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The supply and distribution of essential medicines in Malawi

Leni Wild and Diana Cammack

Introduction

This report sets out the findings of a brief political economy analysis of the procurement, supply and distribution of essential medicines in Malawi. It uses a sectoral political economy framework that provides a more structured form of analysis, working through various stages, including identifying the nature of the problem to be addressed; diagnosing systemic features and key dynamics and incentives; and pinpointing policy options and feasible theories of change. The team worked closely with the UK Department for International Development (DFID) Malawi to identify and explore these issues, although the views and findings presented in this paper are those of the authors.

The team reviewed technical reports on the health sector and medicine supplies, as well as Malawi governance studies. Interviews were conducted with a range of stakeholders, including representatives from the government (national and district level), the Central Medical Store-Trust (CMS-T), development partners, non-governmental organisations (NGOs) and the media, as well as various consultants involved in technical assistance to the sector. The team also observed the annual Health Sector Zonal Review Meeting for the South East Zone (13-14 September 2012) held in Mangochi.

This report is part of a broader programme of work at the Overseas Development Institute (ODI), which seeks to provide practical advice and resources to enable development practitioners to improve their support to the delivery of key public goods and services in countries undergoing governance transitions. We do this by using a three-pronged approach: applied research in selected countries and sectors; embedded engagement with development actors; and extended outreach. Country case studies and analysis are used to pilot and test more systematic ways of conducting political economy analysis in sectors, and to contribute to the development of a range of useful resources.

Problem identification: chronic stock-outs of essential medicines

Despite the formal policy commitment to free essential medicines, on average 75% of facilities are thought to have experienced significant drugs stock-outs in recent years (MoH, 2011). An Oxfam study found only 9% of local health facilities (54 out of 585) had the full Essential Health Package (EHP) list of essential drugs; clinics were frequently out of basic antibiotics, HIV test kits and insecticide-treated nets; and stocks of vaccines had run dangerously low (Oxfam GB, 2012). Similarly, a 2011 report found that high levels of critical medicines in the EHP were not available: only 27% of health facility managers surveyed considered cotrimoxazole (which treats acute respiratory tract and other infections) to be of sufficient supply in their facility; 60% had insufficient stock; and 13% of facilities were completely out of stock (Mueller et al., 2011). In terms of other oral antibiotics, health centres reportedly had only 22-24% of sufficient stock (benzathine-penicillin and erythromycin) (ibid.).

Stock-outs of essential medicines can contribute to a number of challenges for the Malawi health sector. Where health facilities experience stock-outs of essential medicines, they may be available only at private providers. As a result, medicines are more expensive (and may be less available). Service users do not receive free essential medicines: they may be forced to use these private

or informal providers or have to go without. Moreover, there appears to be significant district-level variation in terms of availability and cost of medicines, which results in inequity of service delivery.

In recent years, reform pressures have focused on strengthening the Central Medical Store (CMS). This has been in existence since 1968, responsible for the procurement and supply of medicines and medical products for the government (using either government funds or donations from health partners). In response to reform pressures, in 2008 the CMS was designated a public trust, with a draft trust agreement established in 2009. The CMS-Trust was registered in August 2011, with the full Board and chief executive officer (CEO) confirmed by the spring of 2012.

In theory, as a trust, the CMS-T is envisaged to work in a more business-like fashion, with better cost accounting measures to ensure it is self-financing and with greater independence. In practice, aspects of how the trust will be constituted remain undecided, and it does not yet appear to have the full confidence of key stakeholders with respect to whether wholesale reforms will be realised within the specified time period. In the meantime, a number of development partners are supporting parallel procurement and distribution systems for particular health needs and products. Also, for an 18-month period, a number of development partners have funded the Emergency Drug Procurement Project, which distributes emergency drug kits to health facilities.

Diagnosis: political economy dynamics that contribute to medicine stock-outs

Chronic shortages of medicines reflect issues of resourcing, as the health sector, along with other sectors, faces significant challenges resulting from the country's broader economic climate and particularly the recent foreign exchange crisis. Various technical reforms have also been lacking, for instance in terms of strengthening information management systems and the management of logistics and procurement processes.

There are also features of the wider institutional environment that contribute to these dynamics. This suggests that technical solutions alone may not be sufficient to overcome bottlenecks along the chain of medicine supply and that there may be other entry points for supporting institutional reform and systems strengthening to contribute to improved outcomes.

