



Expanding the health budget through sector collaboration

Kenya



Expanding the health budget through sector collaboration

Malawi

Malawi's exemplar focuses on a multi-stakeholder dialogue process on domestic resource mobilization that helped drive a major increase in the health budget despite severe macroeconomic shocks. The analysis looks at how that process worked, what it produced, and what it may offer to other countries trying to expand fiscal space for health under difficult conditions.

Core exemplar

A multi-stakeholder dialogue process for domestic resource mobilization that helped Malawi substantially increase the health budget despite debt stress, aid volatility, inflation, and currency shocks.

Why it matters for ALM: It shows how dialogue, evidence, parliamentary engagement, and sustained Treasury–Ministry of Health coordination can unlock domestic financing and strengthen accountability under severe fiscal pressure.

Primary ALM contribution: More money for health, supported by stronger governance and accountability.

Replicability potential: High for fiscally constrained countries seeking to improve domestic resource mobilization through structured political and technical dialogue.

1. Context: Fiscal Pressure and the Push for Domestic Health Financing

Malawi's health financing reform emerged from a severe fiscal squeeze. For years, the country spent only about USD 9.9 per person on health, roughly 90% below the WHO reference level of USD 86, while donors financed 54.5% of total health expenditure. That dependence became even riskier during COVID-19 and the broader economic slowdown that followed. Political commitment, signaled through presidential support for the ALM Declaration, created an opening for reform, but the barriers were substantial: Malawi lacked a national health financing strategy, data were fragmented, ministries largely worked in silos, and parliamentary understanding of health financing remained limited. A further complication was that more than 70% of donor funding flowed off budget through NGOs and implementing partners rather than through the central treasury. Ministry of Health resource-mapping identified at least 166 financing sources and 265 implementing partners, creating duplication, limiting visibility over total spending, and making coordinated decision-making far harder. In response, Malawi convened a national health-financing dialogue in October 2022, building on earlier strategy review and landscape analysis and then linking that dialogue to implementation support.

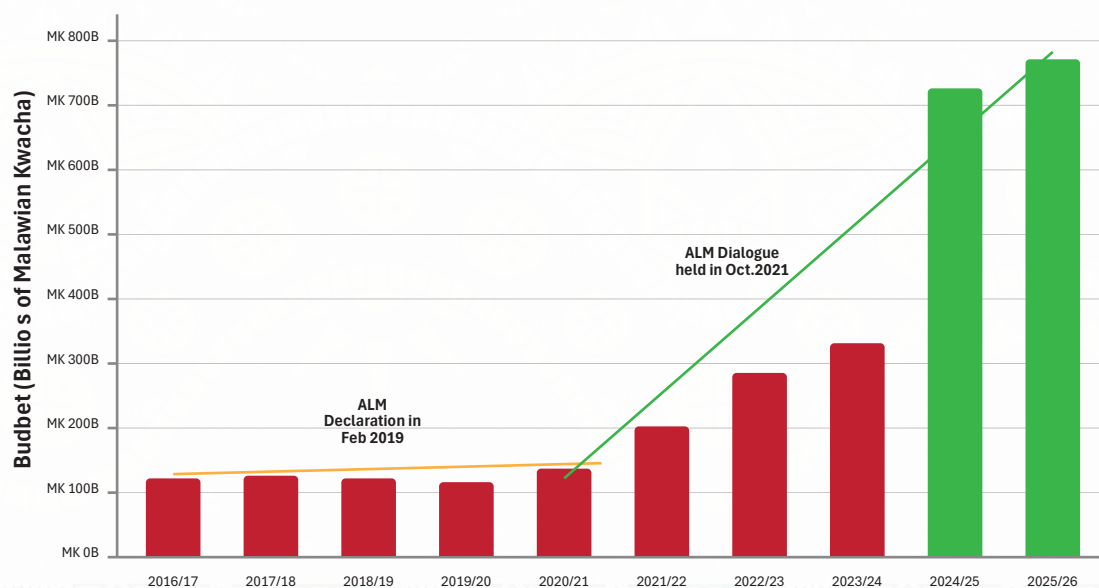
2. Mechanism: Multi-Stakeholder Dialogue and Treasury–Health Coordination

