

Department for International Development

IMPROVING HEALTH IN MALAWI

£100 MILLION UK AID

(2005/6-2010/11)

**A Sector Wide Approach including
Essential Health Package and
Emergency Human Resources Programme**

Programme Memorandum
November 2004

GLOSSARY OF KEY TERMS

ART	Antiretroviral Therapy
CHAM	Christian Health Association of Malawi
EHP	Essential Health Package
GDP	Gross Domestic Product
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
HIPC	Highly Indebted Poor Countries
MoU	Memorandum of Understanding
POW	Joint Programme of Work for a Health Sector Wide Approach
PPEs	Pro Poor Expenditures
SWAp	Sector Wide Approach
TA	Technical Assistance

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1. SUMMARY

1.1 It is recommended that DFID provide £100 million over six years to advance Malawi towards the health Millennium Development Goals (MDGs) and the global HIV & AIDS targets as part of a Sector Wide Approach (SWAp). This will increase DFID spending on health in Malawi by 50%.

1.2 DFID's support will finance: -

- a) an Essential Health Package (EHP) that is designed to deliver a prioritised package of services that focuses on the major causes of morbidity and mortality in Malawi, particularly those that affect the poor;
- b) an Emergency Human Resource Programme that will expand training capacity by over 50% on average, and more in key cadres, and pay higher salaries to attract and retain health workers so as to reduce the push factor overseas and into other jobs within Malawi. While more physicians and consultants are being trained, the programme will pay for volunteer physicians and nurse tutors to fill vacant posts that are critical for training and health services; and
- c) capacity building in financial management, procurement, human resources and health services management.

1.3 The Sector Wide Approach is the vehicle through which Government and donors will work together to support the Essential Health Package. Total Government and donor spending on health will increase by at least a third. The Ministry of Health has developed a Programme of Work to map out how the Essential Health Package will be implemented over the next six years. The Emergency Human Resources Plan is vital for the success of the Essential Health Package including the rollout of ART. It will be integrated into the Sector Wide Approach.

1.4 To finance the Programme of Work, DFID will pool its funds with the World Bank and Norway/SIDA. The Ministry of Finance will channel the pooled funds through the budget to the Ministry of Health. We expect the Global Fund to join the pool. USAID, JICA, GTZ and UN agencies will contribute through project funding. DFID will co-finance the Emergency Human Resource Programme with the Global Fund with smaller contributions from UN agencies and other donors.

1.5 DFID's contribution is allocated as follows:

TABLE 1.1 DFID EXPENDITURE PLAN (£ millions)

	05/06	06/07	07/08	08/09	09/10	10/11	Total
Essential Health Package Programme of Work	5.5	6.0	7.0	7.5	9.5	9.5	45
Emergency Human Resources Programme	8.3	9.2	10.0	10.0	8.3	9.2	55
Total	13.8	15.2	17.0	17.5	17.8	18.7	100

1.6 The Essential Health Package encompasses internationally recognised, public health 'best buys' for reaching the health-related Millennium Development Goals and global AIDS goals, including: -

- a) to address child mortality: an effective extended programme of immunisation, basic nutritional interventions, widespread coverage of

- insecticide treated bed nets for the under fives, and appropriate and timely management of childhood fevers;
- b) to reduce maternal mortality: skilled attendance at birth, promotion of wider birth spacing and prevention of unwanted pregnancies, and intermittent preventive therapy during pregnancy to reduce the burden of malaria;
 - c) to help reduce HIV infections: comprehensive behavioural change strategy, syndromic management of sexually transmitted infection and widespread provision of voluntary counselling and testing;
 - d) to treat AIDS: provision of antiretroviral therapy (ART) free of charge through the public health system;
 - e) to reduce tuberculosis: implementation of the 'DOTS' (Direct Observed Treatment Short course) strategy.
- 1.7 The added element of the Essential Health Package (as compared with current, disease-specific, vertical programmes) will be a district health system that integrates primary care with effective referral. That should provide, inter alia, better access to emergency obstetric care, which is essential for reducing maternal mortality. The SWAp will also provide money for other key interventions to go to scale across the country.
- 1.8 A Memorandum of Understanding (MoU) governs the relationship between the Government of Malawi and collaborating partners and sets out our several undertakings, governance procedures for the Sector Wide Approach and capacity building requirements. The Government has undertaken to ensure the proportion of overall Government budgetary allocation to the health sector is maintained or increased during the period of the Programme of Work. We will require that the Government budget for health is increased by the full amount of pooled aid.
- 1.9 A condition precedent for DFID aid disbursements is agreement on an action plan to improve the effectiveness and integrity of the Central Medical Stores and drugs supply chain.

- 1.10 The proposed salary increases for health staff are only affordable if they are fully funded with additional aid. DFID recognises that the Government of Malawi is therefore vulnerable to the withdrawal of that aid and undertakes to give notice of two financial years if it intends to withdraw or reduce its contribution to salary support.
- 1.11 Overall, we rate the programme as high risk, not because of programme design, which is medium risk, but because of exogenous risks. Malawi has begun a reform process under its new government, but future governments may not sustain it. Health sector funding will be equivalent to \$15 per head, compared to the WHO Commission on Macroeconomics and Health recommended level of \$34, and may not be sufficient.

2. LOGICAL FRAMEWORK

Note: The Programme of Work includes a detailed list of indicators to be measured under the SWAp. This logframe highlights the main indicators, all of which are included in the SWAp monitoring and evaluation plan. The 'Outputs' referred to below, relate to the 6 'Purposes' in the Programme of Work.

