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RESEARCH
REPORT

Malawi Essential Health Services Campaign,

For All Campaign: Country Case Study

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Contents

Acronyms

ADMARC	Agricultural Development and Marketing Corporation
ADB	Africa Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ARI	acute respiratory infection
ART	anti-retroviral therapy
ARV	anti-retroviral
BLM	Banja la Mtsogolo
CABS	Common Approach to Budget Support
CAS	Country Assistance Strategy
CCJP	Catholic Commission for Justice and Peace
CHAM	Christian Health Association of Malawi
CIDA	Canadian International Development Agency
CISANET	Civil Society Agriculture Network
CMS	Central Medical Stores
CONGOMA	Council for Non Governmental Organisations in Malawi
CSC	Centre for Social Concern
CSO	civil-society organisation
DAC	Development Assistance Committee
DFID	Department for International Development (UK)
DPP	Democratic Progressive Party
EC	European Commission
EDF	European Development Fund
EHP	Essential Health Package
EU	European Union
GBS	General Budget Support
GCAP	Global Call to Action against Poverty
GCN	Gender Coordination Network
GDP	gross domestic product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GTZ	German Agency for Technical Cooperation
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HRCC	Human Rights Consultative Committee
IMF	International Monetary Fund
IPT	Intermittent Presumptive Treatment
ITN	Insecticide-treated net
JICA	Japan International Cooperation Agency

KfW	Kreditanstalt für Wiederaufbau
MANET	Malawi AIDS Network
MCTU	Malawi Congress of Trade Unions
MDGs	Millennium Development Goals
MDRI	Multilateral Debt Relief Initiative
MEJN	Malawi Economic Justice Network
MENET	Malawi Education Network
MHEN	Malawi Health Equity Network
MK	Malawi Kwacha
MoH	Ministry of Health
MPRSP	Malawi Poverty Reduction Strategy Paper
NAC	National AIDS Commission
NAPHAM	National Association of People Living with HIV and AIDS in Malawi
PAF	Performance Assessment Framework
PEPFAR	Presidential Emergency Plan for AIDS Relief
PoW	Programme of Work
PPE	Priority Poverty Expenditures
PRGF	Poverty Reduction and Growth Facility
PRSC	Poverty Reduction Support Credit
PRSP	Poverty Reduction Strategy Paper
PSI	Policy Support Instrument
REACH	Research on Equity and Community Health
SDSS	Service Delivery Satisfaction Surveys
SLA	Service Level Agreement
SWAp	Sector Wide Approach
TUM	Teachers Union of Malawi
UDF	United Democratic Front
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Malawi key facts: statistics and timeline

Statistics

Population	Approximately 13 million
Life expectancy	46 years (2007–2008 figures)
Infant mortality rate	79[1] per 1,000 live births (2005 figures)
Maternal mortality	1,100[2] per 100,000 (2000 figures)
HIV prevalence rate	12% among those aged between 15 and 49 years (Demographic and Health Survey 2004 population-based survey and Sentinel Surveillance Survey 2007 based on pregnant women)
Pupils completing primary school	58%
Total GDP and recent GDP growth/ inflation	$2.1bn[3] 7% growth 8.2% inflation
Per capita income	$161[4]
Revenue	22% (2005–2006 figures)
% Government expenditure on health and education in financial year 2007–-2008	Health 13.9% (2007–2008 financial year figures)[5] Education 11.2%
Public-sector wage bill	7.3% of GDP
Biggest donors	DFID ($130m), World Bank ($125m), EU ($75m), and Norway ($50m). DFID, World Bank, and EU account for almost 90 % of all foreign aid.[6]
Total aid 2006	$428m
Budget support 2006	$93m or 22% of aid[7]
Aid to health 2006	$64m or 15% of total aid[8]
Debt relief 2006	$27m[9]

Important events and timelines

Presidential and parliamentary elections	19 May 2009
Budget – financial year	Presented to parliament in June each year.

	Financial year July to June.
Overall planning	Malawi Growth and Development Strategy (PRSP 2) 2006–2007 to 2010–2011
Health planning	Essential Health Package (EHP) agreed 2002.
Health Sector Wide Approach (SWAp)	Runs from 2004-2010. Bi-annual review each April and September. Mid-term review just completed September 2007.
HIV and AIDS strategy	National HIV and AIDS Policy (2003) National Action Framework 2005–2009
IMF Poverty Reduction and Growth Facility (PRGF)	Current PRGF runs until August 2008. New PRGF or Public Sector Investment (PSI) not yet decided.
World Bank Country Assistance Strategy (CAS) and Poverty Reduction Support Credit (PRSC)	CAS 2007–2010/2011-year PRSC 2007–2008, but indicative three years.
EC Country Strategy EDF 10	2008–2014 New budget support agreement to be confirmed.
Common Approach to Budget Support (CABS) Group (Norway, UK, EC, WB, ADB)	Reviews twice a year, Feb/March and Sept/Oct

Executive summary

Health in Malawi

Malawi is one of the world's least-developed countries, ranked number 166 of 177 countries in the United Nations Human Development Index. The government of Malawi, with help from the international community, has made a genuine effort to improve health care in recent years. Increased funding and new policies to ensure greater access to health care have resulted in some successes – with nearly a third more children able to see their fifth birthday today than eight years ago[10]. In addition, close to 130,000 people countrywide are now on vital anti-retroviral therapy (ART) for HIV, up from virtually nil only five years ago.

However, there is a long way to go. Malawi still has some of the worst health indicators in the world. Life expectancy is 46 years. The infant mortality rate remains high and on average one woman in every hundred will die in pregnancy or childbirth. Over 12 per cent of the population also have HIV, making Malawi the ninth worst affected country in the world. An estimated 20,000 children are born each year with HIV, and there are half a million orphans and vulnerable children due to HIV and AIDS. While there have been welcome steps in the right direction by the Malawian government and donors of late, both need to provide more and better financing urgently.

Key obstacles to adequate provision

Access to life-saving medicines is limited in Malawi. Stock-outs of basic antibiotics, HIV-test kits, and insecticide-treated nets (ITNs) have taken place across the country, and vaccines have run dangerously low. Poor procurement and distribution processes are mainly to blame, but Malawi also has very limited ability to produce its own medicines, leaving it dependent on imports, which can be extremely expensive where drugs remain under unfair patenting laws.

Malawi also has a chronic shortage of health workers – with only 252 doctors for the entire population of 13 million. Even in African terms, Malawi does not come out well, with fewer health workers per person than Sudan. The human-resource crisis is mainly due to low numbers of people being trained; very high attrition rates of existing staff migrating to the private sector and overseas; and a loss of workers to HIV and AIDS.

To compound these two problems, vital health facilities are often too far away and too expensive for the people who need to use them. More than half of the population live further than 5km from their nearest formal health facilities, and only 20 per cent of the population live within 25km of a hospital. And while essential health care is meant to be free, the reality is that only 9 per cent of government and mission facilities provide free access to the full essential health package as stipulated by the government.

Government policy, planning, and financing

The government of Malawi has taken some significant steps towards tackling the health crisis. Most importantly, in 2002 it launched a basic Essential Health Package (EHP), which aims to provide free access to essential health care in government clinics in order to treat some of the main ill-health problems in Malawi, such as malaria, diarrhoea, and respiratory infections. This has been a major breakthrough, even if it has not yet been rolled out fully. In one hospital in the Dowa district, making maternal care free resulted in a 30 per cent increase in antenatal visits, and a 44 per cent increase in assisted

deliveries. Even the World Bank has cited the EHP as one of the key reasons why health provision is more equitable in Malawi than in other African countries. This policy has been backed up by increases in national health spending (including spending for HIV and AIDS), which increased four-fold between 2002 and 2006 from MK3.5m to MK13.2m, accounting for approximately 10 per cent of total government expenditure. The Malawian government is expected to exceed the Abuja commitment of spending 15 per cent of their national budget on health from 2007–2008, if HIV and AIDS spending is included.

Despite these victories, there are still major problems in government delivery. There is still a significant gap between what is put in the budget and what is actually spent. In 2006 the Ministry of Health (MoH) failed to spend a significant proportion of its budget due to failures in the procurement of drugs and medical equipment and failures in the completion of infrastructure projects – returning MK 1.3 bn to treasury – which could have paid for 5,500 nurses' annual salaries. Government systems need to be improved so they can absorb money more effectively especially as there is a need for more financing within health, due to the level of need. Even with the budget increases for health, per capita spending on health is still only $14 per year. This is $20 short of what is recommended by the World Health Organization (WHO) as the minimum expenditure required to cover basic health care.

The Malawian government is not able to provide these resources alone. Donors need to scale up their aid commitments and provide more aid in the form of general or sector budget support, on a long-term basis and not tied to harmful economic policy conditions. They also need to help build government capacity to spend this money effectively.

Donors provided $64m in aid to health in 2006, which was 15 per cent of total aid to Malawi. Most of this was aligned with government priorities through the Health Sector Wide Approach (SWAp). [11] Initiatives like the UK's and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM)'s six-year grant for the Emergency Human Resource Programme (EHRP) show just how useful aid aligned to government priorities can be. It has enabled the government to fund a 52 per cent increase in the salaries of key health workers and will hopefully lead to a doubling of the number of nurses in Malawi by 2009/10, by expanding training.

The International Monetary Fund (IMF) estimates that the cost of implementing the Malawi Growth and Development Strategy (MGDS) is 188 per cent of GDP[12] (i.e. around $3.8bn between 2006 and 2011)[13]. However, whilst the Fund predicts aid will increase from 2006–2011 in comparison to 2001–2005, it estimates that aid will only account for 24 per cent of GDP. Worryingly, the proportion of aid delivered directly to the Malawian government in the form of general budget support (GBS) is estimated to stagnate in the next four years, with a rise in project aid.[14] This is despite the fact that budget support (either general or sector) is one of the only ways of using aid money to pay for recurrent costs like teachers' and health workers' salaries. At present, only one in five aid dollars is put through the government budget.

Finally, civil society needs to strengthen its role in holding both the government and donors to account. Civil-society budget tracking in Malawi is among the most developed in the world. However, it needs to be further strengthened and supported by international NGOs like Oxfam. Civil-society scrutiny of the donor community is less advanced. The IMF was criticised by civil society during the food crisis, but beyond this, civil society has failed to hold donors to account. Given its hugely influential role in Malawi, this is an important area where civil society should look to increase its capacity and activity in coming years.

