4.2 Human Capital Development

Human capital is key to poverty reduction in Malawi. A healthy and educated nation leads to increased productivity, better income distribution and a generally improved standard of living. A deteriorating health situation will undermine the ability of individuals to lift themselves out of poverty and will lead to a general decline in productivity. Similarly, an uneducated population does not understand and appreciate better the need and means for achieving higher incomes, reducing infant mortality and population growth as well as improving nutrition and health. Functionally, the major economic sectors of agriculture and industry demand an educated, skilled and healthy workforce to take on the new challenges and aspirations of the sectors. At the same time, with appropriate human capital, the public and private sectors, civil society and poor people themselves would be able to positively influence and impact on processes and outcomes of the entire poverty reduction strategy.

Statistics show that there is much room for improvement on human capital in Malawi. The national illiteracy rate stands at 42 percent[19] due to problems of access to and quality of education. There is also lack of skills development due to inappropriate education curricula at all levels and low access and intake into technical, entrepreneurial and vocational training institutions. In terms of health, life expectancy at birth has reduced from 43 years[20] in 1996 to 39 years in 2000 mainly due to the HIV/AIDS epidemic. Malnutrition is also high among children resulting into about half of all the children being stunted and 30 percent underweight.

In order to address these problems, this pillar has four goals, ensuring the development of human capital through implementation of education, technical, vocational and entrepreneurial education and training (TEVET), health, and nutrition programmes.

4.2.1 Education

Education yields broad social and economic benefits. Not only is education positively associated with agricultural productivity, higher incomes, lower fertility rates and improved nutrition and health, it is also a prerequisite for attaining these outcomes. Hence, education is the centrepiece for the poverty reduction strategy. In particular, basic education will be accorded highest priority in the MPRS. It is recognised, however, that this is not a sufficient

[19] According to the MDHS 2000
[20] According to MDHS 2000

condition for an individual to escape poverty. Sustainable national development also requires the development of secondary, higher and pre-school education.

Poverty reduction through education in Malawi is faced with a number of challenges as some indicators testify. On a positive note, the introduction of Free Primary Education (FPE) in 1994 led to an increase in enrolment from 1.9 million (1993/94) to 2.9 million children (1994/5). This led to an increase in the gross enrolment rate to 132 and the net enrolment rate of 78[21] by 1999. However, the challenges in primary education include dealing with the large numbers of over-aged pupils resulting in high repetition rates.[22] Moreover, this increase in the quantity of primary education has been offset by a decline in quality. For example, there is a serious shortage of teaching and learning materials such as textbooks; the pupil to qualified teacher ratio is high at 118 and the pupil to classroom ratio is high at 95. The national target for the latter two ratios is 60.

Partly as a result of the above problems of quality, retention of children in school is low, especially among poorer households and females. At present, it is estimated that only 30 percent of children who start primary school complete Standard 8[23]. There have also been significant problems of access to basic education for children with special needs, as the necessary enabling environment and infrastructure has been inadequate.

At the secondary level, access is still very limited, with a gross enrolment ratio of 18 percent. Access is also highly unequal, particularly affecting children from low-income families and girls. The latter account for only around 37 percent of gross enrolment (1999). The quality of secondary education is also inadequate and unequal, as demonstrated by poor examination results and the disparities between Conventional Secondary Schools (CSSs) and Community Day Secondary Schools (CDSSs). This is in part caused by the crowding out of quality inputs (such as enough qualified teachers, teaching and learning materials) by expenditures on boarding and administration[24].

Access to higher education in Malawi remains low, with fewer than 4000 places available. Females occupy less than 30 percent of the places. Enrolment is limited by inadequate school

[21] For definition of GER and NER, see Glossary
[22] See Chapter 2 on Poverty Profile
[23] Government of Malawi – Public Expenditure Review 2000, pg. 7
[24] ibid. pg. 8

places, boarding facilities and financial resources. As a result, capacity in terms of physical infrastructure and human resources, is frequently under-utilised. Furthermore, the limited financial resources received are used inefficiently by the University of Malawi, which spends more than half of its resources on boarding and administration[25], yet student to staff ratios remain very high. In addition, the quality of higher education has been undermined by poor linkages to industry in the curriculum and frequent closures of colleges due to the high burden on Government resources.

