

New Norms and Forms of Development

WORKING PAPER III

# Maternal and Child Health

Where does Malawi stand on Millennium  
Development Goals 4 and 5?

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New Norms and Forms of Development: Brokerage in Maternal and Child Health Service Development and Delivery in Nepal and Malawi.

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This working paper series is part of the research project 'New Norms and Forms of Development: Brokerage in Maternal and Child Health Service Development and Delivery in Nepal and Malawi'. This collaborative project involves researchers from School of Social and Political Science and School of Health in Social Science at the University of Edinburgh; Kamuzu College of Nursing in Malawi; and Social Science Baha in Nepal. Funded by a grant awarded by the Economic and Social Research Council and Department for International Development (ESRC/DFID) in the UK, the project runs from 1 May 2014 to 31 October 2016. Web address: <http://newnorms.soscbaha.org>

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First published in electronic format in August 2016.

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## BACKGROUND: MATERNAL CHILD HEALTH, MDGS AND THE WORLD DEVELOPMENT CONTEXT

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Arising out of research for the study, 'New Norms and Forms of Development: Brokerage in Maternal and Child Health Service Development and Delivery in Nepal and Malawi', this working paper examines the Millennium Development Goals (MDGs) Four (reducing child mortality) and Five (improving maternal health) in Malawi within the broader context of global development goals. It provides a brief context for the MDGs and explores different global policy responses towards the achievement of MDG Four and Five targets. More specifically, it examines what has been happening with these targets in Malawi, what country-specific Maternal and Child Health (MCH) activities have been initiated, and whether the targets have been met, while critically questioning the achievements and current challenges related to health service provision in the country.

In 1980, an estimated half a million women died due to pregnancy and childbirth-related causes globally. Almost all (around 99 per cent) of them were impoverished women in low-income countries. By 2010, this number had come down to 300,000 but that figure was not as much as hoped for (Smith & Rodriguez, 2015). Even in 2015, maternal mortality remain unacceptably high, with almost 99 per cent of maternal deaths continuing to occur in low-income countries. It is clear that this is due to poverty and a lack of resources and consequent chronic under-investment in the health sector, including MCH services in low-income countries.

In order to address this challenge, the past three four decades have seen many efforts by women's

rights lobbyists and international health policy experts aimed at bringing maternal health into the global health policy agenda. Smith & Rodriguez (2015: 2) write:

The World Health Organization (WHO) began to study the global maternal mortality problem systematically in the early 1980s, and with the United Nations Population Fund (UNFPA) and the World Bank sponsored the first international conference concerning the issue in 1987. The accompanying launch of the Safe Motherhood Initiative marked the emergence of a global health network, a group of individuals and organizations connected by a shared concern for reducing pregnancy-related deaths around the world...

Women's health began to receive more policy attention after the 1976-1985 UN Decade for Women (Smith and Rodriguez 2015). The Alma Ata conference in 1978 and the 'Convention on the Elimination of All Forms of Discrimination against Women' in 1979 identified women's health as an issue requiring urgent attention. The Fourth World Women's Conference in Beijing in 1995 provided added impetus to women's health issues globally. All these efforts were consolidated further at the Millennium Summit in 2000, when maternal health was given considerable space in the global health and development agenda.

The issue of child health appears to follow a similar pattern as maternal health. In 1996, the World Health Organisation estimated that about 5 million neonates died per year, against the vast majority in low-income countries, and yet this area did not

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The author would like to thank the research team, Address Malata, Deepak Thapa, Ian Harper, Jeevan Sharma, Pam Smith and Obindra B. Chand for closely and carefully reading earlier version and making valuable comments, also for suggesting very useful references.

receive much-needed attention in global health field. Shiffman (2015) suggests that the attention of global policy on child health began only after 1999, and that has led to the growth of a global network of expert and policy advocates for child health. As with maternal health, the Millennium Project has given child health considerable priority.

