



Ministry of Health



National Action Plan for the Prevention and Management of Non-Communicable Diseases in Malawi

2017 - 2022

NCD and Mental Health Unit, Ministry of Health, Malawi

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Foreword

The burden of non-communicable diseases (NCDs) is rapidly increasing in low- and middle-income countries. NCDs caused 70% of deaths worldwide in 2015.¹ Of these 39.5 million deaths attributed to NCDs, it is estimated that 30.7 million, or over 75%, happened in low- and middle-income countries.² The major four conditions (diabetes, cardiovascular diseases, cancers, and chronic lung diseases), while causing 48% of the NCD burden of disease in high-income countries, only account for 39% of the NCD burden in Malawi,³ indicating a broader definition of NCDs that need addressing in Malawi. The probability of dying from a non-communicable disease between the ages of 30 and 70 is highest in sub-Saharan Africa (SSA).

Non-Communicable Diseases (NCDs) are increasingly contributing to the burden of disease in Malawi. NCDs are the second leading cause of deaths in adults after HIV/AIDS in Malawi. They account for 16% of all deaths with 17% in males and 14% in females. Malawi has very high levels of hypertension at 32.9% in adults, which is much higher than many countries in the region. Malawi also has a very high burden of cervical cancer (age standardized incidence of 75.9 per 100,000⁴) which accounts for 9,000 DALYs per year in women.

In Malawi, up to 33% of adults aged 25 years and above have high blood pressure and about 6% have diabetes.⁵ Asthma prevalence is estimated around 5%. For cancer, Kaposi sarcoma remains the leading cancer for men, with oesophageal being the second most common, whereas for women, cervical cancer is the most common.⁶ Epilepsy and mental illnesses also affect a significant proportion of the Malawian population, with mental illnesses estimated to affect 4% of the population.⁷ Road traffic accidents and other injuries including violence relate trauma also contribute significantly to Malawi's public health problems, with estimated road traffic accident (RTA) prevalence at 3.5% in 2009, and injuries other than RTAs estimated to be 8.9%.⁸

¹http://www.who.int/gho/ncd/mortality_morbidity/en/

²http://www.who.int/gho/ncd/mortality_morbidity/en/

³GBD/IHME 2015

⁴GLOBOCAN 2012

⁵STEPS, 2009

⁶Masamba, L. (2015). *The state of oncology in Malawi in 2015*. *Malawi Medical Journal*, 27(3), 77.

⁷http://www.aho.afro.who.int/profiles_information/index.php/Malawi:Analytical_summary_-_Non-communicable_diseases_and_conditions

⁸STEPS, 2009

In 2002, the World Health Organization (WHO) estimated that the burden of NCDs in SSA would overtake that of communicable diseases by 2030 if no action was taken; hence, urgent action is required to avert the serious implications of NCDs on national economic developments. The development of this national NCDs Action Plan (2012-2016) therefore builds on the global call for action against NCDs through the Global Action Plan for prevention and control of NCDs (2008-2013) and on the Health Sector Strategic Plan (2011-2016) which has included non-communicable diseases and injuries (NCDIs) in Malawi's Essential Health Package.

In addition, this action plan is informed by the Malawi National NCDI Poverty Commission, one of 11 National NCDI Poverty Commissions globally, which was launched in November 2016. The Commission brings together experts to describe and evaluate the NCDI situation in Malawi, with a focus on the poorest populations. This analysis involves investigating which NCDIs cause the biggest burden in Malawi, which are more present in the young, and which interventions are available to avert death and disability from NCDIs in Malawi, particularly among the poorest segments of the population.

The NCDIs that have been included in this plan are: cardio-vascular diseases, diabetes, cancer, chronic lung diseases, epilepsy, mental illnesses, and injuries including violence-related trauma. Considering the wide range of NCDIs being tackled, this plan emphasizes the integration of interventions at the point of delivery. Thus, the interventions have been categorized into four thematic areas whose implementation and monitoring can easily be incorporated. These thematic areas are: (1) Diabetes mellitus, cardio-vascular diseases, and chronic lung diseases; (2) Cancers; (3) Epilepsy and mental illnesses; and (4) Injury, trauma, and violence.

The National Action Plan has taken a holistic approach to address the continuum of prevention and control for NCDIs. The planned actions include interventions for primary prevention, secondary prevention (screening and early diagnosis), treatment and follow-up care, as well as palliative and rehabilitation care where necessary. The main preventive aim for these interventions is lifestyle change through reduction of exposure to four shared risk factors: harmful use of alcohol, tobacco smoking, unhealthy diets, and physical inactivity.

This Action Plan is expected to drive all efforts towards the prevention and control of NCDs and injuries in Malawi and to provide a foundation for advocacy, awareness raising, a reinforcement of political commitment, and the promotion of partner and stakeholder collaboration against NCDIs. Its successful implementation will depend on a multisector and multidisciplinary approach. I therefore call upon other

government sectors, development partners, higher learning and research institutions, civil society organizations, the private sector, and all Malawians to join the Ministry of Health in this initiative.

Together, we can fight NCDs and injuries, even as we continue fighting communicable diseases in our nation, Malawi.

Honourable Atupele Muluzi, MP

MINISTER OF HEALTH

November, 2017

Acknowledgements

The National Action Plan for NCDs and Mental Health (2017-2022) is the product of a long process of intensive consultations and teamwork on specific group tasks. The Ministry of Health is therefore very grateful to all institutions and individuals who contributed to the successful development of this Action Plan. The concerted effort of all relevant MOH directorates, district and central hospital representatives, and other stakeholders within and outside the Ministry, who form the sub-Essential Health Package (EHP) Technical Working Group (TWG) on Non-Communicable Diseases and Mental Health, is acknowledged.

The team that actively participated in drafting and creating this Action Plan was comprised of individuals from the following departments and institutions: the Ministry's Clinical Services Department, Department of Planning and Policy Development (including its Central Monitoring and Evaluation Division), Department of Nursing Services, Department of Health Technical and Support Services, Department of Preventive Health Services (Health Education and Epidemiology Units), the Reproductive Health Department, the Trauma and Cancer Units of Queen Elizabeth Central Hospital. Kamuzu Central Hospital's One-Stop Centre, Thyolo and Kasungu District Health Offices, the school Health and Nutrition Department of the Ministry of Education, the College of Medicine (Mental Health, Medical and Paediatric Departments as well as Centre for Reproductive Health), WHO Malawi, Partners In Health, CDC Malawi, St John of God Community Mental Health Services, Diabetes Association of Malawi, Epilepsy Association of Malawi, Palliative Care Association of Malawi, Drug Fight Malawi, and Journalists against AIDS.

Special gratitude goes to the Clinical Services Directorate, particularly the NCDs and Mental Health Unit, for providing leadership in the development of this document. The combined efforts to coordinating meetings, compile vital information, comments, criticisms and suggestions, and the final compilation of this document are greatly appreciated.

The Ministry would also like to appreciate the financial and technical support given by the health development partners during the development of this NCD Action Plan. Specifically, we would like to acknowledge the financial support that UNICEF and Baobab Health Trust contributed that enabled meetings for the finalization of this Plan.

Dr Dan Namarika

SECRETARY FOR HEALTH

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ATLS	Advanced Trauma and Life Support
BLS	Basic Life Support
CDC	Centres for Disease prevention and Control
CDs	Communicable Diseases
CH	Central Hospital
CKD	Chronic Kidney Diseases
CMED	Central Monitoring and Evaluation Division
CMP	Child Maltreatment Prevention
COM	College of Medicine
COPD	Chronic Obstructive Pulmonary Disease
CLD	Chronic Lung Diseases
CSOs	Civil Society Organizations
CT	Computerized Tomography
CVDs	Cardio-Vascular Diseases
DALYs	Disability Adjusted Life Years
DHO	District Health Office
DM	Diabetes Mellitus
EHP	Essential Health Package
EPI	Expanded Program of Immunization
ETAT	Emergency Triage Assessment and Treatment

FEDOMA	Federation of Disability Organizations of Malawi
GCYDCA	Guidance, Counselling and Youth Development Centre for Africa
HCWs	Health Care Workers
HEU	Health Education Unit
HIC	High-Income Country
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HPV	Human Papilloma Virus
HSAs	Health Surveillance Assistants
HSSP	Health Sector Strategic Plan
HTSS	Health Technical Support Services
IAEA	International Atomic Energy Agency
IEC	Information, education and Communication
KAP	Knowledge, Attitude and Practice
KCH	Kamuzu Central Hospital
LMICs	Lower and Middle Income Countries
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring and Evaluation
MCR	Malawi Cancer Registry
MEHUCA	Mental Health Users and Carers Association
MEPI	Medical Education Partnership Initiatives
MGDS	Malawi Growth and Development Strategy
MH	Mental Health
MOH	Ministry of Health

MOU	Memorandum of Understanding
MPI	Multidimensional Poverty Index
MPS	Malawi Police Service
MRI	Magnetic Resonance Imaging
NCDs	Non-Communicable Diseases
NCDIs	Non-Communicable Diseases & Injuries
NCR	National Cancer Registry
NEPI	Nursing Education Partnership Initiative
NGO	Non-Governmental organizations
NHL	Non-Hodgkin's Lymphoma
NSO	National Statistical Office
OSC	One-Stop Centre
OVI	Objectively Verifiable Indicator
PAM	Physical Assets Management
PHC	Primary Health Care
PHIM	Public Health Institute of Malawi
QECH	Queen Elizabeth Central Hospital
RTA	Road Traffic Accident
SSA	Sub-Saharan Africa
STEPs	Stepwise population survey for NCDs
SWOT	Strengths, weaknesses, opportunities and threats
TB	Tuberculosis
TOT	Training of Trainers
TWG	Technical Working Group

UN	United Nations
UNC	University of North Carolina
UNFPA	United Nations Food Programme Agency
UNICEF	United Nation International for Children Education Fund
WHO	World Health Organization

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Section One: Introduction

1.1 Global burden of NCDs

The ageing of populations in developing countries results in a demographic and an epidemiological transition. It will affect the impact of chronic and degenerative diseases on the health of populations. Improvement in economic development mostly meets the needs of societies in terms of their general health. Environmental health, sanitation, maternal, child health and other services have become better. Globally, life expectancy has increased and lifestyles associated conditions such as obesity, hypertension, and injuries tend to become more prevalent. These changes may also include a shift in health-related behavior, which may augment the dietary consumption of fats, alcohol, and increase in smoking and decreased physical activity. Changes in risk factor levels have increased the number of chronic diseases. Depending on the status of development of every country, non-communicable diseases (NCD) emerge, may rapidly increase or become established at high levels. The HIV/AIDS pandemic, gender and poverty are notable determinants of non-communicable diseases.

Non-communicable diseases (NCDs) are disease processes or health conditions that are not infectious or transferable from one human to another. They can be a result of random genetic abnormalities, heredity, lifestyle, or environmental causes. Non-communicable diseases and injuries (NCDIs) account for nearly 70% of deaths worldwide with an estimated 75% of these deaths occurring in low- and middle-income countries.⁹ In low- and middle-income countries, NCDs contribute to 82% of premature deaths (before the age of 70).¹⁰ The major four chronic non-communicable diseases are: cardiovascular diseases (CVD), diabetes, cancers, and chronic respiratory (lung) conditions. However, in impoverished settings such as Malawi, the burden of NCDs needs to be much more broadly defined to encompass all relevant conditions. In fact, these ‘big four’ conditions contribute to just 39% of the burden of NCDs in Malawi.

In sub-Saharan Africa (SSA), communicable diseases, particularly HIV/AIDS, tuberculosis (TB), and malaria are still responsible for the greatest burden of morbidity and mortality. However, non-communicable diseases are increasingly becoming a significant public health problem that require immediate attention,

⁹<http://www.who.int/mediacentre/factsheets/fs355/en/>

¹⁰<http://www.who.int/mediacentre/factsheets/fs317/en/>

before facing what may be called a double disease burden.¹¹ Additionally, non-communicable diseases are introducing significant demands on health care resources in this region and if no action is taken, NCDs will continue to strain the already fragile health system which continuously faces human resource shortages, inadequate diagnostic systems, as well as low supplies of drugs and other medical supplies.^{12,13}

In 2002, the World Health Organization (WHO) estimated that the burden of NCDs in SSA would overtake that of communicable diseases by 2030 if no action is taken. In 2008, WHO further estimated that globally, NCDs will increase by 17% in ten years (by 2018), with up to 27% increase in the African region alone.^{14,15}

1.2 The burden of NCDs in Malawi

Based on Global Burden of Disease (GBD) data, which draws from a significant set of available data sources in Malawi, NCDs make up 25% of the total burden of disease in Malawi and 29% of the mortality, with estimates increasing to 31% of the total burden and 35% of mortality if injuries are included.

Table 1 shows the prevalence of some common NCDs in Malawi and the expected number of Malawians with the conditions. According to the 2009 STEPS survey, 32.9% of Malawi's population aged 25-64 had hypertension (high blood pressure), while 8.9% suffer from cardiovascular diseases. However, experts in Malawi generally agree that the STEPS survey overestimated the prevalence of hypertension, with other estimates and expert opinion suggesting that the prevalence might be closer to 15%. Data from Karonga and Lilongwe suggests a 15.5% prevalence rate amongst urban adults and 13.4% amongst rural adults,¹⁶ while data from Zomba district found a 26.5% prevalence rate for urban patients versus a 21.0% for rural patients.¹⁷

The STEPS survey also showed that 94% of those with hypertension were not on treatment and 75% were unaware that they were hypertensive. STEPS estimated the national prevalence of diabetes at 5.6% and

¹¹Bainngana FK et al. 2006

¹²Nigel U (2001)

¹³Murray CJ et al (1996) *The disease burden study*

¹⁴Nigel U (2001)

¹⁵Harries et al. (2008)

¹⁶MEIRU data, citation pending

¹⁷Divala et al., 2016 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5153818/>

asthma at 5.1%. The prevalence of road traffic accidents (RTAs) was estimated to be 3.5% while injuries (other than RTAs) were at 8.9%.¹⁸

The Malawi National NCDI Poverty Commission was launched in 2016 in order to describe and evaluate the NCDI situation in Malawi, with a focus on the poorest populations. The Commission underwent a rigorous prioritization exercise of the 190 conditions defined as NCDs and injuries, prioritizing conditions that are the most severe, account for a large burden of disease, and affect the poor or the young disproportionately. This process resulted in a list of 37 ‘priority NCDI conditions’ in Malawi that are depicted in Table 2, and accordingly addressed in this Action Plan.

The inclusion of NCDs in Malawi’s Health Sector Strategic Plan (HSSP 2011-2016 and 2017-2022) and the subsequent establishment of a coordinating unit for NCDs and mental health was a response to this evident public health burden of NCDs. Although NCDs have traditionally been non-prioritized and underfunded, this Action Plan serves as a stepping stone for national commitment towards NCD prevention and control.

Table 1: Prevalence of non-communicable diseases (NCDs) in Malawi

Disease/condition	Prevalence	Expected Malawians with the condition, as of 2017 [^]	Data sources
Hypertension	32.9% / 15%		NCD STEPS survey 2009 / cite as above
Cardiovascular diseases (using cholesterol as a marker)	8.9%		NCD STEPS survey 2009 (N=3910, age 25-64 years)
Injuries other than RTA	8.5%		WHS* Malawi 2003 (N=5297, age >=18years)
Diabetes	5.6%		NCD STEPS survey 2009
Asthma	5.1%		WHS Malawi 2003 (N=5297, age >=18years)
Road Traffic Accidents (RTA)	3.5%		WHS Malawi 2003 (N=5297, age >=18years)

¹⁸STEPS, 2009

ADDITIONAL CONDITIONS? (SEE COMMENT)			
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*WHS=World Health Survey

^Population data source

Table 2: NCDI priority conditions in Malawi

Neural tube defects	Major depressive disorder	Low back pain
Epilepsy	Hypertensive heart disease	Anxiety disorders
Oesophageal cancer	Cirrhosis and other chronic liver diseases due to alcohol use	Ischemic heart disease
Sickle cell disorders	Appendicitis	Rheumatic heart disease
Poisonings	Motor vehicle road injuries	Bladder cancer
Paralytic ileus and intestinal obstruction	Non-Hodgkin lymphoma	Breast cancer
Cirrhosis and other chronic liver diseases due to other causes	Peptic ulcer disease	Psychotic disorders
Congenital heart anomalies	Liver cancer due to hepatitis B	Chronic kidney disease
Haemorrhagic stroke	Bipolar disorder	Gender & partner violence
Pedestrian road injuries	Diabetes mellitus	Suicide
Fire, heat, and hot substances	Asthma	Acute lymphoblastic leukaemia
Ischemic stroke	Chronic obstructive pulmonary disease	
Cervical cancer	Cirrhosis and other chronic liver diseases due to Hepatitis B	

1.3 Prevalence of common risk factors for NCDs

According to WHO, 80% of heart diseases, stroke, and type 2 diabetes can be prevented by the use of proven cost-effective strategies that include the elimination of shared risk factors, mainly: unhealthy diets, physical inactivity, excessive alcohol consumption, and tobacco smoking. The 2009 NCD STEPS survey for Malawi showed that 14.1% of adults currently smoke and 16.9% consume alcohol, among which 1 in 5 men engage in heavy episodic drinking (i.e. had 5 or more drinks at one sitting in the previous 30 days). More

women than men were estimated to be overweight, with prevalence rates of 28.1% and 16.1%, respectively. Almost 17% of the adult population had three or more NCD risk factors.

