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System-Wide Effects of the Global Fund in Malawi: Baseline Study Report

October 2005

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- ▲ *Implementation of appropriate health system reform.*
- ▲ *Generation of new financing for health care, as well as more effective use of existing funds.*
- ▲ *Design and implementation of health information systems for disease surveillance.*
- ▲ *Delivery of quality services by health workers.*
- ▲ *Availability and appropriate use of health commodities.*

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Abstract

This paper reports interim findings from research conducted under the auspices of the Systemwide Effects of the Fund (SWEF) research network to assess the effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) on the broader health system in Malawi. The overarching objective of the SWEF research is to assess how GF support has interacted with the health systems of recipient countries, focusing on four thematic areas: (i) the policy environment; (ii) human resources; (iii) the public/private mix; and (iv) pharmaceuticals and commodities. Baseline data were collected through document review, key stakeholder interviews, and facility and provider surveys.

Malawi is the recipient of significant GF resources, largely through a grant to expand HIV/AIDS related efforts within the country, in addition to a smaller grant to focus on malaria. From early on in the GF grant application process, stakeholders in Malawi have acknowledged the importance of addressing health systems issues to ensure achievement of disease-specific goals. However, some systems issues originally included in Malawi's grant application were excluded from the final approved grant agreements. Overall, the baseline SWEF findings suggest that GF support has caused a range of different types of effects on Malawi's health system. While some evidence shows that GF support has aggravated existing weaknesses in the health system, there are also some cases where GF support may contribute to strengthening elements of the system.

The Partners for Health Reform *plus* will conduct follow-up SWEF research in Malawi in 2006, which will shed further light on the systemwide changes related to the influx of GF resources.

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Acronyms

ACT	Artemisinin-based Combination Therapy
ADB	African Development Bank
ART	Antiretroviral Therapy/Treatment
ARV	Antiretroviral
BLM	<i>Banja La Mtsogolo</i>
CBO	Community-based Organization
CCM	Country Coordinating Mechanism
CDC	U.S. Centers for Disease Control and Prevention
CHAM	Christian Health Association of Malawi
CHBC	Community Home-based Care
CIDA	Canadian International Development Agency
CMS	Central Medical Stores
DAC	District AIDS Coordinator
DACC	District AIDS Coordinating Committee
DFID	Department for International Development (UK)
DHTSS	Department of Health Technical Services and Support Services
EHP	Essential Health Package
EHRP	Emergency Human Resource Relief Programme
FBO	Faith-based Organization
FMA	Financial Management Agency
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
IAWP	Integrated Annual Work Plan
IEC	Information, Education and Communication
ITN	Insecticide-treated Net
JICA	Japan International Cooperation Agency
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MACRO	Malawi AIDS Counseling Resource Organization
MAP	Multi-sectoral AIDS Project

MBCA	Malawi Business Coalition against AIDS
MGFCC	Malawi Global Fund Coordinating Committee
MLG	Ministry of Local Government
MOF	Ministry of Finance
MOH	Ministry of Health and Population
MOU	Memorandum of Understanding
MPRSP	Malawi Poverty Reduction Strategy Paper
MTP	Medium Term Plan
NAC	National AIDS Commission
NACP	National AIDS Control Programme
NGO	Non-governmental Organization
NHP	National Health Plan
NORAD	Norwegian Agency for Development Cooperation
OI	Opportunistic Infection
PHR<i>plus</i>	Partners for Health Reform <i>plus</i>
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
POW	Programme of Work
PR	Principal Recipient
PSI	Population Services International
RMS	Regional Medical Stores
SP	Sulfadoxine-pyrimethamine
SWAp	Sector-wide Approach
SWEF	System-wide Effects of the Fund
TB	Tuberculosis
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
UO	Umbrella Organization
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Glossary

Country Coordinating Mechanism (CCMs): country-level partnership that develops and submits grant proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), and then monitors implementation if proposals are funded. CCMs are intended to be multi-sectoral, involving broad representation from government agencies; non-governmental, community- and faith-based organizations; private sector institutions; individuals living with tuberculosis or malaria; and bilateral and multilateral agencies.

Principal Recipient (PR): local entity nominated by the CCM and confirmed by the GF as legally responsible for program results, monitoring and evaluation, and financial accountability in a recipient country. Once the GF Board approves a proposal, the GF Secretariat negotiates and signs a two-year grant agreement in which disbursement of funds to the PR is based on the achievement of measurable results, i.e., performance-based funding. There may be multiple public and/or private PRs in a country.

Local Fund Agent (LFA): independent professional organization that the GF contracts to assess the capacity of the PR to assume financial and programmatic accountability prior to signing a grant agreement. Subsequently the LFA provides independent oversight and verification of progress and financial accountability.

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Lastly, we would like to thank our Secretary, Ms. Mwayi Gumbo, for ensuring that all our appointments were confirmed and for all the secretarial support services that she provided during the execution of the study.

While we believe that we have presented the views of our informants, we also realize that human beings are not error-free. It is with this in mind that we wish to apologize in advance for any errors in the manner we may have misrepresented the information which was provided by our informants.

Executive Summary

In January 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) was established as an additional financial instrument to address these three diseases. Malawi has so far received a substantial GF grant for HIV/AIDS, and another grant for malaria has been approved, although the grant agreement with the GF has not yet been signed.

This report presents the findings of a study aimed at assessing the effects to date of GF support on health systems in Malawi. The study has been conducted as part of the work of the System-wide Effects of the Fund (SWEF) Research Network, a collaborative research network comprising research organizations in the South and North that seeks to understand how monies being disbursed by the GF affect the broader health systems of recipient countries.

The specific objective of the study is to assess the effects of the GF and GF-supported activities on the Malawi health system. Specifically, the study seeks to assess the system-wide effects in the following key areas: (i) policy processes; (ii) public/private mix; (iii) human resources; and (iv) pharmaceuticals and commodities. Key findings from the baseline study are summarized below.

Policy Processes

- ▲ Malawi's original proposal to the GF included health systems strengthening; however, the majority of these elements were excluded from the final grant agreement because of GF requests for the proposal to be scaled down. This has resulted in pressure on human resources and infrastructure at facilities as a result of additional activities related to implementing the GF-supported activities. The GF subsequently permitted the reprogramming of some GF funding to support human resource development.
- ▲ While GF activities are in alignment with the overall national health policies, there are parallel planning structures, with the National AIDS Commission's (NAC's) Integrated Annual Work Plan on the one hand and the Sector-wide Approach Programme of Work on the other. There is a lack of coordination and harmonization between the two programs of work. This has implications for how GF activities are planned and organized, and while the GF did not create this problem, the influx of GF funds has likely exacerbated it. It is recommended that NAC and the Ministry of Health and Population agree on a common planning timetable and approach to ensure harmonization.
- ▲ While Malawi has adopted a sector-wide approach, GF activities are presently operating in a more vertical manner.

Public/Private Mix

- ▲ The GF has greatly enhanced and created many opportunities for interaction and partnership between the public and private sectors. Among the notable interactions cited is the training of private sector staff in voluntary counseling and testing, antiretroviral management, and

care and support. It is recommended that such partnerships be strongly encouraged, as the public sector alone cannot meet the ambitious antiretroviral treatment targets set by the GF and other organizations such as the World Health Organization's 3 by 5 Initiative.

- ▲ There appears to have been a rapid growth of new private not-for-profit organizations – particularly for HIV/AIDS-related efforts – following the receipt of GF resources. Often these organizations have very limited capacity and ability to implement activities, resulting in lowered quality of service.

Human Resources

- ▲ GF-funded activities in Malawi are currently being implemented in an environment of severe human resource shortages, sub-optimal human resource management, and a poor working environment in the public health sector. Against this background, there is evidence that the implementation of GF-supported activities is leading to some undesirable effects, such as excessive workload on health workers.
- ▲ The GF has recently allowed for the reprogramming of \$40 million of Malawi's HIV/AIDS grant to support human resource development under the Emergency Human Resource Program. This support will have positive benefits not only for GF-supported activities, but also to other health sector programs, as it supports all human resources for health.

Pharmaceuticals and Commodities

- ▲ The GF's position on drug selection under GF grants has resulted in some frustrations within Malawi. There is disagreement over the selection of malaria drugs to be purchased with GF monies, with the GF advocating for the use of artemisinin-based combination therapies and national policymakers deciding on the continued use of sulfadoxine-pyrimethamine as the first-line treatment. Issues about national autonomy to determine pharmaceutical policies have come into question.
- ▲ The GF has bypassed the national drug procurement and distribution system (the Central Medical Stores, or CMS) by asking the government to select a third-party procurement agent for GF-related activities. UNICEF has been contracted to conduct these activities, as well as to build the capacity of the CMS in select areas, although the capacity-building efforts have not commenced to date.

Next Steps

Follow-up SWEF research is planned in Malawi for 2005-2006. Final findings from the studies will be available in mid-2006. Interim updates will be provided on the Partners for Health Reform*plus* website.

1. Background

1.1 Introduction

In January 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) was formally established as an additional financial instrument to address the three focal diseases. The GF operates on the basis of seven principles including making available and leveraging additional resources; operating as a financial instrument and not as an implementing entity; operating in a balanced manner in terms of different regions, diseases, and interventions; supporting programs that reflect national ownership; and ensuring transparency and accountability.

Malawi is the recipient of one substantial grant – approved for \$196 million over five years – for HIV/AIDS. The GF Board approved a smaller grant of \$37.6 million for malaria, but an official grant agreement had not yet been signed at the time of the study and thus no activities had been implemented.¹ In submitting the country’s first grant proposal to the GF, the chairman of Malawi’s Country Coordinating Mechanism (CCM)² – and the then-Principal Secretary for Health – noted three principles guiding Malawi’s application including that:

Priority should be given to systems strengthening in the first year, so that all future expanded support from the Fund can be wisely, confidently and effectively directed. Dr. R.B. Pendame, covering letter accompanying Malawi grant application, Round 1, March 2002

The GF is one of many donors to Malawi’s health sector. Among the major discrete donors are the United Nations Development Programme (UNDP), the United States Agency for International Development (USAID), the U.S. Centers for Disease Control and Prevention (CDC), the African Development Bank (ADB), and others. Among the “pooled donors” are the World Bank, U.K. Department for International Development (DFID), Norwegian Agency for Development Cooperation (NORAD), Canadian International Development Agency (CIDA), and the government of Malawi. The GF, however, is the largest funding agent for HIV/AIDS, contributing 69 percent of the total financing of the 2004/05 National AIDS Commission (NAC) Annual Programme of Work (POW).

This report presents the findings of a study aimed at determining the effects to date of GF support on health systems in Malawi.

¹ Malawi’s malaria grant agreement was signed on September 19, 2005, with a start date of October 1, 2005.

² The formal name of this body in Malawi is the Malawi Global Fund Coordinating Committee; however, this paper will refer to it by the GF term, Country Coordinating Mechanism, or CCM.

1.2 Objectives

Without strong health systems, GF-supported interventions and other efforts targeted at HIV/AIDS are unlikely to be effective or sustainable. The current study was undertaken as part of a broader series of studies³ by the System-Wide Effects of the Fund (SWEF) Network which are documenting the effects on the health systems of recipient countries of the processes involved in applying for and receiving a GF grant and implementing GF-supported activities.

The overall objective of the SWEF research is to document the effects of the processes involved in applying for and receiving a GF grant, and implementing GF-supported activities, on the health systems of recipient countries. Findings from the study are being used to derive lessons for national- and global-level stakeholders, including the GF Board and Secretariat. The study focuses on measuring system-wide effects within four thematic areas, including:

- ▲ The policy environment
- ▲ The public/private mix
- ▲ Human resources
- ▲ Pharmaceuticals and commodities

Findings from this study will be used to inform key decision makers and stakeholders – government, private sector, non-governmental organizations (NGOs), and donors – working in the Malawi health system as to which GF-supported activities and strategies are assisting in strengthening the health system. The findings from the study will also serve to highlight the likely impact of allocating large amounts of funds to specific diseases in a relatively short period of time and within the context of a poorly resourced sector.

The report is organized as follows: Chapter 2 provides further information about Malawi's context. Chapter 3 presents the research methodology. Chapters 4 through 7 discuss the effects of the GF within the four thematic areas. Chapter 8 presents recommendations based on the study findings.

³ The USAID-funded Partners for Health Reform *plus* (PHR*plus*) project, a SWEF member, is concurrently publishing reports on baseline studies in Benin (Smith et al. 2005) and Ethiopia (Banteyerga et al. 2005).

2. The Health System and the Global Fund in Malawi

2.1 Background on Malawi's Health System

2.1.1 Malawi's Health Indicators

Sixty-five percent of the Malawian population lives on less than \$1 a day (National Statistics Office 2000) and Malawi's health indicators remain among the poorest in the region (see Table 1).

Table 1. Selected Health Indicators for Malawi

Indicator	1999-2003*
Total population	11.3 million
Infant mortality rate per 1,000 live births	104
Under five mortality rate per 1,000 live births	189
Total fertility rate	6.3
Life expectancy at birth	36.3 years
Crude birth rate per 1,000 population.	46
Population growth rate	1.9
Maternal mortality rate/100,000 live births	1,120
Antenatal care coverage (%)	91.4
Attendance at birth by trained personnel	55
Total HIV-positive population (NAC 2003)	700,000–1,000,000
Contraceptive prevalence rate (DHS 2000)	25
% of low birth weight babies.	13.1
Children under 5 years chronically malnourished	49
Children 12-23 months fully immunized	70
Immunization BCG	89.2
Immunization measles	64.2
Population per physician	101,000
Public health expenditure (PPP/US\$) private/public	11

Source: Various.

*Latest between 1999 and 2003.

** DHS = Demographic and Health Survey

The HIV/AIDS prevalence rate among adults (15-49 years) is 14.4 percent (NAC 2004, 2003 estimates) and HIV/AIDS-related conditions are estimated to account for more than 40 percent of all inpatient admissions (Government of Malawi 2002a). Life expectancy has recently fallen to 36.3 years, mainly as a result of the HIV/AIDS epidemic. Tuberculosis (TB), once on the decline, has also been increasing, with 70 percent of TB patients also testing HIV positive. The maternal mortality rate has increased by 80 percent since 1992, from 620 to 1,120 deaths per 100,000 live births.

2.1.2 Service Delivery

The health infrastructure consists of dispensaries and clinics; health centers; and community, district, and central hospitals, which are linked by a referral system. The Ministry of Health and Population (MOH) operates about two-thirds of all facilities, the Christian Health Association of Malawi (CHAM) 26 percent, *Banja La Mtsogolo* (BLM) about 5 percent, and the Ministry of Local Government (MLG) another 5 percent; the rest are operated by the private sector (see Table 2).

Table 2. Ownership and Type of Facility

Type	BLM	CHAM	MLG	MOH	Other NGO*	Total
Central hospital				4		4
Clinic	27	8	4	2	1	42
Dispensary		8	4	54		66
District hospital				22		22
Health center	1	115	12	288		416
Hospital		27		19		46
Maternity		1	12	2		15
Mental hospital		1		1		2
Rehabilitation center		1				1
VCT center**					3	3
Total	28	161	32	392	4	617

Source: MOH and Japan International Cooperation Agency (2002)

*NGO refers to not-for-profit NGOs.

**Number of voluntary counseling and testing (VCT) centers has increased significantly since this survey was conducted.

In recent years, the private sector has increased its share in health care provision. For example, BLM was founded in 1987 with one clinic and now has 28 clinics country wide, representing approximately 5 percent of all health facilities in the country. It has expanded its services from only family planning to include immunization, treatment for minor ailments, voluntary counseling and testing (VCT), and information, education and communication (IEC). Initially funded by Marie-Stopes International, UK, BLM now receives support from several donors. The Malawi AIDS Counseling Resource Organization (MACRO), which specializes in providing VCT services, has centers in Mzuzu, Lilongwe, and Blantyre and will soon expand to Zomba, Karonga, and Kasungu.

