HEALTH BUDGET BRIEF

2020/21
MALAWI

Improving Public Investments in the Health Sector in the context of COVID-19

KEY MESSAGES AND RECOMMENDATIONS

The health sector, allocated 9.3% of the 2020/21 national budget, has remained the third national spending priority after education (18%) and agriculture (16%) and not counting debt servicing (17%). However, allocations still fall short of existing financial needs and international benchmarks.

Recommendation: The Government is encouraged to finalize and implement the Health Sector Financing Strategy to work toward the closing of the existing funding gaps as well as mobilize the additional resources required in the framework of the continued COVID-19 emergency.

Health remains the second largest sector in terms of planned transfers to Local Councils, receiving 27% of the total in 2020/21. However, resources are allocated to each Local Council based on top ups to the historical amounts, instead of being based on specific characteristics and challenges of each district.

Recommendation: The Government is encouraged to roll out the reviewed Health Resource Allocation Formula (HRAF) to make the apportionment of the health sector resources more equitable, transparent and responsive to the challenges of each district.

The MK1 billion (US$1.33 million) allocated for the procurement of vaccines in 2020/21 marks a significant nominal increase from MK200 million allocated in 2019/20. However, allocations continue to fall short of the estimated financing needs, with the 2020/21 allocation translating to 23% of the amount requested by the Ministry of Health (MoH) of MK4.4 billion (US$5.87 million).

Recommendation: The MoH is encouraged to continuously engage the Treasury to ensure allocations are progressively in line with quantified needs for routine immunizations and co-financing obligations for new vaccines, under the Gavi arrangement. Available estimates from UNICEF show that MK2.4 billion (about US$3 million) is required to meet the EPI needs for 2021/22.

The donor-funded development budget (DI) regularly underperform (by 62% in 2019/20), due to a combination of project management, procurement and absorption capacity challenges.

Recommendation: Government and donor partners are encouraged to work together to address identified challenges including delays in disbursement, low absorption capacity, and red tape in procurement and management of donor-funded health sector development projects.

1. Introduction

This budget brief explores the extent to which the 2020/21 National Budget addresses health financing needs of Malawian citizens, especially children. Specifically, it analyzes the size, composition and equity of budget allocations to the health sector. It also offers insights on how the Government of Malawi (GoM) can increase and improve quality of public spending on health, including by enhancing efficiency, effectiveness and equity in the allocation and utilization of health sector resources.

The analysis is based on an in-depth review of available budget documents, especially the Detailed Budget Estimates and Program Based Budget (PBB). The analysis focuses on the period from 2016/17 (year the PBB was rolled out) to 2020/21, with 2016/17 used as the base year for inflation adjustments. The analysis also benefitted from the report on Immunization and Nutrition Supplies Budget Process Mapping, results of the Health Sector Resource Mapping Round Five as well as the 2020 Multi-Stakeholder Dialogue (MSD) Report on the expanded programme on Immunization Report[1] and the Global Financing Facility (GFF) COVID-19 Brief for Malawi. Comparative analysis of health spending in Malawi to other countries benefitted from a review of a Social Policy working paper produced by UNICEF Eastern and Southern African Regional Office (ESARO)[2]. The health sector budget comprises allocations to Ministry of Health, Local Councils and Subvented Health Organizations (Table 1).

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1 Due to the COVID-19, Malawi convened a multi-stakeholder dialogue (MSD) on the EPI instead of the traditional Gavi-MoH Joint Appraisal. The dialogue reviewed the EPI performance in 2019-2020, the impact of the COVID-19 pandemic on immunization, the needs for maintaining and restoring immunization services in the context of primary health care, planning for short-term catch-up activities and developing a roadmap for further re-allocation/planning within the country's recovery plan.

2 UNICEF-ESA-COVID19-Upending-Investments-Human-Capital-2020.pdf

Table 1
List of Health Sector Budget Lines included in the Brief

Ministry, Department or Agency (MDA)	Programme/Sub-programme included
Ministry of Health (Vote 310)	Entire Vote
Local Councils	Personnel Emoluments
	General ORT for Health Sector
	ORT for COVID-19 Response
	Drugs
Subvented Health Organizations (Vote 275)	National Aids Commission (NAC)
	Medical Council of Malawi
	Kachere Rehabilitation Centre
	Nurses & Midwife Council of Malawi
	Malawi Red Cross Society

2. Overview of Health Sector in Malawi

"Health and Population" is one of the five key priority areas (KPAs) of the Third Malawi Growth and Development Strategy (MGDS III) (2017-2022). Through MGDSIII, Government committed itself to improve access, equity and quality of primary, secondary and tertiary healthcare services. The health sector is guided by the overarching Malawi National Health Policy (2018-2030) and by a set of additional sector policies and plans covering the MGDS III period. These include the Second Health Sector Strategic Plan (HSSP II), the Essential Health Package (EHP) (2017-2022), the Sexual and Reproductive Health Policy (2017-2022), the National Malaria Strategic Plan (2017–2022), the first ever National Community Health Strategy (2017-2022), the National Quality Policy and Strategy and the Multi-Year Plan for the Expanded Program on Immunization (2017-2021).

Malawi has registered notable gains in some child health indicators over the years. For example, data from the UN Inter-Agency Group for Child Mortality Estimation (IGME) show that under five (U5) mortality declined from 54 deaths per 1,000 livebirths in 2015 to 47 in 2017 and 42 in 2019. These rates are better than in most peer countries in the SADC region and the average for Eastern and Southern African Region (ESAR), landlocked developing countries (LLDCs) and least developing countries (LDCs), which are shown in Table 2. The IGME also show that infant mortality for Malawi as of 2019 (31 deaths per 1,000 livebirths) is lowest amongst its peer countries – Tanzania (36), Zimbabwe (38), Zambia (42) and Mozambique (55) – as well lower than the averages for ESAR (39), LLDCs (39) and LDCs (63).

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Table 2
U5 Mortality Rate in Malawi compared to its Neighbors and SDGs Regions' Averages

Country	2015	2016	2017	2018	2019
Malawi	**54**	**50**	**47**	**44**	**42**
Tanzania	57	56	54	53	50
Zimbabwe	62	59	58	56	55
Zambia	68	67	63	63	62
Mozambique	85	82	79	77	74
ESAR	64	62	59	57	55
LLDC	65	62	60	57	56
LDCs	72	69	67	65	63

Source: UN Inter-Agency Group for Child Mortality Estimation (IGME) (2020)

However, more effort is needed to accelerate progress towards the SDGs. Despite declining child mortality rates, 40,000 under five children die every year from preventable or easily treatable diseases, linked to neonatal causes (43%, with 80% of these children dying in the first week of life), pneumonia (14%), diarrhea (8%), and malaria (7%). Under-nutrition and HIV/AIDS remain leading underlying causes. Maternal mortality rate (MMR) and U5 mortality rate remain high (Table 3) and are largely linked to high rates of early sexual debut, child marriage and adolescent birth rates with adverse maternal and neonatal outcomes.

