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Analysis of Non-Communicable Disease Prevention Policies in Malawi



Analysis of Non-Communicable Disease Prevention Policies in Malawi Malawi case study report

Principal Investigator and Research Fellow: Bagrey Ngwira, M.D., Ph.D.

Research coordinator and Ph.D. Fellow: Beatrice Lydia Mwagomba, M.D., Msc.

Data analyst: Misheck Julian Nkhata, Msc.

Collaborating institution: University Of Malawi, The Polytechnic

MALAWI ANPPA PROJECT TEAM

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Abbreviations

ANPPA	Analysis of Non-communicable Disease Prevention
CDC	Centers for Disease Control and Prevention
DALY	Disability Adjusted Life Years
DAPCC	Drug Abuse Prevention and Control Commission
DFM	Drug Fight Malawi
DRNCD	Diet-related Non-communicable Diseases
EHP	Essential Health Package
FAO	Food and Agriculture Organization
FCTC	Framework Convention on Tobacco Control
FORUT	For Utvikling/Development
HES	Health Education Section
HP	Health Promotion
HSSP	Health Sector Strategic Plan (2011-2016)
IMCDC	Inter-Ministerial Committee on Drug Control
MANASO	Malawi Network of AIDS Service Organizations
MAPA	Malawi Alcohol Alliance
MBS	Malawi Bureau of Standards
MDG	Millennium Development Goals
MoH	Ministry of Health
MSA	Multisectoral Action/Approach
NCA	National Committee on Alcohol
NCDs	Non-communicable Diseases
NDCMP	National Drug Control Master Plan
NHSRC	National Health Science and Research Committee



NNPSP	National Nutrition Policy and Strategic Plan
NRSCM	National Road Safety Council of Malawi
OPC	Office of the President and Cabinet
RTA	Road Traffic Accidents
RTD	Road Traffic Directorate
SADC	South African Development Community
SHN	School Health and Nutrition Policy
SSA	Sub-Saharan Africa
STEPS	WHO Stepwise Survey
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approach
TAMA	Tobacco Association of Malawi
TCC	Tobacco Control Commission
TOAWUM	Tobacco Tenants and Allied Workers Union of Malawi
TOR	Terms of Reference
TWG	Technical Working Group
WHO	World Health Organization
WHS	World Health Survey



Executive Summary

Introduction

There is a growing burden of non-communicable diseases (NCDs) especially in low and middle-income countries. Major NCDs such as cardiovascular diseases, diabetes, cancers and chronic lung diseases share risk factors that include harmful use of alcohol, tobacco use, unhealthy diet and insufficient physical activity. The 2011 United Nations Political Declaration on NCDs recognized that actions to prevent and control NCDs require MSA (MSA). In Malawi, the extent to which non-health sectors are aware of NCDs prevention, and their involvement in developing and implementing NCD-related policies, is not documented. Therefore, we joined the Analysis of NCDs Prevention Policies in Africa (ANPPA) research project, to explore and understand the current policy environment for prevention of NCDs in Malawi as a case study site among six sub-Saharan African (SSA) countries. This study aim of the study was to generate evidence on the extent to which MSA plays a role in formulation and implementation of policies related to NCD preventive 'best buy' interventions, which are the World Health Organization's (WHO) recommended measures to cost-effectively deliver the greatest benefit in reducing risk factors for NCDs.

Methods

The study used a mixed-methods design, conducting document reviews and triangulation of findings from various data sources. Qualitative data was collected using key informant interviews. A mixture of purposive and 'snowballing' methods was used to sample the study participants, as well as the Walt and Gilson framework for policy analysis. This analysis focused on four policy factors: contents, actors, processes, and context.

Findings

The biggest gap in availability of policies for NCD prevention in Malawi relates to tobacco as a risk factor. Political and economic factors play a major role in the establishment of national policies for tobacco control. The other risk factors have policies directly or indirectly related to NCD prevention, however, WHO best buy NCD interventions are only partially included in the available policies. The best buy interventions requiring actions from outside the health sector — such as raising taxes on tobacco and alcohol products, putting bans on alcohol and tobacco advertising, protecting people from tobacco smoke, and replacing trans-fat with polyunsaturated fat in food — are not yet addressed. MSA was evidently high at formulation level of some available policies, especially in the harmful use of alcohol. Perceived facilitators for MSA include: shared appreciation of the seriousness of the problem, structured collaboration and coordination for the policy development or implementation, availability of dedicated funding for the process, and political commitment by government. Barriers to effective MSA include financial constraints, conflicts in coordination, difference in interests and mandates across government agencies, and high personnel turnover, especially in government departments.



Conclusion

This analysis reveals critical gaps in NCD policies in Malawi. Accordingly, the government needs to reinforce inclusion and implementation of best buy interventions in legislation and policies related to NCD prevention across all sectors. Enhanced structured coordination, partnerships, and sustainable joint-financing mechanisms are necessary for implementation of MSA for NCDs prevention.



1.0 | Introduction

1.0



Introduction

There is a growing burden of non-communicable diseases (NCDs) especially in low and middle-income countries (1–3). For example, the number of people with diabetes quadrupled since 1980, with about 422 million adults having diabetes in 2014. NCDs also significantly contribute to worldwide mortality (4), accounting for about 63% of mortality globally and 80% of the NCD-related deaths in low and middle-income countries (5,6). Current projections indicate that by 2020, the largest increase in NCD-related deaths will occur in Africa, and by 2030, NCD-related deaths will exceed the combined deaths from communicable diseases, nutritional, maternal and neo-natal deaths (6) by 75%. The World Health Organization (WHO) identified that four NCDs — cardiovascular diseases, diabetes, cancers and chronic respiratory illnesses — were responsible for 75% of all NCD-related mortality (3). NCDs cause more than 36 million deaths every year worldwide (7). These share four common risk factors: tobacco use, unhealthy diet, alcohol abuse, and physical inactivity. These factors are linked to the increase in preventable morbidity and disability in the region.

To address the burden of NCDs and associated risk factors, WHO advocates a ‘whole-of-government’ approach in its most recent global strategy for the prevention and control of NCDs (7). This denotes public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to specific issues. Furthermore, the global NCD strategy recommends that the whole-of-government approach should aim to address the social determinants of health [8]. The social determinants of health are those conditions in which people are born, grow, work, live, age, and the wider set of forces and systems that shape daily life conditions (8). MSA is a key component of the whole-of-government approach. In a health context, MSA refers to actions undertaken by sectors outside health, possibly, but not necessarily, in collaboration with the health sector, on health-related outcomes, or the determinants of health or health equity (9). Therefore, successful NCD prevention needs action MSA to address factors affect the physical, social and political environment and shape the health and well-being of the population.

The 2011 UN Political Declaration on NCDs (10) contains governments’ commitments to give priority to NCD prevention and control. The commitments develop multi-sectoral public policies that create equitable health promoting environments enabling individuals, families and communities to make healthy choices and lead healthy lives. Accordingly, governments pledged to promote, establish or strengthen, and implement multi-sectoral national policies and plans for the prevention and control of NCDs by 2013, taking into account the WHO 2008-2013 Action Plan for the Prevention and Control of NCDs (7). This plan identifies MSA as a cornerstone for NCD prevention at population level.

The WHO recognizes the impact of NCDs on economies worldwide. It identifies evidence-based interventions based on NCD risk factors and recommends countries adopt or adapt, even in resource-limited settings (7). Recommendations include measures to cost-effectively reduce common risk factors in order to deliver the greatest benefit in reducing population-level risks (7). The NCD best buy interventions for each risk factor are detailed in Table 1.

Table 1: WHO-recommended “best buys” intervention for NCD prevention and control

Risk factor	“Best buy” interventions
Tobacco use	Raise taxes on tobacco Protect people from tobacco smoke Warn about the dangers of tobacco Enforce bans on tobacco advertising
Alcohol abuse	Raise taxes on alcohol Restrict access to retailed alcohol Enforce bans on alcohol advertising
Unhealthy diet and physical inactivity	Reduce salt intake in food Replace trans-fats with polyunsaturated fats Promote public awareness about diet and physical activity (via mass media)

Source: World Economic Forum & World Health Organisation (11)

MSA successfully applied tobacco control initiatives in several settings (12,13). However, research in Malawi and SSA is limited on the application and success of MSA for the control of tobacco and other NCD risk factors (such as alcohol abuse, physical inactivity, and unhealthy diets).

1.1 The burden of NCDs in Malawi

Even though Malawi data is limited in NCD prevalence and risk factors, it is evident from a 2009 WHO Stepwise (STEPS) survey (14) that NCDs have become a public health problem and need to be addressed. NCDs account for at least 12% of total Disability Adjusted Life Years (DALYs) and are the second-leading cause of deaths in adults after HIV/AIDS (15).

As shown in Table 2, 32.9% of Malawi's population aged 25-64 has hypertension (high blood pressure) while 8.9% suffer from cardiovascular diseases (16). This level of hypertension in adults is higher than the United States (33%) and the United Kingdom (27%). The STEPS survey also showed that 94% of those with hypertension were untreated and 75% were unaware they are hypertensive (16).

Table 2: Prevalence of non-communicable diseases in Malawi

Disease/condition	Prevalence	Data sources
Hypertension	32.9%	NCD STEPS survey 2009
Cardiovascular diseases (using cholesterol as a marker)	8.9%	NCD STEPS survey 2009 (N=3910, age 25-64 years)
Injuries other than road traffic accidents (RTA)	8.5%	WHS* Malawi 2003 (N=5297, age >=18years)
Diabetes	5.6%	NCD STEPS survey 2009
Asthma	5.1%	WHS Malawi 2003 (N=5297, age >=18years)
RTA	3.5%	WHS Malawi 2003 (N=5297, age >=18years)

*WHS=World Health Survey

Source: STEPS Survey 2009

1.2 Prevalence of common risk factors for NCDs in Malawi

The Malawi STEPS survey on NCDs and risk factors revealed that tobacco smoking, alcohol consumption, and excessive alcohol (harmful use of alcohol) were common risk factors in males as compared to females while overweight and physical inactivity were more common among the females (14). Thus, among men who consume alcohol, 1 in 5 men engage in heavy episodic drinking (had 5 or more units of alcoholic drinks at one sitting in the previous 30 days). The prevalence of overweight is 28.1% and 16.1% for women and men respectively. Table 2 shows the prevalence of the NCD risk factors in Malawi.

Table 3: Prevalence of non-communicable diseases in Malawi

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

Source: STEPS Survey 2009



Malawi embarked on control by including NCDs in the list of priority conditions under the National Essential Health Package (since 2011), followed by the Ministry of Health (MoH) establishing the NCDs Control Program. The health sector is conversant with NCDs as an emerging health problem, although it is not known to what extent other sectors are aware of NCD prevention as well to what extent MSA was deployed in the development and implementation of available NCD-related policies. Additionally, it is not known whether WHO best buy interventions are incorporated in the current and emerging NCD policies on prevention and control in Malawi.

1.3 Study Objectives

This study was part of Analysis of NCD Prevention Policies in Africa (ANPPA), a multiple-case research project (17) implemented in six African countries (South Africa, Malawi, Nigeria, Kenya, Cameroon and Togo) to analyse MSA's role in development and implementation of NCD prevention policies and to identify ways MSA can be operationalized and mainstreamed in NCD prevention efforts in Africa (17).

The specific objectives of the Malawi case study in were to:

1. conduct an in-depth assessment of available policies related to NCD risk factors;
2. assess how and to what extent MSA was used in the formulation and/or implementation of NCD prevention policies;
3. identify enabling factors and/or barriers to MSA in NCD prevention policy processes;
4. generate robust evidence on the extent to which WHO best buy interventions are included in Malawi's NCD-related policies; and
5. Provide evidence-based recommendations to policy and decision-makers on future design and implementation of NCD best buy interventions.

1.4 Guiding Framework

The Walt and Gilson framework for policy analysis (17) was used to guide this study. It acknowledges the non-linearity of the policy process as well as the incremental nature of policy-making. In this framework, Walt and Gilson focus on four policy factors: contents, actors, processes, and context (17). The content of particular policies is examined by looking at objectives, design, whether there is an accompanying implementation plan, and specific mechanisms to actualize the policy

- The policy actors were examined by looking at who was involved in the policy processes, their roles and who else ought to have been involved.
- The analyzed processes include the different stages of the policy-making and strategies employed to involve different actors at formulation and implementation levels.
- The context examination included political, socio-cultural, administrative and economic contexts, as well as any conflicting development agendas between different players and partners.

2.0

 2.0 | Methods



Methods



2.1 Research Design

We used a mixed-methods study design. Data and information relevant for this analysis were from desk review of documents related to each of the four NCD risk factors. Additional data was collected using key informant interviews.

The aim of the desk review was to describe the policy context and content as well as identify existing policy interventions and the gaps therein. The review assessed documents related to NCD prevention, including acts and laws, policies, strategic plans, program action plans, guidelines and protocols, and government directives. Document review also includes published survey reports or grey literature with any quantitative or qualitative data on NCDs and risk factors under study.

The aim of key informant interviews was to have an in-depth understanding of actors' involvement and to illuminate processes for formulation and implementation of NCD-related prevention policies.

2.2 Sampling

Sampling for the study was generally purposive. Documents for desk review met the definition of an NCD-related policy according to this study, were accessible, most recent versions, and in any period of development either before or after establishment of the NCD control program in Malawi in 2011. The documents were accessible during the study period and included: national policies, guidelines, laws, strategic plans and regulations related to the four major NCD risk factors. Other sources included local media, speeches by government officials, draft policy statements, and journal articles. All reviewed documents are listed in Annex 1. Identification of these documents was based on prior knowledge of the researchers, interviews with key informants, reference sections of key national documents and internet searches. Some national policy documents were accessed through consultation with the policy unit of the Office of President and Cabinet (OPC); some came from key informants and others by reaching out to relevant government officials. Very few were available online on government websites.

Actors and/or organizations involved in formulating documents were as identified key informants, some by using a 'snowball' sampling technique during initial interviews, which referred researchers to other actors. A deliberate effort was made to include key informants from line and other related sectors, and from government and non-governmental spheres, including bilateral donors and NGOs involved in NCD interventions. Due to staff turnover between the policy development periods and the time of the study, agency representatives involved at the time of policy formulation were also interviewed.

2.3 Data collection approaches

2.3.1 Key informant interviews

Key informant interviews collected data on the context of policy development, policy content, who was involved in the process and the implementation status of each policy. The interviews also collected data on the strategies and challenges of MSA, how MSA was used, and what MSA approaches worked/did not work during formulation and implementation. For tobacco control, three key informants were re-contacted and two were interviewed after preliminary data analysis

on barriers for tobacco control policies and the implementation of the Framework Convention on Tobacco Control (FCTC) in Malawi.

The interviews were conducted using a structured topic guide with questionnaires aligned to the four risk factors. After obtaining consent and noting participants' demographic data, the interviews were digitally audio-recorded. While one data collector interviewed, another took notes and managed the audio recorder.

2.3.2 Review of documents

Identification of policies, pieces of legislation, and guideline documents was based on their relationship to addressing WHO best buy Interventions and the NCDs. A consultative approach with relevant sectors included all the relevant documents for review. After the investigators accessed the available documents, a research assistant with a masters' degree assisted with detailed document analysis. The data document reviewer was oriented to the study objectives and the desk review process.

The review focused on the year of development, the rationale and objectives of the policy document, whether it addressed the WHO best buy NCD interventions directly or indirectly, other NCD-related interventions, implementation plans, as well as monitoring and evaluation.

A guiding template table documented all findings from the document review, including comments that synthesised the observations (Annexes 1 to 5).

2.4 Data analysis

2.4.1 Qualitative data

The recorded interview data was transcribed by trained research assistants and saved in Microsoft Word before storage on a password-protected computer.

Data cleaning involved reading transcripts by investigators and the data management assistant to become familiar with the data and identify incomplete sections, typographical and formatting errors. The transcripts were imported into NVivo qualitative data analysis software for data coding and analysis.

The data management assistant developed a coding framework, in line with the code book shared by the APHRC project management team, to maintain data analysis harmony across all country study sites.

An organized analysis workshop for investigators and research assistants allowed each team member to code one transcript using NVivo 10 software and then compare the coding methods to ensure consistency. After reaching a consensus, the data management and research assistants coded all the transcripts. Two investigators checked 10% of all coded transcripts for accuracy. After coding, recurring themes were identified and key quotes selected for inclusion in the deductive narrative analysis.

NVivo software was used to analyse thematic content. A preliminary analysis identified text linked to each content area and key themes. Secondary analysis further analysed the data by adding emerging themes outside the established framework (17).



2.4.2 Desk reviews

Analysis of NCD-related policy documents examined the policy rationale, objectives, planned interventions, any accompanying implementation plan or specific mechanisms for actualizing the policy. Specific attention was paid to whether the policy included any intervention-related WHO best buys for NCDs, directly or indirectly. All documents with interventions related to WHO best buys in any of the four NCD risk factors were further analyzed for MSA at either development or implementation stage.

The documents' acknowledgement sections identified policy actors involved in the policy processes, although specific actor roles could not be elicited. This was complemented by information from key informants.

Desk reviews also contributed to the context examination via policy rationale: detailed political, socio-cultural, administrative and economic contexts, as well as any conflicting development agendas between different players and partners, were identified through complementary information from the interviews.

Annex 1 shows a list of the reviewed documents with detailed findings in Annexes 2-5.

2.4.3 Data quality measures

To ensure quality data collection, we recruited four experienced interviewers, who underwent training in qualitative interviewing, transcription and coding. Interviewers piloted collecting data in pairs before transcription, which was used to discuss challenges encountered in data collection, framing of questions, and areas for further probing.

After data collection, another training workshop was organized on coding the data in NVivo using the ANPPA codebook. Each interviewer coded one transcript and discussed it with the rest of the team. During the coding process, investigators recoded 10% of the transcripts to ensure consistency. In the few instances where discrepancies emerged, investigators discussed how to reach consensus before proceeding. This process ensured accuracy in the coded data.

2.4.4 Ethical considerations

The study protocol was reviewed and ethically approved by the National Health Science and Research Committee (NHSRC), approval number NHSRC 1290. All interviews were privately conducted either in participants' office rooms or in ANPPA's Malawi project office.