In light of the positive link between education and poverty reduction, there is a clear need to increase access to and improve the quality of education *at all levels.* To achieve this, there are five main objectives applicable at each level: (1) improve quality and relevance of education; (2) increase access and equity in education, focusing on special needs and girls; (3) strengthen management, planning and finance; (4) respond to HIV/AIDS pandemic; (5) strengthen co-ordination across all players in the education sector, both public and private.

4.2.1.1 Basic Education

In the context of basic education, the objectives are as follows:

1. Improve the quality and relevance of primary education

Improving the quality and relevance of primary education involves four main strategies: teacher recruitment, training and incentives, development of relevant curriculum, teaching and learning materials and supervision and inspection.

In terms of teacher recruitment, training and incentives, Government will improve Teacher Training College facilities to enable the recruitment and training of more primary teachers. In addition, existing unqualified teachers will be provided with initial training and qualified teachers' skills will be upgraded using in-service training (INSET). Moreover, the Teacher Development Unit will be upgraded and further strengthened. Finally, Government will revise teachers' remuneration packages, to ensure retention of teachers, particularly in rural areas.

In order to improve the quality and relevance of education, the teacher and basic education curricula will be revised so that they meet the needs of pupils, potential employers and the

[25] ibid. pg. 100

nation. Students should be offered a curriculum that will equip them with knowledge of life skills, such as technical, entrepreneurial, and agricultural skills. Maintaining quality will also depend on government ensuring that all pupils have access to an adequate supply of instruction materials. This will require a change in management and planning such that the distribution of education materials will be decentralised to a zone based system.

Finally, Government will promote a well-coordinated and more effective supervision and inspection service. Schools will have to meet both instruction and physical infrastructure standards. This will involve training of school communities in community based management, verifying adequacy of pit latrines and safe water points, increasing the Primary Education Advisors (PEAs) to teacher ratio and increasing the number of advisory visits per term.

Table 4.2.1: Selected Basic Education Quality Targets

Indicator	Current Situation (1999)	Target 2004/5
Number of teachers	45,784	51,323
Teacher Trainee graduates	6,317	34,023
Pupil to teacher ratio	118	85
Teacher to school inspector ratio	145	81
Number of boreholes	242	500
Number of pit latrines	3,000	15,000

2. Improve access and equity at the primary level, focusing on special needs education and girls.

Basic education for children with special needs (the visually and hearing impaired, those with learning difficulties and the physically challenged, to name some of the categories) has much room for improvement in Malawi. The current enrolment level of children with special needs is only 5 percent. Special needs education suffers from inadequate learning centres, non user-friendly infrastructure, lack of learning materials and inadequate specialist teachers. In terms of infrastructure, there are currently 15 resource centres for the visually impaired and only 4 centres for the hearing impaired at primary level.

The strategies to improve access, quality and relevance of basic education for children with special needs will involve the establishment of adequate learning centres with adequate accommodation, recruitment and training of specialist teachers, development of relevant curricula for teacher training, procurement of learning materials and equipment and introduction of a bursary scheme for these students. Special needs students will be integrated into conventional schools.

In addition to promotion of special needs education, equitable access will also require social mobilization campaigns which target orphans, those affected by HIV/AIDS, girls and out of school youths.

Table 4.2.2: Selected Primary Education Access Targets

Indicator	Current Situation (1999)	Target 2004/5
Number of new classrooms (cumulative)	1,000	5000
Number of classrooms rehabilitated	-	6,500
Female enrolment	1.4 million	1.5 million
Percent of female enrolment	48 percent	50 percent
Total special needs enrolment	6,745	6,745

3. Increase and improve functional adult literacy and numeracy.

To achieve increased and improved adult literacy Government will revise the adult literacy policy and curriculum, train 24,000 literacy instructors (including primary school teachers) and print and distribute adequate adult literacy teaching and learning materials. Efforts will also be made to open up more Rural Instruction Centres (RICs) in existing communities for adult literacy.

Table 4.2.3: Selected Adult Literacy Education Targets

Indicator	Current Situation (1999)	Target 2004/5
Number of adults enrolled	37,500	300,000
Number of centres	2,500	24,000
Number of instructors	2,000	24,000

4. Provide special education for the out of school youth

The objective will be achieved through the development of multi-purpose youth centres, equipped with appropriate learning materials to impart vocational and technical skills. There will also be a strengthening of out of school youth clubs, lead by trained youth patrons, where it is envisaged that youths will gather to exchange ideas.

5. Expand pre-school education/Early Childhood Development (ECD)

It is important that an adequate supply of motivated new care givers are provided and trained, including training of existing ECD teachers. There will then be a need to identify ECD centres and to construct new ones, where appropriate. Efforts will also be made to provide adequate learning materials and communities will be encouraged to contribute locally made materials.

