Republic of Malawi

Ministry of Health

Malawi Health SWAp Donor Group

GTZ

Human Resources / Capacity Development within the Health Sector

Needs Assessment Study

Final Report
June 2007

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Abbreviations

ART	Anti-Retroviral Therapy
CD	Capacity development
CHAM	Christian Health Associations of Malawi
CIM	Centre for International Migration
CMS	Central Medical Stores
COM	College of Medicine (University of Malawi)
CPD	Continuing Professional Development
COSECSA	College of Surgeons of East Central and Southern Africa
DFID	Department for International Development (UK)
DHO	District Health Officer
DHRMD	Department of Human Resources Management and Development
DIP	District Implementation Plan
DMT	District Management Team
DOH	Directorate of Nursing
DOP	Department of Planning
DP	Development Partner
EFA-FTI	Education for All – Fast-Track Initiative
EHRP	(6-year) Emergency Human Resources Programme
EHP	Essential Health (Care) Package
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GOM	Government of Malawi
GTZ	German Technical Cooperation Agency
HDG	Health Donor Group
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRAC	Human Resources Advisory Committee
HRH	Human Resources for Health
HSA	Health Surveillance Assistant
HSC	Health Service Commission
HSRG	Health Sector Review Group
KCN	Kamuzu College of Nursing
LATH	Liverpool Associates in Tropical Health
MCHS	Malawi College of Health Sciences (Mzuzu University)
MIM	Malawi Institute of Management
MOH	Ministry of Health
MSF	Médecins sans Frontières
MTR	Mid-Term Review
MYR	Mid-Year Review
NGO	Non-Governmental Organisation
OPC	Office of the President and Cabinet
PoW	Programme of Work
PRSP	Poverty Reduction Strategy Paper
TA	Technical Assistance
ToR	Terms of Reference
SADCC	Southern African Development Coordination Conference
SWAp	Sector-Wide Approach
SWOT	Strengths, Weaknesses, Opportunities and Threats
ToT	Training of Trainers
TWG	Technical Working Group
UNDP	United Nations Development Programme
UNV	United Nations Volunteer
VSO	Voluntary Service Overseas
WB	World Bank
WHO	World Health Organisation

1 Summary

1.1 Background

Capacities of the MoH and its subordinated structures and institutions to implement the Health SWAp Programme of Work (POW) and to deliver the Essential Health Package (EHP) are still limited. Hence SWAp partners agreed to design and implement a Capacity Development (CD) Strategy. TOR for a consultancy to assist in this task were approved by all Development Partners (HDG) and the MOH.

The conceptual framework of this strategy is based on the assumption that Capacity Development shall be focussed but not limited to Human Resources Development (HRD); it involves fostering the institutional and the organisational environment in a comprehensive strategic way, including processes of change management. Whereas Human Resources in the Health Sector (HRH) relate to clinical and managerial capacities at central and decentralised levels, institutional and organisational capacities depend on systems, legislations, regulations and procedures.

In order to harmonise the approaches among Development Partners and to increase efficacy and efficiency in the development and the implementation of the CD Strategy, GTZ agreed, for the assessment phase, to focus on human resources and UNDP on institutional and organisational capacities at central level.

This paper summarises the results and recommendations of an assessment study on human resources in health (HRH) available and those still needed in Malawi. Results and recommendations of both the Human Resources Assessment and the (institutional) Capacity Assessment Study, planned to be carried out by UNDP in August 2007, will inform the Overall Capacity Development Strategy to be presented to the MoH and Stakeholders before the end of September 2007 to be fed into the SWAp Mid-Term Review Process.

1.2 Objectives and Methodological Approach

The methodology chosen by the research team was to

- Focus on the scope of the SWAp and its POW and identify core roles and responsibilities at central, zonal and district levels;
- Review previous studies (i.e. functional reviews, headcounts, etc.);
- Analyse achievements of former HRD initiatives undertaken within the SWAp;
- Conduct an in-depth analysis of existing Technical Assistance (TA);
- Analyse existing data and information and report to the MoH and the SWAp Technical Working Group on Human Resources.

A draft version of the report was circulated among Directors of the MoH and SWAp Partners on May 24 and the presentation and discussion of results and recommendations took place in the framework of two meetings, one with MoH Directors on June 25, 2006, and the second one with SWAp partners present at the TWG HR meeting June 27, 2007. The present final report integrates comments and feed back received since the first distribution of the draft version and during these meetings.

1.3 Major Findings

1.3.1 HRH Policy, Planning and Management

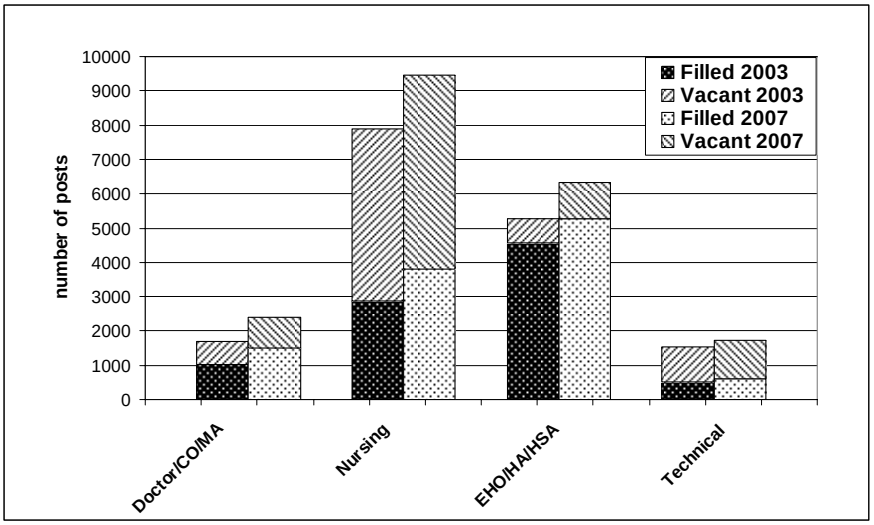
1. Current **administrative arrangements** for public sector management of HRH are complex, dysfunctional and impede satisfactory use of staff, despite efforts made by the MOH and the Health Services Commission (HSC):
   - Filling of vacant posts which is unnecessarily complex, centrally controlled and therefore protracted and open to abuse; New recruits may wait months to get their first pay packet;
   - Recent legislation that confuses rather than guides the various authorities involved: The Health Service Act of 2002 intended to supersede the Public Service Act of 2000 has never been fully implemented and the Health Service Commission has not taken on the full duties vested in it by the Act;
   - The lack of clarity on which public body has the ultimate responsibility for HRH recruitment and setting of employment conditions is a source of ineffectiveness for HRH management.
   - The Local Government Act of 1998, which provides powers to District Assemblies over recruitment and employment of health staff; consequently, the districts developed their own establishments, which often differ from that prepared by MOH;
   - The high turnover rates of those employees who have, or acquire marketable skills and being part of *common service* staff further exacerbates this risk; the lack of continuity negatively impacts institutional memory;
   - The slow progress made by MOH to decentralise HR management responsibilities to districts and central hospitals limits the effective management of the most important resource available.
2. **Planning documents** being prepared by the HR Unit of the MOH (National Strategic HRH Plan, the National Health Sector Recruitment and Deployment Plan, the National HRH M&E Framework, the National Health Sector Training Policy and Plan) do not integrate the Functional Review and the advice from the Global Fund about the need to include support as well as front line staff in HR plans.
3. Weak **Human Resources / Health Management Information Systems** (HR/HMIS). The lack of data is increasingly disturbing. Performance Management and Reporting systems are lacking at all levels. As a consequence it is difficult to evaluate the impact and the effectiveness of POW activities aiming at improved HRH – and thus improved quantity and quality of service delivery.

1.3.2 HRD Programmes

4. With regard to HRH Development, the most important Programme in Malawi, supported by all SWAP Partners is the **6-Year Emergency Human Resources Programme (EHRP)**. The results of this programme were considerable:
   - There have been **3,498 additional posts filled** between 2003 and 2007, including 33 medical officers, 253 clinical officers and 2,249 nurses. However, the increase in filled posts is mirrored by an increase in 3,147 established posts which derived from a revi-

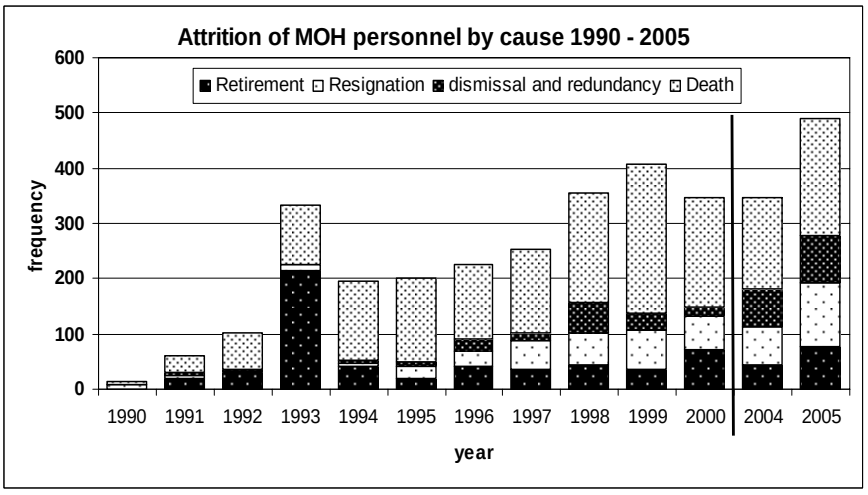
sion of establishments in 2005 (Figure 1) – consequently vacancy levels remained static (46%).

Figure 1 -- Filled and vacant posts MOH and CHAM, 2003 + 2007



- The other reason for a static vacancy rate is the attrition rate, which reached an all time high in 2005 with 491, nearly half (214) being due to deaths (Figure 2).

Figure 2 -- Attrition of MOH staff by cause from 1990 to 2005



5. SWAp Partners filled the **funding gap for the 6-Year EHRP** left by the drop in available HIPC funds of MK 100 million. Main donors to the EHRP are DFID (£55 million or ~ $100 million) and Global Fund (from HIV/AIDS Round I, Malaria Round II and Health Systems Strengthening Round V grants, in total ~$100 million).
6. The accompanying **6-Year Emergency Pre-Service Training Plan** has been a success. Training institutions have increased enrolment by 165% for pre-service and by 79% for post graduate courses between 2003 and 2007 and surpassed the POW annual intake target for basic training in 2006 by enrolling 994/990 students. Evaluation by WHO reassured that quality of training has not fallen so far, despite the increase in throughput of students.
7. In its **emergency recruitment drive** in 2005 the MOH hired 570 staff with another 600 posts approved by DHRMD and MOF. A 'Tracer

Study' conducted by the HSC located 460 nurses, 160 Clinical Officers and 112 Medical Assistants who had retired or resigned from government service. Out of these, 600 indicated their willingness to return to public services, however, in 2006 only 465 were recruited and less than 300 have reported for service.

8. **Expatriate staff** are being recruited through UNV, VSO, and CIM Programmes. By the end of June 2007 there are about 40 doctors recruited and placed filling less than a fifth of the 245 vacancies.
9. To improve **retention** a 52% salary top-up scheme was introduced in April 2005, covering 5,795 staff by 2006 – only 300 less than targeted. After tax deduction the increase in take home pay ranges from 25 to 41%.
10. Other **incentive schemes** of equal importance are: availability of housing, improved health facility infrastructure, and salary supplementation schemes, such as the nurse tutor scheme. MSF is funding a performance based scheme in Chiradzulu district with obviously an immediate impact on the availability of staff.
11. **Locum schemes** have been introduced at MoH hospitals to immediately increase the number of HRH available using extra hours from the current staff. Though this strategy had initially shown some promising effects a number of problems have been identified (Staff refusing to work on weekends unless they be paid locum money; health workers who opt to take their extra hours as off and do "locums" in the private; costs of the locum difficult to control at facility level, and the lack of differentiation between the various cadres).
12. The **impact of** the **incentive schemes** described above is difficult to assess at this early stage but evidence suggests they have some effect: Due to better pay prospects in the health sector, student applications for training have dramatically increased. Data on resignations for 2006 are not available from MOH but in CHAM in 2003/4 187 joined and 20 left, as compared to 2005/6 where 288 joined and 52 left. A multi-country study (Malawi, Lesotho) is being conducted by the COM looking at the effect of different incentives.
13. Despite a crude survey conducted by MOH, policies on incentives for **hard to staff areas** have not been agreed or introduced. The survey identified 135 public health centres across all 27 district considered "hard to staff'". The main issues identified included:
    - Poor transport and communication
    - Lack of electricity and pumped water
    - Poor maintenance
    - Lack of appreciation and acknowledgement, poor access to in service training and feeling of isolation
    - Lack of quality education accessible to their children

1.3.3 HRD Policies and Strategies

14. **Career development** is seen as an important means of retaining staff. A number of initiatives are underway – the plan to have **medical, nursing and clinical officer specialists**, and the introduction of **continuing professional development** (CPD). The lack of a career structure for clinical officers is a serious defect in the HRH system.

The backbone of clinical care has no means of professional progression except by moving out of clinical care itself.

15. **Training in health management.** It is a paradox, not unheard of elsewhere, that efforts to provide an essential package of health care have concentrated on its technical components such as staff, buildings, drugs and health programmes without spending enough effort putting them all together in a way that works. The decentralisation of management to districts is partly a response to the inability to provide vertical programmes effectively. The key to the success of the EHP will be good management at district and sub-district level. There have been good initiatives with regard to **supervision of clinical services**, such as the supervision check list. The key ingredient of supervision to add value to health services is the use of a facilitating mode of supervision rather then an inspectorial one. This links to the need for leadership training.
16. The **zonal support offices** are bedding down and there have been some positive experiences. The challenge for zonal staff is to support district activity without diverting staff from the job in hand and there is also a cost in terms of transferring experienced staff from poorly staffed districts to zones. MSH has shown that refocusing the attention of support to the Zones (e.g. in Drug Management {S-E Zone, and C-E Zone}, HMIS {S-E Zone}) appears to yield very positive results. It is showing to be a good way of providing TA especially for the long term.
17. **In-service clinical training** is common but usually vertically conceived and financed, uncoordinated at district level, unresponsive to local training priorities, and distorted by the perverse incentives of per diem allowances.

1.3.4 Technical Assistance

18. Technical assistance (TA) has been important in supporting the MOH deliver the POW. It comes in two forms – individual TA (18 TAs through SWAp funding at a cost of $3.6 million over two years,, bilateral-donor TAs, a management contract for CMS, numerous small studies, and the TAs from UN agencies) and project based TA.
19. Technical Assistance, whether local or international, recruited to provide additional skills needed to fulfil the tasks of the MOH in the absence of such skills in the organisation, has to be distinguished from the recruitment of local and international staff to fill existing posts, i.e. posts already established and non-established posts (in cases, whereby the MOH wants to recruit additional staff but the posts are not established).
20. For **individual TA** there are four main findings
    a. Individual TA activity has had mixed effect ranging from complete success to failure despite high calibre personnel. The success is partly dependent on the person involved and partly on the systems and situation in which the TA is placed. A long term effect is, however, often absent and usually a product of lack of capacity and skills transfer.
    b. Cost-effectiveness tends to be limited due to
        i. A prolonged orientation period at the start (particularly for expatriate TAs);

ii. Short tenure (often only 2 years);

iii. High costs (travel, accommodation and international salary).

c. Capacity building remains weak. Counter-parting has largely failed either due to lack of the counterpart or too much work on the ground for the mentor to do anything but service work. This happens with full time TAs in a Ministry which is overstretched.

d. Detrimental effects include

i. Poaching of staff working in the MOH;

ii. Tension in directorates due to salary disparities;

iii. Failure to address the functional capacity of the Ministry because of the propping up effect of TAs – providing palliation but not cure;

iv. Failure to address the functional capacity of directorates because directors dislike the harmful and expensive features of the current TA system

21. For **Project based TA** there are three main findings

a. Long term benefits are rare as projects tend to be short term (maximum of 5 years, and usually shorter).

b. Capacity building in relation to the TA part of the project is often absent. NGOs often fail to offer professional training to their own staff and projects are not nested in existing national institutions. Foreign NGOs seem to have a perverse incentive to limit local capacity building as this would put them out of business.

c. Detrimental effects are common and include

i. poaching of staff working in governmental services

ii. Lack of accountability and distortion of priorities particularly in districts.

iii. Diversion of MOH staff time, e.g. to non-priority in-service training at the expense of service work and to respond to the special needs of the NGO, such as hosting overseas visitors.

1.4 Recommendations

1.4.1 Policy, Planning and Management

1. With regard to current **administrative arrangements**

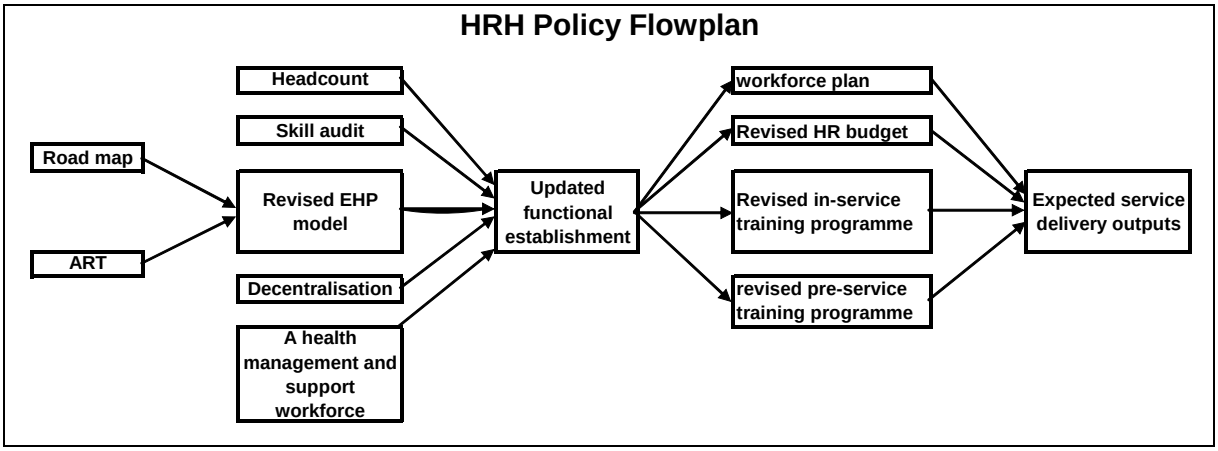
- The role of the Health Service Commission should be clearly defined to make it more efficient and effective. The HSC Secretariat and DHRMD should review the recruitment procedures in order to avoid duplication and increase efficiency of overall HRH Management.
- A high level governmental team shall be charged with the clarification of roles and responsibilities of the MoH HRH Department, HSC, DHRMD and the Ministry of Local Governments in HRH planning, recruitment, deployment and management, considering the envisaged decentralisation of HRH management.
- A Time Table shall be discussed to transfer staff to Local Authorities in line with the Decentralisation Policy.

- The HR management function at district level needs to be upgraded to support District Management Teams as they take on recruitment and management of staff. The principle that individuals are appointed to a post (and not posts to individuals) shall be pursued.
- The MoH should lobby DHRMD to transfer 'common service' employees who wish to become 'dedicated'. Should this option be unattainable, we suggest a moratorium on 'common service' employees being posted away from the Ministry of Health.

2. With regard to **planning and planning documents**
   - National HRH Strategic Framework
   - National HRH M&E Framework
   - National Health Sector Recruitment and Deployment Plan
   - National Health Sector Training Policy and Plan

   They need to be revised to take on board the results of the **Functional Review** and the advice from the Global Fund about the necessity to include support as well as front line staff in HR plans. These documents need to be consistent with each other and comprehensive - for example, the draft HRH strategic framework does not provide a budget, M&E component or a logical framework with targets. As draft versions exist of all documents and are circulating since quite some time it should be possible to finalise them within the next three months to get them ready for the SWAp MTR process
3. Concerning data there is a **need to re-estimate** (in conjunction with the Ministry of Local Governments) the **establishment** of a decentralized health service and its management **considering the extended EHP**. The revision should be informed by studies underway including the skills audit and the headcount, as it is important to base the establishment on quality as well as quantity needs. The revised establishment will have implications for future training needs, and the SWAp funding required to pay for the expanded workforce. Close and constant collaboration is recommended between MoH and the Ministry of Local Governments on all HRH issues that will have an effect on the District Assemblies once HRH management is devolved to Local Governments. There is a logical order of work to address these high level activities:

Figure 3 -- Flow of required central HRH analysis and policy work



1.4.2 HRD Programmes

4. We observe that the planned rapid expansion of health staff by 2010 will require a commensurate increase in funds to pay them. As such the MOH together with SWAp Partners is requested to start planning for this eventuality.
5. It seems that there is widespread confusion about the Global Fund's Health Systems Strengthening Programme and its relationship with the SWAp POW and the EHRP (whether it is considered to be an integral part of the Health SWAp POW or a separate programme). These differences in MOH, DP's and other stakeholders' understandings of EHRP should be analysed and clarified during the coming SWAp Mid-Term-Review-Process in order to promote the most effective use of available resources.
6. The Pre-Service Training Plan shall be reviewed so as to take into account new training institutions (e.g. Mzuzu University) which are now able to help with pre-service training.
7. Follow-up shall be made on the 165 formerly retired staff who were recruited but have not yet reported for service.
8. Funds shall be made available, allowing more UNV, VSO and CIM doctors are recruited as long as vacancies exist and cannot be filled by national staff.
9. Top-up allowances should be revised annually, and awarding should be done according to a differentiated rate, depending on criteria such as hard to staff areas, rural versus urban and performance rather than be a uniform rate provision.
10. The construction of 1200 housing units and all other civil works to improve working conditions at the health facilities shall be expedited.
11. The performance based scheme being piloted in Chiradzulu has been evaluated by MSF. The results and recommendations of this evaluation may be considered when discussing a further role out of the scheme to other districts (e.g. during the SWAp MTR process).
12. The locum system shall be revised and a policy drafted (including budget estimates) to guide its implementation considering other non-monetary benefits as well. Mechanisms to increase efficacy and efficiency in service provision during normal working hours shall be given priority.
13. The potential **impact of** the above mentioned **incentive schemes** shall be a point of discussion during the SWAp Mid-Term-Review Process. The impact analysis may be conducted by members of the MTR expert team. According to the findings of the study group, a **hard to staff facilities** strategy needs to be developed that is
    - based on monetary supplementation to take account of costs of living, locum duties, schooling and travel costs;
    - supported by non-monetary incentives (e.g. housing, training, supervision);
    - different for each type / category of staff; and
    - simple to administer.

1.4.3 HRD Policies and Strategies

14. MOH and partners should urgently start implementing **career development plans** for all critical cadres. The medical specialist plan needs to include a district specialist grade to attract and retain senior medical doctors in district hospitals. The nurse specialist needs to include grades to allow nurses to progress in their career without having to become a manager away from patient care. For Clinical officers a programme may be launched that would allow some of them to upgrade their educational level (biomedical degree programme) and become e.g. a surgeon (programme planned at Mzuzu University). Suitable training institutions in Malawi, (e.g. COM, the Mzuzu University) may be engaged to design and implement an effective **Continuing Professional Development** system. The same institutes could be tasked with **updating and maintaining** existing **training materials,** adding the essential drug manual and guidelines, assuring quality through proper peer review and distributing it with appropriate training to health staff countrywide.
15. **Training in Health Service Management,** both individual and in-service training at all levels of the health care system should be undertaken urgently and a performance / quality management system be introduced in order to measure the impact of improved HRH management at health service level. At the moment the COM is the only training institution in country which provides post-graduate health management training – featured strongly in its MPH courses. COM and other institutions are actually setting up management training for health administrators and accountants, who do not have such opportunities at present. The approach of the MSH project should be rolled out to all other health facilities in Malawi and be sustained by nesting it in the Malawi Institute of Management (MIM) and ensuring link-ups with the Health Sciences Faculty in Mzuzu University and the Department of Community Health at the College of Medicine.
16. Zonal support offices shall remain lean and mean with costs kept to a minimum. Priority should be given to supporting the poorly staffed districts. However, to improve decentralised management of health care provision and services the zonal offices certainly play a key role. This should be considered during the Health SWAp MTR.
17. Concerning **in-service clinical training** we recommend:
    a. All training at district level shall be controlled (following needs assessment and priorities chosen in the training part of the DIP) by districts.
    b. Funds currently used for vertical programmes and from donor projects should be allocated to districts for inclusion in local DIPs.
    c. No training should take place which is not part of the local DIP. Districts may need training in needs assessment and training programme management.
    d. Training allowances need to be kept commensurate with the cost of actually being away from base and not a form of salary supplementation lottery for both trainer and trainee.

1.4.4 New TA Policy

Based on the **axiom that it is better to have Malawians running services from Malawian institutions**, it is assumed that the long term objective of SWAp partners is to **phase out TA** over a ten to 15 year period except for international expertise.

A transition policy needs to be devised and a TA pool funded in the interim. The interim policy options cover needs assessment, recruitment, management, and financial and contractual issues of TA:

1.4.4.1 Needs Assessment

18. Needs assessment for TA is updated by the TWG on an annual basis and TA procurement is based on the gap between in post and requirement.
19. We recommend a special “mentor” scheme being introduced offering intermittent support to senior staff of various MoH departments upon their request;
20. Services shall be based on results (output/outcome) oriented Terms of Reference (instead of input based ToR) provided by experts who would offer pulsed support.
21. In this scheme, the risk of dependency is controlled and the TA concentrates on capacity building.

1.4.4.2 Recruitment

22. A standard procurement procedure is adopted based on best practice as described in the review below.
23. TORs for identified TAs are drafted by MoH, and sent to the TWG for discussion and approval.
24. A local management consulting firm is engaged to manage the TA recruitment process. Support from an international organisation / health consulting firm in the initial phase may be appropriate to assist with international issues.
25. The local management consulting firm advertises the TA posts widely in electronic and print media and to special organisations.
26. For **bilateral and UN agencies TA**, those to be placed or working with the MOH directly, the respective agency advertises the post locally and internationally (the bilateral donor in their home countries as is often the case that nationals from the donor countries are recruited).
27. The shortlisting of candidates for interviews is done jointly by the MOH, donors in the respective TWG and the local management consulting firm. Candidates who score highly according to the agreed criteria are invited to attend for interview.
28. The interviews are held by members of TWG in the area of the TA need, led by MOH with the facilitation of the local management consulting firm.
    a) The results of the interviews should be graded independently by the panel members. The local management consulting firm would prepare an interview report for submission to MOH management TWG for consideration.

b) The MOH should then communicate the names of the successful candidates directly. TA funded from the SWAp TA pool would be recruited by the local Management Consultant.

c) For Bilateral TAs and UN Agencies, the bilateral donor or UN Agency recruits the successful candidates.

1.4.4.3 TA Management

29. Each TA recruited is managed by the appropriate MOH Director. The management consultancy firm shall introduce a **performance management system** which shall be used for TAs as well as other staff. A standard reporting system for all TA assures smooth and effective information flow within the MoH.

30. Annual (or half year) assessments of each TA shall be undertaken in a transparent way using a standard Performance Management System Form bearing the signatures of both the responsible MoH director and the TA. The results of the assessment will be reported to the TWG (the details of information to be given to the TWG, i.e. to the public, have to be specified and would partially depend on the consent of the TA). Where there is underperformance, the MOH can recommend contract termination. The local management consulting firm (or bilateral donor) shall process the termination.

31. UN TA staff shall be accommodated within the respective MOH department and an agreement signed between the UN Agency and the MoH on the formalized working arrangements in terms of time a UN Agency TA based in a Country Office would work in the MOH, availability of office space, etc.

1.4.4.4 Financial and Contractual Arrangements

32. A “Special TA Pool Fund” is allocated within the MOH ORT budget and not included as part of the staff budget. The size of the SWAp pool TA fund would otherwise distort the MOH staff recurrent budget.

33. This Special TA Pool Fund is managed by the local Management Consultant for payment to the TAs. The MOH in consultation with the TWG will determine salaries and benefit packages using best practice examples across the region.

34. As all TA posts are advertised locally and filled with local staff if suitable candidates found, secondments will be common. The movement to and from TA posts will increase experience of staff and allow career development. The cost-effectiveness of TA will increase with lower expenses and shorter learning periods.

35. When a post is unable to be filled locally, and/or requires international expertise, the level of remuneration may be increased appropriately to attract a suitable applicant.

36. Staff employed as service employees (not TA) – on established or temporarily established posts - are offered a remuneration package at the same level as the MOH package for the comparable grade. Parity of salaries will improve relationships within directorates. Poaching will be eliminated.

37. A memorandum of understanding shall be required of foreign NGOs and overseas research projects. The MOU shall include[1]:-

    a. An obligation to have salary parity of locally employed staff;

    b. For district based projects, the inclusion of project plans within the DIP, with annual assessment of performance and account-ability to the District Assembly and MoH through the DHO.

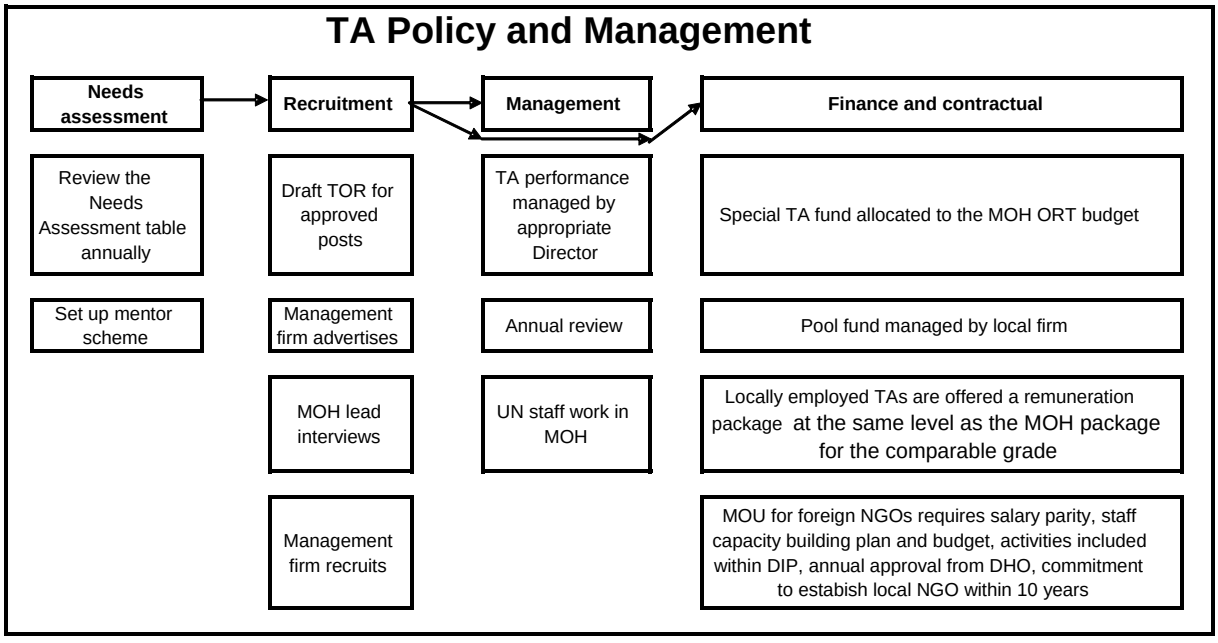
    c. An annual approval of planned activities signed by the DHO at the start of each year, without which the NGO is unable to work.

    d. A staff capacity building plan with budget and an obligation to use local training programmes if such exist.

    e. An obligation to develop a local NGO, under the full control of Malawians, to take over the project within 10 years.

The following Figure 4 summarises options and recommendations for a TA policy and TA management.

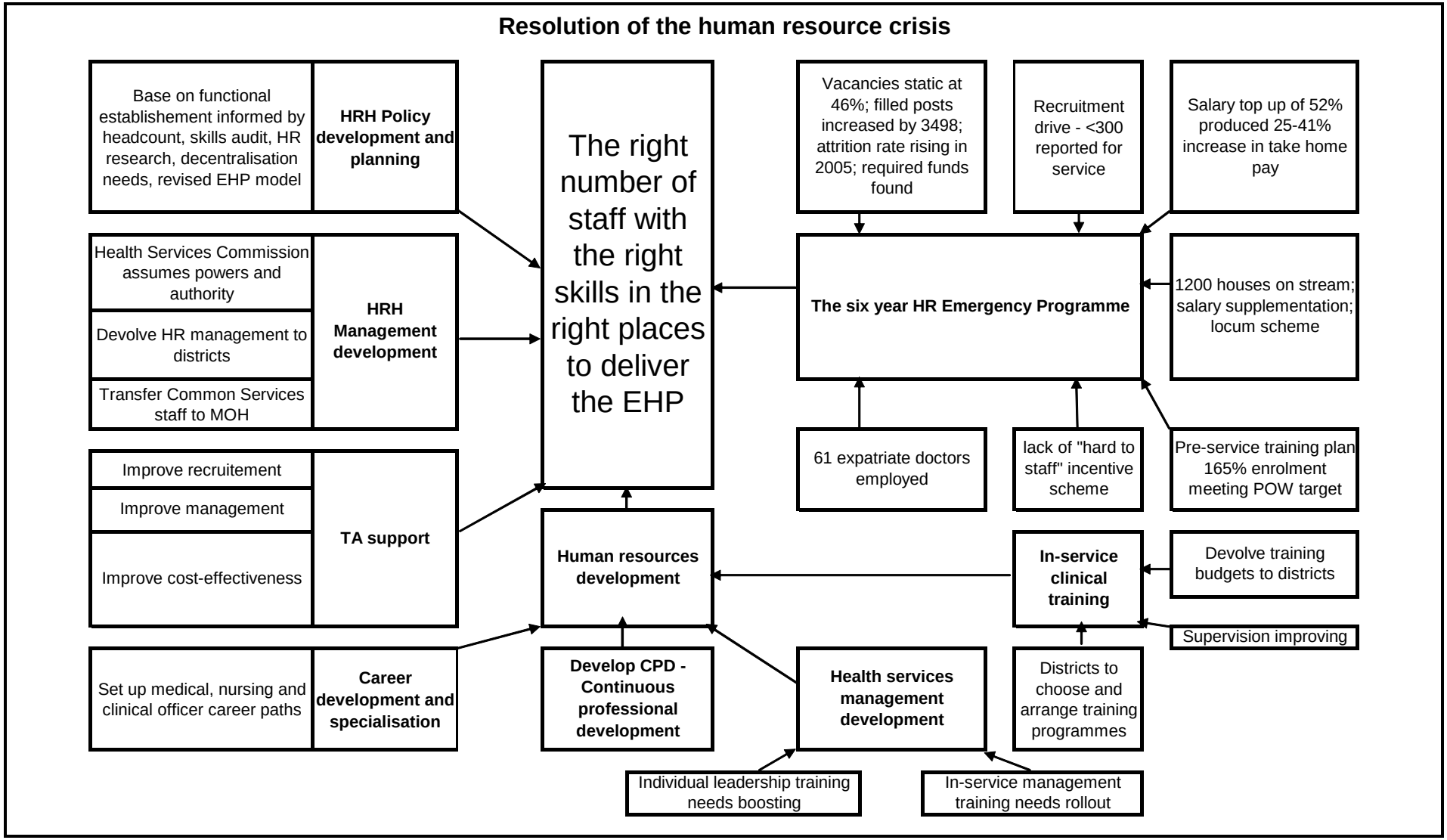
Figure 4 -- TA Policy and Management - Options and Recommendations



A summary of the means of HRH crisis resolution is found in Figure 5.

[1] The current MOU draft has been amended to include our recommendations and is found in the appendix.

Figure 5 -- Policies to resolve the Human Resource Crisis in the Malawian Health Sector - 2007



2 Background

Capacities of the MoH and its subordinated structures and institutions to effectively implement the Health SWAp Programme of Work (POW) according to the timelines given in the programme in order to improve health service delivery and thus the health status of the population are still limited.

Hence, it has been acknowledged by all partners that there is need for a Capacity Development (CD) Strategy to be designed and implemented as part of the SWAp POW. TOR for a Consultancy on the Development of this Strategy had been discussed and were agreed with and approved by all Development Partners (HDG-Meetings) and the MoH. According to these TOR, the main outputs of this Consultancy are the following:

- A Conceptual Framework for Capacity Development
- A Capacity Needs Assessment
- A Capacity Development Strategy
- Mechanisms for effective and efficient TA Management (TA-Pool)

The Consultancy will be led by the SWAp Technical Working Group on Human Resources where MoH and DPs are represented. Contracting and funding will be provided through partners (GTZ and UNDP). The whole process will be organised in close cooperation of GTZ and UNDP combining their Capacity Assessment and Development Approaches.

The Capacity Needs Assessment Study was officially launched on March 1st 2007 in the framework of a workshop bringing together MoH and DP representatives and a panel of experts.

Expert Panel / Human Resources Needs Assessment Study

Prof. Cameron BOWIE	College of Medicine	University of Malawi
Prof. Eta BANDA	Faculty of Health Sciences	Mzuzu University
Mr. Hudson NKUNIKA	Health Service Strengthening Coordinator	MoH
Mr Patrick BOKHO	Principal HRD-Officer	MoH
Dr. Douglas LUNGU	Deputy Dir. Clinical Services	MoH
Ms. Ruth MWANDIRA	Executive Director	CHAM
Mr Takondwa Lucious MWASE	Health Economist	Abt Associates
Leonard NKOSI	Human Capacity Development Specialist	MSH
Dr. Michael NIECHZIAL	Health Service Management Expert	GTZ
Juliette PAPY	Health Project Assistant / Study Coordinator	GTZ

The present report summarises findings and recommendations to be discussed within the MoH and together with all SWAp Partners in the framework of the TWG HR and the HDG meetings. Final results (CD-, HRD, and TA-Strategies) shall be developed before the end of July 2007 to be fed into the SWAp Mid-Term-Review (MTR) process.

It has been agreed between the main implementing agencies of this study (UNDP and GTZ), that **GTZ will focus on the Human Resources** aspects whereas **UNDP will concentrate on the institutional and organisational arrangements** outlining strengths, weaknesses, opportunities, and threats.

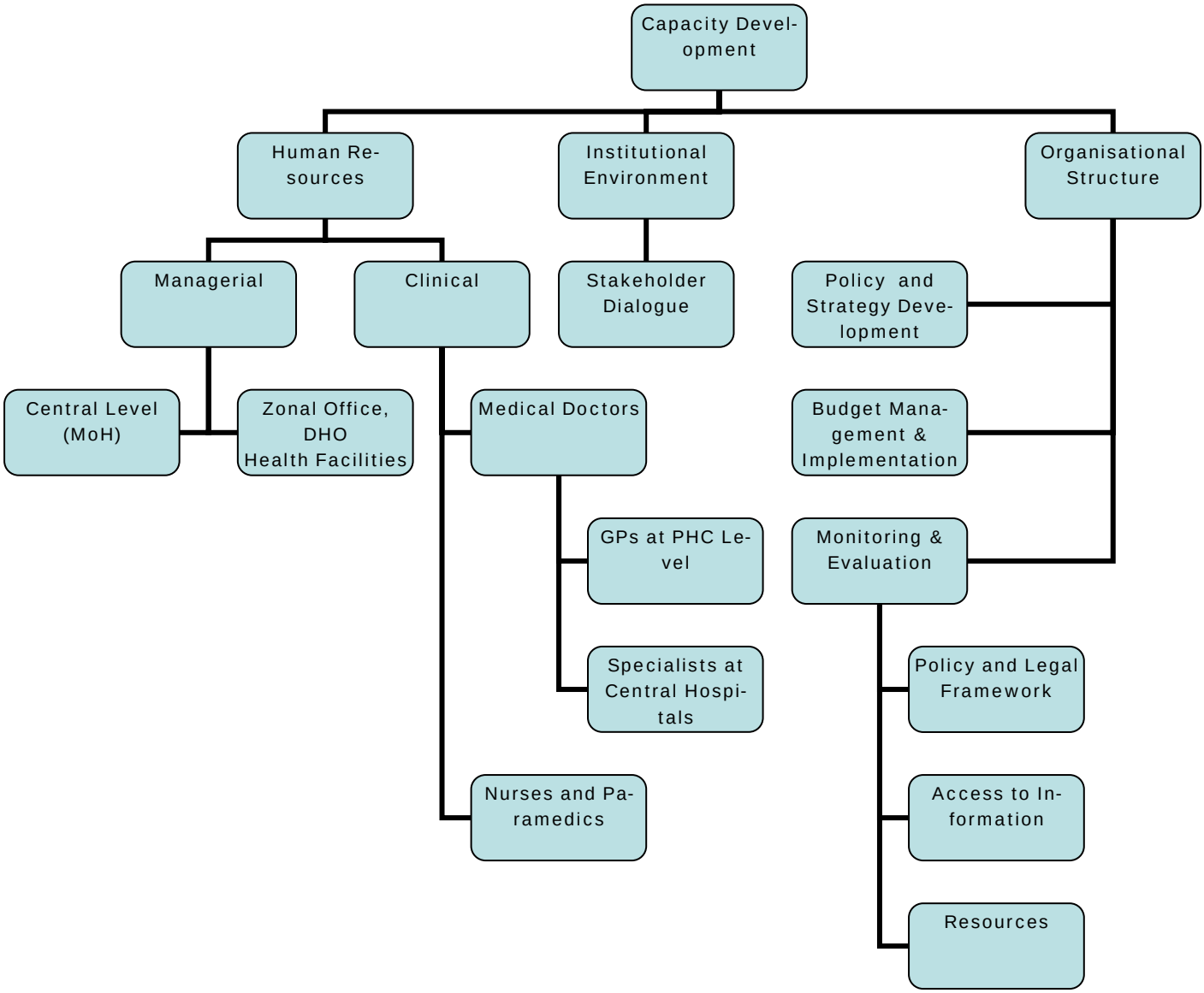
It is evident that both “areas” of CD, Human Resources on one side and Institutional / Organisational aspects on the other side are closely interlinked and that the quality of the study and the utility of its results will depend on a well organised coordination and close collaboration between the organisations and the expert teams working on their specific focus.

