MALAWI HEALTH SECTOR PROGRAMME

TECHNICAL ASSISTANCE COMPONENT

PROGRESS REPORT INTRODUCING NEW SERVICE LEVEL AGREEMENTS

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ABBREVIATIONS

ADRS	Administrative and Dug Reimbursement System
AfDB	African Development Bank
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
DMT	District Monitoring Team
DPPD	Department of Policy and Planning (MOH)
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
HSJF	Health Services Joint Fund
HSSP	Health Sector Strategic Plan (2011-2016)
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
ODIS	Organizational Development and Institutional Strengthening
ORT	Other Recurrent Transaction
PBF	Performance Based Financing
PHC	Primary Health Care
POW	Program of Work
PPPs	Public-Private-Partnerships
PPP-EG	Public-Private-Partnership Expert Group
SDGs	Sustainable Development Goals
SH	Secretary of Health MOH
SLAs	Service Level Agreements
SWAp	Sector Wide Approach
SWOT	Strengths Weaknesses Opportunities and Threats Analysis
UHC	Universal Health Coverage
ZHSO	Zonal Health Support Office

1. INTRODUCTION

This section provides a brief background to the MHSP-TA , the MOU between the Ministry of Health and CHAM and the concept of and experiences with the Service Level Agreements.

1.1 The Malawi Health Sector Programme - Technical Assistance

The Malawi Health Sector Programme (MHSP), funded by DFID, provides support to the health sector of Malawi in the context of the Health Sector Strategic Plan 2011-2016 (HSSP) of the Ministry of Health (MOH). A sizeable component of the MHSP is a Technical Assistance programme (MHSP-TA) with the main aim to strengthen the health system in Malawi. The MSHP-TA is provided by an international development consortium led by Options Consultancy Services Ltd.

The recipients of the MSHP-TA are the MOH, other government entities such as the National Local Government Finance Committee (NLGFC) and the Christian Health Association of Malawi (CHAM). Following completion of the inception phase (mid-2014) it was agreed that MSHP-TA would focus on three key areas: Strengthen stewardship and action across the health sector (output 5.1.1); enhance financial management and democratic accountability in the health sector (output 5.1.2) and; strengthen health service planning and monitoring (output 5.1.3).[1]

1.2 Memorandum of Understanding MOH and CHAM

Over the years, the GOM has recognised the valuable contribution of CHAM in provision of health care to poor communities, in expanding health infrastructure to mainly hard to reach areas and CHAMs investments in training institutions for important cadres of health professionals. A first Memorandum of Understanding (MOU) between the MOH and CHAM (2002-2007) outlined specific GOM support modalities to enable CHAM to consolidate its complementary services to the health sector. However, this first MOU fell short of agreeing on clear eligibility criteria for CHAM health facilities to receive financial support for provision of essential health services, nor did it provide sufficient guidance for staff salary grants entitlements. This led to a situation where some CHAM facilities received unjustified financial support for their services and/or staff and an undesirable situation in which existing inequalities in access to essential health services wasn't properly addressed.

Based on the evaluation of the previous MOU, a revised agreement between the MOH and CHAM was negotiated from 2009 and a new MOU was recently agreed upon (January 2016) and will come into effect on 1st July 2016. The purpose of the MOU is to maximise the equity potential of GOM in working with CHAM to achieve its commitments to Universal Health Coverage (UHC) in Malawi and to advance national health outcomes through partnership and collaboration.[2]

The new MOU defines distinct obligations for both the MOH and the CHAM, underpinning the need for transparency, accountability and M&E, and adherence to national policies, guidelines and standards. While mutually agreeing on the above guiding principles, the MOU spells out that the GOM will pay for all staff salaries of eligible, accredited CHAM health facilities and will provide further financial support for infrastructural expansion, staff

[1] Refer to specific outputs of the logical framework MHSP-TA.

[2] Many CHAM facilities are located in rural areas, some in remote locations, where no state health service is available. GOM policy is to ensure that all Malawians have access to the services defined in the Essential Health Package (EHP) for free. Communities that lie within CHAM catchment areas currently cannot exercise this right, as CHAM facilities charge a fee to patients using their services.

development and specific SLAs of eligible CHAM units under the MOU, if applicable.[3] 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.

The new MOU more clearly defines CHAM health facilities eligible for GOM support: (1) all accredited primary healthcare facilities outside eight (8) KM distance from a non-paying (GOM) health facility taking into consideration the catchment population of 7,000 people or more, the terrain and the services offered by the health facility; accredited health facilities offering secondary and tertiary health services and; accredited medical training schools. For those eligible CHAM health institutions, the MOU essentially consolidates GOM financial support for staff grants and -emoluments; the provision of essential health services; student bursaries to attend CHAM heath training institutions and; investments in health infrastructure.