1 Introduction

This report was conceived of and produced in the context of an expanding campaign for primary health care for all in Malawi. It is intended as a background reference document to be used by Malawian campaigns and to inform policy development, lobbying, and campaign work at international level. It is hoped that by identifying key issues relevant both to the Malawi campaign for health for all, and to Oxfam advocacy work with donors.

A team of Oxfam staff from Malawi and the UK produced the report. Two allies, the Malawi Health Equity Network (MHEN) and the Research on Equity and Community Health (REACH) Trust, worked with Oxfam staff.

The case-study research took place in the last two weeks of September 2007. The team conducted two days of focus-group discussions with communities and health providers in Chiradzulu district, followed by over 40 interviews with key players in the health sector from government, donors, and civil society. Follow-up meetings were held with the IMF and World Bank in Washington DC.

Oxfam's programme in Malawi

Oxfam's programme in Malawi is contributed to by five Oxfam affiliates: Oxfam Novib, Oxfam Hong Kong, Oxfam Ireland, Oxfam Australia and Oxfam Great Britain.[15] Oxfam Great Britain is also the managing agency, responsible for the overview of Oxfam members' joint programming. Oxfam has been active in Malawi since the early 1990s. The programme has evolved from a capacity-building programme, aimed at developing local organisations, to a direct community-support programme that helps poor people to earn a living. Forty-five per cent of the programme focuses on livelihoods, and the remaining 55 per cent is split more or less evenly between HIV and AIDS, disaster preparedness, governance, and gender. Operational programme work takes place in the south of the country, both directly by Oxfam and increasingly through partners. An advocacy programme has been in place since 2001, and there is currently a small advocacy office in the capital Lilongwe, with two policy staff. In the current country plan for 2007–2010, advocacy is mainstreamed across all of Oxfam's five strategic aims.[16]

Structure of the report

The report starts with an outline of the key issues in the health sector that emerged from the study. The next section looks at the policy and financing framework underlying the health sector, and in particular the various donors involved. This is followed by an overview of the budget process for the government as a whole, and an analysis of foreign aid, in particular GBS. An overview is then given of civil society, Parliament, and media involvement in the health sector. The report ends by highlighting the key challenges that will have to be met to resolve the health problems in Malawi.

2 The state of health in Malawi

Malawi has some of the worst health indicators in the world. Life expectancy is 46 years.[17] The infant mortality rate remains high at 79 per 1,000 live births, and indicators show that 5 per cent of under-fives are severely malnourished, 22 per cent underweight, and 48 per cent have stunted growth. Up to 73 per cent of children between the ages of 6 and 59 months are also anaemic.[18]

There has been very little progress made over the last 15 years in tackling maternal mortality. On average one woman in every hundred will die in pregnancy or childbirth. On current trends, Malawi will not meet the fifth Millennium Development Goal (MDG), which aims to reduce maternal mortality by two-thirds, by 2026 (11 years after the MDGs target date).

Malawi remains one of the countries in the world worst-affected by HIV and AIDS. Over 12 per cent of the population have HIV. In recent years the disease profile has evolved, with the majority of new infections being found in women. An estimated 20,000 children are born each year with HIV, and there are half a million orphans and vulnerable children due to HIV and AIDS.[19]

Box 1: HIV and AIDS in Malawi

- Malawi is the ninth worst affected country in the world by HIV and AIDS. The 2003 HIV Sentinel Surveillance Report shows that HIV prevalence for all antenatal care attendees remained stable from 2001 (19.5 per cent).
- Currently 120,000 adults are accessing treatment for HIV. Survival rates are around 70 per cent. This is a huge increase from virtually no one accessing treatment just five years ago.
- Treatment is delivered free on a first-come-first-served basis, through a mixture of government and NGO provision. Access to treatment has become a major issue, with lots of news coverage of people dying while waiting to access treatment.
- 940,000 people are living with HIV; 84,000 of these are children and over 500,000 are women. There are 500,000 orphans due to AIDS-related deaths in the country.[20]
- Every year, 20,000 children are born with HIV. There is a major problem with the availability of paediatric drugs. The National AIDS Commission (NAC) has engaged the Clinton Foundation in discussions about sourcing these medicines.[21]
- HIV and AIDS has generated a substantial increase in the disease burden. HIV-related conditions now account for 40 per cent of all inpatient admissions and about 70 per cent of admissions to medical wards. About 77 per cent of tuberculosis patients are HIV-positive.

The disease burden

Malawi's health profile is still characterised by infectious or communicable diseases. The major burden of disease is due to malaria, HIV and AIDS, tuberculosis, sexually transmitted infections, diarrhoea, and acute respiratory infections (ARIs). At most health facilities, malaria cases contribute up to 35 per cent of outpatient attendances. Reported cases of tuberculosis have been significantly rising because of its association with HIV and AIDS. ARIs, diarrhoea, and malaria are major causes of child deaths. The disease burden is exacerbated by the poor nutritional health of children.

Huge inequity

Even though the World Bank has cited the EHP as one of the key reasons why health provision is more equitable in Malawi than in other African countries, there is a marked

difference in health status between rural and urban areas, between the lowest and highest wealth quintiles, and between the lowest and highest educational level of the mother (see Table 1 below). To a large extent, Malawi's health profile is itself a product of widespread endemic poverty, particularly chronic food deficits.

Table 1: Health inequity in Malawi

	Rural	Urban	Poorest 20 %	Richest 20 %	Least-educated mothers	Most-educated mothers
% births attended by skilled personnel	53.0	83.8	46.6	84.6	42.8	83.4
Probability of dying / 1000 live births	164.0	116.0	183.0	111.0	181.0	86.0
% immunisation of children	77.6	86.8	67.4	88.3	72.1	93.9
% children stunted for their age	49.2	37.8	53.9	32.0	52.4	33.1

Source: Malawi Government, Ministry of Health, 'Report For The Health Sector Annual Joint Review 2007', Malawi

3 Key barriers to basic health care for all

Access to essential medicines

Stock-outs commonplace

Access to medicines remains a major issue in Malawi. There have been stock-outs throughout the country of basic antibiotics, ITNs, and HIV-test kits. And at times, stocks of vaccines have run dangerously low.[22] This is partly because the Central Medical Stores (CMS) has been dogged for many years by problems of poor management. The problems are complex and revolve around there being no systematic way of measuring demand. CMS simply order drugs based on previous consumption levels. This leads to procurement of drugs and equipment that are not needed, while urgently required medicines are often not sourced.

Trade related aspects of Intellectual Property Rights (TRIPS)[23] and medicines in Malawi

Malawi has a very limited ability to produce its own medicines, so is dependent on imports from abroad, which can be extremely expensive if they are subject to patent laws. In the case of some newer medicines that are covered by World Trade Organization (WTO) intellectual property rights, Malawi has to import expensive branded drugs. However, where a patent bar[24] does exist, Malawi relies on cheaper generic drugs manufactured in India, and to some extent in China and South Africa. For example, as part of Malawi's HIV and AIDS treatment programme, anti-retroviral drugs (ARVs) are funded by the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), which relies almost exclusively on generics imported from India.[25] These generics have enabled Malawi to reach up to 200,000 people during the five-year grant from GFATM, as opposed to the original 25,000 if branded drugs had been used.[26] However, there is concern that as resistance develops to first-line ARVs, Malawi will not be able to afford second-line drugs, which currently remain under patent.

Human-resource crisis

High attrition, low training and recruitment

Over 90 per cent of those interviewed for this case study cited the health-worker crisis as the major barrier to universal access to equitable, quality health services. There are only 252 doctors for a population of 13 million people, and the nurse to population ratio is approximately 1:3500. Sixty-four per cent of nursing posts in Malawi are unfilled. Even in African terms, Malawi does not come out well, with fewer health workers per person than Sudan. Anyone requiring the attention of a specialist such as a neurologist or dermatologist, travels outside the country. In 2006, 15 specialist overseas treatments cost the same as the budget of an entire district.[27] District hospitals like Nkhata Bay, with an average of 250 beds, should have 175 nurses. No district hospital has more than 40. 'This leads to some very serious issues from a patient point of view, but also for the health workers themselves. There are large numbers of people crying for services…nurses are on their feet 18 hours a day. It's a situation that creates an enormous amount of tension.'[28]

Moreover, the limited health personnel available are concentrated in urban areas and at secondary (district hospitals which cater for the population in specified districts only) and tertiary (central referral hospitals — there are only four of them in Malawi) levels,

resulting in a disproportionate impact of the health-worker crisis on poor people in rural areas. Half of Malawi's doctors work in its four central hospitals, together with 25 per cent of the country's nurses.[29]

The causes for the crisis are mainly due to low numbers of people attending training, very high attrition rates of existing staff migrating to the private sector and overseas, and loss of workers to HIV and AIDS. The limited size and capacity of training institutions makes scaling up extremely difficult. For example, on average only 20 doctors graduate annually from the College of Medicine.[30] In addition, even when the government has managed to train more doctors, nurses, and health workers, there is no guarantee they will stay in the public system. Between 1999 and 2002 the MoH estimated that Malawi lost 278 registered nurses and midwives to overseas posts, while its training institutions produced only 258. Finally, Malawi's community-based health services are losing health workers who are re-training as HIV and AIDS counsellors – an area of work with a better pay package.[31]

On top of this, it is estimated that 2000 health workers are living with HIV and AIDS. Although HIV and AIDS is by no means the main cause of drastically declining numbers of health workers, it is a significant contributor to staff deaths, incapacity, and absenteeism. For example, only eight MoH staff died in 1990, compared with 270 in 1999 and 200 in 2000.[32] It is estimated that 25–30 per cent of health professionals will die of AIDS in the next decade, and 'before they die they are sick and cannot work'.[33]

Table 2: Staff vacancies

Category	Established and required posts	Filled posts	Vacancies (%)
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
Obstetricians and gynaecologists	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**

Source: Malawi Government, Ministry of Health, 'Report For The Health Sector Annual Joint Review 2007', Malawi

Thin frontline of demoralised women workers

In all Southern Africa Development Community (SADC) countries, nurses, who are mostly women, represent more than 80 per cent of the health workforce. In the quest for

quick results, public-sector work security and service delivery have been undermined by misguided attempts to reform the public sector. A registered nurse's basic salary is MK27,000 per month on average ($6.40 per day). A technician nurse earns approximately MK12,000 per month ($2.80 per day). Here is what Dorothy Phiri, a nurse in a rural facility in southern Malawi, had to say:

> *For the last three years, I have never known on which day I would receive my monthly pay – sometimes it would be up to three months between payments. The amount I receive can last me for ten days, as I am responsible for my father who is sick, my own children, and some nephews, who number six altogether. To make ends meet, I grow and sell some tobacco, and I try to attend workshops so that I can be paid per diem [daily allowance]. I completed my training at Trinity Hospital in 1983 and was so proud to be a nurse. Now… I would definitely not recommend this job to my daughter.*[34]

The solution of paying nurses like Dorothy a decent wage so that they can perform their jobs without worry is not seen as cost-effective. Instead, the reforms being pursued constitute training new nurses only up to nurse technician level – a very low-paid post, at less than twice the average daily income that poor people live on. This level of training is inadequate to deal with the complexity of patients' needs.