3 Conceptual Framework and Approach

3.1 Concepts of Capacity Development (CD)

Following the Paris Declaration on Aid Effectiveness, CD is understood as the process of strengthening the abilities or capacities of institutions, organisations and individuals to make effective and efficient use of resources in order to achieve commonly set goals on a sustainable basis. CD is not a goal on its own. In the Health Sector CD should contribute to improved implementation of the jointly agreed (SWAp) POW, the objective of which is to improve the health status of the population by reducing the incidence of illness and the occurrence of premature deaths through the provision of the Essential Health Package (EHP) as part of the Malawi Poverty Reduction Strategy (PRS).

CD is not limited to Human Resources Development (HRD); it involves fostering the institutional environment and the organisations in a comprehensive, strategic way, including processes of change management.



Conceptual Framework for Capacity Development

Therefore, CD in this study shall be understood as an overall approach addressing issues of institutional, organisational and human resources capacities.

Whereas Human Resources in the Health sector (HRH) relate to clinical and managerial capacities at central and decentralised levels, institutional and organisational capacities depend on systems, legislation, regulations and procedures including management styles and cultures governing the health system as a whole and the organisations, providing health care and managing health services within the system.

Based on this conceptual framework which describes roughly **core issues** of and **entry points** for the capacity needs assessment, different axes of a capacity development strategy will be identified. The following table provides some ideas on these axes for strategic actions:

Capacity Development Strategies

Human Resources	Institutional / Organisational
Education and Training	Knowledge Services and Learning
Staff Management and Deployment Systems	Leadership Development
Performance Monitoring and Evaluation	Institutional Reform and Change Management
Monetary and Non-Monetary Incentives	Multi-Stakeholder Engagement Processes
Etc…	Mutual Accountability Mechanisms

With regard to Human Resources, a total rewards approach similar to that in the sketch hereunder may be worth considering.

3.2 Existing Concepts and Models in the Malawian Context

The definition of capacity has to be very broad in order to encompass its multifarious nature, but at the same time, has to be sector and country-specific. In the Framework of the Education for All – Fast-Track Initiative (EFA-FTI) in Malawi, guidelines were developed intending to promote a more strategic approach to CD at country level. The product of the analysis stimulated by these Guidelines shall be country-specific agendas for priority CD activities and strengthened CD strategies.

The following scheme, summarising the methodological approach suggested in these guidelines was considered in the implementation of the Needs Assessment:

International and Country Context	**Potentials for Change**	**Support**	**Learning from Experience**	**4 STEPS / 3 LEVELS**
Economic and Health Sector data Stakeholders in the Health Care System Interest in strengthened PH Services	Beneficiaries of improved Health Services Patients / NGOs Gov / Donor relationship Health Sector CD strategy as part of the PRSP?	Public Sector Incentive Systems Donor support to CD Performance targets	Coordination between health and other key sectors with regard to CD?	**Enabling Environment** **Institutional level**
What are the lessons of SWOT or stakeholder analyses of the MoH and its sub-units Incentives for Gov. service providers, private sector	CD support to health sector organisations Factors affecting performance of organisations Winners and losers within the sector's organisations	Financing of health facilities and CD measures Education and In-service Training Quality and price of Service Providers	Targets of CD activities Sharing of outcomes through national / district performance reviews Evaluation of pilot programmes against planned outcomes Sharing best practice	**Organisational level**
Qualified staff moving to other countries or sectors? Attraction and retention mechanisms / incentives	Support mechanism for malpractice reports? Change agents within the health system (promoting performance improvement)	Cost effectiveness of Training (ToT) Mentoring of newly trained staff Changes in the system due to training	Follow-up of HRD plans and initiatives (Impact) Stakeholders involvement in performance monitoring	**Individual (Human Resources) level**

3.3 Core Issues and Entry Points of the HR/CD Needs Assessment

Essential aspects (**Core Issues**) of Capacity Development in the health sector are defined by the SWAp POW elaborated by the MoH and its partners. The Health SWAp Programme of Work has been divided into six components:

1. Human Resources
2. Pharmaceutical and Medical Supplies
3. Essential / Basic Equipment
4. Infrastructure / Facilities Development
5. Routine Operations at Service Delivery Level
6. Central Operations, Policy and Systems Development

All steps of the analysis will consider these components and the specific requirements and opportunities for CD. However, as discussed above, the methodological approach presented in this paper will concentrate on the **Human Resources** aspects of capacity development.

Entry points for the needs analysis (key competencies and skills) are:

- Management and Leadership
- Planning and Policy Development
- Stakeholder Dialogue and Involvement
- Access to Information and Knowledge (including M&E and operational research)
- Financial and Physical Resources Management

3.4 Methodological Approach

While conducting the Needs Assessment, the research team has

- Focused on Human Capacity Development (HCD) issues within the current scope of the SWAp and its POW at central, zonal and district levels;
- Reviewed previous needs assessment studies and other documents (i.e. functional reviews, headcounts, work studies, etc.);
- Identified core roles and responsibilities at central, zonal and district levels, with specific emphasis on horizontal & vertical integration of functions;
- Analysed the achievements of former HRD initiatives undertaken during SWAp implementation to build capacity and review remaining needs & gaps;
- Conducted an in-depth analysis of existing TA inputs including management & quality assurance mechanisms and procedures; how they work and how they can be optimised in view of identified essential capacity needs;
- Analysed and summarised the data and report to all stakeholders in the setting of a workshop on central level in order to give feedback, check for consistency and to adopt an inventory of options and suggestions for further action.

4 Situation Analysis of Human Resources in Health

This analysis is based on previous assessments and studies, and new information collected specially for this report.

4.1 Current Administrative Arrangements

Current Administrative Arrangements for Public Sector Management of HRH

The Office of the President and Cabinet (OPC) provides strategic leadership in the overall management and administration of the public service. The Department of Human Resource Management and Development (DHRM & D) which is a Department under OPC is responsible for fostering and sustaining a high quality, responsive, accountable and transparent public service through systematic development and implementation of good human and institutional resources management policies, strategies and practices. *(Source: Government of Malawi Management Handbook, OPC, April 2000)*

The main function of the DHRM & D is to develop, introduce and judiciously administer the public service conditions of service, codes and ethics, precedents and norms to ensure that the integrity of the service, staff morale and welfare and overall performance of the public service continuously remain high. DHRM & D manages human resource for the entire public service, human resources for health (HRH) inclusive. *(Source: Public Service Act, 2000)*

The Health Service Commission (HSC) is responsible for recruitment, management and utilization of HRH, including setting and reviewing terms and conditions of HRH from Grades M to F. *(Source: Health Service Commission Strategic Plan, 2007 – 2012).*

The Health Service Act provides powers and functions of the HSC as to:

- set salaries and conditions of service for persons employed in the Government Health Service;
- appoint persons to hold or act in offices in GHS, including power to promote persons to, and to remove persons from office;
- confirm appointments in GHS;
- exercise disciplinary control over persons holding or acting in any office in the GHS;
- review the terms and conditions of service, training and qualifications of persons employed in the GHS, and any other matters connected with their management and welfare, and to make recommendations to Government; and
- at the request of any District Assembly, recruit personnel for the health service of an Assembly.

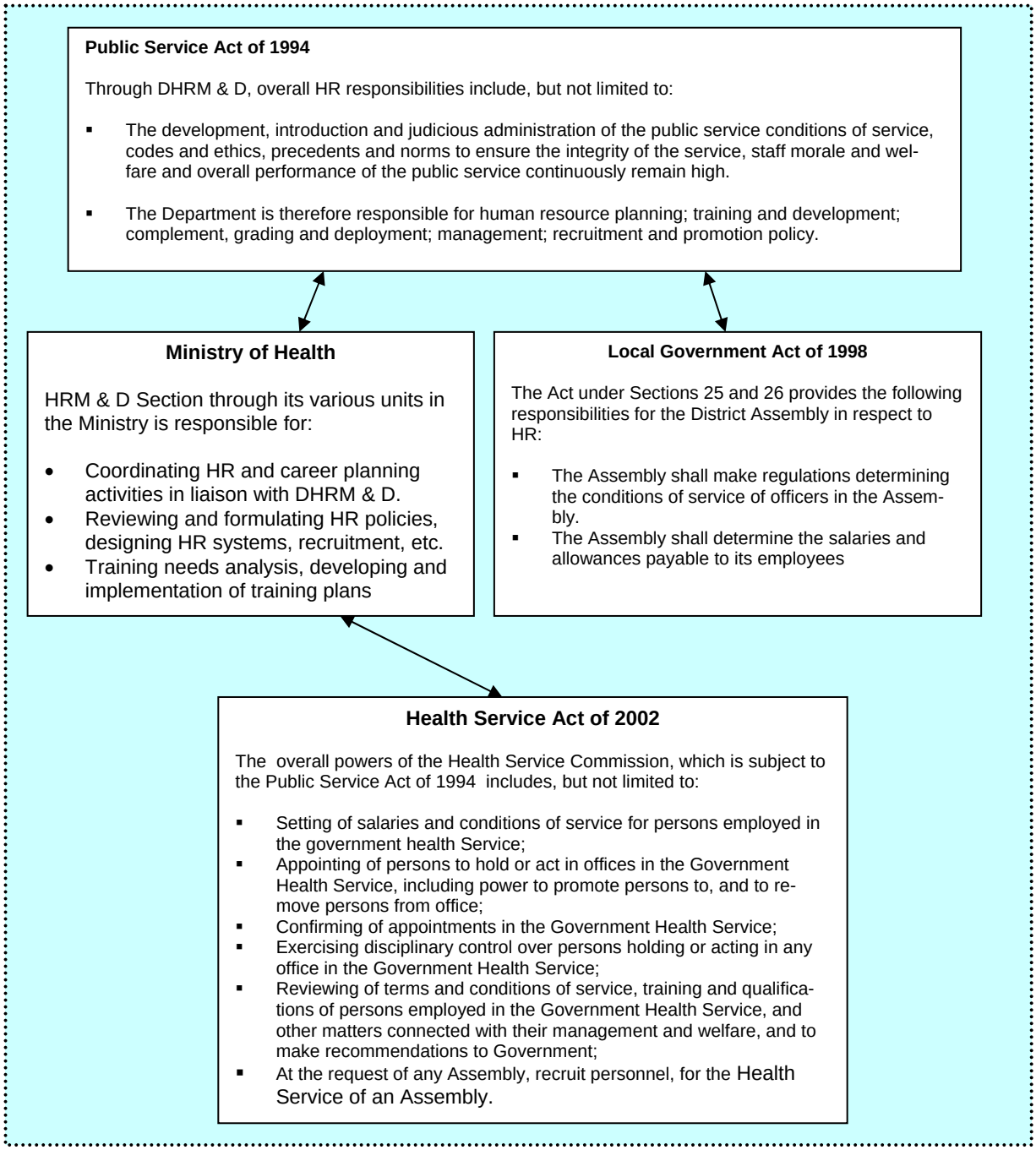
The Ministry of Health (MoH) organisational structure has placed the Human Resources Management and Development function as a section under the Directorate of Finance and Administration (DOFA). The Section is responsible for all aspects of human resource management which include strategic human resource (HR) forecasting, planning, identifying

gaps (vacancies) and recommending for their filling, in addition to ensuring optimum deployment and development of HRH.

Authority to fill vacancies is the prerogative of the DHRM & D while actual recruitment is done by the HSC and Appointments & Disciplinary Committees (ADCs) at the Ministry for higher grades of staff and District / Central Hospitals for lower grades (see Figure 13). *(Source: MoH HRM & D Section, Draft Functional Review document, 2005).*

Human Resources Planning is a function that falls under the Section of HRM & D. Its main responsibility is to continuously analyze the Ministry's human resource capacity and needs under the ever changing conditions so that proper steps are taken to provide the necessary numbers of appropriately skilled personnel and thus ensure long term effectiveness and sustainability. *(Source: Health SWAp, POW 2004 - 2010).*

Figure 6 -- Current HR functionalities and linkages



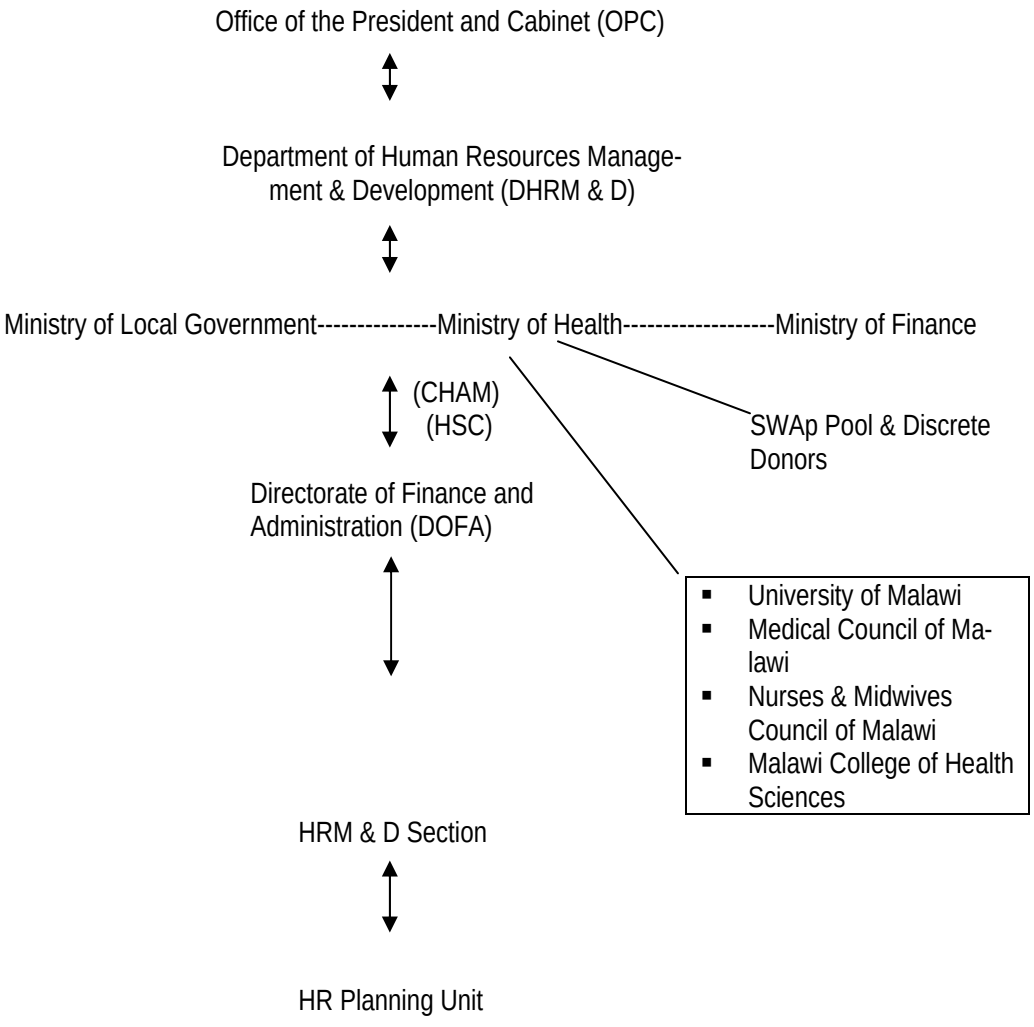
The Ministry of Finance through Treasury provides funding for HRH. *(Source: To The Year 2020: A Vision for the Health Sector in Malawi, May 1999)* The Ministry of Local Government through District Assemblies has assumed control over all devolved sectors. In the Health Sector, devolvement in budgeting process, funding and implementation of the budget started in 2004/2005. *(Source: Ministry of Local Government, Sector Devolution Plan)*

Medical Council of Malawi and Nurses & Midwives Council of Malawi are parastatal registration organizations which exist in the health sector with the responsibility of maintaining standards and regulating practitioners in the health sector. *(Source: Malawi National Health Plan: 1999-2004)*

4.1.1 Cooperation between Authorities

The Ministry of Health recognises that in order for it to achieve its strategic HRH plan it has to work with other stakeholders through such groupings as Human Resource Technical Working Group (HRTWG) and Health Sector Review Group (HSRG). These groups have high level representatives from Ministry of Finance, DHRM & D, SWAp Pool and discrete donors, HSC, CHAM, College of Medicine, Kamuzu College of Nursing, Malawi College of Health Sciences, Medical Council of Malawi, and Nurses and Midwives Council of Malawi. Figure 7 illustrates the linkages. *(Source: 1st Draft HRD Policy for the Public Health Sector).*

Figure 7 -- HR links between MOH and other authorities



Commentary

1. Recent legislation confuses rather than guides the sometimes conflicting roles of the various authorities involved. The Health Service Act of 2002 was intended to supersede the Public Service Act of 2000 and the HSC take on all HRH responsibilities but the Health Services Act has never been fully implemented and the HSC has not taken on the full duties vested in it by the Act.
2. The Local Government Act of 1998 gives powers to District Assemblies over recruitment and employment of health staff. They have prepared there own health establishment, which differs from that prepared by MOH.
3. In anticipation of the **devolution to district assemblies**, the slow progress made by MOH to decentralise HR functions to districts and central hospitals limits the effective management of the most important resource available. The HR management function at district level will need to be upgraded to support DMTs take on recruitment, management and discipline including dismissal of staff.

4.2 HRH Planning

In the current MoH organisational structure, the responsibility for HRH planning falls under the Controller of HRM & D under the Directorate of Finance and Administration (see Figure 7). In an ideal organizational set up where planning responsibility is a cross-cutting issue, final responsibility of HRH planning would best be held by the Directorate of Planning and Policy Development. This optimum configuration has not been considered in the current Functional Review (FR) which is yet to be approved by the DHRM & D. *(Source: Draft Functional Review document).*

There are a number of planning tools which exist. Each tool is described and an assessment is made of their contribution to appropriate planning.

4.2.1 National Strategic HRH Plan

A strategic HRH Plan is available but in a draft form. The Ministry has appointed a task force to review the Plan and incorporate comments made by senior management and Global Fund representatives. The draft copy was sent to the Global Fund since it is one of the conditions required for the release of grant money under the Health Systems Strengthening (HSS) component. Comments from Global Fund HR expert are listed below and will be taken into consideration as the Plan is being reviewed. ***(Source: Draft HRH Strategic Plan)***

An action plan has been developed with TA from the Global Fund giving specific time limits on the completion and endorsement of the Strategic HRH Plan. *(Source: MoH Global Fund Action Plan).*

The draft HRH Strategic Framework (currently under review as a strategic Plan) does not clearly state whether MoH has adopted the definition of HRH according to WHO and SADCC Ministers of Health recommendations. The Health Service Commission Act is also not explicit in its definition and identification of support staff as part of HRH. Building HRH capacity from the perspective of line professionals only will adversely affect HRH capacity due to lack of complementarities with support staff.

COMMENTS ON DRAFT HRH STRATEGIC FRAMEWORK BY GLOBAL FUND HR EXPERT

The document only addresses the need for future health professionals and not HRH. Although these initiatives may be commendable from the priority point of view, they do not address capacity development within the head office environment which is one of the condition precedents of Global Fund to manage donor funds. In the documents it has sent to the Global Fund the MoH has alluded to the fact that there is indeed insufficient capacity in the HR as well as Planning and Policy environment which includes M & E at the central level.

Without sufficient and sustainable staff capacity in the areas of HRM, financial management, supply chain management (including procurement and facilities management), planning and monitoring and evaluation, with most or all of these incumbents employed in terms of the "common service" there would be insufficient capacity to support the line functions within the Ministry. Causes of concern are the relatively high turnover rates of those employees who have, or acquire marketable skills and the fact that being part of the "common service" further exacerbates the need for a strategic focus currently lacking in this regard. This lack of continuity would negatively impact institutional memory.

It would also appear that the ratio of support versus line posts has not been addressed (commonly referred to as the "tooth to tail" ratio). The result could be either insufficient support to the increasing size of the line posts, or that too great a number of support posts and the related costs, crowd out the line post requirements.

There is no mention in the document about the Functional Review (FR) – even the mention that there are posts proposed – although the FR is yet to be approved by government.

No volume metrics (through a functional analysis) have been provided in coming up with the number of posts the Ministry would need, i.e. there is no evidence-based (scientific) justification of determining HR gaps which the HRH strategic framework intends to address. Job analysis and job grading has not been addressed.

The impression gleaned from the document refers to capacity mainly from the numerical point of view than to adding value to performance outcomes.

There is need for the Ministry to come up with a support ratio between number of line professional posts and posts of support staff from the central level down to the district level.

Source: Excerpts from recorded discussions between MoH officials and Global Fund HR expert

We recommend that the Ministry should clearly define who constitute HRH and include in its HRH Strategic Plan capacity development for support staff as well as front line staff.

Nowhere in the HRH Strategic Plan is the customer/client prominently featured although the overall policy goal of the Ministry is to raise the health status of all Malawians. We view the 'Malawian person' as the customer / client. *We therefore recommend that the HRH Strategic Plan articulates how it intends to serve the customer, being central its overall policy goal.*

4.2.2 National Health Sector Recruitment & Deployment Plan

MoH has the initial draft document of a Recruitment and Deployment Plan. However, the document is yet to be reviewed and commented upon by members of the Senior Management Committee. *(Source: Copy of the initial draft Plan document).*

4.2.3 National HRH M & E Framework

The Ministry of Health (MoH), within the context of the Health SWAp POW: 2004-2010 has developed SWAp HRH monitoring and evaluation (M&E) and information systems, aimed at strengthening evidence-based HRH policy, planning and decision making capability, measuring and monitoring the impact of HRH interventions and documenting lessons learned. Capacity to generate and utilize accurate up-to-date information and data to inform HRH policy and decision making relative to a wide-range of critical issues, including staffing levels, skills mix, deployment gaps, attraction, retention, staff motivation, performance, quality assurance and supportive supervision, aligned with sector needs and Essential Health Package (EHP) standards, is extremely weak across the health sector, particularly at the MOH headquarters level as well as District Health Offices (DHOs). *(Source: MoH, HMIU).*

The Fourth Malawi National Health Plan (NHP) 1999-2004 was the Ministry's Strategic Plan. Currently, the Ministry is being guided by a 6-year SWAp POW 2004:2010. We note that no evaluation was done on the Fourth NHP to inform the Ministry whether its HRH national health strategic intentions were met or not. The SWAp POW, which is the de facto MoH Strategic Plan, has not articulated how far the 4th NHP achieved its HRH objectives. *(Source: Joint Program of Work for Sector Wide Approach (SWAp) 2004-2010, page 4).*

We are of the view that although the POW document does articulate its relationship with the 4th NHP, there are no clearly identifiable elements that can be construed as strategic.

We recommend that the Ministry should evaluate the Fourth NHP to see the extent to which it accomplished its HRH objectives. Further, we strongly urge the Ministry to have a strategic focus through the development of the Fifth Malawi NHP probably before the expiry of the SWAp POW.

The HRM & E Framework is embedded within the overall SWAp M & E, and is intended to provide a comprehensive and systematic mechanism to facilitate the establishment, assessment, examination and tracking of HRH across the sector and its linkages and will subsequently contribute to the achievement of the health sector goals.

However, as pointed out by the GF HR expert, the emphasis of the M&E framework is on health care, being the line function. Yet, with reference to HR, one would think e.g. of the need for managing resignations and mechanisms such as an exit interview to determine why employees are leaving the service. Furthermore the number and types of HR related queries being generated, reporting frameworks, information for statistical analyses for forecasting, policy and legislative compliance and impact analyses, all as part of M and E for HR should be included.

4.2.4 National Health Sector Training Policy and Plan

The Ministry has developed the first draft copy of Human Resource Development (HRD) for the Public Health Sector which, when finally approved, will guide management of the training and staff development function. However, the document will have to be fine-tuned before it is presented to Senior Management Committee for approval. *(Source: Copy of the draft policy document).*

4.2.5 Evaluation of the Planning Tools

The question is whether all these planning tools consider the full range of needs at central, zonal and district level?

Financial year 2005-6 has seen important progress towards the development of the comprehensive HRH strategic Plan, Training and Deployment Policy, HRH M & E Framework and an incentive package for hard to reach areas. The failure to conclude the headcount exercise and the Functional Review (FR) is seen as hampering planned scale-up, recruitment and deployment initiatives within MoH, and specifically new staffing requirements for the extended Essential Health Package (EHP) establishment. *(Source: SWAp POW 2004-2010)*

Concerns have been raised regarding lack of clear career structures, succession planning, promotions criteria and delayed implementation of the incentive package, as well as DIP planning guidance to ensure coordinated and integrated in-service training. The roll-out of the Deployment Policy over the next year and the ongoing development of the Health Sector Training Policy and Plan would address these issues. *(Source: Malawi Health SWAp Mid-Year Review Field Team Report, 2006)*

We were unable to ascertain the current situation of health workers in relation to the EHP, and in particular reconcile the existing with the proposed staff establishment. We also note that the draft Functional Review document lacks scientific evidence in coming up with establishment of posts and functions. Conspicuously missing from the FR are issues of workload analysis, job analysis and baseline figures. Our considered view is that even if government approves the FR, it will not be complete.

We recommend that the HRM & D Section of the Ministry start undertaking workload and job analyses immediately despite being in retrospect of the FR to identify gaps in the FR and put in place a deliberate intervention strategy to address the gaps.

4.2.6 Realization of Existing HRH Plans

Data are collected through offices of Health Management Information Systems (HMIS) which are at each hospital. At the central level, the Health Management Information Unit (HMIU) under the Directorate of Planning and Policy Development produces quarterly and annual reports which provide information and interpretation related to several indicators computed on the basis of data generated from the HMIS during the quarter/year. There are only two indicators relating to HRH in the health SWAp POW M & E which are used for systematic monitoring and evaluation of HRH. The strategic HRH plan which is under review has included an M & E component specifically to evaluate HR.

The Ministry does not have an electronic HRH data bank from which to access official data. HR data/information for capacity development needs assessment was sourced from various sources within MoH. For example it was not possible to get staff establishment for districts and central hospitals from the HRM & D Section. On analysing the staff returns, it transpires that some hospitals were using the 1998/99 approved staff establishment while others were using the 2001/2002 staff establishment. Ideally, one would expect the HRM & D Section in the Ministry to be the source of all HRH data/information. In view of the variations encountered, authenticity of some data/information may be disputed depending on which source is used.

We therefore recommend that an electronic HRH data bank be established under the Directorate of Finance and Administration and updated quarterly.

Commentary

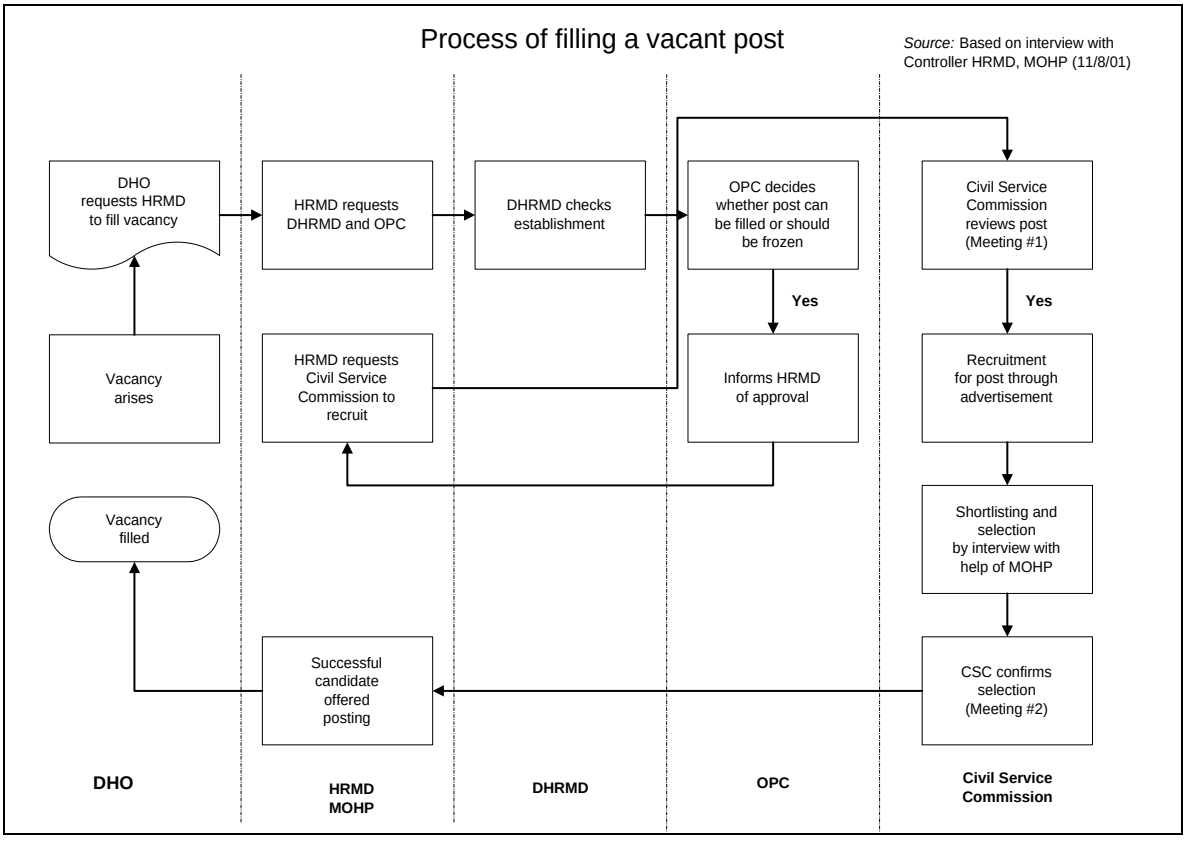
1. The strategic plan needs to include support as well as front line staff in its plans.
2. The documents are not comprehensive and lack quality and structure. This is why Senior Management Committee has directed they be reviewed to fill the gaps. There is also insufficient evidence to form a basis for a thorough needs assessment. For example, the HRH strategic framework does not provide a financial or an M & E component.
3. In addition there is an overwhelming need to estimate the establishment of a decentralized health service management. Decentralisation whether to district assemblies or first to DMTs will affect the capacity needed at central level.

4.3 HRH Management

4.3.1 HRH Recruitment and Deployment Process

The overall authority to recruit public servants including health workers falls under the DHRM & D which has the mandate to authorize the Ministry, in writing, to undertake recruitment of HRH based on need and staff establishment.

Figure 8 -- Process of filling vacant posts - 2001



HSC is responsible for implementation of the recruitment process, that is, the filling of vacancies through open recruitment following standard procedures that are prescribed by DHRM & D from time to time. The process has become more complicated since 2001. A diagram (Figure 8) illustrates the steps required to fill vacancies.

Subordinate and industrial class employees (Grades N-Q) are recruited directly by Appointments and Disciplinary Committees which are set up at MoH, central hospitals and District Assemblies, respectively.

The Ministry is not deploying its staff according to the Deployment Policy because it is still in draft form. Currently, each Head of Directorate decides who to deploy and where and instructs the HRM & D Section to effect a posting instruction. This type of deployment is not done strategically because quite often it is not done based on need. This is further compounded by shortage of staff in almost all the cadres. *(Source: Based on interview with Acting Controller of HRM & D Section, MoH).*

4.3.2 Outstanding HR Policy Issues

We note from various policy documents that HRH capacity development is being construed to mean increasing HRH numbers, especially front line health workers. While HRH capacity development entails aspects of recruiting more HRH, there is little attention given to capacity development in terms of imparting and the transfer of knowledge and skills to the already existing HRH.

We recommend that there should be a deliberate policy of ensuring balance in HR capacity development by increasing numbers with increasing the knowledge/skills to existing employees.

There is still an outstanding issue to be addressed regarding enrolled nurses who undergo a formal training and nursing auxiliaries who are trained on the job and yet receive the same salary. The nursing auxiliary cadre who, unfortunately were employed on permanent and pensionable terms were recruited for a specific period as a stop-gap measure to address the critical nursing shortage while the Ministry was training its own nurses through the 6 Year HR Emergency Plan. Until now, it is unclear what the MoH intends to do with the nursing auxiliary already employed.

We recommend for a clear decision from the MoH on what it intends to do with the nursing auxiliaries to clear the mistrust and misunderstanding between enrolled nurses and this group of nurses. One option would be to allow them undergo a formal basic nursing programme at the Malawi College of Health Sciences.

The current set up at the health centre puts the Medical Assistant who is at Grade M in-charge of the facility. With the upgrading of the enrolled nursing course to diploma level, nurse entry point is at Grade K, which is higher than Grade M. This arrangement where someone of senior grade reports to the one of lower grade is a cause of team friction. The issue needs to be addressed.

We recommend a policy guideline from the Ministry on who should head a Health Centre based on specific criteria.

Interpretation of who is a health worker by the Health Service Commission Act is not clear from the perspective of administrative and support staff. In its 2006 annual report, WHO defined the HRH workforce as: “All people engaged in actions whose primary intent is to enhance health” and this includes those people who are engaged in promoting and pre-

serving health as well as those who diagnose and treat disease; and those who help make the health system function but do not provide health services directly, i.e. health management and support workers. *(Source: WHO 2006 Annual Report).*

SADCC Health Ministers in their HRH Strategic Plan have adopted the WHO definition. Administrative and support staff who are an integral part of the health work force however are not considered part of the HRH in the strategic plan. The Global Fund picked out this omission on the basis that you cannot strengthen one aspect of the HR capacity and leave out another and expect to achieve results.

Should "Common Service" staff in health establishments be integrated into the MOH workforce? The MoH does not have power to unilaterally integrate common service people into its workforce. Common service employees fall under different Ministries and departments: Accounting personnel belong to the Accountant General's Department of the Ministry of Finance and HR personnel fall under the DHRM & D. One of the disadvantages of this arrangement is that the MOH does not have control on the movement of common service personnel and that the movement of staff limits institutional memory. Special health management training is lost if staff are moved from the health sector. The Government's moratorium on recruitment of common service personnel includes managers working in the health sector.

The Global Fund observes that the Functional Review document has not highlighted how it intends to balance HR capacity for line professionals' vis-à-vis common service personnel/support service where the moratorium applies. *(Observations made at the meeting between GF HR expert and senior officers of the HRM & D Section, MoH, March 2007).*

What does the Health Services Act suggest? It outlines two categories of persons belonging to Government Health Service (GHS). These are:

- Health professionals
  - Medical Doctors and Dental Surgeons
  - Pharmacists
  - Nurses and Midwives
  - Allied Health Professionals: - Anaesthetic Officers; Vector Control Officer; Medical Assistants; Dental Technicians and Dental Health Officers / Assistants; Dispensers; Laboratory Technologists / Technicians; Orthopaedic Assistants, Orthopaedic Technologists and Technicians; Occupational Therapists; Physiotherapists; Psychiatric Clinical Officers; Radiographers; Health Inspectors and Assistants; Pharmacy Assistants; Auxiliary Nurses.
- Such administrative, scientific and support staff as may be appointed by the Commission or District Assembly for the efficient administration, management and delivery of health services.

Commentary

There are two high level intra-governmental issues on HR policy which need to be tackled; the transfer of current DHRM & D powers to the HSC as envisaged in the Health Services Act; and the transfer of Common Services staff to the MOH (if the staff agree) and the development of a health management workforce.

4.3.3 Outstanding HR Management Issues

There is delay in introducing newly recruited health workers on the payroll – on average new employees remain unpaid for 4 months – notwithstanding that these cadres are on high demand.

There is variation in the treatment of newly recruited health workers in terms of upkeep allowances and accommodation between one health facility to another. This requires standardisation.

Locum systems have developed piece meal. Who is entitled to do a locum? Some institutions only apply the system to cover nurse shortages yet there are other staff areas in health facilities where shortages are experienced. Clear guidelines are needed as the issue can be a demotivating factor for other members of staff.

4.4 Manpower in the Health Sector, 2007

4.4.1 Basic statistics

4.4.1.1 A Headcounts of HRH

During August 2005, the Ministry embarked on a headcount exercise but the exercise was marred with difficulties. The HRM & D Section at the Ministry which was entrusted the responsibility of the headcount exercise provided the following reasons why the outcome of the headcount exercise could not be taken as reliable:

- DHOs did not provide adequate and / or advance communication to all members of staff in their districts. This resulted in the headcount teams failing to interview certain officers who were not present in their respective duty stations. In some respects, other members of staff filled in the forms for their colleagues who were not available and information provided was inadequate.
- The integrity and completeness of the data provided was compromised because some members of the headcount teams signed for questionnaires forms when in fact the data so provided in the questionnaires were inadequate or inaccurate.
- Due to logical and other planning problems, the data analysis exercise schedule lapsed and this affected the validity of the data collected during the head count exercise. *(Source: Report on the headcount exercise conducted in MoH, August 21-30, 2005).*

In addition, the scope of the headcount exercise did not cover separation of national / international or NGO / private HRH. The Ministry is in the process of procuring services of a consultant to undertake a HRH census for the entire health sector.

4.4.1.2 Vacancies in the public health sector

Data are available only for the entire Ministry and are not segregated according to districts (see Table 0). The number of medical specialists on the MOH payroll is found in Appendix -. These numbers exclude specialists employed by the College of Medicine and volunteer staff.

The overall vacancy rate in February 2007 was 24% with nursing vacancies at 55% and doctors at 45%.

Table 0 -- Vacancy rates in MOH establishments February 2007

VACANCY ANALYSIS AS OF FEBRUARY,2007				
TITLE OF POST	**Auth.Posts**	**Filled**	**Vacancy**	**Vacancy Rate**
ADMINISTRATION (from PS to Security guard)	3371	2932	439	13%
HUMAN RESOURCE (from Controller to Copy Typist)	401	340	61	15%
ACCOUNTING (from Controller to Accounts Assistant)	375	288	87	23%
SPECIALIST (medical and dental)	122	28	94	77%
DOCTORS	156	86	70	45%
CLINICAL (from Director of Clinical services to Medical Assistant)	1151	1109	42	4%
TECHNICAL (from Director of Technical services to laundry attendant)	1212	672	540	45%
NURSING	6102	2775	3327	55%
PUBLIC HEALTH (from Director of Preventive Services to HSAs)	6212	5252	960	15%
ATTENDANTS	3417	3514	-97	-3%
PLANNING	89	58	31	35%
NUTRITION (from Chief Nutritionalist to cook)	498	242	256	51%
Total Established Posts	23106	17296	5810	25%
Total Industrial Class Posts	1,825	1,530	295	16%
Total	24,931	18,826	6,105	24%

Data Source : February Staff Returns

4.4.1.3 Vacancies in CHAM

Vacancy levels for CHAM institutions are higher than MOH levels at 55% (see Table). The nursing vacancy rate is 65% as compared to MOH nursing vacancy rate of 55%. The medical vacancy rate is 79% as compared to the MOH vacancy rate of 45%.

Table 1 -- Vacancy level in CHAM institutions June 2007

CHAM Staffing levels at 06/03/2007				
Title of Post	**Established**	**Filled**	**Vacancies**	**Vacancy rate**
Medical	126	27	99	79%
HIV & AIDS Coordinator	104	3	107	103%
Clinical officers and medical assistants	962	365	597	62%
Nurses	3294	1163	2131	65%
Technical	1213	155	1058	87%
Administration	3675	1914	1161	32%
CHAM Colleges of Nursing	303	158	145	48%
St. John of God Mental Hospital	112	51	61	54%
TOTAL POSITIONS	**9789**	**3836**	**5359**	**55%**

4.4.1.4 Staff Working in NGOs and the Private Sector

There are a number of NGOs who are players in the health sector. For purposes of equitable planning, monitoring and evaluating the impact of NGOs in delivery of health care services, the Ministry has developed a generic Memorandum of Understanding (MOU) document which is intended to inform the Ministry on the number of NGOs, their locality and special field of interest in health care delivery activities. *(Source: MoH, Generic MoU document)* In addition, HMIS has human resources data and private and NGO sectors are supposed to return the required information. An extract is found in Table 2.

Commentary

The accuracy of the HR HMIS data has not been specifically validated. This can be done at the time of the national headcount exercise.

Table 2 -- Staff levels in districts (excluding central hospitals) in July 2005 and June 2006 (HMIS)

HMIS data 05/06	Jul-05			Jun-06		
Staff in post	Private Health Facility	Public Health Facility	Grand total	Private Health Facility	Public Health	Grand Total
Clinical officers in post	39	79	118	70	162	232
Comm Nurses in posts	25	119	144	21	95	116
Enrolled MidWife in post	435	477	912	336	536	872
Environmental Health Officers in post	7	90	97	6	75	81
Laboratory Techn in post	20	28	48	6	16	22
Med Officers in posts	13	9	22	6	10	16
Medical assistants in posts	53	154	207	71	229	300
Pharmacist in post	1	3	4	1	2	3
Pharmacy Techn in post	11	23	34	7	18	25
Radiography Techn in post	5	10	15	2	12	14
Radiologists in posts	0	2	2	0	0	0
Registered Nurses in post	36	80	116	31	96	127
Source:-HMIS July 05 and June 06						

Private health facilities include CHAM.

Vacancies levels have improved somewhat in the 4 years of the POW – Table 3. Comparability between the years is difficult due to grading movements of cadres of staff and changes in establishments.

