

# **The Malawi Essential Health Package**

## **Annex 3: Summary of February 2002 Dissemination Meetings**

EHP Working Group  
Ministry of Health and Population  
Lilongwe  
May 2002

## Contents

<b><u>SUMMARY OF DISCUSSIONS AT THE EHP ROUND TABLE MEETING-LILONGWE HOTEL, 22 FEBRUARY 2002</u></b> .....	<b>4</b>
<b>SESSION 1</b> .....	<b>4</b>
<b>SESSION 2</b> .....	<b>5</b>
<b>SESSION 3</b> .....	<b>7</b>
<b><u>SUMMARY POINTS FROM A MEETING TO DISCUSS THE DRAFT EHP AND DRUG SUPPLY ISSUES</u></b> .....	<b>8</b>
<b>KEY ISSUES DISCUSSED:</b> .....	<b>8</b>
CMS AUTONOMY AND FINANCING: .....	8
CORE BUSINESS OF CMS: .....	8
PILFERAGE: .....	9
INFORMATION SYSTEMS: .....	9
MEDICAL EQUIPMENT: .....	9
COMMUNITY LEVEL: .....	9
PROCUREMENT: .....	10
ROLL OUT OF EHP: .....	10
<b><u>SUMMARY POINTS FROM A MEETING TO DISCUSS THE DRAFT EHP AND HUMAN RESOURCE ISSUES</u></b> .....	<b>11</b>
<b>KEY ISSUES DISCUSSED:</b> .....	<b>11</b>
EXPANSION AND BROADENING OF THE HSA OR OTHER COMMUNITY-BASED HEALTH WORKER CADRE .....	11
INTRODUCTION OF A NEW CADRE OF NURSING AUXILIARY .....	12
PUBLIC-PRIVATE ISSUES .....	12
HEALTH SERVICES COMMISSION (HSC).....	12
HUMAN RESOURCE REQUIREMENTS.....	12
CLARIFICATION ON THE SIX YEAR EMERGENCY TRAINING PROPOSAL.....	13
MIDWIVES.....	13
HUMAN RESOURCE JIP SUB-COMMITTEE .....	13
MANAGEMENT CADRES .....	13
<b><u>DISTRICT EHP MEETING 20<sup>TH</sup> FEBRUARY 2002</u></b> .....	<b>14</b>
<b>GROUP WORK</b> .....	<b>14</b>
STRUCTURE, FUNCTIONS AND RESOURCE REQUIREMENTS OF THE DISTRICT HEALTH OFFICE AND DHMT .....	14
CURRENT DHMT STRUCTURE.....	16
FEEDBACK ON EHP CONTENT, INTERVENTIONS ETC.....	17
POTENTIAL IMPLEMENTATION CONSTRAINTS IN 2002/03.....	18
FINAL QUESTION AND ANSWER SESSION AND PLENARY DISCUSSION: .....	19
<b><u>DISCUSSION WITH MALAWI HEALTH EQUITY NETWORK (MEHN) ON THE DRAFT CHARTER OF PATIENT'S RIGHTS AND RESPONSIBILITIES</u></b> .....	<b>20</b>

<b>GENERAL COMMENTS</b> .....	<b>20</b>
INDUCING DEMAND: .....	20
TIMING OF INTRODUCING A PATIENT'S CHARTER: .....	20
CURRENT DRAFT IS TOO OPEN-ENDED .....	21
TAKING ACCOUNT OF FINANCING STRATEGIES .....	21
LEGAL STATUS OF THE PATIENT'S CHARTER .....	21
<b>SPECIFIC COMMENTS</b> .....	<b>21</b>
<b><u>CHARTER OF PATIENTS' RIGHTS AND RESPONSIBILITIES</u></b> .....	<b>23</b>
<b>RATIONALE</b> .....	<b>23</b>
<b>RIGHTS</b> .....	<b>23</b>
<b>RESPONSIBILITIES</b> .....	<b>24</b>

## **Summary of discussions at the EHP Round Table meeting- Lilongwe Hotel, 22 February 2002**

### **Session 1**

#### **The draft Essential Health Package for Malawi: rationale, content and cost**

Dr H Somanje, Controller Preventive Health Services, MOHP

#### **Delivering EHP drugs through a strengthened Central Medical Stores**

Mr G Kadewele, Chief Pharmacist, CMS

#### **Human resource implications of the EHP**

Mr M Makuti, Controller, Human Resource Development and Management, MOHP

#### **Discussion:**

The EHP, as a means of explicit rationing, is seen as a necessary but insufficient element in improving the efficiency of CMS operations. In terms of improving the level of donor support to CMS in order to better support the delivery of EHP drugs, it was confirmed that discussion regarding possible trust status for CMS is underway. The organisation requires its own bank account, and change in the nature of funding (ie constant exchange of money for drugs) in to order to improve procurement practice.

Although training for midwives was not mentioned during the presentation on HR plans, the MOHP clarified that training has not stopped, but that enrolled nurses and nurse technicians have the option to specialise in midwifery after two years basic training. The compulsory course was dropped due to a high drop out rate, and poor practice in the field as many nurses had no desire to be midwives.

*Point for discussion: Stakeholders may wish to discuss whether making midwifery training 'optional' is a good idea. Staff with only nursing qualifications can often only be successfully deployed in central hospitals. They may not be useful in health centres and district / mission hospitals; as such these nurses will only be beneficial to the urban population and not to the rural poor.*

In response to a question as to whether capacity in the training institutions is sufficient to meet the estimated needs of the health system, MOHP confirmed that this is a limitation, but that all schools including CHAM are operational, and tutors are being trained at the moment in the Kamuzu College of Nursing and in Mzuzu. Improved salary packages are being offered to the tutors as an incentive and it is therefore hoped that there will be an increase in good calibre tutors. The need for a new cadre of counsellors was raised.