1.3 Service Level Agreements

A main instrument under the previous MOU was the introduction of the Service Level Agreements (SLA). SLAs were embraced as an important strategy in the Programme of Work of the SWAp, 2004-2010 (POW) and the Health Sector Strategic Plan, 2010-2016 (HSSP). 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 between the GOM represented by the District or City Council with an individual CHAM health facility, 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.

Since its introduction, a total of 80 CHAM health facilities have entered into an SLA but currently, only 49 SLAs are in operation. Of the current SLAs, 27 target maternal and newborn health services (MNH), 20 SLAs relate to provision of secondary services (including referral services), and two SLAs caters for specialist mental health services and full EHP services respectively.[4]

In 2014, MHSP-TA, together with GIZ, undertook a feasibility study of the SLA programme with the purpose to study the effect of SLAs on health service utilisation and to provide recommendations in view of changed and emerging national policies concerning Public-Private-Partnerships.

The main findings of the study concluded that: [5]

- Experience to date with SLAs, have demonstrated that government contracting of health services through CHAM greatly increases use of the services contracted for, in some cases by 600%;

[3] There are a few accredited CHAM facilities where salary payments will be stopped.
[4] Refer to 'Situation analysis of the SLA', MHSP-TA, Evidence for Change Solutions, February 2016.
[5] Refer to 'Feasibility Study for Future PPP Contracts with Christian Health Association of Malawi (CHAM) Health Facilities', Cindy Carlson and Elena Zanardi, June 2014.

- CHAM health facilities form an important part of the health sector. They help the Government of Malawi to achieve its Health Sector Strategic Plan (HSSP) objectives of increasing health service coverage and ensuring greater equity of access to services across the country. This is due to the fact that CHAM facilities are often based in remote, rural areas not covered by any other health facilities, amongst other reasons;
- CHAM also brings other advantages to the Malawi health sector, including well-staffed and equipped facilities, even in rural areas, offering 24/7 facilities; additional resources that are used for upgrading clinical skills, equipping facilities, improving infrastructure etc, above and beyond the resources provided by government;
- Analysis of Malawi's Burden of Disease and actual treatment provided indicates that there are still significant gaps in services for life saving health services, including maternity care and malaria prevention and treatment, and the Government needs all partners to help to fill these gaps;
- There have been significant challenges experienced with Government of Malawi SLAs with CHAM, mainly due to delayed reimbursement of CHAM invoices by government on the one hand, and occasional anomalies in the invoices submitted on the other;
- Besides contracting for specific services, the GOM pays most of CHAM's health staff salaries as part of the MOU between these two entities, but with no contract that lays out the expectations of what the Government should receive in return for paying these salaries.
- These challenges have led to higher levels of distrust between the Government and CHAM, and it is important now to 'reset' the relationship;
- One way to reset the relationship is to develop a more robust contractual relationship that clearly states the expectations and responsibilities of both parties, with firmer management arrangement in place to monitor the performance of CHAM as a contractual partner;
- The Feasibility Study examines different options available to the Government of Malawi and CHAM for both the content and process areas that should be covered under a new PPP mechanism. These include: What package should be contracted for (ranging from full EHP to partial elements of the EHP package); Payment modalities options; Overhead options; CHAM staff salary payments;
- SLAs (and the MOH-CHAM MOU) are not compliant with the new Malawi Public-Private Partnership Act which came into force in 2011.
- Weak human resource information systems in government and within CHAM, together with almost non-existent monitoring, have reduced confidence that the salary grant is always being used for paying the staff it is intended to pay;
- District health teams have had limited capacity to monitor the quality and scale of service provision agreed through SLAs.

The analysis and recommendations from this feasibility study have influenced MOH views with respect to the content and coverage of the new MOU with CHAM and changed the outlook with regards to entitlement, content and management of SLAs. As a result, GOM salary grants will only invest in those CHAM facilities that provide health services to catchment communities that live outside the 8KM radius of a government health facility, or which meet other eligibility requirements as defined in the MOU. In addition, a sub-set of CHAM facilities will be sub-contracted to provide full EHP service for free to their catchment population.

The government, in collaboration with CHAM, has needed to revise the structure and content of SLAs so that they reflect the changes agreed upon within the MOU. At the same time, stronger contract management and accountability arrangements need to be put in place so that the Government, CHAM and their funding partners can be assured that the investments made through these contracts are sound and achieving their purpose.

2. PRODUCT DEVELOPMENT NEW SLAs

This section provides an overview of the development of informational and administrative tools and methodologies to date in preparation of the new SLA programme.

