National Audit Office

REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL

HC 964
SESSION 2008–2009

30 OCTOBER 2009

Department for International Development

Aid to Malawi

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Amyas Morse
Comptroller and
Auditor General

National Audit Office

21 October 2009

This report examines the extent to which DFID has achieved its objectives in Malawi – objectives which require it to work effectively with and through others. We look at DFID work on health and food security in more detail, areas where DFID has been particularly active.

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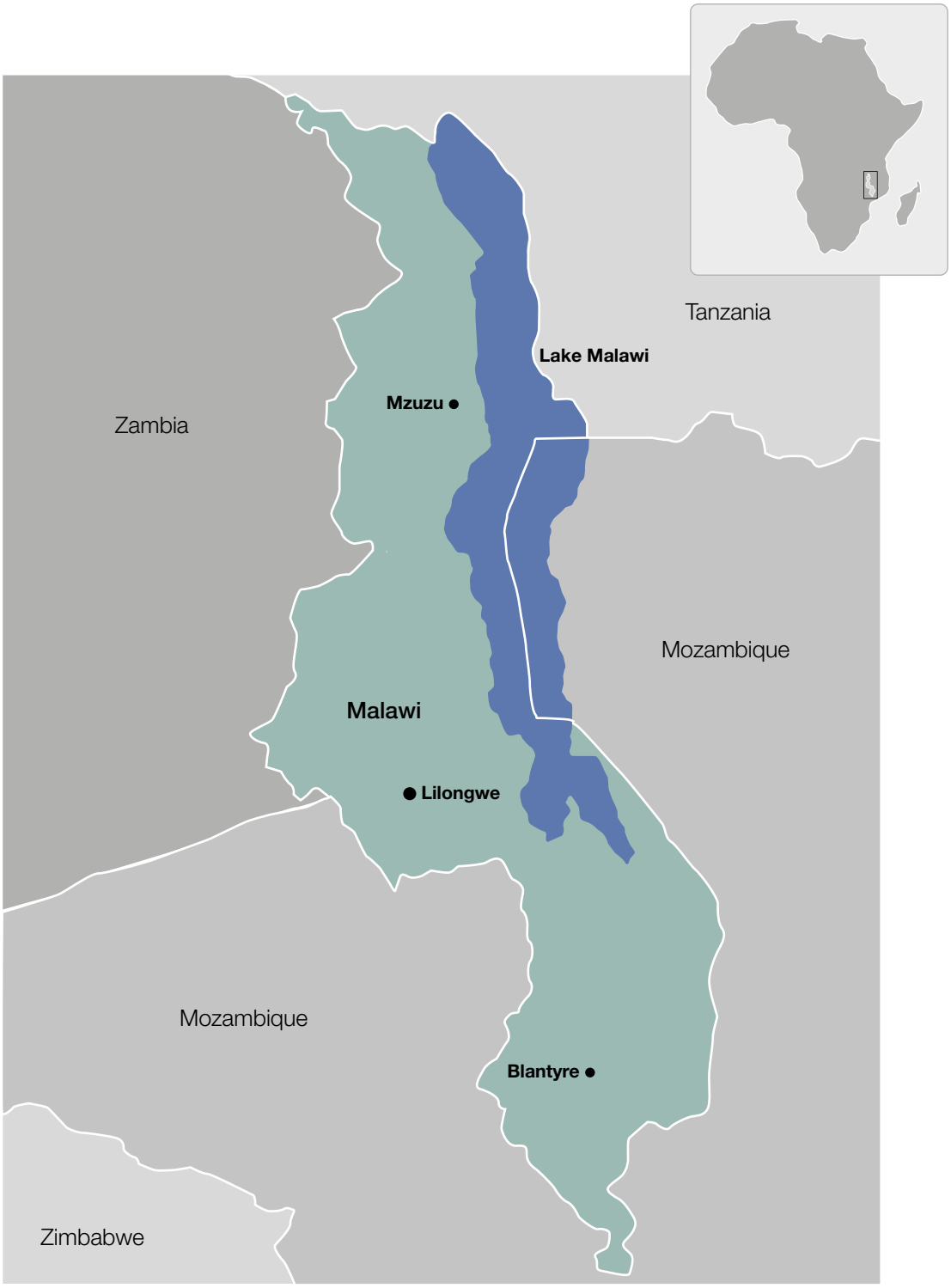
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Lake Malawi
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Zimbabwe

Summary

1 Malawi is one of the poorest countries in the world. It depends on maize for subsistence and on tobacco as its principal export, with few other industries or resources. The population has grown steadily, making Malawi one of the most densely occupied countries in Africa, with most households subsisting on about one hectare. Poor harvests and famine have dominated the lives of ordinary Malawians. Malawi also has inadequate physical and social infrastructure such as roads, utilities, schools and hospitals – particularly in the rural areas where 88 per cent of its people live. Most people are poorly educated. The Government of Malawi (the Government) has very limited financial and economic resources.

2 DFID has provided some £312 million (or 21 per cent of all aid) between 2003-04 and 2007-08[1], rising from £54 million in 2003-4 to a planned £80 million by 2010-11. This report examines the extent to which DFID has achieved its objectives – objectives which require it to work effectively with and through others. We look at DFID work on health and food security in more detail, areas where DFID has been particularly active.

3 Malawi has recently been one of the fastest growing economies in Africa, after decades of relative stagnation, and levels of poverty have decreased. Increased agricultural productivity has reduced hunger. The capacity of the health system has substantially improved, contributing to better health outcomes, although progress has been uneven. In treating AIDS, lowering child mortality and increasing immunisation coverage, improvements are at or above the rates DFID expected. Although maternal mortality has fallen from its 2000 peak, it is still not on track to achieve an internationally agreed target or the related DFID Malawi target. Relatively high rates of pupil enrolment in the free primary school system have not been matched by high pupil attainment. Governance is improving, though slower than DFID had expected – in part because the Government's Parliamentary minority between 2004 and 2009 hindered the passing of legislation and budgets, affecting some DFID programmes.

4 DFID has contributed to these gains. It is well-regarded by Malawi's Government and by other donors. Against recognised international standards for donors its scores well in how it delivers support. Its project performance has improved since 2004, and DFID Malawi staff show increasing confidence in how their business operates. Progress has, nevertheless, been slower than planned: only 61 per cent of the targets DFID Malawi set for June 2008 were achieved on time, and a further 14 per cent within the subsequent year. And measures themselves need to be more robust, unambiguous and relevant: few directly address value for money in project implementation. DFID tracks trends in public access to services, but more tracking of indirect costs encountered by ordinary people would better inform its analysis. DFID Malawi also faces challenges in tracking the use made of its support through central and local government.

5 DFID's interventions in health have been well-designed, concentrating on illnesses that affect most Malawians, and have contributed to the overall positive trends (paragraph 3). But DFID recognises that there are challenges still to be addressed. Malawi's system is funded at about half the level necessary for basic provision, so allocating scarce resources efficiently is vital. More qualified health workers are coming through an expanded training system, but efforts to direct trained clinicians to disadvantaged rural areas, where most poor people live, have so far had little effect. Arrangements for management oversight, motivation, and quality assurance of staff remain weak. Drug procurement and distribution processes have improved, but people told us of frequent stock-outs of simple products, such as anti-malaria nets.

6 DFID has targeted hunger, the top concern amongst Malawians we interviewed, and contributed to reducing hunger: rates of malnutrition have decreased, and since 2005 official statistics indicate that national maize production has exceeded national consumption. During that time DFID has supported a Government programme of subsidised fertiliser and seeds, focused on poor farmers and implemented through issuing coupons. Aspects of DFID support to the subsidy have been particularly good value for money, but the programme's overall value for money depends heavily on maize and fertiliser prices and on how well it is managed. Value for money could be raised by addressing weaknesses in the distribution of coupons and fertiliser, problems with the Government's purchase of fertiliser and the exclusion of private sector distributors.

7 From the early 2000s, DFID has supported development of a further Malawian programme to benefit people unable to farm or afford even subsidised fertiliser. Whilst progress has been made, a national programme is not yet in place. Donors have been divided on which schemes are most appropriate and Malawi's Government has concerns about affordability.

8 Since 2004 DFID Malawi has reduced its running costs while improving its management of aid. It has cut staff numbers from over 100 to under 40, by better matching of staff to the nature of the programme, and transferring project delivery work and staff to the Malawian Government. Additional financial pressures in 2009-10 arising from a weaker pound have led to further reductions in DFID Malawi's front line teams, accommodated partly by sharing posts and responsibilities with other donors.

Conclusion on Value for Money

9 DFID has made well-informed investment choices in Malawi, drawing on internationally recognised good practice, such as in the design of an Essential Health Package (EHP) focusing resources on the most productive treatments. It has also tailored its approach to complement the choices of other donors and address priority needs specific to Malawi, and rationalised its programmes and staffing to good effect. DFID has also worked well in partnership with the Government. DFID's programme has clearly contributed to poverty reduction in Malawi, although it is not possible to attribute accurately a share of that progress to DFID actions.

10 Specific evidence on value for money in implementation is harder to find. Most of DFID Malawi projects have either "mostly" or "partly", rather than "fully", met their objectives. Very few project indicators relate outputs directly to inputs, and DFID has not had sufficient Government data to track unit costs of service delivery over time or in different districts – which could yield information on value for money. Specific studies supported by DFID of the agricultural subsidy programme show the potential for cost-effectiveness, but also opportunities for better value for money.

11 DFID has been taking steps designed to improve value for money through strengthening programme appraisal, monitoring and evaluation. In Malawi DFID has learnt from evaluations to help improve its programme. The following recommendations are designed to further buttress this work.

