PN ABU-970

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Observations on Financing Health Services, and Diarrheal Diseases, including Cholera, in Malawi: Suggestions for USAID/Malawi Programming

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April 24, 1993

Acronyms

CCM	Christian Council of Malawi
CCCD	Combatting Childhood Communicable Diseases Project
CDD	Control of Diarrheal Diseases
CHAM	Christian Health Association of Malawi
DHO	District Health Officer
DHPCC	District Health Planning and Coordinating Committee
EPI	Expanded Programme in Immunisation
GOM	Government of Malawi
HAF	Home Available Fluid
HDA	Health Delivery Area
HSA	Health Surveillance Assistant
KCH	Kamuzu Central Hospital (Lilongwe)
MOH	Ministry of Health
MOW	Ministry of Works
NGO	Non-governmental Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PHICS	Promoting Health Interventions for Child Survival
PHC	Primary Health Care and Primary Health Centre
QECH	Queen Elizabeth Central Hospital (Blantyre)
PVO	Private Voluntary Organization
RHO	Regional Health Officer
SHARED	Support to Health, Agriculture, and Rural Enterprise Development
STAFH	Support to AIDS and Family Health

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Observations on Financing Health Services, and Diarrheal Diseases, including Cholera, in Malawi: Suggestions for USAID/Malawi Programming

Introduction. In response to the distribution of information on the USAID centrally-financed project entitled Private Initiatives for Primary HealthCare (**Initiatives**) the Office of Health, Population and Nutrition of USAID/Malawi invited a staff member of R&D/Health to visit Malawi to:

> review current and proposed approaches to financing health services in Malawi, and
>
> assess the role of the Christian Health Association of Malawi (CHAM) in the financing and delivery of health services and to determine whether CHAM would be an appropriate organization to receive assistance through the **Initiatives** Project.

In addition, R&D/H was apprised of the upcoming evaluation of the USAID/Malawi PHICS Project (Promoting Health Interventions for Child Survival, 612-0231), scheduled for the fall of 1993, R&D/H and asked to review the project paper, interview several staff working on the PHICS Project, and to consider whether the resources of the project could be used to support new initiatives in the health sector. Given the presence of endemic cholera and the increasing incidence of dysentery (bloody diarrhea) in Malawi, R&D/H was asked to assess the current status of the National Program on the Control of Diarrheal Diseases (CDD) and to suggest measures that PHICS could take to improve the operations and impact of the program.

In the course of touching rapidly on the subjects mentioned above, this report also suggests measures that USAID/Malawi could take using R&D/Health (central) resources to increase the impact of existing or proposed USAID/Malawi programs and to enhance the sustainability and impact of public and private sector health services.

It is important to emphasize that this report is not an evaluation of the PHICS Project or any other USAID/Malawi-supported activities. This report can only contribute marginally to a definitive analysis of the dynamics of the Malawian health sector and to any rethinking of USAID strategy. The remarks, conclusions and suggestions set forth are based on brief visits to a number of sites in Malawi during the period April 11-25, 1993, unstructured interviews with a few professionals working in the health sector--mostly expatriates, and a rapid reading of a limited number of relevant documents (See Annex 1 and Annex 2).

It is noted, however, that the information gathered during site visits, interviews and document reviews suggests that USAID/Malawi resources are well focussed to address and resolve conditions that constrain the development of human resources in Malawi. The two major initiatives in the portfolio of USAID/Malawi's Office of Health, Population and Nutrition--Promoting Health Interventions for Child Survival (PHICS) and Support to AIDS and Family Health (STAFH)--are supporting the efforts of the Government of Malawi (GOM) and the private sector (CHAM, NGO/PVOs) to promote the delivery of primary health care, including family planning, to increase the capacity of the total health system to plan and offer essential child survival services on a sustained basis--especially at the household and community level, and to address the most critical health problems, namely malaria, explosive population growth and the increasing prevalence of HIV/AIDS.

This report has two sections. The first, entitled Financing Health, and Diarrheal Diseases (including Cholera and dysentery) in Malawi, briefly describes health service delivery and health care financing systems and practices, and reviews data--incomplete--on diarrheal diseases in Malawi. The second section suggests some actions that USAID/Malawi might take, through the redesigned PHICS Project or other AID resources, e.g., R&D/H BASICS Project, to increase the efficiency and impact of health services.

This brief document does not review the objectives, strategies, accomplishments and lessons learned of the programs supported by USAID/Malawi. It does note that in the currently weak and deteriorating economic climate of Malawi a high percentage of scarce government and donor resources are required to treat AIDS patients at central, district, and Mission hospitals, to attend infants and children with malnutrition, malaria and diarrhea (including cholera), and to provide obstetrical care to pregnant women.[1] It also suggests that program successes in the areas of AIDS, Child Survival and Family Planning should reduce the very high levels of mortality and morbidity and increase the efficiency and quality of health services.