2.1 Memorandum of Understanding

2.1.1 Finalizing and signing of new MOU

As noted above, in 2014, MHSP-TA, together with GIZ, undertook a feasibility study of the existing SLA programme. The study provided new impetus to effectively negotiate and conclude on a new MOU between the MOH and CHAM. After 5 years of deadlock, the new MOU was signed on 18th January 2016 and, with support from MHSP-TA, officially inaugurated on 11th March 2016.

2.1.2 Strategic Plan MOU Implementation

To date few steps have been undertaken to agree on a strategic plan ('Roadmap') to implement the new MOU and a clear and concise outline of strategies and milestones is still to be developed. This is largely because the focus is currently on the SLA component of the MOU. However, given the important obligations of the main partners of the MOU i.c. the central MOH and the CHAM Secretariat, it is important to reflect on these issues in the near future. The roadmap should be realistic also with respect to the organisational capacities of both agencies and their capacity to coordinate their efforts in a joint fashion. It is recommended that the roadmap also considers the best institutional entity to guide and verify MOU implementation and a well functioning PPP-Expert Group (PPP-EG) may be the best option in this regard.

2.2 Revision SLA Guideline

The existing SLA guideline was critically reviewed and a new SLA guideline was drafted and extensively discussed, reviewed and amended in a series of consultative meetings with technical resource persons and main stakeholders in the period February-May, 2016.[6] 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). A final draft was approved by the PPP-EG on 24th May and presented for approval to the MOH and the board of CHAM early June (Annex 1).

The SLA guidelines are particularly targeting stakeholders at the District level such as District/City officials, DHOs, DHMTs and owners and managers of CHAM health facilities. They provide them with a general introduction to SLAs with the purpose to sensitize them and to facilitate negotiations to enter into SLAs. The guidelines give a brief summary of scope, scale and eligibility of SLAs. Furthermore, the guidelines give a structured overview of main aspects and modalities relating to management, implementation, payment, administration and verification of SLAs. The guidelines explain SLAs in the context of the national strategy to advance partnerships between public and non-public agencies and the MOHs strategy to advance collaboration in the health sector.

2.3 Amendment of SLA Contract Template

The existing SLA contract template was critically reviewed and a revised template was drafted and extensively discussed, reviewed and amended in a series of consultative meetings with technical resource persons and main stakeholders in the period February-May, 2016. A final draft was approved by the PPP-EG on 24th May and presented for approval to the MOH and CHAM early June (Annex 2).

[6] MOH and CHAM, 'SLA Guideline, Version 1, 2012-2015'.

To improve the existing SLA contract template and to align it with the Public Procurement Act (2003) and the Public-Private Partnership Act (2010), additional sections (articles) were included clearly defining: (1) SLA contract parties; (2) obligations of the provider (CHAM health facility); (3) responsibilities of the contracting authority (District/City Council); (4) total SLA contract sum; (5) SLA management arrangements; (6) duration, termination, suspension, renewal and; (7) standard business practices. Finally, detailed information is provided on: (8) standard unit prices of all diagnostic and treatment interventions; (9) the fee structure per intervention, disaggregated by type of health facility; (10) a standard payment framework and; (11) the M&E framework with specific SLA management performance indicators.

It is anticipated that the new SLA contract template will provide sufficient direction to all parties to implement and manage SLAs and to handle disputes, if they arise. Minor modifications may be considered based on a review in the first year of implementation of the SLA programme.

2.4 Review SLA Costing, EHP Unit Prices and SLA Payment Framework

2.4.1 SLA Costing

MHSP-TA provided on-going facilitative support to the MOH to come up with allocation formula to calculate the required national SLA budget for the provision of a basic (minimum) EHP per capita. Based the national SLA budget calculation and depending on available resources, the MOH can determine the scope and scale of the EHP to be provided under the SLAs in the new budget year 2016/17. Details are currently being worked out before the Districts can be informed and new SLAs can be agreed upon and signed by first July 2016.
In addition to the SLA budget support from the MOH-HQ, Districts may have additional resources available through their ORT to improve scale and scope of EHP provision under SLAs also in relation to specific BODs.

2.4.2 Review EHP Unit Prices

SLAs is essentially a Performance Based Financing (PBF) system whereby a fee is paid for quality services rendered by a health facility. The review looked into the required input-costs for a defined set of diagnostic and treatment regimes for five patient categories: (1) adult non-surgical; (2) surgical; (3) children aged: 6-12 years; (4) children under 5-years of age and; (5) maternal and newborns. A detailed overview of the revised costs structure per patient category and per diagnostic and treatment regime has been worked out (Annex 3).

