Government of Malawi

Christian Health Association of Malawi

SERVICE LEVEL AGREEMENT GUIDELINES 2016

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LIST OF TEXT BOXES

ABBREVIATIONS

BOD	Burden of Disease
CHAM	Christian Health Association of Malawi
CMST	Central Medical Stores Trust
DHMIS	District Health Management Information System
DHMT	District Health Management Team
DHO	District Health Office
DHS	District Health System
EHP	Essential Health Package
FA	Fiduciary Agent
GOM	Government of Malawi
HAC	Health center Advisory Committee
HF	Health Facility
HRH	Human Resources for Health
HRM	Human Resource Management
HSA	Health Surveillance Assistant
HSJF	Health Services Joint Fund
HSSP	Health Sector Strategic Plan
MDGs	Millennium Development Goals
MHSP-TA	Malawi Health Sector Programme – Technical Assistance
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MOF	Ministry of Finance
M & E	Monitoring and Evaluation
NLGFC	National Local Government Finance Committee
ORT	Other Recurrent Transaction
PBF	Performance Based Financing
PHC	Primary Health Care
POW	Program of Work
PPPs	Public-Private-Partnerships
PPP-TWG	Public-Private-Partnership Technical Working Group
SDGs	Sustainable Development Goals
SLAs	Service Level Agreements
SWAp	Sector Wide Approach
UHC	Universal Health Coverage
ZHSO	Zonal Health Support Office

GLOSSARY

Activities: The specific tasks needed to implement the strategies to meet the strategic objectives outlined in a strategic plan. Activities should be expressed in clear, detailed terms and in chronological order.

CHAM: The Christian Health Association of Malawi, inclusive of its Proprietors, Boards, CHAM Secretariat and Units;

CHAM Unit: A CHAM health facility such as a dispensary, health post, health center, community hospital, hospital and health training institution.

City Council: The Authority with the overall responsibility of planning and managing public services in a City.

Contracting Authority: Agency with the power, mandate, responsibility and accountability to engage in a legal contract with a private business agency.

District Councils: The Authority with the overall responsibility of planning and managing public services in a District.

District Health Management Team: The team at the district level which is mandated to coordinate and implement the Government's policies and strategies at the district level and is mandated to manage the district health system on behalf of the Government.

District Health System: The expertise, structures and organizations at the District level that make possible and contribute to the delivery of health services.

Evaluation: Assessment of the extent to which results are achieved.

General Assembly: The Christian Health Association of Malawi General Assembly.

Government: The Government of the Republic of Malawi, as represented by the Ministry of Health;

Goal: Long-term results that an intervention is intended to achieve.

Health Delivery Area: A (sub-) district in which provision of services are integrated including referral options where the nearest hospital is utilized as referral hospital for surrounding health centers.

Health Management Information System: All different subsystems that provide the necessary routine information for managing health services.

Health System: The expertise, structure and organizations that make possible and contribute to the delivery of health services.

Health System Blocks: All sub-systems of the health system that are mutually interdependent and collectively contribute to the functioning of the overall health system.

Health System Strengthening: Effecting continuous changes and improvements to processes, procedures, structures and functions of all components of the health system.

Health Centre Advisory Committee: Representatives of the catchment population of a Health Centre and the Health Centre management team and oversees the management of health services in a catchment area of a health facility

HTIs: Health training institutions belonging to CHAM.

Indicator: A quantitative or qualitative measurable marker of performance over time.

Impact: Long-term change in the health status of a population, usually the combined result of several programs over time.

Input: The resources needed to achieve a desired result.

Managing: Planning and executing the plan efficiently to produce intended results.

Malawi Health SWAp: The Malawi Government's health sector reform undertaken jointly with its health sector partners in which all stakeholders in the health sector develop, finance and implement one health sector strategic plan with all health expenditures linked to the implementation of this joint sector plan under Government leadership, and adopting common financial management and fiduciary arrangements as well as joint monitoring and evaluation of progress in the sector.

Measurable Result: Outcomes that will be produced when the strategies are implemented.

Mission: A clear and concise statement of an organisation, program, or team's reason for being; an affirmation that answers the question, 'Why do we exist?' A mission provides orientation, uniformity and meaning to the organisation's decision and activities at all levels. It is the core around which staff members focus their best efforts.

