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MALAWI
PRIVATE HEALTH SECTOR ASSESSMENT

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MALAWI
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Acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARVs	Antiretrovirals
BLM	Banja La Mtsogolo
CBO	Community-based organization
CDC	Centers for Disease Control
CHAM	Christian Health Association of Malawi
CIDA	Canadian International Development Agency
CMS	Central Medical Store
CPD	Continuing professional development
CPR	Contraception prevalence rate
CSW	Commercial sex worker
EHP	Essential Health Package
DCA	Development credit authority
DHMT	District health management team
DHO	District health office
DHS	Demographic and Health Survey
DSO	Drug supply organization
FBO	Faith-based organization
FGD	Focus group discussion
FP	Family planning
FPAM	Family Planning Association of Malawi
GDA	Global Development Alliance
GDP	Gross domestic product
GHI	Global Health Initiative
GOM	Government of Malawi

GP	General practitioner
GTZ	German Agency for Technical Cooperation
HIV	Human immunodeficiency virus
HMIS	Health management information system
HRH	Human resources for health
HSSP	Health Sector Strategic Plan
ICT	Information communications technology
ITN	Insecticide treated bednet
IUD	Intrauterine device
LMIS	Logistics management information system
MAM	Medical Association of Malawi
MAO	Medical aid organization
MASM	Medical Aid Society of Malawi
MBCA	Malawi Business Coalition Against HIV/AIDS
MC	Male circumcision
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MCM	Medical Council of Malawi
MDG	Millennium Development Goal
MDHS	Malawi Demographic and Health Survey
MFI	Micro-finance institution
MGDS	Malawi Growth and Development Strategy
MOF	Ministry of Finance
MOH	Ministry of Health
MOU	Memorandum of understanding
MSB	Malawi Savings Bank
MSI	Marie Stopes International
NAC	National AIDS Council

NBS	National Building Society
NGO	Non-governmental organization
NHA	National Health Accounts
NNPS	National Nutrition Policy and Strategy
OI	Opportunistic Infection
OOP	Out-of-pocket
ORS	Oral Rehydration Salts
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHAM	Private Health Association of Malawi
PHASOM	Pharmaceutical Society of Malawi
PMPB	Pharmacy, Medicines and Poisons Board
PMTCT	Prevention of mother-to-child transmission
POU	Point-of-use
POW	Program of work
PPP	Public-private partnership
PSA	Private health sector assessment
PSI	Population Services International
R&D	Research and development
RH	Reproductive health
RMS	Regional Medical Stores
SBM-R	Standards-based management and recognition
SHI	Social health insurance
SHOPS	Strengthening Health Outcomes through the Private Sector Project
SLA	Service Level Agreement
SMD	Society of Medical Doctors in Malawi
SME	Small and medium enterprise
STI	Sexually transmitted infection
SWAp	Sector wide approach

TA	Technical assistance
TB	Tuberculosis
TB DOT	Tuberculosis Directly Observed Therapy
THE	Total health expenditure
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary counseling and testing
WASH	Water, sanitation and hygiene
WHO	World Health Organization

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Executive Summary

Located in southern Africa, Malawi is home to just under 14 million people (WHO, 2011), 72.3 percent of whom live in poverty (UNDP, 2010). Although poor health and economic indicators are widespread in Malawi, there is reason for renewed optimism given large improvements over the last decade in the essential health indicators of modern contraceptive use, under-five child mortality rate, and delivery in a health facility. However, the stability and effectiveness of Malawi's health system is threatened by continued high levels of infectious disease along with widespread poverty that has been exacerbated by a worsening economic landscaped propelled by fuel, foreign exchange and power shortages, leading to a more uncertain landscape for donor funding.

While the public sector is the largest provider of health services in Malawi, approximately 40 percent of services are provided by private actors including the Christian Health Association of Malawi (CHAM), commercial providers, and other not-for-profit actors. These private actors, particularly CHAM, are crucial for expanding access to essential health services in rural areas given the distribution of health facilities in Malawi. Currently, there are enormous challenges facing the sustainability of CHAM as a network and the relationship between CHAM and the Ministry of Health (MOH) has suffered in recent years. In addition to CHAM, there is a small but growing commercial health sector (constituting less than 3 percent of total health services in Malawi) that can be better organized, engaged, and financed.

In June 2011, the International Monetary Fund (IMF) criticized Malawi for failing to comply with conditions set for access to a $79 million loan, which in turn led Western donors, who normally give Malawi around $800 million per year in aid, to suspend their budgetary support. Foreign air represents about a fifth of total government spending in Malawi (The Economist, 2011). Given the realities of decreasing donor funding and a policy environment both at the United States Government (USG)-level and at the MOH-level more amenable to the important role of private providers in the provision of health care, the United States Agency for International Development (USAID)/Malawi commissioned the global Strengthening Health Outcomes through the Private Sector (SHOPS) project to conduct a Private Health Sector Assessment (PSA) in 2011 to examine opportunities and constraints for strengthening the private health sector, and to present a road-map for greater public-private coordination in the provision of essential health services. In preparation for the PSA, SHOPS conducted an extensive review of available published and gray literature pertinent to the objectives of the assessment. Over 80 stakeholder interviews were conducted in May-June 2011 and revealed the prevailing attitudes of public and private sector actors, donors, and implementers towards existing constraints and challenges in strengthening Malawi's private health sector.

The PSA report lays the groundwork for better leveraging the private sector. First, the size, composition and organization of the private health sector are determined, and the role of the private sector in service delivery is established. Secondly, CHAM's current capacity and sustainability as the major private provider of health services is examined in detail. Capacity constraints facing CHAM including a weakened Secretariat; poor financial, management, and contracts negotiation skills; and over-reliance on public sector drug supply are identified. The PSA found that the greatest challenge facing the MOH-CHAM relationship is difficulty in the

implementation of contracting arrangements or service level agreements (SLAs). While these SLAs allow the MOH to contract directly with CHAM and expand life-saving essential health services to rural areas, the SLAs have enormous operational challenges including disagreements over costing and reimbursements; decentralized and inconsistent oversight; and an insufficient policy framework supporting the administration of SLAs.

The PSA report discusses opportunities and constraints for expanding the small but growing commercial health sector. Key opportunities include expanding access to finance for private providers to grow businesses; improving business and management practices for private providers; identifying commercially viable health products with prospects for local manufacturing; and utilizing networking and franchising to organize and strengthen service delivery by private providers. Key constraints include high levels of poverty limiting demand for commercial health services; lack of strong private provider associations and high levels of fragmentation in the commercial sector; and a very limited market for private financing mechanisms including private health insurance and micro-health insurance.

Finally, the PSA discusses the overall policy environment to support private provision of health care in Malawi. While adequate policy mechanisms are in place to support the utilization of the private health sector in national health objectives, there is limited, unorganized, and insufficient private sector representation at key policy decision-making bodies. There are high barriers to entry for private practice, and the regulatory environment can hinder the emergence of new commercial providers. The PSA describes numerous opportunities to foster an enabling policy environment by strengthening regulatory and market conditions more conductive to commercial practice; strengthening the MOH's capacity to provide effective stewardship over the private health sector; revitalizing public-private dialogue through a reinvigorated public-private partnership (PPP) technical working group (TWG); and by improving private sector capacity to partner with the public sector through organization, representation, and better contracts negotiation skills.

Overall, there are tremendous opportunities in Malawi to improve the CHAM-MOH relationship to increase access for essential health services for rural Malawians; promote the sustainability of CHAM beyond MOH support; expand service delivery through the private sector; and improve regulatory and policy conditions for the growth of commercial health services. The PSA provides a roadmap of how to leverage these opportunities for donors, the MOH, and private sector actors while identifying long-standing challenges that have historically hindered the expansion of private health care in Malawi.

Key recommendations from the PSA are summarized in Table 1.

Table 1: Key recommendations from the PSA

Recommendation Area:	Recommendations:
(1) Promote CHAM Sustainability	• Improve the sustainability of CHAM facilities through an organizational benchmarking exercise leading to technical assistance in financial and business management; improving service and product offering; strengthening governance and oversight; and increasing contracts negotiation skills • Strengthen CHAM Secretariat's management capacity so that it can effectively offer value-add coordination and oversight to member units, and strengthen its relationship to facilities, proprietors, and the MOH • Improve CHAM's service delivery performance through expanding Standards Based Management-Recognition to CHAM facilities; incorporating zinc into diarrhea treatment at all CHAM facilities; and improving the distribution and use of micro-nutrients throughout the CHAM network
(2) Expand the Commercial Health Sector	• Strengthen the BlueStar social franchise by improving the business and financial management capacity of BlueStar clinics and strengthening the social franchise model • Strengthen other commercial providers by building the capacity of private provider associations; training commercial providers in business and financial management skills; and adding essential health services to the services offered by non-networked providers • Work with financial institutions to expand lending in Malawi to the private health sector and consider utilizing a Development Credit Authority guarantee • Promote the development and scale-up of innovative financing mechanisms including micro-health insurance, community insurance, provider-based prepaid plans and medical savings accounts • Review and create a regulatory framework for health insurance • Build consensus on the future development of a Social Health Insurance scheme that has clear roles for the private sector both in financing and provision of services • Examine prospects for local manufacturing of hygiene and sanitation products

Recommendation Area:	Recommendations:
(3) Build an Enabling Policy Environment for Private Sector Health Care	• Strengthen the policy and regulatory framework by supporting the development of a strong and standardized PPP policy in health; reviewing and updating the legal/regulatory framework, resulting in a "road map" of reforms; building capacity of the regulatory boards to promote and enforce accreditation and quality standards in service delivery; and promoting involvement of private sector associations in identifying and enforcing standards and quality among their members • Build MOH capacity and systems to engage the private sector by strengthening the PPP TWG to carry out its mandate of promoting and overseeing PPPs in health; assisting the MOH to establish, operationalize and train a PPP unit; and strengthening MOH contracting capacity • Strengthen private sector capacity to dialogue and partner with the public sector through stronger organization of the private health sector and support for public-private engagement and dialogue

1. BACKGROUND

1.1 Introduction

Located in southern Africa, Malawi is home to just under 14 million people (WHO, 2011), 72.3 percent of whom live in poverty (UNDP, 2010). In 2010, Malawi was ranked 153 in the Human Development Index (UNDP, 2010) and as of 2007 life expectancy at birth was only 44 years (WHO, 2011). Although Malawi is well known as the "Warm Heart of Africa," its people contend with poor health and economic indicators.

The macroeconomic situation in Malawi is dire and steeply declining due in large part to shortages in fuel, foreign exchange and power. Suspensions in foreign aid (which represents about 1/5 of total government spending) and a recent slump in the price of tobacco (which roughly 80% of Malawians depend on for their livelihoods), coupled with an increasingly uncompetitive exchange rate, have propelled the major shortages in foreign exchange.

While poverty levels and ill health remain high and daunting, recent results of key health surveillance surveys suggest reason for increased optimism. For instance, according to the Malawi Demographic and Health Survey (MDHS), between 2004 and 2010 Malawi experienced a significant reduction in the under-five child mortality rate, from 133/1,000 live births (NSO, 2006) down to 112/1,000 (NSO, 2011). Similarly promising is the recent increase in the percentage of women whose last delivery took place in a health facility, which grew from 57 percent in 2004 to 73 percent in 2010. Use of modern family planning (FP) is also on the rise in Malawi: between 2004 and 2010 the modern contraceptive prevalence rate (CPR) increased from 28 to 33 percent.

Nonetheless, other indicators have shown less promise. For example, Malawi continues to have one of the highest maternal mortality rates in the world; the 2010 estimate was found not to be differ significantly from the 2006 estimate of 807/100,000 (NSO, 2006). In addition, the HIV prevalence rate of 11 percent of the adult population indicates a generalized epidemic (NSO, 2011). Not surprisingly, TB and HIV/AIDS are closely linked in Malawi with 72 percent of all TB patients co-testing as HIV positive. The overall number of new TB cases reported in 2009 was 48,144 (USAID, 2009).

Moreover, some key health indicators have remained virtually unchanged. The percentage of chronically malnourished children aged 0-59 months has been nearly the same since 1999. According to the MDHS, "malnutrition is one of the most important health and welfare problems among infants and young children in Malawi," and stems from inadequate food intake and illness—especially related to lack of sanitation—which is reflective of "underlying social and economic conditions (NSO, 2006)." While the nutritional status of children has improved since the 2004 MDHS, this has only been by slight increments. The percentage of children who are stunted has decreased from 53 to 47 percent, wasting has decreased from 6 to 4 percent, and the percentage of children who are underweight has decreased from 17 percent to 13 percent (NSO, 2011).

On a more positive note, Malawi is on track to achieve five of its eight Millennium Development Goals (MDGs): eradicate extreme poverty and hunger; reduce child mortality; combat HIV and

AIDS, malaria, and other diseases; ensure environmental sustainability; and develop global partnership for development. The three MDGs Malawi is unlikely to meet include: achieving universal primary education, promoting gender equity, and improving maternal health (MDPC, 2010). While the many positive shifts are encouraging, continued efforts in Malawi are necessary to help combat extreme poverty and poor health conditions.

1.2 Malawi's Health System

Like many Sub-Saharan Africa countries, Malawi embraces a decentralized health system. The decentralization process formally began in 1998, but did not generate significant results until 2004 when the Government of Malawi (GOM) initiated a Sector Wide Approach (SWAp) as a "common framework for planning, budgeting, and performance monitoring" (Pearson, 2010) of health care service delivery. The SWAp included establishing a Program of Work (POW) for 2004 – 2010 that specified six pillars, or focus areas, to guide the health sector. These six pillars focused on the provision of an established Essential Health Package (EHP) to contribute toward the Malawi Poverty Reduction Strategy and focused on the following: human resources; pharmaceutical and medical supplies; essential basic equipment; infrastructure/facilities development; routine operations at service delivery level; and central operations, policy and systems development (MOH, 2004).

Decentralizing the health system necessitated the creation of three levels of health administration: national, zonal, and district. At the national level is the Ministry of Health (MOH). The MOH is responsible for the health system at a macro level – developing, reviewing, and enforcing health policies, reforms, standards, norms, and guidelines for service delivery; regulating the health sector (including the private health sector); mobilizing and allocating health resources; proving technical support supervision; managing research, monitoring, and evaluation; and taking responsibility for the achievement of global initiative targets, like the MDGs.

Responsibility for health administration is then decentralized to the zonal level. Zonal offices provide technical support to District Health Management Teams (DHMTs) and as such play a supervisory role over the lowest level of the decentralized system (district health offices). Technical support offered by zonal offices includes assistance with "planning, delivery and monitoring of health service delivery at the district level and facilitation of central hospitals' supervision to districts" (Rudner, 2011).

The district health offices (DHOs) represent the final level of the health system in Malawi. DHOs fall under the district-level administration and are therefore only partially accountable to the MOH (Rudner, 2011). The DHOs play a crucial role in the health system, seeing as they are the entities held responsible for managing and staffing primary and secondary health facilities. DHOs are also responsible for establishing Service Level Agreements (SLAs) with Christian Health Association of Malawi (CHAM) facilities. CHAM health facilities are typically located in rural areas and charge fees for their services to cover operational costs (which are set by each individual facility). The MOH considers CHAM its biggest partner in health and therefore SLAs are a key component of Malawi's health sector.

SLAs enable DHOs to contract with CHAM to provide essential or priority health services where public health facilities have not yet been established—particularly in rural areas where CHAM

has a large presence. The SLA process is highly decentralized with DHOs contracting directly with individual CHAM health facilities. In addition, whereas each CHAM facility is independently operated, each SLA's structure and content are unique to each partnership (GIZ, 2011). According to MOH figures, there is currently a total of 78 SLAs signed and agreements are in place with 74 of CHAM's 172 health facilities (a few facilities have multiple SLAs) (Lungu, 2011). Most SLAs have been established for the free provision of maternal and child health (MCH) services in CHAM facilities, which remove normal user fees for the determined services and instead require CHAM to invoice the MOH to recoup operational costs based on the number and type of services provided. The GOM also provides CHAM with subsidized drugs and pays all staff costs in CHAM facilities, further linking CHAM with the public sector (MOH, 2011). Overall, the relationship between the MOH and CHAM is of paramount importance in the efficient functioning of Malawi's health system.

The service delivery system comprises three levels of care: primary, secondary, and tertiary. The primary level consists of rural hospitals, health centers, health posts, and outreach clinics and is supported by the secondary level, which includes district and CHAM hospitals. The secondary level provides surgical back-up services (e.g. for obstetric emergencies) and general medical care for common acute conditions. Similar to the secondary level, the tertiary level includes hospitals; however, these facilities offer specialized surgical and medical care and treatment (Rudner, 2011). The public health system is by far the greatest provider of health services in Malawi, responsible for 60 percent of service provision. CHAM is the other significant contributor, providing 37 percent of health services. The remaining three percent consists of contributions from the private-for-profit sector, other not-for-profit entities, military and police health services, and workplace clinics (Manafa et al., 2009).

1.3 The Private Health Sector in Malawi

Private medical practice became legal in Malawi in 1987 and has since grown slowly. To open a private practice, a qualified medical practitioner (including doctors, nurses, midwives, medical assistants, and clinical officers) must have an individual license to practice. Licensing requirements require a provider to be officially registered with the Medical Council of Malawi (MCM) and to have worked for three years or more as a medical practitioner in a qualified health facility. Not only do private practitioners need to meet licensing requirements, but also all private practices must obtain a premises license by meeting MOH equipment, staff, drug, and facility requirements (Jeffreys, 2004). According to the MCM, a medical provider is not allowed to operate more than one private practice at a time; thus limiting prospects for private practice expansion (MCM, 2011).

Of the mere 156 doctors in Malawi, 33 are private for-profit providers and are located entirely in urban areas. The remaining 123 doctors work in the public and not-for-profit private sectors (NGOs and CHAM facilities). Of the 4,182 nurses in Malawi, 436 are private for-profit nurses, located primarily in the southern region. The private for-profit medical workforce also includes a total of 158 clinical officers and medical assistants, a greater proportion of which work in rural areas. This is particularly the case among medical assistants; there are reportedly 26 private for-profit medical assistants in urban areas compared to 86 in rural regions. Disaggregated figures of the number of providers working in the public sector and the CHAM sector are not available, presumably because CHAM is so closely integrated into the public health system

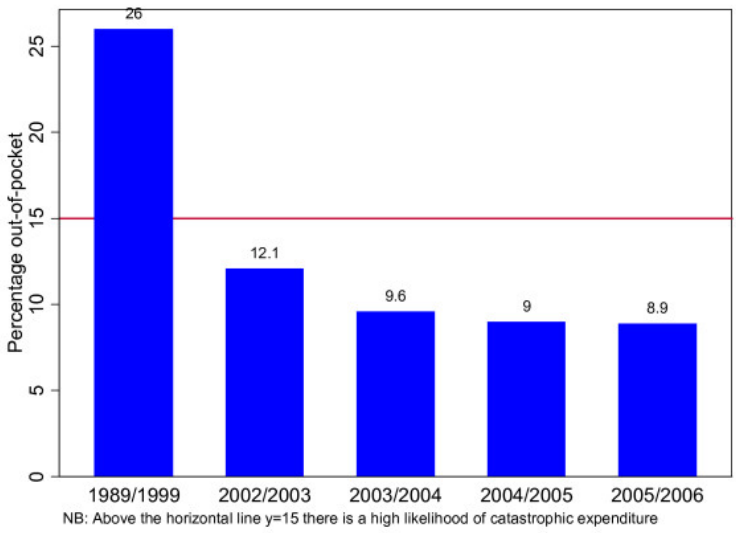
through SLAs and joint payroll. The distinction between public and private becomes further clouded by the large number of public providers who also work in the private sector (which is legal in Malawi). No figures were found substantiating the prevalence of this practice, but it is reportedly common according to interviews with provider association representatives (Jeffreys, 2004).

1.4 Health Financing in Malawi

As of 2005/2006, Malawi spent 9.7 percent of its GDP on health, which is considerably higher than the average 5.8 percent allocated by other Sub-Saharan African countries. Despite this high percentage, per capita spending is comparatively low at $19 compared to an average of $37 in other Sub-Saharan countries. The GOM is highly dependent on donor financing. In 1998/99, the private sector was the primary source of health financing in Malawi. The dramatic increase of donor funding to vertical programs such as the United States President's Emergency Plan for AIDS Relief (PEPFAR), however, has led to a dramatic decrease in both private sector contributions and government expenditures. In 2005/2006, total health expenditure (THE) per capita was approximately $25, of which donors contributed an estimated $15 and the GOM provided only $5. In percentage terms, 21.6 percent of THE originated with the GOM (down from 25.4 percent in 2004/2005), 60.7 percent from donors (compared to 60 percent in 2004/2005), and 18.2 percent from private sources (increased from 14.6 percent in 2004/2005). As a percentage of private health expenditures, out-of-pocket (OOP) expenditures accounted for 49.1 percent, down from 63.8 percent in 2004/2005 (EyobZere et al., 2010). Given that CHAM facilities contracted by DHOs to provide services are not able to charge user fees, and that SLAs only came into existence in 2004, it is not surprising that OOP expenditure decreased in this time period.

Still, given that public health facilities provide the greatest share of health services and do not charge for services, it is notable that private expenditures account for almost 20 percent of health financing, of which nearly half is OOP. OOP payments for the general population are low and have remained stable between 2003 and 2005 (at about $1.82 and $1.81, or 11.5% of THE) as shown in Figure A). However, OOP payments have been considerably higher and have increased over the same time period for people living with HIV/AIDS ($2.14 and $3.42, respectively). Almost all private health sources (with the exception of NGOs) spend the largest amount on healthcare at the hospital level, followed by ambulatory care (though private firms, CHAM and NGOs do allocate funds for prevention and/or primary health care). This is similar to the public sector where, despite a heavy focus in past and current health policy documents on the provision of EHP services in tertiary facilities, Malawi spends approximately 64 percent of all public expenditures on hospitals (central, district, and rural).