Review of particular services are standardized and based on price developments (e.g. CMST, private pharmacies, etc.) of medicines and essential commodities over the last year. Standard prices are based on average cost calculation of these services of a representative sample of CHAM health facilities. Overhead costs such as utility expenses, fuel etc. are included in the review. The revised EHP unit prices have been presented in the PPP-EG meeting on 24th May and is currently awaiting approval by the MOH and CHAM. It is proposed that the EHP unit prices will be evaluated and possibly amended after each year.

2.4.3 Payment Framework

With respect to the SLA management and financial administrative modalities, the MOH has approved a provisional direct-payment system. The proposed SLA payment framework attempts to addresses recurrent weaknesses in the past which have hindered timely SLA payments to the CHAM Units causing avoidable SLA debts and undermining the purpose of the SLA programme. The SLA direct-payment system follows the current well-functioning

payment system for CHAM staff salary grants. Over time it is expected that the payment system will be aligned to the decentralised payment system of the GOM.[7]

The main outline of the direct-payment system is as follows:

- The MOH (through the HSJF) is SLA budget holder. The yearly SLA budget is determined based on the total number of approved SLA contracts in the Districts and available SLA funding through various donor agencies (HSJF and others);
- Based on verification and approval of monthly SLA invoices by the respective DHOs and an independent monitoring team, the MOH pays the total monthly approved SLA invoices directly to the CHAM Secretariat;
- The CHAM Secretariat pays all CHAM units based on approved monthly invoices (DHO and MOH) on a monthly basis (bank transfers).

2.5 Performance Management Indicators

To keep track of SLA implementation, MHSP-TA drafted specific performance indicators, which are incorporated in the SLA contract template. The indicators 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 governance committees oversee SLA implementation. 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 (DHIS2). Hence, no outcome or impact indicators are therefore suggested as part of the SLA programme. The performance management indicators were presented and discussed in consecutive meetings of the SLA management task team, and submitted to the MOH and CHAM for approval.

2.6 SLA Implementation Plan 2016-17

With all preparatory work coming to a conclusion, work has started on drafting the outline of a realistic SLA implementation plan for 2016/17. A first outline was drafted and communicated with the MOH and CHAM Secretariat for input and discussion. It is proposed that the currently active SLAs (49) will be consolidated and part of the currently suspended SLAs (31), with a gradual expansion in number, scale and scope over years to come in line with aspirations of the MOH and CHAM and depending on: (1) availability of national MOH SLA budgets; (2) service readiness as well as management and financial-administrative capability of CHAM health facilities; (3) management and oversight capacity of the MOH, including ZHSO and DHOs and finally; (4) M&E and financial-administrative capability of the CHAM Secretariat. As soon as the national SLA budget 2016/17 is agreed upon, details of the first year implementation plan will be worked out indicating specific objectives, activities, strategies, outcomes and a well- defined and related M&E plan.

[7] The proposed payment system is in line with HSJF requirements.

3 MHSP-TA PROGRAMME SUPPORT

This section highlights the main contribution of the MHSP-TA with respect to capacity building and facilitating a consultative process to strengthen organizational performance of the MOH and CHAM Secretariat, a structured dialogue and mutual commitment and consensus with respect to preparation and implementation of a new nation-wide SLA programme.

3.1 Technical Assistance

In order to support the successful roll out of SLAs, the MHSP-TA, at the request of the MOH and CHAM Secretariat, has put in place two different teams. One team, comprising a senior international consultant and a Malawian counterpart, are working on reviewing, refining and leading all consultative processes, on all the SLA support documentation necessary to inform contracting at District level. A second team, a District Monitoring Team, is comprised of four Malawian consultants supported by a small group of data collectors. This team is tasked to verify, monitor and report on current SLA implementation. Over the period January to March 2016 they provided 'surge' support as it was clear that the MOH team were buried under invoice files and needed help with respect to get everything up to date and manage the huge SLA debts accumulated over the years.

3.2 Review and Refine SLA Support Documentation

MHSP-TA played a leading role in the revising of all SLA support documentation in preparation of the actual start of the program in July 2016 and the introduction of new SLA contracts and relationships nation-wide. Most of the preparations are completed and await decision and approval by the MOH and CHAM.

3.3 Capacity Support and Organisational Development

MHSP-TA provided technical support to various departments of MOH and the CHAM Secretariat, facilitated the effective functioning of various technical SLA task groups and promoted to invigorate the PPP-EG.

3.3.1 SLA Costing Task Team

The SLA Costing Task Team was established in October 2015 and is a sub-committee of the PPP-EG. The task team is comprised of technical resource persons from MOH, CHAM and other relevant organisations or agencies (e.g. pharmacies). The main responsibility of the task team was to review all EHP unit prices. The task team met several times and completed its review in May 2016. MHSP-TA operated as secretariat of the task team also providing technical, logistical and coordination support.