The net impact of the reforms (getting training only up to technician level) is a thin frontline of harassed and demoralised women working long hours for low pay and no security. This is the front line that has to support the growing burden of illness in health facilities, as well as the needs of extended families in addition to their own nuclear family. The cost-effectiveness of this approach must be challenged. In the long term, and looking at broader criteria of effectiveness such as quality and performance outcomes, these reforms are not sustainable.

Box 2: Human resources in the health sector in Malawi

- The nursing to population ratio in Malawi is 1:3500, compared to 1:1000 in Africa as a whole, and 1:102 in Germany.[35]
- Malawi has 252 doctors for a population of 13 million people.[36] There are four qualified dentists working in the health system.
- Vacancy rates vary from 30–80 per cent. The vacancy rate for nurses is 56 per cent. In rural areas this is much higher.[37]
- Only one in four health clinics have the bare minimum recommended number of two nurses and midwives.[38] There are ten districts with no government doctor, and three districts with no doctor at all.[39]
- Between 2002 and 2005, 386 nurses went to work overseas. This represents 10 per cent of all nurses in Malawi. Eight out of ten of these went to the UK.[40] Following the increases in salaries of nurses, the number of nurses going overseas fell from 96 in 2005 to 30 in 2006.
- The EHRP, launched in 2004, is expected to produce 3950 nurses by 2009–2010 (which will nearly double the 2004–2005 levels of 4,717).[41]
- Lack of skilled health workers and severe overloading of the available workers, results in poor-quality care. For example, in antenatal care, a typical health worker faces as many as 100 patients per eight-hour day, implying an average encounter of 4.8 minutes per patient (assuming no rest breaks at all). This compares with the standard of 30 minutes per patient.[42]
- Unskilled workers are doing skilled jobs. A study in one health facility found that ward attendants who have no medical qualification attended 20 out of 34 deliveries.[43]
- Nursing could be considered the most dangerous job in Africa: 57 per cent of nurses giving injections for illness reported suffering at least one 'needle stick' incident in the last 12 months. One in ten needles are used more than once. Given acute shortages of gloves

and other protective clothing, it is not surprising that 96 per cent of service providers perceive risk to themselves from HIV and AIDS exposure, while 93.4 per cent perceive a risk to their clients.[44]

- Staff salaries were very low, but have increased substantially. Relative to other countries, salaries compared very badly. Even now a median salary earner in Malawi's MoH is likely to earn less compared with other countries such as $145 in Zambia and $251 in Tanzania.[45]

Limited access to health services

Distance

Health-care resources are unevenly and inadequately distributed, making access for poor people difficult. The Malawi Poverty Reduction Strategy Paper (MPRSP) highlights that 'physical access to health centres has remained poor, with only 3 per cent of the population living in a village with a health centre'. Meanwhile, only 46 per cent of the population has access to a formal health facility within a 5km radius, and only 20 per cent of the population lives within 25km of a hospital.[46] There is approximately one public-health facility per 17,000 inhabitants, and the situation is worse in rural areas.[47] The Service Delivery Satisfaction Survey carried out by the Malawi Economic Justice Network (MEJN) showed that, on average, respondents had to travel 10.2km to reach the nearest government health centre, with quite noticeable differences between districts. On average the distance travelled to the district hospital is slightly under 30km. Thirty-three per cent of respondents have to travel by foot to the hospital, and 55 per cent said that it takes them over two hours to get there.

This often leads to poor people waiting until they are very ill before they access formal health services. They may not access any health services at all, or they may use traditional healers. A study of those seeking tuberculosis treatment in Lilongwe found that 25 per cent of poor people came with a chronic cough, a sign of waiting a long time before seeking treatment, compared with 15 per cent in richer areas. Women often delay seeking treatment longer than men. Calculations showed that the cost to poor patients of seeking tuberculosis diagnosis was 248 per cent of their monthly income.[48]

Affordability

Despite the government announcing that essential health-care needs are free, only 9 per cent of government and mission facilities (54 out of 585) provide the full EHP. This means that in each district, only one or two facilities have adequate EHP capacity.[49] As a result, out-of-pocket expenditure still accounts for 26 per cent of total health spending, with the poorest households spending up to 10 per cent of their annual expenditure on health care.

The church, through the Christian Health Association of Malawi (CHAM), provides 37 per cent of health services in Malawi. In many rural areas, CHAM facilities are the closest to people's homes. These facilities charge user fees, which are set locally and vary enormously from place to place. In one district, the charge for a caesarean-section delivery in different CHAM hospitals ranged from MK500 ($3.55, £1.72, €2.43) to MK10, 000 ($71.10, £34.48, €48.50).[50] WHO has suggested that in fact the modest fees charged do not prevent poor people's access to services, and that CHAM is an example of a good balance between efficiency, quality, and financial sustainability; but civil-society organisations (CSOs) claim that user fees pose a threat to health equity among various social groups. Interviews with community members clearly revealed that user fees were a barrier for the poorest people when accessing health services.[51] Focus-group respondents, particularly women, were clear that often they would not go to CHAM facilities because of cost, despite their proximity compared with the district hospital.

Respondents also stated that they would not go to mission hospitals for chronic conditions requiring repeated visits, meaning that they only go to CHAM for one-off health incidents. However, it was clear that the quality of care at CHAM facilities is higher than at government ones. This is partly due to the lower utilisation rates because of cost, meaning more facilities and more staff time being available.

4 Health policy, planning, and financing

In 2002, the government of Malawi announced that it was going to deliver some essential health-care interventions for free; in order to meet the basic health needs of a critical mass of Malawians. The EHP, as it became known, selected 11 cost-effective interventions that addressed the major causes of death and disease in the population for free access across Malawi at the point of delivery. These included the so-called 'diseases of poverty', namely diarrhoea, ARIs, cholera, and malaria (see Annex 6 for specific interventions). In order to implement the EHP, a joint Programme of Work (PoW) was collectively developed and subscribed to by the major stakeholders in the health sector, including the government of Malawi, development partners, and major not-for-profit NGOs including CHAM.

The PoW provides a framework for supporting and implementing activities contained in the EHP. It was initially costed at $763m for six years (2004–2010). The agreement to finance and support the PoW was formalised under the SWAp with external donors. Its main aims are to:

- submerge donor goals within a set of shared, country-wide goals;
- provide quality EHP services free of charge at the point of delivery at all levels of the health system – primary, secondary, tertiary;
- integrate all vertical disease programmes into EHP so that technical efficiencies can be achieved;
- ensure that the Health Management Information System (HMIS) provides reliable and complete country data.

Public accountability and transparency is to be achieved through the Equity and Access Sub-Group. This forum has devised the equity-monitoring framework to assess the health sector's capacity and performance. With this information, pro-poor interventions can be determined. The CSO, MHEN, formed in 2000, acts as a lobby group to the Parliamentary Committee on Health in the Malawi National Assembly. Its mandate is to monitor how Malawi's health budget is utilised equitably to benefit poor people.

Health expenditure, government budget, and donor commitments

Overall expenditure

Per capita spending on health in Malawi is approximately $14 per year. Spending by households on health care is very high: approximately $4 comes from out-of-pocket expenditures, $4 from government, and $6 from donors.[52] Funding for health is $20 short of the $34 dollars per capita proposed by the Commission for Macroeconomics and Health.

Government expenditure

Government spending on health has been steadily rising in recent years (see Table 3), driven both by increased government commitment and also by increased donor aid. The government has committed to reaching the Abuja commitment of spending 15 per cent of its overall budget on the health sector. The budget for 2007–2008 specifies that over 19 per cent of the total budget is for health and HIV and AIDS combined.

Table 3: Trends in government expenditure in health

Items	2002–2003 Actual	2003–2004 Actual	2004–2005 Revised	2005–2006 Actual	2006–2007 Actual	2006–2007 Revised
Total health spending in MK million	3,579 ($60.2m)	6,800 ($154.2m)	10,680 ($343.4m)	13,226 ($806.5m)	16,588 ($117.95m)	16,315 ($116m)
Health as % of total government expenditure	9.85 %	7.92 %	11.62 %	10.27 %	10.86 %	10.70 %
Distribution of MoH recurrent expenditure by level of health systems (including CHAM), in MK million						
Headquarters	602	511	1,479	5,556	5,784	4,534
Central hospitals	814	891	1,408	1,920	2,196	2,388
District hospitals	1,998	2,612	3,534	4,772	7,134	7,144
Total recurrent expenditure	3,414	4,014	6,421	12,248	15,114	14,066

Source: Malawi Government, Ministry of Health, 'Report For The Health Sector Annual Joint Review 2007', Malawi

The figures in Table 3 show that total expenditure on the health sector has increased from MK3.5billion ($60.2m) in 2002–2003 to MK16.58billion ($117.95m) in 2006–2007. This is a four-fold increase from 2002 to 2007 in terms of volume. However, as a percentage of the national budget, the health-sector budget (excluding HIV and AIDS spending) remained at an average of 10.8 per cent. In terms of resources going into service-delivery, the budget to district health offices increased from MK3.5bn ($60.2m) in 2004–2005 to MK7. 1bn in 2006–2007, and for central hospitals the increase was from MK1.4bn to MK2.19bn, representing increases of 102 per cent and 56.7 per cent respectively. Thus since the start of the implementation of the SWAp, more resources are being channelled towards infrastructure, supplies, human resources, and drugs at the service-delivery level.

