

Chapter Twelve: Conclusions and Recommendations

This chapter provides a final conclusion of the study and presents some recommendations for health practitioners. There are several areas where this study would like to contribute to for policy recommendations. Some of the recommendations are straight forward that simply require the policy makers and those concerned to implement. However there are a number of recommendations that are in the form of further research.

12.1 Conclusions

In summary this study has established that in Malawi, the HIV and AIDS market is mostly controlled by the government as the main policy guider but working in close partnership with the non-profit sector and trying to get the for-profit sector involved as well in the implementation of HIV and AIDS activities. In addition, there are donors who are also a very crucial partner in the supply of resources. The government and the non-profit sector get most of these resources to implement various HIV and AIDS activities, the for-profit sector does not benefit much from these resources because they are not fully involved in HIV and AIDS programmes and also because of their profit oriented goals which may not fit with the objectives of these funds.

The study has also found that the non-profit sector is playing a very important role in the provision of HIV and AIDS services in Malawi. First this is noted by the recognition that the government gives to the non-profit sector in the Malawi HIV and AIDS Extended National Framework where the NGOs are named as the core implementers of HIV and AIDS activities in Malawi. Interviews with government officials also confirmed and emphasized the vital role that NGOs play in this sector. Although the percentage of patients under the non-profit's care is 34% in the provision of ART services according to the 2008 ART database information, there is a lot of support that the non-profit sector is providing to the government sector which has not been factored in this figure. For example, Medicines San Frontier supports Thyolo district hospital in the provision of ART services, the information in the database only shows Thyolo district as the provider which is a government facility. The same is true with Zomba general hospital which is supported by Diginitas International, another NGO. Therefore, the actual proportion of patients that are supported by NGOs in the ART programme only may be well close to 40% of the entire number of ART patients in the country.

In addition the study has shown that quality of services using mortality as a measure is better in the for-profit sector followed by the non-profit sector and the government comes last. This is revealed through the higher mortality rates per 100 person years lived in the government health facilities compared to those in the for-profit and the non-profit sector. However it should also be mentioned that type of service provider is just one among other factors that influence health outcomes as noted in the Cox regression analysis. It was found that WHO clinical stage or level of CD4 count at the time of starting ART, health facility level, region and year of starting ART also significantly influence health outcomes of patients across the three sectors. Age, sex and location of patients are also additional factors that affect the outcomes of the patients. However this study was mostly interested in the service provider as a factor affecting outcomes. In this case the results showed that after considering all these other covariates, overall patients in the non-profit sector have 25% lower risk of dying compared to their counterparts in the government sector while those in the for-profit sector have 20% lower risk compared to patients in the government ART clinics.

There are some key areas where NGOs have been found to be more critical. One such aspect is their ability to reach out to the poor populations in the rural areas. Both the interviews with the NGOs and donors and results from the ART database confirm this finding. This has been confirmed in this study as one of the NGOs' comparative advantage. The government and the for-profit sector concentrate more in the urban area because this is where they have their hospital infrastructure while the non-profit sector has gone to construct hospitals right in the rural areas to meet the needs of the rural poor. Although not many NGOs are involved, another comparative advantage is that they are actively involved in developing innovative ways of delivering HIV and AIDS services in Malawi. In the case of the ART programme, the Lighthouse in particular has been very instrumental.

This entire success story about the non-profit sector engagement would not have been possible without the good working relationship between this sector and the government with the support of the donor community. The market structure within which NGOs operate in Malawi is considered to be moderately competitive in nature. This is a good attribute because it moderates the actions of the NGOs such that they cannot be too complacent nor under too much pressure for competition so as to be distracted from their work. The moderate competition is necessary to ensure that these NGOs do not relax completely therefore have incentives to produce results or else they risk losing funds to other NGOs who may be more competent. The donors are always interested in achieving certain results

with their resources and would simply work with anyone who is able to produce results. Unlike all the negative sentiments stated in literature regarding the relationships between donors and NGOs, there seems to be a very good working relationship between donors and NGOs in Malawi. There is good communication between the two partners which helps to minimize principal agent problems.