## MDG and MCH

In order to address longstanding issues of global poverty and inequity, in the dawn of the new millennium, world leaders decided to meet and develop some strategies to eradicate extreme poverty from the world, improve peoples' living standards, and provide basic education and health services for all, in particular for those living in low-income countries. In September 2000, the three-day Millennium Summit was held at the UN headquarters, and attended by leaders and political representatives from 189 countries. The Millennium Declaration of 'eight global development goals' was made, goals that are known as Millennium Development Goals.<sup>1</sup> The Declaration was adopted by 189 nations and 147 heads of state were its signatories.

One of the key characteristics of the Millennium Project and the MDGs has been its specific focus on setting quantifiable targets towards achieving the eight global development goals by 2015 (Attaran 2005). Three of the eight MDGs are directly related to health, namely, MDG Four: *reducing child mortality*; Five: *improving maternal health*; and Six: *combating HIV/AIDS, malaria and other diseases*. Member states were required to set out country-specific targets to meet these MDGs. Additionally, a proposed follow-up of the outcome of this resolution was passed by the General Assembly on 14 December 2000 to guide its implementation. Since then there have been a series of events and high-level policy dialogues and meetings at global, regional and national levels, some of which are outlined further down.

In 2005, in order to monitor the progress of the *health-related MDGs* and targets, a 'Countdown to 2015' was set up and a series of high-level policy meetings and international conferences held.

In academic and policy circles there has been a great deal of interest in planning and monitoring the progress made on achieving country-specific targets. All MDG-related initiatives and activities have been supported by foreign aid as there has been a tremendous policy push towards meeting all eight MDG targets in low-income countries. However, while most countries globally have made significant progress, the performance of some low-income countries remains unsatisfactory.

The MDGs aim to serve as a framework for sustainable development that contributes to economic development, while ensuring environmental sustainability. This document, as already noted, is concerned directly with the MCH-related MDGs (Four and Five). Globally, MDG Four aims to reduce under-five mortality by two thirds between 1990s and 2015<sup>2</sup> and MDG Five, to provide women universal access to reproductive health and reduce Maternal Mortality Ratio (MMR) by three quarters between 1990 and 2015.<sup>3</sup> These are global guidelines and all countries were to set their own targets. The progress of MDGs Four and Five, and the current MCH situation in Malawi is discussed below.

## MDG milestones and related development strategies

- 2000 Millennium Summit in the UN Headquarters: UN Declaration to reduce extreme poverty in the world. With eight development goals, time-bound targets were set, with the deadline being 2015.
- 2001 Abuja Declaration (WHO): Encouraged countries in the African Union to raise their annual health budgets to at least 15 per cent of total government expenditure.
- 2002 Millennium Project was commissioned by the UN General Secretary to set out concrete

action plans to end extreme poverty and hunger in the world.

- 2004 At the G8 summit in Gleneagles, Scotland, the G8 countries pledged to increase their levels of Overseas Development Assistance (ODA) to Africa with many of them pledging to reach the target of 0.7 per cent of Gross National Income (GNI) devoted to ODA in total. The OECD (Organisation for Economic Cooperation and Development) secretariat estimated that the new pledges would increase aid from around USD 80 billion in 2004 to nearly USD 130 billion in 2010, an amount consistent with 2004 rates. This represents 0.36 per cent of the estimated GNI of the G8 countries in 2010.
- 2005 WHO report entitled 'Make every mother and child count' added emphasis to the already urgent issue of MCH service provision (MDGs Four and Five).
- 2005 Paris Declaration on aid effectiveness set the direction for funding modality in the MCH sector and other development activities.
- 2005 Jeffrey Sachs, American economist and adviser on MDGs to the UN Secretary-General Ban-ki Moon, presented his final recommendations in a synthesised volume: 'Investing in Development: A Practical Plan to Achieve Millennium Development Goals'.
- 2005 Countdown to 2015 announced at a multi-disciplinary and multi-professional conference in May of 2005. The idea was triggered by the *Lancet* publication on child mortality in 2003 and consolidated in 2005. It focuses on health-related MDGs, specifically, Four and Five with particular interest in 75 countries with poor MCH statistics, which together account for more than 95 per cent of the world's maternal, newborn and child deaths. Full reports on MCH service coverage and tracking of the progress made towards achieving MDGs Four and Five by 2015 have been published in 2005, 2008, 2010, 2012, 2013, 2014 and finally in 2015. These provide a

