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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 23-Nov-2022 | Report No: PIDA35055

Public Disclosure Authorized

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Malawi	P180231	Malawi Emergency Project to Protect Essential Health Services	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EASTERN AND SOUTHERN AFRICA	22-Nov-2022	22-Dec-2022	Governance
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Republic of Malawi	Ministry of Health	

Proposed Development Objective(s)

To provide emergency support and enable the continued delivery of essential health services.

Components

Protecting provision of frontline health service delivery
Provision of essential medicines
Enhancing the efficiency and accountability of public spending in the health sector
Project management

The processing of this project is applying the policy requirements exceptions for situations of urgent need of assistance or capacity constraints that are outlined in OP 10.00, paragraph 12.
Yes

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	100.00
Total Financing	100.00
of which IBRD/IDA	100.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	100.00
IDA Grant	100.00

Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Malawi is a landlocked country in south-eastern Africa and one of the poorest countries in the world.** Malawi's per capita gross national income is US$360 (2018), and 70 percent of the population lives below the international poverty line. Economic development is heavily dependent on the agriculture sector. With limited land, Malawi's environment is already under stress, and sustained population growth will only increase the burden. These challenges are further complicated by Malawi's limited regional integration, landlocked geography, lack of agricultural diversification, and by the growing frequency of climate-related natural disasters, which require improved economic, social, and physical risk management.

2. **Malawi is prone to adverse climate hazards that include dry spells, seasonal droughts, intense rainfall, riverine floods, flash floods, and cyclones.** Climate hazards have increased in frequency, intensity, and magnitude over the past twenty years, with consequences for food and water security, water quality, energy resources, and sustainable livelihoods especially among rural communities. The increasing incidence of floods and droughts has contributed to malnutrition among young children and chronic ailments associated with malaria, cholera, and diarrhea. Projections of malaria in Malawi indicate that incidence of the disease will increase with projected climactic changes and that the disease will become increasingly tied to seasonal weather patterns.[1] Malawi experiences seasonal cholera outbreaks, which are associated with rains in the country and further exacerbated by flooding (the current cholera outbreak is described in paragraph 25).[2] In late January of 2022, Tropical Storm Ana impacted 221,000 households and approximately 60 health facilities. Thirty-seven people were killed in the storm and another 150 injured.[3]

3. **Malawi's economy remains weak following numerous external and domestic shocks.** The COVID-19 pandemic hit at a time when the economy was vulnerable due to sustained macroeconomic imbalances and the impact of two cyclones in 2019. Climate-related shocks, including cyclones, floods and prolonged dry spells in 2018-2020 contributed to subdued economic growth. According to the new Malawi Climate Change and Development Report (CCDR), climate change could reduce Gross Domestic Product (GDP) by 3-9 percent in 2030 and push an additional 2 million people into

[1] https://www.climatelinks.org/sites/default/files/asset/document/2020_USAID_ATLAS_The-Influence-of-Climate-on-Malaria-Incidence-in-Malawi_updated.pdf
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3588220/
[3] https://www.pih.org/article/cyclone-rips-through-malawi

poverty if Malawi stays on its current low-growth trajectory.[4] Following the emergence of the COVID-19 pandemic in 2020, the government implemented mobility restrictions to contain the spread of the virus. The impact of this on the domestic economy and trade resulted in economic growth falling below 1 percent in 2020. At the onset of the recovery process, Tropical Storm Ana and Tropical Cyclone Gombe hit the economy in early 2022, with substantial damage to farmland and infrastructure, disrupting agriculture activity and mobility. The destruction of the Kapichira dam on the Shire River resulted in the loss of one third of Malawi's electricity supply, affecting all sectors of the economy but particularly manufacturing and services. The war in Ukraine has now introduced an additional supply constraint and the subsequent terms of trade shock has aggravated vulnerabilities in the economy. In turn, GDP per capita is projected to contract by over 1 percent in 2022, with only a tepid recovery expected in 2023. In sum, these shocks halved 2022 growth projections over the past year from 3 percent down to 1.5 percent.

4. **The impact of these shocks has contributed to a deterioration of Malawi's fiscal position.** The reduction in budgetary grants following the 2013 "Cashgate" scandal and declining domestic revenue, paired with weak fiscal management and high deficits, has resulted in limited fiscal space. Increased spending pressures to respond to recurring macroeconomic and climate-related shocks, in addition to the COVID-19 pandemic, further pushed the fiscal deficit upwards. Consequently, the deficit deteriorated to a record high of 8.8 percent of GDP in FY21/22. The war in Ukraine has induced additional spending pressures. As a result, the fiscal deficit is estimated to widen to 10.6 percent of GDP in FY23, further constraining fiscal space for the implementation of government discretionary policy as well as to respond to shocks.

5. **A weakened export sector amidst high import demand has resulted in a severe balance of payments crisis.** Exports have been steadily declining in recent years, but trade disruptions from the pandemic and the war in Ukraine exacerbated vulnerabilities in the external sector. The COVID-19 pandemic had disrupted the flow of goods and services. This has since improved with easing of the pandemic. However, war-related rising of commodity prices has increased the import bill for Malawi, further negatively impacting its current account deficit. With declining development assistance and foreign direct investment, the recent rise in commodity prices has depleted foreign exchange reserves. Official reserves have declined to US$95.7 million (about 0.38 months import cover) as of the end of August 2022. To support a fixed exchange rate system amidst diminishing reserves, the Reserve Bank of Malawi (RBM) resorted to contracting short-term foreign exchange swaps. However, persistent liquidity challenges have pressured the RBM to convert the facilities to medium-term commercial external debt. As the shortage of foreign exchange persisted and demand increased, foreign exchange bureaus adjusted their market exchange rate upwards, widening the margin with the official rate. To contain the pressure and align to the market rate, the RBM devalued the exchange rate by 25 percent in May 2022. Combined with elevated global commodity prices, this has resulted in higher domestic prices. Inflation increased to 25.9 percent in September 2022, the highest rate since 2014, with food inflation at 33.7 percent.

