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**Expanding Health Care Provision
in a Low-Income Country:
The Experience of Malawi**

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ABBREVIATIONS AND ACRONYMS

CHAM	Christian Health Association of Malawi
DHO	District Health Office
EHP	Essential Health Care Package
EHRP	Emergency Human Resources Programme
GDP	Gross Domestic Product
HCP	Health Coverage Program
HMIS	Health Management Information System
HRH	Human Resources for Health
MK	Malawi Kwacha
MoH	Ministry of Health
MoU	Memorandum of Understanding
OOP	Out of Pocket
SLAs	Service Level Agreements
SWAp	Sector-Wide Approach Programming
UHC	Universal Health Coverage

Preface to the second round of the Universal Health Coverage Study Series

All over the world countries are implementing pro-poor reforms to advance universal health coverage. The widespread trend to expand coverage resulted in the inclusion of the “achieving universal health coverage by 2030” target in the Sustainable Development Agenda. Progress is monitored through indicators measuring gains in financial risk protection and in access to quality essential health-care services.

The Universal Health Coverage (UHC) Studies Series was launched in 2013 with the objective of sharing knowledge regarding pro-poor reforms advancing UHC in developing countries. The series is aimed at policy-makers and UHC reform implementers in low- and middle-income countries. The Series recognizes that there are many policy paths to achieve UHC and therefore does not endorse a specific path or model.

The Series consists of country case studies and technical papers. The case studies employ a standardized approach aimed at understanding the tools –policies, instruments and institutions– used to expand health coverage across three dimensions: population, health services and affordability. The approach relies on a protocol involving around 300 questions structured to provide a detailed understanding of how countries are implementing UHC reforms in the following areas:

- **Progressive Universalism:** expanding population coverage while ensuring that the poor and vulnerable are not left behind;
- **Strategic Purchasing:** expanding the statutory benefits package and developing incentives for its effective delivery by health-care providers;
- **Raising revenues** to finance health care in fiscally sustainable ways;
- **Improving the availability and quality of health-care providers;** and,
- **Strengthening accountability** to ensure the fulfillment of promises made between citizens, governments and health institutions.

By 2017, the Series had published 24 country case studies and conducted a systematic literature review on the impact of UHC reforms. In 2018 the Series will publish an additional 15 case studies. A book analyzing and comparing the initial 24 country case studies is also available: *Going Universal: How 24 Developing Countries are Implementing UHC Reforms from the Bottom Up*. Links to the Series and the book are included below.

Daniel Cotlear, D. Phil.
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Universal Health Coverage Study Series

Links:

<http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series>
<http://www.worldbank.org/en/topic/universalhealthcoverage/publication/going-universal-how-24-countries-are-implementing-universal-health-coverage-reforms-from-bottom-up>

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Executive Summary

With a real Gross Domestic Product (GDP) per capita of US\$494.40 in 2015 and a Human Development Index of 174 out of 187 countries, Malawi is one of the poorest countries in the world. GDP growth per capita has been minimal, and this has contributed to poor public health service delivery as the government has been struggling to fully finance the health sector. By 2000, the health sector was burdened by a number of problems including a severe shortage of core health workers, a scarcity of medicines and medical supplies, and limited access to health facilities due to physical and financial barriers.

Determined to address the problems in the health sector, the Government of Malawi, with assistance from external development partners and the Christian Health Association of Malawi (CHAM), has been implementing several programs including the Joint Programme of Work (2004–2010), and the Health Sector Strategic Plan 2011–16. Enshrined in the Joint Programme of Work was an attempt to resolve the critical shortage of health workers through implementation of the Emergency Human Resources Programme (EHRP). Over the years, the EHRP has been succeeded by subsequent human resources for health strategic plans. Since 2006, the government has been entering into service-level agreements (SLAs) with CHAM aimed at addressing financial barriers and limited physical access to health facilities.

Investment in the health sector over the years has led to an increase in population coverage, financial protection, and improvements in health outcomes. For example, Malawi is one of the 11 countries in Africa that managed to achieve the Millennium Development Goal (MDG) target of reducing under-five mortality. Malawi has also consistently kept out-of-pocket spending at much lower levels than its neighboring countries in Sub-Saharan Africa. The EHRP (and subsequent human resources for health strategic plans), and SLAs with CHAM contributed to these gains.

Though Malawi still faces several challenges, it has demonstrated how a country with limited financial resources can make substantial progress toward universal health coverage using supply-side interventions.

Introduction

Malawi is a low-income country that is actively working toward achieving universal health coverage (UHC). The government is committed “to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care” as outlined in the Constitution. This commitment is further elaborated in Malawi’s Growth and Development Strategy II, which is the main development plan for the country. In addition, the Joint Programme of Work (2004–2010) and the Health Sector Strategic Plan 2011–16, outline the government’s desire to achieve UHC.

Aspirations to achieve UHC heightened during the early 2000s, when public service delivery was saddled by a myriad of problems including poor health service coverage and health outcomes. Key among the problems was a severe shortage of core health workers (MoH 2004). With economic stagnation and low salaries, most of the core health workers were migrating out of the country which further reduced the availability of health workers while increasing staff workload. This situation worsened as the population increased¹ and as the HIV/AIDS pandemic reached its height (MSH and MSC 2010). Moreover, access to health facilities was a major challenge, particularly in rural areas, due to physical and financial barriers. Given the above and other challenges,² health outcomes in Malawi were poorer in the mid-2000s than currently. For instance, in 2004, the maternal mortality ratio was 699 deaths per 100,000 live births, the infant mortality rate was 76 deaths per 1,000 live births, and under-five mortality was 125 deaths per 1,000 live births.³

To address this situation, the Government of Malawi developed an ambitious six-year Joint Programme of Work covering 2004 to 2010. The Programme of Work had six pillars and was implemented by the Ministry of Health with support from a number of donors, faith-based organizations, and other stakeholders through a Sector-Wide Approach Programming (SWAp) mechanism. Two key reforms that emerged from this were the Emergency Human Resource Programme and the service level agreements with Christian Health Association of Malawi (CHAM) health facilities. The Emergency Human Resource Programme was specifically developed to address human resources for health crises. The CHAM service level agreements allowed for the government to expand its policy of providing free health services through CHAM health facilities located in areas with no public health facilities.

This UNICO case study explores how Malawi has been able to increase population coverage and financial protection by implementing these two supply-side reforms. The study reviews the situation before the two reforms, what the two reforms envisioned, management arrangements, what the reforms delivered (including positive and negative effects), and the long-term scope for achieving UHC in Malawi.

Demographic, Economic, and Health Profile

Almost half (46.5 percent) of Malawi’s population of 16.8 million is under 15 years of age due to a high annual population growth rate of 3.2 percent per year (2015 estimate), and a high total fertility rate, estimated at 4.4 children per woman in 2015 (NSO and ICF 2016). Malawi’s population is expected to reach 26.1 million by 2030 (NSO 2010), and its pre-demographic dividend⁴ status poses a huge challenge to economic growth. For instance, 89 percent of

employed persons in Malawi are engaged in informal employment, while salaries in the formal sector are low (mean and median wages of US\$113 and US\$37, respectively) (NSO 2014). Consequently, Malawi has a large pool of “working poor” and the smallest middle classes in Sub-Saharan Africa (DTUC 2015). Over the years, real per capita GDP growth has been minimal, rising from US\$241.5 at independence⁵ to US\$494.4 in 2015. As a result, poverty levels have been consistently high particularly in rural areas. Based on World Bank estimates using a poverty line of US\$1.90 per day, 69.9 percent of the population was classified as poor in 2015. Malawi also ranks poorly on the United Nations Human Development Index, standing at 173 out of 188 countries in 2014.

Given its poor economic status, Malawi has been receiving significant financial support from external development partners. This assistance, together with government’s investments, has contributed to increased health coverage and significant improvements in some key health outcomes in the past 15 years (table 1). Notably, Malawi is one of the 11 countries in Africa⁶ that met the Millennium Development Goal 4 target of a two-thirds reduction in the under-five mortality rate between 1990 and 2015. Malawi has also been successful in reducing stunting among children under five from 56.4 percent in 2000 to 37.1 percent in 2015/16. Furthermore, Malawi is among eight countries⁷ in Sub-Saharan Africa where female life expectancy increased by more than 10 years, largely due to reductions in HIV/AIDS mortality (GDB collaborators 2016). The free health care policy has also contributed to reduced financial risks associated with ill health, and as such, the country has one of the lowest out-of-pocket expenditures in Africa.

