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Overview of the Essential Health Services in Malawi

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Malaria patient, Lilongwe.

Photo: Eva-Lotta Jansson/Oxfam

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Executive summary

“But the time I came here in 2000, about half the health centres were closed. The whole district was supposed to have 104 nurses but when I came I found we only had 16 nurses. The district hospital was collapsing. It isn’t nice when you are supervising nothing. It was almost useless to go to health centres and find nobody.”

Dowa District Hospital, Malawi

Malawi is one of the poorest countries in the world. Life expectancy at birth was estimated at 36.3 years in 2004, a sharp fall from the 1994 figure of 42 years. This is largely due to the HIV/AIDS epidemic. The problem of HIV and AIDS is compounded by a very weak and under resourced healthcare system that is, in the words of one nurse:

“we are really struggling. Beds are torn from overuse, equipment is breaking down. We’re always running short of gloves, and with AIDS is dangerous to work this way. At times we run short of panados, analgesics, antibiotics – very essential drugs. So we tell patients to buy for themselves, and some can’t afford.”

However despite these challenges the government is making progress. Under-fives and infant mortality rates are steadily decreasing, and local communities have been given more say in the way healthcare resources are allocated. The capacity of the Ministry of Health to access and utilize HIPC (Heavily Indebted Poor Countries), MASAF and the HIV/AIDS Global funds to supplement government expenditures on health offers a great opportunity to reduce the financing gap in the implementation of the Essential Health Package, the cornerstone the government’s healthcare policy.

Despite commitments to healthcare and positive moves by the government such as the policy to decentralise healthcare management services, the government of Malawi is not spending enough on this vital sector. Under the Abuja Declaration on HIV/AIDS, Tuberculosis and other related diseases, adopted on 27 April 2001 by African heads of states and governments, the Malawi government agreed to spend at least 15% of its national budget on healthcare. In 2006 the government dedicated 8% of its national budget to healthcare and is heavily reliant on donors to cover the much-needed additional expenditure for this sector. Consequently this has led to a dramatic shortfall in the number of healthcare workers needed to address the nation’s health requirements. A health facility survey (JICA and MOH) conducted in 2003 showed that of the 26 districts in Malawi, 15 (60%) had fewer than 1.5 nurses per health centre, while 5 (20%) had less than 1 nurse per health centre. It also showed that out of the 26 districts, 10 had no doctor in the government district hospitals and four had no doctor at all. The concentration of healthcare resources, including health workers, in larger urban centres is proving an obstacle to achieving the MDGs and is increasing the overall vulnerability of Malawians to HIV and AIDS.

Retention of healthcare personnel continues to be a real problem in Malawi. The Ministry of Health currently estimates that the vacancy rates for doctors, nurses and laboratory technicians in the public health sector range from 44% to 68%. The vacancy rates for

specialist doctors (surgeons, obstetricians/gynecologists, physicians, pediatricians, pathologists, etc) in the public sector range from 71% to 100%(NAC M& E Report, December 2005). Between 2000 and 2001, 230 nurses left Malawi. Between July and November alone 17 junior doctors resigned, four of these moved to Christian Health Association of Malawi, which offers a Euro 390 per month top-up through Cord-Aid funding. It is not known where others went. The SWAP HR Technical Working Group has established a task team to explore this particular issue further and suggest an appropriate response. However it must be noted that in the context of figures for recent years the 17 resignations are not unusual.

The government has gone some way to address these concerns. As part of the implementation of its medium term Pay Policy, the government implemented a civil service wide pay-rise in February 2006 (backdated to December 2005), which establishes a separate pay scale for health workers and led to a substantial wage increase.

Since April 2005, the government, with the assistance from Department for International Development (DFID), introduced a retention package with the aim of preventing health staff from resigning. All cadres of professional health workers ranging from doctors to dental therapists working in government institutions were targeted with a salary top-up allowance of 52% that has been included into basic gross pay.

This package is a good motivator and should be backed by other major donors as a means of ensuring that the healthcare sector is adequately staffed for the short and medium term. However the government needs to factor this issue into its long term financial planning for the healthcare sector and steadily increase budget allocation to human resource development. This would be in line with the six –year emergency training plan (2001-07) aimed at training an adequate number of health personnel to deliver the Essential Health Package (EHP).

Recommendations to the government

1. In order to ensure the effective decentralization of health care management services the government needs to develop the technical expertise of staff in the district assemblies in the areas of planning, and budgeting and setting up more systems of information management.
2. The government needs to develop effective mechanisms to ensure that the district assemblies manage the funding in a transparent manner so as to increase their accountability to local communities
3. The government needs to move away from heavy reliance on unpredictable donor funding and demonstrate its commitment to its own healthcare policies by allocating 15% of the national budget to healthcare, in line with its commitments under the Abuja Declaration.
4. The government needs to accelerate the Central Medical Stores reform in order to strengthen drug logistics to ensure that the entire drug procurement and distribution system offers reliability to local communities, increase accountability and transparency and reduce the potential for corruption in the health sector.