From studies conducted by the Malawi Epidemiology and Intervention Research Unit (MEIRU), evidence from both Karonga and Lilongwe found key differences between rural and urban populations for common NCD risk factors (table 3). Price et al.¹⁹ found an overall current smoking prevalence of 4.5%, with an urban prevalence of 3.3% compared to a rural prevalence of 5.8%. Similarly, alcohol consumption (in the previous

Risk Factors	Overall	Male	Females	Urban	Rural
Tobacco smoking (current)	4.5%	11.4%	0.2%	3.3%	5.8%
Alcohol consumption (last year)	18.3%	39.7%	5.0%	17.0%	19.8%
Overweight	27.4%	13.4%	36.7%	35.0%	19.2%
Obesity	9.0%	2.3%	13.4%	12.9%	4.7%
Physical inactivity	3.7%	6.1%	2.1%	4.2%	3.1%
Raised blood Pressure (or on medication)	12.6%	14.0%	11.8%	13.0%	12.2%
Raised total cholesterol	14.1%	11.5%	15.7%	14.2%	14.0%
Raised fasting blood glucose / previous diabetes diagnosis	2.4%	2.3%	2.4%	3.0%	1.7%

year) was found to be higher in rural populations, with 19.8% prevalence amongst rural adults compared to 17.0% for urban adults. However, for other risk factors, such as being overweight or obese, being physically inactive, or having a raised blood pressure, raised total cholesterol, or raised fasting blood glucose, adults in urban populations had higher rates compared to rural populations.

Table 3: Data from MEIRU on NCD risk factors

The data from MEIRU presents a different overall and urban/rural prevalence for NCD risk factors compared to the 2009 STEPS survey, highlighting the need for further research into NCD risk factors and the

¹⁹Waiting on Mia for proper citation

difference between wealthier and poorer communities. Furthermore, the differences shown between urban and rural populations emphasises the need for an NCD approach that encompasses all segments of Malawi’s population, including the poor and often marginalised.

In addition to these considerations of the most common NCD risk factors, findings from the Global Burden of Disease and the National NCDI Poverty Commission indicate that there is also an important and significant burden of NCDs in Malawi that are not attributable to these traditional lifestyle-related risk factors. According to GBD estimates, the four major NCD categories (cardiovascular disease, chronic respiratory diseases, diabetes, and cancers) contribute to around 38% of the NCD DALY burden in Malawi (not including injuries), compared to just under 48% in high-income countries (HICs). Additionally, just 17% of NCD DALYs in Malawi come from these four categories and are attributable to behavioural or metabolic risk factors, compared to 30% in HICs. Put another way, 83% of NCD DALYs in Malawi were not found to be attributable to factors relating to lifestyle choices and/or subsequent metabolic risk factors.

Looking at the four categories more closely, there is an even further disparity between Malawi and HICs. For instance, the risk factor attribution for behavioural and metabolic factors for chronic respiratory diseases (CRD) is estimated to be just 5.8% in Malawi, whereas estimates from HICs attribute nearly 49%.

These estimates and comparisons signify an important new perspective when considering the burden of NCDs in a country such as Malawi.

Table 4 shows the statistics for some of the NCD risk factors.

Table 4: Prevalence of risk factors for NCDs in Malawi (source: steps survey 2009)

Results for adults aged 25-64	Males	Females	Total
Percentage who currently use tobacco products	25.9%	2.9%	14.1%
Percentage who have consumed alcohol in their life time	52.6%	12.2%	31%
Percentage who are current drinkers	30.1%	4.2%	16.9%
Percentage who engage in heavy episodic drinking	19%	2.3%	-
Percentage with low levels of physical activity	6.3%	12.6%	9.5%
Percentage of adults who are overweight	16.1%	28.1%	21.9%
Percentage who are obese	2.0%	7.3%	4.6%

Table 5: GBD risk factor attribution from behavioural (b) and metabolic (m) factors for the four main NCD categories

Cause		Malawi	High Income Countries
Neoplasms	Percent B/M	17.5	43.5
	Percent not B/M	82.5	56.5
Cardiovascular	Percent B/M	74	81.3
	Percent not B/M	25.6	18.7
Respiratory	Percent B/M	5.8	49
	Percent not B/M	94.1	51
Diabetes	Percent B/M	100	100
	Percent not B/M	0	0

1.4 Progress in Malawi since the last National Action Plan for NCDs

Ronald will need your input on this section on what WDF IS DOING AND SOME DATA and health initiatives it has supported nationally

Section Two: Situational Analysis

2.1 Cardiovascular diseases

Globally, 17.7 million deaths were attributed to cardiovascular conditions in 2015,²⁰ with an estimated 7.4 million deaths due to coronary heart disease and 6.7 million to stroke.²¹ Like NCDs in general, over 75% of these deaths occur in low- and middle-income countries.²²

In Malawi, total cardiovascular disease prevalence is estimated to be around 4%, with CVDs contributing to nearly 10% of all deaths in Malawi in 2015.²³ GBD data further indicates that CVDs contribute to 3.72% of the total DALYs in Malawi, and nearly 12% of the NCDI burden.²⁴

Furthermore, data from urban and rural populations, stratified by wealth quintiles, suggest that there is large divide between the wealthiest and poorest sections of the population. Adjusting to the WHO world standard population, Price et al.²⁵ found that 15.6% of people from the poorest households had hypertension, compared to 25.3% of people from the wealthiest households. However, people from the poorest households are much more unlikely to be diagnosed or to have ever had their blood pressure measured, with estimates suggesting that only 29.4% of the poorest individuals have ever been tested, or just 25.7% diagnosed if hypertensive, compared to 52.7% and 55.2%, respectively, for individuals from the wealthiest households. This again supports the need for stratified, population-wide data that targets the poorest in Malawi for both preventative and curative interventions.

For Malawi in general, there is great need to increase awareness around the improvement of lifestyle choices and risk factor reductions for CVDs, as well as the improvement of chronic follow-up care for the management and monitoring of outcomes in patients.

2.2 Diabetes mellitus

Type 2 diabetes, one of the most common NCDs of the 21st century, continues to be a growing global concern. The worldwide diabetes prevalence, in adult populations over the age of 18 years, is estimated to

²⁰<http://www.who.int/mediacentre/factsheets/fs317/en/>

²¹*ibid.*

²²*ibid.*

²³IHME 2015

²⁴IHME 2015

²⁵Citation from Mia/MEIRU

have risen from 4.7% to 8.5% in the last 40 years.²⁶ In Malawi, diabetes is estimated to be prevalent in 1.8-5.6% of the adult population (IHME, 2015; STEPS, 2009). Diabetes is estimated to contribute to 2.4% of NCDI DALY burden, and 1.27% of total deaths (IHME, 2015). If the lower end of the prevalence scale is considered, the high percentage of deaths caused by diabetes highlights the critical need for interventions and strategies to tackle this burden throughout the Malawian population.

2.3 Chronic kidney disease (CKD)

Kidney disease can be caused by diabetes, obesity, high blood pressure, and some infections. Chronic kidney disease (CKD) is a key determinant of the poor health outcomes of major NCDs. CKD is associated with an eight to tenfold increase in cardiovascular mortality and is “associated with age-related renal function decline accelerated in hypertension, diabetes, obesity and primary renal disorders.”²⁷ Global CKD prevalence is estimated to be between 11 to 13% for all stages.²⁸

Based on GBD estimates, CKDs have a 2.3% prevalence rate in Malawi, though only contributed to 0.41% of total deaths in 2015 (IHME, 2015). Overall, CKD represents 1.05% of the NCDI DALY burden. However, it has been notoriously difficult to estimate the true impact of CKD on Malawi’s population, due to limited studies and diagnostic difficulties. Yet because early detection and treatment of CKD is relatively inexpensive, the implementation and widespread use of such interventions should be established throughout the country in order to slow or prevent progression to end-stage renal disease (ESRD).

Early detection and treatment of CKD can thus be implemented at low costs, helping to reduce the burden of ESRD, improve outcomes for diabetes and cardiovascular disease (including hypertension), and substantially reduce morbidity and mortality from NCDs. Prevention of CKD is thus a crucial component of this National Action Plan, given the benefits of implementing cost-effective interventions.

2.4 Cancer

Though, like many NCDs, cancer can be mistaken as a disease of the wealthy, currently close to 70% of cancer deaths occur in low- or middle-income countries.²⁹ Cancers are the second leading cause of death worldwide, with nearly one third of these deaths attributed to behavioural factors such as tobacco use,

²⁶<http://www.who.int/mediacentre/factsheets/fs312/en/>

²⁷Hill et al. 2016 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4934905/>)

²⁸*Ibid.*

²⁹<http://www.who.int/mediacentre/factsheets/fs297/en/>

alcohol use, physical inactivity, poor diet, and obesity.³⁰ Cancer is a growing concern in Malawi, causing tremendous morbidity and mortality due to lack of comprehensive cancer care.

According to the 2010 National Cancer Burden Survey,³¹ over 8,100 new cases of cancer are diagnosed annually in Malawi. However, this may be a gross underestimation due to the lack of cancer diagnostic services. According to GBD estimates, neoplasms in general account for 15.98% of the NCDI DALY burden and contribute to 7.1% of mortality.³²

Aggregate data from Malawi shows that breast and cervical cancer have the highest prevalence rates (at around 0.06%), as does non-Hodgkin’s lymphoma (also 0.06%). While it is understood that Kaposi sarcoma has a high prevalence and burden throughout Malawi, it has been deliberately excluded here and , within the GBD estimates, due to its intimate association with communicable diseases (HIV). However, other cancers such as cervical and liver cancer, were included, despite the increased risk and association with infections.

While oesophageal cancer is estimated to be low in prevalence, it contributes the most to NCDI DALYs, showing that while the cancer may not affect many in absolute numbers, the impact on life and premature deaths enacts a significant toll.

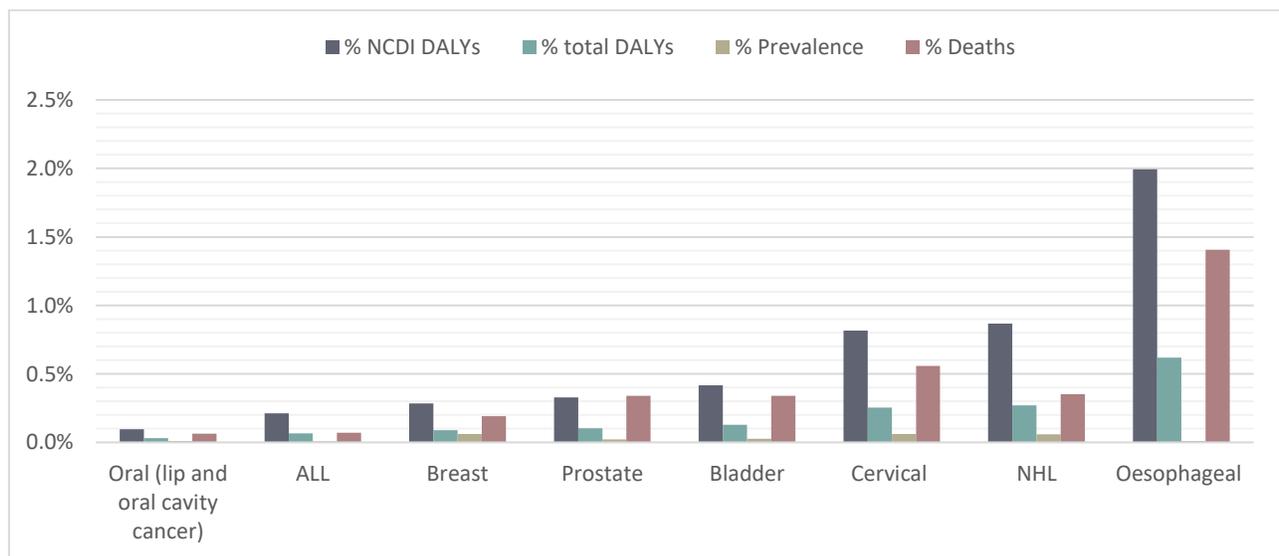


Figure 1: Contribution of cancers to NCDI and total DALYs, prevalence, and deaths in Malawi

³⁰*Ibid*

³¹Msyamboiza et al

³²IHME, 2015

2.5 Injuries and trauma

In 2015, the WHO estimated that road traffic accidents caused 1.34 million deaths per year, making road injuries the 10th leading cause of death worldwide.³³ For the African region as a whole, road injuries remained the 10th leading cause of death, leading to more than 250,000 deaths in 2015.³⁴ GBD data shows that for Malawi, however, injuries contributed to 6.4% of deaths nationally. Therefore, although road accidents produce a significant burden on the Malawian population, they are not within the top ten leading causes of mortality.

Injuries overall in Malawi, including pedestrian road injuries, cyclist injuries, unintentional injuries (such falls, drowning, and fires), as well as injuries caused by self-harm and physical interpersonal violence, contributed to 6% of total DALYs in 2015, and represent 19% of the NCDI DALY burden.³⁵ Therefore, while not amongst the leading causes of mortality, injuries and trauma still remain an essential priority for this Action Plan, because they result in long-term disabilities that are a significant burden. For every death, it is estimated that there are dozens of hospitalizations, hundreds of emergency department visits, and thousands of doctors' appointments. A large proportion of people surviving their injuries incur temporary or permanent disabilities.

Trauma, injury and post-violence care in Malawi is faced with several challenges. There are inadequacies in system organization and continuum of management and care. Lack of first aid and pre-hospital care makes the survival of the injury victims even more unlikely. Monitoring and evaluation is hindered by un-coordinated data systems among the relevant stakeholders and service providers including health, transport, police, gender and social welfare sectors.

This Action Plan therefore seeks to not only prevent injuries, but ensure adequate systems and facilities are in place for the treatment of both accidental and intentional injuries.

2.6 Epilepsy

Epilepsy is one of the most common NCDs. It affects over 50 million people worldwide and 80% are in low- or middle-income countries.³⁶ Within these countries, it is estimated that nearly 75% of people with

³³ (WHO, 2015)

³⁴ (WHO, 2015)

³⁵ IHME 2015

³⁶ <http://www.who.int/mediacentre/factsheets/fs999/en/>

epilepsy do not seek or have access to treatment.³⁷ In Malawi, GBD suggests a 0.20% prevalence rate and a 0.44% mortality rate,³⁸ although due to stigma and discrimination, as well as a lack of national data, these figures could be grossly underestimated. Epilepsy contributes to 1.95% of the NCDI DALY burden in Malawi.³⁹

Epileptic care in Malawi is left to psychiatric personnel and there are no standardized guidelines for epilepsy management and follow up care, at neither the secondary nor primary health care level. This gap in both possible diagnoses and care, as well as standardised guidelines, contributes to a significant burden that can be easily lessened with more targeted interventions and systems. Including epilepsy in this Action Plan thus aims to redress this gap and create an environment wherein epileptic patients can seek and obtain the care that they need.