Recommendations

a While all DFID Malawi programmes and projects have objectives and associated indicators, they do not define what level of performance represents good value for money. Levels of ambition vary, and few indicators focus on efficiency or cost-effectiveness. DFID Malawi should, in time to inform the next Country Assistance Plan:

- Define the levels of performance under each programme that equate to good value for money, and which underpin its bid for funds.
- Include indicators for the efficiency of programme implementation, based on a clear specification of programme outputs.

b Governance has improved in Malawi though not as quickly as DFID envisaged. Governance weaknesses reduce the value for money of development spending generally, and limit the scope to use Government systems to deliver support. An increasing proportion of DFID's aid is channelled through central and local Government systems. DFID should, at its next annual review of the relevant programmes:

- Define outcome indicators which cover programme objectives, and key outputs necessary to secure those outcomes, and rationalise its programme monitoring framework – currently dominated by process.
- Identify the capacity needed in Parliament, the media and civil society to hold Government to account, and specify and monitor outcome indicators to capture the improvements expected from capacity building programmes. Integrate more direct feedback from Malawians on the quality and level of services they receive into its monitoring frameworks.

c DFID has supported the focus of health programmes on basic, highly cost-effective services, in the face of pressures to diversify. It needs to maintain that focus, and by the start of the next health plan period in July 2011:

- Working with Government, revise the funding of the salary top-up to target those skills and locations where needs are most acute.
- Secure Government publication of district health expenditures and activities, and support civil society organisations to analyse them.
- Work with Government to establish indicators covering the efficient use of resources, including unit costs of drugs and key EHP services, to highlight and help address variations between providers and across the country.
- Promote further improvement in drug procurement and distribution, in particular better systems for appraising and responding to local demand.

d DFID support for the agricultural subsidy programme reflects Malawian priorities and addresses hunger, a key barrier to development. But the cost-effectiveness of the programme is highly sensitive to how well it is implemented. DFID should:

- Work with Government to target the subsidy more closely on people who can use subsidised fertiliser but cannot afford commercial prices, by the 2010-11 programme.
- Further develop scheme monitoring and evaluation arrangements to give a clearer picture of the quality of implementation, and associated variations in cost-effectiveness.
- Agree with the Government a programme of more effective actions to stabilise maize prices, as part of any DFID support for the 2010-11 subsidy.
- Build clearer links between the subsidy programme and the longer term development of the agriculture sector, helping the Government produce by mid-2010 a strategy for agricultural subsidies consistent with sustainable agricultural development.

Part One

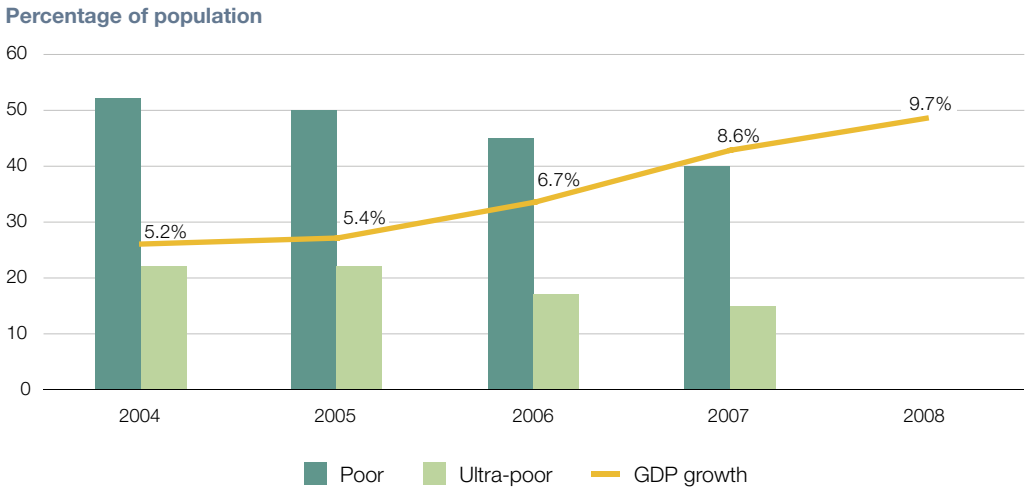
DFID's performance

Progress towards development in Malawi

1.1 Overall progress in the main indicators of development in Malawi is at Appendix 2. All relate directly or indirectly to poverty. Halving poverty between 1990 and 2015 is a global development goal, reflected in the core objectives of the Malawi Government and aid donors. Surveys in 1998 and 2004 showed Malawi as off-track to achieve the Goal.[2] However, data from more recent but less reliable surveys in 2005, 2006 and 2007 when Malawi experienced particularly good harvests show a better trend in estimated poverty, which if continued would halve poverty.[3] Since 2006 Malawi has been amongst the fastest growing African economies, after decades of stagnation. Nevertheless, in 2007 an estimated 40 per cent of the population remained below the national poverty line (equivalent to around 23 pence a day) (**Figure 1** and **Figure 2** overleaf).

Figure 1

The incidence of poverty in Malawi has decreased, and economic growth has accelerated

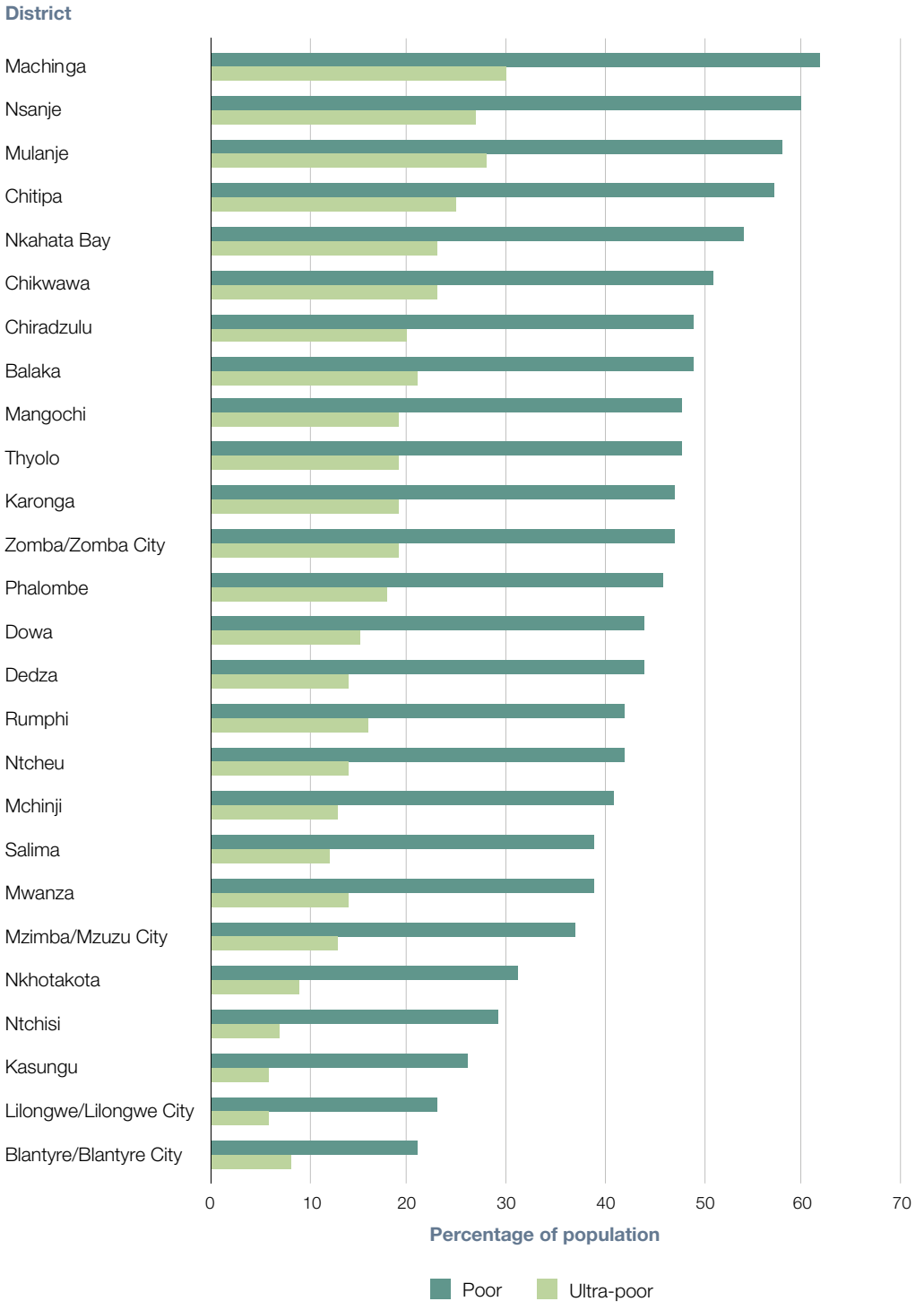


Source: Integrated Household Survey 2004, Welfare Monitoring Surveys 2005-2007

NOTE

'Poor' means consumption below the Government's poverty line; 'ultra-poor' consumption below that required for food. No data are currently available on levels of poverty after 2007.

Figure 2
Poverty is variable across Malawi



Source: Welfare Monitoring Survey 2007

Increasing resources for development

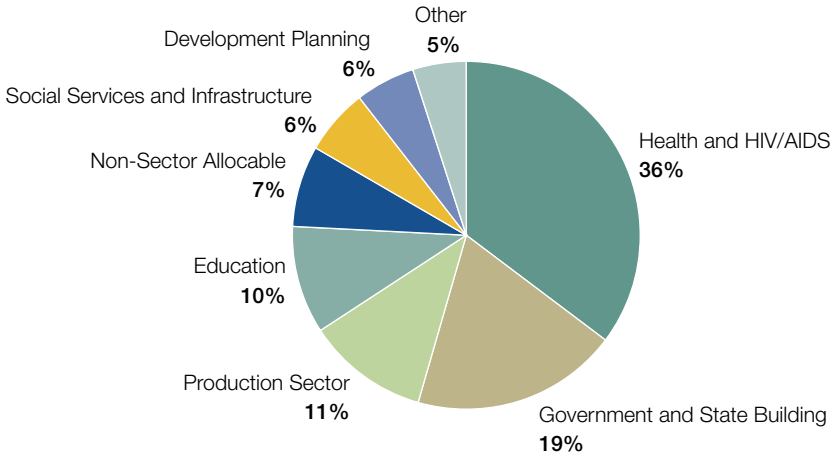
1.2 Development progress has been made in the context of strongly increasing resources for development. Annual economic growth and debt relief have increased Government resources, and donors have increased aid, which now accounts for 21 per cent of Malawi's Gross National Income.

DFID's programme in Malawi

1.3 DFID spent £312 million through its country programme in Malawi between 2003-04 and 2007-08 (**Figure 3**),[4] increasing from £54 million to £70 million per year. Over this period, DFID has been the largest donor in Malawi, providing 21 per cent of all aid.

1.4 Donors including DFID assessed the Government of Malawi's development strategy as supporting growth and poverty reduction. Therefore DFID aligns its work to this strategy[6] and channels most of the aid it gives directly through the Government. DFID has agreed, as part of a division of labour between donors, to spend more in social sectors such as health and education, rather than economic growth and infrastructure development, where other donors focus. Its own analysis in 2006 showed that though a focus on agriculture would be likely to deliver peak growth as early as 2009 through increased production, employment and food, a strategy of aid to social sectors should deliver equivalent levels of income per head by 2019[7]. DFID regards social investment as complementary to growth, by raising literacy, lowering fertility and illness and raising productivity. It also helps to address internationally agreed development goals.

