

**PROJECT INFORMATION DOCUMENT (PID)  
APPRAISAL STAGE**

Report No.: AB862

<b>Project Name</b>	Health Sector Support Project
<b>Region</b>	AFRICA
<b>Sector</b>	Health (100%)
<b>Project ID</b>	P083401
<b>Borrower(s)</b>	GOVERNMENT OF MALAWI
<b>Implementing Agency</b>	Ministry of Health, Government of Malawi
<b>Environment Category</b>	<input type="checkbox"/> A <input checked="" type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> FI <input type="checkbox"/> TBD (to be determined)
<b>Safeguard Classification</b>	<input type="checkbox"/> S <sub>1</sub> <input checked="" type="checkbox"/> S <sub>2</sub> <input type="checkbox"/> S <sub>3</sub> <input type="checkbox"/> S <sub>F</sub> <input type="checkbox"/> TBD (to be determined)
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### 1. Country and sector issues

The social, human capital and income indicators in Malawi are among the poorest in the world, with a per capita GDP of US\$170 and about 55 percent of the population living below the national poverty line. Despite average per capita GDP growth rates of 3.7% between 1990-2001, Malawi still ranks 163rd of the 173 countries included in the Human Development Index (UNDP 2001).

**Poor health indicators but some progress:** The health status indicators in Malawi have been viewed as extremely poor, particularly given the apparent higher levels of health expenditures in Malawi compared to its neighboring countries. But the picture is, in fact, more nuanced. Life expectancy has in the past few years declined to 39 years, mainly as a result of the impact of the HIV/AIDS epidemic. It is estimated that 49% of children under the age of five years may be clinically malnourished or stunted (NSO, 2001), primarily due to the recent droughts in the country. Infant mortality and child mortality remain high at 104 and 189 per 1000 live births, respectively, while the maternal mortality rate has been estimated at 1120 deaths per 100,000 live births (2000). On the other hand, Malawi has done well in improving the overall coverage and the delivery of some key health services, such as child immunization, Directly-Observed Treatment (DOTS) for tuberculosis, and insecticide treated bed-nets (ITNs) for malaria. Malawi's health indicators are now broadly comparable to its neighbors, with a high concentration of morbidity and mortality in the 1-5 year age group for which workable technical solutions, preventive and/or curative, are available.

**Systemic problems:** Achieving the health Millennium Development Goals (MDGs) remains a major challenge for Malawi, particularly given the poor macroeconomic environment with increasing levels of poverty, the HIV/AIDS epidemic, and the critical shortage of human resources in the health sector (vacancies in established government posts are up to 50% at some government, religious mission and NGO-run institutions). The difficulty in achieving the MDG goals is compounded by the high rates of fertility and under-nutrition, poor supply and access to pharmaceuticals, and the fragmented health care delivery system. Access to health services

remains modest with only 54% of the rural population (compared to the richer urban population, which has 84% access) having access to formal health services within a 5-kilometer radius, significant regional variations, only 10% of the health care facilities having the services and staff necessary to deliver the Essential Health Package (EHP), and poor client perceptions of the public health care delivery systems. Paradoxically, the use of health services delivered by the public and non-profit private sector remains high.

A key challenge for the Ministry of Health (MOH), therefore, is to strengthen the performance of the district health systems and to develop integrated health programs to deliver the EHP, particularly given the government's intention of decentralizing the provision of public services. At the same time, the stewardship capacity at the central level needs to be enhanced so that the MOH can reliably formulate and review policies, coordinate implementation and provide support to the district health management teams. Despite these many challenges, however, the successes noted above suggest that Malawi has the potential, with appropriate financial and technical support from its international partners, to make progress towards attaining the MDGs.