2.7 Mental health disorders

Mental health disorders, including depression, bipolar disorder, schizophrenia, autism, and other developmental disorders, affect millions of people globally.⁴⁰ For instance, over 300 million people worldwide suffer from depression, and nearly 800,000 people die each year due to suicide.⁴¹

In Malawi, mental health and substance use disorders are estimated to be prevalent in 12.85% of the population and contribute to 11.60% of the NCDI DALY burden.⁴² When considering depressive disorders, schizophrenia, bipolar disorder, and anxiety conditions (all priority conditions for the NCDI poverty commission), depressive disorders contribute to the highest NCDI DALY burden and prevalence (4.02% and 4.10%, respectively).⁴³

In addition to depression and anxiety disorders, alcohol and substance use or abuse of cannabis and other substances are very common, with practically no drug treatment centres at primary, secondary or tertiary levels available to help these people, except at one facility which is privately run, St. John of God, that has substance addiction programme in Northern and Central region of Malawi. However Zomba Mental Hospital which is a referral center for the Government health facilities does offer programmes on substance addiction programmes and other mental health disorders.

³⁷*ibid.*

³⁸*IHME, 2015*

³⁹*ibid.*

⁴⁰<http://www.who.int/mediacentre/factsheets/fs396/en/>

⁴¹*ibid.*

⁴²*IHME, 2015*

⁴³*ibid.*

The provision of mental health services in Malawi is further hampered by critical shortage of mental health professionals at all levels, lack of infrastructure at district level for patients with mental health problems and the erratic procurement of psychotropic drugs. Although the Malawi government trains at least 10 psychiatric nurses every year, the number of Psychiatric nurses actively doing mental health activities is very low due to general shortage of nurses in health system. There are now 22 psychiatric clinical officers as a result of the degree training program at St. John of God but funding for the trainings has been halted.

There is a 100% vacancy rate for clinical psychologist and consultant psychiatrist positions. Although the GoM trains at least 20 psychiatric nurses and psychiatric clinical officers every year, the number of psychiatric staff actively doing mental health activities is very low due to general shortage of nurses in the health system. There are no mental health counsellors in public health system.

2.8 Other conditions

There are several other conditions not listed above, but defined as priority conditions by the National NCDI Poverty Commission, meaning they contribute to a significant burden of disease in Malawi and may disproportionately affect the poor and the young. These conditions include:

Insert list that isn't yet discussed in situation analysis? – highlighted below

Neural tube defects	Major depressive disorder	Low back pain
Epilepsy	Hypertensive heart disease	Anxiety disorders
Oesophageal cancer	Cirrhosis and other chronic liver diseases due to alcohol use	Ischemic heart disease
Sickle cell disorders	Appendicitis	Rheumatic heart disease
Poisonings	Motor vehicle road injuries	Bladder cancer
Paralytic ileus and intestinal obstruction	Non-Hodgkin lymphoma	Breast cancer
Cirrhosis and other chronic liver diseases due to other causes	Peptic ulcer disease	Psychotic disorders
Congenital heart anomalies	Liver cancer due to hepatitis B	Chronic kidney disease
Haemorrhagic stroke	Bipolar disorder	Gender & partner violence
Pedestrian road injuries	Diabetes mellitus	Suicide
Fire, heat, and hot substances	Asthma	Acute lymphoblastic leukaemia

Ischemic stroke	Chronic obstructive pulmonary disease	
Cervical cancer	Cirrhosis and other chronic liver diseases due to Hepatitis B	

Section Three:

3.1 Justification for NCDs Action Plan

The NCDs burden for Malawi is built on evidence from the 2009 STEPS survey and the Global Burden of Disease study data. While these sources compile nationally available data from many different stakeholders and research teams, the numbers presented here somewhat constrained by the lack of up-to-date national surveys, limited population-based studies, and limited research into all NCDI conditions, especially across income categories. However, the situational analysis described above, even if underestimating prevalence and burdens of disease, still indicates the critical need to invest in NCDI prevention, control, and treatment strategies if Malawi is to truly tackle this growing burden.

The national health budget is already constrained by communicable diseases. It is therefore of paramount importance to act now with cost-effective, proven strategies for NCDs in order to tackle the double burden of disease. Figure 2 shows the great disparity in programmatic funding for various disease types compared to their relative contribution to the overall burden of disease.

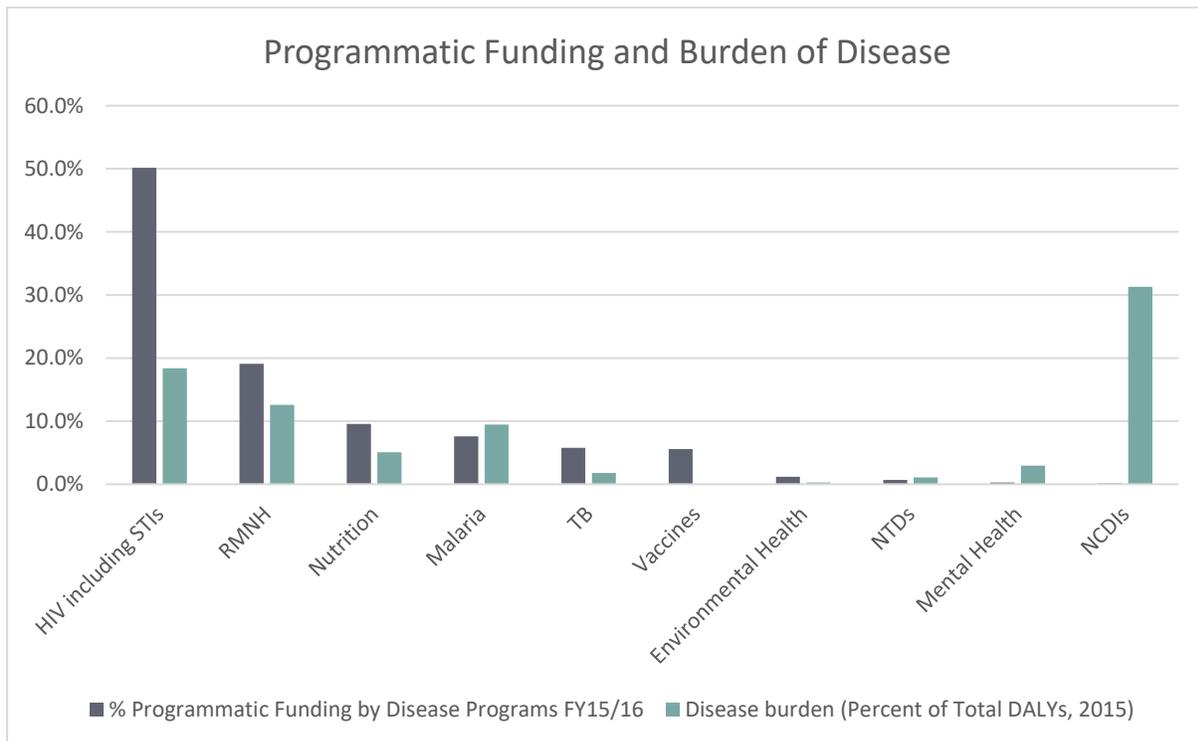


Figure 2. Funding and disease burden by broad categories

Preventive efforts against NCDs have previously been focused on single or few diseases, often with various uncoordinated implementers and supporters. Treatment and care was focused at the individual patient level and often centralized. Therefore, this action plan is a public health initiative that seeks to integrate NCDI care into primary, secondary, and tertiary care.

Concerted, coordinated efforts to implement this plan are likely to improve quality of life for those already affected by NCDs and hence contribute to the global target of 25% reduction in premature mortality from NCDs by the year 2025. By introducing new programmes, and increasing the scale of existing NCDI interventions, this Action Plan also hopes to contribute to the prevention of NCDIs for many Malawian citizens, through targeting risk factors, raising awareness, and treating conditions before they progress to life-threatening stages.

3.2 Strategic linkages

This Action Plan has been linked to global, regional, and national strategies on NCDs management and prevention. The 2008-2013 Action plan for the global strategy for the prevention and control of NCDs forms a basis for a working global partnership to prevent and control the four major NCDs and their four shared risk factors. The Global Action Plan on NCDs prevention and management calls for WHO member states to establish and strengthen national policies and plans for the prevention and control of NCDs. The Global Action Plan was developed by WHO's Non-Communicable Diseases and Mental Health (NMH) Cluster. The WHO AFRO Ouagadougou declaration (2008) further calls for integration of essential NCDs interventions into in Primary Health Care.

At national level, the HSSP (2011-2016) has listed NCDs, including trauma as well as epilepsy and mental illnesses, in the Essential Health Package. This action plan therefore serves as an operational tool for the NCD strategies set out in the current HSSP.

3.3 Key challenges

As identified through a thorough SWOT analysis for each NCD, key challenges to effective NCDs prevention, management, and control include: inadequate comprehensive national legislation and policy frameworks; erratic availability of diagnostic and treatment commodities; limited human, infrastructural, and

financial capacity; as well as disintegrated data systems and a lack of scientific evidence (inadequate research capacity).

Section Four: Broad Strategic Directions

4.1 Vision

A nation with improved quality of life for all people through reduced morbidity and mortality from non-communicable diseases and conditions.

4.2 Overall goal

To reduce the burden of preventable morbidity and disability as well as avoidable mortality due to NCDs & Injuries, including the broad scope of many NCDs impacting the health of Malawians outside of the traditional

4.3 Objectives

The strategic objectives of the NCDs Strategic Plan are basically the strategies derived from the WHO 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non Communicable Diseases and the Malawi National Action Plan for Non-Communicable Diseases in Malawi 2009-2014. Furthermore aligned to the HSSPII 2017- 2022, they address the NCD issues comprehensively and are involving. These strategies are:

1. ***To raise the priority accorded to non-communicable diseases at different development of work at national, district and community levels by June 2022.***

With the rising burden of NCDs, it is essential to address these diseases at different levels of development work so that we address them comprehensively. These diseases and their risk factors are inter-related and contribute to poverty; therefore they should no longer be excluded from global and national discussions on development.

2. ***To establish and strengthen national policies and plans for the prevention and control of non-communicable diseases by June 2022.***

We need to establish and strengthen policies and plans for the prevention and control of NCDs as an integral part of our national health policy and broader development framework. Such policies should encompass the following components: Development of a national multisector framework for prevention and control of NCDs. Integration of the prevention of NCDs into the national health plan Reorientation and strengthening of the health systems.

3. ***To promote interventions to reduce the main shared modifiable risk factors for non-communicable diseases: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol by June 2022.***

(Occupational Health.....strengthen)

Strategies for reducing risk factors for non-communicable diseases should aim to provide and encourage healthy choices for all. As the underlying determinants of non-communicable diseases often lie outside the

health sector, this strategy needs to involve both public and private actors in multiple sectors such as Agriculture, Education, Planning, etc.

4. *To strengthen surveillance, monitoring and research on priority non-communicable diseases by June 2022.*

Monitoring non-communicable diseases and their determinants provides the foundation for evaluating the effectiveness and impact of interventions and assessing progress made. It is also useful for advocacy and policy development purposes. A coordinated agenda for non-communicable disease research is an essential element in the effective prevention and control of non-communicable diseases.

5. *To strengthen health system to support NCDs prevention and control by June 2022.*

Currently, the health system in Malawi is not equipped to comprehensively address NCDs. The reorientation and strengthening of the health systems will enable them to respond more effectively and equitably to the health care needs of people with NCDs.

6. *To strengthen mechanism for Programme Coordination and Management by June 2022.*

Programme coordination and management is important for the prevention and control of NCDs. It is important to have an effective coordination of activities at all levels in the country. Quality control and the impact of NCDs control activities need resources in terms of trained human resources, budget and supervision. Independence of the unit

7. *To promote partnerships for the prevention and control of Non-communicable diseases by June 2022*

A diverse set of partners is a key component to the successful implementation and sustainability of NCDs prevention and control efforts. Partners can help generate support for health promoting policies and they can leverage resources beyond what is available through national and local government. It is important to establish an effective partnership for the prevention and control of non-communicable diseases, and develop collaborative networks, involving key stakeholders as appropriate.

4.4 Thematic areas

Malawi's current priority non-communicable diseases and conditions have been grouped into four thematic areas as follows:

1. Chronic NCDs: Hypertension and other CVDs; diabetes mellitus; chronic lung diseases; chronic kidney diseases; chronic neurologic diseases; chronic blood diseases
2. Cancers
3. Injury, trauma, and violence
4. Mental health and neurological disorders

4.5 Guiding principles

4.5.1 Integrated approach

The approach for this action plan is grounded in the principle that decisions people make about health choices are shaped by the physical, social, economic and legal environment. It, therefore, has a comprehensive confirmation with evidence based policy and action oriented dimensions calling for a change at the institutional, community and public policy levels. It is being designed to overcome the tendency to rely on a disjointed set of small scale projects, factoring integration at all levels and grouping NCDs so that these can be targeted through a set of harmonizing actions, integrating them with existing public health system and incorporating contemporary evidence based concepts.

In addition, given the broad base of the burden of disease in Malawi – for example the identification of 37 priority conditions – necessitates an integrated approach that strengthens the overall health system for addressing the range of conditions afflicting Malawians.

4.5.2 Action level integration

The paradigm of NCD prevention referred to above is multidisciplinary in nature; it calls for a diverse range of actions involving policy development, legislation, regulation, public and professional education, guideline development, media interventions and research.

4.5.3 Holistic approach

The interventions in this action plan are based on the continuum of care for most chronic conditions from prevention to rehabilitation. The preventive efforts are both at primary prevention level, preventing the unaffected from being affected and secondary prevention level, for averting complications in those already affected. The rehabilitative and palliative efforts are aimed at improving quality of life for those faced with complicated and life-threatening conditions.

4.5.4 Equitable access and human rights approach

The interventions set out in this plan shall be delivered to all people in a cultural and age-sensitive manner. Even when delivery is in phased approach, efforts will be made to reach all people by ensuring a roll out of the interventions.

Clients in both public and private sectors, rural and urban, either rich or poor, shall have access to minimum quality care through availability of NCD management standardised guidelines.

This national action plan commits to addressing the critical burden of NCDIs that may disproportionately affect the poor. This is important both from an equity standpoint, and because almost 65% of Malawians are living in extreme poverty and may be at risk for different NCDIs and risk factors. Thus, planning for addressing NCDIs and their risk factors in Malawi must consider the extremely impoverished and potential variation of the burden of disease.

4.5.5 *Community Involvement*

The interventions set out in this plan shall be implemented with involvement of community structures to ensure promotion of healthy life styles, community action and contribution towards reduction of NCD risk factors.

Section Five: Intervention Matrices

Insert matrices from planning meeting in Lilongwe – still to be finalized?

Section Six: Implementation Linkages

6.1 Coordination

In order to achieve the intended goal of this action plan, there shall be coordination and networking among the MOH, development partners, private sector, other key line ministries and, other stakeholders at all levels. At national level, a NCD Technical Working Group (TWG) as a subgroup the EHP TWG shall provide technical oversight for all NCDs interventions. The secretariat to the NCDs TWG shall be the NCDs Unit in the Clinical Services Directorate. **The NCDs Unit shall need to be changed to be a Directorate and have the following positions, a Deputy Director Clinical Services – NCDS, Assistant Deputy Directors – NCDS responsible for each of the four NCD thematic areas and a Technical Assistant responsible for advocacy, resource mobilization and improving the primary health care services for the 38 priority conditions identified through the commission findings and report.** A health promotion officer for NCDs shall be designated by the Ministry's Health Promotion section.

Each NCD thematic area shall have a steering committee that shall report to the NCD sub-EHP TWG. Each steering committee shall be responsible for developing implementation guidelines and monitoring of progress on interventions set out in this action plan.

At district level, each District health office shall have an NCDs coordinator as well as a Mental Health focal person with separate personnel responsible for the Central Hospitals and District Health Offices. Districts will work hand in hand with community structures to promote healthy life styles and positive health seeking behaviours. The NCDs coordinator shall work with the District Health Management Team (DHMT) to ensure implementation of the interventions set out in this action plan as well as reporting to the NCDs Unit through the Zonal Health Offices.

6.2 Partner and stakeholder analysis

The effective delivery of the strategies laid out in this Action Plan requires national and international partnerships and involvement of all relevant local stakeholders. Annex 1 shows the partners and stakeholders so far involved per NCD thematic area. The Ministry therefore calls upon other developmental partners to join in the fight against NCDs in any of the thematic areas

6.3 Monitoring and evaluation plan

Following the Political Declaration on NCDs adopted by the UN General Assembly in 2011, WHO is developing a global monitoring framework to enable global tracking of progress in preventing and controlling major NCDs and their key risk factors.

