Malawi CTAP II - *Country Specific Health Sector Accountability Report*

CTAP
COVID-19 TRANSPARENCY & ACCOUNTABILITY IN AFRICA

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List of Acronyms

CHAM:	Christian Health Association of Malawi
COVID 19:	Corona Virus Disease 2019
CSOs:	Civil Society Organisations
CTAP:	COVID-19 Transparency and Accountability in Africa Project
DEHO:	District Environmental Health Officer
DHMT:	District Health Management Team
DIP:	District Implementation Plan
DC:	District Commissioner
DHO:	District Health Officer
DNO:	District Nursing Officer
ESH:	Essential Health Package
FBO:	Faith Based Organization
HFS:	Health Financing Strategy
HMC:	Health Management Committee
HRH:	Human Resources for Health
HSSP II:	Health Sector Strategic plan II
MoH:	Ministry of Health
NGO:	Non-Governmental Organization
NHA:	National Health Account
NHP:	National Health Policy
PE:	Protective Equipment
PEFA:	Public Expenditure and Financial Accountability
PLWDs:	People Living with Disabilities
WHO:	World Health Organization

Executive Summary

The COVID-19 Transparency and Accountability in Africa Project (CTAP) was commissioned as a civil society-led effort to bolster citizen engagement and promote change in the ways that governments use public resources, and increase the capacity of governments to meet people's needs. **CTAP is collaboration between BudgIT, Connected Development (CODE), Global Integrity, as well as partners in 7 African countries: Cameroon, Ghana, Kenya, Liberia, Malawi, Nigeria, and Sierra Leone. Under CTAP phase I (2020 - 2021), these partners used a combination of approaches to generate information on how COVID-19 funds were used by governments and leveraged that information to advocate and collaborate with governments to bring about change.** In CTAP phase II, these partners worked with diverse stakeholders including government and communities to institute mechanisms for health sector accountability, foster effective & equitable COVID-19 vaccine distribution, and mount effective advocacies that focus on the mainstream health sector's best practices in focal countries.

This study, commissioned under CTAP II, is a baseline evaluation of Malawi's healthcare systems from the lenses of accountability, governance structures, political economy, fiscal management and financing, reforms, legislative oversight, and citizen engagement and access to healthcare. The study was conducted in four districts: Blantyre, Zomba, Phalombe, and Lilongwe, where over 65 respondents were interviewed.

Summary of Key Findings

The study established at least ten major findings:

1. The study discovered that healthcare delivery in Malawi is mainly via government facilities (63%), which have some service limitations but are free at the point of access. Healthcare is also delivered by the Christian Health Association of Malawi (CHAM; 26%) for a small user fee, and by private for-profit and civil society providers (11%).[1]

2. The study revealed that healthcare services delivery in Malawi is guided by the Health Sector Strategic Plan II 2017–2022 (HSSP II). The HSSP II has eight strategic objectives for Malawi's health sector: health service delivery, socio-economic determinants, infrastructure and medical equipment, human resources, medicines and medical supplies, health information systems, governance, and health financing.

3. The study confirmed that the health sector in Malawi faces some challenges concerning accountability. The question of accountability entails three things. Firstly, a demand for demonstrable results (improvements in health outcomes). Secondly, funding relationships i.e.

where public money is being spent must be accounted for. Thirdly, where funding is provided by external development partners (i.e. donors) effective governance is also demanded and implemented.

4. The study ascertained that access to healthcare services in Malawi is hampered by the following factors: costs, insufficient healthcare resources, and attitudinal barriers.

5. The study substantiated that healthcare access for PLWDs is affected by the following barriers: costs of transportation, disability exclusion infrastructures, communication barriers like failure to use sign language and braille in the health facilities, and attitudinal barriers.

6. The study demonstrated that there are several political, bureaucratic and political economy barriers affecting the implementation of health sector reforms in Malawi.
These include pressure from donor agencies, pressure from citizens, and a lack of political will to veto health sector reforms.

7. The study attested that although the government of Malawi has signed the Abuja Declaration to commit at least 15% of the national budget to health, it has consistently failed to meet this demand over the years.

8. The study indicated that citizen's voices on healthcare access and quality can be effectively realized through the Health Management Committees (HMCs) which serves as vehicle for identification and transmission of concerns from citizens and users to health worker, providers and authorities.

9. The study found out that the communities' vision of quality healthcare system in Malawi will be achieved when all their health needs are met. For this to be accomplished, there has to be a sufficient number of health personnel who are qualified to perform various health tasks, good healthcare infrastructure that caters for all aspects of health, availability of medications, and timely and effective delivery of healthcare services.

10. The study established that despite efforts to train healthcare workers, the government has failed to employ and retain sufficient number of health workers; consequently, leading to a perpetual shortage of health workers in the country.

Recommendations

The study made several recommendations and call to action for government and Civil Society Organizations (CSOs). These recommendations were structured under 4 strands: Health sector reforms, healthcare accessibility, Health Management Committees, as well as financial and fiscal management. Some of these recommendations under these themes include:

1. The improvement of bureaucratic interests which determines the pace and actual implementation of health sector reforms. Although donor organizations take a leading role in transferring health sector reforms to Malawi, the speed at which they are implemented depends on the general bureaucratic interest, institutional capacities and the general cultural environment within which such reforms are implemented.

Therefore, this calls for a mindset change for policy makers not to consider health sector reforms as implying a loss of resources, power, influence and control which are highly valued in Malawi due to the hierarchical power structure of the healthcare[9] system. Instead, the government should implement people-centered and health system responsive Universal Health Coverage (UHC) reforms.

2. The government should improve the quality of health care services at government health facilities as this is where most poor people access health services. This is also the primary route towards achieving universal health coverage.

3. The need for a distinguishable mandate of citizens groups i.e. HMCs in the accountability landscape, including the types of issues HMCs could monitor. This also entails coalition building for CSOs working in the health sector to ensure transparency and accountability.

4. The government to facilitate the progress

towards universal access to health care by developing a comprehensive health financing policy and strategy as recommended in the 56 th WHO Regional Committee resolution 2 on health financing and the Ouagadougou Declaration. 3

5. The Ministry of Health and its donor partners should increase allocation and spending on capital items such as infrastructure, medical equipment, training, and research, which could lead to improved quality of health services.

6. The use of Health Surveillance Assistance (HSAs) to expand access to basic health services and information within communities to improve health outcomes. Malawi has adopted progressive strategies and scaled up innovative ways that offer lessons for community health investments like using HSAs in the countrywide COVID 19 awareness and vaccination campaign. Hence, this entails the need to recruit, train, and deploy more HSAs into the communities where people live.

7. The government and CSOs should address the recurring shortages of essential medical products and technologies in the healthcare system in Malawi. This can be achieved by addressing the causative factors of the chronic stock-outs of essential medical products such as: inadequate funding, weak supply chain management, and irrational use of medicines, leakage and pilferage.

8. The need to address inequalities in health outcomes and health access by improving social determinants in the country like wealth status, education, gender, the welfare of marginalised groups like People Living with Disabilities (PLWDs), and geographical location.

9. Staff motivation and an enabling environment are crucial factors for retaining healthcare workers in the Malawian health system. Many of the factors underlying contributing to low levels of retention of healthcare workers can be addressed by improved management practices and the introduction of fair and transparent policies.
Managers need to be trained and equipped with effective managerial skills and staff should have access to equal opportunities for upgrading and promotion. There is also a need for continuous effort to mobilise the resources needed to fill gaps in basic equipment, supplies, and medicine, as these are critical in creating an enabling environment for healthcare workers.

10. The enhancement of the revenue generation potential for innovative healthcare financing in Malawi. This implies deliberate efforts at expanding the country's fiscal space for healthcare to focus on efficiency measures, particularly governance and public financial management.

SECTION ONE

Background and Methodology

1.0 BACKGROUND

It has been observed that African governments' response to COVID-19 has been characterised by instances of mismanagement, waste and blatant corruption. Issues such as unlawful procurement, political use of monetary and other reliefs, and the diversion of funds have led many communities to deal with the hardship of the pandemic in economic and social isolation. This has further affected citizens' trust in government, reproduced social divisions, and increased inequality, leaving countries in a poor position to promote economic recovery. To address this, the COVID-19 Transparency and Accountability in Africa Project (CTAP) was commissioned as a civil society-led effort to bolster citizen engagement and promote change in the ways that governments use public resources, and increase the capacity of governments to meet people's needs.

CTAP is a collaboration between BudgIT, Connected Development (CODE), Global Integrity, as well as partners in 7 African countries: Cameroon, Ghana, Kenya, Liberia, Malawi, Nigeria, and Sierra Leone. Under CTAP phase I (2020 - 2021), these partners used a combination of approaches to generate information on how COVID-19 funds were used by governments and leveraged that information to advocate and collaborate with governments to bring about change. In CTAP phase II, these partners will work with diverse stakeholders including government and communities to institute mechanisms for health sector accountability, foster effective & equitable COVID-19 vaccine distribution, and mount effective advocacies that focus on the mainstream health sector's best practices in focal countries.

1.1 PURPOSE OF THIS RESEARCH

This study was therefore commissioned under CTAP II to evaluate Malawi's healthcare systems from the lenses of accountability, governance structures, political economy, fiscal management and financing, reforms, legislative oversight, and citizen engagement and access to healthcare. The study was carried out in Malawi.

1.2 RESEARCH QUESTIONS

In line with the purpose of this study, there are five research questions this study tried to respond to. These are:

1. What are the healthcare governance structures, systems and processes at the national and subnational levels in Malawi including tiers of responsibility (management, funding and policy), and roles of health sector stakeholders?

2. What are the features and extent of reforms in Malawi's health sector including an analysis of the nature of political, bureaucratic and political-economy barriers and extent of corruption?

3. What is the role and impact of oversight institutions on health sector systemic efficiency including the nature of procurement practices?

4. In what ways has healthcare financing and fiscal management at national and subnational levels evolved including the existing financing patterns, forms of expenditure, gaps and issues of citizen participation and accountability?

5. What is citizen's access to healthcare and their perception of quality healthcare as a public good?

1.3 METHODOLOGY

This section of the final report presents a detailed research methodology that was used in the research study.

1.3.1 RESEARCH DESIGN

The research design for this study consisted of both desk research (literature review) and field research (empirical approach). The desk research was aimed at collecting data from secondary sources while field research was aimed at collecting data from primary sources through interviews and Focus Group Discussions (FGDs).

The research further employed a mixed design approach consisting of qualitative and quantitative research methods.

1.3.2 DATA COLLECTION METHODS

The following data collection methods were used: literature review, key informant interviews, and Focus Group Discussion (FGDs).

1.3.2.1 LITERATURE REVIEW

The study reviewed key documents pertaining to the health sector in Malawi and pertinent to the topic under investigation, namely: "Malawi Health Sector Accountability Report." The documents included:

- Health sector strategic plan II 2017–2022. Lilongwe: Ministry of Health.[4]
- Fresh money for health? The (false?) promise of "innovative financing" for health in Malawi.[5]
- Foreign aid, Cashgate and trusting relationships amongst stakeholders: key factors contributing to (mal) functioning of the Malawian health system.[6]
- Challenges to effective governance in a low-income healthcare system: a qualitative study of stakeholder perceptions in Malawi.[7]
- Non-use of formal health Services in Malawi: perceptions from non-users.[8]
- The Demand for Private Health Insurance in Malawi.[9]
- Understanding the barriers to setting up a healthcare quality improvement process in resource-limited settings: a situational analysis at the medical Department of Kamuzu Central Hospital in Lilongwe, Malawi.[10]
- Policy transfer and service delivery transformation in developing countries: the case of Malawi health sector reforms.[11]
- Transportation barriers to access health care for surgical conditions in Malawi a cross sectional nationwide household survey.[12]
- Socio-cultural predictors of health-seeking behaviour for febrile under-five children in Mwanza-Neno district, Malawi.[13]

4. Government of the Republic of Malawi. Health sector strategic plan II 2017–2022. Lilongwe: Ministry of Health; 2017.
5. Chansa, C., Mwase, T., Matsebula, T. C., Kandoole, P., Revill, P., Makumba, J. B., & Lindelow, M. (2018). Fresh money for health? The (false?) promise of "innovative financing" for health in Malawi. Health Systems & Reform, 4(4), 324-335.
6. Adhikari, R., Sharma, J. R., Smith, P., & Malata, A. (2019). Foreign aid, Cashgate and trusting relationships amongst stakeholders: key factors contributing to (mal) functioning of the Malawian health system. Health policy and planning, 34(3), 197-206.
7. Masefield, S. C., Msosa, A., & Grugel, J. (2020). Challenges to effective governance in a low-income healthcare system: a qualitative study of stakeholder perceptions in Malawi. BMC health services research, 20(1), 1-16.
8. Munthali, A. C., Mannan, H., MacLachlan, M., Swartz, L., Makupe, C. M., & Chilimampunga, C. (2014). Non-use of formal health Services in Malawi: perceptions from non-users. Malawi medical journal, 26(4), 126-132.
9. Makoka, D., Kaluwa, B., & Kambewa, P. (2007). The Demand for Private Health Insurance in Malawi.
10. Agyeman-Duah, J. N. A., Theurer, A., Munthali, C., Alide, N., & Neuhann, F. (2014). Understanding the barriers to setting up a healthcare quality improvement process in resource-limited settings: a situational analysis at the Medical Department of Kamuzu Central Hospital in Lilongwe, Malawi. BMC Health Services Research, 14(1), 1-10.
11. Tambulasi, R. I. C. (2011). Policy transfer and service delivery transformation in developing countries: the case of Malawi health sector reforms. The University of Manchester (United Kingdom).

- Access to health care for people with disabilities in rural Malawi: what are the barriers?[14]
- Allocating resources to support universal health coverage: policy processes and implementation in Malawi.[15]
- Spatial disparities in impoverishing effects of out-of-pocket health payments in Malawi.[16]
- Informal social accountability in maternal health service delivery: a study in northern Malawi.[17]
- Design and implementation of a health management information system in Malawi: issues, innovations and results.[18]
- A strategic approach to social accountability: Bwalo forums within the reproductive maternal and child health accountability ecosystem in Malawi.[19]
- "We come as friends": approaches to social accountability by health committees in Northern Malawi."[20]
- Health financing in Malawi: evidence from national health accounts.[21]
- Health financing at district level in Malawi: an analysis of the distribution of funds at two points in time.[22]
- The supply and distribution of essential medicines in Malawi.[23]

1.3.2.2 KEY INFORMANT INTERVIEWS

15 semi-structured interviews and/or meetings were held with people with a senior management role in the health sector in Malawi. Respondents included an official from the Ministry of Health, District Health Officer (DHO), District Health Management Team members, Director of Health and Social Services, District Environmental Health Officer (DEHO), District Health Administrator, Hospital Administrator, District Nursing Officer (DNO), Human Resource Officer, District Pharmacist, District Hospital Procurement Officer, Health Sector Thematic Committee Chairpersons, District COVID-19 vaccines Chairpersons, People Living with Disability thematic area chairpersons, and Accountability and Transparency Thematic area chairpersons, community leaders, Health Center advisory committees and, Civil Society Organisations implementing health budget tracking, human rights and accountability projects.

