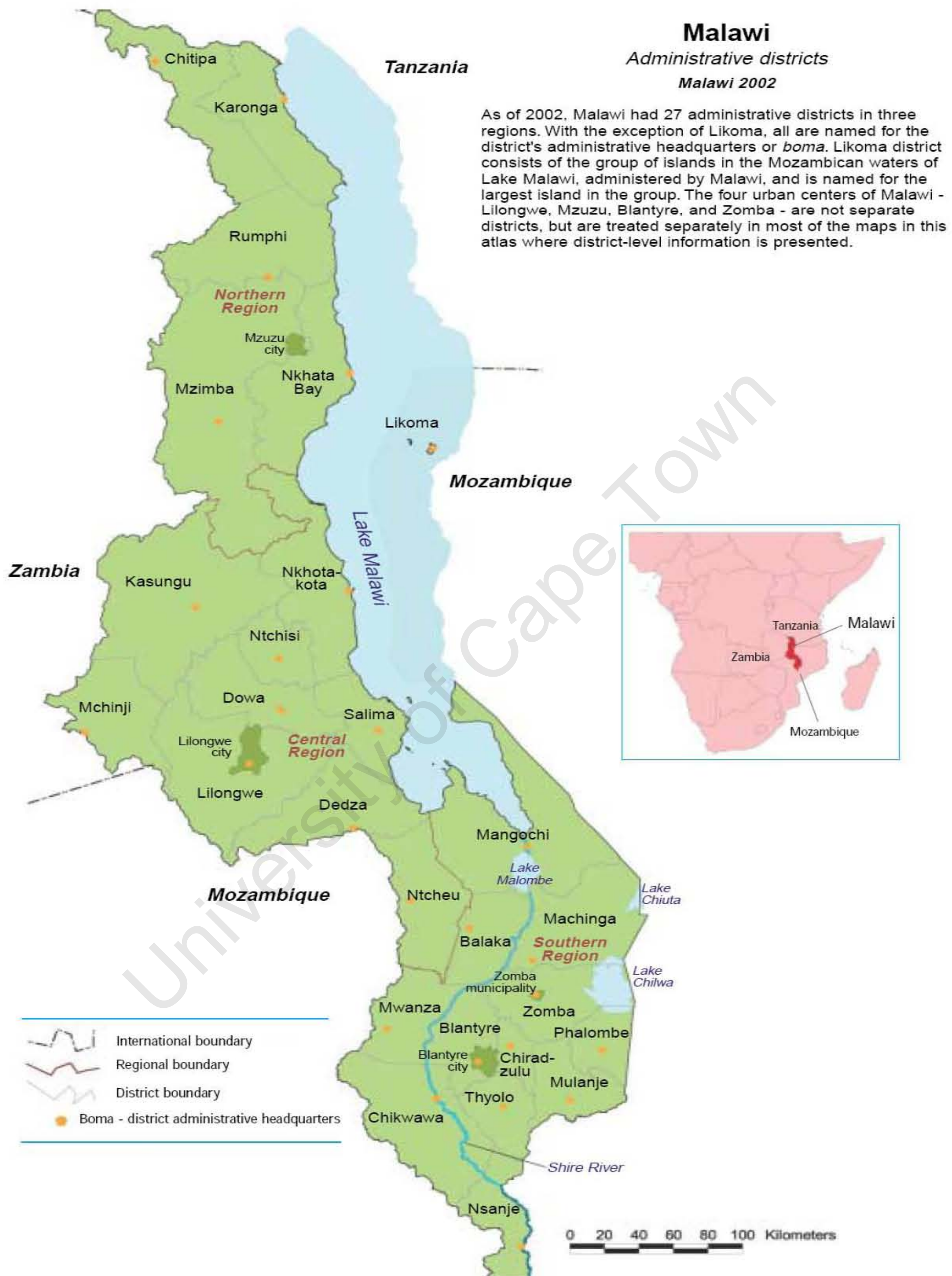
University of Cape Town

8.0 APPENDICES

8.1 Appendix A: Map of Malawi



University of Cape Town

8.2 Appendix B: Ethical approval from Malawi

Telephone: + 265 789 400
Facsimile: + 265 789 431
e-mail doccentre@malawi.net
All Communications should be addressed to:
The Secretary for Health and Population

In reply please quote No. MED/4/36c
MINISTRY OF HEALTH
P.O. BOX 30377
LILONGWE 3
MALAWI

7 February 2008

Judith Ng'ombe Daire
Universty of Cape Town

Sir/Madam,

RE: PROTOCOL # 493: MALAWI'S MARTENAL AND CHILD HEALTH POLICIES: ANALYSIS, LESSONS AND STRATEGIES FOR ADDRESSING GAPS

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has **reviewed** and approved the study.

APPROVAL NUMBER : 493

The above details should be used on all correspondences, consent forms and documents as appropriate.

- **APPROVAL DATE :07th FEBRUARY 2008**
- **EXPIRATION DATE :06th FEBRUARY 2009**
  After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC Secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the NHSRC within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using forms obtainable from the NHSRC Secretariat is required before implementing any changes in the protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on telephone number *+265 1 789 400/314* or by email on doccentre@malawi.net.
- **OTHER**: Please be reminded to send in copies of your final research results for our records (Health Research Database).

Kind regards from the NHSRC Secretariat.

For: **CHAIRPERSON, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE**
Promoting Ethical Conduct of Research

Executive Committee: *Dr C. Mwansambo (Chairperson), Prof. E. Molyneux (Vice-Chairperson)*
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
IRB Number IRB00003905 FWA00005976

8.3 Appendix C: Ethical Approval from the University of Cape Town

UNIVERSITY OF CAPE TOWN

Health Sciences Faculty
Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
e-mail: lamees.emjedi@uct.ac.za

17 October 2008

REC REF: 321/2008

Mrs J Daire
c/o Prof D Khalil
Nursing & Midwifery
Health & Rehab
F Floor
OMB

Dear Mrs Daire

PROJECT TITLE: MALAWI'S MATERNAL AND CHILD HEALTH POLICIES: ANALYSIS, LESSONS AND STRATEGIES FOR ADDRESSING GAPS.

Thank you for submitting your study to the Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study.

Approval is granted for one year till the 24th October 2009.

Please submit an annual progress report if the research continues beyond the expiry date. Please submit a brief summary of findings if you complete the study within the approval period so that we can close our file.