To close this gap, Malawi adopted an integrated, sequenced multi-stakeholder approach. It began with a locally led Landscape Scoping Review that produced credible evidence and helped define the reform agenda. Civil society engagement came early and focused on building parliamentary understanding of health financing while aligning advocacy positions. That groundwork made it possible to hold a unified national dialogue, facilitated with support from SADC and the African Union, that brought together ministries, parliament, the private sector, media, and partners including UNAIDS, the Gates Foundation, and the Global Fund. The outcomes were then translated into action through a Technical Assistance Plan aligned to budget cycles and through monthly Treasury–Ministry of Health working groups that helped institutionalize coordination.

This approach delivered measurable results. Domestic health allocations increased and parliamentary engagement changed in substance. Parliament shifted from being a largely passive observer to becoming an active champion of reform, issuing formal commitments that helped lead to the Health Financing Act of 2023, which established frameworks for national health insurance, sin taxes, and public-private partnerships.

Malawi Health Sector Annual Budget

Tracking the financial evolution from 2016 to 2026 (Figures in Billions of Malawian Kwacha)



That legislative progress was reinforced by the launch of a National Health Financing Strategy and Health Sector Strategic Plan III in January 2023, which helped align stakeholders around a shared UHC agenda. The improved investment climate also helped attract private co-investment, including support for the construction and 2025 presidential inauguration of Malawi's first cancer treatment facility, backed by government offtake guarantees. After the political transition in 2024, the new administration folded these financing mechanisms into its decentralization agenda with support from civil society and SADC technical assistance. Today, civil society networks and parliamentary health committees serve as standing accountability actors, publicly tracking implementation of the Technical Assistance Plan year by year. A central reason the budget increase held was sustained collaboration between the Treasury and the Ministry of Health. The model has since been replicated in 11 SADC and EAC countries.

Critical success factors included: (1) credible locally generated evidence produced before the dialogue; (2) early engagement of parliamentary committees so legislators had real ownership of the reform; (3) visible executive leadership at ministerial and presidential level to create fiscal and political space; (4) independent media acting as a public accountability channel; (5) a technically sound roadmap linked to actual budget cycles through the Technical Assistance Plan; and (6) sustained Treasury–Ministry of Health coordination, reinforced by active civil society and parliamentary oversight. In short, the dialogue worked because it combined political authority with a practical implementation plan rather than ending in declarations alone.

3. Outcomes: Increased Health Budgets

The ALM-linked multi-stakeholder process produced visible system-level results. Total Health Expenditure (in MK) terms grew 9.9-fold from MK 518B (2019/20) to MK 5,120B (2025/26). Most notably, the government’s nominal domestic allocation grew 6.7- fold (from MK 114B to MK 768B).

The significance of that increase became clearest when external budgets were disrupted in 2024–2025: Malawi still had enough political and institutional coordination to regroup and mobilize additional domestic financing while other countries were declaring health-financing emergencies.

The 2025/26 mid-year budget review allocated an additional MK 17.1 billion (MK 8.6 B for central hospitals, MK 8.5 B for district hospitals) specifically to address pharmaceutical shortages and introduced a 2 % motor vehicle insurance levy ring-fenced for the Ministry of Health.

However, Malawi remains very dependent on external support: Domestic health expenditures shrunk proportionally to other sources: from 22% (2019/20) to 15% (2025/26). The Global Fund allocations rose exponentially making it the single largest funder of Malawi health in absolute Kwacha terms — mainly due to recent depreciation of the Kwacha against figures already agreed in 2022. US contribution rose continuously, with an unusual hike in 2024/2025. USA’s January 2025 freeze halved the US share, representing a loss of MK 638B ($\approx$ USD 365M). The World Bank contributions rose, too, reflecting the GFF Investment Case operationalization and IDA20 WHR allocations. This dramatic expansion of donor contributions is primarily driven by exchange-rate depreciation inflating the MK equivalent of dollar-denominated donor flows, not by real resource growth.

