Republic of Malawi
Ministry of Health

HEALTH PROMOTION POLICY

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June 2013

Cover Photo: Support for Service Delivery Integration (SSDI) project - Moyo ndi Mpamba Campaign 2013

FOREWORD

Since the 1960's the Ministry of Health has demonstrated its commitment to health education and health promotion in all aspects of public health in Malawi. An initial step in demonstrating its commitment was the establishment of the Health Education Section in 1969. At that time health education needs were few and less complex, hence the focus was on preventive health. For the past four decades, health education and promotion products and services have been an essential component of the Ministry's strategies for addressing health issues.

Malawi, through the Ministry of Health, has over the years been responsive to the various UN Conventions and agreements aimed at promoting health. The 1978 Alma Ata convention on Primary Health Care (PHC) is one of the global strategies which the MOH fully supported by strengthening the Health Education Section (HES). The challenges of emerging communicable and non-communicable diseases have over the past two decades set dynamic changes in the health education needs, not only for Malawi but globally. These changes have led to a move towards prioritising health promotion.

Furthermore, the current Health Sector Strategic Plan (HSSP) has recognized health promotion as an important component in the delivery of the Essential Health Package (EHP). The need for a Health Promotion (HP) policy is therefore timely to ensure a coherent approach that takes into account both intra-sector and inter-sector collaboration and coordination to address the determinants of health.

At this juncture it has become necessary to put in place a national policy for HP to guide strategy formulation, programming and implementation by partners in health and all other relevant sectors. In addition the policy will clarify mandates of national and district level health promotion within the decentralised government setting. It is envisaged that existence of the HP policy will add value to the efforts of all stakeholders in delivering health promotion services in the country.

I wish to urge all stakeholders to join the efforts in operationalizing the National Health Promotion Policy. The Government shall at all cost provide a supportive and enabling environment to ensure that all Malawians increase control over the determinants of health and thereby improve their health.

Hon. Catherine Gotani Hara, M.P
MINISTER OF HEALTH

CONTENTS

ACKNOWLEDGEMENT

The Ministry of Health would like to thank all individuals and organizations that contributed to the development of the Health Promotion Policy, it is the product of a long, intensive, interactive process which involved consultation, teamwork, specific assignments and information gathering.

Contributors include workers from public and private sector health communication organizations, health training institutions, health cooperating partners and civil society organizations.

Special acknowledgements go to the United Kingdom through the Department for International Development (DFID), World Health Organization (WHO) and USAID through Support for Service Delivery Integration-Communication (SSDI-Communication) for their technical advice and financial support.

We extend our recognition to the three consultants Andy O'Connell, Rodger Drew and Miriam Chalimba who wrote the first draft. Special recognition also goes to Dr Nyamwaya of AFRO WHO office, Mr Hudson Kubwalo of Malawi WHO office and Mrs Trish Araru the Chief Planning Officer at the Ministry of Health for guiding the development of the Health Promotion Policy. The stewardship of past leaders of the HEU, the late Mr Jonathan Nkhoma, Mrs N. Kandoole (retired) and the current leaders Dr Storn Kabuluzi, Director, Preventive Health Services and Mr Hector Kamkwamba, Deputy Director, Preventive Health Services (Health Education Services) and the entire team, among them Mr Henry Chimbali, Mr Austin Makwakwa, Mr Kunkumbira and Mr Adrian Chikumbe, for their input. We acknowledge the input of SSDI-Communication's technical support to the HEU through Dr Ben Chirwa and thank him for his energy in driving the process forward and also the input of the Essential Health Package (EHP) Technical Working Group as well as the EHP Health Promotion and Communications sub group.

It is the hope of the Ministry of Health that the policy will be a roadmap that will lead to a more unified and coordinated effort in the delivery of high quality HP products and services.

Dr Charles Mwansambo
Secretary for Health

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AOP	Annual Operational Plan
ARET	Agricultural Research and Extension Trust
BCC	Behaviour Change Communication
BCI	Behaviour Change Intervention
CHAM	Christian Health Association of Malawi
DA	District Assembly
DAC	District AIDS Coordinator
DFID	Department for International Development
DHEO	District Health Education Officers
DHMT	District Health Management Team
DHO	District Health Officer
DHPO	District Health Promotion Officer
DIP	District Implementation Plan
DP	Development Partner
EHP	Essential Health Package
EmONC	Emergency Obstetric and Neonatal Care
FBO	Faith-Based Organization
FHI	Family Health International
FP	Family Planning
HES	Health Education Services
HEU	Health Education Unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Promotion
HSA	Health Surveillance Assistant
IEC	Information, Education and Communication
LATH	Liverpool Associates in Tropical Health
MCH	Maternal and Child Health
MDHS	Malawi Demographic and Health Survey
MGDS	Malawi Growth and Development Strategy
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MWK	Malawi Kwacha
MOH	Ministry of Health
NGO	Non-Governmental Organisation
NTD	Neglected Tropical Diseases
PAHO	Pan American Health Organization
POW	Programme of Work
PR	Public Relations
PRSP	Poverty Reduction Strategy Paper
RHU	Reproductive Health Unit
RTA	Road Traffic Accident
SBCC	Social and Behavioural Change Communication
SDH	Social Determinants of Health
SRH	Sexual and Reproductive Health
SSI	Semi-Structured Interviews

SWAp	Sector-Wide Approach
SWOT	Strengths, Weaknesses, Opportunities and Threats
TA	Technical Assistance
TB	Tuberculosis
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USD	United States Dollar
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Introduction

The 2003 WHO Afro-region Health Promotion policy calls on all member states to develop health promotion policies that will, among other objectives, strengthen national capacities for health promotion, support priority health programs and increase recognition of health promotion[1]. In fulfilment of this recommendation, the Malawi Health Sector Strategic Plan 2011-2016 prominently features health promotion as an essential tool for improving health status of all Malawians. Therefore this HP policy adopts the Ottawa Charter definition of health promotion as 'The process of enabling people to increase control over the determinants of health and thereby improve their health'[2].

