**United Nations Volunteers in the Health Sector in Malawi**

**Development of an exit or retention strategy**

This is the report on the first part of a two-part mission to Malawi

Mark Wheeler

Independent Consultant for UNDP and WHO

June 2014

**Acknowledgements**

This report could not have been writtenwithout the assistance and support of a large number of individuals engaged in different roles but all striving to improve the health workforce situation in Malawi.

In UNDP I would like to thank Resident Representative Ms Mia Seppo, Deputy Resident Representative Carole Flore-Smereczniak and Assistant Representatives Ernest Misomali and Katarzyna Wawiernia. Mr Millingo (Venge) Nkosi prepared initial briefing papers, guided me to many of the interviews and constantly updated a demanding schedule. Ms Mercy Alidri accompanied me on visits to each of the Central Hospitals and a number of interviews, in addition to introducing me to the UN Volunteers. Ms Amakobe Sande of UNAIDS made constructive suggestions about the funding of a continuing programme.

In WHO, I would like to thank the Country Representative, Dr Eugene Nyarko, first for his initiative in focusing the terms of reference on the needs of Malawi, and then for policy and logistic support throughout the mission. Dr Francis Magombo produced initial drafts of the schedule and accompanied me to significant interviews.

In the Ministry of Health, I am particularly indebted to Dr C Mwansambo, Chief of Health Services, and Dr G Chitope-Mwale, Director of Clinical Services, for guidance on Ministry policies and views on the UN Volunteer scheme. The Project Manager, Mr Enock Phale, described current deployment policy. Valuable information on numbers of Malawian doctors in post, attrition rates and the pipeline of specialists in training was provided from the Directorate of Human Resources by Mrs Gillian Nkhalamba and Mr Patrick Boko. At each of the Central Hospitals, the Hospital Director or his/her Deputy provided the details of their staffing situation and the contribution made by UN Volunteers.

Other Malawian institutions contributed useful advice and information. At the National AIDS Commission I thank Dr Thomas Bisika and his team; at the Malawi Medical Council, Mr C Mkandawire; at the College of Medicine Dr M Mipando and Dr T Dzowela; and at CHAM Dr M Makoka.

I sought help and advice from selected members of the donor community. I would like to thank Miriam Lutz of USAID, then chairperson of the Health Donor Group, for allowing me to attend the meeting of the Group held on 4 June; Ms Hildegunn Tobiassen of the Royal Norwegian Embassy; Ms Katrin Pfeiffer of the German Embassy and Dr Andrea Knigge and Ms Elena Beselin of GIZ.

Last but not least, I have to thank the UN Volunteers, too numerous to name individually, but collectively a source of insights into the health workforce situation in Malawi and their inspiring role in expanding service delivery and leading the next generation of Malawian health workers. It was a privilege to meet them and learn from them their many contributions, frequently far exceeding their formal job descriptions.

While all the above provided useful advice and information, I have to make the customary disclaimer that the use made of them is entirely my own responsibility. The views expressed in this report are solely those of this consultant, and neither UNDP nor WHO can be held accountable for them.

Mark Wheeler, June 2014

**ACRONYMS AND ABBREVIATIONS**

ART Antiretroviral treatment

CHAM Christian Health Association of Malawi

CIM Centre for International Migration

DFID Department for International Development (UK)

GFATM Global Fund to fight against Tuberculosis, AIDS and Malaria

GP General Practitioner (also Medical Officer in Malawi Government)

HIV Human Immunodeficiency Virus

HRH Human Resources for Health

KCH Kamuzu Central Hospital (Lilongwe)

MCH Mzuzu Central Hospital

NAC National AIDS Commission

QECH Queen Elizabeth Central Hospital (Blantyre)

UNDP United Nations Development Programme

UNV United Nations Volunteer

VSO Voluntary Service Overseas (UK)

WHO World Health Organization

ZCH Zomba Central Hospital

**An exit/retention strategy for UN Volunteers in the Health Sector in Malawi**

This report is presented in two parts. Part 1 is an appreciation of the current state of medical staffing in Malawi, and the contribution made by UN Volunteers (hereafter UNVs). Part 2 offers a set of scenarios for the future of the programme. These correspond to deliverables 1 and 2 of the consultant’s terms of reference, reproduced as Annex A.

**Part 1**

*Background*

It is widely appreciated that Malawi has had a long standing problem of insufficient human resources for Health. The factors underlying this condition include:

* Very low salaries and poor working conditions contributing to high attrition
* Insufficient production of health workers
* High rates of attrition attributable to emigration and losses from HIV/AIDS

In the early years of the millennium, the situation was so dire that Malawian doctors were to be found only in the central hospitals (there were doctors in some district hospitals provided by various aid agencies). Vacancy rates for specialists were around 90%, vacancy rates for other cadres against the Ministry of Health established posts were between 30 and 60%. This crisis situation inspired the donor funded Emergency Human Resources Programme, which had three main components: salary supplementation in the form of a 52% across the board uplift to basic government salaries for 11 categories of trained health workers; expanded intakes to training programmes; and the recruitment of volunteers through schemes including Voluntary Service Overseas funded by DFID UK (now largely confined to nurse training institutions) and the UNV scheme supported by the Global Fund. More recently, medical teams have been provided by China, Japan and Germany. Currently the German programme under CIM (Centre for International Migration) employs 2 anaesthetists at the College of Medicine with 1 internal medicine specialist due to arrive shortly, and at Kamuzu Central Hospital 1 paediatrician currently with 1 gynaecologist due to arrive shortly.

