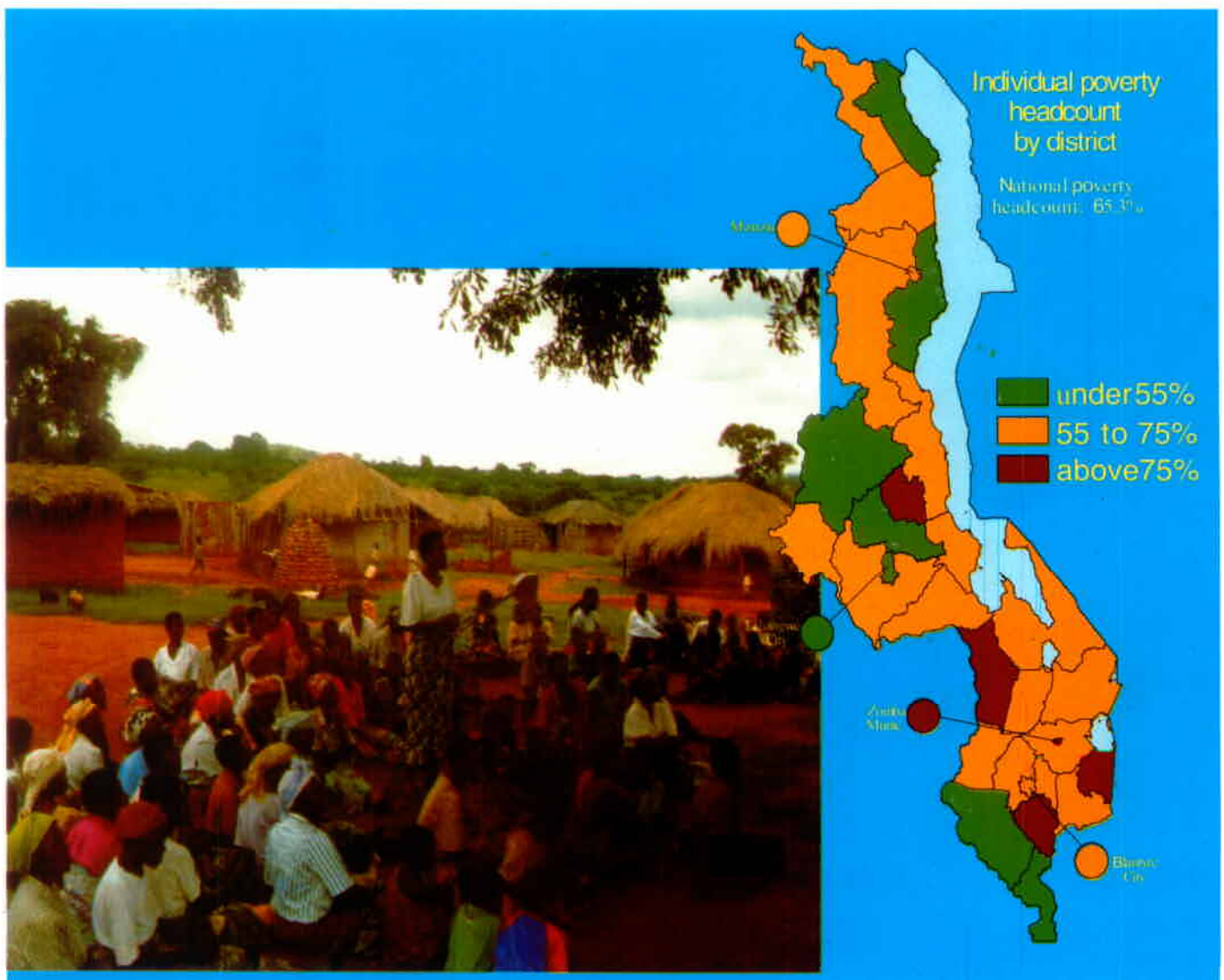




MALAWI

MILLENNIUM DEVELOPMENT GOALS REPORT 2003



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ACRONYMY

AIDS	Acquired Immune Deficiency Syndrome
CPR	Contraceptive Prevalence Rate
CRC	Convention for Rights of the Child
DevPol	Development Policy
EFA	Education For All
EHP	Essential Health Package
GABLE	Girls Attainment in Basic Literacy and Education
GDP	Gross Domestic Product
HESSEA	Household Expenditure and Small Scale Enterprises Activities
HIPC	Highly Indebted Poor Countries
HIV	Human Immuno-Deficiency Virus
HSAS	Health Surveillance Assistants
HSC	Health Surveillance Commission
IHS	Integrated Household Survey
IMCI	Integrated Management of Childhood Illness
MDGs	Millennium Development Goals
MDHS	Malawi Demographic Health Survey
MEG	Malawi Economic Growth
MNGP	Malawi National Gender Policy
MNPFA	Malawi National Platform For Action
MOHP	Ministry Of Health and Population
MPRS	Malawi Poverty Reduction Strategy
MPRSP	Malawi Poverty Reduction Strategy Paper
MSMEs	Micro, Small and Medium Scale Enterprises
MTEF	Medium Term Expenditure Framework
NPASPD	National Programme of Action for the Survival, Protection and Development of Children
NSF	National Strategic Framework
NSSA	National Sample Survey of Agriculture
PAP	Poverty Alleviation Programme
PFPs	Policy Framework Papers
PHC	Primary Health Care
PIF	Policy Investment Framework
PMTCT	Prevention of Mother to Childhood Transmission
RHU	Reproductive Health Unit
RSH	Reproductive Sexual Health
SCGA	Strategic Country Gender Assessment
SIPs	Sector Investment Programmes
SWA	Sector Wide Approach
TFR	Total Fertility Rate
UN	United Nations
UNDAF	United Nations Development Assistance Framework
VCT	Voluntary Counselling and Testing

Foreword


The Malawi Government signed the Millennium Declaration that was adopted in September 2000. There are eight goals in the declaration, ranging from halving extreme poverty to halting the spread of HIV/AIDS. The Government of Malawi and development partners are reorienting their work around the Goals. Despite the commitments to reducing poverty and advancing other human developments, Malawi is already falling short in a number of ways. Progress in the implementation of the Millennium Development Goals (MDGs) is in most cases out of track. Malawi has seen high school drop-out rates, low access to basic health care, deteriorating environment and life expectancy plummeting due to HIV/AIDS.

The MDGs are time-bound, measurable, easily understood and hold both Government and the international community accountable for their achievement. In the case of Malawi, the MDGs will be implemented through Malawi Poverty Reduction Strategy (MPRS) and Malawi Economic Growth Strategy (MEGS). The overall monitoring of the MDGs will be in line with the Monitoring Master plan. The reporting of the annual MDGs, therefore, needs to be synchronized with the Annual Review of the MPRS.

While re-allocating and mobilizing more domestic resources towards targets related to the Goals is of paramount importance, strengthening governance and institutions and adopting sound social and economic policies are all necessary to achieve the goals. Long-term initiatives to halve hunger and poverty require fundamental restructuring of the global trade system where the rich countries will have to dismantle subsidies, lower tariffs and level the playing field. The fight against HIV/AIDS, malaria and other diseases will be lost without effective supplies of affordable and essential drugs to poor countries. Stable, long-term fiscal planning will be impossible for some of the poorest countries without more systematic and sustained debt relief.

In middle-income countries the implementation of the MDGs is integrated with regular budget processes and long-term development strategies. In the least developed countries, like Malawi, poverty reduction strategies are the most appropriate instruments. However, they are only achievable with the right policies and sufficient resources. Poor people care about what happens to their income, gender-sensitive education systems, infectious diseases such as HIV/AIDS, their environment and whether or not they have access to clean water and sanitation. The issues of economic development in Malawi are articulated in Vision 2020, MPRS, Malawi Economic Growth (MEG) and the Public Sector Investment Programme (PSIP).

This Report, therefore, is devoted to assessing whether or not Malawi is achieving the MDGs and ways of addressing the challenges experienced in the implementation of the goals. Although the goals provide the framework for development, the success depends on political will, good governance, the implementation of good development policy statements and economic reforms. The Malawi Government is committed to ensure that the targets set in the MDGs are implemented and achieved.



Dr. Bingu Wa Mutharika
**MINISTER OF ECONOMIC PLANNING
AND DEVELOPMENT**

Preface

The report on 2003 Millennium Development Goals (MDGs) was prepared in collaboration with the UN System and the Government of Malawi. It builds on an earlier report presented at the 2002 Monterrey UN Conference on Financing for Development. The Malawi report was one of the five country case studies which demonstrated the financial feasibility of achieving the MDGs.


