# Chapter 3: Health

Within the MPRSP, issues connected to the delivery of health care are included under Pillar 2, Human Capital Formation. The strategy outlines the principal benefit of making expenditures on health care provision (page 52) as being - *an improved health situation will strengthen the ability of individuals to lift themselves out of poverty and will lead to a general increase in productivity*.

The MPRSP points out that health interventions (both preventative and curative) take place at four levels: community, primary, secondary and tertiary. In the 2002-3 budget, PPEs cover a number of these – primary, preventive and secondary curative, which are the key components of the *Essential Healthcare Package* (EHP). Allocations to health workers' training and drugs are also included as PPEs.

In total MK1,612 million is allocated to the PPEs for the financial year in question, the largest amount being for Secondary Curative Care (MK 901 million) even though the total would seem to omit the PPE allocation to Drugs (MK1,002 million)[7]. It is also interesting to note that although the MPRSP points out (page 53) that [p]*reventative interventions relieve pressure on other levels of healthcare and are less costly to the poor* these receive the smallest allocation under the PPEs (this is highlighted in Budget Document 4a as MK16,200, however it would appear more likely that this should be MK16.2 million).

The SDSS investigated the respondents' access to both the nearest Government Health Clinic and the District Hospital. Firstly, they were asked whether they had any reason to attend the facility in question over the past 12 months. Subsequently, for those who did attend, questions focussed on whether there were appropriate drugs available for their ailment at the facility they visited. This deals with one of the key issues highlighted in the MPRSP (page 59), that *access to drugs is a problem, again particularly in rural areas. This is caused by a combination of low (but increasing) allocations to drugs, and distribution problems, including pilferage and inefficient allocation.*

The MPRSP proposed that this will be dealt with by improving availability, in terms of both quality and quantity, through ensuring that (page 61) *the procurement, logistics, management, distribution, and prescription of drugs is reviewed so that all drugs procured reach the intended patients and are prescribed properly. There is also need to reform the Central Medical Stores to function efficiently. These steps are essential complements to the phased increase of allocations to drugs and medical supplies.* In this regard, the questions asked during the SDSS are more appropriate to assess the success or otherwise of this than the indicators included in the MPRSP, which deal with the input end of the spectrum – specifically drugs and medical supplies expenditure per capita[8]; rather than covering outputs or outcomes (access and use) or distribution.

Further questions dealt with the type of worker providing medical assistance at the facility and respondent's satisfaction with the qualification and performance level of the health worker. At the district hospital level, respondents were also asked about the length of time it takes them to access the facility and how long they had to wait once they get there.

In general, the results of the survey show that respondents feel the health staff that treat them are qualified to do so and are generally satisfied with the service received at the

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[7] See Budget Document 4A – pages 6-7

[8] This is targeted to rise from a per capita "current" level of US$1.25 to US$2.50 by 2005. The actual PPE allocation to drugs is set in budget document 4a as MK1,002 million – the equivalent of US$1.33 per capita, based on the prevailing exchange rate in June 2002 of US$1 = MK 75.6 and a population of 10million. However, if the June 2003 exchange rate of US$1 = MK 92.5 is used the per capita value falls to US$1.08. Taking the average of these two rates, the per capita expenditure would be US$1.19. Treasury allocation to the PPE of drugs appears to be running above target, with 71.2 per cent of the approved provision being disbursed by March 2003, ahead of the expected funding of 65 per cent of the annual provision.

nearest health centre (almost seven out of ten respondents made this response) and district hospital (where 61 per cent of respondents were satisfied). The service provided by the health workers is done within a very difficult environment – one that includes large numbers seeking assistance (over three quarters of all respondents said they had sought some form of assistance at the nearest health centre in the past 12 months), the non-availability of drugs and long distances to reach the centres.

### *3.1 The Nearest Health Centre*

On the subject of access to the nearest health centre, the MPRSP (on page 59) highlights that *physical access to health centres has remained poor, with only 3 percent of the population living in a village with a health centre. Existing health centres are in poor condition, and have an inadequate supply of drugs and medical supplies.*

This assertion is somewhat borne out by the responses received during the survey – on average respondents had to travel 10.2 kilometres to reach the nearest government health centre. There are quite noticeable differences between the districts – those living in Mulanje had the shortest distance to travel (4.4 kilometres), while those living in Salima had the longest (16.3 kilometres).

**Table 3.1: Average distance to the nearest government health centre (KMs)**

| | Total (KMs) |
|---|---|
| Mulanje | 4.4 |
| Phalombe | 5.0 |
| Blantyre City | 5.8 |
| Mchinji | 12.7 |
| Salima | 16.4 |
| Nkhata Bay | 14.3 |
| **Total (n=844)[9]** | **10.2** |

Slightly over three-quarters of all respondents had reason to attend this facility in the past 12 months, with differences between districts being rather small, ranging from a low of 69.4 per cent in Mchinji, to a high of 83.6 per cent in Nkhata Bay (see Table 3.2). These figures can only start to suggest the pressure that staff working there must be under as they attempt to provide adequate care and attention to those visiting the centre[10].