After transferring data to an encryption-secured computer and investigators reviewed transcriptions, the audio-recorded data was deleted from the digital recorders. All transcripts were coded: no names were written on them and all quotes used in the reports, presentations and publications maintain unidentifiable codes. The de-identified transcripts, as well as any required raw data for further reviews, was shared with the APHRC project management team.



3.0 | Findings

3.0



Findings



3.1 Data Sources

3.1.1 Number and types of documents reviewed

The study reviewed 27 documents (see Annex 1), including: national policy documents, published journal articles, and grey literature. 'National policy documents' includes government policies, strategic plans, guidelines and Acts of Parliament, whereas 'grey literature' includes unpublished reports, speeches by senior government officials, online publications and websites of some of key institutional actors. Table 4 details the number for each document type.

Table 1: Documents reviewed

Document type	Total number
National NCD policy documents	16
Published journal articles (relating to NCDs in Malawi)	3
Other grey literature	8
Total	27

3.1.2 Number and types of respondents

Key informant interviews were conducted in two phases, from August to October 2014 and in July 2016. We approached 40 key informants to take part in the study, and of these, 32 were interviewed, recorded and their transcripts included in the study. They were drawn from the health, agriculture, youth, gender, trade and education sectors, and included representatives from both government and non-governmental departments.

Among the remaining eight informants, one agreed to interview but an appointment could not be arranged during the period of data collection. Another key informant asked for an emailed questionnaire but did not respond; another refused to be recorded. Two transcripts could not be loaded after interview due to technical faults. The remaining three respondents did not respond to participants' invitation requests.

As indicated in Table 5, the majority of key informants were state actors from government ministries. Others were from local NGOs and civil society organizations, international organizations, as well as academic and research institutions.

Table 5: Key informant characteristics

Respondent type	Total number
Government actors	19
Health	7
Industry and trade	1
Agriculture	2
Youth	2
Home affairs	3
Labour	1
OPC	1
Other government sectors (parastatal)	2
Non-government/non-state actors	
Private/not-for-profit/NGOs/CSOs/FBOs/CBOs (health)	4
Research/academic institutions (agriculture)	1
International organizations (health)	1
Bilateral organizations (health)	1
NCD associations/alliance (multi-sectoral)	4
Universities/research (non-health sector)	1
NGOs/civil society (health)	1
Total	32

However, for tobacco policy-related questions, only eight key informants responded to discuss Malawi's tobacco control policies and regulations. Three informants were from the government sector while five were from the non-profit sector. As detailed in section 5.3.2, discussions about Malawi tobacco control were controversial, hence most of the government/state study participants did not respond to questions on formulation and implementation of tobacco-related policies.

3.2 Policy Context

3.2.1 Global context

Several global factors influenced the formation of Malawi's few NCD-related policies, including WHO technical reports and conventions. For instance, in 2004, WHO developed the Global Strategy on Diet, Physical Activity and Health to guide development of policies, plans and programs that promote healthy lifestyles among WHO member states. This influenced the development of the Nutrition Guidelines for Prevention and Management of Diet-related Non-Communicable Diseases in 2009. Also of influence was the 2008-2013 Global Action Plan for the Prevention and Control of NCDs (7) and the 2008 WHO AFRO Ouagadougou declaration, which calls for integration of essential NCD interventions in primary health care through adaptation of the WHO Package of Essential NCDs (PEN) interventions (18). The Global NCD Action Plan, formulated in 2008, noted an urgent need for action following projections that the NCD burden would overtake communicable diseases by 2030 (7).

UN Millennium Development Goals (MDGs) also influenced formulation of policies in nutrition and health promotion. The 2013 National Health Promotion Policy based its agenda on MDGs, recognizing that most goals require health promotion for successful achievement. On the other hand, the National Nutrition Policy and Strategic Plan (NNPSP) was influenced by MDG numbers 1, 4 and 5, which are concerned with the reduction of hunger and under-nutrition, child mortality, and maternal mortality. The targets for the NNPSP are drawn from and aligned with MDGs. The NNPSP also recognizes the existence of the United Nations Development Assistance Framework



and adopted the Paris declaration principles on aid effectiveness as policy frameworks guiding the relationship between government and its partners in policy implementation.

Several regional and international treaties and conventions on drug control influenced the formulation of the NDCMP (2005). These include the 1961 Single Convention on Narcotic Drugs, 1971 Convention on Psychotropic substances, 1988 United Nations Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances, and the 1996 South African Development Community (SADC) Protocol on Combating Illicit Drugs.

3.2.1 Local/country context

National NCDs Planning and Coordination

The national response to NCDs started in the health sector when the MoH (MoH) included NCDs in Malawi's HSSP and an NCD control program was subsequently established in 2011 for national coordination. A 2012-2016 National Action Plan for prevention and management of NCDs followed (26). Malawi's National NCDs Action Plan focus on improving national capacity for implementing NCD prevention and control strategies. The action plan states that oversight of national NCDs prevention and control strategies is provided by a multi-sectoral technical working group on NCDs and mental health, which is under the Essential Health Package (EHP) TWG. According to the NCDs TWG terms of reference (TOR), the chairmanship of the NCD TWG is by the Directorate of Clinical Services, while the secretariat is the NCDs and Mental Health Unit. Technical support to the NCDs control program is mainly from WHO Country Office and other health development partners. This shows that national response to NCDs is predominated by the health sector.

National economic context

The economy of Malawi, a landlocked country with a population of about 17 million people, is heavily dependent on agriculture for both subsistence and as a means of earning foreign currency. Malawi has exported tobacco since 1893 and is regarded as the world's most tobacco-dependent economy (19). In 2012, tobacco contributed 52% of Malawi's total export value. Malawi, alongside Brazil and the United States, is a top producer of burley tobacco. In 1970, the Malawi government enacted the Tobacco Act which addresses production, manufactruig and marketing of tobacco. The aim of the act was to increase tobacco production and sales.

Several players protect Malawi's economic interests through tobacco promotion, such as the Tobacco Control Commission (TCC). The Tobacco Act establishes the TCC to advise the government on tobacco sale and export; promote and expand tobacco sales; and control and regulate tobacco sales. The Tobacco Association of Malawi is another important player. Established in 1929 as the Nyasaland Tobacco Association, its two objectives are: "to promote and develop the tobacco industry in Malawi and to advance and protect the interests of sections and classes of producers in any way that may be desirable to the Association" and "to introduce or oppose or encourage the introduction of or opposition to legislation where the interests of the industry are likely to be affected" (20).

Evidence reveals that to diversify the agricultural production, tobacco production must be reduced. A study by the Centre for Agricultural Research and Development (20) suggests that average profits accumulated by both contract and independent farmers are equivalent or slightly less than profits for soya and chili farmers, which suggests that policies supporting transition for tobacco farmers towards sustainable and less socially problematic crops are needed (21). Malawi is one of the few countries that has not yet acceded to the Framework Convention on

Tobacco Control (FCTC), which encourages diversification of national economies to transition from tobacco dependency to control tobacco use.

The tobacco industry's role in influencing policy-makers against the FCTC was noted. At present, five companies are licensed to buy Malawi tobacco for export and domestic use: JTI Leaf Company Limited, Alliance One International, Limbe Leaf, Malawi Leaf Tobacco Company, Premium Tama, and RWJ Wallace (22). An ethnographic study reveals how the industry opposes tobacco control efforts by stressing the economic importance of tobacco for developing countries through job creation and foreign exchange earnings (19). Tobacco-buying companies are also said to control policy-making advisory groups in Malawi (23).

Transitions in management/leadership structures for NCD-related policies

Prior to 2004, policies related to diet improvement were spearheaded by the Ministry of Agriculture and MoH. Through the Food Security and Nutrition Policy of 1990, and others, resources were directed to promoting diets based on the six food groups (vegetables, fruits, legumes and nuts, animal foods, fats and staples), appropriate feeding practices, increasing micronutrient supplementation (Vitamin A and Iron), rehabilitating severely malnourished children, and promotion of school health and nutrition projects (24).

In 2004, the Malawi government established the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet, with a mandate to “provide visionary guidance and strategic direction for the implementation of the national response to nutrition disorders, HIV and AIDS in the country” (25). Based on the levels of malnutrition among children and adults affected by HIV and AIDS, the department's mandate was to spearhead the development and implementation of the nutrition policy by providing visionary policy direction and guidance, coordination, capacity-building, resource mobilisation, establishment of implementation structures and supervision (24).

Among its nutrition-related roles and responsibilities, the department aims to spearhead formulation and review of the NNPS, provide nutrition policy direction and guidance, and provide technical guidance on formulation and review of sectors' nutrition policies and strategic plans. Consequently, a NNPS (2007-2011) was developed and approved by March 2007. In 2014, the Department of Nutrition, HIV and AIDS relocated to the MoH as part of the Malawi government's civil service reforms (26). However, the Nutrition and NCDs units remain distinct entities with different mandates and belong to different departments at the MoH. This poses a challenge to the development and implementation of a harmonised approach to diet and nutrition-related policies.

From 2009-2011, the initial lead government agency on alcohol policy development was the drugs and substance abuse unit of the Ministry of Home Affairs and Internal Security (MOHAIS). Thereafter, the NCD and mental health unit of MoH took over the leadership and secretarial roles. Since the agencies have different mandates and roles, there is a potential implementation conflict for National Alcohol Policy (MoH-led) interventions that require law enforcement.

3.3 Overarching NCD prevention policies

Three documents that directly or indirectly address the common NCD risk factors were reviewed: HSSP 2011-2016, National Action Plan for Prevention and Management of NCDs (2012-2016) and National Health Promotion Policy (2013). The desk review findings for each documents is summarized below.



3.3.1 The Health Sector Strategic Plan (HSSP 2011-2016)

HSSP (29) is a MoH strategy document that replaced the Sector Wide Approach (SWAp) program, which covered the years 2004-2011. HSSP aims to: increase coverage of the Essential Health Package (EHP) interventions, paying attention to impact and quality; strengthen health system performance to support EHP service delivery; reduce health risk factors; and improve equity and efficiency in EHP service delivery.

As part of the HSSP development process, stakeholders at a health sector joint annual review meeting in October 2011 revised the EHP to include prioritization of NCDs as a national public health problem. By 2011, a revised HSSP 2011-2016 launched with an EHP including NCDs.

The HSSP includes several best buy interventions. As a means of reducing risk factors for health (lack of exercise, alcohol and drug abuse, smoking), the HSSP advocates for healthy lifestyles and behaviours. One key intervention to increase financial resources for the health sector is increased taxes on tobacco and alcohol. Although not planned as an NCD intervention, the proposed increases indirectly contribute to reduced exposure to smoking and alcohol abuse. Promotion of physical activity, healthy diets and health risks such as smoking and alcohol are some of the interventions included in the HSSP under the NCDs section (29).

While increasing NCD awareness started in the health sector, there was no evidence found through this study for implementation of other planned NCD best buy-related interventions. The HSSP tobacco and alcohol 'sin' tax has yet not materialised and there is no tangible implementation strategy for that intervention.

3.3.2 The National Action Plan for Prevention and Management of Non-Communicable Diseases in Malawi (The NCDs Action Plan (2012 – 2016))

The National Action Plan for the Prevention and Management of Non-Communicable Diseases is the first strategic document specific meant to guide the NCDs control program in Malawi. It was formulated by a series of stakeholder meetings in the 2011-2012 national fiscal year and was coordinated by the NCDs and Mental Health Unit of the MoH. It was launched and distributed in December 2013. NCD awareness activities with a focus on common risk factors are now included in District Health Implementation Plans. The plan was a response to the growing NCD burden, its risk factors (see Tables 2 and 3), and the disintegrated efforts in NCD response. The plan's objectives include NCD promotion and awareness, healthy lifestyles to reduce risk, advocacy for NCD risk reduction legislation, integrated NCD care, improved capacity to deliver and manage services for NCD control and management; and advocacy for quality research and support of NCD prevention and control.

The guiding principles of the 2012-2016 NCD Action Plan include an integrated, holistic approach and action-level integration. An integrated approach calls for changes at institutional, community, and public policy levels. Action-level integration emphasizes the diversity of actions including: policy development, legislation, regulation, public and professional education, guideline development, media interventions, and research. The NCD Action Plan is a good opportunity for MSA in NCD prevention and control in Malawi, since MSA is key in achieving NCD control holistically and in an integrated manner.

The 2012-2016 National NCDs Action Plan indirectly addresses best buy interventions related to protection from tobacco smoke, retail alcohol access restrictions, and awareness of physical activity and healthy diets. The plan calls for advocacy of policy and legislation to minimize NCD risk factors (27). Lobbying for reduction of exposure to NCD risk factors across all

the Action Plan's NCD thematic areas will achieve this objective (27). Without timelines on when the lobbying would start, three passed Acts of Parliament is one action plan target indicator. However, it does not specifically state which acts.

The National Action Plan for Prevention and Management of NCDs in Malawi (2012-2016) does not include a specific Monitoring and Evaluation framework. Steering committees would develop a detailed Monitoring and Evaluation framework after creating specific implementation guidelines (27). The Monitoring and Evaluation framework would include impact indicators, which are monitored at various long-term intervals through national surveys, and outcome indicators that would be reviewed at year's end to enable annual implementation planning. While the NCDs Action Plan does not have a Monitoring and Evaluation framework, its intervention matrix contains process indicators (27). Formal evaluation of the National Action Plan for Prevention and Management of Non-Communicable Diseases in Malawi (2012-2016) is planned for 2017. By the time of data collection, annual reviews were neither conducted nor reported.

3.3.3 The Health Promotion Policy (2013)

The Health Promotion Policy was developed in 2013 upon recognition of the inefficiency and ineffectiveness of MoH's Health Education Section (HES) in its responsibility of coordinating health education services. The policy provides guidance on implementing health promotion interventions for all stakeholders in health and other sectors. As detailed in Annexes 2 to 5, its mission is to "to create public awareness, facilitate community involvement and participation, and promote activities which will foster health behaviours and encourage people to want to be healthy, stay healthy and do what they can do individually and collectively to maintain sound health and access client-friendly health services in a timely manner" (28). Among others, the Health Promotion Policy objectives include review and enactment of policies and legislations on health promotion, based on national priorities, to support initiatives that enable all individuals and communities to lead healthy lifestyles. The Health Promotion Policy is based on the principles of equitable access and holistic approaches through collaboration with other stakeholders. These principles support the role of MSA towards health behaviour change. The health promotion policy identifies smoking, alcohol abuse, physical inactivity and unhealthy diets as risk factors for poor health leading to NCDs, therefore the promotion of healthy lifestyles through health literacy includes awareness on harms related to NCD best buy interventions.

The policy identifies MoH as its anchor for implementation but recognizes MSA to achieve the objectives. The implementation follows the decentralization approach, in which the Ministry of Local Government and Rural Development is responsible for health delivery at district and lower levels.

The 2013 Health Promotion Policy includes a plan for monitoring and evaluation. The policy has annual and biannual reviews that examine adherence to the policy. A mid-term review for progress and lessons learnt occurs after two-and-a-half years, followed by an end-of-term evaluation after five years. By the time of data collection, none of the reviews were done and reported.

3.4 Tobacco Control Policies

A review of five policy documents indicated that only three documents had information indirectly related to tobacco use prevention and control. The five documents were: the National Action Plan for Prevention and Management of NCDs in Malawi (2012-2016) (27), National Drug Control Master Plan (NDCMP) for Malawi (2005), Nutrition Guidelines for prevention and management



of DRNCs, National Health Promotion Policy (2013) (29), the draft tobacco bill (2014) and the Malawi Health Sector Strategic Plan (2011-2016) (30). These documents do not mention smoking or tobacco. However, the NDCMP for Malawi (2005) and the draft tobacco bill (2014) lack interventions or strategies related to tobacco control.

Key informants also noted there were no specific tobacco control policies and legislations were formulated or under implementation in Malawi.

"At the moment, we don't have tobacco control policies, regulations, so people are not protected. So really ... we people are suffering and there are a lot of problems associated to it, so I don't see any regulations in the country that [are] dealing directly to help the people out of the danger of tobacco use." (0211, Health, Private/Non-profit, Male)

"We don't have policies as regards ... to tobacco smoking, tobacco use in Malawi."(0212, Agriculture, Government-Parastatal, Male)

While there are no specific tobacco control regulations and laws in Malawi, there are some aspects in the health sector policies. As described in the overarching NCD policy section, the health sector raised awareness on tobacco dangers via health education messages. Key informants also cited existing efforts for inclusion of health messages on tobacco packaging and prohibition of smoking by the most vulnerable populations, for instance, those who are under age 18 and unborn children.

"Yes, what is indicated is that no person under 18 years of age should smoke. In fact, on all our cigarettes, they are supposed to indicate that tobacco is harmful to your health, all right, and no person under the age of 18 should buy the cigarettes and smoke the same, so that is clearly stipulated. And [it] is clearly stipulated [that] ... no pregnant lady should be allowed to smoke or should buy cigarettes – that's the one area that I am aware of that is trying to protect the consumer." (0212, Agriculture, Government-Parastatal, Male)

"But I know within our laws of Malawi that there are laws which stipulate the control management and use of tobacco in relationship to age." (010402, Youth, Government, Male)

WHO best buy interventions on tobacco control in relation to addressing NCDs are: Tax increases; smoke-free indoor workplaces and public places; bans on tobacco advertising, promotion and sponsorship; health information and warnings. These interventions require strong policies with wider advocacy and monitoring. There are no specific tobacco policies and laws formulated for NCD control in Malawi. Apart from health information and warnings, other best buy interventions are not available in Malawian national policies and laws. The implementation of tobacco-related best buy interventions is not guaranteed without them.

3.4.1 Tobacco policy content and history

We analyzed government policies, guidelines and laws related to tobacco in Malawi that directly or indirectly relate to smoking, tobacco production, use, management and control. Apart from the three MoH overarching documents on NCDs (HSSP, NCD Action Plan and the Health Promotion Policy), we also reviewed two specific policy documents: the NDCMP for Malawi (2005) and the draft Tobacco Bill (2014). We selected the NDCMP because it addresses smoking as one means of substance abuse. Another policy document that flags up tobacco use as part NCDs control is the 2009 Nutrition Guidelines for Prevention and Management of DRNCs (see Annex 2). This was reviewed in detail under the healthy diets police section.