The question was raised as to whether the EHP and its requirements had been used as the basis for development of the training plan. In response, the MOHP explained that in the knowledge that only 40% of the Established posts are filled, there is a general need to increase output of health professionals of all cadres. However, the new cadres such as the Auxiliary Nurse and a more broadly trained Health Surveillance Assistant are in part a response to the need to implement the EHP as quickly as possible. These junior cadres will need intensive supervision. It was accepted by the MOHP that there is still a problem with deployment, with certain cadres such as Community Health Nurses stuck at hospital level

doing general nursing duties rather than supporting community level activities. The need to address this issue forms part of the rationale for creating the Auxiliary Nurse cadre.

The need to clarify new reporting lines and structure emerging as part of the EHP and reform more generally was stressed. In terms of support to health workers during the process of change, MOHP indicated that a Change Management Unit is being established within the Planning Department, and it is hoped that suitably qualified individuals can be appointed to help facilitate the necessary reforms, including appropriate orientation and support for health staff.

The MOHP was asked whether it considered health workers who left public services but remained within the country as “attrition” or whether these people were still contributing. The question was indirectly answered in discussion of the role of other providers in delivering the EHP, and how the MoHP would hope to develop alternative financing arrangements, such as contracts or agreements with non-government providers, in order to expand access to the EHP quickly.

On the subject of whether there are adequately numbers of qualified entrants to training schools, two strategies were mentioned: screening of the current HSAs to see who might be supported to go on to further basic training; and support to expand science training at secondary school level. However, neither of these strategies currently has funding. In addition, schools are considering taking in students who have not made the traditional grades, and offering additional training.

The question was raised about how drugs and supplies which have multiple uses could be “earmarked” for the EHP or even for conditions within the EHP, rather than just used generally for other activities, potentially resulting in a situation where EHP services cannot be effectively delivered. It was accepted that this is very difficult, but the hope is that by improving supply systems generally the current stockouts of key items will be reduced.

## **Session 2**

### **Delivering the EHP at community level**

Dr A Phoya, Director Health Planning Services, MOHP

### **The role of HSAs in the delivery of health services and immunisation in Malawi**

Mr J Kadzandira, Centre for Social Research, Zomba

#### **Discussion:**

In response to a question about the gender balance among the HSA cadre, it was clarified that among the 121 interviewed in the study, 40% were female. Only 6 respondents stated that they had had problems due to their sex. Men sometimes stop their wives attending sessions led by male HSAs, whereas some female HSAs had problems motivating men, or discussing family planning when not married.

Clarification was also sought as to whether the K1,800 cited as average salary for a HSA included other benefits or allowances. Some of the HSAs were receiving housing allowances, and others, particularly when working in areas supported by NGOs were receiving a duty allowance. HSAs in NGO-served areas also benefited from refresher training, and others had access to customary land so could farm in addition to their daily duties.

The possibility of using HSAs to serve as the link between the public and private sectors was raised, particularly in relation to grocery shops, supervision of traditional healers etc. In addition, although the study presented was done in a rural area, the MOHP was asked about strategies for ensuring the community level of the EHP in poor, urban communities which are often under-served in terms of accessible HSAs at present. The MOHP target of 1 HSA per 1,000 applies to both urban and rural populations, and it was agreed that a review of current provision would be made in order to ensure adequate coverage.

Two amendments were proposed for the job description and thus curriculum of HSAs: to actually perform child immunisation rather than merely mobilise communities to attend sessions; and to be able to administer injectable contraceptives rather than only condoms and pills. The first of these was accepted, but the second was rejected on the grounds that in adequate numbers of HSAs are currently female and it would not be acceptable to have a man injecting a woman in the back.

*Point for Discussion: Given the findings of this study, correcting this gender imbalance among HSA staffing might be able to allow female HSAs to provide Depo Provera injections. Malawi still has a great unmet need for family planning to be met as a matter of urgency, and injectables are the favourite contraceptive in Malawi.*

The structure for supervision of HSAs was discussed. In theory they are supposed to be supervised by a Health Assistant, but due to shortages of this cadre at health centre level, in practice supervision is done by a Senior HSA.

The suggestion was made that it might be preferable to split the community-based cadre and to have people with complementary job descriptions rather than having everyone trained in all aspects of the community level EHP. However, MOHP pointed out that the aim is to achieve holistic care at that level, ie if an HSA is visiting a pregnant woman, s/he can also check the children's nutritional status, treat any minor illnesses etc. Also, if we can achieve the desired ratio of 1 HSA per 1,000 population, this actually translates into relatively few major events of any kind, eg only about 50 children under one will require immunisation within a year, and the HSA should know his/her catchment population well enough to know who and where these children are. Improving the quality of basic training, number, and support in terms of supervision and in-service training are the chosen approaches to improving HSA performance.

*Point for discussion: Stakeholders may wish to consider as policy deploying one male plus one female health surveillance assistant per 2000 population. That will also solve the issue on administration of injectable contraceptives.*

Concern was expressed that reliance on the HSA cadre to improve equity of access, and deliver the MOHP's core poverty reduction strategies might not be sufficient. The MOHP was asked about other possible approaches to target specific areas known to suffer disproportionately in terms of poverty or disease burden, and how to incorporate these proposals in the planning process. MOHP explained that districts are currently preparing their plans for 2002/2003 on the basis of the EHP, but with prioritisation based on their knowledge of particular disease patterns. Further poverty-related targeting occurs through the sectoral allocation formula for the Other Recurrent Transaction (ORT) budget, where district poverty headcounts comprise 20% of the composite allocation formula.