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[1]The 1991 Annual Report for the Ntcheu District (Central Region)--population 500,000--reports the following: "The AIDS epidemic gives rise to major problems: an increasing length of stay of patients in the hospital; an increase in the number of tuberculosis patients; diagnostic and therapeutical dilemmas, especially in children as it is difficult to discriminate between AIDS, TB and malnutrition, only to mention a few...." Malaria cases were more than 40% of patien (total visits: 835,000) who attended outpatient departments in the istrict, and about 34% of children under five were underweight. pp. 2, 10, 27. (The High prevalence of malnutrition is due to the drought of 1991 and the presence of Mozambican refugees in the Ntcheu District.)

Financing Health Services, and Diarrheal Diseases (including Cholera and dysentery) in Malawi.

Financing Health Services. (Public Sector). The National Health Plan 1986-1995 defines the overall goal of Malawian health policy as

> To raise the level of health of all its people through a sound services delivery system capable of promoting health; preventing, reducing and curing disease, protecting life, and fostering general well-being and increased productivity.

The Plan specifies six specific objectives and defines specific strategies to achieve them:

> To improve coverage through a rational network of available and acceptable facilities and services;
>
> To establish effective mechanisms for MOH manpower development and deployment;
>
> To expand the range and quality of services directed at maternal health, children under 12 months, and the children between 1-4 years by addressing priority diseases;
>
> To improve the health status generally by strengthening relevant programs, and
>
> To improve the nutritional status of mothers and young children as a basic strategy for achieving the medium term goals.

In the 1991/92 fiscal year, the Ministry of Health had a budget of 79.3 million kwacha (about US $19 million), distributed as indicated below:

Ministry of Health Estimated Expenditures: 1991/92[2]		
Category	Amt (Kw. mil)	% of Exp.
Salaries	21.3	27
Drugs	14.9	19
Other Goods/Services	39.3	49
Capital Formation	3.8	5
Total	79.3	100

Of the 39.3 million kwacha spent on goods and services, 85% went for hospital-based care; the remaining 15% was spent on promotive, preventive and basic curative services at MOH health posts, health centers and satellite clinics.[3]

The figures above warrant two observations. First, in comparison with ministries of health in most other countries of Africa, the percentage of the health budget that Malawi spends on staff salaries of MOH personnel is very low. It is not uncommon to find 80% of the health budget committed to staff salaries in many African countries. Several factors may explain the striking difference between Malawi and other African countries. First, many of the top posts, especially the Regional Health Officers (RHO) and District Health Officers (DHO), of the MOH are filled by expatriates who are paid by donors. In addition, many MOH posts are not filled. Finally, the salaries of most MOH staff are very low.[4]

Second, like other African nations, there is a clear dichotomy between the pattern of expenditure and health policy. While health policy clearly favors primary and preventive services, only 15% (7.5% of the total health budget) of the health services budget was spent on primary health care. While the amount spent

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[2] Healthcare in Malawi, n.d., 13.

[3] Ibid., 13.

[4] According to a Government of Malawi circular of September 21, 1992, annual salaries for Senior Technical Assistants, Nurses and Technical Assistants are as follows: Senior Enrolled Nurse/Midwife ($1,178); Enrolled Nurse/Midwife ($895), and Technical Assistant ($745). These are the basic salaries and do not include other allowances, e.g., housing. See GOM memorandum (September 21, 1992), "Salaries for Senior Technical Assistants (STA) Nurses and Technical Assistants (TA) and Correction of Circular Letter Reference NO. PD/103/1/214 of 12th May, 1992." A District Health Officer reportedly earns about $3,600/year.

on primary health care is modest when compared with expenditures for inpatient and outpatient curative care, the percentage is probably higher than the average for most African nations. Nigeria, for example, which is repeatedly praised for its programmatic emphasis on primary health care, does not spend more than 7% of the total health budget, a figure comparable to Malawi.

Government policy has been to provide free health services in both urban and rural facilities. Food for inpatients and free transport for referred patients has also been provided by the government. The three major hospitals--Queen Elizabeth Central Hospital (QECH), Kamuzu Central Hospital (KCH) and Zomba General Hospital (ZGH)--and a few district hospitals, e.g., Ntcheu, have facilities for paying patients. The amount generated annually through user fees is estimated to be 900,000 Kwacha (about US $212,000).[5]

In response to recent and severe domestic economic and political crises as well as pressure from the World Bank[6] and other international donors, and recognizing that the demand for service by the growing population (3.3% annually) is steadily increasing along with the cost of health care, the government has begun to question its long-standing policy on free health care. Aware that many health units, including the central hospitals, have recently found themselves without critical supplies of pharmaceuticals and medical supplies and unable to increase the percentage of the government budget allocated to health, the MOH commissioned a study to examine approaches to revenue generation.[7]

The study recommended that user fees be charged for inpatient and outpatient services at QECH and KCH, and argued that user fees could effectively increase the quality and efficiency of services, facilitate coordination with the facilities of the Christian Health Association of Malawi (CHAM)--which charges fees, discourage unnecessary attendance at outpatient departments and health centers, and ensure the ready availability of an adequate supply of effective pharmaceuticals.