**Table 3.2: Proportion of respondents who had reason to attend the nearest government health centre in the past 12 months (%)**

| | % |
|---|---|
| Mulanje | 75.7 |
| Phalombe | 78.7 |
| Blantyre City | 70.5 |
| Mchinji | 69.4 |
| Salima | 80.1 |
| Nkhata Bay | 83.6 |
| **Total (n=927)** | **76.3** |

Of those who attended the facility, slightly over half (56.7 per cent) reported receiving what they consider the correct drugs for the ailment they were suffering from. This figure is as low as 39.8 per cent in Blantyre and as high as 71.7 per cent in Nkhata Bay (see Table 3.3). This figure is consistent with the results of other qualitative exercises (such as the QIM exercise

[9] A number of respondents answered "don't know" to the question "How far is the nearest government health centre", these responses have been omitted from the calculation of the distance

[10] First impressions of this figure are that it appears to be quite high – however, the Integrated Household Survey (IHS) carried out in 1997-8, found that 3.9 per cent of the poor and 4.8 per cent of the non-poor had sought medical attention in the previous two weeks. To provide more information on this issue, future rounds of the SDSS can seek to establish for what precise reason the respondent had attended the health centre.

carried out in 2000[11]), which found that *In terms of accessing medicine for malaria treatment 11 of the 18 communities knew that using* Sulfadoxine Pyriemethamine *(SP) was the most appropriate treatment for malaria – however only four could access the medicine*[12].

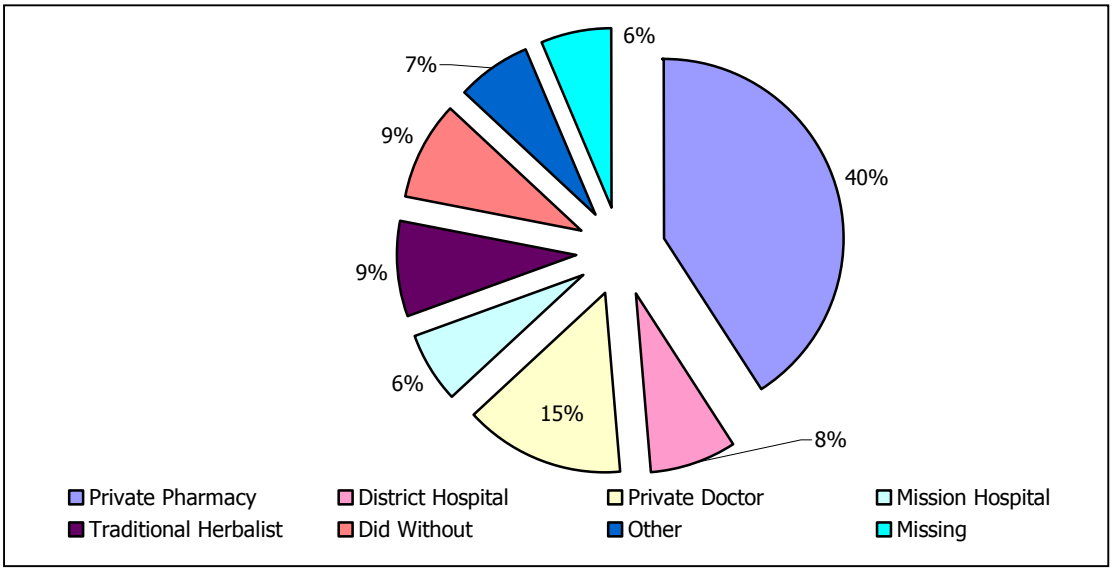
While it is difficult for the respondents to assess what the actual correct drugs are reports from the enumerators suggest that there are two predominant scenarios here – in the first the patient receives no drugs whatsoever, and in the second, at certain health centres, everybody receives Panadol and Fansidar, regardless of what they are suffering from. It was further highlighted to the enumerators at sites near urban centres that the reason for such low numbers of drugs being available is that they are siphoned off to private clinics.

**Table 3.3: Respondents who attended the nearest government health facility in the past 12 months who reported receiving the correct drugs (%)**

| | Yes | No | No Response Given |
|---|---|---|---|
| Mulanje (n=109) | 63.3 | 34.9 | 1.8 |
| Phalombe (n=140) | 57.1 | 42.9 | 0.0 |
| Blantyre City (n=98) | 39.8 | 59.2 | 1.0 |
| Mchinji (n=111) | 66.7 | 31.5 | 1.8 |
| Salima (n=157) | 46.5 | 53.5 | 0.0 |
| Nkhata Bay (n=92) | 71.7 | 28.3 | 0.0 |
| **Total (n=707)** | **56.7** | **42.6** | **0.7** |

The 42.6 per cent of respondents who reported that they did not receive the correct drugs were then asked where did they go – the most common response was that they went to a private pharmacy (40.9 per cent of the total). A surprisingly small amount of respondents (7.6 per cent) said that they went to the district hospital (See figure 3.1 and Table A3.1 in the annex).

**Figure 3.1: Where do those who do not receive drugs at the Government Health Centre go?**




Respondents in Salima pointed out that one of the major difficulties associated with large numbers of local traders selling drugs is that often these are expired, and secondly, that people cannot always afford the full course of treatment. Other potential difficulties with

[11] Malawi Government (2002) "*Qualitative Impact Monitoring of Poverty Alleviation Policies and Programmes in Malawi*", National Economic Council, Lilongwe