Narrative summary	Objectively verifiable indicators (OVIs)	Means of verification (MOVs)	Assumptions
<p>GOAL</p> <p>Improved health status of all Malawians</p>	<p>Reduction in under-five child mortality rate to 104 deaths per 1,000 live births by 2011</p> <p>Reduction in maternal mortality ratio by half from 1120 to 600/100,000 by 2011</p> <p>To reduce the proportion of 15-24 year old pregnant women who are HIV positive to below 14% by 2011</p>	<p>Demographic Health Surveys in 2004, 2008</p> <p>Demographic Health Surveys in 2004, 2008</p> <p>Annual antenatal HIV routine surveillance</p>	
<p>PURPOSE</p> <p>Improved access to & quality, effectiveness and accountability of essential health services.</p>	<p><i>Increase by 2011:</i></p> <p>Increase in health facilities with ability to provide Essential Health Package from 10% to 80%</p> <p>Extended Programme of Immunisation coverage increased to above 85%</p> <p>Increase in deliveries attended by skilled health personnel from 56% to 75%</p> <p>Number of people on antiretroviral therapy from 9000 to 100 000</p> <p>Insecticide Treated Bed Net coverage increased from 35% to 60%</p> <p>Tuberculosis cure rate increased to 75% or above</p>	<p>Health Facilities Survey</p> <p>Demographic Health Surveys in 2004, 2008</p> <p>Demographic Health Surveys in 2004, 2008</p> <p>Health Management Information System</p> <p>Demographic Health Surveys in 2004, 2008</p> <p>Health Management Information System</p>	<p>Reduction in causes of ill-health that cannot be controlled by the health services (e.g. poor environmental hygiene, poor nutrition).</p> <p>HIV incidence significantly reduced in the medium term</p> <p>Additional financing provided as absorptive capacity increases</p>

<p>Outputs</p> <p>1. Adequate numbers of trained and skilled personnel for all health facilities (inc. CHAM)</p>	<p>Vacancy levels in target cadres PE budget Outflow rates Salary structure % of facilities with full staffing complement</p>	<p>Routine MOH and CHAM HR Information Systems</p>	<p>HR Management and development systems enhanced</p>
<p>2. Adequate volume of pharmaceuticals and medical and laboratory supplies at service delivery points (inc. CHAM)</p>	<p>Routine availability of pharmaceuticals and medical supplies at % of health facilities (disaggregated e.g. health centre, district hospitals)</p>	<p>Stock records of EHP items from randomly selected peripheral facilities Drug surveys Service delivery surveys Expenditure on drugs, by level (community, health centre, district hospital)</p>	<p>Drug management and development systems enhanced</p> <p>Willingness of Global Programmes to integrate procurement and delivery</p>
<p>3. Essential medical equipment available (inc. CHAM)</p>	<p>Essential medical equipment available in % of facilities (disaggregated e.g. health centre, district hospitals)</p>	<p>PIAMHAS inventory against standard equipment lists, DIP, reviews</p>	<p>Equipment managed and development systems enhanced</p>
<p>4. Improvements in access to services through facility development (inc. CHAM)</p>	<p>% of facilities operating to infrastructure standards % of population within 5km of a health centre</p>	<p>PLAMHAS, GIS infrastructure surveys, budgets/ expenditure returns, DIP reviews</p>	<p>Infrastructure management and development systems and policies enhanced</p>
<p>5. Routine operations at service delivery level provided (inc. CHAM)</p>	<p>A range of support services effectively delivered</p>	<p>DIPs and DIP review</p>	<p>Management systems improve</p>
<p>6. Central support to service delivery and policy and systems development</p>	<p>Central level institutions effectively staffed Central level institutions effectively operating Adequate policies and systems developed and in-place to efficiently and equitably guide health sector HR</p>	<p>6.1 SWAp review 6.2 Staff returns 6.3 PPPI</p>	<p>Labour supply</p> <p>Recruitment and deployment systems</p> <p>Central HQ capacity</p> <p>Vertical programme change management</p> <p>Streamlining of TA procurement</p> <p>Number of partners joining the SWAp</p>

Activities These are defined in the Programme of Work.	Inputs Annex 1 in the POW estimates total funding requirements over six years as US\$735m (approx. £410m – ex. Rate: 1:1.8) DFID contribution £100m over 6 years		
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3. PROGRAMME RATIONALE

Background

Progress toward Millennium Development Goals

- 3.1 Malawi has made progress, mainly through vertical programmes, in:
- reducing the under-five mortality rate and is on track to meet the MDG to reduce the rate by two-thirds between 1990 and 2015
 - stabilising prevalence of HIV at 14% of people in the reproductive age group, including a significant decline in infection rates in young people in Lilongwe and signs of a similar decline in Blantyre.
 - maintaining tuberculosis cure rates at 70% despite a high mortality rate due to AIDS
 - increasing coverage of insecticide treated bed-nets, and is on track to meet the Abuja target of 60% by 2005
- 3.2 But, overall Malawi health indicators are extremely poor. Life expectancy has declined from 48 to 39 years between 1990 and 2000, mainly as a result of AIDS. Maternal mortality is shockingly high and has worsened since 1990, suggesting a significant decline in the overall health infrastructure and ability to deliver accessible emergency obstetric services.

Underlying problems

- 3.3 Achieving the MDGs in Malawi is a major challenge in the face of increasing levels of poverty. 65% of the population are poor and unable to meet their daily nutritional needs. Fertility rates are high and the HIV/AIDS epidemic has increased demand for health services, whilst reducing the health sector capacity.
- 3.4 Access to health services is modest, and skewed in favour of non-poor and urban populations. Only 54% of the rural population has access to a health facility within 5km. Only 10% of all health facilities have the capacity to deliver the Essential Health Package. Front-line health services suffer from lack of drugs, poor staff-client relations, and poor quality diagnosis and treatment. Public services are free-of-charge at the point of delivery, but out-of-pocket expenditure accounts for 26% of total health spending, with the poorest households spending up to 10% of their annual consumption on health care. The poor have the greatest burden of ill health and are the least likely to access health services.
- 3.5 The current level of staffing in Malawi's health service is inadequate to maintain a minimum level of health care, and is very low by African standards.

TABLE 3.1 STAFF PER 100,000 POPULATION

Cadre	Botswana	South Africa	Ghana	Tanzania	Malawi
Physicians	28.7	25.1	9.0	4.1	1.6
Nurses	241.0	140.0	64.0	85.2	28.6

Staffing is also inadequate to roll out antiretroviral treatment and other HIV/AIDS related services. Vacancies among nursing cadres are over 60%. Ten of Malawi's 29 districts have no government doctor; 4 districts have no doctor at all. Vacancy rates are significantly higher in rural areas.

