Programme Insights

Missing Medicines in Malawi

Campaigning against 'stock-outs' of essential drugs

A community march to protest about the lack of basic medicines at the local clinic. The march was followed by an event to discuss health issues with partner organizations and local leaders. ***Photo:*** *Word Alive Commission for Relief and Development (WACRAD), Malawi.*

Malawi is one of the poorest countries in the world. The government has introduced some measures to improve the health of its people, but a number of major problems remain. One of these is the lack of essential medicines in government health clinics – known as 'stock-outs'. These medicines should be free to poor people, but most find that they have to pay. This paper looks at an innovative campaign which aimed to tackle this problem by enhancing the capacity of local communities and civil society organizations to demand the right to access these medicines. The campaign also lobbied for a commitment to ensure increased availability and accessibility in rural areas and carried out budget and resource tracking. This paper looks at the difficulties the campaign faced and outlines the factors that contributed to its success.

Oxfam

Introduction

Malawi is one of the poorest countries in the world, with more than half its population living on less than a dollar a day. Local-level campaigning on access to medicines took place in six districts in the southern part of the country.

'Access to essential medicines is a human right and a cornerstone of an effective primary health care system.'[1]

Malawi is one of the poorest countries in the world. It ranks 171 out of 187 countries on both the Human Development Index and the Gender Inequality Index.[2] More than half of its 14 million people live on less than a dollar a day. On average, people can only expect to live until they are 54.[3]

In terms of health, although things are slowly improving, real problems remain. Malnutrition among children is a major issue. One woman in every 100 dies in pregnancy or childbirth.[4] HIV and AIDS affect almost a million people, and have orphaned some 500,000 children.[5] In addition, there is a chronic shortage of health workers: the country's entire population is looked after by just 266 registered doctors.[6]

However, during the past ten years, the government has introduced some measures to improve the health of its people:

- The **Essential Healthcare Package (EHP)**, which focuses on a cost-effective package of essential health services: under the EHP, which covers 11 common diseases, medicines are supposed to be free at the point of delivery in public hospitals and clinics;
- A **Sector Wide Approach (SWAp)**, which the government has adopted as the overarching strategy for health. This means that all funding agencies support a shared, sector-wide policy and

strategy, with clear sector targets and a budget and a focus on results;

- **Decentralization of the Health Care Management Service**: Health services, including the EHP, are supposed to be decided on and delivered at district level by the District Assemblies, giving local authorities and communities more power to decide what is needed in each area. But decentralization has only happened partially. There have been no local government structures since 1999 and no elected local councillors since 2005. Local elections have been postponed once more, until 2014. However, citizens have been able to use bodies such as local drug committees to have a say in how issues are prioritized.

Empty shelves: the lack of essential medicines

'Access to basic health services by poor and vulnerable groups living in rural areas is one of the things that need to be improved if poverty is to be overcome.' – Mr. Chris Kang'ombe, former Principal Secretary in the Ministry of Health, 2008.[7]

At the World Health Assembly in 1977, governments made a commitment to ensure that essential medicines were available in public health facilities. Yet more than 30 years later, many African countries stock only about half the core set of medicines used to treat common diseases such as malaria, pneumonia, diarrhoea, HIV, tuberculosis, diabetes, and hypertension. These are the diseases which cause the highest numbers of deaths, and they disproportionately affect poor people, especially in rural areas.[8]

Despite the government's recognition of the importance of this issue, drug shortages and long periods when no medicines are available (known as drug 'stock-outs') are still being experienced in Malawi on a regular basis.

A case study undertaken by Oxfam found that only 9 per cent of local health facilities (54 out of 585) provided the full EHP list of essential drugs. Clinics were frequently out of basic antibiotics, HIV test kits, and insecticide-treated nets, and stocks of vaccines had run dangerously low.[9]

In addition, although basic drugs and services are supposed to be available free of charge under the EHP, in reality most people have to pay for them. The poorest households spend up to 10 per cent of their annual disposable income on health care.

The lack of free essential medicines in government clinics and hospitals is due to a combination of poor investment in personnel and infrastructure, inadequate resources, and corruption and mismanagement. These issues need to be examined and acted upon by those responsible, including the Ministry of Health (MoH), the Central Medical Stores (CMS, the national pharmacy of the MoH), and district health officers.