Monitoring: Regularly tracking interventions and performance indicators over time in order to measure progress towards results by collecting information on inputs, processes and outputs.

Multi-Sectoral: Including institutions from all segments, public, private, voluntary, faith based and communities.

Operational Planning: A plan with a short-term scope, usually one year. Its focus is on achieving objectives and executing activities in the near future. Operational planning is often referred to as an annual (work)-plan and must be aligned with the strategic plan.

Outcome: A medium term change in a beneficiary population as a result of an activity or set of activities.

Output: The immediate or direct product of an activity.

Ownership: The state of having exclusive legal rights to property, which includes the right to possess, use and dispose of the said property.

Party: means the Government of the Republic of Malawi represented by the Ministry of Health or the Christian Health Association of Malawi; as the case may be.

Performance Management: All processes to support, improve and sustain the efficient delivery of health services.

Performance Standards: Thresholds, requirements, expectations or deliverables that must be met.

Periodic Assessment: Regular collection and analysis of achievements against set targets, standards and timelines.

Performance Based Financing: As opposed to input financing, a payment modality based on a fee- for-services provided, conditional on quality.

PPP: A legally enforceable contract in which a contracting Authority partners with a private sector partner to build, expand, improve or develop an infrastructure or service in which the contracting Authority and the private sector partner contribute one or more know-how, financial support, facilities, logistical support, operational management, investment or other input required for the successful deployment of a product or service, and for which the private partner is compensated in accordance with a pre-arranged plan in relation to the risk assumed and the value of the result to be achieved (Malawi PPP framework, 2011).

Processes: The activities carried out through an operational plan.

Regulatory body: A health regulatory institution set by an Act of Parliament.

Routine Data: Information about health service delivery collected on a regular basis through the health information system.

Service level Agreement: A formal agreement between the GOM, represented by a District or City Council and a CHAM health facility where the latter provides an agreed package of health services, free of charge, to the population in its catchment area, and is compensated by the former on the basis of a reimbursement mechanism jointly agreed upon with the GOM upon entering the partnership agreement.

SMART Result: A specific, measurable, appropriate, realistic and time-bound outcome.

Supportive Supervision: A process of helping staff and institutions to improve their skills, knowledge and performance continuously.

Strategy: A statement of what is to be done, that, when accomplished, will signify achievement of the organisation's strategic objectives.

System: A group of interacting, interrelated and interdependent components that form a complex and unified whole.

System Theory: A concept that understands a phenomenon as the result of various interlocked and mutually dependent relationships between various subsystems.

Vision: The image of a desired future state that a team, organization, project, or program can move toward by taking action.

PREAMBLE

This guide explains Service Level Agreements (SLAs) between the District or City Council and health facilities of the Christian Health Association of Malawi (CHAM). The guide introduces SLAs in the context of the Government's strategy to advance partnerships between public and non-public agencies providing health care. The guide describes background of SLAs and important aspects for its implementation, management and verification to assess progress and outcomes in terms of improving access to essential health services by the District's population. The guide is in line with the National policy framework on Public-Private Partnerships enacted by Cabinet in 2011, and the Public-Private Partnership Strategy of the Ministry of Health (2014).

The guide is prepared for stakeholders involved with SLAs particularly the District Health Offices (DHOs) and the managers of CHAM health facilities. We hope that this guide will help them to initiate and manage SLAs to increase access for communities in their Districts to a basic package of Essential Health Services, free of charge. We hope that the guide will help improve responsiveness of our health system to the needs of clients in quality health care.

We would like to thank everyone who contributed to the realisation of this guide, in particular officers from the MOH-DPPD and CHAM as well as members from the PPP-TWG. We also like to thank the financial and technical contributions from the Malawi Health Sector Programme - Technical Assistance (MHSP-TA) to the realisation of this guideline.

1. INTRODUCTION

1.1 Partnerships for Development

Over the last decade partnerships for development have been widely acclaimed and there is a growing consensus that the public service approach is but one of a number of ways in which essential services can be delivered. Since the Johannesburg World Summit on Sustainable Development (2002), public, private and civil society sector organizations have promoted the benefits of working in Partnerships to address development challenges and to more effectively achieve National development goals, MDGs and SDGs. Access to complementary resources, improved focus and coordination and the achievement of greater scale and reach, are cited as the main advantages that Partnerships can offer.

