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NOTICE OF MEETING

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MEETING: Project Review and ECPR Meetings

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DATE:	Feb. 14, 1984	DATE:	Feb. 17, 1984
TIME:	3:00 p.m.	TIME:	10:00 a.m.
PLACE:	Room 3676 N.S.	PLACE:	Room 6941 N.S.

AGENDA

Malawi: Health Institutions Development (612-0211)

Attachment
Field Review Team Report

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AFR/TR/ENG, J. Snead
AFR/TR/HN, C. Gurney
AFR/TR/POP, W. Bair
AFR/TR/SDP, M. Ward

Project Committee Members
AFR/PD/SAP: AHarding
AFR/DP: DWilson
GC/AFR: MAKleinjan

AFR/SA: LPompa
AFR/TR/HN: ACole
AFR/TR/POP: GGilbert

Field Review
of the

OFFICIAL PROJECT
DOCUMENT

M/TITUTIONS DEVELOPMENT PROJECT
(612-0211)

as proposed by

Howard University and Meharry Medical College

Review Team: Albert E Henn, MD, MPH
Barbara Kennedy, RN, MPH
Murl R Baker, USAID/Malawi

Submitted: February 1, 1984
In response to report of ECPR
Meeting of October 19, 1983.

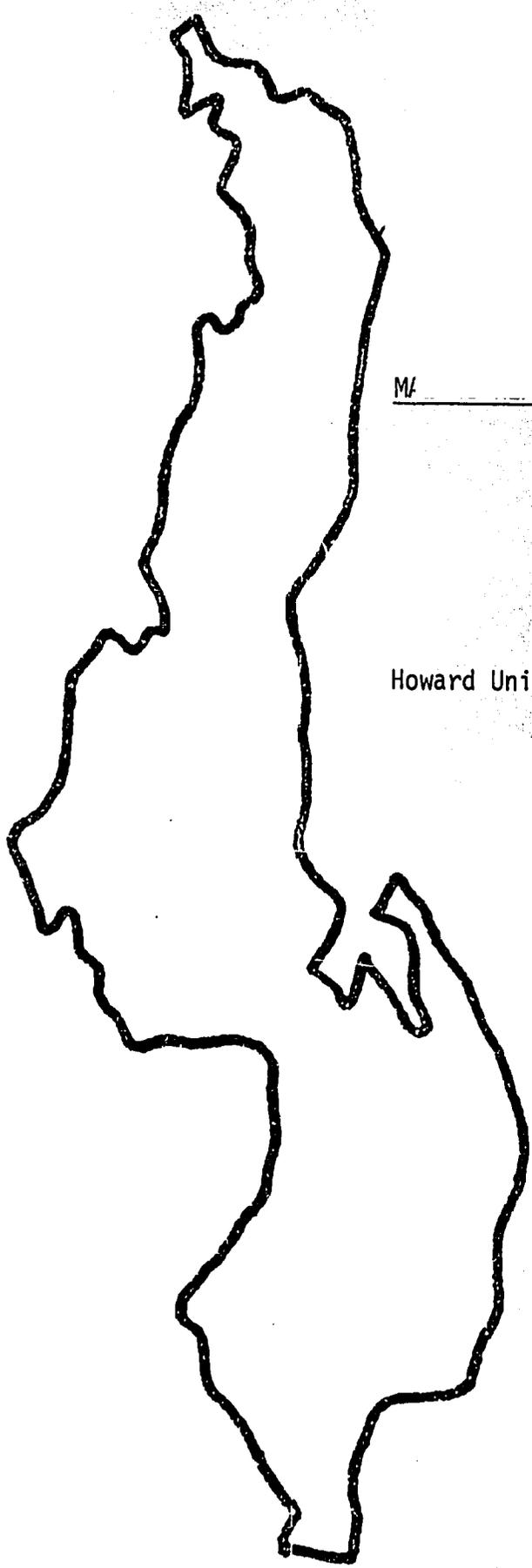


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I. Introduction

The investigation reported on by this document was occasioned by Executive Committee Project Review (ECPR) concerns raised during the consideration of an "unsolicited" health project proposal submitted by Howard and Meharry Universities and entitled "Malawi Health Institutions Development". The proposal describes a 5 year, \$7.5 million project designed to provide training for middle level health workers. The principal concerns of the ECPR relate to the fact that the proposal does not present an adequate description of the overall Malawi health sector context within which the proposed training project would be undertaken. With the limited information provided, it was impossible for the ECPR to determine whether the proposed project represented an appropriate health sector initiative for AID support.

The findings of this team derive from a thorough review of existing Malawi health sector documentation and a series of interviews with Malawian health officials, selected for their respective association with the proposed project. Complete listings of the documents reviewed and individuals contacted appear in the annexes to this report. We believe that the Bibliography annex contains the most comprehensive collection of recent, relevant health documents heretofore assembled in Malawi. It should serve as a basic reference for future health sector investigations here. Most of the documents cited are available at the Mission; the rest can be borrowed from the Ministry of Health.

The body of this report is organized to present the Malawi health sector context within which the project will take place. The content is organized to answer the questions in the ECPR cable of November 3, 1983 (State 314378) in approximately the same order in which they were posed. The report goes on to discuss the options open to AID to assist the Ministry of Health in implementing its Primary Health Care Plan. And it concludes by discussing specific issues related to the Howard/Meharry proposal, including the presentation of alternative approaches to dealing with the Project which AID might consider.

The members of this study team began our work confident that we would have no significant problems in determining and describing the Primary Health Care system context in Malawi, and we were puzzled that this had not been done in the proposal or by the prospective contractors who must have been present at the ECPR meeting. Our expectations proved realistic, and within three days of starting to work, we had assembled enough information to answer the questions left open by the proposal. However, our investigation has led us to a completely unexpected and exciting observation which has definite implications for AID support to the Malawi Primary Health Care effort.

The GOM is embarking upon a remarkable and innovative approach to Primary Health Care which truly represents "state-of-the-art" thinking in this area. The imaginative approach of the current Malawi PHC strategy is a radical departure from the Community Health

Worker -oriented approach that the rest of Third World is attempting with great difficulty. Instead it is a community-oriented approach which will be described in some detail in this report and which may not only prove effective in Malawi, but may also lead the rest of the developing countries to liberate themselves from the need to attempt a model of PHC services beyond their support capacity.

II. General Description of the Malawi Health System

A. Background

Malawi is a relatively small African country with a population estimated at 7.0 million. Its population density of approximately 68 per km² is among the highest in Africa. The combination of tropical climate, inadequate water and sanitation and rural poverty results in a pattern of causes of morbidity and mortality which is common to most of Sub-Saharan Africa. There is a relatively high prevalence of vector-borne and water-borne infections and parasitic diseases, often complicated by compromised nutrition. The leading causes of morbidity and mortality in Malawi, as reported in 1981, are presented in the table below.

Table 1 Leading Causes of Morbidity and Mortality, 1981

<u>Morbidity*</u>	<u>Mortality</u>
Malaria	Respiratory Infection
Diarrhea	Malaria
Respiratory Infection	Measles
Eye Disease	Malnutrition
Dental Disease	Anemia
Other Gastrointestinal Diseases	Diarrhea
Accidents	Unknown
Malnutrition	Perinatal Causes
Measles	TB
Hookworm and other worms	Tetanus

* Morbidity figures are based upon ages 0-4 only, but would not differ significantly from data for all ages.

Vital statistics on the Malawi population vary considerably, according to the source being used; however, the figures below are mostly those reported in the Country Assessment prepared in September 1983 for the Combatting Childhood Communicable Diseases (CCCD) Project. They appear to reflect the best collection of recent information and portray a child health status for the population which is slightly worse than that of neighboring countries.

Table 2 Benchmark Statistics, 1984

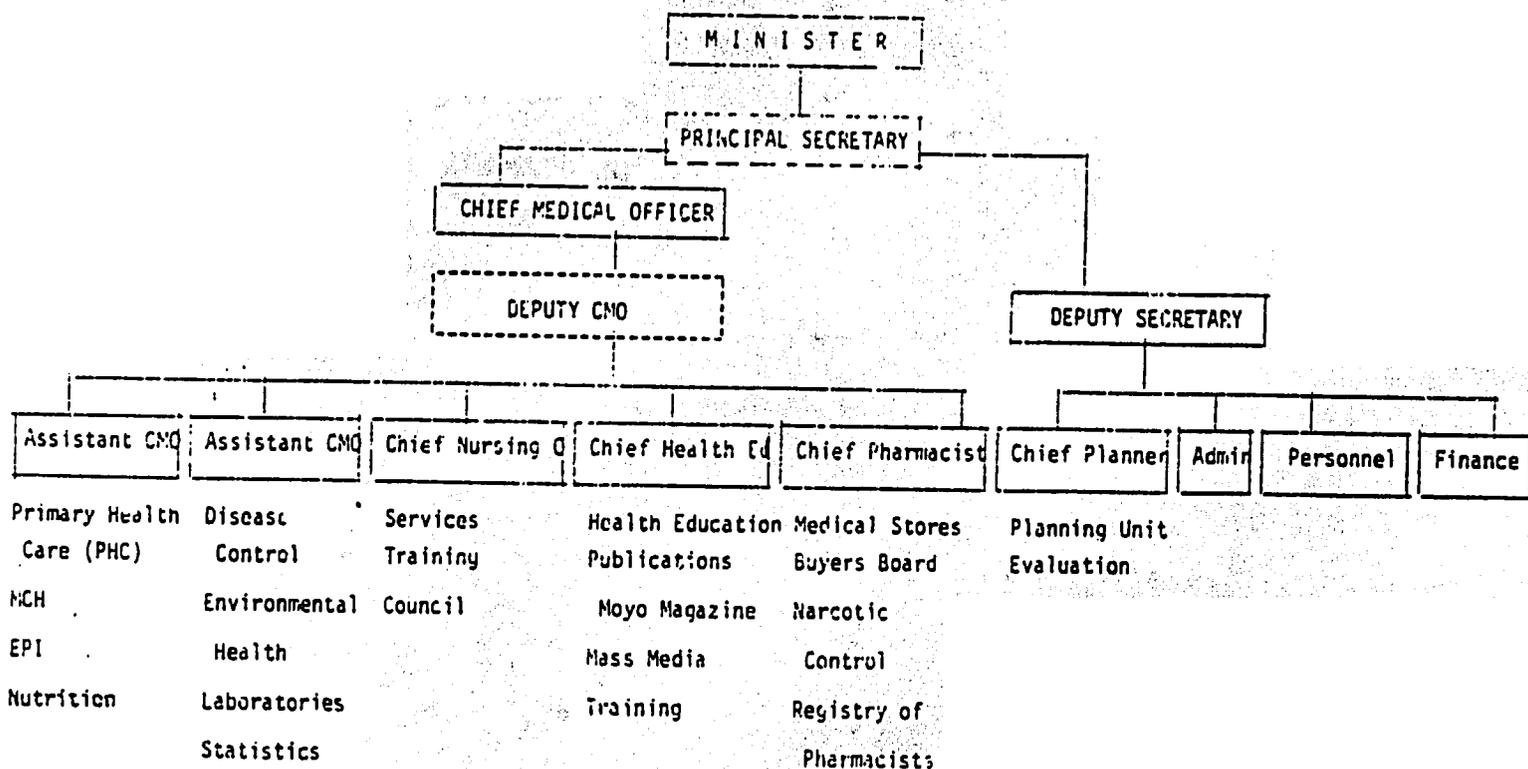
Population	7 million (1984 estimate)
Population Density	68 km ² (1984)
Total Fertility Rate	7.7
Population Growth Rate	2.9 percent annually
Infant Mortality	130-159 per 1000 births
Child Mortality	330 per 1000 children (0-5)
Life Expectancy	42.5 years (at birth)
Adult Literacy	36 percent (1984 estimate)
Rural Population	90 percent
Rural access to safe water	30 percent
Rural access to health services	80 percent

The health services delivery system developed by the Government of Malawi (GOM) has been jointly planned by the Ministry of Health (MOH) and a long succession of external collaborating institutions. There is extensive documentation which describes the evolution of health sector policies in Malawi and the reflection of these policies in the organization and development of the health services delivery system. These documents are cited in the Bibliography of this report.