However, it is not easy for people in Malawi to challenge the authorities. The country has been a democracy only since 1994. Although freedom of speech is guaranteed in the country's constitution, in the past speaking out against government policy was severely punished. Many people still choose to remain silent for fear of retribution. Civil society is still in its infancy, and the majority of non-government organizations (NGOs) are less than ten years old. Few engage in advocacy and campaigning.[10] This is why the Access to Medicines campaign was so important.

The Access to Medicines campaign

'Medicines are a big challenge. We have a lot of gaps. When you come to treat patients it's frustrating when you find that what you were supposed to prescribe is unavailable.' – Dr Matias Joshua, District Health Officer, Dowa hospital [11]

The campaign, which ran from 2007 to 2010, aimed to give poor people equitable access to basic medicines under the EHP. Oxfam's main role was to facilitate civil society engagement so that the voices of poor women and men could be heard. It also provided technical support and partnership management, and supported local civil society organizations (CSOs) to build their capacity on advocacy work.

The campaign had three main objectives:

- To enhance the capacity of local communities and CSOs to demand the right to access essential drugs;
- To lobby for a clear, demonstrable commitment to ensure increased availability and accessibility of drugs in rural areas;
- To carry out budget and resource tracking at local and national levels in order to increase the accessibility of essential drugs in rural areas and accountability in their provision.

The campaign had both a national and a local dimension. At the national level it focused on policy targets, enabling women and men to speak directly to members of parliament, key cabinet ministers, and other actors. National partners included the Malawi Health Equity Network (MHEN),[12] which represents a broad range of CSOs in speaking out on health equity issues, and the National Association for People Living with HIV/AIDS in Malawi (NAPHAM),[13] a network of support groups. Other partners were the Malawi Global Campaign Against Poverty (GCAP) Coalition and the National Organization for Nurses and Midwives. At national level, the campaign lobbied key political figures, used the media to build consistent and co-ordinated messages, and mobilized the public on the issue of shortages of drugs during both World Poverty Day and World Health Day.

At local level, the partners were the Word Alive Commission for Relief and Development (WACRAD), a faith-based organization which works on a number of issues including health and livelihoods, and the Development Communication Trust (DCT), a regional NGO which specialises in governance and which facilitated direct voices on health issues in this campaign.

Oxfam and its partners worked directly with communities in six districts, in particular targeting district health officers. This approach aimed to change district-level policies that had an impact on the availability of medicines. It was also intended to build the capacity of accountability mechanisms, such as local drug committees, to equip them to challenge the systems and mechanisms that had negatively affected the availability of drugs.

Box 1: Ground-level surveys as a tool for advocacy

The campaign undertook surveys every six months to examine people's satisfaction with service delivery. Although the surveys targeted the health service as a whole, they provided a very effective channel through which poor people could express their opinions as to whether local public service providers were living up to their expectations. The views expressed were then used during lobby meetings to push for policy changes and improvements, in line with what people wanted. For example, people from a number of clinics in a given district would indicate that they felt the hospitals there were not delivering a satisfactory service due to a shortage of malaria drugs. This would be taken up during lobbying with the relevant MP or other policy makers responsible for health, using people's opinions as a leveraging point.

Using technology to campaign against stock-outs

'Sometimes you want to do some surgery and you don't have gloves or there's no gauze. Sometimes we're missing bacterin. Anyone who's coughing is supposed to be taking that drug. The excuses are very hard for the patients to understand.' – Dr Matias Joshua, District Health Officer, Dowa hospital [14]

When there is a stock-out at a local rural clinic – i.e. it doesn't have essential drugs on its shelves – the consequences for patients can be serious. They may have to travel to other health facilities or to private sector providers, which are often far away and many times more expensive, they may resort to traditional healers, or they may simply have to go without the medicines they need.

They may also be treated with inappropriate drugs, as Dr Matias Joshua explains: 'In the whole district there's no Fansidar for malaria. That's the first-line drug and malaria is the biggest disease. So we have to use quinine, but that punishes the patient. You're only supposed to give it to very serious cases when other drugs have failed. If they're not serious, to give quinine is very bad. It causes nausea, headaches, and tinnitus (ringing in the ears).'

During the Access to Medicines campaign, one of the strategies used was a 'pill check-out' campaign. This involved regular monitoring of essential drugs in selected local clinics. A list of the drugs unavailable or out of stock was compiled by monitors sending text messages on a mobile phone to a central number. An analysis of this process was then used as evidence to demand better and urgent investment in the drug budget in order to reduce stock-outs. This enabled those who ran the campaign to identify what the shortages were, and then to pressure the government to provide stocks to those who needed them. Action at local level made a crucial contribution to accountability at the national level.