Table 3:
SDG Indicators and Malawi's outcomes

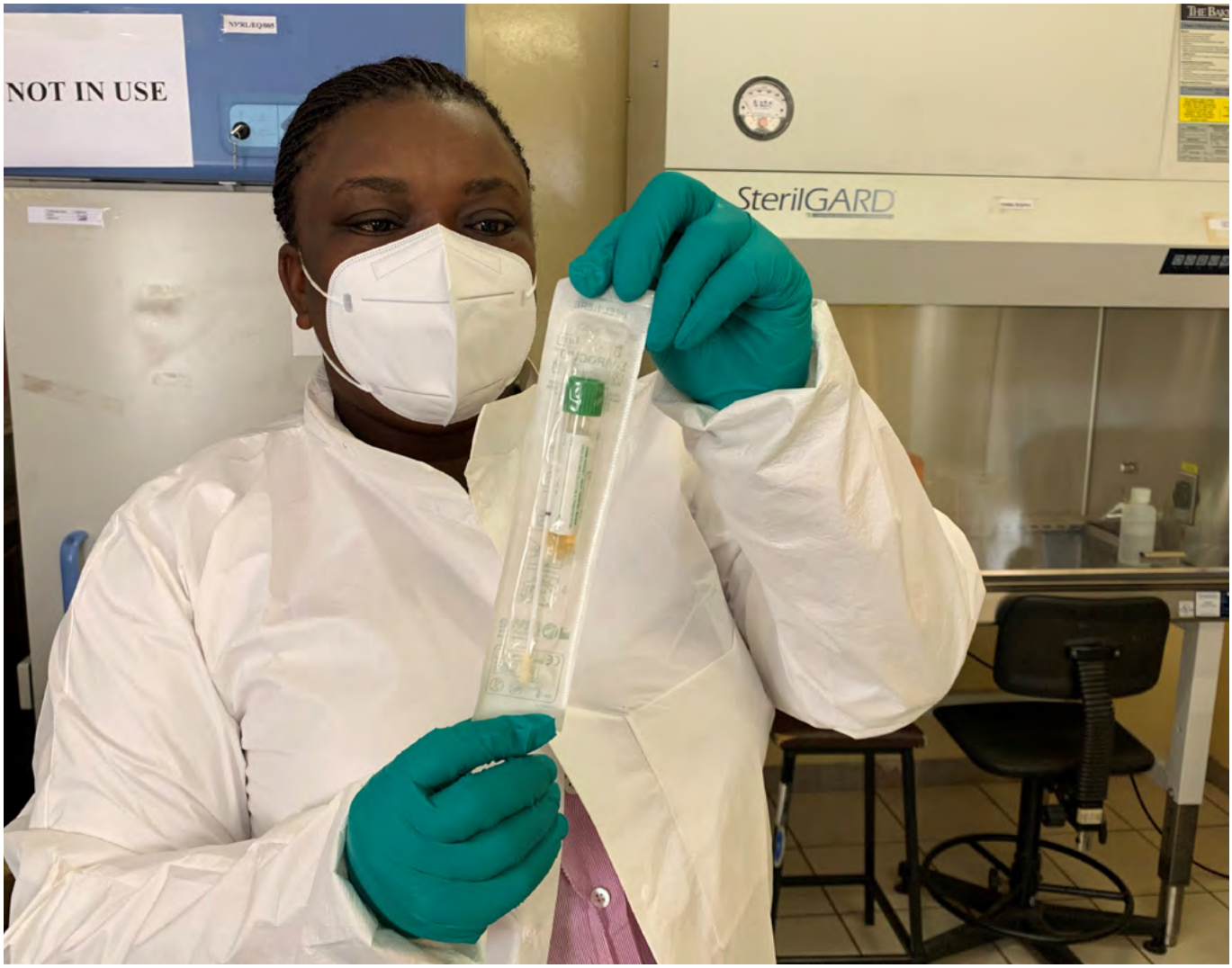
SDG Indicator		SDG Target	Malawi
3.1	Maternal deaths/100,000 livebirths	140	439 (2015)
3.2	Under five deaths/1000 livebirths	25	42 (2019)

Available survey data show a decline in immunization coverage for all six basic vaccinations in Malawi (Figure 1). The 2015/16 Malawi Demographic Health Survey (MDHS) revealed a decline in the percentage of fully immunized children (aged 12-23 months) from 81% in 2010 to 76% in 2015/16. The WHO Global Vaccine Action Plan (GVAP) demands countries to achieve 90% coverage for all antigens and at least 80% coverage for all antigens in 80% of districts by the year 2020 (WHO, 2013). Malawi has sustained high levels of coverage for all the individual antigens in the basic expanded programme on immunization (EPI) package, although it has slightly fallen short of the WHO targets (Figure 1).

According to Ngwira (2018), some of the causes of these lower than recommended rates include cancellation of scheduled immunization sessions; inadequate human resources and supportive supervision, limited capacity of health workers in areas like Reaching Every Child (REC), limited defaulter tracking, poor documentation in Under 2 Registers and Tally sheets. According to the MoH, poor record keeping and information sharing at health facilities remain a major impediment to tracking the immunization status of children, thus hindering gains in immunization coverage. Always according to the MoH, the 2020 COVID-19 outbreak has also negatively impacted negatively on the coverage rate.

Figure 1
Trends in Vaccination Coverage (basic vaccines) in Malawi

Source: Malawi Demographic and Health Surveys (MDHSs) 1992, 2000, 2004, 2010, 2015/16



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Furthermore, despite the success of the HIV prevention of mother-to-child transmission (MTCT) programme (transmission reduced by 84% from 2000 to 2016[3]), children's access to antiretroviral therapy (ART) is only 49%, compared to 68% for adults.[4] About 8.8% of the adult population lives with HIV,[5] as do 90,000 adolescents (10-19 years). In 2016 alone, an estimated 3,200 adolescents died from HIV-related causes.

Progress against key health indicators is hampered by several challenges that are felt through all levels of Malawi's health system. These are particularly evident in the areas of human resources for health (HRH), health information management system (HMIS), access to care and health financing. Malawi faces significant human resource shortages across all professional cadres, which hampers the timely delivery of quality health services. As part of the National COVID Response Plan, the Government recruited an additional 1,920 health surveillance assistants (HSAs) in 2020, bringing the total number to 11,134. However, considering the current population, each HSA is serving over 1,600 people[6], which is significantly higher than the recommended threshold of 1 HSA/1000 population. The Government acknowledges that the insufficiency of community health workforce hampers smooth community healthcare service delivery.

The sector also suffers limited in-service training and poor staff retention. There are also parallel information systems and poor performance of the routine health information system. Quality of health care has also been compromised by drug stock outs, weak supply chains, inadequate basic

3 MDHS 2015-2016

4 UNICEF 2017 HIV Estimates.

5 MDHS 2015-16.

6 The HSA/population ratio is approximately 1HSA/1,666 people, based on the current population (18.56 million people) and total number of HAS of 11,134. This is more than 60% of the recommended threshold of 1HSA/1,000 population as envisioned in the HSSP II.

equipment and infrastructure. Low domestic financing for the sector is also limiting the delivery of quality health services, an issue that was acknowledged by the Government in the recent mid-term review of the MGDS III.

COVID-19 has worsened Malawi's health sector challenges. One clear example is the delivery of essential health services such as routine immunizations for children. According to the MSD Report (2020), COVID-19 resulted in a drop of immunization coverage for all antigens and a high number of cancelled outreach clinic sessions. A steady improvement was then recorded from May 2020 onwards, when the COVID-19 situation eased. Estimates by the Global Facility Financing (GFF) indicate that large service disruptions due to COVID-19 in Malawi could potentially leave 539,400 children without oral antibiotics for pneumonia, 701,200 children without DPT vaccinations, 142,500 women without access to facility-based deliveries, and 583,900 fewer women receiving family planning services. These disruptions are estimated to increase child mortality and maternal mortality by 42% and 66%, respectively, in 2021. This could further exacerbate existing inequalities, putting the poorest and most marginalized communities at greater risk. This stresses the importance of having plans and procedures in place to ensure continuity of essential health services delivery, especially at community level, during shocks, to avoid jeopardizing health outcomes.

KEY TAKEAWAYS

- **Efforts to strengthen the public health system, including filling the critical human resource gaps and capacities – especially for community health workers require more sustainable and equitable investments.**
- **Maintaining essential health services, such as immunizations, even during shocks such as the COVID-19 pandemic, is critical to prevent severe outcomes and protect the gains made over the past years in reducing maternal and child mortality.** Malawi's healthcare system should be made increasingly shock-responsive to avoid such situations.

3. Health Sector Spending Trends

The health sector remains the third largest sectoral spending priority for the Government, receiving 9.3% of the total budget in 2020/21, after education (18%), and agriculture (16%) and not counting debt service. In 2020/21, Government allocated a total of MK204.7 billion to the health sector, compared to MK168 billion in 2019/20 (Figure 2). This constitute an increase in nominal terms of 22% and 10% in real terms, in line with the increase in the total budget between 2019/20 and 2020/21.