Figure A. OOP Expenditures as a Percentage of THE



Source: Health financing in Malawi: Evidence from National Health Accounts

1.5 Human Resources for Health in Malawi

The WHO suggests that countries with fewer than 2.3 doctors, nurses, and midwives per 1000 people fail to achieve recommended levels of health worker coverage for the provision of essential health services (WHO, 2006a)—and Malawi falls far below this ratio (WHO, 2011). In 2003, it was estimated that fewer than 4000 doctors, nurses, and midwives were serving a population of approximately 12 million (Manafa et al., 2009). Ten of Malawi's 26 districts do not have an MOH doctor and four districts are without a doctor at all (Adamson et al. 2005). The average number of nurses in health centers is approximately 1.9, which suggests that many facilities are operated with only one or without any nurses. Further evidence indicates that fifteen districts have fewer than 1.5 nurses per facility, and five districts have less than one (Adamson et al. 2005). Given that health workers are the foundation of health service delivery (Serneels et al., 2010) the health worker shortage in Malawi has the potential for grave implications on the quality of health care delivered across the entire health system.

1.6 Evolving USG Strategy in Malawi

The Global Health Initiative (GHI) is a new, coordinated health strategy under the leadership of the USG with a primary goal in Malawi to "increase access to quality health care to foster a healthier Malawian populace able to participate in the country's economic development." The GHI is a national platform to coordinate all USG spending on global health, including through USAID. The GHI strategy calls for the integration and harmonization of previously vertical health programs and has specific goals in Malawi to reduce maternal and child mortality, unintended pregnancies, and new HIV infections. In addition, GHI investments have a strong focus on policy and governance, with efforts to improve coordination between the MOH and CHAM falling under the purview of the GHI.

Furthermore, the GHI explicitly outlines greater private sector involvement in improving health outcomes in Malawi. The USG and the MOH signed Malawi's Partnership Framework in May 2009, which establishes a strategic vision for the implementation of the Malawi HIV/AIDS response. Referencing the private sector, the guiding principles of the Partnership Framework state that "maximizing public-private partnerships to enhance sustainability, coordination, and sharing of best practices between development partners and implementers" is crucial to the sustainability and success of the national HIV/AIDS response.

To this end, USAID in Malawi has made some initial investments in working with the private sector over the last five years. For example, USAID/Malawi supports a robust social marketing program through implementing partners—primarily through Population Services International (PSI). PSI socially markets many essential health products including condoms, water treatment kits, oral contraceptive pills, injectables and anti-malaria nets. Socially marketed products have been successful in Malawi, with PSI's best-selling product—the condom—having sales of 8 million units annually. Another example is that of SHOPS partner Jhpiego. Under the Maternal and Child Health Integrated Program (MCHIP) in Malawi, Jhpiego has begun to expand its Standards-Based Management and Recognition (SBM-R) approach to private sector health centers and has implemented SBM-R in approximately 10 CHAM facilities as of June 2011. SBM-R is a system to track and improve the performance and quality of services in health care facilities where participants are encouraged to focus on simple performance improvement interventions at first ("low-hanging fruit") to achieve early results. Jhpiego's initial experience with implementing SBM-R in select CHAM facilities has shown that the process can be useful for improving the quality of private sector health care provision.

USAID/Malawi has also shown considerable interest in partnering with Standard Bank. As detailed in the PSA report, Standard Bank recently entered into a Global Development Alliance (GDA) to build the capacity of district assemblies in financial management of development resources through USAID funding. In addition, USAID/Malawi has developed initial plans to discuss a scholarship fund for pre-service education with Standard Bank. Overall, the content of the GHI strategy for Malawi, Malawi's Partnership Framework and initial investments into leveraging the private sector by USAID/Malawi are indicative of a renewed desire to partner with the private health sector to achieve health outcomes.

1.7 Opportune Moment to Partner with the Private Health Sector

In light of the renewed interest from the MOH and the donor community in the critical role non-state actors play in ensuring access to essential health services in Malawi, 2011 has emerged as an opportune moment to prioritize investments in strengthening the private health sector. In its 2011-2016 Health Sector Strategic Plan (HSSP), the MOH explicitly states that the private sector is a key actor in the health system, acknowledging that while "the MOH is the major provider of health services, there are other partners that are playing an important role in the provision of services, especially the private sector. Currently, there are no structures and no policy and guidelines to provide a framework under which the private sector can work with the public sector." This clear acknowledgement of both the important role of the private sector and the insufficient policy guidelines currently in place to effectively work with the private sector mark a departure from earlier health policy documents in Malawi.

During the PSA, key donors—including the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)—spoke of a growing need to leverage the private sector as the donor funding landscape becomes more uncertain in Malawi, and as GOM resources are further stretched. Furthermore, several "private sector champions" were identified during key informant interviews with MOH senior level staff. During the PSA, these potential "champions" demonstrated a clear interest in partnering with the private sector; constructing more efficient systems to contract the private sector; and expanding public-private dialogue. The MOH's commitment to investing in the private sector, donor interest in growing private sector contributions, and the existence of private sector champions to develop relationships with private sector partners all point to the real opportunity and importance of identifying potential areas of expansion for the private health sector in Malawi.

1.8 Scope of Assessment

In response to the changing landscape and growing opportunities to strengthen the private health sector, USAID/Malawi commissioned a PSA through the SHOPS project, USAID's global initiative to increase the role of the private sector in the sustainable provision of essential health services. Armed with a better understanding of the private sector's current role in service provision, the MOH, donors, the private health sector, and other key stakeholders will be in the position to better integrate and maximize contributions of this sector in the health system.

To this end, the scope of the PSA included:

1. 1. Reviewing the impact of stakeholders' perceptions regarding private sector involvement in the health system on Malawi's current policy environment;
2. 2. Analyzing the private commercial sector's involvement in providing essential health services;
3. 3. Examining opportunities for the expansion of private sector provision, including current initiatives in health financing;
4. 4. Determining the financing needs of the private health sector, the extent to which access to credit could improve quality of care or expand service provision, and training needs in business management; and
5. 5. Identifying opportunities to promote the sustainability of CHAM.

(Refer to Annex A for the complete scope of work.)

1.9 Overview of Report

The report is divided into 7 sections, covering a wide range of technical areas. Following the introduction, this report presents the methodology used to conduct the PSA in Section 2. Section 3 provides an overview of organization, size and service delivery by the private sector in Malawi and synthesizes and presents information from three sources: the literature review; secondary analysis of key data sources such as the MDHS, and key-informant interviews. Section 4 describes the unique attributes of CHAM in providing private health services and offers a roadmap for building the capacity of CHAM and other NGOs to offer high-quality health services in partnership with the MOH. Section 5 outlines opportunities and constraints for expanding the commercial health sector in

Malawi. Section 6 details the current policy environment for private health care provision in Malawi. Section 7 summaries and concludes the PSA report.

2. METHODOLOGY

The assessment began with a scan of available published and gray literature pertinent to the objectives of the assessment and implemented a thorough literature review. The literature review helped to inform the assessment, with a particular emphasis on better understanding how the private sector is currently functioning within Malawi's health system and on identifying critical gaps in knowledge about the private sector that could be addressed during the assessment. To understand the political, economic, and social landscape of Malawi, the topics reviewed included: health policy and legislation, the Demographic and Health Survey (DHS), the health care system, health insurance, and National Health Accounts (NHA) data. The literature review revealed several potential opportunities for increased stewardship of the public sector and involvement of the private sector.

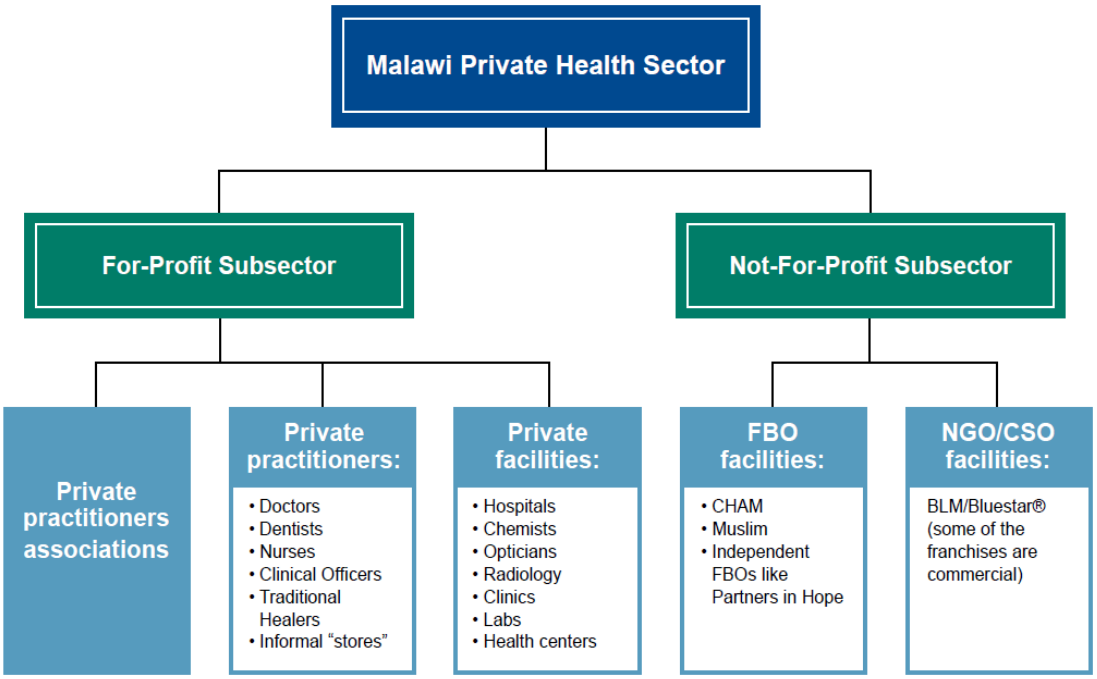
Stakeholder interviews were deemed crucial to understanding salient and prevailing attitudes held by public and private sector actors, donors, and implementers. These interviews were essential to identifying existing constraints and challenges as well as potential solutions. The SHOPS team developed interview guides tailored to each stakeholder group and conducted key informant interviews between May and June 2011. Stakeholders included: government officials, donors present in Malawi, USAID implementing partners, financiers, private health providers, CHAM staff and Board Members, NGO representatives, industry representatives, and others. Over 80 key stakeholders were interviewed over a two-week period. The list of all stakeholders interviewed by sector is included as Annex B.

3. ORGANIZATION OF AND SERVICE DELIVERY IN THE PRIVATE HEALTH SECTOR

3.1 Organization of the Private Health Sector

The organization and structure of the private health sector in Malawi can be summarized in Figure B below.

Figure B: Private Health Sector Actors in Malawi



Private Not-for-Profit Subsector: The private not-for-profit sector in Malawi is much larger and better organized than the private for-profit sector. In fact, CHAM, the largest network in this subsector, provides approximately 37 percent of the health care in the country. The private not-for-profit subsector mainly consists of the following organizations and facilities:

- Christian Health Association of Malawi (CHAM): CHAM is the largest not-for-profit provider in Malawi and is an important actor in the health system because of its large network of providers distributed throughout the country, with a strong presence in rural areas. CHAM provides services to about 4 million Malawians annually. Eighty-percent of CHAM services are delivered in designated hard-to-staff areas of Malawi. Overall, CHAM facilities employ over 7,000 people against an estimated number of 13,000 health care professionals in Malawi. In addition, CHAM boasts a vast health infrastructure with facilities at various levels of care, including health centers and small and large hospitals. As of 2010, CHAM owned and managed a total of 172 facilities comprising 20 major hospitals, 30 community hospitals, 10 training institutions and 112 health centers. In fact, CHAM runs the majority of training institutions for healthcare workers in the country (10 out of 16), with a particular strength in training paramedical staff.

- NGO/CBO facilities and Networks: In Malawi, Banja La Mtsogolo (BLM) has been operating since 1987 and presently runs 31 “static” clinics and 364 community outreach sites. BLM is a locally registered organization and receives technical and management support from Marie Stopes International (MSI). The BLM brand is well known in Malawi and appears to be highly regarded for quality services. All BLM clinics are accredited with the Medical Aid Society of Malawi (MASM) and BLM clinics offer basic primary care and reproductive health (RH)/FP services, including injectables, IUDs, implants and sterilizations. Only five BLM static clinics are certified to provide antiretroviral therapy (ART). In general, BLM operates on a user fee model, though it does provide some free services, including consultations for FP/RH services for youth, HIV volunteer counseling and testing, and referrals for HIV treatment. BLM currently supports more than 400 public sector facilities with long-acting FP methods. In addition, BLM launched the BlueStar social franchise in Malawi in June 2008 and there are currently 34 BlueStar social franchisees in the Southern region of the country.
- The International Planned Parenthood Affiliate in Malawi is called the Family Planning Association of Malawi (FPAM). FPAM is a young organization which was founded in 1999 and opened its first clinic in 2000. Today, FPAM has four clinics and employs approximately 70 total staff. Through their community-based distribution program, FPAM has presence in five districts. With GIZ funding, FPAM has been working with commercial sex workers (CSWs) in HIV counseling/peer education, safe sex negotiation skills, and alternative income/livelihood activities. Additionally, FPAM has many programs for youth including youth-friendly RH services, peer education and youth empowerment through their Youth Life Centers. FPAM has signed SLAs with the MOH in three districts of Malawi: Doa, Ncheo and Lilongwe.
- Other not-for-profit health facilities: there are other interesting hybrid facilities in Malawi that mainly provide HIV/AIDS services. The hybrid models described below represent interesting options for NGOs seeking to diversify funding sources, while remaining true to mission-driven HIV care and treatment to provide free services to Malawi’s most at risk and disadvantaged citizens.
  - Partners in Hope is a Christian FBO located in Lilongwe that provides a full range of HIV services including VCT, ART, and treatment of opportunistic infections (OI). Partners in Hope has a large facility that holds multiple clinical wards that are each organized around a different operating model. The Dalitso Clinic is a private-for-profit clinic and a subscriber to the MASM network and is known for high-quality care where patients largely pay OOP for care, The Moyo Clinic serves low-income clients for free and funds operations through both Church donations and profits from the Dalitso Clinic. While the Dalitso Clinic is distinguished by furniture that appears more luxurious, the entire facility is clean and integrated. In fact, Partners in Hope health practitioners work across the facility. Furthermore, equipment, including laboratory testing, used to service the paying Dalitso Clinic patients is also used for the non-paying Moyo Clinic patients, creating efficient economies of scale. Partners in Hope receives USAID/Malawi funding for HIV research and prevention programs. Partners in Hope has expressed interest in contracting directly with the MOH for the provision of HIV services in Lilongwe and could emerge as one of the first non-CHAM facilities to contract directly with the MOH.

- Lighthouse Trust is a Malawi-registered trust. Lighthouse is co-located at and intricately linked with the public Kamuzu Central Hospital in Lilongwe. In fact, Lighthouse originally began as a small clinic in the basement of the hospital 12 years ago. Now, Lighthouse is considered a public "Center of Excellence" for HIV care, where the hospital refers HIV-positive patients. Lighthouse receives MOH support for the provision of free HIV prevention and treatment. In addition, Lighthouse receives donor funding for research, monitoring and evaluation work and to integrate new components into its HIV care such as FP.

Private-for-Profit Subsector: The private-for-profit sector is relatively young, small and not as well organized as the private not-for-profit sector. This sector provides less than 3 percent (CHAM 2010-2014 SP) of the health care in the country and mainly consists of the following types of facilities:

- Private hospitals, health centers and clinics
- Private company clinics (e.g., employer-sponsored clinics)
- Private chemists and drug stores
- Individual private practitioners including medical, dentist and paramedical private practitioners
- Private laboratories and opticians
- Traditional healers and "shops" (as part of the wider informal care sector)

Most of the private for-profit providers, primarily hospitals and chemists, are situated in urban areas. These facilities mainly serve the middle and upper income quintiles, and a small number of employees who purchase private health insurance coverage through their large corporations. However, the smaller, more informal segment of the private commercial sector, particularly drug "shops" and small clinics owned by paramedical staff, are situated in rural areas where they serve rural, low-income population groups. For example, key informants noted drug "shops" for their critical and important role as alternative sources of medicines and other health commodities in light of frequent stock-outs in the public sector. However, widespread concerns are held regarding the quality of services and commodities available in drug "shops". Traditional healers also play a role in rural areas but there is a lack of reliable data regarding their service provision characteristics.

Professional Associations: Several associations representing the range of health care professional cadres exist in Malawi. Most of these professional associations have both public and private sector practitioner members and are not exclusively for private providers. A list of the key professional associations in Malawi is detailed in Box 1. The Medical Association of Malawi (MAM) is the most established association and was formed in 1967 for doctors and dentists; the Society of Medical Doctors in Malawi (SMD) is affiliated with MAM but exists separately for doctors. The National

Box 1: Key Professional Associations for Health in Malawi:

- Medical Association of Malawi
- Society of Medical Doctors in Malawi
- Malawi Dental Association
- Pharmaceutical Association of Malawi
- National Association of Nurses of Malawi
- National Paramedical Private Practitioners of Malawi

Association of Nurses of Malawi represents nurses, and the Pharmaceutical Society of Malawi (PHASOM) represents pharmacists. The National Paramedical Practitioners of Malawi is a notable provider association because it exclusively represents private providers who are paramedical practitioners including nurses and clinical officers, and does not have public sector members. The Malawi Traditional Healer Association represents traditional healers; the HSSP II outlines the intent for stronger coordination and interaction between the MOH and traditional healers through this association. Unlike many Sub-Saharan African countries, including Kenya and Ghana, there is no specific professional association that represents private hospitals. These fledging professional associations, although not as well organized or strong as CHAM, present an opportunity to organize the key private sector actors –both providers of healthcare services and of medicines/health commodities.

3.2 Size of the Private Health Sector

Accurately determining the size of the private health sector poses a challenge – particularly for the for-profit sector. Reports on the total number of private health facilities and practitioners in Malawi are conflicting. A summary of the number of licensed private practice facilities and practitioners is detailed in Table 2 below.

TABLE 2: Estimates of Health Facilities and Professionals Licensed for Private Practice
(Private not-for-profit and private for-profit)

Health Professionals		
Cadre	**# of professionals licensed for private practice**	**Source/Comment**
Doctors (GP)	29	MCM Gazette, Feb 2010
Doctors (Specialists)	22	MCM Gazette, Feb 2010
Clinical Officers	51	MCM Gazette, Feb 2010
Medical Assistants	97	MCM Gazette, Feb 2010
Physiotherapists, Optometrists, etc.	12	MCM Gazette, Feb 2010
Dentists	12	MCM Gazette, Feb 2010
Lab Technicians	2	MCM Gazette, Feb 2010
Pharmacists	80	PMPB estimate, 2011
Nurses	1464 (CHAM), 436 (PFP)	Nursing Council estimate, 2011
Health Facilities		
Facility Type	**# of facilities licensed for private practice**	**Source/Comment**
Hospitals	17	MCM Gazette, Feb 2010
Health Centre/Clinics	163	MCM Gazette, Feb 2010
Laboratories	2	MCM Gazette, Feb 2010
Pharmacies	80	PMPB estimate, 2011
Drug “Stores”	220	PMPB estimate, 2011
Others (Opticians, dentists, etc.)	46	MCM Gazette, Feb 2010
Private Facility Ownership		
Owner	**# of facilities owned**	**Source/Comment**
CHAM	172	CHAM SP, 2010-2014
BLM	31	BLM
Private for-profit and company facilities	127	MCM Gazette, Feb 2010

Health Professionals		
Other NGO (e.g., Partners in Hope)	Unknown	

The information presented in the above table reflects an initial estimate quantifying the private health sector and is based on a number of sources compiled by SHOPS, including an analysis of the official register of the MCM (mainly though the MCM Gazette of February 2010) and of the registries of other regulatory bodies where relevant. However, it is important to note that a number of key respondents believe that MCM registers and those of other regulatory bodies may underestimate the actual number of facilities and practitioners currently comprising the private health sector. The discrepancies between actual numbers and those recorded in the registers are likely a reflection of inefficiencies in private provider registration and licensing by the regulatory bodies. Similarly, detailed and complete data on the number of licensed nurses and other paramedical professionals in private practice were not available from the appropriate regulatory bodies at the time of the PSA, but some estimates were provided. The approximated data above confirms that the private commercial sector in Malawi is small and that CHAM is the largest non-state actor in the health sector. In addition, official MOH records do not capture the number of traditional health providers in Malawi. The MOH is increasingly recognizing the important role traditional health providers play in the Malawi health system and has submitted a draft policy to regulate this sector. To determine the true size and scope of the private health sector a detailed mapping exercise should be conducted.

3.3 Service Provision in the Private Sector

Based on secondary analysis of the MDHS from 2010, it is apparent that the private sector makes valuable but variable contributions to health care depending on the type of service. Since the 2010 MDHS does not measure health care utilization disaggregated by type of private provider, our understanding of service provision by the private sector is largely aggregated between CHAM and private for-profit facilities. For the majority of services, health care services delivered in the private sector remain far less than those delivered in the public sector. Nonetheless, service delivery in the private sector for maternal and child health services is an important component of Malawi's health system and appears to be growing.