The policy further recognises the wider definition from the Ottawa Charter which defines health promotion not only to as actions which strengthen individual skills and capabilities but also actions which change social, political, environmental and economic conditions that impact on public and individual health and actions that promote quality of life including mental, social and physical well-being.

Malawi's first Health Promotion Policy is based on this understanding of health promotion and has been developed to give direction for programming of health promotion interventions. The policy outlines the background, current situation, vision, mission, themes and implementation arrangements. These are followed by a monitoring and evaluation framework that will guide a process of tracking indicators of success within the proposed 5 year timeframe of the initial implementation.

1.1 Historical Background of Health Promotion in Malawi

During the 1960s, behavioural factors in ensuring improved health became widely recognised. It was then understood that besides biomedical care and improvements in the physical environment, individual lifestyles also influenced morbidity and mortality. Health education therefore became the main method of informing people on how to positively change their behaviour so as to prevent specific diseases and improve their health. At that time, health education was applied through a top-down approach to learning; often using general untargeted messages within a strictly biomedical understanding of health. This changed in the 1970s with the introduction of Health-for-All concept and the Primary Health Care (PHC) strategy encouraging community participation in issues affecting their health. This development gave health education a prominent role in health globally.

[1] Health Promotion: A Strategy for the African Region, WHO, Brazzaville, 2003

[2] WHO, Health and Welfare Canada, Canadian Public Health Association (1986). Ottawa Charter for Health Promotion. First International Conference on Health Promotion.

The implementation of health education in Malawi was carried out through the Health Education Section (HES) that was established by the Ministry of Health (MOH) in 1969. At that time the section was located within the Public Health Department and its staffing and functions were targeted within preventive heath areas, primarily covering education on water, sanitation and hygiene as well as maternal and child health (MCH) including immunization. Since its inception, the demand for the services of the HES has rapidly grown as a result of a changing environment. In response to the growing demand, staffing increased to support processes and production of messages, tools and materials for Information, Education and Communication (IEC). The section utilized print and electronic media including live concerts to disseminate health messages. Among the print media, the quarterly Ministry of Health MOYO magazine remains one of the core publications that promotes policy awareness and discusses emerging issues. To strengthen the delivery of HES at district and community levels, District Health Education Officers (DHEO) became part of the MOH staff establishment and were deployed as part of the district health work force.

1.2 Situation Analysis

The population of Malawi in 2008 was estimated at 13.1 million, with a growth rate of approximately 2.8% per annum, it has a predominantly rural population, estimated at 85%. The literacy rate for women is lower at 59% compared to males at 69%[3]. Low literacy levels especially among women and the prevailing cultural diversity have impacts on the lives of Malawians including their health seeking behavior and acceptance of new developments in the fields of agriculture, health and education, among other sectors.

The Health Sector Strategic Plan (HSSP) has identified a number of risk factors and major causes of diseases as indicated in the table below:

Leading 10 selected factors & diseases or injuries Malawi[4]

Top 10 risk factor			Top 10 diseases		
Risk	***Risk factor***	***% of total***	***Rank***	***Disease***	***%of deaths***
1	Unsafe sex	34.1	1	HIV/AIDS	33.6
2	Childhood and maternal underweight	16.5	2	Lower Respiratory Infections	11.3
3	Unsafe water, sanitation and hygiene	6.7	3	Malaria	7.8
4	Zinc deficiency	4.9	4	Diarrhoeal diseases	7.6
5	Vitamin A deficiency	4.8	5	Conditions arising from perinatal conditions	3.2
6	Indoor smoke from solid fuels	4.8	6	Cerebrovascular disease	2.8
7	High blood pressure	3.5	7	Ischaemic heart disease	2.6
8	Alcohol	2.0	8	Tuberculosis	2.4
9	Tobacco	1.5	9	RTA	1.3
10	Iron deficiency	1.3	10	Protein energy malnutrition	1.0

[3] NSO. (2009). Malawi housing and population census 2008. Zomba: NSO.
[4] 2006 COM Burden of disease study

At the turn of the century the Government of Malawi embarked on Health Reforms during which Malawi adopted a Sector Wide Approach (SWAp) of funding. During the same period, the first Programme of Work (POW) for the period 2004-2010 was developed. The second POW also known as the Malawi Health Sector Strategic Plan (2011-16) was developed and launched in September 2011.

The Essential Health package, during the 1st POW included eleven major causes of ill health and death. The evaluation of the POW recommended that the EHP should be revised to take into consideration the introduction of new technologies, changing disease patterns and available resources. It was recommended that there should also be gradual expansion of the EHP (e.g. by including cost-effective interventions for non-communicable diseases such as cardiovascular disease and diabetes, mental health interventions, and a package of highly cost-effective surgical procedures to be provided in rural and district hospitals). Hence the Essential Health Care Package (EHP) outlined below is as listed in the HSSP 2011-2016:

1. HIV/AIDS
2. ARI
3. Malaria
4. Diarrhoeal diseases
5. Perinatal conditions
6. *NCDs including trauma
7. Tuberculosis
8. Malnutrition
9. *Cancers
10. Vaccine preventable diseases
11. *Mental illness and epilepsy
12. *Neglected Tropical Diseases (NTDs)
13. Eye, ear and skin infections

* denotes conditions or diseases added to the original list of the Essential Health Package.

The major mode of delivery of these services is through Primary Health Care, public health interventions, health promotion, disease prevention and community participation. It is understood that health is influenced by the social and economic conditions, in which people are born, grow, live, work and age, and the systems put in place to deal with illness. These conditions commonly referred to as the 'social determinants of health' (SDH) can either build or destroy peoples' health, they broadly include:

- Environment, including safe water, sanitation and vector control, safe housing and work places
- Lifestyles and behaviours that adversely affect health status such as alcohol, drug abuse, lack of exercise and unsafe sex
- Access to health and social services
- Mental and spiritual health, including gender-based violence and child sexual abuse
- Access to education
- Socio-cultural factors.

It is therefore important that in any given population, an analysis of the risk factors that influence health is well understood to ensure the application of appropriate interventions to reduce the prevalence of ill health.