Given the importance of the EHP in terms of the MOHP contribution to the Poverty Reduction Strategy Paper, and the gap between the estimated cost of the EHP and the available resources, this suggests either need to prioritise further if universal coverage is to be achieved, or abandoning the objective of universal coverage. The question was raised as to which elements of the EHP are most important, if implementing the whole is not feasible.

The response from MOHP indicated that the EHP is already a prioritisation, but it is acknowledged that not everything can be implemented at once. However, the concept of the package is necessary in order to benefit from the synergies between service areas and from overall systems development. Pruning too much from the EHP risk leaving vital services outside that will have to continue to be delivered by MoHP facilities, risking re-verticalization and the inherent technical inefficiencies in this approach. An alternative way of addressing the prioritisation debate is to consider the relationship of the EHP and District Implementation Plans (DIPs). Although the EHP can be said to offer a minimum standard of service, districts will be free to emphasise one EHP service over another, given local variations on demand for health services, over and beyond that minimum standard. Thus the central-level policy "template" is not inherently inconsistent with a bottom-up planning process, and local prioritisation of EHP services can occur.

The absence of interventions addressing water and sanitation was commented upon. MOHP reminded the audience that much of this falls under other government departments. Some work is included under IEC. It was agreed that the potential liaison role of the HSAs with extension workers from other sectors should be further developed and highlighted.

Concern was expressed at the study finding that HSAs seemed to be coming from outside the communities in which they work. The MOHP policy is that, as far as possible, HSAs should be drawn from their own areas, and the current distribution will be reviewed.

The issue about demands on resources from non-EHP services was again raised as a possible constraint to implementation, and the suggestion made that a list of constraints be included and discussed in the report. It was stressed that the EHP is not equal to the health sector, and it is acknowledged that leakage between EHP and non-EHP activities and services will occur, but by strengthening systems generally, serious shortages should be mitigated.

## **Session 3**

### **The way forward**

Dr A Phoya, DHPS

### **Discussion**

It was pointed out that several donors are moving from traditional project support to budget support for a clear statement of sectoral policies and priorities.

The question was raised about re-institutionalising the Regional Health Offices to supervise EHP delivery at district and lower levels. However, the MOHP response was that there are sufficient numbers of appropriately qualified staff at the central level to undertake this critical task, but what is needed is reorganisation of the way in which supportive supervision takes place in order to better coordinate and integrate those areas which are common. This will be taken forward in the implementation plan. It was also pointed out that MOHP has decided to institute quarterly district meetings, to be held in the regions. All controllers currently have zones to supervise and are expected to report to the Secretary for Health and Population following their visits.

## **Summary points from a meeting to discuss the draft EHP and drug supply issues**

Kuka Lodge, 5 February 2002

### **Present:**

Dr Mike O'Carroll	Senior Technical Advisor, MOHP
Dr Somanje	Controller, Preventive Health Services, MOHP
Benjamin Banda	Logistics Officer, RHU, MOHP
Sister Nympha Que	CHAM
Catriona Waddington	Central Medical Stores
Matt Robinson	Planning Officer, MOHP
Sally Lake	EHP Consultant, MOHP/UNICEF

### ***Key issues discussed:***

#### **CMS autonomy and financing:**

In order to function effectively, CMS has to be able to act like a firm, with its own bank account, its own financial management systems, and to expand its client base in order to bring benefits nationwide in terms of cost reductions and quality control. The MOHP will remain the priority client, and thus the provision of items on the Essential Drug List would remain the core business of CMS, although this list might need revision in the light of the EHP.

There is need to change the way in which CMS receives its funding if the organisation is to be strengthened to better support the EHP. Experience in other countries (eg Zambia, Uganda) should be explored.

If donor monies are to be channelled through CMS, there is need to improve the transparency of the procurement process (and to reduce the delays caused by the Government Contracting Unit) and to reduce the mass pilferage/theft of drugs within the country.

#### **Core business of CMS:**

There is a large overlap between the drugs on the National Essential Drug List (NEDL), those contained within the EHP, and those in which CMS does most business, and these number about 150 items. However, the National Drug Committee needs revitalising in order to discuss possible amendments to the NEDL, and in particular those items which are currently labelled as HVA (vital at health centre, and priority for ordering) which do not appear in the EHP.

In addition, while the issue of drugs is relatively straightforward, there is no such list for surgical supplies, and this needs to be rationalised.

The quantification exercise which CMS is embarking upon will explore consumption rather than need (as in the EHP) as previous attempts to base orders upon epidemiological need have led to problems with excess supply and thus expiry. However, some adjustment will be made for the fact that consumption is sometimes inaccurate due to stock-outs. The exercise should reveal average figures for consumption/prescription per 100 outpatients, and districts/facilities showing more than, say, a 25% discrepancy from this figure will therefore be obvious and the causes can be investigated. Forecasting, re-forecasting and re-scheduling of shipments can all be built into the procurement process.

### **Pilferage:**

CMS is now introducing management of drugs by batch number which enables tracking of drugs by box. It is however possible to use embossing of individual tablets with a specified emblem in order to be able to identify MOHP drugs after repackaging at retail outlets.

The issue of theft is serious, and it would be useful to find out what has happened to the plan formulated by the former Minister of Health, Hon. Aleke Banda, to reduce pilferage through special courts, plain clothes policemen etc.