B. Organization of MOH, Facilities and PHC Personnel

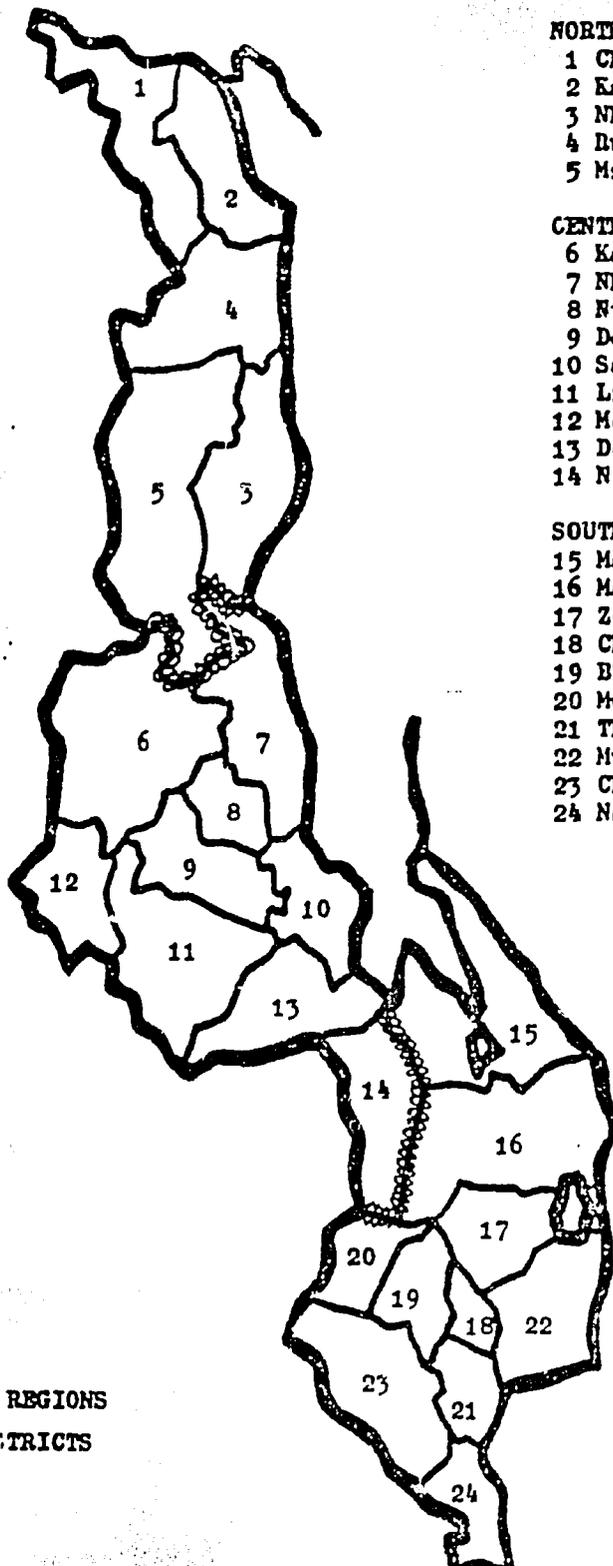
The health care services system is organized under the central direction of the Ministry of Health and is composed of a hierarchical, tiered system of facilities and personnel.

Table 3 Ministry of Health Organization*



*The organization of the MOH above represents the planned organization as of January 27, 1984. As the current planning exercise proceeds, further modifications can be expected.

For administrative purposes Malawi is divided into three regions and 24 districts. Because of the small number of districts, for most purposes the MOH is able to relate directly to the district officials, collaborating with the regional counterparts in working with the districts. The map below shows the location of these administrative units.



Region and District	1977 * Population ('000)
MALAWI	5547
NORTHERN REGION	648
1 Chitipa	72
2 Karonga	106
3 Nkhata Bay	105
4 Dumphu	62
5 Mzimba	301
CENTRAL REGION	2143
6 Kasungu	194
7 Nkhota Kota	94
8 Ntchisi	87
9 Deva	247
10 Salima	132
11 Lilongwe	704
12 Mchizji	158
13 Dedza	298
14 Ntchou	226
SOUTHERN REGION	2755
15 Mangochi	302
16 Machinga	341
17 Zomba	352
18 Chirodzulu	176
19 Blantyre	408
20 Mwanza	71
21 Thyolo	322
22 Mulanje	477
23 Chikwava	194
24 Nsanje	108

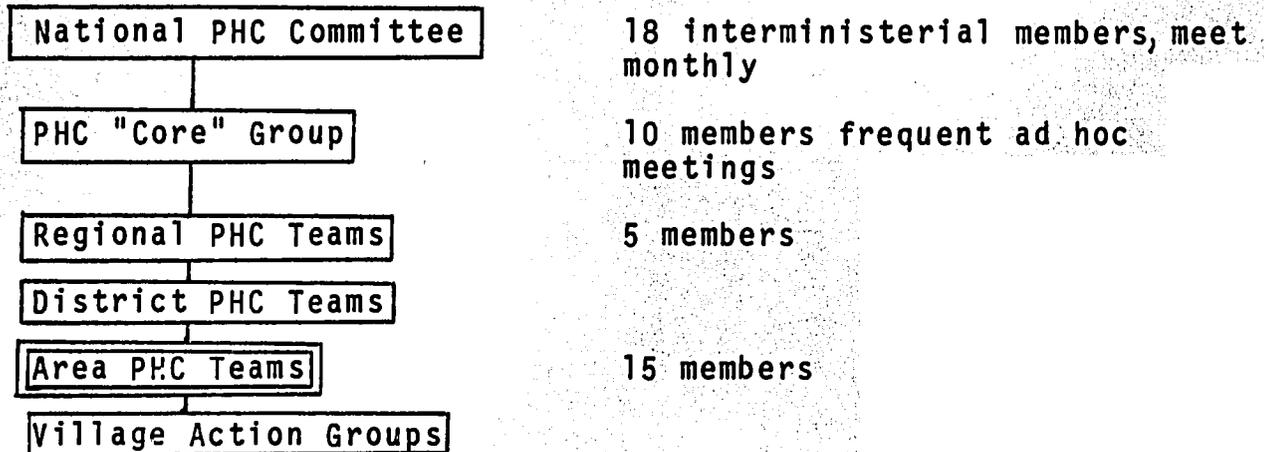
MALAWI REGIONS AND DISTRICTS

* 1984 population estimates are approximately 26% higher overall, with the greatest increases in urban areas.

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Also beginning at the ministry level and extending to the village level, there is a Primary Health Care coordination network organized as follows:

Table 4 Primary Health Care Coordination Network

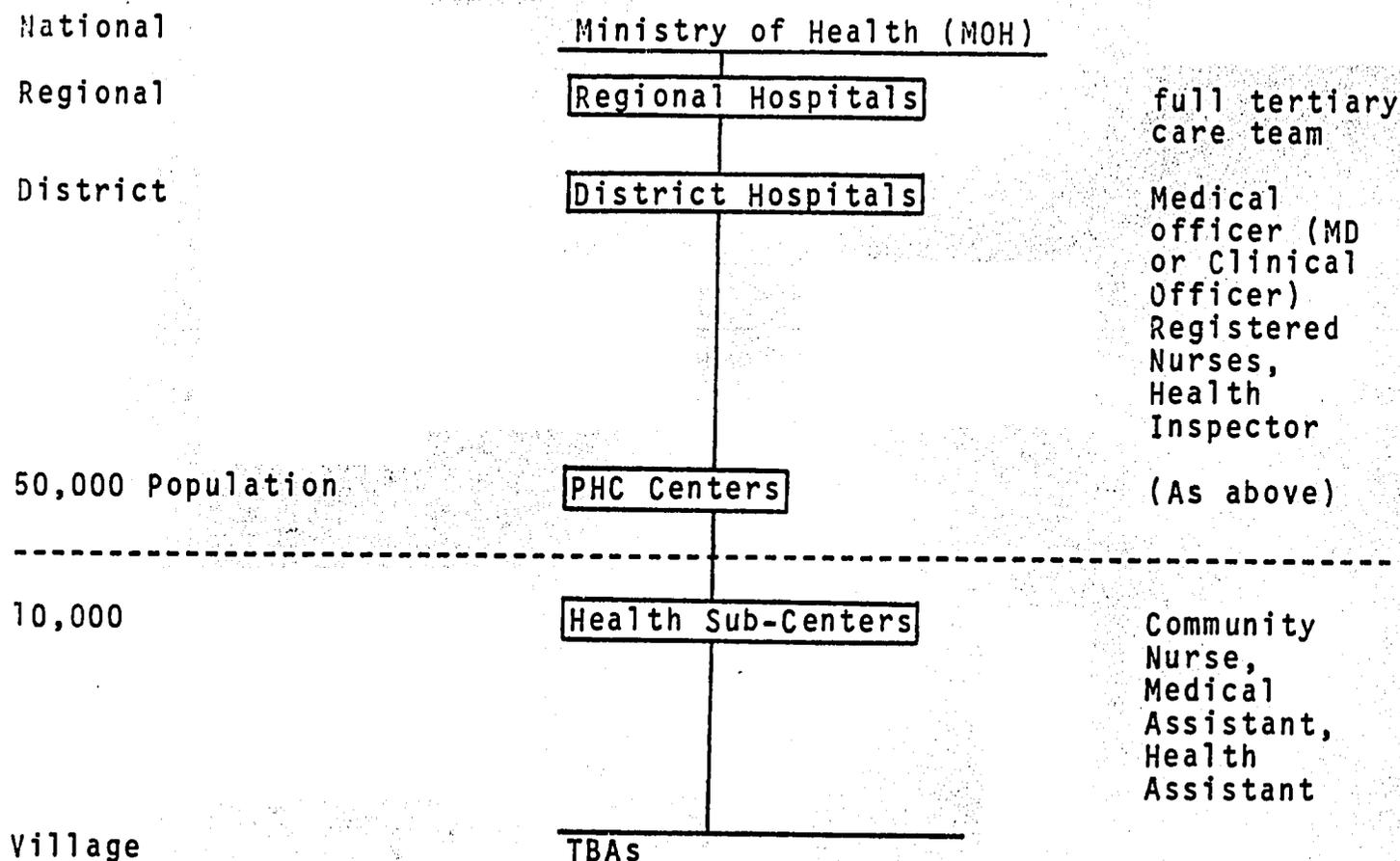


The underlying strategy of the current PHC plan is that PHC be undertaken, not as an activity of the MOH, but as an integrated element of the general approach to development at the community level. The key level of GOM employees to be working in this PHC system is the Area PHC Team Level. These teams will each service a collection of villages having an aggregate population of approximately 10,000 and will be composed of all those government employees now providing various types of development support to villagers, i.e. school teachers, agriculture extension agents, Community Development Assistants, Community Nurses, Medical Assistants and Health Assistants. It is hoped that the AID-supported project will train the MOH representatives to this middle-level "change agent" team: the Community Nurses, the Medical Assistants and the Health Assistants. It is these individuals who will do much to stimulate their colleagues from other development sectors to participate in PHC activities as essential to an integrated approach to community development.

The existing organization of health services facilities and personnel derives from the MOH's "basic health services" approach to sector development, as outlined in Section IV of this report. The diagram below does not include vertical programs or support systems such as training and logistics support, but presents the hierarchical system of services facilities and their respective staffing. Training institutions are presented in Section VI.

Table 5

Health Care Facilities and Personnel



Note that at the present time there are no health posts or community health workers at the village level. The only health worker who is part of the GOM system in the villages is the TBA and nearly 400 of these in Malawi have received training for their role in the system. There are also an estimated 5000 traditional healers in the villages of Malawi. At this time they are not integrated into the health service system, but they do represent an active part of the existing life-support system at the community level and will be either strengthened or de-emphasized in the future, in accordance with the local analyses Village Action Groups undertake.

Beginning in 1981, there was an experiment with training Primary Health Workers (PHW) and establishing separate Village Health Committees. This experiment did not work well and the 30 PHWs trained have been retrained to join the Health Surveillance Assistants who function at the area level (indicated by the dotted line above). The difficulties with implementing the classic PHC model in Malawi have led to the innovative approach to be defined in Section IV. However, most of the the documentation available in Malawi refers to the classic model, and there is repeated reference to the training of PHWS and the establishment of Village Health Committees. That neither the old model nor the new approach, which was just being designed at the time of the last Howard-Meharry design visit, appear in the proposal remains a mystery.

A more detailed presentation of the categories of health sector personnel and their respective training appears in Section IV.

III. Principal Health Sector Problems and GOM Responses

This section will not simply present the vital statistics for the people of Malawi, nor will it review yet again the most common causes of morbidity and mortality in Malawi. This information was presented in the previous section in sufficient detail for it to be evident that Malawi does not differ qualitatively from the rest of Sub-Saharan Africa. The issues to be dealt with in this section include what the MOH is doing in response to both the health conditions which it feels are of greatest importance and the constraints to PHC system development which it has identified as priorities.

A. PHC System Constraints

The priority issues in developing the PHC system will be discussed before dealing with MOH responses to specific health problems because the latter might give the incorrect impression that the MOH favors a vertical program response to health sector development. In fact, as the next section will make clear, the MOH is committed to assuring that all of its activities are integrated, not only within the broad rubric of Primary Health Care, but also within the even broader context of community development activities.

In the health sector studies conducted by a half dozen different donors in recent years, certain observations emerge as the most commonly perceived shortcomings of the Malawi health services delivery system. These include the fact that there is insufficient reliable data available for planning and management; there is a critical lack of trained personnel at every level of the system; there is a lack of institutional capacity for systematic information collection, analysis, policy formulation and health sector planning; there exist deficiencies in management, particularly with respect to transportation, pharmaceuticals and financial control and there is some evidence that the standard model of PHC system development described in Malawi's health sector plans may be beyond the ability of the country to bear the associated costs. The discussions held and reading done in connection with this report indicate that the MOH is definitely aware of the above problems and is moving to deal with them as described below.