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[5] See M.W. Mbvunbula, F.R. Mwanbughi, O.J.B. Itimu, Introduction of Cost Sharing in Government Health Facilities, (draft) August 1992, p. 22. Hereinafter cited as Cost-Sharing.

[6] A condition of the World Bank Health Population and Nutrition Sector Grant is that Malawi will introduce user fees at certain health facilities.

[7] Cost-Sharing.

The study recommended that user fees be introduced in April 1993 and evaluated in April 1994.[8] In spite of pressure from the World Bank, the government has not introduced cost-sharing. Reports indicate that the government is reluctant to introduce user fees until the urban health units in Blantyre and Lilongwe have been rehabilitated and the June 14, 1993 referendum on the future of the one-party system has taken place. The government suggests that the "cost-sharing program" can begin on October 1, 1993. In the meantime, the government has begun to define the managerial policies and procedures needed to implement the new user fee system, e.g., establish the cost-sharing secretariat at the MOH, print stamps and cards, etc.

At present, therefore, the government finds itself politically unable to alter the policy on health services and economically unable to increase the MOH allocation to a level sufficient to meet all the costs of the system. As a consequence, many health centers in the MOH network are without personnel and pharmaceuticals, and unable to offer a comprehensive program of care. At the same time, the district and central hospitals are overcrowded and incapable of meeting the demand for service.

Financing Health Services (Private Sector). The Christian Health Association of Malawi (CHAM). The Christian Health Association of Malawi (CHAM), which operated as the Private Hospital Association of Malawi (PHAM) from its founding in 1966 until February 1992, is a network of 147 predominantly church-affiliated health facilities[9] distributed throughout Malawi, and a secretariat based in Lilongwe. The largest percentage of members of CHAM are affiliated with either the Episcopal Council of Malawi (ECM), a Roman Catholic organization, or the Christian Council of Malawi (CCM), a Protestant organization; each group holds 14 seats on the 30-member CHAM Council. The table below lists the facilities directed by the MOH and CHAM.

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[8] An estimated 2.1 million Kwacha will be generated following the introduction of the cost-sharing scheme. However, the estimated cost of introducing and operating the scheme at QECH and KCH is 2.4 million Kwacha. Ibid., pp. 22, 26.

[9] Within the CHAM network are 16 hospitals, 22 rural hospitals, i.e., "primary health centers," 82 health centers, 20 dispensaries, 3 maternity units, and 4 health posts. See Ministry of Health/Malawi, Report of Health Services in Malawi: Report of a Study on Co-ordination and Collaboration between the Ministry of Health and the Private Hospital Association of Malawi, February 1992. Hereinafter cited as Study on Co-ordination.

Number of Health Facilities by MOH and CHAM[10]		
Type of Facility	MOH	CHAM
Hospitals	24	20
Leprosaria/Mental Hospitals	2	0
Rural Hospital/Primary Health Center	20	19
Dispensary/Maternity	113	63
Maternity Unit	9	11
Dispensary	94	24
Total number of units	262	137

Unlike the MOH facilities, CHAM units charge for inpatient and outpatient services, although preventive services are free. The fees received cover on average 35% of the expenses of the CHAM facilities; at many facilities, however, the percentage is smaller, e.g., reportedly 20% at St. Luke's Hospital in Malosa in the Southern Region of Malawi. Although fees at CHAM units are not uniform, they are comparable and, since most CHAM units operate in the rural areas of Malawi where 88% of the population is resident, these facilities have limited ability to raise user fees dramatically and substantially in response to increase costs or utilization.

Most CHAM hospitals charge outpatients a basic fee per illness; this fee covers the cost of consultation, inexpensive drugs (e.g., aspirin, chloroquine), and registration cards. The fee at Nkhoma, for example, is 1 kwacha for adults and 50 tambala for children; it is less at some other CHAM facilities. St. Luke's at Malosa, like most of the Anglican facilities, has a different system. Outpatients pay a fee that covers treatment for one month; adults pay 1 Kwacha per month and children are charged 50 Tambala.

Inpatient fee vary across CHAM facilties. Charges are itemized and include accommodation, drugs, medical supplies and sometimes food. Charges per day and per item vary by facility and most CHAM units have a ceiling on charges.[11] At St. Luke's, for example, the ceiling is 50 Kwacha for adults and 25 Kwacha for

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[10] Healthcare in Malawi, n.d., 4. See also Government of Malawi and United Nations in Malawi, The Situation Analysis of Poverty in Malawi, pp. 179-180. Hereinafter cited as Poverty in Malawi.