For Malawi's NCD strategy, Process indicators have been included in the intervention matrix. However, a detailed M&E framework for each thematic area will be developed by the steering committees when developing implementation plans. There shall be impact indicators which will be monitored at different

relevant intervals and outcome indicators shall be reviewed at the end of every year to enable annual implementation planning. Formal evaluation of this Strategic Plan will be conducted in 2022.

Annex 1: Partner and Stakeholder Matrix

Insert updated matrix

The main stakeholders for NCDs include patients with NCDs and associations of people living with NCDs, the central government particularly MOH and relevant government line ministries and departments, CHAM, the private sector, civil society organizations, local communities, and the international community. Table presents a summary of the key stakeholders and their primary interests.

STAKEHOLDERS	ROLE OF STAKEHOLDER	CURRENT STATUS
<i>General population and communities</i>	<ul style="list-style-type: none"> • Accessing equitable delivery of quality NCDs prevention and management, as close to the communities as possible. • Involvement in the fight against the NCDs. 	<ul style="list-style-type: none"> • NCDs burden increasing within the communities. • NCDs related health services are inadequate and not equitably distributed. • Inadequate community involvement and participation in NCD prevention and control.
<i>Patients with NCDs (including associations of people living with NCD)</i>	<ul style="list-style-type: none"> • Receiving quality, efficient and effective curative, care and support services, for their respective NCDs, as close to their families as possible and at an affordable cost. • Being involved in community education regarding NCDs prevention and management. 	<ul style="list-style-type: none"> • Morbidity due to NCDs has significantly increased. • NCDs treatment, care and support services are inadequate and not equitably distributed. • The cost of accessing NCDs' management is high.
<i>Civil Society Organizations (CSOs)</i>	Advocating for: <ul style="list-style-type: none"> • Delivery of quality NCDs health services to communities. • Transparency and accountability. • Community participation in NCDs prevention and control programmes. 	<ul style="list-style-type: none"> • Several CSOs implementing programmes relevant to NCDs prevention and management. • Weak coordination and harmonization of CSOs. • Inadequate involvement and participation of CSOs in NCDs prevention and control programmes.
<i>Health Workers</i>	<ul style="list-style-type: none"> • To have appropriate training, exposure and support in the prevention and management of NCDs. • To have good working conditions • To have a Community health worker package that includes prevention and control of NCDs 	There have been improvements in the numbers of health workers. However, there are still challenges, including: <ul style="list-style-type: none"> • Shortages of specialists in NCDs, particularly in rural areas. • Inadequate training of health workers in NCDs. • Inequitable distribution of health workers. • Shortage of community health workers
<i>Suppliers of goods and services.</i>	<i>To supply, in a fair and transparent manner, goods and services to MoH and Directorate of Community Health for the control and management of NCDs.</i>	<ul style="list-style-type: none"> • A comprehensive and transparent procurement system is in place, based on international best practice. • Lack of reliable local suppliers of specialized medical equipment for respective NCDs.
<i>Central</i>	<ul style="list-style-type: none"> • Ensuring the health and productivity of the population. 	<ul style="list-style-type: none"> • High political will towards NCDs as prioritized in the HSSP II.

<i>government</i>	<ul style="list-style-type: none"> • Providing overall policy direction on health. • Prioritization of NCDs and resource mobilization. 	<ul style="list-style-type: none"> • Funding to the health sector, particularly to NCDs is inadequate.
<i>Community Health Directorate.</i>	<ul style="list-style-type: none"> • Directing and coordinating the national health agenda. • Development and enforcement of health policies, regulations and implementation frameworks. <p>Coordination and management of the NCDs at community level</p>	<ul style="list-style-type: none"> • NCDs prioritized in the HSSP II 2017-22. • NCDs organizational structure strengthened. • Challenges in respect of coordination, availability of health workers, specialized infrastructure and equipment, essential drugs and medical supplies, and transport
<i>Other government line ministries and departments</i>	<p>Government ministries and departments have specific roles in combating NCDs risk factors. These include:</p> <ul style="list-style-type: none"> • Ministry of Local Government (MoLG) – implementation of the Public Health Services Act. • Ministry of education (health education and promotion of healthy lifestyle as well as capacity building for health care) • Ministry of Youth, Sport and Child Development (MOYSCD) – Promotion of sport/physical activity. • Ministry of Agriculture and Water Irrigation Development– Food security and nutrition. • Ministry of Home Affairs (MOHA), especially the Malawi Police Victim Support Unit, and the Drug Enforcement Commission (DEC) - Enforcement of specific legislation and regulations relevant to NCDs prevention. • Selected government departments, including the National Food Reserve Agency (NFRA), and the Pharmacy and Poisons Regulatory Body (PPRB). • What of ministry of finance to ensure that taxes accruing from tobacco alcohol and unhealthy foods are disbursed directly to the health sector for prevention and control of the resultant health effects from these commodities • Custom and excise department to prevent smuggling and collect taxes • Police to enforce laws relating to alcohol use etc. • Ministry of Economic Planning and Development for poverty eradication programmes • Ministry of Agriculture to support alternative livelihoods particularly for tobacco farmers. 	<ul style="list-style-type: none"> • These are formally established government ministries and departments. The work being done is supported with appropriate policies and legislation. • Inter-sector coordination regarding work related to the control of NCDs risk factors is weak.

<i>The faith-based health sector/ CHAM</i>	<i>Provision of affordable health services to the general public, including NCDs prevention, treatment and care, within the national health policy, regulatory and strategic framework.</i>	<ul style="list-style-type: none"> • Extensive coverage, particularly in rural areas. • Challenges: inadequate appropriate infrastructure and equipment, health workers and supplies of drugs and medical supplies for NCDs.
<i>Private health institutions</i>	<i>Provision of private commercial health services to the general public, including NCDs prevention, treatment and care, within the national health policy, regulatory and strategic framework.</i>	<ul style="list-style-type: none"> • The private health sector is growing. • Systems for broader private sector participation are weak.
<i>Traditional health practitioners</i>	<i>Provision of traditional health services for the management of NCDs.</i>	The policy and regulatory frameworks for traditional health are inadequate and need strengthening, to safeguard lives.
<i>The international community</i>	<i>Provision of financial and technical support to the sector, within the established policy, strategic framework and priorities.</i>	Inadequate support to NCDs prevention and management.

KEY RESULT AREA	STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Health Promotion and Education	<ul style="list-style-type: none"> -Availability of IEC materials e.g. Booklets for hypertension, diabetes, diet related conditions and posters for hypertension. - Commemoration of World Health Special Days - Ministry of Health Radio programme. - Availability of Health Promotion Personnel 	<ul style="list-style-type: none"> - Inadequate distribution and dissemination of IEC materials. - Lack of communication strategy - Limited funds - Inadequate advocacy -Inadequate education to the public on NCDs 	<ul style="list-style-type: none"> -NGO's involvement - Media - High literacy level (Educated society) 	<ul style="list-style-type: none"> - Competing resources - Cultural Beliefs - Low Socio-economic status - Fast Food Industry
Surveillance	<ul style="list-style-type: none"> - Availability of Cancer registry - Stepwise Survey 2009 and 2017 results available 	<ul style="list-style-type: none"> - No comprehensive NCDs surveillance - Lack of consistent health information system - Unreliable/ incomplete data (duplication of entries) - No standard case definitions for NCDs 	<ul style="list-style-type: none"> - Existing health information systems(DHIS II) - Future medical school - Private health care system 	<ul style="list-style-type: none"> - Competing priorities - Bureaucracy
Research Merchandise	<ul style="list-style-type: none"> - Availability of research unit 	<ul style="list-style-type: none"> -Unavailability of research agenda - Limited coordination of research 	<ul style="list-style-type: none"> -Limited research on NCDs in the country 	<ul style="list-style-type: none"> -Lack of funds
Case Management		<ul style="list-style-type: none"> -No standardized protocols -Weak linkage of referral system - Centralized services (only 3 	<ul style="list-style-type: none"> - Upgrading of district hospitals - Committed political will - Provision of health care services by private 	<ul style="list-style-type: none"> - No standard fees (private facilities) - No monitoring of standards of practice for private practitioners - Traditional

		referral hospitals) - Inadequate trained personnel. - Current structures not enough to cater for the growing population	practitioners - Traditional Medicine	medicine
Medicines and Equipment	- Availability of CMST - Regulatory Bodies	-Irregular supply of essential drugs - Inadequate equipment -Inadequate maintenance of equipment	External support	Bureaucracy
Risk Factors a. Tobacco use	-Available medical knowledge on health effects -Legislation in place -Annual commemoration of No Tobacco day	-Inadequate enforcement of legislation	Political commitment Stop smoking support groups	Cheap price of tobacco in the country Cross border advertising Free merchandising
b. Alcohol Consumption	-Available medical knowledge on health effects -IEC materials available -Alcohol Levy in place -Liquor Act available - Alcohol Policy available	-More focus on modern alcohol beverages than traditional ones -Inadequate enforcement of legislation -Traditional alcohol beverages not well studied -Inadequate Research on Alcohol	Proposed liquor act Support from church community Incorporation of alcohol and tobacco education in school curricula	Poverty/ socio economic status Limited leisure/recreation Culture/socialization Easy access to alcohol outlets
c. Dietary habits	Coordinating unit in place under the Nutritional Directorate.	-Inadequate dieticians and nutritionists -Limited agricultural diversification of crops	Food consumption survey Promotion of Traditional dishes	Fast Food Industry Culture
d. Physical inactivity	-Physical Education in schools	-Lack of knowledge on physical activity -No	Availability of school/college programs that promote P E	Designing and planning of roads and towns does not

	-Workplace wellness programmes -School Health Program	<i>programme for physical activity</i>	<i>Private gyms/ sporting centers Global strategy on diet and physical activity</i>	<i>accommodate walking, cycling. Limited sporting activities in schools Gyms not affordable</i>
e. Environmental and Occupational hazards	-Programme of management of chemical safety in place -Public Health Act -Programmes in place (occupational, environmental health)	-Inadequate enforcement of existing legislation -Control of import of chemicals not adequate -Inadequate awareness on environmental and occupational hazards	<i>Dept of pollution control Atmospheric pollution control Licensing authority Atomic energy control act Agro chemicals act Waste management act</i>	<i>Increase in pollution (vehicle, industrial, burning of domestic refuse) Improper management of Health care/ medical waste Industrialization Increase in mining activities</i>
f. Infections leading to cancer	-Programmes in place (HIV/AIDS, SRH, EPI/IMCI, Integrated --Cancer of the cervix screening) - Existence of laboratories	-Inadequate health promotion activities - Inadequate trained personnel Inadequate integration of programmes	<i>UN system support Cancer Association of Malawi</i>	<i>Competing resources Increase in incurable diseases</i>

Add salt to the diet table.

NON COMMUNICABLE DISEASES LOGFRAME

Strategic Objective One: Improve public awareness about chronic NCDs in order to increase service uptake

<i>OBJECTIVITIES</i>	<i>IMPLEMENTING ACTIVITIES</i>	<i>STAKEHOLDERS</i>	<i>INDICATOR</i>	<i>TIMEFRAME</i>
To utilize mass education campaigns to educate the public about NCDs	<i>Develop NCD Communication Strategy</i>	<i>MoH, MoE, Ministry of Labour, Ministry of Trade, WHO, UNICEF, NGOs, CBOs, OPC, Home Affairs, Civil Societies, Patient Advocacy Groups, Ministry of Information, Ministry of Civic Education</i>	<i>NCD Communication Strategy Developed</i>	<i>2018-2019</i>
To advocate for the integration of NCDs into Government and Private Sector Policies and Plans	<i>Establish National NCD taskforce</i>		<i>National NCD task force established</i>	

Strategic Objective Two: To establish and strengthen national policies and plans for the prevention and control of non-communicable diseases by June 2022

<i>OBJECTIVES</i>	<i>IMPLEMENTING ACTIVITIES</i>	<i>STAKEHOLDERS</i>	<i>INDICATOR</i>	<i>TIMEFRAME</i>
Establish supportive environment for tobacco control, physical activity, healthy eating, and prevention of harmful use of alcohol.	<p>Develop national NCD policy and strategic plan</p> <p>Strengthen implementation of the Alcohol Policy.</p> <p>Advocate for and contribute to tobacco control, alcohol use and fast foods and</p>	MoH, MoE, Labour and Home Affairs, Malawi Police Services, MoLG, AGs chambers, WHO, Civil Society Organization Consumer watchdogs	<p>Availability of NCD Policy and strategic plan</p> <p>Number of position papers on alcohol, tobacco control and fast food regulations submitted</p>	<i>2020</i>

	<p>sweets, sugar and beverages regulations.</p> <p>Support implementation of existing programmes which facilitate availability and access to fresh fruits and vegetables</p> <p>Support wellness activities in all sectors</p>		<p>Number of policies implemented that support healthy behaviours.</p> <p>Number of enforcement activities to support health promoting policies.</p>	
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Strategic Objective 3: Promote interventions to reduce the main shared modifiable risk factors for non-communicable diseases: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol by June 2022. (Environmental.....??? To look into this)

<i>OBJECTIVES</i>	<i>IMPLEMENTING ACTIVITIES</i>	<i>STAKEHOLDERS</i>	<i>INDICATOR</i>	<i>TIMEFRAME</i>
Promote management of modifiable risk factors of NCDs	<p>Capacity building for health professionals on modifiable risk factors management</p> <p>Civil Society on management of NCD modifiable risk factors</p> <p><i>Availability of rehabilitation centres for substance abuse</i></p> <p><i>Social environment.....Safety shelters for partner abused</i></p> <p><i>Develop the Tobacco Policy on Public smoking</i></p>	<p>MoH, Telecommunication Providers (TNM, AIRTEL, MTL, e.t.c) MOE, MoLG</p> <p>Civil Society Organizations, Tertiary Education Council, Min of Labour and Home Affairs <i>Ministry of Gender, MoJ,</i></p> <p><i>MoH, MoA, MoL,OMG</i></p>	<p>Number of health professionals trained on management of modifiable risk factors of NCDs</p> <p>% of health facilities, NGOs, CBOs offering comprehensive NCD services</p>	

Strategic Objective 4: Strengthen surveillance, monitoring and research on priority non-communicable diseases by June 2022

<i>OBJECTIVES</i>	<i>IMPLEMENTING ACTIVITIES</i>	<i>STAKEHOLDERS</i>	<i>INDICATOR</i>	<i>TIMEFRAME</i>
To strengthen surveillance for non-communicable diseases.	<p>Incorporate NCDs variables based on National Programmatic Indicators into the Health Management Information System Strategy.</p> <p>Conduct national health surveys on major risk factors of NCDs. Strengthen the national cancer registry <i>Integrating the NCD module into existing EMR systems..... specific activities on the system???</i></p>	MoH WHO MoLG	<p>NCDs variables incorporated into the HMIS strategy.</p> <p>Availability of reliable, national mortality and morbidity reports on NCDs.</p> <p>Availability of up-to-date data on NCD risk factors</p> <p>Availability of timely Cancer reports</p>	
To promote research in the prevention and control of non-communicable diseases	<p>Review and develop a new NCD research agenda.</p> <p>Strengthen Research Committees in the health facilities. Build capacity in research within the programme.</p> <p>Develop budget for research</p> <p>Formation of a Research Technical Working Group Conduct a baseline qualitative study (KAP) on NCD's.</p>	MoH WHO MoLG	<p>Availability of research agenda</p> <p>Number of researches initiated and participated</p> <p>Budget available for operational research Research Technical working group formed with Terms of Reference KAP report available on NCD</p>	

Strategic objective 5: To strengthen health system to support NCD prevention and control by June 2022 (use of the health systems building blocks)

<i>OBJECTIVES</i>	<i>IMPLEMENTING ACTIVITIES</i>	<i>STAKEHOLDERS</i>	<i>INDICATOR</i>	<i>TIMEFRAME</i>
To facilitate the provision of screening , early diagnostic and treatment services	<p>Develop/strengthen comprehensive screening guidelines for NCDs.</p> <p>Develop an implementation plan for cancer prevention and control</p> <p>Develop and implement evidence-based treatment guidelines on major NCDs.</p>	<p>MOH WHO UNICEF MoE UNFPA MoLG Civil Society Organizations</p>	<p>Comprehensive guidelines on screening for NCD available</p> <p>Implementation plan for cancer control and prevention available</p> <p>Availability of guidelines on treatment of major NCD</p>	
To provide technical support for optimal care	Build capacity to support the implementation of the treatment guidelines		Number of health care workers trained on guidelines	
To ensure availability of essential services at all levels of health care.	<p>Strengthen existing NCD intervention on prevention and control programmes within the health system</p> <p>Develop referral guidelines for NCDs</p> <p>Facilitate the provision of essential equipment, drugs and infrastructure to all health care centers for early diagnosis, treatment and monitoring of priority NCDs.</p>	<p>MoH MoLG NGO's partners MoE</p>	<p>Referral guidelines for NCD patients available</p> <p>Availability of essential services at all levels of health care</p> <p>Availability of drugs and consumables at all levels of health care</p> <p>Availability of functioning and reliable equipment's at all</p>	

			levels of care	
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Strategic Objective 6: To strengthen mechanism for Programme Coordination and Management by June 2022.