comprehensive picture of all progress made and full updates.<sup>4</sup>

- 2005 The 58th WHA (World Health Assembly) requested Member States to reaffirm the MDGs as critical for health development, and to develop nationally relevant 'roadmaps' that would incorporate their actions as a guide to accelerating progress towards achieving health-related MDGs.
- 2005 A high-level Forum on the MDGs in Asia and the Pacific met in Tokyo, in June 2005, and reviewed the progress made and the challenges faced by countries in Asia and the Pacific, and highlighted actions that could be initiated at the individual country level.
- 2007 MDG Five: two global targets were added. a) Maternal Mortality Rate (MMR) to reduce by three quarters, between 1990 and 2015 b) Universal access to reproductive health by 2015
- 2010 Summit on the MDGs, adoption of a Global Action Plan on keeping the promises: United effort to achieve the MDGs and the announcement of a number of initiatives against poverty, hunger and disease with a major push to accelerate progress on women's and children's health.
- 2012 Countdown reports from all 75 countries are collected (annually since) and progress has been monitored closely. Countdown to 2015 report, entitled 'Building a Future for Women and Children: the report 2012', suggests that the 75 Countdown countries have made varied levels of progress in achieving MDGs Four and Five, while some countries have made significant improvement in their MCH services.
- 2015 Final MDG meeting in September, and '17 Sustainable Development Goals' to continue MDG activities have been decided.<sup>5</sup>

Malawi is one of the 75 Countdown low-income countries, with poor maternal and child health statistics. As noted above, these countries have been receiving increased amounts of foreign

aid and technical assistance to achieve MDGs Four and Five (and six) targets. According to the 'Countdown to 2015' reports, amongst 75 countdown countries, some have made phenomenal progress, while others are still lagging behind.

With the final date for achieving MDGs being September 2015, the past few years have seen a phenomenal increase in academic and policy interest and activities around MDG achievement,

focussing on what has been achieved so far and asking the 'what next' question. In September 2015, the idea of '17 Sustainable Development Goals (SDGs)' emerged from MDG's concluding summit, and the SDGs has taken over the role and functioning of the MDGs.<sup>6</sup> Within this backdrop, this paper will now focus more specifically on the situation and progress updates of MDGs Four and Five in Malawi (and the companion paper discusses the same for Nepal).

## MALAWI: COUNTRY CONTEXT

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Like the other country included in the study, Nepal, Malawi is a landlocked country. It lies in sub-Saharan Africa, bordering Mozambique, Tanzania and Zambia and has a population estimated at 14 million in 2013. In 2014, Malawi celebrated 50 years of independence from Great Britain. Over the five decades of independence under five presidents<sup>7</sup> Malawi has been considered one of the most peaceful countries in sub-Saharan Africa. As one of the poorest countries in the world, Malawi faces significant fiscal as well as political challenges but it has also been the recipient of a great deal of foreign aid and technical assistance for development (Shawa 2012; Sida 2005).

Malawi also has poor health statistics in general and MCH statistics in particular. In fact, its statistics is one of the worst in sub-Saharan Africa. Illiteracy, lack of health service facilities, a serious shortage of healthcare professionals, high prevalence of HIV/AIDS, Malaria and other communicable diseases, are the major development challenges identified in research literature, policy debates and health and development statistics (GoM 2011; Palmer 2006). As a result, Malawi has been one of the 'Focus Countries' for foreign donors such as DfID and USAID.

