Analysis of the 2005/2005 Health Sector Budget

For

The Parliamentary Committee for Health and Population
National Assembly, Lilongwe

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By

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Promoting Participatory Economic Governance in Malawi

1. INTRODUCTION

The Budget Analysis Report was prepared by the Malawi Economic Justice Network for the Parliamentary Committee on Health and Population in response to the 2005/06 Budget presented to the National Assembly on 10th June, 2005. The report is intended to assist the Members of the Committee and all the Honourable Members of the House to have a better understanding of the budget. The report covers budgetary allocations to the entire health sector including HIV/AIDS. Coverage of the report is therefore limited to the budget analysis and does not intended to cover all the activities that the Committee has done throughout the financial year.

The Ministry of Health is no longer responsible for the portfolio of "Population" which has gone back to the Ministry of Economic Planning and Development [MEPD]. This budget analysis is only for the Ministry of Health and the National AIDS Commission [NAC].

2. SITUATIONAL ANALYSIS OF THE HEALTH SECTOR IN MALAWI

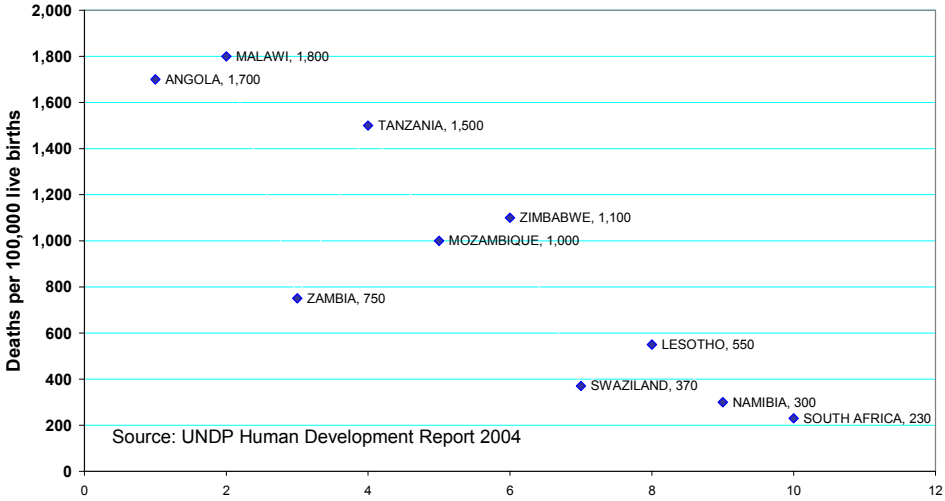
The health sector in Malawi is in deep crisis. The biggest crisis that the whole country is alarmed with is that of the **HIV/AIDS** which has very devastating effects on our population. However, it is **malaria** that remains the number one killer disease in Malawi. It is not the intention of this report to give all the health indicators. However, it is very important to recapitulate on the major indicators that are outstanding. The intention is not to alarm the members of the Committee but rather to help the author paint the correct picture of the nature of the crisis which Malawi finds itself in.

2.1 According to the World Bank ***crude death rate*** indicator (per 1,000 deaths from all the different causes of deaths per year), **the indicator for Malawi is 24.48, which is the highest crude death rate in the whole of Sub-Saharan Africa**. This is probably the most threatening indicator which tells us that we cannot just sit around and continue with business as usual. [See annexe 1].

2.2 Equally threatening is the ***maternal mortality rate*** which is the second worst in the World. The rate has deteriorated from 620 per 100,000 live births in 1990 to 1,120 in 2000 (Source Demographic and Health Survey, 2000). According to the most recent UNDP Human Development Report 2004, the adjusted rate for maternal mortality in Malawi is 1,800 for the year 2003, which is the second worst rate in the World. The worst case is Sierra Leone with 2,000 per 100,000 live births. This is the indicator that brings a lot of shame to this country and we need to do better that we have been doing in the past. Chart 1 compares the maternal mortality rates for the SADC region. As can be appreciated from Chart 1, Malawi can do better than the present position.

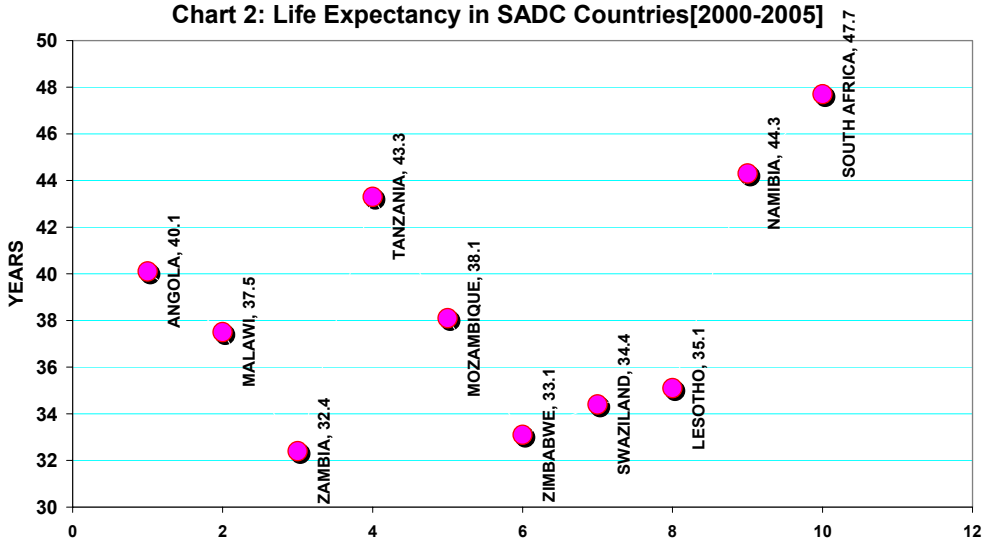
Malawi is doing rather badly in her efforts to achieve the MDG goal of 155 per 100,000 live births by the year 2015. Maternal Mortality rate is the MDG indicator that Malawi is very unlikely to achieve unless something drastic is done between now and the year 2015.

Chart 1: Maternal Mortality (adjusted rate) in SADC



2.3 Life expectancy in Malawi has worsened from the all time high of 51 reached in the 1980s to 37.4 in 2003. Again, this is not an indicator to be proud of as a country. Chart 2 shows that Malawi is somewhere in the middle when compared with other SADC Countries.

