Maximizing access to essential medicines for church health services and their clients in Malawi: A baseline study

Ecumenical Pharmaceutical Network (EPN)

1 INTRODUCTION

Church health services (CHS) in Malawi provide approximately 37% of available health care. The Christian Health Association of Malawi (CHAM) reports that church health care facilities in Malawi number 33 hospitals and 132 clinics at the time of research. The government pays all health personnel salaries in CHSs and some allowances such as housing and transport. Government facilities offer free health care (including consultation and medications), while the CHSs charge. In many areas, the CHS is the sole provider of health care.

This study used four methods to discover more about the situation:

- Tool 1 Church health service self-assessment survey (35 responses).
- Tool 2 Desk review.
- Tool 3 Guided self-assessment workshop and focus group for 10 hospitals, including spider diagrams, force field analysis, and problem trees.
- Tool 4 Drug supply organization self-assessment survey.

1.1 Identifying guidelines for increasing access

Step 1: Each EPN country focal point was asked to identify the strengths and weaknesses of the CHSs in their country. From the combined responses, a list of common factors was drawn up.

Step 2: A specialist working group then examined these factors in detail against the following criteria:
- What factors affect the cost of pharmaceuticals to the CHS?
- Factors are external to the CHS?
- Factors are internal to the CHS?
- What factors affect the cost of pharmaceuticals to patients?
- Which of the resulting factors can EPN and CHSs address?
- What are the initial values of indicators for these guidelines?

Step 3: The results of the working group were presented to a larger meeting of 16 drug supply organizations and EPN Board members, who together agreed to add a number of guidelines, prioritized their importance, and addressed the search for indicators for each of the guidelines.

2 THE MALAWI CONTEXT

The current health situation in Malawi is dominated by immediate food shortages. A broader look at data from http://www.unicef.org/infobycountry/malawi_statistics.html (sourced from UNICEF, World Bank, IMF, UN Population Division) and WHO Roll Back Malaria and StopTB programmes gives the following picture.

Total population, 2003	12,110,000
Life expectancy at birth (years), 2003	38
Under-5 mortality rate (per thousand), 2003	178
Population (thousands) under age 18,2003	6,386
Population annual growth rate 1990–2003 (%)	1.9
GNI per capita (US$), 2003	170
GDP per capita average annual growth rate (1990–2003) (%)	1.0
Average annual rate of inflation (1990–2003) (%)	31

% of population living below $1 a day (1992–2002)	42
% of central government expenditure allocated to health (1992–2004)	7
Adult HIV prevalence rate (15–49 years), end 2003, estimate	14.2
Estimated number of people living with HIV, 2003 (in thousands), adults and children (0–49 years)	900,000
Estimated number of people living with HIV, 2003 (in thousands), children (0–14 years)	83,000
Estimated number of people living with HIV, 2003 (in thousands), women (15–49 years)	460,000
Tuberculosis: all new cases including HIV-positive cases (2003)	53,053 [442 per 100,000 population]
Tuberculosis: all deaths, including HIV-positive cases (2003)	13,008 [107 per 100,000 population]
Malaria: endemic in 97% of the population of Malawi—cases in 2001	2,323,629 [20,080 per 100,000 population (1 in 4)].

At the time of the study, the objectives of the Ministry of Health Policy (National Health Plan 1999–2004) were (Government of Malawi – http://www.malawi.gov.mw/health/mohpobj.htm):

- Range and quality of health services for mothers children under the age of five years expanded
- Better quality health care provided in all facilities
- Health services to general population strengthened expanded and integrated
- Efficiency and equity in resource allocation increased
- Access to health care facilities and basic services increased
- Quality of trained human resources increased, improved equitably/efficiently distributed
- Collaboration and partnership in health sector strengthened
- Overall resources in health sector increased.

Since the study the Government has taken on a new health policy that includes a SWAPS focus.

2.1 Overall conclusions

It is clear that the dominant trend for church health facilities in Malawi is a worsening of their situation or, at best, little change. Informal discussions indicate that the departure of missionary health staff, the continuing brain drain, and the increasing poverty of a population frequently facing famine, all contribute to this situation.