Over the past few decades an increasing number of international donors and External Development Partners (EDPs) have begun supporting Malawi in its bid to improve health service development and delivery and also to meet all its MDG obligations by 2015. For example, Scotland and some Nordic countries have established a special relationship or partnership with Malawi in development.<sup>8</sup> China, too, appears to have emerged as a significant player in the past decade or so, having an increased influence in infrastructure development, including in the health sector. A Chinese-built maternity waiting home in Northern Malawi was reported in Malawi's national news in 2014,<sup>9</sup> and China has also donated medical equipment to the Kamuzu Central Hospital (KCH) and Chinese volunteer doctors are currently working in KCH. The Christian Health Association of Malawi (CHAM) and national and international non-governmental organisations are significant contributors in the health sector.

Malawi has 28 administrative districts and three health regions (Northern, Central and Southern). Currently, there are four major tertiary-care referral hospitals: Mzuzu Hospital in Mzuzu, northern Malawi, Kamuzu Central Hospital in Lilongwe, Central Malawi, and Queen Elizabeth Hospital



in Blantyre and Zomba hospital in Zomba, both in Southern Malawi. Most areas also have district hospitals. Since the government administration system was decentralised in 2004, all districts health offices and hospitals are responsible for their own health service planning and management. The Malawi government has been firmly supported by donors and EDPs to deliver health services in the country and to meet its country-specific MDG targets and, now, achieve SDGs.

### **Major milestone and significant events health related to MDGs Four Five (and Six)**

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|---|---|
| <p>2001 Malawi was one of the signatories of the Abuja Declaration. This agreement requires countries in the African Union to increase their annual budget to improve health service provision to at least 15 per cent.</p> <p>2004 The Malawian president visited Scotland and the agreement for a special relationship was signed, promising funding support from the Scottish Government to the Malawian health sector.</p> <p>2004 The sector-wide approach (SWAP) was introduced to harmonise foreign aid-funded development activities, including in health.</p> <p>2004 Decentralisation in government functioning, including in the health sector, was initiated.</p> <p>2004 The MoH declared that Malawi had a critical shortage of Human Resources for Health (HRH), with a report suggesting that the HRH situation in Malawi is 'critical, collapsing and collapsed, meltdown' (Palmer 2006).</p> <p>2004 DfID, in alliance with some other EDPs, supported a six-year Emergency Human Resources for Health Programme in Malawi (EHRHP 2004-2010). The EHRHP included: a 52 per cent salary top-up to HRH to improve retention; expanding the domestic training capacity by over 50 per cent; using internal volunteer doctors and nurses as a stop-gap measure while preparing more staff; using international experts to bolster</p> | <p>expertise; and, finally, establishing a robust monitoring and evaluation system (Palmer 2006).</p> <p>2005 The Road Map for reduction of maternal and newborn mortality and morbidity was developed.</p> <p>2011 Countries in the African Union, including Malawi, revisited the Abuja Declaration, and urged donor countries to 'fulfil the, yet to be met, target of 0.7% of their GNP as Official Development Assistance (ODA)' to developing countries.</p> <p>2011 A Resource Mapping Exercise began in Malawi with help from the Clinton Health Access Initiatives (CHAI) to support SWAP and also to help the National Health Strategy Plan (NHSP).</p> <p>2012 Upon the death of the President Bingu Wa Mutharika, Vice-President Joyce Banda took up the role of the president after a few days of constitutional crisis.</p> <p>2012 A Safer Motherhood Presidential Initiative was launched in April, led by President Banda. Activities included building Maternity Waiting Homes in various parts of the country.<sup>10</sup> Banda also aimed to train over 1000 new Community Midwives by 2014 to staff Maternity Waiting Homes.<sup>11</sup></p> <p>2013 In September, the 'Cashgate' scandal was exposed and some foreign aid donors pulled out of funding Malawi through the government system. DfID froze its support to the Malawian government and many international donors lost faith in the Malawian government system.</p> <p>2014 Presidential election held in May and Joyce Banda defeated. Peter Mutharika, younger brother of the late President Bingu wa Mutharika, became the fifth president of Malawi.</p> <p>2015 The Government passed a bill announcing that the legal marriage age for girls was now to be 18 years, up from the previous 16. The idea was to encourage girls to stay in school for longer, and have children later, as part of</p> |
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improving female reproductive health and adolescent health.