### **Information systems:**

35 drugs are included in the HMIS, and the RHLMIS tracks family planning commodities and STI drugs. However, RHLMIS has given up on stock control at the facility level as it is simply not happening, most likely due to shortage of staff and thus time for such essential administrative tasks. This should be addressed within the EHP. Tracking 20 commodities, however, and would be impossible with the 150 or so included on the potentially revised Essential Drugs List. The solution might be to pick a few, important in terms of quantity and/or public health implications for daily monitoring, and others for monthly or quarterly monitoring. It is likely that some 20% of drugs account for 80% of pilferage in the system.

### **Medical equipment:**

CMS is the logical place to store and distribute equipment such as that ordered through HIPC funds, but would need an increase in staff and storage space. In the absence of this, tenders should be specified per facility, pre-packaged and scheduled to reduce distribution problems.

### **Community level:**

The Chitipa example of giving drugs to HSAs in order to decongest health centres could be piloted and closely monitored in a few districts. Relevant formats could be developed to monitor drug consumption at that level.

Drug revolving funds have traditionally worked where there is no alternative (affordable) supply, which is not envisaged as the case under the EHP. Private sales through DRFs, grocery shops etc should be permitted alongside the EHP/HSA system to which we are expanding access. This would provide an alternative supply for those who can afford or

who choose to bypass the publicly funded system<sup>1</sup>. However, there is a need to approach the Pharmacy and Poisons Board to review legislation in this area.

A system is required for ensuring distribution of drugs from district to health centre and from health centre to community, and for monitoring this. Such a system could involve the Village Health Committee signing for deliveries, as the relevant body for ensuring that their community entitlements are met. District Assembly members could play a role at district-health centre level. Such distribution issues could be covered in an integrated supervisory checklist.

### **Procurement:**

Most drugs and medical supplies pass through CMS. EPI vaccines are separate. Others which are not integrated into CMS for procurement and distribution include TB drugs, drugs for the Child Lung Health project, commodities for the Sexual and Reproductive Health Programme and uncoordinated NGO purchases. It is accepted that it is neither realistic nor sensible to merge successfully running systems with a less than fully functional CMS, but increased collaboration between different procuring agencies is required. A centralised procurement plan, and a donations policy would assist in this matter.

### **Roll out of EHP:**

The main point here is that the EHP needs to take account of human resource and training requirements rather than expecting to lead with improved drug supply.

---

<sup>1</sup> NB there is still an issue about permitting CMS to sell to the private sector in order a) to improve quality control within the country as a whole, and b) to enable price reductions for the public sector through bulk purchasing. Obviously sales would not be made directly to each small grocery store but through private wholesalers

## **Summary points from a meeting to discuss the draft EHP and human resource issues**

Kuka Lodge, 12 February 2002

### **Present:**

Dr Wes Sangala	Chief Technical Advisor, MOHP
Dr Mike O'Carroll	Senior Technical Advisor, MOHP
Dr Ann Phoya	Director, Health Planning Dept, MOHP
Diane Jere	Kamuzu College of Nursing
Jean-Marion Aitken	DFID
Maryjane Lacoste	JHPIEGO
Matt Robinson	Planning Officer, MOHP
Sally Lake	EHP Consultant, MOHP/UNICEF

### ***Key issues discussed:***

#### **Expansion and broadening of the HSA or other community-based health worker cadre**

The MoHP has accepted that there is urgent need to both expand the number of HSAs in order to reach a target of 2 per 2,000 population, and to broaden their training in order to cover more elements of the EHP. A curriculum is under development, following recognition that expansion of a salaried cadre is more cost-effective than scaling up of volunteer cadres such as Community-Based Distribution Agents for family planning commodities, based on the experience of the World Bank supported Population and Family Planning project. In addition, it is accepted that the current HSAs are generally performing well, but that they are overloaded, inadequately supervised and do not benefit from in-service training.

It is envisaged that the new training will take 10-12 weeks, and will have increased emphasis on maternal and child health. The expansion also offers the opportunity to increase the number of female HSAs. The idea of a polyvalent worker makes more sense at this level than to split by function, as the community based workers have greater access to households and can thus assess differing needs of women, men and children.

Development of an implementation plan for HSA training is urgently required, as there are proposals not only to undertake training of new HSAs, but also to offer additional training to those already in place, and also to upgrade some of the existing, well-performing HSAs to cadres such as Medical Assistant. It is important that communities are not left without access to any HSA cover during these plans. One proposal is to pilot within the POP-FP pilot districts, where supervision structures are already in place.

## **Introduction of a new cadre of Nursing Auxiliary**

The meeting was informed that the MOHP has decided to introduce a new cadre of Nursing Auxiliary, in order to address the chronic shortage of staff at both hospital and health centre level. It is envisaged that training for this cadre will take place at district hospital level, and that this cadre will be recruited locally in order to enable them to be posted within their districts of origin. Accommodation during training could be covered within a training allowance. At the end of the training, they would either be retained in the hospital with bedside nursing duties, thus enabling fully qualified nurses to be posted out to the health centres, or would themselves be posted/return to their local health centre to provide support to other trained staff. Once posted, NAs would be responsible for their own housing costs.

A nucleus of trainers, largely from the Kamuzu College of Nursing, will be developed, but is expected that the training will be largely “hands-on” within the hospital, with classroom work done on site. Supervision would be undertaken by the licensed nurses with whom they were working. A full career path is proposed. Initially training of 15 NAs per district per year is envisaged, and these would then be employed within the civil service. NA trainees would have the option to continue studying for the Malawi Certificate of Education whilst training, as this would enable those who then perform well in post to compete for places to continue their training as nurses.