3.4.2 National Drug Control Master Plan for Malawi (NDCMP 2005)

The NDCMP (2005) was developed to coordinate efforts controlling production, trafficking and abuse of drugs, and guide the Malawi national response to emerging issues and threats. The plan aims to curb drug abuse through law enforcement, civic education, community mobilization, economic empowerment and health. The NDCMP development rationale focuses on the ineffectiveness of efforts to combat drug abuse because of disjointed interventions. According to the NDCMP, the interventions were based on sectoral, legislative and administrative frameworks to control drug abuse. Further, as a signatory to several international drug-related conventions and treaties, Malawi is obligated to fulfil these commitments by controlling drug and substance abuse. Although tobacco and alcohol are among priority substances for global control, the NDCMP (2005) for Malawi focuses neither on tobacco nor alcohol, but instead on cannabis sativa and how to control it as an illegal product (see Annexes 2 to 5).

Principles/values stated

The NDCMP has no clear principles and values. It addresses key areas in terms of law enforcement, civic education, economic empowerment, community mobilisation, legislation and health. It acknowledges that drugs abuse results in various health problems including mental illness, sexually transmitted infections (STI) and HIV/AIDS. It advocates for a community approach establishing drug abuse drop-in centres across the country, as well as civic education to increase public awareness of illicit drug abuse and trafficking as one way of drug control. It encourages review of legislation to incorporate relevant international conventions and strengthening of capacity for enforcement.

The NDCMP rationale and values only address mental illness as an NCD that potentially emanates from substance abuse. While the NDCMP recognises the link between health and substance abuse, this emphasis is on the how substance abuse increases the risk for the spread of HIV and other STIs.

Extent to which WHO best buys are addressed

The NDCMP (2005) for Malawi does not focus on tobacco, but on cannabis sativa (or 'chamba') and efforts to control it. As such, it does not address any tobacco best buy interventions. As public awareness is a key component of the NDCMP, this increases awareness of the dangers of substance abuse.

Other interventions included

The NDCMP focuses on tackling drugs. As cannabis sativa is usually taken through smoking, the plan's efforts eradicate chamba smoking. There is no strategy on tobacco smoking.

Policy development timelines

NDCMP (2005) development started in June 2004 following consultations with various stakeholders (who are not mentioned in the document). By September of 2004, the Inter-Ministerial Committee on Drug Control (ICMDC) started sensitization meetings with various stakeholders. ICMDC was established in response to a global call to curb drug and substance abuse. Its activities were financially supported by international NGOs through the Ministry of Home Affairs and Internal Security.



Availability of Implementation/actions plans

The NDCMP (2005) proposes establishing the Drug Abuse Prevention and Control Commission (DAPCC) and a secretariat within the Ministry of Home Affairs and Internal Security. The secretariat is responsible for the coordination and implementation of the NDCMP while the DAPCC coordinates and implements multi-sectoral programs in the fight against drug abuse and trafficking.

The implementation plan for NDCMP (2005) includes clear objectives, activities, responsibilities, timelines, performance indicators, means of verification and estimated budget. It is divided into eight focus areas: institutional framework and policy development; information, research and networking; legal systems and implementation of the law; integrated drug demand reduction; national law enforcement and control capacities; health and the linkage between drug abuse and HIV; international cooperation; and monitoring and evaluation.

Monitoring and evaluation plan

The NDCMP has a monitoring and evaluation plan to ensure the NDCMP is implemented as expected. Key activities include establishing baseline indicators for drug abuse in Malawi as well as conducting mid-term, annual, and end-line reviews. These responsibility for these activities is on the Ministry of Home Affairs and the DAPCC.

The monitoring and evaluation plan lacks specific details in its implementation. For example, timelines for implementation are not clearly stated. Further, responsibilities for conducting annual reviews and establishing baseline indicators are assigned to the DAPCC and the Ministry of Home Affairs.

Multi-sectoral involvement in policy processes

NDCMP formulation involved several sectors and was led by the Inter-Ministerial Committee on Drug Control (IMCDM), which was formed in 1997 to coordinate, manage, monitor and provide technical support on drug related matters. Its main function is to harmonise multi-sectoral plans and activities on drug control. IMCDM is chaired by the Ministry of Home Affairs and Internal Security. Other actors involved in the formulation of the NDCMP include: the Malawi Police Service; Malawi Prison Service; Department of Immigration, Malawi Revenue Authority; Ministry of Youth, Sports and Culture; Ministry of Local Government and Rural Development; MoH, Ministry of Education and Vocational Training; Ministry of Women and Child Development Services; Ministry of Agriculture and Food Security; Ministry of Labour; Ministry of Information and Tourism; Ministry of Justice and Constitutional Affairs; High Court of Malawi; Office of the President and Cabinet; Zomba Mental Hospital; National Statistical Office; and the National Youth Council.

From the NDCMP review it is understood that formulation involved multi-sectoral actors from health, education, agriculture and internal security. While linkage between health and substance abuse is addressed, its focus is on the spread of HIV/AIDS, not NCDs.

NDCMP data analysis of from desk review. The study does not include key informants because they were unavailable during the data collection period, therefore data on various actors' involvement, positions, and extent of implementation were not included.

Table 1: Summary of tobacco control policies

Policy	Best buy intervention addressed	Year of development	Source of information (Reference number or interviewee code)
National Action Plan for Prevention and Management of Non-Communicable Diseases in Malawi (2012-2016)	Indirectly addresses control of public smoking	2013 (2012-2016)	Desk review
NDCMP for Malawi	None addressed	2005 (2005 – 2009)	Desk review
Nutrition Guidelines for Prevention and Management of DRNCDs	None addressed	August 2009	Desk review
National Health Promotion Policy	Addresses information and health warning interventions through promotion of lifestyle changes, health literacy and creating awareness.	June 2013	Desk review
Tobacco bill (draft)	None addressed	2014	Desk review
National Health Sector Strategic Plan (HSSP)	Indirectly addresses information and tax interventions by indicating need to increase awareness of NCD risk factors and lobbying for introduction of sin taxes on alcohol and tobacco.	2010 (2011 – 2016)	Desk review

3.4.3 Tobacco control best buy interventions implemented so far

While there is no specific NCD policy on tobacco use and control, some sectors use other laws to lobby for implementation of best buy interventions on tobacco, as described below:

“We had a case where we were using the Environmental Management Act to force government to come up with laws that would ban public smoking and unfortunately the court said that we should take it at the constitutional court. ... When the director in the Environmental Affairs Department came to court, she said they were in the process of doing a policy. I'm not sure if there's one now, but I haven't seen it. But they said they are doing a policy towards that.” (0205, Health, Private/Non-profit, Male)

“We are very much actively involved, because we are working in a way with young people and these form part and parcel of our policies and strategic plan and activities. When it comes to smoking, drug and alcohol abuse, we are much involved to create awareness, to bring information to young people on the health hazards of tobacco.” (010402, Youth, Government, Male)

In terms of funding, key informants noted that NGOs such as Drug Fight Malawi (DFM) had access, but it was limited to specific activities. None of the key informants mentioned there was a joint budgeting and financing mechanism between government and NGOs for national tobacco control interventions.

No specific tobacco policy-related monitoring and evaluation plan was in all the reviewed policy documents. However, all the policy documents recognize the need for annual, mid-term reviews that track implementation progress. Additionally, no specific outcome or impact indicators were identified.



3.4.4 Facilitators and barriers for tobacco use policies

Key informants mention several factors that facilitate formation of tobacco policies and legislation (albeit limited and selected) in Malawi. These include: global pressure and WHO influence towards ratification of the Framework Convention on Tobacco Control (FCTC); evidence of the negative health effects of tobacco smoking; rising prominence of NCDs and the role of civil society in advocating for the formulation of tobacco control policies and legislation.

One key informant noted that most tobacco smoked in Malawi is imported, so controlling tobacco through import duty would not negatively affect foreign exchange earnings.

Key informants cited the following barriers to formulation of legislation and policies: resistance from government; lack of political will; tobacco industry influence and the fact Malawi has not ratified FCTC. Informants noted the government lacks political will to formulate tobacco production and consumption policies. For some, this is because government is caught in a conflict of interest as it balances controlling tobacco production and tobacco's foreign exchange earnings.

"I hope you are aware that currently we haven't started developing tobacco policy. ... We are not ready to make that policy. ... Like I've indicated, in alcohol, there is a policy draft, but for tobacco, there is some resistance from the government since tobacco ... is [what] we rely on [as a] country to get its forex. ... While globally there is some force for member states to actually develop a policy in relation to tobacco control, Malawi is a country where there is actually some resistance. Even in the ratification of framework convention of tobacco control ... as a country we haven't done anything. I don't know why ... of course discussions are continuing, but we haven't come to a point where we can say: as a country let us come up with a tobacco policy." (010103, Health, Government, Male)

For some, the lack of political will is a result of the influence of the tobacco industry.

"The tobacco industry is exerting enormous pressure on government ... to ensure that it doesn't ratify the FCTC because ratifying the Framework for Tobacco Control is a trigger; it has a triggering effect. The moment Malawi ratifies the FTCT, I am telling you that definitely you [will] now see NGOs coming in to say that, 'okay, now let's implement a smoke-free policy [that] is going to ban public smoking'." (0203, Health, Private/Non-profit, Male)

Despite the barriers, key informants mentioned opportunities and facilitators for FCTC ratification. One interesting factor was agreement that FCTC needed ratification among key informants, some of whom were from the health sector and TCC. The informants cited several advantages of ratification: one said that Malawi's misconceptions could be clarified if the government ratified the convention. Another key informant said ratifying the convention would allow Malawi to have her voice heard.

"What is happening now is that we are meeting, and we are not allowed as a country to be in that meeting, in those meetings. For example, somewhere in November this year, we are meeting in India to discuss tobacco issues, but we are not allowed to go inside, but we will be there and we will be participating outside the hall, so just imagine: ... as a country, even those representing the government will not be inside, apart may be from the health ministry and ... but as a country we are not contributing in there, so we are saying let's join so that we fight from within." (0212, Agriculture, Government-Parastatal, Male)

Advocacy efforts from international and local non-state actors is another opportunity for influencing Malawi to ratify the FCTC. One of the local organizations involved in advocacy on tobacco control in Malawi, DFM, is a member of several international tobacco control organizations, for example the Framework Convention Alliance and the African Tobacco Control Alliance. These organizations help DFM attend international meetings that discuss FCTC.

“All right, unfortunately for Malawi, since we haven’t yet ratified the convention, there is completely no implementation, because how can we implement when we are not part and parcel of the convention? But I do also understand that whenever the countries are meeting to discuss on implementation of the convention, Malawi is always there.” (0211, Health, Private/Non-profit, Male)

Apart from the DFM, there are also other organizations that are lobbying for Malawi to ratify the convention. In a letter to the State President of Malawi, His Excellency Professor Peter wa Mutharika, the Tobacco Tenants and Allied Workers Union of Malawi (TOAWUM) stated:

“The government of Malawi must demonstrate courage and commitment to breaking our addiction to tobacco. A first step is accede to the World Health Organization Framework Convention on Tobacco Control. At its core, FCTC is designed to protect public health by reducing consumption of tobacco products and creating a platform for farmers to choose to grow non-tobacco crops. In October 2014, countries will try to finalize protocols for the FCTC at the Conference of the Parties 6 in Moscow, Russia. By becoming a party to the treaty, the Government would potentially be able to be a leader implementing Articles 17 and 18 to address the social and environmental costs of tobacco. This will have a profound impact on tenant and smallholder farmers in Malawi, who are affected by the prices of tobacco. Key for the successful implementation of the FCTC, however, is effective implementation of Article 17 and 18 through which all countries have committed to helping farmers currently dependent on tobacco farming, including members of TOAWUM and other tenant and small holder farmers. These groups support a reduction of their dependence on tobacco farming and the creation of markets for alternative food and cash crops.” (31)

Policy implementation

Key informants mentioned several FCTC ratification barriers and different actors’ involvement in implementing FCTC articles.

The main barrier to FTCT ratification among key informants was the lack of political will. This was linked to the perception that tobacco is Malawi’s main source of foreign exchange. Some felt the Malawi economy is overreliant on tobacco, hence tobacco issues are overly political as it is considered a ‘strategic crop’. Such sentiments were clear from statements from several government officials published in newspapers.

“I want to further agree with the speech by the Tobacco Association of Malawi president that Malawi government must do all it can to ensure the FCTC’s recommendations through Articles 17 and 18 do not see the light of the day. We are aware that these articles are set for ratification during the forthcoming FCTC CoP5 [fifth session of the Conference of the Parties to the WHO FCTC] meeting this November in South Korea. I would like to assure the tobacco farmers and all stakeholders that the Malawi government will send a high-powered delegation to the meeting to ensure its position is safeguarded when it comes to tobacco matters. I know there is a question of Malawi not yet being party to FCTC, which we are being urged to accede. Let me advise: as government, we are following all [the] right procedures and steps to ensure we do what is best for the country’s citizens, and rest assured, this is under serious consideration.” – Speech by Minister of Agriculture, Tobacco Growers’ Day, 2014 (32)

There are other misconceptions of the implications of convention ratification related to tobacco as main foreign exchange earner. Some informants said the government fears that ratifying the convention implies implementing all articles – including FCTC articles 17 and 18, which discourage support for tobacco farming – and this would mean reducing tobacco production and negatively affecting the national economy.



“...probably fear ... unknown[s] from the government, probably they feel that if they sign the convention then automatically they will stop cultivating tobacco, which is not true. Because there some countries which are part and parcel of the convention, like Zambia and Zimbabwe, but they are still cultivating tobacco, so it's the fear of the unknown.” (0211, Health, Private/Non-profit, Male)

Further, there are competing interests among government ministries. Informants felt that in these competing interests, the MoH is less of a priority than the Ministry of Agriculture or the Ministry of Trade and Industry. As a result, efforts to accede, ratify and implement the tobacco control articles, as guided by the FCTC, face several challenges because the public health argument is not taken on board.

“... maybe because of the understanding that government has, that tobacco is a foreign exchange earner number one in this country, that's what they say. Whether this is correct, this is something that I have already explained [that] any efforts by the health sector to implement articles of the FCTC always face challenges in whatever form. I remember one time the MoH was advocating lobbying for use of DDT [dichlorodiphenyltrichloroethane] for malaria control for prevention of malaria but it hit a brick wall, why? The Ministry of Agriculture was saying if you use sort of a military style of implementation of spraying all, all the dwelling houses including offices, office spaces in this country, from Karonga to Nsanje in spaces of may be every year ... there was a much higher chance of eliminating malaria in this country, that's what our most of our neighbors have done, but it temporarily [hit] a brick wall. Then the argument of the ministry of agriculture was that there would be contamination of the [tobacco] leaf so, those are some of the examples.” (0208, Health, International Organization, Male)

“I think, in terms of barriers you might think of different agencies or departments, line ministries have different interests, so that one becomes a challenge. For example, Ministry of Agriculture, Ministry of Finance, they will see tobacco as ... a backbone of the economy, however, you will see that some other ministries will have challenges in terms of tobacco use including ministry of labor, whereby there are issues of child labor involved in tobacco farming you would have tobacco industry itself benefit from the proceeds of tobacco, so those are some of the barriers in terms of ratifying the FCTC or even implementing some of the articles within the FCTC, because I think FCTC was once tried to be tabled, but I think it has been rejected, so it was rejected I think cabinet did not approve ratification of FCTC so I think it means there are different stakeholders I think who had reservations in terms of ratifying the FCTC. I think of late, I think companies like TAMA and others, they still have a different view, towards I think implementation of such kind of frameworks or policies regarding tobacco use or farming, so those are some of the barriers which have affected ratification or coming up with policies regarding tobacco control.” (010109, Health, Government, Male)

One key informant felt that the main barrier to FCTC implementation is the perception that Malawi is not a smoking nation as smoking prevalence is low and most tobacco grown in Malawi is exported and smoked outside the country, which suggests that smoking is not a problem that warrants legislation and policies.

“[...] because of [a] lack of hospital equipment and other related things, people think that tobacco is not causing a lot of problems to the population of the country.” (0203, Health, Private/Non-profit, Male)

“Basically in Malawi ... it's for smoking, for snuffing ... maybe just 1% of Malawi tobacco is ... used in Malawi ... otherwise 99% of Malawi's tobacco is exported, so we are not a heavy smoking country. ... The tobacco that is being produced is exported.” (0212, Agriculture, Government-Parastatal, Male)

The tobacco industry's influence is another factor noted as a barrier to FCTC ratification and implementation.

Use of MSA in policy formulation

Several factors are barriers to MSA in formulation of tobacco legislation and policies. Most notably, key informants mentioned the conflict of interest among the various actors, especially in government. For example, key informants mentioned the divergence of interests of the MoH, Ministry of Agriculture and the Ministry of Trade and Industry.

"Unless maybe at the MoH but otherwise from the Ministry of Trade point of view, actually we are the ones, whenever there's those issues, we are the ones who are supposed to side with the tobacco production companies as the ministry of trade cause it's a forex earner so it's a big challenge to the [formulation process]. It's the same government: MoH wants something else, ministry of industry and trade wants something else, and Ministry of Finance wants something else. So for tobacco, the interests are coming from so many different angles ministry of agriculture, ministry of labour, etc. So tobacco, it's a problem, it will be a big problem, it's a challenge. (010302, Trade & Industry, Government, Male)

Some key informants noted a lack of responsiveness from government departments, despite interest from NGOs, as well as from other stakeholders. For other key informants, financial resources to support meetings for the policy formulation process were unavailable.

Use of MSA in tobacco policy implementation

Similar factors were mentioned by key informants as facilitating use of MSA in tobacco policy implementation. These include interest by several actors in NCDs and recognition that NCDs are a health issue and threat to economic productivity. One key informant attributed this to a shared common interest following the dissemination of the NCDs STEPS survey results.

"I think the working together basically is driven by the passion which a lot of organizations have towards reducing the chronic disease burden in Malawi. Because of the STEPs [Survey] findings which have been widely disseminated to all the key actors, we have realized that NCDs are a growing threat apart from the communicable disease." (0203, Health, Private/Non-profit, Male)

Barriers to MSA in implementation were similar to those mentioned regarding policy. These included lack of resources, differences in interests, and a lack of capacity to implement NCD programs. Of interest among the barriers mentioned, is the absence of civil society coordination in the implementation of NCD programs.