A number of political and governance dynamics, for example, exist in Malawi and have implications for the health sector in general and medicine supply in particular. These include:

- **Legacies of past rule and implications for performance**: Legacies of Dr Banda's thirty-year strong man rule (1964-94), and his manipulation of public resources to retain power, remain today (Booth et al 2006). Neopatrimonial tendencies remained after transition to multi-party rule, as shown in examples of forms of patronage in the awarding of contracts and staff appointments; the use of state resources to promote the ruling party (especially during elections); and in the centralisation of power (vis-à-vis local government, parliament, chiefs) (Booth et al 2006; Cammack 2012). National political dynamics impact in the health sector and on medicine supply, though examples of the non-meritorious appointment of staff or awarding of contracts, weaknesses in the rule of law, and poor performance monitoring.
- **Erratic decentralisation and policy incoherence**: Erratic decentralisation in the health sector has contributed to an institutional vacuum at local levels, with unclear lines of decision making and a lack of defined roles and responsibilities, including in relation to oversight of medicine procurement and distribution. This has contributed to policy incoherence, with mandates not clearly defined horizontally and jurisdictions overlapping across sectors and administrative boundaries. Policy incoherence is also present vertically, in that health sector and district policies are not always well aligned or coordinated. This has contributed to a lack of financial sustainability: district health officers (DHOs) have run up debts to the CMS to the point where they have undermined its viability and that of medicine supply, which reflects a lack of checks and balances horizontally (through district commissioners) and vertically (through the Ministry of Health (MoH) and the Treasury).
- **Disrupted state–society relations**: These political dynamics have had particular effects on the nature of citizens' relationships with the state. In general, recent analysis points to limited evidence of citizens' 'empowerment', that is, awareness of their rights and ability to hold decision makers, such as politicians, to account (Wild and Harris, 2012). Instead, decisions flow outwards from the centre, often reinforced by a majority of the population with low levels of education, who remain isolated and largely removed from centres of power: in practice, there is 'little shared understanding of what is in

the "public interest"' (ibid.). This has affected forms of bottom-up monitoring in the health sector. For instance, drug committees have been established in health facilities to monitor delivery and distribution of medicines, with the involvement of selected community members. In practice, their activism has been measured in terms of whether these committees sign for drug deliveries, and many feel that, in practice, they are not fully functional in many areas. This reflects in part the fact that committee members do not feel empowered to challenge those in authority within health centres or to follow up on inconsistencies identified. Local power dynamics mean community members may perceive it to be socially unacceptable to criticise seniors or fear that their access to services will be curtailed as a result.

Alongside these underlying features of the governance environment, specific features within the health sector also shape incentives and behaviour (Mcloughlin and Batley, 2012). These include the following:

- Where the supply of medicines has been centralised (i.e. in a CMS), it can be particularly prone to monopoly tendencies, which can result in a lack of open private sector competition and reduce incentives to improve performance and accountability. Moreover, medicines are themselves lucrative, and may be more vulnerable to pressures for patronage, corruption or theft.
- Curative care in general can be particularly challenging to standardise and plan, as it is necessarily reactive to different disease burdens and trends. This can make service delivery harder to plan and monitor, something that is particularly pronounced in Malawi, given its poor data availability and forecasting.
- In addition, individual needs for curative care are often episodic and unpredictable, with quality of care most important in times of severe illness. This will undermine users' ability to plan or insure, making them more vulnerable to bottlenecks in supply. Moreover, the level of technical knowledge needed – for instance to understand whether the correct medicines have been prescribed – can further undermine users' ability to make choices based on evaluations of quality or efficiency. This is likely to limit forms of bottom-up monitoring, and addressing the issue may require professional oversight.

Conclusions: what can be done?

These dynamics pose a number of implications for addressing chronic stock outs of essential medicines. They suggest that procurement of medicines is likely to be affected by patronage dynamics and vulnerable to corruption. This is not unique to Malawi – it is a common challenge in many countries – but is exacerbated by some of Malawi's historical legacies. External assistance alone is unlikely to be able to resolve these challenges in the short to medium term and it should perhaps be seen as a 'binding constraint'. However, there may be greater room for manoeuvre for external assistance to strengthen aspects of policy coherence, coordination, and performance monitoring which would improve the effectiveness of medicine supply and distribution in incremental ways. In light of this, we identify the following conclusions:

- **Work with government to improve policy coherence:** Forms of policy incoherence (across government and between different levels of government) have undermined the financial sustainability of CMS-T and performance monitoring. Decentralisation has complicated the process for paying for drugs, for instance. Reviewing and rationalising agency structures, processes and interactions may support improved delivery of medicines.
- **Transition out of parallel systems:** Policy incoherence and poor monitoring systems may have been unintentionally exacerbated by the existence of parallel systems. There is a danger that Development Partners (or other third parties) become locked into external procurement and provision of medicines indefinitely. Maintaining parallel systems can undermine incentives for change, and undermine the link between citizen-and-state, as people do not hold government responsible for service provision and leaders no longer feel responsible. As a result, exit strategies need to be designed to move away (even in incremental steps) from the use of parallel systems.
- **Focus on the whole supply chain, not just CMS-T:** The significant focus of reform efforts to date has been on strengthening the CMS function, through the new Trust. This is needed, but represents only part of the supply chain. Even if reforms are realised here (which seems challenging within current timeframes), it may not lead to significant improvements without concurrent reforms in how medicines are ordered, distributed and accessed at local levels.