Table 1: Trends in Key Health Indicators

	2000	2002	2004	2006	2008	2010	2012	2014	2015
Infant Mortality Rate (deaths per 1,000 live births)	103.5	88.8	75.5	67.1	61.7	57.5	50.2	45.1	43
Under-5 Mortality Rate (deaths per 1,000 live births)	174.4	148	125	110	100	90.9	77.3	66.9	64
Maternal Mortality Rate (deaths per 100,000 live births)	890	839	699	614	629	629	624	638	634
Total Fertility Rate (Number of children per woman)	6.25	6.14	6.03	5.9	5.73	5.53	5.32	5.13	4.4
Stunting among Children under Age 5	54.6		52.5	53.2		47.8		42.4	37
Children with Fever Receiving Antimalarial Drugs (% of children under-5 with fever)	27		28	25		43.4	32.5	39.1	
Births Attended by Skilled Health Staff (% of total)	54.2	60.5	56.1	53.6		71.3		87.4	
Immunization, Measles (% of children 12–23 months)	73	69	80	85	88	93	90	85	

Source: World Development Indicators.

General Health System Overview and Financing

Decentralization

Malawi embarked on the process of devolving health service delivery to lower levels in 2004, aimed at enhancing primary- and secondary-level service delivery. In 2005, the MoH developed “Guidelines for the Management of Devolved Health Service Delivery,” which

outlined the functions and activities to be devolved to district assemblies, and the role of the central Ministry of Health (MoH) in monitoring and evaluating devolved functions. Currently, there are three levels of health care delivery: primary, secondary, and tertiary. Primary health care consists of community initiatives, health posts, dispensaries, maternity facilities, health centers, and community and rural hospitals, and is managed by the District Health Office (DHO). Secondary health care includes district hospitals that also act as referral facilities from primary facilities. DHOs and secondary health facilities are managed by District Hospital Management Teams. Tertiary health care consists of four central hospitals that provide referral health services from secondary facilities, and these are managed by the central hospital directors who report directly to the MoH.

Decentralization in Malawi has resulted in minimal or no improvements in financial autonomy and decision making at the district level. There are three reasons. First, roles and mandates between the MoH and the district administration are not clear. This has created duplication of roles and competition between the MoH and the district administration (Tambulasi and Mlalazi 2015). Compounding the problem is that DHOs only partly answer to the MoH, as they are part of the district administration, headed by the District Commissioner. Second, recruitment of health workers has not yet been decentralized, and therefore, district councils do not have the autonomy to hire and fire. Third, financial resources are not evenly distributed among districts, and this makes it difficult for districts to fully implement their programs (Tambulasi and Mlalazi 2015).

Description of the Health Financing System

Malawi's health financing system can be described as a pooled supply-side publicly financed system. Through the Essential Health Care Package (EHP), a minimum package of health services is supposed to be provided free at all government facilities. In practice, the EHP acts more as a tool for priority setting. The EHP contains 11 key public health priorities and interventions to address the most common causes of mortality and morbidity in Malawi. This includes malaria, tuberculosis, HIV/AIDS, malnutrition, diarrhea, cholera, and acute respiratory tract infections. The EHP was originally projected to cost US\$17.53 per capita, but was later revised to US\$28.03 per capita, and finally to US\$44.40 per capita after including more interventions. All interventions outlined in the EHP are supposed to be provided free-of-charge in all government health facilities, and in CHAM facilities where service level agreements exist. But while the EHP has created a universal sense of entitlement to free health care at the point of use, inadequate supplies in most government health facilities necessitates out-of-pocket spending at private health facilities (Abihiro, Mbera, and Allegri 2014). Government health expenditure per capita, estimated at US\$10 per year during 2009/10–2014/15 (figure 1), is considerably below the EHP benchmark of US\$44.40 per capita.

On the demand-side, there is no social health insurance scheme in Malawi, and only 1.2 percent of the population has some form of health insurance coverage through voluntary private health insurance, corporate, and other risk-pooling schemes (World Bank 2017). Growth of the health insurance market is inhibited by the small size of the formal sector, low salaries in the formal sector, widespread poverty, and the predominance of the “free public health care system” (MoH 2014). As such, health insurance as a proportion of total health expenditure was only 3.3 percent in 2014/15 (MoH 2016).

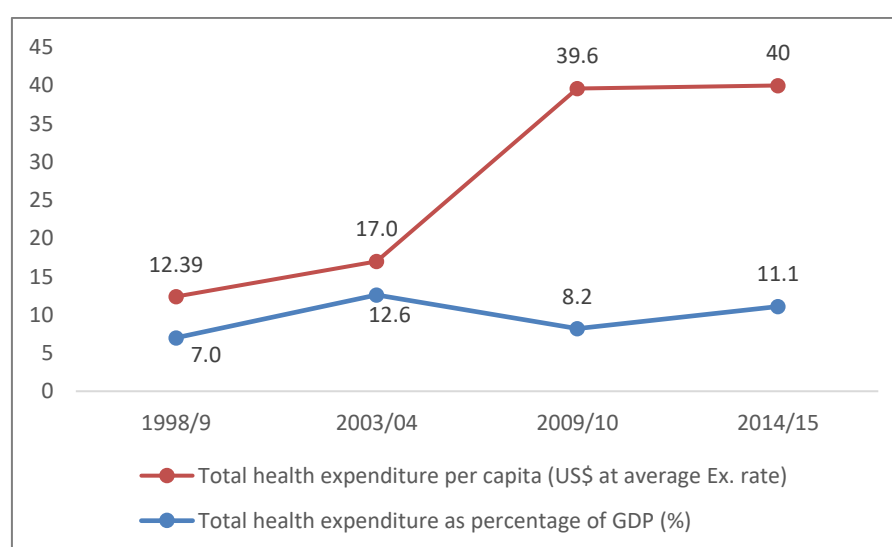
Private health insurance is predominately provided by the Medical Aid Society of Malawi and Metropolitan Health Malawi, with over 95 percent of the market, covering mostly formal sector employees in parastatals and industrial companies, groups, individuals, and families. Each health insurance company offers prescribed health insurance products or coverage, which includes a benefits package of outpatient, inpatient, and funeral services up to a maximum amount. Insurance premiums are prepaid via payroll deductions, and via company, group, and individual contributions. The insured access health care services from accredited public and private health facilities, and practitioners. These include hospitals, clinics, pharmacies, laboratories, panel and specialist doctors, dentists, opticians, and physiotherapists.

Overview of The Key Financing Sources

During 1998/9–2014/15, total health expenditure in Malawi increased by 440 percent in nominal terms, from US\$123.9 million in 1998/9 to US\$669.6 million in 2014/15. As a share of GDP, Malawi spent 7 percent on health in 1998/9, rising to 11.1 percent in 2014/15 (figure 1). A breakdown of total health expenditure by financing sources during 2009/10–2014/15 shows that health financing in Malawi is predominantly donor driven, averaging 63 percent of total health expenditure per year, followed by government at 23 percent, households at 10 percent, and employers and local NGOs at 4 percent (figure 2). In comparison with countries with the same level of income and those in Sub-Saharan Africa, external financing on health as a proportion of total health expenditure is estimated at 28.3 percent and 10.8 percent, respectively, which shows that external financing for health in Malawi is very high.

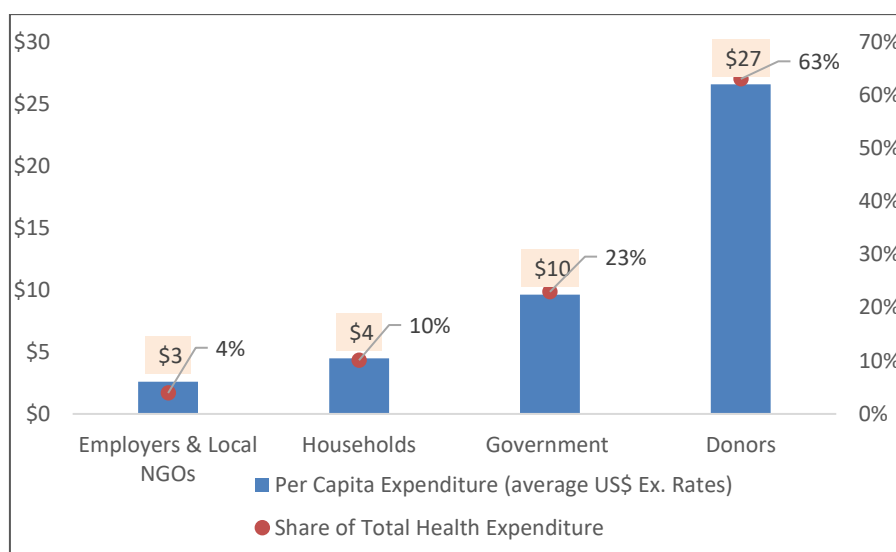
In per capita terms, total health expenditure per capita more than tripled from US\$12.4 in 1998/9 to US\$40 in 2014/15 (figure 1). The bulk of the EHP is funded by donors, estimated at US\$27 per capita during 2009/10–2014/15, more than twice the government health expenditure per capita, which is estimated at US\$10 over the same period (figure 2). Reliance on external financing reduces the government’s flexibility in resource allocation, and its ability to reprioritize funding to emergent needs. In 2014/15, 62 percent of the total external health expenditure was earmarked for three diseases: HIV/AIDS, which consumed 35 percent of the resources; malaria, which consumed 16 percent; and reproductive health, which consumed 11 percent (MoH 2016).