5. Parliament and the executive arm of government, should sign bilateral agreements with relevant countries to protect the Malawi government's investment in trained health and recipient countries consummately and formally compensate ensuring that emigration of health and medical professionals.

Recommendations to Donors

- Donors should provide long term predictable funding to allow the Malawi health service to invest in staff training and development and in long-term infrastructure development.

Donors such as USAID, GTZ, CIDA, among others, should provide funding to the government to ensure that the government's top up scheme for healthcare workers can be expanded.

1.0 Introduction

Malawi is one of the poorest countries in the world, ranked 161 out of 174 (Human development Index, 2000) with a population of about 11 million people and per capita income of \$180 (HIS, 1998). Over 65% of the population - approximately 6.5 million people - live below the poverty line, the proportion being higher among rural residents (66.5%) than urban residents (54.9%). In addition to this poor economic index, income is unevenly distributed, with 80% of the wealth being in the hands of the richest 10% of the population. This is according to the latest figures in the Malawi Poverty and Vulnerability Assessment Report.

1.1 Health Indicators

Life expectancy at birth in Malawi has fallen sharply over the past decade; it was estimated at 36.3 years in 2004 compared to around 42 in 1994. This decline has largely been attributed to the HIV/AIDS epidemic. Preliminary data from the Malawi Demographic Health Survey (MDHS, 2004), however, show that, in the period 2000-04, the under five mortality rate was 133 per 1000 live births while the infant mortality rate was 76 per 1000 live births, figures which are substantially lower than those reported in the preceding years. The under five mortality rates were 190 and 187 per 1000 live births in the periods 1990-1994 and 1995-1999 respectively. The corresponding figures for infant mortality rates in these years were 104 and 112 respectively. Despite this recent improvement, Malawi's under-five and infant mortality rates remain among the poorest in sub-Saharan Africa and worldwide.

The maternal mortality ratio (MMR) in Malawi rose sharply from 620 to 1120 per 100,000 live births from 1992 to 2000. The preliminary report of the MDHS shows a figure of 984 maternal deaths per 100,000 live births. Even with this figure, again Malawi remains one of the countries with the highest MMR in the world.

Malnutrition is a serious problem among children in Malawi. The rates of malnutrition or stunting (restriction of growth due to chronic under-nutrition) among under five children have remained constant since 2001. The MDHS 2004 indicate that 48% of under-five children were malnourished or stunted as compared to 49% in 2001. Recurrent food shortages due to poor rains and the low education status of rural communities are among the major reasons for the persistent malnutrition problem. Malnutrition increases children susceptibility to a host of infectious diseases, as well as stunting intellectual growth.

1.1.1 Cause of the poor health indicators

“In most cases we don't have enough equipment, infrastructure or instruments. We're supposed to have a scanning machine but we don't have it. Transport is a problem. We only have two ambulances for the district and our vehicles are very old. The equipment in theatre isn't enough. We have one sterilising machine but when we wanted to do a C-

section for a patient it broke down. We had to take the patient to Lilongwe. Yes, lives are lost.”

Health Officer, Dowa District Hospital

“If you can’t even find a thermometer how can you give patients quality care?”

Nurse, Kamuzu Central Hospital, Lilongwe.

The majority of the causes of morbidity and mortality in Malawi are preventable. In children, infectious diseases such as malaria, pneumonia, and diarrhoea are the major contributors. In pregnant women, the major causes of death are bleeding before or soon after delivery (pre- and postpartum haemorrhage) and reproductive system infections, which develop after delivery. These deaths are easily prevented with the provision of the right health care.

HIV and AIDS is currently the leading cause of morbidity and mortality in the most productive age group (20-49years). As a result of the HIV epidemic, Tuberculosis (TB) has become an important direct cause of morbidity and mortality in this age group. The number of reported TB cases has increased at least five fold in the last 20 years, from 4,863 in 1984 to 26,375 in 2004 (Malawi National TB Control Program, 2004). The major underlying poor health indicators include widespread poverty, chronic malnutrition, low education status (particularly among women), poor sanitation, poor access to safe water, and inadequate capacity of the health care system to deliver quality and accessible health services. According to MOHP, 2003 report, it is estimated that only 61% of the population has access to safe drinking water (94% of urban and 56% of rural population), and 78% have good sanitation facilities (97% urban and 75% rural).



Above: Babies with suspected malaria, Kamuzu Central Hospital, Lilongwe.

Photo: Caroline Hooper-Box/Oxfam

The majority of the causes of morbidity and mortality in Malawi are preventable. In children, infectious diseases such as malaria, pneumonia, and diarrhoea are the major contributors.

1.2 Government Policies on Health Care

The Ministry of health and Population (MOHP) is mandated to set policies for the health sector. Currently, the overall policy goals of the health sector set by the Ministry is to raise the level of health status of all Malawians through a delivery system capable of promoting health prevention, reducing and curing diseases, protecting life and fostering the general well-being and increased productivity, and reducing the occurrence of premature death.