Overall, the primary source of health services is the public sector, with CHAM providing another significant portion. Included in the remaining 3 percent of service provision are other private for-profit and not-for-profit providers like the BlueStar social franchise and the BLM not-for-profit clinics managed by MSI. The assessment team is cognizant that there are considerable questions about the exact size of the commercial sector in Malawi given the number of commercial enterprises that may not be registered with the MCM and as such, service provision estimates for the private sector may under-report service provision occurring in the commercial sector. BLM is a significant source of private sector FP, voluntary council and testing (VCT), and male circumcision (MC) in Malawi. In 2010, 9.3 percent of MDHS respondents obtained their modern contraception method from a BLM clinic (CHAM facilities provided 8.9 percent and private for-profit providers just 3.5 percent). Three percent of respondents obtained FP from informal "shops." BLM reports that it has a very good relationship with the government, particularly at the district level. It currently supports outreach for MOH centers with contributions from the National AIDS Council (NAC). In addition, each of its clinics has an outreach schedule

with a focus on FP services. BLM also supports more than 400 public sector facilities with long-acting FP services. Outreach programs utilize RH assistants who function like community health workers and are paid for by BLM. The RH assistants provide oral contraceptives and condoms and some are trained to provide injectables, which is a very popular method in the outreach program. The RH assistants also provide referrals to BLM clinics for long-term methods. BLM also conducts some outreach with tents and are considering expanding this model. BLM is exploring developing a dedicated outreach model, breaking it out from the clinics as a separate business line.

The private sector is an important source of maternal and child health services. According to aggregated data from the 2004 MDHS, 58.7 percent of caregivers sought treatment for illnesses in a child under five (diarrhea and fever/cough) from the private sector, compared to 41.3 percent from the public sector. The majority of private sector services for child health (82 percent) are delivered by non-formal providers, of which “shops” represent the largest provider (70.4 percent) (Montagu et al., 2011). Slightly more than half of all deliveries occur in the home (either in the person’s home or the home of a traditional birth attendant) (Montagu et al., 2011).

To date, Malawi’s MOH has been supportive of social marketing of subsidized child health products via commercial distribution networks. PSI, with the support of the MOH and donors including USAID, launched its Thanzi oral rehydration salt (ORS) brand in 1999—Thanzi has become synonymous with ORS throughout the country (NSO, 2005). The MOH also supported PSI to introduce its WaterGuard point-of-use (POU) water disinfection product in 2002, which is locally manufactured by Chemicals & Marketing Ltd. WaterGuard remains the only POU product widely available to rural Malawian consumers, selling over 500,000 bottles annually, each of which is capable of treating 570 liters of water. PSI has also marketed their Chitetezo brand of insecticide treated bednets (ITNs) for malaria control, targeting pregnant women and caregivers with children under the age of five in rural areas.

Following GOM subsidization of ART offered through the private sector, engagement of the private sector in the provision of HIV/AIDS care and treatment is growing. In December 2006, 38 private facilities were delivering ART to 3347 patients at a subsidized monthly rate of $3.28 per patient (MOH, 2007). Four years later in 2010, 59 private facilities were providing ART, treating 3.9 percent of total ART patients in Malawi (MOH, 2010). To qualify for the GOM program, private practitioners must complete a private sector specific two-day ART course. The Malawi Business Coalition against HIV/AIDS (MBCA) bears primary responsibility for coordinating the scale-up of the private sector ART program (including facilitating the two-day training with the MOH) and for supervising the private sector clinics accredited under this program. As an umbrella organization of private sector companies, the MBCA was established as a mechanism to coordinate the private sector response to HIV/AIDS and encourage communication and cooperation with the GOM and other private sector actors. MBCA offers three additional courses specifically for the private health sector: prevention of mother to child transmission (PMTCT), management of sexually transmitted infections (STI), and HIV counseling and testing. The MBCA is funded through membership fees and the NAC (MBCA, 2011).

Tuberculosis Directly Observed Therapy (TB DOT) can be provided through the private sector and some providers do offer TB DOT, for a fee. However, given that TB DOT is offered for free

in the public sector (including through CHAM), most private providers find the treatment to be too costly and complicated to be profitable. Nevertheless, private providers are engaged in TB efforts aside from treatment and serve as an important patient referral mechanism to public facilities. A recent pilot program engaged grocery shops and traditional healers as part of the referral system for TB cases (Jeffreys, 2004). The three main private hospitals in Malawi (Mwaiwathu, Chitawira, and Seventh Day Adventist) offer gratis diagnosis and treatment (Jeffreys, 2004).

4. ENSURING THE SUSTAINABILITY OF CHAM

NGOs serve a critical gap in health care provision that is often not fully addressed by the public or commercial sector. NGOs often fill vacancies when the public sector does not have either the willingness or capacity to meet all of the health care needs and when the commercial sector does not have the market incentives to do so. As such, NGOs face the difficulty of fulfilling their mission while remaining financially, institutionally, and programmatically sustainable. This balance is especially challenging in times of economic constraint and in the face of decreasing or uncertain donor commitments.

Globally, the majority of NGO funding comes from private donations. However, in the case of clinically-based health NGOs, many are finding ways to become sustainable through their service delivery platform. The SHOPS approach to NGO sustainability encompasses helping NGOs achieve the following:

- Maximize their service delivery platform and market access;
- Increase efficiency to facilitate the provision of high-quality services at affordable prices;
- Diversify donor sources to reduce over dependence on any one institutional client; and
- Focus donor subsidies toward reaching the most-in-need target populations.

These strategies entail leveraging the organization's physical infrastructure and other capital assets; its know-how and human resources; and its brand image although many of these assets may have been acquired through years of donor support. The accumulated value of this support and these assets over time are part of what should allow an NGO to offer high-quality services at less than full commercial prices. The ultimate goal of NGO sustainability is attainable when the cumulative value of previous donor support allows an NGO to offer services indefinitely at affordable prices, with ongoing donor support used strategically to achieve specific health objectives—more efficiently than the public sector would be able to directly.

CHAM is a good example of an NGO combining an essential social mission with valuable assets. CHAM's physical infrastructure, being predominantly located in rural areas of Malawi, is its largest asset and is what allows CHAM to create high social value. Most of the CHAM facilities were built by missionaries over 50 years ago, before the Malawi MOH existed. Today, CHAM still has a larger footprint in the rural areas of the country than does the MOH and many CHAM facilities are assets acquired from previous donor support (e.g., church donations). Overall, the accumulation of these assets not only offers high value to CHAM, but also and more importantly to the entire country.

4.1 Background and Organization of CHAM

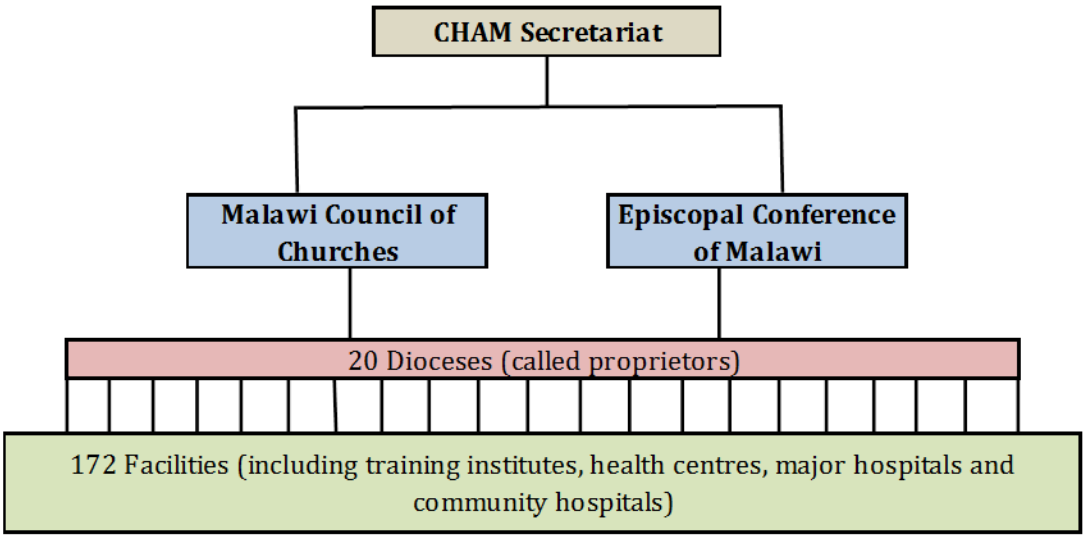
CHAM was established in 1966 and before changing its name in 1992 was originally called the Private Hospital Association of Malawi. Currently, CHAM has 172 facilities and as a result of its missionary legacy, most of these facilities are in rural areas. The breakdown of health facilities owned by CHAM is described in Section 3. CHAM is the second largest provider of healthcare in the country after the MOH and is the largest provider in the private sector.

CHAM is made up of two mother bodies: the Malawi Council of Churches and the Episcopal Conference of Malawi. These two bodies comprise the general assembly of CHAM and are the custodians of the CHAM constitution. The two mother bodies are each a network of dioceses. It is the dioceses that own the health facilities, and therefore are referred to as the "proprietors." One diocese can own multiple facilities. For example, the Anglican Diocese of Lake Malawi owns two hospitals and five health centers, as well as mobile clinics. There are about 20 proprietors in the CHAM family and approximately 62 percent of CHAM facilities are owned by Catholic dioceses.

The CHAM Secretariat has 21 staff members and its main role is to coordinate and liaise with the CHAM network and external stakeholders, addressing and responding to network-wide needs, and monitoring, reporting and ensuring compliance with quality of care standards. The Secretariat has its own Board of Directors.

CHAM receives funds from a variety of sources including user fees levied at their facilities, SLA reimbursements, salary subsidization from the MOH, and external donor funds. CHAM donors include numerous church groups as well as international donor support from USAID, CDC, GIZ, Norwegian Church Aid, Danish Church Aid[1], the European Union, Unicef and others. Figure C below shows the organizational structure of the CHAM network.

Figure C: Diagram of the CHAM network



CHAM also receives full subsidization of staff (including clinical and administrative) in all its facilities from the MOH. The subsidization includes salaries, paid time-off and salary top-ups or additional financial incentives as allocated in the MOH annual budget. The staff subsidy totals approximately $16 million per year. Until recently, subsidization has been paid to the CHAM Secretariat according to CHAM payroll accounts. The CHAM Secretariat then distributes the funds to its facilities. Due to widespread concerns regarding ghost employees throughout the

[1] Interview with Rose Ng'oma, CHAM Executive Director, during Private Sector Assessment, May 2011

civil service and at CHAM (BBC News, 2011), the GOM revised its salary payment system and as of February 1, 2011, all government paid salaries were to be paid by direct deposit, including the CHAM staff salary payments. The GOM announced this policy change in late 2010 and gave workers several months to open bank accounts. The Treasury Secretary claims that the direct deposit system is substantially saving the GOM millions of dollars per year (News24, 2011). CHAM has been accused of being one of the largest sources of ghost employees in the past; therefore, this policy change should address the issue of CHAM potentially misusing funds allocated for the staffing subsidy for other purposes. However, the direct deposit system will deeply affect the CHAM Secretariat's cash flow. As depicted in Figure D, approximately 80 percent of CHAM's income comes from the GOM – of which the vast majority is for staff salaries.

Overall, the CHAM Secretariat is entirely dependent on the GOM subsidies and external donors. This over-reliance leaves the Secretariat in a precarious position. Ideally, the CHAM Secretariat should be able to cover a significant portion of its costs through internal-network revenues such as drug supply which would provide a small margin to the Secretariat and/or through dues from CHAM facilities. However, in order to make that level of cost recovery feasible, the Secretariat needs to provide services to the facilities which are perceived as helpful, appropriate and valuable.

On the other hand, CHAM facilities are the part of the network with the highest debt levels, and their operations also present a risky financial scenario. Therefore, sustainability at both the Secretariat and at the facility level needs to be addressed to improve the sustainability of CHAM overall. Figure D below shows current sources of funding for the CHAM Secretariat and CHAM health facilities.

4.2 THE CHAM-MOH RELATIONSHIP

CHAM and the MOH have a mutually dependent relationship. The ministry depends on CHAM to provide EHP services in areas where the MOH does not have sufficient coverage—largely in rural areas. Additionally, CHAM training institutes are critical to addressing Malawi's human resources issue as CHAM trains enrolled nurses, nurse midwife technicians, laboratory technicians, clinical officers and psychologists. In fact, CHAM trains approximately 70 percent of all nurses in Malawi. However, CHAM is financially dependent on the MOH for an average of 50 percent of income across the various levels of the CHAM network (and at a level of 80 percent for the CHAM Secretariat).

Both CHAM and the MOH are multi-layered, complex entities which are highly decentralized. The level of decentralization in Malawi's health system creates challenges in managing the relationship between the two entities due to variations in district-level manifestations of the relationship across the country. Some are positive, some are negative – and most are somewhere in between.

In 2002, CHAM and the MOH signed a memorandum of understanding (MOU) which was meant to structure their cooperation and partnership. The MOU outlines general terms for CHAM staff subsidization, other personnel support and SLAs, but does not outline a clear fee schedule for

the SLAs. The MOU also establishes commitments such as 40 percent of medical providers matriculating from CHAM training colleges are supposed to be placed in CHAM facilities for service afterwards. The current MOU is evergreen, meaning that it does not have an expiration date. However, both parties agree that the MOU needs to be revised and are in the process of discussing a new MOU. While the SLAs were conceived to expand coverage of the EHP, in its entirety, currently only 2 CHAM facilities fully cover the EHP. The rest of the SLAs with CHAM facilities only cover maternal and newborn health (60 facilities) or services for children under age 5 (12 facilities) (Lungu, 2011).

The MOH contracts out to CHAM to provide 32 MCH services through SLAs as listed in Annex C although only a few SLAs cover all 32 services. CHAM proprietors and the DHO negotiate and determine the services that will be covered and at what reimbursement rate, taking into consideration disease burden, capacity of the facility and other factors. The SLAs allow CHAM to provide services to the population free-of-charge and to be reimbursed by the MOH at pre-determined rates set in the individual contract. In theory, SLAs are for servicing geographic areas where there is a CHAM facility and not an MOH facility and, according to the MOU between the two entities, neither is supposed to build a new facility within 8 kilometers of the other. The SLAs are agreed upon and executed between the DHO and the CHAM proprietor. Generally, they are signed for a 12-month period; however, most SLAs are renewed multiple times for subsequent 12-month periods.

During the PSA, medical providers claimed that the SLAs are an important life-saving mechanism because clients come to seek treatment earlier in the disease cycle, knowing that they can receive services free-of-charge. Medical providers stated that they have witnessed a noticeable decrease in delays to seeking care.

Though the SLAs are critical to ensuring provision of essential health services, their structuring and implementation are currently very problematic for both CHAM and the MOH and have caused considerable tension between the two major actors in the Malawian health system. Correspondingly, discontent about the SLAs, along with allegations of ghost employees (Chapulapula, 2011), have engendered a negative image of CHAM to many stakeholders, including the general public.

Originally, the use of SLAs began as a pilot. Although an evaluation of the SLAs was implemented in 2009, many CHAM facilities had already signed SLAs with DHOs in the intervening years. Many DHOs felt that the services provided under the SLAs were so critical that there was no point in waiting for the pilot to be evaluated. However, as a result of this somewhat spontaneous process, the SLA pricing was implemented haphazardly, on an ad hoc basis. In some cases, DHOs and the facilities used the fee schedule from the pilot, but in many cases they established their own as part of a one-off negotiation between the facility and the DHO. As a result of this lack in standardization, many in the MOH claim that CHAM is over-charging the MOH and making profit from the SLAs, while CHAM declares that it is losing money on the SLAs. The tension is exacerbated by budget constraints within the MOH and CHAM's own financial woes.

CHAM claims that the current negotiated fees make assumptions which are not reflective of reality. For example, the SLA reimbursement rates by service assume that related drugs and

medical supplies will be obtained for free from the Central Medical Store (CMS) via the Regional Medical Stores (RMS). However, CMS has serious stock-out issues regarding essential medicines, experiencing widespread chronic shortages. Because of the CMS stock-out issue, CHAM facilities are often forced to procure medicines locally at commercial prices through one-off emergency type purchases. This procurement practice causes CHAM to incur high costs which are not reimbursed under the SLAs. Additionally, even when CHAM is able to obtain essential medicines through CMS, there are transportation and other logistics-related costs that are not accounted for under the SLAs.

Because of the pricing dispute, many SLAs have expired and have not been renegotiated. CHAM facilities have continued providing services, and in many cases the DHO has continued to reimburse CHAM using the fee schedule as negotiated in the expired agreement. However, many DHOs are paying late and some have ceased reimbursement. At the time of the PSA, CHAM claimed that the MOH has outstanding payments to CHAM facilities totaling approximately $400,000. Many facilities within the CHAM network are experiencing high levels of debt, mostly in the form of outstanding accounts payable. The lack of predictable cash flow under the SLAs strains the facilities and jeopardizes their ability to continue providing services. However, at the time of the PSA, only one CHAM facility had ceased providing services even in the face of these tremendous challenges.

In an effort to resolve the fee schedule issue between CHAM and the MOH, GIZ commissioned a costing study of the SLAs in 2010, which was conducted by EPOS Health Management. The study used a two-pronged approach to analyze the pricing arrangement; applying both a step-down cost allocation methodology and a “micro-costing” technique. The study used a sample of 20 CHAM facilities with SLAs, including 10 hospitals, one community hospital and nine health centers. The sample included four facilities from the North and eight each from the South and Central regions.

There are criticisms of both costing methods amongst technical experts. The criticism of the step-down approach is that it overestimates CHAM’s costs because it does not account for the large salary subsidization. However, the criticism of the “micro-costing” approach is that it underestimates CHAM’s costs because it does not account for fixed costs and does not use real cost inputs on variable costs. The micro-costing approach uses the basic standard of care according to the Malawi Standard Treatment Guidelines as the default assumption in terms of time, equipment, medicines, and supplies for each service, and does not cross-check with actual costs. For example, in the case of drug procurement in Malawi, actual costs can vary dramatically with assumed costs. The two methodologies used by EPOS showed large variance in drug costs. The EPOS consultants, presumably in an effort to strike a balance, used the two-method approach; however, in most of their analyses, they only considered variable costs.

Unfortunately, in the end, the costing study did not provide the neutral, indisputable analysis that could have dissipated much of the tension and ended the pricing debate. The controversy has now evolved into a worsened relationship - with CHAM claiming underpayment, armed with the results of the step-down method, and the MOH claiming overpayment, armed with the results of the micro-costing technique. The study gave both sides “proof” of their claim and the SLA pricing debate has deteriorated into a political back-and-forth.

The timing over this disagreement in costing has added to the pressure to negotiate a new MOU that will serve as the framework of the whole relationship. Under the new MOU, the MOH has expressed interest in changing the SLA pricing structure from fee-for-service to a capitation system. CHAM is concerned about a pure capitation structure for several reasons. The three major issues for CHAM regarding a capitation system are: a) doubt about the accuracy of population estimates; b) potentially inaccurate assumptions about use per capita and c) the fact that political boundaries do not necessarily dictate where an individual seeks services. For example, the Nkoma Hospital, per its SLA, serves a catchment area based on its political boundary. However, there are communities approximately 10 – 15km away which seek services at Nkoma Hospital (since it is closer to their homes) although they are from a different political district and are supposed to seek services at the MOH hospital for that district. CHAM fears that a capitation system would exacerbate this issue and potentially cause more financial burden on CHAM (by subsidizing clients not covered under the SLA, but who believe they are), decreased service levels and/or dissatisfied clients. CHAM is hoping to strike a balance with a “band of services” model which would entail a set fee for a package of services, such as immunizations, pre-natal care, etc.

Overall, establishing a new MOU guiding the CHAM-MOH relationship, and structuring new SLAs that accurately capture costs for both CHAM and the MOH, are actions of paramount importance for the future of Malawi’s health system. Currently, though, tension in the relationship between these two main actors threatens the implementation of the next round of SLAs. Challenges in the facilitation of SLAs threaten the health system since the SLAs are necessary in expanding access to life-saving essential health services for millions of rural Malawians.

4.3 CHAM'S Role in Pre-Service Education

CHAM facilities in Malawi not only provide health services, but also train health workers to staff public and private facilities throughout the country. CHAM has ten affiliated training institutes that provide an estimated 40 percent of overall health worker pre-service training and 70 percent of pre-service training for nursing and midwifery. CHAM's nursing and midwifery pre-service training produces 77 percent of all nursing personnel in Malawi (Pearl et al., 2009a). An estimated 600 health workers—including laboratory technicians, nurses, midwives and counselors—enroll annually in CHAM's training institutions. In 2009, over 500 health professionals graduated from these training institutes (CHAM, 2009). Among scholarship recipients attending CHAM pre-service institutions, approximately 40 percent of graduates work for CHAM and 60 percent for the public sector (Pearl et al., 2009). Each year about 20 medical doctors, 450 nurses, 70 clinical officers, and 90 medical assistants graduate in Malawi (Jeffreys, 2004). Sixty-percent of the staff working at the 10 CHAM training colleges is MOH staff seconded to CHAM although CHAM hopes to attract more of its own health workers as teachers in coming years.

CHAM also holds a range of in-service trainings. Several in-service trainings are offered in collaboration with international NGOs or educational institutions such as Management Sciences for Health, Japan International Cooperation Agency, and several Norwegian colleges. CHAM estimates that approximately 200 employees from its health facilities participate in these trainings annually (Pearl et al., 2009b).