Figure 1: Total Health Expenditure



Sources: MoH 2001, 2007, 2014, 2016.

Figure 2: Composition of Total Health Expenditure, Period Average, 2009/10–2014/15



Sources: MoH 2014, 2016.

Out-of-Pocket Expenditure and Effects on the Poor

Between 1998/9 and 2003/04, out-of-pocket (OOP) expenditure on health as a percentage of total health expenditure declined by 63 percent and remained at 10.4 percent on average between 2003/04 and 2014/15 (figure 10). OOP expenditure was high during the 1990s due to the increasing use of private providers as the underfunded public health system steadily lost its patients to the private sector due to declining quality in public health facilities. Households had to make OOP payments for various items in short supply at public facilities, particularly drugs. With the introduction of service level agreements and other interventions since the mid-2000s, some Malawians have been able to access free health services, as highlighted on figure 9, which shows a reduction in the proportion of households reporting inadequate consumption of health care. However, declining OOP expenditure could also be an indication that the poor are foregoing care. Some studies show that a proportion of the population foregoes health care for financial reasons (NSO 2012).

Health Coverage Program (HCP) Institutional Architecture and Interaction of HCP with Rest of Health System

Institutional Context and Objectives

Malawi faced a health service delivery crisis in the early 2000s that its government described as “near collapse” (MoH 2004). The supply of health services was critically low due to a shortage of health workers across the country; an inadequate number of health facilities, particularly in rural areas; and financial barriers at the point of access. Moreover, the demand for health services was peaking primarily due to population growth and a high incidence of HIV/AIDS (MoH 2004). With only 3.4 core health workers (doctors, clinical officers, nurses, and midwives) per 10,000 population in Malawi in 2004, this was far below the World Health Organization’s recommended 23 core health workers per 10,000 population. In addition, 55

percent of nursing posts were vacant, and the only medical school at the time was graduating 20 doctors a year (MSH and MSC 2010). Public health facilities were severely understaffed as most health workers were shunning the public health service due to low salaries and poor working conditions (MSH and MSC 2010).

Other than the shortage of health workers, the country also faced challenges with covering the entire population with the existing limited number of public health facilities. The aspiration of the Government of Malawi is for each individual to live within a radius of 8 kilometers of the nearest health facility, and to provide free public health services to the entire population. However, there were no public health facilities in some remote and rural areas of the country where the need for affordable health services is high, and the government did not have the resources to construct new health facilities.

To address the above problems, the government instituted two major strategies: the Emergency Human Resources Programme (EHRP) and service level agreements (SLAs) with CHAM. The overall reform process started in 2002 when the government developed the Poverty and Reduction Strategy, which acknowledged that an improved health system could help increase productivity and lift people out of poverty (GoM 2002). In addition, adoption of the health SWAp in 2004 as a platform for joint planning and implementation of programs in the health sector enabled the government to adequately implement the EHRP and SLAs. These two strategies were implemented as part of the broader Programme of Work,⁸ which had seven components: Human Resources, Pharmaceutical and Medical Supplies, Essential Basic Equipment, Infrastructure/Facilities Development, Routine Operations at Service Delivery Level, Systems Support, and Development – Non-District-Level Operations.

The EHRP and SLA strategies were given priority due to the crisis the country faced at the time, that is, a huge shortage of health workers and a limited number of public health facilities, particularly in rural areas. This was conceived out of government recognition that the EHP could not provide effective coverage until the supply-side infrastructure was strengthened. For instance, Scheil-Adlung, Behrendt, and Wong (2015) observe that shortages of health workers weaken the health system and hinder the achievement of UHC. Health worker shortages also have a negative impact on socioeconomic development, especially in poor countries where they act as drivers of health inequities (Scheil-Adlung, Behrendt, and Wong 2015).

To address this problem, the Global Health Workforce Alliance observes that investment in the health workforce improves synergies with education, facilitates decent employment in the formal sector, and contributes to economic growth (WHO 2016). For example, investing in midwifery education alone can yield a 16-fold return on investment in terms of lives saved and costs of caesarean sections avoided (UNFPA 2014). Based on this evidence, the importance of an adequately staffed health workforce with the right mix of medical personnel to improving health service coverage and health outcomes cannot be overemphasized. However, success depends on strong political and technical leadership (WHO 2013). Countries that have shown progress in improving availability, accessibility, acceptability, and quality dimensions of the health workforce have strong political commitment (WHO 2013).

Emergency Human Resources Programme

The Government of Malawi in the early 2000s strove to take unprecedented steps to address the massive health worker shortage. The MoH did a global search for examples of countries that implemented the type of large-scale, comprehensive human resources for health (HRH)

reforms they aimed to achieve. However, many examples focused on single initiatives, and few consisted of employing an extensive set of incentive programs to attract and retain health workers in the public sector. After drawing lessons from Cameroon, Indonesia, Rwanda, and Tanzania the government launched the Emergency Human Resources Programme (EHRP). The EHRP (2004–10) was a six-year strategy that sought to increase the number of health workers from 5,453 in 2004 to 10,543 in 2010, an increase of 93 percent (MSH and MSC 2010).

In partnership with key development partners, the program focused on the recruitment, training, deployment, and retention of 11 health cadres including physicians, nurses (including midwives), clinical officers, and medical technicians. The cadres were identified through a consultative process between the MoH and local training schools and professional associations. The program itself consisted of five main elements, as outlined in table 2.

Table 2: The Five Main Elements of the Emergency Human Resources Programme

Element 1: Staff Incentives	Improving incentives for recruitment and retention of Malawian staff in government and mission hospitals through a 52% taxed salary top-up for 11 professional cadres, coupled with a major initiative for recruitment and reengagement of qualified Malawian staff
Element 2: Expanded Training	Expanding domestic training capacity by over 50% overall, including doubling the number of nurses and tripling the number of doctors and clinical officers in training
Element 3: International Volunteers	Using international volunteer doctors and nurse tutors as a stopgap measure to fill critical posts while Malawians were being trained
Element 4: Ministry of Health Human Resources Capacity	Providing international technical assistance to bolster capacity and build skills within the Ministry of Health’s human resources planning, management, and development functions
Element 5: Human Resources Monitoring and Evaluation Capacity	Establishing robust monitoring and evaluation capacity for human resources in the health sector

Source: MSH and MSC 2010.

The first two elements eventually made the largest contribution to increasing the number of trained health workers and staffing levels. The goal of Element 1 was to increase the recruitment and retention of health workers at government and mission hospitals through the provision of attractive incentive packages (that is, salary top-ups) to graduates, in-service, and health workers willing to be reengaged. The goal of Element 2 was to increase the number of graduates at four main training institutions by increasing the number of trainees and training capacity. It was anticipated that the number of graduates would increase by 50 percent of the training output in 2004.

Element 3 had no specific targets set at the start of the program. It essentially was planned as a stopgap measure while local health worker capacity was being bolstered. Under Element 4, three consultants were recruited to provide long-term technical assistance to help implement the EHRP. Finally, Element 5 aimed at establishing a robust monitoring and evaluation system for tracking human resources in the health sector. However, there was no clear plan for this element at the start of implementation.

The EHRP had a formal governance structure and implementation of the program was under the responsibility of the MoH. Within the MoH, the Health Sector Working Group took the lead as the overall coordinating body. Member of the Health Sector Working Group included the MoH and other ministries and departments, training institutions, regulatory bodies, research institutions, community service organizations, the private sector, and CHAM. The Health Sector Working Group was the natural choice to implement and manage the EHRP because it could provide joint planning, coordination, and financing arrangement for activities. Centering activities at the Health Sector Working Group allowed the program to avoid duplication of efforts and avoid concentrating resources or provision of activities in any specific regions or districts. In addition, the EHRP was monitored by a technical working group through the SWAp.

Memorandum of Understanding between the Government of Malawi and CHAM

Health facilities owned by the Government of Malawi do not fully cover the entire country. This was the case in the early 2000s, and is still the case. Distribution of major health facilities⁹ in 2002 shows that the government owned 69 percent of the major health facilities in the country while CHAM owned 29 percent. With the bulk of the free public health facilities located in urban areas, access to health services for poor people in rural areas has been a challenge.

In December 2002, the government signed a memorandum of understanding (MoU) with CHAM that outlined CHAM's role in complementing the government's efforts to address the HRH crisis, and reducing physical and financial barriers to access. The MoU stipulated the government's support to HRH training at CHAM training institutions, provision of staff salaries (and other personal emoluments) to all members of staff at CHAM training institutions and health facilities, and financial support for service delivery through SLAs (GoM and CHAM 2002). In particular, since 2006, District Health Offices (DHOs) have been entering into SLAs with CHAM health facilities for the provision of free maternal and child health services. This is because CHAM health facilities charge user fees for health services they provide and this is problematic for the largely poor clientele they serve.