Chart 2: Life Expectancy in SADC Countries[2000-2005]



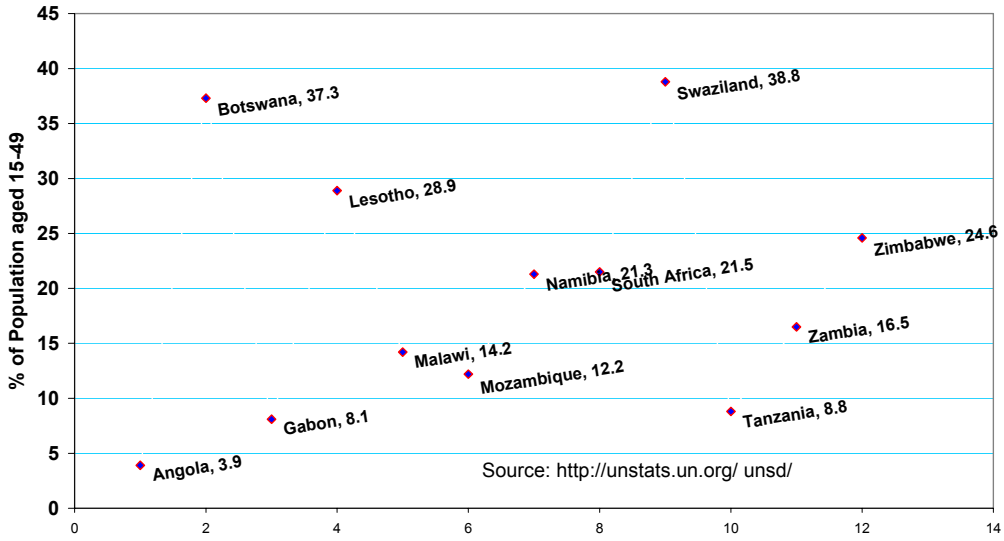
2.4 Malaria has been singled out as "*the most serious health problem facing Malawi today*". It remains the number one killer disease in Malawi. The 2000 Demographic and Health Survey estimated that the Government of Malawi spends US$2.7 million per annum in treating malaria cases, including both inpatients and outpatients. It is obvious that if we consider expenditure of NGOs, donors and private sector and individual households, then the figure could be much higher today. There are 8 million episodes

of malaria illness per year experienced by Malawi's population. About 40 percent of the deaths in children less than two years old are related to malaria.

The UN Global Fund for Malaria committed a total of $44 million for Malawi. Under the initial programme, the expected inflow from the Global Fund during the 2005/06 financial year is $10 million.

2.5 The HIV/AIDS prevalence rate in Malawi is officially at 14.9 of the population of ages 15-47. Chart 3 compares the HIV/AIDS prevalence rates for SADC countries. Malawi may not be the worst case in SADC but being 8th in the whole World is very serious indeed. The impact of AIDS is devastating to the whole economy. World Bank studies estimate that Malawi loses about 2% growth in the GDP due to the devastating effects of HIV/AIDS [World Bank, Country Economic Memorandum,2003].

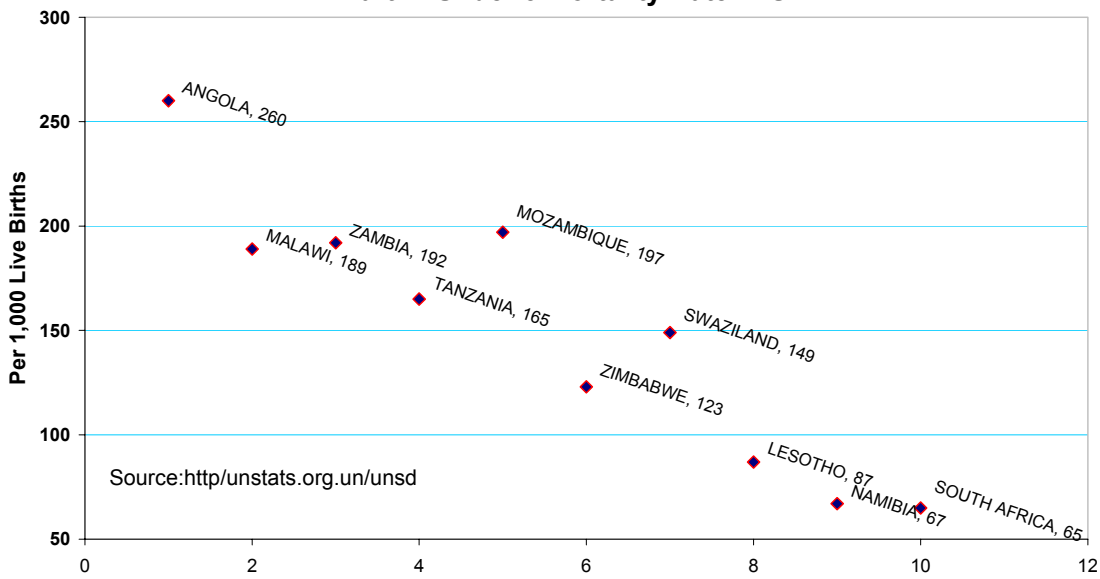
CHART 3: HIV/AIDS PREVALENCE RATE IN THE SADC REGION 2003



The HIV/AIDS prevalence rate is worse for pregnant women. The UNDP database estimates a prevalence rate of 18.0 percent for pregnant women in Malawi. This looks like a very conservative estimate because recent statistics reported in the press have mentioned rates of more than 50% in Thyolo, Mulanje and Chiradzulu. The message is very clear; HIV/AIDS is a disease we need to fight by providing adequate resources to the health sector. The UN Global Fund for HIV/AIDS committed a huge amount of $196 million over a period of 5 years for Malawi. Under the initial agreements, the expected inflow from the Global Fund in 2005/06 is $28.2 million.

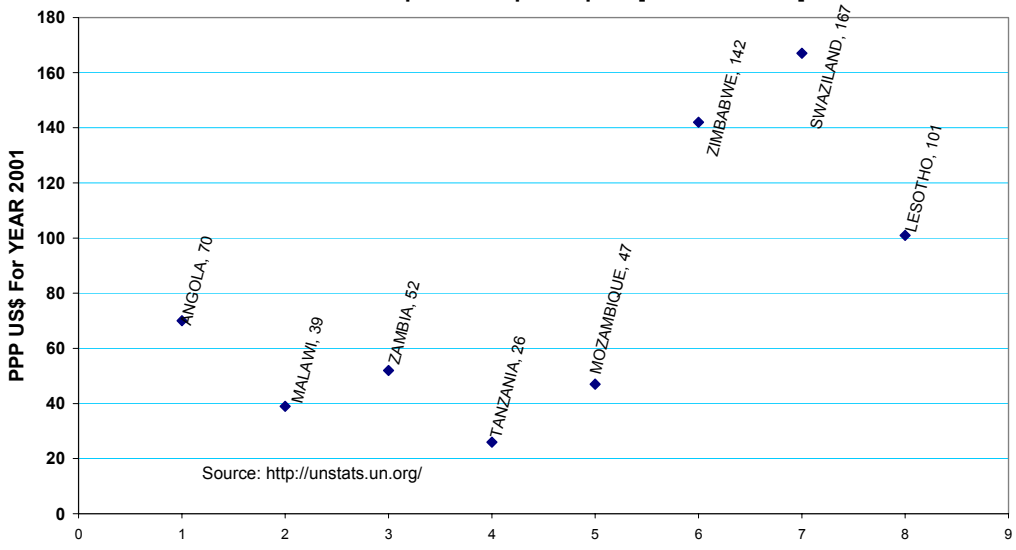
2.6 The Under-Five Mortality Rate [UFMR] for Malawi is 189 per 1,000 (DHS 2000). This is a very high rate when compared with other SADC countries. Under the Millennium Development Goals (MDGs), Malawi aims at achieving a UFMR of 150 per 1,000 by 2007/08. Chart 4 compares Malawi's UFMR with those of other SADC Countries.