Neonatal Mortality

Neonatal Mortality Rate (NMR) estimated at 33 deaths per 1000 live births (slightly higher in rural areas with 34 deaths per 1000, against 30 in urban areas). About half (48%) of mothers did not receive any postnatal care[5]; attributed to lack of emphasis on community and family care; lack of adequate treatment for neonatal infections and lack of information on danger signs coupled with poor hygiene practices.

HIV/AIDS

Early sex initiation before the age of 15 years is high with relatively high HIV prevalence among those aged 16-19 years at 11.7%[6] (2010 MDHS). It is a fact that as the number of people get infected with HIV correspondingly the demand for putting more people on ART also increases. The increasing number of new infections is attributed to several factors among which the lack of safer sex negotiation skills among adolescents is paramount. While WHO recommends Voluntary Male Medical Circumcision (VMMC) for communities at risk, among adult males only 2.5% in the Northern, 10.1% in the Central and 37.8% in the southern regions of Malawi are circumcised. In the regions and areas where circumcision is more prevalent there is still a need to promote VMMC in HIV high-risk groups e.g plantation workers, fishing communities and amongst married men.

Malaria

With approximately six million episodes treated annually, malaria is responsible for about 40% of all hospitalization of children less than five years old and 34% of all outpatient visits across all ages. Sleeping under treated bed nets is at 56 percent for children under the age of 5 years[5] and ITN utilization among children tends to decrease with age. Children less than 12 months old are 1.3 times more likely to sleep under an ITN compared with children age 48-59 months (63 percent and 49 percent, respectively). Children in rural areas are slightly more likely than children in urban areas to use ITNs (56 percent and 54 percent, respectively). Utilization of mosquito nets among pregnant women is at 51 percent and pregnant women in rural areas are more likely to use a net than those from urban areas (47 percent versus 51 percent respectively). Among households with at least one ITN 70 percent of the household members use those nets. Other risk factors for malaria include lack of drainage, rubbish clearing, late treatment seeking behavior and inadequate indoor residual house spraying.

Tuberculosis (TB)

Malawi implements the DOTS strategy. There has been a steady increase in proportion of patients successfully treated reaching 88% by 2010**.** The TB/HIV

[5] Malawi DHS 2010
[6] Malawi DHS 2010

Co-infection rate consistently remains above 60%.[7] The risk factors include: lack of access to diagnosis and treatment; poor health status (HIV, malnutrition, mental illness); environmental conditions (poor housing and overcrowding in prisons); lifestyle (alcohol and drugs abuse) and poor hygiene.

Water and Sanitation

Dehydration from diarrhoea is one of the major causes of death in young children worldwide. The prevalence of diarrhoea overall in Malawi is estimated at 17.5% with 38% in children aged 6-12 months. The 2010 MDHS shows a higher percentage of reported cases without access to improved drinking water and sanitation. Recent data shows that in 60% of cases, treatment was sought from a formal health provider and 24.2% of children under six months reportedly did not receive any treatment at all[8]. Burden of Disease BoD11[9] assessment calculates that the number of episodes of acute diarrhoea in children under five years of age is over 13 million per year, and yet the health service treated only 324,000 in 2010.

The major risk factors include poor sanitation, poor access to safe water and health services; lack of knowledge on the benefits of ORS and zinc and the dangers of dehydration; poor hygiene practices including lack of resource for fuel to boil water to drink.

Acute respiratory infections (ARIs)

It is estimated that 14% of admissions and 20% of deaths among under five children are due to asthma. There has been reduction in pneumonia case fatality from 18% in 2000 to 5.7 % in 2008. Risk factors associated with Acute Respiratory Infections (ARIs), especially asthma and bronchitis, include the use of solid fuels with poor ventilation (approximately 98%) and poor hygiene and hand washing practices. Recent data shows that only one in five caregivers knows the two key symptoms of pneumonia (fast and difficult breathing) and few of the caregivers seek treatment for children from health care providers when early detection and prompt treatment could avert many deaths.

Nutrition

In Malawi, 47% of children under 5 years are stunted with 1.5% severely wasted (acute malnutrition) and 4% wasted[10]. The risk factors include; prevalence of worms (hookworm,); poor hygiene resulting in diarrhoea; poverty leading to food insecurity at community and household levels and poor diet with low intake of iron-rich foods.

Neglected Tropical Diseases

Neglected Tropical Diseases (NTDs) have been included in the HSSP because of their potential to affect more people and their subsequent effects. The

[7] National Tuberculosis Programme data 2010
[8] Malawi DHS 2010
[9] http://www.medcol.mw/commhealth/publications/national%20research/Burden%20of%20BOD%20and%20EHP7.docx
[10] Malawi DHS 2010

prevalence for Schistosomiasis ranges from 0 to 43% with 30% average in children attending school.

The prevalence for blindness is currently at 1%[11] and while Leprosy prevalence is 0.5 % with fluctuations yearly from 500-700 cases. Risk factors include poor hygiene and sanitation; swimming in infected water.

Trypanosomiasis and onchocerciasis also still remain significant diseases in the EHP and require urgent attention. Most of the NTDs require mass drug administration to treat, control and prevent their occurrence. However, their continuous presence in the communities is a sign of poor vector control and lack of access to screening and treatment.

Mental Health

It is estimated that 28.8% of the patients attending primary care have common mental health problems of depression or anxiety while 19% have depression alone.[12] Risk factors for mental conditions are complex and include social and physical environment at work and at home; family violence; childhood sexual abuse; high consumption of alcohol and drug abuse.

All of these risk factors are compounded by lack of access to treatment and recognition/diagnosis of diseases and family history of mental health problems.

Trauma

The incidence of trauma due to Road Traffic Accident (RTA) is 3.5% and injuries other than RTA are at 8.9%. The major risk factors include unsafe workplaces, careless driving due to alcohol and poor skills and lack of access to rapid treatment including First Aid; lack of emergency transport and referral systems.

Non-Communicable Diseases

Non-Communicable Diseases (NCDs) such as hypertension, diabetes, cancers and chronic respirator infections are increasingly becoming a major problem in Malawi and within the African region. Some of the major NCD conditions share same risk factors. Some of the risk factors include poor dietary habits, smoking, excessive alcohol consumption and physical inactivity.