"The [other] major problem [is] lack of civil society coordination because many civil society organizations out there are not yet aware of the NCDs. To bring them together is practically a problem." (0203, Health, Private/Non-profit, Male)

One of the factors preventing MSA in tobacco policy formulation and implementation is lack of stakeholder interest. In other cases, other sectors are not involved, despite their willingness.

"No, we have never been involved. I think we tried to engage the Department of Environmental Affairs and the MoH, they never responded to get us involved. I think it is only recently that I think I had written a letter to WHO, that case had failed, and we don't have enough funds to do constitutional case, that's when WHO at least responded and then that's we had to have some linkage with the MoH. But we haven't really [been involved], we, we are getting there, but at least we are talking." (0205, Health, Private/Non-profit, Male)

3.4.5 Next steps for tobacco policy and implementation

The most probable thing to happen for Malawi regarding tobacco control is to accede and ratify the FCTC, if the momentum observed during this study continues. For instance, the Minister of



Agriculture disclosed the government's intention on FCTC during a visit one of the tobacco sales grounds (Limbe Tobacco Auction Floors) in 2014.

"Government is seriously considering ratifying the convention so that our voice as Malawi can be heard, especially considering that tobacco is a crop of strategic importance to our economy." Minister of Agriculture, speech at Limbe Tobacco Auction Floors (33)

The political motivation for FCTC ratification is evidently the need to fight for Malawi's stance on tobacco production from within the treaty. However, ratification is likely to be advantageous towards tobacco control policy since Malawi could learn from the experiences of other countries who ratified the convention but are still in transition.

Beyond FCTC ratification, the sustainability of the national economy and tobacco farmers' livelihoods should be assured. Therefore, the introduction of tobacco control policies should be accompanied by introduction of economic diversification interventions. This was also expressed during key informant interviews whereby one key informant felt that ratifying the convention would 'force' the country to think seriously about diversification and reduce its overreliance on tobacco.

3.5 Alcohol Control Policies

3.5.1 Alcohol policy content and history

Existing alcohol policies

The policy documents and legislation on alcohol control reviewed were: 1979 Liquor Act; 2015 Liquor (Production, Marketing and Distribution) Regulation, Malawi Gazette Supplement 30 April 2015; MBS Act; Taxation Act (2006); Road Traffic Act (1998); Consumer Protection Act (2003); the National Alcohol Policy (cabinet paper, 2015); National Road Safety Strategic and Five-year Action Plan (2015-2020); Drug Control Master Plan (2005); National Action Plan for Prevention and Management of NCDs in Malawi (2012-2016); Nutrition Guidelines for Prevention and Management of DRNCDs; and National Health Promotion Policy (2013). The documents were assessed by how well they addressed the WHO NCD best buy interventions. These policy documents mentioned alcohol regardless of intervention type. Only those with interventions that directly or indirectly relate to the WHO NCDs best buy interventions were further assessed for extent of MSA at formulation and implementation.

Policy objectives/rationale

The Road Traffic Act (1998) was developed to control RTAs by road users. It stipulates the optimal requirements of vehicles, drivers, and other road users to prevent accidents. The act restricts driving under the influence of alcohol or with excessive amount of alcohol in the blood; driving a vehicle when one has consumed intoxicating alcohol (allowing a maximum alcohol level in blood or urine of no more than 0.08mg per 100ml or 0.08mg per 210 liters of breath). It is expected that people will not consume excessive alcohol, especially when driving and thereby contributing to the prevention and control of NCDs.

The 1979 Liquor Act was developed to give powers to local governments to regulate the manufacture and retail sale of opaque and traditional beer by granting permits/licenses to alcohol manufacturers.

The Consumer Protection Act (2003) was developed to protect the rights of consumers, address the interests and need of consumers, establish a consumer protection council, and provide an effective redress mechanism for consumer claims and similar matters. The objective



of the act is to protect consumers by protecting their economic interest, health and safety in the consumption of goods and services. Although the objectives of this act are concerned with harms caused by the product quality and not harms caused by the patterns of consumption, the act indirectly contributes to control of alcohol misuse by monitoring alcohol standards set by the MBS specifications as well as the recent 2015 liquor distribution regulations.

The Taxation Act (2006) empowers the government through the Commissioner of Taxes to collect from businesses and individuals with income source within the country. The government can closely monitor the type of business and assess whether it complies with the requirements for operation.

MBS Act (2012) established MBS as a parastatal organization, and the Malawi Standards Board to promote standardization and quality assurance of manufacturing, production, processing or treatment of commodities, including alcoholic beverages, for public consumption. In collaboration with the 2015 liquor regulations, the MBS regulates quality by only recognizing liquor products that abide by the standards. Through this act, the bureau develops and issues standards, makes arrangements to provide facilities for testing and calibration of precision instruments, provides for the testing of locally manufactured or imported commodities, and controls standardization mark use. There are mainly four standards regarding alcohol: MS 50:1988 beer specification; MS 208:1990 opaque beer; MS 107:1988 alcohol beverages; and MBS 210:1990 spirits specifications.

The 2015 Liquor Production, marketing and Distribution Regulations (Malawi Gazette Supplement of 30 April 2015) were developed to prohibit/ban manufacturing and importation of intoxicating liquor packaged in plastics or polythene bags, as well as the packaging of industrial-grade ethanol for consumption purposes. They also aimed at regulate the quantities and packaging standards of alcoholic beverages. The regulations control and prevent the availability of cheap liquor, eventually stopping people from consuming liquor in harmful quantities.

The National Alcohol Policy (January 2017 cabinet approval), which is an overarching policy document for control of harmful use of alcohol in Malawi, was developed to “increase awareness of the effects of alcohol and curb harmful consumption of alcohol including underage drinking through provision of a comprehensive mechanism for developing, implementing, coordinating, monitoring and evaluating health, social and economic interventions related to harmful alcohol consumption in Malawi” (34). The policy aims to reduce the health and social burden caused by alcohol abuse through the following strategies: ensure effective regulation of alcohol product availability; promote health services’ and other sectors’ response to alcohol abuse, ensuring the reduced demand for alcohol products through behavior-change interventions, and monitoring, surveillance and research on harmful use of alcohol.

The National Road Safety Strategic and Five-year Action Plan (2015-2020) guides operations and actions on road safety issues. The plan aims to curb driving under the influence of alcohol. Although targeted at motor vehicle drivers only, this policy document contributes to the control of harmful consumption of alcohol through provision of monitoring equipment such as Breathalyzers and random sobriety checkpoints.

Extent to which best buy interventions are addressed

Among the alcohol-related policy documents reviewed, only four addressed WHO best interventions. Of the three for NCDs, which are tax increases, bans on alcohol advertising and restricted access to retailed alcohol, only access restriction had wider coverage among the four documents. For instance, the 1979 Liquor Act stipulates the permitted hours for supply of opaque beer from 6am to 10pm, and it can only be supplied by permit holders approved by the



local government. The act also stipulates the age limit for persons to buy beer, so those under age 18 are not allowed to buy it, contributing to the reduction in access.

The 2015 Liquor Regulations address the same best buy intervention by imposing restrictive standards on intoxicating liquor packaging, production, and quantities requirements. The restrictions control the wider availability of alcoholic beverages in small quantities, which are cheap and easily accessible.

On the other best buy interventions, the HSSP (2011-2016) and the National Alcohol Policy advocate for tax increases for alcohol but do not provide the actual implementation strategy. However, the trend of the 2011-2014 annual tax regimens show that taxes imposed on alcohol sachets rose by 150%-300% until they were banned in 2015. Advertising bans are not covered in any alcohol policy document. Although the National Alcohol Policy touches most WHO recommended policy options, the two best buy interventions of tax increases and advertising bans are not specifically covered.

A summary of the best buy interventions included in the reviewed alcohol policies is shown in Table 6, but all contents – including the other interventions included, the implementation plans as well as the monitoring and evaluation plans of all the alcohol-related policy documents as identified by the desk reviews – are detailed in Annex 3.

Table 7: Inclusion of WHO “best buy” interventions in alcohol policies

Policy	Best buy intervention addressed	Year of development	Source of information (Reference number or interviewee code)
1979 Liquor Act	Restricted access to the retailed alcohol	2001	Desk review
2015 Liquor (Production, Marketing and Distribution) Regulation, Malawi Gazette Supplement of 30 April 2015	Restricted access to the retailed alcohol	2015	Desk review
MBS	None	2012	Desk review
Taxation Act	None	2006	Desk review
Road Traffic Act	None	1998	Desk review
Consumer Protection Act	None	2003	Desk review
The National Alcohol Policy (cabinet paper, 2015)	Restricted access to retailed alcohol; and Proposes Tax increases.	2015	Desk review
National Road Safety Strategic and Five-year Action Plan (2015-2020)	None	2015	Desk review
Drug Control Master Plan	None	2005	Desk review
National Action Plan for prevention and Management of NCDs in Malawi (2012-2016)	None	2012	Desk review
Nutrition Guidelines for Prevention and Management of DRNCD	None	2009	Desk review
National Health Promotion Policy	None	2013	Desk review
National Health Sector Strategic Plan	Proposes Tax increases	2011	Desk review



Other interventions included:

Despite shortfalls in addressing the WHO best buy interventions, the alcohol-related policies include other alcohol harm reduction interventions. These are detailed in Annex 2, but some of the interventions are covered below.

The drink-driving countermeasures as covered by the Road Traffic Act and the Road Traffic Strategy: It does not tackle access restrictions. The act restricts excessive alcohol consumption by setting thresholds to blood, urine or breath concentrations, but the limits are still above current WHO recommendations. The National Alcohol Policy proposes a review of the Road Traffic Act to lower the threshold below the current standard.

Increase awareness of alcohol-related harm through education and community mobilization: the best buy interventions can be effectively implemented when the general population is well informed. Awareness-raising and behavior change interventions were included in the National Alcohol Policy, the Health Promotion Policy, National Action Plan for prevention and Management of NCDs in Malawi (2012-2016), the Nutrition Guidelines for Prevention and Management of DRNCDs, the Consumer Protection Act and the Road Traffic Safety Strategic Plan.

Laws and regulation enforcement is another intervention included in the policies, as implementation cannot be effective without strong enforcement. Finally, health systems' response is highlighted as an intervention by the Malawi National Alcohol Policy. This intervention promotes early identification and relevant treatment interventions to individuals who are at risk or already affected by harmful use of alcohol.

Implementation/action plans stated

All the reviewed policy documents indicated implementation plans with lead institutions. Implementation of most policies are at sectoral/departamental/ministerial level, with uncoordinated inter-sectoral linkages (see Annex 3). However, the National Alcohol Policy recognizes the importance of institutional MSA in implementation. Therefore, it calls for the NCA, which comprises ministry directorates, NGOs, CSOs, the police and others, to be responsible for the technical direction and implementation of alcohol-control programs. The policy also highlights IMCDC's critical role in policy oversight.

Monitoring and evaluation plans

Monitoring and evaluation plans included in most of the alcohol-related policy documents lack specific monitoring indicators on alcohol harm reduction. Some documents suggest that process development and progress tracking is conducted as part of implementation. Annual reviews and mid-term evaluations were indicated in all the documents. However, by the time of the data collection, no key informant reported recent policy evaluation. It is therefore difficult to ascertain from this study whether the planned interventions were actually implemented.

A detailed monitoring and evaluation plan based on the implementation strategy is included specifically for the National Alcohol Policy. The plan focuses on performance monitoring in terms of whether the agreed-upon outputs and annual output targets are effectively and correctly implemented. It also looks at whether: the required resources [inputs] are provided in a timely manner; the outputs are being realized and if the outcomes are being achieved; and there is any impact on development of sustainable and reliable transport infrastructure.



3.5.2 Alcohol Policy process

Alcohol policy formulation process and important national events

According to presentations from the national NCD program manager (MoH) and the executive director of DFM at an alcohol policy implementation strategy meeting on 22 May 2013, a nationwide alcohol policy process started as early as 2006. The alcohol industry made the initial attempt, which was to develop policy that encourages responsible drinking. Some of the NGO and CSO representatives invited to the alcohol policy meetings organised by the alcohol industry recognised that any industry-initiated policy would not be comprehensive. Therefore the NGOs and CSOs decided to initiate another alcohol policy development process, this one involving relevant government ministries.

By 2009 a national task force (NTF) formed to develop a national alcohol policy. The NTF has members from all government-relevant departments such as Ministry of Home Affairs and Internal Security; MoH; Ministry of Education; Ministry of Trade and Industry; Ministry of Youth; Ministry of Local Government; Ministry of Gender; Ministry of Information; Ministry of Justice; Malawi Police Service; National Youth Council; and members from civil society organizations. Led by a consultant, the NTF collects ideas and views from the public. Eight districts were consulted on the need for a national alcohol policy with as much regional representation as possible. The consultation meetings took place at district commissioners' chambers, and stakeholders such as traditional leaders, teachers, religious leaders, local NGOs and the general public were encouraged to participate. A consultant hired by Norwegian NGO FORUT (For Utvikling/ Development) helped with the zero drafting of the policy, which was reviewed by NTF.

A national stakeholders meeting was held in June 2011 to validate the draft. Industry representatives were present and raised concerns following a formal written complaint to the government, citing concerns that they felt excluded from the process; the draft content demonised alcohol; and the document's 'awareness' component was weak. This necessitated further NTF review of the draft policy by September 2012 through coordination with MoH before moving on with to the endorsement process. Some positive industry input was addressed and incorporated in the pre-final draft.

In February 2013, the revised (pre-draft) national alcohol policy was presented to the health sector EHP TWG, where it was recommended to give formal feedback to the industry. The industry concerns were presented in a formal dialogue meeting chaired by the Secretary for Health on 7 March 2013. NTF developed a policy implementation strategy by 22 May 2013 and the draft national alcohol policy moved further on the endorsement processes, which includes presentation to: senior MoH management, the inter-ministerial principal secretary's committee, the parliamentary committee on health, and the cabinet committee on social and health issues. All these committees made comments that were taken into consideration when the final policy cabinet paper was submitted to the full cabinet in 2015.

Important international events/meetings

Some key informants observed a growing recognition on NCD importance worldwide. It was internationally noted that WHO has pushed the NCD agenda, with some stating that it is a WHO requirement for each country to have a policy on alcohol use.

"I think at the global level ... there has been a drive within the WHO to try and come up with control factors for NCDs." (0209, Health, International NGO, Male)

Reviewing the draft Integrated National Alcohol Policy (34) also reveals:

"In May 2010, the World Health Assembly endorsed the global alcohol strategy and urged all Member States to take appropriate action towards reducing harmful use of alcohol in their

respective jurisdictions. In September of the same year, African MoH endorsed the regional strategy to reduce harmful use of alcohol in the African region (WHO 2010), that takes into account specificities of the region, such as the need to address illegal and informal alcohol production and calls for integrated approaches to prevention and treatment.” (33)

Further, some key informants noted that the MoH started to recognize and prioritize NCDs following a WHO regional ministerial meeting held in Ouagadougou, Burkina Faso, in 2008.

3.5.3 Multi-sectoral involvement

As the policy indicates, and as mentioned by key informants, a wide range of actors were involved in the formulation of a comprehensive national alcohol policy in Malawi. The actors were from:

Government Ministries

- Ministry of Health
- Office of the President and Cabinet
- Ministry of Industry and Trade
- Ministry of Home Affairs
- Ministry of Local Government
- Ministry of Gender and Community Services
- Other government bodies/parastatals
- Malawi Bureau of Standards
- National Youth Council
- Teachers Union of Malawi

Non-governmental organizations

- Drug Fight Malawi
- Consumer Association of Malawi
- Diabetes Association of Malawi

International organizations

- For Utivikling/Development (FORUT)
- WHO

Research/academic institutions

- College of Medicine, University of Malawi
- Centre for Social Research, Chancellor College, University of Malawi

Actor involvement – leadership role

A review of the policy shows that MoH, through the NCDs and Mental Health Unit, took a leading coordination role in the national alcohol policy formulation process in 2011. It was supported by the WHO, which provided technical support; and DFM, which provided financial and advocacy support. From 2009-2011, the initial consultation and formulation process was led by the Ministry of Home Affairs and Internal Security with support from DFM and FORUT.

Level of involvement of each participating organization

The table below shows a summary of the level of involvement for each participating organization in alcohol policy processes.

Table 8 Level of Involvement in Alcohol Policy Formulation

Alcohol Policy Document	Actors	Level of involvement
National Alcohol Policy (final draft, 2015)	MoH (NCDs, health education; environmental, nursing, policy and planning units)	High: leading role in development and implementation; coordination by NCDs unit
	Home Affairs and Internal Security	High: Initial lead ministry (2009-2011), active participation throughout formulation and a key enforcement agency for some policy strategies
	FORUT; Drug Fight Malawi; Malawi Alcohol Alliance (MAPA) network	High: financial, technical and advocacy support
	WHO Country Office	Technical support
	Ministry of Industry and Trade; OPC; Education, Science and Technology; Local Government and Rural Development; Information and Civic Education; Gender, Children and Social Welfare; Justice; Labour; Youth and Sports; Malawi Police Service; RTD; National Youth Council; Malawi Bureau of Standards; National Road Safety Council; Teachers Union of Malawi; Malawi Human Rights Commission; Malawi Network of AIDS Service Organizations (MANASO); NGO-Gender Coordination Network; Malawi Girl Guides Association; Boys Scouts Association of Malawi; Journalists' Association Against AIDS	Medium: stakeholders involved as part of national task force during alcohol policy formulation; active participation in the writing and review meetings
2015 Liquor (Production, Marketing and Distribution) Regulation	Ministry of Industry and Trade; including Malawi Bureau of Standards	High: Leading government agency at formulation; mandated by the cabinet to curb access to cheap liquor
	MoH	High: Technical information provider at formulation level
	Ministry of Justice	High: Writing and gazetting
	Ministry of Local Government	High: Formulation and implementation
	Ministry of Home Affairs and Internal Security	Medium: Law enforcement at implementation
1979 Liquor Act	Ministry of Local Government; local councils	High: Involvement at both the formulation and implementation levels

Funding for the process

Key informant interviews and a review of the alcohol policy revealed the formulation process received financial support from FORUT through DFM. FORUT financially supported all community engagement activities, writing and stakeholder review meetings.