In terms of phasing, this will be dependent on the development of a curriculum and the districts having the staff to undertake the necessary training activities. Options would include using retired or private sector/NGO employed tutors. The Planning and Nursing Departments will work together to determine the cost of the proposed development of this cadre.

## **Public-private issues**

Incentives and the relationship between the public and the mission sector in particular still needs further work. The Memorandum of Understanding between the MOHP and CHAM is not yet signed, partly due to lack of agreement on the MOHP subsidy for staff working in CHAM institutions. One possibility would be to include staff costs within an overall capitation grant to accredited CHAM facilities, thus granting them the freedom to determine their own staff mix and conditions.

## **Health Services Commission (HSC)**

The proposed HSC is expected to offer some leeway in setting pay and conditions, with the HSAC recruiting on behalf of a given District Assembly. However, this needs to be examined in the context of overall government resources. The issue of which health workers would be included under the HSC is still not decided.

## **Human resource requirements**

There is still need to determine what establishment is actually required to deliver the EHP. Various alternatives exist (Establishment, Functional Review, Change Management) and these have not yet adequately been compared with available staff, or with the envisaged workload of the EHP. This will be further elaborated between the

Planning and Human Resource Development and Management Departments. This must be made explicit when discussing introduction of new cadres, and in the finalisation of the Emergency Training Proposal.

### **Clarification on the Six Year Emergency Training Proposal**

This was developed by asking CHAM, KCN and the Malawi College of Health Sciences to come up with realistic figures for training assuming no budget constraint. Current costs were used, and the budget constraint took into account existing ORT funds, HIPC monies and currently available donor monies for training. MCHS has a full complement for 2002, and MOHP undertook to find and circulate the breakdown of students currently in the system.

It was noted that the costs are likely to be different when considering increased intake within existing capacity, and expanding capacity of the training institutions.

### **Midwives**

The issue of midwives came up as they were not included in the original Emergency Training Plan, and yet are critical for the EHP and in order to address the problem of the high maternal mortality rate. Midwifery is still an unpopular option, and when it was compulsory, was felt to lead to bad practice in the field, hence a return to compulsory basic training is not considered an option. At the same time, the MOHP needs to consider which are the priority areas for basic training, and perhaps limit the entry into alternatives such as ophthalmic and psychiatric nursing. Ideally, the EHP requires midwives rather than nurses at the health centre level if the National Health Plan target for institutional deliveries is to be reached. It was agreed that a stock and flow analysis of midwives in the system needed to be undertaken. JHPIEGO are planning to undertake an analysis of why people choose midwifery (or not) and although this was scheduled for June, there may be a possibility to bring it forward.

### **Human Resource JIP sub-committee**

This JIP sub-committee has been largely defunct for over a year, yet is one of the most critical within the MOHP. All the issues under discussion in this small meeting are potential agenda items for the JIP sub-committee, and regular meeting and circulation of minutes would go far to increase awareness of MOHP activities and outstanding issues in this area.

### **Management cadres**

There is still need to further discuss the need for technical training in planning, management, administration etc which is required to run a district and in particular to support the EHP, as DHOs were felt to be failing in some places. Performance-related bonuses and regular appraisal were mentioned as some possibilities, but established systems for basic and in-service training is also critical. The requirement for a Medical Officer to head a district needs review given the shortage of Medical Officers throughout the country and the need for them to perform clinical rather than administrative duties. The ongoing devolution and the need for DHMTs and District Assemblies to plan together implies a joint learning process.

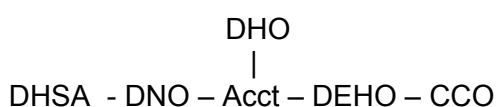
## **District EHP meeting 20<sup>th</sup> February 2002**

### ***Group work***

### **Structure, functions and resource requirements of the district health office and DHMT**

#### **Group 1:**

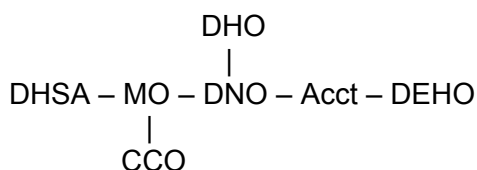
#### **Appropriate structure of DHMT**



#### Recommendations:

- Proper grading and issue of seniority -> reporting line
- ? programme coordinators

#### **Proposed structure for the DHO**



#### Core functions of DHO:

- Support supervisory visits
- Coordination with NGOs
- Planning and budgeting
- Collection, compilation and analysis of data etc

#### Resources:

- Vehicles and motorbikes – combined supervisory visits
- Computers and personnel
- Stationery
- Fax machines
- Radio communication
- Fuel

#### Required assistance from headquarters:

- Technical supervision
- Staffing levels addressed
- Financial assistance

**Group 2:**

Structure:

- DHO – chair
- DHSA – Secretary
- DNO, DEHO, Accountant – members. Also head of Clinical Services (?)