The strategy of pill check-outs was meant as a way of maintaining pressure on policy makers, but it also provided information about the immediate availability of medicines, thus giving people a basis on which to raise their concerns with their leaders. For example, in November 2009 the campaign revealed that key antibiotics were out of stock in a number of district hospitals. CSOs used the figures to pressurize the Director of Medicines in the Ministry of Health to address the situation.

Pill check-outs now happen every three months, and such is the success of the campaign that many local people spontaneously send text messages when medicines are missing. The pill check-outs also generated a huge amount of interest from the media. A direct consequence of this was that the local community no longer had to request that their campaign be covered by local media because there was enough interest for the media themselves to take the initiative. There was also a real empowering effect as ordinary people felt themselves to be in control and able to influence decision makers by using text messages.

Keeping a check on government: the main achievements

'The civil society organizations in the Access to Medicines campaign did a fantastic job … They kept a check on the government and always reminded the government of its policy commitments.' – Chris Kang'ombe, former Principal Secretary in the Ministry of Health[15]

So what has the Access to Medicines campaign achieved? In many ways, stock-outs are part of a wider problem in health provision and cannot be solved on their own. The real successes of the campaign have been:

- A significant increase in knowledge and understanding on the part of service providers about the challenges of poor access to medicines;
- A realization by communities about their right to be heard on issues of health;
- Recognition of the fact that people can demand increased accountability from government and have greater access to resources, and that local action on national issues can make a real difference.

The campaign has been more successful in rural than in urban areas, perhaps because there is more space to be influential. In urban areas, there are many more layers of bureaucracy and far larger and denser populations, which complicate people's ability to really influence local government.

The campaign has created an atmosphere of solidarity and has raised awareness of rights around service provision. It has ensured that people's voices are heard on issues relating to medicines, thereby putting pressure on policy makers to act. There have been cases where a community has heard about or witnessed the success of the campaign, and as a result people have initiated similar systems in their own districts.

An evaluation in June 2010 found that: 'There are more financial and human resources available for health services now than there were three years ago. Decentralisation of health service management has allowed financial resources to flow directly to districts, where services are delivered, giving greater control over how these resources are used to district health managers. While assuring a steady supply of essential drugs has been problematic, it is also clear that there are more drugs and medical supplies in stock in health facilities and hospitals than before.'[16]

More specifically:

- From 2007, the **budgetary allocation** to health increased from 8 per cent to 21 per cent of the total in 2009. Though it fell to 13 per cent in 2010, this was a remarkable achievement.
- The campaign was acknowledged in **mid-year and end-of-year reviews** by the Minister of Health and also by a number of members of parliament and candidates during their election campaigns.

- **Improved drug supply:** The 2010 SWAp evaluation by DFID noted: 'Reforms have improved the efficiency of health spending. They may also have improved service delivery by curbing the frequency of drug stock-outs.'[17] An evaluation of the campaign in October 2011 observed: 'Increased availability of essential drugs was the largest achievement especially considering previous reports on major disruptions in essential drug stocks. Reports over the period 2007–2008 indicated that 90 per cent of essential drugs were available for use at health service delivery points. As part of reforms at the Central Medical Stores (CMS), the Ministry had succeeded in obtaining a cabinet approval to change the CMS into a public trust.'[18]

- **Local drug committees**, which had not been operating, have now been revived. These are bodies comprised of ten men and women from the community. Their primary responsibilities are to monitor the movement of drugs to and from the clinic. They also act as community representatives in ensuring that local voices are heard when clinics draw up priority lists of drugs that need to be procured.

- The **voices of ordinary women and men** have been heard at national and local levels through the targeting of key players via campaign events, parliamentary elections, events such as World AIDS Day and World Health Day, solidarity marches, and the media. During the election period alone, the campaign attracted over 14,000 people to events, with more than 1,000 signatories to petitions. The steady stream of popular mobilization activities also contributed significantly to making health one of the top election issues. At local level, WACRAD mobilized people to speak out and demand access to basic medicines. This local-level participation and mobilization will help to enable people to continue to hold their leaders to account.