<i>OBJECTIVES</i>	<i>IMPLEMENTING ACTIVITIES</i>	<i>STAKEHOLDERS</i>	<i>INDICATOR</i>	<i>TIMEFRAME</i>
<p>To ensure efficient planning and coordination of the NCD Programme.</p> <p>To mobilize Resources for the management of NCD Programme</p>	<p>Develop the programme structure</p> <p>Develop and implement national plan for NCD prevention and control</p> <p>Establish multi-sectoral and multi- disciplinary expert advisory board Develop and implement Human Resource Plan</p> <p>Facilitate budget to support the implementation of national policy, strategy and programmes for NCD prevention and control</p> <p>Development an M&E Plan.....?????????</p>	<p>MOH – HRD HMIS MoF</p>	<p>NCD Programme structure available</p> <p>Availability of the NCD strategic Plan Existence of the national NCD advisory board with TOR</p> <p>Availability and implementation of the Human Resource plan for NCD programme</p> <p>National Budget (vote for NCD Programme) available Resources mobilized from other partners</p> <p>Number of proposals made and donors identified</p> <p>Proportion of funds mobilized from the alcohol levy</p>	

Strategic objective 7: Promote partnerships for the prevention and control of Non-communicable diseases by June 2022

<i>OBJECTIVES</i>	<i>IMPLEMENTING ACTIVITIES</i>	<i>STAKEHOLDERS</i>	<i>INDICATOR</i>	<i>TIMEFRAME</i>
To strengthen public and private partnerships	<p>Develop Public, Private Partnership guidelines</p> <p>CHAM – NCD patients.....???</p> <p>Identify, prioritize areas of need and engage partners in the prevention and control of NCDs.</p>	<p>MOH, , Cancer Association of Malawi, WHO, UNICEF, Civil Society, MoLG, Community Based Organizations, MOE, Private Companies, Diabetes Association of Malawi, Private Practice. CHAM, UNFPA,GAVI, UNC, World Bank, Lighthouse,Dignitas, BAOBAB, Line Ministries- MINISTRY OF LABOUR</p>	<p>Availability of Public, Private Partnership guidelines on NCD</p> <p>Areas of priority in NCD control and prevention identified</p> <p>Number of partnerships established on the prevention and control of NCD</p>	

MONITORING AND EVALUATION FRAMEWORK

Strategic Objective	Objective	Activities	Indicator	Measure	Level	Baseline	Target	Source	Frequency	Responsibility
1.To raise the priority accorded to non-communicable diseases in development work at national, district and community levels by June 2022	1.1 To advocate for the integration of NCDs into government and private sector policies and plans	<i>Establish National NCD task force</i>	<i>NCD task force established</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>1</i>	<i>MoH WHO</i>	<i>Annually</i>	<i>NCD programme</i>
		<i>Conduct targeted high level advocacy</i>	<i>Number of target groups reached(selected groups reached per level)</i>	<i>Number</i>	<i>Output</i>	<i>0</i>	<i>Parliamentary committee on health, Inter-ministry committee on sustainable social development, inter-ministry committee on drug control and Health Donors Group, SMT-MoH,</i>	<i>MoH</i>	<i>Quarterly</i>	<i>NCD programme</i>
		<i>Develop proposal for incorporation into other sector policies</i>	<i>No of proposals submitted</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>- Ministry of Sports, Ministry of Gender, Ministry of Labour, Ministry of Trade, Ministry of Finance, Ministry of Home Affairs, Ministry of Justice, Malawi Bureau of Standards and Regulatory bodies, Ministry of Transport, Ministry of Agriculture</i>	<i>MoH WHO</i>	<i>Once</i>	<i>NCD programme</i>
	1.2 Strengthen Health Education and Promotion)	<i>Develop NCD communication Strategy</i>	<i>NCD communication strategy developed</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>-1</i>	<i>MoH AND WHO</i>	<i>Once</i>	<i>NCD programme</i>

2.To establish and strengthen national policies and plan for the prevention and control of non-communicable diseases by June 2022	2.1Establish supportive environment for tobacco control, physical activity, healthy eating, and prevention of harmful use of alcohol.	<i>Develop national NCD policy and strategic plan</i>	<i>Availability of NCD Policy and strategic plan</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>- 2</i>	<i>MoH WHO</i>	<i>Every 5 years for the plan and 10 years for the policy</i>	<i>NCD programme and other stake holders</i>
		<i>Advocate for and contribute to tobacco control, alcohol use and fast foods regulations</i>	<i>Number of position papers on alcohol, tobacco control and fast food regulations submitted</i>	<i>Yes/No</i>	<i>Output</i>	<i>-</i>	<i>- 1 each for position papers and policies</i>	<i>MoH WHO Ministry of Trade and KTP Malawi</i>	<i>Annually</i>	<i>NCD programme</i>
		<i>Support implementation of strategies that facilitate availability and access to fresh fruits and vegetables</i>	<i>-</i>	<i>Yes/No</i>	<i>Output</i>	<i>-</i>	<i>- MoHto engage MoA, MoT.</i>	<i>MoA and MoH</i>	<i>Annually</i>	<i>NCD programme</i>
		<i>Support wellness activities in all government and private sectors</i>	<i>-</i>	<i>Yes/No</i>	<i>Output</i>	<i>-</i>	<i>- 20</i>	<i>-</i>	<i>Annually</i>	<i>NCD programme</i>
3.Promote interventions to reduce the	<i>Capacity building for health</i>	<i>Capacity building for health</i>	<i>Number of health professionals</i>	<i>Number</i>	<i>Output</i>	<i>0</i>	<i>30/year/district/central hospital</i>	<i>MoH</i>	<i>Annually</i>	<i>NCD programme</i>

main shared modifiable risk factors for non-communicable diseases: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol by June 2022	<i>professionals on modifiable risk factor management</i>	<i>professionals on modifiable risk factor management</i>	<i>trained (short-term) in management of modifiable risk factors and case management</i>							
			<i>Health of professions on case management</i>	<i>Number</i>	<i>Output</i>	<i>0</i>				
	<i>Capacitating CBOs, Civil Society on public awareness management of NCDs modifiable risk factors</i>	<i>Capacitating CBOs, Civil Society on public awareness management of NCDs modifiable risk factors</i>		<i>Percentage</i>	<i>Output</i>	<i>0</i>	20% OF EACH DISTRICT	<i>MoH</i>	<i>Annually</i>	<i>NCD programme and other stake holders</i>
4.Strengthen surveillance, monitoring and evaluation and research on priority non-communicable diseases by June 2022	4.1. To strengthen surveillance for non-communicable diseases.	<i>Incorporate NCD variables into the integrated Disease Surveillance and Response Strategy</i>	<i>NCD variables incorporated into HMIS strategy</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>1</i>	<i>MoH- HMIS</i>	<i>-</i>	<i>NCD programme and CMED</i>
		<i>Conduct national health surveys on major risk</i>	<i>Availability of up-to-date data on NCDs risk</i>	<i>Yes/No</i>	<i>Output</i>	<i>1</i>	<i>1</i>	<i>MoH and WHO</i>	<i>Every 5 years</i>	<i>NCD programme and other</i>

		<i>factors of NCDs.</i>	<i>factors</i>							<i>stake holders</i>
		<i>Strengthen the national cancer registry</i>	<i>Availability of timely Cancer reports</i>	<i>Yes/No</i>	<i>Output</i>	<i>1</i>	<i>1</i>	<i>National Cancer Registry</i>	<i>Every 3 years</i>	<i>NCD programme and other stake holders</i>
		<i>Develop the national Trauma Registry</i>							<i>Review yearly</i>	
<i>To promote research in the prevention and control of non-communicable diseases</i>		<i>Develop NCDs research agenda</i>	<i>Availability of research agenda on NCDs</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>1</i>	<i>WHO</i>	<i>Once</i>	<i>NCD and other stake holders</i>
		<i>Build capacity in research within the programme</i>	<i>Number of researches initiated and participated</i>	<i>Number</i>	<i>Output</i>	<i>0</i>	<i>3</i>	<i>MoH WHO</i>	<i>Every 3 years</i>	<i>WHO.NCD and other stake holders</i>
		<i>Develop budget for operational research</i>	<i>Budget available for operational research</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>1</i>	<i>MoH WHO</i>	<i>Every 3 years</i>	<i>Department of Public Health /NCD programme</i>
		<i>Formation of research technical working group for NCDs</i>	<i>Research Technical working group formed with Terms of Reference</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>1</i>	<i>WHO</i>	<i>Once</i>	<i>NCD programme</i>

		<i>Conduct a baseline qualitative study(KAP) on NCDs</i>	<i>KAP report available on NCDs</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>1</i>	<i>WHO MoH</i>	<i>Every 10 years</i>	<i>WHO,NCD Program and other stakeholders</i>
5.To strengthen health system to support NCD prevention and control by June 2022	5.1 To facilitate the provision of screening and early diagnostic services	<i>Finalize the development of comprehensive screening guidelines for selected priority NCDs</i>	<i>Availability of guidelines on treatment of major NCDs</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>-</i>	<i>WHO</i>	<i>Annually</i>	<i>WHO.NCD and other stake holders</i>
		<i>Develop an implementation plan for cancer prevention and control</i>	<i>Existence of training program</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>-</i>	<i>WHO MoH</i>	<i>Annually</i>	<i>WHO,NCD Program and other stakeholders</i>
		<i>Develop and implement evidenced based treatment guidelines on major NCDs</i>	<i>Availability of treatment guidelines on major NCDs</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>-</i>	<i>WHO MoH</i>	<i>Every 10 years ????</i>	<i>NCD programme and other stake holders</i>
	5.2 To provide technical support for optimal care	<i>Train health care workers on guidelines in the management of NCDs</i>	<i>Number of health care workers trained to implement guidelines.</i>	<i>Number</i>	<i>Output</i>	<i>0</i>		<i>WHO MoH</i>	<i>Every 10 years ????</i>	<i>NCD programme and other stake holders</i>

	5.3 To ensure availability of essential services at all levels of health care.	<i>existing NCD intervention on prevention and control programmes within the health system</i>	<i>Availability of essential services at all levels of health care</i>	<i>Yes/No</i>	<i>Output</i>	-	-	<i>WHO MoH</i>	-	<i>NCD programme and other stake holders</i>
		<i>Develop referral guidelines for NCDs patients through all</i>	<i>Referral guidelines for NCDs patients available</i>	<i>Yes/No</i>	<i>Output</i>	0	-	<i>WHO MoH</i>	-	<i>NCD programme and other stake holders</i>
		<i>Facilitate the provision of essential equipment, drugs and infrastructure to all health care center's for early diagnosis, treatment and monitoring of priority NCDs.</i>	<i>Availability of drugs and consumables at all levels of health care Availability of functioning and reliable equipment's at all levels of care</i>	<i>Yes/No</i>	<i>Output</i>	-	-	<i>MoH</i>	<i>Annually</i>	<i>MoH</i>
6.To strengthen mechanism for Programme Coordination and	6.1 To ensure efficient planning and coordination of the NCD Programme	<i>Finalize the development of the programme structure</i>	<i>Programme structure available</i>	<i>Yes/No</i>	<i>Output</i>	0	-	<i>MoH</i>	-	<i>MoH</i>
		<i>Develop and</i>	<i>Availability of</i>	<i>Yes/No</i>	<i>Output</i>	0	-	<i>MoH</i>	<i>Every 5</i>	<i>NCD</i>

Management by June 2022		<i>implement national plan for NCDs prevention and control</i>	<i>the NCD strategic Plan</i>						<i>years</i>	<i>program</i>
		<i>The NCDI Poverty Commission to have a multi-sectoral and multi-disciplinary expert advisory board</i>	<i>Existence of the advisory board with TOR</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>-</i>	<i>NCDI Poverty Commission Co-Chairs</i>	<i>-</i>	<i>NCD programme and other stake holders</i>
	6.2 To mobilize Resources for the management of NCD Programme	<i>Develop and implement Human Resource Plan</i>	<i>Availability and implementation of the Human Resource plan</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>-</i>	<i>MoH</i>	<i>-</i>	<i>NCD program</i>
		Facilitate budget to support the implementation of national policy, strategy and programmes for NCD prevention and control	<i>National Budget (vote for NCD Programme) available</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>-</i>	<i>Parliamentary Committee on Health</i>	<i>Annually</i>	
			<i>Resources mobilized from other partners</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	<i>-</i>	<i>MoH</i>	<i>-</i>	<i>NCD Program</i>
	<i>Number of proposals made and donors</i>	<i>Number</i>	<i>Output</i>	<i>0</i>	<i>-</i>	<i>MoH</i>	<i>-</i>	<i>NCD Program</i>		

			<i>identified</i>							
			<i>Proportion of funds mobilized from the alcohol levy</i>	<i>Proportion</i>	<i>Output</i>	<i>0</i>		<i>MoH</i>	-	<i>NCD Program</i>
7.Promote partnerships for the prevention and control of Non-communicable diseases by June 2022	7.1To strengthen public and private partnerships	<i>Develop Public, Private Partnership guidelines on NCD</i>	<i>Availability of guidelines on NCD</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	-	<i>MoH</i>	-	<i>NCD Program</i>
		<i>Identify, and prioritize areas of need and engage partners in the prevention and control of NCDs.</i>	<i>Areas of priority in NCD control and prevention identified</i>	<i>Yes/No</i>	<i>Output</i>	<i>0</i>	-	<i>MoH</i>	-	<i>NCD Program</i>

THE THEMATIC MONITORING AND EVALUATION FRAMEWORK

Key Result / Thematic Area:		Chronic NCDs								
Strategic Outcome		Improved level of sustained, accessible, comprehensive, and integrated chronic NCD services that incorporate prevention, early detection and screening, diagnosis, referral, and treatment, in-order to improve the quality of life for Malawians								
Strategic Objective 1		Improve public awareness about chronic NCDs in order to increase service uptake								
Strategy 1.1		Utilize mass education campaigns to educate the public about chronic NCDs								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017-18	2018-19	2019-20	2020-21	2021-22			
1.11	Produce and feature TV programming on chronic NCDs	Number of TV programmes produced	52	52	52	52	52	TV Clips	Coverage and funding	Partners and MOH
1.12	Produce and feature radio programming on chronic NCDs	Number of Radio programmes produced	52	52	52	52	52	Radio Clips	Coverage and funding	Partners and MOH
1.13	Community interface health education forums	Percentage of planned community interface health education programs conducted	80%	80%	80%	80%	80%	Reports	Funding	DHOs and Partners

1.14	Create Annual National NCDs Day	Celebrated annual National NCDs day	1	1	1	1	1	Reports	Funding	MOH, WHO and Partners
1.15	Create Annual National Epilepsy Day	Annual National Epilepsy day	1	1	1	1	1	Reports	Funding	MOH and Partners mainly WHO
1.16	Collaboration of Ministry of Health and Media groups	Number of review meetings	4	4	4	4	4	Minutes	Funding	MACRA and NCD unit MOH
Strategy 1.2		Utilize targeted education campaigns to reach more people								
Output Description		Objectively Verifiable indicator	Annual Output Targets					Source and means of verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
1.21	School targeted education campaigns	Percentage of schools reached	10%	20%	30%	40%	50%	Reports	Funding	DEM / DHO & partners
1.23	Targeted education campaigns with religious groups and traditional leaders	Number of religious groups reached	10%	20%	30%	40%	50%	Reports	Funding	DHOs and religious associations
1.24	Targeted outreach with other public sectors (e.g. police, teachers)	Number of sectors reached	2	2	2	2	2	Reports	Funding	NCD Unit and partners
1.25	Target the corporate world and professional associations	Number of associations and corporations reached	10%	20%	30%	40%	50%	Reports	Funding	MOH
Strategic Objective 2		Reduce the risk of developing chronic NCDs								
Strategy 2.1		Decrease burning of solid fuel for indoor cooking								
Output Description		Objectively Verifiable indicator	OUTPUT TARGETS (PER FINANCIAL YEAR)					Source and means of verification	Risks and Assumptions	Responsibility