It was noted that there is no designated funding for alcohol control in the government budget.

“... I think one of the challenges is that there is no actual funding that you can say is specific ... for the regulation of alcohol policy. It's scattered. You will find little pieces of money at MoH level, some resources at council level, at different ministries, in NGOs, but nothing consolidated into one, let's say, 'resource basket' ... specifically ... for alcohol control and regulation.” (0201, Health, NGO/Non-profit, Male).

The policy mentions government annual budgetary allocation to alcohol control programs through relevant implementing ministries as well as support from partners as a financing plan.

MSA application at policy formulation

It was evident that MSA was fully applied at the national alcohol policy's formulation level. Key informants argued there were benefits for involving several sectors in NCDs policy development. Involving several sectors allowed a variety of opinions to inform policy options.

"I think the benefits were that we were able to share the information, which I think maybe as ... one person you may not have that broad perspective to the issue. So I think bringing together several stakeholders enriched the policy development process." (010105, Health, Government, Male)

Some felt involving several sectors improved ownership of the policy formulation process, hence making implementation potentially less difficult.

"So I think it was important to have ... various views and ideas into the policy, so if you involve those sectors, ownership of that law, I think people will own it other than just involving those few people. I think the ownership of the law cannot, I mean, can be challenged, but if you involve everybody, each and every sector, for example, as I said, the retailers, I think if they know at the beginning of the formulation of the law, I think it is important for them because they will own it, and I think implementation will not be difficult." (010105, Health, Government, Male)

MSA application at policy implementation

Key informants said multiple sectors' involvement is important, even at implementation level, because roles including public awareness, advocacy and enforcement are all are required for effective policy implementation.

"It's not only the MoH or Ministry of Home Affairs which are supposed to implement it. Each sector has a role in the implementation of the alcohol policy ... because for the implementation, it's not [a] one-man show. It involves other sectors for it to be implemented." (010201, Home Affairs, Government).

"As NGOs, the role is mainly to do continuous advocacy in relation to the dangers of heavy consumption of alcohol. Also lobbying for the enforcement of the policy, like for internal security home affairs to assist in addressing the challenges encountered." (010103, Health, Government, Male)

3.5.4 Implementation, monitoring and evaluation

Key informants were not impressed by policy implementation for alcohol control in Malawi. Some of the issues these policies were meant to address continue to be rampant despite the Liquor Act existing since 1980.

"My personal opinion is that I don't think much is being done, because with alcohol, we have seen how ... youth abuse [it] ... even adults ... Alcohol is abused and ... I don't think there's much that is being done, in my own opinion, to make sure that youth are not abusing alcohol. Especially in places like colleges, you find that some of the youth don't do well in colleges or even in other schools, secondary schools, because they indulge in alcohol." (010107, Health, Government, Female)



The comprehensive National Alcohol Policy in Malawi (2015 cabinet paper) is yet to be implemented. It awaits final endorsement by the full government cabinet to become official policy. Some informants perceive this delay as resulting from alcohol industry influence.

"I cannot say that the policy has been implemented because the policy has not yet ... it hasn't been endorsed yet. The national alcohol policy is not functional ... because government through cabinet has not yet endorsed the national alcohol policy ... I don't know why they are delaying, maybe there are a lot of technical issues ... I think the government is dilly-dallying because of the pressure ... from the alcohol industry. That is a fact because you know what ... there is a threat ... the national ... I mean the alcohol industry ... you know they are not happy with the national alcohol policy because they feel [it] is aimed at reducing their profits." (0203, Health, Private/Non-profit, Male)

However, one policy option proposed by the national alcohol policy, banning access to alcohol sachets and regulating alcohol packaging, was implemented via the 2015 liquor (production, marketing and distribution) regulation. Alcohol sachets are no longer on the open markets, although 200ml plastic bottles of spirit alcohol at concentrations similar to the banned sachets proliferate the markets. This contravenes the regulation that alcoholic beverages must be packaged in clear glass bottles (2012 MBS Act, 2015 Liquor Regulation).

"Best buy" interventions implemented so far

The strategies for restricting retail alcohol access were partially implemented through licensing of manufacture and sale premises; and banning alcohol packaged in sachets and plastic bottles. Although these efforts limit affordability, enforcing the strategies continues to be erratic.

Outputs and outcomes of implementation

The 2015 liquor regulation was partially an output of the national alcohol policy since the regulation addresses many of the issues raised by it. However, implementing the ban of alcohol sachets was followed with proliferation of 200ml bottles that were slightly bigger than the 100ml pouches. The bottles are still relatively cheap as they are packaged in plastic. Local councils and the Department of Home Affairs, through police officers, monitor sachet availability but not the packaging regulation.

3.5.5 Facilitators and barriers for alcohol policies

Several factors facilitated the collaboration of different sectors in formulating the alcohol policy. Key among these is the vibrant DFM NGO, which led the process. DFM was instrumental in the formulating the policy. The initial stages of development were led by the Ministry of Home Affairs and Internal Security through the Inter-Ministerial Committee on Drug Control. It was later agreed that MoH should lead the policy formulation. Ministerial backing also made the process a national issue and improved participation of different sectors. Further, most sectors were dedicated to the process of the formulating the policy.

One of the factors that facilitated MSA was a common understanding of the problem among actors. Each stakeholders felt there was a need to formulate this policy.

"I think basically we all saw that we had a common interest. In terms of how the MoH presented the problem, everyone saw that it was a serious issue, how alcohol was being abused by children ... so the biggest factor was that one, just cause everyone saw that this is serious, let's tackle this issue, develop a policy and after that maybe we have to have a regulatory framework and

some laws. So the biggest factor was simply the seriousness of the problem.” (010302, Trade & Industry, Government, Male)

While all stakeholders were keen on developing an alcohol policy, it was based on different perceptions of the problems that alcohol causes. Interests ranged from perceived negative impact on education, especially among young people; road traffic accidents and increased cases of gender based violence; and increasing prevalence of NCDs.

Regular update meetings and communication among stakeholders was also highlighted as a key factor for MSA in the policy’s formulation. This was made possible with availability of limited funds.

“So there were these back and forth communication[s] between the regional office and the country office, and the other stakeholders at the national level, providing the advice, to what extent can we ... involve the industry. So those were some of the key ... guidelines to make sure that the process of developing the policy was ... actually ... meeting the public health objectives that [it was] previously intended for.” (0208, Health, International NGO, Male)

Barriers for use of MSA in policy formulation

Key informants identified several challenges to involving different stakeholders. One barrier was funding, as there was limited available to involve different stakeholders in meetings and workshops.

“I think costs. Meetings costs, you know. The NCD unit sometimes did not have the funding, probably that also could be the reason why they couldn’t have so many people.” (010102, Health, Government, Female)

“Well I think the ... one of the challenges is resources, to try and get everybody’s opinion on board, of the different stakeholders.” (0209, Health, International NGO, Male)

The second barrier was coordinating the different sectors to get their views. The variety of sectors meant contrasting opinions, which was difficult to accommodate.

Further to this, different people represented the sectors were at different meetings and workshops. Sometimes there was no proper handover of discussion points for subsequent meetings. High staff turnover most commonly affected government ministries and departments.

“The major challenge was coordination. If you are having different sectors, the first thing is, it’s not possible to have consistent participation of the members saying this, so you keep on having new members coming in, some members being transferred, of course some of the sectors like education, some of the NGOs, civil societies like Teachers Association of Malawi would have permanent members who even up to now if saying we are having a meeting to look at, take stock of what has happened of the alcohol policy, they would still come, the same people, even in Home Affairs, we still have same people who have been in the process from that beginning to the moment, but other sectors like Ministry of Trade would have a senior person coming in, and would have a junior person coming in, and that sort of sometimes caused problems.” (0208, Health, International NGO, Male)

“I think the biggest challenge was continuity whereby you are doing a process, a policy process, and whenever you call a meeting, a different person comes in. You call another meeting, a different person who doesn’t know that process comes in, you know how the government sometimes ... works. It was a big challenge just ‘cause there was the problem of continuity. And of course logistically just ‘cause nowadays some people just come to meetings as long as they will be paid and stuff ... but that was a minor challenge just cause the Norwegians were providing the funds for all those meetings.” (010302, Trade & Industry, Government, Male)



Conflict also arose between different sectors due to differences in mandates and objectives. Initially, there was competition as to who would lead the process between the MoH and the Ministry of Trade and Industry.

The alcohol industry was again noted as a barrier. Initially, the industry took part in discussions on alcohol policy formulation. During these meetings, alcohol industry representatives reported facts that countered what government and NGOs presented, specifically arguing that alcohol is not as harmful as the NGOs claimed. The industry also tried to influence members involved in the alcohol policy formulation.

"When you look at the alcohol industry, the way I've seen them behaving is that they will make direct contact with those who are trying to formulate ... the policy or the different key ministries that are stakeholders, so they'll also approach the ministers and they'll give them a reason why alcohol is important to Malawi. They give [a] very convincing story, taxes and so on and so forth, the effects on the budget and so on and so on, but they don't really talk about the health impact of alcohol, health and social impact of alcohol. So they'll go to influential leaders of the society to try and get them on their side and maybe to try and reduce the progress of the alcohol policy rolling out." (0209, Health, International NGO, Male)

Barriers for use of MSA in alcohol policy implementation

One MSA barrier was the perception that each sector has its own mandate and doesn't have to implement the policies/guidelines of other sectors.

"I wouldn't say they were necessarily coming together to implement but I think sections were implementing as sections because they have the mandate to do that, they are mandated to do that. For example, the home affairs or the police, they are mandated to look after or to enforce the laws, because of that they are able to implement because it's their mandate. The same with other players, they have certain mandates which they are supposed to fulfil. So I think that if a ministry or any institution has been given a mandate, then they are better placed because there will be lesser questions ... as to why you are doing this when X is supposed to do that." (010105, Health, Government, Male)

Some key informants also felt conflicting interests prevented different sectors from working together.

"Maybe the other factor would be different interests at certain levels within the government. As the Ministry of Trade, you may want to implement something else, but maybe at the MoH, they want to implement something else. So how at certain levels within the government system there is no corroboration at very higher levels, just because of mainly politics. The issues of politics and again maybe some personal interests at certain levels within the government framework. But otherwise at certain level, at lower levels, people are always ready to work together but there are people who are supposed to make the decisions ... And again issues of knowledge, just because I may know issues of alcohol, I may know certain issues but maybe someone at management levels maybe the PS [Principal Secretary], he doesn't care, he doesn't know what is there. For example this is Ministry of Industry and Trade [and yet] you are talking about NCDs. I understand what you mean just because there are issues of tobacco,...but somebody might say this is about diseases, this is MoH." (010302, Trade & Industry, Government, Male)

Barriers for general alcohol policy implementation

Lack of law enforcement is the main perceived barrier to implementation.

"The challenges are ... there is no enforcement of the laws. Now our laws say that somebody below the age of 18 should not be found in the bottle stores, but those laws are not being enforced. So enforcement of the laws is very weak in Malawi. So that that is a challenge." (010402, Youth, Government, Male)

Lack of enforcement leads to non-adherence to the regulations and non-implementation of interventions. For example, there is a proliferation of illegal liquor sale points because licensing regulation is not enforced.

3.5.6 Next steps for alcohol policy and implementation

The National Alcohol Policy (2015, cabinet paper) should be approved to resume full implementation. If the proposed implementation structures are instituted, coordination is enhanced and monitoring becomes feasible. However, there is no guaranteed financing mechanism, which leads to piecemeal implementation. A committed national budgetary allocation to the National Committee on Alcohol is one way to sustaining implementation.

3.6 Healthy Diet Policies

3.6.1 Existing healthy diet and nutrition policies

In total, three policies addressing healthy diets in Malawi were reviewed: NNPS, Nutrition Guidelines for Prevention and Management of DRNCD (2009) and the National School Health and Nutrition Policy (2015).

Other policies and guidelines based on nutrition but not directly related to promotion of healthy diets for NCD control are:

- Strategic plan for 0-1000 days child nutrition (SUN MOVEMENT)
- Adoption of six food group policy/guidelines
- National Nutrition Education and Communication Strategy

In addition to the desk reviews, key Informants were asked their views on how healthy diets are promoted to control NCDs. Nine key informants (six from government sector and three from private/non-profit sector) responded to questions about policies related to healthy diet promotion. They worked in the following areas: health, trade, sports and agriculture.

Table 1: Summary of nutrition and diet policies

Policy	Best buy intervention addressed	Year of development	Source of information (Reference number or interviewee code)
NNPS	Best buy number 3 through sensitization campaigns on good nutrition and balanced diet to prevent malnutrition	2009	Desk review
Nutrition Guidelines for Prevention and Management of DRNCDs	None addressed	August 2009	Desk review
National School Health and Nutrition Policy	None stated	2015	Desk review



3.6.2 Nutrition policy content and history

Policy objectives/rationale

NNPSP was formulated from 2007 and launched in 2009 by the Department of Nutrition, HIV and AIDS in the office of the President and Cabinet and is the guiding document for championing government priorities on nutrition. It is designed for all nutrition stakeholders, including government; civil society and faith-based organisations; the private sector; and development partners. It provides the framework and context to formulate, monitor and coordinate sectors and other strategic plans and recognises the role of MSA in nutrition-related interventions.

The rationale of the policy is to address elevated levels of malnutrition in Malawi due to previous policies failing to make significant impact. According to one key informant, the rationale was to improve nutrition at national level due to increasing yet preventable nutrition-related disorders.

“As I’ve already said, just cause it has so many interventions, which were already being done or implemented, ... because we wanted to have a proper framework for better coordination and to avoid duplication, that’s why we had to form the policy framework for the implementation.”
(010302, Trade & Industry, Government, Male)

The guidelines provide information on essential actions to prevent and manage DRNCDs for individuals who do and do not have disease or disorder. They were developed as one way of the implementation of the NNPSP, which expressed government’s commitment to reduce DRNCDs.

Principles/values stated

NNPSP (2007-2011) set 12 guiding principles: political will and commitment; good governance; rule of law; economic governance; human rights; accountability and transparency; community empowerment; sustainable use of natural resources and systems; gender equity; equity in nutrition for vulnerable groups; and science and evidence-based interventions.

Extent to which best buys and other interventions are addressed

The WHO best buy interventions for control of unhealthy diets include: reduced salt intake, replacement of trans-fats with polyunsaturated fat, and public awareness through mass media on diet.

NNPSP (2009) does not explicitly state any best buy interventions related to diet, but it “promotes healthy life styles, diet diversification, increased public nutrition education and awareness” (24). This is closest to best buy intervention #3. The policy also recommends the need for control of nutrition-related NCDs through developing and reviewing NCD guidelines and recommendations.

In terms of salt intake, NNPSP advocates for promotion the use of iodized salt through raising public awareness of iodine. The guidelines also promote awareness on breastfeeding, support for lactating mothers, behaviour change towards prevention of disease, and practicing health-seeking behaviour.

Although NNPSP is already involved in public awareness, these activities are not based on best buy interventions. Further, promoting use of iodized salt could be mistaken as promotion of salt intake, which would contravene the best buy intervention on reducing salt intake. Also important is the fact that NNPSP does not mention polyunsaturated fats.



Implementation/action plan

The NNPS (2007-2011) has an implementation framework that emphasizes the need of MSA for implementation. According to the NNPS, nutrition is a multi-disciplinary issue that requires a well-coordinated MSA. It notes that a lack of an institutionalised coordinated mechanism for nutrition, resulting in duplications of interventions and convergence of resources, is one of the factors contributing to non-effectiveness of past interventions. However, it does not provide clear strategy by which MSA would be implemented.

To ensure coordination during MSA implementation, a new institutional arrangement was set up within the government to strengthen nutrition coordination structures at national and local levels. In its role of provision of policy direction, guidance and oversight, the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet is responsible for coordinating implementation, monitoring and evaluation of NNPS. The NNPS also emphasizes the need to strengthen sectoral capacity at national and local authority levels to effectively coordinate programme implementation. It lists critical stakeholders for the policy implementation, including civil society and faith-based organisations, the private sector, and development partners.

The NNPS recognises policies from other sectors that “complement it by addressing other critical determinants factors of human well-being which have not been included in the NNPS since they are best addressed by other sectors” (24). These policies are from: agriculture (Agriculture and Food security policy [2006], Fisheries and Aquaculture Policy [2001], Strategic Plan to Improve Livestock Production [2003-2008]) and gender (Gender Policy [2000] and Implementation Plan [2004]). It also recognises other policies within the health sector that complement its activities, including Reproductive Health Policy (2002), EHP (2002), MoH Plan (1999 – 2004) and Programme of Work (2004).

Apart from complementary policies, the NNPS notes other policies that operationalise its activities from different sectors, including: education (National Education Sector Programme [2009]), agriculture (Agricultural Development Programme [2008]) and gender (Integrated Early Childhood Development Policy [2004] and Accelerated Child Survival and Development Plan [2007-2011]).

Even though the NNPS only emphasizes the need for MSA in implementation, it is clear that implementation hinges on inter-sectoral coordination. There is need to clearly spell out the responsibilities of not only the coordinating body, but also other stakeholders and actors within the health sector as well as in other sectors including education, gender and agriculture.

Monitoring and evaluation plan

The NNPS includes a monitoring and evaluation framework that tracks implementation and monitors results at impact and outcome levels. Building on systems established during the implementation of the NNPS, the monitoring and evaluation system tracks high-impact nutrition interventions that can be quickly upscaled.

Key monitoring activities include: quarterly field monitoring visits to check progress on service delivery and implementation of activities; national integrated nutrition surveillance to track output and outcome indicators; biannual nutrition review meetings; Nutrition Steering Committee Meetings/Government Development Partner Meetings; and the development of a database to coordinate information storage and easily access nutrition information analysis.

Key evaluation activities include: construction of baseline targets, annual nutrition sector reviews, periodic nutrition surveys, mid-term and end-of-NNPS evaluations.