For proposed structure, see separate page

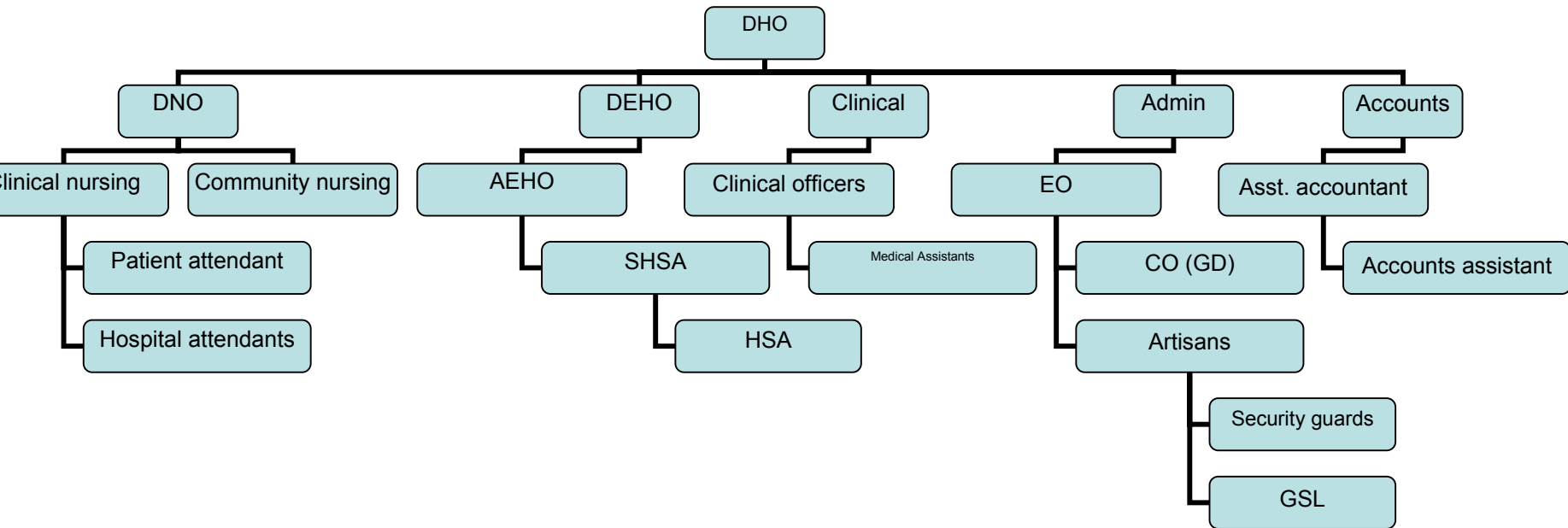
Core functions of the DHO:

- Implementation of government policies with regard to curative and preventive services
- Providing technical advice to the District Assemblies on health related issues
- Coordination of stakeholders in the district
- Ensure that medical ethics are adhered to
- Training of health workers
- Supportive supervision of all health activities
- Maintenance of equipment and structures
- Deployment of staff and other resources
- Discipline of health workers
- Disease surveillance in the districts
- Maintenance of HMIS in the district
- Financial management
- Monitoring of drugs and other supplies
- Transport management
- Public relations on health issues

Resources required:

- Transport for supervision, delivery of drugs and supplies, referrals
- Communication facilities: radios, telephones, fax, email
- Human resources, and more office space and office equipment
- Drugs
- Finances
- Medical equipment
- Headquarters support supervision

### Current DHMT structure



## Feedback on EHP content, interventions etc

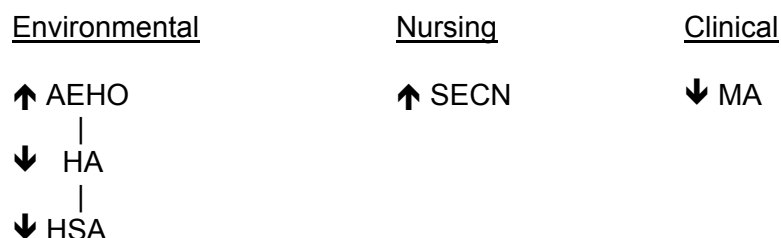
### Group 2:

Major gaps:

- ❖ Component 1: Why only the treatment of measles – what about the treatment of other immunisable diseases?
- ❖ Component 3: Environmental management, especially sanitation
- ❖ Component 4: Ante-partum haemorrhage, intra-uterine deaths
- ❖ Component 5: active case detection
- ❖ Component 6: water and environmental sanitation (WES) management
- ❖ Component 9: community nutrition programme to be worked with Ministry of Agriculture
- ❖ Component 10: treatment of other skin conditions

Comments on the proposed delivery system, particularly community level:

- ❖ System not clear with EHP. What changes are to be made?
- ❖ The current management structure is vague with a poor hierarchy which with WHP needs to be changed:



- ❖ Are we to maintain the old structure – health post/health centre/hospital? What about community hospitals and Health Delivery Areas?
- ❖ We need to define reporting structures for community personnel – Medical Assistant, HSA
- ❖ We need to define health structures and their functioning in relation to other community structures in line with decentralisation – Village Health Community, Community Health Committee, HAC, ADC, DDC
- ❖ Generally the management support functions should be redefined – so far it is trial and error
- ❖ Cost of the management support functions be separate. EHP costing more on core functions

### Group 5:

ARI: IMCI is on pilot basis and should be accelerated to all districts

Malaria: sanitation part is omitted

Maternal: PIH is omitted; APH is left out; TBAs are omitted (train young ladies who may possibly have a teachable spirit)

TB: treatment of the contacts, eg breastfed babies

Diarrhoea: preventive measures are left out; the treating staff (HSAs) are from preventive not clinical staff