Donor expenditure

Donors fund 43 per cent of health expenditures.[53] This was historically almost all outside the government budget, but with the inception of the PoW and the SWAPp this has improved dramatically. The vast majority of donors have now signed up to the PoW. Within the PoW, 62 per cent of finance is now on budget. Within this, the UK, Norway/SIDA, UNFPA, GFATM, and the World Bank have gone further, to pool their funds. The German government, through Kreditanstalt für Wiederaufbau (KfW), joined the pool in late 2007, as did the United Nations Children's Fund (UNICEF). Pool donors share the same plan, financial reports, annual implementation plan, and progress reviews, and use government systems. GFATM is an exception, and could be described as being 'in' the pool but not 'of' the pool, using its own systems with some duplication – but it has improved significantly in recent months.

A number of other donors, such as WHO, are signed up to the PoW but use their own systems and do not pool funding, again leading to duplication. Finally, other donors,

notably then United States Agency for International Development (USAID) and the Presidential Emergency Plan for AIDS Relief (PEPFAR), are completely out of the PoW. Thirty-eight per cent of development-partner support for the health sector is off-budget, and in 2005–6 only 40 per cent of discrete donor-funding commitments were disbursed, despite requiring 18 separate bank accounts and procurement procedures.[54] Data on existing donor commitments shows there will be a continued financing gap for meeting the resource requirements of the EHP.[55] However, Table 4 shows that pooled donor inputs into the health sector have been increasing since the SWAp started. From 2008 onwards, the World Bank is pulling out of the health SWAp.

Table 4: Summary of annual donor inputs to the health sector, $m, 2006–2007

Donor	**2004–2005**	**2005–2006**	**2006–2007**
Norway	5.0	19.4	18.7
DFID	4.6	16.3	26.1
World Bank		7.7	5.0
UNFPA		0.1	0.1
GFATM		6.4	14.5
Grand total	**9.6**	**49.9**	**64.4**
Amount pledged by donors	20.2	40.1	55.5
Surplus or (shortfall) on pledges	(10.6)	9.0	8.9

Source: IMF, Malawi-Study on Public Expenditure Review, p 86

5. Health successes

The new government policies and additional financing for health by government and donors in Malawi are beginning to deliver change, tackling the health-worker crisis, helping to make progress on removing user fees, and fighting HIV and AIDS with free distribution of vital drugs.

Tackling the health-worker crisis

Over the years, the government of Malawi has put together a number of plans to tackle the human-resource crisis, without much donor interest. This changed in 2005, when a six-year grant from the UK's Department for International Development (DFID) and other donors, notably GFATM and the EHRP, enabled the government to fund a 52 per cent increase in salaries for key workers in the health sector.[56] This has resulted in a slow-down in out-migration of nurses from Malawi, from the average of 100 nurses a year to 13 in 2006, and 30 in 2007. The EHRP is also expected to produce 3,950 new nurses by 2009/10. This would almost double current levels.[57]

Table 5: Migration destination and numbers

Malawian nurses validated abroad						
Destination	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
UK	83	90	64	85	9	10
USA	3	10	9	6	4	3
South Africa	7	2	1	5		8
Canada	1					
New Zealand	5	1	1			6
Botswana	3	1	1			
Zimbabwe	1		2			
Uganda			1			
Australia		4				
Ireland						3
Total	**103**	**108**	**79**	**96**	**13**	**30**

Source: Malawi Government, Ministry of Health, 'Report For The Health Sector Annual Joint Review 2007', Malawi

Removing user fees in mission facilities

The government of Malawi is working to remove user fees in mission facilities. It is negotiating Service Level Agreements (SLAs), where the government reimburses CHAM facilities for providing maternal and neonatal services free of charge. CHAM units are autonomous; therefore, an SLA has to be negotiated for every mission hospital or clinic – a complex and time-consuming process. Approximately 50 of these SLAs have now been

negotiated, but the majority only cover maternal and neonatal services, and not the full EHP. As more SLAs are negotiated, it is also likely that demand for services at CHAM facilities will increase, putting pressure on them and almost certainly leading to a decline in quality unless sufficient resources are available. So far, some facilities have seen a ten-fold increase in demand for maternal services once SLAs have been signed. There is a need for increased donor support to the health sector that will enable the government to expand its own service delivery through construction of more health centres and recruiting more health workers. Donors also need to make adequate resources available to CHAM so they can provide the full EHP free of charge.

Fighting HIV and AIDS

The massive disease burden of HIV and AIDS is eased by treatment. The Executive Director of NAC has said: 'Treatment has revolutionized the whole HIV and AIDS response. People are coming out in the open in large numbers to go for an HIV test. We have doubled HIV and AIDS testing over the last year, because people see treatment at the end of the tunnel'.[58]

The government, thanks to help from donors, has been able to put close to 120,000 people country-wide on ART, due to its policies to enable free access to these drugs (this figure is up from virtually nil only five years ago).[59] This has had a profound impact on awareness of the disease, as survival is now a genuine option. The distribution of these free drugs is on a first-come-first-served basis. It has often been inequitable, with long waiting lists and heartbreaking stories of people dying before getting drugs. Nevertheless, the progress towards universal access is a real success story.

Over 19 per cent of the Malawian government health budget in 2007–2008 is for overall health and HIV and AIDS combined[60]. Malawi was given a positive rating by GFATM and is one of a number of well-performing countries asked to make an application for the Rolling Continuation Channel, to start in 2008. If successful, this is likely to be the biggest source of health financing for Malawi for the coming five years. This money will be channelled through NAC, and not the MoH, raising some concerns about co-ordination and/or competition.

The government targets for scaling up access to HIV treatment are based on two scenarios – baseline and low. Under the baseline, 75 per cent of those who need it will be receiving treatment by 2010. The total cost will be $143m annually by 2010, rising to $210m in 2013. The largest cost is medicines like ARVs, which currently account for 40 per cent of the cost of providing ART in 2007 and will rise to 57 per cent by 2013. It is very likely that these are underestimates, as they do not include administration or management, and are based on assumptions about availability of second-line drugs, implementation bottlenecks, health-system constraints, accuracy of data used, and so on.

Continuing problems in health delivery

Further investment in training health workers is needed immediately

Policies must be put in place to retain more of the new graduates, including enforcement of the policy to ensure recently qualified health workers to work for the public system. CHAM has recently instituted a two-thirds female-only enrolment policy, as men in particular were completing training only to work outside the public sector.[61] There is also a need to have more incentives put in place to get more health workers out to rural areas.

Better financial flows and quicker processes

Decentralisation of health-service management has enabled financial resources to flow directly to districts, giving greater control over how these resources are used. However,

far more could be done to improve these flows and ensure that money is reaching the frontline in the right amounts. The burdensome public drug-procurement system also gives incentives to district health authorities to buy drugs from private suppliers, who charge up to four times as much.

Better match between budget and expenditure

Although in recent years under the new government there have been major improvements in budget execution, a significant gap still remains between what is put in the budget document and what is actually spent. For example, the MoH failed to spend a significant proportion of its budget in 2006–2007, due to failures in the procurement of drugs and medical equipment, and failures in the completion of infrastructure projects. The MoH returned MK1.3bn to the treasury – this could have paid for more than 5,500 nurses' annual salaries.[62]

The government needs to build its capacity to absorb funding for health and set in place more effective procurement processes particularly. There is also a need for quicker reporting on expenditure to the public. At present, indicative projections on what was actually spent are only made public the next year, and a full audit takes between two and three years.

No clear plans for massive scale up

The current situation is that the government and CHAM provide the vast majority of available health services. The government provides around 60 per cent of services, and CHAM provides 37 per cent, with the remainder being provided by NGOs and the private sector. [63] The very poor health outcomes demonstrate that there is a significant need to expand health services in Malawi.

It is certain that maximising the capacity of the CHAM system to deliver the EHP free of charge is a key way of expanding the amount of services available. As described above, this involves signing contracts with each CHAM facility, negotiated at the district level, which is a complex, time-consuming, and ultimately expensive process. Moves have been made to identify an agreed unit cost for different EHP services, to facilitate the signing of these contracts, but the logistics of negotiating them country-wide remain daunting. The only other major service provider is Banja la Mtsogolo (BLM), which provides family planning in peri-urban areas. They charge for their services, but recently have begun certain community-outreach services for free.

Beyond the maximum utilisation of CHAM capacity, and rehabilitation of the government system, both of which are huge tasks, there does not seem to have been much discussion of the necessary further expansion of the public health system.

Earlier in the decade, a number of donors, including the World Bank, were pressing for a reform agenda for the health sector, which involved identifying extra-budgetary sources of finance, linked to an increased role for the private sector. Private medical practice was allowed in 1991, and since then, the for-profit sector has expanded. This has led to many health workers leaving government service or taking second jobs in the private sector where services are less accessible to poor people.[64] At the same time, ancillary services have been outsourced as part of a recent World Bank loan, and plans were put forward to give major hospitals greater autonomy to charge those who are able to pay for the services despite international evidence confirming that such approaches, which require identifying poor people for exemption from user fees, consistently fail.[65] The devolution of services to the district level, without clear central regulation, also risks further fragmentation of the system.[66]

It is promising that with the exit of the of the World Bank from the health sector, this reform agenda promoting a greater role for the private sector seems less in evidence. However, there is still no real vision for an expanded and universal health system. The

EHP needs to be seen less as a technical intervention and more as a political vision for the sector based on universal, free, and predominantly public provision for all. The negotiation of the National Health Strategy (2007–2011) will be an important moment to raise these issues.

6 Donor aid to Malawi

Aid and budget support

The IMF predicts that aid to Malawi is subject to considerable uncertainty over the coming years. The IMF is clear that without scaling up of aid, the government will not be able to implement the MGDS. The IMF estimates the cost of implementing the MGDS at 188 per cent of GDP over the period 2006 to 2011, which Oxfam estimates to be $3.8bn. However, it only estimates that aid will account for 24 per cent of GDP during the same period.

Several major donors are currently preparing or have just completed medium-term plans. The World Bank CAS predicts that World Bank lending will be around $340m over the period 2007–2010. The European Union Development Fund (EDF 10 agreement)[67] is tentatively predicted to provide €350m over a six-year period, with scope for additional aid depending on performance. DFID is also finalising its new Country Assistance Strategy (CAS). However, this is not nearly enough to fill the funding gap.