			2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022			
2.11	Campaigns for clean burning cookstoves - education and distribution	Number of campaigns conducted	2	2	2	2	2	Reports	Funding	DHOs and Partners
Strategy 2.2		Decrease risk factors for cirrhosis								
Output Description	Objectively Verifiable indicator	OUTPUT TARGETS (PER FINANCIAL YEAR)					Source and means of verification	Risks and Assumptions	Responsibility	
		2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022				
2.21	Continue schistosomiasis eradication campaigns	Number of national campaigns conducted	1	1	1	1	1	NTD program	Funding	DHOs and Partners
2.22	Continue Hepatitis B vaccination of all healthcare workers	Percentage of HCWs vaccinated	25	50	75	90	90	Hep B Unit	Funding	DHOs and Partners
Strategy 2.3		Decrease cardiovascular risk factors at a population level								
Output Description	Objectively Verifiable indicator	OUTPUT TARGETS (PER FINANCIAL YEAR)					Source and means of verification	Risks and Assumptions	Responsibility	
		2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022				
2.31	Write and pass Tobacco policy	Tobacco policy created and passed	0	1	1	1	1	N/A	Political will	NCD Unit
2.32	Advocate for tax imposed on soft drinks	Soft drink tax created and passed	0	1	1	1	1	N/A	Political will	NCD Unit
2.33	Advocate for legislation on salt and sugar content of food	Salt and sugar legislation created and passed	0	1	1	1	1	N/A	Political will	NCD Unit

Strategy 2.4		Decrease epilepsy risk factors								
Output Description		Objectively Verifiable indicator	OUTPUT TARGETS (PER FINANCIAL YEAR)					Source and means of verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
2.41	<i>Incorporate epilepsy prevention into other disease programs: malaria, safe motherhood, HIV, IMCI</i>	<i>Number of other programs incorporating epilepsy prevention</i>								
2.42	<i>Screening and follow up of at risk groups: premature babies, children surviving severe cerebral infections or head trauma</i>									
2.5	<i>DECREASE DIABETES RISK FACTORS AT POPULATION LEVEL</i>									
Strategic Objective 3		To provide quality, comprehensive screening, diagnosis, referral, and treatment services								
Strategy 3.1		Capacity building and workforce development								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
3.11	<i>Expand clinical guidelines to include chronic liver, kidney, plus missing conditions from the existing guidelines</i>	<i>Complete set of clinical guidelines</i>	0	0	1	1	1	N/A	<i>staff time limited</i>	<i>NCD Unit and partners</i>

3.12	Print and distribute complete clinical guidelines	Number of districts with printed guidelines	0	0	14	29	29	N/A	funding	NCD Unit and partners
3.13	Training for primary, secondary, and tertiary facilities on complete clinical guidelines	Number of districts with staff trained on guidelines	0	0	14	29	29	N/A	funding	NCD Unit and partners
3.14	Develop HR strategic plan for NCD care at primary-secondary-tertiary levels, including cadres, training programs, certifications, etc (e.g. renal physician and nursing, cardiac echo technicians, cardiology, cardiac surgery expertise, properly trained technicians for secondary and tertiary care for chronic NCDs, advanced diabetic nursing, hematologists, neurologists, neurosurgeons, etc)	HR strategy for NCD created	0	0	1	1	1	NCD Unit	staff time limited	NCD Unit and partners and MOH HR
3.15	Develop, print, and distribute job aids for expanded list of chronic NCDs	Number of districts with job aids	0	0	14	29	29	N/A	funding	NCD Unit and partners
3.16	Institute district hospital mentorship system for chronic NCDs with specialists from central hospitals	Average number of mentorship visits per district	4	4	6	12	12	N/A	funding, limited HR	NCD Unit and partners
3.17	Create a government post for dieticians in district and central hospitals	Number of government posts	0	4	18	33	33	N/A	political will, MOH capacity	MOH HR
3.18	Create a government post for podiatry in central hospitals for diabetes foot care	Number of government posts	0	4	4	4	4	N/A	political will, MOH capacity	MOH HR
3.19	Formalize the link between chronic NCD clinics and eye clinics at district and central hospitals									

3.2	Create a government post for respiratory technician cadre at central hospitals	Number of government posts	0	4	4	4	4	N/A	political will, MOH capacity	MOH HR
3.21	Create a post for neurologist at central hospitals	Number of neurologists								
3.22	Establish NCD Center(s) of Excellence for clinical care, training, capacity building, research, and international opportunities for exchange visits/trainings (urban / rural, different levels of care)	Number of centers of excellence	0	0	0	0	2	N/A	funding	NCD Unit and partners
3.23	Establish specific role and job description for district NCD coordinators, focusing on expanded list of conditions	Number of districts with NCD coordinators	29	29	29	29	29	N/A	MOH capacity	DHO
Strategy 3.2 Infrastructure and equipment										
		Objectively Verifiable indicator	Annual Output Targets					Source and means of verification	Risks and Assumptions	Responsibility
Output Description			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
3.21	Construct / renovate to provide chronic NCD clinics at all central hospitals	Number of central hospitals with adequate chronic NCD clinic space	0	0	0	2	4	N/A	funding	NCD Unit and partners
3.22	Provide inpatient space at central hospitals to care for expanded list of complicated chronic NCDs (chronic neurologic, kidney, hematologic, cardiovascular, pulmonary conditions)	Number of central hospitals with dedicated space for hospitalized chronic NCD patients	1	2	3	4	4	N/A	funding, political will	NCD Unit

3.23	Establish adequate space at district hospitals for expanded list chronic NCD clinics								N/A	funding	Local government
3.24	Pulmonary function testing capacity at central hospitals	Number of central hospitals with PFTs	0	1	2	3	4		N/A	funding	NCD Unit and partners
3.25	Laser machines at all central hospitals	Number of central hospitals with laser machines	0	1	2	3	4		N/A	funding	NCD Unit and partners
3.26	Equip district and central hospitals for advanced cardiac care with echo machines, debrillators, ECG machines	Number of hospitals with equipment for advanced cardiac care	5	10	15	25	33		N/A	funding	NCD Unit and partners
3.27	Equip district hospitals for advanced diabetes care: chemistry machines, A1C machines	Number of hospitals with equipment for advanced diabetes care	5	10	15	25	33		N/A	funding	NCD Unit and partners
3.28	Working CT machines in all central hospitals	Number of central hospitals with working CT machines	0	1	2	3	4		N/A	funding	NCD Unit and partners
3.29	Equip central hospitals with EEG and video telemetry	Number of central hospitals with EEG	0	1	2	3	4		N/A	funding	NCD Unit and partners
3.3	Expand lab capacity at central hospitals for chronic liver disease: Hep B complete panel, liver function tests, autoimmune panels	Number of central hospitals with lab capacity for chronic liver disease	0	1	2	3	4		N/A	funding	NCD Unit and partners

3.31	Establish dialysis unit at Mzuzu Central Hospital, continue at QECH & Kamuzu; with consistent supplies	Number of functioning dialysis units	2	2	3	3	4	N/A	funding	NCD Unit and partners
3.32	Sickle cell testing at central hospitals	Number of central hospitals with sickle cell testing	2	2	3	3	4	N/A	funding	NCD Unit and partners
Strategy 3.3 Drugs and supplies										
Output Description		Objectively Verifiable indicator	Annual Output Targets					Source and means of verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
3.31 1	Establish the list and quantities of essential drugs and supplies for chronic NCDs needed in Malawi on an annual basis	List of essential drugs and supplies created	1	1	1	1	1	N/A	staff time limited	NCD Unit and partners
3.31 2	Advocate for inclusion of the essential chronic NCD drug and supply list in national procurement	Number of advocacy meetings	0	4	4	4	4	N/A	political will, funding	NCD Unit
3.31 3	Advocate for funding and large donors to contribute to chronic NCD drug and supply purchasing	Number of new donors for NCD drugs and supplies	0	1	2	3	4	N/A	political will, funding	NCD Unit and partners
Strategy 3.4 Service delivery systems										
Output Description		Objectively Verifiable indicator	Annual Output Targets					Source and means of verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			

3.41 1	Operationalize standard screening procedures for HTN, DM, Hep B at OPD, with other preventive health services	Average percentage of a district's health facilities doing routine screening at OPD	10%	20%	40%	60%	80%	DHIS2 reporting - NCD monthly report of new clients referred	funding, limited HR	DHOs and Partners
3.41 2	Integrate screening campaigns for HTN and DM in the community with other community outreach activities	Number of districts doing integrated outreach screening for HTN and DM	5	10	15	20	29	DHIS2 reporting	funding, limited HR	DHOs and Partners
3.41 4	Roll out screening register for OPD and community integrated screening (HTN, DM, nutrition, HIV, etc)	Number of districts with the screening register	5	10	15	20	29	N/A	funding	NCD Unit and partners
Strategic Objective 4		Advocacy & Policy								
Strategy 4.1		Establish strong platform for advocacy								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
4.11	Advocate for the use of ARVs to treat chronic Hepatitis B									
4.12	Package NCD burden data in an easily understandable manner for advocacy messaging to politicians, funders, media, and policymakers (burden, access to care, financing gaps, etc)	Printed packet of NCD advocacy data	1	1	1	1	1	N/A	staff time limited	NCD Unit and partners

4.13	Establish patient advocacy groups around chronic NCDs (learning lessons from Diabetes Association of Malawi)	Number of new patient advocacy groups	1	2	3	4	5	N/A		civil society
4.14	Critical review of legal issues involving epilepsy and proposed policy actions	Number of meetings held to review epilepsy legal issues	0	1	1	1	1	N/A	funding, political will	NCD Unit
Strategic Objective 5		Research and data management								
Strategy 5.1		Research								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Engage partners and research bodies to conduct operational research on service delivery models for chronic NCDs	Number of operational research publications on chronic NCDs in Malawi	5	5	5	5	5	pubmed	funding, staff time	NCD Unit and partners
Output 2	Develop research priorities for chronic NCDs in Malawi	Research priorities document updated	1	1	1	1	1	N/A	staff time limited	NCD Unit and partners
Output 3	Repeat STEPS survey; incorporate research priorities and lessons learned from first STEPS survey	STEPS survey done	0	1	0	0	0	N/A	funding	NCD Unit and WHO

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Strategy 5.2		Data Management								
Output Description		Objectively Verifiable indicator	Annual Output Targets					Source and means of verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
5.2.1	Develop mastercards for additional chronic NCDs (chronic liver disease, chronic kidney disease, CHF/RHD, sickle cell / chronic blood disease)	Number of new mastercards finalized	4	0	0	0	0	N/A	staff time limited	NCD Unit and partners
5.2.2	Print and distribute mastercards for the additional chronic NCDs	Number of new mastercards printed and distributed (to all districts/health centres?)	0	4	0	0	0	N/A	funding	NCD Unit and partners
5.2.3	Implement comprehensive reporting system from mastercards to reports to DHIS2 data entry, based on national indicators	Reporting system finalized	1	0	0	0	0	N/A	staff time limited	NCD Unit and partners
5.2.4	Engage partners to trial and scale up electronic medical records, based on the national NCD M&E plan	Number of new facilities with EMR for NCDs	2	4	6	8	10	N/A	funding, staffing	NCD Unit and partners
5.2.5	Develop standard partner reporting requirements for chronic NCDs, based on the national M&E plan	Partner reporting template finalised	1	0	0	0	0	N/A	staff time limited	NCD Unit and partners

	Strategy 1.1	<i>Increase Public Awareness and Education</i> <i>Diet</i> <i>Physical Activities</i> <i>Tobacco and Alcohol</i>							
	<i>early detection through Early Screening</i>								
	<i>Improve the quality of care</i>								
	<i>Training and Mentorship</i>								
	<i>Drugs and Supplies (consumables)</i> <i>Equipment AND supplies</i>								
	<i>Infrastructure</i>								
	<i>Monitoring and Evaluation.</i> <i>KPI</i> <i>Governance and quality assurance</i>								
	<i>Decentralized approach on PHC – Health center (Nurse lead clinics)</i>								

	<i>Strengthen Referral pathway (top bottom and up bottom)</i>							
	<i>Treatment Guidelines finalized</i>							
	<i>Revision of the EDL to include drugs at health facility level (policy)</i>							
	<i>Laboratory capacity at all service delivery levels</i>							
	<i>Strategy 1.2</i>	<i>Prevention of complications</i>						
	<i>Screening of retinopathy, renal, cardiovascular, complications</i>							
	<i>Advocate for the legislation of herbalist and religious bodies</i>							
	<i>Strategy 2.3</i>	<i>Timely treatment of complications/ management of HT</i>						
	<i>Increase Public Awareness and Education Diet Physical Activities</i>							
	<i>early detection through Early Screening</i>							
	<i>Improve the quality of care</i>							

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	Strategic Objective 4													
	Strategy 4.1	injuries												
	Output Description													
	<i>Increase Public Awareness and Education Tobacco and indoor smoke (green stoves – interv.), occupational exposure, Health seeking behavior</i>													
	<i>Improve the quality of care</i>													
	<i>Training and Mentorship Drugs and Supplies (consumables)</i>													
	<i>Equipment AND supplies</i>													
	<i>Infrastructure</i>													

	<i>Monitoring and Evaluation. KPI Governance and quality assurance</i>												
	<i>Decentralized approach on PHC – Health center</i>												
	<i>Strengthen Referral pathway (top bottom and up bottom) Treatment Guidelines finalized</i>												
	<i>Revision of the EDL to include drugs at health facility level (policy)</i>												
	<i>Laboratory capacity at all service delivery levels</i>												
	Strategy 4.4												
	Output Description												
	Output 1	<i>E s t a b l i h a p a t</i>											

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		l d e n t i f y p a t h o l o g y l a b o r a t o r y s p a c										
	<i>Output 3</i>											

		e s i n a l l c e n t r a l h o s p i t a l s									
	Strategy 4.5	Prevention of Diabetes,									
		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility	
	Output Description		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022				
	Output 1	I n c r e									

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	<i>Output 6</i>	E q u									

		<i>i p m e n t , s</i>											
	<i>Output 7</i>	<i>I n f r a s t r u c t u r e</i>											
	<i>Output 8</i>	<i>M o n i t o r i n g a n d E v a l</i>											

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Output 9

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		<i>c a p a c i t y a t a l l s e r v i c e d e l i v e r y l e v e l s</i>										
	<i>Prevention of complications</i>	<i>S</i>	<i>Consumables for screening to be listed in the annexe. Under Quality of Care.</i>									

		<i>m p l i c a t i o n s , d i a b e t i c f o o t c a r e</i>									
	<i>Timely treatment of complications/ management of diabetes</i>		<i>Quality of care</i>								
	<i>Strategy 4.6</i>	<i>Improve clinical standards of practice</i>									

	Output Description	Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
	Output 1	Inclusion of topics relating to basic cancer care		56	56	56	56	training reports and attendance lists	funding availability	MoH

		<i>c e r c a r e i n C P D t o p i c s a t a l l h e a l t h c a r e</i>										
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		l e v e l s									
		l n t e n s i f y s u p p o r t i v e s u p e r v i s i o n o f	<i>Number of supervisions conducted</i>								
	Output 2			4 (1 per zone)	4	4	4	4	supervision reports	funding availabilit y	MoH

		<i>h e a l t h w o r k e r s i n p r i m a r y c a r e f a c i l i t i e s</i>										
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	Strategic Objective 5	Improve the treatment of cancer and related morbidities by the year 2017								
	Strategy 5.1	Establish a national cancer centre								
		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
	Output Description		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
	Output 1	Number of scholarships awarded	2	2	2	2	2	training lists and assessment report	funding	MoH

		<i>in in g o f c l i n i c a l o n c o l o g i s t s a n d c a n c e r s</i>										
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		u r g e o n s										
		P r o v i d e d t r a i n i n g t o s p e c i a l i z e d c	<i>Number of cancer nurses trained</i>									
	Output 2			2	2	2	2	2	2	<i>training lists and assessment report</i>	<i>funding availability</i>	<i>MoH</i>

		a n c e r n u r s e s										
		Strategy 5.2	Improve access to palliative care services									
			Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility	
		Output Description		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022				
		Output 1	<i>Number of scholarships awarded</i>	2	2	2	2	2	training lists and assessment report	funding availability	MoH	