In support of the overall health sector, five supporting health sector policies (strategies) were adopted to guide the operations of the health sector (MOHP, April 2003). These are:

1. Introduction of the Essential Health Care Package (EHP)
2. Implementation of the Bakili Muluzi Health Initiative (BMHI)
3. Introduction of the Sector Wide Approach (SWAP)

4. Decentralization of the Health Care Management Services
5. Introduction/Strengthening of Cost Recovery/User Fees

This report will focus on EHP, SWAP and the decentralization of the Health Care Management Services

2.0 Conceptual Understanding of the Essential Health Package (EHP)

2.1 Background and context of the EHP in Malawi

The EHP in Malawi is based on the country's implementation of the Primary Health Care strategy whose fundamental principle is to improve the health status of the population by focussing on a cost effective package of essential health services through the involvement of the beneficiaries themselves in service delivery.

The Ministry of Health (MOH) indicated its intention to adopt the EHP in its 4th National Health Plan (NHP) covering the period 1999-2004. The policy objective was to focus on promoting the provision of a basic, cost effective package of preventive and curative health services determined on the basis of scientific and practical experience in service delivery and its ability to have a significant impact on the health status of the majority of the population.

The EHP addresses the major causes of morbidity and mortality that mainly affect the poor and most vulnerable groups in society. Because it targets the poor, it constitutes a major part of the MOH's contribution to the implementation of the country's Poverty Reduction Strategy (PRS). Thus, the EHP is expected to contribute to the country's economic development by improving the health status of the poor and thus rendering them potentially capable of uplifting themselves from poverty. To ensure maximum benefit by the poor, it is government policy that the EHP be provided "free" of charge at the point of delivery at all public health facilities. This implies that every Malawian is entitled to EHP services at any government facility free of charge irrespective of their socio-economic status. Where government facilities have introduced "private wards" and user fees are enforced, only those patients choosing to access such privileged services will pay the requires fees.

2.2 Concept and Components of the EHP

The Essential Health Package (EHP) was developed as a means to limit the scope of health services to a narrow range of effective interventions, which will match available resources, and as a way of priority setting. There is realization that providing a whole range of service is not always possible in a resource constrained environment if quality and effectiveness are to be maintained. The idea behind EHP is to select only those cost effective interventions which when delivered will complement each other, reduce the total cost to both the provider and client and will address the major causes of death and disease in the population. The rationale behind the EHP as a pro-poor strategy is its focus on the major causes of morbidity and mortality, both amongst the general population and

particularly on medical conditions and service gaps that disproportionately affects the rural poor. The EHP is expected to be cheaper to deliver because the interventions share the same technology, are delivered by multi-skilled health workers and share the same facilities i.e. at one visit, it is possible to access more than one service e.g. postnatal care for the mother, immunization for the baby and the management of other child hood interventions of children under the age of five years.



Above: A cheerful sight for children at Kamuzu Central Hospital, Lilongwe.

Photo: Eva-Lotta Jansson/Oxfam

The EHP is thus the basis for health service planning and budgeting in Malawi. The medium term health strategy for the sector, the Sector Wide Joint Program of Work (POW) 2004-2010, is based on the need to improve access to quality EHP services.

The following disease conditions comprise EHP in Malawi: Vaccine Preventable Diseases (EPI), Malaria, Adverse maternal and neonatal outcomes (including family planning/reproductive health/safe motherhood initiatives), Tuberculosis, Acute Respiratory Infections (ARI), Acute Diarrheal diseases, Sexually Transmitted Infections (STIs), Schistosomiasis, nutritional deficiencies, common injuries, eye, ear and skin infections.

2.2.1 Implementation of the EHP

2.2.2 The Sector Wide Approach (SWAP)

The Malawi Government (GoM), adopted SWAP as the over arching strategy for overall health development in Malawi. In Malawi, as in a number of sub-Saharan African countries, the concept of SWAP has gained support as a means of getting partners-government, donors and other non-governmental stakeholders - to work together in order to develop and operate the systems and structures for effective and equitable health service delivery. This move came as a result of re-thinking the modalities of external support and how to ensure that it is used in the most effective manner.

Under this approach, the Malawi EHP is intended to provide the basis for a shared vision of the health sector in terms of what should be supported with public funds, including external support. This process in Malawi, begun with the joint development of the National Health Plan. The SWAP therefore, can be seen as a mechanism for sectoral planning around the MOHP core business of the EHP service delivery; and, as a means of enhancing donor coordination and joint working.

The core aim of SWAP is to provide quality EHP services free of charge at the point of delivery at all levels of the health system- primary, secondary and tertiary

2.2.3 Structures and Levels of Health Care in Malawi

Health Services in Malawi are provided at three levels; primary, secondary and tertiary. At primary level, services are delivered through rural hospitals, health centers, health posts, outreach clinics and community health initiatives such as Drug Revolving Funds. District and Christian Health Association of Malawi (CHAM) hospitals provide secondary level health care services. The secondary level provide surgical back up services, mostly for obstetric emergencies and general medical and pediatric in patient care for common acute conditions. The tertiary or central hospitals act as referral hospitals, to which district hospitals send their difficult cases.



Above: A nurse cleans bedding at the Kamuzu Central Hospital, Lilongwe.