Box 3: Facts on aid

- Malawi receives approximately $500m in aid a year, or $39 per person.
- Without debt relief, Malawi would have been paying $123m back to creditors in 2007 – instead it will repay just $4.5m.[68]
- At most, only 18 per cent of the aid Malawi receives can be used to pay government salaries.[69] Only one in five aid dollars is given as support to the government budget.
- The UK is the largest donor to Malawi, followed by the World Bank, the EC, and the Norwegian government.
- Three donors: DFID, the World Bank, and the EC, account for approximately 80 % of all foreign aid.
- A quarter of all aid to Malawi goes through NGOs and not through the government.
- To implement the MGDS over the next five years would require more than twice as much aid as is currently predicted.[70]
- Aid to Malawi has fluctuated considerably over the last 20 years, ranging from a low of 13 per cent of GDP in 1997 to 31 per cent in 2003.
- Donors have set up 69 project-implementation units separate and parallel to government systems, and the USA accounts for 30 of these.[71]
- The IMF is predicting that aid levels will fall slightly over the coming three years.

Table 6: Aid to Malawi as % of GDP

		2001–2005	2006–2010
Overall aid	Net official aid to Malawi	19.7	24.0
	Net aid to government	10.7	18.2
	Gross aid	13.2	18.4
Of which	Programme aid/budget support[72]	4.5	4.4
	Project aid	8.7	13.9
	Grants to NGOs	9.0	5.9

Source: IMF Malawi 2006 Article IV Consultation, page 13

Table 7: Biggest donors to Malawi

Donor	Amount ($m)[73]
UK DFID	130
World Bank	125
EU	75
Norway	50
USAID	25
GFATM	21
ADB	18
UNDP	15
GTZ/KFW	12
JICA	4

Source: World Bank (2007) 'World Bank Country Assistance Strategy 2007–2010', Washington: World Bank, and Development Assistance Committee (DAC)

Malawi and budget support

The majority of aid to Malawi has historically been project-tied aid and is predicted to remain so for the foreseeable future. Budget support and debt relief equated to 29 per cent of all aid to the Malawian government in 2007. Budget support (excluding debt relief) is predicted to remain on average $115m, or 18 per cent of aid to Malawi between now and 2010. It is delivered by a group of donors operating under the Common Approach to Budget Support (CABS).

Levels of budget support have varied substantially, usually in response to perceived poor fiscal performance by the Malawian Government, reflected in failure to maintain an IMF programme. Fiscal indiscipline was a major problem with the last administration, particularly between 2000 and 2004. An IMF Poverty Reduction and Growth Facility (PRGF) was signed in 2004, but only the first review was ever completed, and Malawi

went off-track in 2001. This led to a suspension of much of their budget support, which in turn set up a vicious cycle of greater recourse to domestic borrowing, rising interest rates and widening fiscal deficits. These trends were exacerbated in 2002 by a food crisis that required the importation of maize and fertilisers thereby depleting external reserves. By the end of the period 2003–2004, domestic debt interest payments were taking up to a quarter of the government budget.[74] So donors pulled out of budget support just when they were needed most, but on the basis of genuine concerns about poor macroeconomic management. Malawi was one of the countries included in a multi-country analysis of budget support[75], which concluded that there was not enough analysis of underlying political conditions and government commitment when the budget-support initiative started. This was corroborated when the suspension of budget support in 2001 had no impact on poor financial management by the government or on over-spending. Instead of cutting expenditure the government simply resorted to domestic borrowing. The study concludes that conditionality is neither a substitute for, nor does it promote, ownership and recommends that in difficult policy contexts like Malawi, if donors are going to give budget support they should commit for the long term.

One lesson from Malawi appears to be that the short-term damage done by suspension is very significant and that henceforth, suspension should take place by allowing aggregate fiscal discipline to be maintained except in very exceptional circumstances.

The Common Approach to Budget Support (CABS)

The CABS group formed in 2000. The current members of CABS are DFID, the EC, the Norwegian government (and through them the Swedish government), and the World Bank. The IMF, GTZ, and UNDP are observers. The CABS group meets twice annually to monitor government adherence to the Performance Assessment Framework (PAF), which currently has 29 indicators used by donors to assess the government's performance (see Annex 4).

The negotiations between the CABS group and the government remain very much behind closed doors, and the specific legal agreements with each donor are not available, with the exception of the World Bank. The group is also worryingly uncritical of the IMF and seems happy to defer to them on all macro-economic issues. The addition of conditions relating to privatisation, linked to the World Bank Poverty Reduction Support Credit (PRSC), was also of concern, with intense negotiation over the indicators that the World Bank was seeking to make part of the PAF, with some being substantially watered down from their original proposal, notably private-sector involvement in the distribution of subsidised fertiliser.

Good economic performance in recent years by the new government has meant the continued support of CABS donors, despite ongoing political disputes.

CABS harmonisation, conditionality, and predictability

While the CABS group has led to one co-ordinated dialogue with respective donors, the funding from each of the donors has been guided by separate bilateral agreements. These reveal that donors have maintained different emphases and conditions for the release of funding. For example, Norway officially does not require the government to have a PRGF agreement with the IMF. The CABS group does not therefore represent complete harmonisation. For the government, the key player is the IMF. A programme with the IMF is seen as the condition underlying GBS releases.

CABS disbursements have increasingly been aligned with government systems, although some are much better than others. As a result of the review in March 2008, CABS donors now undertake to at least indicate clearly their disbursement plans over the next year, with optional indications for subsequent years.

Recently, the EC has decided to make an advance release of the full amount committed at the beginning of the fiscal year, contributing to further improvement in the Malawian government's cash management. This means that the review of past performance for 2006–2007 will impact on funding for 2008–2009 not 2007–2008, making funds more predictable and flexible for government.

Predictability

In recent years, budget support has been very unpredictable, and was suspended for a period. In the latest CABS review, donors have given indications of their proposed future financing of budget support, with different levels of specificity. The EU does not give any indication beyond the expiry of the current agreement in 2008, despite ongoing negotiations around the future six year funding of the the EDF 10. DFID says 'budget support is expected in subsequent years to remain at about 30 per cent of DFID's total programme', which is a very vague statement[76]. Norway gives indicative figures for the next two years, as does the Africa Development Bank (ADB). The World Bank commitments over the next three years are laid out in the PRSC.

Government, the CABS group, and IMF conditionality

Government negotiation with the CABS group and the IMF is a lot more robust under the current government. Under the previous regime, the IMF apparently would write the Malawian Government's program priorities that the IMF are meant to fund. Now the government writes its own program priorities (the letter of intent). In one interview, the example given was the 20 per cent increase in civil-service salaries in this year's budget, equal to a 10 per cent increase over inflation. A similar increase is being called for in this year's budget. Equally, the government was apparently very strong in negotiating over the various indicators for the PAF that the World Bank was proposing.

The World Bank and the CABS group

Between 2000 and 2004, the World Bank was not part of the CABS group, although it was giving substantial budget support. This led to problems at times. With the new PRSC, signed in October 2007, the World Bank has become a full member of the CABS group, which has both advantages and disadvantages. However, what is clear is that the World Bank, by joining CABS late, will not dominate the group as is the case in some other countries.

The PRSC will provide $75m over three years in budget support, given in three annual tranches. PRSC 1 is for $20m, and has seven prior actions that the government must implement before receiving its funding. The second tranche, PRSC 2, has eight trigger conditions, which need to be met before the third and final tranche is released. The actions or conditions attached include part-privatisation of the state marketing board (see Annex 5). All PRSC conditions are included in the PAF for the CABS budget support group, with the exception of the establishment of commercial courts.

European Union and budget support

The EU currently gives around a third of its assistance to Malawi in the form of budget support. Roads, livelihoods, and a large-scale social fund supporting micro-projects across the country take up the remainder. Large NGOs and a number of the UN agencies also access EU money, but directly from Brussels. Under EDF 10, the intention is to increase budget support to around 50 per cent of EU aid.

Unlike the World Bank, the EU legal agreement with the government is not available publicly, but was made available to Oxfam when we enquired. The agreement is for two years, for a total of €34m, and budget support is given in two annual tranches, one fixed and the other variable. The fixed tranche and the variable tranche are based on

performance on a selected number of indicators in the PAF, relating to public financial management and social outcomes, with a large number corresponding to indicators from the health SWAp. In the last year, the variable tranche was going to be maximum €5m, but in the end only €4.2m was disbursed, because the outcome indicator requiring 85 per cent immunisation coverage was missed by 3 per cent. A team of three people is employed by the EC in Malawi to monitor budget support (see Table 8).

Table 8: EC budget support

Tranches	Amount (€m)
2006–2007 Fixed tranche	8
2006–2007 Variable tranche	5 (PFM 2 and social sectors 3)
2007–2008 Fixed tranche	8
2007–2008 Variable tranche	9 (performance 2 and PFM 4 and social sector 3)
Technical assistance	4
Total	**34**

Source: Figures supplied by EC Malawi office

The IMF

The current PRGF has run smoothly to date, and is due to expire in August 2009. The Minister of Finance is keen to move to a Policy Support Instrument (PSI), a new IMF instrument, which is designed for countries that no longer want or need financial assistance from the Fund, but want Fund endorsement of their economic policies. The IMF provides no money, but still puts policy conditions on the country. The IMF is much more circumspect. The current PRGF has a waiver on spending under the health SWAp, including the 52 per cent increment in health-worker salaries. The overall fiscal framework remains conservative however, with a ceiling on the overall public-sector wage bill. The projections on government spending after this year are the same or less than inflation, and there is a target to achieve fiscal surplus after grants. Substantial resources have been spent on paying off domestic debt and building up reserves, but given that the domestic-debt interest was taking up 23 per cent of government spending in 2004–2005 (it is now down to 7.2 per cent), and reserves stand at just 1.7 months' cover, this use of resources was hard to argue with. However, with greater stability Malawi now needs to increase spending on poverty reduction as rapidly as possible, and there are no plans on how this could be achieved.

The IMF resident representative was clear that he did not think there would be a wage-bill ceiling in the new arrangement, as there is a clear steer coming from Washington to move away from these. The IMF is also open to the use of more than one scenario in the new discussions. Subsequent follow-up meetings as part of our research in Washington confirmed that there would not be a wage-bill ceiling, but the IMF remained concerned about the wage bill. They revealed that the government is also looking for another 20 per cent increase in civil-service salaries for the next financial year.

Aid quality and the Paris Agreement

There is considerable awareness of the Paris process on aid effectiveness among donors and civil society, and on the face of it this seems to be having an impact on the thinking of a number of donors. For example, the German Government mentioned the agreement as a reason for their cutting back support to three priority areas and thinking about coming into the health SWAp.