This report describes the progress made towards achieving these goals. It reviews the development context of Malawi and assesses all the development goals, except the eighth goal on global partnership for development. The findings indicate that halving the proportion of people without access to safe drinking water and reducing under-five mortality rate by two-thirds, could probably be achieved by 2015. It is also feasible to achieve, by 2015, the following goals:

- (i) halving the proportion of people living in extreme poverty,
- (ii) providing universal primary education,
- (iii) halting and reversing the spread of HIV/AIDS.

However, reducing the maternal mortality rate, by three-quarters, would not be achieved if the current trend continues. Overall, the report indicates that progress is being made towards the achievement of some goals, but not others.

The reduction of maternal mortality rate is of great concern. In Malawi, for every 100,000 live births, 1,120 mothers die and this rate has almost doubled in less than ten years. This is a clear indication of women's limited access to quality reproductive and health services. The HIV/AIDS prevalence rate for young women, aged between 15-24 years, is six times higher than that of males of the same age group. Some issues that have been identified and which contribute to this situation are women's low socio-economic status, the culture of silence on sexuality and sexual reproductive health. Others, particularly among females, include gender-based violence and traditional practices that pre-dispose young females to early and unprotected sexual relations. Furthermore, wide gender disparities remain in the education sector, although it is acknowledged that education is a key to women empowerment. The literacy rate is 51 percent for women compared to 64 percent for men. Enrolment for both girls and boys, at primary school level, has increased almost to parity as a result of introducing free primary education in 1994, and other interventions made by the Government, such as, the Girls Attainment in Basic Literacy and Education (GABLE) Project. Nonetheless, there is a high drop-out rate among girls in higher classes.

The key challenge for Malawi, therefore, is to transform the fundamental socio-cultural factors that create and perpetuate gender inequalities in the society. This requires some culture-specific research and interventions, knowledge and skills in gender research, analysis and planning. In addressing the gender dimensions of HIV/AIDS, which increase women's susceptibility to infection and their vulnerability to the impact of the disease, it is critical to ensure equal participation of women and men in issues aimed at reversing the epidemic. The UN System will continue to provide substantive support and capacity to Malawi in its endeavour to address these development challenges and commit its full support to the strategies that would lead towards the achievement of the Millennium Development Goals.



Zahra Nuru
United Nations Resident Coordinator



ACKNOWLEDGEMENTS

The Government of Malawi and the United Nations Country Team prepared the progress report on the 2003 Millennium Development Goals for Malawi, with financial support from UNDP. The consultancy, led by a national stakeholder task force, was organised by the Malawi Poverty Reduction Strategy Paper Secretariat and composed of the Ministry of Finance and the Ministry of Economic Planning and Development. It involved partners from Government, donors, UN agencies, civil society organizations and the private sector.

The Mission, therefore, wishes to thank the National Statistics Office, various government departments, UN agencies and other partners who provided the information and statistical data used in this report. The involvement of the ministries, UN staff, civil society organizations and development partners who contributed to the preparation of this report is highly appreciated.

Status at a Glance

Malawi's Progress towards achieving the development goals		
Goals/Targets	Feasibility of achieving the target	Support status
Extreme Poverty Halve the proportion of people living in extreme poverty by 2015	Potentially	Fair
Education Achieve universal access to primary education by 2015	Potentially feasible	Fair
Child Mortality Reduce under-five mortality rate by two-thirds, by 2015	Probable	Strong
Maternal Mortality Reduce maternal mortality rate by three quarters by 2015	Unlikely	Weak
HIV/AIDS Halt and reverse the spread of HIV/AIDS by 2015	Potentially feasible	Weak but improving
Access to Safe Drinking Water Halve the proportion of people without sustainable access to safe drinking water by 2015	Probable	Strong

Introduction

In September 2000, Heads of State and Governments, including Malawi, adopted the Millennium Declaration at the Millennium Summit in New York. The Declaration synchronises a set of time-bound, inter-related and mutually reinforcing goals and targets into a global agenda of combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. These have now been named the Millennium Development Goals (MDGs). The MDGs are a culmination of commitments made at a series of global conferences held in the 1990's on human development and refined over the past fifty years. The declaration should achieve, by 2015, eight goals to be monitored by using 48 indicators. These goals are:

1. Reduce extreme poverty and hunger,
2. Achieve universal primary education,
3. Promote gender equality and empowerment of women,
4. Minimise child mortality,
5. Improve maternal health,
6. Combat HIV/AIDS, malaria and other diseases,
7. Ensure environmental sustainability, and
8. Organise a global partnership for development.

As a follow up of the Millennium Declaration, individual countries were expected to produce reports indicating progress made on these goals. The country reports were intended to raise awareness and advocacy, as well as focus the country's development agenda on key human development issues. In Malawi, the analysis of the requirements for the achievement of the MDGs was derived from, and based on, sectoral medium term policy frameworks, strategic plans, investment plans and the Malawi Poverty Reduction Strategy Paper (MPRSP). The strategies, activities and costing, articulated in the MPRSP, were extensively utilised.

Brief Overview

Malawi is located in the Southern African sub region, sharing common borders with Tanzania, Zambia and Mozambique. It is a land-locked country and, as such, it has a special interest in the progress made towards achieving the goals mentioned above. Particular attention is given to the goal on organising a global partnership for development which recognises the challenges faced by land-locked countries and small island states. The Millennium Development Goals, as explained in the 2003 Global Human Development Report, support the collective and individual responsibility of all nations, rich and poor, towards their achievement.

Malawi is one of the least developed countries with a GDP per capita of US\$195.3. According to the 2003 Global Human Development Report, the Human Development Index for Malawi is 0.387, which means that close to two-thirds of the population of 10 million people, 51 percent of whom are women, live in poverty. The Integrated Household Survey (IHS) of 1998 estimated that 65.3 percent of the population, representing about 6.3 million people, live in poverty. Further, the IHS indicated that 28.7 percent of the population live in extreme poverty. Inequality, as measured by the Gini Coefficient, was 0.52 for urban areas and 0.37 for rural areas. The survey further showed that the richest 20 percent of the population, consumed 46.3 percent of the total goods and services available while the poorest 20 percent consumed only 6.3 percent.

The annual population growth rate declined from 3.2 per cent in 1987 to 1.9 per cent in 1998. A reduction in the population growth rate is considered desirable, if brought about by a decline in both fertility and mortality rates. However, the decline in the population growth rate as a result of an increase in mortality rate is a serious concern and should continue to be a programme priority.

MALAWI : DEVELOPMENT CONTEXT

Sustained economic growth has been very difficult to achieve in Malawi during the 1990's, (Tables 1 and 2). The economic performance of the country during the period 1990-2003 was largely influenced by both political developments and climatic changes. This period was characterised by cycles of droughts, deterioration in the terms of trade and slippages in microeconomic management, as well as intermittent disruptions in donor inflows. The economy was disrupted between 1992 and 1995 when non-humanitarian donor aid to Malawi was suspended in order to force the Government to accept political liberalisation. From 1994-2003, the annual average growth rate was 3 per cent. This growth was mainly attributed to strong agricultural performance, combined with a booming economic activity in the distribution sector. Meaningful poverty reduction is expected to take place when there is a sustained high economic growth rate of over 5 percent, but GDP growth rate in the early 1990s followed a very unpredictable pattern.

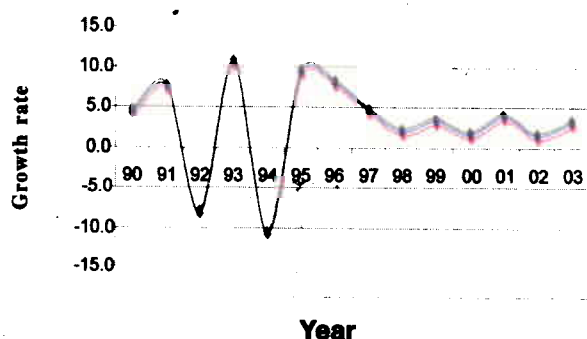
Table 1: Basic Macroeconomic Indicators

Indicator	year			
	1994	2000	2002	2003*
GDP growth rate	-10.4	2.0	1.8	3.4
Inflation rate (average, %)	34.7	29.6	14.8	10.0
Domestic savings/GDP (%)	-3	3.4	-3.5	-0.4
Investment/GDP (%)	29.1	13.6	10.5	9.9
Interest rate (lending rate, %)	31	53.6	44.1	46
Current account deficit/GDP (incl. grants, %)	-13.4	-2.0	-12.8	-
Exchange rate (MK/US\$, averag	8.7	59.5	76.7	-
External debt/GDP (%)	150.6	197.6	92.3	135.4

Note: * refers to preliminary outturn for 2003.