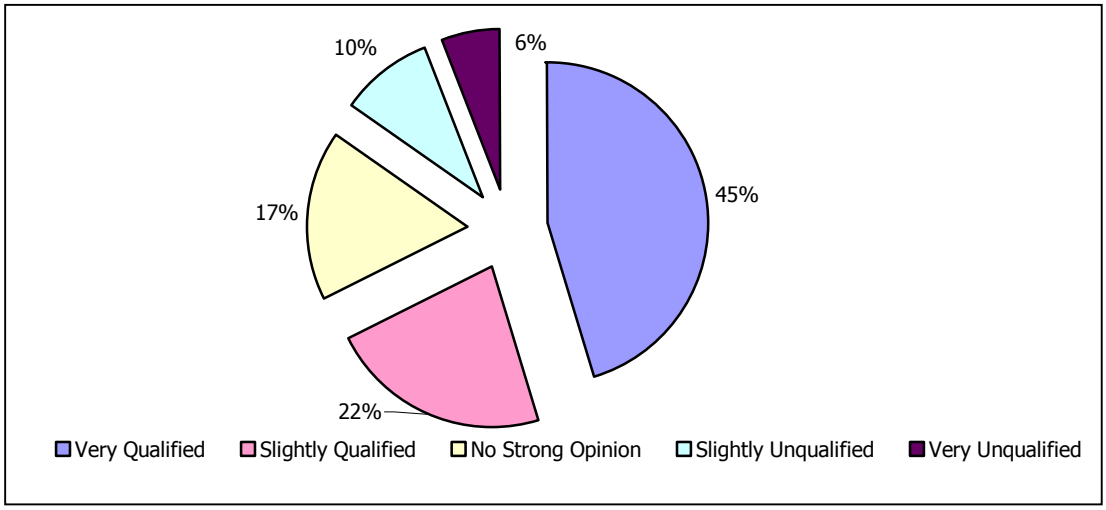
[12] While not directly comparable, it is worth drawing attention to the findings of a survey carried out by the Malawi Health Equity Network in FY 2001-2 on the subject of drug availability. This states that *Of the 36 clinics surveyed, all were out of stock of at least one vital drug on the MHEN list, and one clinic was out of stock of 15 of the 16 drugs surveyed. The average number of vital drugs of which clinics were out of stock was six.*

using vendors as such an important source of drugs are connected with dose scheduling and potential complications in terms of overdose or negative reactions.

Respondents were also asked what type of health worker was providing medical assistance at the nearest health facility – in total, 18.9 per cent said it was a Health Surveillance Assistant, 22.1 per cent said it was a medical assistant, and 20.6 per cent said it was a nurse. A further 28.4 per cent said there was more than one worker at the facility, only 1.6 per cent of respondents said there were no qualified staff[13].

Respondents were asked their perceptions on the qualifications that those serving them at the nearest facility had (it is important to remember that the actual qualifications of those working in the facility were not checked, this question relates purely to the perceptions of the respondent). Almost half the respondents felt the health workers they dealt with were very qualified, a further 22 per cent said they were slightly qualified – only 15.3 per cent of respondents felt they were either slightly or very unqualified (See figure 3.2 and Annex table A3.2). When these results were further analysed by the gender of the respondents, no major differences were identified (See Annex Table A3.4)

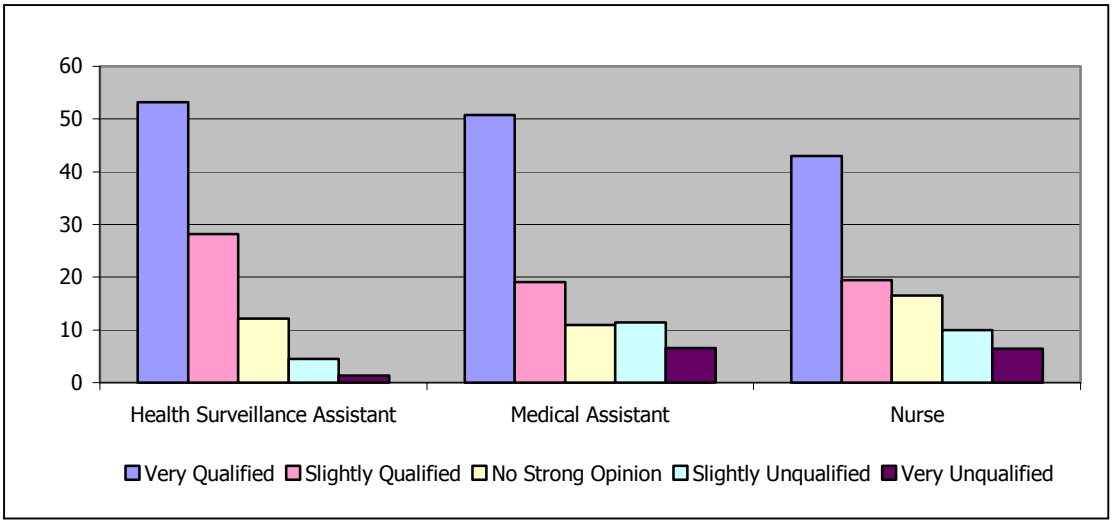
**Figure 3.2: Perceptions on the level of qualification on workers at nearest Government Health Centre**




Further analysis was carried out on the responses given to ascertain the levels of satisfaction with the different type of health worker (bearing in mind the caveats mentioned previously). From this analysis it appears that respondents thought that Health Surveillance Assistants were the most qualified, followed by the medical assistants and then nurses (see figure 3.3).