***Significant client commitment:*** In 1995, the Government of Malawi (GOM), supported by its partners, initiated a Medium Term Health Expenditure Framework (MTEF), which was instrumental in increasing the annual government health expenditures from 6-9% in the 1990s to a high 12-15% by 2001. Malawi also received Heavily Indebted Poor Countries (HIPC) funds that are in part being channeled to the health sector. The Malawi National Health Plan (1999-2004), the Poverty Reduction Strategy Paper (PRSP) (PRSP, 2002), and the recently published six-year Program of Work (PoW), 2003-2009) of the MOH collectively provide a convincing framework for targeting an essential health package of services to the poor. The Essential Health Package (EHP) guides the sectoral priorities at all levels, and also tries to promote an integrated approach as opposed to the existing independent vertical disease control programs. Improved access to the EHP is considered key to the improvement of the "health status of Malawians by reducing the incidence of illness and occurrence of premature deaths in the population," thereby contributing to "the achievement of sustainable poverty reduction through the enhancement of human capital development" (PRSP, 2002).

## **2. Objectives**

***Development Objective:*** As noted, the overall objective of the government's SWAp program for the sector is to improve the effectiveness, efficiency and equity of the essential health care delivery system in Malawi. Within this general context, three key aspects of the sector stand out as requiring particular attention if the SWAp is to succeed. These are: a) human resources, where there is a danger of the human resource situation slipping into an emergency crisis if substantial steps are not taken, b) ensuring the provision of the essential package of services – the minimum required – throughout the country, and c) strengthening the support and referral systems relevant to this package of services.

***Principal outputs and outcomes:*** The principal outputs expected are: (a) Improved availability of quality health care and EHP for the poor and vulnerable populations; (b) Improved human resources, especially skilled personnel; (c) Strengthened health systems through equitable health financing, increased human resources, reliable pharmaceutical and supplies logistics and effective monitoring and evaluation; (d) Enhanced capacity of MOH for stewardship and policy

development; (e) Strengthened District Health Management systems for planning, budgeting and delivery of quality health services; and (f) Community participation in the delivery of essential health interventions.

It is anticipated that these outputs would contribute to the ultimate goal of the health sector in Malawi, which is to address the three MDGs of reducing child mortality, improving maternal health and - linking with MASAF - contribute to the reduction of poverty by protecting the poorest and the vulnerable from economic loss due to ill health and disability. The project would also contribute to the achievement of a fourth MDGs - that of combating HIV/AIDS - by working in concert with the Bank's MAP project grant (P073821) and related initiatives, such as the support being provided by the Global Fund.

Agreed upon outcome indicators for assessing the long-term impact of the HSSP are as follows (to be measured in aggregate and disaggregated by income, gender and geography):

- Infant Mortality Rate (IMR)
- Maternal Mortality Ratio (MMR)
- Contraceptive Prevalence Rate/Total Fertility Rate (CPR/TFR)
- Prevalence of HIV in Ante-Natal Clinic Clients and among the youth
- % of low birth weight (LBW) newborns

The following output indicators are proposed to monitor the Bank project components:

- Overall: Proportion of GOM budget allocated to/received by the health sector at the national and district levels; Trends in per capita government allocations to the health sector; % of health facilities with ability to effectively provide EHP; Proportion of population within easy reach of EHP.
- Delivery of EHP: % facilities without 7-day stockouts of essential EHP drugs; % fully immunized at 1 year; % births attended by skilled attendant; TB cure rates.
- Human Resource and Management: Comprehensive HRM plan; % facilities with minimum staffing norms; % established positions filled; % new graduates from training colleges employed in the health sector in Malawi.
- Health Support and Referral Systems: % facilities offering EmOC ; Proportion of MOH budget allocated to districts; Proportion of budget allocated to health centers; % facilities regularly supervised by DHMT; No. of VHCs established and functioning as evidence of community participation in delivery of EHP.