1.3 Problem Statement

The implementation of the health education and health promotion interventions by different players within the health sector and beyond are not well coordinated and the existing guidelines for the implementation of the activities are only limited to the health sector, disregarding other important stakeholders. Additionally, many people including policy makers still regard health promotion as exclusively the domain of the health sector and this presents a challenge considering that determinants of health are multi-sectoral.

[11] National strategic plan for eye care in Malawi 2010 MOH
[12] Draft Mental Health Strategic Plan 2011

Ministers of Health in the African region at the WHO meeting in Brazzaville in 2003 agreed and endorsed resolutions calling for the adoption of the health promotion approach in all the African countries. However the current health education programs in Malawi do not fully embrace health promotion approaches.

1.4 Rationale

Though the Health Education Section (HES) has been responsible for coordinating health education, the coordination has not been efficient and effective and its central role has often been perceived as IEC materials production. The development of the HP policy therefore, recognizes the fact that there are many players in HP in the face of current health challenges and that health promotion is much broader than just the production IEC materials. The policy will therefore guide the coordination with other players in health promotion with a much broader perspective.

The Health Promotion Policy will provide a comprehensive approach that goes beyond communication and education to embrace advocacy for addressing the social determinants of health including social mobilisation, empowerment for social behaviour change and other wider socio-economic and environmental factors to address the current burden of diseases that include both communicable and non- communicable diseases.

Health Promotion (HP) is defined by WHO as the process of enabling people to increase control over the determinants of health and thereby improve their health[13]. The emphasis is on '*people to increase control over the determinants of their health'* at primary preventive stage and also at secondary and tertiary preventive stages. Therefore, there is increasing need for health promotion to be enhanced since it has the potential to reduce the ever-increasing costs of curative services through the prevention of disease occurrence and complications. Effective implementation of health promotion interventions would therefore reduce the burden of diseases with an eventual overall reduction of treatment costs of otherwise preventable diseases.

Besides communicable and non-communicable diseases, Malawi is also entangled in poverty, low levels of literacy, risky behaviours, poor lifestyles and other cultural practices and attitudes that do not promote health. Health promotion will enhance greater individual and collective participation in addressing such barriers.

1.5 Linkages with other relevant policies and strategies

The HP policy has based its agenda on the Millennium Development Goals (MDGs) covering 2000-2015 period and beyond. The MDGs spell out critical priority development indicators that include:

- eradication of extreme poverty and hunger
- promotion of gender equality and empowerment of women
- reduction of child mortality
- improve maternal health

[13] (Adapted from WHO 1998, Health Promotion Glossary, WHO/HPR/HEP/98.1) p.1.

- combat HIV/AIDS, malaria and other diseases
- sustainable environmental management
- Global Partnership for Development.

Health promotion plays a fundamental role in the achievement of most of these socio-economic goals.

The Health Promotion Policy falls within the framework of the Malawi Growth and Development Strategy (MGDS) and by extension addresses social determinants of health.

The HP policy lays down objectives, strategies and targets that are aimed at promoting the achievement of sustainable socio-economic development in the country as envisaged in the MGDS. The policy takes into context that the MGDS has the following thematic and priority areas including sustainable economic growth; social development; social support and disaster risk management; infrastructure development, governance, and gender and capacity development. The key priority areas are agriculture and food security; energy; industrial development; transport infrastructure; education, science and technology; public health; sanitation; Malaria and HIV/AIDS management; integrated rural development, green belt irrigation and water development; child development, youth development and empowerment and climate change, natural resources and environmental management. .

The Health Sector Strategic Plan 2011-2016 emphasizes the need to recognize and scale up health promotion interventions in the implementation of the Essential Health Package. The HP policy has also been aligned to the main policies for health in Malawi such as 2011 National Health Policy and various programs and policies as well as the national decentralization policy.

1.6 Purpose

The purpose of this policy is to provide guidance in the implementation of health promotion interventions for all the stakeholders in health and other sectors.

1.7 Key Challenges and Barriers

1.7.1 Institutional challenges

The following institutional challenges exist:

- Lack of harmonisation of HP services within MOH and among all relevant stakeholders. HP is currently implemented in a fragmented manner. For example within the MOH central level, there are no mechanisms for effective coordination of HP with all departments, primary, secondary, tertiary levels of care and stakeholders partly due to acceptance of program-based health promotion plans.

- The scope of health promotion is very broad in the sense that it addresses health and non-health issues. At district level, the district health Education Officers are currently not members of the District Health Management Teams (DHMTs) and are perceived as part of

Environmental Health Services. This limits the scope of their work and creates a major gap in the way they participate in decision-making and action from a health promotion perspective.

- Community participation in the primary health care context is very complex and requires integrated and holistic approaches. The policy envisages community involvement and participation as the cornerstone in the implementation of HP.

- Health promotion requires in-house production of various materials including print and electronic (radio, television and video). Basic radio equipment is available and requires installation. The video studio has outdated equipment that requires replacement.

- The band musical instruments that have been effectively used for social mobilisation are old and require replacement.

- Health promotion interventions require electronic data storage and retrieval for easy access. The Health Education Section requires a website and social media capabilities that are currently not available.

- Some NGO partners work in isolation or work on discrete issues and are outside the coordination web of the DHE Officers.

1.7.2 Financial challenges:

- The Health Education Services at all levels has inadequate financial allocation from both government and donor community. Government prioritization of health promotion as reflected in the Health Sector Strategic Plan is not matched with appropriate allocation of funds to the Health Promotion Services. Further, in the reduction of funding within the health sector it is likely that health promotion will suffer a further loss in funding.

- Health promotion interventions require significant funding. The strategic plan will therefore clearly define cost estimate and potential funding gaps.

1.7.3 Human resource challenges:

- Health promotion is a professional discipline that requires specialized training at both undergraduate and postgraduate level in order to deliver health promotion services effectively and efficiently.

- There are currently insufficient health promotion posts in the Ministry of Health establishment and many vacancies for health education posts in the MOH staff establishment at all levels are not filled. Currently, Health Promotion has no posts and officers at both Zonal and Health Centre levels. There will be need to regularly review these establishments in line with trends and health needs.z

- Lack of standardized modules for training of all health workers in progressive health promotion in both pre and in-service training.