The partnership between MoH and CHAM is justifiable and innovative because CHAM has a substantial effect on the health of individuals and communities in Malawi, particularly in rural areas. In 2002, CHAM had 143 major health facilities (29 percent of the total number of health facilities in Malawi). By the end of 2014, CHAM's network of health facilities increased to 175 (37 percent of the total number of health facilities in Malawi¹⁰), which includes 40 hospitals, 12 of which serve as training colleges and provide training in clinical medicine, mental health, and nursing and midwifery. With a catchment population of 6,546,807 people in 2014, CHAM health facilities serve approximately 40 percent of Malawi's population.

Moreover, considering that 85 percent of Malawi's population is rural and that CHAM health facilities are predominantly located in rural areas, it is estimated that CHAM provides up to 75 percent of health services in rural areas.¹¹ And though 59 percent of CHAM health facilities are located beyond 8 kilometers of the nearest health facility, they are the closest and only health facilities available to the people in most parts of the rural areas in Malawi. This makes them critically important for extending population coverage in remote and underserved areas. In fact, as part of the requirements for entering into an SLA with the government, the distance between nonpaying health facilities should be at least 7 kilometers.¹²

With regard to human resources training and service delivery, CHAM graduates 80 percent of Malawi’s midlevel health care professionals, most of whose fees are paid through scholarship programs provided by the Government of Malawi.¹³ CHAM health facilities are more likely to have the majority of the 14 essential medicines in stock than health facilities managed by the government and other authorities (MoH and ICF 2014). Health facilities managed by CHAM are also more likely to offer quality prenatal care services¹⁴ and provide various diagnostic tests than facilities managed by government and other authorities (MoH and ICF 2014). Table 3 shows population coverage and service provision at government, CHAM, and other health facilities in Malawi.

Table 3: Population Coverage and Service Provision, Malawi 2013/14

	Government	CHAM	Others
Share of Major Health Facilities ^{a*}	69%	29%	2%
Catchment Population (2015) ^{**}	16,310,431 ^c	6,546,807 ^{***}	
Percentage of Health Facilities Offering all Basic Prenatal Care Services	85%	91%	26%
Percentage of Health Facilities Offering all three Basic Child Health Services (growth monitoring, vaccination, and child curative care)	91%	93%	30%
Percentages of Facilities with Equipment for High-Level Disinfection ^b	55%	74%	62%

Sources: All figures from Malawi Service Provision Assessment 2013–14 except for *MoH (2016), and **CSO 2010 population projections, and ***CHAM Secretariat.

Note: a. This only includes hospitals, health centers, and clinics. Small facilities such as dispensaries, rehabilitation centers, voluntary counselling centers, and so forth, are not included. b. Availability of an electric pot or other pot with heat source for high-level disinfection by boiling or steaming, chlorine, formaldehyde, CIDEX, or glutaraldehyde for high-level chemical disinfection. c. Represents the total population in Malawi in 2015.

In general, the MoU between MoH and CHAM has achieved the following: (a) formalization of working relationships between the government and CHAM, (b) cushioning the financing gap at the CHAM Secretariat through the payment of salaries and other personnel emoluments for health workers at all CHAM training institutions and health facilities, (c) increasing the training output for health workers, (d) increasing the number of health workers in-post, and (e) reducing physical and financial barriers to access through SLAs. These factors have in turn contributed to increased access to health services and improved population coverage. Notwithstanding the above, the eligibility criteria for CHAM health facilities and entitlement to staff salary grants were unclear in the 2002 MoU (Sesani and Gunneweg 2016). This led to some CHAM facilities receiving unjustified financial support for their services, and perpetuation of inequalities in access to essential health services (Sesani and Gunneweg 2016). To address this problem, a new MoU was signed in January 2016 and came into effect on July 1, 2016.¹⁵

CHAM Service Level Agreements

The first set of service level agreements (SLAs) was signed in 2006. SLAs did not automatically apply to all CHAM facilities as each of the 28 DHOs was given the mandate to decide whether the government should contract with CHAM facilities in their area. In order to make this decision, a prescribed set of criteria needed to be met. First, the DHOs would conduct a situation analysis of health service coverage in the district and determine areas without a

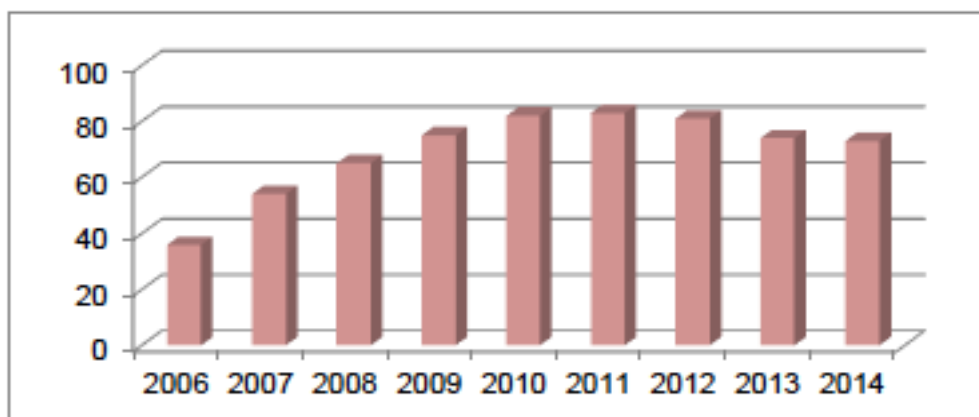
public health facility.¹⁶ Then, a CHAM facility would be considered for an SLA if there was:

- Unmet need for the services among the CHAM facility catchment population
- Lack of access to a government facility that provides free EHP services
- Lack of resources (for example, infrastructure, staffing) at government facilities such that the facility does not provide all EHP services
- Excess demand for services beyond the capacity of the government facility
- Capacity at a CHAM facility to fill the identified gap in the catchment area
- Willingness of the government and CHAM to enter into and commit to the SLA.

Once the assessment is done, the DHO would then negotiate the SLA with the local CHAM facility on an individual basis. In general, as part of the conditions for the SLA contract, the government would pay all staff costs, subsidize medications, and recoup operational costs. In return, CHAM facilities would not charge user fees for maternal and child health services. Note that for the vast majority of SLAs, the entire EHP was not free from user fees, but only maternal and child health services. Still, these SLAs allowed the government to extend part of their affordable care program to areas with no public health facility.

Before implementation, each CHAM facility would agree explicitly on the output to be delivered. Initially, each DHO would discuss the fees that the CHAM facility would charge the MoH on an individual basis. This was later replaced by standard costing and fees set by the CHAM secretariat and MoH that would cover the average cost of inputs per month. Thus, payments to CHAM facilities are based on performance. Figure 3 shows the number of CHAM facilities with SLAs between 2006 and 2014. The figure shows an increasing trend until 2012, when new guidelines for the SLAs were developed, leading to a slight reduction. By the end of 2014, 76 of the 175 CHAM facilities had SLAs.

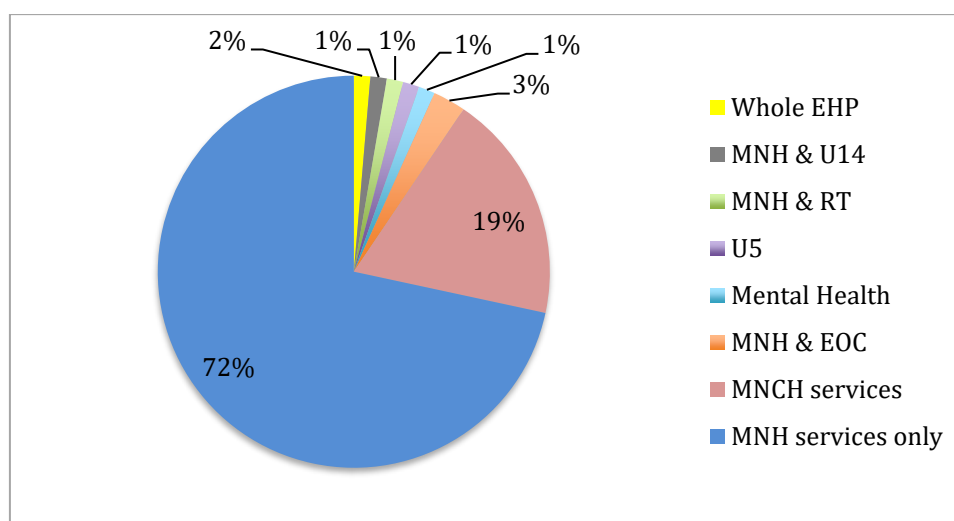
Figure 3: Number of CHAM Facilities with SLA, 2006–14



Source: Carlson and Zanardi 2014.