1.3.2.3 FOCUS GROUP DISCUSSIONS

The study conducted a total of four Focus Group Discussions (FGDs). They took place in Blantyre, Zomba, Phalombe, and Machinga. The Focus Group Discussions were conducted from 24th March to 1 April 2022.

FGDs addressed research theme (e) question number 5 (citizen's access, perception to healthcare etc.), and their participation in healthcare budget and expenditure (an element under research question number 4) in Malawi.

FGDs involved the following groups of participants: Health centre in-charge, health centre data clerks, health management committees, representatives of CSOs working in the health sector, and community leaders.

1.3.3 SETTING OF THE STUDY

The study was conducted in four districts of Malawi- Blantyre, Zomba, Phalombe, and Lilongwe.

12. Varela, C., Young, S., Mkandawire, N., Groen, R. S., Banza, L., & Viste, A. (2019). Transportation barriers to access health care for surgical conditions in Malawi a cross sectional nationwide household survey. BMC public health, 19(1), 1-8.
13. Chibwana, A. I., Mathanga, D. P., Chinkhumba, J., & Campbell, C. H. (2009). Socio-cultural predictors of health-seeking behaviour for febrile under-five children in Mwanza-Neno district, Malawi. Malaria journal, 8(1), 1-8.
14. Harrison, J. A., Thomson, R., Banda, H. T., Mbera, G. B., Gregorius, S., Stenberg, B., & Marshall, T. (2020). Access to health care for people with disabilities in rural Malawi: what are the barriers?. BMC public health, 20(1), 1-17.
15. Twea, P., Manthalu, G., & Mohan, S. (2020). Allocating resources to support universal health coverage: policy processes and implementation in Malawi. BMJ Global Health, 5(8), e002766.
16. Mulaga, A. N., Kamndaya, M. S., & Masangwi, S. J. (2022). Spatial disparities in impoverishing effects of out-of-pocket health payments in Malawi. Global Health Action, 15(1), 2047465.
17. Lodenstein, E., Ingemann, C., Molenaar, J. M., Dieleman, M., & Broerse, J. E. (2018). Informal social accountability in maternal health service delivery: a study in northern Malawi. PLoS One, 13(4), e0195671.
18. Chaulagai, C. N., Moyo, C. M., Koot, J., Moyo, H. B., Sambakunsi, T. C., Khunga, F. M., & Naphini, P. D. (2005). Design and implementation of a health management information system in Malawi: issues, innovations and results. Health policy and planning, 20(6), 375-384.
19. Butler, N., Johnson, G., Chiweza, A., Aung, K. M., Quinley, J., Rogers, K., & Bedford, J. (2020). A strategic approach to social accountability: Bwalo forums within the reproductive maternal and child health accountability ecosystem in Malawi. BMC health services research, 20(1), 1-16.
20. Lodenstein, E., Molenaar, J. M., Ingemann, C., Botha, K., Mkandawire, J. J., Liem, L., ... & Dieleman, M. (2019). "We come as friends": approaches to social accountability by health committees in Northern Malawi. BMC health services research, 19(1), 1-14.
21. Zere, E., Walker, O., Kirigia, J., Zawaira, F., Magombo, F., & Kataika, E. (2010). Health financing in Malawi: evidence from national health accounts. BMC international health and human rights, 10(1), 1-11.

1.3.4 SAMPLE SIZE

The sample size for the study was 65 participants. 20 healthcare workers participated in the study, and they came from District, Community and Private Hospitals in Malawi. Their interview focused on the following themes: health sector governance, political economy of the health sector, legislative oversight, and financing and fiscal management. These themes are under research questions number (1-4).

The study interviewed 10 community leaders in order to obtain data regarding research theme (e) question number 5 (citizen's access, perception to healthcare etc.), and their participation in healthcare budget and expenditure (an element under research question number 4) in Malawi. Focus Group Discussion[24] were conducted with the community leaders.

The study also interviewed 10 members of the Health Management Committee (HMCs) and obtained data for research theme (e) question number 5 (citizen's access, perception to healthcare etc.), and their participation in healthcare budget and expenditure (an element under research question number 4) in Malawi. Focus Group Discussions[25] were conducted with the HMCs.

The study also interviewed 10 representatives of CSOs working in the Health Sector in Malawi.

Data was obtained for the research theme (e) question number 5 (citizen's access, perception to healthcare etc.), and their participation in healthcare budget and expenditure (an element under research question number 4) in Malawi. Focus Group Discussions[26] were conducted with the representatives of the CSOs.

The study also interviewed 15 key informants drawn from the national and district levels of the health sector in Malawi. Their interview focused on the following themes: health sector governance, political economy of the health sector, legislative oversight, and financing and fiscal management. These themes are under research questions number (1-4).

1.3.5 DATA ANALYSIS

The data for the study was analysed by using both qualitative and quantitative techniques. Qualitative data were analysed by using thematic analysis approach while quantitative data was analysed using SPSS.

1.3.6 ETHICAL CONSIDERATIONS

Four ethical considerations were adopted when conducting this research study: protection from harm, right to privacy, professional conduct, and informed consent.[27] In the context of the COVID-19 pandemic, the study adopted ethical considerations that enhanced COVID-19 prevention both for the researchers and participants.[28]

24. *Wong, L. P. (2008). Focus group discussion: a tool for health and medical research. Singapore Med J, 49(3), 256-60.*
25. *Ibid.*
26. *Ibid.*
27. *Leedy, P. D., & Ormrod, J. E. (2001). Practical research: Planning and research. Upper Saddle.*
28. *https://www.idrc.ca/en/research-ethics-practices-during-covid-19, (Accessed 20 March 2022)*

SECTION TWO

Health Sector Overview, Governance And Stakeholders

2.0 INTRODUCTION

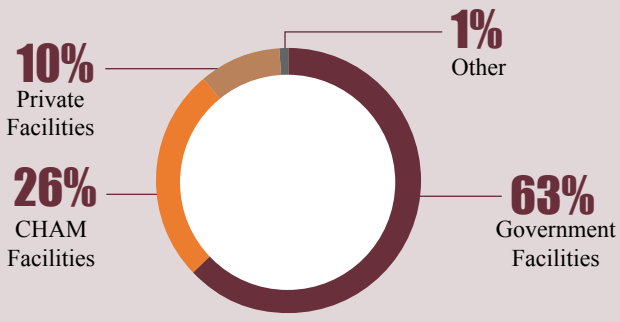
This section of the study presents the health sector overview, governance, and stakeholders.

2.1 THE HEALTH SECTOR OVERVIEW

Malawi is one of the poorest countries in the world.[29] It has low per capita spending on health of 39.2 USD, which is significantly lower than the Sub-Saharan Africa average of 98 USD.[30]

Healthcare delivery is mainly via government facilities (63%), which have some service limitations but are free at the point of access. Healthcare is also delivered by the Christian Health Association of Malawi (CHAM; 26%) for a small user fee, and by private for-profit and civil society providers (11%).[31]

Figure 1: Health Care Delivery in Malawi



29. World Bank. Malawi Overview. Washington, D.C.: World Bank; 2020. https://www.worldbank.org/en/country/malawi/overview.(Accessed 20 March 2022).
30. Chansa, C., Mwase, T., Matsebula, T. C., Kandoole, P., Revill, P., Makumba, J. B., & Lindelow, M. (2018). Fresh money for health? The (false?) promise of "innovative financing" for health in Malawi. Health Systems & Reform, 4(4), 324-335.
31. World Health Organization. WHO country cooperation strategy at a glance: Malawi. Technical documents: World Health Organization; 2018. https://apps.who.int/iris/handle/10665/136935. (Accessed 20 March 2022).

The health system is highly dependent on donors. In 2014/15 donor aid contributed 53.5% of the nation's total health expenditure. However, this was down from 68.3% in 2012/13 due to donors withdrawing direct financing (via a basket fund) for the Ministry of Health's (MoH) strategic and implementation plans in response to a financial corruption scandal that broke in 2013, known as Cashgate.[32] This erosion of donor confidence produced an accountability crisis across the health sector. The financial arrangements and trust between civil society organisations (CSOs) and donors were also adversely affected, as donors feared widespread government corruption within the government and non-government health system.[33]

The government recognised the essential role of governance in enforcing and monitoring the actions required to achieve their health objectives, and leadership and governance were identified as priority areas in the Health Sector Strategic Plan II 2017–2022 (HSSP II).[34] HSSP II is the strategic framework for the National Health Policy (NHP II) which focuses on strengthening governance in the health sector to improve efficiency and optimise existing resources (human, financial, material), particularly by improving the domestic financing mechanisms. The Minster for Health acknowledged that the country's health sector is highly dependent on external financing, and the vital importance of continued aid to support health gains. Demonstrating improved governance, which includes building better relationships with stakeholders, is essential for rebuilding the damaged relationship between the government and donors in order to achieve continued donor contributions and a more coordinated approach to the funding and provision of healthcare in Malawi.[35]

There have been, consequently, a series of measures to improve the governance of the health sector. For example, in 2018 the MoH created the new role of hospital ombudsman to ensure better service delivery in public and CHAM health facilities with greater socialaccountability between the facilities and communities via improved connections between the service users and providers. However, significant concerns regarding health sector governance, particularly around financial and resource efficiencies, and tensions between government stakeholders remain to be resolved.[36]

2.1.1 THE HEALTH SECTOR STRATEGIC PLAN II (HSSP II) 2017-2022

The Health Sector Strategic Plan II (HSSP II) 2017-2022 is the health sector's medium-term strategic plan outlining objectives, strategies and activities and guiding resources over a period from 2017-2022, It succeeds the HSSP I (2011-2016). HSSP II builds on the successes achieved under the previous plan while addressing areas where targets were not met and progress was slow.[37]

The HSSP II aimed to further improve health outcomes through the provision of a revised essential health package (EHP) and health systems strengthening for efficient delivery of the EHP. Specifically, the HSSP II sets eight strategic objectives for Malawi's health sector, each with strategies and targets to implement by 2022:

1. Health Service Delivery: Increase equitable access to and improve quality of health care services. Objective 1 builds on the successes of the Essential Health Package (EHP), which has outlined the health care interventions available to all Malawians, free at the point of access, since 2004. The aim was to achieve universal free access to a quality revised Essential Health Package (EHP), irrespective of ability-to-pay, to all Malawians.

2. Socio-Economic Determinants: Reduce environmental and social risk factors that have had a direct impact on health. Objective 2 focuses on strategies that address the environmental and social risk factors that impact on health care requirements and health

32. Ibid.
33. Ibid.
34. Ibid.
35. Adhikari, R., Sharma, J. R., Smith, P., & Malata, A. (2019). Foreign aid, Cashgate and trusting relationships amongst stakeholders: key factors contributing to (mal) functioning of the Malawian health system. Health policy and planning, 34(3), 197-206.
36. Masefield, S. C., Msosa, A., & Grugel, J. (2020). Challenges to effective governance in a low income healthcare system: a qualitative study of stakeholder perceptions in Malawi. BMC health services research, 20(1), 1-16.
37. Government of the Republic of Malawi. Health sector strategic plan II 2017–2022. Lilongwe: Ministry of Health; 2017.

outcomes. Specifically, the objective focused on behaviours and lifestyles, water and sanitation, food and nutrition services, housing, living and working conditions. This objective will be largely implemented at the community level.

3. Infrastructure & Medical Equipment: Improve the availability and quality of health infrastructure and medical equipment. Objective 3 attempts to ensure existing health facilities are of sufficient quality and properly equipped to address their specified health care requirements and to increase the proportion of the population of Malawi living within 8km of a health facility.

4. Human Resources: Improve availability, retention, performance and motivation of human resources for healthy and effective, efficient and equitable health service delivery. Objective 4 focused on improving the absorption and retention rate of health workers in the public health sector while also achieving an equitable distribution.

5. Medicines & Medical Supplies: Improve the availability, quality and utilisation of medicines and medical supplies. Objective 5 focused onimproving the efficiency of the supply chain for medicines and medical supplies to ensure the availability of the EHP.

6. Health Information Systems: Generate quality information and make it accessible to all intended users for evidence-based decision-making, through standardised and harmonised tools across all programmes. Objective 6 focused on improving and harmonising data collection and management at all levels of the health system, through improving ICT capacity, data protocols and linkages between levels.

7. Governance: Improve leadership and governance across the health sector and at all levels of the health care system. Objective 7 focused on improving communication and strengthening coordination in the health sector particularly with the goal of reducing duplication and fragmentation.

8. Health Financing: Increase health sector financial resources and improve efficiency in resource allocation and utilisation. Objective 8 focused on attempts to increase the sustainable finances available to the health sector through both revenue raising and efficiency saving.[38]

2.2 GOVERNANCE IN MALAWI'S HEALTH SECTOR

The World Health Organisation (WHO) defines governance as 'stewardship' and calls for strategic policy frameworks combined with effective oversight, regulation, incentives, and accountability. This definition is based on the ideology that a health system can be influenced by transparent rules, governed by effective oversight and strong accountability.[39]

The World Health Organisation considers good governance in the health sector to imply the making of pro-health legislation and frameworks for the implementation of strategic policies combined with effective regulation, monitoring, system design and social accountability.[40] According to the World Health Organisation, good governance of health requires maintenance of the strategic direction of policy development and implementation; monitoring the health system to detect adverse trends in efficiency; advocating for health in national development; regulating the behaviour of health stakeholders (including financiers and healthcare service providers); and establishing effective and transparent social accountability mechanisms. These are difficult to deliver in situations where resources, capacity, staffing and infrastructure remain limited in practice and the health system (financing and services) is often distributed (e.g. between the government, donors, non-governmental organisations (NGOs) and faith-based providers). For this reason, an important way of improving the governance of the health system in countries like Malawi is through an effective collaboration with non-government stakeholders in order to tackle issues of accountability and corruption.[41]

Public provision of health care in Malawi is enshrined in the republican constitution, under

38. Ibid.
39. Reddy, S. K., Mazhar, S., & Lencucha, R. (2018). The financial sustainability of the World Health Organization and the political economy of global health governance: a review of funding proposals. Globalization and Health, 14(1), 1-11.
40. World Health Organization. (2010). Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. World Health Organization.

sections 13(c), 16 and 45, which says that the State is obliged *"to provide adequate health care, commensurate with the health needs of the Malawian society and international standards of health care from time to time."* [42]

The study discovered that health sector governance in Malawi is coordinated by the MoH which reports to the Office of the President and Cabinet (OPC). The study established four key governance challenges in the health sector in Malawi. First, is the need for better coordination within the MoH. For instance, some departments or institutions with overlapping responsibilities create inefficiencies. Second, various stakeholders in the health sector should have an effective communication system that ensures synergy and lessens duplicity of tasks. Third, the need to improve coordination between MoH and its partners and among partners themselves in order to increase efficiency and avoid duplication of roles. Fourth, is the need to establish proper entry point channels for donors/NGOs utilising both the MoH and District Health Officers (DHO) in order to complement health service delivery and achieve accountability.