The extent of the crisis may be illustrated by the following cross country comparisons:

**Health workers per 100,000 population (estimated date 2002-3)**

 Botswana RSA Ghana Tanzania Malawi Malawi 2007

Doctors 28.7 25.1 9.0 4.1 1.6 1.9

Nurses 241.0 140.0 64.0 85.2 28.6 33.7

Source: Impact Evaluation of the Sector Wide Approach, Malawi, HDRC report for DFID (2010). The Malawi Strategic Plan for Human Resources has different numbers for other countries, but similar numbers for Malawi.

As is shown in the last column, the situation in Malawi had improved by 2007, but only slightly. In absolute terms, at 0.36 per thousand Malawi falls far short of the threshold level of 2.3 health workers (doctors and nurses) per thousand population identified by WHO as the level at which attainment of key health coverage indicators is feasible.

*History of the UNV programme*

Promptly in response to recognition of the human resources crisis in the health sector, UNDP funded the recruitment of 9 medical specialists under the UNV programme in 2004. From 2005, the scheme was expanded through agreements with the Ministry of Health and the Global Fund to fight Tuberculosis, AIDS and Malaria (GFATM) to use part of GFATM grants for the UNV programme, adding GPs and ART supervisors to the categories to be recruited. These agreements had a total duration of six years, corresponding to the originally planned six years of the Emergency Human Resources Programme but lagged by one year, ending December 2011.

The numbers of UNVs reached a peak in 2011 when 65 were in post against a target of 75 (there were subsequent calls for the target to be raised to 90). Of the 65, 39 were specialists against a target of 40, 21 were GPs against a target of 30, and 5 were the zonal ART supervisors. As early as 2009 the Tripartite Review Meeting (now the Capacity Development in Health Project Board) began to call for an exit strategy, based on a long range plan for human resources for health. Another issue that began to surface was the desire of the Ministry of Health that UNV GPs should be phased out. The following year, UNDP objected to the unilateral decision of the Ministry to no longer recruit GPs on the grounds that it was incompatible with obligations set out in agreements with the funding source, GFATM, and this decision was promptly reversed. However, the Ministry has recently re-stated its view that Malawi has sufficient GPs in the light of the larger numbers now graduating from the College of Medicine.

There has also been a shift over time in the deployment of UNVs. Whereas in early periods it was assumed that doctors, even specialists, might be deployed in district and CHAM hospitals, there has been a marked process of concentration in the four Central Hospitals. In part, this reflects the Ministry policy of concentrating specialists in the Central Hospitals, but it has also been applied to the now smaller number of GPs. At some stage not clearly evident from the written record, In addition to doctors the UNV programme also began to recruit dentists and physiotherapists.

With the conclusion of the six year programme in December 2011, there has not been long term guaranteed finance for the continuation of the programme. Short term bridging finance was provided to mid-2012, when a new Programme Support Document was prepared by UNDP with multi-agency support, but it disclosed a financing gap in excess of $8 millions against an estimated cost for the four year period 2012 – 2016 of $9.9 millions. As a consequence, there was a minor financial crisis at the end of 2012 and a major financing crisis towards the end of 2013 when termination notices were issued to 28 of the UNVs. These were withdrawn when promised funds were released by NAC (National AIDS Commission) and the Royal Norwegian government provided a grant, which together provide adequate resources for 2014, but the hiatus produced by this funding crisis has had an effect on both recruitment of new and retention of existing volunteers, so the total fell from 52 at December 2013 to 38 at May 2014.

*The current situation of the UNV programme*

Apart from the HIV Programme Supervisors who are located in the zonal offices, all except one of the current UNVs are concentrated in the four Central Hospitals: Kamuzu Central Hospital, Lilongwe (KCH); Queen Elizabeth Central Hospital, Blantyre (QECH); Zomba Central Hospital (ZCH); and Mzuzu Central Hospital (MCH). The exception is one GP who is situated at Bwailo Hospital in Lilongwe. The distribution is summarised in the table below:

**UNVs by category and location as at 31 May 2014**

 KCH QECH ZCH MCH other Total

Medical specialists 5 5 4 4 18

GPs 1 1 3 1 1 7

Dentists 3 1 1 5

Physiotherapists 2 1 3

HIV Programme Supervisors 5 5

Totals 11 7 8 6 6 38

NB. 2 additional specialists arrived at the beginning of June, and a further 3 late in June.

During this consultancy, visits were made to each of the Central Hospitals, and the College of Medicine in Blantyre. At each site, the Hospital Director or his/her deputy, and about three quarters of the volunteers, were interviewed. The Hospital Directors were unanimous in regarding the UNVs as a valuable addition to their staff, and in Zomba and Mzuzu, in each of which there is only one Malawian specialist, they were regarded as indispensable. In the words of the Director of Zomba Central Hospital “If they were to leave, we would cease to be a referral hospital”. This good opinion extended also to the GPs who, although not qualified as medical specialists, were often performing specialist roles.

