



Macroeconomics and Health in Malawi:

What Way Forward

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Summary

The Commission on Macroeconomics and Health (CMH) was established by former World Health Organization Director-General in January 2000 to assess the place of health in global economic development. In 2001, the Commission released a major report highlighting the link between a country health condition and its socio-economic performance. It is pointed out that extending the coverage of crucial health services, including a relatively small number of specific interventions, to the world's poor could save millions of lives each year, reduce poverty, spur economic development, and promote global security. Based on the proofs that investing substantially more in health will result in greater economic returns, the CMH proposes to see the health sector not longer as a 'resources consumer sector', but as a productive economic sector with a very high returns on investment when resources are effectively used to reach targets of interventions.

The government of Malawi has been one of the first African countries to show interest in the Macroeconomics and Health (M&H) sensitising initiatives held after the publication of the report in 2001. In early February 2004 a first WHO-AFRO mission was organised to advocate for a M&H strategy in Malawi. The MoHP, the national M&H focal point and the AFRO M&H coordinator agreed that a second longer support mission would have taken place to 'make the ball rolling'. Under this rationale, a second support mission was organised between August and September 2004. Specific objectives of the second support-mission were: collect data and indicate sources on disease burden, poverty, and health financing. Analyse the structure and organization of the health systems and the current health strategy. Review work undertaken by national and international institutions on the national health expenditures and accounts and analyse current investment flows and funds supporting existing health sector and sustainable development initiatives.

The health indicators of Malawi have generally remained poor (see table 2.1). The implementation of the 4th National Health Plan 1999-2004 has not fully achieved all its ambitious objectives and most of them have been kept as a constitutive part of the newly designed Programme of Work 2004-2010 between the Ministry of Health and concerned stakeholders. Infant and child mortality rates are high even for Sub-Saharan standards. While recognising the difficulties of getting a fully comprehensive and reliable picture, the MMR of Malawi is one of the highest in the world and it doubled in the last 10 years. Most deaths are due to lack of quality in services provision, incorrect interventions, omissions and incorrect treatment. Delays in seeking care, poor referral systems, lack of appropriate drugs and equipment, and inadequate number of health staff also play an important role.

Poverty in Malawi is widespread and severe; nearly 60% of Malawians lived below the poverty line in 2000 (table 2.3). During the 1990s, poverty levels in rural areas remained largely unchanged, while urban poverty increased. As a consequence of poverty, most social indicators are very low compared to the rest of Africa. Not only is Malawi among the world's poorest countries, but it simultaneously suffers from an extremely skewed distribution of income. With a Gini coefficient of 0.62, Malawi has one of the highest income-distribution disparities in the world, lower only than that of Brazil. As a consequence poverty is both widespread and most likely to severely affect the poorest of the poor.

Malawian macroeconomic development has been characterised by high economic instability. Since 1995, the three key price indicators-inflation, interest rates, and the exchange rate-have all been high and volatile, with volatility strongly correlated with changes in money supply. Fiscal discipline remains elusive, as a result of parastatal losses, unbudgeted spending on emergency relief, ineffective control mechanisms for regular spending, and inadequate management of aid flows. The poor are bearing the biggest burden of an unstable economic growth and a number of macroeconomic interventions founded through foreign aid are simply not sustainable in the medium and long term. Accordingly, in compliance with the WB and the IMF supported Structural Adjustment Programmes, the MPRS foresees tight monetary policies and prudent fiscal discipline as a precondition to economic growth and stability.

Despite the government expressed commitment to reach and maintain expenditures allocated to the health sector between 12%-13%, and despite the recommendations of last NHA of an increase needed in health sector's share of government spending -especially in the wake of increases in funding for the social sectors under the HIPC initiative, the progresses made until 2001/02 have been followed by a steady decline to 8.36%. This suggests a U-turn of the

government in allocating funds to the health sector to match previous political commitments and to comply with previous recommendations. The cost of this reverse trend can be calculated in terms of less deaths avoided, less chronic diseases prevented and less economic productivity for a substantial part of the Malawian population.

Analysis highlighted that Malawi has a very low performance in achieving health outcomes when compared to similar African countries. Overall, this suggests that the health sector in Malawi is not only characterised by low financial investments, but that the outcomes from those investments is below the expectations and potentialities. Thus implying the necessity to also identify non-financial constraints currently hampering the achievement of better health outcomes using the resources already available.

Explanations for under performance should be sought in technical efficiency (how well the system and individual facilities are managed), in the incentive structure for staff and program managers (salary levels, degree of autonomy, appropriateness and mix of skills, counterproductive coping mechanisms of staff), and in the overall institutional environment (the ability of MOHP to plan, marshal, and deploy resources to areas and services in greatest need). The quality of health services being provided also need to be further examined, and remedial measures taken -at both community and national level.

At the community level, non-financial constraints are to be addressed through:

-Improve trust building processes and community-based initiatives related to the health sector. A number of studies reveal that people from different economic backgrounds are willing to pay for accessing quality of services. They often by-pass the closer and more appropriate health facilities to reach the health service where they believe they will get better treatment because they trust the personnel. This is justified by lack of drugs availability at the lower level, but it is also often simply motivated by lack of knowledge of the services available or lack of trust in the personnel operating in those structures. Thus, there is the need to make communities more involved in the health services activities. This will strengthen the concept of local ownership and consolidate community mobilization initiatives.

-Strengthen health worker-patient communication and promote preventive practices. All the main killer diseases of Malawi have a preventable and curable nature and they account for the 64% of in-patients deaths. This means that the patients themselves must bear the main role of promoting and protecting their health status through adopting preventive behaviours. Prevention and promotion of preventive behaviours should be the prime focus of Malawi health expenditures and strategic planning because more cost-effective and sustainable. There is the need to strengthen health workers-patients communication and education capacity on preventive practices. This also should account for promote timely reporting of illnesses and seek for care before than curable diseases enter into a chronic and irreversible stage. Again, community based initiatives can be of a strong support in promoting preventive health care.

-Use antenatal visits as priority platform for advocacy. From data available we observed a very high percentage of antenatal visits (89%), despite only a minority of them decide to have assisted delivery (see table 2.10). Therefore, this means that advocacy for assisted delivery is not properly implemented in the health centres. This raises high both the rate of maternal mortality and the rate of neonatal mortality. The neonatal mortality rate is responsible for the 40% of the all-infant mortality rate, and both maternal mortality and infant mortality are two of the leading concern in the health sector. The already in place high proportion of antenatal visits is, *de facto*, an extremely important entry point to strategically address both, maternal mortality and neonatal mortality rates.

At the Health Sector Level non-financial constraints are to be addressed through:

-Target Cost-effective intervention which are likely to have a broad impact (preventive and promotive health). Admittedly, the level of government health allocation is too low, but instead of focusing on cost-effective services with large public-health impact -generally provided at the primary level-, the government has opted to finance all existing health programs and infrastructure including cost-ineffective interventions. Some donors have contributed to the crisis by offering infrastructure expansion with little regard for their recurrent-cost implications. This will also account for rationalise capital investments and reallocate funds to preventive services.

-Tighter coordination is required among the Ministry of Health, the Ministry of Finance and the Ministry of Economic Planning and Development. There is the expressed need from the ministry of Finance and Economic Planning and Development to strengthen their cooperation with the Ministry of Health as well as Water and Sanitation and Environment. This enhanced cooperation and share of information will strongly benefit planning and monitoring activities and allocation of budgetary resources according to expressed priorities and needs. It is suggested that a task force from the different ministries meet regularly to review finance implications and requirements of main activities. The scarcity of resources demands more circumspect policymaking, planning, programming, budgeting, and releasing functions and tighter coordination of these functions. Discussions are needed within the government on the budgetary implications -especially recurrent cost implications- of each health policy, program, service, or function. The MoHP must routinely undertake an exercise of making alternative choices given alternative funding scenarios. This is particularly important in the process of decentralised planning.

-Appropriately channel financial resources to first-line health clinics. After the institutionalisation of the fiscal reform, decision was taken to transfer governmental budget allocations for the health sector directly to districts hospitals to avoid delays in transfers from the central to the periphery and to avoid ‘leaking’ of funds at the different levels. At the moment, financial resources for health care centres at the primary level are channelled to the competent district hospital. These funds are often diverted from their original allocation and they can be used to implement not planned activities at the district level thus never reaching the health care centres at the primary level. This creates inefficiency and does not ensure that appropriate funds go to planned areas and that key health priorities are adequately funded on time.

-Address Human Resource Capacity Constraints through the development of a comprehensive policy and programme of work. The Government and development partners have recently embarked on various capacity building initiatives but they seem to operate in a vacuum outside any sort of rational medium-term holistic plan for human resources development. Thus, the main constraint to be addressed is the lack of a comprehensive policy on human resources development within the health sector.

-Accelerate pharmaceutical sector reforms. A recent survey on the public drug supply system in Malawi carried out by WHO has highlighted the main areas of concern for an efficient delivery and management of drugs in the country. Among other factors, the survey indicates the need to strengthen data collection mechanisms to better foresee customer’s drugs requirements, reduce the time between ordering and delivering, create an equitable system for supporting the poorest in the payment of drugs, renovation of storage facilities, increase the information management and strengthen financial management as well as procurement. Finally, the mission encourages the implementation of a market analysis to evaluate the possibility of developing a public or private local sector for the production of essential drugs.

Financial constraints to be addressed:

Given the low per-capita investment in health, re-orient the ongoing strategies of investment and shift resources from secondary to primary health care provision without at the same time mobilise more resource will not lead to substantially increased outcomes. Thus a scaling-up of donors’ funds in the health sector is necessary despite relevant data on the absorption capacity of the health sector have not been found during this mission. However, in a context already heavily supported by donors, it is necessary also to find alternative ingenious plans to mobilise internal resources for health care provision, paving the way to the future financial sustainability of the sector. It is clear that the international community’s support is to be maintained and possibly strengthened in the coming years and that the ongoing support is highly below the minimum standards foreseen and recommended by WHO. As clear is that to reach minimum levels of care provision the ongoing financial investments in health (both domestic and foreign) have to be at least doubled and. Implications for donors are not only the one of increasing the financial resources invested in the health sector, but also to promote a fair-trade that will most benefit Malawian economy and will give the possibility to the country to generate more internal resources to be re-invested in the sectors at stake such as health.

The following observations intend to provide preliminary suggestions on strategies to increase domestic resources in the health sector or areas that need to be further researched for eventually considering the hypothesis of implementing pilot projects:

-Further refine the National Health Plan as the basis for priority setting, programming, and budgeting. The SWAp will reduce the heavy fluctuations in donors' support, strengthening the MoHP capacity for mid and long-term strategic planning. However, as the funding gap analysis has shown, the NHP's, the POW and the financial requirements for the implementation of the extension health package are far greater than the available resources forecasted for the medium term. While advocating for an increased investment in the health sector, the government and donors should consider to sharper the focus of the Plan identifying a smaller package of services that intend to be delivered with an achievable increase of resources available.

-Identify and implement as soon as possible an equitable policy for the funding and provision of non-essential services. The MoHP's inability to appropriately finance the health needs of Malawians through tax revenues should encourage it to explore other financing modalities that are compatible with the population's ability -and willingness- to pay. There is the strong believe within the government's authorities that no user fees must be introduced in the health sector until the quality of services increases its standards. It is believed by this mission that quality of services and their financing mechanisms should move, progressively, on a parallel track. This implies that from a strategic point of view, the same quality of services could progressively result from reinvesting the resources generated by user fees in improving the quality of the services which generated those resources.

-Build on the pilot programs on drug revolving funds and expand them. Pilot-testing of drug revolving funds (DRFs) under the International Development Association's (IDA) Population, Health and Nutrition (PHN) Project has shown that they can be a viable source of sustainable financing and can facilitate community access to basic pharmaceutical supplies.

-Improve health insurance reimbursement. Health insurance coverage is small in Malawi but it has potentiality for growth. However small, it represents a significant pool of those with the ability to pay and thus provides a potentially major payment system for hospitals. Hospitals have to review their fee schedules and reimbursement rates to patients under medical aid schemes or health insurance coverage to align them with actual costs and remove unnecessary government subsidy for these patients with the ability to pay.

Towards A Plan of Action for Macroeconomic and Health in Malawi

The mission on macroeconomics and health achieved a very high consensus building among stakeholders and within the government of Malawi. The advocacy and dissemination work done has been extensive and comprehensive of all the key agents that should play a role within a macroeconomics and health approach to the health sector. Additionally, besides the high commitment found from the government, there is also an extremely favourable timing given the fact that the SWAp is defining its plan of action in these months and given the willingness of including the macroeconomics and health initiative on board.

After discussion with the Ministry of Health, Finance, Economic and Planning, Water and Sanitation and Environment, and after the presentation of the work done on Macroeconomics and Health in Malawi, few ideas have emerged on how to take the issue forward. These ideas do not define a working plan for M&H in Malawi, but are a shared starting point that will pave the way to a more detailed working plan and implementation process. The issue of Macroeconomics and Health will be inserted within the existing SWAp programme of work and harmonised with it. It is suggested that within the SWAp, a small working group (co-chaired by the the MoHP, MoF and MoEP) will act as the referral point on the issue every time it comes to planning and decision making.

Consensus has been reached in identifying WHO as the key role player in 'keeping the ball rolling'. It has been argued by the MoHP and MoF that this mission should have been done much earlier, possibly within a few months from the 2nd Consultation on M&H 'Increasing Investments in Health Outcomes of the Poor' held in Geneva in October 2003. Since that meeting a number of Ps, directors and key political people have changed creating a gap of knowledge, decrease of enthusiasm and loss of institutional memory. Now that activities of

awareness raising and consensus sharing have been implemented filling the delays, there is the compelling need for WHO to timely sustain the M&H process from within the country.

In particular, as strongly argued by relevant stakeholders, officers available are already over-burdened, and the macroeconomics and health process requires strong coordination, advocacy and full-time work in producing and implementing a M&H plan of work to be inserted within the SWAp as soon as possible, as well as identifying monitoring and evaluation mechanisms. Despite the strong political commitment of the government, a constant activity of advocacy and technical support played by WHO is certainly needed to maintain the issue of M&H high in the political agenda and to translate this initial stage into a working plan to be shortly implemented. It is suggested to organise as soon as possible a second mission that will have as a main objective the one of operationally inserting the process of M&H within the SWAp program of work. As well as implementing in-depth research in the identified areas where information is missing and starting the process of implementation of the M&H programme of work.

A final reason for not missing the opportunity to provide a timely support to the Malawian government is given by the implementation of the third Demographic and Health Survey -from September 2004- and the second Integrated Household Survey -from early next year. These two extensive surveys will provide an important up-date on the situation of the country in terms of poverty and health indicators, thus paving the way to review current investment strategies, achievements and objectives on the basis of fresh data. They will form the background for new policy orientation and long-term planning. This is when major changes in resources allocation are likely to be discussed and, if appropriate, to take place. Again, M&H can strongly support the government in interpreting and using those new data for planning purposes.

Areas of Initial Priority for Macroeconomics and Health in Malawi

Following the presentation of the findings of the M&H report on Malawi, few priorities have been identified that could represent the skeleton of the working plan for M&H in Malawi. These priorities are divided in three areas: research, policy guidance and implementation projects, monitoring and evaluation.

Research

Priority areas where narrow and detailed follow-up research is needed are:

- Why efficiency levels in delivering health services in Malawi are low compared to the resources available?
- How to strengthen preventive activities against the leading illnesses of the Malawian disease burden?
- What are the causes for the low rate of assisted delivery?
- Implement a market analysis to evaluate the possibility of developing a local sector for the production of essential drugs.

Policy Guidance and Implementation Projects

The following are the priority areas where M&H can effectively contribute to policy guidance, design of implementation strategies and contribute to securing funds:

- Rationalise capital investments and reallocate funds to preventive activities against the leading illnesses of the Malawian disease burden.
- Reduce MMR and IMR through strengthening antenatal and postnatal services and delivery assistance.
- Identify a policy for the funding and provision of non-essential services.
- Improve trust building processes and communication between patients and health workers.
- Promote the shift from raised awareness to behavioural change.

Monitoring and Evaluation

For all the previously identified implementation projects, M&H should also identify appropriate indicators to monitor and evaluate progresses so to stimulate and facilitate the mobilisation of internal and external funds.

It is intended that these strategies have to be inserted within, and aligned with the SWAp's programme of work towards a comprehensive national health investment plan.

Abbreviations and Acronyms

ADC:	Area Development Committee
AIDS:	Acquired Immunodeficiency Syndrome
ARV:	Antiretroviral
CBO:	Community Based Organisation
CIDA:	Canadian International Development Agency
CHAM:	Christian Health Association of Malawi
CMH	Commission on Macroeconomic and Health
CMS:	Central Medical Stores
DALYs	Disability-Adjusted Life Years
DDC:	District Development Committee
DEC:	District Executive Committee
DFID:	Department for International Development
DHO:	District Health Officer
DHMT:	District Health Management Team
DHS	Demographic and Health Survey
DOT:	Directly Observed Therapy
EHP:	Essential Health Package
EU:	European Union
GAVI:	Global Fund on Immunization
GDP:	Gross Domestic Product
HIV:	Human Immunodeficiency Virus
IUATLD:	International Union against TB and Lung Diseases
IHS:	Integrated Household Survey
ITN:	Insecticide Treated Nets
MASM:	Medical Aid Society of Malawi
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
M&H	Macroeconomics and Health
MoHP:	Ministry of Health and Population
MoF:	Ministry of Finance
MoLG:	Ministry of Local Government
MPRS	Malawi Poverty Reduction Strategy
NAC:	National Aids Commission
NACP:	National Aids Control Program
NGO:	Non-Governmental Organisation
NHA:	National Health Accounts
NORAD:	Norwegian Agency for Development
NSO	National Statistics Office
OPD:	Out-Patient Department
PE:	Personnel Emolument
PER:	Public Expenditure Review
PMCT:	Prevention of Mother to Child Transmission
POW	Plan of Work
SSA:	Sub-Saharan Africa
STD:	Sexually Transmitted Disease
SWAp:	Sector-Wide Approach
TA:	Traditional Authority
TB:	Tuberculosis
TBA:	Traditional Birth Attendant

UNICEF: United National Children's Fund
UNDP: United Nations Development Program
USAID: United States Agency for International Development
VCT: Voluntary Counselling & Testing
VHC: Village Health Committee

1. Introduction

1.1 Summary of the Macroeconomic and Health Report

The Commission on Macroeconomics and Health (CMH) was established by former World Health Organization Director-General in January 2000 to assess the place of health in global economic development. Although health is widely understood to be both a central goal and an important outcome of development, the importance of investing in health to promote economic development and poverty reduction has been much less appreciated.

In 2001, the Commission released a major report highlighting the link between a country health condition and its socio-economic performance. It is pointed out that extending the coverage of crucial health services, including a relatively small number of specific interventions, to the world's poor could save millions of lives each year, reduce poverty, spur economic development, and promote global security. Thus, the report provides a scientific basis and quantitative measurements on the relationship between a country's disease burden and how this negatively affects its economy and achievement of poverty reduction goals. The report also stresses that worldwide poor and chronic poor bear the highest burden of an inappropriate health environment and they are the ones more likely to suffer the most from the economic consequences of poor health systems performance. Poverty itself imposes a basic financial constraint, though waste does exist and needs to be addressed.

1.1.1 *The Conclusions of the Report*

Accordingly, the CMH advocates for substantial increased investments in the health sector of middle and low developing countries arguing that achieving better health status of the poor is not just a fundamental human right but also a strategic, sustainable and cost-effective investment to reducing poverty levels. This because investing in health and health-related sectors contributes not only to the improvement of the health status of the population but it also contributes to tackling poverty levels through fostering economic growth. Expanding the quantity and quality of services provided by minimum health packages in developing countries is indeed not only a desirable objective for the health sector per se but it is an activity likely to strengthen positive economic growth.

On the other side, poor performance of the health sector in developing countries has negative consequences on an individual, life-cycle, intergenerational and social level.

■ On an individual level, high expenditures for ensuring minimum levels of health care, low effective treatment of illnesses, and loss of income for recovering from illnesses determine poor people high vulnerability, loss of income, livelihoods insecurity, low life expectancy and an overall decrease of well-being. Economists talk of disability-adjusted life years (DALYs) saved, which add together the increased years of life and the reduced years of living with disabilities.

■ On a life-cycle level, low health status of a mother reduces foetus' inter-uterine growth, emotional and psychological stability of the new-born, it raises high the probability of delivery complications with clear implications for infant and maternal mortality rates. Besides, low health status at an early age reduces school performances decreasing the probability of appropriate job opportunities with a consequent reduction in the levels of salary attainment.

■ On an intergenerational level, low health status of income providers reduces income availability of the all household, exposing children to under-nutrition and famine. This will also hamper their access to school as well as exposing them to the treat of becoming premature orphans. In the case of diseases such as HIV/AIDS, the health status of parents will determine in full the life chances and opportunities of their children. Life insecurity for new generations will also increase fertility rates as well as dependency ratios. Investments in reproductive health, including family planning and access to contraceptives, are crucial accompaniments of investments in disease control. The combination of disease control and reproductive health is likely to translate

into reduced fertility, greater investments in the health and education of each child, and reduced population growth.

■ On a social level, a high burden of diseases implies an increase in national expenditures for treating people, a high job turnover, low productivity, less private savings and investments and low revenue from taxes in the case of high mortality rate. This will also account for higher expenses for social security.

A number of studies reviewed by the CMH report form a solid background in showing how macroeconomic stability and GDP growth are dependent and partially conditioned by health indicators such as infant mortality, TB and Malaria prevalence, HIV/AIDS pandemic, etc.. Thus, one of the important conclusions of the report is that while high levels of poverty have a detrimental impact on health indicators, increased investments in health will substantially ameliorate a country macroeconomic performance and profile.

The CMH estimated that by the year 2015, the benefits from effective investments on health in the year 2001 will be equivalent to six times the original investment. Accordingly, investing in health is a sustainable, profitable and strategic choice to fight poverty and enhance economic growth.

1.1.2 The Recommendations of the Report

Based on the proofs that investing substantially more in health will result in greater economic returns, the CMH proposes to see the health sector not longer as a 'resources consumer sector', but as a productive economic sector with a very high returns on investment when resources are effectively used to reach targets of interventions. The key recommendation of the Commission is that the world's low and middle-income countries, in partnership with high-income countries, should scale up the access of the world's poor to essential health services, including a focus on specific interventions. The low- and middle-income countries would commit additional domestic financial resources, political leadership, transparency, and systems for community involvement and accountability, to ensure that adequately financed health systems can operate effectively and are dedicated to the key health problems. The high income countries would simultaneously commit vastly increased financial assistance, in the form of grants, especially to the countries that need help most urgently, which are concentrated in sub-Saharan Africa.

Thus, the report recommends to the international community the scaling up of their contributions for the improvement of the health sector of developing countries, passing from a total annual contribution of 6 milliards US\$ in 2001 to 22 milliards by 2007 and 31 milliards by 2015. The same scaling up of resources invested in the health sector should simultaneously be pursued by developing countries themselves through increasing their annual budget allocated to health and health related sectors. Public spending should be better targeted to the poor, with priorities set on the basis of epidemiological and economic evidence. There is scope for private out-of pocket spending in some cases being replaced with prepaid community financing schemes. Yet for the low-income countries, we still find a gap between financial means and financial needs, which can be filled only by the donor world if there is to be any hope of success in meeting the MDGs.

The commitment of massive additional financial resources for health, domestic and international, may be a necessary condition for scaling up health interventions, but the report also recognises that such a commitment will not be sufficient. Past experience shows compellingly that political and administrative commitments on the part of both donors and countries are key to success. Building health systems that are responsive to client needs, particularly for poor and hard-to-reach populations, requires politically difficult and administratively demanding choices. Thus, the report also pinpoints the necessity to remove non-financial obstacles that have limited the capacity of poor countries to deliver health services in an equitable manner. Incongruence of health policy at a country level, weak political will, lack of appropriate human resources, political instability, low salaries, low transparency, scant middle and long term planning capacity, weak capacity to absorb and effectively manage increased resources in the health sector, lack of coordination among

stakeholders and non implementation of a sector-wide approach, inappropriate information system and non effective use of resources already available are all non-financial constraints that can limit the effective development of the health sector.

A war against disease requires not only financial resources, sufficient technology, and political commitment, but also a strategy, operational lines of responsibility, and the capacity to learn along the way, and this was the rationale for the implementation of a macroeconomics and health support mission to Malawi.

1.2 Macroeconomic and Health in Malawi

The government of Malawi has been one of the first African countries to show interest in the Macroeconomics and Health (M&H) sensitising initiatives held after the publication of the report in 2001. The government participated to the inter-country workshop for developing plans of action for taking forward M&H related work held in Addis Ababa in August 2003. From that meeting the government and WHO drafted a preliminary plan of action mainly based on identifying and sensitising key stakeholders on M&H issues including building consensus among the concerned ministries, directors and senior managers of the government. It was agreed that one of the first activities to be undertaken was the identification of main areas for strengthening and setting up institutional arrangements.