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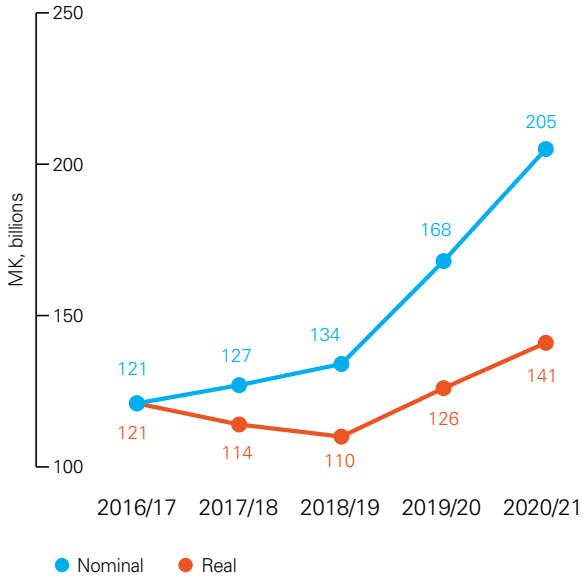
Figure 2
Evolution of Health Sector Spending



Source: Government Budget Documents (2017/18-2020/21)

However, health sector allocations expressed as a share of the total budget and GDP have stagnated over the past three years and have been consistently lower than the 2016/17 levels (Figure 3). Health sector allocations averaged 9.3% of the total budget over the period 2018/19-2020/21, after peaking at 10.6% in 2016/17. Malawi has consistently been missing the Abuja Declaration target for African States to allocate 15% of their total budgets to the health sector. In relation to GDP, health sector budgets have averaged 2.7% over the past three years, compared to 3.2% in 2016/17.

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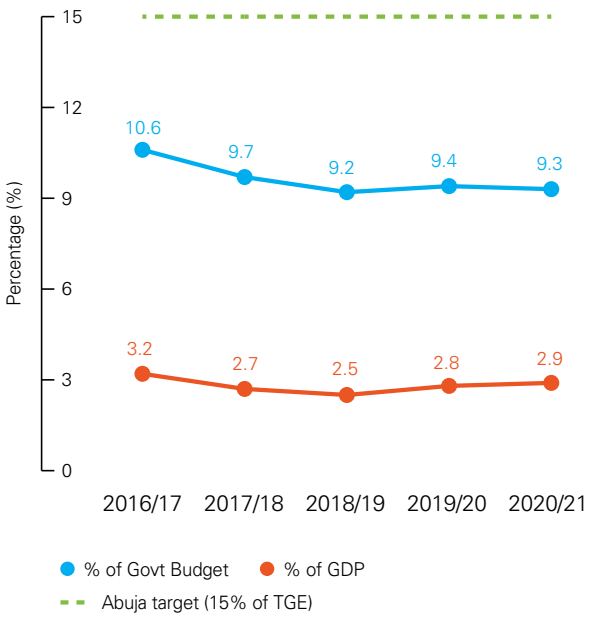
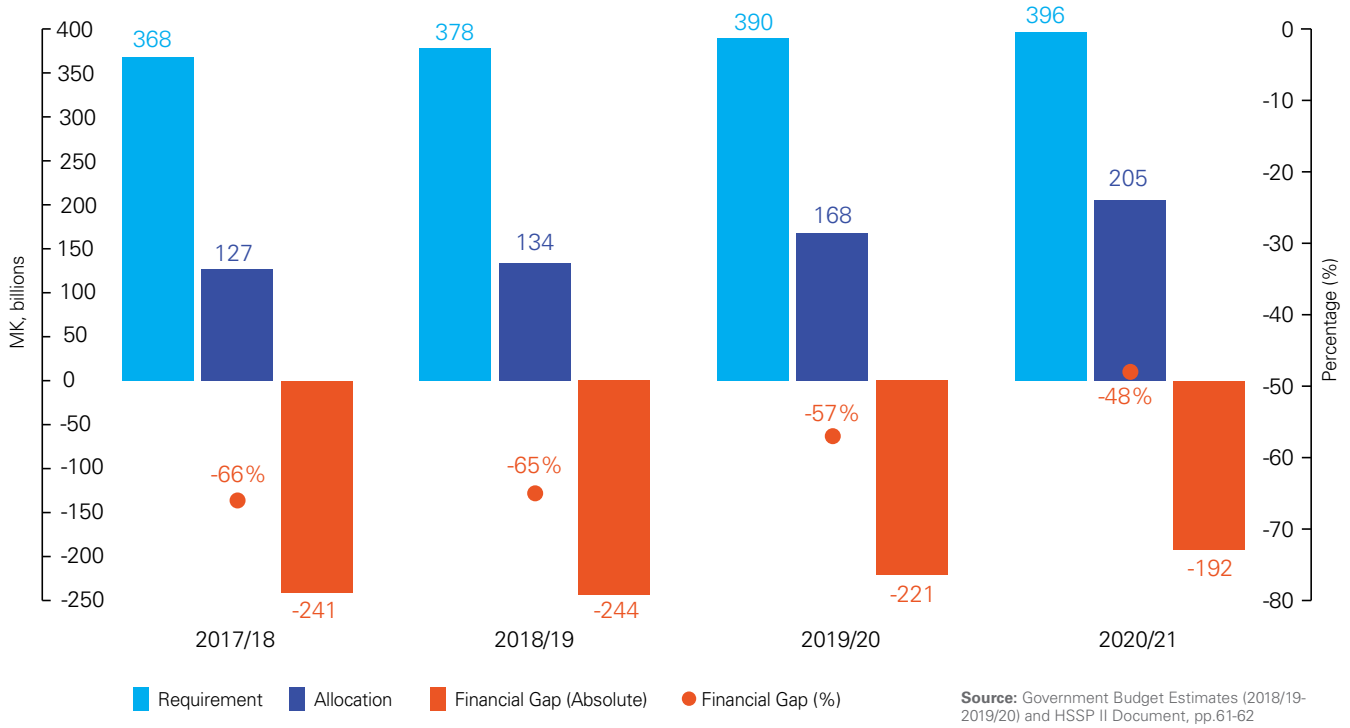
Figure 3
Health Sector Spending as a Share of Total Budget and GDP



Source: Government Budget Documents (2017/18-2020/21)

Figure 4
Health Sector Spending as a Share of Total Budget and GDP



Source: Government Budget Estimates (2018/19-2019/20) and HSSP II Document, pp.61-62

Government spending on health continues to fall short of spending targets (Figure 4). The current health sector allocation represents approximately 52% of the amount required by the HSSP II (MK396 billion, or US$528.3 million). Encouragingly, the 2020/21 financing gap (48%) represent an improvement from the 2019/20 gap of 57%. Current health sector spending per capita levels (US$15.5) are just over 50% of HSSP II requirement of US$30, and merely 18% of the World Health Organization (WHO) minimum per capita investment (US$86). The HSSPII financing gap is mostly covered by resources from donors, which are channeled to communities through off-budget means. Including off-budget resources, per capita health spending in Malawi is estimated at around US$34. The HSSP II estimates the total available health budget (including off-budget resources) for 2020/21 to amount to MK317 billion, leaving a financial gap of 19%.

In Malawi, health spending as a percentage of GDP and TGE is aligned to the regional peers (or it outperforms them). Yet, per capita spending remains comparatively low. The latest available data from the WHO Expenditure Database shows that average per capita public health spending (including off-budget donor funding) in Malawi is around US$34, lower than in most countries in the region, with the exception of Mozambique (Table 4). However, when viewed in relation to total government expenditure (TGE) and GDP, Malawi's public spending on health is aligned or better than the levels in neighboring countries.