Chart 4: Under 5 Mortality Rate in SADC



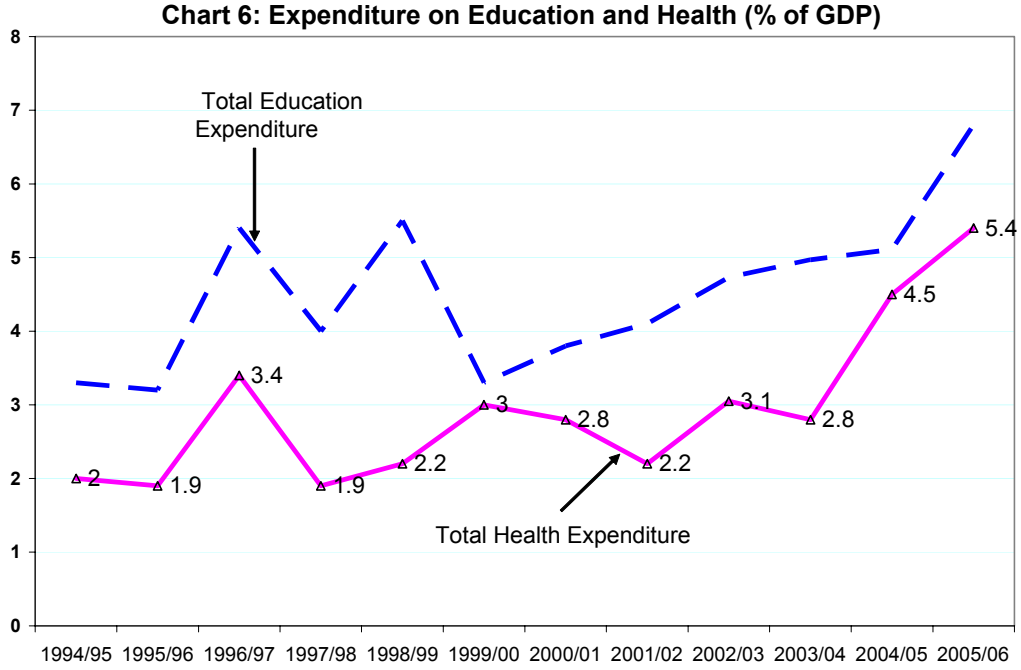
2.7 All the health indicators given above are just but a few that show the very disturbing situation in which Malawi finds itself. What has the Malawi Government done in response to the worsening situation in mortality rates? The per capita expenditure to health is one such indicator that shows the government efforts towards the health sector. Chart 5 compares Malawi's per capita expenditure to those of other southern African countries. It shows that the expenditure in Malawi is the second lowest of 8 countries; the lowest being Tanzania.

Chart 5:Health Expenditure per Capital [PPP US$ 2001]



The other way of measuring the dedication of government to solve the problems in the health sector is by calculating the ratio of total health expenditure to GDP. The calculation is done in Chart 6 for the social sectors of Health and Education. There is a steady growth in both ratios. It has been Government policy to see to it that the social sectors of Health and Education are allocated more and more resources. The only snag is that more and more of the financing directed towards the social sectors emanates from outside the country thereby increasing the dependency rate and vulnerability of the social sectors. The total expenditure on health excludes funding that goes towards HIV/AIDS. If all the money spent on HIV/AIDS is to be included in the 2005/08 financial year, then the ratio to GDP would increase to 8.3 percent

Chart 6: Expenditure on Education and Health (% of GDP)



2.8 Before analysing the 2004/05 financial year, it would be of importance to recapitulate on the institutional structure of the health sector in Malawi. Government runs 392 facilities which include clinics; district hospitals etc [see Table 1]. Apart from these institutions, there are a lot of private health centres all over the country. Those that are neither affiliates of CHAM but are privately owned are not counted in the total number of institutions that adds up to 617 as shown in Table 1.

The Malawi Government went into service agreements with CHAM whereby the Malawi Government pays salaries for all health workers affiliated to CHAM hospitals. Furthermore, Government of Malawi contributes K200,000 towards the training expenses of every CHAM student. According to some officials of the Ministry of Health, this arrangement is meeting several challenges among which are the following:-

[a] The CHAM health workers who get their salaries from government are also paid additional allowances and some benefits by CHAM. When compared with civil servants, the health workers under CHAM are going with better packages in the end. As a result, there are a lot of civil servants who are leaving to join CHAM hospitals for better perks.

[b] Some of the CHAM students are made to pay extra fees on top of the K200,000 contributions given by Government. CHAM officials deny that such a thing is happening but reports to the Ministry of Health support that indeed, some schools demand extra fees.

TABLE 1: NUMBER OF MAJOR HEALTH FACILITIES IN MALAWI

TYPE	BLM	CHAM	LG	MOH	NGO	Total
CLINIC	27	8	4	2	1	**42**
DISPENSARY	-	8	4	54	-	**66**
DISTRICT HOSPITAL	-	-	-	22	-	**22**
HEALTH CENTRE	1	115	12	288	-	**416**
HOSPITAL	-	27	-	19	-	**46**
MATERNITY	-	1	12	2	-	**15**
MENTAL HOSPITAL	-	1	-	1	-	**2**
REHABILITATION CENTRE	-	1	-	-	-	**1**
VCT CENTRE	-	-	-	-	3	**3**
TOTAL	**28**	**161**	**32**	**392**	**4**	**617**

Source Budget Document No.4 page 353

BLM= Banja la Mtsogolo
CHAM= Christian Hospitals Association of Malawi
LG= Local Government
MoH = Ministry of Health
NGO = Non-governmental Organisation

Beginning this year, Government is entering into service agreements with CHAM hospitals whereby the latter treat patients freely and charges government for the services rendered. This arrangement will be more encouraged under the decentralised system whereby District Assemblies will be enter into service agreements with CHAM and other private health service providers. These arrangements will be very important wherever it is obvious that public institutions can not suffice to render all the services demanded by the local population. Under such understanding, Dowa District Assembly is finalising arrangements with Ntengowanthenga Hospital to provide free services to patients and to bill the District Assembly for the services rendered. Such arrangements have already been applied for anti-natal services where government subsidises an amount of K50 per pregnant women per delivery. The system has had very successful results in that there are more women delivering their babies in proper clinics.

There is need to strengthen the monitoring within the Ministry to check on some institutions who are selling free drugs that have been donated by either the Malawi Government or by other donors. There is apparent abuse which needs to be checked before the system gets entrenched.

As for ambulances that government donates to CHAM to improve the delivery of health services, it is understood that some CHAM affiliates are

charging a token fee of K50 per Km for the patients who hire the ambulances. There is a lot of resistance from people who are resisting paying the fee on the grounds that the ambulances are donated by Government. Government policy is that the institutions can demand the patients to pay a little something as their contribution towards the running costs of the ambulance. It is only where CHAM hospitals would be charging market rates that carter more than the running costs of the ambulances that the Ministry of Health would have an objection.

3. REVIEW OF 2004/05 HEALTH BUDGET

In 2004/05, total approved budget to the Ministry of Health was K9.138 billion, of which K4.849 was total recurrent budget and K4.289 billion was development budget. The recurrent budget was broken down into personal emoluments (K1.99 billion) and ORT for K2.86. Revised figures show that total expenditure for the Ministry went beyond the approved amount by 4 % to K9.5 billion.