Malawi's health system is organised at four levels namely: community, primary, secondary and tertiary. These different levels are linked to each other through an established referral system. Community, Primary and Secondary level care falls under district councils. The District Health Officer (DHO) is the head of the district health care system and reports to the District Commissioner (DC) who is the Controlling Officer of public institutions at district level. Decentralisation was introduced at the district level since 1998. District Health Management Teams (DHMTs) are located in district hospitals and are also responsible for managing all district health services.

There are three key challenges regarding the DHMT. First, role confusion among the DHMT members. Second, lack of Terms of Reference (TORs) and a clear job description for individual positions. Third, replacements among DHMT members are high; hence, affecting continuity and institutional memory. DHMTs produce District Implementation Plans (DIPs) to guide implementation at the district level. A number of local oversight institutions exist in order to ensure accountability and transparency of health facilities. However, these bodies rarely exist and when they do, they perform their roles ineffectively. Civil Society Organisations (CSOs) at district level have limited capacity to hold public servants accountable. DHOs have instituted stakeholder coordination mechanisms to address the lack of coherence and coordination of resources. These mechanisms work better in some districts than in others. But, some local partners have not subscribed to these mechanisms due to a lack of awareness and capacity to engage with the health structures.

2.2.1 ACCOUNTABILITY IN MALAWI'S HEALTH SECTOR

Asha observed that there is widespread recognition, and greater social accountability which supports more responsive health policies and more effective services, and hence the need for leadership to drive the strengthening of governance in the health sector.[43] Accountability in this paper, means building answerability through the engagement and direct or indirect participation of citizens/the public. The following factors ensure the effectiveness of accountability: openness, dialogue, enforceability (ensuring an action is taken and that consequences or remedies for a failure to do so are punished), honesty and responsiveness on the part of politicians, policymakers, and healthcare providers to explain and justify their actions.[44]

In Malawi, the question of accountability entails three things. Firstly, a demand for demonstrable results (i.e improvements in health outcomes). Secondly, funding relationships i.e. where public money is being spent it must be accounted for. Thirdly, where funding is provided by external development partners (i.e. donors) effective governance is also demanded and implemented.[45]

41. Adhikari, R., Sharma, J. R., Smith, P., & Malata, A. (2019). Foreign aid, Cashgate and trusting relationships amongst stakeholders: key factors contributing to (mal) functioning of the Malawian health system. Health policy and planning, 34(3), 197-206.
42. https://www.constituteproject.org/constitution/Malawi_2017.pdf?lang=en, (Accessed 28 March 2022).

Apart from the accountability mechanisms implemented by the government, social health accountability has been on the rise in Malawi. Social accountability refers to citizens' demands for greater accountability from political and governmental actors in their actions and decisions, as well as for service delivery failures.[46] Translated to the level of frontline service provision, social accountability may involve the monitoring of health services by the public and the use of feedback and complaint mechanisms to address failures in service delivery. Through a process of assessment, demand articulation, feedback and negotiation with providers, changes in provider behaviour and facility practices are expected.[47] Over the past few decades, civil society organisations, often with international development support, have sought to facilitate these processes by organising and structuring procedures for citizen monitoring and feedback and community-provider dialogue, for example through social audits or community score cards.[48]

Studies on the health system in Malawi paints a gloomy picture of the accountability landscape which portrays citizens as having a limited range of social action.[49] Moreover, it is difficult to reach most rural health providers with formal accountability mechanisms.[50] On the demand side of social accountability, a study on the perceptions of care and accountability in Malawi by Jones et al. (2013) showed that even though health service users are aware of their rights and expectations in healthcare, they lack effective channels through which they can voice their concerns and complaints and hold health professionals accountable.[51] Health Management (HMCs) constitute the formal channel for user input into local service delivery, but they are hampered by a lack of proper training and resources to perform their tasks.[52] Beyond the HMCs, citizens rarely approach other representatives such as local councillors, Members of Parliament (MPs) or government officials to give their view or report issues.[53]

In order to promote the citizen's voice in service delivery and address the above-mentioned accountability failures, non-governmental organisations (NGOs) support several initiatives in Malawi, such as Citizen Hearings and Community Score Cards in maternal health service delivery. While these initiatives have triggered attention to service delivery failures even in the media, national implementation has been uneven and challenges remain in linking such initiatives to the wider health system.[54] On the supply side of accountability, formal accountability measures within the health system are considered weak. Monitoring and supervision by district personnel is often not conducted as required, one of the reasons being the high costs and the lack of qualified supervisors.[55] **A study by Bradley et al. (2013) in Malawi found that many rural facilities are monitored infrequently by District Health Management Teams, while another study reports that 28.7% of health workers in Malawi receive no supervision at all.[56] The lack of supervision and peer support leaves rural health workers feeling abandoned and remote from the government.[57]**

It may be assumed that a lack of leadership and accountability from staff at the service level may be hampering achievement of the specific targets related to healthcare facilities[58]; however, the apparent lack of government-led leadership and oversight in the implementation of accountability policies negatively influences the citizens' ability to hold the government to account for their (in) actions.[60]

2.2.2 CORRUPTION IN MALAWI'S HEALTH SECTOR

Corruption is a pervasive problem affecting the health sector. At the level of individuals and households, there is mounting evidence of the

43. George, A. (2003). Accountability in health services: transforming relationships and contexts. Harvard Center for Population and Development Studies, Working Paper Series, 13(1).
44. Danhoundo, G., Nasiri, K., & Wiktorowicz, M. E. (2018). Improving social accountability processes in the health sector in sub-Saharan Africa: a systematic review. BMC Public Health, 18(1), 1-8.
45. Masefield, S. C., Msosa, A., & Grugel, J. (2020). Challenges to effective governance in a low-income healthcare system: a qualitative study of stakeholder perceptions in Malawi. BMC health services research, 20(1), 1-16.
46. Lodenstein, E., Dieleman, M., Gerretsen, B., & Broerse, J. E. (2017). Health provider responsiveness to social accountability initiatives in low-and middle-income countries: a realist review. Health policy and planning, 32(1), 125-140.
47. George, A. (2003). Using accountability to improve reproductive health care. Reproductive health matters, 11(21), 161-170.
48. Joshi, A., & Houtzager, P. P. (2012). Widgets or watchdogs? Conceptual explorations in social accountability. Public Management Review, 14(2), 145-162.
49. NEWELL, P., & WHEELER, J. (2006). Overview: Rights, resources and corporate accountability. Rights, Resources and the Politics of Accountability, 3, 163.
50. Lodenstein, E., Ingemann, C., Molenaar, J. M., Dieleman, M., & Broerse, J. E. (2018). Informal social accountability in maternal health service delivery: a study in northern Malawi. PLoS One, 13(4), e0195671.
51. Oxford Policy Management, Jones, S., Kardan, A., Jakobsen, M., & Sekidde, S. (2013). Local Perceptions, Participation and Accountability in Malawi's Health Sector. Norwegian Agency for Development Cooperation.
52. Chikonde, N. (2017). Training clinic health committees: a vehicle for improving community participation in health (Master's thesis, University of Cape Town).
53. http://afrobarometer.org/sites/default/files/media-briefing/malawi/mlw_r5_presentation3.pdf, (Accessed 4 March 2022).
54. Lodenstein, E., Dieleman, M., Gerretsen, B., & Broerse, J. E. (2017). Health provider responsiveness to social accountability initiatives in low-and middle-income countries: a realist review. Health policy and planning, 32(1), 125-140.

negative effects of corruption on the health and welfare of citizens. Transparency International defines corruption as the 'misuse of entrusted power for private gain', corruption occurs when public officials who have been given the authority to carry out goals which further the public good instead, use their position and power to benefit themselves and others close to them.[61]

Savedoff argues that risks of corruption in the health sector are uniquely influenced by several organizational factors. The health sector is particularly vulnerable to corruption due to uncertainty surrounding the demand for services (who will fall ill, when, and what will they need); many dispersed actors including regulators, payers, providers, consumers and suppliers interacting in complex ways; and asymmetric information among the different actors, making it difficult to identify and control for diverging interests. In addition, the health care sector is unusual in the extent to which private providers are entrusted with important public roles, and the large amount of public money allocated to health spending in many countries.[62]

Expensive hospital construction, high tech equipment and the increasing arsenal of drugs needed for treatment, combined with =-99a powerful market of vendors and pharmaceutical companies, present risks of bribery and conflict of interest in the health sector.[63] Government officials use discretion to licence and accredit health facilities, providers, services and products, opening risk of abuse of power and use of resources. The patient-provider relationship is also marked by risks stemming from imbalances in information and inelastic demand for services. Resulting corruption problems include, among others, inappropriate ordering of tests and procedures to increase financial gain; under-the-table payments for care; absenteeism; and use of government resources for private practice.[64]

2.3 STAKEHOLDERS IN MALAWI'S HEALTH SECTOR

Health stakeholders can be defined as organisations and individuals involved in the production, consumption, management, regulation or evaluation of a specific health activity, including governance of the health system or health policy development.[65] Eliciting stakeholder perspectives allows healthcare to be seen from multiple angles, enabling exploration of differences and similarities in the understanding of specific issues (e.g. health services or policies) and perceived health needs of different individual stakeholders or groups (e.g. policy-makers versus service users).[66] While the public sector is the largest provider of health services in Malawi, approximately 40 percent of services are provided by private actors including the Christian Health Association of Malawi (CHAM), commercial providers, and other not-for-profit actors. These private actors are crucial for expanding access to essential health services in rural areas of Malawi.[67]

The SHOP study established that there are a significant number of independent for-profit health service facilities in Malawi that are not associated with either a faith-based organization (CHAM) or affiliated with an NGO franchise. Forty percent of facilities are independently managed.
The remainder- 29 percent are faith-based facilities; 35 percent are affiliated with an NGO, primarily a Blue Star or PSI franchise; and five percent are associated with a business or estate- receive some financial, technical or managerial support from their affiliated organization.[68]

56. *Bradley, S., Kamwendo, F., Masanja, H., de Pinho, H., Waxman, R., Boostrom, C., & McAuliffe, E. (2013). District health managers' perceptions of supervision in Malawi and Tanzania. Human resources for health, 11(1), 1-11.*
57. *McAuliffe, E., Daly, M., Kamwendo, F., Masanja, H., Sidat, M., & de Pinho, H. (2013). The critical role of supervision in retaining staff in obstetric services: a three country study. PloS one, 8(3), e58415.*
58. *Agyeman-Duah, J. N. A., Theurer, A., Munthali, C., Alide, N., & Neuhann, F. (2014). Understanding the barriers to setting up a healthcare quality improvement process in resource-limited settings: a situational analysis at the Medical Department of Kamuzu Central Hospital in Lilongwe, Malawi. BMC Health Services Research, 14(1), 1-10.*
59. *Masefield, S. C., Msosa, A., & Grugel, J. (2020). Challenges to effective governance in a low income healthcare system: a qualitative study of stakeholder perceptions in Malawi. BMC health services research, 20(1), 1-16.*
60. *Rispel, L. C., De Jager, P., & Fonn, S. (2016). Exploring corruption in the South African health sector. Health policy and planning, 31(2), 239-249.*
61. *Wang, H., & Rosenau, J. N. (2001). Transparency international and corruption as an issue of global governance. Global Governance, 7(1), 25-49.*
62. *Savedoff, W. D., & Hussmann, K. (2006). The causes of corruption in the health sector: a focus on health care systems. Transparency International. Global Corruption Report.*
63. *Kassirer, J. (2006). The corrupting influence of money in medicine. Transparency International. Global Corruption Report, 2002.*
64. *Di Tella, R., & Savedoff, W. D. (Eds.). (2001). Diagnosis corruption: fraud in Latin America's public hospitals. Idb.*
65. *Hyder, A., Syed, S., Puvanachandra, P., Bloom, G., Sundaram, S., Mahmood, S., ... & Peters, D. (2010). Stakeholder analysis for health research: case studies from low-and middle-income countries. Public health, 124(3), 159-166.*
66. *Gilson, L., Erasmus, E., Borghi, J., Macha, J., Kamuzora, P., & Mtei, G. (2012). Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project. Health policy and planning, 27(suppl_1), i64-i76.*
67. *https://shopsplusproject.org/sites/default/files/resources/Malawi%20Provider%20Mapping%20Report.pdf(Accessed 25 March 2022).*
68. *Ibid.*

SECTION THREE

Political Economy Of The Health Sector In Malawi

The political economy of the health sector in Malawi demonstrates various reforms in line with the Public Service Reforms in at least five areas: central hospital autonomy, decentralization of the district health system, health efficiency reforms, optional paying services, and service delivery public private partnerships with the Faith Based Organizations (FBO).[69]

Reform Area 1: Central Hospital Autonomy

The first reform area addresses the question of Central Hospitals' lack of management autonomy to make key operational decisions resulting in inefficiencies.

This reform area led to an approval for granting management autonomy to all Central Hospitals. The key task now is to set Board of Trustees and operationalize the management autonomy of Central Hospitals. The expectations associated with Central Hospitals' autonomy reform include: increased managerial decision making, increased efficiency, and improved tertiary level service delivery. There are also benefits associated with the implementation of Central Hospitals' autonomy reforms. First, increased managerial autonomy will improve real time decision making and as a result improve service delivery. Second, creation of Central Hospital Boards of Trustees will increase oversight. Third, increased managerial autonomy will improve the planning and efficient use of resources in central hospitals.

Reform Area 2: Decentralization of the District Health System

The second reform area addresses the issue of the decentralization of the District Health system. It was further observed that although the Government enacted the Local Government Act (1998) and promulgated the Decentralization Policy (1998), the health sector has not fully decentralized.