In the Central Hospitals, UNVs had two main functions: direct service provision and teaching. In numerous instances, they were able to report an impressive increase in the number of patients treated and/or a significant extension of the scope of service. Examples of specific service developments are paediatric surgery in QECH, and neurosurgery in KCH. In both cases, the incumbents were recruited as general surgeons, and they still take part in general duties including being on call for the entire department, but at the same time they were able to deploy their specialist skills to serve previously neglected groups of patients. UNV physiotherapists in QECH and KCH took over and developed moribund departments.

The opportunities for teaching vary with the location. In each location, the UNVs are teaching the staff of their own departments through morning handovers, ward rounds and in theatre sessions. The departmental staff concerned are junior doctors, clinical officers and nurses. Formal instruction of medical undergraduates mostly takes place in Blantyre, and of interns in Blantyre and Lilongwe, so these categories of students are not present at other sites. Along with Malawian colleagues and staff of the College of Medicine, UNV specialists participate in the practical teaching in the clinical setting of undergraduates, interns and residents in speciality training programmes. Dentists teach dental therapists who deliver the bulk of medical care in Malawi, while the core function of the HIV Programme Supervisors is to mentor the Clinical Officers, Medical Assistants and others providing ART in health centres and clinics. Given that the UNV programme has developed from a gap filling to a capacity building phase, it can be said that everyone bar the most recent arrivals can demonstrate an impressive contribution to training their juniors.

UNVs surpass their job descriptions in all kinds of enterprising and constructive ways. Several have mobilised funds, either from friends and family, or from the commercial sector, to buy much needed equipment and supplies for their departments. The dentist at ZCH used his personal connections to obtain $27,000 worth of equipment and supplies. The physiotherapists at KCH sourced K45M from commercial connections to equip the department. These stories could be multiplied.

Some specialists undertake research, for example, the neurosurgeon at KCH is investigating epilepsy, while the paediatric surgeon specialist at QECH undertook research on patient management which led to a considerable reduction in length of stay. At MCH, all the UNV specialists undertook outreach visits to district hospital in the short interval (Oct-Dec 2013) when fuel was available, paid by the programme. In some cases they were able to treat patients at the district hospital (lack of surgical equipment and supplies precluded this at some) and in all cases they were able to instruct the district level clinicians on the indications for referral (and contra-indications in cases where a disease process was so advanced that nothing could be done for the patient and referral raised false hopes). Not all UNV specialists functioned as heads of department, even when they were the most qualified member of a department. If a Malawian specialist was available, or even a senior medical officer, he or she would normally be the departmental head. In ZCH and MCH UNVs were heads of department with all the administrative duties that attach to that position. The majority of UNVs have shown enthusiasm and dedication above and beyond the call of duty. Where a few have been discouraged by the constraints of operating in a low resource environment, they have been encouraged and sustained by their volunteer colleagues. Of course, it is not credible that in any group of 40 men and women, all reach the same standard of excellence, but although specific enquiry was made on this point, none of the Hospital Directors were dissatisfied with any of those currently in post. The cases of unsatisfactory performance that they cited were all historic.

The clear conclusion that can be drawn from this appraisal is that the UNV scheme is meeting, if not surpassing, legitimate expectations.

*The current deployment of UNVs*

The following series of tables focus on medical specialists based at the four Central Hospitals. It should be understood that in customary usage in the Malawi public service, terms such as General Surgery or General Medicine embrace all the subspecialties. Hence neurosurgeons, trauma and paediatric surgeons are all included under General Surgery. The exception is orthopaedic surgeons, who are included in the heterogeneous “other” category. Similarly, cardiologists and oncologists are included under General Medicine. The category “other” comprises a mixed group who are identified in footnotes wherever possible

Although not medical specialists, dentists and physiotherapists are included in these tables because there are UNVs in these categories. It should also be noted that these tables do not include the five UNVs who are designated as HIV programme supervisors, because they are based at the zonal offices and not at the Central Hospitals.

Specialist Medical staffing of Central Hospitals at 31 May 2014 based on site visits – KCH (Lilongwe)

 Malawi Government UNV College of Medicine Other

General Surgery 2 2

General Medicine 2

Paediatricians 2 1

Obs/Gyn 2

Anaesthetists

Pathologists 1 1

Other specialists 3 (a) 1 (b) 4 (c)

SUB-TOTAL 11 5 5

Notes. (a) 2 ophthalmologists, 1 radiologist (b) 1 pathologist (c) 3 orthopaedic surgeons, 1 pathologist

--------------------------------------------------------------------------------------------------------------------------------

GPs n.a. 2 (d) 6 (e)

Dentists 1 2

Physiotherapists 2 1

Notes (d) 1of the 2 GPs is located at Bwailo Hospital in Lilongwe (e) Chinese medical team. No specific enquiry was made of the number of Malawian GPs.