TABLE 3.2: CURRENT AND REQUIRED HUMAN RESOURCES (MINISTRY OF HEALTH & CHRISTIAN HEALTH ASSOCIATION OF MALAWI - CHAM*)

Cadre	Ministry of Health target for Malawi	Required for, HIV and AIDS programmes	Current number in post	Current vacancies
Physicians	433	10	139	294
Nurses	8440	3401	4717	3723
Clinical Officers	1405	689	942	463
Medical Assistants	1500	500	718	782
Laboratory Technicians	507	386	251	256
Pharmacists	285	344	93	192
Environmental Health Officers	1662	10	304	1358

*CHAM provides approximately 30% of healthcare in Malawi

- 3.6 There are two main reasons for staff shortfalls: poor retention of existing staff due to low pay, poor working conditions and a resulting decline in morale; and inadequate production of trained workers. AIDS has doubled attrition rates and increased absences through ill health and attendance at funerals. Some of the investment made in training is being lost as staff choose to move out of public health service into other better-paid and/or less frustrating work. The most experienced nurses and midwives are emigrating at a rate over 100 per year, primarily to the UK.
- 3.7 A further problem has been the 'balkanisation' of the health sector by donors. This has led to 'islands of excellence' operating within an ever weakening public health structure. Many of the individual donor projects are 'off-budget', but require significant support from government in terms of management time, supervision and reporting.
- 3.8 Financial management systems in government are generally weak and capacity is low at Ministry and district level. The Government currently operates manual accounts. These systems, while antiquated, are adequate, as long as routine book keeping and reporting is completed in a timely and regular fashion. In the past that has not been the case, reflecting both weaknesses in management, and a chronic shortage of trained accountants.

- 3.9 Corruption was a major problem under the previous government, especially in drugs procurement and the supply chain. The World Bank conducted a Country Procurement Assessment Review in 2004, following a procurement capacity assessment of Ministry of Health and Central Medical Stores in December 2003. It assessed the risk as high.

4. GOVERNMENT HEALTH POLICIES AND PROGRAMME APPROACH

Essential Health Package

4.1 The 'Essential Health Package' (EHP) is in line with the recommendations of the WHO Commission on Macroeconomics and Health. It will target Malawi's limited resources on eleven public health interventions that will be made accessible to everyone who has need of them.

TABLE 4.1: SUMMARY OF THE INTERVENTION AREAS OF THE ESSENTIAL HEALTH PACKAGE

Essential Health Package Component	
1	Prevention and treatment of vaccine preventable diseases.
2	Malaria prevention and treatment
3	Reproductive and neonatal health interventions (including reproductive health, family planning, safe motherhood and PMTCT)
4	Prevention, control and treatment of Tuberculosis.
5	Management of Acute Respiratory Infections.
6	Prevention, treatment and care for Acute Diarrhoeal Diseases (including cholera)
7	Prevention and treatment of sexually transmitted infections (HIV/AIDS, ARVT and VCT)
8	Prevention and treatment of Shistosomiasis and related complications
9	Prevention and management of Malnutrition, Nutrition deficiencies, and related complications
10	Management of eye, ear and skin infections.
11	Treatment for common injuries.
Support services	
	Essential laboratory services.
	Drug procurement, distribution and management.
	Information, Education and Communication.
	Pre- and in-service training.
	Planning, budgeting and management systems.
	Monitoring and evaluation.

4.2 Between 2001 and 2002, a comprehensive consultation exercise and document review was conducted with all levels of the health service and with health sector partners. This process resulted in consensus on the essential interventions to combat major infectious diseases and malnutrition in Malawi. These interventions are recognised internationally as the most cost-effective measures to reduce illness and death rapidly. The interventions are organised in an integrated package, focussing on primary health services supported by effective referral to a district hospital. The consultation also emphasised the health needs of the poor by: establishing a minimum standard of health care for all, to be provided free of charge; expansion of community-level health services; and prioritising allocations to peripheral health services, poor geographical areas and areas with the greatest health needs.

Emergency Human Resource Programme

- 4.3 With encouragement from Peter Piot and Suma Chakrabarti during their visit in February 2004, the Ministry of Health developed its existing training and human resource development plans into a comprehensive approach to the human resource crisis in Malawi's health sector. The product was its *Proposed 6-Year Human Resource Relief Programme for the Malawi Health Sector*. The programme is dovetailed with the Programme of Work and takes account specifically of the requirements for the scale-up of ART. A particular concern was to recruit staff for the roll-out of ART so that the opportunity provided by Global Fund money of treating people with AIDS did not become an added burden on the rest of the health service. (A fuller description of the Emergency Human Resources Programme is at Annex 3).
- 4.4 The Emergency Human Resources Programme aims to bring Malawi approximately up to Tanzania's staffing levels. This is short of a desirable outcome for providing basic health services, but was thought to represent an affordable and implementable initial target. In the event, promises of funding at this stage were less than expected and the scheme has been scaled back to about three quarters of its previous level.
- 4.5 The Programme covers ten professional and technical health staff cadres working for the Ministry of Health and Christian Health Association of Malawi (CHAM). It aims, first, to re-employ trained Malawian nurses and clinical officers as well as retaining staff already in the service. These are the crucial grades for ART rollout. It is estimated that 800 or more registered nurses who have left the profession are potentially available in Malawi for re-recruitment. Part of the strategy for recruitment and retention involves increasing salaries: by 100% in the original plan; now scaled back to a 50% increase to match resources. Re-engagement targets have consequentially been reduced from 100 to 75 nurses per year and 80 to 60 clinical officers per year. Retention policies for trainees will be enforced and a redeployment strategy will relocate staff to priority, difficult-to-fill locations by offering a 'hardship incentive'.
- 4.6 Secondly, training capacity for all cadres of staff will be increased by over 50% on average, and more in key cadres: trebling the numbers in physician training and doubling nurse training. That requires an investment in the infrastructure and teaching staff of existing medical schools. The impact will begin to be seen in front-line services in terms of increased numbers of staff within three years. Physicians take five to seven years to train and the third leg of the programme addresses the gap that leaves.
- 4.7 So, thirdly, the programme provides for overseas recruitment of physicians and nurse tutors through volunteer organisations on two-year contracts. The Government plans to recruit 50 additional physicians and nurse tutors per year for three years through volunteer organisations such as VSO and UN volunteers.