Photo: Caroline Hooper-Box/Oxfam

In short, the health system in Malawi works through a referral network. Patients are first expected to contact one of the points at the lower level of the system – usually the health centre. If the patient needs more complicated treatment than the health centre can offer, the patient is referred to the district hospital. In-turn, if the district hospital cannot cope, the patient is referred to the central hospital. The main objective of a referral system is to ensure that the health sector guarantees continuity of care for the EHP. Findings from the budget tracking exercise conducted by MHEN (2006 draft) reveal that, in some cases staff are forced to refer patients they would otherwise have treated either because they have run out of drugs or equipment is not available. In some cases staff will not be able to refer patients on time because the communication system is not working or ambulances are not available. Most of the funding goes to the Central Hospitals on the premises that this is where most complicated illnesses are referred, hence the need for more resources. However, most of the rural poor people may not access these services due to delays in referral and transport problems.

3.0 Status of Health Care in Malawi

3.1 Prioritisation and Spending in the Health Care

The Abuja Declaration on HIV/AIDS, Tuberculosis and other related diseases adopted on 27 April 2001 by African heads of states and governments requires African governments to spend at least 15% of their national budget on health.

The annual allocation to the health sector in Malawi since Abuja has ranged from 7% to 10% of the national Budget. In this fiscal year 2006/07, the Health Sector has been allocated a total budget of K10, 937,476,022. This represents 8% of the total government budget, which is far below the Abuja Declaration’s minimum of 15%. K7, 838,702.022 is for recurrent expenditure that comprises administration and support services, curative health services, among others.

Table1: Total Allocations to Ministry of Health

Item Description	Approved Estimate for 2005/06	Revised for 2005/06	Estimate for 2006/07	Variance	% Change
Total Budget for Health	8,703,752.857	12,359,707,317	10,592,466,752	(1,767,240,565)	(14)
Recurrent	6,982,857	10,683,207,316	7,488,692,752	(1,215,060,105)	(11.37)
Development (Capital)	1,720,800,000	1,676,500,001	3,103,774,000	1,427,273,999	85
Part 1	1,475,800,00	1,475,800,000	2,956,774,000	1,480,974,000	100.35
Part 11	245,000,000	200,700,001	142,000,000	(58,700,001)	(29.25)

Personal Emoluments	13,559,964	21,145,960	21,713,796	7,585,996	55.94
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Source: Ministry of Finance (2006): Budget Document number 3

Despite the substantial increase in the commitment and availability of financial resources from donors and government since the mid-1990s, (e.g. Malawi Social Action Funds, HIPC, Global HIV/AIDS Funds) delivery of health services is currently hampered by the lack of skilled health workers, particularly in peripheral health facilities which provide basic health services to rural population. A health facility survey (JICA and MOH) conducted in 2003 showed that of the 26 districts in Malawi, 15 (60%) had less than 1.5 nurses per health center, while 5 (20%) had less than 1 nurse per health center. It also showed that out of the 26 districts, 10 had no doctor in the government district hospitals and four had no doctor at all. These statistics were far worse than those from Malawi/s neighboring countries. The Ministry of Health currently estimates that the vacancy rates for doctors, nurses and laboratory technicians in the public health sector range from 44% to 68%. In addition to the above mentioned shortages, the vacancy rates for specialist doctors (surgeons, obstetricians/gynecologists, physicians, pediatricians, pathologists, etc) in the public sector range from 71% to 100% (NAC M& E Report, December 2005) About one million people are living with HIV and AIDS in Malawi. The number of people in need of access to treatment, care and support is on the increase.

3.2 HIV/AIDS and the Home Based Care Model

“HIVAIDS has brought a lot of patients. We’re now dealing with double, three times the number of patients the hospital was designed to cater for. It’s frustrating.”

Nurse, Kamuzu Central Hospital, Lilongwe:

The National HIV/AIDS Policy (October 2003) stipulates that comprehensive treatment, care and support include the provision of ART and other medicines; diagnostics and related technologies for the care of HIV/AIDS, related opportunistic infections (OI) and other conditions, good nutrition, social spiritual and psychological support; and family or community home-based care.

HIV infection results in serious medical, emotional, psychological, social and economic consequences for the affected individual and family. In addition, most opportunistic infections associated with HIV infection can be treated with affordable drugs. Proper nutrition and psychosocial support, including support counseling, as well as community home-based care (CHBC), can help to improve the quality of life. This argument coupled with the failure of the health delivery system to care for every patient has led to the mushrooming of Home Based Care groups (HBCs). The government policy is to promote the delivery of quality CHBC as an essential component on the continuum of care for PLWHAs and to ensure that treatment of HIV/AIDS related infections is provided according to the EHP. However, lack or inadequate drugs for opportunistic infections

compromise the HBC model. Poor patients have to walk long distances to the nearest health center to get drugs that are often unavailable.

In addition, most of those involved in taking care of the sick in the HBC groups, are poor, marginalized and untrained women living in rural areas. The government must provide support to the caregivers in form of training, drugs, gloves and other necessities to lighten the burden and to enable them have quality essential health care services in Malawi.