- Recruitment of personnel without health background and without training in health promotion poses challenges in understanding health concepts in designing ealth promotion programs.

For health promotion interventions to spread at lower levels (household and community level) participation of all health workers is required including environmental health cadres, Health Surveillance Assistants (HSAs), community health nurses and other community based health workers who equally play a critical role interfacing with communities and community-based governance structures such as village development and health committees. For effective contribution to Health Promotion, the cadres require capacity building in health promotion. However, the Ministry of Health has a critical shortage of health workers who could be trained and utilized in health promotion.

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CHAPTER TWO

BROAD POLICY DIRECTIONS

2.1 Vision

Malawi's first Health Promotion policy envisions a population that values, adopts and maintains health behaviors in a supportive environment.

Purpose
Provide guidance in the implementation of Health Promotion interventions

Vision
A population that values and adopts and maintains health behavior

Mission
To create public awareness, facilitate community participation and access client-friendly health services.

2.2 Mission

The HP mission is *'*to create public awareness, facilitate community involvement and participation, and promote activities which will foster health behaviors and encourage people to want to be healthy, stay healthy and do what they can individually and collectively do to maintain sound health and access client-friendly health services in a timely manner*'.*

2.3 Principles

In order to fulfil the mission, a number of principles need to be followed:

2.3.1 Equity of access

Equitable access to health care services that are culturally sound and age-appropriate.

2.3.2 Total inclusion and non-discriminatory HP

The active participation of intended audiences (including vulnerable populations) in the design, implementation and monitoring of health promotion programs.

2.3.3. Mainstream

Mainstream HP in all priority program areas. Ensure that health promotion responsibilities and activities are incorporated in the functions of all relevant stakeholders: Health, Agriculture, Education, Information and Road Traffic directorates, to name but a few.

2.3.4 Evidence-based HP intervention

HP interventions need to be evidence-based and documentation mechanisms must be put in place for all HP interventions as well as research on social, cultural, economic, behavioural, environmental, policy, legislation and service-related aspects.

2.3.5 Theory or Model based HP

In developing a communication strategy or starting a programme or campaign a theory or model will be used to guide the programme or campaign.

2.3.6 Human Rights Based Approach

HP services shall be made available to all people without distinction in terms of ethnicity, political or religious beliefs, economic and social condition or geographical location. The HP policy shall adhere to the binding nature of related human rights protocols.

2.3.7 Gender Sensitivity

Gender issues shall be mainstreamed in the planning and implementation of all HP programs.

2.3.8 Coordination

Consultation and coordination at all levels with government, NGOs, international organizations, FBOs, CHAM, institutions and associations through a planned program of activity in order to promote quality health promotion interventions. Ensure that healthcare professionals are included in this coordinated approach.

2.3.9 Client friendly services

Services that encourage health-seeking behaviour and ensure client satisfaction.

2.3.10 Sustained HP Human Resource interventions

Availability and capacity of HP human resources.

2.4 Overall Goal of Health Promotion Policy

The goal of the HP in Malawi is: ***'to reduce preventable deaths and disability through effective health promotion interventions'.***

Policy objectives

2.4.1 To provide effective leadership and coordination and to advocate for development, review and enactment of policies and legislation on health promotion based on national priorities.

2.4.2 To strengthen national, district and community capacity in planning, coordination, implementation and monitoring and evaluation of HP interventions.

2.4.3 To support initiatives that enable all individuals and communities to lead healthy lifestyles.

CHAPTER THREE

HEALTH PROMOTION THEMATIC AREAS

3.1 Leadership, Coordination, Public Policy and Legislation

Goals

- To ensure health promotion interventions that are well coordinated and guided at all levels and across all sectors and partners.
- To put in place healthy public policies that create an environment that reduce or eliminate the risk of developing disease as well as prevent injury or disability.

Objective

- To provide effective leadership and coordination for health promotion, based on national priorities.
- To advocate for the development, review and enactment of health policies and legislation.

Strategies

- Establish/inter-sectoral coordination mechanisms for health promotion at all levels.
- Coordinate development and implementation of national health communication strategies.
- Reposition health promotion functions (activities, functional review, TORS, Job descriptions linked to capacity).
- Promote partnership in health promotion interventions.
- Advocate for the review, development and implementation of specific health public policies based on the EHP priorities (including legal instruments and regulations that affect gender equity and health of marginalized populations).

3.2 Building capacity

For health promotion interventions to be successful it is essential to build comprehensive capacity in policy formulation and implementation, inter-sectoral partnerships, political commitment, health promotion management of health problems, quality research, workforce development and evaluation.

Goal

Enhanced HP capacity and effective support for district and community interventions to all stakeholders and partners.

Objective

- To strengthen national and district capacity in planning, coordination, implementation and monitoring and evaluation of HP interventions at various levels.

- To strengthen mechanisms of health promotion training, both for health professionals and professionals in other sectors as a cornerstone for the broad approach to improving health in today's society.

Strategies

- Strengthen human resource capacity in health promotion at all levels
- Ensure equitable allocation of financial and material resources, including new technologies
- Ensure existence of appropriate standards, guidelines and checklists for HP delivery
- Advocate for, and support integration of HP in sector plans
- Promote training of health promotion professionals

3.3 Individual empowerment and self-efficacy

Individual empowerment provides the means for an individual to make healthy choices, but it also provides a means to negotiate and demand changes in their environment that are obscuring their healthy choices through social action.

Goal

Empowered individuals and communities that have the ability and knowledge to improve their health status (control over their own health /determinants) and reduce health risk factors.

Objectives:

- To promote community participation in the development, implementation and monitoring of HP interventions.

- To support initiatives that enable individuals and communities to lead healthy lifestyles (socio-economic groups, gender, age, disability and education).

- To empower people achieve a certain level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions.

- Promote healthy lifestyles.

- Promote healthy environment.