3.3.2 SLA Management Task Team

The SLA Management Task Team was re-established and is a sub-committee of the PPP-EG. The task team is comprised of representatives from central MOH, ZHSO, DHOs, CHAM health facilities and CHAM Secretariat. The task team was responsible for revision of the SLA guidelines, contract template and the M&E framework, including the review of performance management indicators. The task team met several times in the period October 2015 to May 2016 discussing and amending SLA documents. MHSP-TA operated as secretariat of the task team, and provided technical input and support in drafting all documents. Moreover, MHSP-TA provided the necessary logistical and coordination support. The TOR of the task team is currently under review to widen its responsibilities to also include support, guidance and oversight of the implementation of the new MOU.

3.3.3 PPP Expert Group

The PPP-EG is comprised of MOH officials, CHAM officials, development agencies, NGOs and private sector representatives. It is a national-level committee for discussion and advising the MOH on public-private collaboration and partnerships in the health sector. Although the PPP-EG could potentially play an important role in the health sector to facilitate a more robust public-private partnership agenda, it has been rather inactive over the last years. MSHP-TA has been providing technical, facilitative and logistical support to the PPP-EG to approve and oversee the preparatory work done on SLA documents by the various SLA task teams.

3.3.4 CHAM Secretariat MOU/SLA Desk

MHSP-TA has been instrumental in advocating for the establishment of a designated MOU/SLA desk within the CHAM Secretariat. The establishment of such a desk is important to cater for the extra workload under the MOU and the new SLA program. It is advised that the desk consists of sufficient number of qualified staff to manage, implement and monitor all related aspects of MOU/SLA program at national level in collaboration with the MOH. Moreover, the desk is to provide support, back-up and capacity building to all CHAM health facilities participating in the SLA programme. The desk is to work in close collaboration with functional departments of the CHAM Secretariat (finance, personnel, etc.). Core responsibilities of the desk are project management, capacity building, financial administration and M&E.

3.3.5 MOH-CHAM MOU/SLA Technical Project Team

MSHP-TA has been providing technical and facilitative support to MOH departments, particularly to the DPPD and is currently promoting the institution of a small MOU/SLA project team consisting of technical officers from the MOH and CHAM Secretariat. The main objective of the team is to drive MOU/SLA programme implementation. The team should also take on secretarial functions for existing MOU/SLA task forces as well as for the PPP-EG, a function that is currently executed by the MHSP-TA. The team should work in close collaboration with relevant departments of the MOH and CHAM Secretariat (DPPD, finance and administration, HR, etc.).

3.3.6 CHAM Constituency

MSHP-TA has been providing technical support to the larger CHAM community through preparation and facilitating regional consultative meetings to review the current SLA programme in preparation of a modified new SLA programme.

3.4 Situation Analysis of the SLAs

Early 2016, MHSP-TA conducted a situation analysis of the SLA programme. The situation analysis provided an accurate overview of the actual status of the SLA programme. It established the number of functioning and non-functioning SLAs as well an overview of related challenges.[8] Although about 80 CHAM facilities entered into SLAs, it was observed that only 49 SLAs were still in operation, the rest being cancelled or suspended due to non-payment of SLA invoices by the Government for various reasons.[9] An outcome of the situation analysis was the establishment by MHSP-TA of an independent District Monitoring team to regularly follow-up on SLA implementation and to particularly document and verify outstanding SLA debts accumulated over the years.

[8] Refer to 'Situation analysis of the SLA', MHSP-TA, Evidence for Change Solutions, February 2016.
[9] Reasons cited for non-payments of SLA invoices are: (1) insufficient and/or incorrect documentation to justify SLA invoices and; (2) insufficient district SLA budgets.

3.5 Verification and Payment SLA Debts

Necessitated by a systematic weakness of the M&E capacity in the health sector, the MHSH-TA instituted a District Monitoring Team (DMT) to monitor actual SLA implementation and to verify and report on the SLA debts accumulated over the previous years. The DMTs information proved indispensable for the MOH and CHAM to start resolving the accumulated SLA debt burden. MHSP-TA was able to follow up on SLA debts with the MOH, particularly with the Accounts department and the Department of Policy and Planning (DPPD) and CHAM Secretariat and to suggest practical solutions to reconcile discrepancies between the MOH records and the DMTs reports. Moreover, practical solutions were suggested to strengthen proper division of tasks between the various MOH departments and CHAM Secretariat involved, to improve verification protocols and to fast-track processing of outstanding payments. Finally, MHSP-TA was instrumental to facilitate the dialogue between the MOH and donor agencies and to suggest practical ways of settling the accumulated invoices in line with available resources (AfDB and HSJF).