The daily reality of people living with HIV and AIDS is that they are confronted with a health system that is utterly overwhelmed: the numbers of health care providers are grossly inadequate and inequitably distributed. The main constraints to scaling up the ARV program are:

- Capacity of the health sector to deliver ARV drugs to people in need
- Capacity of UNICEF and Central Medical Stores to procure and distribute ARV drugs to patients demanding for HIV testing and ARV therapy

By 2002, on average, Malawi had a population-to-nurse ratio of 3500:1 and population-to-doctor ratio of 64,000:1(JICA and MOH, Health Facility Survey, 2002). The Malawi government has been losing health workers, especially nurses and doctors, to the private sector, foreign greener pastures like the United Kingdom. This has compounded the shortage of health workers.

Table 2: Gap Analysis of the Human Resource Situation in Malawi

Description	Current	Required	Shortage	Remark
Established posts in the health sector	16,397	21,337	4,940	Vacant posts should be filled
Establishment of nurses in the public sector	2,178	6,084	3,906	Fill vacant posts
Establishment for Clinical Officers	3,852	2,825	1,027	Fill vacant posts
Medical Assistants	692	327	365	Fill vacant posts
Population to nurse ratio for Malawi	3,500	1,100	2,400 (overage)	This is equivalent to 28.6% per 100,000 for Malawi from 47.1 for South Africa; 128.7 for Zimbabwe; and 85.2 for Tanzania (some districts in Malawi have 1 nurse per 7,800 persons. Based

				on the Norm for Africa, Malawi needs 12,000 nurses. Currently, it has slightly over 4,000
Nurses in health centres	1.9 nurses	2 enrolled nurse/mid-wives	1	This is an indication that many are by none at all. Some health centers are now manned as health posts by Health Surveillance Assistants with 10 weeks of training.
Nurses in district hospitals per facility	1.5	2	1	15 of 26 districts have less than 1.5 nurses per facility, and 5 districts have less than 1
Surgeons	115	17	98	
Pathologists	22	0	22	There are 100% vacancies
Medical specialists	65	3	62	
Anesthesiologists	14	4	10	71% vacancies that need to be filled
Obstetricians/gynecologists	126	11	115	91% vacancies to be filled
Pediatricians	60	5	53	92% vacant

- The number of facilities ready to implement the Essential Health Package based on the Ministry's expressed staffing pattern is 9.2%.
- There are 156 physicians working in MoHP and CHAM. The MoH has 103 physicians working in all health facilities. Of these, 81 are working in Central Hospitals, with 22 available outside of these. On third of the 156 are with CHAM.

- WHO lower case of 30 years ago, call for 1 doctor per every 12,000 people. At this rate, Malawi needs another 850 medical doctors.
- There are 10 districts without a Ministry of health doctor and four districts without any doctor at all.
- The national ratio of doctors to population is 1.6 to 100,000. South Africa has 56.3 per 100,000; Zimbabwe 13.9 and Tanzania has 4.1.

Source: Ministry of Health, April 2004: Human Resources in the Health Sector: Toward a Solution

“We have very good qualified people here. You are trying your best but you can be alone with 90 patients. On the paediatrics ward you can find two nurses on night duty, looking after them all, critically ill children. They might need blood, emergency treatment, everybody comes to you wanting something. The nurse-patient ratio is very important..”
Nurse, Kamuzu Central Hospital, Lilongwe.

“The focus has been so much on those who are leaving. Maybe we should be focusing on the people we have here. We need to seriously look at what we can afford to help them do what they have committed to doing as health workers.”
Dr Douglas Lungu, Deputy Director (Clinical) in the Ministry of Health

“The impact of the salary top up? It’s too early to say the impact so far but early indications are that might work. The top-up offers people hope. It can help us to retain people in the system. My worry is what happens after six years? This programme has to continue; we have to sustain it.”
Health official, Lilongwe.

Apart from deaths and retirements, brain drain has contributed a lot to the shortage of human resource in the health sector. Table three below is a summary of the brain drain in the health sector from 2000 to 2003. Between 2000 and 2001, 230 nurses left Malawi.

Table 3: Nurses and Midwives that left Malawi after seeking validation certificates from Nurses and Mid- Wives Council of Malawi

Year	US	Botswana	New Zealand	South Africa	Zimbabwe	UK	Australia
2002	3	1	5	7	1	83	0
2003	10	1	1	2	0	90	4

Source: Ministry of Health, April 2004: Human Resources in the Health Sector: Toward a Solution

Since April 2005, government with the assistance from Department for International Development (DFID) introduced a retention package with the aim of preventing health staff from resigning. All cadres of professional health workers ranging from doctors to dental therapists working in government institutions were targeted with a salary top-up allowance of 52%. By October 2005 the total top-up wage bill was K31, 803, 608 for

3,808 workers. The 52% retention package (top-up allowance) being given to all health professionals working in government health institutions is a good motivator. There is need however to sustain this facility beyond DFID who are currently supporting the program. Government may find itself in a tight corner should DFID decide to discontinue the assistance. This needs developing, what is the benefit / impact of this and what would be the impact of not continuing, is there a recommendation here on long term predictable funding for this particular program.