The proposed outcome of the decentralization of the District health system reform area aims at achieving full decentralization of the District Health System. Expectations associated with the decentralization of the district health system will make health services more responsive to the needs of the citizenry and will also improve

69. http://www.reforms.gov.mw/psrmu/sites/default/files/Ministry%20of%20Health%20Reforms%20Contract%202020.pdf, (Accessed 29 March 2022).

health status of the people. There are four benefits arising from the implementation of the decentralization of the district health system. First, District Assemblies and community development Structures will be empowered to have oversight and managerial responsibilities including management of public resources at each level of the District Health System, identifying and tackling the determinants of health, and identifying and tackling the health challenges that affect them. Second, functional/organizational review of health centers, community, and district hospitals will provide clarity on human resources for health (HRH) needs by district and motivate the Government to fill the vacancies. This will eventually ensure equitable availability of HRH. Third, separate resource allocation formula for Essential Health Package (EHP) service provision at primary and secondary level will lead to efficient and equitable resource allocation based on community needs and expected volume of services. Fourth, separate cost centers for secondary and primary health care facilities will improve equity and efficiency in the use of resources.

Reform Area 3: Health Efficiency Reforms

The third reform area addresses the issue of health efficiency. It was observed that inefficiency is a critical contributor to the lack of resource for implementing health service activities in Malawi and other health systems strengthening activities. **There are a fourfold proposed outcome for the health efficiency reforms. First, urban primary health care services will be reorganised into a practice type of system based on a variant of health posts which are the lowest level of health facility in the health sector. Second, an objective resource allocation formula and reimbursement mechanism for Central Hospitals. Third, human resources for health in-service training will be more integrated. Fourth, exploration for the creation of Centres of Excellence in cardiovascular and eye care in Central Hospitals.** The expectation for undertaking the health efficiency reforms will lead to a drastic reduction of wastage and misuse of resources.
There are also two benefits arising from the implementation of the health efficiency reforms. First, increasing efficiency in the health sector will generate efficiency savings which will be used for more investments in the sector. Second, a specific Central Hospital resource allocation formula and a change in reimbursement mechanisms will also improve quality of care as the focus will be on outputs and not just inputs.

Reform Area 4: Optional Paying Services

The fourth reform area addresses the issue of optional paying services. It was observed that financial resources for implementing health services at both the Central Hospital and the District Hospital levels in the public sector are limited but there is a demand for optional paying services at these levels which can alleviate the challenges of limited financial resources. The proposed outcome of the optional paying services is such that optional paying wings will be institutionalised at the Central Hospital level and will be established in selected District Hospitals. The expectation for undertaking the optional paying services reforms will increase the amount of revenues available for service delivery. Benefits arising from the implementation of the optional paying services reform constitutes increased revenues available to Central and District Hospitals for use at the discretion of the hospitals will improve the delivery of non-paying services at hospitals.

Reform Area 5: Service Delivery Public Private Partnerships with Faith Based Organisations

The fifth reform area addresses the issue of service delivery public private partnerships with Faith Based Organizations (FBOs). It was observed that approximately 20% of the

population in Malawi live in catchment areas which are not covered by public health services. The proposed outcome of the service delivery public private partnerships with Faith Based Organizations (FBOs) reforms entails selected services targeting key priority populations in the catchment areas which are not covered by public health services will be offered for free at the point of care. The expectation for undertaking the service delivery public private partnerships with Faith Based Organizations (FBOs) was aimed at addressing poor service utilisation and associated poor health outcomes for selected vulnerable populations. The key target services are in the areas of maternal, neonatal, and child health plus nutrition services. Benefits arising from the implementation of the service delivery public private partnerships with Faith Based Organisations (FBOs) reforms leads to the improvement of maternal, neonatal, and child health plus nutrition service utilisation and outcomes.

Political, Bureaucratic and Political Economy Barriers

The study discovered that there are several political, bureaucratic and economic barriers affecting the implementation of health sector reforms in Malawi. These include pressure from donor agencies, pressure from citizens, and the lack of political will to veto health sector reforms.

Pressure from Donor Agencies

While developing countries undertook health reforms voluntarily, developing countries were influenced by donor organisations as conditions for aid.[70] Particularly, for the health sector, the World Bank in its 1993 World Development Report declared that "countries that are willing to undertake reform of the health system should be strong candidates for increased aid, including donor financing.[71] This advice has two implications. First, the developing countries had to comply by instituting health reforms if they were to access the much-needed aid. Second, donor organisations had to use conditionality as their *modus operandi*.[72]

Study findings revealed that pressure from donor agencies compelled the Government of Malawi to institute health reforms. An official of the MoH reported during an interview that: **"these reforms are happening in many countries and we copied from them. We saw other countries doing it so we followed suit through the help of our donor, USAID."** Another MoH official collaborated in the interview saying that: "This is a situation whereby donors will say 'we will fund these health sector reforms' but who decides that we need the reforms?" In other words, the reforms are not emanating from the aspiration of the Malawi government but are coming up as a result of the pressure from donor agencies; consequently, there was little political will from the government.

The CEO of an NGO working in the health sector in Malawi concurred that: *"many health sector reforms that are happening are actually donor driven but this is not surprising because the government is desperately looking for money; therefore, they will always agree with what the donors are saying for them to get the donor money."*

A stakeholder in the health sector commented: *"not everybody feels comfortable to discuss problems with donors because they feel that they (the donors) can get annoyed and withdraw their aid."* Consequently, the donors have capitalised on this aid dependency context by influencing policy development to the extent that they *"are stepping on the government's toes hijacking its policy function."*[73]

Veto Points for Health Sector Reforms in Malawi

The cabinet and parliament are important veto points whose support is required for a successful implementation of health sector reforms. An interview with a MoH official revealed the following four critical factors for health sector reforms to be vetoed:

70. World Bank. (1993). World Development Report 1993: Investing in Health, Volume1. The World Bank.
71. Ibid.
72. Tambulasi, R. I. C. (2011). Policy transfer and service delivery transformation in developing countries: the case of Malawi health sector reforms. The University of Manchester (United Kingdom).
73. Chinsinga, B. (2007). Reclaiming policy space: lessons from Malawi's 2005/2006 fertilizer subsidy programme. Research Paper, 6.

- The degree of its responsiveness to the government's agenda. In other words, this can be expressed in the following sentiments: *"nothing is going to pass if it will compromise the government's vision and goals."*

- Nothing is going to pass that compromises the long term micro-economic growth of the country.

- No reform will pass if it does not gather enough political consensus. This largely depends on the extent of political will from various political players in the country.

- No reform will pass if it has serious political implications, especially for donor driven reforms. In this case, politicians are concerned with power preservation.[74]

Pressure from Citizens

Citizens are important stakeholders in health sector reforms in Malawi since the reforms have a direct bearing on their access to health services. The study discovered that citizen's views on the reforms concerning optional paying services were somehow divided. A MoH official gave the following narrative: *"A certain group in the society is willinging to pay for services because they want quality health services. This group can afford to pay for the health services. But, there is another group of people who cannot afford to pay for health services, these makeup the majority and would want to continue with free health services. The politicians are very cautious in dealing with this group of people because they don't want to disappoint them and lose votes during the elections."*

Political Bureaucratic Culture

Political Ministers (the cabinet) and senior government officials played a crucial role in determining the acceptability of various health reforms. To this end this study confirms a finding by Tambulasi (2011) who asserted that: "The resistance emanating from the ministers who have served the MoH over the years and senior executives at the MoH contribute to the failure of many health reforms in Malawi ... They would like to have control as a result they are afraid of any reforms that would make them lose control, power, and resources."[75]

74. Tambulasi, R. I. C. (2011). Policy transfer and service delivery transformation in developing countries: the case of Malawi health sector reforms. The University of Manchester (United Kingdom).
75. Ibid.

SECTION FOUR

Legislative Oversight And Procurement Practices

Poor supply and restocking system of drugs have been a major weakness of the public health system in Malawi. Stockouts were attributed to limited government funding for drugs, a fragmented drug procurement system, inadequate drug supply and distribution, theft, and political disinterest in providing drugs and specific medical devices.

"Health service providers prescribing drugs and asking patients to buy them, using their own resources has become a norm now, which most people are getting used to, and if you go to central medical stores you will find the same drugs in stock, they will tell you they are waiting for the specific districts to place an order", said one of the participants from a health SCO.
The study revealed that when it comes to major drug procurement decisions, what drugs to stock and when to stock it, the DHMTs have less control. Sometimes, orders could take ages, thereby creating stockouts in health centres; and sometimes, they could have an oversupply of one particular drug because of unsystematic delivery times.
The government's drug policy is that they have 'a final say on what to do with the drugs, where to distribute them and how to distribute them' said a data clerk from a health centre. **Some drugs are included in the Essential Health Policy (EHP), but additional drugs may need to be procured for conditions not covered. 'The government was perceived as not understanding the differences in the needs of different communities: 'in reality, each district orders drugs based on the local needs and dynamics. The EHP in the Health Sector Strategic Plan II (HSSP II) provides an ideal scenario, but in practice we have to respond to local realities, said DHMT participants.**

The study also found out that the government was considered impervious to variation in population needs - even when evidence of a need for drugs/medical devices can be provided using information management systems, the government had failed to respond. 'I remember we have been travelling to Lilongwe's Kamuzu Central Hospital to access sunscreen creams and shades for people with albinism because

Dowa district hospital never stocks them. When we engaged the health authority at the district, he said he cannot order the creams because last time when he ordered them, he was told there was no demand at the hospital' said a participant with albinism.

The government requires all national health system drug-procurement to be via the Central Medical Stores (CMS) or ensuring that their approval is sought before using other sources or distributing donations. When this procedure is followed the supply can be poor, sometimes drugs are available in the CMS but not received by the hospitals. There were calls from the interviewees for an improved system to coordinate between the CMS and the hospital pharmacies, and for better auditing of drugs at healthcare facilities.

In reality, drugs are accessed from a variety of sources i.e. the CMS, District Health Officers, donors and disease-specific programs and Christian Health Association of Malawi (CHAM), all of which use their preferred suppliers as an alternative to the CMS. Even though the service providers are supposed to consult the government about distribution when they receive donations of drugs (including prenatal multivitamin tablets for pregnant mothers) from 'international well-wishers' they rather distribute them as they deem fit, according to the needs of the community. Other providers usually refuse them as the drugs received are based on donor preferences. The MoH has given District Health Officers the powers to refuse drugs which are not in high demand, saying it's expensive to stock drugs that are less likely to be needed because it costs more to receive drugs that will not be used.

'Ideally, a country should have one drug procurement agent but the current system in the country is chaotic. Sometimes, we could wait for ages to receive drugs from CMS, and sometimes we could receive drugs that are nearing their expiry date, or receive equipment that are of the same size, making it difficult to cater for demand of other sizes, said one member of the DHMT.

4.1 INFLUENCE IN DECISION-MAKING

The health stakeholders interviewed consistently felt that they did not have any power to influence healthcare decision-making, particularly in the development of health policy (the NHP II and HSSP II); whilst donors were perceived as exerting a largely positive governing influence over the government.

'***The deficit in health sector governance is exacerbated by a lack of top down leadership- the systems for effectiveness are simply not there in the public health sector and in the end, there is chaos. The lack of proper functioning across the system is worsened by the fact that we do not have the leadership that understands the importance of functional systems and how much it would save on time and resources,' said one of the respondents.***

They added that the governance mechanism of the parliamentary committee on health is underfunded, 'meetings of the committee only takes place when parliament is able to fund the committee'. Governance is not considered a priority by the MoH and the Government of Malawi more broadly, 'having a well-funded and functional committee is not a priority at the moment. Nothing will change in terms of legislative oversight without additional funding' said one of the SCO leaders implementing a health project.

Arguably, unequal power over the health sector is also maintained by the MoH's insistence on oversight of top-level appointments to the boards/committees of organisations and facilities which receive (partial) government funding, such as the National AIDS Commission. This degree of government oversight raised

questions about transparency and the risk of corruption. There were also concerns about disproportionate influence in the relationship of the government to health facilities.

Donors were perceived as the only health stakeholder to exert any influence over the government and health system governance, possibly even requiring the development of a strategic framework for the NHP II as a condition of aid (i.e. the HSSP II) said a respondent. There was the widespread perception of greater governance when donors were involved, *'The challenge in Malawi is that things only work when there is a donor funded project which has a higher standard of accountability in terms of milestones and reporting'.*

Due to distrust in the government, some donors continue to operate in Malawi but independent of the government 'since cashgate donors do not trust the government system and cannot transact their resources through the government system. So far USAID is not open to cooperating or collaborating with the government systems, but DFID is more open to collaboration or harmonization'. The internal governance mechanisms used by donors, international NGOs and multi-level organisations were regarded as indirectly affecting healthcare governance. For example, Oxfam conducts citizen satisfaction surveys to assess the impact of their programmes. These baseline and monitoring assessments are used to guide the program's strategy and assess its success, but are also used to determine the focus and provide evidence for their advocacy agenda, they don't rely on Government health strategic direction anymore. Ultimately, it was felt that the donors had and could have great influence over governance in the health sector, 'as donors have leveraged on this because their funds are the lifeline of the health sector. So, everyone has to listen to their views,' said one of the respondents.

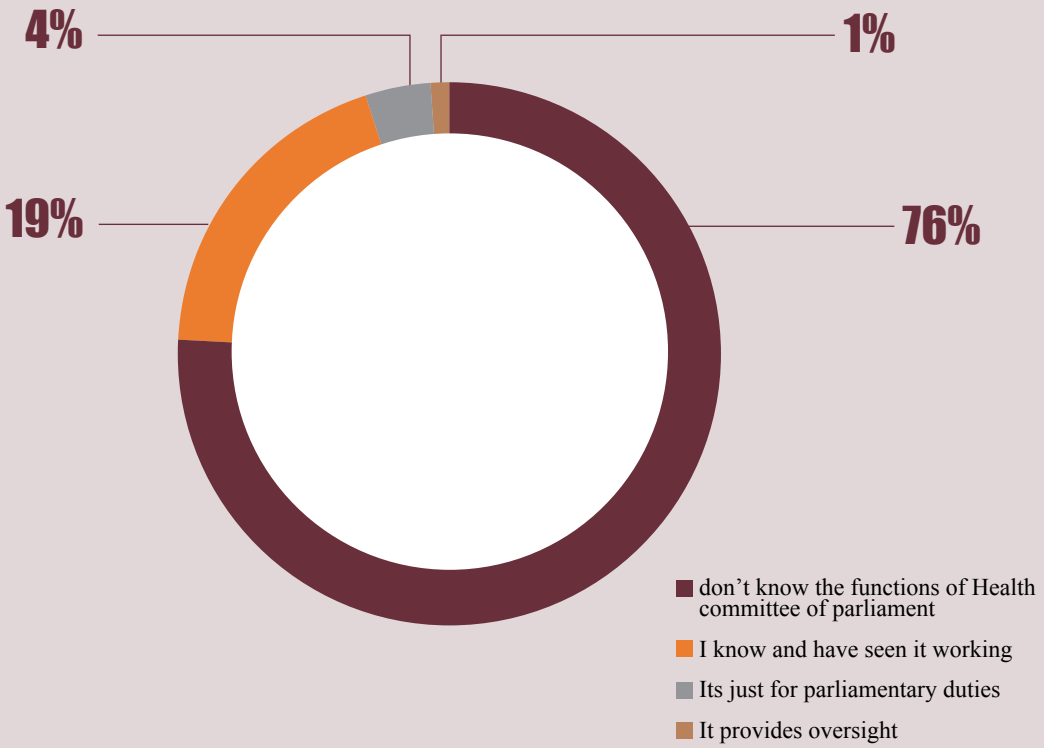
4.2 CITIZENS INVOLVEMENT IN LEGISLATIVE OVERSIGHT

Frustration was expressed about the lack of citizen level awareness and advocacy for greater government social accountability, with several respondents mentioning lack of places where they could go to in other to express their dissatisfactions.

