CASE STUDY

MALAWI

All essential health care services in Malawi's public sector are in theory free at the point of delivery; however, the services offered are severely limited by the lack of available resources, with facilities making services available in an ad hoc manner. Efforts to prioritize, although supported at the policy level, have been hampered by the health system's lack of capacity to deliver even prioritized services, and by resource limitations at all levels of implementation, insufficient communication of policies to health workers, and duplicative parallel systems due to reliance on development partner funding. Government spending makes up 25.5% of total health expenditure, with development partners contributing on average 61.6% between the financial years 2012/13 and 2014/15. Of Malawi's public budget, 10.4% is spent on health.[1] Ninety-one percent of births are attended by a skilled attendant. The proportion of pregnant women aged 15-49 receiving antenatal care from a skilled provider is 95%, while only 51% of pregnant women receive four or more antenatal visits. Maternal mortality is high at 439 per 100,000 live births. Under-5 mortality has fallen considerably in recent years but was still at 63 per 1,000 live births in 2016.[2] See Table 1 for key demographic and health indicators.[3]

Prioritizing the benefits package: Malawi Essential Health Package is currently in its fourth version. The latest package, for the period 2017-2022, is prioritized principally according to health maximization. Under this criterion, interventions were deemed cost-effective if their incremental cost-effectiveness ratio was below Malawi's cost-effectiveness threshold of US$ 61 per disability-adjusted life year (DALY) averted. After considering cost-effectiveness, burden of disease was calculated for each intervention. Interventions were then ranked according to their impact on total population health (assuming expected case numbers) measured in DALYs averted. Other criteria included equity, continuum of care and complementarity of services. The package was validated and approved through a deliberative process. The estimated cost of drugs and commodities in the package is US$ 194 million per annum for the period 2017/18-2021/22. Programme management costs are US$ 108 million per annum, equivalent to approximately 58% of the estimated total strategic plan cost per annum and 71% of total health expenditures recorded in 2014/15.[4] This is high considering that the government contributes only 25% of total health expenditures; however, previous iterations of the package had much higher associated cost estimates, rising to approximately 134% of total health expenditure in 2015.

SRHR interventions were included in the prioritized package under the RMNCH category, as documented in Table 2 below. Of the interventions recommended by the Guttmacher-Lancet

1 Ministry of Health, 2016. Malawi National Heath Accounts Report for Fiscal Years 2012/13, 2013/14 and 2014/15. Ministry of Health, Department of Planning and Policy Development.

2 National Statistical Office of Malawi. Malawi Demographic and Health Survey 2015-2016 report.

3 General Disclaimer. Indicator estimates in this case study may differ from those listed on the WHO Global Health Observatory or other UN estimates' websites.

4 Malawi National Health Accounts. 2015 report.

Commission on SRHR, none were included relating to comprehensive sexuality education, sexual and gender-based violence, infertility, or information, counselling and services for sexual health and well-being. Treatment of complications from unsafe abortion was also not included, although post-abortion case management was. The cost of implementing the full package of RMNCH interventions was estimated at US$ 34 million annually, compared with an estimated US$ 12 million for RMNCH in 2017-18.[5] According to the most recent resource mapping in the year 2017/2018, funding from development partners amounted to 99% of all resources for RMNCH. (This number excludes commodities because no data on these were available from Central Medical Stores Trust; however, other data indicate that development partners contributed a similar proportion of the cost of commodities.