Nutrition and diet policy formulation process

Data on policy formulation processes was collected through desk review and interviews with key informants involved in policy formulation. From the desk review, it was clear that NNPS (2009) underwent a two-stage process in formulation from October 2008 to March 2009. The first process involved nationwide consultations with men, women, youth, service providers, policy makers, traditional leaders, donors, civil society and local authorities through workshops, focus group discussions, and face-to-face meetings at national, district and community levels. This process culminated in five documents: policy, strategic plan, programme, business plan and communication plan. The second process involved consolidating these documents, which involved “initial consolidation by a multi-sectoral TWG and engagement of experts through a local consulting company, to speed up the finalisation and ensure alignment of the policy and strategic plan to the MGDS”(24). These experts were backstopped by a task force comprising key sectoral ministries involved in nutrition work, such as Health, Agriculture, and Education, as well as representatives of development partners and civil society, chaired by the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet, who was mandated to provide guidance and quality control.

3.6.3 Multi-sectoral involvement

Formulation of NNPS (2009) included several actors from government, development partners and civil society. A review of the policy documents does not specifically list the key sectoral ministries involved in the formulation of the policy. However, data from key informant interviews reveals the actors who were involved in the formulation of the policy. Key informants within the government indicated that the following ministries were involved in the formulation of the NNPS: Office of the President and Cabinet (through the Department of Nutrition, HIV and AIDS), Ministry of Health, Ministry of Agriculture, and Ministry of Industry and Trade. The formulation of the policy and strategic plan also included the following: academic institutions (Bunda College of Agriculture, Chancellor College), Consumer Association of Malawi (CAMA) and United Nations agencies, including WHO, UNICEF and the Food and Agriculture Organization (FAO).

The process of formulating the NNPS was led by the Department of Nutrition, HIV and AIDS in the Office of the President. The department hired a consultant who led the process of drafting the policy document. Other stakeholders were only participated in document review meetings.

“The nutritional policy formulation cuts across all the sectors in the government. It also includes what we call non-state actors, those who are not in the government. We all formulated it [the Nutrition Policy] under the leadership of the Department of Nutrition HIV and AIDS, the coordinating office, it’s supposed to be the coordinating office for all the nutrition [issues] in the country.” (010702, Agriculture, Government, Female)

3.6.4 Implementation monitoring and evaluation

NNPS (2009) implementation was meant to start from 1st January 2007 to 31st December 2011. The formulation process was delayed and the policy was only launched in 2009. The NNPS states that some activities were already being implemented when the NNPS was launched in 2009.

Key informants revealed that there was implementation of policies and guidelines promoting health diets although they were not directly meant to address NCDs. Informants highlighted that only recently has this been emphasized.

"I can mention the national nutritional policy to be one of the policies, which has a lot of attention ... So there are a lot of organizations who are doing a lot of activities in terms of NCDs." (0203, Health, Private/Non-profit, Male)

The main activity that is being implemented is advocacy and nutritional education.

"Implementation goes on. It hasn't stopped because implementation is, according to the different [areas of] ... our ... focus, we implement according to our areas of focus, so for us, we subscribe to things like diversified production, looking at how agriculture program[s] should ... not only be producing but also produce to ensure that it contributes to good nutrition. We also have nutrition education. In addition to that, we also consider the different vulnerable groups." (010702, Agriculture, Government, Female)

As noted above, the NNPS does not include specific best buy interventions, so such interventions have not been implemented.

Funding available for implementation

Participants indicated there were two main funding sources for implementation. The first source of funding is the government, which provides for day-to-day activities, although one participant noted the funding is always inadequate.

"We normally get funding in this department, but the past year it hasn't been easy. Normally we get other recurrent operations money, which has always been underfunded so much ... [and] because of lack of funding we haven't done much in terms of research." (010107, Health, Government, Female)

Apart from government, several organizations were mentioned as providing funding for implementation of nutrition-related policies, even though their focus was not specifically NCDs. Many support interventions for malnutrition in HIV-affected adults and children under age 5.

"I think many people know about nutrition, unlike NCDs to be specific. So there are a lot of attention ... there is Save the Children, the Bill and Melinda Gates [Foundation]. You know there are lot donors, a lot of NGOs who are supporting that." (0203, Health, Private/Non-profit, Male)

"We have different types of funding. For example, one of the biggest programs we have in this department is [funded by] the World Bank. We have World Bank and we also have funding from Irish AID. But we also have indirect funding from UNICEF and from USAID. We have other smaller programs or international NGOs that also provide funding for example there's Catholic Relief Services, DAPP and other smaller organizations [that fund activities]." (010107, Health, Government, Female)

3.6.5 Facilitators and barriers for nutrition policy formulation

Key informants mentioned several factors that facilitated NNPS (2009) formulation, one of which is the coordinating department responsible for budgeting and bringing together different actors.

"We have a department which was coordinating, I don't know what it's going to be now, but was coordinating, so they tried to have everybody working together ... You do your part in terms of the budgeting, in terms of the implementation, so those are some of the factors having this coordinator." (010102, Health, Government, Female)



Another key informant cited the role of external influences, mentioning a WHO study that showed the extent of malnutrition in several countries, including Malawi. The Global Alliance for Improved Nutrition was also advocating for the development of nutrition policies in SSA.

Participants also identified barriers dealing with nutrition and diet. One barrier was the fact that of the many policies formulated, they are dis-linked. There is need to tailor the existing policies to suit the calls for healthy diets for prevention and control of NCDs.

Another key barrier was the delays of other ministries. For example, the Ministry of Justice was delaying the formulation of the food law despite the MoH already formulating it.

Use of MSA in policy formulation

Several factors facilitated MSA in policy formulation and implementation. Goal-sharing was cited as one factors that enabled sectors to work together on the implementing the nutrition policy.

"As government we want to make sure that we reduce the figures of the children that are malnourished. We want to make sure that at least people are healthy; they are eating well. And then the UN ... I think the concern I can say is the same for everyone. And we would like to make sure that we ... unite all the forces to make sure that at least a child has good nutrition, a pregnant woman has good nutrition, and everybody else is eating well. I think the unity of purpose ... has made us to work together very well." (010107, Health, Government, Female)

Similar to policies in other sectors, bringing together actors with different interests and objectives prevents the use of MSA in formulation and implementation of policies promoting healthy diets.

"Yeah the experiences is that it's a challenge to come up with those documents ... because you have to tailor them to suit other policy documents from other sectors. So that is a challenge because the way you look at an issue is not the same way the MoH will look at the same issue. So those are the challenges to tailor the document in respect of other policy documents from other sectors. It's a challenge." (010402, Youth, Government, Male)

Incorporating diverse interests was also perceived as a barrier to MSA as it requires more time for actors from different sectors to reach a consensus.

3.7 Physical Activity Policies

The WHO best buy intervention addressed is the promotion of public awareness through mass media on physical activity. Two of the four documents reviewed highlight this need.

In addition to the desk review, key informants shared their views on how physical activity is promoted in the country through policies. They were asked about policies promoting physical activity and how the policies were formulated. Only five key informants, all from health, sports and the police services, discussed physical activity policies.

3.7.1 Physical activity policy content and history

In the desk review, four documents were reviewed that were related to physical activity in Malawi including: the National Action Plan for Prevention and Management of NCDs in Malawi (2012-2016), National Health Promotion Policy (2013), Nutrition Guidelines for Prevention and

Management of DRNCs, and the National Sports Policy (2007). Only the National Sports Policy was specifically developed for direct sports interventions.

3.7.2 The National Sports Policy (2007)

Policy objectives/rationale

The National Sports Policy was formulated in 2007 after the department of sports was rotated among the Ministry of Education, Youth and Local Government, which hampered sports development. The rationale for the development of the National Sports Policy is the recognition of sports as a developmental issue. The policy was developed in response to deteriorating sports standards in Malawi, including inadequate funding, high costs and “decline in the enforcement of physical education and sports programs in schools and other institutions of learning” (35). The policy recognizes the importance of sports for health and fitness at individual level, contributing to good health and quality of life at community level and the development and maintenance of a healthy community at country level. The policy promotes sports in the country through awareness, research, and infrastructure development.

Principle/values stated

The driving principle for the draft National Sports Policy (2007) is the concept that every individual has a right to participate in sports for recreation and competition. The policy is also based on the principle that government takes cognizance of sports in its social sector development programs.

Extent to which best buys and other interventions are addressed

The National Sports Policy (2007) addresses WHO best buy interventions on promoting mass awareness of the importance of general fitness, health, recreation, and leisure. By creating an enabling environment for mass participation in sports and a strategy on promoting sports for health, the national sports policy is in line with WHO best buy interventions for physical activity. Other interventions addressed by the policy include reinforcing physical education in school curriculum and promoting sports for health.

The National Sports Policy (2007) has timeframes for policy implementation. These are subject to periodic review. By the time of data collection, no report for any review was identified or reported.

Implementation/actions plans stated

The draft National Sports Policy (2007) puts the responsibility on the ministry responsible for sports to coordinate implementation. The sports council implements the policy through its registered associations. The Malawi National Sports Council, the implementing arm of the Department of Sports, implement the policy through its sports associations.

Based on the recognition of “the importance of collaboration of various other government institutions and non-governmental organizations for effective implementation” (35), the policy has an implementation plan outlining the roles and responsibilities of various stakeholders, including: ministries responsible for sports, gender, people with disabilities, education, local government, finance, lands; the Malawi National Council of Sports; national sports associations;



volunteer organizations; service organizations; religious organizations; and the private sector. The health sector is not directly mentioned as an actor in sports policy implementation.

Monitoring and evaluation plan

Even though the National Sports Policy (2007) does not have a monitoring and evaluation plan, it places the responsibility for monitoring progress on the Department of Sports and the Malawi National Sports Council. According to the policy, a detailed monitoring and evaluation framework would be developed later in consultation with sector institutions. This was not done; there was no other document reported nor made available to the investigators during the collection period.

Policy process

The National Sports Policy was formulated in 2007 “following a series of consultative processes that involved, the executive, private sector, sports associations and the local community” (35).

Multi-sectoral involvement

Key actors from the government sector and academia were involved in the formulation of the National Sports Policy. According to one informant, the following actors were involved: Ministry of Education, Ministry of Trade and Industry, MoH, Ministry of Transport through the department of works, and the department of human resources.

Other actors were from parastatals, including the National Sports Council, national sports associations such as the Football Association and the Netball Association, and tertiary education institutions.

Level/extent of involvement

The National Sports Policy, led by the Department of Sports in the Ministry of Youth, Sports and Culture, initiates and manages the whole process. According to one informant, the Ministry of Sports, Youth and Culture is the sports policy holder:

“As the ministry, since we are the policy holders, we were at the forefront of formulating that policy through the sports department.” (010402, Youth, Government, Male).

However, this study did not find the extent of involvement of other stakeholders.

Implementation monitoring and evaluation

The implementation started in 2007 when sports officers were engaged at district level. The presence of the district sports officers enhanced coordination of sporting and recreational activities at local levels.

“I am not in the ... in the sports department ... I see that now we have sports officers all over the country, district sports officers. [When] we didn't have sports officer[s], our sporting activities and recreation were being handled solely by the youth officers and now we have sports officers. You can recall that since multipartism, we used to have what we call sports organizers in the districts, but after multipartism, those sports organizers disappeared. So sporting activities at the district level were not well-coordinated and articulated and the policy was not there. So policy is in place,

officers are put in place, associations now are being coordinated and guided. And because of that, now we have our activities per youth activities on ground; sporting activities and recreation has been enhanced. So all that to us is we are going on, we are on the right direction.” (010402, Youth, Government, Male)

Funding available for implementation

A review of the National Sports Policy (2007) shows that government recognises the role of financing as “successful implementation of the policy strategies will require substantial amount of financial and material resources” (Annex 5). These resources are expected to come from government and other development partners, although no evidence of sustainable government funding was reported during this study.

Key informants noted there is little funding available for implementation of activities.

Barriers for sports policy implementation

Key informants cited several factors that prevent implementation of physical activity policies in Malawi. One is the lack of necessary infrastructure, for example, playgrounds, especially in rural areas. These facilities are not available even in the urban areas,

The other barrier deals with local perceptions of physical activities. Some informants argued that people perceive physical activity as being inappropriate for older people.

“The other challenge is the cultural attitude, you know in Malawi, when you are in [your] 30s people say you are grown up, you cannot play, and they just regard sports as something for leisure. And particularly when you are married, they don’t even expect you to go and play in the field, so we have got the cultural challenge that.” (010403, Youth, Government, Male)

The other barrier, which could also be related to use of MSA in implementation of these policies, is the ministry’s lack of financial capacity to implement these policies.

“Financially we are not well-equipped. We have the policies ... but we don’t have enough resources to implement the activities which are supposed to be implemented.” (010403, Youth, Government, Male)

One informant attributed the lack of financial resources to lack of political will. This could influence the differences in priorities among the different actors:

“I am saying there is lack of will politically to put a lot of funds in sports sector. As of now, the money, which is given as grant to Malawi national council of sports, is around six hundred million, but how many associations do we have?” (010403, Youth, Government, Male)

Another barrier is the priority difference among the various actors. One informants cited challenges faced during the implementation of physical education in Malawian schools. He argued there were differences in priorities among the different actors.

“The physical education policy has been implemented, but partially, because previously when we had MYP, physical education was fully implemented because the instructors which were in secondary school, for example, ... [belonged] to the Ministry of Youth, so there was there [was this] vibrant ... type of physical education, both theory and practical. Now ... we can see that these policies are not very much implemented because the teachers who are for physical



education ... [belong] to the Ministry of Education now. There they meet a challenge. The ... schools concentrate on examinable subjects, neglecting those which are non-examinable, and unfortunately physical education is one of the non-examinable subjects.” (010403, Youth, Government, Male)

The lack of coordination between different actors means that in some instances, such actors act in competition, which hinders MSA.

“The other challenge is that we still have problems with coordination between different sporting associations. You know we have split associations which are just scattered. So we still have problems in coordinating those associations so those are some of those challenges ... I think the factors in Malawi, we have got this challenge that we work in competition within the government or within the NGOs or what. So every ministry feels it should have the impact and the resources on its own.” (010402, Youth, Government, Male)

Use of MSA in policy formulation

Informants mentioned several challenges to MSA sports policy implementation. The first factor was the need to further actors' interests in sporting activities: either as entertainment, economic activity, or the need to improve health status or reduce NCDs.

“They looked at the importance of these policies, for example, in sports we can say ... people find entertainment, hence reduce their worries. [Through] sports, people get physically fit, which reduces the NCDs like hypertension, the diabetes. There is an economic aspect attached to sports. As for these private sectors, they advertise through sporting activities. Now with that they are able to come in and implement sports policies, so they are several issues being attached to sports policy.” (010403, Youth, Government, Male)

One key informant argued that these policies is out of the need to be in tune with current affairs, to be seen as 'politically correct' or out of obligation.

“There are two factors. The first factor is that the government, the people of Malawi, I should say, wanted to be seen to be politically correct. When we say something is 'politically correct', it's like as good as saying men and women are equal. This is [a] very politically correct statement, so people will be disgruntled with me ... if I say that men and women are not equal. Okay even if I know in my heart, in my private setting, I feel that, know that men and women are not equal, but I [can] not say it ... publicly because it's not politically correct. So the implementation of these physical activities issues was for Malawi want[ing] to be seen to be moving with times, you know.” (0206, Health, Private/Non-profit, Male)



4.0



4.0 | Discussion



Discussion



DISCUSSION

Very few national policies in Malawi address prevention of NCDs. The biggest gap in prevention policies is in tobacco as a risk factor. Political and economic factors play a key role in establishing national policies for tobacco control. WHO best buy interventions are only partially included in the available policies related to NCD prevention. Mass awareness is the most common intervention across all NCD risk factors. The best buy interventions requiring actions from outside the health sector – such as raises on tobacco and alcohol taxes, bans on alcohol and tobacco advertising, protection from tobacco smoke and replacement of trans-fat with polyunsaturated fat in food – are not addressed. MSA was evidently high at formulation level of policies related to alcohol control.

4.1 Gaps in NCD policy development and implementation

Several gaps in policy development were identified across the reviewed policies. The first gap concerns inclusion of WHO best buy interventions in each policy. For example, most of the policies for tobacco control do not address the WHO best buy interventions, as only the National Health Policy touches on the need for the promotion of healthy lifestyle (WHO best buy intervention #4). However, other policies and guidelines address the need for users to stop or reduce smoking, which is the decision of an individual. In alcohol control, four of the 10 documents addressed only the best buy intervention that restricts retailed alcohol access. The alcohol policies in Malawi fall short on the alcohol tax increases and alcohol advertising bans. Although several strategies in line with WHO best buy intervention on restriction of access to retailed alcohol (#3) are included in the National Alcohol Policy, they are not specific enough. The policy implementation plan indicates that there will be reviews of the legislative and regulatory frameworks to effectively achieve the policy goals. From observation, regulations restricting access to cheap alcohol by banning sachet packaging were already addressed in the Liquor (Production, Marketing and Distribution) Regulation, Malawi Gazette Supplement of 30 April 2015.

The second gap relates to the extent that policies address the risk factors in NCD control. Notably, most policies do not address all risk factors. This could be partly attributed to the fact that the policies were formulated with different objectives in mind.

The third gap is the lack specific policies addressing NCDs risk factors, especially in tobacco control. While there are some pertaining to tobacco production and sales, the study did not find any policy document that directly deals with tobacco control or consumption. This seems to be influenced by a lack of political will driven by the economic argument in favor of tobacco production as a main foreign currency earner. The failure of Malawi to ratify the FCTC is a related issue. Our findings show resistance from several key players in the Malawi tobacco industry. Similarly, an ethnographic study shows how tobacco companies influence the government citing 'economic concerns' (19). Study participants also mentioned these economic concerns. We therefore believe reduction of this gap requires high-level political commitment to develop tobacco policies that target prevention and control of health consequences.

4.2 Gaps in MSA approach

The importance of MSA is recognised in several of the reviewed policies. For example, the National Action Plan for Prevention and Management of NCDs in Malawi specifically calls

for collaboration among stakeholders and partners from government sectors, development partners, higher learning and research institutions, civil society organizations and the private sector, and indicates that successful implementation will depend on an approach that is both multidisciplinary and multi-sectoral.