6. **The twin fiscal and balance of payments crises have worsened public sector debt vulnerabilities, pushing the country into debt distress in the most recent World Bank-International Monetary Fund (IMF) Debt Sustainability Analysis (DSA).** The financing of fiscal deficits with high-cost domestic financing has resulted in the increased accumulation of high-cost domestic debt. As of the end of FY22, domestic debt had increased to 42 percent of GDP in FY22 from 27 percent in FY21 At the same time, the conversion of short-term foreign exchange swap facilities into medium-term commercial debt has rendered external debt vulnerable, increasing it to 36 percent in FY22 from 33 percent in FY21. The recent joint World Bank-IMF DSA reported that Malawi's public debt is in distress, with debt restructuring negotiations ongoing. Debt servicing costs have gone up, and the GoM projects that interest expense

[4] World Bank, 2022. Malawi Country Climate and Development Report (CCDR), *https://openknowledge.worldbank.org/bitstream/handle/10986/38217/P1772201ced75ce9182e7142761bde013662bca4fe42.pdf?sequence=1&isAllowed=y*

alone will take up 30 percent of budgeted revenues in FY23.

7. **Foreign exchange shortages are constraining external debt servicing and the importation of strategic commodities.** The RBM has defaulted on several foreign exchange facilities. At the same time, shortage of foreign exchange reserves has negatively affected importation of strategic commodities, including fuel, fertilizer and pharmaceuticals. The government has prioritized importation of fuel, which has negatively impacted the availability of foreign exchange for other strategic commodities. The country currently faces a severe shortage of fertilizer at the onset of the growing season.

8. **Limited fiscal space constrains the ability of the GoM to respond to pressures in the health sector.** The government is implementing fiscal consolidation measures aimed at reducing deficits as it seeks to improve fiscal governance and the sustainability of public debt. However, to attain this, the government will need to prioritize spending within the approved targets. This will entail implementing austerity measures for the second half of FY23 and beyond, which may affect provision of essential social services including health. At the same time, health spending demands are expected to increase, especially with elevated pressures to respond to the current cholera outbreak, which is the worst in ten years. Given these resource constraints, planned allocations to the sector will not be adequate to address needs. Furthermore, as in previous fiscal austerity years, the health sector is likely to experience delays in funding, which may also strain service provision.

Sectoral and Institutional Context

9. **The health service delivery system in Malawi is organized at three levels (primary, secondary, and tertiary), which are linked by a referral system.**[5] The services are delivered through a network of public, Non-Governmental Organizations (NGOs), Private-not-for-Profit, and Private-for-Profit providers. Health services in the public sector are free-of-charge at the point of use. As of 2019, there were a total of 1,098 health facilities in Malawi, of which 52 percent were owned by the government, about 23 percent were Private-for-Profit and the remaining 25 percent were private-not-for-Profit, NGO, and institutional clinics (e.g., military).[6] The public health facilities deliver nearly 60 percent of health services and directly employ over 70 percent of the health workforce. The Christian Health Association of Malawi (CHAM)[7] owns 15 percent of health facilities and delivers about 35 percent of health services. CHAM complements public facilities through a memorandum of understanding (MOU) or Service Level Agreements (SLAs) with the MoH. The MoH provides oversight to the health sector in Malawi and its specific functions include strategic planning, policy making, standards setting, technical support, monitoring and evaluation, quality assurance, resource mobilization, and international representation.[8] Five Zonal Quality Management Offices (QMOs) are an extension of the central level MoH and provide technical support to districts. The MoH is also responsible for the oversight of central hospitals. At the district level, in line with the decentralized architecture, District Councils oversee the management, planning, execution, and evaluation of the health District Implementation Plans (DIPs) and budgets. The councils' secretariats have several directorates of which one is for Health and Social Services, whose director heads the District Health Management Team (DHMT). The functions of the DHMT include managing all public health facilities at district level and directing provision of both primary and secondary level health services at the district level.

10. **Malawi has made significant progress in improving the health of its population over the last decade, but significant challenges remain**. Average life expectancy has increased over the last 10 years for both men and women.[9]

[5] The primary care level is intended to meet the needs of general medical care and comprises health centers and their constituent clinics.
[6] Ministry of Health, "Malawi Harmonized Health Facility Assessment," Ministry of Health, Lilongwe, 2019.
[7] Christian Health Association of Malawi (CHAM) is a non-governmental faith-based organization providing preventive and curative health care services through its health facilities and training colleges. In rural and hard-to-reach areas, CHAM provides a majority of the health services, allowing access to populations in areas where public health facilities do not exist or are hard to reach. https://cham.org.mw/
[8] Ministry of Health, "Malawi Health Sector Strategic Plan III (Draft)," Ministry of Health, Lilongwe, 2022.
[9] Ministry of Health, "Health Sector Strategic Plan III: Situation Analysis Report," Ministry of Health, Lilongwe, 2022.