Medical staffing situation of Central Hospitals at 31 May 2014 based on site visits - QECH

 Malawi Government UNV College of Medicine (d) Other

General Surgery 2 2 8

General Medicine 2 (a) 5

Paediatricians 2 (b) 1 5

Obs/Gyn 2 (c) 4 2

Anaesthetists 1 1 3

Pathologists

Other specialists

SUB-TOTAL 9 4 25 2

Notes. (a) Of the 2 recorded, 1 is part time. (b) Of the 2 recorded, 1 is studying abroad (c) Of the 2 recorded, 1 is actually a specialist in family medicine (d) The College of Medicine staff divide their functions between clinical work, teaching and research. A rough estimate is that on average half their time is given to clinical work in QECH

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GPs n.a. 1

Dentists 1

Physiotherapists 1 1

NB. The figures above do not include junior doctors (registrars) in training programmes for specialist qualifications. No specific enquiry was made into the numbers of Malawian GPs

Medical staffing situation of Central Hospitals at 31 May 2014 based on site visits - ZCH

 Malawi Government UNV College of Medicine Other

General Surgery 1

General Medicine

Paediatricians 1

Obs/Gyn 2

Anaesthetists

Pathologists

Other specialists 1 (a)

SUB-TOTAL 1 4

Note. (a) 1 Ophthalmologist

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GPs 2 3

Dentists 1

Physiotherapists

Medical staffing situation of Central Hospitals at 31 May 2014 based on site visits - MCH

 Malawi Government UNV College of Medicine Other

General Surgery 1 1

General Medicine

Paediatricians 1

Obs/Gyn 1

Anaesthetists

Pathologists

Other specialists 1(a)

SUB-TOTAL 1 4

Note. (a) 1 Orthopaedic surgeon

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GPs 7 1 6 (b)

Dentists 1

Physiotherapists

Note (b) Chinese medical team

These tables show the extreme dependence of MCH and ZCH on the UNV programme for medical specialist staffing, so that any early removal of this support would have a devastating impact on the capacity of these two hospitals. UNV medical specialists constitute a much smaller proportion of the total in KCH and QECH, but their absence would have a severe impact on both service delivery capacity and the effectiveness of teaching, because those loads would be transferred to already hard pressed colleagues on account of the large number of students, interns and residents for which each is already responsible.

*The supply of qualified Malawians*

The justification for the presence of UNVs is not only that they perform well, but also that they cannot be replaced by nationals; both conditions have to be present before it can be said that volunteers are “needed”. It is clear that, in the case of GPs, there is a very large volume of students in the pipeline. Recent graduates from the College of Medicine were 46 in 2012, more than 50 in 2013, and barring failures, 57 are due to graduate in 2014. Numbers already enrolled in earlier years are:

Year 1 74

Year 2 106

Year 3 85

Year 4 71

Year 5 57

These numbers can be compared with 344 authorised posts of which 168 were filled at June 2012 according to the HRH Strategic Plan. The latest available figures for March 2014 after the graduation of two further cohorts suggest the establishment is filling up (insert when available).

There is of course no one-to-one correspondence between numbers graduating and the filling of Ministry of Health posts. First, after graduation, students must undertake an 18 month internship, consisting of four months in each of the main specialities (surgery, medicine, obs/gyn and paediatrics) plus two months in administration. Second, even after completing internship, there is no guarantee that doctors will choose the Ministry of Health, since there are other employments open to them. Even after joining the Ministry of Health, analysis of attrition over the last three and a quarter years suggests an annual loss averaging 18 doctors, or around 10.7% p.a. based on the mid-period total of 168 at June 2012. The overwhelming majority of these losses were attributable to resignation or absconding (leaving service without giving official notice). Despite this high rate of attrition, it is clear that the total numbers available will soon make GPs an abundant resource in the Malawian health service.

While there may be sufficient numbers in aggregate, it seems it is difficult to deploy them to the Central Hospitals which need them. In 2011, 8 GPs were posted to ZCH. Only 2 arrived, and both left within a year. There is now only one Malawian GP at ZCH. A similar story was told at MCH, though there are currently 7 Malawian GPs in post.

Concerns have been raised about the quality of recent Malawian medical graduates for two reasons. First, the College of Medicine has much the same teaching resources available to it now, when the average annual cohort is close to 100, as it had when the entering cohort was fewer than 20. Second, the fact that only QECH and KCH are used for internships means that there is great pressure on space and clinical material, particularly at QECH, where undergraduates in their clinical years, interns and residents all compete for the attention of a limited number of clinical supervisors. As a result, the size of groups making ward rounds becomes unwieldy, and not all students can be close enough to fully benefit from observation and the exposition of the teacher. The potential solution is to make ZCH and MCH teaching hospitals, but to qualify for this status each would have to have at least 2 specialists in the four main disciplines. This situation is a long way off, as can be seen from the series of staffing tables above.

It has been assumed hitherto that the need for medical specialists was virtually infinite, because the gap between the number of posts on the Ministry of Health Establishment and post filled was so large. At June 2012 these numbers were 228 and 32 respectively, giving a vacancy rate of 86%. For 3 of the 4 Central Hospitals (ZCH was omitted for unexplained reasons) the average vacancy rate in medical specialities was 89%, and 100% for anaesthetists and pathologists. The absolute number of Malawi Government specialists currently found in the four Central Hospitals is 21, the difference between that figure and the total for the Ministry (32) being composed of those in the highest posts in administration and some clinicians such as psychiatrists not located in Central Hospitals.

