Malawi Health Swap Mid-Term Review

Summary report

NORAD COLLECTED REVIEWS 22/2008

Cindy Carlson, Monique Boivin, Arnold Chirwa, Simon Chirwa, Fenwick Chitalu, Geoff Hoare, Mechtild Huelsmann, Wedex Ilunga, Ken Maleta, Andrew Marsden, Tim Martineau, Chris Minett, Albert Mlambala, Friedrich von Massow, Hatib Njie, Ingvar Theo Olsen

Commissioned by the Ministry of Health, Malawi

Norad collected reviews
The report is presented in a series, compiled by Norad to disseminate and share analyses of development cooperation. The views and interpretations are those of the authors and do not necessarily represent those of the Norwegian Agency for Development Cooperation.

Norad
Norwegian Agency for Development Cooperation

P.O. Box 8034 Dep, NO- 0030 OSLO
Ruseløkkveien 26, Oslo, Norway
Phone: +47 22 24 20 30 Fax: +47 22 24 20 31

ISBN 978-82-7548-332-2

FINAL REPORT

MALAWI HEALTH SWAP MID-TERM REVIEW

SUMMARY REPORT

Authors: Cindy Carlson, Monique Boivin, Arnold Chirwa, Simon Chirwa, Fenwick Chitalu, Geoff Hoare, Mechtild Huelsmann, Wedex Ilunga, Ken Maleta, Andrew Marsden, Tim Martineau, Chris Minett, Albert Mlambala, Friedrich von Massow, Hatib Njie, Ingvar Theo Olsen

January 2008

TABLE OF CONTENTS

LIST OF ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy
AIDS	Acquired Immunodeficiency Syndrome
AIP	Annual Implementation Plan
ARI	Acute Respiratory Illness
ART	Anti-retroviral Therapy
BLM	Banja La Mtsogolo (Marie Stopes International affiliate)
CHAM	Christian Health Association of Malawi
CMS	Central Medical Store
DC	District Commissioner
DFID	Department for International Development (United Kingdom)
DH	District Hospital
DHO	District Health Office
DHRMD	Department of Human Resources Management and Development (OPC)
DHMT	District Health Management Team
DMO	District Medical officer
DMS	Drug and Medical Supplies
DOFA	Director of Finance and Administration
DOTS	Directly Observed Treatment , Short Course (for TB)
EHP	Essential Healthcare Package
ERP	Enterprise Resource Planning
EHRP	Emergency Human Resource Programme
EPI	Expanded Programme of Immunisation
FDA	Food and Drug Agency
FEFO	First Expiry First Out
GFATM	Global Fund for AIDS, TB and Malaria
GMP	Good Manufacturing Practices
GTZ	German Technical Cooperation
HC	Health Centre
HIV	Human immunodeficiency Virus
HMIS	Health Management Information Systems
HR	Human Resources
HRMD	Human Resource Management and Development section
HSA	Health Surveillance Assistant
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illness
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MEPD	Ministry of Economic Planning and Development
MNH	Maternal and Newborn Health
MOF	Ministry of Finance
MOH	Ministry of Health
MOLG	Ministry of Local Government and Rural Development
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OPC	Office of the President and Cabinet
OPD	Out Patient Department
ORT	Other Recurrent Transactions
PE	Personal Emoluments
PHC	Primary Health Care
PIC-S	Pharmaceutical Inspection Cooperation – Scheme
POW	Programme of Work
PS	Principal Secretary (e.g. Secretary of Health)
QA	Quality Assurance

RMS	Regional Medical Store
SLA	Service Level Agreement
SMC	Senior Management Committee
SOP	Standard Operating Procedure
SP	Sulfadoxine/Pyrimethamine
STTA	Short Term Technical Assistance
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

ACKNOWLEDGEMENTS

The Mid-Term Review team would like to thank the Malawi Ministry of Health staff; the staff of MOH Central East, Central West, Northern, South East and South West Zonal Offices; MOH and district staff of Blantyre Central, Lilongwe, Mzimba, Rumphi, Salima and Zomba Districts; staff of the Malawi College of Health Sciences, Kamuzu College of Nursing, College of Medicine; CHAM staff at headquarters, health facilities and training institutions; staff of the Ministries of Finance and Local Government and Development; staff of the Malawi Health Equity Network and members of the Health Donor Group for their welcome, patience and openness that greeted us during the mid-term review. We would particularly like to express our deep appreciation for the support provided us by Dr. Ann Phoya, Dr. Haldon Njiko, Ms Trish Araru and Mrs. Grace Chirwa of the MOH SWAp Secretariat, whose help, ability to locate documents and chivvying of others to meet with us and give us the documents we needed made our own work far easier.

This version of the Malawi Health SWAp Mid-Term Review Report is the final revised version submitted in January 2008, with revisions based on discussions at the Malawi Health Annual Review, 25th – 28th September 2007, inputs from SWAp partners and dialogue with Health SWAp stakeholders.

EXECUTIVE SUMMARY

The Government of Malawi in collaboration with Development Partners finalised the six-year Programme of Work (POW) for the Health Sector in 2004. The basis for this plan was the Essential Health Package (EHP), which entails a minimum package of services to be provided free of charge at the point of delivery to all Malawians. The POW has been implemented at the national and district level since October 2004 with financial and technical support form the Government of Malawi and Development Partners. The implementation of the POW was costed at US$ 763 million for six years.

COMPONENTS OF THE EHP AND THE POW PILLARS

No	CONDITIONS & their Complications	PILLARS
1	Vaccine Preventable Diseases	Human Resources Development
2	Acute Respiratory Tract Infections	Pharmaceuticals & Medical Supplies
3	Diarrhoea, including Cholera	Essential/Basic Health Equipment
4	Adverse Maternal and Newborn outcomes, including Family Planning	Infrastructure Development
5	Malaria	Routine Operations at service delivery level
6	Tuberculosis	Central Operations, including policy & systems development
7	HIV/AIDS & STI	
8	Schistosomiasis	
9	Malnutrition, including Micronutrients	
10	Eye, Ear and Skin infections	
11	Common injuries, accidents and trauma	

The agreement to finance and support the POW was formalised in a Memorandum of Understanding with signatories agreeing to work together under the umbrella of a Sector Wide Approach (SWAp). This has provided a common framework for health sector planning, budgeting, financing, financial management, and reporting and monitoring and evaluation, as well as agreement on both yearly and mid-term reviews. In line with this provision, a Mid-Term Review (MTR) of the Health Sector Programme of Work was proposed.

Aim and Objectives of the Mid-Term Review

The overall aim of the review was to assess the progress made in reaching the purpose of the POW, i.e. ensuring increased availability of quality EHP services as well as increased utilisation of EHP and other health services.

Specifically the MTR team was requested to:

1. Assess progress in meeting POW output targets and trends towards meeting health outcome targets as stipulated in the SWAp ME&R framework;
2. Assess the progress and achievements in the implementation of the pillars of the POW and related health sector policies and strategic plans in the delivery of the Essential Health Package;
3. Identify resource and capacity needs as well as constraints in implementation of the POW;

4. Review financing modalities, harmonisation, alignment and the systems that have been developed to coordinate and implement the SWAp MOU;
5. Identify and propose relevant policies that would accelerate achievement of POW goals and objectives.

Findings

The MTR team was comprised of specialists in public health and in the pillar areas. The Terms of Reference for the MTR not only asked the team to address the above issues, but also to answer specific questions related to:

- Essential Health Package progress
- Planning, Monitoring and Evaluation
- Institutional Development and Decentralisation in the Health Sector
- Pharmaceutical Technical Aspects
- Human Resources Aspects
- Financial Management and Economic Analysis Aspects
- Procurement Aspects
- Governance and Harmonisation Aspects

Summaries of these reports can be found below in relevant sections in the main report, and in more detail in the annexes.

Progress towards meeting the purpose of the POW has been mixed. While evidence gathered indicates that more people are accessing some EHP services, this is not the case for the entire essential health package. Furthermore, EHP progress that has been made in the last three years is in danger of being reversed, especially in EPI , malaria prevention and HIV prevention, due to problems with ensuring adequate stocks of drugs, vaccines, test kits and nets.

The POW pillars: Human Resources Development; Pharmaceuticals and Medical Supplies, Essential/Basic Health Equipment, Infrastructure Development, Routine Operations at service delivery level and Central Operations remain highly relevant for the achievement of health sector goals and objectives. The analysis of challenges that existed in 2002/2003 when the current Programme of Work was being designed remain pertinent today. The six pillars are all systems and procedures related and were developed to address the main bottlenecks to delivering universal and effective health services to Malawians. The MTR team has found that while some progress has been made in improving these systems and procedures, further, long term support is required to make sure they are of adequate quality, standard and stability to have an enduring impact on the quality, effectiveness, efficiency and sustainability of Malawi's health services.

Areas of Success and Good Progress

Good progress on certain health outcomes
Good progress has been made against a number of Essential Health Package indicators. OPD use has steadily increased over the last three years and is on track for meeting the 2010 target of 1000 visits per 1000 population. The tuberculosis cure rate is also on track, having reached 76% in 2006/07 (with a target of 85% in 2010). It is also encouraging to see that basic emergency obstetric care services are being scaled up significantly through the POW, and, if anticipated levels of support materialise, the MTR team is optimistic that current efforts will ensure that 50% of facilities are offering BEmOC by 2010. Malaria prevention interventions have progressed very well since 2004, with many more people

having access to ITNs through both free distributions and social marketing outlets. Finally, HIV counselling and testing, PMTCT and anti-retroviral treatment services have expanded tremendously in the last three years.

Good progress on improving physical access to health services
Improvements on physical access to health services has occurred through a combination of infrastructure development, increasing numbers and working hours of staff and through service level agreements. Rehabilitation and construction works described to, and observed by, the MTR team indicated that health centres and hospitals are more pleasant and efficient places to come as patients and guardians. The mixture of increased numbers of trained staff coming into, or returning to, front-line health services and staff working more hours through locum or relief arrangements means that health centres that were previously closed are re-opening and health centres with only one trained staff person can now provide more services as they are joined by other trained providers. At the same time, service level agreements with non-governmental providers have improved access to existing facilities that poorer community members could not previously afford to use.

Good progress on improving resources into health service delivery
There is no doubt that there are more financial and human resources available for health services now than there were three years ago. Decentralisation of health service management has allowed financial resources to flow directly to districts, where services are delivered, giving greater control over how these resources are used to district health managers. There are more places in training institutions, and more students entering pre-service training, in some cases doubling annual intakes over numbers in 2004. The numbers entering the health workforce have been boosted by increased pay and special allowances for health professionals, incentives to bring retired workers back into the workforce, and by creative initiatives that allow health staff to work additional hours and be paid for their time. While assuring a steady supply of essential drugs has been problematic (see findings and challenges below) it is also clear that there are more drugs and medical supplies in stock in health facilities and hospitals than before, even though they are not always the most needed. Some of the crisis in essential drug supply has been eased by districts having their own budgets from which they can purchase drugs privately that are not available through the public system.

Good progress on strategy development and planning throughout the health system
It is important here to note that Malawi has a national health strategy, the Programme of Work, which is well known by all stakeholders, and which forms the basis of all strategic and operational discussions on how to engage with the health sector. The annual implementation plan planning process is a needs-driven exercise, starting with compiling health facility level plans into district plans, and then finally pulling these together into the national annual plan. All the major national technical programmes have strategic plans that outline what is required to achieve improved health outcomes within their particular technical area. Many of the support functions within the MOH, such as human resources, monitoring and evaluation, procurement and central medical stores, have prepared strategic plans or improvement plans that give guidance for how these departments need to develop over the next few years, though these are in varying stages of implementation.

Oversight and coordination mechanisms have been developed
Evidence and experience from across the world has demonstrated the importance of coordination, oversight and governance in sector wide approaches. Malawi has put in place a number of oversight and coordination mechanisms, including a Memorandum of Understanding between Development Partners and the MOH, a SWAp governance structure (as outlined in the MOU), a multi-stakeholder joint bi-annual review process and a SWAp Secretariat. These mechanisms not only provide the means for agreeing how the national strategy can and should be taken forward, but they also help with sharing

information, holding institutional memory and improving accountability of the health sector. With high turn-over of most of the top positions in the MOH, the SWAp Secretariat has been especially important as one of the only sources of institutional memory left in the MOH, in the form knowing what documents exist and where they are, pulling information together from across the ministry and maintaining good working relations across the ministry departments and with external stakeholders. The bi-annual reviews, and the aide-memoires that arise from these reviews, are an important part of ensuring that a wide group of health sector stakeholders are kept informed about progress towards meeting health sector objectives and through which they can hold the ministry to account for delivering on its commitments.

At an operational level, the oversight mechanisms put in place through the zonal offices and district supervision systems are commendable. Zonal office supervision and coordination is allowing for better collection of health information and sharing of good practice across districts, and provoking more poorly performing districts to improve. Integrated supervision from district health managers is an important step forward for improving health facility performance.

Key Challenges That Need Addressing

The progress outlined above is laudable, and yet fragile. Much of the progress could easily stall if care is not taken now to sustain coordination, prioritisation and resources to strengthen the EHP and POW pillars. If steps are not taken now to address the outstanding questions on sustaining gains in human resources for health, then the situation could revert back to where it was in 2003 by 2009/2010. If drug and health supply procurement systems are not addressed immediately gains in EPI, malaria prevention, HIV testing and counselling and PMTCT will be lost and even reversed. The MTR team received a strong sense from MOH staff and health stakeholders that the SWAp has reached a critical point in its life cycle. The gains seen now are the result of planning and initiatives begun two to three years ago. If strategic direction and partnership working begin to unravel now, the consequences will begin to show in less time, and achievements gained will be quickly reversed. These challenges can only be faced and responded to through coordinated and joint action between government, its development partners and its implementing partners. The key challenges are presented below with a summary of strategic recommendations. Full recommendations and suggested actions are provided in Section 6 of the report.

1. Improving coordination, cohesion and accountability

The purpose of bringing in a sector-wide approach is to improve the harmonisation of different actors' interventions in a sector, and to increase alignment with government policies and procedures. It is vital that all actors contributing to the health sector in a country discuss and agree the nature, scope and scale of the common strategic framework, its implementation and the nature, scope and scale of each partner's contribution. A SWAp therefore requires strong and open partnership working, where the vision and requirements of each partner are discussed, challenged and, where possible, accommodated to ensure that the health sector policy and strategies remain coherent and focused on improving health.

With regards to providing and promoting strategic programme direction, there is a worrying view expressed by some senior MOH staff that even though the POW remains the national health strategy, should any development partner offer to provide services outside the framework of the POW and EHP, the Ministry is unable to say 'no', and must accept what is on offer. Such a viewpoint would indicate that MOH staff may not feel empowered to prioritise interventions and not hold development partners to account when they stray too far away from agreed strategies and work plans. Weak coordination may arise partly from

misunderstanding the nature and purpose of the SWAp more generally and the lack of prioritisation of activities within the EHP and POW specifically. Development partners are also contributing to weak coordination by not assuming lead roles for technical areas amongst themselves, and not holding each other to account if there is movement away from a harmonised, aligned approach.

Coordination, cohesion and accountability are also being hampered by irregular meetings of some key technical working groups and the senior management committee. These structures were put in place in 2004 precisely to ensure that lines of communication were open and transparent across the ministry and between the ministry and its different partners.

Strategic direction and cohesion within the POW pillars is being hampered by a number of factors. Many of the key ministry departments do not have permanent directors in place and there has been very high turn over of staff in these positions. High turn over of staff, and key vacancies in the MOH also mean those staff who are left have very heavy workloads, with senior managers in particular under pressure to produce. In the human resources section, for example, the Controller of HRMD post has been vacant for most of the last two years. Filling this critical post with an experienced, competent HR manager would allow the section to take a more strategic approach to addressing human resource challenges across the health sector. Similarly, the head of the Pharmacy Section in the ministry needs to have the capacity and authority to pool district drug consumption data and needs information to facilitate better forecasting and quantification of drug need in the country, and to initiate procurement in good time so that major stock-outs can be avoided. Finally, the absence of a central coordinating body for all monitoring, evaluation, and research in the health sector has left the implementation of ME&R activities to occur in the margins of the national plan, without clear direction, leadership, or integration. Multiple donor-driven demands for data give way to multiple reporting forms, draining resources and precious time from the system.

Coordination and cohesion for guiding the implementation of the EHP also needs strengthening. Many of the technical units continue to operate in a vertical fashion, often with little discussion between them, or at a higher level in the MOH, about what the consequences of new programmes or interventions might have on the rest of the health system. For example, technical programmes do not appear to have integrated their training activities with those of the Central Ministry, and the training policy that would ensure this has yet to be approved. As a result, a multiplicity of technical workshops is held, often targeting the same district or frontline health staff. The frequent absence of MOH, district and frontline staff from their posts adds to the sense that human capacity is being spread far too thinly across the health system.

Furthermore, zonal office institutional status within the Ministry of Health remains unclear. These offices are beginning to hold key coordinating functions for the districts they supervise, and zonal supervisors themselves are reasonably clear about their own functions. Zonal supervisors believe they are the key supervisory link with districts and district assemblies aimed at supporting the implementation of the programme of work through District Implementation plans. Unfortunately the understanding of the role of the zonal offices does not appear to be shared with the Technical Directorates of the MoH that are continuing to bypass and deal directly with DHOs, and thus to some extent undermining their effectiveness. For whatever reason, the central technical directorates ignore the role of the zonal offices. On the other hand, Zonal Supervisors reporting lines are not clear, as to whether they are accountable to the Director of Planning or the Principal Secretary. There have also been weak linkages between zonal offices and central hospitals, though some zones are beginning to rectify this.

Recommendations

URGENT

- Improve partnership and joint ownership through the reconstitution and revitalisation of the key TWGs, HSRG and SMC
- Improve the effectiveness of TWGs
- Strengthen human resources leadership
- Re-invigorate the HRH strategic thinking process and develop the strategic framework to ensure ownership
- Establish the Monitoring, Evaluation and Research Unit as originally envisaged in the POW and MOU
- Strengthen coordination and communication within zones and between zones and centre

MEDIUM TERM

- Improve coordination and mutual accountability within the Health Donor Group
- Strengthen coordination and alignment of planning and monitoring between the MOH, MOLG and districts
- Clarify and strengthen the respective coordination roles of MOH pharmaceutical and procurement sections and Central Medical Stores with regards to health supply forecasting, quantification, procurement, distribution and management

2. Enhancing integration of M&E and health planning

It is clear that health information is underused throughout the health system. At health facilities visited by the team, most staff view their registers and monthly reports as one more (onerous) administrative task, and not as an important tool for understanding health trends in their locality. Very few offices at health centre, district or central level have any current charts or graphs of health trends on their walls, which could serve to remind health managers of what objectives they are trying to achieve. At central level, data for key indicators in critical problem areas, such as drugs and human resources, are not even known, or if known not made use of. Epidemiological data is not being used to inform drug forecasting. For human resources, a census is planned to obtain baseline information on human resources, but there needs to be a dependable way to keep the system updated for routine analysis to address human resources problems. Also, the HRH census, if completed by the end of the year provides opportunities both for starting the process of workforce planning and for better overall monitoring of the production, deployment and retention of the health workforce.

The importance of the use of M&E data (from HMIS and surveys) for planning and implementation will only be realised within the health sector when there is support and elevation of this field from the top levels of leadership. It is only when directors begin demanding good quality data, facilitate its collection and use it to provide feedback on performance that those responsible for recording and reporting health data begin to understand its relevance in their own work. Further incentives to improve M&E could be increased through the introduction of performance based management, where reporting and use of data are indicators of performance.

Recommendations

MEDIUM TERM

- Top leadership and persons responsible for planning at every level, from the PS, and the Director of Planning at central level, to the In Charge at facility level, should champion and model the importance and use of data for improving programme planning, implementation, and service delivery.
- Devise and develop a health service performance management plan for the SWAp that can be used by zonal offices and DHMTs to monitor service delivery and health service management
- Broaden the terms and conditions of the SLAs so that they a)include more of the EHP and b) are performance based Broaden the terms and conditions of the SLAs so that they a)include more of the EHP and b) are performance based

- Institute a system of mentoring in data use and strategic planning throughout all levels of the health system.
- The current revision of the HMIS should be expedited and completed to thoroughly address issues of harmonisation and streamlining.
- Use data to support development, implementation and monitoring of the HR strategy
- Improve data quality
- Improve understanding of the impact SLAs are having on increasing service access overall

3. Sustaining improvements in financial and human capacity for health service delivery

Sustaining improved financial capacity

Although the overall funding of the health sector in general and the POW in particular has increased immensely since the starting of the SWAp, increasing by 115% in the period, starting off with a total of MK 8.14 billion in 2004/05, against a total of MK 17.15 billion in 2006/07. The major increase comes from the pooling partners, which contributed only MK 1.1 billion the first year and a total of MK 8.98 billion in 2006/07. According to the figures, the discrete partners only contributed MK 0.51 billion, although many of these also contribute directly to activities, often off budget. The total contributions to the POW (on and off budget) are thus considerably higher than captured in these figures, but this has not been estimated by the MTR Team, or by others.

The donor share of actual net funding has gradually increased from 30% in 2004/05 to 56% in 2006/07. With the relative low potential for increased government revenue, there is a strong need to sustain the level of funds from the partners. Development partners, both the pooling and the discrete partners, need to commit themselves for as long period as possible and communicate this to government. Malawi Government also needs to clearly express its continued commitments, and should indicate whether and when it will fulfil its commitments from the Abuja declaration of 15% of its budget to be allocated for health.

With regards to MOH and CHAM financial capacity, several of the actions outlined in the financial improvement plan, which was developed to respond to weaknesses identified by the MOH's external auditors, have yet to be implemented. These include the filling of key vacancies in the MOH, as well as providing training for both MOH and CHAM financial staff to improve financial reporting. Weak financial capacity has had a knock on effect and has had particular consequences for internal audit functions within the MOH, and the ability of the MOH to address the grave findings of recent audit reports.

Improving financial reporting

At present it is not possible to make any links, through financial reporting, between financial inputs and programmatic outputs (and eventually, outcomes). This is a very serious challenge for the MOH, as the more MOH staff can demonstrate 'value for money' the more likely they will be able to leverage increased funding from both the MOF and from external sources. The new Chart of Accounts does provide the means for the MOH to move in this direction, though there have been substantial delays in introducing the Chart of Accounts in the Ministry.