The study has also attempted to do a cost-effective analysis to find out whether NGOs have a comparative advantage in this area. However, the results have shown that the non-profits are less cost-effective compared to the government sector. These results concur with the perceptions of the donors whose responses indicated that the NGOs were not cost-effective in their programme/project implementation. Although the cost-effectiveness analysis was based on staff salaries, training costs and drug costs only, it still provides a picture of what the situation is like in terms of the costs incurred in the provision of ART services in Malawi.

Finally, the study also endeavoured to compare programme effectiveness by looking at the type of donor that supports the particular programme by using the example of ART programme in selected health facilities. The results of this analysis has shed some light highlighting that generally clinics that receive some direct support from donors have higher chance of producing better outcomes than those that are funded through the government funding system and more especially those in the district hospitals.

In conclusion, this study has contributed to the rare knowledge on cost-effectiveness of service providers in ART service provision in Malawi and beyond. This is an area that has never been tackled by researchers in the HIV and AIDS sector. Further the study has established that NGOs do possess certain comparative advantages such as reaching the poor however they are not cost-effective. In addition, these NGOs have been found critical in the provision of ART services in Malawi as noted by the 34% patient cover under their care. The market approach to the study is equally a great input as it helps to explain how intermediate factors such as market structures can influence service provision of agents. This analytical framework can be adapted in other research areas with similar focus.

It is however important to indicate that generalizability of these results in terms of the role of NGOs is limited to Malawi because the study was done in Malawi only and therefore these conclusions can comfortably apply to the Malawi NGOs. In addition, this study concentrated in the HIV and AIDS sector, therefore these findings may also not be generalized to all NGOs in all sectors in Malawi because the market arrangement in the other sectors might be different from the one in the HIV and AIDS sector. However, for those countries that are

involved in similar HIV and AIDS activities and also have a similar market structure may apply these results because the sample was representative as it was done through a systematic random sampling of all eligible NGOs and donors. The ART database also included all the patients that were eligible for the analysis. As such, there is no bias in the results. As for those countries that do not have similar background like Malawi, it may be necessary to conduct more research in other countries to get a cross-sectional picture that could have a wider application. In addition, there is need to conduct this study in other sectors as well in order to be able to generalize the results to all NGOs. Initially, this study intended to analyse the education sector as well but due to time and resource limitations this was not possible.

In general, it is quite difficult to come up with a very concrete conclusion when dealing with the study of NGOs as already indicated. Salamon et al. (2000) after conducting a cross-national assessment of NGOs' impacts in 40 countries could not still provide a definite conclusion citing variations in weights attached to the different impacts and that these impacts can also differ according to type of organisation and countries. Therefore it is only possible to get a general picture rather than concrete answers due to these diversities.

12.2 Recommendations for immediate application

First the study outlines recommendations that policy makers can work on immediately as a result of the findings that have been revealed through this study.

First and foremost, this study has found out that one of the factors that affect performance of health facilities in providing quality services to their clients is lack of human capacity. Although this is not a new revelation and some steps have been undertaken to reduce this challenge, the problem is not yet solved as 60% of the facilities interviewed still reported about this setback. They complained that they have too many patients in relation to staff which means that they are overstretched and are unable to provide quality services to their clients. Therefore there is need for government together with its implementing partners to keep on finding ways to increase the human capacity in the health sector in general so that the ART programme can also benefit from the same.

Related to the first recommendation, is the proposition for government to aim at identifying strategies or policies that ensure more involvement of the for-profit sector in this area. There is need for some incentives for the for-profit sector to be actively involved in ART provision because they are profit oriented and government has to consider this fact. The cost-effectiveness ratios have shown that the for-profit sector has the worst figures in comparison

to the government and the non-profit sector mostly due to the small numbers of patients they have under their care. This can be considered as a waste of resources. The use of one fits all policy in implementation of health services has rendered the for-profit sector in ART provision very cost-inefficient. For example designing a more comprehensive and well thought through health insurance system for all who are in formal employment or own businesses with a certain amount of monthly revenues. These should contribute to this insurance fund and those that cannot afford, need to be subsidised by the government. In such a way everyone will be free to go to any hospital including the ones owned by the for-profits.