The ministry has also responded to the critical shortage of health workers by allocating more resources to human resource development. This is in line with the six –year emergency training plan (2001-07) aimed at training an adequate number of health personnel to deliver the Essential Health Package (EHP). It takes six years to train a doctor, three years for a medical assistant and four years for nurses/midwives. Government has also provided funds to attract retired staff at clinical officer, medical assistant and nursing levels back into the health system to support both the ARV delivery and non-ARV services.

Overall the impact of top-ups is good for middle and lower grade health staff. Verbal reports from DHOs suggest that top-ups have slowed the exodus of nurses, and are also helping attract back staff on month-to-month contracts. Ministry of Health reports that the top-ups are helping attract new recruits. The number of staff receiving salary top-ups is slowly but steadily rising, indicating improved aggregate staffing numbers. The increase in numbers in the eleven focus cadres (at 450 after nine months) is slightly below the EHRP program target of 700 in year one.

Despite the increase in overall staff numbers, losses from Ministry of Health (reflected in deletions from the payroll) are high. Nearly 45% of these losses are due to death. A further 22% are due to resignation. High numbers are being interdicted, suspended and dismissed. In contrast CHAM data for Financial Year 2003-04 shows 187 staff were recruited, while 20 left service. In FY 2005-06, 228 joined and 52 left CHAM.

The emigration of Registered Nurses is still high and Nurses and Midwives Council suggests that many emigrating nurses might have initiated the process prior to implementation of the top-up.

Seventeen junior doctors resigned between July and November 2005. Four of these moved to CHAM, which offers a Euro 390 per month top-up through Cord-Aid funding. It is not known where the rest have gone and the SWAP HR Technical Working Group has established a task team to explore the issue further and suggest an appropriate response. The 17 resignations are not unusual compared to figures for recent years.



Above: With a chronic shortage of nurses, relatives are often called on to fill in the gaps.

Photo: Eva-Lotta Jansson/Oxfam

As part of the implementation of its Medium Term Pay Policy, Government of Malawi implemented a civil service wide pay-rise in February 2006 (backdated to December 2005), which establishes a separate pay scale for health workers. Basic pay has increased by 60-70% for grades F and G, by 40% for grade H. This declines to 20% for grade K and 12% for industrial class workers. The scale of the pay increases is expected to substantially increase Ministry of Health's ability to attract and retain professional staff. Under the new pay scale, the 52% top-up has been rolled into basic gross pay for the eleven cadres. In contrast to strict limits on recruitment in Malawi Civil Service, DHRMD has anticipated ongoing recruitment in the health sector, which will accommodate the Emergency Human Resources Program target staffing increases.

Table 4: Number of GoM and CHAM Staff Receiving 52% Top-Ups (plus associated costs)

Month	No. of GoM Employees	Cost of GoM Salary Top-ups	No. of CHAM employees	Cost of CHAM Salary Top-ups	Total employees receiving top-ups	Total cost of Salary Top-ups
Apr-05	3763	31,254,932.00	1582	13,600,015.00	5,345	44,854,947.00
Jan-06	4031	34,938,225.83	1764	14,556,061.00	5,795	49,494,286.83

Source: MoH Mid-Year Report of the Work of the Health Sector, July to December 2005

Table 5: MoH Payroll Deletions 2004 and 2005

Year	Deceased	Resigned	Retired	Absconded	Interdicted	Other	Total
2004	164	67	45	11	30	29	346
2005	214	115	77	37	28	20	491
Total	378	182	122	48	58	49	837

Source: Mid-year Report of the Work of the Health Sector, July to December 2005

3.3. IMF, World Bank Policies Effect on the Health Sector

“My message to rich countries? We would love to save our people. We don’t want to go out because of the money. If the money can come here and help our relatives that would be much better. Home is the base.”

Nursing Officer, Dowa District Hospital

“Rich country governments and international agencies such as the World Bank should be crucial partners in supporting public systems, but too often they block progress by failing to deliver debt relief and predictable aid that supports public systems. They also hinder development by pushing private sector solutions that do not benefit the poor.”

In the Public Interest – Oxfam/WaterAid global report, Sept 1st 2006.

“What poor country governments need is aid that is well co-ordinated, predictable, and channelled through public systems and national budgets. What poor countries typically get is insufficient, unpredictable aid, disbursed through a jumble of different projects that directly compete with public services for staff and scarce resources.”

In the Public Interest – Oxfam/WaterAid global report, Sept 1st 2006.

One of the reasons why there are insufficient, unpredictable and unsustainable funds is the prescription of macro-financial institutions, most notably the International Monetary Fund (IMF).

IMF policies impose fiscal ceilings that restrict spending on the public health and education in developing countries and insist on single digit and low inflation target requirement for national budgets. The IMF sets a low inflation target (such as 5%) in consultation with a poor country’s finance ministry and central bank behind closed doors. Poor countries which are desperate for more foreign aid will go along with whatever the IMF says is necessary for “macroeconomic stability”. Once the borrowing country and the IMF agree upon the exact low inflation target, then a limit is created for how much spending can happen in the year (money supply).