Sustaining increases in skilled staff across the health sector

An emerging risk identified in this review is the ability to sustain the laudable gains in human resources that have been made to date. The gains have been made through what have been referred to explicitly as emergency measures. For example, the staffing of training institutions has been achieved by short-term secondments of service delivery staff by means of incentives of further training prior to the secondment and expensive additional allowances. This investment in further training could lead to a better qualified workforce when the staff return from their secondments, but equally there is the risk that having been

upgraded staff are no longer willing to fill the gaps they once did, or having become more marketable, they find employment elsewhere. Staffing gaps are being filled by effectively paying staff overtime and by the "relief" system in remote postings. Both solutions are being financed from the ORT budget, reducing the money available for other needs. Short and long term technical assistance, as well as clinically trained volunteers are being brought in to fill capacity gaps. The innovative recruitment and employment strategies currently in place are both labour intensive and probably quite expensive. The TA and volunteers are not being used effectively to build local capacity. Without wishing to detract from these successes, these emergency measures are easier than developing and implementing the longer term policies and strategies for sustaining the workforce. At this point in the POW it is important that, whilst building on the gains made so far, these more challenging issues are addressed with the same creativity and enthusiasm as for the emergency measures.

Improving human resource management and performance

The emphasis of the EHRP has been on increasing staff numbers and less attention has been given to assuring staff quality and improving staff performance. There are plans for developing a performance appraisal system, updating job descriptions, developing systems for managing absence, etc in the broad work plans. These systems, which are largely targeted at the individual, can work effectively in organisations that already have a good performance culture. However, they are difficult systems to develop and even more difficult to institutionalise so that they actually lead to better performance and are not really carried out as part of a bureaucratic ritual. There are a number of initiatives across the sector that are targeted more at performance at organisational level. For example, the control of infection in hospital; maternal death audit, etc. It would be useful to examine the impact of these initiatives on performance at the level of the organisation, but also as drivers of individual performance including absenteeism. If these initiatives are effectively developing a "performance culture" in the organisation, it may be better to concentrate on the expansion of this type of initiative rather than performance management systems aimed at the individual -- the least in the short to medium-term.

Recommendations

URGENT

- Accelerate and complete actions recommended in the Financial Improvement Plan
- Undertake a detailed analysis of expenditure trends to assess the overall financial sustainability of the POW/EHP

MEDIUM TERM

- Shift financial reporting to be more output based, linking financial inputs and programme outputs
- Integrate budgeting and procurement planning processes
- Start development of strategies to improve the performance culture
- Further develop TA needs assessment process described in the Needs Assessment Study report to ensure other options are reviewed for addressing capacity problems (e.g. 1) short-term TA for specific tasks 2) contract out functions for which MoH lacks expertise 3) for administrative tasks hire competent graduate on fixed-term contract).

4. Unblocking hindrances in planning, procurement, supply and distribution of essential drugs and other health supplies

Pillar 2 'Pharmaceuticals' was the only key element in the POW where health service staff suggested that the 'SWAp hasn't started yet'. Unlike improvements in other pillars, there has been little progress in ensuring that a stable and reliable medicine supply is available through the public health service in Malawi. At the time of the MTR there were stock-outs throughout the country of basic anti-biotics, Insecticide Treated Nets (ITNs) and HIV test kits. Stocks of vaccines are running dangerously low, with no solution in sight for replenishing them. This review has found that there are many hindrances to procurement of

drugs and other health supplies. These hindrances are most often the result of confusion over who takes responsibility for procurement, as well as capacity to initiate the supply line and manage procurement. Procurement capacity is weak across the health system, and most worryingly so at Central MOH level.

Forecasting drug and health supply need

There is no systematic measure of consumption of drugs at hospitals or health facilities. Supply chain manager, a system implemented through a technical assistance by USAID Deliver appears to be measuring consumption from hospital and health facility pharmacy stores. Even with USAID Deliver Supply Management system, there is no designated responsible person from MOH who collates and analyses the data and provides management information on the quantities of drugs to be procured each year. Drugs appear to be procured based on a determination by Central Medical Stores. There is a clear mismatch between the demand generated at health facility level, with requests for re-supplies moving up the chain from health facility to district to RMS, and the CMS supply side, which simply orders drugs based on its own previous consumption data. While this mismatch between supply and demand persists Malawi is unlikely ever to have adequate essential drugs to cover the EHP.

During the last three years little consultation has been made by the CMS in determining the equipment needs of the hospitals. The CMS has regardless proceeded to supply in large numbers, at different times and to different hospitals, equipment that is not required such as trolley, mattresses, beds, wheel chairs, blood pressure equipment, medical trolleys and bedside screens when these were either not required or in quantities exceeding requirements.

Procuring essential drugs and medical supplies

Ensuring sufficient and appropriate drugs are continually in stock remains a perennial challenge for the MOH. The review observed that (i) there is lack clarity of procurement responsibilities for health sector goods between MOH Headquarters and Central Medical Stores (ii) there is limited capacity at MOH Headquarters for procurement of health sector goods (iii) there is inadequate procurement planning including financial planning for procurement of these goods (iv) Quantification to determine country needs is not systematic and there is no central point of reference for quantification of requirements (vi) there is inadequate experience in process requirements for procurement of health sector goods at Central Medical Stores and (vii) there has been over reliance on UNICEF as a stop gap measure with little informed desire to build capacity within the system. These areas need urgent attention and rectification. The respective roles of CMS and the MOH in particular need to be decided on, and recommendations are provided below in this regard. The Drug and Medical Supply TWG also needs to be made better use of so that stock crises in drugs and other health supplies can be called attention to, and solutions found, much more rapidly.

Increasing procurement capacity

The existing staff clearly does not have experience to carry out procurement of consultant services and works. As the staff in the MOH is being used to provide guidance and coordinate procurement in the SWAp, the current inadequate capacity will slow down procurement and do little to improve procurement capacity and support of the components. Several procurement of works and consultant services were found to have been delayed. MOH should seriously consider mixture of long term and short term training in procurement of staff with prerequisite basic qualification to understand procurement with short term training focusing on procurement of works and consultants as a matter of urgency.

Recommendations

URGENT

- Government and development partners negotiate and agree solution to the current crisis in ITN, vaccines and other essential drug supplies

MEDIUM TERM

- Develop procurement capacity at all levels of the health system
- Revise the current procurement procedures, balancing fiduciary risk management with pragmatism
- Establish a single procurement and distribution channel for pharmaceuticals within the MOH
- Standardize pharmaceutical documentation, reporting and supportive supervision
- Enhance high level supply chain monitoring

5. Using lessons learned to revise the EHP and to elaborate the next national health plan (2011 onwards)

Essential Health Package

The Essential Health Package has evolved from when it was originally developed. While the list of core, priority health problems remains the same (and should continue to do so), the interventions for managing these health problems have changed or are changing. This has both cost and training implications for the MOH, making updating the EHP protocols and costings an urgent priority.

Planning the National Health Strategy 2011 - onwards

The Programme of Work was developed to respond to the key bottlenecks existing in the health system in 2002/03. Significant achievements have been made and all partners should be commended for their part in this. However as can be seen from this review, many of the critical bottlenecks persist and will continue to need attention and action. The pillars in the POW are input oriented, and the same is true for planning, monitoring and reporting. The setup of the SWAP and the M&E framework revolve around translating these inputs into improved health outcomes and while achievements have been made challenges remain. The MTR team do not recommend at this midway stage to re-write the Programme of Work, as this would distract attention and valuable time away from getting the jobs done that need doing. It is important that lessons that have been learnt from implementing and monitoring the POW are recorded, analysed and used for development of the next national health plan.

Recommendations

URGENT

- Revise diagnosis and treatment protocols of the EHP programmes to reflect organic changes that have taken place during implementation. The team does not recommend changing the 11 priority EHP conditions,

MEDIUM TERM

- Constitute a strategic planning working group to draw up a concept paper for next National Health Plan based on a synthesis of lessons learned on how the POW and related information systems are structured,

MID-TERM REVIEW OF THE PROGRAMME OF WORK FOR THE MALAWI HEALTH SECTOR

DRAFT REPORT

1. BACKGROUND

The Government of Malawi in collaboration with Development Partners finalised the six-year Programme of Work (POW) for the Health Sector in 2004. The basis for this plan was the Essential Health Package (EHP), which entails a minimum package of services to be provided free of charge at the point of delivery to all Malawians.

Table 1 COMPONENTS OF THE EHP AND THE POW PILLARS

No	CONDITIONS & their Complications	PILLARS
1	Vaccine Preventable Diseases	Human Resources Development
2	Acute Respiratory Tract Infections	Pharmaceuticals & Medical Supplies
3	Diarrhoea, including Cholera	Essential/Basic Health Equipment
4	Adverse Maternal and Newborn outcomes, including Family Planning	Infrastructure Development
5	Malaria	Routine Operations at service delivery level
6	Tuberculosis	Central Operations, including policy & systems development
7	HIV/AIDS & STI	
8	Schistosomiasis	
9	Malnutrition, including Micronutrients	
10	Eye, Ear and Skin infections	
11	Common injuries, accidents and trauma	

The POW has been implemented at the national and district level since October 2004 with financial and technical support form the Government of Malawi and Development Partners.

The agreement to finance and support the POW was formalised in a Memorandum of Understanding using a Sector Wide Approach (SWAp). This has provided a common framework for health sector planning, budgeting, financing, financial management, and reporting and monitoring and evaluation, as well as agreement on both yearly and mid-term reviews. In line with this provision, a Mid-Term Review (MTR) of the Health Sector Programme of Work was proposed. The review was to incorporate key health sector and other relevant reports from other sectors from the financial years 2004/05 – 2006/07. The Mid Term Review was the primary focus on the Joint Health Sector Annual Review meeting in September 2007.

2. AIM OF THE MID-TERM REVIEW

The overall aim of the review is to assess the progress made in reaching the purpose of the POW, i.e. ensuring increased availability of quality EHP services as well as increased utilisation of EHP and other health services.

Specifically the MTR was expected to:

1. Assess progress in meeting POW output targets and trends towards meeting health outcome targets as stipulated in the SWAp ME&R framework;
2. Assess the progress and achievements in the implementation of the pillars of the POW and related health sector policies and strategic plans in the delivery of the Essential Health Package;
3. Identify resource and capacity needs as well as constraints in implementation of the POW;
4. Review financing modalities, harmonisation, alignment and the systems that have been developed to coordinate and implement the SWAp MOU;
5. Identify and propose relevant policies that would accelerate achievement of POW goals and objectives.

3. METHODOLOGY

Data Gathering Methods

The multi-disciplinary MTR team engaged in a number of activities in order to achieve the MTR objectives. A more detailed breakdown of the questions that needed to be asked in order to respond to each question is provided in the inception plan matrix attached to the TORs in Annex 1. In order to answer these questions team members reviewed documents, interviewed key stakeholders and observed practice at policy and service delivery levels.

Document Review

Team members were provided a number of documents to draw on to produce findings and help their analysis of the overall situation. These documents included the original SWAp Programme of Work, the SWAp Memorandum of Understanding, Annual and Mid-Year Review reports, Annual Implementation Plans and financial reports amongst many others. Team members also sought out further documentation from key informants internal and external to the MOH. International reviews of health SWAps, and health systems and procedures were used to provide a basis for comparison. Team members queried these documents and extracted relevant information to help inform their analysis. A list of documents reviewed by team members can be found in Annex 2.

Stakeholder Interviews

a. Meetings with Head of Departments, Units within the MoH and other relevant GoM Ministries, Health Professionals Regulatory bodies and Departments such as MoF, MoLG among others
b. Meetings with other Health SWAp Partners including CHAM Secretariat, Development Partners and Non Governmental Organizations
c. Meetings with Chairpersons of Various Technical Working Groups of the Health SWAp and attend ongoing /specially convened TWG meetings.

Field Visits and Observation

1. Visits to South West Zone, Zomba District, South East Zone, Blantyre District, Lilongwe District, Salima District, Dowa District, Northern Zone, Mzimba District
2. Visits and observations in a sample of health facilities
3. Visits to a selection of health worker training facilities around the country.

Most of the districts, health facilities and training facilities visited were initially suggested by the MOH SWAp secretariat both for their convenience and as representing the range of health activity supported by the SWAp. Team members requested other visits and meetings on the basis of findings from documents and initial interviews.

A list of places visited and people interviewed can be found in Annex 3.

Analysis

Once data was collected and compiled, the evaluation team's findings were analysed with regards to the first four specific objectives that the MTR was asked to achieve.

Following this analysis, the team then considered the implications for future policy directions for the programme, and have provided recommendations for new policies and strategies to be undertaken to reduce bottlenecks and fill gaps in order to improve implementation of the POW.

Review Team

The review team was a multi-disciplinary team whose contributions were funded by different donors to the health sector. The Health Sector Review Group provided coordination of which organisation should provide which inputs to the overall review. The team was coordinated by a team leader, who reported to the Director of the SWAp Secretariat. The team leader discussed individual work plans and outputs needed with team members. The team met together to discuss progress on their work twice over the course of the review period, in order to exchange findings, seek information from each other and to highlight key issues arising. Members of the team also met with Ministry of Health staff to provide initial, provisional findings and to seek feedback on factual content. They also debriefed with senior members of the Ministry, including the Minister of Health.

Review Limitations

The review team was only able to visit a limited selection of districts and facilities in order to verify information found in document reviews. Therefore the findings and conclusions from field visits are based on only a sample of districts, facilities and staff. No concerted effort was made to choose either the best or the worst districts, facilities or schools and therefore the findings can be construed as reflective of the general situation.

The review team also did not have access to detailed district financial records for all districts for the first period of the Programme of Work. They have therefore not been able to provide a full analysis of health SWAp expenditure as only aggregate figures were provided.

Finally, SWAp partners were not able to identify an appropriate person to evaluate the infrastructure and equipment aspects of the POW. Therefore this component was coverend only superficially during MTR team visits to health facilities.

4. FINDINGS

Mid-Term Review team findings are summarised throughout the sections here below. More detailed data backing these findings can be found in the accompanying annexes and are referred to where relevant in the text.

4.1 Progress in meeting POW output targets and trends towards meeting outcome targets

This section focuses primarily on Essential Health Package output and outcome indicators, as these are the main measures for demonstrating whether or not the Ministry of Health has achieved its goal of 'reduced incidence of illness and premature death'. Other POW outputs are discussed in sections 4.2 and 4.3. Table 2 provides an overview of progress against indicator targets from Jan 2005 to December 2006, taken from the MOH HMIU SWAp Indicator Matrix.

4.1.1. To what extent have output targets expected to be met by this time actually been achieved?

EHP output targets focus on raised community awareness of EHP diseases, as well as increased access to health services.

Increased access

Increased health service access is measured by the percentage of the population residing within 5 km of a health facility and by % of monthly drug deliveries monitored by facility Health Committees. A health service mapping exercise is due to take place later in 2007/08 and so empirical information on progress towards achieving greater numbers within reach of health services is not yet available. However, service access has been increased through the use of Service Level Agreements with Church Health Association of Malawi (CHAM) facilities, which have made fee-for-service health interventions for mothers and children free to users. Some districts are reporting up to a doubling of numbers of women attending antenatal clinics and delivering their babies in CHAM facilities since the start of SLAs.

Monitoring of monthly drug deliveries is reported to have risen to 58% by the mid-year point in 2006/07, and is likely to have achieved the annual target of 60% when end of year reports are available.

Antenatal services

Antenatal Care services have achieved near universal coverage (for at least 1 visit per pregnancy) for over many years now. The national coverage rate for first visit for 2006-2007 FY was 82% compared to 86% in the first year of implementing the POW. The long-term trend based on successive DHS reports confirms a stable rate of over 90% consistently. Progress towards increasing antenatal care in the first trimester is less impressive and was reported to be at 6% at mid-year, against a target of 10% for 2006/07.

Anti-Retroviral Treatment

141 ART clinics (103 public sector, 38 private sector), 85,200 patients ever registered so far, 46,400 patients newly registered during 2006, 61,430 alive and on ART versus a target of 60,000 at this time and 71% and 70% were alive on therapy at 12 and 24 months respectively after initiation of ART.

TABLE 2 – Ministry of Health Health Management Information Unit - SWAp/POW Indicator Matrix – Progress on Indicators 2004–2006

Level	*Indicator*	Data Source	Baseline	Target for 2005-06	Progress made in 2005-06	Target for 2006-07	Progress made in 2006-07	Target for 2007-08	Target for 2010	Comments
GOAL										
Reduced incidence of illness/ premature death	- IMR	DHS (NSO)	76/1000(2000-2004)	-	-	-	-	-	48/1000 by 2011 (MGDS)	To be measured in 2009
	-U5MR	DHS (NSO)	133/1000(2000-2004)	-	-	-	-	-	76/ 1000 by 2011 (MGDS)	To be measured in 2009
	- MMR	DHS (NSO)	984/100,000 (2000-2004)	-	-	-	-	-	560/100,000 by 2011 (MGDS)	To be measured in 2009
	- HIV prevalence among 15-24 year old pregnant women	ANC Sentinel Surveillance (MOH)	14.28% (2005)	-	-	<14.28%	N.A.	-	<12% by 2011 (MGDS)	Results from 2007 Sentinel Surveillance awaited
	-Life expectancy (at birth)	Census/NSO	40 yrs (NSO, 2005)	-	-	-	-	42 yrs.	45 by 2011 (MGDS)	To be measured in 2008 Census
Objective 1:										
Increased utilization and effectiveness of EHP and other services	- OPD service utilization	HMIS (HMIU)	800/1000 population (HMIS 2004-2005)	850/1000 population	1100/1000 population (HMIS 2005-06)	900/1000 population	918/1000 population (HMIS July-Dec '06)	>1000/1000 population	>1000/1000 population	
	-Proportion of 1 year-old children immunized against measles	EPI	82% (EPI 2005)	85%	82% (EPI 2005-2006)	85%	79% (EPI Jan-Dec '06)	83%	90% by 2011 (MGDS)	Coverage was particularly low in Nov. & Dec '06
	- % surveyed population satisfied with services (by gender and rural/urban)	SDSS (MHEN)	To be established in 2006	Baseline established	MHEN presented report without measuring the indicator	Baseline established	MHEN carrying out the survey in 2007, results awaited	Baseline to be established	> Baseline	MHEN received technical inputs from MER TWG for 2007 survey
	-CPR (modern methods)	DHS (NSO)	28.1% (DHS 2004)	-	-	-	-		40% by 2011 (MGDS)	To be measured in 2009

	-Proportion of births attended by skilled health personnel	HMIS (HMIU)	38% (HMIS 2004-2005)	40%	40% (HMIS July-Dec 2005)	41%	41% (HMIS July-Dec '06)	42%	75% by 2011 (MGDS)	Assumption is that all institutional deliveries are conducted by skilled health personnel
	-% of pregnant women and children who slept under an insecticide treated net (ITN) the previous night	DHS (NSO)	14.7% pregnant women 14.8% children (DHS 2004)	-	-	-	-	-	60%	To be measured in 2009
	-% of children under five years of age with fever in the preceding two weeks who received antimalarial drugs the same/next day	DHS (NSO)	45.5% (DHS 2004)	-	-	-	-	-	60%	To be measured in 2009
Objective 2:										
Increased availability of quality EHP services	- EHP coverage (% Facilities able to deliver OPD, Imm., FP & mat. services and having 2 Medical Asst./Cl. Officer /Doctor , 2 Nurse/ Midwife & 1 H.A.)	Facility Survey	9% (JICA study 2002)	15%	Not measured	15%	To be measured in 2007-08	-	40%	Facility survey to be carried out in 2007/2008
Objective 2 (contd.): Increased availability of quality EHP services	- TB detection rate	Prevalence Survey (NTCP)	40% (WHO 2004)	Prevalence survey planned for 2007	-	-	-	Prevalence survey planned for 2008-09	70%	Prevalence survey delayed for want of funds
	- TB cure rate	HMIS (HMIU)	74% (HMIS/ NTCP, 2004-2005)	75%	73% (HMIS/NTCP, Jan-June 2005)	75%	76% (HMIS/ NTCP, Jul-Dec 2006)	76%	85%	On target

	-% of HCs offering basic EmOC services	HMIS (HMIU)	2% (2005, EmOC survey)	25%	Measurement made difficult by lack of proper definition	13.4% (74 targeted out of 552 facilities)	4 % (22/552) (reports from DHOs at MYR Apr 07)	15%	50%	Delay in definition delayed target setting. External reviewers reported 20% coverage at MTR.
	-Doctor/population and Nurse/population ratios	HRH M&E database	1 doctor /62,000 pop (2005) 1 nurse/4,000 pop (2005)	1 doctor /60,000 pop 1 nurse/ 3,900 pop	 1 nurse/ 3,653 pop	1 doctor /60,000 pop 1 nurse /3,900 pop	1 doctor /44,453 pop 1 nurse/ 3,653 pop	1 doctor /42,00 pop 1 nurse/ 3,500 pop	1 doctor /31,000 pop 1 nurse / 1,700 pop	Presumption is all those registered (3,477 nurses and 287 doctors/ specialists) are continuing to work in the country
EHP Outputs										
Community awareness and access to services increased	-% of population residing within 5 km of a health facility	GIS Mapping	46% (EHP document, 2004)	55%	Not measured	55%	To be reported by DHOs	55%	85%	To be undertaken in 2007
	-% of monthly drug deliveries monitored by Facility Health Committees	HMIS (HMIU)	To be established in 2006	BE	59.59% (reports from DHOs at MYR Apr 06)	BE	58% (321/552) (reports from DHOs at MYR Apr 07)	60%	85%	
	-% of pregnant women starting antenatal care during the first trimester	HMIS (HMIU)	7% (HMIS 2004-2005)	10%	6% (HMIS 2005-06)	10%	6% (HMIS July-Dec '06)	7%	20%	
	- Condom use at last high risk sex (with non-marital or non-cohabiting partner)	DHS (NSO)	30%women 47%men (DHS 2004)	-	-	-	-	-	35%women 55%men	To be measured in 2009

	- # of people alive and on treatment (HAART) at the end of each year	HMIS (HMIU)	30,000 (HIV Unit, December 2005)	60,000	85,001- ever started 61,430 (72%) alive (Dec'06)	60,000	59,980 alive and on treatment (Country-Wide Survey of HIV / AIDS services - 2006)	70,000	208,000	Calendar year 2006 Survey report published in July 2007
	-# of ITNs sold/distributed in the country (annually)	HMIS (HMIU)	1,323, 557 (NMCP, 2004)	1,500,000	1,234,000	1,500,000	1,324,921 (reports from DHOs at MYR Apr 07)	1,500,000	1,800,000	On target
	-% of under five children with symptoms of ARI and/or fever in the preceding two weeks for whom treatment was sought from a health facility/provider	DHS (NSO)	19.6% (DHS 2004)	-	-	-	-	-	30%	To be measured in 2009
	-% of under five children with diarrhoea in the preceding two weeks who received oral rehydration therapy	DHS (NSO)	70.1% (DHS 2004)	-	-	-	-	-	85%	To be measured in 2009
	-% of young women and young men aged 15-24 yrs with comprehensive correct knowledge about AIDS	DHS (NSO)	23.6% women 36.3% men (DHS 2004)	-	-	-	-	-	50% women 50% men	To be measured in 2009
	-% of men who do not know any signs or symptoms of pregnancy complications	DHS (NSO)	64.8% (DHS 2004)	-	-	-	-	-	40%	To be measured in 2009