As a result of this preliminary work, the MoHP and MoF of Malawian government participated to the 2nd Consultation on M&H 'Increasing Investments in Health Outcomes of the Poor' held in Geneva in October 2003. The initiative allowed countries to share approaches and achievements in the M&H process. Discussion among ministries of health and finance, bilateral and multilateral partners and financing institutions contributed to further focus M&H work on improving access to health care. As well as identifying innovative solutions to address the obstacles that hindered efficient use of financial resources.

Following that Consultation, the MoF and MoHP partially failed in taking forward the issue and sharing the outcome of the meeting with relevant human resources within the government that could have designed and implemented a national plan of action on M&H. From its side, WHO partially failed in providing a prompt technical assistance to strengthen the process at the country level, resulting in a missed opportunity.

In early February 2004 a first WHO-AFRO mission was organised to advocate for a M&H strategy in Malawi. The MoHP, the national M&H focal point and the AFRO M&H coordinator agreed that a second longer support mission would have taken place to 'make the ball rolling'. The political elections of May 2003 slowed down the preparation of the second support mission and they also brought substantial changes within the ministries with shift and re-assignment of key people who participated in the early preparatory work (even including a change in the key ministries). Despite that, in June 2004 the MoHP confirmed its commitment in M&H issues, issuing a letter asking for technical support from WHO to take the issue forward.

Under this rationale, a second support mission was organised between August and September 2004.

1.3 Objective of the Mission to Malawi and ToR of the Study

The main objective of the second support mission is to conduct a situation analysis in Malawi to be used in mapping the way forward for poverty reduction initiatives (MDGs, Macroeconomics and health, poverty reduction strategies) in the countries. The support mission will:

1. Make an inventory and collect data and indicate sources on disease burden, poverty, and health financing (domestic resources -incl. health insurance- and donor contributions).
2. Analyse the structure and organization of the health systems; the current health strategy and planning documents describing health planning, financing and reforms and management; the roles/impact of public-private partnerships and civil society in health, the strength/weakness of monitoring and evaluation systems to track progress and impact on population's health outcomes by household income quintile;
3. Review work undertaken by national and international institutions on the national health expenditures and accounts (financing mechanisms: cost-recovery mechanisms, social security schemes, etc; out-of-pocket expenses and other financial barriers to access for the poor; flow of donor support for the health sector);
4. Analyse current investment flows and funds supporting existing health sector and sustainable development initiatives.

These objectives represented a very ambitious target for a four weeks mission. However it has been agreed to keep them as a broad framework of reference, while acknowledging the many limitations that time constraints will give to the mission capacity to collect and analyse all relevant data. Priority of analysis will be given to the first two points according to data availability, and particular attention will be paid to identify the way forward for M&H initiatives in Malawi.

Additionally, during the preliminary meetings held with the directors and Ps of the Ministry of Health, a few issues were raised to be further investigated during the support mission or by a follow-up country support task force. Particularly The government was also interested in including observations on (a) the relevance and possible link between SWAP and M&H initiatives, and (b) issues of HR availability and competencies needed at the central and regional level to effectively implement M&H initiatives.

Finally, during the first part of the mission, the ministry also requested a preliminary and up-dated comparative analysis between Malawi and selected African countries on health care investments, provision and outcomes. These requests were also accounted for in the following report.

1.4 Data Source and Methodology

The study equally relies on primary and secondary data obtained using qualitative and quantitative methods of investigation. However, given the very strict timeframe, the majority of quantitative data were from secondary sources, while the support mission concentrated more on gathering qualitative primary data.

The majority of secondary data are from the Demographic and Health Surveys 2000 (DHS)², the Integrated Household Survey 1998, the National Health Account (NHA) 2001 and the drafted NHA of 2004, the Health Management Information Bulletin, and the Public Expenditures Bulletins as well as other governmental periodic and non-periodic publications. The data, where possible, were cross-checked and up-dated using the last information available from the Malawian National Statistics Office³, government and stakeholders. Previous studies from a number of sources (national, international and governmental) also constituted an invaluable support for both data collection and analysis.

² The DHS are large-scale household sample surveys carried out at periodic intervals in approximately fifty countries across Asia, Africa, the Middle East, Latin America and the former Soviet Union. In each country, the DHS program collects information about a large number of health, nutrition, population and health service utilization measures, as well as data on respondents' demographic, social and economic characteristics. It does so through a standard set of questionnaires, similar in all countries, to collect data at individual, household and community levels.

³ Many data are available on-line at www.nso.malawi.net.

Primary data were collected from concerned stakeholders: multilateral organisations, government officials at different levels, as well as practitioners. Method of investigation were non-structured interviews and group discussions. These meetings were also used to build awareness upon the macroeconomics and health initiative, its added value and the role and mandate of WHO regarding the issue. At the end of field research a workshop was organised among stakeholders to divulgate the findings, to gather consent and to foster discussion upon the topic. The feedbacks and comments from the workshop were successively included in the study.

Thus, while relying on information partially already available (at least for the quantitative data), the study accomplished the major effort to bring together all the information and stakeholders relevant to macroeconomics and health and to present original observations, findings and suggestions that fit into the ongoing efforts for poverty reduction and health care improvements in Malawi.

2. The Malawian Context

2.1 Demography and Vital Statistics

Malawi is a landlocked country in Sub-Saharan Africa of about 118,500 square kilometres of which one-tenth of the total area is composed of Lake Malawi. It runs for 475 Kilometres length from North to South, bordering Tanzania, Zambia and Mozambique.

The country is divided into three administrative regions: Southern, Central, and Northern regions and it counts 27 districts (see Annex 1). Administratively, each district is divided into Traditional Authorities, presided over by chiefs. In turn, each traditional authority is divided into villages, the smallest administrative unit presided by village headmen.

The population in 2004 is about 11,937,900 and it is growing at an average rate of 2.2 per year. Malawi suffered from rapid population growth especially in the first half of 90s when a National Population Policy was introduced in 1994 (and reviewed in 2001/2002) to contain population growth. Nowadays the stress of intervention on population is on family planning and health care programmes, school -especially female- enrolment and employment opportunities⁴. This will reduce the dependency ratio and increase households' well being.

According to the DHS 2000, fertility rates remain high (an average of 6.3 children each woman during her lifetime) but it has been decreasing of 6% during the past decade, especially for women with more than 30 years old. Fertility rate in urban areas are 4.5 children per woman against the 6.7 children per woman in rural areas. While in urban areas the fertility rate dropped of 18% in the last decade, in rural areas the decrease has been very marginal (the 3% in the same period). Education levels of mother significantly correlate with fertility rates: women with no education have an average of 7.3 children, 6.7 for women within the first 4 years of primary education, 6.0 for the ones who attained the remaining four years of primary education and 3.0 for women with more than primary education.

Malawi has a relatively young population. The 1998 Census indicates that the under-5 age cohort accounts for 17% of the total population: 4% are under 1 year, 27% fall within the 5-14 year age bracket, 52% are 15-64 years, and 4% are aged 65 years or older. The median age is 18 years. It has been calculated that life expectancy at birth has significantly dropped from 51 in 1992 to the present 40 years, mainly as a result of HIV/AIDS epidemic⁵.

The Southern region is the most densely populated followed by the Central and Northern region. Most Malawians live in the rural areas. Only 14% of the total population lives in urban areas. Of this, 11% lives in the four major urban centres: Blantyre, Lilongwe, Mzuzu, and Zomba. Although the growth rate of urbanisation has slowed down in recent years, these four conglomerations continue to grow and the population growth in these centres continues to put an increasing pressure on the already over-stretched provision of basic services of education, health, water and sanitation⁶.

2.2 Health Situation and Disease Burden

The main health problems highlighted in the 1999-2004 National Health Plan include:

⁴ (NSO 2001b).

⁵ (NSO 2001b; WHO 2004).

⁶ (MoH 2004c).

- High child mortality and morbidity
- High maternal mortality and morbidity
- High HIV sero-prevalence and deaths due to HIV/AIDS related illnesses

The health indicators of Malawi have generally remained poor (see table 2.1). The implementation of the 4th National Health Plan 1999-2004 has not fully achieved all its ambitious objectives and most of them have been kept as a constitutive part of the newly designed Programme of Work 2004-2010 between the Ministry of Health and concerned stakeholders. Infant and child mortality rates are high even for Sub-Saharan standards. While recognising the difficulties of getting a fully comprehensive and reliable picture, the MMR of Malawi is one of the highest in the world and it doubled in the last 10 years. An Obstetric Quality of Care Assessment conducted in 2003 showed that most deaths were due to direct factors, including obstetric complications of pregnancy, incorrect interventions, omissions and incorrect treatment. Delays in seeking care, poor referral systems, lack of appropriate drugs and equipment, and inadequate number of health staff also play an important role.

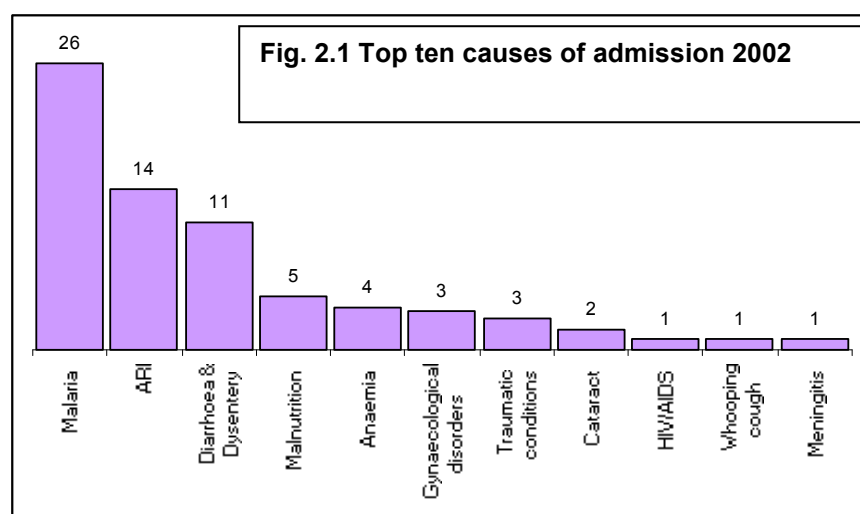
Infant Mortality Rate per 1,000 live births	104
Child Mortality	189
Under-5 MR per 1,000 live births	189
Maternal Mortality Rate/100,000 live births	1,120
Antenatal Care Coverage (%)	91.4
Attendance at birth by trained personnel	57
% of Underweight children under-5	23
% children 12-23 months fully immunized	70
% adult HIV sero-prevalence (15-49)	15

Sources: MoHP 2003; NSO 2001; MoHP 2003.

Neonatal mortality rate has been reported at 42 per 1000 live births, which is 35% higher than the expected rate for a developing country. This also constitutes 40% of the infant mortality experienced in Malawi. The major causes of this mortality are infections, complications during delivery (e.g. asphyxia and trauma) and pre-maturity. This calls for more attention at delivery points⁷.

2.2.1 Disease Burden

The major causes of mortality and morbidity are mostly preventable, with malaria as the leading cause of outpatient visit (30%). Diarrhoeal diseases including cholera, and acute respiratory infections also contribute significantly to outpatient visits. STDs, HIV/AIDS in particular, are a serious threat affecting all aspects of socio and economic life in Malawi. Tuberculosis, once thought to be on the decline, has of late reportedly increased five-fold in the past few years⁸.



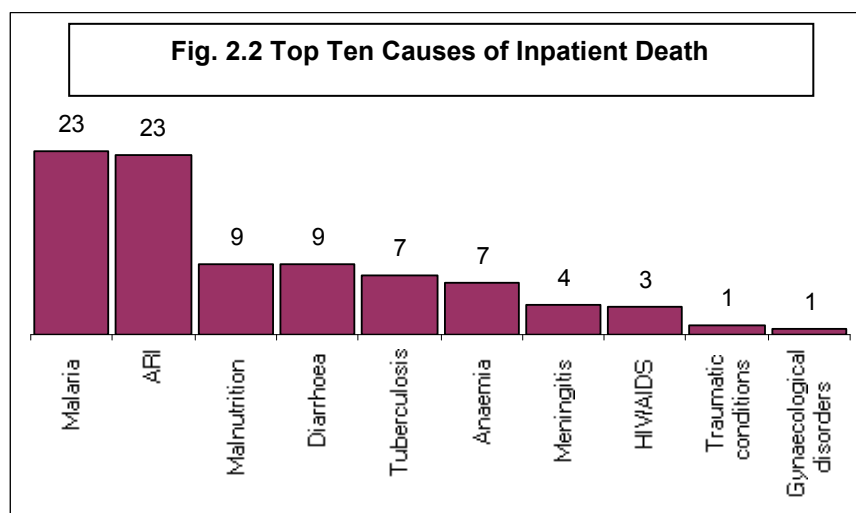
⁷ (WHO 2004).

⁸ (MoH 2003a).

The recent 2002 Health Management Information Bulletin provides a clear picture of the top 10 causes of morbidity, mortality and admission in Malawi (figure 2.1.and 2.2)

Out of 391,000 cases admitted in different hospitals, 26% were diagnosed as malaria, 14% were diagnosed as acute respiratory infections, 11% diarrhoeal and dysentery, 5% malnutrition, 4% anaemia, 3% gynaecological disorders, 3% traumatic conditions, 2% cataract and 1% each of AIDS, whooping cough and meningitis.

Out of almost 30,000 inpatient deaths recorded in different hospitals in 2002, 23% was diagnosed as malaria, another 23% was diagnosed as acute respiratory tract infections, 9% was diagnosed as malnutrition, another 9% was diarrhoea, 7% was TB, 7% anaemia, 4% meningitis, 3% AIDS, and 1% as traumatic condition and gynaecological disorders each.



The fact that malaria, acute respiratory infections, malnutrition and diarrhoea constitutes at the same time about the 60% of the causes of admission and the 60% of inpatient death, jointly with the fact that they are preventable and curable diseases when not in a chronic phase, is a strong indication of delays in reporting illnesses and seeking care.

2.2.2 HIV/AIDS

The HIV/AIDS epidemic in Malawi is extremely severe (see figure 2.3). With an estimated one million adults and children infected with HIV in 2001 (national prevalence is estimated to be about 8.4%, but prevalence among adults aged 15-49 is estimated to be about 14%), Malawi has more people living with HIV/AIDS than North America and Western Europe combined⁹. A total of 740,000 people are estimated to develop or to have already developed AIDS¹⁰. According to the WHO, of the total people living with AIDS only 5% are receiving the anti-retroviral needed to enhance their lives, and only 1% of those in the Sub-Saharan region have access to ARVs.

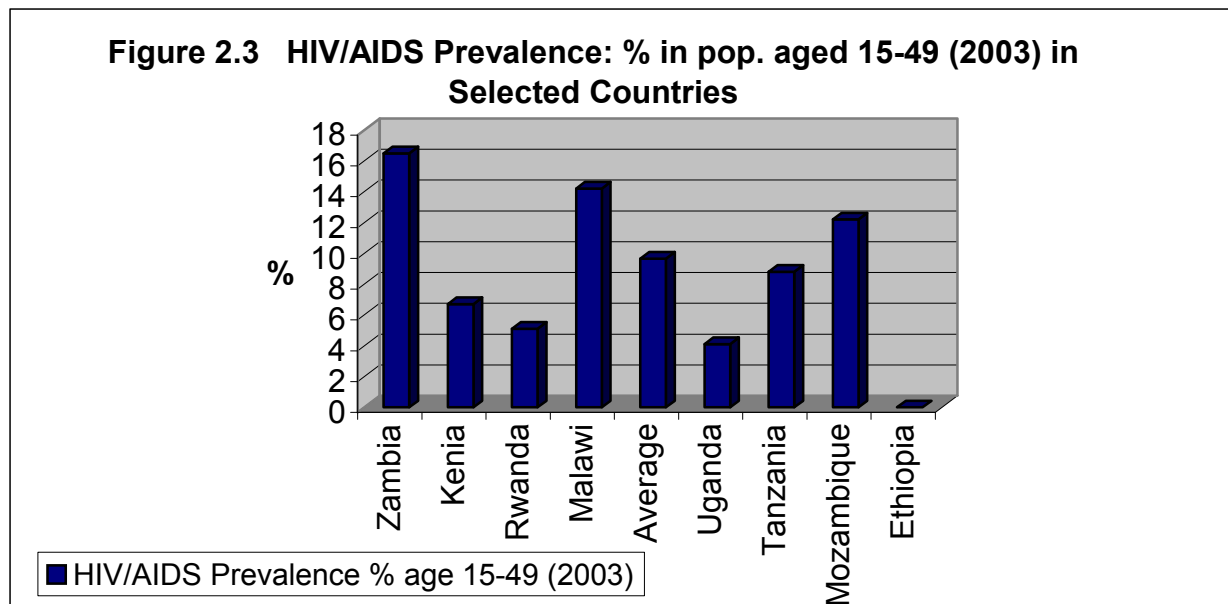
The DHS reported a very high coverage of general awareness of HIV/AIDS (nearly the 99%), however there is still work to be done to improve the understanding and the acceptance of preventive measures to avoid transmission. Overall, unprotected sex with casual partners due to cultural traditions and the economic vulnerability of poor females, plays the predominant role in the spread of the disease. This means that awareness raising did not translate into behavioural change.

Women are contracting HIV at a younger age than men and they have higher prevalence rates (as much as four to six times higher in the 15-29 age group). Most transmission is through heterosexual contact (90%), with mother-to-child transmission a distant second (8%), but the very high rates of HIV prevalence in women of reproductive age (24% on average), combined with high fertility, suggests that future mother-to-child transmission rates will increase significantly. AIDS-

⁹ (WB 2003; MoH 2004c; WHO 2004).

¹⁰ (UNAIDS/WHO 2000; NSO 2001b).

related deaths are rapidly depleting the ranks of key health and education employees as well as the labor force, putting tremendous pressure on an economy that has not been able to maintain positive per capita growth over the last few years¹¹. The precise impact of HIV/AIDS on Malawi's economy is not yet fully clear, but the government has already issued terms of reference for a comprehensive study on the issue that will be shortly implemented.



Source: (UNDP 2004a).

Adult mortality is also the leading cause for the sharp increase in the number of children leaving without one or both parents. In 2000 their number was estimated to be 1.20 million and it is expected to increase drastically in the next decade.

Malawi is now expected to join in with the rest of the world to co-operate in the WHO 3x5 which is an attempt to put about 3 million people world-wide on ARVs by the year 2005. The initiative is to compliment existing efforts in addressing the high cost of medicines and technologies towards health, and ensuring ethical and equitable distribution of treatment among other goals.

2.2.3 TB

Like other countries, the problem of TB has a long and changing history. Before 1985, between 4,000 and 5,000 cases of all forms of TB were reported in Malawi and the number rose to about 20,000 by 1996 and further increased to 24,595 by 2002. The bulk of these cases is attributed to HIV infection. Intensified IEC activities of the national programme probably also contributed to increased case reporting. An independent review on TB programs in the region reveals that Malawi TB approach has been very successful. Despite the devastating HIV/AIDS epidemic and a case fatality of 20%, the National TB Programme has constantly maintained high cure rates and low defaults rates. However, mortality rate in smear negative patients range from 30% to 50% and this raises great concern. Lack of facilities, shortage of personnel, and poor quality of services and high infection rate of HIV in TB patients may be the major contributory factors to the high mortality.

2.2.4 Malaria

To this day, malaria is still the deadliest killer disease in the country and has received profound priority in the past years. 40% of deaths of children of less than 2 years are related to malaria. In addition, malaria is a cause of pregnancy loss, low birth weight, and neonatal mortality.

¹¹ (WB 2003).

The malaria policy target in Malawi is to keep all people free from the burden of malaria. To-date malaria is still the number one cause of morbidity and mortality amongst Malawians. The most recent development is that malaria is being incorporated in the Essential Healthcare Package within the context of SWAPs whereby all district health plans and budgets will incorporate malaria, donors will link their support to these district plans of action to fall in an integrated implementation framework.

2.2.5 Diarrhoeal diseases and cholera

Diarrhoeal diseases, especially in children, and cholera epidemics are common in Malawi. According to DHS 2000, 18% of under-five children are reported to have experienced diarrhoea during the past two weeks preceding the survey. Malawi experienced a devastating food-crisis in 2001/2002 which was compounded by the worst nationwide cholera epidemic which affected over 34,000 people and caused 958 deaths.

2.2.6 Other communicable diseases

Other communicable diseases contributing significantly to total disease burden in Malawi are schistosomiasis, trypanosomiasis, onchocerciasis, leprosy and bacterial pneumonia. Vaccine preventable diseases include tetanus (including neonatal tetanus), measles, pertussis, poliomyelitis, diphtheria and tuberculosis. Coverage for child immunization has dropped from 82% in 1992 to 70% in 2000. The drop might be due to decreased access to services. This is also suggested by a decline in percentage of those possessing a vaccination card, from 86% to 81% during the same period¹². Polio is undergoing the eradication phase; the last confirmed case of polio in Malawi was in 1992. Malawi is currently trying to fulfil the final requirements for certification. measles and NNT have been eliminated in Malawi (although several imported measles cases were recently confirmed in the Southern Region). Active surveillance for AFP, NNT and measles is underway to ensure that all possible suspected cases are investigated and laboratory confirmed. Meanwhile, pentavalent vaccine has been introduced in the country to extend protection of children to include Haemophilus influenza and hepatitis B¹³.

2.2.7 Non communicable diseases

Up until now, the health sector in the country focused its attention on communicable diseases. There is, however a growing awareness of the increase of non-communicable diseases such as hypertension, diabetes, cancer, asthma, mental health problems and oral health. Currently there is insufficient information on non-communicable diseases on which to determine trends in magnitude and to monitor morbidity and mortality. However, there are indications from clinical settings that cases of diabetes, hypertension and cancer are on the increase¹⁴. However, due the already stretched allocation of fund among different health and health related issues, priority of interventions will be still focussing on communicable diseases.

2.3 Human Resources in the Health Sector

The Government of Malawi in general and MoHP in particular is challenged by an acute shortage of skilled personnel. The delivery of public services is immensely retarded by the increased capacity depletion in the public sector. Capacity erosion has been increased since 1990 due to a number of reasons including resignation resulting from poor working conditions, migration to other sectors, low salaries, deaths of employers as a result of HIV/AIDS. Recently, the shortage health personnel has been exacerbated by attrition as a consequence of brain drain of skilled people who depart to industrialized countries, particularly the United Kingdom (of 108 nurses leaving Malawi in 2003, 90 went to the UK). A World Bank report of 1996 revealed that by 2005 between the 25 and

¹² (NSO 2001b; MoH 2003b).

¹³ (WHO 2004).

¹⁴ (WB 2000; WHO 2004).

the 50% of the working age group will die for AIDS. On the other side, the poorly staffed health institutions also suffer from frustration, high levels of stress, low morale and burnout. HIV/AIDS epidemic also affects the health services delivery through high levels of morbidity resulting in high rates of absenteeism and low productivity in the working place¹⁵.

Compounding the problem is the inequitable distribution of available human resources. The distribution of staff favours urban areas at the expense of rural areas where 87% of the population reside. This is due to the unattractive working environment in rural areas i.e. lack of social and educational facilities and accommodation. According to the National Health Plan (1999-2004) the distribution of medical officers and registered nurses is in favour of tertiary care facilities with 68% of medical officers and 64% of registered nurses located in tertiary care services¹⁶.

The Malawi Obstetric Quality of Care study revealed that cleaners and Health Surveillance Assistants were conducting deliveries in health institutions because of shortage of health personnel. This situation has also decreased the trust of people in the health care facilities and their utilisation. The status of personnel establishment in MoHP is summarized in table 2.2.

Tab. 2.2 Established Posts and Vacancies within MoHP, 2004

Category	Established Posts / Required	Filled posts	Vacancy (%)
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Category	Established Posts / Required	Filled posts	Vacancy (%)
Nurses	6,084	2,178	64%
Clinical Officers	356	212	40%
Medical Assistants	692	327	53%
Doctors:			
Generalists	356	212	40%
Surgeons	115	17	85%
Ob-Gyn	126	11	91%
Medicine	65	3	95%
Paediatrics	60	5	92%
Anaesthetists	14	4	71%
Pathologists	22	0	100%
All Categories	7,890	2,969	62%

Sources: *Human Resources in the Health Sector (draft) April 2004 MoHP, and WHO 2004.*

There are approximately 29 nurses per 100,000 population in Malawi, compared to 472, 129 and 85 per 100,000 in South Africa, Zimbabwe and Tanzania respectively. Only 11 of 357 health centres meet MoHP staffing standards, and District Hospitals are equally under-staffed, with an average of 22 nurses per district hospital compared to 175 nurses required. 10 of 27 districts have no MoHP doctor (and are manned at district level by a clinical officer), and four districts are without any doctor in either public or private sector. There is 1 doctor per 100,000 population, compared to 56 in South Africa and 7 in Zambia.

2.4 Poverty

Poverty in Malawi is widespread and severe; nearly 60% of Malawians lived below the poverty line in 2000 (table 2.3). During the 1990s, poverty levels in rural areas remained largely unchanged, while urban poverty increased. As a consequence of poverty, most social indicators are very low compared to the rest of Africa. Only one in three children complete five years of education, and less than one percent attains a desirable level of literacy¹⁷.

¹⁵ (GoM 2004).

¹⁶ (GoM 2004; WHO 2004).

¹⁷ (WB 2003).