Strategies:

- Support the implementation of community action interventions to address prioritized HP interventions in multi-sector settings at all levels.
- Strengthen initiatives that target individuals to improve their skills, knowledge and motivation to improve their health and well-being.
- Promote participation of communities in the formulation of DIPs/District Development plans.
- Promote local resource mobilization/investments (village banks) advocate for economic empowerment.
- Screening.
- Diet and exercise.
- Health literacy.

3.4 Strengthening health systems

Health promotion and health systems are inextricably linked (WHO, 2007)[14]. Applying a health promotion lens at the national and health program level can ensure a system that focuses on keeping people well. It would foster:

- universal reach with equitable access to essential products and technology
- a well-performing workforce
- mechanisms for community participation
- appropriate financing
- a well-functioning information system
- good leadership and governance.

Health promotion closely aligns with and reinforces efforts to bring in health systems reforms based on social justice and people-centred care. Bringing health promotion into health systems supports reforms of primary health care that ensure universal coverage and thereby equitable access to health services for all people. Service delivery reforms that ensure health care are people-centred and based on expectations and needs of people are vital for effective health promotion, just as much as healthy public policies.

It is now widely accepted that health outcomes can be better secured when health systems are functioning effectively[15]. However, health programs and health systems are not responsive enough to keeping people healthy. Therefore, health programs can do better by using a health promotion *lens* and supporting community action, individual health skills, and advocacy for policy action. Health systems can also change ways in which the work is done and funding is allocated in order to strengthen their orientation to prevention and health promotion.

[14] World Health Organization 2007 The role of WHO in international health systems agenda
[15] PAHO/WHO 2000 Prevention, Control and elimination of neglected diseases in the Americas; Pathway to integrated, interprogrammatic, intersectoral action for health and development

Goal
To ensure a health system that focuses on keeping people well, and fosters universal equitable access to essential health products and technology, a well-performing workforce, mechanisms for community participation, appropriate financing, a well-functioning information system, and good leadership and governance.

Objectives:
- To align with and reinforce efforts in bringing in health system reforms based on social justice and people-centred care.
- To bring health promotion into health systems by supporting primary health care.
- To promote and support universal coverage and equitable access to health services for all people.
- To promote service delivery reforms that ensure health care is people-centred and based on expectations and needs of people including healthy public policies.

Strategies
- Capacity building of health workers in health promotion
- Costing and sustainability planning
- Governance and health insurance
- Resource mobilization
- Establishing health promoting healthcare institutions

3.5 Inter-sectoral action and collaboration
Inter-sectoral action for health refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector.[16] The priority health issues faced by communities share common social determinants of health, these can be best tackled together, as changes in each social determinant can contribute to multiple health objectives. Some policy measures may also effect changes in several social determinants for example poverty alleviation leads to social inclusion, better health and so on.

Goal
Mobilized public and private sectors that work together for better health of the community by addressing social determinants of health.

Objective:
- To increase participation of various sectors (public and private) in the promotion of health.

Strategies
- Create forum for public and civil society participation.
- Mainstream health promotion policy into existing policies to achieve comprehensive health strategies.

[16] (PAHO/WHO, 2000).

3.6 Community Empowerment

Disease-focused, one-on-one approach to healthcare is insufficient to address the broader determinants of an individual's health. If the social, political, economic and environmental determinants of health are to be addressed, then healthcare programmes need to incorporate the social action objective of health promotion (i.e. mobilise communities, governments and businesses to address the social determinants of health in order to challenge health equity, reduce the health impact of poverty, and strengthen community capacity[17]. For social action and change to occur, community empowerment through integrated community-based health promotion interventions should be strengthened alongside specific efforts in policy advocacy and policy interventions.

Goal

To enable communities take control over their health.

Objectives:

- Promote community ownership and action that explicitly aims to improve health by embracing social and political change.

- To build partnerships and coalitions with other sectors in finding solutions to health problems.

- Mainstream community-based health promotion approaches that can be applied to people, places and health issues.

Strategies

- Equip community members with problem solving skills through participatory training methods.
- Strengthen the scale and capacity of social/community mobilization.
- Build community-based networks to identify and implement relevant health agenda.
- Mainstream community based activities within the existing community groups and organizations.

[17] WHO 1986, Health and Welfare Canada, Canadian Public Health Association. Ottawa Charter for Health Promotion. First International Conference on Health Promotion.

CHAPTER FOUR

INSTITUTIONAL ARRANGEMENTS

4.1 Management

The Ministry of Health (MOH) is the line ministry responsible for health services and for the formulation and implementation of health related policies and legislation, leadership and high-level advocacy. The Health Promotion Policy will be anchored in the MOH.

Following the Decentralization Act of 1997, the Ministry of Local Government and Rural Development has the overall responsibility for delivering health services at district and lower levels. Thus the implementation of the Health Promotion Policy at district level will follow the same vehicle. The policy recognizes that apart from the Ministries of Health and Local Government and Rural Development, there are also other ministries and departments that provide health services and these include, the Army, Police and Prisons. Other Ministries such as the Department of Forestry, Agriculture, and Food Security contributes to health by ensuring that people in Malawi especially vulnerable groups, the poor, women and children are food secure. In addition, the NGOs, the FBOs and the CBOs are also involved in the delivery of health promotion services.

Core functions of HP

a) Policy formulation
b) Leadership and coordination.
c) Convene Health Promotion TWGs both at national and district levels
d) Set standards for Social Behaviour Change Communication.

Traditional medicine practitioners are popular in Malawi and the MOH has mainly worked with the Traditional Birth Attendants. They will be guided in their work by the Policy through the Technical Working Group (TWG) both at national and district levels (see appendix 2).

A number of organisational structures will be developed and strengthened to implement this policy:

- Government of Malawi through the Ministry of Health shall explore the possibility of restructuring the Health Education Section (HES) to the Health Promotion Directorate whose mandate shall include Health Promotion policy formulation, coordination, technical advice, mentorship, production of promotion materials, and resource mobilization with international and national representation. The Health Promotion Directorate will identify and establish linkages with relevant

national and international bodies and ensure constant update and dissemination of evidence-based best practices.