A representative of a government-funded governance body stated that the process of parliamentary committee reviews is responsive, whereby issues are brought to their attention, triggering a review. However, they found that 'Malawians are not proactive in demanding the committee's legislative intervention.' Given the example of the Mental Health Act, which they said was out of date, yet no one has requested a review or an amendment. NGO and CSO representatives remarked on a sense of apathy towards governance among the general population. A Malawian representative of an international NGO stated: 'The problem with most Malawians is that they view human rights as a charity or a favour, not as an entitlement. When government fails to uphold or protect their rights, they therefore are not to demand rights as an entitlement.

76% of the 65 respondents interviewed said they don't really know the functions of the health committee of parliament, while 19% said they have interacted or seen it in functions delivering speeches and sharing policy direction, while the last five said that it's there to pursue health related laws in parliament, only when parliament is in session.

Figure 2: Public Awareness of the function of Health Commitee of Parliament

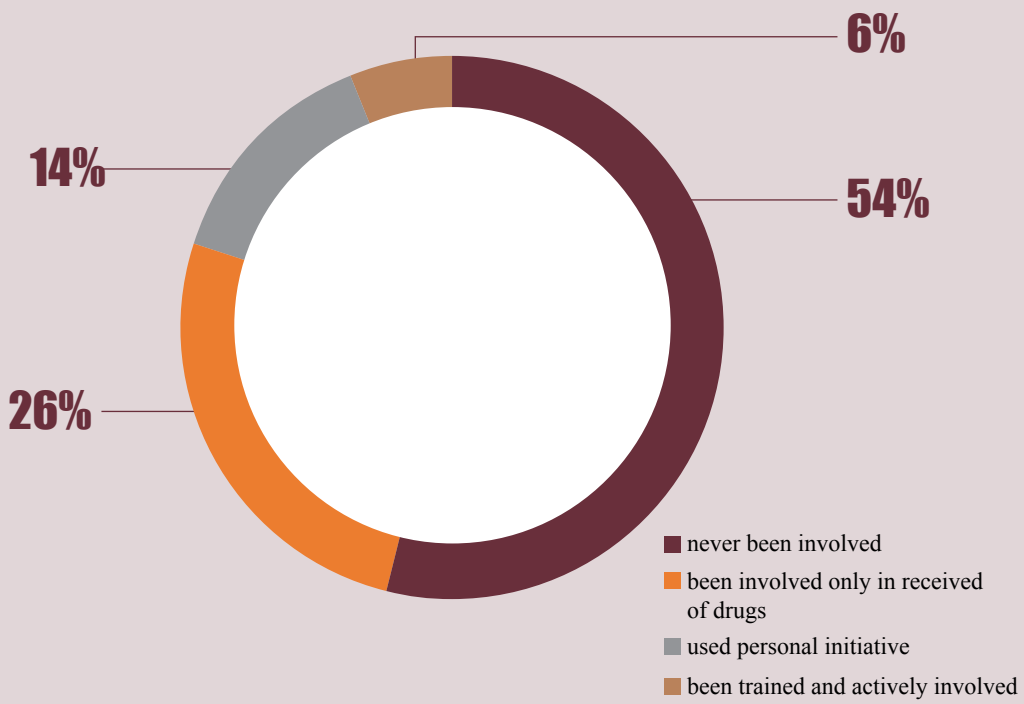


The study revealed that the health management committee (HMC) elected to provide checks and balances at the health center is dysfunctional. Most of the respondents are of the view that, authorities create or maintain a chaotic system because they are benefiting from it, the chaotic system makes it easier for them to pilfer drugs and other supplies, to get themselves in corrupt practices and never be tracked, because there is no one who is responsible for tracking. Neither does anyone have the capacity, technical knowledge, or the resources to do so.

'We were elected into a health management committee at our health facility, we were not trained, let alone oriented of our mandate, 8 months down the line, there is nothing tangible we are doing, even the local people lost trust in the system. I think our lack of capacity is benefiting someone, it is deliberate that they don't want us capacitated,' said one chairpersons of health management committee.

When asked if they have ever had any meaningful engagement worthy reporting, 54% of 45 respondents interviewed said since being elected they have never been involved in any, 26% said they have been involved in the receiving of drugs, but not tracking, while 14% said they have been actively engaged out of their own initiative, while 6% said they were trained and are always involved in each and every process at the health facility.

Figure 3: Level of Engagement of Health Management Teams



4.3 EFFORTS BY OTHER NGOs

The study revealed that another approach used by other non-governmental organisations was to train the community members in initiatives aimed at equipping communities and individuals in local government and health service delivery (e.g. health advisory and health center management committees, faith-based NGO and district health management teams, local government councillors) with skills in budget analysis and monitoring to become advocates for governance and hold to account the service providers that they interact with. 'The training came too late when some of us were completing our tenures, but we then realized that we missed a lot of opportunities. Only if we were trained earlier, we could have made a great difference,' said one health management committee respondent.

SECTION FIVE

Financing And Fiscal Management

The Government of the Republic of Malawi has signed the Abuja Declaration to commit at least 15% of the national budget to health, but only allocated 9.8% in 2018.[76] In the 2021/2022 Budget, government allocated Malawian Kwacha (MK) 187 billion to the health sector representing about 9.4% of the National Budget in line with the average allocation of the past five years.[77] Malawi has in the 2022-23 National budget failed to meet the 15% target for health sector set by the Abuja Declaration despite allocating K283 billion to the sector.[78]

The five-year cost of the HSSP II is estimated to be USD $2,613 million. Costs increase from $504 million in 2017/18 to $540 million in 2021/22. The total cost per capita each year remains constant at about $30.[79]

According to the latest Resource Mapping exercise, the Government of Malawi and donors have committed allocations of approximately $607 million to the health sector in fiscal year 2016/17. Commitments to the sector are lower for subsequent years ($565 million in 2017/18, $432 million in 2018/19, and $423 million in 2019/20). Based on these projections and the HSSP II cost estimates, the HSSP II has a funding gap ranging from about $89 million in 2018/19 to $117 million in 2021/22.[80]

There are significant variations between the approved, disbursed and executed health budgets, especially for donor-funded capital projects (DI). According to the MoH, the regular underperformance of DI is linked to late disbursement of donor funds, while the low absorption rates are due to multiple financial management and reporting requirements by the donors that are not aligned to existing Government systems. In 2020/21, for example, only 11% (MK3.7 billion) of the MK34.8 billion committed by donors was disbursed by end of fiscal year. The ORT budget is generally fully honoured and utilized while expenditure overruns on the PE budget are largely linked to in-year adjustments on wages and salaries. The discrepancies in spending, outside the +/-5% variance provided by the Public Expenditure and Financial Accountability (PEFA) framework undermine the credibility of the budget as a strategic tool for resource allocation.[81]

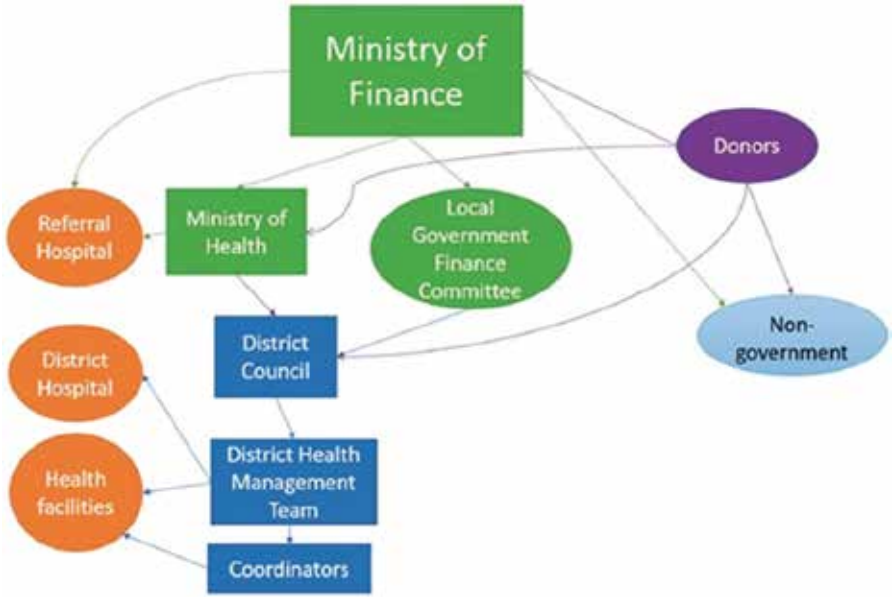
76. *Government of the Republic of Malawi. Health sector strategic plan II 2017–2022. Lilongwe: Ministry of Health; 2017.*
77. *https://www.unicef.org/esa/media/10506/file/UNICEF-Malawi-2021-2022-Health-Budget-Brief.pdf (Accessed 4 April 2022).*
78. *https://times.mw/malawi-still-falling-short-on-abuja-health-declaration/?amp=1, (Accessed 4 March 2022).*
79. *Government of the Republic of Malawi. Health sector strategic plan II 2017–2022. Lilongwe: Ministry of Health; 2017.*
80. *Ibid.*
81. *https://www.unicef.org/esa/media/10506/file/UNICEF-Malawi-2021-2022-Health-Budget-Brief.pdf, (Accessed 4 April 2022).*

The is a high incidence of donor funding in the health sector, coupled with the current fragmentation, risks the sustainability of health financing, with potential negative implications on service delivery. The Health Sector Financing Strategy (HFS), which is being finalized, provides an opportunity for the government to work towards promoting financial sustainability, efficiency, and health system resilience in the framework of the continued COVID-19 emergence.

5.1 HEALTH CARE FINANCING AND MANAGEMENT

Health care financing and management in Malawi is decentralized. At the district level, health care is managed by a District Health Management Team (DHMT). Districts develop the District Implementation Plan (DIP), annual plans for health service delivery and related budgets, in consultation with providers and communities. Districts receive funds from the Ministry of Finance (MoF) as block grants to cover district level health activities. These funds originate from domestic sources (tax revenue) and from external sources, through general budget support. Districts also received basket funding from donors, pooled funds for the health sector from non-governmental organisations implementing health related activities. These funds are channelled to districts through the Ministry of Health (MoH). Donor funds are also channelled straight to districts through the Local Government Financing Committee or through non-government channels as vertical (discrete) programmes. Health services at government facilities and at selected non-profit private facilities contracted by the MoH are officially free at the point of use.[82] However, in practice, if drugs are out of stock then patients will pay Out of Pocket (OOP) at private pharmacies. Patients also pay for care in private for-profit facilities. OOP payments are not a source of financing for districts in Malawi, nor would levels of OOP payments be taken into account within resource allocation decisions.[83]

Figure 4: Flow of Funds in Malawi Health Sector



Schematic representation of the flow of funds in the Malawian health sector. Note to figure: arrows represent (financial) resource flows[84]

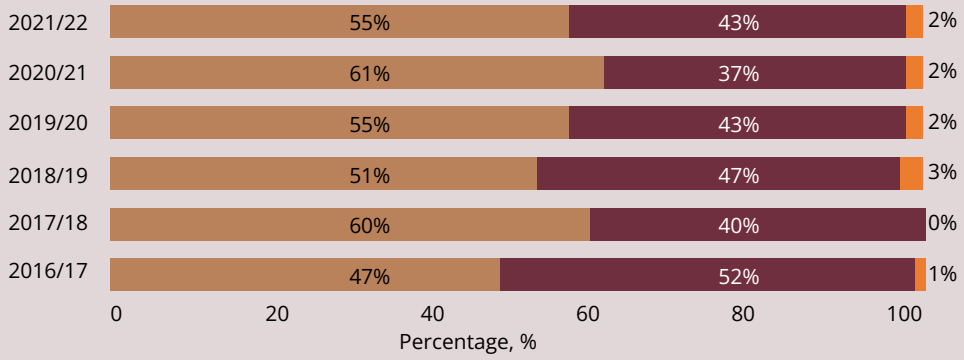
82. (Chirwa et al. 2013).
83. (Chirwa et al. 2013).
84. Health Policy and Planning, Volume 33, Issue 1, January 2021, Pages 59–69, https://doi.org/10.1093/heapol/czx130

5.2 COMPOSITION OF HEALTH SECTOR SPENDING

The study revealed that about 55% of the health sector budget is channelled through the MoH, with another 43% channelled through Local Councils, mainly for personnel emoluments (PE). The rest (2%) is allocated to subverted health organizations (SHOs). The large part (78%) of the total health sector allocations are directed towards recurrent expenditures, mainly (64%) for wages and salaries of health personnel. The rest (36%) covers other recurrent transactions (ORT) namely drugs, medical supplies and operations, including for subverted health organizations. The share allocated to development projects has declined from 25% in 2020/21 to 22% in 2021/22 on account of relatively lower grants from donors for the COVID-19 response. In line with the Health Sector Strategic Plan II, much of the health development budget is spent on physical structures, such as hospitals and clinics, and medical equipment.