6. Respond urgently to problems created by the HIV/AIDS epidemic

The HIV/AIDS pandemic has adversely affected the education sector. The toll through loss of teachers and the related burden of welfare costs erodes the resources provided for the sector. So far there has been no coordinated and consolidated effort to fight the disease.

In order to deal with HIV/AIDS in the education sector, Government will implement a sector-specific strategic plan on HIV/AIDS, involving prevention and mitigation among teachers and pupils. In addition, HIV/AIDS education will be imparted to the youth through the media and youth clubs.

7. Decentralise administrative and planning responsibilities

Decentralisation will be the major driving force in strengthening efficiency and accountability of resources and results. Basic education will be made accountable to local level authorities with development and operational responsibilities transferred from central government to the districts. In addition, teacher training and institutions will be decentralised by making them independent coast centres and by reducing central controls. Further strategies include the strengthening of monitoring and evaluation systems so that data collection and analysis is carried out in order to make informed decisions, through the establishment of an Education Management Information System (EMIS).

4.2.1.2 Secondary School Education

Whilst basic education is the minimum necessary for an individual to escape poverty, secondary education is also necessary for equipping students with the skills required for private and public sector employment. Moreover, secondary education is expected to enhance entrepreneurial skill and business management, capabilities which are important for self-employment. In addition, secondary education encourages further studying.

The objectives of secondary education will be as follows:

1. Increase access and equity to secondary schools

There are two aspects to access and equity issues in secondary education: firstly, increasing access to secondary education for girls, children from poor families and children with special needs and secondly, increasing the total number of secondary school places to absorb the increasing number of primary school graduates.

In order to increase access for girls, children from poor families and those with special needs, a combination of bursary schemes and more secondary school places is needed. Further, school blocks will be made user-friendly for students with special needs.

In terms of general access, Government will introduce double shifting to improve efficient utilisation of existing infrastructure, provide distance learning and build new school blocks.

2. Improve quality and relevance of secondary education

This objective involves eight key strategies: (i) upgrading facilities and equipment; (ii) curriculum development, (iii) teacher recruitment, (iv) training and remuneration, and (iv) increased teaching and learning materials

The upgrading of facilities and equipment will focus on bringing Community Day Secondary Schools (CDSSs), to which the poor have more access, up to the standards of Conventional Secondary Schools (CSSs). In addition, Government will ensure that there are adequate resources for the maintenance and rehabilitation of existing infrastructure, much of which is in a state of disrepair. Initially, only minimum standards will be enforced.

In order to improve the relevance of education, the teacher and secondary education curricula will be revised so that they meet the needs of students, potential employers and the nation. Students should be offered a curriculum that will equip them with knowledge of life skills, such as technical, entrepreneurial, and agricultural skills. The curricula will be reviewed every ten years to ensure it is up-to-date. Finally, there will be periodic reviews of the examination system to improve efficiency and effectiveness.

Quality secondary school education also depends on the recruitment, training and retention of teachers. This will involve instituting a rigorous programme of teacher education in all higher education institutions, both public and private. Non-residential training will also be introduced and subject specialisation encouraged. Various refresher courses will be undertaken for teachers. These actions, in combination with a revision of remuneration packages, will create an environment conducive to teacher retention.

Finally, Government will ensure an adequate supply of teaching and learning materials. This will involve the strengthening of textbook revolving funds and the introduction of cost sharing, in conjunction with the bursaries mentioned above.

Table 4.2.4: Selected Secondary School Targets

Indicator	Current Situation (1999)	Target 2004/5
Number of students	236,500	324,031
Number of private students	16,555	64,806
Number of students entering MCDE	-	11,550
Number of teachers	5,269	11,000
Female gross enrolment	19%	25%
Schools teaching information and communication technology	8	100

3. Improve management and administration of secondary education

Efforts will be made to improve the efficiency and effectiveness of secondary education by decentralising responsibilities, strengthening managerial capacity at district and school level, and rationalising the use of resources. This rationalisation will involve phasing out or introducing cost recovery for non-core services, such as boarding, and ensuring that human and financial resources are allocated according to needs. This, in turn, will require ensuring the Education Management Information System (EMIS) covers the secondary system.