However, the workshops conducted by EPN also produced indications that there was a willingness to change, as well as recognition of the need to change.

There were also important examples of success and improvement, in particular areas, in particular facilities. However, while one facility might be able to implement a particular SOP, a different facility would fail to implement in that particular area but succeed in another.

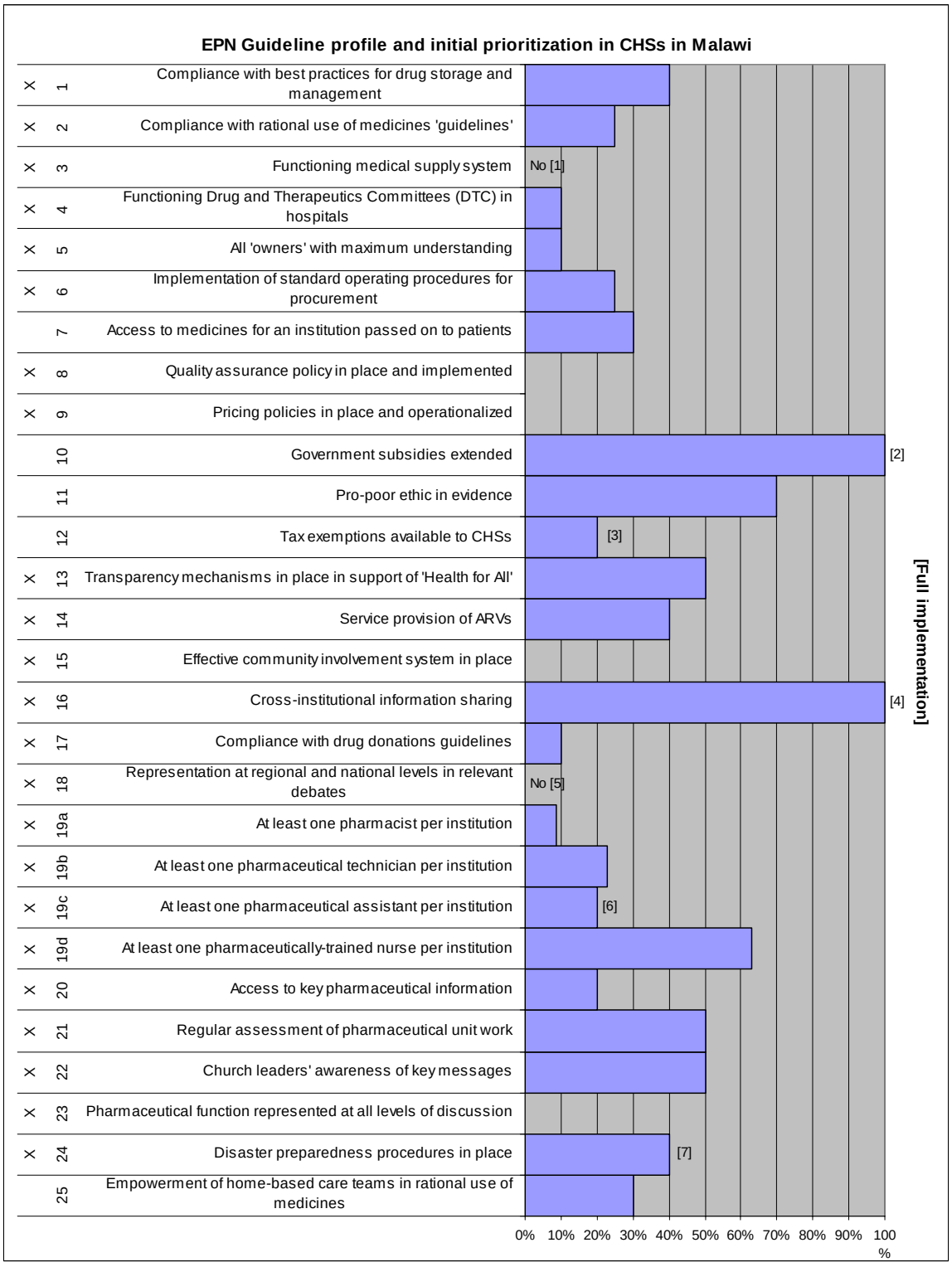
These examples indicate that many solutions to church health service problems in Malawi do indeed lie within Malawi, and that capturing these experiences and passing these approaches on within the country could successfully increase access to health care through church health services.