2015 Malawi met its MDG Four target, which was to reduce child mortality from 247 in 1990 to 83 by 2015. However, its MDG Five target remained unmet.

### **Reduce child mortality: MDG Four in Malawi**

Although its child health policy in relation to MDG Four (improving child health) received political attention much later than some other low-income countries (such as Nepal and Bolivia), since the development of its 'Road Map', Malawi has made significant progress in newborn survival rates (Smith *et al* 2014; Zimba 2012). The WHO Africa office drafted the original Road Map template for Malawi. Called the Road Map for Accelerating the Reduction of Maternal and Newborn Mortality and Morbidity in Malawi, it was linked to the SWAP with a budgeted implementation plan (MoH [Malawi] 2005).

Many foreign aid-funded child health programme have been active in Malawi in 2015-16. For example, Helping Babies Breathe (HBB) has been up-scaled to a nationwide programme (McPherson 2013). The most recent 'Countdown' report suggests:

...Over 30% of Malawi's population lives in severe poverty, yet it is one of only a few countries in sub-Saharan Africa on track to achieve MDG 4 by reducing under-5 mortality by two-thirds between 1990 and 2015 [from 247 to 83)...<sup>12</sup>

Under-five mortality in 1990 was 244 per 100,000 live births (according to the Countdown to 2015) and in 2013 this number has come down to 83. While there has been much improvement in overall under-five (child) mortality, neonatal mortality remains at an unacceptable level. The HBB programme focuses on reducing neonatal death by providing quality care to neonates immediately

after birth.

### **Improving Maternal Health: MDG Five in Malawi**

Unsafe abortion (or termination of pregnancy) is quite common in Malawi, and contributes to its high maternal mortality rate, with nearly 20 per cent of maternal deaths occurring from complications due to unsafe abortion. The IPAS study suggests that roughly 18,700 women were treated in health facilities for complications due to unsafely performed induced abortion in the community in 2009 (IPAS 2014).<sup>13</sup> Marie Stopes International has also been working in the country for over the past 25 years, offering reproductive health services, including contraceptive and safe abortion facilities.

Other interventions designed to improve maternal health include maternity incentive programmes (rewarding women for attending health facilities for antenatal check up and birth) have been piloted /implemented in some districts in central Malawi (Option Malawi 2015). In line with MDGs Four and Five, the most prominent current foreign aid-funded activities in Malawi seem to be increasing MCH service coverage and capacity building activities. This means more clinics and health facilities, and more supplies and staff members are required to provide services. There are some major *infrastructure-building* projects currently on-going in Malawi as well. In order to increase access to MCH services in the rural areas, the construction of maternity waiting homes and birthing centres is very evident across the country. Construction work across the country seems to be rapidly increasing with the help of foreign aid. Alongside, a further focus has been the strengthening of referral systems to provide obstetric and neonatal emergency services.

As in many other low-income countries such as Ghana, Nepal and Kenya, Malawi has been facing a critical shortage of human resources for

health (HRH), which has severely affected its health service delivery countrywide. In order to address this issue, DfID and other international donors have made significant investments in HRH strengthening programmes (WHO GHWA 2008; Palmer 2006). All possible resources, including increasing the number of international volunteers have been mobilised to improve the staffing situation—by supporting Malawi to produce more health professionals as well as retaining them in the country. As a result, the number of nurse education seats has increased phenomenally in the past decade (Palmer 2006).

