

Country Profile: Malawi

Demographic Context

The population progressively increased from 17M to 20M between 2017 to 2022 as shown in **figure 1**. Infants aged below 12 months and those below the age of 5 years accounted for less than 7% and 20% of the entire population respectively.



Figure 1: Population Trends in Malawi

During the same period, the Human Development Index remained just below 0.5, a below average performance on individual longevity, education and income capabilities (**Figure 2**). The Human Capital Index was 0.4, which was below average in terms of the expected productivity of future generations owing to deprivations related to health and education. This implied that children born during the period would attain only 40% of their productivity potential. The life expectancy at birth in 2019 was 63 years.

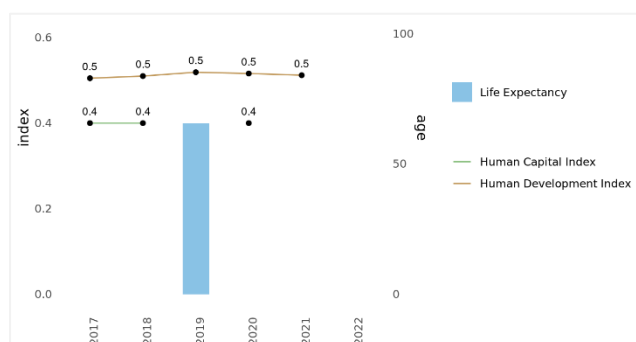


Figure 2: Development and Productivity Potential in Malawi

Economic Context

The Gross National Income Per Capita progressively increased from USD 488 to USD 633 during the period of analysis (**Figure 3**). This matched the initial self-financing phase for GAVI eligibility (GAVI, 2022). The Tax to GDP ratio declined from 12% to 11% implying an underperformance relative to the regional threshold of 15% for adequacy of financing public services. The Debt to GDP ratio nearly doubled from 40% to 70% within the period of interest hence above the SADC regional threshold of 60% for debt sustainability and adequacy of financing public services beyond debt repayment.

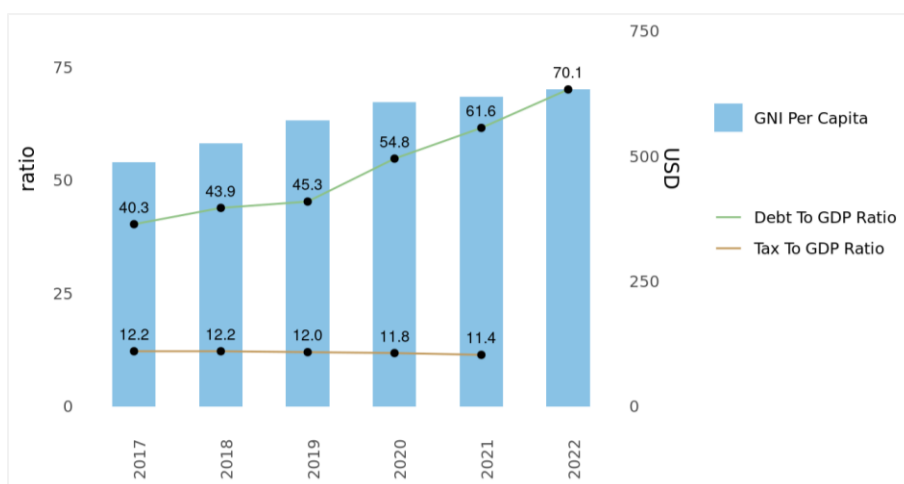


Figure 3: Economic Performance in Malawi

Highlight

The rising debt levels in Malawi beyond the regional threshold highlights potential risk of debt repayments crowding out expenditures on other essential public services including health and immunization. Coupled to the low tax revenues, these further reduce the fiscal space for health and immunization.

Health System Context

The top 3 causes of death in the population were HIV/AIDS, neonatal conditions and lower respiratory tract infections. neonatal mortality, malaria, pneumonia and diarrheal diseases were the main causes of under 5 mortalities.

There was a steady decline in the Infant and Under Five Mortality Rates over the period of analysis. The Infant Mortality Rate (IMR) declined from 36 to 31 deaths per 1000 live births, while the Under Five Mortality Rate declined from 51 to 42 deaths per 1000 live births as shown in **figure 4**.