		<i>f o r d o c t o r s t o t r a i n a t a m a s t e r s l e v e l a s</i>										
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		<i>r e t r a i n i n g</i>										
	Output 3	<i>P r o v i d e 2 s c h o l a r s h i p s t o n u r s</i>	<i>Number of scholarships awarded</i>							<i>training lists and assessment report</i>	<i>funding availability</i>	<i>MoH</i>
				<i>8</i>	<i>8</i>	<i>8</i>	<i>8</i>	<i>8</i>				

		<i>e s t o u n d e r t a k e d i s t a n c e l e a r n i n g f u r t h e r</i>										
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		<i>education in palliative care</i>									
	Strategy 5.3	Roll out palliative care services to all secondary level hospitals									
		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility	
	Output Description		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022				
	Output 1	<i>Review palliative care training manual</i>	<i>1</i>					<i>Workshop report, minutes, actual</i>	<i>Availability of funding to move the</i>	<i>MoH</i>	

		<p>e w</p> <p>p a l l i a t i v e</p> <p>c a r e</p> <p>t r a i n i n g</p> <p>m a n u a l</p> <p>t o</p> <p>i n t e</p>							<p>printed document</p>	<p>review process</p>	
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		v i c e s									
		P i l o t r e v i s e d M O H p a r a l l e l l a t i v e c a r e m a	Number of pilot trainings conducted								
	Output 2			3						Training report, attendance list	MoH

		n u a l									
		T r a i n h e a l t h p r o f e s s i o n a l s a t a l l l e v	<i>Number of health professionals trained</i>								
	Output 3				40	60	40	60	<i>Training report, attendance list</i>	<i>Availability of funds</i>	<i>MOH & Stakeholders</i>

		el s o f h e a l t h c a r e										
		M e n t o r s h i p a n d s u p e r v i s i	Number of DH's and CHAM hospitals visited									
	Output 4			6	6	6	6	6	6	supervision reports	availability of funds	MOH & Stakeholders

		o n o f p a l l i a t i v e c a r e p r o v i d e r s i t e s									
	Output 5	C l i n i c	Number of clinicians and nurses undertaking attachments	100	100	100	100	100	training reports	availability of funds	MOH & Stakeholders

		<i>a</i> <i>l</i> <i>a</i> <i>t</i> <i>t</i> <i>a</i> <i>c</i> <i>h</i> <i>m</i> <i>e</i> <i>n</i> <i>t</i> <i>s</i> <i>f</i> <i>r</i> <i>o</i> <i>m</i> <i>e</i> <i>m</i> <i>e</i> <i>r</i> <i>g</i> <i>i</i> <i>n</i> <i>g</i> <i>d</i> <i>i</i> <i>s</i> <i>t</i> <i>r</i> <i>i</i> <i>c</i> <i>t</i> <i>P</i> <i>C</i> <i>p</i>									
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		<i>r o v i d e r s i t e s t o e s t a b l i s h e d c e n t r e s o f e x</i>										
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		<i>c e l l e n c e</i>										
	Strategy 5.4	Improve cytotoxics and related cancer drugs availability										
		Objectively Verifiable Indicator					Annual Output Targets			Data Source and means of Verification	Risks and Assumptions	Responsibility
	Output Description		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022					
	Output 1	<i>I n c l u d e c y t o t o x i c s , o p i o i</i>								<i>EHP drug list</i>	<i>lack of will</i>	<i>MOH</i>

		<i>d</i> <i>s</i> <i>,</i> <i>a</i> <i>n</i> <i>d</i> <i>r</i> <i>e</i> <i>l</i> <i>a</i> <i>t</i> <i>e</i> <i>d</i> <i>c</i> <i>a</i> <i>n</i> <i>c</i> <i>e</i> <i>r</i> <i>d</i> <i>r</i> <i>u</i> <i>g</i> <i>s</i> <i>o</i> <i>n</i> <i>E</i> <i>H</i> <i>P</i> <i>d</i> <i>r</i> <i>u</i> <i>g</i> <i>l</i>										
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		i s t												
	Strategic Objective 6	Advocate for Policy and legislation to minimize risk factors to the development of cancer												
	Strategy 6.1	Lobby legislators, civil societies												
		Objectively Verifiable Indicator					Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
	Output Description		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022							
	Output 1	Lobby for legislation on guidance		1							WHO/FCTC reports	political will, tobacco lobby	MOH and Stakeholders	

		<i>n g s m o k i n g i n p u b l i c p l a c e s</i>										
	Output 2	<i>F i n a l i s i n g d e v e</i>	<i>Finalised and disseminated policy document</i>							<i>disseminat ion reports, media reports</i>	<i>funding availabilt y</i>	<i>MOH & Stakeholde rs</i>

		<i>l o p m e n t o f c a n c e r c o n t r o l p o l i c y</i>									
	Output 3	<i>U n d e r t a k e</i>	<i>Number of reviews undertaken</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>program reports, joint health sector reviews</i>	<i>funding availability</i>	<i>MOH & Stakeholders</i>

		<i>f</i> <i>e</i> <i>a</i> <i>s</i> <i>i</i> <i>b</i> <i>i</i> <i>l</i> <i>i</i> <i>t</i> <i>y</i> <i>r</i> <i>e</i> <i>v</i> <i>i</i> <i>e</i> <i>w</i> <i>t</i> <i>o</i> <i>s</i> <i>u</i> <i>p</i> <i>p</i> <i>o</i> <i>r</i> <i>t</i> <i>l</i> <i>m</i> <i>p</i> <i>l</i> <i>e</i> <i>m</i> <i>e</i> <i>n</i> <i>t</i> <i>a</i> <i>t</i> <i>i</i>										
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		<i>o</i> <i>n</i> <i>o</i> <i>f</i> <i>n</i> <i>a</i> <i>t</i> <i>i</i> <i>o</i> <i>n</i> <i>a</i> <i>l</i> <i>H</i> <i>P</i> <i>V</i> <i>v</i> <i>a</i> <i>c</i> <i>c</i> <i>i</i> <i>n</i> <i>a</i> <i>t</i> <i>i</i> <i>o</i> <i>n</i> <i>p</i> <i>r</i> <i>o</i> <i>g</i> <i>r</i> <i>a</i> <i>m</i>										
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Key Result Area:		Injuries, trauma, violence, emergencies(?)								
Strategic Outcome		To reduce incidence and impact of trauma and injuries and their consequential disabilities in Malawi through effective policy action, targeted primary prevention interventions, effective emergency and rehabilitative services, strong research capacity and effective advocacy.								
Strategic Objective 1		To promote primary prevention methods of trauma and injury								
Strategy 1.1		Improve the public awareness in trauma and injury								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Conduct mass awareness campaigns in all districts (TV, radio, newspaper, online forums)	Number of successfully conducted campaigns (A radio programme trauma and injuries... slots)	All year	Media bulletins, TV Clips	Coverage and funding	MoH and Partners				
Output 2	Conduct and disseminate audits to the public and all relevant stakeholders	Audit findings disseminated for injuries and traumas in each district	1 report per district per year	Reports	Funding	MoH and Partners				

Output 3	<i>Incorporation of NCDI awareness and prevention into primary school curriculum and community gatherings (including road safety, fire safety, falls, drowning, violence (adults and children) accidental poisonings, etc)</i>	<i>Module developed</i>	<i>Final module created</i>	<i>Link with other sectors on any existing module Adoption by MOE and implementation in divisions</i>				<i>Module Developed</i>	<i>Participation and funding</i>	<i>Ministry of Gender, Ministry of Transport, Moh & MOE</i>
Output 4	<i>Participate in commemoration of Road Traffic Injuries Day, Ministry of Gender, Ministry of Labour</i>	<i>Annual participation and speech by Minister of Health. Presentation of road accident and injury data</i>	<i>3rd week of November</i>	<i>3rd week of November</i>	<i>3rd week of November</i>	<i>3rd week of November</i>	<i>3rd week of November</i>	<i>Report of the Events</i>		<i>MoH</i>
Strategy 1.2		<i>Position paper</i>								
Objectively Verifiable Indicator		Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility	
Output Description		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022				
Output 1	<i>Engage road safety directorate and relevant</i>	<i>Number of meetings</i>	<i>2/year</i>	<i>2/year</i>	<i>2/year</i>	<i>2/year</i>	<i>2/year</i>	<i>Reports</i>	<i>Cooperation</i>	<i>NCD and RTA</i>

Output 2	Work with Ministry of Transport in improving road infrastructure, pedestrian walkways, and sign postage on the roads of Malawi	Number of meetings (planning meeting and implementation/follow-up meeting)	2/year	2/year	2/year	2/year	2/year	2/year	Visibility of new road infrastructure in proposed areas	funds	Ministry of Transport
Output 3	Audits on the most common causes of trauma and injuries per hospital/region	Audit findings disseminated for injuries and traumas in each district	1 report	1 report	Report	funds and personnel	MoH and Partners				
Output 4	Advocate for Road Traffic Act to be updated	Updated Act						Complete	Report	funds and Time	RTA & MoH
Strategy 1.3		Advocate safety checks for buildings and other public infrastructure implicated with risk of causing trauma and injury									
Objectively Verifiable Indicator		Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility		
Output Description		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022					
Output 1	Conduct advocacy meetings with line ministries and district assemblies to conduct regular safety check procedures (work with the	Review of standards and inspection records		9	0	1	2	Reports	funds and relevant documents	MoL & Partners & MoH	

	MoL to ensure work-place safety standards are adhered to)									
Strategic Objective 2		To provide quality and integrated services in managing the trauma and injury victims by 2022								
Strategy 2.1		Capacity building in emergency medicine								
		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
Output Description			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Provision of Scholarship of doctors and clinical officers trained to provide emergency medical care	Number of trained specialists		2	2	2	2	HR MoH Report	funds	MoH & Partners
Output 2	Increase number of specialist nurses trained to provide emergency medical care	Number of trained specialists	8	3	3	3	3	HR MoH Report	funds	MoH & Partners
Output 3	Finalise training curriculum for EMS providers	Final curriculum developed	Completed report							

Output 8	Assign paramedics to places of most need			75	75	75	75	Reports	funds	EMS steering Committee
Strategy 2.2		Increase number of First Aid volunteers in the community who can assist victims on the site of an accident								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Hold consultative meetings with Red Cross on first aid in communities	Number of meetings	3	1	1	1	1	Reports		Red Cross
Output 2	Creation of first aid clubs in communities	Number of first aid clubs created	40	40	40	40	40	Reports		Red Cross & MoH
Output 3	Procure and distribute first aid kits to communities	Number of kits distributed	40	40	40	40	40	Delivery Reports		Red Cross & MoH
Strategy 2.3		Train police, fire fighters, and teachers first aid skills and basic life support (BLS) techniques								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of	Risks and Assumptions	Responsibility

			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	Verification		
Output 1	Adapt course for non-healthcare providers in first aid and BLS	Course development	Complete							
Output 2	Conduct First Aid and BLS courses for non-healthcare providers.	Number of courses run		2	2	2	2	Reports	funds	MoH & Red Cross
Strategy 2.4		Advocate for change in standard design of hospitals to incorporate emergency and trauma one stop centres								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Conduct meetings with planning department and funding agencies on best designs	Number of meetings						Reports		
Output 2	Develop detailed design specifications	Standard design specifications								
Strategy 2.5		Equip district and central hospitals with necessary infrastructure and equipment in managing trauma and injury								

Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Conduct advocacy meetings with NGOs, government									
Output 2	Procurement of contractors for construction and/or reburishment									
Output 3	Renovate and improve trauma facility infrastructure in central, district, and community hospitals	Construction or reburishment of trauma facilities	2 central, 3 district, 1 rural	2 central, 3 district, 1 rural						
Strategy 2.6		Build knowledge capacity in emergency triage assessment and treatment (ETAT), basic life support (BLS), and advanced trauma life support (ATLS) in all hospital personnel								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Conduct ETAT, BLS, and ATLS training of trainer (TOT) trainings	Number of TOTs trained. Training Unit for Emergency Care Int level	4	4	0	0	0			

Output 2	Conduct ETAT, BLS and ATLS trainings in hospitals	Number of trained hospital personnel	40	40	40	40	40			
Output 3	Adapt and disseminate standard guides for ETAT, BLS, and ATLS	Guides distributed	Created	All district hospitals	Community hospitals					
Strategic Objective 3		To improve rehabilitation and support services to victims involved in trauma and injury accidents								
Strategy 3.1		Provide more efficient and integrated response to all survivors of injury and trauma and their continuum of care								
		Support the establishment of short term training in trauma Establish emergency units in district & central hospitals Emergency structures								
		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
Output Description		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022				
Output 1	Follow up clinics (One Stop Centres/Victim Support Centres) for all victims of trauma and injury operational at all central/district hospitals	Number of operational clinics	5	5	5	5	6			

	<i>Advocate for safety shelters for victim support</i>									
Output 2	<i>Establishment of posts for physiotherapists, occupational therapists, and social workers at all hospitals</i>	<i>Number of posts established</i>		15	15	15	15	18		
Strategy 3.2		<i>Injury, disability and violence research and surveillance</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>Include Injury, disability, and violence indicators in HMIS</i>	<i>Number of HMIS reports (district and central hospitals) National Trauma Registry</i>		32	32	32	32	32		
Strategic Objective 4		<i>To enhance the national capacity of MoH and other sectors in violence prevention and management</i>								
Strategy 4.1		<i>Train MoH and other sector staff in violence prevention</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of	Risks and Assumptions	Responsibility

			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	Verification		
Output 1	Conduct trainings with health workers on case management of gender based violence clients.	Number of trainings held		9	0	1	2			
	gender-based violence prevention training session for staff in remaining 8 districts		2	2	2	1	1			
Output 2	Train district level decision makers in CMP in 8 districts									
Output 3	Conduct Child Maltreatment Prevention on Case Management of CMP victims TOT training for tutors from health, social, education training, police institutions plus officers for remaining 8 districts	Number of trainings held								
			2	2	2	1	1			

Strategy 4.2		<i>Raise awareness among Child Maltreatment Practices sub group members, and other national managers working child related programs on the CMP concept</i>								
7 Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>Conduct awareness seminar for CMP sub group members, and other national managers working child related programs on the CMP concept</i>	<i>Annual meetings</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>1</i>			
Output 2	<i>Create an annual report on the CMP situation analysis and present an acceptability study report to stakeholders</i>	<i>Presentation of annual report</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>1</i>			
Strategy 4.3		<i>Establish networking mechanism for violence prevention stakeholders</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of	Risks and Assumptions	Responsibility

			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	Verification		
Output 1	Conduct bi-annual coordination meetings	Number of meetings	2	2	2	2	2			
Strategy 4.4		Advocate for violence prevention training into health care and relevant sector training institutions								
		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
Output Description			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Creation of violence prevention modules for training	Completed module	Complete	8	8	8	8			
Output 2	Advocate for inclusion of violence prevention modules in pre-service training	Number of sessions with training institutions	8	8	8	8	8			
Strategic Objective 5		To enhance the national capacity for multi-sectoral response to violence against women, THE ELDERLY and children								
Strategy 5.1		Provide One Stop Centre Services to all Districts								

<i>Output Description</i>		<i>Objectively Verifiable Indicator</i>	<i>Annual Output Targets</i>					<i>Data Source and means of Verification</i>	<i>Risks and Assumptions</i>	<i>Responsibility</i>
			<i>2017/2018</i>	<i>2018/2019</i>	<i>2019/2020</i>	<i>2020/2021</i>	<i>2021/2022</i>			
Output 1	<i>Identify and train remaining 11 districts on the OSC Concept</i>	<i>Number of districts oriented</i>	3	2	2	2	2			
Output 2	<i>Build One Stop-Centres in remaining 11 district hospitals</i>	<i>Number of functioning OSCs</i>	3	2	2	2	2			
Output 3	<i>Establish and train TOTs for OSC</i>	<i>Number of TOTs trained</i>	3	2	2	2	2			
Output 4	<i>Run awareness campaign for OSC</i>	<i>Number of campaigns</i>	3	2	2	2	2			
Strategy 5.2		<i>Maintain up-to-date policies and laws on GBV and violence against children AND THE ELDERLY</i>								
<i>Output Description</i>		<i>Objectively Verifiable Indicator</i>	<i>Annual Output Targets</i>					<i>Data Source and means of Verification</i>	<i>Risks and Assumptions</i>	<i>Responsibility</i>
			<i>2017/2018</i>	<i>2018/2019</i>	<i>2019/2020</i>	<i>2020/2021</i>	<i>2021/2022</i>			