**Poverty focus:** Delivery of the EHP to each citizen is at the core of the Government of Malawi's health strategy and therefore of the SWAp. Consistent with international best practice, the EHP targets the most important health problems of the poor. It fits within the policy and strategy framework contained in the National Health Plan, the "Vision 2020" document, and the Malawi Poverty Reduction Strategy Paper (PRSP). Importantly, while the objectives of these policy

documents are relatively broad, they do include the intention to adapt the MOH's role to that of "steward" of the sector rather than direct service provider, in the context of decentralization.

***Efficient and equitable access:*** The design of the EHP as both a rationing and targeting strategy for health interventions provides an opportunity for the efficient and equitable utilization of health resources. Furthermore, it is possible to identify a poverty-focused hierarchy of objectives in the national policy and strategies. Thus, *improved access to, and quantity, quality and cost-effectiveness of EHP-related services* contributes to *improved health status for all Malawians*, which in turn supports *sustainable reduction in poverty* – where the italics are national objectives as expressed in GOM's own wording. This structure is explicitly focused on poverty reduction and equity.

***Relevance to objectives of CAS, Bank HNP strategy, and Africa HNP Strategic Priorities:*** The Bank's 2003 Malawi Country Assistance Strategy (CAS), building on the PRSP, makes improved health status in Malawi a priority for poverty reduction. The CAS identified the need for renewed engagement of the Bank in the health sector and provided for a US\$15 million IDA grant to support a new health project, supported by a modest allocation for analytical work. The project, as described below, is also in conformity with the Bank's Health, Nutrition and Population (HNP) strategy and the HNP Strategic Priorities outlined by the African region.

### **3. Rationale for Bank involvement**

***Client initiatives in sector:*** Recognizing the recent move to strengthen the MOH's stewardship role, while devolving responsibility for the management of health programs to the elected district-level authorities, and in order to promote greater cohesion in the health sector, harmonize donor support, and ensure a more targeted and equitable delivery of health services, MOH is developing a Sector Wide Approach (SWAp) in health. The six-year PoW for the proposed SWAp, prepared through a consultative process, has received enthusiastic support from key domestic and international stakeholders. The consultative approach adopted by the MOH in designing the SWAp presents an opportunity for broad-based ownership and partnership in the implementation of the EHP.

The Local Government Act (CAP 22.01) provides the necessary legal framework for the decentralization policy, which will facilitate the participation of the poor in health planning and decision-making through existing democratic structures. Over the years, GOM has also strengthened its partnership with non-governmental organizations (NGOs), most importantly by the recent signing of a Memorandum of Understanding (MOU) with the Christian Health Association of Malawi (CHAM), which provides over 25% of all health services in Malawi. The signing of this MOU, which has been strongly endorsed by the collaborating partners, offers a genuine opportunity for the enhancement of collaborative efforts aimed at increasing access to the EHP by the poor, and provides a basis for objective resource allocation to non-government providers of health. Furthermore, the introduction of service-agreements intra-and extra-district for the provision of the EHP to underserved areas should help in increasing access to the EHP. Finally, the resource allocation formula now in place is a step in the right direction towards adopting a "needs-based" approach to health care provision, as it takes into consideration the population, existing infrastructure, and poverty levels in the various districts in Malawi.

**Request for IDA Assistance:** To finance the PoW, GOM has sought assistance from its development partners, including IDA, and has already received initial support from the major donors – DfID and the Kingdom of Norway - with the expectation of further commitments from the African Development Bank (AfDB) and other bilateral and multilateral donors. Also, there has been a strong demand from the GOM and other development partners for policy advice and analytical support from the Bank.

**IDA's comparative advantage:** The Bank has been a strong supporter of SWAp in the health sector in a substantial number of African and Asian countries with generally encouraging results. The Bank has also been a key driving force behind the PRSP. With the only previous Bank health project having closed in 2000, a well-implemented LIL for Population and Family Planning (Pop/FP) having closed on December 31, 2003, and a limited health presence in the country office (which has only been remedied very recently), IDA's contribution to the sector dialogue in Malawi has been limited. Since work has been ongoing on the SWAp for 2-3 years, IDA is also a late entrant in the SWAp discussions. In order to enhance the development impact, it would be appropriate for the Bank to provide technical input and help bridge the financing gap in the proposed health SWAp. The GOM and the partners would strongly support such an initiative.