Since February 2016, a considerable number of outstanding invoices for the period June 2015 to February 2016 have been paid, totalling MWK 181,197,925.00 representing 77% of total outstanding accumulated debts. A considerable number of invoices covering the same period and totalling MWK 50,107,445.93 is yet to be paid and still subject to review and approval by the MOH. The MHSP-TA is currently coordinating the collection and verification of SLA invoices for March 2016 up to June 2016 which will be paid centrally by MOH using the AfDB funding.

3.6 Assessment MHSP-TA Support

3.6.1 Relevance

Relevance of MHSP-TA to invigorate the SLA programme is appropriate. It is in line with the Government's policy on PPP and priorities and leading strategies and objectives of the public health sector in Malawi.[10] Scope and scale of actual MHSP-TA support is based at the request of main stakeholders and informed by: (1) a recent assessment of the current SLA programme with clear recommendations; (2) a continuing analysis ('SWOT') of the organizational and institutional context of the SLA programme and; (3) capacity concerns and –gaps of its main stakeholders; the MOH and CHAM at national, zonal and district level. Activities and outputs of MHSP-TA are consistent with attainment of the SLA programme objectives and aspirations.

3.6.2 Effectiveness

MHSP-TA has clearly and significantly contributed to provide guidance to conceptualize and agree upon the new MOU between the MOH and CHAM and to effectively mobilize stakeholders to revitalize the SLA concept. The advanced progress in developing new SLA tools and administrative frameworks can be clearly attributed to MHSP-TA and are effective considering recurrent capacity and resource constraints among the main stakeholders. An important element of these was the finalising the SLA costing documents with assistance from SLA task team members. This involved taking the list of inputs for each EHP condition that task team members agreed needed to be included, inputting these into Excel spreadsheet templates, tracking down the updated essential medicine and supply costs from CMST and private pharmacies and inputting these, linking all worksheets and coming up with summary treatment costs and overheads for each condition. Finally, the 'surge' support that MHSP-TA provided to assist the MOH to assess and manage the huge SLA debts, followed by regular M&E visits by the DMT was important and effective.

[10] Refer to Refer to: (1) 'Feasibility Study for Future PPP Contracts with Christian Health Association of Malawi (CHAM) Health Facilities', June 2014 and ; (2) The Health Sector Strategic Plan 2011-2016.

3.6.3 Efficiency

In general, MHSP-TA has applied an efficient mix of support modalities to achieve measurable results and outputs. The major support modalities have been: (1) long-term embedded capacity support through local TA; (2) short-term capacity support through local TA; (3) short-term international TA and; (4) financial and logistical support. Selection of a specific support modality is based on: (1) scale and scope of the problem to be addressed; (2) available expertise of stakeholders; (3) available resources of stakeholders and; (4) efficiency and strategy considerations.

3.6.4 Outcomes and Impact

MHSP-TA was effective in contributing to specific outcomes with regard to assessing the current SLA program and trouble shoot and manage specific elements of the programme, most notably the accumulated debt burden. Finally, MHSP-TA was instrumental in preparing important administrative tools for the new SLA programme and to mobilise MOH and CHAM to prepare, collaborate and agree on a new SLA programme. The impact of these achievements in terms of improved access to essential health services and enhanced national health outcomes is unclear at this moment. However, based on the evaluation of the current SLA programme, impact may be significant.

4. CHALLENGES and RECOMMENDATIONS

With respect to rolling out SLAs going forward, a number of challenges are foreseen and a focussed response of MHSP-TA, MOH and CHAM Secretariat is recommended.

4.1 MOH Stewardship

The MOH have been important to negotiate and agree upon the new MOU with CHAM and in conceptualising a revised SLA agenda to progress access to universal health for the Malawi population particularly in hard to reach areas. Stewardship of the MOH remains imperative to bring the PPP agenda forward, to implement all aspects of the MOU and to institutionalise the SLA agenda across the country. MOH leadership is furthermore required to: (1) mobilise engagement and provide guidance for the SLA agenda at zonal and district level, particularly among ZHSOs and DHOs; (2) improve institutional arrangements to govern and manage the MOU and the SLA agenda e.g. improve mandate and functioning of the PPP-EG; (3) improve organisational capacity and functionality of MOH departments central to the SLA programme e.g. the Accounting and Finance department (e.g. claim processing, etc.); (4) improve coordination and communication between various MOH departments concerned with the SLA programme, and lastly; (5) sustain engagement and commitment from the international donor community to finance the SLA programme in the longer run.