Output 1	<i>Review National Gender Policy</i>	<i>Number of review meetings</i>	2	2	2	2	2			
Output 2	<i>Advocate for Review Sexual and Reproductive Health Rights Policy</i>	<i>Number of review meetings</i>	2	2	2	2	2			
Output 3	<i>Review National Youth Policy</i>	<i>Number of review meetings</i>	2	2	2	2	2			
Output 4	<i>Work with all sectors to enact national plans that involve children, women, and gender-based violence (MGDS II, National Plan of Action to Combat Gender-Based Violence in Malawi, JSSP, Education for All National Action Plan, and HSSP II)</i>	<i>Joint meetings held</i>	2	2	2	2	2			
Output 5	<i>Review and update national guidelines as needed</i>	<i>Number of guidelines updated and reviewed</i>		1	1	1	1			
Strategy 5.3		<i>Support child maltreatment prevention program</i>								

Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Provide health workers to be trained on CMP program to work with multi-sectoral partners	Number of health workers trained		32	32	32	32			
Strategic Objective 6		To create an enabling environment for monitoring of violence cases								
Strategy 6.1		Establish a system to identify, record, and report violence cases								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Integration of the GBV into the HMIS reporting system.	Number of workshops held per region		1	1	1	1			Dialogue between CMED and NCD
Output 2	Train health, social workers and register officers on identification, documentation and reporting	Number of trainings per region	1	1	1	1	1			

	<i>of violence cases</i>										
Output 3	<i>Train HMIS officers on violence indicators and reporting of violence</i>	<i>Number of trainings per region</i>									
			1	1	1	1	1				
Strategy 6.2		<i>Advocate for evidence-based interventions, policies, and guidelines for prevention and management of violence</i>									
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility	
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022				
Output 1		<i>Number of joint meetings held</i>									
			1	1	1	1	1				
Output 2	<i>Continue dissemination campaign for child violence prevention interventions (and engage local chiefs)</i>	<i>Number of campaigns</i>									
			1	1	1	1	1				
Strategic Objective 7		<i>To maintain evidence and prevent and reduce cases of child and intimate partner violence</i>									

Strategy 7.1		<i>Continue systematic research</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>research On Violence</i>	<i>research on violence featured in the NCD Annual Conference</i>		1		1				
					1		1			
Output 3			2	2	2	2	2			
Strategy 7.2		<i>Advocate for the child violence prevention intervention</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>Increase public awareness through mass media campaigns</i>	<i>Number of mass media campaigns</i>	1	1	1	1	1			

Output 2	<i>Engage local leaders and community members</i>	<i>Engagement meetings per district</i>								
			1	1	1	1	1			
Strategy 7.3		<i>Decrease child, GBV, and IPV</i>								
		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
Output Description			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>Continue training health and social workers (especially in remaining 11 districts) on identifying cases, referring for further assessment, providing basic counselling support, and manage emergency cases</i>	<i>Number of trainings per district</i>								
				1		1				

Key Result Area:		Mental health								
Strategic Outcome		Improved mental health of Malawians, which will enable them to effectively contribute to, and enjoy socio-economic development								
Strategic Objective 1		To improve policy and legislative framework for mental health service delivery								
Strategy 1.1		Finalise and implement national mental health policy								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Draft Mental Health Policy review by all MH stakeholders	Finalised MH policy draft in place	1					Report from meetings, draft policy	Delay in review due to conflicting roles	NCDS Unit
Output 2	Draft Mental Health Policy endorsement	MH Policy endorsed by Senior MOH Management		1				Senior Management Report		
Output 3	Draft Mental Health Policy approval	Final MH Policy signed by the Minister of Health		1				Approval Documentation		
Output 4	Approved MH policy printing	MH policy hard copies available			1			invoices and procurement report		

Output 5	MH policy launch dissemination	Number of MH policy launch meetings (national & zonal)			7					Activity Report		
Strategy 1.2		Finalise review of Mental Health Act for Malawi										
		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility		
Output Description			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022					
Output 1	Review mental health bill Stand alone 'legislation on suicide by all stakeholders'	Number of stakeholder consultative meetings		3						Report from meetings, draft policy		
Output 2	Draft Mental health bill	Drafted mental health bill in place with feedback incooperated		1						Draft copies		
Output 3	Draft Mental Health Bill endorsement	Mental Health Bill endorsed by senior MOH Management								Endorsement letter		
Output 4	Draft Mental Health Bill approval	Final Mental Health Bill signed by Minister of Health		1						Approval Documentation		
Output 5	MentalHealth Bill submission to Parliament	Mental Health Act in place		1						Act		

Strategy 1.3		Strengthen the core- functions of the Inter-minsterial committee on Drugs and Alcohol								
		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Review the inter-ministerial committee membership through the ministers of the MOH and home affairs	Number of meetings	1					Reports		
Output 2	Co-facilitate inter-ministerial Drug and Alcohol technical meetings	Number of inter-ministerial meetings held		1				TORs		
Output 3	Establish the Taskforce for mental health	Taskforce on Mental Health and Drugs and Alcohol in place						Minutes of Meeting		
Output 3	Quarterly meetings initiated by the Taskforce	Number of meetings		4	4	4	4	Minutes of Meeting		
Output 4	Brief the inter-ministerial committee on the approved and gaps related to other drugs	Policy briefing meetings conducted						Reports		
Strategic Objective 2		To promote mental health in all population groups by 2022								

Strategy 2.1		Improve public awareness of mental health through mass media								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Coordination between NCD-MH and Education Unit in the Ministry of Health to develop a strategy for creating awareness about mental health	Strategy developed and reviewed	1						Activity Reports	MOH and Partners
Output 2	Develop and disseminate key messages and materials for sensitising communities about mental health problems	Key messages developed and disseminated		2	2	2	2	2	Dissemination reports	MOH and Partners
Output 3	Train HSAs and volunteers at community level to enable them disseminate messages about mental health	Number of HSAs and volunteers trained		2500	2500	2500	2500	2500	List of trained HSAs	MOH and Partners
Output 4	Establish and collaborate with other programmes to intergate mental health messages in their promotion strategies	Number of collaboration meetings		3	3	3	3	3	Activity reports	MOH and Partners
Output 5	Commemoration of World Mental Day	World Mental Day commemoration		1	1	1	1	1	Activity Reports	MOH and Partners

Strategy 2.2		Improve awareness of mental health among adolescents and the youth								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	Coordinate with the Health Education Unit in the Ministry of Health to review strategy for creating awareness about mental health to include youth and adolescents.	Strategy reviewed	1	1	1	1	1	Activity reports		MOH and Partners
Output 2	Develop and disseminate key messages and materials for sensitising adolescents and youth about mental health problems	Key messages and sensitising materials developed and disseminated	2	2	2	2	2	Materials, and dissemination reports		MOH and Partners
Output 3	Include mental health in the school curriculum (primary, secondary, and tertiary)	Mental health included in the school curriculum		5	5			curriculum review minutes		MOH and Partners
Output 4	Orientation of teachers in mental health and basic skills in counselling	Number of teachers oriented to mental health			3000	3000	3000	list of teachers		MOH and Partners
Output 5	Conduct mental health awareness campaigns in schools and/or colleges	Number of awareness campaigns conducted	28	28	28	28	28	reports		MOH and Partners

Strategy 2.3		<i>Improve mental health awareness in workplaces and other institutions</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>Work with the Health Education Unit in the Ministry of Health to include a strategy for creating awareness about mental health in the work place</i>	<i>Strategy for mental health awareness in the work place developed</i>		1	1	1	1	reports		MOH and Partners
Output 1	<i>Develop and disseminate key messages for sensitising employers and employees at work place</i>	<i>Number of dissemination meetings</i>		2	2	2	2	<i>communication materials developed</i>		<i>MOH and Partners</i>
Output 2	<i>Collaborate with the Ministry of Labour to reinforce organisational policies and programs aimed at supporting employees with mental health issues</i>	<i>Organizational policies developed</i>		1	1	1	reports			<i>MOH and Partners</i>
Strategy 2.4		<i>Improve mental health awareness in special population groups such as health workers, prisoners, people with disabilities, pregnancy and perinatal women, parents and guardians of children with disabilities, people with chronic health conditions eg HIV, NCDs etc</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			

	<i>advocate for promotion of rights of people with mental health problems</i>									
Strategic Objective 3		<i>To strengthen/build capacity for health system in provision of mental health care</i>								
Strategy 3.1		<i>Improve the capacity of health workers in management of mental health problems and disorders at all levels of health care</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>Advocate for the Review of mental health curriculum for, clinical officers, medical assistants and nurses</i>	<i>Reviewed curriculum for each education level</i>		1	1	1	1	<i>Reports</i>		<i>Medical Council, Nurses Council, MOH and Partners</i>
Output 2	<i>Train HSAs and volunteers at community in identification and screening of mental health</i>	<i>Number of trained HSAs and volunteers</i>		2500	2500	2500	2500	<i>Training Report</i>		<i>MOH and Partners</i>
Output 3	<i>Training of nurses, and clinicians in psychiatric mental health (Bsc, diploma, MSc)</i>	<i>Number of health workers trained</i>		12	12	12	12	<i>Training Report</i>		<i>MOH and Partners</i>
Output 4	<i>Orientation of health workers in mental health disorder management and basic skills in counselling</i>	<i>Number of health workers oriented</i>	500	2500	2000	2000	2000	<i>Report</i>		<i>MOH and Partners</i>

output 5	<i>Develop standardised screening tools to identify mental health disorders and alcohol related disorders at all levels</i>	<i>Standardised tool in place</i>								<i>Developed Tools</i>	<i>MOH and Partners</i>
Output 6	<i>Capacity building to health workers on the standarzed assessment tool</i>	<i>Number of trained health workers on adapted assessment tools</i>		<i>2000</i>	<i>2000</i>	<i>2000</i>	<i>2000</i>			<i>Training Report</i>	<i>MOH and Partners</i>
Strategy 3.2		<i>improve human resource base to improve service delivery of of mental health services</i>									
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility	
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022				
Output 1	<i>Training and recruitment of psychiatrists, psychologists, rehabilitation/occupation therapists and other relevant cadres, mental health attendants.... Separate the professions.</i>	<i>Number of trained psychologis and psychiatrists</i>								<i>Recruitment Report</i>	<i>MOH and Partners</i>
Output 2	<i>Training of psychosocial counselors</i>	<i>Number of counselors trained</i>								<i>Training Report</i>	<i>MOH and Partners</i>
Output 3		<i>Advocate for Programme development for clinical psychology</i>								<i>2 meetings</i>	<i>MOH and Partners</i>

		<i>courses</i>								
Output 4				12	12	12	12	HR report		MOH and Partners
Output 5	<i>Review establishment for mental health professionals</i>	<i>Number of reviews conducted</i>		3	3	3	3	HR report		MOH
Strategic Objective 4		<i>To improve access to mental health care at all levels</i>								
Strategy 4.1		<i>To integrate mental health and epilepsy\ in primary and secondary care settings</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>Sensitise/orient all HCWs in screening and treatment and referral for people with mental health problems</i>	<i>Number of health care workers trained</i>	2000	2000	2000	2000	2000	Training Report		MOH and Partners
Output 2	<i>Ensure availability of essential drugs for the treatment of mental health disorders and epilepsy at all levels</i>	<i>Number of facilities with access to essential drugs for mental health problems</i>	800	800	800	800	800	Drug Supply Report		MOH and Partners

Output 3	Construction of a mental hospital in Lilongwe	Mental Hospital constructed in Lilongwe						1		MOH and Partners
Output 4	Establish psychiatric wing/short stay in district and rural hospitals	Number of hospitals with a psychiatric wing		7	7	7	7	7	Progress Reports	MOH and Partners
Output 5	Ensure the establishment of rehabilitation units for people with substance use disorders in each region	Number of rehabilitation units constructed			1	1	1	1	Progress Reports	MOH and Partners
Output 6	Provide special treatment and support for special groups (e.g. suicidal cases)	Number of established psycho-social support services		7	7	14	7	7	Programme Reports	MOH and Partners
Output 7	Establish/intergrate support groups in all mental health delivery centres	Number of support groups formed		120	120	120	120	120	Reports and meeting minutes	MOH and Partners
Output 8	Provide mental health and epilepsy services in prisons	Number of prisons with operational mental health services	3	3	3	3	3	3	Progress Reports, DHMIS Reports	MOH and Partners
Output 9	Integration of mental health training syllabus in the national HSA curriculum, PHC level	Inclusion of mental health in HSA and PHC curriculum		1					Curriculum	MOH and Partners
Output 10	Allocation of full time district mental health officers and counsellors, rehabilitation assistants, mental health psychiatric nurses	Number of full time mental health officers per cadre available at all levels		14	14	14	14	14	HR Report	MOH and Partners

Output 11	Conduct continuous professional skills development for health workers	Number of CPD sessions	2	2	2	2	2			MOH and Partners
Strategy 4.2		Build capacity for provision of mental health services in Malawi								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
Output 1	Impl			1				Curriculum		MOH and Partners
Output 2	Advocate for 12% of district budget to be spent on mental health									
Strategic Objective 5		Strengthen monitoring & evaluation and research relating to mental health								
Strategy 5.1		national surveys (see weakness)								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
Output 1	Develop mental health and epilepsy research agenda for Malawi and implement studies	Mental health research agenda in place	8	9	0	1	2	Research Agenda		

Output 2	Conduct KAP survey to identify misconception, stigma and negative attitudes towards people with mental disorders	Report on KAP survey			1	1	1	1	Survey Reports		
Output 3	Advocate for inclusion of mental health indicators in DHIS and STEPS survey	Mental Health variables included in the DHIS and STEPS survey	1						DHIS and survey Report		
Output 4	Develop a national mental health data base	Database developed					1		Reports		
Strategy 5.2		Routine MH data reporting									
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility	
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022				
Output 1	Advocate for inclusion of mental health indicators in HMIS	Mental Health variables included in the HMIS		1					Reports		
Output 2				1					Reports		
Output 3	Incorporate data on standardized assessment tools in M&E	Tools for alcohol and other disorders adapted to suit Malawi						1	Reports		

Strategy 5.3		<i>Strengthen, conduct and dissemination of MH research (include it into research agenda)</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>Develop mental health research agenda for Malawi and implement studies</i>	<i>Mental health research agenda in place</i>								
Output 2	<i>Annual MH research conference</i>	<i>Number of research conferences conducted</i>		1	1	1	1	Reports		
Strategic Objective 6		<i>To strengthen partnerships and stakeholder collaboration in mental health care</i>								
Strategy 6.1		<i>Mental health networking and advocacy</i>								
Output Description		Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility
			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>Stakeholder analysis on integration of mental health services into all health programs. eg (maternal mental health</i>	<i>Number of stakeholder consultative meetings</i>		8				Activity Reports and Minutes of Meeting		

	into safe motherhood initiatives)										
Output 2											
Output 3	Collaborate with safe motherhood / Reproductive Health Unit and other health programs to determine the mental health activities that can be implemented	Number of meeting reports	1	1	1	1	1	1	Reports		
output 4	Develop/ adopt the assessment tools	Assessment tools relevant to specific health programs developed	1	1	1	1	1	1	Tools Developed		
Output 5	Orient health workers on the assessment tool	Number of health workers trained	2000	2000	2000	2000	2000	2000	HR Report		
Output 6	Commence implementation of the determined mental health activities	Number of programs with mental health intergrated into care	1	1	1	1	1	1	Reports		
	Strategy 5.2	Advocacy for financial and technical support									
Output Description	Objectively Verifiable Indicator	Annual Output Targets					Data Source and means of Verification	Risks and Assumptions	Responsibility		

			2017/2018	2018/2019	2019/2020	2020/2021	2021/2022			
Output 1	<i>Advocacy meeting with potential donors</i>	<i>Number of meetings</i>	2	2	2	2	2	<i>Minutes of Meetings</i>		
Output 2	<i>Development of proposal for possible funding</i>	<i>Proposal document developed</i>	1	2	2	2	2	<i>Proposal documents</i>		