**Need for continuing support:** It should be noted, though, that the proposed IDA grant of US\$15 million over three years, while demonstrating the Bank's support for the SWAp (that could potentially also leverage other funds), is considerably smaller than the amounts indicated by DfID (\$60 million) and the Kingdom of Norway (\$25-30 million), and leaves a significant financing gap in the sector. Based on the sectoral performance, additional support to the sector could be considered in the future.

## 4. Description

The HSSP is expected to achieve the stated development objective over the next three years and, based on the foregoing, would strategically have three components, exclusively drawn from the PoW<sup>1</sup>: **(a) Support extension of quality health care coverage through delivery of EHP; (b) Support human resource development and management; and (c) Strengthen health sector support and referral systems** (see details in Annex 4). In order to maximize its impact, every effort will also be made to strengthen the linkages of the HSSP (and the broader SWAp) with the ongoing Bank-supported HIV/AIDS program (through the Malawi MAP) and MASAF project.

During the first year of the HSSP, a gradual build up of the joint PoW is expected and the usual problems of transition envisaged as the EHP concept is rolled out. Year two would be used to remedy any deficiencies and shortcomings observed during the first year leading to the all important Mid-term review (MTR). The recommendations of the MTR, which shall include assessment of the progress against performance indicators, would be used to consolidate the gains and ensure that the project is on course during the second half of its life.

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<sup>1</sup> The six programs of the six-year PoW, which are largely focused on inputs, have been re-aggregated to a different presentation which links inputs more closely to the activities, i.e. the delivery of the essential health package, human resources development, and support systems. This re-aggregation does not affect the integrity of the PoW.

**Component 1 - Delivery of the EHP:** The objective of this component is to improve the health status of the Malawian population by increasing access to quality essential health services. The main mechanism for delivering quality care would be by making the already-defined EHP accessible to all, but especially in the most rural and disadvantaged districts and to the poorest and vulnerable populations. The component would support community sensitization and mobilization as well as establishment of standards and packages of care to be delivered at each level – community, health center, district and central hospitals. In addition, the component will also support in-service update of health worker and management skills as a way of improving staff performance and strengthening service provision. Efficient logistics and sustained availability of pharmaceuticals, medical and laboratory equipment and supplies, so critical for effective delivery of the EHP will also be supported by this component. The EHP will be introduced in an incremental manner by adapting and strengthening existing services to co-opt the EHP concept. It is understood that infrastructural improvement (in the form of rehabilitation, refurbishment, etc.) will be needed to ensure that all health facilities can support the delivery of the EHP; however, it is not the intention of this component to rapidly expand the infrastructure through the construction of new freestanding health facilities. Instead, the emphasis will be on balancing infrastructural development with ensuring the availability of, *inter alia*, adequate staff, equipment and supplies.

**Component 2 - Human Resources Development and Management:** The major thrust of this component, in the short term, is on increasing the number of staff available through continuation of the six-year emergency training plan, a concerted recruitment campaign, financing and then filling current vacancies, the use of volunteers and contract staff and other stop-gap staffing strategies. The component will look comprehensively at the government and the NGO sectors. Greater attraction and retention of staff will be achieved by ensuring salaries are paid promptly and in full and by increasing the overall remuneration package, though interim measures may be required. In addition, effective implementation of the existing measures for effective HR management will be ensured. Personnel policies will be reviewed to improve working conditions. Staff will be used more effectively by matching posts to workload, developing performance management systems and by streamlining the provision of in-service training. Support systems will be improved including HR information systems, HR planning (including coordination with training institutes), and a review of the current structures managing the HR systems. Technical assistance will be needed to support the strengthening of the HR systems. Longer-term Human Resources (HR) strategies include the development of improved career structures, and improving recruitment and deployment systems.