Recommendations:

1. Please would you give some indication in the information sheet/consent form of how long the questionnaire might take to complete and interviews might last.
2. Additionally, you might want to consider stating in the questionnaire when respondents can tick more than one answer.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

lemjedi

University of Cape Town

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

8.4 Appendix D: Covering letter for pilot questionnaire

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences

School of Health & Rehabilitation Sciences

Division of Nursing & Midwifery
Old Main Building · Groote Schuur Hospital
Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21/4066323
January 2008

University of Cape Town

Dear Sir/Madam (name),

<u>Re: PhD Research-Analysis of Maternal and Child Health Policies in Malawi</u>

My name is Judith Daire, I am a Malawian pursuing a PhD at the University of Cape Town. I am conducting the above mentioned study as a requirement for the academic qualification. As part of my research, I am piloting this questionnaire to test it. The study aims to analyze Maternal Child Health in Malawi, identify lessons and gaps. In addition, the study will recommend possible solutions for improving maternal and child health services in Malawi. I hope you will be willing to take part in answering the attached questionnaire. The questionnaire is aimed at Directors of MCH services from Ministry of Health head office and health professionals involved in MCH policy process. I hope that the questions will be able to explore the process for MCH policies in Malawi.

My request is that you please kindly try to answer all the questions as much as possible. Your contributions through answering the questions will help me to restructure the final questionnaire. In addition to answering the questions, suggestions for improving question format and organization are welcome.

Attached is the study description for your reference to the study.

Many thanks for your support and cooperation

Yours truly,
Mrs. Judith Ng'ombe Daire

Cc: Research supervisors

8.5 Appendix E: permission to access health facilities

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences

School of Health & Rehabilitation Sciences

Division of Nursing & Midwifery
Old Main Building · Groote Schuur Hospital · Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21/4066323

The Government of Malawi
December 2008

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

Dear Sir/Madam (name),

Re: PhD Research-Analysis of Maternal and Child Health Policies in Malawi

My name is Judith Daire; I am a Malawian pursuing a PhD at the University of Cape Town. I am conducting the above mentioned study as a requirement for the fulfilment of the academic qualification. The study aims to analyze Maternal and Child Health (MCH) polices in Malawi from 1964 to 2008, to identify lessons and gaps. In addition, the study aims to recommend possible solutions for improving maternal and child health services in Malawi. I would like to visit tertiary hospitals, District Hospitals and two health centres selected districts for the study to observe how maternal and child health policies are implemented. I am therefore writing to ask for your permission to access tertiary hospitals, District Hospital, and the recommended two health centres.

I will be coming to Malawi in April 2008 to collect data through questionnaires and interviews in addition to the field visits. Attached is the brief study description for your reference about the study

Many thanks for your support and cooperation.
Yours truly,
Mrs. Judith Ng'ombe Daire

Cc: Research Supervisors

University of Cape Town

8.6 Appendix F: Information sheet (Study description)

This study is an academic requirement for the fulfilment of a doctoral degree (PhD) which is being pursued at the University of Cape Town. The study aims to analyze maternal and child health (MCH) polices in Malawi from 1964 to 2008, to identify lessons and gaps. In addition, the study aims to recommend possible solutions for improving maternal and child health services in Malawi. The outcomes for the study will include a report to Ministry of Health and a workshop with Ministry of health and other stakeholders will be conducted to disseminate the findings and discus the way forward as regards the study recommendations. Qualitative research methodology will be employed for the study. Evaluation research and multiple case studies and grounded theory will be used as research designs. Data will be collected through official documents review, self-administered questionnaires, and interviews. Data from the three data collection methods will be compared and contrasted. The study will start with a pilot study from February to March 2008 and data for the study is planned to be collected from March to November 2008. The participants for the study will be Directors of health services from Ministry of Health National head office, District Health Offices, MCH Coordinators, Nurses, Doctors, Clinical Officers, and Midwives.

In addition to collecting data through the mentioned methods, I would like to visit all levels of health facilities (Central Hospitals, District Hospital and health centres) to see how MCH policies are implemented. The proposed tertiary hospitals are Mzuzu, Lilongwe and Queen Elizabeth Central Hospitals. The selected districts include Mzimba and Rumphi from northern region, Ntcheu, Ntchisi and Mchinji from central region. Selected districts from southern region include Mulanje, Thyolo, Chiradzulu and Machinga. In addition to District Hospitals two health centres in each of the selected districts for the study will also be visited. The specific health centres will base on the recommendations from District Health management Teams of selected District Hospitals for the study.

Ethical considerations throughout the research process and after the research will be observed. For instance the research will get approval from the Ethical Committee and MOH. In addition, the researcher will gain consent from participant and key informants to participate in the study and for their information to be included in the study results as well as for publishing. Participation in the study will be voluntary and participants will be free to withdraw from the study any time without any penalties. This study will be conducted under the supervision of two academic researchers, Dr. M. Chirwa from the University of Malawi (College of Medicine) and Professor D. Khalil from the University of Cape Town. Data will be analyzed and final results will be presented as PhD thesis at the University of Cape Town in South Africa. After which tapes and scripts of raw data will be destroyed.

For more information, my contact details are as follows: e-mail judydaire@yahoo.co.uk
Mobile phone in South Africa +27 797841341, in Malawi +265 8 733 729

University of Cape Town

8.7 Appendix G: Permission to access official documents in Malawi

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences

School of Health & Rehabilitation Sciences

Division of Nursing & Midwifery
Old Main Building · Groote Schuur Hospital · Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21/4066323
The Government of Malawi
January 2008

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

Dear Sir/Madam (name),

Re: PhD Research-Analysis of Maternal and Child Health Policies in Malawi

I write to request for permission to access official documents (policies) concerned with Maternal and Child Health (MCH) in Malawi. I am a Malawian currently studying at the University of Cape Town. I am conducting a research study as a requirement for the fulfilment of the academic qualification, Doctoral Degree (PhD).

The study aims to analyze MCH polices in Malawi from 1964 to 2008. The study will involve reviewing of official documents, distribution, and collection of self-administered questionnaires. In addition, the study will also involve conducting interviews with participants and key informants, and field visits. The study will start with a pilot study from February to March and data for the study is planned to be collected from April to November 2008.

Attached is the brief summary of the research proposal for details. Thank you for your favourable consideration

Yours truly,
Mrs. Judith Ng'ombe Daire

University of Cape Town

8.8 Appendix H: Questionnaire

Questionnaire for a research on analysis of Maternal and Child Health (MCH) policies in Malawi

Instructions
Tick what you think is the appropriate answer from the given responses. If you have a different opinion, write in the provided space for others.