Ill-health and access to health care is central to people's analysis of poverty. Hunger, poor medical facilities and diseases, in particular HIV/AIDS, are reported amongst the greatest challenges said to be facing people. The major shocks or 'life crises' that result in impoverishment are famine/hunger, deaths, diseases, drought and floods. The poor were said to suffer most from diseases because of having unhygienic homes, no food, lack of peace of mind and lack of money to pay for medical treatment or transport to clinics or hospitals. In general, although health facilities were recognised as one of the most important institutions in people's lives, there was the general perception that the quality of services had declined.

Table 2.3 Poverty Levels in Malawi

	Southern rural		Central rural		Northern rural		Urban		National	
	<i>Actual</i>	<i>Base</i>	<i>Actual</i>	<i>Base</i>	<i>Actual</i>	<i>Base</i>	<i>Actual</i>	<i>Base</i>	<i>Actual</i>	<i>Base</i>
Mean daily per capita consumption *	11.12	9.27	11.43	9.96	11.49	9.97	19.09	14.08	12.07	10.08
Poverty headcount	62.47	61.85	58.75	57.08	60.59	57.75	49.55	46.18	59.56	58.03
Poverty gap	25.80	25.53	22.27	22.29	22.49	23.24	18.18	18.12	23.35	23.31
Squared poverty gap	13.72	13.58	11.06	11.40	10.71	12.17	9.00	9.41	11.92	12.18

* Units are in MK per capita per day (in real terms).

These computations are based on the more restricted data set of 6,586 households from the Malawi Integrated Household Survey, which gave a poverty headcount nationally of 59.6 percent, rather than the larger 10,698 household data set which gave a poverty headcount of 65.3 percent.

Source: (PMS 2001)

2.4.1 Key causes of Poverty

Poverty in Malawi is caused by a myriad of factors. Many of these factors are constraints on the economic productivity of land, labour, capital and technology. Constraints on labour include generally low levels of education, poor health status, including HIV/AIDS, lack of or limited off-farm employment, rapid population growth and gender inequalities. All these factors causing poverty are exacerbated by generally weak institutional capacity within the country. Distinguished but partially overlapping is the category of vulnerable people defined to include those affected by disasters; households headed by orphaned children, elderly and single parents (especially female-headed); persons with disabilities; under-five children, lactating and pregnant mothers; orphans (including street children, those in institutional care and those staying with extended family); the unemployed and underemployed in urban areas; the land-constrained in rural areas; and technology-constrained small-scale farmers. It is noted, however, that this general categorization does not mean that all people or households falling under these categories are the most vulnerable¹⁸.

The National Statistics Office together with the National Economic Council recently published an important study focussing on the determinants of poverty in Malawi as reported here below¹⁹.

Looking at **demography**, it is important to note that households headed by older individuals in rural areas, holding other variables constant, will tend to be poorer than those headed by younger individuals. In contrast, in the urban centres the level of household welfare does not seem to be determined by the age of the head. One reason for this finding may be in the differences between the nature of economic activities in urban areas and those in rural areas. If they have

¹⁸ (PMS 2000a).

¹⁹ (NSO 2001a).

insufficient labour within their households, older household heads in rural areas are at a disadvantage economically in undertaking the heavy physical labour required in agriculture in Malawi. In contrast, the less physically demanding occupations more common in the urban centres will not place an older household head at an economic disadvantage, particularly if the household head has a relatively high level of education.

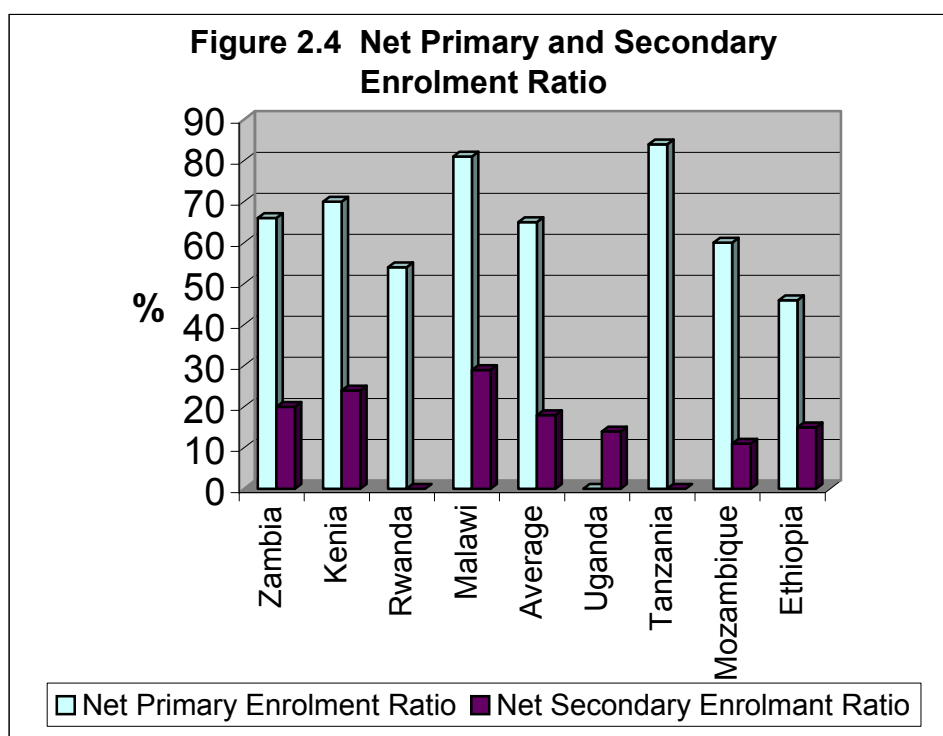
Simulating the effect of adding a child to all households in Malawi²⁰, irrespective of whether or not they have children there is a dramatic reduction in per capita consumption in the urban areas by 26.9%, while in rural areas consumption reduces by 18.6% in the Southern, 14.5% in the Central, and by 18.9% in the Northern rural areas. With this change in household composition the poverty headcount index increases by an estimated 18.4% nationally, with the largest increase in the urban areas. The poorer will be the most adversely affected by the added burden of the increasing numbers of orphans in Malawi society.

Attainment of higher **levels of education** will provide higher levels of welfare for the household, this despite Malawi has already a good enrolment rate in primary and secondary education when compared to other selected countries (figure 2.4). Raising the maximum level of education attained by adults in the household by one step, i.e., from Standard IV to Standard VIII, from Standard VIII to JCE, or from JCE to MSCE, will raise household per capita consumption on average by 22% in Southern rural, by 19% in Central rural, by 11.5 percent in Northern rural, and by 17% in the urban centres.

The coefficient for this variable for women allows one to infer that the level of per capita consumption in an urban household in which an adult women who has completed the MSCE is resident should be 47% higher than a similar urban household in which no adult woman has attained such an educational level, all other things being equal. In contrast, the presence in the household of an adult male who has completed the MSCE should provide a level of consumption 29% above that of similar households without an adult male with an MSCE, all other things being equal.

In summary, the results of the model can be interpreted to mean that the attainment of higher levels of education by women in the urban centres of Malawi, both at the JCE and at the MSCE level, will provide large welfare gains for the households of which they are a part. In contrast, urban men need to attain an educational qualification of at least an MSCE to be assured of deriving welfare benefits for their household from their education. With MSCE attainment by adult women, we see a dramatic increase in per capita consumption by 34.4% overall in urban areas, with less dramatic but substantial increases in household welfare in the rural areas. The corresponding decrease in poverty levels is by 28.1% in the urban areas, 10% in Southern rural, 8.8% in Central, and 5.3% in Northern rural.

²⁰ This simulation seeks to capture the effect on household welfare of orphans being taken in by households, as this is an issue of current importance with increasing numbers of HIV/AIDS orphans in Malawi.



Source: UNDP 2003.

The results of these education simulations suggests that:

- There are limited welfare returns to higher levels of educational attainment in rural areas. Although higher education does provide some welfare benefits in rural areas, the results of the simulation indicate that they are less than those found in urban areas, and they occur at levels of education of JCE or lower. The economic returns to raising one's education from JCE to MSCE in rural areas are very small, likely because there are so few economic opportunities there which provide significant benefits to those with higher levels of training.

- There are important welfare benefits for urban households of women attaining the JCE level of education and, if slightly less so, the MSCE. The larger welfare increase through female education occurs at the JCE level or below, and less so in moving from JCE to MSCE.

- Men need to attain an MSCE level of education in urban areas if they are to derive significant welfare benefits for their households. Simply attaining the Junior Certificate will provide relatively modest economic returns for men in the urban centres.

The variable **access to services**, which measures access to general infrastructure at the household level, shows, as expected, that the more time in hours it takes on average to reach the health centre, bank, ADMARC, bus station, or post-office the more negative is the marginal effect on welfare.

Observation: Unfortunately, the reported studies only take the health status as a dependent variable of welfare-levels, without exploring the other way around. Through a more holistic M&H approach (see following paragraph) it is however possible to see how health and poverty correlate on a double relation of causality.

2.5 Correlation between Health and Poverty in Malawi

The World Bank issued in 2000 a number of statistic tables on the socio-economic differences in health and nutrition of Malawian population by quintiles²¹. Unfortunately, instead of using more recent data, the assessment team relayed on data from the 1992 DHS.

The correlation presented in table 2.4 confirms that the poorest quintiles are also generally characterised by low and very low levels of health and nutrition. However there are surprising exceptions. For instance, when considering IMR and U5MR the poorest two quintiles perform better than the middle and fourth quintiles. For others indicators such as the percentage of children stunted or underweight the levels are more or less equivalent in all quintiles with the only exception of the richest one. For other issues such as knowledge of HIV/AIDS the middle quintile seems to be more disadvantaged than the others.

More recently, the Poverty Monitoring System (PMS) analysed the link between selected health indicators (child survival, child nutritional status, morbidity and immunization coverage) and the economic well-being of the poor using data from 1998 survey. The link between poverty and health resulted even less stronger, leading to the conclusion that more research was needed²².

Table 2.4 Health, Nutrition and Poverty using data from 1992

Indicator	Summary Definition (*)	Quintiles					Population Average	Poor/Rich Ratio	Concentration Index
		Poorest	Second	Middle	Fourth	Richest			
HNP Status Indicators									
IMR	Deaths under age 12 months per thousand births	141.2	133.7	154.1	139.2	106.1	136.1	1.331	-0.03448
U5MR	Deaths under 5 years per thousand births	253.1	248.3	257.9	256.3	172.4	239.7	1.468	-0.04601
Children Stunted (%)	Below -2 sd z-score, height for age, children under 5 years	54.5	55.4	50.8	48.2	35.6	49.2	1.531	-0.06911
Children Underweight (% moderate)	Below -2 sd z-score, weight for age, children under 5 years	34.1	32.6	28.5	24.1	17.4	27.6	1.960	-0.11754
Children Underweight (% severe)	Below -3 sd z-score, weight for age, children under 5 years	12.4	7.5	7.6	6.5	4.0	7.7	3.100	-0.18183
Low Mother's BMI (%)	Body Mass Index < 18.5	14.1	11.3	8.1	8.9	6.0	9.7	2.350	-0.15107
Total Fertility Rate	Births per woman age 15-49	7.2	7.0	6.9	6.4	6.1	6.7	1.180	-0.03293
Age Specific Fertility Rate (15-19 years)	Births per 1000 women age 15-19	143.0	171.0	196.0	162.0	131.0	161.0	1.092	-0.01894

²¹ (WB 2000).

²² (PMS 2000b).

Indicator	Summary Definition (*)	Quintiles					Population Average	Poor/Rich Ratio	Concentration Index
		Poorest	Second	Middle	Fourth	Richest			
HNP Service Indicators									
Immunization coverage (%):									
Children age 12-23 months, by vaccination card or mother's report									
-- Measles		77.2	84.0	83.8	90.6	93.2	85.9	0.828	0.03375
-- DPT3		78.7	87.5	90.7	91.2	93.8	88.6	0.839	0.02795
-- All		73.0	78.8	80.3	87.1	89.3	81.8	0.817	0.03774
-- None		6.6	3.7	1.1	1.0	0.7	2.5	9.429	-0.44555
Medical Treatment of Illnesses									
Treatment of Diarrhea (%):									
-- Prevalence	% ill in the preceding 2 weeks	23.7	20.7	23.4	19.3	21.0	21.7	1.129	-0.02576
-- ORT use	ORS, RHF, or increased liquids	65.5	67.7	71.7	77.4	86.9	73.3	0.754	0.05458
-- Seen Medically	Brought to a health facility if ill	46.7	40.1	48.5	49.4	61.6	49.0	0.758	0.05770
-- % Seen in a Public Facility	Among those medically treated	36.1	28.1	34.1	33.8	41.6	34.7	0.868	0.03195
Treatment of Acute Respiratory Infection (%):									
-- Prevalence	% ill in the preceding 2 weeks	16.8	14.4	13.8	13.6	13.3	14.4	1.263	-0.04288
-- Seen Medically	Brought to a health facility if ill	49.2	54.7	53.4	49.0	65.1	53.7	0.756	0.03455
-- % Seen in a Public Facility	Among those medically treated	31.2	39.0	32.7	39.4	43.0	36.5	0.726	0.05203
Antenatal Care Visits (%):									
-- to a Medically Trained Person	Doctor, nurse, or nurse-midwife	84.0	85.7	89.7	95.1	96.7	90.1	0.869	0.03006
-- to a Doctor		4.3	4.7	5.8	6.7	10.5	6.3	0.410	0.17201
-- to a Nurse or Trained Midwife	Nurses and nurse-midwives	79.7	81.0	84.0	88.4	86.2	83.9	0.925	0.01940
-- 2+ visits		81.6	85.4	88.8	93.9	93.0	88.5	0.877	0.02798
Delivery Attendance (%):									
-- by a Medically Trained Person	Doctor, nurse, or nurse-midwife	44.6	46.2	50.4	58.8	77.9	54.9	0.573	0.10860
-- by a Doctor		2.3	2.9	4.0	5.1	8.3	4.4	0.277	0.24320
-- by a Nurse or Trained Midwife	Nurses and nurse-midwives	42.2	43.2	46.4	53.7	69.5	50.5	0.607	0.09711
-- % in a Public Facility		34.6	35.3	35.6	43.5	59.7	41.2	0.580	0.10603
-- % in a Private Facility		9.6	11.5	15.6	15.8	18.4	14.1	0.522	0.12009
-- % at Home		53.8	50.7	47.6	37.6	20.7	42.7	2.599	-0.14135
Use of Modern Contraception (%):									
Currently married persons using a modern method									
-- Females		3.9	3.6	5.6	6.9	17.2	7.4	0.227	0.31104
-- Males		4.8	8.6	6.1	13.2	24.9	12.5	0.193	0.29997
Knowledge of HIV/AIDS Prevention (%):									
Knows sexual transmission routes of HIV/AIDS									
-- Females		61.3	57.1	56.3	65.0	68.0	61.5	0.901	0.02783
-- Males		51.5	61.4	53.6	71.8	73.4	64.3	0.702	0.06671

Source (WB 2000)

2.5.1 Correlation between Child Survival and Poverty

In particular, based on the findings from the IHS, the PMS's analysis revealed very little difference between wealth groups on child survival. Overall, non-poor women who have given birth are slightly less likely to have had a child die, but the children born to poor women are slightly more likely to still be alive. The more important contrast is rural-urban, which is presented in the table here (table 2.5).

Table 2.5 Child Survival and Poverty

	Rural		Urban	
	Poor	Non-poor	Poor	Non-poor
Children ever born to women aged 15 to 45 who are still alive (%)	78.5	76.4	87.4	89.7
Women aged 15-45 who have given birth who have had no children die (%)	55.2	57.3	73.4	78.2

Source: PMS, 2000

The children of rural mothers are more likely to die than those of urban mothers. The preliminary conclusion is that receiving good quality health care for children in Malawi is more a function of where one lives than whether one is living in poverty or not.

2.5.2 Correlation between Child Nutritional Status and Poverty

Height and weight measurements were taken for many of the children aged 6 to 59 months in the sample households of the IHS. Using reference distributions, the PMS has determined whether a child was stunted, wasted, or underweight²³ (table 2.6).

As shown in the table, any correlations between anthropometric indicators and wealth status is not strong. Children from non-poor households are only slightly less likely to be in poor nutritional condition than those from households in the poorest quintiles line. In specific cases the result is even surprising. For instance, the percentage of extremely stunted children is the same in the four poorest quintiles. Again, the percentage of wasted children is higher in the wealthiest quintiles than the 2nd poor quintile. And extremely wasted children are more or less in the same percentage from the 2nd to the wealthiest quintile. This is surprising as malnourished children should not be found in what should be well-fed, non-poor households. Yet, quite high rates are found. This might suggest that intra-household distribution of income and food can be highly discriminative against children.

Table 2.6 Child Nutritional Status and Poverty

MALAWI	Poorest	2nd	3rd	4th	Wealthiest	All
Stunted (HAZ* <= -2)	60.7 (2.87)	61.5 (2.50)	59.3 (2.92)	58.0 (3.36)	51.7 (4.75)	59.1 (2.57)
Extremely Stunted (HAZ <= -3)	36.1 (2.14)	38.8 (2.94)	36.0 (2.73)	36.1 (3.01)	32.5 (3.92)	36.3 (2.19)
Wasted (WHZ* <= -2)	10.6 (2.14)	9.0 (1.73)	9.3 (1.62)	7.6 (1.54)	9.5 (1.59)	9.3 (1.35)
Extremely Wasted (WHZ <= -3)	4.1 (1.00)	3.5 (0.82)	3.3 (1.06)	3.2 (1.17)	3.4 (1.02)	3.6 (0.73)
Underweight (WAZ* <= -2)	34.0 (1.92)	30.4 (2.32)	29.3 (2.01)	23.8 (1.96)	25.7 (2.25)	29.6 (1.34)
Extremely Underweight (WAZ <= -3)	12.2 (1.16)	11.4 (1.72)	10.5 (1.22)	9.8 (1.13)	8.2 (1.36)	10.8 (0.77)
Percent age group with HAZ-score	65.7	63.6	62.9	68.5	69.0	65.5
Percent age group with WHZ-score	63.2	62.3	61.7	67.5	68.3	64.0
Percent age group with WAZ-score	78.0	79.7	79.4	80.7	82.0	79.6
Weighted pop. aged 6-59 mo	387,017	314,651	247,337	206,274	152,097	1,307,376
IHS sample aged 6 to 59 mos.	1,896	1,503	1,179	987	744	6,309

* HAZ = Height-for-age Z-score; WHZ = Weight-for-height Z-score; WAZ = Weight-for-age Z-score. Based on the reference heights and weights of the WHO. Stunting is indicative of chronic malnutrition. Wasting suggests acute malnutrition.

Source: PMS, 2000 and PMS, 2001

2.5.3 Correlation between Morbidity and Poverty

Morbidity indicates the vulnerability to being sick or ill. The HIS collected information on the level of illness of respondents over the previous two weeks by wealth group - what percentage of

²³ Stunting, a low ratio of height for age, is indicative of long-term or chronic malnutrition. Wasting, low weight for height, results from acute malnutrition, as in a situation of famine. Underweight, low weight for age, is a combination of the effects of wasting and stunting.

individuals considered themselves ill and what percentage were ill enough to stop their normal activities.

The pattern revealed in table 2.7 is counter-intuitive as more wealthiest people were ill and stopped to work as a consequence of illnesses – theoretically we would expect the opposite to be the case. Although the differences are not great, the trend is for the non-poor to be more likely to be subjected to morbidity than the poor. One would expect that, given the level of deprivation under which they live, the poor would be more subject to illness than would be the relatively better fed, better housed, and better clothed non-poor.

However, caution is needed in interpreting this data because the information whether one was ill or not in the previous two weeks was self-reported by respondents. As such, the poor may very likely have a higher threshold in regards to feeling out of sorts before they would classify themselves as “ill”. Consequently, the *illness* of the poor may not be directly comparable to the *illness* of the non-poor because subjectively assessed.

Table 2.7 Morbidity and Poverty

MALAWI	Poorest		2nd		3rd		4th		Wealthiest		All	
	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.
Individuals ill in past 2 weeks	20.7 (1.70)	25.0 (1.88)	23.5 (1.94)	25.5 (1.98)	24.5 (2.31)	29.6 (2.37)	26.6 (2.04)	29.7 (2.24)	26.1 (2.02)	31.8 (2.21)	23.9 (1.83)	27.8 (1.95)
Individuals seriously ill enough to have to stop normal activities	13.3 (1.41)	15.3 (1.49)	14.7 (1.42)	16.1 (1.51)	15.4 (1.46)	18.6 (1.45)	16.2 (1.53)	16.9 (1.43)	15.9 (1.55)	19.3 (1.32)	14.9 (1.29)	17.0 (1.31)

Rural	Poorest		2nd		3rd		4th		Wealthiest		All	
	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.
Individuals ill in past 2 weeks	21.5 (1.90)	25.6 (2.08)	23.9 (2.09)	25.9 (2.13)	25.9 (2.52)	30.7 (2.56)	27.9 (2.22)	31.2 (2.40)	29.6 (2.31)	35.2 (2.48)	25.2 (2.05)	28.9 (2.17)
Individuals seriously ill enough to have to stop normal activities	13.8 (1.59)	15.7 (1.64)	15.0 (1.52)	16.4 (1.62)	16.3 (1.60)	19.3 (1.56)	17.1 (1.68)	17.8 (1.55)	18.4 (1.80)	21.9 (1.46)	15.8 (1.44)	17.7 (1.46)

Urban	Poorest		2nd		3rd		4th		Wealthiest		All	
	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.
Individuals ill in past 2 weeks	14.0 (2.14)	18.3 (2.28)	18.3 (2.69)	20.9 (3.06)	9.8 (2.01)	17.3 (2.61)	14.0 (2.50)	14.4 (2.26)	11.6 (1.51)	16.7 (1.94)	13.3 (1.55)	17.6 (1.61)
Individuals seriously ill enough to have to stop normal activities	8.3 (1.01)	11.9 (1.60)	11.0 (2.58)	11.8 (2.58)	6.2 (1.40)	11.6 (2.63)	7.9 (1.97)	7.9 (1.74)	5.7 (1.05)	8.3 (1.19)	7.5 (1.11)	10.2 (1.24)

Source: PMS, 2000; PMS 2001.

2.5.4 Correlation between Immunization and Poverty

The HIS also recorded the immunization coverage for children aged 6 to 59. Quite high levels of coverage are found consistently in poor and non-poor and in rural and urban households (see table 2.8). The health services provision of Malawi would appear to be doing a good coverage in providing children with basic immunisation despite their household’s income levels. And the percentage of coverage for the poorest is, again, better than the ones provided for the wealthiest.

However, the IHS did not inquire as to the timeliness of the vaccinations. Consequently, medical professionals argue, one should distinguish between children who are *fully* vaccinated – all vaccinations received *and* at the proper time – and those who are *completely* vaccinated – all vaccinations received. Here information of the latter sort is provided.

Table 2.8 Immunization Coverage and Poverty among children aged 6 to 59 months

	Poorest		2nd		3rd		4th		Wealthiest		All	
	Boy	Girl	Boy	Girl	Boy	Girl	Boy	Girl	Boy	Girl	Boy	Girl
Malawi												
Completely immunized	83.5 (1.71)	79.2 (1.98)	81.1 (2.19)	82.4 (1.81)	82.3 (1.79)	81.2 (2.18)	82.5 (2.04)	81.1 (2.02)	80.0 (2.55)	78.9 (2.69)	82.2 (1.26)	80.6 (1.19)
Partially immunized	9.3 (1.23)	12.1 (1.45)	12.2 (1.92)	12.0 (1.46)	10.4 (1.67)	10.8 (1.64)	10.5 (1.75)	11.0 (1.53)	10.6 (2.08)	10.4 (1.95)	10.5 (1.01)	11.5 (1.00)
Has received no vaccinations	1.5 (0.32)	1.2 (0.45)	0.9 (0.43)	1.2 (0.45)	1.1 (0.47)	0.7 (0.39)	0.9 (0.52)	1.9 (0.59)	1.8 (0.90)	2.0 (0.82)	1.2 (0.29)	1.3 (0.25)
No vaccination info. on child acquired	5.7 (0.87)	7.5 (1.14)	5.9 (0.97)	4.4 (0.75)	6.2 (1.08)	7.3 (1.56)	6.0 (1.11)	6.0 (1.12)	7.7 (1.59)	8.6 (1.59)	6.1 (0.58)	6.6 (0.59)
Rural												
Completely immunized	83.9 (1.81)	80.0 (1.96)	81.5 (2.30)	82.3 (1.90)	82.7 (1.87)	81.5 (2.27)	83.7 (2.12)	81.5 (2.13)	82.2 (2.65)	79.1 (2.91)	82.9 (1.32)	81.0 (1.24)
Partially immunized	9.7 (1.38)	11.6 (1.38)	12.5 (2.04)	12.3 (1.56)	10.8 (1.77)	11.1 (1.72)	10.2 (1.79)	11.6 (1.62)	9.9 (2.19)	10.3 (2.03)	10.7 (1.09)	11.5 (1.05)
Urban												
Completely immunized	79.9 (4.26)	71.3 (8.28)	75.6 (6.15)	83.6 (5.96)	77.2 (6.41)	75.6 (7.03)	62.3 (8.19)	76.0 (5.58)	59.6 (9.48)	77.6 (6.87)	73.5 (3.78)	76.1 (3.65)
Partially immunized	4.6 (1.56)	17.2 (7.15)	8.0 (4.07)	6.4 (3.30)	5.2 (3.41)	5.7 (3.95)	15.1 (8.63)	3.5 (2.80)	17.0 (7.13)	11.2 (6.68)	8.5 (1.91)	10.4 (3.22)

(Completely immunized refers to all vaccinations, while 'partially immunized' refers to just a part of them).