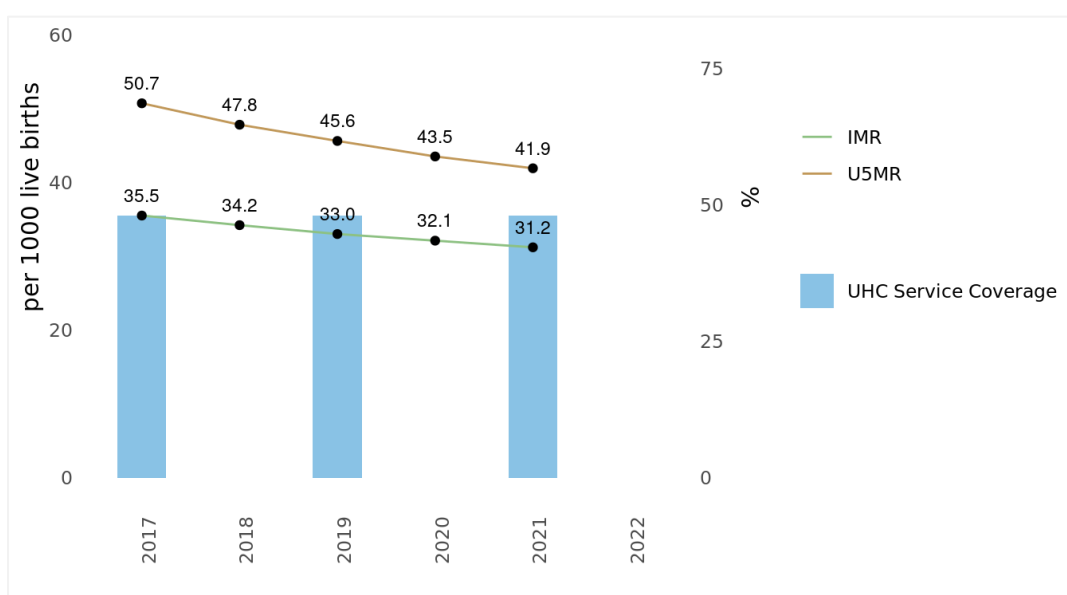


Figure 4: Health System Performance in Malawi

The UHC service coverage index in 2021 was 48% implying that only 48% of the population had access to essential health services including reproductive, maternal, newborn and child health, infectious diseases, and non-communicable disease services.

Health Financing

Government spending on health was at 2% of the GDP which was markedly below the minimum of 5% recommended for progression towards UHC(McIntyre et al., 2017). The per capita spending on health was between USD 30 and USD 38, which was substantially below the recommended per capita target of USD 86(McIntyre et al., 2017). Further, the government expenditure on health relative to other sectors ranged between 7% and 8% across the years, which was substantially below the 15% Abuja target **(Figure 5)**.

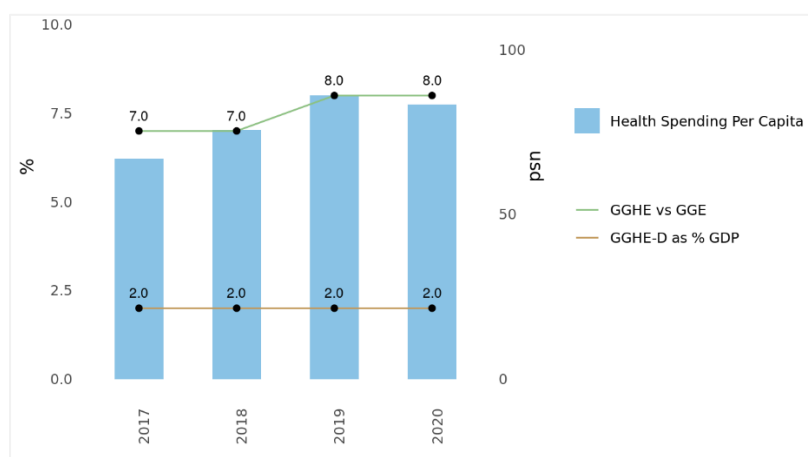


Figure 5: Health Financing Trends in Malawi

External aid and government transfers were the largest sources of health financing during the period of analysis. Though declining, the external aid accounted for between 36% and 60%. Government funding increased from 23% to 36%, while OOPs declined from 13% to 20%. Other sources accounted for less than 10% of health financing during the period. There were no contributions from social health insurance **(Figure 6)**