Section a
1. General information

a) Highest level of education
JCE [ ] High school (MSCE) [ ] Certificate [ ] Diploma [ ]
First degree [ ] Post graduate Diploma [ ]Postgraduate masters degree [ ]
PhD [ ] Specialist [ ]

b) Profession
Medical Officer [ ] Clinical Officer [ ] Medical assistant [ ]
Registered Nurse [ ] Registered Nurse Midwife [ ] Nurse Technician [ ]
Nurse Midwife Technician [ ] Enrolled Nurse [ ]
Enrolled Nurse Midwife [ ] others …………………………………………..

c) Position
Director of Planning [ ] District Health Officer [ ] Head of Department
District Nursing Officer [ ] Hospital Nursing Officer [ ] Coordinator [ ]
In charge [ ] Others [ ] (specify……………………………………………)

d) Level of health system
Tertiary/Central Hospital [ ] District Hospital [ ]

Health Centre [ ] Other [ ] (Specify………………………………………)

e) Department/Ward
Antenatal [ ] Labour/Maternity [ ] Post-natal [ ] Nursery [ ]

Paediatric [ ] Gynaecological [ ] Other (Specify……………)

Section b

2 Content of MCH policies in Malawi

a) Which of the following policies are you aware of?
National health plan [ ] Reproductive health strategy [ ] National HIV/AIDS Policy [ ] Reproductive health policy [ ] child health policy[ ]
Others [ ] (specify………………………...…) Not aware of any policy [ ]

b) Which of the following policies do you have?

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National health plan [ ] Reproductive health strategy [ ] HIV/AIDS Policy [ ]
Reproductive health policy [ ] child health policy [ ]
Others [ ] (specify……………………………………)
Do not have any policy [ ]

c) Do MCH policies contain rationale for the policy?

Yes [ ] No [ ] Others [ ] Specify..

Do not know [ ]

d) Do MCH policies in Malawi have goals and objectives

Yes [ ] No [ ]

Comments about policy goals and objectives
....
....
....

e) Which of the following resources are outlined in MCH policies as allocated resources for policy implementation?

Financial resources [ ] Human resources [ ]

Physical resources [ ] All of the above [ ]

f) Are the allocated resources for implementing MCH policies adequate?

Yes [ ] No [ ]

Give reasons for your response
....
....
....
....

g) Do MCH policies have plans for implementations

Yes [ ] No [ ]

Comments ....

h) Do MCH policies have plans for monitoring and supervision?

Yes [ ] No [ ]

Comments ....

i) Do MCH policies have plans for policy review and evaluation?
Yes [ ] No [ ]

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Comments ....

3 Contexts of MCH policies in Malawi

a) List factors affecting MCH policies in Malawi?
....
....
....
....
....
....
....
....

4 Process of MCH policies in Malawi?

a) From your experience, how do policy makers know there is a problem concerning Maternal and Child Health?

Meetings with health workers [ ] Through pressure groups [ ] International Trends[ ] Research findings [ ] MCH service records [ ] MCH service reports [ ] Reports from community leaders [ ]
Reports from parliamentarians [ ] Others [ ] (specify……………………….)
Do not know [ ]

b) When does a problem become an issue for MCH policy agenda?
When it becomes a crisis in the nation [ ] When it affects political power [ ]
When it is an international priority policy issue [ ] When it's a National priority [
Others [ ] Specify……………………………… Do not know [ ]

c) What factors influence MCH issues to get onto policy agenda?
Donor requirements [ ] Political influence [ ] Availability of funding [ ]
Needs of the population [ ] International trends [ ] Others [ ] Do not know [ ]

d) How are MCH policy priorities selected?
Voting [ ] Consensus [ ] debate [ ] imposed [ ]
Others [ ] (specify……………………………………………

e) How are MCH policies communicated to implementers?)
Distribution of policy documents [ ] Policy briefing through staff meeting [ ]
In service training [ ] Policy campaigns [ ] Other means of communication [ ]
policies are not communicated to implementers [ ] Do not know [ ]

f) Are MCH policies in Malawi monitored?
Yes [ ] No [ ] Do not know [ ]

g) If yes, how are they monitored?
Supervision [ ] midterm evaluation of MCH policy[ ] keeping of records [ ]
HMIS data [ ] Annual reviews [ ]
Others [ ] Specify………………………………….. Do not know [ ]

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h) How is the information from monitoring used?

For changing policy goals [ ] For making corrections or supplementing policies [ ]
For improving implementation of polices [ ] For tracking Implementation progress
[ ] Others (specify………………………………..) Do not know [ ]

i) Are MCH policies reviewed?

Yes [ ] No [ ] Do not know [ ]

j) For what purpose are MCH polices reviewed?

For revising or evaluating a policy [ ] To track implementation progress [ ]
To make corrections or supplementations [ ] For developing another MCH policy [ ] Other purposes [ ] Please specify……………………………
Do not know [ ]

k) When are policies reviewed?

At the end of implementation [ ] In the middle of implementation [ ]
When developing a new policy [ ] other times [ ] specify …………….
Policies are not reviewed [ ] Do not know [ ]

l) When are MCH policies evaluated?

At the end of implementation [ ] When developing a new policy [ ]
Policies are not evaluated [ ] Do not know [ ]

m) What sources of information are used for developing MCH policies in Malawi?

Demographic health surveys[ ] Research specifically initiated for MCH policy[ ]
General Research [ ] Information from international organizations and donors [ ]
Reports on best practices from other countries [ ]
Other sources of information [ ]................……………..… Do not know [ ]

5 Stakeholders

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a) Which of the following stakeholders are involved in formulating MCH policies?

MoH [ ] DHOs [ ] Technical Working groups[ ] international organization [ ]
Health Workers [ ] beneficiaries [ ] international donors [ ] Civil Society Organizations [ ] Others [ ] Do not know [ ]

c) Who formulates policy goals and objectives?

District Health Officers [ ] Minister of Health [ ]
Principal Secretary for Health [ ] Director of planning [ ]
Technical working groups in Ministry of Health [ ]
Director of Reproductive Health Unit [ ]
Others [ ] (specify…………………………) Do not know [ ]

d) Who monitors MCH policies?

District health Officers [ ] DHMT [ ] Programme coordinators [ ]
Special monitoring task force [ ] External monitors [ ] ZHSO [ ]

Others (specify……………………………) Do not know [ ]

e) Who is involved in MCH policy review?
District Health Officer [ ] Director of Planning [ ] Director of Reproductive Health Unit [ ] Director of Preventive Health Services [ ] Technical working groups [ ] Civil Society Organizations[ ] Principal Secretary for Health[ ] Health workers[ ] Community leaders [ ] Director of clinical services [ ] Others [ ] Please specify………………………………………

f) Who evaluates MCH policy in Malawi?
Ministry of Health [ ] Special Evaluation team [ ] Donors [ ]
Others [ ] Specify………………………………. Do not know [ ]

7 Lessons and gaps in MCH policy development and implementation

a) What lessons should policy makers draw from current MCH policy development process?
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b) What do you think are the gaps in MCH policy development in Malawi?
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c) What lessons do you think should be drawn from MCH policy implementation in Malawi?
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....
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d) What constraints do you encounter when implementing MCH policies in Malawi?
…………………………………………………………………………………….....
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....

University of Cape Town

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Please use this space for additional comments:

Thank you for participating in the study

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8.9 Appendix J: Interview guide

Interview briefing

I am a student at the University of Cape Town and currently doing a research for a PhD thesis and the purpose for the interview is collect data for my research. Before going to Cape Town, I worked as the Acting Matron at Mulanje mission hospital and as a Project Manager for Sexual and Reproductive Health at CARE International in Lilongwe. I have also taught at Mulanje and Phalombe Nursing colleges as well as the University of Malawi, Kamuzu College of Nursing.