## **Potential implementation constraints in 2002/03**

### **Group 4:**

- ❖ People
  - Shortage of all staff
    - Loss through death, resignations, retirement, with no matching replacement
    - Retention of staff – how?
  - Competence: at community level, so far what is the level of competence of HSAs in handling the 'basic' EHP medical conditions?
  - Equitable distribution of staff: attract people to work in 'hard areas'
- ❖ Funding
  - Plan with devaluation in mind, quote ceilings in dollars
  - NGO funds for projects in districts not known to DHOs
  - Budget cuts
  - MOHP – part in deciding which items would be ideal for Malawi when aid is to be given
- ❖ Drugs/medical supplies/equipment
  - Priority ones need to be realised by Central Medical Stores
  - ? storage conditions of drugs in the communities
  - drug budgeting is done somewhere else, not at the districts
  - no flexibility to allow the DHOs to source these when CMS does not have them
  - pilferage: this is still on!
- ❖ Infrastructure
  - Rehabilitation
  - Replacement
  - Expansion
  - new ones to be built
- ❖ Communication
  - Vehicles, motorcycles, bicycles
  - Phones
  - Radio messages
  - .....

### **Group 6:**

- ❖ Cadres in particular in short supply:

Medical assistant	Nurses
HSAs	Laboratory technicians
Anaesthetists	Clinical officers
Medical officers	Community health nurses
- ❖ In bringing services closer to the community, need is there to increase service providers at that level, ie at Health Centre, medical assistants and auxiliary nurses
- ❖ For quality services, entry point for HSAs should increase to MSCE level and intake should be increased for training and appointments

- ❖ Establishments should be reviewed for community health nurses at health centre and community level
- ❖ Training of auxiliary nurses for basic knowledge and skill
- ❖ Upgrading of MAs to specialty departments be reviewed
- ❖ Return MAs sent for upgrading to their previous stations/districts
- ❖ Volunteers to help HSAs
- ❖ Position of Medical Officer to be established along with decentralisation

All elements of EHP will suffer if the above are not addressed.

- ❖ Activities which will suffer with inadequate funding:
  - Utilities
  - Cleaning materials
  - Food for patients
  - Transport for referrals, outreach, and supervision
  - Drugs
  - Maintenance of infrastructure
  - Provision of equipment
- ❖ Other constraints
  - Tendency to bypass lower levels of health delivery system
  - No community empowerment (IEC)
  - Time factor for awareness
  - Deployment of staff to lower areas (denial of postings by health workers)
  - Drug security as supervisors at community level (HSAs)

### **Final Question and Answer session and Plenary Discussion:**

- Amoxicillin and ampicillin syrup left out of EHP
- MOHP has advocacy role in WES, with Water Dept taking responsibility for provision of water, but hygiene and sanitation being MOHP's job
- Need to train younger women to be TBAs as can't reach 100% institutional deliveries with trained staff
- Need to include pre-eclampsia, not just eclampsia (PIH)
- Has the MOHP taken any steps to analyse DRFs and what is the current thinking re charging for health services

## **Discussion with Malawi Health Equity Network (MEHN) on the Draft Charter of Patient's Rights and Responsibilities**

CHSU - 26<sup>th</sup> March 2002

### **General Comments**

#### **Inducing demand:**

A charter is at some point crucial to inducing patient demand for EHP services. At present, many people do not access the health system at all (46% of all maternal cases, 50% of all smear-positive TB cases in Lilongwe district); probably due to perceived or real costs of access or low quality of health services. Others only access the system when illnesses have become acute, resulting in poorer health outcomes and higher costs to the health care system.

The EHP aims to lower the costs of access (through closer-to-client services with more emphasis on the community and health centre level, and improved support services e.g. more reliable ambulatory transport and drugs supplies), and also improve the quality of those services (through more and better trained HR, improved facilities etc.).

However, these are supply-side steps towards reaching the final objectives of the EHP, which include promotion of equity of access and contribution to poverty reduction (among others<sup>2</sup>). In order to achieve these objectives, demand-side measures must also be part of EHP implementation. Initially, thoughts were to hold a large public awareness campaign to make clients aware of the services the EHP would deliver. However, a patient's charter, geared around EHP services, would now seem to be the ideal foundation for such a large and nation-wide campaign, and inducing the demand the EHP needs to meet to achieve its objectives.

As such, the first steps of developing a patient's charter are to be strongly welcomed and the MHEN congratulated.

#### **Timing of introducing a patient's charter:**

This needs to be done very carefully. The EHP does not have to be fully implemented and all of its improvements visible for the charter to be introduced. The EHP's objectives may realistically be at least a decade off being met. Meanwhile, the charter can be a powerful advocacy tool to induce demand for EHP services as they develop.

---

<sup>2</sup> Aiding priority setting, realizing efficiency gains and forming the basis for a health SWAp are others.

However, introducing the charter now whilst services are poor or often unavailable risks creating false expectations and disillusioning potential clients. Many of the people the EHP wants to attract are not comfortable or able to use MoHP services without considerable effort at present, so to encourage them to do so on the basis of a “right” to certain services, and then not deliver those services, is dangerous and risks alienating these clients for a long period.

### **Current draft is too open-ended**

Health needs are unlimited, and exceed resources even in the most successful economies. The situation in Malawi is particularly acute. Hence, guaranteeing rights to an open-ended range of health services (e.g. as according to “medical need”) is unrealistic and dangerous, as it will never be achieved in the foreseeable future. The patient’s charter should instead refer to a right to access a limited package of basic health services, delivered as close to the client as possible, and with the appropriate referral systems to higher levels of care, e.g. the EHP.