- **Women** in the targeted communities spoke out, using their own testimonies, in face-to-face meetings with policy makers. During community meetings they composed songs demanding that essential medicines should be available in rural clinics. A number of women's organizations took part in the campaign on an ongoing basis. For instance, the campaign used the experiences of the Women's Forum, a member of MHEN, to bring forward rural women who had faced challenges in accessing medicines, and who were now at the forefront of speaking on behalf of others in the community. This was a new experience for most of them.

- Numerous articles have appeared in **print and electronic media** in Malawi, including the *Daily Times* and *Nation* newspapers. There have been many news broadcasts and interviews on both public and private radio stations, and panel debates on both radio and TV. Apart from highlighting major issues, these stories have helped to put pressure on policy makers to respond on the issues that have been raised.

- Although they were used only minimally for the actual campaign, radio listening clubs (see Box 2) were also an important strategy in enabling communities to raise demands relating to their rights and to engage in dialogue with those in power around health issues.

Box 2: 'Walking all day for drugs' – radio listening clubs

The Dziwe Radio Listening Club is a community-based committee that was established by the Development Communication Trust (DCT) in 2005, with funding from Oxfam. According to chairperson Joseph Mukhawa, the club intervened after receiving complaints from people in the community that the distances they had to travel to the hospital were making it difficult for people living with HIV to receive antiretroviral drugs (ARVs).

'These people were experiencing a lot of problems,' says Mukhawa. 'Most were walking to reach the mission hospital, which took almost the whole day. They would then wait in a queue at the hospital to get their medicine since everyone from the district was receiving their drugs from the same hospital. Some people were discouraged and ended up not going, which was dangerous.'

The Chitekesa support group for people living with HIV approached the club to influence Phalombe District Assembly to dispense ARVs at Chitekesa Health Centre.

'We invited the community to discuss the issue in October 2006,' recounts Mukhawa. 'We recorded all the concerns that people raised during the community meeting [and] we took the recording to the district health officer so that he could listen to the community voice and make a decision.'

The club also sent the recording to the DCT, where it was packaged into a radio programme and aired on Radio 1 of the Malawi Broadcasting Corporation. The District Health Office responded positively to the request and all health centres in the district started dispensing the drugs, which cut distances and the costs of accessing ARVs tremendously for poor people.

'Radio is our main strength because it is a very powerful tool for development,' says Fanny Nangoma, monitor of the club. 'When people responsible for making decisions know that what we do goes on radio, they respond positively. It also helps people from different parts of the country to learn what others are doing and to do similar things for their own communities.'

What worked…

Combating stock-outs of essential medicines is not an easy task. But a number of factors contributed to the campaign's success:

- **Relevance of the issues:** Access to medicines was an issue that affected people's lives and which they felt about deeply. This made it possible to galvanize a lot of support from people at different levels.
- **Empowerment:** The different people involved in the campaign were empowered, first by their participation and, more importantly, because they were able to express their concerns publicly to policy makers and politicians. This was a new experience for most of them, and something that they do not have the opportunity to do on a daily basis. Their sense of empowerment was crucial to the success of the campaign and is something that they can build on for the future.
- **Capacity building:** Activities such as training, lobbying, and workshops helped not only to strengthen capacity, but also to build on the successes achieved. This was because the organizations involved increased their own capacities to engage directly with the government, members of parliament, and other policy makers.
- **Involvement of both women and men:** Access to essential medicines is vital for both women and men, and so it was critical that both were included in the campaign. The issue of putting women at the centre of programming has always been a challenge. By ensuring that both women and men could express the issues and concerns important to them, the campaign made a contribution towards building women's capacity to freely raise issues around health.
- **Coalition building and partnerships:** Planning and strategizing with partners was another key area. Organizing partnerships from both the programme side and advocacy/campaigning for this work ensured that it had broad-based support. It was also useful to be working on a number of different fronts at the same time to build maximum support. Working with a range of organizations ensured that the campaign was self-sustaining and that it will be able to attract more support and voices as it continues.
- **Use of the media:** The media were key to the success of the campaign and to getting people involved at both local and national levels. Events were well publicized (by posters, radio, word of mouth) to ensure a good turn-out and a huge sense of solidarity.
- **Non-alignment:** It was important that the campaign was seen to be politically independent. Therefore it targeted all political parties – in particular the three in power. This minimized the risk of being associated with a particular political group and made it very difficult for the media to describe the campaign as being affiliated with any one party.
- **Legitimacy:** The issues that the campaign tackled were identified first through Oxfam's Malawi case study,[19] and verified through consultations with partners and as a felt need of the populace. This meant that involving different groups, including people directly affected, was easy as they identified with the

issues involved. It also made it much easier to benefit from the support of other solidarity movements, such as GCAP.