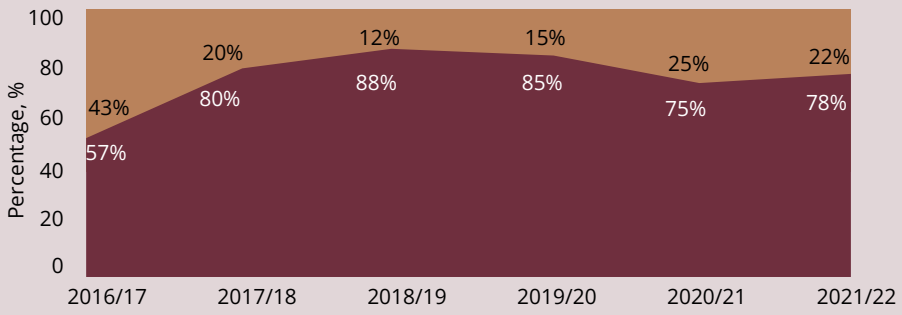
The distribution of the health sector resources by implementing agency has reverted to its pre-COVID-19 levels of 2019/20 (Figure 5)

Figure 5: Trends in the Composition of Health Sector Budgets by Impementing Agency



Source: Government Budget Documents (2017/18 - 2021/22)

Figure 6: Trends in the Composition of Health Sector Budgets by Economic Classification

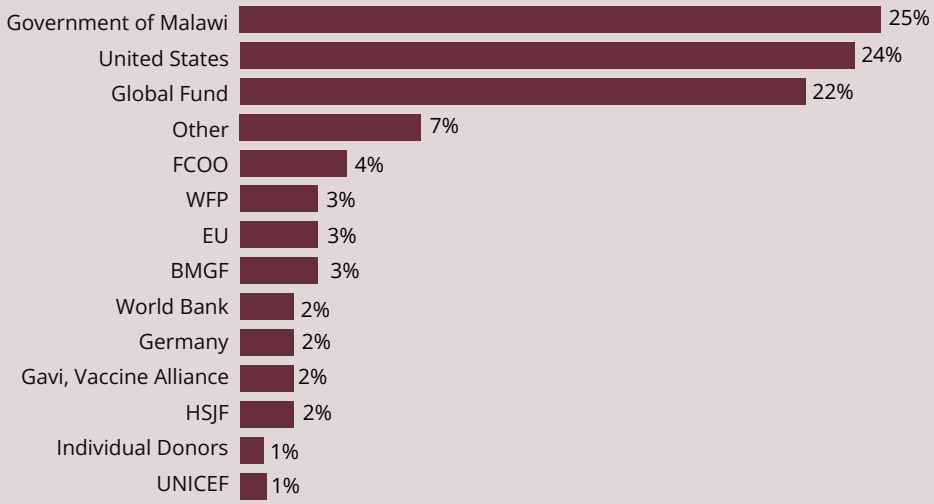


Source: Government Budget Documents (2017/18 - 2021/22)

5.3 HEALTH SECTOR EXTERNAL FINANCING

Malawi's health sector relies heavily on external financing, which is largely channelled as off-budget support. The results of the Health Sector Resource Mapping (HSRM) Round 6 showed that donors contributed an average of 75% to the funding of the health sector between 2018 and 2019, with the bulk of the funding coming from multilateral and bilateral partners (Figure 12). These resources are mostly off-budget. The World Bank PER (2020) revealed that about 74% of donor funding to the health sector was off-budget in 2017/18, with only 24% being pooled under the Government budget. Households are also increasingly contributing to financing health activities, with their expenditures growing by 35% between 2014/15 and 2019/20 (World Bank, 2020)

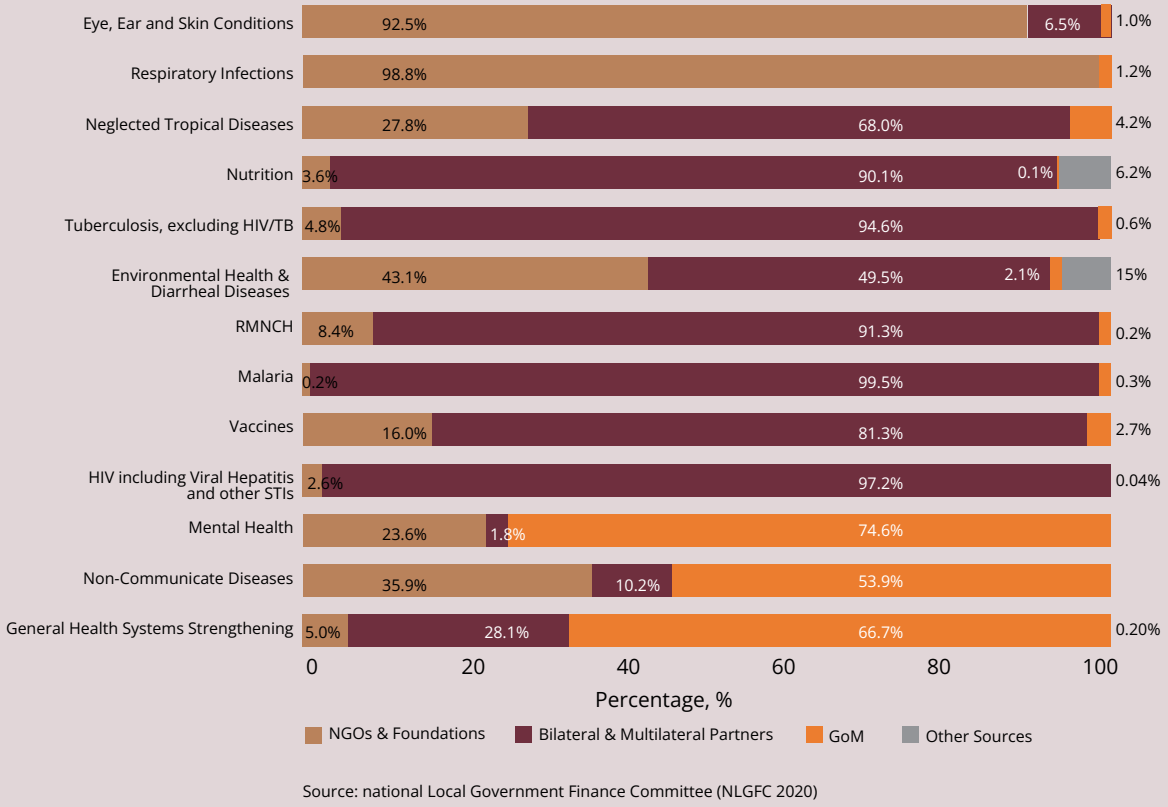
Figure 7: Financing of the Health Sector by Source (excluding Households), Average 2018-19



Source: HSRM Round 6

Funding for most programmatic interventions is also heavily donor dependent with over 90% of funding for malaria, RMNCH, tuberculosis, HIV (including sexually transmitted infections (STIs), environmental health and diarrheal diseases, nutrition and vaccines coming from donors. The Government is the largest financier for mental health, NCDs and general health systems strengthening (HSS) programmes. There are several factors undermining the efficiency of health sector spending, largely linked to weak Public Financial Management Systems (PFM). According to the HSRM round 6, the high incidence of off-budget donor support has led to a proliferation of agencies and NGOs managing financial resources on behalf of donors. These agencies mostly use their own planning, financing, procurement, and monitoring and evaluation systems bypassing Government systems, thereby negating the five principles on aid effectiveness. This contributes to fragmentation of the planning and budgeting, delivery, and monitoring and evaluation systems in the health sector. To cover the gap of alternative funding for health, the Government instituted HSRM, which helps to better understand the resource inflows in the sector and inform planning and budgeting decisions by policy and budget makers in Government.

Figure 8: Financing of Programmatic Health Interventions by Source, Average 2018-19



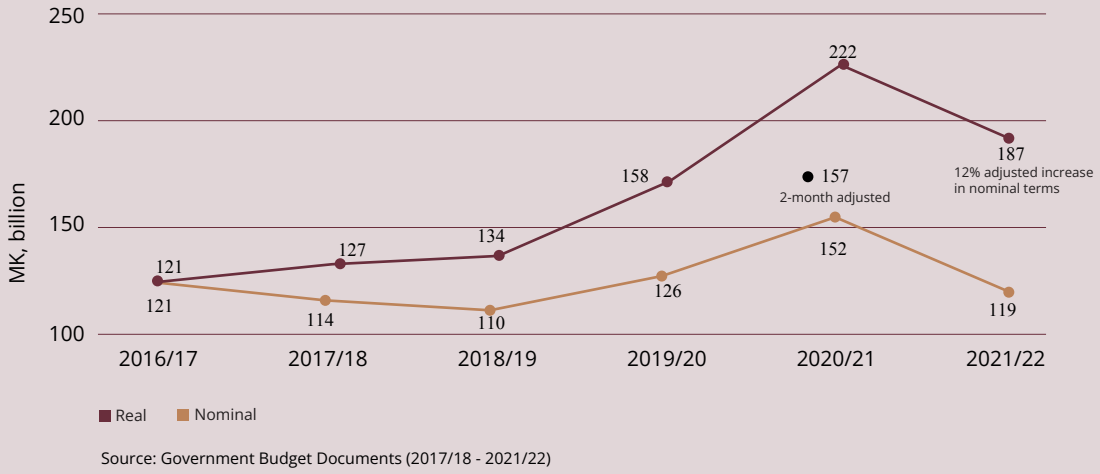
Source: national Local Government Finance Committee (NLGFC 2020)

5.4 HEALTH FINANCING

The health sector has received about 9.4% of the National Budget in 2021/22, in line with the average allocation of the past five years. It has however been overtaken by transport and public works (10.5%) to become the fourth national spending priority after education (16.5%), agriculture (14.3%), and not counting debt servicing (15.1%). The health sector remains the second largest decentralized sector, receiving 27% of the total planned transfers to Local Government Authorities (LGAs) s or 43% of the total health sector budget in 2021/22.

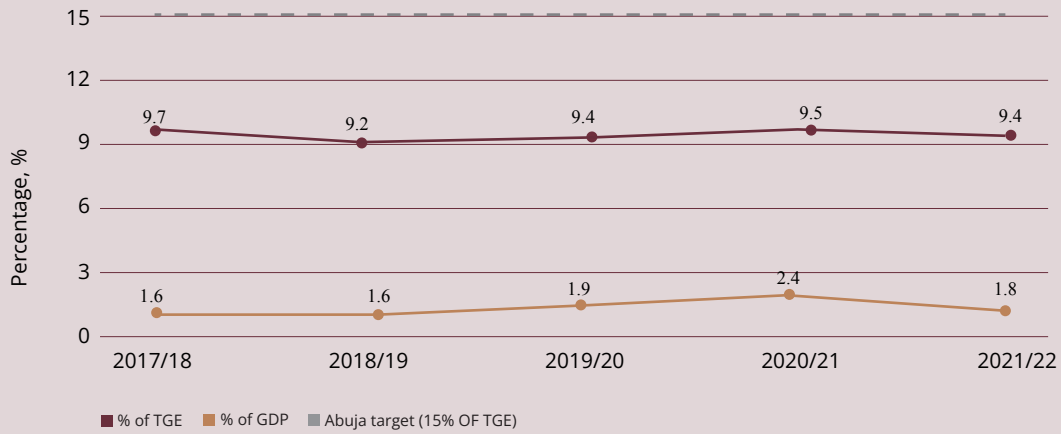
Figure 2: shows that Malawi has steadily been missing the Abuja Declaration target for African States to allocate 15% of their total budgets to the health sector since 2017/18. The observed decline in allocations as a share of GDP is linked to a rebasing of the country's GDP carried out in October 2020.

Figure 9: Evolution of Health Sector Spending



Source: Government Budget Documents (2017/18 - 2021/22)

Figure 10: Trends in Health Sector Spending % Budget and GDP[3]



Source: Government Budget Documents (2017/18 - 2021/22)

Health sector allocations remain steadily below estimated financial needs (Figure 3). The 2021/22 adjusted financing gap (41%) has narrowed from the 2020/21 gap of 44%, in relation to cost estimates in the second Health Sector Strategic Plan (HSSP II). A 2020 Report by the World Bank4 revealed that more than half (56%) of health facilities in Malawi are unable to comprehensively deliver the health services under the Essential Health Package (EHP). In per capita terms, the current health sector allocations (US$14) remain far short of the World Health Organization (WHO) minimum per capita investment (US$86). Although this suggests the need for more resources, there is currently limited room for additional financing (both domestic and external), given the already relatively high share of the budget committed to the health sector.

5.5 PECULIARITIES WITH THE HEALTH BUDGET PROCESS

The study revealed that the quality of public financial management (PFM) significantly affects service provision and health outcomes. This is driven by the fact that improving the management in public funds has a positive impact on efficiency and contributes towards reaching other service delivery goals, like accountability of service provision, equity, and quality.

District councils have limited authority and oversight over district spending. While they are mandated to deliver services at the local level, their ability to do so is constrained by the fact that they only manage a small share of spending. Decisions on key health inputs such as salaries and wages, infrastructure, and drugs and medical supplies are all made at the central level. Moreover, as information systems are not well integrated, District Health Management Teams (DHMTs) have limited oversight over how funds are allocated and used, which undermines their leadership position.

Sometimes we draw budgets with health sector implementing partners after collecting commitments through District Implementation Planning meetings, we remove activities pledged by other players, and find it impossible to fulfil when a partner has failed to honour their commitment. Sometimes we have partners coming in and duplicate the efforts being made by the DHMT, that if communicated earlier, we could have allocated the resources elsewhere. Said one of the Directors for Health and Social Services who was interviewed.

And the Director of Finance shared that "Service delivery spending is complementary, limited oversight and information makes it difficult to allocate resources efficiently. In this sense, it is challenging to hold districts to account for service delivery performance when they only have control over non-wage recurrent spending such as electricity, water, and other operational costs."

That said, it is understood that districts do generally receive the resources they are entitled to as outlined in the national budget. This has provided confidence at the district level that planned activities, over which they have control, can be implemented. In addition, sector-specific allocations within districts also tend to be reliable, with health receiving about 22 percent of the recurrent budget at district level. While there is some evidence of delayed transfers and intersectoral borrowing of earmarked funds, these factors do not appear to create major bottlenecks for service delivery.

Resources provided to health centers and hospitals are insufficient and do not link to anticipated service volume and need, which impacts on the quality of services. Available funds have also been eroded by inflation. To overcome this, facilities are considering Budget formulation Planning and budgeting processes which do not adequately support prioritization of activities. Other options to increase resources through the government budget with more efficient management of government funds, should therefore be pursued. Quality concerns are also exacerbated by the inability of service providers to balance inputs such as human resources, drugs and medical supplies, or other operational expenses.

The fact that DHMTs are responsible for financial management, while service providers at health centers and hospitals are accountable for the delivery of services, creates an accountability gap.

Budget execution Guidelines governing the way DHMTs can spend emphasize execution over flexibility, which creates significant constraints. DHMTs are the lowest spending unit in the health system in Malawi and oversee the

execution of the budget in their respective districts, including for health centers and hospitals. Standard PFM protocols, issued by the central government, state that the budget must be implemented as planned. However, protocols at the district level require input-based controls of the line-item budget, which means that there is limited scope to adjust to changing needs.