The study aim is to analyze MCH polices in Malawi, to identify lessons and gaps. in addition the study aims recommend possible strategies for improving Maternal and Child Health services in Malawi. The study will be carried out under the supervision of Dr. M. Chirwa from the University of Malawi (College of Medicine) and Professor D. Khalil from the University of Cape Town. I will be in Malawi from January to December 2008, from March to December 2008, collecting data on maternal and child health policies. Permission to conduct the study and access to health facilities has been obtained from the National Health Sciences Research Committee and Ministry of Health. The study involves distribution and collection of self-administered questionnaires by the researcher herself. In addition, the study will also involve conducting interviews and field visits to all levels of health facilities. As a participant, you can choose either to fill the self-administered questionnaire or to be interviewed.

If you choose to be interviewed, I would like to ask for your permission to tape record our conversation for capturing information accurately, before we start the interview. You are free to turn the recorder off if you feel that certain information should not be recorded. I will transcribe both the information from questionnaires and interviews on the tape to a text and I will send you a copy for you to verify the information, make clarification, and consent its inclusion in the final report. Feel free to ask me any questions about my research.

Be informed that your participation is voluntary and you can terminate the interview if you are not comfortable. Before we start our interview, I would like you to sign agreement form indicating that I explained the study and you have adequate information to base your decision on for your participation in the study. Read the information on the consent form carefully and ask me where you need clarification. If you are satisfied with the information, please sign the agreement on the provided space. Thank you so much for the opportunity to talk to you about my study. I will ask you questions about………..

Data to be entered

Position or profession of the respondent…………………………………………..
Institution of the respondent……………………………………….
Role in MCH service delivery……………………………………………………….
Assigned number for participant or key informant for identification

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Questions to guide interview sessions

Content of MCH policies in Malawi

- Is there a standard on the content of MC policies in Malawi?
- Why do MCH policies in Malawi not have plans for implementation, monitoring supervision, review and evaluation?

Context of MCH policies in Malawi

- What factors influence MCH polices in Malawi?

Process of MCH policies in Malawi

- How are MCH policies initiated and developed?
- How are MCH policies implemented?
- How are MCH policies in Malawi monitored and evaluated?

Stakeholders in MCH policies in Malawi

- Who are the stakeholders for MCH policies and what their roles are?
- How are the stakeholders involved in MCH policy development and implementation?

Lessons and gaps in MCH policy development and implementation

- What lessons can be drawn from the current policy development process and implementation?
- What would you say are the challenges or gaps in MCH policy development process and implementation?
- What would you recommend that could be done to improve MCH services in Malawi?

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8.10 Appendix K: Field visit observation guide

This is a highlight of issues observed at public tertiary hospitals, District Hospitals and health centres.

What to look for	**Observation comments**
Route to the health facility (accessibility)	
Stability of the infrastructure	
Space (if adequate or not)	
Number of staff compare with number of patients	
Availability of medical equipment	
Posters on available services	
Guidelines for service provision	
Utilities (water, electricity)	
Opening and closing times	

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8.11 Appendix L: A letter to District Health Management Teams

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences
School of Health & Rehabilitation Sciences
Division of Nursing & Midwifery
Old Main Building · Groote Schuur Hospital · Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21/4066323
March 2008

District Health Management Team
Through District Health Officer

Dear Sir/Madam,

Re: PhD Research-Analysis of Maternal and Child Health Policies in Malawi

My name is Judith Daire, I am a Malawian pursuing a PhD at the University of Cape Town. As a requirement of my PhD, I am conducting a study whose aim is to analyze Maternal and Child Health policies in Malawi. In addition to analyzing maternal and child health policies, the study will identify lessons and gaps and recommend possible strategies for improving maternal and child services in Malawi. An approval for the study has been obtained from the Ministry of Health and your district is of the selected districts for the study. I hope the Ministry of Health has already communicated this to you. I am writing to request for your kind assistance in recommending two health centres to be included in the study. The criteria for selecting the health centres should be accessibility in terms of transport and distance.

I will be coming to Malawi in April 2008 to collect data through questionnaires and interviews. I will visit the District Hospital and health centres to observe how policies for maternal and child health are implemented. Attached is the study information sheet for your reference about the study.

Many thanks for your support and cooperation.

Yours truly,

Mrs. Judith Ng'ombe Daire

University of Cape Town

8.12 Appendix M: Cover letter for final Questionnaire

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences

School of Health & Rehabilitation Sciences

Division of Nursing & Midwifery
Old Main Building · Groote Schuur Hospital · Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21/4066323
April 2008

Dear Sir/Madam,

Re: PhD Research-Analysis of Maternal and Child Health Policies in Malawi

My name is Judith Daire; I am a Malawian pursuing a PhD at the University of Cape Town. As a requirement for my academic qualification, I am conducting the above mentioned study. I write to request for your support in relation to the attached questionnaire, which is part of my PhD research. The study aims to analyze maternal and child health polices in Malawi, identify lessons and gaps. In addition, the study aims to recommend possible strategies for improving maternal and child health services in Malawi. The approval to conduct the study has been obtained from the Ministry of Health. I would be very grateful if you would kindly complete the attached questionnaire.

Be informed that participation in this study is voluntary and you are free to withdraw from the study at any time. Your information will be regarded as confidential and your name will not be used in the final report. You can choose to fill the self-administered questionnaire or to be interviewed. In whichever case I kindly ask for your permission in participating in the study by signing the agreement form attached to this letter. Read the information that is presented to you carefully before signing the agreement and you can ask me for any clarifications. Your participation in the study is greatly appreciated.

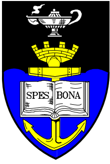
Thank you so much once again
Yours truly,

Mrs. Judith Ng'ombe Daire

University of Cape Town

8.13 Appendix N: Invitation letter for interview

UNIVERSITY OF CAPE TOWN



Faculty of Health Sciences

School of Health & Rehabilitation Sciences

Division of Nursing & Midwifery
Old Main Building · Groote Schuur Hospital · Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21/4066323
April 2008

Dear Sir/Madam,

Re: PhD Research-Analysis of Maternal and Child Health Policies in Malawi

My name is Judith Daire, I am a Malawian pursuing a PhD at the University of Cape Town. As part of my degree, I am conduct a research that aims at analyzing maternal and child health polices in Malawi. In addition, the study will identify gaps and lessons and recommend possible solutions for improving maternal and child health policies in Malawi. Data for the study will be collected through documents review, questionnaires, and interviews. I am writing to request for your kind participation as one of the participants or key informants to be interviewed.