- Government of Malawi will establish a multi-sector health promotion committee at national level to provide guidance and facilitate coordination on HP policy issues. The composition shall include representatives from health and non-health sectors, including private sector and civil society organisations. At district level, policy shall be implemented through existing district committees like DEC, ADC, VDC.
- Government of Malawi shall ensure that training institutions have the capacity to train HP Officers.
- The Ministry of Health shall recruit Health Promotion workers with public health, community health and a specialist training in Health Education or Health Promotion or Social Behaviour Change Communication.

4.2 Finance

In order to fully implement the HP Policy, there will be need to increase overall financial resources to health promotion. The HP Policy recognises that there are several sources of funding. Therefore, there will be multiple sources of funds for HP. These include Government, development partners and NGOs.

A HP Strategy (A national health Communication Strategy) for communicating the Essential Health Package will be developed. It will tie all government and health partners efforts together towards influencing peoples health behavior. The strategy will provide details of the program as well as the resource envelope.

4.3 Risks

The policy identifies several risks that would threaten its successful implementation. Immediate risks include:

- Inadequate support within the decentralized setting and SWAp financial arrangement.
- Current financial arrangement does not take into account material development, printing and human resources required for HP services.
- Other partners may not be willing to collaborate and coordinate in the implementation of the HP policy and strategy.

CHAPTER FIVE

MONITORING AND EVALUATION

5.1 Means of Monitoring and Evaluating

The monitoring and evaluation (M&E) of the HP policy will ensure that its implementation is on course. This will be done through annual and biannual reviews which will examine the extent to which the policy is being adhered to. At the end of two and half years a mid-term review (MTR) will be conducted to review progress made and lessons learnt. An end of term evaluation (ETR) will be conducted after five years.

The source of data for monitoring and evaluation will be from the Health Management Information System, the Malawi Demographic and Health Survey, and other surveys commissioned by the MOH and stakeholders.

The Health Promotion Strategic Plan will be developed and based on the Health Promotion Policy. It will be tracked by monitoring changes in health-related behaviour resulting from the HP program in Malawi.

There is much debate about the appropriate means of evaluating health promotion, the approach will be selected with respect to appropriateness, cost and rigour.

5.2 Review of Policy

This Policy shall be reviewed every 5 years to assess progress and identify areas requiring modification. Policy recommendations emerging from such reviews will lead to appropriate action for policy adjustment, change and/or redress.

APPENDICES

Appendix 1: GLOSSARY AND DEFINITION OF TERMS

The HP policy is developed in a field where a wide range of terms are used; hence an attempt to provide definitions of some of these terms is included below. There are strong and divergent views among stakeholders as to what particular terms mean or imply and which terms should be used.