This also raises accountability concerns and could be overcome by providing more flexibility on budget execution at the district level. Proximity to DHMTs has a bearing on communication and procurement of supplies. While government-run facilities do not have autonomy to procure inputs, funding releases from treasury are usually communicated better when health facilities are closer to their respective DHMT. In these cases, health centers or hospitals receive alerts that funding has arrived and can request supplies based on their needs. On the other hand, where health facilities are located far away from the DHMT, communication is considerably worse resulting in fewer supplies being requested. These facilities also tend to receive supplies that do not reflect priority needs.

In terms of their day-to-day operations, service providers also lack adequate information regarding the delivery schedules and quantities of essential supplies. These depend on when budget at the DHMT-level is available, how the DHMT decides to spend it, and which providers will benefit. Moreover, medical staff are inadequately consulted during procurement of drugs and medical supplies, as this happens at the district level, leading to inflated prices and poor-quality supplies.

SECTION SIX

Citizens Voices On Healthcare Access, Quality And Vision

This section of the study presents findings from Focus Group Discussions that were conducted with various health stakeholders i.e. community members, members of the Health Management Committee (HMC), and representatives of Civil Society Organisations (CSOs) working in the health sector in Malawi.

Citizens' Access to Healthcare Services

Participants in the study explained that access to healthcare is hampered by the following factors: costs, insufficient healthcare resources, attitudinal barriers,

Cost as a Barrier

Study participants explained that one of the main barriers of access to healthcare services in Malawi is cost barrier in three ways. The cost barrier was explained in three dimensions: transport cost, cost of a health passport, and cost of drugs.

A study participant explained that: *"One of my relatives got seriously ill and we had to travel about 45 km to reach the nearest health center in our area. We contributed money in the village and managed to hire two motorbikes to take the patient and some guardians to the hospital. But it was not easy holding the patient on the motorbike and it took us almost four hours to reach the hospital."*[85]

The transportation barrier in accessing healthcare services is further compounded by three issues i.e. the transportation mode to a healthcare facility, the availability of money for transportation to a healthcare facility, and long distances to the healthcare facility.[86]

Another participant in the study explained her ordeal as follows: "I was seriously ill and went to the hospital for treatment; however, I was not helped because I did not have a health passport book. I was told that I will be treated once I have bought the health passport book. I just left the clinic without being treated because I did not have the money to buy the health passport book."[87]

An elderly man, Maganizo Phiri, aged 68 years old also narrated his experience with health passports, which caused him not to access healthcare services:

85. Interview at Chiringa, Phalombe, (31 March 2022).
86. Varela, C., Young, S., Mkandawire, N., Groen, R. S., Banza, L., & Viste, A. (2019). Transportation barriers to access health care for surgical conditions in Malawi a cross sectional nationwide household survey. BMC public health, 19(1), 1-8.
87. Ibid.

"Sometime back I had diarrhoea and I went to the health facility for treatment. I was asked to buy a health passport but I had no money. I was sent back to look for money first for the health passport before being given treatment. I pleaded with the health worker but I was told to go home and get back to the health facility if only I bought the passport. Without the passport I am failing to access the services and because I am very old and I have difficulties in walking, I do not go to the facility for the services anymore. Instead of going to the hospital I just resorted to using traditional medicine once am sick."

Munthali et al (2014) elaborated that health workers were using pieces of paper to write prescriptions for patients. However, this method presented difficulties in keeping records for patients; hence, the MoH introduced health passports. But, the introduction of health passports has brought a number of problems resulting in non-access of health care by certain vulnerable groups, such as the elderly and the poor, as some fail to purchase these health passports.[88]

A recurring theme from the Focus Group Discussions concerned the cost of drugs. Study participants unanimously expressed their concerns about the cost of drugs although health services are free in Malawi. One participant narrated as follows: *"I went to the hospital when I was sick and the doctor diagnosed me with a chronic cough. So, I was given paracetamol and was told to buy the other drugs at the pharmacy or from local street vendors who sell drugs."*

This finding demonstrates that a substantial proportion of patients get their medication from an untrained healthcare provider, particularly from street vendors and retail pharmacy workers. These sources of treatment are convenient in terms of proximity and availability of the drugs. However, studies have raised doubt about the quality of drug dispensing, such as the provision of ineffective drugs and stock-outs of drugs.[89]

Insufficient Healthcare Resources as a Barrier
The Focus Group Discussions further revealed that citizen's access to healthcare is compromised due to insufficient healthcare resources. Study participants explained that healthcare provision was frequently inadequate to meet their medical needs, mostly due to functional, practical and systemic problems. Citizens expressed three reasons for their dissatisfaction with health care provision: unreliable drug supply, a shortage of doctors, and a lack of diagnostic testing or specialized treatment.

A participant narrated her experience as follows: *"I am a hypertensive (high blood pressure) patient and I usually go to hospital to get medication like HTCZ and junior aspirin. But recently I failed to get this medication on several occasions."*[90]

Another participant explained about the shortage of human resources; particularly, a dentist, been a health discrimination factor for the citizens in Phalombe. He said that: *"There is no dentist in the whole Chiringa Health Zone. Reports have been going to the District Health Officer (DHO) but up to now we don't have a dentist in our area. You know how painful a toothache can be and to imagine that in all our health centers you can't be helped because there is no dentist, it's a very sad development."*[91]

Healthcare Access by People Living with Disabilities (PLWD)

Healthcare access by PLWDs in Malawi is limited by several factors. A recurring theme that emerged from the Focus Group Discussion demonstrated that attitudinal barriers play a crucial role for PLWDs to access healthcare.[92] One participant narrated her story: *"I am a person with disability and when I was pregnant, I went to the hospital for delivery and the*

88. Munthali, A. C., Mannan, H., MacLachlan, M., Swartz, L., Makupe, C. M., & Chilimampunga, C. (2014). Non-use of formal health Services in Malawi: perceptions from non-users. Malawi medical journal, 26(4), 126-132.
89. Chibwana, A. I., Mathanga, D. P., Chinkhumba, J., & Campbell, C. H. (2009). Socio-cultural predictors of health-seeking behaviour for febrile under-five children in Mwanza-Neno district, Malawi. Malaria journal, 8(1), 1-8.
90. Interview, Zomba, (28 March 2022).
91. Interview, Chiringa, Phalombe, (31 March 2022).
92. Harrison, J. A., Thomson, R., Banda, H. T., Mbera, G. B., Gregorius, S., Stenberg, B., & Marshall, T. (2020). Access to health care for people with disabilities in rural Malawi: what are the barriers?. BMC public health, 20(1), 1-17.

healthcare workers started mocking at me that even a person like me is getting pregnant. They said that I should feel sorry for myself ..."[93]

Apart from negative attitudes towards disability, some participants of this study generally gave very positive responses when asked how they were treated by people in their community and health workers at the hospital:

"The people in my community are very friendly and I don't experience discrimination from them. They just know that when communicating with me they have to speak loudly so that I will be able understand them."[94] ***(Jennifer,21)***

"At the hospital they have accepted me and they know that I am physically handicapped person and I use a wheelchair. Although at our health center we don't have disability friendly infrastructure, when I am there the health workers do help me with mobility around the hospital premises until I have been helped. They make me feel comfortable but it's my desire that they can build disability friendly structures in order to lessen our movement problems."[95] ***(Simon, 33)***

Another recurring theme throughout all the Focus Group Discussions regarding PLWDs access to healthcare services was that of dependence and needing support. It was clear that reliance on family, friends and the community could give rise to a social barrier to timely and adequate health care, with some participants losing their source of support, and others at the mercy of their care-giver's availability, financial situation and, ultimately, compassion.

Study participants described dependence on others as a barrier to access healthcare in four ways: financial support, transport and distance to a healthy facility, and communication. The communication barrier was more emphasized since we don't have sign language interpreters working in health facilities in Malawi. Also, communication in braille is not available in Malawi's health facilities; therefore, PLWDs with hearing and visual impairments have several challenges in accessing healthcare services due to inaccessible communication formats.[96]

Participants in this study also mentioned a lack of disability friendly infrastructure as a barrier to PLWD in accessing healthcare services. Most health facilities in Malawi have no disability friendly infrastructure which brings mobility problems for PLWDs. One participant explained that *"at our recently constructed health center, they have put big steps which poses difficulties for PLWDs to enter the health facility and move around. Also, at the maternity wing, they have built big steps without pavements to be used by PLWDs. This is not fair and our expectation is that when they are making architectural designs for health facilities, they should consider PLWDs as well."* [97]

Citizens' Perception of Quality Healthcare Services

Participants in the Focus Group Discussions mentioned the fact that Malawi has progressive health legislation and policies but the main problem with the health sector in Malawi is implementation. To this end, study participants identified several problems that compromise the quality provision of healthcare services in the country.

The following recurring themes emerged from the FGDs:

- Corruption which is manifested in at least four ways. First, the stealing of medicines in hospitals by healthcare workers. Second, the selling of drugs from government health facilities to private hospitals and pharmacies. Third, transferring of health equipment from government hospitals to private hospitals. Fourth, asking for bribes from patients in order to be treated at the health facility or unlawful subscription fees.

93. Interview, Blantyre, (24 March 2022).
94. Interview, Zomba, (30 March 2022).
95. Interview, Chiringa, Phalombe, (31 March 2022).
96. Interview, Blantyre, (24 March 2022).
97. Interview, Chiringa, Phalombe (31 March 2022).

- Using unqualified health workers i.e. Health Surveillance Assistants (HSAs) to perform tasks assigned to the qualified medical doctors.
- People travel long distances to access health care.
- Lack of privacy in most health facilities.
- Unfriendly healthcare services mainly to PLWDs and the youth who wants to access Sexual and Reproductive Health Services (SRHS).
- Shortage of healthcare workers, medication, and equipment.
- Lack of transparency and accountability on healthcare resources by duty bearers.
- Poor communication or unfriendly approach by health workers and also community members insulting the health workers.
- Stigma and discrimination against PLWDs and particular patients taking antiretroviral drugs.
- Some cultural and religious beliefs hinder people from accessing health care services.[98]

What Can Citizens do to Ensure Quality Healthcare Services?

Participants in the Focus Group Discussions brainstormed means and ways of ensuring quality healthcare provision in Malawi. The following themes were mentioned:

- Raising awareness for citizens' rights and responsibilities regarding the healthcare sector in Malawi.
- Whistleblowing of corrupt activities in order to notify other CSOs to engage collectively in curbing malpractices.
- Advocacy with duty bearers in pertinent or emerging mishaps in the health systems. Empowering the Health Management Committees to effectively discharge their role and responsibilities.
- Utilizing the services of health ombudsmen.
- We need to make every person angry about corruption and do a grassroot mobilization in the fight against corruption in the health sector.
- Utilize the decentralization structures to follow the money and empower the citizens on how to do budget tracking for the health sector.
- To make coalition building for CSOs working in the health sector so that we can come up with collaborative advocacy.

What is the Citizens' Vision of Quality Healthcare Services?

Study participants explained that their vision of quality healthcare is that the health system in Malawi should be able to meet all their health needs. For this to be accomplished, there has to be a sufficient number of health personnel who are qualified to perform various health tasks, good healthcare infrastructure that caters for all aspects of health, availability of medications, and timely and effective delivery of healthcare services.[99]

98. *Focus Group Discussion in Blantyre and Phalombe (24 and 31 March 2022).*
99. *Ibid.*

SECTION SEVEN

Conclusion And Route To Reforms (Recommendations And Call To Action For Government And Civil Society)

7.0 INTRODUCTION

This section of the study presents the conclusion and route to reforms by making recommendations and calling both the government and civil society to action.

7.1 HEALTH SECTOR REFORMS

The study has demonstrated that not all health sector reforms that were coercively transferred to the country's policy agenda through hierarchical aid mechanisms were implemented. This is because at the executive level, there were national specific filters that determined which reforms were acceptable and which were not. Consequently, the implementation of foreign health reforms depends more on the underlying 'political feasibility,' and its 'antecedents' that are beyond the technical satisfaction, efficiency and effectiveness gains promised by the policy instruments.

The afore-mentioned implication demands that donor organizations should move away from their modus operandi of transferring reforms wholesale through aid conditionalities.

Therefore, the study recommends that donor agencies need to build meaningful capacities of policy makers in Malawi for increased voluntary learning. In this regard, policy-makers in Malawi would choose health sector reforms as a rational response to both perceived and real problems in the health sector. Moreover, this will lead to policy reform ownership and commitment from the national players and address contextual issues.

The study further recommends that Malawi should implement people-centered and health system responsive Universal Health Coverage (UHC) reforms to achieve at least five health targets. These are:

1. Simultaneous implementation of appropriate demand and supply interventions.

2. To tackle the community defined financial protection gaps in the use of private/CHAM facilities.

3. To address several healthcare accessibility gaps in the public sector.

32. *Ibid.*
33. *Ibid.*
34. *Ibid.*
35. *Adhikari, R., Sharma, J. R., Smith, P., & Malata, A. (2019). Foreign aid, Cashgate and trusting relationships amongst stakeholders: key factors contributing to (mal) functioning of the Malawian health system. Health policy and planning, 34(3), 197-206.*
36. *Masefield, S. C., Msosa, A., & Grugel, J. (2020). Challenges to effective governance in a low income healthcare system: a qualitative study of stakeholder perceptions in Malawi. BMC health services research, 20(1), 1-16.*
37. *Government of the Republic of Malawi. Health sector strategic plan II 2017–2022. Lilongwe: Ministry of Health; 2017.*

4. To implement reforms that adopts a bottom-up approach driven by local evidence reflecting context-specific needs.

5. To implement complementary micro-health insurance financing.

7.2 HEALTHCARE ACCESSIBILITY

The study highlighted nine critical areas concerning healthcare accessibility which needs urgent attention in the health sector in Malawi. These are:

1. A pressing need for improved drug supply to healthcare facilities;

2. Scaling up of accessible healthcare services;

3. Improvement in the number and distribution of trained medical personnel;

4. Improvement of healthcare infrastructure; and

5. Training of Health Management Committees (HMCs) to ensure their effectiveness and efficiency as mediators between the health care providers and the community. Also, the HMC is crucial in curbing corruption in the health sector.

6. The co-existence and interconnectivity of healthcare accessibility challenges suggests the use of a multi-dimensional approach which facilitates integrated rather than isolated interventions.

7. The government should improve the quality of health care services at government health facilities as this is where most poor people access health services. This is also the primary route towards achieving universal health coverage.

