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Malawi's Health SWAp: Bringing essential services closer to the poor?

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Abstract

The Government of Malawi has committed itself to reaching the poor with effective health services. The Government agreed to implement 'The Essential Health Package', re-affirmed its' commitment to provide essential health services free of charge and undertook to monitor the new health Sector Wide Approach on its performance in reaching the poor. In August 2005, five papers were commissioned by the Equity and Access Sub-group of the Ministry of Health Monitoring and Evaluation Technical Working Group The overarching recommendation arising from these analyses is the need to bring essential services much closer to the poor– not only in geographical proximity, but also affordability, cultural acceptability, and epidemiological relevance. The call is not to change policy, but rather to ensure its more energetic and effective implementation

Background:

The Malawi Government's Concern for Reaching the Poor

Malawi is one of the world's poorest countries, with well over half of its population consuming the equivalent of less than a single U.S. dollar per day. Within this low overall level, there are inequalities that, while not larger than those found in higher-income countries like the United States, are nonetheless significant.[1] The Government of Malawi has committed itself to reaching poor and excluded population groups with effective health services. It has taken a number of important steps in this direction. In 2002 it agreed to implement a package of health services free of charge, the Essential Health Package (EHP) whose principal objective is "to contribute to reduced poverty...".[2]

In 2005 the Government and its collaborating partners formally launched a health Sector Wide Approach (SWAp) as the vehicle to deliver the EHP.[3] In August 2005, at the onset of the SWAp, five papers, plus a background paper on general economic and health inequalities were commissioned.[4] The purpose of the papers was to produce a synthesis of available information on issues of access and equity in the health sector, including a baseline analysis for SWAp monitoring, and practical recommendations for ensuring that essential health services are accessible to and used by those who need them most. Each of the five papers dealt with a specific health issue within the Essential Health Package.

In-depth analysis of equity in health service use in Malawi

Each of the five papers present similar types of information, covering both illness prevalence and service coverage.

Malaria

The information available from the several available studies on the distribution of malaria is somewhat contradictory.[5] Studies that include a test for the malaria parasite itself tend to find higher levels of infection among the poor than the better-off, while those using reported fever as a proxy for malaria generally find much smaller inter-class differences. This may reflect the inadequacy of self-reported fever as a malaria proxy.

From DHS data in 2000, both the ownership and use of treated bed nets was considerably higher among less poor than among the poorer segments of the population. However, bed net distribution efforts have expanded greatly since then and more recent information suggests a reduction in differences of coverage. Treatment of childhood fever is notably greater for children of higher economic groups than for children in lower ones. Although almost all women, poor as well as better-off, visit antenatal clinics at least once during their pregnancies, better-off women are much more likely to receive preventive treatment for malaria during these visits.

Immunisable diseases

Immunization levels are surprisingly high and reasonably equitable across all economic groups.[6] While economic inequalities in coverage exist, with coverage in poorer groups being lower than better-off ones, the differences are relatively modest and are generally high enough to confer immunity through the herd immunity effect. As elsewhere in Africa, urban children are more likely to have been immunized than rural ones. Differences also emerge by educational level of the mother, with the children of more educated women being significantly more likely to have received immunizations than children of less educated or uneducated women. Immunization rates are lower in the Central Region than in the Northern or Southern Region. This equitable coverage is likely to relate to the service level at which immunization is offered, at health centres and communities through outreach initiatives.

> ***the (immunization) programme demonstrates the success in Malawi of a programme reaching all strata of society and with herd immunity in force, protecting all children, however rich or poor their parents.***

HIV/AIDS: focusing on counselling and testing and antiretroviral therapy

In Malawi, HIV prevalence is nearly twice as high in urban as in rural areas, implying that prevalence is likely to be higher in upper than in lower economic groups since economic conditions in urban areas tend to be significantly above those in rural parts of the country.[7] Prevalence is also thought to be much higher among young women than among young men; at older ages, the situation is unclear. Prevalence is considerably higher in the south of the country than in the north.

Uptake of voluntary counselling and testing (VCT) is higher among upper than lower economic groups, with coverage rates in the top 20% of the population around twice those found in the

bottom 20%. Congruent with this, testing coverage is much higher among urban than among rural residents, as it is between the better-educated relative to the less educated and the uneducated. Information about access to antiretroviral therapy (ART) by economic status is not available. Gender-specific information shows that 60% of therapy recipients are female, 40% male. In brief, on the basis of what is now known, VCT and access to ART appear to be more frequent among more privileged than among disadvantaged groups, whether privilege is determined in economic or geographic terms.