2.1.3 Access to Health Care and Health Care Spending

Access to health care, especially in rural areas, remains relatively low, with only 54 percent of the rural population having access to formal health services within a 5-kilometre radius. Financial accessibility to services is also a problem, especially at CHAM facilities (which account for 30

percent of health service delivery), where patients are charged user fees. The poor spend about 7.4–10 percent of their annual consumption on health care. According to the National Health Accounts (1998–99), per capita health expenditure was about US\$ 12 and, out of this, government expenditures accounted for about 25 percent, donor expenditures for 30 percent, and private financing sources for 45 percent (this includes 19 percent from employers contributions and 26 percent from household's out-of-pocket spending) (Government of Malawi 2001a).

2.2 Strategic Planning in the Health Sector

2.2.1 The Malawi Poverty Reduction Strategy Paper

In May 2002, the government of Malawi launched the Malawi Poverty Reduction Strategy (MPRSP). The overall goal of the MPRSP was to achieve “sustainable poverty reduction through empowerment of the poor.” The centerpiece of the MPRSP health strategy was the Essential Health Package (EHP). As stated in the MPRSP, the EHP addresses the major causes of morbidity and mortality among the general population and focuses particularly on medical conditions and service gaps that disproportionately affect the poor. The EHP is a bundle of health services – costed at \$17.53 per capita – that addresses a prioritized list of diseases provided at community, primary, and secondary levels.

There are three main strategies of the EHP:

- ▲ *Improving the quality of essential health care* through development of human resources for health (including cadres such as health surveillance assistants, nurses, medical assistants, and clinical officers; increasing availability of drugs and medical supplies; and expanding and promoting clinical and technical support services).
- ▲ *Improving access to and equity of essential health care* through rehabilitation of existing infrastructure. Delivering the EHP at the health center level is contingent upon well-maintained health centers with fully functioning support systems.
- ▲ *Strengthening the management and financing of essential health care services.* The MPRSP stated and adopted the policy that financing and management of essential health care services would be strengthened through the development of a Sector-wide Approach (SWAp) in the health sector.

2.2.2 The 4th National Health Plan

The overall planning document for the health sector in Malawi was until recently the 4th National Health Plan (NHP) (1999–2004) (see below for post-2004 plans). Unlike previous health plans, which were developed centrally, the 4th NHP was developed using a more bottom-up approach and involved district health staff, communities, and private health partners. As part of the planning process, working groups were formed to provide input into the development of the plan. Working groups were formed on human resource development, health care financing, hospital autonomy, decentralization, and the EHP.

The NHP focused on five priority areas including: (i) Reproductive Health (including HIV/AIDS); (ii) Child Health; (iii) Health Promotion, Prevention, and Rehabilitation (including malaria and TB); (iv) Diagnostic and Treatment Services; and (v) Environmental Health Services. The following strategies were adopted for implementation:

- ▲ Implementation of the EHP to strengthen primary health care, focusing on the provision of a cost-effective package of promotive, preventive, and curative health services⁴
- ▲ The development of a SWAp
- ▲ Decentralization of health care management
- ▲ Cost recovery/user fees
- ▲ Strengthening of policy formulation and regulation including strengthening of coordination and monitoring of health initiatives and private sector participation in the provision of health services
- ▲ Strengthening the health management information system
- ▲ Human resource strengthening.

2.2.3 Sector-Wide Approach

As noted above, Malawi has recently adopted a SWAp within its health sector. Following the expiry of the 4th NHP and in line with the MPRSP, a Joint Programme of Work for the health SWAp was adopted for the period 2004–2010. While the SWAp Memorandum of Understanding (MOU) was signed in November 2004 and both DFID and NORAD have disbursed funds into the SWAp, the SWAp is only just beginning to function.⁵ As stated in the SWAp Joint POW document, “...*the POW is effectively the equivalent of the National Health Plan for the 2004-2010 planning period.*” Thus, the SWAp represents Malawi’s current health strategy and complements other relevant policy documents and operational plans in use.

The priorities of the SWAp Joint POW are centered on the provision of the EHP. The Joint POW is divided into six components, including:

1. *Human Resources Implementation* addresses the need to produce a sufficient number of health care staff to deliver the EHP and the strategy is centered on the implementation of the MOH’s *Six-Year Emergency Human Resource Programme for the Malawi Health Sector (EHRP)*,⁶ which includes filling vacancies, promoting retention, and in-service training.

⁴ Malaria, acute respiratory infection and immunizable diseases, acute diarrhoeal disease, nutritional conditions/deficiencies, maternal conditions/pregnancy complications, sexually transmitted diseases including HIV/AIDS, TB, eye and ear infections, common injuries and schistosomiasis. Although HIV was a major cause of poor health in Malawi, the provision of antiretroviral treatment and treatment for opportunistic infections was initially excluded from the EHP, because these interventions were deemed to be very expensive.

⁵ The SWAp was formally launched at the end of June 2005.

⁶ The name of this document has changed in different documents from being called the 6-year Pre-Service Emergency Training Plan in the SWAp POW or the 6-Year Human Resource Relief Programme in others. For consistency, the document is henceforth referred to as the EHRP.

2. *Pharmaceutical and Medical Supplies* seeks to improve the quality of EHP services through strengthening procurement, distribution, and stock management systems for medical and non-medical consumables.
3. *Essential Basic Equipment* calls for the provision of basic equipment according to an agreed standard list in support of EHP delivery. This also calls for the establishment of a preventive maintenance program for equipment.
4. *Infrastructure–Facilities Development* aims to improve physical access to quality EHP services through the rehabilitation, upgrading, and construction of new health facilities and training institutions.
5. *Routine Operations at Service Delivery Level* aims to ensure that there are adequate financial, material, and human resources to support the routine operations for delivering EHP and non-EHP services within MOH and CHAM institutions.
6. *Central Operations, Policy, and Systems Development* aims to facilitate the strengthening of institutional processes aimed at enhancing central support to the operational level through the implementation of SWAp and decentralization of the health sector.

In order to fully implement the EHP and related services over the six-year period of the POW (2004-2010), about US\$1.5 billion or US\$22 per capita per year would be needed. However, due to limited financial resources and the fact the health sector does not have the capacity to absorb this level of resources, it was decided that the six-year budget for the SWAp would be reduced to US\$735 million or about US\$17.5 per capita per year. It has been estimated that about 71 percent of the funds required to implement the SWAp POW will have to come from donors and about 29 percent from the government of Malawi.

2.2.4 HIV/AIDS Policies

Following the emergence of the HIV/AIDS pandemic in the mid-1980s, the government of Malawi instituted strategies aimed at controlling its spread. This included the establishment of the National AIDS Control Programme (NACP) within the MOH, which later was transformed into the National AIDS Commission. In the Medium Term Plan I (MTP I) for the AIDS sector, spanning 1989 to 1993, and MTP II for the period 1993 to 1998, the NACP developed several intervention strategies including mass education, blood screening, counseling, care and support, and surveillance. The National Strategic Framework has emphasized prevention, advocacy, and behavior change; treatment, care, and support; sectoral mainstreaming; impact mitigation; and the role of surveillance and monitoring. The framework for HIV/AIDS placed much emphasis on mainstreaming HIV/AIDS control and management activities (NAC 2000, NAC 2003a).

Malawi has a national HIV/AIDS Policy that was officially launched in 2003. The policy provides guidance to all HIV/AIDS programs and has two main goals: (i) prevent the further spread of HIV infection; and (ii) mitigate the impact of HIV/AIDS on the socioeconomic status of individuals, families, communities, and the nation. To achieve those goals, the policy pursues the following objectives:

- (a) Improve the provision and delivery of prevention, treatment, care and support services for people living with HIV/AIDS (PLWHA);

- (b) Reduce individual and societal vulnerability to HIV/AIDS by creating an enabling environment; and
- (c) Strengthen the multi-sectoral and multi-disciplinary institutional framework for coordination and implementation.

The Integrated Annual Work Plan (IAWP) for 2003/04 provides a good understanding of the significance of the GF in the country's efforts to address HIV/AIDS. Although it places much emphasis on consolidating the systems that have been developed to manage the response (such as the grants facility, financial/procurement systems, and monitoring and evaluation framework), the IAWP also highlights the need to rapidly scale up the national response, now that increased resources are available from the GF and the pooled basket partners (NAC 2004).

2.2.5 Participation of Local Stakeholders in the Strategic Planning Process and Priority Setting

Local stakeholders (i.e., at the district level) started to be involved in priority setting for the health sector with the formulation of the 4th NHP. Previously, priority setting was done centrally by the MOH. Under the SWAp, district health committees put together their district implementation plans, which are incorporated into the overall SWAp POW.

2.3 The Private Sector and Delivery of Health Care

The private sector is not new to the delivery of health services in Malawi and the MOH recognizes its important role. In addition to government, the main actors in the health care system in Malawi are the aforementioned CHAM, an association of Christian mission hospital providers, not-for-profit NGOs such as BLM and MACRO, and the private for-profit sector.

Both BLM and MACRO services complement those of government and they follow government policies and regulations in their operations and system of cross-referral. The government has involved both NGOs in relevant policy formulation. In addition to CHAM, BLM, MACRO, and local authorities, some big commercial companies and numerous private for-profit practitioners are also important players in the delivery of health services in Malawi. A good example of private for-profit service providers is Mwaiwathu hospital in Blantyre or City Centre clinic in Lilongwe and the numerous specialist doctors and health centers in the major cities of the country. Though not legally and professionally recognized, the private for-profit service sector also includes the shop owners, traditional healers, and the formal pharmacies.

In the initial government HIV/AIDS plans, the role of the private sector, particularly with regard to the biomedical aspects of HIV/AIDS interventions, was rather neglected. Over the years, however, a number of private companies have started workplace interventions (see Kadzandira 2003a). In the public sector, the Ministry of Labour and Vocational Skills Training started workplace-based HIV prevention programs in the first part of the present decade and has been providing technical support to various institutions in the design and implementation of HIV/AIDS activities in the workplace through Project HOPE (Kadzandira 2003).

Malawi has a very small health insurance industry operated by a not-for-profit entity, the Medical Aid Society of Malawi (MASM), which covers care in the private sector.

2.4 Major Challenges in the Public Health Sector 1999-2004

2.4.1 The Human Resources Challenge

The implementation of the EHP has been threatened by several weaknesses in the health delivery system, particularly the chronic shortages and inequitable geographical allocation of skilled health workers in the public health sector. This problem is compounded by low health worker outputs from training institutions and high staff attrition rates. When the 4th NHP was launched, only 61 percent of the established posts in the MOH were filled. Vacancy rates were particularly high (>45 percent) among the registered nurses and specialist doctors. In addition, there was an inequitable distribution of technical health personnel, with 68 percent of medical doctors and 64 percent of registered nurses working in the tertiary hospitals.

In recognition of the human resource problems in the public health sector, the 4th NHP proposed to increase the output of health worker training institutions and to improve retention of existing health workers by improving their working conditions. In addition, the MOH sought to establish the Health Services Commission, which would formulate policies and guidelines for improving the working conditions and performance of health workers, and for equitable deployment of health workers. However, donors and other health sector partners critiqued the 4th NHP mainly for the lack of a detailed implementation plan and prioritization of proposed activities, and the inadequate analysis of the financial and human resource implications of the proposed activities. The plan was regarded as overly ambitious, and it was ultimately ineffective at attracting donor support.

During the course of implementation of the 4th NHP, the human resources capacity in the public health sector worsened. Staff shortages were particularly severe among nurses (64 percent of the 6,084 establishments were vacant) and specialist doctors (with vacancy rates ranging from 71 to 100 percent). The major causes of the human resources crisis were:

- ▲ Resignation of skilled medical personnel from the public health sector due to poor salaries and working conditions in the sector. These individuals sought better jobs within Malawi (in NGOs and private hospitals) and outside Malawi (particularly nurses) or simply changed careers.
- ▲ Inadequate output of health care workers from training institutions to meet the staff requirements of the public health sector.
- ▲ High death rates (up to 2.0 percent per annum) among health workers with clinical officers and laboratory technicians most severely affected (Harries 2002, Government of Malawi and U.N.Development Program (UNDP)/Lilongwe 2002). Although the exact causes of death were unknown, it is speculated that most of the deaths were HIV/AIDS-related.

The human resource problem has had a major impact on the delivery of health care at primary and secondary-level facilities. A health facility survey undertaken by the MOH and Japan International Cooperation Agency (JICA) in 2002 to assess the extent to which infrastructure in both the public and private sector can support the EHP found that 15 of the 26 districts had less than 1.5 nurses per health facility while five districts had less than one nurse per facility. In addition, 10 districts had no MOH doctor, while four districts did not have any doctor at all. The survey also found that only 30 percent of the health facilities had the infrastructure to support delivery of the full EHP.

As outlined earlier, the government has undertaken efforts to address the extreme human resource crisis in Malawi. In 2001, the MOH produced a document entitled *Six-Year Emergency Training Plan for Health Workers to Tackle the Human Resources Crisis in Health* in which it articulated the human resources crisis in the health sector and requested donor support to strengthen capacity of training institutions in order to increase the output of health workers. Based on this plan, training schools for doctors, clinical officers, and nurses have now increased their student intake. Additionally, in its efforts to address the human resources crisis in a comprehensive manner, the MOH produced another document in April 2004 (*Human Resources in the Health Sector: Toward a Solution*) in which it requested donor assistance in the key areas, such as staff retention and reduction of brain drain, among other priorities.

Based on this document, the MOH developed a definitive proposal to donors, entitled the *Six-Year Human Resource Relief Programme for the Malawi Health Sector (EHRP)* which was budgeted at approximately US\$272 million over six years. However, due to limited availability of donor funding, the scope and level of support to the EHRP was recently scaled down to a budget of approximately US\$170m over the six year plan period. Some areas affected in the scaling back of the initial EHRP proposal include the level of salary/allowance increase for health workers (from 100 percent to 50 percent increase) and the number of nurses to be recruited (reduced by 25 percent from the initial targets).

The MOH started implementing components of the EHRP in April 2005 as part of the human resource program of the SWAp. DFID has committed \$100 million (of which \$15 million has been released) to support the program. As described further in Section 6.1, \$40 million of GF resources were reallocated in 2005 to support the EHRP (of which \$4 million has been released). With this funding, the MOH has started to implement a 52 percent salary increase for all health workers in Malawi from April 2005.

2.4.2 The Challenge of Procurement and Management of Medical Consumables and Equipment

The Central Medical Stores (CMS), a unit within the MOH, has the mandate for the procurement, distribution, and management of medical consumables and equipment. The Department of Health Technical Services and Support Services (DHTSS) is responsible for overseeing the operations of CMS and is in charge of all issues relating to drug and laboratory supplies and medical equipment. A Medical Buying Committee chaired by the Principal Secretary for Health and composed of independent members, including the Ministry of Finance (MOF), reviews and evaluates bids, the results of which are forwarded for approval to the Office of the Director of Public Procurement.

Typically, medical consumables and equipment purchased locally or externally are received at CMS and quality tested. Appropriate medical supplies and equipment are then distributed to the Regional Medical Stores (RMSs) in the Central, Southern, and Northern Regions. MOH and CHAM health facilities send their requisitions to the RMSs, which then distribute to the facilities directly.

When the 4th Malawi NHP was launched in 1999, the MOH highlighted the shortage of essential drugs, medical supplies, and equipment as one of the major challenges facing the public health sector, especially the MOH facilities. The shrinking of the drug budget in the face of the local currency devaluation and increased pilferage of drugs were cited as the main causes of the shortage. Against this challenge, the MOH undertook to strengthen the drug and medical supplies management by adopting several strategies including:

1. Strengthening the CMS so that it would have the infrastructure and the financial and human resource capacity to procure, quality test, and distribute drugs and medical supplies;
2. Training additional pharmacy assistants and pharmacy technicians, and providing in-service training for existing staff in the management of drug and medical supplies and in the rational prescription of drugs;
3. Establishing committees for monitoring drug distribution to end users and establishing/strengthening drug and medical supplies monitoring committees in the health facility catchment areas.