Pillar 1: HR										
Staffing norms obtained at all health facilities	- % health centers with minimum staff norms (having 2 Medical Asst., 2 Nurse/ Midwife and 1 Health Asst.)	HMIS (HMIU)	23% (2002)	25%	19.42%	25%	-for nurses= 40% (220/552) (reports from DHOs at MYR Apr 07)	-for nurses= 50% (276/552)	85%	Districts reported only on facilities with nurses/midwifes
	-# students graduating from health training institutions (category-wise)	HR M&E Database	Doctors: 16 Nurses: 475 All categories: 798 (2004)	20 513 1228	19 486 915	Doctors:20 Nurses:513 All categories: 1228	Doctors:22 Nurses:48 All categories: 424 (Doctors, Cl. Ofs., MAs, HAs & Nurses)	Doctors:60 Nurses:470 All categories: 840 (Doctors, Cl. Ofs., MAs, HAs & Nurses)	64 670 1534	Considerable number of students were expected to graduate out of the HTIs prior to June 2007
Pillar 2: Pharmaceuticals										
Supply chain functioning adequately	- % health facilities without stock-outs of TT vaccine, Oxytocin, SP, ORS and cotrimoxazole for more than a week at a time	LMIS	SP: 85% ORS: 81% Cotrimoxazole: 82% Composite: 89% (LMIS 2004)	100% 100% 100% 100%		100% 100% 100% 100%	SP: 97% ORS: 89% Cotrimoxazole: 83% TT: 91% Oxytocin: 88% Diazepam: 65% HIV Test kits:82% TB drugs:89% (Reports from DHOs at MYR Apr 07)	SP: 100% ORS: 100% Cotrimoxazole: 100% TT: 100% Oxytocin: 100% Diazepam: 85% HIV Test kits:100% TB drugs:100%	100% 100% 100% 100% 100%	Indicator modified to Drug Days Availability prior to Mid-year review in April 2007. List of drugs monitored expanded at MYR in April 2007.
Pillar 3: Essential basic equipment										
Essential medical	-% health facilities	PAMIS	To be	Baseline	Survey to	Baseline	Still to be	Survey	90%	Not measured at

equipment available at all health facilities	with equipment in line with standard (to be defined)equipment list		established in 2006	established	be done	established	measured	planned in 2007-2008.		mid-year because standard equipment list remained to be defined by PAMIS. List to be ready by Sep2007.
Pillar 4: Infrastructure										
Adequate health facilities available	- % health facilities with functioning water, electricity and communication	PAMIS	59% (HMIS 2003)	65%	74%	65%	-functiong. water=63% -functiong. electricity= 56% -functiong. communication=80% (reports from DHOs at MYR 07)	-functioning water=85% -functioning electricity= 80% -functiong. communication=100%	90%	A fourth dimension (fully renovated) being measured from MYR Apr 2007
	- % districts with functioning ambulances that satisfy requirements	Transport Unit	To be established in 2006	Baseline established	Not measured	Baseline established	Not measured at MTR	Transport unit to define and set	80%	To be provided by Transport unit
Pillar 5: Routine Operations										
Routine operations at service delivery level adequately carried out	- % health facilities regularly supervised by extended DHMT using integrated supervision checklist	HMIS (HMIU)	To be established in 2006	Baseline established	72.11%	73%	73% (403/552) (Reports from DHOs at MYR Apr 07)	75% (414/552)	80%	
Pillar 6: Central Institutions, Policy & Systems										
Central institutions support strengthened	-% districts reporting timely data -% facilities reporting data	HMIS (HMIU)	Timeliness: 10% Reporting status: 88% (HMIS 2004)	Timeliness: 60% Reporting status: 100%	Timeliness: 10% Reporting status: 94% (HMIS July-	Timeliness: 60% Reporting status: 100%	Timeliness: 12% Reporting status: 91%(HMIS	Timeliness: 60% Reporting status:100%	Timeliness 100% Reporting status:100%	Facilities continue to lag behind in submitting reports to districts. Situation expected to improve with

					Dec 2005)		July-Dec 2006)			introduction of monthly facility level reviews & quarterly district and zonal reviews
Health Financing										
Entire health sector funded adequately	- % GoM budget allocated to health sector	MOF	11.1% (2004-05) Source: MOF,2005	11.5%	10.7%	11.5%	8.7% (2006-07)	12.6%	15.0%	MoH requested GoM to compensate the under funding of 2006-07 in 2007-2008 budget allocations.
	- % of Budget and Funds utilised annually	MOH	% Annual Budget Funded: 70% % Recurrent Funding Utilised: 91% (2004/2005)	% Annual Budget Funded: 80% % Recurrent Funding Utilised: 75%	% Annual Budget Funded: 137% % Recurrent Funding Utilised: 87%	% Annual Recurrent Budget Funded: 85% % Recurrent Funding Utilised: 80%	% Annual Recurrent Budget Funded: 117% % Recurrent Funding Utilised: 99%	% Annual Recurrent Budget Funded: 90% % Recurrent Funding Utilised: 85%	% Annual Recurrent Budget Funded: 90% % Recurrent Funding Utilised: 85%	This analysis is for pool funds only. See Multi-year trend circulated by finance dept. for details of discrete funding.
	- per capita allocation (GoM and donor) to health sector (USD)	MOF	US$ 5.1 (2003/2004) Source: MOEPD	US$11.5	Not measured	US$ 11.5	US$ 9.21	US$ 13	US$17.53	Per capita national expenditure on health was found to be 18 US$ in 2003-2004 and 22 US$ in 2004-2005 as per NHA 2002-2004.

ACRONYMS:AIDS=Acquired Immune Deficiency Syndrome, ARV=Anti-Retrovirals, CPR=Contraceptive Prevalence Rate, DHMT=District Health Management Team, DHS=Demographic and Health Survey, EHP= Essential Health Package, MOEPD = Ministry of Economic Planning and Development, GIS=Geographic Information System, GOM=Government of Malawi, HAs=Health Assistants, HIV=Human Immuno-Deficiency Virus, HMIS=Health Management Information System, HTIs=Health Training Institutions, IMR=Infant Mortality Rate, ITN=Insecticide Treated Nets, JICA=Japan International Cooperation Agency, KABP=Knowledge, Attitude, Behaviour and Practice, LMIS=Logistics Management Information System, MAs= Medical Assistants, ME&R=Monitoring, Evaluation and Research, MGDS=Malawi Growth and Development Strategy, MMR= Maternal Mortality Ratio, MOEPD =Ministry of Economic Planning and Development, MOF=Ministry of Finance, MoH=Ministry of Health, N.A.=Not available, NHA=National Health Accounts, NSO=National Statistics Office, NMCP=National Malaria Control Programme, NTCP=National Tuberculosis Control Programme, OPD=Out-Patient Department, ORS=Oral rehydration salt, PAMIS=Physical Assets Management Information System, RCH=Reproductive and Child Health, SDSS=Service Delivery Satisfaction Survey, SP=Sulfadoxine Pyramethamine, SWAp=Sector Wide Approach, TB=Tuberculosis, TT= Tetanus Toxoid, TWG =Technical Working Group, U5MR=Under five morality rate, US=United States, WHO=World Health Organization

Insecticide Treated Nets

The cumulative number of ITNs distributed in the country and the proportion of Under-5s sleeping under ITNs continued to rise but the overall level of Under-5's using ITNs was reported to be very low, at 15%, by the 2004 Demographic and Health Survey (DHS 2004). However, a UNICEF household survey undertaken the same year found ITN usage at 35.5% of under-fives and 31.4% of pregnant women. This large difference may be explained by the surveys being done at different times of the year. The target for 2006/07 was to distribute 1,500,000 ITNs, with almost 1,325,000 having been distributed by the mid-year point. Unfortunately at the time of the MTR there was a national stock-out of ITNs due to procurement problems, and should the problems persist the level of ITNs distributed are likely to return to pre-2004 levels.

Other community awareness and access targets

None of the other community awareness EHP output indicators have information collected to measure progress on a routine basis. These include targets related to parental health seeking behaviour when a child has signs of acute respiratory infection, fever or diarrhoea, correct, comprehensive knowledge about AIDS amongst 15-24 year olds and % of men who know the signs and symptoms of pregnancy complications. This represents a serious problem in terms of monitoring EHP/POW progress. Furthermore, some of these output indicators are being used as outcome indicators in other parts of the national programme (e.g. % of young women and men aged 15-24 years with comprehensive, correct knowledge about AIDS), pointing to a certain discordance within the MOH (HMIU and HIV&AIDS programme) and between the MOH and the National AIDS Commission.

4.1.2. What are the trends towards meeting outcome targets?

POW outcome targets focus primarily on preventive service outcomes, service utilisation and some treatment outcomes.

Out Patient Department Service Utilisation

OPD utilisation was 800/1000 in 2004/05, the baseline year for this indicator. It had risen to 918/1000 by mid-year 2006/07, above the target of 850/1000 for the year. Should current trends persist, (and these are heavily dependent on the presence of trained personnel and drug supplies in health facilities) then the targets for this indicator are likely to be met.

EPI

The EPI programme's 2007 target was to achieve a 95% national immunisation coverage with at least all districts achieving a full coverage rate of > 82%; a measles immunisation coverage of 85% and a drop out rate of less than 10%. In general, there was been a steady increase over the past three years in coverage rates for most antigens but the coverage remains short of the targets and the drop out rates remain above 10%. The number of pregnant women receiving at least two doses of TTV has also declined steadily since 2003 and is estimated at 61% as of June 2007. The proportion of fully immunised children shows improvement from population based figures (MDHS and MICS) to 71% coverage in MICS 2006 compared to 64% as per MDHS 2004. However these figures fall short of those recorded in 1992 (82%) and 2000 (70%). Also, at the time of the review there were significant stock outs of vaccines at the central level (no BCG and DPT in central stores) due to procurement problems, which if not corrected could seriously compromise the performance of the programme in 2007/08 and beyond. There is a real danger that no only will EPI outcome targets not be met, but could continue to slide in reverse.

Service User satisfaction
The baseline for this indicator is being established through a survey recently conducted by the Malawi Health Equity Network. It is hoped that preliminary results of this survey will be available for the annual review in September 2007.

Contraceptive Prevalence Rate (CPR)
This indicator is for CPR related to modern methods. The baseline rate was 28% in 2004/05, though no current rates are available. Family planning services are provided through a combination of public health facilities and NGO facilities, most owned by BLM. BLM also provides outreach clinics and family planning clinics in public facilities where staff are not able to deliver these services themselves. Renewed interest in family planning by government and donors could translate into a more concerted effort being made on increasing CPR. If this is the case, then targets for CPR could be met or come close to being met.

Proportion of births attended by skilled health personnel
The proportion of deliveries conducted by trained personnel remains far below the % of women attending ANC service, as just over half of mothers in Malawi (40%, HMIS Bulletin, 2005-2006 and 54%, MICS 2006) deliver under supervision by trained personnel (i.e. excluding trained TBAs in accordance with the international definition). There is as yet no indication that this seemingly intractable problem is being influenced by the SWAp/POW. Values for this indicator have barely changed over the past two decades with the MDHS rates hovering between 54% and 58%, identical to the MICS 2006 rate cited above. Some encouraging news is coming from CHAM facilities, where increases in women seeking skilled attendance at birth are rising now that these services are free to women. However, barriers to women using health facilities for giving birth appear to be substantial and not well understood. It is likely that more work will need to be done on both community safe motherhood promotion and changing the attitudes of maternity staff to help them become more friendly and supportive to women using their services.

% of Health Centres offering basic EmOC services
Undoubtedly, the most defining achievement in RH so far under the POW is the establishment of the evidence on the current status of RH services through the 2005 EmOC assessment and the resulting Maternal Health Road Map. While at the time of the assessment only 2% of health facilities could offer basic EmOC services, during the last year (2006/7), there has been a dramatic increase in the number of staff trained and facilities equipped for BEmOC. The ADB4 programme will focus specifically on supporting expansion of these services over the next 3 years, with added support from USAID and UNFPA, and it is likely that targets for this indicator will be met.

Malaria: Use of ITNs and % of children <5 presenting with fever and receiving treatment
Although the dramatic trend in cumulative number of ITNs distributed in the country and the proportion of Under-5s sleeping under ITNs continued to rise, if only slowly, these trends mask the still very low level of 15% of children sleeping under nets. There has been good achievement in reducing the burden of malaria in Malawi. There has so far been a trend of substantial and sustained decline in the number of cases reported in health facilities countrywide, with the number of cases falling from around 300,000 in 2004 and 2005 to under 200,000 in 2006. At present there is no routine information being collected on the % of children <5 presenting with fever and receiving treatment. This will be measured during the 2009 Demographic and Health Survey.

Tuberculosis
The EHP/SWAp monitoring matrix includes two TB indicators, namely, TB Case Detection Rate and TB Cure Rate. Data for the TB case detection rate awaits the national survey planned for later this year. Some indicative relevant TB program performance indicators

for Malawi are: TB Cure rate was 76% at end 2006 compared to 74% 2004 baseline and 76% for 2008 target; TB treatment success rate 78% in 2006 against program target of 85%; Case defaulter rate was a low 3%; Treatment Failure rate was 1% - consistently one of the best in the region; Case fatality rate was high at 17% - co-infection with HIV being a contributory factor; Multi-Drug resistant TB rates are unknown but inferred to be low from the low defaulter and failure rates. With current progress it is likely that tuberculosis outcome targets will be met by the programme.

EHP Coverage

The baseline figure for EHP coverage was 9% in 2002. The MTR team's field visits and discussions with district and zonal staff indicated that there has been a real improvement in capacity to provide the full EHP in many districts. New clinical staff entering the health labour force, combined with incentives to bring retired clinicians and nurses back to work, locum opportunities to provide relief in understaffed health centres and Service Level Agreements with CHAM facilities are all contributing to increases in coverage. The team was not able to measure this in terms of a percentage across the country as the data was not available..

Doctor/population and Nurse/population ratios

Proportions of doctors and nurses to population are beginning to change as training institutions are beginning to graduate more students and staff who had left the health service are encourage to return. Mid-year figures for 2006/07 are encouraging, with 1 doctor/44,453 registered (against a target of 1 doctor/60,000) and 1 nurse/3,653 registered (against a target of 1 nurse/3,900). There is a presumption made that all doctors and nurses registered in the country are practising health, which may not be the case. However, the trend is encouraging, and final outcome targets are likely to be achieved as long as training, incentives and innovative use of human resources remain key parts of government strategy.

4.1.3. How equitable is performance across districts in meeting selected targets?

Performance across districts and across different geographical areas (especially rural/urban) remains highly variable and inequitable. Some rural health centres are still staffed by a single nurse, assisted by a few HSAs, which means that nurse is on duty 24 hours a day and 7 days a week. The good news is that no district is performing uniformly poorly on health indicators, though the reverse is that no district is performing uniformly well either. Strategies are being put in place to improve performance across the country in some national programmes, though problems persist as highlighted for selected health programmes below:

EPI: To offset the regional differences, the EPI programme started implementing the Reaching Every District (RED) approach. The programme is targeted towards districts with DPT+HepB+Hib3 and measles coverage below 80%. The programme started in Chitipa, Mzimba, Kasungu, Ntchisi, Nkhotakota, Salima, Lilongwe, and Chiradzulu targeting DHMTs and health centre staff. The programme has since expanded to Nkhatabay, Mchinji, Dedza, Mangochi, Phalombe, Thyolo, Blantyre and Chikwawa. 1500 health workers have been trained in the red approach and training materials for Mid Level Management (MLM) have been adapted and initial training of trainers courses have been run for 6 districts. These approaches will help reach groups of people residing in hard to reach areas, for example, some religious groups such as the Zion and Apostolic sects which do not allow their members to have vaccination, and refugees and migrants in some parts of the country.

ARI: Despite impressive improvements in case management at facility level, leading to improvement in case fatality rates, the progress at community level has lagged. Most of the improvements in case management have been recorded in facilities previously supported by the Child Lung Health Project, which hitherto has been restricted to public facilities excluding CHAM facilities that serve a significant section of the population in Malawi. While efforts are underway to implement similar interventions in those CHAM facilities that have service level agreements with MOH, it is likely that the majority of the underserved rural population in Malawi dependent on CHAM and private facilities still does not have access to the improved case management. In any case the service agreements have been restricted to select interventions in maternal and child health. By excluding other interventions and admission services, the poor who are meant to be beneficiaries of this arrangement are likely to be experiencing poor access to other, effective interventions.

HIV/STI: Because the interventions are primarily facility based, there is wide geographical variation in terms of access. Disparities in HTC, PMTCT and ART delivery are emerging with some districts lagging behind and differences are being seen in terms of gender and socioeconomic status. Disparity in HTC delivery and uptake has been identified in nine districts in the Southern and Central regions, correlating with the number of HTC sites per population. Similarly, a disparity in male HIV testing was identified nationally, potentially affecting ART treatment outcomes. For PMTCT, disparity in PMTCT delivery and uptake was identified in six districts in the South and Centre. This disparity, however, is not correlated to the number of sites per rate of pregnancy in these districts..

Balancing out Disparities – the Role of Zonal Offices

Good Practice example – Zonal Offices

Three out of the five health zonal offices were visited as part of the MTR: Northern, Central West and South West. Further conversations were held with the M&E officer in Central East zone. The MTR team found that Zonal Health Officers are playing an important role in improving systems and processes at district level (supporting health planning, reviewing HMIS reports and facilitating cross district learning. This is ensuring that at least from a health management perspective there is greater equity across districts. Their full potential for helping districts to improve health outcomes is not yet being met, and opportunities for building on this potential now need to be explored

Between district disparities are being examined and tackled at zonal level by zonal supervisors and their teams. The MTR team found that the setting up of zones to extend supervision and quality assurance closer to districts is achieving much greater communication between districts and motivation to make improvements. Areas of notable progress due to assistance from the zonal offices include:

- Ensuring that the districts understand the current policy direction of the Ministry of Health;
- Rolling-out of provision of EHP services (from concentration at district level to health centres);
- Rolling-out of infection prevention practices from the district hospital to the periphery.
- Emphasising the ownership of data and its use in decision making (institutionalisation of quarterly HMIS/DIP reviews);
- Proper and systematic infrastructure development agenda for the districts (in order to provide an enabling environment);
- Implementation of a package of incentives e.g. locum, relief and upkeep (these have been harmonised within the zones to avoid migration of staff to districts perceived to be of greener pastures);
- Ensuring the development of a proper transport policy/ guidelines (realising that transport expenditure constitutes a bigger share of total district ORT);

- Harmonisation of management structures at district level in the zone (e.g. DHMT, Hospital Advisory etc.)

Financial equity

From a financial perspective MoH has formulated a resource allocation formula for allocations to districts (for ORT), which consists of the following

- Population 50%
- Poverty 15%
- Under 5 Mortality 20%
- Remoteness 5%
- Presence of CHAM facilities 5%
- Presence of District Hospital 5%

The MoF accepts the formulae and does its allocations accordingly, in practice following previous year's allocations with minor revisions, e.g. new districts or needs due to new facilities in place.

The recent National Health Accounts calculated the MOH per capita recurrent expenditure by geographic region, finding that the North was highest (MK 559), followed by the South (MK 406) and the lowest in the Centre (MK 340). Although there is a need to calculate this by individual district, the general picture is that percentages of population classified as poor and under 5-mortality rates are higher in the South, whereas percentage stunted growth is highest in the Centre.

It was also found in the NHA that the health centres/dispensaries/maternity units were the major providers of health care, consuming 29% of total health expenditure, whereas Public Health consumed 31% and hospitals 25%. However, of MoH allocations, about 64% of all expenditure occurred in hospitals, including central, district and rural. As the district as such is one cost centre, it is virtually impossible to obtain regular detailed information on actual allocations to levels below District Hospital. The NHA argues that the district budget should be separated in two, one part for the district hospital and one part for the rest.

Finally, the NHA stresses that the MoH continues to provide free care for services that fall outside the EHP, including cost of overseas referrals. An example from 2004/05 is provided where approximately MK 129 million was spent on treatment abroad for about 15 patients; the equivalent to the recurrent budget of a full health district and equivalent to US$ 78,812 per person.

4.1.4 What progress is being made in improving the performance of national technical programmes?

Many programmes are showing good progress in their development, with national strategies and plans in place and being implemented (e.g. TB, EPI, HIV, ARI, Malaria, and IDSR). Other programmes continue to struggle, for example Leprosy and Skin conditions, Schistosomiasis, Reproductive Health and Nutrition. The poor performance of some of the technical programmes is related to severe understaffing and long periods of instability due to high turnover of technical staff e.g. in Reproductive Health. In some cases, there are no focal persons nor specific programmes e.g. management of eye and ear conditions which are rightly integrated within normal clinical care. The lack of specific programmes and focal persons may have resulted in less attention being paid to these conditions which however were considered important enough for inclusion in the EHP. Of the programmes that are

performing well some have benefited from substantial external technical assistance e.g. TB and HIV.

The implementation of technical working sub-groups (e.g. RH, Malaria, TB, and HIV etc.) and establishment of focal persons at the zone level (M&E, RH) are strategies that have been implemented to improve performance of some of the technical programmes. For other programmes what may be required is just having a designated focal person to oversee the agenda of the technical programme. Additionally the recent functional review will result in increasing staffing levels for some of the technical programmes that have hitherto been understaffed for adequate performance (e.g. epidemiology unit and reproductive health) and this should improve performance of the technical programmes.

Despite the above, there are elements of the national technical programmes that could be improved further e.g. by ensuring that their function remains restricted to policy direction and advice and that they relinquish implementation to the DHMTs. Furthermore the remit of the TWGs needs to be clearly defined so that concerns as expressed by some technical programmes that TWGs have engaged in micromanagement could be avoided. Finally, while technical assistants have improved performance of the technical programmes, the tendency of using TA as implementers instead of building local capacity due to understaffing or high staff turn over needs serious review and reflection to ensure there is adequate internal ministry capacity to improve performance of the technical programmes. Examples in this regard include the Reproductive Health Unit, HIV Unit and Epidemiology unit.

At health service delivery level, the decision to extend the role and training of HSAs to include ANC, cIMCI, TB sputum collection, amongst other activities, will expedite attainment of wider coverage of EHP interventions. However, concerns over the potential increased workload, regulation of service delivery (especially where there is apparent encroachment into services previously delivered by nurses and other clinically qualified staff who have formal regulatory mechanisms) needs to be addressed at the same time.