Table 3 -- Vacancy level trend in MOH and CHAM facilities between 2003 and 2007

HR Vacancy Levels against Establishment 2003 and 2007									
		MOH				CHAM			
Cadre	Grades used for 2007 comparison	2003		2007		2003		2007	
		Establishment	Vacancy rate (%)	Establishment	Vacancy rate (%)	Establishment	Vacancy rate (%)	Establishment	Vacancy rate (%)
Specialist Doctor		151	82	122	77%	0	0		
Medical Officer		93	32	156	45%	36	53	108	75%
Clinical Officer	d-k	563	25	420	-36%	121	36	747	76%
Medical Assistant	l-o	464	39	622	32%	271	55	215	15%
Reproductive Officer		258	100	-	-	-	-	-	-
Nursing Officer	d-j	883	76	1705	80%	(55)	-	145	63%
Nursing Sister	k-l	2791	88	1915	44%	(280)	(96)	1626	58%
Psychiatric Nurse		118	24	190	38%	(52)	-	59	93%
Community Nurse		268	30	403	53%	(207)	-	325	90%
Enrolled Nurse/Midwife	m	1906	42	1886	44%	(1301)	-	1198	78%
Nursing (combined)	d-m					1933	52		
Environmental Health Officer	d-i	483	76	281	76%	0	-	128	91%
Health Assistant		475	70	1169	73%	-	-		
Health Education Officer		76	89	-	-	-	-		
Health Surveillance Assistant		4324	0	4762	-2%	-	-		
Laboratory Related		190	60	218	41%	342	66	256	82%
Pharmacy Related		207	31	217	28%	344	84	211	91%
Radiology Related		149	76	163	67%	93	90	274	80%
Dentistry Related		15	0	109	-7%	203	74	274	91%
Total		13414	43	14338	33%	3343	59%	5566	72%

Source: POW for 2003; CHAM and MOH data for 2007

Combining the vacancy rates for MOH and CHAM the level has remained more or less constant over the four years, 46% in 2003 and 44% in 2006. However establishments have increased substantially over the four years from 16,757 to 19,904. What is dramatic is the 24% increase in filled posts over this period.

The following additional posts have been filled in selected disciplines:

Additional posts	
Medical	33
Clinical officers	253
Medical assistants	194
Nurses	937
Health assistants	173
HSAs	545
All posts	2188

Table 4 -- Filled posts in MOH and CHAM facilities: 2003 – 2007

HR Filled posts against Establishment 2003 and 2007														
Cadre	Grades used for 2007 comparison	MOH				CHAM				MOH/CHAM Combined				
		2003		2007		2003		2007		2003		2007		% increase in filled posts
		Establishment	Filled posts	Establishment	Filled posts	Establishment	Filled posts	Establishment	Filled posts	Establishment	Filled posts	Establishment	Filled posts	
Specialist Doctor		151	27	122	28	0	0	0	0	151	27	122	28	4%
Medical Officer		93	63	156	86	36	17	108	27	129	80	264	113	41%
Clinical Officer		563	425	420	572	121	77	747	183	684	502	1167	755	50%
Medical Assistant		464	285	622	420	271	123	215	182	735	408	837	602	48%
Reproductive Officer		258												
Nursing Officer	d-j	883	208	1705	349	(55)		145	53					
Nursing Sister	k-l	2791	341	1915	1064	(280)		1626	676					
Psychiatric Nurse		118	90	190	118	(52)		59	4					
Community Nurse		268	189	403	191	(207)		325	34					
Enrolled Nurse/Midwife	m	1906	1113	1886	1053	(1301)		1198	258					
Nursing (combined)	d-m	5966	1941	6099	2775	1933	922	3353	1025	7899	2863	9452	3800	33%
Environmental Health Officer	d-i	483	117	281	68			128	11	483	117	409	79	-33%
Health Assistant		475	143	1169	315					475	143	1169	315	121%
Health Education Officer		76	8							76	8			
Health Surveillance Assistant		4324	4324	4762	4869					4324	4324	4762	4869	13%
Laboratory Related		190	76	218	128	342	115	256	46	532	191	474	174	-9%
Pharmacy Related		207	142	217	156	344	54	211	19	551	196	428	175	-11%
Radiology Related		149	36	163	54	93	9	274	54	242	45	437	108	140%
Dentistry Related		15	15	109	117	203	53	274	25	218	68	383	142	109%
Total		13414	7602	14338	9588	3343	1370	5566	1572	16757	8972	19904	11160	24%

4.5 Trends in HRH Financing and Expenditures

The major proportion of financial resources to support the health SWAp POW which has the component of HRH is derived through a pool funding system where co-operating partners and Malawi Government put their resources into one basket. There are also discrete donors who provide vertical funding to the Ministry. *(SWAp POW, 2004 – 2010)*

Substantial quantities of private finance are not yet incorporated into the financing mechanism. For example, regulatory, licensing, supervisory and inspectorate function of the MoH are still in development stage and these financing mechanisms will be important if private sources of finance are to contribute towards minimum standards of service quality. The Ministry is also contemplating introducing health insurance scheme into the POW financing envelope. *(SWAp POW, 2004 – 2010.)*

4.5.1 Planned Interventions

Human Resources for Health is Pillar number one in the POW. According to the POW, Table 1 below lists the major outputs envisaged at the end of the POW in 2010.

Table 5 -- Human Resources for Health Resource Requirement by Intervention: 2004/05-2009/10

INTERVENTION	IDEAL REQUIREMENTS-FULL EHP (US$M) 6 yrs		ANNUAL PROGRAMMED COSTS (US$M)						TOTAL PROGRAMME COST-6 yrs US$M	POTENTIAL SOURCE OF FINANCE
	Capital	Recurrent	04/05	05/06	06/07	07/08	08/09	09/010		
Total	55.2	407.3	28.2	34.1	39.1	44.6	48.6	53.1	247.7	
1.Pre-service training	55.2		9.2	9.2	9.2	9.2	9.2	9.2	55.2	
1. 1 Finance implementation of the 6 year Pre-service Training Plan	55.2		9.2	9.2	9.2	9.2	9.2	9.2	55.2	MOF SWAp Pool Donors
2.Maintaining current staff, filling establishments and aiding retention through salary top-ups			18.25	23.7	28.7	34.2	38.2	42.7	185.75	
2.1Pay salaries and allowances on time and in full for staff currently in post-2003/04-GOM district level		50.92	13.7	13.7	13.7	13.7	13.7	13.7	82.2	MOF
2.2 1Pay salaries and allowances on time and in full for staff currently in post-2003/04-CHAM		11.07								MOF Subvention to CHAM
2.3 Pay salaries and allowances on time and in full for staff currently in post-2003/04-GOM Central hospitals		20.95								MOF
2.4 Finance filling HR posts in line approved establishment-GOM district level		37.85	2.0	4.0	6.0	8.0	10.0	12.0	42.0	MOF/SWAP Pool
2.5 Finance HAS and Auxiliary nurses posts establishment-GOM district level		25.40								
2.6Finance HAS and Auxiliary nurses posts establishment-CHAM		16.36								MOF Subventions to CHAM/SWAP Pool
2.7 Finance HR posts in-line with approved establishment MOH central hospitals		25.54								MOF/SWAP Pool
2.8 Increase remuneration for health workers (at full establishment level, not HAS or aux. nurse)-GOM district level		88.78	2.55	6.0	9.0	12.5	14.5	17.0	61.55	MOF/MOF Subventions to CHAM SWAP Pool
2.9 Increase remuneration for health workers-CHAM		27.43								
2.10. Increase remuneration for health workers-GOM central hospitals		46.49								
2.11. Finance flexible TA fund for specialist, non-established staff needs at district level		12.48	To be added to POW when financial availability and cost of the programme known							MOF SWAp Pool Project Finance
2.12. Finance for TA volunteers at district level		1.56								
2.13 Finance for a flexible TA fund for specialist, non-established staff at central hospitals		14.40								
3. In-service training		28.07	0.8	1.2	1.2	1.2	1.2	1.2	6.7	MOF/SWAp pool/ Project Finance

From the table it can be seen that the ideal requirements for full implementation of the EHP was estimated at US$55.2 million for capital (investment) and US$407.3 million for recurrent expenditures giving a total of US$465.5 million over the six year period. However, after a series of reviews and consultations between the MOH and Development Partners taking into account 1) the limited absorptive capacity of the MOH and CHAM, and 2) the resources committed by development partners at that time (2004), it was decided that the ideal requirements for HR full implementation of the EHP be scaled down so as to reflect the reality on the ground. Through several iterations within this pillar-HR, a figure of **US$247 million over the six year period** was arrived at as seen in Table 5 above.

4.5.2 DP's Contributions

DFID are by far the largest contributor to HRH development through the pool for the 6-year Emergency Human Resource Programme (EHRP) including infrastructure development and salary tops ups. Other pool donors for the POW are the Global Fund, Norway, World Bank, UNFPA, and KfW (planned for 2007/08).

The additional budget for the EHRP dovetails with the POW. The donors to the EHRP are DFID (£55 million or ~ $100 million) and Global Fund (from HIV/AIDS Round I, Health Systems Strengthening Round V, and Malaria Round II grants. In total ~$100 million). Global Fund have consolidated their financing for EHRP under their 'Health Systems Strengthening' Framework (cf. section 4.8.8).

4.5.3 Trends in Expenditure by MoH

As it can be seen from Table 8 below, the share of personal emoluments (PE) to total MOH recurrent actual health expenditures before SWAp commencement in 2003/04 financial year were around 33 % of total MOH recurrent expenditures.

With the introduction of salary top-up of 52% in 2004/05 financial year, the share of PE in total MOH recurrent expenditures rose to around 40%. From 2005/06-2005/06 financial year even though these are not actual expenditures but revised estimates (which might not be very different from the actual expenditures once published), it is clear that there is decrease in the share of PE in total MOH recurrent expenditures, despite increase in the number of staff recruited during the period.

However, in absolute terms there was a huge increase of 75.8% between 2004/05 and 2005/06 financial years. Various factors could be advanced to explain the drop in the share of PE in total MOH recurrent expenditures: 1) higher increases in other recurrent transactions expenditures and drugs and medical supplies of 151%, 2) high attrition rate experienced in 2005/6 of high paid staff (about 491).

Table 6 -- MOH Expenditure and Estimates 2003/04-2006/07

Items	2003/04 Actual (MK'000)	2004/05 Actual (MK'000)	2005/06 Revised (MK'000)	2006/07 Approved (MK '000)
Personal emoluments	1300.6	1,989.0	3,497.4	3,710.6
% increase in PE per annum	0	52.9	75.8	6.1
PE as % of Total Recurrent	32.5	40.6	32.7	27.8
Other recurrent transactions including drugs and medical supplies	2701.3	2,860.0	7,187.8	9642.2
% increase				
Total	4,001.9	4,899.0	10,685.2	13,352.8

Malawi Government Consolidated Annual Appropriation Accounts for the Financial Year Ended 30th June (Various and MOH Expenditure print-outs)

4.5.4 Requirements and Expenditures 2004/05 - 2006/07

Table 8 shows the trends in POW financing requirements (converted in Malawi Kwacha) and actual and estimated expenditures in MOH between 2004/05 to 2006/07.

As it can be seen from the table, it appears there has been no gap between the estimated requirements for HRH in 2004 and the actual expenditures by the MOH during the period under review. Even with the inclusion of CHAM funding by the SWAp pool for training institutions and salary top-ups, this will more likely not change the picture dramatically. In summary, DPs who committed to fund the HRH programme in 2004 have fulfilled their commitments. Indications for the FY 2007/08 and thereafter up to 2010 show that adequate funds will be available from SWAp pool partners and other discrete partners for HRH Programme.

Table 7 -- POW Financing Requirements and Actual Expenditures and Estimates: 2004/05-2006/07

	2004/05			2005/06			2006/07		
	Estimated POW Requirement	Actual Expenditure	Gap/Surplus	Estimated POW Requirement	Revised Expenditure	Gap/Surplus	Estimated POW Requirement	Approved	Gap/Surplus
	MK '000	MK '000	MK '000	MK '000	MK '000	MK '000	MK '000	MK '000	MK '000
Personal Emoluments	1,989.25	1,989.0	+0.25	3,318.0	2,397.3	+920.7	4,018.0	3,710.6	+308.0
% increase				66	20.5		21.9	54.8	
Pre-service training				1,288.0	619.5	+668.5	1,288.0	722.7	+565.3
External training				0	35.0	+35.0	0	15.6	+15.6
In-service training				105.0	-				
Acquisition of Technical services							0	2.9	+2.9
Total	1,989.25	1,989.0	+0.25	4,711	3,051.8	1,624.2	5,306	4451.8	+889.6

Notes: + means Surplus, - means Gap
Source: POW 2004-2010 and Malawi Government Annual Appropriation Accounts and MOH Expenditure Print-Outs.

4.5.5 Future Implications

HRH Programme in particular personal emoluments and partly in-service training are funded from government general tax revenues. SWAp pool donors and other discrete donors finance pre-service training, technical assistants, salary top-ups and capital development. As observed in Table 7 SWAp pool funding has increased the MOH recurrent expenditures dramatically and in particular personal emoluments by around 75%. This trend is more likely to continue up to 2010 due to costs of expanded recruitment and alternative pay increases.

Rough estimates suggest that recruitment costs to fill existing vacancies gradually increases from US$8.4 million in 2005 to US$15.6 million in 2010; over the same period, proposed pay increases range from US$11.7 million to US$47.7 million a year, depending on the scenario assumed (Staple, 2004). This is a massive increase which will more likely be unsustainable after 2010 or even earlier in an event of disagreements with development partners. Compounding the situation is the fact that economic growth prospects to support such massive expenditure increases are modest.

Furthermore, much as there has been debt relief which is more likely to release additional funds into the economy, the government faces equally important competing demands for its limited resources from other sectors-education, water, infrastructure etc. For example, total actual heath expenditure (including donors, government, private firms and households) in Malawi per capita in 2004/05 was around US$20 (MoH NHA Report 2007).

This figure falls critically short of the US$34 total health expenditures per capita recommended by the WHO Commission on Macroeconomics and Health (CMH) in 2001 to deliver a basic package of cost effective interventions in developing countries such as Malawi. In order to reach this $34 mark for instance in 2004/05, with government resources alone, it would have translated into 18.5% of GDP and yet total government revenue during the same year was just around 20%. This therefore implies that almost all government general revenue in 2004/05 would have been spent on health in order to reach $34 per capita mark. This of course, would not have been feasible.

The same scenario is more likely to happen in 2010 as expenditures would have greatly increased and even surpassing the US$34 per capita per annum but with moderate economic growth prospects, the government alone will not be able to support such huge expenditure outlays.

This being the case, the MOH with support from partners need to commence the process of developed a Sustainable Health Care Financing Strategy for Malawi before the end of the POW 2010. To this effect, we have identified the need for a Long Term TA with extensive skills and experience in health financing and health sector reforms to assist the MOH in developing a Comprehensive Sustainable Health Care Financing Strategy for Malawi and also assist with all other health financing issues which could impede the smooth implementation of the POW.

4.6 Recent HR Developments and Particular Issues

4.6.1 Research in the Offing

- The division of Community Health within the College of Medicine (COM) is undertaking two multi-centre HR research projects (Malawi, Lesotho, South Africa and Tanzania) in conjunction with Trinity College Dublin, funded by Irish Aid looking at job satisfaction of district level staff and the response to the incentive schemes in use, and motivation.
- Kamuzu College of Nursing (KCN) is assessing performance preview processes of nurses
- COM is identifying CPD needs of medical and clinical officers, funded by the CHAM capacity building project (CORDAID funded).

4.6.2 Role of the Health Surveillance Assistants

The role of the Health Surveillance Assistants (HSA) has been redefined and extended and the HSA now:-

1. Provides under-five and assist in antenatal clinics outreach services which include immunizations, growth monitoring, and nutrition supplementation and counselling;
2. Administers presumptive treatment for malaria, ARI, acute diarrhoea, eye and skin infections and minor injuries;
3. Refers patients with danger signs of chronic cough, ARI (pneumonia), pregnancy, malaria, dehydration and any other conditions;

4. Promotes behavioural change communication of information to individuals, families and communities on EHP targeted conditions;
5. Facilitates the creation and support activities of the Home Basic Care / Community Support Groups;
6. Provides support to home based care and palliative care for HIV & AIDS and terminal conditions;
7. Trains and supervises all community support groups;
8. Conducts community assessment and collect essential health data that includes vital statistics (deaths, births and population variables) in the community;
9. Orders, keeps, dispenses and maintains up-to-date records of selected medical supplies and contraceptives;
10. Observes and reports disease outbreaks;
11. Maintains equipment utilized, e.g. bicycles, refrigerators, etc.
12. Promotes safe water supply and sanitation such as inspection and chlorination of water sources and proper disposal of waste;
13. Promotes use of Insecticides Treated Nets (ITN); and
14. Promotes safe delivery practices in the community.

Source: HSA Training Manual

Table 7 below shows number of HAS in post by district and vacancy rates in 2005.

Table 8 -- HSAs in post by district, vacancy rates and ratio / population, 2005

District	Total Population	No. Required to achieve 1:1000 Ratio	Established Posts	No. in post	Vacancies against established posts	Current shortfall against Requirements	Current Ratio HSA:Pop.
Balaka	304,969	305	110	131	-21	174	2:033
Blantyre	1,070,173	1,070	289	227	62	843	4:298
Chikwawa	437,678	438	194	164	30	274	2:245
Chiradzulu	282,158	282	133	99	34	183	2:687
Machinga	425,609	426	204	239	-35	187	1:818
Mangochi	732,653	733	282	282	0	451	2:873
Mulanje	522,893	523	214	211	3	312	2:188
Mwanza/Neno	167,956	168	106	35	71	133	1:555
Nsanje	228,656	229	175	159	16	70	1:485
Phalombe	290,042	290	136	146	-10	144	1:871
Thyolo	556,700	557	232	221	11	336	2:175
Zomba	676,143	676	229	183	46	493	3:314
Dedza	602,696	603	222	229	-7	374	2:790
Dowa	483,110	483	185	161	24	322	2:640
Kasungu	608,917	609	187	172	5	437	3:383
Lilongwe	1,795,112	1,795	482	529	-47	1,266	3:090
Mchinji	409,590	410	157	192	-35	218	2:028
Nkhotakota	283,761	284	112	142	-30	142	2:071
Ntcheu	459,331	459	201	212	-11	247	2:157
Ntchisi	215,501	216	101	96	5	120	2:177
Salima	319,947	320	129	147	-18	173	2:782
Chtipa	157,872	158	86	99	-13	59	1:595
Kalonga	236,748	237	110	121	-11	116	1:894
Mzimba	645,368	645	276	274	2	371	2:123
Nkhatabay	202,058	202	100	124	-24	78	1:804
Rumphi	225,529	226	98	118	-20	108	1:819
Total	12,341,170	12,644	4,750	4,713	37	7,931	2:619

Source: MoH, PHC Unit

4.6.3 Loss Rate of Medical Staff

The HRH crisis continues to undermine the Malawi Health Sector with vacancy rates for doctors as well as nurses continuing to exceed 45% across both MOH and CHAM. Apart from migration, attrition through deaths and resignations are also contributory to the loss rate of medical and other professional staff (Tables 11-13). The attrition level in MOH staff was at an all time high of 491 in 2005 – see Figure 9. Data for 2006 from the Nurses and Midwives Council suggest a reduction in migration from the levels of previous years. *(Source: Report of the annual Review of the Health Sector, 2005-2006 FY)*.

Table 9 -- Migration of Nurses Abroad in the period 2000-2005

Destination/Country	2000 & 2001	2002	2003	2004	2005	Total (excl. 2000 & 2001)
United States of America		3	10	9	3	25
Australia		0	4	0	0	4
Botswana		3	1	1	0	5
Canada		1	0	0	0	1
New Zealand		5	1	1	0	7
South Africa		7	2	1	5	15
United Kingdom		83	90	64	80	317
Zimbabwe		1	0	2	0	3
Uganda		0	0	1	0	1
Total	203	103	108	79	88	378

Source: Nurses and Midwives Council of Malawi, January 2006

Table 10 -- Overall Attrition of key cadres (2002) (Flow Indicator)

Nature of Outflow	Death	Abscond-ment	Resignation	Retirement	Dismissal
Medical Doctor					
Enrolled Nurse	19	3	12	1	
Assistant Environment Officer	1		1		
Health Surveillance Assistant	42	4	12	1	2
Medical Assistant	6	1	1		
Community Nurse	1		1	1	
Nursing Sister	8		9	1	
Clinical Officer	3		7		
Psychiatry Nursing					

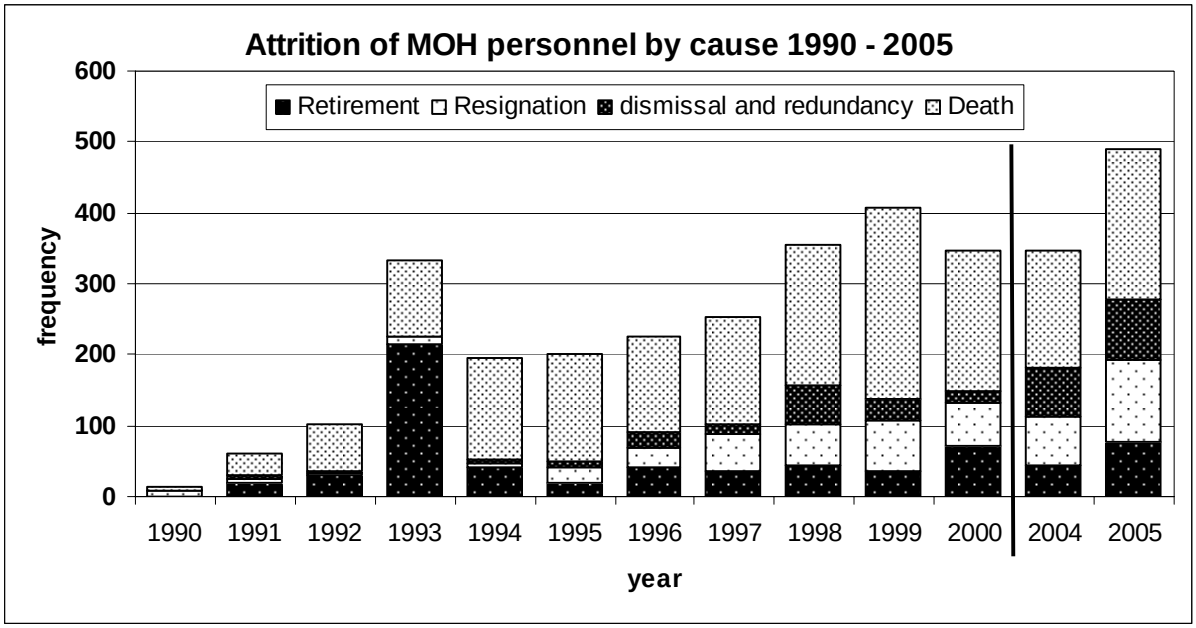
Source: SWAp POW (2004 – 2010)

Table 11 -- MoH Payroll Deletions: 2004 and 2005

Year	Deceased	Resigned	Retired	Absconded	Interdicted	Other	Total
2004	164	67	45	11	30	29	346
2005	214	115	77	37	28	20	491
Total	378	182	122	48	58	49	837

Source: MoH Human Resources Management & Development Section

Figure 9 -- Attrition of MOH staff by cause between 1990 and 2005



Source: UNDP 2002 (taken from Human Resources and Financing for Health in Malawi – World Bank) and MOH RMD Section for 2004 and 2005

4.6.4 Doctors and Nurses in Clinical Care

Table 12 -- Professionals registered with Medical Council of Malawi, March 2007

Cadre	No.		
Specialists	41	Orthopaedic Clinical Officers	1
Medical Practitioners	71	Medical Assistants	201
Dentists	4	Medical Laboratory Technicians	46
Intern Medical Practitioners	4	Medical Laboratory Assistants	2
Physiotherapists	2	Dental Therapists	20
Occupational Therapists	2	Radiography Technicians	22
Clinical Officers	126	Environmental Health Officers	29
Intern Clinical Officers	13	Health Assistants	29
Orthopaedic Clinical Therapists	13	Dental Technicians	1
TOTAL	726		

Commentary

The Ministry has no HRH data bank. Statistics shown in this document vary from one source to the other depending on who collected the data. Thus, these variations may be disputed. The HR Department can work with the HMIS Unit to produce a consolidated data bank.

4.7 Joint Annual Health Sector Review - HR Recommendations

Each year the SWAp partners review the activities of the health sector and make recommendations. This section of the report assesses the progress to date of implementing the actions recommended which involved HRH – Table 13.

Table 13 -- JAHSR – HRH Recommendations and Milestones

Milestone	Responsible	Progress to-date	Remarks
1. Finalize the Strategic HRH Framework	CHRM&D TA (HRM&D)	Framework endorsed by HR TWG, presented to MOH Management for Approval in March but rejected. Currently undergoing review and re-drafting	Major comments on the document include: lack of time bound targets, monitoring framework
2. Finalize Health Sector Deployment Policy	DHRM&D CHRM&D TA (HRH&D) HSC	Draft Policy endorsed by HR TWG and presented to MOH Management for approval in March 2007.	No mention of decentralisation of HR management and implications for deployment
3. Finalize National Health Sector Training Policy (NHSTP)	DHRM&D CHRM&D TAs (HRM & HRD)	Draft policy endorsed by HR TWG and is scheduled to be presented to MOH Management on 16th April, 2007 for approval.	Requires major addition of priorities, choices and numbers of required courses and financial envelope.
4. Finalize update the existing 6-year Pre-service training plan, aligned with National Health Sector Strategic Training Plan	CHRM&D TAs (HRM & HRD	Not action taken	
5. Initiate skills Audit for HR staff at MOH Headquarters, Central and District Hospitals	CHRM&D TAs (HRM & HRD	TNA/Skills audit tools designed and implementation process commenced with Headquarters and Central Hospitals	
6. Develop an Enhanced Retention Strategy for all Cadres by: • Formulating a clear/uniform Promotions Policy & criteria (up to P5 Grade) • Designing a Career Development Scheme with clear Career streams/paths for all cadres	CHRM&D TAs (HRM&HRD	Draft career scheme for Doctors completed	
• Commence actual implementation of incentive packages for staff deployed at identified remote, hard to reach underserved health facilities	SH	• Housing designs completed by MD Initiative who were contracted by DFID. • Revised plans incorporating MOH comments presented 03/2007. Tender placed in local print media for open competition to identify a Consulting company and Architect. Tender for construction of 700 units including flats for central hospitals, houses for district centres and remote, difficult to reach / underserved areas • Special preference access to loans / advances scheme drafted and costed. • Detailed costing of the 14 approved incentives awaiting formation of task force	

Milestone	Responsible	Progress to-date	Remarks
7. Initiate Workforce Planning through • HRH Head Count Survey and Analysis • Comprehensive Workload Analysis for all categories of health workers-(comprehensive Workload Analysis for EHP, to include current and planned scale-up (ART, HIV, EmOC etc)	CHRM&D HMIS STA (HRM&D)	Expression of interest (EIO) developed and placed in the local print media to identify experienced consultant to undertake the survey on behalf of the Ministry	

4.8 Health SWAp - HR Achievements and Remaining Needs

A number of initiatives have been undertaken to strengthen capacity of HRH. These are reviewed and remaining needs and gaps identified.

4.8.1 Workforce Planning for EHP Delivery

The EHP delivery, the AIDS epidemic, the Road Map for reducing maternal and neonatal deaths has made previous HRH planning ratios and other parameters outdated. In addition, MOH's focus on providing EHP using government, CHAM/NGO, and community partners requires a new approach to planning HRH requirements. It has been decided that a workload analysis be undertaken to identify optimum staffing levels by type of institution and location. However, to-date such a study has not been undertaken (tenders for soliciting consultants to undertake the study on behalf of the MOH have just been floated in the local print media) even though the Functional Review which proposes new structures and establishment has been completed and is awaiting approval.

The current roles of different cadres should also be reviewed to make the best use of available staff, with particular attention given to the largest groups such as the HSAs. Findings from the workload assessment should be used to revise the policy on setting establishments. A longer-term view should be linked to the development of a broader HR strategy.

As such, the upcoming HRH census provides a firm base for developing options on the type of staffing that is appropriate for Malawi in the next 10-15 years taking into account both the type of services that will be needed and a realistic view of the future labour market.

Commentary

It is important that HRH planning parameters be updated in the context of the extended EHP including Road Map and Universal access to ARV using the results of a workload assessment.

4.8.2 Implementation of Existing HRH Plans

There have been several HRH planning documents developed since 1999 as follows:

4.8.3 Human Resources Development Plan (1999-2004)

The Human Resource Development Plan (1999-2004) was launched in 1999. The key priorities of this 5 Year plan were:

- The training of clinical cadres-medical doctors, nurses, clinical officers, medical assistants, technical support staff (pharmacy, laboratory, radiology technicians etc)
- A National Training Policy and Plan
- A National Deployment Plan
- A National Appraisal and Incentive System
- The Health Services Commission, and
- A Human Resource Information System.

Soon after the launch of this document, it was felt that there was need to monitor its implementation. To this effect, a **Human Resources Advisory Committee (HRAC)** was formed, under the chairmanship of the Secretary for Health. This Committee was multi-sectoral. The major task for this Committee was to mobilize adequate resources needed to implement this document.

4.8.4 Project Financing Proposal for HRH

In order to implement The Human Resources Development Plan (1999-2004) successfully, the HRAC decided that there was need for developing a human resources financing proposal with estimated costs of implementing the six priority areas. As such, the Human Resources Advisory Committee supervised and monitored the development of the national **Project Financing Proposal for Human Resource Development in the Health Sector** which was released in March 2000 and aimed at mobilizing financial, material and physical resources. In this proposal, estimated costs and justification for each of the six priority components were outlined. It was not successful in mobilizing the much needed resources from donors.

4.8.5 Six Year Emergency Pre-service Training Plan

With this unfavourable response, the MOH decided to focus on immediate pre-service training needs of the Malawi health sector. This meant leaving out all other five components for future action. Work on training needs of the health sector commenced in 2001. This work involved developing a **6-year Emergency Pre-service Training Plan.** This Plan was formally launched in July 2002. The major objective of this Plan was to ensure that all pre-service health training institutions in Malawi were operating at 100% capacity, so as to meet projected output targets.

The major components of this plan include:

- Basic Nurse Technicians and Generic Registered Nurses;
- Upgrading of Nurse Technicians
- Medical Assistants and Clinical Officers
- Technical Support Services;

- Post Basic Training and Auxiliary Nurses;
- Health Surveillance Assistants and Nurse Midwives.

The estimated cost needed to support the training plan was $US 29,926,472 and was to be partly provided by donor agencies and partly by Malawi government. The proposed numbers of people to be trained was as follows:

- CHAM to increase Basic Nurse Technicians training enrolment to 410 via two enrolments by the year 2005
- KCN Registered Nurses to increase to 60 per year
- MCHS (Zomba and Blantyre) and KCN Upgrading of Nurse Technicians at 150 per year, 50 per institution
- MCHS (Zomba and Blantyre) and Malamulo Medical Assistants enrolment of 125 per year between institutions
- MCHS (Zomba and Blantyre) and Malamulo Clinical Officers enrolment of 75 between institutions
- MCHS (Zomba and Blantyre) and Malamulo Support technical staff (Pharmacy, Laboratory, Radiography) enrolment of 110
- Post Basic Training by MCHS, Mzuzu College, KCN, Polytechnic, COM 180 in total per year between all training institutions
- Training of Auxiliary Nurses by 28 cost centres (24 districts and 4 Central Hospitals) 20 per institution

The current status of the pre-service training plan is found in Table 15.

Table 14 -- Pre-service training – number of graduates 2004-2007 by cadre and institution

Pre-service training	Institution	Status, end February 2007	Target
Basic Nurse Technicians	CHAM	916	60/year
MT	CHAM	107	
Registered Nurses (Bsc)	KCN	146	150/year 50/Institution
Nurse Technicians	MCHS (Zomba, Blantyre)	99	
Nurse Technician Upgrading	KCN	72	
Medical Assistants	MCHS (Zomba, Blantyre)	276	125/year
	CHAM	86	
Clinical Officers	MCHS (Zomba, Blantyre)	141	75/year
	CHAM	76 +30 CO Upgrading	
Pharmacy	MCHS (Zomba, Blantyre)	52	110/year
Laboratory	MCHS (Zomba, Blantyre)	39	
	CHAM	20	
Radiology	MCHS (Zomba, Blantyre)	50	
Post basic training	MCHS		180/year
	Mzuzu University		
	KCN (degree)	90	
	Polytechnic,		
Medical Doctors	COM		
Training of Auxiliary Nurses	24 districts and 4 central hospitals	?	20 per institution/year

Source: Various

4.8.6 HRH - Towards a Solution

Even though, the implementation of the Six-Year Pre-service Training Plan had progressed successfully in its early stages, the human resources crisis however continued to dominate the Malawian health sector. In order to respond to this situation the MoH prepared an additional document titled **Human Resources in the Health Sector: Towards a Solution** which was launched in April 2004. This document contained the following eight priority components:

1. Retention of Current Staff and Prevention of Brain Drain
2. Special Tutor Incentive Programme
3. Securing of Specialist Physicians
4. Financial Support for the Six Year Emergency Training Plan
5. Attracting Back into the System Those Who Have Left and Are Still in Malawi
6. Support for Regulatory Bodies
7. Technical Assistance in the Area of Human Resource
8. Provision of Basic Diagnostic Sets for Clinical Health Personnel.

This proposal was estimated at US$187.6 million.

4.8.7 6-year Emergency Human Resources Programme (EHRP)

The 6-year Emergency Human Resources Programme (EHRP) which builds on the eight components contained in the **Human Resources in the Health Sector: Towards a Solution** mainly focuses on issues of retention, deployment, recruitment, training and tutor incentives.

It has an estimated cost of US$ 272 million for a period of six years. It is currently under implementation through the SWAp pool (for more details on the financing sources see section 4.5.2, with regard to achievements of the EHRP see Table 47).

Some important components crucial to solving the HRH crisis in Malawi were addressed in a separate document for the attention of the Global Fund which included:

- Special tutor incentive programme (financed by GTZ for one year)
- Support for the recruitment of (international) nurse preceptors and support to operating expense shortfall to training institutions
- Support for regulatory bodies
- TA in the area of HR planning and management and infrastructure and operating costs to support the implementation of the EHRP.
- In-service training
- Support to the Health Services Commission
- Strategic/policy/plan development, dissemination and implementation (national training, deployment , performance management);
- HR management information systems

Global Fund have consolidated their financing support for EHRP under their ‘Health Systems Strengthening’ Framework (cf. 4.8.8). There

seems to be a widespread understanding that this Programme is a separate initiative, unrelated to the EHRP. In their comments to this report DFID pointed out that this is not their understanding, nor the basis for the DFID funding for the EHRP. These differences in MOH, DP's and other stakeholders' understandings of EHRP should be analysed and clarified during the coming SWAp Mid-Term-Review-Process in order to promote the most effective use of available resources.

4.8.8 Health Systems Strengthening Programme

A part of the SWAp-Approach, the GFATM has approved the provision of resources for the EHRP from HIV/AIDS Round I, Malaria Round II and Health Systems Strengthening Round V grants (In total ~$100 million). This makes the GFATM the second biggest contributor to HRH development in Malawi. Priorities for the Health Systems Strengthening Programme include:

- Increasing the supply of skilled and motivated HSAs and other health sector HR, such as community nurses and clinical officers
- Building capacity of laboratory staff
- Increasing the number of senior tutors and support facility expansion
- Recruiting of nurses, clinical officers and doctors
- Improving quality of training for nurses by reinforcing and hiring of tutors, upgrading (rehabilitation/expansion) of training schools;
- Retention of health workers.

4.8.9 Deployment of UNV, VSO, CIM (and others) Doctors

One of the components of **6 Year Emergency Human Resources Programme** is the securing of specialist Physicians. In order to implement this component, efforts have been made to identify UNV, CIM and VSOs general practitioners and specialist doctors who have been posted in various District and Central hospitals. In early 2007, 72 such positions were filled in this way. For more details on the current status of deployment of UNV, CIM and VSO doctors see Table 16.

Table 15 -- Deployment of UNV, CIM and VSO by Institution, 2007

Activity	Institu-tion	Position	Placement	Status end February 2007
1.Deployment of UNV Specialists	UNDP	Surgeon	KCH	5
2. Deployment of UNV Doctors	GFTAM	General Practitioner	Chiradzulu	1
			Balaka	1
			Zomba	1
			Mulanje	1
			Kasungu	1
			Mzimba H	1
			Mangochi	1
			Chikwawa	1
			Mchinji	1
			KCH (Paediatrics)	1
			Nkhata Bay	1
			Blantyre	1
			Salima	1
			Dedza	1
			Karonga	1
			Dowa	1
			Nkhotakhota	1
			Karonga	1
			Salima	1
		ART Supervisor	Zomba	1
			Lilongwe - Lighthouse	1
			QECH	1
Deployment of VSO Doctors	DFID	Medical Doctor	Thyolo (05)	2
			Mwanza (05, 06)	2
			Rumphi (05,06)	2
			Chitipa (05)	1
			Nsanje (06, 07)	2
Deployment of VSO Allied Health Professionals		Allied Health Professional	MCHS, Llw (Sep '05, 06)	4
			KCN, Lilongwe (June'06)	1
			MCHS BT (September '06)	1
Deployment of VSO Staff not funded by DFID		Medical Doctor	Paediatrics Lecturer, Queen Elizabeth Hospital, Blantyre	1
			St Lukes Hospital	1
			Trinity Mission Hospital	2
			Kamuzu Central Hospital	1
			Bwaila Hospital (*Short term)*	1
		Physiotherapist	Kachere Rehabilitation School	2
		Lab Technologist	Trinity Hospital	1
		Administrator	Kamuzu Central Hospital	1
Deployment of VSO Nurse Tutors	DFID	Nurse Tutor	St John's College of Nursing (04/05)	2
			MCHS, Zomba (April '05)	2
			Nkhoma College of Nursing (04/05)	2
			Malamulo College of Nursing (04/05)	2
			Trinity College of Nursing (02/06)	1
			St Lukes Nursing School (02/07)	1
			Mzuzu University (February '07)	1
Deployment of VSO Lecturers	DFID	Lecturer	MCHS, Llw (Sep '05)	1
			MCHS (Zomba) (April '06)	1
			MCHS BT (September '06)	1
Deployment of VSO Hospital Maintenance Supervisors / Engineers	GTZ	Hospital Maintenance Supervisor	Physical Asset Management Unit, Lilongwe	1
		Hospital Maintenance Engineer	Thyolo District Hospital	1
			Chitipa District Hospital	1
			South East Health Zonal office-(Zomba)	1
			Bwaila Hospital, Lilongwe	1
Deployment of VSO Psychiatry personnel			St John of God college of mental health sciences (May 2006)	1
Deployment of CIM Doctors				
TOTAL				72

Source: UNDP/Malawi, VSO Office/Malawi

4.8.10 HRH Strategic Framework

As can be seen there have been several efforts made to find solutions to the HRH crisis in Malawi. However in order to have an effective and sustainable production, deployment, development and management of a nation's health sector human resource, it was felt that there was need for developing a base upon which all the efforts outlined above could be rooted. To this effect, a **Strategic Human Resources for Health Framework** has been drafted whose main aim is to provide effective oversight and leadership, including the coordination and engagement of a wide range of multi-sector key stakeholders at national level. This document mainly targets and identifies critical areas, gaps, constraints, risks and assumptions affecting the current and projected human resource situation; which in turn will necessitate a rigorous analysis of human resource specific trends, data and information.

Its scope focuses on a comprehensive and complex range of areas relating to issues as diverse and wide-ranging as: national and sector-specific policy; financing; human resource leadership, planning, management & development systems and processes; inter-sector collaboration; health systems strengthening initiatives; public-private partnership, education and training systems; and technical assistance planning and utilization requirements, within the context of effective health service delivery and in line with the basic provision of the Malawi Essential Health Package (EHP) over the next five years.

The various outputs, strategies, interventions and targets established under the umbrella of the HRH strategic framework are designed to guide the growth, development and utilisation of human resources for the health sector in Malawi and inform the proposed development and implementation of comprehensive and focused HRH Annual Implementation Plans (AIP), covering an agreed period of five years. In a nutshell, the focus of the document is about increasing the number of trained health care workers in the sector, increasing the number of skilled and competent health workers and strengthening of HRH policy and systems. As of mid March, 2007, this document was undergoing review.

The main issues arising include:

- The development process began in November 2005 with broad participation of all concerned TA, LATH, DFID, HRM&D and several MoH Directors and Deputy Directors (Finance and Administration, Planning, M&E, HR, HIV/AIDS). A core team of the above followed through on this process to produce a draft, however, several attempts to widely distribute the draft document for comment, input, etc were not successful due to undefined responsibilities within the MoH;
- The document as it stands represents a guiding framework – as soon as its endorsement is achieved, based on the agreed strategy, a detailed Implementation Plan defining institutional responsibilities and funding sources and including key performance indicators / targets and M&E matrix, has to be developed / refined.

Commentary

The implication of this is that the HRH Strategic Framework needs revision and update. It needs to include a logical framework with indicators incorporating all the recent developments including decentralisation, new training institutions available and funding streams.

4.8.11 Funding of HR Programmes

Detailed work on projections of resources needed to implement the EHRP was completed through short-term technical assistance under DFID. By September 2004, a revised resource envelop for the EHRP was agreed upon between the MOH and its development partners amounting to US$171.6 million during the six year period. With this amount, it was clear that there was a gap of US$100 million from the estimated total costs of US$272 million required (for more details see Table 16 below).

However by December 2004 the resource requirements were revised in two scenarios:

- Scenario 1, a total estimated requirement of US$193 and
- Scenario 2, a total estimated resource requirement of US$229.

The revised resource requirements under scenario 1 and the actual expenditures to-date can be found in Table 16 below.

One of the major cost components of the EHRP includes training activities as well as capacity expansion both for students, staff as well as infrastructure. As noted above, implementation of the Programme is currently under way through SWAp financing and management arrangement. Several institutions have already benefited from the funds disbursed through SWAp.