As part of the effort to improving the efficiency of the CMS in its operations, the MOH resolved to give autonomy to the CMS to enable it to operate as a self-sustaining institution. In addition, the MOH decided to re-capitalize the CMS, and allow it to purchase drugs on tender and supply all health facilities with a predetermined mark-up to cover CMS operating costs.

Contrary to the intentions of the improvements outlined in the 4th NHP, the supply of drugs and medical supplies in the MOH facilities remains erratic, with frequent stock-outs of essential drugs and basic medical supplies. Similarly, recurrent stock-outs of essential drugs and basic medical supplies at CMS warehouses are also typical. Some of the main reasons for this situation, which have been described previously, include:

1. Financial, material, and human resources constraints within the CMS
 - △ CMS does not have the financial means to regularly replenish stocks of drug and medical supplies which have been distributed to MOH health facilities. The MOF is supposed to effect payment for supplies on behalf of the health facilities. However, the MOF usually does not fully pay for the supplies, leading to decapitalization of the CMS and inability to maintain buffer stocks of essential drugs.
 - △ CMS does not have full control over the drug tendering process (the Medical Buying Committee, the MOH, and the MOF are all involved), which leads to uncertainty on the timing of the external procurement of drugs. Lengthy approval processes also contribute.
 - △ CMS lacks adequate skilled manpower to conduct its routine operations.
 - △ CMS lacks sufficient vehicles for the timely distribution of drugs.
2. Inability of health facilities to provide accurate estimates of drug utilization due to poor stock management capacities, leading to frequent over- or under-supply of drugs. As a result, CMS is also unable to estimate the national drug requirements to assist them in procurement of drugs.

Because of the perceived weaknesses of the CMS, several vertical programs (such as TB, Sexually Transmitted Infections, and Safe Motherhood) had decided to procure drugs and medical supplies independently. These programs do, however, utilize the CMS distribution system. In these cases, monitoring of drug supply and drug utilization is performed by the vertical program staff.

In 2000, the MOH engaged technical assistance supported by DFID to strengthen the capacity of CMS, with the view to transforming it into a CMS Trust. However, this was not realized due to a difference of opinion between the MOH and the technical assistance regarding the specific areas of CMS that needed capacity strengthening.

More recently, under the SWAp health sector reform program, there have been renewed efforts to improve the management of drugs and medical supplies capacities in country to enable the health system to deliver drugs for the EHP. During the implementation period of SWAp (2004-2010), a wide range of activities have been planned to strengthen the capacity of CMS, health facilities, and the Pharmacy, Medicines and Poisons Board (the drug regulatory body) in the management of drugs and medical supplies.

2.5 The Global Fund in Malawi

In February 2002, Malawi's CCM (as noted in Section 1, formally known as the Malawi Global Fund Coordinating Committee) submitted to the GF a proposal entitled "An Integrated National Response to HIV/AIDS and Malaria." Out of a total funding request of \$267 million, \$196 million was actually approved for the HIV/AIDS component over five years.

The HIV/AIDS grant has four components:

- ▲ Voluntary Counseling and Testing,
- ▲ Prevention of Mother-to-Child Transmission (PMTCT),
- ▲ Community Home-based Care (CHBC), and
- ▲ Treatment and Management of Opportunistic Infections (OIs) and Antiretroviral (ARV) drugs.

In addition, there are two crosscutting components, including some health systems strengthening activities, and management and institutional support. A two-year grant agreement between the GF and the Registered Trustees of the NAC – the Principal Recipient (PR) for the HIV/AIDS grant – for US\$41 million was signed on January 24, 2003, and officially became effective on March 1, 2003. The Local Fund Agent (LFA) for the grant is PricewaterhouseCoopers. Table 3 outlines the disbursement history of the grant.

Table 3. Disbursement of Funds, Malawi HIV/AIDS Grant

Date Disbursed	Amount Disbursed	Activities Covered
June 2003	US\$314,000	Preparatory program activities
January 2004	US\$7.6 million	Scaling-up of VCT, PMTCT, CHBC, systems strengthening, and institutional support
February 2004	US\$4 million	Direct bank transfer to the United Nations Children's Fund (UNICEF) in Copenhagen for the procurement of health products including ARV drugs
December 2004	US\$14 million	Direct bank transfer to UNICEF for the procurement of health products including ARV drugs

* UNICEF is currently the procurement agent for ARV drugs and related products for the MOH.

Thus, by April 20, 2005, Malawi, through NAC, had drawn down \$36 million out of the \$41 million two-year grant agreement (88 percent). A request for continued funding for the remaining US\$155 million for years 3, 4, and 5 was submitted in March 2005.

According to the NAC, a number of achievements have been made since the initiation of the HIV/AIDS grant:

- ▲ A free ARV program was started in June 2004 in select MOH and CHAM hospitals and other facilities that meet MOH eligibility criteria.⁷
- ▲ As of end March 2005, there were 17,500 patients on ARVs in Malawi. This figure increased to 23,000 by the end of June 2005. (The plan was to put at least 36,000 patients on ARVs by July 2005 and 55,000 by December 2005.)
- ▲ Various guidelines and manuals have been developed and printed to facilitate scaling up of VCT, PMTCT of HIV, CHBC, and OI management including provision of ARV drugs.
- ▲ More than 300 health workers (doctor, nurses, and clinical officers) have been trained in management of OIs including provision of ARV therapy (ART).
- ▲ IEC materials for VCT, PMTCT, CHBC, ART and OI management have been developed and are being used.
- ▲ A CHBC model for Malawi was developed in collaboration with the University of Natal in South Africa and is currently being piloted in three districts, with plans for broader roll-out.
- ▲ GH total cost of \$2 million to support scale-up of interventions including delivery of ARVs and other health products.
- ▲ Grant awards worth \$10 million have been made to various institutions and community-based organizations (CBOs) for various HIV/AIDS-related interventions or activities in line with the GF grant agreement.

In September 2002, Malawi submitted a malaria proposal to the GF during the Round 2 proposal process. The GF Board approved this smaller grant of \$37.6 million for malaria, but an official grant agreement had not yet been signed at the time of the study and thus no activities had been implemented prior to or during the study period. The final grant agreement was signed in September 2005, after several postponements (Chapter 4 explores some of the issues around the delay in signing of the malaria grant). The PR for the malaria grant is the MOH of the Republic of Malawi.

Malawi has not, to date, submitted a TB proposal to the GF, as TB has been considered well funded by other donors.

2.5.1 Other HIV/AIDS and Malaria Initiatives in Malawi

Malawi also receives substantial funding from a number of other global health initiatives currently being implemented. Other large HIV/AIDS and/or malaria programs include:

⁷ The MOH plan to scale up ARV distribution aimed to cover 59 health facilities throughout Malawi by December 2004. These include MOH and CHAM hospitals, as well as select Malawi Defence Force, Malawi Police hospitals and private sector health facilities that met MOH eligibility criteria. As of May 2005, only 34 health facilities were providing ARVs in the country. A press release issued in late June 2005 indicated that the number of health facilities providing ARVs had now increased to 59.

1. *The World Bank's Multi-Sectoral AIDS Project (MAP)*: This \$35 million project has the objective of reducing HIV transmission, improving quality of life of those infected and affected by AIDS, and mitigating the impact of HIV/AIDS. MAP provides funding to the NAC IAWP for 2003–08 through the basket (or pooled) funding arrangement⁸.
2. *World Health Organization (WHO) 3 by 5 Initiative*: WHO is providing technical assistance in Malawi to help make a contribution to its global 3 by 5 Initiative targets of providing ART to 3 million people living with AIDS in developing and transition countries by 2005.
3. *Other initiatives*: A number of other donors such as the U.N., USAID, U.S. CDC, ADB, DFID, CIDA, and NORAD also have HIV/AIDS-related programs in Malawi. All of these are coordinated by NAC through various funding arrangements, such as the basket or pooled funding arrangement, and discrete funding. The Malawi government also provides approximately US\$2 million per year to the NAC IAWP. (Note: Malawi is *not* a beneficiary of U.S. President's Emergency Plan for AIDS Relief nor of the Clinton HIV/AIDS Initiative.)
4. *Roll Back Malaria and Abuja Declaration on Malaria*: The MOH has developed a Five-Year Strategic Plan on Roll Back Malaria (2001–05), which states, "*Malawi has embraced the process of the Roll Back Malaria movement, launched in 1998 to address the global problem of malaria and is fully committing its efforts and resources to achieve the movement's overall goal, which is to halve the burden of Malaria by 2010. It also aims to meet targets for prompt treatment, proper chemoprophylaxis of pregnant women, increased bed net coverage, which were set out at the summit of heads of African nations held in Abuja, Nigeria, in April 2000*" (Government of Malawi 2001). In 2002, Malawi launched a Malaria Policy to assist in the coordination of various malaria initiatives.

2.5.2 HIV/AIDS Coordination Bodies

A number of national-level bodies exist in Malawi to promote partnerships and inform policy and planning for the three focal diseases as well as for the wider health sector. In addition to the Malawi CCM, which monitors GF-funded activities, the following groups are involved in coordinating, planning, and monitoring the national HIV/AIDS response:

1. *Cabinet Committee on HIV/AIDS*: The role of this committee is to report on policy issues and action relating to HIV/AIDS. With the new government, this committee has been dissolved and it is understood that responsibility for HIV/AIDS issues will be under the Cabinet Committee on the Economy.
2. *Parliamentary Sub-Committee on HIV/AIDS*: This is a tool that Parliament uses to monitor the implementation of the National Response to HIV/AIDS.
3. *NAC Board*: The role of the Board, which is appointed by the President, is to oversee the implementation of the National Response to HIV/AIDS.
4. *Health Sub-Group of Aid Coordination Group*: This is a sub-group of the Aid Coordination Group and meets monthly to share information on implementation issues pertaining to the

⁸ Other pooled, or basket, donors include the World Bank, DFID, NORAD, CIDA, and the Malawi government.

- health sector. The sub-group is co-chaired by the MOH and an elected donor, which is currently DFID.
5. *U.N. Theme Group on HIV/AIDS*: This is composed of heads of the U.N. agencies based in Malawi and looks at policies and *strategies of the U.N. pertaining to HIV/AIDS in Malawi*.
 6. *HIV/AIDS Technical Working Group*: This is a relatively large group of government agencies, donors, and NGOs chaired by NAC; its objective is to track progress and plans of various organizations relating to HIV/AIDS.
 7. *MOH HIV/AIDS Implementation Group*: This is an internal group of the MOH, chaired by the Deputy Director of the HIV Unit (Clinical Services), whose mandate is to plan, coordinate, and monitor implementation of all HIV/AIDS-related activities being undertaken by the ministry.
 8. *Malawi Business Coalition Against HIV/AIDS (MBCA)*: This is an association of about 38 private sector members whose mandate is to coordinate the private sector response to HIV/AIDS.

According to a report titled “An Assessment of the Adequacy of the National Level HIV/AIDS Response Coordination Mechanisms” drafted in November 2004 by the USAID-funded POLICY Project, despite the large number of coordination structures in place in Malawi dealing with HIV/AIDS issues, there is no “*single overarching coordination structure that cuts across all of them*.” This has resulted in a situation of stand-alone structures with no mechanism for follow-up on decisions and recommendations. The problem is exacerbated by the lack of formal linkages between any of these structures.

3. Research Objectives and Methods

3.1 Research Objectives

The overall objective of the SWEF research is to document the effects of the processes involved in applying for and receiving a Global Fund grant, and implementing GF-supported activities, on the health systems of recipient countries.

Findings from the research are intended to derive lessons for several audiences, including:

- ▲ Stakeholders in Malawi, and other countries facing similar challenges and opportunities, so as to inform policies and implementation strategies for GF-supported activities;
- ▲ The GF Board and Secretariat, so as to help improve GF processes and guidelines in order to ensure that GF-supported activities enhance broader health care systems; and
- ▲ The broader donor and global community regarding how best to channel efforts to scale up substantially the assault upon AIDS, TB, and malaria and other diseases of poverty in low- and middle-income countries.

3.2 The SWEF Research Protocol

A common research protocol was developed by the SWEF Research Network, and has been adapted to fit the context, policy and information needs of each participating country. The SWEF common research protocol combines baseline and follow-up quantitative surveys of health facilities and health staff, with in-depth interviews of stakeholders at national and sub-national level. The research aims to produce and share results in a timely fashion that allows course correction by decision makers.

The research protocol focuses upon four thematic areas, namely:

- ▲ *Effects upon the policy environment.* By encouraging new and innovative partnerships among stakeholders within recipient countries, GF proposal and planning processes are designed to enhance the range of actors involved in informing policy and implementing disease control activities. The SWEF studies assess the extent to which this occurs. The development and implementation of GF-supported activities interfaces with other planning and aid frameworks such as sector-wide approaches and poverty reduction strategy papers, as well as other new financing mechanisms (such as MAP) targeted at HIV/AIDS. SWEF aims to assess the effects of GF support upon the broader pattern of health system funding, and the extent to which the policy and operations pursued by the GF are in alignment with existing structures.

- ▲ *Effects upon the Public/Private Mix.* The GF explicitly welcomes innovative approaches to expanding service coverage and approaches that draw private sector actors into the health care system; accordingly, a greater role for private sector actors may evolve. The SWEF studies aim to evaluate the effects of GF support upon the number, distribution, and organization of different types of providers (public, private for-profit, private not-for-profit) and relationships between public and private sectors (such as the number of public/private partnerships in non-focal areas, and the degree of trust and cooperation between sectors). In addition, the studies explore the implications of these changes for overall health system performance.
- ▲ *Effects upon Human Resources.* Many GF proposals include training activities for health workers, and some address issues of staff retention and motivation. Where health workers are in short supply, GF-supported activities may overburden capacity. GF-supported activities may also affect the skills, motivation and distribution of health workers, and may cause shifts in the distribution of health workers from non-focal disease programs/functions. SWEF studies aim to evaluate the extent of these effects and identify the mechanisms through which they occurred.
- ▲ *Effects upon Pharmaceuticals and Commodities.* Approximately 50 percent of GF money already committed will procure pharmaceuticals and commodities. This injection of funding may affect procurement, supply and distribution systems, and the quality and prices of other drugs and commodities. The SWEF protocol considers issues of drug management (procurement, distribution, utilization/rational use, and monitoring and evaluation) as well as access (geographic access, physical availability, financial affordability, quality, and specific issues of pricing/subsidies) to investigate the effects of the GF upon pharmaceuticals and commodities within countries.

3.2.1 Study Methods in Malawi

In Malawi, due to significant delays in initiating the research, it was agreed that a scaled-down version of the SWEF protocol should be undertaken. The Malawi SWEF study focuses, therefore, on the qualitative elements of the protocol, comprised largely of in-depth interviews at the national and district levels, and a review of relevant literature.

Qualitative In-depth Interviews

Through discussions with PHR*plus*, the MOH, and USAID, a total of 44 respondents were selected for interviews on issues relevant to their roles in GF-supported activities. The informants included individuals from various sections and departments in the Ministry of Health, Ministry of Finance, Office of the President and Cabinet, National AIDS Commission, Malaria Control Programme, TB Control Programme, and the private sector (mainly the private not-for-profit actors).

A breakdown of the sample is shown in Table 4.

Table 4. Respondents by Category

Category of respondent	Number of interviewees
Central government	16
Health staff	5
Donor community	10
Private sector	10
Other (professional councils, local fund agent)	3
Total	44

SWEF in-depth interview guides were utilized to guide the interviews, with different sets of questions targeted to different types of interviewees. Interviews were conducted in May and June 2005. As part of obtaining the informed consent of the respondents, all respondents interviewed were told that their participation in the study was voluntary and they were assured that their views and statements would be held in confidence and that no statement in the report would be attributed to specific individuals or positions.

Detailed notes of all interviews were made and transcribed. Dominant themes were then identified and discussed within the four thematic areas of the study.