Periods of high economic growth from depressed years were followed by periods of negative growth up to 1994, mainly due to droughts. Between 1995 and 2002, GDP growth rate declined (Table 1 and Figure 1). The fiscal position was not healthy either, especially when grants were excluded. The fiscal imbalances are generally mirrored in the current account balance, in the external sector, whose consistent deficits have been funded by grants and loans.

Figure 1: GDP Growth Rate



The financing of the fiscal imbalances, as well as deterioration of the Terms of Trade, have been translated into persistent depreciation of the Malawi Kwacha (Table 1 and Figure 2). Consequently, the country has experienced high inflation rates, as well as, unstable exchange rates, (Figure 2). One of the few positive aspects, during the period 1995/96, was an increased spending on social services, especially in education.

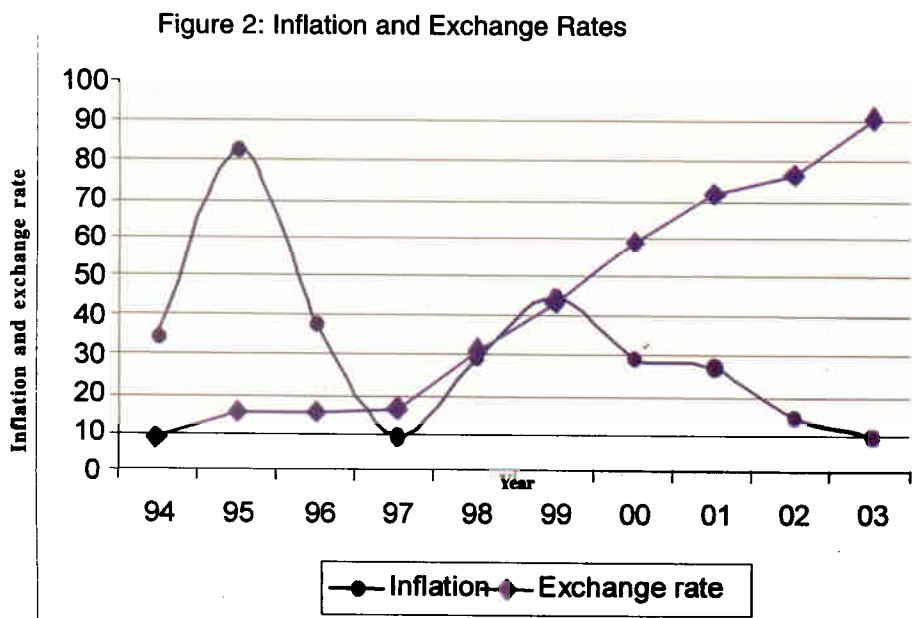
Social services consumed an average of 31 percent of the total public expenditure while the share of the education sector, during the period 1994/95-1999/2000, was approximately 14 percent of the total budget .

Table 2: Key Development Indicators

Indicator	Value	Year
GDP Per Capita (US\$)	195.3	2003
Population in millions	9.99	1998
Population growth rate (1998 Census in %)	1.9	1998
Population below poverty line (%)	65.3	1998
Pop. without food 4-6 months before harvest (%)	50	2000
Rural Pop. with chronic food insecurity (%)	55	2000
Pop. unable to satisfy their basic calorific needs (%)	40	2000
Adult literacy (%)	59.2	1999
Adult literacy - male (%)	73.8	1999
Adult literacy - female (%)	45.3	1999
Combined primary, secondary and tertiary GER (%)	73	1999
Primary Gross Enrolment Rate (%)	132	1999
Primary Net Enrolment Rate (%)	78	1999
Life Expectancy at birth (years)	39	2000
Pop expected to live up to 40 years (% of cohort)	50.4	95-2000
Population with access to essential drugs (%)	44	1999
Population with access to safe water (%)	57	1999
Population with access to sanitation facilities (%)	77	1999
Proportion of under-five children stunted (%)	48	95-2000
Infant mortality rate (per 1,000 live births)	104	2000
Under-5 mortality rate (per 1,000 live births)	189	2000
Maternal mortality rate (per 100,000 live births)	1120	2000
HIV/AIDS prevalence rate (% of the 15-49 age group)	14.4	2003

Source: UNDP, NSO, World Bank, UN, GoM.

Only a few indicators registered some progress, such as the HDI, infant and under-five mortality rates, combined school enrolment and adult literacy, respectively. On the other hand, retrogression was registered with regard to some indicators, particularly the maternal mortality rate, which nearly doubled in the past few years.





Relevant Planning Frameworks and Strategies

The period 1990 to 2000 was influenced by a number of policy frameworks, which included the Second Statement of Development Policies (DEVPOL), which ran from 1987 to 1996. The second DEVPOL was supported, in the 1990s, by Policy Framework Papers (PFPs), the National Programme of Action for the Survival, Protection and Development of Children (NPASPD), which was produced in response to international agreements and conventions such as Education for All (EFA) and the Convention for the Rights of the Child (CRC). After the change of Government in 1994, the present Government launched the Poverty Alleviation Programme (PAP). Sectoral policy frameworks and other planning tools, such as Medium Term Expenditure Framework (MTEF), Sector Investment Programmes (SIPs) and Sector Wide Approach (SWA), were developed in support of PAP. Later in 1996, the Government embarked on a long-term perspective study to capture the aspirations of the people and define the future of the country. The study culminated in the Malawi Vision 2020, which was launched in 1998. However, both the PAP and the Malawi Vision 2020 lacked effective implementation mechanisms.

In order to address this acknowledged shortcoming, Government took advantage of the Highly Indebted Poor Countries-led (HIPC) process to prepare MPRSP as a first step in the operationalisation of the Malawi Vision 2020. The MDGs will be implemented and monitored in the context of MPRSP.

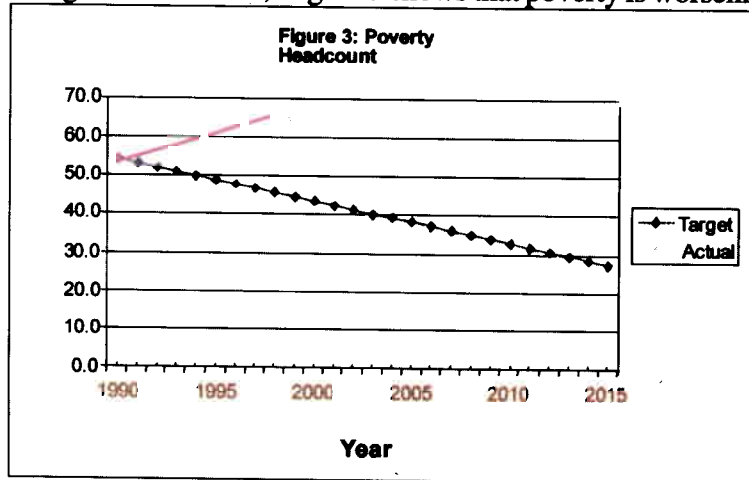
Frameworks and Strategies for Pro-poor Growth in the 1990s

The key message in the policy frameworks in the 1990s stressed the need for growth with equity. This was to be achieved through greater involvement of the private sector, particularly in agriculture, micro and small enterprises development, and the informal sector. Specific measures were undertaken to create an enabling environment to facilitate this growth strategy. Key measures taken included trade liberalisation, tax reform, privatisation of parastatals, review and repeal of out-of-date legislation, administrative procedures and processes, creation of institutions to support the private sector, and clearing up the backlog of infrastructure maintenance. An active programme of new investments in economic infrastructure complimented the action taken.

Target: Halve the proportion, by 2015, of people living in extreme poverty

1. The Nature of Poverty

The international focus on poverty reduction, at the turn of the 1990s, prompted Government and its development partners to consider ways of measuring poverty. The World Bank, in particular, attempted to measure poverty in 1992 and 1995 by using the Household Expenditure and Small Scale Enterprise Activities (HESSEA) and the National Sample Survey of Agriculture (NSSA), respectively. In the 1992 exercise, the World Bank estimated poverty in Malawi as comprising nearly 55 percent of the population, out of which approximately 20 percent were categorized as ultra-poor. In the 1995 exercise, poverty incidence was estimated at 60 percent. Although the two exercises were carried out by the same institution, the results were not comparable because of differences in the data set. Despite the shortcomings of the data set, Figure 3 shows that poverty is worsening.