4.8 The cost of the programme is as follows.

Emergency Human Resources Programme (\$US Million)

STRATEGY	Base	05/06	06/07	07/08	08/09	09/10	10/11	TOTAL
TOTAL COSTS OF INCREASED REMUNERATION	6.95	21.2	22.8	24.5	24.7	26.6	28.4	148.2
TRAINING	0	4.8	6.1	6.1	6.1	6.1	7.3	36.5
VOLUNTEER PHYSICIANS	0	1.5	2.6	2.6	2.6	2.6	1.3	13.2
MONITORING	0	0.2	0.2	0.2	0.1	0.1	0.1	0.9
TOTAL	6.95	28.4	31.3	33.0	33.1	35.0	38.0	198.8

4.9 The Ministry will address the non-financial factors that affect retention and performance including postings and promotions policies, performance management, re-grading, skills upgrading opportunities, gender issues and quality of housing. It will strengthen its human resources planning and management. The Ministry will recruit three long-term technical assistants to build capacity in programme management and policy development.

Procurement

4.10 Malawi is in the process of procurement reforms. A new Public Procurement Act became effective in 2003 that decentralises the government procurement function to Ministries such as Health under the supervision of a new Office of the Director of Public Procurement (ODPP). While this is encouraging, the Government will face substantial problems implementing the Act, principally because of the severe shortage of trained procurement specialists and the need to build a new ethic around the procurement function.

4.10 As part of the SWAp arrangements, a time bound Procurement Improvement Action Plan was agreed between the Ministry and partners. This is designed to accelerate full implementation of the 2003 Procurement Act, building capacity in the Ministry and districts and, in the interim, includes safeguards against the weaknesses of the present systems. The arrangements provide for: the Ministry to draw up a detailed annual procurement plan; World Bank procedures to be used for International Competitive Bidding (ICB); an independent procurement audit to be conducted annually; and three long-term technical assistants to be recruited to build capacity and assist with

managing procurement activities in the Ministry. (A summary of the plans to improve procurement is in Annex 4).

The Central Medical Stores and drugs supply chain

- 4.11 DFID has financed technical assistance to the Central Medical Stores for several years and has an insight into its operations. A recent OPR concluded that the management of the Stores had no intention of implementing any of the recommendations made for improving its performance. DFID Malawi has indicated that it would be unable to proceed with the SWAp if the management remains unchanged. The Office of the President and Cabinet in the Malawi Government has indicated that it plans to review the management of the Stores and will consider contracting out the Stores function (the Kenyan and Zambian approach), contracting in a whole new management (the Tanzanian approach) or recruiting new staff for the key management posts.
- 4.12 The Minister of Health is also concerned very appropriately with pilferage and diversion of drugs in the supply chain at more local levels.
- 4.13 A condition precedent for the release of DFID funds is agreement between the Government and Pooled donors including DFID on an approach to the management of the Central Medical Stores and the drugs supply chain.

Financial Management

- 4.14 The new Government is determined to impose greater fiscal discipline and accountability. In part, this is simply a matter of requiring that existing procedures are implemented and returns are provided in a timely way. The Ministry of Health has contributed to this tightening up process by, for example, bringing bank reconciliations up to date at district level and by recording arrears.
- 4.15 The Government is also giving a greater impetus to systemic reforms across Government that DFID and other donors are supporting. Those reforms will take time to have an impact. The Ministry of Health is therefore proceeding with financial management reforms in the health sector ahead of similar reforms to be introduced across the public sector, so as to give donors assurance about how their aid will be used and accounted for.
- 4.16 Financial management arrangements for the SWAp have been developed to provide those fiduciary safeguards, while simultaneously building capacity at central and district levels. They include a time bound Financial Management Improvement Plan; a commitment to fill accountant vacancies; annual and semi-annual independent audits of the SWAp; three long-term Technical Assistants who will have mentoring, management and supervisory responsibilities at central and district levels. (A summary of the plans to improve financial management are in Annex 5).

4.17 All institutions supported through the SWAp will produce monthly financial statements, classifying, analysing and reporting data covering income and expenditures from all sources. The financial management systems used for the implementation of the Programme of Work will vary depending on the level of implementation and the type of institution involved. They are spelt out in the MoU (Annex 1).

Decentralisation

4.18 Malawi plans to devolve control of services at the district level including health to District Assemblies. The Ministry would retain stewardship responsibilities for the health sector including policy, establishment of standards, training and curriculum development. In practice, Districts lack capacity and the Ministry is properly limiting their involvement to consultation on District Implementation Plans.

5. RATIONALE FOR DFID SUPPORT

- 5.1 DFID is already committed to assisting Malawi achieve the health related MDGs. Addressing the burden of ill health, which is known to be a major constraint on economic development, is also consistent with reducing income poverty. DFID is supporting action on the other key factors for pro-poor growth which are, in the Malawian context, macro-economic stabilisation, education and improved governance.
- 5.2 Hitherto DFID operated in the health sector through DFID or UN agency managed projects covering immunisation, malaria, safe motherhood, sexual and reproductive health and TB. While these projects were effective and achieved some successes, their impact on health outcomes was limited by restricted geographical coverage and weaknesses in supporting health services.
- 5.3 The time is now ripe to address health service issues in a more coherent way. A lot of the groundwork was done under the previous Government by a dedicated group of Malawian officials, with support from Ministers with a medical background. They designed the Essential Health Package and the Emergency Human Resource Programme. The new Government provides the previously missing element. It is committed to the kind of fiscal discipline and fiduciary reforms that are necessary to make the programmes and a SWAp work.
- 5.4 The promise of large additional sums of money from the Global Fund and pooled donors also makes it feasible to think in terms of service-wide improvement. Without such an approach, there was a risk that antiretroviral treatment, partly funded by the Global Fund, would divert resources, especially human resources, away from other health services.