3.2.2 Literature Review

In addition to the in-depth interviews, a review of relevant documents related to policy issues, public/private mix, human resources, pharmaceuticals and commodities in the health sector was also conducted.

4. Effects of the Global Fund on Policy and Planning, Processes and Structures

Global Fund proposal and planning processes are designed to enhance the range of actors involved in informing policy and implementing disease control activities. The SWEF studies assess the extent to which this occurs. The development and implementation of GF-supported activities interfaces with other planning and aid frameworks such as sector-wide approaches and poverty reduction strategy papers, as well as other new financing mechanisms (such as MAP) targeted at HIV/AIDS. SWEF aims to assess the effects of GF support upon the broader pattern of health system funding, and the extent to which the policy and operations pursued by the GF are in alignment with existing structures. This chapter considers the effects of GF-related activities on the policy processes in Malawi.

4.1 Global Fund Structures

4.1.1 Country Coordinating Mechanism

The GF requires (apart from in exceptional circumstances) that all proposals submitted to it are reviewed and supported by the country's CCM. Although CCMs are often similar in composition to existing bodies (such as national AIDS commissions) these new entities constitute additional new actors in the policy and planning arena. The Malawi CCM was officially established in February 2002. The CCM currently has about 18 members (see Annex A) and is chaired by the Principal Secretary for Health. NAC acts as the secretariat to the committee.

Most key informants involved in the GF activities in Malawi, including those who have been members of the CCM as well as non-members who are familiar with the CCM's operations, viewed the committee as being fairly representative in terms of composition. However, a few informants expressed their concern on the low representation of PLWHAs and the private sector.

Guidelines recently approved by the GF Board in April 2005 stipulate that their constituents nominate CCM members, and they also suggest that the Principal Recipient should not also serve as CCM chair. CCM members were originally selected directly by the then informal coordinating committee chaired by the Principal Secretary for Health, Dr. Richard Pendame, without official nomination or election from their respective constituents. Due to these new policy provisions, Malawi's CCM is currently being revised in terms of members and chairmanship. Various constituents were recently in the process of electing representatives to serve the CCM. According to study respondents, the new 'nomination' approach to selecting representatives to serve on the CCM is viewed as a great improvement and would improve overall representation.

Some informants expressed concern about the relatively large size of the CCM (at the time of the study, 18 members) and suggested that this inhibited its effectiveness as a decision-making body.

The CCM needs to be smaller in size and there's no need for the CCM to have representatives from various constituencies dealing with HIV/AIDS. Perhaps it is the NAC Board that needs to have representatives from various constituencies. Currently, the CCM is composed of people with mixed interests and it is hard to imagine how decisions are reached. Donor representative

In terms of technical expertise for guiding and monitoring implementation of the GF country activities, the CCM was viewed by most respondents as being fairly competent with an appropriate mix of skills and expertise. A few respondents, however, speculated about the rationale for selection of some CCM members – questioning whether certain members were selected for their technical expertise or other reasons, such as funding. (This was particularly a concern with respect to some donor representatives.) Many informants also perceived dialogue within the CCM as democratic and open, with a few exceptions. In some cases, it was viewed that donors dominated decision-making processes because of the relative financial contributions they make to the NAC basket fund. Concerns were also expressed by some informants that the committee is composed of health-related actors, limiting in some way the range of expertise required for a multisectoral approach to addressing HIV/AIDS.

4.1.2 The CCM and the NAC Board of Trustees

NAC is a Trust whose members are appointed by the President of the Republic of Malawi. The function of NAC and the NAC Board is to coordinate Malawi's national response to HIV/AIDS, the development and implementation of government policies on HIV/AIDS, mobilize resources for HIV/AIDS, conduct HIV/AIDS advocacy, and monitor and evaluate the national response to HIV/AIDS. The NAC Board reports to the President through the Office of the President and Cabinet.

There is some confusion on the ground about the relative roles and responsibilities between the NAC and the CCM, even among members of each body. The major underlying concern was that existing channels of communication and lines for reporting to the government for both the NAC Board and Secretariat are not clear. The creation of the CCM – which is mandated to communicate with the GF Secretariat in Geneva – further confuses matters. Specific concerns were noted about overlapping responsibilities between the two bodies. As one respondent put it:

The CCM is one example of a confusion brought about by the Global Funds....
Donor representative

More generally there was a concern about the proliferation of HIV/AIDS coordinating bodies, with eight different HIV/AIDS coordinating and policy bodies being identified at the national level (see sub-section 2.5.2).

4.1.3 The Role of the Principal Recipient

The PR for the HIV/AIDS grant is NAC. (The PR for the malaria grant is the MOH, but at the time of the study, the malaria grant had not yet been signed or initiated). NAC was chosen as a PR by the CCM directly, without competitive bidding, as it was decided at the time that NAC was the only appropriate organization with the financial and administrative capacity to manage the GF grant. Due to limitations in capacity, however, the GF Secretariat recommended that the PR engage with an

independent Financial Management Agency (FMA). This FMA would be responsible for managing the NAC grants facility – which is composed of funds from various donors including pooled donors, as well as a small amount from the GF. The FMA would manage these funds for two years, while NAC builds and strengthens the capacity in its internal finance department. The FMA, DCDM of Mauritius, an international accounting company, was chosen by international open competitive tender. The relationship between the FMA and NAC appears to be cordial, with the two groups working and operating closely together.

To ensure that HIV funds are easily accessible at the district level, NAC entered into several two-year contracts with umbrella organizations (UOs) to disburse and manage NAC funds at the district level as capacity building is going on in the local assemblies. (Please see Section 5.2 for more information on these UOs and their roles and operations.)

4.1.4 The Local Fund Agent

The LFA is PriceWaterhouseCoopers. The role and function of the LFA is to act as the eyes and ears of the GF in Malawi, including receiving receiving from the PR all reports, disbursement requests, and audit reports. The LFA is also mandated under the grant agreement to review all books and records relating to the program and perform ad hoc site visits. The LFA is an accounting and auditing firm and refers non-accounting issues, such as procurement, to its Geneva and Johannesburg offices, which have these skills or contracts them. This has led to concerns among some stakeholders about the LFA's local capacity in specialized areas. As noted by one stakeholder:

...this lack of local capacity has in some cases resulted in delays as the LFA has to consult its Geneva office and wait for them to come back... CCM member

PriceWaterhouseCoopers has also been appointed LFA for the malaria component, under which the MOH will be the PR. The LFA appeared to have a more cordial relationship with NAC than with the MOH. While this is likely somewhat related to the LFA's role in questioning the capacity of the MOH to act as PR for the malaria grant (discussed in more detail later), this is also likely due to the limited extent of interaction between the LFA and the MOH to date, given that the malaria grant had not been signed nor activities started.

4.2 GF Proposal Development

Prior to the launch of the GF, Malawi had already developed a comprehensive \$1.6 billion national proposal to address the HIV/AIDS and malaria crises, to be used to solicit external donor support. The proposal was developed in collaboration with various key stakeholders in HIV/AIDS prevention and treatment, including training institutions (such as the College of Medicine), donors, international NGOs (including *Médecins Sans Frontières*) and a district health office representative. A team from the Harvard University School of Medicine also provided technical input into the proposal's development.

When the GF was launched in 2001, Malawi used this national proposal as the starting point for development of its Round 1 HIV/AIDS proposal to the GF. The earlier proposal was scaled down substantially, and a \$360 million HIV/AIDS proposal for five years was submitted to the GF. In the GF proposal, quite significant amounts of funding were directed at broad health systems strengthening (more than \$33 million), including human resource development. The Principal

Secretary for Health, and the then-Chair of the CCM, noted in his covering letter the importance of these elements of the proposal (see Section 1.1), to ensure that the remaining activities would be carried out with success and to improve sustainability.

However, according to informants, most of the systems strengthening elements of the original HIV/AIDS proposal were ultimately cut from the approved grant agreement. Only recently were some health systems strengthening activities re-instated into the HIV/AIDS grant, specifically to support human resource development, with the reprogramming of \$40 million of GF resources to support Malawi's EHRP (as described further in Section 6.1). As stated by one stakeholder:

The GF had used a one-size-fits-all approach in removing the health systems strengthening from Malawi's proposal and now recognizes that countries are different. Donor representative

The Round 2 malaria proposal was developed with the support of an external consultant funded by UNICEF. The \$39.7 million proposal was submitted in 2002. The proposal development process was perceived to be very consultative, involving a wide range of stakeholders. Participants in the process included the College of Medicine, Gates Malaria Alert Centre, WHO, UNICEF, JICA, World Vision International, Canadian Physicians for Aid and Relief, Plan International, district health office representatives, CHAM, and others. Moreover, to facilitate wider participation, press releases were placed on the radio and in the local newspapers.

4.3 Alignment of Global Fund Activities with Existing Policy and Planning Processes

4.3.1 The Global Fund and the MPRSP

GF activities appear to be closely harmonized with those of the MPRSP. The centerpiece of the MPRSP HIV/AIDS strategy is comprised of the Integrated National Response to HIV/AIDS and the National HIV/AIDS Strategic Framework – both of which served as the basis for Malawi's HIV/AIDS GF proposal. In the MPRSP, HIV/AIDS is treated as a crosscutting issue that should be mainstreamed in the national development agenda in order to reduce poverty. In addition, malaria and TB, are also addressed in the MPRSP, as part of the Essential Health Package.

4.3.2 The Global Fund and SWAp

Malawi has adopted a SWAp for planning and programming in the health sector, although the SWAp was only signed in November 2004, after the GF HIV/AIDS grant agreement had already been signed. In general, the activities programmed with GF support at the program level are linked to the SWAp through the EHP – under which malaria, HIV/AIDS, and TB services are integrated at the service delivery point with other health services. While planning for GF-supported activities is aligned with (and encompassed by) the NAC IAWP, concern was expressed by respondents about the parallel planning processes for the development of the NAC IAWP and the MOH SWAp.

The NAC IAWP covers not only GF-funded activities but also all activities funded by NAC's funding partners including pooled and discrete donors. There is, however, a disconnect between the IAWP and the SWAp in terms of coordination and planning. One of the major recommendations of

an Independent Multi-Disciplinary Review Team of the National AIDS Program, was that, in the future, NAC and MOH agree to a common planning timetable and approach to ensure harmonization of the MOH SWAp and NAC IAWP. Note that this parallel planning process was not caused by the GF, although planning for GF-supported activities was most probably affected by it and the influx of GF funding has likely exacerbated the problem.

On another note, the GF will in the future be funding the HIV/AIDS component of Malawi's SWAp Program of Work, but GF funds will be channeled separately – not through the common SWAp pool into which other donors channel their funds in support of the SWAp plan of work. This separate financing channel creates a further parallel system. For the Malawi malaria grant, the MOH requested that the GF monies be channeled through the SWAp. According to local informants, the GF counter-proposed that the monies be channeled through a structure similar to the FMA (used by the HIV/AIDS grant). The debate about how the funding should flow appears to be linked to the extensive delays experienced in signing the malaria grant.

In terms of the malaria component, as the MOH will be the PR and government systems and structures will be used to plan and disburse funding, it may be less likely for problems of harmonization and coordination with the SWAp to arise. However GF concerns about the MOH's capacity, particularly in terms of financial and procurement systems, may mean that it is not possible to use routine systems but that some modifications will be necessary.

4.3.3 Global Fund Alignment with Decentralization

As described above, the basis for Malawi's GF proposals was the national comprehensive HIV/AIDS and malaria proposal that had been previously developed through several extensive planning processes and involving a wide range of stakeholders, including sub-national stakeholders. Malawi was therefore in the fortunate position of being able to draw upon the products from prior planning processes to develop their GF proposal.

The health sector in Malawi is already somewhat decentralized, including structures that support HIV/AIDS activities in particular. At the district level, the institutional coordination and planning structure for HIV/AIDS activities occurs under the district assembly through a district AIDS coordinator (DAC). The DAC also acts as the secretary of the district AIDS coordinating committee (DACC). The DACC is made up of representatives of key ministries – such as Gender, Youth, Information, Health, and Education – as well as representatives of NGOs and community-based organizations. DACs work closely with the MOH, NAC, and other stakeholders to implement district level activities in support of the national HIV/AIDS response.

These district-level HIV/AIDS structures are relatively new, however. As of February 2005, all DACs (28 in total) had been recruited across the country, but only 21 had reported for duty (the rest were in transition from their previous jobs) (Bowie et al. 2005). There remains a need to build the capacity of both DACs and DACCs in technical capacities, as well as a need for more developed financial and logistical systems.

NAC has also instituted a decentralized system for channeling and managing NAC funds at the district levels. In mid-2004, at the request of the pooled donors, NAC entered into subcontracts with Umbrella Organizations to support district- and community-level HIV/AIDS interventions. These UOs were intended to provide support to local assemblies to mainstream HIV/AIDS in local-level development planning, as well as to channel sub-grants to CBOs and faith-based organizations (FBOs). Five UOs were contracted, all of which are international NGOs, including:

- ▲ Canadian Physicians for Aid and Relief
- ▲ Action Aid
- ▲ Save the Children (USA)
- ▲ PLAN International
- ▲ World Vision

In partnership with DACs, the UOs submit proposals to NAC for district-level HIV/AIDS activities. These proposals are based on broader district implementation plans. Once funding has been received by the UOs from NAC, the UOs then work with local CBOs and FBOs in the preparation of district-level HIV/AIDS proposals for possible funding. In addition to proposal-development capacity building, the UOs also provide training in budgetary/finance and project management to the CBOs and FBOs. As noted, the UOs work simultaneously to build the capacity of the DACs to carry out their roles.

The contracts between NAC and the five UOs are for two years each, ending in June 2006; after this time, it is intended that the DACs will carry out the function of community mobilization. Some respondents voiced concern that there was no formal performance assessment of the UOs to verify if the expected DAC capacity-building efforts were underway.

While the UO structure was not established by or for the GF in particular, the structure is being used to implement GF-supported activities. While the UO grants facility does receive some GF support, the structure is funded mostly by the pooled donors (75 percent).

4.3.4 Vertical Programs in the Context of Integrated Service Delivery

In several countries receiving significant new funding from global health initiatives, there is some evidence of a “re-verticalization” of services with the influx of such significant levels of disease or service specific resources, particularly for HIV/AIDS. This “re-verticalization” is counter to a general trend in many developing countries that are aiming to integrate service delivery.

In Malawi, the majority of central-level MOH respondents viewed GF activities as a vertical program operating within a health system that is reforming to implement integrated health services delivery through the SWAp.

A particular concern that arose from this vertical orientation, and was commonly voiced by respondents, was the perceived excessive focus on treatment rather than prevention.

Under the GF, there is too much focus on ARVs, PMCT and issues of prevention are not addressed. FBO official

The GF has recently expressed interest to be more integrated with the SWAp in terms of funding a common pool, but whether this will become a reality remains to be seen.

4.3.5 Global Fund Alignment with Existing Budget Policies

NAC maintains several separate accounts, with one for the GF; one each for discrete donors (UNDP, CDC, and ADB); and one for pooled donors (World Bank, DFID, NORAD, CIDA, and Malawi government). GF funds are transferred directly into NAC's bank account, which is separate from the other donor funds. Thus, while NAC has one Integrated Annual Work Plan, each donor funds specific activities within the IAWP.

Under the SWAp arrangement, the GF will be supporting the HIV/AIDS component of the POW, but GF funds will be channeled separately and not as part of the common SWAp pool into which all donors will be putting their funds.

In the case of the malaria component of the GF, once the grant agreement is signed, the MOH will be the PR and funds will be channeled to the ministry.

Regarding budget ceilings within the sector and GF implications for this, the Ministry of Finance allocates budget ceilings to each ministry and sector. In the case of the GF, according to the MOF budget section, the GF funding is under NAC and therefore it does not affect the ceiling of the MOH. However, the situation may be different for GF malaria funds, which will be channeled through the MOH.