Table 2: 2004/05 Recurrent Budget by Programme

	2004/2005 Approved	2004/2005 REVISED	% Over	2005/2006 Estimate	Estimate / Approved	Estimate / revised
	K	K		K		
01-Administration and support services	924,015,965	1,244,672,384	34.7	3,068,561,252	232.1	146.5
07-Curative Health services	2,391,462,118	3,120,454,132	30.5	1,833,294,265	-23.3	-41.2
13-Environmental Management	300,617,489	325,356,442	8.2	267,938,103	-10.9	-17.6
22-Information and Communication Technology	15,499,596	20,201,410	30.3	20,712,641	33.6	2.5
23-Infrastructure Development Rehabilitaion	125,696,632	167,291,769	33.1	251,004,175	99.7	50.0
27-Manpower development	256,000,000	348,374,825	36.1	763,954,439	198.4	119.3
28-Media and Information	9,920,980	13,291,806	34.0	29,442,081	196.8	121.5
30-Nutrition and Food Security	67,468,075	89,431,935	32.6	158,428,342	134.8	77.1
31-Planning Services	22,517,651	29,103,160	29.2	34,943,449	55.2	20.1
32-Preventive Health Service	121,818,061	155,928,790	28.0	236,866,579	94.4	51.9
35-Research, Technology Generation and	1,594,954	2,051,911	28.7	3,033,842	90.2	47.9
44-Technical Support	612,388,524	904,428,289	47.7	314,773,689	-48.6	-65.2
Total	**4,849,000,000**	**6,420,586,853**	32.4	**6,982,952,857**	44.0	8.8

Source: Budget Document No.5 Vol.II page 1370

Personal emoluments overshot mostly because of the general increase in the salaries of all health workers implemented in October 2004 and the 52% salary top-up to technical staff that became effective on 1st April 2005. The salary top- up which was supposed to be for all technical staff was done in a phased manner so much so that the measure has still not yet been implemented to some eligible members of staff. The Ministry just managed to convince the belligerents not to go on strike but the threat of them doing so still lingers.

The revised figures for 2004/05 show that total recurrent expenditure overshot by 32.4 percent to K6.42 billion. Table 2 shows that the over-expenditure was in all the budget lines of the recurrent budget. The highest overrun was in *Technical Support* which spent 47.7 % more than the approved amount.

The 2004/05 Development Budget was approved as K4.289 billion. However, the breakdown of projects given in 2004/05 Approved Budget Document No4

Page 294, the actual total was to be K6.658 billion. Details of the development budget are as presented in Table 3 below. As can be appreciated from the table, the approved amount for the 2004/05 development budget should have been K6.658 billion and not K4.289 billion as indicated in the budget documents. This shows a common mistake that is usually made by the Ministry of Finance by not including all donor-funded projects in the development budget. In fact, the total of the PSIP prepared by the Ministry of Economic Planning and Development usually differs with the figures in the budget documents.

Table 3: PROJECTS UNDER THE DEVELOPMENT BUDGET FOR 2004/05

Programme / Project Title	Funding Agency	ESTIMATE 2004/05		
		Part 1	Part II	Total
Rural Health Care III	ADF/MG	1,095,225	39,674	1,134,899
Medical School Project	MG		15,512	15,512
UNFPA/WHO Support to Reproductive Health		451,267		451,267
DFID Support to Reproductive Health		1,176,278		1,176,278
USAID Support to reproductive Health		1,297,330		1,297,330
Support to NACP	ADF/MG	552,500		552,500
Medical Council Office Block	MG		33,000	33,000
Upgrading/ rehbilitation of Health Centres	MG	2,500		2,500
Replacement of Zomba Central Hospital	MG/ KFW	63,000		63,000
Maintenance Work at Central Hospitals	MG		30,000	30,000
Maintenance Work at DistrictHospitals			40,000	40,000
Dialysis machine for QECH	MG		30,000	30,000
New Blantyre District Hospital	Libya/ MG	113,322		113,322
New Phalombe District Hospital	BADEA/MG	500,000		500,000
New Balaka District Hospital	BADEA/MG	500,000		500,000
New Mortuary at Balaka and Chikwawa	MG		3,500	3,500
New Nkhotakota District Hospital	OPEC/MG	645,000	70,000	715,000
TOTAL		6,396,422	261,686	6,658,108

Source: 2004/05 Budget Document No.4 Approved Budget Page 294

According to information gathered from the Ministry of Health Headquarters, the total resource package for the year 2004/ 05 was K17.857 billion (including K3.438 billion from the Global Fund for the National AIDS Commission (NAC). Table 4 gives the sources of funding per donor.

TABLE 4: TOTAL FINANCING TO THE HEALTH SECTOR				
	2002/2003	2003/2004	2004/2005	2005/2006
Funding Agent	Kwacha	Kwacha		
ADF	94,436,981	583,782,882	1,583,340,000	
CIDA	278,278,424	562,436,718		
DFID	1,715,713,570	2,500,619,541	2,178,396,000	1,764,882,000
EU	108,130,179	157,409,227	181,610,000	189,865,000
GTZ	225,525,131	228,315,231		
GTZKFW			117,040,000	226,550,000
ICEIDA	45,773,449	47,299,150	47,850,000	70,150,000
JICA	78,801,707	123,579,430	51,700,000	32,200,000
KFW	280,465,251	340,016,275	0	
NAC	0	0	3,438,944,740	3,775,023,431
NORAD +SIDA	1,172,803,024	1,991,508,508	699,977,190	115,821,445
NORAD+SIDA SWAps			440,000,000	1,478,571,560
UNDP	56,894,057	103,676,300		
UNICEF	1,126,154,250	1,451,468,200	2,200,161,810	1,521,434,366
UNFPA			68,594,020	19,404,985
USAID	1,288,621,492	1,542,234,209	1,540,964,552	1,691,558,814
WB	33,729,457	301,380,534		1,150,000,000
WFP	0	0		
WHO	86,627,250	0	129,031,722	134,896,800
CDC			330,902,990	221,214,000
GoM	3,529,169,700	3,654,299,584	4,849,000,000	6,027,857,960
TOTAL	**10,121,123,922**	**13,588,025,789**	**17,857,513,024**	**18,419,430,361**

Source: Budget Document and Ministry of Health [Planning Department]

The outputs that were not achieved during the 2004/05 financial year are numerous. In the recurrent budget, the outputs that were either not done or those that were carried forward to the 2005/06 fiscal year are as follows:-

- Develop and operationalise a personnel management policy in light of the Essential Health Package (EHP) – not done. Rescheduled to 2005/06
- Use of computers in information management by key administrative staff in all cost centres by June 2005 – rescheduled to 2005/06
- Robust and desired financial management services provided – not fully achieved, will be implemented in 2005/06
- Financial audit systems in MoH and CHAM strengthened – not achieved. Rescheduled to 2005/06.
- Zonal Support Services put into operation – Not yet operationalised – staffing problems
- Provide adequate ambulances and other utility vehicles for hospital operations – Not fully achieved – most cost centres operating at 50-60% capacity.