The Development section of the HR Directorate in the Ministry of Health has a list of 52 specialists in training, of whom 2 are taking MPH courses. An updated list has 57 names. Unfortunately, neither list gives the expected date of completion. There is some uncertainty about the precise numbers, because it is not always possible to match the entries, owing to variations in the spelling of names and recording of specialities. It is known that 12 specialists have completed training within the last 12 months, while a related tabulation shows 8 due to complete in 2014 and a further 17 in 2015, giving an average of 12 annually. Admittedly these numbers are well below the specialist training plan projecting completions from 2009, but relative to the existing 32 in the Ministry of Health, the 94 registered by the Malawi Medical Council in the public sector, or even the grand total of 148 specialists in both public and private sectors, an additional 12 specialists annually will soon make a significant difference to current staff levels. As with GPs, there are likely to be some delays in taking up positions. Not all doctors will complete their specialist training four years after embarking on it; a number will take longer, and a few will withdraw from the training programme. Upon completion, some will take employment other than with the Ministry of Health (the College of Medicine is an alternative employer in the public sector) but the fragmentary evidence from the most recently completing cohort suggests that the majority will join the Ministry. Of the 12, the destinations of 8 are known. Only one has left Malawi for South Africa where he trained. Of the remaining seven, six have taken up positions at KCH and one at QECH. Of those whose destinations are unknown, one was self-sponsored and therefore assumed to be unlikely to join the Ministry. If this distribution is repeated by subsequent cohorts, the Ministry could be gaining 8-10 specialists annually for the next few years. This would be nowhere near enough to eliminate vacancies on the current establishment within a 5-year planning horizon, but it would transform the current specialist staffing picture., by more than doubling the number of Malawian specialists in Ministry employment. Moreover, it is predictable that attrition rates attributable to retirement from the specialist cadre would be low, because the average age of the newly qualified will be low. The empirical evidence of attrition is unreliable because of the very small numbers involved.

The conclusion from this discussion of the alternative to UNV medical specialists is that it is clear that the UNVs are needed for the next few years, in increasing numbers if available, but that need may become less acute as the end of the five year planning horizon is approached. As time passes, it will become necessary for the Ministry to become more specific about precisely in which specialties gaps are appearing. Of the 57 names on the longer list, only 7 are studying paediatrics, and 7 internal medicine and its sub-specialities. Surgical specialities are better represented, with 11 in obstetrics/gynaecology and 8 in general surgery with a further 2 in orthopaedics. The remaining specialists in training are scattered across a wide range of further disciplines.

For two other categories of health workers the need is easily identified. There is as yet no dental school in Malawi and no organised programme for overseas training. As a result, only a trickle of self sponsored dentists who were trained abroad may be expected to return for at least the next five years, and these will most likely take up private practice rather than Ministry of Health employment.

In the case of physiotherapists, there is an acute immediate need to support the training programme at the College of Medicine, and to supervise the imminent cohort of interns, but this need will be short-lived, as that very first cohort will soon be ready to take up leadership and teaching positions in which they will replace UNV physiotherapists.

The category of UNVs for which the need is most uncertain is the HIV Programme Supervisors. All parties are agreed that there is a need for more supervisors, because one individual cannot effectively cover a complete zone. The outstanding issue is whether UNVs could be replaced by Malawian GPs given additional training. The answer hinges less on the competence of Malawian doctors than on their willingness to take up what may well be perceived to be an unattractive job with few long term career prospects..

**Part 2**

*Introduction*

The consultant was asked at the beginning of this mission to produce a range of options. The original expectation was that there might be two dimensions to this range: timing, and category of volunteer. Then, designating timing alternatives as A, B, C and category options as 1,2,3 a 3 X 3 matrix of options could be generated. This plan is carried through in the separate treatment of timing and category issues in the next two sections. However, it soon became clear on closer acquaintance with the programme that the 3 x 3 matrix concept was untenable; rather, there were separate timing implications for the continuing need for each category of volunteer. In effect, this reduced the options to two: closure of the programme at the end of 2014, or continuation of the programme with different dates of closure for each category of volunteer.

Since the first option is based purely on financial considerations, not on the needs of Malawi, and it implies perverse donor behaviour since it would constitute a disaster for the operation of health services and training in the public sector, this option is not considered in depth. In the extreme situation where the donors refused to fund a continuation in any form, early closure could be easily implemented. This leaves only the second option, within which there is room for adjustments by modifying dates or numbers, each of which would constitute variants on the base case proposal. The final outcome then is a single proposal for continuing the programme for a five year period, with earlier exits for two categories. None of the figures in the single proposal is sacrosanct; both dates and numbers are open to revision.

*Scenarios for the future---timing*

In terms of timing, it may be suggested that the realistic alternatives for the future of the UNV programme range between closure at the end of 2014 and continuation in some form (the forms are considered in more detail in the next section) for a maximum of a further five years. An intermediate position would be continuation for a further three years.

The first option would become inevitable if the donor community were to decide that no further finance could be provided for the programme. This would imply no new recruitment from an early date (the next few weeks at the outside) and no renewal of existing contracts. There are already some contracts which have a termination date in 2015. In advance of detailed calculations, it is assumed that the existing funding would be sufficient to permit honouring of all existing contracts, because there would be savings (a) because fewer UNVs have been recruited than planned for 2014 (b) from the non-renewal of contracts expiring before the end of 2014, and possibly (c) premature resignations of UNVs looking to escape the uncertainties and secure their futures elsewhere.

The second and third options would allow some certainty for the UNV programme managers, in contrast to the uncertainty which prevails currently and at the end of the two previous years. This uncertainty itself may have been a factor in the lower than planned level of recruitment achieved this year. With a defined budget and/or a defined terminal date, it will be relatively simple to manage the rundown of the programme.