Figure 3
DFID expenditure in Malawi 2003-04–2007-08



Source: DFID

NOTE
DFID's support to food security is within 'Production Sector' and 'Social Services and Infrastructure'. 'Other' includes Humanitarian Assistance and Water and Sanitation. Budget Support is allocated pro-rata to sectors.[5]

1.5 As DFID channels aid through Government and other organisations, it has emphasised influencing them to work effectively to reduce poverty. It has performed well against accepted international criteria used to measure how effectively donors and partner governments work together[8]. For most indicators, DFID's performance has improved, and is better than the performance of donors as a whole in Malawi[9]. DFID performed best in harmonised working with other donors, using common procedures. DFID frontline staff estimate that they spend 35 per cent of their time in dialogue with the Government, other donors, civil society and other external stakeholders[10].

DFID's performance against its Country Assistance Plan

1.6 DFID's plan for assisting Malawi from 2007 to 2011 contains targets and annual milestones consistent with the objectives of Malawi's development plan. DFID Malawi met 61 per cent of the milestones it set for itself for achievement by June 2008, and a further 14 per cent of these within the subsequent year (**Figure 4**). Only a minority of milestones measured exclusively DFID performance, reflecting DFID's desire to facilitate better performance by Malawian institutions. Some of the milestones were not well-designed, making assessment of progress difficult (**Figure 5**). For example, some targets sought unquantified "improvement", whilst others envisaged complete resolution of intractable problems. Others were open to differing interpretations. DFID Malawi recognises the need to improve its performance framework, to focus on fewer indicators of better quality.

Figure 4
Performance against milestones for DFID's Country Assistance Plan

	Number of milestones	Achieved (%)	Late achievement (%)	Not achieved (%)
Budget Support	5	80	0	20
Governance	11	36	27	27
Growth and Agriculture	6	83	0	17
Social Protection	5	100	0	0
Education	6	33	17	50
Health	10	60	10	30
HIV/AIDS	6	67	17	17
Water & Sanitation	2	50	50	0
Total	**51**	**61**	**14**	**24**

Source: National Audit Office assessment

NOTES

Achieved means achieved by the June 2008 milestone. Late achievement means achieved by June 2009. Non-achievement does not mean that no progress was made.

DFID project performance

1.7 DFID also scores its larger projects for their likelihood of success against their objectives, annually and on completion. DFID Malawi's average project scores have improved (**Figure 6** overleaf). This improvement is a result of DFID closing some poorly performing older projects, as well as improved performance of some current projects. It coincides with a decrease in the number of projects run by DFID Malawi.

Budget Support and governance

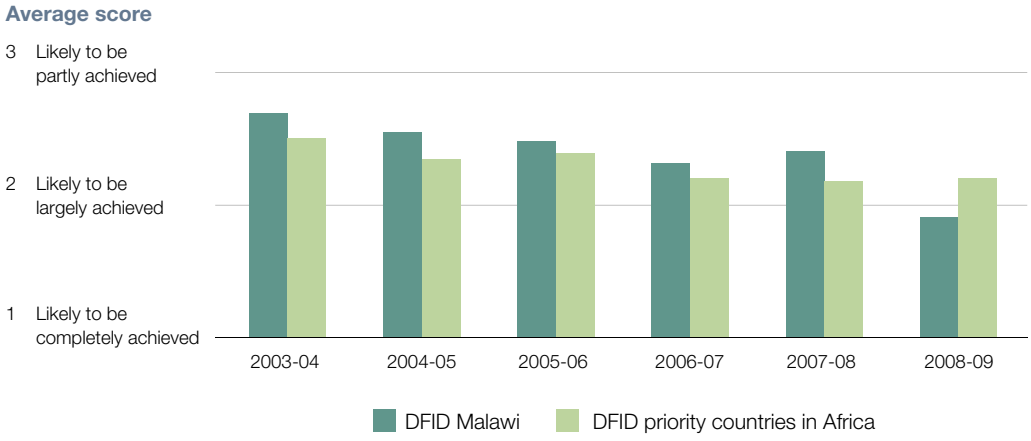
1.8 Budget Support and governance programmes affect all areas of development performance. General Budget Support is aid provided directly to a partner government's central exchequer and not earmarked for specific purposes. Besides financing development it can secure influence for DFID with recipient governments. It comprises about a third of DFID Malawi's support – a relatively low proportion compared with DFID programmes in countries with similar standards of governance and public financial management. In Malawi DFID set Budget Support at this level to moderate the risk of funds being used badly, reflecting its experience before 2004, when poor budget management by the previous Government led DFID and other donors to suspend Budget Support. DFID's objectives for Budget Support cover macroeconomic stability, growth, service delivery and Government capability. Since 2004 Malawi's economy has grown impressively, and Government expenditure on public services has increased. Of the specific targets donors use to monitor performance against Budget Support, 54 per cent have been fully achieved over the last four years, and 16 per cent partially achieved. Performance in 2008-09 was better, with 63 per cent of targets fully achieved and 20 per cent partially achieved.

Figure 5
Performance against milestones for DFID's Country Assistance Plan

Milestone	NAO commentary
"Comprehensive national social protection policy in place"	The policy is in draft form and was endorsed by top officials by June 2008. It was tabled to Cabinet twice, but has not yet been approved. DFID contend that this policy is already influential, assessing the milestone as achieved. The meaning of a policy being "in place" is open to different interpretations.
"Monitoring and Evaluation system aligned to Development Strategy prepared and implementation at institutional level supported by consultant"	This measure relates to a complex and lengthy process which had started by June 2008, but was ongoing in mid 2009. It is difficult to assess the extent of progress against the measure; a better measure would separate alignment and implementation processes to show specific progress. This milestone was assessed as not achieved.
"Drug supply pipeline filled"	An immensely challenging milestone, since drug supply in Malawi has longstanding issues with many players involved. The milestone would need to specify which drugs, and which stages in the pipeline, and with what levels of stock, in order to be useful. Improvements have been made but the milestone was not achieved.

1.9 Achievement of governance targets has been weaker, with only 40 per cent fully achieved over the last four years and 31 per cent partially achieved, although performance was better in 2008-09, with 45 per cent fully achieved and 36 per cent partially achieved. Good governance is important to ensure the effective use of resources, and DFID supports Government and non-government organisations to strengthen it. For example, DFID and the Foreign and Commonwealth Office funded the Malawi Electoral Commission. Observers concluded that elections in May 2009 were credible overall and a major step forward for Malawi, though state media resources were used to the undue advantage of the incumbent.[11] Authoritative sources (**Figure 7**) show partial recovery in governance from a low point in the early 2000s. However, concerns remain: financial management improved between 2004 and 2008, but then declined in the run-up to the May 2009 elections, with unplanned expenditure on the Government's agricultural subsidy programme posing increased risks to economic stability. This extra expenditure also raised concerns over the lack of scrutiny of public funds, as it was made without assurance from the Ministry of Finance of resources being available.

Figure 6
Average DFID Malawi project scores (lower is better)



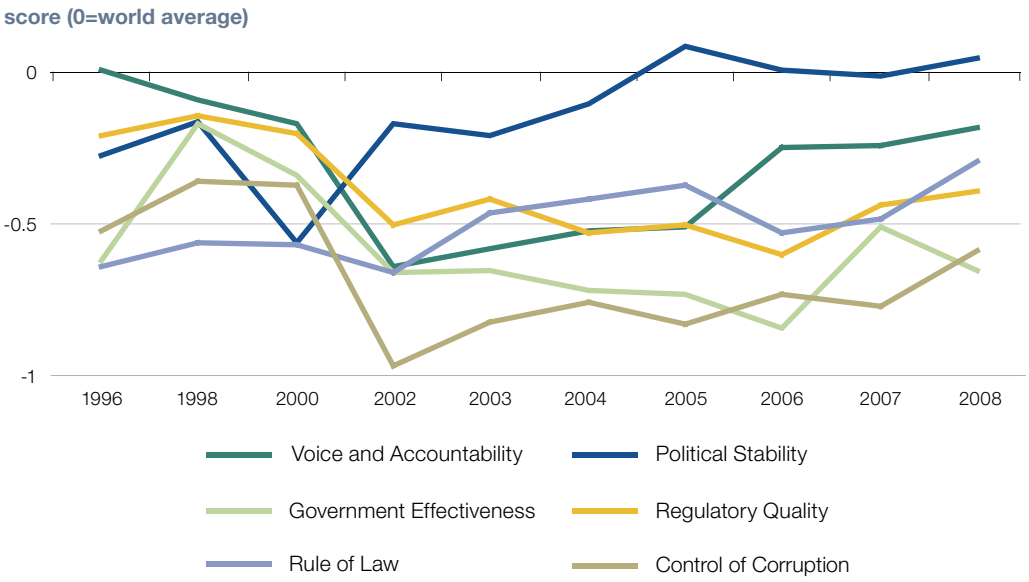
Source: DFID

1.10 There is more to be done to sustain the independence and capacity of key governance institutions. Malawi's Anti-Corruption Bureau has an important role in identifying, deterring and prosecuting corruption, and receives some £0.5 million each year from DFID. It has had three Directors since mid 2006, two having been replaced by Presidential decision. Though appointments have received formal Parliamentary scrutiny, dismissals have not. The organisation's independence would be promoted by greater security of tenure. The Bureau's capacity has also suffered from chronic shortages of professional investigating staff. By 2008 it was reduced to its last remaining qualified lawyer, although it now has four. Despite these difficulties, the Bureau reports increased prosecutions and convictions[12].

1.11 The State Audit Office had also faced resourcing problems which had prevented it from fully discharging its remit. Delays in submitting audit reports have undermined Parliament's oversight and hindered transparency of the use of public funds. For two and a half years until May 2008, Malawi's National Audit Office lacked an Auditor General. Since then, the backlog of unaudited Government accounts has been removed. DFID Malawi has recently committed £0.8 million to help the Audit Office buy in private sector auditors, to enable it to extend its coverage to District Assemblies, through which increasing public funding now flows.

