

Demographic, health, and health financing context

The population of Malawi has progressively increased from 17 million to 20 million between 2017 to 2022. Infants less than 12 months and children under five years old account for less than 7% and 20% of the entire population respectively. The top three causes of death in the population between 2017 and 2022 were HIV related infections, neonatal conditions and lower respiratory tract infections. Neonatal mortality, malaria, pneumonia and diarrheal diseases were the main causes of under 5 mortalities.

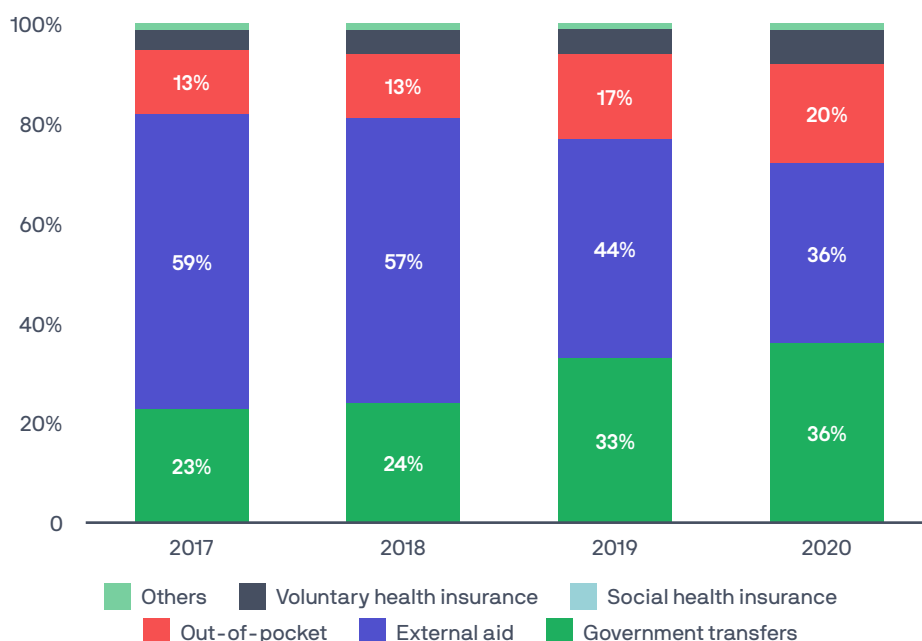
Government spending on health was at 2% of the Gross Domestic Product (GDP) which was markedly below the minimum of 5% recommended for progression towards UHC (McIntyre et al., 2017). The per capita spending on health was between USD 30 and USD 38, which was substantially below the recommended per capita 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.

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 Out-of-Pocket (OOP) payments 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 1)

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.

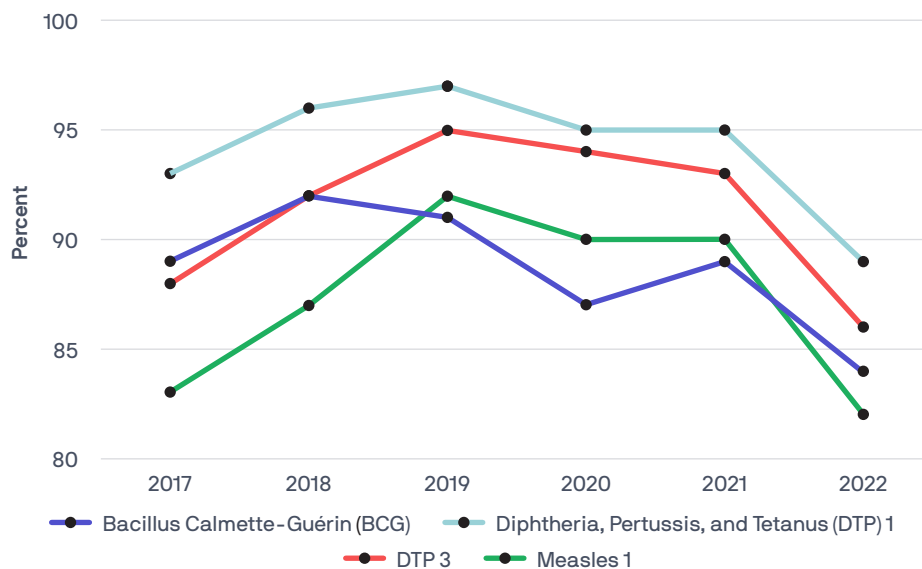
FIGURE 1. Health Financing Sources in Malawi



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 2).

FIGURE 2. Immunization coverage in Malawi



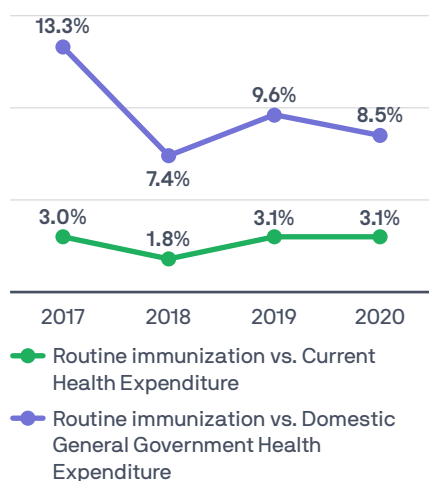
Overall, lower income groups had higher under five mortality rates, and lower immunization coverage which indicate income related inequities. There was a gap of more than 20 deaths per 1000 live births among the under-fives between the wealthiest and poorest income groups. The coverage gaps for DTP3 and MCV: Meningococcal Conjugate Vaccine (MCV) 2 between the wealthiest and poorest income groups were 15 and 10 percentage points respectively.