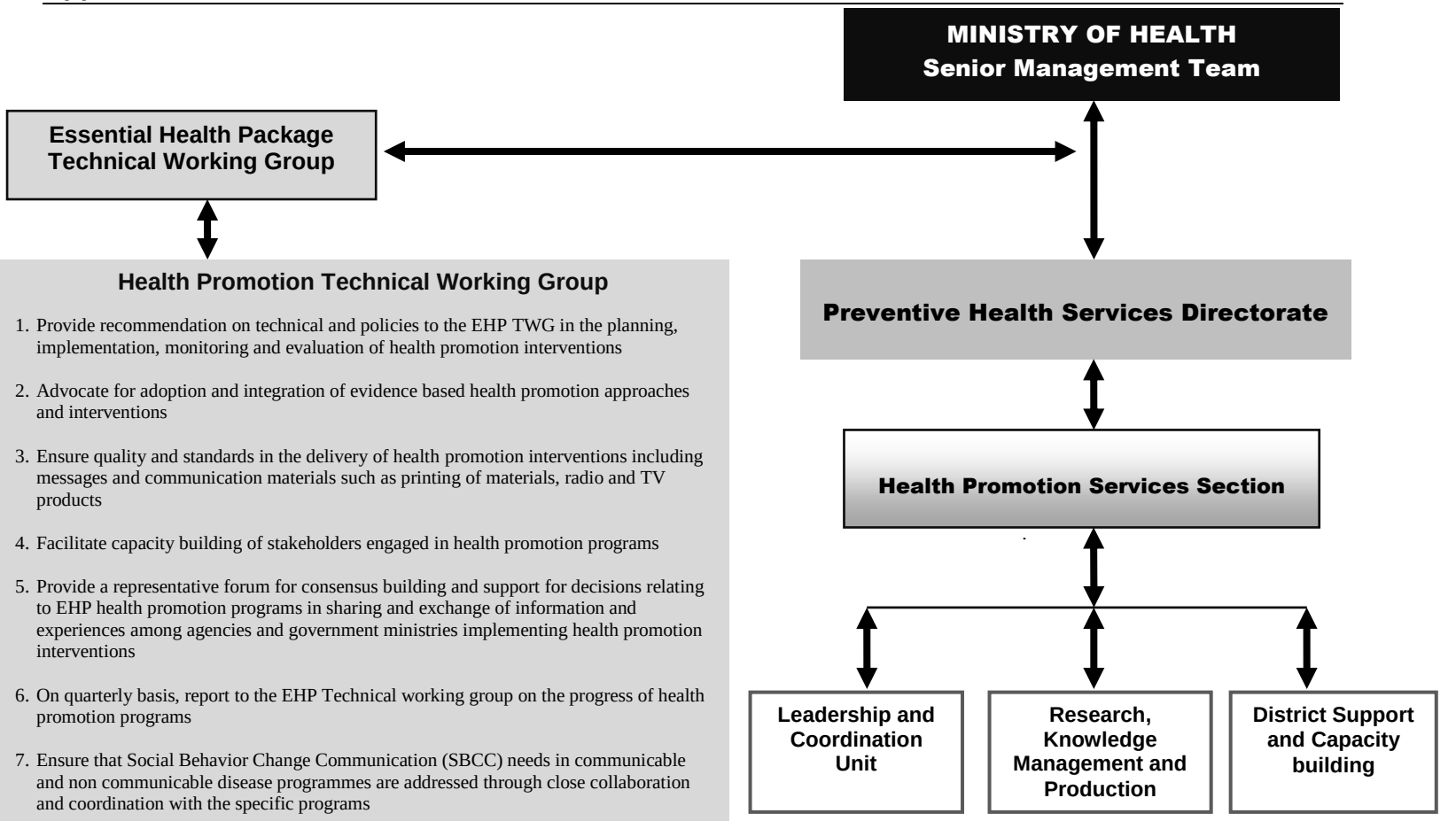
Definition of Terms

Health Education	Providing information and teaching people how to behave safely and in a manner that promotes and maintains their health.
Health Communication	A key strategy to inform the public about health concerns and to maintain important health issues on the public agenda[18].
Health Information	Any information, whether oral or recorded in any form or medium, that relates to health of an individual[19].
IEC	Information, Education and Communication. In practice, this is seen largely as synonymous with health education.
Health Promotion (HP)	HP is the comprehensive social and political process, which involves actions directed at strengthening the skills of individuals to improve their health. It also involves changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. HP is the process of enabling people to increase control over the determinants of health and thereby improve their health (Adapted from WHO 1998, Health Promotion Glossary, WHO/HPR/HEP/98.1) p.1 Major HP outcomes include positive changes to and/or enhancement of personal behaviour, skills and/or social norms, actions, organizational practices and public policies. (*WHO 2004, INTERCOUNTRY Seminar to Strengthen National Capacity for Health Promotion, Brazzaville)*
BCI	Behavior change intervention: a combination of activities/interventions tailored to the needs of a specific group and developed with that group to help reduce risk behaviors and vulnerability to a disease, particularly HIV, by creating an enabling environment for individual and collective change.

[18]However, it should be noted that this is a fairly narrow use of the term which fits with its use in the term IEC. It is used in a wider sense in the Ministry of Health's Communication Strategy for Health Sector Reform, for example, including more target audiences than the general public only. This broader sense of health communication is also explored in this document.

[19]This is a fairly broad definition which would include health education materials but is more strongly focused on materials which would form part of the health management information system (HMIS).

Appendix 2: HP INSTITUTIONAL ARRANGEMENT



Health Promotion Technical Working Group

1. Provide recommendation on technical and policies to the EHP TWG in the planning, implementation, monitoring and evaluation of health promotion interventions
2. Advocate for adoption and integration of evidence based health promotion approaches and interventions
3. Ensure quality and standards in the delivery of health promotion interventions including messages and communication materials such as printing of materials, radio and TV products
4. Facilitate capacity building of stakeholders engaged in health promotion programs
5. Provide a representative forum for consensus building and support for decisions relating to EHP health promotion programs in sharing and exchange of information and experiences among agencies and government ministries implementing health promotion interventions
6. On quarterly basis, report to the EHP Technical working group on the progress of health promotion programs
7. Ensure that Social Behavior Change Communication (SBCC) needs in communicable and non communicable disease programmes are addressed through close collaboration and coordination with the specific programs

Appendix 3: DOCUMENTS REVIEWED

1. A Call to Renewed Action: National HIV/AIDS Policy, Office of the President and Cabinet, National AIDS Commission, October 2003.

2. A Joint Programme of Work for a Health Sector Wide Approach (2004-2010), Republic of Malawi, Department of Planning, Ministry of Health, December 2004.

3. Advocacy Implementation Plan for Working with Six Key Social Groups in Malawi on Behaviour Change, Ministry of Health and Population & National AIDS Commission, September 2003.

4. Communication Strategy for Health Sector Reform, The Joint Programme of Work (POW) 2004-2010, Ministry of Health, Malawi, April 2004.

5. Guidelines for Annual District Implementation Plans, Planning Department, Ministry of Health, February 2005.

6. Handbook and Guide for Health Providers on the Essential Health Package in Malawi Produced by Planning Department, Ministry of Health, April 2004.

7. Health Education Unit Work Plan 2005/6 Document headed Form: HQ1 Activity Budgeting Format.

8. IEC Dissemination Workshop for STDs, HIV/AIDS and FP: Towards Determining the Next Steps Dissemination Report Series No. 2, STAFH Project, 2001.

9. Information, Education and Communication A progress report submitted for the Ministry of Health's Annual Report, Health Education Unit, Ministry of Health, September 2005.

10. Malawi Decentralisation Policy, Government of Malawi, (undated).

11. Malawi Health Sector Strategic Plan 2011-2016, Ministry of Health, 2011.

12. National Behaviour Change Interventions Strategy for HIV/AIDS and Sexual Reproductive Health, National AIDS Commission & Reproductive Health Unit, April 2003.

13. National Guidelines for Health Promotion of Priority Health Programmes Report, Workshop report, Kambiri Lodge, Salima, 8-13 September 2002.

14. National HIV/AIDS Action Framework 2005-2009, Final Draft, Government of Malawi, April 2005.

15. National HIV/AIDS/SRH Behaviour Change Interventions Literature Review, To support the situation assessment for the BCI Strategy, Yolande Coombes, June 2001.

16. National TB Programme Strategic Plan for IEC, Ministry of Health 2001.

17. Policy guidelines for IEC functions at district/city levels, WB Bomba, July 1998.

18. A Primer for Mainstreaming Health Promotion, 7th Global Conference For Health Promotion,"Promoting Health and Development Closing the Implementation Gap", Nairobi, Kenya, 2009.

19. Strategic Behavioral Communication (SBC) for HIV/AIDS: A Framework Produced by FHI, 2005.

20. Strengthening of the IEC and Social Mobilisation Unit of the Ministry of Health, Health Education Unit, Ministry of Health, June 1990.

21. SWAp Implementation Plan, Ministry of Health and Population, October 2002.

22. The National HIV/AIDS Action Framework 2005-2009 Power Point presentation, Anonymous (undated).

23. To the Year 2020: A Vision for the Health Sector in Malawi, Ministry of Health and Population, May 1999.

24. WHO (2007) The role of WHO in the International Health Systems Agenda.

25. WHO, Health and Welfare Canada, Canadian Public Health Association (1986). Ottawa Charter for Health Promotion. First International Conference on Health Promotion.

26. WHO/PAHO 2000 Prevention, Control and Elimination of Neglected Diseases in the Americas: Pathways to integrated, Interprogrammatic, Intersectoral Action for Health and Development.