Source: PMS, 2000 and PMS 2001.

2.5.5 Observations and further Analysis on Poverty and Health in Malawi

The data previously presented are to some extent surprising and counter-intuitive, calling for further observations and investigations. In particular the general information that these preliminary data seem to suggest is that the health status of the majority of Malawian is neither dependent, nor a determinant of economic well-being. This result is in opposition to the CM&H report findings that indicated a strong link between these two variables across the world. This can be due to a different number of reasons: reliability of data and the fact that the government is strongly pursuing a politic of free health care for everyone, among others²⁴.

A different interpretation we propose is that the income dimension of poverty is not a good indicator in Malawi to define the well-being of the different quintiles. In the Malawian context, poverty measurement is better captured not using household income data but consumption and expenditure information. These are more suitable for several reasons:

■ First, particularly in an agricultural economy such as Malawi, income is often very lumpy. Farming households receive a large amount of cash income in May and June, and receive very little the rest of the year. On an income basis, a household which most would view as wealthy may be categorized as poor if the interview of that household is done after all farming income for the year was received. This creates substantial problems in appropriately allocating households in the different quintiles. In contrast, households are constantly expending their income and consuming. Expenditure and consumption are smoother measures of welfare through time.

■ Secondly, consumption and expenditure can be viewed as realized welfare, whereas income is more a measure of potential welfare. In an agricultural context like Malawi, access to and

²⁴ Despite that, the last data available on private expenditures for health care provision obtained using 1998 HIS data, strongly indicated that out-of-pocket health expenditures accounted for not less than the 26% of sector's finances. This is a clear indication of how the politics of free health for all is not fully implemented at the ground level.

availability of food more than income are the key issues (which also account for vulnerability to natural disasters and negative meteorological shocks). For instance on 27 February 2002, the Government of Malawi declared a State of Disaster indicating that “Malawi is facing a catastrophic situation with up to 78% of farm families (2.2 million people) being without food”²⁵.

■ Thirdly, data on expenditures are generally more reliable and stable than income data. Households are often more willing to truthfully report their consumption and expenditure than their income, particularly when dealing with government enumerators.

■ Fourthly, in a strongly subsistence oriented economy such as Malawi, much income is derived from self-employed business or subsistence-oriented agricultural production. Assigning income values to the proceeds of these enterprises is often problematic²⁶.

■ Finally, for the World Development Report (2000/1), a consultation with poor people in Malawi was conducted to better understand how poor define themselves in the country²⁷. That study revealed that poor people define ‘well-being’ in terms of access to the basics of life. These include food, decent medical care, good shelter, and a regular source of income. Ill-being, or poverty, was defined as lacking access to these essential basics of life. When evaluating poverty through participatory exercises, the link between health issues and non-income dimensions of poverty was presented as a strong one by the poor. As reported in a participatory poverty assessment conducted within urban Lilongwe²⁸, the urban poor were characterised as living in poorly ventilated and constructed houses, having few assets, earning income from casual labour or petty trading, and being food insecure. Illness was cited by poor as one of the major problems they face in their everyday life. In the same study, poor and non-poor TB patients were asked about the impact of their illness on their lives. Although both poor and non-poor experienced negative consequences of TB, poor patients adopted coping strategies which were likely to increase their poverty and have a further negative health impact. Coping strategies included sale of assets (such as pots and pans); taking on *katapila* (local loans) at a high interest rate; missing meals and not purchasing water from the communal tap. Non-poor patients were able to mitigate the economic impact of the illness by drawing upon savings or the sale of less-essential valuable assets.

This suggests that the correlation between poverty and health should not be mainly researched on the ground of income dimensions of poverty but by observing other poverty-related variables such as food security or accessibility to services for instance. This observation is extremely important because shows to which extent in the Malawian economy health issues relate to food-security, access to water and sanitation and environments. This discourse has clearly strong implications when comes to monitoring and evaluation of progresses achieved in fighting inequality and improving the health outcomes of the poorest. In particular, it is suggested to abandon the use of income-based quintiles to evaluate the effectiveness of health policy to tackle inequality and to use, instead, evaluations on consumption-based quintiles.

For most of the data presented in the previous tables for instance, the important variable is whether living in rural *vis a vis* urban areas more than being economically poor against being non-poor, and this can be due to proximity issues to health care facilities. Variables such as accessibility are not considered for the calculation of the Poverty Head Count and they might be a very important issue in a context such as the Malawian one.

On the ground of these considerations, more research on accessibility, availability of health care services in specific geographical areas, real per capita consumption and they correlation with poverty was undertaken during the mission.

²⁵ (WFP, 2002).

²⁶ (NSO 2001a).

²⁷ (Khaila *et al*, 1999).

²⁸ (Nhlema *et al*, 2002).

Table 2.9 Simulation on how Improving Access to Services can Improve Per Capita Consumption

Simulation	Percent change in real per capita consumption					Percent change in poverty headcount				
	South Rural	Central Rural	Northern Rural	Urban	National	South Rural	Central Rural	Northern Rural	Urban	National
Access to services by household										
Reduce time to reach key services by one hour, for HHs who now spend over 2 hours to services	2.7	2.3	4.0	-	2.3	-2.6	-2.6	-4.2	-	-2.6

Source: (NSO 2001a).

Results presented in table 2.9 show that improving access to services by 50% will bring very little and marginal improvement in the real per capita consumption of households. Thus, in terms of macroeconomics and health this means that the hours spent waiting for being visited by health care personnel, the time of transports from and to health care centres, the health complications or deaths occurred as a consequence of delays in the access to health care structures have only a limited impact in the household's per capita consumption. Therefore reducing those costs might not substantially reduce levels of poverty.

Additionally, when considering for instance the results of maternal death reviews during 2001 in the Southern region²⁹ (the poorest region of Malawi in terms of both Poverty Head Count and Ultra-Poverty head Count) the 'accessibility' issue is not a particularly relevant factor contributor to maternal mortality. In fact, only the 13% of maternal deaths recorded were to some extent linkable to delays in arrival at referral unit and patient's delay was the principal avoidable factor of maternal deaths only for the 15% of the cases.

The same data strongly indicated that quality of services provision, more than accessibility, plays a leading role in a variable such as maternal mortality. Deficient hospital or health centre care was indicated to be the principal avoidable factor of maternal deaths in the 43% of the cases. Besides, among all maternal deaths, the quality of health care was judged to be below-standards for the 50% of the cases. Thus leading to the conclusion that the issue of accessibility, while important to be addressed, is secondary to issues of quality of service provision.

The last observation which corroborates this assumption is given by the percentage of woman receiving iron, TT and other services of antenatal care, including assisted delivery (see table 2.10). It is surprising to note that despite 89% pregnant women having antenatal check-up on average for 3 times, only 81% received adequate TT, 76% received adequate iron and 71% received 2 dosage of SP³⁰. This data reveals that these essential components of antenatal services are not always available to the clients, drugs are not timely provided and trained personnel is not always effective in sensitising for assisted delivery more than traditional practices. If under reporting is adjusted, the percentage of delivery by trained health personnel could be as high as 45-50%. Comparing with the antenatal coverage, it appears very little influence of antenatal services in the choice of place of delivery. Otherwise, at least 89% deliveries could have taken place at health facilities.

²⁹ (SMP 2001).

³⁰ (MoH 2003b).

Table 2.10 Antenatal Coverage and Assisted Delivery

	Antenatal Visit During Any Trimester	Pregnant Women Receiving Adequate TT Doses	Pregnant Women Receiving Adequate Iron Supplementatio n	Pregnant Women Receiving Sulpha Pyrimethamine	Delivery by Trained Personnel ³¹	Delivery by TBA ³²
Malawi	89%	81%	76%	71%	35%	22%

Source: {MoHP, 2003 #16}.

From a number of qualitative interviews emerged that patients are more interested in the skills of health care personnel than their actual number. Human resources' competencies are perceived by beneficiaries as of paramount importance in delivering quality services. Thus trust plays a main role in determining where the patient will seek health care and in many cases beneficiaries by-pass the nearest health centre to reach the health service where they believe they will get better treatment because they trust the personnel. Even if drugs are not available, people deeply value the careful visits and considerations of health professionals and this might raise high the trust of the patient toward a specific health post or health worker.

However, what patients perceive as 'quality service' might be substantially different from the government parameters to assess quality. For instance, in patients' perception the number of pills and injections they receive is a straight forward signal of quality of services delivery, but this might suggest nothing on the appropriateness of the drugs prescribed for treating specific diseases. This indicates the necessity to improve the health professional-patient communication and information sharing and trust building mechanisms.

2.5.6 Inequality Issues

Not only is Malawi among the world's poorest countries, but it simultaneously suffers from an extremely skewed distribution of income. With a Gini coefficient of 0.62, Malawi has one of the highest income-distribution disparities in the world, lower only than that of Brazil. As a consequence poverty is both widespread and most likely to severely affect the poorest of the poor. Going back to table 2.4, it provides important measurement of inequality among selected health indicators.

In particular, it provides the analysis with two important statistical indicators: the *poor/rich ration* and the *concentration index*. We observe from the data that the poor/rich ratio is generally high, implying a substantial difference in the health status between the poorest and the wealthiest.

Measurement of Inequality

Poor/Rich Ratio. This is the ratio between the rate prevailing in the poorest population quintile and that found in the richest quintile. Thus, a poor-rich ratio of 2.0 for infant mortality, would mean that the infant mortality rate in the poorest quintile is twice the rate in the highest. This is a rather crude index since it provides no information about the middle three quintiles. It does, however, provide a general order or magnitude of differences between the poorest and the

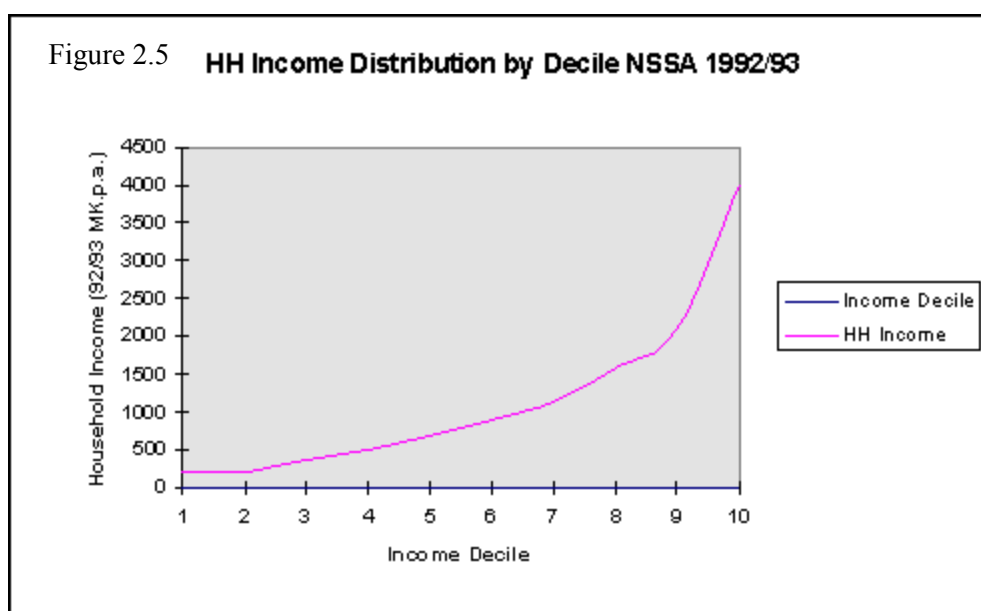
³¹ Deliveries conducted from central hospitals are not included in this figure.

³² Deliveries conducted from central hospitals are not included in this figure.

richest 20 percent in their access to better health status or services (Wagstaff, Paci *et al.* 1991; Wagstaff and Watanabe 1999).

Concentration Index. The concentration index, whose value can vary between -1 and $+1$, is similar to the Gini Coefficient frequently used in the study of income inequalities. It measures the extent to which a particular health status variable is distributed unequally across all five asset quintiles – that is, the concentration of inequality. The closer is the index to zero for any one health indicator, the less concentrated is the wealth inequality for that indicator; conversely, the further away is the index from zero, the greater is the inequality. The sign on the index (negative or positive), and the meaning of the sign with respect to health inequality, reflect the expected direction of the relationship of an indicator with poverty and inequality. For example, there is typically an inverse relationship between infant mortality and wealth, so that a negative concentration index implies a regressive situation as concerns wealth inequality. Conversely, the relationship between immunization and wealth is typically direct, so that in this case a positive concentration index implies a regressive relationship (Wagstaff, Paci *et al.* 1991; Wagstaff and Watanabe 1999).

Figure 2.5 below, illustrates inequality graphically, showing household incomes from the poorest 10% (decile 1) to the richest 10% (decile 10).



Overall, the poorest 20% of the population are consuming about only 6.3% of total goods and services, whilst the richest 20% are consuming 46.3%. Consumption is also more unequally distributed within urban areas where the Gini coefficient is two-third higher than for rural areas.

High inequality is in part a legacy of the previous political system, which was characterized by an inegalitarian distribution of land, as well as policies which favored large estate-owners and limited the majority of the population to do little more than provide a pool of cheap labour to the estate sector. The new Government has begun to reverse these policies, however it is proving difficult to have any rapid effect on poverty. Liberalization of burly tobacco growing (previously a monopoly of the estate sector) has led to increases in income among the moderately poor; and although this has resulted in a substantial injection of cash income into rural areas, it has not been sufficient to have affected household incomes among the majority of the poorest³³.

³³ (UNDP 2004b).

2.5.7 Gender Differences

It has been increasingly realised that full and complete development requires the maximum participation of women on equal terms with men in all fields. Women constitute 51% of Malawi's population and have largely been discriminated against, both in terms of participation in development efforts and benefiting from the outcome.

When focussing on the health sector, the main gender-based difference is not in the quality of services delivered between men and women but in the access to those services. In fact, a number of qualitative interviews pinpoint women's fewer capacity to timely access proper care services. Reasons are mainly due to a reduced mobility of women when compared to men. In particular, women are often overburdened with households chores and they are reluctant to timely seek proper care abandoning their household work. Additionally, ownership of income available at the household level is an important issue and women have little control over the household's income, resulting in their reduced capacity to dispose of cash income for urgent health necessities. Finally, problems related to reproductive health care are sensitive issues that are not easily dealt and discussed within the household, resulting in delays in reporting and assistance. In a number of cases, women seek health counselling and assistance when going to health centres for their children. The attitude of health personnel, often stressed, not fully equipped and competent has also been presented as a potential detrimental factor pushing many women to seek care through traditional practices avoiding medical health centres.

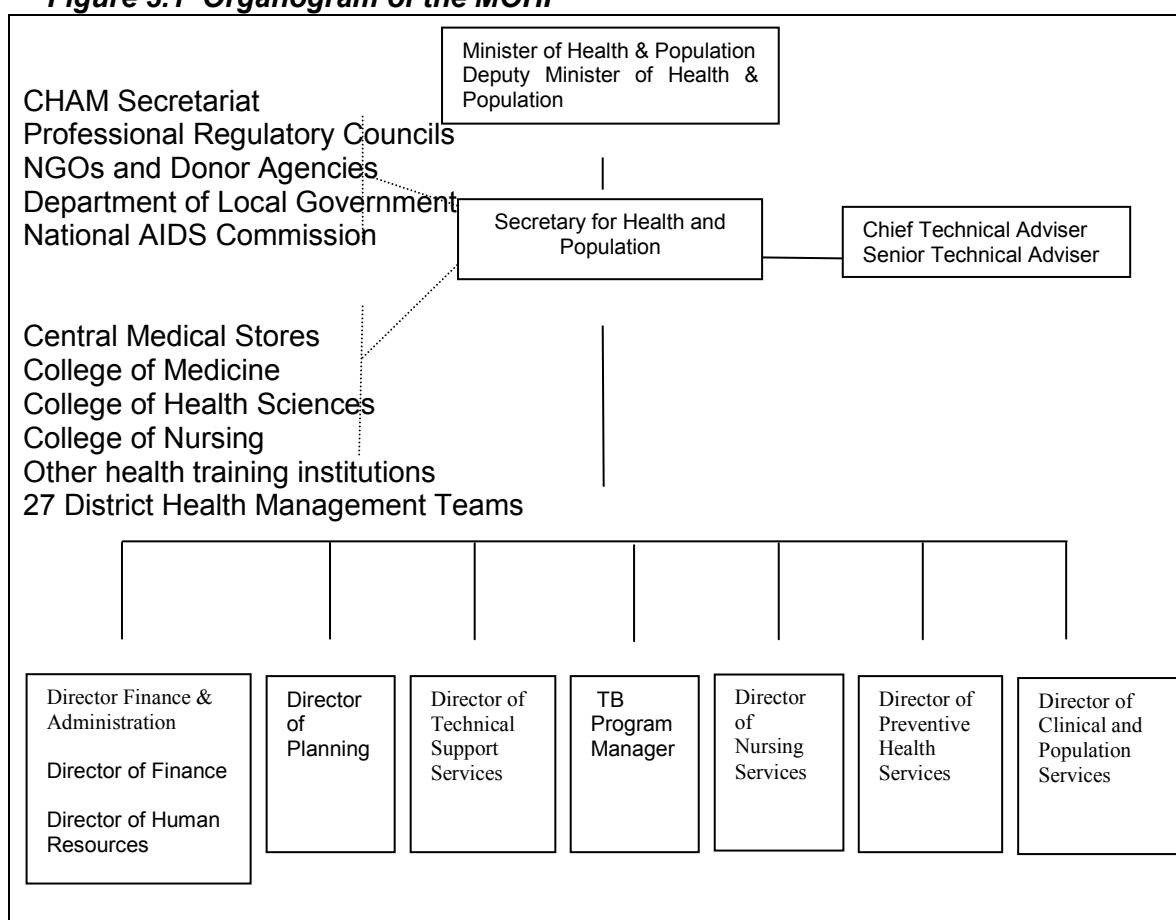
3. The Health Sector and its Actors

3.1 Ministry of Health and Population

The MOHP is currently undertaking a major process of health sector reform. The Local Government Act 1998 provided the legal framework for devolution of service delivery functions to local government at district level. It is the policy of the MoHP, as expressed in the MPRS, to implement the provision of an Essential Health Package for all the people of Malawi. Legislation has been approved to establish a Health Services Commission to regulate employment of health service workers; work is also underway to develop central hospital autonomy. The MoHP has approved a design for a SWAp in Malawi³⁴.

The core functions of the MoHP range from policy to project implementation at the service delivery level. Many departments have a large involvement in the operational level, through being involved in the management and implementation of a multitude of projects and programmes. This means that a central MoHP department may be involved in setting the policy, setting the standards, managing the intervention and monitoring the output at the same time. There is no clear distinction between who is setting standards, their implementation and monitoring the adherence to policy and standards³⁵. The overall organisational structure of the MOHP is shown below in Figure 3.1.

Figure 3.1 Organogram of the MOHP



Source: National Health Plan 1999-2004, Roundtable meeting with senior officers in the MOHP, May 2003.

³⁴ (Ager, Chinula *et al.* 2004).

³⁵ (Ager, Chinula *et al.* 2004).

Main Constraints of the Organisational Structure of MoHP:

- All Directors report directly to the office of the Secretary for Health and Population, resulting in an unrealistically wide span of control for the chief executive.
- A whole range of external agencies including CHAM, NGOs and other bodies report directly to the office of the Secretary for Health and Population, further stretching the span of control in the office of the chief executive.
- The Advisers to the Minister and Secretary for Health and Population appear to fill the void of a management level between the office of the Secretary for Health and Population and the Directors in what is a very flat structure at the top.
- There is no clear identification of who has responsibility for a particular function, e.g. for overall policy, standards setting, regulation, etc.
- Career paths are clearer on a technical level but not so in relation to the development and progression of people with the necessary skills to fulfil the core functions of the MoHP.
- The undertaking of core functions is spread across many technical departments and in divisions or projects/programmes, making it difficult to guarantee co-ordination or a cohesive approach.
- Projects funded by development partners have tended to focus on technical specialities rather than supporting a cohesive approach to the strengthening of systems to address the core functions of the MoHP.

Source (Ager, Chinula et al. 2004).

When specifically referring to the problem of human resources within the MoHP, a number of senior officers pointed out that the lack of planning capacity in the health sector is more an issue of skills development than number of human resources available. It is perceived that the human resources available are sufficient for a proper planning, what they require is strengthening their skills in planning, evaluations and management.

At the district level it has been reported the need for economists and people with strong planning capacity, while at the moment there are only health workers. It has been argued that there is often no clear connection between the financial resources available, staff's share of tasks, priorities and medium-term plans. Additionally it has been lamented the lack of a proper link between the planning cycle and the budget allocation process³⁶.

3.1.1 National AIDS Commission

Since 1985 when the first case of HIV/AIDS was diagnosed, a lot of effort has been put in framing a response to deal with the disease. Some of the major ones include setting up of the National Aids Control Program (NACP) by the Ministry of Health in 1988. The NACP was established to co-

³⁶ Planning activities start at the district level and they go up to the national level which incorporates them into a comprehensive framework. Then these plans are costed and presented to the ministries responsible for budget allocation. Unfortunately at this stage, after the definition of ceilings coming from the Economic and Planning division, the plans go back to the MoHP which has now the responsibility to modify the plans according to budget ceilings. But this adjustment is made at the central level because there is no time to go back to the single districts asking them to modify their plans according to the ceilings. Once the share of the budget among the different ministries has been defined, financial resources are transferred directly to the districts without passing from the central level. Most of the resources go to primary health care, but do not reach the health posts because they do not have financial facilities, so these resources hardly reach the health post, which is where more financial resources should be available to implement preventive programs. The biggest part of financial resources is spent in the district hospitals, including the part originally planned to be allocated to the health post.

ordinate all the efforts against the disease. This was done through campaigns aimed at disseminating HIV/AIDS information to promote knowledge of issues such as the symptoms of AIDS, reducing and preventing transmission, prolonging lives and managing its impacts and negative consequences and furthermore, strengthening institutional capacity for a more effective response to the battle.

The NACP was later changed to National AIDS Commission (NAC) which has more or less same functions albeit with a little more autonomy. The latter has focused on behaviour change and adopted the practice of scaling up various forms of successful interventions.

3.1.2 TB Programme

The response to deal with TB cases was founded in 1964 by the government in what has been known as the National TB Program. The aim of the program is to reduce the burden of the disease, including morbidity and mortality by treating as many TB patients as possible. Malawi is well known for the pioneering role it played under the International Union against TB and Lung Diseases (IUATLD) strategy which was eventually adopted by the WHO Directly Observed Therapy (DOT) that is being carried out up to this day. This entails diagnosis through sputum smear microscopy, DOT uninterrupted drug supply and a robust method for monitoring and evaluation. The major challenge faced by this intervention lies in the varied degrees of commitment of patients to continue with systematic observations as some abort the process midway while others spend their time trying traditional medicine from time to time to meet the demands of their cultural beliefs.

A snapshot on TB programs in the region reveals that Malawi TB program has been very successful. However, TB and any other disease specific interventions have to be scaled down to smaller units within the MoHP, and will be required to maintain some of the good characteristics that would fit in with the new formation, as they are being streamlined for efficiency. The Ministry of Health and Population has already committed itself to these health reforms, though yet to commence.

3.1.3 Malaria Programme

The efforts to deal with malaria began as far back as 1984 with the setting up of the National Malaria Control Committee which was mandated to study and design sound management guidelines for malaria. Before the 1990s, the government adopted the approach of disease management with focus on training health workers and shop owners in rational prescription practices, malaria treatment at different levels, competencies in laboratories and surveillance work among others activities. Lessons drawn from this phase led to adopting another approach of malaria prevention using insecticide-treated nets (vector control) and intermittent treatment of pregnancy cases.

By 1996, further efforts to combat the disease were made and these included establishing the Malaria Control Programme, which has focused on building and strengthening capacity at community levels of the national health system. In 1998 a sector wide health approach was adopted in collaboration with partners such as the WHO, UNICEF, WB and UNDP among others, to enhance some critical elements such as evidence based decision-making, rapid diagnosis and treatment, multiple prevention, focused research and more organised partnership among stakeholders.

3.1.4 Decentralisation Process

As reported in the Sector Devolution Analysis Document, there are a number of core function that will be devolved to District Assemblies. In terms of health service provisions, these functions include: preventative services (health centres services, outreach, community based), curative services (district facility based services), nursing and health technical support (drug management, supply and distribution). In terms of administrative functions, these include the issue of human resources management (including recruitment/hiring, disciplining, training, performance appraisal,

promotion, transfer and deployment). Finally, for health planning and financial management and budgeting, these functions include: situational analysis, prioritisation, strategy development, budgeting, implementation, monitoring and evaluation, collaboration with stakeholders, contracting services, rational use of resources (financial and human), intersectoral collaboration, community mobilization, financial management, expenditure control, financing strategy, research.