4.3.1 Financing Pre-Service Education

Interviews with key stakeholders revealed considerable confusion about the government's plans for financing pre-service education. A major determinant in the creation of new health workers is the affordability of pre-service education. Historically, most enrollees relied on government scholarships or OOP payments for tuition in order to attend pre-service educational institutions in Malawi.

In 2009, the GOM suspended its scholarship program, resulting in student dropouts and considerable financial stress on CHAM facilities. In 2010, the government reinstated scholarships. There currently is some confusion and disagreement between key stakeholders about the status of the scholarship program and a student loan scheme that is being initiated with the government-owned Malawi Savings Bank (MSB).

SHOPS held a focus group with 10 principals of CHAM training facilities during the PSA. According to the CHAM principals, approximately 90 percent of their students receive government scholarships and they would not be able to continue operations if scholarship funding is suspended. The GOM is currently paying CHAM training institutes directly for students on scholarship. Average tuition and board is MK $1991 per annum. Through the scholarship program, the GOM pays $1783 and the student contributes $208 directly.

During the suspension of scholarships in 2009, the CHAM training institutions attempted to develop payment plans with students for the remaining part of year. However, most students dropped out and those who agreed to the payment plans in most cases did not pay. The CHAM principals claim that only a few honored their payment plan and those who did repay had other

private sponsorship. As a result of the scholarship suspension, there will be no new graduates in 2012 from the CHAM training colleges and the production of new health workers in Malawi will be stalled. Clearly, the suspension of GOM scholarships present a serious threat to enrollment in CHAM training facilities as the CHAM principals estimate that less than 10 percent of pre-service students are able to pay OOP for tuition and accommodation.

The principals agreed that there is talk of a new student loan program but there was some disagreement on whether and how it will be implemented. Some principals believe that the new program will be a hybrid between a loan and a scholarship scheme. Theoretically, the GOM will continue paying $891 as a scholarship for tuition directly to the training institute. The student will continue paying $208 OOP. In addition, students will be eligible for a loan from the state-owned MSB to cover room and board that will be repaid by the student at the end of the term. Others believed that the GOM will repay the loan and require the student to work for five years in the public sector as a condition of receiving the scholarship.

Overall, there is a high level of confusion among key stakeholders about the terms, coverage and repayment requirements on the MSB, GOM-guaranteed human resources for health (HRH) loan products and prospects for high levels of repayment are limited. The GOM has a history of launching student loan products that are viewed by the public as scholarships, and this may well be the fate of this recent attempt with the MSB. MSB is not expecting to make a profit on the student loans and is concerned about repayment. The existence of this highly subsidized product will make it unlikely that commercial banks would be willing to enter the HRH student loan market. Still, financing pre-service education in CHAM training institutes is both critical to alleviating Malawi's overall HRH shortages and to building the sustainability of CHAM. While the prospects for the emergence of a commercial HRH student loan product are limited at this time, CHAM requires assistance from both the MOH and key donors including USAID/Malawi in ensuring that bursaries remain in place from new prospective health workers enrolling in CHAM training institutes.

4.4 Supply-Side Challenges Facing CHAM

The MOH's CMS has struggled to comply with its mandate to supply drugs to public sector service delivery points and to its service delivery partners, such as CHAM. High levels of stock-outs have caused donors to look for interim solutions to address the severe supply issues. Some reports claim that stock levels in 2006 and 2007 were as low as 35 percent at the CMS level and a staggering 7 percent at the health center level.

Because CHAM relies on CMS for EHP-related drugs for their facilities, the stock-out problems at CMS have directly impacted CHAM. CHAM purchases drugs for all its facilities through CMS. In the case of facilities with SLAs, the cost of drugs (per CMS' cost list) are recovered through the SLA (transportation costs and external procurement costs are not included). For non-SLA facilities, CHAM still purchases through the CMS, but without cost recovery, with a few exceptions. Stakeholders interviewed inside and outside of CHAM explained that CMS through the RMS prioritizes public sector facilities over CHAM facilities and in a low supply situation, the CHAM facilities are the most likely not to receive drugs. This perceived disparity has caused CHAM to conduct ad hoc procurements in the commercial sector which are much more costly and also can create quality issues. As a result, CHAM has intentions to create their own Drug

Supply Organization (DSO) rather than continuing to rely on CMS. CHAM's Board of Directors has approved the establishment of a "state of the art" non-profit DSO with the ambitious goal "to increase the range of good quality medicines and other medical supplies to CHAM health facilities and the Malawian population."

CHAM's Secretariat established its own pharmaceutical department a few years back to provide support, guidance, technical advice and training to its member units on pharmaceutical issues. In response to the challenges faced by the member units in ensuring the continuous supply of quality and affordable pharmaceutical supplies for its clients, CHAM, with the support of its partners, established a drug revolving fund, managed by the pharmaceutical department, for the supply of essential pharmaceutical products to its member units to address chronic gaps. However, based on interviews with members of the Secretariat and CHAM facilities, drug supply continues to be a pressing need and remains as the largest unrecovered facility-level cost for CHAM.

CHAM hopes to create a fully functioning DSO in order to achieve the following:

- Decreased dependency on CMS
- Decreased stock-out rates
- Achievement of economies of scale and volume pricing through bulk purchasing
- Improved quality through consistent, well-managed drug supply

The current drug supply and distribution service, which is being managed by CHAM's pharmaceutical department, operates a rented warehouse and stocks a total of 140 products, mainly essential drugs and medical supplies. The department has 2 staff members; a pharmacy technologist and a warehouse assistant. In addition to low human resource capacity, the drug procurement and distribution service is confronted with a number of challenges resulting in its inability to effectively discharge its mandate to the satisfaction of member units and clients. These include but are not limited to:

TABLE 3: Challenges Facing CHAM's Drug Supply and Distribution Service

Product Selection	• Given the limited availability of funds and high demand for pharmaceutical products from the member units, coupled with the wide variety of services provided by the member units, the department is faced with the challenge of selecting the essential products that meets their needs
Forecasting, financing and procurement	• Lack of reliable utilization data from member units • Very weak procurement systems (contracting, technical expertise) • Lack of adequate financial resources, weak cash flow management strategies • Delayed delivery of procurements
Inventory Management	• Lack of standardized inventory control systems and practices (e.g. standardized procedure for correctly calculating order quantities based on logistics data from facilities does not exist, stock keeping practices, Maximum/minimum inventory system) • Lack of adequate and appropriate storage capacity (warehouses, etc.)

	• Largely manual systems currently being used • Insufficient cold chain systems
Distribution	• Inadequate distribution assets (vans) • Inefficient distribution system • Multiple ordering systems in place (phones). • Need for a formal system which includes scheduled order cycles, submission of formal requisition forms (which captures consumption data, etc.)
Logistics Management Information System (LMIS)	• Lack of LMIS for collecting and reporting data on consumption, unmet demand, losses and adjustments, and stock on hand (need for drug management software)
Quality Assurance/ Monitoring	• Lack of standardized quality control guidelines for supplies during the procurement process • Lack of post market surveillance • Inadequate pharmacovigilance

CHAM has developed a concept note and a costs-inclusive business plan for this venture. Although CHAM's concept note makes a clear case for the need of creating the DSO, it is heavily focused on storage and cold chain capacity in the implementation plan. Although these are important issues, CHAM will also need technical assistance (TA) in forecasting, procurement and tendering (especially contracts negotiations), LMIS, downstream distribution, and product offering portfolio design if the DSO will succeed. By operating more like a business in terms of drug supply management and reducing dependence on CMS, CHAM can provide a much-needed valuable service to its member facilities while increasing its own sustainability.

4.5 CHAM's Current Capacity to Address Challenges

CHAM is a critical health care provider in Malawi. However, there are limitations to its capacity in a few key areas. Currently, at the CHAM Secretariat, there has been massive organizational change and streamlining. Before the re-organization, the Secretariat had 45 staff, and currently it has two. Most of this change was implemented in response to an issue with financial mismanagement at the organization. In an effort to address this situation, CHAM required all staff to re-apply for their position and in several cases the new minimum qualifications were not met by the person previously occupying that position. CHAM believes the strategy was effective in providing it with a "fresh start" with the right configuration; however it has also caused a high-level of vacancies. Currently, the CHAM Secretariat still has 12 vacancies, including for essential positions such as Director of Finance, Director of Human Resources, Drug Supply Coordinator, and until recently, the Executive Director.

4.5.1 Financial Capacity at the Secretarial Level

As mentioned above, the re-organization was implemented as a result of a financial mismanagement issue where the CHAM Secretariat used funds from one donor-funded project to pay for the staff or activities of another. Although the details of the management were not disclosed to the PSA team, the CHAM Secretariat explained that as a result of financial

mismanagement, they had to return money to some donors. As a result, they lost the support of two donors, Norwegian Church Aid and Danish Church Aid, although Norwegian Church Aid has begun supporting CHAM again.

CHAM, under new executive leadership, is currently developing a Financial Turnaround Plan as a strategy to bounce back from the fallout around past financial mismanagement. Elements of this Financial Turnaround Plan are intended to allow the CHAM Secretariat to provide services to facilities and externally which are valued enough to help the organization cover its costs better. Other elements of the plan include addressing the drug supply (which facilities claim represents 70 percent of their total costs) and prioritizing real engagement in TWGs with other stakeholders to improve CHAM's external image and "put CHAM at the table" in policy discussions. Currently, the CHAM Secretariat has a severe core funding issue. Because of the internal controls put in place as a result of the financial mismanagement issue, there is rigidity in the use of funds and few resources are considered unrestricted.

4.5.2 Contracts Negotiation Capacity

Additionally, CHAM enters into agreements and contracts with donors, the MOH and others without having strong contracts negotiation capacity. For instance, CHAM is still learning how to present direct vs. indirect costs in proposals to potential donors and thus has limited capacity to cover senior management salaries and other indirect costs. The SLAs pricing issue has not only led to a precarious financial situation for CHAM, but has also tarnished its external image because people claim CHAM is making profit. Since agreements and contracts are the core mechanism for CHAM to deliver health services, the organization urgently needs to invest in developing its contracts negotiation capacity. Additionally, if CHAM wants to create its DSO (as detailed in Section 4.4) in order to resolve procurement issues and reduce costs, it will need to enter into large purchasing contracts and negotiate favorable terms in order to minimize risk for the organization. CHAM has little capacity in this area and in fact, pre-paid the IDA Foundation for a consignment of drugs in August 2010 and as of the time of the PSA, still had not received the shipment.

4.5.3 Monitoring and Evaluation Capacity

Although a third-party quality audit has not been performed, there is anecdotal evidence including from the MCM and the MOH that CHAM facilities in general have a higher quality service than the MOH. CHAM apparently has strong technical, clinical capacity even when it is operating their facilities with less than recommended staffing levels. However, CHAM's ability to capture service statistics and client outcomes in its facilities is low. CHAM should improve its ability to capture data, share outcomes and data with the MOH, and speak of its accomplishments using evidence with a wide variety of stakeholders.

4.5.4 Business and Management Capacity of CHAM Facilities

As described above, the CHAM Secretariat is currently experiencing enormous financial difficulties. In addition, while SLAs have greatly expanded access, they have resulted in significant cashflow, human resource and operational shocks to CHAM facilities. For instance, Mlambe Hospital, a Catholic mission hospital near Blantyre, indicated that the MOH was six months behind on payments and as a result it has not been able to pay its staff on time. Mlambe had to increase

staffing to deal with a 40-50 percent increase in patients. The influx in patients resulted in increased wear and tear on the facilities that they do not have the money to maintain. Increased patients also led to sanitation problems. In addition, the hospital's relationship with creditors has become strained as it can no longer pay its bills on time. Another challenge that Mlambe is facing is drug stock outs. Drug stock outs force Mlambe to purchase drugs commercially in small quantities rather than at subsidized rates from the government. As a result, drugs are now consuming approximately one third of their budget.

4.6 Recommendations for Ensuring the Sustainability of CHAM

Given that CHAM is a layered network, improving its overall sustainability will requiring strengthening CHAM at various levels of the organization. The following three recommendation areas address improving Secretariat and facility-level sustainability, CHAM's service delivery performance and improving its role and position, both actual and perceived, in the overall health system in Malawi.

1. Improve the sustainability of CHAM facilities

a) Apply an organizational capacity indexing exercise for CHAM health clinics to 8 – 10 of CHAM's largest facilities as a baseline for measuring where the facilities are on the sustainability continuum and identifying current strengths and weaknesses

b) In accordance with the results of the indexing exercise, develop a tailored package of interventions by facility to improve sustainability, which may include improving financial management, improving service and product offering, strengthening governance and oversight, improving service quality, and/or improving general and clinical management capacity

c) Provide TA to CHAM in implementing the package of interventions at 8 – 10 facilities

d) Adapt business and financial management training for CHAM facilities and proprietors. The courses will be adapted following a thorough training needs assessment. Training topics may include:

- Bookkeeping
- Stock management
- Financial statement development and reporting
- Cashflow management
- Budgeting
- Managing accounts receivables and accounts payables

e) Provide TA, as appropriate, in restructuring SLAs and in basic contracts negotiation skills for facilities and proprietors

2. Strengthen CHAM Secretariat's management capacity so that it can effectively offer value-add coordination and oversight to member units, and strengthen its relationships with facilities, proprietors, and the GOM

a) Provide TA to CHAM to implement a sustainable DSO

- Provide TA to CHAM to re-package its original DSO concept note and business plan to enhance its viability and attract the needed funding
- Work with CHAM to re-engineer/ address the challenges of the current pharmaceutical procurement and distribution service in order to lay a solid foundation for the introduction of the "state of the art" non- profit DSO
- Provide TA in launching a DSO for an eventual build-up to 140 products

b) Provide TA to the CHAM Secretariat and Health Coordinators in designing and implementing an efficient, accurate monitoring and evaluation program which allows CHAM to accurately capture and report data. This monitoring and evaluation program will require upgrading health management information systems (HMIS) and shifting to a culture of data analysis and data-based decision-making.

c) Provide leadership and management training, using a values-based management approach, which fosters a new organizational culture based on performance and meritocracy, objective decision-making and accountability

d) Provide specific training in professional project management for a select group of people from the CHAM Secretariat and the Health Coordinators in order to improve performance on donor-funded projects

e) Build contracts negotiation capacity at the CHAM Secretariat including training and providing TA to CHAM in creating a contracts position to help protect its interests in both buying and selling contracts, as well as monitoring compliance with regulations

2. Improve CHAM's service delivery performance

a) Building on the MCHIP experience in Malawi, expand the SBM-R approach to 10 – 15 additional CHAM facilities to improve clinical quality and monitor results of all CHAM facilities implementing SBM-R

b) Train a cohort of trainers selected from non-Catholic CHAM facilities on implants and interval and post-partum IUD insertions and removals. Following the training of this initial cohort, train clinical officers and nurses in the methods across the non-Catholic CHAM facilities in order to allow for a broader, more rationale method mix

c) Provide TA in designing and implementing an initiative to incorporate zinc into diarrhea treatment at all CHAM facilities including updating clinical guidance from the CHAM Secretariat, procuring and distributing zinc throughout the CHAM network, and training of providers in correct zinc usage

d) Conduct a rapid assessment of the state of micro-nutrients' (other than zinc) distribution and use through CHAM facilities. Based on the results of the assessment, design recommendations for improving the distribution and use of micro-nutrients throughout the CHAM network

5. OPPORTUNITIES AND CHALLENGES FOR EXPANDING THE COMMERCIAL SECTOR IN MALAWI

As observed from the discussion on the size of the private sector in Malawi in Section 3, the commercial health sector in Malawi is relatively new and likewise small. Despite its size, all key stakeholders and most of the private providers that were interviewed during the PSA believe that the private health sector has been growing—particularly in the last three years—and will continue to do so. Moreover, opportunities exist to help shape the private health sector as it grows to expand the delivery of priority public health services.

As it stands currently, the private sector has already begun to show its importance as a provider of public health services. As reported in the 2004/2005 National Health Accounts, seven percent of all RH expenditures were accounted for by the commercial health sector. This small percentage is not insignificant given that commercial providers provide less than 3 percent of health services in Malawi. Similarly, according to the MBCA, 59 private clinics (privately-owned and company clinics) are accredited to provide ART for HIV treatment and of 300,000 ART clients in Malawi, more than 13,000 (about 5 percent) are registered in the private sector. In assessing the BlueStar social franchise, the PSA team found that before joining the franchise almost none of the individual clinics provided FP services and now all of them do. In spite of the small scale of the BlueStar social franchise, this finding indicates that networking commercial providers is one important way to expand the basket of available priority health services. Commercial health sector providers interviewed by the PSA team agreed that the moment is ripe to add and improve priority public health services, such as MCH, FP, and VCT although crucial challenges for the development of the commercial health sector remain.

5.1 CURRENT STATE OF THE COMMERCIAL SECTOR IN MALAWI

5.1.1 Fragmentation in the Commercial Sector

The PSA revealed that private providers in Malawi are isolated and that the private health sector is highly fragmented. Both BLM and PSI mentioned that private providers are difficult to identify and that data from the MCM is not completely up to date. Not only is there incomplete information regarding the location of commercial providers (compared to public and CHAM facilities), but there is also insufficient knowledge concerning the demand for commercial services. In addition, providers cited limited opportunities for networking and sharing information. As previously discussed, private provider associations are weak and have limited membership. The PSA did not find any examples of group practice and found only a few examples of provider networks or other types of organizationally complex business models (such as the BlueStar network or MASM's clinics) that provide scale and efficiency gains.

5.1.2 Constraints for the Growth of Commercial Sector Businesses

In 2010, prior to the PSA, SHOPS conducted interviews and focus group discussions (FGDs) with commercial health service providers in Malawi, although commercial providers were also interviewed during the 2011 PSA. Table 4 below displays a tally of the major constraints identified by commercial providers during the interviews. Access to finance was cited as an important constraint, along with business management capacity, clients' inability to pay,

insufficient demand, and lack of collaboration with the public sector. Both BLM and PSI identified business training as an essential strategy to strengthen business management capacity in the private sector. According to BLM, providers in the BlueStar network that are not able to operate their businesses viably are hindered in their ability to provide quality services. PSI identified lack of cash flow management skills as a constraint to private providers buying and stocking more products, which impacts the level of care provided to their clientele. The BlueStar case study presented in Annex D provides a more detailed discussion of constraints identified by this network of private providers in Malawi.

TABLE 4: Comparison of Constraints Identified by Commercial Providers in Malawi

	BlueStar Franchisees (18)	Other Private Providers (7)
Patients inability to pay	✓	✓
Lack of access to financing	✓	✓
Lack of demand	✓	✓
Increased competition from the private sector	✓	
Lack of collaboration with the public sector	✓	✓
Lack of collaboration with the insurance sector		✓
Lack of bookkeeping/financial skills	✓	✓
Lack of specific clinical skills	✓	
Disorganization within private sector		✓
Lack of trained clinicians and/or inability to retain them		✓
Lack of marketing skills	✓	
Excessive government regulation	✓	

5.1.3 BlueStar Social Franchise

MSI operates the BlueStar social franchising program, which is active in nine countries around the world. In June 2008, BLM launched the BlueStar social franchise in Malawi.

As part of this launch, BLM conducted a mapping exercise to locate small, private clinics; assessed 86 potential franchisees; and selected 60 independent clinics to become BlueStar network members. The selection criteria included: geographic location, quality of service, and commitment to offering FP services. BLM has since conducted a comprehensive mapping exercise of the private sector in ten districts in Malawi.

Box 2: BlueStar Memorandum of Understanding

BlueStar provides:

- Branding
- Multimedia marketing campaigns
- Clinical training
- Operations manual
- General support and customer care

Franchisees agree to:

- Maintain and not copy branding
- Attend all training offered
- Adhere to operations manual
- Keep current FP/RH client and sales records
- Review contract and pay annual fee

For an annual franchise fee of $65, each clinic receives a number of benefits from BlueStar. During the PSA, the franchisees interviewed cited training and access to subsidized drugs, supplies and equipment as key challenges prior to joining the franchise. This finding suggests that business and management training may play a dual role within the BlueStar franchise by offering a tangible benefit to franchisees which also improves the financial sustainability of member clinics and thus the franchise at large. See Box 2 for a summary of the terms of the MOU between BLM and the franchisees.

Over the past three years, the number of BlueStar franchisees in Malawi has decreased and there are currently only 34 BlueStar franchisees in the Southern region. This decrease is due to several factors: some providers have dropped out of the franchise; some have been shut down by the MOH; and some have gone out of business. Before expanding to include additional providers, BLM is now in the process of consolidating the franchise and improving the franchise model and services provided to its franchisees. BLM frankly admits that viability issues and poor business management affect the quality of services that the BlueStar clinics are able to provide to clients. In addition, demand for FP services in the commercial sector is relatively feeble given free provision in the public sector and at CHAM facilities that have SLAs for FP services. BLM has identified improving business management and access to finance as important strategies for strengthening the franchise. For example, BLM has connected franchisees with MASM and is using its purchasing power to buy drugs in bulk for resale to franchisees.

In June 2010, the SHOPS project conducted an assessment of the BlueStar franchise, examining business and financing constraints of franchisees. This assessment consisted of two FGDs with 10 clinic owners and interviews using a semi-structured questionnaire with eight clinic owners. The findings from these earlier FGDs were validated during the PSA through discussions with clinic owners and BLM staff. Key findings from the 2010 interviews are included in the BlueStar case study (Annex D).