Figure 7

Governance indicators for Malawi show partial recovery from an earlier decline



Source: World Bank Governance Indicators

NOTES

1 The scale ranges from +2.5 to -2.5.

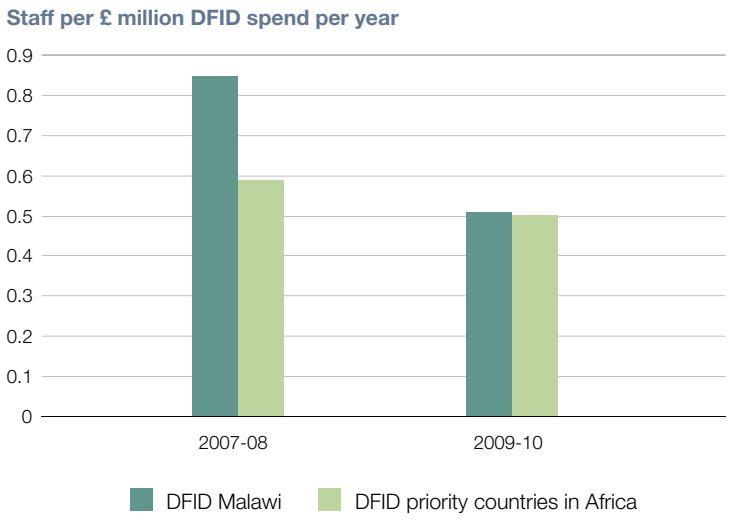
2 Malawi scores better than the Sub-Saharan Africa average in 2008 for all six indicators.

DFID Malawi efficiency

1.12 DFID has reduced its total running costs in Malawi by some 25 per cent in real terms between 2003-04 and 2007-08. It has reviewed its complement in Malawi to match staffing to the needs of the programme, and to meet corporate pressures on running costs. As with DFID as a whole, DFID Malawi has done this in the context of an increasing aid programme.

1.13 DFID Malawi has reduced staff numbers (**Figures 8 and 9**) by working more closely with the Government and others to shape policies and programmes, focusing less on delivering projects. In 2007-08 it transferred to the Education Ministry eight officials delivering primary school infrastructure. Despite the reduced complement, current DFID Malawi staff views were more positive than those of former staff about most aspects of DFID's operations and performance in Malawi. Project scores have also improved (Figure 6), and audits indicate improvements in administration. Current DFID Malawi staff question, however, whether current staffing is sufficient, and express concern about the implications of further reductions. A 20 per cent per cent fall in sterling against the local currency since 2008 has put pressure on running costs. In response, DFID increased the administrative budget for its Malawi operation in 2009-10, from £2.5 million to £2.6 million, which has addressed about half the projected shortfall in 2009-10, leaving a deficit of some £100,000. This has necessitated four posts being cut or left vacant since autumn 2008, accommodated partly by sharing posts and responsibilities with other donors.[13]

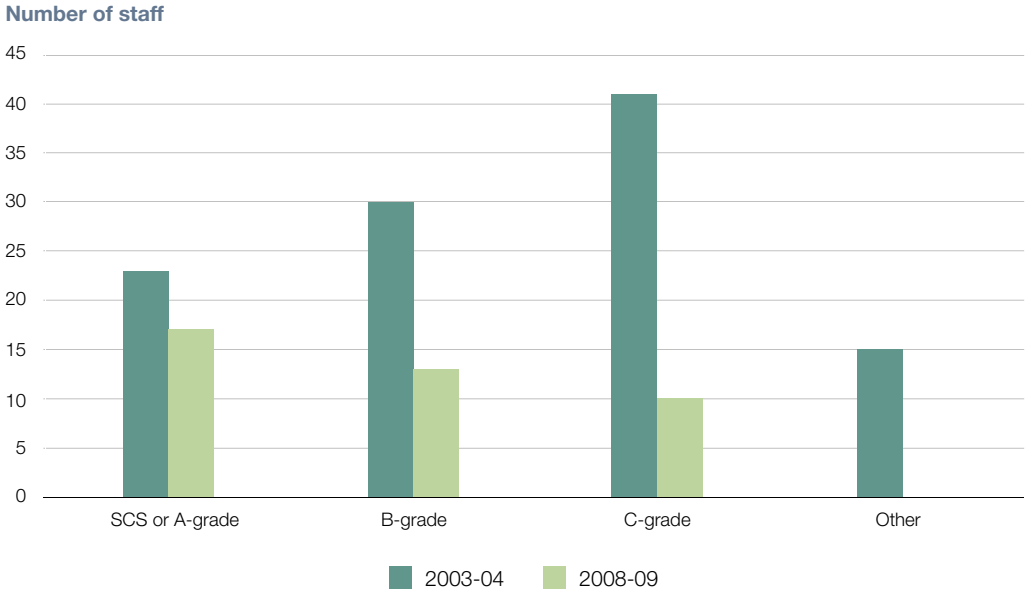
Figure 8
DFID Malawi staffing is now close to the DFID Africa average



Source: DFID

NOTE
Planned expenditure for 2009-10.

Figure 9
DFID Malawi has reduced staff numbers



Source: DFID

NOTE
SCS or A-grade staff are managerial or technical specialists; B-grades are Executives; C-grades are support staff.

Part Two

DFID's aid to health

DFID's role in Malawi's health sector

2.1 DFID has increased its support to Malawi's health system since 2004 (**Figure 10**) when a new Malawi Government introduced policies of prudent economic management. It has been the biggest bilateral donor in health, contributing through a health Sector Wide Approach (SWAp), in which donors pool their funding in support of the Government's health policy and programmes, and through general financial support to the Government's budget. DFID also supports family planning services, and helps address gaps in expertise in health organisations.

2.2 From 2002 DFID, with other donors, played a key role in helping the Health Ministry develop an Essential Health Package (EHP), a programme to address 11 key health conditions that international experience shows offer the best return on investment in developing countries. It has been instigator of and leading contributor since 2004 to the Emergency Human Resources Programme, particularly by supplementing the salaries of health workers to help address critical shortages. It has supported Malawi's successful bids for additional resources from international agencies. In particular, Malawi has won nearly US$500 million of resources from a Global Fund in several rounds of funding since 2003.[14]

2.3 DFID is well regarded by Malawi's health ministry and by other donors. Norway's officials in Malawi responsible for managing its own substantial health investment felt DFID's team to be well-informed and active. Senior Health Ministry officials considered DFID to be a key and supportive donor, adding that the Emergency Human Resources Programme would probably not have happened without DFID support.

Figure 10
DFID has committed increased funds to health in Malawi

	2003-04 (£m)	2004-05 (£m)	2005-06 (£m)	2006-07 (£m)	2007-08 (£m)
Specific projects and programmes	15.3	13.6	12.3	13.6	15.7
Share of Budget Support allocated to Health	1.9	2.9	9.2	11.0	14.2
Total	**17.2**	**16.5**	**21.5**	**24.7**	**29.9**

Source: DFID

NOTE
DFID support in 2007-08 represented some 30 per cent of total donor support to Health in Malawi.

Overall progress in health in Malawi

2.4 Between 1990 and 2000 life expectancy of Malawians declined from 48 to 39 years, mainly due to AIDS. At 14 per cent of the population, HIV/AIDS prevalence was the ninth highest in the world. Maternal mortality had worsened to amongst the highest in the world. Immunisation of children had fallen well below the 80 per cent levels needed to prevent transmission across the population.

2.5 Malawi had an especially weak health service with which to address these problems. During 2000-2004 staff shortages became critical, with rising attrition due to poor working conditions, low pay and morale, and HIV. Under-investment and policy initiatives in the late 1990s had led to the closure of training institutions, seriously reducing the supply of health workers. By 2004 only ten per cent of health centres were capable of delivering the new EHP. Numbers of doctors and nurses were low even by sub-Saharan standards (**Figure 11**).

2.6 Since this low point, investment by the Government and donors including DFID has contributed towards progress (**Figure 12** overleaf). Health trends are positive, if at different rates for different conditions.[15] A prominent achievement has been increased provision of antiretroviral drugs for people living with AIDS, from almost no-one in 2003 to 164,000 people by mid 2008, approaching two thirds of those requiring medication. Over this period HIV prevalence receded from 14 per cent to 12 per cent. Progress in other areas has been more limited. Malaria remains Malawi's most prevalent disease, representing nearly half of patient attendances. There are some 6.5 million estimated annual episodes for a population of 13 million, with health workers combating rising prevalence by changing to newer drugs. It costs Malawi's workers an average 25 days work a year.

Figure 11
Medically qualified staff per 100,000 of population in 2004

Cadre	Botswana	South Africa	Ghana	Tanzania	Malawi
Physicians	28.7	25.1	9.0	4.1	**1.6**
Nurses	241.0	140.0	64.0	85.2	**28.6**

Source: DFID

2.7 NAO discussions with ordinary Malawians and front line staff corroborate official statistics. Most villagers and nearly all healthcare workers perceived overall improvements in health standards over the last five years. Notwithstanding this, most villagers still regarded the current state of health in their area as not particularly good, citing common diseases, perceived causes of poor health and the practical challenges of obtaining treatment.

"…according to the requirements for a health centre we are enough here, but as I have said the services are increasing every day for us to do. So to us who are doing the job, we see that there is a shortage" – service provider

"…I have been in the health system for close to 13 years, I have to be frank, the outcomes are better, they are better, they are improving" – district official[17]

Figure 12
Overall aims of DFID support

Goal: to achieve improved health status of all Malawians, through quality, effectiveness and accountability of essential health services, and improved access.

Key indicator, set by DFID for achievement by 2011	Current Status	Comment
Increase in health facilities with ability to provide EHP from 10 per cent to 80 per cent	On track	The Government considers 74 per cent of facilities to be already capable in principle of providing the EHP, although provision in practice depends on sufficient trained staff and medical supplies.
Extended programme of immunisation coverage increased to above 85 per cent	On track	Immunisation of one year-olds is at this level for most districts. In four of 28 districts immunisation is close to the 80 per cent level necessary to prevent measles spread.
Increase in deliveries attended by skilled health personnel from 56 per cent to 75 per cent	Off track	The proportion was 54 per cent in 2006.[16] National data suggest that the proportion of births in health facilities has risen since 2004, although this does not itself ensure delivery by skilled personnel.
Number of people receiving antiretroviral therapy (drugs for treating aids) from 9,000 to 100,000	Exceeded	Some 165,000 people are already receiving antiretrovirals.
Insecticide treated bed net coverage increased from 35 per cent cent to 60 per cent	Not clear	Nets prevent mosquito-borne diseases like malaria. Some five million have been distributed since 2003, for a 13 million population. The Government estimates usage by vulnerable groups (e.g. pregnant women or under-fives) is near 50-60 per cent, pending 2009 survey results.
Tuberculosis cure rate increased to 75 per cent or above	On track	Cure rates above 70 per cent achieved in 2005-06 and maintained during transition to the Sector Wide approach.