8. Catastrophic health expenditures are still prevalent in rural areas even though there has been some improvement in financing and access to health services by the poor. Therefore, there is a need to further increase access for poor households to CHAM and private health facilities, especially in areas where there are no government health facilities. This could be achieved through the introduction of vouchers in addition to the existing service level agreements between the government and CHAM.

9. The study has several implications associated with PLWDs' access to healthcare services in Malawi. First, the need for a better implementation of social security systems in Malawi to reduce the financial barriers to healthcare commonly experienced by PLWDs. These barriers are frequently due to lack of employment opportunities. Hence, we recommend that efforts to improve PLWDs healthcare access should be guided by the Malawi's National Policy on Equalization of Opportunities for People with Disabilities.100 Second, the health sector in Malawi should eliminate communication barriers for enhancing PLWDS access to healthcare. For instance, there is an urgent need for the introduction of the use of braille and sign language in the health facilities. Third, the development of disability friendly health infrastructures in order to facilitate easy movements of PLWDs at various health facilities in the country.

7.3 HEALTH MANAGEMENT COMMITTEES (HMCs)

Study findings have highlighted the significance of intermediary structures like the Health Management Committees (HMCs) which serves as vehicles of identification and transmission of concerns from citizens and users to health worker, providers and authorities. The HMCs also plays a crucial role in ensuring social accountability for the health sector. In this regard, the strengthening of HMCs social accountability role at the local level and the optimization of vertical integration requires actions at multiple levels. These are:

100. Chilemba, E. M. (2014). Malawi. Afr. Disability Rts. YB, 2, 207.

1. The need for a distinguishable mandate of citizens groups i.e. HMCs in the accountability landscape, including the types of issues HMCs could monitor. In Malawi, the 'Charter of Patients'[101] and Health Workers' Rights and Responsibilities' and the 'Charter on Safe and Respectful Maternity Care'[102] have been widely disseminated, also among HMCs, and they could be used as starting points for social accountability.

2. Investments in the quality and principles of accountability processes are needed. This involves the strengthening of capacities of both HMCs and health workers to conduct broad-based community consultation on perceived and experienced care and to strengthen dialogue and negotiation skills, documentation and transparent reporting procedures. The role of statutory HMC meetings as central forums of accountability and spaces of negotiation could be enhanced. HMC capacity strengthening strategies should take a holistic perspective; the findings support observations in earlier research that HMCs are heterogeneous entities with multiple roles, responsibilities and functions and that they are confronted with diverging expectations from communities, service users, health workers, and health authorities.[103] The accountability role of HMCs should be understood in this context; it is part of a more comprehensive set of activities HMCs perform to support local health service delivery which varies per context. A focus on strengthening HMCs capacities in monitoring or complaint management would be a too narrow approach.

3. In order to enhance vertical integration, reporting and responsiveness mechanisms need to be clarified between HMCs and district authorities. Furthermore, the linkages between social accountability and service delivery programming, supervision and evaluation and quality improvement programmes can be improved. For example, the role of community structures such as HMCs in the provision and monitoring of services could figure more prominently in national sexual and reproductive health policies or quality improvement strategies. This would be more effective than strengthening the accountability interface role of HMCs as a stand-alone project. The strengthening of social accountability relations requires long-term repeated and extended interactions between citizens, health workers and provider organisations.[104]

4. Finally, there is no doubt that continued investment in material and human resources for health services will be essential for both the performance of health workers and the effectiveness of social accountability.

7.4 FINANCIAL AND FISCAL MANAGEMENT

The study highlights the significance of improving public finance management and efficiency. In this regard, the study makes the following four recommendations:

1. There is a need for increasing government's contribution to the total health expenditure to at least the levels of the Abuja Declaration of 15% of the national budget. This will increase the total health expenditure to levels that would cover the Malawi Essential health Package and possibly match the recommendations of the Commission on Macroeconomics and Health. However, to avoid potential problems related to absorptive capacity due to a relative increase in financing to the sector, appropriate measures need to be taken to strengthen performance of the health system.

2. Prepayment schemes are still at a nascent stage. Hence, to facilitate the progress towards universal access to health care, it is necessary to develop and implement a comprehensive health financing policy and strategy as recommended in

101. Muula, A. S. (2005). Will health rights solve Malawi's health problems. Croat Med J, 46(5), 853-859.
102. Alliance, W. R. (2011). Respectful maternity care: the universal rights of childbearing women. White Ribbon Alliance.
103. Lodenstein, E., Molenaar, J. M., Ingemann, C., Botha, K., Mkandawire, J. J., Liem, L., ... & Dieleman, M. (2019). "We come as friends": approaches to social accountability by health committees in Northern Malawi. BMC health services research, 19(1), 1-14.
104. Ibid.

the 56th WHO Regional Committee resolution[105] on health financing and the Ouagadougou Declaration.[106]

3. Enforce use of the existing public finance management guidelines at district level. Integrating accounting systems at the district and central government levels should also be prioritized in order to improve financial reporting in the health sector.

4. The National Health Account (NHA) study[107] demonstrated that donor funding and out-of-pocket payments are relatively high in terms of domestic financing of Malawi's health sector. This has implications for both sustainability and equity. Opportunities should be identified to mobilize additional domestic resources and focus on allocation of budgets within the health sector so that available funds are used efficiently and equitably.

5. The Ministry of Health and its donor partners should focus health spending on primary healthcare and preventive health services that are generally considered to be more cost-effective and would be a good investment of scarce resources.

6. The Ministry of Health and its donor partners should increase allocation and spending on capital items such as infrastructure, medical equipment, training, and research, which could lead to improved quality of health services.

105. World Health Organization. Regional Office for Africa. (2006). The health of the people: The African regional health report. World Health Organization.
106. World Health Organization. (2000). World Health Organization Regional Office for Africa-WHO/AFRO.
107. http://www.healthpolicyplus.com/ns/pubs/18434-18787_NHASummary.pdf, (Accessed 7 April 2022).

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Annexes

Table 1: Details Of Respondents

Personal Data	Category	ALLOCATED DAYS
Medical Personnel	Facility clinicians in charge	9
	Data Clerks	8
	Environmental Health Officers	3
	Hospital Ombudsman	2
	DHMT member	7
Community leaders	Health management committee member	10
	Local Chiefs	5
	Area Development Committee members	5
Other Stakeholders	Civil Society Organisations	13
	Ministry Officials	3

Research Tools

Consent Form

Research Project Tittle: Country Specific Health Sector Accountability Research
This consent form is for participants in a research study entitled: "Country Specific Health Sector Accountability Research."

NAME OF PRINCIPAL INVESTIGATORS: Dr. Jones Mawerenga
NAME OF SPONSOR: Follow the Money Malawi CTAP Project

This Informed Consent Form has two parts:
• Information Sheet (to share information about the study with you)
• Certificate of Consent (for signatures if you choose to participate)

Part I: Information Sheet
Introduction
I am Dr. Jones Mawerenga and we are conducting a research on a topic entitled: Country Specific Health Sector Accountability Research." We are going to give you information and invite you to be part of this research.

Purpose of the Research
The purpose of this research is to evaluate Malawi's healthcare systems from the lenses of accountability, governance structures, political economy, fiscal management and financing, reforms, legislative oversight, and citizen engagement and access to healthcare.

Type of Research Intervention
This research will involve your participation through responding to a questionnaire which will take approximately 20 minutes.

Participant Selection
You are being invited to take part in this research because we feel that your experience as program implementer, partner or stakeholder of health systems and programming can contribute much to our understanding and knowledge of health sector accountability.

Voluntary Participation
Your participation in this research is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate all the services you receive from and provide in public health systems, and your community role or job will continue and nothing will change.

Also, note that the choice that you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier.

Procedures
We are asking you to help us learn more about health sector accountability. We are inviting you to take part in this research project. If you accept, you will be asked to participate in the following ways: an interview, focus group discussion, online survey, or workshop.

Duration
The research takes place over a period of two weeks in total. During this time, you will participate in some of our research activities like an interview, focus group discussion, online survey, or workshop and each of these activities will last for about 30 minutes to 3 hours each, depending on the activity.

Risks
Please note that since the topic involves service provision and political decisions, there are some risks associated, In a worst scenario, it might generate misgivings by concerned parties, but whatever you are going to share will not be shared with anyone. However, be assured that the principal investigators of this study have successfully conducted similar studies in Malawi and no harm has been reported so far.

Benefits
Your participation is likely to help us find out more about health sector accountability in Malawi, the findings will inform programming aimed at improving on gaps that will be identified for the benefit of service beneficiaries.

Reimbursements
You will not be provided any incentive to take part in the research. However, we will give you refreshments and travel expense (if applicable).

Confidentiality
The research being done in the community may draw attention and if you participate you may be asked questions by other people in the community. We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except the research sponsors but they will not be able to identify who gave that particular data.

Sharing the Results
Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge that we get from this research will be shared with study participants as well as other stakeholders at a meeting that you will be invited to attend then we will publish the results so that other interested people may learn from the research.

Right to Refuse or Withdraw
You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may stop participating in the [discussion/interview] at any time that you wish without your job being affected. I will give you an opportunity at the end of the interview/discussion to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

Who to Contact?
If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact any of the following:
Primary Point of Contact: Rodger Kumalire Phiri
Phone Number: +265 999 263 850
Email: rodger.phiri@gmail.com

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study
Print Name of Participant:_____
Signature of Participant:_____
Date:_____
Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1. The participant is expected to respond to our questions.
2. We will document or record the responses.
3. We will take the responses for data analysis and they will form part of the study findings.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent:_____
Signature of Researcher /person taking the consent:_____
Date:_____
Day/month/year

HEALTH CARE WORKERS TOOL

CTAP/Follow the Money Malawi
Country Specific Health Sector Accountability Research

	PLEASE ENSURE THIS BOX IS FILLED IN
Participant ID	
INTRODUCTION	Hello, as part of the Country Specific Health Sector Accountability Research you are about to begin, we would like to understand more about you and your work. Over the entire research, you will be completing surveys this survey questionnaire. The purpose of this research is to evaluate Malawi's healthcare systems from the lenses of accountability, governance structures, political economy, fiscal management and financing, reforms, legislative oversight, and citizen engagement and access to healthcare.
District	
Cluster	
Full Name of Research Assistant	
Date	
Sex (circle)	Male / Female / Other
Age in years	
Profession	Please circle the response which closest describes your job: ■ Community Health Officer ■ Nurse ■ VCT Counsellor ■ ART Officer ■ Clinician ■ Clinical Administrator ■ Health Surveillance Assistant ■ Other healthcare professional ■ CSO/NGO Worker or Volunteer
INSTRUCTIONS	Please complete the survey as honestly and accurately as possible. The results of this study will be used to inform future interventions targeting health service accountability and transparency across Malawi. If you have a question please don't hesitate to ask at any point of the research. The survey should take you about 25 minutes to complete. Please complete the survey independently and without speaking to anyone else. Remember, your responses will remain private and will never be attributable to you.

Q# - Question	Answer (circle)	Skip Rule
PART 1: For each question, please CIRCLE your response in the 'Answer' column		
Q01 Do you give your consent to participate in this study?	Yes..... 1 No 2	If NO STOP
Q02 What is the highest level of education you have completed?		

1. What are the differences in the health services provided by different types of service providers? (e.g. Government clinics, faith based organisations, private sector and traditional healers). Do preferences differ for men and women?
2. What do you understand by participation and accountability in the health sector?
3. What are the informal 'demand driven' mechanisms through which different individuals and groups within the community participate in the health sector? Do men and women use different mechanisms?
4. What are the formal 'invited' accountability channels in the health sector?
a. What is the level of demand for these? How widely are these known?
b. How frequently are these used?
c. How effective are they?
5. Who participates in these formal and informal mechanisms? And for what purpose or motive?
6. What are your views on community participation and its effectiveness?
7. What are the conditions for effective participation? What are the cultural, social, political and economic barriers to participation in the health sector?
8. What is the impact of participation and accountability on health sector outcomes?
9. How are resources ordered, stored and accounted for in your facility?
a. If you have a chance to improve the current system, what would you change and why?

COMMUNITY/SCO LEADERS TOOL

CTAP/Follow the Money Malawi
Country Specific Health Sector Accountability Research

	PLEASE ENSURE THIS BOX IS FILLED IN
Participant ID	
INTRODUCTION	Hello, as part of the Country Specific Health Sector Accountability Research you are about to begin, we would like to understand more about you and your work. Over the entire research, you will be completing surveys this survey questionnaire. The purpose of this research is to evaluate Malawi's healthcare systems from the lenses of accountability, governance structures, political economy, fiscal management and financing, reforms, legislative oversight, and citizen engagement and access to healthcare.
District	
Village	
Full Name of Research Assistant	

Date	
Sex (circle)	Male / Female / Other
Age in years	
Profession	Please **circle** the response which closest describes your job: ■ Local Chief ■ VDC Committee member ■ Health Management Committee member ■ Community Policing Member ■ Religious Leader ■ Civil Servant ■ Social Worker ■ Human rights activist ■ CSO/NGO Worker or Volunteer
INSTRUCTIONS	Please complete the survey as honestly and accurately as possible. The results of this study will be used to inform future interventions targeting health service accountability and transparency across Malawi. If you have a question please don't hesitate to ask at any point of the research. The survey should take you about 25 minutes to complete. Please complete the survey independently and without speaking to anyone else. Remember, your responses will remain private and will never be attributable to you.

Q# - Question	Answer (circle)	Skip Rule
PART 1: For each question, please **CIRCLE** your response in the 'Answer' column		
Q01 Do you give your consent to participate in this study?	Yes..... 1 No 2	If NO STOP
Q02 What is the highest level of education you have completed?		

10. What are the differences in the health services provided by different types of service providers? (e.g. Government clinics, faith-based organisations, private sector and traditional healers). Do preferences differ for men and women?
11. How do you understand by participation and accountability in the health sector?
12. What are the informal 'demand driven' mechanisms through which different individuals and groups within the community participate in the health sector? Do men and women use different mechanisms?
13. What are the formal 'invited' accountability channels in the health sector?
a. What is the level of demand for these? How widely are these known?
b. How frequently are these used?
c. How effective are they?
14. Who participates in these formal and informal mechanisms? And for what purpose or motive?
15. What are your views on community participation and its effectiveness?
16. What are the conditions for effective participation? What are the cultural, social, political and economic barriers to participation in the health sector?
a) Have these been experienced in this area?
b) How effective has community participation been like?
c) What role has community participation played on accountability of the health system?
17. What is the impact of participation and accountability on health sector outcomes?
18. How are resources ordered, stored and accounted for in your facility?
a. If you have a chance to improve the current system, what would you change and why?


cTAP
COVID-19 TRANSPARENCY & ACCOUNTABILITY IN AFRICA
Positivo
Follow The Money