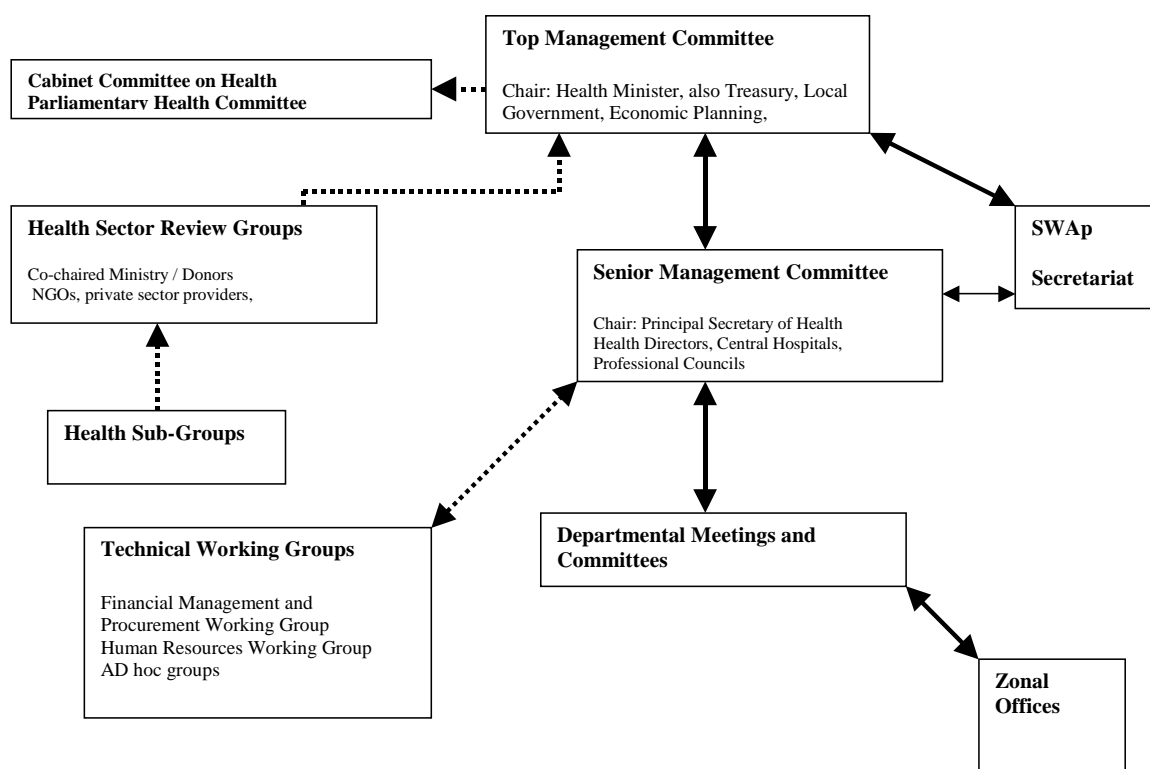
6. MANAGEMENT & MONITORING

Governance structure

6.1 A Memorandum of Understanding (MoU) governs the relationship between the Government of Malawi and collaborating partners. The MoU refers to the financing arrangements, coordination and monitoring instruments, including joint annual reviews, and a code of conduct for partners. The design of the SWAp management arrangements takes account of experience with other SWAp. A copy of the MoU is attached at Annex 1.

6.2 The governance structure is set out in the organogram below.

FIGURE 6.1 GOVERNANCE STRUCTURE OF THE SWAP



Data collection

6.3 Malawi already implements a comprehensive Health Management Information System that has been rolled out to all levels of the health system. This includes 110 indicators of which 42 indicators have been chosen to monitor the implementation of the POW (see Annex 2). Other sources of data will be operational research and periodic surveys, such as the Demographic and Health Survey, which will be conducted next in 2005 and provides a baseline against which to measure progress in health outcomes.

6.4 The MoU includes a final set of SWAp indicators at input, output, and impact at district and national levels. Each indicator will have specified

baseline and target values. Every effort will be made to discourage individual donors from imposing their own indicators and targets. The SWAp Secretariat in the Planning Unit of the Ministry of Health will coordinate programme monitoring. The technical departments will monitor service delivery. The Ministry will recruit a long-term technical assistant and short-term assistants to: help with the Health Management Information System; create capacity to commission relevant operational research and surveys; and work on data preparation and analysis for the mid-year and annual review processes.

Pro-poor performance

- 6.5 Health service performance will also be assessed for its capacity to reach the poor. This includes the extent to which resources are allocated to pro-poor interventions and to peripheral (sub-district) health services. Data for key monitoring indicators will be disaggregated, where possible, by sex, age, location and service level and supplemented by action-oriented research on barriers to access by the poor.

Donor role in governance

- 6.6 Donors will interact with the Ministry of Health at several levels within the SWAp governance structure. Collaborating Partners (pooled and non-pooled donors) and NGOs and private sector providers will be part of the Health Sector Review Group, which will be co-chaired by Ministry of Health. This group will review progress in the implementation of the Programme of Work and annual work plans. A health donor sub-group will report to this Health Sector Review Group.
- 6.7 In addition, Pooled Donors will be represented on Technical Working Groups. Standing Groups will include the Financial Management and Procurement Improvement Monitoring Working Group and the Human Resources Management Group. The Secretary for Health will chair the Groups. They will review progress quarterly and submit written reports to the SWAp Senior Management Committee and Health Sector Review Group.
- 6.8 Donors will also participate in the Annual Joint Review, coordinated by the SWAp Secretariat. The Swap Secretariat will compile the Health Sector Annual Report, which will be submitted to all partners by 15 September each year, together with the Annual Consolidated Financial Audit and Procurement Audit.
- 6.9 DFID intends to set up a joint health office with Norway/SIDA to improve our effectiveness and lower transaction costs for the Government and other Collaborating Partners. The office will contain both DFID and Norwegian staff, who will coordinate their activities but report separately to their respective organisations.