Debt Relief

Malawi qualified for Heavily Indebted Poor Countries (HIPC) debt relief in December 2000. However, due largely to fiscal problems and an inability to complete its IMF programme, Malawi did not reach completion point until September 2006. On reaching completion point, Malawi also automatically qualified for the Multilateral Debt Relief Initiative (MDRI)[77] Gleneagles debt-cancellation deal. If HIPC and MDRI had never happened, Malawi would have been paying $123m in debt repayments in 2007 – instead it is predicted that it will pay $4.5m. Without the MDRI, this would have been $25m.[78]

7 Power and participation

Civil society in Malawi is weak but improving

Civil society in Malawi remains a recent phenomenon, and although increasingly vocal and engaged, suffers from weak institutions and structures, making quality advocacy and campaigning quite rare, with some notable exceptions.

The majority of NGOs are less than ten years old. National NGOs are often poorly managed, and lack institutional depth, centred on one or two key individuals. They are also urban-based and often donor-driven. Financial probity and governance are an ongoing problem. Large numbers of international NGOs are present in Malawi, but relatively few are involved in supporting or engaging in advocacy work.

Unions and professional associations

The major union actors in Malawi are the Malawi Congress of Trade Unions (MCTU), the Teachers Union of Malawi (TUM), and the Nurses and Midwives Association of Malawi. Although active on issues such as labour rights on the tea and tobacco estates, the MCTU has traditionally been close to government, as has the leadership of TUM. The majority of teachers and nurses are union or association members however, so the potential for collective action is strong. The nurses' association, although not fully a union, is very vocal in defending the interests of its members, and is potentially a key partner in any campaigning on the health-worker issue. Oxfam has worked with them closely on a number of visits, including that of the German pop star Campino and of the head of health for one of the largest UK unions, UNISON.

Rise of civil-society networks and advocacy work in recent years

Recent years have seen growth in the number of civil-society networks focusing on advocacy. Some of the key networks are the Human Rights Consultative Committee (HRCC), Gender Coordination Network (GCN), MENET[79], MEJN, Civil Society Agriculture Network (CISANET), and the MHEN. Of these, HRCC is perhaps the most established, and MEJN the most visible and vocal. In the area of HIV and AIDS, the Malawi AIDS Network (MANET) and the National Association of People living with HIV and AIDS in Malawi (NAPHAM) are also important. All have suffered setbacks after initially promising beginnings during the period of Malawi's first PRSP from 2000–2001, but they have all weathered some difficult times and are now re-establishing themselves.

MEJN works on economic-justice issues, which includes work on areas such as trade and economic partnership agreements, but their main focus has been budget analysis and tracking, together with surveys of people's satisfaction with government services. MEJN is also the key link point with the IMF, and on issues regarding donors and aid quality. MEJN has been financed at different times by a number of donors, including Oxfam, Trocaire, Christian Aid, ActionAid, the Canadian International Development Agency (CIDA), and DFID. It currently has a total of about ten staff.

MHEN has focused mainly on budget tracking, and surveys of people's satisfaction with health services. They currently have three full-time staff, with two working on policy issues. The overall governing body of NGOs is the Council for Non Governmental Organisations in Malawi (CONGOMA), which is also the lead on the Global Call to Action against Poverty (GCAP) in Malawi.

Networks and budget tracking

Budget-tracking activity in Malawi is some of the most developed in the world, although quality has fallen in recent years, and there is a lot of scope for further improvements. MENET, MHEN, CISANET, and MEJN have all prioritised working on budgets and budget tracking, since they were formed during the first PRSP in 2001. CISANET has also worked on the privatisation of the state marketing board, ADMARC, with help from MEJN. MEJN leads on budget analysis at the time of the budget speech, and on briefing parliamentarians, and has continued to do this to a relatively high standard, even when the organisation was going through serious internal problems.

The budget-tracking work evolved from concerns about the implementation of the PRSP and the budget under the previous government, and the fact that budget allocations were largely fictional, with money going missing during the year and not being spent on what it should be. In order to try and counteract this, the various civil-society networks got together and firstly called for the government to identify Priority Poverty Expenditures (PPEs) in each sector, and then to publish regular reports during the year of spending under each of these PPEs. At the same time, the networks carried out nationwide surveys of clinics, schools, and agricultural extension activity to try and establish whether key items such as textbooks or essential drugs were actually reaching the school and clinic level. They would then publicise this to embarrass the government into action. For example in 2001, MENET identified that 51 per cent of schools had no textbooks. Action by civil society helped ensure that the government continued spending on PPEs even in the face of a fiscal crisis.

In addition to these tracking surveys, MEJN has also led on nationwide opinion surveys, known as Service Delivery Satisfaction Surveys (SDSS), which collect people's views on services. These have been relatively successful and were a complement to budget tracking, but were hampered by the cautious approach Malawians take in criticising government.

In recent years, only MENET has consistently continued to carry out these budget-tracking surveys. There is an urgent need to revamp and rebuild this work, particularly by MHEN in the health sector.

Religious organisations

The church is a major player in Malawian civil society. The Catholic Church in particular played a key role in the downfall of President Hastings Banda. The Catholic Commission for Justice and Peace (CCJP) and the Centre for Social Concern (CSC) are key offshoots of the church working on issues of economic justice and advocacy. Both are subject to the same weaknesses facing other elements of civil society. The involvement of the Malawi Council of Churches in GCAP enabled Malawi to have over 3 million people [80]'Stand Up' against poverty in 2006.

Civil society and economic justice

MEJN is the leading actor on broad issues of economic justice, but not the only one. Also important is the CSC, which monitors the cost of a basic basket of goods on a regular basis, providing good data on salaries versus the cost of living.

Civil society in the health sector

MHEN and the Reach Trust are the key Oxfam partners in the health sector. MHEN was set up in 2001, and has a membership that nominally at least includes all the major players in health in Malawi. After an initially positive start, they suffered a leadership crisis and were fairly dormant between 2004 and 2006. However, since then, under new leadership, they have improved their work and have a lot of potential to do work

convening advocacy in the health sector, particularly work on budget analysis, donor analysis, and tracking of expenditures in health.

The Reach Trust evolved from the TB Equity Project, a well-regarded DFID-sponsored project. They are part NGO and part research consultancy, and have some very good-quality staff. They continue to produce excellent research and analysis into the health sector in Malawi, including considerable work looking at equity in health services. They have a depth of analysis and quality of work that is not common in civil society, and should be a key partner, underpinning health advocacy and campaigning with solid analysis.

Parliament

Malawi has a strong tradition of collaboration between parliamentary committees and civil society. This is particularly true of the Budget and Finance Committee, but also of sectoral committees in education and health. When this relationship has really worked, analysis and budget tracking by civil society has been taken up by parliament to add both gravitas and respectability to figures and to increase the pressure on government. So far this relationship has focused mainly on scrutiny of government and not donors. Parliamentary committees are paid for with money from USAID, which funds each committee to have a complement of research staff. During the case study we met with the deputy chair of the Parliamentary Committee on Health and three of his researchers, who were reasonably well informed.

A major blockage to further work with committees is the high cost of allowances demanded by MPs. Also in recent years, this relationship has been strained following the various political crises between opposition parliamentarians and the government, and this is likely to continue until the next election. However, in the medium term the link between civil society and parliamentary committees is likely to continue to be important.

The media

Print media in Malawi is dominated by two daily publications, *The Nation* and *The Daily Times*, both of which have clear political affiliations. Both have a very small circulation of around 17,000, but are read by decision-makers and so remain very influential. Coverage of advocacy, economic justice, and health is common, but the quality of journalism and depth of analysis is very poor.

Broadcast media is dominated by the government, which runs Television Malawi (TVM), and the Malawi Broadcasting Corporation, which has national radio coverage, about 90 per cent of this in local languages. Getting issues covered by these outlets is possible, as long as there is no criticism of government.

In addition there are a number of urban-based radio stations that are largely music stations, but with some coverage of issues. Beyond this, there is a new national radio station, Zodiac, which is independent and has some excellent coverage, largely in local languages. Zodiac could be a key partner in any advocacy and campaigns work. Civil society is relatively good at working with the media, but more could be done.

8 Conclusions and challenges

This report has revealed that there are three key challenges for essential health services in Malawi. The challenges are: (1) access to essential medicines; (2) access to health services, compounded by user fees, especially in CHAM hospitals; and (3) the human-resource crisis.

The following actions should be prioritised in order to address these challenges:

Government investment in the health sector needs to be scaled up

The human-resource crisis is a big challenge that needs strategic solutions. The MoH must fill the 6,062 vacant posts. Huge investment is needed to train the required health workers. The government must put in place a clear plan for salaries to avoid future obstacles in the health sector that are likely to surface when the DFID project currently subsidising health-worker salaries comes to an end.

The EHRP that the government has put in place needs to be consolidated with a permanent expansion of capacity for training Malawi's health workers. The government also needs to develop a clear-costed human-resources plan, including further salary increases and suggestions for how to improve benefits to ensure that at least 50 per cent of new health workers choose to stay working with the government.

The government should maximise the capacity of CHAM to deliver the EHP in all its hospitals by enhancing the subsidy it provides to CHAM.

Civil-society organisations must play a strong scrutiny role

Civil-society scrutiny of the donor community is not yet advanced. The IMF was criticised during the food crisis, but beyond this, civil society has been remiss in holding donors to account. Given its hugely powerful role in Malawi, this is an important area where civil society should look to increase its capacity and activity in coming years.

Malawi has made major improvements in budget execution; however, a significant gap still remains between what is put in the budget document and what is actually spent. This is why quality budget tracking is still a challenge in Malawi and international NGOs like Oxfam can play a great role in building local NGOs' capacities on expenditure tracking.

Donor support must increase

Donors need to rapidly scale up their aid to Malawi and must provide more of their aid via GBS or sector budget support in health.

All donors in Malawi should provide their aid on a long-term basis and commitments should be made in a transparent and timely manner to enable effective planning.

The CABS group donors should stop tying their support to an IMF programme, and their funding should be fully harmonised and not guided by separate bilateral agreements, as is the case at the moment.

Germany, UNDP, and Japan, as significant donors to Malawi, should join the CABS group and start giving direct budget support or sector budget support to Malawi.