It is appreciated that there are a number of factors which might influence donor decisions on the duration of future funding, over and above the merits of the arguments for continuation, which in turn may vary between categories of volunteers, see below. These other factors include donor planning cycles, preference for financing modalities, and wider aid policy considerations. Arguably, financing modality considerations might work in favour of the UNV scheme, since administration of funds by UNDP might be reassuring to donors given recent events.

*Scenarios for the future---categories of volunteer*

Although all UNVs enjoy the same terms of service, closer acquaintance makes it clear that there are five separable components of the current programme in Malawi. For each there may be a separate need in the Malawi health system and a different justification. The five components are:

* Medical specialists
* General medical practitioners
* Dentists
* Physiotherapists
* HIV programme supervisors

The case for maintaining, even expanding, the number of UNV medical specialists for the longest possible time is the most compelling. Medical specialists occupy a unique position at the apex of the medical hierarchy. In the ideal situation, each specialist leads a team of less experienced, less educated and less proficient junior clinicians for whom he is an exemplar in both teaching and clinical practice. They are expected to learn from him or her, both by explicit instruction and by assimilating the techniques, attitudes and values embodied in the daily care of patients. They are also expected to relieve him or her of mundane tasks by progressively developing their skills and knowledge by practical application under his instruction. In the absence of a carefully proportioned pyramid of supporting staff or students (the two are combined in internship and residency programmes), neither the service delivery function nor the teaching function can be performed effectively. Without the specialist leader of the team, high quality services cannot be delivered, and without his superior knowledge and expertise, junior clinicians lack a model and a mentor in their learning. It is this indispensable role in the development of the next generation of capable physicians that makes the numbers of medical specialists such a critical determinant of the functionality of a health system, and explains why the Ministry of Health attaches greatest weight to their recruitment and retention within the public system. As has been shown above, there is no possibility that Malawians could replace the UNV medical specialists within the five year planning horizon.

Superficially at least, Malawi has or will shortly have sufficient GPs. Even with the high rates of attrition experienced by this cadre, the increasing numbers of medical graduates in successive cohorts almost guarantees that there will be sufficient Malawians to fill all the funded positions in the very near future. The Ministry of Health has already suggested that further recruitment of GPs in the UNV programme is not necessary. On the other hand, the Hospital Directors at Mzuzu and Zomba value the services of UNV GPs above Malawian recent medical graduates on the grounds that they have much greater experience (and that they find it difficult to retain GPs posted to those hospitals). This discussion suggests two options for GPs. One is to phase them out immediately by suspending new recruitment with immediate effect and not renewing contracts of GPs as they expire. This would eliminate all UNV GPs by mid-2015. The other alternative is to allow renewal of existing contracts or even undertake new recruitment on the condition that UNV GPs serve at either ZCH or MCH. This might imply 3 UNV GPs in 2015, 2 in 2016, 1 in 2017 and nil thereafter.

The argument for continuing to recruit UNV dentists is that there is an apparent need for many more than the current stock of Malawian dentists, and because Malawi does not have either a Dental School or a planned overseas production programme, only a trickle of Malawian dentists willing to work in the public sector can be expected for the foreseeable future. Simply in order to maintain public hospital dental services at their present level, and to continue to train dental therapists, would require maintenance of the existing number of UNV dentists (5).

There are no qualified physiotherapists employed by government at present. There are 3 UNVs and 1 at the College of Medicine. The first group of 20 physiotherapy students undergoing training at the College of Medicine are due to graduate later in 2014 (since the above was first written, it is now known that 17 passed the final examination)and then embark on a year of internship, divided between Blantyre and Lilongwe. Arguably the 2 physiotherapists based at Blantyre are too few to adequately teach the 80+ students (assuming cohorts of 20 in each of four years) plus supervise 10 interns plus run a busy department. The need to either retain the existing slots for UNV physiotherapists or even increase them will be short-lived, because from late 2015 onwards there will be increasing numbers who have completed their internship and will be ready for both service and teaching positions. On this basis, allowing for an interval for some of the first cohort to become effective department heads and teachers, the need for UNV physiotherapists will have fallen away by end 2017. Until then, it is proposed that there should be 5 UNV positions.

Perhaps the greatest uncertainty attaches to the position of UNV HIV Programme Supervisors. All parties are emphatic that there need to be more supervisors, because the work calls for more than one individual per zone. The question is whether UNVs are required for these positions or whether Malawian GPs can be recruited and trained for these positions and over what time period. In the absence of a clear succession plan for these posts, it might be assumed that the existing number of UNVs should be maintained over the next five years, and any Malawian recruits be used to expand the total number of supervisors rather than replace existing UNV staffed positions. However, alternative plans are possible, and further work is needed to more precisely identify the continuing need for UNV staffing of these posts.

Emerging from these considerations, a single proposal is put forward as a basis for further consideration of the details. The essence of this proposal has been discussed with the Ministry of Health, and with the possible exception of what is proposed in relation to GPs, it reflects their known preferences. However, this does not imply that the Ministry agrees with each of the dates and numbers. This proposal is put forward as a basis for discussion, as a result of which both dates and numbers can be varied.