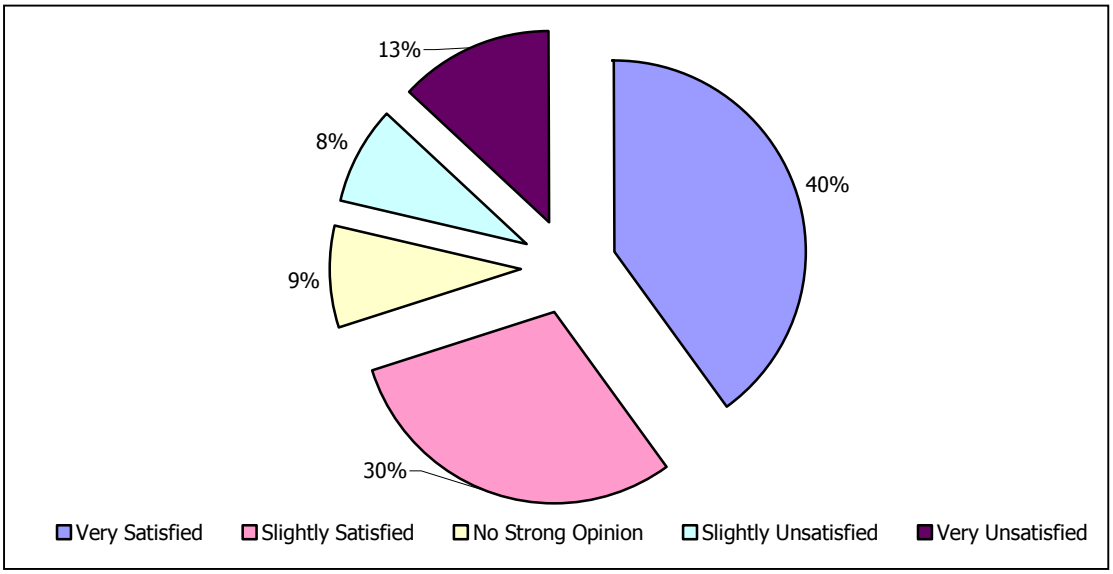
[13] It is important to clarify that enumerators were not requested to check this information; what is included here is the opinions of the people as to what type of worker is providing medical assistance at the nearest facility.

**Figure 3.3: Perception on the level of qualification of health workers by type of worker (%)**




Perhaps more tellingly, respondents were also asked about their satisfaction with the performance of the staff at the nearest health centre. Overall 40 per cent were very satisfied and 30 per cent slightly satisfied with this performance – respondents in Phalombe had the highest score for very satisfied (53.9 per cent), while those in Blantyre had the highest for very unsatisfied (22.7per cent) (See Table A3.3 and figure 3.4). When the responses were analysed by gender, again there was only a negligible difference[14].

**Figure 3.4: Satisfaction with the performance of health staff at the nearest Government Health Clinic**




As with the earlier question, these responses were also analysed in terms of the type of health staff available at the nearest government facility. Respondents seemed to be most satisfied with the HSAs (46.2 per cent very satisfied and 33.3 per cent slightly satisfied) and least satisfied with the medical assistants (11.5 per cent slightly unsatisfied and 19.7 per cent very unsatisfied). However, as mentioned previously, the enumerators were not requested to reconfirm the actual grades and qualifications of these staff.

[14] See Annex Table A3.5, which shows that 42.5 per cent of males were very satisfied, with 41.8 per cent of females giving the same response.

In terms of which district is most satisfied with the qualifications of staff and the services they offer at the nearest government health centre, using the weightings and calculations outlined earlier in the report, it appears that respondents in Mulanje are the most satisfied and those in Blantyre City are least satisfied. Overall, the single digit score for satisfaction with the service offered from the nearest government health facility (0.836) places it towards the upper end of slightly satisfactory on the scale.

**Table 3.4: Satisfaction with services at nearest government health facility**

| | Perceptions on the qualifications of the staff at the health centre | Satisfaction with the health worker | Total | Rank |
|---|---|---|---|---|
| Mulanje | 1.225 | 1.051 | 1.138 | 1st |
| Phalombe | 0.994 | 1.084 | 1.039 | 2nd |
| Nkhata Bay | 0.888 | 0.720 | 0.804 | 3rd |
| Mchinji | 0.916 | 0.566 | 0.741 | 4th |
| Salima | 0.704 | 0.643 | 0.674 | 5th |
| Blantyre | 0.773 | 0.309 | 0.541 | 6th |
| Total | 0.917 | 0.755 | 0.836 | -- |

## *3.2 The District Hospital*

From the responses to the questionnaire, it appears that the average distance travelled to the district hospital is slightly under 30 kilometres, almost three times the distance that respondents had to travel to the nearest health centre (10.2 kilometres). Respondents in Phalombe travelled the furthest (56.5 kilometres), probably because they must access this facility in one of the neighbouring districts[15]. Those in Blantyre had the shortest distance to travel, at an average of slightly over 12 kilometres. (See table 3.5).

**Table 3.5: Average distance to the nearest district hospital (KMs)**

| | KMs |
|---|---|
| Mulanje | 17.9 |
| Phalombe | 56.5 |
| Blantyre City | 12.1 |
| Mchinji | 31.4 |
| Salima | 43.6 |
| Nkhata Bay | 30.3 |
| **Total (n=915)** | **29.9** |

Over half of the respondents in the exercise said that they had reason to attend the district hospital in the past 12 months – 59.7 per cent of the total, considerably less than the number who had to attend the nearest health centre (76.3 per cent). This appears to be a very high proportion and would appear to give some backing to the assertion made in the MPRSP that *it is estimated that as many as 85 percent of central hospital admissions could be treated at lower- level facilities*.

**Table 3.6: Proportion of population attending district hospital in the past year (%)**

| | % |
|---|---|
| Mulanje | 69.7 |
| Phalombe | 44.1 |
| Blantyre City | 52.3 |
| Mchinji | 62.6 |
| Salima | 55.6 |
| Nkhata Bay | 77.0 |
| **Total (n=958)** | **59.7** |

[15] Respondents attend the nearest district hospital to them – those living in the proximity of the Zomba boundary use the district hospital there, those near Mulanje use that district hospital and those near Chiradzulu attend there.