On the basis of the 1997/98 Intergrated Household Survey (IHS), poverty incidence in Malawi was estimated at 65.3 percent, affecting nearly 6.3 million people (Table 3). The survey also showed that about 28.7 percent of the population lived in extreme poverty (89.8 percent in rural and 10.2 percent in urban areas, respectively).

Table 3: Poverty Incidence, Gap and Severity

Poverty	Headcount (% population)	Poverty gap index	poverty severity index
National	65.3	0.23	0.12
Rural	58.6	0.23	0.12
Urban	6.7	0.19	0.10
Ultra-Poverty			
National	28.7	0.09	0.04
Rural	25.8	0.09	0.04
Urban	2.9	0.07	0.03

Source: National Economic Council (2000) profile of Poverty in Malawi, 1998.

The differences in the methodology in the various attempts to estimate and analyse developments in poverty incidence between 1990 and 1998, makes it difficult to undertake a meaningful MDG gap analysis. However, 1998 was chosen as the base year for this exercise since the most comprehensive analysis was carried out only for that year.

With the current poverty incidence of 65.3 percent, the MDG poverty incidence for 2015 is expected to be 32.7 percent. Assuming a simple straight-line reduction in poverty incidence, this means an annual reduction in the poverty incidence of roughly 2 percent. However, the reduction rate in poverty incidence is influenced by a number of other parameters such as, income growth and distribution, gender equality as well as deliberate efforts made towards targeted pro-poor growth. With more pro-poor growth, human resource development and vulnerability protection, the reduction could be greater than the annual average of 2 percent.

2. Challenges

Malawi faces an uphill task as she undertakes the obligation of meeting the MDG to halve, by 2015, the proportion of the population living in poverty. In order to achieve this MDG, the poverty incidence should decline by 2 percent per annum. On the basis of different income distribution patterns, the target could only be achieved with economic growth of about 3.8 to 6.0 percent per annum. The lower limit of 3.8 percent is achievable, noting that real GDP growth averaged 4.2 percent during the period 1990 to 2000.

Although it is estimated that the composition of GDP would not vary substantially, the MPRS proposes to allocate more resources to rural areas, rural infrastructure and support for small and micro-enterprises. This should trigger more sustainable and equitable growth through improving the productivity of labour intensive sectors and narrowing the gap between modern and traditional sectors in agriculture, manufacturing, and services.

The economy of Malawi has been extremely vulnerable to internal and external shocks. Therefore, this requires the provision of greater incentives for economic development to broaden income and employment opportunities for both men and women in urban and rural communities. However, higher and sustained growth demands a favourable environment for economic growth, particularly in sectors involving traditional agriculture, small production units and both urban and rural micro-enterprises.

Malawi Poverty Reduction Strategy recognises that population and reproductive health programmes are critical in order to meet the Millennium Development Goals of halving poverty and hunger by 2015, reducing maternal and child deaths, curbing HIV/AIDS, advancing gender equality, and promoting environmentally sustainable development. However, implementation of the MPRS does not adequately address these concerns.

3. Policy Framework and Strategies

The MPRS recognises that the levels of productivity and competitiveness will be increased by taking concrete action in the areas of rural development, road infrastructure, technical assistance, technology and development of small enterprises. However, attention should be given to the development of micro-finance, access to land and land tenure, which are the strategic objectives of increasing opportunities for the population and which have more short- and medium-term effects on growth.

The major policy shift should aim at enhancing productivity of smallholder farmers by increasing their capacity to diversify crop and livestock production, ensuring property rights and expanding employment options for both women and men in the rural areas. This should include the provision of production infrastructure such as irrigation and micro-irrigation systems, rural electrification, rural roads, rural telephones and legal security in land tenure. Consideration should also be given to technological support in management, production, processing and marketing of agricultural produce and other non-farm goods and services. Such measures should make it possible to increase agricultural production and enhance profitability of other rural economic activities such as tourism and handicrafts, thereby adding to the diversification of employment opportunities and increased incomes.

Micro-finance services should be intensified and diversified in order to expand spatial coverage. This should help Micro, Small and Medium Scale Enterprises (MSMEs) to establish linkages amongst themselves and with larger businesses that could generate a sustained export supply, consistent with the demand and quality requirements of international markets.



A greater role of MSMEs is also anticipated in the domestic market, through active participation in the provision of goods and services, at all levels, such as construction and maintenance of roads, construction of irrigation and micro-irrigation works and basic sanitation.

MPRSP identified clustering as an important element of organising production of small firms. Malawi should place emphasis on the development of competitive industry clusters through the integration of key industries, suppliers, critical supporting business services, requisite infrastructure and institutions.

4. Assessment of Progress

Given the challenges outlined above, and the interventions mentioned in the Malawi Poverty Reduction Strategy Paper, there is considerable room for improvement, if the goal of halving those living below US \$1/day is to be achieved by 2015.

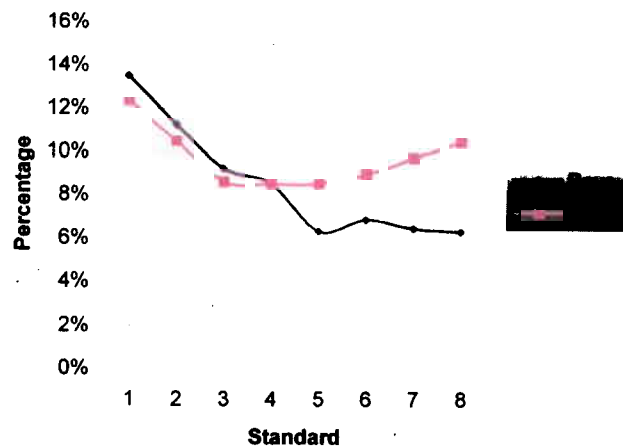
ACHIEVE UNIVERSAL PRIMARY EDUCATION

Target : Ensure that, by 2015, children should be able to complete a full course of primary education.

1. The Status of completion of a full course of primary schooling

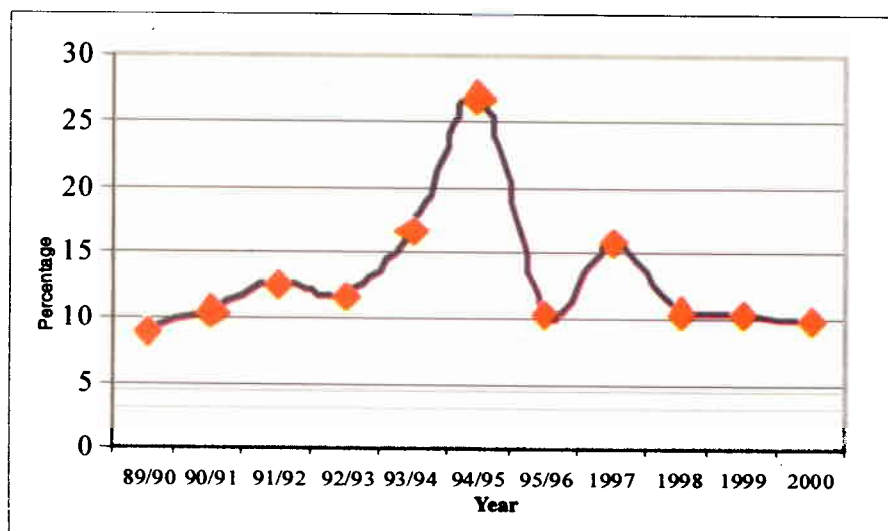
The enrolment gains registered by the introduction of Free Primary Education were quickly negated by high drop-out rates, especially between Standards 2 and 3, (Figure 4). Figure 4 also shows that the drop-out rate for girls, though lower in the first three standards, increased to surpass that of boys after Standard 4. The poor literacy situation among women could be largely explained by this factor. According to the IHS, enrolment in urban areas continued to exceed that of rural areas.

Figure 4: Drop-out rates in Primary Education (2000)



The reasons for the increased drop-out rate were, among other things, negative attitudes of certain communities towards education, especially for girls, long distances covered by pupils to school, early pregnancies, lack of food and clothes in households and poverty. Figure 5 shows that the drop-out rate was steady between 10 and 15 percent, except in 1994/95 when the rate rose to 27 percent.