4.2.1.3 Higher Education

The MPRS will transform the higher education system to respond to new realities and opportunities within the context of poverty reduction. The sector will increase the participation rate for both men and women to meet the demand for highly trained graduates in different fields taking into account labour market and poverty reduction needs. The sector will strive to advance high-level capacity through the expansion of post-graduate training to support scientific and technological improvement and social development.

The main focus of the MPRS will be on improving efficiency and quality education measured by increased access of females, males and disadvantaged students in higher education, reduced unit costs, production of highly qualified graduates and less dependency on subvention through cost recovery and decentralization. The sector will also focus on increasing motivation of teaching and research staff.

1. Increase access and equity in higher education

The first strategy is to ensure full capacity utilisation of facilities including the introduction of double shifting and distance learning. The University Education Act will be reviewed to accommodate private sector initiatives.

In order to increase equity, about 30 percent of intake will be reserved for girls and this proportion will be increased to 50 percent by the year 2012. In the context of increasing user fees discussed below, scholarship schemes will be introduced for girls and needy students and loan schemes will be strengthened for other students.

2. Improve quality and relevance of higher education

Higher education institutions will introduce programmes in non-traditional subjects such as science and technology, gender, food security, human rights, biodiversity and HIV/AIDS, among others. This will involve the establishment of adequate research centres that would be addressing emergent development issues, providing grants to graduate students so that they participate in teaching undergraduate courses and as research assistants.

The second strategy is to increase the motivation of teaching and research staff, by reviewing salary packages and encouraging privately funded research. The private sector will also be encouraged to participate in the definition of subjects, curricula and research and to give visiting lectures and classes so as to improve the relevance of higher education.

3. Reduce reliance of higher education on subventions

Reducing the reliance of higher education on Government subventions involves two types of interventions: firstly, reducing costs of provision of higher education and secondly, generating alternative sources of resources. In order to reduce costs, non-core services such as catering and boarding will be commercialised and contracted out. Further, administrative staffing levels will be reduced and administration decentralised to constituent colleges of the University of Malawi. As a result, the role of the central University of Malawi Office will be reviewed so that staffing and costs are substantially reduced.

In order to generate alternative resources, the University will introduce cost recovery for non-core services, such as boarding, and will increase cost sharing for tuition, both in the context of strengthened scholarship and loan schemes. Institutions will create business development

units to generate resources by charging for the use of existing facilities and for collaborative programmes outside school sessions.

Table 4.2.5: Selected Higher Education Targets

Indicator	Current Situation (1999)	Target 2004/5
Number of students	3,526	6,824
Students in private colleges	35	1,100
Number of distant learners	0	558
Number of female students	698	2,047
Number of needy students	500	1,706
Females in non-traditional subjects	225	801
Number of students with disabilities	20	30
Number of students in information technology	821	1,500

4.2.2 Technical, Entrepreneurial Vocational Education and Training

According to the labour market survey of 1998, about 300,000 people leave the formal education system every year. However, only 30,000 enter formal employment annually. This leaves 270,000 people who enter the labour market annually and seek some other source of income other than wage employment and therefore it is this number of people who can be helped through skills training. These figures indicate that technical, entrepreneurial vocational education and training (TEVET) needs to cut across all levels of education for people to become active players in poverty reduction. This will require development of relevant competence based curricula at primary, secondary and post-secondary levels as well as the development and acquisition of appropriate teaching and learning materials and equipment. In addition, qualified teachers will be necessary to impart the vocational and technical skills.

The existing TEVET system has failed to satisfactorily meet the potential demand for a number of reasons. In terms of providing places, the current annual capacity within the public technical colleges is 1,441 and within private provider institutions is 18,000. These capacities are not adequate to cater for prospective entrants into the TEVET system. The focus on formal, full-time residential training, particularly in public technical colleges, has undermined the possibilities of achieving better coverage and outreach, and at the same time, has taken attention away from the potential offered by more flexible, demand-driven training, such as that provided by the Malawi Entrepreneurship Development Institute (MEDI). Demand for places has also been limited by a number of factors. Firstly, lack of basic education, high illiteracy and lack of knowledge, exposure and information pertaining to the

provision of vocational training. Secondly, cultural factors have led to lack of exposure to the prospective subsistence and carrier opportunities. Thirdly, lack of access to funds catering for tuition fees, boarding fees, transport and utilities. Finally, limited recognition of vocational skills has led to poor investment in human resources and infrastructure.