Respondents were asked what means of transport they take to the district hospital, 25.9 per cent said they took a bus, 19.8 per cent said they used a bicycle, 33 per cent travelled on foot and 17.8 per cent had access to a private motor vehicle (See Table A3.6 in the annex for a more detailed breakdown on this information). Respondents were then asked how long it took them to reach the district hospital, using this means of transport. In total 55 per cent of respondents took over two hours to travel to the district hospital, while only 9.2 per cent were able to get there in less than 30 minutes. As can be expected the largest proportion of respondents taking over two hours was in Phalombe (where, as previously highlighted, there is no district hospital), while the lowest percentage taking more than two hours is in Blantyre[16], where it is still a quite high 42.6 per cent.

**Table 3.7: Length of time taken to reach the District Hospital, by district (%)**

| | Less than 30 minutes | 30 Minutes to 1 Hour | Between 1 and 2 Hours | More than 2 Hours |
|---|---|---|---|---|
| Mulanje | 17.9 | 20.1 | 24.6 | 37.4 |
| Phalombe | 0.7 | 8.8 | 19.6 | 70.9 |
| Blantyre | 8.2 | 13.1 | 36.1 | 42.6 |
| Mchinji | 11.7 | 5.4 | 29.8 | 53.2 |
| Salima | 1.5 | 12.9 | 19.1 | 66.5 |
| Nkhata Bay | 15.8 | 14.2 | 11.7 | 58.3 |
| **Total (n=968)** | **9.2** | **12.2** | **23.7** | **55.0** |

As with the respondents who attended the local health facility, those who had attended the district hospital were asked whether they were able to get the appropriate drugs. When compared to the results for the nearest health centre, a much greater proportion of those interviewed responded positively in this instance; 72.7 per cent said the drugs were available, while 21.9 per cent said they were not. However, this is considered to be still a rather high figure (See Table 3.8 for more details).

**Table 3.8: Respondents who attended the district hospital in the past 12 months who reported receiving the correct drugs (%)**

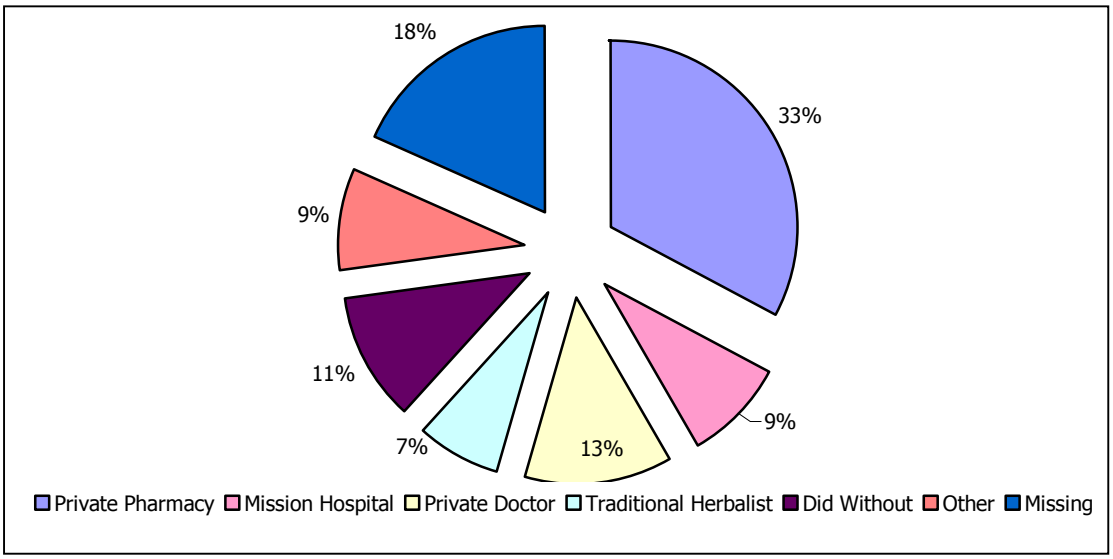
| | Yes | No | Not Applicable or Missing |
|---|---|---|---|
| Mulanje | 73.0 | 20.5 | 6.6 |
| Phalombe | 81.7 | 8.5 | 9.9 |
| Blantyre City | 69.1 | 25.0 | 5.9 |
| Mchinji | 67.2 | 27.7 | 5.0 |
| Salima | 70.5 | 22.9 | 6.7 |
| Nkhata Bay | 77.0 | 23.0 | 0.0 |
| **Total (n=572)** | **72.6** | **21.9** | **5.6** |

Those who did not receive the correct medication were asked where they then went – again the most common response was a private pharmacy (32.8 per cent) or a private doctor (12.8 per cent) (see Figure 3.5 and Table A3.7 in the annex[17]).

[16] Blantyre does not have a district hospital as Queen Elizabeth Central Hospital (QECH) is technically not a district hospital, even though respondents treat it as such and are not clear about this distinction