Immunization financing

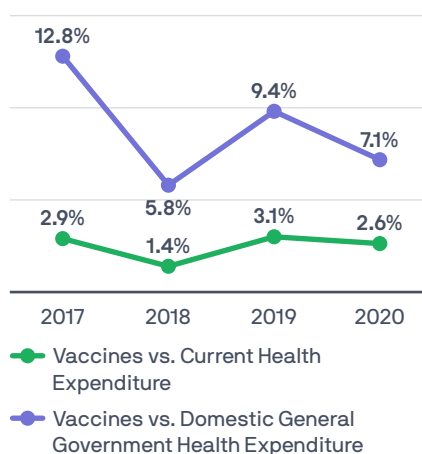
Expenditures on Routine Immunization in Malawi declined during the period of analysis. Routine immunization accounted for about 3% of the Current Health Expenditure (CHE); and between 7% and 13% of the Domestic General Government Health Expenditures between 2017 and 2020 (Figure 3).

FIGURE 3. Prioritization of immunization and vaccines in Malawi

Immunization prioritization



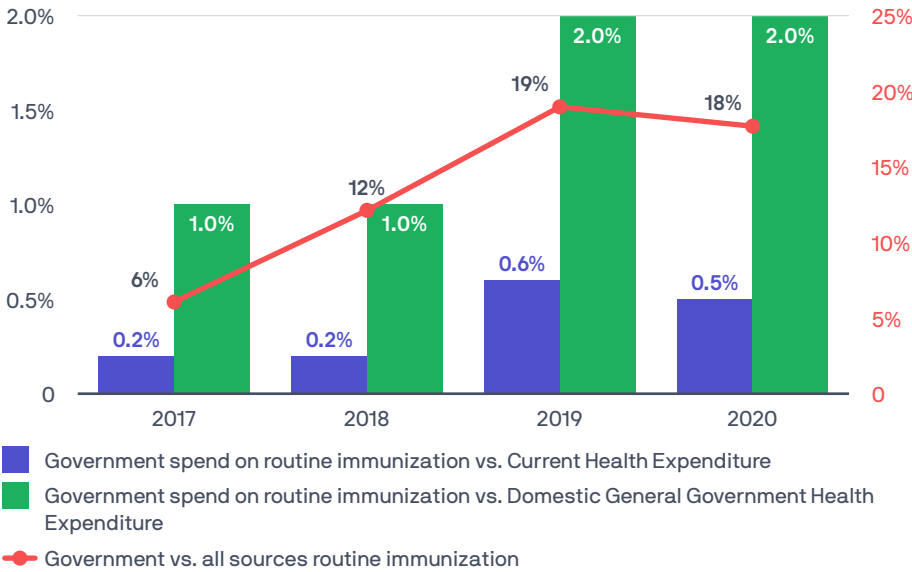
Vaccine prioritization



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.

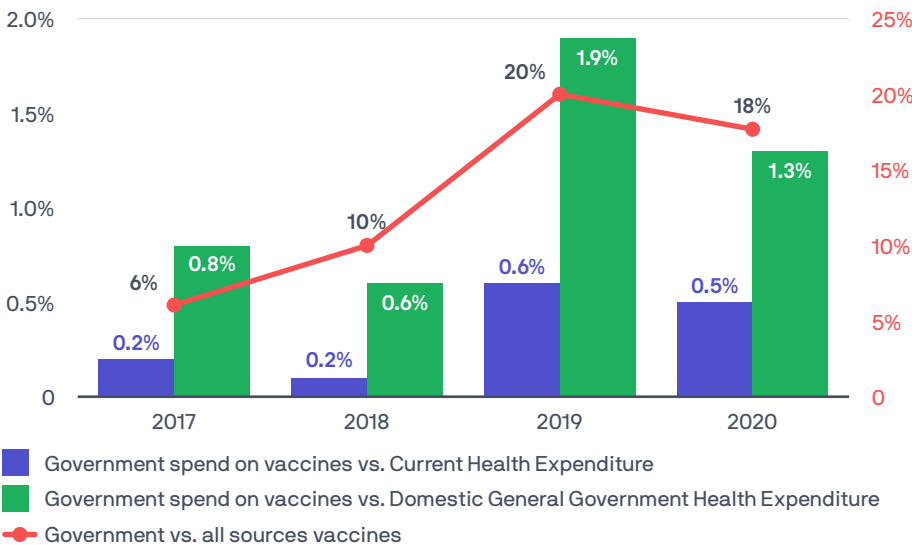
Government funding as a source of immunization financing increased from 6% to 19% between 2017 and 2020. This accounted for less than 1% of Current Health Expenditures and below 3% of the Domestic General Government Health Expenditure (Figure 4).

FIGURE 4. Government prioritization of immunization 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 5. Government prioritization of vaccines in Malawi



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 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.

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>