In view of these challenges, it is recommended that:

- MHSP-TA continues to provide Organisational Development and Institutional Support (ODIS) to MOH related to governing and managing all aspects of MOU and SLAs;
- MHSP-TA continues to support the M&E of the SLA programme through continued support of the external DMT (refer to 3.5);
- MHSP-TA provides technical support to the NLGFC when the provisionally agreed direct-payment system will be aligned with the decentralised GOM payment systems;
- The MOH, in partnership with CHAM Secretariat, firmly supports the effective functioning of the MOU/SLA technical project team in order to drive MOU/SLA programme implementation (refer to 3.3.5);
- The MOH, in partnership with CHAM Secretariat, enables the active operation of the PPP-EG, possibly under a new and revised mandate (TOR).

4.2 CHAM Secretariat

The CHAM Secretariat has been successful to negotiate a new MOU and to argue for a continuation and extension of the current SLA programme. In agreeing to the new terms of the MOU and an extension of the SLA programme, it is paramount that the Secretariat reviews some of its internal organisational and management structures to fulfil its obligations under the new MOU and to effectively implement the SLA programme such as: (1) HRM, including HR establishment and staff payroll management; (2) financial administration and; (3) M&E, including operational research. Apart from these operational aspects, CHAM may consider to review the role of the Secretariat to become more oriented towards lobby and advocacy for health policy development and –change, rather than being primarily a client-service oriented organisation.

Next to review of the Secretariat's organisational and management structures, the Secretariat needs to develop a concise program to build capacities of its health coordinators and health facilities in the areas of: (1) health facility management and governance; (2) personnel management; (3) financial administration; (4) service readiness including quality aspects; (5) participation with DHOs/DHMTs and; (6) M&E (DHMIS).

In view of these challenges, it is recommended that:

- MHSP-TA continues to provide broad ODIS support to CHAM related to governing and managing the MOU and the SLA programme and to improve relevance and functionality of the Secretariat, the health coordinating offices and the CHAM health facilities;
- The Secretariat firmly supports the effective functioning of the new internal MOU-SLA desk to drive and coordinate MOU/SLA programme implementation within CHAM and in collaboration with the MOH (refer to 3.3.4);

4.3 CHAM Health Facilities

Service performance of many CHAM health facilities with respect to current SLAs is in various degrees hampered by: (1) insufficient number, mix or capacity of professional medical staff; (2) lack of adequate laboratory services; (3) inadequacy of other resources such as finances, drugs and other essential amenities (power and water supply, basic equipment, etc.) and, in the case of health facilities operating an Administrative and Drug Reimbursement System (ADRS) under the SLA; (4) persistent stock-outs or late replenishment of some drugs at the Central Medical Stores (CMST). In addition, many health facilities do not receive adequate supportive supervision from DHMTs and ZHSOs, and are generally not very cognizant about status of the SLA programme and the resolution of outstanding debts due to poor communication with the DHOs and the CHAM Secretariat respectively.

In view of these challenges, it is recommended that:

- The MHSP-TA provides support to CHAM Secretariat and ZHSOs to improve a systematic and integrated approach toward supportive supervision including development of TORs, protocols and M&E;
- The MHSP-TA provides support to the ZHSO to conduct quarterly SLA review meetings involving all major stakeholders concerned;
- The CHAM Secretariat finalises the current staff establishment review asap and negotiates with the MOH feasible increases in essential staff positions;
- The CHAM Secretariat continues to provide broad support to its health facilities related to improving and maintaining service readiness;
- The CHAM Secretariat updates its information and communication strategy.

4.4 SLA Debt Settlement

Late settlements of debts have clearly affected SLA service performance of CHAM health facilities. Although a significant percentage of SLA debts have been settled related to the period June 2015 to February 2016, there remains an amount of MWK 50 Million still to be settled (refer to 3.5). In addition, another debt, accumulated over the period 2010 to June 2015, is still outstanding and amounts to an estimated MWK 218 Million. As the AfDB declined to pay these debts, a new funding source is yet to be identified. This continuing unresolved and outstanding debt burden has contributed to financial challenges in a number of CHAM facilities and clearly undermined motivation of some CHAM health facilities to engage in a new SLA programme.

In view of unresolved debt burden, it is recommended that:

- MHSP-TA continues to provide facilitative support through the DMT, CHAM Secretariat and MOH to update and resolve outstanding SLA debts amounting to an estimated MWK 268 Million, as well as processing current SLA invoices;
- The MOH seeks donor support (DFID, etc.) to settle outstanding SLA debts prior to June 2015.