Malawi: Disaggregated Health Financing Sources in Absolute Kwacha (2019/20–2025/26)
Grouped bars show each funding source in MK Billions; black line = Total Health Expenditure

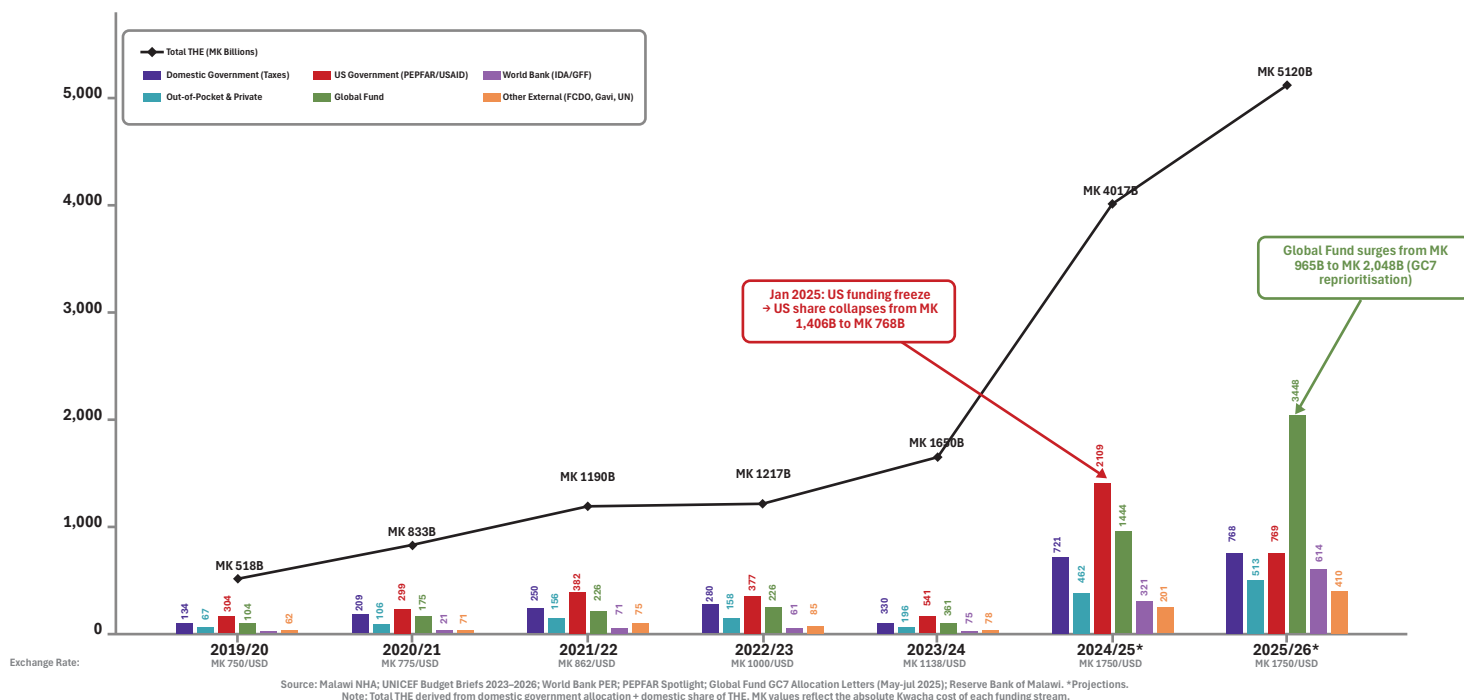
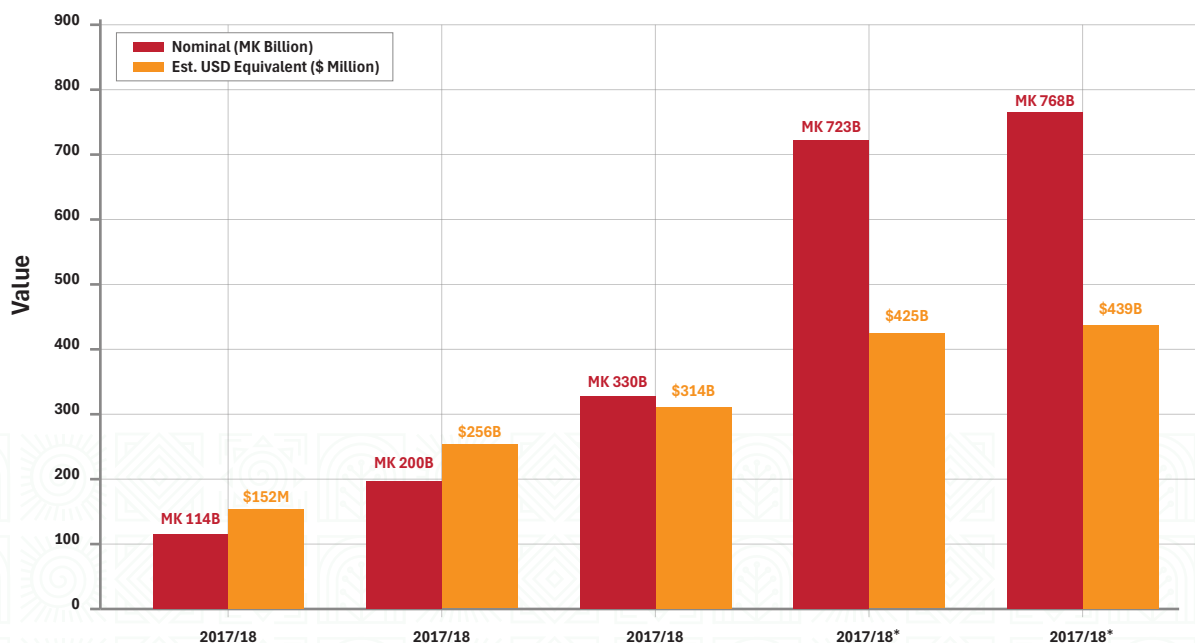