Figure 5: Trends In Drop-out Rates



2. Challenges

Poverty and the low value attached to education were major causes of high drop-out rates. Pupils dropped out of school by choice, citing reasons such as poverty and poor quality of education. Girls dropped out due to early marriages and pregnancies. Drop-out rates by gender clearly showed that girls dropped out at a faster rate than boys.

Poor quality school environment also contributed to the high levels of school drop-out rate. Overcrowding and lack of recreation facilities were cited as reasons for dropping out in junior classes. Lack of gender-sensitivity by the teaching staff, and inadequate sanitary facilities in many schools prevented girls in senior classes from attending school during menstrual period. This led to the girls' high rate of drop-out.

3. Policy Framework and Strategies

In the early 1990's, the education policy could be characterized as being cautious, emphasizing increased access to education. Under the Girls Attainment in Basic Literacy and Education (GABLE), girls were not required to pay school fees as long as they did not repeat classes. Government introduced free primary education, starting with Standard 1 in 1990/91 and subsequent standards, thereafter. By 1994, standards 1 to 4 were free. In the 1994/95 school year, the Government introduced free primary education and abolished school uniform as a requirement to attend classes. This greatly increased gross enrollment in primary schools which increased from 1,895,423 in 1993/94 to 2,860,819 in 1994/95. However, this was followed, in the same year, by high drop-out rates, negating the gains in increased enrolment.

The current education policy and the MPRSP address problems of access, equity and quality. In particular, there are plans aimed at increasing the number of schools, permanent classrooms, sanitation facilities, qualified teachers, teachers' houses, desks, teaching and learning materials. The plans also provide for special education for children with learning disabilities. However, these plans do not ensure that all children of school going age enroll and stay in school regardless of the discouraging attitude of their parents.

4. Assessment of progress

Although progress has been made in primary school education, there is still room for improvement.

Promote Gender Equality and Empower Women

Target: Eliminate gender disparity in primary and secondary school education and at all levels, preferably by 2005

1. The status of gender equality and empowerment of women

Women in Malawi continue to form a major force in the country's socio-economic activities. Although women constitute about 52 percent of the population, serious gender disparities still exist in terms of access to and control of productive resources and opportunities for participation in the development process. Gender Development Index for Malawi of 0.374 indicates that large disparities between men and women still exist.

The Malawi Poverty Reduction Strategy (MPRS) acknowledges that gender disparities in Malawi are one of the major causes of poverty. The 1998 Integrated Household Survey showed that 52 percent of the 65.3 percent of Malawians living in poverty were females and that 25 percent of the households were female-headed.

Education is a key to women empowerment; but wide gender disparities remain in the sector. The 1998 Census indicated a literacy rate of 51 percent for women as compared to 64 percent for men. Enrolment for both girls and boys at primary school level increased almost to parity through the introduction of free primary education in 1994, and other interventions such as the Girls Attainment in Basic Literacy and Education (GABLE) Project. However, high drop-out rates among girls in senior classes, imply that more boys than girls receive education.

Fewer women participate in decision-making as compared to men. The 1995 Civil Service Census indicated that out of the 112,975 employees, only 25.4 percent, in the civil service, were females. The majority of the women were support staff. Out of the 698 officers in decision-making positions, only 12.32 percent were females (Department of Human Resource Management and Development, 2003). In the political domain, only 17 (8.7 percent) out of the 194 members elected to the legislature, in 1999, were females. However, this is an improvement since only 9 females (5.6 percent) were elected in 1994.

Gender-based violence is another issue in Malawi which, until recently, has received little attention and yet, it is one of the factors promoting the spread of HIV/AIDS. Efforts to reduce gender-based violence have, so far, mainly focused on raising awareness. Effective reporting mechanisms and a supportive legal framework which are essential for addressing gender-based violence, have not been put in place.

2. Challenges

The key challenge is to transform the fundamental socio-cultural factors that create and perpetuate gender inequalities in the Malawi society. This requires some cultural specific research and interventions considering that Malawi is a multi-cultural country. Knowledge and skills in gender research, analysis, planning, monitoring and evaluation are, therefore, critical for reducing gender disparities.

In addressing the gender dimensions of HIV/AIDS, which increase women's susceptibility to infection, on one hand, and increase their vulnerability to the impact of the disease, on the other, it is important to ensure equal participation of women and men in development activities.

Limited human capacity, at all levels, has undermined progress towards achieving the gender equality and objectives of women's empowerment. The Gender Department in the Ministry of Gender and Community Services is understaffed and experiences high turn-over of middle level staff with expertise in gender. The department does not have its own staff at district level. A study commissioned in 2002 by the Ministry of Gender and Community Services showed that capacity to mainstream gender in the development process at district level, was inadequate, as evidenced by a number of district development plans, in which gender issues were not included.

Increasing the number of women in decision-making positions, in a sustainable manner, is a challenge that will require long term measures of raising enrolment and retention rates for girls in schools at primary, secondary and tertiary levels. This is dependent on creating more space and girl-friendly environment in schools and colleges, finding innovative means of tackling the socio-cultural factors that limit girls' participation in education and introducing more programmes to support girls' education.

3. Policy Framework and Strategies

The Government of Malawi and its development partners acknowledge the importance of addressing gender disparities in all sectors for sustainable socio-economic development. The Ministry of Gender and Community Services was, therefore, established in the early 1990s as the national machinery to facilitate the formulation, implementation, coordination, monitoring and evaluation of policies, programmes and activities related to gender, in all sectors and at all levels.


The Malawi Government launched the Malawi National Platform for Action (MNPFA) in 1997, following the adoption of the Global Platform for Action at the Fourth World Conference on Women in 1995. The MNPFA, which focuses on poverty alleviation and empowerment, the girl child, violence against women and peace, was the basis for the formulation of a number of projects in education, health, human rights and the environment.

The Malawi National Gender Policy (MNGP) was launched in 2000 to provide guidance in the attainment of gender equality and empowerment of women. It focuses mainly on education and training; reproductive health; food and nutrition; security; natural resources and environmental management; governance and human rights; poverty eradication and economic empowerment.

The Government of Malawi, through the MPRS, laid down some objectives aimed at reducing the existing gender disparities and empowerment of women. These included engendering sectoral budgets, eradicating gender-based violence, enhancing women's participation in leadership and decision-making processes and increasing access to quality reproductive health services.

In the education sector, the Policy Investment Framework (PIF), was formulated in 2001 as a response to the Government of Malawi Poverty Alleviation Programmes and to facilitate the implementation of the objectives of education for all. In addition to improving access to education for all Malawians, the PIF also aims at reducing existing gender disparities by increasing participation of girls and women in education.

A paper, outlining gender-related laws of Malawi, aimed at facilitating gender responsive laws and legal systems in Malawi, was written in 2003. This initiative is a positive stepping stone for the creation of a legal framework that should facilitate the elimination of injustices, emanating from unequal gender relations as well as promote women's rights.



Finally, a Strategic Country Gender Assessment (SCGA) on Malawi, has recently been completed. It provides a cost benefit analysis, which justifies increased investment in education for sustainable poverty eradication. It also gives a practical demonstration of benefits by including gender issues in all development sectors which should give development partners information on strategies for assistance.

4. Assessment of Progress

Progress towards reducing gender disparities and empowering women has been slow. However, in view of the prevailing policy environment and strategies, as well as the support from development partners, some significant progress could be made towards realizing the goal, if all proposals are operationalised.

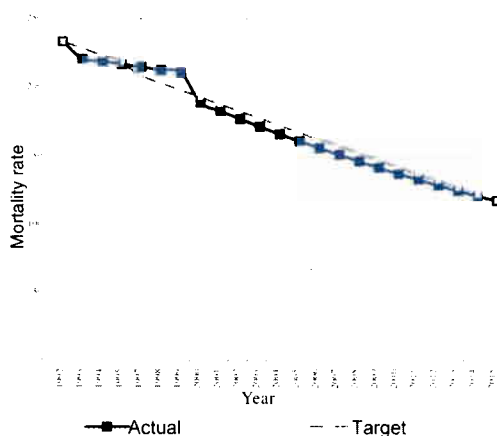
REDUCE CHILD MORTALITY

Target: Reduce, by two-thirds, between 1990 and 2015, the under-five mortality rate

1. The Status of Under-Five Mortality

Progress towards reducing the under-five mortality rate, in Malawi is on target, reflecting the success of Government interventions in the sector, supported by its development partners. According to the 1992 Malawi Demographic Health Survey (MDHS), under-five mortality rate was 234 deaths in every 1,000 live births. Figure 6 shows that there is a strong correlation between actual and targeted reduction of under-five mortality rate.