Overall, the PSA found that the BlueStar social franchise is an important entry point for organizing the commercial sector, though the current scale of the franchise is small. There are important opportunities to work with BLM to scale-up and add essential health services through the BlueStar network, such as VCT, safe water, and nutritional supplements. However, persistent issues related to low demand for commercial sources of EHP services remain. High levels of poverty in Malawi and the free provision of EHP services through the public sector and some CHAM facilities inhibit the growth of BlueStar.

5.1.4 Other Commercial Health Providers

The BlueStar social franchise, while important, is a small sub-section of the overall commercial sector. One major provider is PSI. Through donor support, PSI utilizes demand creation techniques including radio shows and videos to raise demand for their socially marketed health products, including condoms, water treatment kits, oral contraceptive pills, injectables and anti-malaria nets. Its best-selling product is the condom with sales of 8 million annually. Currently, PSI is working with 215 commercial health service providers outside the BlueStar network, the majority of which are small clinics owned by nurses and clinical officers operating in peri-urban (60 percent) and urban (40 percent) areas. PSI uses these providers as a platform to sell its products, however there may be an opportunity to work with PSI to help develop a more formal network of providers and strengthen the quality of health services and business skills of these providers.

Other entry points for collaboration with the commercial sector include the 59 private ART clinics affiliated with the MBCA. The MBCA is a useful entry point to scale-up the provision of HIV treatment in the private sector; SHOPS could provide TA in designing and implementing training courses specifically for private sector providers including integration of HIV/AIDS services with other essential health services.

Overall critical knowledge gaps remain about the role and prospects for growth of commercial providers in Malawi. A comprehensive mapping exercise that examines the proximity of commercial providers compared to public and CHAM facilities could be used to catalogue which EHP services are offered by commercial providers and examine demand for health services in the commercial sector among the poor.

5.2 Opportunities to Expand Access to Finance to Commercial Providers

All commercial health providers interviewed during the assessment raised lack of access to finance as a major constraint to growing their businesses. This finding was further corroborated by key stakeholders, including BLM, PSI and a representative of the MCM. Access to finance impacts the development of a private health care business in a number of ways. Without access to finance a private health care provider is not able to add and expand services, invest in quality improvements and may not have the cashflow to sustain operations and provide a consistent, reliable level of care in the community. In most countries, access to finance is impeded when financial institutions are not lending to the health sector in a significant way and when health care enterprises lack the business and financial management skills to prepare bankable loan applications. The PSA team conducted a financial sector assessment to determine the extent to which financial institutions are lending to the private health sector. Key findings are presented below.

5.2.1 Overview of the Financial Sector in Malawi

Overall, the landscape of commercial lenders in Malawi is sparse. There are 11 commercial banks in Malawi and 2 discount houses, all regulated by the Reserve Bank of Malawi, and 21 microfinance organizations that are members of the Malawi Microfinance Network.

Malawi's economy suffered a setback in 2010 with real GDP dropping to 6.6 percent from 7.6 percent in 2009. GDP is expected to fall to 6.1percent in 2011. Malawi's economy has been affected by fluctuating prices in the tea, coffee and tobacco sectors along with massive power and fuel shortages. Moreover, due to the global economic recession, official development assistance, foreign direct investment and remittances to Malawi have declined. Many of the banks and pharmaceutical companies spoken with during the assessment brought up the foreign exchange shortages that are impacting the economy in addition to persistent inflation leading to volatile exchange rates. At the time of the assessment, banks reported that the base lending rate was 17.5 percent and commercial bank interest rates ranged from 22-25 percent.

Liquidity does not seem to be a constraint among the banks interviewed, except for foreign exchange shortages. Several of these banks are expanding into the small and medium enterprise (SME) market segment, which includes most private health care businesses. Some of the banks have new SME departments and/or SME managers, and are launching SME products. One bank has an International Finance Corporation line of credit for SMEs and several banks have a USAID development credit authority (DCA) guarantee in the agriculture sector. Nevertheless, most lending is concentrated in the more established corporate sector.

5.2.2 Assessment of Financial Institutions' Potential to Expand Health Sector Lending

During the PSA, the SHOPS team met with four banks, including Indebank, the National Building Society (NBS), Standard Bank and MSB, and one micro-finance institution (MFI), Opportunity International Microfinance Bank of Malawi. In 2010, SHOPS also met with National Bank and First Merchant Bank as well as the Bankers' Association of Malawi and the Malawi Microfinance Network. While some of these banks have small health sector portfolios, none have targeted the sector in a significant way.

Financial institutions cited a number of constraints in lending to the health sector. These include:

- Lack of acceptable collateral. Medical facilities cannot be shut down easily and medical equipment is too specialized and may be difficult to resell.
- The health sector is too small to focus on
- Private health businesses are too small to require significant financing and/or be capable of repayment of a large loan
- Lack of financial records
- Many private health businesses are poorly managed. They are owned by clinicians that lack adequate management and financial skills.

- No succession plans exist. The clinics are often completely dependent on the owner, which poses a risk to the bank should the owner become incapacitated.
- Adequate liquidity to repay a loan
- Low demand for commercial health services

Despite these constraints, financial institutions view the health sector favorably and would consider expansion into the sector if provided with incentives such as a health sector DCA guarantee to minimize the risk of entering the health care market. The DCA is a type of GDA that leverages local financing for USAID's development objectives. Through the DCA guarantee, USAID shares up to 50 percent of the risk of loss with local financial institutions, encouraging them to lend to underserved markets like the health sector. In addition to a DCA guarantee, financial institutions were also interested in receiving more information about the health sector, borrower referrals, and training in lending to and entering the health market. They also mentioned the importance of business training for private health care providers.

The SHOPS team assessed each institution's potential to lend to health sector borrowers (including their geographic presence, type of products, and interest in the SME market[i]), overall interest in lending to the private health sector, experience with the DCA and responsiveness in sharing information. This information is summarized in Table 5 below. Financial institutions are listed in order of asset size, where National Bank is the largest with $410 million in assets followed by Standard Bank with $319 million in assets. Among the members of the Microfinance Network Opportunity Bank has the largest market share of the total micro and SME portfolio. Please refer to Annex E for more detailed findings on each of the financial institutions.

> ***"We can go flat out for it"***
>
> *Opportunity Bank*, in reference to interest in lending to the health sector.

Overall NBS, Opportunity Bank, Standard and Indebank were the financial institutions most interested in the health sector. Despite NBS' relatively small SME portfolio, PSA informants indicated NBS' interest in the SME market. NBS has a banking relationship with several BlueStar clinics, and expressed interest in developing a prepaid health card that could be marketed through the BlueStar network. While Opportunity Bank charges the highest interest rates of all the financial institutions interviewed, it has the most flexible collateral requirements, which would be important for many smaller private health providers. Standard Bank's Managing Director believes there is an opportunity for financing larger health facilities and would be interested in exploring a product for BlueStar franchisees. Standard Bank has a DCA in the agricultural sector as well as significant experience partnering with USAID in Malawi, having recently completed a GDA to build the capacity of 16 district assemblies in financial management of development resources. The institution's SME loan ranges, however, are out of reach for many small, private health providers and in previous interviews Standard Bank staff had expressed skepticism about lending to the health sector. Further discussions are therefore needed to determine Standard Bank's interest and capacity to lend to the health sector. Finally, Indebank has appropriate products and experience for entering the health market but limited geographic reach.

The SHOPS team proposes further discussions with these financial institutions to identify two to three financial institutions to partner with in lending to the private health sector.

TABLE 5: Comparison of Financial Institutions

Institution	Strengths			Weaknesses		
	SME focus*	Appropriate products	DCA experience	Limited coverage	Limited interest in health sector	Inflexible requirements
	✓	✓			✓	
National Bank	✓		✓			?
Standard Bank		✓				
New Bldg. Society		✓			✓	
First Merchant Bank	✓	✓				
Malawi Savings	✓	✓	✓	✓		
Indebank	✓	✓	✓			
Opportunity Bank						

5.3 Opportunities to Grow Private Sources of Health Financing

Overall the commercial sector in Malawi is small and provides less than 3 percent of all health services in the country. One key reason for its small size is the high level of poverty in Malawi and the limited ability of most Malawians to pay OOP for commercial services when there are services available for free through the public sector or CHAM. Another barrier to growth of the private health sector is the current lack of social health insurance (SHI) schemes in Malawi (although the MOH plans to introduce a SHI scheme in HSSP II) as well as the lack of government funding for private provision of services. Private health insurance could be one method to increase utilization of the commercial sector by reducing OOP expenditure at the point of service and spreading risk. However, private health insurance is still nascent in Malawi and consists of the following entities:

- Medical aid organizations (MAOs) such as Momentum and MASM
- Indemnity health insurance schemes provided by formal insurance companies such as NICO Insurance
- Emerging health micro-insurance schemes being developed by insurers, MAOs and MFIs

Table 6 provides information on the size and scope of private insurance schemes in Malawi, although limited information is available about these schemes.

TABLE 6: Private Health Insurance Schemes in Malawi

MEDICAL AID ORGANISATIONS (HMO)			
Name	**# of lives covered**	**Benefit Type (In patient/Outpatient)**	**Comment**
MASM	110,000 (2011)	IP & OP	Largest private scheme in Malawi. Mainly corporate schemes. Covers HIV/AIDS but not FP. Owns clinics and pharmacies
Momentum	N/A	IP & OP	
Oasiz	N/A	IP &OP	
INDEMNITY INSURANCE			
NICO Insurance	**N/A**		
MICROINSURANCE			
MASM Tobacco Farmers Cover	N/A	IP &OP	
Migo Life & CUMO (MFI)	N/A	25,000 MKW cash benefit for medical expenses	In design stage Challenge of getting providers on board.
FINCA (MFI)	N/A		Early stages
Micro Loan Malawi (MFI)	N/A		Early stages
MUSCO (Coops and Saccos umbrella organization)	N/A		Early stages
Pride Malawi (MFI)	N/A		Design stage
OIBM (MFI)	N/A		Design stage
Various MFIs	N/A	Medical loans to members or direct payments to providers	Opportunity for micro-insurance and prepaid provider based schemes
CHAM	N/A		Concept and market analysis stage

Private health insurance in Malawi is constrained by several demand- and institutional-level factors. According to a study by University of Malawi (D. Makoka et al, 2007) the leading demand constraints were low household income and high poverty levels, awareness of health insurance (estimated at about 2 percent) and household size (the smaller the family size the greater the likelihood of purchasing health insurance). Institutional-level constraints include:

- Challenges of setting up an appropriate healthcare provider network, including skewed distribution of providers, awareness of insurance among providers, quality of services and cost of services
- Gaps in the regulatory framework and lack of a specific national healthcare financing strategy. Health insurance is regulated by the Central Bank like any other financial service, yet there are many issues unique to the health market that require specialized regulation.
- Inadequate technical and management capacity among financial institutions to design and manage innovative health insurance products and services
- Lack of reliable market analysis and information for decision-making

Box 3. Medical Aid Society of Malawi (MASM)

MASM is one of the most dynamic actors in the private health sector with insurance, health service provision and pharmaceutical divisions. The private health insurance sector in Malawi appears to be consolidating, and MASM holds the majority of the market share as a mutual registered under the Trustees Act. Both employers and individuals can participate in MASM health insurance throughout the country. MASM enters into service provider agreements with public, not-for-profit and commercial service providers to offer care to its members. Tariffs are negotiated on an annual basis and MASM evaluates and accredits providers to ensure quality standards are met. Accredited providers range from small clinics in communities to large private and referral hospitals. MASM offers three main insurance products, including an Econoplan for 800 MKW per month that covers up to 400,000 MKW per year in benefits at BLM clinics, mission hospitals and government facilities. This product caters to blue collar workers and lower income groups. MASM's Executive plan is priced at 2,600 MKW per month and provides up to 2.5 million MKW in benefits and access to private clinics and hospitals (with a co-pay) in addition to BLM, mission and government facilities. The VIP scheme is priced at 5,200 MKW per month and has a 6 million MKW annual limit. It provides the same coverage as the Executive plan but with a lower co-pay as well as a medical transfer plan that pays 50% of the costs for care outside the country and an airline ticket. Approximately, 110,000 people are covered by MASM health insurance: 40 percent in the Executive Plan, 35 percent in the VIP plan and 25 percent in the Econoplan.

Currently, both the VIP and Econoplan are self-sustaining but the Executive Plan operates at a loss. MASM is concerned that the insurance market is weak and is not growing. Without a mandatory health insurance scheme, MASM believes that growth in the Malawi insurance sector is limited. As such, MASM is seeking to contain costs and continue growing its business by developing its own networks of private clinics and pharmacies. It currently has four clinics and plans to open two more in Lilongwe with additional expansion in the future. Clinics are open to MASM members as well as the general public on a fee-for-service basis. In addition, MASM operates a pharmaceutical wholesaler with two retail outlets.

MASM offers the most developed private health insurance product on the market. Box 3 details the private health insurance approach utilized by MASM and prospects for expanding MASM coverage. Beyond MASM, most existing conventional private health insurance products are targeted at middle and upper income groups in formal employment. MASM includes treatment for HIV/AIDS in its cover benefits (including basic ART) but does not cover FP. As such, expanding current MASM benefits to include FP counseling and commodities would help promote the provision of FP services through the commercial sector. While MASM is primarily serving an upper and middle income clientele, they are an innovator in the market and operate at a scale that is unique in Malawi, and are open to partnership with the public sector. USAID/Malawi should consider opportunities to work with

MASM in Malawi to achieve its health objectives. Potential opportunities include adding FP services to MASM's health insurance packages; developing insurance for low income populations; helping MASM expand their clinic and pharmacy networks to ensure that a broad range of public health products and services are available.

There is growing interest among financial institutions, especially micro institutions, to develop low-cost private insurance products and services to reach low income earners. Several MFIs in the Malawi Microfinance Network have begun piloting health micro-insurance as part of their financial services to meet the demands of their clients. These MFIs are now searching for suitable partners among insurers, MAO and provider networks, and have expressed the need for technical capacity to develop and manage the products as well as the partnerships. Healthcare provider networks are also interested in private health insurance products. For example, CHAM is conducting a market analysis with the goal of introducing a low-cost private insurance plan including community insurance. They are also exploring how to market and link their provider network to a suitable micro-insurance scheme.

Establishing a viable micro-insurance health scheme in Malawi, however, is challenging. OIBM, an affiliate of Opportunity International (a network of microfinance banks), is currently providing financing to micro and small businesses in Malawi. OIBM is interested in offering health micro-insurance to its clients through a partner/agent model but has faced great challenges in finding a partnering insurance company. OIBM was interested in partnering with MASM, but a willingness to pay study showed that its clients could only afford a premium of $1 a month (the lowest monthly premium MASM would offer was $2.38). Furthermore, MicroEnsure, the Opportunity International micro-insurance subsidiary, determined that Malawi was not a market that it was interested in for expansion.

5.4 Opportunities to Grow More Sustainable Sources of Product Supply for the Private Sector

The majority of private providers delivering EHP services in Malawi do so through some type of public-private collaboration, such as CHAM through SLAs or individual private providers through the TB-DOTS WHO PPP. Because these arrangements include the provision of essential medicines, public sector drug supply issues greatly affect private providers in terms of the availability of EHP-related products. There are a few NGOs that have their own supply sources such as PSI, BLM/MSI, and FPAM, but these vary in effectiveness and cost-efficiency.

Drug supply issues are so pervasive in Malawi that donors have created two parallel drug supply chains in order to ensure delivery of procured products. The public sector drug supply agency, CMS, is rife with managerial problems and is currently undergoing a major re-structuring. CMS procures the majority of its drugs from international research and development (R&D) companies either through international procurements or through local distributors with brand licensing rights. However, there is a small Malawian drug manufacturing sector, comprised of four companies that produce mostly generic versions of R&D drugs. Though the local manufacturing sector is small, it remains an untapped source to explore.

5.4.1 Opportunities to Grow the Commercial Pharmaceutical Market in Malawi

According to the World Bank (2009), the value of the commercial pharmaceutical market in Malawi is far smaller than the total CMS budget for pharmaceuticals. The breakdown of the value of Malawi's pharmaceutical market is as follows:

Total CMS Budget for Pharmaceuticals	$20-75M
Value of Parallel Donor-Supported Commodities	$45M
Value of Commercial Market	$4-5M
Estimated Total	***$69 - 125M***

Overall, local commercial manufacturing is very limited in Malawi. An estimated 90 percent of pharmaceuticals are imported, primarily from India and other African countries such as South Africa, Kenya, Tanzania, Zambia and Zimbabwe. Generics account for about 99 percent of the market.

The GOM tenders both international and local procurements from the commercial sector depending on the products required. Erratic stock-out problems have created the need to tender frequent emergency procurements from the commercial sector through wholesalers/distributors and thus products are procured primarily on the basis of price and delivery times. Considering the myriad of organizational problems within the CMS, it is highly doubtful that a strong quality assurance system is in place to respond to emergency pharmaceutical procurements and to ensure high quality delivery of essential health products. One commercial sector interviewee observed that bioequivalence testing at the time of registration is not strongly enforced and resources such as testing reagents are not readily available.

Multinational manufacturer offices and plants are non-existent in Malawi. After ensuring that their products hold registration licenses in Malawi, multinational manufacturers work through local agents or distributors to sell these products to service delivery points and retail outlets generally serving the highest income quintiles. Global manufacturers known for R&D capabilities such as Janssen-Cilag (Johnson & Johnson subsidiary), Merck, Novartis, and Pfizer hold registration licenses in Malawi, while many other international firms from India, China, Kenya, Tanzania, and Bangladesh hold both business operating and product licenses.

With respect to local manufacturing, the GOM has supported the development of the pharmaceuticals industry since the Banda Administration in the late 1960s. The 2003 Public Procurement Act encourages local manufacturing growth, and as of June 2011, four local manufacturers (Kentam (Mzuzu-based), Malawi Pharmaceuticals Limited (MPL; Blantyre-based), Pharmanova (Blantyre-based), and SADM (Lilongwe-based) were negotiating a framework agreement with the GOM utilizing a favorable pricing percentage scheme. In turn, the GOM has requested updated production capacities indicating a desire to understand and explore manufacturing plans.

- The local manufacturers interviewed during the PSA expressed a strong interest in pursuing partnerships with USAID/Malawi and shared their plans for production expansion. However, capacity for local manufacturing, even of less complex health products, remains severely limited. According to manufacturers, challenges include:
    - The local commercial market is small, limited the volume of sales to private pharmacies, shops, institutions.
    - Companies meet local GMP but not WHO GMP and donor procurement is limited to firms meeting WHO/UNICEF GMP standards
    - Quality of pharmaceuticals produced locally varies
    - Limited local production capacity to meet CMS needs
    - Dearth of skilled pharmacists and professionals
    - Importers can procure whole containers of drugs at a lower cost than local pharmaceutical companies can import the raw materials
    - Foreign exchange crisis further inhibits local ability to import raw materials and power cuts disrupt production.

In addition, the tender process does not favor local manufacturers in the area of payment. Foreign companies are issued a letter of credit upon placement of the order, allowing them to obtain a loan to purchase raw materials. Local companies, however, do not receive letters of credit and must front costs of importing raw materials and producing drugs.

While the CMS is encouraging the development of the local industry, providing local importers or manufacturers with a 15-20 percent discount on price, at the same time, the GOM is also discussing pooled bulk procurement of drugs and medical supplies with Southern African Development Committee and COMESA to achieve economies of scale on price while ensuring the good quality. While this pooled procurement plan may not come to fruition, if it is finalized such a plan would make it very difficult for local pharmaceutical manufacturers to compete.

Due to the many challenges facing local manufacturers, the PSA does not recommend exploring local production of medications at this time.

Nonetheless, it should be noted that Malawi has had a few successful experiences with locally manufacturing health-enhancing products. For example, the Plumpy'Nut (Chiponde in Chichewa) product has been successfully produced through the USAID-supported Project Peanut Butter – Malawi has one of 10 worldwide local Plumpy'Nut manufacturing units. GOMAs such, a possible avenue for local manufacturing is in the area of water, sanitation and hygiene (WASH) efforts. PSI has been socially marketing a household level water treatment product called WaterGuard in Malawi since 2003 and PUR WaterGuard Wa ufa since 2006, with modest success. PSI introduced WaterGuard nationwide in 2002 through Fast-Moving Consumer Goods outlets. While PSI has seen increased sales of the product, overall use remains low. In 2008, 1,000,000 bottles were sold annually yet only 11 percent of mothers reported using WaterGuard. The current retail price is 40 MK (not including an 11 MK subsidy). In December

2011, the price is expected to increase to as much as 80 MK when the subsidy is removed.. At the same time, Unicef has engaged commercial drillers through contracts in order to expand access to piped water and has been supporting a hygiene promotion campaign and a Community-Led Total Sanitation initiative. Despite these efforts to date there is still ample room to involve local manufacturers, particularly in two WASH markets: low-cost latrine construction and related materials (e.g. PVC, fiber glass and concrete) and soap manufacturing and distribution.

5.5 Recommendations for Strengthening the Commercial Sector in Malawi

This section details a number of entry points for strengthening the commercial sector including through the BlueStar social franchise; through networking other commercial providers; by expanding access to finance for commercial providers; by growing private health insurance to remove financial barriers to utilizing the commercial sector for health services; and by building prospects for commercial manufacturing of essential commodities to promote sustainability and stable supply.