Table 4
Public Health Sector Spending in Malawi and Comparator Countries, Average 2017-2019

Country	Per capita (US$)	% of TGE	% of GDP
Mozambique	14	8.2	2.8
Malawi	**34**	**9.4**	**2.5**
Tanzania	46	6.3	1.5
Zimbabwe	82	9.9	0.9
Zambia	58	9.2	2.4

Source: WHO Health Expenditure Database (April 2020) and Government Spending Watch (2020)

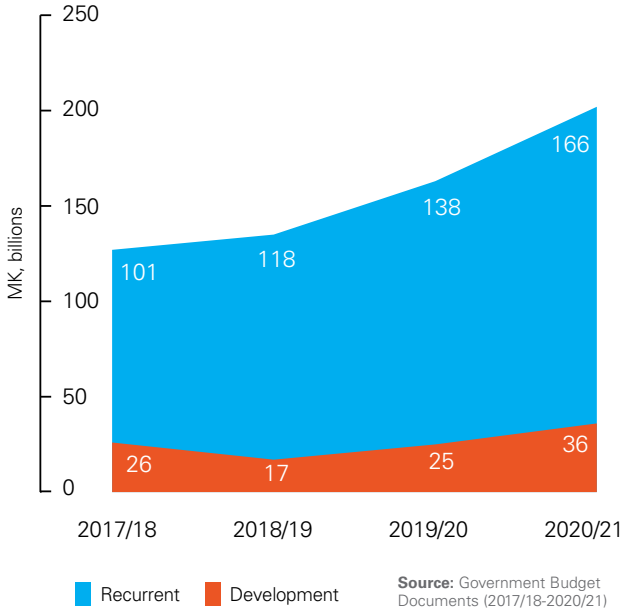
KEY TAKEAWAY

➤ **The trends in health spending (increase in nominal and real terms, but stagnation as shared of TGE and GDP) contributed to a gradual closing of the financial gap as compared to the sector plans, but not to bring Malawi closer to international health spending benchmarks.**

4. Composition of Health Sector Budgets

The large part of the health sector allocations (82% or MK168 billion) are directed towards recurrent expenditures (Figure 5). About 60% (MK101 billion) of the recurrent budget caters for wages and salaries of health personnel. The rest (40%) covers other recurrent transactions (ORT) namely drugs, medical supplies and operations, including for subvented health organizations. The share of the health sector budget allocated to development projects has increased from MK24.8 billion (or 15%) in 2019/20 to MK35.8 billion (or 18%) in 2020/21. This represents an increase of 44% in nominal terms and 30% in real terms.

Figure 5
Composition of Health Sector Budgets by Economic Classification



Source: Government Budget Documents (2017/18-2020/21)

The Government's own contribution (DII) to the development budget increased from 16% in 2019/20 to 23% in 2020/21. The Government allocated MK8.2 billion to fund development projects in the health sector, more than doubling the MK3.9 billion allocations of 2019/20. The increase in DII is linked to increased allocation for three ongoing construction projects – Domasi Community Hospital (MK750 million to MK2.6 billion), New Phalombe District Hospital (MK1 billion to MK1.9 billion) and Cancer Centre (MK1.3 billion to MK2.4 billion).

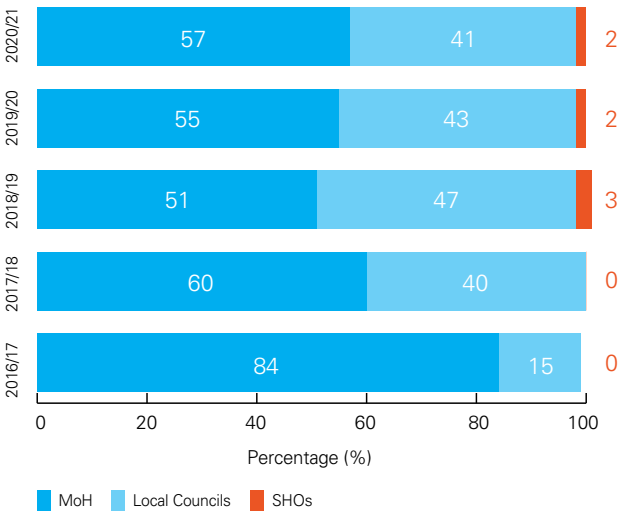
About 57% of the health sector allocations are channeled through the MoH, with another 41% channeled through District Councils, mainly for personnel emoluments (PE). The remainder (2%) is allocated to subvented health organizations (SHOs). The distribution of health resources has generally remained the same compared to 2019/20, as shown in Figure 6.

About 43% of the 2020/21 budget for the MoH was allocated towards the provision of health services (EHP). The health services budget as a share of the MoH budget increased from 37% in 2019/20 to 43% in 2020/21 (Figure 7). The Government allocated MK49 billion to "Health Services" (programme 21) in 2020/21, representing a 44% nominal increase compared to MK34 billion in 2019/20. As a share of the MoHP budget, the budget for support to service delivery increased from 33% in 2019/20 to 37% in 2020/21. A total of MK42 billion was allocated towards support to service delivery, representing 39% increase from MK31 billion allocated in 2019/20.

Environmental health and sanitation in health facilities, historically underfunded, received a sizeable allocation in 2020/21 as part of the COVID-19 response. The Government allocated MK763 million for environmental health, under the MoH, which is 3.6 times the 2019/20 level of MK213 million. An additional MK480 million was allocated to health promotion (sub-programme 22.02). This brings the total allocation to "environmental and social determinants of health' (programme 22) to MK1.24 billion, more than twice the 2019/20 size of MK588 million. This programme is aimed at reducing environmental and social risk factors that have a direct impact on health.

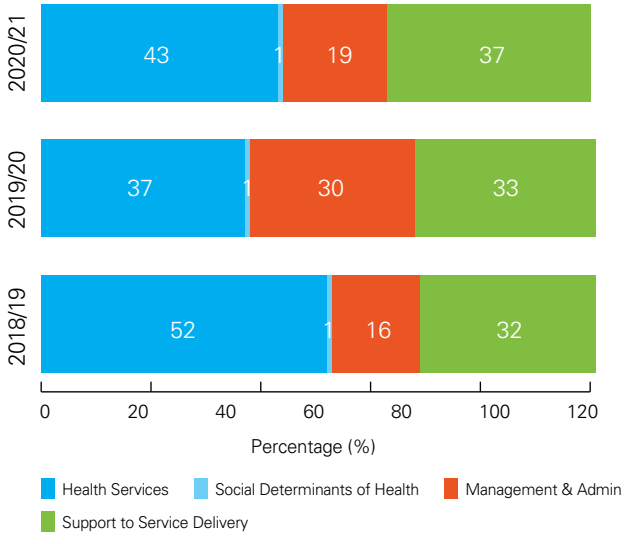
The health services budget as a share of the MoH budget increased from 37% in 2019/20 to 43% in 2020/21. The Government allocated MK49 billion to Health Services in 2020/21, representing a 44% nominal increase compared to MK34 billion in 2019/20.

Figure 6
Evolution of Health Sector Budget by Delivery Channel



Source: Government Budget Documents (2017/18-2020/21)

Figure 7
Trends in the Programme Composition of the MoH Budget



Source: Government Budget Documents (2017/18-2020/21)

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The National Aids Commission (NAC) received about 74% of the total allocation to SHOs for 2020/21 (Figure 8), whilst the remaining 13% goes to Kachere Rehabilitation Council, 8% to the Malawi Red Cross Society, 3% to Nurses and Midwife Council of Malawi and 2% to the Medical Council of Malawi. Compared to 2019/20, the budget for the NAC increased by 5% in nominal terms, while that of Kachere Rehabilitation Council more than doubled, from MK310 million to MK640 million in 2020/21.

