

Malawi's Emergency Human Resources Programme

An Overview

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*Matt Gordon
(Former) Health & HIV/AIDS Adviser
DFID Malawi*

DFID

Soon there will be no angels on earth




Treat nurse/midwives well

Retain all nurse/midwives

Train more nurse/midwives



Cordaid 

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1. Context & Inception of Programme
2. What is the EHRP?
3. Impact?
4. Sustainability?
5. Lessons emerging

Context & Inception of Programme

- **Malawi's health sector today (2008 Census)**
 - 1,030 health institutions (from tertiary hospital to health post, including training colleges)
 - 83% provide only primary care, 10% secondary as well
 - 50% government, 16% churches (but 30% of services), 20% private sector
 - Approximate population / facility ratio is 10,000 in urban and 15,000 in rural areas
 - 33,376 "health workers" of which 71% "provide health services" (includes pharmacists):
 - 30% lay health workers
 - 13% nurses
 - 1% physicians
 - 4% mid-level cadres (eg clinical officers)
 - 4% technicians (eg pharmacists)

Context & Inception of Programme

- Regional WHO staff estimates (2004, per 100,000 population)

Cadre	South Africa	Botswana	Ghana	Zambia	Tanzania	Malawi
Doctors	69.2	28.7	9.0	6.9	2.3	1.1
Nurses	388.0	241.0	64.0	113	36.6	25.5

- In 2000, 20% of Malawian nurses & 60% of Malawian doctors worked abroad (estimated, Clemens 2007)
- Top-heavy problem: 2004 vacancy rates for Surgeons, Pathologists, Medical Specialists and Obstetricians = 98%, 100%, 95%, 92%
- Lack of support from domestic or international sources for MoH HR Development Plan finalised 2000

Context & Inception of Programme

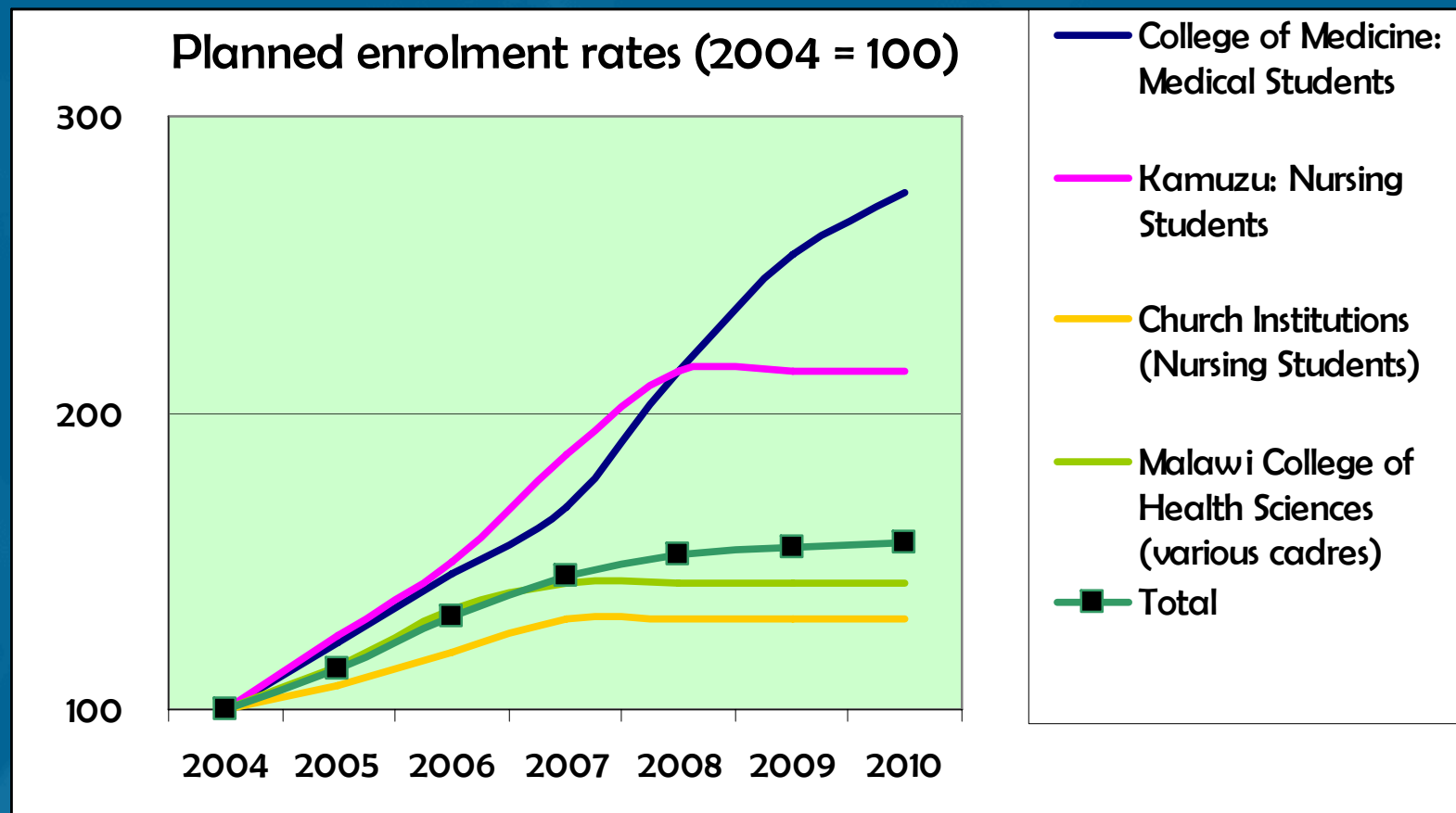
- **New government in 2004: fiscal control**
 - Reduced domestic government debt
 - Introduced control over budget & interest payments
 - Increased commitment to health sector
 - Increased commitment to recurrent expenditure
- **In turn:**
 - Donor confidence enhanced
 - Greater preparedness to fund recurrent expenditure
 - Momentum for health Sector Wide Approach
- **Political will:**
 - DFID / UNAIDS senior management 2004