[11] The Catholic facility at Matisi, for example, does not have a ceiling on fees.

children. If patients are judged unable to pay, fees are waived.[12]

CHAM facilities generally have four sources of income: grant funds from the MOH--used to pay Malawian staff salaries and support nursing students, user fees, foreign donations in cash and kind, and locally generated revenues.[13] While the percentage that each of these categories contributes to the income of any given CHAM unit varies markedly, the MOH grant is generally the highest percentage, estimated to be 38% on average.[14] Some CHAM units receive few foreign grants and donations; others, e.g., Nkhoma and Mlambe, receive significant support.[15] Although it ranges from modest to considerable, this foreign support is often the element that allows a given CHAM unit to break even or operate at a surplus.

As noted in the recent MOH/CHAM report (1992) on coordination and collaboration between CHAM and the MOH,

> PHAM [CHAM] health facilities function as autonomous units with little influence or support from PHAM [CHAM] or from PHAM [CHAM] units of other churches. There is also little coordination and collaboration in delivery of health services within the same church, between dioceses and synods, for example. Furthermore, there are no formal links between health facilities operated by the MOH and the churches.[16]

Operationally, CHAM is different from other PVO health networks in African countries, e.g., the Church Health Association of Kenya. In many of these networks, a strong secretariat provides technical assistance to member facilities (units) in need and fosters collaboration between MOH and PVO units. However, given that the constitution of CHAM only allows the secretariat to have "advisory and coordinating functions," it is not surprising to find that the CHAM secretariat provides very few professional,

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[12] At Nkhoma hospital, for example, clinical officers and doctors determine the patient's ability to pay.

[13] Some of the CHAM units have training programs for health personnel, e.g., Nkhoma, St. Luke's (Malosa). The fees received are generally included in the income position.

[14] Study on Co-ordination, p. 32.

[15] Mlambe Hospital (outside Blantyre), for example, has an endowment in the Netherlands--The Friends of Mlambe--that generates interest sufficient to cover most of the cost of the annual pharmaceutical requirement.

[16] Study on Co-ordination, p. 11.

technical, financial and administrative services to the membership.

In some measure, many CHAM members do not look to the secretariat for technical assistance. For many, technical assistance comes from the foreign congregations and associations that supply personnel, finance and supplies. In the minds of many members, the Secretariat has two principal roles:

> first, to lobby the Government of Malawi to provide the annual grant, first authorized in 1978, needed to pay the salaries and benefits of Malawian staff,[17] and
>
> second, to ensure that CHAM units can continue to purchase pharmaceuticals and medical supplies through the Central Medical Stores of the MOH.

In the minds of many members, the Secretariat--supported by grants from international donors, e.g., UNICEF, and church organizations, e.g., DANCHURCHAID, rent from the Medical Council of Malawi, and a member contribution of 2% of the amount that each receives in the form of Malawian staff salaries from MOH grant--is fundamentally a lobby that protects the interests of the member units before the MOH. While the staff of CHAM units are aware of the inconsistencies and inefficiencies within the operations of CHAM units and between CHAM and MOH facilities, each CHAM unit aggressively defends its autonomy.[18]

CHAM and the MOH hotly debate the percentage of services that each contributes to the Malawian population. In general, the MOH has argued that CHAM units are underutilized and more fully

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[17] The MOH authorized a grant to CHAM of 7.1 million Kwacha for the 92/93 fiscal year but only paid about 5 million Kwacha. Some of this shortfall is being covered by a bridging grant from USAID/Malawi through the PHICS Project. CHAM units are appropriately concerned that the MOH will not be able to provide an allocation sufficient to cover Malawian staff salaries in 93/94, forcing some unit to threaten to close. St. John's (Mzuzu) threatened to close in 1992 but received funds and remains open. The grant for 91/92 was 4.6 million Kwacha.

[18] Study on Co-ordination, p. v. "An MOH/PHAM [CHAM] Liaison Committee is ineffective because it is an informal arrangement with neither terms of reference nor a fixed membership. It met only three times between 1982 and 1991.... Furthermore, there is no specific officer in the MOH responsible for liaison with PHAM [CHAM] and other non-governmental organizations." The staff of the CHAM units visited--Nkhoma, St. Luke's, Mlambe--noted that it was expensive to have to supervise and support health centers that were quite distant from the central CHAM hospitals. However, since these centers had been established by the congregation, the hospital staff was expected to supervise their operations. In many cases, the staff passes MOH units to supervise and support activities at the centers affiliated with the CHAM institution.

staffed than government facilities.[19] Ministry personnel have claimed that CHAM units attract better-off clientele, although most Malawians are relatively poor, and that CHAM units have more to offer because of foreign grants and donations in kind.

CHAM generally has cited its record of inpatient care and the contribution the network has made to developing health manpower in Malawi.[20] CHAM has also claimed that foreign donations in cash and kind have allowed units to compensate Malawian health professionals at levels mandated but not provided by the MOH and to continue to offer services when pharmaceuticals and medical supplies are out or in short supply at the Central Medical Stores.