In taking structural reform forward, it is important that the operational level is clearly distinguished from the central, strategic level, and that MoHP resources are explicitly retargeted in the latter area. This is because as the policy of decentralisation through devolution continues there will be less and less involvement of the central MoHP in the management at the operational level of districts or central hospitals. All operations should be reflected in annual work-plans, i.e. the District Implementation Plans, and full responsibility for their implementation will lie at the district level. Therefore, reforms of MoHP structure need to explicitly strengthen capacity which is more focused on effective roles at a strategic level and not for operational management. The relationship with operations is established through policy, setting standards and regulation, rather than service management, though it is acknowledged that certainly in an interim or transitional period that the central MoHP will retain aspects of non-core functions³⁷.

Thus, the challenge ahead is to address the new needs of the MoHP under the decentralisation process. This will require a 'reshaping' of the MoHP such that its structure reflects its new, emerging strategic functional tasks. This will include empowering the MoHP to take clear leadership and ownership of the SWAp process, as well as enhancing efficiency of the MoHP's working practices to build capacity to provide effective technical support to district health sector.

3.2 The Donor Community and the Sector-Wide Approach (SWAp)

Great efforts have been made by the government in recent years to move towards sector-wide approaches (SWAps) in education, health, agriculture, and local government/decentralization, although discussions on sector strategies and expenditure programs are proceeding very slowly. In 1999, in order to substantially improve the overall management of the health sector, the MoHP decided to move away from a separate-project approach to health development, towards a more comprehensive SWAp. In 2001, a WHO-supported consultancy took place with the twin objectives of: raising awareness among health sector partners on issues involved in SWAp; and, based on both an assessment of the Malawian context in respect of SWAp, and international experience, sought to achieve consensus among key stakeholders on the current situation and to determine options for further development of a Malawian SWAp³⁸. Since then, the SWAp process undertook a number of consecutive steps forward such as the realisation of a SWAp Implementation Plan. Within this overall Plan, seven major components have been designed: Institutional Development; Technical Services; Human Resources Development; Health Financing; Financial Management; Procurement; and Management Information Systems.

The SWAp process within the health sector came to a crucial stage when in June 2004 the government together with the health sector development partners presented a Memorandum of Understanding (MOU) which sets out the terms and procedures for the Government and the Collaborating Partners' assistance to the implementation of the health sector joint Program of Work and the Annual Implementation Plans to be formulated each year. The MOU explicitly recognises and stresses the inter-sectoral dimensions of health, including water, housing, sanitation, nutrition, education, and income, and recognizes the importance of collaboration between the Government, civil society organizations and the private sector within these broader aspects of health. It also intends to incorporate initiatives in these inter-related fields when planning and monitoring implementation of the Essential Health Package.

³⁷ {see /Ager, 2004 #26, for a complete discussion of this}.

³⁸ (MoH 2004b).

3.3 Private Health Sector

3.1 *Christian Hospital Association of Malawi (CHAM)*

Non-governmental organizations play a very important part in Malawi's health sector. Among them, mission facilities organised under the CHAM, surely have a leading role in providing health care services throughout the country. CHAM is the largest non governmental group in the health sector, accounting for 19% of all facilities, 38% of beds, and 10% of outpatient visits. Most of these health institutions support the government in covering the population with basic health services and provide training for nurses and other health personnel. One third of CHAM operating funds come from fees, sale of drugs, and other internally generated revenues, nearly the 42% from subvention grants, and the 25% from donations.

CHAM facilities are organized as a network although they operate autonomously in the planning, financing and delivery of services. Hospital finances, including fee revenues, are managed by independent committees; fee schedules are made at the local level. In districts where there are no government hospitals, CHAM facilities may be designated to fulfil their functions. These district-designated CHAM hospitals receive financial support (subvention) from the Ministry of Finance covering most of their salary costs.

All CHAM facilities charge modest fees. Besides, district-designated CHAM hospitals have private wings that generate revenues. Fees are paid in cash but in-kind payments are also accepted in rural areas. CHAM waives payment only in exceptional cases. The larger hospitals have written criteria and regulations on who can be waived or exempted, but these are not very transparent in smaller facilities. A study on outpatient paying patterns commissioned by UNICEF in 1995 indicates that 95% of all CHAM patients pay treatment fees, 19% pay associated health-service fees, and 22% pay for transport costs. In contrast, only a negligible percentage of MoHP patients pay treatment fees, only 12% pay associated health service fees, and only 9% pay for transport costs³⁹.

CHAM organisation is a remarkable example of a good balance between efficiency, quality and financial sustainability in delivering health care services. Services provided are cost-effective and the modest fees charged do not prevent poor people's access to the services. On the other side, they are a useful revenue covering a large part of costs. Patients are willing to by-pass nearer free public health centre to go to CHAM facilities when they believe they can get a better treatment - even if at a small cost. The perceived quality of services provided is the main justification pushing patients to be willing to pay modest fees for receiving better health care. And this is proved to be valid not only for the middle-income population, but also for the low-income population. In particular, it has been argued that the fees they pay are low if compared with the cost of seeking care following times in the eventuality of not having received appropriate treatment in the first place.

Thus, CHAM facilities can be taken by the government as a model of health care facilities able to internally generate an important part of their costs, and able to provide quality of services to the different social classes of the population.

3.2 *Private For-Profit Health Providers*

Private estates and corporations, usually provide on-site health services to employees, their dependents. In a small number of cases they also provide health assistance to non-employees and

³⁹ (WB 2002).

non-dependents⁴⁰. The MoHP should consider appropriate mechanisms to encourage private estates and corporations that do not currently provide health services to their employees and their dependents to set up such services. The role of these private for-profit health providers receives very little attention by both government and NGOs despite the very good potentialities that the sector can provide. Thus, the role of these corporations needs to be seriously discussed and comprehensively incorporated within a country-wide strategy for the improvement of the health sector.

Since 1991, when private medical practice was in first legally allowed, the for-profit sector has dramatically expanded, all full and part-time professionals practicing in cities and large town. New regulations also made it possible for government health workers (doctors and medical officers) to have second jobs as private practitioners, allowing a very important secondary source of income for these public workers, able to integrate their low salaries. On the other side, government doctors have migrated to cities and paramedics to periurban areas. A missing information in the literature is how this liberalisation of the medical sector has affected health-service access, equity, or quality of care. Drug shops are both a convenient source of pharmaceuticals and medical advice.

Traditional healers are well-established in the country and they can earn more than the government doctors. Patients going for traditional consultations and treatments are many, some traditional healers report seeing as many as 200 patients a month, pushing the MoHP to make a major effort in September 2004 to regulate this practice⁴¹.

3.3 Health insurance

The World Bank (2003) has explored this emerging sector showing that the slow structural transformation of the economy and a narrow base of formal employment had so far a negative impact in the development of social/compulsory or private/voluntary health insurance sector in the country. Nevertheless, despite the small-scale dimension of the sector, Malawi has a small established private health insurance industry. Though the membership base remains small, it is a profitable sector and expects market expansion.

The self-insuring agencies operate their own health insurance schemes – Federal Reserve Bank, the Post Office, National Bank, Inde Bank, Admarc, Levy Brothers. The government encourages parastatals to establish health insurance and medical aid schemes for their employees. All parastatals currently have some form of health insurance for senior staff, while a number operate clinics for junior staff. Scant information exists on the organization of these schemes, their number, coverage, benefit packages, or utilization patterns.

Always the WB report of 2003 presents moral hazard as the major issue facing private insurance schemes in Malawi. Contracted private providers tend to over-use laboratories and x-rays, over-treat through prolonged confinement, and over-prescribe drugs. This problem encouraged agencies to take greater control of the provision of care through direct equity investments in a hospital and a pharmacy. The second major problem has to do with AIDS because most of insurance contracts exclude AIDS care, but to avoid losing clients, they do not strictly enforce this clause. This approach can continue as long as AIDS patients do not demand the expensive cocktail of AIDS drugs available in Western countries. As soon as they make such demands, the premium rates will have to be adjusted to such an impossibly high rate that private health insurance may become unviable, throwing such patients back into the ill-funded government system. This is a critical issue that GOM must tackle. Fiscal difficulties have triggered proposals to

⁴⁰ The Nchima Plantation, for instance, operates a clinic staffed with five nurses and one medical assistant and supplied with drugs from the UK, courtesy of the Nchima Trust. The clinic charges token fees, which are fixed for a course of treatment or service.

⁴¹ (WB 2003).

explore social health insurance for the formally employed, but Malawi's National Health Plan provides no specific actions to pursue it.

3.4 Household health expenditures

The 1998 household survey registered data on household expenditures on health (table 3.1).

Table 3.1 Household Per-capita Daily Expenditures

<i>(pct. of mean per capita daily expenditure)</i>	<u>Rural</u>		<u>Urban</u>	
	Poor	Non-poor	Poor	Non-poor
Food	80.9	69.7	57.5	29.8
Fuels	3.5	3.6	7.7	3.0
Clothing	5.1	7.3	5.5	7.0
Services	1.7	1.7	1.7	7.5
Health	0.8	0.8	2.2	2.4
Housing	0.9	3.3	11.3	21.4
Durables	2.0	3.7	2.8	4.4
Non-durables	2.8	2.6	3.4	3.1
Travel	0.5	1.5	1.8	5.1
Gifts	1.4	4.7	4.2	9.4
Other	0.5	1.2	2.1	7.1
<i>Mean expenditure (MK)</i>	<i>5.09</i>	<i>14.91</i>	<i>14.00</i>	<i>58.71</i>

Source (PMS 2000a).

Rural household spending is generally very low, with no difference in the percentage of health expenditures between poor and non-poor. On the contrary, urban expenditures on health are remarkably higher for both poor and non-poor.

Rural household underspending can be alleviated with more intensive public spending, but the trend in MoHP expenditures does not point in this direction. In March 1995, UNICEF conducted a survey indicating the degree of leakage and undercoverage of fee programs in Malawi. At the national level, as much as 61% of non-poor households get health services without paying (leakage) while as much as 43% of poor households end up paying (undercoverage). Thus, many households with capacity to pay for health services are freeloading while just as many households with scant means are paying for care.

The government should consider to follow-up previous recommendations to sharpen the focus of fee programs (imposing fees on free-care urban facilities where those with capacity to pay are mostly located) and to establish clearer waiver and exemption systems in both urban and rural facilities. Additionally, the survey did not disaggregate respondents by the type of facility used (MoHP, CHAM, local authorities, private for-profit), making it difficult to recommend institution-specific reforms, yet this is an area where further research is needed to properly assist policy planning.

4 Poverty Reduction and Health Improvement Initiatives

4.1 Vision 2020

The Vision 2020 is the basis for the preparation of short and medium term plans that will lead to the vision that Malawi sees for the year 2020. The vision defines national goals, policies and strategies that will help government and private sector to improve development management.

The national priorities defined are: democratic governance, sustainable economic development, vibrant culture, infrastructure development, science and technology, equality, food security and nutrition, sustainable natural resources and environmental management.

The vision 2020 has been subsequently sharpened and made more operational through the realisation of the Malawi Poverty Reduction Strategy Paper.

4.2 Malawi Poverty Reduction Strategy and the Essential Healthcare Package

Since 1981, Malawi has implemented a series of policy interventions through World Bank and IMF backed Structural Adjustment Programmes (SAPs) in order to address structural weaknesses and adjust the economy to attain sustainable growth. From 1994, these interventions have been complemented by the Poverty Alleviation Programme (PAP), which emphasises the need to raise national productivity through sustainable broad-based economic growth and socio-cultural development. Despite some successes, early efforts suffered from the absence of a well-articulated action plan to ensure a holistic approach to implementation of poverty reduction strategies.

To address this weakness, a comprehensive Malawi Poverty Reduction Strategy (MPRS) was established as the overarching strategy for all development activities in the country. The MPRS is built around four pillars. These pillars are the main strategic components grouping the various activities and policies into a coherent framework for poverty reduction. The first pillar promotes rapid sustainable pro-poor economic growth and structural transformation. The second pillar enhances human capital development. The third pillar improves the quality of life of the most vulnerable. The fourth pillar promotes good governance. The MPRS also mainstreams key cross cutting issues such as HIV/AIDS, gender, environment, and science and technology⁴².

The key factors that will contribute to an environment conducive for pro-poor growth are macroeconomic stability, access to credit, and improved rural infrastructure. Efforts are also made to improve enabling infrastructure, strengthen trade and investment arrangements and review taxation policy. Macroeconomic stability is a prerequisite for private sector development and economic growth in Malawi.

When focussing on the health sector, the overall objective presented within the MPRS is to improve the health status of Malawians by improving access to, quality and equity of health services. This will be achieved through the design and implementation of an Essential Healthcare Package (EHP).

4.2.1 Essential Healthcare Package

The EHP will address the major causes of morbidity and mortality among the general population and focuses particularly on medical conditions and service gaps that disproportionately affect the rural poor.

⁴² (MoEPD 2002).

The key strategies under the EHP are to recruit, train and adequately remunerate nurses and other health workers, to promote the construction of health facilities, especially through the construction of rural health centres and to increase the availability of drugs. These delivery components will be supported by ongoing reforms to health services, focussing resources on preventative and primary healthcare, and decentralising management and administrative responsibilities.

Malnutrition is both a cause and a consequence of poverty. In order to improve the nutritional status of Malawians, the MPRS includes strategies aimed at improving infant and young child feeding, promoting community based nutrition interventions, and encouraging people to diversify and modify their diets.

The program to deliver the EHP will form the basis of the MoHP's joint program of work with development partners and other providers of health services. This also means that the EHP will be delivered in an integrated manner through multipurpose health facilities, multipurpose staff and integrated service functions. The planning of service delivery will involve other sectors and emphasize on multipurpose programs as opposed to specialized program delivery, where possible⁴³. The EHP will form the basis upon which the districts will develop their District Implementations Plans (DIPs).

The EHP will be delivered through a well functioning referral system which effectively links the community level, health centre level and the first referral (district) hospital level, including CHAM and other providers of health care.

4.3 Other Initiatives

A number of other bi- and multi-lateral initiatives and framework of reference are also currently implemented in the country, however not specifically focussed on the health sector. Among others, the policy documents and agreements which have a major impact in shaping current development planning are: the NEPAD initiative, the Country Assistance Strategy of the World Bank, the United Nations Development Assistance Framework (2002-2006), the IMF's Poverty Reduction and Growth Facility (PRGF) arrangement, and the HIPC debt relief initiative.

⁴³ (MoH 2004a).

5 Health Sector Budgeting, Planning and Expenditures

5.1 Macroeconomic Condition

Since the UDF-led Government took office in 1994, economic stability has been recognised as top priority in order to create a conducive environment for poverty reduction. The stabilisation process was characterised by the adoption and implementation of a number of structural adjustment programmes suggested under the supervision of the WB and IMF. In particular, the Fiscal Restructuring and Deregulation Programme meant to liberalise the economy, broaden and diversify the production base, and allocate resources more productively.

This section discusses the Malawian macroeconomic framework mainly focussing on reviewing macroeconomic targets and real achievements as expressed in the MPRS and recent Annual Review Reports. It also discusses the progress of implementation of fiscal and monetary policy, their shortfalls and constraints.

5.1.1 Macroeconomic Targets

Malawian macroeconomic development has been characterised by high economic instability. Since 1995, the three key price indicators-inflation, interest rates, and the exchange rate-have all been high and volatile, with volatility strongly correlated with changes in money supply. Fiscal discipline remains elusive, as a result of parastatal losses, unbudgeted spending on emergency relief, ineffective control mechanisms for regular spending, and inadequate management of aid flows⁴⁴.

The poor are bearing the biggest burden of an unstable economic growth and a number of macroeconomic interventions founded through foreign aid are simply not sustainable in the medium and long term. Accordingly, in compliance with the WB and the IMF supported Structural Adjustment Programmes, the MPRS foresees tight monetary policies and prudent fiscal discipline as a precondition to economic growth and stability. Consistent with this analysis, the MPRS aims at achieving some agreed macroeconomic targets in terms of GDP, inflation and exchange rate. These targets were used to identify the resources needed in the sector. Table 5.1 compares the MPRS targets, the budget targets and the actual resources that were effectively available during the considered period (outturn)⁴⁵.

Target	MPRS Target	Budget Target	Outturn
Real GDP growth rate	4.5	4.5	4.4
Inflation Rate	5	9.4	9.6
Exchange Rate	74	89	97
External Assistance US\$ mn	191.32	179.88	110.05

(MoEPD 2003)

There have also been delays in structural reform. Monopolies or oligopolies continue to operate in any large industries (sugar, cement, petroleum retailing, tobacco auctioning, and transportation) and many small- and medium-sized enterprises continue to operate in protected environments which are not necessarily conducive to Malawi's long-term competitive advantage. Despite some progress on privatization, many productive and trading enterprises remain under public control-often at arms length through ADMARC or the Malawi Development Corporation (MDC). The National Bank of Malawi (NBM) remains in Government hands; and cross-ownership and –

⁴⁴ (WB 2003).

⁴⁵ (MoEPD 2003).

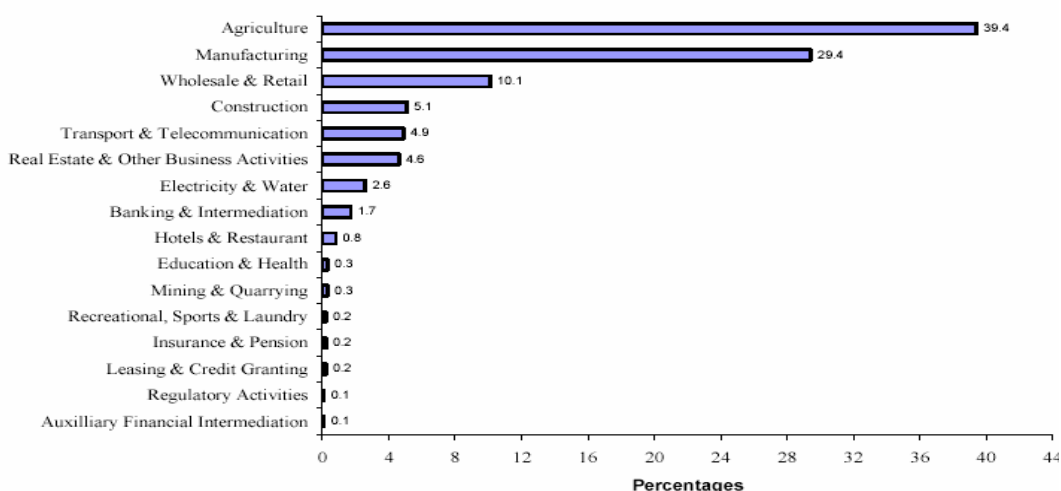
directorships of financial institutions by conglomerates such as ADMARC and the Press Corporation (which dominates many sectors of the economy) continue to confuse incentives⁴⁶.

5.1.2 Economic Growth

At independence in 1964, Malawi had three major economic and social policy objectives: to improve agricultural production, to diversify into manufacturing and industrial processing, and to eliminate ignorance, disease and poverty. Over the past 40 years, economic growth has been fluctuating from about 6% (1964-1979) down to about 0.6% (1990-1994). In 1995/96 the real economic growth rate rose to 13.8%. The growth rate has since been declining. In 2001/02 the economy had a growth rate of -1.5% and in 2002/03 raised at 4.4%⁴⁷. Within the LDCs, Malawi is among the poorest⁴⁸. The major reasons for GDP fluctuations in the last years have been a series of exogenous shocks such as high import prices, disruption in trade routes, influx of refugees and draughts. Policy weaknesses and slippages have also contributed to declines in growth⁴⁹.

Agriculture is the mainstay of the economy and the biggest market for employment, mainly self-employment (see figure 5.1). The agriculture sector is however highly vulnerable to adverse weather conditions. In spite of this agriculture accounts for about 35% of GDP, 93% of export earnings and provides more than 80% of employment. Tobacco is the main export earner, accounting for more than 70% of Malawi's agricultural exports⁵⁰.

Figure 5.1 Percentage Share of Average Employment for 3 Year Period (1999-2001)



Source (AES 2001).

Table 4.2 below gives other selected economic indicators for the years 1994 to 2001. Domestic savings as a proportion of GDP has been on the increase particularly in the years 2000 and 2001⁵¹.

⁴⁶ (WB 2003)

⁴⁷ (MoH 2003a; WB 2003; WHO 2004).

⁴⁸ (Human Development Report, 2004).

⁴⁹ (WHO 2004).

⁵⁰ (OVP 2001; WHO 2004).

⁵¹ (WHO 2004).

Table 5.2 Selected Economic Performance Indicators

Year	1994	1995	1996	1997	1998	1999	2000	2001
GDP Growth rate (%)		13.8	10.4	7.0	2.2	3.6	2.0	-1.5
Current Account Deficit (MKmn)	-2344.8	-2693.7	-4325.5	-6115.7	-4672.5	-12751.2	-11981.4	-10482.9
CAD/GDP, excluding grants (%)	-22.8	-12.6	-12.2	-14.3	-8.6	-16.1	-11.5	-7.3
Aver. Annual Inflation (%)	34.7	83.1	37.7	9.1	29.7	44.9	29.6	27.2
Average Exchange Rate (MK:1US\$)	8.7	15.3	15.3	16.4	31.1	44.1	59.5	72.2

Source:(WHO 2004).

Malawi's macroeconomic performance has been modest during the second half of the 1990s. Between 1995 and 1997 there was remarkable growth in real Gross Domestic Product (GDP) owing largely to the provision of the free farm inputs through the Starter pack and the targeted input programmes. As both were highly donor dependent this progress could not be sustained. It can therefore be seen from the table that between 1997 and 2001 real GDP growth rate never went beyond the 5.5% that is required to reduce the numbers of the population beyond the poverty line and was in fact negative in 2001⁵². Overall, per capita GDP growth averaged 1.5 for the entire period 1990-2001⁵³. Inflation rate was generally high over the period, above 27% for all years except 1997 when it was 9.2%. This was mainly due to huge depreciations in the Malawi Kwacha over the same period. Inflation in Malawi tends to be dependent on movements in the exchange rate because of the country's heavy dependence on imported inputs. The current account deficits (CAD) show fluctuations that are attributable to fluctuations in tobacco export earnings, which in turn, is susceptible to the vagaries of weather. In order to finance the current account deficit, the Government resorted to external borrowing, hence the huge increases in the external debt stock as a share of GDP from 90.8% in 1997 to 150.3% in 2000⁵⁴.

5.1.3 Fiscal Deficit

The fiscal deficit is the difference between the total revenue and grants and the total expenditures in a particular year. This difference, if negative, is financed through external borrowing or domestically. The fiscal deficit (excluding grants) as a percentage of GDP has been steadily increasing from 1993/94 to 2000/01, passing from an initial 8.63% to a bigger 13.01%. However, when considering the grants allocated by donors, the deficit significantly drops and it passed from 5.55% in 1993/94 to 2.63% in 2000/01. This clearly shows an heavy dependence of the country upon external support to finance a considerably high proportion of its budget operations⁵⁵.

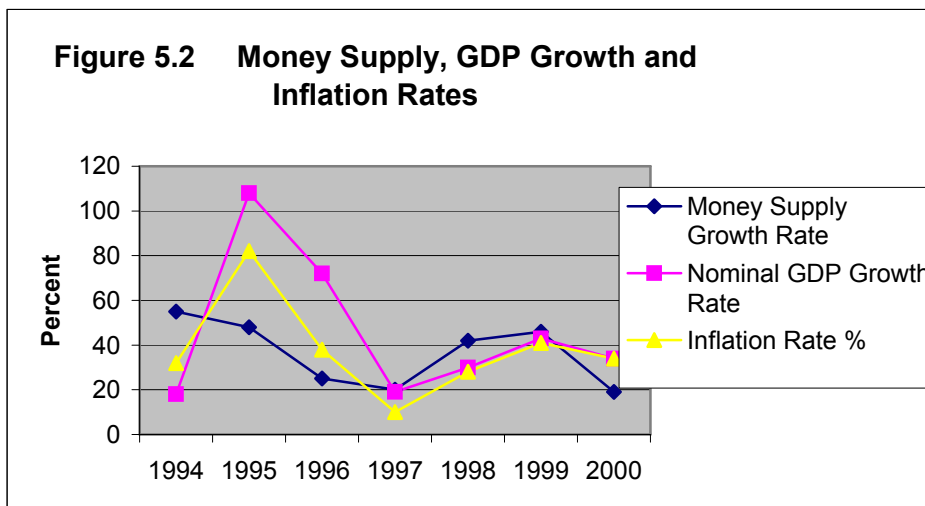
To finance its current debt, the government is forced to use monetary policy. Money supply is supposed to expand at the same rate than the nominal growth rate of GDP, and any differential are inflationary, accounting for the domestic financing of the budget debt. Money supply, GDP Growth and Inflation are considered in figure 5.2.

⁵² (MoEPD 2003).

⁵³ (World Development Report 2003).

⁵⁴ (WB 2003; WHO 2004).

⁵⁵ (OVP 2001).