Specific recommendations include:

- **Strengthen the BlueStar social franchise**

Despite its struggles, SHOPS believes that the BlueStar franchise represents an important attempt to organize fragmented private providers that are reaching lower income groups. BlueStar has been successful in introducing FP to providers that were not previously offering these services. SHOPS believes that BLM needs to strengthen the benefits it provides to franchisees and assist them to improve their viability through business management training, advisory services and access to finance. A stronger network represents an important platform for USAID and other donors to scale-up the delivery of essential health services through the private sector. Specific recommendations for working with BlueStar are summarized below:

- Strengthen the business and financial management capacity of BlueStar clinics to improve the sustainability and quality of services
    - Build the capacity of a local training partner to roll out the SHOPS business training course to additional franchisees
    - Develop additional follow-up training and advisory services for franchisees in business and financial management
- Work with BLM to strengthen and improve the BlueStar social franchise model
    - Develop the capacity of BLM staff to reinforce and monitor business training and advisory services
    - Work with BLM to strengthen product sales and become a bulk purchaser for franchisees and assist them in developing a credit management system
    - Work with BLM to scale-up and add essential health services through the BlueStar network, such as VCT, safe water, and nutritional supplements

- **Strengthen other commercial providers**

Engaging other non-BlueStar commercial providers should be considered. As a starting point, a comprehensive private sector mapping exercise to identify types and location of commercial providers, health services offered, and demand for these services, should be commissioned. Based on findings of this mapping, the following strategies could then be employed:

- Build the capacity of private provider associations to reach out and serve the needs of commercial members
- Adapt BlueStar business and financial management training and roll out to private health providers working with associations and a local training partner
- Consider working with PSI to develop a network of clinics. This work could include developing a credit management system, similar to the one developed for BLM, as well as rolling out health service delivery training and access to finance for networked clinics. This network could employ quality assurance mechanisms like the SBM-R platform.
- Work with partners, such as PSI and BLM, to assist non-networked providers in adding essential health services such as FP, MCH, VCT services and nutritional supplements.
- Look for additional entry points for strengthening the commercial sector through quality assurance, business and management training, and training in health service integration. The private clinics accredited for ART and associated with MBCA are a useful entry point for strengthening the ability of private clinics to provide integrated HIV/AIDS services.

- **Work with financial institutions to expand lending in Malawi to the private health sector**

In order to develop the private health sector in Malawi, it will be important to address the access to finance constraint. SHOPS recommends working with at least two to three financial institutions to expand lending to BlueStar clinics and other private health care businesses. Further discussions should be held with Opportunity Bank, NBS, Standard Bank, Indebank, and MSB (which would not be eligible for a DCA guarantee). SHOPS recommends conducting market research on the private health sector and providing banks with TA and training on the following topics:

- Understanding the health care market, financing needs and repayment capacity
- Lending to the health sector
- Marketing to the health sector

- **Consider a DCA guarantee for the private health sector**

In addition to TA, USAID/Malawi should also consider supporting a health sector loan portfolio DCA guarantee to share risk with banks and encourage them to move into the health care

market. Based on the PSA findings, a $2 million guarantee would most likely be appropriate for loans to private health care businesses.

- **Promote the development and scale-up of innovative financing mechanisms including micro-health insurance, community insurance, provider-based prepaid plans and medical savings accounts**

There is strong interest from a variety of stakeholders to introduce and/or scale-up financing mechanisms that have been successfully implemented in other Sub-Saharan African countries. These models seek to reduce financial barriers to accessing the commercial sector for health services in Malawi. Examples of opportunities include:

  - CHAM is conducting a market analysis with the goal of introducing a low-cost private insurance plan including community insurance. They are also exploring how to market and link their provider network to a suitable micro-insurance scheme.
  - There are several initiatives to develop low cost private insurance products and services to reach low income earners among private insurers such as MAOs, MFIs and healthcare provider networks such as CHAM.
  - MASM and other health insurance schemes have expressed interest in expanding benefits coverage to include priority areas such as HIV/AIDS, FP and MCH.

The GOM, through a future national health finance policy, can further stimulate these types of initiatives by creating favorable policies and market conditions. Moreover, a national health finance policy will serve to identify PPPs that will help coordinate efforts among various stakeholders. In addition to designing a national healthcare financing policy, the MOH and donors alike will need to provide funding and TA to build management and administrative capacity and skills to avoid costly mistakes and lost opportunities to expand insurance coverage. Support will also be needed to develop innovative provider payment mechanisms and reduce the predominance of fee-for-service.

- **Review and create a regulatory framework for health insurance**

The GOM will also need to tackle the issue of how to regulate the various forms of health insurance before the market expands and complications arise. For example, what kind of vehicle will be required to deliver health insurance products? How will MAOs be regulated compared to formal insurance companies? How should the regulator handle MAOs that combine healthcare financing (insurance) and healthcare provision (running clinics to provide the insured services) due to the inherent conflict of interest? The main aim of the regulation should be to promote the sustainable growth of various types (social and commercial) of health insurance products and to protect consumers. The regulator should also have some monitoring and evolution functions, particularly in assessing the effectiveness, efficiency, and equity of the various health insurance models.

- **Build consensus on the future development of a SHI scheme that has clear roles for the private sector both in financing and provision of services**

The GOM plans to introduce SHI in Malawi (HSSP II draft). A basic SHI scheme is a useful strategy to expand coverage and increase access to care by removing economic barriers among poor and rural population groups. The private sector can play an instrumental role in the success of a SHI – as a healthcare provider, as a private insurer, and/or as a contributor through taxes. To ensure the private sector contributes fully to the social purpose of a SHI it is absolutely fundamental that the GOM include the private sector in all stages of the policy design and program implementation. Failure to do so can result in mobilizing the private sector to become effective opponents instead of partners to SHI.

- **Examine prospects for local manufacturing of key EHP products**

SHOPS proposes conducting a WASH market assessment focusing on soap/ hygiene products. The WASH assessment will be done in two phases, the first phase will be a stakeholder mapping exercise of actors and influencers involved in the value chain of the market (such as manufacturers, distributors, retail outlets, public sector entities, NGOs and finance organizations) and the second will involve an analysis of the data to identify technical, socio-economic and cultural constraints and determine the barriers to the growth of this product market. Based on the results of the WASH assessment strategies for expanding access to hygiene products through commercial partnerships will be developed.

6. POLICY LANDSCAPE FOR THE PROVISION OF PRIVATE HEALTH SERVICES

6.1 Background and History of Private Practice in Malawi

In this section, the SHOPS team examines the policy and enabling environment supporting the role of the private sector in various components of the Malawi health system. For the purpose of this discussion, the private sector includes both not-for-profit and for-profit entities in the health sector. Private medical practice was not permitted by law in Malawi until 1987. The relatively late emergence of private medical practice in Malawi was primarily due to the government's longstanding socioeconomic policy framework that had a strong emphasis on equity and free (government financed) healthcare services for all at public health facilities.

Most of the initial 'private practice' in Malawi was limited to not-for-profit, faith-based health facilities (largely CHAM facilities) that have been in operation in Malawi since the pre-independence era. CHAM was registered in 1966 as the successor of the Private Health Association of Malawi (PHAM) and is owned by the Episcopal Conference of Malawi and the Malawi Council of Churches. Such facilities have had a longstanding relationship with the government in expanding access to healthcare, particularly among the rural poor population.

In 1987, the government allowed private medical practice and this legislation heralded the emergence of private for-profit practitioners and facilities. Since this change in policy is relatively recent, it may account for why the private for-profit health sector is still small and fledgling in the country. The idea of 'free' healthcare services is still a strong socio-political ethos in Malawi today and the private sector will need to take into account this important environmental factor in designing their operational and growth strategies.

In addition to service delivery, the private sector also contributes to the health sector in other important areas such as the delivery of medicines and health commodities and training of healthcare professionals. The private health sector has developed a complete supply chain – importers, wholesalers/distributors and retail outlets – by which to distribute medicines and health products. Moreover, CHAM is the largest training entity in Malawi, owning 11 out of the 16 training institutions in the country with a focus on training nurses and clinical officers in rural areas.

Overall, the policy and enabling environment is conducive to private sector growth. There is no direct policy or legal limitation of private sector investments in the health sector, except for the common regulatory requirements, that may present challenges to establishing a private practice. However, a key and important constraint to the growth of the private health sector is high levels of poverty and limited demand for commercial health services.

6.2 Policies and Mechanisms Supporting the Private Health Sector

The GOM has several necessary building blocks to leverage the private health sector's resources including a policy framework, regulations, and a mechanism governing PPPs. Despite these critical tools, the MOH has yet to realize its full potential as steward of the private sector and to effectively tap into these resources.

Overall Policy Framework: The GOM has a comprehensive development plan and policy framework guiding all the socioeconomic sectors including health. This overarching policy framework is contained in the Malawi Growth and Development Strategy (MGDS), which is the basis for the MOH's HSSP. The MOH is currently in the process of developing a second HSSP for 2011-2016 (HSSP II), and recently developed an overall National Health Policy that is still in draft form. In these policy instruments, the relevant and key policy guidance as far as the private sector is concerned includes:

- Recognition and promotion of the role of the private sector in supplementing the government's efforts to increase access to health services; and
- Promotion of PPPs in health.

During the PSA, private sector players raised some concerns related to the formulation of and consultation process on these policies. Generally, private sector actors felt that there is room to improve private sector voice and participation in policy dialogue and formulation. While CHAM has been extensively involved in various policy fora and structures, commercial and NGO representation is far more limited. CHAM is also significantly involved in the SWAp mechanism as a signatory and relatively active participant in SWAp coordination meetings.

Public-Private Partnerships in Health: The GOM recognizes the need for partnering with the private sector in various sectors of the economy including health. PPPs in health are also mentioned explicitly as a government strategy in the current drafts of both the National Health Policy and HSSP II. The draft HSSP II intends to utilize PPPs by:

- Expanding contracting of the private sector to provide health services based on the revised EHP. Expanding contracting arrangements will entail developing SLAs with other non-state actors beyond CHAM such as the BLM franchise and other NGOs. The HSSP II acknowledges that partnership with the private for-profit sector has been weak to date;
- Recognizing the role of the private sector in implementation of the HSSP II;
- Recognizing the need to formulate a national PPP policy for health and to disseminate the policy at all levels of the health system;
- Establishing structures at national and district levels to coordinate PPP activities;
- Mapping and identifying potential new partners for PPPs;
- Signing of a new MOU with CHAM to deliver EHP services and revisiting the SLAs to ensure value for money;
- Developing incentives to attract private practitioners to underserved and rural areas;
- Including private for-profit providers in the HMIS data system; and
- Promoting prioritization of EHP by private providers through incentives.

Instructively, the HSSP does recognize the need to partner with the private sector in other pillars of the health system beyond service delivery, specifically in healthcare financing. One overall goal of the HSSP II will be to promote private sector investments in the various building blocks of the health system such as infrastructure, information communications technology (ICT), and

employer health financing schemes. While these goals remain good policy intentions, their realization will require developing strong leadership and commitment between the MOH and the private sector, formalizing relations and building trust between the public and private sectors, and adequate resources to implement PPPs.

Public-Private Partnership Unit: There is growing experience among African Ministries of Health to create a PPP Unit to assist the MOH in improving interactions with and integration of the private health sector. The main functions of a PPP Unit are: i) to serve as a liaison and provide information on MOH policy and plans to the private sector; ii) to track and monitor the private health sector; iii) to include the private sector in the design and formulation of health policy and iv) to identify and promote PPPs in health. In Malawi, the MOH intends to form a PPP Unit to support private sector engagement and implement PPP projects.

Public-Private Partnership Technical Working Group (PPP TWG): The PPP TWG reports to the SWAp Secretariat and the GOM's privatization commission on PPPs in health and currently primarily focuses on SLAs with CHAM facilities. The PPP TWG is composed of the MOH, donors, regulatory bodies and CHAM. The private for-profit sector was invited to join the PPP TWG but does not participate partly due to its poor organization and lack of viable representation through private provider associations.

6.3 Regulations and Other Market Conditions Influencing the Private Health Sector

Regulation and Oversight of the Private Health Sector: Regulation and oversight of the private health sector, specifically private health practice, is the mandate and responsibility of the various regulatory boards established under various Acts of the Malawi Laws and Constitution. The Boards regulate both public and private health sectors. The key regulatory bodies include:

- MCM, which regulates doctors, dentists, clinical officers and other paramedical staff excluding nurses. It also licenses all health facilities and regulates training.
- The Nursing Council, which regulates the practice and training of nurses and midwives.
- The Pharmacy, Medicines and Poisons Board (PMPB), which regulates pharmacy practice and training (for pharmacists, pharmaceutical technologists and pharmacy assistants) and also regulates pharmacy businesses, including chemists/drug stores, wholesaler/distributors/importers and manufactures. The mandate of the PMPB also includes veterinary medicines.

Regulatory acts in Malawi allow the regulatory bodies to set the terms and conditions for licensing a health worker to start a private practice. Most of the preconditions for licensing private practice are therefore largely left to regulations and guidelines issued by each board.

According to the MCM, there was no significant regulation of medical practice prior to 1987. In the preceding years, most medial practices were largely in the hands of paramedics and foreign/missionary doctors. The MCM started its work in 1988 by accepting all practitioners in the country but insisting on upgrading education and training. According to the MCM, private health facilities have been growing rapidly since the deregulation of the sector through the 1987 law allowing private practice.

The main regulatory boards interviewed during the PSA identified the following challenges to fulfilling their governance mandate:

- **Inadequate funding**: Recently, the MCM's funding was cut by half due to current economic challenges in the country. The Council budget relies on 50 percent of its contributions from the MOH and 50 percent from fees. The PMPB's budget is also heavily dependent on fees, which account for 98 percent of its total budget. Dependency on membership fees greatly comprises the ability of these regulatory bodies to remain autonomous and objective, and regulate private practice free from concerns about membership fee payment.
- **Inadequate number of inspectors** and unreliable means of transport for inspections cause delays in routine inspections.
- A **significant and growing number of unlicensed providers**, such as street medicine vendors place consumer health at risk and require higher numbers of inspections at a time of decreasing budgets.
- A **weak re-licensing system** causes private providers to not consistently renew clinical skills and current best practices in the provision of health care. Some regulatory bodies, such as the PMPB, do not yet have continuing professional development (CPD) systems in place. Others bodies do not have the technical capacity to implement a proposed CPD system.
- **Inadequate resources and capacity to regulate training institutions** weakens the ability of regulatory bodies to monitor pre-service educational institutions. For instance, the Nursing Council reported that out of 17 training institutions for nurses, only 6 met the Council's accreditation criteria.
- There are **multiple quality and accreditation standards** that confuse inspection procedures and outcomes.
- **Long delays to revise outdated laws and new acts** weakens regulation of the health sector. For example, the 1998 PMBP Act has been a MOH priority and a revised PMPB Act was passed in 2007. However four years later, the draft Act has still not been passed into law.

Barriers to Private Sector Entry into the Health Market: Key informant interviews revealed that multiple obstacles prevent growth of the private health sector. They include:

Work requirement to start private practice. Health workers are required to work several years before they can qualify for a private practice license. The length of experience required before one can start a licensed private practice (full- or part-time) varies by health professional cadre (see Box 4). Though well intentioned to promote quality health care service provision, entry requirements for private practice should set in light of the serious shortage of health workers in Malawi; high staff turnover in the public sector as well as with the need to ensure safe and quality services in private practice.

- **Access to capital.** MOH regulations specify the type of equipment and infrastructure needed to license a private facility. Many private providers require capital to meet these infrastructure requirements, but it is difficult to access. Several of the regulatory bodies have been pragmatic in their approach to licensing private facilities, recognizing the difficulty in meeting these infrastructure requirements.
- **Competition with free services and small market size:** There is a very limited market for non-CHAM private providers to deliver EHP services for a nominal fee given that 97 percent of health facilities in Malawi offer EHP services for free. Currently, the commercial market largely reaches those population groups with higher incomes and/or private health insurance. It is unlikely that the non-CHAM private health sector will reach "down market" and expand access to poorer population groups unless market incentives including contracting arrangements and/or access to subsidized drugs are introduced by the MOH.

BOX 4: Entry Requirements for Private Practice

- Doctors – 2 years post-internship
- Nurses – experience required but duration is variable. Depending on experience, nurses can prescribe certain drugs such as emergency drugs, basic antibiotics, ARVs and MCH/FP medicines
- Clinical officers – 6 years
- Medical Assistants – 8 years
- Lab technologists – Immediately on qualification
- Radiographers – 1 year
- Dental therapists – 1 year
- Pharmacists –Immediately on qualification. Pharmaceutical technologists cannot run their own independent private pharmacies

Facilitating Factors for Private Health Sector Growth: Key informant interviews revealed that in addition to an enabling policy framework, there are other supporting factors leading to a greater private sector role in health care. These factors include:

- **Clear guidelines governing dual practice.** Health workers in the public sector are allowed to complete part-time private practice on the condition that the MOH gives a "no-objection" letter to the MCM before licensing. The part-time private practice license clearly stipulates the times when the public sector health provider can complete private practice to avoid compromising public service duties and quality of care. The MCM reported that they have not had any significant cases of health workers breaching these terms. Interestingly, some health workers in CHAM facilities also carry out part-time private practice in commercial settings.
- **Consolidating Regulatory Functions.** The GOM is in the process of merging all the health regulatory boards into one National Health Service to streamline regulation of the health sector. While most of the regulatory bodies welcome the idea of consolidation, there is concern that plans for consolidation have not been thoroughly discussed or vetted for key stakeholders. In addition, given an environment of budgetary shortages and uncertainties for regulatory bodies, consolidation could result in fewer resources for inspections of health facilities.
- **Continuing education requirements.** The MCM instituted a CPD system three years ago. All practice licenses, including private practice licenses, are renewed annually on achievement of set CPD points. The Councils have adopted a graduated performance

improvement approach in enforcing this new requirement rather than an adversarial one. The institution of a CPD system helps to ensure quality of care in the private health sector.

- **Movement towards performance-based quality standards.** The MCM is aware that most of its accreditation and quality assurance standards are largely based on health care inputs (infrastructural) and rarely measure outcomes of care. However, there is an ongoing process to remedy this discrepancy by introducing updated clinical care standards under the supervision of the MOH.
- **Consumer advocacy to address quality concerns in private sector.** Most of the regulatory boards have a system to receive complaints from health care consumers and do encourage users to raise any grievances. For example, the MCM has worked with the NAC to create awareness of the rights of health care consumers to raise complaints, suggestions and grievances about their health care experiences. Although various Malawian acts do stipulate the process of investigating and remedying any cases of malpractice, regulatory board are constrained by lack of enforcement and inspection capacity (e.g, the MCM only employs 2 full-time inspectors).

6.4 Policy Framework for SLAs

In December 2002, the MOH and Ministry of Finance (MOF) in Malawi signed a MOU with CHAM as the culmination of many years of partnership in service delivery and training of health workers. The principle objectives of the MOU were to:

- Formalize and improve the relationship between the MOH and CHAM;
- Recognize CHAM's significant role in complementing government health services in rural areas; and
- Expand access of EHP services to underserved populations.

The MOU stipulated the terms and conditions of the partnership between the MOH and CHAM. On the one hand, the MOH would give financial support to all CHAM facilities to cover health worker expenses including salaries, housing allowances, leave grants and pensions. In addition, the MOH would reimburse CHAM facilities for the provision of certain essential health services. In exchange, CHAM is required to be accountable to the MOH on its governance structures, financial management, operations and infrastructure development. Any disputes arising from the MOU are to be resolved by arbitration. The MOU could be terminated at any time by issuing a three month notice.

Based on the principles of this MOU, 74 CHAM facilities and District Health Authorities (DHAs) in 28 of 29 health districts entered into SLAs since 2004 for the delivery of EHP services primarily for maternal and neonatal health (Lungu, 2011). The services include antenatal care, normal delivery services, pre-referral management of obstetric complications, newborn complications treatment, postnatal care, vacuum extraction and any other illness during pregnancy. CHAM facilities under SLAs are required to deliver these services free of charge, conform to MOH clinical and treatment guidelines, and seek reimbursement for costs incurred from the DHAs.

The MOH and CHAM developed a fixed fee structure for the package of essential services with a range of minimum and maximum rates. Services not covered under the tariff structure were to be charged as per prevailing user fee rates already levied by CHAM facilities. Overall, there is a lack of clarity and consistency for the application of tariff structures for each SLA. A clear mechanism for reviewing and standardizing SLA cost and reimbursements rates is not in place.

In terms of cost structure, each SLA contains a negotiated maximum payout per month to each CHAM facility. Each DHO is required to pay participating providers using existing allocated annual funding from the Malawian treasury and cannot request additional funds for SLA payments. Quality improvement activities, though mandated, are not specifically described or written into the SLA. Direct payments to providers under SLAs for healthcare services are largely performance-based (payment for delivery of a certain basket of healthcare services) although quality of care and services offered are not clearly measured.

A district steering committee consisting of the DHO and DHMT, Zonal Health Officer, District Commissioner and CHAM representatives is charged with monitoring and evaluating the quality and performance of the health services offered under the SLA. Disputes are to be resolved locally but if local resolution is not possible, disputes are referred to the Secretary for Health. In certain unresolved cases, arbitration could follow and is chaired by the Secretary for Health.

The PPP TWG has overall oversight of the SLAs at the national level and is mandated to ensure that SLA objectives are met, monitoring and evaluation is completed, and disputes are resolved. However, the actual contracting and day-to-day administration of the SLAs, including payment for services rendered, is facilitated by the DHO.