The following table is simply a projection of numbers of UNVs by category by year:

**Projected numbers of UNV by category by year**

 2015 2016 2017 2018 2019

Medical specialists 25 25 25 25 25

GPs 3 2 1

Dentists 5 5 5 5 5

Physiotherapists 5 5 5

HIV Programme Supervisors 5 5 5 5 5

TOTALS 43 42 41 35 35

This programme has been costed at a little over $13 million dollars (at constant 2014 prices).

**ANNEX A**

**Terms of reference for the Consultant to Develop an Exit Strategy and Retention for the United Nations Volunteer (UNV) Doctors’ Programme**

**1 Back ground**

The Ministry of Health in collaboration with UNDP has been implementing a capacity development in health program whose main aim is to recruit International United Nations Volunteers (UNV) doctors and place them in Malawian central and district hospitals. The UNV doctors have been filling the necessary gaps in the health sector while the MoH increased recruitment of local junior doctors to eventually take over. For this purpose the specialist UNV doctors and general practitioners have been deployed in central and district hospitals. For more than 8 years of its existence the programme has built on experiences and lessons learnt and the challenges encountered in its implementation. The overall goal of the programme is to strengthen the capacity of the Ministry of health to deliver quality health services in Malawi. The expected outputs for the programme are:

* Central, districts, and CHAM hospitals, have increased coverage of expanded Essential Health Package interventions by 2016
* UNV doctors have increased coverage of the expanded Essential Health Package interventions in central, selected District and CHAM hospitals by 2016
* Three Central hospitals (Mzuzu, KCH and Zomba) establish specialized units for Physiotherapy, Cardiology and Oncology to remedy non-communicable disease conditions by 2016

**2 Purpose**

The support to the Ministry of Health that the UNV doctors have been providing has been running for over eight years now. At the same time the College of Medicine, University of Malawi has been increasing the production of local doctors, some of whom have also received specialist training. It is the understanding that with these developments it is necessary now to review the UNV doctors’ situation and come up with an assessment of which of the specialties and responsibilities that are being undertaken by them still need their support.

**3 Objective:**

* To provide expert advice on managing the UNV doctors situation in relation to the health system in the country

**4 Specific Activities**

* Conduct a quick assessment of the UNVs situation in relation to the existing HRH Strategic Plan and the existing HRH retention strategy documents
* Outline the modalities and steps for elaborating an exit strategy and/or the retention (where necessary) strategy for the current UNV doctors’ project
* Elaborate a costed exit and/or retention strategy for the UNV doctors

**5. Deliverables**

1. Assessment report/situation analysis
2. Outlined modalities for UNV doctors’ exit and retention strategy
3. A costed exit/retention strategy for UNV doctors
4. An implementation plan for the UNV doctors exit and/or retention strategy

**6. Duration**

It is expected that the assignment will take 4 weeks divided into two visits of two weeks each.

* During the first two weeks the consultant is expected to do the initial consultations with the UNV doctors, Ministry of Health, UNDP., WHO and other relevant stakeholders in order to come up with deliverables **(a)** and **(b)**.

The last two weeks will be for the finalization of the work focusing on deliverables **(c) and (d)**