**Component 3 - Health Sector Support and Referral Systems:** The objective of this component is to improve the effectiveness and efficiency of both the health system and the referral network to support delivery of the EHP. It will be divided into two subcomponents: **(a) Support for central operations** and, **(b) Support to district operations**. Greater emphasis will be placed on support to operations at district and lower levels.

The sub-component for central operations will strengthen institutional processes aimed at enhancing central support to implement the SWAp in delivery of the EHP and for the decentralization of the health sector. The aim is to put in place the policies, coordination and

regulatory frameworks, organizational structures, procurement and financial instruments, training programs, and information, monitoring and evaluation systems that would enable the MOH to effectively steward the PoW. The central operations would focus on managing the process of decentralization and be geared towards effective support of the devolved district health system. Specific output areas for the subcomponent include: (i) Policies and planning systems to support EHP; (ii) Health financing and financial management systems; (iii) Procurement policy and logistical system for drugs, equipment and supplies; (iv) Equitable distribution of financial and human resources; (v) Development of standards and quality assurance systems; (vi) Supervision, including Zonal support; and (vii) Health information systems for monitoring and evaluation.

The sub-component on district operations in the devolved health system will strengthen coordination and planning to ensure uninterrupted availability and maintenance of adequate financial, material and human resources to deliver effectively the EHP in the districts for both MOH and NGO services. Specific output areas include: (i) orientation of staff and other stakeholders on SWAp and the concept of EHP; (ii) Timely preparation of high quality District Implementation Plans (DIPS); (iii) Financial management; (iv) Procurement, storage and distribution of adequate drugs equipment and supplies; (v) Effective communication and referral framework; (vi) Effective execution of other routine operations by DHMTs; (vii) Strengthening community participation and delivery of EHP, including intersectoral linkages; (viii) Effective linkages with MASAF; and (ix) Quality technical advice to District Assemblies.

## 5. Financing

Source:	(\$m.)
BORROWER/RECIPIENT	212
INTERNATIONAL DEVELOPMENT ASSOCIATION	15
UK: BRITISH DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID)	60
NORWAY: NORWEGIAN AGENCY FOR DEV. COOP. (NORAD)	30
NON-POOLING DONORS	375
Financing Gap	43
Total	735

## 6. Implementation

IDA, and the two other development partners (DfID and the Kingdom of Norway) who have committed to contributing to a common pool, have worked under Government of Malawi leadership to negotiate and agree on a Memorandum of Understanding (MOU) to govern their partnership within the SWAp. This MOU was formally signed by the pooling partners on October 29, 2004. Certain other partners are also expected to join the financing pool in the near future. The MOU refers to the PoW, overall resource envelope, financing arrangements, coordination and monitoring arrangements including joint annual reviews, and a code of conduct for partners. Other donors, who will also sign the MOU, will continue to provide earmarked support, but within the confines of the PoW for the SWAp (see details below).

The GOM and the pooling partners have agreed on a realistic pace for capacity building and institutional change and on a pattern of disbursement linked to progress. This has given the government confidence about donor funding commitments, and given the funders confidence that spending will be used for the purposes and within the timetable agreed. The pattern of disbursement is linked to milestones to be agreed as part of the consultation process. Examples of milestones include progress in financial and human resource management systems; human resource development; appropriate arrangements for decentralization; civil society's role in monitoring health care delivery; service provision; and development of public-private partnerships. These milestones will be incorporated in a realistic timetable in the Annual Implementation Plans.

The indicative approximate financing amounts for the health SWAp from the three agencies pooling funds are currently expected to be: DfID 40 million pounds grant; the Kingdom of Norway 42 million US dollars grant (currently 23 million US dollars in projects and vertical programs, and 19 million US dollars to the pooled funds); and IDA 15 million US dollars grant. While IDA will finance the SWAp over a three year period, other agencies will finance it over the 5-6 years implementation period. IDA will also reimburse retroactively its share of the eligible SWAp expenditures beginning from October 29, 2004, as soon as the project is effective.