The recent economic difficulties confronting the Government of Malawi may have rendered this debate moot. At present, many government health centers are without drugs; some have no staff and are not functioning. Consequently, the outpatient departments of central and district hospitals (Ntcheu, QECH and KCH) are bursting and CHAM units appear to be experiencing higher than average utilization rates. Likuni Hospital (Lilongwe), for example, classified as "averagely busy" in the Study on Co-ordination (1992), currently has a current inpatient utilization rate in excess of 100%.[21]

Although CHAM is beginning to promote primary health care at the household and community level, in response to government policy and the clear recognition that steps must be taken to decrease the demand for curative care, progress has been slow. Most CHAM units continue to focus on their traditional course of facility-based curative care. Only a few CHAM units, e.g., St. Luke's at Malosa (Southern Region) and Ekwendeni (Northern Region), appear to have a serious commitment to the promotion of PHC.

Diarrheal Diseases, including Cholera and dysentery. The recently available Malawi Demographic and Health Survey notes that Malawi continues to have high rates of infant (134/1,000),

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[19] "There are distortions in health service utilization with MOH services heavily utilized and PHAM [CHAM] unit generally underutilized and therefore relatively overstaffed. For example, in 1990 out of total outpatient attendances of 11 million, 8 million (72%) visited MOH facilities whereas 1.3 million (12%) attended PHAM [CHAM] facilities although PHAM [CHAM] units have the capacity to treat many more patients." See Study on Co-ordination, p. 16. CHAM, of course, questions the accuracy of government data and notes that CHAM units provide almost 40% of inpatient services in Malawi.

[20] CHAM has nine nurse training schools that produce nearly 70% of Malawi's enrolled nurses.

[21] Study on Co-ordination, p. 88. This was also noted during an observational visit.

childhood (114/1,000) and under-five mortality (233/1,000).[22] These rates are among the highest in Africa, if not the world. The MOH estimates that pneumonia/TB/respiratory (AIDS?), nutritional deficit, malaria, diarrhea and malaria are the commonest causes of mortality (1990) for all ages of the population, and that malaria (18.6%), nutritional deficit (17.3%), anemia (12.8%), pneumonia (12.6%) measles (10.7%), and diarrhea (8.1%) are the most common cause of under-five mortality.[23].

Although the Malawi DHS offers no information on malaria, the data on diarrhea and malnutrition suggest that both contribute significantly to high rates of mortality. The data indicate that diarrhea is highest during ages 6-23 months, the period when weaning liquids and foods are introduced. Thirty-six percent (36%) of the children in the Malawi DHS had diarrhea within the two weeks prior to the survey. It is noteworthy that women's education did not seem to effect the data on prevalence of diarrhea but was significant when reviewing data on responses to questions on the treatment used for the diarrhea episode.

Most troubling in the Malawi DHS are the data on malnutrition which reveal that more than 50% of the children under five are stunted, "about half of these moderately or severely stunted or very short for their age."[24] Reports by CHAM and MOH staff who were recently visited indicate that inpatient diarrhea cases among children are particularly severe and that approximately 75% of the malnourished children with diarrhea fail to respond to treatment.

The MOH has had a National Control of Diarrheal Diseases Program in place since 1985 and released a second five-year plan in 1990. This recent plan notes that

> Diarrhoeal diseases are a major cause of morbidity and mortality in Malawi, especially among young children. Diarrhoea is the fourth cause of health facility visits among children under five after malaria, respiratory infection and skin disorders. Eight percent of under five hospitalizations and seven percent of hospital deaths are due to diarrhoea. Considering the close association between diarrhoeal diseases with other major causes of childhood

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[22] National Statistical Office - Republic of Malawi, Malawi Demographic and Health Survey, (First Report), 1992, table 14, p. 31. Hereinafter cited at Malawi DHS.

[23] See Poverty in Malawi, p. 163.

[24] Malawi DHS, p. 10.

diseases such as measles and nutritional deficiencies, the problem of diarrhoea in Malawi is considerable.[25]

However, as many note, since the departure of the staff of the Combatting Childhood Communicable Diseases Project (CCCD) in 1988, the National CDD Program has not moved as aggressively as some other child survival interventions, e.g., Expanded Programme on Immunisation (EPI). At present, for example, while coverage surveys show that 82% of children under five are fully immunized, the percentage of inpatient child deaths from diarrhea have remained relatively constant for the period 1985-1990.[26]

The National CDD Program has emphasized correct case management of diarrhea using oral therapy. However, there is a less than clear policy on the use of ORS at the household level and incomplete information on the nature and efficacy of home-available fluids (HAF) used by mothers to treat diarrhea. In addition, little has been done to develop and disseminate messages promoting appropriate actions to prevent and/or treat diarrheal diseases, although there are indications that more than 50% the mothers in the Malawi DHS were treating their children with some form of oral rehydration solution; "32 percent with a solution prepared form pre-packaged sachets, and 35 percent with a home-based preparation."[27]