Table 1. Malawi: key demographic and health indicators

Total population (2016)[1]	18,092,000
GNI per capita (PPP international US$, 2013)[1]	750
Life expectancy at birth M/F (years, 2016)[1]	61/67
Total expenditure on health as % of GDP (2014)[1]	11.4
Out-of-pocket expenditure as % of current health expenditure (2016)[2]	11
Voluntary health insurance as % of current health expenditure (2016)[2]	3
Nurses & midwives/10,000 pop.(2016)[3]	2.528
Physicians/10,000 pop. (2016)[3]	0.157
Percentage of births attended by skilled health personnel (2015-2016)[4]	89.8
Percentage of married or in-union women of reproductive age whose need for family planning was satisfied with modern methods (2016)[4]	74.6
Abortion at the woman's request (Y/N)[5]	Not specified

[1] WHO Global Health Observatory https://www.who.int/gho/en/
[2] Global Health Expenditure Database http://apps.who.int/nha/database/Select/Indicators/en
[3] Ministry of Health, HRH Assessment Report 2016 accessed via WHO Global Health Observatory https://www.who.int/gho/en/
[4] Demographic and Health Survey 2015-2016 https://microdata.worldbank.org/index.php/catalog/2792
[5] Global Abortion Policies Database https://abortion-policies.srhr.org/country/malawi/

5 Authors calculation based on resource mapping: http://www.health.gov.mw/index.php/reports?download=54:resource-mapping-round-5

Participation and process: The process was government-led; the Centre for Health Economics at the University of York in the UK provided the framework for prioritization. An economic evaluation was undertaken to rank interventions, followed by a consultative process to take into account a wider set of political, ethical and health system considerations. During the first stage, a threshold was set for cost-effectiveness of interventions, in terms of cost per DALY averted. The interventions were then ranked according to their effect on population health, taking into account, as far as possible, the characteristics and limitations of the existing health system, including their overall effect on the health budget. During the second stage a series of consultations was held with stakeholders to take account of existing services and cultural expectations, continuum of care and complementarity of interventions, health system limitations and equity considerations. Considerations such as equity were considered with reference to expert opinions, rather than equity-adjusted quantitative methods, so it is difficult to assess how gender, socioeconomic and geospatial inequities were accounted for: this may be particularly salient for SRHR.

Challenges: Much of Malawi's health budget is funded by development partners, and many of those funds are earmarked for particular activities. There is therefore very limited scope for assigning resources according to the technical prioritization criteria. There are few levers at policy level to allocate resources so as to affect what is implemented directly. As a result, much health spending is out of line with the prioritized package and national priorities. In addition, data to support both technical prioritization and more granular decision-making is very limited. For example, only 87 of the Essential Health Package's 250+ interventions were supported by sufficient data on disease burden, efficacy of interventions or cost of implementation for consideration in the cost-effectiveness analysis framework.

A small number of development partner-funded interventions were explicitly included in the cost-effectiveness exercise. For example, GAVI funding for essential vaccines and antiretroviral therapy funding from the Global Fund were included because they are considered stable in the medium term; however, less predictable development partner-funded interventions, for which future financing might be withdrawn, were not included. Operational challenges are anticipated in areas such as contraceptive commodities: development partners are likely to continue funding some Essential Health Package interventions in parallel with government, and without proper coordination this could lead to duplication of services and inefficient resource allocation.

The Health Sector Strategic Plan II states that "Essential Health Package provision has been inequitable in practice because failure to fully fund it has meant varying degrees of coverage for different interventions, by level of health care system and geographical location". This has implications for equity. Health workers and the general population have had little knowledge about the Essential Health Package, and many will not be aware of this policy-level prioritization exercise. Combined with resource limitations, the fact that financing or payment is not

linked to the implementation of the package, and that prioritization is not reflected in clinical practice guidelines or the essential medicines list, means that services actually implemented at facility and community levels often fail to reflect these priorities.

Successes: The 2016 revision instituted a reasonably transparent process for designing and prioritizing health services, and brought the package of prioritized services closer to affordability than was previously the case. Evidence from Malawi and comparable settings was used to inform the prioritization process, which in turn was used to inform policy-makers, who added ethical and pragmatic considerations to the technical ranking through an appropriate participatory process. Despite the challenges involved in using this revision to allocate resources or implement the package, the creation of this process, and its perception as an objectively fair process, is a good first step towards prioritizing resources for UHC.