This is attributed mainly to reductions in adult and childhood mortality because of robust implementation of HIV and maternal and child health lifesaving interventions. The maternal mortality ratio declined from 439 per 100,000 live births in 2015 to 349 per 100,000 live births in 2019. Under-5 mortality rate declined from 63 per 1000 live births in 2015 to 56 per 1000 live births in 2019. Infant mortality rate and neonatal mortality have trended downwards with 42 and 27 per 1000 live births in 2015 and to 40 and 26 deaths per 1000 in 2019 respectively. Similarly, mortality from HIV has decreased by more than 50 percent since 2010 with a stable TB death rate of 14 cases per 100,000 people in 2020. Despite these gains, Malawi is still lagging in certain health outcomes. About 40 percent of Malawi's children below the age of five are stunted, 3 percent are wasted, and 12 percent are underweight. The adult survival rate in Malawi is also worse than the averages for regional and peer countries. Non-communicable disease and injury mortality has been on an increase over the last decade and now account for over 40 percent of mortality in Malawi. Only 73 percent of the children aged 15 in Malawi today will survive until the age of 60 and adolescent fertility rate, which was estimated at 132 births per 1,000 women aged 15-19 in 2018, is higher than the averages for regional and peer countries.

11. **The COVID-19 pandemic as well as the recent polio and cholera outbreaks threaten to reverse the progress made in health outcomes.** These public health emergencies have added strains to the health system in terms of shortages of health workforce, financial resources, and essential medicines/supplies to support the provision of services. As a result, the delivery of EHS such as those for sexual and reproductive health, vaccine-preventable diseases, malaria, integrated management of childhood illnesses, tuberculosis, nutrition, and HIV/AIDS services has been negatively affected. An analysis of the routine data reported by public health facilities to the Health Management Information System (HMIS) shows recurrent disruptions in outpatient consultations, child vaccination, antenatal care, institutional deliveries, and postnatal care between April 2020 and December 2021. For instance, the number of fully immunized children during the pandemic was consistently below expected levels, with the largest disruption observed during the peak of the COVID-19 second wave (February – March 2021). Similarly, institutional deliveries were consistently lower than expected during the first wave of the pandemic (May – November 2020). Lapses in the delivery of EHS could erode the hard-fought gains over the last decade on some of the key health outcomes. Malawi is ranked 154 out of 195 countries on the 2019 Global Health Security Assessment (GHSA)[10], which suggests that its ability to prevent, detect, and respond to epidemics and/or pandemics is limited. Hence, the risk of public health emergencies remains high due to limited capacity for pandemic preparedness and response. The recent polio and cholera outbreaks have put further intense pressure on the health system, especially on the health facilities at the district levels, which are ill-prepared to cope with the increased demand for health services arising from emergencies, over and above the regular demand for public health services.

12. **Malawi has a chronic shortage of critical health workers, which has further been exacerbated by recent fiscal and foreign exchange constraints.** The health system, which serves over 19 million people, has about 12,000 core health workers, comprising 21 percent clinical staff, 31 percent nurses and midwives, 5 percent auxiliary staff, and 43 percent preventative services staff. Approximately 70 percent of the health workforce is made up of female health and social workers, making health the sector that employs more women in Malawi. The overall health workforce density is 10.42 core health workers per 10,000 population, which is significantly below the WHO target of 23 health workers per 10,000 population. The vacancy rate for key health workers stands at 61 percent in 2022, including 77 percent, 43 percent and 81 percent among medical doctors, nurses, and lab staff, respectively. The shortage of health workforce overstretches the health providers and affects the quality of care. The provider caseload (the average number of outpatient consultations conducted by a health provider per day) in Malawi is 40.1, which is substantially higher than the caseloads reported in Kenya (13), Tanzania (10), and Sierra Leone (8). The caseloads are higher in rural (43.3) compared to urban health facilities (23.6). Despite the high vacancy rate, huge shortages, and immense need for health workers in Malawi, the MoH has been unable to fully absorb and utilize the health professionals. In 2015, the

[10] Global Health Security Assessment (2019): https://www.ghsindex.org/wp-content/uploads/2019/10/2019-Global-Health-Security-Index.pdf

government suspended mass recruitment in civil service due to budgetary and fiscal constraints.[11] The MoH has since been unable to recruit all the new health workforce graduating from the training institutions, which has led to high unemployment and a vacancy rate, which has almost doubled in the last two years.

13. **Expenditures on the health workforce absorb over half of the total public funds in the health sector**. Between 2014 and 2019, an annual average of 51 percent of total public expenditure on health was on personnel emoluments. This is even higher at the district level, where the share of spending on personnel emoluments was 73 percent in 2019.[12] The public health sector wage bill, as a share of total public expenditure on health in Malawi, is higher than some of the lower middle-income countries in the African region such as Angola, Tanzania, Kenya, and Lesotho (while the salary level of health workers in Malawi is among the lowest in the region), but lower than Zambia, Zimbabwe, and Seychelles. High expenditure on health staff has crowded out spending on medicines and other supplies. Expenditure on Other Recurrent Transactions (ORT) comes second followed by expenditures on drugs and medical supplies, and lastly infrastructure development. Between 2017 and 2019, expenditure on drugs and medical supplies as a share of the total public expenditure on health remained constant at 16 percent, which only represents 52 percent of the actual resources required. The current level of funding only caters for about six months' supply of drugs and supplies, which leads to persistent shortages in health facilities. Development expenditure, as a share of the total public expenditure on health, has varied from 5 percent in 2014/15 to 22 percent in 2021/22, and mostly constitutes expenditure on physical structures and medical equipment.