4.3.6 Monitoring and Evaluation

Monitoring and evaluation (M&E) of GF-supported activities is to be carried out by the CCM, although these responsibilities have been delegated to NAC, which is responsible for the design, implementation, and communication of the M&E process. All partners in the national HIV/AIDS response are participating in the M&E process.

The M&E systems to be used have been operational for only a short period of time and will need to be strengthened as the national response is scaled up. Problem areas identified so far include indicator definitions and data collection.

Several respondents pointed out the need to harmonize the M&E systems of the NAC IAWP, GF activities, and the SWAp, in order to take advantage of common information systems, and the limited skills in-country in M&E.

4.3.7 Donor Harmonization

As mentioned in Chapter 2, there are several other global health initiatives being carried out in Malawi. In Malawi, respondents typically believed that GF support was effectively harmonized with the support provided by other donors. As noted, all HIV/AIDS activities – including those supported by the GF and by other donors – are incorporated in the NAC's IAWP, which was perceived to be an effective way to coordinate efforts.

In terms of harmonization between GF-supported activities and the World Bank's MAP, the GF has adopted the World Bank's procurement and financial reporting procedures. In addition, information is often shared between the two programs, especially the Bank's advisory and analytical work, such as that on human resources and health financing.

Although the GF-supported scale-up of ARVs preceded the WHO's announcement of the 3-by-5 Initiative in 2003, there has been discussion at the global level of using WHO's technical expertise to support ARV scale-up in Malawi. For example, the WHO's Malawi office is supporting the training of private sector medical practitioners in ART administration by co-funding two day training and certification courses. These private providers, once certified, will be eligible to access GF-financed ARV drugs.

4.4 Timeliness and Process of Global Fund Disbursements

4.4.1 Delays Related to Interactions with GF Secretariat Level

The timeliness and process of GF funds disbursement was a key point of concern raised by most stakeholders. Many respondents perceived that the GF Secretariat in Geneva is understaffed, with one portfolio manager being responsible for several countries implementing GF activities. Respondents felt that this made it difficult for countries, Malawi in particular, to receive timely responses or guidance from the Secretariat. Study respondents also cited concerns about the GF Secretariat regarding the inconsistent nature in which advice/guidance was provided during proposal development processes. For example, according to several respondents in Malawi, staff from the GF Secretariat had sent multiple, uncoordinated queries to Malawi over similar issues, which resulted in frustration among local decision makers:

...you respond to this query thinking that now everything is now finalised, another query comes ... MOH official

Furthermore, respondents complained that the responses received from the GF Secretariat were sometimes contradictory, with one GF staff person proposing one thing and, subsequent to that advice being heeded in Malawi, a different Secretariat officer coming back with a different proposal (sometimes reverting to the original thinking). Several respondents questioned the clarity of guidelines for GF-supported proposals. Respondents considered high staff turnover within the GF Secretariat and high workloads for GF Secretariat staff as contributing to these problems.

As noted, significant delays have been encountered in formalizing Malawi's malaria grant. The grant agreement for malaria was only signed in September 2005, three years after the proposal was approved. This delay has led to significant frustrations among stakeholders in Malawi.

...money is sitting there in Geneva as people are dying here. The GF system is rigid and lengthy. They [the Secretariat] do not call to give reasons for the delays. We keep on answering queries, one after another, and they keep bringing up one issue at a time, instead of raising all the queries at the same time. Some of the questions they raise are very trivial. Look, the GF was approved in 2002 and this is 2005. MOH official

The reasons for the delay in signing of the malaria component are rather unclear, and different respondents had varied interpretations of the problem. According to several respondents, the GF had apparently expressed concerns about the capacity of the proposed PR – the MOH – to implement the grant. The GF Secretariat also raised concerns about the MOH financial system, and requested several changes in the system in order for the MOH to act as PR. There have also been discussions about the

malaria funds being used in line with the SWAp, as desired by the MOH; however, the GF proposed instead that the monies should be channeled via a structure similar to the FMA (as is currently being used for the HIV/AIDS grant). Debate about how the funding should be channeled appears to have contributed to delays.

In addition, the malaria proposal to the GF indicated that sulfadoxine-pyrimethamine (SP) would be the first-line drug for malaria. The GF, however, recommended that artemisinin-based combination therapy (ACT) be adopted as the first-line treatment rather than SP. Malawi's technical committee responsible for such decisions did not agree with this recommendation, and thus further delays were encountered (see more on this in section 7.2).

Most government respondents suggest that the main reason for such significant delays in launching the malaria grant is that the GF Secretariat has been too slow in responding, and that there were several inconsistencies in the advice provided by the GF Secretariat on certain elements of the proposal. According to some informants, the delay in disbursing the malaria grant has caused significant problems in programming for malaria in country. For example, Malawi faced a near stock-out of the supply of insecticide treated bednets (ITNs), which were to be purchased under the GF grant, which was only resolved by an emergency grant from JICA.

Less severe delays have also been encountered in the HIV/AIDS grant, but informants suggested that this related more to weaknesses on the part of the LFA. Purchase of ARVs was apparently delayed because the LFA in Malawi did not have any procurement expertise and therefore had to hire a consultant to conduct the procurement assessment.

The delays in signing the malaria component and in the subsequent remittance of funds for HIV/AIDS activities have resulted in general frustration among stakeholders. Below are some of the quotes voicing concerns.

... Global Funds are like stars in the sky, you can see them, admire them, appreciate their abundance ... but fail to touch them... MOH official, quoting a Namibian presenter at a regional forum on malaria

..... I think the GF Secretariat should have and use both 'process and impact' indicators because, as of now, they seem to be concerned with process issues more than impacts ... how many people are dying from malaria when they are still delaying disbursements due to process issues? MOH official

4.4.2 Delays in Disbursements at Country Level

One of the causes for delay of disbursements of HIV/AIDS grant monies from the NAC to the MOH was the fact that the Contractual Agreement for Disbursement and Management of NAC funds was only signed 3–4 months after the start of the financial year. The MOH was also partially responsible for delays by late submissions in the request for disbursement of funds, given the time necessary for NAC to process disbursement requests. It should also be noted that there was no format in terms of request for disbursement until about September 2004, thus leading to lack of a common agreed format before that time.

In terms of the UOs, these systems have been in operation for a limited time (the UOs were only contracted by NAC towards the end of 2004). The procedures used by the UOs for disbursements of sub-grants to CBOs and FBOs are simpler than those of the FMA (which are based on World Bank procedures) and this has facilitated the faster absorption of GF resources by the local implementers. It appears that there is difficulty and delay in the whole grant disbursement systems from grant application to disbursement, with average times ranging from 3–4 months.

There are too many committees that look at and approve proposals... proposals are often altered that by the time the proposal comes back to the applicant, often without his further input, it's a number of months down the line. NGO official

As organizations become more experienced in grant applications, it is likely that the process will become more routine and shorter. On their part, NAC and the FMA have commissioned and undertaken an internal review of the grants facility.

4.5 Country Ownership

While alignment of GF-supported activities with the government's plans should be conducive to a strong sense of country ownership, in practice several respondents questioned the extent to which Malawi was able to control the funds available. Several examples were provided of the GF Secretariat providing advice or requesting procedures that conflicted with the Malawian view. In most instances these were relatively minor disputes but cumulatively added to the sense of lack of ownership.

For example, in the malaria proposal to the GF, Malawi indicated that the funds would be used in line with the SWAp while the GF Secretariat wanted GF monies to be channeled via an FMA-type structure. This was met with relative disappointment among several stakeholders.

... our feeling is that by disbursing funds via the FMA-like structure, a lot of money is lost in fees which could be used to procure a lot of mosquito nets and drugs... MOH officer

Another example relating to the malaria proposal concerns the selection of the PR. In Malawi's malaria proposal, the MOH was listed as the PR, since the MOH is responsible for overseeing the overall health sector under the SWAp. Many study respondents perceived that the GF did not want the MOH to be the PR. According to one respondent who spoke on this:

... this therefore raises the question 'who makes decisions of a health system in a given country such as Malawi – is it the MOH and national governments or someone sitting in the U.S.?' ... MOH officer

4.6 Summary of Findings of Effects of the Global Fund on Policy and Implementation Issues

The focus of this chapter was on the effects brought about by the global initiatives on the policy processes and implementation of health care delivery in Malawi. From the discussion presented above, the following key issues arise:

- ▲ The GF has enhanced the participatory nature of existing planning processes (and has benefited from earlier participatory planning processes in country). The recent requirement that CCM members be elected by their constituencies rather than being unilaterally appointed, was thought by respondents to be an important step in securing even greater legitimacy and representativeness in CCM decision making.
- ▲ Most of the informants thought that the CCM is fairly large in number (18) and they feared that the current increasing the CCM to 26 (as is being discussed) would make the grouping unwieldy. Stakeholders emphasized that what mattered was not more members on the CCM but effective representation of all relevant stakeholders, especially PLWHA and the private sector.
- ▲ Some confusion exists among informants concerning the respective roles of the CCM and NAC Board. There is a need to ensure that stakeholders and NAC itself are very clear about the roles of the CCM and NAC Board. Further, there is need for improving the coordination of the various HIV/AIDS coordinating structures presently in place.
- ▲ While planning for GF-supported activities forms part and parcel of the NAC's IAWP, concern has been expressed by respondents, and in previous reports, about the parallel planning processes for development of the NAC IAWP and that for the MOH's SWAp. These two plans need to be better harmonized. While this problem is not directly attributable to the GF, the influx of GF resources has likely exacerbated the issue.
- ▲ The CCM has proposed that funding for the malaria grant be channeled through the SWAp and some informants felt that it would have been better to channel the HIV/AIDS grants in this way. However countervailing fears were expressed that should this happen, then the focal diseases (HIV/AIDS, TB and malaria) would not be prioritized in the same way.
- ▲ Several new, interim structures, such as the FMA and UOs have been established at the behest of the GF and other funders to support rapid implementation. It is critical that either an exit strategy for these two entities is established, or their present contracts are extended. The UOs' contracts are due to expire in May–June 2006 and there was widespread skepticism that adequate capacity had been built in local assemblies to take over the work of the UOs.
- ▲ Funding for HIV/AIDS activities has been demand driven and some informants feared that this might lead to inequalities between districts in the distribution of GF funds. Respondents were of the view that there should be a formulae-based allocation system for GF monies in the interests of equity.
- ▲ There seems to be very good synergies between the GF and other global health initiatives and this should be further strengthened.
- ▲ Concerns were expressed about the delays on the part of the GF Secretariat in releasing funds once Malawi submitted its proposals, which has particularly been the case for the malaria proposal. Respondents perceived this to be due to understaffing and the frequent staff changes within the GF Secretariat in Geneva; inconsistent advice on proposal changes; too much emphasis on process issues; and the GF wanting to play too strong a role in determining the content of national proposals.

5. Effects of the Global Fund on the Public/Private Mix

As the Global Fund explicitly welcomes innovative approaches to expanding service coverage and approaches that draw private sector actors into the health care system, a greater role for private sector actors may evolve. SWEF aims to evaluate the effects of GF support upon the number, distribution, and organization of different types of providers (public, private for-profit, private not-for-profit) and relationships between public and private sectors (such as the number of public/private partnerships in non-focal areas, and the degree of trust and cooperation between sectors). The study seeks to explore the implications of these changes for overall health system performance.

This chapter looks at the changes brought about by the GF on the nature and types of private/public relationships in the Malawian health sector and how these relationships have evolved since the GF arrived.

5.1 Effects upon the Private Sector Role in Policy Making

As discussed in Chapter 2, the role of the private sector in policy development was already emphasized prior to the arrival of the GF in Malawi; for example, previous policy development processes such as those related to the National Strategic Framework for HIV/AIDS and the MPRSP included substantial participation by non-state sector actors.

The SWEF study aimed to ascertain the extent to which the private sector – including both not-for-profit and for-profit actors – have been involved in policy-making processes. Most respondents indicated that private for-profit partners have been left out in most of decision-making processes within the health sector both in the period before the GF and after Malawi started receiving the GF resources to support HIV/AIDS activities in the country. Private for-profit actors were not highly involved in the development of Malawi's first proposal to GF, nor have they been included to any significant extent in the preparation of subsequent proposals (including the malaria proposal and the recent Round 5 proposal). Some private for-profit actors were involved, however. For example, the Medical Aid Society of Malawi participated in the preparation of proposals and other policy-making processes, although it does not directly represent the interests of the broader group of private for-profit service providers.

On the other hand, the private not-for-profit service providers have been actively involved in policy processes within the health sector, including those related to the GF. Furthermore, many private not-for-profit actors sit and participate on several technical working committees set up by the Ministry of Health, National AIDS Commission, National Malaria Control Program, and the TB Control Programme. Notably, BLM, CHAM, Population Services International (PSI), and numerous other not-for-profit service providers have been party to the policy-making processes.

In general, some respondents felt that it is sometimes difficult to involve local CBOs and NGOs in national-level deliberations because of the multitude of entities concerned, but according to

district-level informants, some local non-state actors do typically participate in the preparation of district implementation plans.⁹ District-level respondents believed, furthermore, that GF support has increased the activities of local CBOs, enabling increased interaction between the district health offices and local private sector actors. This increased collaboration could have positive spin-off effects to other, non-GF-related health efforts within the districts.

5.2 Emerging Private Sector Players

Nearly all of the study informants perceived that, since the time Malawi began receiving GF support, a considerable number of new CBOs and NGOs have emerged (for HIV/AIDS activities in particular). According to the informants, some NGOs that pre-date the GF have had to change their mission objectives or to expand their scope of work. Some respondents were concerned about the extent to which these new organizations had the necessary capacity to perform their new roles. On the other hand, several informants applauded NAC's efforts to engage local CBOs and NGOs, because informants viewed this as one of the best ways of ensuring that GF support trickled down to where the funds are needed.

As noted earlier, some GF activities are being implemented through the existing grants facility which utilizes the umbrella organizations to channel resources from the national to district levels (and to build local capacities within district AIDS structures and local CBOs and NGOs). Most respondents felt that the role of UOs was particularly innovative. Although not created for the GF activities in particular, the UO structure is being utilized for GF implementation. As previously described in Section 4.3.3, each of the five UOs was given responsibility for supporting district-level planning and expenditure for GF funds, and has a two-year contract with the NAC to help build and strengthen the capacity of the district assemblies so that each district assembly is able to coordinate district-level responses to HIV/AIDS. Respondents viewed this capacity-building function as a very significant contribution of the GF on the public/private mix in the country. However, some respondents were concerned that there was no clear exit strategy for the UOs, and they also expressed concern that no milestones had been developed to monitor the progress of capacity building of the district assemblies.

In terms participation of the broader for-profit community in health sector planning and decision making, prior to 2002 such involvement was somewhat limited. At that time, while there was a Private Sector Working Group on HIV/AIDS, its membership and role was narrow. This working group was largely comprised of (large) companies that offered HIV Workplace programs. Given the limited focus of this group, which was principally focused on employee health programs, the working group was not widely recognized by the broader private sector. In 2002, however, the Malawi Business Coalition Against AIDS was established with the overall objective of coordinating the HIV/AIDS response within the business (for-profit) sector. The presence of the GF in Malawi played a beneficial role in the establishment of this new private sector group, as described by one study informant:

... Discussion to establish the MBCA started in 2002 following a visit by a Senior Advisor of the GF who held discussions with the Malawi Chamber of Commerce on the role played by the private sector in the fight against HIV/AIDS...from the discussion, it became apparent that government had ignored the private sector in

⁹ The district implementation plan refers to district plans developed for the general health sector, including activities funded by the GF and all other sources.

developing HIV policies and programs...this was not surprising because the government had never included the private sector in the dissemination of the National Health Strategy ... at a certain private sector sub-regional forum, it became apparent that the private sector in Malawi was not conversant with HIV/AIDS issues and the Global Fund, and was lagging behind counterparts in neighboring countries ... Private sector informant

The establishment of the MBCA presents a clear example of how the GF, albeit indirectly, has contributed to the incorporation of the private sector in broader health sector efforts to address HIV/AIDS. Although the establishment of the MBCA Secretariat was funded and supported by UNAIDS, WHO, and the pooled donors of NAC, most of the study respondents who talked about the MBCA applauded the GF for proposing the idea.