Table 16 -- Projected annual resource envelop (US$ millions) for 6 Year HR Emergency Programme

Donor	Year 1	Year 2	Year3	Year 4	Year 5	Year 6	Total
DFID	15.0	17.0	18.0	18.0	15.0	17.0	100
Global Fund	3.5	13.7	13.7	13.7	0	0	44.7
UNICEF	1.2	1.2	1.2	1.2	1.2	1.2	7.2
CIM	1.0	1.0	1.0	1.0	1.0	1.0	6
ROC	1.5	1.5	1.5	1.5	1.5	1.5	9
NORAD	4.7	0	0	0	0	0	4.7
TOTAL	**22.2**	**34.4**	**35.4**	**35.4**	**18.7**	**20.7**	**171.6**

Source: EHRP Short-Term Consultancy Report, December 2004.

These institutions include: the College of Medicine, CHAM training institutions, Kamuzu College of Nursing and Malawi College of Health Sciences. The total cost of expanding training capacity was estimated to be US$62.3 million including expenses for capital development, staff development, increased operating costs, and salary costs for newly hired staff. However after review of the available resources it was not possible to provide this entire amount and the allocation was reduced to US$31 million.

The GFATM has been very instrumental in supporting the EHRP, in particular the training component including estimates for capital development and compensation for newly hired staff estimated at US$17 and US$4 million respectively over six years. The total request submitted to the Global Fund was US$37 million as follows:

- Recruitment US$ 0.5 million
- Retention US$ 15 million
- Training US$ 21.5 million.

For more details on the training component see Table 17 below.

Table 17 -- Global Fund Training Activities

Institution	Estimated required capital costs	Estimated compensation for newly hired staff	TOTAL
	US$ (millions)	US$ (millions)	US$ (millions)
College of Medicine	5	2.9	7.9
Kamuzu College of Nursing	5	0.9	5.9
CHAM	2.2	0.5	2.7
Malawi College of Health Sciences	4.8	0.2	5.0
TOTAL	**17**	**4.5**	**21.5**

Table 18 -- Resource requirements and expenditure (US$Million)

STRATEGY		2005		2006		2007		2010	Gap
	Base	Projected	Actual	Projected	Actual	Projected	Actual	Projected	
RETENTION	6.95	12.3		14.0		15.8		98.7	
DEPLOYMENT	0	0.2		0.2		0.2		0.6	
RECRUITMENT*									
PHYSICIANS	0	2.2		2.2		2.2		13.2	
NURSES	0	2.0		2.0		2.0		9.0	
OTHER	0	1.0		1.0		1.0		4.5	
HOUSING**	0	5.9		5.9		5.9		35.4	
TRAINING	0	3.7		4.3		4.8		30.7	
MONITORING	0	0.2		0.2		0.2		0.9	
TOTAL**	6.95	27.5		29.8		32.3		193	

*Notes: *Includes housing costs for physicians,*
*** Resource Requirements under Scenario 1 which appear to be more realistic*
Source: Six Year Human Resource Relief Programme: Revisions and Year One Implementation Plan. Short Term Consultancy Report, December 2004.

4.8.12 Areas of Emerging Needs and Gaps

New training institutions

A thorough review of the training component shows that there's lack of accommodation for emerging programmes that prepare health professionals and a case in point is the Mzuzu University, Faculty of Health Sciences which started in 2005 with nursing and has biomedical, pharmacy and dental students coming on line in 2007. This faculty needs funding for students, staff and infrastructure. In addition there is need to include the Catholic University which is poised to take over Malamulo College of Health Sciences which is currently funded via CHAM. Lastly, Livingstonia Univ. needs to be accommodated as it is responsible for the Ekwendeni College of Nursing that is now being funded via CHAM.

New training programme

The College of Medicine submitted its training plan, which came to MK 379.4 million over the Six Year period. The total cost for the six years was estimated at MK 2.005 billion based on actual expenditures at that time. The COM figure is **not** included in the MK 2.005 billion.

Funding

200 million MK were committed from HIPC funds for 2002/03. This dropped to MK100 million in the 2003/04 FY. Therefore, the MoH faced severe constraints in keeping this 6-Year Plan on track. Since some of the courses are of 4 year duration, funds must be committed and 'ring fenced' for the duration to avoid serious personal and systemic problems. The short fall in the early years was taken care of through donor funding such as Global Fund. In 2007, the MOH is expecting to benefit from debt relief funds. As yet, the supplementary budget has not been approved by parliament.

Commentary

It is clear from above that a huge amount of resources is funded by donors through the SWAp financing and management arrangement. However, it should be noted that the implementation of the POW through the SWAp arrangement ends in 2010. It is likely that by the end of 2010, most of the 6 Year HR Emergency Plan outputs such increased training capacity, recruitment of additional health workers and their retention, construction/expansion/rehabilitation of training institutions, staff houses, etc will have been achieved. Such an expansion implies a huge increase in recurrent resources needed annually to sustain it. As such, it is hoped that Government through the MOH, is already taking this situation into account.

4.9 Achievements with Regard to Education and Training

4.9.1 Response to the Pre-Service Emergency Programme

The following table provides a summary of achievements of the training institutions – see Table 19. Overall there has been a **168% increase** in numbers, well on the way to achieving the programme goal.

4.9.2 Evaluation by WHO

An external evaluation of training programmes was conducted by WHO in 2005 following internal assessments in the COM, KCN and College of Health Sciences which are primary beneficiaries of the 6 year Emergency training funds. The generic main findings were as follows:

- Excellent and honest self-evaluation reports
- Enthusiastic and dedicated staff
- Educational programmes generally good
- Existence of a six year HRH emergency plan
- Resource constraints at all levels
- Not all categories of health workers trained (pharmacy, dentistry, managers)
- Curricula overload

University of Malawi - The College of Medicine

- Established in 1991, fifth and youngest of UNIMA Colleges
- Mission – to be an academic centre of excellence, responsive to the needs of Malawi and its neighbours within the Southern Africa region in training of professionals, provision of clinical services and medical research
- Has trained 265 graduates – Malawian with Bachelor of Medicine and Bachelor of Surgery (MBBS)
- Expected output is 49 in 2007 and 60 in 2008
- Located in Blantyre at Mahatma Gandhi and has a teaching Annex in Mangochi

Table 19 -- Annual enrolment in Malawian health training institutions in 2003 and 2006

Pre-service annual enrolment in Training Institutions 2003 and 2006						
	All institutions			POW TARGET		
BASIC COURSES Cadre	Actual 2004	Capacity 2006	Actual 2006		% increase from 2004	% of POW target by 2006
Dip. in Clinical Medicine (Clinical Officer)	55	100	100	75	82%	133%
Cert. in Clinical Medicine	49	110	74	125	51%	59%
Diploma in Dental Therapy	15	20	35	35	133%	100%
Dip. in Environmental Health	21	25	21	25	0%	84%
Dip. in Biomedical Sciences	14	20	22	25	57%	88%
Diploma in Pharmacy	18	20	20	25	11%	80%
Nurse Technician Certificate	59	60	63	150	7%	42%
B.Sc. in Nursing	48	60	200	60	317%	333%
Cert. in Nursing & Midwifery	236	391	370	410	57%	90%
BSc Biomedical sciences/ lab sciences			36			
MB BS Medicine	20	60	53	60	165%	88%
Total	535	866	994	990	86%	100%
POST BASIC COURSES						
Cert. in Community Nursing	32	35	28	20	-13%	140%
Dip. in Environmental Health	28	30	0		-100%	
Dip. in Biomedical Sciences	6	10	53		783%	
Dip. in Clinical Ophthalmology	27	30	21	20	-22%	105%
Cert. in Cataract Surgery	17	20	0		-100%	
Cert. in Psychiatry Nursing	16	0	17	12	6%	142%
Dip in Pharmacy			25			
Midwifery	30	35	17		-43%	
B.Sc. in Nursing	28	35	30		7%	
Post basic BSc Nursing			30	30		100%
POST GRADUATE COURSES						
MPH	14	25	25		79%	
GRAND TOTAL	1268	1952	2234		76%	

- In 2005 had 231 students (15 foreign from other African States as a way of supporting neighbouring states that have no medical education programmes and the priority countries are: Lesotho, Botswana, Swaziland and Namibia)
- Has an MPH programme preparing leaders and managers for the Health sector
- Has programmes preparing hospital specialists and leaders in clinical areas
- Has a Centre for Reproductive Health
- Developing clinical research for the health sector by setting up a Research Support Centre
- Supports information dissemination for health via the Malawi Medical Journal

- Programmes provided are as follows:
  - 5 year Bachelor's Programme in Medicine & Surgery (MBBS)
  - 1 year intensive Premedical Science Programme
  - 4 year Bachelor of Pharmacy Honours Degree
  - 4 year Bachelor of Science in Medical Laboratory Technology
  - Part-time Masters Degree in Public Health (MPH)
  - Medical specialist 4 year Masters Degree (M Med) in
    - Anaesthesia, Medicine and Paediatrics
    - Surgery , Obstetrics and Gynaecology
    - Public health
    - Ophthalmology

Evaluation results: Main findings

- Innovative staffing supplementation (Sustainability?)
- Strong research programmes
- Existence of a 4-year strategic plan (Vision++)
- Modern educational programme including community-based learning

Statistics

Statistics are provided for enrolment and graduates

Table 20 -- College of Medicine Enrolment 2004-2007

Course	2002	2003	2004	2005	2006	2007
Pharmacy					8	18
MLT				20	16	27
MBBS	31	67	61	42	53	54
Pre-Med	49	45	44	52	65	
MPH		14	25	24	25	26
Total	80	126	130	138	167	125

Table 21 -- College of Medicine Graduates 1992 - 2006

YEAR	MALE	FEMALE	TOTAL	CUMULATIVE TOTAL
1992	12	1	13	13
1993	17	2	19	32
1994	12	8	20	52
1995	14	4	18	70
1996	13	2	15	85
1997	9	3	12	97
1998	15	2	17	114
1999	13	3	18	132
2000	7	9	16	148
2001	13	4	17	165
2002	16	1	17	182
2003	14	4	18	200
2004	10	5	15	215
2005	15	1	16	231
2006	12	12	24	255
Total	192	61	255	
Gender ratio		24%		

Table 22 -- College of Medicine MPH Students and Graduation

Year	Intake	Pass	Graduate
2003	14	12	10
2004	25	5	0
2005	24	0	0
2006	25	0	0
2007	26	0	0

4.9.2.1 University of Malawi - Kamuzu College of Nursing

- Established in 1979 (as a conversion of the Blantyre School of Nursing established in 1965);
- Has 2 campuses (Lilongwe and Blantyre), capacity for 300 students, and 75 members of staff;
- HIV/AIDS policy in place; information ofth e2005 evaluation was used for curriculum review;
- Offers one undergraduate degree in nursing, two upgrading programmes (Diploma for nurse technicians) and a post basic degree for RNs and a University certificate in Midwifery;
- Increased its intake as a response to the 6 year emergency plan;
- Needs to increase its infrastructure but has not yet done so although tendering process was conducted (new student hostels, one at Blantyre and the other at Lilongwe campus both of 100 beds each).

Findings of the evaluation

- Basic courses offered at the same campus
- Existence of critical mass of teachers (5 PhD, 29 Masters, 17 BSc)
- Infrastructure available
- Sensitive to the needs of the nation i.e. programmes have responded to the needs of the nation
- Internationally acceptable standards especially UK
- Programmes are university based and approved

Statistics

Table 23 -- KCN Students Enrolment and Graduation 2004-2007

Name of Programme		2004	2005	2006	2007
Generic BSc.	Enrolment	63	63	150	
	Graduation	50	43	53	
Diploma Upgrading	Enrolment	30	30	30	
	Graduation	20	25	27	
Midwifery	Enrolment	20	30	17	47
	Graduation	25	30	12	
Post Basic BSc	Enrolment	30	30	30	
	Graduation	30	30	30	

4.9.2.2 Mzuzu University

Mzuzu University was enacted by the Parliament of Malawi in May 1997 and admitted its first students in January 1999. The vision of Mzuzu Uni-

versity is to contribute to Malawi's future through education, training and research.

Mzuzu University has 4 Faculties: Education, Environmental Sciences, Information Sciences, and Health Sciences. The Faculty of Education offers among others a BSc (Health Science Education) programme, a two year upgrading degree programme.

In 2005 the Faculty of Health Sciences was established. Its vision is to be an academic centre of excellence in health research, the training and education of healthcare professionals for quality services and for socio-economic transformation for the people of Malawi and beyond.

The faculty of Health Sciences has the following degree programmes:

- Bachelor of Science (Nursing and Midwifery) – started 04/2006 with a class of 50 students; a second batch of 50 students started 04/07
- Bachelor of Science in Biomedical Sciences - provides knowledge for a wide range of career opportunities in health (medicine, dentistry, laboratory, etc.). 30 students started in April 2007.
- Bachelor of Science (Optometry) - 30 students started in April 07
- Doctor of Dental Surgery (DDS) - a four year programme, first intake expected 09/2007, with students being placed at Muhimbiri and Capetown (link arrangement).

In the pipeline are the following Degree programme/courses:

- Diploma in Intensive Care Nursing
- BSc Degree and Diploma in HIV/AIDS Systems Approach to Care in conjunction with Mildmay International and the University of Manchester – at proposal level, to be launched by 08/2008
- Clinical Officer upgrade (biomedical degree programme) – specialising in surgery, 20 per year x 4 years in conjunction with CHAM, and CO CPD Project – needs funding
- MPH programme to be launched in April 2008 to prepare leaders for both the public and private health sector
- A Masters Degree for Midwifery Tutors in partnership with UCLAN / ECSACON and Commonwealth Secretariat, beginning with a trainers course at UCLAN, UK 01/2008, needs funding

The Faculty of Health Sciences has developed strategic plans for the period 2006 through 2010 and the following tables show some strategic areas needing support as presented below.

Table 24 -- Mzuzu University Faculty of Health Sciences Student Projections 2006 to 2010

Number of Students	2006	2007	2008	2009	2010
Dentistry	20	40	60	80	80
Nursing	50	100	150	200	200
Biomedical Sciences	20	40	60	80	80
Physiotherapy		20	40	60	80
Public Health		20	20	20	20
Medicine				20	40
Pharmacy					20
Total	90	220	330	460	520

The nursing and biomedical programmes are currently running and students use borrowed space at Mzuzu Central Hospital and staff houses for accommodation. For laboratory work students borrow space at Ekwendeni College of Nursing and the space for such training in not adequate as the lab at Ekwendeni is for nurse technicians. The distance to Ekwendeni also creates problems. Table 25 and Table 26 below give the cost estimates for the level of support required.

Table 25 -- Estimates for Nursing Midwifery Degree Programme, Mzuzu University FHS

ESTIMATED COSTS AND FUNDING (US$)	SCHOOL OF NURSING					
	2006	2007	2008	2009	2010	TOTAL
No. Of Students	50	100	150	200	250	
INVESTMENT COSTS						
Construction of Teaching Complex	1,100,000	250,000	-	-	-	1,350,000
Construction of 500-bed Hostel	600,000	200,000	-	-	-	800,000
Construction of Cafeteria	350,000	150,000	-	-	-	500,000
Teaching Equipment	500,000	100,000	100,000	100,000	100,000	900,000
Teaching Vehicle	200,000	100,000	100,000	100,000	100,000	600,000
Books	100,000	15,000	10,000	10,000	10,000	145,000
TOTAL INVESTMENT COSTS	2,850,000	815,000	210,000	210,000	210,000	4,295,000
OPERATIONAL COSTS						
Curriculum Development	20,000	15,000	10,000	10,000	10,000	65,000
Staff Development	30,000	25,000	25,000	25,000	25,000	130,000
Research	20,000	20,000	20,000	20,000	20,000	100,000
Teaching Materials	100,000	100,000	100,000	100,000	100,000	500,000
TOTAL OPERATIONAL COSTS	170,000	160,000	155,000	155,000	155,000	795,000
TOTAL COSTS	3,020,000	975,000	365,000	365,000	365,000	5,090,000

Table 26 -- Estimates for biomedical sciences degree programme, Mzuzu University FHS

ESTIMATED COSTS AND FUNDING (US$)	SCHOOL OF BIOMEDICAL SCIENCES						
	2005	2006	2007	2008	2009	2010	TOTAL
No. Of Students	0	50	100	150	200	250	
INVESTMENT COSTS							
Construction - teaching bloc	0	250000	250000	0	0	0	500000
Construction of Hostel	0	250000	150000	0	0	0	400000
Teaching Equipment	0	100000	100000	100000	100000	100000	500000
Teaching Vehicle	0	100000	100000	100000	100000	100000	400000
Books		100000	15000	10000	10000	10000	145000
TOTAL INVESTMENT COSTS	0	800000	615000	210000	210000	210000	2045000
OPERATIONAL COSTS							
Curriculum Development	0	15000	15000	10000	10000	5000	55000
Staff Development	0	30000	30000	30000	30000	30000	150000
Research	0	25000	25000	25000	25000	25000	125000
Teaching Materials	0	100000	100000	100000	100000	100000	400000
TOTAL OPERATIONAL COSTS	0	170000	170000	165000	165000	160000	730000
TOTAL COSTS	0	970000	785000	375000	375000	370000	2775000

One other important element in education of nursing and medical students is the need for hospital, district and community learning experiences. Mzuzu hospital offers support for teaching in Mzuzu, however the students need other learning experiences and the district facilities in the northern region were not built with students learning in mind and so additional structures are needed to support students learning as follows:

Table 27 -- Mzuzu University Faculty of Health Sciences Estimates for District Teaching Sites

ESTIMATES FOR DISTRICT TEACHING SITES US$					
		2008	2009	2010	TOTAL
Teaching Block - Karonga Hospital		200,000	100,000	50,000	350,000
Hostel Block - 50 bed Hostel - Karonga		200,000	100,000	50,000	350,000
Teaching Block - Mzimba Hospital		200,000	100,000	50,000	350,000
Hostel Block - 50 bed Hostel - Mzimba		200,000	100,000	50,000	350,000
Teaching Block - Nkhata Bay		200,000	100,000	50,000	350,000
Hostel Block - 50 bed Hostel – Nkhata Bay		200,000	100,000	50,000	350,000
Apartments for Postgraduate/Interns – Luwinga		200,000	100,000	50,000	350,000
TOTAL		1,400,000	700,000	350,000	2,450,000

All other cost estimates are in the strategic plan which is available for sharing, but one key observation is that Mzuzu University, Faculty of Health Sciences started after the POW and Swap were already in place and is not benefiting from the financial support. Even the Global Fund proposal submitted in June 2005 which compliments efforts of SWAp did not include Mzuzu University.

4.9.2.3 Malawi College of Health Sciences

Background

Malawi College of Health Sciences (MCHS) is a major training institution for health care workers in essential health care services in Malawi. The products of the institution are very important for the implementation of the Program of Work (POW 2004-2010) and the Essential Health Package (EHP). Since EHP is meant to combat the main causes of disease burden in the country in a cost-effective manner, MCHS is shouldered with the responsibility of contributing to education and training of health workers who are to be based at three levels, the district hospital, the health centre and the community levels. MCHS therefore plays a significant role in the delivery of the EHP.

The college has three campuses, i.e. Lilongwe, Zomba and Blantyre campuses. Currently, the college runs basic and post-basic upgrading certificate and diploma courses that are recognized and accredited by health professional regulatory authorities in Malawi, i.e. the Medical Council of Malawi, the Pharmacy, Medicines, and Poisons Board and the Nurses and Midwives Council of Malawi. The college also provides short courses in various areas as part of continuing medical education for health care workers in Malawi.

Programs

The Programs MCHS is offering include the following under each one of the four faculties:

Faculty of Clinical Science

- Diploma in Clinical Medicine Program (Lilongwe and Blantyre)
- Diploma in Dental Therapy (Lilongwe Campus)
- Certificate in Clinical Medicine (Lilongwe and Blantyre Campuses)

Faculty of Medical Sciences

- Basic Science department (all campuses)
- Diploma in Pharmacy, Radiography and Laboratory Technology (Biomedical) Laboratory Programmes (Lilongwe Campus)

Faculty of Nursing Sciences

- Diploma in Nursing Program (Blantyre Campus)
- Certificate in General Nursing and Midwifery (Zomba Campus)
- Certificate in Psychiatric Nursing (Zomba Campus)

Faculty of Public Health Sciences

- Diploma in Environmental Health (Lilongwe Campus)
- Certificate in Community Health Nursing (Lilongwe Campus)

Evaluation (WHO in 2005)

- MCHS should consider rationalising the number of courses
- incorporate students in College organisational structures
- plan, institute and implement a staff development programme
- enhance courses and staff evaluations
- and consider inclusion of MCHS in the University of Malawi
- it has a central role in supplying health care staffing needs for the country and has close relationship to the MoH.

Conclusion

The evidence available shows that MCHS is in the right track in helping MoH achieve its mandate as dictated by the POW through its participation in the implementation of SWAp Program. However, it falls short of fully addressing the needs of the EHP as its education and training programs are not regularly updated and streamlined to focus on the current needs of the health sector in terms of meeting the needs of the community and direct patient care, as the evaluation report suggests.

Statistics

There has been a 15% increase in enrolment and a 24% increase in graduates in the four years to 2006.

Resource Mobilisation

MCHS draws its financial support from other recurrent transactions (ORT) as sub vented from Government and the SWAp Arrangement. Under SWAp, the college has been able to draw funds for improving its human resource needs, the needs of improving infrastructure (buildings), the needs of upgrading or updating equipment, plant and vehicles, etc, in order to meet the demand for it to double its student body (i.e. previously was 700, now 1270 and when the current capital development initiatives are completed, MCHS will have 1400) and in line with the Ministry's Six-year Emergency Plan.

Table 28 -- Intake and Graduate Statistics MCHS 2002 - 2006

	Basic Courses		2006	2005	2004	2003	2002
1	Clinical Officers	Enrolment	94	90	90	97	50
		Graduates	75	41	25	39	19
2	Dental Therapists	Enrolment	15	10	10	16	10
		Graduates	7	8	9	15	9
3	Ass. Environ. Health Officers	Enrolment	21	20	22	22	30
		Graduates	20	16	22	21	16
4	Laboratory Technicians	Enrolment	22	20	42	32	20
		Graduates	15	13	11	14	
5	Pharmacy Technicians	Enrolment	20	20		30	20
		Graduates	14	16	22	18	21
6	Pharmacy Assistants						
7	Radiography Technicians	Enrolment	22	20	20	30	20
		Graduates	27	14	9	13	1
8	Medical Assistants	Enrolment	124	120	121	105	100
		Graduates	98	89	89	44	
9	Nurse-Midwife Technicians	Enrolment	63	60			
		Graduates			72	61	86
10	Nurse Technicians	Enrolment			82	65	65
		Graduates		59	40		
11	State Registered Nurses	Enrolment	40	40			
		Graduates					
	TOTALS	Enrolment	421	400	387	397	315
		Graduates	256	256	299	225	163
	Post Basic Courses		2006	2005	2004	2003	2002
1	Community Health Nurses	Enrolment	28	30	26	28	30
		Graduates	30	29	25	32	29
2	Environmental Health Officers	Enrolment				39	
		Graduates		35			28
3	Ass. Environ. Health Officers	Enrolment				39	
		Graduates					
4	State Registered Nurses	Enrolment	25	25	24	26	40
		Graduates	26	18	31		
5	Clinical Officers	Enrolment					35
		Graduates				35	25
6	Laboratory Technicians	Enrolment					6
		Graduates			5	6	22
7	Pharmacy Technicians	Enrolment	25				
		Graduates	25		27		
8	Psychiatric Nurses	Enrolment	17	10	10	20	17
		Graduates	12	10	14	17	34
9	Midwives	Enrolment		40	38		
		Graduates	39	38			
10	Ophthalmic Technicians)	Enrolment	21	29	28	27	25
		Graduates	18	29	28	27	25
	TOTALS	Enrolment	116	134	153	140	153
		Graduates	150	159	103	117	163
	GRAND TOTALS	Enrolment	537	534	540	537	468
		% increase	115%	114%	115%	115%	100%
		Graduates	406	415	402	342	326
		% increase	124%	127%	123%	105%	100%

4.9.2.4 CHAM Training Institutions

- Established in 1928 originally training grade 3 midwives
- Comprising of 10 training schools for 2 year nurses and midwives technician programmes with a common curriculum
- Housed in 9 of its hospitals and have a capacity of 957 and are capable of producing 200 nurses per year
- Have a Training College Technical Committee of Principals of all 10 Training Institutions; Nurses and Midwives Council; Medical Council of Malawi; MoH, KCN, Malawi College of Health Sciences
- Are included in the 6 year Emergency Training Plan and been given targets by MOH to double or triple intake
- Receive funding from MoH, via the SWAp basket mechanism, and via Norwegian Church AID.
- MOH provides operational costs e.g. salaries, rentals, tutors, part-timers, transport, accommodation, meals, fees (as for Health Sciences) - The money for infrastructure that was to come directly from the MOH has been problematic and not much progress has been made on this.
- GTZ has been providing an incentive package for tutors for the period 2001 to 2005, was terminated in 2005 when government effected 52% salary increases; will now be renewed yearly.
- Areas of strength - good management of schools; committed; strong partnership with government; provide quality care;
- Weaknesses - dependent on tutors seconded by government; shortage of tutors/ lack of incentives, rural/remote areas, transport problems for staff and students
- Opportunities - long and very good relationship with MOH, donors and development partners; HPIC funding
- Threats - staff motivation; insufficient donor support; HIPC funds do not cover incentives

The training institutions are as follows:

- **St. Johns College of Nursing**, Mzuzu, Dioceses of Mzuzu - RC, takes girls only, does nurse technician and midwifery
- **St. John of God College**, they conduct a BSc in Psychiatry and a Certificate course in Counselling
- New Christian University, started in 2003 with 25 students
- **Ekwendeni Nursing College**- co education, nurse and midwifery technician, diploma (has 2 campuses: Ekwendeni and Livingstonia)
- **Nkhoma Training School**, under Nkhoma, Synod, CCAP, co-education, nurse and midwifery technician programmes , diploma
- **St. Lukes Nursing School**, Malosa, Upper Shire, Anglican, co-education, nurse and midwifery technician, diploma
- **St. Joseph, Nguludi**, RC, co-education, nurse and midwifery technician

- **Mulanje Mission** , CCAP, Blantyre Synod, co-education, nurse and midwifery technician, diploma
- **Holy Family**, Phalombe, Arch-dioceses, co-education, nurse and midwifery technician, diploma
- **Malamulo College of Health Sciences**, 7th Day Adventist, different from all other CHAM facilities in that it offers more courses
  - co-education, nurse and midwifery technician, diploma
  - Clinical officer 3 years plus 1 year internship, diploma
  - Medical Assistant, 2 years, certificate
  - Lab technician, 3 years, diploma
  - Bsc. in Clinical Medicine – new programme being developed
- **Trinity Mission** –Arch-diocese of Chikwawa , RC offer co-education, nurse and midwifery technician, diploma

Statistics

The CHAM institutions have more than doubled their 2003 intake from 205 in 2002 to 463 in 2006. – see Table 29.

Table 29 -- CHAM Training College graduates 2000 - 2006

CHAM Training Colleges 2000 to 2006 Graduating Students Cohort Form							
Training Institution	2000	2001	2002	2003	2004	2005	2006
Trinity College	20	16	32	45	25	38	16
Holy Family		42	26	39	36	39	30
St. Johns	28	15	27	27	35	48	35
Nkhoma	30	48	44	34	40	43	18
St. Lukes		42	22	40	37	32	
St. Josephs							
• NMTs	35	25	25	42	40	48	36
• MTs							61
Malamulo							
• Nursing	20	27	22	33	37	37	25
• Medical Assistants					64		22
• Clinical officers	19	18	22	16	18	30	*58
• Lab Tech	11	5	11				20
• Biomedicals							33
Mulanje							
• NMTs	27	12	27	33	42	38	40
• MTs							24
Ekwendeni							
• NMTs	15	11	20	28	28	30	23
• MTs							22
Total	205	261	278	337	402	383	463

**= (30 upgrades,28 generic).*

4.9.3 Health Care Specialists

The availability of specialist follows the same pattern as other health care workers. There is need to train, recruit, deploy and retain these specialists. Every health worker cadre is capable of producing specialists but for our current discussion we will concentrate on doctors, nurses and clinical officers.

4.9.3.1 Medical Specialists

The development of medical and health specialisation in Malawi

Until now, without its own medical graduates, Malawi has not had to consider the range and skills it needs of its doctors. It now does have medical graduates coming in significant numbers so it needs to plan now many specialists of different types are needed.

A balanced health service requires a mix of specialist and generic medical and clinical staff. The success of a health service requires highly experienced generic doctors and clinical officers working with and leading clinical teams in district hospitals, where the majority of patients are treated. The generic doctor and generic clinical officer need to be as experienced and trained as a specialist for a number of reasons:-

- A small team of doctors needs to deal with all potential health problems
- Geography makes referral and assistance from specialists difficult and often impracticable
- Leadership and supervision of district clinical services requires special skills.

Countries with a distribution of district hospitals as Malawi have developed a specialty called the ”District Hospital Specialist”. Such a person is required to undergo specialist training of a similar duration as the usual specialist – four years in medicine. The College of Medicine has prepared a M Med (District Specialist) training course which could be set up to provide the training for those doctors interested, as many are, in district hospital work.

The brain drain in Africa, besides being a result of doctors and nurses leaving the continent, also occurs with doctors leaving the rural for urban areas within a country. This happens if specialist posts are only available in central hospitals in urban areas. The value of the specialist district hospital doctor grade becomes twofold. It:-

- Ensures that the majority of doctors in rural areas are expert and fully trained.
- Ensures that doctors remain in district hospitals and do not migrate to the cities.

Commentary

There are many advantages for setting up a district specialist grade. The issue needs to be debated and a training programme set up by the College of Medicine.

Current situation

The current situation according to the EHRP on medical specialists

- Of the 115 surgeons required only 17, or 15% are filled and 98 or 85% are vacant.
- Of the 22 pathologists required, there are 100% vacancies.
- Of the 65 medical specialists required, there are 3, leaving 62 or 95% vacant.
- Of the 14 anaesthetists required there are four in post, leaving 10 or 71% vacant.

- Of the 126 obstetrician/gynaecologists required, there are 11 in post leaving 115 or 91% vacant.
- Of the 60 paediatricians required there are 5 in post, leaving 53 or 92% vacant. (EHRP document)

Under activity 2.2.4 in the Strategic Human Resources for Health Framework, there is a plan on how to go about recruiting from abroad, with the requirement to develop and monitor contractual arrangements through existing mechanisms for internationally recruited health workers (i.e. VSO, UNV, CIM, etc.) to be achieved by undertaking the following tasks:

- Assess and refine current contracting procedures and processes
- Implement new and improved procedures (e.g. establishment of clearing house, flexible working and contracting arrangements, development of compensation packages, performance management systems, job descriptions, job plans, etc.)
- Establish procedures for registration, licensing and practice with the national regulatory bodies (i.e. Medical Council of Malawi, Nurses & Midwives Council, Pharmacy, Medicines & Poisons Board)
- Recruit targeted physicians and other health professionals, by category, as outlined in the EHRP and Annual & 5-year Recruitment and Deployment Plans, using new procedures
- Develop M&E indicators for monitoring procedures and staff performance (include in HRH M&E Framework)

UNDP and VSO have been asked, using funds from the EHRP, to recruit doctors to meet some of this shortfall. From the vacancy rates it is clear that the limiting factor is the funding available for this exercise. So far six specialists have been brought in by UNDP and six have been recruited but have not yet arrived. VSO has five specialists deployed and are looking at increasing the number of short term specialist volunteers.

By the end of April 2006, CIM a German organisation had brought in 15 specialists 3 of whom are co-funded under the EHRP. *(Source: SWAP Review April 2006)*

The recent success in securing the services of paediatricians, albeit for short terms is indicative of the willingness of foreign senior medical staff to live and work in Malawi. There would be substantial merit in examining the feasibility of international secondments and /or sabbatical agreements for highly qualified health staff, but only if these individuals have past African experience. *(Source: A Comprehensive Workload Analysis Framework and Implementation Plan 2006)*

Training of Specialists

Malawi currently only trains surgical specialists in orthopaedics and general surgery through the College of Surgeons of East Central and Southern Africa (COSECSA). So far only two have graduated through this college trained in Blantyre. All other specialties are trained abroad. With the vacancies displayed above there is need to meet the short fall. The solution selected has been to recruit specialists from abroad for the next three to four years using SWAp funding.

As part of the EHRP the MOH had budgeted for ten doctors to go for specialist abroad and so far only five have gone. There are also three doctors under the Taiwanese funding undergoing specialist training *(Source: MOH Training Plan)*.

The current MOH Functional Review creates Registrar training posts at all the central hospital in anticipation of starting medical specialists training in Malawi. It is hoped that initially the specialist training will involve a period in which the trainee will have to go abroad for the parts that can not be done in Malawi. Another alternative is to include a fellowship year at the end of the training that allows for exposure to wider experience of the chosen field. *(Source: MOH Functional Review 2006)*

The major constraint on the training of specialists is the number of medical practitioners in the field ready to go for this training. In 2006 MOH advertised for doctors working in MOH to apply for specialist training. The vast majority of those who applied were intern doctors who did not qualify for sponsorship for specialist training. In the end only five were identified and of these four have gone for training in South Africa. This was highlighted in the EHRP report on Training and Tutor Incentives which concluded that; *'the cost of in-country specialist training is estimated at $13,000-$20,000 per person year. This would clearly be more cost effective than external recruitment or training. However, a key constraint is that there are only 186 doctors (mostly non-specialist) currently in Malawi. To take them out of service to upgrade their skills might leave a significant gap in service providers.*' The cost implication is a strong motivating factor to encourage specialist training in Malawi.

4.9.3.2 Nurses Specialist Training

There are very few documents that deal with nurse specialist training in the MOH. Indeed there is considerable disagreement as to what a nurse specialist is. The confusion mostly stems from the number of terminologies used to describe nurse specialists. Added to this is the new concept of nurse practitioner. The UK official graduate careers website describes a nurse specialist in the following terms:

A specialist nurse (SN) specialises in a particular area of nursing, caring for patients suffering from diseases such as cancer, diabetes or Parkinson's, viruses such as HIV/AIDS, or other conditions such as chronic heart failure. An SN provides direct patient care and support and can play a vital role in helping improve quality of life by educating the patient on the management and control of symptoms and offering support following diagnosis. In many cases, the involvement and intervention of an SN can prevent patient re-hospitalisation.

Typical work activities include:

- educating newly-diagnosed patients;
- conducting a detailed lifestyle assessment and offering consultations for patients at the start of treatment;
- providing advice on treatment side-effects and how to manage these;
- visiting patients at home, in specialist clinics or on hospital wards;
- adjusting drug doses within set limits; observing, evaluating and recording changes in symptoms and assessing signs of destabilisation;
- participating in nursing research; educating and encouraging the patient to assess his or her condition and understand fully the proposed treatment plan;
- discussing treatment plans with patients, evaluating patients' adherence to proposed treatment plans and offering support and reinforcement when necessary;

- responding to patients' and their families' questions;
- making follow-up calls to patients who have been discharged and arranging follow-up appointments as required;
- offering emotional support and counselling to patients and their families to assist with adapting to changes to their lifestyle;
- acting as the healthcare liaison for the patient and their family;
- liaising with community workers and the voluntary sector.

Currently in Malawi there are four institutions that provide post basic training for nurses.

- Mzuzu University now trains Nurse Tutors to Degree level and is also soon to provide ICU specialist training.
- KCN which does mostly upgrading of nurses from certificate to diploma / degree.
- Malawi College of Health Sciences upgrades nurse diploma level and also trains community nurses, nurse anaesthetist and ophthalmic nursing.
- St John of God trains nurses to degree level in psychiatric nursing.

The intakes and future outputs of these institutions have already been described elsewhere in this document.

Commentary

There is need to ask the Nurses and Midwife Council to define what is meant by nurse specialist. There has been no work done on assessing the needs for different nurse specialists.

A proper career ladder needs to be developed that includes this grade of nurse. While it may seem appropriate to seek to standardise the terminology with standard international terminology, registered nurses in Malawi already perform many of the tasks prescribed to nurse practitioners. The level of autonomous diagnosis and prescribing for a more specialised nurse will be different in Malawi than in Europe.

4.9.3.3 Clinical Officer Specialisation

Clinical officers are the back bone of clinical care in Malawi. Currently specialization takes place in the following categories: Orthopaedics, Anaesthesia, Ophthalmology, Surgery, Dermatology, and Education / Clinical Officer Tutors. Some of these categories are in effect sub-specialists, in that medical assistants and other health professionals are promoted on completion of twelve or 18 months training to a clinical officer grade. Although they have the specialist training they do not have the more broad based clinical training of the newly trained COs.

Originally clinical officer specialist training took place under a medical specialist outside a training establishment. These were funded through proposals to donor agencies such as DFID, WHO, Sight Servers etc. With the advent of SWAP most of these activities have been integrated into existing colleges. Currently orthopaedic, ophthalmic and anaesthesia clinical officers are being trained under Malawi College of Health Sciences. The surgical clinical officer training and tutor training is under Mzuzu University.

The medical specialist gap will take a long time to bridge and in any event the clinical specialist will be needed particularly in the rural areas if medical / paediatric and surgery specialists are trained. The training of clinical officer specialists is less costly and they are easier to retain. There is need to define their role within the clinical team so that specialisation does not result in fragmentation of services. As the numbers of medical specialists increase, the competencies of the specialist clinical officer will also improve.

Developing the specialist Clinical Officer

The training of specialist clinical officers is not directly catered for in the EHRP. This may because they were outside the formal training institutions when this document was being developed. Discussion with the heads of the orthopaedic and anaesthesia schools indicate that although it has been accepted to integrate the schools into College of Health Sciences the process of getting funding from SWAp has been difficult.

The MOH needs to decide in consultation with the professional councils how many different clinical officer specialties there should be. MOH has expressed the concern that if the numbers of subspecialties increase there could be inadequate senior clinical officers, which would affect the overall quality of care. A phased training plan is therefore necessary.

The Medical Council registration of the Clinical Officer specialist should also be clarified. There has been confusion about how to register the Clinical Officer specialist who has a basic nursing or other health allied qualification. In the mean time schools needs to make sure that the student undergoing clinical officer specialisation are indeed clinical officers. Previously intake has included nurses, environment health officers, radiographers and medical assistants. This has made it difficult for them to be registered with the Medical Council upon completion and also promotion within the government system. Standardisation is needed.

Commentary

The lack of a career structure for clinical officers is a serious defect in the HR system. The backbone of clinical care has no means of professional progression except by moving out of clinical care itself. A policy on clinical specialist staffing needs to be formulated.

What are the actually implemented measures to ensure systematic continuous medical education (CME) of clinical staff at all levels of health service delivery?

Medicine is a dynamic field. It is important therefore that medical practitioners are regularly updated with knowledge and skills in order to fulfil their ethical responsibility of ensuring patient safety and at the same time maintaining public confidence in the performance of members of the profession (Medical Council Draft CPD document).

When the EHP was being set up it was realised that there was need to ensure that the actual content of the services was uniform and updated regularly. As part of the resources for setting up the EHP, a **continuous medical education CD** was produced. The contents are fairly comprehensive. It is divided into Support at Community level, Health Centre level and at District and Referral Level. The CD is user friendly and can be adapted and up graded.

The contents of the CD are:

1) Introduction to the essential health package for Malawi
2) Staff management & development
    a) Supervision and Staff management and development
    b) Clinic management
    c) Decentralisation and Planning
    d) Training of Trainers
3) Health and Human Rights
4) Social mobilisation & health education
    a) IEC, BCI and advocacy
5) Intervention areas of the EHP
    a) Child Health
        i) Vaccine preventable diseases – EPI
        ii) IMCI (including CDD, Malaria and ARI)
        iii) Breastfeeding and child nutrition (including growth monitoring)
    b) Reproductive Health
        i) Maternal and neonatal health (including safe motherhood and PMTCT)
        ii) Post abortion care
        iii) Family planning
        iv) STI
    c) Clinical Treatment And Support
        i) HIV/AIDS (including VCT and ARVT)
        ii) TB
        iii) Skin infections
        iv) Eye and ear infections
    d) Communicable Disease Control
        i) Infection prevention
        ii) Malaria prevention and treatment (cf IMCI)
        iii) IDSR, including acute diarrhoeal diseases and cholera
        iv) Schistosomiasis
    e) Common Injuries and Medical Emergencies
        i) Emergency surgery and emergency medicine
    f) Support Services
        i) Monitoring and evaluation (including HMIS)
        ii) Drug procurement, distribution and management
        iii) Essential laboratory services
        iv) PAM
        v) Financial management

Although this training resource has been available since 2004, it does not seem to have been used and in discussion with clinicians the districts have no knowledge of it. Some districts have CME clinical meetings for which they make up their own materials. This resource would be helpful to those who organise these meetings.

Commentary

This useful training material is unused and becoming out of date. A consortium of training institutes should be tasked and funded with maintaining the material, adding to it (the essential drug manual and guidelines would be important additions), assuring quality through proper peer review and distributing it to health institutions countrywide.

4.10 Other Initiatives

The Medical Council is in the process of instituting Continuous Professional Development (CPD) for all cadres that are registered by it. This will be a requisite for renewal of registration in future. This will supplement the CPD that accompany the EHP.

The College of Medicine is also implementing CPD for the district and a pilot is already off the ground. Their system will use satellite communication to deliver the contents to the district. The district can download but will not be able to upload anything and will need a different mode to give feedback.

There is a surgical course supported by CHAM for Clinical Officers which is a good example of quality CPD. The structure and content can be replicated elsewhere.

Commentary

CPD is in its infancy in Malawi and can learn from the experiences of other countries. An expert team of postgraduate and in-service trainers together with representatives of the professional councils should be commissioned to write a policy on how it should be introduced in Malawi to maximise EHP manpower.