It is therefore envisaged that the MPRS will address some of these problems. To achieve this, the following strategies will be implemented:

1. Promote self employment through skills development initiatives

The MPRS will empower the poor in the informal sector through establishment of skills development initiatives in the rural areas. Government will expand and increase outreach and coverage of TEVET programmes through mobile village polytechnics[26] in all districts. This will involve establishing and running polytechnics, mounting and running mobile training units, and linking decentralised units to designated resource colleges in catchment areas.

Further, skills development will involve implementing on the job training programs in specific occupations for the youth in collaboration with MASAF and other stakeholders, conducting demand-driven specialised skills training programmes, and training of trainers for entrepreneurship development in the informal sector.

Youth specific skills development will be achieved through developing multipurpose youth centres and providing resource and educational information, training youth patrons and leaders and providing actual vocational training.

2. Improve quality and relevance of TEVET

The relevance and quality of TEVET will be improved by reviewing, developing and implementing competency-based curricula. This will involve revising all existing curricula in primary and secondary schools and within the TEVET sector, developing new curricula within all occupations (including HIV/AIDS prevention messages and the use of appropriate technologies), and training teachers in using new curricula.

The quality of TEVET will also rely on the development of appropriate and sufficient human capacity by establishing a flexible and cost effective technical teacher training system.

[26] Village polytechnics involve setting up simple structures at EPA level to train people in specialised skills they require in that area

3. Rehabilitate existing infrastructure and equipment

The MPRS will ensure sustainability and quality standards by promoting maintenance and effective operation of equipment in education institutions and other training colleges. Strategies include taking stock of existing equipment and assessing needs within public technical colleges, training staff from public colleges and private providers in preventive and corrective maintenance, and rehabilitating classrooms, workshops and existing public colleges.

4. Strengthen management and financing of TEVET

Government will strengthen the partnership between the public and private sector, and take measures to improve compliance with the TEVET Levy.

Table. 4.2.6 – Vocational Training Targets

Indicator	Current Situation (1999)	Target 2004/5
Public training capacity % of population	0.01%	0.03%
Public vocational training % of districts	21.43%	28%
Private training capacity % of population	0.18%	0.20%
Private vocational training of districts	75%	78%
Enrolment ratio female	20%	26%
Enrolment ratio male	80%	74%
HIV infection rate students	15%	13.5%
HIV infection rate teachers	15%	14.2%
Boarding Capacity (% of training capacity	22.7%	20.5%

4.2.3 Health and Population

The health of an individual is directly related to economic and social well-being. An improved health situation will strengthen the ability of individuals to lift themselves out of poverty and will lead to a general increase in productivity. However, as described in Chapter 2 and Table 4.2.8, health indicators in Malawi have remained poor despite a relative increase in resource allocation towards the sector over the past ten years.

Health interventions (both preventative and curative) take place at four levels:community, primary, secondary and tertiary. Preventative interventions are focussed on nutrition, sanitation and public information campaigns, for example on the use of mosquito nets. Preventative interventions relieve pressure on other levels of healthcare and are less costly to the poor. Community level healthcare is delivered through Health Surveillance Assistants (HSAs), some of whom manage Drug-Revolving Funds and Bakili Muluzi Health Initiatives in conjunction with Village Health Committees (VHCs). Primary healthcare is delivered through health centres and clinics, is aimed at improving maternal and child health and the

promotion of early treatment of common disease conditions. Secondary healthcare, delivered through the district hospitals, is aimed at treating more specialised conditions. Finally, tertiary healthcare, delivered through central hospitals, provides referral services for highly specialised conditions.

Table 4.2.7 Comparative Health Indicators

	Public Health Expenditure per capita (US$)	**Infant Mortality rate (per 1000 live births) 1999**	**Under-five mortality rate (per 1000 live births) 1999**	**Maternal mortality rate (per 100000 live births) 1999**	**Life expectancy at birth 1999**
Kenya	79	76	118	590	52.2
Malawi	36	132	211	620	40.7
Zambia	52	112	202	650	40.5
Zimbabwe	-	60	90	400	42.9
South Africa	623	54	69	-	56.7
Uganda	65	83	131	510	41.9
Mozambique	28	127	203	1100	40.6
Sub-Saharan Africa	-	107	172	-	48.8
OECD	-	13	15	-	76.4

Source: UNDP Human Development Report 2001, p.159-169

An overview of the health sector shows that the health system had been centralised with a lot of centrally designed and vertically managed projects, resulting in substantial duplication of effort, poor co-ordination and high administration costs. In addition, there has been inadequate support to private sector providers, such as the Christian Health Association of Malawi (CHAM) and certain NGOs.