Most respondents did not perceive that there had been the same emergence of new private sector actors for malaria or TB, largely because these services were already well established with existing providers (as well as the fact that the amount of new funding for these services was not as significant as the new resources for HIV/AIDS).

5.3 The Public/Private Mix in the Delivery of Services

In the HIV/AIDS arena, some districts have formed proposal review committees – composed of government officials, private not-for-profit NGOs, and umbrella organizations – which have enhanced the working relationships among these partners in the districts.

In Malawi, all HIV testing and ARV treatment (i.e., at both MOH and CHAM facilities) is free of charge.¹⁰ In contrast, for drugs to treat opportunistic infections, only those financed by the GF are provided free of charge (although GF-financed OI drugs are a relatively small fraction of all OI drugs). Approximately 30 percent of OI drugs go to CHAM facilities. While drugs for testing, ART, and certain OIs are free of charge at CHAM facilities, a fee is charged for the consultation itself. To remove this financial barrier and encourage patients to use both MOH and CHAM facilities, the government and CHAM are working out service agreements whereby the MOH will pay CHAM for consultation fees. These service agreements will be funded by a number of sources and the agreements will cover general health care and not only HIV/AIDS.

It is planned that a few selected and qualified private medical practitioners will provide GF-purchased ARVs at highly subsidized price (in effect, the ART will be free, and a small fee will be charged to cover the operational costs of the programs). According to informants, each client will be asked to pay Malawi kwacha (MK) 500 (US\$4.50), from which MK200 will be retained by the practitioner as his/her fee. MK300 will be remitted back to the NAC and these funds will be used to run and strengthen the program, which will be coordinated by MBCA. This arrangement will also be extended to members of private medical aid schemes such as the Medical Aid Society of Malawi. Through the coordination of MBCA, some private employers will soon launch their ARV programs for their employees and their families.

Attempts are also being made to scale up VCT services in the private sector. Currently JICA funds Banja La Mtsogolo VCT services in three district in the northern region, Nkhatabay, Mzuzu

¹⁰ According to one informant at the MOH, of the 59 formal health-sector facilities providing ARVs, approximately 40 percent are operated by CHAM and the remainder are operated by government.

and Rumphu. The MOH has recently approved a proposal by BLM to support a number of VCT centers countrywide with GF funds.

Several other options are also being explored as means of scaling up private sector service in the country even though the private sector is often viewed as being expensive because of high overhead costs. On condom distribution, PSI works closely with NAC and the MOH to distribute condoms in the country; this ongoing relationship will likely be further strengthened through the implementation of GF-supported activities. It would appear, however, that there is already some degree of market segmentation in terms of the HIV/AIDS services which private sector providers are often engaged in versus those services usually provided by government and CHAM. For example, most NGOs are involved largely in activities such as behavior change and care/support and short-term impact mitigation, while with the exception of a few larger NGOs (such as BLM), NGO involvement in treatment and VCT efforts are limited. As one informant stated:

...VCT and treatment are seen as government and CHAM responsibility....
District-level informant

At the district level, there seems to be a growing sense of partnership between public and private providers. A district-level government respondent noted that because NGOs and CBOs were increasingly receiving funding through NAC to implement GF-funded activities, the district health offices were also benefiting because the offices are responsible for oversight and supervision of all activities.

With respect to the public/private mix in malaria programming, the MOH has had long-term relationships with many existing partners – such as UNICEF, WHO, World Bank, UNDP, and PSI – in the distribution of heavily subsidized insecticide-treated nets and re-treatment kits to MOH and CHAM health facilities (the ITNs are subsidized by donors, including UNICEF, has had long-term relationships with many existing partners – such as UNICEF, WHO, World Bank, and WHO). These ITNs are targeted at pregnant women and children under five years of age and to the village health committees or local distribution agents in rural areas, which serve primarily poor households. ITNs are also distributed to the general public via commercial outlets. Many respondents believed that GF resources would serve to foster and strengthen these existing relationships, as well as to facilitate financial access to nets for the very poor through GF subsidies for which criteria have been developed.

5.4 Benefits to the Private Sector

One area of interest of the SWEF study was to find out if the private sector itself feels it has benefited from the presence of GF support in Malawi. Although time constraints prevented interviews of private for-profit medical practitioners, the general feeling among private not-for-profit service providers and other stakeholders interviewed was that benefits to the private sector have thus far been only minimal. This is likely because GF resources have only recently started flowing into the country and because initial GF-supported efforts were largely focused on issues related to establishing appropriate financial management mechanisms for channeling and monitoring funds (as opposed to service delivery activities and other implementation).

While benefits may have been limited to date, there are some discrete examples of how private sector partners have benefited from GF support. For example, a small number of private not-for-profit service providers, such as BLM, have benefited from participation in training in VCT, HIV

management, and OI management, with some NGOs and CBOs receiving training in care and support. These local organizations are also benefiting from increased collaboration with district health offices. And some private medical practitioners have started administering ARVs after being trained by the MOH.¹¹ This training is coordinated by the MOH, and funded largely by WHO as well as some limited funding from the GF grant.

Another example is the use of GF resources to purchase utility vehicles for CHAM to facilitate the transport of ARVs and other drugs to CHAM facilities. One donor respondent also noted that GF sub-grant recipients (including private sector actors) were acquiring financial and drug management skills through participation in GF-financed activities, because of needs for complying with strict requirements for handling finances and ARV drugs. The informant believed that these improved skills had the potential to trickle down to non-HIV activities, thereby helping to improve overall financial and drug management in both the government and the private sectors.

Local CBOs and NGOs have also benefited, as described above, through UO-coordinated efforts to build capacity in proposal development.

5.5 Concerns about Private Sector Participation in Global Fund Activities

The participation of the private sector in GF-supported activities has raised a number of concerns among some stakeholders, including those in donor organizations, government, the NGO community, and even the private for-profit sector itself. The following sections discuss these concerns.

5.5.1 Government Willingness to Subcontract

The majority of respondents felt that the government's view of the private sector is changing. Increasingly, government recognizes that the private sector's participation will be crucial to the country achieving its agenda targets.

Many respondents also pointed out, however, that in most cases, the government does not endorse the private sector's role in official communications nor does the government fulfill its promises to further engage the private sector. An example given was that the government voices a need for involving the private sector in ART delivery, but does not actually find the sector qualified when it comes to implementation. Several respondents sought to explain this tendency by suggesting that the government may be reluctant to widely utilize the private sector because it does not want to be perceived as having inadequate capacity to implement activities in the GF proposal.

The option of referring patients to other private facilities or CHAM hospitals to receive ARVs is a non-starter, government would not allow it. Government does not want to show that it is not capable of delivering HIV services with the current resources in the hospitals.... Hospital official

¹¹ The MOH and the Medical Council of Malawi are requiring that all clinicians and nurses who provide ART services, including those in the private sector, should attend a formal training course and be certified in ART delivery. These training courses are free and last an average of two days for the private sector.

Similar views were also expressed by an informant working in the malaria sector, i.e., because government did not want to show its lack of capacity to distribute ITNs, it was reluctant to allow PSI to do so. This has led to some frustration among private sector actors.

...unless this feeling in government is done with, Malawi may not be on course to achieving most of the-ARV targets... Private sector respondent.

5.5.2 Capacity Limitations within the Private Sector

A second concern expressed was related to the fact that the private sector in Malawi is seriously underdeveloped¹² – with limited infrastructure and inadequate ability to access necessary resources. Some respondents have noted concern about the ability of private sector actors to carry out the activities they present in proposals to the Principal Recipient for GF resources – for example, due to limited staffing capacities (in terms of both quantity and skill level/training). While NAC tries to involve these organizations through UO partnerships, there remain concerns that there is no process in place to monitor how the UOs are building the capacity of these local entities, particularly with regard to the implementation of GF-funded activities.

In the HIV/AIDS arena, most of the local NGOs and CBOs have concentrated on raising awareness among the population, care and support, and impact mitigation activities. While NGO performance in awareness and prevention activities appears to be good, it is difficult for NAC to ascertain the quality of care and support and of impact mitigation activities conducted by these organizations, particularly in rural areas. There is fear among some respondents that some private practitioners wanting to provide ART are not properly trained, or do not have the necessary equipment to assess the CD4 counts of HIV-positive clients and determine whether they are eligible for treatment. Respondents who expressed this fear also felt that involvement of the private sector in the delivery of ARVs should be limited initially to a small number of practitioners, and scaled up only as adequate monitoring to ensure compliance is established. Finally, some respondents also expressed fear that private practitioners may place profit ahead of good quality of care.

...most local NGOs and private facilities are run individually and motives are different ... Private sector respondent

As described previously, since June 2004, NAC has been disbursing large amounts of money through the grants facility to local NGOs and CBOs under the NAC/FMA and UO arrangements. While these structures were applauded by most of respondents, several respondents also feared that some of these organizations would perhaps not utilize the funds prudently, noting that the motives of some local NGOs are not very clear. This is particularly true for those organizations that have emerged recently with the arrival of GF resources in country.

According to some informants, there is concern that NAC is moving funds to implementers on the ground through the grants facility (to be able to access subsequent GF funding tranches), but is doing so without adequately considering issues of quality or monitoring and evaluation¹³. Echoing this

¹² This is not limited to the health sector but true for sectors such as the agriculture, transport, and education.

¹³ It should be noted that UOs and district assemblies are the responsible for assessing the capacity of the local CBOs and NGOs.

view, some private sector respondents questioned whether the local NGOs and CBOs actually fulfill FMA reporting requirements that are quite strict.

5.5.3 Poor Coordination within the Private Sector

As discussed earlier, the private health sector in Malawi is not very well coordinated, with limited knowledge among partners of who is doing what. The establishment of the MBCA has been viewed as a positive step towards forming a more coordinated approach among private sector actors. However, some of the study respondents were concerned that, because the MBCA is new and not an initiative stemming from the private sector itself, it may not be agreeably recognized or adopted by some private sector actors – particularly those large companies which were operating their own HIV/AIDS workplace programs long before GF resources arrived in Malawi. Concerns were noted that because these workplace programs do not always follow national guidelines on ARV regimens and because the MBCA will be advocating for national guidelines, conflicts are likely to emerge. As such, there is a need for the larger private sector players to ‘buy-in’ to the MBCA if coordination is to improve.

...some big companies have active ARV programs funded through their own recurrent budgets and use state-of-the-art patented drugs. They are mandated by international law to ensure good health of their employees as part of the corporate social responsibility. Some of these companies are unwilling to comply with the national guidelines to use generic ARVs. They are also unhappy with the taxation of their drug budget and feel that this is a disincentive for other companies to start implementing the ARV programs. Private sector respondent

Some initiatives are now being put in place to establish linkages and better coordinate the activities of local CBOs and NGOs. For example, the Malawi Network of AIDS Support Organizations is an initiative that attempts to coordinate all the organizations working in HIV/AIDS support efforts. The UO arrangement is another example of an initiative to identify and coordinate CBOs/NGOs in the districts. A forum for international NGOs is in the process of being established. However, despite there being all these initiatives, much remains to be done in terms of coordination of local NGOs.

5.6 Summary of the Effects on the Private/Public Mix

This chapter focused on the effects of the GF on the nature and level of relationships between the public and private sectors in Malawi. The following key issues emerged:

- ▲ The GF has enhanced and created many opportunities for public/private interaction. Among the notable interactions which respondents cited is the training of staff in VCT, ARV management, and care and support. Nevertheless, the private for-profit actors lag behind in their participation. Another area where public and private actors were reported to have increased their interactions was the role of the UOs in the capacity building of the district assemblies.
- ▲ With the GF, Malawi has witnessed the birth of new CBOs and NGOs in the HIV/AIDS area and in some cases existing NGOs/CBOs have had to change their mission objectives or to expand their scope of operations.

- ▲ The private for-profit actors have seen the founding of the MBCA, which is viewed as a way towards coordinating HIV/AIDS response in the private for-profit sector.
- ▲ The GF has enabled the private sector to expand its services in existing facilities and, in some cases, to expand to other areas. Some of the private for-profit medical practitioners have been certified to provide ARVs in their clinics as part of the scale-up process. Contracts have been prepared for some private NGOs to scale up VCT services.
- ▲ While applauding the GF for improving the public/private mix, the informants also had reservations about current trends, particularly with regards to:
 - △ Government seeming reluctant to involve private for-profit actors because it may be concerned that this would be interpreted as a lack of government capacity;
 - △ Limited capacity among the private sector itself to implement the activities, monitor, and report on them and liquidate the funds appropriately;
 - △ Possible issues about service quality among CBOs and NGOs and the lack of performance monitoring;
 - △ Possible issues of abuse of funds as not all the beneficiaries of the GFATM have the same motives;
 - △ High overheads charged by some private actors; and
 - △ Poor coordination among the private sector actors.

6. Effects of the Global Fund on Human Resources

Human resource constraints are increasingly recognized as one of the most important obstacles to scaling up priority health services in low-resource countries, especially in sub-Saharan Africa. While most Global Fund-supported programs have significant in-service clinical training components, broader systemic issues such as motivation and retention are rarely addressed. Where health workers are in short supply, GF-supported activities may overburden capacity. The activities may also affect the skills, motivation and distribution of health workers, and may cause shifts in the distribution of health workers from non-focal disease programs/functions. Important human resource issues such as workload, motivation, remuneration, and capacity development are explored through the SWEF studies.

This chapter addresses the GF's effects on human resources in Malawi – where the human resource crisis is well documented – especially on challenges caused by additional workloads associated with scale-up of HIV/AIDS services.

6.1 Human Resources in Malawi's Global Fund Proposal

As stated earlier, before the inception of the GF, the Malawi National AIDS Control Programme (later transformed into the National AIDS Commission) had already started developing a comprehensive HIV/AIDS proposal for Malawi costing about US\$1.6 billion, which was to be used to solicit funding from potential donors such as the World Bank, WHO, and UNAIDS.

When the GF was announced in November 2001, the initial proposal was scaled down to approximately \$306 million, with an emphasis on health systems strengthening including human resource and infrastructural development. As noted, most health system strengthening elements were excluded in the final approved \$196 million grant.

After Malawi's GF proposal was approved, the MOH revised components of the Essential Health Package to include ARV and OI treatment. It soon became clear to many stakeholders that the rapid scale-up of HIV/AIDS treatment and support services would be hampered by chronic human resource constraints in the public health sector. The Malawi NAC estimated that to operate daily ART outpatient services, a clinic required a minimum staff complement of one nurse, one clinician, and one clerk. Considering the severe staff shortages in health facilities in Malawi, especially at primary and secondary levels, many study respondents felt that, in the short and medium term, ART provision would not extend to the most peripheral units of the Malawi health care system.

In February 2004, the UNAIDS Director and the DFID Permanent Secretary visited Malawi and noted that the human resource crisis in the public health sector would severely hamper the scale-up of ART and other GF-supported activities. Following this visit, the GF agreed that \$40 million of the five-year approved HIV/AIDS grant budget could be reprogrammed to fund Malawi's Emergency Human Resource Plan to help address the human resource crisis within the health sector. These GF

resources have now been included in the “resource envelope” for the EHRP. According to the MOH, the recent decision by the GF to allow Malawi to re-program \$40 million of its GF budget to support the EHRP is a welcome development, since it will not only assist in the implementation of GF activities but also the delivery of health services for other non-focal diseases. GF support to the EHRP has far-reaching positive spin-off effects to other areas of the health sector beyond HIV/AIDS activities, as the EHRP will provide benefits to all health workers, not only those involved in GF-supported activities.