Similarly, several informants highlighted advantages and benefits of involving several actors in formation and implementation, such as perception of policy ownership leading to high likelihood of implementation involvement.

The harmful use of alcohol is the only NCD risk factor that has the highest scope of MSA compared with unhealthy diets, physical inactivity and tobacco. Although each risk factor has some policy documents in other government sectors outside health, most of the interventions included do not mention NCDs, let alone tackle the WHO best interventions for NCDs control. Even the health sector policies do not mention all the best buy interventions necessary for the control of NCDs.

4.3 Most significant facilitators to NCD policy development

Where MSA was employed, especially in the alcohol policy development process, the following were perceived as the key facilitators:

- I. appreciation of the seriousness of the problem by various players; understanding of the fact that each sector has a necessary role that cannot be played by another sector;
- II. presence of a lead ministry that actively ensures participation by other sectors;
- III. structured organisation and coordination, such as establishing a specific multi-sectoral task team for policy development or to oversee implementation;
- IV. Availability of dedicated funding from local and international non-governmental actors (Related to this is the existence of NGOs that lobby government for these issues. For implementation of the FCTC, institutional networks and support from external agencies including the WHO and the Centers for Disease Control and Prevention (CDC), facilitated the implementation of some articles in the FCTC (36)); and
- V. political commitment by government department of HIV and AIDS

4.4 Most significant barriers to NCD policy development

Limited government funding for formulation and implementation of NCD prevention policies was an issue that crossed all four thematic areas. Even what little funding was available to coordinate the few notable MSAs came from external sources. A lack of sustainable budgeting and financing mechanisms for NCDs prevention policies in all relevant sectors is a barrier to effective adaptation and implementation of the WHO best buy interventions. Implementation of each of the policies depended on government funding. MSA might be limited in this regard.

Another important barrier are the differences in interests among different actors and mandates for different governmental departments and agencies. The most prominent example was in tobacco control, where MoH focuses on public health interests and the ministries of Finance



and Trade and Industry see tobacco as a source of economic growth. As a result, public health interests are considered secondary. This was further influenced by players in the tobacco industry who influenced government officials not to formulate or assent to tobacco control initiatives such as the FTCT (19). The lack of political will to formulate these policies is partly a result of the fear of being seen to discourage tobacco growth, which is a main source of income for the country's tobacco farmers.

Also of importance is turnover in government departments. The transfer of government staff within ministries prevents continuity in formulation or implementation of interventions.

4.5 Study Limitations

There are some limitations to this study: some of the documents we analyzed were very old, and it was difficult to access all copies. Actors involved during the formulation of those policies have since left their organizations or departments, meaning key informants were not directly involved or could not fully recall what happened during the policy formulation processes. They might not have adequate information regarding the process.

Additionally, a few key informants were unable to participate in the study due to other commitments. Some potential informants, for instance the Ministry of Agriculture officials, refused to take part without institutional clearance; several attempts to obtain authorization were unsuccessful.

Most of the key informants interviewed were from the health sector, either from different MoH departments or NGOs working in collaboration. Although we attempted to reach and interview informants from other sectors, only those who were readily available and willing to participate were included. As a result, our findings could be biased towards health sector views.

Inability to objectively assess MSA at implementation level was also a limitation as the process only allowed for assessment of the formulation in more detail than the follow-up implementation of the policy.



5.0 | Conclusions & Recommendations

5.0



Conclusions & Recommendations



5.1 Conclusions

Policies for NCDs in Malawi are predominantly in the health sector; therefore interventions requiring non-health sectors to enforce and implement are lagging. Preventing NCDs was not the core part of the rationale for tobacco, nutrition and sports policies reviewed in this study. On policy content, WHO best buy NCD interventions are only partially included in some of the available NCD-related policies. The best buy interventions requiring actions from outside the health sector – such as raises on tobacco and alcohol taxes, bans on alcohol and tobacco advertising, protection from tobacco smoke and replacement of trans-fat with polyunsaturated fat in food – are not yet addressed.

The biggest gap in availability of the NCD prevention policies is in tobacco use. Political and economic factors play a key role in establishing tobacco policies related to NCDs prevention.

5.2 Recommendations

The following are our recommendations, in consideration of the views from national NCD stakeholders, as discussed in a stakeholder engagement meeting that validated the study findings of 21 December 2016:

- i) the government of Malawi should reinforce inclusion and implementation of best-buy interventions in the legislations and policies related to prevention of NCDs across all sectors;
- ii) establish an inter-ministerial committee on NCDs (health, education, agriculture, home affairs, sports and other relevant government departments), revising the terms and references regularly;
- iii) set up a national coordinating mechanism modelled similar to the National AIDS Commission, which can coordinate planning, joint financing, implementation and monitoring ; and
- iv) consider a national financing platform integrating all sectors with ring-fenced funding for MSA towards NCDs.



6.0



z0 | References



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Annexes

Annex 1: List of reviewed documents

Risk factor	Policy/guidelines/strategic plan
Tobacco use	Health Sector Strategic Plan (2011-2016) National Action Plans for Prevention and Management of NCDs in Malawi (2012-2016) NDCMP for Malawi (2005) Nutrition Guidelines for Prevention and Management of Diet-related NCDs National Health Promotion Policy (2013)
Alcohol	1979 Liquor Act 2015 Liquor (production, marketing and distribution) Regulation, Malawi Gazette Supplement of 30 April 2015 Malawi Bureau of Standards Act Taxation Act (2006) Road Traffic Act (1998) Consumer Protection Act (2003) National Alcohol Policy (cabinet paper, 2015) National Road Safety Strategic and Five-year Action Plan (2015-2020) Drug Control Master Plan (2005) National Action Plan for Prevention and Management of NCDs in Malawi (2012-2016) Nutrition Guidelines for Prevention and Management of Diet-related NCDs National Health Promotion Policy (2013)
Physical inactivity	National Action Plans for Prevention and Management of NCDs in Malawi (2012-2016) National Health Promotion Policy (2013) Nutrition Guidelines for Prevention and Management of Diet-related NCDs Draft National Sports Policy (2007)
Unhealthy diet	National Action Plan for Prevention and Management of NCDs in Malawi (2012-2016) Nutrition Guidelines for Prevention and Management of Diet-related NCDs National Nutrition Policy and Strategic Plan National School Health and Nutrition Policy Consumer Protection Act (2003) National Health Promotion Policy (2013)



Journal articles

- Otanez MG, Mamudu HM, Glantz S.: Tobacco Companies' Use of Developing Countries' Economic Reliance on Tobacco to Lobby against Global Tobacco Control: The Case of Malawi. *Am J Public Heal* 2009, 99:1759–1771
- Msyamboza KP, Ngwira B, Dzowela T, Mvula C, Kathyola D, Harries AD, Bowie C: The Burden of Selected Chronic Non-Communicable Diseases and Their Risk Factors in Malawi: Nationwide STEPS Survey. *PLoS One* 2011, 6:e20316.
- Otañez MG, Mamudu H, Glantz SA: Global leaf companies control the tobacco market in Malawi. *Tob Control* 2007, 16:261–269.

Media reports

- Nation Online: Mutharika restructures OPC [<http://mwnation.com/mutharika-restructures-opc/>]
- Staff Writer: Malawi considers ratifying FCTC. *The Nation* 2014.

Grey literature

- Centre for Agricultural Research and Development: Farm-Level Economics of Tobacco Production in Malawi
- Tobacco Control Commission: Buying Companies [<http://www.tccmw.com/stakeholders.php>]
- Tobacco Association of Malawi: The Constitution of the Tobacco Association of Malawi (Revised 2008) [<http://www.tamalawi.com/about-tama/tamas-constitution.html>]
- Department of Nutrition HIV and AIDS: Department of Nutrition, HIV and AIDS Mission and objectives [http://www.dnha.gov.mw/index.php?option=com_content&view=article&id=108&Itemid=472]
- Tobacco Association of Malawi: SPEECH BY THE GUEST OF HONOUR PROFESSOR PETER MWANZA, MP, MINISTER OF AGRICULTURE AND FOOD SECURITY [www.tama.com]
- TOAWUM: Letter to the President of the Republic of Malawi. 2014.



Annex 2: Desk review of guidelines, policies and pieces of legislation on tobacco

POLICIES IN PLACE	RATIONALE	WHO BEST BUY INTERVENTIONS ADDRESSED	OTHER INTERVENTIONS INCLUDED	OBJECTIVES	IMPLEMENTATION PLANS STATED	MONITORING AND EVALUATION (M&E) INCLUDED	Development or revision year	Summary of key document analysis findings
		Tax increases Smoke-free indoor workplaces and public places Bans on tobacco advertising, promotion and sponsorship Health information and warnings						
National Action Plans for Prevention and Management of NCDs in Malawi (2012-2016)	In recognition of the growing burden of NCDs in Malawi, and the disintegrated efforts in their response, this plan was developed to address this challenge in order to save resources while tackling NCDs in a coordinated multi-sectoral approach.	Best buy #2 indirectly addressed through intention to lobby for a law that regulates smoking in public places.	General awareness raising of NCDs common risk factors that includes tobacco smoking/use.	The main objective of this policy is to reduce the burden of preventable morbidity and disability as well as avoidable mortality due to NCDs, including mental health and neurological disorder. This will be achieved through the promotion of awareness, risk reduction, quality and comprehensive care, advocate for enhanced policy and legislation, improved capacity of health systems, and support for research.	The policy states the importance of a coordinated effort and networking among implementers including the MoH and key stakeholders at all levels.	No specific M&E plan was included, except the plans to develop process and impact indicators to track progress and the annual reviews to be conducted at the end of each year.	This plan was developed to cover the 2012-2016 period.	This document is a critical foundation for other initiatives to reduce the burden of NCDs. It acknowledges that smoking is a major risk factor for developing NCDs; however, it does not directly address the WHO tobacco best buy interventions.
NDCMP for Malawi (2005)	This plan was developed to promote a coordinated effort in controlling the production, trafficking and abuse of drugs and substances, and to guide the Malawi national response to emerging drug issues and threats on the dynamic environment.	None addressed	This plan focuses of tackling drugs, where Cannabis sativa (Chamba) is a form of drug that is usually taken through smoking in Malawi. The plan's efforts curb and eradicate chamba smoking.	The plan aims to curb drug abuse in the country through law enforcement, civic education, community mobilization, economic empowerment, and health.	The plan highlights the critical role of the Inter-Ministerial Committee on Drug Control to be responsible in the implementation of this plan.	The plan recognizes the need for tracking progress and effectiveness of the interventions hence DAPCC's responsibility to carry out a mid-term review and periodic evaluations.	This plan was developed to cover the period from 2005-2009.	The plan concentrates on cannabis sativa and all efforts to control it; also focuses on stopping chamba smoking.

Nutrition Guidelines for Prevention and Management of Diet-related NCDs	Due to the emerging problem in increased prevalence of diet-related NCDs in Malawi as one of the main causes of mortality among adults and the need to provide guidelines this document provides guidance and strategic direction for implementation of the national response to nutritional disorders, HIV and AIDS.	None stated	Smoking was highlighted as an underlying cause of NCDs, hence their prevention requirements of avoiding or quitting smoking.	The main objective of these guidelines is to provide information on actions that are essential in preventing NCDs for individuals who do not have them and those who already have the disease.	Although there is no statement of an implementation plan in these guidelines, their implementation is based on an individual basis to use the recommendations outlined if one is at risk or already affected by the NCDs.	Not stated	15 August 2009	These guidelines are not meant to be implemented at an institutional level but rather are recommendations for individuals to make use of if they are to prevent NCDs or manage the disease if they are affected.
National Health Promotion Policy (2013)	HES is responsible for coordinating health education, which is neither efficient nor effective. Its central role is often perceived as IEC materials production. This policy guides coordination with other players in health promotion by providing a comprehensive approach that goes beyond communication and education to embrace advocacy.	The policy identifies (best buy #4) smoking as a risk factor for poor health leading to NCDs, therefore, the promotion of health lifestyles through health literacy includes awareness of its harm.	None	The goal of the policy is to reduce preventable deaths and disability through effective health promotion interventions by providing effective leadership and coordination, strengthening human capacity, and supporting initiatives that lead to healthy lifestyles.	The policy identifies the MoH as the anchor for implementation but recognizes the multi-sectoral approach in order to achieve the objectives. The implementation follows the decentralization approach in which the ministry of local government and rural development has the responsibility for health delivery at district and lower levels.	The policy will be reviewed through annual and biannual reviews that examine the adherence of the policy. After two and a half years, a mid-term review for progress and lessons learnt will be introduced followed by an end of term evaluation after five years.	The development was finalized in June 2013.	The policy describes the promotion of health at institutional level and identifying stakeholders that assist in implementation, but acknowledges all the risk factors of NCDs, including tobacco use.





Annex 3: Desk review of guidelines, policies and pieces of legislation on alcohol

POLICIES IN PLACE	RATIONALE	WHO BEST BUY INTERVENTIONS ADDRESSED	OTHER INTERVENTIONS INCLUDED	OBJECTIVES	IMPLEMENTATION PLANS STATED	MONITORING AND EVALUATION INCLUDED	Year of Development or revision	Summary of key document analysis findings
		(1) Tax increases (2) Bans on alcohol advertising (3) Restrict access to retail alcohol						
1979 Liquor Act	This act was developed to give powers to local governments to regulate the manufacture and retail sale of opaque and traditional beer.	The act stipulates the permitted hours for the supply of opaque beer from 6am to 10pm (best buy intervention #3). Opaque beer is only supplied by permit holders approved by local government, after the permit holder satisfies requirements for approval, which also restricts beer sales. The act also stipulates that persons under age 18 cannot be sold beer.	None specific	The act's main objective is to regulate the sale of opaque and traditional beer by granting permits to businesses intending to sell or manufacture beer.	This act will be implemented by local governments in their jurisdiction areas.	No specific M&E plan is indicated in the act, although it mentions the powers of permit officer and authorized persons who can enter or remain in any premises with the view to ascertain whether the provisions of the act are being complied with.	Not indicated	The document highlights the powers given to local governments to regulate the sale and manufacture of opaque and traditional beer. These by-laws need to be reviewed to adjust the fees needed for permit applications and other requirements. The act only specifies opaque beer. One best buy is covered (#3).
2015 Liquor (Production, Marketing and Distribution) Regulation, Malawi Gazette Supplement of 30 April 2015	These regulations were developed to prohibit the manufacturing and importation of certain intoxicating liquor, packaging industrial grade ethanol for purposes of consumption, packaging intoxicating liquor in plastics or polythene, and authorizing the quantities and packaging of intoxicating liquor.	The regulations address best buy interventions by imposing requirements on packaging, production, and quantities of liquors that restrict easy access.	These restrictions intend to control the wider availability of liquor in small, cheap, and easily accessible quantities. The indication restricts production to established manufacturers.	The main objective of these regulations is to restrict availability of liquor in small quantities that can be packaged in cheaper material, making it easily accessible to the population.	Not stated	Not stated	30 April 2015	These restrictions are intended to control and prevent the availability of cheap liquor, eventually stopping people from consumption of too much liquor.

Malawi Bureau of Standards (MBS) Act	This act was developed to establish the Malawi Bureau of Standards and the Malawi Standards board, whose responsibility is to promote standardization and quality assurance of commodities and of the manufacture, production, processing or treatment of commodities for public consumption.	None indicated	In collaboration with 2015 liquor regulations, MBS advocates and recognizes products that abide by the regulations and will label products with the standardization mark, which regulates availability.	The act gives the powers to the bureau to: promote standardization in commerce and industry; prepare and issue standards and to administer schemes based on the standards; make arrangements to provide facilities for testing an calibration of precision instruments; provide for the testing of locally manufactured or imported commodities; control the use of standardization marks; and more.	MBS is responsible for the implementation of the standards under the direction of its board.	The act provides powers to MBS inspectors who can work with police officers if there is belief of obstruction during inspection.	Published 27 July 2012	The Standards Act forms the basis of development for manufacturers or producers follow to ensure their products are approved for public consumption. There are four standards alcohol and liquor: MS 50:1988 beer specification; MS 208:1990 opaque beer; MS 107:1988 alcohol beverages; MBS 210:1990 spirits specifications.
Taxation Act (2006)	This act is intended to empower the Malawi government through the commissioner of taxes to collect tax revenues from businesses operating in the country.	The act does not explicitly address best buy interventions.	Imposing tax on business indicates that it is legit and operates under the country's legal requirements; specifically, it abides to liquor regulation. Imposing tax on individuals means they must spend their income wisely.	The objectives of this act include: empowering tax commissioners to collect taxes on behalf of the government; bringing attention to individuals; and businesses operating in Malawi on income tax remittance to the government.	Not stated	Not stated	1 January 1964	Imposing taxes on businesses or individuals accessing their income in Malawi implies that the government can closely monitor the type of business and source of income and assess if the business complies with the requirements of operation as stipulated in the 2015 liquor regulations.





Road Traffic Act (1998)	This act was developed to control road traffic accidents. It stipulates the optimal requirements of vehicles, drivers, and other road users in order to prevent accidents.	The act does not explicitly address best buy interventions.	The act provides restrictions regarding driving under the influence and blood alcohol content. It allows a maximum alcohol level in blood or urine of 0.08mg/ml per 100ml or 0.08mg of alcohol per 210 liters of breath.	The main objective of this act is to prevent traffic accidents, which is achieved by provision of requirements for vehicles and roads users.	For this act to be implemented, it requires the responsibility of traffic police officers, who upon suspecting the driver of to be under the influence, to request the driver take a breath test or provide urine or blood sample for testing.	Not stated	Amended 15 January 1998	By virtue of implementing this act, people will not consume excessive liquor, especially if they are driving, and eventually contribute to NCDs control.
Consumer Protection Act (2003)	This act was developed to protect the rights of consumers, address the interests and need of consumers, establish a consumer protection council, and provide effective redress mechanisms for consumer claims.	Not highlighted	The act protects consumers from the sale of substandard products and empowers them to report if such products are on the market. The act also stipulates trader obligations to provide goods that cannot harm to consumers. This is done through consumer education. The council has powers to withdraw products that do not comply with consumer standards or products capable of causing public harm.	The act's main objective is consumer protection by protecting their economic interest, health and safety in the consumption of goods and services.	The act empowers local authorities with the responsibility of implementing its provisions and any other matters written on consumer protection.	Not stated	Developed and gazetted on 21 November 2003	This act address the control of liquors that do not comply with the 2015 liquor regulations.