… and challenges

'It takes time for policy to be fully implemented and the results effectively delivered and felt ... Government officials are always busy and under pressure. They have very little time for quality control issues, checking themselves, identifying gaps in policy implementation issues, following up on their failures … These were the roles the civil society organizations played in this campaign.' – Mr. Chris Kang'ombe, former Principal Secretary in the Ministry of Health, Lilongwe[20]

The campaign also faced a number of challenges, not least of which was the changing political context. The campaign spanned three years, which included an election period filled with party political tension. At the same time came the global economic slowdown, which eroded some of the gains made. Grounding active grassroots involvement and building active citizenship are still a challenge as most ordinary Malawians still face challenges in working on rights issues. And while many partners proved robust, some faced instability and a lack of capacity for this kind of work.

In addition, in districts where hospitals have never been challenged regarding their use of resources, it was very difficult to work with the community and the hospitals to promote change. There need to be some degree of openness on the part of hospitals, willingness by local people to engage, and a degree of capability among community members in order to initiate an effective campaign.

Within Oxfam, opportunities for linkages with programmes on the ground were not fully utilized. In future, more and better linked-up planning and deliberate linkages between programmes and campaigns could produce even better results. Ideally, there should be a fair balance of campaigning at national level, linked to programme-level activity and programme partners on the ground.

The Access to Medicines campaign officially ended in 2010. However, action is continuing in the communities. The pill check-outs still take place and the committees still meet to continue monitoring, reviewing, and campaigning. The main challenge now is how to retain the optimism and enthusiasm that have been built up by the campaign in the face of new funding problems.

Notes

[1] Stop Stock-outs campaign.
[2] UNDP, '2011 Human Development Report', http://hdr.undp.org/en/
[3] UNDP, '2010 Human Development Report', http://hdr.undp.org/en/
[4] Oxfam International (2009) 'Too poor to pay: Over sixty organizations call on world leaders to make free healthcare a reality for millions', press release. http://www.oxfam.org/en/pressroom/pressrelease/2009-09-14/too-poor-to-pay-free-healthcare
[5] The Global Fund to fight AIDS, Tuberculosis and Malaria, http://portfolio.theglobalfund.org/en/Country/Index/MLW (accessed February 2012).
[6] Oxfam International (2009) 'Too poor to pay', *op. cit*.
[7] The Malawi Health and Equity Network (2008) Access to Medicines campaign launch.
[8] The Communication Initiative Network (2011) 'Stop Stock-outs'. http://www.comminit.com/node/288347
[9] Oxfam International (2008) 'Malawi Essential Health Services Campaign, For All Campaign: Country Case Study', Oxfam Research Report.
[10] *Ibid.*
[11] Interview with Dr. Matias Joshua, District Health Officer, based at Dowa hospital. Helen Palmer, Oxfam GB.
[12] Malawi Health Equity Network, http://www.who.int/workforcealliance/members_partners/member_list/mhen/en/index.html (accessed February 2012).
[13] National Association for People Living with HIV/AIDS in Malawi. http://napham.net/
[14] Dr Matias Joshua, interviewed by Helen Palmer.
[15] Social Development Institute Malawi (2011) Access to Medicines Campaign evaluation report.
[16] DFID Human Development Resource Centre (2010) 'Impact Evaluation of the Sector Wide Approach (SWAp), Malawi'.
[17] *Ibid*.
[18] Social Development Institute Malawi (2011) *op. cit.*
[19] Oxfam International (2008) *op. cit.*
[20] Social Development Insitute Malawi (2011) *op. cit.*

This paper was written by Shenard Mazengera. It was edited by Nikki van der Gaag and Caitlin Burbridge provided research assistance.

For further information please email policyandpractice@oxfam.org.uk

ISBN 978-1-78077-103-8

www.oxfam.org.uk/policyandpractice

Oxfam GB

Oxfam GB is a development, relief, and campaigning organization that works with others to find lasting solutions to poverty and suffering around the world. Oxfam GB is a member of Oxfam International.

Oxfam House, John Smith Drive, Cowley, Oxford, OX4 2JY
Tel: +44.(0)1865.473727, E-mail: enquiries@oxfam.org.uk