In the development budget, the outputs that were reported on and not finalised are as presented in Table 5

Table 4: PROJECTS UNDER THE DEVELOPMENT BUDGET FOR 2004/05			
Programme / Project Title	**OUTPUTS**	**Output Indicator**	**Achievement**
Rural Health Care III	1.Access to health care enhanced	22 Rural Health centres	Nearly completed
Medical School Project	Development of College of Medicine	2 laboratories and 2 students	Partly done - insufficient funding
UNFPA/WHO Support to Reproductive Health			Not reported on
DFID Support to Reproductive Health			Not reported on
USAID Support to reproductive Health			Not reported on
Support to NACP	Support to NACP		Done
Medical Council Office Block			Not done
Upgrading/ rehabilitation of Health Centres	Health centres upgraded	20	Not done
Replacement of Zomba Central Hospital	Construction of New Hospital	New Hospital constructed	Underway- insufficient funding
Maintenance Work at Central Hospitals			Partly done
Maintenance Work at DistrictHospitals			Underway- insufficient funding
Dialysis machine for QECH	Dialysis unit estaablished	2 units	Underway- donation by Spain
New Blantyre District Hospital	New Hospital Constructed		Preparations Underway
New Phalombe District Hospital	New Hospital Constructed in Phalombe	1	Not done - no funding
New Balaka District Hospital	New Hospital constructed in Balaka	1	Not done - no funding
New Mortuary at Balaka and Chikwawa	New mortuaries in Balaka and Chikwawa Hospitals	2	Not done - no funding
New Nkhotakota District Hospital	New Hospital built in Nkhotakota	1	Underway - delayed due to lack of

Most of the projects in the development budget for 2004/05 were either not done or were not completed because of lack of funding. What is interesting is that even for donor-funded projects like the New Blantyre District Hospital, funding is still a problem.

The outputs which were completed during the 2004/05 financial year were:-

- 1,817 health workers of various cadres were trained
- Recruitment of new Health Surveillance Assistance (HSAs) - 1,000 HSAs in 26 districts (38 per district and two more in Bt, Za, LL, KU, Mz, KA)
- Under the Rural Health Care III - 22 rural Health centres in 5 districts have their infrastructure improved.
- The Drug Control System was strengthened and standard operation procedures were developed for logistics management including tracking of supplies from CMS to the service delivery points.
- New 300 bed district Hospitals at Chiradzulu and Thyolo were finalised and opened
- 18 health centres and a student hostel at Mzuzu Hospital were completed
- Construction work at Chitipa District Hospital and six health centres in the district were completed

- ☞ 48 ambulances and other utility vehicles were procured and distributed to districts, central hospitals and the Central Medical Stores.

4. ANALYSIS OF THE 2005/06 PROPOSED BUDGET

The 2005/06 budget has a total of K18.4 billion to the Health sector, of which K5.3 billion is funding to the National AIDS Commission. Recurrent expenditure to MoH is K6.982 billion. However, K4.07 billion will be allocated to District Health Offices (DHOs). This brings the total recurrent budget to K11.0 billion. The breakdown of the origin of the K18.4 billion to the health sector is as tabulated in table 4.

Some contributions by donors have not yet been factored into the budget because of the uncertainties surrounding the exact amounts of the funding. The ones who are likely to contribute something but have not yet been included are:- The Malaria Global Fund, WFP, KFW, ADF, and CIDA. It is therefore most likely that the amount of resources to the budget may increase once the exact amounts from these donors are known.

The most important change that has happened to the health sector beginning this year is the decentralisation of resources to district assemblies. District Commissioners and Chief Executives of town and city assemblies have been made signatories. This is a very important policy shift intended to bring public resources close to the people.

	Table 5 : Summary of Health Budget to District											
	DISTRICT	DRUG (inc. vaccines)	Medical and Lab Supplies	Medical Equipement	Motor Cucle Ambulance	Infrastructure	Bed and linen	Uniforms & Protective Clothing	Other Services	Total Health Budget for District	TOTAL BUDGET	Heath as Percent of Total DA
1	BALAKA	31,201,796	9,905,332	27,667,901	1,380,000	2,225,640	2,002,000	1,001,000	43,683,238	119,066,907	149,929,498	79
3	BLANTYRE	108,480,921	34,438,388	27,212,492	1,380,000	18,049,405	4,011,000	2,005,500	74,317,767	269,895,473	309,758,621	87
5	CHIKWAWA	44,865,452	14,285,001	27,749,577	1,380,000	13,350,094	2,457,000	1,228,500	43,638,599	148,954,223	188,171,127	79
6	CHIRADZULU	28,908,283	9,177,233	20,645,674	1,380,000	6,832,334	2,359,000	1,179,500	46,480,900	116,962,924	148,004,988	79
7	CHITIPA	16,115,909	5,116,162	19,498,879	1,380,000	7,416,405	2,016,000	1,008,000	37,779,757	90,331,112	115,764,534	78
8	DEDZA	61,458,217	19,510,545	23,107,335	1,380,000	8,331,500	3,045,000	1,522,500	64,876,097	183,231,194	225,611,496	81
9	DOWA	49,598,552	15,745,572	22,271,967	1,380,000	23,609,000	3,171,000	1,585,500	50,316,505	167,678,096	207,846,983	81
10	KARONGA	24,278,301	7,707,397	19,861,469	1,380,000	3,220,300	2,016,000	1,008,000	42,300,951	101,772,418	132,034,871	77
11	KASUNGU	62,168,541	19,736,045	23,169,347	1,380,000	19,125,054	2,233,000	1,116,500	50,549,968	179,478,455	224,993,500	80
12	LIKOMA	1,040,260	330,241	8,000,000	1,380,000	5,187,479	560,000	280,000	7,925,817	24,703,797	33,270,216	74
13	LILONGWE	181,621,698	57,657,682	33,597,797	1,380,000	20,894,456	4,921,000	2,460,500	95,141,969	397,675,102	478,121,336	83
14	MACHINGA	44,075,335	13,992,170	21,589,782	1,380,000	2,096,490	2,478,000	1,239,000	57,922,615	144,773,392	180,247,805	80
15	MANGOCHI	75,062,028	23,866,215	24,294,969	1,380,000	10,630,777	3,381,000	1,690,500	65,912,329	206,217,818	259,360,440	80
16	MCHINJI	41,708,679	13,240,851	22,775,169	1,380,000	4,861,057	2,457,000	1,228,500	45,795,172	133,446,428	174,346,764	77
17	M'MBELWA	74,016,068	23,497,165	24,203,655	1,380,000	23,667,908	3,745,000	1,872,500	62,471,507	214,853,803	274,327,156	78
18	MULANJE	53,469,342	16,974,394	22,409,893	1,380,000	3,814,555	2,835,000	1,417,500	64,329,861	166,630,545	212,820,106	78
19	MWANZA	17,176,434	5,452,836	19,241,465	1,380,000	4,274,050	2,107,000	1,053,500	60,980,371	111,665,656	135,515,326	82
20	NKHATA BAY	19,832,708	6,296,098	19,986,720	1,380,000	2,154,900	2,170,000	1,085,000	48,074,629	100,980,055	129,203,961	78
21	NKHOTAKOTA	29,047,604	9,221,462	20,657,837	1,380,000	4,469,517	2,156,000	1,078,000	46,243,500	114,253,920	148,969,311	77
22	NSANJE	23,566,078	7,481,295	20,312,649	1,380,000	3,054,900	2,135,000	1,067,500	50,926,482	109,923,904	143,698,741	76
23	NTCHEU	46,806,863	14,859,322	21,828,248	1,380,000	2,648,372	3,087,000	1,543,500	69,911,861	162,065,166	198,779,426	82
24	NTCHISI	21,953,231	6,969,280	19,658,487	1,380,000	2,651,000	2,002,000	1,001,000	45,409,471	101,024,469	132,008,669	77
25	PHALOMBE	29,557,391	9,383,299	20,322,342	1,380,000	2,026,004	2,009,000	1,004,500	42,816,453	108,498,989	141,327,156	77
26	RUMPHI	15,415,929	4,893,946	19,231,770	1,380,000	18,063,350	1,918,000	959,000	28,507,585	90,369,580	117,396,148	77
27	SALIMA	32,601,229	10,349,597	21,054,792	1,380,000	16,014,185	2,835,000	1,417,500	61,062,865	146,715,168	178,329,369	82
28	THYOLO	56,953,624	18,080,515	22,714,077	1,380,000	3,000,000	3,052,000	1,526,000	69,376,371	176,082,587	216,740,377	81
29	ZOMBA	69,019,525	21,910,960	24,067,449	1,380,000	7,319,233	2,842,000	1,421,000	59,693,755	187,653,922	234,575,146	80
TOTAL MINISTRY		**1,259,999,998**	**400,079,003**	**597,131,742**	**37,260,000**	**238,987,965**	**70,000,000**	**35,000,000**	**1,436,446,395**	**4,074,905,103**	**5,091,153,071**	**80**