## Brief discussion on MMR statistics and progress in Malawi

As in many other countries, there are obvious inconsistencies in Malawi's MMR statistics related to the progress made in maternal mortality reduction. First, it is not clear, as the graph below demonstrates, why, despite considerable international support and funding, MMR statistics in Malawi from around 2005 do not seem to progress as well as between 1990 and 2005. However, the country seems to have responded to the global policy direction quite quickly. For example, in line with the WHO's 'Roadmap for

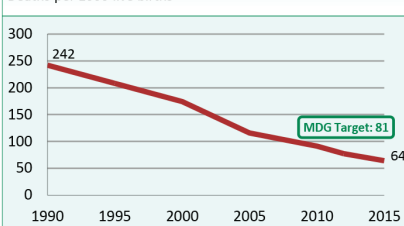
## Countdown to 2015: Progress made and challenges faced by Malawi in achieving MDG Four and Five targets

### DEMOGRAPHICS

Total population (000)	17,215	(2015)
Total under-five population (000)	2,954	(2015)
Births (000)	665	(2015)
Birth registration (%)	2	(2011)
Total under-five deaths (000)	40	(2015)
Neonatal deaths (% of under-five deaths)	34	(2015)
Neonatal mortality rate (per 1000 live births)	22	(2015)
Infant mortality rate (per 1000 live births)	43	(2015)
Stillbirth rate (per 1000 total births)	24	(2009)
Total maternal deaths	3,400	(2013)
Lifetime risk of maternal death (1 in N)	34	(2013)
Total fertility rate (per woman)	5.0	(2015)
Adolescent birth rate (per 1000 girls)	143	(2012)

#### Under-five mortality rate

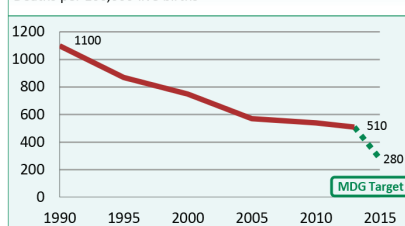
Deaths per 1000 live births



Source: UN IGME 2015

#### Maternal mortality ratio

Deaths per 100,000 live births



Source: MMEIG 2014

In terms of MMR, as the above graph suggests Malawi started from a very disadvantaged position, with MMR at 1100 (since it is not consistent in the literature, it is not clear whether this baseline is from 1990 or 2000), one of the highest and worst rates in the world. According to Palmer (2006), MMR in Malawi increased from 620/100,000 live birth in 1990, to 1120 in 2000, a rate that was one of the highest in sub-Saharan Africa. The MDG Five target was to reduce this to 280 by 2015. According to Malawi's Demographic and Health Survey (2004), MMR began to improve only from 2004 onwards.

Reduction of Maternal and Newborn Mortality', Malawi also developed its Road Map in 2005. There has been an increased amount of foreign aid for the Malawian health system since 2005, when SWAP started and health-care programmes were supposed thereafter to have been better coordinated and harmonised. Despite the implementation of the Emergency Human Resource for Health plan, the Roadmap for Reduction of Maternal and Newborn Mortality and increased donor support, progress in maternal health (according to the 'Countdown to 2015' report) seems to have slowed down. The reason for this remains unanswered.

Another obvious inquiry is about the worsening MMR in the late 1990s and early 2000, when MMR actually started rising, a fact that is not widely

discussed in the literature and not even mentioned in Countdown to 2015. Palmer (2006) however, speculates that it could have been due to the increase in HIV/AIDS and other communicable diseases, something that is not mentioned in the MDG and MMR debates.

An additional point is that while the above graph clearly suggests Malaria is one of the major killers of women and children in Malawi, the MDG-related MCH intervention does not seem to directly focus on this issue.

## Major Donors/EDPs in Malawi

According to our engagement with various stakeholders involved in foreign aid and MCH in Malawi, it is clear that DfID, USAID, Clinton Health Access Initiative (CHAI), Global Fund, Flanders and the Norwegian Government figure among the significant donors and EDPs in Malawi. It is, however, not possible to discuss in detail about the contribution made by the individual donors and EDPs in Malawi's health system in this paper.