The limit on the allowable level of money in the economy then is the basis for determining the ceilings on the national resource envelope, which includes both tax revenues collected domestically as well as any foreign aid coming into the country for the

year (minus debts paid to foreign creditors in the rich countries). The ceiling for the national resource envelope then determines the ceiling for the overall national budget in the year. This includes any budget deficit spending the IMF permits or any budget surpluses the IMF insists upon.

Based on the limit set for the overall national budget, then individual budget ceilings are decided for each sector of the national economy such as health, agriculture and education. In this way, the original IMF low inflation target ultimately ends up translating into direct spending limits for the health sector. These limits can and do prevent governments from hiring the additional doctors, nurses, and health workers desperately required to scale up the fight against HIV/AIDS, procurement of drugs and ambulances to facilitate transportation of patients and developing infrastructure through construction and maintenance. These national and sector ceilings become the basis for the 3-year budget planning in the Medium-Term Expenditure Frameworks (MTEFs). The MTEF is a tool that provides budget discipline and prevents various ministries such as the Health ministry from over spending in any given year no matter how relevant the budget line may be.

IMF and World Bank also prescribe privatisation, which is extended to essential services that have a bearing on health status. Privatisation influences people's health behaviour and health care consumption. For instance, the introduction of user fees are known to lead to lower and different utilization rates, exclusion and coping strategies particularly among the poor. Policies like the Poverty Reduction Growth Facility (PRGF) continue to have negative impacts on people's welfare, education and health despite promises that these will be streamlined and selective. Thus, the poor are deprived of essential health services due to privatisation through the introduction of user fees and outsourcing critical areas to private companies. Private companies are profit oriented and most of the rural poor may not have access to these companies in the Malawian context. The government must therefore ensure that essential services that directly benefit the poor should not be privatised nor outsourced to private companies.

4.0 Challenges and Opportunities of achieving Essential Health Services in Malawi

4.1. Opportunities

Several opportunities are available to create a conducive environment for the implementation of the EHP.

- Government's commitment to the health sector by increasing annual expenditures on health from an average of 6-9% of voted expenditures in the 1990s to 12-15% in 2001.
- The Local Government Act provides the necessary legal framework for the decentralization policy to facilitate community participation in health planning and decision-making.
- The signing of the Memorandum of Understanding (MOU) between the MOH and CHAM offers a great opportunity for the enhancement of the collaborative

efforts aimed at increasing access to the EHP by the poor. This constitutes a basis for objective resource allocation to non-government providers of health.

- The signing of the SWAP MOU by the pool of funding agencies has been and is a major boost on the prospects of mobilizing a significant amount of resources to the implementation of the EHP.
- The capacity of the MOH to access and utilize HIPC (Heavily Indebted Poor Countries), MASAF and the HIV/AIDS Global funds to supplement government expenditures on health offers an opportunity to reduce the financing gap in the implementation of the EHP.
- The commitment that the Ministry of Health has shown in improving Malawi's health system will motivate and in the long term act to stem the exodus of health workers to other countries. In the meantime, heroes of the public service keep the system going against the odds.

“I have been tempted to leave. If I'm offered 80000 can I refuse that? With 29,000 that's a very big difference. But... serving the people, the spirit is there. The job satisfaction is very great – especially when you see the patient who was in very bad shape and has recovered, you feel great. I feel like it's better you help your people because the government paid for your training, so it's nice to serve some years. I think I will serve some more years.”

Nursing Officer, Dowa District Hospital.



Above: Dr Kondwani Chalulu is the only surgeon working in Malawi's public health system.
Photo: Caroline Hooper-Box/Oxfam

"If I was to work in England I wouldn't be as useful. I've chosen to stay in the government system because I feel it's more rewarding to contribute something to Malawi."

Dr Kondwani Chalulu, surgeon, Queen Elizabeth Hospital, Blantyre.

"Money alone is not happiness – you need job satisfaction ...If there's one resource we're not short of it's patients. Children are very nice to work with. It's very satisfying, as soon as they feel better they start running around."

Dr Charles Mwansambo, paediatrician, Kamuzu Central Hospital, Lilongwe.

"I'm not leaving. If all of us go, who's going to look after all of them? (pointing at queues of mothers waiting with small children). I have had chances to go and work elsewhere, I'm well qualified. I have been tempted but then I think twice because of what we're doing here, the children we're helping. That's what keeps me here – not the top-up."

Senior nurse, Kamuzu Central Hospital, Lilongwe.



Above: Dr Douglas Lungu is Deputy Director (Clinical) in the Ministry of Health. A surgeon, he has chosen to go into government, to work to improve the system.

Photo: Caroline Hooper-Box/Oxfam

“I believe in the system in this country. I needed to do this. At the moment I still operate, two weekends a month. Things need to be done – we need to believe in the system. I say ‘join it now and help it become better’. This year, out of 18 doctors graduating, we have managed to get commitment from all of them to work for government hospitals. There is optimism in the system at the moment, but we can’t persuade the next group with words. Gloves, Disprin - these are not things we need a donor for. We need our own people, we need to fix the system.”