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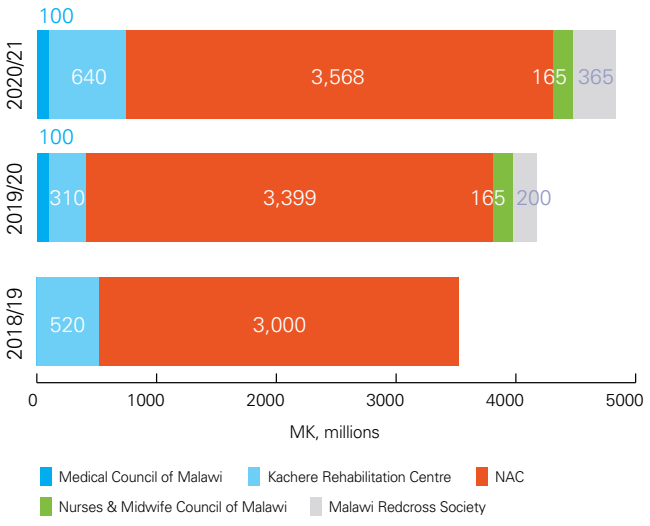
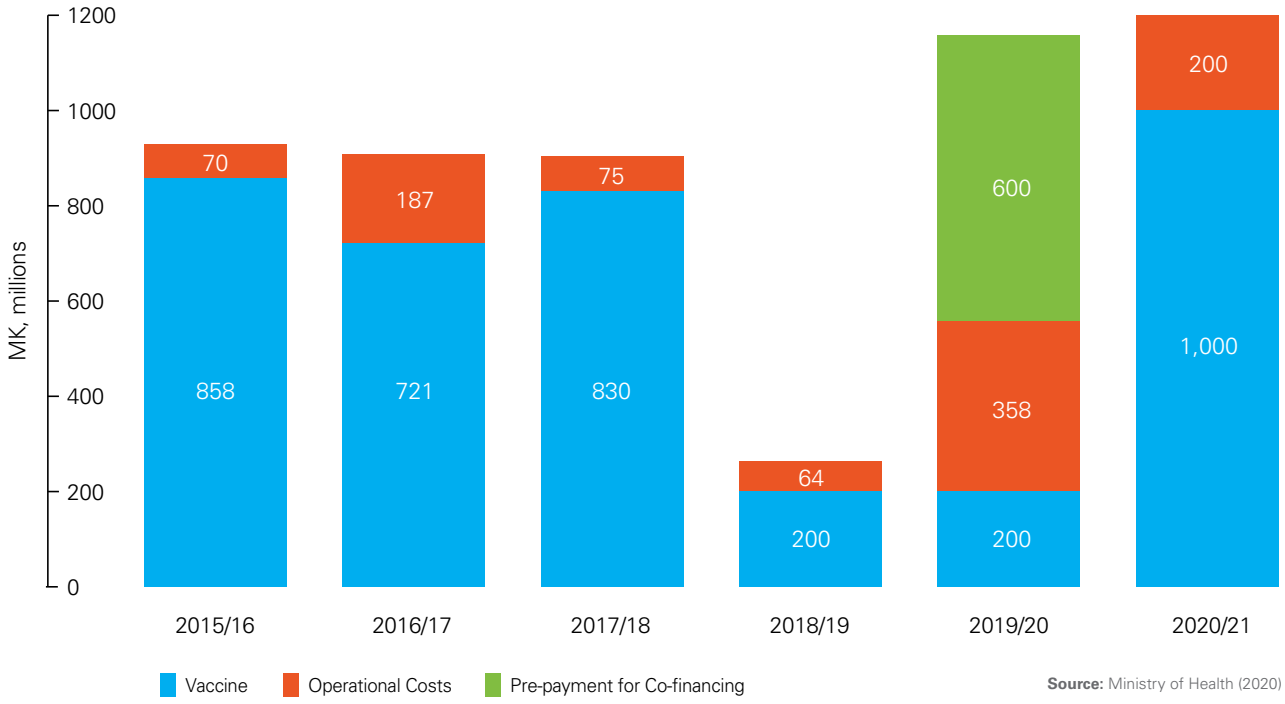
Figure 8
Trends in the Composition of Budget Allocations to SHOs



Source: Government Budget Documents (2017/18-2020/21)

Figure 9
Trends in Budgetary Allocations to EPI



Source: Ministry of Health (2020)

The 2020/21 budgetary allocation for vaccines[7] quintupled in nominal terms as compared to the previous year's allocation (Figure 9). The Government allocated a total of MK1 billion (~US$1.33 million) for the purchase of vaccines in 2020/21, up from MK200 million allocated between 2018/19 and 2019/20. In real terms, the budget for the procurement of vaccines increased by 4.5 times, relative to the 2019/20 level.

This notable increase is attributed to continuous high-level engagement between the MoH and Ministry of Finance on the need to ensure adequate funding for immunization services. In addition to the vaccine budget, the MoH allocated MK200.3 million towards EPI related operational costs (fuel and lubricants, maintenance of medical equipment, subsistence allowances and other consumables). However, the budget allocation for operational costs represents a 44% and 50% decline in nominal and real terms, respectively, compared to the MK358 million of 2019/20.

7 It should be noted that the EPI budget combines funding for traditional vaccines and Government's co-financing contributions to the Gavi.

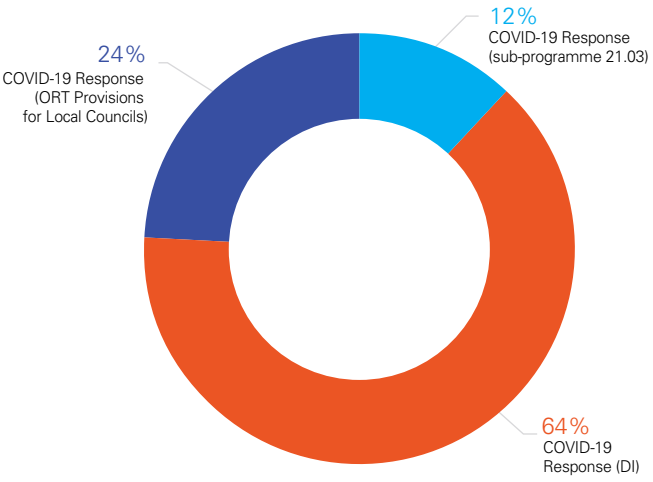
In real terms, the budget for the procurement of vaccines increased by 4.5 times, relative to the 2019/20 level.

Despite the increase, Government spending on vaccines have consistently fallen short of the estimated financial needs. In 2020/21, for example, the MoH requested a total of MK4.4 billion (US$5.87 million) for co-financing and routine immunization procurement, but was only allocated MK1 billion (US$1.33 million), translating to a gap of 77%. The Government budget allocation for vaccines translates to 5.2% of the estimated cMYP needs for 2020/21 (US$25.68 million). To date, Malawi has been supported by the health sector joint fund (HSJF) to meet its EPI budgetary needs. The HSJF committed US$2 million to EPI in 2020/21.

The Government allocated MK11.2 billion for the COVID-19 Response. This is equivalent to 5.5% of the 2020/21 health budget. The bulk (63.5%) of this budget is from donors, recorded under donor capital budgets (DI) in the MoH PBB (Figure 10). However, it is not clear whether this budget is indeed for capital projects as no breakdown is provided. The Government's own allocation (MK1.33 billion), through the MoH, is recorded under a dedicated sub-programme "COVID-19 Response" (21.03), which falls under the "Health Services Programme" (21). The increase in the Health Services budget is therefore linked to the budget for COVID-19 Response.

The Government allocated MK11.2 billion for the COVID-19 Response. This is equivalent to 5.5% of the 2020/21 health budget. The bulk (63.5%) of this budget is from donors.

Figure 10
Budget Allocations for COVID-19 Response



Source: 2020/21 PBB for MoH and NLGFC (2020)