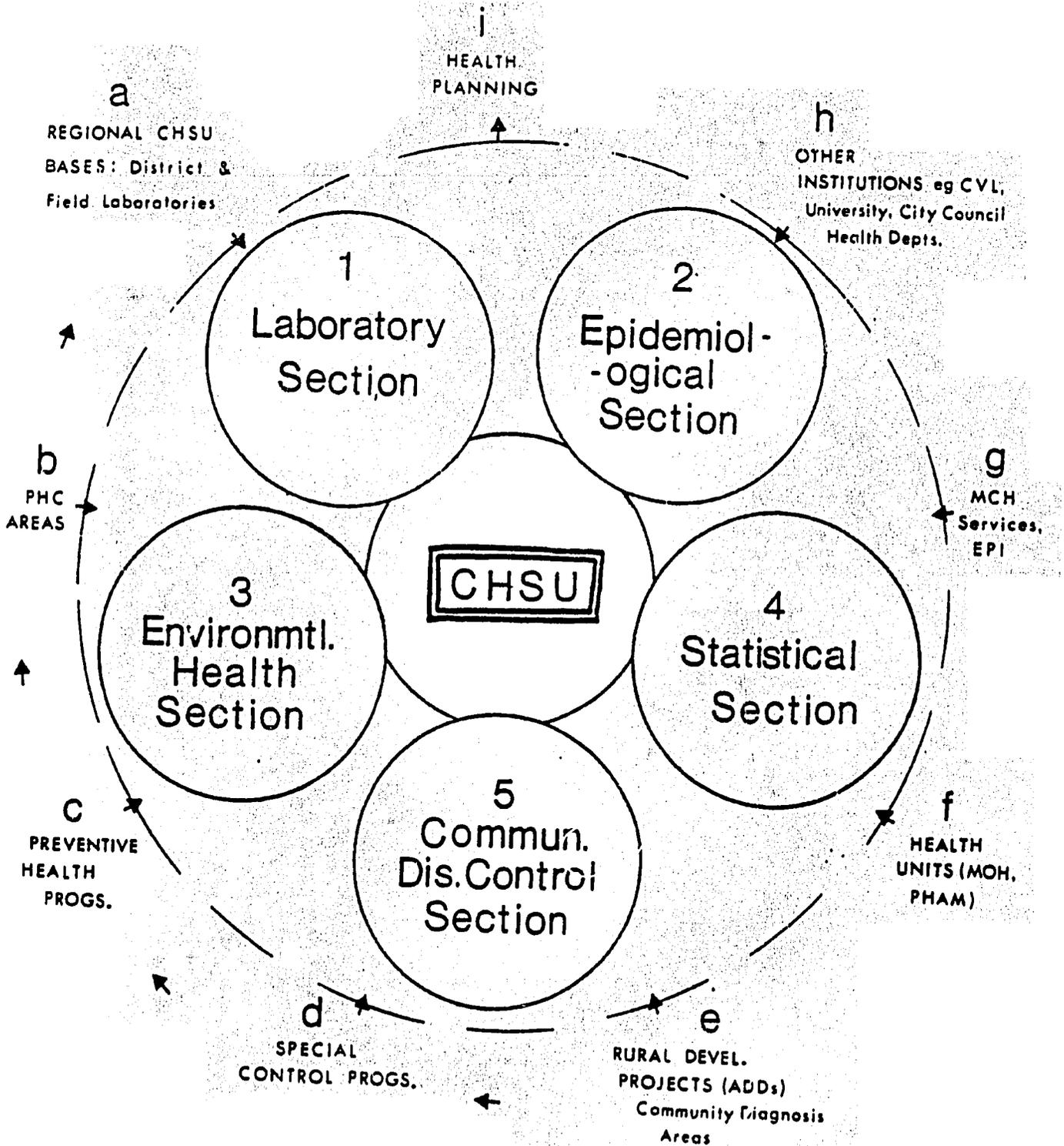
1. Insufficient Reliable Data - In the absence of a working system for the routine collection of reliable health information, the series of national health plans described in the next section depended upon health status estimates based on the uneven quality of data collected in health facilities and occasional special surveys. The MOH is now collaborating with the Centers for Disease Control (CDC), through the Combatting Childhood Communicable Diseases (CCCD) Project, to develop a national epidemiologic surveillance system and with the World Bank (IBRD) to identify the other kinds of regular information input the Ministry requires for its planning and management functions.

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2. Personnel Shortages - Although every health sector assessment performed in Malawi calls attention to the critical shortages in manpower from the level of physicians to community health workers, these observations have come from either seeing the significant percentage of health facility posts which are vacant or from comparing the number of existing Malawian health workers with internationally proposed ratios of health workers per population base for each category. Each approach indicated that Malawi needed to make a major commitment to health manpower development. This has been made, and Section VI of this report presents the status of this personnel training effort which has received the help of almost every donor active in the health sector. What is most important to this effort is that Malawi undertake the systematic determination of its own manpower needs and develop a unique, local manpower development plan which is particularly suited to Malawi's PHC plan and its own resources limitations. Such an exercise is currently underway in the MOH, with assistance being provided by IBRD.

3. Health Planning Capacity - The sequence of very detailed, sophisticated health sector plans for Malawi, which is reviewed in the next section, shows that there is little accuracy in the many health sector analyses which state that Malawi has done no effective health planning. What these documents mean to criticize is not that health planning has not occurred in Malawi, but that it has usually been done in sporadic flurries of intense activity, often in response to donor initiatives, and the capacity for continuous, systematic health sector planning has not been institutionalized within the MOH. However, the IBRD is supporting a project which is just getting underway which will strengthen the Health Planning Unit of the MOH and support the formulation of a new National Health Plan by the end of 1984. As elements of this exercise, subsectoral plans are first being developed and these include a manpower development plan and a pharmaceuticals management plan. As part of the institutionalization of this analysis and planning capacity, a new unit - the Community Health Sciences Unit (CHSU) - will be set up under the IBRD-supported project to involve itself in the collection and analysis of epidemiologic and other health sector information as needed for strategic health planning and effective management. It is hoped that the CHSU will eventually liberate Malawi from the endless visitations of donors who find they are still unable to proceed with the provision of assistance because of inadequate background data. The following diagram illustrates the central role the CHSU will have within the MOH and the relationship of this role to the wide spectrum of community health services.

COMMUNITY HEALTH SCIENCES UNIT



4. Management Deficiencies - The IBRD supported project first deals with the observed deficiencies in the areas of managing transportation, pharmaceuticals, personnel and financial control by establishing and maintaining the necessary management information system as mentioned above. In addition IBRD, WHO, CDC and other donors are supporting numerous short-term management training efforts which will confront the management needs at the national level. Other projects, including the proposed AID project, will include management training as appropriate for more peripheral health workers.

5. Recurrent Costs - Section VII of this report deals with the GOM capacity and willingness to allocate sufficient resources to the health sector. At this point it should be emphasized that the MOH response to the need to define a PHC system with recurrent cost implications which are within the limits of Malawian resources has been to envision the possibility of by-passing the still costly level of Primary Health Workers, at least for the present, in order to go straight to the communities themselves to work on establishing a community-based PHC system. This experiment is further detailed in the next section.

B. Specific Health Problems

While most of the health sector interventions being promoted by the MOH are designed to improve the overall operation of the integrated PHC system, there are several special programs which have been developed in response to specific health status problems. Included for brief mention here are immunizations, oral rehydration therapy, child spacing, and water system development.

1. Expanded Program on Immunization - The EPI program has been underway in Malawi for several years and is a key element of the CDC executed CCCD Project. This program to protect Malawian children from six common childhood diseases is being supported by WHO, CDC and UNICEF and has attained a complete immunization coverage of approximately 50% of the target population at this stage.

2. Oral Rehydration Therapy - ORT is supported in Malawi through a combination of WHO, UNICEF and AID (CDC) support. It is hoped that an effective ORT promotion campaign will reduce the significance of diarrheal dehydration in children from its present status of one of the leading causes of Malawi's unusually high Child Mortality Rate of 330 per 1000 live births.

3. Child Spacing - The issue of Malawi's stand on child spacing is discussed in Section VIII of this report. The GOM has taken a significant step forward in recent months with its October 1983 declaration that henceforth it is official policy that child spacing is to be considered an important element of the country's Maternal and Child Health program.

4. Water System Development - AID is one of several donors aiding the GOM in its efforts to improve the quantity and quality of water available to the population. The high prevalence of waterborne and poor sanitation-related diseases in Malawi is clearly related to the fact that only approximately 30% of the rural population has access to safe water.

5. Other Disease Control Efforts - there are a few other specific diseases which have special programs for their control in addition to their being addressed through the integrated PHC system. Principal among these diseases are malaria, schistosomiasis, TB and leprosy. In each case the special programs have assistance from one or more donors.

The PHC system and health status problems presented above have been selected because of the frequency with which they have been cited in health sector analyses in Malawi. In each case the problem described is receiving the combined attention of the GOM and the international health community. There appears to be a coordinated approach to the identification of problem areas and the mobilization of indigenous and external resources to deal with them. The IBRD Health Planning Project will institutionalize this process more firmly within the MOH. In the meantime it can be seen that U.S. assistance in these areas, through the rural water project, the CCCD project and the proposed health manpower training project, are all important elements of a reasonably well-orchestrated PHC system development effort. It is important that the AID support to the proposed project not be further delayed, if possible, as the trainees are needed as soon as possible to permit the outreach of the system as described in the next section.

IV. Health Planning and Policies

Health planning in Malawi, from the time of independence in 1964, has had four basic phases including the current phase which emphasizes community-based primary health-care.

1. 1965-1969 Five Year Health Plan - stressed the training of manpower to staff the network of curative services - oriented facilities inherited from colonial times,
2. 1973-1988 15 Year National Health Plan - developed in 1971 in collaboration with WHO, this plan followed the "basic health services" philosophy of WHC at that time and set forth a very detailed, comprehensive plan to extend all necessary services from the central ministry and hospitals out to the village level. This plan identified the priority health conditions to be addressed and established targets for the construction of facilities and training of personnel.

The 267 page health plan includes the philosophy of "basic health services," an organization plan for the system's health units and their respective staffing, information systems, special programs, legislative needs and recurrent costs analysis. Aside from its being essentially facilities-oriented, this plan describes a well-balanced comprehensive services system - perhaps beyond the foreseeable reach of Malawi. Its main features were:

a. Essential Conditions

- The community must actively participate in the service;
- The health personnel should work in a team;
- The responsibility of each health worker must be clearly defined and controlled, and geographical areas in which they are to work must be specified;
- There must be a system of referral to the next higher unit;
- The next higher unit must exercise supervision and give constant in-service training, guidance and encouragement;
- Facilities, supplies and equipment must be available to enable workers to perform their activities;

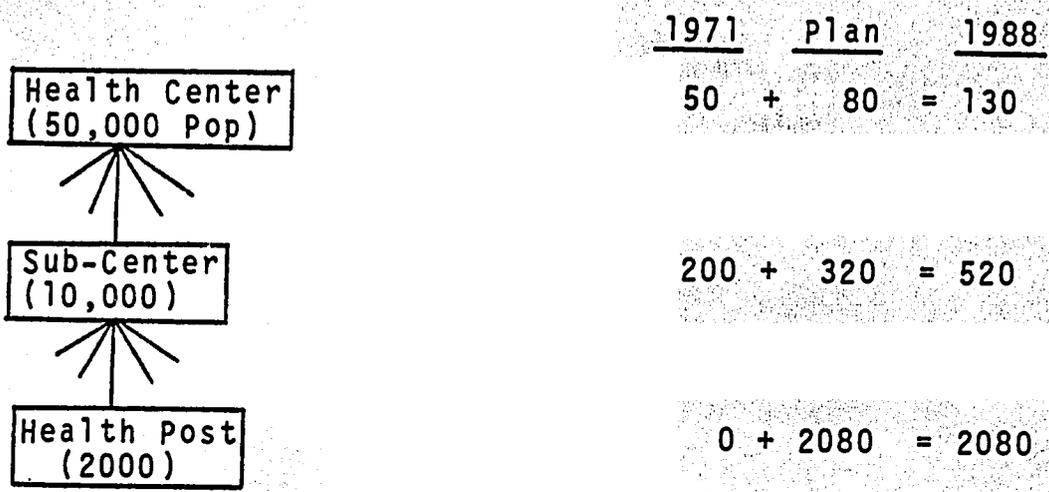
- Basic Health Services will particularly depend on the widespread use of auxiliaries as professional staff is in short supply and it is inefficient and uneconomical to use them for routine tasks.

By and large the effectiveness of the auxiliary is dependent on constant supervision and guidance by the professional supervisor, and on in-service training.