As mentioned, CHAM facilities with SLAs did not all cover the same types of services. They would individually negotiate with their DHO on what would be covered based on the disease burden of their community and the capacity of both the health facility and DHO. Figure 4 shows what types of services were covered by these SLA contracts.

Figure 4: Number of SLA Contracts with Specific Types of Contracts



Source: Based on Carlson and Zanardi 2014.

Note: EHP = Essential Health Care Package; EOC = Emergency Obstetric Care; MNCH = Maternal, Neonatal, and Child Health; MNH = Maternal and Neonatal Health; RT = Road Traffic Accidents; U5 = under-5; U14 = under-14.

Management of Funds in the HCPs

Emergency Human Resources Programme

Strong collaboration through the SWAp structures ensured that the EHRP was successfully implemented (MSH and MSC 2010). The SWAp also played a central role in funding the EHRP. The main sources of funding were the Government of Malawi and several development partners. All the elements of the EHRP were costed and funded through annual budgetary allocations. Spending on the EHRP increased steadily over the course of implementation (2004–09). The first two elements of the EHRP consumed the bulk of the funds for the EHRP, as shown in table 4.

Table 4: Overall Expenditures by EHRP Component (US\$)

EHRP Component	Amount Spent (US\$)	Percentage
Health worker incentives	34,267,840	35.8
Expanding domestic training capacity	53,347,861	55.8
International volunteers	6,378,802	6.
International technical assistance	1,479,977	1.5
Strengthening monitoring and evaluation capacity	112,529	0.1
TOTAL	95,587,009	

Source: MSH and MSC 2010.

CHAM Service Level Agreements

To meet the financial requirements of the SLAs, the Government of Malawi allocates resources to DHOs via annual budget allocations through the Ministry of Finance, Economic Planning and Development. This allocation is based on the population, number of facilities, and existing resources. It is not based on disease burden and poverty levels. However, the actual amounts disbursed to CHAM facilities on SLAs are based on outputs that are linked to the services provided. Each DHO enters into an SLA with each CHAM facility based on the criteria described earlier. The CHAM facility then provides the agreed upon health services for free, and then invoices the DHO on a monthly basis. Nearly half of the total expenditure at CHAM health facilities with SLAs is from MoH, 39 percent is from user fees, and the rest is from donor-funded disease projects and/or a variety of Christian organizations and benefactors.

Management of Information in the HCPs

Context in Malawi

The Health Management Information System (HMIS) is the major source of secondary data used to monitor and evaluate key indicators for the SLAs and EHRP. Prior to 1999, most government and CHAM health facilities did not adequately collect, share, and use information required for evidence-based decision making. The five-year National Health Plan of Malawi (1999–2004) identified the need to strengthen the country's health information systems. This prompted the establishment of an HMIS to provide data on preventive, promotive, curative, and rehabilitative health services. A Health Management Information Unit was also established at the MoH to coordinate and manage this system. To date, information is regularly disseminated through bulletins and annual reports. However, there are challenges with data collection, management, and use. The root cause of these challenges is lack of adequate and skilled personnel to carry out data collection, analysis, and dissemination, and inadequate financial resources for managers to act on issues identified.

Emergency Human Resources Programme

To track implementation, MoH would consolidate data relevant to the EHRP from the HMIS. Moreover, the key highlights would be incorporated into the Annual Economic Report prepared by the Ministry of Finance and Economic Planning and presented to Parliament. A final independent evaluation report for the EHRP was carried out in 2010/11 and the recommendations informed the formulation of the Health Sector Strategic Plan (2011–2016).

CHAM Service Level Agreements

MoH and the CHAM secretariat engage in joint quarterly monitoring and evaluation visits to CHAM facilities to monitor implementation of the SLAs. This involves matching claims with actual level of services provided and compliance with pre-agreed prices; tracking availability, performance of health workers, and numbers getting paid; utilization of health services; payments to CHAM providers; and overall program implementation. Independent bodies are also used to conduct independent evaluations, which consistently update the MoH and CHAM on the cost-effectiveness of SLAs.

At the district level, Local Assemblies undertake monthly supervision visits using a standardized supervision checklist. They subsequently compile and send the results to the MoH and CHAM secretariat via quarterly supervision reports. The Health Committee of the Local Assembly meets biannually to discuss issues arising from these reports, as well as other issues related to implementation of SLAs. At the facility level, the Health Sub-Committee of the Area Development Committee oversees the establishment, management, and monitoring of SLAs. This committee reports to the Area Development Committee, which in turn reports to the Health Committee of the Local Assembly.

Contribution of the HCPs to Improved Service Delivery

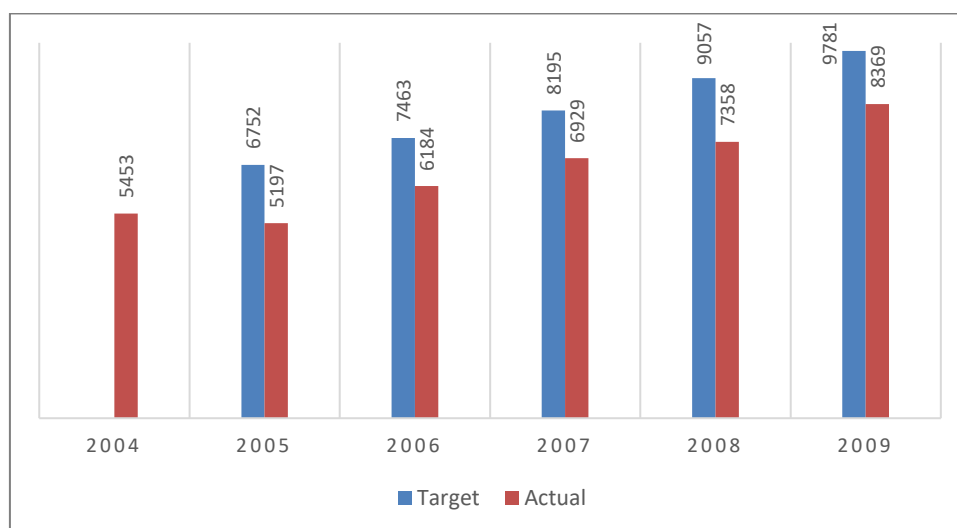
Emergency Human Resources Programme

The EHRP made a positive contribution to addressing the health workforce crisis the country faced in the early 2000s. In addition, the EHRP set up the basic supply-side framework needed to meet EHP requirements, and advancement toward UHC. This section focuses on Elements 1 and 2, since they made the biggest contribution to improving the HRH situation in Malawi.

Element 1: Improving Incentives for Recruitment and Retention of Health Workers

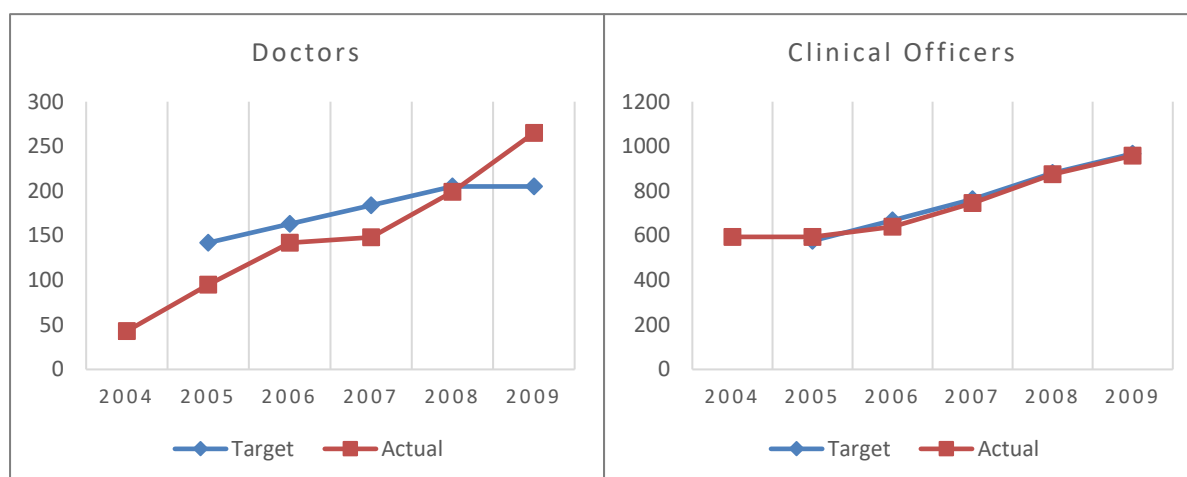
In 2004, Malawi had 5,453 health workers across the 11 cadres targeted by the EHRP. Element 1 of the EHRP aimed at increasing the total number of health workers in-post to 9,781 by 2009 (representing a 79 percent increase), and to 10,543 by 2010 (representing a 93 percent overall increase). Review of the EHRP in 2010 showed an overall increase in the total number of health workers in-post by 53 percent, which was less than the target of 79 percent in 2009. Figure 5 reveals a consistent increase in the actual number of health workers in-post, but less than the targeted numbers for each year. However, a breakdown of the health workers by cadre (figure 6) shows that the annual target for doctors was met in 2009, while that of clinical officers was met in 2005, but missed slightly in the subsequent years. This suggests that the annual targets for the other health cadres (nurses, midwives, and paramedics) were not fully met.