Source: Official Malawian surveys

2.8 The programmes started in 2004 are four years through their planned six years. Donor and Government investment has increased training capacity by at least 50 per cent; though since it takes three to five years to train nurses and doctors the effects are still working through. Nevertheless, better training and measures to attract medical professionals back to the health service have increased the number of practising doctors and nurses by 33 and 40 per cent, respectively. But the numbers required have also increased, so the vacancy rate for nurses remains high at 70 per cent.[18] And although the Government now estimates some 74 per cent of health centres to be "capable" of delivering the EHP, only 13 per cent have the ideal staffing complement to do so.[19] The Government enlists private sector providers to deliver public health services free at the point of delivery where public provision is lacking. The Christian Health Association of Malawi (CHAM)[20] provides about a third of healthcare, and over 90 per cent of its facilities are in more disadvantaged rural areas. By 2009, the Government had contracts in place with 66 of the 171 CHAM facilities to deliver free public health services. This has increased access to, and take-up of, health services. We found no donor analysis of the relative value for money provided by CHAM and Government health facilities.

"…now, all our health centres are operational. So the only problem is inadequacy of skilled personnel because, per health centre you are supposed to have two medical assistants and two nurses. .. in the health centres that are operational, maybe there will be only one nurse, may be one medical assistant despite huge population. But… it is still an improvement because we are talking of a situation whereby the health centres were not able to open, but at least now the community is being served…" – District Health Officer[21]

2.9 We did not find robust measures relating specific outputs and outcomes to the associated costs such as the unit cost of drugs or the cost per episode of treatment. Civil society organisations supported by DFID have analysed annual health budgets, but there is little tracking of expenditure through the health system. As a result, DFID and other donors cannot easily analyse trends in value for money over time or between districts or providers. DFID Malawi is working with the Health Ministry to obtain better information in these areas.

2.10 There are some indications of good value for money. The design of the EHP has focused on global best buys; investments known to offer the greatest reductions in mortality and morbidity proportionate to investment. The EHP also addresses the major causes of death and illness in Malawi (**Figure 14** overleaf). DFID and Government have so far resisted pressures to extend it to include high cost interventions like cancer treatment which would divert scarce resources. Some anomalies remain. In 2004-05 the Government spent some US$1.2 million on treatment abroad for 15 patients, equivalent to the recurrent budget of a full health district, or some US$79,000 per case.[22] DFID is working with the Government to look at more cost-effective ways of dealing with such conditions. It is particularly important to maintain a focus on basic needs, because EHP is resourced only to about half of Malawi's needs: some US$17 per person per year, compared to US$34 required.[23]

2.11 A key new feature of the EHP was the creation of a district health system to integrate primary care with effective referral. This was intended to provide, amongst other benefits, better access to emergency obstetric care, which is essential for reducing maternal mortality. Maternal mortality has fallen substantially from its year 2000 peak (**Figure 13**), but Malawi remains among a group of five countries ranked ninth equal in terms of being worst affected. It is not on track to meet Malawi's 2011 target (560 deaths per 100,000 live births), a target derived from the international Millennium Development Goals and also reflected in DFID Malawi health programme targets.

Figure 13
Maternal Mortality in Malawi remains very high

Year	Maternal Mortality Ratio[1]	Band[2]
1992	620	Very High
2000	1,120	Very High
2004	984	Very High
2006	807	Very High

Source: Malawian Demographic and Health Survey, Multiple Indicator Cluster Survey

NOTES

1 The number of maternal deaths per 100,000 live births.

2 DFID and UNICEF define four bands: of which the highest is "Very high" above 550.

Figure 14
The EHP addresses the main causes of death and disability

Conditions addressed through the EHP	Main causes of death in Malawi[1] (ranked)	Main causes of disability in Malawi[1,2]
HIV/AIDS & STI	1	1
Acute Respiratory Tract Infections	2 – lower respiratory infections	9 – asthma
Malaria	3	3
Diarrhoea, including Cholera	4	
Adverse Maternal and Newborn outcomes, including Family Planning	5 – perinatal conditions 9 – maternal haemorrhage	6 – abortion 7 – perinatal conditions
Tuberculosis	6	
Common injuries, accidents and trauma	7 – road accidents 10 – drownings	
Malnutrition, including Micronutrients	8	5
Eye, Ear and Skin infections		2 – cataracts

Sources: Health SWAp documentation, World Health Organisation (2002)

NOTES

1 World Health Organisation, causes ranked by prevalence for total years of life lost and total years lost due to disability 2002.

2 Main exclusions: [4] Depressive disorders, [8] Lymphatic Filiarsis (a mosquito-borne infection) and [10] Iodine Deficiency.

Improving value for money in health services

Managing the effects of water and sanitation on health

2.12 DFID has been the biggest donor in Malawi's health sector, but its achievements can be affected by sectors where other donors lead. Poor sanitation jeopardises communities through diarrhoea, cholera and other diseases. Unclean water causes water-borne diseases such as cholera and typhoid, and travelling to collect clean water imposes a large burden on the poor. The main health concerns of ordinary Malawians relate at least as much to these factors as to the provision of specific health services (**Figure 15** overleaf).

2.13 Official figures show 65 per cent of people having access to safe drinking water and 49 per cent to improved sanitation. The NGO WaterAid questions the robustness of these figures, noting that 31 per cent of water points do not work. Progress has been better for water than sanitation (Appendix 2). Moreover, continued population growth – 2.8 per cent annually since 1998 – is projected to lead to periods of clean water shortage from 2025. Until recently the sector has experienced fragmented donor activity and low donor expenditure.[24] Since 2006 investment by donors has been recovering from a low base. DFID has contributed, for example, by supporting improved sanitation in some schools, and by support for US$25 million of World Bank investment. A recent assessment identified the required investment for water and sanitation up to 2015 as US$1.75 billion.[25] Since late 2007 the Government and donors have worked more closely together, aided by stronger planning capacity and more stable leadership in the Water Ministry. But pending institution of a sector wide approach, first discussed as early as 2001, there is still poor targeting on locations in greatest need and on maintenance and renewal of existing facilities.

Figure 15
Most frequently cited health challenges, ranked

Challenge	Community Focus Groups	District officials	Local service providers
Lack of hygiene	1		
Scarce and unsafe water	2		
Limited health care facilities	3	1	1
Insufficient food	4		
Distances to Health centres	5	3	
No ambulance/lack of transport to health centre	6	3	=2
Staff Shortages at health centres	=7	2	=2
Mosquito bites/Malaria	=7		
Access to Mosquito nets	=7		

Source: Qualitative Research by ITAD/Kadale for the National Audit Office (2009)

"The area has a lot of water as it is close to the lake, but the water is not safe to drink. The whole village has four boreholes of which two are not functioning." – local person

"Every household has a toilet but they are not very strong to withstand the rains. There are talks about construction of concrete toilets but that is not implemented." – local person

"as a district we are much better off because there has been a number of interventions coming from the NGO community particularly WaterAid…. Of course they have not touched all the traditional authorities." – local official

"…other places are still drinking from the rivers but for three-quarters, you can go around and you can find people are drinking safe water." – local official[26]

Obtaining a balance between prevention and treatment

2.14 Preventing disease through education can be more cost effective than treating avoidable illness. Such initiatives within the EHP are having some effect. Official surveys show increased health awareness amongst Malawians. Our focus groups confirmed that awareness of approaches to reproductive health, tuberculosis, infection control and HIV/AIDS had improved, due in part to communication with health workers and contact with testing or treatment programmes.[27]

2.15 A 2008 independent review of Malawi's national response to HIV/AIDS concluded, however, that prevention efforts were uncoordinated. Prevention remains centralised around urban areas and lacks targeting on high risk groups. The review concluded that finalisation of a national prevention strategy and action plan was long overdue for a country with high HIV/AIDS prevalence and a large treatment programme. The national prevention strategy was subsequently finalised and launched in 2009.[28] DFID has funded the main body responsible for coordination, Malawi's National AIDS Commission, since 2003.[29] Some 17 per cent (US14.41M) of NACs budget was spent on prevention and behaviour change in 2007/8, though its larger spend on treatment, impact mitigation and mainstreaming will also have had prevention effects.[30]

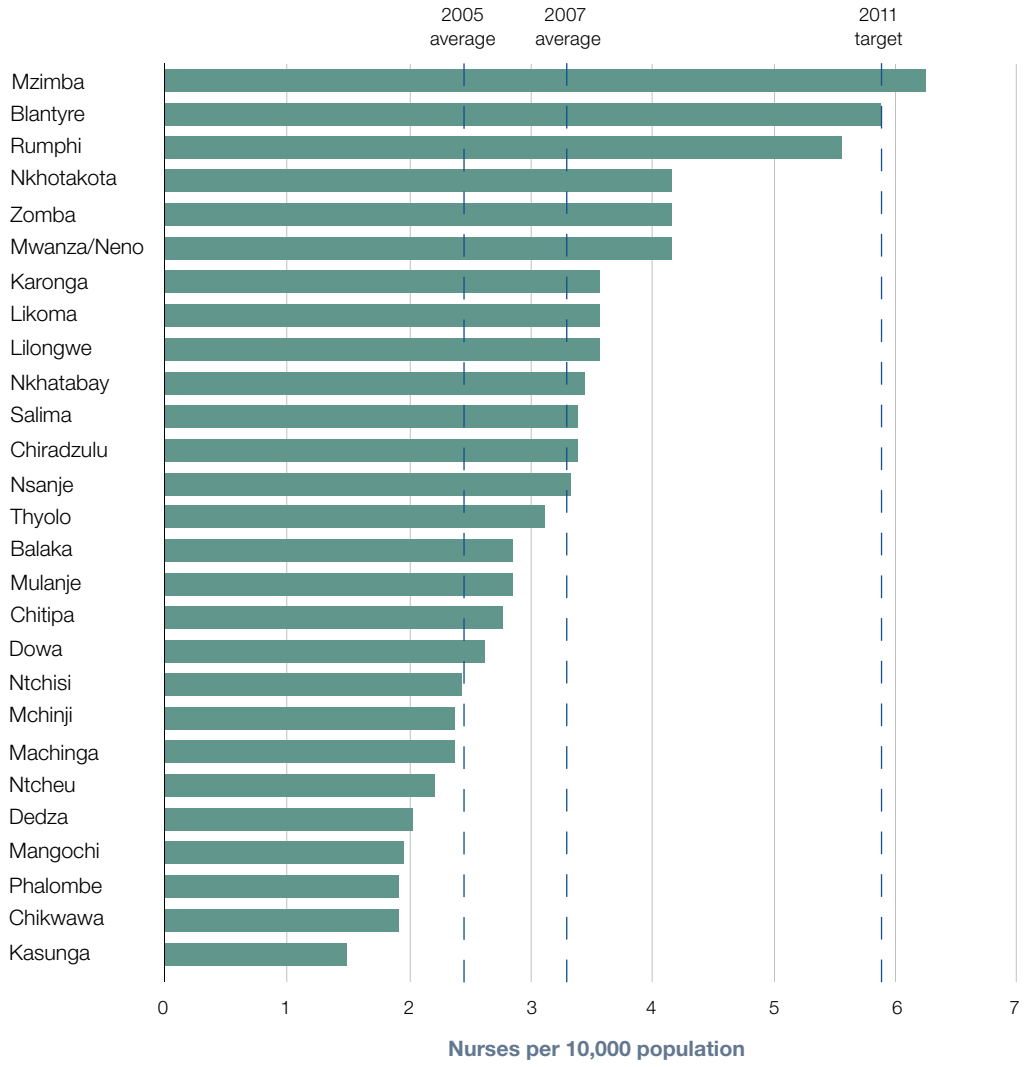
Managing the health workforce to best effect