1.2 Policy and Regulatory Framework for Partnerships

The premise for effective operational partnerships arrangements is the presence of an overarching policy and a legal, regulatory and institutional environment that enables for public and non-public stakeholders to collaborate within and across sectors. The primary policy framework for partnerships for the Government of Malawi (GOM) is provided by the National Public-Private Partnerships (PPPs) Policy framework, which was enacted by Cabinet in 2011. The PPP framework outlines a new arrangement of procuring infrastructure projects and service by the public sector. The policy sets out the framework for initiating, designing and implementing PPPs in Malawi in the context of the Government's social and economic priorities and, among others, identifies the health sector as apriority area. The PPP policy recognizes the following benefits of Partnerships (text box 1):

Text Box 1: Benefits of Partnerships

- ✓ Speedy, efficient and cost-effective delivery of projects;
- ✓ Value for money;
- ✓ Added value by integration and cross transfer of public and private sector skills, knowledge and expertise;
- ✓ Alleviation of capacity constraints;
- ✓ Increased accountability through performance based management and a regulatory regime;
- ✓ Innovation and diversity in provision of public services and;
- ✓ Effective utilization or public assets.

1.3 Partnerships in the Health Sector

The need for partnerships in the health sector is prompted by the pluralistic outlook of the health sector with both public as well as non-public service providers. Partnerships in the health sector are endorsed by various sector policy documents in the recent years. In 2014, the MOH produced the Public-Private Partnership Strategy for the Health Sector to operationalize the National PPP Policy. The health sector PPP strategy is furthermore based on the Malawi Growth and Development Strategy II (MGDS-II) and the Health Sector Strategic Plan (HSSP) 2011-2016.

The purpose of the PPP strategy for the health sector is to guide public-private sector collaboration as well as the development of PPPs in the health sector with the aim of strengthening the national health system and increasing access to quality health services for the population of Malawi. Partnerships involves the encouragement of different institutions and stakeholders both, public and non-public agencies, to work together to achieve the common objective of improving health, based on mutually agreed roles and the principle of sharing resources, risks and results. Particular advantages of partnerships in the health sector are: (text box 2)

Text Box 2: Advantages of Partnerships in the Health Sector

- ✓ Fosters a conducive environment that encourages and facilitates private sector investments and partnerships;
- ✓ Provides framework and institutional arrangements that establish the meanings and boundaries and clarifies roles and responsibilities between the various actors;
- ✓ Leverages, harmonizes and maximizes available health sector resources to improve quality, expand coverage and ensure equity;
- ✓ Improves cost effectiveness and efficiency of public health resources and delivery of health services and products;
- ✓ Guarantees equitable access to affordable, quality health services with the aim to reach universal coverage of an Essential Health Package (EHP);
- ✓ Builds capacity in both public as well as private sectors to partner effectively to deliver quality health services.

1.3.1 Memorandum of Understanding MOH and CHAM

The recently signed Memorandum of Understanding (MOU) between the GOM/MOH and CHAM constitutes an overall framework for partnerships in the health sector. The purpose of the MOU is to maximize the equity potential of the GOM working with CHAM to achieve its commitments to universal health coverage (UHC) in Malawi and to advance national health outcomes through partnership and collaboration. The MOU was signed in January 2016

and came into effect on 1st July 2016. The MOU is based on a number of guiding principles and practices to which both parties adhere to (text box 3):

Text Box 3: Memorandum of Understanding MOH- CHAM: Guiding Principles

- ✓ Commitment to free EHP to every citizen;
- ✓ Work towards UHC of the EHP;
- ✓ Providing services based on equity, justice and human rights irrespective of gender, religion, tribe or societal status;
- ✓ Adhering to national quality service standards;
- ✓ Transparent and accountable.

While mutually agreeing on the above guiding principles, the MOU spells out that the GOM will pay for all staff salaries of accredited CHAM health facilities and will provide further financial support for infrastructural expansion, staff development and specific SLAs of eligible CHAM units under the MOU, if applicable. The CHAM Secretariat is responsible for overall Human Resource Management (HRM) and payroll management of all staff paid for by the GOM. Furthermore, CHAM is accountable for the proper oversight of its heath facilities through establishing and managing appropriate governance structures.