Figure 5: Targeted and Actual Staffing Levels at MoH and CHAM Facilities



Source: Based on MSH and MSC (2010).

Figure 6: Health Workers In-Post by Cadre, MoH and CHAM Facilities



Source: Based on MSH and MSC 2010.

Element 2: Expanding Domestic Training Capacity

The objective of Element 2 was to increase the number of students graduating from four training institutions: the Malawi College of Health Sciences, Kamuzu College of Nursing, the College of Medicine, and the network of nine CHAM training institutions (Ekwendeni, Holy Family, Malamulo, Mulanje, Nkhoma, St. John, St. Luke, St. Joseph, and Trinity). To accomplish this goal, the government and development partners provided scholarships to students, and rehabilitated infrastructure at the targeted institutions. In addition, funding was provided to Malawi's health regulatory bodies (the Nurses and Midwives Council, Medical Council, and Pharmacy and Poisons Board) to scale-up inspectorate and certification activities. Funding was also provided to DHOs to train Health Surveillance Assistants on the job.

The total number of graduates from all the targeted training institutions increased from 917 in 2004 to 1,245 in 2009, an increase of 36 percent (table 5). This is below the overall target of a 50 percent expansion for all health cadres, doubling the number of nurses, and tripling the number of doctors and clinical officers by 2010. However, increasing the training output of doctors by 72 percent, clinical officers by 100 percent, and paramedics by 45 percent between 2004 and 2009 was commendable. However, cessation of payment of student fees by the government in 2009 caused a drop in training outputs for all health cadres in 2009 except for Clinical Officers. Other challenges faced during implementation include the lack of adequate teaching space and accommodation, and a shortage of tutors.

Table 5: Number and Percentage of Graduates, 2004–09

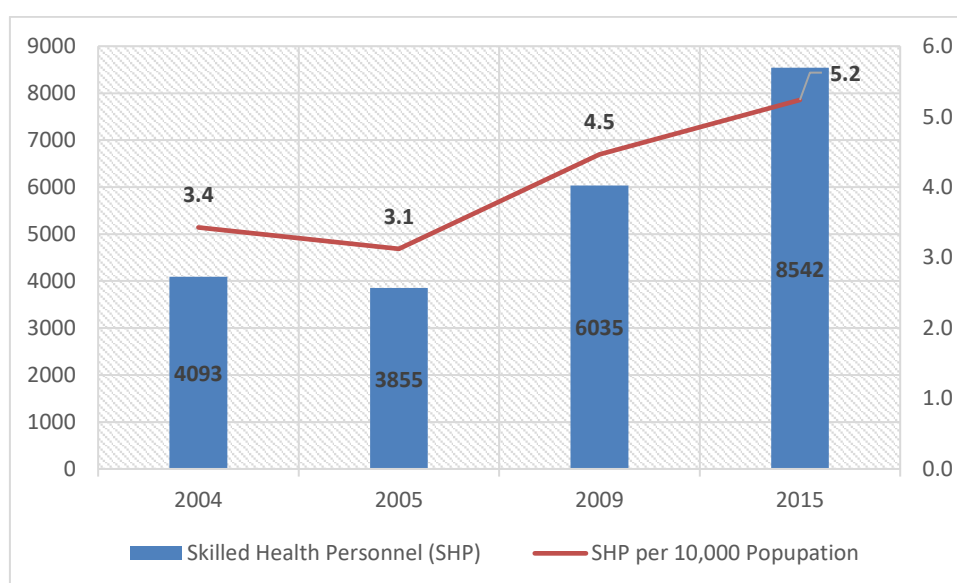
	2004	2005	2006	2007	2008	2009	% Change
Doctors	18	13	25	40	46	31	72
Clinical Officers	80	87	112	112	91	160	100
Nurse and Midwives	575	611	599	668	703	699	22
Paramedics	244	212	288	250	297	355	45
Total	917	923	1,024	1,070	1,137	1,245	36

Source: Based on MSH and MSC 2010.

Overall Contribution of the EHRP

The total number of health workers working at MoH and CHAM health facilities increased by 53 percent between 2004 and 2009 when the EHRP was being implemented. Migration of nurses to foreign countries also dropped from an annual average of 108 to 16 in 2009 (MSH and MSC 2010). Since expiration of the EHRP in 2010, successive HRH strategic plans have been implemented. These plans have further escalated the gains, as demonstrated in figure 7. The density of skilled health providers increased from 3.4 health workers per 10,000 population in 2004 to 5.2 health workers per 10,000 population in 2015. It is evident that the EHRP provided the foundation for addressing the HRH crisis in Malawi, and advancement toward UHC as demonstrated through the continued increase in the density of skilled health providers (doctors, nurses, midwives, and clinical officers).

Figure 7: Availability of Skilled Health Providers, Malawi, 2004–15



Source: Author based on MoH and CHAM data.

CHAM Service Level Agreements

CHAM health facilities are extremely important entities for the advancement of UHC in Malawi. Through SLAs, the government has been able to extend free coverage for maternal and child health services in remote and hard-to-reach rural areas where only CHAM health facilities are available. This subsection highlights the contribution of the SLAs to increasing population coverage, utilization of services, and financial protection.

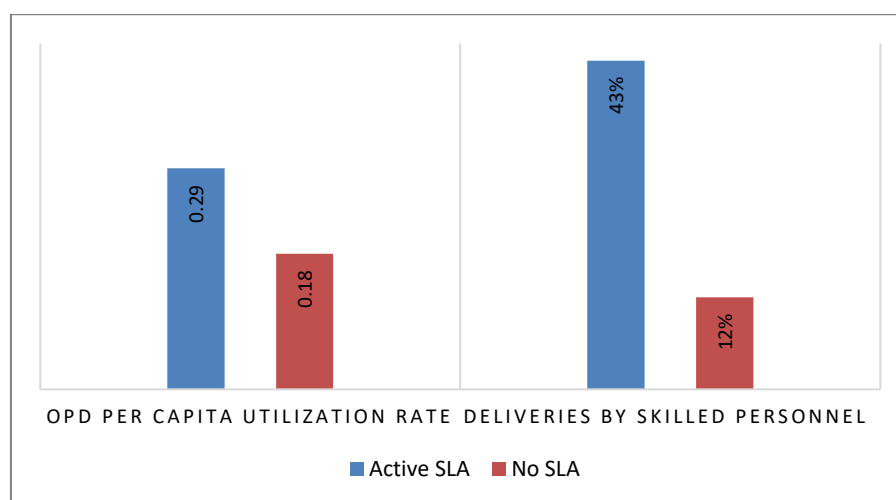
Population and services covered

SLAs have been associated with improved utilization of health services. This is evident from a series of studies commissioned by the Ministry of Health, the College of Medicine, and other partners. A more recent study by Chirwa et al. (2013) observes that SLAs have the potential to improve health and UHC, particularly for vulnerable and underserved populations. Using data from the CHAM Secretariat and the Ministry of Health, we observe that 76 of the existing 175 CHAM health facilities had active SLAs by the end of 2014. This represents a catchment population of 2,629,039 for CHAM health facilities with SLAs compared to a catchment

population of 3,917,768 for CHAM health facilities without SLAs. CHAM health facilities with SLAs represent 16 percent of the total population of Malawi and 40 percent of the total CHAM health facilities catchment population. Despite the low catchment population for CHAM health facilities with SLAs, there is higher per capita utilization and delivery by trained health workers at CHAM health facilities with SLAs (figure 8). Another study also found huge increases in institutional deliveries ranging between 50 percent and 169 percent at a sample of CHAM health facilities pre- and post-SLA (Carlson and Zanardi 2014) (table 6).

Looking at these trends, we can conclude that SLAs have contributed to increased utilization of maternal health services, especially among the targeted poor. In financial terms, implementation of SLAs at the 76 health facilities estimated at MK 636 million per year in 2014, has been relatively cheaper than the provision of salaries and personal emoluments to all CHAM health facilities, estimated at MK 6.48 billion per year in 2014. Nationwide, comparison of results from the 2005 and 2011 integrated household surveys shows a reduction in the proportion of households reporting inadequate consumption of health care from 60.3 percent in 2005 to 32.7 percent in 2011 (figure 9). A further review of the results by income status shows a 27.1 percentage point reduction in the proportion of households reporting inadequate consumption of health care among the poorest 20 percent of the population compared to a 22.3 percentage point reduction among the richest 20 percent of the population. These improvements could be associated to the free health care policy, and to SLAs.

Figure 8: Utilization of Health Services, CHAM Health Facilities, 2013/14



Source: Author based on MoH and CHAM data.