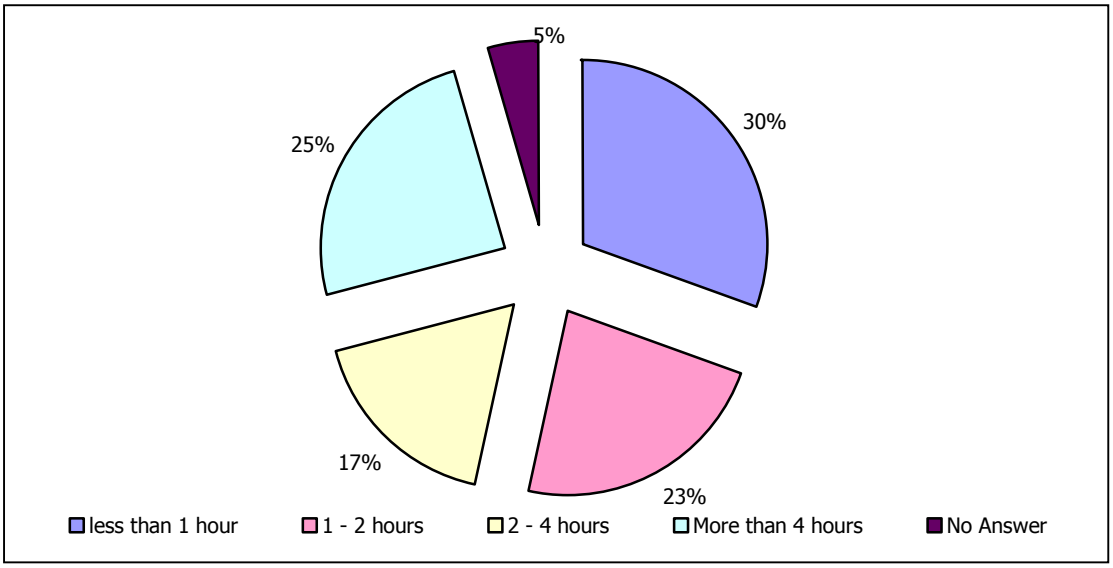
[17] Caution is urged in using drawing district level inferences from the information in Table A3.7 because of the small number of responses.

**Figure 3.5: Destination of those who did not receive drugs at district hospital at last visit**



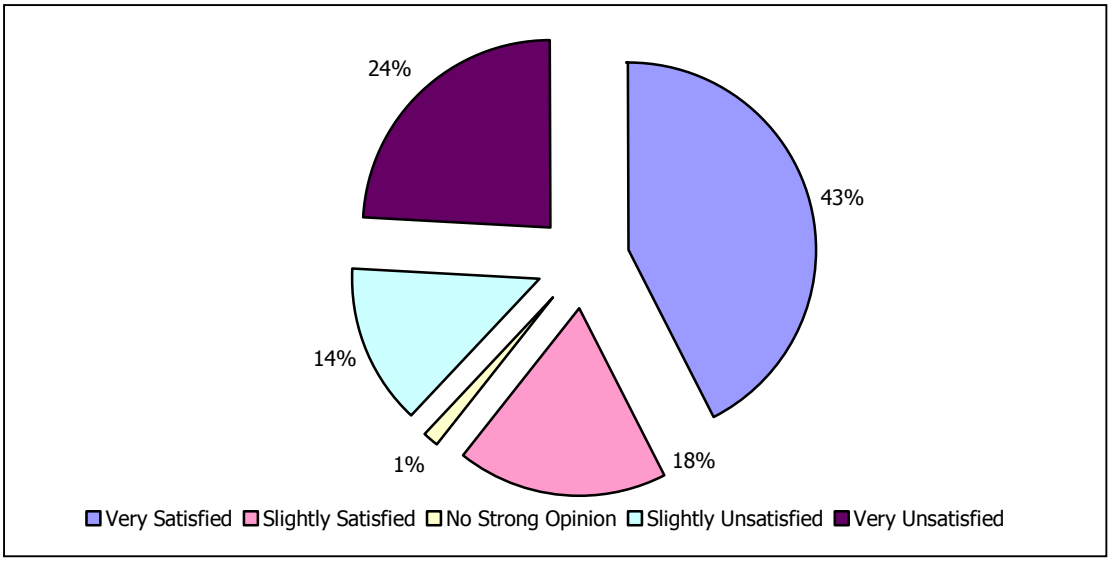

Respondents were also asked how long they had to wait to be treated at the district hospital on their last visit. Overall, 30.6 per cent had to wait for less than one hour to be treated, but almost one in four (24.7 per cent) had to wait for over four hours. Respondents in Blantyre had a worse than average experience, 41.2 per cent of respondents there said they had to wait for over four hours (See Figure 3.6 and Table A3.8).

**Figure 3.6: Length of time respondents were expected to wait at the District Hospital**



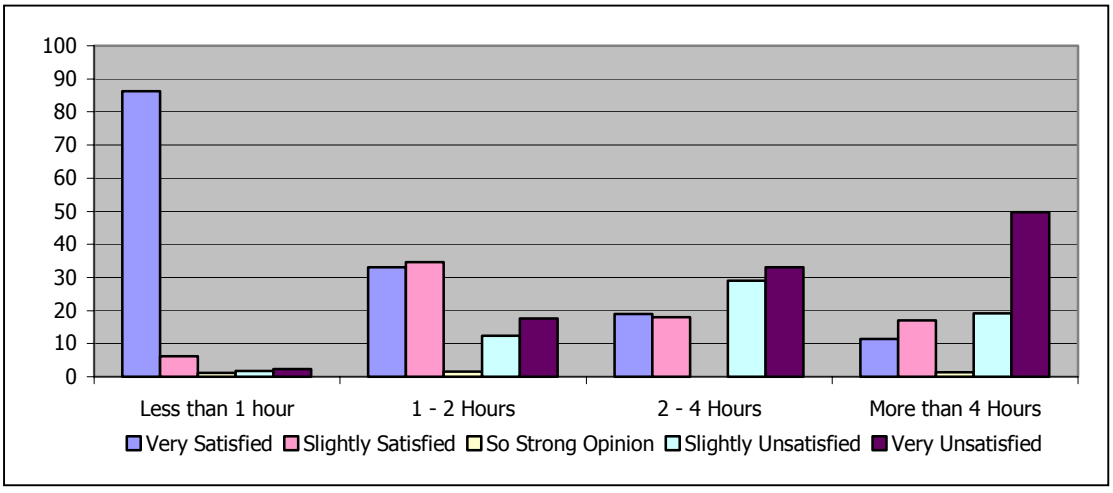

Over 40 per cent of respondents (40.7 per cent) were very satisfied with the time they were expected to wait, while at the same time 23.1 per cent were very unsatisfied. Perhaps unsurprisingly, judging from the proportion of respondents who had to wait over four hours for attention, respondents in Blantyre had the highest percentage of respondents saying they were very unsatisfied (44.1 per cent). (See Figure 3.7 and Table A3.9)