- **Strengthen bottom-up monitoring in new ways**: The nature of citizen-state relations means that current bottom up monitoring mechanisms (e.g. drug committees) are unlikely to be effective. There are some local actors, however, who might be able to play greater roles as monitors, although they are currently not well incentivised to do so. For instance, traditional chiefs remain a core part of the social fabric of Malawi and if trained, empowered and regulated, could help monitor medicine distribution in facilities but also within communities (including identifying illicit access or pilferage and alerting relevant authorities).
- **Build greater understanding of realities of decentralisation:** Decentralisation was designed to rationalise the various levels and jurisdictions of government. This has not (yet) taken place, but instead, there are multiple agencies working in the same areas and sectors, with overlapping responsibilities, uncoordinated strategies and operational procedures, and competitive staff. As result, there are knowledge gaps in terms of realities of decision making and implementation at local levels and major stakeholders may lack a full understanding of how these processes currently shape medicine supply.

In light of this, we identify a number of potential entry points for reform. These would need to be further developed and tested, with government and community stakeholders taking the lead. They focus on i) strengthening forms of policy coherence and performance monitoring in the shorter term and ii) building longer term support for local level monitoring, planning and resource allocation.

Strengthening policy coherence and performance monitoring

A number of different measures could improve policy coherence and performance monitoring, even where there are strong pressures towards patronage or corruption. These include:

- **Providing change management support to the CMS-T** and technical assistance to MoH that seeks to address particular weaknesses identified, especially to clearly define roles, responsibilities and mandates. To date, assistance to the CMS-T has focused on discrete functions, such as logistics or procurement. Given the scale of the reforms being enacted (new management, staff, policies, warehousing and so on), strategic change management support is likely to be needed. This can focus on rationalising processes and strengthening systems (financial, management, human resources). In each area of focus, change management support should explore how to manage resistance to change, including how to overcome tendencies for old ways of working to reassert themselves. This will require analysis and ongoing monitoring of the organisation's 'culture', including the nature of larger (political, financial, etc.) pressures and incentives acting on staff.
- **Facilitating a sustainable financing arrangement**, with the Treasury and in relation to district budgets, in order to make the CMS-T viable. Our analysis points to a significant lack of clarity on this issue at present, yet this is a key milestone that must be met in the next few months if the trust is to work effectively next year. In the shorter term, this may mean financing medicines through centralised systems and virtual accounts held at the Treasury is preferable to releasing funds to DHOs until better systems and sufficient capacity have been developed at local levels.
- **Developing exit strategies for the joint development partner Emergency Drug Procurement Project** that identify feasible benchmarks (e.g. financial sustainability, clear roles/responsibilities), as part of a package of support to improve financial sustainability. This might include working towards outsourcing of procurement to reliable third parties, under transparent CMS-T control, rather than direct procurement by development partners. This would support greater financial controls but allow development partners to move away from current direct involvement. In addition, development partners could be well placed to support discussions between relevant stakeholders (Treasury, MoH, CMS-T) on future financing models for medicines.

Supporting improved local-level monitoring and delivery

As a first step, much greater clarity is needed as to the realities of local-level decision making and processes in all sectors, but especially in relation to medicine supply. This could be accompanied by efforts to strengthen local monitoring of performance. This might include:

- **Exploring the potential for shared analysis with the government of Malawi** examining decentralisation within the health sector and

current resource decisions for medicines supply. There is potentially real shared interest between government, development partners, civil society and others to better understand district-level processes to improve performance. Options might include Public Expenditure Tracking Surveys (PETSs) and/or more qualitative assessments.

- **Extending the Kalondolondo scorecards programme, or similar programmes, to look at essential medicines in health facilities** could also be a useful way of improving bottom up monitoring. One of the key factors in success of previous work by Kalondondo was the use of local 'brokers' – in education, for instance, this was often local CSOs who understood local dynamics and were well connected (Wild and Harris 2012). For issues of medicine supply, there may be scope to involve other actors, such as local chiefs or professional health associations with the necessary technical knowledge.

These entry points represent a range of areas that could usefully complement ongoing technical reform processes. Moreover, political and governance dynamics are likely to remain pronounced in the run-up to elections in 2014. Availability of medicines is likely to be highly politicised in this respect, alongside other tangible public resources such as fertiliser subsidies. This may contribute to higher levels of political will and could create greater incentives for reform than normally exist. The reforms suggested above would help capitalise on this space.

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Overseas Development Institute
203 Blackfriars Road
London SE1 8NJ, UK

Tel: +44 (0)20 7922 0300
Fax: +44 (0)20 7922 0399

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