Although cholera has been endemic in parts of Malawi--especially the Southern Region--since 1971, the outbreak in 1992/93 took place at a time when the National CDD Program was relatively unprepared. The government delayed purchasing adequate stocks of pharmaceuticals, especially ringer's lactate and ORS, because of foreign exchange shortages. Also, the country was afflicted with drought. Finally, UNICEF's orders for ORS, placed with UNIPAC/Copenhagen and with Pharmanova Ltd. (Blantyre), were slow to arrive. As a consequence, supplies were not adequate when the cases of diarrhea, cholera and shigella dysentery began to appear at the health facilities and in the refugee camps.[28] At present

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[25]Ministry of Health, Malawi National Control of Diarrhoeal Diseases Programme: Five-year Implementation Plan - 1990-1994 (draft), 1990. Hereinafter cited as Malawi National CDD Programme.

[26]Deaths from diarrheal disease may have increased during the drought. Data are not available to draw this conclusion.

[27]Malawi DHS., p. 9.

[28]Shigella dysentery appeared in 1992/93. The Regional Health Officer for the Central Region reports that dysentery had not been a problem until 1992/93.

(April 1993), there are more than adequate stocks on hand to treat current and expected cases.[29]

The figures in the table below, which offer incomplete data on the cases and deaths by region for cholera and dysentery, suggest that the Southern Region may have been most affected. These data do not include data on non-cholera, non-dysentery diarrhea, nor information on the cholera and dysentery situation in the refugee camps. It is noteworthy that in 1989, the most recent year for which data on "enteritis and other diarrhoea" are available, there were more than 275,000 outpatient visits by children under-five and 7,000 admissions, a figure many times larger than the estimated cases of cholera and dysentery.[30]

Cholera and Dysentery by Region: 1992/93[31]								
Region	Cholera (1992)		Dysentery (1992)		Cholera (1993)		Dysentery (1993)	
	Cs	Ds	Cs	Ds	Cs	Ds	Cs	Ds
North	71	5	139	13	11	3	2,180	28
Central	?	?	29,744	237	2,771	143	19,246	56
South	?	?	?	?	18,819	283	20,582	253

It should also be emphasized that in 1992/93 diarrhea, cholera, and dysentery occurred during a severe drought. The drought undoubtedly influenced nutritional status adversely which, in turn, may have increased the severity and duration of the diarrhea diseases. Poor nutrition lowers the body's resistance to infection, and undernourished children and adults become more prone to common infectious diseases, recover more slowly, or die from infections.

Since the departure of CCCD staff, UNICEF has been the primary donor supporting MOH activities in CDD. With an annual budget of approximately US $200,000, UNICEF has purchased ORS and supported the training of extension and PHC workers, and the revision and

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[29] Personal communication with the pharmacists at Central Medical Stores (Blantyre) and visual inspection of the pharmacies at the hospitals and clinics visited.

[30] Malawi National CDD Programme, p. 13.

[31] The figures were provided by the Regional Health Offices in the three regions. Figures for 1993 are for the three months period, January to March. See also the articles in the February 1993 issues of Southern African Economist on cholera in the region.

printing of the diarrhea treatment chart, as well as some IEC materials.[32] Some of the resources of USAID/Malawi's PHICS Project have also supported activities in CDD.[33] These and other PHICS-supported activities are scheduled to be evaluated in the fall of 1993.

Suggestions for USAID/Malawi Programming.

Malawi does not appear to be an appropriate site for work by the R&D/Health-financed **Initiatives** Project, an activity designed to encourage private--primarily for-profit--providers working in peri-urban location to incorporate primary and preventive services in their predominantly curatives practices. Most Malawians reside in rural areas (88%) and urban-based private providers are few.

However, the rate of urbanization is rapidly increasing in Malawi. Blantyre, Lilongwe and Mzuzu, the principal cities in the three regions, are steadily incorporating communities once considered rural. In addition, more physicians are opening private clinics and dispensaries, although the total number in private practice is still very small. For example, within the last year a Malawian physician who had been residing abroad has returned to the country and opened a clinic in Mzuzu. Also, within the last four months three physicians working at Kamuzu Central Hospital (KCH) have opened a private clinic at City Centre, just opposite the USAID/Malawi offices. These physicians see private patients at noon and in the evening.

USAID/Malawi should track the urbanization trends and monitor the growth of private medical practices, both physician and non-physician. CHAM might be encouraged to establish a membership category that allows private providers to join the association. In return for membership fees paid to CHAM, private physicians could receive training on the latest techniques and up-to-date materials on child survival interventions, family planning, and HIV/AIDS. CHAM might also explore the possibility of providing contraceptive supplies and a limited number of essential drugs, e.g., ORS, to private providers.