Co-operation and co-ordination between large hospitals and all other health services is of fundamental importance.

b. Facilities organization

The population of Malawi was to be divided into service units of 50,000 each, with each unit served through the following set of facilities:



The figures to the right of the diagram show how many new facilities would have to be built to reach the number needed for the projected 1988 population of 6.5 million (which has already been passed by .5 million). In the first 10 years of the 15 year period covered by the plan, health centers have been renovated extensively, but the number has not increased significantly; there are about twice as many Sub-Centers (450) and hardly any Health Posts (51). Except for the Health Posts, these facilities are the same as those required for the latest plan, which was outlined in Section II.

c. Manpower Planning

A staffing plan is presented for the entire Malawi health system from the national central hospital to the two other regional general hospitals, the 24 district hospitals and the entire network of rural facilities described above. In all, dozens of categories of health workers are described, but very little attention is given to the Health Post or village level personnel. It is not surprising therefore that this plan did not lead to the training of

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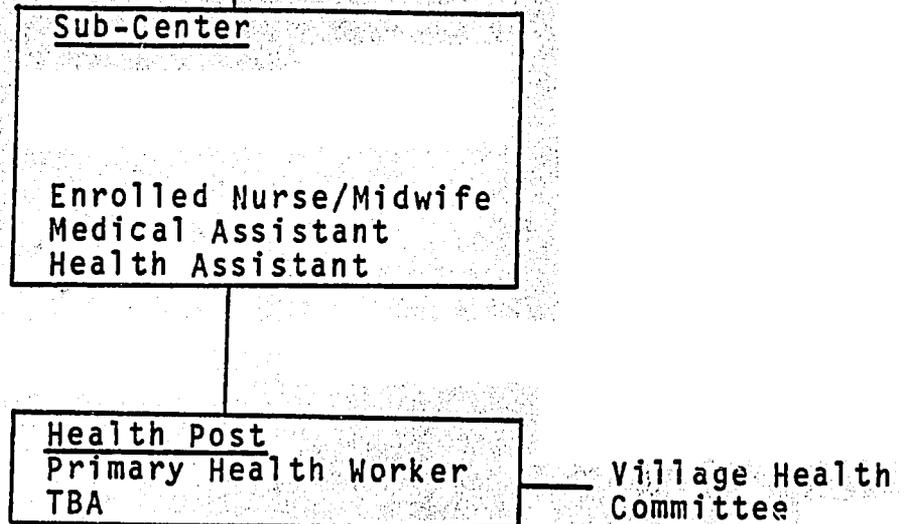
3. 1978-1983 Primary Health Care Plan - Malawi organized a national interministerial conference in 1978 to consider its approach to Primary Health Care. The GOM later participated in developing and fully endorsed the Declaration of Alma Ata and began to design and implement a PHC system in Malawi. The national health policy, that was developed by the Ministry of Health in 1980, combined the objectives of the 15 year health plan and the PHC movement and consisted of the following strategies:

- To provide a comprehensive health care delivery system throughout the country. While the basic health service network, consisting of a Primary Health Center for every 50,000 people, a subcenter for 10,000 people and a Health Post for 2,000 will be established, health services at community level will be provided by Primary Health Workers.
- To strengthen and expand Maternal and Child Health Services and health education.
- To replace and renovate old and inadequate hospital facilities in rural and urban areas.
- To strengthen measures for the prevention and control of communicable diseases. These include vector control, provision of basic sanitation facilities and water supply, and early detection and treatment of diseases.
- To train health personnel at all levels and orientate health manpower development towards meeting the needs of the communities.

In 1982 two basic GOM PHC policy documents were issued: "Plan of Work for the Primary Health Care process in Malawi" and "Implementation of Primary Health Care in Malawi, 1982-1985, Phase One." The details of this PHC plan and strategy are presented below. Although this plan is undergoing further modification in the present, fourth phase of Malawi health planning, the third phase still applies to the present system, except for its description at the community level. It was this third phase Primary Health Care Plan which was undoubtedly operative when the Howard/Meharry design team was in Malawi.

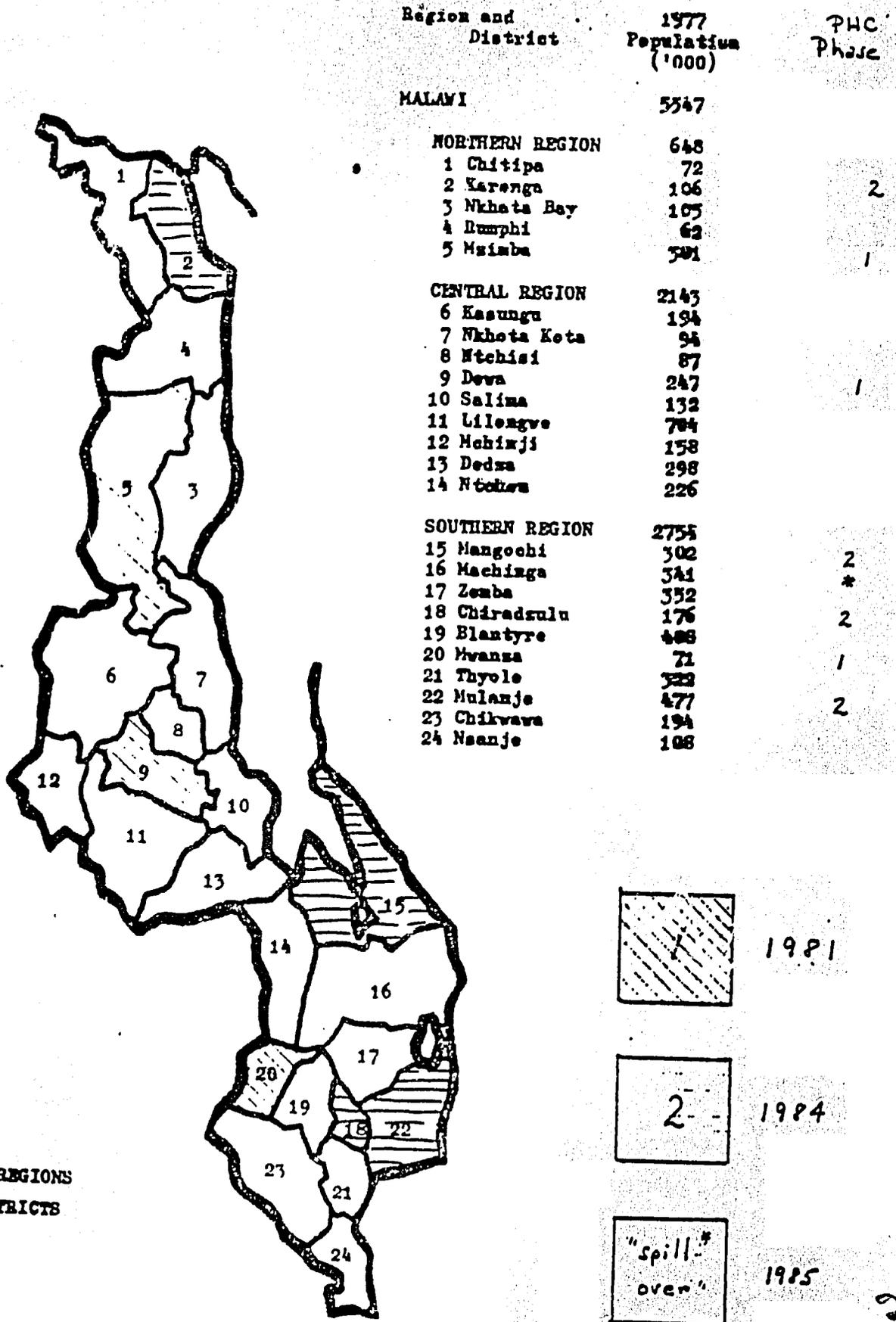
With the adoption of the Primary Health Care international movement, Malawi moved from the basic health services approach above to a new approach which emphasized village level health workers and their immediate supervisors. Plans were made to initiate a reorientation process for all health personnel from the MOH to the Sub-Center level to prepare them for their respective roles in supporting PHC and to phase in the actual establishment of Village Health Committees and the training of village PHC teams, first in three pilot districts and then

in 4 more districts annually until full coverage was attained. The model for the new system was to be added to that for the basic services system and is described below:



The TBAs already existed in the reality of village life and it proved possible to identify them for training and begin the process of integrating them into the PHC system.

Village Health Committee development was attempted and 30 Primary Health Workers were trained in 1981 for work in the first 3 pilot zones of Mzimba, Dowa and Mwanza Districts. The following map indicates these three districts as well as the 4 scheduled for the next phase.



MALAWI REGIONS AND DISTRICTS

PHC SYSTEM PHASES

The Primary Health Care Plan goes into great detail concerning the role that each level of health workers will play in the system and gives special attention to the district level PHC team and the Sub-Center staff. The proposed AID project is to provide the training (both basic and in-service) for the three categories of health worker at the Sub-Center level to prepare them for their roles in working with the Village Health Committees and the Primary health Workers and TBAs. The following descriptions apply to these three village level groups:

a. Village Health Committee - The main vehicle for the development of PHC, at community level will be through the Village Health Committees. Village Health Committees are comprised of local leaders and should represent a cross-section of the community; it is essential that a significant proportion of the VHC members be women. There are normally 10 members in each VHC who are elected by the community. These committees will provide the managerial structure for PHC at community level. The functions of the health committees will include planning and management of maternal and child health, water and sanitation and the treatment of simple diseases. One of the major objectives of PHC is to reduce high morbidity and mortality among infants and children. Thus it is necessary to include activities such as nutritional surveillance of children who are not brought to child clinics, promotion of nutrition in homes, ante-natal screening, supervision of deliveries, management of diarrhea in children, immunizations and prophylaxis and treatment of malaria. VHC should therefore actively encourage participation of women. The other main areas of emphasis will be creating awareness of types of health problems in the area.

b. Primary Health Worker - is responsible for:

- Promotion of sanitation, construction of pit latrines and refuse pits;
- Monitoring Water Sources;
- Monitoring Potable Water;
- Surveillance of Epidemics;
- Treatment of: malaria, simple eye infections, diarrhea, wounds;
- First Aid; and
- Health Education.

c. Traditional Birth Attendant - is responsible for:

- Ante-natal care;
- Deliveries;

- Referral of At-Risk-Cases;
- Treatment of anemia;
- Nutrition advice;
- Advise women to take children to Under-Fives clinics;
- Monitoring child development through growth charts; and
- Health Education.

The Malawian Government clearly could not afford to pay the PHC team members at the village level, but the international PHC movement stresses the importance of community participation, management and financing. The Malawi PHC Plan makes this clear, " It is important that the community realize that the PHC programmes belong to them and not the Ministry of Health. Salaries or stipends will not be given to PHWs by Government, therefore, encouragement should be given to the community that they should find ways to compensate the PHWs. In the case of the TBAs, this is already taking place. With other PHWs, they will be working only part time, so full remuneration would not be required."

During the Phase I, three pilot districts attempted to implement this classic, world-wide accepted model of PHC, it became clear that there were a number of problems, central among which were the problems of getting Village Health Committees to take over their local systems and getting adequate support for Primary Health Workers. All other aspects of this PHC model still appear appropriate and persist in the latest model to be conceived. At present the Health Post, per se, has been dropped from the model; the 30 PHWs have been retained for other roles, and a new approach to working with the community is being developed.

4. 1984 - Community-based Primary Health Care - During the past 6 months, the PHC Core Group has been working to identify an approach to Primary Health Care that would allow the GOM to skip over the troublesome Primary Health Worker issue and go directly to the communities to collaborate in the development of a PHC system based on existing community resources.

Malawi are: The basic principals of this new approach to PHC in

(a) Primary Health care is shaped around the life of the population it exists in;

(b) The improvement of primary health care should be an integral part of the national development service system, and all echelons of service should be designed to support the needs of the community, especially with regard to technical supply, supervision, and referral of problems;

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(c) The local population should be actively involved in the formulation and implementation of improved PHC activities, so that PHC can remain in line with local needs and priorities. Decisions as to the community's needs should be based on continuing dialogue between the people and the services;

(d) PHC should place maximum reliance on available community resources, especially those that have hitherto remained untapped; and

(e) Primary health care should involve an integrated approach of preventive, promotive, curative and rehabilitative services in all sectors.

For these reasons the organization of PHC coordination presented in Section II was designed. This organization places major emphasis on the interaction between the multisectoral Area PHC Teams and the Village Action Groups.

The following pages are taken from the materials used by the PHC Core Group in their most recent effort to orient the national level health workers and the members of the National PHC Committee to the present PHC philosophy.

"An Approach to Primary Health Care.

Much confusion exists about the meaning and interpretation of the words Primary Health Care. Part of the confusion has arisen because many have felt that PHC is a new kind of service to people - that it is a technology that can be delivered in some kind of package - and that this service has at its center the health services. This is obviously confusing if the approach is indeed to be multi-sectoral as well as community-based!

Such feelings ignore the great success with which the majority of people have been brought up since time began. In fact, it is clear that this total care surrounding an individual (protection, nurture, treatment and self-care) is primary health care. It is also clear that for a large minority of people, aspects of this care have been inadequate or have not existed. Therefore these aspects of primary health care have to be improved for that minority.

There are a number of advantages stemming from this approach to PHC.

Firstly, we are building on what the people have.

Secondly, we are building on success.

Thirdly, we need talk only about improvement of what exists.

Fourthly, it allows improvement at a steady pace

Fifthly, everyone can immediately be involved.

This is not to say that there are not entirely new elements to be incorporated into the approach to the improvement of PHC. In fact its improvement does require a radically different way of thinking about health problems. It also requires new management skills within all services, and different patterns of resources allocation.

What the People Have

Sophisticated mechanisms of care for individuals and communities have been built up over millenia. There are natural instincts, rituals, practices and beliefs surrounding birth, care of the newborn, breast-feeding, child-spacing, care of the child, prevention of accidents, and prevention and treatment of illness, disease and impairment. There are societal mechanisms for protection of the family and the community. There are accepted mechanisms of support for those who fail to cope. Knowledge of these things, when not instinctive, is passed on and reinforced from generation to generation. All this can only be termed as primary health care.

In addition, the forms of care external to the family have grown more and more complex and have become institutionalized. A complex web of welfare services has grown up and is provided by both governmental and non-governmental agencies.

Building on success

It is a remarkable fact that the majority of people survive their first five years of life. If they survive beyond this, then their life expectancy shoots up dramatically. Something over 60% of children survive these first five years.