4.10.1 Training in Health Management

It is a paradox that efforts to provide an essential package of health care have concentrated on its individual components such as staff, buildings, drugs and health programmes without spending effort putting them all together in a way that works! The decentralisation of management to districts is largely a response to the inability to provide vertical programmes of increasing sophistication effectively. The key to the success of the EHP will be good management at district and sub-district level.

Management training has two strands. On the one hand there should be personal training courses for individuals who wish to be become managers. This needs to be placed in training institutions and provide courses for all types and levels of management – senior and middle level, administrators, accountants, clinical and technical staff. Without intellectual development staff trained to be professionals with special skills will find it difficult to become generic managers and successful leaders.

On the other hand in-service in-the-district training of district management teams and their subordinates is as important as personal training. The value of good management is evident in those districts and commu-

nity hospitals in Malawi with experienced and well trained managers. The key to success lies, therefore, in strengthening district management through training and establishing management systems that work well in Malawi. In this report we are relying on the experience of the strengthening management capacity project run by MSH for the MOH since 2003, and the health reform programme, called the hospital autonomy project, which has also had some successes.

4.10.1.1 Individual training in health management

The MPH course run by the College of Medicine devotes a third of its course to health management. In southern Africa, management must be a major component of any Masters course. Theory is all very well on its own, but putting theory into practice is the key to public health success. The course, started in 2003 has 114 on the course or graduated, of whom a third are MOH staff. The course content is being expanded to include more management modules with academic support through the Scottish Malawi initiative with Queen Margaret's University College, Edinburgh. The objective, originally agreed with the MOH, is to have two DMT and central hospital management members and senior staff involved in public health in the MOH, CHAM with an MPH – requiring 100 graduates in post. It will take twelve years or more of the current level of intake (ten places per year for MOH) to provide the required numbers, assuming staff remain in post.

KCN runs a health management BSc course for its nursing students. MIM runs ad hoc courses. Otherwise no other health management courses are run in Malawi. The two month medical intern management programme has been modernised recently and consists of a two month internship in a district with discrete duties and a range of management competencies to develop.

There is a need for a range of health management courses for other cadres, particularly hospital administrators and hospital accountants. The COM and Mzuzu University are preparing such courses. A special health management course starts at the COM in May.

Commentary

Health management should be the priority training area in the in-service training programme and the $100,000 a year originally earmarked for the MPH course should be re-identified and ring fenced. Additional funds need to be identified for other management courses ($100,000 a year).

4.10.1.2 In-service training within districts

MSH experience

MSH in Malawi started its work as a foreign NGO funded by USAID on 1st April, 2003 ***to reduce child morbidity and mortality and strengthen systems for the delivery of health care*** in eight districts of focus and two central hospitals (i.e. KCH and QECH). Its areas of focus in strengthening management systems included the following:

1. General Management
2. Human Resource Management and Development
3. Health Management Information Systems (HMIS)
4. Drug Management
5. Financial Management

6. Transport Management,
7. Planning and Budgeting as in District Implementation Planning (DIP)
8. Quality Assurance

Before implementation of its activities, MSH conducted a baseline survey to develop a picture of the status of the management systems in the districts and central hospitals under its focus. The aim of the survey was to assess the capacity of the districts to manage the health care delivery system in each district by identifying material, skill and technical needs (i.e. gaps, shortfalls or deficiencies) which were to help in planning, prioritising, and allocating resources for remedial interventions in the districts; and set yardsticks for measuring performance in future.

The survey established clear gaps in the management systems which included the following:

General Management

1. Unavailability of some policy guidelines for the DHMTs in a number of management areas;
2. Inadequate orientation of DHMTs to their roles and responsibilities as DHMT members;
3. Irregular meetings of the DHMTs (and the Extended DHMTs), and scanty records of minutes of those meetings that ever take place;
4. Irregular supervisory and clinical visits to health facilities;
5. No culture among DHMT members and coordinators of sharing important management documents and using data for decision making.

Human Resource Management

1. Critical shortage of staff (especially medical staff);
2. Inadequate record keeping and management system, many records were out of date and in some instances the system collapsed (no records being kept at all);
3. No equipment for HR and other records, e.g. no files and filling cabinets or they were broken;
4. Monthly staff returns not submitted on a regular basis.

Health Management Information System (HMIS)

1. Lack of training in HMIS data collection and dissemination;
2. Lack of appreciation by staff involved in HMIS in the importance of having quality data for use at all levels of the health system.
3. Little and inadequate supervision and follow-up on HMIS data collection and dissemination system

Drug Management

1. Lack of training in drug management and distribution;
2. Lack of computer skills
3. Irregular drug supply due to an unclear system;
4. Ineffective LMIS reporting

Financial Management and Accounting

1. The DHMTs lacked financial and other management skills;

2. Lack of computer skills among accounting staff
3. General laxity in observance of government accounting procedures
4. Irregular submission of monthly or periodic returns and reports

Transport Management and Communication

1. There was generally an ineffective transport management system, i.e. no policy guidelines to help regulate the transport management and fleet management systems;
2. Inadequate use of transport management tools (i.e. log books, trip authority forms, vehicle returns, ambulance registers, vehicle inspection reports, vehicle inventories, etc.)
3. Inadequate communication and other equipment in health centres and ambulances

Planning and Budgeting as in District Implementation Planning

1. There were no guidelines for planning and budgeting at district (and central) hospital level(s);
2. There was little or no deliberate systematic planning, budgeting, budget reviews and monitoring implementation;
3. Lack of participation of NGOs and other stakeholders in planning of DIPs (and CHIPs/JIPs) jointly with DHMTs (CHMTs), and hence no joint implementation of plans and no joint DIP reviews (CHIP/JIP Reviews)(also see report on Hospital Reform Project);
4. Lack of training staff involved in planning and budgeting process.

Quality Assurance

Need for instituting quality assurance activities from scratch, (e.g. there were no infection prevention activities in place).

Efforts by MSH to Strengthening Management Systems

A full report of the project is available. A summary of the activities follows:

Activity	Examples
Improvement of general management	District transport policy formulated
	Quality assurance policy implemented
	Supervision scheme introduced
	HMIS used for decision making
Human resource management	Updated and use of HR records
HMIS	Improve data quality and timeliness
	Analysing and using the data
	Competition for best district and health centre
Drug management	Improve inventory management
	Functional drugs and therapeutic committees
Financial management	Assessment of financial skills
	Computer skills and accounting training
Transport management	District transport policy implemented
Planning and budgeting	DIP guidelines simplified
	Supported Service Level Agreements with CHAM institutions
	Planning based on local needs
	Implementing DIP
Quality assurance	Accredit district hospitals on infection prevention

Experience of other district management training initiatives

The lack of sustainability of previous management initiatives (the previous USAID projects are good examples) offers three lessons:

1. Management projects which are not linked to personal intellectual development will be treated with little enthusiasm. Staff moves on, continuity is lost, and good management practice laps. The health sector needs a group of managers who pick up good practice wherever they are posted.
2. Management projects not housed in local training institutions fail to build management trainer and training capacity.
3. Vertical training from HQ and associated donor funded programmes fail to address the crucial district integration issues. In addition HQ staff are rarely good management trainers.

Commentary

1. Vertical training programmes should be treated with great suspicion. All training at district level should be controlled (following needs assessment and priorities chosen in the training part of the DIP) by districts. Funds currently used for vertical programmes should be allocated to districts.
2. The success of the MSH project needs to be rolled out and continued. The failure of MSH to nest within a Malawian training establish4ment makes sustainability problematic. However, the Health Sciences Faculty in Mzuzu University and the Department of Community Health at the College of Medicine, are combining to offer a follow-on training package to role out the successful parts of the training provided by MSH to other districts with associated mentorship. It will need funding but being Malawi based will be much cheaper than the existing project. But will USAID be interested in funding local institutions?

4.10.1.3 Hospital management training initiatives

The Hospital Autonomy (now called the Hospital Reform) project has run alongside the MSH district initiative. An excellent detailed report describes the issues encountered and the initiatives introduced[2]. The thrust of the project was developing management systems for large hospitals and seeking autonomy from central HQ – both identified as necessary in a base line survey. A concerted effort over a number of years will be needed to see these systems used and management improved. Lack of delegation including HR management limits any likely success.

4.10.1.4 Supervision

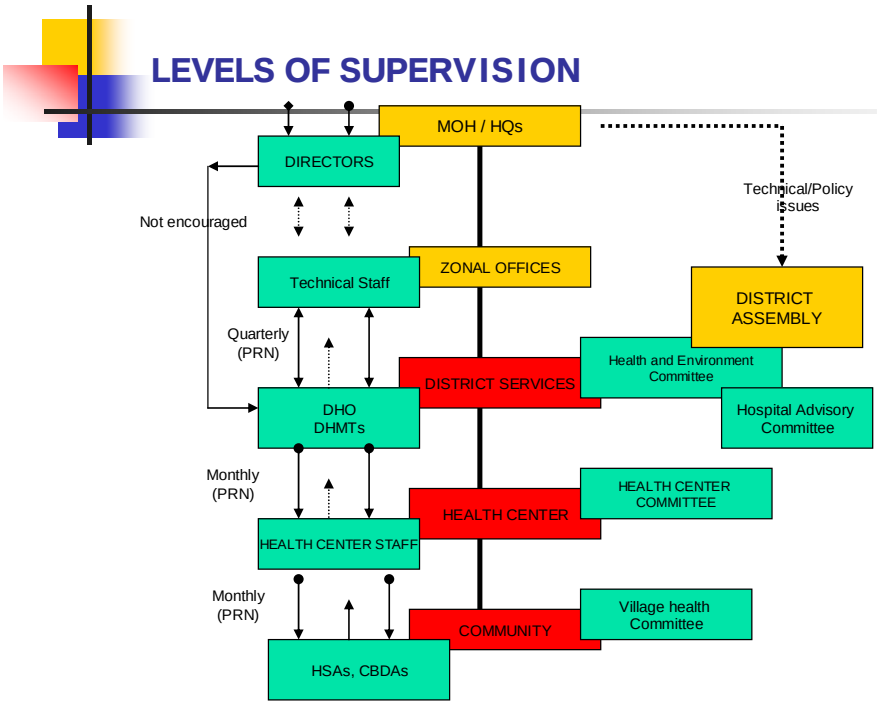
The responsible directorates for supervision in the MOH are Planning, Nursing and Quality Assurance. The MOH also works with development partners that have expertise in management systems such as MSH and GTZ on supervision issues. For a long time, the Ministry has had national, regional and district level supervision systems. But in the 90's, a decentralization with focus on district management came in and regional structures were abolished and supervision was direct between national and districts.

[2] L.C. Nkosi. MSH/HPSA Hospital Reform Program. April 2007 – Page 140.

At the central/national level each of the directors was assigned districts that he/she was responsible for supervision and there were also some national programmes that conducted their supervision vertically and linked directly with programme officers at district level - at times bypassing the management team. This system did not work well too and the Ministry in 2004/2005 begun to re-explore the use of zonal offices.

According to Sikosana, (2004) the MOH values and defines supervision as a process of guiding, helping, training and encouraging staff to improve their performance in order to provide high quality and acceptable health services. The belief is that in order for people to perform well, they must know what they are supposed to do and how they are expected to perform. The MOH has identified levels of supervision and all structures involved as shown in Figure 10.

Figure 10 -- Levels of supervision



The policies which address supervision

There is no specific national policy document on supervision but there is a stated intention to develop a national supervision policy. There is an integrated checklist developed by the MOH (piloted) and several programme based checklists for most programmes, some of these jointly prepared with MSH and GTZ or specific programmes partners such as UNICEF, WHO etc.

Supervision processes include: baseline assessment, mentoring, supporting, feedback, reporting, monitoring.

The MOH has also provided guidance on who can be a supervisor:

- Person responsible for the performance of clinical/non-clinical staff.
- On-site supervisor (as part of everyday activities).

- Someone who makes periodic supervision visits.
- other categories of individuals:
  - clinicians, public health workers or any other health worker.
  - persons who can either have the word “supervisor” in their titles or called “manager”, “in-charge”, or even something other than “supervisor”.
  - either could have received some formal training in supervision or have had no such training.

The responsibilities for a supervisor have been identified by the MOH as:

- Identify standards of good performance and communicate them to staff.
- Work with staff to assess their performance compared to these standards and existing policies.
- Provide feed back to staff about their performance.
- Work with staff and other stakeholders to identify appropriate interventions that will improve performance.
- Help mobilise resources necessary to make the above possible.

Particular skills of a supervisor have also been delineated:

- Technical competence – in health or health related field.
- Team building skills.
- A motivator who is also able to inspire staff.
- Ability to conduct meetings and discussions.
- Ability to identify strengths in staff and build on positive aspects.
- Ability to provide constructive, timely and interactive feed back.

Guiding Principles for Supervision

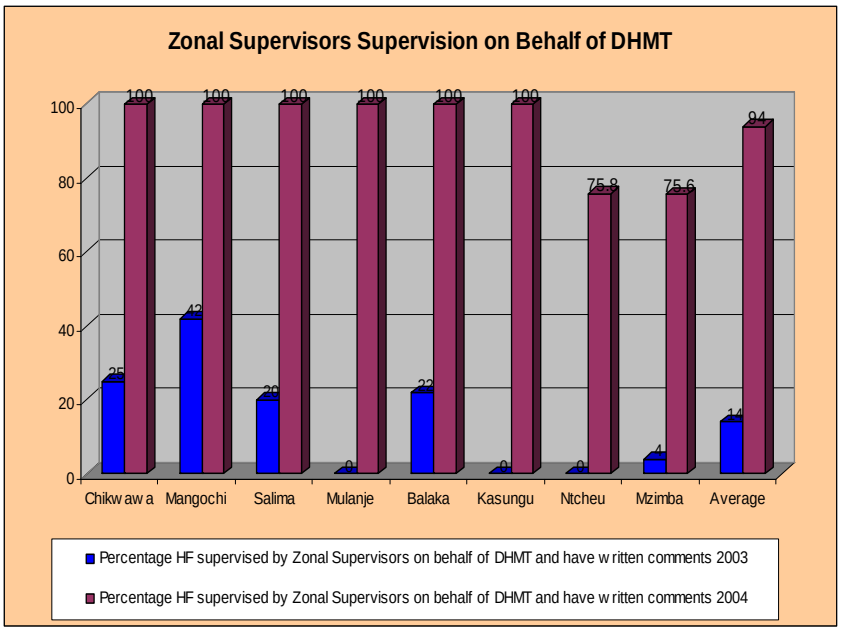
1. Supervision must be part and parcel of each and every manager or in-charge.
2. Supervision must be undertaken in an integrated, uniform and standard manner based on an agreed format and guidelines – the checklist.
3. External supervision visits must be based on a mutually agreed schedule, prepared well in advance of the visits in collaboration with sites to be visited.
4. The MOH discourages supervision based on vertical programs – the checklist should make it possible for every technically competent health manager to undertake complete and effective supervision of EHP delivery.
5. Supervision visits must be complemented by in depth program reviews.
6. Each visit must have a though and complete feedback report which must be deposited and discussed with the sites visited, the Zonal Offices and District Assemblies – as well as being acted on.

District supervision of health centres

In the last three years, MSH has worked with DHMTs and district program coordinators to identify problems with the supervisory approaches they were using and developed an integrated supervision system. MSH stared working with eight districts in April 2003, by March 2004 after baseline assessments were conducted Districts reported that supervision has traditionally been carried out by each of the many district program coordinators (or by the DHO when visiting health centres to provide clinical care). Because of the logistical and time commitments involved, such supervision was infrequent at any given health centre. It was reported that such supervision was often unstructured and provided health centre staff with only limited feedback. After consultation between DHMTs and MSH, the eight districts (Balaka, Chikwawa, Kasungu, Mangochi, Mulanje, Mzimba, Ntcheu, and Salima) agreed to introduce "integrated zonal supervision" whereby a single district staff would be responsible for visiting each of a subset of health centres (e.g. five health centres per supervisor) once each month to supervise using a set of integrated supervisory checklists. The checklists (a "red flag list", a "regular review list" and six or more specialized instruments) were adapted from instruments originally developed for the MSH-supported Equity Project in South Africa. Three new checklists were developed for malaria, nutrition and skin conditions which were needed in Malawi as identified by the DHMTs and programme coordinators. All eight districts used this same model set of checklists for a trial period of 6 months before reviewing and further revising the checklists and the approach.

Surveys conducted in October 2003 and October 2004 found that the percent of health centres reporting documented supervision in the last three months had increased from less than 25% (ranging from 0-22% to 75% or greater in each of the eight districts. District staff felt that the approach would likely permit more regular supervisory visits while reducing transport requirements compared to supervision by each program coordinator.

Figure 11 -- Zonal Supervisor visits on behalf of DMTs



In addition the system was found to be working well because there was quality improvements occurring in various areas of health delivery services and the supervisory teams were taking responsibility for resolving issues in a timely manner. The supervisors also explained that because of the increase interaction with DHMT team work was instituted between DHMT/PC/Health areas supervisors. They also found that reports and feedbacks were being given to DHMT/PC/Health facilities and the team checked their own progress against indicators during such review session, which was not the case during the previous system. There was also community involvement in planning and decision making which the community appreciated.

In summary the positive features of the system are:

- Follow-up action taken on issues
- Improved coverage in and quality of supervision
- Improve human resource utilization
- Improved information sharing
- Improved response to issues requiring immediate action
- Provider relief and feeling of being supported

MSH has assisted national health officials to develop a model integrated supervisory checklist for use by Zone Supervisors. The MOH Planning Unit has indicated that they would introduce the integrated supervisory approach to the future zonal offices and to each district in the country and this has been initiated. MSH has shown that refocusing the attention to the Zones (i.e. in Drug Management {S-E Zone, and C-E Zone}, HMIS {S-E Zone}) appears to yield very positive results. It is showing to be a good way of providing (TA) especially for the long term.

Commentary

The supervision check list and other approaches have ensured that supervision is alive. The key ingredient to adding value to the health service is the use of a facilitating mode of supervision rather then an inspectorial one. Targeted support to the zonal level, as shown by the MSH experience, may improve quality and efficiency in health care provision and thus sustainability of the SWAp POW objectives

Box 1 -- Change management and leadership skills

Leadership is an important aspect for the development and survival of any organization including the Ministry of Health. Leadership is important in making sure that functions such as scanning, focusing, inspiration, mobilization/alignment of resources take place in a manner which allows the organization to achieve its goals and mission. The other aspect of the leadership function is the management function which makes sure that the jobs get done and this involves planning (operational and strategic), organizing, staffing, recruitment etc (including implementing) budgeting and monitoring and evaluation.

Examining the HR documents and POW currently guiding the Ministry in its RH requirements, one key observation is a lack of emphasis on leadership development. The HR framework does not address issues of leadership preparation. The POW has developed its programmes based on the EHP which has eleven intervention areas (all clinical) and a support system which covers elements that have management aspect but no leadership component. The areas mentioned include supervision and staff management and development, clinic management, decentralisation and planning, training of trainers, health & human rights, support services- drug management (procurement, distribution, and management. There is also a section dealing with essential laboratory services, PAM and Financial management.

The Ministry of Health has professionals being prepared from the training institutions as a response to the HR and POW requirements and the College of Nursing, the College of Medicine, CHAM etc, and these training institutions focus programmes for the beginning professional entry level requirements. You will notice that the nursing programmes have traditionally included management courses in their curricula and also run a post-graduate programme with some students majoring in management. The College of Medicine has traditionally prepared clinicians with substantial community health training (unlike medical courses elsewhere), and have always included some (but perhaps not enough) management content in the undergraduate course. CHAM and COHS prepare technicians and clinician level graduates without management skills.

The College of Medicine currently runs a Masters programme in Public Health which is an effort at preparation of health professional at leadership level as the programme has management courses and it is not clear from the available documentation if SWAp continues to support that program. CHAM sends some of its staff to the MPH course with support from CORDAID thereby preparing a few of its staff for management and leadership roles.

The Ministry of Health like any other public sector organization has an opportunity to send staff to Malawi Institute of Management for management courses and it also has sent individuals abroad for additional preparation.

There are several NGO s in the country that support the MOH with capacity building and strengthening but most of these focus on clinical skills. The exception to the rule is Management Sciences for Health (MSH) which has been instrumental in leadership development in eight districts by empowering district management team members, supervisors and programme managers with management skills. The areas covered by MSH have included: planning, budgeting, health management information systems, drug management, supervision, quality assurance, transport management, financial management, monitoring and evaluation skills etc. The outputs from such programmes are covered else where in this paper. In addition MSH through their Management and Leadership programme (in Boston) offers a Diploma Course in leadership and in 2004/5 included Malawi in this Virtual Leadership course and a group of 20 have graduated from that course. In 2007 this course is to be run as a regional course in ECSA and some training institutions have been included such as Mzuzu University (six faculty members have enrolled).

During the period that the SWAP programme has been in place the Ministry of Health has gone through a lot of change and these have included the decentralization system in government, structural changes in the Ministry itself, staffing changes at central MOH as well as proposals for hospital reforms. All these changes require appropriate leadership to facilitate the change process while not losing focus of the goal and mission of the Ministry of Health.

4.10.1.5 The zonal support offices

Five zonal health support offices have been established and staffed (with four functional In South East, South West, Central East, Central West Zone (vacant) and North). The role of zonal offices is to provide technical, management and administrative support and to coordinate the activities of a cluster of up to seven districts in a zone in the most effective and efficient manner possible and to facilitate the transition to devolution.

Specific objectives are:

- to provide policy guidance and technical support to the districts
- to facilitate the integration of health services in line with the EHP and SWAp POW
- to facilitate inter-district collaboration and networking
- to facilitate central MOH liaison with stakeholders in health at district level
- to facilitate access to specialist support from the central MOH or other appropriate agencies as and when required
- to provide and/or coordinate in-service training for district staff
- to facilitate and encourage central hospital support to the districts
- to facilitate and support the mutual learning processes being developed for DHMTs and District Assemblies

Functions of the zonal health support office are:

- Providing front-line technical support in health services management and delivery to the districts and to facilitate a more integrated approach to disease prevention and control, health care delivery and the implementation of the EHP POW.
- Supporting districts in terms of administrative and financial management in line with the policies of the government.
- Coordinating curative, nursing and preventive health services from a professional and technical perspective within the zone.
- Providing technical guidance for comprehensive health planning, implementation and monitoring & evaluation.
- Analysing shortfalls in technical and administrative services at district level and supporting their resolution.
- Coordinating the HIV/AIDS health sector response within the zone.
- Providing managerial and technical guidance to District Assemblies in managing devolved health service delivery.
- Ensuring effective and timely data collection, aggregation and analysis at local level for informed decision-making and planning in line with the HMIS policy.
- Monitoring equity in resource allocation and efficiency in resource utilisation at district level.
- Ensuring national coherence in the provision of quality health services and programmes across the districts and adherence to national policies.
- Developing a zonal policy on district supervision which should stipulates:
  - the structure of the district supervisory system
  - the regularity and duration of supervisory visits
  - the activities and components of a supervisory visit and the responsibilities of central

Box 2 -- Strengthening or slimming Zonal Health Supervisory Offices in the decentralizing process?

Under the current decentralization initiative, questions are being asked whether it was, and indeed still is, prudent and in line with current Government Decentralization Policy (1998) to strengthen the Zonal Health Supervisory Offices (ZHSO) after the abolition of the Regional Health Offices. The Functional Review Report on Assemblies queries the proposition to Government by Ministry of Health, in its efforts to implement an effective and efficient health delivery system in Malawi, to create an '…intermediate level organization…which will provide technical and administrative support to Districts' (Ministry of Health, A Report on the Creation of the SWAp Coordinating Unit p1). The Review Report says this is in sharp contrast with the spirit of decentralization which requires that the centre relinquishes authority to District Assemblies. The Review Report states that District Assemblies, not District Hospitals or District Health Offices, as independent entities will approach the Ministry of Health for guidance should there be problems relating to health service delivery in any district and as such there is no need to create parallel central government structures at zone level. It strongly recommends that the Ministry of Health (just as other ministries would do) will continue to provide technical support to the District Hospital or the District Health Office through the Directorate of Health and Social Services (for of ministries through their respective directorates) in the District Assembly (DHRM&D, February, 2004, p19).

To justify this, the decentralization process created directorates at District Assembly level in an organization structure that was supposed to render obsolete any intermediate technical, administrative and supervisory structures (regional or otherwise) as follows: Directorate of Planning and Development; Public Works Directorate; Directorate of Health and Social Services; Directorate of Education, Youth and Sports; Directorate of Agriculture, Environmental Affairs and Natural Resources; Directorate of Commerce and Industry; Directorate of Finance; Directorate of Administration; and Internal Audit Directorate.

The proposed local government institutional set up implies the transfer of real decision making powers and authority to local jurisdiction with clear geographical boundaries, and with a legal status and autonomous personnel. The Decentralization Policy initiative therefore calls for devolving administration and political authority to the district level; integrating government agencies at the district and local levels into one administrative unit, through the process of institutional integration, human resource absorption, composite budgeting and provision of funds for decentralized services; diverting the centre of implementation responsibilities and transferring these to districts; and assigning functions and responsibilities to various levels of Government. The last statement, therefore, means the policy does not disqualify outright the need for intermediary supervisory structures to ensure 'technical' efficiency and effectiveness of sector institutions at district and lower levels. Instead, the Policy advocates for 'devolution' rather than 'de-concentration' of functions and decision-making which implies 'spreading' of central government functions and staff into the field. In the absence of the Regional Health Offices, Ministry of Health tried to provide such supervision from the centre, but without success.

It is therefore strongly recommended that the Zonal Health Supervisory Offices be strengthened through building the capacity of the staff, institutional structure and functions (including clarification of roles and responsibilities and streamlining its goals, objectives and targets against which their performance would be measured) in order to carry out its supervisory and administrative functions efficiently and effectively with a proper balance between technical and administrative staff. After all, the Ministry of Health was not alone in proposing this intermediary arrangement which did indicate that there were indeed gaps left by the dissolution of intermediary technical and administrative support and supervisory structures. Ministry of Agriculture still clung to its Agricultural Development Divisions (ADDs), Forestry still has their Regional Forestry Offices, Ministry of Education has created Divisional Education Offices, the Malawi Police Service has maintained Divisional Offices, etc, all of which equally act as intermediary structure between the centre and the district and lower levels in the periphery.

Despite the strong pull the decentralization process tends to exert on existing Government Institutions to decentralize completely, there appears to be lack of readiness that this can be achieved over short period of time. The pace at which the phased approach to decentralization is going, and the lack of readiness to take on the challenge of added responsibilities that come with full decentralization by the District Assemblies, seem to justify the need to strengthen the ZHSOs, whose effectiveness is already evident.

Commentary

The zonal support offices are bedding down and there have been some positive experiences. The challenge for zonal staff is to support district activity without diverting district staff from the job in hand. There is also the cost in terms of transferring experienced staff from poorly staffed districts to zones. Work needs to be done to help zonal support offices be lean and mean with costs kept to a minimum.

4.11 HRH Attraction and Retention Mechanisms

4.11.1 Salary top-ups

The six-year US$273 million Emergency Human Resource Programme (EHRP) is currently being implemented in partnership with the Health Services Commission, increase retention and attraction. MOH introduced a 52% salary top-up in April, 2005 supported by DFID. This initially applied to eleven priority health cadres only. There are however plans to include HSAs to be the 12th cadre with funding under the global fund, round five. The number of staff receiving this 52% is steadily increasing; 5,345 in 2005 to 5,795 in 2006. This number however is lower than the 700 projected increase in year one that was the EHRP target.

Table 30 -- GOM and CHAM Workers receiving 52% Top-up

Month	No. of GoM Employees on Top-ups	Cost of GoM Salary Top-ups	No. of CHAM Employees on Top-ups	Cost of CHAM Salaries Employees Top-ups	Total Cost of Salary Top-ups
April 2005	3,763	31,254,932	1582	13,600,015	44,854,947
January 2006	4,031	34,938,225	1764	14,556,061	49,494,286
January 2007			1796	17,544,914	

Source: MoH 2006 and CHAM 2007

Notice that the DFID funding resulted in a 40% increase in net pay and for some cadres e.g. the TO (K) and STOs (J) in even less take home pay for them compared to prior net pay in November 2005. The increase was partially neutralised by the government's decision to begin taxing allowances, which they had not done previously. The increase in the take home pay ranges from 25 to 41% in MOH and CHAM facilities.

As part of the implementation of its Medium Term Pay policy, GOM implemented a civil service wide pay rise in Feb 2006 backdated to December 2005 which establishes a separate pay scale for health workers incorporating a separate eighteen-grade salary structure for government health service and increases of between 60-70% across the board, through revised and consolidated gross pay inclusive of all special, professional and top-up allowances. Basic pay increased by 20-70% in most grades. Under this new pay scale the 52% top up was rolled into basic gross pay for the priority eleven cadres.

Senior physicians have seen the most dramatic increases in salaries. The gross P4 monthly salary has risen from US$ 243 to US$ 1,600. However, salaries at most grades have risen in the order of 40–60 percent. Mid-level nurse gross monthly salaries have risen from USD 108 to USD 190.

4.11.2 Impact on availability of HRH

Despite an overall increase in staff numbers, loses as indicated by deletions from the MOH payroll remain high and show a slight increase (346 in 2004 to 491 in 2005). Nearly 45% of these are due to death, 22% to resignations and a high number are being interdicted, suspended or dismissed. Data for Financial Year 2003-04 show 187 joined and 20 left, as compared to 288 joined and 52 left CHAM in FY 2005–06.

The Nurses and Midwives Council register indicates no decline in the number of registered nurses validated in readiness to move abroad. This suggests that the 52% has proven insufficient to affect nurse migration or it may be too early to say.

17 junior doctors resigned from the MOH between July and November 2005. Four moved to CHAM which offers a Cord-Aid funded top up but it is not clear where the rest went. The SWAp Human Resource Technical Working Group established a task force to explore further the issue of loss of junior doctors and suggest an appropriate response. That task force has presented their preliminary report which contains various options for the retention and attraction of doctors.

Medical Council figures show from 12 to 19 medical doctors emigrating every year since 2002. Of these just over half planned to work in their destination stations. The others went for further training and in theory should return.

Table 31 -- Health Workers per 100,000 Population

CADRE	BOTSWANA	SOUTH AFRICA	TANZANIA	MALAWI
Physicians	28.7	25.1	4.1	1.6
Nurses	241.0	140.0	85.2	28.6

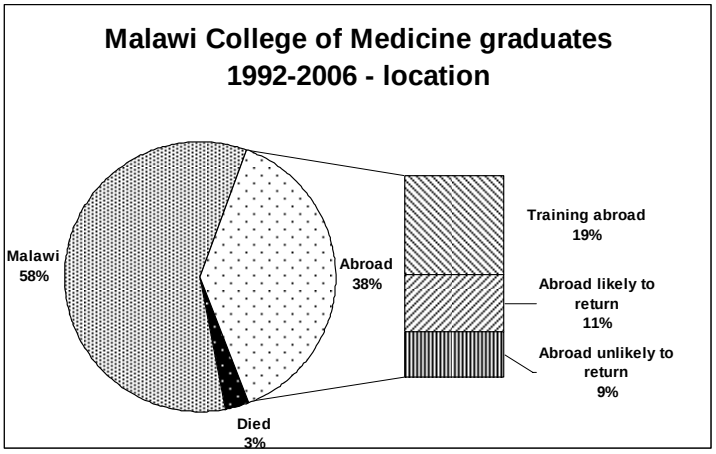
Source:Akerman, 2006

As Table 30 demonstrates, comparing Malawi to some of its neighbours, the HRH concerns in Malawi exceed those of its neighbours. Yet the reality is that the remuneration gap for skilled medical staff between say, the UK and Malawi is so great, that these increases are likely to do little to reduce the incentives for staff to migrate. In the UK a newly qualified nurse earns £19,166 (USD 33, 290), a new junior physician £30,433 (USD 52,871), and a new senior physician £69,991 (USD 121,556). For these newly qualified nurses, junior doctors and senior physicians this is still equivalent to around ten or more the equivalent in Malawi. Hence it is hardly surprising that the exodus continues. However, to be fair, the primary objective of the SWAp-funded salary top-up is not to compete with international labour markets, but to lift Malawi's health workers out of poverty, to ensure that workers receive at least a "satisfying level of income", and to discourage workers from leaving the health profession within Malawi.

Yes the salaries have been increased for HRH but the challenge is whether the increase is sufficient to motivate or retain staff. The impact of the 52% top-up varies between different cadres. The effect for graduates is significant resulting in more job attraction; this is still not true for doctors. Secondly, the salaries before the top-up were already low compared to the cost of living which made the 52% plus the tax not very much felt in the long run. Thirdly the 52% top-up was applied broadly across the targeted cadres without any differentiation between areas (rural and urban).

Recent data about the location of graduates from the College of Medicine are revealing. Although 38% are abroad the majority are in training and only between 10-20% will probably stay there (Figure 12). This is a very different pattern compared to other African countries and before Malawi had its own College.

Figure 12 -- Location of the 255 Malawi COM graduates



Source: Zijlstra E, Broadhead R. COM Dissemination Conference 2006.

The vacancy rates still remain very high and the issue of inadequate numbers of HRH continues to be the greatest challenge for the health sector. Of the 28,000 posts, only 17,000 (MOH and CHAM) are filled representing an overall 39% vacancy rate. The training institutions are also not yet producing enough numbers to fill the gaps and also to replace the losses from the sector.

4.11.3 Locums

The human resource numbers will take time to improve and for the foreseeable future there will be need to get extra hours from the current numbers. Within the MOH hospitals there has been an attempt to do this by introducing locums. This allows use of an off duty staff or a staff on holiday to cover for shortages. This had initially shown some promise but due to lack of proper structures and policy guidelines is now breaking down and the resulting effects threaten to be worse than before it was introduced. The following problems have been identified from discussion with staff on the ground:

- Staff are refusing to work on weekends unless they be paid locum money
- The cost of the locum is unregulated and adversely affects the ORT budget
- There is no rationale or review system of the locum rates that have been set
- There is no differentiation of the different cadres
- The counting of hours has allowed some health care workers to opt out of locum duties and take more time off. For example anaesthetic Clinical Officers at KCH have managed to clock their weekly hours in just 3 days and some have opted to go and do locums in the private thereby interrupting the service.

4.11.3.1 Clinicians and Nurses.

Nurses usually work on a shift basis of 40-hours per week. Additional hours for night duty are usually given as compensatory time off. Extra nursing time is usually purchased through a locum system and nurses in the public sector are usually entitled to participate in such systems. Other overtime/call systems are usually arranged for allied health professions depending on staffing levels and service demands. The scheme can help support the overworked health centre staff.

Clinicians in the public sector seldom work a 40-hour week. The vast majority of them provide patient care work 60 to 80 hours per week on site. From this it is clear that to pay locum fees to clinicians the same way as nurses would take up a considerable amount of the ORT. There is need to find another way to compensate clinicians that is sustainable and fair.

4.11.3.2 Recommendation:

- Overtime should be remunerated a 1.5 times the basic salary rate during the week and at 2 times the basic rate on Sundays (subject to national labour law).
- The current locum payment based on hours worked would not apply to clinicians. For them:-
  - There is a need to place a ceiling on the number of extra hours that can be worked per week so a package is usually negotiated with clinicians (both SA and Namibia use a 16 hour ceiling). Overtime allowance calculated on this basis amounts to an additional allowance of at least 60% of basic salary
  - Overtime is paid for on site work and not for "call".
  - If medical administrators or heads of department want to participate in overtime they must be part of on site service rota.
- It must be emphasised that only doctors, medical assistants and clinical officers participate in this type of overtime allowance.
- The scheme will be based on the total 24 hr clinical cover needed in district hospitals and other major facilities.
- A task force or a consultancy should be set up to work out how this could be implemented.

4.11.4 Housing and Other Infrastructures

Preparation for construction and upgrading of staff housing has started. According to the Deputy Director of Technical Support Services, an estimated 1200 units are to be constructed throughout the country. Architectural drawings have been done by the firm that won the contract and funds released from DFID.

From June 2005 government stopped giving housing allowance when they consolidated the salaries. But it was clear that the doctors could not afford housing so MOH requested treasury to make an exception until institutional houses are built. So currently for hands-on doctors, housing is paid for.

The September 2006 Swap Review indicated that most of the institutions have carried out major renovations and maintenance work. Kasungu District has renovated a sewage works that had been neglected for the past 20 years thereby improving the staff working conditions.

A comprehensive Capital Improvement Programme as part of the POW under the SWAp is in place for Malawi health training institutions, including the College of Medicine, the College of Health Sciences, Kamuzu College of Nursing and CHAM institutions which will result in increased pre-service training output and capacity from an anticipated annual enrolment total of 2,380 in 2005, rising incrementally to 3,750 by 2010. As part of this programme but with direct funding from the Norwegian Government through the NCA, CHAM colleges have from December, 2005

built 24 tutor houses and hostels with a total student capacity of 120 beds. The CHAM target is to build 65 tutor houses and increase student hostel capacity from 763 to 1480 beds by 2010.

From the SWAp review reports and interviews done with some DHOs and in CHAM, inadequate and poor accommodation stills remains one of the biggest challenges in most health facilities in staff retention and attraction.

With the consolidation of allowances including housing allowances into the basic salary and the subsequent taxation of the same, the net pay is not adequate to afford the current market rates for houses for the majority health workers not housed in institutional houses. Current salaries cannot afford the cost of housing particularly in urban areas resulting in staff residing in areas very far off from the health facilities. This calls for expedition of the housing program under the capital investment plan of the POW.

Commentary

It is evident that immediate attention must be paid to improve and increase staff accommodation in the health facilities coupled with provision of essential amenities such as electricity and water.

4.11.5 Incentives for Hard to Staff Areas

A crude survey conducted by MOH (popularly known as the quick and dirty survey) identified 135 health centres across all 27 district considered “hard to staff”. These exclude CHAM health centres. This survey failed to go into detail on what were the main issues that would attract staff to work in the rural areas. The main issues identified included:

- Poor transport and communication
- Lack of electricity to staff housing
- Lack of pumped water to staff housing
- Poor maintenance
- Lack of health centre staff appreciation and acknowledgement of their long hours compared to their district colleagues
- Poor access to in service training and lack of cover meant that they could not leave the duty station
- Quality education available to their children
- Feeling of isolation (efforts by one DHO to undertake regular supervisory visits were appreciated by staff).

4.11.6 Career Planning at Different Levels

Through the functional review for district and central hospitals, staff establishment and career progressions have been proposed to start implementation in the next financial year starting in July, 2007. The Directorate of Clinical Services has drafted revised career structures for Clinical Officers and Medical Doctors which have been presented to management of MOH and incorporated in the functional review awaiting approval by DHRMD. There are some specialized cadres such as dental, ophthalmic and physiotherapists whose career structure is not yet in place.

The functional review also incorporates registrar posts at all the central hospitals which are special training posts for medical specialist. This is both to have a structured postgraduate training and anticipate specialist medical training within Malawi.

The Nursing Directorate has also got a draft career structure for nurses which proposes nurses to go up to P4 grade which has been presented to MOH management.

The Hospital Autonomy Programme provided as part of a Human Resource Systems and Procedure Manual an attempt to give a career path for clinicians.

There is however poor career planning for nurses who go for upgrading into the nursing education field. While their posts as nurse educators exist in CHAM training institutions where they are seconded, there is no upwards career progression in the field of nursing education in the MOH. This means that those nurse educators who would like to take up nursing education as a career risk vegetating on the same grade without promotion no matter how good they are. There are currently examples of some tutors who have not been promoted for years because they choose to remain in the nursing education field rather than go into management positions in the hospitals.

4.11.7 Emergency Recruitment Plans and Programmes

MOH has developed a two year recruitment plan, identifying 1659 priority vacancies for 2005/06 and 2347 for 2006/07. 570 staff were recruited between July and December 2005. A further 600 staff posts have been approved by DHRMD and MOF.

A 'Tracer Study' conducted by the Health Service Commission has located over 460 nurses, 160 Clinical Officers and 112 Medical Assistants who have retired or resigned from government service. Out of these, 600 indicated their willingness to return to government service (HSC Report, 2006). The recruitment gala in 2006 only recruited 465 and only less than 300 have actually reported for service. Some of these people are too old to move from where they live and for others the package is not attractive enough or conditions of service not conducive.

Expatriate Staff are being recruited through UNV and VSO. By the end of October 2006 there were 51 doctors and 15 nurse tutors recruited and placed. 15 CIM doctors were also expected.

4.11.8 Others

4.11.8.1 Promotions

1000 staff were internally promoted in 2005. Many nurses were promoted through challenge exams and other substantive promotions. But for SRNs, promotion means going into a management position which has resulted in some central hospitals having too many matrons. There is need to open up the career ladder lines to clinical and nursing specialisation where nurses and clinicians can be promoted to higher grades but still continue bedside care.

Commentary

It seems the current functional review has not comprehensively taken clinical specialisation into consideration except for a few cadres such as doctors.

4.11.8.2 The Policy Environment and HR Systems

The public sector and health sector policy context in Malawi is both diverse and dynamic. In July 2005 the MOH formally launched the health sector wide approach (SWAp), thus facilitating the streamlining of the way in which the 'business of health' is now conducted. The SWAp is essentially a systems-based approach, requiring various key integrated components to be in place, which ensure its effectiveness. Thus, without an appropriate number, quality and mix of competent and motivated health workers on the ground, supported by responsive HRH systems, the effectiveness and impact of the Malawi health SWAp will be severely constrained.

The HRM section in the MOH which has been lacking capacity, is now fully fledged and ready to tackle and address HR issues. A baseline survey with the HMIS is underway to build an HR data base system to address HR issues. Right now with the current manual system, it is not possible to establish the actual numbers of staff in MOH. A final draft Strategic HRH framework document has been produced which has now looked at a wider scope of HRH that includes support staff as part of HRH in the health sector.