Annex 1: General overview of Malawi

Malawi is one of the world's least-developed countries, ranked number 166 of 177 countries in the United Nations Human Development Index. Of its 12.8 million people, 85 per cent reside in rural areas where subsistence farming is their primary livelihood. AIDS is the leading cause of mortality in Malawi; the World Health Organization estimates that 940,000 adults and children (7 per cent of the population) are infected, and 78,000 die each year. Despite the government's commitment to improving health, life expectancy at birth is just 46 years.

Significant inequality

Within the high degree of generalised poverty, there are considerable socio-economic inequalities. The richest 20 per cent of the population consumes 60 per cent of goods and services, compared with 6 per cent consumed by the poorest 20 per cent. These inequalities have spatial characteristics. In urban areas, the average income is MK25 per day, while it is only MK10 per day in rural areas. Income poverty levels are highest in the southern region. Meanwhile, women are disadvantaged in terms of access to health, education, and agriculture services.

Turmoil tests Malawi's nascent democracy

The current President, Bingu wa Mutharika, was elected in 2004 after the previous incumbent Bakili Muluzi nominated him for the leadership of the United Democratic Front (UDF), following his failure to secure constitutional change that would have enabled him to stand for a third term. Muluzi's ten-year presidency had started on a good note, notably the introduction of free primary education in 1994. But increasingly, corruption became pervasive, and the lack of policy direction, macro-economic management, and economic progress led to economic decline. Bingu wa Mutharika left the UDF, and formed his own party, the Democratic Progressive Party (DPP). The DPP is a minority in parliament and this has led to a legislation gridlock. For instance, the opposition parties delayed the approval of the 2007–2008 budget by three months, insisting on debating Section 65 of the Constitution, which if implemented would result in most of the DPP MPs losing their seats in parliament. This political turmoil does not appear to have had any serious impact on government development programmes, although it is deeply concerning for Malawi's nascent democracy. It is likely that the political instability will continue.

Improving international relations

External financing, particularly from the IMF, was suspended several times under the previous regime due to uncontrolled spending, but since Mutharika's election, relations with donors and the IMF have improved considerably, as he is seen to have a commitment to fight corruption and improve fiscal discipline. A three-year PRGF was agreed in 2005, and Malawi reached HIPC completion point in 2006, slashing $3.1bn from its $3.2bn debt stock. Malawi enjoys good relations with bilateral donors, namely the USA, the UK, Germany, and Japan. However, dependence on foreign aid makes the country vulnerable to external pressure. Malawi was historically one of the few African countries to recognise Taiwan, but it performed a dramatic about-turn in December of 2007 and now officially recognises mainland China. This is likely to lead to a significant investment.

Annex 2 : Malawian government sources of finance 2003–2009 ($m)

	2003	2004	2005	2006	2007	2008	2009
Overall aid	270.0	308.8	387.7	428.6	492.5	482.6	504.8
Of which							
Grants	164.0	213.4	281.9	327.7	381.9	379.1	393.4
Loans	106.0	95.3	105.8	100.9	110.6	103.5	111.4
Balance of Payments Support	60.1	99.5	115.3	92.7	111.9	113.3	115.1
Debt Relief	47.5	47.0	57.6	55.9	26.6	17.7	6.4
Budget Support as % of Aid	22	32	24	21.6	22.7	23.4	22.8

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007	2007–2008	2008–2009
Aid to government	6.7	12.1	12.4	18	17.9	18.2	16.6
Revenue	20	22.6	25.1	24.4	24.2	24.5	24.1
Total expenditure	38.3	42.5	42.9	43.5	43.5	42.7	42.4
Overall balance	-11.6	-7.8	-5.4	-1	-1.4	-0.4	-1.7
Aid as % of government expenditure	17.4	28.4	28.9	41.3	41.1	42.6	39.1

Source: All figures drawn from IMF Malawi 2006 Article IV Consultation, table 4b p 32

Annex 3: The budget process in Malawi

The financial year in Malawi runs from June to July, with the budget discussions by parliament in June. A mid-year review of the budget is held in January, and soon after this, planning for the next year's budget starts in earnest.[81] The minister of finance normally has a number of outreach sessions with civil society, the private sector, and the public in March or April. IMF involvement is critical at this stage in the budgeting process. A critical point is when the indicative budget ceilings for each department are proposed; these are of course very politicised and are dependent on firm revenue projections, not least firm donor commitments, which often leads to delays. For example, the ceilings were delayed in 2007 from January to April, making budgeting very difficult. The entire budget is published on a line-by-line basis. However, another document is prepared called the output book, which seeks to redraw these expenditures in terms of the outputs they would produce, e.g. 250 nurses trained – MK40m, 50 nurse houses built – MK16m. This output version of the budget is not comprehensive and is lacking in many instances, but obviously makes budget tracking far easier.

Malawian government expenditure 2004–2008 ($m and % of government spending)

	2004–2005 (%)	2006–2007 (%)	2007–2008 (%)	2006–2007(USD million)
Agriculture	10	14.7	11.9	162
Health	12	10.7	10.2	118
Education	12	11.2	10	123
Public debt	23	10.1	7.2	111
Total government expenditure				1100

Source: Figures from Malawi Economic Justice Network, F7 2007 Final Budget Analysis Report except for Health, taken from Malawi Government Health Sector Final report.

Priority poverty expenditures

A number of expenditures have since 2001 been designated PPEs. Such items include teacher training or salaries for health workers.[82] These were an attempt to mimic the Poverty Action Fund in Uganda, by protecting vital expenditures from having their spending cut or reallocated to other expenditures that were non-poverty reducing. During the last government, where overall expenditure was very poorly controlled, they were a particularly useful political tool, seized on by donors and civil society, to at least ensure a minimum level of protected expenditure. The ministry of finance is supposed to collate spending reports on each PPE on a quarterly basis. Interviews with the ministry of finance highlighted that monitoring of these PPEs is not as good as it had been in the past. This is partly a reflection of greater government probity and financial performance, but nevertheless PPEs remain a useful way of highlighting these important expenditures, and civil society, parliament, and donors should work with government to revive them.

Annex 4: Common Approach to Budget Support

The CABS group has a Performance Assessment Framework (PAF), introduced in 2005, which currently has 29 indicators under four headings: (1) Public Financial Management; (2) Economic Growth and Social Protection; (3) Social and (4) Governance sections. They are drawn from the Malawi Growth and Development Strategy-the overarching development strategy for Malawi. The PAF brings together different indicators used by donors, rather than agreeing on a single set of indicators or to use them in a uniform way. Instead, the indicators reflect the different preferences of the various CABS donors, with a number of outcome indicators linked to the EC, and a number of new indicators that correspond to conditions in the proposed World Bank PRSC. These include privatisation of part of the state marketing board, ADMARC. There was quite intense negotiation over the indicators that the World Bank was seeking to make part of the PAF, with some being substantially watered down from their original proposal, notably private-sector involvement in the distribution of subsidised fertiliser. This almost led to the World Bank pulling out at one point. This means that some of the indicators are in fact used for aid negotiations for some donors and not for others. It is not clear how that affects negotiations. Although there are 29 official indicators, there are in effect a number of sub-indicators under each heading. The first indicator requires Malawi to be on track with the IMF PRGF for example, meaning that the multiple quantitative and structural conditions of the IMF programme are all subsumed under one indicator.

Annex 5: World Bank conditionality

World Bank Economic Policy Conditionality
Some of the conditions attached to Poverty Reduction Strategy Credit 1 & 2 and now part of the CABS donor group
Breaking up of State Marketing Board, ADMARC, with a commercial company, MAWATCO being set up to take on the 'commercial' aspects of ADMARC, with ADMARC remaining to service rural areas where there is little private sector penetration. There are two indicators under this CABS condition (i) MAWTCO established and operational in 2007 (ii) Substantial progress in ADMARC restructuring as proposed in the agreed business plans in 2007. Item (ii) refers to defining the 'social role' ADMARC will play. Only item (i) is a trigger condition for the PRSC (i.e. has to be delivered before Bank will release funding), arguably showing the priority the WB still gives to privatisation.
Other condition: Ensuring that at least 28 per cent of the distribution of fertiliser is by the private sector'. This condition was originally a lot stronger- 70 per cent on some reports, but was lowered following considerable resistance from government.
There are no social sector conditions in the World Bank PRSC apart from approval by cabinet of a new Social Protection Policy.

Source: World Bank (2007) International Development Association Program Document for a proposed grant in the amount of SDR 13.1 million for the first poverty reduction support grant: support to the Malawi growth and development strategy to the Republic of Malawi. Washington: World Bank

Annex 6: Interventions included in the EHP in the health SWAp

1. Prevention and treatment of vaccine-preventable diseases.
2. Malaria prevention and treatment – ITN promotion, Intermittent Presumptive Treatment (IPT), and case management.
3. Reproductive health interventions – including safe motherhood initiatives, essential obstetric care, and prevention of mother-to-child transmission of HIV.
4. Prevention, control, and treatment of tuberculosis and related complications.
5. Prevention and treatment of schistosomiasis and related complications.
6. Management of ARIs and related complications.
7. Prevention, treatment, and care for acute diarrhoeal diseases
8. Prevention and management of HIV and AIDS, sexually-transmitted infections, and related complications, including voluntary counselling and testing, and provision of ART.
9. Prevention and management of malnutrition, nutrition deficiencies (iodine, Vitamin A, Iron) and related complications, especially those associated with HIV and AIDS.
10. Management of eye, ear, and skin infections and related complications.
11. Treatment of common injuries – including emergency care for accidents and trauma, and their complications.

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Notes

[1] UNDP (2008) *Human Development Report 2007–2008*, New York: UNDP.

[2] *Ibid.*

[3] This is taken from 2007 World Development Indicators. Malawi is currently in the process of re-drawing the national accounts which have consistently underestimated GDP. GDP is likely to rise by 33 per cent as a result of widespread implications.

[4] UNDP (2005) *Human Development Report 2005*, New York: UNDP, Table 14, p. 280. Figure from this report.

[5] Malawi Government (2007) 'Malawi Government Budget Statement for 2007–2008 financial year', Malawi. Figure from this report.

[6] World Bank 'Fourth Country Assistance Strategy, 2007–2010', Washington: World Bank. Figure from this report.

[7] Figures from the IMF Poverty Reduction and Growth Facility.

[8] Malawi Government (2006) 'Annual Debt and Aid Report 2005–2006', Malawi. Figures from this report.