From the MOH perspective, consideration of the human resource requirements for implementing GF activities was taken on by NAC with minimal consultation with the Human Resources Department of the MOH Health Planning Unit. Even when the system strengthening component of the initial GF proposal was scaled down, NAC did not engage the Human Resource Department to re-strategize on how the GF activities would be implemented within the context of existing severe human resource constraints. Instead, when the revised GF proposal was approved, NAC dealt directly with departments responsible for specific program implementation in the MOH to address how activities would be implemented with the existing workforce. That said, some informants felt that this lack of extensive consultation did not necessarily affect human resource planning to any large extent within the MOH, since the MOH and its collaborating partners had already designed the EHRP and the SWAp human resource program in order to relieve the general human resource problems in the public health sector.

6.2 Perceived Effects of GF-supported Scale-up on Human Resource Capacity and Performance

Since the initiation of GF-supported activities in Malawi in 2003, the majority of efforts for launching GF-supported programs have been undertaken at the central level. This is largely attributable to the fact that the process of applying for, planning, and beginning to implement GF-supported programs consumed a considerable proportion of the time of key country policy and decision makers. Given the large amount of resources involved, there was frequently great pressure upon policy and decision makers from very senior ranks of government to ensure timely implementation. For example, the bulk of activities, such as conducting planning meetings, developing guidelines and training materials for VCT, PMTCT, and CHBC, renovating of health facilities for VCT and ART, and purchasing drugs and medical supplies for the ART program, have been carried out largely by central-level stakeholders.

Before the influx of GF resources in Malawi, the MOH had established structures to coordinate HIV/AIDS activities initially through the AIDS Control Programme, the precursor of NAC, and then following the creation of NAC, the MOH established an HIV/AIDS Coordination Unit headed by the MOH Director of Clinical Services. The role of this unit is to coordinate all HIV/AIDS activities within the ministry and with all external stakeholders. With the arrival of such significant new HIV/AIDS resources through the GF, this unit has assumed a very large workload. As a MOH official working on HIV/AIDS put it:

There is a need for more senior staff members in the MOH to supervise and coordinate the implementation of HIV/AIDS activities in the public sector. Currently TAs [external technical advisors] outnumber full-time senior MOH staff, a situation which might lead to loss of local ownership of HIV/AIDS programmes in the MOH. The SWAp initiative will bring in five technical advisors... MOH official

Since mid-2004, various activities have begun to be implemented at central hospital and district levels mainly related to VCT and delivery of ART – so experience on the ground in the implementation of GF-supported service delivery activities is relatively new, and many potential effects on human resources at the facility level have not yet been felt significantly. Nonetheless, some facility-level staff voiced concerns about the human resource implications associated with scale-up of HIV/AIDS services, and respondents have already identified some potential constraints.

The delivery of inpatient services in central and district hospitals has, in some cases, been adversely affected by the introduction of ART clinics because dedicated nursing and medical staff for the clinics have been drawn from the existing staff complement at the hospitals. At one central hospital, the ART clinic has been overwhelmed with patients:

The ART clinic is overwhelmed with patients ...currently there is a waiting period of about three months for eligible patients to receive treatment. This is not because we have run out of ARVs but because we do not have enough clinicians to manage the patients. Gradually we have increased the number of clinicians working in the ART clinic from one to three, much to the detriment of the delivery of other hospital clinical services. We want to expand the ART clinic but there are no clinicians to see the patients. Surely there is a need to open up new delivery sites for ARVs ... There is no plan to hire extra clinicians to run ARV clinics and GF activities.” Health worker

This hospital has no plans to hire extra clinicians to run ART clinics and other GF activities because the hospital is not mandated to hire and, even if the powers were granted, the hospital cannot attract clinicians and nurses working outside the public sector due to poor working conditions. A similar story was told at the district level:

We have not recruited additional staff due to the GF but we have allocated more responsibility to the same individuals. We would love to recruit more staff but the processes are long. As a district we cannot recruit on our own – even the lowest level of staff. District-level respondent

Some respondents raised concerns about the effects of scaling up HIV/AIDS services on other non-focal-disease services. For example, one MOH official stated that GF activities such as PMTCT and HIV counseling do affect other services such as reproductive health by diverting attention and human resources, although the official added that HIV/AIDS is also a reproductive issue. Another respondent suggested that:

The GF is taking away resources from diseases such as malaria to VCT where there are funds. Donor representative

No major shift of health workers from the private health sector to the public health sector or vice versa has occurred. There have been limited movements of staff from the public sector/MOH to NAC (which is also a public sector institution) and a few NGOs that are engaged in ART delivery. This insignificant shift may partly be due to the fact that HIV/AIDS activities requiring skilled health workers are mostly being implemented in the public health sector. In the future, it is not expected that there will be a proliferation of NGOs and private health institutions that will recruit health workers specifically to provide ART, thereby attracting health workers away from the public sector.

In Malawi, a potential pitfall in carrying out capacity-building efforts among health workers was observed. The MOH instituted a policy permitting non-medical health workers conduct VCT for HIV/AIDS. Since this policy shift, there is evidence that health surveillance assistants – employed by the MOH to implement health promotion and preventive health services at the community level – are “specializing” to become VCT providers. This “specialization” could potentially weaken community-based health services for non-HIV/AIDS-related services. While not directly attributable to the GF, this shift has been augmented due to the rapid scale-up of HIV/AIDS services under the GF-supported program.

6.3 Staff Motivation and Retention

While activities to improve the capacity of health staff is frequently addressed in GF proposals – including Malawi’s – very few countries have addressed issues of health worker motivation or retention. These issues were found to be important concerns among many respondents.

In Malawi, health workers are not being provided with significant new incentives to offset the increased workload or responsibilities they face in the implementation of GF-supported activities. Because participation in GF-related activities does not correspond to increases in grade or salary, the most significant financial motivation for health workers often comes in the form of training allowances. As noted by a district-level informant:

The staff we have here in the district do not demand additional money for the additional activities. I think its because they get some allowances for training and for implementing some of the activities... We make sure that every staff be it clinician or nurse benefit from these activities. District-level respondent

While salary increases are not linked to involvement in the implementation of GF-supported activities, all health workers in Malawi have recently received salary increases through the EHRP (which the GF supports). Despite the perception among donors and MOH officials that the 50 percent salary increase instituted through the EHRP will help to retain health workers in the public sector, respondents believe that this increase has had a minimal impact on staff morale. Many informants sensed that this was due in part to “heavy” taxation that results in a take-home remuneration package that remains very low. Some informants from the management levels within district and central hospitals speculated that the salary increase would not have the desired effect, because the base salaries upon which the increases were calculated were dismally low.

Respondents lamented the worsening working environment in their hospitals due to the chronic shortages of basic medical supplies and drugs, which would adversely affect the MOH’s staff retention program.

A nurse will not continue to work in an environment where there is a continuous shortage of gloves, syringes, and drugs even though she is reasonably well paid.
MOH official

Respondents believed that it would be advantageous to use GF resources to support other components of the SWAp POW, such as the management and distribution of basic medical equipment and drug supplies. Other respondents pointed out that poor health services delivery (which will predictably affect the implementation of HIV/AIDS activities) is due not only to lack of human

resources but also poor overall organization of the health system including poor staff supervision and limited on-the-job training, which is particularly poor at primary and secondary health care facilities. Respondents further suggested that GF activities should help to support the MOH and its implementing partners to strengthen of the entire district system, instead of concentrating only on HIV/AIDS activities. In consideration of these concerns, MOH and NAC officials acknowledged that there is currently an attempt to harmonize GF-supported activities and the SWAp POW to ensure these programs are complementary, and to further ensure that GF support goes to assist strengthening the general health system. Malawi's 5th Round GF proposal aimed to strengthen this aim, with emphasis on system strengthening.¹⁴

6.4 Summary of Effects of the Global Fund on Human Resources

This chapter focused on the effects of the GF on human resources in the health sector. Key points of the discussion are as follows:

- ▲ Prior to applying for GF support, the government of Malawi had already prepared a comprehensive national proposal to address HIV/AIDS. This proposal highlighted human resource development and strategies were incorporated for possible funding from other donors. Subsequent to submitting its HIV/AIDS grant proposal to the GF (which included human resource approaches), Malawi was requested by the GF to scale down the proposal. As a result, systems strengthening interventions – including human resource development – were excluded. Many stakeholders felt this created a large gap, with increased responsibilities being placed on a sector that was already poorly resourced.
- ▲ GF activities in Malawi are currently being implemented in an environment of severe human resource shortages, sub-optimal human resource management, and a poor working environment in the public health sector. Against this background, there is some evidence that the implementation of GF-supported activities is causing some undesirable effects in the general operation of health facilities. Although the GF has recently committed to finance the MOH endeavors to improve the human resource capacity of the public health sector (by reprogramming funds to support the EHRP), most respondents felt that GF resources need to be used to support other components of the SWAp POW that are aimed at strengthening the broader health system.
- ▲ Current efforts by the MOH and NAC to harmonize the NAC IAWP and the SWAp POW are likely to improve the performance of the public health sector in delivering not only HIV/AIDS activities but also general health services.
- ▲ The implementation of GF-supported activities has not resulted, to date, in any significant shifts of staff from public to private sectors, since most activities are being implemented in the public sector. However, GF-supported activities have implied a greater workload for the health staff and in some instances has shifted staff away from other services toward HIV/AIDS services.

¹⁴ Note, the GF added a new health systems strengthening component during its 5th Round Proposal process to allow CCMs to submit proposals explicitly for health systems strengthening.

7. Effects of the Global Fund on Pharmaceutical Procurement and Distribution Systems

Approximately 50 percent of Global Fund money committed worldwide is targeted towards the procurement of pharmaceuticals and commodities. This large injection of funding may affect procurement, supply and distribution systems, and the quality and prices of other drugs and commodities. This chapter focuses on the effects of the GF on the procurement, distribution, and management of pharmaceuticals and other commodities.

7.1 Planning for Procurement and Distribution of GF-Financed Drugs and Supplies

According to GF policy documents, “Principal Recipients (PRs) are responsible for ensuring that all procurement and supply management conducted under its grant(s), including that conducted by other entities (such as sub-recipients), conforms to GF requirements” (GF 2005). Following the initial approval of Malawi’s HIV/AIDS grant, the Local Fund Agent conducted an assessment of the Central Medical Stores – again, the national body that coordinates overall pharmaceutical procurement and distribution in Malawi – to ascertain capacity for pharmaceutical procurement and management. The LFA concluded in this assessment that the CMS did not have adequate procurement capacity, which resulted in the GF issuing a request to the MOH and CMS to identify an alternate procurement agent by either (i) going through a “lengthy” international tendering process or (ii) by directly engaging a member of the U.N. family (pre-qualified with the World Bank). To expedite the overall process, and ultimately to accelerate the delivery of ART, MOH/CMS recommended that UNICEF be contracted to procure drugs and medical commodities on behalf of the MOH.

A memorandum of understanding was subsequently signed between the MOH/CMS and UNICEF, in which UNICEF was tasked to build the capacity of the CMS specifically in the area of procurement and medical supply management. This resolution envisaged that the CMS would gradually take over specific tasks from UNICEF, in a phased manner, so that CMS could eventually handle all the procurement and distribution activities. The MOU has no set time limits, but is subject to renewal. The MOH does not place an obligation on either party, but the MOH/CMS and UNICEF were required to draw up a program of work and define milestones, at least one month after signing of the MOU, to monitor the progress of the capacity building process.

During the initial phase of the agreement, the MOH/CMS was tasked with compiling an order list for drugs and medical supplies and forward it to UNICEF. UNICEF would then procure the items through its offices in Copenhagen and ensure that supplies were quality tested. ARVs would be prepackaged in Copenhagen and delivered by UNICEF directly to the health facilities, while other drugs and medical supplies would be procured by UNICEF but then sent to CMS for distribution to health facilities through regular CMS distribution systems.

The MOH made a decision to use simplified standardized ART regimen comprising stavudine, lamivudine, and nevirapine (available in a single combination tablet called triomune, administered twice daily) as first-line HIV treatment. The MOH plans were to distribute the ARVs to MOH and CHAM hospitals that had been pre-certified to administer ART. Hospitals were certified if they had, among other things, good safe storage space for ARVs and a dedicated team of ART health workers who had been trained in ART management. Apart from ARVs, all drugs and medical supplies (including HIV testing kits) purchased by the GF were to be distributed to all hospitals. External monitoring of ART drug management was to be performed by the HIV/AIDS Unit in the MOH while the CMS was to monitor management of other non-ART drugs and medical supplies. Currently all ARVs in MOH facilities are purchased through the GF, while CHAM facilities have ARVs from the GF and other sources.

Recently, the MOH has decided to distribute ARV drugs to private medical practitioners and hospitals in an effort to rapidly scale up the delivery of ART. ART management training sessions have already been conducted for interested private practitioners. It is envisaged that UNICEF will distribute ARVs directly to the private practitioners (just as in the public sector) while the HIV/AIDS Unit, in collaboration with the Malawi Business Coalition Against HIV/AIDS, will monitor drug management in private facilities. While ARVs are provided free of charge in the public health sector, in the private sector they will be provided at a subsidized rate of MK500 (~US\$4.50) per month (compared to the commercial rate of MK5000 [~US\$45] per month). It is expected that the private practitioner will retain MK200 from the ART fee while MK300 will be remitted to the NAC. This amount will be used for capacity-building activities at the MBCA so that they can monitor ART management in the private sector.

The Department of Health Technical Support Services and CMS had great reservations regarding the manner in which UNICEF was contracted to procure and distribute (in part) drugs and medical supplies for the GF-supported activities. Respondents felt that the LFA's assessment of CMS was not conducted in a fair manner, suggesting that the assessment had been largely based on the findings of a previous assessment (commissioned by DFID). Respondents felt that the LFA failed to identify the true reasons for any sub-optimal performance of CMS, resulting in erroneous recommendations being presented to the GF Secretariat. In the view of the DHTSS and the CMS, the inefficiencies of CMS are due largely to shortages in human, material, and financial resources at central and regional levels, coupled with limited capacity for drug forecasting at the health facility level.

Respondents from the DHTSS and CMS also expressed dissatisfaction with the progress of the capacity-building efforts that UNICEF was supposed to undertake. Respondents noted that UNICEF has not proposed a workplan or milestones for the capacity-building process, even though it has been almost a year after they entered into the contract with the GF and signed an MOU with the MOH/CMS. At the time of the study, the only capacity-building activity that had been undertaken was a visit by MOH/CMS officials to the UNICEF procurement division in Copenhagen. One respondent noted:

UNICEF is specialized in addressing the needs of children in poor countries. UNICEF does not have the expertise in building or strengthening the capacity at Central Medical Stores. The Ministry should have recognized that UNICEF is not the right organization to conduct capacity building and should have influenced the Global Fund to select another organization to do this job. Donor representative

Study findings show that DHTSS itself feels sidelined on most issues pertaining to the GF and GF-supported activities. In their view, the HIV/AIDS Unit in the MOH has assumed oversight over

distribution of ARVs, when in fact this was the mandate of the DHTSS. (Note: All ARVs supplied by the MOH to both MOH and CHAM facilities are funded by the GF. Private for-profit entities can procure ARVs from any source and are responsible for their own procuring, distribution, etc.) DHTSS reports that it does not receive reports on ARV drug distribution from UNICEF and it is unclear whether UNICEF submits the reports to the HIV/AIDS Unit. In their view, a parallel drug distribution has been set up for GF-financed ARVs in Malawi and it is unclear who will assume oversight of ART management upon the expiry of UNICEF's contract. In summary, there appears to be a lack of consultation between the DHTSS, the MOH HIV/AIDS Unit, CMS, and UNICEF. Some respondents believe that there are strong pressures on Malawi to adopt a procurement and distribution system preferred by specific donors.

Despite the concerns raised by the DHTSS and CMS, officials from UNICEF state that their MOU with MOH/CMS is very specific, and that UNICEF is responsible for strengthening the procurement capacity of CMS through several explicit activities including:

- ▲ Preparation of international tendering;
- ▲ Supplier identification; and
- ▲ Identification of best quality products at a lower price.