Source: Ministry of Health Headquarters

Table 5 gives the breakdown of the health budget to districts. **The total amount that will be transferred to district assemblies is K5.091 billion**. Ministry of health alone is transferring K4.074 billion to district assemblies representing 80 percent of total resources to be transferred to district assemblies. Table 5 gives details of how the resources to each district assembly will be broken down into the different budget lines.

Total budget for drugs in the 2005/06 Budget is K1.8 billion, up from K1.5 billion last year. Table 5 shows that K1.26 billion will be used to buy drugs destined for distribution in the district assemblies. The K1.26 represents 70 percent of the total budget for drugs. The difference will be for drugs to be used in central hospitals and the mental hospital. For administrative reasons, the procurement of the drugs will still be administered by the Ministry Headquarters. It is hoped that purchases in bulks will benefit from reduced prices and other benefits linked to economies of scale.

The Ministry of health requested for K50.0 million to buy bed nets. However this is not provided for in the budget because the ceiling given by the Ministry of Finance could not accommodate the said budget item.

According to the Ministry of Health the required estimate for medical and laboratory supplies was K840. 0 million. However, the ceiling only allowed for K350.0 million. The ministry pushed for the ceiling to be raised to K400.0 million and was successful. However, there is a danger of having this budget reduced from the present K400 million.
The Ministry of Health has been directed to include the purchase of 50 ambulances in this years budget. However, the money for the purchase of the ambulances has not been provided. The Ministry estimates the cost of the 50 ambulances to be around K320 million. Given that this is a directive to the Ministry, the Controlling Officer may be forced to try to get the resources by reducing another budget item. Strictly speaking, there is no budget line that can be tampered with in order to accommodate the purchase of the 50 ambulances. If anything, it will be the budgets for "*Medical and laboratory Supplies*", "*Medical Equipment*" and/or "*infrastructure*" that may suffer the chop. However, doing that would be doing great injustice to these budget lines which are already at their minimum.

Last year there were 48 ambulances purchased and distributed. This year, the Ministry has budgeted for motor cycle ambulances for every district assembly (see table 5). There is very high probability that through the African Development Fund (ADF) and the Malaria Global Fund, Malawi is likely to get about 60 ambulances in the course of this financial year. The professional advice from the officers within the Ministry of Finance is that the purchase of the 50 ambulances should either wait or the number should be reduced. The other option is just to leave all the other budget lines intact and provide for an extra K300 million in the budget for the purchase of the 50 ambulances.

Recommendation: The Ministry of Health has been directed to buy 50 ambulances but funding for that has not been included in the budget. For the Ministry to buy the ambulances, it would mean cutting some budget lines to accommodate the ambulances. However, there is no budget line that can be reduced without causing major imbalances. There are two options that would make sense. The first option is for the Ministry to wait for the offers from the Global Fund and the ADF to materialise in which case there would be no need to buy the ambulances. This option goes with the consideration that there were already 48 ambulances bought last year and most of them are still in good condition. Furthermore, the motor cycle ambulances which will be bought for every district assembly are very efficient and can go to places where even a 4X4 ambulance can not reach. The purchase of the 50 ambulances would therefore not be a top priority as at now.

The second option is simply to request the Minister of Finance to provide more resources (K50 million) to the Ministry to enable it to purchase the 50 ambulances without having to tamper with any budget line.

5. ISSUES TO BE CONSIDERED BY THE HEALTH COMMITTEE

5.1 LOBBY FOR THE INCREASE IN THE BUDGET TO INCLUDE THE PURCHASE OF 50 AMBULANCES.

Officials from the Ministry of Health say that the directive to include the purchase of 50 ambulances came from the Minister of Finance. It is surprising that the directive came without the supporting budgetary provision. The Minister of Health should be queried where the directive came from and why the Minister of Finance (if the directive came from him) can not just provide the resources for the 50 ambulances.

5.2 SHORTAGE OF DRUGS IN HOSPITALS

It is a bit comprehensible when drugs are in short supply because of lack of resources to purchase more. However, it is totally unacceptable for suppliers to be paid money without honouring their contract. There are such cases happening in the Ministry. One case reported in the press is that of a certain businessman in Blantyre (Mr Mathumula). There is another case of a supplier based in Malawi but of foreign origin who did not supply drugs after receiving payment (Bisnowarty). These people have to be probed.

5.3 PILFERAGE OF DRUGS

The law should be very stiff to those who misappropriate drugs in any way. There are still cases of officers stealing drugs or diverting them to their private clinics. The budget documents say that the Drug Control System has been strengthened and that standard Operation procedures have been developed. The Committee should demand an explanation on how the system has bee n strengthened.

5.4 MILLENNIUM DEVELOPMENT GOALS: MATERNAL MORTALITY

It is very shameful for Malawi to have such alarming maternal mortality rates. Government needs to have a deliberate policy to address this problem in the immediate. This year's budget does not treat the problem as an urgent matter because it gives no special attention in the budgetary allocations. The recommendation from the MDG report is for countries to include a strategy on the attainment of MDGs in the budget. Malawi has not done that. The Minister of Finance should be asked about Government's strategy to attain the MDG of maternal mortality.

5.5 PPES TO INCLUDE HEALTH WORKERS' SALARIES

Health workers' salaries were included in the original list of protected pro-poor expenditures (PPEs). However, they have since been excluded. This has resulted in delays in the payment of salaries to some staff. By protecting the salaries as PPEs, we would be sure that the salaries get the priority they deserve and that there will be no more delays in the payment of salaries.

5.6 The 52% Salary top-up to all technical staff in the health sector was meant to apply to all staff in that category. However, some eligible health workers have not yet received their dues up to now. They are threatening strikes and a solution needs to be found as soon as possible. This policy only affected the civil servants employed by the Ministry of Health. However, there are some health workers working under other arms of Government like the Army and the Police who are demanding equal treatment. Government should clearly state its policy and make it equitable.

5.7 TAXATION ON PHARMACEUTICALS

Previously because pharmaceutical finished products were zero rated the local manufacturers were allowed to reclaim input VAT on raw materials and packaging materials. Because of the change of pharmaceutical and medical services, from zero rated to exempt status, the manufacturers are now obliged to pay VAT without refund.

The impact of such a change is: -

1. Local manufacturing is disadvantaged in comparison with local importers whose position has not been changed by the amendment because VAT paid by manufacturers on input of raw materials will be an additional cost whereas importers do not pay any VAT and hence will now enjoy an advantageous position over the manufacturers. The Government has always said it wishes to encourage local manufacturing but this change will have the opposite effect.