4.5 Sustainability of SLA Programme

Sustainability of the SLA programme is highly insecure as its major financing is fully donor dependent and current donor commitment is only secured up to the end of 2016 (AfDB and HSJF). The government's own SLA tax-based funding through the DHO is limited and often diverted to finance other recurrent costs. In the short run, additional donor funds may be contracted however this requires a committed and targeted intervention from the MOH. In the longer run is seems unavoidable to look into more sustainable health financing options, including a tax-based health insurance.

In view of the challenges, it is recommended that:

- MHSP-TA engages with the MOH and other main stakeholders to look into feasible long-term financing options for the health sector, including the establishment of a tax-based health insurance.
- The MOH seeks long-term financial (donor) support to finance a SLA programme across Malawi beyond 2016.

5. CONCLUSIONS and WAYS FORWARD

MHSP-TA has effectively facilitated a focussed effort to: (1) renew the obsolete MOU between the MOH and CHAM; (2) review the current SLA programme and come up with recommendations for improvement; (3) develop and approve new SLA guiding documents; (4) engage and commit main stakeholders and build their organisational and individual capacities and finally; (5) address unresolved issues of current SLA programme particularly related to the huge debt burden.

5.1 Conclusions

Based on the work undertaken so far, the following conclusions can be drawn:

- With the signing of the new MOU between the MOH and CHAM, the GOM strengthens its obligation to implement a meaningful PPP agenda in the health sector. The new MOU provides a robust contractual relationship that clearly states the expectations, roles and responsibilities of both parties, with firmer management arrangement in place to monitor the performance of the MOH and CHAM as contractual partners;
- With the signing of the new MOU and the commitment to invigorate and finance an extended SLA programme across the country, the GOM confirms its appreciation for CHAG as a strategic partner in the health sector in its contribution to increasing health service coverage and ensuring greater equity of access to services across the country, particularly in remote and rural areas not covered by any other health facilities;
- The MOH has approved the updated SLA guidelines and the revised SLA contract template which are now compliant with the relevant PPP Act.
- The SLA contract template provides a robust contractual relationship that clearly states the expectations, roles and responsibilities of both parties, elaborating firm management and governance arrangement to monitor SLA implementation and performance of partners;
- Recurrent challenges with respect to delayed reimbursement of CHAM invoices by GOM have hindered the current SLA programme. Although about 70% of accumulated SLA debts for the period 2015/16 have been settled in the past months, overall there remains uncertainty about payment of significant number of outstanding invoices, and this may affect enthusiasm among some CHAM health facilities to participate in the new SLA programme.
- Financing of the SLA programme for the current budget year 2016/17 is likely to be secured through AfDB and HSJF. However, longer-term financing is yet to be identified.

5.2 Immediate Next Steps

With the approval by the MOH of the revised SLA guidelines and SLA contract template, the preparatory phase is about to be concluded and the SLA programme can enter a next phase of actual implementation.

5.2.1 Formulation SLA implementation plan 2016/17

A realistic SLA implementation 2016/17 needs to be worked out and approved by the end of June. A first draft is currently being discussed with the MOH and CHAM Secretariat based on a consolidation of current number and scope of active SLAs (49) and a renewal of part of currently suspended SLAs (31). As soon as the national SLA budget 2016/17 is agreed upon and actual district SLA budgets are determined, details of the 2016/17 action plan will be worked out indicating specific strategies, objectives, outcomes and activities. Part of the 2016/17 action plan is a focussed sensitization plan to inform and engage district stakeholders. Finally, a comprehensive M&E plan should be developed indicating a clear outline how and when to validate progress and performance of respective SLAs and the SLA programme as a whole.

5.2.2 SLA Budget 2016/17

Importantly, the total SLA budget 2016/17 has to be determined and approved by the MOH asap, also specifying total SLA budgets per District and respective CHAM health facilities. Currently there is only an indicative National budget projection based on a per-capita formula.

5.2.3 District SLA Negotiations 2016/17

Immediately after approval of district-based SLA budgets and possibly as part of the sensitization exercise, negotiations between districts and CHAM health facilities need to be facilitated to conclude and agree upon individual SLAs. A realistic action plan needs to be agreed upon to conclude this exercise in the period July to September 2016. It is expected that the current active SLAs (49) may be extended without too much trouble, whereas contract partners of the currently suspended SLAs may need some assistance from either the ZHSO or from the CHAM Secretariat to agree on new SLAs.

5.2.4 Agreeing and Working-out Operational Modalities

It is expected that detailed operational modalities of various aspects of the SLA programme will need to be agreed upon and further developed or refined such as the most functional and effective payment arrangements, financial-administrative modalities and M&E arrangements.

ANNEX I SLA GUIDELINE

ANNEX II SLA CONTRACT TEMPLATE