14. **Despite increases in health expenditure, Malawi's per capita expenditure remains well below the estimated need to provide EHS.** Malawi's total Current Health Expenditure (CHE) is estimated at US$39 per year and is lower than the funding that is required to provide essential healthcare as outlined in the national Essential Health Package (EHP).[13] Thus, only 44 percent of the health facilities in the country can comprehensively deliver health services outlined in the EHP. This is significantly below the 80 percent target outlined in the second Health Sector Strategic Plan (HSSP II) 2017-2022. The 2019 Malawi Harmonized Health Facility Assessment (MHHFA) revealed that there is limited health worker capacity, inadequate medical supplies and equipment, and weaknesses in governance and management. Specifically, the assessment established that on average health facilities (i) have 38 percent of the essential medicines; (ii) can perform 47 percent of the basic diagnostic tests; (iii) have 64 percent basic amenities items and 75 percent of basic equipment items; and (iv) lack the trained staff, guidelines, equipment, medicines and commodities, and diagnostic capacity required to deliver health interventions.

15. **The health system has not yet recovered from the unprecedented impact of the COVID-19 pandemic, and the ongoing fiscal and balance of payments crises could worsen the situation.** Beyond human resources, there is also evidence of payment arrears for electricity, fuel, and food supplies for in-patients, as well as for drugs and medical supplies. Persistent stock-outs of critical drugs and medical supplies have been reported and many public facilities including hospitals are asking patients to buy prescribed medicines from private pharmacies out-of-pocket. The country is also responding to a major cholera outbreak with limited basic essential supplies needed to save lives such as intravenous fluid and first line antibiotics, and this has contributed to a high fatality rate. The extent of these problems is still being estimated; however, the adverse effect on service delivery is already evident.

16. **While drug shortages in public health facilities are not new, the current situation has been exacerbated by drug supply shortages globally and scarcity of foreign currency.** The country relies on imports for 90 percent of pharmaceutical products while local manufacturers also rely on imported raw materials. The Central Medical Store Trust (CMST) is the largest purchaser of medicines in the country, accounting for 70-90 percent of total annual

[11] S. Jerving, "Devex," 06 February 2018. [Online]. Available: https://www.devex.com/news/despite-efforts-to-train-health-professionals-malawi-s-government-isn-t-hiring-91994.
[12] World Bank Group, "Public Spending in the Health Sector in Malawi," World Bank, Washington DC, 2020.
[13] Ministry of Health, "Essential Health Package," Ministry of Health, Lilongwe. https://www.health.gov.mw/index.php/essential-health-package

pharmaceutical consumption at a value of US$10 million to US$100 million, while the private sector is much smaller (around US$4 million to US$5 million). Most importers are running on reduced capacities of about 30 percent due to the current foreign currency charges, exacerbated by the general increase in price of goods due to external shocks. This has led to an increase of up to 106 percent in the price of pharmaceutical products with medicine used to treat common infections. The import gap for pharmaceuticals has been quoted at about US$14 million needed to cover backlogs and about US$10 million required per quarter for essential medicines for both central and district hospitals.

17. **The recent foreign exchange crisis has impaired CMST's ability to meet the demands of essential medicines as the backlog of payments in US$14 million has accumulated, affecting its ability to procure the types and quantities needed by public health facilities.** This has resulted in unreliable distribution or persistent stock-outs of essential medicines (especially fast-moving commodities), including those that are lifesaving, for a prolonged period of time. While the country has benefited from donor-funded programs largely in the areas of HIV/AIDS, TB, malaria, and family planning, and thereby receives a steady flow of commodities associated with these programs, essential medicines have not been supported by any of the donor programs and are the most affected by the current crisis. Anecdotal evidence backed by visits to selected health facilities revealed that fast-moving drugs and commodities, such as antibiotics, antifungals, antiseptics, syringes, IV fluids and cannula, catheters, and feeding tubes for neonatal intensive care units are in severe shortage or out of stock. Patients seeking care at public health facilities are predominantly economically vulnerable populations. When there are no essential drugs available at health facilities for their prescribed needs, they are asked to go to pharmacies to purchase medicines out of pocket, placing economic strain on the already disadvantaged households. Sterilizers at a number of hospitals are left non-functional due to the government's inability to pay for service/maintenance contracts, affecting infection prevention and control.

18. **These constraints to health service delivery risk being further exacerbated by the reemergence of polio and cholera in Malawi.** The multiple waves of COVID-19 and the government's mostly successful efforts to contain the virus and its vaccine deployment efforts at health facilities and in communities disrupted the provision of other EHS. An already weak health system was stretched further as the demands on medical staff increased due to rising pandemic-related needs. While the pressure from the pandemic has eased, the emergence of polio and an outbreak of cholera, the worst in ten years, is posing another health risk in the country. In February 2022, the MoH declared an outbreak of wild poliovirus type 1 in Lilongwe, and has since ramped up efforts in polio vaccination, mobilizing facility-based and community-based health care workers. Cholera has spread rapidly since the current outbreak was declared in March 2022. The case fatality rate, at 3.10 percent (national average; with wide variability across districts), is significantly higher than the World Health Organization (WHO) benchmark of 1 percent for cholera epidemics. Insufficient access to safe drinking water and inadequate sanitation, poor access to health services (including long distances), and lack of awareness on how to support affected people are contributing to the high case fatality rate. As of November 7, 2022 the cumulative number of confirmed cases and deaths reported was 7,030 and 207 respectively across all 28 districts in Malawi, indicating that the outbreak has now spread across the whole country. This is of significant concern when considered alongside the early onset of rains this year, combined with the dire impact cholera can have on 3.8 million food insecure individuals. Cholera Treatment Units (CTU) have limited resources and inadequate supplies needed to treat the high number of cases, along with challenges to provide quality case management, infection, prevention, or cholera control. Health care workers in CTUs and Health Surveillance Assistants (HSAs) in communities are overstretched with other competing priorities such as polio and COVID-19 response and vaccination efforts, and global shortages of cholera vaccines continue to impact the country.[14]