As for service delivery, agreements with the Christian Health Association of Malawi hospitals, who provide health services to 30-40% of the population, have increased access to the benefits package and other services, particularly for the rural poor. The second Health Sector Strategic Plan incorporated the Essential Health Package in 2017, and annual implementation plans are based upon this, which may help to make the benefits specified in the package more accessible in practice.

Reforms, revisions and plans for the future: The government is working to better coordinate resources from the Ministry of Health and development partners in order to reduce gaps in the Essential Health Package through resource tracking data. Several reforms are being considered to carry policy-level decisions to implementation, including revision of provider payment mechanisms, review of the Central Medical Store's procurement processes, classifying items on the essential medicines list as either Essential Health Package or non-Essential Health Package commodities, hospital management reform and a move to performance-based budgeting led by the Ministry of Finance. A new Health Financing Strategy is being developed to define and prioritize some of these options. In addition, the government continues to seek further sources of funding for SRMNCH through mechanisms such as the Global Financing Facility. These efforts are intended to result in alignment with the Essential Health Package, the Health Sector Strategic Plan II and existing aid coordination tools, to avoid these initiatives further fragmenting the financing landscape.

The Health Sector Strategic Plan II indicates that practical implementation of the Essential Health Package will depend on its incorporation into the Essential Medicines List, the Essential Equipment List and Standard Treatment Guidelines, which inform procurement and clinical processes at facilities and in communities. As noted above, ensuring that key SRHR commodities are included in the Essential Medicines List and that national treatment guidelines are in line with WHO clinical guidance offers an important opportunity for SRHR advocates to exert some influence. Policy-makers have also indicated that provider payment mechanisms may be reformed to link more explicitly to the Essential Health Package.

Table 2. Interventions recommended by the Guttmacher-Lancet Commission on SRHR included in/omitted from Malawi's health benefits package

Interventions recommended by Guttmacher-Lancet Commission	Malawi's Essential Health Package: interventions included/omitted
Comprehensive sexuality education*	• Not included
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Injectables • Intrauterine devices • Implants • Pills * • Female sterilization • Male condoms
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Tetanus toxoid (pregnant women) Deworming (pregnant women) • Daily iron and folic acid supplementation (pregnant women) • Syphilis detection and treatment (pregnant women) • Intermittent presumptive treatment (pregnant women) • Insecticide-treated bed net distribution to pregnant women • Urinalysis (four per pregnant woman) • Clean practices and immediate essential newborn care (in facility) • Active management of the 3rd stage of labour • Management of eclampsia/pre-eclampsia (magnesium sulphate, methyldopa, nifedipine, hydralazine) • Neonatal resuscitation (institutional) • Caesarean section with indication • Caesarean section with indication (with complication) • Vaginal delivery, skilled attendance (including complications) • Management of obstructed labour • Newborn sepsis - full supportive care • Newborn sepsis – injectable antibiotics • Antenatal corticosteroids for preterm labour • Maternal sepsis case management • Cord care using chlorhexidine • Hysterectomy • Treatment of antepartum haemorrhage • Treatment of postpartum haemorrhage • Antibiotics for preterm premature rupture of the membranes
Safe abortion services and treatment of complications of unsafe abortion	• Post-abortion case management
Prevention and treatment of HIV and other sexually transmitted infections	• Cotrimoxazole for children • Prevention of mother-to-child transmission of HIV • HIV testing services • HIV treatment for all ages – antiretroviral therapy and viral load
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence	• Not included
Prevention, detection, and management of reproductive cancers, especially cervical cancer	• Human papillomavirus vaccine • Testing of pre-cancerous cells (vinegar)
Information, counselling and services for subfertility and infertility	• Not included
Information, counselling and services for sexual health and well-being	• Not included

* Comprehensive sexuality education is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.

The Partnership for Maternal, Newborn & Child Health

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