The really high inflation rate of 1995 (83%) was due to a money supply higher than the rate of nominal GDP growth⁵⁶. This huge money supply operation was in response to the enormous deficit in 1994/95, when the deficit (excluding grants) was 27.51% of GDP. The following year monetary policy was tight leading a significant drop in inflation rate in the subsequent period. The same monetary policy has been repeated for the following year leading to a further sharp drop of inflation to 9.2% by the end of 1997. Thus, the significant reduction in money supply exerted downward pressure in inflation. In 1997 money supply and nominal GDP experienced the same rate of growth and this was a remarkable macroeconomic achievement, especially when considering the deficit of previous years. The devaluation of Kwacha and a major budget deficit of 1998 started to push up inflation again, recorded until 1999. A further squeeze of money supply in 2000 led the inflation down to 30%⁵⁷.

5.2 Health Sector Financing, Planning and Expenditures

This section concentrates on the analysis of recurrent and development budget expenditure of the health sector compared to other sectors, and recurrent and development budget expenditures within the health sector. Functional classification of recurrent expenditure divides the expenditures into four broad categories: General Public Services, Social and Community Services (including the health sector), Economic Services and Unallowable Services (including public debt, pensions and gratuities).

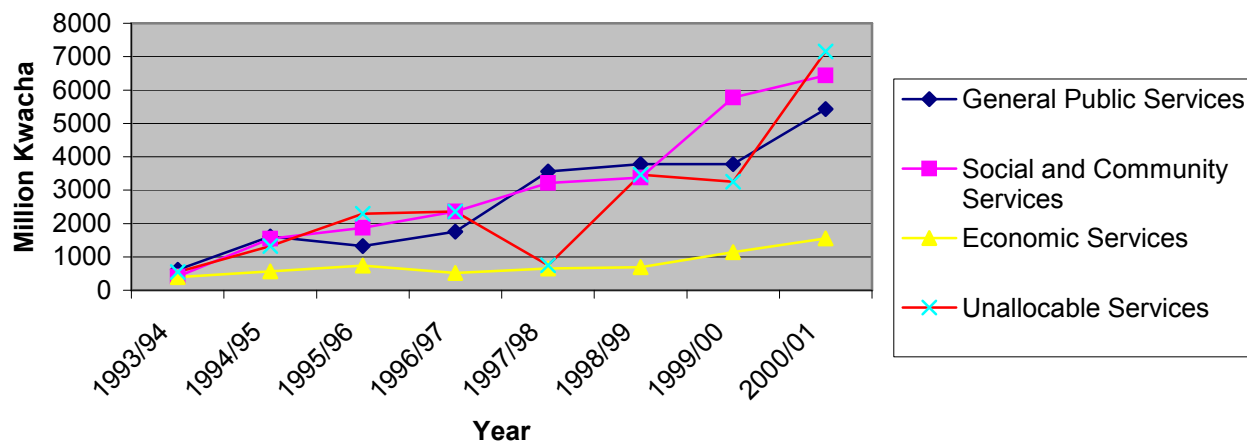
As presented in table 5.3 below, social and community services have experienced a considerable increase in the budget allocation when compared to other sectors, passing from a percentage of 20% in 93/94, to 37,3% in 2003/04. Unfortunately the increase of the budget allocated to the Social and Community Services (which includes the health sector) has been linear only in absolute terms, but it experienced high fluctuations in terms of percentage of the total recurrent expenditures.

Since 1999, the allocation of budget resources to Social and Community services became the top priority in the share of recurrent expenditure (see Figure 5.4)

⁵⁶ The nominal GDP of 1995 is exaggerated because the GDP in 1994 is a factor cost (1994=100), see OVP, 2001.

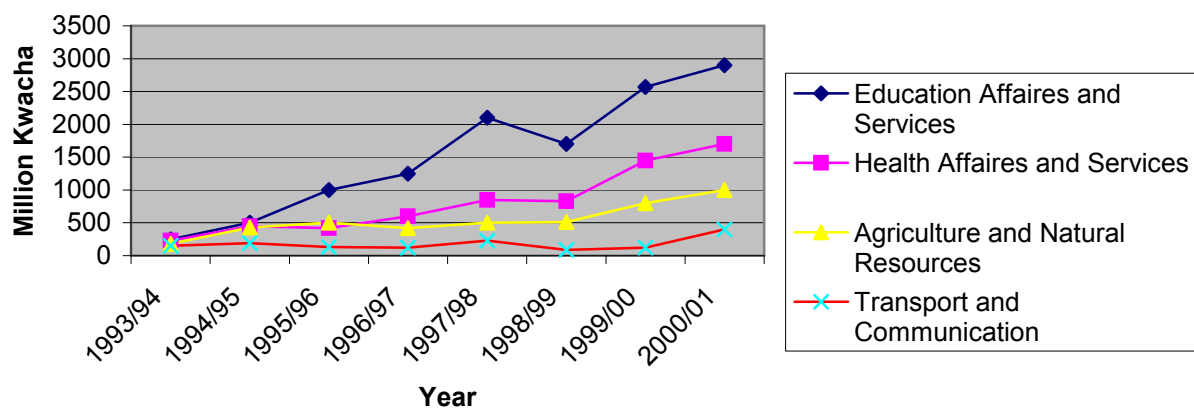
⁵⁷ (OVP 2001).

Figure 5.4 Share of Recurrent Expenditure in Current Prices (K million)



When we compare the allocation of recurrent expenditures within the Social and Community services the two main determinants are allocations for Education Affaires and Services and Health Affaires and Services, with the former enjoying a constantly bigger share of the allocation. Figure 5.5 presents the nominal trends of the allocation of expenditures for selected Social and Economic Services.

Figure 5.5 Nominal Trends in Expenditures for Selected Social and Economic Services



From the graphics results clear that Education Affaires and Services has been the main sector where government has allocated resources, followed by Health Services (see section 6 for an analysis on productivity of these investments in terms of increased health outcomes). However, until 1998 the government of Malawi was approximately allocating the same amount of resources for Health and Agriculture. On the other side, investments in Transport and Communications have been highly unstable and generally very low when compared to the other sectors.

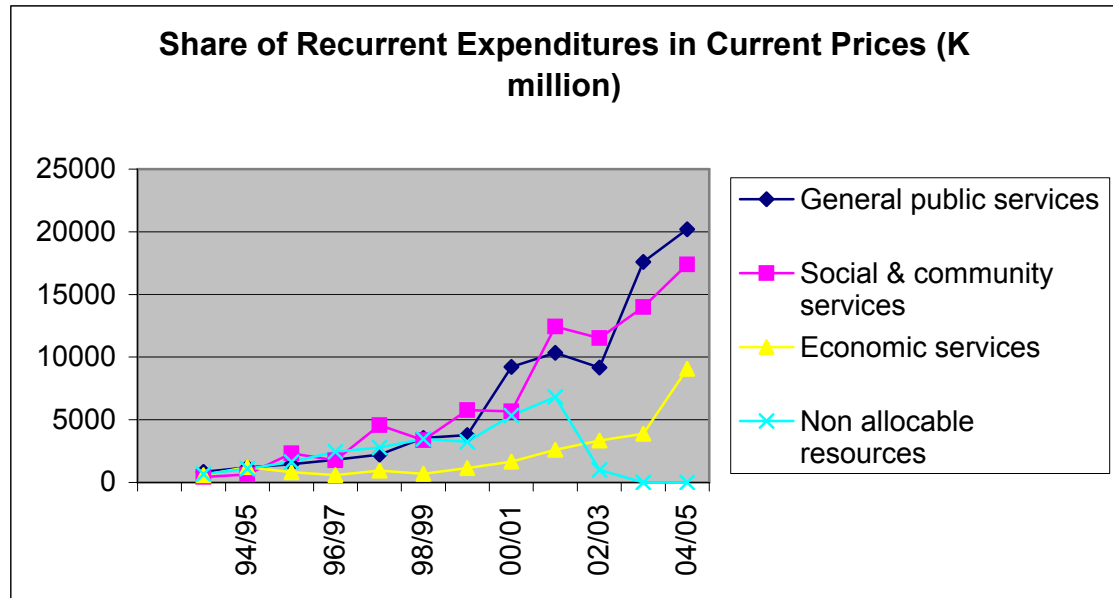
Table 5.3 Share of recurrent expenditure in current prices (K million)

Fiscal Year	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05
General public services	834	1.209	1.454	1.807	2.211	3.557	3.778	9.210	10.333	9.172	17.594	20.187
Social & community services	446	628	2.314	1.751	4.567	3.375	5.778	5.657	12.431	11.521	13.985	17.396
Economic services	583	1.226	827	592	940	689	1.143	1.662	2.615	3.339	3.869	9.074
Non allocable resources	657	1.090	1.633	2.452	2.778	3.462	3.251	5.327	6.821	1.005	-	-
Total recurrent exp	2.235	3.745	6.229	7.231	11.405	11.083	13.950	21.856	32.199	25.037	35.449	46.657

Share of Recurrent Expenditures In %

Fiscal Year	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05
General public services	37,3%	32,3%	23,3%	25,0%	19,4%	32,1%	27,1%	42,1%	32,1%	36,6%	49,6%	43,3%
Social & community services	20,0%	16,8%	37,1%	24,2%	40,0%	30,5%	41,4%	25,9%	38,6%	46,0%	39,5%	37,3%
Economic services	26,1%	32,7%	13,3%	8,2%	8,2%	6,2%	8,2%	7,6%	8,1%	13,3%	10,9%	19,4%
Non allocable resources	29,4%	29,1%	26,2%	33,9%	24,4%	31,2%	23,3%	24,4%	21,2%	4,0%	0,0%	0,0%

From 93/94-02/03 the figures are Actual expenditures, 03/04 revised, 04/05 estimates



Overall, it seems appropriate to observe that the government of Malawi has highly neglected the identification of appropriate investments in productive and functional sectors such as Agriculture and Transport/Communication. These are important economic services able to generate profit and to strengthen economic growth as well as strongly related to health issues. The lack of appropriate resources devoted to them might have hindered economic growth in the country. These sectors, if well supported and financed, will have an immediate positive impact on the health sector guaranteeing food security and better nutritional status, higher income available at the household level to seek appropriate care etc.

Allocations to the Social Sector have been increasing according to the recommendations from the WB and IMF⁵⁸. However, the question one would ask is whether those allocations have borne any real change when output variables are considered. The second question that could be asked is whether those allocations were adequate to the real needs of the population specifically in terms of health.

5.2.1 Are the Resources Allocated to the Health Sector Appropriate to the Needs of the Country?

The report from the CM&H sets a minimum of 34 US\$ per person per year to deliver essential interventions on health care, a very modest sum indeed, especially compared with average per capita health spending in the high-income countries of more than \$2,000 per year⁵⁹. This is though to be the minimum investment worldwide, but in the Sub-Saharan region, according to the higher and increasing disease burden, the investment should probably be more substantial.

In 1998/99 the national expenditure on health was 2.30 US\$ per capita. The following year it increased to 3.20 US\$ per capita. In 2001/02 dropped to 2.58 US\$ and in 2002/03 raised again to 4.93 US\$⁶⁰. This very low per capita investment severely restricts good services delivery and an effective planning for reaching the MDGs as well as the goals of the Vision 2020. Under the PAI I was recommended that the expenditure should be increased by 0.5 US\$ per year so as to move closer to minimum standards.

When we consider the allocation to national health as a share of total government budget, the figure is not more encouraging. As presented in table 5.4, budget allocation to the health sector as a share of the total recurrent expenditures varies greatly from year to year. This is due mainly to unplanned reasons which undermine stability in the health expenditures.

Table 5.4 Health Expenditures as % of Total Expenditures						
97/98	98/99	99/00	00/01	01/02	02/03	03/04
7.51	10.45	8.52	6.50	11.56	8.57	8.36
Health Expenditures as % of GDP						
1.72	2.54	2.15	1.71	3.98	2.82	2.99
<i>Source: MoHP, MoF.</i>						

Despite the government expressed commitment to reach and maintain expenditures allocated to the health sector between 12%-13%, and despite the recommendations of last NHA of an increase needed in health sector's share of government spending -especially in the wake of increases in funding for the social sectors under the HIPC initiative-, the progresses made until 2001/02 have been followed by a steady decline to 8.36%. This suggests a U-turn of the government in allocating funds to the health sector to match previous political commitments and to comply with previous recommendations. The cost of this reverse trend can be calculated in terms of less deaths

⁵⁸ (OVP 2001).

⁵⁹ (CM&H 2001).

⁶⁰ {MoHP, 2003 #7}.

avoided, less chronic diseases prevented and less economic productivity for a substantial part of the Malawian population.

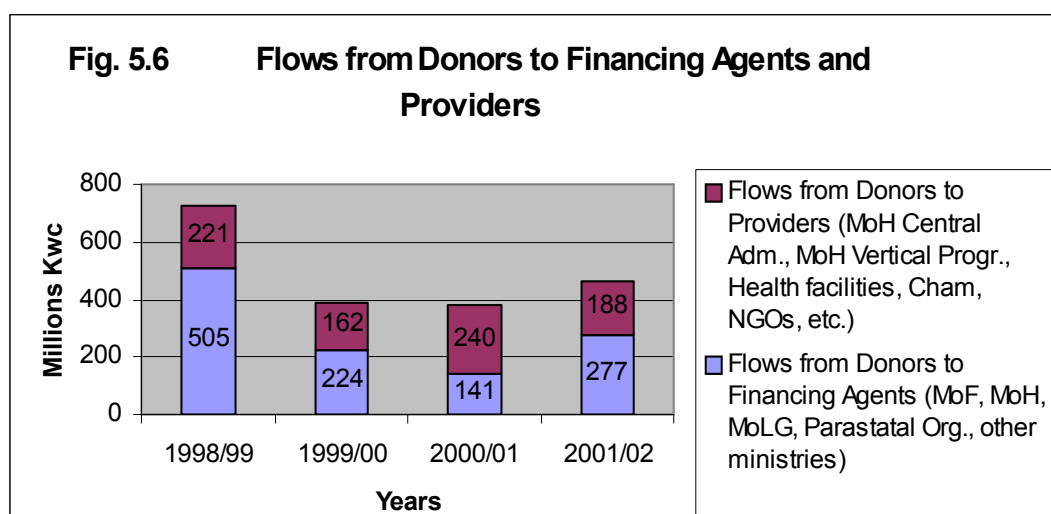
When we consider also the budget allocated to ministries related to health such as water and sanitation, agriculture and environment, the figure does not substantially improve as presented in table 5.5, reaching only a scarce 12.7%. As reported by qualitative interviews, this also suggests a rather narrow definition of the health sector by the government of Malawi, a definition which is still highly when not exclusively dominated by the activities typically falling under the MoHP.

Table 5.5 Total Budget for the Broad Health Sector 2003/2004

	Budget 2003/04 (million Kw)
Ministry of Health and Planning	3,064,652
Preventive Health Services	
Curative Health Services	
Health Workers Training	
Health Infrastructure	
Technical Services	
Clinical and Population Services	
Drugs	
Agriculture (only Agriculture Extension)	855,324
Water	172,961
Natural Resources and Environment	493,328
Total	4,586,265
Percentage of the total budget	12.7%

Source: calculated from Malawi Economic Justice Network 2004.

Full data on the donors' contribution to the health sector is not available (see Annex 2 for data on contributions of main donors). However, when considering the flows of finances from donors to financing agents and Providers for the period 1998-2002, we observe an unstable and fluctuant trend (figure 5.6). In particular, donors' contribution has substantially decreased from the level reached in 1998/99, both in terms of flows to financing agents and providers. Proportionally, we observe a shift in donors' preference to allocate financial resources directly to providers than to financing agents. In 1998/99 the 30.5% of the total resources allocated by donors to the health sector passed through allocations to financing agents, while in 2001/02 this proportion raised at 40.5% and it had a peak of 63% in the previous year.



Source: Calculated from NHA 2001 and NHA 2004.

Overall a dismal picture characterises the investment in the health sector and recent trends suggest that the situation is not likely to experience significant changes in the near future unless specific action is taken. Resources allocated to the health sector are extremely low when compared to the real needs of the country, this should be a matter of concern for both international community and government. Additionally, donors' contributions have been subjected to heavy fluctuations making the medium-long term planning exercise difficult to be achieved.

5.2.2 What Responses to the Financial Constraints are already in Place?

The situation analysis previously presented called for additional resources, both domestic and international, to scale up investments in the health sector. This is further required when looking at the costing exercise of the EHP presented in 2002. The Malawian EHP has been costed at about 17.5 US\$ per capita but a review of that estimate using additional data sources related to missing and/or new activities (such as the inclusion of ARVs, DHMT, etc.) revealed an increased per capita cost of 22 US\$ to provide the essential package. This translates to a total of 1.5 billion US\$ over six years (US\$ 127 million for capital costs and US\$ 1.430 for recurrent costs) to fully deliver the EHP. With an ongoing per capita investment (GoM and donors) of only 4.93 US\$, the target of 22 US\$ is far beyond the current capacity of donors and government to fill the financial gap, and far beyond the current capacity of the health system to absorb sudden increased financial flows.

International community and MoHP, within the SWAP approach to health development, realised that is not at the moment feasible to mobilise that huge amount of resources in the nearer future, however, they designed a joint Plan of Work (POW) for the years 2004-2010 aiming at moving toward a substantial scale up of resources -this also accounted for internal budget ceilings (table 5.6).

	Year 1		Year 2		Year 3		Year 4		Year 5		Year 6		Total	
Domestic Resources	33.5	37%	35.7	31%	36.9	31%	35.3	28%	35.5	26%	35.9	24%	212.7	29%
IDA	56.4	63%	79.2	69%	81.0	69%	92.7	72%	101.5	74%	112.1	76%	523.0	71%
Total	89.9		114.9		117.9		128.0		137.0		148.0		735.7	
Gap	1410.1		1295.2		1177.3		1049.3		912.3		764.3			
Pro Capita Gap ⁶¹	19 US\$		17.5 US\$		15 US\$		13 US\$		11 US\$		9 US\$			

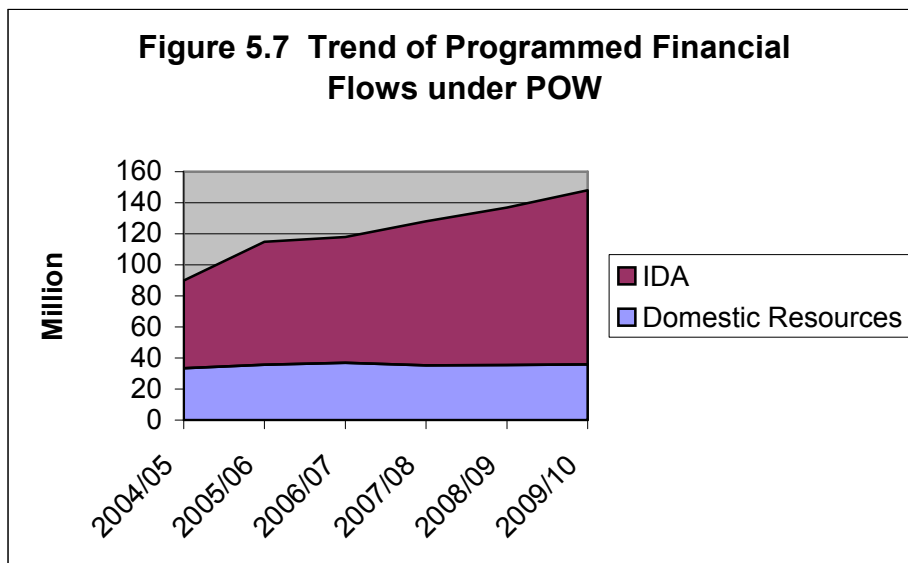
Source: Calculated from MoHP 2003 and National Statistics Office.

The growth trend is roughly linear (figure 5.7) apart from year two where a disproportionate jump is occasioned by the need to finance the recapitalisation of the Central Medical Stores during a one year period. Additionally, it is expected that the resource forecast will increasingly become uncertain after the first three years of the POW and should be repeated during annual reviews of the POW⁶².

As observed, even at the end of the planned six years work for scaling up financial resources in the health sector, the gap will be still huge, more than the 50% of what initially required, and the foreseen pro capita gap –accounting for population projections- will be about 9 US\$.

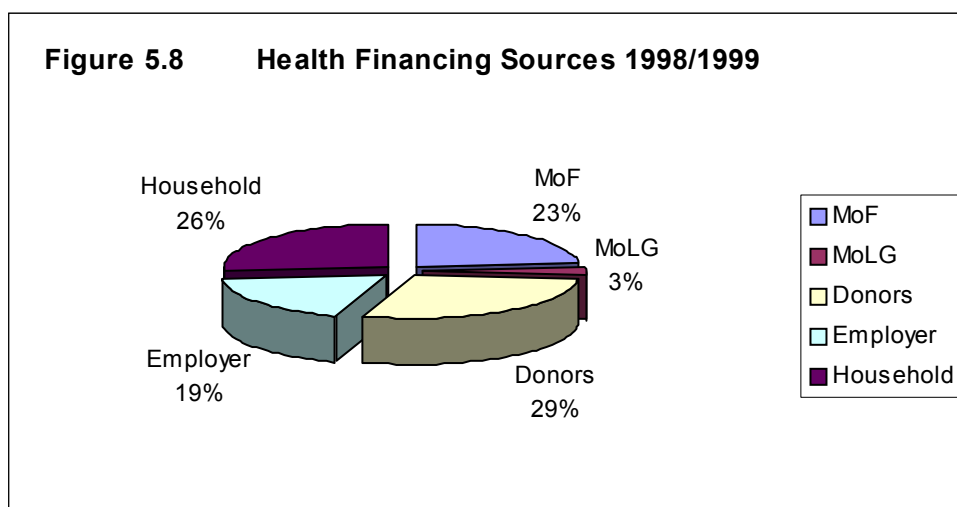
⁶¹ Using population Projection provided by the National Statistics Office of Malawi.

⁶² (MoH 2003a).



5.2.3 Is the Financing Structure of the Health Sector Sustainable?

When we look at the financing situation of the Malawian health sector in 1998/99, we observe a very good share of financing sources among government, civil society and private sector. In particular, as reported in figure 5.8 government provided the 26% of the financial resources available to the health sector. Governmental financial flows were provided by the MoF and the MoLG to a number of financing agents such as the MoHP, MoF, MoLG and a number of other ministries such as Ministry of Natural Resources and Environment, Agriculture and Food Security, Water Development. Donors contributed for one third of the total health sector financing. Donors' flows of resources were transferred for the 33% to the MoHP, and for the remaining 67% were resources directly managed by the donor community. Most surprisingly, household's out-of-pocket health expenditures accounted for the 26% despite the claim of a universally free-health service in the country. Finally, private companies, estates and parastatals expenditures on their employees and residents accounted for reasonable 19% of the total. Overall, the Government showed a strong commitment in ensuring free health care for all, but admittedly the unsatisfactory quality of services provided in public facilities is often the cause for people, including the poor, seeking proper care in private clinics, charity institutes or NGOs. Those are institutes which require payment for their services (for-profit or at the cost-level) and this has in impact on the household's income availability, negatively affecting especially poor households and contributing to raise inequality.

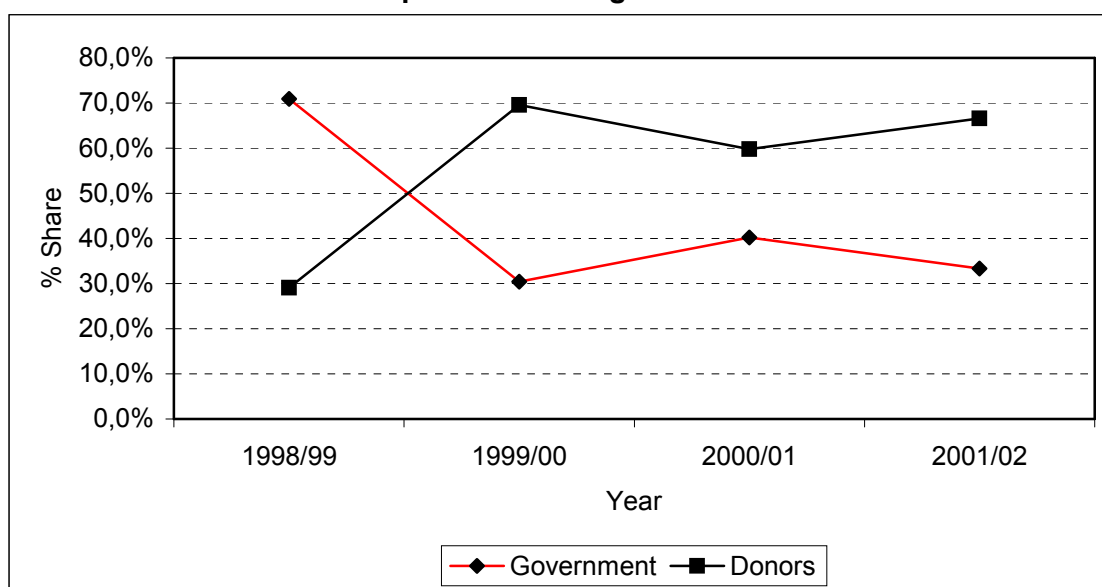


Source: MoHP 2001.