Despite all these progressive initiatives by MOH, the HR systems still remain not user friendly. The Public Civil Service bureaucratic procedures are still a bottle neck, for example, to get clearance to recruit new staff takes a long time as this is still the mandate of the Public Civil Service Commission. Where recruitment has occurred, there are problems of delayed payment of salaries for new recruits because it can sometimes take as long as 3-12 months to be put on the payroll, thereby demotivating staff.

Although the Health Services Commission was established to set conditions of service including salaries, as yet it falls short of its full intended mandate. There is no linkage between the people who hire, who supervise and those who reward. Most critical in the MOH is the absence of a policy on performance management except for contract staff. The closed civil service appraisal system was abolished some years ago and a new appraisal system has not replaced the phased out closed appraisal system. The lack of a performance management system results in lack of ownership of results and motivation to perform to the optimum levels. People who are high performers are not properly recognised, no proper feedback mechanisms exist and often non-performers get undeserved rewards such as promotions demoralising the high performers.

The HR management information systems have not been computerized up to now which makes manual work tiresome and unreliable. It is hoped that once the HR HMIS study baseline is completed, the data will help set a base on which to build a computerized system thereby improve efficiency and reliability of HR data.

4.11.8.3 Predictable funding for both drugs and ORT

Predictable funding for both drugs and ORT have resulted in improved health workers morale and confidence in their work and a cleaner work-

ing environment which gives workers some sense of security. DHOs are able to sustain the locum system which is an incentive for health workers to put in more work and earn some extra income. On the downside of the locum system, there is need to evaluate the productivity and impact of the locum hours on the quality of service delivery and on individual well being. It should be appreciated that everyone needs a rest and that one is bound to make more mistakes when tired or burnt out no matter how good is the money. Currently nurses get K600 for day duty, K700 for night duty and K800 – K900 during weekends as locum. The question is whether this is enough considering the cost to the employee.

4.11.9 Continuing Education and Career Development

A training plan for June 2006 to July 2007 is in place at the MOH and a draft training and development policy is awaiting approval by management. The EHRP has also attracted medical doctors who are interested in post graduate training at a later date. This has been sited by most junior doctors as a strong incentive.

There has been a lot of continuing education for both managers and health personnel translated into different forms of trainings. Other forms of learning include on the job learning, coaching and mentoring. For instance the medical intern management programme has been changed from a lecture based course to on-the-job exposure to district hospital management in accredited districts where management is of high quality. Other ways, such as meetings and workshops to increase knowledge are not seen as a form of education, although these meetings seem to be organized. As these courses provide payment of per diems, many health workers perceive participation as an income generating activity. However, health workers feel that not all staff have equal access to these training programs, which is a reason for some to feel that they lack training and of course income from the trainings.

There are many trainings which are mostly supplier driven arranged by a multitude of suppliers targeting the same health workers. This has a negative effect on the already too few numbers of health workers in the health facilities particularly the health centres which affects the quality of care to the clients and at the same time overburdens the few remaining staff. Plans are underway by the DHOs for the future that all relevant trainings should be incorporated in the District implementation plans so that trainings are district priority driven.

Commentary

Salary consolidation appears to be popular with the Ministry of Finance. The next salary consolidation required is to add per diem training allowances to salaries and so remove the perverse effects of these allowances.

4.11.10 Regular Supervision and Recognition

The Mid term SWAp report 2006 indicated that regular supervision by some DHOs was very much appreciated by health centre staff. Motivation is likely to suffer when workers think that nobody will notice their hard efforts or when they see workers whose productivity is low receiving rewards equal to those who try harder (Lawler, 1990).Some health workers report that feedback after a supervisory visit is one way to show

appreciation and recognition by managers and colleagues, which are a most important motivating factors for the health worker.

4.11.11 Financial Aspects

As part of the implementation of its Medium Term Pay policy GOM implemented a civil service wide pay rise in Feb 2006 backdated to December 2005 which establishes a separate pay scale for health workers. Under this new pay scale the 52% top up was rolled into basic gross pay for the priority eleven cadres. This means that MOF has accepted the liability of financing the 52% beyond the end of the 6 yr EHRP. Sustainability of this top up is thereby assured.

4.11.12 Satisfaction of NGO Health Care Staff

4.11.12.1 CHAM

CHAM functions in the context of a health system lead by the government and it is furthermore accountable to the church bodies which own the health facilities. It equally faces competition for the scarce health workers from the MOH, from NGOs, and from migration. As such, CHAM by necessity has needed to be creative and actively seek out solutions under most difficult circumstances. Specific to retention, faith-based institutions like CHAM in most countries have some advantages. Their institutional autonomy permits them to negotiate individually with employees and tailor their benefit schemes to their particularly needs and environment. In a survey of 18 CHAM hospitals there were 23 different types of salary bonus/topping schemes including the Cordaid doctors top up and the tutors incentive package. Their features are:

1. The range was from MK200 to MK30,000 per month.
2. Common type of allowances range from call allowance, hardship allowance, salary top up allowance, responsibility allowance and duty allowance.
3. The CHAM salaries are paid by Government and the employees also benefit from the 52%.
4. For doctors in CHAM they get the Cord-Aid funded top up allowance of €300 to €390 which is not taxed. There are discussions on phasing out this allowance because it jeopardizes CHAM's relationship with government. The Cord-aid top-up results in two times increase in take home pay for doctors.
5. Has it retained doctors? 78% of CHAM doctors are in the rural compared to 31% of MOH doctors.
6. Although the doctor vacancy rate at present in CHAM is 70% this is a major improvement from the previous year's position of over 90% vacancy rate. The few in post were mostly expatriate doctors. There were only four Malawian doctors in CHAM in 2002 but with the Cordaid top-up introduced in 2003, there are now 27 Malawian doctors in CHAM.

CHAM Tutors

The key findings of a consultancy study by the Capacity Project (March, 2006) are that the nurse tutor retention scheme in CHAM Training Colleges was successful at retaining tutors, with such features as:

- Salary top ups. A tutor incentive package which was at MK7500 has been increased to MK12,000 with effect from July, 2007. Reports from CHAM Principal Tutors indicate that the tutor incentive has had a positive impact in attracting and retaining tutors in the colleges.
- Free staff housing
- Obligation to serve for a period of time in return for educational scholarships (bonding).

Additional incentives offered by some institutions have proved effective at retaining nurse tutors, including:

- Additional salary top ups
- Transportation to work for commuters
- Transportation for home visits
- Training and educational opportunities
- Free utilities.

Other key factors in attracting and retaining tutors are:

- Proximity to home and to family.
- Promotions within institutions.

The tutor retention scheme was targeted and selective, which contributed to its success. Planners knew that the supply of tutors was scarce and worked to ensure that there would be a reliable supply. A public and private partnership through seconding of government health workers to private, faith-based training institutions is another important feature of the scheme.

Often overlooked retention benefits of faith-based facilities is that they provide a greater sense of community than do government institutions, in that the work is more than a job, but that it is indeed a "mission." Staff often work under trying circumstances but are usually quite dedicated (Capacity Project, 2006). Despite the varied incentive schemes CHAM has a total vacancy rate of 49% and the actual vacancy rate for the health professional posts is over 60%.

4.11.12.2 MSF-MOH in Chiradzulu

In order to increase quality of care administered by health care professionals where MSF is operational in the Chiradzulu District, an incentive plan was established in September 2006 through an MOU between MSF and Chiradzulu DHO. The focus areas are the paediatric, male, female, TB wards, laboratory, pharmacy, X-ray and HIV Clinic. The incentive plan is performance based on attendance and quality of medical care provided to patients. The plan targets COs, nurses and managers working in the mentioned areas and ranges from K5000 to K10, 000/month. The immediate impact is that staff are found in working stations more than before and also on time. It is too early to assess its full impact.

4.11.12.3 Banja La Mtsogolo

To curb the problems BLM has had to develop a strategy to retain staff members who are seen to be assets to the organisation. The retention strategy addresses the following components: remuneration, staff development, promotion, sabbatical leave and fair treatment in handling of grievances.

The remuneration at BLM is very competitive and performance based with set targets. This means it is quite rewarding to the staff who are hard working. The vacancy rates for BLM as at March 2007 stood at less than 2%. Staff retention has gone up with the introduction of the retention policy and vacant posts are filled within 14 days. Attrition rates are around 5 to 10%.

Table 32 -- Recruitment/Retention - Strengths of Government, CHAM, and International NGOs

Government	CHAM	INGOs
Increased opportunity for training	*No bureaucracy, decisions made autonomously at the institution. Thus more responsive to the staff person's need.*	*Competitive package and salary*
Government has a transferable system between units, eventually can move closer to family	*Find CHAM facilities provide a sense of community, staff have social network.*	*Pay higher allowances, attractive to employees as well as communities*
Ultimate controller of salary funds	*Top Ups for Higher Pay*	*To whom are they accountable?*
Revisions to salaries and benefits go first to government employees	*Doctors are in charge of institution, can make independent decisions*	*Least job security, project related and subject to discontinuation*
Better medical insurance system	*Accountable to community, government, church, and donors*	
Higher pension scheme (25% v 15%)	*Workforce which works under trying circumstances, yet are dedicated and committed.*	
Higher job security	*CHAM security is there in salary*	
More Hierarchical		

Source: Akerman, 2006

Although there are current initiatives in place to attract and retain health workers, these have yielded limited success in terms of engaging junior doctors, 17 of whom resigned during the period June - November 2005. It remains too early to adequately assess the impact of these initiatives, specifically in terms of nursing categories which account for approximately two-thirds of all core established health workers posts in the sector. The Nurses and Midwives Council validation figures (2005) for the preceding periods to 2002 indicate of a trend of between 80-110 preparing to leave the health sector annually. However while it will remain difficult to reverse this trend it is anticipated that corresponding figures for 2006 will at least point to a slowdown in nurse attrition.(Strategic HRH Framework. 2007).

A literature review and commentary in relation to Malawi

According to Staples report, (2004), to tap the existing supply levels, we must first understand the labour market and what incentives will effectively attract and retain staff. While a labour market survey is required, there is need to know that the cause for the supply crisis is the high attrition or wastage rates estimated to be roughly 2.5-3.5% annually for higher level professional staff. One report estimated that up to 30% of MoH employees leave the service each decade and that almost 15,000 new recruits would be required for the health sector over the next ten years to replace leavers. Attrition is largely due to retirement (21%) and resignation (12%) both of which occur early in staff careers. Most resignations occur before age 35 and almost half of those retiring in key jobs were younger than 50 years old.

Low health worker salaries and benefits are an important dimension of the current global health worker crisis, particularly in Sub-Saharan Africa. Civil service reforms have often compressed salary scales and failed to provide effective incentives to allow the retention of more senior and more capable staff. Recent initiatives in Malawi, Uganda and Tanzania have focused on increasing health worker salaries, but there is little data on health worker salaries and how these have varied over time, or information to guide government policy on what health worker salaries and benefits should be (GHWA 2007). The health sector in Malawi should look into three interlinked areas of research:

1. *patterns and trends of health worker 'salaries and benefits';*
2. *determinants of health worker 'salaries and benefits'; and*
3. *the impact of health worker 'salaries and benefits' on the provision of care.*

The research should also look at "What effect are private sector forces having on the set of incentives of the public health workforce?" Furthermore, "how can the private sector workforce itself be more effectively regulated and made to synergise to the maximum extent possible with that of the public sector?" The effect of the proposed policy which will require NGOs to pay comparable salaries to MOH and CHAM will need to be assessed for reduction in adverse effects such as poaching.

Top-ups that are applied across the board and not differentiated very soon stop being seen as an incentive. Efforts should be tried to differentiate the rates of top-ups with hard to staff areas getting higher rates.

There is a small but growing body of qualitative studies looking at motivation of health workers in developing countries that indicate the limitations of financial incentives on motivation and that reveal the importance of non-financial incentives. A study in South Africa on the effects of a newly introduced, so-called "rural allowance" showed the limited impact on retention and motivation. Similarly, analysing the role of wages in health worker migration, Vujicic et al. conclude that what they call non-wage instruments may be more effective in reducing migration flows, as portrayed in a WHO report in their study on health workers' motivation and performance in Benin. Alihonou et al. suggest introducing non-financial incentives while also improving structural conditions. Stilwell shows, by reference to Zimbabwe, that health workers based in remote areas, despite lack of financial incentives and hard working conditions, frequently exhibited a high level of motivation to perform well. She traces this motivation to good leadership and supportive management, among other factors. Her analysis suggests that certain non-financial incentives can have a beneficial effect on motivation, even under adverse conditions of insufficient pay and equipment, understaffing, etc. In a review of theories and empirical evidence of health workers motivation, Dolea and Adams equally stress the importance of non-financial incentives.

Workers may feel they have little to gain from working hard or being responsive to either their clients or superiors. Poor career paths and promotion opportunities lead to health workers feeling 'stuck', while official salaries often cover only part of a worker's needs or overall income (given alternative livelihood strategies, such as engaging in part-time private sector health services or entirely different informal occupations).

There are low cost methods of providing incentives such as recognition systems, reallocation of existing budgets and posting of performance data (Luoma, 2006).

A few interviews on what health workers need reveal some of the following HR issues. Salary revisions should look at the cost of living and determine the salary package from there. Our recommendations are:-

- *Introduce incentives schemes such as various loan schemes.*
- *Open up more career advancement opportunities;*
- *Improved accommodation with electricity and running water and improved communication facilities.*
- *Institution of protection of more protection measures in the workplace where there is zero tolerance to violence.*
- *Further education or upgrading opportunities to be prioritized for those working in hard to staff areas.*
- *A gender and fair deployment policy to actually work and not just be another document on the MOH shelves so that staff trust that they will not be forgotten in hard to staff areas.*
- *More improvements in the working environment such as adequate supplies and equipment.*
- *For nurses, they would like to buy them full uniform including shoes to be bought by the employer.*
- *The staff in hard to staff areas would like frequent transport to trading places, quality education facilities for their children.*
- *Migration to be properly managed. There can be mutual benefits from properly managed migration. MOH to sign MOUs with employing organizations that recruit finished products to incorporate a component of supporting training.*
- *The DIPs to include in-service modules. Annual registration with NMCM and MCM could use participation in these in-service training as a precondition for registration.*
- *Easy access to loan facilities to purchase items that cannot be bought from the salary.*
- *Recruit more staff to reduce the heavy workloads.*
- *Improve working environments such as reducing overcrowding in the health facilities, increase nurse:patient ratios, reduced workloads, reliable supplies and equipment, HIV/AIDS protective supplies (i.e. gloves), and improve water at many district hospitals or install electricity in health centres;*
- *Provide regular supervision and effective HR management systems.*
- *Develop a policy on performance management.*

Commentary - what needs to be done?

1. From the many reports studied it is clear that income is only one factor, albeit an important one, in the complex and challenging area of retention. The Six Year Programme of work envisaged the development of a national deployment policy and plan, a national training policy and plan, a national appraisal system and the development of a Human Resources Information System. It can only be hoped that the Heath Service Commission will be given its intended mandate to address the central issue of salaries versus allowances as well as issues of other general conditions of service.
2. HR Research needs to addresses the issues raised. A Malawi / Lesotho job satisfaction survey is underway and a Malawi / South Africa / Tanzania motivation survey is soon to start both conducted by the Community Health Department of COM. Results will feed into the next policy assessment.

4.12 Remaining Constraints / Future Needs

4.12.1 New and Expanded Programmes

One of the assumptions of the POW was that the government will not add services over and above the EHP during the course of the plan period (2004-2010). What may not have been anticipated was that successful programmes could unduly apply pressure on the plan by over expanding in an improved environment created by the SWAP. At the same time failing programmes may need reinvigorating or new programmes such as ART to be introduced. The size and complexity of an extended EHP will impact on the HR as on other inputs.

4.12.1.1 ART

The ART scale-up plan has not been linked to the target staffing increases of the EHRP. Further work is needed to ensure the two processes are consistent, including a workload analysis for the PMTCT and HIV/AIDS related services and other EHP services. *(Aide Memoire 2006 Annual Review)*

As part of the fourth quarter ART report the HIV unit looked at the number of health worker days required to serve an ARV clinic. In all facilities, a record was made of the number of days in a week that the ARV clinic is open to see either new or follow-up patients and the number of staff who operate the clinic when it is functioning. The total number of days in a week given for ART at all facilities in Q4 2006 was 295, translating into an average of 2.8 working days in a week when facilities operate an ART clinic. Table 32 shows the number of staff days per week for clinicians (mainly clinical officers), nurses and clerks for each of the regions and for the country as a whole.

The FTE (Full Time Equivalent) parameter indicates the number of clinicians, nurses and clerks working the equivalent of full-time per week on ART. Thus, for the country as a whole, the equivalent of 77 clinicians and 86 nurses were working full-time in ART delivery each week (see Table 33). Per 1,000 patients on ART, there was a need for 1.6 clinicians, 1.8 nurses and 1.4 clerks at the time of assessment. The workload to man ART clinics is obviously increasing quarter by quarter (compare previous reports) (ART Q4 2006 Report).

Table 33 -- Workload of clinical officers and registered nurses at ART clinics Q4 2006 - Malawi

	Clinician days/week	Nurse days/week	Clerk days/week
North: 22 sites	47	52	44.5
Central: 38 sites	172	178	133
South: 43 sites	168	200.5	144.5
Total: 103 sites	387	430.5	322
FTEs	77	86	64

From this analysis it is clear that the projected patients to be put on ART according to the strategic plan for ART scale up of 250,000 will require 400 clinicians, 450 nurses and 350 clerks. Obviously there will be other follow up patients that may just need HSAs. ART programme is already looking for ways to mitigate for this.

Table 34 shows the impact of the ART programme on front-line clinical and registered nursing staff. 76% of the current numbers clinical officers and 27% of registered nurses will be needed for ART clinics.

Table 34 -- Workload of clinical and nursing staff for ART roll-out

Size of ART workload for clinical officers and registered nurses in 2006/7 and at full roll-out		
	Clinical officer	Registered nurse
ART work expressed as FTE in Q4 2006 (48,000 enrolled)	77	86
Expected ART at full roll out (250,000 enrolled)	400	450
Current staff in post Q1 2007 – MOH	355	784
Current staff in post Q1 2007 – CHAM	169	861
Current staff in post Q1 2007 – Combined	524	1645
% of current staff required for future ART	**76%**	**27%**

4.12.1.2 Maternal Road map

This programme was not factored in the current EHRP recruitment and deployment targets. All though some of these are referred to as new interventions in reality they simply constitute scaling up of what was agreed in the POW. The Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi highlights its aim to: 'Ensure EMOC is the highest priority in the Emergency Human Resource Programme for the re-engagement of staff, re-deployment of staff and placement of volunteer specialist doctors and nurse tutors'. *(Source: Road Map)*. However, this prioritisation has not been agreed with the MOH human resources unit managing the EHRP, and may be at odds with the ambitions of the ART scale up strategy, which also implicitly assumes it will benefit from a substantial proportion of the gains in staffing. *(Aide Memoire 2006 Annual Review).*

Table 35 -- Extract - Maternal Road Map on HRH requirements

			Base-line	2010	2015
Ensure EMOC is the highest priority in the Emergency Human Resource Programme for re-engagement of staff, re-deployment of staff and placement of volunteer specialist doctors and nurse tutors	HR RHU	Nurse/midwife technicians	4717	7035	
		Registered Nurse/midwives			
		Clinical Officers (with midwifery and obstetric skills)	942		
		Medical Assistants (with midwifery skills)	718		
		Medical Officers with obstetric and neonatal skills	139		
		Volunteer specialist doctors			
		Nurse/Midwife tutors			
		Average norm of number of births to practising skilled attendants	350	250	175
		% of births attended by skilled health personnel	19	40	60

The costing of the Road Map indicates that the source of funding for its HR related activities is the EHRP.

Commentary

As much as the problem of human resource is being re-assessed for one part of the EHP there is a danger that the rest of the EHP may be undermined by unplanned scale-ups in particular programmes. An important point to note is that the original EHP contains the most cost-effective interventions saving the most lives for the least cost. We will save fewer lives overall if these original programmes are undermined.

4.12.2 Training

The capacity of the higher training institutions is such that although schools are operating at maximum residential intake capacity, they are currently unable to train sufficient numbers to sustain basic levels of service. This is partly due both to an acute shortage and quality of tutors, limitations of the physical capacity of buildings and inability to identify and absorb alternative methods of training delivery, such as day release programmes.

The current infrastructure seems to be limited by the amount of hostel space. There is need to allow students to identify their own accommodation around the schools. This will even encourage private business people to provide hostel accommodation for a small cost.

Given the requirement to achieve the intake and output targets detailed for implementation of the EHP,1,534 enrolments by 2010 in line with the EHRP training cost model projections, there will be need to increase the number of tutors considerably in all training institutions. Major limiting factors for increase in enrolments include expansion and improvement of training institution infrastructure which will allow for both increase in tutors and students.

The Principal of one of the training institution who visited St Joseph Nursing College reports that tutors have to be brought in from Blantyre every morning and there is a loss of the first three teaching hours most of the time. This affects the quality and morale of the students and teachers. The school although needing a minimum of 18 tutors has only four houses for tutors.

There is also pressure on the curricula to include ever widening subspecialties and innovations with the intention that if it is taught in pre-service then there will be no need for the in-service training. There is need to make sure that these curricula are not taken over by interest groups at the expense of the basic training needed.

4.12.3 HR Planners and Support Staff

Human resource has been identified time and time again as a major rate-limiting factor to successful implementation of the EHP. To this end a considerable effort has been taken to address this. How that human resource is managed and utilised will need a qualified human resource specialist and support staff at each hospital. There is need for these people to have common goals and objectives for the system to respond to the sudden increase in personnel.

HRH planning norms have been based on broad population ratios, planned and existing types of healthcare facilities and estimates of rates of attrition. It is accepted that whilst this approach is entirely appropriate to kick start a complex and imaginative programme, the point has been reached when it is now necessary to refine the process such that forecasting and skills mix meet the requirements for access targets for ART interventions, Maternal Road Map Interventions, new health initiatives and service delivery package, whilst at the same time ensuring that they do not disadvantage or impair ongoing mainstream health service provision. (*Draft Report Comprehensive Workload analysis Framework*)

4.12.4 Expanded EHP

MOH should be alert to the fact that the current EHRP targets will be inadequate to meet the long term HRH requirements of the proposed Workforce Plan for health sector, which will need to be defined in the context of an expanded EHP (including ART, Road Map).

Commentary

The original EHP model of inputs (HR, drugs, infrastructure and costs) and outputs (numbers treated and HMIS indicators) needs to be reworked.

4.12.5 Service Agreements

The introduction of service agreements within the districts (with CHAM institutions and others) and between contiguous districts for the provision of EHP services to underserved localities is sited in the POW as one of its strengths.

Discussion with Banja La Mtsogolo (BLM) indicated that as part of their planning to sign service agreements with MOH they intend to increase their staff numbers in order to meet the increase in workload anticipated from the free services they will offer. The Administrator of St Joseph Mission Hospital also echoed this need for increase in personnel following signing a service agreement with Chiradzulo DHO.

It could be argued that the money in the service agreements is part of the EHP and human resource needs may already have been include in the calculations. But there will be a shift of human resource to these private organisations that need to be managed and included in all training plans and vacancy calculations.

5 TA Analysis

5.1 Introduction

The technical assistance (TA) in the health sector of Malawi comes in various forms, for various reasons, and is delivered in various ways to achieve different ends. These varieties are first described, followed by an analysis of the current TA activity. The final section offers options on how to improve TA activity in the second half of the POW.

5.1.1 Types of TA in Malawi

There are six ways in which current TA becomes available:

1. **SWAp pool** financing and management arrangement with funding from DFID, recruited by the Ministry of Health (MOH) with assistance of LATH. These TAs are managed by LATH on behalf of the MOH through a management contract with DFID.
2. **Bilateral donors** as part of a project; the donor identifies, funds, and manages individual TAs who are posted to MOH Central/Zonal/District levels. e.g. JICA and GTZ, or through a private company or NGO e.g. MSH, JSI e.g. USAID
3. **MOH** outsourcing the management of certain services with donor support, e.g. management contract of the Central Medical Stores (CMS) where TAs have been hired by a company to manage CMS on behalf of MOH.
4. **Short term** "ad hoc" hiring of a TA for a short period to deliver a discrete output - e.g. provision of TA support to produce SWAp management structures.
5. **UN Agencies**:
   - recruiting TAs internationally and posting them at Central and District hospitals e.g. UNDP recruitment of UNV Doctors; and
   - On occasional basis, providing direct TA to MOH at Central and District levels by UN employees stationed at the country/regional/head offices. e.g. WHO and UNICEF.
6. **Foreign NGOs**[3] providing TA as part of a project e.g. Save the Children, MSF, FHI.

5.1.2 Reasons for TA

Technical Assistance (TA) to the Malawi health sector is sought for five main reasons:

- serious shortages of human resources in the health sector to implement the required activities;
- inadequate skills existing in the health sector capable of producing the desired outputs;
- weak organisational and institutional structures capable of producing desired results;
- as a way of minimising fiduciary risks; and
- as part of a project provided by foreign NGOs.

[3] This category of TA was included on the advice of the steering group

5.1.3 TA delivery

Technical Assistance is mainly delivered in five ways to provide:-

- **mentoring** - providing technical advice to individuals or units – so called "counter-parting". This is where a TA is paired with national and is mainly delivered under a long term contract of one year or more
- **substitution** - filling vacancies – in established or necessary posts[4] undertaking tasks necessary to complete the health delivery or management function for the POW. This is mainly delivered under a long term contract of one year or more
- **management** - TA managing certain strategic institutions through a management contract on behalf of MOH. This is mainly delivered under a long term contract of one year or more
- **"Ad hoc"**- hiring of a TA for a short term period to deliver an agreed and limited output - e.g. provision of TA support to produce SWAp management structures. This is mainly delivered under a short-term contract usually of between two and 52 weeks duration
- **foreign NGOs** - as part of a service project provided by foreign NGOs.

5.2 Current situation

The current situation of TA will be presented by type, describing the current number and status, the recruitment, remuneration, management and an assessed impact of each. The information collected and analysed has come from a wide range of senior ministry officials, donors and TAs, listed in the Appendix.

5.3 Pool Financed TA

5.3.1 Number and Status of Agreed TA

The majority of TAs were recruited by the MOH in 2005 with funding from DFID and managed by LATH. The MOH in collaboration with partners in the SWAp, agreed on the areas which needed TAs in order to implement the POW effectively and efficiently. The following areas were agreed upon:

5.3.2 Areas where TA has not agreed

There were some areas where agreement was not reached on the need for TA. An example is malaria control. The Director believes TA support is not required; some donors and partners believe it is. The unit is staffed with three high calibre senior staff but has failed to deliver a successful global fund proposal in the last three years. It also has an ambitious strategic plan to implement. Free technical assistance is available from CDC, WHO and UNICEF. However, what is probably needed to provide a functional and technically appropriate control unit is, besides the three existing staff, an M&E expert to interpret malaria data, an epidemiologist to assess current endemicity, an IEC expert to manage health promotion activities and a drug supply expert to coordinate and implement procurement of necessary drugs and equipment.

[4] A "necessary post" is defined here as one which is not an established post but one which has been found to be necessary to deliver the POW and associated MOH functions

Table 36 -- SWAp funded TA, March 2007 current and future status

Area of focus	Contract start	Current status	Future status
Procurement			
Senior Procurement Specialist	April 2007	Contract renewed for the next 15 months	Post to be down graded with all current benefits
Procurement Specialist (x2)	April 2007	Only one post to be renewed for the next 15 months	Due to arrival of counter-parts, no need for the other TA
Human Resources			
Senior Human Resources Management & Development Specialist	April 2007	Contract not renewed	Post to be downgraded to HRH Planning TA
Human Resources Manage-ment Specialist	April 2007	Contract renewed for the next 15 months	
Human Resources Develop-ment Specialist	April 2007	Contract renewed for the next 15 months	
Planning and Policy Development			
Monitoring and Evaluation Specialist	April 2007	Contract renewed for the next 15 months	
Technical Officer Health Planning	April 2007	Contract renewed for the next 15 months	
Finance and Administration			
Senior Financial Manage-ment Specialist	April 2007	Contract renewed for the next 15 months	
Financial Management Spe-cialist	April 2007	Contract renewed for the next 15 months	
Assistant Financial Manage-ment Specialist	April 2007	No extension	Counterparts now in place
Senior Technical Advisor	April 2007	No extension	
Technical Programmes			
Essential Medical Laboratory Services	April 2007	Contract renewed for the next 15 months	
Maternal & Neonatal Health	April 2007	Contract renewed for the next 15 months	
Sexual Health	April 2007	Contract renewed for the next 15 months	

Source: MOH Planning Department

Commentary

The different perceptions of TA need may be due an attempt to (i) live frugally and minimise malaria control unit expenditure, (ii) the assumption of perpetual “free” TA from WHO, UNICEF and CDC, (iii) a reluctance to accept the lack of sufficient technical competence of existing staff and (iv) a dislike of the TA system which seems to reward disloyal staff and cause the tensions created by divisive salaries.

Reducing distortions, improving the TA recruitment and management processes and increasing TA cost-effectiveness may all improve the acceptance of TA when it is really needed.

5.3.3 The Recruitment Process

Ten TA posts[5] were recruited directly by the MOH through a competitive and open process facilitated on behalf of the MOH and its collaborating partners by LATH. Additional TA funded under the DFID Sexual and Reproductive Health Programme was recruited using the same procedure led by MOH (this procedure was in fact developed under the Sexual and Reproductive Health Programme).

The recruitment process for the ten TAs has been hailed as transparent and objective in that the formulation of TORs, short-listing of candidates and interviewing for the posts were carried out by representatives of the Technical Working Groups in Financial Management and Procurement; Monitoring and Evaluation and Human Resources Management & Development led by the MOH[6]. Their participation in this process was hailed as one way of strengthening SWAp ways of working.

The advertisements for the posts were also widely circulated both internationally and locally in print media, internet and targeted organizations and professional bodies which resulted in a large number of applicants (255). This process provided healthy competition.

Commentary

The recruitment process followed for the ten TA posts serves as a 'best practice' example in the SWAp pool financing and management arrangement. As such, there is need to use a similar process in the future.

The facilitation of the recruitment process by an international consultancy firm - LATH was rated as excellent in that it has experience and expertise in managing an international recruitment process successfully.

In future, however, a local management consultancy firm could be identified through an open tendering process to facilitate the recruitment process, perhaps with support from an International Consultant early on.

5.3.4 The Remuneration Process

All TAs under SWAp pool arrangement are paid by DFID through LATH under a two year management contract with DFID worth £3.6 million including LATH management costs to April 2007.

Commentary

DFID knows the overall cost of each TA including LATH overhead. The actual salary for each TA is not known. Similarly, the MOH does not have any knowledge of the employment conditions of each TA. In short, there is lack of transparency in the current SWAp TA. This has implications for the MOH in terms of future budgets should there be a pool fund. There are both advantages and disadvantages of knowing the actual cost per TA and management costs:

- **Financial planning** - It will ease the planning for procurement of TAs as the cost will be known which will be factored into MOH recurrent budget under the SWAp pool fund

[5] These post are Senior Procurement Specialist, Procurement specialist, Senior Human Resources Management & Development specialist, Human Resources Management & Development specialist, Human Resources Management specialist, Human Resources Development specialist, Monitoring and Evaluation specialist, Senior Financial Management specialist, Financial Management specialist and Assistant Financial Management specialist

[6] The role of these working groups composed of members from MOH and its collaborating partners is to technically advise and monitor the Health SWAp

- **Cost-effectiveness** - since all TAs funds will be pooled and combined in the MOH recurrent budget, this budget will rise to an appreciable extent. If half of the £3.6 million (since this is for two years - July 2005-April 2007) were transferred to the recurrent annual MOH budget in 2006/07 financial year, this would represent an increase of 12% of the total personal emoluments and about a 3% increase in total MOH Recurrent budget. With such an increase, the MoF may assume that the MOH budget has been raised and funding is close to meeting the health needs of the population (estimated cost of the EHP per capita) and the regional agreed targets such as Abuja Declaration of allocating 15% of national budget to health. Yet this is brought about by the funding of only 17 TAs. As such, questions need to be asked about the cost-effectiveness of such spending. For example, these funds are equivalent to funding all nurses in post in MOH in the 2004/05 financial year. Attempts to reduce such expenses could act as a disincentive to prospective TAs and could also lead to hiring TAs of low quality or no TAs at all[7] and yet there is great need for quality TA.
- **Divisive salary differences** – these lead to unnecessary tensions between TAs and government employees whose salaries are critically low compared to those of the TAs despite similar qualifications and often greater responsibilities. In such a situation, it is more likely that the effectiveness of the TAs will not be achieved and succession plans not realised. In addition, staff vacancies occur due to poaching of government employees.
- **Fiduciary risk -** It must be appreciated that donors are putting in huge amounts of their tax payers money in the SWAp pool with weak procurement and financial management functions. The Malawi SWAp pool is very different to that of Mozambique SWAp pool- where funds from the SWAp pool meet with those of the government at the service delivery point. The Malawi SWAp pool was commenced with this understanding of inadequate capacities and with the overt intention of assisting the Ministry strengthen these functions. This is laudable. Some donors have clearly stated that one reason why TAs are encouraged to be in MOH strategic areas is to mitigate against fiduciary risks and to provide donors with internal intelligence of what is actually going on in the Ministry.

5.3.5 TA Management, Monitoring & Evaluation

The management and monitoring of the TAs is expected to be with the MOH directors. They are expected to agree the job descriptions and monitoring indicators. LATH's role is expected to be the production of quarterly assessment reports of the technical support programme.

Much as there has been some adherence to the above processes of TA management and quality assurance, our findings indicate that the management, monitoring and evaluation of TAs are weak.

Currently most MOH senior managers do not monitor the processes and outputs of the TAs in their directorate. In all cases objectives are set at the beginning of the contract and signed. However, the Directors do not monitor closely the progress and achievement of the agreed objectives - i.e. they do not sit down with the TAs and review each objective thoroughly so as to establish progress made, performance of the TA, need for improvement, challenges etc. There are many cases were TAs have

[7] Anecdotal evidence is given by MOH staff who recall that when the salary of the Population Health and Nutrition (PHN) Project Coordinator who was an expatriate was slashed US$6,000 to US$1,000 per month in 1995 due to concerns that he was getting too much money compared to equally qualified MOH staff, he immediately resigned. Replacement by a senior government employee whose salary was at US$1,000/month led to demotivation and abuse of project resources and the subsequent dismissal of the official.

never been evaluated by their managers over the whole contract period despite the TA submitting quarterly reports to the Director.

What normally happens is that when the time comes for the TAs to send the quarterly progress reports to LATH, the TAs prepare these reports which are submitted directly to LATH with copies to their director. LATH then synthesises the reports and submits them to DFID for its payment for managing the contract. There is neither systematic scrutiny nor verification of the TAs reports by MOH directors. Compounding the situation further is the fact that once the reports are submitted to DFID, they are not discussed with MOH top management i.e. DFID and MOH do not discuss the TA reports.

Furthermore, there has been confusion in the reporting structure, with some TAs reporting directly to the PS while others reporting to Directors. This inappropriate reporting may have arisen due to lack of proper procedures for managing TAs in MOH or be due to TAs attitudes - some TA feeling more superior to the Director in whose directorate they work.

It is alleged that some individual TAs are seen to be paying heavy allegiance to the funding organisation - DFID (even though DFID prefers a 'hands off' policy) and LATH rather than the MOH management. At first glance this observation, confirmed and by MoH Directors and by TAs interviewed, seems to be in contradiction with the DFID evaluation report on the TA that stated the contrary (TA being loyal to MOH and even very willing to challenge DFID). However, this divergence may be explained by a) the fact that this report points out some individual (and rather critical) but characteristic experiences and b) by the difference in time both evaluations took place and the experiences that were made in framework of the TA programme and the changes that occurred in the MoH in the meantime.

What remains a fact is that this type of situation had affected interpersonal relationships amongst the TAs themselves on one hand and between the TAs and the MoH officials on the other hand and negatively influenced the performance of the whole TA programme and thus has to be addressed in any future concept of TA (pool) management.

The 'remote management'[8] of TA programme by LATH has not been very effective in solving some of the problems highlighted above. LATH management only has limited options to verify the authenticity of the quarterly reports produced by the TAs and MOH senior staff did not have the time or the interest to scrutinise the quarterly reports thoroughly. No wonder, the accusations and counter accusations have continued and they are likely to re-surface in the extended 15 month contracts if not resolved.

Commentary

In light of the limited performance management culture in MOH, a solution may be to hire a local management consultancy firm with expertise and experience in Human Resources Management and Development to introduce a performance management system in MOH which could be the vehicle for managing the TAs on a routine basis while simultaneously strengthening the whole performance management system of MOH. This firm could handle all TA issues including recruitment, day to day management performance reviews etc. There are advantages and disadvantages to this approach:

[8] LATH did not establish an office in Malawi in order to manage the TAs. There was an agreement that a local Company (Management International) would be involved in TA management on behalf of LATH. However, this did not happen.

Advantages

- There will be transparency in recruitment and management of TA
- TAs management issues, which can affect TAs performance in achieving the agreed upon objectives can be resolved quickly
- In managing the TAs directly, there is more likely to be positive externalities to a government-wide system on performance management. The likely effect will be to improve the management culture in the sense that managers will appreciate the need to monitor and evaluate all staff members in their departments as they all contribute to the achievement of the department's performance and subsequently to the goal of the MOH.

Disadvantages

- Recruitment and managing international and local TAs requires skills, experience and integrity which may be lacking locally. We would encourage initial support from an international consulting firm.
- The cost-effectiveness of this approach could be questioned by some quarters especially if the management costs are high.

In summary, the causes of this weak TAs performance management are a symptom of

- No active performance management system in the MOH
- Uncoordinated output monitoring of TAs
- Confused line management arrangements.

5.3.6 Evaluation of TA Impact

The impact of TAs can be evaluated in various dimensions. However, in the MOH situation under the LATH contract it can be best evaluated in three important dimensions:-

1. Gap filling - the extent to which the TAs undertook their tasks in filling the existing gaps in the identified critical areas in terms of quality and quantity of outputs. Did the TAs do what was sought (sticking to the brief), successfully and with long term benefits?
2. Capacity development – did the TA build capacity of the counterparts? – Did the TA enhance in-country expertise?
3. Detriment – did the TA produce unforeseen detrimental effects such as distracting staff working on priority activities, development of inappropriate documents (ending up being rejected by MOH or requiring additional resources to re-do them).

We have reviewed documents produced by TAs, examined the MOH evaluation form for each TA and held several interviews with MOH senior managers, programme managers and TAs themselves. We have assessed them by typology and success using the criteria above.

Table 37 -- Findings of SWAp funded TA Impact

TA focus area	Effectiveness of TA in terms of Outputs		Effectiveness of TA in terms of Capacity building-skills transfer	Detrimental effects of TAs
	Quality	**Quantity**		
Procurement	Very good	Did all the work assigned to them satisfactorily	None-as they were no counterparts available during most of the period, counterparts came at the end of contract	None
Human Resources	Very good	Did all the work assigned to them satisfactorily	Very minimal - only one counterpart was available / cooperation e.g. on the production of key documents was weak	None
Health Planning & Policy Development (SWAp, M&E and Research)	Very good	Did all the work assigned to them satisfactorily	Good – counterparts available and counterparts greatly appreciated the skills transfer process	None
Finance and administration (Financial Management)	Very good	Did all the work assigned to them satisfactorily	Good - worked with counterparts	None
Technical programmes				
HV/AIDS	Very good	Did all the work assigned to them satisfactorily	Very minimal - Only one counterpart was available	None
Reproductive Health	Good	Did most of the work assigned to them satisfactorily	Very minimal - Only one TA worked with counterpart and transferred skills	None

Commentary

From the Table 37 above, it can be seen that there are six main findings in regard to this group of TAs:

1. Almost no capacity has been built. Counter-parting has largely failed either due to lack of the counterpart or too much work on the ground for the mentor to do anything but service work. Full time TA will tend to have this effect in a Ministry which is overstretched.

For example, some TAs in their TORs had the responsibility of developing HRH management systems. However this was not possible with the serious shortages of staff and skills in the HRMD Department at MOH. As such, the TAs ended up implementing the activities directly - as government officials. *"Who will operate the systems in the absence of skilled government employees even if they can be developed?"*

This has a serious impact on determining the succession plan for TAs in the MOH. As long as MOH personnel with relevant skills are not paired with counterparts, the concept of skills transfer will continue to remain a dream and the need for TA to do the job will continue to be justified. We offer a suggestion of how mentoring can be clearly separated from gap filling in our recommendations.

2. There were also other factors which have led to ineffective transfer of skills in cases where a counterpart was available such as:
   - a prolonged orientation period at the start (particularly for expatriate TAs); and
   - short tenure of the contracts (less than 24 months)
3. Where TAs were gap filling, there were high quality documents produced and a large volume of work accomplished. This is a success story of TA placement. However, past experience suggests that there is unlikely to be sustainability or reproduction of such outputs once the TAs leave.
4. Serious detrimental effects were observed and centre around the issue of divisive salaries, with the interpersonal tensions that these salary distortions produce. The serious shortage of experienced MOH staff is partly due to resignation of staff to take up TA positions.

Bilateral Donors e.g. JICA and GTZ as part of a project component; identifies funds and manages individual TAs who are posted by MOH or through a private company or NGO e.g. MSH, JSI, USAID.