## **7. Institutional and implementation arrangements**

The Principal Secretary MOH is overall responsible for SWAp implementation including the outputs and quality assurance. To guide and advise him, a detailed 'governance' structure for the SWAp has been established. This structure builds upon and modifies arrangements for ministerial and donor coordination that were already operational. Details are included in the MOU, but the line management structures include a Top Management Committee (Ministerial level), a Senior Management Committee (Department Director level) – both serviced by the SWAp Secretariat – and Departmental Meetings. On the advisory side, there is a Health Sector Review Group (the main donor/government group) with sub-groups on selected key topics.

Within the MOH and CHAM, day-to-day implementation of the SWAp funded activities will be implemented by the responsible subject/technical departments and units following the agreed detailed annual work plans. To ensure full ownership and capacity building within the MOH, no project implementation unit will be established. A three person SWAp Secretariat is being established, that will deal mainly with the donors, monitoring and evaluation, and facilitate the implementation of the SWAp governance structure. The head of the SWAp Secretariat reports to the Director of Planning and the Planning Department will continue to take the lead in the substantive aspects of the SWAp, as they have done throughout the preparation process. The Director of Planning is of course responsible for coordination with senior staff and especially the Chief Technical Adviser, Department Heads, and with CHAM.

The main risks identified in a procurement capacity assessment undertaken by IDA are unfamiliarity with procurement procedures of multilateral financial institutions, inadequate procurement systems and unreliable quantification of requirements for health sector goods. Given the weak systems and capacities, the large amount of funds involved in the SWAp, the complications introduced by the involvement of NGOs in program implementation, and the

challenges of pooling funds have been identified as critical risks for effective financial management and internal control. To promote timely implementation, long-term technical assistance in the key areas of financial management and procurement is being implemented. Procurement of goods, works and services will be the responsibility of the Head of the (to be established) MOH Procurement Unit, working closely with the (to be recruited) Procurement Agent/Adviser, the Director of Finance and Director of Planning. The Director of Finance will be responsible for all financial management and accounting matters under the SWAp (Further details on financial management and procurement are given in Annexes 7 and 8).

At present, the MOH operates a centralized management system. The four Central Hospitals and District Health Teams (including the District Hospitals) are enjoying an increasing level of autonomy, but still have only limited administrative and financial powers. It is government policy that ministries decentralize. The MOH is in the process of devolving the management of Health Centers in the main cities to the city councils. MOH's plan is to prepare for full phased devolution to the District Assemblies over the coming several years. Many managerial, administrative, political, reporting and communications issues have yet to be addressed – but the SWAp will be instrumental in facilitating this process. Beneficiary consultation and involvement will, of course, become more systematic. Devolution to districts will be a major change in the way in which the SWAp is implemented; it will be a focus, among other issues, of the annual review process.

The SWAp provides an important vehicle for developing national implementation systems and capacity. The establishment and expansion of common implementation systems is an important feature of the SWAp, both to build capacity and to reduce waste on parallel systems and procedures. It is expected that all major donors to the health sector will participate in the SWAp, thus offering the opportunity for increased cooperation. Ultimately, it is hoped that this will facilitate and encourage all donors to move towards a common set of implementation procedures – and thence program support – for the government's total health program. Compared with neighboring countries, there are relatively few donors actively involved in the health sector, which will simplify this process. However, this also makes the sector vulnerable to the very frequent changes in individual donor health representatives. This has slowed preparation and remains a risk to effective implementation.