**Figure 3.7: Satisfaction with the time they were expected to wait at the district hospital**



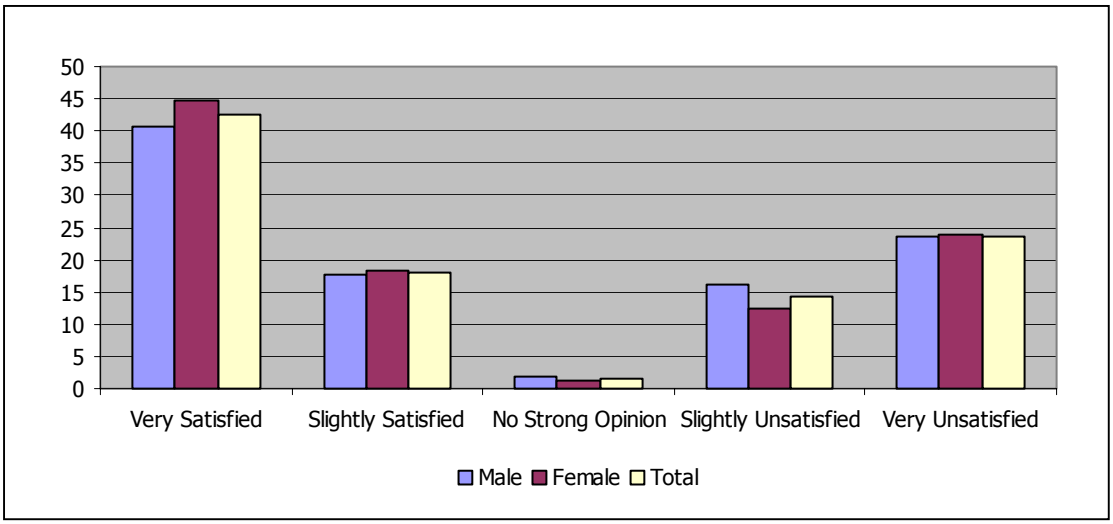

When one analyses the satisfaction ratings by the length of time respondents were expected to wait, the results reveal no major surprises. Those who had to wait less than an hour are generally very satisfied, while those who had to wait for more than four hours have the largest proportion of respondents saying that they are least satisfied (See figure 3.8 for a representation of this).

**Figure 3.8: Satisfaction with length of time waited at District Hospital (%)**



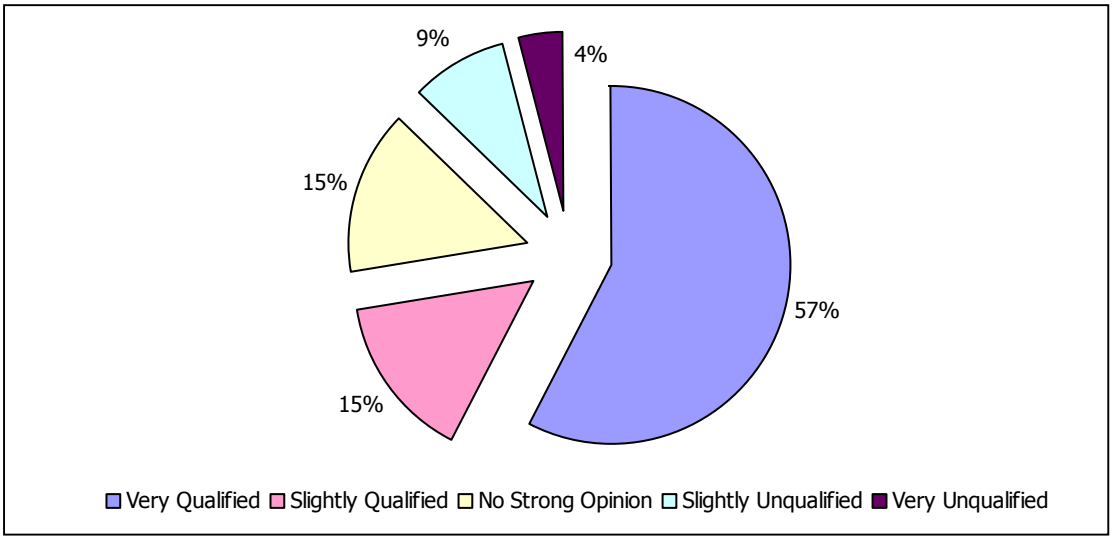

These responses were also analysed in terms of the gender of the respondents, with the expectation that women may have to wait longer at the hospital, or that women may be better positioned to make a response on this question, bearing in mind the fact that they may have to attend more often with children. However, as with the other responses that were analysed in these terms there appears to be only minor differences, with slightly more females (44.6 per cent as apposed to 40.8 per cent) saying they were very satisfied with the time they waited. (See Figure 3.9 and Annex Table A3.10).