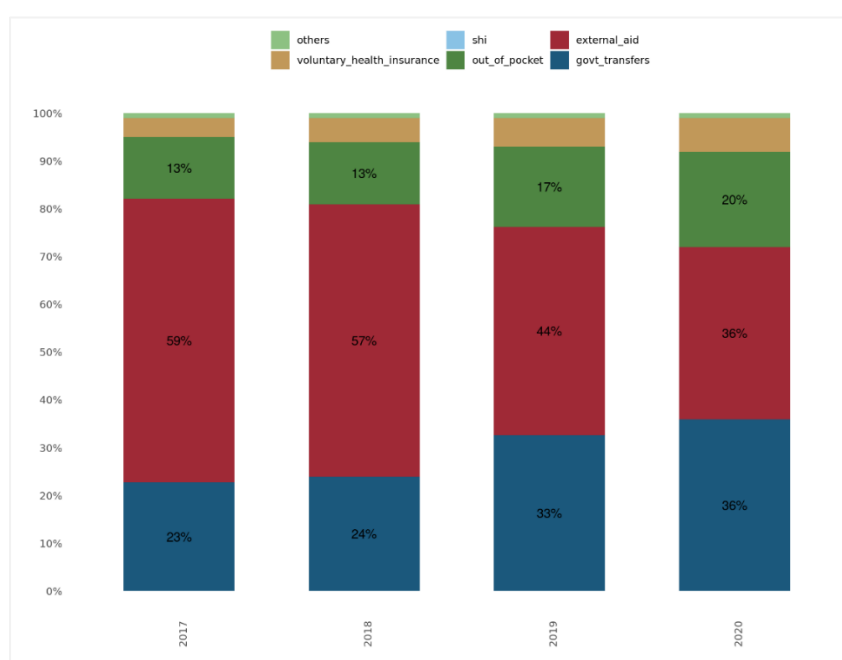


Figure 6: Health Financing Sources in Malawi

Highlight

The low UHC service coverage index highlights the need for system wide improvements to facilitate access to quality essential healthcare in Malawi.

Though improving, there was still a high dependence on donors and Out of Pocket expenditures in financing health in Malawi. Increased government allocations are essential to guarantee financial protection and sustainability of health services, including immunization services.

Immunization Coverage

The national immunization coverage rates showed a positive trend between 2017-2019, however, between 2020 and 2022, all the selected indicators declined (**Figure 7**).

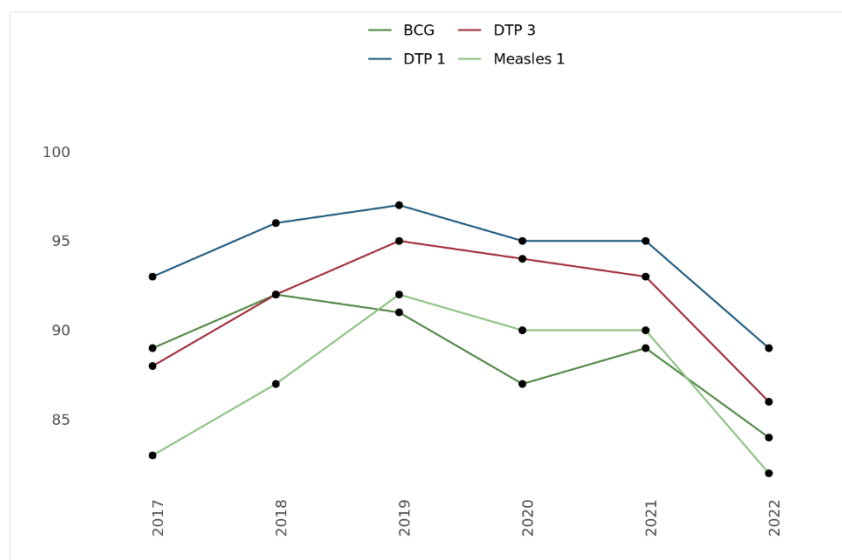


Figure 7: Immunization Coverage in Malawi

Overall, lower income groups had higher under five mortality rates, and lower immunization coverage which indicate income related inequities (**Figure 8**). There was a gap of more than 20 deaths per 1000 live births among the under-fives between the wealthiest and poorest income groups. The coverage gaps for DTP3 and MCV2 between the wealthiest and poorest income groups were 15 and 10 percentage points respectively.