19. **Persistent implementation gaps in Public Financial Management (PFM) and institutional capacity are**

[14] The International Coordinating Group on Vaccine Provision approved the application for 2.9 million oral cholera vaccine doses for Malawi, which are expected to be in country by mid-November,2022. The vaccines will protect at risk populations and contribute to the control of the outbreak in 14 districts across the country, including districts which have not been vaccinated previously.

continuing to affect value-for-money in delivery of health services. Ministries Departments and Agencies (MDAs) across Government (including MoH) continue to underutilize the new Integrated Financial Management Information System (IFMIS) capability for cash management and commitment controls. This weak management of commitments is resulting in a continued build-up of arrears, restricting fiscal space and affecting the ability to finance planned service delivery. This lack of controls, in turn, weakens the trust of development partners in the governance and financial management of the health system. Consequently, the majority of the support for the sector is being channeled through off-budget systems, which makes it cumbersome to track. In addition, payroll of the essential CHAM workers supported by the government is outside the Human Resource Management Information System (HRMIS), making it difficult to track efficiency of the system and this wage bill has been rising significantly in recent years.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To provide emergency support and enable the continued delivery of essential health services.

Key Results

a) Percentage of women with live births that received ANC 4 or more times
b) Percentage of children fully immunized
c) Number of deliveries attended by skilled health personnel (Corporate Result Indicator)
d) Number of facilities reporting stock-outs of essential tracer medicines
e) Citizen satisfaction (disaggregated by gender) with accountability and adequacy of provision of essential health services at front-line facilities

D. Project Description

20. **The proposed project will ensure temporary emergency funding for essential expenditures necessary for delivering health services for the citizens of Malawi in the midst of crisis response.** Specifically, the operation will: (i) protect the provision of resources for payment of front-line health service providers and timely access to essential operating expenditures (Component 1); (ii) provide bolstered provision of essential medicines to health facilities while investing in increasing confidence in systems for procurement and last-mile distribution to health facilities (Component 2); and (iii) strengthen core HRM, PFM, and accountability systems in the health sector (Component 3).

Component 1: Protecting provision of frontline health service delivery

21. **This component will provide emergency financing to support the government to protect and sustain delivery of EHS.** The bulk financing will support wages and salaries of frontline health workers already on the payroll of the MoH that are providing primary health care services at the frontlines of service delivery in health facilities particularly in vulnerable communities, including in climate vulnerable areas. It will also provide additional 'surge financing' for essential operating expenditure that ensures health facilities remain functional, provide EHS, and remain resilient to current and future pandemics and other crises.

22. **PBCs will incentivize the strengthening of human resource and financial management systems that are essential for efficient delivery of the emergency financing.** The PBCs are explicitly designed to ensure that the project operates as a holistic framework for encouraging government to proceed with financial system strengthening across key health sector areas. Following the joint DHRMD-MoH payroll controls action plan, PBC 1 on payroll integrity will incentivize the implementation of regular checks of the payroll's accuracy (including staff verification) – moving away from a system that currently undertakes 'one-off' checks at times and without systemic follow-up of findings. PBC 2 on timely and predictable budget releases will incentivize the protection of the current recurrent health budget in light of

increasing fiscal constraints while the project provides additional financing to fight cholera and polio outbreaks. Finally, PBC 3 on implementation of commitment controls will incentivize the use of central IFMIS to record all commitments at the point of contract signing to prevent crowding out of essential service delivery as the expense of arrears that are accumulating outside of formal systems. By tying receipt of PBC-triggered financing to strengthening of core systems of control and oversight in the health budget, the proposed operation seeks to strengthen fiduciary controls over the use of funds. In the medium term, it is expected that the impacts of the PBCs will further strengthen the confidence in and incentives for both the government and development partners to provide more resources on-budget to support Malawi's health service delivery.

Subcomponent 1.1: Support to frontline health workers

23. **This subcomponent will cater for wages and salaries of frontline health workers providing primary health care services at the district level, who are already on the payroll of the MoH.** The wage bill for the entire Malawi public health sector is US$152 million in FY22/23 and comprises of 34,308 workers spread across District Health Facilities, Central Hospitals, MoH headquarters, and representation in other select MDAs. Of these, frontline health workers and HSAs form the largest number – totaling 67 percent of the entire health sector labor force (24,410 workers) and tending to patients at the point of service delivery in facilities across Malawi. Public health service provision is complimented by CHAM health facilities. CHAM services the health sector in areas where government facilities are non-existent. In October 2022, a total of 10,085 CHAM health workers were paid for through the CHAM Secretariat with GoM support.