Of course this means that anything up to 40% of children don't survive, and that is a tragedy that all are committed to dealing with, but it is still a minority. The population of the world has continued to grow since its beginning. The question is, why do the majority survive? The answer is simple: They have had access to the all-embracing system of primary health care described above. The role of modern services has often been shown to have had only a minor impact on this system, and for this reason can be considered only as potentially supportive of primary health care, rather than providing it directly.

However, we also have to ask, why do the minority not survive? This is because some aspects of this primary health care have been inadequate or non-existent for a special group. Perhaps

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the best way of defining this group is "those who fail to cope" in their environments. This failure can be either due to personal inadequacy or to conditions in their environment (social, political, economical, or geographical) that tie them to their condition.

If we could understand the mechanisms of coping, as well as ways of altering environments so that all people not only have improved knowledge but also the "room for manouevre" to use that knowledge successfully, then we would be well on the way to "Health for All".

A further point is that traditional mechanisms in society for the protection of those that fail to cope have largely been eroded by the changes in society that have led to monetarization and central control of the economy, and urbanization. While such measures benefit the majority, there are at present no clear structures to replace the traditional mechanisms for support.

Improvement of what exists

It will be clear by now that there is much that needs to be improved. Not only do we have to find out more about the problems people face, and the mechanisms of coping, but we also have to improve all services so that they are more relevant to the problems and the environments that control the health of people.

There have been many surveys, for example, that show that knowledge is not the limiting factor in development. Most mothers know about oral rehydration, or food groups - but the problem is that some people face constraints when it comes to putting this knowledge into practice. Therefore, at the very least, there has to be a revolution in educational techniques - so that those administering services learn from the people just what they have to teach!

In addition, there has been considerable inefficiency in the management of services and resources that, in effect, means that services can not be provided more extensively - since money that would go towards such provision has been "lost". Therefore, any improvement of primary health care must have in parallel an improved management and coordination of services.

Finally, not only must approaches to education be improved, but ordinary people should be helped to be more self-reliant, or independent, in the decisions they take about the support for primary health care. This will ease the burden on services, as well as provide an improvement of what people are already doing.

It will also mean that we move away from the idea that services, even in theory, can by themselves improve primary health care - because it is well known that they cannot.

(A good example is the weighing of children at clinics. Unless the society does something about those who are underweight, then the weighing is clearly not useful).

Improvement at a steady pace.

None of these changes can be presented as a neat package or project, nor can they occur in a short space of time. All services have to examine their structures and relevance very carefully, new training methods have to be instituted, and relations have to be well-established between services and the communities. These latter relationships have to be based on mutual trust and an attitude that all people are equally important when it comes to assessing how to approach problems. Also, in the improvement of services, infrastructures and personnel have to continue to be provided.

Therefore, there is nothing dramatic that can be "introduced". We can't go to the village headman, or whomever, and say "we are starting primary health care today, could you tell us your problems please so that we can answer them". Instead, the approach has to be low-key and has to take place over a very long period of time so that all efforts are well-planned, integrated and coordinated.

It is certainly by no means clear that we need "Primary Health Workers" (at least in their present understood form) until we have clearer ideas of what can be done with existing resources inside and outside of the communities.

Immediate involvement of everyone.

In the improvement of primary health care, there are two clear requirements. The first is that if all services are to improve their relevance to primary health care, then they all have to adopt the same questioning, humble, problem-oriented approach to those whom they serve. This requires learning of certain skills in communication and education. As a result, communities will know where they stand with whatever service approaches them.

The second requirement is that there is a controlled, cooperative effort on the use and sharing of resources. Such resources include personnel, vehicles, donations and training facilities.

The implication is obvious - everyone can start improving primary health care immediately by changing their approach to communication and education, by adopting a self-critical attitude, and by improving the management of their services. There can be no defined end-point to this process, as society and knowledge are always changing, but unless this process is adopted, there will be few improvements in health.

It will be noted that health services have, like every other service, a minor but equal and important role in the support of primary health care. Because primary health care is dependent on so many aspects of society, the coordination of all service efforts should not, ideally, rest in the hands of any one service body, but should instead be controlled by those responsible for general development. If this were the case, then there would be no implication that any one service was more important than any other."

The purpose of quoting from these materials at such length is to illustrate the "state-of-the-art" nature of this innovative approach to PHC and the central importance of the training proposed for AID support. To participate effectively in developing the training for the Community Nurses, Medical Assistants and Health Assistants, the Project's long term field technicians and the short term consultants will have to be entirely appreciative of and committed to the objectives stated above. It is unlikely that anyone who has not already been deeply immersed in the PHC movement in Africa could make an adequate contribution to this effort.

5. The Future National Health Plan - as mentioned in Section III, the MOH is now engaged in a year-long exercise to formulate a new, revised National Health Plan. Numerous planning exercises are currently underway in connection with this effort, and the new plan is expected to be approved in 1985.

V. Other Donor Health Sector Activity

Within the context of Malawi's PHC strategy, development of the PHC system would be extremely difficult without external assistance, even though self-reliance is an ultimate objective of the strategy. Accordingly, assistance is sought in the following areas:

- A. Assisting with the planning process
 - 1. Manpower plan
 - 2. Financial analysis.
 - 3. Drugs and supplies
 - 4. Transport management and analysis of existing situation and needs.
- B. Co-operation with the training programme.
 - 1. Local costs for seminars and training of PHC
 - 2. In-service training in PHC Management for District and HC Teams.
 - 3. Outside the country - fellowships for Malawi counterparts.
 - 4. Inputs to new auxilliary training schools or increasing the capacity of existing ones.
- C. Technical Collaboration for:
 - 1. Communication support, development:
 - 2. Information system development;
 - 3. Curriculum development.
- D. Buildings
- E. Equipment
- F. Systems for procurement, packaging and distribution of Drugs and other supplies.
- G. Transport and maintenance systems
 - 1. Vehicles
 - 2. Spare parts
 - 3. Maintenance training and workshops.
- H. Special Studies

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The GOM has collaborated with numerous donors throughout the evolution of its development of the health sector. In 1981 about 5% of all donor assistance to Malawi went to the health sector. A complete list of the 1981 external partners in health development follows:

Beit Trust	ADB/ADF	FAO
Canada (CIDA)	EEC/EDF	UNCDF
Denmark (DANIDA)	Overseas Religious Organizations	UNDP
France	OXFAM	UNICEF
Germany, Federal Republic of	Save the Children Fund (UK)	UNFPA
Japan		World Bank
Netherlands		WFP
Republic of South Africa		WHO
South Korea		
United Kingdom		
United States		

The level of support from the principal donors in 1981 was:

SOURCE OF FUNDS	MULTILATERAL/BILATERAL COOPERATION	CAPITAL AID	EXTERNAL LOANS AND CREDIT
United Kingdom	556 870	---	---
Fed. Rep Germany	---	628 147	---
United States of America	61 000	---	---
France	187 430	---	---
Denmark	810 637	---	---
Japan	507 500	---	---
Canada	50 400	87 800	---
FAO	15 750	---	---
WHO	294 200	---	---
UNFPA	195 280	---	---
WFP	1 972 116	---	---
UNICEF	307 000	---	---
EEC/EDF	---	456 442	---
UNCDF	---	1 306 916	---
ADB	---	---	1 053 873
UNDP	242 000	---	---
TOTALS:	5 201 183	2 479 305	1 053 873
GRAND TOTAL:	8 734 361		

And the principal activities supported at that time were:

Source of Funds	Programme/Project/Activity	Duration of Aid	Amount Committed	Remarks
The African Development Fund (ADF)	<u>Rural Health Centres Project</u>	1982 - 1984	Approximately US\$ 7.3 million	These funds have lent to the Malawi Government to be repaid in 40 years after 10 years grace period. The loan attracts an interest of 3/4% per annum.
	(a) Construction, furnishing and equipping two district hospitals in replacement of the existing ones at Mchinji and Salima.			
	(b) Construction, furnishing and equipping two new health subcentres at Kaigwesanga and Mikundi, both in Mchinji District.			
	(c) Strengthening the planning division of the Ministry of Health by providing technical expertise and fellowships.			
European Development Fund (EDF)	<u>Construction and Equipment of New Mangochi Hospital</u>	1975 - 1980	UA 1 932 000	Completed
European Development Fund (EDF)	<u>Construction and Equipment of New Nsanje Hospital</u>	1975 - 1980	UA 2 068 000	Completed
European Development Fund (EDF)	<u>Construction and Equipment of New Yaronga Hospital</u>	1980 - 1985	UA 4 000 000	Funds committed implementation expected to start early next year
UNCDF	<u>Rural subcentres development</u>	1980 - 1983	HK 1 418 000	
OXFAM	<u>Non-medical equipment for 8 health subcentres</u>	1982 - 1983	HK 46 312	
CSC	1. Health Facilities at settlement schemes	1979 - 1980	HK 6 000	
	2. Health services for children	1979 - 1980	HK 79 000	
	3. Development of health centres services, Phase III	1980 - 1983	HK 123 300	
	4. Non-medical equipment for the health centres	1982 - 1983	HK 48 160	
Beit Trust Beit Trust Beit Trust	(i) Dwambazi Rural Hospital (ii) Kaporo Rural Hospital (iii) Chitipa District Laundry	1979 - 1980 1979 - 1980 1979 - 1980	HK 10 000 HK 8 000 HK 10 000	Completed
French Government	<u>New Medical Auxiliary Training School-Lilongwe</u>	1979 - 1980	HK 289 000	Completed
Government of FRG (KFW)	<u>New Ncheu Hospital</u>	Since 1978	DM 4.4 million	Completed
Government of FRG (KFW)	<u>New Mzimba Hospital</u>	Funds committed in 1979	DM 5.25 million	Not started
Government of Canada (CIDA)	<u>Replacement of Rural Health Subcentres</u>	Since 1978	CDN\$ 1 330 000	
United Kingdom	<u>Upgrading of Rural and District Hospitals</u>	Started before 1977	£ 1 767 817 estg.	Completed
United Kingdom	<u>Peripheral Health Units in Urban Areas</u>	Started before 1977	£ 1 636 815 estg.	Completed
DANIDA	<u>New Medical Auxiliary Training School-Lilongwe</u>	Since 1974	Dkr. 346 411	Completed

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Since that time DANIDA has also been very much involved with the rehabilitation of health facilities; UNICEF aided PHW training; UNICEF, UNFPA and WHO support TBA training and supply; IBRD is supporting the major health planning effort; and AID is supporting rural water supply development, childhood diseases control and epidemiologic surveillance.

VI. Manpower Development

A. Overview of Programs and Problems

One of the high priorities of the Ministry of Health and a major objective of the 1980 National Health Policy is the training of health personnel. The MOH created a Training Unit in the Ministry in 1978 responsible for the coordination of all health personnel training both in and outside the country. The Government has many types of medical and paramedical health workers some of which include Medical Doctors, Clinical Officers, Registered and Enrolled Nurses, Medical Assistants, Midwives, Health Inspectors, Health, Dental, Laboratory and Radiographic Assistants and other allied health personnel. In 1982, there were 24 different categories of health personnel identified and a chart listing the categories, total numbers and place of employment is attached at the end of this section.

Malawi does not have a medical school, however in 1981 WHO conducted a feasibility study and recommended that one be established at the University of Malawi. Even though the government accepted the recommendations of the report, most likely due to competing demands for scarce health resources, no follow up action has taken place. Therefore, the training of medical doctors and other senior level health personnel such as pharmacists, dentists, and specialized nursing is done abroad. For those that have gone for out of country training, a very low percentage have returned to work in Malawi. One recent World Bank Report estimated that only 5% of medical doctors trained abroad return. (p. 33 Malawi Health Sector Review November 1981). It is felt that the primary reason is due to the monetary incentives for practicing medicine in the developed countries of Western Europe and North America. Whatever the reason, this has created a serious shortage of medical doctors in the country.

In fact, there is a general, shortage of certain categories of health personnel which has created a major problem for Malawi. In 1980, 50% of the technical posts in the Ministry of Health were vacant and over half of the 24 districts lacked a medical officer. Likewise, 27% of the positions for clinical officers and 14% of the positions for medical assistants were vacant. One way the government has compensated for these vacancies has been to use expatriate staff. About 60% of the 121 physicians in the country and approximately 32% of the registered nurses working in Mission hospitals are expatriates.

There are currently 18 schools and hospitals that provide training for health workers in the country. Both government and Private Hospital Association of Malawi (PHAM) Mission Hospitals support training of nurses, midwives, medical assistants and other allied health workers.

B. Training of MCH Personnel

1. Training of Nursing and Midwifery Personnel

Malawi began training State Registered Nurses in 1965 and currently has two schools, the Kamuzu School of Nursing in Lilongwe 30

and the Blantyre School of Nursing at Queen Elizabeth Hospital. Both schools offer a four-year program that includes nursing and midwifery and the annual intake for each school is 30-40 students per year. Of the 506 State Registered Nurses currently working in the country, most are based in general and district hospitals where they fill the positions of matrons, tutors and administrators. The basic curriculum for registered nurses was revised in 1982 and more focus has been placed on primary health care in line with the new MOH emphasis on this area. For the first time, child spacing is also included in the syllabus as an important aspect of integrated MCH services. A post graduate Public Health Nursing Certificate program has also recently been opened at the Lilongwe School for Health Sciences. It is a one year program that can accommodate 12-15 nurses per class.