A major problem leading to Malawi's poor health indicators is a lack of qualified and adequately compensated medical staff, in terms of doctors, nurses and related personnel. This problem is particularly acute in rural areas, and has been exacerbated by the HIV/AIDS pandemic and internal and external "brain drain" due to low remuneration and poor career prospects. This results in extremely high population per physician ratios, estimated at 45,737[27]. Furthermore, access to drugs is a problem, again particularly in rural areas. This is caused by a combination of low (but increasing) allocations to drugs, and distribution problems, including pilferage and inefficient allocation.

There is also an acute shortage of clinical and technical support services in most hospitals and health centres. These include laboratory services, pharmacy services, radiology, ambulance

services, district and regional-level blood bank, orthopaedics and physiotherapy. This is due to low investment in these facilities particularly in district hospitals. Technical support services play a crucial role in empowering persons with disabilities to undertake activities for daily living.

Referral bypass currently poses major challenges to the health sector. This is both a cause and a consequence of poor health facilities and services at primary level, particularly in rural areas. People seeking medical services avoid clinics, due to the poor quality of infrastructure and the shortage of medical workers, drugs and medical supplies. As a result, it is estimated that as many as 85 percent of central hospital admissions could be treated at lower-level facilities[28]. This concentration of cases at secondary and tertiary levels further draws resources away from primary facilities.

The primary healthcare system has suffered disproportionately from the general problems outlined above. In particular, it has suffered from a combination of high human resource demands in terms of Health Surveillance Assistants (HSAs), nurses and clinical officers, with low levels of financial resource allocations. In addition, physical access to health centres has remained poor, with only 3 percent of the population living in a village with a health centre. Existing health centres are in poor condition, and have an inadequate supply of drugs and medical supplies.

In addressing these problems, the overriding objective is the design and implementation of an Essential Healthcare Package (EHP). Essentially an EHP is a bundle of health services provided at primary and secondary levels, supported by the necessary administrative, logistics, and management systems. The EHP will address the major causes of morbidity and mortality among the general population and focuses particularly on medical conditions and service gaps that disproportionately affect the rural poor. In recognition that not all services can be provided to all people, an EHP can be seen as having a particular equity focus, through guaranteeing access to a minimum standard of health care for everyone. Thus an EHP is an explicit form of rationing, through identifying certain services as high priority. This is contrasted to the current implicit rationing of health services as witnessed through drug stock-outs, staff inavailability and long queues. The EHP development process provides an

[27] World Bank (2001) "Malawi Public Expenditures: Issues and Options", pg.37

opportunity to revisit the distribution of funding in order to determine whether the relatively scarce resources might achieve greater impact through a shift in their allocation.

Table 4.2.8 Conditions Addressed in the Proposed Malawian EHP

Disease Condition	Selection Criteria	Services
Malaria	1st cause of outpatient first attendance: 36.4% under-5; 28.8% 5 and over	IEC, including promotion of ITNs Vector control Diagnosis and treatment of simple malaria Referral
Acute respiratory infection and immunisable diseases	Upper respiratory infection 2nd cause of outpatient first attendance: 13.8% under-5; 11.5% 5 and over	BCG immunisation Polio, measles, DPT Diagnosis and treatment of ARI Referral
Acute diarrhoeal disease	Other diarrhoeal disease 3rd cause of outpatient first attendance: 8.8% under-5; 5.7% 5 and over	IEC Water and sanitation facilities at health centres Treatment of mild diarrhoea with ORS Case management of acute diarrhoea and cholera Referral
Nutritional conditions/deficiencies	49% stunting among under 5s, half of whom are severely stunted;	Provision of Vitamin A Provision of iodine Anaemia Deworming
Maternal conditions/pregnancy complications	Maternal mortality estimated between 600 and 1100 per 100,000 live births	Antenatal care Clean and safe delivery Postnatal care (tetanus injections) Family planning Referrals IEC
Sexually transmitted diseases, including HIV/AIDS		IEC Screening for syphilis, contact tracing, treatment VCT Treatment of opportunistic infections Condom promotion
Tuberculosis	Leading cause of inpatient mortality	IEC Screening, contact tracing, treatment Referral
Eye and ear infections		
Injuries		
Schistosomiasis		Vector control Treatment (mass)

Source: EHP Design Team

4.2.3.1 Preventative Healthcare

The key areas for preventative healthcare are nutrition, water and sanitation, and prevention of common diseases such as malaria. Issues of nutrition and water and sanitation are covered under separate sections in Pillar 2 and 1 respectively. Issues of common disease prevention

[28] ibid. p. 37

are covered under the EHP, as shown in Table 4.2.9 above, and described under the section on the EHP below.