24. **Frontline health workers in Malawi remain strained due to a combination of compounding public health crises and fiscal pressures.** Frontline health workers have been at the forefront of Malawi's response to the recent series of public health emergencies beginning with COVID-19 and continuing through the current cholera and polio crises. Malawi faces health workforce shortages of 48 percent against its national targets, with only 1.48 health workers per 1,000 population (below the recommended minimum of 4.45 doctors, nurses, and midwives per 1,000 population). Non-technical, frontline workers such as HSAs are meant to fill this gap and represent almost 40 percent of the health workforce in recent years.[15] The health sector wage bill has been growing (alongside the overall wage bill), estimated to have increased 22 percent in FY22/23 over the previous year and equivalent to 1.87 percent of GDP. Despite this growth in the health workforce, health centers remain understaffed and current staff are stretched. Furthermore, Malawi's macro-economic framework currently under negotiation will require employee compensation to reduce to 5.2 percent in FY25/26 (compared to 6.4 percent of GDP in FY21/22). These looming constraints are compounded by historical gaps in HRM, including the existence of ghost workers on MoH, district-level, and CHAM payrolls and mismatches in payments against grades identified in head count audits.

25. **The financing under this subcomponent will ensure that the existing wages and salaries for frontline health workers are paid in full, on a predictable and timely basis.** Frontline health workers and HSAs have the responsibility to: (i) provide primary health care along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care, (ii) ensure equitable access to services, and (iii) reach vulnerable populations, particularly during health and climate-related crises. Given their essential role in health service provision, the proposed operation will focus on supporting wages and salaries for this segment of the overall health workforce, the majority of which are women. Their wages and salaries will be supported from third quarter of FY23 and run an equivalent of two fiscal years, up to the first quarter of FY25.

26. **Implementation of this subcomponent involves a robust control and oversight framework to ensure that the financing is being used to meet eligible expenditures.** As such, details of placements in the health sector were shared

[15] HSAs are recruited by the government, must have secondary school level education and receive 12 weeks training. Once employed, they are supposed to reside in their catchment area, working mainly in health promotion and prevention for a population of about 1,000. They are attached to a hospital or health center, but are supposed to spend most of their time in the community.

to DHRMD by the MoH, and updated payroll records were shared with MoFEA/Accountant General Department (AGD) for processing of wages and salaries. A detailed review of wages and salaries for the health sector has been carried out as part of the DHRMD payroll audit and by the MoH. The MoH prepared an action plan and is working with DHRMD to address recommendations from the two assessments, including migration of payroll data for CHAM health workers supported under the government's wage bill into the HRMIS. Achievement of PBC 1 through regular checks to test the payroll's accuracy will systematize the real-time cleaning of the payroll and introduce enhanced incentives for maintaining payroll integrity.

Subcomponent 1.2: Support to frontline health facilities

27. **This subcomponent will ensure health facilities remain functional by increasing by 25 percent the financing available for essential and eligible non-wage operating costs.** The annual MoH budget allocated to the prioritized list of essential recurrent expenditures to maintain health services is US$14 million. This allocated budget is insufficient, given the increasing demand for services with growing population, ranging from maternal, neonatal, child health and nutrition services, family planning, infectious disease control and treatment and treatment of injuries, to managing chronic diseases. The situation is exacerbated by the frequent and prolonged power outages Malawi has been experiencing, which affect service delivery. Health facilities are therefore faced with constant and increasing demand for fuel to run generators to minimize disruption. The recent rise in utility and fuel costs has added financial strain on the already tight budget for operating costs, affecting not only services at health facilities but also ambulatory services critical for emergency care, including emergency obstetric care and referral. The financial strain experienced by health facilities has also affected their ability to maintain service contracts for equipment and to cover the cost of food rations for patients who utilize public facilities, affecting primarily poor households. The achievement of PBC 2 on timeliness of budget releases will incentivize the timely and predictable release of the GoM health budget for essential recurrent expenditures in addition to funds provided by this subcomponent.

28. **Eligible items for support under this subcomponent are the following**: (i) service agreements for CHAM facilities[16]; (ii) service contracts for equipment; (iii) utility costs for health facilities; and (iv) fuel for ambulances and generators. Expenditure tracking to ensure the financing is being used for eligible items will be undertaken through review by the internal auditors of the MoH under the Comptroller of Internal Audit in combination with third-party monitoring (TPM) with competencies in internal audit including IT audits.

Component 2: Provision of essential medicines (US$13 million)

29. **The emergency financing under this component will support the MoH to address the issue of severe drug and medical supply shortage that Malawi is experiencing.** The proposed operation will ensure additional surge financing to support increased procurement and delivery of essential medicines to central and district-level health facilities to meet urgent needs. As 90 percent of essential medicines are imported, the Project Steering Committee (PSC) co-chair (Secretary to Treasury) in collaboration with the Reserve Bank Governor will undertake foreign exchange tracking of allocation towards essential medicines which will be reported upon at every PSC meeting. *Procurement* of essential medicines is anticipated to follow two modalities; first by UNICEF as the supplier contracted by Government and eventually by CMST procuring through the open market, the decision of which will be guided by assessments and system strengthening interventions supported by the proposed operation (see paragraph 48). In both modalities, *distribution* of essential medicines will be undertaken by CMST through its central and zonal warehouses and network

[16] Service-Level Agreements, or "SLAs", are agreements between CHAM facilities and District Health Offices (DHOs) of the Malawi government. wherein CHAM agrees to provide critical care services, free of charge, to communities that would otherwise not be able to access critical health services. DHOs then reimburse CHAM facilities for the cost of these services, allowing them to continue on their mission of delivering high-quality care to all.

of distribution system.