Note: OPD = outpatient department.

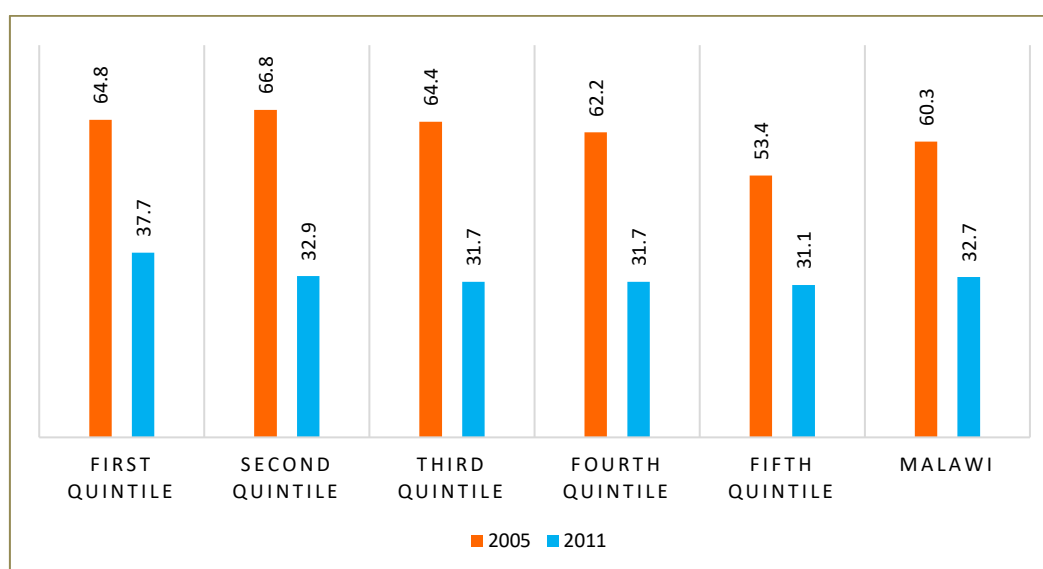
Table 6: Service Use in a Sample of Facilities Before and After the Start of SLAs

Facility	District	Monthly Deliveries before SLA	Monthly Deliveries (immediately) after Start of SLA	% Increase Due to SLA
Mzambazi Health Centre	Mzimba	22	33	50
Kankao Health Centre	Balaka	35	60	71
Mua Mission Hospital	Dedza	78	140	79

Facility	District	Monthly Deliveries before SLA	Monthly Deliveries (immediately) after Start of SLA	% Increase Due to SLA
Koche Health Centre	Mangochi	67	115	72
Malamulo Mission Hospital	Thyolo	49	132	169
Pirimiti Health Centre	Zomba	62	154	148

Source: Carlson and Zanardi 2014.

Figure 9: Proportion of Households Reporting Inadequate Consumption of Health Care



Source: NSO 2005, 2012.

Financial protection

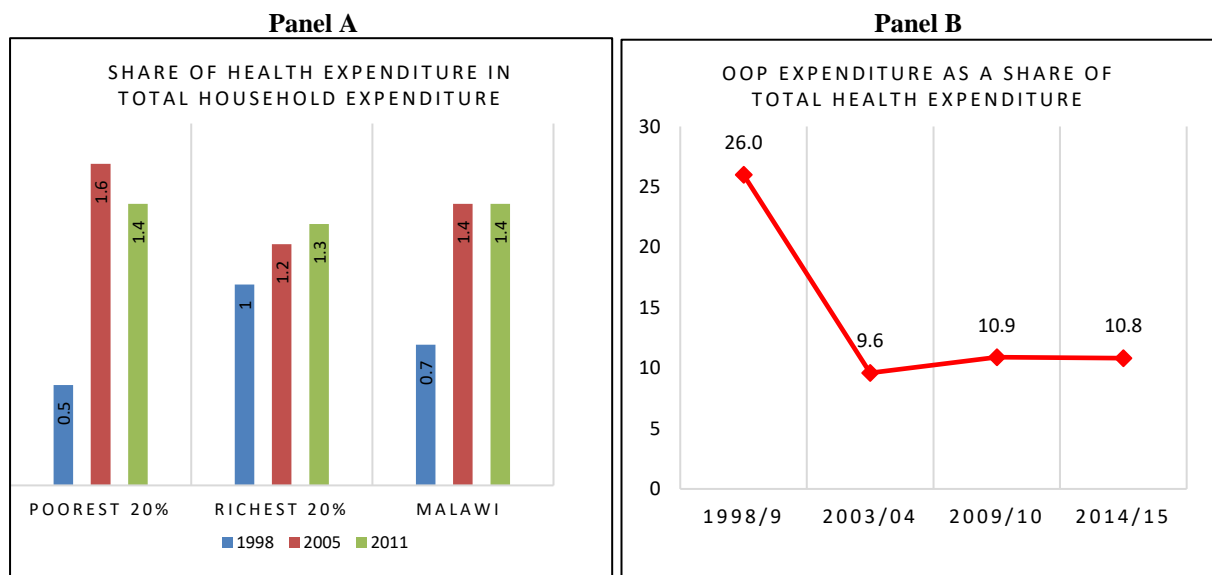
Between 1998 and 2011, household health expenditure as a percentage of total household expenditure increased from 0.4 percent in 1998 to 1.4 percent in 2005, and remained at 1.4 percent in 2011 (figure 10). Further analysis of household expenditure on health as a percentage of total household expenditure by income status shows a consistent increase among the richest 20 percent of the population, who spent 1.0 percent in 1998, 1.2 percent in 2005, and 1.3 percent in 2011. For the poorest 20 percent of the population, household health expenditure as a percentage of total household expenditure increased from 0.5 percent in 1998 to 1.6 percent in 2005, then declined to 1.4 percent in 2011 (figure 10). This suggests minimal or no relationship between socioeconomic status and health spending in Malawi by 2011 (NSO 2012).

Furthermore, there is a low burden of catastrophic health expenditure in Malawi, with only 2.5 percent of households spending over 10 percent of total household expenditures on health, and 0.1 percent spending 40 percent in 2011 (figure 11). In fact, the percentage of households spending over 10 percent of their total household expenditures on health declined from 8.9 percent to 2.5 percent, and the percentage spending 40 percent declined from 1.0 percent to 0.1 percent between 2005 and 2011. Furthermore, the 2011 figures for Malawi are lower than

neighboring Zambia (a lower-middle-income country), where 5.3 percent of households spend over 10 percent of their total household expenditures on health, and 1.1 percent spend over 40 percent (World Bank 2012b).

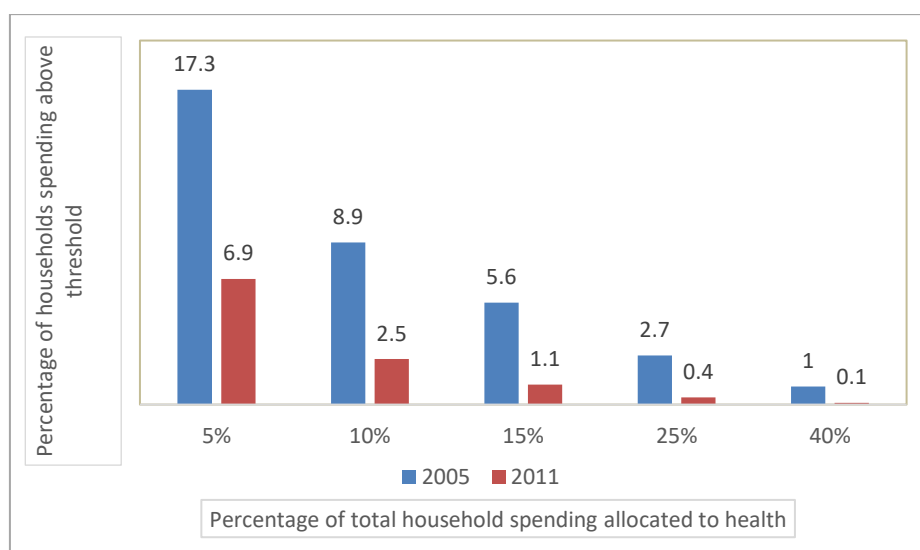
Some studies have concluded that SLAs have contributed to providing financial risk protection in Malawi through reduced OOP expenditure (Gama 2013). OOP expenditure was high during the 1990s, partially due to user fees at CHAM health facilities,¹⁷ and increasing use of private providers by households due to declining quality of care in public health facilities. However, the situation improved between 1998/99 and 2003/04, when OOP expenditure on health as a percentage of total health expenditure declined by 63 percent, and remained at around 10.4 percent on average between 2003/04 and 2014/15 (figure 10). With OOP expenditure on health at around 10.4 percent of total health expenditure on average between 2003/04 and 2014/15, Malawi has one of the lowest OOP expenditures on health compared to 26 percent on average among a pool of 11 comparator countries in Sub-Saharan Africa.¹⁸

Figure 10: Shares of Health Expenditures



Sources: MoH 2001, 2007, 2014, 2016; NSO 2012.