Examples of appropriate approaches for technical programmes include:

- RHU working with DHMTs to identify the health centres that are most ready to undertake EmOC services
- Training of midwives working in the health centres identified in life saving skills and filling any existing gaps in basic equipment as delivery packs, vacuum extractors, suction machines, MVA kits, etc.
- Providing Motorcycle ambulances and radio communication systems to facilitate speedy referral of cases
- Undertaking infrastructure development such as refurbishment or extension of labour ward facilities with inclusion of running water and electricity.
- The TB control programme, which already delivers DOTS down to household level is now implementing a national program to overcome the main bottleneck to TB diagnosis and therefore case detection. This is being addressed through the extension of diagnostic (microscopy) services to selected health centres; this service is currently only available at hospital level.
- The program has also extended its net to cover the private health sector, TB “hot-spots” such as the prisons and the peri-urban slum areas.

The MTR team recognises that speedy implementation of the various improvement plans for the 6 Pillars of the POW is a necessary prerequisite to attaining improved performance of the national technical programmes. Progress in achieving the POW pillars is discussed in the following sections.

4.2. Progress in achieving the pillars of the POW and other health sector strategic plans in delivery of the EHP

4.2.1 How relevant is each POW pillar in relation to achieving health sector goals and objectives?

The POW pillars: Human Resources Development; Pharmaceuticals and Medical Supplies, Essential/Basic Health Equipment, Infrastructure Development, Routine Operations at service delivery level and Central Operations remain highly relevant for the achievement of health sector goals and objectives. The Routine Operations pillar has been found to be overlapping with the first four pillars. Overall, the analysis of challenges that existed in 2002/2003 when the current Programme of Work was being designed remains pertinent today. The six pillars are all systems and procedures related and were developed to address the main bottlenecks to delivering universal and effective health services to Malawians. For each of the pillars examined in detail by the team, serious problems remain (Human Resource capacity, Pharmaceutical and Medical Supplies, Routine and Central Operations (especially financial operations at all levels, and accuracy of health information at service delivery level). These are detailed in sections below as well as in the annexes. The MTR team has found that while some progress has been made in improving these systems and procedures, further, long term support is required to make sure they are of adequate quality, standard and stability to have an enduring impact on the quality, effectiveness, efficiency and sustainability of Malawi's health services.

The pillars are input-oriented, creating difficulty in mapping EHP outputs, outcomes, and impact into the pillars, especially with regards to mapping financial inputs against EHP outcomes.. The Health SWAp M,E &R Framework fortunately provides a clearer mapping of the key indicators into the pillars. The interventions required to meet the POW objectives are included in the POW document, for the most part. However, the balance of focus now needs to be shifted more onto the actual delivery of the EHP. For instance, the encouraging construction of much-needed additions to hospitals and the frustrating lack of human resources have become the primary focus in many settings. These are indeed important for improving health services, however focus on these areas should not cause staff to lose sight of the actual delivery of the EHP. EHP output and outcome targets should be the central focus of M&E and planning activities, and form the basis of performance management throughout the system.

4.2.2. How well have M&E systems and procedures been set up and how well are they operating?

<u>M&E System at Central Level</u>

The current M&E system for the health sector is comprised of several key data sources. The Health Management Information System (HMIS) located in Planning Department of the Ministry of Health (MoH) is the primary source of data for the M&E system for the health sector, as it is the mechanism through which routine data is collected. The National Statistics Office (NSO) also provides data for many key indicators through reports compiling the results of national surveys such as the Demographic and Health Survey (DHS) and the Multiple Indicator Cluster Survey (MICS).

Under the HMIS, there are a number of subsystems covering areas such as integrated disease surveillance and response and logistics management information. Rather than integrate these subsystems into one system, the Health Management Information Unit

(HMIU) has instead attempted to ensure that the subsystems are strengthened independently and remain in communication with each other.

Attempts have been made to better integrate disease specific programmes with the HMIS. However, a dynamic of competition and isolation still remains. Complementary rather than competitive roles need to be defined and implemented. Greater harmonisation and alignment between disease specific programmes and the HMIS are goals of the on-going revision of the HMIS. There is hope that this will help to resolve the differing data sources being used for the same indicators, the dual data routes, different reported values for the same indicators, and parallel reporting systems.

One of the main reasons for dual data routes continues to be the delays in reporting through HMIU. The timeliness and completeness of HMIS data has improved dramatically over the past three years. However, HMIS reports are still delayed by many months due to missing data from just a few sites. Dual data routes are creating inconsistencies in reported data. Vertical programmes hesitant to trust the quality of HMIS data have requested that data be sent to their headquarters directly from the districts. When numbers are questioned, they often institute their own data verification measures. When the HMIS report is later issued, the values it contains do not match vertical programme reports in some cases. Questions then ensue as to which values are more accurate. The lack of data verification and data quality assurance mechanisms at every level of the HMIS put the quality of its data into question.

HMIU has been operating on skeletal staffing. In a positive development since the new Director of Planning has come into his position, two key posts have been filled in the HMIU in recent months. However, the HMIU needs substantial reorganisation and expansion to play the role of a Monitoring, Evaluation and Research Unit (MERU) that is so desperately needed. Moving to the MERU structure will enable the Unit to provide direction to and oversight over monitoring, evaluation, and research activities regarding the health sector. It will also allow for more attention to data quality assurance and mentoring of the zonal offices to ensure stronger supervision and capacity-building by the zonal staff at district level. Greater capacity at headquarters would also allow for time to be invested in strengthening the relationships with vertical programmes, clarifying roles between entities, and cultivating the supportive role MERU should be playing in relation to the vertical programmes rather than perpetuating the competitive relationship that has existed.

<u>M&E at Decentralised Levels</u>

Data reliability from health facilities has improved, though challenges in reliability and validity remain. Registers are being religiously attended to at most facilities. However, an examination of clinical registers at the facility level reveals the lack of page summaries in almost all cases. Failure to create page summaries results in the arduous task of adding totals of different types of cases for a month at a time. As no notes are made in the register, no separate pages are able to b e produced where these cases have been tallied, and nearly every person who has performed the function of filling in the reporting forms confirms that they have spent hours or days at the end of the month adding the totals

Good Practice – M&E

One glowing exception to this norm is Mzuzu Central Hospital where the new director has championed the use of data for improving service delivery. One of the first things she did upon appointment to her post, was to impress upon every department head the importance and relevance of data to their job. This has resulted in a more attentive staff attuned to the needs of patients and focused on improvement of service delivery.

In Dowa DHMT the HMIS officer produces his own HMIS bulletin for the district, which provides both the DHMT and DC with up to date information on health matters, and allows for better planning for district health improvement.

in their head, one can only imagine the number of errors that occur. Furthermore, data generated at facility level is not being used by those facilities, so that filling in the HMIS forms has become more of a mechanical process rather than seen as a critical function.

The completeness and reliability of district compiled HMIS is heavily dependent on the quality of data coming from health facilities in the district and the interest shown by DHOs in the data produced. The degree of interest shown by DHOs and their staff has been variable. However, the MTR team found examples of good practice, such as work being done by the Dowa District HMIS officer, who produces his own HMIS bulletin for the district.

Zonal offices are playing a critical role in ensuring that HMIS is taken more seriously at district level and below. The reinstating of zonal offices has helped immensely in creating more accountability and oversight for districts. Less pressure now rests on the HMIU at headquarters to follow-up on incomplete and late reporting of data

4.2.3. How well have planning systems and procedures been set up and how well are they operating?

Planning at District Level

The Health annual planning and budgeting cycle begins at health facility level and feeds into district planning. In principle the districts are supposed to have received their budget ceilings to plan from already in January, but this is sometimes delayed to April, hampering the planning process. Health facility teams tend to consider what resources they need to develop (human, infrastructure, equipment) and what community programmes they might undertake. This is provided as a 'wish list' to the district health office. The District Health Management Team (DHMT) then pulls together requests from facilities along with needs of the district hospitals and proposals from CHAM facilities to develop the District Implementation Plan. The extent to which the data is actually used for planning and monitoring is largely determined by level of recognition and support this individual receives from the District Health Officer (DHO). The planning process is further complicated by the fact that annual plans and budgets are focussed on inputs and not linked sufficiently to the outputs and outcomes expected in the POW. The District Implementation Plans for health do not align with the POW and are frequently more focused on the list of resources desired than on a strategic approach to addressing health needs in the district. Moreover, in many cases, they do not incorporate a full assessment of the needs at all.

Decentralised level planning has continued to pose challenges for DHOs and District Commissioners (DCs). Support and mediation from zonal supervisors has helped to reduce problems and helped DHOs to see how they can fulfil the requirements of the MOH DIP while also providing the information required for District Development Plans. In addition, Management Sciences for Health has been providing technical support in district planning processes for a selected number of districts. This extensive assistance and capacity building work throughout the District Implementation Plan (DIP) formation process has improved both the process and the product. However, the health planning process still remains detached and insufficiently incorporated into the general district plans. Furthermore, planning processes for Central Hospitals are not well integrated with the planning processes for the districts they serve.

Planning at Central Level

District Implementation Plans and Central Hospital Implementation Plans, once completed, are then compiled by the MOH Department of Planning into a single MOH Annual Implementation Plan (AIP), which also incorporates Central Ministry programmes and requirements. It is unclear how health trends as identified through HMIS bulletins are taken into account during the annual planning process. However, the monitoring of implementation of the AIP is done primarily through using the SWAp monitoring indicators and targets, with limited attention to the detail of the plan's implementation itself. Even though there is poor correspondence between what is found in AIPs, DIPs and CHIPs and how the POW is monitored, there is also almost complete agreement that the SWAp monitoring indicators and targets are satisfactory and that their use rather than their revision needs to be the focus of attention at this point. Meanwhile, so many concerns have been voiced with regard to the indicators and targets used by the HMIS, that it is under revision at this time.

Better use of national data for planning and monitoring will depend on ensuring better timeliness and completeness of data available to national decision makers. Efforts to ensure that the HMIS will be able to produce more relevant and accurate data in the future have been kept alive largely through the efforts of the HMIU with the support of the Director of Planning and several development partners. Through sheer persistence on the part of the Chair of the Monitoring, Evaluation, and Research Technical Working Group (ME&R TWR), the TWG has continued meeting within a difficult environment for TWGs. In addition, the current Director of Planning has made a point of attending these meetings and playing a vocal role in supporting the importance of the HMIU in recognition of the fact that if the Department of Planning is not receiving the necessary information for decision-making and planning in the health sector, then there is cause for serious concern. Key indicators, results, and targets need to be at the height of consciousness for persons responsible for planning and implementation. Questions about what is going wrong and what can be done to improve performance in key areas such as human resources and drug supply are not sufficiently covered by current reports.

4.2.4. How well have drugs and medical supply systems and procedures been set up and how well are they operating?

Forecasting, procurement, distribution and supply of drugs inclusive of aspects of quality assurance

Forecasting: No evidence of systematic attempts at national level forecasting was identified prior to 2006 for essential drugs. Forecasts are now achieved primarily by utilizing consumption data (in a similar manner to the methodology deployed to compute family planning requirements) in consultation with a large group of stakeholders, twice yearly. Morbidity data, which might serve to validate the forecasting exercise, is not considered as part of this exercise, and this is a serious gap. Approximately 120 items from the about 400 item catalogue are currently the subject of the stakeholder forecasting exercise. The provenance of the remainder of items required for national level forecast is unclear. Whilst significant improvements have been witnessed to the essential drugs forecasting exercise during 2007, a "second wave" evaluation of methodology, data integrity, incorporation of best practice and also to address future data provisions would be useful. In summary, at present the resulting figures (= quantities awarded after tendering) are very likely to be insufficient; even after correction due to national health statistics (epidemiologic figures).

Procurement: The majority of medicine lots from the last 2004 tender were awarded to pharmaceutical wholesalers located in Malawi. However, most of these items are of foreign origin – because imported drugs are tax exempted and, in consequence, cheaper than locally produced ones. The tender procedure is based on the forecasting procedure described above and requires about ten steps (see Annex 7 for details); these steps require about nine months to complete. If one also calculates the time spent for preparation at CMS the total lead time to distributing drugs comes to about one year or more. This unacceptable long lead time of more than 12 months could be cut down by several months' lead time, if the tender/purchase procedure used multi-year prequalification and framework contracts awarded for a two years period (with the option to extend for one more year).

Distribution: Distribution systems were developed on the basis of a population based 'push' system to ensure equity across regions. Drugs and medical supplies are received by the CMS through a tender process by the MoH, from donations, through private purchase and through UNICEF. All commodities received by CMS are then pushed to the RMSs according the following formula: 20% to the North, 35% to the Center and 45% to the South. When a health facility runs low on drugs, the in-charge will send a request for replenishment to district level, where the district pharmacist compiles a list of district needs to be sent to CMS/RMS. If CMS does not have the required drugs in store then the request becomes stuck. Districts are now able to unblock the situation to some extent through purchasing of drugs their facilities need through the private sector. However, the costs of doing so can be up to four times the cost of supplies through CMS, and not all required drugs are easily available in country from the private sector.

Supply: Long lead times in drug procurement have created several problems with regards to drug stocks available in Malawi, both at central and facility level. In February 2007, at the Regional Medical Store "Centre" 151 drug items were out of stock plus 6 new expiries (value: US$ 35,049 by 2006/07 catalogue prices), i.e. a total of 158 items out of 267 were not available (= 59.18%). By the end of July 2007, 187 stock items (=70.04**%)** were already out of stock. These included critical items such as anti-biotics, HIV test kits and certain vaccines. The current stock and distribution situation results in particular from the tender of 2004 based on 2002/03 data and awarded in 2005. In addition an emergency supply contract awarded to UNICEF in October 2006 has taken around 11 months to arrive in Malawi, though all 106 containers are now in.

Integration of Supply Systems

Integration at central level: Reviewing the integration of the supply chain showed that there has been documented progress made upon the financial integration of pharmaceuticals in the SWAp. However, for the supply chain specifically, there has been less obvious levels of integration. The vertical programs, such as *family planning*, *TB* and most recently the *President's Malaria Initiative*, whether or not they administer their systems of supply through the CMS network, have not fully devolved responsibility for the forecasting and/or procurement elements of their programs. Incremental support may still be provided to CMS to ensure availability, effectively creating subsystems within CMS which, although they might result in maintenance of performance standards, are not truly integrated systems. In future (and in the expectation there will always be priority programs amongst the donors), the benefits of resourcing and best practice for such vertical activities should always be incorporated for the benefit of the mainstream supply chain. The *HIV/AIDS program* has proved an exception and although currently highly vertical is developing an integration plan to harmonize all functions, procurement excepted, into the CMS network.

Integration at regional and at peripheral level: At the facility level, where such upper-level integration issues are not visible, or indeed of direct concern, the problem is primarily

unfulfilled lines in the reorders submitted to the regional medical stores; stock-outs create considerable extra work in order to correct. Rectification might occur via a number of mechanisms including; private sector sourcing, NGO-sourcing, borrowing/redistributing or subsequent reordering from the regional medical stores. These activities however are all considered burdensome and unwelcome. Additionally, there are known quality issues and risks associated with alternative sources to those supplied by CMS. With discrete sources of supply, distribution and reporting and different methodologies ("push" rather than "pull" from the national level), supply chain activities continue in isolation. At facility level, this is not seen as an issue, as the lack of attendant administrative workload and decision-making associated with reordering in a 'pull' or demand led system is viewed positively.

Drugs Availability at Health Facility Level

Drug availability figures show the following:

- All three RMSs show a drug availability of around 34% (stock out = 66%)
- Only about 53 % of all A-items are out of stock if referring to **all** RMSs at the same time.
- Three Central Hospitals show drug availability of 45 – 60 %
- The DHO Pharmacy visited has a drug availability of 33 %
- HCs show a drug availability of 7.5 – 41 %

The following 13 items are out of stock at all RMSs, but listed for all health facility levels, and they are of great concern to fulfill the EHP: Vitamin A capsules, Adrenaline injection, Benzylpenicillin injection, Diazepam injection, Ergometrine+Oxytocin injection, Gentamycin injection, Lignocaine injection, Tetanus antitoxin, Amoxycillin suspension, Cotrimoxazole syrup, Erythromycin oral suspension, Metronidazole oral suspension, Oral rehydration salt sachets. On the other hand, Health Centres keep drugs which they are not supposed to keep according to CMS catalogue i.e.: *tablets/capsules*: Diazepam, Indomethacin, Phenobarbitone, Propranolol, Pyridoxine, Quinine, Vitamin B complex, *Injections*: Benzylpenicillin, Chlorpromazine.

In general, the drug availability at Central Hospitals is higher than at RMSs. This results from private market purchases (at remarkably higher prices) from local wholesalers which sometimes also supply CMS (but sometimes do not fulfill their lot-contract in time). At all health centres it was difficult to obtain an updated *availability stock status*, as this data is not readily available. In several cases it was said that a copy of last months stock status had been given to the director or administrator and no copy had been kept. Others had severe problems to retrieve this information from the computer, as computers were not working well or run very slowly. Computer knowledge is generally poor and the electronic and manual filing system is organized in such a way that data retrieval is difficult. Many computers have viruses, another reason for erratic function.

Other issues related to drug availability, including the quality of pharmaceutical staff managing drug supplies, are discussed in more detail in Annex 7.

Validity of quantification data and methods applied in forecasting

A logistic infrastructure to report on drug status/availability is in place. The relevant reporting tools at Central Hospital and District Level have been developed by donors. The calculation of order quantities at DHO pharmacies for drugs and medical supplies is uncertain as this is not uniform. Some DHO pharmacies adjust these *quantities required* to their own knowledge/ perception of what they think might actually be needed by respective HCs. RMSs, DHOs, DHs and HC do not quantify data for quantification at national level; they provide stock status data (stock on hand and stock consumption) and channel these to the CMS. However, as noted above, stock status information can be difficult to obtain and may be unreliable.

Quantification of drugs and medical supplies is only performed at Central Level. At Central Level quantification of drugs and clinical supplies is based on erratic consumption data received from lower level. Quantification is performed by different people at different times for different Programs, thus there is no unique quantification for Malawi as too many players run their own vertical program, and use their own quantification systems. Quantification before 2007 was very unsystematic and confusing. In February and August 2007 more precise forecasting and quantification took place for CMS procurement. At present, the quantification exercises have not yet revealed a procurement process. A nation wide physical stock count is envisaged for December 2007 at all health facilities. Thereafter in January 2008 an even more scientific forecasting and quantification is planned. To increase better forecasting and quantification the list of drugs will be extended. However the exercise is still likely to be based on erratic consumption data because of the paucity of accurate information for the reasons outlined above..

IT Tools Used in Supply Chain Management

The USAID/Deliver Supply Chain Manager system, now in situ in all districts, has strengthened the ability to apply a consistent reordering methodology nationwide to essential drugs and supplies. The routine submission of stock-on-hand and consumption data would seem to have been effectively introduced and the districts can now aggregate and submit orders on behalf of all their facilities. Major issues that now constrain more effective deployment identified are as follows :

- Inability to identify an audit trail regarding quantification decisions
- Uncertainty and inconsistency on the methodology for computing the consumption data inputs.
- Inflexible product base data in order to address variants (eg pack size) of the same product.

Progress on Implementation of the CMS Improvement Plan

The “CMS Improvement Plan”, in conjunction with various other relevant documents (for example, the Strategy Plan, the Inception Report, the Glocom contract, the SWAp milestones and the Business Plan) collectively help to identify a road map for CMS performance improvements. The Glocoms Inception Report, approved by the Drug and Medical Supplies TWG is now the guiding document for CMS/Glocom activities. Unfortunately, the tracking mechanisms which might identify progress, as identified in the Inception Report and Strategic Business Plan, has been lost insofar as the Drug and Medical Supplies Technical Working Group does not convene regularly to discuss progress reports provided by Glocom and in any event, would not appear to have a formal mandate to exercise performance oversight in this area.

Assessment of access to pharmaceuticals, supplies and sundries recommended for usage at different levels by the proposed set of essential health care package

As detailed above, the 13 basic drugs for usage at all levels of health care for the EHP are not accessible at present, since none of the RMSs has any stock of these drugs. Annex 7, Appendix 9b in the Pharmaceutical Report gives a detail overview of the stock status of essential drugs required for treatment of focus EHP diseases. This inventory confirms that numerous drugs needed for delivering quality EHP services were not available at the time of assessment. This is very worrying since this translates into no access to basic health care in some areas. Reasons for non-availability are multifold (i.e. erratic data sources that result in low figures in forecasting and quantification) and have been discussed above extensively. A further problem uncovered by the team was that the standard treatment protocols have not been updated since the mid-1990s. Therefore, mapping of EHP diseases and current treatment is not a straightforward exercise.

4.2.5. How well have procurement systems and procedures been set up and how well are they operating?

In general, procurement systems and procedures remain very weak throughout the health system. Poor capacity and poor documentation continue to hamper progress in this key area of the POW.

Institutionalising the procurement function at district, central hospital and MOH headquarters

The institutionalisation process has begun for integrating procurement functions at most levels, except in the Malawi College of Health Sciences (MCHS). Despite this, public health institutions at all levels do not have adequate procurement staff in place. Procurement is often being undertaken by non-procurement specific staff within these institutions. This situation threatens the long term development and institutionalization of procurement and capacity building. Though capacity building has been undertaken with certain staff the current approach may not be sustainable as capacity is being built in staff that are not intended to carry out procurement. Also potential conflicts of interest exist within many institutions (i) same staff carry out procurement process, evaluations and approvals in the IPC's (ii) UNICEF is used both for Technical Assistance (TA) and as Supplier including on procurement where they may have offered TA.

Procurement Capacity

The capacity of the MoH headquarters to carry out procurement is currently inadequate. The existing staff clearly do not have the experience to carry out procurement of consultant services and works. As the staff in the MoH are being used to provide guidance and coordinate procurement in the SWAp, the current inadequate capacity will continue to slow down procurement and do little to improve procurement capacity and support of the EHP components. Low MOH procurement capacity is delaying procurement of works and consultant services. For example the MCHS signed a contract to procure vehicles using SWAp funds in November 2006. Yet at the time of this review in September 2007 delivery of the vehicles had not taken place. The delay is due to both weak understanding of procurement procedures within the MCHS and the MOH and of changes to the laws on tax exemption, as well as delays in responses from the Treasury to MOH requests for clarification. In fact, in this case the waiver was not necessary in the first place and evidence is not available that the MoH advised the MCHS accordingly to avoid unjustified delays as there was adequate budget to fund the vehicles' procurement inclusive the payment of taxes.

Procurement capacity at Central Medical Stores is also worrying. Central Medical Stores is in the process of restructuring itself and have the experience in procurement of large contracts. However the capacity of CMS is propped up by Consultants. With the consultants' contract expiring in April 2008, it is imperative that CMS urgently (i) recruit all key positions in procurement such as Chief Procurement Officer and Procurement Pharmacist (ii) Consider the employment of a short term procurement consultant after April 2008 to build capacity of newly recruited staff for a period of up to one year should current technical assistance contract come to an end.