Health sector financing in 1998/1999 appeared to be balanced and to a large extent sustainable, with the donors' community accounting for just the 29% of the total and employers supporting the sector for the 19%. The figure is substantially different when considering the data reported in the 2004 NHA. It must be stressed that while the previous NHA was comprehensive to included public, private and household sectors in the analysis of the flow of funds, the 2004 NHA has been limited to public sector. This is due to a number of reasons, but among others this was caused by the unavailability of new data on households expenditure (the next Household Expenditures Survey is planned for 2005). However, from interviews with government officers emerges that the proportion of out-of-pocket expenditures is expected to be unchanged so far⁶³.

Finally, figure 5.9 shows trends in the flow of funds from government and donor sources to public sector agents for the years 1998/99 to 2001/02. In the financial year 1998/99, the largest proportion of funding (71%) for the public health sector came from government itself, with donors supplying only 29%. However, in the year 1999/00, the opposite occurred. Donors accounted for 70% of the total public sector health funding. In subsequent years, donors have remained the dominant source of financing in the public health sector and although their percentage share of the total decreased, donors were still major financiers in the year 2000/01, accounting for 60% of public sector health financing. This rose again to 67% in the year 2001/02.

Figure 5.9 Trends in flow of funds from government and donor sources to public sector agents



Source: MoHP 2004.

Despite the figure is not completed and lacks of important information on the flows of resources that the donor community, private sector and households have conveyed into the health sector (see table 4.7) without passing from the public sector agents, it is possible to observe a very high presence of donors funds in supporting the Malawian health sector. Donors strong support and willingness in improving the Malawian health sector has not been doubled with government real commitment in increasing internal resources invested in health.

In the 2001 NHA, it was observed that the MoHP was the major provider of health care services in Malawi, spending 35.4% of the health sector's finance, followed by NGOs and firms⁶⁴. It is not

⁶³ (PMS 2000a).

⁶⁴ (MoH 2001).

possible to make such a conclusion from the 2004 NHA because private firms, NGOs, and households have been excluded as financing agents. Similarly, private sector providers (firms, private practitioners, shops, and traditional healers) have not been included in the category of health providers. However, it can still be seen from table 5.7 that the MOHP is by far the dominant health care provider, receiving more than 90% of the combined financing from government and donors⁶⁵.

At present, and with data available, the financing structure of the health sector seems to have become less solid and sustainable than the one that was in place in 1998/1999. This is mainly due to a strong increase of the proportion of donors funds on the total funds available for the health sector, not matching a substantial increase of the share of the national budget allocated to the health sector (see section 6.4 for details on NGOs coordination with government and their fee systems).

Table 5.7 Flows of finances from financing agents to provider (Millions of Kwacha, at 1990 Prices)⁶⁶

Provider	Financing Agent 1998/99						
	MOF	MOHP	MOLG	Donor	Total	%	
MOHP Central Administration		17.8		6.9	24.7	7.0%	47.4%
MOHP Vertical Programmes		6.4			6.4	1.8%	
Tertiary hospitals		25.9		4.2	30.1	8.5%	
Secondary hospitals		42.8		52.6	95.4	27.0%	
Primary Facilities		10.3		0.3	10.6	3.0%	
MOLG			15.8		15.8	4.5%	
Other Government				0.1	0.1	0.0%	4.5%
Parastatal organisations					0.0	0.0%	
CHAM Facilities	12.5			9	21.5	6.1%	
NGOs				148.3	148.3	42.0%	
	12.5	103.2	15.8	221.4	352.9	100.0%	
TOTAL	3.5%	29.2%	4.5%	62.7%	100.0%		

Provider	Financing Agent 1999/00						
	MOF	MOHP	MOLG	Donor	Total	%	
MOHP Central Administration		47		96.8	143.8	48.7%	95.9%
MOHP Vertical Programmes		-		18.5	18.5	6.3%	
Tertiary (Central) hospitals		17.4		11.7	29.1	9.8%	
Secondary (District) hospitals		60.2		28.8	89.0	30.1%	
Primary Facilities		-		3	3.0	1.0%	
MOLG			0.7	0	0.7	0.2%	
Other Government				1.4	1.4	0.5%	0.7%
Parastatal organisations				0.1	0.1	0.0%	

⁶⁵ (MoH 2004c).

⁶⁶ Millions of Kwacha for all years were reported at 1990 prices(real values) to eliminate the effects of inflation between the first and the second NHA periods, thereby, making figures comparable.

CHAM Facilities	7.4			0	7.4	2.5%	
NGOs				2.5	2.5	0.8%	
	7.4	124.6	0.7	162.8	295.5	100.0%	
TOTAL	2.5%	42.2%	0.2%	55.1%	100.0%		
Provider	Financing Agent 2000/01						
	MOF	MOHP	MOLG	Donor	Total	%	
MOHP Central Administration		68.8		92.9	161.7	40.9%	
MOHP Vertical Programmes				40.6	40.6	10.3%	
Tertiary (Central) hospitals		20.3		25	45.3	11.5%	
Secondary (District) hospitals		56.3		42.2	98.5	24.9%	
Primary Facilities				31.2	31.2	7.9%	95.4%
MOLG			0.1	0	0.1	0.0%	
Other Government				1.8	1.8	0.5%	
Parastatal organisations				4	4.0	1.0%	0.5%
CHAM Facilities	9.1			0.1	9.2	2.3%	
NGOs				3.0	3.0	0.8%	
	9.1	145.4	0.1	240.8	395.4	100.0%	
TOTAL	2.3%	36.8%	0.0%	60.9%	100.0%		
Provider	Financing Agent 2001/02						
	MOF	MOHP	MOLG	Donor	Total	%	
MOHP Central Administration		34.6		21.9	56.5	14.6%	
MOHP Vertical Programmes		-		42.2	42.2	10.9%	
Tertiary (Central) hospitals		40.9		5.8	46.7	12.0%	
Secondary (District) hospitals		110		65.4	175.4	45.2%	
Primary Facilities		-		43	43.0	11.1%	93.8%
MOLG			0.7	0	0.7	0.2%	
Other Government				1.8	1.8	0.5%	
Parastatal organisations				5.7	5.7	1.5%	0.6%
CHAM Facilities	13.2			0.5	13.7	3.5%	
NGOs				2.3	2.3	0.6%	
	13.2	185.5	0.7	188.6	388.0	100.0%	
TOTAL	3.4%	47.8%	0.2%	48.6%	100.0%		

Source:NHA 2004.

6 Challenges and Opportunities for Scaling-up Resources on Health and their Efficiency

6.1 Comparative Analysis on Health Investments and their Outcomes

Before asking what are the possible strategies to scale-up resources in the health sector, we concentrate on a comparative evaluation of financial and health indicators between Malawi and a number of selected African countries⁶⁷. This will provide insight on how effective the expenditures on health have been in fostering improvements of selected health indicators. Thus, this exercise will evaluate financial resources invested in the Malawian health sector and its performances when compared to similar countries in terms of macroeconomic indicators. This will increase understanding on the degree of efficiency in using resources deployed and will assess how the same resources generated outcomes that can be translate into the improvement of health development indicators such as life expectancy, infant and maternal mortality, etc..

Starting by comparing the per capita expenditures on health (figure 6.1), Malawi is performing on the average, with a total (public and private) of 12 US\$ identical to the total per capita health expenditures of Rwanda and only slightly better than Uganda and Tanzania (figure 6.2). In absolute terms, the per capita 4 US\$ invested in health by the government of Malawi is a good performance when compared to the other countries. But in relative terms, the share of Malawian financial resources that goes to the health sector as a percentage of GDP is low compared to the other selected countries. Thus countries like Rwanda, Uganda and Mozambique which have slightly lower per capita public expenditures on health are de facto investing in their respective health sectors a bigger share of their GDP, showing a stronger political commitment in investing in health.

It is now possible to investigate what are the outcomes of the investments in health of the different countries in terms of selected indicators. This will give a rough indication on how countries with similar expenditures perform. The first possible comparison is on life expectancy (figure 6.3). Arguably, expenditures on health have a final goal which is to improve the quality of life of the population and this can comprehensively be captured by the life expectancy at birth in a specific country.

All health indicators have an impact on life expectancy and it can be considered a general indicator of how well the country is performing in pursuing the ultimate goal of promoting increased quality of life. When considering figure 6.3, Malawi has the lower life expectancy at birth after Zambia. Countries such as Rwanda, Uganda and Tanzania have the same or slightly smaller per capita expenditures on health but they all perform better in ensuring a longer life to their populations. On the other side, Mozambique spends about a half of the Malawian per capita GDP on health, but it achieves the same level of life expectancy, while Ethiopia spends on health one-third of Malawi but it achieves much higher life expectancy level.

⁶⁷ These countries were selected paying particular attention to their macroeconomic conditions and trends that are comparable with the macroeconomic situation registered in Malawi. We also imposed as initial hypothesis that the total (public plus private) per-capita health expenditures of Malawi being equal to the average of the per-capita health expenditures of the selected countries. This will allow to observe if Malawi's performances are generally better or worse than the average performance of the selected countries for selected indicators.

Figure 6.1 Per Capita Health Expenditures (US\$)

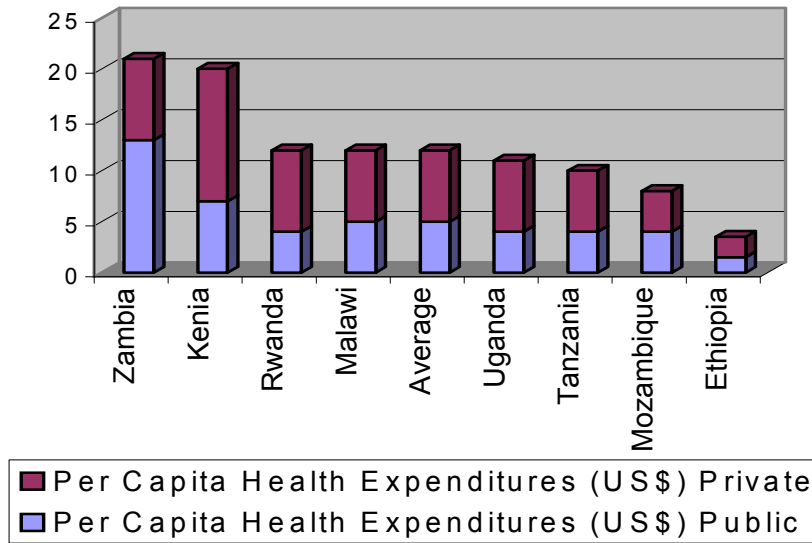


Figure 6.2 Public Health Exp. As % of GDP (2001)

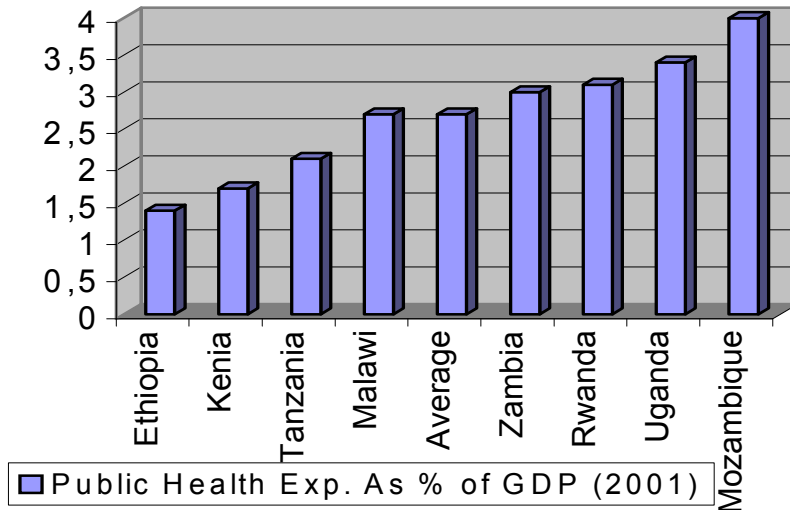
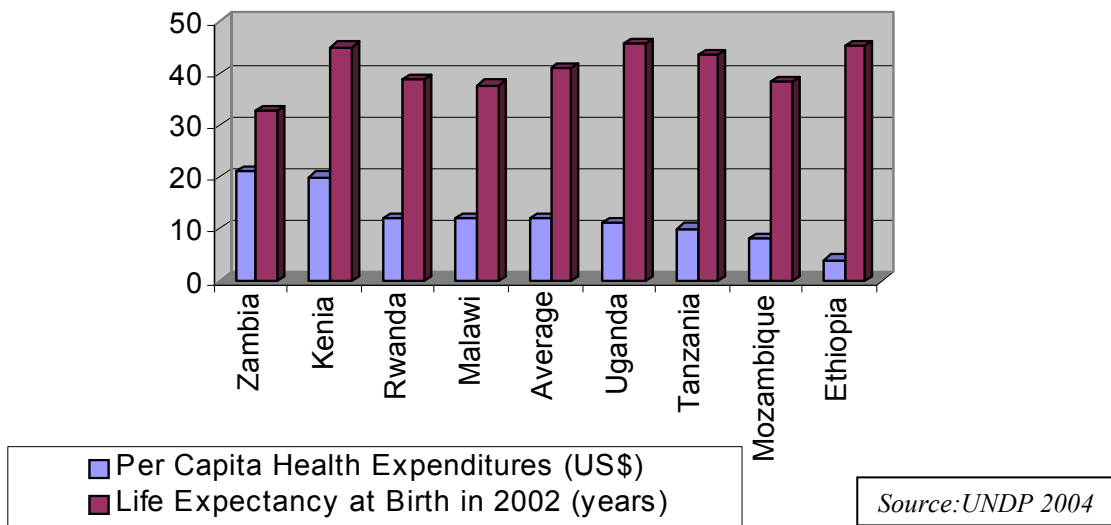


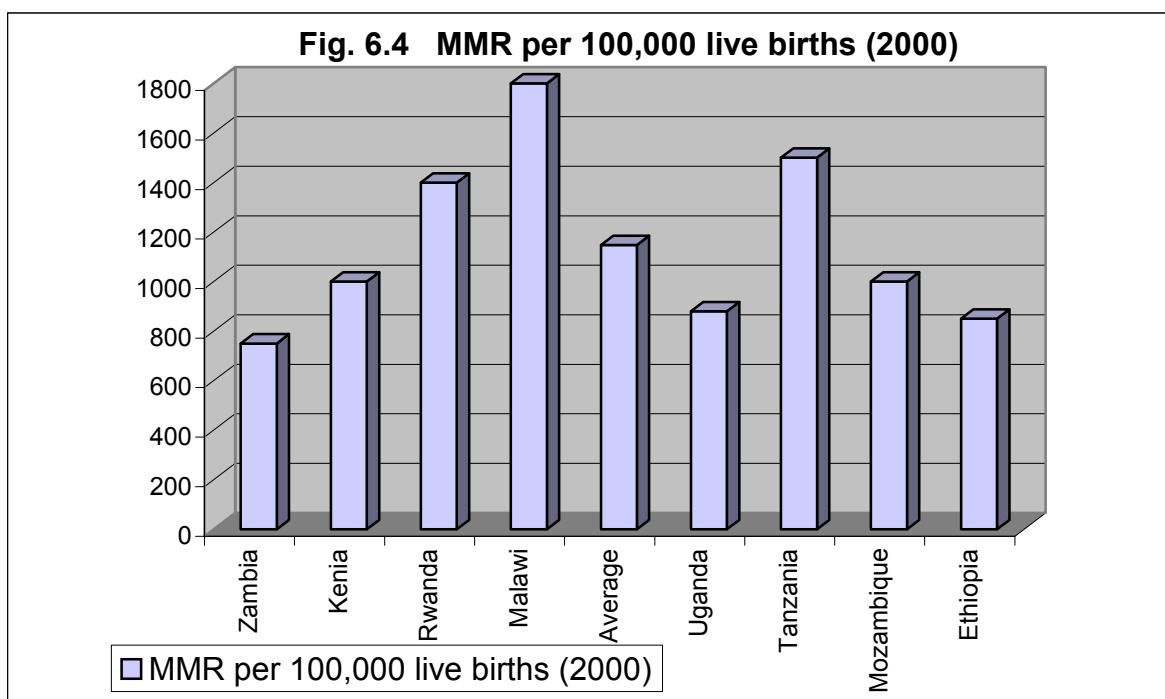
Fig. 6.3 Per Capita Health Expenditures-Life Expectancy



Source: UNDP 2004

This difference in performance can partially be attributed to the HIV/AIDS epidemic. Going back to figure 2.3, we observe that Zambia, Malawi and Mozambique are the three countries with the lowest life expectancy and the highest prevalence of HIV/AIDS. However this is not the only factor. Despite data on the prevalence of HIV/AIDS was not available for Ethiopia in 2003, last estimations present a prevalence within the range of 12-14%, but its life expectancy is higher than the other selected countries.

Moving away from the generic variable 'life expectancy', it is possible to strengthen the analysis by comparing different countries' performance on specific health indicators such as maternal mortality rates, nutritional levels, immunization coverage and number of deliveries attended by skilled health personnel. When considering the MMR (figure 6.4), Malawi is the worst performer. A country such as Rwanda has the same per capita health expenditures but a considerably lower MMR. Uganda scores half of the Malawian MMR while investing in health less than Malawi. During the first presentation of this report to senior managers and directors of the MoHP, it has been raised an interesting point which will require future attention and in-focussed research. In particular, it has been requested through econometric simulations to calculate the impact on GDP per-capita that a reduction in MMR will imply.



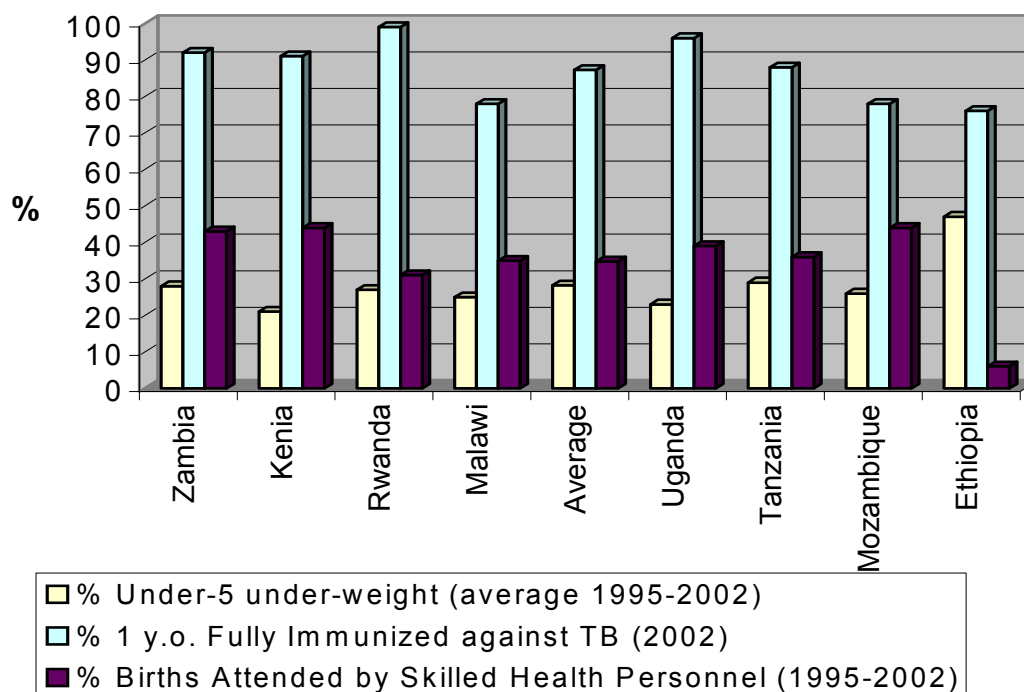
Source (UNDP 2004a). Note that the data reported are adjusted to consider the typical under-reporting of maternal mortality, estimated to be an average of 30 to 35 % of the reported cases.

The overall figure is not substantially different when considering basic immunization, under-weight and assisted delivery percentages (figure 6.4). Malawi is among the worse performers while investing in health more than the majority of the other countries. And this very low performance cannot be attributed to low education rate because, as observed in figure 2.4, Malawi has one of the highest enrolment ratio both for primary and secondary education, meaning that the causes for the low performance has to be researched within the health sector's capacity to deliver appropriate services.

Overall, this suggests that the health sector in Malawi is not only characterised by low financial investments, but that the outcomes from those investments is below the expectations and

potentialities. Thus implying the necessity to also identify non-financial constraints currently hampering the achievement of better health outcomes using the resources already available.

Fig. 6.5 Basic immunization, U5 Under-Weight and Assisted Delivery



Source: UNDP 2004

	Per Capita Health Expenditures (US\$)	Life Expectancy at Birth in 2002 (years)	% Under-5 under-weight (average 1995-2002)	% 1 y.o. Fully Immunized against TB (2002)	% Births Attended by Skilled Health Personnel (1995-2002)	% Pop. with access to essential Drugs (1999)	Under-5 MR per 1,000 live births (2002)	MMR per 100,000 live births (2000)	HIV/AIDS Prevalence % age 15-49 (2003)
Zambia	21	32,7	28	92	43	50-79	192	750	16,5
Kenia	20	45,2	21	91	44	0-49	122	1000	6,7
Randa	12	38,9	27	99	31	0-49	183	1400	5,1
Malawi	12	37,8	25	78	35	0-49	183	1800	14,2
Average	12	40,975	28,25	87,25	34,75		169,25	1147,5	9,65
Uganda	11	45,7	23	96	39	50-79	141	880	4,1
Tanzania	10	43,5	29	88	36	50-79	165	1500	8,8
Mozambique	8	38,5	26	78	44	50-79	197	1000	12,2
Ethiopia	4	45,5	47	76	6	50-79	171	850	n.a.

6.2 Non-financial Constraints to be Addressed

From what previously presented, scaling-up financial resources for the health sector will not necessarily lead to an improvement of health care outcomes. This because there are a number of non-financial constraints filtering and conditioning the effective use of financial resources already

available in the health sector. There is clearly a lack of efficiency in the use of already available resources that policymakers in the health sector need to face. Poor sector performance cannot be blamed entirely on the low level of health spending (some comparison countries have lower spending per capita), or on the allocation of these expenditures (other countries have more skewed resource allocation).

Explanations for under performance should be sought in technical efficiency (how well the system and individual facilities are managed), in the incentive structure for staff and program managers (salary levels, degree of autonomy, appropriateness and mix of skills, counterproductive coping mechanisms of staff), and in the overall institutional environment (the ability of MOHP to plan, marshal, and deploy resources to areas and services in greatest need)⁶⁸. The quality of health services being provided also need to be further examined, and remedial measures taken -at both community and national level.

6.2.1 Community Level

■ **Improve trust building processes and community-based initiatives related to the health sector.** A number of studies reveal that people from different economic backgrounds are willing to pay for accessing quality of services. They often by-pass the closer and more appropriate health facilities to reach the health service where they believe they will get better treatment because they trust the personnel. This is justified by lack of drugs availability at the lower level, but it is also often simply motivated by lack of knowledge of the services available or lack of trust in the personnel operating in those structures. There is the believe that even primary-level services are better performed by tertiary-level structures.

This misbelieve can be tackle by improving health worker-patient trust at the community level. Even when drugs are not available, people deeply value the careful visits and suggestions of health professionals. Thus, there is the need to make communities more involved in the health services activities. This will strengthen the concept of local ownership and consolidate community mobilization initiatives. Besides, this will increase the trust in the health centre, but will also foster community mobilisation in finding ingenious solutions appropriate to the specific problems of services delivery in their area.

■ **Strengthen health worker-patient communication and promote preventive practices.** As observed in figure 2.1 and 2.2, all the main killer diseases of Malawi have a preventable and curable nature and they account for the 64% of in-patients deaths. This means that the patients themselves must bear the main role of promoting and protecting their health status through adopting preventive behaviours. Prevention and promotion of preventive behaviours should be the prime focus of Malawi health expenditures and strategic planning because more cost-effective and sustainable. There is the need to strengthen health workers-patients communication and education capacity on preventive practices.

This also should account for promote timely reporting of illnesses and seek for care before than curable diseases enter into a chronic and irreversible stage The fact that malaria, acute respiratory infections, malnutrition and diarrhoea constitutes at the same time the majority of the causes of inpatient admission and the majority of inpatient death, jointly with the fact that they are curable diseases when not in a chronic phase, are strong indications of delays in reporting illnesses and seeking care by patients. This can be partially avoided through strengthening Malawian referral system, communication on dangerous symptoms, promote periodical medical checks and community visits by qualified personnel.

⁶⁸ (WB 2002).

Again, community based initiatives can be of a strong support in promoting preventive health care. For instance, in a number of countries students of secondary-level have compulsory in their curricula the duty to perform few hours per week of voluntary service in their community by raising awareness on preventive measures to avoid communicable diseases. In other countries the same activities are carried out through religious initiatives. These are no-cost initiatives for the government which are likely, if supported by the government, to have a lasting and strong impact in increasing the health status of the population.

■ However important, **raising awareness alone is not sufficient when it does not lead to behavioural change**. For instance, the recent DHS reported a very high coverage of general awareness of HIV/AIDS (nearly the 99%! of interviewed people knew at least two ways of contagion). Despite that, qualitative interviews revealed that there is still much work to be done to improve understanding and the acceptance of preventive measures to avoid transmission. Overall, unprotected sex with casual partners due to cultural traditions and the economic vulnerability of poor females, still play the leading part in the spread of the disease, meaning that general knowledge of the issue failed in promoting significant behavioural change.