The bulk of nursing care in the country is provided by the Enrolled Nurse/Midwife. She is expected to work in the hospital, sub-centers and the community. Once the Primary Health Care program begins implementation, the Enrolled Nurse will also be expected to train and supervise Traditional Birth Attendants and serve as an important member of the Primary Health Care Team. In line with the new MOH emphasis on integrated MCH/CS services, the Enrolled Nurse/Midwife will also be responsible for delivering Child Spacing information and services.

Enrolled Nurse/Midwives are trained in 12 schools throughout the country. The MOH operates one school in Zomba and the remainder are trained in mission schools run by PHAM. The program is a three year certificate program that includes two years of basic nursing and a year of midwifery. Although to date, the training programs have been hospital based and curative-oriented, the MOH is planning to make revisions in the basic training program and develop refresher training programs for Enrolled Nurse/Midwives to include community health, preventive health care, MCH and child spacing. As there are over 1000 ENMs currently working in the country, which represents the largest number of any single category of health worker, the role that they will play as front line providers of primary health care is extremely important. The MOH is planning to train all existing ENMs in short 12-14 week refresher courses in MCH/CS over the next few years. In addition, a 12 month Community Nurse/Midwife Training Program for selected ENM's will be developed for those nurses responsible for organizing, supervising and conducting a wide range of preventive and promotive health services.

The training of nurses and midwives in Malawi is governed by the Nurse and Midwife Council. The Council determines the qualifications, practice and training syllabus for a nursing and midwifery personnel and is responsible for examinations for registration and licensure. Representatives from the Council have already participated in initial discussions with the MOH on the need for upgrading and strengthening the community health aspects of existing training programs and will have the primary responsibility for developing the Community Nurse/Midwife training curriculum, as soon as requested by the MOH.

2. Training of Traditional Birth Attendants

In 1978, the MOH began training Traditional Birth Attendants (TBAs) on a pilot basis, in three districts. The program was extremely successful and after a formal evaluation in 1980, the TBA Training program was expanded. By the end of 1982, each of the 24 districts in the country had trained at least 10 TBAs. To date, 350 have been trained through the program. Public Health Nurses are responsible for conducting the training programs which take place at district levels. The primary purpose of the four week course is to improve the TBA's skills in handling normal deliveries and care of the newborn and to identify and refer high risk cases and complications. It has been reported that the percentage of referrals by TBAs to health centers and hospitals has increased since the training, and that in some cases TBAs have reported an increase in the number of deliveries they handle. The TBA has already been shown to be an important resource whose care can improve with training. She will also be a crucial PHC member by providing direct service and care to the community and serving as an important link to health care provided in centers and dispensaries.

3. Summary of Needs

One of the constraints of the MOH is the lack of adequately trained health personnel to work in the community. The need to retrain nurses and midwives to strengthen their skills and role in PHC including MCH and Child Spacing is apparent. The challenge will be to inventory and analyze their present role in light of their new responsibilities and to assist in designing programs that are task-oriented and respond to the specific needs of the community. Care should be taken not to overload nurses with unnecessary information and responsibilities.

Those that provide assistance in the training of nurses and other primary health workers will need to be flexible and continue to work closely within the context of the overall PHC program. As the program is now in the early stage of development, it was not possible to list tasks and functions as requested. These are now being determined. The MOH sees the training of midlevel health workers, such as the Enrolled Nurse/Midwife, as an enormous task which necessitates the MOH request for assistance in the design of curriculum, training of tutors and training of Community Nurses on a large scale to assure the integration of PHC and MCH/CS services. Based on discussions with the MOH, the Nurse and Midwife Council, and review of MOH documents, training syllabus and training materials, it is felt that this request is a priority need of the MOH and complements the government's overall plan for PHC.

C. The Lilongwe School for Health Sciences

The Lilongwe School of Health Sciences (LSHS) was opened in 1976 and is located near the grounds of the Kamuzu Central Hospital. The School has impressive new facilities and operates seven different certificate programs which include training of medical assistants,

dental assistants, laboratory assistants, pharmacy assistants, radiography assistants and health assistants. The school also administratively handles the Public Health Nursing post graduate training program. A chart listing all categories of personnel trained, enrollment, entrance requirements and length of training is attached at the end of this section. The total number of students the school can accommodate is 230, and although only 191 students are currently enrolled, this is due to a new intake of students expected in April/May 1984.

1. Medical Assistant and Health Assistant Training

For the purpose of this report, emphasis will be placed on discussing the two categories of LSHS trained personnel included in the project proposal, that is, the Medical Assistant and the Health Assistant.

The government has been training Medical Assistants since 1953. The LSHS operates one of two schools for Medical Assistants in the country. The Program is three years and has an average annual intake of 30-40 students. Due to a shortage of medical personnel, the Medical Assistant serves as the surrogate physician being directly responsible for health care provided in sub-centers. The Medical Assistant almost exclusively provides only curative care. As the head of a large out-patient clinic, the Medical Assistant often diagnoses and treats up to 200 patients per day. Although the basic curriculum for Medical Assistant training has been revised and updated periodically, the training continues to focus on curative care. As the Medical Assistant will be a key member on the PHC team at the area level, the Medical Assistant will have to assume a major leadership role in supervising and providing primary health care in balance with their curative work. The MOH plans to revise the basic training course for Medical Assistants and also conduct refresher training programs for the existing 442 Medical Assistants currently working in the community. These training programs will include an orientation to PHC and will include MCH and child spacing.

The LSHS also operates the only training program for Health Assistants. Health Assistants have been trained for a number of years and have been providing community based services which include prevention of communicable diseases, vector control and monitoring public health ordinances. The LSHS Health Assistant training program is a two year course with an annual intake of 25 students per year. The MOH has determined Health Assistants will also need refresher training to expand their role in such areas as environmental health, community organization and health education. The LSHS has recently reviewed the basic Health Assistant curriculum, and in line with the new orientation to PHC has added subjects in PHC, sociology and management to the training program.

2. Summary of Needs.

Generally the areas in need of strengthening at the LSHS are: (a) preparation of tutors in training skills and concepts of

PHC including MCH/CS; (b) Assistance in organizing and upgrading the basic curriculum for MA's and HA's and in conducting short refresher courses in PHC for all MA's and HA's working in the field in order that they are better able to understand and practice PHC; and (c) expansion of training facilities to include classroom, dormitory, laboratory facilities and teaching equipment to increase the present number of MA and HA students and to accomodate the proposed Community Nurse/Midwife training program.

After discussions with the MOH and the staff at the LSHS and review of MOH plans, course syllabus and training materials, it is felt that those components of the MHIP Proposal that address strengthening the LSHS are priority needs, fit into the MOH Manpower Development Plan for PHC and complement the work and activities of other MOH and donor supported programs. Very few of the 17 tutors at LSHS have had formal courses in training skills or specialty training beyond their basic training. The MA and HA will be important members on the PHC team. Their training has been primarily curative, and there is a need to strengthen their supervisory and practical skills in preventive community-based health care.

Last, without the expansion of facilities at the LSHS, those planned training programs will not be able to take place.

NUMBER OF HEALTH PERSONNEL BY CATEGORY AND PLACE OF EMPLOYMENT

<u>Category of Personnel</u>	<u>Category</u>			<u>1982 Totals</u>	<u>1984 Totals</u>
	<u>Government</u>	<u>PHAM</u>	<u>Other</u>		
Medical Officer	54	37	30	121	127
Senior Clinical Officer	39	4	3	46	66
Clinical Officer	48	9	4	61	136
Medical Assistant	321	90	136	547	442
Registered Nurse	245	136	21	402	506
Enrolled Nurse/Midwife	696	438	159	1,293	1,302
Dentist	3	2	1	6	13
Dental Technician	5	1	-	6	11
Pharmacist	7	4	-	11	13
Pharmaceutical Assistant	10	4	2	16	20
Laboratory Technician	15	16	-	31	27
Laboratory Assistant	44	36	5	85	86
Veterinarian	39	-	-	39	-
Veterinary Technical Officer	71	-	-	71	-
Veterinary Assisnt	310	-	-	310	-
Veterinary Scouts	90	-	-	90	-
Radiographic Technician	6	1	3	10	10
X-Ray Assistant	-	2	-	2	8
Health Inspector	45	-	7	52	54
Health Educator	-	1	3	4	3
Health Assistant	145	-	16	161	107
Homecraft Workers	27	69	17	113	110
Medical and Nursing Aids	1,023	594	84	1,701	1,624
Other	281	910	44	1,235	

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MALAWI HEALTH PERSONNEL TRAINING INSTITUTIONS

TRAINING INSTITUTIONS	CLINICAL OFFICER	S R N/M	MEDICAL* ASSISTANT	ENROLLED* NURSE	ENROLLED* MIDWIFE	LABORATORY ASSISTANT	PHARMACY ASSISTANT	RADIOGRAPHY ASSISTANT	HEALTH INSPECTOR	HEALTH* ASSISTANT	DENTAL ASSISTANT	PHYSICIAN ASSISTANT
Kamuzu School of Nursing		+										
Queen Elizabeth Hospital		+										
Zomba School of Nursing				+	+							
Lilongwe School of Health Sciences	+		+			+	+	+		+		
Polytechnic, U of Malawi												
St Johns Hospital				+	+							
Nkhoma Hospital				+	+							
Hguludi Mission Hospital				+	+							
St Annes Hospital					+							
Malosa Hospital				+								
Trinity Hospital				+	+							
Malamulo Mission Hospital			+	+	+	+						
Phalombe Hospital				+	+							
Mulanje Mission Hospital												
Ekwendeni Hospital												

*Those proposed for training under MHIP
Ministry of Health 1983

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LILONGWE SCHOOL OF HEALTH SCIENCES

Annual Intake, Category of Personnel, Entrance Requirement and Training Period

<u>Category</u>	<u>Annual Intake</u>	<u>Training Period</u>	<u>Entrance Requirements</u>
Clinical Officers	20	4	Malawi Certificate of Education (with minimum of four credits must include English, Mathematics and Science subjects.
Medical Assistants*	30 - 40	3	Junior Certificate with passes in English, Mathematics and Science subjects
Dental Assistants	10	3	"
Laboratory Assistants	10	2	"
Pharmacy Assistants	10	2	"
Radiography Assistants	10	2	"
Health Assistant*	25	2	"
Public Health Nursing	12 - 15	1	SRN/M Registration

*Those proposed for training under MHIP

Malawi Certificate of Education equals 12 years of education

Junior Certificate equals 10 years of education

VII. Health Budget Analysis*

Total expenditures on health services (public and private, recurrent and capital costs) in 1980/81 (the year covered by the Health Sector Financing Survey) were about 52 million kwacha (\$65 million), roughly 5 percent of GDP and about \$10 per capita. This level of expenditures is above average for comparable low income African countries. The estimated sources of these expenditures were:

Government	MK 18.0 million	(35%)
Employers/Organizations	MK 3.4 million	(07%)
Public/Private Foreign Aid	MK 18.5 million	(35%)
Individuals/Families	MK 11.7 million	(23%)
Total	MK 51.6 million	

Source: 7 (in Bibliography)

The Survey estimates that total health sector expenditures in 1980/81 were used in the following pattern:

<u>Use Category</u>	<u>Percentage of Total Health Sector Expenditures</u>
Hospitals (tertiary)	14.8 %
District Hospitals (secondary level)	14.4 %
Domestic Water Supply	14.3 %
All other health care institutions	10.6 %
Health administration and transport	9.4 %
Drugs and medical supplies	8.5 %
Private practitioners and traditional healers	7.1 %
Nutrition	6.1 %
Communicable Disease Control	5.0 %
Sanitation	2.7 %
Training of health personnel	2.1 %
Other	5.0 %
Total	100 % of MK 52 million

This expenditure pattern, which is still considered to reflect current uses of financial resources, indicates that approximately three quarters of total health expenditures were on medical care, including health administration, with the balance spent on water, sanitation and nutrition programs. Personal health services made up approximately 60 percent of total health sector expenditures, while about 40 percent are for non-personal services. The 1980/81 survey estimates that 60 percent of total health sector expenditures serve the urban population and 40 percent is for the rural population.

*Sources 6, 7, and II were relied upon heavily for the preparation of this section of the paper. The major new source of information is the GOM Health Financing Survey of June 1983.

The financing survey concludes that health expenditures are overly concentrated in Malawi's central hospitals and, to a lesser extent, in district hospitals and that the share of funding available to support lower levels of health facilities (Health Centers, MCH clinics, etc.) is inadequate. As a partial result of this expenditure pattern, the services available from hospitals tend to be superior to those provided by health outposts. This in turn results in an under-utilization of primary health facilities and resources and an overloading of hospital facilities for broad scale outpatient care instead of their intended referral purposes.

The Government of Malawi maintains two budgetary accounts, a revenue account and a development account. The revenue account contains public revenues appropriated to cover essentially recurrent-type costs (salaries, operating expenses, etc.) and some minor capital expenditures (i.e. vehicle purchases, minor equipment procurement, etc.). The development account originates largely from external official aid sources and is intended to finance major capital investments. In practice, however, the development account may also contain both external funds for recurrent-type costs and GOM counterpart financing, regardless of its intended use.

The MOH has the third largest revenue account budget in the GOM, exceeded only by revenue budgets for the Ministries of Education and Defense. Trends in the revenue account of the MOH are shown in Table 1.