Overall procurement capacity is further challenged by delays occasioned by organisations supporting the implementing institutions. One organisation designed to support many GoM departments and which is contributing to delays is the Department of Buildings. Other key institutions that cause delays are World Bank, ODPP and UNICEF. Often the requirements of the supporting organisations, such as ODPP or World Bank, are poorly understood by staff initiating a procurement process, and poor communication between the two entities lengthens the entire procedure.

Procurement Improvement plan achieving the actions recommended in the procurement audit

There is institutional awareness of the findings of the previous procurement audit and recommended actions but no concerted effort has been put in place to improve the situation. Developing and implementing the procurement improvement plan lacks a champion at MOH headquarters level. Also, there is no systematic reporting from district or central level on progress towards implementing the improvement plan.

Progress on implementation of Procurement Plans

Procurement plans are not being consistently prepared at peripheral and departmental level, nor are they being shared with the Office of the Director of Public Procurement. Rather than preparing plans strategically, the procurement plans reviewed by the MTR team appeared to be based more on whatever funds were received for that month. This lack of strategy can be seen by the fact that there is a missing link between DIPs, budgets, the district procurement plan and the cash flow plan.

Difficulties found in preparation of adequate procurement plans can be partly attributed to the poor capacity described above. In many cases, those preparing plans are also missing the tools that have been developed to help them. Not all institutions have the main procurement documents designed to guide planning, and on most occasions documents handed out during training workshops are not shared with colleagues. Some documents are missing key areas of information, such as mechanisms for payment, delivery and complaint handling. Many staff are also having difficulty understanding those documents that they do have to hand. Finally, many institutions are not clear on how to handle clarifications, debriefing of bidders and how to handle complaints. Complaints from bidders are most often poorly managed, and are based more on emotional reaction or fear of authority.

4.2.6. Degree to which relationships with key Ministry of Health government partners are helping or hindering effective implementation of the POW

The key MOH government partners with a direct relationship to the Programme of Work are the Ministry of Finance, the Ministry of Local Government, National AIDS Commission, Office of the Director of Public Procurement and the Office of the President and Cabinet/Directorate of Human Resource Management and Development. Relations vary between the MOH and these different partners depending on degree of inter-dependence, whether there is a health focal person within the government partner, and whether there is a focal person within the MOH with whom the government partner can relate.

Ministry of Finance: Overall, relations with the Ministry of Finance are functioning well, and MOF processes are assisting with the implementation of the POW to a large extent. The Deputy Director of the Department of Aid and Debt in the MOF chairs the Financial Management and Procurement TWG, therefore acting as the key focal person within the MOF with whom the MOH may interact. The MoF has accepted the district resource allocation formula developed by MOH, implying the two ministries' ability to collaborate on this. The Ministry of Finance is disbursing funds from the health accounts on a regular basis, which has helped the managers in different cost centres gain confidence that the funds in their approved budget will actually come to them. The one area of hindrance at present has to do with how the MOF disburses to cost centres. MOH staff indicated that even if they attempted to provide cash flow projections to the MOF, these are ignored by the MOF, which tends to divide the cost centre budget by 12 and disburses in monthly tranches. This has caused problems with procuring large infrastructure projects and other

big ticket items that fall under the cost centre budget, but which need a large amount of funding available at certain points in time.

Ministry of Local Government: The MOLG is managing the national decentralisation process and should therefore be an important partner to the Ministry of Health. Interviews with both MOLG and MOH staff indicated that no strong relationship has been built up between the two ministries, and there appears to be some confusion as to who should be responsible for what 'triggers' to keep the decentralisation process moving. There are also fairly striking differences of opinion between the two ministries as to what stage of decentralisation the MOH has actually achieved. At present there are no focal persons within either ministry and so lines of communication are difficult.

National AIDS Commission: The NAC is an important stakeholder in the MOH as a large amount of funding flows through NAC to the MOH for implementing the HIV&AIDS bio-medical response. MOH capacity constraints have at times had a serious impact on progress of the national HIV&AIDS response, and this has put strains on the relationships between the two organisations. There is no clear single line of communication for NAC within the MOH. While most of the relationship can be mediated through discussions with the HIV&AIDS Unit, this unit is not always able to cater for the large scale of NAC's requirements, and sometimes decisions are required from higher up within the MOH to make progress. Within NAC it appears to be essentially the Executive Director who is the point person with the MOH, which can also hamper dialogue as he has multiple priorities and calls on his time.

Office of the Director of Public Procurement: ODPP has oversight of all government body procurement. There is a focal person for health assigned within ODPP who is the contact person for MOH staff on any procurement issues. As detailed in the Section 4.2.4 above, weak procurement capacity within the MOH has hindered good communications and relations with ODPP. These have been further hindered by lack of clarity in some of the circulars and documents prepared by Office of Director of Public Procurement and disseminated to procuring entities. Given the degree to which procurement issues are hindering overall progress in implementing the POW building a better relationship with ODPP should be a top priority for the MOH.

Directorate of Human Resource Management and Development: The Directorate of Human Resource Management and Development located in the Office of the President and Cabinet has a key role in controlling human resources across the Ministry through tight and effective establishment control. The processes for creating posts and filling posts are very complex, slow and unresponsive to what appear to be service needs. The recent MOH/Malawi Health SWAp Donor Group report "Human Resources / Capacity Development within the Health Sector – Needs Assessment Study" (June 2007) provides an excellent analysis of the present situation.

4.2.7. Degree to which the decentralisation process has helped or hindered the effective implementation of the POW

The wider public sector reform envisaged by the Local Government Act 1998 specifies that the implementation of public services at district level should be devolved from the central government ministries to local government in the form of District and City Assemblies. Thus responsibility for the provision of health services, including implementing the programme of work and the essential health package for all Malawians would shift from

the civil service, controlled centrally, to 28 assemblies. Each would employ its own workforce to deliver services.

There is some confusion as to what stage the MOH is actually at with regards to decentralisation. The Ministry of Health's Principal Secretary is of the view that devolution to local government control will not happen during the lifetime of the SWAp, that is up to 2010. Having said that, the Ministry of Local Government is of the view that the process of transfer will begin as early as 2008, starting with education and with the other ministries, including health, following on fairly quickly afterwards. Finally, as far as at least one District Commissioner is concerned, the services are already devolved. He regards the fact that he is the Controlling Officer for all health expenditure in his district means that he is in charge. He regards the health staff in his district, currently employed as part of the civil service as being on secondment to the district. It is important to note though that the DHO of this same district, when pressed, regarded herself, ultimately, as being accountable to the Principal Secretary of the Ministry of Health.

In spite of the Principal Secretary's view that devolution will not happen during the lifetime of the SWAp a number of measures that will enable and facilitate devolution are already in place:

- The fact that the ministry has already largely decentralised the delivery of its services to the district level, strengthened District Health Management Teams and has developed zonal offices to support the decentralisation process.

- Operational health budgets have already been devolved to District Assemblies with the District Commissioner as the Controlling Officer for those funds and budgets are not further disaggregated below district level. The district as such is one cost-centre, and it is not possible from the financial documents to identify lower level activities. .

- The Office of the President and Cabinet has recently approved an implementation warrant that, following a functional review of the MoH, clarifies the approved establishment for the centre and districts. The warrant establishes a Directorate for Health and Social Welfare in each district headed up by a Director: Health and Social Welfare. This post reporting directly to Assembly's District Commissioner/Chief Executive.

- There are already examples of positive collaborative working at district level with District Commissioners engaging in the leadership and management of health services through the district and zonal health offices. Similarly District Health Officers are already members of an Assembly's top management team, the District Executive Committee.

- The fact that one of the key mechanisms for extending the delivery of the essential health package, service level agreements, are developed, implemented and managed at district level. The SWAp Secretariat and the CHAM Secretariat have extensively supported districts and members of the CHAM engaging in these agreements but, ultimately, the responsibility lies with the signatories to each agreement at district level. It would therefore be relatively straightforward to transfer these contracts to district assemblies.

The MTR team believes that the above measures have had a positive impact on the implementation of the POW. Giving more control over implementation to DHOs and DCs has meant that they have been able to adjust their implementation plans to local circumstances. One DHO described the combined impact of the funding provided through

the SWAp and the decentralisation process as allowing her to "*walk majestically free with power*". The impact of both increased funding and local decision making was evident during the MTR field visits, from widespread health facility rehabilitation and construction projects, installations of water and electricity in health facilities, purchasing out-of-stock drugs and use of ORT (Other Recurrent Transactions) budgets to buy in more staff capacity to fill gaps in hard to reach areas.

4.2.8. Effectiveness of public-private partnerships in supporting the achievement of POW outputs or outcomes.

The development of service level agreements and contracts to deliver elements of the Government's POW through non-government appears to have the potential to be a key strategic vehicle for the implementation of the POW. There are approximately 55 service level agreements for the provision of health services that have been signed and are in operation in Malawi. The majority of these have been signed with health facilities that fall under the umbrella of the Church Health Association of Malawi (CHAM). Almost all SLAs have been for provision of mother and under-5 services as these are priorities within the EHP. Other funding arrangements are in place to support scaling up of health worker training in CHAM owned facilities

The SWAp Secretariat and the Secretariat of the CHAM have worked effectively with other key players through the Public Private Partnership Technical Working Group to develop a framework for the development of service level agreements at local level. The process is about to enter its third annual round of negotiations.

The facilitation and support role of the SWAp and CHAM secretariats has been key to the success of the service level agreement initiative. An indication of their success is that, in all the districts visited, by the MTR team, the DHO feels able to explore and develop ways of extending the range of services provided with more providers.

SLAs may be having a positive impact on achieving POW/EHP outputs and outcomes, at least for those services that are covered by the agreement. For example, Dowa and Rumphi districts visited during the MTR indicated that CHAM facilities had seen a dramatic rise in the number of women attending antenatal clinics, and who were coming to deliver in their facilities. There is some question as to whether this is a real increase in numbers of for the district, which needs further examination. Where government is supporting health worker training, training colleges have been able to double their annual intake of students. These first intakes are now graduating, with increased numbers entering the workforce (see section 4.3.2. below for more detail).

Good Practice Example – SLA

One of the few comprehensive SLAs found by the team is between Rumphi DHMT and Livingstonia Hospital. Livingstonia is 100 kms away from Rumphi District centre and is the only other hospital in the district. The DHO has signed an SLA with Livingstonia to provide maternal health services, as well as provide emergency services and care for people with chronic diseases. There are still some administrative wrinkles to work out, as staff at Livingstonia Hospital were still charging patients for certain drugs that should have been covered under the SLA. However it is worth following the progress of implementing this SLA as it is one of the most comprehensive ones seen by the MTR team.

The immensely positive aspects of these public-private partnerships are countered by only a few problems, and many of these are due to the fact that this type of relationship is

relatively new for both the MOH and its non-governmental partners. Some SLA facilities have complained that when they invoice they experience long delays before receiving reimbursement. Some districts suspect that the amount of charging agreed with individual facilities is too high, and that the district is therefore paying too much. These suspicions are not helped by the fact that some CHAM facilities are heavily subsidised by their own church institutions, and so can afford to charge less in their SLAs than other facilities.

Furthermore, the service level agreements are generally one year agreements, and CHAM is concerned that many of these are in urgent need to be renewed in order for the services not to stop. They feel they have to push for this to happen. CHAM is in the process of evaluating the arrangement with SLAs.

Most District Health Officers believe that service level agreements will be one of the main mechanisms at district level for the implementation and delivery of the SWAp programme of work. As yet DHOs have given no consideration to the idea of DHMTs developing a commissioning arm to extend the use of SLAs with the private sector, e.g. company health facilities providing services to workers and their families on agricultural estates. However they all see service level agreements as a long-term arrangement and, for the foreseeable future, that the CHAM hospitals and government would collaborate through a strategic partnership rather than compete with each other for resources.

One area for future development is to make SLAs increasingly performance based. At present there is no explicit link made between SLA outputs and their contribution to district health outcomes. By incorporating performance measures into SLAs DHMTs and zonal offices could make a more direct connection between the services provided under the SLA and the overall health goals of the district, and therefore to POW outcomes. Such performance based SLAs could also provide a model for performance based management throughout the public health system.

4.3. Resource and Capacity Needs and Constraints in Implementing the POW

4.3.1. Financial Resource and Capacity Needs and Constraints in Implementing the POW

Flow of Funds

One of the most important findings of the MTR is that *availability of funds to the districts has increased substantially from before the introduction of the SWAp.* The overall funding of the programme increased by 115% in the period, starting off with a total of MK 8.14 billion in 2004/05, against a total of MK 17.15 billion in 2006/07. The majority of the increase comes from the pooled partners, which contributed only MK 1.1 billion during the first POW year and a total of MK 8.98 billion in 2006/07. According to the figures, the discrete partners only contributed MK 0.51 billion, although many of these also contribute directly to activities, often off budget. The total contributions to the POW (on and off budget) are thus considerably higher than those captured in these figures, but this has not been possible to estimate by the MTR Team, or by others.

The donor share of actual net funding (to cost centres, less transfers from SWAp a/c plus sundry) has increased from 30% in 2004/05, to 46% in 2005/06 and 56% in 2006/07 (with Government. funding at 44% the same year), with a total cumulative funding of 47% (GOM. 53%).

Whilst on face value, the spending increase is significant, much of this increase in nominal spend must be attributed to price increases, not least in staffing and drug costs. Notwithstanding these price increases, the figures reveal that in certain areas there is a considerable underutilisation of funds suggesting relatively low absorptive capacity.

Comparing the budgeted vs. the actual expenditure for the different pillars in this period, there has been an apparent under spending against the POW budget on training of about MK 1 billion; drugs of about MK 1.6 billion; medical equipment of about MK 0.5 billion; and construction of health facilities MK 1.5 billion.

There is an under spending by the cost centres both relative to the POW and to the overall funding. The cumulative funding excess shown in the table below reflects this, where a total of MK 5.59 billion is unspent (including balances from earlier). Based on the 79% Government vs. 21% Donors shares for PE and the equivalent 55% vs. 45% for ORT according to the MoU, the under spending of Government funds is MK 4.30 billion of this whereas MK 1.29 billion is donor funds.

The unspent funds are kept in the SWAp account (MK 4.83 billion); discrete accounts (MK 9.67 billion) and GOM account (0.55). Funds in the SWAp account can be carried over from one year to the next, whereas it is not clear what the conditions are with other accounts.

Table: Total SWAp funding (billion MK)

	Govt (1)	Pool funders	Discrete funders	**Total**	POW (4)
2004/05	5.70	1.10	1.34	**8.14**	10.37
2005/06	8.64	6.70	0.27	**16.08**	15.62
2006/07	7.66	8.98	0.51	**17.15**	16.39

Table: Actual cost centre spending (billion MK)

	Pooled/ recurrent (2)	Discrete (3)	**Total**
2004/05	6.24	1.07	**7.31**
2005/06	10.80	0.98	**11.78**
2006/07	12.75	1.26	**14.01**

Table: Cumulative funding excess (billion MK) (5)

	Govt.	donors	**Total**
2004/05	1.95	-1.54	**0.41**
2005/06	4.01	0.14	**4.15**
2006/07	4.30	1.29	**5.59**

(1) Funding to cost centres. less transfers from SWAp a/c plus sundry
(2) Spending excludes commitments
(3) Excludes unbudgeted NAC and UNICEF
(4) POW at average exchange rates
(5) Based on Govt. 79% vs. Donors 21% shares for PE and 55% vs. 45% for ORT

The rapid increases in expenditures over the first 3 years of the PoW have already been highlighted in this report. What is less clear are the factors underlying these increases and the likely trend over the remaining 3 years of the PoW and beyond. Part of the difficulty in projecting expenditures is related to the problem discussed elsewhere in this report, namely, the difficulty of separating out the effects on programme expenditures of price effects, quantity changes and changes in the timing of implementation. Since the original PoW design and costing exercise there have been numerous incremental changes to the scope of the PoW. Some activities have been enlarged in scale or scope, whilst in other cases new elements have been tagged on to the PoW. The current status of many of

these changes is unclear, and so too therefore is the net impact upon programme costs. It is particularly unclear what health expenditure is in fact PoW related, leading to concerns that there may be an even greater underspend against the original PoW cost projections than estimated by the MTR team. There is an urgent need to clearly articulate the content of the PoW so that a revised costing can be produced and assessed against expenditures to date, as recorded through a revised coding and reporting system.

Accounting Systems

From the outset of the SWAp the GoM's own financial management systems have been used to record expenditures. This has probably resulted in a higher level ownership of the program than would otherwise have been the case. The use of various degrees of pooled funding combined with monthly district expenditure returns has undoubtedly improved the flow of funds for the PoW. However, there exist a number of problems with the GoM's systems that require improvement. These include the reconciliation of accounts with the Central Governments records of income and expenditure, missing documents and lack of some basic accounting controls at the cost centres.

A series of field visits by members of the MTR team provided the opportunity to observe financial practice in the districts at first hand. The MoH has been used as pilot for the roll out of its computerised system (IFMIS) since November 2005. That roll out is only partially completed with IFMIS installed in at MOH HQ as well as its Central Hospitals, though not yet to the Districts. Before IFMIS was rolled out to the MoH the SWAp used manual systems to record transactions. Field visits to DHOs confirmed that the districts are still reliant on manual systems, albeit supplemented by more recent computer additions. Approved budgets and authority to spend are captured in various vote books, whilst transactions under each vote are recorded in respective commitment ledgers. A serial list of all transactions is also kept. Whilst somewhat archaic, these manual systems are tried and tested, and familiar to all working at the district level. Properly adhered to, they should ensure that resources are spent for approved purposes and that spending does not exceed ceilings under any expenditure head or subhead, unless the responsible officer has received prior authorisation for virement from the Treasury. The MTR team feel that these control systems have been compromised with the transfer of administrative and financial responsibility to districts. Salima and Dowa District financial records were scrutinised by the team, in which several virements had been made. However, no evidence was provided to the MTR team that either district received the necessary authorisation. One can only speculate on the reasons for this breakdown of control. One possibility is that district administrators, lacking any real health experience, are deferring to the judgement of the DHO's and allowing them a degree of financial discretion they have not hitherto experienced under MoH control. Virement authorisations are available for transactions in other districts, though the MTR team did not have the opportunity to examine these other districts records during the review period.

These manual systems are supplemented at district level by a customised MS Access database. This computerised database allows district financial staff to enter their monthly transactions and produce individual monthly and cumulative expenditure returns according to the respective government accounting codes. Each district sends a monthly printout of the expenditure returns from the MS Access database to the MOH finance section, along with a photocopy of the district's cash book showing its monthly transactions in detail. The finance section in the MOH operates the same MS Access database program as the districts, albeit covering all districts and other MOH cost centres. Even though the Access database is of relatively recent design, the data from districts cannot be imported into the MoH database electronically but must be entered manually from the printed returns. Discussions with staff in the MoH finance section responsible for the database indicates frequent discrepancies between figures on the printed returns and those calculated from the cash book photocopies.

Aside from limitations on the input side, the MS Access database is further limited in outputs (i.e. the reports in can produce). One format allows for reporting by the standard GOM accounting codes. Another format allows the same expenditures to be expressed according to the 6 SWAp Pillars. Other than that, customised reports can only be produced, it seems, by exporting data to a spreadsheet and manipulating it using pivot tables or other data handling tools.

Some concerns must be expressed above the validity, reliability and accuracy of the data being recorded. A small sample of data collected during district field visits (i.e. the monthly printed returns) were checked against the figures held in the aggregate MOH database and several differences were noted between the two sources. Given that the monthly returns are calculated from the cash book entries it would be much simpler if districts were to send an Excel file containing the transactions for each month. It would be a simple process thereafter to merge the files from all districts, and other MOH cost centres to produce the aggregate monthly reports. If district finance staff could be persuaded to work with their colleagues to code their monthly transactions in accordance with the coding being developed as part of the revised chart of accounts, their expenditures could be analysed to yield important management information.

Financial and Activity Reporting

Many of the problems of expenditure tracking noted in this report stem from limitations of existing government accounting systems. A particular problem has been the inability of those systems to record programme expenditures according to key costs centres (i.e. to link programme inputs to programme activities and outputs). Inputs coded at district level using the government accounting system are re-coded by the 6 pillars of the SWAp POW. In effect the coding simply groups resource inputs by type under the GOM system and reassembles them, again by input type under the SWAp PoW. This is why the expenditure financial reports currently being produced have concentrated on the inputs and on what was purchased for the PoW. Table 1 in Annex 9 illustrates these problems. These types of reports are not informative enough, and it is surprising how little information the PoW format provides. SWAp reports do not readily allow link inputs and expenditures to be compared to outputs or impacts. During the period under review there have been no reports produced that link the reported expenditures to the physical progress of the specific activities that are being funded. The lack of these kinds of reports is a serious weakness because the impact of the funding under the SWAp for the last three years cannot be measured. It is strongly recommended that in addition to the financial expenditure returns that are produced, serious consideration be given to the production of reports that will measure the impact which should be monitorable so that at the end of the program it is possible to measure whether the objectives of the SWAp were achieved or not.

The format used to present the SWAp in the MoU is essentially the same mechanism used for reporting physical and financial progress under the PoW. Each Annual Implementation Plan (AIP) listed PoW outputs under the 6 Pillars of the PoW and the activities to be carried out to achieve those outputs. The AIP also includes cost estimates (i.e. budgets) for the individual activities in each year's workplan although the basis on which these costs are calculated is seldom clarified. Unfortunately, limitiations in the GoM accounting system mean that budgeted costs are never compared to actual expenditures because the latter are only recorded at a higher level of aggregation.

Another problem is that activities in the SWAp programme comprises a curious mixture of recurrent budget support and other "one-off" development activities with significant long term recurrent consequences. For example, the initial training of new health workforce recruits entails not only the "one-off" costs of training per se, but also the long term costs

of permament and pensionable employment. Although it is possible to get accurate figures for total expenditures under the PoW, the bottom line is that it is difficult to discern the long term effects of PoW activities on sector costs. It is also almost impossible to determine whether the budgeted costs of PoW activities are accurate since costs are only reported in the aggregate. In large part, the problem stems from the PoW design and the adoption of the 6 pillars which to all intents and purposes are input classifications rather than output oriented.

The MOH recognises these limitations and has been working with the Accountant General's office and the Budget Section of the Ministry of Finance to revise the Government of Malawi's Chart of Accounts (CoA). This will allow the GoM system to be better able to deal with the requirements of development partners for multiple expenditure reporting formats, and particularly those of the SWAp POW. The various classifications possible under the proposed new CoA are also being incorporated into the government's new computer-based accounting system IFMIS. By the time IFMIS is rolled out to the districts it will be possible to code expenditures according to multiple classifications, including the six programme areas of the SWAp.