## MAIN CHALLENGES FACED BY MALAWI IN RELATION TO HEALTH-RELATED MDGS

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Malawi faces a number of critical challenges in overall health service provision that need to be considered while making health service planning to provide quality and equitable health service to its people. Some of the major challenges are briefly discussed below.

***Malawi is becoming increasingly donor-dependent, and there is lack of donor coordination:*** In the past five six decades (basically since its independence from the British in 1964), Malawi has increasingly become a donor-dependent country, as a significant portion of development funds, including the health budget, is supported by foreign aid. Donors and EDPs not only provide financial assistance to the government, but also direct health services to people outside of the government system. One such example is CHAM (Christian Health Association of Malawi), with its service-level agreement with the government in health service provision, currently providing almost 37 per cent health care service to Malawians (Manthalu 2014). While international donors contribute a significant amount of aid to the government health system in Malawi, it is

important to note that the government system in fact meets only 20 per cent of overall health resources in the country. Independent service providers (charities, NGOs, INGOs and the private sector) provide 80 per cent of the country's health resources.

In the absence of universal coverage in healthcare, household out-of-pocket spending for health is common in Malawi. Also, it is important to note that in the past two decades with donor commitment and support towards universal coverage, out-of-pocket expenses on health is reported to have decreased significantly, from 26 per cent in 1998/99 to 12.1 per cent in 2005/2006 and 12 per cent in 2013, relieving this debilitating burden on economically disadvantaged households (Mamaya 2015; Mwandira 2011; Zere *et al.* 2010)

***The recent scandal of financial mismanagement impacting on health sector financing:*** Financial mismanagement and fraud have been major issues in Malawi for some time (Shawa 2012; Booth *et al.* 2006; Sida 2004). Unfortunately, the acute and reverberative problem of the 'Cashgate'

scandal, which broke in the summer of 2013, has further complicated the financing of the country's health sector as well as the government's overall financial management system. Senior civil servants, politicians and private business contractors (those supplying goods and services to the government) have been found involved in vast amounts of fraud and the misuse of government funds (Baker Tilley 2014). Many international donors and EDPs appear to have lost faith in Malawian politics and the government's financial management system. As a result some of the key donors such as the DfID and Flanders have withdrawn financial support for government provision of basic health services, and started exploring alternative ways to support Malawi. A culture of mistrust has grown since 'Cashgate'.<sup>14</sup>

**Critical shortage of health workforce and technical:** Since the early 2000s, Malawi has successfully attracted global attention on its crippling HRH situation. There was a significant migration of health professionals internationally, particularly nurses from Malawi. As noted above in Malawi's major milestone section, the critical shortage of health professionals, exacerbated by migration (national and international) in

the country has posed a major challenge to the health system (Grigulis 2010; Adamson 2006; Palmer 2006). In early 2000, because of the critical shortage of HRH, along with many other health service challenges, Malawi became a focus country for DfID and USAID in sub-Saharan Africa. DfID supported Malawi with emergency human resources plan, helping the government to recruit and retain the health workforce within the government system. At present (2015-16), Malawi still faces an overall shortage of health professionals in the country.

**Multiple factors causing a high MMR in Malawi:** At first glance, high maternal mortality can be seen to have been caused by poor or lack of access to maternity services. While it is one of the many factors contributing to high maternal mortality, other factors seem to play a critical role. For example, the Countdown report shows that malaria during pregnancy seems to be one of the major causes of maternal mortality and morbidity. Quite often, malaria during pregnancy can be confused with eclampsia/preeclampsia, and as a result women get misdiagnosed and receive inappropriate treatment—if they get any treatment at all.

## CONCLUSION

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Since it became independent in the mid-1960s, Malawi has been accepting external assistance for development. Over the past five decades the country has fully embraced global development goals and in recent years has achieved many of the MDG targets as well.