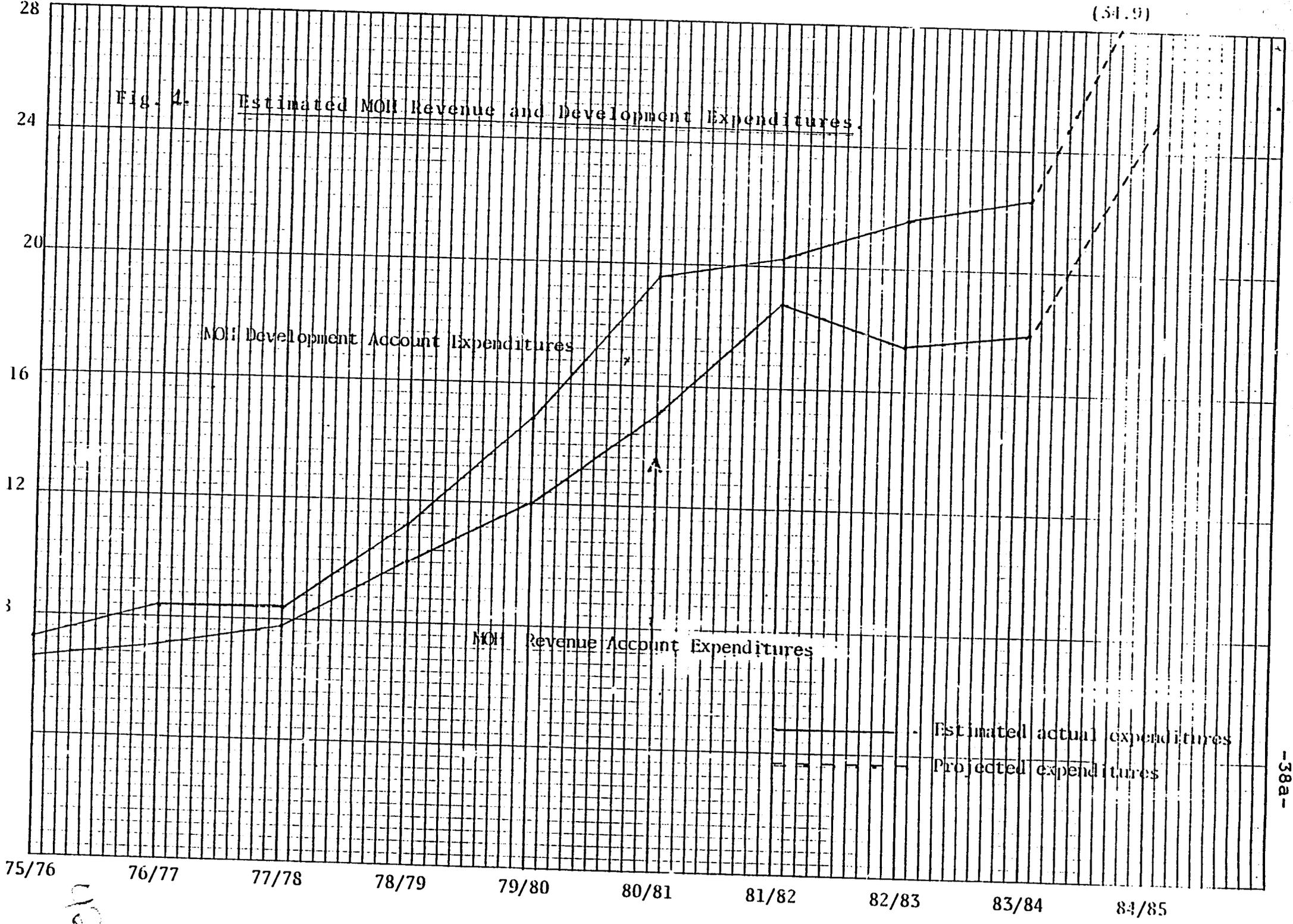
Table 1: Estimated Revenue Account Expenditures of the Ministry of Health (in millions of Malawian Kwacha)

<u>GOM Fiscal Year</u>	<u>Estimated Expenditures</u>	<u>Percentage Changes</u>	<u>MOH Revenue Account As Percentage of GOM Revenue Account</u>
1975-76	6.4	-	7.6
1976-77	7.0	+ 9.38	7.6
1977-78	7.8	+11.43	7.2
1978-79	10.3	+32.05	7.3
1979-80	12.0	+16.50	7.3
1980-81	15.0	+25.00	7.2
1981-82	18.7	+24.67	6.2
1982-83	17.4	- 6.95	Not Available
1983-84	18.1	+ 4.02	Not Available
1984-85	25.0 (est.)	+38.12	Not Available

Note: Table 1 shows estimated expenditures of the MOH revenue account. Most other referenced sources have shown trend analysis based on approved budget figures. In the past several years, the MOH has experienced some difficulties staying within their reduced level of approved expenditures. The estimates presented here, while not official, are a more valid indicator of actual revenue account expenditures than the published and approved budget levels.

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Fig. 4. Estimated MOH Revenue and Development Expenditures



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The MOH development account is relatively small when compared to the same account for Agricultural and Natural Resources, Education, and Transportation. Normally there is considerable inter-annual variation in development accounts, depending largely on external donor financing decisions. GOM allocations are only 5-10 percent of the total MOH development account. As such, the GOM and the MOH have limited control over the allocation of resources to the development account. The smallness of the documented MOH development account is somewhat misleading. For example, many documents do not include capital investment in water and sanitation, which in 1980/81 was MK 6.7, as a health sector capital investment. Secondly, health related investments financed by the National Rural Development Program are contained within the Agricultural Development Account rather than that of the MOH. Table 2 shows the evolution of expenditures made by the MOH from its development account.

<u>GOM Fiscal Year</u>	<u>Estimated Expenditures</u>	<u>% Change</u>	<u>MOH Development Account As Percentage of GOM Development Account</u>
1975-76	1.8	-	3.0
1976-77	1.7	- 5.56	1.1
1977-78	0.9	-47.06	0.9
1978-79	1.0	+11.11	2.1
1979-80	2.8	+180.00	2.0
1980-81	4.2	+50.00	2.4
1981-82	1.6	-61.90	N/A
1982-83	4.3	+168.75	N/A
1983-84	4.2	- 2.33	N/A
1984-85	9.9 (est.)	+135.71	5.4 (est.)

In recent planning documents (Source 1), central government officials note the necessity of higher levels of investment in the health sector if a sound and comprehensive primary health care system is to be established. Accordingly, recent plans project increasing development account expenditures from their traditional levels of 2-2.5 percent of the total GOM development account to approximately 5.4 percent. With this increased investment, a corresponding increase to the revenue account is planned to operate and maintain the higher level of capital investment.

As Tables 1 and 2 clearly show, MOH expenditures have increased substantially between 1975 and 1980, although health's relative share of central government expenditures still decreased slightly. Since 1980, the decline in health's share has been much more pronounced, and this decline has been in both absolute and relative terms as the GOM is reducing public spending and emphasizing investments with short term pay offs. There is some evidence that this recent trend has reached bottom and will gradually reverse itself over the next several years; both MOH and central government planning projections indicate such a future trend. The planned increased investment will depend to a certain extent on the ability of the GOM to continue to consolidate its health strategy, design sound projects and attract donor support for its programs.

In terms of the MOH's ability to attract greater levels of both foreign and domestic financing, several recent studies point out areas where cost efficiency could be improved. First, it is believed that the MOH's pharmaceutical procurement system can be improved and can result in considerable savings. The existing system is now under review. Secondly, a recent GOM audit of vehicle use points out areas where significant cost reductions can be made through better control and management. MOH is preparing plans for these improvements. Thirdly, the need is obvious to increase the amount of cost recovery. The MOH is presently reviewing its charge structure for services that are presently being provided on a cost recovery basis and is expected to increase such service charges. More substantial cost recovery measures are expected to result from the planned MOH/IBRD health financing plan. Finally, the MOH, with IBRD assistance, is preparing a new primary health plan which is expected to contribute substantially to more efficient utilization of available resources, including financial, human and physical infrastructure.

It is impossible to determine at present what the long term financial implications of these efforts will be. While substantial improvements are expected in terms of the GOM's ability to self-finance the recurrent costs of its health services delivery system, foreign donor assistance will continue to be required for the foreseeable future.

In short, with continued donor assistance for capital investment, the GOM should be capable of financing the operational costs of its health services delivery system. Major considerations which support this conclusion are the following:

(a) the MOH is developing a cost efficient health delivery plan which emphasizes better resource utilization and management and program consolidation;

(b) as part of the above, the MOH is developing a health financing plan which reduces operational costs and promotes greater levels of cost recovery or local financing of health services; and,

(c) the GOM has committed itself to increasing the level of funds appropriated to the health sector.

The proposed Malawi Health Institution Development project will be an important part of the MOH's efforts to better utilize existing resources as it will retrain existing mid-level health staff for the promotion of preventive and primary health care services and place much greater reliance on community participation and resources.

VIII. MCH and Child Spacing

A. History of GOM Interest in MCH and Child Spacing

The Government of Malawi began a National MCH program in 1975 which provides MCH services to the community through static and mobile clinics. Since 65.9 percent of the population is made up of mothers and young children and they have been determined to be a vulnerable at-risk group, the government has allocated substantial resources to improving MCH services and has already produced some impressive results. Nearly 80 percent of women and children currently attend MCH clinics, and it is estimated that through 600 antenatal clinics, 66 percent of pregnant women attend a clinic for at least one ante-natal visit. Also, an estimated 50 percent of young children attend Under Fives Clinics through 377 static and 638 mobile clinics throughout the country.

MCH services include nutrition surveillance, immunization, health education, antenatal care, delivery, postnatal care and identification and referral of high risk pregnancies.

The MCH approach adopted by the government has considerably expanded access to services, especially through the training of TBAs. TBAs, selected by their communities, have been trained in all 24 districts of the country. However, expanding the delivery of existing services has not been enough. Mothers attending clinics have expressed the need for modern methods of contraception, primarily because of the high failure rate of traditional child spacing methods. In Malawi, the concept of child spacing is not new, but has only been understood through the use of traditional methods, which are no longer widely practiced. In response to this expressed need, the government decided to add child spacing to the existing activities of the MCH program. In October 1983, the MOH issued a directive stating that child spacing information and services would be made available to enable couples to space pregnancies and permit adequate time between births to assure healthy mothers and children.

The definition of child spacing in Malawi therefore emphasizes the health benefits of spacing pregnancies, and contraception is not seen as a means to reduce fertility or control population. Rather, it will enable couples to choose the number and timing of their children through the use of modern methods.

The MOH has developed a Technical Review Committee on child spacing which will serve as an advisory body to coordinate child spacing activities and to set policy and guidelines for the delivery of child spacing information and services. The committee has already convened and will continue to do so periodically to provide guidance to the MOH on the best ways to integrate child spacing with other MOH programs.

The overall objectives of the child spacing program are to:

- a. promote training on child spacing for all categories of professional and auxiliary personnel, including TBAs;
- b. educate couples on the importance and necessity of child spacing; and
- c. provide child spacing as a part of MCH services.

B. Current Child Spacing Program

The MOH plans to initiate child spacing activities by conducting a Family Formation Survey; planning information, education and communication programs; training health workers and providing services. In 1983, as part of a larger health assistance package, the World Bank provided \$0.9 million to assist the MOH in introducing the child spacing program in both urban and rural areas. World Bank support includes monies to renovate antenatal facilities at Zomba General Hospital and 15 district hospitals. The Family Formation Survey will also be conducted, which will describe the level and trends of birth spacing, measure the duration and frequency of breastfeeding and the timing of supplemental feeding and gather information on preferred spacing between births and desired family size. An IEC strategy will be developed to orient community leaders to the importance of child spacing and the availability of services. The training of health workers to deliver child spacing information and services will also be part of the project.

C. The Training of Health Workers for Child Spacing

The MOH plans to use a phased approach in the training of health workers in child spacing. First, senior staff at Central and District Hospitals, to include Medical Officers and Registered Nurses/Midwives, will receive training and begin providing services. Three nurses have already been sent for advanced clinical training at the Margaret Sanger Center in New York and have returned to work under the preceptorship of Medical Officers. One Margaret Sanger graduate working in Zomba recently reported that she sees 20-30 new child spacing clients each week and including return visits, handles a total weekly caseload of 50-60 child spacing clients. These nurses have also informally started training other nurses.

The second phase will include the training of Enrolled Nurse Midwives in MCH and child spacing. The MOH plans to organize and conduct 12-14 week refresher training courses for ENMs to strengthen their MCH skills and teach them how to provide child spacing information and services to couples in their communities.

As the child spacing program is only four months old and is just getting underway, it is not possible at this point to clearly differentiate the child spacing skills and knowledge that each category of health workers would be expected to attain once training has been completed. The roles and responsibilities of these health workers are now under discussion, and the MOH has asked for assistance in the

training of ENM's in MCH/CS. One of the first activities will be to determine tasks and responsibilities for each worker, followed by the development of appropriate training courses. The nurses who went to Margaret Sanger are providing child spacing services, and in preliminary discussions with the MOH, they realize that to make child spacing accessible, ENMs will have to provide both counseling and services.