30. **Support to meet the immediate and urgent needs of essential medicines (drugs and supplies, including those for cholera) will be provided through the proposed operation and the Malawi COVID-19 Response and Health Systems Preparedness Project (P173806)**. Support under the Malawi COVID-19 operation is already under process and will cover up to two quarters of essential medicines on the "must-have" list (selected from the Essential Medicines List) provided by the MoH.[17] Procurement of these batches of essential medicines will be provided by UNICEF as supplier contracted by Government on the procedures agreed for the COVID-19 operation, while distribution will be undertaken by CMST. During this phase, the procured medicines will follow a push-system of delivery to facilities (as are other donated medicines and vaccines) based on the distribution plan developed by the MoH, which will be informed by the Logistics Management Information (LMIS) data. It is anticipated that this will enable the stocks at CMST and at health facilities to be gradually stabilized.

31. **Under the proposed project, procurement and distribution of essential medicines to health facilities will follow a pull-system of delivery.** The proposed project will contribute to ensuring that essential medicines are procured and stocked at CMST's central warehouse (whether through UNICEF as the supplier contracted by Government or by CMST procuring from the open market), from where health facilities will "pull" (order medicines) based on their utilization and needs by paying for drugs and cost of delivery by drawing on the allocated budget for drugs. It is critical that CMST regains and maintains its capital (revolving fund) to enable purchasing of drugs and supplies to maintain its stock so that it is able to effectively respond to demands and orders from health facilities; the proposed project will contribute to this process. The MoH Health Technical Support Services is responsible for monitoring and supervision of the supply chain system and has developed a quarterly supervision plan to undertake routine spot checks at selected facilities in selected districts.

32. **The procurement agent of the essential medicines under the proposed operation will be determined by an assessment of CMST's capacity to procure, manage, deliver and track dispensing and utilization to minimize the potential for leakage.** This assessment, together with knowledge gained from other development partner-funded assessments (e.g., Global Fund, USAID, etc.) and their on-going support to supply chain system strengthening will inform what aspects of the system need to be enhanced that can be supported by the proposed project to enable gradual transition of the procurement role from UNICEF to CMST. Innovative approaches to tracking of meds (e.g., barcodes, QR codes) already in place in countries in the region (Uganda, Tanzania, Zambia) will be explored and utilized.

Component 3: Enhancing the efficiency and accountability of public spending in the health sector (US$4 million)

33. **This component will strengthen core institutional systems that relate to efficient service delivery and accountability in the health sector.** Efficiency in service delivery has suffered from continued build-up of arrears, which has created uncertainty for suppliers and therefore higher prices. Quality of service delivery has suffered from insufficient budgets and the ever-present risk of delayed budget releases and funding; and inadequate payroll management has led to accountability concerns and efficiency losses. Addressing these issues is paramount in Malawi's fiscally constrained environment to allow for better resource utilization to maintain service delivery standards. In addition to the PBCs already identified in Component 1, this component will provide targeted technical assistance (TA) to the CMST.

34. **TA will be provided to strengthen processes and systems for more efficient resource management and expenditure control.** Achievement of results under Components 1 and 2 requires both high-level government

[17] Procurement of these batches of essential medicines will be undertaken by UNICEF as the procurement agent based on the procedures agreed for the COVID-19 operation, while distribution will be undertaken by CMST. Procurement of WaterGuard to support cholera response is complemented by the Malawi Investing in Early Years for Growth and Productivity Project (P164771).

commitment, and resolution of lower-level technical challenges. To support the GoM in overcoming the technical aspects of these reforms, targeted TA will be provided through Component 3. The TA is expected to focus on enhancing value-for-money in delivery of emergency financing for frontline service delivery in Component 1 and medicines procurement and distribution in Component 2. The delivery of this TA will be overseen by the Project Implementation Committee (PIC) and its precise nature will be determined based on progress under the components, achievement of the associated PBCs and the identification of other institutional bottlenecks.

35. Specifically, the TA activities will support components and results in the following ways:

a) **Payroll Management.** Recent audits and other reviews have indicated HRMIS control weaknesses that could potentially compromise wage bill management. Expected TA will cover: (i) an independent review of the robustness and effectiveness of controls covering the payroll processing environment in GoM; (ii) support to DHRMD for the migration of CHAM workers to the central government HRMIS; and (iii) support to DHRMD to develop an ongoing payroll robustness and verification strategy, including both desk-based and in-person inspection elements.

b) **Commitment controls within IFMIS.** Arrears within the health sector – and across government – have built up over recent years and pose a threat to future orderly budget execution. Technical assistance will therefore address the following: (i) training for relevant IFMIS users on current and future commitment controls within IFMIS in the MoH; (ii) review of the IFMIS Chart of Accounts structure in relation to MoH expenditure tracking needs to address any gaps in the current configuration, particularly any issues that are preventing effective deployment of commitment controls within the wider sector; (iii) support government to develop and deliver a plan for an arrears stock take in the MoH and the wider health sector; and (vi) development of a strategy to acquit the identified MoH and health sector arrears.