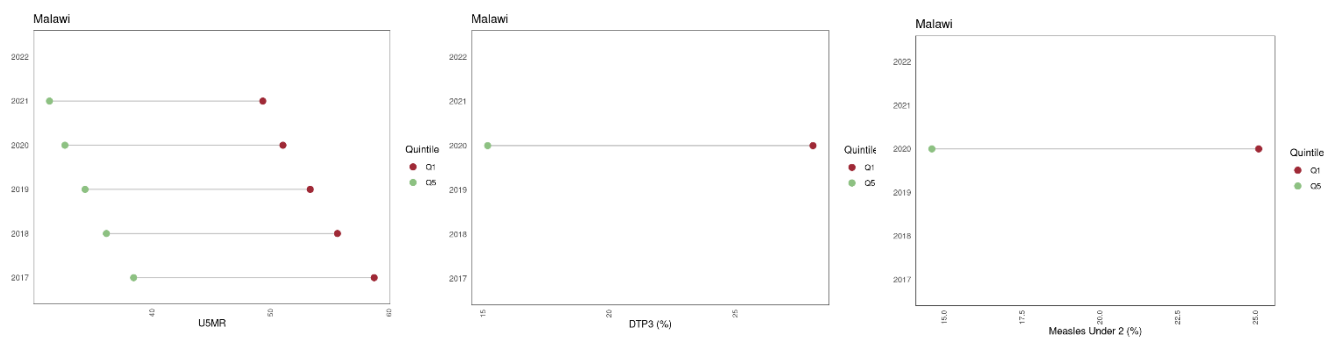


Figure 8: Equity Analysis of Immunization, and U5MR in Malawi

Immunization Financing

Expenditures on Routine Immunization in Malawi declined during the period of analysis. Routine immunization accounted for about 3% of the Current Health Expenditure; and between 7% and 13% of the Domestic General Government Health Expenditures between 2017 and 2020 (**Figure 9**).

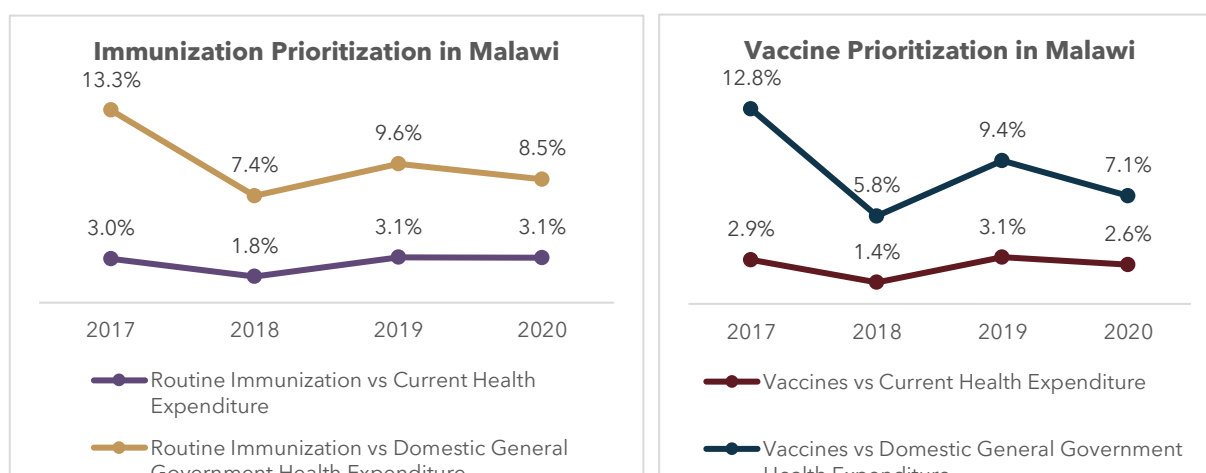


Figure 9: Prioritization of Immunization and Vaccines in Malawi

Vaccine related expenditures, while declining, accounted for less than 3% of the CHE, and declined from 13% to 9% of the Domestic General Government Expenditures.