- Malawi's HRH crisis judged to be due to:
 - Insufficient production of health workers
 - Low & declining pay (relative to opportunities outside public sector & abroad):
 - eg, 2001/02 average health worker remuneration in real terms was less than half that in 1980
 - Poor non-pecuniary terms & conditions
 - Poor recruitment strategies by the public sector
 - Crumbling health system giving poor support to staff

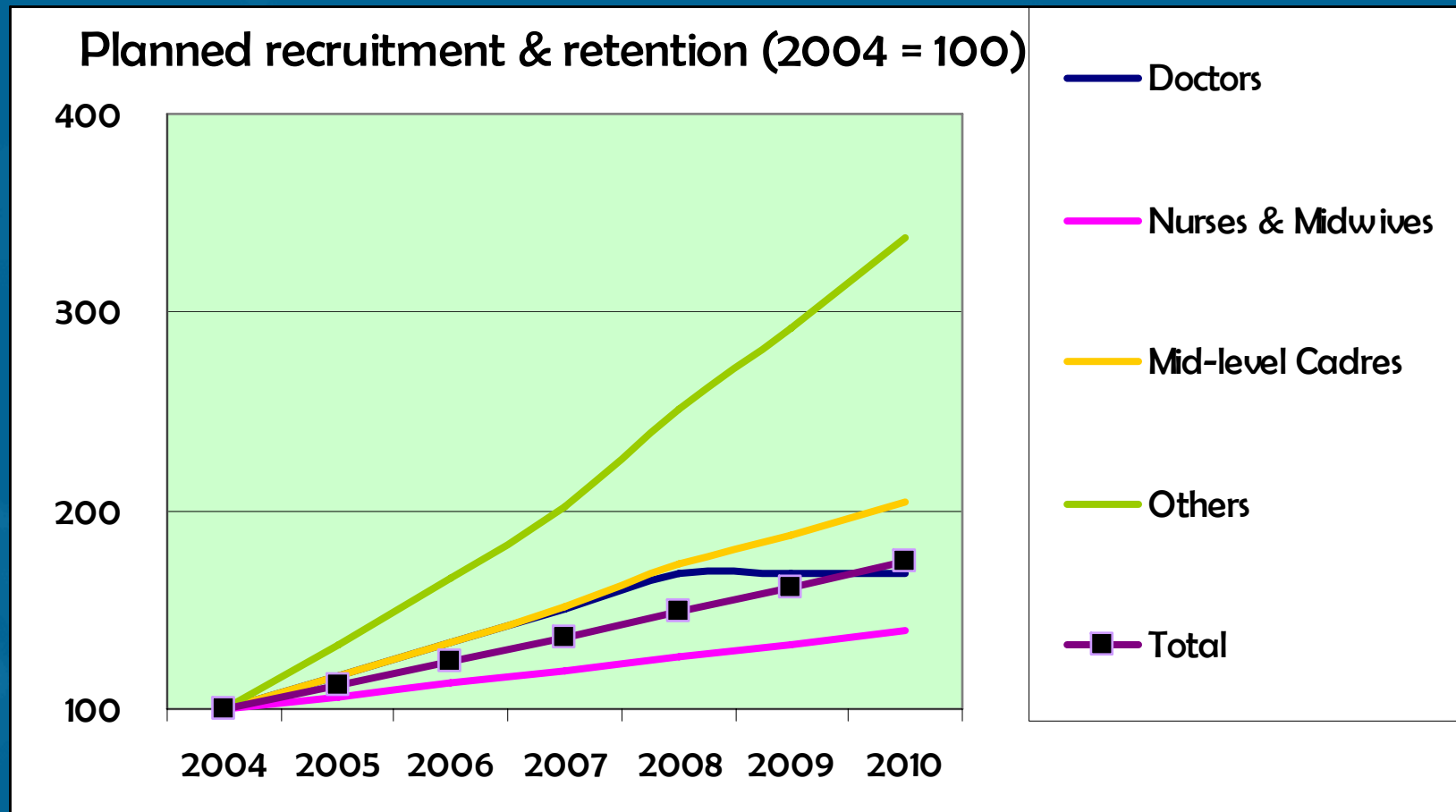
What is the EHRP?