SWAp financing originates from two groups of sources. Those partners who are able to pool funds (DfID, the Kingdom of Norway and IDA – together with the government of course) and those partners who are not. The latter group will finance health sector activities under the SWAp umbrella, but typically using project modalities. The pooling (or basket) partners will provide funds to a common account that is replenished quarterly<sup>2</sup>. The joint disbursement methods, financial management, reporting, procurement, auditing, etc. are formalized in the detailed Memorandum of Understanding that has been signed by the pooling partners. Arrangements for the non-pooling partners and the pooling partners are described somewhat separately in the Memorandum of Understanding (Parts A and B respectively).

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<sup>2</sup> DfID and the Kingdom of Norway will put the majority of their funds for the pool but, in addition, continue to finance a limited number of projects.

A joint review will be held annually in September. This will be a major event, the main annual program review and will cover overall progress during the preceding year, expenditure and audits, procurement progress – and implementation, procurement and other plans for the coming year (including the link to the Mid-Term Expenditure Framework [MTEF]). Pooling partners will also agree on their allocations to the pool for the coming year. A smaller review will take place in the off-six months, in February, which will focus more on technical and service related issues.

## **8. Sustainability**

Sustainability of the proposed health SWAp needs to be viewed from a programmatic and a financial perspective.

### **Programmatic Sustainability**

***Change from project approach to a sector-wide approach:*** Promoting a sector-wide approach in the planning and financing of the sector signals both the government's and donors' willingness to do away with the fragmented approach prevalent under the traditional projects, which has been shown to distort sector allocation priorities and also to be unsustainable in the long run.

***Focusing on government capacity:*** Rather than creating temporary, separate management entities (such as a PIU) which employ parallel systems, procedures and staff, the SWAp also focuses attention on developing and strengthening government systems and procedures (planning, budgeting, financial management, procurement), and civil service capacity.

***Budgetary reform, prioritization and rationalization:*** The Program supports the budgetary reform initiatives under the Medium-Term Expenditure Framework (MTEF). External resources for the health sector, most of which were extra-budgetary, have been increasingly incorporated in the MTEF to help clarify the real resource envelope for the sector. Reform initiatives supported under the Project and Program are intended to enhance fiscal predictability and sustainability, as well as allocation efficiency in the health sector. The sustainability of investment costs (typically financed by donors) can also be better assessed under the SWAp.

### **Financial Sustainability**

***Sustainability of government spending:*** The sustainability of PoW expenditures and, more directly, of MOH expenditures, can best be analyzed in the context of the sustainability of overall government spending. As discussed in detail in Annex 9, the Government succeeded in protecting expenditures in health over the past six years (FY97/98 to FY02/03), with a dramatic rise in the share of MOH to total government spending occurring in 2001. MOH expenditures were also protected from erosion due to inflation and population growth. Thus, real per capita MOH spending (at constant 1995 prices) rose from MK60 in FY97/98 to MK85 in FY01/02. (In current terms, these are equivalent to MK103 and MK423, respectively.)

Although the MOH's share of government spending has been increasing, it still falls short relative to need, and relative to the 15 percent allocation to health that African Governments committed themselves to meet in the OAU Summit in April 2001 in Abuja, Nigeria. The 15

percent target for adequate and sustainable government financing for health would be within Malawi's ability to meet if not for the heavy load of "nondiscretionary" or "unallocable" expenditures that the government needs to set aside, mainly to pay off its large domestic debt. Nondiscretionary expenditures have ballooned in recent years, accounting for around 23.5 percent in FY01/02, or an average share of 20.6 percent from FY97/98 to FY01/02. Because of this burden, further expansion in government allocation to the MOH and other social sectors has been constrained. Thus, if the GOM adopts a strategy of bringing domestic borrowings down, significantly more domestic resources could be made available for health. On the other hand, if it fails in this area, government discretionary expenditures (including health) could be further squeezed, reducing the sustainability of the PoW.