MOH Audit Reports

Serious financial management accountability issues have been highlighted in a series of external and internal audit reports (i.e. reports for the fiscal years ended 30 June 2005 and 30 June 2006; the mid-year financial systems audit to 31 December 2006; and, the Internal Audit reports). Problems include non-compliance with the Public Finance Management Act, the Public Procurement Act and the SWAp Memorandum of Understanding. Many of these problems relate to poor record keeping which manifests itself in missing documents; a failure to check/approve bank reconciliations; a failure to follow-up on long outstanding reconciling items; and a lack of documentation to establish the basis on which contracts were awarded to the suppliers. Whilst the external auditors report improvements in some areas, in others progress is slow.

In the two audit reports received for fiscal years 2004/5 and 2005/6 (i.e. the first two years of the SWAp) the auditors gave qualified opinions which meant that they were not fully satisfied. The qualified audit opinion in 2004/5 was due to long outstanding reconciling items on the Bank reconciliations and the non confirmation of funds by discrete donors. In 2005/6 the qualification was because balances could not be confirmed by Central Government and lack of confirmation amounts to the MoH by Ministry of Finance and some discrete donors. These qualifications are a source of worry as they indicate the underlying poor accounting controls.

The MOH's own internal audit echoes the findings of the external audit. It is especially critical of the lack of stores and record systems for drugs and general stores and the overall lack of accountability for these items. For example, a report on accountability of drugs and medical supplies at Queen Elizabeth Central Hospital in February 2007 revealed that: there were no records maintained for drugs amounting to MK 35, 609,996; there were drugs not recorded on stock cards to the value of MK 4, 573,438. Another report on accountability of drugs and medical supplies by Central Medical Stores and District Health offices (dated August 2006) showed glaring anomalies in accounting for drugs in particular. Taken cumulatively, these findings appear to be typical of the situation in hospitals and DHOs nationwide. Given these anomalies and the general lack of accountability it is unclear whether funds spent are being used for their intended purposes, let alone with due consideration for economy and efficiency.

With the serious weaknesses identified in the accounting system for drugs and general stores, it is recommended that the MoH as a matter of urgency should produce a time

bound strategic plan with milestones on how to strengthen the whole stores accounting system.

Staff shortages beset the MoH internal audit as they do the rest of the ministry. Whilst the internal audit is doing a commendable job with skeleton staff of 4 against approved establishment of 7, vacant posts need to be filled with appropriately qualified staff. Moreover, the unit requires targeted training in such techniques as risk based and value for money auditing.

A review of the progress made on the implementation of the existing Financial Management Improvement Plan indicated that not all of the agreed activities were undertaken. Particular problems were experienced in the recruitment of staff, provision of training and production of a multiyear internal audit plan. The status of FMP progress at the time of the review is presented as appendix. For some activities there are differences in the MoH headquarters and CHAM Secretariat accounts of what was done for CHAM. According to CHAM most of the activities on the improvement plan have not been implemented due to lack of funding from the SWAp Secretariat

A new FMP is being produced consisting of activities brought forward from the previous plan, although it does not currently address some of the serious concerns already expressed regarding stores and supplies management. The new plan will need to respond fully to the seriousness and magnitude of the accounting weaknesses that have been identified. It should include a comprehensive training plan that identifies the staff to be trained; the type of training required (which should indicate the specific issues to be covered); the location, timing and duration of training; and, the training resource persons required. If capacity is a constraint consideration should be given to outsourcing this function.

4.3.2. Human Resource and Capacity Needs and Constraints in Implementing the POW

This section looks at how successful the strategies outlined in the POW have been in reducing the crisis in human resources for health in Malawi. It explores what has been achieved to date, what is working in terms of bringing new workers into the health services and keeping them there, and what is hindering, or may hinder in future, the long term sustainability of gains made in the last few years. It is important to note here that a well functioning health care delivery systems needs capacities in two areas – medical care and pharmaceutical care. The present deficiencies in drug supplies (cf. 4.2.3) result *inter alia* from an imbalance of these two areas.

<u>Likelihood that targets will be achieved for the 6-year training plan and the Emergency Human Resource Programme</u>

Training institutes are currently at full capacity and have surpassed the target of 990 per year. As for progress on the EHRP: vacancies are being filled (see below); recruiting back approximately 300 health workers who have left the health service (but not all reported to duty); salary increase (see below); housing – in progress, but delayed; pre-service (see below); remote area incentives: the incentive packages were endorsed by HRTWG and approved by MOH management.; 72 expatriates have been employed to fill key gaps.

<u>Increasing Recruitment and Retention of Staff</u>

The number of formally employed staff available for providing services in the health sector is determined by a number of linked steps: 1) the number of suitably qualified school leavers choosing to enter training for health or allied professions; 2) the number of

students who successfully graduate; 3) the number of graduates (new graduates, and those who are returning from working elsewhere and foreign graduates) who are willing and able to enter the labour market, and of those the number that enter the health sector and 4) the subsequent losses to the sector. The human resources crisis in Malawi means that graduates are in a position to choose from a wide range of employers. As long as they remain as health service providers they are likely to contribute to the implementation of the POW, no matter who their employer is.

Trends in the above four linked steps have been as follows:

Suitably qualified school leavers entering health training: Despite the low enrolment rates at secondary level in general there seems to be a sufficient supply of school leavers wishing to enter training for health professions to support the challenging training targets in the EHRP. In some cases this increase is due to the opening of nurse training to male applicants. The principal of one college training nurse technicians reported that the student intake for this year was more than 75% male. The explanation from several sources was that boys tend to do better in sciences, an important entry criterion, than girls. There is a recognition that this gender imbalance may be problematic when these students enter health facilities.

The College of Medicine MBBS programme, which has the most challenging entry qualifications, is also managing to increase recruitment in line with EHRP targets -- though with some delays. This would not be possible without the two-year pre-med course that brings students up to a sufficient standard, particularly in the sciences, to meet the entry criteria. External funding for students to attend the College of Medicine will continue to be required to ensure it reaches its target of graduating 60 students annually by 2010.

Good Practice Example – Nursing Student Recruitment

Both Kamuzu and Ekwendeni Nursing Colleges have improved their recruitment of nursing students. The Kamuzu College of Nursing was losing trainees before they had completed their course. An evaluation found that some of these dropouts had not been very sure about following a nursing career when they applied for the course. Candidates are now given more information about nursing careers and screened through interviews, resulting in fewer in-course dropouts. Ekwendeni staff visit secondary schools to explain what a career in nursing involves, what is required to get into the college and actively advocates for students to join the nursing profession.

Training places have also been increased as a result of increased funding through the POW/SWAp. This funding has been instrumental in bringing in more tutors, so that the quality of training is not compromised and in paying students' fees and expenses while attending their course. Government training facilities have also been expanded through POW funding, though non-state (notably CHAM) training institutions have had to seek out funding for expanding their physical infrastructure. The results of these investments have been very encouraging: there has been an 86% increase in annual enrolment for pre-service training over enrolment in 2004. There are problems on the horizon, including how to replace current tutors when their two year contracts are up, and how to maintain the level of funding within the POW to continue paying tutors and student fees.

The number of students who successfully graduate: Data on attrition from courses is difficult to attain. College principals in interviews indicated that attrition rates are low, and that between 90% to 100% of their students complete and graduate from their courses. There have been follow on problems where even though students have graduated, they

may not make good quality service providers, and some hospital staff interviewed indicated that male graduates in particular are reluctant to do bedside nursing.

Number of trained staff willing and able to enter the health labour market, and able and willing to stay: Vacancy analyses are calculated by comparing the number of posts filled with the total number of posts in the establishment. The measurement of vacancy rates between 2003 and 2007 is complicated as the establishment went through some minor revisions during this period. There appears to have been an increase in establishment of about 7% for the MoH and a surprising 66% for CHAM. The overall situation when using the measure of vacancies looks bleak with the exception HSAs, but there is an overall increase of skilled health staff of 24%. Some of the increases in vacancies may in some cases indicate the re-cycling of staff through up-grading courses (especially in nursing) so this does not indicate an overall loss the employer.

The establishment is often out of step with the actual service needs – both in terms of numbers but also positions. For example in the current establishment there are no posts for laboratory technicians, though clearly people are being employed to do the job. The new establishment has just been finalised as a result of a lengthy Functional Review, though aggregate staffing figures are not yet available.

The number of posts available in the MoH may be at variance to the perceived need – especially for the scaling up of programmes like ART. Individual programmes may have calculated staffing needs to deliver their particular services, but an overall workforce plan combining the needs of all areas of the service has yet to be developed.

The basic 'need' – or minimum staffing standard – was developed as part of the planning of the EHP and is used as an indicator for the POW. This is particularly useful for the level of health centre as below this minimum the centre cannot deliver adequate and safe services. At the time of writing this report the full set of indicators is not available. However, data on the percentage of facilities with the minimum number of nurses is encouraging. This has risen to 40% from a baseline of 23% in 2002.

Attrition, shortages and inequitable distribution of staff are being successfully addressed in a number of ways. Improved pay and allowances, combined with improvements in living and working conditions is attracting more staff into the health service and keeping them there. Shortages and provision of services are being tackled by increasing the numbers of hours worked by staff through the use of the 'locum' system, and through a 'relief' system. In both cases staff are paid for extra hours work. The term 'locum' is a misnomer as most of the work done appears to be in the same place of work and might therefore more appropriately be called overtime. 'Relief' is where staff move from one facility to another one, usually a remote understaffed health centre, to provide extra support, usually for around a month. This is funded from the ORT budget, thus disguising the true Personal Emolument (PE) costs.

Subsequent losses to the sector: It is difficult to track losses and in particular to get information giving the reasons. Requests from overseas employers for confirmation of registration from professional councils can be used as a proxy for migration overseas. Data from the Nursing and Midwives Council shows an average annual loss of under 100 per year (2002-5), which represents about 2.5% of the total 3,800 combined nursing complement in the public sector or about 25% if those leaving are all Registered Nurses. The losses for 2005 account for about less that 3% of the total workforce. By most standards this seems extremely low and suggests that not all data on losses is being captured. One possible explanation is that staff are working outside the MOH on secondment (for example, the staff working as temporary tutors) or on some other arrangement.

In addition to the increases in remuneration, the MoH (and other employers) is trying to find ways of retaining staff. Death rates (and long-term absence) may be reduced with the provision of ART for staff. The recent change in government policy on the retirement age, which has now been raised from 55 to 60 – apparently without any lead time, should have an important impact on staff retention and lead to an overall increase in the staff complement.

In spite of these attempts by the MOH to retain, resignations are likely to continue to rise if the NGO sector maintains the current rate of growth. An assumption of several HR-related sub-outputs in of the POW in Pillar 6 was that there would be an adequate understanding of the labour market. The 'Tracer study' addressed the question of how big the pool of qualified health workers was that could attracted back to the health sector. However, there is no further documentation of the comparative terms and conditions of different employers since the EHRP was designed.

Performance

Neither the POW nor the ERHP deal with staff performance with the exception of in-service training to match skills to the job and supervision. In-service training seems to have two different effects on staff performance. The first is that staff gain skills for tasks they could not perform before. There are many examples of where this has been effective. The negative effect is well known: staff are away from the workplace so performance of the service delivery suffers. Because of the financial incentives attached to attending training courses, it is difficult to ensure rational use of training that balances service delivery requirements for enhanced skills and the need for people to be available to deliver the services.

The Annual Implementation Plan for 2006/7 includes a sub-output on improved productivity and performance of health workers. The related activities include the provision of orientation on codes of conduct; development of mechanisms of managing staff absence; designing performance management systems; and updating job descriptions, job plans, appraisal mechanisms, etc. However, no budget appears to have been assigned, so it is assumed that this work is still outstanding.

It should also be recognised that individual performance is often driven just as effectively by organisational level performance management systems. This includes accreditation for infection-free facilities, maternal death audits etc. With a few of these systems in place it is possible to develop a performance culture.

HR Policies and Systems

The employment of MOH staff is overseen by the Department of the Human Resource Development (DHRMD) of the Office of the President and Cabinet. The day to day administration, including processing posting, promotions and disciplinary actions is managed by the HRMD section in the MOH under the Director of Finance and Administration. The recruitment of health professionals is now carried out by the Health Service Commission, with the exception of sub-ordinate class staff including HSAs who are recruited at district level jointly by the District Health Office and the District Commissioner's Office.

In the design of the SWAp it was an unstated assumption that the HRMD section would take a strategic role in implementing Pillar 1 -- a huge responsibility with a potential budget of $273 million. This would include developing policies, strategic plans and detailed workforce plans, monitoring of the use of investments and the coordination of both pre-service and in-service training. However, the current HRMD section is really designed to carry out administrative rather that strategic functions. The head of section, the Controller, is one grade below that of a Director. Few of the posts are technical. In the new

Functional Review, which was based on a wide consultation process, there is no mention of leading the human resource strategy for the whole sector, and the human resource planning function is described as "succession planning", which is far less strategic than workforce planning. The HRMD section has also been staffed for administrative rather than strategic functions. Only one member of the section has a management qualification. More seriously, the section has been without a Controller for most of the last two years which has deprived it of a voice at senior management level.

The HRMD section has contributed significantly to the scaling up of the pre-service training programme and improving recruitment and employment of new graduates. It is also improving data collection through staffing returns and some basic analysis of the data. However, much of the time -- including that of the TAs -- is spent carrying out routine work and "fire-fighting". This has led to the delay in producing and getting approval for a number of policy documents and an HRH strategy -- and in general the ability to strengthen systems and develop capacity.

The HRMD section is not alone in the Ministry in dealing with human resource matters. The directors responsible for service delivery are all making decisions about the deployment of their related cadres. The Planning Department is making overall decisions about health plans, and until recently was producing strategy and policy documents on human resources. The Health Information Unit was collaborating with the development of a monitoring and evaluation framework, and will be overseeing the HRH census exercise. The benefit of the contributions from these different actors has not always been maximised, partly because of insufficient coordination at a high level. Directors appear to make decisions about deployment without involving the HRMD section. There has been duplication of effort in the development of policy and plans because of issues of ownership. There is duplication of data collection with the HRMD section, the Director of Nursing (and probably other technical directorates) and the Health Information Unit all operating parallel systems.

Part of the coordination challenge is the fact that the ministry is working to a multiple set of human resource plans -- long-term plans as well as immediate action plans -- that are not clearly linked. As well as the programme of work and the Annual Implementation Plans derived from this, there is: the 6-year pre-service training plan (which now needs updating as it enters its final year); the Emergency Human Resource Plan; sets of milestones produced by the annual and mid term reviews; the action plan for meeting "conditions precedent" for the Global Fund developed in April 2007; and most recently an action plan developed as a result of the Needs Assessment Study; and shortly after the HRH census is complete it will be necessary to develop a workforce plan with long-term staffing projections. In addition to the problems of coordination, the MTR team found it difficult to get a high-level view of how well Pillar 1 is progressing.

4.3.2. Infrastructure Resource and Capacity Needs and Constraints in Implementing the POW

The Mid-Term Review Team unfortunately did not have an infrastructure and equipment consultant within the team, and so this report is not able to respond to the specific questions asked about progress on the infrastructure and equipment pillars. We are only able to comment on the fact that substantial progress is being made on rehabilitating health infrastructure in many of the districts visited during the MTR field trips, and that there is also a fair bit of new construction occurring to replace or to expand buildings that are no longer fit for purpose. All health facilities visited had received new equipment for a

variety of areas of health work. This included equipment to assist with infection control (e.g. sterilisers and incinerators), basic emergency obstetric care equipment, surgical beds, delivery beds and kitchen equipment. In every DHO interview, when asked what different the SWAp had made, the DHO would invariably begin with improvements in infrastructure and equipment.

The head of the new Infrastructure Unit in the MOH has indicated that one of his first tasks will be to review the Capital Investment Plan and to bring it up to date. This review should be given high priority within the MOH. The Unit, with support from the Infrastructure and Equipment TWG, should then look at how to improve the planning and implementation of infrastructure projects at district level, focusing on those districts that have had a harder time moving their own projects forward.

4.4. Financing Modalities, Harmonisation and Alignment within the SWAp

4.4.1 Effectiveness of financing modalities of each partner for supporting POW implementation

Total development support to Malawi in 2005/06 was US$ 497 million (*Malawi Government Annual Debt and Aid Report July 2005 – June 2006*). General budget support was 29% of total, with health as the largest recipient sector receiving 13% of this and HIV/AIDS as a functional sector receiving slightly below 6%, a figure which is likely to have increased since 2005/06. The donors providing budget support were DfID, World Bank, EU and Norway. From 2006/07 the World Bank ended its general budget support, and there are just three donors left providing GBS. All the above except EU also provided pooled funds for health.

The largest group of development partners is frequently referred to as *discrete partners*. In practice the *definition varies* according to the information/data available, for example, the MOU refers to modes III and IV, and sometimes even mode II. For all practical purposes discrete donors may be defined as those funding through all mechanisms other than general budget support and pooled funding, though working in the SWAp context, supporting the POW.

Relative strengths and weaknesses of the different funding modalities are summarised in the Financial Report Annex, using a number of different variables, such as flexibility in utilisation, predictability, ease of disbursement, administrative overhead/transaction costs, effectiveness, alignment and harmonisation.

These are summarised as follows:

- *General budget support* is the preferred option for MOF, providing the highest flexibility, predictability, as well as the highest degree of alignment (with MOF procedures), often with relative low transaction costs.
- *Pooled funding* is the preferred option for MOH, as it is likely not only to increase the overall budget available, but also provides high degree of predictability of funds coming in, flexibility in use (although depending of conditions), disbursement according to agreed principles, relatively low long term transaction costs due to common approach, high degree of harmonisation between donors, and even more important, high degree of alignment with Government.
- *Direct funding*, but through a separate account may share many of the same benefits as pooled funding, although with somewhat higher transaction costs (e.g. separate account requiring separate routines, mechanisms, etc.), but may have a high degree of harmonisation and alignment.

- *Direct funding, but earmarking*, is often a preferred option for development partners, due to focus on a specific priority. This is often an important mode in politically unstable situations, as well as to protect certain groups or health problems which are particularly vulnerable to changes. The summary of the transaction costs of such funding is often found to be very high, and harmonisation and alignment relatively low.
- *Project funding* may be the only alternative in many cases, either due to poor implementing capacity of the MOH, complex/unstable political situations or fragile states, areas or groups with poor coverage or special conditions from the donor's side. By definition, a project has a beginning and an end and sustainability becomes a key issue. From the MOH side this may be seen as separate and even outside their scope of work, but may also be seen as an addition or supplement to the work carried out. Transaction costs to the MOH may be low, but the ability to integrate (align as well as harmonise) is the weakest aspect of this modality. The long term effectiveness in obtaining improvement in a broader set of health outputs and outcomes may often be relatively low, but depending on the profile and stability of the project.

The MTR team has found that financing modality as such is of less importance than the degree to which individual development partners are aligning their planning, implementation monitoring and reviews with government processes. While budget support and pooled funding may force a degree of alignment, individual funders may be part of a pooled fund but still Impose separate procedures (e.g. Global Fund and World Bank). There is in fact enough pooled funding making up the health SWAp to help smooth over some of the rough edges created by earmarked, project oriented discrete funding. However, it should be noted that discrete funds continue to bring with them added burdens in terms of separate planning frameworks, different reporting frameworks (programme and financial) and different sets of meetings, thus increasing transaction costs.

4.4.2. Appropriateness and sustainability of the current level of health care financing

The Ministry of Health budget proposal for 2007/08 exceeds the ceilings set by Treasury by MK 5.5 billion. The overall budget proposal is MK 20.192 billion, with approximately MK 4.5 billion for PE, MK 12 billion for ORT (including drugs) and MK 3.8 billion for development budget. Development partners are expected to fund more than 90% of the latter.

The overall donor pledges captured in this set up are MK 11.9 billion (US$ 85 million) plus district allocations of MK 6.7 billion, but it is not entirely clear whether this overview is comprehensive enough, i.e. when it was last updated and what is not included. Government contributions is budgeted to MK 11.185 billion, which would be 48% of total

Provided the budget is approved, the overall budget will have increased by 17.7%. Relative to the actual spending in 2006/07 the increase would be 36%. With experiences from previous years in mind there should be concerns about the absorptive capacity to manage this increase, particularly in the areas of drugs and medical supplies, but also in general procurement as well as in construction of 250 new houses, new laboratories, etc.

4.4.3. Alignment and harmonisation of development partners' operational requirements as per the Health SWAp MOU, in particular harmonisation of planning, monitoring and evaluation activities with those of the MOH and GOM/

The pool donors (DFID; Norwegian Government; World Bank; UNFPA, Global Fund and, soon, German Government) have aligned many of their processes with those of the Ministry of Health's, as outlined within the Memorandum of Understanding. Alignment is working well in terms of:

- sharing a common strategic plan (POW)
- sharing a common financial report (FMR)
- agreeing to fund a common operational plan (AIP) on an annual basis
- using the MOH's programme progress reports and bi-annual review process as their own review and reporting mechanism.
- sharing successes and failures and loosing attribution of outputs and outcomes to particular partner inputs.
- recognising that there is a trade off on both sides with government sharing its prerogative for decision making while retaining reasonable final say; with partners forgoing attribution and hands-on control of their inputs.

The only exception to this amongst pool donors is the Global Fund, which could be described as being 'in' the pool, but not 'of' the pool. Global Fund planning cycles are separate to those of the MOH, and resemble more the bilateral planning exercises undertaken by USAID or ADB. The Global Fund also sets 'conditions precedent' bilaterally with the MOH without discussion with other health donors. In order to monitor progress towards meeting these conditions precedent (as well as to set further ones) the Global Fund/LFA may initiate their own assessment processes. The results of these assessments may not be communicated to either government or other health donors, except to say whether the conditions are deemed to have been met and funds can be disbursed, or that conditions have not been met (or new conditions are to be imposed) and therefore funds cannot be disbursed. The process for how assessments are undertaken and communicated is laid out in the Global Fund's LFA Communication Protocol, and specifically states that assessment results cannot be communicated directly by the LFA.

The Government of Malawi is holding up its own side well on many of the operational requirements of the MOU. However, much more improvement is needed both in terms of increasing the GoM's proportion of its own funding to the health sector and in terms of adhering to the provisions on governance of the sector (see 4.4.5 below).