2.16 Malawi remains undersupplied with trained health workers, and needs to use those it has to best effect. Historically, shortages have been most severe in rural and remote areas. At the start of the SWAp in 2004 four of Malawi's 28 districts had no qualified doctor. Major cities like Blantyre and Lilongwe were relatively well served but most rural districts were not. Four years later, overall ratios of health workers to population have improved significantly, but disparities remain (**Figure 16** overleaf). Three of the four districts previously without any doctor now each have one, but staffed temporarily by expatriates. By the end of 2007, many districts (a third for nurses and two thirds for doctors), remained behind 2005 national average baselines, let alone national targets for subsequent improvement. Other districts, mainly those with urban centres, have already approached or surpassed targets for 2011.

2.17 Surveys of Malawian practitioners identify resistance to rural deployment, citing concerns over lack of suitable housing and local amenities, and less professional support and interaction, facilities and supplies than in district hospitals. The Government has built 500 staff houses in particular "hard to staff" locations. Some Districts have tried to improve working conditions for staff, including supplying energy and water to accommodation and meeting transport costs. But by 2008 no comprehensive national incentive scheme for "hard to staff" areas had been agreed, let alone implemented. Civil society organisations monitoring Malawi's health system confirmed that incentives to move to disadvantaged areas were not proving sufficient.

Figure 16

Ratios of nurses to population vary by district



Source: Government of Malawi Health Census end 2007

2.18 A part of Malawi's response has been to enable nurses and clinical officers to diagnose and prescribe in place of doctors, and junior health workers to dispense medication. Delegation to lower graded staff is not without risk: tests of health centre workers indicate a low level of knowledge concerning certain critical conditions, particularly obstetric complications. Eighty-one per cent of hospital staff felt adequately trained for their job but only 57 per cent of health centre staff did so.[31] Government and donors recognise the need to improve quality in training institutions.

2.19 In 2005 DFID started its principal contribution to the Emergency Human Resources Programme, an emergency 52 per cent salary "top-up" designed to help increase overall staffing levels in a period of crisis. Most staff, including many non-medics, receive it.[32] DFID has also worked with UK Department of Health to help stem the migration of scarce health workers: in 2005 some 96 registered nurses and midwives left to work overseas, mainly in the UK; by 2006 that outflow had fallen to 30. Outward migration involves a relatively small proportion of Malawi's health workforce. DFID has lacked up-to-date information on overall attrition amongst health workers to inform its judgment on the effectiveness of this aspect of its £55 million contribution to the Emergency Human Resources Programme. The health ministry does not compile annual data, and attrition will be measured in an evaluation of the programme between September 2009 and June 2010.

2.20 As the numbers working in the health sector increase, donors are starting to review the effectiveness of the staff deployed. Surveys indicate problems of staff absence, induced partly by an allowance culture within Malawi's public service that encourages workers to attend training or other events away from their normal place of work.[33] Arrangements for staff supervision and quality assurance are not strong. Weak management oversight, support and continuing professional education of staff, contributing to apathy and absenteeism, were the most prevalent concerns voiced to us by UK volunteers working in health institutions.[34]

Addressing barriers to access for health services

2.21 Health services in Malawi are equitable by the standards of sub-Saharan Africa, and designed to be free of charge at the point of delivery. Our fieldwork revealed no complaints about health workers making improper charges.[35] Better-off urban Malawians receive only slightly more than their proportionate share of health services.[36]

2.22 Ordinary Malawians still face barriers to access. They visited health facilities on average 1.2 times in 2008, up from 0.8 in 2005 but still well behind the two to three visits common in other southern African countries, and there are also significant variations in visits per head between districts.[37] Villagers describe the main constraints as the costs of transport and the opportunity costs of long travel and waiting times. Local service providers and district officials acknowledged that the lack of ambulances led to the referral system not working well. On average, patients have to travel 10km to reach the nearest Government health centre and 30km to district hospitals, with significant differences between districts.[38] Each of Malawi's 28 districts is allocated only one ambulance; the Ministry is acquiring 250 motorcycle ambulances to improve the situation.

"People from far areas have a problem as they have to spend some money on hiring a bicycle to the health centre. Some who are very ill… have to find an ox-cart. Once at the health centre, they are asked to buy a health passport at MK 50.00 which most of them do not have." – local person

"… the referral system is affecting the health system since if we had an ambulance close, referrals could be easier and emergencies could be sent to Mulanje district hospital." – service provider

"the problem we have here is the ambulance, when travel to Mzimba, the patient arrives there more serious than before, because of the distance – there is no ambulance stationed at the health centre." – service provider

"… I remember we had some bush ambulances we were getting in 2000, but as of now they are not functioning so it's a problem." – service provider[39]

Making the drug supply system work effectively

2.23 Longstanding problems with the procurement, ordering, and distribution of drugs and supplies have been reduced but not yet resolved. The successful procurement and distribution of anti-retroviral drugs for people living with AIDS has been achieved through separate arrangements.

2.24 Procurement is protracted, typically taking 12 months from commencement of procurement to receipt of supplies. Orders can still be incomplete as much as two years later. During our visit in February 2009, the health ministry expressed concern over a hiatus in national procurements of drugs since before September 2008, due to a gap in arrangements for procurement oversight. DFID participated in measures which subsequently filled this gap.[40]

2.25 Once drugs arrive in Malawi the challenge is to distribute them securely and promptly to health centres via the Central Medical Stores system. Improved arrangements for the delivery of supplies to district pharmacies include tracking of vehicles and formal reception of consignments, and studies indicate that losses in storage or transit are almost non-existent. However, the existing medical stores are old, insecure and too small to hold buffer stocks for more than three to six months' national consumption; a fundamental problem when procurement normally takes at least a year. Donors are considering currently unfunded Government proposals for a modern, larger store.

2.26 Improved distribution to districts is confirmed by annual Government surveys reporting better district-level stocks of selected tracer drugs. But stock-outs persist at points of treatment, according to civil society organisations and independent reviewers. Ad-hoc checks recording availability at "frontline" health centres have shown 45-60 per cent availability of essential EHP drugs at hospitals and from 7.5 to 41 per cent at local health centres. Most of our Malawian discussion groups concluded that medication and essential consumables were not generally available, though villagers and health workers indicated overall improvements in recent years.[41] Contributory factors to remaining difficulties include:

- Poor estimation of order quantities at health centres and hospitals, based on inconsistent past consumption data and suspect stock records, with insufficient attention to current disease prevalence. Different logistic and drug management systems are in use, reflecting in part different donor interventions.
- A lack of trained pharmacists to help address inconsistent drug management. A review in late 2008 identified 78 pharmacists, technicians and assistants in post compared to a requirement for 518, with shortages most acute at local health centres.[42] Past DFID plans to import pharmacy skills alongside emergency drug consignments did not prove feasible.
- Delays establishing sufficient stocks in health centres before transport links are disrupted by the rainy season, as well as incomplete fulfilment of orders by suppliers.
- Mismatches between orders and supply, with districts allocating orders to health centres in fixed proportions rather than relative to projected demand.
- Poor value for money through alternative channels. Though Districts can purchase drugs from the open market when the central system cannot supply, prices of such procurement can be up to four times higher, and quality is more variable.

"Most of the times, we are told to buy drugs from shops. Drugs come from very far and it takes time to restock when they have run out of stock here at our health centre. Drugs for some diseases are not available always and we are referred to Mzimba hospital." – local person

"… some people go back home without getting any help because of overpopulation at the hospital. Within a short period of time, we find that drugs have run out. So we can say that health services are not good." – local person

"At times we face shortages; we receive low quantities, other months satisfactory, and the other month just very low drugs received to this health facility… I don't know what is happening." – service provider

"In the past years, the problem we had would have been drugs would maybe run out 10 days before the other drugs come in. ….. currently we are getting them right away from central medical stores. So I think that has been a good part of it." – service provider[43]

Part Three

DFID's support to increase food security

3.1 Food security means that all people always have access to sufficient, safe and nutritious food. Food insecurity has been a major problem in Malawi for decades, although the situation has improved in recent years. As recently as 2005-06, five million people (41 per cent of Malawians) required emergency food aid, towards which DFID spent £21 million.

3.2 Since this crisis, Malawi's Government has implemented an Agricultural Input Subsidy Programme, which aimed to increase productivity and to improve food security for households and nationally. It has also tried to improve the functioning of maize markets, the income of Malawians, and food distribution through better transport links.

3.3 The Subsidy supplies coupons for subsidised fertiliser and seeds to about half of all farmers. It is a response to declining soil fertility, low incomes and access to credit, and aims to target the 'productive poor' who can afford the subsidised price of these items and use them but who cannot afford non-subsidised prices. The programme has had a high political profile, especially approaching national elections in May 2009, and widespread popular support. Villagers and local officials we consulted saw lack of affordable fertiliser and seed as the major constraints to improving smallholder farming. Since 2005-06 the Subsidy has consumed a rising share of the Government's budget, due to increased purchases and higher global fertiliser prices (**Figure 17**). DFID contributed £26 million between 2005-06 and 2008-09, half through its Budget Support and half through direct funding of specific elements of the programme.