4.2.3.2 Essential Healthcare Package (EHP)

The EHP covers issues of community, primary and secondary healthcare. EHP strategies are grouped under three main objectives: improving quality and availability of essential healthcare inputs, improving access to and equity of essential healthcare, and strengthening administration and financing of essential healthcare services.

1. Improving quality of essential healthcare

The first component of the EHP is to promote clinical human resource development. Human resources are an absolutely critical delivery input of the EHP implementation. This will involve ensuring that clinical teaching and training institutions are fully utilised and expanding the training of various clinical cadres like HSAs, nurses, medical assistants, clinical officers, and technical support services (such as radiographers, orthopaedic technicians and pharmacists). Government will also review the remuneration and career structures for medical staff in order to address problems of attrition through "brain drain".

The second component is to increase the availability of drugs and medical supplies. The drugs and medical supplies required in an EHP must be constantly present in health facilities, both in adequate quantities and of appropriate quality. To achieve the availability, there is need to ensure that: the procurement, logistical, management and information of drugs is reviewed so that all drugs procured reach the intended patients and are prescribed properly. There is also need to reform the Central Medical Stores to function efficiently. Only if these steps can be achieved, and current funding of drug levels used more efficiently should the drug budget be increased beyond current levels.

The third strategy is to expand and promote clinical and technical support services. This will involve expanding and promoting clinical and technical services by ensuring that certain services are present in district hospitals and health centres. These include; laboratory services, pharmacy services, radiology, ambulance services and district or regional-level blood bank.

2. Improving access to and equity of essential healthcare

Government will ensure increased access to healthcare facilities by rehabilitating existing infrastructure and increasing mobile health services. In particular, delivering the EHP at health centre level will depend on the existence of well-maintained health centres with fully functioning support systems, piped or bore-hole water supply, solar, stand by generator or ESCOM power and radio and telephone communication systems.

3. Strengthening management and financing of essential healthcare services.

The first strategy is to develop financial and managerial resources so as to strengthen planning, budgeting and transport management, particularly at a district level. This will involve training and retraining financial managers/accountants, administrators, senior nurses and matrons.

In order to improve the financing of essential healthcare, Government will develop and implement an integrated financing strategy for the EHP. Operational research will guide the decision as to whether the EHP will be free at the point of entry, or subject to user fees charges with an exemption mechanism for poor or targeted groups. Non-EHP services in government facilities will be financed through cost-recovery schemes (for example, mandatory user fee schemes) or health insurance coverage. The financing strategy is also likely to recommend voluntary user fees for core EHP services that have an additional comfort or practical element (such as private wards, better food, faster attention etc). This element will also be part of expanded health insurance coverage. This financing strategy will take full account of the fact that many Malawians can afford to contribute towards better health care: the National Health Accounts (2001) has shown that the richest 40 percent spent K822 million in 1999 to 2000 on health care.

The financing and management of essential healthcare services will also be strengthened through the development of a Sector Wide Approach (SWAp) in the health sector. The major role of the SWAp is to coordinate, strengthen and make more effective donor and government financing of the EHP. This will largely leave private sources of finance to develop the rest of the (non-EHP) health sector. In its early stages the SWAp will detail a joint vision of the donor and government funded component of the health sector, and describe a joint programme of work and monitoring systems.. In later stages, joint financial systems maybe developed and utilized, including the co-mingling of funds.

Finally, the ongoing decentralisation of the health sector, within the context of the broader devolution to the local government through district assemblies, will create the setting in which the EHP is to be delivered. One common objective of decentralisation is to take the planning of health services closer to the people they are intended to serve. If local involvement is to be meaningful, there should be flexibility for district managers, in consultation with health staff and community members, to "weight" resource allocation to the various components of the EHP according to local needs (e.g. less bilharzia or more malaria in specific districts).

4.2.3.3 Tertiary healthcare

In tertiary healthcare, the key challenges are to reduce referral bypass, to reduce crowding out of tertiary services by primary and secondary services. This will in large part rely on the improvements to primary and secondary healthcare at health centre and district hospital level outlined in the above section on the EHP. However, in addition, Government will strengthen the referral system and promote hospital autonomy.