■ **Address intra-household gender and age disparities in power relations**. As observed throughout this work, a number of health indicators concerning children and women are not substantially different among quintiles. Suggesting that there are important issues of quality of services to be addresses but also intra-household relations of power. Thus, it is suggested to build an effective collaboration among concerned ministries to promote campaigns of sensitisation on intra-household discriminations, unbalance of power and resources allocations and their effects on children and maternal health.

■ **Use antenatal visits as priority platform for advocacy**. From data available we observed a very important element which is the very high percentage of antenatal visits (89%), despite only a minority of them decide to have assisted delivery (see table 2.10). Therefore, this means that advocacy for assisted delivery is not properly implemented in the health centres. This raises high both the rate of maternal mortality and the rate of neonatal mortality. The neonatal mortality rate is responsible for the 40% of the all-infant mortality rate, and both maternal mortality and infant mortality are two of the leading concern in the health sector. As the comparative figures have shown, Malawi is among the worst performers in the world in this two health indicators.

The already in place high proportion of antenatal visits is, *de facto*, an extremely important entry point to strategically address both, maternal mortality and neonatal mortality rates. Part of the high mortality rates can be reduced simply through increasing awareness on basic health issues and strongly advocating for pregnant mothers to decide to have an assisted delivery. But this, alone, will not be sufficient and will require scaling up of investments for making prenatal supplements and immunisations timely available.

6.2.2 Health Sector Level

■ **Target Cost-effective intervention which are likely to have a broad impact (preventive and promotive health)**. Admittedly, the level of government health allocation is too low, but instead of focusing on cost-effective services with large public-health impact -generally provided at the primary level-, the government has opted to finance all existing health programs and infrastructure including cost-ineffective interventions. Some donors have contributed to the crisis by offering infrastructure expansion with little regard for their recurrent-cost implications. Looking at

the 2004/5 protected pro-poor expenditures⁶⁹, the allocation between preventive health care, curative health care and health infrastructure development and rehabilitation is highly uneven and has been subjected to drastic reduction from previous years (see table 6.2). This allocation of funds is penalising the primary health care sector hampering the real possibility to promote cost-effective interventions which are likely to have a broad impact on the population.

However, as observed by senior managers from the MoHP, there is the need to create a proper strategy to balance the investments at the primary level with investments at the secondary and tertiary level to avoid mistakes already done in the past when the focus was on investing in secondary and tertiary levels partially neglecting the primary level.

	Approved 2003/04	Revised 2003/04	Estimates 2004/05
Preventive Health care	686,535.88	709,376.33	100,754.00
Health Workers Training	140,917.40	148,784.70	1,500,000.00
Drugs	1,260,075.00	1,260,075.00	256,000.00
Curative Health Services	887,881.36	906,715.22	935,589.00
Health Infrastructure Dev. And Rehabilitation	119,827.02	104,825.47	304,788.00
Health Technical Services	17,526.21	21,877.34	510,724.00
Total	3,112,762.87	3,151,654.07	3,608,855.00

Source: (MoF 2004).

■ **Rationalise capital investments and reallocate funds to preventive services⁷⁰.** Given a limited planning and regulatory capacity, a Malawian NHP that is essentially a “wish-list” for infrastructure projects undermines any rational approach to sector investments because it leaves open the possibility of investors and donors offering projects to the government, even if such projects worsen the recurrent-cost situation of the budget. A key tactic in solving the recurrent-cost problem is to rationalize capital investment decisions⁷¹. Key actions in this area involve:

- Enforcing a thorough and comprehensive financial analysis of the recurrent-cost implications of any new government- or donor-funded project, and developing stringent health-planning and public-finance standards to appraise these projects. In this regard, the National Economic Council, working with the MOHP, should specify project-approval criteria that can then be used to set national investment priorities.
- Accept from donors not rationalised investments in health structures only if the donor is willing to fully or partly cover the running costs of the infrastructure in the medium term. Imposing policy conditions in donor projects can also rationalize investments.

Much of these problems will be resolved when the SWAP will be fully operational.

■ **Tighter coordination is required among the Ministry of Health, the Ministry of Finance and the Ministry of Economic Planning and Development.** From consultations held, there is the expressed need from the ministry of Finance and Economic Planning and Development to strengthen their cooperation with the Ministry of Health as well as Water and Sanitation and Environment. This enhanced cooperation and share of information will strongly benefit planning and monitoring activities and allocation of budgetary resources according to

⁶⁹ These are expenditures incurred on activities which have direct and immediate impact on poverty reduction as outlined in the MPRS. These Expenditures are protected from any cuts in the event of cash flow problems during budget implementation.

⁷⁰ (WB 2003).

⁷¹ (WB 2002; MoH 2003a; WB 2003).

expressed priorities and needs. It is suggested that a task force of economists from the different ministries meet regularly to review finance implications and requirements of main activities.

On a more general basis, Malawi has to tighten the coordination and institutional locus of planning and budgeting⁷². The scarcity of resources demands more circumspect policymaking, planning, programming, budgeting, and releasing functions and tighter coordination of these functions. Discussions are needed within the government on the budgetary implications — especially recurrent cost implications—of each health policy, program, service, or function. The MoHP must routinely undertake an exercise of making alternative choices given alternative funding scenarios. This is particularly important in the process of decentralised planning. An often repeated complain is that the budget requirements planned at the district level and then passed at the central level are drastically un-met. In particular, in the last period of budget consolidation, the MoHP is often obliged to modify previous plans to comply with ceiling requirements for the fiscal year. This is a ‘last-minute’ exercise and the MoHP has no time to consult the districts to adjust their plans and budget requirements according to the ceilings obtained. The result is that these adjustments are defined at the national level and they are often non perfectly rational, cost-effective and appropriate when considering the districts needs.

Key actions in this area involve strengthening the capacity of the MoHP Planning Unit to undertake health needs, costing, and cost-effectiveness analyses; to analyse budgetary, service-performance, demographic, and socio-economic data and propose adjustments on expenditure flows; and to analyse the recurrent cost implications of major health investments (donated or not) and recommend the best course of action on these proposed investments.

■ ***Appropriately channel financial resources to first-line health clinics.*** After the institutionalisation of the fiscal reform, decision was taken to transfer governmental budget allocations for the health sector directly to districts hospitals to avoid delays in transfers from the central to the periphery and to avoid ‘leaking’ of funds at the different levels. At the moment, financial resources for health care centres at the primary level are channelled to the competent district hospital. It has been observed that these funds are often diverted from their original allocation and they can be used to implement not planned activities at the district level thus never reaching the health care centres at the primary level. This creates inefficiency and does not ensure that appropriate funds go to planned areas and that key health priorities are adequately funded on time.

■ ***Address Human Resource Capacity Constraints.*** As expressed in the 2003 MPRS review Report, the MPRS outlined three strategies to achieve this objective: increase the number of qualified personnel in key positions; mitigate against the impact of HIV/AIDS; and address gender imbalances in civil service. The planned activities included: develop career path; ensure adequate supply of key professional cadres; design and implement HIV/AIDS impact mitigation plan, including additional recruitment and training and prevention; and provide equal opportunities for qualified men and women.

The Government and development partners have recently embarked on various capacity building initiatives. Additionally, preliminary evidences from this mission suggest that there is the need to implement an in-focus assessment on human resources development requirements for governmental staff at the central but especially at the district level to support decentralisation processes in the health sector. Areas of possible interest are requirements for capacity building in planning, monitoring, evaluating and managing programmes.

On the other side, when considering the HR issue of services providers, the main constraint to be addressed is the lack of a comprehensive policy on human resources development within the

⁷² See also recommendations presented in WB 2002.

health sector. There are a number of projects and initiatives but they are operating in a vacuum outside any sort of rational medium-term holistic plan for human resources development. The MoHP is at the moment using a general manual on human resources development produced by the Ministry of Human Resources, but it was agreed in previous meetings that each ministry should have started from the manual to move toward the planning and implementation of a specific strategy on human resources able to address the specific needs within each ministry. This is a process of paramount importance that must be followed up as soon as possible

■ **Accelerate pharmaceutical sector reforms.** As noted in the 2003 World Bank paper on priority services in Malawi, drug availability is the lynchpin that joins major flanks of any health sector reform. If drugs are unavailable, community drug revolving funds cannot operate and fee-based cost-sharing programs cannot succeed. Without a good revenue base from fees to cushion the impact of reduced budgetary support, tertiary hospitals cannot become autonomous. Given the centrality of pharmaceuticals in the whole health sector reform effort, it is important to accelerate the restructuring of the CMS to make it more autonomous, sustainable, and efficient. Without these CMS reforms, the financing, procurement, and distribution of drugs will continue to be imperilled. The supply-side reforms in pharmaceuticals need to be supported by corresponding improvement in consumption patterns. This can be achieved through a variety of mechanisms including imposing partial or full-cost fees on prescription drugs at government facilities, and establishing therapeutic committees and drug registers at hospitals to keep track of drug consumption, and encourage the development of demand-driven system.

A recent survey on the public drug supply system in Malawi carried out by WHO has highlighted the main areas of concern for an efficient delivery and management of drugs in the country. Among other factors, the survey indicates the need to strengthen data collection mechanisms to better foresee customer's drugs requirements, reduce the time between ordering and delivering, create an equitable system for supporting the poorest in the payment of drugs, renovation of storage facilities, increase the information management and strengthen financial management as well as procurement.

Finally, the mission encourages the implementation of a market analysis to evaluate the possibility of developing a public or private local sector for the production of essential drugs.

■ **Finalise service agreements.** Given the burgeoning private medical practice, the Government can consider the external contracting of clinical services. Lessons learned from nearby countries such as South Africa should inform the design of contracts, price negotiation, and other considerations. At the moment the government is contracting out only few logistic services to external providers but, importantly, is currently finalising a number of service agreements that can be a first step toward a future strategy to external contracting of clinical services.

6.3 Financial Constraints to be addressed

Given the low per-capita investment in health, re-orient the ongoing strategies of investment and shift resources from secondary to primary health care provision without at the same time mobilise more resource will not lead to substantially increased outcomes. Thus a scaling-up of donors' funds in the health sector is necessary despite relevant data on the absorption capacity of the health sector have not been found during this mission. However, in a context already heavily supported by donors, it is unwise to have as the only strategy the one of scaling-up health investments by 'submitting bills' to the donor community relying even more on external finance. It is necessary also to find alternative ingenious plans to mobilise internal resources for health care provision, paving the way to the future financial sustainability of the sector. It is clear that the international community's support is to be maintained and possibly strengthened in the coming years and that the ongoing support is highly below the minimum standards foreseen and recommended by WHO. As clear is that to reach minimum levels of care provision the ongoing

financial investments in health (both domestic and foreign) have to be at least doubled and the international community should bear the biggest share of the burden. Implications for donors are not only the one of increasing the financial resources invested in the health sector, but also to promote a fair-trade that will most benefit Malawian economy and will give the possibility to the country to generate more internal resources to be re-invested in the sectors at stake such as health.

The following observations intend to provide preliminary suggestions on strategies to increase domestic resources in the health sector or areas that need to be further researched for eventually considering the hypothesis of implementing pilot projects. Thus, they should not be seen as recommendations but as possible entry points to foster debate.

■ **Further refine the National Health Plan and the SWAP's programme of Work as the basis for priority setting, programming, and budgeting.** The SWAp will reduce the heavy fluctuations in donors' support, strengthening the MoHP capacity for mid and long-term strategic planning. However, as the funding gap analysis has shown, the NHP's, the POW and the financial requirements for the implementation of the extension health package are far greater than the available resources forecasted for the medium term. While advocating for an increased investment in the health sector, the government and donors should consider to sharpen the focus of the Plan identifying a smaller package of services that intend to be delivered with an achievable increase of resources available. The government has already identified the basic services and costing out the package itself, as well as identifying and costing out the support services and other incremental inputs needed to implement the package (staff training, information and education campaigns, supervision and monitoring, information systems support). What is needed now, is to adjust the services included in the package on the basis of their costs and available fiscal resources over the next six years.

It is perceived that given the enormous gap between the effective financial requirements and the financial capacity of donors and government, not big scaling-up can be achieved. On the contrary, if the package of services is sharpened so that the gap between what provided and what should be provided to achieve more realistic objectives reduced, donors will be more committed in filling the gap because these less ambitious objectives will become potentially attainable.

This will not imply to cut even further the EHP which is already at the minimum level. On the contrary, this will imply to clearly identify and set priorities of implementation that might be different according to the different health priorities of districts and regions.

■ **Identify and implement as soon as possible a policy for the funding and provision of non-essential services.** The MoHP's inability to appropriately finance the health needs of Malawians through tax revenues should encourage it to explore other financing modalities that are compatible with the population's ability -and willingness- to pay. There is the strong believe within the government's authorities that no user fees must be introduced in the health sector until the quality of services increases its standards.

It is believed by this mission that quality of services and their financing mechanisms should move, progressively, on a parallel track. This implies that from a strategic point of view, the same quality of services could progressively result from reinvesting the resources generated by user fees in improving the quality of the services which generated those resources. To be successful, user fees must be introduced progressively on services which are less likely to affect the lower social strata of the population and they must be calculated on the base of the real quality of services provided.

Given the scarce resources of the health sector, it is necessary the political and administrative definition and approval of an official policy on the provision and funding of non-essential or out of package health services. These services are non-essential and they can be provided against

appropriate fees by users. Again, according to the economic background of users, the payment for those services can be established to cover part of the cost of the service, the entire cost, or allow for different margins of profit. This strategy on non-essential services provision can easily generate internal resources a part of which can be also invested in scaling-up the free essential services provided within the EHP.

■ **Build on the pilot programs on drug revolving funds and expand them.** Pilot-testing of drug revolving funds (DRFs) under the International Development Association's (IDA) Population, Health and Nutrition (PHN) Project has shown that they can be a viable source of sustainable financing and can facilitate community access to basic pharmaceutical supplies. As the WB (2002) report highlights, there are potentially 600 villages that can participate in these schemes. Key interventions will require to conduct appropriate training programs at the community level on DRF and their management, and to align DRF programs with the Central Medical Store reform. A successful investment on DRFs is critically dependent on the speed and quality of foreseen activities to restructure the CMS capacity of achieving financial and institutional efficiency.

There is the expressed fear that drug revolving funds can create discrimination among communities, some of them will have access to free health care and some will access the health care through drug revolving funds. So far the pilot projects have targeted areas where no public structure was operating, thus filling a gap in the nation health care coverage. A possible way to use drug revolving funds without penalise the poorest of the poor is to combine the use of GIS poverty map with the expansion of the revolving funds. In particular, there are geographical areas where poverty levels are extremely high and introducing revolving funds can objectively jeopardise poor people access to primary care. But there are other geographic areas where the experience of revolving funds could be successfully replicated, because poverty levels are extremely low. Further pilot projects can be a middle-term viable solution.

■ **Implement formal cost-sharing programs in government hospitals.** Despite years of intent, government hospitals have not formally established institutionally sustainable fee programs. As previously noted by a number of reports, existing efforts are uncoordinated and they have not been properly evaluated. Current disparities exist between MoHP facilities, which do not formally impose fees, and district-designated mission and local-authority health facilities, which do. Partly because no fees are charged at the hospital level, and partly because government primary-care facilities are ill-funded, all tertiary government facilities are clogged with patients who by-pass the referral system. As already recommended by previous similar evaluations, MoHP needs to develop a national government fee policy covering district hospitals, district-designated Christian Hospital Association of Malawi (CHAM) facilities receiving government subventions, and local-authority facilities.

The national fee policy should permit (a) central and district hospitals to impose fees and have private wards based on fees; (b) permit 100 percent retention of fee revenues at the hospital level; (c) permit hospital use of fee revenues subject to specified guidelines from MoHP and spending authorities designated by the government; (d) synchronize fee schedules among the different levels of care; and (e) specify waived or exempted health services, persons, or areas to protect the poor.

Besides, there is the need to develop guidelines on the accounting, safekeeping, and planning and use of generated revenues⁷³.

■ **Improve health insurance reimbursement.** Health insurance coverage is small in Malawi but it has potentiality for growth. However small, it represents a significant pool of those with the

⁷³ (WB 2002).

ability to pay and thus provides a potentially major payment system for hospitals⁷⁴. Hospitals have to review their fee schedules and reimbursement rates to patients under medical aid schemes or health insurance coverage to align them with actual costs and remove unnecessary government subsidy for these patients with the ability to pay⁷⁵.

6.4 Encourage Private Health Expenditures

In Malawi there is a healthy and well-established non-profit sector (Christian Hospital Association of Malawi or CHAM) and a growing for-profit sector (mainly private clinics). These are extremely positive elements that can make a difference in improving the quality, quantity and availability of health care services. These parallel sectors to the public are important sources of health financing and they are built upon significant private health expenditures by people from different economic backgrounds. Regrettably, private health expenditures are overlooked and not properly studied or strategically inserted into a comprehensive national policy for improving health financing. Thus there is scope to encourage but regulate private for-profit health providers.

When considering CHAM facilities, they provide services to more than a third of the Malawi population, mostly in rural areas where there are no government providers. A third of their financial resources are from user charges and sale of drugs generated from modest fee schedules that do not deny poor patients access to care. It has been proved that even poor people are willing to pay a reasonable user fee when the quality of services will prevent them to return to seek proper care a second time or will prevent them health consequences that will might hamper their income generating capacity even further. A system similar to the one adopted by CHAM can be evaluated and eventually adapted to governmental public hospitals.

Household's expenditures on health can be promoted, but we must, at the same time improve protection systems for the poorest. A UNICEF-commissioned survey in 1995 reveals substantial freeloading (households with capacity to pay for health services but do not) and undercoverage (households with scant capacity to pay but who do) in health facilities across the country. Fee programs, if established, must address the issue through proper supervision.

Finally, in Malawi, as observed throughout the paper, most of the problems related to health, inequality and poverty have roots in rural areas and they are compounded by very low agricultural outcomes. The 74% of the Malawian poor own less than 0.5 ha per capita. A comprehensive strategy for health improvements should probably start from strengthening the capacity of these poor people to self-generate more food-crop production in a sustainable way. Thus, this work suggests to undertake a follow-up in-depth study on how and to which extent the health sector could benefit from minor agricultural improvements in a sort of 'food for health approach'.

⁷⁴ (WB 2002; WB 2003; WHO 2004).

⁷⁵ (WB 2002).

7 Towards A Plan of Action for Macroeconomic and Health in Malawi

The mission on macroeconomics and health achieved a very high consensus building among stakeholders and within the government of Malawi. The advocacy and dissemination work done in the country has been extensive and to large extent comprehensive of all the key agents that should play a role within a macroeconomics and health approach to the health sector.

Additionally, the mission highlights that beside the high commitment found from the government, there is also an extremely favourable timing given the fact that the SWAp is defining its plan of action in these months and given the willingness of including the macroeconomics and health initiative on board.

After discussion with the Ministry of Health, Finance, Economic and Planning, Water and Sanitation and Environment, and after the presentation of the work done on Macroeconomics and Health in Malawi, few ideas have emerged on how to take the issue forward. These ideas do not define a working plan for M&H in Malawi, but are a shared starting point that will pave the way to a more detailed working plan and implementation process.

The issue of Macroeconomics and Health will be inserted within the existing SWAp programme of work and harmonised with it. It is suggested that within the SWAp, a small working group (co-chaired by the MoHP, MoF and MoEP) will act as the referral point on the issue every time it comes to planning and decision making. During the present mission, an important pull of human resources (both governmental and multilateral) from relevant stakeholders have been identified and consulted. This pull of human resources will definitely be a good starting point toward the identification of the working group.

Consensus has been reached in identifying WHO as the key role player in 'keeping the ball rolling'. It has been argued by the MoHP and MoF that this mission should have been done much earlier, possibly within a few months from the 2nd Consultation on M&H 'Increasing Investments in Health Outcomes of the Poor' held in Geneva in October 2003. Since that meeting a number of Ps, directors and key political people have changed creating a gap of knowledge, decrease of enthusiasm and loss of institutional memory (i.e. the Ministry of Health who took part in the Geneva meeting is now the Ministry of Education). Now that activities of awareness raising and consensus sharing have been implemented filling the delays, there is the compelling need for WHO to timely sustain the M&H process from within the country.

In particular, as strongly argued by relevant stakeholders, officers available are already overburdened, and the macroeconomics and health process requires strong coordination, advocacy and full-time work in producing and implementing a M&H plan of work to be inserted within the SWAp as soon as possible, as well as identifying monitoring and evaluation mechanisms. Despite the strong political commitment of the government, a constant activity of advocacy and technical support played by WHO is certainly needed to maintain the issue of M&H high in the political agenda and to translate this initial stage into a working plan to be shortly implemented.

It is suggested to organise as soon as possible a second mission that will have as a main objective the one of operationally inserting the process of M&H within the SWAp program of work. As well as implementing in-depth research in the identified areas where information is missing and starting the process of implementation of the M&H programme of work. This will also include to identify the requirements and the steps to produce a National Health Investment Plan that will incorporate the main recommendations presented in this report.

A final reason for not missing the opportunity to provide a timely support to the Malawian government is given by the implementation of the third Demographic and Health Survey -from September 2004- and the second Integrated Household Survey -from early next year. These two

extensive surveys will provide an important up-date on the situation of the country in terms of poverty and health indicators, thus paving the way to review current investment strategies, achievements and objectives on the basis of fresh data. They will form the background for new policy orientation and long-term planning. This is when major changes in resources allocation are likely to be discussed and, if appropriate, to take place. Again, M&H can strongly support the government in interpreting and using those new data for planning purposes.

7.1 Areas of Initial Priority for Macroeconomics and Health in Malawi

Following the presentation of the findings of the M&H report on Malawi, few priorities have been identified that could represent the skeleton of the working plan for M&H in Malawi. These priorities are divided in three areas: research, policy guidance and implementation projects, monitoring and evaluation.

Research

Priority areas where narrow and detailed follow-up research is needed are:

- How to strengthen preventive activities against the leading illnesses of the Malawian disease burden?
- What are the causes for the low rate of assisted delivery?
- Implement a market analysis to evaluate the possibility of developing a local sector for the production of essential drugs.

Policy Guidance and Implementation Projects

The following are the priority areas where M&H can effectively contribute to policy guidance, design of implementation strategies and contribute to securing funds:

- Rationalise capital investments and reallocate funds to preventive activities against the leading illnesses of the Malawian disease burden.
- Reduce MMR and IMR through strengthening antenatal and postnatal services and delivery assistance.
- Identify a policy for the funding and provision of non-essential services.
- Improve trust building processes and communication between patients and health workers.
- Promote the shift from raised awareness to behavioural change.

Monitoring and Evaluation

For all the previously identified implementation projects, M&H should also identify appropriate indicators to monitor and evaluate progresses so to stimulate and facilitate the mobilisation of internal and external funds.

It is intended that these strategies have to be inserted within, and aligned with the SWAp's programme of work towards a comprehensive national health investment plan.

Annex One

Malawi
Administrative districts



Annex Two

Budget allocation and expenditures of donor projects: as of end-FY97/98 (in thousand U.S. dollars)

Donor/project name	Life of project*	Budget allocation	Expenditures to date
CIDA			
Family health project	4/96-3/98	1,032	1,032
Social sector grant	4/96-3/97	1,845	1,845
Southern Africa AIDS training	5/97-12/97	143	143
DfID			
Contraceptive supply and reproductive health	7/93-12/97	1,416	1,369
Anesthetic training and support	10/93-3/98	700	692
Technical assistance to health sector reform	8/94-7/98	600	564
Malawi reproductive health project	9/94-3/01	16,518	6,912
Support to national AIDS coordination program	7/95-12/97	404	384
Interim contraceptive supply project	8/96-12/97	1,180	972
Support to national tuberculosis control program	8/97-7/99	1,771	1,055
European Union			
Rural health program (building and equipment)	12/87-n.d.	8,882	7,078
STD prevention project	1/93-n.d.	1,104	995
Health sector project identification	8/94-n.d.	170	162
Technical assistance to MOHP	10/96-n.d.	481	108
Health reform and decentralization	10/96-n.d.	17,211	76
HIV/AIDS prevention	7/97-n.d.	718	0
Donor/project name			
Life of project*			
Budget allocation			
Expenditures to date			
GTZ			
Strengthening of Machinga district health services	1991-2000	12,000	8,521
Strengthening of Zomba district health services	1997-2000	2,000	0
JICA			
Community health science project	1994-1999	3,500	3,500
USAID			
PHICS	6/89-12/98	23,493	15,550
STAFH project	9/92-9/98	45,000	17,685
CHAPS project	9/95-9/00	15,000	53
COPE 1 project	7/95-9/97	539	538
IDA			
PHN project	1991-1999	55,500	23,000

UNAIDS			
Assistance to national AIDS control program	1/96-1/98	289	154
UNDP			
Health component	1/93-12/98	980	980
UNFPA			
Census: basic data collection	1992-2001	1,743	912
Demography training	1992-2001	849	512
Population policy	1992-2001	2,658	1,605
Family planning	1992-2001	9,355	5,974
IEC	1992-2001	5,213	3,985
UNICEF			
Country program in health	n.a.	3,732	3,732
World Food Program			
Vulnerable group feeding	1996-1998	10,161	5,305
WHO			
Technical cooperation	1997-1998	300	300
Total	—	246,484	115,693

* Months of initiation and termination of projects given when known.

Source: WB 2002

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