7. FINANCING

The Programme of Work

- 7.1 The Ministry of Health has had to match the design of the Programme of Work to the funds available. It followed a three-stage process. First, it developed an 'Ideal Resource Requirements' scenario, reflecting WHO recommendations that was costed at US \$1.5 billion over six years. Recognizing that this was not financeable, it then conducted a constraints analysis – which looked at both the level of funding that could plausibly be available and at absorptive capacity. Finally, it prioritised the Ideal Requirements to fit within the latter funding level, producing a 'realistic but challenging' Programme of Work costed at US \$735 million.
- 7.2 Total Government and donor funding commitments for the Programme of Work are of the order of \$139 million per annum. This allows some room for slippage in donor disbursements without disrupting implementation. Whilst project funders' current commitments tail off towards Year 3, it seems reasonable to anticipate future commitments at current levels. The process of preparing annual implementation plans will allow Government to take account of actual funds available.
- 7.3 Table 7.1 shows the total estimated financing of the Programme of Work for 2005/06, along with indicative figures for 2006/07 and 2007/08.

TABLE 7. 1: PROGRAMME OF WORK FINANCING (US\$ MILLION)

Source	05/06	06/07	07/08
Government:	39	39	39
Donor:	100	100	100
<i>Pooled</i>	25	29	32
<i>Project</i>	75	71	68

- 1.12 The Memorandum of Understanding sets out the Government undertaking to ensure the proportion of overall Government budgetary allocation to the health sector is maintained or increased during the period of the Programme of Work. We will require that the Government budget for health be increased by the full amount of pooled aid.

The Emergency Human Resources Programme

- 7.4 The money available to finance the Emergency Human Resources Programme is about three quarters of the amount required to finance the original plan. It is possible that the Global Fund may provide additional support if and when it holds a fifth round of allocations. The Ministry of Health has revised the programme to match the funds available which still amount to the substantial figure of US \$199 million over six years.

- 7.5 The Government of Malawi contribution will be its current payments for the salaries of staff and the recurrent cost of training colleges. This contribution for the cadres of professional staff included in the Programme amounts to US\$7 million per year or US \$42 million over six years.
- 7.6 The Country Coordinating Mechanism for the Global Fund has agreed a contribution of \$40 million and will submit a proposal to the Global Fund for the scheduling of the payments. UN agencies and other donors have project aid related to the Programme that amounts to US\$17 million.
- 7.7 DFID's contribution will be £55 million equivalent to US \$100 million at current exchange rates. The present schedule of contributions is set out below. It may be changed by agreement between the Government of Malawi and DFID depending on the needs of the Programme.
- 7.8 Raising salaries for the professional cadres included in the Programme represents a long-term obligation for the Government. The donors can offer the Government the following assurances. First, donor funding is sufficient to cover the cost of the increase for the duration of the Programme, which is the lengthy period of six years. DFID's contribution alone is sufficient to cover the cost of the salary increase. Second, DFID will give an assurance that, in the unlikely event the UK Government felt it necessary to terminate this aid to Malawi, DFID will give two financial years notice of the withdrawal of the salary component of its aid.

DFID's contribution

- 7.9 DFID's contribution of £100 million over six years will be allocated as follows:

TABLE 7.3 DFID EXPENDITURE PLAN (£millions)

Activity	05/06	06/07	07/08	08/09	09/10	10/11	Total
Essential Health Package Programme of Work	5.5	6.0	7.0	7.5	9.5	9.5	45
Emergency Human Resources Programme	8.3	9.2	10.0	10.0	8.3	9.2	55
Total	13.8	15.2	17.0	17.5	17.8	18.7	100

Out of the total of £100 million, up to £10 million will be Technical Cooperation funding.

- 7.10 DFID has been funding the following national programmes: Sexual and Reproductive Health (including Safe Motherhood), Tuberculosis, Malaria Control, and Expanded Programme of Immunisation. All the national programmes are part of the Essential Health Package and will be integrated in to the Programme of Work and fully funded through the SWAp by 2007/08.
- 7.11 In addition, DFID is funding Banja La Mtsogolo (BLM), a local NGO and partner to Marie Stopes International. BLM provides 40 percent of all family planning services in Malawi. BLM's activities are nested within the National Sexual and Reproductive Health Programme. However, inclusion of its funding within the SWAp will depend on strengthening the Ministry's relationship with NGO private providers.

8. APPRAISAL

Economic and financial appraisal summary

8.1 The essential economic appraisal issues concern whether the activities included in the POW are the highest priority ones and whether they will be undertaken in a cost-effective way (See annex 6 for the full Economic and Financial Appraisal).

8.2 The World Bank – which led the economic appraisal for the SWAp partners – concluded that:

‘The POW costing exercise was found to be generally sound’; and ‘based on the trends of diseases analyzed ...[earlier] and the global cost-effectiveness rates, it is clear that the Malawi EHP has been chosen judiciously based on universally accepted “global best-buys”.’

In other words, both the unit costings on which the Programme of Work has been based and the prioritization process are considered sound.

8.3 Total expenditure on health services in Year 1, including the Essential Health Package and the Emergency Human Resource Programme, is estimated at US\$170 million. This is equivalent to about 8-9% of GDP or US\$15 per capita. This compares with the WHO Commission on Macroeconomics and Health’s minimum recommended expenditure of US \$34 per capita. Health is expected to remain at about 12% of Government non-interest expenditure (excluding SWAp funding).

8.4 The proposed human resources programme has been devised with reference to the macro-economic impact. Proposals for increasing staff compensation have implications for the Government’s pay reform policies, pension fund and agreements with the IMF, and have been assessed within that context. The Government recently began implementing pay policy reform, with which these proposals are consistent. It does not yet have a wider civil service reform programme.