1. Strengthen referral system

In order to ensure only genuine cases are referred to central hospitals, a strengthened formal referral system will be introduced, with unsubsidised outpatient fees for self-referral cases and civic education on the role of central hospitals.

2. Hospital autonomy

Government will autonomise central hospitals within 3 years. Once the hospitals attain full autonomy, they will be able to introduce cost recovery programmes, re-capitalise their facilities to compete with other providers for insurance of referral contracts. Further, the autonomised hospitals will be encouraged to contract out non-core services (such as catering, laundry and mortuary services) to the private sector and to improve the efficiency of resource allocations.

Table 4.2.9 Health Targets for 2007/8

Indicator	Current Situation (1999)	Target 2007/8
Infant mortality (per 1,000 live births)	104	90
Under 5 mortality rate (per 1,000 live births)	189	150
Maternal mortality rate (per 100,000)	620	400
Nutrition (% children underweight)	30%	20%
Population (fertility rate)	6.1	5.5

4.2.4 Promotion of Good Nutrition

Malnutrition is both a cause and a consequence of poverty. Increased illness and mortality as well as reduced work productivity due to malnutrition have exacerbated poverty and continue to slow down economic growth and development. Therefore good nutrition is a precondition for, and not merely a result of human and economic development.

The immediate cause of malnutrition is inadequate dietary intake, which is caused by a combination of underlying factors including household food insecurity, poor child-feeding and care practices, and inadequate education and lack of knowledge. The situation is further worsened by frequent and persistence infections, especially malaria, diarrhoea, acute respiratory infections (ARI) and HIV/AIDS.

Statistics show that 49 percent of children are stunted (height for age); 25 percent are under weight and 6 percent are wasted. In addition, malnutrition has caused widespread mental retardation. For the past decade there has been no significant improvement in the nutritional status, as shown in table 4.2.10.

Table 4.2.10 Nutrition Indicators

Year of Survey	Stunted growth rate %	% of underweight	% of wastage
1992 MDHS	44%	27%	7%
1995 MSIS	48%	30%	7%
2000 MDHS	49%	25%	6%

If the situation remains unchanged loss of life, reduce productivity and increased poorly will continue. The goal is therefore, to prevent and control protein, energy and micronuteint deficiencies. This will be achieved through:

1. Improve infant and young child feeding

Poor infant and young child feeding practices contribute greatly to malnutrition. For instance the majority of infants are not exclusively breast fed up to 6 months and they are later fed on low energy and nutrient-dense complimentary foods. In order to address these problems, the MPRS includes strategies to promote exclusive breastfeeding and complementary feeding through Baby Friendly Health Initiative (BFHI). Conducting campaigns on breastfeeding, complementary feeding, and feeding during illness and convalescence.

2. Diversification and modification of diets

Dietary diversification is very poor in Malawi. The diet is monotonous, predominantly with *nsima* made from maize with vegetables. This lack of diversification is reinforced by inadequate awareness of nutrition issues among policy makers and the general public. There is need to change peoples attitude towards making *nsima* from one type of cereal as it could be made from different starchy foods. Therefore it is important for to diversify diets using other locally available foods.

This will be achieved through community awareness campaigns on nutrition, food and security and nutritional policy, together with campaigns on HIV/AIDS and nutrition. Further, Government will organise short courses for various workers in all districts on the prevention and control of malnutrition, will train senior personnel on food and nutrition, and will review the curricula of extension agents, primary and secondary school teachers in order to incorporate nutrition issues.

3. Strengthen institutional capacity

Effective implementation of nutrition interventions requires well co-ordinated efforts from different stakeholders. Currently nutrition activities and research are uncoordinated and have resulted in little impact. In order to address this problem, Government will create a Food and Nutrition Council as a technical machinery to spearhead the implementation and coordination of nutrition activities and research. In particular, it will coordinate relevant research on food and nutrition, monitoring of fortified foods, evaluation of food nutrition programs and establishing sentinel nutrition surveillance system.

4.3 Improving the Quality of Life of the Most Vulnerable

The proposed broad-based growth in Pillar 1 and the inclusive human capital development in Pillar 2 will go a long way in reducing the numbers of the poor. However, it is recognised that there are still going to be some sections of the population that are not going to benefit and will need direct assistance for them to improve their living standards. The overall goal of the third pillar is, therefore, to ensure that the quality of life of the most vulnerable is improved and maintained at an acceptable level by providing moderate support to the transient poor and substantial transfers to the chronically poor.