KEY TAKEAWAYS

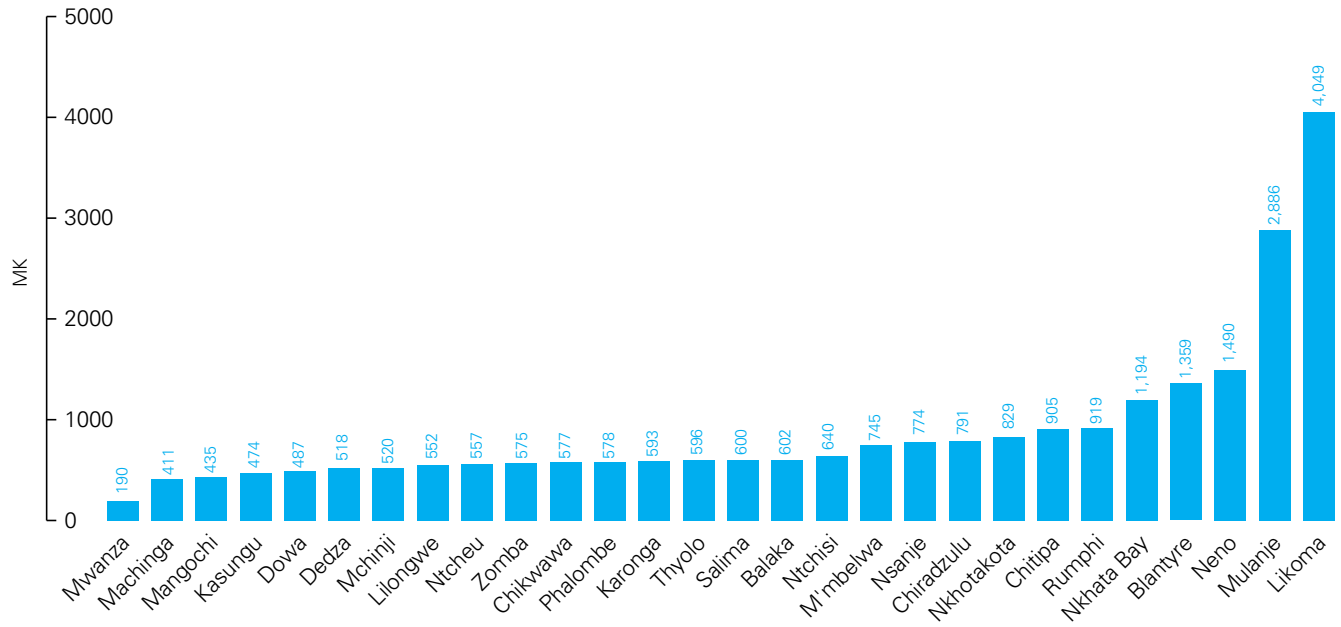
- **The creation of a dedicated sub-programme on COVID-19 Response will help ensure transparency in Government spending to support the COVID-19 health response.**
- **The doubling of the Government contribution to the health development budget is commendable and should be sustained to help close infrastructure gaps in the sector.**
- **The significant increase in the budget for vaccines is a positive step towards meeting co-financing needs** and should be sustained to help safeguard the high immunization coverage rates realized over the past years.

5. Equity of Health Sector Budgets

There are notable inequalities in child health outcomes amongst districts, between rural and urban populations, and across wealth quintiles. For example, U5 mortality is higher in rural than urban areas (77 deaths per 1,000 live births compared to 61 deaths per 1,000 live births, respectively). By region, U5 mortality is highest in the Central Region (81 deaths per 1,000 live births) and lowest in the Northern (57 deaths per 1,000 live births). Stunting in under five children is 46% among children in the lowest wealth quintile, 37% among those in the middle wealth quintile and 24% for children in the highest wealth quintile. There is also uneven distribution between rural and urban of the available health care workers.

As part of efforts to respond to such disparities, the MoH and the NLGFC are currently finalizing the review of the health resource allocation formula (HRAF). The formula is a key tool for achieving equity in health financing, given the highly decentralized nature of the sector. While the reviewed formula is expected to respond to observed needs and disparities in health outcomes across districts, the phasing in strategy adopted would see allocations to districts not budge for a number of years. In 2020/21, per capita health sector ORT allocations to Local Councils range from as low as MK190 in Mwanza to MK4,049 in Likoma, the least populated Island district with 14,527 people (Figure 11). This pattern has been the same since 2016/17 as the current allocation mechanism has been based on a historical precedent and does not respond to objective criteria linked to the demographics or the socio-economic situation of the different districts (hence the imbalances shown in Figure 11).

Figure 11
Per Capita Health Sector ORT Transfers to Local Councils in 2020/21



Source: NLGFC (2020): MTEF District Ceilings

KEY TAKEAWAY

➤ **The review of the Health Resource Allocation Formula (HRAF) will contribute towards more equitable, adequate and transparent allocations to the districts.**

6. Health Sector Budgets and Fiscal Decentralization

The health sector is the second largest fiscally decentralized sector after education. As shown in Figure 12, the district health budget has steadily increased since 2018/19, with the 2020/21 allocation totaling MK82 billion, from MK71 billion in 2019/20. This MK82 billion represents 27% of the total allocation to Local Councils of MK303 billion and is the second largest after the education sector allocation of MK181.4 billion. Considering the ORT allocation only, the health sector actually received the largest share of 32%, compared to the education sector share of 28% and agriculture (5%). Overall, about two-fifths of the total health sector budget will be managed at district level.

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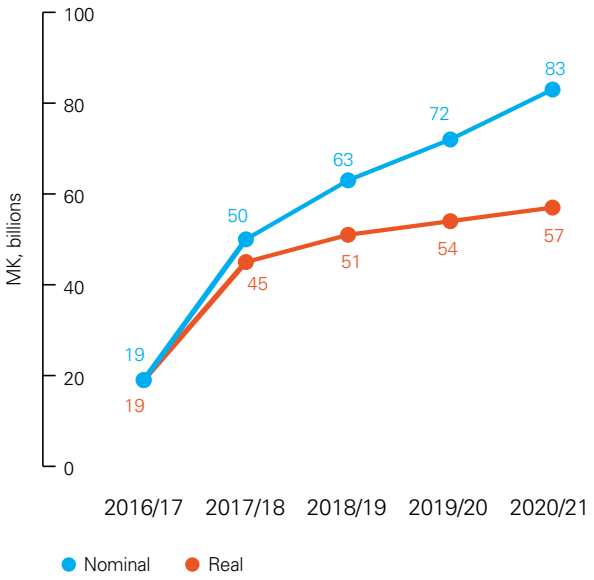
Figure 12
Trends in the District Health Budget



Source: Government Budget Documents (2017/18-2020/21)

The district health budget has steadily increased since 2018/19, with the 2020/21 allocation totaling MK82 billion, from MK71 billion in 2019/20.

Compared to 2019/20, the district PE budget increased by 14% from MK47 billion to MK54 billion in 2020/21.

Two-thirds of the district health budget is for salaries and wages for district health staff (Figure 13). Compared to 2019/20, the district PE budget increased by 14% from MK47 billion to MK54 billion in 2020/21. The rest of the 2020/21 district health budget was allocated towards drugs (20%), general ORT (12%) and COVID-19 Response (3%). Compared to the previous year, the amount allocated for the purchase of drugs in 2020/21 (MK16.3 billion) increased by 4% in nominal terms but decreased by 6% after adjusting for inflation.

A provision of MK2.72 billion was made for the COVID-19 Response at local level. This is mainly for the purposes of testing, screening, supplies, surveillance, enforcement and coordination and monitoring. The allocation per district range from MK17 million in Likoma to MK257 million in Lilongwe. In per capita terms, the allocations range from MK54 in Mwanza to MK1,154 in Likoma (Figure 14).