1.3.2 Service Level Agreements

Under the previous MOU between the GOM and CHAM (2002) both parties engaged in so called Service Level Agreements (SLAs); a contract between District Councils and individual CHAM health facilities. SLAs were embraced as an important strategy in the Programme of Work of the SWAp (POW) 2004-2010 and the Health Sector Strategic Plan (HSSP) (2010-2016) and since its inception, about half of all CHAM health facilities (80) have entered into an SLA mostly focusing on maternal and newborn health services (MNH).

The purpose of the SLAs is to improve equity of access to health services through provision of health services and timely referral to nearest hospitals in catchment areas where the government has no health facility and where CHAM facilities already exist, but charge user fees. Essentially, SLAs are partnerships contracts with the purpose to remove the financial barrier to accessing health services by the population who should otherwise have had free health service at the point of service delivery if they were within the catchment area of a government health facility. The SLAs replace user fees with government reimbursements thus removing the financial barrier for poor people to access essential health services.

2. GUIDELINES

This part of the guide provides an overall introduction to some important aspects of the SLAs.

2.1 Definition, Scope and Scale of SLA

2.1.1 SLA Definition

An SLA is a formal agreement between the GOM, represented by a District or City Council and a CHAM health facility where the latter provides an agreed package of health services, free of charge, to the population in its catchment area, and is compensated by the former on the basis of a reimbursement mechanism jointly agreed upon with the GOM upon entering the partnership agreement.[1]

2.1.2 Scope and Scale

The scope and scale of health services agreed upon in the SLA ranges from the provision of limited to full EHP, depending on the level and capacity of the respective CHAM health facility to render specific primary, secondary and tertiary health services and scope and scale of un-met need for health services as defined by the DHO of the respected District also in context of National priorities.

2.1.3 Eligibility

Eligible for a SLA are all CHAM member facilities that are duly registered with the Medical Council of Malawi and that (text box 4):

Text Box 4: SLA Eligibility Criteria

- ✓ Provide primary health care services outside eight kilometers radius of a non-paying facility or;
- ✓ Provide services within a eight kilometers radius of a non-paying facility but where the catchment population is higher than 7,000 persons or;
- ✓ Provide services in a hardship area; to be decided by DHO or;
- ✓ Offer complimentary secondary or tertiary health care services which are not available in the catchment area.

2.2 SLA Contract Partners and Stakeholders

2.2.1 SLA Contract Holders

The SLA is a legally enforceable contract between a Contracting Authority and a Private Sector Partner to provide a service for which the private

[1] SLAs differ from PPPs as defined in the national PPP-act in that they are not awarded as a result of a competitive bidding process.

partner is compensated in accordance with a pre-arranged plan in relation to the risk assumed and the value of the result to be achieved.

Text Box 5: Contract Holders SLA

- ✓ The District or City Council is the SLA '*Contracting Authority*' and is represented by the District Commissioner (DC) and the DHO.
- ✓ The CHAM Health Facility in the District is the '*Private Sector Partner or Provider*' and is represented by the facility proprietor and the facility administrator.

2.2.2 Stakeholders and Institutional Support Facilities

Although not directly involved as *SLA Contract Partners,* some actors are important for the successful conceptualization, policy development, oversight, verification, financing of the SLA as well as capacity building of the respective contract holders.

Central and Zonal MOH

As the steward of the health sector in Malawi, the MOH is an important stakeholder as it provides policy direction, guidance and standards of service delivery. The MOH provides important conceptual guidance on SLAs in close coordination and collaboration with the Secretariat of CHAM, monitors its implementation and measures and verifies their impact in terms of health outcomes for the population. Moreover, the MOH is responsible for setting financial thresholds for health services, for SLA budget allocations and to oversee and strengthen functionality and performance of DHOs and District Health Management Teams (DHMTs) through its Zonal Health Support Offices (ZHSO).

CHAM Secretariat

The CHAM Secretariat plays an important role to support SLA conceptualization, design and oversight on behalf of its members and in collaboration and partnership with the MOH at central, zonal and district levels. Furthermore, the CHAM Secretariat is responsible for executing all matters related to the MOU between the MOH and CHAM particularly with respect to HRM, payroll management and overseeing that its members adhere to government policies, quality standards of service provision and accepted levels of financial accountability and transparency. CHAM Secretariat is furthermore responsible for mobilizing members participation to engage and properly execute SLAs in good collaboration and partnership with the DHOs.