The interviews have been scheduled for months of June and July in 2008. I will be very grateful if you would be able to provide me with the date and time for the interview that is convenient for you. Participation in this study is voluntary and you are free withdraw from the study at any time if you feel like so. In addition, your information will be regarded confidential and your name will not be used in the final report. In addition, study results will be presented in a manner your identity will not be known. Before you participate in the study by being interviewed, I kindly ask you to sign the agreement form attached to this letter to show that you voluntarily agree to participate in the study. Please read the agreement form carefully before you sign and ask me for any clarifications where you do not understand.

Thank you for your support for my study, looking forward to hearing from you.

Yours truly,

Mrs. Judith Ng'ombe Daire

University of Cape Town

8.14 Appendix P: Informed consent

A Questionnaire

Faculty of Health Sciences

School of Health & Rehabilitation Sciences

Division of Nursing & Midwifery
Old Main Building · Groote Schuur Hospital ·
Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21/4066323
April 2008

Dear Sir/Madam (name)

Re: A request for your consent to participate in a study

I am writing to invite you to participate in a research study by filling in a self-administered questionnaire. The purpose of the study is to analyze maternal and child health policies in Malawi. Your participation in this study is of considerable value because you will provide information that will help to improve maternal and child health in Malawi. The study will benefit you because you will reflect your role and contribution to maternal and child health in Malawi. The researcher is not anticipating any harm on you by providing the information, however in case of unforeseeable risks the researcher will make appropriate arrangements with the management of your facility.

Your participation in this study is voluntary such that you are under no obligation to participate and you are free to withdraw at anytime if you are not comfortable with the study process. There will be no repercussions or penalties for withdrawing from the study. Your responses will be transcribe into a text and sent to you for verification and consent to be included in the final report. Your information will only be accessible to the researcher and her two supervisors and once the data is analyzed, raw data will be destroyed. In addition your identity will not be used on both questionnaire and the final report. Results will be presented in a manner that does not reveal your identity.

Research ethics Committee of the University of Cape Town in South Africa and National Health Sciences Research Committee in Malawi have approved the study and its procedure. If you have any questions about the study or about participating in the study, please feel free to ask me (Judith Daire). My mobile numbers are +27 797841341 in South Africa and +265 8733 729 in Malawi.

I have discussed the above points with the participant. It is my opinion that the participant understands the benefits, risks and obligations involved in participating in the study.

______________________________ ________________________

Investigator Date

The study has been explained to me, I understand that my participation is voluntary and that I may refuse or withdraw my consent from participating in the study at any time without penalty. I hereby give consent to take part in this research study.

______________________________ ________________________

Signature of the study participant Date

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B Interview – letter to participants and key informants

Faculty of Health Sciences

School of Health & Rehabilitation Sciences

Division of Nursing & Midwifery
Old Main Building · Groote Schuur Hospital ·
Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21/4066323
May 2008

Dear Sir/Madam (name)

Re: A request for your consent to participate in a study

I am writing to invite you to participate in a research study by being interviewed. The purpose of the study is to analyze maternal and child health policies in Malawi.

Your participation in this study is of considerable value because you will provide information that will help to improve maternal and child health in Malawi. The study will benefit you because you will reflect your role and contribution to maternal and child health in Malawi. The researcher is not anticipating any harm on you by providing the information, however in case of unforeseeable risks the researcher will make appropriate arrangements with the management of your facility.

Your participation in this study is voluntary such that you are under no obligation to participate and you are free to withdraw at anytime if you are not comfortable with the study process. There will be no repercussion or penalty for withdrawing from the study. In order for me to capture your responses accurately, I would like to record the interview. I therefore also ask for your permission to tape record the interview. Your responses will be transcribe into a text and sent to you for verification and consent to be included in the final report. Your information will only be accessible to the researcher and her two supervisors and one the data has been analyzed raw data will be destroyed. In addition your identity will not be used on both interview transcripts and the final report. Results will be presented in a manner that does not reveal your identify.

Research ethics Committee of the University of Cape Town in South Africa and National Health Sciences Research Committee in Malawi have approved the study and its procedure. If you have any questions about the study or about participating in the study, please feel free to ask me (Judith Daire). My mobile numbers are +27 797841341 in South Africa and +265 8733 729 in Malawi.

I have discussed the above points with the participant/key informant. It is my opinion that the participant understands the benefits, risks and obligations involved in participating in the study.

__________________________ __________________________

Investigator Date

The study has been explained to me, I understand that my participation is voluntary and that I may refuse or withdraw my consent from participating in the study at any time without penalty. I hereby give consent to take part in this research study and give permission to this interview to be tape-recorded.

__________________________ __________________________

Signature of the study participant Date

University of Cape Town

8.15 Appendix Q: Post questionnaire letter to participants

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences

School of Health & Rehabilitation Sciences

Division of Nursing & Midwifery
Old Main Building · Groote Schuur Hospital · Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21/4066323

December 2008

Dear Sir/Madam (name),

Re: PhD Research-Analysis of Maternal and Child Health Policies in Malawi

I write to thank you for participating in my research. I am so grateful for the tremendous contribution you made to the data I collected by answering the study questionnaire. I have transcribed your responses to the questionnaire into a text as I promised. I have attached a copy of the transcribed responses for you to review and verify the information you provided. In addition, I am also asking for your consent to include the information in the study.

Kindly read through and make the appropriate corrections, I will also welcome any additional comments that you feel will better reflect MCH polices in Malawi.

You can email your corrections and comments to judydaire@yahoo.co.uk or mail by post using the enclosed stamped and self-addressed envelope sent to you together with the transcribed questionnaire responses.

I will greatly appreciate if you could return you corrections and comments to me as soon as humanly possible.

Many thanks once again

Mrs. Judith Ng'ombe Daire

University of Cape Town

8.16 Appendix R: Post interview letter to participants and key informants

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences
School of Health & Rehabilitation Sciences
Division of Nursing & Midwifery
Old Main Building · Groote Schuur Hospital · Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21/4066323
December 2008

Dear Sir/Madam (name),

Re: PhD Research-Analysis of Maternal and Child Health Policies in Malawi

I write to thank you for participating in my research. I am so grateful for the tremendous contribution you made to the data I collected by being interviewed. I have transcribed the tape-recorded interview that we had into a text as I promised. I have attached the copy of the transcribed interview for you to review and verify the information you provided. In addition, I am also asking for your consent to include the information in the final report of the study.

Kindly read through and make the appropriate corrections, I will also welcome any additional comments that you feel will better reflect MCH polices in Malawi.

You can email your corrections and comments to judydaire@yahoo.co.uk or mail by post using the enclosed stamped and self-addressed envelope sent to you together with the transcribed interview.

I will greatly appreciate if you could return you corrections and comments to me as soon as humanly possible.