Figure 13
Evolution of the Composition of District Health Budgets

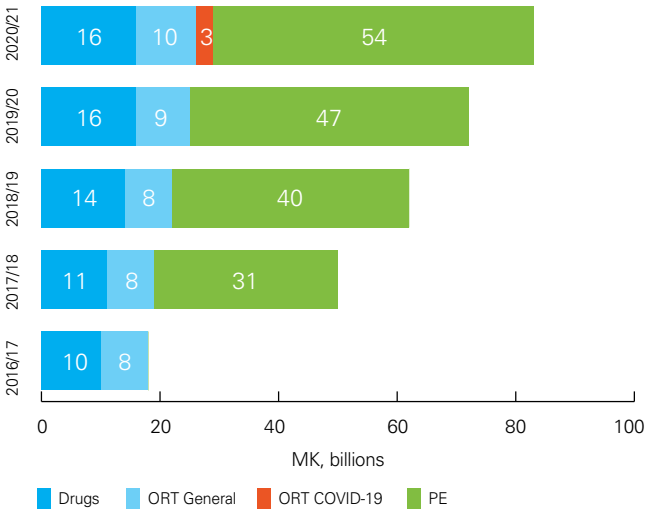
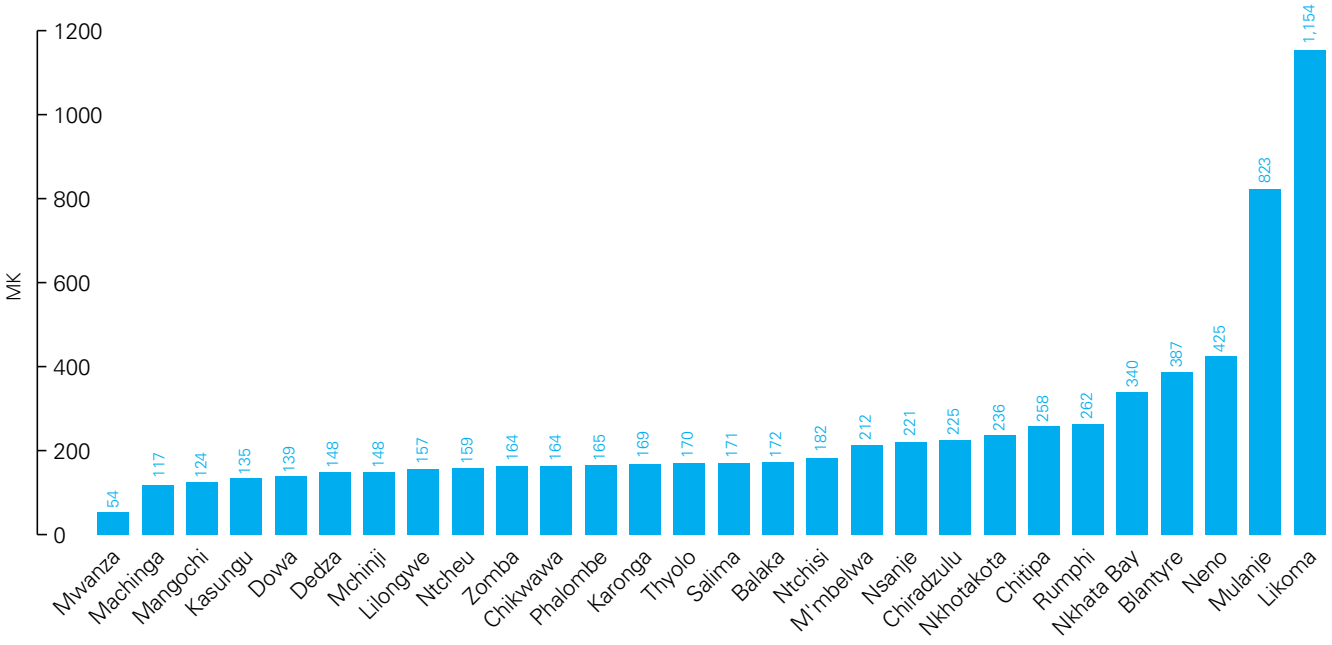


Figure 14
2020/21 Per Capita COVID-19 Budget by District



Source: NLGFC (2020): MTEF District Ceilings

KEY TAKEAWAYS

- The highly decentralized nature of the health sector and the relatively high percentage of resources allocated to the local level of government **require continuous efforts to strengthen health financing and expenditure systems at local level.**
- **The Government should ensure timely and actual disbursement of the allocated funds for the COVID-19 Response to facilitate effective and timely response by districts.**

7. Budget Credibility and Execution

Budgets for development projects, especially those funded by donors, regularly underperform. The donor-funded development budget (DI) underperformed by 38% in 2019/20 (Table 5). In contrast, the Government funded development budget exceeded its approved target by 5%. This is within the ±5% variance provided by the Public Expenditure and Financial Accountability (PEFA) framework for a budget to be deemed credible. The ORT budget is generally fully honored and utilized while expenditure overruns on the PE budget are largely linked to in-year adjustments on wages and salaries. In 2019/20, the PE budget was revised upwards by 15% at mid-year and exceeded the revised levels by 3% by end of year.

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Table 5
Performance of Selected Budget Categories under MoH (Vote 310) in 2019/20

Budget Category	Approved (A)	Revised (B)	Actual (C)	% Variance* (D)
MoH (Total)	**87,047**	**92,154**	**80,305**	**(8)**
PE	32,565	37,423	38,625	19
ORT	29,875	29,875	29,831	(0)
DI	20,907	20,907	7,960	(62)
DII	3,700	3,950	3,889	5

Note: *The % variance is the percentage ratio of the difference between the actual (preliminary outturn) (C) and approved estimates (A) divided by the approved budget (A) i.e. D=(C-A)/A*100

Source: Draft Financial Statement for 2020/21

The underperformance of DI (62%) is linked to a combination of project management, procurement and absorption capacity challenges. The MoH faces procurement challenges, including limited capacity, especially at the central level; lack of clear guidance for departments on procurement processes, including central-level procurements for districts; unclear role of the central government in procurements undertaken at the district level, and excessive emergency procurements.[8] Moreover, although the MoH prepares procurement plans every year, they are rarely followed, especially in emergencies, resulting in ad hoc procurements and accumulation of arrears.

8 See MoH, http://www.health.gov.mw/index.php/directorates/administration/procurement

According to the MoH, the procurement challenges are exacerbated by the commissioning of multiple audits by different partners and the operation of a parallel system of oversight not aligned to country systems.

According to the MoH, the procurement challenges are exacerbated by the commissioning of multiple audits by different partners and the operation of a parallel system of oversight not aligned to country systems. Delays in the approval of projects have also contributed to underperformance of development budgets. In addition, absorption capacity challenges have contributed to delays and failure to disburse committed funds by some donors, thus affecting the overall performance of the donor-funded development projects.

KEY TAKEAWAY

- **Key drivers of inefficiencies and absorption capacity challenges from the Government side as well as the impact of red tape in procurement and management of donor-funded health sector development projects are widely known but have not yet been fully tackled.**

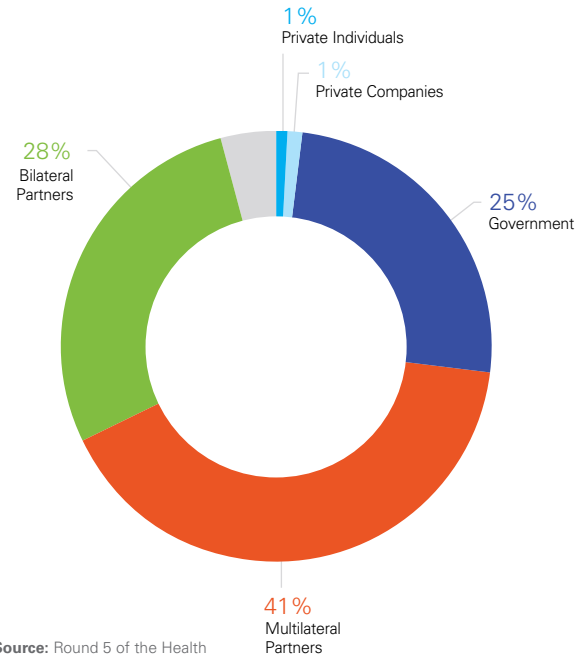
8. Financing of the Health Sector in Malawi

The Malawi health sector relies heavily on external financing, which is largely channeled as off-budget support. The results of the Health Sector Resource Mapping Round 5 showed that donors contributed an average of 80% to the funding of on-budget development projects while the Government's contribution (DII) averaged 20%. Overall, direct budget support from donors (World Bank and Joint Health Fund) have financed about 15% of the total public health budget since 2016/17.

The share goes up to 75% if off-budget resources are included, according to information in the fifth round of the Health Sector Resource Mapping (2017/18-2019/20). As shown in Figure 15, the bulk of the funding comes from multilateral and bilateral partners. These include the Global Fund (28%), the United States (16%), the Joint Health Fund (6%)[9], the United Kingdom (5%), the World Bank (4%), Germany (4%) and Gavi, the Vaccine Alliance (2%).

9 The Health Services Joint Fund is supported by Norway (43.5%), DFID (39.9%), and German Development Cooperation (KfW) (16.6%).