The PPP Technical Working Group

The PPP Technical Working Group (PPP-TWG) plays an important role to the MOH and CHAM. It is comprised of MOH officials, CHAM officials, Development Partners, NGO and private sector representatives. It is the forum at central level for public/private sector discussions on policy, planning and sector-wide issues affecting the private sector. The PPP-EG has two Task Teams: (1) the SLA Costing Task Team and; (2) the SLA Management Task Team. These guidelines are developed in consultation with, and implementation monitored by, the SLA Management Task Team.

2.3 SLA Implementation

2.3.1 Initiating SLAs

The need or opportunity for an SLA may be identified by the DHO and the CHAM health facility, based on a health mapping of the District health sector, a situation analysis of the Burden of Diseases (BOD) and an inquiry of un-met needs for rendering EHP services to population segments or areas in a District. Ideally, a mapping and situation analysis of the District is done in a participatory manner involving both the DHO and the CHAM facilities and is part of a regular health planning, monitoring and evaluation exercise (M&E).

SLA Assessment Criteria

The following criteria may be applied to consider usefulness and relevance to engage in a SLA (text box 6).

Text Box 6: Assessment Criteria to engage a SLA

- ✓ There is unmet need for health services in the catchment population due to:
  - The population does not have access to a government facility or any other facility that provides EHP services free of charge
  - Lack of resources at a government facility to an extent that it cannot provide the full range of EHP services;
  - Excess demand for services beyond the capacity of the government facility.
- ✓ All parties must be committed to engage into a SLA.
- ✓ The potential CHAM facility has adequate capacity to effectively deliver the services required.
- ✓ The District (or MOH) is able to guarantee funding for SLAs.

2.3.2 Health Facility Readiness Assessment

As a condition to provide service under a SLA, the CHAM health facility will need to have a valid accreditation with the Medical Council of Malawi. In addition, the health facility will be assessed by members of the DHMT supported by the ZHSO on a number of important criteria related to

organizational readiness and health services to be provided under the SLA (text box 7).

Text Box 7: Health Facility Assessment Criteria

- ✓ Availability of human resources with proper clinical skills;
- ✓ Available infrastructure and basic equipment;
- ✓ Organization, leadership and management;
- ✓ Safety and quality management;
- ✓ Out-patient and in-patient care;
- ✓ Maternity care;
- ✓ Secondary and tertiary care;
- ✓ Diagnostic and pharmaceutical services.

2.4 Finances

2.4.1 Costing

SLAs are based on Performance Based Financing (PBF). PBF is a payment modality whereby a fee is paid for quality services rendered by a health facility. All-in estimates of particular services are standardized, based on actual market prices (e.g. CMST, private pharmacies, etc.) and the average cost of these services of a representative sample of CHAM health facilities. Overhead costs such as utility expenses, fuel etc. is included in the costing, based on the SLA-client ratio. Costing of services is subject to a yearly review by the MOH in consultation with CHAM and is based on market price development of essential drugs and commodities. Review of the services cost may also be done within a year when there is a major economic change translating into an inflation rate of 30% or more.

2.4.2 Budget

The SLA budget estimate for districts and health facilities is determined based on an estimated per capita expenditure for essential services, multiplied by the catchment population of a district and health facility respectively. [2] In determining the actual SLA budget ceiling per district and health facility, the available funding through the MOH is also critical, which may differ from year to year depending on the SLA resource envelope.

2.4.3 Invoicing and Verification

The CHAM health facility submits a consolidated invoice to the DHO on a monthly basis. The invoices raised are based on a cost-sharing principle of the

[2] A separate document is available listing all CHAM health facilities eligible for SLA with their respective catchment population and indicative SLA budgets.

EHP unit prices agreed upon in the SLA. [3] The DHO is responsible for verifying and approving each invoice and making sure that all required documentation is complete and accurate. A final verification of the monthly invoices, before payment, will be carried out by an external monitoring team on behalf of MOH and its donors. [4]

Text Box 8: SLA Invoice: Required Documentation

- ✓ Referral letters ('coupon') from Health Surveillance Assistant (HSA);
- ✓ Signed and Valid SLA Contract;
- ✓ A consolidated summary invoice indicating total amount with breakdown of clients seen, numbers of patient records/files, investigations carried out and related fees.