Figure MW-1. Malawi: Disaggregated health financing sources in absolute Malawi Kwacha (MK billions), 2019/20–2025/26. Each coloured bar represents one funding source. The black diamond line traces Total Health Expenditure. The US share (red) collapses from MK 1,406B (2024/25) to MK 768B (2025/26) after the January 2025 foreign-aid freeze, while the Global Fund share (green) surges from MK 964B to MK 2,048B under GC7 reprioritisation. Exchange rates shown below each year.

Health Budget in MK Billions vs. Estimated USD Equivalent



Note: MWK/USD exchange rate deteriorated from ~750 (2019) to ~1,750 (2025). Imported medicines priced in USD means the ministry is purchasing fewer drugs today than in 2019 despite a 6x nominal increase

Figure MW-2. Malawi: MK Billions vs USD Purchasing Power (2019/20–2025/26). Nominal MK growth (left panel) of 6.7x is striking, but Kwacha devaluation from ~750 to ~1,750 MWK/USD reduces real USD purchasing power growth to only 2.9x. Since medicines and medical supplies (16 % of domestic health spend) are overwhelmingly imported, the practical effect is that the Ministry of Health purchases fewer drugs today than in 2019 — exacerbating the chronic stockouts that force out-of-pocket purchases from private pharmacies.

4. Proof of resilience: PEPFAR Freeze + Global Fund GC7 Reprioritization

The January 2025 US foreign-aid freeze suspended an estimated USD 178 million in annual PEPFAR allocations to Malawi (PEPFAR 2024: USD 180 M; 2025: USD 178 M), and by August 2025, 65 % of USAID's PEPFAR awards globally had been terminated, with Malawi among the hardest-hit countries — terminated awards accounted for 25–50 % of planned PEPFAR resources. Specifically affected in Malawi: HIV prevention education, VMMC, community-based outreach, drop-in centres for key populations, and the entire DREAMS programme were suspended or halted. The Global Fund in May–June 2025 simultaneously communicated reduced GC7 allocation envelopes to all recipient countries, before the USG signed an agreement for support in 2026.