2. Local manufacturers will be disadvantaged when compared with both local and foreign finished goods suppliers when competing for the Government tender business because the increases in input costs will

inevitably result in the need to increase tender prices for locally manufactured goods.

3. Having recently been awarded a tender contract by the Government, the industry will be forced to request an increase in the tender prices as provided under the conditions of the tender bid document to compensate them for increased input costs.

4. Pharmaceutical manufacturing businesses will be forced to consider increases to their trade selling prices to reflect increased input costs, thus making locally produced medicines more expensive and less affordable to the Malawian people and less competitive when compared with imported products.

5. The pharmaceutical manufacturing industry by its nature requires substantial investment in buildings, plant and machinery when compared with a wholesale operation. By its nature it also employs many more Malawians and hence pays more taxes. It is thus inequitable that as manufacturers they are disadvantaged by this amendment. The amendment acts as an incentive to concentrate on wholesale importing only and to close local manufacturing facilities. This is a most unfortunate development particularly since recently Government requested the local manufacturers to start to work together on a proposal to locally manufacture ARVs here in Malawi.

5.8 CONSTRUCTION OF BLANTYRE DISTRICT HOSPITAL

There are no funds committed by LIBYA for the construction of the Hospital. Does this mean that Malawi will go it alone?

5.9 SYSTEMS OF FINANCIAL CONTROL IN THE DISTRICT ASSEMBLIES

The amount of money to be administered by district assemblies is a lot. There are currently not enough personnel with adequate skills to run the financial management efficiently and effectively. Funds to the health sector constitute 80 percent of the total funds to be transferred to the district assemblies. The stake is very high for the Ministry of Health to make sure that the system if free of fraud, corruption and financial mismanagement. The budget does not include money to strengthen the financial systems.

5.10 MALARIA PROJECT

Malaria remains the number one killer disease in Malawi. For Government to allocate only K7 million to the Malaria Control Programme is a mockery.

5.11 HOW MANY HEALTH WORKERS DOES THE MINISTRY INTEND TO TRAIN THIS YEAR

The budget documents are not very clear on how many health workers the Ministry intends to train during the 2005/06. There is need to demand the breakdown for each category of health workers.

5.12 HAS THE SALARY INCREASE AND SALARY TOP UP ACHIEVED THE OBJECTIVE OF INCREASED RATE OF RETENTION?

There is need to know whether the retention rate of health workers has increased following the salary increase and the 52% salary top-up for technical staff.

5.13 ZONAL SUPPORT SERVICES

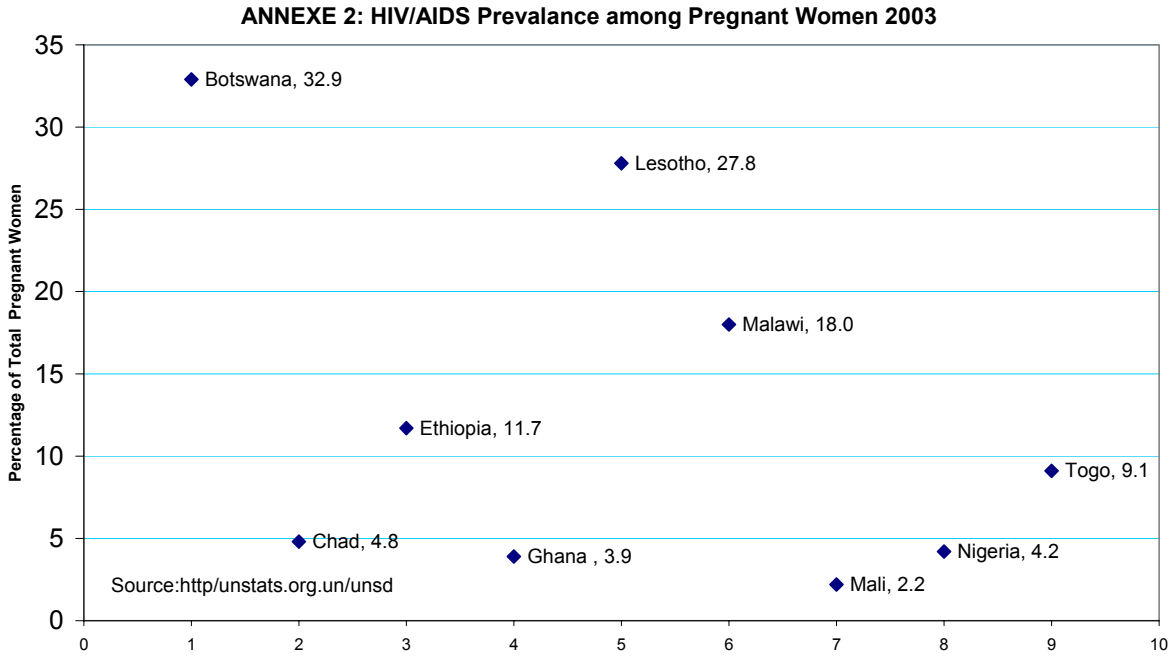
There will be 5 Zonal Support Centres in the country. USAID has shown interest to run finance the running of two zonal support centres and KFW will be running the one in Zomba. This leaves only one to be financed by the Malawi Government. When will these centres become operational? Is the money in the budget just for one centre or for all the 5 centres?

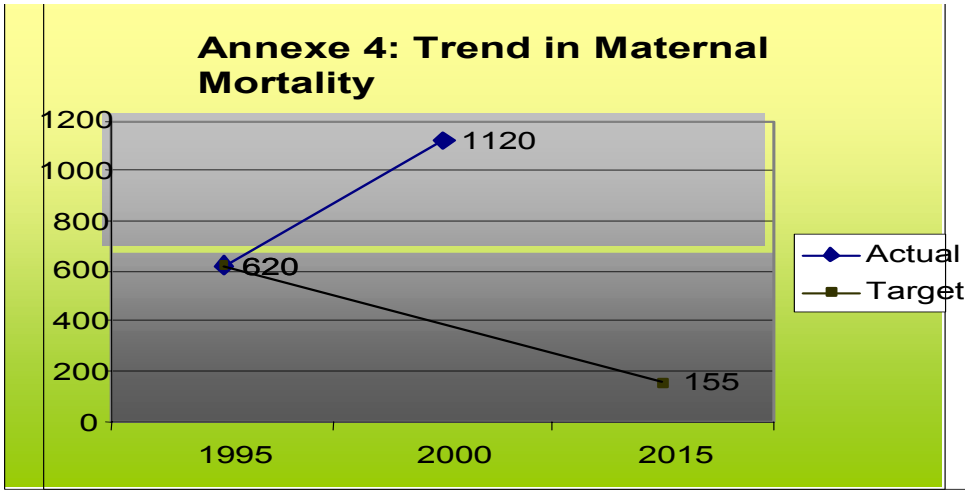
5.14 DEPARTMENT OF NUTRITION AND HIV/ AIDS

Government has decided to create a new department within OPC called "Department of Nutrition, AIDS/HIV and National AIDS Commission. The move is not popular among staff of NAC and officers in the Ministry of Health. It is felt that the creation of a department within OPC will just create more bottlenecks to the implementation of programmes. Moreover, the TORs of the Department do not seem to justify the creation of the department. The Health Committee need to have a stand on this.