The study has also shown that NGOs in Malawi are making a great contribution in the HIV and AIDS sector as discussed in the study findings and the introduction. However the extravagance image they portray to the general public sometimes makes them vulnerable to unnecessary criticisms. Therefore the NGO sector needs to make an effort to improve its public image because some of the negative sentiments against this sector are based on the negative signals/images that the NGOs display. This may have negative implications on their funding prospects. For example, one NGO confessed that they started losing funding from donors because the donors felt that the organisation already had a lot of money by looking at the fleet of vehicles that could be seen around the city. The NGO did not have so many vehicles but due to the organisation's logos that could be seen from far meant that even if the people have seen three cars of the same logos, it felt as if they have seen so many vehicles as this sticks into people's minds than looking at so many cars that do not have any conspicuous identity. The NGO decided to remove the logos from their vehicles so that they could not be easily noticed on the roads anymore. This was an effort to improve their public image. Not that they are hiding anything. Sometimes they simply need to put their identity in small fonts that cannot be noticed from a far. Similarly, other strategies could be identified that could improve the entire image of this sector because they are capable of doing a great job and this negative image should not be a hindrance for them to do more.

It has been learnt from the for-profit sector that the close contact between a patient and the doctor is likely to increase the patients' survival chances because the doctors have a good history of each patient and know how best to handle the patient and prescribe the right treatment to their patients at any given time. This is possible because for-profits have consistent doctors in their clinics and the patients have the possibility to choose which doctor they want to attend to them. This is usually not the case with the government and the non-

profit sector due to work shifts and also frequent transfers to other hospitals. It would be necessary whenever possible for the government and the non-profit sectors to consider being more flexible in this regard. If a patient comes and would like to meet a specific doctor who first diagnosed the patient with the disease and has been following the trend of the patient, the patient should be given the chance to see this particular doctor. In clinics where there is only one doctor this is already happening, but in clinics where they have more doctors, this may not be the case. In this case, a doctor may mean a clinical officer, medical assistant or nurse that is in charge of seeing patients in that particular clinic. This gives patients more confidence and hope and they are freer to express themselves to someone they already know and is familiar with their illness history.

The revelation that use of CD4 count as criteria for initiating patients on ART would ensure that most patients start ART on time and therefore increase their chances of survival as noted from the study findings. Those patients that started ART at WHO stage 1 and 2 have more than 50% lower risk of dying compared to those who start much later. Cost-effectiveness analyses from various countries have proved that starting ART earlier is more cost-effective than late start. Unfortunately, without CD4 counts, it is difficult to determine the right time to start ART using clinical signs. At the moment very few health facilities have CD4 count machines, therefore ART initiation in most cases is based on WHO clinical staging. The ART database showed that only about 13% of the patients on ART were initiated at WHO clinical stage 1 and 2 while the rest (about 87%) started in WHO stage 3 and 4. This has a negative impact on the survival of patients. It is therefore my recommendation that government should invest more in buying CD4 count machines so that all patients who test HIV positive should promptly undergo a CD4 count test to ensure that everyone starts treatment at the right time. If need be, a cost-effectiveness analysis could also be carried out to find out whether this approach is cost-effective in the long term or not.

The ministry of health needs to come up with a system that provides unique identities to patients in order to trace patients who have transferred from one health facility to another. This will ensure that the survival times of these patients are also calculated even if they change clinics several times.

Since socio-economic status is an important variable for health outcomes, I recommend that the HIV and AIDS should add this particular variable in the ART database to enrich the database in terms of co-variables that influence patient outcomes on ART.