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[32] Malawi National CDD Programme, p. 16.

[33] See PHICS, Project Paper, pp. 22-44. "The main objectives of PHICS support for Malawi's CDD/ORT program include: to improve the quality of services available at fixed facilities; to extend the availability of ORT/ORS services to the community level; to provide families with the means to prevent, diagnose and treat diarrheal diseases at home, and to prevent diarrheal diseases through increased access to and utilization of safe water, sanitation, and hygiene education (pp. 18-19).

Financing Health Services (Public Sector). The World Bank has been pressing the Government of Malawi to introduce a cost-sharing, i.e., a cost-recovery, program at KCH and QECH. If, as expected, health budgets remain constant or increase only slightly while the cost of care, especially pharmaceuticals, and demand for services increase dramatically, the government's ability to offer service will be severely constrained. While it was not possible to visit all MOH and CHAM units, it is clear from interviews and visits that many MOH units are not operating, that the outpatient departments of the large central hospitals are experiencing increased service demand, and that utilization rates at CHAM units are increasing.

With World Bank assistance and persuasion, the government is beginning to examine and support several activities designed to address the current crisis in the delivery of health services:

- enhance the ability of the health units operating at the periphery of the system to provide more effective primary health care services and to refer fewer clients;

- increase the number of health professionals, e.g., Health Surveillance Assistants, working at the village level and teach them to identify and serve "families at risk" with primary health care services, and

- introduce cost-sharing programs at all outpatient departments.

Supporting outreach activities should enhance the quality of the health services at the periphery of the system and reduce the demand on the district and central hospitals. If properly estimated and implemented, introducing cost-sharing should generate revenues needed to offset recurrent costs and discourage inappropriate or misuse of health services.

USAID/Malawi should actively support the efforts of the World Bank to persuade the Government of Malawi to introduce cost-recovery mechanisms. If the GOM is interested in reviewing experiences in health financing in other countries, USAID/Malawi might ask the R&D/H-financed Health Financing and Sustainability (HFS) Project to send information on the results of applied research and technical assistance activities.

At the same time, the evaluation of the PHICS Project, scheduled for the fall of 1993, offers USAID/Malawi an opportunity to consider reprogramming the project's resources to support decentralization of health services and the promotion and provision of child survival services, especially CDD, ARI,

Malaria at the household, village and district level.[34] As one observer noted, "PHICS is a name but not an activity." Although developed "to increase the institutional capacity of the MOH and the MOW to deliver child survival services on a sustained basis, and to increase the supply and utilization of these services at the community and family level,"[35] most of the resources are consumed by the headquarters staff of the MOH; reports indicate that few resources are targeted to reach and strengthen the operations and activities of the regions and the districts.

The evaluation team should consider the manner in which project resources can be targeted directly at the regional and district levels without first passing through or being approved by the authorities at the national level. Thought should be given to supporting the development and implementation of annual district and regional workplans that set forth targets and budgets designed to increase the quality and quantity of child survival services. Plans should include indicators that tabulate more than process, e.g., number of HSAs trained; the focus of the plan should be to document the capacity of trained personnel and the quantity, quality, and impact of the services provided.

While increased attention should be given to supporting regional and district level activities, as articulated in the government's policy on PHC and decentralization, some activities should remain at the national level, e.g., manpower planning and HIS at CHSU. It remains for the evaluation team to specify the level of support required at the national level and to define the indicators that measure progress toward a specific objective.[36]

Financing Health Services (Private Sector). The Christian Health Association of Malawi (CHAM). CHAM was recently awarded a SHARED (Support to Health, Agriculture, and Rural Enterprise Development) Project grant of slightly more than US $100,000. Housed in the CHAM secretariat, the grant will support

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[34] USAID/Malawi should consider inviting R&D/H staff and perhaps staff of the new R&D/H-financed BASICS Project to participate in the evaluation. Dr. Al Bartlett, Dr. Jerry Gibson and Ms. Holly Fluty designed the new BASICS Project, which replaces the R&D/H-financed PRITECH, REACH and HealthCom Projects, and are familiar with issues related to integrating and strengthening child survival services throughout the health system.

[35] PHICS, Project Paper, p. 1.

[36] If, for example, the objective is to increase the capacity of the HSAs to deliver child survival services and messages at the household and village level, indicators other than "workshops attended" will have to be introduced and tracked.

the preparation of a five-year workplan plan, to be prepared by the Centre for Social Research at the University of Malawi,

the development of a health information system (HIS), designed to document the clinical and managerial operations of the CHAM units, and

the provision of management training for the staff of CHAM and the member units.

This grant may make a useful contribution to enhancing the managerial capacity of secretariat staff. At the same time, unless a strenuous effort is made to involve CHAM units in the activities supported under this grant, the tensions between the secretariat and the units could increase. As evidenced at the recent semi-annual CHAM Council Meeting (April 21-22, 1993), there is a considerable amount of miscommunication between the secretariat and the units and a perception on the part of the units that the secretariat is not always "serving the interests of the members."