Figure 17
Subsidy costs have increased

	2005-06	2006-07	2007-08	2008-09
Fertiliser costs (Malawian Kwacha per tonne)	55,000	68,600	82,665	179,000
Programme cost (US$ million)	51.0	74.0	115.0	221.4
as % national budget	5.6	8.4	8.9	13.5
Estimated DFID contribution to Subsidy (%)	**20.9**	**15.4**	**11.8**	**5.0**

Sources: Dorward and Chirwa (2009), DFID financial information

Progress towards food security

"Malnutrition and nutrition deficiency are there in our village, this is because of food scarcity. We eat once sometimes or not even eating for the whole day. This causes children to become malnourished… When one is given drugs at the health centre, he or she is supposed to eat first before taking the drugs. ……but we have problems as there is no food here." – local person[44]

3.4 The maize harvest is central to food security, and official data show production exceeding total national requirements since the harvest in 2006 (**Figure 18**), although the extent of surpluses has been widely questioned by experts. The Subsidy and relatively good rainfall (**Figure 19**) have contributed to the increased harvests. But even when there is enough maize in the country, some households are not able to get enough to eat. So, although the proportion of people too poor to get enough food has fallen from its 2004 value of 22 per cent, the 2007 value was still 15 per cent.[45, 46] Similarly, the proportion of children under five who were underweight fell from 30 per cent in 1995 to 14 per cent in 2007.[47]

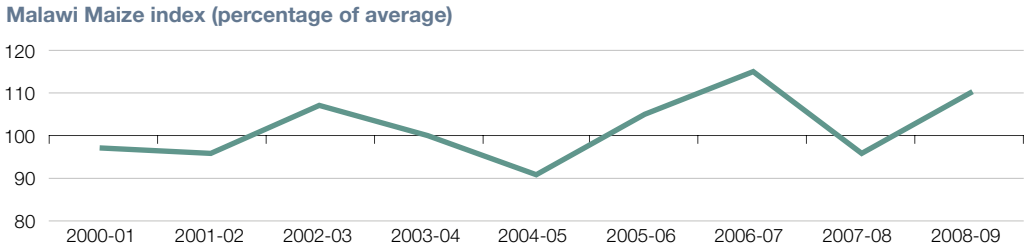
Figure 18
Maize production and consumption requirements over time

Source: Government of Malawi

NOTE

1 2008-09 figure is an estimate.

Figure 19
Effect of rainfall on maize production



Source: The Malawi Maize Index

"We are not fully food secure, because we have maize after harvest April to December. As of now things are better, we are able to eat comparing with the past years." – local person

"We are likely to have some families who still have some food shortages during certain time of the year, like this time of the year. But overall when they do, if they have money and they want to buy, they can easily access maize within the community. Unlike what was the case in the past where even when people had money it was a bit difficult." – district official

"Most of the time ADMARC (a Government distributor) does not receive adequate maize for sale to the villagers. Maize is sold to villagers in small quantities, which is very often not enough for large families." – district official[48]

3.5 An external evaluation, part-funded by DFID, estimated that the 2006-07 Subsidy had increased maize production by between 500,000 and 900,000 tonnes.[49] Limited data on yields prevented a reliable estimate of the benefit cost ratio, although further data are being collected. But the evaluators estimated that each £1 spent on the 2005-06 to 2007-08 programmes produced between £1.59 and £0.99 of benefits in increased production and income for producers, depending on the maize yields achieved, which is affected by the quality of implementation. The return is also affected by changing maize and fertiliser prices. On the basis of provisional fertiliser and maize prices, the evaluators estimated that very high fertiliser prices reduced the return in 2008-09 to between £1.15 and £0.72 of benefits for each £1 spent.[50]

3.6 Some of DFID's support to the Subsidy has been particularly good value for money. DFID encouraged the Government to include subsidised improved seeds and committed some two thirds of the £3 million annual cost over 2007-08 to 2010-11. Estimated yields from certain types of improved maize can be more than three times those achievable from local varieties. DFID has also helped to fund a unit which assists and tracks implementation, which other donors and experts view as critical to promoting good implementation.

Improving value for money in increasing food security

Improving implementation of the Subsidy

3.7 Improving timing of the distribution of coupons and the supply of subsidised seeds and fertiliser would increase the economic returns from the Subsidy, because farmers must plant seeds and apply fertiliser at the right time to achieve the highest yields. In 2007-08 coupon distribution started in late November instead of September as planned, and arrived after the rains had started and some farmers had already planted maize. Timeliness has improved over the lifetime of the Subsidy, although late receipt of coupons or availability of subsidised inputs remained a problem for some beneficiaries in 2008-09. Some farmers complained of long distances to redeem coupons and of queuing for two to three nights. Some reported that the extra transportation added substantially to the cost of fertiliser – sometimes more than doubling it.[51]

3.8 External evaluation estimated that 25 to 35 per cent of subsidised fertiliser would have been bought without subsidy by people who could afford to buy at commercial prices. But DFID did not identify acceptable degrees of displacement at the start of the programme. Better targeting for coupons and less displacement offers scope for the Subsidy to achieve greater benefits. Targeting criteria are not clear because of the dual goals of improving the amount of maize produced at a national level and the number of households that produce enough food. And the Subsidy does not incorporate poverty indicators into its allocation of coupons between Districts.

"A cross-section of people benefited; the poor were included and … I should think the majority were the poor. But as you are aware this type of programme… some people would still find their way in, even if they are not that poor." – service provider.

"…I have seen some of those who are benefiting are better off than those who are left out. I think the way they target, there is need for more to be done." – service provider.[52]

3.9 The Government purchased more fertiliser than planned in 2005-06 and 2006-07, and DFID wanted assurance that the future programme would reflect sound financial management. DFID therefore obtained an agreement with the Government in December 2007, which limited the amount of fertiliser the Government would buy to 170,000 tonnes in each of 2007-08 and 2008-09. In practice the Government distributed an additional 47,000 tonnes in 2007-08, and procured an additional 72,000 tonnes in 2008-09. It bought some of the extra fertiliser for 2008-09 in December 2008 at mid-2008 prices, not the lower prices available after international prices had dipped. It has not fully explained the reasons, but it has confirmed to DFID and other donors that none of the extra fertiliser was distributed in 2008-09 but is stored for later use. Donors estimate that the Government has incurred an estimated US$35 million of extra costs through buying surplus fertiliser at peak prices.[53]

3.10 DFID aimed to increase private sector participation in the Subsidy and the number of outlets where farmers could obtain subsidised seeds and fertiliser to promote long-term sustainable access to agricultural inputs. DFID and other donors initially persuaded the Government to increase private sector participation, which was included in the agreement signed in 2007 with the Government. But in practice in 2008-09 the Government decided not to allow private firms to retail subsidised fertiliser, against the views of donors, although subsidised seeds continued to be sold entirely by commercial retailers. DFID re-allocated the funds it planned to use to increase private sector involvement in fertiliser retail to subsidising seeds. The Government has confirmed that the private sector will be involved in subsidised fertiliser retail in 2009-10.

Systematically addressing the food security of the poorest

3.11 The poorest in Malawi are not targeted directly by the Subsidy, although the Government and DFID considered that they would benefit indirectly through increased food availability and lower prices. The availability of food has increased, but food prices decreased only after the first year of the Subsidy but then rose and have remained high (**Figure 20**). This reflects Government decisions on grain storage and markets and in response to high international food prices. In 2007, the Government exported 300,000 tonnes of maize to Zimbabwe, adding to price pressures in Malawi. In 2008, the Government reacted to high maize prices for consumers by setting a maximum price for the sale of maize. But the Government retailer could not defend the maximum price because it was not supplying high enough volumes to set market prices. Private traders were unwilling to sell their maize at the Government price, which was below the prices they had paid for stock. Another impact of the Subsidy has been to increase rural wage rates, which has helped to offset these higher maize prices for some of the rural poor.

3.12 DFID aimed to introduce a range of measures to decrease volatility in maize markets. Weather insurance is the only such measure currently implemented. In 2008, DFID paid a premium of US$500,000 on behalf of Malawi for up to US$5 million of cover for the Government in the event of a drought. DFID was not able to fund another instrument planned for 2008-09, involving private sector storage of maize in Malawi, as a result of the Government banning the private sector from purchasing maize.

Figure 20
Local maize market prices at annual pre-harvest peaks

	Lowest (Malawian Kwacha/kg)	Highest (Malawian Kwacha/kg)
February 2009	46.58	103.14
February 2008	26.78	57.79
February 2007	11.68	30.00
February 2006	20.83	67.75

Source: Famine Early Warning System

3.13 Efforts to tackle the vulnerability of the poorest to hunger have been fragmented, without effective Government leadership and coordination. DFID has recognised this, and has worked to influence the development of a Government-led national 'social protection' policy and programme to systematically tackle hunger and poverty amongst the poorest through, amongst other things, welfare payments.

3.14 Some progress has been made. DFID has helped to shift policy discussions from short-term, ad-hoc approaches towards providing predictable transfers to the long-term poor and vulnerable. It has contributed to an evidence base for interventions to inform the policy formulation and programming, and the Ministry of Economic Planning and Development has produced a draft policy with DFID support[54], although it has not been approved yet by the Government of Malawi's Cabinet.

3.15 But progress on a national programme has been slower than planned. There is still a lack of consensus on what mix of instruments is appropriate and affordable in Malawi. Disagreements between donors, in particular between DFID and UNICEF, on which instruments are most appropriate, have meant that donors have not promoted a consistent message to Government. The Government also has concerns about affordability.