Component 4: Project management

36. **This component will finance the operational costs of delivery which will be prioritized around the emergency nature of the response.** The component will provide support for the array of project management functions to be undertaken with leadership by MoH as implementing agent. The component will support the institutionalization of functions for project implementation in a streamlined fashion within MoH and prioritize building on existing capacities. The core functions of project implementation will be undertaken by existing GoM staff and project staff from ongoing World Bank operations within the MoH wherever possible. A full-time Project Coordinator, Financial Management Specialist, Procurement Specialists (one in MoH and one in CMST) and Project Officer will be financed by this component. The component will finance fiduciary TPM) that will work alongside internal audit functions of MoH and DHRMD and the Independent Verification Agent (IVA) for verification of the PBCs.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

37. Overall the environmental and social safeguard risk rating for the project is moderate. The project will not finance any physical or civil works, there will be no acquisition of land or restrictions on access to land or natural resources, no indigenous persons are affected, therefore, the potential environmental impacts on biodiversity and on tangible or intangible assets and income, or cultural heritage are limited and are not likely to have any notable environment and social footprints on the ground. The potential direct and indirect negative impacts are related to non-compliance of waste management measures and labor and working conditions and resultant impacts on community health and natural resources, however these are localized and can be appropriately avoided, reduced, mitigated and managed. The impacts will be managed by the Project through the development and implementation of an Environmental and Social Management Plan (ESMP) and Stakeholder Engagement Plan (SEP). In addition, an Environmental, Social and Quality Management System Due Diligence will be undertaken.

E. Implementation

Institutional and Implementation Arrangements

38. **The MoH will be the implementing agency, responsible for the overall coordination, planning, implementation, and monitoring of the project.** It is responsible for delivering EHS and ensuring achievement of results, working in close collaboration with other key agencies including the MoFEA, CMST, DHRMD, and the Ministry of Local Government (MoLG). Implementation of the proposed project will be mainstreamed to the existing institutional arrangements of the MoH to ensure ownership and sustainability; no parallel structures will be developed for the purpose of this project.

39. **The project implementation structure reflects the emergency nature of the operation.** The functions of project implementation including managing the day-to-day operations of the project will be housed in the Department of Policy and Planning Development (DPPD) of the MoH. These core functions will be undertaken by existing GoM staff and project staff from ongoing World Bank operations within the MoH wherever possible. Any new recruitments will be undertaken under World Bank emergency procurement procedures allowing for streamlined, direct selection in line with qualifications set out in Terms of Reference (ToRs). The MoH will hire/appoint a full-time, dedicated Project Coordinator with primary responsibility for working across MDAs on implementation of the operation – with a particular focus on coordination between MoH, MoFEA, DHRMD, and CMST. Additional positions that will be hired/appointed with sole dedication to the operation will be: (i) Project Officer; (ii) Financial Management Specialist; and (iii) Procurement Specialists (one in MoH and one in CMST). The Environmental and Social Safeguard Specialist and Waste Management Specialist functions will be performed by consultants already employed by the COVID-19 operation. Finally, functions around (i) Monitoring and Evaluation (M&E), (ii) Human Resource/Wage Bill Management, and (iii) Public Financial Management will be undertaken by existing MoH, DHRMD, and MoFEA staff who will provide contributions to the project as part of their ongoing responsibilities. Detailed ToRs for the dedicated project implementation positions will be captured in the PIM. Where necessary, the team will be supported by additional consultants financed by the project. Other agencies involved in project implementation (including CMST; DHRMD; MoFEA – Budget Division, Cash Management Division, PFM Division, AGD; MoLG) will appoint focal persons who will serve as the link with the project team. The project implementation functions of this project and the Project Implementation Unit (PIU) of the COVID-19 operation will be linked and coordinated through the PIC.

40. **High-level leadership for the proposed operation will be provided by the PSC jointly chaired by the Secretaries for Health and the Treasury.** The PSC will provide strategic oversight and promote coordination and planning between entities in the implementation and monitoring of the operation's activities – which will be particularly critical for achievement of the PBCs which require co-production across MDAs. Members of the PSC will also include the Principal Secretary of Administration at the MoH and the Secretary of the Office of President and Cabinet (OPC). The Project Coordinator will serve as the Secretary to the PSC and will be responsible for organizing its meetings. The PSC will meet

initially every month for the first three months after project effectiveness, and thereafter quarterly. The ToRs for the respective committee members will be elaborated in the PIM.

41. **Chaired by the Chief of Health Services, the PIC will provide routine oversight and technical guidance during project implementation.** The PIC is responsible for ensuring that the implementation of the project is carried out efficiently and with the necessary technical quality. The members of the PIC will include: (i) Project Coordinator; (ii) Directors of relevant departments of MoH (including HR, Finance); (iii) Director from CMST; (iv) Accountant General; (v) Budget Director; (vi) Cash Management Director; (vii) Director from DHRMD; (viii) Director of Local Government Services from MoLG; (ix) Executive Director from the National Local Government Finance Committee; (x) Director from Internal Audit Unit; (xi) Director from Malawi National Audit Office; and (xii) Director from the Public Procurement and Disposal of Assets Authority. In addition to the delivery of project funded expenditures, the PIC representatives will have the primary responsibility for the coordination on achievement of the PBCs on areas on PFM and HRM in health. Representatives from other MDAs will participate in meetings as necessary. The PIC will meet initially every month for the first three months after project effectiveness, and thereafter quarterly. It will report to the PSC and ensure that implementing teams comply with agreed policy guidelines. The PIC can also call technical meetings with the participation of other project representatives to discuss issues of a cross-cutting nature and interface with the project, as and when required.

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