With the beginning of the new millennium, or with the implementation of the Millennium Project in the country, some of the major Maternal and Child Health initiatives introduced include the provision of clinic-based (safe) abortion; maternity incentives

schemes for women attending institutional birth; improvement in emergency maternal and neonatal referral systems; overall expansion of maternal and child health services; and maternal and child nutrition. With the strengthening of the service-delivery mechanism, Malawi has been actively training health professionals to provide MCH services across the country—all undertaken with the help of foreign aid. However, service expansion and new initiatives have also created a demand for more resources and resulted in additional strain on the health system that is already over-stretched.



Female literacy rate has improved and women's participation in public-sector jobs has increased. Women's access to maternity and reproductive health services has expanded. While abortion is illegal in Malawi, Marie Stopes International has been working on safe termination of pregnancy and promoting reproductive health for the past 25 years. Also, as noted in the background section above, women's participation in overall development plays a crucial role in improving health in the family as well as maternal and child health. All these changes in the socio-political context have certainly contributed towards meeting MDG Four targets.

Despite major socio-political, geographical and economic challenges, Malawi has been successful in meeting its MDG Four target of reducing child mortality. While the country has made big strides

in improving Maternal Health, it did not manage to meet that MDG Five target. Malawi's progress in improving child health and reducing mortality since 1990 has been presented globally as a positive story, with MMR having declined from 1100 in 1990 to 510 in 2014. Similarly, child mortality has improved, from 247 in 1990 down to 48 in 2010.<sup>15</sup> The success story has featured in a number of authoritative policy reports, academic and research forums globally (Zimba 2012; Shiffman et al 2014).

Foreign aid and on-going commitments made by EDPs, as well as the government's commitment towards achieving MDGs, have been key to these successes (Smith et al 2014). At the same time, poor donor coordination and programme duplication have posed an additional challenge to Malawi's health system.

## ENDNOTES

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- 1 Eight MDGs were: eradicate extreme poverty and hunger; achieve universal Primary Education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria, and other diseases, ensure environmental sustainability and develop a global partnership for development. <http://www.un.org/millenniumgoals/>
- 2 [http://www.who.int/topics/millennium\\_development\\_goals/child\\_mortality/en/](http://www.who.int/topics/millennium_development_goals/child_mortality/en/) accessed on 9/2/2016
- 3 *ibid*
- 4 All progress reports are available at the 'Countdown to 2015' website: <http://www.countdown2015mnch.org>
- 5 <http://www.un.org/sustainabledevelopment/sustainable-development-goals/>
- 6 <http://www.mhtf.org/topics/post-2015-whats-next-for-maternal-health/>
- 7 The first or the founding president was the late Hastings Kamuzu Banda (1966-1994). Bakili Muluzi ruled for the subsequent ten years (1994-2004), then the late Bingu wa Mutharika was in post for the next eight (2004- April 2012), being succeeded by Dr Joyce Banda (2012-2014). Professor Arthur Peter Mutharika came into power after the election in May 2014 and is currently running the country (as at August 2015).
- 8 Detail information can be found at: <http://www.scotland-malawipartnership.org>
- 9 <https://www.youtube.com/watch?v=W4T0s8i9Zg0>
- 10 reported in Malawi News agency, November 2013, available online at: <http://allafrica.com/stories/201311111209.html> accessed on 3/11/2015
- 11 How Malawi is improving a terrible maternal mortality rate through good design. <http://blog.ted.com/how-malawi-is-improving-a-terrible-maternal-mortality-rate-through-good-design/> Jan 2013, accessed on 3/11/2015
- 12 <http://www.countdown2015mnch.org/country-profiles/malawi>
- 13 IPAS is a global non-profit organization working to eliminate deaths and injuries from unsafe abortion and increase women's ability to exercise their sexual and reproductive rights. More information is available at: <http://www.ipas.org>
- 14 Personal communication with an officer at the Planning and Budgeting Department, Ministry of Health, Malawi
- 15 <http://www.countdown2015mnch.org/country-profiles/malawi>

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