Appendix One

Methodology

Our approach was designed to determine whether DFID has achieved what it set out to in Malawi since 2003. We focused on Health and Food Security, where DFID Malawi has been particularly active. The methods we used included:

Selected method	Purpose
1 Reviewing documentation on some 30 DFID projects, and on the development strategies of DFID and the Government of Malawi	To evaluate progress against plans
2 Evaluating statistical, financial and economic data	To determine levels of investment and progress made
3 Interviewing senior officials in Government ministries and agencies in Malawi, and representatives of NGOs, Civil Society Organisations and other donors	To gather views of development progress and DFID's performance
4 Qualitative research (semi-structured interviews and focus group discussions) by consultants with beneficiaries, district officials and local service providers	To gather views on progress in health, agriculture and social protection
5 Online survey of current and former DFID Malawi staff	To gather views of operations and performance of DFID Malawi
6 Survey of volunteers working in Malawi through Voluntary Service Oversees (VSO), in Health, Education and Agriculture	To gather views of development progress
7 Meeting DFID Malawi staff	To follow up issues raised by our other work

A more detailed description of our methodology can be found at: www.nao.org.uk

Appendix Two

Progress towards development goals in Malawi

	MDG 1: Eradicate extreme poverty and hunger		MDG 2: Achieve universal primary education	
Millennium Development Goal Indicator	**Population below the national poverty line (%) (See Paragraph 1.1) (1991 – 54%)**	**Underweight children (%) (1992 – 27%)**	**Primary school enrolment (%)**	**Primary school completion (%)**
1998	54	–	–	–
1999	–	–	99	67
2000	–	25	–	66
2001	–	–	–	66
2002	–	22	–	68
2003	–	–	–	–
2004	52	22	95	57
2005	50	–	93	56
2006	45	19	92	55
2007	40	–	–	–
Internationally set 2015 MDG target applied to Malawi data	27	14	100	100

Key to progress[1]: On track Off-track Seriously off-track

Sources: UN Statistics Division, UNAIDS, World Bank (WDI), UNICEF, Malawian official surveys

NOTE

1 Traffic light assessment has been applied using DFID's methodology for monitoring its Public Service Agreement and does not necessarily represent the views of the Government of Malawi. Different data to that used by DFID in these assessments has been used in some cases on the advice of DFID Malawi staff that it better reflects progress. This affects the assessments for the sanitation and national poverty line targets.

MDG 3: Promote gender equality and empower women		MDG 4: Reduce child mortality		MDG 5: Improve maternal health	
Gender parity at primary school (ratio of girls to boys)	**Gender parity at secondary school (ratio of girls to boys)**	**Under five mortality rate (probability of dying (per 1000) under age five years) (1990 – 221)**	**Immunisation against measles (%) (1990 – 81%)**	**Maternal Mortality Ratio (1992 – 620)**	**Births attended by skilled midwives (%) (1992 – 55%)**
–	–	–	90	–	–
0.96	0.70	–	83	–	–
0.96	0.75	155	73	1120	56
0.97	0.77	–	82	–	–
0.97	0.78	–	69	–	61
–	–	–	77	–	–
1.03	0.81	–	80	980	56
1.03	0.82	125	82	–	–
1.04	0.84	120	85	810	54
–	–	–	–	–	–
1.00	1.00	74	Increase	155	Increase

	MDG 6: Combat HIV/AIDS, Malaria and other diseases		
Millennium Development Goal Indicator *continued*	**HIV prevalence among population aged between 15-49 (%) (1990 – 2%)**	**Under 5s sleeping under insecticide treated nets (to combat malaria) (%)**	**TB deaths per year per 100,000 population (1990 – 75)**
1998	14	–	121
1999	14	–	120
2000	14	3	127
2001	13	–	118
2002	13	–	124
2003	13	–	119
2004	13	15	116
2005	12	–	115
2006	12	23	111
2007	12	–	–
Internationally set 2015 MDG target	● Decrease	○ Increase	● Decrease

MDG 7: Ensure environmental sustainability

Land covered by forest (%) (1990 – 41%)	Proportion of population without access to improved water sources (%) (1990 – 59%)	Population without access to improved sanitation (%) (1990 – 54%)
–	–	–
–	–	–
38		
–	–	–
–	–	–
–	–	–
–	–	–
36	–	–
–		
28	35	51
Increase	30	27

Endnotes

1 Our examination covers the period since DFID's previous Assistance Plan for Malawi in 2003.

2 Integrated Household Surveys in 1998 and 2004.

3 Welfare Monitoring Surveys in 2005, 2006 and 2007. A new Integrated Household Survey in 2009 should clarify the extent of progress.

4 In addition to what it spent though its country programme in Malawi, DFID spent £75 million between 2003-04–2007-08 through its funding to multilateral organisations that operate in Malawi, as well as funding projects and programmes in Malawi directly.

5 Pro rata allocations of budget support are allocated in proportion to shares of these sectors in the Government of Malawi's budget.

6 The Government of Malawi's Growth and Development Strategy (2006-2011) focuses on six areas it considers critical for achieving the country's medium term development and poverty reduction objectives (agriculture, irrigation and water, transport and infrastructure, energy, integrated rural development, HIV/AIDS and nutrition), and four cross-cutting themes (good governance, social development, disaster risk management, sustainable economic growth).

7 ODI (2006) Drivers of Change and Development in Malawi.

8 The Paris Declaration is an international agreement to which DFID committed itself to increase efforts to improve the effectiveness of aid.

9 OECD 2008 Survey on Monitoring the Paris Declaration http://www.oecd.org/department/0,3355,en_2649_15577209_1_1_1_1_1,00.html

10 NAO survey of DFID Malawi staff, conducted in December 2008.

11 Commonwealth Observer Group (2009) Report on Malawi Parliamentary and Presidential Elections http://www.mec.org.mw/Elections/2009ResultsReports/tabid/98/Default.aspx

12 Some cases have yielded substantial recoveries. For example, the Bureau claims to have facilitated a £2.9 million recovery in 2006 by the UK authorities of money laundering proceeds arising from drug trafficking.

13 One post in the DFID Governance team has been cut, one post responsible for climate change was left vacant, and DFID Malawi has now recruited a Joint Climate Change Adviser with Norway and Ireland. Another post responsible for gender matters is being filled by reallocating duties amongst other staff and cooperation with other donors. A post in DFID Malawi's Corporate Services Team was also cut.

14 Global Fund to fight HIV TB and Malaria Round 5: Health System Strengthening. In 2006 Malawi was one of only three countries to bid successfully for funds from the Global Fund for strengthening the country's underlying health system. The others were Cambodia and Rwanda. The Global Fund usually supports programmes for specific diseases rather than strengthening the underlying health system. Support from DFID and other bilateral donors from 2004 towards strengthening Malawi's health system was important in unlocking the Global Fund contribution.

15 Progress data is not currently complete. The key four-yearly Demographic Health Survey for Malawi last took place in 2004, and the next takes place in 2009. Similarly, a survey for prevalence of Tuberculosis has not taken place over the period, due to the need to gear up for a more sophisticated test which tests for the incidence of TB alongside HIV/AIDS, these conditions being increasingly co-incident.

16 Data drawn from the Multiple Indicator Cluster Survey. Results differ from annual Ministry of Health data. Conclusive results from Malawi's Demographic Health Survey will be available in 2010.

17 Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

18 A review in 2007 identified the need for a further 45 per cent increase in the number of posts. So reported vacancy rates are higher than those reported in 2004.

19 The 2:2:1 complement of 2 nurses, 2 health assistants and 1 clinician, which Malawi aspires to. The proportion of centres staffed at this level has increased from 6 per cent in 2004 to 13 per cent.

20 CHAM is an ecumenical, not for profit non-governmental umbrella organisation of Christian owned health facilities. It estimates that it provides some 37 per cent of health services in Malawi.

21 Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

22 Sourced to the latest National Health Accounts available, cited in the Health SWAp mid-term review.

23 The EHP was funded at this level because of limits in donors' resources and because of concerns that the country lacked the capacity to rapidly assimilate full funding.

24 Sources include a report by the Overseas Development Institute and WaterAid: Implementation of Water Supply & Sanitation Programmes in Malawi, Uganda, Tanzania and Zambia (2004).

25 Government of Malawi.

26 Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

27 Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

28 Independent Review of Malawi's national response to HIV and AIDS 2007-08 December 2008, ITAD. DFID advised us in July 2009 that the Board of the Commission had adopted the draft prevention strategy.

29 DFID contributions of up to £1million a year from 2003-2007 were key to building capacity in the National AIDS Commission. The Commission's stated role is to prevent the spread of HIV infection, provide access to treatment, and mitigate the impacts of HIV and AIDS on individuals, families, communities and the nation.

30 Disbursement of grants for prevention by the NAC were US$140,000 in 2007-08. Treatment programmes themselves incorporate prevention – for example, education to prevent onward transmission.

31 Paper by D Mueller et al (2008) Constraints to the EHP. London School of Hygiene and Tropical Medicine and the Malawi Ministry of Health and Population.

32 The 2008 re-costing of the Health SWAp showed that the salary uplift was applied to administrators, tradesmen, clerical staff, some catering and laundry staff, and most staff of the Ministry of Health; the main exceptions being messengers, labourers, drivers and security guards. Conversely, Health Surveillance Assistants do not receive the uplift.

33 A survey in 2007-08 in three districts found average absences of between 3 and 5 working days per month for nurses, clinical officers and assistants with "training" the predominant factor.

34 NAO survey of VSO volunteers working in Malawi, conducted in January 2009.

35 Local opinion surveys and Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

36 Mangham and Castro-Leal, F Dayton J, Demery, L Mehra K. (2006) Public Spending on health care in Africa: Do the poor benefit?

37 D Mueller et al (2008) Constraints to the EHP.

38 Service Delivery Satisfaction Survey by the Civil Society Organisation 'Malawi Economic Justice Network' 2007.

39 Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

40 Specifically a procurement oversight function, a condition of donor support, was withdrawn by the World Bank in September 2008, and alternative arrangements had to be set in place. DFID has contributed to resolving this difficulty by providing an interim oversight agent with effect from March 2009.

41 Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

42 Health SWAp mid term review 2008.

43 Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

44 Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

45 Welfare Monitoring Survey 2007.

46 Integrated Household Survey 2004.

47 Multiple Indicator Cluster Survey 1995 and Welfare Monitoring Survey 2007.

48 Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

49 School of Oriental and African Studies (SOAS), Wadonda Consult, Michigan State University (MSU), Overseas Development Institute (ODI) (2008) Evaluation of the 2006-07 Agricultural Input Subsidy Programme, Malawi: Final Report.

50 Dorward and Chirwa (2009) The Agricultural Input Subsidy Programme 2005 to 2008: Achievements and Challenges.

51 Qualitative Research by ITAD/Kadale for the National Audit Office (2009) and monitoring by civil society organisations.

52 Qualitative Research by ITAD/Kadale for the National Audit Office (2009).

53 African Development Bank (AFDB), Department for International Development (DFID), European Commission, Norway, World Bank (2009) Common Approach to Budget Support (CABS) March 2009 Review Aide Memoire.

54 This support has included DFID staff participating on Government 'social protection' committees, as well as DFID funding experts to work within the Government.