Many thanks once again

Mrs. Judith Ng'ombe Daire

University of Cape Town

8.17 APPENDIX S: Programme Research dissemination

SRH DISSEMINATION MEETING
3rd - 4th JUNE 2009 CAPITAL HOTEL, LILONGWE
TENTATIVE PROGRAMME

TIME	ACTIVITY
Day 1: **Chairperson- Evelyn Zimba, Save the Children** **Rapporteurs- Eric Tsetekani- Mai Khanda & Olive – Futures**	
8:00- 8:30am	Registration of Delegates
8:30- 9:00am	Arrival of Guest of Honour- **Secretary for Health**
9:00-10:00am	**OFFICIAL OPENING/WELCOME REMARKS**
10:00-10:30am	Situation of Reproductive Health - ***Deputy Director RHU (Mrs. F. Kachale)***
10:30-11:00am	**REFRESHMENTS**
11:00-11:30am	SRH Policy – ***Director of RHU , Dr. Chisale Mhango***
11:30- 12:00noon	Obstetric Fistula study – ***Dr. Linda Kalirani, CRH***
12:00-12:30pm	Plenary/Discussion
12:30-13:30pm	**LUNCH**
13:30- 14:00pm	Rapid Needs Assessment (Female Condom)- ***Sandra/Chikondi (UNFPA/UNICEF)***
14:00- 14:30pm	Obstetric protocols- ***Prisca, RHU***
14:30- 15:30pm	Plenary/Discussion
15:30- 16:00pm	**REFRESHMENTS**
16:00- 17:00pm	Community RH Guidelines & Community Mobilisation – ***Prisca/Anna Chinombo***
	Plenary/Discussion
	Meeting for Rapporteurs
Day 2	**Chairperson, Deliwe Malema - MSH** **Rapporteurs Maggie – SAVE & Nancy - RHU**
8:00- 8:30am	Recap of Day 1 proceedings – ***Olive & Eric***

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8:30- 9:00am	DMPA Community Guidelines- ***Jean & Olive***
9:00- 9:30am	RH Commodity Security Strategy- ***Sam Chirwa/Stanley Manondo***
9:30- 10:0am	YFHS Monitoring tools- ***Juliana Lunguzi, UNFPA***
10:00- 10:30am	Plenary/Discussion
10:30- 11:00am	**REFRESHMENTS**
11:00- 11:30am	Rape & Sexual Assault Guidelines- ***Prisca/Hans***
11:30- 11:40am	Community Based Maternal & Neonatal Care Package- ***RHU/SAVE***
11:40- 11:50pm	Community Based Maternal & Neonatal Care Package- District experience- ***DHO (Thyolo or Dowa)***
11:50- 12:00 noon	Cervical Cancer updates on implementation
12:00- 12:30pm	Plenary/Discussion
12:30- 13:30pm	**LUNCH**
13:30- 14:00pm	Malawi's Maternal and Child Health Policies: Analysis, Lessons & Strategies for addressing gaps **(Judith Daire)**
14:00-15:00	Plenary/ Discussion & Way forward
	Departure

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8.18 Appendix T: International Conference Presentations

Abstract A

Title: Malawi's Maternal and Child Health (MCH) Policies: Review, Lessons and Strategies For Addressing Gaps

Presented at: The 2008 International Conference "Healthy People For A Healthy World" June 25-27, 2008. Hosted by Mahidol University, Bangkok, Thailand

Purpose of the study
Health indicators in Malawi have remained poor despite the substantial inputs that have been invested in the health sector over the past three decades, of which one is maternal mortality rate. Studies and the evaluations of maternal health in Malawi have mainly concentrated on service delivery (implementation and outcomes) aspect. However, improvement of health has a basis from effective health policy process of which implementation and outcomes are components of the wider perspective, hence the need to review maternal health policies in Malawi

Methods
The study was based on secondary data collected through reviewing of official documents (maternal and child health policies) from 1964 to 2007. The policies were analysed in terms of the policy content, context, process and actors (stakeholders)

Results
MCH has been a priority in all the policies and there is a progressive shift from MCH to MNCH and RH agenda. The study found out that MCH policy development in Malawi is mainly driven by donors, politicians and Government officials. Health policy process in Malawi is not structured and therefore does not provide opportunities for stakeholders' involvement. In addition, the process is initiated from top to bottom, not provider or community initiated and is uncoordinated and mostly donor driven. Furthermore, MCH policies do not have plans for implementation, monitoring and evaluation.

Conclusions
The study recommends that MCH policy process should be country led process as such the Ministry of Health should involve health providers and beneficiaries of MCH as local partners to ensure ownership and acceptability of MCH programmes through strategies like;

- Service providers should have means of informing policy developments for ownership and commitment to implement it
- Communities be mobilised into discussion groups to inform policies.
- Existing operational plans should be followed and Government should ensure the partners participate within existing coordination mechanism.
- MNCH policies should be country demanded, local partners coordinated and their support should be mainstreamed into the existing plans
- Plans for implementation, monitoring and evaluation should be planned and budgeted for as well as included in policy document to ensure commitment.

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Abstract B

Title: Malawi's maternal and child health policies: analysis, lessons and strategies for addressing gaps Abstract (Research Proposal)

Presented at: Western cape Nursing Research Forum, Division of Nursing and Midwifery in collaboration with Groote Schuur Hospital Nursing Division and Red Cross War Memorial Children's Hospital, Friday 22 August 2008

Aims and objectives

The aim of the study was to analyze maternal and child health policies in Malawi. In addition, the study aims to explore lessons and strategies to addressing gaps in MCH policy development and implementation in Malawi.

Methodology

Qualitative research methodology will be employed and the study will use evaluative research and multiple case studies as research designs.

Methods of data collection

Data will be collected through official document review, self administered questionnaires and interviews. In addition, field visits to health facilities will be conducted for the researcher to observe implementation of MCH services in Malawi.

Data analysis

Analysis of data from official document review, self administered questionnaires and interviews will be done separately. Then findings from the three data sources will be triangulated to validate and cross-check findings. Qualitative data will be analysed using a computer package called "STATISTICA 7" to conduct a basic descriptive statistical analysis of closed-ended question responses. Qualitative data analysis will use content analysis approach and "NVivo 7"qualitative data analysis computer package will be used to facilitate coding and identification of categories and themes from the data.

Benefits and expected outcomes.

The study will recommend strategies for addressing gaps in MCH policy development and implementation in Malawi. This is envisaged to improve MCH services in Malawi and health of mothers and children through effective policy formulation and implementation. The study findings will be presented to the MOH as a report and a workshop will be conducted to share the results. Further to that, at least five articles based on the study will be published in peer- reviewed journals. The results will be presented at international conferences. Finally, the study will be presented as a PhD thesis to the University of Cape Town in South Africa.