The discrete donors interviewed that are signatories to the MOU (: UNICEF, WHO, CHAM and GTZ) display tremendous good will and desire to be better aligned and harmonised with MOH systems and procedures. Even though their own organisational requirements require these partners to use separate, centrally determined planning and reporting formats, those interviewed suggested that they are using, or moving towards using, MOH procurement systems and reports as their own. However, there is still some way to go before monitoring and reporting are fully aligned with MOH systems. UNFPA undertook a separate review of the MOH's sexual and reproductive health activities in parallel to the POW Mid-term Review, though efforts have been made to include the UNFPA review results within the MTR. UNICEF is funding a separate review of the EHP, with a focus on costing, but which also is looking to update elements within the EHP in line with new evidence on effective health interventions (e.g. they are hoping to include further pediatric AIDS interventions in a revised EHP). It is unclear how the results of this EHP review are likely to be discussed within the appropriate Technical Working Groups, or Health Sector Review Group, forums created for debating revisions to MOH strategies. As seen in Section 4.2.2, health information used for reporting on UNICEF, UNFPA or WHO funded

national programmes (EPI, SHR or TB) is often different to health information reported on for the same activities in the MOH HMIS, which is leading to contradictory statistics between national disease programmes and the HMIS reports..

The widest discrepancies between the systems and procedures of 'non-signatory' discrete donors and the MOH lie with the planning and monitoring processes. It would appear that some discussions occur between the individual donor planning team and the relevant technical department within the MOH. It is less clear where discussions take place about what impact the proposed new project will have on the rest of the health sector, especially in terms of consequences for front line staff time (both in terms of training them up and then time for delivering services), and on MOH support services. USAID, for example, were carrying out two parallel exercises during the period of the mid-term review. One exercise, to assess the logistics capacity of the Central Medical Stores (re: the imminent introduction of new malaria treatment, ACTs), overlapped with the work of the review team members assessing pharmaceutical procurement, logistic and supply chain capacity. The other exercise, planning for the next phase of HIV&AIDS funding, appeared to be recommending strategies for enhancing AIDS M&E capacity, without reference to reinforcing overall MOH HMIU capacity, which is responsible for gathering, analysing and reporting on all HIV&AIDS bio-medical activities in the country.

4.4.4. Extent to which M&E activities have been harmonised with other frameworks, such as the MDGs, MGDS, NAC's M&E and MOLG's M&E

The M&E framework being used to measure progress in the health sector is the Indicator Matrix for the SWAp Programme of Work. The POW indicators are fully aligned with the strategic outcome indicator of the Malawi Growth and Development Strategy, and are in line with Malawi's commitment to contributing to Millennium Development Goal targets for MDGs 4, 5 and 6. The MGDS goes further and underscores the central importance of the POW pillars as key strategies for achieving shared MGDS and Ministry of Health objectives. The National AIDS Commission's M&E framework is currently being revised. The proposed new NAC indicator matrix impact measures are in line with the MOH's impact indicators (Life expectancy at birth and HIV prevalence among 15-24 year olds). However there are contradictions in indicators at outcome level, as a proposed NAC outcome indicator (% of young women and young med aged 15-24 years with comprehensive correct knowledge about AIDS) is an output indicator in the SWAp matrix.

MOH and MOLG have not yet discussed their respective planning, monitoring and evaluation needs at a strategic level. It is evident from district level that there is a mismatch between the requirements of the MOH and of the MOLG. As decentralisation progresses it is possible that further strains will be put on DHOs to try and accommodate the requirements from both ministries.

4.4.5. Effectiveness of the Health SWAp Governance structures, partnerships and review processes in promoting harmonisation, coordination and collaboration, and reducing transaction costs.

The Memorandum of Understanding Operational Guidelines specifies a comprehensive governance structure (Figure 1 in Annex 11). This governance structure is in line with international best practice on SWAp governance, as it is built around the principles of partnership and transparency, with clear lines of responsibility for decision making. Review of meeting minutes, an analysis of the frequency of meetings and interviews with

MOH and health stakeholders indicates that governance structures and partnerships are not being used effectively at present, and, as a result, lines of communication and coordination between government, non-governmental and development partners are weakening. Key findings on the dynamics related to MOH managerial line structures and partnership structures are provided below.

Meetings within the Ministry Managerial Lines

During interviews with MOH staff it became clear that departmental meetings seldom take place or may not take place at all. Zonal offices, which have a quality assurance and support supervision role vis-à-vis district health offices, have no clear link into central level where they can feed in concerns coming up from district level and below. For the most part they may raise their concerns or problems with individual programme managers or departmental heads, or through TWGs. The MOH opted not to convene the Health Sector SWAps Steering Committee as it was considered inappropriate for Principal Secretaries from other Ministries to have decision making authority over Ministry of Health policy and strategy. The Senior Management Committee is comprised of the Secretary for Health, all Directors & Deputy Directors, Programme managers, Central Hospital Directors, and Registrars of Health Regulatory bodies. The committee liaises with the Health Sector Review Group. Its purpose is to approve and review health sector policy and the Programme of Work. The SMC approves annual work plans and budgets, facilitates communication with health sector stakeholders, reviews evidence and initiates policy innovation within the sector. It is therefore the most important part of the internal MOH governance structure for the POW, in the absence of the HSS Steering Committee. However, the SMC has only met four times since the POW became operational in 2004, and its last meeting was in October 2006.

The MOH is holding weekly Monday morning meetings, chaired by the Minister. There are no terms of reference for these weekly meetings. Interviews with staff indicated that these meetings tend to cover MOH operational issues, which would mean that there is therefore no regular or routine forum within the Ministry where the SMC constituents (e.g. senior department and programme managers plus zonal supervisors) can meet with the PS to focus discussion on the strategic elements covered in the SMC TORs..

Technical and Partnership Advisory Meetings

The SWAp Governance structure pictured in Annex 11 gives a clear indication of where Ministry of Health staff and health sector stakeholders external to MOH may discuss and debate how the national health strategy is being implemented. Technical Working Groups (TWGs) and sub-groups include Ministry of Health staff, representatives of development partners and representatives of NGOs working in health. Six TWGs have been meeting more or less regularly since 2005: Drugs and Medical Supplies, Financial Management and Procurement, Human Resources, Infrastructure and Equipment, Monitoring and Evaluation and Public-Private Partnerships. A seventh TWG was created in 2007, the Essential Health Programme TWG, to provide a single forum to discuss wider EHP issues. The EHP TWG is meant to be an umbrella TWG within which the many technical sub-groups (e.g for EPI, Malaria, HIV&AIDS, Sexual and Reproductive Health) may operate and to which they may report.

The Health Sector Review Group (HSRG) is comprised of Secretary for Health, Co-opted Directors, Donors, NGOs, Private sector providers, local government representation and regulatory bodies. The HSRG has both advisory and oversight functions. In its TORs the functions of the group include reviewing progress on the Programme of Work, and in particular progress on achieving annual targets, as well as reviewing audit reports and monitoring progress on milestones set during mid-year and annual review meetings. The Secretary for Health co-chairs this group with an elected member from within the HSRG

constituency. The HSRG is therefore the senior most partnership forum and a key part of the governance structure.

Table 1 in Annex 11 demonstrates that a number of TWGs and the HSRG have not been meeting as regularly as anticipated, or indeed required. This should be cause for concern as the MTR review team has found several areas where concerted action is needed to stop reverses in achievements in some pillars and in achievement of the EHP objectives, particularly with relation to Drugs and Medical Supplies.

Though not included in the governance structure diagram, a further governance mechanism in the sector is the bi-annual review process. Twice yearly the MOH convenes a four day joint review meeting to which a wide variety of internal and external stakeholders is invited. The review meetings are highly appreciated by all stakeholders interviewed. District level officers indicated it was the only opportunity that they had to interact with and hear from decision makers at central level in a direct fashion. Non-governmental and private service providers and health service users appreciate the opportunity to assess the current state of implementation of the POW and to input their views on achievements and on problems they have experienced.

Mid-year and annual progress reports are produced from these review meetings. They have often been delayed, primarily due to problems with pulling in all the data required to complete the SWAp M&E forms. The progress reports also indicate progress against milestones agreed in the previous joint review meeting, and sets out the milestones to be achieved in the next period. The formatting of these milestones has not been consistent across the different progress reports, so it can be difficult to analyse trends in meeting these milestones across reporting periods. Also, there appears to be no follow up on milestones 'not yet achieved' from one period to the next unless one of the review meeting working group decides to carry forward a particular milestone.

5. ANALYSIS AND DISCUSSION

The findings outlined above, and detailed in the attached annexes demonstrate that good progress has been made in some areas of the Programme of Work, and that there are many examples of good practice demonstrated throughout the health system. However, the MTR team found that there are considerable constraints that continue to challenge both the progress made to date and future scaling up. This section pulls together both successes/strengths of progress to date, and the challenges that remain to be tackled over the next three years of POW implementation.

5.1. Strengths and Successes

5.1.1. Good progress on certain health outcomes

Good progress has been made against a number of Essential Health Package indicators. OPD use has steadily increased over the last three years and is on track for meeting the 2010 target of 1000 visits per 1000 population. The tuberculosis cure rate is also on track, having reached 76% in 2006/07. It is also encouraging to see that basic emergency obstetric care services are being scaled up significantly through the POW, and the MTR team is optimistic that current efforts will ensure that 50% of facilities are offering BEmOC by 2010. Malaria prevention interventions have progressed very well since 2004, with many more people having access to ITNs through both free distributions and social marketing outlets. Finally, HIV counselling and testing, PMTCT and anti-retroviral treatment services have expanded tremendously in the last three years.

5.1.2. Good progress on improving physical access to health services

Improvements on physical access to health services has occurred through a combination of infrastructure development, increasing numbers and working hours of staff and through service level agreements. Rehabilitation and construction works described to, and observed by, the MTR team indicated that health centres and hospitals were not only more pleasant places to come as patients, but also are becoming a better working environment for staff. The addition of water and electricity is also helping to ensure that more services can be provided in rural areas (e.g. night-time emergencies). The mixture of increased numbers of trained staff coming into, or returning to, front-line health services and staff working more hours through locum or relief arrangements means that health centres that were previously closed are re-opening and health centres with only one trained staff person can now provide more services they are joined by other trained providers. Finally, service level agreements with non-governmental providers has improved access to existing facilities that poorer community members could not previously afford to use. This has been especially important in districts where there may only be one government hospital and the only other hospital is non-governmental and is some distance away serving an entirely different population.

5.1.3. Good progress on improving resources into health service delivery

There is no doubt that there are more financial and human resources available for health services now than there were three years ago. The Ministry of Health has taken significant steps to decentralise the delivery of the Programme of Work and the Essential Health Package to strengthened District Health Management Teams and has developed zonal offices to support the decentralisation process. Decentralisation of health service management has enabled financial resources to flow directly to districts, where services

are delivered, giving greater control over how these resources are used to district health managers. In particular, operational health budgets have already been devolved to District Assemblies with the District Commissioner as the Controlling Officer for those funds. District Health Officers are, increasingly, empowered to develop and implement District Implementation Plans to ensure these reflect local priorities in the context of delivering the EHP to all Malawians. A good example of this is the way DHOs have used service level agreements to extend the delivery of local maternal and child health services to more citizens. The support of the SWAp and CHAM Secretariats has been key to this progress There is greater flexibility for local planning and decision making over how district level resources should be allocated, so that district health managers can be more responsive to local needs. At the same time, there are more places in training institutions, and more students entering pre-service training, in some cases doubling annual intakes over numbers in 2004. Increasing numbers of people entering and graduating from health training institutions is a pre-requisite for bringing greater numbers of skilled health workers into health services. The numbers entering the health workforce have been boosted by incentives to bring retired workers back into the workforce, and by creative initiatives that allow health staff to work additional hours and be paid for their time.

While assuring a steady supply of essential drugs has been problematic (see findings and challenges below) it is also clear that there are more drugs and medical supplies in stock in health facilities and hospitals than before, even though they are not always the most needed. Some of the crisis in essential drug supply has been eased by districts having their own budgets from which they can purchase drugs privately that are not available through the public system.

5.1.4. Good progress on strategy development and planning throughout the health system

It is important here to note that Malawi has a national health strategy, the Programme of Work, which is well known by all stakeholders, and which forms the basis of all strategic and operational discussions on how to engage with the health sector. The annual implementation planning process is a needs-driven exercise, starting with compiling health facility level plans into district plans, and then finally pulling these together into the national annual plan. All the major national technical programmes have strategic plans, which outline what is required to achieve improved health outcomes within their particular technical area. Many of the support functions within the MOH, such as human resources, monitoring and evaluation, procurement and central medical stores, have strategic plans or improvement plans that give guidance for how these departments need to develop over the next few years.

5.1.5. Oversight and coordination mechanisms have been developed

Evidence and experience from across the world has demonstrated the importance of coordination, oversight and governance in sector wide approaches. Malawi has put in place a number of oversight and coordination mechanisms, including a Memorandum of Understanding between Development Partners and the MOH, a SWAp governance structure (as outlined in the MOU), a multi-stakeholder joint bi-annual review process and a SWAp Secretariat. These mechanisms not only provide the means for agreeing how the national strategy can and should be taken forward, but they also help with sharing information, holding institutional memory and improving accountability of the health sector. With high turn-over of most of the top positions in the MOH, the SWAp Secretariat has been especially important as one of the only sources of institutional memory left in the

MOH, in the form knowing what documents exist and where they are, pulling information together from across the ministry and maintaining good working relations across the ministry departments and with external stakeholders. The bi-annual reviews, and the aide-memoires that arise from them, are an important part of ensuring that a wide group of health sector stakeholders are kept informed about progress towards meeting health sector objectives and through which they can hold the ministry to account for delivering on its commitments.

At an operational level, the oversight mechanisms put in place through the zonal offices and district supervision systems are commendable. Zonal office supervision and coordination is allowing for better collection of health information and sharing of good practice across districts, and is provoking more poorly performing districts to improve. Integrated supervision from district health managers is an important step forward for improving health facility performance.

5.2. Challenges

5.2.1 Improving coordination, cohesion and accountability

The Malawi Health SWAp was set up and agreed by the Government of Malawi and its funding partners, using as their guiding principles that there would be: a single health strategic framework, a common expenditure framework, a common monitoring framework and better coordinated procedures for funding and procurement. The purpose of bringing in a sector-wide approach is to improve the harmonisation of different actors' interventions in a sector, and to increase alignment with government policies and procedures. It is therefore vital that all actors contributing to the health sector in a country discuss and agree the nature, scope and scale of the common strategic framework, its implementation and the nature, scope and scale of each partner's contribution. A SWAp therefore requires strong and open partnership working, where the vision and requirements of each partner is discussed, challenged and, where possible, accommodated to ensure that the health sector policy and strategies remain coherent and focused on improving health.

With regards to providing and promoting strategic programme direction, there is a worrying view expressed by some senior MOH staff that even though the POW remains the national health strategy, should any development partner offer to provide services outside the framework of the POW and EHP, the Ministry is unable to say 'no', and must accept what is on offer. Such a viewpoint would indicate that MOH staff may not be willing to prioritise interventions and not hold development partners to account when they stray too far away from agreed strategies and work plans. Weak coordination may arise partly from misunderstanding the nature and purpose of the SWAp more generally..

Coordination, cohesion and accountability are also being hampered by irregular meetings of key technical working groups, the health sector review group and the senior management committee. These structures were put in place in 2004 precisely to ensure that lines of communication were open and transparent across the ministry and between the ministry and development partners.

Strategic direction and cohesion within the POW pillars is being hampered by a number of factors. Many of the key ministry departments do not have permanent directors in place and there has been very high turn over of staff in these positions. In the human resources section the Controller of HRMD post has been vacant for almost two years. Filling this critical post with an experienced, competent HR manager would allow the section to take a

more strategic approach to addressing human resource challenges across the health sector. Similarly, the head of the Pharmacy Section in the ministry needs to have the capacity and authority to pool district drug consumption and need information to facilitation better forecasting and quantification of drug need in the country, and to initiate procurement in good time so that major stock-outs can be avoided. Finally, the absence of a central coordinating body for all monitoring, evaluation, and research in the health sector has left the implementation of ME&R activities to occur in the margins of the national plan, without clear direction, leadership, or integration. Multiple donor-driven demands for data give way to multiple reporting forms, draining resources and precious time from the system. A stronger coordinating unit with a larger scope of work would be able to manage a more cohesive and streamlined M&E system.

Coordination and cohesion for guiding the implementation of the EHP also needs strengthening. Many of the technical units continue to operate in a vertical fashion, often with little discussion between them, or at a higher level in the MOH, about what the consequences of new programmes or interventions might have on the rest of the health system. For example, technical programmes do not appear to have integrated their training activities with those of the Central Ministry, and the training policy that would ensure this has yet to be approved. As a result, a multiplicity of technical workshops are held, often targeting the same district or frontline health staff, adding to the sense that human capacity is being spread far too thinly across the health system.

Furthermore, zonal office institutional status within the Ministry of Health remains unclear. These offices are beginning to hold key coordinating functions for the districts they supervise, and zonal supervisors themselves are reasonably clear about their own functions. Zonal supervisors believe they are the key supervisory link with districts and district assemblies aimed at supporting the implementation of the programme of work through District Implementation plans. Unfortunately the understanding of the role of the zonal offices does not appear to be shared with the Technical Directorates of the MoH that are continuing to bypass and deal directly with DHOs, and thus to some extent undermining their effectiveness. On the other hand, Zonal Supervisors reporting lines are not clear, as to whether they are accountable to the Director of Planning or the Principal Secretary. There have also been weak linkages between zonal offices and central hospitals, though some zones are beginning to rectify this.

5.2.2. Enhancing integration of M&E and health planning

It is clear that health information is underused throughout the health system. At health facility level, most staff interviewed view their registers and monthly reports as one more (onerous) administrative task, and not as an important tool for understanding health trends in their locality. Very few offices at health centre, district or central level have any current charts or graphs of health trends on their walls, which could serve to remind health managers of what objectives they are trying to achieve. At central level, data for key indicators in critical problem areas are not even known. For example, a census is planned to obtain baseline information on human resources, but there needs to be a dependable way to keep the system updated for routine analysis to address human resources problems. Also, the HRH census, if completed by the end of the year provides opportunities both for starting the process of workforce planning and for better overall monitoring of the production, deployment and retention of the health workforce.

The importance of the use of M&E data (from HMIS and surveys) for planning and implementation will only be realised within the health sector when there is support and elevation of this field from the top levels of leadership. As has happened in Mzuzu Central

Hospital, it is only when directors begin demanding good quality data, facilitate its collection and use it to provide feedback on performance that those responsible for recording and reporting health data begin to understand its relevance in their own work.

There is wide experience of introducing performance management systems at institutional level in the health sector to help encourage better reporting, use of data and service delivery outputs, leading to health outcomes. The MOH has a prime opportunity of piloting performance management in its SLAs, and from this experience roll out performance management to the public sector as well.

5.2.3. Sustaining improvements in financial and human capacity for health service delivery

Sustaining improved financial capacity

Although the overall funding of the health sector in general and the POW in particular has increased immensely since the starting of the SWAp, the commitments by development partners is time limited. This varies from one year at the time to the entire period of the POW and even beyond this. With the relative low potentials for increased government revenue, there is a strong need to sustain the level of funds from the partners. Development partners, both the pooling and the discrete partners, need to commit themselves for as long period as possible and communicate this to government. Malawi Government also needs to clearly express its continued commitments, and should indicate whether and when it will fulfil its commitments from the Abuja declaration of 15% of its budget to be allocated for health.

With regards to MOH and CHAM financial capacity, several of the actions outlined in the financial improvement plan have yet to be implemented. These include the filling of key vacancies in the MOH, as well as providing training for both MOH and CHAM financial staff to improve financial reporting. Weak financial capacity has had a knock on effect and has had particular consequences for internal audit functions within the MOH, and the ability of the MOH to address the grave findings of recent audit reports.

Improving financial reporting

At present it is not possible to make any links, through financial reporting, between financial inputs and programmatic outputs (and eventually, outcomes). This is a very serious challenge for the MOH, as the more MOH staff can demonstrate 'value for money' the more likely they will be able to leverage increased funding from both the MOF and from external sources. The new Chart of Accounts does provide the means for the MOH to move in this direction, though there have been substantial delays in introducing the Chart of Accounts in the Ministry.

Sustaining increases in skilled staff across the health sector

An emerging risk identified in this review is the ability to sustain the laudable gains that have been made to date. The gains have been made through what have been referred to explicitly as emergency measures. For example, the staffing of training institutions has been achieved by short-term secondments of service delivery staff by means of incentives of further training prior to the secondment and expensive additional allowances. This investment in further training could lead to a better qualified workforce when the staff return from their secondments, but equally there is the risk that having been upgraded staff are no longer willing to fill the gaps they once did or having become more marketable they find employment elsewhere. Staffing gaps are being filled by effectively paying staff overtime and in remote postings by the "relief" system. Both solutions are being financed

from the ORT budget, reducing the money available for other needs. Short and long term technical assistance, as well as clinically trained volunteers are being brought in to fill capacity gaps. The innovative recruitment and employment strategies are both labour intensive and probably quite expensive. The TA and volunteers are not being used effectively to build local capacity. Without wishing to detract from these successes, these emergency measures are easier than developing and implementing the longer term policies and strategies for sustaining the workforce. At this point in the POW is important that, whilst building on the gains made so far, these more challenging issues are addressed with the same creativity and enthusiasm as for the emergency measures.

Improving human resource management and performance

The emphasis of the EHRP has been on increasing staff numbers and less attention has been given to improving staff performance. There are plans for developing a performance appraisal system, updating job descriptions, developing systems for managing absence, etc in the broad work plans. These systems, which are largely targeted at the individual, can work effectively in organisations that already have a good performance culture. However, they are difficult systems to develop and even more difficult to institutionalise so that they actually lead to better performance and are not really carried out as part of a bureaucratic ritual. There are a number of initiatives across the sector that are targeted more at performance at organisational level. For example, the control of infection in hospital; maternal death audit, etc. It would be useful to examine the impact of these initiatives on performance at the level of the organisation, but also as drivers of individual performance including absenteeism. If these initiatives are effectively developing a "performance culture" in the organisation, it may be better to concentrate on the expansion of this type of initiative rather than performance management systems aimed at the individual -- the least in the short to medium-term.

5.2.4 Unblocking hindrances in procurement of essential drugs and other health supplies

Pillar 2 ‘Pharmaceuticals’ was the only key element in the POW where health service staff suggested that the ‘SWAp hasn’t started yet’. Unlike improvements in other pillars, there has been little progress in ensuring a stable and reliable medicine supply is available through the public health service in Malawi. At the time of the MTR there were stock-outs throughout the country of basic anti-biotics, ITNs and HIV test kits. Stocks of vaccines are running dangerously low, with no solution in sight for replenishing them. This review has found that there are many hindrances to procurement of drugs and other health supplies. These hindrances are most often the result of confusion over who takes responsibility for procurement, as well as capacity to initiate and manage procurement. Procurement capacity is weak across the health system, and most worryingly so at Central MOH level.