The National Alcohol Policy (cabinet paper, 2015)	The policy was developed to increase awareness of the effects of alcohol and curb harmful consumption, including underage drinking through provision of a comprehensive mechanism for developing, implementing, coordinating, monitoring and evaluating health, social and economic interventions related to harmful alcohol consumption in Malawi.	Although policy areas touch on best buy intervention #3, they are not specific enough. The interventions address the review and enforcement of previous acts and regulations specifically about commercial production, distribution and sales system of alcohol products; ensuring comprehensive regulation of marketing of alcohol products; and regulating the production and sale of informally produced alcohol.	The provision of education and training on alcohol abuse that focus on behavior change in respect to consumption patterns of age, sex, culture, and type of alcohol.	The main policy objective is to reduce the health and social burden caused by harmful use of alcohol, thereby saving lives, reducing disease and preventing injuries. While the specific objectives include: ensuring the effective regulation of the availability of alcohol products, promoting health services' and other sectors' response to harmful use of alcohol, ensuring the reduced demand for alcohol products through behavior change related interventions; and promoting monitoring, surveillance and research on harmful use of alcohol.	The policy recognizes the importance of institutional MSA in its implementation. It calls for the establishment of the National Committee on Alcohol (NCA), which comprises ministry directors, NGOs, the police and others, who will be responsible for the technical direction and program implementation.	The policy will develop the M&E framework in collaboration with MoH to lead, coordinate and ensure timely reporting and dissemination of alcohol-related performance and outcomes.	June 2014	The policy falls short in emphasizing the alcohol tax increases and the bans on alcohol advertising, but does address WHO best buy #3 intervention on restriction of access to retail alcohol. The policy statements are not specific enough and the implementation plan highlights the need to review the acts and regulatory frameworks to effectively achieve these goals. Some regulations were already reviewed and addressed in the 2015 liquor regulations (Liquor Act addendum).
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National Road Safety Strategic and Five-year Action Plan (2015-2020)	The Malawi government acknowledges that road traffic accidents have had great socio-economic impacts on the most productive population group. It reconstituted the Road Traffic Directorate (RTD) in July 2010 by merging it with the National Road Safety Council of Malawi (NRSOM) to improve operation efficiency. This strategy was developed to guide operations of the RTD on road safety from 2015-2020.	Not stated	Through the enforcement of road traffic safety laws and regulations, the plans include curbing driving while under the influence of alcohol. The procurement plan for traffic law enforcement equipment entails obtaining breathalyzers to monitor drinking and driving.	The strategy's main aim is to regulate the road transport industry through law enforcement, development of policies, standards and practices and provide civic education in order to ensure well-coordinated, efficient, reliable, sustainable road transport safety systems.	RTD services will be responsible for implementing this strategy through the stakeholder coordination. In addition, the established National Road Safety Strategy Implementation Committee, chaired by the RTD, will be responsible for implementation of the strategy.	The M&E Plan's focus will be on performance monitoring in terms of whether the agreed-upon outputs and annual output targets are effectively and correctly implemented. It will also focus on whether the required resources [inputs] are provided in a timely manner; the outputs are realized; the outcomes are being achieved; and there is any impact on development of sustainable and reliable transport infrastructure in the country.	The strategy was revised for a period of five years from 2015-2020.	This document is critical and supports other initiatives by providing monitoring equipment such as breathalyzers.
Drug Control Master Plan (2005)	This plan was developed to promote a coordinated effort in controlling the production, trafficking and abuse of drugs and guide the Malawi national response to emerging drug issues and threats.	None addressed	None related to alcohol	The plan aims to curb drug through law enforcement, civic education, community mobilization, economic empowerment, and health.	The plan highlights the critical role of IMCDC in the implementation of this plan.	DAPCC carries out mid-term reviews and periodic evaluations.	This plan was developed to cover the period from 2005-2009.	The plan only concentrates on drugs but should highlight the impact of drug and alcohol combinations, as well as the need to address the two together.

National Action Plan for prevention and Management of NCDs in Malawi (2012-2016)	This plan was developed to address the growing burden of NCDs in Malawi and the disintegrated efforts in their response in order to save resources while tackling NCDs in a coordinated, multisectoral approach.	Not stated	Promoting awareness campaigns on NCDs and their risk factors implies addressing the risk factor of alcohol. Advocating for road traffic safety implies that the policy supports the prohibition of drunk driving, which is one major intervention for road traffic safety.	The main objective of this policy is to reduce the burden of preventable morbidity and disability as well as avoidable mortality due to NCDs, including mental health and neurological disorders. This will be achieved through the promotion of awareness, risk reduction, quality and comprehensive care, advocacy of enhanced policy and legislation, improved capacity of health systems, and support for research.	The policy states the importance of a coordinated effort among the MoH and key stakeholders at all levels.	The M&E plan highlights the development of process and impact indicators to track progress and the reviews conducted at year end.	This plan was developed to cover the period from 2012-2015.	The policy is focused on addressing NCDs and little is mentioned about tackling the underlying causes such as alcohol or liquor despite being mentioned as risk factors for NCDs.
Nutrition Guidelines for prevention and management of DRNCDs	Due to the increased prevalence of DRNCDs in Malawi as one of the main causes of mortality among adults and the need to provide guidelines, this document provides guidance and strategic direction for implementation of the national response to nutritional disorders, HIV and AIDS in Malawi.	None stated	Prevention to reduce alcohol-related NCDs includes reduced alcohol intake, total stoppage of alcohol consumption, and avoiding consumption of alcohol.	The main objective of these guidelines is to provide information on actions that are essential in preventing and managing DRNCDs for individuals who do not have, or those already having the disease or disorder, respectively.	Although there is no statement of an implementation plan in these guidelines, their implementation is based on an individual basis to use the recommendations outlined if one is at risk or already affected by the NCDs.	Not stated	15 August 2009	These guidelines are recommendations for individuals to make use if they are to prevent NCDs or manage the disease if affected.





National Health Promotion Policy (2013)	HES is responsible for coordinating health education, which is neither efficient nor effective, and its central role has often been perceived as IEC materials production. HP policy development recognizes many players in the face of current health challenges. This policy provides a comprehensive approach that goes beyond communication and education to embrace advocacy for addressing the social determinants of health.	None	The policy identifies excessive alcohol consumption as a risk factor for NCDs so advocates promotion of healthy lifestyles through health literacy.	The goal of the policy is to reduce preventable deaths and disability through effective health promotion interventions by: providing effective leadership and coordination, strengthening human capacity, and supporting initiatives that lead to health lifestyles.	The policy identifies MoH as its anchor for implementation, but recognizes MSA to achieve objectives. The implementation follows the decentralization approach, in which the ministry of local government and rural development has responsibility for health delivery at district and lower levels.	The policy is subject to annual and biannual reviews that examine the adherence of the policy. After two-and-a-half years, a mid-term review for progress and lessons learnt will be introduced, followed by an end of term evaluation after five years.	The development was finalized in June 2013.	The policy describes the promotion of health at institutional level and the means to identify stakeholders who can assist in implementation and acknowledges all NCD risk factors.
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Annex 4: Desk review of guidelines, policies and pieces of legislation on nutrition and diet

POLICIES IN PLACE	RATIONALE	WHO BEST BUYS INTERVENTIONS ADDRESSED	OTHER INTERVENTIONS INCLUDED	OBJECTIVES	IMPLEMENTATION PLANS STATED	MONITORING AND EVALUATION INCLUDED	Year of Development or revision	Summary of key document analysis findings
		(1) Reduced salt intake (2) Replacement of trans-fat with polyunsaturated fat (3) Public awareness through mass media on diet						
National Action Plan for prevention and Management of Non-Communicable Diseases in Malawi (2012-2016)	In recognition of the growing burden of NCDs in Malawi and the disintegrated response, this plan was developed to address this challenge to save resources while tackling NCDs in a coordinated MSA	NCD public awareness campaigns in which diet is included as a discussion topic (best buy intervention #3).	None	The main objective is to reduce the burden of preventable morbidity and disability as well as avoidable mortality due to NCDs, including mental health and neurological disorders. The goal is achieved through the promotion of awareness, risk reduction, quality and comprehensive care, advocate for enhanced policy and legislation, improved capacity of health systems, and support for research.	The policy states the importance of a coordinated effort and networking among MoH and key stakeholders at all levels.	The M&E plan highlights the development process, impact indicators to track progress, and the reviews conducted at the end of each year.	This plan was developed to cover a four year period from 2012-2015.	This critical document supports other initiatives to reduce the NCD burden, whose underlying risk factors include poor nutrition but are not directly tackled.
Nutrition Guidelines for prevention and management of DRNCDs	Due to the DRNCDs problem in Malawi, this document provides guidance and strategic direction for the implementation of the national response to nutritional disorders, HIV and AIDS.	Guidelines stress the reduction or change in consumption of fatty foods – mainly from animal sources with high trans-fats – to foods low in fat, such as fish and skimmed milk with polyunsaturated fats (best buy intervention #2). In addressing diabetes, the guidelines stress the need to reduce intake of: salt (best buy intervention #1) to one teaspoon a day, saturated fats (best buy #2), salt-cured or salt-pickled food (best buy #2). These guidelines disseminate how they can prevent and manage NCDs (best buy #3).	None	The main objective of these guidelines is to provide information on essential actions that prevent and manage diet-related NCDs for individuals who do not have and those already having the disease or disorder respectively	Although there is no plan in these guidelines, their implementation is based on an individual basis to use the recommendations outlined if one is at risk or already affected by NCDs.	Not stated	15 August 2009	These guidelines are meant to be recommendations for individuals to make use of to prevent NCDs or manage the disease if affected.





NNPSP	As malnutrition is one of the major contributing factors to the high morbidity rates among various population groups in Malawi, the NNPSP seeks to enhance Government's response towards the malnutrition crisis.	Not explicitly indicated, but the policy stresses sensitization campaigns on good nutrition and balanced diet to prevent malnutrition (best buy #3).	The policy highlights DRNCD controls to develop and review guidelines.	The policy is intended to facilitate the standardization; coordination and improvement of the quality of nutrition services and in turn reduce the prevailing nutrition disorders to reasonable levels. The policy is expected to lead to the attainment of improved nutritional status and productivity among various population groups so that they contribute effectively to the economic growth and development of the country.	The policy has a framework and emphasizes the need for MSA in implementation. It lists the critical stakeholders for this policy implementation.	A M&E framework provides stakeholders with relevant information useful in evidence-based decision-making, planning and implementation of nutrition interventions. It indicates monitoring tools such as quarterly field visits, and evaluation tools such as baseline surveys.	The policy covers the period from 2007-2011.	This policy explains the approaches in addressing the malnutrition burden. Poor nutrition is one of the causes of malnutrition. NCDs are also tackled.
National School Health and Nutrition Policy (SHN) (2015)	Since the introduction of School Feeding in Malawi, the education system has operated without a school health and nutrition policy. While there are strategies and activities in the area of school health, they are fragmented and often borne by the interest of partners who sustained these interventions for a limited time. The SHN policy offers an opportunity for concerted and coordinated efforts mobilization and implementation in school health, feeding, hygiene, sanitation, child protection and related mainstreaming in the curriculum.	None stated	The provision of nutritious meals corresponding to national standards in terms of nutrition and food safety.	the objectives of this policy include; promoting effective SHN-intervention, management of the national school-feeding programme by the Government, and providing equitable access to education for specific vulnerable groups	This policy calls for deliberate participation from key players; their inclusion helps fulfill aspirations of the national education long-term vision and provision of guidelines for early childhood development, primary and secondary education. It includes all stakeholders to be part of the implementation.	M&E plan highlights the need for evaluation every three to five years of policy implementation.	The policy was developed in August 2015.	This policy mainly highlights the implementation and improvement of Malawi's school feeding program, but does not specifically indicate addressing poor nutrition.

Consumer Protection Act (2003)	This act was developed to protect the rights and needs of consumers, establish a consumer protection council, provide an effective redress mechanisms for consumer claims and provide for other matters.	Not highlighted	None highlighted	The main objective of the act is consumer protection by protecting their economic interest, health and safety in the consumption of goods and services.	The act provides powers to district local authorities to have the responsibility of implementing the provisions and other matters of consumer protection.	Not stated	The act was developed and gazetted on. 21 November 2003	This act prevents substandard products from being sold on the market. It does not concentrate on the type of diet one has to address poor nutrition.
National Health Promotion Policy (2013)	HES is responsible for coordinating health education, which has not been efficient and effective and its central role has often been perceived as IEC materials production. The development of the HP policy recognizes there are many players. This policy coordinates with other HP players by providing a comprehensive approach that goes beyond communication and education to embrace advocacy for addressing the social determinants of health.	The policy identifies the promotion of health lifestyles including diet awareness (best buy #3).	None	The goal of the policy is to reduce preventable deaths and disability through effective health promotion interventions by providing effective leadership and coordination, strengthening human capacity, and supporting initiatives that lead to healthy lifestyles.	The policy identifies MoH as the anchor for implementation but recognizes MSA in order to succeed. The implementation follows the decentralization approach in which the ministry of local government and rural development has the overall responsibility for health delivery at district and lower levels.	The policy is reviewed through annual and biannual reviews, which examines the adherence of the policy. A mid-term progress review for lessons learnt occurs after two and a half years, followed by an end-of-term evaluation after five years.	The development was finalized in June 2013.	The policy describes health promotion at institutional level and identifies stakeholders that might assist in implementation but acknowledges all NCD risk factors.





Annex 5: Desk review of guidelines, policies and pieces of legislation on physical activity

POLICIES IN PLACE	RATIONALE	WHO BEST BUYS INTERVENTIONS ADDRESSED	OTHER INTERVENTIONS INCLUDED	OBJECTIVES	IMPLEMENTATION PLANS STATED	MONITORING AND EVALUATION INCLUDED	YEAR OF DEVELOPMENT OR REVISION	SUMMARY OF KEY DOCUMENT ANALYSIS FINDINGS
		1. Public awareness through mass media on physical activity						
National Action Plans for Prevention and Management of NCDs in Malawi (2012-2016)	In recognition of the growing burden of NCDs in Malawi and the disintegrated response, this plan was developed to address this challenge to save resources while tackling NCDs in a coordinated MSA.	None addressed	None highlighted	The main objective of this policy is to reduce the burden of preventable morbidity and disability as well as avoidable mortality due to NCDs, including mental health and neurological disorders. This will be achieved through promotion of awareness, risk reduction, quality and comprehensive care, advocacy for enhanced policy and legislation, improved capacity of health systems, and support for research.	The policy stresses the importance of a coordinated effort and networking among MoH and key stakeholders at all levels.	M&E plan highlights the development process and impact indicators to track progress and the reviews conducted at the end of each year.	This plan was developed to cover a four-year period from 2012-2015.	This critical document supports other initiatives to reduce the burden of NCDs whose underlying risk factors include lack of physical activity but are not directly tackled.
National Health Promotion Policy (2013)	HES is responsible for coordinating health education, which was neither efficient nor effective. Its central role is often perceived as IEC materials production. This policy guides coordination with other players in HP by providing a comprehensive approach that goes beyond communication and education to embrace advocacy for addressing the social determinants of health.	The policy identifies the promotion of health lifestyles, including exercise awareness (best buy #1).	None	The policy aims to reduce preventable deaths and disability through effective health promotion interventions by providing effective leadership and coordination, strengthening human capacity, and supporting initiatives that lead to healthy lifestyles.	The policy identifies MoH as its anchor for implementation but recognizes MSA in order to achieve its objectives. The implementation uses decentralization approach in which the Ministry of Local Government and Rural Development has the overall responsibility for health delivery at district and lower levels.	The policy is reviewed through annual and biannual reviews that examine adherence to the policy via a mid-term review for progress and lessons learnt and an end-of-term evaluation after five years.	The development was finalized in June 2013.	The policy describes the promotion of health at institutional level and identifies stakeholders that might assist in implementation but acknowledges NCD risk factors.

Nutrition Guidelines for Prevention and Management of DRNCs	Due to the increased prevalence of DRNCs in Malawi as one of the main causes of mortality among adults, this document provides guidance and strategic direction for the implementation of the national response to nutritional disorders, HIV and AIDS.	None stated	The guidelines indicate the promotion of light to moderate physical activity to prevent or manage NCDs.	The main objective of these guidelines is to provide information on essential actions in preventing and managing diet-related NCDs for individuals who do not have, and those already having, the disease or disorder, respectively.	Although there is no statement of a plan in these guidelines, their implementation is based on an individual basis to use recommendations outlined if one is at risk or already affected by NCDs.	Not stated	15 August 2009	These guidelines are recommendations for individuals to make use of if they are to prevent NCDs, or manage the disease if they are affected.
Draft National Sports Policy	Previously the Department of Sports rotated between the ministries of local government and Education and Youth, which hampered the development of sports. This policy rectifies and directs sports administration to give Malawians equal opportunities to practice the sport of their choice.	The policy directly includes the WHO best buy intervention on physical activity by having a specific goal of making sports accessible to the masses and includes a specific strategy on promoting sports for health.	The policy also highlights the following strategies: provide access to sports for persons with disability, the aged, women and children; use sports as a tool for disseminating information on HIV and AIDS and other health related matters; and reinforce physical education in the national school curriculum.	The policy objective is to promote sports through awareness, research, and infrastructure development. The specific WHO best buy-related objective promotes mass awareness on the importance of general fitness, health, recreation and leisure for Malawians through sports.	The policy puts the responsibility on the ministry responsible for sports to coordinate the implementation of this policy, and on the sports council to implement policy through the sports associations registered under it.	The policy mentions the importance of M&E and that the department of sports and sports council will be responsible for M&Es whose frameworks are yet to be developed.	Not indicated in the policy but a search in other documents shows it was formed in 2007.	The policy is in line with WHO best buy interventions for physical activity through creation of an enabling environment for mass participation in sports, and a strategy on promoting sports for health.





APHRC CAMPUS, KITISIRU, NAIROBI, KENYA



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