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Abstract C

Title: A Review of Malawi's Maternal and Child Health Policy Process: Strategies for Involving Stakeholders in Policy Development

Presented at: NET2008 CONFERENCE: 19th Annual International Participative Conference, Churchill College: University of Cambridge, CB3 0DS, United Kingdom. Tuesday 2-Thursday 4 September 2008

Introduction:

The progress of improving maternal and child health is not making progress as it should despite existing Maternal and Child Health (MCH) policies and programmes since independence in Malawi. For example, maternal mortality rate doubled from 1992 to 2002 (from 620 to 11120 per 100,000 live births) and still remains high to this date (984/100 000 live births). In addition, for the past 15 years (1990-2005) infant and under- five mortality rates decreased at a slow rate. The estimates indicate Infant Mortality Rate declined by 30 percent (from 104 to 76 per 1,000 live births) and Under Five Mortality Rate declined by 27 percent (from 190 to 133 per 1,000 live births). This indicates that existing MCH policies seem not to be impacting mothers and children's health as expected despite MCH being a priority health issue in the country. *On the other hand, the process of existing MCH policies in Malawi since has not been clear.* The Ministry of Health planning unit is supposed to be the policy development department of the MOH. However, the practice is characterised by uncoordinated policy formulation often at the influence of donors. This study therefore aims to analyse maternal and child health policy process in Malawi and recommend strategies for involving stakeholders in policy development in Malawi.

Methodology

The analysis of Malawi's maternal and child health policies cover the period 1964 to 2007. It focussed on policy content, process, context and stakeholders to identify lessons, gaps and strategies for stakeholders in policy development. The study was based on secondary data collected through reviewing of official documents (Maternal and Child Health policies) from 1964 to 2008. The policies were analysed in terms of the policy content, context, process and actors (stakeholders). This is the first phase of data collection for a PhD study. The policies' content was analysed according to the objectives and the data was reduced into themes addressing each of the objectives.

Findings

MCH has been a priority in all the policies and there is a progressive shift from MCH to MNCH and RH agenda. The study found out that MCH policy development in Malawi is mainly driven by donors, politicians and Government officials. Health policy processes in Malawi are not structured and therefore does not provide opportunities for stakeholders' involvement. In addition, the process is initiated from top to bottom not provider or community initiated and it is uncoordinated and mostly donor driven.

Lessons

Although policy is driven by donors, politicians and Government officials, it affects service provision since it impacts and influences the local structures. For example, current policies determine resource allocation which has a direct impact on the accessibility and availability of a service. Whilst acknowledging that the direction of the National policy as being appropriate, MCH remains high on the list of unfinished agenda in Malawi. The shortcomings alluded to need to be addressed by structuring a policy process that provides opportunities for involvement of target groups, service providers and **educational institutions**. In addition, efforts should be made to include greater use of evidence based policy. MCH policies unless informed by evidence and participation of interested groups are

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unlikely to address gaps in MCH programmes late alone improve the health of mothers and children.

Recommendations

- Opportunities are available for involving members of **educational institutions** through technical working groups, research, policy reviews/evaluation and impact assessment. The Ministry of Health should therefore involve members of **educational institutions** through existing opportunities
- MCH policy process should be a country led process as such Ministry of Health should involve health providers and beneficiaries of MCH as local partners to ensure acceptability of MCH programmes through strategies like
    - **Service providers should have means of informing policy development for ownership and commitment to implement it.**
    - **Communities be mobilised into discussion groups to inform policies**
    - Existing operational plans should be followed and Government should ensure the partners participate within existing coordination mechanisms.
    - MNCH policies should be country demanded. Local partners coordinated and their support should be mainstreamed into the existing plans

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Abstract D

Title: Malawi's maternal and child health policies: analysis and strategies for addressing implementation challenges

Presented at: International Conference: Health and the Changing world, November 11-13, 2008. Praboromarajchanokk Institute and Ministry of Public Health, Bangkok, Thailand

ABSTRACT

Since independence, substantial resource inputs have been invested in the health sector over the past three decades, nevertheless health indicators in Malawi have remained poor. Maternal mortality rate (MMR) doubled from 620 to 1120/ 100 00 from 1992 to 2000, as of 2004 maternal mortality rate was estimated to be 984/100 000 which is still high. In addition, there has been a slow progress in improving infant and child health during the 15-year period of 1990 to 2005. The estimates indicate that under-five mortality declined by 30 percent and infant mortality declined by 27 percent. The persistent poor MCH indicators in Malawi clearly indicate need for strategies for improving MCH in Malawi starting from policy development to implementation.

The aim of this study was to analyze MCH policy implementation process with specific objectives of exploring the experiences of health care personnel and NGOs providing MCH programmes in Malawi; determining types of constraints and problems encountered by organisations implementing MCH programmes in Malawi; and examining the relationship between Government resources, policies, and actual MCH implementation in Malawi. The study employed a qualitative research methodology using evaluative research and multiples cases research designs. Data was collected through questionnaires, interviews and observation. The study used STATISTICA 7 computer package for analyzing basic statistical data and content analysis for analyzing qualitative data. The study found out that, challenges of MCH policy implementation are based on inadequate resources (financial, human, health facilities, drugs medical supplies). This study therefore recommends that as health systems are going through a transformation/health sector reforms in a bid to improve health systems' effectiveness and quality of healthcare delivery, the basics in strengthening the health system should not be forgotten.

University of Cape Town

Abstract E

Title: PMTCT in policy context: policy analysis, lessons and strategies for addressing gaps

Accepted to be presented at: The 5th IAS International Conference on HIV pathogenesis, Treatment and Prevention, 19-22 July 2009. International Aids Society, Cape Town, South Africa (poster presentation).

Introduction: The progress of improving maternal and child health is not making progress as it should despite existing Maternal and Child Health (MCH) policies and programmes since independence in Malawi. Maternal and child mortality rates still remain high to this date. One of the contributing factors is HIV/AIDS which is both direct and indirect cause of mortality and morbidity. This abstract is part of a study for a PhD thesis on Malawi's maternal and child health policies: analysis, lessons and strategies for addressing gaps.

Objective: The aim of the study was to analyze HIV/AIDS policies in Malawi, in order to identify lessons, gaps and strategies for addressing gaps in PMTC programme.

Method: The study employed a qualitative approach and triangulated evaluation, case study and ground theory research designs. Data was collected through official document review, questionnaires and key informant interviews. Data from each data source was analyzed separately through content analysis. Findings from each data collection method were triangulated to validate the results and field visits were also conducted to observe MCH services in health facilities.

Results obtained: PMTCT services are heavily dependent on international donors who provide both financial and technical assistance in Malawi and there are no mechanisms yet for mobilizing resources locally to sustain expanding PMTCT programmes. PMTCT programmes are implemented using the existing staff, infrastructure and equipment. There are problems of persistent inadequate human resources; medical supplies and drugs; and inadequate and poor infrastructure that are constraining achievement of health outcomes in the health system as a whole. The same problems affecting the health system in Malawi also affect PMTCT services in terms of availability, accessibility and quality of PMTC services. On the other hand HIV policies are formulated by Government official through various technical working groups. This has made the **p**olicy development process to be dominated by to-down approach which does not include implementers. Further to that, HIV/AIDS National policies are not translated to operational policies at implementation level i.e. District Hospitals, which makes managers and staff not to be committed. Furthermore, district level management is not evidence based/result based i.e. district level managers do not use local data from HMIS for planning, monitoring and evaluation.