Government Funding

8.5 Given that insufficient resources are available to meet the ‘Ideal Resource Requirements’, the Programme of Work has been scaled back to fit within a realistic estimate of resources. The key financial appraisal issue, therefore, is what level of resources is likely to be available. We look first at Government and then at donor funding.

8.6 The Government does not have medium term expenditure plans or scenarios. Medium term projections are complicated by Malawi’s fiscal crisis. Government domestic debt more than doubled to 26% of GDP over the two years to June 2004. As a result, interest jumped to 33% of domestic expenditure in 2003/04 - crowding out much essential expenditure. Government plans to reduce the interest charge and to repay domestic debt starting in 2005.

- 8.7 There are three reasons for confidence that Government will maintain its' current level of funding of about \$46 million. Firstly, the new Finance Minister is committed to sticking to the approved Budget. Secondly, some 70% of the Health budget is classified as 'Pro-Poor Expenditure' (PPE), and Government has a good record of protecting PPEs. In 2003/04, 97.7% of Health PPE funding was disbursed. Thirdly, PPEs are a condition of HIPC support.

Donor Funding

- 8.8 A recent Ministry of Health survey of donors reported total estimated commitments in 2004/05 of \$116 million to activities that will fall within the Programme of Work (POW) (plus \$8 million for non-POW health activities). Most of this aid would have been project aid. Since disbursements of project aid are always below estimates, the assumption in the financing plan for donor project aid of US\$ 75million in 2005/6 is realistic and reasonable reliable. The other uncertainty with project aid is the level of commitments in future years. Few donors commit funding more than three years ahead. However, there is no reason to anticipate any reduction in donor health funding by project aid funders. Similar uncertainties do not arise with pooled funding to the same degree. We are reasonably confident therefore that donor funding of the order of \$100 million per annum or more will be available for the duration of the Programme of Work.
- 8.9 90% of the donor funding for the Emergency Human Resources Programme will come from DFID and the Global Fund. All of this will be paid through the Government budget except some payments by DFID to VSO and for technical assistants. We are therefore more confident of the reliability of estimates of funding for this programme.

Public health appraisal summary

- 8.10 The key public health appraisal issues are whether policies and strategies to be supported through the SWAp are sound and whether implementation of the programme will match up to these aspirations in practice? The following paragraphs are a summary of a fuller assessment set out in Annex 7.
- 8.11 The need for reform and support has been made above in terms of the scale of the health problems in Malawi and the deficiencies of its health service. The Essential Health Package is in line with international norms for health services for the poor, and correctly focuses on proven cost-effective interventions. The interventions are packaged into an integrated district-based approach, in line with international consensus for health system support and the draft recommendations of Millennium Development Commission. If this programme is implemented, Malawi will make steady progress towards the health related Millennium Development Goals and the Global AIDS targets. The progress will be accelerated if Government can make complementary interventions to reduce income poverty and malnutrition, to improve water and sanitation and to reduce gender inequities.

- 8.12 Malawi has then a mature policy environment, which has been recognised by international awards. But implementation has been a weakness, with the exception of a few, vertically managed interventions. The overall quality of services has been poor, reflecting a broad range of problems including staffing, management, facilities, drugs supply and commodities.
- 8.13 Appropriately, given this context, the Programme of Work, the MoU and the Emergency Human Resource Programme have a heavy emphasis on capacity building and, in the interim, arrangements to make the health sector work better pending the impact of that capacity building kicking in. For most areas, the plans are well developed. This applies to financial management, procurement and human resources. The arrangements include the deployment of technical assistants which is the model favoured by the top management of the Ministry. The relatively few policy makers in the Ministry headquarters have made good use of such technical support in the past, although they remained overloaded.
- 8.14 Probably, the single biggest constraint on health programmes in Malawi has been the shortage of health professionals at all levels and locations, with the greatest impact on peripheral services. The Government's intention, in line with global AIDS goals, to roll out antiretroviral therapy as rapidly as possible and free of charge would have diverted more staff resources from the delivery of other essential health services had no action been taken. The international focus on the human resource emergency and the development of the SWAp has opened up the opportunity to address human resources more comprehensively, and to link the scale up of antiretroviral therapy to broad health systems strengthening. If the Emergency Human Resources Programme is to have a significant impact on health outcomes, staffing health services in rural and remote locations needs to be a priority.
- 8.15 Overall, we believe that there are reasonably good prospects of progress with the implementation of the Programme of Work. The strong commitment and ownership of the Programme under its present management has been and will continue to be important for success

Governance and institutional appraisal summary

- 8.16 This governance and institutional appraisal addresses a number of key issues. (The full Governance and Institutional Appraisal is given in Annex 8).
- 8.17 First, experience in Africa suggests that it is possible to reform institutions in a sector, but that the improvement will not be maintained without institutional reform across the public sector. What are the prospects in Malawi? The answer is reasonably good. In the first ten years of democracy, the quality of the public service declined. The new

President is intent of reversing that process. He has purged the government of the most corrupt ministers and officials. He has restructured and reduced the number of government departments and a new work ethic has been introduced from the top. The Government is implementing a new pay policy. It is encouraging that the Government and donors are discussing the organisation of reforms on a broader front.