The PHICS evaluation team should work with the CHAM secretariat to (1) determine what needs to be done to identify and support the needs of the membership, (2) encourage the members to provide primary and preventive care through outreach programs, (3) document the cost, quality and impact of the service provided and (4) provide the information collected and analyzed to the MOH and international donors.

The PHICS evaluation team should review the managerial structure and capacity of the CHAM secretariat and suggest how the secretariat could provide:

the MOH and international donors with the financial information and health service statistics needed to secure support for the ongoing operations of the CHAM units, and

the membership of CHAM with the services required to enhance their capacity to manage and document their activities, giving special emphasis to the promotion and provision by CHAM units of PHC at the household and village level.

The proposed organizational structure below has been discussed with the Executive Secretary and the Chairperson of CHAM and attempts to incorporate the twin objectives of CHAM. The committees and staff noted are already in place but not currently viewed by the membership as especially helpful or effective.

CHAM Organizational Structure					
CHAM Council (30 members)					
Executive Secretary: liaison with Executive Committee functions: 1. inform and lobby MOH and donors 2. direct operations of the secretariat to support the field operations of CHAM units (supported by Secretariat staff)					
Staff Committees[37]	Deputy Director Mgmt/Finance/Administration			Coordinator Primary/Curative Services	
Primary Health Care	X	X	X	X	
Drug management	X	X	X	X	X
HIV/AIDS	X	X	X	X	X
Training	X	X	X	X	X
Planning	X	X	X	X	X
Promotion	X	X	X	X	X
Operations Research	X	X	X	X	X

Through visits to CHAM units and discussions with the secretariat staff the PHICS evaluation team could define the priorities of the units and the measures that need to be taken by the secretariat staff to support and document the work of the member units. While secretariat staff can only provide "advice and coordination," staff should not hesitate to encourage the units to streamline activities based at fixed facilities, reduce recurrent costs, and to promote outreach activities. The motto of CHAM staff, at both the secretariat and among the member units, should be "better not bigger," meaning that the organization should emphasize quality, efficiency and equity.

The MOH and CHAM have spent considerable time and energy discussing coordination and collaboration. It is clear from written reports and discussions that the MOH questions the value of the annual contribution made to CHAM and appears to want to incorporate the association within the MOH system. On the other hand, CHAM supports and follows MOH guidelines and policies, e.g., Malawi National Formulary, but retains a significant degree of autonomy. It would be useful for the PHICS evaluation team to review the reports on coordination and collaboration and to suggest how some of the objectives of each party might be attained. It is also noted that collaboration and coordination are often praised as noble objectives but seldom realized.

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[37] Wherever an "X" appears, some activity is required. For example, when dealing with PHC, CHAM must provide training and support in both clinical and managerial aspects.

CHAM offers the population of Malawi a separate channel for accessing health care. At a time when the MOH is unable to meet the demand for service and reluctant to alter policies that might increase the amount and quality of services, e.g., cost-sharing schemes, should coordination, collaboration and integration be emphasized? Or, should CHAM be urged to document and promote what it is doing to provide primary and curative health care to Malawians? Could the PHICS evaluation team suggest concrete activities, agreeable to both CHAM and the MOH, that foster collaboration but do not make one system subservient to the other?

Diarrheal diseases, including Cholera and dysentery. Diarrheal diseases are a well-documented seasonal phenomenon in Malawi. While cholera and dysentery are expected to occur in the future, their prevalence should be reduced since the drought has ended. However, as long as water supply and sanitation programs are inadequate to cover the entire population, diarrhea will continue to be a significant percentage of mortality and morbidity among young children.

This report suggests that the PHICS project should be redesigned to support activities at the regional and district level but recognizes that the National CDD Program needs strengthening. With the withdrawal of CCCD staff, UNICEF has been playing a central role in supporting CDD activities. UNICEF should be encouraged to continue to be the focal point for donor assistance at the national level. UNICEF, along with WHO, should be invited and supported to work with the National CDD Program Manager and the staff of the MOH to ensure that all components (policy, training, promotion, supplies, monitoring, etc.) of the National CDD Program are defined and in place.

The PHICS evaluation team should work with regional and district health officers to examine conditions in the southern and central regions, where diarrhea is most prevalent. The PHICS evaluation and RHOs and DHOs should define what can be done to inform the population and to improve the availability and quality of case management at the household and health facility levels. In the area of diarrheal diseases, the PHICS Project should support the development and implementation of measures that increase the knowledge and improve the health-behavior of clients with diarrhea, including cholera and dysentery.[38] At the same time, PHICS resources should enhance the capacity of the local health system to plan and ensure the delivery of effective care.

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[38]The recently released information sheet on bacillary dysentery (shigellosis) might be helpful to a clinical officer but of little use to the average client.

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