Figure 11: Incidence of Catastrophic Out-of-Pocket Spending



Sources: World Bank 2012a, 2013.

The sustained low level of OOP expenditure and low incidence of catastrophic OOP spending in Malawi could be attributed to the policy of free health care, and to SLAs. However, the government has been implementing a number of reforms since the mid-2000s, and these could also have had an effect. This includes a large inflow of donor funds in 2004/05, when Malawi adopted the health SWAp. Donor funding as a percentage of total health expenditure increased from 30 percent in 1998/99 to 60 percent in 2004/05. During 2009/10–2014/15, donor contribution was on average 63 percent of total health expenditure per year (MoH 2014, 2016). Implementation of the EHRP contributed to the availability of health workers in public health facilities, which could have induced an increase in perceived quality and utilization of health services in public health facilities rather than costly private health facilities.

Despite the reduced OOP expenditure and low incidence of catastrophic OOP spending, there is evidence indicating that some proportion of the population foregoes health care for financial reasons. For example, of those who did not seek care at a health facility, about 2 percent indicated they had no money for transport and/or to pay for treatment (NSO 2012). Another study observes that unofficial fees are being charged at public health facilities, especially at district hospitals and health centers (MoH 2014). Furthermore, review of OOP expenditure by disease shows an increasing trend in OOP spending on Malaria (MoH 2014), a major concern because Malaria is among the top 10 leading causes of years of life lost in Malawi (GDB collaborators, 2016).

In addition, despite the low burden of catastrophic health expenditure in Malawi, Mchenga, Chirwa, and Chiwaula (2017) suggest that households residing in rural areas, and those with middle-income status, have a higher risk of encountering catastrophic health expenditure. Gaps in financial protection are mainly triggered by supply-side access barriers in the public health sector such as shortages of medicines, lack of emergency services, shortage of health personnel, poor health worker attitudes, distance and transportation difficulties, and perceived poor quality of health services (Abihiro, Mbera, and Allegri 2014). Gama (2013) also concludes that SLAs have contributed to improving access to maternal and child health services and reduced financial risk, but there is little evidence of meaningful improvement in quality and efficiency.

Pending Agenda

Based on the above, it is fair to suggest that the EHRP and the government's partnership with CHAM through SLAs has been fruitful. In particular, HRH training, recruitment, and staff in-post have increased, while supply-side interventions through the SLAs with CHAM have contributed to increased population coverage, utilization of health services, and financial protection in remote and underserved areas. Despite the successes, there are challenges with the implementation of the EHRP and SLAs.

For the EHRP, key challenges are on how to sustain the gains made during the reform. For instance, the main driver for attracting and retaining health workers was through salary top-ups, and scholarships for the 11 targeted health cadres, but the government has reduced and/or stopped providing these benefits. As seen in 2009, the cessation of payment of student fees by the Government of Malawi caused a drop-in enrolments in the training institutions. While the government still sponsors students at CHAM training institutions, provisions of the 2016 MoU for 60 percent of the funded graduates to be deployed in the public sector should be adhered to (GoM and CHAM 2016). Notwithstanding the challenges, the EHRP provided a sustainable framework for addressing the HRH crisis in Malawi. After its expiration in 2010, successive HRH strategic plans have been implemented aimed at sustaining and scaling up the gains.

The major challenges with regard to SLAs include late payment of bills, lack of transparency, poor communication, and lack of systems to monitor SLA and health worker performance (Chirwa et al. 2013). A study by Tambulasi (2014) reveals that MoH is often accused of delaying payments to CHAM providers. By March 2016, unpaid SLA invoices were valued at MK 400 million. To address these challenges, institutional arrangements between the government and CHAM were revised through a new MoU that was effected on July 1, 2016. The 2016 MoU stresses the need for increased transparency and accountability, aimed at further strengthening the relationship between the government and CHAM toward the achievement of UHC. In particular, more SLAs will be signed to reach the desired target, while government is determined to honor its obligation.

In conclusion, though the country still faces several challenges, this case study demonstrates how a low-income country with severe service delivery and financial challenges is still able to make significant progress toward achieving UHC. By implementing innovative and unprecedented service delivery reforms, Malawi has expanded access to its largely rural and poor population, and charted a path forward toward UHC.

Notes

¹ The population growth rate was 3.3 percent per year between 1999 and 2004.

² Other challenges were frequent stock-outs of medicines and medical supplies, inadequate equipment and infrastructure, inequitable health service coverage, low government financing, and fragmented donor support.

³ Statistics from World Development Indicators.

⁴ The demographic dividend is a temporary opportunity for accelerated economic growth that is made possible by a sustained decline in birth and deaths rates, which leads to an increase in the ratio of working-age population relative to young dependents.

⁵ World Development Indicators, GDP per capita (constant 2010 U.S. dollars).

⁶ Egypt, Ethiopia, Eritrea, Liberia, Madagascar, Malawi, Mozambique, Niger, Rwanda, Uganda, and Tanzania.

⁷ The other countries are Botswana, Ethiopia, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe.

⁸ The Programme of Work was implemented by the Ministry of Health with support from a number of donors, faith-based organizations, and other stakeholders through the health SWAp mechanism.

⁹ This only includes hospitals, health centers, and clinics. Small facilities such as dispensaries, rehabilitation centers, and voluntary counselling centers are not included.

¹⁰ <http://www.cham.org.mw/health-facilities.html>.

¹¹ <http://www.cham.org.mw/our-impact.html>.

¹² This was revised to 8 kilometers in the 2016 MoU.

¹³ <http://www.cham.org.mw/our-impact.html>.

¹⁴ Tests for hemoglobin, urine protein, urine glucose, blood grouping and rhesus factor, syphilis, and HIV conducted; essential medicines and tetanus toxoid vaccine for prenatal care available on the day of the assessment; and counselling on pregnancy-related warning signs provided.

¹⁵ The 2016 MoU stresses the need for transparency, accountability, and monitoring and evaluation, and adherence to national policies, guidelines, and standards. It is envisaged that the 2016 MoU will foster the relationship between the government and CHAM toward the achievement of universal health coverage in Malawi.

¹⁶ According to the 2002 MoU, the preconditions for a CHAM facility to be considered for an SLA were (a) the distance to the nearest facility is at least 7 kilometers in the case of health centers, and at least 20 kilometers in the case of hospitals; and (b) the facility has a catchment population of at least 7,000 in the case of health centers, and 25,000 in the case of hospitals. In the 2016 MoU, this was revised to (a) all accredited primary health care facilities outside 8 kilometers from a nonpaying public health facility taking into consideration the catchment population of 7,000 people or more, the terrain, and the services offered by the health facility; (b) accredited health facilities offering secondary and tertiary health services; and (c) accredited medical training schools.

¹⁷ This was disastrous to poor people residing in remote areas where CHAM health facilities are the only health providers available.

¹⁸ Angola, the Democratic Republic of Congo, Ghana, Kenya, Lesotho, Malawi, Mozambique, Uganda, Tanzania, Zambia, and Zimbabwe.

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The Universal Health Coverage (UHC) Studies Series was launched in 2013 to develop and share knowledge regarding pro-poor reforms seeking to advance UHC in developing countries. The Series recognizes that there are many policy alternatives to achieve UHC and therefore does not endorse a specific path or model.

The Series consists of country case studies and technical papers. The case studies employ a standardized approach aimed at understanding the tools –policies, instruments and institutions-used to expand health coverage across three dimensions: population, health services and affordability. The approach relies on a protocol involving around 300 questions structured to portray how countries are implementing UHC reforms in the following areas:

- **Progressive Universalism:** expanding coverage while ensuring that the poor and vulnerable are not left behind
- **Strategic Purchasing:** expanding the statutory benefits package and developing incentives for its effective delivery by health-care providers
- **Raising revenues** to finance health care in fiscally sustainable ways
- **Improving the availability and quality of health-care providers**
- **Strengthening accountability** to ensure the fulfillment of promises made between citizens, governments and health institutions

By 2017, the Series had published 24 country case studies and a book analyzing and comparing the initial 24 case studies. In 2018 the Series will publish 15 additional case studies. Links to the country case studies and the book are included below.

COUNTRY CASE STUDIES:

<http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series>

GOING UNIVERSAL (BOOK):

<http://www.worldbank.org/en/topic/universalhealthcoverage/publication/going-universal-how-24-countries-are-implementing-universal-health-coverage-reforms-from-bottom-up>



The Universal Health Coverage Study Series aims to provide UHC policy makers and implementers with knowledge about available and tested tools—policies, instruments and institutions—to expand health coverage in ways that are pro-poor, quality enhancing, provide financial risk protection and are fiscally sustainable.



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