Major challenges have arisen in the implementation of this notable and large-scale PPP initiative. The main challenges in the facilitation of SLAs between CHAM and the MOH include:

- **Unclear and inaccurate costing of services** in some cases leading to under or overcharging by CHAM facilities. Key informants explained the challenges in accurately costing services as such:
    - Accounting for existing MOH subsidies (under the MOU) has not been adequately addressed;
    - Little mechanism to evaluate whether current rates are adequate for the provision of EHP services; and
    - Concerns from the MOH that they are not receiving “value for money” through the contracting arrangement.
- **Delayed payments** affecting the cash-flow of CHAM facilities. Overall, the MOH estimates that CHAM facilities are owed roughly $400,000.
- **Poorly functioning dispute resolution mechanisms** leading to many unresolved dispute cases and several suspended SLAs (although, in some cases, service provision continues even when a SLA is suspended)
- **Lack of adequate budget** from the MOH to offer expanded access to services in CHAM facilities

- **Inadequate technical and management capacity** to negotiate and manage contracts at all levels of the MOH and across CHAM
- **Some suspected cases of abuse** of the reimbursement system by CHAM facilities
- **Weak policy and legal basis supporting contracting and PPPs** to deliver health services.
- **Perception that patients are bypassing district health facilities** to avail of EHP services at CHAM SLA facilities

In light of government policies and intentions to expand SLAs to other CHAM facilities and to other private sector providers, the challenges outlined above urgently need to be addressed in order to allow an environment for more effective and trustful contracting to emerge.

6.5 Recommendations for Fostering an Enabling Policy Environment

The Malawi environment presents many opportunities to harness the private sector. The GOM has established a very progressive policy supporting the private sector in multiple sectors of the economy including health. Moreover, there is strong MOH commitment and interest in partnering with the private sector, both not-for-profit and for-profit, to leverage added resources to expand access to health care for all Malawians.

By all accounts, there are no major policy obstacles to leveraging the private health sector and the MOH is cognizant of existing challenges. Most importantly, the MOH has a precedent – the SLA – in contracting non-state actors to deliver specific health services for the rural and poor. Addressing and improving the SLA mechanism with CHAM can reinvigorate the long-standing and essential working relationship between CHAM and the MOH. In addition, the SLA structure provides a platform for the MOH to partner with other private actors like the commercial sector and could address a major barrier—reimbursements for the cost of providing EHP services—for the growth of the commercial sector in Malawi.

Below is a summary of key recommendations to assist the MOH in its intent to effectively partner with CHAM and other private sector actors in health to expand access and improve quality of care. The recommendations are organized into three objectives: 1) strengthen the policy and regulatory framework, 2) build MOH capacity and systems, and 3) build private sector capacity to partner with the MOH.

1. Strengthen the Policy and Regulatory Framework

- Support development of a strong and standardized PPP policy in health and the necessary legal reforms to support these policy objectives. The MOH has already recognized this need for a stronger PPP policy and its formulation can be a quick win in building goodwill between public and private actors in health. Using examples from Sub-Saharan African, the MOH could form a multi-sectoral committee comprised of representatives from the public, CHAM, and private health sectors to provide recommendations to the MOH on draft language for a PPP policy.
    - Strengthen and rationalize the regulatory framework to facilitate a greater role for the private health sector and improve quality of services.

- Review and update the legal/ regulatory framework, resulting in a "road map" of reforms. The planned merging of all the regulatory boards is a good starting point for the outlining of these reforms.
- Build capacity of the regulatory boards (or new unified regulatory authority) to promote and enforce accreditation and quality standards in service delivery.
- Promote involvement of private sector associations in identifying and enforcing standards and quality among their members.

2. Build MOH Capacity and Systems to Engage the Private Sector

- Strengthen the SWAp Secretariat and specifically the PPP TWG to carry out its mandate of promoting and overseeing PPPs in health. Strengthening tasks include: defining its mandate, assigning roles and responsibilities, and funding the PPP TWG. Also, ensure CHAM, private for-profit and other non-state actors are involved and play their roles effectively in the PPP TWG proceedings.
- Assist the MOH to establish and operationalize a PPP Unit. Building on African experience in Kenya, Nigeria, Tanzania, Uganda, and South Africa, the MOH can draft terms of references for a private sector and/or public-private sector unit that maps out the purpose, mission and objectives, guiding principles, core functions, organization and structure, and operating budget.
- Assist the MOH to staff and train the new PPP Unit, including developing a first-year work plan and training in core skills such as : i) running productive meetings, ii) facilitating participatory policy and planning, iii) leading a policy dialogue process, iv) negotiating contracts, and v) monitoring and evaluating the risk/value of contracts. Work with PPP Unit staff to carry out initial activities, such as a private provider mapping exercise to better identify commercial actors.
- Strengthen MOH contracting capacity through SLAs using African experience in South Africa and Tanzania as a guide. Strengthening tasks include: i) developing systems to procure and award contracts, ii) developing model service agreement contracts; iii) agreeing on transparent costing methodologies; iv) designing processes to track and assess impact/value of contracts; and v) training in principles of and new procurement systems.
- Build capacity of DHOs to engage with and contract the private sector. This capacity-building should include stakeholder engagement, negotiation, contract management and monitoring and evaluation skills.

3. Strengthen Private Sector Capacity to Dialogue and Partner with the Public Sector

- Facilitate stronger organization of the private health sector to more effectively engage the government.
  - Strengthen existing professional associations representing practitioners and facilities in the commercial sector.

  - Build the organizational capacity of CHAM to better execute its mandate and play a key role in partnering with the MOH.
  - Support creation of an alliance of all non-state actors in health to have a fairly unified voice, better engage the MOH, and leverage their potential and bargaining power.
- Support public-private engagement and dialogue to build trust and foster a whole market approach in heath sector planning and service delivery.

7. CONCLUSION

The PSA provides multiple recommendations to promote the sustainability of CHAM; improve the MOH-CHAM relationship; expand the role of commercial health providers in Malawi; and foster an enabling policy and regulatory environment conducive to well-functioning partnership with private providers. The GOM and its development partners could pursue many of these recommendations to strengthen the participation of the private sector in the provision of essential health services. The MOH's new HSSP II makes clear that improvements are necessary in the way that the MOH works with the private sector, but affirms that the private sector is a critical provider of health care services in Malawi.

Key over-arching recommendations of the PSA include building the capacity of CHAM as a self-sufficient network and organization. Once CHAM achieves sufficient financial and organizational capacity, it can better partner with the MOH to provide life-saving health services in rural areas. Likewise, improving the MOH's ability to steward the private sector and effectively implement clear and well-costed contracting arrangements with the private sector is essential.

While the PSA focuses heavily on the role of CHAM given that the network provides 37 percent of health services in Malawi, other innovative private, not-for-profit models are identified. For instance, some NGOs providing HIV care and treatment expressed a desire to pursue their own SLAs with the MOH to increase the number of individuals receiving HIV/AIDS care and treatment services at their clinics. Strengthening the MOH's overall policy framework for partnering with the private sector should allow more effective contracting with other non-CHAM private actors as well as improve the implementation of SLAs with CHAM.

The PSA outlines many of the steps needed to expand the commercial health sector in Malawi. These steps include reforming the regulatory and policy environment to better allow the emergence of private practice; organizing disparate private providers through networks and franchises to improve service delivery quality; revitalizing private provider associations to play a key role in health policy decision-making; expanding access to finance for commercial providers; identifying opportunities for sustainable, commercial product supply of essential health commodities; and reducing barriers that have to date stymied the development of a large private health insurance market. However, these recommendations must be evaluated against the backdrop of Malawi's high levels of poverty and low demand for commercial health services. Growing the commercial health sector in Malawi requires both the types of interventions suggested in the PSA as well as overall economic development and reduction in poverty in the country.

The goal of these recommendations and ultimately of the PSA is to build a vibrant mixed health care system that highlights and leverages the unique capabilities of both the public and private health care sectors. Malawi's high levels of poverty, reliance on CHAM for rural health services, strong history of free health care and low demand for commercial services will continue to determine the types of solutions that should be proposed to improve health indicators for Malawians. Throughout the health system, particularly in the case of CHAM, there are strong public sector elements and financing mechanisms guiding the provision of private health care and many of the models discussed in the PSA are hybrid models with both public and private elements. The true test of success for the innovations and recommendations proposed by the

PSA is not whether they are purely “public” or “private” but whether they improve access to essential health care for all Malawians in an efficient manner.

ANNEX A: SCOPE OF WORK FOR THE PSA

Scope of Work: SHOPS Malawi Private Health Sector Assessment

BACKGROUND

With nearly 13.9 million inhabitants, Malawi is a relatively densely populated country. It is also one of the least developed countries in the world, relying on an agriculture-based economy. The per capita gross national income in Malawi is only $203 (World Bank, 2008). Malawi ranks 160 out of 182 on the Human Development Index (United Nations Development Program, 2009).

In recent years, Malawi's total health expenditure has increased to over 10 percent of gross domestic product, with private expenditure accounting for 29 percent of total health expenditures. Of that, out-of-pocket expenditures are 31 percent and private prepaid plans are 16 percent (WHO, 2008).

Health indicators in Malawi are relatively poor with a low life expectancy of 41 years and a maternal mortality rate of 984 per 100,000 live births (DHS 2004). The country has a high national HIV prevalence of 12 percent among the adult population aged between 15 and 49 (DHS 2004). The modern contraceptive prevalence rate among women in union is 38 percent (MICS 2006) and there is an unmet demand for FP of 28 percent among women in union (DHS 2004). The total fertility rate is six per woman (DHS 2004).

Adding to this difficult environment, Malawi faces a critical shortage of human resources in the health sector. The most recent data indicate less than one health service provider in the country per 10,000 people (WHO, 2004). This shortage is the result of a number of factors, including medical workers emigrating overseas, deaths related to HIV/AIDS and the limited production of new medical workers within the country.

The commercial health sector in Malawi is relatively new as private practice was not legal until 1987. As a result, the sector is still quite small. It is difficult to obtain accurate numbers on the size of the health sector and estimates vary. One of the leading private sector healthcare providers in Malawi is Banja La Mtsogolo (BLM), or BlueStar, which is a social franchise that was developed by MSI. BLM clinics are important providers of FP services, voluntary counseling and testing (VCT), and male circumcision. There are currently 55 BlueStar clinics operating in the Southern region and BLM plans to expand the franchise to the Central region in the near future.

OBJECTIVES

While there are many constraints to private sector provision of services, there are also numerous opportunities to expand its role. SHOPS will conduct an assessment of the private health sector in Malawi to assist USAID and other stakeholders to develop a strategy for further engaging the private sector in Malawi. The strategy will complement and augment current efforts within the public and private sectors with a focus on FP/RH, maternal and child health (MCH), and HIV/AIDS services.

The assessment will focus on the following main components:

1. Human Resources for Health (HRH) in the private sector;
2. The policy and regulatory environment for private provision of health products and services;
3. NGO and faith-based organization (FBO) sustainability;
4. Current initiatives in health financing and opportunities for the expansion of private sector provision as part of those initiatives;
5. Financing needs of the private health sector, the extent to which access to credit could improve quality of care or expand service provision, and training needs in business management; and
6. Supply of and demand for private sector provision of health products and services.

STATEMENT OF WORK

Human Resources for Health in the private sector

- Assess the diversity and distribution of private sector, for-profit providers and other health sector entities.
- Identify needs, gaps, and reasons for these gaps in the availability of human resources for health in the private sector generally and by provider type.
- Document the range, distribution and contribution of private sector health care providers and other commercial and health sector players in Malawi, including their activities, products and/or services, their consumer targets, and their influence on one another.
- Assess private provider networks (including professional associations, training and insurance schemes, social franchises, etc.) for their feasibility in creating entry points to working with private health providers, quality assurance, access to training and provider inputs, data collection, etc.
- Assess provision by the private sector of the continuum of care for HIV/AIDS (prevention, treatment, care and support) and existing PPPs with government entities. Assess scale-up of potential existing models for private sector provision of HIV/AIDS services, including counseling and testing, treatment, palliative care, hospices, PMTCT and make recommendations for increasing scale-up of potential existing or emerging commercial sector models.
- Conduct focus groups among individual private providers (such as doctors and midwives) to determine their client profile, services offered, TA and financing needs.

Policy and regulatory environment for private provision of health products and services.

- Assess the level of cooperation and exchange between public and private sector providers.
- Examine existing policy and regulatory frameworks and other environmental factors impacting the private sector provision of health products and services. Determine the mechanisms for accrediting, regulating and monitoring private commercial providers of health products and services and their relative effectiveness.
- Assess opportunities for public sector contracting of private sector providers.

- Assess the extent to which regulations hinder or favor private sector product and service provision, consolidation of separate private product or service practices, and ownership of accredited health facilities.
- Explore opportunities to strengthen links between the private commercial and public sectors (e.g. private providers as source of surveillance and other health data, collaboration with Ministry of Health officials, public investments which may leverage and help the commercial sector expand, public sector contracting of private provision).
- Analyze health care reform or other government-led initiatives that may impact private providers.

NGO and faith-based organization (FBO) sustainability.

- Examine the current levels of financial, technical institutional, and market sustainability of select NGOs and FBOs
- Gather information from each organization on products and services offered; operations such as staffing, structure and management systems; sales/income, product distribution, and service data from the last 2-3 years; marketing plans or strategic planning documents;

Health financing initiatives and opportunities for the expansion of private sector provision as part of those initiatives.

- Assess the availability and coverage of existing health financing and insurance schemes
- Analyze financing options, such as insurance schemes and third-party payment mechanisms, and the opportunities they present for expanding access to private sector coverage of health services.
- Determine the existing or potential health financing mechanisms that can be used to bridge any gaps between willingness to pay and cost of providing care in the private sector.

Financing needs of private health sector businesses

- Examine access to financing to determine if it is a constraint to the delivery of FP, MCH and/or HIV/AIDS services and/or products in the private sector.
- Identify how start-up capital is typically obtained.
- Assess financial institutions lending to the health sector, to what areas of the health sector, and what type of loan products/terms are available.
- Identify the financial management, business support service, and business management training needs by private health care businesses.

Supply of and demand for private sector provision of health products and services.

- Utilize available consumer surveys to analyze the existing and potential demand for private sector provision of health products and services and understand the main factors that affect demand.
- Identify potential opportunities to create or increase demand for private sector provision of health products and services.
- Assess recent efforts to create demand for health products and their prospects for growing the market for RH and HIV/AIDS products and services.
- Evaluate the private sector supply chain for health products—both pharmaceutical and over the counter, such as drug manufacturing and distribution firms, local chemists, other drug shops and retail outlets involved in selling and distributing health products. Consider which sources of supply and distribution have adequate quality controls on products and whether uncontrolled products negatively impact the market for health products. Assess whether parallel distribution systems could be expanded to better serve the commercial sector.
- Estimate the commercial sector's likely market share for increased demand relative to the public sector and the NGO/non-profit sector. Make recommendations about how the demand creation activities can improve market segmentation between these three sectors.

Based on the assessment findings, the assessment team will provide a range of options and recommendations for consideration by USAID and other stakeholders (including identifying potential formal PPPs) to further engage the private sector in Malawi.

In addition, SHOPS will hold a Stakeholder dissemination workshop to discuss the results and prioritize policy, program, and investment priorities for a private sector strategy. SHOPS believes that stakeholder workshops serve two purposes. First in helping determine and establish buy-in and support from the government, NGO and other key stakeholders on the priority assessment recommendations for USAID, the GOM and other donors. Second, in making a business case for the private sector itself to participate in follow on activities as prioritized.

ANNEX B: LIST OF STAKEHOLDERS INTERVIEWED DURING THE PSA

Name	Position	Organization
Peter Makwinja	Board Member	CHAM Secretariat
Bishop Francis	CHAM Proprietor	Anglican Diosces of Lake Malawi
Massiye Nyang'wa	Health Coordinator	Lilongwe Archdiocese
Dr. Reynier Ter Haar	Director	Nkoma Medical Center
Grace Banda	Head of Health Programs	CHAM Secretariat
Rose Ng'oma	Executive Director	CHAM Secretariat
Godfrey Soko	Hospital Administrator	Daeyang Luke Mission Hospital
Eun Seok Kim	Visiting Doctor	Daeyang Luke Mission Hospital
Janet Guta	Country Coordinator	IYCN/PATH
Osborne Sibande	Training Consultant	IYCN/PATH
Dr. G. Chithope-Mwale	Director of Clinical Services	MOH
Kelita Kamoto	Director, HTSS	MOH
Dr. Anne Phoyo	Director, SWAP	MOH
Ellious Chasukwa	HIV/AIDS Manager	CHAM Secretariat
James Tully	Regional Operations Mgr	International SOS
Mathias Chatuluka	Director of Programmes	FPAM
Effie Pelekamoyo	Executive Director	FPAM
Modibo Kassogue	Chief of Health & Nutrition	Unicef
Kondwani Mkandawire	Assistrant Registrar	Medical Council of Malawi
Fannie Kachale	Deputy Director - RH Unit	MOH
Brendan Hayes	Projects Director	Banja La Mtsogolo
Francis Chafulumira	Outgoing Controller	Central Medical Stores/MOH
Ivy Zingano	Incoming Controller	Central Medical Stores/MOH
Erik Schouten	Senior HIV Advisor	MSH
Giuseppe Liotta	Researcher	University of Tor Vergata
Dr. Sam Phiri	Executive Director	Lighthouse
Dr. Caryl Feldacker	M&E Advisor	Lighthouse
Richard Pendame	Former Advisor to Minister of Health	LATH/Nairobi
Takondwa Mwase	Health Economist	Abt Associates, Inc.
	Principals (from all 10 training institutes)	CHAM Training Institutes
	Accounting Department	CHAM Secretariat
	HR & Administration Officer	CHAM Secretariat
Mafase Sesani	HMIS, SLAs & M&E	CHAM Secretariat
Blackson Matatiyo	Research Officer	National AIDS Commission
Tambudzai Rashidi	Chief of Party/Country Director	MCHIP, Jhpiego
Innocent Chamwalira	Pharmacist & HIV Logistics	JSI/Deliver
Willy Kabuya	Chief of Party	JSI/Deliver
	Pharmacy Section	CHAM Secretariat
James Chibisa	Head of Credit	Indebank
Martin Ndaferankhande		Indebank
Issa Mmadi	Branch Manager	Malawi Savings Bank Limited
Alice Abilu	Deputy Director	Opportunity Bank of Malawi
Mr. Mudiwa	Managing Director	Standard Bank
Joel Chilenga	Head, Human Resources	Standard Bank
Felizarda Mbewe	Business Development Manager	NBS Bank
Mayamiko Kalizang'oma	Business Development Manager	NBS Bank
Andrew Kambalame	SME Manager	NBS Bank

Name	Position	Organization
Ezekiel Phiri	Chief Executive Officer	CUMO
Veronic Chikafa	Capacity Building Coordinator	Malawi Business Coalition against HIV/AIDS
Stuart Chuka	ARV Programme Officer	Malawi Business Coalition against HIV/AIDS
George Goliati	Principal Hospital Administrator	Mlambe Hospital
Chiku Malunga	Organization Development Practioner	CADECO
Mr. Fibu	Director	Unichem
Mr. Msowa	Vice President of NAPPM Association and Owner of Monekela clinic	National Association of Paramedics and Paraprofessionals and Monekela Private Clinic
Sidney Chikoti	Chief Executive Officer	Medical Aid Society of Malawi
Felix Manjomo	Owner	Moyo Private Clinic
Mrs. Chinkhata	Campus Director	Malawi College of Health Services
Florence Chipungu	Director	Adventist Health Services
Joseph Mwadira	Program Manager	Adventist Health Services
Mrs. Zingani	Director	Mwaiwathu Private Hospital
Dr Sam Phiri	Executive Director	Lighthouse Trust
Sam Lumba	Coordinator	BlueStar
Nathan Mwafulirwa	Senior Programme Officer	Japanese Int'l Cooperation Agency
Peter Killick	Director	CIDA, Malawi-Canada Programme Support Unit
	Principles of Pharmanova	Pharmanova Ltd.
Abraham George	Managing Director	Malawi Pharmacies Ltd. (2005)
Wynn C Chalira	General Manager	Malawi Pharmacies Ltd. (2005)
Abdul Majid Panjwani	Managing Director	Unichem
	Pharmacist Manager	Worldwide Pharmaceutical Distributor
Gertrude Mhango	Managing Director	Mudi Pharmacy Limited
Charles M. Mudiwa	Managing Director	Standard Bank
Joel Chilenga	Head, Human Resources	Standard Bank
James Chibisa	Head of Credit	Indebank
Martin Ndaferankhande	Head, Human Resources	Indebank
Stewart Kondowe	Executive Director	Malawi Microfinance Network
Hellen Dzoole Mwale	CBHFA Coordinator	Malawi Red Cross
Stuart Chuka	ARV Programme Officer	Malawi Business Coalition Against HIV/AIDS
Veronica Chikafa	Capacity Building Coordinator	Malawi Business Coalition Against HIV/AIDS
Dr. Chiku Malunga	Organisation Development Practitioner	Capacity Development Consultants (CADECO)
Kirby Kasinja	Chief Executive Officer	Blantyre Adventist Hospital
George Goliati	Principal Hospital Administrator	Mlambe Mission Hospital
Dr. Dieter Koecher	Health Coordinator	GIZ
Lilly Banda	Deputy Team Leader (Health Office)	USAID/Malawi
Ndasowa Chitule	HIV/AIDS Specialist	USAID/Malawi
Violet Orchardson	Nutrition Advisor	USAID/Malawi
Beth Deutsch	Sr. HIV Prevention Advisor	USAID/Malawi

Name	Position	Organization
Catherine Chiphazi	Child Health Specialist	USAID/Malawi
Ben Zinner	Health Officer	USAID/Malawi
Dr. Perry Jansen	Director	Partners in Hope
Dr. Giuseppe Liotta	Program Director	Dream Program
Florence Chipungu	Executive Director	Adventist Hospital Services

ANNEX C: LIST OF SERVICES COVERED BY MCH SLAS

1. Antenatal Care (ANC)
2. Normal delivery
3. PPH treatment
4. Manual removal placenta
5. Eclampsia treatment
6. Voluntary counseling & testing
7. 3rd / 4th degree tear repair
8. Assisted delivery vacuum extraction, breech, twin
9. Obstructed labour hysterectomy
10. Severe anemia treatment
11. Puerperal sepsis treatment
12. Abortion complications treatment
13. Ectopic pregnancy – laparotomy
14. Newborn complications treatment
15. Syphilis in pregnancy treatment
16. Post-partum complications (PPC)
17. Condoms (three months: 36)
18. Oral contraceptives (three months)
19. Parenteral contraceptives (three months)
20. Norplant
21. Intrauterine device/ intrauterine contraceptive device (IUD/IUCD)
22. Bitubal Ligation (BTL)
23. HIV Treatment including PMTCT
24. Simple/elective caesarean
25. Emergency/complicated caesarean
26. Pregnant women with TB

27. Severe Malaria in pregnancy
28. Neonatal sepsis
29. Acute Respiratory Infection (Under 5)
30. Diarrhoea (Under 5)
31. Malaria (Under 5)
32. Malnutrition (Under 5)

ANNEX D: BLUESTAR SOCIAL FRANCHISE CASE STUDY

In June 2008, BLM launched the BlueStar social franchise. BlueStar is Marie Stopes International's social franchising program that is active in nine countries around the globe. BLM conducted a mapping exercise to locate small, private clinics; assessed 86 potential franchisees; and selected 60 to become BlueStar network members. The selection criteria included geographic location, quality of service, and commitment to offering FP services. Subsequently, BLM has conducted a comprehensive mapping exercise of the private sector in ten districts in Malawi.