Tuberculosis

National-level survey information is not available for tuberculosis (TB) prevalence; however good quality national notification data are available, together with rich evidence from smaller-scale studies about differential access to TB diagnosis rates and the underlying reasons for the observed differences.[8]

In urban Lilongwe, the number of identified chronic cases and smear positive TB cases in poor squatter areas was far below that in comparable high density areas so much so that, assuming that actual rates in the two areas should be the same, up to half of cases in the poor squatter areas were being missed. Similarly, it costs the poor in urban Lilongwe up to two and a half times their available monthly income to access a TB diagnosis; twice as much as the non-poor. For the poor, this cost rises to almost six times their available monthly income after essential food expenditure is counted. This is in an urban setting where public health services are provided free-of-charge and are available within 6km

Maternal Mortality

Unlike the very large inter-group differences documented in other countries, Malawi data suggests only modest differences in maternal mortality across economic groups with rates being almost the same in the top four quintiles, and 15-20% higher in the lowest.[9] There is little difference in maternal mortality between rural and urban areas.

There are notable inter-group disparities in attended delivery. 71% of women in the top 20% of the population were attended by a medical professional (doctor, nurse, or trained midwife) at delivery compared with 55% of women in the population's poorest 20%. Disparities across educational groups appear considerably larger. Overall, poorer and rural women have less access to skilled attendance and delivery because of delays in the decision to seek care, in arrival at the point of care after the care-seeking decision had been taken and in the provision of adequate care upon arrival at a suitable facility.

It is likely that HIV infection, which increases maternal mortality, distorts the observed socio-economic differences in mortality rates. The incidence of HIV is higher in urban populations, the vast majority of whom occupy the higher two wealth quintiles. Thus the wealthier women may be likely to die because of HIV, while poorer, less educated and rural women are more likely to die because of lack of access to essential services.

Inequalities of Health Service Use in Malawi in comparison with the Developing World

Government Health Services

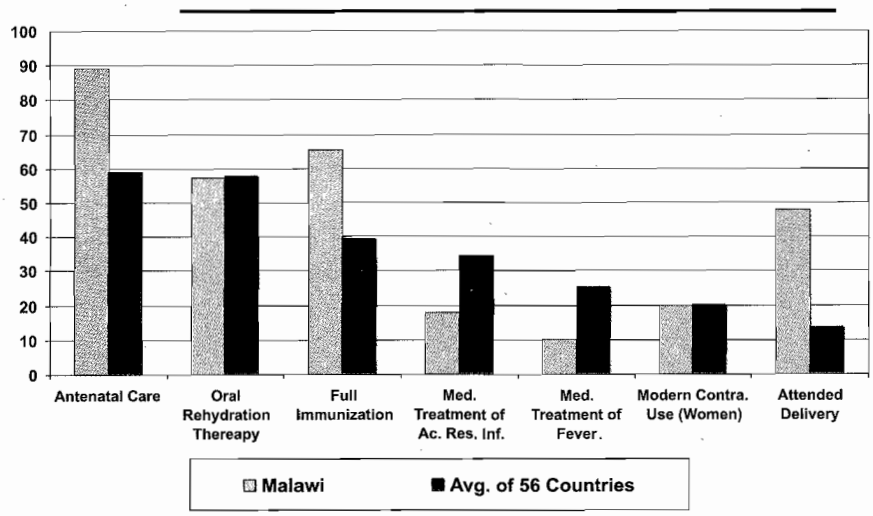
Evidence from recent studies conducted in 14 countries suggest that in the developing world, the top 20% of the population typically receives about two and a half times the benefit from government health service expenditure as does the bottom 20% (30% of the total vs. 12%). The inequality is particularly marked for expenditure on government hospitals. The benefit incidence analysis of the Malawi Second Integrated Household Survey suggests that overall curative health spending is more equitable than other countries in the Africa region - the poorest 20% of the population receive 15.8% of the benefits whilst the richest 20% receive 21.2% of benefits.[10]

Basic Health Services

Recent tabulations of data for DHS surveys executed in over 50 low and middle income countries allow an analysis of maternal and child health inequalities. These inequalities include economic status, gender, and urban-rural place of residence. In all 50 countries, health service coverage rates are higher for upper-income groups than for lower-income groups for all of the seven services assessed. But the degree of difference varies greatly, from quite small (for the use of oral rehydration), to dramatic (for attended deliveries). Similarly, coverage rates for all seven services are higher in urban than in rural areas. Excluding the services that are relevant only for females antenatal care, modern contraceptive use among women and attended deliveries - coverage of males and females is roughly equal, although in each case slightly higher for males.