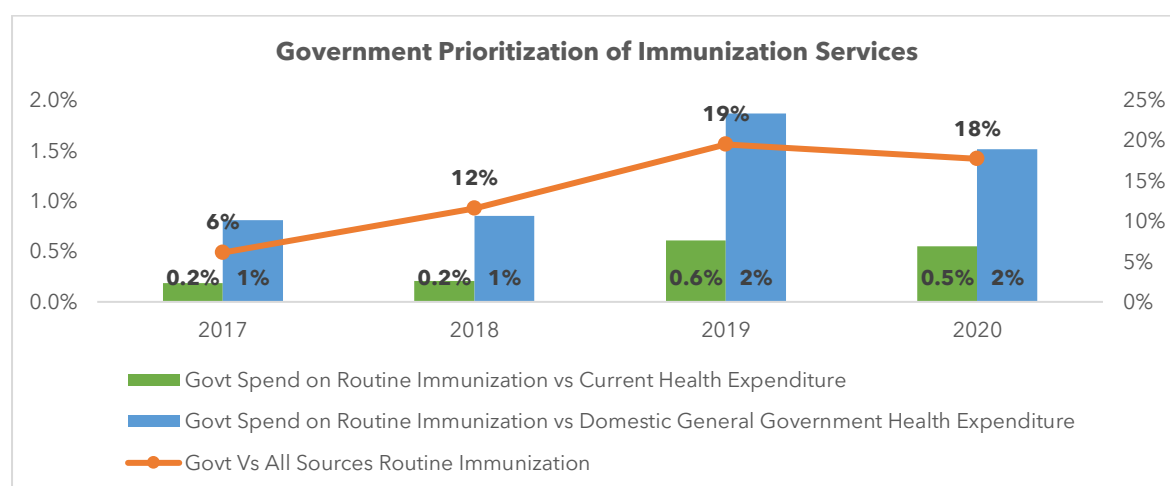


Figure 10: Government Prioritization of Immunization in Malawi

Government funding as a source of immunization financing increased from 6% to 19% between 2017 and 2020. This accounted for less than 1% of Current Health Expenditures and below 3% of the Domestic General Government Health Expenditure (**Figure 10**).

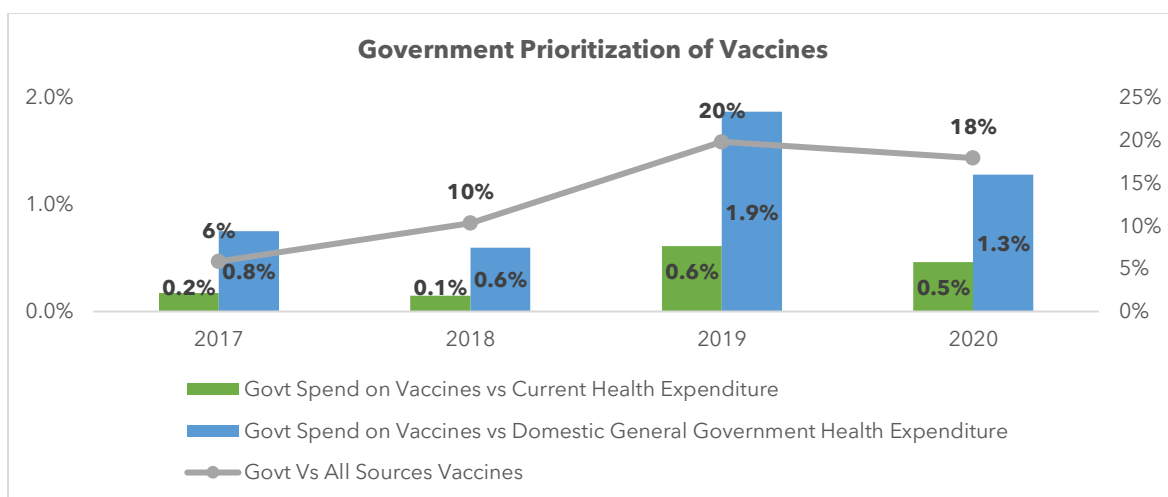


Figure 11: Government Prioritization of Vaccines in Malawi

Government funding as a source of vaccination financing increased from 6% to 20% between 2017 and 2020. This accounted for less than 1% of Current Health Expenditures and less than 2% of the Domestic General Government Health Expenditure (**Figure 11**).