Figure 15
Overall Health Sector Financing by Source and Type, Average 2017-18



Source: Round 5 of the Health Sector Resource Mapping

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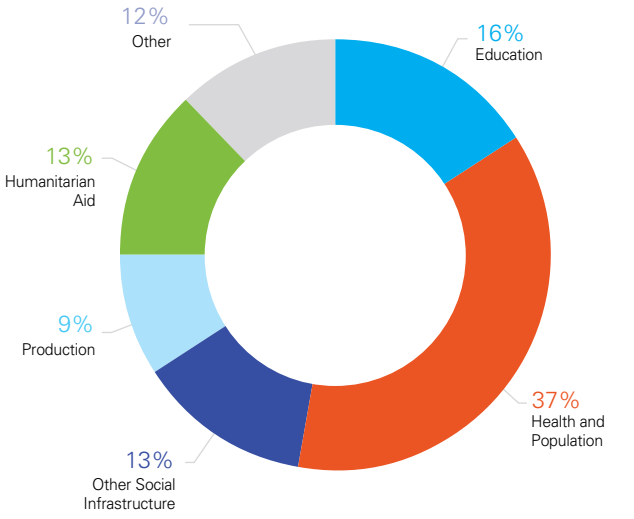
The results of the Health Sector Resource Mapping Round 5 showed that donors contributed an average of 80% to the funding of on-budget development projects while the Government's contribution (DII) averaged 20%.

The achievement of most of the HSSP II objectives is thus strongly dependent on donor funding choices. The results of the Health Sector Resource Mapping Round 5 showed that seven out of the eight HSSP II objectives receive over half of their funding from donors (Figure 16). Only Objective 4: human resources for health (HRH) has more funding (67%) from the Government. Funding for most programmatic functions is also heavily donor dependent with over 90% of funding for malaria, RMNCH, tuberculosis, HIV (including sexually transmitted infections (STIs)), environmental health and diarrheal diseases and vaccines coming from donors. Immunization financing is also overwhelmingly donor-funded, with Government contribution averaging 9% over the past five years. Gavi remains the major source of immunization financing in Malawi.

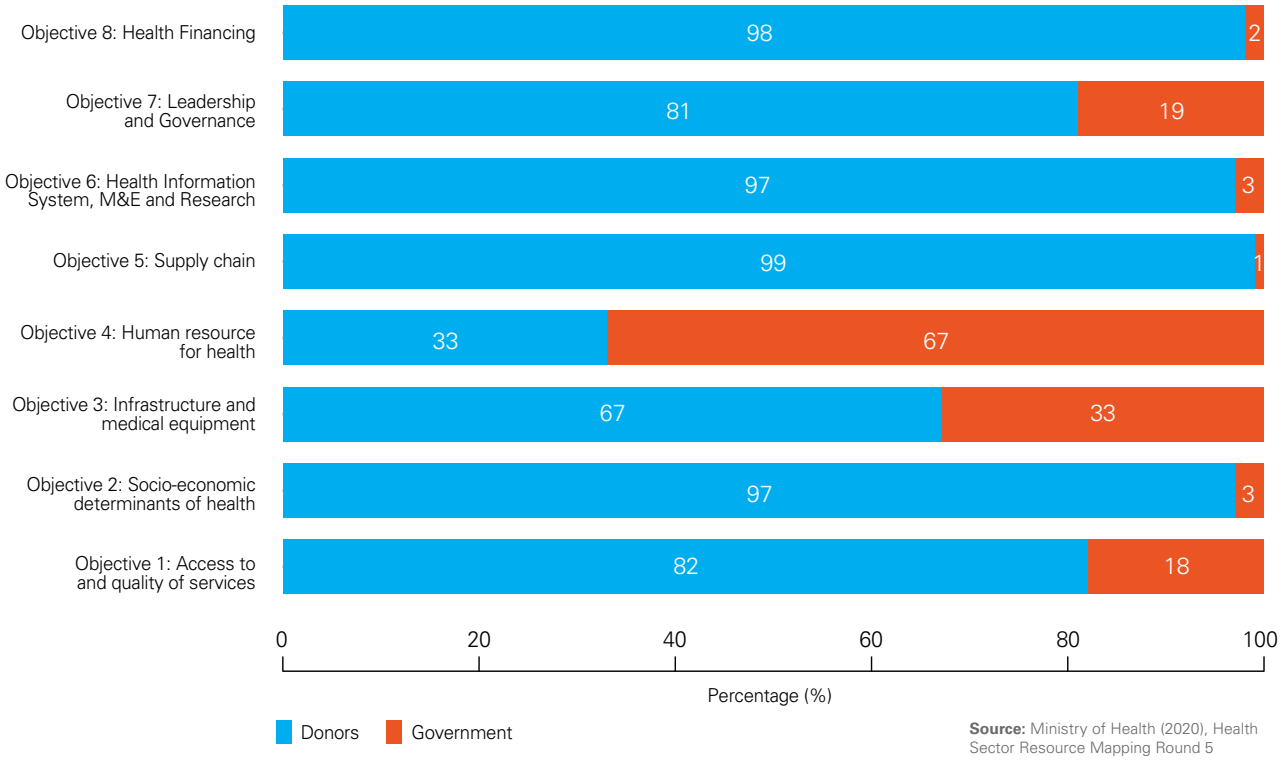
The health sector is the largest beneficiary of external funding to Malawi (Figure 17). Between 2017 and 2018, the health sector received an average of 37% of ODA flows to Malawi, followed by the education sector (16%). Over the same period, the humanitarian sector and other social infrastructure, such as WASH, each benefitted an average of 13% of the ODA flows to Malawi. In addition, about 9% of the ODA flows benefited the production sector, while the rest (12%) benefitted other sectors, such as transport, energy and security.

Figure 17
Sectoral Distribution of Bilateral ODA for Malawi, 2017-18 Average



Source: OECD-DAC CRS Data

Figure 16
Financing of HSSP II Objectives by Source, Average 2017-18



Source: Ministry of Health (2020), Health Sector Resource Mapping Round 5

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The size of the external funding channeled to the sector is reflected by the numerous partners involved in implementation. The Health Sector Resource Mapping Round 5 reported a total of 261 organizations that were implementing health sector projects in 2017/18. Government is the main implementer, followed by NGOs and foundations (29%), multilateral partners (12%), private companies (6%), bilateral partners (2%), and CHAM (1%).

The large number of implementing partners implies a high level of resource fragmentation in the sector. The Government acknowledges that the increasing number of off-budget donors has led to a proliferation of numerous agencies with resources that are often hard to trace and prone to misalignment with health sector priorities. Linked to this, the issue of fragmented reporting systems and limited information is raised by the MoH as one of the key programme issues in its 2020/21 PBB.

The MoH is currently developing a health financing strategy (HFS) for Malawi. As part of the process, the MoH plans to undertake consultative meetings on the HFS in 2020/21 and have the strategy in place by 2021. Once finalized, the HFS will be a useful framework to guide the Government in equitably and sustainably mobilizing resources as well as efficiently utilizing them to implement sector plans and strategies. It is expected that the HFS will help in addressing challenges with the current financing system; providing a basis for aligning resources to health sector priorities and creating opportunities for efficiency gains in the health sector.

Following the global recession caused by the COVID-19 pandemic, ODA inflows to Malawi are likely to reduce further with knock on effects on health financing. Malawi is facing these negative prospects with a high deficit (worth 10.5% of GDP) and increasing and increasingly costly stock of debt, the service of which is worth 17% of the 2020/21 budget. Furthermore, the effectiveness, efficiency and transparency of the health sector spending are negatively affected by high levels of fragmentation of funding sources and implementing partners. Against this background, the financing perspectives for the health sector look challenging and will require a major Government effort to ensure their sustainability, possibly through the HFS.

KEY TAKEAWAYS

- **The Health Sector Financing Strategy that is being developed, will guide the Government's efforts in mobilizing resources,** improving joint planning and coordination with development partners and ensuring resources are aligned with health sector priorities.
- **Going forward, there is need for better alignment of donor resources to improve pooling for better access and a more equitable distribution of healthcare to ensure universal health coverage.**

Acknowledgements

This budget brief was produced by Alessandro Ramella Pezza and Tapiwa Kelvin Mutambirwa, under the guidance of Beatrice Targa. Valuable inputs were provided by Tedla Damte, Steve Okokwu and Bejoy Nambir from the Health Section and Mathew Cummins and Bob Muchabaiwa from the Regional Office.

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