### **Taking account of financing strategies**

Any final draft of the patient’s charter will need to take account of whatever financing mechanisms the MoHP and partners decide will deliver the EHP. If there are to be compulsory user-fees subject to exemption mechanisms, the process of being exempted and the fee structure will need to be made clear. If the EHP is to be delivered free, with non-EHP services charged at cost-recovery, this also needs to be made clear. The charter will also have to make clear that clients may use other providers (CHAM, NGOs, where their facilities are under contract) to receive EHP services. The MoHP and partners should take this decision during 2002.

### **Legal status of the patient’s charter**

What will be the legal status of the charter? Will it be binding – this could mean individuals could sue the government for failure to provide certain services!?

### ***Specific Comments***

*“The right to choice of care”*: The Malawian health system, even under a full functioning EHP, will not be able to deliver choice for the foreseeable future. For rural areas, where the majority of the population lives, providing meaningful choice through a range of providers is a duplicative, inefficient delivery structure for a basic health package. In fact, the MoHP is overtly trying to move away from duplication by pioneering the use of service arrangements. There may be some more flexibility in urban areas, but presumably for paying services only.

*“ The right to adequate information”*: This is where links with the financing mechanisms in place must be made, e.g. fee structure, exemption criteria etc.

*“ The right to emergency treatment”*: The mention of private providers is problematic; they may not accept patients who cannot pay, unless a (probably complex) contract is created with the MoHP to cover emergency cases.

*“ Quality of Medicines”*: The EHP can list what drugs should be permanently available at each level of the health system (e.g. community/ health centre/ district hospital). It might be worth including this explicitly in the charter. However, doing so is another reason why the charter cannot be rushed and must be introduced in parallel with service quality improvements.

*“ Right to a Guardian”*: This needs to carefully specify what a guardian has a right to (e.g. food/ accommodation/ transport). No guardian services have been costed in the EHP development, apart from long-stay mothers at nutritional rehabilitation units (RHUs).

*“ Right to complain”*: What channels?

Draft

## **Charter of Patients' Rights and Responsibilities**

### ***Rationale***

***Health, defined as a complete state of physical, mental, social and spiritual well-being is a fundamental right. The State has the responsibility to ensure that its citizens have access to health care services. We are all patients, one time or the other. Oftentimes, health service delivery is less than optimal, sometimes due to lack of observance of fundamental human rights and responsibilities on the part of both patients and health care workers. The Patients' Charter of Rights and Responsibilities is an attempt by Civil Society in Malawi to raise the general health status of all Malawians through respect of rights and responsibilities by both patients and their guardians and health care workers.***

### ***Rights***

#### **Right to Access to Care**

Every individual shall have access to care and treatment according to their medical need. The patient has the right to be cared for by a competent health worker

#### **The Right to Choice of Care**

Every patient shall have the right to choose a health facility from which to obtain care  
Every patient shall have the right to a second opinion while obtaining health care

#### **The Right to adequate information**

Every patient shall have the right to know the identity and professional status of the person providing the care.

Every patient shall have adequate information regarding all aspects of care including; the right to adequate information on diagnosis and tests performed; medicine prescribed thus including reason for prescription, the dose and duration of taking medicine and their side effects and their safety.

Every patient shall be informed of the reason for any referral to another health facility of health care provider

Every patient shall be given information about self-care, drug administration and disease prevention

Every patient or guardian shall provide informed consent before any surgical procedure is carried. This provision may be waived in case of emergency or in certain psychiatric cases

Every patient has the right to know his or her prognosis

### **The Right to Participation**

The patient shall have the right to participate in decision making affecting their own care

### **Right to Respect and Dignity**

Every patient shall be treated with care, consideration, respect and dignity without discrimination of any kind whatsoever

### **The Right to Emergency Treatment**

Every individual shall have the right to prompt emergency treatment from the nearest public or private medical/health facility

### **Quality of Medicines**

All medicines, vaccines and other pharmaceutical supplies shall be given to patients only be of acceptable standards in terms of quality, efficacy and safety

### **Right to a Guardian**

Every child admitted to hospital shall, wherever possible, have the right to the company of a parent or guardian

### **The Right to health education**

Every individual shall have the right to seek and obtain information regarding preventive, curative and rehabilitative medicine

### **The Right to Privacy and Confidentiality**

Every individual shall have the details regarding their diagnosis, treatment, prognosis and other aspects of their care kept confidential. There may be situations when there may be need to disclose the patient's information, for instance;

- If authorized by the patient
- If it is in the patient's own interest
- If the information is required for due legal process
- If medical records will be required for continued care by another health care provider

### **The Right to a Health Environment**

Every individual shall have the right to an environment that is conducive to health. Health care facilities shall be maintained and kept in such a manner as to pose unnecessary health risk to patients and health care workers

### **The Right to Complain**

Every patient shall have the right to complain through appropriate established channels

## ***Responsibilities***

The patient shall exercise their rights responsibly and reasonably

The patient and their family shall ensure that they understand the diagnosis and purpose of any investigations and treatment

Every patient shall so conduct themselves so as not to interfere with the rights or well-being of other patients

The patient and their guardian(s) shall accept the consequences of their informed consent

Every individual has the responsible to ensure or maintain their own health and that of society by refraining from;

- Consumption of unwholesome food and water
- Drug and substance abuse
- Irresponsible sexual activity and other lifestyles that are hazardous to health

The patient and their guardian(s) shall provide accurate and complete information which the health care provider about the patients health and medical history

Patients and their families must be aware of health care providers and the health system

Where applicable, the patient is responsible to settle their bills at times as requested by the health care provider

The patient shall keep appointments and shall inform the health professional in good time if unable to do so

**Dr Adamson S. Muula**  
**Coordinator**  
**Malawi Health Equity Network (MHEN)**

**November 2001**