Figure 6: Under-five mortality rate



2. Challenge

Challenges in this area are water- and food-borne diseases, the high incidence of malaria among children and pregnant mothers, resulting in anemia and low birth weight of the children.

The main human resource challenges are encountered at community and district levels. There is need to increase knowledge and skills of key players in the management of breast feeding, food preparation and feeding of young children. It is also necessary to raise the awareness of key players, including traditional leaders, on the care for pregnant and lactating mothers, use of sanitation facilities, family and personal hygiene and general health practices in the household. This requires recruitment and training of trainers of trainers and front line health workers, including health surveillance assistants, at district and community levels, respectively. Likewise, there is need for proper staffing of health centres and district hospitals. It is acknowledged that the planned Essential Health Package (EHP) has already included the human resource requirements.

3. Policy Framework and Strategies

The current National Health Plan attempts to address most of the epidemiological and health system problems that cause infant and child morbidity and mortality. For example, an Integrated Management of Childhood Illnesses (IMCI) approach was adopted to deal with the major illnesses among infants and children, namely malaria, diarrhea, respiratory infections and nutrition deficiencies. In addition, a national Malaria Policy was also approved, which included action to respond to this number one killer among the under-five age group. Efforts to reduce infant and child mortality should be linked to HIV/AIDS prevention strategies such as voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT) of HIV. These measures reduce the risk of HIV infection of children.

Another programme of integrated essential services the Government has developed is dubbed, Essential Health Package (EHP), which targets major conditions such as HIV/AIDS. It incorporates preventive, educational and clinical services delivered through the community, health centres and district hospitals. The MPRSP also proposes concentrating resource on the EHP as part of its objectives to increase the pro-poor budget.

4. Assessment of Progress

Significant progress has been made with respect to this target. Under-five mortality rate has fallen from 234/1000 live births in 1992 to 189/1000 in 2000. If this trend is maintained, then there is a high probability of reaching the target of reducing the under-five mortality rate by two-thirds, in 2015.

IMPROVE MATERNAL HEALTH

Target: Reduce maternal mortality rate, by three-quarters, between 1990 and 2015,

1. The status of reproductive health including maternal health

With fertility and maternal mortality rates being among the highest in the world, Malawi is facing enormous challenges. Maternal mortality has increased by 80 percent since 1992, from 620 to 1,120 deaths per 100,000 live births. This is mainly due to haemorrhage, sepsis, pregnancy-induced hypertension, obstructed labour and abortion complications.

Ante-natal delivery and post-natal services have critical impact on maternal and child health. The 2000 MDHS reported an ante-natal coverage of 91 percent. However, the proportion of deliveries assisted by skilled birth attendants, remained at 56 percent since 1992 (MDHS, 2000).

The Total Fertility Rate (TFR) reported by the Malawi Demographic Health Survey (MDHS, 2000) is 6.3 percent, reflecting a 6 percent decline in fertility from the 6.7 percent reported in 1992. The Malawi Contraceptive Prevalence Rate (CPR), rose from 1 percent in 1986 to 7 percent in 1992 and to 26 percent at present, which is a positive indication that Malawians are increasingly changing their attitudes toward family planning. If CPR continues to rise significantly, the target of 4.9 TFR set by the Ministry of Health and Population (MOHP) could probably be reached by 2012. Table 4 gives details of reproductive indicators.

Table 4 Reproductive Health Indicators

Indicator	year	
	1992	2000
Maternal mortality ratio	620/100,000	1,120/100,000
Percentage of deliveries by skilled Birth Attendant	56%	56%
Contraceptive Prevalence rate	7%	26%
Total Fertility Rate	6.7%	6.3%

Source: DHS, 1992-2000, Malawi

2.Challenges

Increasing access to general and maternal health care services and adoption of modern family planning as well as reducing teenage pregnancies is critical for reducing the high maternal mortality rate. However, this is undermined by a weak health delivery system, particularly at primary health care level; traditional practices such as initiation rites that encourage early marriages; and cultural beliefs that prevent women from using modern contraceptive methods.

Finally, the transmission of HIV to pregnant women, mothers and their children, represents an additional major threat to maternal health, child survival and family stability. HIV has a disastrous impact on pregnancy and childbirth in the country. With an adult HIV prevalence of 15 percent, the rate of infection among pregnant women who attend ante-natal clinics, could be as high as 35 percent in some urban areas. Prevention of HIV among women and mothers is, therefore, an area that requires critical and concerted efforts.

Another important aspect which deserves consideration is that of mothers who die during child birth, leaving behind many children that are deprived of maternal care. As a result, these children are more likely to die within a few years, after birth, than those with mothers. The impact of maternal mortality and morbidity on families and society, as a whole, is so multi-faceted that it cannot be measured in its entirety. A multi-sectoral approach is, therefore, required to deal with these issues.

The effectiveness of the health system in Malawi is severely affected by the continuous depletion of human resources due to a high turnover of staff, particularly nurses and midwives who migrate to other countries. Other factors include; increasing deaths due to HIV/AIDS and low output of health personnel by training institutions. According to recent estimates, there is an attrition rate of at least two nurses per week in the Malawi health system. The critical shortage of human resources has been exacerbated by the increasing demand for health services due to HIV/AIDS, which has caused a burden on the personnel. Reproductive health services are, therefore, not adequately provided since the few staff available also perform other duties. Replenishment and retention of staff in the Malawi health sector, particularly in the rural areas where the shortage is more acute, is a challenge in providing quality reproductive health services to individuals of different age groups.

Prioritization and coordination of the vertical and sometimes, uncoordinated reproductive health programmes and activities supported and provided by various stakeholders, is another challenge. This has tended to increase working hours of an already over-burdened human resource base.


The reproductive health programme is, currently, sufficiently provided with resources although it is over-dependent on development partners. It is, therefore, important to allocate national resources towards reproductive health service if the gains are to be sustained.

3. Policy Framework and Strategies

In order to show its commitment to the ICPD Programme of Action, and to respond to the potentially catastrophic situation, the Government of Malawi created an enabling policy environment for the provision of integrated reproductive health services. A Reproductive Health Unit (RHU) was, therefore, established in 1997, in the Ministry of Health and Population, to formulate, disseminate and review the Reproductive Health Policy. It was also responsible for defining programme goals, objectives, strategies, interventions and quality assurance mechanisms. It coordinated all donors and stakeholders in Reproductive and Sexual Health (RSH); guiding and monitoring implementation of RSH programme; and mobilizing resources in order to achieve the goals of RSH programme.

The MOHP and the donor partners embarked on a Sector Wide Approach (SWA) with an Essential Health Package (EHP) to ensure that quality health care is available to all. The SWA ensures coordination of technical assistance, as well as, funding from donor programmes to support health activities in line with MOHP's priorities.

In order to address the inter-related challenges, the Ministry of Health and Population has established a Health Service Commission (HSC) whose main objective is to improve the conditions of service for health workers. The Ministry of Health and Population has also developed a 6-year emergency training plan to fill the gap of the existing human resource. The plan includes the resumption of training of Medical Assistants and auxiliary nurses, respectively. In addition, more Health Surveillance Assistants (HSAs) will be trained to a very high level so as to enable them to assist in the delivery of the EHP.



Most of the human resources are required at district and community levels, respectively. Each district will require a dedicated team to run the community mobilization campaigns. It will be necessary to train trainers from community-level personnel that would conduct counselling on their own and provide education on reproductive rights. There will be need to recruit and train counsellors, educators and birth attendants. At health facility level, there will be need to train and upgrade health care managers. Again, the EHP has already included human resource requirements for all basic services.

The replenishment initiative by the UN system in the health sector will also use maternal mortality as an entry point to tackle the inter-related problems of both HIV/AIDS prevention, under-five mortality and gender empowerment..

Assessment of Progress

The increase in contraceptive prevalence rate and reduction in total fertility rate, indicate that significant progress is made towards realizing the reproductive health goal. However, it is unlikely that the goal of reducing maternal mortality rate by 75 percent to 155/100,000 will be achieved. It is possible to reverse the current regressive trend if all stakeholders support the policy and strategies that are in place and if there is a political will and commitment.