Figure 1 uses DHS data to compare health service coverage rates to the poorest 20% of the population in Malawi to the average for 56 developing counties. Service use between gender in Malawi is similar to that of average low- and middle-income countries.

Figure 1: Coverage of basic maternal and child health among the poorest 20% of the population in Malawi and other countries



DISCUSSION

The evidence suggests that although Malawi performs reasonably in terms of equity of benefit from public health spending as well as in comparison to other developing countries, significant inequities remain in the use of basic health service, particularly for key public health interventions. In Malawi, essential services are not likely to fully benefit the poor because of the existence of many barriers to use of services by disadvantaged groups.

User fees in general constitute an important barrier to service use by the poor. The Malawi Government's decision not to impose fees is no doubt one of the significant reasons why Malawi's coverage inequalities are lower than elsewhere. Thus, the availability of the EHP at no cost thus constitutes an important step toward assuring use of services by the poor.

However, user fees constitute by no means the only barrier to service use.[1] Others include:

1. financial – the cost of travel and income lost during the time spent seeking medical care.
2. lack of knowledge – knowledge of availability and benefits of health care is typically more widespread among better-off, better-educated groups than the poor.
3. "social distance" – differences in social class between the poor and those attending to them, which can make the poor reluctant to seek health services and impede communication when they do.

Recommendations

The five synthesis studies highlight the need to bring more effective basic services closer to the poor. Specific recommendations for each illness issue are outlined in the five synthesis studies presented in this issue of the Malawi Medical Journal. However, cross-comparison of the papers allows general health system-wide recommendations:

- Strengthening health centre and community-level services, especially in poor rural areas, since these tend to be considerably more equitable than urban, higher-level services.
- Expanding the number of health surveillance assistants (HSAs) to the ratio of one per 1,000 population as agreed for the EHP.
- Reducing the cost of accessing services by continuing to provide EHP services free of charge and expanding their geographic coverage through contracts with CHAM and other NGO providers.
- Improving the availability of drugs and equipment through reform of the Central Medical Stores, strengthening of logistics management and quality assurance mechanisms and related measures.
- Strengthening district performance through stronger district planning, budgeting, management and reporting.
- Developing better health management information, especially concerning health conditions and service use among poor population groups and how poor patients view the services available to them.
- Reducing reliance on hospital services which are particularly inequitable. This calls for use of appropriate technologies to provide more services at the health centre level, and the improvement of referral systems.

These recommendations focus primarily on what are often referred to as "supply-side" factors: that is, policy measures that service suppliers might take in order to increase use of their services by excluded groups; further attention will need to be given to "demand side" factors to increase the ability of the excluded groups to effectively call on the development of services more relevant to their needs and more available to them.

Implications of the Recommendations of the SWAp

This recommended re-emphasis of the EHP, particularly at the health centre and community levels is entirely consistent with the Government of Malawi's stated intention for the delivery of the EHP. What is required to reach poor populations is not a change in policy, but a more energetic and rigorous implementation of a policy that is well established and accepted. In the words of the maternal mortality paper authors:

"The problem... in Malawi does not appear to be a lack of knowledge of the problem, or lack of strategies, but a lack of implementation of those strategies"

This locus of the problem – policy implementation rather than policy design – is far from surprising or unique to Malawi. So long as EHP is not implemented, Malawi's poor will not benefit. Thus, the question becomes what can be done to move effectively beyond words to action. Implementing the EHP requires not simple changes at the margin, but a fundamental reorientation of Malawi's health care system. To illustrate the point, consider the following examples:

Human Resources - the configuration of health personnel in Malawi, as in other countries, is heavily imbalanced in favour of higher-level personnel in urban areas, to the detriment of cadres working at the periphery. Accordingly, the synthesis papers uniformly point to the need for the Government of Malawi to implement its stated commitment to providing one Health Surveillance Assistant per 1000 population for integrated EHP services. Similarly, addressing Malawi's maternal health crisis will require ensuring that trained midwives are available in remote areas. How can this be done? One obvious option would be to redesign salary supplement programs to give the greatest increase in remuneration, in the form of generous hardship allowances, to health staff, particularly midwives and those trained in midwifery skills living and working in specified remote areas.

Pharmaceutical Supplies – stock-outs of essential drugs are frequent, and when they occur, rural health centers tend to be particularly affected. A fundamental reform of the drug procurement and supply system, in particular the Central Medical Stores, is required. Priority to the procurement and supply of essential drugs and equipment for peripheral health services should underline this reform.

Anything less than such profound change is to acquiesce to the primacy of vested interests favouring the better-off.

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