In March 2010, BlueStar clinics had 21,566 client visits, of which 1,811 (8 percent) were for FP (MSI, 2010). A client exit survey of 117 clients at 24 BlueStar clinics, commissioned by Marie Stopes International in November 2009, found that 50 percent of clients live below the average national household income and their median age is 28 years (MSI, 2009).

Clinic Start-up and Operations

The PSA found that franchisees have owned their businesses for an average of over ten years, with two-thirds having used savings to fund start-up. Another 22 percent received either a gift or loan from family or friends to start their business. Approximately 50 percent of interviewed BlueStar clinic owners are medical assistants and 50 percent are clinical officers. The owner is the only clinician on staff in most of the clinics, although part-time nurses are hired during the malaria season. The average number of employees is five. One-third of the franchisees own their clinic facilities, and two-thirds rent.

Service Provision

All 18 franchisees interviewed by SHOPS agreed that the most common services at their clinics were for malaria and pneumonia. Sales of drugs account for over 80 percent of total clinic revenue. An average of 33 clients were seen per day, and ranged from 15 – 50. All providers offer FP services and some offer HIV/AIDS-related services. In addition, 78 percent offered laboratory services and one offered maternity care.

Clinic owners reported that FP clients ranged from 5 – 10 percent of total patients. All clinics offer male and female condoms, oral and injectable contraceptives, with injectables being the most popular method. 83 percent offer IUDs and only 11 percent offer implant contraceptives and bilateral tubal ligations. All clinicians stated that they would like to be trained to offer FP services that they are not offering. Table A below summarizes the percentage of BlueStar clinics interviewed that offer the FP methods listed.

TABLE A: Percent of Interviewed BlueStar Clinics that Offer FP by Method

N=18

Method	Percent
Injectables	100%
Oral contraceptives	100%
IUDs	83%
Female condoms	67%
Male condoms	56%
Tubal ligations	11%
Implants	11%

The BlueStar clinics also report offering a range of HIV/AIDS services, including VCT (67 percent), ART (17 percent), and male circumcision (44 percent). Of those that do not offer these services, most were interested in adding male circumcision and VCT and some were interested in expanding ART.

Revenue

Self-reported monthly revenue ranged widely from $389 to $3,892, and averaged approximately $2,270, with monthly net income before owners' draws averaging $973. Approximately, one-third of the franchisees are accredited by the MASM and most have agreements with corporations to offer care for employees. Despite these arrangements, the majority of clients pay out-of-pocket for products and services.

Competition

The franchisees report that their main competitors are nearby private clinics. The owners are nevertheless optimistic about the future of their businesses because their reputation for quality service is spreading; most agree that the quality of public health services is not improving, therefore they do not consider MOH clinics to be their main competitors.

Constraints Faced by Clinics

The BlueStar franchise clinic owners identified a number of constraints to operating a profitable business. A key constraint was lack of access to financing. Other constraints included government regulations and lack of collaboration with the public sector, business management, insufficient demand from consumers for FP services from the commercial sector, marketing, and patients' inability to pay.

Regulatory Constraints

BlueStar franchise owners cited a number of constraints related to their relationship with the government. Many complained that the length of time that clinical officers and medical assistants are required to serve in the public sector constrains the development of the private sector. They also complained that there are limited opportunities for the private sector to participate in clinical training and continuing education, though the Medical Council stated that private providers are the most enthusiastic participants of continuing education programs since it has become a requirement for licensing. A number of clinic owners mentioned concerns about taxation and perceptions by the revenue authorities that private health providers make a lot of money. Several clinics mentioned concerns that the government considers the private sector to be competitors, instead of collaborators.

Business Skills

Business management skills varied among the franchisees interviewed, but only one of the 18 had done financial projections; none had written business plans. Only 50 percent had any system of inventory management; 33 percent did not reconcile cash on a daily basis; and 67 percent produced no financial statements. Not surprisingly, lack of business management skills was mentioned as a constraint to growing their businesses.

In addition, BLM mentioned the importance of training in stock control and general business management skills. PSI, which sells products to some of the BlueStar clinics, as well as other clinics and retail outlets, cited the need for cash flow management training. They believe that providers often are not able to purchase significant quantities of products because they are not managing their cash flow well. This cash flow problem may also be related to the lack of access to supplier credit or working capital lines of credit to purchase supplies.

All business owners interviewed by SHOPS expressed a desire to learn more about the following topics: stock management, business management, bookkeeping, financial statements, marketing, budgeting and access to finance. Given that the private clinic owners expressed that they have a limited amount of time to devote to business management training, the SHOPS team assessed the most pressing topics needed by these clinics for business sustainability and growth. The team found that stock management, basic business management, bookkeeping, financial statements, and access to finance are most needed.

Credit History and Future Financing Needs

All clinics that were interviewed have current accounts with the following banks, in order of popularity: National Bank, New Building Society (NBS), Standard Bank, Malawi Savings Bank, and Indebank. Some have multiple accounts and a few have savings accounts as well.

Access to financing was cited more often than any other constraint to business. Only one of the 18 BlueStar franchisees obtained a bank loan to finance 50 percent of his start-up costs. Close to half of the clinic owners had borrowed subsequently for their businesses. The average loan amount was approximately $1,946, for equipment and furniture, including one ambulance. The average term was one year and collateral included business assets (equipment and furniture), property (usually without a deed), and homes. Some borrowers had problems repaying on time, and one owner who had borrowed $9,732 to build his clinic ended up defaulting and having his clinic repossessed by the bank. NBS was the most popular lender, followed by National Bank. Of the half who had no borrowing experience, some were turned down because they could not satisfy the collateral requirements. Other constraints cited were: restrictive conditions, lack of responsiveness by the financial institutions, and high interest rates. Others were not interested in borrowing because they had adequate savings or were afraid of debt.

88 percent of the BlueStar franchise owners interviewed wanted to borrow in the next year. They were interested in amounts ranging from $3,244 to $32,438 but clustered in the $6,488 – $19,463 range. The most common purpose was to expand or build a clinic, followed by equipment purchases, drug purchases and adding new services. The preferred term was 18 months, and all were willing to offer collateral, although few had property deeds, which are required by many of the financial institutions. Table B below shows the details of the franchisees' estimated future credit needs. It should be noted that for the most part, the size of the loans that clinics are interested in are realistic given the self-reported income levels. Clinics will most likely be able to cover monthly loan repayments with income generated by the clinic.

Table B: BlueStar Clinic Financing Needs

N=18

Percent of interviewed	Desired loan amount (in MWK 000s)	Purpose	Preferred term	Available collateral	Affordable monthly payments
22%	500 – 999 MWK	Expand clinic building/ working capital	18 months	Building, equipment, home	50,000 MWK
56%	1,000 - 3,000 MWK	Equipment; extend or buy building; buy land; offer new service	1-1/2 to 2 years	Clinic building and land (w/ and w/o deed); equipment	80,000 – 120,000 MWK
11%	> 3,000 MWK	Buy land and build clinic	3 to 5 years	Home; land; equipment	80,000 MWK

SHOPS Development and Pilot of Financial Management and Record Keeping Guide for BlueStar Franchisees

Based on the above findings, the SHOPS project developed and piloted a business and financial management training curriculum for BlueStar franchisees in April 2011. The course goals were for clinic owners to develop basic business and financial management skills to support the ongoing development of private clinical practices, to move them towards greater sustainability and profitability, and to improve their capacity for growth. The course covers the following topics:

(1) Diagnose the business health of clinics
(2) Establish measureable and achievable goals
(3) Explain stock management and apply tools
(4) Apply bookkeeping tools to track financial transactions
(5) Create financial statements and cash flow projections
(6) Assess financing needs and analyze options

23 individuals participated in the two-day course, including 14 BlueStar clinic owners, five BLM field staff, and four BLM head office staff. The learning assessments showed a 19 percent improvement from 61 percent correct answers in the pre-test to 80 percent in the post-test. The evaluations showed 96 percent of the participants rated the course “excellent” or “very good” and “extremely useful”. The participants reported that 70 percent are more likely to apply for a bank loan because of the skills they learned in the course. At the end of the course, many of the franchisees requested additional training and felt that the course was too short. Due to the low level of development of these businesses, additional training and follow-on advisory services would be important. During the PSA, SHOPS determined that 65 percent of training participants had already made changes to the way they were managing their practices. Based on this pilot, SHOPS is recommending that the course be rolled out to the rest of the social franchisees and then adapted to be rolled out to other private providers.

ANNEX E: FINANCIAL SECTOR ASSESSMENT

This annex contains notes from interviews with 7 financial institutions in Malawi as well as a table summarizing key findings. Data was collected during assessment trips in 2010 and 2011.

National Bank

National Bank is the largest bank in Malawi. With 30 percent of its portfolio in the SME segment, National Bank has the largest SME portfolio in Malawi.

Capacity to Meet Borrowing Needs of Private Providers: Interest rates on SME loans are higher than some of the competitor banks, but the leasing product is more competitive. Collateral is required for loans and property with a deed is preferred, but not absolutely necessary. National Bank would serve the upper-end of the BlueStar franchises, as annual revenue for National Banks' SME borrowers ranges from 5.0 million MWK ($32,000) to 70.0 million MWK ($455,000), and loans range from 500,000 MWK ($3,300) to 70.0 million MWK ($455,000).

Financial Strength: Capital adequacy is 18.5 percent and non-performing loans are 2.1 percent, both within the norms.

Interest in a Health Sector DCA: National Bank is interested in a health sector guarantee because it believes the risks are relatively high (lack of financial records, succession plans, good management, and acceptable collateral). National Bank has worked in the past with a Japanese guarantee for vehicles, but not a DCA guarantee.

Standard Bank

Standard Bank is 60 percent owned by Standard Bank of South Africa. It has 32 branches all over Malawi. There are 20 SME loan officers in 7 branches, who report to the Head of Business Banking.

Capacity to Meet Borrowing Needs of Private Providers: Standard Bank's average SME loan is between 5.0 million MWK ($32,000) and 25.0 million MWK ($163,000), so it would serve only the larger BlueStar franchises. For loans over 1.0 million MWK ($6,500), hard collateral is required, that is, property with a deed. In urban settings, the coverage is 2:1; in rural settings, coverage needs to be 4:1. The Managing Director, however, did express an interest in creating a specialized loan product for BlueStar franchises.

Financial Strength: Standard Bank has a 19.8 percent capital adequacy ratio and its non-performing loans are impressively low at 1.3 percent. The SME portfolio has an approximate 4 percent non-performing ratio.

Interest in a Health Sector DCA: Standard Bank has a $6.0 million agricultural DCA, and is interested in a health sector DCA. The Managing Director was very interested in expanding into the health sector, mentioning opportunities with high end hospitals as well as the possibility of developing a loan product for BlueStar franchises. This contradicted information gathered in 2010, when one manager said that the health sector had been on a list of "untouchables" – meaning that bank management considered the sector too risky and discouraged loan officers from positively considering private health sector loan applications.

New Building Society (NBS)

This bank was a government-owned mortgage bank until 2004 when it became a commercial bank, with Nico Insurance owning 60 percent. Home mortgages still comprise the largest percentage of its portfolio (some 35 percent). It has 14 branches plus 13 agencies, three service centers and two vans which provide mobile banking at six sites.

Capacity to Meet Borrowing Needs of Private Providers: NBS recently started an SME department with support from the International Finance Corporation (IFC) in training and with a $2.0 million credit line which is fully utilized. Although the SME sector only accounts for about 2 percent of NBS' total portfolio, it intends to market to the SME sector with its 12 SME loan officers in three branches. SME loans range from 200,000 MWK ($1,300) to 50 million MWK ($325,000), with the average at 700,000 MWK ($4,600). If the borrower repays 50 – 100 percent of the loan within 6 months, it can get an additional loan for a lower interest rate. Loans under 1.0 million MWK ($6,500) do not require hard collateral, so personal and business assets are sufficient. NBS would be interested in developing a specialized health sector loan product, as it wants to diversify away from the agricultural sector. NBS also mentioned developing a prepaid health card that it could market through the BlueStar network.

Financial Strength: NBS has a relatively high non-performing ratio of 4.4 percent, with the SME rate at 5 percent. Its capital adequacy ratio is below average at 9.4 percent.

Interest in a Health Sector DCA: Approximately 10 percent of its SME portfolio is in the health sector (clinics, suppliers to government hospitals and retail pharmacies). These loans are performing well. NBS claims that the cash flow of health care businesses is a bit unpredictable and often the projections do not support the borrowing, but a health sector DCA guarantee would help mitigate these risks.

First Merchant Bank Limited (FMB)

Capacity to Meet Borrowing Needs of Private Health Providers: FMB is currently not lending to the health sector and its SME loan portfolio is very limited. They did not appear to be very enthusiastic about the sector and will need approval from their directors for further discussion. SME loans are up to 5 million and 5 years and they will consider a variety of collateral, including property, debentures, bill of sale and guarantees.

Financial Strength: The non-performing loan ratio is 2.7 percent.

Interest in a Health Sector DCA: FMB is potentially interested in a health sector DCA but would need to receive approval from directors before further discussion.

Malawi Savings Bank (MSB)

Malawi Savings Bank is 100 percent government owned. It has the largest branch network, with 43 branches located in every district but one.

Capacity to Meet Borrowing Needs of Private Health Providers: MSB's SME loans range from 250,000 MWK ($1,600) to 5 million MWK ($33,000). Personal guarantees with a 1:1 coverage are acceptable collateral if the individual's net worth is quite strong.

Financial Strength: Non-performing loans over 90 days was reduced in 2009 to 4.0 percent, although its capital adequacy ratio of 7.4 percent is the lowest among the financial institutions interviewed.

Interest in a Health Sector DCA: Being a government bank, MSB is not eligible for a DCA guarantee. Yet, with fewer than ten customers in the health sector, MSB would like to increase its loans to the health sector with a guarantee facility because it prefers to focus on programs that have a social impact.

Health Worker Student Financing: MSB recently launched a health student financing product that was sponsored by the government and is not expected to make a profit. The interest rate on the product is 4-5 percent compared to 24 percent charged on commercial loans. When students leave school the bank is capable of increasing the rate to the commercial rate. These loans carry 4 year terms and should be repaid before the student leaves school. They just began disbursing the loans two months ago so they do not have repayment information yet but they expect that it will be bad given the government's previous experience with student loans. The government is guaranteeing 100 percent of the loans. The MSB manager says the loans are students going to public schools are eligible for the loans. The loans do not cover tuition, just books and other allowances.

Indebank

Indebank, initially a government investment and development bank, was privatized in 1992. It only has nine branches. Approximately 30 percent of its portfolio is in the SME sector.

Capacity to Meet Borrowing Needs of Private Health Providers: With few branches, Indebank does not have adequate geographic coverage to conveniently reach many of the BlueStar and other commercial clinics. Although it can do accounts receivable financing,

most clinics operate on a cash basis and thus such a loan product may not be in high demand among clinics. Indebank does not have a leasing product.

Financial Strength: Capital adequacy is at 12.5 percent and non-performing loans are at 3.4 percent; neither ratio is as strong as the larger banks such as NBS and National Bank.

Interest in a Health Sector DCA: Indebank has an agricultural DCA but has not booked many loans under it. It is interested in a health sector DCA.

Opportunity Bank

Opportunity Bank began as a microfinance NGO and then was granted a full commercial banking license in 2002. It can offer current accounts, but has made a strategic decision to only offer savings accounts. Borrowers have an obligation to retain in saving 15 percent of their loan amounts. Opportunity Transformation Investments US owns 60.5 percent of the bank. It is Malawi's largest financial institution specializing in microfinance, with its portfolio approximately doubling in 2008 and again in 2009. It covers the entire country with 31 branches (including 10 kiosks).

Capacity to Meet Borrowing Needs of Health Providers: Since 50 percent of its portfolio is SME, Opportunity has appropriate loan products for the BlueStar franchises. Its SME loans range from 650,000 MWK ($4,200) to 50 million MWK ($325,000), with the average around 2.0 million MWK ($13,000). For up to 1.0 million MWK ($6,500), 1.2 coverage with any asset is acceptable. Opportunity Bank prefers that loans greater than 1.0 million MWK have collateral with property deeds, but it is flexible on this.

Financial Strength: Opportunity has a portfolio at risk rate of 10 percent of which 50 percent is in the SME portfolio.

Interest in a Health Sector DCA: Opportunity has several private clinic borrowers, and all but one is performing well. Opportunity recognizes the importance of health to its clients, so "lending to the health sector would be strategic"[1] and they could "go flat out for it"[1]

Summary of Financial Institution*									
Name	**Branches**	**Total Asset size (in MWK)**	**Portfolio % SME**	**Avg SME loan size (in MWK)**	**SME loan terms**	**Current health sector portfolio**	**Non-performing loans**	**Capital adequacy**	**DCA experience?**
National Bank**	19	63 B	30%; Leasing:	500M -	Base + 6%; 1% fee; Collateral is	Minimal; small market, small	2.1%	18.5%	None

Summary of Financial Institution*									
Name	**Branches**	**Total Asset size (in MWK)**	**Portfolio % SME**	**Avg SME loan size (in MWK)**	**SME loan terms**	**Current health sector portfolio**	**Non-performing loans**	**Capital adequacy**	**DCA experience?**
(2008)			11%	70 MM	required - deed is preferred.	businesses;			
Standard Bank (2009)	23	49 B	20%;	1 -400 MM; Avg: 5 - 25MM	Base + 1 - 5%; fee: 2%; Need hard collateral (w/ deed); 2:1 .	Govt. suppliers w/ contract as guarantee.	1.3%; SME: 4%.	19.8%	Agriculture: $6.0 MM; w/o DCA
NBS (2009)	37	29 B	2% (308 MM MWK)	200M - 50 MM; Avg: 700 M	2 - 3%/mo. + 1% fee; 3 mos -3 yrs; avg. term: 7 mos.	Govt. suppliers; clinics; pharmacies; 30 MM.	4.4%; SME: 5%	9.4%	Agriculture DCA - expired
FMB ** **(2009)**	20	21 B	Minimal-just started last year.	Up to 5MM	Base+4%-6%, up to 5 yrs; guarantee, property, bill of sale, debentures	No	3.0%	37.0%	None
Malawi Savings Bank (2008)	43	14 B	25% (K1.9 B)	250 M - 50 MM;	Base + 4-5%; 1.5% fee; guarantee or RE (1.25:1); 1-3	<10 customers; performing better than other sectors.	4.0%	7.7%	None (Italian guarantee for loans < 500 M MWK)

Summary of Financial Institution Information*									
Name	**Branches**	**Total Asset size (in MWK)**	**Portfolio % SME**	**Avg SME loan size (in MWK)**	**SME loan terms**	**Current health sector portfolio**	**Non-performing loans**	**Capital adequacy**	**DCA experience?**
					yrs.				
Indebank (2008)	9	7.9 B	30%	50M- Avg 2.5MM-5MM	Base + 5%; 3 years, 70% loan to value, property, debenture	15-20 clients. Arranging a facility to a medical equip supplier for 3 clinics	3.4%	12.5%	Agriculture DCA - not used much
Opportunity Bank (OIBM)	31 (inc. 10 kiosks)	4.2 B	50%	1MM – 10 MM; avg: 2MM; 1,000 clients	27% + 1.5-2.0% fee; 1.2 collateral (any asset); 1- 4 yrs.	<10 healthcare businesses	10% PAR		Agriculture DCA

[1] http://www.gfmag.com/gdp-data-country-reports/227-malawi-gdp-country-report.html#axzz1SsHgaJdW
[1] Ibid
[1] Financial institutions' level of lending to the SME sector is relevant, as most private health care providers in Malawi would be considered small and medium-sized enterprises. Experience has shown that banks with developed SME products and lending skills can more quickly and easily expand lending to private health care SMEs than those without such lending expertise and experience.

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