Target: Halt by 2015 and begin to reverse the spread of HIV/AIDS

1. HIV/AIDS Incidence

The Millennium Development Goals on HIV/AIDS require that all countries begin to reduce and reverse the spread of the infection. Malawi has a track record of HIV/AIDS epidemic since 1994, using estimates based on data of pregnant women from 19 ante-natal centres. Ante-natal data indicated that HIV/AIDS prevalence, among pregnant women, rose from 17.4 percent in 1994 to 24.1 percent in 1998 and declined to 19.5 percent in 2001. The prevalence has since remained relatively stable, reaching 19.8 percent in 2003 (*Sentinel Surveillance Report, NAC 2003*)

The 2003 estimates showed that the prevalence of HIV/AIDS among adults, between the ages of 15-49 years, was 14.4 percent. This translated to approximately 760,000 infected people in that age group, 58 percent of whom were women. The prevalence was higher in urban areas, at 23 percent and lower in rural areas, at 12.4 percent. The national HIV/AIDS prevalence in Malawi, remained stable, at 14-15 percent since 1998 (*Sentinel Surveillance Report, NAC 2003*).

2. Challenges

Although HIV/AIDS prevalence remained relatively stable over the past five years, new infections are still occurring at a rate of about 80,000 people per year (*Estimating National Prevalence, NAC 2003*). One of the reasons for the increase in the transmission of HIV/AIDS is that people are still not practicing preventive measures, despite almost universal awareness of the mode of infection. For example, condom use still remains relatively low in Malawi. According to the 2000 MDHS, condom use among women was only 5 percent, and 14 percent among men, respectively. In addition, condom use with non-cohabitating partners in 2000 was 29 percent by women and 39 percent by men as compared to 20 percent among women and 38 percent among men, in 1996. Access to condoms has proved to be a problem in some areas of the country. According to the 2000 MDHS, more than half of the women and one third of the men, aged between 15-49 years, reported that condoms were not available.

Another challenge is that most Malawians do not know their HIV serostatus. HIV testing and counseling is another strategy that has the potential of halting and reversing the epidemic.

Approximately 8 percent of HIV transmission in Malawi is believed to occur from mother to child, accounting for an annual HIV-positive births of more than 20,000 cases (Joint Annual Review, 2003). Currently, access to PMTCT services is limited, although Government and its partners have made a lot of effort to make the services more widely available.

Negative social attitudes towards sex and condoms, especially female condoms, cultural beliefs and poverty are blamed for the slow translation of the HIV/AIDS knowledge into change of behaviour. Culturally, men are tolerated to have multiple partners, either through polygamous unions or extra-marital sexual relations. Some cultures encourage young girls to have sexual relations with men after their menarche. Other young men and women have multiple partners just for fun. In some cases, from an early age, women, driven by poverty, engage in pre-marital and extra-marital sex with multiple partners to earn money. Again, condom use is viewed as 'unnatural' and a taboo within families even when there is need to protect a sex partner. Above all, there is some resignation among the sexually active population concerning their HIV status.

3. Policy Framework and Strategies

In the 1990's, the policy frameworks (National Health Plan and NPASPD) focused on Primary Health Care (PHC) with emphasis on the provision of services to mothers and children on nutrition, child spacing, and a range of priority disease programmes including, most recently, AIDS (GOM, 1987:112). All policy frameworks emphasized reduction in infant, child and maternal mortality rates and incidence of HIV/AIDS.

With these highly entrenched attitudes, some of which are acquired at an early age, the fight against HIV/AIDS pandemic requires more than casual civic education, voluntary counselling, testing and publicity of condoms. The 1999 Policy Analysis Initiative pinned its hopes on the youth who were yet to form their attitudes towards sex through proper and continuous sex education by parents and teachers. It also proposed mandatory testing for those seeking government scholarships to universities, training institutions and secondary schools and those preparing for marriage. It further contemplated introducing mandatory testing and re-testing for the sexually active age group of both men and women.

The new HIV/AIDS Policy grapples with the difficulty of acting on the recommendation made by an article in support of beneficial disclosure or partner notification, as well as expanded basis for diagnostic testing. The MPRSP, focusing on the HIV/AIDS Strategic Plan, concentrates on:

- (i) prevention of infection among the youth by incorporating HIV/AIDS in school curricula at all levels, as well as, increased adolescent reproductive health services and downplaying of initiation rites,
- (ii) sexual abstinence and increased use of both male and female condoms,
- (iii) control of mother to child transmission, and
- (iv) promotion of VCT underlined by the introduction of services at health centres, district and referral hospitals.

These strategies should be complemented by the seemingly radical measures aimed at protecting the youth and the HIV-free adults, even if it means infringing on some traditional rites.

In October 1999, the National Strategic Framework (NSF) for HIV/AIDS was analysed. Nine key areas, which were to be addressed by the National AIDS Commission, were identified. The framework enabled donors to direct their funding towards national priorities and allowed the National AIDS Commission to monitor areas that were not adequately addressed. A Joint Annual Review of the NSF in March 2003 concluded, among other things, that the NSF did not adequately address issues of treatment of infections and gender.

The Malawi Government also approved a National HIV/AIDS Policy, in November 2003. The policy, which was developed through a consultative process, builds upon Malawi's experiences in HIV/AIDS over the past fifteen years. Principles of the policy, include a public health approach to the epidemic, promotion and protection of human rights, greater involvement of people living with HIV/AIDS, political leadership and commitment. The policy also calls for renewed action and goes beyond "business as usual" in the fight against HIV/AIDS. The policy addresses complex issues which include beneficial disclosure, expanded basis for HIV testing and counseling and diagnostic testing.

4. Assessment of progress

While HIV prevalence has remained relatively stable over the past few years, large numbers of new infections have been registered. As such, Malawi must intensify its efforts in key strategies that could reduce new infections. These include condom use, prevention of mother to child transmission, HIV testing and counseling and treatment of infections.

Ensure Environmental Sustainability

Target: Halve by 2015, the proportion of people without sustainable access to safe drinking water

1. The Status of access to potable water

Access to potable water, within one kilometre, has not changed much since 1990 (Table 5). According to the second DEVPOL, 47 percent of the rural population and 85 percent of the urban population (averaging 52 percent of the entire population) had access to potable water in 1985. In 1992, access to potable water, in the rural areas, was lower than in 1985. In 2000, access had increased to 62 percent (Table 5).

Table 5: Access to Potable Water
(percent of households within 1km of water source)

Year	Rural	Urban	Malawi
1990	47	85	52
1992	42	89	47
1995	44	92	48
2000	58	85	62

Since 1996, an intensive programme for sinking boreholes led to an increase in rural coverage, of which 58 percent were new. However, out of the total number of 18,795 boreholes, only 81 percent (15,287) were functional (Table 6). These figures were confirmed by a study conducted by Water Aid in 2003 which covered a number of districts in the country. The classification for access to water used in the Water Aid study was a density of 4 water points per 1,000 people. In urban areas, water supply did not keep pace with urban population growth.

Table 6: Status of boreholes by region

Region	Number Boreholes	Number Functioning	Number Not Functioning
Northern	2770	1971 71%	799 29%
Central	8635	7163 83%	1472 17%
Southern	7390	6153 83%	1237 17%
Total	18795	15287 (81%)	3508 (19%)

2. Challenges

On the basis of the 1985 estimates, the Millennium Development Goals in 1990 were to increase the number of people with access to potable water, from 52 percent to 78 percent, by 2015. The country coverage, according to 2000 estimates, was 62 percent and access increased by about 1 percent per annum. Assuming the increase is sustained, it would take sixteen years to achieve the target of 78 percent. However, the Millennium Development Goal could be achieved since the Government is planning to increase the number of boreholes and water schemes, and to intensify the maintenance of existing boreholes and water schemes through an active involvement of communities in water management. Currently, there are 15,287 hand pumps, sufficient to serve 4 million people. There are also 56 rural gravity-piped water supply schemes with over 10,000 taps that could reach an additional 1.2 million people. Unfortunately, about 40 percent of these taps are not functional; implying that the number of people served under this scheme could be less than estimated.

The challenge is to ensure continued community commitment, continuous training of community committees and availability of spare parts for repair works.

3. Policy Frameworks and Strategies

The main goal of the NPASPD under the water sub-sector was the provision of safe drinking water to all by the year 2000. The strategy was to rehabilitate old water schemes and provision of more wells and rural piped water projects. Community involvement in this process was considered crucial. Communities were to form committees and provide labour in the construction and maintenance of rural piped water schemes, form repair teams, and provide volunteer pump caretakers.