Conclusion and recommendations: Technical and financial support from development partners have facilitated the progress in PMTCT Programmes. In addition to continued international funding, Malawi needs to establish mechanisms for sustaining the expanding response to PMTCT. In addition, strengthening the health system capacity as a whole by addressing problems of inadequate human resources; inadequate medical supplies and equipment; and inadequate and poor infrastructure will also improve PMTC services. Further to that, MOH should emphasize translation of National policies to operational policies and result/evidence based management at district level to promote ownership and commitment to services. Additionally, there is need for an established system for implementers to inform National policies. Finally, improving accessibility and quality of health and MCH services in general both at policy development and implementation level will also improve PMTCT services.

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Abstract F

Title: Shortage of human resource in the context of Maternal and child health (MCH) policies in Malawi: analysis and retention strategies to ensure an effective workforce

Accepted to be presented at: The Third EQUINET Regional Conference on Equity in Health in East and Southern Africa; Speke Conference Centre, Munyonyo, Kampala, Uganda. September 23-25, 2009

Background: The Government of Malawi in general and the Ministry of Health in particular is challenged by an acute shortage of skilled personnel.

: The study aimed at exploring lessons and gaps in MCH policy implementation in Malawi by investigating types of constraints encountered at Government and private health facilities in implementing MCH policies.

Methodology: Qualitative approach was deployed for the study and data was collected through official document review (MCH Government policies), self-administered questionnaires, and interviews. Study participants were drawn from public health facilities and whilst key informants were drawn from MoH National Headquarters; local and international NGOs; and the private sector. Analysis of data used content analysis approach to identify pre-corded categories and themes from the data. Data from each data source was analysed separately and then triangulated.

Results: Results from review of official policy documents showed that shortage of human resource is one of the constraints encountered in both public and private health sector in Malawi. Responses from questionnaires and interviews indicated that the Government and its donor partners are implementing strategies for addressing shortage of human resource in the health sector. For example, giving top up salaries for professional health workers, increasing enrolment in training institutions. However responses from questionnaires and interview also revealed that the Government is training more staff but it is failing to retain them within the public sector. Information from interview responses indicated that most of the health workers are within the country but working in private sector, training institutions and in NGOs. Reasons cited for health workers leaving the Government included poor human resource management i.e. no reward for hard working and no supportive supervision; and poor working conditions i.e. low pay, poor infrastructure, workload and lack of resources. On the other hand the study found out that some of the strategies for dealing with shortage of staff further deplete the health systems workforce and compromise the quality and equitable access to health services. For example, task shifting has resulted in unqualified staff performing critical clinical procedures worse still without training and supervision.

Conclusion: It is a well known fact that providing maternal and child health care requires a viable and effective health workforce, yet the numbers of health workers still remain inadequate across all the levels of the health system in Malawi. Although the Government is training a lot of health workers, it is still failing to retain them within the public health sector. The study recommends that apart from taking urgent corrective action on salaries and increasing training capacity of health professional workers, conditions to ensure effective workforce in the health sector, strategic decisions must be made in three areas: training, deployment, and retention of health workers. Even though retention strategies seem to be of low priority, they can attract health workers from the private to public sector as well as further reduce brain drain from public to private. The study further recommends that in addition to staff salary and benefits retention strategies should also look at effective human resources management systems and styles, work environment and provision of resources to work with. Furthermore, retention strategies for health professional workers should also be applied to non health professional workers who support health workers in delivery healthcare to the population.

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8.18 Appendix V: Journal Articles Submitted for Publications

Article 1

Authors: Daire, J and Khalil, D.

Title: Conceptual framework for health policy analysis in LMIC: the case of MCH policies in Malawi.

Journal: Journal of Health Politics, Policy and Law (submission ref: JHPPL-A-1000308)

Abstract

Substantial literature shows that less attention has been given to how to do health policy analysis in LMIC both from the methodological and conceptual perspectives. This article describes a case study in which a theoretical conceptual framework for analyzing health policies was adapted for a study which analyzed Maternal and Child Health (MCH) policies in Malawi. The framework for analyzing MCH policies in Malawi was based on theoretical models of public policy development and analysis from literature. An adapted conceptual framework guided data collection, analysis and presentation of findings. However the challenge was that analysis of health policy study is broad and there is limited literature on conceptual frameworks. The paper concludes that the field of health policy analysis in developing countries would be advanced if researchers approached it more systematically within explicit frameworks. Finally the paper recommends that health policy research calls for more critical application of existing frameworks and theories of public policy development and analysis to inform and guide data collection, data analysis and presentation of findings in health policy studies.

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Article 2

Authors: Daire, J and Khalil, D

Title: Application of qualitative research approach in health policy analysis: the case of MCH policies in Malawi.

Journal: Nurse Researcher: The International Journal of Research Methodology in Nursing and Healthcare (Submission re: NR130)

Abstract

The article reports on how qualitative research approach was applied for analyzing Maternal and Child Health policies in Malawi. Qualitative research methodology was employed and the study triangulated evaluation, multiple case studies and grounded theory research designs. Data was collected through documents review, self-administered questionnaire and key informant interview. In addition field visits to health facilities was conducted to validate information collected through the three methods of data collection. Purposive sampling technique was applied for selecting health facilities, study participants and key informants. Analysis of data from each data source was done separately and triangulated to compare consistency of data collected. The article concludes that the multidimensional nature of MCH policies like any other health policies calls for a combination of research designs as well as methods of data collection and analysis.

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Article 3

Authors: Daire, J and Khalil, D

Title: Analysis of Maternal and Child Health Policies in Malawi and strategies for addressing implementation challenges

Journal: Health Policy and Planning (Submission ref: HEAPOL – 2009 – June -0029

Abstract

The aim of this study was to analyze MCH policy implementation process with specific objectives of exploring the experiences of health care personnel and NGOs providing MCH programmes in Malawi; determining types of constraints and problems encountered by organisations implementing MCH programmes in Malawi; and examining the relationship between government resources, policies, and actual MCH implementation in Malawi. The study employed a qualitative research methodology using evaluative research and multiples cases research designs. Data was collected through questionnaires, interviews and observation. The study used STATISTICA 7 computer package for analyzing basic statistical data and content analysis for analyzing qualitative data. The study found out that, challenges of MCH policy implementation are based on inadequate resources (financial, human, health facilities, drugs medical supplies). This study therefore recommends that as health systems are going through a transformation (health sector reforms) in a bid to improve health systems' effectiveness and quality of healthcare delivery, the basics in strengthening the health system should not be forgotten.

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