**Figure 3.9: Satisfaction with length of time waited at District Hospital, by Gender (%)**




Respondents were also asked their opinions on the qualifications of staff at the district hospital. It is important again to point out that the respondents were not asked to identify the actual qualifications of the medical staff, nor were attempts made to ascertain the level of these qualifications, simply, respondents were asked their opinions as to whether they felt the staff there were qualified or not. As with the question asked concerning the local health facility the majority of people felt that the staff were qualified, with 57.4 saying they thought they were very qualified, and only 12.8 per cent saying they thought they were unqualified (See Figure 3.9 and Table A3.11 for a district level breakdown of the figures).

**Figure 3.10: Perceptions of the qualifications of staff at the district hospital**




Respondents were also asked whether they had been requested to make a payment to speed up their treatment at the district hospital - only 2.9 per cent of respondents said this was the case. They were further asked how much this payment was – on average this amounted to MK171. However, while the numbers responding that they had to make a payment to an official to be seen more quickly was quite low, respondents were also asked whether they felt having a relative working in the district hospital would help speed up their treatment. In this instance, half of the respondents felt that this would be the case (See table 3.9). An

alarmingly high number of respondents in Blantyre (85.3 per cent) answered this question positively[18].

**Table 3.9: Respondents who attended the district hospital who felt having a relation working at the hospital could speed up their treatment(%)**

| | Yes | No | No Response |
|---|---|---|---|
| Mulanje | 47.5 | 21.3 | 31.1 |
| Phalombe | 39.4 | 28.2 | 32.4 |
| Blantyre City | 85.3 | 2.9 | 11.8 |
| Mchinji | 58.0 | 22.7 | 19.3 |
| Salima | 39.0 | 23.8 | 37.1 |
| Nkhata Bay | 36.8 | 13.8 | 49.4 |
| **Total (n=572)** | **50.0** | **19.6** | **30.4** |

In terms of which district is most satisfied with the service offered from the district hospital, this has been assessed based on the questions *satisfaction with time expected to wait* and *qualification of the staff*. From this it appears that respondents in Phalombe are most satisfied (this would appear to be something of an anomaly as they are the ones who have to travel the furthest to the district hospital, suggesting that they are simply relieved to receive any service because of this). The most dissatisfied respondents live in Nkhata Bay. The single digit score for satisfaction with the district hospital (0.762) places it towards the upper end of slightly satisfactory on of the scale, but lower than the value received for the local health centre.

**Table 3.10: Satisfaction with services at district hospital**

| | Satisfaction with time to wait | Qualifications of the staff | Total | Rank |
|---|---|---|---|---|
| Phalombe | 1.18 | 1.48 | 1.333 | 1st |
| Mulanje | 0.58 | 1.27 | 0.927 | 2nd |
| Salima | 0.60 | 1.03 | 0.817 | 3rd |
| Mchinji | 0.29 | 1.04 | 0.669 | 4th |
| Blantyre | -0.13 | 1.28 | 0.573 | 5th |
| Nkhata Bay | -0.23 | 0.77 | 0.270 | 6th |
| Total | 0.39 | 1.13 | 0.762 | |

## *3.3 Conclusions*

The areas the respondents live in are characterised by long distances to reach the nearest health centre or district hospital, compounded by drug shortages (or unavailability) and long waits to receive treatment at the district hospital, which many respondents felt would not be the case if they had a relative working there.

In general, satisfaction ratings with the services provided by the staff of the medical facilities is high. There is little to choose between the satisfaction ratings of the two major types of health facility, even though respondents seem to be marginally less satisfied with the service received at the district hospital than that received at the nearest health facility. One can postulate that this is partly due to the time waited at the district hospital: for one quarter of all respondents this is over four hours.

However, the proportion of respondents who felt they were able to receive the correct medication is considerably higher at the district facility and the staff are perceived as being better qualified (57.4 per cent said they felt the staff were very qualified in the district hospital against 45.4 at health clinic). It is reasonable to assume that this is taken into account when deciding on which facility to use. As long as this perception prevails it will continue to be difficult to convince people to utilise the local health centre, despite reports that patients are

[18] Further discussions with a frontline service providers at this level revealed that, while this may be the case, they feel that they do not have any alternative. They also felt that sometimes when they are forced to prioritise the sickest patients, people interpret this as favouritism for relatives.

turned away from district hospitals because they do not have referral letters from lower level facilities.

Of particular concern is the numbers saying they do not received the correct medication when they visit the various facilities, this is 42.6 per cent of those attending the nearest health centre and 21.9 per cent at the district hospital. These high levels are disconcerting because of the laudable commitments to improving accessibility to drugs contained in the MPRSP and the substantial allocations made to this under the PPEs in the budget. It would appear from the results of the survey that a complete overhaul of how drugs are delivered is needed to ensure a more equitable (and intelligent) distribution of drugs is achieved, so that health centres are not without drugs and individuals do not have to seek alternative sources for these.

Of further concern are the destinations of those who are are not receiving medication at the government facilities. The most frequent response was to purchase this medication from private pharmacies, many of which are purely local traders. There are reports that these vendors sell medication that is out of date. Further, the cost of this medication can be prohibitive for the respondents, meaning they do not take the full course of drugs, leaving them susceptible to relapses.

The results of the SDSS also suggest that it is important to reassess what is considered as "corruption" in the delivery of health services. It is apparent that only a very small proportion of respondents have ever been asked to provide a payment to receive better treatment, however, the numbers feeling that if they had a relative working in the district hospital in particular they would receive a better quality of treatment is of particular concern. In this regard, those using the district hospitals should know how long they can expect to wait, and all patients should be dealt with by the same criteria when it comes time for treatment. One potential solution for this is to offer more autonomy to Health Management Committees who can deal directly with such complaints as they arise.