UNICEF has already started carrying out these tasks and maintains that other aspects of capacity building were not assigned to them. Some respondents noted that DFID previously invested significant resources to reform the CMS, but such efforts failed. Some believe that the problems at CMS are very complex because of CMS's linkages with the MOF and MOH, and feel that to resolve the problems, CMS should be transformed into an autonomous body.

7.2 Alignment with Existing Pharmaceutical Policy

Another main area of concern noted in the study was alignment with existing pharmaceutical and commodities-related policies and processes, namely the selection of drugs to be purchased with GF support.

Several respondents in Malawi expressed serious concerns about the GF Secretariat 'interfering' with MOH independence in terms of its existing antimalarial drug policy (this 'obstacle' was noted even though the malaria grant remains to be signed). Since early 2004, the GF has been going through a process of determining how to best facilitate the scale-up of artemisinin-based combination therapies as the first-line malaria treatment in appropriate contexts (that is, where other treatments are no longer effective).

Due to high sulfadoxine-pyrimethamine failure rates in Malawi, the GF recommended that ACT be used as the first-line malaria treatment in the country. The Malawi Malaria Control Committee – the national malaria policy-making body – had however made a recent decision that SP should continue to be the first-line antimalarial treatment in Malawi, and that it should be purchased for GF-supported malaria activities. Some respondents were frustrated that the GF advocated for a change to ACT treatment policies in Malawi, despite the national policy decision.

... the same Global Fund stated that countries are free to make their own malaria policy, but on the other hand they insist that we should procure ACTs as first-line treatment instead of SP... our Malaria Control Committee decided to continue

using SP [as first-line treatment] based on local experiences and realities but the Global Fund would like to impose ACTs on us. MOH official

Some respondents suggested that if the GF maintained that ACTs be procured rather than SP, that the MOH was contemplating excluding the purchase of antimalaria drugs from their malaria GF grant and seeking other funding sources for the purchase of SP.

7.3 Perceived Effects of the Global Fund on National Management of Drug and Medical Supplies

Despite the strong reservation expressed by the DHTSS and CMS regarding the process of procurement and distribution of GF-financed ARVs, several informants welcomed the contribution of the GF in the following areas:

- ▲ Financial support to the drug regulatory body, the Pharmacy, Medicines, and Poisons Board, which will strengthen their operations in safeguarding the provision of high quality drugs in Malawi
- ▲ Financial support to the School of Pharmacy, which will help to alleviate the human resource problems at CMS
- ▲ Financial support to the MOH to enable it regularly update the National Drug Policy, the Essential Drug List and the Malawi Standard Treatment Guidelines, which will improve the prescribing practices of clinicians
- ▲ Support to the CMS with utility trucks which will improve the drug distribution system
- ▲ Support to the CMS with equipment and technical assistance in drug quality testing

Although these areas of support were made to improve the management of HIV-related drugs, the DHTSS and CMS viewed these activities as crosscutting support which will improve the management of all drugs in the public and private sector.

7.4 Perceived Effects of the Global Fund on Drug Management in Health Facilities

According to members of hospital management teams who were interviewed, after the hospitals had been certified by the MOH HIV/AIDS Unit to start delivering GF-financed ART services, delays were encountered in the initial supply of ARVs. However, informants stated that the HIV/AIDS unit informed facilities that these delays were due to logistical problems outside Malawi, beyond MOH control. After the ART programs had commenced, the hospitals have reportedly had no drug stock-outs (although the ART program has only been running for a short time). Respondents attributed this good ARV supply to strict MOH policies that limit the quantity of new patients that ART clinics can enroll each month. Some respondents also acknowledged that there are strict accounting and storage requirements unique to ARVs (all GF-financed). One hospital official is quoted as follows:

...there are special lockable storage cabinets for ARVs.....every day a nurse from the ART clinic has to sign for ARVs out and back into the pharmacy. Health worker

Despite improved security for ARVs, there was some doubt cast on whether these mechanisms would have any spin-off effects on the security and accountability of drugs for other non-focal diseases. Unlike the other drugs, the monitoring system for ARVs is strong and regular, and ART nurses, clinicians, and pharmacy technicians received special training on ARV management.

In contrast to the ARVs, some hospitals are already experiencing stock-outs of drugs for OIs. District-level informants suggested that the supply of OI drugs is inconsistent.

...sometimes our patients go to other districts when they hear of good stocks of drugs.... Sometimes we just prescribe and advise our patients to procure drugs from local shops and pharmacies... Health worker

The security system for some OI drugs is as strict as for ARVs but the hospitals continue to have stock-outs, perhaps because there are no limitations on the number of patients that can be treated for OIs. The hospitals reported that there is no system currently in place to accurately estimate or forecast requirements for OI drugs and that the monitoring system for OI drugs is not as strict as that for ARVs.

As of June 2005, no ARVs had been supplied to the private health facilities as planned by the MOH. However, a respondent from the private not-for-profit sector expressed caution against the plan to widely introduce subsidized ARVs in the private sector, which is currently poorly supervised by the MOH, suggesting that if there was unregulated introduction of ART that drug pilferage as well as patient confidentiality issues could arise. Notwithstanding this cautionary note, the same respondent stated that the successful introduction of ART in the private sector would assist many HIV-infected patients who are on private medical insurance schemes, because medical insurance companies are likely to include ART in their package of medical benefits (currently ART is excluded from medical insurance schemes because of the high cost).

With regard to the pricing of drugs, respondents did not express concern that the volume of the subsidized ARVs would be large enough to affect the price of commercially available ARVs.

... the current demand for ARVs is so high and it is unlikely that government will meet the demand, judging from the pace of the ARV scale-up programme... Private not-for-profit official

Prior to the GF, there were a few large companies in Malawi offering ART to employees (mostly top and middle management levels only) through private hospitals. In the absence of national ART guidelines, many of these companies were using western guidelines and utilizing expensive drug combinations. Now that there are national guidelines and subsidized ARV drugs will be introduced into the private sector, such companies may be able to extend their medical schemes to all employees (given significant costs savings from ART subsidies). Other companies may also be encouraged to introduce in-house medical schemes given that commercial ARV prices may not be as prohibitive.

7.5 Summary of the Effects of the Global Fund on Pharmaceuticals and Other Commodities

This chapter focused on the effects of the GF on pharmaceuticals and other commodities. The following key points emerged:

- ▲ The GF has provided the opportunity for Malawi to increase the volumes and range of drug and medical supplies for HIV-infected individuals both in the public and private health system.
- ▲ GF support has also provided an opportunity for Malawi to update its general drug regulatory system and prescribing guidelines.
- ▲ A new parallel drug procurement, distribution, and monitoring system has effectively been set up for GF-financed ARVs, which does not appear to complement the existing drug management system.
- ▲ Clearly, the apparent misunderstanding among UNICEF, DHTSS/CMS, and the MOH HIV/AIDS Unit may limit the extent of GF help in the long term. In the short-term, there is an urgent need for the various MOH departments to meet and resolve their apparent misunderstanding with UNICEF and draw up a capacity-building POW that should be based on, and complement plans in the SWAp POW to strengthen the CMS.
- ▲ Through the SWAp health sector reform, there appears to be a consensus within the MOH and between MOH and the donors, on the best way to improve the operations of CMS and the general drug management system. GF resources could be used to advance this consensus and support some activities outlined in the SWAp POW.

8. Conclusions and Next Steps

The section summarizes the main conclusions and proposes recommendations for both local stakeholders and the Global Fund, based on the study findings.

One significant finding from the study is the gap left following the removal of health systems strengthening elements from Malawi's original HIV/AIDS proposal. The original proposal contained significant amounts of funding directed at human resource and infrastructure development. It has become very clear that, absent functional health systems, it is quite difficult to implement the activities proposed. To achieve success in implementing such extensive scale up of disease-specific services, the health system needs to be working, with adequate resources, systems and infrastructure.

The approved GF proposal had assumed that there was a functioning health system with adequate human resource capacity. However, it has now become apparent that the absorptive capacity of the public health system is limited. MOH official

The Global Fund had used a one size fits all approach in removing the health systems strengthening from Malawi's proposal and now recognizes that countries are different. Donor representative

To its credit, the GF has permitted Malawi to reprogram \$40 million of GF funds to support human resource development through the EHRP. This is a welcome development, as it will not only assist in the implementation of GF-supported activities but also the delivery of health services for other non-focal diseases.

Furthermore, the GF's recent policy change that explicitly invited health systems strengthening proposals in its Round 5 proposal process is also welcome. Malawi submitted a Round 5 proposal, which if funded will further enhance its capacity to improve the broader health system at the same time as addressing the focal diseases.¹⁵

8.1 Policy Process

One of the key findings of the study relating to policy processes is the limited coordination and harmonization between planning for the NAC IAWP (which covers not only GF-funded activities but all activities funded by NAC's funding partners, including pooled and discrete donors) and the SWAp POW. This situation has resulted in the creation of a parallel planning process. The majority of respondents at the central MOH viewed the GF as a vertical program operating within a health system

¹⁵ The GF approved Malawi's Round 5 health systems strengthening proposal in September 2005, although a grant agreement has not been signed.

that is reforming to implement integrated health services delivery through the SWAp. While NAC is doing a commendable job of coordinating all donors who currently fund HIV/AIDS activities, a number of informants expressed concern that NAC is operating a vertical system for GF-funded activities, and that GF and all HIV/AIDS funds should be directly channeled through the SWAp. This view is countered by some informants who feared that, should this happen, the SWAp may shift priority with less focus on the focal diseases.

It is recommended that NAC and the MOH agree to a common planning timetable and approach to ensure harmonization of the overlapping SWAp and NAC IAWP.

8.2 Public/Private Mix

Encourage More Public/Private Partnerships

An important finding on the effects of the GF on the public/private mix is that the influx of GF resources has greatly enhanced collaboration, and created many opportunities for interactions, between the public and private sectors. Among the notable examples is the training of private sector staff in VCT, ARV management, and care and support.

It is recommended that such partnerships be strongly encouraged as the public sector alone cannot meet the ambitious ART targets set by the GF, or WHO's 3 by 5 Initiative.

Assess Capacity of Emerging Private Not-for-profit Organizations

The arrival of the GF in Malawi has witnessed the birth of a number of new NGOs and CBOs in the HIV/AIDS area and, in some cases, existing NGOs and CBOs have changed their mission objectives or expanded their scope of operations. In some cases, there is limited capacity among these actors to implement activities, monitor, and report on them and liquidate funds appropriately. The multiplicity of actors may also entail lower quality services as not all NGOs and CBOs have the same expertise and knowledge and there is also the possible abuse of funds. Concern was raised by some informants from the private sector about whether the local NGOs and CBOs which are being funded by NAC through the UOs are fulfilling FMA reporting requirements.

It is recommended that NAC adopts a more rigorous screening mechanism for private not-for-profits with particular focus on the new, emerging ones and that mechanisms to ensure that they meet minimum capacity and reporting requirements are in place to ensure quality.

8.3 Human Resources

Increase GF Support to Human Resource Development and Management

The recent GF decision to allow Malawi to reprogram \$40 million of its GF budget to support the EHRP is a welcome development because it will not only assist in the implementation of GF activities but also the delivery of health services for other non-focal diseases. In addition, the bulk of funding for Malawi's 5th Round GF proposal is aimed at further strengthening the human resource

capacity of the public health sector. The GF-funded activities in Malawi are currently being implemented in an environment of severe human resource shortages, sub-optimal human resource management, and a poor working environment in the public health sector. Against this background, there is evidence that the implementation of GF-supported activities is causing some undesirable effects in the general operation of health facilities.

In view of the above, it is recommended that the GF maintain its recognition and commitment to human resource development and management and continue to support the EHRP.

8.4 Pharmaceuticals and Other Commodities

By bypassing the Central Medical Stores and recommending the use of an external pharmaceutical procurement agency, the GF has introduced a parallel drug procurement, distribution, and monitoring system. While some elements of capacity building have been included in the agreement with UNICEF, this has not appeared to work to date, and limits longer term ability of the CMS to carry out its function.

Under the SWAp, consensus has been reached between the MOH and donors on the best way to improve CMS operations and the general pharmaceutical management system; it is recommended that the GF buy into this consensus and support the activities contained in the SWAp POW on strengthening of CMS and the general pharmaceutical management system, since a strengthened and functional CMS is in the best long-term interest of the country.

8.5 Next Steps

Follow-up SWEF research is planned in Malawi, allowing for more in-depth consideration of systemwide changes related to the influx of resources from the GF. This will enable comparative analysis and assessment of the impacts upon utilization for non-focal disease services such as immunizations or family planning, pressures on health workers, and resource availability. Findings and final reports from this study will be available in mid-2006.

Interim updates on the status of SWEF activities will be posted to the PHR*plus* website at www.phrplus.org/swef.php.

Annex A: Malawi Global Fund Coordinating Committee: Terms of Reference, Members

As noted in the body of the report, the Global Fund Coordinating Committee is the formal name of Malawi's Country Coordinating Mechanism.

Terms of Reference

1. Review and transmit country coordinated proposals to the Global Fund;
2. Review and transmit annual work-plans to the Global Fund;
3. Review and approve a national timetable and criteria for accessing the funds;
4. Review and approve the implementation plans for activities supported through the Global Fund and submit copies to the Global Fund;
5. Undertake programme monitoring and evaluation to determine progress;
6. Review and submit financial and technical reports on national programme within the Global Fund Framework;
7. Report progress on implementation of various programmes on the Global Fund to Government; and
8. Serve as the official mouthpiece on all issues pertaining to the Global Fund and the programme it supports.

Membership (as of June 2005):

1. PS for Health (Chairman)
2. NAC Board Chairman
3. NAC Director

One member from each of the following:

1. State/Faith Taskforce
2. Ministry of Finance
3. Salima AIDS Support Organisation – representing CBOs and CSOs
4. John Hopkins Research Group (for technical advice on HIV/AIDS)

5. College of Medicine – Malaria Research (TA on malaria)
6. College of Medicine (representing academic institutions)
7. HIV/AIDS Activists/PLWHAs
8. Embassy of Norway – representing foreign missions/donors
9. Chief – representing traditional leadership
10. Project HOPE – representing international NGOs
11. UNAIDS
12. CHAM
13. TB Programme
14. National Youth Council

Annex B: Human Resource Activities Financed under the Sector-wide Approach

The SWAp will finance the following activities, of which some were partly or fully included in the EHRP (**highlighted**)

1. Filling human resource vacancies.
 - a. **Implementing the Six-Year Emergency Pre-Service Training Plan.**
 - b. **Financing the filling of human resources posts in line with the establishment at Government of Malawi district and CHAM institutions.**
 - c. Financing a flexible Technical Assistance (TA) Fund for specialists for non-established staff needs at district level.
 - d. Financing TA for volunteers at district level.
 - e. **Financing filling of posts at central hospital level – in line with the establishment.**
2. Strengthening human resources retention.
 - a. Paying salaries and allowances on time for the government of Malawi and CHAM.
 - b. **Increasing remuneration for health staff at district, CHAM, and central hospitals.**
 - c. **Providing in-service training.**
3. Integrating in-service training of health workers.

In addition to the above-mentioned activities falling under the human resource program, the SWAp POW aims to improve the routine management of human resources by undertaking the following activities (which fall under the Central Institutions, Policy and Systems Development Programme);

1. Developing post basic and in-service training policies and systems.
2. Developing national recruitment and deployment policies and strategies.
 - a. Matching the establishment to the EHP requirements.
 - b. Undertaking a workload analysis.
 - c. Developing and enforcing a human resources deployment policy and plan.
 - d. Developing clear guidelines for staff recruitment practices.
3. Developing and putting into operation a human resources information system.
4. Developing and implementing human resources management systems.

5. Developing and enforcing a personnel management policy.
 - a. Developing clear career structures for the health sector for different cadres.
 - b. Undertaking a functional review of the MOH.
6. Putting in place an individual performance management system and standards.

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