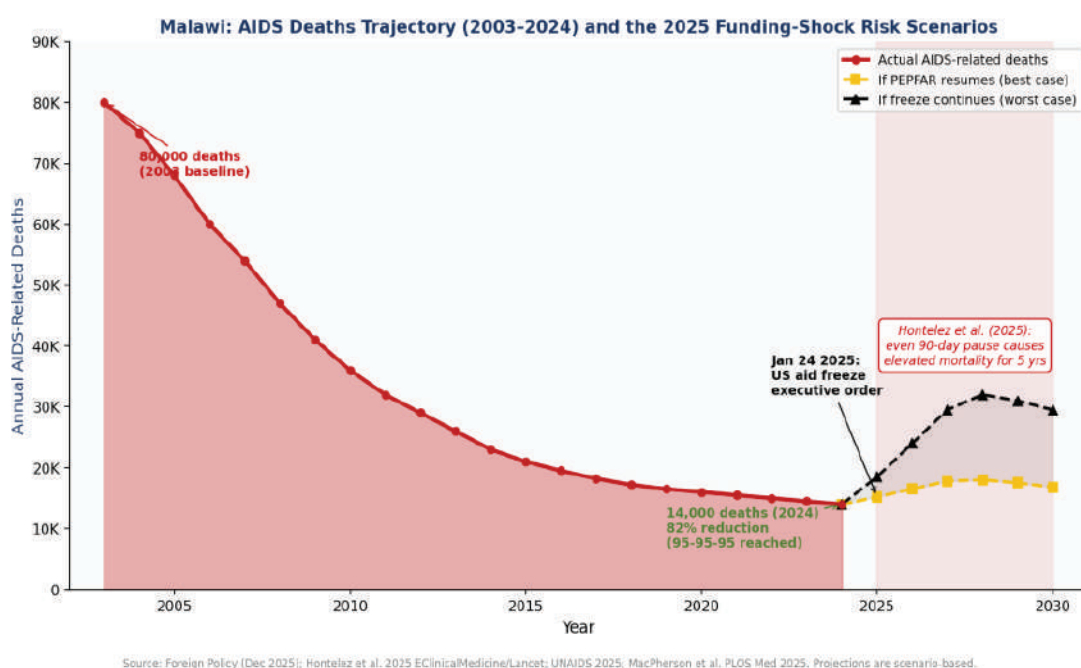


Figure MW-3. Malawi: AIDS-Related Deaths (2003–2024) and 2025 Funding-Shock Risk Scenarios. Under PEPFAR support, annual AIDS deaths fell from 80,000 in 2003 to 14,000 in 2024 — an 82 % reduction and the achievement of UNAIDS 95-95-95 targets a year ahead of schedule. The January 2025 US foreign-aid freeze puts this trajectory at risk: the optimistic scenario (PEPFAR resumes) projects deaths stabilizing in the 15–18K range; the pessimistic scenario (freeze continues) projects a return toward 30K deaths annually by 2028.

PEPFAR funded the supply-chain logistics and health workforce that delivered the drugs; the Global Fund financed the drugs themselves (an estimated 40 % of Global Fund allocations, and up to 90 % for some grants, are used to purchase health commodities, the vast majority of which are manufactured outside the African continent). Without both, Malawi would have to reallocate budgets from other sectors to forestall running out of life-saving chemical compounds. Mathematical modelling by Hontelez et al. (2025, EClinicalMedicine/Lancet) predicted that even a 90-day pause followed by full resumption would cause elevated mortality and incidence for up to five years. The Thanzi La Onse whole-health-systems model (MacPherson et al., PLOS Medicine 2025) projects a 7–16 % increase in DALYs across all likely DAH funding scenarios.