ANNEXE 1: SOCIAL INDICATORS FOR SUB-SAHARAN AFRICA

		Death rate, crude (per 1,000 people)	Illiteracy rate, Adult Male	Illiteracy rate, Adult Total	Life Expectancy at birth
		2001	**2001**	**2001**	**2001**
1	Algeria	5.22	22.852	32.204	70.597
2	Angola	18.8	..	..	46.621
3	Burkina Faso	19.26	65.089	75.181	43.549
4	Burundi	19.74	43.057	50.823	41.829
5	Cameroon	14.96	20.122	27.615	49.241
6	Cape Verde	5.6	15.09	25.141	68.93
7	Central African Republic	19.66	39.157	51.836	42.749
8	Chad	16.34	46.966	55.772	48.402
9	Comoros	8.06	36.655	44.01	61.05
10	Congo, Dem. Rep.	17.14	25.841	37.251	45.484
11	Congo, Rep.	14.3	11.812	18.195	51.46
12	Cote d'Ivoire	16.96	39.661	50.329	45.528
13	Egypt, Arab Rep.	6.28	32.806	43.879	68.341
14	Equatorial Guinea	15.22	7.2144	15.789	51.317
15	Ethiopia	20.08	51.872	59.693	42.208
16	Ghana	11.84	18.944	27.308	55.949
17	Guinea-Bissau	19.92	44.752	60.388	45.145
18	Kenya	15.32	10.539	16.657	46.256
19	Lesotho	18.48	26.731	16.102	43.324
20	Liberia	19.16	28.705	45.198	47.113
21	Libya	4.46	8.6959	19.227	71.912
22	Madagascar	11.98	25.8	32.695	55.063
23	Malawi	24.48	24.986	39.016	38.171
24	Mali	20.72	63.333	73.601	41.458
25	Morocco	5.8	37.44	50.217	68.002
26	Mozambique	20.78	38.84	54.761	41.74
27	Namibia	18.78	16.626	17.349	44.329
28	Sao Tome and Principe	9.1	..	..	65.419
29	Senegal	12.84	51.854	61.699	52.307
30	Seychelles	6.75	..	..	72.646
31	Somalia	17.14	..	..	47.269
32	South Africa	17.78	13.693	14.388	47.139
33	Tanzania	17.68	15.475	23.951	43.722
34	Togo	14.74	26.621	41.581	49.463
35	Trinidad and Tobago	6.8	1.0097	1.6144	72.473
36	Tunisia	5.6	17.689	27.889	72.377
37	Uganda	18.12	21.876	32.029	42.807
38	Zambia	22.26	14.224	20.955	37.46
39	Zimbabwe	19.52	6.7114	10.658	39.446
	Source: World Bank: African Social Indicators				


ANNEXE 2: HIV/AIDS Prevalance among Pregnant Women 2003
Percentage of Total Pregnant Women
Botswana, 32.9
Lesotho, 27.8
Malawi, 18.0
Ethiopia, 11.7
Togo, 9.1
Chad, 4.8
Ghana , 3.9
Nigeria, 4.2
Mali, 2.2
Source:http/unstats.org.un/unsd


Annexe 4: Trend in Maternal Mortality
1120
620
155
1995
2000
2015
Actual
Target

ANNEXE 5: 2005/06 BUDGET FOR MINISTRY AND FOR DISTRICTS

	Name of District Health Office	2004/05 Revised	2005/06 MoH Estimates	2005/06 DHO Budget	Total for District
1	Balaka Disctrict Health Office	108,705,966	53,836,867	119,066,907	172,903,774
2	Blantyre Disctrict Health Office	172,510,136	69,342,036	269,895,473	339,237,509
3	Chikwawa Disctrict Health Office	131,838,240	48,254,988	148,954,222	197,209,210
4	Chiradzulu Disctrict Health Office	113,361,520	46,342,036	116,962,924	163,304,960
5	Chitipa Distric Office	102,675,991	24,673,945	90,331,112	115,005,057
6	Dedza Disctrict Health Office	163,547,046	64,110,517	183,231,194	247,341,711
7	Dowa Disctrict Health Office	126,860,306	44,966,124	167,678,096	212,644,220
8	Karonga Disctrict Health Office	109,946,529	84,930,447	101,772,419	186,702,866
9	Kasungu Disctrict Health Office	140,045,888	63,879,969	179,478,455	243,358,424
10	Likoma District Health Office	10,747,290	314,492	24,703,798	25,018,290
11	Lilongwe Disctrict Health Office	236,207,025	152,043,660	397,675,102	549,718,762
12	Machinga Disctrict Health Office	152,327,682	68,608,704	144,773,292	213,381,996
13	Mangochi Disctrict Health Office	171,963,965	71,596,323	206,217,818	277,814,141
14	Mchinji Disctrict Health Office	138,286,760	61,047,632	133,446,428	194,494,060
15	M'mbelwa District Health Office	212,360,339	35,163,945	214,853,803	250,017,748
16	Mulanje Disctrict Health Office	148,064,152	59,640,588	166,630,546	226,271,134
17	Mwanza Disctrict Health Office	113,534,931	46,929,649	111,665,657	158,595,306
18	Nkhata-Bay District Health Office	108,058,098	45,311,496	100,980,055	146,291,551
19	Nkhotakota Disctrict Health Office	114,659,005	41,338,448	114,253,920	155,592,368
20	Nsanje Disctrict Health Office	108,558,030	42,418,528	109,923,903	152,342,431
21	Ntcheu Disctrict Health Office	133,515,790	59,170,060	162,065,166	221,235,226
22	Ntchisi Disctrict Health Office	100,321,110	42,373,888	101,023,968	143,397,856
23	Phalombe Disctrict Health Office	83,463,357	27,502,294	108,498,989	136,001,283
24	Rumphi District Heralth Office	106,629,828	45,276,439	90,369,579	135,646,018
25	Salima Disctrict Health Office	120,240,434	52,505,758	146,715,167	199,220,925
26	Thyolo Disctrict Health Office	147,724,817	26,054,131	176,082,587	202,136,718
27	Zomba Disctrict Health Office	129,372,289	45,819,960	187,653,923	233,473,883
28	Health Service Commission	27,704,255	37,005,738		
		6,420,586,853	**6,982,952,857**	**4,074,904,503**	**5,498,357,427**

Source: Budget Document No.5 Volume II Page 1369

Annexe 7: HEALTH INDICATORS FOR SELECTED SADC COUNTRIES

		LIFE EXPECTANCY 2000-05	MATERNITY MORTALITY RATE		INFANT MORTALITY (per 1,000 live births) 2002	UNDER 5 MORTALITY (per 1,000 live births) 2002	HEALTH EXPENDITURE PER CAPITAL (PPP US Dollar) 2001
			Ratio reported (per 100,000 live births)	Ratio Adjuded (per 100,000			
1	ANGOLA	40.1	-	1,700	154	260	70
2	MALAWI	37.5	1,100	1,800	114	189	39
3	ZAMBIA	32.4	650	750	108	192	52
4	TANZANIA	43.3	530	1,500	104	165	26
5	MOZAMBIQUE	38.1	1,100	1,000	125	197	47
6	ZIMBABWE	33.1	700	1,100	76	123	142
7	SWAZILAND	34.4	230	370	106	149	167
8	LESOTHO	35.1	-	550	64	87	101
9	NAMIBIA	44.3	270	300	55	67	342
10	SOUTH AFRICA	47.7	150	230	52	65	652

Source: UNDP Human Development Report 2004