2.4.4 SLA Payment Framework

A provisional and direct-payment framework is agreed upon which addresses recurrent weaknesses in the past which have hindered timely SLA payments to the CHAM Units.[5] The SLA payment framework follows the current well-functioning payment system for CHAM staff salary grants (refer text box 9).

Text Box 9: SLA Payment Framework

- ✓ The SLA budget will be held at the MOH/HSJF;
- ✓ Monthly SLA invoices and supporting documentation are confirmed and approved by the DHOs;
- ✓ Approved SLA invoices by DHO are verified and approved by an external monitoring team before submission to the MOH/HSJF;
- ✓ Monthly invoices are verified and approved by MOH/HSJF;
- ✓ Total approved SLA invoices are paid by MOH/HSJF directly to the CHAM Secretariat;
- ✓ CHAM Secretariat pays all CHAM units based on approved monthly SLA invoices.

No matter the source of financing, payment of SLAs may only be done based on a signed SLA. The DHO is required to verify and approve all SLA invoices including copies of all required documentation. All invoices and supporting documents will be reviewed by an external monitoring team on behalf of the MOH and the HSJF, before payment is made to the CHAM Unit via the CHAM Secretariat.

[3] The SLA contract template consists of a full list of agreed unit prices per interventions and diagnostics as well an overview of the fees that the health facility can charge for each intervention (fee structure).
[4] From July 2016 a new donor consortium, the Health Services Joint Fund (HSJF), will contribute to the financing of SLAs.
[5] The provisional direct-payment system will be reviewed in due time and possibly aligned with the existing decentralized payment system of the GOM.

2.4.5 Financial Administration and Reporting

The CHAM health facility is required to operate a robust financial administrative system to account for SLA expenditures in accordance with the Public Financial Management Act, Public Audit Act and the Public Procurement Act. Financial administration of SLA is subject to an annual external financial audit.

2.4.6 Accountability and Audits

Both, the DHO and the CHAM health facility will promote and maintain a climate of transparency, openness and mutual accountability in all transactions and share relevant information to keep each other informed. In addition, both parties will apply the national anti-corruption strategy and respect national legal instruments in this respect. SLA accounts and administration will be subject to an annual external audit.

2.5 Reporting, Supportive Supervision, Monitoring and Evaluation

To ensure effective implementation of the SLA a structured and regular system of reporting, supportive supervision, monitoring and evaluation will be instituted.

2.5.1 Reporting

CHAM health facilities will submit a monthly summary report on SLA implementation to the DHO. The DHO confirms receipt of the report and communicates follow-up action, if applicable. The DHO will submit a monthly consolidated summary report on progress and performance disaggregated by SLAs in the District to the ZSHO with copies to the MOH and the CHAM Secretariat.

2.5.2 Supportive Supervision

Supportive supervision will be conducted by the DHMT, ZHSO and CHAM Secretariat as part of their routine follow-up visits. Supportive supervision is focussed on strengthening individual staff capacity as well as supporting organisational and management capacity of the CHAM health facility.

2.5.3 Monitoring and Evaluation

M&E will be conducted by the DHMT, ZHSO and CHAM Secretariat as part of their routine M&E visits and periodic assessment. M&E will assess performance and outcome of SLA implementation. Additional M&E is may be conducted on an ad-hoc basis by development partners contributing to the SLA programme.

2.5.4 M&E Indicators

As the SLA aims to boost health service delivery of the health facility, its outcomes in terms of increased client utilisation rates of specific EHP services will be captured by the routine District Health Management Information System (DHMIS). A limited set of additional SLA Management indicators will be used to keep track of the extent, quality and effectiveness of the SLA contract management by the two contract parties as well as the degree in which the District SLA steering committee supervises implementation of the SLAs.

2.5.5 External Monitoring Team

Next to the routine supportive supervision and M&E carried out by the DHMT, ZHSO and the CHAM Secretariat, an external Monitoring Team may be instituted to verify progress of the SLA on behalf of development partners and donor agencies.