**Annex B Completed Schedule**

**Mark Wheeler – 1st Mission to Malawi**

**Consultancy to Formulate a CD Health UNV Doctors Exit Strategy**

*1st Visit: Sunday, May 25 to Friday, June 6, 2014.*

| ***Date*** | ***Time*** | ***Contact Person*** | ***Venue*** | ***Contact No.*** |
| --- | --- | --- | --- | --- |
| Sun., May 25 | **Arrival in Lilongwe, Malawi** |
|  |  |  |  |  |
| Mon., May 26 | 08:30 – 09:30 hrs | Introductory Meeting with Ms. Mia Seppo, UN Resident Coordinator and UNDP Resident Representative/Dr. E. Nyarko, WHO Resident Representative/Carol Flore-Smereczniak, UNDP DRR/P/Ernest Misomali, UNDP ARR  | UNDP Offices |  |
| 09:40 – 10:30 hrs | Courtesy Call on Dr. E. Nyarko, Resident Representative | WHO Offices |  |
| 10:30 – 12.00 hrs | Meeting with UNDP Project Management Team -- Ernest Misomali/Venge Nkosi/Mercy Alidri – CD Cluster and Rosemary Kumwenda, Advisor on HIV/AIDS | UNDP Offices | 099 9 919-106 |
| 14:00 – 15:00 hrs | Meeting with the Royal Norwegian Embassy – Ms. Hildegunn Tobiassen | Royal Norwegian Embassy Offices | Tobiassen, Hildegunn *hildegunn.tobiassen@mfa.no* |
| 15:00 – 16:15 hrs | Discussions on the Schedule | Nature Sanctuary |  |
|  |  |  |  |
| Tues., May 27 | 09:00 – 10:00 hrs | Meeting with Former Project Manager, Dr. Titha Dzowela  | College of Medicine Lilongwe Campus Room Number 8 | 099 1 712-115*tdzowela@yahoo.co.uk* |
| 10:00 – 12:00 hrs |  Meeting with Director of Clinical Services/Director of HIV AIDS Unit/Director of Planning/Deputy Director of Planning/Chief Human Resource Management Officer/Director of Human Resource Development | Ministry of Health Offices | Dr. Charles MwansamboMr. Kandoje, Dr. Chithope Mwale; Mr. S. Sumaisi; Mrs. Nkhalamba; Mrs. R. Malata; Mr. J. Boko |
|  | **FREE** – Going through documentation provided during visits to different organizations as input into the “ Situation Analysis & Modalities for the UNV Exit/Retention Strategy” |  |  |
|  |  |  |  |
| Wed., May 28 | 09:00 – 10:00 hrs | Meeting with Hospital Director | Kamuzu Central Hospital  | Dr G. Chiudzu*chiudzug@yahoo.co.uk* |
| 10:15 – 12:30 hrs | Meeting with UNV Doctors | Kamuzu Central Hospital  |  |
| 13:30 – 16:50 hrs | **Travel to Blantyre** |  |  |
|  |  |  |  |
| Thur., May 29 | 09:00 – 10:00 hrs | Meeting with Hospital Director | Queen Elizabeth Central Hospital Offices | Dr A. Gonani*agonani@yahoo.com*/*andrewgonani@gmail.com* |
| 10:15 – 12:30 hrs | Meeting with UNV Doctors | Queen Elizabeth Central Hospital Offices |  |
| 14:00 – 15:30 hrs  | Meeting with the College of Medicine | College of Medicine Offices | Prof Mwapatsa Mipando, Principal*mipando@medcol.mw/**mipando@yahoo.co.uk*Mrs Mpesi (Secretary to the Principal)*mmpesi@medcol.mw* |
| 15.30 – 17.00 hrs | One-on-One Meeting with Students of College of Medicine | College of Medicine |  |
|  |  |  |  |
| Friday., May 30 | 09:00 – 11:00 hrs | One on-one Meeting with UNV Doctors  |  |  |
| 11:30 hrs | **Travel to Zomba** |  |  |
| 13:30 – 14:30 hrs | Meeting with Hospital Director | Zomba Central Hospital Offices | Dr M. Joshua*martiasjoshua@yahoo.com* |
| 14:30 – 16:30 hrs | Meeting with UNV Doctors  | Zomba Central Hospital Offices |  |
| 16:30 – 17:00 hrs | One-on-one Meetings with UNV Doctors | Zomba Central Hospital Offices |  |
|  |  |  |  |
| Sat,; May 31 | 08:00 – 12:00 hrs  | **Travel to Lilongwe** | Lilongwe |  |
| Sun., June 1 | 12:30 – 16:50 hrs | **Travel to Mzuzu** |  |  |
|  |  |  |  |
| Mon., June 2 | 09:00 – 10:00 hrs | Meeting with Hospital Director | Mzuzu Central Hospital Offices | Mrs Rose Nyirenda*nyirendarose@gmail.com**dzimadzi@yahoo.com* |
| 10:00 – 12:30 hrs | Meeting with UNV Doctors  | Mzuzu Central Hospital Offices |  |
| 13:30 – 17:30 hrs | **Travel to Lilongwe** |  |  |
|  |  |  |  |
| Tues., June 3 | 08:15 – 09:15 hrs | Meeting with the Executive Director, Christian Health Association of Malawi (CHAM) | Golden Peacock Hotel | Dr Mwai Makoka *mwaimakoka@yahoo.com* |
| 09:30 – 10:30 hrs | Meeting with District Health Officer, Lilongwe (Bwaila Hospital) | Lilongwe |  |
| 10:30 – 11:30 hrs | Meeting with Amakobe Sande, UNAIDS Country Director  | UNAIDS Offices |  |
|  |  |  |  |
| 13:30 – 14:30 hrs | Meeting with Chairperson, Health Donor Group | USAID/Malawi Offices |  |
| 14:30 – 15:30 hrs | Meeting with the Executive Director, National AIDS Commission (NAC) | NACOffices | Susan Lwanda*lwandas@aidsmalawi.org.mw* |
| 15:30 – 16:30 hrs | Meeting with Mr. Mkandawire, Director, Medical Council of Malawi (MCM) | MCM Offices |  |
| Wed., Jun 4  | 08:00 – 12:00 hrs | Meeting with members of the Health Donor Group | To be arranged by RR/WHO  |  |
| 12:00 – 16:00 hrs | **FREE** - Finalization of the “ Situation Analysis & Modalities for the UNV Exit/Retention Strategy” | Hotel |  |
| 16:00 – 17:00 hrs | Debriefing with Ernest Misomali, CD Cluster, Assistant Resident Representative | UNDP Offices |  |
| Thur., Jun 5 |  |  |  |  |
|  | **FREE** - Finalization of the “ Situation Analysis & Modalities for the UNV Exit/Retention Strategy” | Hotel |  |
| 14:00 – 15:00 hrs | Courtesy call/Debriefing Meeting with Mr. Chris Kang’ombe, Secretary for Health | Ministry of Health Offices |  |
| Fri., June 6 | 08:30 – 09:30 hrs | Debriefing, Mia Seppo, Eugene Nyarko, Carol Flore-Smereczniak, UNDP DRR/P, Amakobe Sande, Country Director, UNAIDS and UNDP/WHO Staff involved in the Exercise | UNDP Offices |  |
| 10:00 hrs | Departure for the Airport |  |  |
| 10:00 hrs | **Departure for the Airport** |
|  |