[9] Figures from the IMF Poverty Reduction and Growth Facility.

[10] Oxfam calculations based on Ministry of Health official statistics (September 2007), 'Report for the Health Sector Annual Joint Review'

[11] Malawi Government, Ministry of Health, 'Report For The Health Sector Annual Joint Review 2007', Malawi

[12] IMF (2006) 'Article IV Consultation and Third Review Under the Three-Year Arrangement Under the Poverty Reduction and Growth Facility', page 13 table on Malawi: Financing the MGDS, 2006-11, Washington: IMF

[13] Oxfam calculations based on – *ibid*.

[14] Oxfam calculations based on – *ibid*.

[15] The other programme run jointly by more than one Oxfam affiliate is in Honduras. Until recently Zambia was also a joint programme, and there are plans to return to this framework soon.

[16] Oxfam's GB's five aims are: the right to life and security; the right to a sustainable livelihood; the right to basic social services; the right to be heard and; the right to equity. Oxfam's work is grouped under these broad strategic aims.

[17] UNDP (2008) *op.cit.*, Table 10, p. 264.

[18] Figures taken from the Malawi Government, Ministry of Health (2006) 'Health sector Annual Report 2006' and the Malawi Government, Ministry of Health (2007), 'Report For the Health Sector Annual Joint Review 2007', Malawi

[19] National AIDS Commission.

[20] Figures from UNAIDS-Global Fund - http://www.theglobalfund.org/programs/countrystats/?lang=en&countryID=MLW (last accessed November 2008).

[21] Personal communication with NAC official, September 2007.

[22] Malawi Ministry of Health (2008) *SWAp Mid-Term Review Summary Report*, Malawi: Norad, p. 53. 2006.

[23] TRIPs is an agreement among members of the WTO to enforce stricter intellectual property regulations, including granting and enforcing patents lasting at least 20 years and copyrights lasting 50 years.

[24] A patent bar prevents the inventor of a new product or process from having exclusive rights to the manufacture, use, or sale of that invention.

[25] Louis-Lettington, R.A. (2004) 'A Survey of Policy and Practice on the Use of Access to Medicines-Related TRIPS flexibilities in Malawi', London: DFID Health Systems Resource Centre.

[26] Personal communication with NAC official, *op.cit.*

[27] Malawi Government, Ministry of Health, 'Report For The Health Sector Annual Joint Review 2007', Malawi.

[28] Interviews with Médecins Sans Frontières Official, (Chiradzulu, September 2007)

[29] McCoy *et al.* (2005) p. 6.

[30] *ibid*. p. 17.

[31]'The Global Fund [for HIV and AIDS, TB and Malaria] is taking away human resources from diseases such as malaria, and moving them to VCT [voluntary testing and counselling for HIV and AIDS] where there are funds', a donor representative quoted in Stillman, K and Bennett, S (2005) 'System-wide Effects of the Global Fund: Interim Findings from Three Country Case Studies', Maryland: Abt Associates, p. 30.

[32] World Bank (2007) 'Malawi Public Expenditure Review', Malawi: World Bank. 'Front line health workers exposed to unacceptably high risk of infection, further compounding staff attrition. 96 per cent of service providers perceive risk to themselves from HIV and IDS exposure, while 93.4 per cent perceive a risk to their clients. These fears are well founded given poor management and injection safety. Syringe re-use rates, particularly in immunisation programmes, were as high as 10 per cent, 49 per cent of health workers giving vaccinations, and 57 per cent giving curative injections, reported suffering at least one needle stick injury during the last 12 months. 1 per cent of all new HIV cases are through unsafe medical practices.

[33]Noten, S (2005) 'Deaths rob Malawi of warriors in its assault against AIDS', *The Toronto Globe and Mail*, 21January. Quote is from a technical advisor for the Malawi Ministry of Health.

[34] Interview and quotes with chairperson of the Nurses and Midwives Association, Malawi, September 2007.

[35] WHO (2006) 'Working together for health: the world health report 2006', Geneva: WHO. Oxfam calculations.

[36] Global Fund, Health Systems Support Proposal.

[37] *ibid.*

[38] World Bank (2007) 'Malawi Public Expenditure Review', Malawi: World Bank.

[39] *ibid.*

[40] Nurses and Midwives Council of Malawi (2006) 'Malawi Health Sector Report', Malawi, p. 25. Between 2002 and 2005, 386 Malawian nurses went to work overseas. Of these, 322 went to the UK (84 per cent). This represents approximately 10 per cent of all nurses working in Malawi (estimated at 3,477 in 2006).

[41] World Bank (2007) 'Malawi Public Expenditure Review', Malawi: World Bank. p.79, taken from Rashidi, Tambudzai (2003). Deployment of Reproductive Health Care

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[45] World Bank (2007) 'Malawi Public Expenditure Review', Malawi: World Bank, p82.

[46] McCoy *et al.* (2005) p. 6.

[47] Arrehag *et al.* (2006).

[48] Simwaka, B.N., Bello, G., Banda, H. Chimzizi, R., Squire, B.S.B., and Theobald, S.J. (2007) 'The Malawi National Tuberculosis Programme: An equity analysis', *International Journal for Equity in Health* 6(24).

[49] World Bank (2007) 'Malawi Public Expenditure Review', Malawi: World Bank

[50] Malawi Government, Ministry of Health (April 2007) 'Malawi Government Joint Country Programme Review', Malawi

[51] Conticini (2004)

[52] Figures from the Global Fund Health Systems Grant Proposal.

[53] Malawi Government, Ministry of Health, 'Report For The Health Sector Annual Joint Review 2007', Malawi.

[54] Malawi Government, Ministry of Health (April 2007) 'Malawi Government Joint Country Programme Review', Malawi

[55] World Bank (2007) 'Malawi Public Expenditure Review', Malawi: World Bank.

[56] However, this wage differentiation has been the source of dissatisfaction in the rest of the civil service, although it has not been a discernable source of overall wage pressure as yet. Those interviewed during the research welcomed the 52 per cent but drew attention to the fact that at the time it was implemented, overall reforms of government salary structures meant that allowances for items such as housing became taxable for the first time. This meant that many nurses saw very little improvement in their take-home pay.

[57] World Bank (2007) 'Malawi Public Expenditure Review', Malawi: World Bank.

[58] Interview with GFATM.

[59] Personal communication with an official from Research on Equity and Community Health, September 2007.

[60] Malawi Government, Ministry of Health, 'Report For The Health Sector Annual Joint Review 2007', Malawi Figure computed based on figures from this report.

[61] Interview with CHAM Training Coordinator, September 2007.

[62] Interviews with the chairperson of the Midwives and Nurses Association, Malawi, September 2007.

[63] Most respondents questioned were sceptical about the ability of NGOs to deliver services at scale. A number of respondents made the point that an assessment needs to

be made of the total capacity available nationally, and that expanded NGO provision means that health workers, for example, leave government to work for NGOs.

[64] M.Koivusalo, and M.Mackintosh (2004), 'Health Systems and Commercialisation: In Search of Good Sense'. Paper prepared for the UNRISD International Conference on Commercialization of Health Care: Global and Local Dynamics and Policy Responses www.unrisd.org, last accessed 28 October 2008. Private provision of health services can increase inequity of access because this naturally favours those who can afford treatment. Data from 33 low-and middle-income countries suggests that higher levels of private sector participation in primary health care are assocated with higher overall levels of exclusion of poor people from treatment and care.

[65] N. Brikci and M. Philips (2007) 'User fees or equity for low-income countries' *The Lancet* 369(9555): 10-11

[66] For a good overview of these plans see McCoy *et al.* (2005).

[67] The European Development Fund (EDF) is the main instrument for Community aid for development cooperation in the African, Caribbean, and Pacific countries and the Overseas Countries and Territories.

[68]IMF(2006) 'Malawi-Debt Relief at the Heavily Indebted Poor Countries Initiative Completion Point and Under the Multilateral Debt Relief Initiative', Washington: World Bank, table 10.

[69] Overall aid 2006–2010 is estimated at 24 per cent of GDP; of this, programme aid is 4.4 per cent (IMF, 2006)

[70] IMF (2006) 'Article IV Consultation and Third Review Under the Three-Year Arrangement Under the Poverty Reduction and Growth Facility', page 13 table on Malawi: Financing the MGDS, 2006-11, Washington: IMF. Figures drawn from this report.To implement the MDGs over the period 2006–2011/12 would require 188 per cent of GDP –net aid flows over the period are predicted to be 94 per cent of GDP

[71] OECD DAC survey, www.oecd.org/dataoecd/62/15/3898441.pdf

[72] A type of structural adjustment loan used to help finance a government's budget, for example, the World Bank's Poverty Reduction Support Credit.

[73] World Bank 'Fourth Country Assistance Strategy, 2007–2010', Washington: World Bank. All figures drawn from this report, apart from Global Fund, taken from DAC

[74] *Ibid.*

[75] A joint Evaluation of the General Budget Support commissioned by the donor agencies and seven partner countries in 2006 under the auspices of the OECD Development Assistance Committee.

[76] EC, DFID, Norwegian Embassy Malawi, and African Development Bank (2007) 'Common Approach to Budget Support (CABS) in Malawi – Norad Collected Reviews', Malawi: Norad

[77] MDRI provides full debt relief to poor countries so as to free up additional resources to help these countries reach the MDGs.

[78] IMF(2006) 'Malawi-Debt Relief at the Heavily Indebted Poor Countries Initiative Completion Point and Under the Multilateral Debt Relief Initiative', Washington: World Bank, table 2, p42. For comprehensive figures and a list of the PPEs see this report.

[79] Formerly known as the Civil Society Coalition for Quality Basic Education (CSCQBE).

[80] The Global Call to Action Against Poverty (GCAP) organises a worldwide protest on World Poverty Day on the 17th of November where millions worldwide are asked to 'Stand

Up' and read a pledge to show their support for an end to poverty. In 2006 23 million stood up worldwide, with 3 million coming from Malawi. See www.whiteband.org.

[81] Interview with the Malawi Government, Ministry of Finance, Budget Division, 26 September 2007.

[82] IMF(2006) 'Malawi-Debt Relief at the Heavily Indebted Poor Countries Initiative Completion Point and Under the Multilateral Debt Relief Initiative', Washington: World Bank, table 2, p42. For comprehensive figures and a list of the PPEs see this report.

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For further information on the issues raised in this paper please e-mail advocacy@oxfaminternational.org.

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