Mitigating Debt and Aid Freeze Vulnerabilities

Malawi faces a sovereign-debt trap that makes the 2025 US funding freeze an unmitigable disaster within the current macroeconomic framework, not merely a budget hurdle. With debt servicing consuming over 50 % of domestic revenue and public debt at 63 % of GDP (nearly double the IMF's 35 % threshold, with external debt at 131 % of exports against a 30 % limit), the government is structurally blocked from replacing the USD 178 M in frozen PEPFAR funds. Simultaneously, the Global Fund contracted GC7 allocations, meaning the institution expected to absorb the US withdrawal was shrinking. The MK 17.1 billion (~USD 9.8 M) allocated in the 2025/26 mid-year review for pharmaceutical shortages is roughly 1/18th of what PEPFAR alone was providing annually. Malawi's 6× nominal budget growth masks a real-terms contraction in pharmaceutical purchasing power due to Kwacha devaluation. Despite all these, Malawi has been able to increase both the nominal and real health budget and weather the storm. It is likely that without the multisectoral dialogue Malawi would not have weathered this storm well.

5. Malawi on the ALM Scorecard

Malawi's scorecard shows very strong overall performance, with nine commitments rated On Track and one rated Partial. The strongest ratings reflect the country's multi-stakeholder dialogue model, its accountability architecture, and its effective use of AU and regional platforms to drive reform. The only Partial rating relates to PMPA harmonization, where progress remains constrained by limited manufacturing and regulatory capacity rather than weak political commitment. The 2025 double shock of the US aid freeze and Global Fund contraction both validated the value of Malawi's collaboration model and exposed the need for stronger regional pharmaceutical resilience.

ALM Scorecard Heat-Map	
Country	Malawi
1. Political Agenda	Green
2. Leverage Partners	Green
3. Domestic Mobilization	Green
4. Private Sector	Green
5. PMPA Harmonization	Amber
6. Operational Undertakings	Green
7. Monitoring & Reporting	Green
8. Accountability Framework	Green
9. Hosting Role	Green
10. Leveraging AU Support	Green

Legend:

- Green = On Track
- Amber = Partial
- Red = Off Track

6. Key Lessons and Policy Implications

- Start with evidence. In Malawi, the Landscape Scoping Review helped legitimize the reform agenda and reduced the perception that the process was being driven from outside. Countries trying to replicate this model should invest in credible evidence before convening high-level dialogue.
- Use civil society as a bridge, not only as an advocate. By helping parliamentary committees understand health budgets and reform options early, CSOs turned lawmakers from possible critics into informed co-owners of the process. That sequencing is highly replicable.
- Ministerial engagement matters. Technical working groups alone rarely create fiscal space. Direct engagement among the ministers of Finance, Health, and Local Government was critical, and making those commitments public raised the political cost of inaction.
- Treat the Technical Assistance Plan as the bridge from dialogue to delivery. In Malawi, the TAP linked legislative drafting to realistic timelines and to the Medium-Term Expenditure Framework, which helped move the process beyond a communiqué and into actual implementation.
- Institutionalized Treasury–Ministry of Health coordination made the difference. The budget gains held because collaboration became routine and survived the change in administration. For countries where finance and health still operate in silos, this is one of Malawi’s most practical lessons.
- Dialogue still has limits. Malawi’s case shows that even strong multi-stakeholder mobilization cannot fully offset sovereign debt burdens that consume more than half of domestic revenue. Domestic resource mobilization needs to be paired with debt-relief and debt-restructuring advocacy, where the AU and regional bodies may have a unique role.

Editorial Oversight: Caroline Kwamboka N.

Technical review: Matthias Brucker

Technical writer: Chris Alando

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ALM score card sources: Malawi (9/10 On Track, 1 Partial)

C1: Political agenda — On Track Indicators: Presidential ALM endorsement; Health Financing Act 2023; Presidential leadership, PP and inauguration of cancer facility 2024; MOH, MOF, Ministry of Local Government, donors and non state actors represented in national health financing working group at PS and director level; Presidency leading Decentralization Process Sources: Health Financing Act 2023 (malawilii.org); Govt press releases, National Scoping Report; OP, Globesolute HREP (2026) Decentralization Strategy for Malawi;