- **EHRP addresses this for 11 cadres:**
 - **Rapid scale up of training infrastructure & staff**
 - **52% top-up of base pay and some allowances**
 - **Staff housing expansion programme & rural hardship incentive package (pending)**
 - **Recruitment galas**
 - **Emergency gap-filling using 90-100 volunteers per year (VSO & UNV)**
 - **Nested within six pillars of work in the health SWAp designed to address health system constraints**

- Training plan



■ Recruitment & Retention Plan



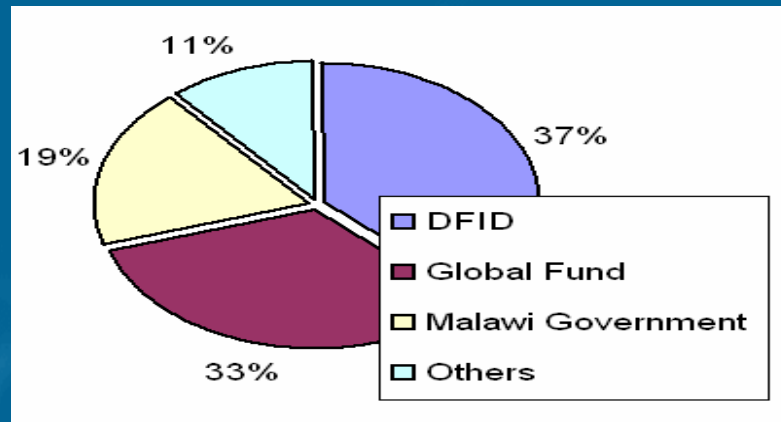
What is the EHRP?

- Overall cost \$272m over six years to:
 - Expand training capacity by 50% (170% for physicians) at a cost of \$62m (crude marginal cost approx \$10,000 per place per year)
 - At a cost of \$210m, attract staff back, recruit new graduates, and retain them, with 2010 public sector targets of (increase in brackets):
 - 205 (68%) physicians
 - 5,776 (39%) nurses / midwives
 - 1,054 (118%) clinical officers
 - 1,145 (93%) medical assistants
 - 1,074 (256%) environmental health officers
 - 369 (310%) lab technicians
 - 209 (99%) pharmacy technicians
 - Approx 1,000 (249%) other skilled staff excluding managers

- **Improved health worker ratios:**
 - Physicians: from 1.1 (2004) to 1.9 (2007)
 - Nurses & midwives: from 25.5 (2004) to 34 (2007)
- **Reduced nurse emigration:**
 - From 147 (2004) to 23 (2006) to 8 (2007)
- **Training targets approximately being met**
 - Falling short of nurse/midwife targets
 - Exceeding doctor / clinical officer / medical assistant targets
 - Delays in expansion of training infrastructure
- **Recruitment & retention targets slightly missed across the board**
 - 10% shortfall (doctors, nurses, clinical officers)
 - Delay in implementation of staff housing programme

- **Lack of data:**
 - Absolute numbers entering & leaving service
 - Motivation behind entrance and departure from sector
 - Underlying determinants of attraction and attrition
 - Impact of salary changes on real disposable income
- **Forthcoming evaluation:**
 - Procurement process commencing November
 - Partial impact evaluation
 - Assessment against experiences of comparable countries
 - Assessment of impact of top-ups on real disposable income
 - Assessment of underlying determinants of rises in retention & falls in emigration

- Funding sources



- Overall public health sector resources:

- 06/07 - MK16bn (US\$120m) of which 56% from donors
- 07/08 – MK25bn (US\$180m) of which 72% from donors

- HIV / AIDS

- Target ART rates 2010 are 208,000 on treatment @ \$251pp (2007 \$) – total contingent liability of \$52m
- Estimated resources = \$200m (2007 \$) of which \$60m from Government of Malawi
- Using Hirschorn et al ratios, ART scale up requirement would require 50% of all nurses, clinical officers & medical assistants retained using EHRP; 5x as many doctors; 6x as many pharmacy staff

- Insist on tight M&E for programmes which provide models for other countries
- Paying staff more works
- Ground salary top-ups in an analysis of labour market conditions
- Partnership essential – especially to keep Global Fund resources flowing
- Planning – not just at the start
- Even the EHRP (a 30% lift in total public health sector resources in Malawi over six years) will not cope with a 2.5% population growth rate & a rapid scale up of ART;
- “task-shifting” is essential in the short term

Thank you