Lessons learned regarding the methodology include:

- Straightforward questions such as ‘do you implement rational use of medicines guidelines’ often provoked a positive response (taken literally, what ‘rational’ person would say no?) However, on examination of responses to further ‘test questions’ in the survey, it became clear that the answer was actually ‘no’.
- Despite a request to complete the survey during a management committee meeting or to have the most senior staff member complete it, this often did not happen – as indicated by the high number of ‘don’t know’ or incomplete responses.
- The institutions responded very positively to the EPN visits (despite some organizational problems). The workshop and focus group participants were all excited

about being asked and also about the process of asking. The survey process, on the other hand, indicates the need for training on teamwork for the institutions.

3 RESULTS



[1] Incomplete research, but the indications are that the answer may be no.

[2] The Government of Malawi pays for basic salaries for medical staff, training, education, public infrastructure, and medicine/health campaigns, but offers few subsidies on the costs of medicines, which are free at government hospitals.

[3] In fact, tax exceptions on medicines are available and used by all, but this is not common knowledge. So this result should actually be 100%.

[4] A system exists, but the information is poorly used.
[5] A system exists, but it is rarely used.
[6] These results need to be read in the context of the training received by staff in each type of post. Pharmaceutically-trained nurses, for example, have a wide variety of training, or are lacking training in key areas.
[7] There appears to be a great deal of confusion between disaster preparedness and emergency medical procedures, so it is thought that this result should be much lower.

Potential priorities

There appears to be an issue of understanding of pharmaceutical terminology, particularly where certain terms that have particular pharmaceutical meanings are being interpreted literally, such as 'rational use of medicines'.

In nearly all EPN Guideline areas, there is at least one hospital that indicates it has implemented the Guideline. This means that a significant impact could be achieved through networking efforts and sharing local examples, rather than only through external guidance.

The Guidelines can also be linked to problems identified through the force field analysis. Below are four issues identified as areas where the greatest positive change could be achieved, partnered with corresponding Guidelines.

1. **Lack of resources:** While it is extremely difficult to do anything directly about increasing institutional resources, the implementation of some of the EPN Guidelines could indirectly increase resource availability.
    - Pricing policies in place and operationalized.
    - Compliance with drug donations guidelines.
    - Implementation of standard operating procedures for procurement.
2. **Need for improved management:** The following EPN Guidelines directly respond to the hospital-based recognition of the need for improved management.
    - Compliance with best practices for drug storage and management.
    - Functioning Drug and Therapeutics Committees (DTC) in hospitals.
    - All 'owners' with maximum understanding of roles, best practice, and management information, understanding of revolving fund concept and implementation of methods of increasing access for the poorest.
    - Quality assurance policy in place and implemented.
    - Transparency mechanisms in place in support of 'Health for All'.
    - Pharmaceutical function represented at all levels of discussion.
    - Disaster preparedness procedures in place.
3. **Human resources training:** The particular importance of training of human resources is reflected in the need to train staff in the areas above (point 2) and to support the implementation of further EPN Guidelines, including:
    - Compliance with rational use of medicines 'guidelines'.
    - At least one pharmaceutically trained person per facility.
    - Access to key pharmaceutical information.
    - Regular assessment of pharmaceutical unit work.
4. **Policies and politics:** The identification of government policies and politics could be addressed in part by the implementation of the following EPN Guidelines:
    - Effective community involvement system in place.
    - Cross-institutional information sharing, including provision of information to national drugs policy and national health management information systems.
    - Mechanism in place to allow for representation at regional and national levels in relevant debates.
    - Church leaders' awareness of key messages.