The Government developed a Water Resources Management Policy and Strategy in 1994 to ensure that a large proportion of the population should have access to potable water. The backbone of the strategy was community involvement in the management and maintenance of water supply systems in their areas.

The current revised, Water Resources Management Policy and Strategies, ensure that the number of people with potable water increases and remains high. The policy and strategies were re-enforced by the approved MPRS. The planned development of new rural piped water schemes, construction of communal water points in urban areas, rehabilitation of existing schemes and maintenance of boreholes by communities should contribute towards meeting these targets. This approach responds to one of the critical elements in the policy framework which is to ensure sustainability of water supply systems through community involvement in the planning, construction and maintenance.

4. Assessment of progress

The target of halving the number of people without sustainable access to safe drinking water could probably be reached by 2015.

THE ROLE OF THE UNITED NATIONS SYSTEM IN SUPPORT OF THE GOVERNMENT OF MALAWI

The framework for UN system development cooperation in Malawi is oriented by the Malawi Vision 2020 paper and the Poverty Reduction Strategy Paper 2002-2004. The Government conceptualised the Malawi Poverty Reduction Strategy (MPRS) as the major instrument for managing progress towards the goals and objectives enshrined in the Vision 2020. Accordingly, all development partners are expected to design their cooperation programmes in support of the activities that should contribute towards achieving MPRS objectives. Within this national context, the second United Nations Development Assistance Framework (UNDAF), for the period 2002-2006, was developed as the UN system's response to this more structured approach to development management, adopted by the Government of Malawi. The UNDAF offers the UN agencies both the opportunity and the means for enhancing goal-oriented collaboration and programme coherence. It also provides mutual reinforcement in addressing national development priorities and needs, in keeping with the continuing UN Reform Programme. Furthermore, the human rights approach, on which the UNDAF is based, was re-affirmed at the Millennium Summit in 2000.

The UNDAF is designed to increase the impact of the UN system's development programmes and activities in Malawi, with special attention to women and children, the poor, people living with HIV/AIDS, those with disabilities and the disadvantaged. Three development challenges have been approved for support within the UNDAF. These are:

- (i) Governance – with the aim of increasing the level and scope of popular participation in national affairs and the economic empowerment of local communities;
- (ii) Poverty – promoting active participation by beneficiaries in the conceptualization and implementation of poverty reduction programmes, improving coordination among stakeholders and providing assistance to such programmes. These should be achieved through, *inter alia*, enhancing skills acquisition so as to improve the income earning capacity of vulnerable groups; increasing their access to basic social services; reducing vulnerability to food insecurity and malnutrition and the fair equitable distribution of resources; and
- (iii) HIV/AIDS – strengthening the effectiveness of prevention, care and impact mitigation towards a significant reduction in the incidence of HIV and improved quality of life for people living with HIV/AIDS.

In addition, four cross cutting areas were selected, which should be integrated, wherever possible, within the three core development areas, namely: Human Rights, Population, Gender and the Environment.

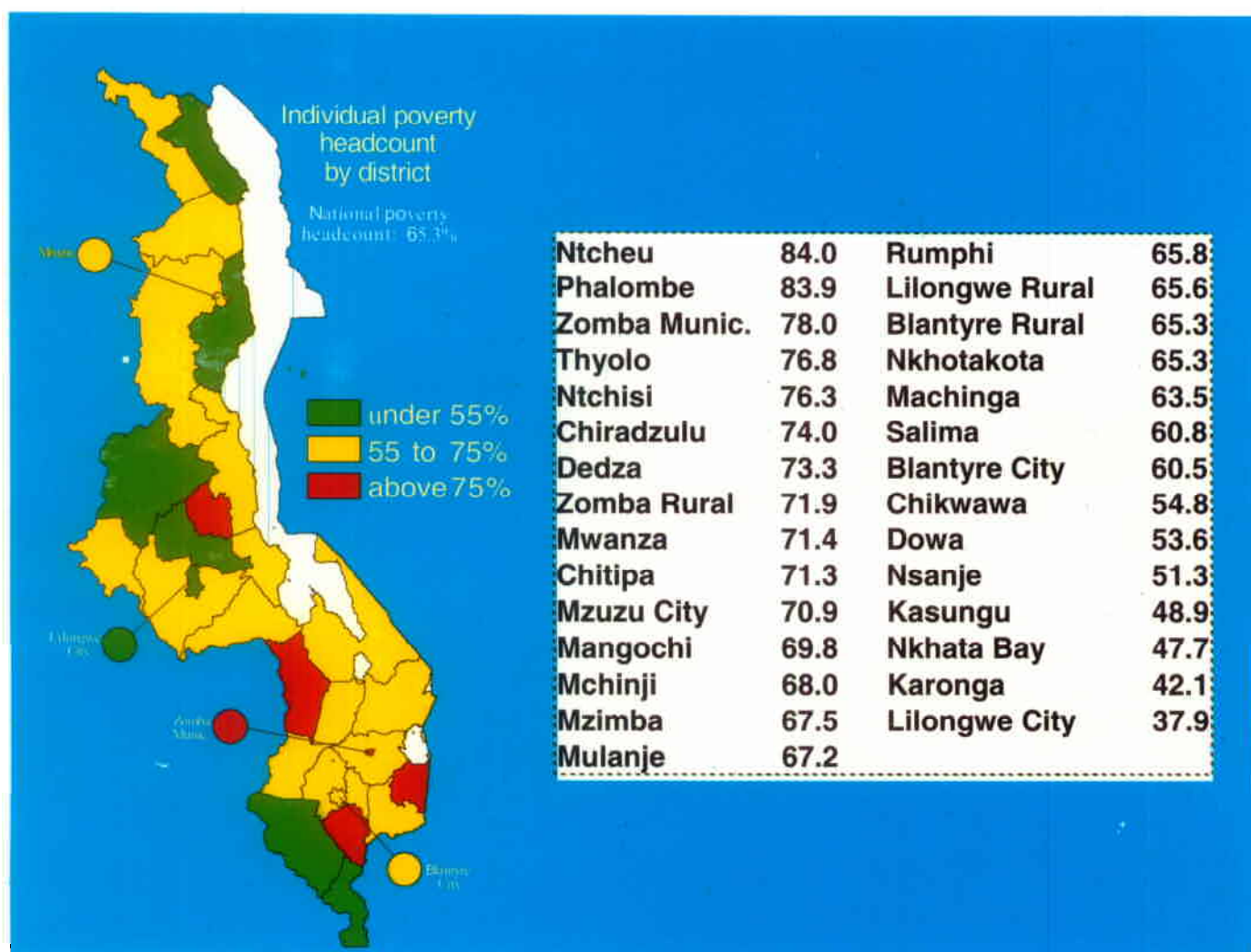
The UNDAF contains strategies aimed at achieving the objectives related to each of the three development challenges, which elaborate the specific mechanisms through which collaborative action should be pursued among the agencies, taking into account their respective mandates, policies and framework of engagement. A cooperative strategy framework was developed to facilitate and coordinate the planning, design, implementation, monitoring and evaluation of collaborative programmes. The framework also identifies specific cooperation strategies, taking into consideration the three development challenges and cross cutting areas. It harmonizes collaborative programmes and rationalizes the utilization of resources among the UN agencies and cooperating partners.

Strategies exist for each of the development challenges, which elaborate the specific mechanisms through which collaborative activities of various UN agencies should achieve the intended objectives. In recognition of the number and diversity of stakeholders, in terms of their missions, policies, framework of engagement, as well as resource constraints, a cooperative strategy framework was developed to facilitate and coordinate the planning, design, implementation, monitoring and evaluation of collaborative programmes. These are:

- (i) improved focus and results orientation, identifying where the system could make the most difference, by using its unique strengths as a development partner;

- (ii) stronger unity of purpose and team spirit within the UN System in the country;
- (iii) increased collaboration through a mix of agencies, parallel and collaborative programming;
- (iv) better integration of the normative and operational aspects of development cooperation;
- (v) increased dialogue and stronger partnership and alliances with other members of the development community, such as national and global civil society organizations; the private sector, bilateral donors, the World Bank, other international financial institutions and the European Commission;
- (vi) more efficient use of limited resources, based on improved division of labour, rationalization of resource allocation and streamlining of procedures; and
- (vii) improved opportunities for securing increased resources in support of national needs and priorities.

MALAWI: District-Level Poverty Headcount 1998



Printed by Capital Printing Press