***Fiscal decentralization and the sustainability of PoW investments:*** It is unclear to what extent the PoW expenditures can be sustained at the district level when primary health services are eventually devolved to local authorities. The challenges during this period of transition, and the proposed approach for dealing with them, are: (a) To ensure that local authorities devote as much (or more) resources to priority health interventions as the current PoW. One approach that a number of devolved countries have employed to solve this problem is to establish categorical or conditional grants that specify priority activities to be funded. This has its pros and cons, but it ensures that in the short-term, PoW activities are adequately funded; b) To ensure that fiscal transfers to districts are made on an equitable basis, i.e., that no district will be made worse off than it was before the devolution. This requires that the existing district allocation formula be reformulated to take account of the resource requirements of assets and personnel actually transferred, and health needs that were previously not captured in the "incremental budgeting" practice.

***Sustainability of referral services and hospital financing:*** Although no final decisions have been made, discussions with MOH policymakers revealed the following: (a) their interest in pursuing social health insurance as one mechanism for providing much-needed financing for catastrophic and referral health services, (b) the recent issuance of a policy making all inpatient hospitalization and outpatient consultations at central hospitals subject to fees, and (c) ongoing technical assistance being provided to assist in making the four central hospitals become autonomous.

## **9. Lessons learned and reflected in the project design**

The following lessons relevant to Malawi, the HNP sector in general, and the HNP sector in Malawi in particular, have been carefully considered in designing the Malawi HSSP.

***Malawi Lessons:*** ICRs for recent Bank-supported projects in Malawi have emphasized the importance of realistic objectives with greater specificity and focus, which can be translated into operational and monitorable terms. In the same vein, it has been recognized that effective monitoring and evaluation is key to good programmatic implementation. The need for project design to be compatible with implementation capacity and pay adequate attention to "software" activities has also been stressed.

***HNP Lessons:*** Experience from HNP projects in developing countries, and particularly those in Sub-Saharan Africa, shows that multiple discrete projects lead to the fragmentation of services,

preclude government ownership, and impose an undue management burden on governments. Fungibility of resources also implies that, when donors focus on financing cost-effective interventions (e.g., primary health care), government resources can sometimes be redirected towards less cost-effective interventions. A more comprehensive strategy approach, that is based on a government-led strategy and program, focused on building local capacities, and firmly rooted in an agreed-upon financing framework should be considered. It has also been recognized that for optimal results, in the health sector, governments need to focus increasingly on financing and stewardship, while encouraging greater private sector participation in service delivery.

**Malawi HNP Lessons:** Significant lessons from Malawi HNP work are that: (a) infrastructure expansion needs to be synchronized with staffing and supplies; (b) community driven initiatives can significantly improve certain health related behaviors at the household level, such as the use of contraceptives; and (c) the absence of an IDA technical presence in the field has constrained the policy dialogue with the GOM and other partners.

## 10. Safeguard policies (including consultation)

Safeguard Policies Triggered by the Project	Yes	No
<a href="#">Environmental Assessment (OP/BP/GP 4.01)</a>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Natural Habitats ( <a href="#">OP/BP 4.04</a> )	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pest Management ( <a href="#">OP 4.09</a> )	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cultural Property ( <a href="#">OPN 11.03</a> , being revised as OP 4.11)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Involuntary Resettlement ( <a href="#">OP/BP 4.12</a> )	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Indigenous Peoples ( <a href="#">OD 4.20</a> , being revised as OP 4.10)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Forests ( <a href="#">OP/BP 4.36</a> )	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Safety of Dams ( <a href="#">OP/BP 4.37</a> )	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Projects in Disputed Areas ( <a href="#">OP/BP/GP 7.60</a> )*	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Projects on International Waterways ( <a href="#">OP/BP/GP 7.50</a> )	<input type="checkbox"/>	<input checked="" type="checkbox"/>

The project has been rated as “S2” on safeguards and as “B” on environmental screening.

### List of Factual Technical Documents

#### 9. Contact point

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#### 10. For more information contact:

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\* By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas

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