C2: Leverage partners — On Track Indicators: SADC+AU+GF+Gates+UNAIDS dialogue; IDA \$2.5 Billion USD (2025); 2025 PEPFAR+GC7 double shock Sources: CGD USAID disruption analysis (cgdev.org), National Dialogue Report, Budget Report, Malawi NHA, Global Fund Annual Reports

C3: Domestic mobilization — On Track Indicators: Increase in Domestic Budget; Scoping Study; Passage of Sin Taxes; Regulations on Health Insurance; Engagement in Debt to Health Swaps Sources: UNICEF Budget Briefs 2024-26 (unicef.org/ Malawi); MoF Mid-Year Review (finance.gov.mw); National Health Financing Dialogue Report 2022; Technical Assistance Plan for Implementation; HREP Engagement with Parliament 2025

C4: Private sector — On Track Indicators: Private Sector Health Financing Commitments at dialogue implemented; Banking sector supporting health (FDH); Reserve Bank of Malawi; PPP law revamped; Cancer treatment facility PPP with offtake guarantee completed; HFA 2023 PPP framework; private insurance <2% Sources: Health Financing Act 2023; PPP Framework; Technical Assistance Plan; Health Financing Strategy

C5: PMPA — Partial Indicators: Domesticated PMPA objectives; Planned for domestic pharma manufacturing; near-total import dependence; PMRA limited; MK 750→1,750/USD Sources: McAuslane, N., Bujar, M., Sithole, T., Ngum, N., Owusu-Asante, M., & Walker, S. (2023). Evaluation of Risk-Based Approaches to the Registration of Medicines: Current Status Among African Regulatory Authorities. *Pharmaceutical Medicine*, 37, 251–260. <https://doi.org/10.1007/s40290-023-00472-0>; Ncube, B. M., Dube, A., & Ward, K. (2023). The domestication of the African Union model law on medical products regulation: Perceived benefits, enabling factors, and challenges. *Frontiers in Medicine*, 10. <https://doi.org/10.3389/fmed.2023.1117439>

C6: Operational — On Track Indicators: NHFS Jan 2023, Operational Plan 2023; HSSP III; HFA 2023 NHI+sin taxes+PPPs (not operational); Treasury-MOH joint working groups Sources: HSSP III (moh.gov.mw); NHFS Jan 2023 launch documentation; National Health Financing Dialogue Technical Assistance Plan.

C7: Monitoring — On Track Indicators: M&E Plan for health financing has domesticated AU ALM Tracker; NHA since 2011; Tracker and Scorecard since 2023; UNICEF Budget Briefs; WB PER; 166+ financing sources mapped; 70%+ off-budget Sources: UNICEF Health Budget Briefs; Yoon et al. (2021) PMC10803193; NHFS M&E Plan 2023

C8: Accountability — On Track Indicators: CSOs as political brokers; parliamentary health committees permanent; media watchdog; model replicated 11 countries Sources: Health Policy Watch ALM Feb 2026 article;

C9: Hosting role — On Track Indicators: Hosted Africa's first National Health Financing Dialogue under ALM 2022, GF Board Meeting 2024, Private sector meetings; Co-facilitated in South Africa Regional Dialogues; Shared at Mauritius and Namibia Dialogues, Dialogue model replicated across 11 SADC/EAC countries; not ALM-branded host but methodological template Sources: SADC RHFH replication records; Global Fund annual reports on health financing 2024 and 2025; AU Briefing to Heads of State (2025)

C10: Leveraging AU — On Track Indicators: SADC+AU+GF+Gates+UNAIDS single coordinated process; AU TA for IMF/WB debt engagement; SADC TA from 2022-2024; Sources: AUDA-NEPAD engagement reports; SADC RHFH; Global Fund ESA Domestic Financing Annual Report; Health Policy Watch

African Renaissance Trust

2nd Floor, Jumuia Place 1, Lenana Road
P.O. BOX 18332 Nairobi, Kenya 00100 GPO
dialogue@the-african-renaissance.org
www.the-african-renaissance.org