D. Summary of Needs

One of the first steps in the development of training programs for health workers in MCH/CS should be to clearly define the tasks and responsibilities that each worker is expected to perform. Evaluation and follow up should be included as important components of training to determine how well trainees are implementing new skills. Once workers are trained, it is equally important to assure that services are made available, which includes adequate equipment and supplies. Central Hospitals have already experienced contraceptive shortages, and the MOH will have to carefully plan its commodity needs well in advance to assure adequate stock and distribution. This should include a simple record keeping system to track the commodities and users in the program. While FPIA is currently providing some commodities, it is doubtful that they will be able to continue to provide all commodities needed by the MOH over the next five years. Other donors such as World Bank and UNFPA apparently believe that AID will provide contraceptives, so they are not providing contraceptives as part of their present programs.

The MOH is aware of this potential problem^{of} contraceptive supply and has agreed that commodities be included as part of the request to AID for assistance through this project. It is therefore recommended that commodity provision be included in the Project. The ordering of contraceptives should be phased and start in the second year. As exact requirements are impossible to determine at this time, it is recommended that the amount ordered start off small (e.g., calculating contraceptives for one percent of the at risk population per year) with small incremental increases. Technical assistance in the development of a management information system to include logistics and service statistics can be provided by AID centrally funded programs, such as the Centers for Disease Control Project, at no additional cost.

IX. GOM Capacity to Sustain AID-Supported Initiatives

The capacity of Malawi to carry on its work in the health sector is severely limited at present by the financial constraints described in Section VII and the manpower constraints described in Section VI of this report. However, the current PHC strategy in Malawi is aimed at developing the PHC system by building upon existing processes and resources. The widespread donor assistance to this effort derives from the belief that Malawi has opted for an approach to health sector development which it might be able to sustain with massive donor support.

With respect to the training of middle level PHC health workers, as is defined for the AID-supported project proposal, there is every indication that Malawi will be able to continue the in-country training once it is established. Furthermore, the successful training of Community Nurses, Medical Assistants and Health Assistants can be expected to expedite the process by which communities are engaged in developing local PHC systems that they will be able to sustain. The success of these local systems, especially in the areas of preventive services and child spacing, will not only enhance Malawi's ability to sustain its health sector activities but will also enhance the effectiveness of community-based efforts in the other development sectors.

X. AID's Options for Health Sector Assistance

Although there is a wide spectrum of areas of assistance which AID could provide to help launch Malawi's PHC system, the GOM is counting on AID to focus its assistance on the area of middle level manpower training. The GOM meets regularly with different donor groups and has managed to coordinate external assistance for most of the priority areas in the health sector. The FY 86 Malawi CDSS will present the long-range options for AID health sector assistance, but for the present, the MOH will be satisfied if AID can provide the expected training support in a timely and technically sound fashion. The MOH is also aware that AID is already providing valuable assistance to its water and disease control efforts.

Just as AID is not likely to consider still further development of the health sector program in Malawi until it can be determined how well the current and proposed projects work out, the GOM is not likely to want to make any more elements of its PHC strategy dependent upon AID support until it can be demonstrated that working with AID does not jeopardize their success. The delays experienced in the design of the proposed project have not been encouraging in this regard.

For the present it would appear most appropriate for AID to concentrate on demonstrating the quality of its health sector assistance through its existing projects, including the proposed training project. This project could be designed to permit more intensive child spacing assistance later in the Project, if more technical assistance and commodities are sought in this area once the full impact of the new pro-child spacing declaration is known.

XI. Conclusion: Issues and Options

In broad terms this report is intended to examine the issues of whether there is an appropriate PHC context within Malawi for AID to consider supporting the proposed project, whether the design of the proposed project is complete and appropriate to the Malawi setting, whether there are other outstanding issues and finally, whether there are alternative approaches to proceeding with project development and implementation which deserve AID consideration.

A. Current PHC Context in Malawi

The preceding sections of this report have presented the information, lacking in the proposal, which describes Malawi's approach to developing its Primary Health Care System and demonstrates the key role of the training to be supported by the proposed project. It is the opinion of this team that the GOM does have a well thought out, appropriate approach to PHC. In fact, this approach is so innovative in terms of its focus on working with the community and its overall support system, that Malawi might lead the way for other LDC countries which are struggling with their fixation on the training and support of community health workers. AID has an exciting opportunity to participate in Malawi's imaginative approach to community-based PHC through the support of middle-level health worker training, critical to the success of this effort.

B. Technical Quality of Proposed Project Design

We feel that the basic design of the proposed project is appropriate to Malawi's plans for developing the PHC system. The competency-based training approach to preparing Community Nurses, Medical Assistants and Health Assistants for their critical roles as the MOH representatives on the Area PHC Teams is appropriate, and the actual content of the respective curricula should be developed in the field as an early project activity, and as proposed.

There are, however, a few areas of the technical sections of the proposal which might be modified to advantage:

1. Evaluation of Training - the proposal should be more explicit regarding how evaluation methodology will be applied to the project's training activities to assure their effectiveness. For example, for each category of project supported training, the evaluation sequence might include, inter alia:

- a. Pre- and post testing of trainees to further identify training needs and assess immediate impact of training;
- b. Post training survey of trainees to evaluate their impressions re the relevance of their training;
- c. Skills application survey 3-6 months after field placement of trainees;

- d. Service utilization survey 1-2 years after field placement of trainees; and,
- e. Health status impact survey 5 years after field placement of trainees.

For evaluations c, d, and e to be useful there would have to be corresponding baseline data available for the period prior to the field placement of trainees. If data were also available for matched communities which did not benefit from the placement of project-supported trainees, a case-control analysis might allow attribution of improvements in services utilization and health status to the project, however, the MOH's intention to reach all communities with its PHC system should not be compromised for the sake of more scientific evaluation.

2. Participant Training - it would appear that too much emphasis has been placed on the training of both long-term and short-term participants at the proposing institutions. In the experience of this team, it is likely that the most appropriate training which can be arranged for these participants would be that which could be conducted either in Malawi or at other African sites. The proposal does not make it clear that African-based training has been adequately explored. Nor it is apparent that the proposing institutions are the best available off-shore training sites.

3. Management Plan - there should be a more explicit demonstration that the proposer has a clear understanding of the GOM-MOH/AID/grantee relationships. The Mission would like to have the Project Implementation Plan emphasize the necessity for the field development of annual work plans which would require MOH and Mission approval for continued disbursement and expenditure of project funds.

4. Contraceptive Supply - the MOH feels that its present sources of contraceptives are adequate for their projected needs. It is recommended that the MOH be provided with assistance in analyzing contraceptive demand, establishing stock control procedures and a logistics management system. However, this support can be provided through non-project sources, such as the CDC/ESAMI program being set up with the help of the REDSO Population Office.

AID might wish to add the capacity for the future provision of contraceptive supplies to this project, and provisional demand estimates could be based upon the current population size. In no case, should the addition of a contraceptive supply capacity to this project delay the progress toward project implementation still further while more study teams are fielded.

C. Outstanding Issues

The remaining issues to be discussed here are the need for there to be a single project document which rationalizes the contents of this report with the elements of the training proposal, the need to expedite progress toward project implementation and the need to resolve additional questions raised by our review of the Howard/Meharry proposal. 50

1. Need for a Comprehensive Project Document - for AID management purposes there needs to be developed a single document which combines the relevant health sector analysis material presented in this report and the training assistance information of the proposal. The comprehensive document could take the form of the grant, cooperative agreement or contract to be entered into with the proposing institution or of a conventional AID Project Paper. In either case, this team feels that the necessary information exists in the proposal and this report to preclude the necessity of fielding another team in order to draft a single comprehensive project document.

2. Need to Expedite Project Implementation - the fact that the standard approach to AID project design was not followed in this case has already resulted in certain high-ranking GOM officials questioning AID's seriousness re this project. The MOH is trying to orchestrate the multidonor support of its approach to PHC, and it has discouraged other interested donors from assisting with the proposed middle level health workers training because this was the area of assistance to be developed with AID. Since this will be AID's first major effort in the health sector, and since it will be a substantial part of the overall AID program in Malawi, AID's credibility as a serious donor/partner is dependent upon both the timeliness and the quality of the assistance provided. The MOH is already very frustrated with the delays in getting this project to implementation, and this team would strongly recommend any decisions made to expedite the arrival of quality project technicians in Malawi with adequate backstopping. It is unlikely that any further design team visits would be tolerated by the GOM.

3. Howard/Meharry Proposal Issues - while the ECPR cable makes it clear that selected aspects of AID's review of the proposal are not considered within the scope of work for this team, there are certain issues which demand our comments within the context of our professional review of the project.

a. Drop-out of Meharry University - the proposal is predicated upon Meharry University playing a significant role in the project. Now that Meharry has reportedly withdrawn from the proposal, the impact of this withdrawal upon the proposed activity must be carefully evaluated.

b. Failure to identify candidates for field positions
- Under normal circumstances major factors which would govern the selection of an institution to implement a project would include the proposed field team and project backstopping arrangements. These factors are equally important for this proposal and unfortunately project personnel are not clearly identified in the existing proposal. For this project especially well-qualified field personnel must be assured in view of the facts that (a) the PHC system is in a state of evolution in Malawi which will require field technicians who are flexible and can contribute to the continued improvement in the system's design, (b) that there is no full time health officer in the Mission and

(c) that the proposing institution does not have a strong history of managing either large overseas technician teams or large overseas training programs.

c. Institutional experience and capability - before risking the success of the project upon which much of its credibility in Malawi will depend, AID must satisfy itself that Howard University has the requisite experience and capability to undertake the project. Howard's previous experience in managing large overseas teams or in managing large overseas training programs is not known to this team. The team has found Howard's failure to describe the PHC system within which the training programs will fit and the failure to present a slate of qualified candidates as part of the proposal somewhat disconcerting. It is not clear from the proposal just how the construction elements of the project are to be handled, but Howard's ability to manage this aspect of the project must also be assessed, and an acceptable construction management plan must become part of the comprehensive project document.

D. AID's Options

This section of the report presents a discussion of the two basic options facing AID, i.e., whether to pursue the project through the unsolicited proposal mechanism already put into motion or to revert to an appropriate stage of the standard AID procedure for the development of major bilateral projects. This report treats these options only from technical perspective and does not address the political exigencies faced by AID in dealing with this matter.

1. Modification of the Present Proposal - the minimum requirement for proceeding with the present proposal would be for Howard University to revise the proposal so that:

- a. it demonstrates their clear understanding of the context material in this report and describes how their activities in the field will be integrated into Malawi's current PHC system plan;
- b. it presents full documentation of qualified candidates for the long-term and key short-term technicians; and
- c. it presents a management plan which defines Howard's capacity and procedures for backstopping the field personnel, taking over the former Meharry portion of the project and managing project construction. Howard may wish to replace Meharry as a collaborating institution if it feels that it needs more institutional experience or capability in any of these areas.

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The advantage of proceeding with the existing proposal is that it may be the fastest way to proceed to project implementation. On the other hand, there is a possible risk associated with trusting an important AID health sector first effort to a relatively inexperienced and untested institution.

2. Reverting to AID SOP for Bilateral/Projects - if AID were to choose this option in the interest of regaining some control over the quality of project design, it may be found that the design activities, documentation and ECPR evaluation to date satisfy AID's pre-Project Paper requirements. If this is the case and authorization can be given to proceed with the drafting of the PP, it should not be necessary to field yet another design team. Instead, it should be possible to put together a complete PP from the available documentation, drawing primarily from this report and the proposal. Any steps which delay getting to implementation should be resisted, although it would be expected that doing a PP would lead to competitive contractor selection.

The advantage of reverting to the standard competitive procedures for bilateral project development include that it would allow the application of proven AID criteria to both project design approval and contractor selection, it would gain the project (and the GOM and USAID) access to the full spectrum of qualified institutions and individuals in the international health community, it would permit more appropriate management of project construction, and it would afford AID the opportunity to include appropriate conditions precedent and covenants in the agreement with the GOM. The principal disadvantage that this option presents is the possibility of further delaying the implementation of the project, for which the delays already experienced are taxing the credibility of AID in Malawi.

It is the position of this team that we recommend the second option if a mechanism can be identified which will assure the arrival of the field team in Malawi before the end of FY 84. We feel that the position of the MOH would be to favor staying with Howard University if all the questions regarding the quality of the proposed field personnel and the institution's technical and managerial capabilities can be satisfactorily resolved. No agreement (grant, cooperative agreement or contract) should be executed by AID without its first being reviewed and approved by the GOM. If the unsolicited proposal process is to be used, this GOM review could also consider the draft of the agreement to be executed between the GOM and the grantee at the same time.

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Annex B: Persons Contacted During the Investigation

Ministry of Health

Dr. M. C. Chirambo	Chief Medical officer
Mr. B. M. Phiri	Deputy Secretary
Dr. G. W. Lungu	Temporary Deputy CMO
Ms. L. Kadzamira	Chief Nursing Officer
Dr. A. R. Msachi	Asst. Deputy CMO (MCH)
Mr. E. K. Bongula	National PHC Coordinator
Mr. J. Chikakuda	EPI Coordinator
Mr. A. M. D. Mosiwa	Training Officer
Ms. S. Sagawa	Registrar, Nurses & Midwives Council
Dr. A. Klauda	PHAM, PHC Coordinator
Mr. R. Ainsworth	Water Program Advisor
Dr. Rangaraj	Health Planning Advisor

Lilongwe School of Health Sciences

Mr. P. S. P. Tembo	Principal
Mr. W. H. Kumwenda	Deputy Principal
Dr. K. M. Robertson	Tutor, Clinical Officer Program
Mr. G. P. Malikebu	Tutor, Health Assistants Program