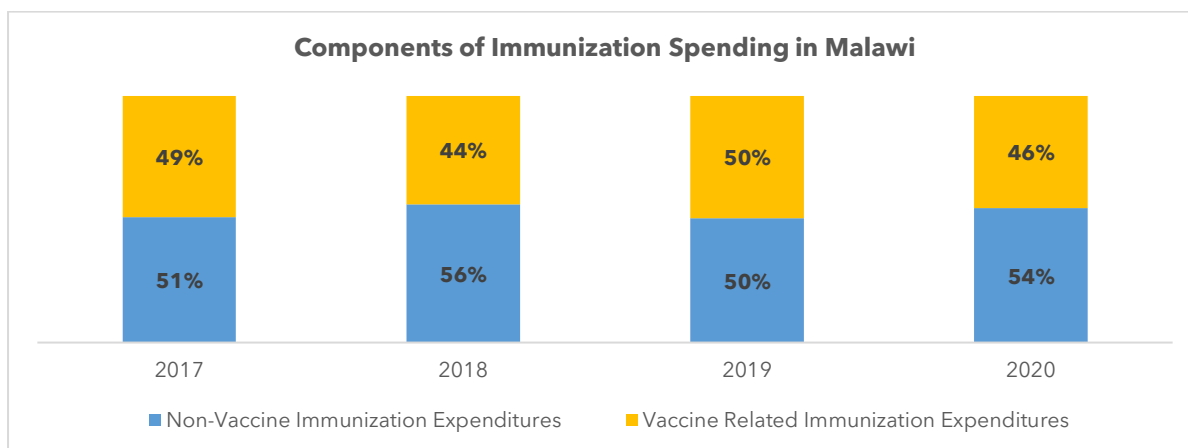


Figure 12: Components of Immunization spending in Malawi

Procurement of Vaccines accounted for about half of the immunization expenditures between 2017 and 2020 in Malawi (**Figure 12**).

Highlight

There is still significant donor dependence for immunization financing in Malawi. This threatens sustainability of immunization services. Progressive increments in government financing of health and immunization will help mitigate against donor dependence and financial hardship among households as they seek for immunization services.

Recommendations towards improving Immunization services in Malawi

- **Access to healthcare:** Expand mobile and outreach vaccination services, improve transportation infrastructure, partner with community leaders.
- **Healthcare worker shortages:** Invest in training and education programs, provide incentives to work in rural areas, optimize use of existing workers.

- **Vaccine availability and supply chain:** Strengthen supply chain management, invest in cold chain equipment, explore alternative procurement mechanisms.
- **Community awareness and education:** Conduct targeted awareness and education campaigns, engage with community leaders and religious groups, use social media.
- **Cultural beliefs and practices:** Work with community leaders and traditional healers, highlight the benefits of vaccination, and empower communities.
- **Gender and cultural norms:** Work with community leaders and women's groups, empower women, and provide female-friendly vaccination services.
- **Religious beliefs:** Engage with religious leaders and communities, highlight the compatibility of vaccination with religious beliefs, work with religious leaders to develop and implement vaccination campaigns.
- **Socioeconomic factors:** Implement social safety nets, provide free or subsidized transportation, and offer flexible vaccination schedules.
- **Geographic challenges:** Partner with community organizations, advocate for improved transport infrastructure, and embrace innovative technologies such as drones as in Rwanda and Kenya.
- **Political stability:** Work with government, development partners, civil society and security officials in the development and implementation of contingency plans.
- **Health system strengthening:** Invest in building and maintaining healthcare facilities, train and deploy more healthcare workers, implement electronic health records.
- **Vaccine acceptance:** Conduct regular surveys, address vaccine hesitancy, and progressively build trust in the healthcare system.
- **Disease outbreaks:** Strengthen surveillance and early detection systems, develop and implement contingency plans, and ensure adequate availability of vaccines and other resources.

Recommendations towards improving Immunization Financing

- Increase domestic government funding for immunization programs as a proportion of the overall healthcare budget.
- Align immunization financing with national priorities and strategic plans.
- Explore innovative financing mechanisms, such as public-private partnerships.
- Develop a multi-year funding plan for immunization programs to secure predictable and sustained government support.
- Improve transparency and accountability in immunization financing to build trust and confidence among stakeholders.
- Invest in domestic vaccine manufacturing capacity to reduce reliance on imported vaccines and reduce costs.
- Support partnerships between local and international vaccine manufacturers to transfer technology and knowledge such as the Africa Vaccine Markets Accelerator (AVMA) and the Partnership for African Vaccine Manufacturing (PAVM)¹ under the GAVI Alliance and African Union.
- Create a favorable investment environment for domestic vaccine manufacturers e.g., regulatory framework, tax incentives among others.
- Advocate for debt relief from the international community to free up resources for immunization and other essential healthcare programs.
- Advocate for predictable external donor funding for immunization.

¹ [new-era-vaccine-manufacturing-in-africa-wp.pdf \(gavi.org\)](https://www.gavi.org/publications/new-era-vaccine-manufacturing-in-africa-wp.pdf)

References

- GAVI. (2022). *Gavi Alliance Eligibility and Transition Policy Version 4*. <https://www.gavi.org/types-support/sustainability/eligibility>
- McIntyre, D., Meheus, F., & Rottingen, J. A. (2017). What level of domestic government health expenditure should we aspire to for universal health coverage? *Health Economics, Policy and Law*, 12(2), 125-137. <https://doi.org/10.1017/S1744133116000414>