Dr Douglas Lungu, Ministry of Health Deputy Director (Clinical)

4.2 Challenges

Sectoral analyses of poverty show that social, human capital and income indicators in Malawi are very poor with the country ranking 161 out of 174 on the Human Development Index in 2000 (UNDP 2001). All these are significant determinants of health status and thus a threat to the achievement of the targets set for the EHP. The following are some of the challenges in the achievement of the EHP:

- The poor and unfavourable macro-economic environment which threatens government’s per capita contributions to expenditures on health
- The negative impact of the HIV/AIDS epidemic which has reached such proportions as to threaten the economic potential of the country
- The frequent occurrence of states of disaster occasioned by frequent droughts contributing to food crises
- The critical shortage of human resources for health due to brain drain, deaths and other personnel that are leaving the health sector for other fields
- Corruption and theft of drugs meant for public hospitals. E.g. the recent K80million Goba drug case that revealed a presence of systemic problems in the Ministry of Health, particularly Central Medical Stores and the District Hospitals and how the poor are deprived of essential health services due to mismanagement of controlling officers
- A very high burden of disease mainly due to preventable diseases and conditions such as malnutrition, poor sanitation, lack of universal access to safe water
- Poor technical and client-perceived quality of health services characterized by poor staff attitudes, drug shortages, referral inaccessibility and poor physical infrastructure.
- Weak capacity to plan and budget for the efficient delivery of the EHP services at the district level
- Rural poor people are barred from accessing health services due to user fees charged in mission hospitals, long distances walked to access treatment at the nearest health centre and shortage of drugs

- Inadequate financial management system and accountability within the health sector
- Low expenditure levels towards the health sector in the midst of a sick community
- Due to the high prevalence of HIV/AIDS, and the failure of the health delivery system to care for every patient leading to a huge number of HBCs with most care givers being overburdened women who are not trained and are poorly resourced

5.0 Conclusion and Recommendations

5.1 Conclusion

The guiding principles of the health sector in Malawi are based on the Malawi Poverty Reduction and the current Malawi Growth and Development Strategy (MGDS). The Essential Health Care Package was therefore developed to limit the scope of health services to a narrow range of interventions that matches with the available resources targeting the poor and the most vulnerable in the society. The role of civil society in civic education, advocacy and as a watch dog of government cannot be overemphasized if the EHP is to be implemented successfully. There are however several challenges as outlined above which need to be overcome.

5.2 Recommendations

5.2.1 Recommendations to government

- In line with the on going decentralization, the Ministry of Health should ensure that its priorities are translated into district level priorities. This means that district level decision makers should be made more accountable for implementing the full EHP hence the need for building the technical expertise of staff in the assemblies in the areas of planning, and budgeting and setting up more systems of information management.
- In order to ensure the effective decentralization of health care management services the government needs to develop the technical expertise of staff in the district assemblies in the areas of planning, and budgeting and setting up more systems of information management.
- The government needs to develop effective mechanisms to ensure that the district assemblies manage the funding in a transparent manner so as to increase their accountability to local communities
- The government needs to move away from heavy reliance on unpredictable donor funding and demonstrate its commitment to its own healthcare policies by allocating 15% of the national budget to healthcare, in line with its commitments under the Abuja Declaration.
- The government needs to accelerate the Central Medical Stores reform in order to strengthen drug logistics to ensure that the entire drug procurement and

distribution system offers reliability to local communities, increase accountability and transparency and reduce the potential for corruption in the health sector.

- Parliament and the executive arm of government, should sign bilateral agreements with relevant countries to protect the Malawi government's investment in trained health and recipient countries consummately and formally compensate ensuring that emigration of health and medical professionals.
- To reduce barriers for poor people in accessing health services equitably, government should provide adequate drugs and training as outlined in the EHP to health centers. Government should also fully subsidize the costs that poor people incur when they access mission hospitals and to remove user fees on all drugs that fall under the EHP

- The Ministry of Health and the public health system should provide clear policy direction, resource support and health extension services to HBCs to help deliver quality health services to the many people who are using their services. Besides, training should be provided to the HBC care givers so that they administer their work consistently and professionally

5.2.2 Recommendations to Donors

- Donors should provide long term predictable funding to allow the Malawi health service to invest in staff training and development and in long-term infrastructure development.
- Donors such as USAID, GTZ, CIDA, among others, should provide funding to the government to ensure that the government's top up scheme for healthcare workers can be expanded.
- IMF and World Bank must remove policy prescriptions, which impose fiscal ceilings that restrict money spent on public health in developing countries like Malawi. The single digit inflation target requirement for national budgets and privatization conditionalities should be removed if we are to go a long way to help the poor access essential health services, particularly persons most seriously affected by HIV/AIDS, who are mostly women

5.2.3 Recommendations to Civil Society

- Civil Society should intensify civic education, advocacy and monitoring of the EHP and its implementation