- 8.18 Second, a substantial part of health services are provided by the voluntary sector. The SWAp needs to incorporate them. At present, collaboration between the Ministry and the second largest provider – The Christian Health Association of Malawi (CHAM) – is substantial. Government contributes towards salaries of CHAM staff, contracts their services in areas not served by state health units and is working closely with CHAM on the roll-out of Anti-Retroviral Treatment across Malawi. The for-profit private health sector is fragmented and difficult to liaise with, and the Ministry remains suspicious that donor support for NGO activity can be a distraction. Government is slowly recognizing the contribution of other non-governmental service providers and the SWAp will lead to more policy dialogue. Major private sector providers will sit alongside donors in policy discussions with the Ministry of Health.
- 8.19 Third, an important question is whether the human resources programme is likely to produce a sustained improvement in staffing. The approach would not make sense outside the context of the SWAp as the SWAp creates the possibility of using all resources, including human resources, more effectively. Together, the Essential Health Package and the Emergency Human Resource Programme address the main incentives for employment and improving performance. These are pay and job satisfaction through the provision of more resources of all kinds with which to do the job. We know these factors matter in Malawi. Only experience will tell whether the mix of incentives is right. Heavy emphasis has been placed on monitoring the programme as it progresses.
- 8.20 In order to make best use of the additional staff, the Ministry will need to improve its human resource management substantially. The Ministry has identified a range of issues that it needs addressed. The centre of government that deals with the issues is being helpfully re-orientated to a reform agenda. The Ministry will recruit three technical assistants to help implement the programme including strengthening the Ministry's human resource management capacity.
- 8.21 Fourth, the human resources programme is novel in reverting to the employment of substantial numbers of expatriate professionals. The evidence from the 1980s was that technical cooperation outside a reform context did not have impact. The SWAp provides that context in Malawi's health sector. It is also significant that these expatriates will work in front line service delivery and in teaching. They will be doers, not advisers. Experience of those roles in the 1970s and 1980s was mainly positive, unlike the experience of advisory roles. The schemes

that DFID then financed were ended because of their high cost, which is addressed in the new programme by using volunteers, and concerns that the provision of expatriates was a deterrent to developing home-grown talent. In this case, the volunteer and training programmes are dovetailed.

- 8.22 There is a risk that the education system may be unable to produce enough adequately educated people to be trained as health workers. Fortunately, most do not require higher-level entry qualifications and the College of Medicine have introduced pre-med courses for medical students. Increasing coordination between the Ministries of Health and Education will be necessary. We are encouraged by the new Government's determination to introduce relevant reforms to the education sector.
- 8.23 Fifth, the human resources programme will raise health professional salaries only and that apparent inequity could lead to industrial unrest and political problems. The Government is fully seized of the risk. The Ministry of Finance sees the proposed arrangement as consistent with its pay policy. It brings forward, for the health sector, its plans to reward professional workers more highly. These would have had 50% pay rises over coming years in any case. The Minister of Finance seems confident that such a presentation and the public interest in better health services will help them deal with other unions. The Ministry of Health has also been careful to present the volunteer physicians scheme as not competing with existing medical cadres by emphasising that the physicians are specialists who are not represented adequately in Malawi at present.
- 8.24 Sixth, Malawi's public service has operated for some years in an accountability vacuum. Greater accountability could become a key means of improving service delivery in the health sector, but will take some years to develop, in part because district level capacity is particularly weak. It has been agreed to prioritise internal accountability within the health sector in the short term.

Social appraisal summary

- 8.25 Health indicators in Malawi reflect the depth and severity of poverty amongst the population. The priority for SWAp implementation is to ensure the accessibility of essential health services. (The full Social Appraisal is given in Annex 9).
- 8.26 Time lost and distance to health services present major barriers to the poor. Furthermore, the low quality of care provided at each level within the public sector, but particularly at the periphery, also presents a barrier to care. Repeated visits and unnecessary referrals lead directly to further impoverishment of patients and their families.
- 8.27 Gender relations in Malawi also have a great impact on who benefits from health care. Women in Malawi have less access to cash, fewer

economic opportunities and limited control over household resources and decision-making. Women also provide a disproportionate burden of informal health care provision in households and communities. Social roles and expectations, and norms and values of behaviour mean that women are more vulnerable to ill health, yet have fewer resources and opportunities to protect their health or to seek care.

- 8.28 The Essential Health Package addresses many barriers to access by giving emphasis to access to peripheral health services in the 'Community Health Package'. Central to this package of basic public health interventions are the Health Surveillance Assistants (the community-based health workers). DFID will need to support the further development of the Community Health Package and continue to highlight the role of the Health Surveillance Assistants in the implementation of the Emergency Human Resource Programme. CHAM and NGOs also have important roles in providing essential health services to remote or hard-to-reach populations.
- 8.29 Community and civil society participation is important to processes, voice and accountability in health service delivery. Some project initiatives in Malawi have successfully built on community engagement and increased ownership. Such approaches are recognised in the Programme of Work but will need to be built upon in SWAP implementation over time.
- 8.30 Improved health outcomes will not depend solely on health service provision. Major health gains will be achieved through inter-sectoral linkages. The SWAp governance structure, and the involvement of civil society, could promote cross-linkages across sectors. For example, the provision of safe water and sanitation, better education, and promotion of gender equity, will all impact on the health of the poor, particularly women. This inter-sectoral working on health will need to be strengthened over time.

9. RISKS

- 9.1 The most serious risks to the programme are exogenous to its design. Overall sector funding is below recommended levels and may be inadequate to produce a significant impact on health outcomes. We assume that more aid will become available in due course. Second, a future government may revert to the pattern of corruption and mismanagement that undermined attempts to improve health service performance in the past. As a preventative measure, donors supporting Government plans to institutionalise political reform in the hope that stronger institutions will make backsliding more difficult.
- 9.2 There are also risks that are endogenous to the programme. The management load of making a sector approach work is substantial under any scenario. In Malawi, it will be more difficult, because of the lack of depth in management and the weak capability of the institutions. The large proportion of project to pooled funding will make co-ordination more time consuming. To offset this to some extent, the Principal Secretary, Health, plans to recruit technical assistants – that is experts who ‘do’ as well as ‘advise’.
- 9.3 Second, the shortage of professional skills extends beyond the health professions to other crucial support services including accountancy and procurement. DFID stands ready to extend the emergency human resources programme to cover those services to the health sector if it proves necessary.
- 9.4 The appraisal section notes a number of risks that are also recorded in the matrix below. Overall, we rate the programme as high risk, not because of programme design, which is medium risk, but because of the exogenous factors.

TABLE 9.1 RISK MATRIX

Impact Probability	Low	Medium	High
Low			Management load too great
Medium	Education system fails to supply trainees	a) Labour market unresponsive to new incentive structures b) Shortages of non-health professions not addressed	a) Sector funding not supplemented & inadequate b) Future Governments lack commitment
High	Other public employees disruptive		