5.3.7 The management process

The procurement of TA process is either (e.g. JICA or GTZ):

1. A bilateral donor outside the SWAp pool discusses with the MOH on the possible areas of technical support. The donor designs a project within which provision of TA is one of the components.
2. The advertisement, selection and recruitment of the TA is done by the funding organization.
3. The TA is expected to be managed by the appropriate MOH Director and in cases where the Director is not in post, the TA is expected to be managed by the Deputy Director.

Or (e.g. USAID)

1. A bilateral donor outside the SWAp pool discusses with the MOH on the possible areas of support. The donor designs a project and floats a Request for Proposals (RFP) for companies or NGOs to bid. The company or NGO is selected by the donor to provide TA in the agreed areas.
2. A contract is signed between the donor and the company providing TA known as ‘Contractor’ on the payments and deliverables while the MOH and bilateral donor sign an agreement on the project objectives and outputs. The MOH does not know the total cost of TA component.
3. The ‘Contractor’ then prepares annual workplans which are discussed with the MOH and then signed by both parties.
4. The TA is expected to work hand in hand with the MOH employees - coaching, skills transfer and gap filling. It is expected that at the end of the project, capacity is strengthened and the MOH has delivered quality and quantity services.

Commentary

Much as the TAs share the work plans with the MOH managers and report to them on technical issues requiring immediate decisions, there is no strict monitoring and evaluation of the TAs performance by MOH Directors on a semi-annual or annual basis. The MOH Directors seem to have little powers to monitor whether the activities are achieved satisfactorily or not or if there is need for improvement in some areas. Neither does the MOH at central level such as in Health Planning & Policy Development Department have a monitoring mechanism for company TA outputs.

At lower levels such as central hospitals and district, the same problems of lack of skills and systems to undertake management performance by MOH employees exist. As such, the reports produced by the contractors to the funding agency can not be easily authenticated. In some cases they are disagreements between lower level staff and the contractor when presenting progress reports to the central level.

5.3.8 Evaluation of TA Impact

Using the same framework as in Table 2 above and having reviewed the TA assessments by the MOH and various reports, the impact of TAs under bilateral arrangements is described in Table 38:

Table 38 -- Impact of bilateral donor (non-SWAp) funded TA impact

TA focus area	Effectiveness of TA in terms of Outputs		Effectiveness of TA in terms of Capacity building-skills transfer	Detrimental effects of TAs
	Quality	Quantity		
Health Technical support services (PAM)	Very Good	Do all the work in their workplan satisfactorily	None	None
Health Planning &Policy Development (Health Services Planning)	Good	Do most of the work assigned to them	Still new	None

Commentary

It is clear that in this context, the TAs are gap filling and there is little or no capacity development taking place. For example there is one TA whose quality and quantity of outputs is highly rated in the Health Technical Support Services – PAM Division. However there has been no replacement of the counterpart following the death of the initial counterpart in 2005. As such, the MOH stands to lose all the excellent expertise and experience of this TA once his contract expires in 2010 unless a new counterpart is found.

Within the project period, it should be a condition that the funding agency supports short and long term training courses of MOH employees in areas of the expertise of the TA. This will ensure smooth succession in the event of the TA departure. Once MOH employees are trained, the retention of staff will need to be seriously considered by the MOH under conditions already addressed by the deployment and retention policies etc.

This type of technical support is greatly appreciated by MOH employees in that it strengthens the systems and brings new ways of solving problems. The efficiency and effectiveness of the TAs and the systems introduced are greatly valued by MOH employees.

However, once the project has ended, there is little or no skills available to continue with the excellent work undertaken during the project period. No serious skills transfer occurs due to several reasons:

- Lack of counterparts with relevant skills close to the TAs. As such, the TAs end up doing day to day activities-gap filling
- Unwillingness of the TAs to impart skills to counterparts for fear of losing their jobs once all skills are transferred to the counterpart.

Thus prior to commencement of the project, there is need to identify the skills gap, the counterparts with skills close to those of TAs and a training programme to fill the gap. This will ensure that once the project finishes, at least some skills will be available to continue the excellent work of the TAs. Failure to do this will perpetuate the need for TA.

Management contract - TA managing certain key strategic institutions on behalf of MOH.

This is mainly delivered through long term contracts e.g. Management of Central Medical Stores.

Due to persistent human, organizational and institutional weakness, the MOH and its development partners have agreed to 'outsource' the management of certain key strategic institutions such as the Central Medical Stores and soon the Regional and District Maintenance Units.

The donors agree to fund the management costs of the hired firm on behalf of the MOH. The recruitment and selection of firm is expected to be done by the donor in consultation with the MOH.

5.3.9 Evaluation of impact of TA

Using the same framework for TA assessment and having reviewed the TA assessments by the MOH and various reports, the impact of TAs under management contract is described in Table 39.

Table 39 -- TA impact of management contracts

TA focus area	Effectiveness of TA in terms of Outputs under gap filling situation		Effectiveness of TA in terms of Capacity building-skills transfer	Detrimental effects of TAs
	Quality	Quantity		
Central Medical Stores	Very Good	Doing all the work as per agreement satisfactorily especially towards systems development and strengthening	None - no counterparts in place	None

Commentary

As it can be seen from Table 39 above, the management TAs are producing very good quality work and they are completing the agreed programme of work satisfactorily.

However, there are neither counterparts in place to whom the TAs can transfer the skills to once the contract expires in 2008 nor MOH employees in long-term training who could take over from the TAs after 2008. This has three main implications:

- The TA contracts may have to be extended past 2008. This is assuming funds are available from donors, otherwise the MOH needs to start planning on how to manage the CMS after 2008.
- There is no sustainability of the system in the medium to long term as the MOH will perpetually rely on TAs in the absence of its own employees.
- The cost-effectiveness of the use of TAs over such a long period will more likely be lower than that of MOH employees especially in our resource constrained environment.

"Ad hoc"- hiring of a TA for a short term period to deliver an agreed output - e.g. support to SWAp management structures.

5.3.10 The Recruitment Pocess

This short term limited type of TA is generally provided on an "ad hoc basis". It is mainly delivered under a short-term contract usually of 2 to 52 weeks duration. The MOH/development partners identify the need for short term TA in a specific strategic area. The MOH approaches the DPs for funding and identification of the TA or alternatively, the DPs offer the Ministry both the TA and its funding.

5.3.11 Management and Quality Assurance

The TAs and the Directors concerned go through the TOR of the assignment, agree on the conceptual framework and the fieldwork methodology prior to commencement of the assignment. The TA prepares the report and submits it to the MOH and the funding agency for comments. The MOH reviews the TAs draft report and makes comments for consideration by the TA. If the MOH is satisfied with report, it notifies the funding organization to pay the consultant or inform the consultant that the report has been approved, if not satisfied; the TA is expected to include all the comments of the MOH before final approval of the report or payment.

Commentary

The MOH strictly reviews the TA reports under this arrangement. The report is considered a draft and the TA is not paid until the TA has addressed all the MOH concerns. This is the only system whereby the MOH monitors and evaluates the performance of TAs strictly and in a transparent and objective manner. It can be regarded as one of the 'best practice' examples in the MOH in terms of monitoring and quality assurance of the TA inputs and Outputs.

This system of TA management and quality assurance could be adopted in the case of all longer term TA contracts as it ensures that the MOH and development partners get real value for their money.

5.4 UNV and VSO Assistance

5.4.1 Recruitment

One of the components of the Six Year Emergency Human Resources Programme is the placement of (foreign) medical specialists and general practitioners in central and district hospitals.

UN Agencies have procured the United Nations Volunteers (UNV) doctors and the German Government finances the positing of doctors in the framework of its CIM (Centre for International Migration) Programme. Currently (June 2007), there are 30 UNV doctors in post (19 GPs, 7 Specialists, and 4 ART supervisors) and 25 applications under investigation. 9 CIM-doctors are actually posted (15 planned) in referral hospitals / medical centres in Lilongwe, Zomba, Blantyre and Mangochi. 44 VSO (Voluntary Services Overseas) doctors, nurses and medical supervisors are actually working at District Hospitals, CHAM health facilities, at the COM and a zonal office. The programme will be extended to 50 posts expected to be filled by Septembver 2007. UNDP (7) and the Global Fund (23) pay for the costs of UNV doctors while the VSO programme for the EHRP is funded by DFID through an accountable grant. DFID have committed £1,125,143 (approx $2 m) over 3 years.

5.4.2 Monitoring and Evaluation

The UNV Doctors are expected to be managed by the hospital director at central hospitals and the DHO at district hospitals as all other health workers. However, in some districts due to the absence of the DHO, UNV Doctors are the most senior members of staff; hence it is difficult to monitor their performance directly.

Commentary

As with the other MOH employees the UNV doctors do not participate in a performance monitoring system. They may attend hospital management meetings together with other senior health workers at the facilities.

Where Malawian DHOs exist, VSOs are well managed and their contribution appreciated. In the absence of DHOs in some districts, the UNV doctor may assume the role of the DHO for an entire district. This has some implications in terms of:

- Poor communication between the TA and patients - high illiteracy levels in Malawi necessitating the use of local languages while the TAs are only fluent in English
- Time to learn about the environment and the administrative procedures, and hence affecting management of services.

There are indications that the UNV/VSO doctors are settling well and their quality and quantity of outputs is valuable - they are doing well in gap filling. Table 40 provides a short and global impact assessment based on the observations made in three districts and one zonal office.

Table 40 -- Impact assessment of VSO Individual TAs

Name	Type	Effectiveness	Capacity built	Detriment
District 1	3 VSOs	Excellent; filling necessary vacancies	Trying to train local staff but limited success	None, except limited contract periods which are inefficient!

Name	Type	Effectiveness	Capacity built	Detriment
District 2	2 VSOs	Excellent		One not supervised initially but now involved.
District 3	1 VSO	Slow start in new medical position	None	None – giving full feedback!
Zone	2 VSOs	1 effective; 1 slow start but improving	Also using TAs from MSH for district training	Double salary and allowances causes discord. TA had to be reminded who is "TA's boss".

Commentary

It is too early to judge UNV/VSO doctor's capacity development efforts with regard to transfer of skills. However, in the absence of counterparts with similar technical skills as the TAs, it is unlikely that they are able transfer skills to MOH doctors. However, as is the role of all doctors, there is potential that they mentor clinical officers and medical assistants, thereby improving quality of care in the district.

As a stop gap measure, the UNV Doctors are doing a commendable job and this is a welcome development. However, VSOs do not currently have a mechanism for feeding back their lessons learned and experiences directly to the MoH, which, according to anecdotal evidence, can result in frustration if they are not included in the teams they are working with. In terms of performance monitoring, there is need to ensure district monitoring occurs. Lack of supervision could produce undesirable consequences such as prescribing practices which do not conform to national guidelines as well as difficulties in communicating with clients. Some VSOs need to be reminded that their allegiance should be to the local district health officer and his team and not to their paymaster.

5.5 TA provided by UN Organisations

5.5.1 Recruitment

UN Organizations such as WHO and UNICEF recruit local and international staff. These are TAs who are expected to provide technical support to the host government's institutions, in this case MoH. In particular, WHO's mandate is that of provision of TA to government's ministries of health on any priority health matter.

Apart from Country Office UN employees there are also others who are stationed in Regional and Headquarters Offices who can be requested by the Country Offices to provide special technical support.

5.5.2 Monitoring & Evaluation

The UN offices -in particular WHO- monitor and evaluate the performance of each TA using their *Performance Management Development System*. In the WHO case, the WHO representative and the TA agree on the objectives and expected outputs to be accomplished at the end of the year. Semi-annually they are monitored and final evaluation takes place at the end of the year where the Representative and the TA sit down and go through the set objectives thoroughly.

Commentary

The UN Agencies in particular WHO is providing high quality technical support to various technical programmes of the MOH such as Reproductive Health, Malaria, TB and HIV/AIDS among others. Support in health systems especially in the area of health financing – the national health accounts in particular and efficiency analysis have just started with the arrival of a health economist responsible for health system development support at the WHO country office.

There are indications that the MOH is not making full use of the TAs in UN offices especially those in the WHO and UNICEF country office who have extensive local, regional and international experience. The UN staff spend most of their time working on their own projects or office assignments and limited time is made available to supporting MOH technically especially in health systems strengthening issues.

The UN offices are poaching capable MOH and other local staff in a situation where HRH numbers and skills are seriously inadequate. Once poached their contribution to the MOH is limited due to institutional factors which are beyond the capabilities of the TAs.

Most individuals and organizations interviewed during this study indicated that WHO should regain its technical leadership role in health systems and services development, providing technical advice to MOH. WHO should be at the centre of organizing TAs for MOH and providing overall TA support in all areas as it is doing in the technical (vertical) programmes by working with officials from MOH directly. WHO TAs should have counterparts in MOH to whom they should transfer skills and most of the time of the TAs should be spent assisting the MOH.

Instead of UN Agencies being involved in direct implementation of programmes, its TAs should be working hand in hand with MOH counterparts in those programmes thereby strengthening overall health systems. This means that the UNICEF “hands on” approach will have to change.

UN TAs produce high quality outputs such as guidelines on specific topics requested by the MOH which greatly assist in improving programme design and delivery of health services. These tools are highly appreciated by MOH especially those in technical programmes and recently in health systems strengthening areas.

Very minimal impact in terms of skills transfer occurs as the period of duration the TAs work with MOH officials is often very short.

Commentary

UN Agencies, in particular WHO and UNICEF, have TAs who are highly qualified and experienced both at local, and international levels. However, MOH is not benefiting much from these TAs as they spend most of their time working on their office assignments. Even though WHO TAs are highly commended in the technical programmes there is the view that more could be achieved if there was a system which allowed them to work on a systematic rather than on an ad hoc basis. One reason behind this situation may be that there is no formalised working arrangement between MOH and the UN agencies. In some countries for example, such as Namibia, a health economist TA in the WHO Country Office has an office in the Health Planning Department of the MOH and he is regarded as the Chief Technical Advisor on most of the issues in health systems strengthening in the ministry.

Such working arrangements need to be created in Malawi especially bearing in mind that the country faces serious shortages of skilled HRH personnel in health systems and services development areas and most technical programmes and yet there are many qualified UN Agencies staff working in the health sector who are not fully utilized by MOH. WHO Country Office is willing and ready to release its staff such that they agree with MOH on the allocation of hours they can spend working directly with MOH. However, this also calls for improvements in MOH systems such as availability of space, communications systems-e-mail, internet etc.

5.6 TAs at District level provided by NGOs

The assessment of three districts and one zonal office was undertaken using DHO and Zonal officer advice. Detailed findings are found in the annex to this document. A summary of findings is found in Table 41.

Table 41 -- Assessment of District level TA provided by foreign NGOs

Name	Type	Effectiveness	Capacity built	Detriment
District 1	7 foreign NGOs.	1 excellent; 2 moderate; 4 ineffective. 2 of 7 attend extended DIP meetings. Most do not follow MOH policies.	Limited except for in-service training, which are often not priority areas, but which remove staff from duties.	Poaching; divisive salaries; distorting priorities of village health committees. *"No NGOs – no cholera"* is a quote when the DHO took charge of cholera prevention.
District 2	5 foreign NGOs	Breakthrough in all but one with NGOs attending and contributing to DIP. Only one able to respond to emergencies and local priorities. All reasonably cost-effective.	In-service training removes HSAs from priority duties.	Misdistribution of resources due to NGO priorities conflicting with district ones i.e. maternal mortality not being addressed.
District 3	8 local and foreign NGOs and 1 research project.	Beginning to contribute to DIP but not budgets yet. Lack of accountability to DMT. Geographical anarchy makes coordination almost impossible.	Practically no capacity building.	Some poaching but also some local system of supplementing MOH staff which mitigates differential salaries

Commentary

There are four main findings:-

1. Effectiveness varies from success to failure, despite often high quality personnel
2. Long term benefits are rare as projects tend to be short term (maximum of 5 years, and usually shorter)
3. Capacity building is usually absent. NGOs usually fail to offer professional training to their staff. Projects are not usually nested in existing national institutions. Foreign NGOs have a perverse incentive to limit local capacity building as this would put them out of a job
4. Detrimental effects are common and include:-

a. Poaching of staff

b. Lack of accountability and distortion of priorities particularly in districts.

c. Diversion of MOH staff time to non-priority in-service training at the expense of service work and to respond to the special needs of the NGO, such as hosting visits of overseas visitors.

One exemplar foreign NGO provides an example of how an NGO can minimise disadvantages and maximise advantages of TA support:-

a. Full involvement in DIP, both planning and implementation

b. Full transparency such as NGO budget included in DIP

c. Funding of a MOH staff incentive scheme

d. Targets for NGO included as part of DIP, assessed and counted using HMIS

e. In-service training agreed in DIP to meet local priorities and planned (to allow staff rotas and minimise disruption to services).

f. Ability to respond to district emergency priorities with resources.

Even such a good example has unresolved problems:-

a. Salary disparity, poaching and resentment despite salary support

b. Lack of local capacity building or exit strategy.

5.7 Future Requirements

TA Needs Assessment

The future need for TA depends on as assessment of the gap between required and existing skills and expertise in the MOH. For this, an assessment of the current capacities of the ministry's employees in various departments was made and their quality and quantity of outputs were reviewed with directors, deputy directors, programme managers and some current TAs. Furthermore, the proposed Functional Review Report, which has not yet been approved, was used to appreciate the already articulated needs of various departments and the potential capacity gaps. The TA assessment report by MOH which provides a summary of TAs whose contracts are being renewed for a further 12 -15 months was also reviewed.

A summary of needs is presented by Departments and using the established posts as a basis for evaluating availability of staff and educational background and experience of existing staff (tables 40 - 42). Since the functional review has not yet been approved, it will therefore not be used in this study. However the tables provided can be modified in the light of approvals after discussions and debate. These tables should then become the basis of future TA procurement.

Table 42 -- Central Level: TA Needs: Definition of positions/Functions needed

Department /Programme /Unit	Current situation			Existing skills &experience	Future skills needed	TA skills needed		
	Estab-lished posts	In-post	Gap/ surplus			Short-Term	Long-Term	Remarks
Health Planning& Policy Department								
1. Health Services Planning	11	7	-4	Heath Planning and health economics. No adequate skills in health sector reforms. Inadequate experi-ence-only one em-ployee has over 10 years experience in health planning	Health financing policy development and analysis, EHP, economic evaluation, resource allocation and resource tracking, health systems and services development, health sector reforms etc	Revision of Re-source Allocation Formula Development of pro-vider payment mechanisms-e.g. Performance Based Financing	Long-Term TA with skills and extensive ex-perience Health Financ-ing and Health Sector Reform	1 Fellow in place up to 2008 with skills in health economics but limited experience in health planning and health financing
2. Monitoring, Evaluation &Research	4	2	-2	Statistics and health information systems, medicine and public health. Extensive ex-perience in statistics and health information systems and in pro-duction of HMIS publi-cations	Monitoring, Evaluation and Research	Epidemiology		1 Long-Term TA in M&E already in place for the next 15 months and counter-part already in place
3. Infrastructure Unit	0	0	0	None	Infrastructure planning, design, moni-toring/supervision, evaluation, quanti-fication of bills of quantities etc		Long Term TA in Architecture Long-Term TA in Quantity Surveying	

Department /Programme /Unit	Current situation			Existing skills &experience	Future skills needed	TA skills needed		
	Estab-lished posts	In-post	Gap/ surplus			Short-Term	Long-Term	Remarks
4. SWAp Secretariat	0	2	+2	Health services delivery and management , stakeholder dialogue and involvement, health services planning	Health services planning and Stakeholder Dialogue, Involvement and health systems and policy development	Health Systems and Policy Development Health Services Planning	None	1 Long-Term TA in stakeholder dialogue and involvement already in place for the next 15 months together with counterpart
Health Technical Support								
1. Physical Assets Management (PAM)	2	1	-1	General health planning, administration and management. Extensive experience- more than 15 years	Technical coordination of physical assets planning, management and monitoring and evaluation, policy development, public/private partnerships approach to CHAM, training of maintenance and users of equipment, development of training plan for users of equipment, training needs assessment	Training needs assessment TA funded by JICA already in place until March 2007. Further TA support to be provided by JICA and GTZ on the basis of identified needs	No need for TA as PAM will be 'outsourced' and Long-Term TA already in place	1 Long-Term TA supported by GTZ up to 2010 already in place but has no counterpart. Need for counterpart. 1 Long-Term TA supported by JICA already in place until 2008. But has no counterpart
2. Essential Medical Laboratory Services				Extensive skills and experience in medical laboratory services	Strategic planning and implementation of Essential Medical Laboratory Services, completion of refurbishment of District Laboratories, review strategic plan, establishment of information systems			1 Long-Term TA already in place up 2009 and Counterpart already in place.
Finance & Administration								

Department /Programme /Unit	Current situation			Existing skills &experience	Future skills needed	TA skills needed		
	Estab-lished posts	In-post	Gap/ surplus			Short-Term	Long-Term	Remarks
HRH Department				General human resources management and development	Development of performance Management System, HRH planning and development, development of HRH deployment training , retention policies, development of HRH monitoring systems etc	HRH surveys such as 'Census'	Long-Term TA in Human Resources Planning	2 TAs already in place for the next 15 months and counterparts now in place. Need to ensure that CD is taking place and HRM management and monitoring systems are developed and they are functional
Finance/Accounting				Accounting, financial management systems	Accounting, financial management systems			2 TAs in for the next 15 months. Counterparts not yet assigned
General Administration				General health administration and management	Health systems Performance Management and Leadership-setting strategic program priorities, ensuring flow of adequate resources (human resources management, supply management, quality assurance, financial management and revenue generation); improvement in staff performance-communicating programme priorities and clear expectations, coaching and acknowledgement of performance) ensuring flow of accurate information for decision-making Partner Coordination and Dialogue	Health systems performance Management and Development, SWAp Coordination & Management		

Department /Programme /Unit	Current situation			Existing skills &experience	Future skills needed	TA skills needed		
	Estab-lished posts	In-post	Gap/ surplus			Short-Term	Long-Term	Remarks
Technical programmes								
Technical pro-grammes	0	3	+3	Medicine, public health in particular HIV/AIDS and care management	Coordination and implementation of PMTCT, Coordination of District As-semblies and other stakeholders at the district level in PMTCT and HTC, capacity building in HTC, capacity building of ART trainers and supervi-sors, monitoring and coordination of Global Fund with NAC, tracking HIV/AIDS resources, quantification of ART and medical supplies	No need for TA but need to provide Short-Term training to staff members	TAs already in place. How-ever there is need for coun-terparts or sending MOH personnel into long-term training	TA for PMTCT in place up to 2009; HIV Testing and Counsel-ling TA in place up to 15 months, HIV&AIDS Care and Support TA available up to 2008 and HIV/AIDS TA for coordination in place up to 2009.
HIV/AIDS Unit								
Reproductive Health Unit				Technical coordination and support of SRH Programme, updating STI Guidelines& train-ing materials, training of health workers, development of sexual assault guidelines	Provision of effective technical sup-port for the implementation of the Road Map for reducing maternal and neonatal deaths, monitoring and evaluation etc			Long-Term TA in Ma-ternal and Neo-natal Health already in place for the next 15 months.
Central Laboratory				Extensive skills and experience in microbi-ology, parasitology, Haematology bio-chemistry, his pathol-ogy etc	Confirming outbreaks, setting stan-dard for laboratory activities (Quality Control), provision of specialised laboratory services, modern tech-niques of disease diagnosis requiring skills in molecular biology, virology and immunology	Molecular Biology	Long-Term Specialist in Virology Long-Term Specialist in Immunology	2 TAs up to 2008 already in place but not working in the new areas of identi-fied TA need

Table 43 -- Zonal Level: TA Needs: Definition of positions/Functions needed

Department /Programme /Unit	Current situation			Existing skills &experience	Future skills needed	TA skills needed		
	Estab-lished posts	In-post	Gap/surplus			Short-Term	Long-Term	Remarks
Health Planning & Policy Devel-opment	0	3	+3	Medicine, public health and district health care admini-stration and man-agement	Health systems development and services man-agement, Health Services planning, Budgeting and resource allocation, health services monitoring and evaluation, leadership and management skills such analysis of service statistics, align and inspire/ or-ganize people, efficient resource utilization, integra-tion of vertical programmes etc	Performance Management Development System Health ser-vices planning Monitoring and Evaluation Resource allo-cation Budget-ing		5 TAs up to 2009 funded by GTZ al-ready in place. How-ever, only 3 have counterparts
Technical Pro-grammes								

Table 44 -- District Level: TA Needs: Definition of positions/Functions needed

Department /Programme /Unit	Current situation			Existing skills &experience	Future skills needed	TA skills needed		
	Estab-lished posts	In-post	Gap/surplus			Short-Term	Long-Term	Remarks
General Health Administration				Medicine and public health care man-agement	Leadership and performance management, health planning, resource allocation and budg-eting, partner coordination, monitoring and evaluation	Logistics and fleet manage-ment Leadership and performance management Monitoring and evaluation Quality assur-ance	Long-Term TA on District Health Sys-tems and Services Development and EHP Delivery	Only one Long-Term TA for a group of districts with extensive skills and experience in health systems and services devel-opment in particular EHP deliv-ery will be adequate
Curative Health Care Services				Medicine, nursing, health technical support-laboratory, pharmacy etc			Same as above	
Preventive Health Ser-vices								
Technical pro-grammes						Integration of vertical pro-grammes at the district level	Same as above	

5.8 Conclusions and Recommendations

The conclusions and recommendations provide options to maximise success and minimise disadvantages of TA.

5.8.1 Summary of findings and analysis

For individual TA performance there are four main findings:-

1. Individual TA activity has had mixed effect ranging from complete success to failure despite high calibre personnel. VSOs are usually effective. The success is partly dependent on the person involved and partly on the systems and situation in which the TA is placed. A long term effect is, however, often absent and usually a product of lack of capacity and skills transfer.
2. Cost-effectiveness tends to be limited due to:-
   - a prolonged orientation period at the start (particularly for expatriate TAs)
   - short tenure (often only 2 years)
   - high cost – travel, accommodation and international salary.
3. Almost no capacity has been built. Counter-parting has largely failed either due to lack of the counterpart or too much work on the ground for the mentor to do anything but service work. This happens with full time TAs in a Ministry which is overstretched. We recommend a special "mentor" scheme offering intermittent support on a non-residential basis for those senior staff who request such support. In this scheme the TA provides pulsed support for two weeks every three months; dependency is not possible and the TA concentrates on mentoring.
4. Detrimental effects include
   - poaching of staff working in the MOH
   - tension in directorates due to salary disparities
   - failure to address the functional capacity of the Ministry because of the propping up effect of TAs – providing palliation but not cure
   - failure to address the functional capacity of directorates because directors dislike the harmful and expensive features of the current TA system

For Project based TA there are four main findings:-

1. Effectiveness varies from success to failure, despite often high quality personnel.
2. Long term benefits are rare as projects tend to be short term (maximum of 5 years, and usually shorter).
3. Capacity building is usually absent. NGOs usually fail to offer professional training to their staff. Projects are not usually nested in existing national institutions. Foreign NGOs have a perverse incentive to limit local capacity building as this would put them out of a job.

4. Detrimental effects are common and include:
   - Poaching of staff
   - Lack of accountability and distortion of priorities particularly in districts.
   - Diversion of MOH staff time to non-priority in-service training at the expense of service work and to respond to the special needs of the NGO, such as hosting overseas visitors.

5.8.2 Long term objective

Based on the axiom that it is far better to have Malawians running services from Malawian institutions, it is assumed that the long term objective of SWAp partners is to phase out TA over a ten to 15 year period except for international expertise.

A transition policy needs to be devised and a TA pool funded in the interim. The recommendations contain policy options based on this analysis. The interim policy options cover needs assessment, recruitment, management and financial and contractual issues of TA.

5.8.3 Interim policy options

It is recommended that the following interim policy options are adopted.

Needs assessment

1. The needs assessment TA tables (40, 41, 42) are updated by the TWG on an annual basis and TA procurement is based on the gap between in post and requirement.
2. A mentor scheme is offered to senior staff and appropriate funds identified for this purpose.

Recruitment

1. A standard procurement procedure is adopted based on best practice described in the review (see paragraph 5.3.3).
2. TORs for identified TAs are drafted, and sent to the TWG for discussion and approval.
3. For TAs under SWAp Pool:-
   - a local management consulting firm is engaged to manage the TA recruitment process - similar to the role played by LATH during the recruitment process of the 9 TA posts in 2005. Support from an international health consulting firm in the initial phase may be appropriate to assist with international issues.
   - the local management consulting firm advertises the TA posts widely in electronic and print media and to specialized organizations.
4. For Bilateral TAs and UN agencies
   - the bilateral donor or UN agency advertises the post locally and the bilateral donor in their home countries (as is often the case that nationals from the donor countries are recruited)
5. The shortlisting of candidates for interviews is done jointly by the MOH, donors in the TWG and the local management consulting firm.

Candidates who score highly according to the agreed criteria are invited to attend for interview.

6. The interviews are held by members of TWG in the area of the TA need, led by MOH with the facilitation of the local management consulting firm. The chairperson of the interview panel should be one from the HSC.
7. For SWAp Pool TAs
   - The results of the interviews should be graded independently by the panel members. The local management consulting firm should prepare an interview report for submission to MOH management TWG for consideration.
   - The MOH should then communicate the names of the successful candidates directly.
8. For Bilateral TAs and UN Agency
   - The bilateral donor or UN Agency recruits the successful candidates.

TA management including performance monitoring and evaluation

1. Each TA recruited directly under the SWAp pool arrangement is managed by the appropriate MOH Director. MOH hires a management consultancy firm to introduce performance management which is then used for TAs as well as other staff. Each TA reports to a director and not to the PS.
2. Annual assessment undertaken in a transparent way, bearing the signature of the MOH director, of each TA is reported to the TWG. Where there is under performance, the MOH can recommend contract termination. The local management consulting firm (or bilateral donor) shall process the termination.
3. The assessment should consider the performance not only of the TA but the performance of the department / entity of the MoH supported by the TA against EHRP/POW targets (TA impact). The following points may be of relevance: Performance in providing information / issuing reports; implementation of planned activities; finance performance (where applicable); performance of MoH Department in driving the respective Technical Working Group; etc. This will help inform the decisions on where TA should be used and for how long.
4. UN TA staff are accommodated within the MOH department.

Financial and contractual arrangements

1. A “Special TA Pool Fund” is allocated within the MOH ORT budget and not included as part of the staff budget. The size of the SWAp pool TA fund would otherwise distort the MOH staff recurrent budget.
2. This Special TA Pool Fund is managed by the local management firm for payment to the TAs.
3. Locally employed TAs are offered a remuneration package at the same level as the MOH package for the comparable grade. As all TA posts are advertised locally and filled with local staff if suitable candidates found, secondments will be common as salaries will not change. The movement to and from TA posts will increase experience of staff and allow career development. The cost-effectiveness of TA will increase with lower expenses and shorter learning periods.

Parity of salaries will improve relationships within directorates. Poaching will be eliminated.

4. When a post is unable to be filled locally, is not a MOH vacancy and is a post requiring international level expertise, the level of remuneration may be increased appropriately to attract a suitable local applicant. The salary would need to be approved by the TWG to ensure parity with equivalent technical posts in the MOH is maintained.
5. A memorandum of understanding will be required of foreign NGOs and overseas research projects. The MOU will include[9]:-
   - An obligation to have salary parity of locally employed staff
   - For district based projects, the inclusion of project plans within the DIP, with annual assessment of performance and accountability to the District Assembly and MOH through the DHO. An annual approval of planned activities signed by the DHO at the start of each year, without which the NGO is unable to work.
   - A staff capacity building plan with budget and an obligation to use local training programmes if such exist.
   - An obligation to develop a local NGO, under the full control of Malawians, to take over the project within 10 years.

5.8.3.1 Questions and answers about the proposed TA policy

Q Higher than government salaries helps to raise pay of Malawians and keeps them from the brain drain.

A *This may be true for the few but not for the majority in the government service. A more fundamental effect is that the pressure to improve senior/middle grade government salaries is reduced*.

Q Some foreign NGOs like to have comparability of salaries between countries.

A *If salary parity is a requirement in Malawi for the NGO to work here, the NGO will have to decide which is more important – working in Malawi with salary parity, or not working here.*

Q Why include foreign research organisations with foreign NGOs in the TA policy?

A *Part of the work of a research organisation is equivalent to TA. In addition research organisations poach staff such as research nurses.*

Q Some TA posts are setting up programmes of limited duration. Should these be included in the MOH establishment?

A *Most programmes roll on from one to the next development requiring a stream of senior staff. Take for example HMIS. The first TA helped to set up HMIS. The second is helping to use and update HMIS. A third will be required in two years time to take HMIS to its next stage of development. In effect a senior post is and will always be required to assist the director of HMIS, and should therefore be part of the establishment.*

Q How does a foreign NGO set up a sister Malawian NGO?

[9] The current MOU draft has been amended to include our recommendations and is found in the appendix.

A *The Red Cross and Churches in Malawi provide examples of vibrant organisations in Malawi run by Malawians providing health services. Why not have MSF (Malawi)? The alternative to establishing a new NGO would be incorporation into an existing Malawian institution. For example a project largely involved in training such as that run by MSH might have asked to come under the umbrella of MIM or the COM and by so doing enhance local capacity to continue district strengthening activities once the project finishes.*

Q If foreign NGOs and organisations cannot pay higher salaries they will not attract good staff to work for them.

A *Their attraction will become non-monetary – a new challenge, a different range of colleagues and issues, perhaps some special training and the opportunity to widen experience – a similar range of incentives as offered in developed countries by NGOs. There, NGOs usually pay less than the government!*

Q Some donors and foreign NGOs might be put off by these conditions.

A *Please return to the findings and review the cost-effectiveness and harmful effects of some TA. These conditions will improve cost-effectiveness, accountability and reduce distortions. Donors will be pleased if TA becomes more cost-effective. MOH staff will approve the removal of distortions. Foreign NGOs will enjoy their new role as parents!*

6 Analysis and Summary of Study Findings

This section of the report analyses the data and summarises the findings of the study. It will be available for use by stakeholders in the setting of a workshop at central level in order to give feedback, check for consistency and to adopt an inventory of options for further action.

6.1 Progress towards the POW HR targets

Objectively verifiable indicators and their means of verification for Programme 1 – Human Resources are contained in the logical framework matrix of the POW (see Table 47). In addition some HR activities are contained in Programme 6 – Central functions such as HR policy development (6.2.1), coordination of TAs by Planning Department (6.2.5.1.4), quality assurance (6.2.5.5), setting up zonal support offices (6.2.7.1.4) and district health offices strengthening (6.2.7.2). Many indicators offer no baseline on which to judge achievement. Specific enrolment targets are available for the pre-service programme (Table 45). The SWAp indicators also contain HR indicators and targets (Table 46).

Table 45 -- Pre-service annual enrolment in training institutions in 2006 compared to POW target

Pre-service annual enrolment in Training Institutions 2003 and 2006						
BASIC COURSES Cadre	All institutions Actual 2004	Capacity 2006	Actual 2006	POW TARGET	% increase from 2004	% of POW target by 2006
Dip. in Clinical Medicine (Clinical Officer)	55	100	100	75	82%	133%
Cert. in Clinical Medicine	49	110	74	125	51%	59%
Diploma in Dental Therapy	15	20	35	35	133%	100%
Dip. in Environmental Health	21	25	21	25	0%	84%
Dip. in Biomedical Sciences	14	20	22	25	57%	88%
Diploma in Pharmacy	18	20	20	25	11%	80%
Nurse Technician Certificate	59	60	63	150	7%	42%
B.Sc. in Nursing	48	60	200	60	317%	333%
Cert. in Nursing & Midwifery	236	391	370	410	57%	90%
BSc Biomedical sciences/ lab sciences			36			
MB BS Medicine	20	60	53	60	165%	88%
Total	535	866	994	990	86%	100%

Table 46 -- SWAp Indicators for HR with achievement by 2006

SWAp Indicator on HR	Achievement by 2003/4 (baseline for POW)	Proposed targets for POW (-2010)	Achieved by 2006	Comments
Annual output of training health human resources:				
doctors	39	>60	24	5 yr training - 53 enrolled in 2006
general nurses	435	670	386	
clinical officers	75	125	133	
medical assistants	125	200	120	
HSAs	160	800		
Doctor:population ratio (per 100,000 popn.)	1.6		1.3	Assume 25 academic+5 private
Clinical officers + doctors : population ratio			7.4	Assume 10 academic
Nurse:population ratio (per 100,000 popn.)	28.6		31.6	Assume 20 academic+200 private
Percentage of health centres with minimum staff norms (2 nurse	0.23	>50%		
Doctor : patient ratio				
Nurse : patient ratio				
Wastage rate - doctors				
Wastage rate - clinical officers				
Wastage rate - nurses				

Table 47 -- Programme 1 – HR logframe showing achievements to 2007

		INTERVENTION LOGIC	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS AND RISKS	ACHIEVEMENT TO APRIL 2007	IDEAL REQUIREMENTS -FULL EHP(US$M) over 6 yrs		ANNUAL PROGRAMMED COSTS (US$m)					
							Capit.	Recc.	04/05	05/06	06/07	07/08	08/09	09/10
1		Purpose 1: Finance adequate numbers of trained and skilled personnel for all health facilities (incl. CHAM)	1. Vacancy levels 2. PE Budget 3. Outflow rates 4. Salary structure 5. % of facilities with full staffing complement	Routine MoHP and CHAM HR Information Systems	1. HR Management and development systems enhanced 2. Resource Availability	1. Vacancy levels in clinical posts – MOH 43% in 2003 to 33% in 2007 despite increase in establishment of 924 posts. CHAM 67% in 2007 (no 2003 data available). 2. Increase in filled clinical posts from 8972 in 2003 to 12470 in 2007 – 39% increase. 2. PE Budget – 3. Outflow rate – MOH attition level highest ever at 491 in 2005. 4. Salary structure modified and take home pay increased by 25-41% 5. No data available	55.3	407.3	28.2	34.095	39.095	44.595	48.595	53.095
1.1		Output: Pre-service Training							9.2	9.2	9.2	9.2	9.2	9.2
1.1	1	Finance implementation of the 6 year Pre Service Emergency Training Plan	1. Number of students graduating each year, by cadre 2. Number of institutions operating at full capacity	Enrolment students list(s)	1. Financial availability 2.Capacity of training schools 3. Quality of training	1. Clinical officers/MA 174; dental 35; EH 21; Lab 58; Pharm 20; medical 53; nursing 633 2. POW target of full capacity 990 – 2006 intake 994 of which 90 from Mzuzu. For other institutions – working to 91% capacity.	55.30		9.2	9.2	9.2	9.2	9.2	9.2
1.2		Output: Maintaining current staff, filling establishments and aiding retention through salary top-ups							18.25	23.7	28.7	34.2	38.2	42.7
1.2	1	Pay salaries and allowances on time and in full for staff currently in-post in 2003/4 -GoM district level	1. % PE budget expended 2. Outflow of HR from health sector	1. PPPI 2. Human Resource Surveys 3. CHAM HR information system 4.	Strengthening of Financial Management systems (see 6.3.4)	1. Finance data not available 2. See details of slow HR salary system in paragraph - The Policy Environment and HR Systems		50.92	13.7	13.7	13.7	13.7	13.7	13.7
1.2	2	Pay salaries and allowances on time and in full for staff currently in-post in 2003/4 -CHAM			Strengthening of partners' Financial Management systems			11.07						
1.2	3	Pay salaries and allowances on time and in full for staff currently in-post in 2003/4 –GOM central hospitals	As above but Central Hospital Level		Strengthening of Financial Management systems (see 6.3.4)			20.95						
1.2	4	Finance filling HR posts in-line with approved establishment -GoM district level	1. Vacancy levels against establishment, disaggregated by cadre (nurses, clinical	1. PPPI 2. Human Resource Surveys 3. CHAM	1. Throughput of training institutions maximised 2. Adequate recruitment and deployment policy in place 3. Establishment revised to reflect EHP development and functional review 4. PPPI accuracy enhanced. See Output 6 for HR systems and policy development	1. MOH and CHAM vacancy levels 2007 by cadre / 2007 Vacancy rate (%) Specialist Doctor 77% Medical Officer 60% Clinical Officer 35% Medical Assistant 28% Nursing Officer 78% Nursing Sister 55% Psychiatric Nurse 37% Community Nurse 69% Enrolled Nurse/Midwife 57% Environmental Health Officer 81% Health Assistant 73% Health Surveillance Assistant -2% Laboratory Related 63% Pharmacy Related 59% Radiology Related 75% Dentistry Related 52% Total 46%		37.85	2.0	4.0	6.0	8.0	10.0	12.0
1.2	5	Finance HSA and auxiliary nurses posts establishment -GoM district level						25.40						

		INTERVENTION LOGIC	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS AND RISKS	ACHIEVEMENT TO APRIL 2007	IDEAL REQUIREMENTS -FULL EHP(US$M) over 6 yrs		ANNUAL PROGRAMMED COSTS (US$m)					
							Capit.	Recc.	04/05	05/06	06/07	07/08	08/09	09/10
1.2	6	Finance filling HR posts in-line with approved establishment -CHAM						16.36						
1.2	7	Finance for filling HR posts in-line with approved establishment - MoHP Central Hospitals	As above but Central Hospital Level	1. PPPI 2. Human Resource Surveys 3. Expenditure/ Salary returns 4. CH Annual Plans				25.54						
1.2	8	Increase remuneration for health workers (at full establishment level, not HAS or aux. nurse)-GoM district level	1. New remuneration structure a closer reflection of labour market 2. Upgrading of posts/positions 3. Outflow of HR from health sector	1. Salary Structures 2. Labour market studies 3. Health Service commission documents	1. Establishment of Health Service Commission 2. Willingness to make special exception for health sector 3. Adequate capacity of the labour market to meet health sector needs	1. New remuneration structure in place with take home pay increase of between 25-41%		88.78	2.55	6	9	12.5	14.5	17
	9	Increase remuneration for health workers -CHAM	As above but for CHAM			As MOH		27.43						
1.2	10	Increase remuneration for health workers -GoM Central Hospitals	As above but Central Hospital Level					46.49						
1.2	11	Finance for a flexible TA fund for specialist, non-established staff needs at district level						12.48	To be added to PoW when financial availability and cost of programme known					
1.2	12	Finance for TA volunteers at district level						1.56						
1.2	13	Finance for a flexible TA fund for specialist, non-established staff needs at central hospital level						14.40						
1.3		Output: Provision of in-service training							0.8	1.2	1.2	1.2	1.2	1.2
1.3	1	Integrated in-service training of health workers	1. # of health workers receiving IST per district 2. IST contained in DIPs	1. HR Information system 2. DIP reviews	1. Development of a IST policy and system (see section 6.3.1)	No data available		28.07	0.75	1.195	1.195	1.195	1.195	1.195

6.2 Key issues for SWAp

The findings of this review are that:-

In filling vacancies

1) Filling posts has been successful (2335 new posts – a 26% increase) though filling vacancies has not (only a 3% improvement). The reason for the conflicting results is the increase in the establishment of 3030 new posts on top of the 2003 establishment of 16757.
2) Implementation of the six year emergency pre-service training plan has been successful. The training institutions are training at full capacity (994 in 2006) and they have reached the POW student enrolment target (990 per year).
3) Financing the filling of human resources posts in line with the revised establishment at GOM District and CHAM institutions has occurred although time to obtain approval for new staff can take ages and delays in paying newly trained staff are common.
4) Financing a flexible Technical Assistance (TA) fund for specialists and volunteers has occurred and 50 doctors and 15 nurse tutors are in post with 15 CIM doctors expected.