Forecasting drug and health supply need

There is no systematic measure of consumption of drugs at hospitals or health facilities. Supply chain manager, a system implemented through a technical assistance by USAID Deliver appears to be measuring consumption from hospital and health facility pharmacy stores. Even with USAID Deliver Supply Management system, there is no designated responsible person from MoH who collates and analyses the data and provides management information on the quantities of drugs to be procured each year. Drugs appear to be procured based on a determination by Central Medical Stores. There is a clear mismatch between the demand generated at health facility level, with requests for re-supplies moving up the chain from health facility to district to RMS, and the CMS supply side, which simply orders drugs based on its own previous consumption data. While this

mismatch between supply and demand persists Malawi will never have adequate essential drugs to cover the EHP.

No consultation has been made by the CMS in determining the equipment needs of the hospitals. The CMS has regardless proceeded to supply in large numbers at different times and to different hospitals equipment that is not required such as trolley, mattresses, beds, wheel chairs, blood pressure equipment, medical trolleys and bedside screens when these were either not required or in quantities exceeding requirements.

Procuring essential drugs and medical supplies

Ensuring sufficient and appropriate drugs are continually in stock remains a perennial challenge for the MOH. The review observed that (i) there is lack clarity of procurement responsibilities for health sector goods between MoH Headquarters and Central Medical Stores (ii) there is no capacity at MoH Headquarters for procurement of health sector goods (iii) there is inadequate procurement planning including financial planning for procurement of these goods (iv) Quantification to determine country needs is not systematic and there is no central point of reference for quantification of requirements (vi) there is inadequate experience in process requirements for procurement of health sector goods at Central Medical Stores and (vii) there has been over reliance on UNICEF as a stop gap measure with little informed desire to build capacity within the system. These areas need urgent attention and rectification. The respective roles of CMS and the MOH in particular need to be decided on, and recommendations are provided below in this regard. The Drug and Medical Supply TWG also needs to be made better use of so that stock crises in drugs and other health supplies can be called attention to, and solutions found, much more rapidly.

Increasing procurement capacity

The existing staff clearly does not have experience to carry out procurement of consultant services and works. As the staff in the MoH is being used to provide guidance and coordinate procurement in the Swap, the current inadequate capacity will slow down procurement and do little to improve procurement capacity and support of the components. Several procurement of works and consultant services are delayed. MoH should seriously consider mixture of long term and short term training in procurement of staff with prerequisite basic qualification to understand procurement with short term training focusing on procurement of works and consultants as a matter of urgency

5.2.7. Using lessons learned to revise the EHP and to elaborate the next national health plan (2011 onwards)

Essential Health Package

The Essential Health Package has evolved from when it was originally put together, and as new evidence and technologies have developed. While the list of core, priority health problems remains the same (and should continue to do so), the interventions for managing these health problems have changed or are changing. This has both cost and training implications for the MOH, making updating the EHP protocols and costings an urgent priority.

Planning the National Health Strategy 2011 - onwards

The Programme of Work was developed to respond to the key bottlenecks existing in the health system in 2002/03. As can be seen from this review, many of those bottlenecks persist and will continue to need attention and action. However, the pillars in the POW are input oriented, and as a result planning, monitoring and reporting are equally input

oriented. It is very difficult to translate these inputs into programme outputs and outcomes, though the SWAp M&E framework makes an admirable attempt to do so. The MTR team do not feel that it is worthwhile at this midway stage to re-write the Programme of Work, as this would distract attention away from just getting the jobs done that need doing. It is important, though, that lessons drawn from implementing and monitoring the POW are recorded, analysed and used for development of the next national health plan.

6. CONCLUSIONS AND RECOMMENDATIONS

The Ministry of Health and its development partners took a large leap of faith in 2003 when together they agreed to move towards a sector wide approach. This move was made in full recognition of the weak capacity and weak systems within the health sector at the time. Those who signed up to the SWAp did so on the understanding that time would be needed to sort out the many problems, but also in recognition that the process of strengthening the health system had to start somewhere. Since the start of the SWAp, with the first tranche of funding for the Programme of Work in late 2004, improvements have been made. As far as the Pillars are concerned, more health workers are being trained than ever before, and there are more staff working in health facilities. Physical infrastructure is being improved and equipment purchased and updated. New institutional arrangements, such as decentralisation and service level agreements, are shifting the locus of decision making and resources to local areas. Most importantly, there is a trend towards improvement in key health indicators.

Much progress has been made, but there are many, many challenges left to overcome. For example, if drug and health supply procurement systems are not addressed immediately gains in EPI, malaria prevention, HIV testing and counselling and PMTCT will be lost and even reversed. If steps are not taken now to address the outstanding questions on sustaining gains in human resources for health, then the situation could revert back to where it was in 2003 by 2009/2010. The MTR team received a strong sense from MOH staff and health stakeholders that the SWAp has reached a critical point in its life cycle. The gains seen now are the result of planning and initiatives begun two to three years ago. If strategic direction and partnership working begin to unravel now, the consequences will begin to show in less time, and achievements gained will be quickly reversed. These challenges can only be faced and responded to through coordinated and joint action between government, its development partners and its implementing partners.

RECOMMENDATIONS

No.	Recommendation	Suggested key responsibility for action	Suggested processes/action
1. Improving coordination, cohesion and accountability			
URGENT – TO BE ACTIONED BY DECEMBER 2007			
1.1	Improve partnership and joint ownership through reconstitution and revitalisation of the key TWGs, HSRG and SMC	Secretary for Health	• Call for a joint meeting of the members of the Senior Management Committee and of the Health Donor Group, as defined in the current TORs. The purpose of this meeting is to identify why committees are not meeting and to agree on a calendar of meetings for the next year • The HSRG and SMC should agree to meet once a month for the next 6 months in order to cover all outstanding business and renew working relationships; • Consider the creation of a Ministry Executive Committee that includes the Minister in its membership. The MEC would be responsible for overall policy direction and approving policy proposals. The SMC would concentrate its efforts on policy planning and implementation, overseeing coordination of the implementation of POW pillars and technical programmes. • Designate chairs and deputy chairs of each TWG, whose responsibility it is to ensure the TWG is convened regularly, and TWG reports are fed regularly to the HSRG and SMC.
		Chair, Health Donor Group	• At its next meeting, the HDG chair should facilitate agreement on representatives of at least two, and at most three, DP organisations to take responsibility for attending TWGs, according to their comparative advantage and expertise. • These representatives should then be tasked with feeding back reports from TWGs to the HDG through the listserve and through monthly HDG meetings
1.2	Improve the effectiveness of TWGs	PS and TWG chairs	• Determine the minimum organisational membership and technical qualification required to sit on each TWG • Work with TWG constituencies to communicate what is required from each organisation, included the level of representation required to make sure meetings are meaningful • Ensure that each TWG has a chair and deputy chair to reduce the risk of meetings having to be postponed or cancelled.
		TWG chairs, deputy chairs and secretaries	• Devise an annual schedule of each TWGs meetings, which is then circulated to the membership at the beginning of each year. • Ensure minutes of meetings are sent to TWG members and the SWAp secretariat within two weeks of the meeting taking place, and including the date, time and place of the next meeting • Any changes to scheduled meetings, and calling of extraordinary meetings, should be

			given with at least one week notice, and done by telephone and email, to reduce problems with unreliable IT
1.3.	Strengthen HR leadership	PS DOFA HRH TWG	• Fill Controller HRMD post with competent person • Establish HR sub-group of SMC to meet regularly to monitor progress against HRH framework and jointly solve problems (or increase frequency of HRH TWG and modify TOR to take on this function). • Review of HR functions across key actors (to support HRH skills analysis) –to improve coverage (gaps and overlaps) and coordination
1.4.	Re-invigorate HRH strategic thinking process and develop framework with ownership; consolidate various action plans into revised AIPs	HRMD section with support from PS/DOFA	• Ensure a senior management support behind this process; DOFA to project manage the process • Catalogue all plans and other elements to be included in the framework • Recruit expert on strategic planning and HR to facilitator process (2-3 wks) • Complete draft framework by November 2007 • Consultation, revision, approval by December 2007 • Develop means of monitoring implementation of framework (when developing the framework) • Modify AIP 07/08 as required • Develop into one comprehensive strategy (after a year or so)
1.5	Establish the Monitoring, Evaluation and Research Unit as originally planned in the POW and MOU	Director of Planning HMIU M&E TWG	• Begin implementing all aspects of the plans for the transition that can be put in place while awaiting final approval of the Functional Review. • Allocate the appropriate human resources and finances for MERU to begin functioning in full capacity. • Make public the transition from HMIU to MERU and the mandate for MERU to function as a coordinating body for M,E&R activities in the health sector.
1.6.	Strengthen coordination and communication within zones and between zones and centre	Director of Planning	• Establish formal link between the zonal teams, DHMTs and Central Hospitals through mandatory quarterly meetings to be convened by the head of Zonal Support team. • Include Zonal Supervisors as members of the revitalised Senior Management Committee • Strengthen routine communications between zonal offices and central ministry - Analyse alternatives, such as having a zone liaison officer in Planning Department, or clearer lines of management between zones and central level
MEDIUM TERM – TO BE STARTED BEFORE DECEMBER 2007 AND COMPLETED BY END 2008			
1.7	Improve coordination and mutual accountability within the Health Donor Group	Chair and members of the HDG Global Fund	• Members of the HDG to ensure they are making full use of the listserve and monthly meetings to share information about programme planning and programme assessments they are undertaking. • Add a regular agenda item to HDG meetings that gives time for debate on donor initiatives that have not been discussed, or which are creating concerns; • The Global Fund should review and revise its 'Communication Protocols for Local Fund Agents' to allow for open planning for, and sharing the results of, PR assessments with both the Principal Recipient and other development partners.

1.8	Strengthen coordination and alignment of planning and monitoring between the MOH, MOLG and districts	PS MOH with Director of Planning	• Meet with PS and Director of Local Government in MOLG to discuss and review district planning processes • Set up a joint working group () to devise a common framework for integrating DIPs with District Development Plans • Include district representation for both ministries as well as vertical programme teams as part of the joint working group to ensure that the experience and interests of both are catered for. • Facilitate joint training between DHMT and district commission teams on new planning framework to ensure there is a good understanding of what is required and what can be expected.
1.9.	Clarify and strengthen the respective coordination roles of MOH pharmaceutical and procurement sections and Central Medical Stores with regards to health supply chain management, i.e. in particular: quantification, forecasting, procurement, distribution and supply	PS DMS TWG	• MOH pharmaceutical section to take lead role in forecasting and quantification of drug need, - MOH commission a study of real drug need and use for EHP essential drugs, to include CMS consumption data, district private procurement and private donations to hospitals, districts and health centres. • MOH pharmaceutical section provides oversight of drug procurement and supply management, through regular meetings with CMS - Produce, document and agree a workplan which addresses appropriate systems development, partner integration, provision of TA & training and procedural oversight - Identify & agree logistics sub-committee TOR's. Initiate such a forum and conduct periodic meetings - Derive, agree and track Key Performance Indicators to support CMS operational decision-making • With the development of CMS as a Trust, move towards CMS being the only entity to procure and distribute pharmaceuticals (e.g. define, document and agree respective supply chain responsibilities) •
2. Enhancing integration of M&E and health planning and performance management			
MEDIUM TERM – TO BE STARTED BEFORE DECEMBER 2007 AND COMPLETED BY END 2008			
2.1.	Top leadership and persons responsible for planning at every level, from the PS, and the Director of Planning at central level, to the In Charge at facility level, should champion and model the importance and use of data for improving programme planning, implementation, and service delivery.	PS Department of Planning, and HMIU	• Incorporate into all existing planning meetings review and utilisation of data for planning purposes. • Use examples from existing data to illustrate the importance of practical analysis and use of data to guide interventions.
2.2	Devise and develop a health service performance management plan for the SWAp, based on routine data already collected, which can be used by zonal offices and DHMTs to monitor service delivery and health service	PS with Director of Planning	• Take as starting point the output indicators in the SWAp indicator matrix and integrated district supervision currently in use; • Review how performance management is implemented in other countries (e.g. Uganda and Rwanda), and consider adaptation of similar models; • Develop a monitoring process that includes indicators that also monitor financial

	management		expenditure by type (curative v preventative, hospital v health centre) and HMIS reporting indicators; • Strengthen data quality assurance mechanisms to ensure data is rigorous enough for monitoring purposes • Based on agreed indicators and targets, consider what incentives and sanctions to put in place (including financial such as prizes, team recognition such as certificates, as well as 'special measures' for non-performers
2.3	Broaden the terms and conditions of the SLAs so that they a)include more of the EHP and b) are performance based	Directorate of Planning	• Increase the numbers of services covered by the SLA. If it is not realistic to contract for all EHP related services, ensure that at least all maternal and under-five related services are covered; • Determine a few performance indicators to be used by districts and zones to monitor how well facilities with SLAs are performing and how they are contributing to improving health in a district • Suggested indicators could include o % of SLA facilities with infection control certification; o % of SLA facilities sending in fully completed HMIS reports on time o EPI coverage of SLA catchment o Antenatal visit coverage of SLA catchment o Assisted delivery coverage of SLA catchment o % of SLA invoices paid within four weeks of receipt • Designate zonal offices as the responsible body for validating district performance monitoring of SLAs
2.4	Institute a system of mentoring in data use and strategic planning throughout all levels of the health system.	HMIU; Zonal Health Offices; District Health Offices	• Supervisions should be combined with mentoring and follow-up to ensure effective data use and strategic planning that takes into consideration the needs of all constituents. • Training and upkeep with regards to the incoming computers and printers should be put in place to allow for optimal use.
2.5	The current revision of the HMIS should be expedited and completed to thoroughly address issues of harmonisation and streamlining.	HMIU	• Finalise the harmonised and streamlined indicator list and targets. • Eliminate all parallel reporting systems. • Eliminate dynamics of competition and isolation within the health sector (between HMIU and disease-specific programmes) and cultivate understanding, partnership, complementary roles and collaboration through strong leadership on the part of MERU.
2.6.	Use data to support development, implementation and monitoring of the HR strategy	DOFA Director of Planning; HRMD	• Make better use of existing staffing data • Improve data collection and analysis on training: intake, graduation, attrition by cohort to monitor impact of training investments
2.7.	Improve data quality.	HMIU Director of Clinical Services	• Use page summaries when tabulating data from health facility registers. • Strengthen data verification and quality assurance mechanisms for every level of the HMIS. • Strengthen the internal quality assurance process to ensure that it is functional. • Put in place an external data quality assurance system.

			• Revise the clinical guidelines and provide training regarding the new guidelines to improve the accuracy of diagnosis.
2.8	Improve understanding of the impact SLAs are having on increasing service access overall	ME&R TWG	• Commission a study that seeks out and examines the impact SLAs are having on overall access to and use of services from a district perspective. Key questions to ask would be: 1. Is there an overall increase in use of antenatal and delivery services by women, or are women who would normally use a public provider shifting to use an SLA provider?
3. Sustaining improvements in financial and human capacity for health service delivery			
URGENT – TO BE COMPLETED BY THE END OF DECEMBER			
3.1.	Accelerate and complete actions recommended in the Financial Improvement Plan	DOFA Director of Finance Accountant General	• Prioritise filling the remaining key posts in the MOH Finance Section in liaison with the Accountant General • Improve capacity of existing and new staff in MOH and CHAM to analyse better and plan strategically, as well as to operationalise financial management plans • In particular, increase and improve internal audit capacity in the MOH
3.2.	Undertake a detailed analysis of expenditure trends to assess the overall financial sustainability of the POW/EHP		• The MoH should update its cost projections for the SWAp by updating the parameters used in the original model to reflect changes in price, quantities, scope and timing of implementation. • The costing update should also take into account the work completed to-date and thereby provide a separate estimate of the costs of outstanding activities. • A special costing exercise should be undertaken in respect of the health workforce so as to be able to disentangle the effects of changing numbers and skill-mix from pure price effects. • The MoH should ensure that it allow proper analysis of important trends and patterns, by maintaining comprehensive disaggregated data sets on expenditures and activities. Should the MoH not have the capacity to undertake such analyses in house it should consider the possibility of contracting out such work. •
MEDIUM TERM – TO BE COMPLETED BY THE END OF 2008			
3.2	Shift financial reporting to be more output based, linking financial inputs and programme outputs	DOFA Director of Planning	• Initiate use of the new Chart of Accounts • District financial planning and budgeting systems should be realigned to better reflect the objectives and outputs of the SWAp PoW. A particularly urgent requirement is to be able to disaggregate expenditures on district hospitals from expenditures on district primary health care facilities. • Immediate action should be taken to familiarise district staff with the coding possibilities of the new Chart of Accounts (CoA) so that the are ready to implement any new codings associated with a new SWAp • Ensure use of all coding categories to allow for maximum disaggregation of financial information • Provide a simplified coding structure for facilities below district level so as not to overburden

			• Provide financial training on new coding and formatting on a zone by zone basis.
3.3	Integrate budgeting and procurement planning processes	DHOs DOFA MOH Procurement Zonal supervisor	• Budget submission should always be supplemented by a Procurement Plan • Procurement plans should be on an annual basis, accompanied by projected cash flow requirements, so that funds arrive in districts in time to implement plans; • All plans should be revised after budget approval and a final version of plans formally submitted to MoH. • Zonal offices should monitor quarterly procurement reports against plans • Budgeting and procurement planning process to identify and align procurement to relative strengths of central and decentralized levels. Should allow for identified procurement to be done by centre (e.g. drugs and civil works) and rest by decentralized levels.
3.4	Start development strategies to improve performance culture	HRMD section + directors	• Identify current performance improvement initiatives (eg infection prevention, QA, MCH model, supervision) • Publicise findings; decide whether it is better, at this point in time, to focus organisational performance management than to attempt to install systems targeted at the individual e.g. performance appraisal system
3.5	Further develop TA needs assessment process described in Needs Assessment Study report	PS DOFA	• Ensure that alternatives are considered to the use of TA in the needs analysis process
4. Unblocking hindrances in procurement of essential drugs and other health supplies			
URGENT – TO BE UNDERTAKEN IN THE NEXT FOUR WEEKS			
4.1	Government and development partners negotiate and agree solution to current crisis in ITN, vaccines and other essential drugs	DMS TWG HSRG	• Develop list of critical shortages and forecast need for next six months • One development partner (not UNICEF, due to potential conflict of interest) to take lead role on behalf of the group to work with MOH
MEDIUM TERM – TO BE STARTED BEFORE DECEMBER AND COMPLETED BY END 2008			
4.2	Develop procurement capacity at all levels of the health system	MOH Procurement Section ODPP World Bank Procurement Advisor	• Appoint key procurement officers for CMS and appoint procurement officer for each district who should be the prime target for capacity building in procurement • Develop pharmaceutical professional capacity at all levels of the health system, which includes in particular the following aspect: stock management, dispensing, documentation, and procurement. – Ensure there is at least one person/facility with specific training in pharmacy • ODPP to organize short courses on preparation of bid documents and evaluation of bids for works and consultants for procurement staff in position. • World Bank to organize another training in procurement of health sector goods for CMS and MoH Headquarters • Head of each institution (MOH departments, technical programmes, DHOs, Zonal offices, Central Hospitals, CMS, etc) to catalogue list of key documents for implementation of PoW by subject and demand relevant departments to have copies of the documents. Each institution to have at least MoU, PoW, yearly approved budget, Financial Management Act and Procurement Act. • Each institution to prepare a circular of 2-3 pages interpreting difficult to understand documents. Seek guidance from MoH headquarters and ODPP
4.3	Revise current procurement procedures,	DOFA	• Take opportunity of changes in World Bank role in health sector and commission a

	balancing fiduciary risk management with pragmatism	ODPP FMP TWG	review of current procurement standards and procedures, including delegation of scrutiny function; • Address current and possible future causes of delays by considering alternatives (contracting World Bank to continue current role with extra TA, handing procurement management to a different development partner, contracting out procurement management to a separate company, etc.)
4.4	Establish a single procurement and distribution channel for pharmaceuticals within the MoH	MoH and partners CMS, Operations & Systems	• Empower the CMS as the only MoH entity to procure and distribute pharmaceuticals (e.g. define, document and agree respective supply chain responsibilities) • Introduce tender procedure that brings in 2-year framework contracts • Derive, agree and track Key Performance Indicators to support CMS operational decision-making • Address short-term CMS planning/ decision-making with available resources • Supply chain system strategy paper requires developing, documenting and agreeing • Reinforce CMS management and implementation staff structure with permanent staff as long term capacity building and sustainability strategy instead of use of consultants which is short term and not sustainable.
4.5	Standardize pharmaceutical documentation, reporting and supportive supervision	Chief Pharmacist; Dir.Medic.Services	• Develop, implement and enforce Standard Operating Procedures • Install 2 independent documentation systems on drug consumption (patient records; stock records)
4.6	Enhance high level supply chain monitoring	MoH and partners	• Re-install regular meetings of TWG Advisory role - Follow up milestones - Establish working groups for priority issues (e.g. to track commodity availability) as well as coordinate any/all new CMS supply chain interventions (eg PMI & drug leakage recommendations) that ongoing supply operations are not detrimentally affected - Derive, agree and track drug availability indicators (w/HMIS) • Document and communicate to all stakeholders prevailing supply chain pipeline, including orders(s) status, plus immediate and longer-term consequences of status quo as a prelude to further interventions and joint action plans
5. Using lessons learned to update current EHP and elaborate the next national health plan (2011 onwards)			
URGENT – TO BE COMPLETED BEFORE DECEMBER 2007			
5.1	Revise content of EHP to reflect organic changes which have taken place during implementation	MOH/EHP TWG	• Programmes to submit strategic plans that are in line with the POW and highlight deviations or suggested inclusions to original EHP document. Specifically - Malaria to include new drug policy - Nutrition to include CTC and develop a strategic plan specific for the health sector - Leprosy and skin diseases programmes to develop a multi year plans of action for achievement of the targets of the POW. - Eyes to finalise draft eye care plan and ensure that it is in tandem with the EHP - HIV unit to include ART delivery and costs in the EHP • MOH ensure that EHP TWG meets regularly • EHP TWG should then advise on revisions to the EHP content to reflect and consider suggested changes from the disease technical programmes.

			• No new interventions should be considered at this time until the present ones have been implemented to avoid dilution of the implementation.
MEDIUM TERM – TO BE STARTED BEFORE END DECEMBER 2008 AND COMPLETED BY END 2009			
5.2	Constitute a strategic planning working group to draw up a concept paper for the next National Health Plan (post 2010) based on a synthesis of lessons learned on how the POW and related information systems are structured	Lead: Director of Planning Support from SWAp Secretariat and HSRG + SMC	• Identify working group members with good experience of conceptualization and strategic planning from amongst HSRG and SMC constituents • Review and analyse current structure of POW against EHP outcome measures • Develop a concept paper that outlines options for how the new national health plan will be constructed, in readiness for 2009 planning exercise