12.3 Recommendations requiring further research

Considering the increasing need for ART provision in Malawi, it is essential that the Malawi government is able to establish cost-effective ways of providing its ART services. To do this, there is need to carry out several cost-effectiveness analyses that look at various ways of providing ART and how cost-effective these approaches are. This should guide them in the implementation of the ART programme in the most cost-effective manner. This study has attempted to do a cost-effectiveness analysis by comparing the three types of health providers. However this CEA is not perfect. There is need to get more data on costs so that a full CEA is done and then compare the results. This will be able to reveal where the government sector can save resources and the same for the for-profit and the non-profit sector. As it is now, none of these providers had ever thought of the actual costs of ART provision. They simply integrate it in their normal programmes and work as if there is no cost for ART because the costs of drugs and training are taken care of by government through the Global Fund. The health facility only indicates how much of the drugs they require and they get all the drugs they need. With the dwindling sources, Malawi has to get more prepared and find cost-effective means of delivering the services when donors are no longer able to support this programme. A few countries in sub-Saharan Africa have done some cost-effectiveness analysis studies on their ART programmes, but Malawi has not. It is my strong recommendation that Malawi conducts a full cost- effectiveness analysis on the provision of ART services because this is one component within the HIV and AIDS service delivery package that requires a lot of resources due to its life time treatment nature. It means that the people who have started taking the treatment now will have to do so for the rest of their lives and this will forever require a lot of resources because the number of those requiring the treatment is increasing every day. At the same time, donor commitment is declining. As a country, Malawi needs to find cost-effective and sustainable ways of providing this treatment.

One problem that the study faced was how to make conclusion on why the for-profit sector had consistently better patient outcomes compared to the government and the non-profit sector. One of the probable reasons is that there might be some self-selection of patients with regards to their decision for choosing a specific health facility. It may mean that patients of a certain socio-economic class go to particular health facilities which may mean that the outcomes from these patients may be different based on this social differentiation. It is my recommendation that a study be conducted to find out the criteria that patients use to enrol in the ART programme with a specific clinic i.e. what factors influence patients in making this choice?

Also related to the second recommendation for further research is the need to study the reasons why patients transfer from one facility to another. The ART database records all the patients that transferred out as an outcome for those patients. The assumption is that these people are in treatment somewhere only that due to lack of identity they cannot be traced in the new clinics because they are given another identity. Research has been conducted on patients that have been lost to follow up and have found out reasons for their non-show up to the facilities and also estimations of mortality among these patients have been done. However, no studies have been done on patients who transfer out. It is assumed that these patients are somewhere in a certain clinic receiving treatment. This assumption may be correct because there is some correlation between number of patients that were transferred and those that were recorded as transfer-ins. The major interest in this case is to establish where these patients actually go after transferring from one clinic. Do they go to the same type of provider or they switch providers and if so why? For example, would it be that the MK500 fee is still too much for some patients so that they are compelled to go to public clinics instead of private clinics? The reason is to further understand why the for-profits have a much higher percentage of transfer-outs compared to the government and the non-profit sector. This study would provide some insight into better understanding on the perceptions of patients on the different providers and how this affects their survival prospects.

One of the major challenges of this study is that due to time limitation it was not possible to collect any information from the patients to get their views on how they judge quality of services from the various providers. The conclusions on quality are based on data from the ART database and the interviews with the health providers. I recommend that the next study should be designed to consider interviewing patients to get their views on quality of services they get from their respective providers using standardised quality indicators.

The unavailability of administrative costs for the calculation of cost-effectiveness analysis was a big disadvantage in this study because it would have helped to give a better comparison of cost-effectiveness in ART service delivery in the three sectors. I therefore recommend that the monitoring and evaluation tools developed by the HIV and AIDS Unit should include information on administrative costs so that the real costs of ART are well documented and known. The real costs of this programme need to be known to those in decision making so that they can efficiently allocate resources to different health

programmes including the provision of ART. The current system of giving a blind eye to such costs as if these costs are negligible compromises on the quality of services rendered to the patients. For example, health workers reported that sometime they run short of basic equipment such as latex gloves for handling patients because the ART clinic does not have any specific budget for such important items. This also jeopardises the lives of the health workers who at times are forced to work without proper handling materials and risk of getting infected with the virus. Most of the health facilities interviewed felt that this study was an eye opener for them as they could now see the need to have these costs to be spelt out to avoid unnecessary shortages of materials for handling ART work.