In strengthening human resources retention

5) There are still problems paying salaries and allowances on time for GOM and CHAM staff. *HR processes can be improved.*
6) Some incentive schemes have been introduced. Take home pay for health staff has increased by between 25 – 41%. *The incentives need to be evaluated and successful ones rolled out.*
7) Models of good in-service training have been developed but integration of vertical programmes and devolution to organise and fund at district level still needs tackling.
8) A career structure for clinical officers is absent. A strategic specialist plan for doctors, clinical officers and nurses is needed to shape continuing professional development and specialist training needs.
9) Managing staff remains difficult due to:-
   - Limited devolution of HR authority to districts
   - Insufficient emphasis on health management and leadership, for which a strategic plan (including training programme) is needed
   - Insufficient HR management capacity at district level, *which needs to addressed in the functional review.*

Some policy issues need to be addressed

10) The Health Services Commission is still unable to take on the full range of responsibilities laid down in the Health Services Act and needed for successful HR management. *This needs ministerial and UNDP involvement.*
11) There is a myriad of un-approved draft HR policies. *The most important is the HR Framework without which Global Funds will not be released*.
12) None of the HR policies deal with the imminent decentralisation of health including its human resources to district assemblies. The

concept of decentralisation is absent from them, and yet the movement to local government will have a profound effect on health staff. *A combined initiative by the MOH and the Ministry of Local Government could rest the power of HR currently held by DHRM&D.*

Technical Assistance

13) Technical assistance is usually effective, but is failing to build capacity, has serious detrimental effects and is expensive.

14) An overarching policy needs to be agreed – that a process needs to be established so that TA is unnecessary in ten years.

15) Recommendations are offered which will improve recruitment, management, and cost-effectiveness of TA while building local capacity and removing the distortionary and divisive effects of salary disparity.

7 Capacity Development Strategy

Based on the results of the Human Resources Situational Analysis and Needs Assessment Study and the input provided by UNDP through their analysis of the MoH institutional and organisational capacities, a draft CD Strategy for the Health Sector dealing with the identified needs & gaps will be developed and discussed with all stakeholders.

Within this strategy, the following areas of Capacity Development will be considered:

- Particular needs in the area of basic and continuous medical education and professional development: specialist training, tutoring / supervision of students and staff, educational (pedagogical) training of teachers, coaching programmes.
- Development and implementation of Clinical Practice Guidelines / Pathways
  - e.g. Paediatric Hospital Initiative / Integrated Management of Childhood Illnesses (IMCI)
  - Zonal Supervisors / Training of Trainers Approach
- Health Systems and Services Management skills at Zonal and District Levels
- Availability of decentralised budgets (including zonal offices)!
- Monetary and non-monetary incentives
  - Performance based financing including staff premiums (PBF)
  - Quality (Assurance) Award (for outstanding performance)
  - Housing / Accommodation / Transport / Hardship Area allowances
  - Scholarships
- Involvement of Private Sector / NGOs in the implementation of the CD strategy
- Continuous Capacity Development through TA
  - How to deal with the Counterpart Principle when Counterparts are not immediately available - what are intermediate strategies?
  - What would be the (future) focus of TA in order to better fulfil the role of Capacity Builders (rather than gap fillers)?

8 People interviewed

Dr. N. ALIDE	DHO, Thyolo	MOH
Ms. T. ARARU	Technical Assistant, SWAp Secretariat	MOH
Dr. S. BABU	Technical Assistant, Monitoring, Evaluation & Research	MOH
Mrs. S. BANDAZI	Ag. Director, Nursing Services	MOH
Prof. E .BORGSTEIN	Dean of Postgraduate Studies, COM	COM
Dr. C. CAMPBELL	CDC, Blantyre	CDC
Dr. B. CHILIMA	Deputy Director, Public Health Laboratories	MOH
Mr. I. CHINGWALU	Technical Assistant, HRHD	MOH
Ms. C. ELDRIDGE	DFID Fellow, Health Planning & Policy Department	MOH
Mr. GODDIA	Head of Anaesthesia School	MCHS
Mr. D. HORNEBER	Technical Assistant, PAM Programme	MOH
Dr. P. JISKOOT	Project Manager CO Surgical Training	CHAM
Dr. M. JOSHUA	Zonal Supervisor Central East Zone	MOH
Dr. S. KABULUZI	Deputy Director, Community Health Sciences Unit	MOH
Mr. G. KACHEPA	Director of Finance	MOH
Mr. V. KANG'OMBE	Secretary for Health	MOH
Mr. E. KATAIKA	Deputy Director, Health Planning & Policy Department	MOH
Dr. J. KEMP	Health Advisor	DFID
Mr. H. KUCHANDA	Technical Assistant, HRHM	MOH
Dr. D. LUNGU	Deputy Director, Clinical Services	MOH
Mrs F. LUNGU	Clinical Tutor, Malawi College of Health Sciences	MCHS
Ms J. LUNGUDZI	UNFPA	UNFPA
Mrs. F. MATSIMBE	Senior Deputy Secretary	MOH
Ms MHUTU and Mr A MHANGO	DMT, Blantyre	MOH
Mr K. MKANDAWIRE	Malawi Medical Council	MCM
Dr. N. MKANDAWIRE	Head of Orthopaedic School	COM
Dr. M. MOETI	WHO Representative	Malawi
Mr. C. MOYO	Deputy Director, Monitoring, Evaluation & Research	MOH
Dr. J. MPUNGA	DHO Chiradzulu	MOH
Mrs L. MWASE	Program Manager (Health) VSO	VSO
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Mr. M. PHIRI	Ag. Director, Technical Support Services	MOH
Dr. A. PHOYA	Head, SWAp Secretariat	MOH
Dr. E. RATSMA	Zonal Office – Zomba	MOH/GTZ
Mr. T. SAMBAKUSI	Statistician, Monitoring, Evaluation & Research	MOH
Dr. E. SCHOUTEN	Technical Assistant, HIV/AIDS Unit	MOH
Dr. H. SOMANJE	Director, Preventive Health Services	MOH
Dr. E. SOME	Head, Health Section	UNICEF
Mr E. WOCHI	Controller of Human Resource Management and Development	MOH
Dr. NN	MSF Chiradzulo	MSF
Administrator	St Joseph Hospital	CHAM
Principal	St Joseph Nursing College	CHAM

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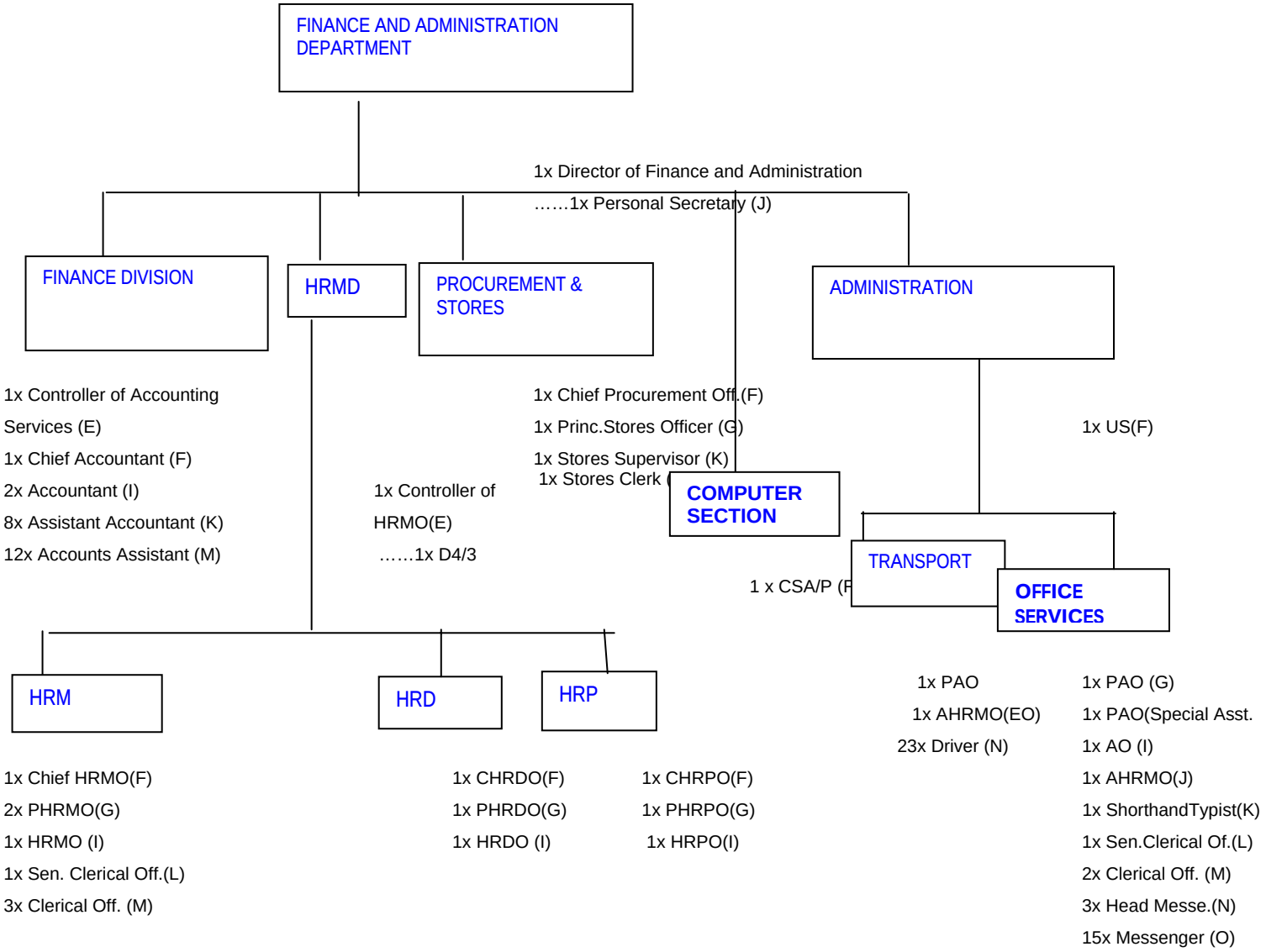
Figure 13 -- Organogram for DOFA as recommended in the Functional Review



11 Appendix

11.1 Detailed Assessments of Three Districts and Zonal TA

11.1.1 Thyolo

Name	MSF (Luxemburg)
Type	foreign NGO
Service	AIDS prevention and treatment
Effectiveness	Excellent. Superb TA and resources to fund drugs, medical services, logistics, and community involvement. Unable to respond to local priorities quickly but tries to over time. Plans now part of DIP but planning year not synchronised with DIP. Has own targets of performance – to be incorporated into DIP.
Capacity building	Very limited; no apparent exit strategy; one staff member sent to foreign learning institution; one member of staff refused study leave for MPH; in-service training programme now part of DIP.
Detrimental effects	limits poaching to MOH staff outside district; trying to hold back salaries and using incentive bonuses; salaries differentials still divisive.
Name	Africare
Type	foreign NGO
Service	Nutrition, community IMCI
Effectiveness	District chosen by UNICEF – vertical programme; no flexibility to meet local priorities; frustrates horizontal integration at community level; not part of DIP; occasionally comes to coordination meetings; own training programme taking staff from duty; probably cost-ineffective.
Capacity building	None
Detrimental effects	poaching of staff; not answerable to DHO.
Name	Oxfam
Type	foreign NGO
Service	Sanitation
Effectiveness	Desk officer holds huge amount of funds; inefficient and not cost-effective; funds could be channelled through district EHO schemes.
Capacity building	None
Detrimental effects	Poaching of staff; not answerable to DHO.
Name	COMWASH
Type	foreign NGO
Service	Water and sanitation
Effectiveness	Limited; *"half the taps were broken before they left";* no continuity or sustainability.
Capacity building	None
Detrimental effects	poaching of staff; not answerable to DHO.
Name	World Vision
Type	foreign NGO
Service	Development work in one area
Effectiveness	Very costly and cost-ineffective; not targeted; no plans submitted or part of DIP
Capacity building	None
Detrimental effects	poaching of staff; not answerable to DHO.

11.1.2 Chiradzulu

Name	MSF (France or Belgium)
Type	foreign NGO
Service	AIDS prevention and treatment
Effectiveness	excellent. A model of cooperation. Superb TA and resources to fund drugs, medical services, logistics and infrastructure. Has ability to respond rapidly to district priorities. Plans, both service and training, now part of DIP. Budget now also included – a battle but relented;
Capacity building	very limited; no apparent exit strategy; in-service training programme now part of DIP, planned at least one month in advance to ensure staffing is not compromised and limited to maximum of 1 week.
Detrimental effects	Giving incentive bonuses to MOH staff to be included in next year's budget (5-8000Kw/month). Still huge disparities in salaries – *"MSF driver gets same salary as DHO".* Refuses to poach from MOH.
Name	Concern Universal
Type	Foreign NGO
Service	Water and sanitation; nutrition
Effectiveness	Attend extended DIP. Villages not chosen by DHO.
Name	Oxfam
Type	Foreign NGO
Service	HIV/AIDS; nutrition
Effectiveness	Attend extended DIP. No budget.
Detrimental effects	Poached one nurse from Mulanje. Works in only 2 TAs – resentment from other TAs.
Name	DAPP
Type	NGO
Service	HIV/AIDS
Effectiveness	Does not attend any meetings.
Name	World Vision
Type	Foreign NGO
Service	HIV/AIDS; nutrition
Effectiveness	Attend extended DIP. No budget.

11.1.3 Blantyre

Name	Goal
Type	Foreign NGO
Service	AIDS prevention and treatment
Effectiveness	Difficult first year but brought into line this year contributing to DIP and pursuing district policies. Locations not appropriate. No budget.
Capacity building	Partial – one senior staff on MPH – self funded but study leave given.
Detrimental effects	Poaching from local staff not occurring.
Name	DAPP
Type	NGO
Service	HIV/AIDS
Effectiveness	Does not attend any meetings but has put plans but not budget to DMT this year.
Name	BLM
Type	Local NGO
Service	Urban family planning.

Effectiveness	Not involved in mat mort meetings despite abortion service deaths. Not open about services, plans or budgets. Tubal ligation complications threaten whole TL programme. Lack of transparency and shared governance.
Name	World Vision
Type	foreign NGO
Service	Water and sanitation; nutrition
Effectiveness	Attend extended DIP. No budget. Villages not chosen by DHO. Multiple small sites makes overall coverage impossible. Lots of noise – less sound activity.
Name	Oxfam
Type	foreign NGO
Service	HIV/AIDS; nutrition
Effectiveness	Attend extended DIP. No budget. Taken one whole TA. Easier to manage.
Name	Hunger Care
Type	foreign NGO
Service	Nutrition
Effectiveness	Limited contribution to NRUs in hungry seasons.
Name	Salvation Army
Type	Acts as foreign NGO
Service	HIV/AIDS
Effectiveness	Cost-ineffective; limited technical expertise; not integrated into pastoral church work.
Name	FHI
Type	foreign NGO
Service	Acts as donor
Effectiveness	No contribution to DIP. No accountability locally; subcontracts to other NGOs; highly cost-ineffective (middle man with no added value); USAID funding has restricted use and no flexibility; reneges on promised funding putting a range of home based care projects into jeopardy.
Capacity building	Very limited – one MPH self funded student given study leave.
Detrimental effects	High salaries poach staff.
Name	Roravirus vaccine research project
Type	foreign funding through COM
Service	Clinical Trial in peri-urban sites
Effectiveness	Displaces staff efforts.
Capacity building	None to MOH
Detrimental effects	High salaries poach staff from Queens but not community, where salary supplement in place for HC nurses.

11.2 MSH/HPSA Hospital Reform Program

11.2.1 Background

USAID is providing support to the MoH Program on Hospital Reform (previously known as Hospital Autonomy) through the "Reducing Child Morbidity and Strengthening Health Care Systems in Malawi" Program being implemented by Management Sciences for Health (MSH) in partnership with Health Partners South Africa (HPSA). The focus of the Hospital Reform Program is on strengthening central hospital management systems and institutional development. A critical step in the

Roadmap for Hospital Reform was to undertake a baseline survey of management systems at QECH and KCH focussing on those systems that could be strengthened prior to passing legislation on hospital reform scheduled at the time for later in the year 2004.

11.2.2 The Approach

The overall objectives of the baseline survey were to:

- Develop a thorough understanding of central hospital management systems that are critical to improving the overall performance of the hospitals.
- Provide baseline information for assessing the impact of the Hospital Reform Program and to identify key milestones/ performance indicators that can be used to monitor progress, and
- Formulate proposals and an implementation plan for strengthening central hospital management systems in each hospital over the next twelve months.

The baseline survey addressed the following eight areas:

- Decentralisation of management (both from MOHP to central hospital and from hospital management to cost centres),
- Strategic and operational planning and performance management,
- Financial management,
- Human resource management,
- Documentation of hospital management systems,
- Management of equipment, drugs and medical supplies, and dental, radiographic and medical laboratory supplies,
- Care delivery improvement, and
- Hospital management information system.

From each area listed above, the baseline survey identified the main activities undertaken, highlighted key findings/gaps and proposed critical interventions required of the program to address the gaps. The initial selection of interventions focussed on those areas that could be implemented prior to legislation being passed, where implementation activities were to be under the control of the hospital management in order to have a significant impact on hospital services. In this presentation, efforts were made to highlight the achievements in the last three or so years and cite the remainder of needs, problems, concerns, or challenges to be noted for capacity building.

11.2.3 The Gaps/findings from the Baseline

11.2.3.1 Decentralized Management from MoH to Hospital

The decentralisation from MoH to hospital management was very limited and hospital managers were frequently mere operational coordinators. This had an adverse impact on the day-to-day operations as well as strategic management of the hospital. Although the hospital did the “footwork” for various strategic and operational requirements, they could not make decisions due to the centralised decision-making process. Decision-making was seen as highly centralised for organisational de-

velopment and review, personnel administration, medical stores, financial management, procurement and clinical service contracting. Many of the problems identified required legislative reform to improve central hospital management.

11.2.3.2 Decentralising Management from Hospital to Cost Centres

The organizational structures of hospitals that existed in 2003 were based on a "silo" approach to organizational development that was not conducive to cost centre management. The following aspects, which were critical for effective unit operations, required improvement in management at a cost centre level:

- Budgeting & expenditure control
- Personnel management
- Revenue management
- Performance review

Cost centres required a management structure that could take into consideration the needs of both clinicians and administrators. At QECH the structure of the cost centres required incorporation of the College of Medicine (CoM) as a significant role player. This was seen as a huge advantage in that the CoM was seen as having the ability to harness additional resources that could be used to complement and improve service delivery. In general, the development of cost centres was seen as a significant step in order to transform the hospitals from passive recipients of donated goods, to active recruiters of resources that could be channelled in a co-ordinated and prioritised manner.

11.2.3.3 Resource Management at Department / Cost Centre Level

Based on discussions with numerous heads of department, the following aspects of resource management at department / cost centre level became apparent:

- Revenue generation was fairly limited and the ability of different departments to raise revenue varied.
- There were other resources like human resources, equipment and in kind donations that various departments had access to that highlight the needed to think "beyond revenue" to harnessing all kinds of other resources. Management of these resources needs to be formalized.
- Central hospitals in Malawi have inherent "assets" that attract academics, research organisations, funders and private providers to invest in the hospitals. These "opportunities" could become the basis for collaborative partnerships with donors, universities, private organisations, such as pharmaceutical companies (e.g. Pfizer Global Health Fund), but the opportunities were not utilized.
- Private sector practitioners may be interested in giving their time to support the services (e.g. dental department) in exchange for their patients having access to the hospital facilities. This was not explored.

In order to create a more favourable context in which donations could be accepted, it was envisaged that the hospitals could:

- Set the agenda (prioritise the areas in which support, equipment, etc would be needed);
- Set the terms for co-operation, and
- improve linkages/co-operation between departments.

11.2.4 Hospital Business Planning

The hospitals conducted strategic planning from a budgetary point of view, and all strategic objectives and goals were aligned with the budget compilation process. Although the MoH had a strategic framework, the hospitals did not have a consolidated annual business plan. Instead, they had a strategic financial plan which incorporated a personnel budget, a capital development budget, a maintenance budget and a recurrent expenditure budget. There ware no annual hospital performance reviews that would use a business plan as baseline.

11.2.5 Integrated Service Delivery Framework

The number of beds within the various clinical units did not relate in any way to the number of patients and the number of admissions in specific units. There was no integrated service delivery framework that defined the type, level and quantity of services to be delivered in a unit in relation to logistical and clinical support units to optimize service delivery. This had a significant effect on the expenditure of the units in relation to their workloads. The lack of operational planning may have resulted in inappropriate expenditures in clinical areas and also contributed to ineffective performance management in terms of service delivery protocols. The hospitals at the time rendered all levels of care within the health system at inappropriate costs, actually subsidizing district hospital services and health centre services. Without a clear integrated service delivery framework, the central hospitals would continually suffer high expenditure and provision of inappropriate levels of care.

11.2.6 Availability of Accurate Information

For any hospital to do adequate strategic, service and operational planning, it needs accurate and readily available information. At the time of the baseline, a wide range of data sets were available but the accuracy and relevance thereof was questionable, which meant that hospital planning was not always reliable.

11.2.7 Hospital Performance Management

There were no hospital performance management reviews carried out, as performance was not measured against set objectives and no benchmarks were in place. Expenditure was not analysed against workloads within the various clinical and other units, although selective analysis was done within certain units, but not to the extent of measuring performance. There was no integrated system or approach to hospital performance management, and managers did not have a set of key hospital performance indicators that could be used for hospital performance reviews.

11.2.8 Findings/Gaps in Financial Management

11.2.8.1 Budgeting Process, Cycle and Format

The hospital's centralised budgeting process had a gap between the budget allocation and expenditure of units. Units were not aware of the funding brackets available and the allocation thereof. The hospitals had committees that undertook budget compilation based on the needs that were prioritised by an internal procurement committee from the needs submitted by various units. From the submitted needs, 5 different budgets were compiled:

- Recurrent expenditure budget
- Personnel budget
- Capital planning/maintenance budget
- Drug & medical supplies budget (Not hospital based)
- Supplementary recurrent expenditure budget

Although units were represented on the budgeting committee they did not set budgets for their own respective units. Each units did not have a comprehensive budget against which they it could monitor expenditure. For example, units could not analyze expenditure against workloads and set objectives.

11.2.8.2 Revenue Management

The hospitals had no revenue management system in place. Analysis was only done in terms of fluctuating revenue collected on a quarterly basis. Analysis of potential revenue that could be collected, revenue identified (billed), and actual revenue collected against paying patient workload was not done. No annual revenue targets were being set. A national policy had been approved that enabled hospitals to retain 80% of the revenue collected, but hospitals did not take advantage of this provision. There were various developments underway on patient classification structure and patient fee structure but once these structures were approved they must be implemented within the context of optimizing the identification, billing, collecting of revenue as well as the setting of revenue targets. The implementation of these structures without having an appropriate revenue system to facilitate the process, would not achieve the anticipated increased effectiveness in the revenue management process.

11.2.8.3 Expenditure Reviews

The existing expenditure reviews were not adequate in addressing the various areas of expenditure containment. Expenditure from the various units were not analysed in relation to their outputs/workloads. There were no means for identifying inappropriate expenditures other than the internal procurement committee prioritising the needs submitted by the units. These priorities were not always aligned with the service delivery outputs of the units. There was a general feeling that not all of the unit supervisors were appropriately trained for effective financial management. This was the main reason why the finance function was highly centralised.

11.2.8.4 Management Accounting System for Hospitals (MASH)

The management accounting system for hospitals (MASH) that had been developed and introduced at Kamuzu Central Hospital, was used partially to assist the hospital with its human resource audit process. The MASH system was a very comprehensive system which incorporated almost all aspects of hospital information systems and human resource systems. This could be used as a costing tool that could calculate expenditure per unit and per item. However the system was too complicated for establishing basic management inputs and outputs required for day-to-day decision-making. MASH was fed by the PMIS, HMIS and PAM. Currently not all the required data fields within the MASH system are captured because it requires very detailed information e.g. square meters utilized by a person, costing each pen, paper and equipment utilized, etc. This is beyond the capacity of existing information systems and can only be activated once the systems "feeding" MASH are producing accurate information reflecting the true nature of each specific area. There are however specific utilities within the MASH system that can be utilized with minimal inputs. It was proposed that the basic areas of the system would be incorporated into the IPMS.

11.2.9 Finding/Gaps on Documentation of Health Management

11.2.9.1 Lack of Policies and Procedure Manuals

Policy documents relevant to most management systems were being issued by the MoH and other Ministries on an ad hoc basis. However, these documents were not readily available to all employees that are required to implement them. There was a general lack of documentation of management processes and procedures and virtually no formal management manuals existed. The lack of procedural guidelines meant that there was in general no framework within which to operate and that performance could not be measured as norms and standards were not in place.

Policies, as determined by the MoH, were to be used as the basis from which to work, and the procedures that outline the step-by-step process to follow were to come from these policies. The lack of procedural documentation for both clinical and non-clinical services could hamper effective day-to-day hospital management and service delivery. The majority of the systems were run manually, often without the correct mechanisms in place for optimal expenditure and cost management.

11.2.9.2 Lack of Human Resources policy and procedure manuals

There was a general lack of human resource policy and procedure manuals, and what was available, is not always up to date. Certain Human Resources documents were available but the forms only recorded data, without the necessary means of verification, analysis and consolidation.

11.2.9.3 Human Resource Management

Human Resources management was loosely run and the function is not integrated with the strategic and operational hospital management. Human Resources statistical data was not always available or consolidated and reports provided fragmented information.

11.2.9.4 Performance Management

No performance management system was in place and the annual salary increases were not subject to any formal performance rating or evaluation. No performance agreements or other performance-related documents were available. There was no mechanism in place to identify training needs, or to track individual development plans.

11.2.9.5 Human Resources Plan

There was no human resources plan in place in either hospital.

11.2.9.6 Post and Job analysis

In most jobs, there were no job descriptions, and where there were some available, they needed to be up dated.

11.2.9.7 Registry System

The registry offices lacked procedural guidelines and did not have an effective mail or staff filing management system. Incoming and outgoing mail was not recorded and mail was not collected or delivered to the various sections in the hospital. Salary slips were not always delivered or signed for by the section heads or the individual employees. Employee numbers were not recorded on the personnel files, and files were located in a different register. Finding files for instance was therefore time-consuming and the files contained large volumes of different categories of information, not filed in a systematic manner.

11.2.9.8 Human Resources Development and Training

There was no human resources development and training policy and procedure manual, and there were no training-related data, information or documentation available. Training needs analyses were not conducted, individual development plans were not in place, and there was no skills and competency database. Most training was conducted on an ad hoc basis.

11.2.9.9 Staff Attraction and Retention Strategy

No staff attraction and retention plan was available, nor was there a specific strategy in place for the employment of foreign-qualified doctors. There appeared to be no memorandum of understanding or agreement for staff exchanges with local or international academic institutions at the hospital level.

11.2.9.10 Leave Management System

The leave management system was not functioning properly as there were no procedures or documentation in place. The leave records were not up to date and the leave application forms reflected what each individual stated the leave balance to be, and not based on records. No leave reconciliation was being done and monthly leave reports were not being generated for verification by managers.

11.2.9.11 Development of the Manager's Toolkit

There were no guidelines for managers and no management development programme in place for management, other than the centrally arranged block of training that clinicians attend prior to commencing duties at the hospital, and documentation on this was not available.

11.2.10 Improvement in Central Hospital Functioning

11.2.10.1 Main achievements

During the course of three years, there have been a lot of improvements towards the hospital reform program. There have been developments in the documentation of management systems as undertaken in human resource (HR) administration, transport guidelines, pharmaceutical management, and cost centre management procedures.

11.2.10.2 Human Resource Administration

Implementation of Human Resource Policy and Procedures (documented in the HR manual) proceeded at cost centre level at both hospitals, i.e. KCH and QECH. Cost centre managers have made recommendations on some changes to the documents. The registry systems continued to be functional and filing and retrieval of files has been made much easier ensuring that essential information is readily available. HR Admin is operational at both hospitals and the production of reports and monthly returns has improved information flow to hospital management and MoH.

11.2.10.3 Financial Management Information System

The program introduced ACCPAC accounting system. The functionality of the system has improved considerably at both hospitals. Much of the backlog in data entry has been caught up and monthly reports are being produced. Systems at both hospitals were rolled over to the 2006/07 financial year and data capturing for each current financial year has started.

11.2.10.4 Decentralization of Financial Management to Cost-Centers

Decentralization of financial management to cost-centers is underway. The involvement of Cost Centre Managers in decision making is generating a high sense of belonging and has improved information flow down to the staff. Although considerable progress has been made in developing cost centre business plans, generating HMIS reports and allocation of HR resources, progress on decentralization of financial management has been slow. However, the demands from cost centre managers for allocation of financial resources to cost centres and producing better financial reports is encouraging and provides much needed impetus to improving data capturing in ACCPAC and generation of financial reports that can inform decision making.

The consolidation of cost centre business plans into a consolidated hospital business plans are near a reality in both hospitals and the process involves documents being distributed to cost centre managers and core management team members for their input before being finalized. This develops ownership and commitment to implementation. Both KCH and QECH will be able to produce Annual Report for circulation.

11.2.10.5 Central Hospital Information System

The Central Hospital Information Systems is now operating smoothly. The units continued to get demands for information from various departments and provide the necessary reports for performance reviews.

11.2.10.6 Periodic Performance Reviews

An expenditure and performance review covering the period January to June was held which incorporated the annual review. Included among the usual key performance indicators regularly reviewed were human resource indicators and analysis of patient complaints.

Example of Performance Management at QECH

The Initial Problem
There was no hospital performance management at QECH before. As such, the hospital did not set objectives or benchmarks against which performance could be measured. Although selective analysis was carried out in certain units, it was not done to the extent of measuring performance. Expenditure was not analysed against workloads within the various clinical and other units. An integrated system or approach to hospital performance management was not in place, and managers did not have a set of key hospital performance indicators that could be used for hospital performance reviews. Assisted by MSH/HPSA, QECH began to have Performance Management in 2004.

Rationale for Performance Management
At the beginning of the Performance Management Cycle, the hospital is required to sets performance objectives with benchmarks and performance indicators as part of the business plan. This is done in order to provide a baseline against which performance would be measured at the end of the cycle/year.

Performance Indicators
A Performance Indicators Manual was developed and is made available and distributed to all heads of sections and departments. The Manual stipulates the type of indicators to be considered in each cost centre/department. It provides their definitions, how they are calculated, the rationale for having them, data sources for each indicator, and actions to take to achieve desirable results.

Analysis of Indicators
All indicators are analysed, discussed, and their implications in terms of allocation of resources (staff, finances, transport, etc) against quality of care, are identified. The financial indicators include revenue generated against the budget/released ORT, cost per patient day, drug cost per PDE, etc and their implications and interpretations are analysed using graphs and other visual illustrations.

The Ten Step Cycle
The performance cycle includes a review of the vision, mission and objectives of the hospital and objectives of each cost centre; a definition and description of the desired performance in each cost-centre / department; setting performance objectives and benchmarks as part of the Business Plan; reviewing the performance of the previous year; identifying resources and developing the Business Plan for the year; agreeing as to activities for the year as part of the implementation plan for the Business Plan; in the course of the year, implementing the plan activities; conducting Performance Reviews, at agreed periodicity i.e. monthly, at cost-centre level, and quarterly, at Hospital level and make adjustments; at end of the year, conducting an Annual Performance Review and assessing achievements, i.e. using the Business Plan, with its set objectives and benchmarks and agreed indicators, as baseline; and developing and setting objectives and action plans for the Business Plan for the coming year, as part of the Hospital Annual Report to be produced.

COMMON HOSPITAL INDICATORS

These usual hospital indicators include:
- Admissions,
- In-patient deaths as a percentage of discharges,
- OPD attendance month to month,
- Paediatric OPD attendance versus admissions,
- Medical OPD attendance versus admissions,
- Hospital in-patient days,
- In-patient deaths per 1000 admissions,
- In-patient death rate month to month and annual trends,
- Direct obstetric death rate month to month and annual trends,
- Average length of stay month to month and annual trends,
- Bed occupancy rates by department and annual trends,
- Bed turn-over rates, etc.

Performance Review Meetings
Those who attend the quarterly and Annual Performance Review Meetings include all heads of sections and departments with their unit matrons, representatives of Blantyre DHO, College of Medicine (COM) Department of Community Health, the Technical Specialist from Management Sciences for Health, representatives from ZHSO (SW) and the HMIS officer.

During the reviews, participants examine available data and information consolidated by the HMIS Officer in form of tables/graphs of calculated indicators and raw data to all departments one to two weeks in advance of each meeting. In the meeting, the participants analyse and discuss trends, review implications, financial and otherwise, and inform the business planning processes of what is happening. The results of the review meetings feed into the Hospital Business Plan which becomes part of the Hospital Annual Report.

11.2.11 Physical Assets Management

At KCH the medical equipment inventory exercise undertaken by the equipment standardization task team, completed its work and data was entered into the MoH database by Physical Assets Management (PAM).

11.2.12 Strengthening Drug/Pharmaceutical Management

Considerable progress was made in pharmaceutical management strengthening at both hospitals. At QECH, the renovation of the pharmacy was completed and has strengthened supervision, improved both storage and dispensing environments and enhanced security. Other improvements include developing a new stock control system, designing data collection forms and electronic compilation files to track pharmaceutical consumption by cost centre, production of a pharmacy bulletin which is distributed to prescribers, and training of the pharmacy clerk on computer operation for service level reports and management of electronic files for procurement records.

At KCH, the rolling out of electronic pharmaceutical inventory control system (ePICS) at pharmacy stores and strengthening its functions continued and included introducing electronic stock cards, activating the transactions of lending and exchanging drugs, introducing automatic reminders for stock control, introducing a board-off drug list, and improving some operating procedures. New reporting and supervision systems for ePICS were established including installation of a touch screen computer in the director's office so that he is able to supervise the activities in pharmacy stores and check/produce reports from his office any time.

11.2.12.1 Needs/Problems/Challenges Encountered

- Financial management at both hospitals is compromised by delays in data entry in ACCPAC and inadequate financial reports. Maintaining dual systems places additional burdens on staff.
- The revenue management system (RMS) at QECH has sometimes stagnated. Despite the patient charge sheets being completed, no reports were generated from the system. With the stability in the implementation of ACCPAC, focus now will be directed towards RMS.
- Introduction of a new salary payment system by the MoH resulted in staff receiving new salary numbers which will have to be entered in HR Admin system to replace the old numbers.
- HMIS departments at both hospitals are experiencing problems including poor performance of computers, shortage of clerks for data collection, and delays in data submission.
- Implementation of pharmaceutical management systems at both hospitals is compromised by shortage of clerks and pharmacy technicians (intake of pharmacy technicians at institutions like MCHS to increase to meet the demand/gap), dysfunctional computers, and lack of essential equipment.
- Integration of the DHIS and PMIS at KCH needs to be improved to ensure that accurate patient activity data is being produced for use by the HMIS and performance reviews. The hospital has identified

the need to undertake a joint review of both systems to ensure that linkages are strengthened and training of users is combined.

- The quarterly expenditure and performance reviews to be regular in order to facilitate timely preparation of reports.
- There is a critical shortage of clerical staff in the KCH Registry, which limited progress on human resource management improvements.
- Implementation of new management systems continue to be hindered by the lack of senior medical personnel, the high turnover of staff (especially management), HR shortages, limited capacity of existing staff, and underlying abuse of current systems.

11.2.13 Improving Health System Functioning

11.2.13.1 Main Achievements

Improving the Referral System

Efforts to improve the referral system to KCH are underway and meetings have taken place to discuss modalities. It has been agreed that referral meetings should be held quarterly and a task team representing all districts and CHAM hospitals will start the process of developing referral guidelines for KCH and its referring districts and CHAM hospitals.

QECH held a number of discussions including the scheduled bi-monthly regional referral meeting that incorporates issues of specialist visits to districts**.** During the discussions, the department of paediatrics committed itself to start district visits to nearly all districts in the region. Other specialties continued their visits as before. There was also a one-day training workshop for district staff. This was the first training workshop and was conducted by the department of obstetrics and gynecology to help districts manage obstetric conditions better.

Suggestion on complaints for Improvements

The number of suggestions/complaints received from the suggestion boxes has continued to increase at QECH. The monthly analysis of complaints also continued. Departments are given complaints specific to their areas. During the quarter outpatients, dental, paediatrics and obstetrics and gynecology held departmental meetings to discuss complaints received. Punctuality in the outpatients department improved tremendously after the discussions. A number of compliments were received concerning the paediatric accident and emergency unit.

Transport Management System

Programme staff at both hospitals have began participating in the meetings to improve transport management with the task teams on transport where the National Transport Policy and the Ambulance Policy were merged to come up with the Draft National Health Transport Policy, yet to be adopted by the MoH.

On Recruitment and Retention of Doctors

Discussion on recruiting and retaining the services of medical practitioners in Malawi have started and MoH has used specialist presentations of discussion papers on the subject as a point for developing a national plan for improving availability of medical practitioners.

Strengthening District Health Services in Lilongwe and Blantyre

More discussions on strengthening the district health services in Blantyre and Lilongwe districts are planned to explore strategic options to be considered by the MoH as it formulates a policy and strategic plan to improve the availability and quality of district health services in these two districts.

11.2.13.2 Needs/Problems/Challenges Encountered

Problems encountered with regard to the referral systems of both hospitals include:

- Low rate of referral feedbacks from central hospitals,
- Inadequate documentation of referral guidelines, and
- Lack of clinical guidelines to guide the district clinicians in case management.

Challenges encountered in the complaint analysis include limited capacity to analyze and respond to large numbers on complaints and drug related complaints are likely to continue as the solutions are beyond the hospital.

The absence of district hospital facilities limits devolution options. Medium to long term capital and service delivery planning is required to change the current paradigm of health service delivery in both cities.

11.2.13.3 Key Current and Future Activities

- Finalize the MoU between CoM, MoH and QECH.
- Facilitate the next meeting of the Central Hospital Reform Steering Committee Meeting.
- Finalize national policy on biomedical research.
- Complete second draft of National Health Policy for Malawi.
- Strengthening hospital management systems relating to HR administration, revenue, registry, transport, HMIS, infection prevention, equipment and pharmacy.
- Continue to strengthen cost unit management.
- Strengthen reporting function of ACCPAC accounting system and generate monthly and annual reports for 2005/6 financial year.
- Continue facilitating quarterly performance and financial reviews at both hospitals.
- Continue facilitating production of annual reports of central hospitals.
- Facilitate finalization of business plans for the central hospitals.
- Further development of ePICS at KCH.
- Develop presentations for dissemination meeting.
- Facilitate development and implementation of district plans for strengthening services in Blantyre and Lilongwe districts, including medical services and IMCI training.

Conclusion

It is believed that through some basic interventions to strengthen management systems and documentation around human resource management, the creation of cost centres and development of basic financial processes, and strengthening of the information system, the central hospitals can be more efficient providers of services to the public. Through the co-ordination of services between departments, and definition of roles and responsibilities to provide a co-ordinated vision for the hospital, donations of various kinds can be constructively channelled to address shortages and maximise opportunities. This will be in keeping with the Hospital Reform Program currently under way.

Table 48 -- Medical specialist posts filled – Central Hospitals – Malawi 2007

Institution/Zone	Specialization	No. of specialists
Kamuzu Central Hospital - Central West Zone	Paediatrics	2
	Chief Surgeon	1
	Obstetrician & Gynaecology	2
	Ophthalmology	1
	TB Specialist	1
	Anaesthetist	1
	Dental Surgeon	1
	HIV Specialist	1
Zomba Central Hospital – South East Zone	Paediatrics	1
	Chief Surgeon	1
	Obstetrician & Gynaecology	1
	Anaesthetist	1
	Physician	1
Zomba Mental Hospital – South East Zone	Psychiatric Specialist	1
Queen Elizabeth Central Hospital – South West Zone	Paediatrics	1
	Chief Surgeon	1
	Obstetrician & Gynaecology	1
	Ophthalmology	2
	Physician	2

Source: Payroll, February 2007

11.3 MoU between MoH and NGOs